THE HEALTH POLICY RESEARCH CONSORTIUM
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50 YEARS LATER (Part 2 of 2)

Medicaid – Still Going Strong

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Introduction

President Lyndon B. Johnson signed Medicaid into law on July 30, 1965, the same day as Medicare. It was actually the same piece of legislation (an amendment to the Social Security law[1]), but Medicare tends to be better understood by the general public. A recent Kaiser Family Foundation poll found that more members of the general public correctly identified Medicare as the primary source of health insurance for people over 65 (72%), than those who identified Medicaid as the primary source of health insurance for low-income people (65%)[2].

Whereas Medicare[3] covers the elderly, the disabled, and people with End Stage Renal Disease (ESRD), Medicaid[4] covers low-income families, pregnant women, people of all ages with disabilities, and people who need long term care.[5] Both programs cover the disabled, the major distinction being whether the beneficiary had been receiving Social Security Disability benefits prior to eligibility (Medicare), or receiving cash assistance under the Supplemental Security Income (SSI) program (Medicaid)[6]. Crucially, Medicaid is the nation's dominant insurer of long-term care services, even for the elderly and the disabled[7].

Medicare and Medicaid are also administered differently – the former by the federal government, the latter by the states, albeit with federal support and oversight from the federal government. Consequently, Medicaid eligibility[8] and benefits vary by state. The outcomes[9] vary as well, as do the number of states that have opted to expand[10] Medicaid as a result of the Affordable Care Act (ACA).

History

"Despise not the day of small beginnings[11]…" So goes the old adage, which seems apropos Medicaid's early days.

Medicaid funding first became available to the States on January 1, 1966, according to a historical snapshot prepared by the Centers for Medicare and Medicaid Services (CMS)[12], the federal agency responsible for regulation and oversight of both Medicare and Medicaid. In the early days, the program served about 19 million individuals. It was also optional for the states – 'opt in', not 'opt out'.

MEDICAID MILESTONES

- **1965** – President Lyndon Baines Johnson signs Medicare and Medicaid legislation into law.
- **1967** – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) introduced. EPSDT designed to ensure comprehensive preventive care for Medicaid beneficiaries under 21.
- **1972** – Supplemental Security Income (SSI) enacted under Social Security, allowing states to link Medicaid to SSI for elderly, blind, and disabled residents who meet the criteria.
- **1977** – Health Care Financing Administration (HCFA) established to administer Medicare and Medicaid, transferring the responsibility from the Social Security Administration.
- **1981** – States required to subsidize hospitals (known as Disproportionate Share Hospitals) that see a disproportionate share of low-income patients who are unable to pay their hospital bills. Subsidy would become known as the DSH (pronounced 'dish') payment.
- **1982** – Arizona becomes the last state in the union to opt into Medicaid.
- **1986** – States granted the option to allow Medicaid coverage for pregnant women and infants (up to 1 year of age), up to 100% of the federal poverty level (FPL). This would become a mandate in 1988. The next year the mandate was extended to include children from birth to 6 years of age, and from 100 to 133% FPL.
- **1990** – Medicaid Prescription Drug Rebate program established. The program is an agreement between CMS and drug manufacturers (about 600 now participate), wherein the manufacturer gives the state a rebate on drug purchases. In exchange the state's Medicaid program would cover most of that manufacturer's drugs.
- **1995** – President Clinton[1] vetoes a bill passed by the U.S. Congress that would turn Medicaid into a 'block grant' program. A block grant is a fixed amount of money allocated at the start of a budget cycle. A state would get no supplemental funds if the block grant runs out before the next budget cycle, which would happen when demand spikes, such as during economic recessions. The block grant idea resurfaces cyclically, usually during election campaigns.
- **1997** – Children's Health Insurance Program (CHIP) established. Known as SCHIP at the time, it was intended to wrap around traditional Medicaid coverage for children whose parents earned too much to qualify for Medicaid, but not enough to afford private health insurance.
- **2000** – Uninsured women are granted Medicaid coverage for breast or cervical cancer regardless of income or resources, a state option made possible by the Breast and Cervical Cancer Treatment Act of 2000.
- **2001** – HCFA renamed Centers for Medicare and Medicaid Services (CMS).
- **2009** – CHIP reauthorized. American Recovery and Reinvestment Act of 2009 (aka "the stimulus") also enacted, providing a temporary increase in federal matching funds for Medicaid in response to the most severe economic recession since the Great Depression.
- **2010** – The Patient Protection and Affordable Care Act (aka the ACA) is enacted after rancorous debate, creating the nation's most significant health care overhaul since Medicare and Medicaid were established. It provides for Medicaid expansion up to 138% FPL. Significant opposition leads to legal battles that culminate in landmark Supreme Court cases.
- **2012** – The Supreme Court rules that the ACA passes Constitutional muster, but allows each state to decide whether or not they would like to participate in the Medicaid expansion.
- **2013** – Open Enrollment (including Medicaid expansion) under the ACA begins. Rocky start for many states, including Maryland. Medicaid coverage begins 1/1/2014.

