
There's Something About Medicaid

Medicaid suffers from a chronic mismatch between what we ask it to do and what we are willing to pay.

by Alan Weil

PROLOGUE: In the realm of political rhetoric, Medicaid has never been able to shake its metaphorical status as a stepchild—“fundamentally a welfare program for the poor,” as one powerful congressional committee chairman dismissively described the program last year. In reality, however, it is much more than that. Medicaid has now overtaken Medicare in both enrollment and spending to become the largest health insurance program in the United States. It insures one-fifth of the nation's children and pays for one-third of all childbirths. It finances nearly 40 percent of all long-term care expenses, more than one-sixth of all drug costs, and half of states' mental health services. It is, in a much-improved metaphor coined in the following essay, the “workhorse” of the U.S. health system.

In this overview of Medicaid's indispensable role, Alan Weil of the Urban Institute explains how and why the program has been “called upon to solve all manner of health-related problems that no other institution or sector of the economy is willing to address.” Services for pregnant women and children are the best-known example, but Medicaid is also the largest payer for services for AIDS patients, supports coverage under the “ticket to work” program for people with disabilities, covers treatment for breast and cervical cancer in forty-four states, and pays for drugs and cost sharing for lower-income Medicare beneficiaries.

Weil explains that the flexible state-federal structure and funding of the Medicaid program has been the key to its utility in filling out the infrastructure of the health system. But in the periodic fiscal crises that put the program in the crosshairs of state budget overseers, it becomes a victim of its own success. Medicaid is inevitably subject to daunting cost increases, and the people it serves are much less able than Medicare beneficiaries are to make their voices heard when the pressure to rein in public spending is greatest.

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ABSTRACT: In the thirty-seven years since its creation, Medicaid has grown in terms of whom it covers and what it costs. Current rates of Medicaid enrollment and cost growth are high relative to state budget capacity, but not by historical standards. The current Medicaid fiscal crisis is a result of weak state fiscal conditions and the gradual accretion of populations and services covered by Medicaid. States view Medicaid as an essential part of their current strategies to provide insurance to their low-income populations, cover the chronic care needs of people with disabilities and the elderly, and finance the health care safety net. Medicaid has accomplished much, and it can continue to do so if the underlying fiscal pressures and tensions built into it are addressed.

AFTER A GOOD RUN OF FIVE YEARS, Medicaid is back in the crosshairs. In 1995 Congress passed legislation to repeal the program and replace it with “Medigrants,” which would have provided states with a fixed sum of money and tremendous flexibility regarding which populations and services to cover. With President Clinton’s veto of the legislation, efforts to convert Medicaid into a block grant came to an end. Total expenditures on the program then grew at their lowest rate in history—an average of 3.6 percent between 1995 and 1999.¹ After years of growth, Medicaid declined slightly as a portion of state budgets during this period.² In 1997 strong federal revenue projections created room in the budget for the new State Children’s Health Insurance Program (SCHIP). For the last half of the 1990s Medicaid was out of the spotlight, while states and the federal government focused their attention on implementing welfare reform and SCHIP.

Those days have come to an end. In 2001 and 2002 Medicaid spending growth rates broke back into double digits.³ The Congressional Budget Office (CBO) now projects a federal growth rate of 12 percent in 2002 and an average of 9 percent a year for the next ten years.⁴ States reported an 11 percent increase in their Medicaid spending in 2002.⁵ This news comes at a time when state budgets are under unprecedented pressure. The Rockefeller Institute reports the sharpest decline in state tax revenues since it began tracking them in 1991. The second quarter 2002 decline of 10.4 percent from the same period one year earlier follows on the heels of three previous quarters of year-on declines, and September 2002 data suggest that the third quarter 2002 will continue this downward trend.⁶ Thirty-one states reported fiscal year 2001 Medicaid spending in excess of budget appropriations, and as of May 2002 twenty-eight states reported this for FY 2002.⁷ The federal budget is in deficit in FY 2002 after four years of surpluses.

In 1995 the need to cut growth in the program to balance the federal budget kicked off debates over major Medicaid reforms. Now states are taking the lead, proposing fundamental changes in the fiscal relationship between states and the federal government.⁸ States are not asking for block grants, but the word “unsustainable” appears in most descriptions of trends in Medicaid spending.

If money is at the heart of debates over Medicaid, the millions of indigent people whose varied and complex medical needs are met by the program are its soul.

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The amount of human suffering the program alleviates is immense. In the absence of a comprehensive health care system that meets the acute and chronic care needs of the nation, Medicaid perfectly fits the metaphor of the “safety net.”

Medicaid is a program loved by few, denigrated by many, and misunderstood by most. It is at least three different programs in one: a source of traditional insurance coverage for poor children and some of their parents; a payer for a complex range of acute and long-term care services for the frail elderly and people with physical disabilities and mental illness, many of whom were once middle class; and a source of wraparound coverage for low-income elders on Medicare. Eligibility criteria, services used, and costs vary greatly across these populations, challenging those who would make generalizations about Medicaid.

