MEDICAID is the largest health insurer in the United States, in terms of eligible beneficiaries, covering medical services and long-term care for some 41.3 million people. In 1997, Medicaid expended $159.9 billion (12.4 percent of total national health care expenditures) to pay for covered services for low-income people who were elderly, blind, disabled, receiving public assistance, or among the working poor. The vast majority of such persons fall outside the employment-based insurance system, the mainstay of coverage for the working population. This fifth report in the series on the American health care system examines the federal and state roles in Medicaid, program expenditures, eligibility for coverage, and Medicaid managed-care plans.

In recent years, Medicaid has changed in important ways. The change that has affected the greatest number of people is the expansion of the population eligible for Medicaid, from 28.3 million in 1993, when I last wrote about the program in a series similar to this one, to 41.3 million today. The Republican-controlled Congress enacted legislation to shift most of the responsibility for Medicaid to state governments, but President Bill Clinton vetoed the measure in 1995. The growth in Medicaid expenditures, which almost tripled over the past decade, has slowed in recent years, with the smallest annual increase ever in 1997. An increasing number of eligible beneficiaries have enrolled in or are being required to join managed-care plans as a result of policies that no longer give them a choice of providers. However, none of these changes have made the program any more attractive to physicians, most of whom do not provide care for Medicaid beneficiaries because the payments to providers are low, and the associated administrative burden can be quite large.

Although Medicaid and Medicare were the key elements of historic legislation enacted in 1965 as part of President Lyndon Johnson’s Great Society, Medicaid was essentially a creature of Congress. After Johnson’s landslide victory in 1964, the enactment of Medicare seemed almost a foregone conclusion, although its final design reflected countless compromises. Medicaid, however, was largely a product of the House Ways and Means Committee and its powerful chairman, Representative Wilbur Mills (D-Ark.), who favored the expansion of earlier federal efforts (embodied in the Kerr–Mills Act) to provide medical assistance to elderly and disabled people. During the congressional debate over the two programs, conservative legislators and the American Medical Association promoted a federal–state model for Medicare, but Mills instead chose this model for Medicaid. Wilbur Cohen, who worked closely with Mills in crafting the Medicaid legislation and later became secretary of the Department of Health, Education, and Welfare, wrote: “Many people, since 1965, have called Medicaid the ‘sleeper’ in the legislation. Most people did not pay attention to that part of the bill. . . . [It] was not a secret, but neither the press nor the health policy community paid any attention to it.”

The structures of Medicare and Medicaid have little in common, except that both are now administered at the federal level by the same agency, the Health Care Financing Administration (HCFA). Congress made it clear in 1965 that providing health insurance to the elderly through Medicare was a federal responsibility. But the division of authority over Medicaid between the federal and state governments resulted in a persistent struggle over how to apportion payment of the bill. In 1997, of the total expenditures of $159.9 billion, the federal share was $95.4 billion, and the states’ contribution (combined in some jurisdictions with local expenditures) was $64.5 billion. The federal share of expenditures is determined by a formula based on each state’s per capita income, with a legislatively set minimum of 50 percent and a maximum of 83 percent. States with relatively low per capita incomes receive proportionately more federal funding. Medicaid expenditures represent about 40 percent of all federal funds received by the states.

STATE MEDICAID PROGRAMS

Following broad national guidelines established by Congress and monitored by HCFA, the states set their own standards of eligibility; determine the type, amount, duration, and scope of covered services; establish the rate of payment for services; and administer their own programs. At first, a guiding principle was to provide mainstream medical services to the poor. But Medicaid was crafted administratively onto state welfare programs, largely because the only social-service agency operating in every state at the time was the welfare authority, and its clients were recipients of public assistance. Thus, the seeds of Medicaid as a welfare program were sown at the beginning, and ever since, it has been treated as a political stepchild by HCFA, the executive branch, and Congress. Nevertheless, Medicaid is the main public insurance program for many people of limited means. Studies have found that poor persons enrolled in Medicaid are more likely to have a usual source of care, have a high-
er number of annual ambulatory care visits, and have a higher rate of hospitalization than poor persons with no public or private health care coverage. Medicaid’s eligible population comprises 21.3 million children, 9.2 million adults in families, 4.1 million elderly persons, and 6.7 million blind or disabled persons. Over the past decade, the national expansion in Medicaid’s eligible population was driven by federal requirements to increase health care coverage for pregnant women and children, state efforts to cover more uninsured people of low income, and court-ordered expansions in coverage for the disabled. On average, Medicaid beneficiaries account for about 11 percent of a state’s population, but some jurisdictions have substantially higher percentages, including Tennessee (21.7 percent), the District of Columbia (17.8 percent), Vermont (17.4 percent), New Mexico (16.1 percent), New York (15.1 percent), West Virginia (14.1 percent), California (13.6 percent), Michigan (13.6 percent), Washington (12.9 percent), Georgia (12.8 percent), Kentucky (12.8 percent), Mississippi (12.3 percent), and Hawaii (11.4 percent).

