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MEDICAID: ENTERING THE THIRD DECADE

by Charles N. Oberg and Cynthia Longseth Polich

Prologue: *After more than twenty years of operation, it has become clear to health professionals and public policymakers alike that Medicaid, the federal/state health care program for the poor, is riddled with gaps. Some 35-37 million Americans, many of whom have incomes that fall below the poverty level, remain uninsured; eligibility levels vary dramatically across states; the low-income elderly, facing gaps in coverage under Medicare, are relying increasingly on Medicaid, thus straining its resources for the nonelderly poor; and program costs continue to increase. In this article, authors Charles N. Oberg and Cynthia Longseth Polich of InterStudy present an overview of the Medicaid program and outline an agenda for reform. "Medicaid must be reorganized to emphasize cost-efficient and effective care from a more integrated system," write the authors. The use of managed care is one component of their strategy for reform. This study grew out of the numerous requests for information on the impact of health maintenance organizations (HMOs) on Medicaid, according to Polich. InterStudy, a research center near Minneapolis founded in 1973, historically has been perreid as an advocate of HMOs. Today, InterStudy has expanded its mission to include evaluating the impact of HMOs and managed care on the health system. It also has broadened its interest into the areas of aging and long-term care, and quality of care. Oberg is both a practicing pediatrician at Hennepin County Medical Center and a health policy analyst at Inter-Study. He received his medical degree from the University of Minnesota Medical School and has served as a congressional fellow. Polich, who holds a master's degree in public affairs from the University of Minnesota, has been affiliated with InterStudy since 1985. She replaced InterStudy founder Paul Ellwood as president in 1987.*

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Over two decades ago, President Lyndon Johnson declared War on Poverty with the passage of Medicaid and other programs designed to alleviate the devastation of poverty. Medicaid was designed to finance health care for selected low-income individuals.

In this article, we present an overview of Medicaid and offer recommendations for reform as Medicaid enters its third decade. Medicaid is an entitlement program but is means-tested, with income and asset limitations for eligibility. In other words, one must be poor to qualify and receive Medicaid benefits. The federal government matches state expenditures based on a formula using a comparison of each state's per capita income. The federal contribution ranges from approximately 50 to 78 percent of total program costs. Since it is a federal/state program, states have considerable flexibility in setting service and eligibility requirements. However, the federal government has defined three general categorical groups that may be eligible for Medicaid within a specific state.[1]

The first are the *mandated* categorically needy, those individuals and families that receive cash benefits from two programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). SSI is for individuals who are aged, blind, or disabled. All states choosing to participate in Medicaid must include these groups in their program. The SSI program has uniform federal eligibility criteria, whereas the AFDC program has specific income and asset limits that vary substantially from state to state.

The *optional* categorically needy (which a state may elect to include in its program) are selected groups of individuals who are financially eligible for cash assistance but are ineligible either because they do not meet certain family status requirements or because they choose not to receive cash assistance. If a state includes the optional categorically needy, it must extend to this group the same Medicaid benefits provided to the mandated recipients.

The third category of eligibility is the "medically needy" program, which allows the state to extend Medicaid coverage to families with incomes above the AFDC income and asset criteria. These families become eligible for Medicaid if they incur significant medical expenses, resulting in the reduction of their net income to the Medicaid eligibility limits. As of 1985, thirty-four states and the District of Columbia had established medically needy programs.[2]

Many states also have programs to serve other individuals who do not meet Medicaid's eligibility requirements but do lack health care coverage. These are state-only programs, that is, the state does not receive a federal match.

