Health Policy Report

MEDICAID

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WHEN Medicaid was enacted in 1965 as a legislative afterthought to Medicare, few would have predicted its evolution into a basic component of the American health care system. In this report, I examine Medicaid, which has become one of the most complex social-welfare programs, and consider prospects for its reform.

OVERVIEW OF THE PROGRAM

Medicaid, codified under Title XIX of the Social Security Act, provides federal financial assistance to states operating approved medical-assistance plans. Unlike eligibility for Medicare, eligibility for Medicaid is means-tested (i.e., there are financial criteria for enrollment); like Medicare, however, Medicaid is an individual legal entitlement.[1,2] In 1999, Medicaid payments accounted for more than 15 percent of national health care expenditures.[3]

In 1998, 1 of every 10 people under the age of 65 years was insured through Medicaid,[4] and the program covered a total of 40.4 million persons, including nearly 30 million pregnant women, parents under the age of 65 years, and children, as well as more than 11 million persons with disabilities and elderly persons who had low incomes or who were impoverished because of medical expenses.[5] The program's impact in certain sectors of the health care system has been enormous: in 1998, Medicaid paid the costs of one third of all births in the United States, nearly half of all nursing home care, and health care for 25 percent of children under the age of five years.[5] Medicaid is the single largest source of financial support for essential community health services. It covers over 45 percent of inpatients in public hospitals and more than a third of patients who obtain care at federally funded community health centers.[6]

Although it operates as a single program, Medicaid is actually an agglomeration of programs spanning the full spectrum of health care. Over the years, Medicaid has served as the legislative vehicle for an extraordinary range of reforms (Table 1). Because of the persons it covers and the services it pays for, Medicaid has also become the central source of health care financing for persons with human immunodeficiency virus (HIV) infection or full-blown AIDS.[17]

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Federal financing of state Medicaid plans is open-ended. Each participating state is entitled to payments up to a federally approved percentage of state expenditures, and there is no limit on total payments to any state. Payments are calculated according to a federal formula linked to state revenue and range from 50 percent to over 80 percent of approved state medical expenditures.[18] With federal contributions limited only by the size of state programs, Medicaid encourages its own growth and expansion.

In fiscal year 2000, state and federal Medicaid outlays totaled $207 billion — $10 billion more than total Medicare expenditures.[19] As with other health care programs, Medicaid's annual rates of growth have historically exceeded those for nonmedical goods and services. In February 2001, before the recession and the catastrophic events of September 11, it was estimated that the average annual rate of growth over the next decade would be between 8 percent and 9 percent.[19]

STATE FLEXIBILITY AND FEDERAL REQUIREMENTS

Because Medicaid is designed to help the states finance their health care initiatives, the states have considerable discretion with respect to the criteria for eligibility, the services covered, and program administration. In 2000, Medicaid accounted for 50 percent of total state health care expenditures.[20] However, approximately one third of total Medicaid expenditures and 79 percent of all expenditures for long-term care are attributable to state choices rather than federal requirements.[21]

Medicaid is both an entitlement program and a conduit for transferring an enormous amount of federal revenue to state budgets. Consequently, federal law prescribes certain standards for state Medicaid plans. Because Medicaid is an entitlement program, persons wishing to apply for assistance must be allowed to do so without delay and must receive prompt medical assistance once their eligibility has been confirmed.[9] States may not set an upper limit for enrollment, arbitrarily restrict program expenditures under their approved plans, or unreasonably delay the provision of assistance.[22] Since financing is open-ended, during economic downturns enrollment can grow in proportion to need, as persons lose their jobs and thus lose health insurance provided by their employers. The surge in Medicaid enrollment in New York City after the events of September 11 illustrates the program's ability to respond to sudden, unanticipated needs on a large scale.[23] States may reduce their Medicaid expenditures only by formally revising their programs to scale back eligibility, benefits, payments to providers, or other features of their plans.

The eligibility standards for Medicaid, which are

TABLE 1. SELECTED REFORMS INTRODUCED THROUGH THE MEDICAID PROGRAM.

Insurance coverage for low-income, uninsured pregnant women and low-income children[7]
Support for the deinstitutionalization of persons with physical and mental disabilities through community-based, long-term care[8,9]
Insurance coverage for persons moving from welfare to work and their families, for low-income workers without access to coverage provided by an employer, and for the families of such workers[7]
Insurance coverage for persons with disabilities who are able to work if they have adequate medical support[10]
Supplemental insurance coverage for low-income Medicare beneficiaries[11]
A national vaccine-purchasing system to ensure adequate vaccine coverage for low-income, publicly insured or uninsured children[12]
Treatment of tuberculosis[13]
Establishment of managed-care systems for beneficiaries with both basic and complex physical and mental health care needs[14]
Support of institutions participating in the "health care safety net" through special compensation arrangements[15]
Insurance coverage for uninsured women with diagnosed cervical or breast cancer[16]

legendary in their complexity, are an outgrowth of federal cash welfare programs. There are two basic criteria for eligibility: financial need (as evidenced by low income or impoverishment due to high medical bills) and a federally recognized eligibility category (e.g., a household with dependent children, an age of 65 years or older, and disability). Both criteria must be met for enrollment.

