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# Medicaid at Forty

Diane Rowland, Sc.D.

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*This article examines Medicaid's evolution over the last four decades in its role as a health insurer for low-income families, a source of health and long-term care (LTC) coverage for people with disabilities, and as the supplement to Medicare for low-income aged and disabled Medicare beneficiaries. Medicaid's role and impact on each of these beneficiary groups is assessed.*

## INTRODUCTION

The Social Security Amendments of 1965 established both Medicare and Medicaid to provide health insurance coverage and assistance to the Nation's elderly and low-income population. Originally designed as a Federal-State program to pay for medical expenses as an extension of public assistance for the aged, blind, and dependent children, Medicaid has grown over the last four decades into the Nation's largest health care program and a source of assistance to over 52 million Americans.

In 2003, Medicaid provided health insurance coverage to 39 million children and adults in low-income families, health and LTC assistance to 8 million low-income people with disabilities, and supplementary coverage and LTC assistance to 7 million elderly and disabled Medicare beneficiaries (U.S. Congressional Budget Office, 2004; Holahan and Ghosh, 2005). Medicaid now covers one in four American children, 18 percent of Medicare beneficiaries, and 60 percent of nursing home residents

(Kaiser Commission on Medicaid and the Uninsured, 2005a; Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2005; Harrington, Carillo, and Crawford, 2004) (Figure 1).

To finance these multiple roles, the Federal and State governments combined spent \$275 billion in 2003, accounting for 17 percent of overall personal health spending (Urban Institute, 2004; Centers for Medicare & Medicaid Services, 2005b). Of the total, \$252 billion financed direct services, with the bulk of spending (69 percent) going to health and LTC services for the aged and disabled (Figure 2). The Federal share of Medicaid spending ranges from 50 to 77 percent, with a higher Federal share in poorer States.

As Medicaid marks its 40<sup>th</sup> year, it is timely to review the evolution, current role, and impact of Medicaid for its three major beneficiary groups—low-income families, people with disabilities, and elderly and disabled Medicare beneficiaries.

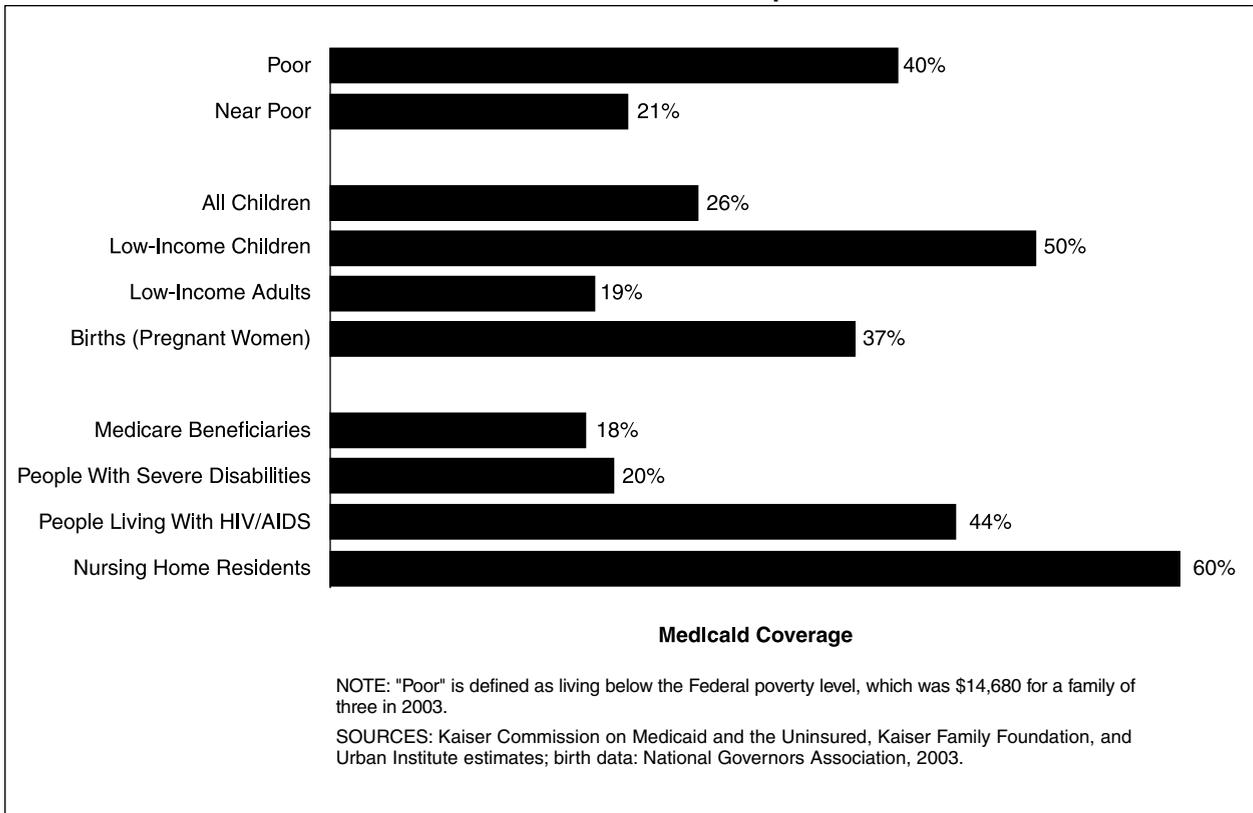
## LOW-INCOME FAMILIES

Medicaid was enacted in 1965 to provide matching funds to States for care of the medically indigent. State participation in the program was voluntary, but if a State chose to participate, all persons eligible for welfare assistance through the Aid to Families with Dependent Children (AFDC) program were automatically eligible for Medicaid. States set the eligibility standard for AFDC (both the income level and allowed assets). Initial coverage under Medicaid focused mainly on welfare-eligible single mothers and their children,