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Medicaid Growth, Expenditures, And Programmatic Changes

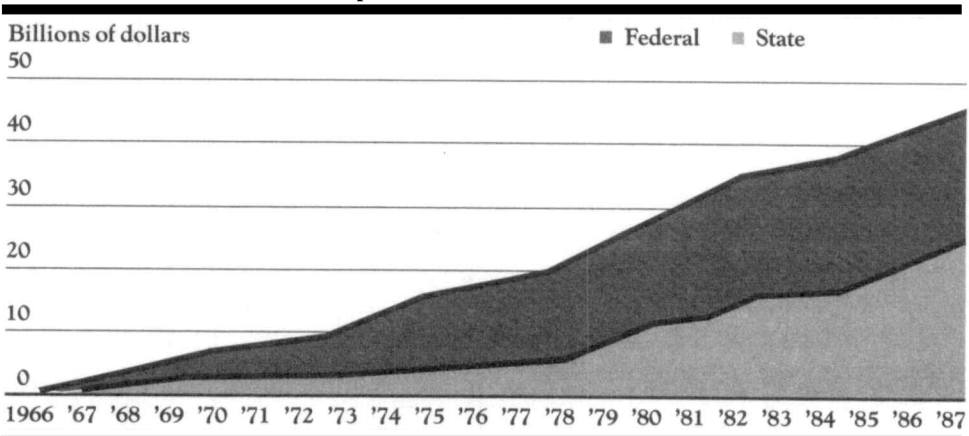
When Medicaid was enacted, its major purpose was to consolidate several grant programs that already were administered by the states. It was believed initially that Medicaid would add only $250 million to the health care expenditures of the federal government.[3] Exhibit 1 depicts the growth in Medicaid expenditures over the past twenty years. In the first year of operation, the combined federal and state outlays were $1.5 billion. By 1975, spending had increased to $14.2 billion, and in 1987 the expenditures exceeded $47 billion.[4] Enrollment has increased as well. In 1968 there were only 4.5 million recipients. Enrollment peaked at 24 million in 1977 and since has dropped to approximately 23.2 million in 1987. Medicaid currently accounts for over 10 percent of our nation's total health care expenditures.

If the Medicaid program is examined not in terms of the growth of actual expenditures but rather the annual percentage rate of real growth of the program, it appears to have had two distinct periods of existence. Exhibit 2 shows the annual percentage of real growth in the program from 1967 to 1985.

The decade of expansion, 1966-1975. Medicaid grew tremendously in its first decade. States quickly adopted the Medicaid option. In 1966, twenty-six states had operating Medicaid programs. By 1970, all states participated except for two: Arizona and Alaska. In 1982, Arizona began a Medicaid demonstration project, being the last state to participate in the program.

In addition to rapid expansion in expenditures and enrollment, there

Exhibit 1
Federal And State Medicaid Expenditures, 1966-1987



Source: Health Care Financing Administration

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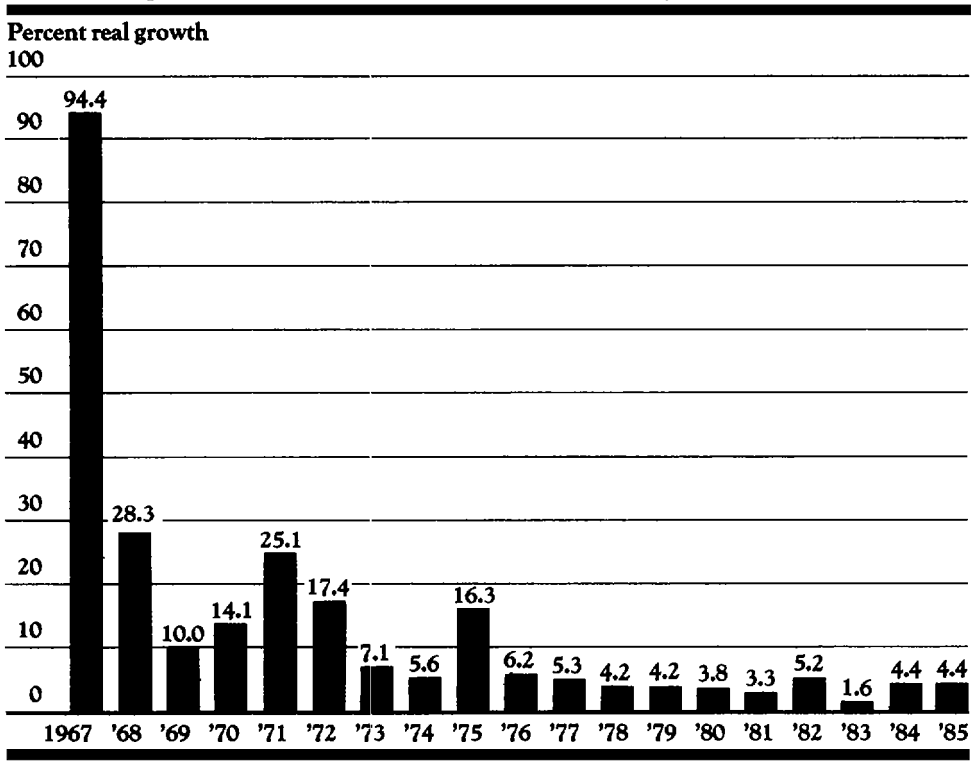
Exhibit 2
Medicaid Expenditure Growth, Consumer Price Index Adjusted, 1967-1985