According to federal law, participating states must provide Medicaid coverage for certain groups of persons, with the option to extend coverage to dozens of other groups.[24] The mandatory groups are families that qualify for cash welfare programs for families with dependent children; families in which a parent is making the transition from welfare to work; low-income pregnant women and low-income children (defined as persons under 19 years of age); persons who are elderly or disabled, as defined under the Social Security Act, and who qualify for cash benefits under the Supplemental Security Income program; and certain other low-income Medicare beneficiaries. In the case of pregnant women, children, and Medicare beneficiaries, the definition of low income is tied to the federal poverty level, which in 2001 was an annual income of $8,590 for a single person and $14,630 for a family of three.[25] For families with children whose eligibility is based on their qualification for welfare programs, the states may establish the financial criteria for Medicaid eligibility, and in many states the criteria are extremely restrictive. In 1999, for example, parents who had dependent children and who worked full time at the minimum wage were eligible for Medicaid in only 19 states and the District of Columbia.[4]

The most controversial aspects of Medicaid are evident in the area of coverage. Medicaid resembles insurance in its coverage of defined classes of medical benefits. Because of the groups it covers and the services it pays for, however, the Medicaid program requires that state plans provide much more extensive coverage than that provided by private insurance plans, prohibits nearly all cost sharing by patients, and applies these requirements to virtually all beneficiaries, regardless of their age or status with respect to disability.

Just as federal law mandates coverage of certain groups of people, it establishes the level of coverage that must be provided for all beneficiaries, as well as the exclusions and limitations that can be imposed — two areas in which private insurance plans have nearly total discretion.[26,27] Common restrictions in the coverage provided by private insurance plans, such as the exclusion of coverage for preexisting conditions and a required waiting period for coverage, are prohibited, and the limits on coverage must meet specific criteria for reasonableness. In addition, all federally recognized classes of benefits, whether or not they are provided to adults, must be furnished to children (defined as persons under 21 years of age). The adequacy of coverage for children is determined by tests of reasonableness that emphasize growth, development, and the prevention of disability rather than simply the treatment of illness or injury.[28]

Federal law prohibits arbitrary exclusions and limitations that are based on a diagnosis, such as limits on outpatient and inpatient services for the treatment of mental illness or AIDS, whereas private insurers often single out certain conditions for limitations and exclusions.[26,27] Because Medicaid assists so many persons with serious illnesses and disabilities, discrimination in coverage based on the ability to recover from an illness or injury is prohibited; unlike private insurers, state Medicaid plans cannot stop providing coverage simply because "significant improvement" is not possible.[26,27] In short, whereas private insurers structure their coverage to limit or prevent financial risk, the states are not allowed to do so. Thus, Medicaid is technically not insurance at all but instead a mechanism for financing many forms of health care that would be considered uninsurable and beyond the reach of the commercial market.

MEDICAID ENROLLMENT AND EXPENDITURES

Analyses of beneficiary groups and program expenditures provide very different pictures of the Medicaid program. In 1998, nearly 75 percent of all enrollees were nondisabled, working-age adults and children (Fig. 1).[29] However, roughly two thirds of program expenditures were for services provided to

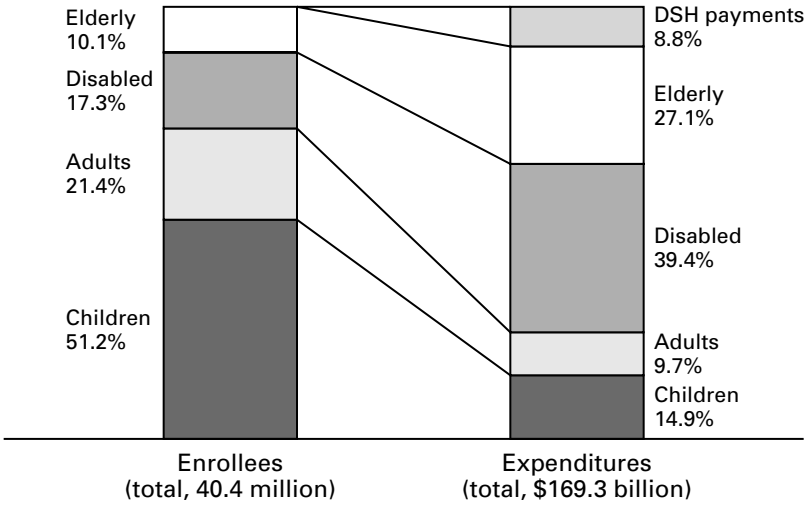

Figure 1. Medicaid Enrollment and Expenditures According to the Beneficiary Group, 1998.

