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SYMPOSIUM

FOREWORD: RECONCEPTUALIZING MEDICAID

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At its thirty-fifth anniversary, Medicaid bears only a familial resemblance to the hastily-conceived program added by Chairman Wilbur Mills to the Medicare bill pending before the House Ways and Means Committee in 1965.[1] Medicaid clings, albeit somewhat tenuously, to its roots as an entitlement program designed to supplement welfare by financing the provision of health services through shared state-federal financial and administrative responsibility. To be sure, Medicaid still serves as the guarantor of health care and provides a safety net for many whose economic plight or medical circumstances make private health insurance unobtainable. At the same time, however, many of its foundational concepts and goals today seem almost quaintly anachronistic. For example, Medicaid never came close to its promise of assuring access to mainstream healthcare to the poor, or, as described at its origin, affording "the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves."[2] Likewise, rather than fulfilling its promise to pay providers at

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1. *See* ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974); THEODORE MARMOR, THE POLITICS OF MEDICARE 67-68 (1973).

2. U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE ADMINISTRATION, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, Supplement D, Medical Assistance Programs, § 5140, *quoted in* Rand E. Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CINN. L. REV. 643, 650 (1975).

market rates that would induce investments and services comparable to those serving privately insured populations, Medicaid's hybrid concept for control and funding led to miserliness and political conflict that subverted its original goals.

At the same time, however, there have also been significant expansions over the last twenty years that have vastly broadened the program's reach and established its pivotal position in the American health care system. This is somewhat ironic given that Congressional sponsors added Medicaid to the original legislation with the goal of "fencing in Medicare"—i.e., preventing future expansions of social security-based health care beyond the aged and disabled.[3] It was apparently assumed that a welfare health program would stave off demands for broader social insurance. Not only has Medicaid come to serve as a convenient relief valve for many of the most intractable public health and access issues facing our health system, it is also increasingly the vehicle for expanding access to health care services to broad segments of society. Beginning with changes in the 1980s that expanded coverage to families with two children and increased eligibility for pregnant women and children, followed by liberalized waiver policies in the 1990s allowing states to expand coverage to the working poor, and culminating in the adoption of Children's Health Insurance Program (CHIP) which reaches children in families with incomes up to two hundred percent of the poverty level, Medicaid has progressed far beyond its welfare origins. Thus, today's Medicaid is the locus for diverse public programs serving the elderly, low income working families, those with mental and physical disabilities, low income Medicare beneficiaries, and, most prominently in recent years, mothers and children.

A stranger to American attitudes might be excused for assuming that a health care program with more than thirty-five million beneficiaries that pays for thirty-five percent of all new births, provides care for twenty percent of all children and spends nearly twenty-eight percent of its $161 billion dollar budget on the elderly and another thirty-eight percent on the blind and disabled would command widespread recognition and perhaps admiration among the citizenry. But here, too, we find ambiguity. Medicaid was pilloried in the 1990s and faced severe cutbacks and tightened administrative controls at the state level. Although attempts to limit federal controls by converting it to a block grant program failed, there was an unmistakable sense that, as a welfare program, it would ultimately become subject to state administrative control.[4]

3. MARMOR, *supra* note 1, at 79.

4. *See* Sara Rosenbaum & Kathleen A. Maloy, *The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and Its Impact on Medicaid for Families with Children*, 60 OHIO ST. L.J. 1443, 1457 (1999); *see generally* Deborah

However, the events of recent years seem to have reflected yet another shift in attitudes. With the passage of its new sibling, CHIP,[5] Medicaid came to be perceived as a partial solution to uninsurance among low-income workers—so much so that both candidates in the 2000 Presidential election promised major expansions. Equally significant, most states have imported managed care into their programs, often relying on private sector entities as contractors. Although there are reasons to be skeptical, some observers see Medicaid's expanded coverage of low-income workers and reliance on private sector managed care providers as an important step toward affording beneficiaries access to "mainstream medicine," if not toward providing universal coverage through public financing.