Source: Health Care Financing Administration and Bureau of Labor Statistics.

was a significant expansion of benefits provided to recipients in the first decade. In 1967, the Early Periodic Screening Diagnostic and Treatment (EPSDT) program was enacted, which guaranteed preventive services for children receiving Medicaid benefits. The next major change came with the passage of the Social Security Amendments of 1972, which federalized the SSI program to a greater extent and established national standards for SSI benefits. At this time, all SSI recipients were deemed eligible for Medicaid benefits.

A period of retrenchment, 1976-1985. The second decade was characterized by a period of retrenchment with a deceleration of expansion, reductions in services, and other alterations intended to control the growth of the program. Initially, the retrenchment was secondary to the double-digit inflation of the late 1970s. During this period, increases in Medicaid expenditures offset the escalating inflation. While the program costs continued to increase by 15 percent annually during this period, the growth was mostly accounted for by inflation rates of 12 percent.[5] The retrenchment, however, was accentuated in the early 1980s and is most

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characterized by changes that were enacted as part of P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981 (OBRA). OBRA mandated reductions in the federal match to states for a three-year period.[6] In addition, it modified provisions of the "work incentive" program within the AFDC program. As a result, an estimated 442,000 working poor families were eliminated from Medicaid.[7] These changes resulted in a period of no real growth, concluding this decade of retrenchment. The impact of this retrenchment is discussed in the next two sections.

Balancing Resources Between Populations

Since the inception of Medicaid, there has been a need for a balance between the two categorical groups entitled to Medicaid benefits: recipients of AFDC and SSI. While these are not adversarial groups, the program has experienced considerable stress because the designers did not foresee the aging of the population. Elderly Americans over age sixty five increased from roughly 3 million in 1900 to nearly 28 million in 1984 or 12 percent of the population. The oldest old (those over age eighty five) now represent the fastest-growing segment of our population. Though only 1 percent of the population now, they will reach nearly 2 percent by the year 2000 and may exceed 5 percent by 2050.[8]

The Social Security Amendments of 1972 shifted the balance between the two groups of Medicaid recipients significantly. These amendments federalized the SSI program and reduced states' flexibility and discretion in the administration of the program. That is, SSI benefits were now available for all individuals who were aged, blind, or disabled as determined by federal eligibility requirements. In addition, these groups became automatically eligible for Medicaid benefits. The AFDC portion of the program was left to vary from state to state. This alteration disrupted the program's equilibrium and has changed the growth trends substantially since 1972. Also, as a result of the inadequacy of the nation's long-term care financing system, Medicaid became the primary payer for nursing home care in this country. The combination of this unintended benefit, the expansion of eligibility for the elderly and disabled, and the growing elderly population have resulted in a dilemma that continues to plague the Medicaid program.