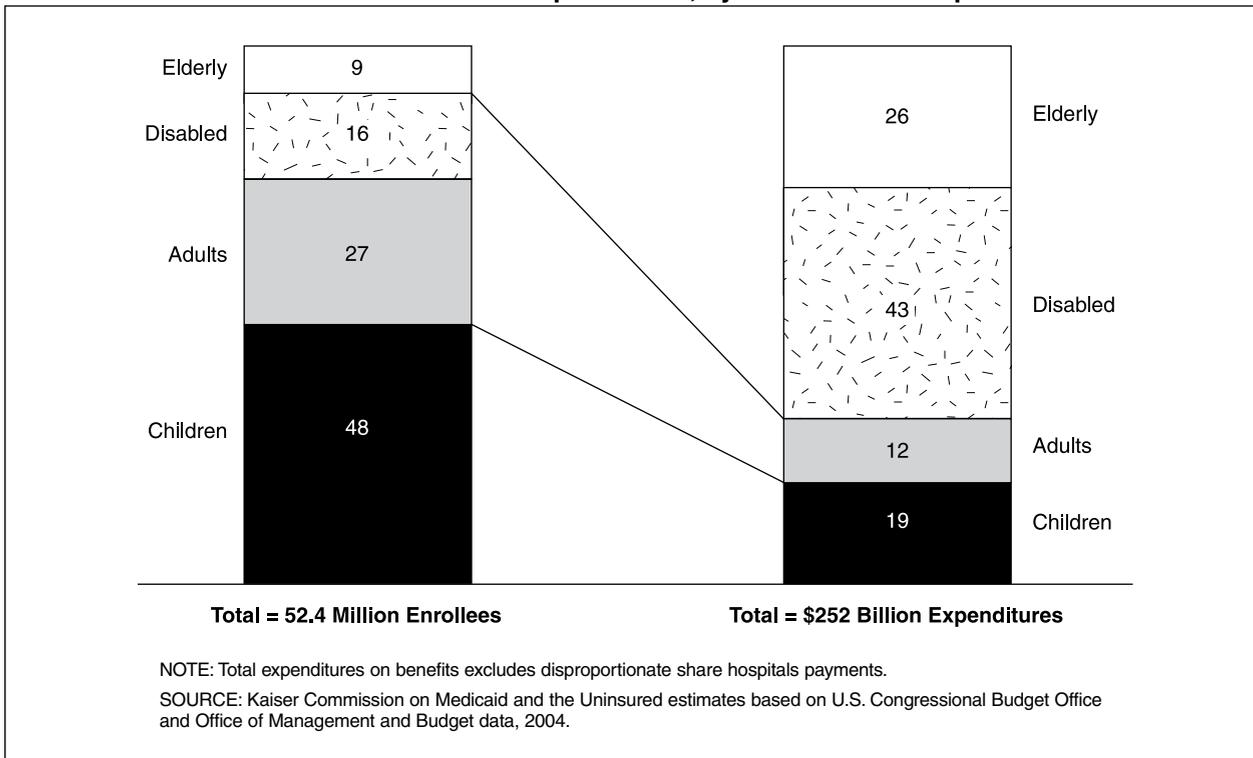
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The author is with The Henry J. Kaiser Foundation. The statements expressed in this article are those of the author and do not necessarily reflect the views or policies of The Henry J. Kaiser Foundation or the Centers for Medicare & Medicaid Services (CMS).

**Figure 1**  
**Medicaid's Role for Selected Populations**



**Figure 2**  
**Medicaid Enrollees and Expenditures, by Enrollment Group: 2003**



but legislative changes over time have substantially expanded coverage for low-income families<sup>1</sup>.

### **Coverage for Low-Income Families**

The 1967 amendments to the Social Security Act gave States the option to cover children in two-parent families who were poor but not on welfare and established the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to provide preventive screening and benefits for children. These provisions initiated Medicaid's dual role as a financing vehicle for health coverage and a source of comprehensive care and treatment for America's poorest children.

By 1974, all States (except Arizona which initiated Medicaid in 1982) elected to participate in Medicaid and were covering welfare families as well as the aged and disabled on cash assistance. Some States broadened coverage to additional low-income children in two-parent families and to the medically needy. During the decade from 1974-1984, enrollment remained relatively stable at close to 20 million beneficiaries. Eligibility standards for women and children varied widely across the States and were closely tied to the very low income levels in place for welfare assistance (Centers for Medicare & Medicaid Services, 2003).

The 1980s saw the beginning of Medicaid's growing role as a source of health coverage for low-income children and pregnant women. In 1984, Federal legislation required States to extend coverage to poor pregnant women and young children in two-parent families, marking the beginning of efforts to extend coverage to children. By 1990, Federal law required States to cover all pregnant women and children under age 6 with incomes at or below 133 percent of the Federal poverty

<sup>1</sup>A timeline of key legislative milestones in Medicaid's history is available at The Kaiser Family Foundation Web site: <http://www.kff.org>.

level (FPL) and gave States the option of extending coverage up to 185 percent of the FPL. In 1990, the Federal law was expanded to phase-in coverage a year at a time for poor children from age 6-18. As a result, in 2002, all children under age 19 in families with incomes below the FPL became eligible for Medicaid in all States regardless of welfare status.