Being poor does not automatically make a person eligible for Medicaid. Indeed, in 1997, Medicaid covered only 44.4 percent of nonelderly persons with an income of less than $13,330 for a family of three (Salganicoff A, Henry J. Kaiser Family Foundation: personal communication). Most people become eligible by meeting a federally defined criterion (i.e., advanced age, blindness, disability, or membership in a single-parent family with dependent children). Within the federal guidelines, the states set their own criteria for eligibility with respect to income and assets, resulting in large variations in coverage from state to state. Indeed, it is no exaggeration to say that there are actually more than 50 Medicaid programs — one in each state, plus the program in the District of Columbia and those in the U.S. territories — because the rules under which they operate vary so enormously.

THE CONCENTRATION OF MEDICAID SPENDING

Although adults and children in low-income families account for nearly three thirds of Medicaid beneficiaries, their medical care accounts for less than 30 percent of program expenditures (Fig. 1). Elderly and blind or disabled persons account for most of the expenditures because of their greater use of acute and long-term care services. In 1997, Medicaid’s costs per beneficiary were $9,539 for elderly persons, $8,832 for blind or disabled beneficiaries, $1,810 for adults in low-income families, and $1,027 for children (Hoffman D, HCFA: personal communication). The figures for elderly and blind or disabled persons do not include Medicare payments. Payments to physicians represented only 5.9 percent of Medicaid’s total expenditures in 1996, less than the program paid out for home health services or prescription drugs (Table 1). By comparison, payments to physicians made up 25.4 percent of Medicare expenditures in 1996. According to the most recent study of Medicaid’s payments to physicians, in 1993 average payments were about 73 percent of Medicare payments and about 47 percent of private fees.

Medicaid covers a broad range of services with nominal cost-sharing requirements because of the limited financial resources of beneficiaries. The benefit package extends well beyond the services covered by Medicare and most employer-sponsored plans. By federal law, states must cover inpatient and outpatient hospital services; care provided by physicians, midwives, and certified nurse practitioners; laboratory and radiographic services; nursing home care and home health care; early and periodic screening, diagnosis, and treatment for persons under 21 years of age; family planning; and care provided by rural health clinics and federally qualified community health centers. Medicaid also acts as a supplementary insurance program for elderly and disabled Medicare beneficiaries of low income, paying their Medicare premiums and cost-sharing requirements and covering additional services, most notably prescription drugs. The states have the option to cover additional services for Medicaid recipients and receive matching federal funds for them. Items commonly covered by the states include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care, and services provided by intermediate-care facilities for the mentally retarded.

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**Figure 1. Medicaid Beneficiaries and Expenditures in 1996, According to Enrollment Group.**

Total expenditures exclude administrative expenses. DSH payments denotes disproportionate-share hospital payments. Percentages do not sum to 100, because of rounding. Data provided by the Kaiser Commission on Medicaid and the Uninsured.
THE DEVOLUTION OF FEDERAL AUTHORITY

When Republicans took control of the Congress in 1995, one of their overriding policy goals was to devolve federal authority and money to state governments, particularly in the realm of social welfare. A year later, Republicans were successful in reforming welfare policies, many of which had been enacted in 1935 as part of President Franklin D. Roosevelt’s New Deal. The debate in Congress included “a massive re-examination of who ‘deserves’ public assistance.”11

The main decisions were that the states should decide who is needy, welfare should be linked to work,12 cash assistance should be temporary, and immigrants who arrive in this country after the law’s enactment should not receive full Medicaid benefits.12 Congress scrapped the federal guarantee of cash assistance for the nation’s poorest children and granted states the authority to operate their own welfare and work programs, largely with federal resources. These changes were incorporated into the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which President Clinton signed into law over the vigorous protest of the liberal wing of the Democratic Party.