Exhibit 3 shows the shift in spending for AFDC children versus SSI recipients for 1972-1987. In 1972, 18 percent of Medicaid expenditures went to AFDC children less than age twenty-one. By 1984, this percentage had declined significantly to 11.7 percent and since then has increased marginally. The SSI population, which consumed 52.8 percent of program expenditures in 1972, escalated to 73.0 percent by 1987.

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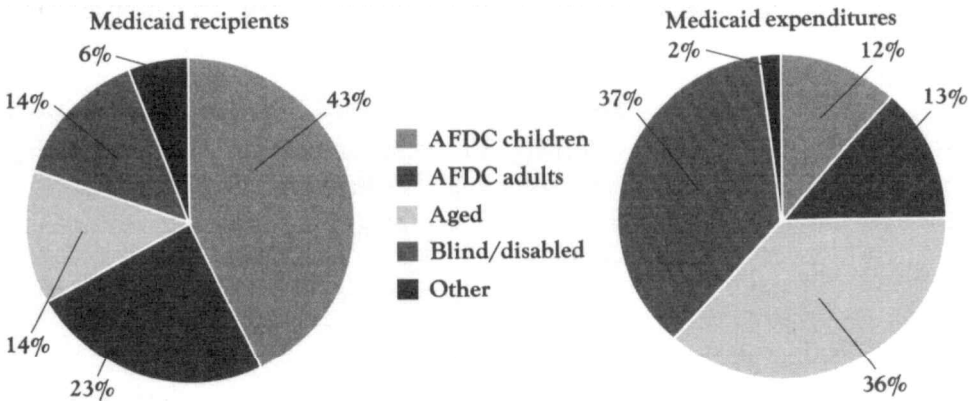
Exhibit 3
Medicaid Expenditures For AFDC Children Versus SSI Recipients, Fiscal Year 1972-1987, Amounts In Millions[a]

Year	Total Medicaid expenditures[b]	AFDC children under 21		SSI recipients	
		Expenditures[b]	Percent	Expenditures[b]	Percent
1972	$ 6,300	$1,139	18.1%	$ 3,324	52.8%
1973	8,639	1,426	16.5	5,315	61.5
1974	9,983	1,694	17.0	6,159	61.7
1975	12,242	2,186	17.9	7,503	61.3
1976	14,091	2,431	17.3	8,830	62.7
1977	16,239	2,610	16.1	10,382	63.9
1978	17,992	2,748	15.3	11,929	66.3
1979	20,472	2,884	14.1	13,928	68.0
1980	23,311	3,123	13.4	16,360	70.2
1981	27,204	3,508	12.9	19,381	71.2
1982	29,399	3,473	11.8	21,144	71.9
1983	32,391	3,836	11.8	23,321	72.0
1984	33,895	3,979	11.7	24,795	73.2
1985	37,508	4,412	11.8	27,548	73.4
1986	40,878	5,096	12.5	29,943	73.3
1987	**45,170**	**5,536**	12.3	32,963	73.0

Source: Office of the Actuary, Medicaid Statistics Branch, Health Care Financing Administration, Historical Medicaid Table 7 (for fiscal years 1972-1984) and Medicaid State Table 8 (for fiscal years 1985-1987).
Note: AFDC is Aid to Families with Dependent Children; SSI is Supplemental Security Income.
[a]Represents Medicaid vendor payments, excludes administrative expenditures.
[b]Millions of dollars.

The profile of Medicaid changes depending on whether one examines recipients of benefits or expenditures (Exhibit 4). In 1987, the AFDC population comprised 66 percent of all Medicaid recipients yet generated

Exhibit 4
Comparison Of Medicaid Recipients And Expenditures, 1987



Source: Health Care Financing Administration, Office of the Actuary, Medicaid State Tables 2,8 (fiscal year 1987).

