
Health Care for the Poor: Medicaid at 35

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Over its 35-year history, Medicaid has grown from a program to provide health insurance to the welfare population to one that provides health and long-term care (LTC) services to 40 million low-income families and elderly and disabled individuals. Despite its accomplishments in improving access to health care for low-income populations, Medicaid continues to face many challenges. The future of Medicaid as our Nation's health care safety net will be determined by Medicaid's ability to broaden health coverage for the low-income uninsured, secure access to quality care for its growing beneficiary population, and manage costs between the Federal and State governments.

INTRODUCTION

When Medicaid was enacted as Title XIX of the Social Security Act in 1965, it was conceived as an important new form of Federal assistance to States to improve health care services for the Nation's needy welfare population. Over its 35-year history, the program has grown into a major component of our Nation's social safety net, evolving from a program primarily covering those who qualified for cash assistance to become an essential provider of health and LTC coverage for millions of low-income Americans.

Today, Medicaid covers more than 40 million low-income people at a cost of \$169 billion to the Federal and State govern-

ments that finance it (Urban Institute, 2000). Medicaid has brought expanded health coverage for our poorest families, the elderly, and disabled populations, which in turn has led to measurable gains in access to care and improved health outcomes for the low-income population.

Since its enactment, Medicaid has also been the subject of public debate. The program has been criticized for the limits of its reach in providing health insurance to the poor, its ties to the welfare system and image problems, its variations across States, and the fiscal burdens imposed on Federal and State budgets as the program has grown in scope and spending (Rowland, 1995). These debates over Medicaid's role and structure continue, particularly as proposals to extend coverage to our growing uninsured population bring Medicaid again to the forefront of the policy debate. By examining Medicaid's role today as a safety net for the health and LTC needs of low-income Americans and its evolution, accomplishments, and challenges, we provide an overview of what we have learned about financing and delivering care to the poor through Medicaid and assess the implications for future directions.

MEDICAID TODAY

Today, Medicaid is the source of insurance for more than 1 in 7 Americans, accounts for 15 percent of our Nation's spending on health care, and is the major source of Federal financial assistance to the States, accounting for 40 percent of all Federal grant-in-aid payments to States

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(Kaiser Commission on Medicaid and the Uninsured, 1999a). From its roots as a program to help States cover their welfare populations, Medicaid has developed into a program that addresses the needs of low-income families, the elderly, and those with chronic, disabling health conditions. In these multiple roles, Medicaid is configured and operated somewhat differently in each of the 50 States and the District of Columbia.

Medicaid is a health insurance program that insures 21 million children and 8.6 million low-income adults. (Unless otherwise noted, all spending and enrollment data are based on unpublished Urban Institute analysis of HCFA-2082 and HCFA-64 reports [Urban Institute, 2000].) The program covers one in four American children and 40 percent of all births (Kaiser Commission on Medicaid and the Uninsured, 1999a). For most of the families covered through Medicaid, private health insurance is unavailable or unaffordable; with Medicaid, they gain access to a broad range of medical, dental, vision, and behavioral health services, including preventive care, acute care, and LTC, with little or no cost sharing.

Medicaid is also an acute and LTC support system for nearly 7 million low-income people with severe disabilities, ranging from people with physical impairments to those with severe mental or emotional conditions to those with specific disabling conditions, such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). For many, private insurance coverage does not cover necessary services, is not available due to pre-existing condition exclusions, or is simply prohibitively expensive. Medicaid coverage provides an essential link to a broad array of services in the community or in institutions. Currently, Medicaid is the source of coverage for one in five non-elderly persons with a specific, chronic

disability who live in the community and is the single largest source of public financing for HIV/AIDS-related care (Schneider, Strohmeier, and Ellberger, 2000; Westmoreland, 1999).

