After decades of political reform efforts to achieve national health insurance, Congress enacted Medicare and Medicaid in 1965 as Titles XVIII and XIX of the Social Security Act. Medicare is a social insurance program; Medicaid is a means-tested public assistance program (to be eligible, recipients must demonstrate their need for assistance by meeting established income and asset eligibility criteria).

Robert Ball, one of the architects of Medicare and commissioner of Social Security under Presidents Kennedy, Johnson, and Nixon, has argued persistently that Medicare’s original designers viewed Medicare as a first step toward universal coverage (Ball, 1995). They reluctantly crafted a program that was politically viable by focusing on the elderly and building on a Social Security pension system that already provided income support for adult retirees.

Before Medicare, half the nation’s older adults lacked health care coverage, and millions more had inadequate coverage. Private insurance rates for older adults were very expensive, and the idea of pooling risks for this population was appealing. The final element of the compromise was to establish a separate program for low-income families. With the spotlight on economically disadvantaged groups during President Johnson’s War on Poverty, Congress enacted Medicaid to address the needs of this population.

Medicare and Medicaid have enabled millions of adults and children to access health care and have contributed significantly to the social and economic welfare of individuals and the nation as a whole. Medicare has reduced poverty among older adults and people with disabilities measurably. Medicare provided health care coverage to 41.4 million people in 2007 (Kaiser Family Foundation, 2008a), and Medicaid provided health and long-term care coverage to 59 million people (Kaiser Family Foundation, 2008b).

When the programs were enacted, the federal government did not place any limits or restrictions on hospital and physician fees. Within a few years, however, the nation’s health care costs skyrocketed. As discussed
in Chapter 3, during the 1970s, health maintenance organizations (HMOs) emerged, and during the 1980s, the Reagan administration, despite its opposition to regulation, established a prospective payment system. In 1997, after bitter legislative struggles between the Republican-controlled Congress and the Clinton administration, Congress passed the Balanced Budget Act (BBA) of 1997. Until recently, with the landmark enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) by the Bush administration, the 1997 legislation introduced the most significant changes to Medicare and Medicaid since they were enacted.

Today, the costs associated with the Medicare and Medicaid programs continue to draw sharp attention. In 2005, Congress passed the Deficit Reduction Act in an effort to slow the pace of spending growth in both Medicare and Medicaid by $11 billion between 2005 and 2010. In 2009, Medicare expenditures are expected to reach $477 billion, and in 2007, the Medicaid program cost more than $333 billion (Kaiser Family Foundation, 2008a, 2008b; U.S. Dept. of Health and Human Services, 2008). Over the next 20 years, state Medicaid spending is expected to reach $1.6 trillion for long-term care coverage with an additional federal cost of $2.1 trillion or a total of $3.7 trillion in 2027 for long-term care alone (Gostick and London, 2008). For most of us, these numbers are mind-numbing and difficult to conceive, but they are real and troubling, nonetheless.

This chapter will provide an overview of the provisions of Medicare and Medicaid, recent proposals for reform, and future issues of concern. In the absence of a universal system for health insurance, Medicare and Medicaid remain the two most important health care programs in the United States. Medicare finances approximately one-third of all physician and clinical services and almost half (45 percent) of all hospital services (Kaiser Family Foundation, 2005d, 2005e). Medicaid is the primary payer for long-term care.

**Medicare**

**Benefits and Financing**

Medicare is one of a group of social insurance programs legislated by the Social Security Act referred to as OASDHI—Old Age (OA), Survivors (S), Disability (D), and Health Insurance (HI or Medicare). The original Social Security Act of 1935 provided old-age pensions for retired workers. In 1939, retirement benefits were extended to workers’ dependents and survivors. Congress amended the act again in 1956 to add disability insurance for employed workers who were unable to continue working due to physical or mental impairments. Medicare was added in 1965. Medicare has four components: Hospital Insurance (Part A), Medical Insurance (Part B), Medicare Advantage (Part C), and Medicare Prescription Drug (Part D). Medicare is administered by the federal government, which governs policies related to eligibility criteria, financing, benefits, payments to providers, and decisions about service delivery (e.g., fee-for-service [FFS] vs. managed care). Figures 6.1 and 6.2
FIGURE 6.1  Overview of Medicare Benefits and Financing (Parts A and B)

PART A (HOSPITAL INSURANCE) Mandatory

<table>
<thead>
<tr>
<th>Hospital benefits:</th>
<th>Covers first 60 days of hospitalization (semiprivate rooms, meals, general nursing, supplies, other services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary pays:</td>
<td>Benefit period (annual) deductible ($1,068 in 2006)</td>
</tr>
<tr>
<td></td>
<td>No monthly premium with 40 employment quarters (99% of beneficiaries)</td>
</tr>
<tr>
<td></td>
<td>Monthly premium for those with fewer than 40 employment quarters ($443 in 2009)</td>
</tr>
<tr>
<td></td>
<td>Daily coinsurance for hospital stays between 61 and 90 days ($267 in 2009) and over 90 days ($534 in 2009)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skilled nursing care:</th>
<th>Covers 20 days (semiprivate room, meals, nursing and rehabilitative care, supplies, other services) subject to 3-day prior hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary pays:</td>
<td>Daily coinsurance for care between 21 and 100 days ($133.50 in 2009) For all care over 100 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home health care:</th>
<th>Covers part-time skilled nursing, physical therapy, occupational therapy, speech–language therapy, home health aides, supplies, durable medical equipment, other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary pays:</td>
<td>No daily coinsurance, but must pay 20% of approved cost of medical equipment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice care:</th>
<th>Covers Medicare-approved medical and support services, drugs, short-term respite care, other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary pays:</td>
<td>Small copayment for prescription drugs and respite care</td>
</tr>
</tbody>
</table>

PART B (SUPPLEMENTARY MEDICAL INSURANCE) Voluntary

Physician and other provider services, outpatient medical and hospital services and supplies, diagnostic tests, approved ambulatory surgery, and durable medical equipment Mammograms and other cancer screening tests added in 1997

Additional preventive benefits, including initial routine physical examinations, cholesterol and blood lipid screening tests, and diabetes screening tests added in 2005

Beneficiary pays: Monthly premium ($96.40 in 2009) Starting 2007, beneficiaries’ premiums based on income (a 25 to 80 percent share of the costs) with beneficiaries with higher incomes paying higher premiums

Outpatient therapy, occupational therapy, speech–language therapy, and mental health care Hospice consultation and end-of-life counseling added in 2005

Beneficiary pays: Annual deductible ($135 in 2009) Starting in 2006, Part B deductible indexed to increase in average cost of Part B services

20% coinsurance for most health services

50% coinsurance for most outpatient mental health services

Approved clinical laboratory tests (no cost)

Home health visits and other outpatient hospital services not covered by Part A

Beneficiary pays: 20% of approved cost of medical equipment Predetermined copayment for outpatient services

Source: www.medicare.gov
provide an overview of the benefits and services provided by the Medicare program (see www.medicare.gov for updated information regarding premiums, deductibles, and copayments). Additional basic information is provided in the following sections.

**Hospital Insurance (Part A).** Part A covers inpatient hospital, skilled nursing facility, home health, and hospital care. Most nursing home care is custodial and is **not** covered by Medicare. Part A is funded by a dedicated tax (2.9 percent of earnings shared equally by the employer and the employee).

**Medical Insurance (Part B).** Part B covers physician and other providers, outpatient, and preventative services. With the MMA of 2003, Part B deductibles are indexed to the increase in the average cost of Part B services. Part B is funded by general revenues and beneficiary premiums.