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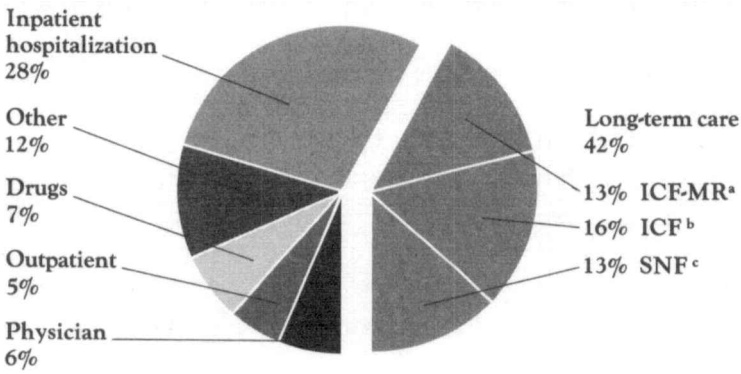
only 25 percent of Medicaid expenditures. The SSI population, which comprised only 28 percent of recipients, generated almost three-quarters, or 73 percent, of expenses.[9]

Exhibit 5 shows Medicaid payments by service type and again demonstrates the disproportionate amount of expenditures generated by the SSI population. Medicaid recipients who reside in nursing homes (skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded) account for only 7 percent of total recipients but generate over 42 percent of the program costs.[10] Medicaid now pays for almost half of all nursing home expenditures in this country.

Exhibit 5
Medicaid Expenditures By Type Of Medical Service, 1987



Source: Health Care Financing Administration, Medicaid State Table 9 (fiscal year 1987).
[a]Intermediate care facility for the mentally retarded.
[b]Intermediate care facility.
[c]Skilled nursing facility.

Medicaid, Poverty, And The Uninsured

What impact, then, has the retrenchment of Medicaid's second decade and the shift of equilibrium in allocation of resources had on the effectiveness of the program? If one examines the health care utilization of Americans in poverty, it appears that Medicaid has had reasonable success in improving access to health care for the low-income population.

Poor Medicaid recipients' utilization rates of physician and hospital services are essentially the same as for those covered by other health insurance mechanisms, if one controls for health status. However, such analysis fails to look at the population of individuals who neither are eligible for Medicaid nor have health care coverage through an employ ment-based or individual plan. It is estimated that, in 1985, 37 million

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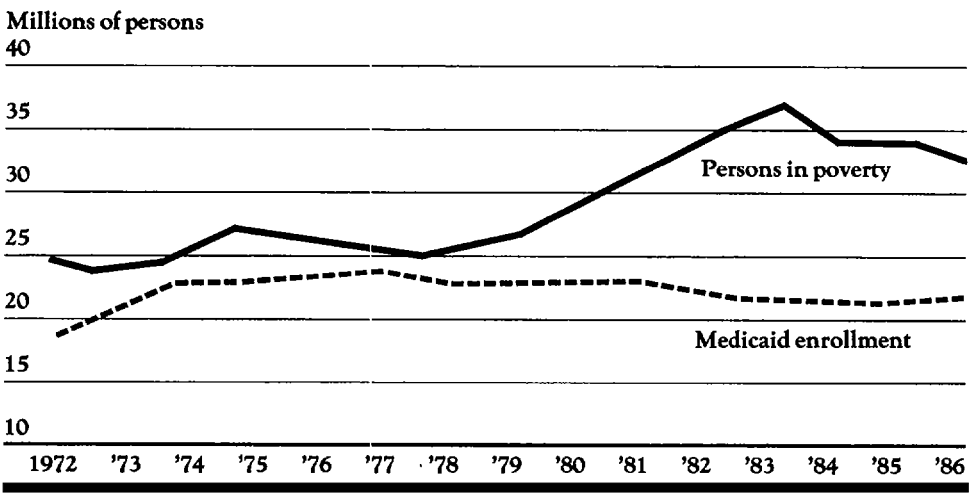
Americans were uninsured, of which 11 million were children.[11] This disproportionate representation of children is due in large part to the wide variability in AFDC eligibility from state to state. The ten states with the lowest AFDC income levels cover only 38 percent of their children living below the poverty threshold. An aggregate national percentage has Medicaid covering less than half of the poor children in this country.