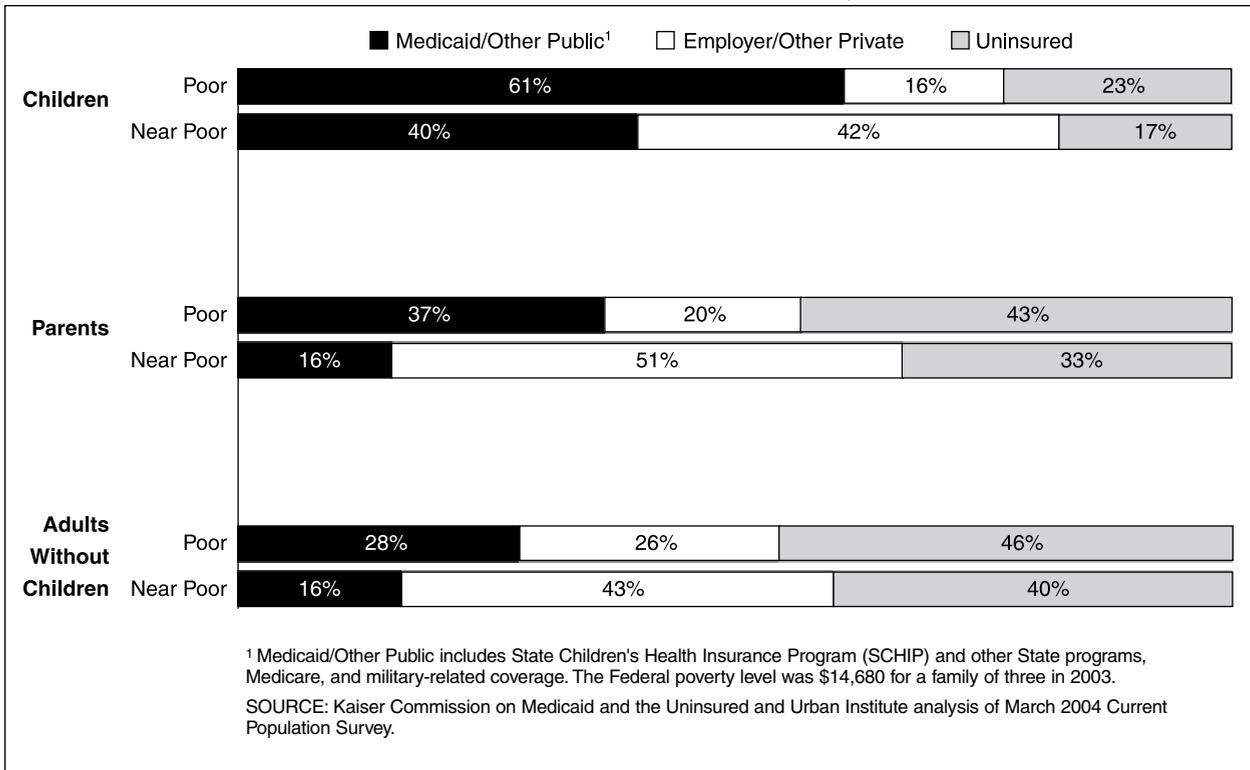
States have opted to extend coverage to children and some of their parents beyond the minimums required by Federal statute. These expansions, coupled with the enactment of welfare reform in 1996 that replaced the AFDC program, transformed Medicaid to a broad-based health insurance coverage program for low-income children. The new welfare law (Temporary Aid to Needy Families [TANF]) left Medicaid eligibility rules intact, but gave States the ability to broaden health insurance coverage for non-welfare families receiving cash assistance was no longer the primary pathway to Medicaid eligibility for low-income families.

The role of public coverage to address lack of health insurance among the low-income population was further extended in 1997 with the enactment of the State Children's Health Insurance Program (SCHIP). SCHIP provided States with additional Federal assistance to either expand Medicaid or create a separate program to cover low-income uninsured children with incomes above Medicaid eligibility levels. The Federal share of spending was increased under SCHIP, but the program's financing was capped with each State receiving an annual allotment of funding.

### **Today's Role**

Medicaid's most widely acknowledged role is as the source of insurance coverage for 39 million low-income children and parents (U.S. Congressional Budget Office, 2004). By providing fundamental health

**Figure 3**  
**Medicaid's Role for Children and Adults, 2003**



insurance protection, Medicaid keeps millions of poor children and their parents from adding to our growing uninsured population. Although more needs to be done to broaden outreach and facilitate enrollment to achieve full participation by all eligible uninsured children, coverage through Medicaid and SCHIP has helped to offset the decline in employer coverage and reduce the increase in the uninsured population (Holahan and Ghosh, 2004).

As a result of the legislative expansions and availability of Federal matching funds, Medicaid coverage remains mostly targeted at children and poor pregnant women. This translates into Medicaid coverage for 61 percent of children from poor families, but only 37 percent of poor parents and 28 percent of poor adults without children (Hoffman, Carbaugh, and Cooke, 2004) (Figure 3). Medicaid is the dominant payer of prenatal care and delivery ser-

vices for low-income women. Nationally, Medicaid covers more than one-third of all births, and in some States, over one-half of all births (National Governors Association Center for Best Practices, 2003).

For those eligible for Medicaid, the scope of coverage is geared toward meeting the health needs of a low-income population. The EPSDT program added in 1989 expanded coverage for preventive health services for children under age 21, including immunizations; vision, dental, and hearing services; and other treatment needed to correct health problems. Medicaid's benefit package is comprehensive, prohibits cost sharing on services for children, and allows only nominal cost-sharing amounts for adults. The goal is to promote access to care—especially preventive and primary care—without undue financial burden in recognition of the very low incomes and limited resources of the covered families.

Reducing financial barriers to accessing necessary health services has been integral to Medicaid's role as the source of health coverage for the low-income population.

While Medicaid's role has expanded for America's low-income children, the program has been far more limited in its reach to low-income adults. Parents of covered or eligible children are most often not eligible themselves for coverage because the parent eligibility levels in most States remain far below the income levels now embraced for children. Only 17 States (including Washington, DC) offer coverage to parents at or above 100 percent of the FPL, in contrast to 39 States (including Washington, DC) covering children at or above 200 percent of FPL (Cohen Ross and Cox, 2004).

In addition to the limited coverage of low-income parents under Medicaid, the lack of coverage for low-income adults without dependent children remains a major impediment to Medicaid's ability to provide coverage and reduce the uninsured rate within the low-income population. Federal Medicaid matching funds are available to States that opt to cover parents at levels comparable to children's coverage, but are not authorized for coverage of adults without dependent children, no matter how poor. A few States have extended coverage to this group by obtaining waivers from the Federal Government to use Medicaid or SCHIP funds for this purpose, but such coverage remains limited. Overcoming this vestige of Medicaid's welfare past and the welfare-related categories for coverage remains a significant hurdle in efforts aimed at broadening health coverage among the low-income uninsured.