**Medicare Advantage (Part C).** The Medicare Advantage program, formerly called Medicare + Choice, gives beneficiaries the option to join private managed-care plans that provide hospital and supplementary medical benefits (Parts A and B). Most of these plans are HMOs, though enrollees are now being encouraged to join regional preferred provider organizations PPOs. Enrollment in managed-care Medicare plans has fluctuated, but has declined overall since this option was first introduced in 1997. Medicare Advantage plans essentially provide all Medicare-covered benefits, but are required to pass along savings to beneficiaries in the form of lower premiums and

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**FIGURE 6.2 Overview of Medicare Benefits and Financing (Part C and Part D)**

<table>
<thead>
<tr>
<th>PART C (MEDICARE ADVANTAGE) Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private managed care plans (HMOs and PPOs) that provide Parts A, B, and D benefits</td>
</tr>
<tr>
<td><strong>Type of MA plans:</strong></td>
</tr>
<tr>
<td>Medicare Health Maintenance Organizations (HMOs)</td>
</tr>
<tr>
<td>Medicare Preferred Provider Organizations (PPOs)</td>
</tr>
<tr>
<td>Medicare Private Fee-for-Service Plans (PFSS)</td>
</tr>
<tr>
<td>Medicare Special Needs Plans (SNPs)</td>
</tr>
<tr>
<td>Medicare Medical Saving Accounts (MSAs)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART D (PRESCRIPTION DRUGS) New as of January 1, 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiary pays:</strong></td>
</tr>
<tr>
<td>Annual deductible (upto $295)</td>
</tr>
<tr>
<td>25% of pharmaceutical expenses up to $2,700 (2009)</td>
</tr>
<tr>
<td>For all prescription costs over $2,700 upto $4,350(or a total of $1,650)</td>
</tr>
<tr>
<td>Catastrophic coverage (no more than 5% of costs over $4,350)</td>
</tr>
<tr>
<td>Monthly premium ($30 in 2009)</td>
</tr>
<tr>
<td>Beneficiaries with incomes under 150 percent of the FPL not required to pay premiums or deductibles</td>
</tr>
</tbody>
</table>

*Source: www.medicare.gov*
copayments, additional benefits, or contributions to a reserve fund. However, from 1999 to 2004, out-of-pocket expenses for enrollees in Medicare managed-care plans tripled (Kaiser Family Foundation, 2004a) and rose again in 2005 (Kaiser Family Foundation, 2008). Enrollees are allowed to disenroll from these plans once a year during a three-month period. According to a study by the Kaiser Family Foundation (2005a), by 2013, enrollment is expected to reach somewhere between 16 and 30 percent of all Medicare beneficiaries (see Chapter 5 and Figure 5.1 for an overview of Medicare Advantage), and Part C already accounts for 24 percent of Medicare benefit spending (Kaiser Family Foundation, 2008a).

Medicare Prescription Drug (Part D). Medicare Part D is a voluntary outpatient prescription drug benefit offered under private plans that contract with Medicare (effective January 1, 2006). Medicare reformers have hoped for a prescription drug benefit for many years. However, according to Families USA (2004), there are winners and losers with the structure of this new benefit. Most Medicare beneficiaries will have coverage that is limited to an approved drug list and will pay high premiums and deductibles that will continue to rise each year. The pharmaceutical companies, on the other hand, were able to defeat efforts to reduce the cost of prescription drugs through governmental price negotiations and the importation of prescription drugs from Canada and other countries (as discussed in Chapter 5). According to Anderson et al. (2004), “If the Medicare program were to pay comparable prices . . . [as Canada, the U.K., and France] it would be possible to eliminate the ‘doughnut hole’ [$1650] cost to the beneficiary] in its prescription drug benefit.”

As of January 1, 2006, “dual eligibles” (eligible for both Medicare and Medicaid) no longer receive drug coverage through the Medicaid program; instead they are covered by the new MMA Prescription Drug program. States contribute to the financing through a complex formula that includes a provision known as the “clawback” payment, because it creates an incentive for states to drop dual eligibles from the Medicaid program. As noted by Families USA (2005b), some states (Florida, Mississippi, and Missouri) have already begun to reduce or eliminate Medicaid coverage for dual eligible older and disabled poor adults, many of whom live at home or with their families. This policy change puts them at risk for losing other important Medicaid-funded health services. Dual eligibles that remain in state Medicaid plans also face enormous difficulties because states automatically enroll these recipients in Medicare managed-care plans that will not cover the drugs they need, such as benzodiazepines (such as Valium) or weight-loss or weight-gain drugs.

Gaps in Coverage and Cost Sharing. A major concern with Medicare is its gaps in coverage. The new legislation enacted in 2003 adds coverage for prescription drugs and initial routine examinations starting in 2006. However, Medicare still does not provide payment for routine dental and eye examinations, hearing aids, regular physical examinations, and immunizations (except annual flu shots and shots for pneumonia and hepatitis B, which are covered). Perhaps most importantly, Medicare does not cover long-term custodial care, home health visits not
covered by Part A, and other outpatient services (Centers for Medicare and Medicaid Services, 2005b).

Out-of-pocket costs and cost-sharing requirements are another concern. Most physicians who treat Medicare patients accept the program’s approved fees as full payment for their services, but others exercise their right to charge beneficiaries an additional restricted fee. The cost of physician fees, omissions in coverage, premiums, deductibles, and copayments add up to significant costs that must be paid either out-of-pocket or with supplemental insurance. About 20 percent of beneficiaries purchase private Medigap, or Medicare Supplement Insurance, to provide coverage for the gaps in Medicare coverage, and less than one-third (31 percent) receive supplemental coverage through employee retirement benefits (Kaiser Family Foundation, 2008a). About 14 percent have Medicaid coverage through the Medicare buy-in program, and 12 percent participate in Medicare HMOs (Kaiser Family Foundation, 2005c).

The Medicare buy-in program or “Medicare Savings Program” was originally introduced in the 1988 Medicare Catastrophic Coverage Act (see Chapter 3). Although the 1988 legislation was repealed, the provisions of the buy-in program were adopted and expanded through legislative reforms passed in 1990, 1993, 1995, and again in 1997 with a block grant program. The Medicare buy-in program allows Medicaid to cover premiums, deductibles, and coinsurance payments for beneficiaries whose incomes are below or near the federal poverty level (FPL) (Families USA, 2005a).

In 2003, Medicare covered only 45 percent of the health care services received by beneficiaries. Older adults spent almost one-quarter of their incomes on health care services and insurance premiums (Kaiser Family Foundation, 2005d). The Medicare Savings program was established to prevent individual financial hardship, but there are often insufficient outreach efforts, difficulties with enrollment processes, and delays in activating eligibility (Kaiser Family Foundation, 1999a). Mandatory Medicaid benefits are made available to low-income Medicare beneficiaries through four primary categories of eligibility: Qualified Beneficiaries (“quimbies”), Specified Low-Income Beneficiaries (“slimbies”), Qualified Working Disabled Individuals, and Qualifying Individuals (in addition to Supplemental Security Income [SSI] beneficiaries).

Medicare Benefit Payments. From 1987 to 1997, Medicare spending increased at an average rate of 10 percent each year. The 1997 Medicare reforms (discussed in Chapter 5) mandated $115 billion in savings by 2002; and from 1997 to 2000, the average rate of growth in spending declined to 1.4 percent annually. In 2004, 69 percent of Medicare costs were spent on only 10 percent of the Medicare population, which had much higher than average medical needs and costs (Kaiser Family Foundation, 2005d). Although the rate of growth in spending for Medicare has been slower than the rate of growth in the private sector, Medicare spending is projected to grow from $325 billion in 2005 to $444 billion in 2010 (U.S. Congressional Budget Office, 2005). The federal budget for the new Medicare prescription drug program is projected to be $724 billion between 2006 and 2015 (Kaiser Family Foundation, 2005d). Changes in funding will be necessary to ensure that the trust fund is sufficient to cover growth projections that will occur due to a retiring
baby-boom generation and a decline in the number of workers per beneficiary in the system. The MMA requires that Congress take action when general revenues are projected to fund more than 45 percent of Medicare for two years in a row.

**Beneficiaries**

In 2008, Medicare insured 38 million older adults over age 65 and 7 million younger individuals with disabilities and end-stage kidney disease; Medicare was amended in 1972 to include the latter group. The Medicare program serves the medical needs of a diverse population with variations in age, race, ethnicity, gender, income, and health status. However, Medicare serves a higher number of older women than older men and a higher number of disabled men than disabled women. Only 9 percent of the Medicare population in 2005 was African American, and only 8 percent was Latina/o. This reflects the racial disparities in health discussed in Chapter 7. The majority of Medicare beneficiaries are very poor; 45 percent have incomes below 200 percent of the FPL (Medpac, 2008).

**Older Adults.** The overwhelming majority of Medicare beneficiaries are over age 65. Demographic projections for the United States suggest that the older population is likely to continue to grow as a percentage of the population. In the late 1990s, older adults made up 13 percent of the U.S. population; by 2030, this group is expected to grow to 20 percent. Moreover, within the older population, those over age 85 are the fastest-growing group of older adults and by 2050 could represent 23 percent of the Medicare population. Older people tend to be sicker than younger people and to spend more on health care. Thus, the changing demographics of Medicare fuel concerns about financing the program’s costs (Fronstin and Copeland, 1997).

