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## Medicaid at Thirty-Five

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## MEDICAID AT THIRTY-FIVE

SARA ROSENBAUM\* AND DAVID ROUSSEAU\*\*

### I. INTRODUCTION

This article presents a broad overview of Medicaid, the nation's largest means-tested health care financing program. In an era of health policy ferment (as all eras of U.S. public policy) this article is intended to give readers a sense of Medicaid's place within the health system as a whole, the essential market-transcendent functions it performs, the modernization challenges that it faces, and the prospects for reform. The immediate impetus for this article was a symposium on Medicaid conducted in March 2000 by the Saint Louis University School of Law. The observations offered here reflect years of ongoing discussions with many scholars who have studied Medicaid's immense contributions and major shortcomings.<sup>1</sup>

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1. Over the course of many years, Professor Rosenbaum has benefited greatly from her association with a number of people who have thought deeply about Medicaid. A relatively recent convert to the close-knit world of people entranced by Medicaid policy, Mr. Rousseau has benefited from these associations as well. In particular we would like to acknowledge the work of the members and staff of the Kaiser Commission on Medicaid and the Uninsured (specifically, its Chair, James Tallon, Drew Altman, President of the Foundation, Diane Rowland, Executive Vice President and Director of the Commission, and Barbara Lyons, the Commission's Associate Director), Andy Schneider, Esq., whose knowledge of the program is unparalleled, and Patricia Riley, President of the National Academy for State Health Policy (and a member of the Kaiser Commission) for her guidance over the years on state Medicaid dynamics. We also would like to acknowledge Dr. John Holahan and the rest of the health policy group at the Urban Institute, whose statistical studies of the Medicaid program not only support the work of the Kaiser Commission (and are presented in this article) but also have become a basic building block of Medicaid policy making. Finally, Professor Rosenbaum wishes to thank James Weill, Director of the Food Research and Action Center in Washington D.C. and Professor David Chavkin of American University, Washington College of Law, both of whom helped Professor Rosenbaum take the Medicaid plunge in the early years and whose early work on behalf of program beneficiaries is still recognized today.

Part II opens this article with an overview of Medicaid's place in the modern health system and the multiple roles it plays. Part III presents a legal and statistical overview of Medicaid. The article concludes in Part IV with an analysis of the major challenges that confront the program and the prospects for reform.

In brief, we argue here that even though Medicaid is in tremendous need of modernization, its continuation as a federal legal entitlement to a range of health services, which surpass what is available under conventional insurance, is critical to the very survival of the nation's market-driven health system. Medicaid is the means by which public policy makers have stabilized Medicaid financing and the foundation on which the system flourishes. In our view, it is possible to imagine the national health scheme without Medicaid only at the point when policy makers choose to move the American health system off of its market-principle base and onto a comprehensive social insurance platform with universal coverage. Since policy makers do not show any indication that they are inclined to undertake such a momentous shift in health policy thinking, the modernization of Medicaid becomes essential.

## II. MEDICAID AND THE AMERICAN HEALTH SYSTEM

Building on previous public assistance programs, Medicaid began as a modest legislative companion to Medicare<sup>2</sup> and has come to occupy a singular position in American health policy. Simultaneously lauded for its achievements in improving health care access for low income and medically vulnerable persons<sup>3</sup> and heavily criticized for its structural deficiencies and immense size,<sup>4</sup> Medicaid at thirty-five is far more important to the American health care system than it was at the time of its original enactment. The seminal question is whether Medicaid can be modernized without sacrificing its core strength as an individually enforceable legal entitlement program for low income and medically indigent persons.

With prospects for the enactment of comprehensive national health insurance so limited,<sup>5</sup> Medicaid reform can be expected to be a dominant and

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2. See ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 42-51 (1974) [hereinafter WELFARE MEDICINE].

3. Mark L. Berk & Claudia L. Shur, *Access to Care: How Much Difference Does Medicaid Make?*, HEALTH AFF., May-June 1998, at 169-80.

4. See, e.g., THE CENTURY FOUNDATION, THE BASICS: MEDICAID REFORM: WHAT'S WRONG WITH MEDICAID? 1, available at [http://www.tcf.org/publications/Basics/medicaid/Whats\\_Wrong.html](http://www.tcf.org/publications/Basics/medicaid/Whats_Wrong.html) (last visited Oct. 27, 2000).