Finally, the tumultuous changes of recent years remind us that Medicaid does not operate in a vacuum. Its path has been governed as much by political and market influences as by the programmatic changes and legal interpretations that have shaped its formal dimensions. Since its inception, Medicaid has provided financing for those who are unable to obtain insurance or purchase health services. That is, it serves individuals who fall outside the market's interplay of consumers' preferences and suppliers' offerings. As a financing system, however, Medicaid operates within commercial markets. It provides financing for purchases of services from providers and others whose prices and range of products are dictated by a large and profitable private marketplace. This tension, which has long bedeviled policymakers seeking to find the appropriate blend of market-based and regulatory solutions, has become more pronounced as Medicaid has changed over the years. To give one example from economic research, studies have shown that while Medicaid eligibility *increases* the intensity with which beneficiaries are treated in the hospital, eligibility *reduces* treatment levels for middle-income individuals who drop their private insurance.[6] Medicaid's lower reimbursement levels obviously impacts care received. As Medicaid and companion programs have changed so as to reach the working poor, to serve a wide variety of societal goals, and to employ competition among firms serving the private sector, it has become increasingly obvious that its impact depends importantly on how well

A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287 (1993).

5. The Children's Health Insurance Program, established by the Balanced Budget Act of 1997, allocates $20 billion in federal matching funds to assist states in providing coverage for children from families with incomes above Medicaid minima. States may satisfy the program's requirements either by expanding Medicaid or through new programs. *See* Sara Rosenbaum et al., *The Children's Hour: The State Children's Health Insurance Program*, HEALTH AFF., May-June 1998, at 75.

6. JANET CURRIE & JONATHAN GRUBER, TECHNOLOGY OF BIRTH: HEALTH INSURANCE, MEDICAL INTERVENTIONS AND INFANT HEALTH 1 (Nat'l Bureau of Econ. Research, Working Paper No. 5985, 1997), http://papers.nber.org/papers/W5985.pdf.

it integrates with institutions serving other sectors of the health care market. Problems such as "crowd-out" of private insurance and the impact of privatization on safety net providers illustrate the dilemmas confronting Medicaid in this era of change.

Moreover, Medicaid operates in a world of interdependent and sometimes competing political institutions. Its efficacy in meeting policy objectives depends on cooperation among various branches of government that cross state-federal boundaries. Furthermore, reforms may be subject to political nullification. A recent study of the effect of changes to California's Medicaid program in 1990 illustrates this point. The study revealed that local governments reduced their subsidies to public hospitals one dollar for each dollar of Disproportionate Share Program (DSH) funds received.[7] Thus the improved financial incentives to support indigent care were effectively negated by the operation of local officials. At the same time, private for-profit and not-for-profit hospitals used the DSH funds to increase their holdings of financial assets rather than improve the quality of medical care for the poor. The authors conclude that in the first five years of the DSH programs, virtually none of the funds led to increases in medical care inputs.

Thus, a Symposium offering a portrait of the Medicaid program at the turn of the century is both timely and ambitious. The Center for Health Law Studies at Saint Louis University School of Law is fortunate to have assembled an outstanding group of scholars, practitioners and government officials who have thoughtfully examined the state of Medicaid at this critical juncture. In this issue of the *Saint Louis University Law Journal*, Sara Rosenbaum, Sidney Watson, John Jacobi, Jane Perkins and Joel Ferber offer insights from a variety of perspectives into some of the pivotal issues facing policy makers concerned with Medicaid's future. Their work should help guide the debate over future directions for the program and spur future research. We are also indebted to those who participated at the live Symposium, including Sue Nestor, Senior Vice President, Ascension Health and Cindy Mann, Director, HCFA Center for Medicaid and State Operations, Medicaid Family and Children's Health Program Group.

Special thanks to a number of people who made this Symposium possible: to Mary Ann Jauer, whose tireless work on every aspect of the program made the day-long event a success; to Sarah Beatty and the other editors of the *Law Journal*, whose assistance on these articles was invaluable; and to our newest colleague in the Center for Health Law Studies, Professor Sidney Watson, who

7. MARK G. DUGGAN, HOSPITAL OWNERSHIP AND PUBLIC MEDICAL SPENDING (Nat'l Bureau of Econ. Research, Working Paper No. 7789, 2000), http://papers.nber.org/papers/w7789.pdf; *see also* Leighton Ku & Teresa A. Coughlin, *Medicaid Disproportionate Share and Other Special Financing Programs*, HEALTH CARE FIN. REV., Spring 1995, at 27 (stating that one-third of DSH Payments were returned to state treasuries).

brought her unparalleled energy and expertise to help plan and organize the Symposium as well as contribute to these pages.