For nearly 6 million low-income Medicare beneficiaries, Medicaid serves as a supplementary insurance program. Medicare's gaps in benefits and financial obligations can impose significant financial burdens on low-income beneficiaries, many of whom have more extensive health care needs than the average beneficiary but cannot afford costly private coverage to supplement Medicare (Rowland and Lyons, 1996). Medicaid provides additional coverage for services not covered by Medicare (notably, prescription drugs and LTC) and helps to cover Medicare's premiums and cost-sharing requirements.

For disabled and elderly low-income people, Medicaid is more than a health insurance program: It is also the only significant public program providing financing for LTC, covering home and community-based services, and providing institutional care. Serving both the very poor and those with higher incomes who have incurred significant health and LTC expenses, Medicaid covers 70 percent of nursing home residents and nearly one-half of nursing home costs nationwide (Niefield, O'Brien, and Feder, 1999). Medicaid's coverage of institutional care assists beneficiaries with those extremely expensive services and also helps to promote high-quality care by tying payment to quality standards. Medicaid's coverage of home and community-based services, as well as other non-medical social and supportive services, also allows many with LTC needs to remain in the community.

Medicaid is also a financing system for the Nation's safety net of clinics and hospitals that serve low-income and uninsured populations. In addition to its rules that

guarantee payment of clinic providers, Medicaid, through its disproportionate share hospital (DSH) program, makes supplemental payments available to institutions that serve a large portion of low-income and uninsured patients. Medicaid's financing is crucial to ensuring the solvency of many of these providers, providing 41 percent of revenues for safety-net hospitals and 34 percent of revenues for community health centers (National Association of Public Hospitals and Health Systems, 1996; Kaiser Commission on Medicaid and the Uninsured, 2000). Medicaid is also a key third-party resource to supplement funding for State public health efforts, such as tuberculosis control and family planning programs, as well as other Federal programs, such as the Ryan White Care Act and the Maternal and Child Health Block Grant.

From the perspective of who is served, Medicaid is predominantly a program assisting low-income families, but from the perspective of how Medicaid dollars are spent, Medicaid funds primarily serve the low-income aged and disabled population. Adults and children in low-income families make up 73 percent of enrollees but account for only 25 percent of spending. In contrast, the elderly and disabled account for 27 percent of enrollees and the majority (67 percent) of spending, largely due to their intensive use of acute care services and the costliness of LTC in institutional settings. In 1998, the average per capita cost for a child covered by Medicaid was \$1,225, almost all of which went to basic acute care, while the corresponding figures for the disabled and elderly were \$9,558 and \$11,235, respectively, a significant portion of which went to LTC services (Urban Institute, 2000).

EVOLUTION OF MEDICAID

The 1965 enactment of Medicaid was a tremendous step forward in financing and providing health care to many segments of the poor population. Modeled on the 1960 Kerr-Mills legislation providing Federal matching grants to States for care of the indigent aged, Medicaid initially offered the States Federal matching grants to finance medical care for the poor receiving welfare payments. Coverage—and the availability of Federal matching funds—was linked to the State-determined income levels for welfare assistance and to the categories of eligibility for welfare: primarily, single parents with dependent children, and aged, blind, and disabled individuals. Income and asset standards for Medicaid coverage were tied to State-based welfare policy, with eligibility rules and processing done by the welfare offices.

From these early roots, Medicaid evolved in several directions: to become a broader source of health insurance coverage for children and pregnant women, to take on additional responsibility for coverage of the low-income aged and disabled population, and to provide assistance with Medicare premiums and cost sharing for low-income Medicare beneficiaries. Underlying each of these expansions was the goal of improving coverage for a vulnerable part of the low-income population by, in most cases, Federal legislation first giving States the option to broaden their program and later requiring that States cover those whose income was below a federally established floor (Rowland et al., 1992).