## **Impact**

Medicaid financing has helped move many low-income families from dependence on charity and free care to financial

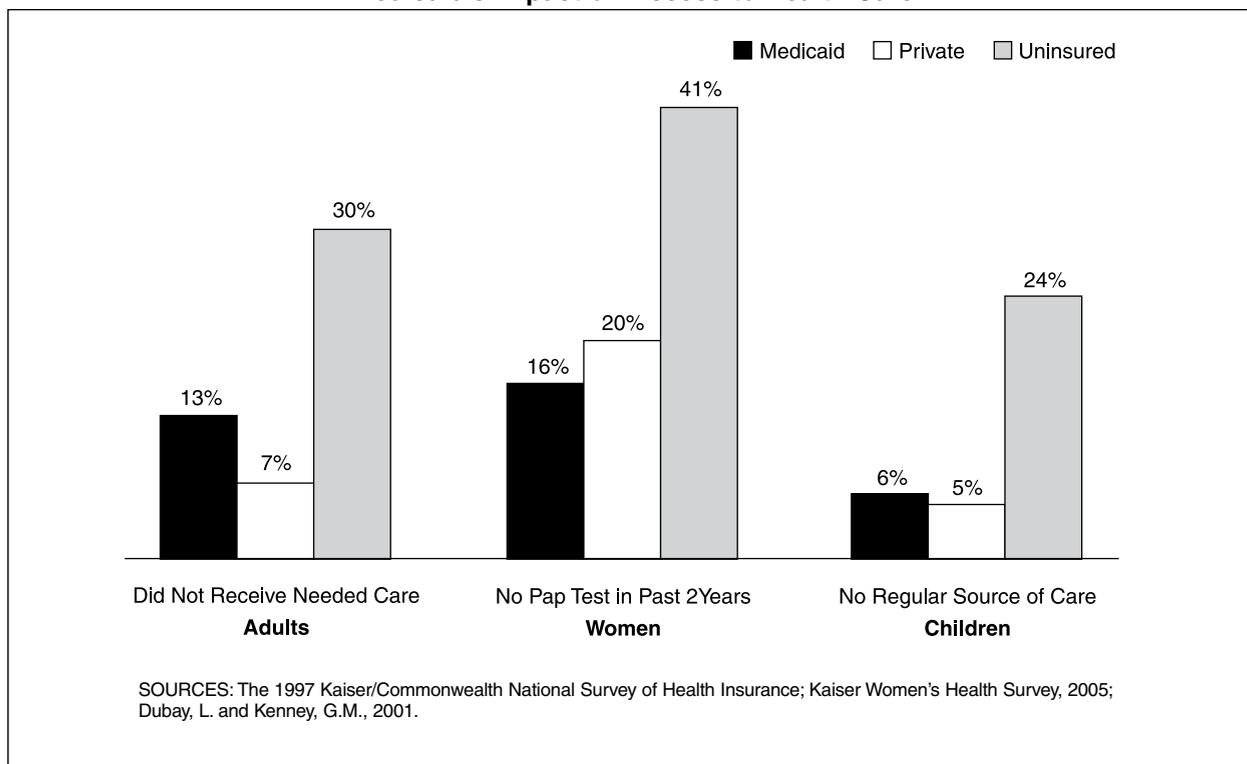
access to both public and private providers. In doing so, it has offered assistance to millions of low-income children and adults and provided a healthier start in life to many of the Nation's children. The coverage provided by Medicaid has helped to narrow the gaps in access to care faced by those without insurance and promoted broader use of preventive and primary care services. Medicaid's impact on low-income families can be seen both in the numbers of people served and the access to care provided.

Medicaid's greatest achievement for low-income families has been its sustained growth in covering a higher proportion of the low-income population, especially our Nation's youngest and poorest children. Without this program, millions of children would potentially be uninsured. As employment-based coverage continues to erode, Medicaid has been able to offset employment based losses for children—thus holding down overall growth in the uninsured. Between 2000 and 2003, while the percent of non-aged uninsured adults rose, the percent of children who were uninsured declined (Holahan and Ghosh, 2004).

Despite these accomplishments, recent State fiscal constraints have led States to curtail mass outreach efforts and implement policies that make it more difficult for families to get enrolled and stay enrolled in the program. Many States have also increased premiums and cost-sharing amounts, which can pose a struggle for families living on limited budgets. For low-income children who are eligible for Medicaid and not enrolled, effective outreach and streamlined enrollment and renewal processes are critical to improving coverage (Cohen Ross and Cox, 2004).

Medicaid also has demonstrated success in improving access to care for the low-income population, most notably reflected in the comparability of Medicaid to private

**Figure 4**  
**Medicaid's Impact on Access to Health Care**



insurance for many access indicators where uninsured people fall far behind (Figure 4). Among low-income children, Medicaid, like private insurance, enables them to have a usual source of care—the key entry point into the health care system (Dubay and Kenney, 2001). For adults, those with Medicaid are less likely to report not receiving needed care and more likely to use preventive services than those who are uninsured (The Henry J. Kaiser Family Foundation and The Commonwealth Fund, 1997; Salganicoff, Ranji, and Wyn, 2005).

This achievement is particularly striking given that Medicaid serves both a sicker and poorer population than private insurance. Within the low-income population, those with Medicaid are predominately from families with income below the FPL (69 percent), nearly one-half (48 percent) report their health as fair or poor, and 61 percent have health conditions that limit work; compared to 27 percent poor, 16 per-

cent in fair or poor health, and 15 percent with conditions that limit work with private coverage (Coughlin et al., 2004).