Medicaid is often criticized, and often for contradictory reasons. Medicaid is costly, its budget is difficult to control, and governors argue that rising Medicaid costs get in the way of other priorities such as education and public safety.⁹ Yet providers are routinely paid less by Medicaid than they are by other payers, enrollees often learn that finding a provider who will accept Medicaid is not easy, and concerns periodically emerge about quality, especially in nursing homes and managed care—problems that could be ameliorated by spending more money.¹⁰

Medicaid is criticized for its rigid rules—with multipage application forms, extensive documentation requirements, dozens of federally defined eligibility categories, and court-imposed benefits. Yet states establish eligibility levels, determine which services are covered, set payment rates for providers, and define licensing and quality standards for providers and health plans, leading to tremendous variety in who has and what it means to have a Medicaid card. States vary in the percentage of the population they cover with public programs and in how much they spend on them.¹¹ Waivers—the federal government’s process for granting states flexibility within constraints—have freed the program from some of its rigidity but have also opened the program to criticism for undermining the basic rights of the eligible population and contravening congressional intent.¹²

In this paper I argue that the fiscal pressure Medicaid now faces is more an indication of the program’s success than of its failure. Medicaid has become the workhorse of the U.S. health care system. When the nation has identified a new problem—from a population that needs health coverage to a provider or health system in need of financial support—Medicaid has gotten the call. These decisions, initiated at times by the federal government and at times by states, have yielded the large and rapidly growing Medicaid program we have today. Medicaid’s crises are an indication of the mismatch between our ambitions for the program and the resources we commit to it.

What Is Medicaid?

■ **Eligibility.** Medicaid eligibility has expanded steadily since the program's enactment in 1965.¹³ The program began as an adjunct to cash welfare, meaning that it primarily covered very-low-income single parents and their children, and the aged, blind, and disabled. Expansions beyond this base have been most notable for children and pregnant women. As of 30 September 2002 the phase-in of a 1989 federal law is complete, making all poor children under age nineteen eligible for Medicaid. States must also cover children under age six and pregnant women with incomes up to 133 percent of the federal poverty level. States can set more generous eligibility standards, and thirty-eight have done so for infants and pregnant women, while twenty-two have done so for children ages 1–5.¹⁴ Most states have extended eligibility to children up to 200 percent of poverty through SCHIP.¹⁵ Medicaid covers 55 percent of all poor children and about 20 percent of children overall.¹⁶

Coverage of nondisabled adults is far more limited. While children are eligible based upon family income, adult eligibility is limited to pregnant women and parents in families eligible for cash welfare under historical rules.¹⁷ Since the income threshold for welfare in the median state is only 45 percent of poverty, most low-income parents are ineligible for Medicaid.¹⁸ Thirty-nine states have medically needy programs for adults who fall into an eligibility category but whose incomes exceed formal program standards.¹⁹ Notably absent from the list of eligible adults are those without children in the home, who make up 62 percent of the adult uninsured population.²⁰ These adults can be covered only through waivers. In 1999 Medicaid covered 5 percent of nonelderly adults and 15 percent of those with incomes below 200 percent of poverty.²¹

People of all ages with disabilities are eligible for Medicaid if they meet the stringent income, asset, and disability standards of the federal Supplemental Security Income (SSI) program or if they are receiving similar state supplements and the state chooses to extend eligibility to this group. States have a variety of additional federal options available to them to extend eligibility to people requiring long-term care services even though their income exceeds SSI eligibility limits.²² Certain low-income elders on Medicare are eligible for assistance with Medicare cost sharing. Qualified Medicare Beneficiaries (QMBs), with incomes below poverty, have all Medicare cost sharing covered, while Specified Low-Income Medicare Beneficiaries (SLIMBs), with incomes up to 120 percent of poverty, have their Medicare Part B premiums covered.

■ **Covered benefits.** Medicaid provides a comprehensive benefit package for those who enroll. The federal government mandates coverage of thirteen services, including inpatient and outpatient hospital services; physician services; laboratory testing and x-rays; nursing home and home health care; family planning; and for children under age twenty-one, a broad supplementary package known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). There are also more than a dozen optional benefit categories, including prescription drugs, which all states

cover; intermediate care facilities for the mentally retarded (ICF-MR), which twenty-two states cover; and optometric services (twenty-eight states), dental services (twenty-six states), and prosthetic devices (thirty-one states).²³

Medicaid benefits must be provided at no cost to children and pregnant women and with only “nominal” copayments for adults, which the federal government has interpreted to mean generally no more than \$3, with coinsurance rates up to half the cost of the first day of institutional care.²⁴ No premiums can be charged, and there are no deductibles to meet before coverage begins.²⁵ States have latitude to define the “amount, duration, and scope” of the services they provide, and some states have chosen to limit the number of prescriptions, inpatient hospital days, and various therapies a recipient can receive each month.