**Adults with Disabilities.** In the United States, the majority (56 percent) of working-age adults with disabilities (about 33 million) are employed (U.S. Department of Labor, 2008). However, approximately half have severe disabilities, and only one of every four in this group is employed. Most of the 7 million Medicare beneficiaries who are disabled have disabilities that are classified as severe. Disability (see Terminology Box for a discussion of this term) is a broad concept for conditions that can result from a number of different physical, developmental, or mental conditions, ranging from spinal cord injury to AIDS to Alzheimer’s disease. A primary issue regarding disability and Medicare is the definition that is used. The definition used by the Medicare program to determine eligibility is not a medical definition; it is a socially defined, functional term. To qualify, recipients must be unable to work. Thus, beneficiaries who can return to work are at risk of losing their health insurance.

**Women.** Women make up about 58 percent of Medicare’s beneficiaries and about 70 percent of beneficiaries with incomes below the FPL (American Association of University Women, 2003). Half the female beneficiaries who live in poverty have incomes that are below twice the poverty level. In addition, 70 percent of
Medicare beneficiaries over age 85 are women. Almost two-thirds of these women have incomes that are under double the poverty level (Kaiser Family Foundation, 1999b). Two-thirds of Medicare beneficiaries who need assistance with one or more activities of daily living, such as eating, are women. Two-thirds of Medicare beneficiaries who receive home health services are women. Women represent three-quarters of nursing home patients (Kaiser Family Foundation, 1999b).

Clearly, the Medicare program is vitally important to women. Women are more likely to live in poverty than men are and many outlive their husbands. As discussed in Chapter 8, women have experienced economic inequity through occupational segregation, job discrimination, and pay inequity. Consequently, older women in particular often depend on their spouses for financial support; widowhood or divorce compounds this problem.

Women are also more likely to live alone than are men due to increased longevity, a tendency to marry slightly older men, and higher remarriage rates for widowed men than for widowed women (Health Care Financing Administration, 2000b). Because of their longevity, women are more susceptible to multiple chronic conditions, such as hypertension, arthritis, and osteoporosis, and have a greater need for long-term care. These concerns are addressed in greater depth in Chapter 8.

Managed Care and Medicare

Chapter 5 describes the introduction of managed care into the Medicare program in the early 1980s, its growth and development through the 1990s, and more recent problems encountered in efforts to enroll beneficiaries and attract health plans. Medicare + Choice was introduced in 1997 and renamed Medicare Advantage in 2003. In an effort to control costs, beneficiaries have been encouraged to enroll in HMOs and PPOs. However, serious problems with the government’s ability to attract private insurance companies and expand managed-care options, beneficiaries’ ability to comprehend the complexities of these plans, and the government’s ability to regulate quality of care in these plans have created more doubt than anything else in the “advantage” of managed care in Medicare.

In fact, until 2005, there was a steady decline in enrollment in Medicare HMO plans, and more Medicare beneficiaries were enrolled in traditional FFS plans (88 percent) than in 1998 when Medicare + Choice was first introduced (Kaiser Family Foundation, 2005d). However, enrollment in private fee-for-service (PFFS) plans in particular, grew dramatically in 2006 and 2007, and 57 percent of all new Part C enrollment from 2005 to 2007 occurred in these plans. While PFFS plans seem to be increasingly popular because they promise reduced out-of-pocket costs and fewer restrictions to access to care, questions have been raised about the ability of these plans to deliver these services (Blum et al., 2007). Critics have also raised concerns about the federal government encouraging this option and paying higher premiums for these plans per enrollee; the federal government now pays 113 percent more for Medicare Advantage (Part C) than the traditional Medicare program(Kaiser Family Foundation, 2008a).
CHAPTER SIX / Medicare and Medicaid

TERMINOLOGY BOX

Disability

Disability is defined as inability to function. To be included in the U.S. Bureau of the Census as disabled, individuals must meet one of the following criteria:

<table>
<thead>
<tr>
<th>Disabled</th>
<th>Severely Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty with functional activities, including sight, hearing, walking Difficulty with activities of daily living, including bathing, dressing, eating</td>
<td>Use of wheelchair for mobility or long-term use of canes, crutches, walkers</td>
</tr>
<tr>
<td>Difficulty with instrumental activities of daily living, such as taking prescribed medication or keeping track of money</td>
<td>Completely unable to perform activities of daily living</td>
</tr>
<tr>
<td>Specific conditions, such as learning disability, Alzheimer’s disease, Down syndrome, mental retardation, or other developmental or mental conditions</td>
<td>Alzheimer’s disease Developmental disabilities</td>
</tr>
<tr>
<td>Limited in ability to do housework</td>
<td>Completely unable to do housework</td>
</tr>
<tr>
<td>Limited in ability to work</td>
<td>Completely unable to work</td>
</tr>
<tr>
<td>Receiving federal benefits based on inability to work</td>
<td>Receiving federal disability benefits</td>
</tr>
</tbody>
</table>

*Source: Alliance for Health Reform, 1997.*

Future of Medicare

The future of Medicare is uncertain. According to the Social Security and Medicare Trustees, the Medicare Hospital Insurance (HI) Trust Fund will run out of funds in 2020 (Social Security Administration, 2005). Between 2005 and 2030, spending on Medicare is projected to increase by 331 percent, while the GDP grows by only 72 percent (U.S. Government Accountability Office, 2005). Much of this growth in costs is due to the introduction of new technologies, which are expensive to develop and also bring “added years of life,” resulting in higher lifetime spending (Lubitz, 2005). Even less costly technology can “result in higher aggregate costs” due to the “expanded population being treated” (Lubitz, 2005, p. W5-R81).

Despite these concerns, the prospects for Medicare may not be quite as dire as some studies suggest (Cutler, 2005). Keeping people healthy before they reach age 65 could reduce costs later in life, and postponing morbidity “until age eighty-five or ninety, when people would then succumb to pneumonia or other less costly illnesses” could also result in significant savings (Cutler, 2005; Lubitz, 2005,
pp. W5-R78–79). In addition, studies by Wennberg et al. (2005) have found widespread geographic variation in per capita Medicare spending with little difference in patient outcomes or satisfaction. According to Mark McClellan, the director of the Center for Medicare and Medicaid Services under George W. Bush, “Medicare spending may be 35 percent higher than it needs to be” (cited in CBS News, 2004). Finally, as Vladeck (2005) notes, the fundamental source of health care inflation is not the aging of the population, but the high cost of health care in the United States. Bringing costs under control would do much to moderate Medicare’s financial problems.

Medicaid

Benefits and Financing

Medicaid was also enacted in 1965 as part of the compromise reform effort to expand health insurance coverage in the United States. Today, millions of low-income children, adults, older adults, and individuals with disabilities depend on Medicaid for access to health care. Medicaid is a jointly funded federal–state program administered by the states. It provides a broad range of basic health and long-term-care services. The federal government establishes rules for state governance, but states have increasingly wider discretion with the program’s policies regarding eligibility, benefits, payments, and delivery of services.

When Medicaid was first enacted, it was designed to provide insurance to older adults, disabled individuals, and dependent children and mothers. During the Clinton administration, significant reforms extended coverage to low-income children and pregnant women, and some Medicare beneficiaries who would not have met earlier guidelines for Medicaid eligibility. More money has been spent on nursing home care and long-term-care services, and Medicaid has become the nation’s major source of financing for institutional and in-home care for both young and old.

However, in 1997, in an effort to reduce spending driven primarily by an ideological shift in Congress, the federal government allowed states to mandate Medicaid managed-care plans without pursuing federal waivers, except for Medicare–Medicaid dual eligibles, children with special needs, and Native Americans. It also allowed states to create managed-care plans with 100 percent Medicaid enrollment by doing away with the policy of limiting a plan’s Medicaid membership to 75 percent (U.S. General Accounting Office, 1996). In 2001, the controversial Health Insurance Flexibility and Accountability Initiative was passed to give states even more flexibility in the federal waiver process, but many criticized this as an invitation for states to scale back costs by reducing benefits and coverage. In 2004, the Bush administration proposed that states have even greater responsibility for Medicaid by giving block grants to the states to fund the program; the federal government would no longer provide matching dollars to the state and federal funding for Medicaid, and the State Children’s Health Insurance Program (S-CHIP) would be reduced by $500 billion over a ten-year period (Families USA, 2003).
While the Bush administration was unable to withdraw federal support to the states, it did enact the Deficit Reduction Act (DRA) of 2005. The DRA impacted almost all aspects of the Medicaid program, including determination of eligibility (e.g., resource and asset rules, citizenship documentation, third party liability), scope of benefits (prescription drug coverage, non-emergency transportation services, case management), and state purchasing of long term care insurance. It also introduced home and community-based care options for children and adults with disabilities. States were given more flexibility by allowing them to make individuals ineligible for services or limiting the range of benefits provided. Although new strict requirements for citizenship documentation (such as original birth certificates and photo identification) do not apply to Medicare or SSI recipients, they are used for other categories of Medicaid recipients, including poor and low-income pregnant women and children and S-CHIP.