In the case of low-income families, Medicaid has evolved by extending coverage to low-income children and pregnant women regardless of cash-assistance status

or family situation. Federal legislation in the 1980s and 1990s broadened eligibility beyond traditional welfare populations by requiring coverage of children and pregnant women in either single- or two-parent families as long as they were income-eligible, thus ending the categorical restrictions that focused eligibility on single-parent families. Medicaid coverage for pregnant women and children was set at uniform Federal standards tied to the poverty level, with States given the option to establish higher income standards for these groups.

With welfare reform in 1996, the link between cash assistance and Medicaid eligibility was officially severed. The welfare law left Medicaid eligibility levels intact but also established a new Medicaid eligibility category (section 1931) through which States had broad authority to extend Medicaid coverage to low-income families. In 1997, the passage of the State Children's Health Insurance Program (SCHIP) further redefined Medicaid as a health insurance program distinct from welfare, providing funds for States to expand coverage to children up to at least 200 percent of the Federal poverty level. This program also gave States the option of either directly expanding Medicaid or creating a new separate program for children from families with incomes above Medicaid levels.

This broadening program scope for low-income families is reflected in trends in enrollment and spending. The number of children and adults enrolled in Medicaid increased substantially, from 9.8 million children and 4.6 million adults in 1985 to 21 million children and 8.6 million adults in 1998. The majority of that increase was comprised of enrollees receiving Medicaid only (as opposed to those also receiving cash assistance). Although low-income families were the fastest growing eligibility group within the Medicaid program, they

accounted for only a small amount of the growth in spending during this time because of their relatively low per capita costs (Feder et al., 1993).

Medicaid also evolved as a program to assist low-income elderly and disabled populations. The 1972 amendments to the Social Security Act were a primary step in this evolution. First, by establishing a Federal program for cash assistance for the aged, blind, and disabled (Supplemental Security Income, or SSI), with national eligibility criteria and income standards, State variations in Medicaid coverage of these groups were largely replaced with a uniform national minimum benefit and a national eligibility standard, which increased the number of people covered. Second, changes in the Medicaid benefits package expanded the range of covered services for the disabled and elderly by adding services furnished by intermediate care facilities and intermediate care facilities for the mentally retarded (ICFs/MR) as an optional benefit eligible for Federal matching funds. Subsequent additions to the Medicaid benefits package, particularly in home and community-based LTC services, further expanded the role of the program for these populations in the 1980s.

Although enrollment of the elderly and disabled in Medicaid increased more moderately than that for low-income families, these groups continued to be a major spending focus of the program because of their heavy reliance on acute care and, more importantly, utilization of LTC services. As a result of Medicaid's expanding role for the low-income elderly and disabled, the program's total LTC spending accounted for nearly 40 percent of Medicaid's total expenditures by 1998 (Urban Institute, 2000). (LTC services include nursing facilities, ICFs/MR, mental health, home health services, and personal care support services.) Medicaid

spending on nursing home care, which covered just 11 percent of national nursing home spending in 1966, helped fuel the growth of this industry and covered 48 percent of national nursing home spending by 1999 (Health Care Financing Administration, 2000). Medicaid's expanding role in financing LTC has in turn given the program a key role in setting quality standards in the area, enabling the Federal Government to use its purchasing power to implement comprehensive nursing home reform to raise standards for nursing home quality and establish protections for "spousal impoverishment" in the late 1980s.

A related expansion in Medicaid's role for the low-income elderly and disabled is its evolution as a Medicare supplement. As beneficiary financial obligations for Medicare coverage grew over time, Federal legislators looked to Medicaid to help provide financial protection to the lowest income Medicare beneficiaries. Since 1965, most Medicare beneficiaries receiving cash assistance through SSI (roughly 5 million) have been covered by Medicaid for Medicare premiums and cost sharing and additional benefits not covered by Medicare. Over time, assistance with Medicare's premiums and cost sharing has been extended to additional low-income Medicare beneficiaries through a series of incremental expansions. As health care costs rise, medigap costs increase, retiree coverage declines, and service delivery relies more and more on prescription drugs and LTC services, the importance of Medicaid's expanding role for Medicare beneficiaries becomes more and more evident.