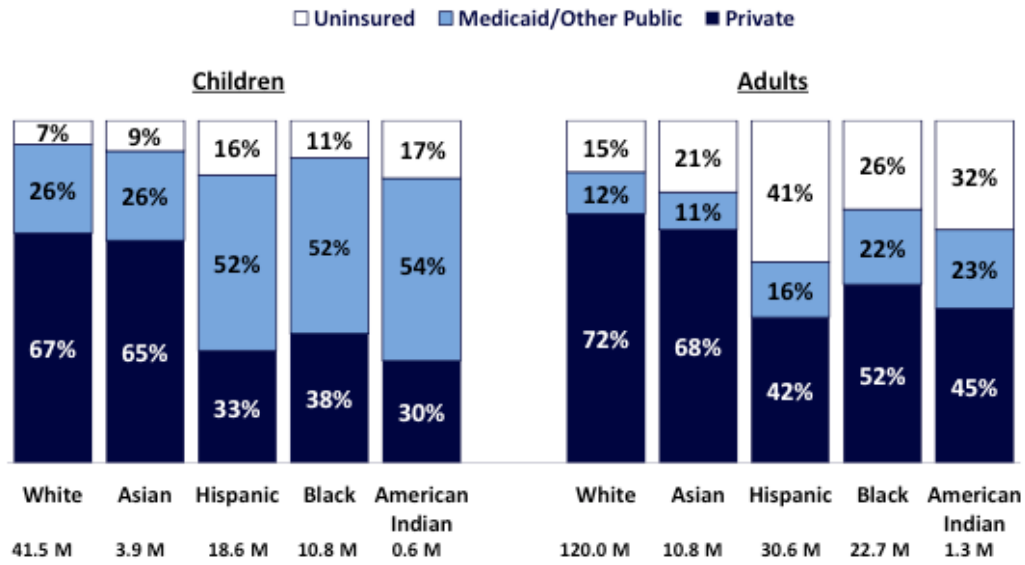
Source: Key Milestones in Medicare and Medicaid History, Selected years: 1965-2003. Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/05-06Winpg1.pdf Retrieved from the Internet. July 28, 2015.

Growth

Medicaid now serves a lot more people than it did in 1966, including millions of children covered under the Children's Health Insurance Program (CHIP)[13], which is managed, in most states, by the same agency that is responsible for Medicaid. CHIP was enacted in 1997. It was intended to provide a safety net for children whose parents could not afford to provide coverage in the private insurance market, but earned too much to qualify for Medicaid. As of May 2015, Medicaid and CHIP enrollment in all states totaled 71,637,638[14], an increase of 12.8 million individuals since coverage expansion began on October 1, 2013 under the Affordable Care Act (ACA). In Maryland[15] there were 1,113,338 individuals enrolled in Medicaid and CHIP as of May 2015, a 30.02% increase since October 1, 2013. Compared to their White and Asian counterparts, Hispanics, Black and American Indian children are far more likely to be enrolled in Medicaid or other public insurance programs (See Fig. 1).

Figure 1

Health Insurance Coverage by Age and Race/Ethnicity, 2011



Asian group includes Pacific Islanders. American Indian group includes Aleutian Eskimos. Two or more races excluded. Data may not total 100% due to rounding.

Source: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS. Available at http://kff.org/disparities-policy/slide/health-insurance-coverage-by-age-and-raceethnicity-2011/

Health Outcomes

The Oregon Health Insurance Experiment[16] was a randomized control trial conducted to gather evidence about the impact of Medicaid coverage on adults. Randomized control trials are the most reliable way to determine causality, that is, if consequence B is the direct result of taking action A. This ongoing study began in 2008, with the state of Oregon holding a lottery among Oregonians on a Medicaid waiting list. Those who won the lottery were enrolled in Medicaid, those who played the lottery and lost were

assigned to the control group. Researchers have since followed the low-income Oregonians in both groups, assessing the use of health care, financial strain, and self-reported health.