The comprehensive nature of Medicaid benefits is often misunderstood. The breadth of covered services reflects the complex needs of the disabled population the program serves. The strict limitations on cost sharing reflect the recipients’ absence of disposable income; median annual household income of children enrolled in Medicaid was \$11,300 in 1997, and for nonelderly adults it was only \$10,000.²⁶ These aspects of Medicaid have led some to refer to it as a Cadillac and to object to the provision of very-low-cost health services to some when other low-income people without health insurance receive no government assistance at all. These critics raise legitimate questions about the fair allocation of limited resources, especially as Medicaid expands beyond the poorest population. Still, the program design reflects the needs and resources of the population it serves.

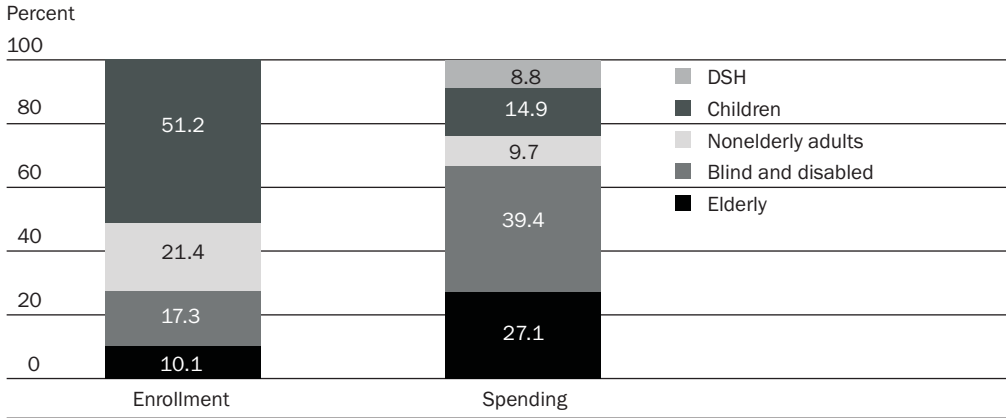
■ **Enrollment and spending.** Enrollment in Medicaid has climbed from four million in 1966 to forty-seven million in 2002.²⁷ During the same period expenditures have grown from \$0.4 billion to \$257 billion.²⁸ Although children and nondisabled adults account for the majority of Medicaid enrollment, two-thirds of spending goes toward services for the elderly and disabled (Exhibit 1).

Not everyone who is eligible for Medicaid enrolls. Enrollment is free, but it is not always easy or convenient. Seventy-two percent of eligible children and 51 percent of eligible nonelderly adults are estimated to actually enroll.²⁹ Participation among eligible QMBs is estimated at 78 percent, while it is only 16 percent for SLIMBs.³⁰

Exhibit 2 breaks down Medicaid spending by service. Nursing home care, managed care (which covers hospital, physician, and other services), and inpatient hospital care dominate the program, although home care and prescription drugs also represent substantial shares.

A common misperception is that the elderly and disabled primarily use long-term care services, while spending on acute care services is primarily for other adults and children. In fact, while almost all nursing facility, ICF-MR, and home health spending is on behalf of elderly and disabled enrollees, this group also accounts for 85 percent of prescription drug costs, more than half of inpatient and outpatient hospital spending, and nearly half of physician services.³¹

EXHIBIT 1
Medicaid Enrollment And Spending, By Eligibility Group, 1998

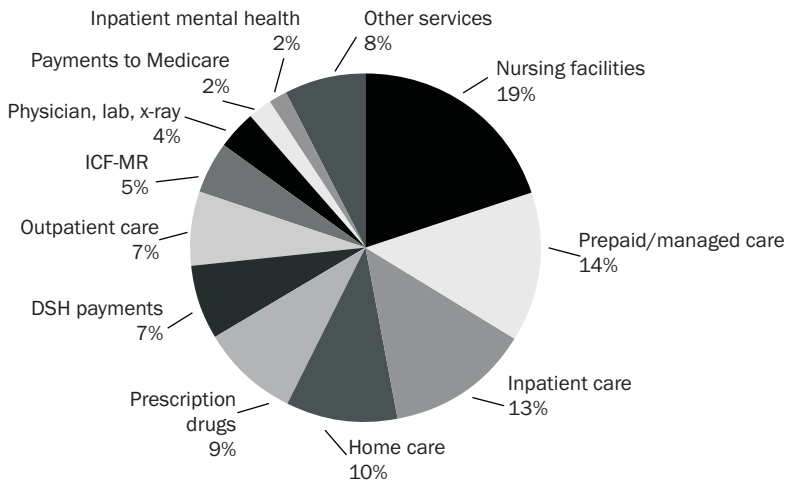


SOURCE: Urban Institute estimates prepared for Henry J. Kaiser Family Foundation, “The Medicaid Program at a Glance” (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2001).
NOTES: DSH is disproportionate-share hospital. Administrative expenses are excluded.

The Perfect Storm?