IMPACT OF MEDICAID

To understand the full effect of Medicaid's contributions to health care in America, it is necessary to look at the impact that the pro-

gram has on the individuals it serves. Over the past 35 years, the program has demonstrated the importance of health care coverage and achieved remarkable success in helping to close gaps in access to care for low-income groups. Prior to Medicaid's passage, the poor were essentially outside mainstream medical care, relying on the charity of physicians and hospitals and public hospitals and clinics for their care, and often facing discrimination in their attempts to access services. The difficulties associated with this patchwork of health services resulted in fewer services being provided to the poor compared with the non-poor, despite the fact that the poor are in poorer health (Rogers, Blendon, and Moloney, 1982). Medicaid has reshaped the availability and provision of care to the poor and helped to improve health status, access to care, and satisfaction with the health care system among the poor. The value of Medicaid is underscored by the contrast in outcomes between the poor with Medicaid and the uninsured poor, where studies consistently show that the uninsured lag well behind those with Medicaid, while those with Medicaid fare comparably to the privately insured (Lillie-Blanton, 1999). Children with Medicaid are only slightly less likely than privately insured non-poor children to have a regular source of care and reasonable access to care, but poor uninsured children face significant deficits (Lyons, 2000).

Medicaid has also played a significant role in reducing the financial burdens and barriers to care for low-income elderly and disabled Medicare beneficiaries. Comparisons of access to care for those solely dependent on Medicare coverage versus those with Medicaid or private supplemental insurance again show that Medicaid provides substantial assistance in reducing barriers for some of Medicare's poorest beneficiaries (Rowland and Lyons, 1996). Those with Medicare

only are more likely to delay care because of cost and less likely to have a regular source of care and use care than those with Medicaid as a supplement (O'Brien, Rowland, and Keenan, 1999).

As a safety net for the most vulnerable and needy Americans, Medicaid has faced the daunting challenge of serving low-income people whose health and social needs are extremely complex. This charge catapults Medicaid into many of our country's most difficult health and social issues: urban violence, teen pregnancy, substance abuse, and HIV/AIDS. In the face of these challenges, Medicaid has done a remarkable job of improving health care for millions of low-income Americans.

CHALLENGES FACING MEDICAID

Despite its 35 years of accomplishments in assisting the Nation's needy and vulnerable low-income populations, Medicaid remains a program struggling to meet its expectations within the constraints of Federal and State fiscal and policy differences. The future of Medicaid as our Nation's health care safety net will be determined by how well Medicaid is able to address the challenges of broadening health coverage for the low-income uninsured, securing access to quality care for its growing beneficiary population, and managing costs between the Federal and State governments.

Expanding Medicaid's Reach

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. The share of the non-elderly population with Medicaid coverage rose each year from 1987 through 1995, helping to offset loss of employer-sponsored coverage and

thus restraining growth in the uninsured population (Hoffman and Schlobohm, 2000). Although recent years have seen a decline in Medicaid enrollment among adults and children, in the absence of the expansions of coverage, we would see as many as 10 million more low-income children added to the 11 million children uninsured today (Lyons, 2000).

With the availability of additional resources to help provide insurance to children in working families through SCHIP, there are even greater opportunities to reduce the problem of uninsurance among our Nation's poorest families. In providing States with the option of covering all children in families with incomes up to 200 percent of the poverty level (in many States, this limit is even higher), Medicaid in combination with SCHIP could extend health insurance to all low-income children—an expansion that would cover 19 percent of the total uninsured population in America today (Feder and Burke, 1999). As of December 1999, nearly 2 million previously uninsured children were covered under SCHIP in addition to the 21 million children with Medicaid coverage (Smith, 2000).