The Robert Wood Johnson Foundation's analysis of access to care shows the extent to which Medicaid-covered individuals have incomes below or near the poverty level.[12] In 1972, Medicaid included 32 percent of those at or below the poverty level. The program reached its peak in 1975, when 63 percent of low-income individuals were eligible for Medicaid. As the government began efforts to constrain the program's budget, the percentage started to fall. In 1980, 50 percent of the poor and near-poor were eligible for Medicaid. In 1985, it was estimated that the program served only 46 percent.

An analysis of this problem is not complete unless we ask whether this situation is due to a decrease in Medicaid recipients or an increase in poverty. The answer is .a combination of both. As Exhibit 6 shows, during the decade of expansion the poverty rate remained relatively constant with a rapid increase in Medicaid enrollment. As we entered the period of retrenchment, there was a striking divergence of the curves with a slow but steady decrease in Medicaid recipients and an escalation of the

Exhibit 6
Persons In Poverty Versus Medicaid Enrollment, In Millions, 1972-1986



Sources: U.S. Bureau of the Census; and Office of the Actuary, Health Care Financing Administration, Historical Medicaid Tables.

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poverty rate. In addition, those most affected by this escalation of poverty have been children. The Congressional Budget Office (CBO) recently estimated that the poverty rate among our children is at its highest level in eighteen years, with 14 million children, or 22 percent, living in poverty.[13] Thus, the retrenchment within Medicaid occurred at a time when that coverage was needed most by a growing poor population.

The Inequity Of Medicaid

As Medicaid proceeds through its third decade—the decade of maturity—it is time to reevaluate this important entitlement program and other publicly funded health care. It is essential to begin this critical analysis with a summary of the persistent flaws within the Medicaid program. Such an evaluation is essential to highlight the fragmented, cumbersome, and inconsistent nature of publicly financed health care.

Medicaid was mandated to provide access to care to low-income Americans. Initially, it was envisioned that all poor Americans would be covered by 1970. The efficacy of Medicaid has been hindered by certain restrictions and inequities, making fulfillment of this goal difficult. Several of these restrictions were incorporated into the original legislation to make it more politically acceptable to assure passage. Others were enacted in the decade of retrenchment to curb program growth. Three major inequities of Medicaid persist and need to be addressed.

The inequity of eligibility and geographic variations. Analysis by The Robert Wood Johnson Foundation demonstrated Medicaid's increasing inability to extend access to health care services to those in or near poverty. Medicaid's failure to provide care for even half of this low-income population indicates its restrictive eligibility design, which denies coverage to certain categorical groups, and state-by-state variations in AFDC income standards, which unfairly limit access solely because of geographic location.

Currently, 17 percent of our nonelderly population is uninsured for health care, of which children make up a disproportionate share. Medicaid covers 100 percent of the health care costs of those fortunate to be eligible. However, for those who fail to qualify and are uninsured, the responsibility of payment rests with the individual, regardless of income status. The inability to pay for needed care makes the uninsured and ill among the most vulnerable of groups. It has been demonstrated that the sick uninsured use less than 50 percent of the health care services used by their Medicaid-eligible counterparts.[14] The plight of these uninsured Americans is visible in the excessive number of reported cases of "patient dumping" and "economic transfers" resulting in a refusal of care because

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of inability to pay. The 1986 Robert Wood Johnson Foundation survey on access to care demonstrated that the most vulnerable populations—women, children, and minorities—may have experienced a deterioration in access to care. As a result, over a million families have been unable to obtain care because of a presumed inability to pay.[15]

The inequity between eligible groups. As mentioned earlier, the SSI population, which makes up only 27 percent of Medicaid recipients, generates 73 percent of expenditures with a substantial portion used to finance long-term care arrangements. AFDC children now account for only 13 percent of Medicaid expenditures. In addition, those funds earmarked for EPSDT, the preventive outreach program within Medicaid, account for less than 1 percent of Medicaid expenditures.