The preferred metaphor for Medicaid and state budgets today is “The Perfect Storm,” recalling the movie of that name in which a powerful and unusual confluence of events led to disaster. According to this story, the three winds of today’s Medicaid storm—growing enrollment, high medical inflation, and plummeting

EXHIBIT 2
Medicaid Spending By Service, 2001



SOURCE: B. Bruen, Urban Institute, unpublished data.
NOTES: ICF-MR is intermediate care facilities for the mentally retarded. DSH is disproportionate-share hospital.

state revenues—are combining to place extreme pressure on the program.

Medicaid costs are certainly rising through a combination of enrollment growth and medical inflation. According to the National Association of State Budget Officers (NASBO), state-funded Medicaid spending increased by 11 percent from FY 2000 to FY 2001 and is expected to increase by another 13.4 percent in 2002.³² Two recent analyses have examined the components of this growth. Brian Bruen and John Holahan use administrative and case-study data to examine Medicaid's challenges in 1999 and 2000. They find that a number of factors are at play: rebounding enrollment after declines in the wake of welfare reform, continued steady increases in enrollment of the elderly and people with disabilities, rapidly growing drug costs, and the demise of managed care as a source of cost control.³³ Vernon Smith and colleagues interviewed Medicaid officials in all fifty states. They identify four factors most commonly cited by state officials to explain increasing Medicaid spending in 2002: prescription drug costs, enrollment increases, increased cost and use of medical services, and long-term care.³⁴

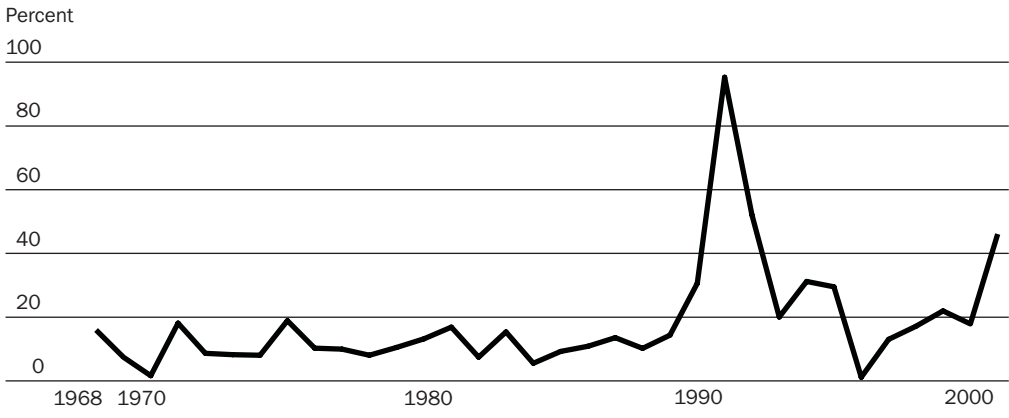
Yet these two winds in today's storm, while strong, are generally consistent with past experience. Medicaid enrollment has picked up, but if it is largely the result of SCHIP outreach and a rebound after welfare reform, it is concentrated among the least costly populations. In fact, enrollment growth among people with disabilities, the most expensive Medicaid population, averaged 5.3 percent per year over the past twenty-five years—a rate higher than in recent years.³⁵ Similarly, recent annual increases in national health spending of 8–9 percent are high compared with the mid- and late 1990s, but they are quite consistent with growth rates experienced in much of the 1970s and 1980s.³⁶

It turns out that states have a remarkable ability to absorb even high rates of Medicaid cost growth. Exhibit 3 shows the percentage of new state tax revenues generated each year that have been devoted to Medicaid. With the exception of a spike during the fiscal crisis of the early 1990s, states have had many new revenues to spend each year even after paying for Medicaid cost increases.

Today's storm is almost entirely attributable to the tremendous stress on state budgets. As noted above, state revenue collections have fallen for the past few quarters. The scale of these revenue declines was largely unanticipated: States' collections from their major tax sources are running 5.6 percent below the estimates that were used when FY 2002 budgets were enacted.³⁷ When data for 2002 are available, the line in Exhibit 3 will go off the top of the chart, since the ratio is infinite in today's unique circumstance of declining nominal state tax revenue.

■ **The underlying fiscal problem.** The danger in dissecting each Medicaid fiscal crisis is that it makes them appear to be anomalies, each with its own etiology that if diagnosed and treated will resolve the crisis until an entirely new problem emerges. Unfortunately, a more appropriate view is to recognize that Medicaid operates from a high base of growth that is easily susceptible to shocks. Medicaid pays for health care services, which exhibit long-term growth rates in excess of general inflation

EXHIBIT 3
Percentage Of Increase In State Tax Revenues Consumed By State Medicaid Spending, By Year, 1968–2001



SOURCES: Centers for Medicare and Medicaid Services (CMS) Form 64 data; and U.S. Census Bureau, Annual Survey of State and Local Government Finances and Census of Governments, various years.