The DRA also gave the states expanded authority to impose cost sharing on Medicaid beneficiaries, and in 2008, new federal Medicaid rules were written giving states the authority to charge premiums and higher copayments for doctors’ services, hospital care and prescription drugs provided to low-income people, and to deny care or coverage to Medicaid beneficiaries who do not pay their premiums or their share of the cost for service. This is a significant change in the Medicaid program, one that reflects continuing concerns about cost and the Bush administration’s desire to shift these costs to the states (National Health Law Program, 2007). Until these more recent efforts to reduce cost, the most significant change has been the rapid growth in managed care as a means of delivering Medicaid services.

**Mandatory and Optional Benefits.** States participate in the Medicaid program on a voluntary basis; however, all states participate. To receive federal funding, states must provide coverage for the following services:

- Inpatient and outpatient hospital care
- Physician, medical, and surgical dental services
- Prenatal care
- Pediatric and family nurse practitioner services
- Vaccines for children
- Nurse midwife services (authorized by the state)
- Laboratory and X-ray services
- Nursing facility and home health care for adults over age 21
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children and youth under age 21
- Family planning services and supplies
- Rural health clinic services and federally qualified health center services (Health Care Financing Administration, 2000a)

Each state receives between 50 and 77 percent of the cost of these mandated services based on a formula that incorporates per capita income (Kaiser Family Foundation, 2005g). States also receive funding for a wide range of optional services,
such as dental, hearing, and eye care, and intermediate facility care for individuals with mental retardation, and also to extend services to optional populations. The majority of state funding for optional benefits is spent on long-term-care services and (until 2006) prescription drugs for older adults and disabled beneficiaries (Kaiser Family Foundation, 2005g).

**Mandatory and Optional Eligibility.** States must provide benefits to five specific categories of poor or low-income individuals: (1) pregnant women, (2) children, (3) older adult Medicare recipients (called dual eligibles because they are eligible for both Medicare and Medicaid), (4) parents (under age 65) with dependent children (Aid to Families with Dependent Children [AFDC] recipients until 1996; now Temporary Assistance to Needy Children [TANF] recipients), and (5) children and adults with disabilities (SSI recipients).

However, millions of poor and low-income individuals do not meet the criteria for these defined categories, including adults without dependent children and those who are not disabled. Without federal support, states are increasingly unlikely to extend coverage to these individuals because they would bear the full cost of coverage. In addition, federal matching funds may be available for some individuals within an eligible category, yet not available for others (Schneider et al., 1998).

As stated by Schneider et al. (1998), states must comply with five broad eligibility policies, two based on financial criteria (income limits and resource limits) and three based on social status and residency criteria (categorical eligibility, immigration status, and residency). The requirements for each can be found at www.hcfa.gov.

As of 2004, twenty-three states had extended coverage to immigrants ineligible for Medicaid or S-CHIP due to the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Some states have extended coverage to undocumented immigrants, primarily pregnant women and children. Most of these programs provide the same benefits. State coverage for immigrants remains a pressing issue because recent immigrants are less likely to have health insurance than others, and the disparity in coverage between recent immigrants and other citizens has widened since the PRWORA was legislated (Kaiser Family Foundation, 2004c).

**Medicaid Benefit Payments.** In the early 1990s, Medicaid spending grew primarily due to increases in hospital payments for disproportionate share reimbursements. These are payments made to hospitals that serve a disproportionate share (DSH) of poor or low-income patients and are supplemental to the regular payments hospitals receive from Medicaid. However, between 1992 and 1995, growth in spending declined significantly to approximately 10 percent annually. This occurred for several reasons, including low rates of inflation and new federal limits on DSH payments (Kaiser Family Foundation, 1999d).

In the mid-1990s, growth in spending declined to a historic low (approximately 3 percent annually) because of the welfare reforms discussed earlier and a reduction in DSH payments. With TANF and Medicaid delinked, one major unintended consequence of welfare reform was the decline in the number of Medicaid beneficiaries. In addition, payments to DSH hospitals declined overall during this period due to leg-
islation passed in 1993 (Kaiser Family Foundation, 1999d). From 1997 to 1998, enrollments remained steady, but spending increased significantly due to the rising cost of prescription drugs, the increase in home and community-based care, and the increase in the size of the disabled population (Kaiser Family Foundation, 2001).

From 2000 to 2002, both spending and enrollment rose significantly; Medicaid spending increased $70 billion due to enrollment growth, particularly among working families, as adults lost employment-based health insurance due to the country’s economic downturn. Since 2003, however, spending has slowed due to state efforts to control costs, a decline in DHS spending and reduced use of upper payment limits that allow states to receive extra federal funds (Kaiser Family Foundation, 2005f). There has also been an administrative effort to promote the use of Section 1115 waivers to restructure state Medicaid programs through the Health Insurance Flexibility and Accountability Initiative launched in 2001 by the Department of Health and Human Services. Some states, such as New York, have used this initiative to expand coverage, but others, such as Oregon and Tennessee, have made program changes that reduce or eliminate coverage for optional Medicaid categories. These waivers have also been used by the states to shift federal SCHIP funds to coverage for populations other than children. Seventeen states have had waivers approved since 2001 (Kaiser Family Foundation, 2005g).

Perhaps most significantly, the 2005 Congress threatened to reduce federal spending on Medicaid by as much as $10 billion, and President Bush created a commission to study proposals to achieve this goal. The National Governors Association boycotted the commission and instead offered its own proposals (July, 2005). Some of these proposals could harm Medicaid recipients, such as changes in cost sharing, allowing states to offer different benefit packages to different groups of people, and expanding state flexibility to make changes without federal waivers (Families USA, 2005a). As mentioned earlier, the new federal Medicaid rules enacted in 2008 gives states the option to require new or higher copayments from an estimated 13 million low-income recipients, allowing states to shift some of the burden of rising costs to recipients (Kaiser Family Foundation, 2008c).

Recipients

In 2005, the Medicaid program provided health insurance coverage for 58 million people. The program served 29.4 million children, 15.2 million adults in families with dependent children, 8.3 million individuals with disabilities, and 5.8 million older adults (Kaiser Family Foundation, 2005d). Although the vast majority of recipients are children and adults living in poor families, 70 percent of the cost of Medicaid is spent on older adults and people with disabilities (Kaiser Family Foundation, 2005e).

During the early 1990s, the number of Medicaid recipients increased significantly when the program expanded to include pregnant women, infants, and young children up to 133 percent of the FPL. States were given the option to expand coverage to pregnant women and infants up to 185 percent of the FPL. Court decisions also mandated coverage to children with learning disabilities. However, enrollments have declined steadily since 1995 due to state and federal reforms.
in AFDC that culminated in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Kaiser Family Foundation, 1999c). Until recently, enrollment projections showed modest growth (1 percent annually) until 2010 (Health Care Financing Administration, 2000a). However, with the nation’s dramatic economic downturn in 2008, a Center on Budget and Policy Priorities survey (Lav and McNichol, 2009) found that at least 47 states are expecting budget shortfalls totaling more than $350 billion during fiscal years 2000 to 2011. Economists predict that unemployment will rise to 9 percent or higher due to the economic recession, which will reduce state income taxes and increase demand for Medicaid.

The Obama administration recognizes the importance of federal assistance to the states to address this problem. The 2009 American Recovery and Reinvestment Act includes approximately $135 to $140 billion — or about 40 percent of projected state deficits—to help states maintain their Medicaid programs and reduce fiscal deficits. As reported by Lav and McNichol (2009), these funds will significantly reduce the depth of state budget cuts and moderate state tax and fee increases due to budget shortfalls, but some health officials have warned that this may not be enough support to stem a reduction in services during this economic crisis.