Congress also enacted legislation in 1995 to recast Medicaid as it had welfare, converting the program from an open-ended entitlement program for eligible beneficiaries to essentially a state-operated program funded largely by a capped federal block grant. Clinton vetoed this measure and offered his own counterproposal, which the Republicans rejected. Two years later, in the Balanced Budget Act of 1997, Congress and the administration finally agreed on a new federal–state division of authority for Medicaid, although the debate on this subject continues.14-16

Among various provisions, all of which granted the states more authority, the budget law repealed the Boren amendment (named after the Oklahoma senator who initially sponsored it),17 which stipulated that the states must provide payments for services at levels that meet the costs incurred by “efficiently and economically operated” hospitals and nursing homes.

THE ELIGIBILITY MAZE

Medicaid’s complex eligibility policy, which “both states and the federal government have relied on . . . as a tool for limiting their financial exposure for the cost of covered benefits,”18 makes the program difficult for its beneficiaries to understand and for the states to administer. Before welfare reform

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**Table 1. Medicaid Payments for Selected Fiscal Years, According to Type of Service.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Payment†</th>
<th>Distribution in 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1985</td>
<td>1994</td>
</tr>
<tr>
<td>Total</td>
<td>37,508</td>
<td>108,270</td>
</tr>
<tr>
<td>Inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General hospitals</td>
<td>10,645</td>
<td>28,237</td>
</tr>
<tr>
<td>Mental hospitals</td>
<td>9,453</td>
<td>26,180</td>
</tr>
<tr>
<td>Nursing facilities†</td>
<td>1,192</td>
<td>2,057</td>
</tr>
<tr>
<td>Intermediate-care facilities‡</td>
<td>5,071</td>
<td>27,095</td>
</tr>
<tr>
<td>For mentally retarded persons</td>
<td>11,245</td>
<td>8,347</td>
</tr>
<tr>
<td>For all other persons</td>
<td>4,719</td>
<td>8,347</td>
</tr>
<tr>
<td>Physicians’ services</td>
<td>2,346</td>
<td>7,189</td>
</tr>
<tr>
<td>Dental services</td>
<td>458</td>
<td>969</td>
</tr>
<tr>
<td>Other practitioners’ services</td>
<td>251</td>
<td>1,040</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>1,789</td>
<td>6,342</td>
</tr>
<tr>
<td>Clinic services</td>
<td>714</td>
<td>5,747</td>
</tr>
<tr>
<td>Laboratory and radiologic services</td>
<td>337</td>
<td>1,176</td>
</tr>
<tr>
<td>Home health services</td>
<td>1,120</td>
<td>7,042</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>2,315</td>
<td>8,875</td>
</tr>
<tr>
<td>Family-planning services</td>
<td>195</td>
<td>516</td>
</tr>
<tr>
<td>Early and periodic screening</td>
<td>85</td>
<td>980</td>
</tr>
<tr>
<td>Rural health clinics</td>
<td>7</td>
<td>188</td>
</tr>
<tr>
<td>Other care</td>
<td>928</td>
<td>6,522</td>
</tr>
</tbody>
</table>

*Data are from the Health Care Financing Administration.
†Payments exclude premiums and capitation amounts. Total payments include payments for unknown services, which are not shown in this table. The percent distribution is based on rounded numbers.
‡Beginning in 1991, nursing facilities included skilled nursing facilities and intermediate-care facilities for all persons other than the mentally retarded.
was enacted, adults and children in low-income families that qualified for public assistance were automatically eligible for Medicaid. The new welfare law severed this link between Medicaid and public assistance, with the goal of preserving Medicaid coverage for poor families facing possible cutbacks in public assistance, but now one must apply to the program in order to be declared eligible for medical coverage. This policy has had an unintended consequence. As welfare caseloads have declined nationally, by about 42 percent since 1994, there have been unexpected reductions in the number of people seeking Medicaid coverage. In recent meetings involving administrators of state human-service agencies and specialists in Medicaid eligibility, sponsored by the Kaiser Commission on Medicaid and the Uninsured, the participants concluded that because many people now view public cash assistance as a temporary benefit, “even when Medicaid enrollment would be in the economic interest of the beneficiary, fewer potential recipients are likely to apply for coverage or to maintain Medicaid enrollment.”

If the decline in Medicaid enrollment were explained by the transition from welfare assistance to jobs that offered health insurance, neither HCFA nor the states would be concerned, but most former welfare recipients who have found employment are in low-paying positions that do not provide health care coverage.