NOTE: Revenue is reported for state fiscal years; spending is reported for federal fiscal years.

and in excess of prevailing economic growth. The most expensive populations Medicaid serves—elders and people with disabilities—are growing steadily. These two characteristics assure that on average, Medicaid will experience cost trends that outpace overall economic growth (Exhibit 4). The Medicaid cost crises of the early 1990s and early 2000s represent extremes, but Medicaid cost growth is substantial even in normal times.

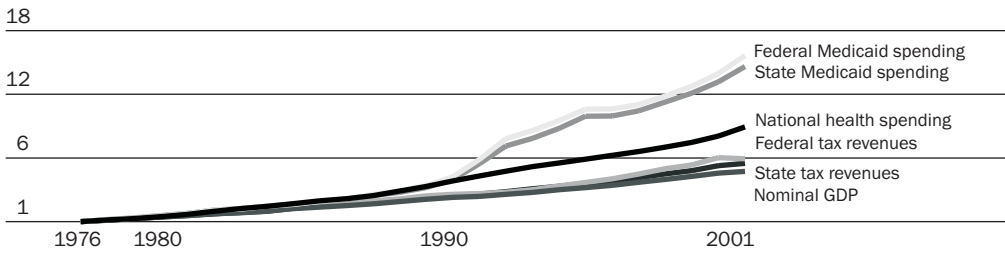
Thus, it turns out that the appellation “The Perfect Storm” is somewhat misplaced. A better characterization would be to view the late 1990s as “The Perfect Calm.” A period of low medical inflation, stable or declining Medicaid rolls, and booming state revenues represents the true anomaly. In the longer view, it is the late 1990s, not the early 2000s, that stand out as different.

The Curse Of Success

Another important part of the Medicaid cost story is that the program is called upon to solve all manner of health-related problems that no other institution or sector of the economy is willing to address. The Medicaid platform has been built upon to cover new populations, support critical health care providers, compensate for the limitations in public and private insurance programs, and support other institutions facing fiscal difficulties.

■ **Covering populations.** Medicaid coverage has expanded well beyond the original cash-assistance populations of single mothers with children and people receiving payment under state Aged, Blind, and Disabled programs. In fact, the majority of Medicaid recipients do not receive any cash benefits.³⁸ Over the years Medicaid eligibility has expanded to meet the needs of various new populations.

EXHIBIT 4
Growth In Various Indicators, 1976–2001, Indexed To 1976 Values (1976 = 1)



SOURCES: For federal and state Medicaid spending, Centers for Medicare and Medicaid Services (CMS) Form 64 data; for national health spending, CMS Office of the Actuary; for federal tax revenues, Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years, An Update* (Washington: CBO, August 2002); for state tax revenues, U.S. Census Bureau, Annual Survey of State and Local Government Finances and Census of Governments, and U.S. Census Bureau, Governments Division, July 2002; and for nominal gross domestic product (GDP), U.S. Department of Commerce, Bureau of Economic Analysis.

NOTE: National health spending and GDP are reported for calendar years, state tax revenues for state fiscal years, and Medicaid spending and federal tax revenues for federal fiscal years.

Pregnant women. In 1989 the federal government required states to cover low-income pregnant women who were not receiving cash welfare. This coverage was designed to improve access to prenatal care, thereby improving birth outcomes. Medicaid now pays for one-third of all childbirths. Many low-income pregnant women had been receiving prenatal care in hospitals and clinics funded by states and counties.³⁹ Thus, as is the case with many Medicaid expansions, this one had three effects: to increase access to care, to shift part of a historically state and local funding responsibility to the federal government, and to reduce the uncompensated care burden on some providers.

Children. As discussed above, coverage for children has expanded well beyond the base of those in families receiving cash welfare payments. While children are the least expensive eligibility group per capita, costs for infants can be substantial.

HIV/AIDS. Medicaid is the largest payer of medical services for people with AIDS. The program serves more than half of all people with AIDS and as many as 90 percent of children with AIDS.⁴⁰ However, because SSI is only available to people who are disabled, people who are HIV-positive but asymptomatic or with limited symptoms cannot obtain Medicaid under traditional eligibility rules. California recently decided to apply for a waiver to cover people in this circumstance.⁴¹

Undocumented immigrants. Undocumented immigrants are prohibited from receiving most public social service benefits, including cash welfare. While Medicaid does not cover the routine medical needs of this group, it does pay for emergency services, including childbirth. This policy reflects recognition that these services must be provided under the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 and therefore will be provided as uncompensated care if there is no other payment source.

Ticket to Work. In 1999 Congress enacted the Ticket to Work and Work Incen-

tives Improvement Act, which allows states to expand Medicaid coverage to certain people with disabilities whose incomes are too high to qualify for SSI. This new source of coverage is designed to address the fact that many people with disabilities are able to work but by choosing to do so earn too much income to qualify for Medicaid. These workers may work in firms that do not offer health insurance, may work too few hours to qualify for that coverage, or, if they do have coverage, are likely to find that the benefits do not include certain therapies, home care, durable medical equipment, or expensive pharmaceuticals.

■ **Supporting systems.** Medicaid coverage benefits providers as well as patients, and some Medicaid policies reflect the goal of supporting specific providers.