**Poor and Low-Income Pregnant Women, Children, and Families.** Until the mid-1980s, Medicaid was essentially limited to recipients of public assistance (AFDC and SSI). Some states provided Medicaid to people defined as medically needy, a term used to describe individuals who meet the categorical requirements of Medicaid and have catastrophic medical expenses, but whose incomes are too high to meet the income requirements of the program. In these cases, states have the option to allow these individuals to spend down, or offset their excess income, by deducting their medical expenses from their income during a specified period of time. This process allows them to qualify for Medicaid (U.S. General Accounting Office, 1995).

In 1986, Congress expanded access to Medicaid by giving states the option to cover pregnant women, infants, and children (up to age 8) with family incomes up to 185 percent of the FPL. Beginning in 1989, states were required to cover individuals with incomes at or below 75 percent of the FPL. They were also required to cover pregnant women and children up to age 6 with family incomes up to 133 percent of the FPL by 1990. In 1990, states were also given the option to gradually phase in children born before September 30, 1983 (aged 6 to 10), with family incomes up to 100 percent of the FPL. The purpose of the phase-in expansion was to encourage states to cover all poor children through age 18 by 2002 (U.S. General Accounting Office, 1995).

After almost a decade of federal–state efforts to expand coverage to children, Medicaid “helped cushion the effect of [the] declining employment-based health insurance” discussed in Chapter 4, but many children remained uninsured (U.S. General Accounting Office, 1995, p. 20). For example, in 1995, only twenty-seven states had expanded coverage in their Medicaid programs to 185 percent of the FPL. Only twelve states had increased coverage to children to the upper age limit of 19 (U.S. General Accounting Office, 1995). By 1997, only two more states (Wisconsin and Arkansas) had expanded coverage to 185 percent of the FPL. A number
of states increased the upper age limit from 12 to 14, 16, 17, or even age 18, but no additional states had expanded coverage to the age of 19. Even among children eligible for Medicaid, more than one-third had not been enrolled (U.S. General Accounting Office, 1995; National Governors Association and National Conference of State Legislatures, 1998), and studies found that families seemed to be unaware of their children’s eligibility or avoided enrollment because they perceived stigma attached to Medicaid (U.S. General Accounting Office, 1995).

State Children’s Health Insurance Program (S-CHIP). In 1997, as part of the BBA, Congress enacted Title XXI of the Social Security Act, the S-CHIP. The purpose of S-CHIP, which became effective January 1, 1999, was to increase health insurance coverage to children in low-income working families. Matching funds were provided to the states to expand coverage to children in families with incomes up to 200 percent of the FPL. States were given three broad options to increase coverage:

1. States could expand Medicaid by increasing the age of eligibility, the income level for eligibility, or both. The program had to be offered statewide.
2. States could establish new state programs or expand the state-run health insurance programs already available to children.
3. States could provide some combination of both options by changing the state Medicaid program and establishing or expanding a state-run program. (Edelman, 1999).

States that had already made provisions for families at 200 percent of the FPL were allowed to expand coverage to 300 percent. Medicaid, health maintenance plans (HMOs), the state employees’ plan, or the federal employees’ Blue Cross Blue Shield plan could administer the benefit plans; in most states, the Medicaid plan was already the most comprehensive. Premiums or copayments could be charged only if the state decided to establish a new plan. Children eligible for traditional Medicaid coverage (family incomes less than 133 percent of poverty) would not be eligible for the new S-CHIP program (Edelman, 1999).

The primary targets of the S-CHIP program were children with parents who were unemployed, in transition between jobs, or employed in jobs that did not provide health insurance benefits. The states had to identify and reach families through outreach and provide flexible approaches to expand coverage to children in these families. Private insurance mechanisms, such as waiting periods for new employees, premiums, copayments, and deductibles, were known to be barriers to coverage for families with moderate incomes. The S-CHIP program allowed states to coordinate benefits coverage with private employers, subsidize employer-based insurance, pay for private insurance copayments and deductibles, and simplify the application, enrollment, and eligibility determination process. The stigma associated with Medicaid was also addressed by giving the states the option to give the program its own name (Reschovsky and Cunningham, 1998).
Initially, states moved quickly to receive the program's matching federal funds. By September 1998, fifty states had submitted plans for their state programs. Four states raised eligibility to 300 percent of the FPL, and four others established eligibility requirements higher than 200, but lower than 300 percent of the FPL. Nineteen more states determined eligibility as 200 percent of FPL, but the remaining states were still at 185 percent or less (National Governors Association and National Conference of State Legislatures, 1998). By 1999, there was concern about the failure of states to reach out to uninsured children; in May 1999, less than 20 percent of available funds were being spent (Pear, 1999). In addition, a Families USA (1999d) study of the twelve states with the largest number of uninsured children (totaling two-thirds of all uninsured children in the United States) showed that from 1996 to 1999 almost 1 million children had lost Medicaid. Although the S-CHIP program had expanded coverage to children in low-income working families, AFDC reforms enacted in 1996 (Personal Responsibility and Work Opportunity Reconciliation Act) had reduced the number of enrollees. The combined effect was a decline in coverage for children.

*Personal Responsibility and Work Opportunity Reconciliation Act of 1996.* The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 ended AFDC, the federal income assistance program that originated with the Social Security Act of 1935. The bill replaced AFDC with TANF, a block-grant program that provides state funds for income assistance for low-income families. PRWORA eliminated the federal entitlement to public assistance and gave each state a block grant to administer its own program.

The legislation delinked Medicaid and TANF; prior to these reforms, most AFDC recipients were automatically eligible for Medicaid. This changed with the creation of TANF; eligibility for TANF and Medicaid became separate determinations. However, states are required under Section 1931 of the Social Security Act to provide coverage for families with dependent children who meet the income and resource eligibility criteria in effect prior to the repeal of AFDC on July 16, 1996 (Greenberg, 1998). However, income eligibility standards (percent of FPL) for AFDC had been set so low by the states that many working parents were ineligible for coverage (Families USA, 2000). Congress gave states the option to use less restrictive guidelines and, as of August 1998, to provide coverage to two-parent low-income families (Health Care Financing Administration, 2000a). Thus, even if families were no longer eligible for TANF because of time limits, they were still likely to be eligible for Medicaid.

In 1997, as an “unintended consequence” of the new legislation, “an estimated 675,000 low-income people became uninsured . . . more than three out of five (62 percent) were children” (Families USA, 1999c, p. 2). The Families USA study found that most of the children should not have lost coverage because they were still eligible for Medicaid. Coverage was lost in three primary ways. First, when recipients were terminated from income assistance, they were not informed of their eligibility for Medicaid. TANF recipients are terminated after two years if the recipient does not
find employment or if he or she reaches the lifetime maximum of five years. As families reached these time limits, administrative errors led to loss of Medicaid.

Second, recipients lost coverage when they moved from “welfare to work,” as prescribed by the PRWORA. Adult recipients typically found employment in jobs that did not offer health insurance benefits and were eligible for Medicaid only if they earned very little money (less than the FPL). Their children, on the other hand, were eligible at higher (family) income eligibility standards; yet they too were terminated at this point. Third, some states discouraged enrollment in the TANF program. They diverted families from the application process toward job-seeking activity, lump-sum cash payments, and other options. If families were unaware of their right to Medicaid independent of the TANF program, they were at risk of losing coverage.

Studies conducted by the Urban Institute (Ellwood, 1999; Garrett and Holahan, 2000) confirmed these findings. A follow-up study by Families USA (2000) showed that Medicaid enrollments declined from 1996 to 1999 not only for children, but also for low-income parents. In the fifteen states with the highest enrollments of low-income adults, almost a million parents lost Medicaid coverage. In addition to the causes cited in the earlier study, this study found that few states had taken advantage of the options to expand coverage to low-income parents. A report prepared for the government suggested “an urgent need for welfare workers to be given assistance in understanding complex eligibility rules, and for automated eligibility systems to be brought up to date” (Dion and Pavetti, 2000, p. 32).