The number of people who are not taking advantage of Medicaid coverage is quite large, and the problem speaks to the obstacles that many poor people face in trying to navigate publicly run systems. State governments, in turn, have only limited success in persuading parents to enroll their children in the Medicaid program, almost regardless of the specific circumstance. One recent federal study estimated that 4.7 million children were uninsured despite their eligibility for Medicaid, representing about 2 of every 5 uninsured children in the United States. A similar problem faces the new State Children’s Health Insurance Program, which authorizes the expenditure of $24 billion over a period of five years to extend coverage to low-income children who are not already eligible for Medicaid. Congress gave the states the option of using this money to expand their existing Medicaid programs, create new programs, or implement combined approaches. Recognizing the challenge of actually signing up children, federal and state governments and private foundations are investing hundreds of millions of dollars in outreach efforts to identify eligible children and enroll them in Medicaid or the State Children’s Health Insurance Program.

THE STATES’ BOOMING ECONOMIES

Although the states are grappling with the multiple challenges of welfare reform, the State Children’s Health Insurance Program, and Medicaid, they have more room to maneuver because the costs of Medicaid have been brought under strict control and the economies of most states are booming. Total Medicaid expenditures increased by only 3.8 percent in 1997, the slowest annual rate of growth since the program’s inception. In its latest report on national health care expenditures, HCFA’s Office of the Actuary stated:

Average annual growth in Medicaid spending decelerated to 5.9 percent over the 1994–1997 period, compared with 12.7 percent for 1991–1994 and 19.5 percent for 1988–1991. The rapid growth over the 1988–1994 period is attributable to three basic factors: (1) an increase in the number of Medicaid enrollees, (2) an increase in nominal (not adjusted for inflation) spending per recipient, and (3) explosive growth in disproportionate-share hospital payments, a substantial portion of which states used to supplement their state treasuries in ways that Congress has now outlawed. (Disproportionate-share payments, which totaled $15 billion in 1996, are made to compensate hospitals for the higher operating costs they incur by treating disproportionately large numbers of low-income and Medicaid patients.

At the start of 1999, despite five straight years of tax cuts and moderate increases in expenditures, all the states except Alaska and Hawaii had healthy budget surpluses that collectively are estimated to total $31 billion. As a percentage of the overall budget for all the states, this surplus is twice that of the federal budget, according to a report issued by the National Governors’ Association. Nevertheless, many governors have adopted social policies designed to slow, if not prevent, further expansion of publicly financed insurance programs. For example, California made an explicit decision under its former Republican governor, Pete Wilson, not to accept the full federal allotment of funds from the State Children’s Health Insurance Program. Such policies reflect the concern that federal funding for Medicaid will eventually decline, forcing the states to make up the shortfall. In addition, Republicans see little political gain in creating new publicly financed programs in this era of limited government. Only Kentucky, Massachusetts, Nevada, and Vermont have said that they plan to spend their full allotment of funds from the State Children’s Health Insurance Program this year. Many other states are in earlier stages of implementing the program and may not be able to spend all the available program funds in 1999.

MEDICAID MANAGED CARE

Since the 1980s, many states have experimented with managed care, largely as a means of limiting Medicaid expenditures, but they had no authority to require eligible beneficiaries to enroll in managed-care plans. Moreover, the beneficiaries had no incentive for enrollment, such as the extra benefits that elderly persons could obtain if they signed up with health maintenance organizations (HMOs) under Medicare. To make managed care mandatory, the states
had to receive a waiver from HCFA. Under President Clinton, a former governor, HCFA adopted a liberal policy of issuing such waivers, which enabled some 40 states to make managed care mandatory in whole or in part for certain groups of beneficiaries. The Balanced Budget Act of 1997 eliminated the waiver requirement altogether, except for persons who are eligible for both Medicare and Medicaid (disabled and elderly poor people), children with special needs, and Native Americans. The budget law also eliminated the requirement that in HMOs with Medicaid beneficiaries, at least 25 percent of the members must receive coverage from third parties other than Medicaid. Congress had imposed this stricture as a proxy for ensuring that the plans would provide high-quality care.