Medicaid also provides that coverage at a lower cost. In 2001, Medicaid's per enrollee cost is \$749 for children's coverage and \$1,752 for non-disabled adults compared to \$1,098 and \$2,253, respectively, for the low-income privately insured (Hadley and Holahan, 2003/2004).

Provider participation remains one area where improvement is needed to secure access to care for beneficiaries. Medicaid provider payments have historically been substantially below those of private insurance and Medicare. Medicaid's low payment rates coupled with administrative burdens for providers have resulted in limited access for some services, especially specialty care. As States have grappled with their budgets over the last few years, provider payments have been frequently targeted to curtail Medicaid spending.

State efforts over the last 20 years have broadened the use of managed care arrangements, both as a cost control mechanism and as a way to secure better provider networks for Medicaid beneficiaries. From 1994 to 2004, the percent of enrollees in managed care has grown from 23 to 61 percent of Medicaid—largely composed of low-income children and their parents (Centers for Medicare & Medicaid Services, 2005a). The use of managed care and its structure varies widely with some populations enrolled in primary care case management arrangements and others in capitated health maintenance organization (HMO)-type plans. Nearly all States utilize managed care arrangements for family coverage and more than 30 States have moved into managed care arrangements for some of the special needs children and disability populations (Kaye, 2001). While managed care has the potential to improve the delivery and coordination of services, the inherent financial incentives to provide fewer services under capitated arrangements needs to be balanced against the higher utilization needed to address the health of those with disabilities and chronic conditions.

The Medicaid population is a disproportionately low-income and disadvantaged group, living in poor and often environmentally and physically hazardous neighborhoods, where poverty and complex social needs combine with a multitude of other factors to shape health outcomes. Health coverage alone cannot be expected to reverse the effects of poverty and deprivation on the health and well-being of America's poorest residents, but Medicaid has demonstrated over the last four decades that it is an important lever to help improve access to health services and hopefully the health of America's poor children and families.

## **LOW-INCOME PEOPLE WITH DISABILITIES**

Medicaid is now the largest single source of health and LTC coverage and public financial support for people with disabilities, covering 8 million children and adults with severe disabilities in 2003 (U.S. Congressional Budget Office, 2004).<sup>2</sup> Medicaid's disabled population includes people with physical impairments and limitations, such as cerebral palsy, epilepsy, HIV/AIDS, and multiple sclerosis; mental or emotional conditions, such as depression, bipolar disorder, schizophrenia, and mental retardation; and other functional limitations.

### **Coverage for People with Disabilities**

Under the 1965 legislation, States were only required to cover populations receiving cash assistance, including individuals age 18 or over receiving aid for the permanently and totally disabled under Title XIV of the Social Security Act, and the elderly qualifying for Old Age Assistance. Some States also offered coverage to the medically needy—those who met the categorical requirement for cash assistance and had high medical expenses that reduced their income to below the income cutoff for eligibility.

The most significant change in eligibility and coverage of people with disabilities and the elderly came in 1972 with the enactment of a Federal income-assistance program for people with disabilities—the Supplemental Security Income (SSI) program—which replaced the State-based welfare system with a Federal cash assistance program with national income and asset standards as well as a uniform national definition of disability. States were required to provide

<sup>2</sup> A timeline of key legislative milestones in Medicaid's history is available at [www.kff.org](http://www.kff.org).

Medicaid coverage either to all their federally qualified SSI recipients or to all the elderly and individuals with disabilities using their State's eligibility standard in effect in 1972. The national standards substantially raised eligibility levels in many States and provided automatic increases in the income eligibility levels, tied to indexed increases in the cash assistance eligibility level (roughly 74 percent of FPL) under SSI.

In addition to the eligibility-related changes, other major changes to Medicaid for people with disabilities involved making assistance in the community and at home an alternative to institutional nursing home care, promoting improvements in the quality of care in nursing homes, and assisting people with disabilities to return to work while retaining Medicaid coverage. Some reforms gave States new options, while others placed new requirements on States as a condition for Federal matching funds. In 1981, the home and community-based waiver program (1915(c) waivers) allowed States to provide care in the community to the elderly and disabled at risk of institutional care. In 1999, the landmark U.S. Supreme Court (1999) ruling in *Olmstead v. L.C.* required States to provide community-based services to individuals for whom institutional care is inappropriate in order to comply with the 1990 Americans with Disabilities Act.

Enabling people with disabilities to return to work without jeopardizing their health coverage remains a prominent area for policy changes in Medicaid. Legislation has been directed at minimizing work disincentives for the disabled associated with income eligibility criteria for SSI and Medicaid. In 1986, Congress required States to continue Medicaid coverage for working disabled individuals with severe impairments who lose their eligibility for SSI due to earnings. Recognizing both

