Topic Page: Medicaid

Definition: **Medicaid** from *Black's Medical Dictionary, 43rd Edition*

A joint state and federal health insurance scheme in the United States that provides cover for poorer people but whose coverage varies across the country depending on the attitude of the particular State legislature, although it has been significantly enlarged by the passage of the Affordable Care Act ('Obamacare'). Medicaid has been in the forefront of innovations such as community health centres, experiments in delivering care and the community home movement (see also MEDICARE).

Image from: **Medicare and Medicaid were debated for almost two...** in *Landmark Debates in Congress: From the Declaration of Independence to the War in Iraq*

Summary Article: **Medicaid**
From *Encyclopedia of Health and Aging*

Medicaid was enacted in 1965, under Title 19 of the Social Security Act, to assist states in paying for the health care of the very poor. Medicaid set minimum national standards of who should be covered and what services they should receive, but it gave the states the flexibility to determine the remainder of their individual state programs. As a result of this flexibility, each state Medicaid program is unique. An individual eligible for services in one state might not be eligible in another. Moreover, the services covered in one state might not be covered in another.

Eligibility

In general, eligibility is based on fitting into a specific category of eligibility and meeting an income and resource test. These financial tests vary not only across states but also by service needs within a state. Covered categories include being aged, blind, disabled, or a member of a single-parent family with dependent children. Income tests are usually tied to specific levels related to poverty, and the resource test is based on having financial and other "countable" assets under specific thresholds. In some states, the income test can be met when needed medical care costs are sufficiently high to reduce income. Pregnant women and children whose family incomes are below 133% of the federal poverty level and recipients of adoption or foster care assistance are also eligible. In 2004, some 42.4 million people were enrolled in Medicaid. In 2003, Centers for Medicare and Medicaid reported spending $267 billion on Medicaid services. Children accounted for 46% of enrollees, adults in families accounted for 25%, nonelderly blind and disabled people accounted for 19%, and aged people accounted for 10%. Although children and nondisabled adults constitute the largest number of beneficiaries, they consume the smallest share of the expenditures. In 2003, 30% of Medicaid payments were for older people, 41% were for nonelderly people with disabilities, only 16% were for children, and only 10% were for adults in families, according to Kaiser Family Foundation figures published in 2006.

Different State, Different Program

Medicaid was established such that states have a tremendous amount of latitude in establishing an administrative structure, what services they will pay for, how much and by what method they will pay providers, how they calculate income and assets, and in which optional categories benefits will be covered. States receive federal matching funds for every dollar spent on Medicaid services, but the precise federal match, or participation rate, is inversely related to the state's fiscal capacity (measured

primarily by using per capita income), ranging from no more than 83% for the poorest states to no less than 50% for the richest ones.

Consequently, each of the 50 states, the District of Columbia, and each of the 5 U.S. territories has a different Medicaid program. Someone who is eligible in one state, district, or territory might not be eligible in another. Expenditures vary greatly between states, ranging from a per capita average of $2,334 in California to $7,749 in New York, according to Centers for Medicare and Medicaid figures in 2004.

What Medicaid Covers

Mandatory health services provided under Medicaid include inpatient and outpatient hospital care, physician services, laboratory and X-ray services, primary and preventive care, nursing facility and home health care, and other medically necessary services. But Medicaid also provides coverage for some Medicare beneficiaries when Medicare does not cover their needs. In 2002, Medicaid provided supplemental health coverage for 7.2 million Medicare beneficiaries (18% of all Medicare enrollees), according to Commission on Medicare and Medicaid figures in 2002. This kind of spending constitutes 42% of all Medicaid expenditures, according to the Kaiser Commission on Medicaid and the Uninsured in 2004. For certain low-income Medicare beneficiaries, Medicaid pays the Medicare Part B premium (which covers physician services) as well as the Medicare deductibles and copayments. Medicaid is also a major source of coverage for long-term care, financing 47% of national long-term care expenditures. In 2001, 35% of Medicaid spending went toward long-term care, as the Health Policy Institute noted in 2002.