Although Medicaid and SCHIP have been instrumental in providing health insurance coverage to low-income children and hold the promise of extending coverage in the future, the ability of the programs to reach their full potential is undermined by barriers in outreach and enrollment. Nearly one-half of uninsured children are eligible for Medicaid or SCHIP but are not enrolled (Kaiser Commission on Medicaid and the Uninsured, 1999b). Some may be unaware that they are eligible for coverage, and others may not be able to navigate the eligibility process. The majority of parents of eligible children attach a high level of importance to having coverage and say that Medicaid and SCHIP

are valuable programs but want the eligibility process simplified and made more suitable to working parents' schedules (Perry et al., 2000). The barriers to enrollment are not inherent to the Medicaid program but are problems with practical, feasible solutions that some States are trying and all States can implement.

The implementation of welfare reform has raised another set of obstacles to Medicaid's ability to broaden coverage to the low-income population. The welfare reform legislation of 1996 severed the automatic link between Medicaid and welfare eligibility and has contributed to the apparent loss of Medicaid coverage for many low-income adults and some of their children (Lyons, 2000). Low-income families moving from welfare to the workplace are still eligible for Medicaid, but many appear to lose their Medicaid benefits in the transition. Studies show that 1 year after leaving welfare, 49 percent of females and 29 percent of children formerly covered by Medicaid were uninsured, largely as a result of confusion over eligibility rules and systems errors (Garrett and Holahan, 2000). In addition, as fewer families apply for cash assistance, many do not know they are still eligible to obtain Medicaid coverage. This confusion has contributed to the recent declines in Medicaid enrollment and helped boost the number of uninsured Americans despite our robust economy.

Medicaid's ability to serve the low-income uninsured is also severely constrained by limits on Federal matching funds, especially for coverage of low-income adults without children. Though the program is slowly advancing beyond its welfare roots, many eligibility categories are still targeted primarily to children, pregnant women, and those with disabilities. For adults who are not pregnant or disabled, eligibility is limited to parents with very low incomes (at standards set at

former welfare levels—on average, about 41 percent of the poverty level, or less than \$6,000 for a family of 3). In 32 States, a parent working full-time at minimum wage earns too much to qualify for Medicaid coverage (Guyer and Mann, 1999). Adults without children are ineligible for Medicaid coverage, no matter how poor, unless they qualify as disabled individuals. These limits on eligibility categories are one reason that 40 percent of poor and 32 percent of near-poor females and 50 percent of poor and 40 percent of near-poor males are uninsured (Hoffman and Schlobohm, 2000).

States have the ability to use the Medicaid program to extend coverage more broadly to parents and, in some cases, childless adults, but coverage remains limited. Eighteen States now have Federal waivers of Medicaid law (known as section 1115 waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs and to use Federal dollars to cover additional people. With welfare reform, States were also given a new mechanism (section 1931) that allows for expanded coverage of low-income families under Medicaid, but few States (10) have embraced the new option (Ku and Broaddus, 2000).

Medicaid's ability to reach and cover the uninsured is one of its most daunting challenges. Among the 44 million uninsured Americans, more than one-half have incomes below 200 percent of the Federal poverty level, and nearly two-thirds of the low-income uninsured are children and their parents (Hoffman and Schlobohm, 2000). As employer-based coverage for low-wage working families continues to decline, there is growing pressure on Medicaid to assist with their health insurance needs. Building on and improving Medicaid and SCHIP for children and extending coverage to their parents and

other low-income adults has the potential to reach nearly one-half of the uninsured population (Hoffman and Schlobohm, 2000).

Improving Coverage for Medicaid Beneficiaries

If Medicaid is to remain a successful program, it must ensure that it ably meets the health needs of the population it serves. On average, Medicaid enrollees are sicker than those with private insurance, require more care, and use more services. In many cases, they require highly specialized medical services or chronic care that is both expensive and difficult to manage. These populations and their complex service needs fall uniquely to Medicaid because this type of coverage generally falls outside the purview of private insurance policies and Medicare.