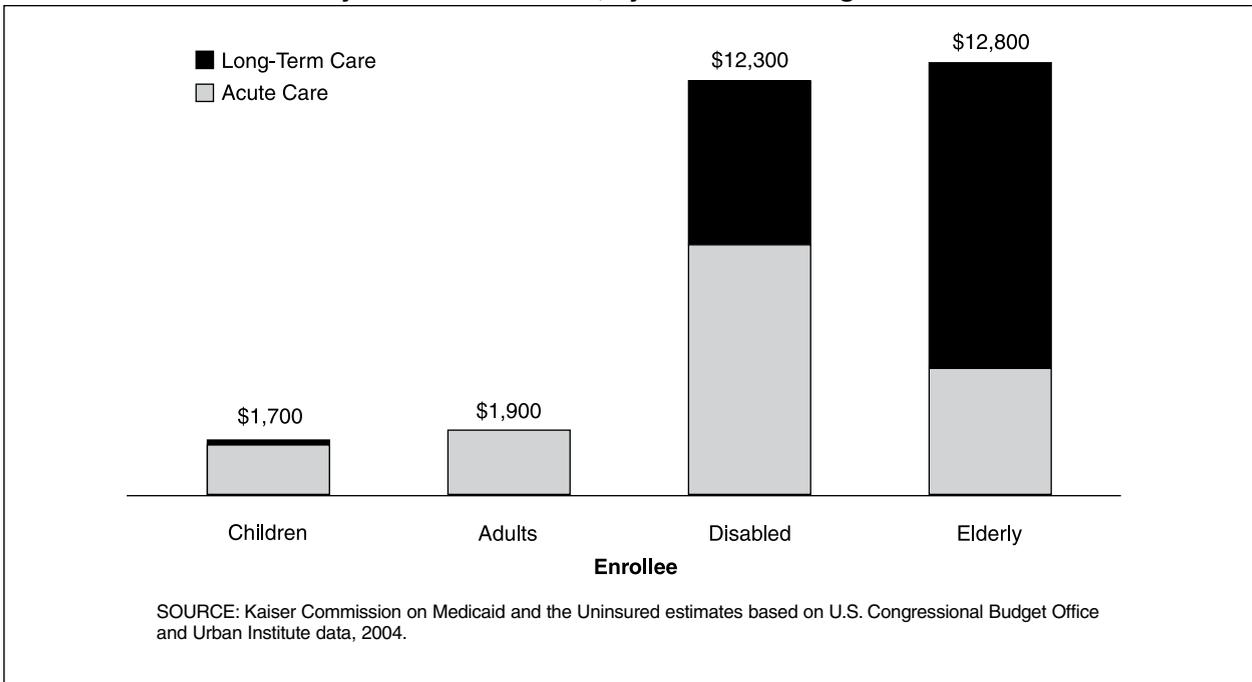
the limits of private health insurance coverage and the disincentive to employers to bring a disabled individual into their health insurance pool, legislation in 1997 and 1999 allows States to help people with disabilities enter the workforce and retain Medicaid coverage with incomes that can exceed 250 percent of FPL.

## Today's Role

All of these changes have combined to make Medicaid the primary source of coverage for people with disabilities and the low-income elderly, especially those needing LTC. Individuals with disabilities make up 16 percent of Medicaid beneficiaries, but account for 43 percent of total Medicaid spending due to their intensive use of services and the high cost of their LTC services. Medicaid spends, on average, seven times more on a disabled beneficiary than on a non-disabled child. In 2003, per capita expenditures were \$12,300 per disabled beneficiary compared to \$1,700 per child (Kaiser Commission on Medicaid and the Uninsured, 2005a) (Figure 5).

Of the 25 million non-elderly Americans considered to have a specific, chronic disability—defined as a disabling condition or impairment that has lasted 1 year or is expected to last for 1 year—who live in the community, 20 percent are covered by Medicaid (Crowley and Elias, 2003). Medicaid covers 43 percent of poor non-elderly adults with disabilities and provides benefits to over 2 million disabled individuals who are also Medicare beneficiaries (Meyer and Zeller, 1999; Holahan and Ghosh, 2005). In addition, Medicaid is also the largest single payer of direct medical services for people with HIV/AIDS, covering over one-half (55 percent) of people with AIDS, and up to 90 percent of children with AIDS (Centers for Medicare & Medicaid Services, 2004).

**Figure 5**  
**Medicaid Payments Per Enrollee, by Acute and Long-Term Care: 2003**



Medicaid provides supportive services to people with disabilities that complement medical care and help them maintain their independence. These services are not traditionally covered by other sources of insurance or are subject to strict utilization limits or high cost sharing (Foote and Hogan, 2001; Perry, Dulio, and Hanson, 2003; Pollitz, Sorian, and Thomas, 2001). Medicaid’s broad benefits for people with disabilities are delivered primarily on a fee-for-service basis, but States are increasingly looking to expand managed care for people with disabilities.

**Impact**

Medicaid coverage helps to provide health insurance to the low-income disabled who are either not in the workforce or otherwise without access to private insurance. Private health insurance, including both employer-based and individually purchased coverage is often unavailable or unaffordable for people with disabilities, as

they are less likely to be working and more likely to have lower incomes (Hanson et al., 2003; Meyer and Zeller, 1999). The private, individual insurance market can be particularly daunting for an individual in less-than-perfect health—coverage can be denied due to pre-existing conditions; premiums can be prohibitively expensive for low-income people with disabilities; and the benefit package is likely to be limited or subject to high cost sharing, especially with regard to LTC (Pollitz, Sorian, and Thomas, 2001). Medicaid actually helps make the private insurance market work by removing many of the high risk and cost individuals with special health needs from insurance pools (Burwell, Crown, and Drabek, 1997; Hadley and Holahan, 2003/2004; Hanson et al., 2003).

Medicaid has a substantial role in financing care for those with severe mental health problems and developmental disabilities. In 1971, Congress authorized Federal Medicaid funding for care provided in residential intermediate care facilities for the

mentally retarded (ICF/MR). Medicaid's role for people with mental health needs grew significantly in the 1970s, when SSI was established and tied to Medicaid, and further expanded in the mid-1980s due to changes in the SSA's disability eligibility criteria. The shift away from institutional care toward LTC provided in the home and community allowed States to close institutions and shift some of the costs of what was previously fully State financed to the Federal government. The shift was meant to improve care, but was not smooth or without consequences and in some cases contributed to an increase in the homeless population as institutions closed.

Although Medicaid is still the dominant source of financing for care in nursing facilities and ICF/MRs, covering 46 percent of spending, Medicaid has helped to shift more care to home and community-based settings, facilitating access to these services, as well as people's ability to maintain function and independence (Centers for Medicare & Medicaid Services, 2005b). Enacted in 1981, the home and community-based waiver program (1915(c) waivers), provides Federal matching payments to States that provide these services to individuals who would otherwise receive care in a nursing facility and allows Medicaid to pay for non-medical services necessary for care in the home, such as case management, personal care, and adult day care (Smith et al., 2000). In 2002, there were over 250 waivers in place across the country, allowing nearly 1 million individuals with mental retardation/developmental disabilities, physical disabilities, and the elderly to receive home and community-based care as an alternative to institutional care (Kitchener et al., 2005).