Forty-nine states (all except Alaska) now rely on some form of managed care to serve their Medicaid populations. The proportion of Medicaid beneficiaries enrolled in managed-care plans increased from 9.5 percent (2.7 million people) in 1991 to 48 percent (15.3 million) in 1997. The states use one of three forms of Medicaid managed care: arrangements with primary care physicians to act as gatekeepers, approving and monitoring the provision of services to individual beneficiaries in return for a fixed fee; enrollment of beneficiaries in HMOs that assume the full financial risk of providing a comprehensive package of services; and contracts with medical clinics or large group practices, which provide services but do not assume the full financial risk for them. In areas where HMOs are prepared to assume the full financial risk of enrolling Medicaid beneficiaries, the states are choosing this approach and turning away from the other two.

The most comprehensive examination of the effect of Medicaid’s growing relationship with managed care is being conducted by researchers at the Urban Institute as part of an ambitious project called Assessing the New Federalism.28 The project, funded by private foundations, is a major new effort to understand changes in health care and social programs at the state level.29-37 Researchers have examined the effect of Medicaid managed care in 13 states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). Their preliminary conclusions, reached three years after the start of the study, which will continue for another three years or more, are as follows:

The Medicaid managed care revolution has been more of a skirmish than a revolution. The goals of Medicaid managed care were to expand access to mainstream providers and to save money, but success on both fronts has been limited. Medicaid managed care is predominantly limited to children and younger adults; few states have extended enrollment to more expensive elderly and disabled enrollees, limiting potential savings. States are also finding that managed care savings are modest because traditionally low Medicaid fee-for-service payment rates make it difficult for states to substantially slash capitation levels or for HMOs to negotiate further discounts. In addition, safety net providers that need Medicaid revenues to survive have received special protections from states, which has both reduced potential savings and steered Medicaid beneficiaries to traditional providers of charity care. The combination of low capitation rates and protections for safety net providers have limited the willingness of commercial HMOs in several states to contract with states, thus restricting the expansion of access to maintain providers.38

A number of commercial HMOs that were enrolling Medicaid beneficiaries have withdrawn from the program in the past year, citing multiple reasons for their dissatisfaction.39,40 In interviews conducted recently by Hurley and McCue at the Medical College of Virginia, state policy makers, health-plan executives, venture capitalists, and stock analysts expressed little optimism that commercial HMOs would continue to enroll Medicaid beneficiaries, particularly in states with very low per capita payment rates. Citing the views of stock analysts, Hurley and McCue note:

The early promises of profitable market opportunities were overshadowed by unexpected rate rollbacks, contracting volatility, and administrative burdens which soured analysts and investors on the Medicaid market. . . . Given this history, stock analysts see limited opportunities for success in Medicaid and view the exodus from the Medicaid market as evidence of management’s desire to enhance stockholder wealth.41

CONCLUSIONS

Medicaid underscores the ambivalence of a society that continually struggles with the question of which citizens deserve access to publicly financed medical care and under what conditions. On a more positive note, Medicaid now provides health insurance to a larger population of poor persons than ever before, reflecting the strength of a bullish economy and expanded criteria for eligibility. Yet, nationally, the number of uninsured people grew to 16.1 percent of the population in 1997, the largest level in a decade, because employer-sponsored coverage has eroded.2,3 This divergence prompts a question: What potential does Medicaid have for further expanding its eligible population so that poor families with incomes that minimally exceed the federal poverty level could be insured through this program? Some states (Massachusetts, Minnesota, Oregon, Tennessee, and Wisconsin are examples) have used public funds to broaden private coverage through managed care, and the welfare-reform law permits the states to raise the threshold for income and assets so that more beneficiaries will be eligible for Medicaid. But many states have shifted to managed care without expanding coverage for the working poor, a population that constitutes the bulk of the uninsured pop-
ulation, and rates of payment to providers remain woefully low.

Medicaid’s architects envisioned a program that would provide poor people with mainstream medical care in a fashion similar to that of private insurance. As the decades have passed, that vision has largely faded, and several tiers of care have emerged. Mainstream medical care is provided to people covered by private insurance or Medicare. For the most part, poor people continue to rely on providers that make up the nation’s medical safety net: public and some private not-for-profit hospitals and clinics and their medical staffs that, by virtue of their location or their social calling, provide a disproportionate amount of care to the poor. These providers are increasingly stressed as Medicaid diverts funds to managed-care plans. The United States remains the only industrialized nation that has never settled on a social policy that, however policy makers choose to accomplish it, offers a basic set of health care benefits to all residents regardless of their ability to pay — certainly a regrettable failure in a nation blessed with so many resources.

REFERENCES