The inequity of long-term care financing. At the same time Medicaid has become incapable of financing health care for our nation's poor, it has become the primary payer for long-term care. Yet even the long-term care portion of Medicaid is far from adequate. Many aged and disabled individuals must sacrifice their income security to gain access to Medicaid for their long-term care needs. In addition, there is significant difficulty in coordinating benefits between Medicare and Medicaid.

Restructuring Medicaid

Medicaid has evolved into a major entitlement program with an array of programmatic objectives. The wide state-to-state variations in eligibility, services, and administration makes evaluation difficult. Add to this the multitude of program options, and the direction of Medicaid can easily be lost. To develop a more rational and effective public health care system, the Medicaid program must be restructured. A model must be developed that acknowledges the need to coordinate the delivery of acute, intermediate, and long-term care for the elderly and improve access to health services to the poor and uninsured. This could be accomplished by removing the low-income elderly and disabled from the Medicaid program and providing care to them through Medicare. Approximately 15 percent of the aged and 21 percent of the disabled Medicare beneficiaries also receive Medicaid benefits.[16] Combining these programs would facilitate the integration and coordination of services so desperately needed by our aged and disabled population.

It can be argued that Medicaid's higher spending on the elderly reflects a greater need due to the increased propensity for illness and chronic disease. For this very reason, the "dual-eligible" population should be removed from Medicaid. As the program faces finite resources, the demographics of aging and the increased health needs of the elderly will

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prove an ever-increasing burden, making it fiscally difficult to extend benefits to other low-income persons. Once the acute supplemental and long-term care provisions used by these "dual-eligible" persons are removed from the Medicaid program and the low-income aged and disabled are reintegrated into Medicare, Medicaid will reemerge as the primary financing mechanism for the delivery of acute care services to low-income families. To strengthen Medicaid's ability to meet this goal, four directives should be taken.

Low-income children. First, greater priority must be placed on meeting the health care needs of low-income children. The escalation of poverty among our children and Medicaid's inadequacy in meeting their health care needs deserves greater attention. In actuality, significant changes already have been enacted at the start of Medicaid's third decade. P.L. 98-356, the Deficit Reduction Act of 1984 (DEFRA), contained certain provisions called the Child Health Assurance Program (CHAP).[17] CHAP altered Medicaid's categorical eligibility requirements to include a larger number of women in need of prenatal care services. It expanded coverage to include first-time pregnant women and pregnant women from two-parent households in which the main wage earner is unemployed. DEFRA also extended Medicaid coverage to all children less than age five born after October 31, 1983, whose family income falls below the state's income eligibility floor. P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), completed the CHAP amendments, and covered the last group of low-income expectant mothers–those pregnant women in families in which the parent(s) may be working, but in which the income is insufficient to raise the family income above the state's asset and income requirements for AFDC eligibility. [18]

State variation. Second, the Medicaid program should be federalized to reduce state variation in eligibility by *mandating* a federal floor of eligibility at 100 percent of the federal poverty standard. The passage of P.L. 99-509, the Sixth Omnibus Budget Reconciliation Act of 1986, moved in this direction, giving states the option to raise eligibility to 100 percent of the federal poverty level for this vulnerable group of expectant mothers, infants, and children less than age five. In addition, the recently passed Medicare catastrophic legislation contained a Medicaid provision that will require states to cover all pregnant women and infants up to age one living below the federal poverty level.