## **ROLE FOR MEDICARE'S BENEFICIARIES**

Medicaid subsidizes care for some of the poorest of Medicare beneficiaries by providing coverage to fill in Medicare's gaps.<sup>3</sup> Medicare's lack of LTC or prescription drug coverage and substantial financial requirements for premiums and cost sharing pose a financial burden that Medicaid eases for Medicare's lowest income beneficiaries, the population known as dually eligible beneficiaries. For the disabled who qualify for SSI, Medicaid provides full coverage during the 29-month waiting period for Medicare and wraps around Medicare coverage thereafter.

During the 1980s and 1990s, Medicaid's role as a supplement to Medicare and a source of financial assistance with Medicare premiums and cost sharing was expanded to protect low-income Medicare beneficiaries from increases in Medicare premiums. States were initially given an option to provide Medicaid protections to Medicare beneficiaries with incomes above SSI levels, but below 100 percent of the FPL. In 1988, the Medicare Catastrophic Coverage Act made that option a requirement on States, and thus provided coverage for Medicare's premium and cost-sharing requirements for all Medicare beneficiaries with incomes below the FPL. These provisions were retained when that act was repealed in 1989. Later legislation extended more limited assistance with Medicare's premium to individuals with somewhat higher incomes. However, in 1997, with rising costs a concern for the States, Congress limited Medicaid's liability for cost sharing on Medicare-covered services to the total payment Medicaid would pay for such

<sup>3</sup> A timeline of key legislative milestones in Medicaid's history is available at [www.kff.org](http://www.kff.org).

services and released the requirement that States pay the full amount of Medicare cost sharing.

## **Role Today**

As important as Medicare is to the elderly and people with disabilities whom it covers, the program's premiums, cost-sharing, and significant service gaps leave beneficiaries exposed to considerable health care costs. Medicaid helps relieve the financial burdens facing low-income Medicare beneficiaries in two ways. First, it pays their monthly Medicare Part B premium, which now amounts to over \$900 a year, and pays the cost-sharing charges for many Medicare services. Second, Medicaid covers a range of important benefits excluded from Medicare: prescription drugs (until January 2006), LTC, dental and vision care, and other key services.

Quite simply, Medicaid wraps around Medicare coverage and assists with Medicare's financial obligations to make health coverage affordable and comprehensive for Medicare's poorest beneficiaries. Almost 7.5 million Medicaid beneficiaries (about 5 million elderly and 2.5 million non-elderly disabled), are dually eligible beneficiaries with joint enrollment in both programs (Holahan and Ghosh, 2005). Dually eligible beneficiaries account for 14 percent of Medicaid enrollees and 18 percent of Medicare beneficiaries (Holahan and Ghosh, 2005; Cubanski et al., 2005). Virtually all of the elderly and over one-third of the non-elderly with disabilities covered by Medicaid are dually eligible beneficiaries. These dually eligible beneficiaries are poorer, sicker, and more in need of LTC than other Medicare beneficiaries: 73 percent have annual incomes below \$10,000 compared to 12 percent of all other Medicare beneficiaries. Over one-half are in fair or poor health, twice the rate of oth-

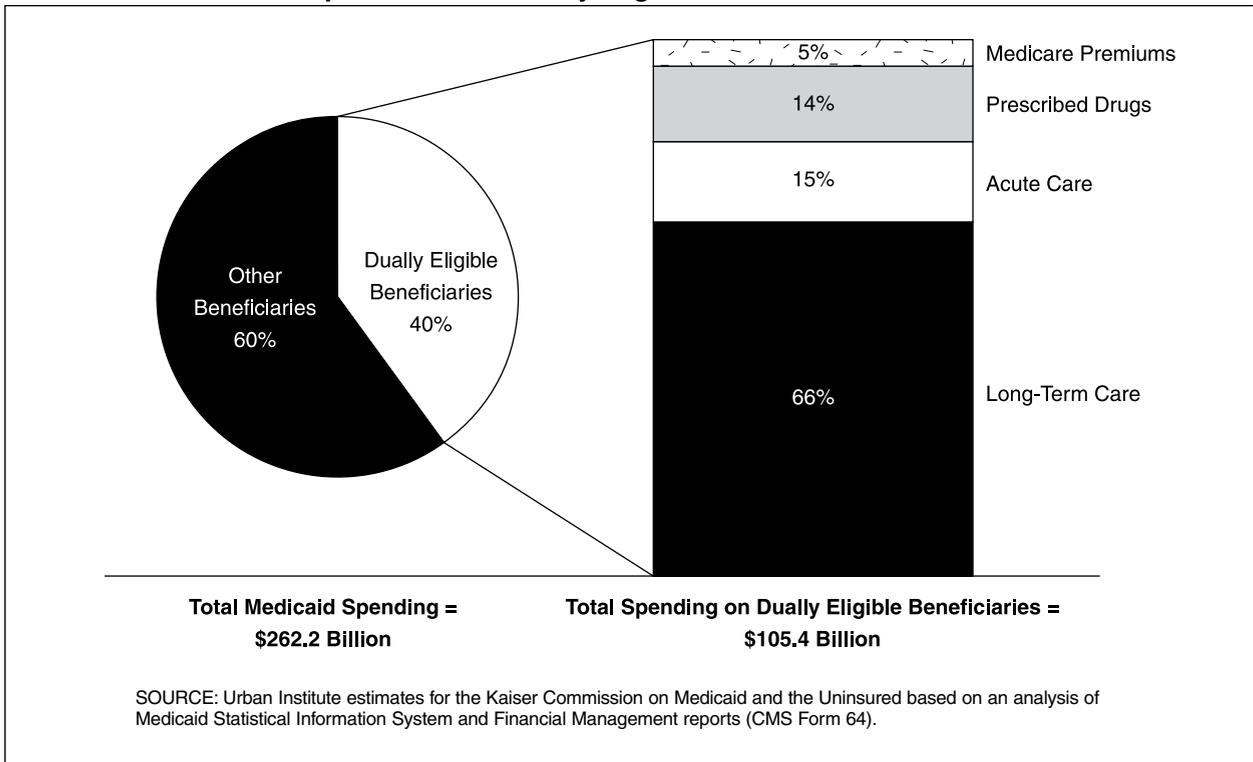
ers in Medicare; and 19 percent live in LTC facilities, compared to 3 percent of other Medicare beneficiaries (Cubanski et al., 2005).