To date, their health outcomes findings[17] include the following:

- Medicaid increased the probability that people self-report 'good or excellent' health (as opposed to 'fair or poor' health).
- Medicaid has no significant effect on measured blood pressure, cholesterol or glycated hemoglobin (helps track blood sugar).
- Medicaid significantly increased the probability of being diagnosed with diabetes after the lottery, and likewise increased the probability of the use of diabetes medication.
- Medicaid reduced observed rates of depression by 30%.
- Medicaid increased the use of preventive care, including a 50% increase in cholesterol monitoring and a doubling of mammograms.

Their other findings, including the reduction of financial hardship and the increased use of emergency rooms (which leads to higher costs) by those who won the lottery, generated copious commentary on both sides of the policy debate.

The experiment will continue to enjoy intense scrutiny however, because it is still 'the only game in town'. The bottom line conclusion from this study - for proponents nationwide - has been that Medicaid makes beneficiaries more proactive and thus less anxious about their health, leading to more prevention and primary care. The nation would be well-served if more states were to conduct a similar experiment, especially in states with large Medicaid-eligible populations.

One key challenge for the program remains increasing the number of physicians willing to see Medicaid patients, given the low reimbursement[18] rates relative to private insurance. Improving the number of primary care appointment slots would likely reduce the number of Medicaid beneficiaries who use emergency rooms for their care, which would bode well for controlling costs.

Customer Satisfaction

According to a nationally representative survey conducted by the Kaiser Family Foundation (KFF)[19], the Medicaid program is generally well-liked, and about two-thirds of all respondents reported some family connection to the program. About eight in ten said they would enroll themselves or a child in the program, and most Medicaid beneficiaries feel financially well-protected by the program.

Challenges Ahead

The picture is not all rosy, however. There are currently 20 states that have not yet expanded Medicaid under the ACA, although Utah's governor and their legislature are reportedly working on a deal this summer. This means about 6,537,000 of the most vulnerable Americans will remain uninsured across the nation, according to a Families USA[20] estimate. This would include populations who would most benefit, including uninsured adults, parents with dependent kids, uninsured veterans and their spouses, and working adults who earn too much to qualify for their state's Medicaid but cannot afford to buy coverage on the health insurance marketplaces created by the ACA. These individuals are characterized as falling into "the coverage gap", a modern day version of the "doughnut hole" created in the mid-2000s by the Medicare Part D Drug benefit (which the ACA has since closed)[21].

A significant percentage of these unfortunate (mostly hardworking[22]) citizens also happen to be people of color, and they reside, predominantly, in the Deep South and the Midwest. States like Florida, Texas, and Virginia have hundreds of thousands of uninsured people of color between them.

They also live in regions of the country where chronic diseases are rife – obesity, hypertension, cardiovascular diseases[23], asthma, HIV/AIDS and cancer all run rampant. It is well-established that

uninsured people postpone[24] care because they are afraid of the bills (which can quickly turn into debt), and often seek care in an emergency situation when the condition has become more complex, and much more expensive to treat. That cost is passed along to those who are insured, resulting in higher premiums in those markets. The costs are not limited to direct medical costs. There is also indirect cost in the form of lost productivity due to wages not earned and taxes not paid. Then there are the costs associated with disability (or death), compounded by forfeited economic activity occasioned by the foregone Medicaid revenue.

The latter is not insignificant. Medicaid is an economic multiplier[25], given that it helps to keep safety net hospitals viable. Many such hospitals[26] have been forced out of business in states that refused to expand Medicaid. These hospitals are often major employers in their communities, and several other small businesses depend on them for their own viability. Their survival matters, not just to the health of the people, but to the health of local economies, especially in rural areas. The problem is even more acute in places where emergency rooms are few and far between.

Conclusion

The 50th anniversary celebrations are now in full swing, and some of the retrospectives have been circulating awhile. Proponents and opponents alike are considering the way forward for the next half century. Medicaid's role will continue to grow, given that it is the main vehicle for ACA coverage for the nation's most needy. Opponents consider this the biggest problem, namely that there will come a day when the federal government will be unable or unwilling to shoulder the lion's share of the economic burden. Proponents are likely to counter that Medicare[27] has reduced costs (overall and per member), reduced hospitalizations (both how often members are admitted and how much it costs per admission), and made beneficiaries healthier. Who's to say Medicaid's successes won't be as dramatic?

There will be a full review fifty years hence.

Endnotes

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