5. As of the summer of 2000, health reform had once again emerged as a major issue in the Presidential race. Both candidates had fashioned health proposals, which, while different in certain significant respects, were incremental in nature in that they attempted to address the need for coverage of various pockets of uninsured individuals rather than replacing the existing pluralistic system of coverage in the U.S. with a single national policy and legislative scheme.

recurrent theme in the coming years. This continued interest in Medicaid reflects the extraordinary policy attention that the program has received since its inception. Over the past three decades, Medicaid has served as a legislative vehicle for an astonishing range of medical and public health initiatives including: the reduction of infant mortality and improvement of child health among low income women and children;<sup>6</sup> the improvement of community-based long-term care services for the frail elderly, and children and adults with physical and mental disabilities;<sup>7</sup> the provision of insurance coverage for low income working families<sup>8</sup> and persons with disabilities who return to work;<sup>9</sup> assistance to the lower income Medicare beneficiaries without the means to purchase private supplemental insurance;<sup>10</sup> the development of a public childhood vaccine purchasing system to assure an adequate supply of pediatric vaccines for low income and uninsured children;<sup>11</sup> initiatives to improve the treatment of persons with HIV/AIDS<sup>12</sup> and tuberculosis;<sup>13</sup> the reform of the

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Elizabeth White & Kurt Fernandez, *Bush and Gore Vary on Health Care Policy Issues*, 8 BNA HEALTH CARE POLICY REPORT, Aug. 14, 2000, at 1385. It is worth noting, moreover, that even in the Clinton Administration's national health reform plan, which would in fact have replaced existing public and private insurance arrangements with a single legislative scheme, the Administration elected to preserve various components of Medicaid that provide coverage for long-term care as well as additional services for children and adults with chronic illnesses and conditions. See generally The Health Security Act, S. 1757, 103d Cong. (1993). The ongoing need for Medicaid benefits and services even following the presumed enactment of national health reform is a testament to the program's capacity to address issues that fall outside of normative concepts of health insurance, a matter discussed at length in this article.

6. Between 1984 and 1990, Congress expanded Medicaid on seven separate occasions to expand eligibility for pregnant women, infants and children and to improve coverage for maternity and pediatric care. Sara Rosenbaum, *Medicaid Expansions and Access to Care*, in MEDICAID FINANCING CRISIS: BALANCING RESPONSIBILITIES, PRIORITIES, AND DOLLARS 45, 48 (Diane Rowland et al. eds., 1993).

7. STAFF OF HOUSE COMM. ON ENERGY AND COMMERCE, 103D CONG., 1ST SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 UPDATE) 800, 816, 873 (Comm. Print 1993) [hereinafter MEDICAID SOURCE BOOK].

8. Medicaid was amended to add an extended transitional work program for families making the welfare to work transition. 42 U.S.C. § 601 (1994 & Supp. IV 1998).

9. ANDY SCHNEIDER & RISA ELLBERGER, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID-RELATED PROVISIONS IN THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT OF 1999 2 (PUB. L. 106-170) (2000), available at <http://www.kff.org>.

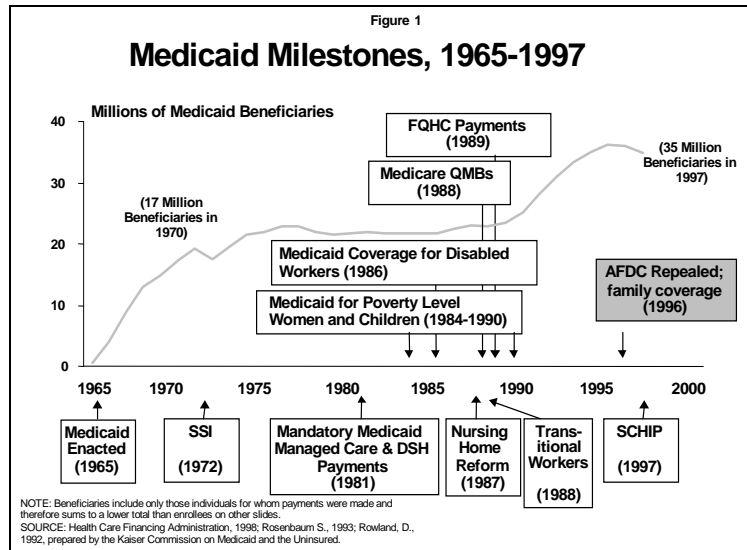
10. Social Security Act §1902(a)(10)(A)(ii)(X), 42 U.S.C. §1396a(a)(10)(A)(ii)(X) (1994).