The majority of dually eligible beneficiaries (6.2 million) receive full Medicaid benefits and assistance with Medicare premiums and cost sharing. The remaining 1.3 million benefit mostly from the Medicare savings programs and primarily receive assistance with their Medicare premiums and cost sharing (Holahan and Ghosh, 2005). Given their extensive health care needs, these beneficiaries require and use more services than others in Medicare. On average, their total health care costs are double those of other Medicare beneficiaries. This group of beneficiaries accounts for 40 percent of total Medicaid spending (Figure 6). Their LTC services account for 66 percent; prescription drugs for 14 percent; acute care services to supplement Medicare for 15 percent; and payment of Medicare premiums for 5 percent of Medicaid spending for dually eligible beneficiaries (Kaiser Commission on Medicaid and the Uninsured, 2005b).

## **Impact**

Medicaid's coverage helps assure that access to care for dually eligible beneficiaries is not jeopardized by Medicare's premiums, cost sharing, and benefit limits. Many of the services that Medicaid provides, such as custodial care and some therapy services (and prescription drugs until January 2006), are critical to the management of their health conditions. The high prevalence of activity of daily living limitations and mobility problems results in the need for services and supports that go well beyond Medicare's medical model. These beneficiaries do not have the financial resources to obtain services that are not covered by Medicare. Medicaid's broad

**Figure 6**  
**Medicaid Expenditures for Dually Eligible Beneficiaries: Fiscal Year 2003**



benefit package, which spans medical and LTC services, is an indispensable adjunct to Medicare for this group. However, coordination of care between Medicare and Medicaid to provide an integrated approach to care delivery for beneficiaries remains a challenge for both programs.

One of Medicaid’s key roles has been to provide LTC assistance for dually eligible beneficiaries. With the cost of nursing home care reaching \$70,000 a year, many Medicare beneficiaries who need LTC quickly exhaust their resources and become eligible for Medicaid (MetLife Mature Market Institute, 2004). Per capita spending for beneficiaries in nursing home averages \$44,600, or about four times greater than spending for those living in the community (\$10,900) or for other Medicare beneficiaries (\$8,400). Because Medicare does not cover LTC, the high costs for the institutionalized fall heavily on the Medicaid Program and account for nearly

4 out of 5 dollars that Medicaid spends on dually eligible beneficiaries (Kasper, Elias, and Lyons, 2004). Many of these beneficiaries spend down to qualify for Medicaid LTC, but access to initial nursing home care can be difficult with long waiting lists and limited supply due to Medicaid payment rates.

### LOOKING AHEAD

Over the last 40 years, Medicaid has been an essential and effective health safety net for millions of our poorest and sickest Americans. It has performed remarkably well in filling many of the cracks in our health system for the poor and the vulnerable. Its role in providing health and LTC services to our Nation’s most vulnerable people and its widening safety net responsibilities have brought notable improvements in coverage of low-income families and assistance to the elderly and

individuals with disabilities. As the primary source of financing and coverage for the low-income population, Medicaid has been a critical force in moderating the growth in America's uninsured population over the last four decades. Without Medicaid, millions of our Nation's poorest children could be added to our growing uninsured population.

Medicaid continues to provide coverage beyond that of private insurance or Medicare to the most vulnerable and frail in our society—acute and LTC services for persons with chronic mental illness and retardation; medical and LTC services and drug therapy for those with AIDS; assistance with Medicare's premiums, cost-sharing, and prescription drug coverage for poor Medicare beneficiaries; and home-based and institutional care for those with severe physical and mental disabilities that require LTC. In the absence of Medicaid, it is hard to envision how these enormous societal needs would be met.

Yet, one of the most daunting challenges facing Medicaid is how to meet the Nation's growing need for health and LTC coverage within the constraints of Federal and State financing. There are no easy answers to reducing the cost of providing care to over 50 million Americans who now depend on Medicaid. The high cost of caring for this population is reflective of their serious health problems, not excessive spending by the program. Program costs grow in response to downturns in the economy, the needs of an aging population, and emerging public health crises and emergencies. Medicaid costs rise because it is the Nation's health safety net.

The fiscal situation in the States, coupled with the growing Federal deficit, makes assuring adequate financing and meaningful coverage for low-income families, the elderly, and people with disabilities a

growing challenge. In meeting this challenge, we need to not only recognize the role Medicaid has played in filling the gaps in our Nation's health system over the last four decades, but also begin filling those gaps.

Underlying the debate over Medicaid's future is thus a more fundamental debate about how we, as a Nation, fill the gaps in our health care system to provide and finance care for the poorest and sickest among us. The solution to making Medicaid more sustainable is to make it less necessary. If we had universal health coverage and assistance with the high cost of LTC, the need for Medicaid's safety-net role in the future would undoubtedly be dramatically reduced. But in the absence of broader solutions, policymakers need to find ways to maintain the Medicaid safety net, because without it, millions more would be uninsured, and many of our poorest and sickest citizens would be unable to obtain or afford the care they need. Until we solve the many gaps in our health system, we need to strengthen and improve Medicaid's ability to meet the many challenges we ask the program to address in its multiple roles.

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Reprint Requests: Diane Rowland, Sc.D., The Henry J. Kaiser Family Foundation, 1330 G St. NW, Washington, DC 20005. E-mail: [DRowland@kff.org](mailto:DRowland@kff.org)