To address challenges in service delivery, many States are now moving to enroll increasing numbers of their Medicaid populations in managed care. As States have gained greater flexibility from the Federal Government to utilize managed care in their Medicaid programs, enrollment has grown from 2.7 million beneficiaries enrolled in Medicaid managed care plans in 1991 to 16.6 million in 1998 (Kaiser Commission on Medicaid and the Uninsured 1999c). By 1998, more than one-half of all beneficiaries were enrolled in managed care, mostly concentrated among low-income families, though States are beginning to also enroll disabled and elderly populations. Managed care includes a range of plan types, from loosely structured networks of providers or gatekeeper models to full-risk, capitated plans, but much of the recent growth has been among full-risk plans.

This shift in Medicaid's delivery system to managed care has the potential to improve care by emphasizing preventive and primary care and providing care coordination through a clearly identifiable health care provider but can also raise problems with underservice in a needy population. To be effective and to preserve access to needed services, it is important to ensure that plans have provider networks in place, educate both providers and enrollees about managed care, and respond to the unique needs of the Medicaid population. Unless States monitor implementation carefully, commit additional resources to program management, and assess the adequacy of the quality of care provided by providers and plans, quality and availability of care could be compromised.

Payment levels, particularly in managed care arrangements, are an important aspect of service delivery. Operating under tight budget constraints, Medicaid has often paid providers at rates that are substantially below private sector rates—especially for physician services, where low rates have jeopardized willingness to participate. If Medicaid payments to managed care plans, especially capitated plans that are fully at risk, are set below market rates to achieve savings, the result may be poorly financed plans and poor quality care for Medicaid enrollees, with limited participation of mainstream plans.

In addition to the challenge of managed care implementation, Medicaid must also tackle the issue of meeting the needs of an aging population. In the next 30 years, the Medicare population is expected to nearly double, with major increases in the population over age 85—those at greatest risk of needing nursing home care. With this increase, the pressure on the Medicaid

program to assist the low-income elderly and disabled is likely to intensify. Moreover, if future Medicare program changes, such as the implementation of a new drug benefit, result in increases in Medicare premiums, deductibles, or cost sharing, new pressure will be placed on Medicaid to help low-income beneficiaries continue to meet Medicare's financial obligations.

Restraining Costs and Addressing State Diversity

One of the biggest challenges facing the Medicaid program is how to meet the growing need for health and LTC coverage within the constraints of Federal and State financing. Although Medicaid is jointly financed by the Federal and State governments, many of the basic coverage and provider payment decisions that determine overall expenditures are made at the State level. Because States make different decisions about whom to cover, what benefits to provide, and what to pay for services, the scope and cost of the program vary widely across States.

The program's spending history has shown much volatility in recent years, although spending patterns for Medicaid prior to the early 1990s showed lower annual growth than private health care spending, and current increases have substantially moderated. The requirement for States to match Federal dollars with State dollars has served as a constraint on overall spending but also motivates creative financing in the Federal and State fiscal battles. Provider taxes and donations, DSH payment policies, and other State innovative financing practices allowed States to accrue additional Federal financing in the early 1990s and dramatically increase Federal spending (Feder et al., 1993; Holahan and Cohen, 1996).

Eliminating these practices that allow States to spend Federal dollars without commensurate matching funds from State revenues has helped to moderate current Medicaid spending, but such practices remain strong reminders of the tensions and the potential for cost shifting in a jointly financed program.

But beyond the financing tensions, split responsibility with State discretion over major aspects of program eligibility and coverage inevitably lead to differences across States. Medicaid is not a uniform national program for health care for the poor; where one lives determines the scope and availability of Medicaid coverage. In recent years, federally mandated expansions for pregnant women and children have leveled the playing field across States by establishing eligibility floors linked to the Federal poverty level. However, States still have the option to extend coverage to higher levels, vary the benefit package, and set payment levels for care.