Total expenditures exclude administrative expenses. DSH denotes disproportionate-share hospitals (i.e., those serving a disproportionate number of low-income and publicly insured persons). Data are estimates prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured.[29]

elderly or disabled beneficiaries; expenditures for nondisabled working-age adults and children amounted to less than 25 percent of total expenditures (Fig. 1).

There are large differences in per capita Medicaid expenditures for acute and long-term care, depending on the basis of eligibility (Fig. 2). Per capita payments for acute care services for disabled persons far exceed those for nondisabled beneficiaries, reflecting much higher levels of expenditure for physicians' services, prescription drugs (which are subject to especially comprehensive federal rules for coverage), and inpatient and outpatient care. The high per capita payments for persons with disabilities underscore the enormous differences in health status between persons with employer-sponsored coverage through private health plans and those who depend on Medicaid coverage.

The number of persons who receive Medicaid because they are disabled is a substantial underestimate of the prevalence of disability among beneficiaries, particularly children. According to a study that compared Medicaid beneficiaries enrolled in private managed-care plans with other persons enrolled in such plans, the health care costs for Medicaid beneficiaries who were not officially classified as disabled were 25 percent higher than those for non-Medicaid enrollees.[30] The definition of disability under the Social Security Act is so restrictive that it limits coverage to persons who are virtually incapacitated.[31] Consequently, children and adults with mild-to-moderate disabilities are not enrolled unless they meet another criterion for eligibility, such as poverty or qualification for cash welfare for families. Among children covered by Medicaid who have chronic physical or mental conditions or disabilities, about 14 percent qualified for enrollment on the basis of these conditions or disabilities; most qualified for other reasons.[32]

REFORMING THROUGH LEGISLATION AND DEMONSTRATION PROJECTS

Medicaid has had far-reaching achievements, including improved access to health care.[33] Persons who lose Medicaid coverage are three times as likely as insured persons to lack a regular source of health care and twice as likely to have made no visits to a physician's office in a year.[4] In the absence of Medicaid, the number of uninsured people in the United States would increase dramatically, since most Medicaid beneficiaries have no alternative source of coverage.

Despite these achievements, Medicaid has serious problems, although reaching agreement on what the most important problems are turns out to be as politically difficult as resolving them. Some analysts point to the program's limits on eligibility. Because of Medicaid's roots as a cash welfare program, in the absence of a federally sanctioned demonstration project, no

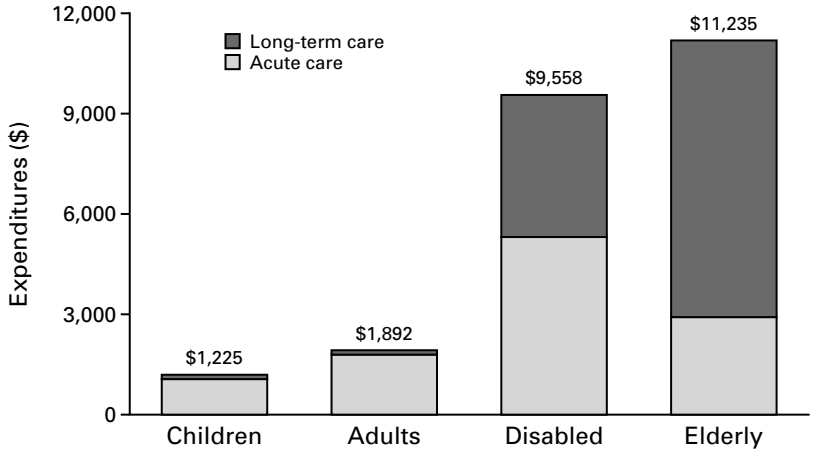

Figure 2. Medicaid Expenditures for Acute and Long-Term Care per Enrollee, 1998.