Safety-net hospitals. Medicaid is the source of 41 percent of revenues for safety-net hospitals.⁴² Most of these revenues are earned through traditional payments for services delivered to Medicaid-enrolled patients. Some safety-net hospitals also receive funds through the disproportionate-share hospital (DSH) program. Enacted in 1981, DSH requires states to consider the burden of serving a large number of Medicaid recipients or other low-income people when setting hospital payment rates. Many states have also sought to protect funding streams to safety-net hospitals as they have entered into managed care contracts.⁴³

Community and migrant health centers. Medicaid is the source of 34 percent of revenues for community health centers (CHCs).⁴⁴ Included in the list of services that must be covered under Medicaid are those provided by federally qualified health centers (FQHCs). Of course, FQHCs are not a service at all—rather, they are a group of providers. Many FQHCs receive direct funding through Sections 320 and 330 of the Public Health Service Act, and until recently Medicaid law guaranteed that these providers would be paid 100 percent of their costs in providing services to Medicaid enrollees.⁴⁵ Thus, federal Medicaid policy assures an additional funding stream to support these critical-access providers.

Mental health systems. Medicaid is now the largest source of public funding for mental health services.⁴⁶ Medicaid's role here is complex. States ran and paid for mental health institutions when Medicaid was enacted. The federal government, attempting to ensure that federal funds would not simply supplant existing state funds, designed Medicaid eligibility standards in a manner that barred Medicaid from covering states' adult institutional populations. Yet in the 1990s some states designated their mental health institutions as DSH recipients, effectively circumventing the federal bar. The General Accounting Office (GAO) reported on six states that in 1996 were directing between 20 and 89 percent of their DSH funds to state psychiatric hospitals.⁴⁷ Medicaid is the primary source of funding for community-based mental health services, which also receive direct funding through other programs. In addition, Medicaid is a major payer of substance abuse treatment services.⁴⁸

School health. School health systems are a recent addition to the list of providers funded partially by Medicaid. If they meet the appropriate legal standards, schools

can bill for services provided to Medicaid-enrolled children just as any other provider can. This represents a large potential revenue stream for children receiving special education. In the 1990s some states hired private consultants that used cost-allocation techniques to determine the share of school health services that could appropriately be considered Medicaid administrative costs.⁴⁹ Medicaid paid these costs, often simply replacing existing funding streams in schools.

■ **Patching holes.** Medicaid has been used to fill in holes in other public and private coverage.

Medicare. While Medicare is an essentially universal program for people over age sixty-five, it has substantial gaps in coverage: the near-absence of long-term care benefits, the limitation of drug coverage to hospital inpatient stays, and the existence of cost-sharing provisions that place burdens on low-income elders. Medicaid has received the call to fill in all three of these gaps. The “dually eligible” population (eligible for both Medicaid and Medicare) receives the full Medicaid package as a supplement to Medicare and thereby has coverage for long-term care services and prescription drugs. QMBs and SLIMBs receive assistance with Medicare’s premiums and cost sharing. Medicaid spending for Medicare eligibles now accounts for about one-third of the program’s costs.

Breast and cervical cancer treatment. The Centers for Disease Control and Prevention (CDC) provides free or low-cost screening for breast and cervical cancer. However, the CDC program does not include funding for treatment services. Recognizing the cruelty of providing screening without treatment, Congress enacted the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000, which gives states the option of providing Medicaid coverage to those who are found to have cancer through the CDC screening process. As of August 2002 plans for this type of coverage had been approved in forty-four states.⁵⁰

State Fiscal Burden And Fiscal Relief

Medicaid imposes a substantial fiscal burden on states, and it provides a source of fiscal relief. The burden comes from growing costs associated with a program that has expanded dramatically in scope. The relief comes from three sources: states’ ability to take what had been state, local, or private costs and obtain a federal matching payment to offset a portion of the costs; states’ ability to meet new needs while bearing only a portion of the cost; and states’ ability to manipulate the program to obtain federal matching funds for costs they did not actually bear.

State enrollment and spending reports do not contain sufficient detail to quantify the share of Medicaid cost growth that can be attributed to the program’s many new responsibilities acquired over time. Nor do they offer a complete picture of how much fiscal relief the program has provided.

State-federal relations have been harmed by a series of efforts some states have made to maximize federal revenue, especially when states succeed in capturing new federal funds without contributing their own general funds. States have re-

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lied upon an alphabet soup of methods: DSH, intergovernmental transfers (IGT), and upper payment limit (UPL) strategies.⁵¹ While these schemes appropriately gain a high profile, they obscure the facts that a substantial share of DSH funds go precisely to the purpose established in the program and that the overwhelming majority of increased Medicaid costs borne by states during the program’s existence reflect actual costs associated with a growing eligible population requiring services whose costs grow at a rate that greatly exceeds general inflation.

Why Choose Medicaid?

If Medicaid is the subject of such political contention and is regularly criticized for crowding out other spending priorities, why do we so frequently build upon its base when we are confronted with a new health policy challenge? There are at least four reasons, which I discuss below.