A key question for the future is how many Federal dollars should be used to promote equity in coverage by income across the country and how much should go toward providing States funds that allow them the flexibility to develop programs tailored to State priorities that may differ from national objectives. Addressing differences across States is yet another challenge facing Medicaid.

FACING THE FUTURE

The evolution and current state of Medicaid provide valuable insights with which to confront these challenges. Above all, Medicaid has shown us that providing health insurance matters for the low-income population. It improves access to care and health outcomes and helps to close differentials in care by income. Expansion of Medicaid has helped to

increase coverage and reduce the growth in our uninsured population, providing valuable assistance to families whose limited resources make cost sharing and premiums financial barriers to care.

But we have also learned from Medicaid that links to welfare and the structural barriers that often accompany a means-tested program can limit the reach of the program. Medicaid's eligibility roots in welfare-based categories and income levels, as well as its reliance on the welfare system for eligibility determination and process, have created roadblocks for working families and have severely hampered the program's ability to reach its full potential as a health insurance program for low-income people. Moreover, State flexibility in setting income standards and eligibility has led to wide variations in coverage across States. The future of the program and its effectiveness in addressing the high rates of uninsurance in the low-income population depend upon whether the program can be transformed into a health insurance program for low-income people, with simplified enrollment processes and forms, broader outreach, and eligibility that includes all low-income individuals, regardless of family status.

Any expansion of coverage through Medicaid also requires a continued commitment to making sure that the program can provide quality health care for its beneficiaries. Medicaid has shown us that, too often, a program for the poor is also a poor payer for health care services, leading to provider unwillingness to participate and creating access barriers for Medicaid beneficiaries. Providers of services to the Medicaid population need to be both adequately paid and monitored to ensure that mainstream medical care and high-quality LTC services are afforded to Medicaid beneficiaries. Wherever possible, differentials

in payment levels between Medicaid and private insurers should be minimized and access to the broadest range of health providers in the community assured. In addition, our experience with Medicaid teaches us that meeting the health and LTC needs of the most vulnerable members of our society—those with serious and chronic illness and/or debilitating physical and cognitive limitations—is extremely complex. Solutions widely used in the private market, such as capitated managed care, pose special challenges to the Medicaid program and require additional resources and planning. Particularly as Medicaid's role for the elderly grows, better integration of acute and LTC services and improved coordination of Medicare and Medicaid coverage are essential.

Finally, Medicaid's 35 years also offer insights into the inherent complexity of Federal and State partnerships in programmatic and fiscal responsibility. The Medicaid experience shows that uniformity across States can only be achieved with Federal requirements for minimum income standards for eligibility or mandated rules for coverage. State flexibility over program design invariably leads to major variations in coverage and program scope across the States. Moreover, shared fiscal responsibility provides both levels of government with an incentive to restrain costs to stay within budget but also inevitably leads to tension over who pays and how much. Medicaid has in fact shown us that States can be quite creative in finding ways to maximize Federal dollars and reducing the need for State matching funds. Clarification of goals and responsibilities between the Federal and State governments over program eligibility and scope of services and fiscal accountability would do much to improve the operation of Medicaid at both the Federal and State levels.

This experience tells us that at 35, Medicaid is a vital and important program to millions of low-income Americans—an essential part of our Nation’s safety net for its poorest and most vulnerable population. The limitations in Medicaid’s scope and the flaws in its operation are not without solutions. What is needed for the future is that we recognize Medicaid’s strengths and build on this base to address its current limitations, forging an even stronger program to meet the growing demands of the new millennium.

ACKNOWLEDGMENTS

The authors are grateful for the guidance of the members of The Kaiser Commission on Medicaid and the Uninsured, especially Chairman Jim Tallon, as well as the Commission staff, especially Barbara Lyons, Deputy Director.

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