As of fiscal year 2000, seventeen states had not reached the expanded income eligibility standard of 200 percent FPL, while ten states exceeded the standard with 200 to 300 percent FPL criterion. S-CHIP had reached and enrolled over 3 million children, but more than 6 million were eligible and still not enrolled (Children’s Defense Fund, 2000; Health Care Financing Administration, 2000c; see www.hcfa.gov/init/fy200_.pdf for new state enrollment statistics). In an effort to reach these children, Congress passed the Medicare, Medicaid, and S-CHIP Benefits Improvement and Protection Act in December 2000. This legislation adjusted the formula for reallocation of the unspent funds. The bill allowed states that had already spent their allocation to apply for up to 40 percent of the unspent funding, and states that had not used their full allocation to receive up to 60 percent. All states could use 10 percent of the funds for outreach activities (Children’s Defense Fund, 2000). These incentives led to modest gains in the enrollment of low-income children through 2002. However, as of 2008, only forty-three states and the District of Columbia have reached the eligibility standard of 200 percent of the FPL (Kaiser Family Foundation, 2008d).

In recent years, as states have struggled with decreased revenues, TANF families have also been at risk of losing their Medicaid benefits due to policy changes that deny these benefits. For example, about one out of every four states has imposed sanctions that deny cash assistance and Medicaid benefits to TANF recipients for violation of the state’s work requirements. In Texas alone, the TANF population declined by almost one-third between 2003 (when the work violation sanction was introduced) and 2005, primarily due to this new sanction. Many of these recipients have difficulty complying with this requirement because they
have physical and mental health problems, not because they are unwilling to seek and maintain employment (Dunkelberg, 2005; Hagert, 2005). As occurred during the last recession, Congress is likely to increase Medicaid matching funds and general grants to the states to assist with the increased demand for Medicaid created by the economic downturn in 2008–2009.

In recent years, states have experienced significant declines in state revenues and major shortfalls in state budgets. In an effort to control spending, many states have imposed restrictions on both Medicaid and S-CHIP. Between 2003 and 2004, twenty-three states introduced changes that made it more difficult for low-income families and children to be eligible for S-CHIP. These actions included freezing enrollments, increasing premiums, and adopting more complex enrollment procedures. For the first time since S-CHIP was introduced in 1997, enrollment actually fell in 2003. Most states have eliminated outreach efforts (Kaiser Family Foundation, 2005b), and current financing issues with S-CHIP are projected to result in further declines in coverage for low-income children (Kaiser Family Foundation, 2005c).

In 2007, the Bush administration issued a directive to prevent states from expanding S-CHIP coverage to children in families above 250 percent of FPL unless states could comply with a series of strict benchmarks. Although Congress considered bipartisan bills to reauthorize S-CHIP and expand coverage, the Bush administration vetoed these efforts. Meanwhile, enrollment remained stagnant.

S-CHIP Today. With the election of President Obama, S-CHIP was finally given support and approval and reauthorized by Congress in February 2009 as the Children’s Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA or “CHIP” (no longer S-CHIP) adds $33 billion to the program for 2009–2013 and is expected to provide health insurance to an additional 4.1 million children who otherwise would not have been covered (Kaiser Family Foundation, 2009b). Bush’s directive to limit coverage to 250 percent of the poverty level was withdrawn by President Obama, and CHIP now establishes an upper income limit of 300 percent of the federal poverty guideline.

Other changes legislated by the reauthorization allow states to cover certain low-income pregnant women through a state plan amendment, require states to cover dental services, and require parity of mental health services. Coverage for parents of enrolled children will be phased-out of the program, as will coverage for non-pregnant childless adults for the few states that had received federal permission to do so. CHIP removes the five-year waiting period for legal immigrant children and pregnant women to enroll, provides millions of dollars for outreach and enrollment activities, and gives the states more options to offer premium assistance. A decade after S-CHIP first became effective, it has finally received significant support from the federal government to sustain and expand its mission to cover uninsured children.

Poor and Low-Income Children and Adults with Disabilities. Most Medicaid recipients with disabilities qualify for the program because they are eligible for the SSI program. SSI was established under President Nixon in 1972 as a federal income-
assistance program for poor elderly, blind, and disabled persons. Age is not a factor; SSI provides income assistance to children, youth, and adults. In 2007, SSI served 7.4 million individuals (U.S. Social Security Administration, 2007); more than 85 percent were adults. However, the number of children with disabilities served by SSI (1.1 million) has grown since the *Sullivan v. Zebley* case (discussed next). SSI recipients are eligible for assistance due to a wide range of disabling conditions, including mental retardation, mental illness, drug addiction and alcoholism, blindness, and diseases of the central nervous system.

The Supreme Court ruling with the greatest potential for changes in long-term services in Medicaid is the case of *Olmstead v. L.C.* (June 22, 1999). The Olmstead case found that unjustified institutional isolation of people with disabilities is a violation of the Americans with Disabilities Act of 1990. The case involved two women in Georgia with mental retardation and other mental illnesses who had been institutionalized and denied community-based care for a number of years. Medicaid requires states to provide institutional services as a mandatory service, but classifies community-based care as an optional service. The court viewed this as a bias toward institutionalized care, particularly at a time when states and communities increasingly recognize the value of community-based services. The court’s decision has not changed Medicaid, but advocates of civil rights for people with disabilities see this ruling as one that will help them combat barriers to community integration of people with disabilities (Kaiser Family Foundation, 2004b).

SSI and Children. Before 1983, SSI used a different definition of disability for adults than for children. For adults, disability was defined as physical or mental health problems that interfered with the ability to work. For children, specific medical criteria, such as mental retardation or deafness, were used. In 1983, a class action suit, *Sullivan v. Zebley*, was brought against the federal government by the Legal Services office in Philadelphia on behalf of all children with disabilities who had been denied benefits. The Supreme Court ruled in favor of the children in 1990 and expanded the program’s listing of eligible medical conditions to include learning disabilities, such as attention deficit disorder (ADD), and other functional impairments of activities of daily living, including speaking, walking, and bathing. In addition, because of the court’s decision, two new standards for determination of eligibility were established: individualized functional assessments (IFA) and functional equivalence. In essence, children who could not function at a level appropriate for their age became eligible for SSI (U.S. General Accounting Office, 1998).

As a result of these changes, between 1983 and 1990, the federal government reevaluated 288,000 denied cases at a cost of $3 billion in back payments (Pear, 1990). From 1989 to 1996, the number of children eligible for SSI tripled to almost 1 million because of the Supreme Court decisions (U.S. General Accounting Office, 1998). In 1995, as part of its focus on welfare reform, Congress considered elimination of the IFA and revision of the medical listings. With the program’s growth and the increase in the number of children eligible for SSI and Medicaid, the Republican-controlled Congress questioned the objectivity and consistency involved in determining need.
It also believed that some families were guilty of fraud and abuse because of coaching their children to misbehave or fake disabilities (Pear, 1997b).

The PRWORA of 1996 changed the SSI eligibility criteria for children by eliminating the IFA and restricting the medical listings, thus making it more difficult for children to qualify. Under the new law, effective July 1, 1997, children with medically proved physical or mental conditions that resulted in marked and severe functional limitations would be eligible, whereas children with more moderate, maladaptive conditions would not. The Social Security Administration projected that children with mood disorders would be affected most. However, they also found that children with pulmonary tuberculosis, mental retardation, burns, intracranial injuries, schizophrenia, and arthritis would be denied benefits. The Congressional Budget Office estimated that 48,000 children would lose coverage between 1997 and 2003 and that 315,000 children who would have qualified under the previous law would be denied coverage (National Association of Social Workers, 1996).

In fact, in 1997 disability benefits were terminated for 95,180 children; most had mental health disorders (Pear, 1997a). However, in appeals and reviews of these cases, it was determined that many children were wrongly terminated, and the decisions were reversed (Pear, 1997b). More importantly, the BBA of 1997 restored Medicaid eligibility for children with disabilities who lost their SSI benefits due to the new restrictions (National Association of Social Workers, 1997).

In 1998, the Social Security Administration issued a new plan for quality reviews of children’s disabilities to improve the accuracy and consistency of determinations across the states (U.S. General Accounting Office, 1998). Nonetheless, the number of SSI awards for children with mental health disorders began increasing after 1997 and reached an all-time high in 2003 (U.S. Social Security Administration, 2008).

SSI and Adults. The PRWORA of 1996 also had a significant impact on adults with disabilities. Under the new policy, SSI benefits were denied to legal immigrants (for exceptions, see Figure 6.3) until they became U.S. citizens, and Medicaid was denied to legal immigrants for a period of five years after entering the country. Legal immigrants with disabilities would be denied SSI and Medicaid until they could meet these new requirements.