■ **Infrastructure.** A primary reason to build upon Medicaid is that it offers the only existing infrastructure flexible enough to handle new challenges. The program has a track record of working with a heterogeneous mix of clients: young families, the frail elderly, people with serious physical impairments, and those with chronic mental illness. Medicaid has relationships with a diverse set of providers: generalist and specialist physicians, clinics, hospitals, pharmacists, medical equipment suppliers, nursing homes, home health agencies, therapists, and health plans.

Medicaid is flexible, adapting to changes in the health care market, such as the advent of managed care. Medicaid systems are public, assuring that they respond to political pressures whether coming from client advocates or from providers. Administrative costs of the program are low, accounting for less than 5 percent of total costs. None of this is to suggest that Medicaid is flawless, but rather that Medicaid provides a base from which almost any health matter can be addressed.

■ **Low-cost purchaser.** Medicaid payment rates are routinely lower than those paid by Medicare and the private sector.⁵² The reason for this is simple: State Medicaid programs buy at the margin for populations that would otherwise be able to make only a small payment or none at all. Medicaid’s low payments often offset what would otherwise be completely uncompensated care. This gives Medicaid overwhelming leverage: It sets low rates and generally finds providers willing to accept those rates. The downside of these low rates is limited access and financial strain on providers that may affect the quality of care.

■ **Financing structure.** Medicaid’s matched financing structure is inherently expansionary. The federal government can offer or mandate an expansion in services or population, knowing that it will only pay somewhat more than half the cost, since states must pick up the balance. While the era of increasing federal mandates may have come to an end, the fiscal dynamic has not. Even today the federal government

can offer states options to expand, such as Ticket to Work or the BCCPTA, knowing that the federal government's cost will only be a share.

While states are on the receiving ends of mandates, when it comes to options they face a dynamic similar to that of the federal government. States can take advantage of federal options within Medicaid with cost to their own taxpayers of much less than the total program cost. This makes Medicaid an attractive vehicle for economic development, with modest state appropriations yielding total in-state spending of a far greater amount. It also offsets the natural political tendency to underinvest in spending on low-income populations.⁵³

■ **Safety valve.** Ultimately, we turn to Medicaid because it provides a safety valve for the failure of other systems. The employer-based insurance system is voluntary. If we ask too much of it, employers will threaten to or actually drop coverage. Medicare is a highly politicized and ossified system, and proposed expansions inevitably become mired in broader debates about the structure of the program. Direct appropriations to solve social problems, such as the precarious financial health of safety-net providers, are hard to come by. It is not easy, but it is easier, to obtain funding as part of the much larger Medicaid budget.

Opportunities For Medicaid's Future

While Congress and the president debate Medicare prescription drugs and a patients' bill of rights for the umpteenth time, a quiet revolution has been under way in state health policy. States are constantly seeking to recalibrate their Medicaid programs to meet emerging needs. Before the current fiscal downturn began, two major models of innovation were emerging.

In acute care, the new state model is an effort to combine employer, individual, and sometimes community or philanthropic contributions with state and federal funds to provide an adequate health insurance package to those who are uninsured. The model takes many forms: premium subsidy or buy-in programs in which the state contributes to the cost of employer-sponsored health insurance coverage; expansions of public coverage, sometimes combined with scaled-down benefit packages; and individual buy-in programs that allow a person or family to purchase coverage through the state at a subsidized price.

In long-term care, states are gradually but steadily increasing their spending on home health care and waiver programs designed to offer alternatives to institutional care.⁵⁴ States are also experimenting with consumer-directed care programs that give clients far more control over the services they obtain and who provides those services.

What do these innovations have in common? All are trying to smooth out Medicaid's rough edges—to change it from an all-or-nothing program to one that meets a continuum of needs. Yet therein lies the rub. Medicaid costs have been lower than they would otherwise because of its rigid boundaries. If you do not offer people what they need, fewer will sign up. Blending funding streams and offer-

ing a continuum of services makes for a better—yet potentially more expensive—program.

How do we capture the power of this innovation and build upon the strong base Medicaid has already created? This paper can only take a small step in proposing a better direction for Medicaid. I recommend changes in three areas.

■ **Increased federal funding.** The federal government is in a better position than states are to respond to increases in health care costs and fluctuations associated with economic cycles. National health expenditures and Medicaid expenditures have been rising faster than either state or federal tax revenues (Exhibit 4). Thus, a shift in the cost burden from the states to the federal government does not eliminate the problem of Medicaid's consuming an increasing share of public resources. However, compared with the states, the federal government has a broader tax base, one that is not eroding because of shifts in consumption patterns, and is not constrained by balanced budget rules that assure that Medicaid spending spikes will coincide with tight fiscal conditions. There are many ways to structure an increased federal role in funding Medicaid. The details are less important than that a substantial shift occur.