Long-term care includes services provided by nursing facilities, intermediate care facilities for the mentally retarded, mental health services, and home health services. Acute care includes inpatient, physician, laboratory, radiographic, outpatient, clinic, prescription-drug, family-planning, dental, vision, and hospice services; care provided by other practitioners; and early and periodic screening, diagnosis, and treatment. This category of expenditures also includes payments to managed-care organizations and payments to Medicare. Expenditures do not include payments to disproportionate-share hospitals, adjustments of federal payments, or administrative costs. Data are estimates prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured.[29]

public health insurance is available for low-income, nondisabled, working-age adults without children.[34,35] In addition, the restrictive definition of disability under the Social Security Act excludes persons with serious conditions that could be disabling in the absence of medical care (such as children with debilitating mental illness or persons with HIV infection, which is not considered disabling until it becomes AIDS).[35] Medicaid's eligibility and enrollment systems can be daunting because of the length of the application and the difficulty of having to apply at a welfare office. As the recent situation in New York illustrates,[23] when a state eases the process of enrollment, tens of thousands of persons may seek assistance. Furthermore, coverage can end abruptly because of arbitrary restrictions on eligibility. Finally, since its inception, the program has been plagued by low participation rates among physicians and other providers.[8]

State officials recognize these problems but tend to focus on the program's extensive coverage requirements.[36] Some officials have noted that because Medicaid is an entitlement program, the states must maintain open enrollment even when it is not financially feasible to do so. The states are required to cut back on eligibility rather than impose waiting periods, which is perceived as a less severe means of controlling the number of beneficiaries. State officials also view federal benefit requirements as barriers to the provision of less expensive coverage. With regard to overall spending, the current federal formula is problematic. Despite its relative generosity, state Medicaid expenditures can be burdensome, particularly during an economic downturn, when there is a need for expanded coverage and revenues are diminished. On the other hand, conservative analysts point to Medicaid's status as an entitlement program and its open-ended financing as the basic policy problems. An open-ended entitlement structure limits the ability to control federal expenditures.[37]

The failure to agree on what the most important problems are — the size of Medicaid, its limitations, or the need for greater flexibility — has prevented all but incremental legislative reforms. However, a substantial restructuring of the program, even in the absence of a legislative consensus, is possible through demonstration projects.

Since 1962, the Social Security Act has given the secretary of health and human services unilateral authority to implement demonstration projects in order to restructure federal grant-in-aid programs, such as Medicaid. This authority is codified in section 1115 of the Social Security Act. This section vests nearly unlimited discretion in the secretary to decide which types of demonstration projects to pursue and which program requirements to override.[37] On only

a few occasions have courts prohibited such projects on the grounds that they exceed the department's authority,[38,39] and Congress has almost never intervened.

Although the executive branch has used section-1115 authority sparingly, the Clinton administration made extensive use of it to permit states to mandate the enrollment of Medicaid beneficiaries in managed-care plans in many states and, in a few cases, to expand eligibility.[39] As of 2000, approximately half of all beneficiaries, including those with disabilities, were enrolled in managed-care plans.

In August 2001, apparently in response to recommendations by the National Governors Association, the Bush administration announced a section-1115 demonstration initiative known as Health Insurance Flexibility and Accountability (HIFA).[40] This program would permit states to provide very limited coverage for low-income persons who are currently ineligible for Medicaid (e.g., coverage restricted to primary care for adults without dependent children), while explicitly permitting reductions in coverage for many groups of current beneficiaries.

The initial purpose of HIFA may have been to permit reductions in coverage as a trade-off for a limited expansion of eligibility. Recent remarks by federal and state officials suggest that the Bush administration may now be willing to consider proposals such as the one from Washington State, which would reduce benefits to low-income beneficiaries, increase cost sharing, and limit enrollment without expanding eligibility to include currently uninsured persons.[41] Because applications for demonstration projects are not routinely made public, it is impossible to know how many states have submitted proposals, what they have proposed, what benefit reductions are under consideration, or what conditions the federal government may impose.

OUTLOOK FOR THE FUTURE

HIFA appears to be an attempt to restructure Medicaid as a program that provides "premium support," with the states subsidizing the enrollment of low-income persons in private insurance plans that offer more limited coverage than the traditional Medicaid program. Were most or all states to apply for participation in the HIFA program (section 1115 does not impose an upper limit on the number of participating states), then eventually the principles of Medicaid coverage would parallel those of private insurance coverage. In 1997, Congress took a step in this direction when it enacted the State Children's Health Insurance Program. This program gives states the option of buying private insurance for uninsured children in families near the federal poverty level, rather than expanding Medicaid to cover them.[42]

The long-term consequences of such changes for the millions of beneficiaries with chronic illness or disability are unclear. As of the end of 2001, Congress had held no oversight hearings on HIFA. Nor has there been congressional scrutiny of the program's emphasis on demonstration projects that help low-income workers buy coverage through their employers when it is available — despite concern about "health insurance crowd-out." This phenomenon occurs when public funds are substituted for employers' contributions to health insurance coverage.[43]

In view of the fundamental disagreement over which features of Medicaid are problematic, much less how to change them, broad congressional action is unlikely in the near future. It remains to be seen whether Congress will permit the Bush administration to transform Medicaid into a premium-support program and to do so with a minimum of oversight.

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