Changes to Medicaid

Historically, Medicaid was tied to eligibility in other public assistance programs, such as Aid to Families with Dependent Children (AFDC) and Supplemental Security Insurance (SSI). However, beginning in 1984, a series of expansions in Medicaid coverage reflected a significant shift in the philosophical underpinnings of the program. First was a critical change to provide coverage of prenatal care, and in 1988 Medicaid began to assist low-income Medicare beneficiaries with their Medicare deductibles, copayments, and premiums. For persons age 65 years and older with incomes below 100% of the federal poverty level, Medicaid pays Medicare Part A and Part B premiums, deductibles, and coinsurance; for those with incomes between 100% and 120% of poverty, Medicaid pays the Medicare supplementary medical insurance Part B premium. Finally, individuals who were receiving Medicare because of disabilities but lost entitlement to Medicare benefits because they returned to work may now purchase Medicare Part A. Alternatively, individuals who have incomes below 200% of the federal poverty level and are not eligible for Medicaid benefits may qualify to have Medicaid pay their monthly Medicare Part A premiums.

Increased Coverage Through Managed Care

Increasingly, managed care is becoming the dominant form of reimbursement for Medicaid services. Managed care provides financial incentives to avoid inappropriate and marginally useful services and to focus more attention on primary care and coordination of care. Between 1991 and 1994, the number of Medicaid beneficiaries enrolled in managed care plans nearly tripled, from 2.7 million to 7.8 million, reaching 25.3 million by 2003.

Medicaid waivers states are always looking for ways to control state health care spending and expand coverage to the uninsured. States can propose to the federal government demonstration programs

that are exempt from federal requirements. If approved by the Centers for Medicare and Medicaid Services, states are still able to receive federal matching funds so long as the program promotes Medicaid objectives and the effect on the federal government is budget neutral. The advantage to a state of requesting a waiver is that it can establish a program that does not necessarily serve all beneficiaries or necessarily serve a group of beneficiaries across the state. Moreover, such programs can have different eligibility requirements and waiting lists. Many waivers exist in each state. The greatest number of waivers are in the area of long-term care. Less than a handful of states have established statewide home- or community-based long-term care services, and yet every state has multiple waivers to provide some aspect of home- or community-based care. These experiments are being performed in hopes of finding better ways to offset nursing home care (which is a required statewide service).

Sometimes, waivers are so successful that they become an integral part of health care delivery. For example, the Program of All-Inclusive Care for the Elderly (PACE) began as a federal demonstration waiver and is now a unique capitated managed care benefit for the frail elderly. It features a comprehensive medical and social service delivery system financed by integrated Medicare and Medicaid dollars. The Balanced Budget Act of 1997 (BBA) established PACE as a permanent entity within the Medicare program and as a state option under the Medicaid program. As of 2003, 17 states had approved PACE providers and 2 states had pending PACE activity. The BBA also authorized the State Child Health Insurance Program (SCHIP) known as Title XXI. SCHIP enables states to initiate and expand health care to uninsured low-income children.

Tightening Coverage and Eligibility

Medicaid represents a real political conundrum for policymakers. This program covers millions of people who otherwise would not have health care coverage. As a result, access to necessary care is improved and health care providers can get paid for providing this care. Although most Medicaid beneficiaries are relatively low cost (because they are children or healthy mothers), many Medicaid beneficiaries are disabled or quite ill. Therefore, the program, which is now larger than Medicare in both numbers of people and dollars expended, is a significant part of each state budget.

This does not, however, diminish the desire of many to find ways to spend less on Medicaid. On February 8, 2006, President George W. Bush signed into law the Deficit Reduction Act of 2005. The Congressional Budget Office estimates that this legislation will reduce Medicaid expenditures by $43.2 billion over the next decade, according to the Kaiser Commission on Medicaid and the Uninsured in 2006. Approximately half of the reductions in expenditures will be through the provision of premiums and higher copayments and deductibles for beneficiaries. But states will also be able to change the benefits covered. In addition, this law dramatically changed the way in which the distribution of savings prior to Medicaid would be examined and counted. Prior to this change in the law, individuals applying for nursing home care needed to divest all but approximately $2,000 in financial and other countable assets. Those who transferred assets at below-market rates within 3 years of applying to Medicaid were subject to a delay in eligibility based on how long it has been since they transferred those assets. Under the new law, instead of 3 years, Medicaid will look back 5 years. Moreover, instead of applying the penalty to the date of the asset transfer, the penalty date will be applied to the date of application, resulting in a longer period of time during which one will be denied Medicaid. Furthermore, anyone with more than $500,000 in home equity will not be able to apply for Medicaid benefits.

See also

Medicare

Further Readings and References

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