■ **Constrained state options on spending.** While state “Medicaid maximization” strategies are legal, and federal payments are only made in accordance with federal rules, certain schemes undermine the integrity of the program and harm state-federal relationships. They also undercut states' legitimate claims that they are having difficulty bearing the financial burden of a growing Medicaid program.

With the exception of DSH and administrative payments (discussed in a moment), states receive federal matching payments only when an enrolled client receives a covered service and the state pays for the service. The definition of “enrolled client” is unambiguous, and “covered services” are also fairly clearly defined.

States legitimately bristle at the idea that the federal government will tell them how to generate their revenues. In general, whether a state wishes to rely upon broad-based taxes, local funds, tobacco settlement dollars, or other revenue sources to pay the state portion of Medicaid costs should be of little concern to the federal government.

An alternative intervention for the federal government to return the program to fiscal integrity is more active oversight of payment levels for providers along the lines of recent UPL limitations. Unfortunately, the track record of the federal government's intervening in payment rates is poor, with the Boren Amendment leading to federal courts' determining nursing home payment rates and FQHC payment rules impeding the development of managed care. Still, this is the only fix that is likely work. If the federal government knows that its matching payments are being used to pay a reasonable price for a covered service delivered to an eligible client, that should answer all critics and clarify the reasons for Medicaid cost increases.

Changes in federal policies that affect state revenues and provider payments

must also address DSH, another funding stream that provides critical support to some institutions but cannot be defended in its current form. These changes must be undertaken with great care, should not be made in the middle of a recession, and must be phased in. Yet, they are necessary if limited federal and state funds are to be directed to where the need is greatest, not to where state fiscal creativity has been employed.

■ **Revised waiver system.** States legitimately want to experiment with new approaches to Medicaid, and the nation gains from these activities. Yet “research and demonstration” waivers now seem less about research and demonstration and more about an opportunity to fundamentally modify the program. This view is nicely captured in policy of the National Governors’ Association (NGA), which says that a state’s waiver should become permanent after five years if the state meets the waiver’s terms and conditions and that any state should be able to adopt another state’s waiver without any review.⁵⁵ These are policies appropriate for plan amendments, not experiments.

The Bush administration’s new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative creates a streamlined template for states to submit waivers under Section 1115 of the Social Security Act. The new waiver policy raises a variety of risks, but key among them is the possibility that its primary function becomes to lock in SCHIP funds that states are on the verge of losing because of low spending on that program. If manipulating spending projections and financing streams becomes a major feature of the next round of waivers, this will further erode trust between states and the federal government.

What Medicaid needs is a bifurcation of the current waiver process. On one path are true experiments, which can teach us the answers to critical questions such as (1) What are the effects of cost sharing for very-low-income populations on enrollment, utilization, and health status? (2) Can employer subsidies be structured in a manner that encourages participation and guarantees an appropriate level of benefits? (3) Can individuals select and manage their providers with positive health, social, and financial results? For these experiments, the requirement of budget-neutrality should be eliminated. The nation has a tremendous stake in learning the answers to these questions. Surely the Medicaid program can afford to spend some money to learn if it is using its \$257 billion effectively.

On another path should be a series of state plan options that can be adopted without waivers. States wishing to simplify eligibility standards, eliminate categorical boundaries to include adults in their programs, or adopt managed care should be able to do so without a waiver. The available options should be defined in statute, so that their consideration is public and their implications understood. In this regard, if states are to be given the option to scale back benefits, charge premiums, or increase cost sharing for some populations, then it should be Congress that establishes them.

MEDICAID IS ON A ROLLER-COASTER RIDE. Just a few years ago states were expanding their programs: aggressively pursuing outreach and enrollment and considering and adopting coverage for parents and prescription drug programs for elders. While states have largely protected Medicaid from budget cuts in 2002, if the economic and fiscal downturn continues, cuts in the program could be substantial.⁵⁶ Presumably the current Medicaid crisis will pass as state budgets recover, but at what cost to the low-income population?

Despite its detractors, Medicaid has shown itself to be the best among few options for addressing a multitude of health problems in the United States. The greatest risk for Medicaid is that we will continue to ask it to do more, while failing to provide the resources necessary to carry out its complex mission. It is amazing how much the program has accomplished under consistent fiscal stress punctuated by periodic crises and rare lulls. Imagine what it could do to address our remaining needs if it were not running so close to the edge. Failure to address Medicaid's underlying fiscal problems risks marginal care for our nation's most vulnerable populations and fitful progress toward our nation's health care goals.

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This paper was prepared as part of the Assessing the New Federalism project, which has received major funding from the Annie E. Casey, W.K. Kellogg, Robert Wood Johnson, Henry J. Kaiser Family, Ford, David and Lucile Packard, John D. and Catherine T. MacArthur, and Charles Stewart Mott Foundations. The views expressed are those of the author and do not necessarily reflect those of the Urban Institute, its board, or its sponsors. Excellent research assistance was provided by Stephanie Schardin. Lisa Dubay, John Holahan, Genevieve Kenney, Cindy Mann, and three anonymous referees provided helpful comments on an earlier draft.

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