**FIGURE 6.3 Legal Immigrants with Mandatory Medicaid Eligibility (No Restriction)**

Veterans and their dependents
Active-duty military personnel and their dependents
Refugees, asylees, and Cuban and Haitian immigrants for seven years after entering country
Amerasian immigrants for five years after entering country
Permanent residents with Social Security (40 credited quarters)
Canadian-born immigrants with 50% or more North American Native heritage

*Source: Families USA, 1999b.*
However, the Balanced Budget Reconciliation Act of 1997 restored Medicaid benefits to some immigrants by giving states the option to provide coverage to legal immigrants who entered the country prior to August 22, 1996, if they became disabled after this date. Such immigrants can receive emergency medical services only. S-CHIP, however, must be made available to legal immigrant children who entered after August 22, 1996. In 1998, new regulations restored SSI–Medicaid-linked benefits to legal immigrants who were denied coverage based on the 1996 reforms, if they were receiving benefits on August 22, 1996.

Other changes in SSI have had a significant impact on the Medicaid program and coverage for adults with disabilities. In 1988, the U.S. Justice Department included acquired immune deficiency syndrome (AIDS) in the list of approved medical conditions. Today, Medicaid serves about 55 percent of all individuals living with AIDS and about 90 percent of all children living with AIDS; most of these recipients are SSI recipients. Medicaid is the single largest payer of services for people with AIDS. The Centers for Medicare and Medicaid Services (2005a) estimated that 8.5 billion in federal and state Medicaid dollars would be spent providing coverage to 231,000 individuals in fiscal year 2003. This is double the number of individuals served and Medicaid dollars spent in 2001 (Health Care Financing Administration, 2001a).

One of the most dramatic changes in the SSI program was the elimination of drug and alcohol addiction as the sole reason for eligibility for SSI and Medicaid. In 1994, Congress passed the Social Security Independence and Program Improvements Act, which restricted SSI benefits to thirty-six months and required recipients to be in treatment. SSI recipients dropped from SSI could continue to receive Medicaid, as long as they remained in treatment for twelve successive months. In 1999, all benefits (SSI and Medicaid) for all individuals solely disabled by alcohol or drug addiction were terminated from the program, effective January 1, 1997. Over 200,000 recipients were notified and, after reviewing their disability status, 50,000 were terminated. This group was given a second look in 1998, and a few hundred additional enrollees were terminated (Nibal, 2000).

The most significant change for disabled individuals who want to work is the Ticket to Work and Work Incentives Improvement Act of 1999. Beginning on October 1, 2000, states had the option to expand Medicaid to (1) to individuals with disabilities who want to work by increasing the amount they can earn and (2) to employed individuals with medically improved disabilities who lost their Medicaid coverage because they no longer met SSI’s adult definition of disability. States can establish their own income and resource eligibility standards and impose premiums on a sliding scale basis (Health Care Financing Administration, 2001c).

Medically Needy. Children and adults with disabilities can qualify for Medicaid if they are “medically needy” and “spend down” to the state’s standard. Although states have the option to set standards for income that should be protected from high medical expenses, the federal government limits the standard to 133 percent of the state’s 1996 AFDC payment level. Thus, the medically needy standard is usually set well below SSI payment levels.
In addition, because there is significant variation in the 1996 AFDC payment levels among the states, there are significant disparities in access based on medical need. For example, in 1999 in Vermont, elderly recipients had to spend down to a monthly income of $683, whereas elderly recipients in Louisiana were required to spend down to $100 monthly income. These guidelines also create inequities among older adults within states. For example, in Louisiana, an elderly SSI beneficiary with disabilities would receive full Medicaid coverage and $500 monthly income, whereas someone who is medically needy would receive only $100 monthly income. To make matters worse, nearly one-third of the states have no programs or coverage for the medically needy (Families USA, 1999a).

With states struggling to reduce spending over the past few years, some have introduced Section 1115 waivers (since 2001), which make it more difficult for medically needy children and adults to enroll in Medicaid. For example, Oregon reduced its enrollment by half in 2003 by increasing premiums for poor adults and eliminating their Medically Needy program, and about 325,000 of the poorest recipients in Tennessee are projected to lose coverage with the state’s new definition of “medical necessity” (Families USA, 2005a; Kaiser Family Foundation, 2005g).

**Poor and Low-Income Older Adults (Medicare and Medicaid Dual Eligibles).** Without question, the largest health insurance program in the United States for older adults is Medicare. However, Medicaid is also a vital source of health insurance for poor and low-income older adults. About half (21 million) of Medicare beneficiaries have incomes below 200 percent FPL. In 2004, over 7 million Medicare beneficiaries with incomes below the FPL were eligible for Medicaid services not covered by Medicare and assistance with the cost of Medicare Part B premiums and cost sharing. The remaining Medicare beneficiaries with incomes near poverty level were eligible for Medicaid assistance with the cost of Medicare Part B premiums and cost sharing (Kaiser Family Foundation, 2005a). Although Social Security and Medicare play a major role in reducing poverty among older adults, many are still struggling to get by. Average out-of-pocket expenses and cost-sharing requirements are very high; for this population of poor and low-income recipients, these expenses can be financially devastating.

Medicare–Medicaid dual eligibles are poorer and sicker than other Medicare beneficiaries; they tend to be over age 85, female, and people of color. They also have a higher prevalence of chronic conditions, including mental disorders, significant limitations of daily living, and are highly reliant on prescription medication. Nearly 25 percent are in nursing homes, compared to 2 percent of other Medicare beneficiaries (Kaiser Family Foundation, 2005a). Yet, Medicaid does not cover nearly half of all poor and low-income Medicare beneficiaries eligible for coverage (Schneider et al., 1999). There are many reasons for the low enrollment, including the complexity of the program, inadequate outreach efforts, and the stigma associated with public assistance programs (Nemore, 1997).

States have had the option to expand Medicaid coverage to poor and low-income Medicare beneficiaries through a number of program options, and with
funds made available through block grants established by the BBA of 1997. (The eligibility criteria can be found at www.hcfa.gov.) Prior to 1997, states met the 20 percent cost-sharing requirement for dual eligibles who received full Medicaid benefits. However, because state Medicaid payments are often set lower than Medicare rates, states now pay cost sharing only up to the Medicaid rate. Also, physicians and other Medicare providers are prohibited from billing dual eligibles for copayments and deductibles not covered by the state.

The transition to Medicare Part D Prescription Drug coverage has been difficult for this population. During the recent transition to coverage, many recipients were charged unnecessarily for their prescriptions or lost coverage; states provided assistance to maintain uninterrupted drug coverage for serious chronic conditions, including HIV/AIDS, but many still need assistance with understanding this relatively new benefit. In addition, increases in monthly premiums by Medicare drug plans will force many recipients into lower-cost plans during the program’s annual open enrollment period. A study conducted by The Lewin Group on behalf of the Medicaid Health Plans of America (MHPA) and by the Association of Community Affiliated Plans (ACAP) found that enrolling all 8 million dual eligibles in managed care plans over five years could save $50 billion of state and federal dollars and $300 billion over 15 years. Forty percent of all Medicaid spending is attributed to dual eligibles, while this population accounts for about 25 percent of Medicare’s expenditures (Medicare Rights Center, 2008).

Managed Care and Medicaid

Chapter 5 provides an overview of the origins and development of Medicaid and managed care. In 1981, states were given the option to seek federal waivers to establish mandatory managed-care plans. From 1983 to 1997, states experimented with managed-care plans primarily for AFDC recipients; enrollment in these plans grew from 3 million to 17 million recipients (Kaiser Family Foundation, 1998a). By 1998, as a result of changes promoted by the BBA of 1997, 25 percent of all disabled Medicaid recipients were enrolled in managed-care plans due to state initiatives to experiment with plans for the disabled (Kaiser Family Foundation, 1998a). By 2000, the majority (57 percent) of Medicaid managed-care recipients were enrolled in managed-care plans (Health Care Financing Administration, 2001b).

A few states sought federal waivers to establish managed-care plans for dual eligibles, though few were enrolled (U.S. General Accounting Office, 2000b). Many states experimented with mandatory managed-care plans for children with special needs. Children eligible for SSI were most often enrolled, and the number of children enrolled in both SSI and Medicaid managed care increased from 32 percent in 1990 to 71 percent in 1998 (National Academy of State Health Plans, 1999). The GAO’s report of safeguards to ensure access to specialists found that states varied tremendously in these efforts (U.S. General Accounting Office, 2000a).