Low-income families. Third, coverage should be expanded further to extend access to the large number of low-income, uninsured families. The first session of the 100th Congress saw two legislative initiatives that embodied this principle. S. 422, the "Medicaid Infant Mortality Amend-

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ments of 1987," was introduced by Sen. Bill Bradley (D-NJ) during the opening days of the session, as was its companion, H.R. 1018. The purpose was to provide Medicaid to additional poor children and pregnant women. It gives states the option of expanding Medicaid coverage to the large number of uninsured pregnant women and children under age one whose family income is between 100 and 185 percent of the federal poverty standard. These bills also call for an acceleration of coverage for the children under age five who were mandated coverage under DEFRA and would extend that age limit to include children under age eight. All of the major provisions of the Medicaid Infant Mortality Amendments of 1987 were included in PL. 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

"MedAmerica Act of 1987" (S. 1139), introduced by Sen. John Chafee (R-RI), is similar to the infant mortality amendments but significantly broader in scope. The Chafee bill would allow states to provide Medicaid coverage to all people with family incomes less than the federal poverty standard, essentially eliminating the concept of categorical eligibility. In addition, the bill would allow all persons with incomes between 100 and 200 percent of the poverty level to buy into Medicaid. Though S. 1139 has little chance of passage, it attempts to complete a trend that began with the CHAP amendments of DEFRA, that is, a decoupling of Medicaid from the categorical, cash-assistance programs of the past. The DEFRA and COBRA Medicaid amendments expanded eligibility. OBRA 1986 and the catastrophic Medicaid provisions have increased the income criteria for selected populations, moving us toward a federal floor of eligibility. Finally, OBRA 1987 will extend financial access to a portion of the low-income, uninsured population previously not eligible for Medicaid benefits.

These incremental legislative changes indicate the direction Medicaid should take in this "decade of maturity." In the early years of the third decade, Medicaid has been not only sheltered from significant federal budget reductions, but substantially expanded. These changes represent the realization that access to high-quality health care services ought to be independent of age, income, employment status, or family composition.

Managed care. Finally, the use of managed health care systems to ensure the efficient use of resources should continue to be strongly encouraged and strengthened. An increasing number of states have turned to alternative health care systems for their Medicaid populations. These include health maintenance organizations (HMOs), prepaid health plans (PHPs), and health insuring organizations (HIOs). In December 1986, Medicaid enrollment in HMOs had increased to 800,606 persons in 101 plans, with contracts in twenty-five states and the District

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of Co1umbia.[19] By December 1987, over two million Medicaid recipients were enrolled in either HMO, PHP, or HI0 prepaid systems nationwide.[20] Greater use of alternative health systems will allow states to capitalize on the incentives for preventive services and ambulatory care, rather than those of acute and institutional care. This is particularly clear with the use of prenatal care and maternal and child health services, where preventive care does result in documented cost savings.

It also may be possible, through the continued use of alternative health care systems, to extend Medicaid coverage to a portion of the more than thirty-seven million uninsured persons in this country. The savings generated by the more efficient use of services could be earmarked to expand Medicaid. Such expansion could reverse the trend witnessed over the decade of retrenchment, when fewer and fewer persons in poverty received health coverage. This trend is already evident at the state level; the Intergovernmental Health Policy Project (IHPP) survey on Medicaid and Indigent Care Programs characterized 1985 as a year of expansion. Twenty-eight states expanded eligibility by extending coverage to other categorical groups, creating "medically needy" programs, and relaxing income eligibility requirements. In 1986, more than a third of the states expanded benefits, and most others either relaxed limits or slightly expanded coverage under existing benefits.[21]

As we proceed through the third decade of Medicaid, a reorganization of the program is essential. It will be driven not only by the need to contain costs, but by a desire-to provide comprehensive, high-quality care to the diverse groups currently receiving benefits and a need to expand eligibility to a larger group of currently uninsured families and individuals. The continued aging of the population will focus our attention continually on the needs of the elderly as well. It is not reasonable to expect Medicaid to be both the financing mechanism for acute care services for low-income Americans and the primary payer for long-term care for the elderly and disabled. Not only is this approach very costly, but it results in unacceptably fragmented care. Medicaid must be reorganized to emphasize cost-efficient and effective care from a more integrated system. Through that, we will be able to provide the quality of care that most Americans expect.

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