The initial growth of managed care in the Medicaid program was driven by state efforts to reduce rising costs, particularly during the late 1980s and early 1990s
(Families USA, 2001). However, despite (1) doubts about the ability of managed care to adequately serve low-income recipients, older adults, and individuals with greater health needs than the rest of the population (see Chapter 5); (2) concerns about inadequate access to medical specialists and social services, and cost shifting rather than cost savings (Holahan et al., 1998; Rowland et al., 1995); and (3) inadequate consumer information about plans, interruptions in treatment, barriers to filing grievances, and insufficient assurance of quality of care (Families USA, 2001), the number of Medicaid managed-care plans grew by 16 percent between 2000 and 2003 (Kaiser Family Foundation, 2005g). Today, about two-thirds of all Medicaid beneficiaries are enrolled in managed-care plans (Centers for Medicare and Medicaid Services, 2005a; Kaiser Family Foundation, 2009a), and increased utilization of mental health services, specifically, was reported as one of the leading causes of increased spending in 2008 (Kaiser Family Foundation, 2008c).

**Future of Medicaid**

The downturn in the U.S. economy in 2008 demonstrates the importance of Medicaid as a safety-net for those who would be without coverage if this program did not exist. Although the Obama administration has responded to the recent economic crisis with the most unprecedented federal stimulus package since the Great Depression of the 1930s, while unemployment remains high, the states will need to find ways to maintain and expand their Medicaid programs to meet growing demand for coverage. As mentioned earlier, the American Recovery and Reinvestment Act of 2009 will provide states with only about 40 percent of projected state deficits. Meanwhile, as the Obama administration and Congress wrestle with major health policy challenges that are intensified by these problems, the role of both Medicare and Medicaid in broader plans for health care reform remains unclear.

**Medicare Milestones**

- Created in 1965 as Title XVIII of the Social Security Act.
- In 1967, Early and Periodic Screening, Diagnosis and treatment (EPSDT) added for children under age 21.
- Health Care Financing Administration (HCFA) created in 1972.
- In 1980, home health services coverage expanded and Medicare supplemental insurance, Medigap, brought under federal oversight.
- Tax Equity and Fiscal Responsibility Act of 1982 provides incentives for HMOs to join Medicare program and expands quality oversight efforts.
- Tax Equity and Fiscal Responsibility Act of 1982 provides incentives for HMOs to join Medicare program and expands quality oversight efforts.
- In 1983, inpatient acute hospital prospective payment system (PPS) created (replaces cost-based payments).
■ Emergency Medical Treatment and Labor Act of 1985 requires hospitals to provide appropriate emergency room medical screenings and stabilizing treatments.
■ Balanced Budget Act of 1997 established new managed care and other private health plan choices for beneficiaries designed to slow the rate of growth in spending and extend the life of the trust fund (Part C).
■ www.medicare.gov launched in 1998 to provide updated information.
■ In 1999, nationwide toll-free number (1-800-MEDICARE) made available and first annual Medicare & You handbook distributed to beneficiary households.
■ Benefits Improvement and Protection Act (BIPA) of 2000 increases payment level to providers and managed health care organizations, reduces certain copayments, and improves coverage of preventive services.
■ In 2001, HCFA renamed Centers for Medicare & Medicaid Services.
■ Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 establishes most significant changes since enactment; creates a prescription drug discount card until 2006, allows for competition among health plans to foster innovation and flexibility in coverage, covers new preventive benefits, and other changes.
■ In 2006, new voluntary Part D outpatient prescription drug benefit made available.

Medicaid/CHIP Milestones

■ Created in 1965 as Title XIX of the Social Security Act.
■ In 1972, linked to new Supplemental Security Income (SSI) program.
■ Health Care Financing Administration (HCFA) created in 1972.
■ Omnibus Budget Reconciliation Act (OBRA) of 1981 adds payments to hospitals treating disproportionate share of low-income patients and extends coverage to home and community-based long-term care.
■ OBRA 1985 extends coverage to all who qualify for AFDC.
■ OBRA 1986 expands coverage for emergency care of illegal immigrants.
■ OBRA 1986, 1988, and 1990 expand coverage and benefits to additional pregnant women and children by changing income level requirements.
■ OBRA 1990 created prescription drug rebate program.
■ Personal Responsibility and Work Opportunity Act (PRWORA) of 1996 ends AFDC and creates TANF and delinks income assistance program to Medicaid.
■ Ticket to Work and Work Incentives Improvement Act (TTWIA) of 1999 gives states the option to cover working adults with disabilities.
Balanced Budget Refinement Act of 1999 improves coverage of certain women’s health services.

Deficit Reduction Act of 2005 creates new eligibility restrictions and requires strict citizenship documentation for poor and low-income women and children and S-CHIP.

In 2008, new rules give states the option to require new or higher copayments and disenroll beneficiaries who do not pay their premiums.

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reintroduces 300 percent of the poverty level as the eligibility ceiling and provides millions of dollars to expand coverage to uninsured children.

The American Recovery and Reinvestment Act of 2009 provides much needed support to the states to address budget shortages and help maintain state Medicaid programs.

**Highlights**

Medicare, a social insurance program, provides health insurance to almost 42 million adult retirees, employed individuals with disabilities who have difficulty continuing their employment, and individuals with end-stage kidney disease.

Medicaid, a means-tested program, provides health insurance to 59 million individuals of all ages who are poor and low-income pregnant women, children, and families; elderly adults; and people with disabilities. Although the vast majority of recipients are children and adults living in poor families, almost 70 percent of the cost of Medicaid is spent on older adults and people with disabilities.

Medicare has four parts: (Part A) Hospital Insurance, (Part B) Medical Insurance, (Part C) Medicare Advantage, and (Part D) Medicare Prescription Drug (effective January 1, 2006). Parts C and D were created by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Medicare is financed by a payroll tax on employers and employees; self-employed workers pay both taxes. Recipients incur substantial out-of-pocket expenses for additional physician fees, copayments, deductibles, and services not covered by Medicare. The most costly services not covered are prescription drugs, long-term care, and physician payments.

About two-thirds of Medicare beneficiaries purchase Medigap insurance or have supplemental insurance through their employers that provides additional coverage; the remaining third have reduced some of their expenses by joining managed-care plans or participating in the Medicare buy-in program. However, many eligible enrollees do not participate in the buy-in program as dual eligible beneficiaries.

Medicaid, which is administered by the states, has mandatory and optional benefits. Mandatory benefits include hospital and health care provider ser-
vices, and nursing facility and home health care. Optional benefits, which many states provide, include dental care, hearing devices, and intermediate care for mentally retarded individuals. General revenues finance the program; the federal government provides matching funds to the states. States must comply with a number of eligibility policies that limit coverage to specific groups of poor and low-income persons who meet income and assets criteria, immigration status, and residency requirements.

- The most significant expansion of the Medicaid program occurred in 1997 with the creation of the State Children’s Health Insurance Program (S-CHIP). Starting in 1999, states had the option to expand coverage to children in working families with incomes between 200 and 300 percent of the FPL. However, in recent years, many states imposed restrictions on both Medicaid and S-CHIP and, for the first time since S-CHIP was introduced in 1997, enrollment fell in 2003.
- In an effort to encourage states to make use of their S-CHIP allocations, Congress enacted legislation that allowed states that had exhausted their funding to apply for additional funds. However, with a decrease of about 1 million children from Medicaid between 1996 and 1999 due to welfare reforms enacted in 1996, coverage for children declined further. Recent legislative efforts by Congress to expand eligibility were vetoed by President Bush.
- The most significant reform in both Medicare and Medicaid was the introduction of managed care in the early 1980s and its expansion since the 1990s.
- The introduction of managed care to the Medicaid program represents a dramatic change in the way services are delivered to this population. Many concerns have been raised about the inability of managed care to reduce costs for low-income families with few resources and disabled and poor elderly individuals with significant health and medical needs. Studies have shown that state Medicaid managed-care plans have had difficulty ensuring adequate access to specialists and raise doubts about cost saving with this population.
- The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Websites to Obtain Updated and Additional Information

www.hhs.gov/Medicare
www.hcfa.gov/Medicaid
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

www.kff.org
Kaiser Family Foundation
REFERENCES


CHAPTER SIX / Medicare and Medicaid


PART THREE / The U.S. Health Care System Today