11. Social Security Act §1928(a)(1)(A), 42 U.S.C. §1396s(a)(1)(A) (1994).

12. MEDICAID SOURCE BOOK, *supra* note 7, at 1093-94. For a comprehensive review of Medicaid and HIV/AIDS, see TIMOTHY WESTMORELAND, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID AND HIV/AIDS POLICY (1999), available at <http://www.kff.org>.

13. Social Security Act § 1902(a)(10)(A)(ii)(XII), (z), 42 U.S.C. § 1396a(a)(10)(A)(ii)(XII), (z) (1994 & Supp. IV 1998).

nursing home industry;<sup>14</sup> the establishment of managed care systems for beneficiaries with both basic and complex physical and mental health care needs;<sup>15</sup> aid to “safety-net” hospitals and clinics that serve large numbers of poor and uninsured patients;<sup>16</sup> and coverage of women with breast and cervical cancer.<sup>17</sup> Indeed, the evolution of Medicaid, captured in Figure 1, makes clear that even a partial summary of Medicaid’s amendments since its original enactment underscores its policy significance.<sup>18</sup>



14. MEDICAID SOURCE BOOK, *supra* note 7, at 854-55.

15. Social Security Act § 1932(a), 42 U.S.C. § 1396u-2(a) (1994 & Supp. IV 1998).

16. This assistance has taken two basic forms. First, hospitals that serve a “disproportionate number” of Medicaid and low income individuals are entitled to receive additional payments. Social Security Act § 1902(a)(13), 42 U.S.C. § 1396a(a)(13) (1994 & Supp. IV 1998). Second, clinics that receive federal funding under the Public Health Service Act, as well as certain other clinical entities that meet PHS Act standards, are classified as “federally qualified health centers” under the law and are entitled to receive cost-related reimbursement for the covered services they furnish to Medicaid beneficiaries. Social Security Act § 1905(a)(2)(C), (l)(2)(A)-(B), 42 U.S.C. § 1396d(a)(2)(C), (l)(2)(A)-(B) (1994). For an extended analysis of the relationship between safety net providers and Medicaid, see INSTITUTE OF AMERICA, AMERICA’S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED I (Marion Ein Lewin & Stuart Altman eds., 2000). For a review of state disproportionate share payment policies see Teresa A. Coughlin & David Liska, *Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals*, HEALTH AFF., May-June 1998, at 118.

17. Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, 114 Stat. 1381 (2000).

18. See Figure 1.

Beyond its role as a vehicle for national health priority initiatives, Medicaid has served as a policy and programmatic springboard for state-based health reform efforts under special waivers by the federal government of otherwise applicable federal Medicaid law.<sup>19</sup> These health reform efforts have not always been without controversy;<sup>20</sup> however, they have succeeded in moving Medicaid into the modern managed care era. Furthermore, Medicaid has achieved greater levels of health coverage among uninsured low income working families<sup>21</sup> and, thus, had encouraged policy makers to reconceptualize Medicaid beyond its original roots as a companion to cash welfare assistance and a source of financing for medically indigent persons who fall outside the workforce.<sup>22</sup>

Part of the explanation for the frequency with which Medicaid has been used to address significant health policy issues lies in the fact that, from its inception, the program has been associated with the provision of care to the poor and underserved.<sup>23</sup> As a result, policy makers have logically turned to Medicaid as the need to address problems affecting vulnerable populations arose.

In our view, however, the program's ongoing role as a legislative powerhouse for public health policy extends beyond mere temporal legislative convenience. Medicaid's ability to adapt itself to such a broad range of health needs stems from the fact that despite its legendary complexity,<sup>24</sup> the program

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19. Sara Rosenbaum et al., *Section 1115 Medicaid Waivers: Charting a Path for Medicaid Managed Care Reform*, in THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, ACCESS TO HEALTH CARE: PROMISES AND PROSPECTS FOR LOW-INCOME AMERICANS 179, 181-82 (Marsha Lillie-Blanton et al. eds., 1999), available at <http://www.kff.org>.

20. See Leighton Ku et al., *Medicaid Managed Care Programs in Hawaii, Oklahoma, Rhode Island, and Tennessee*, in REMAKING MEDICAID: MANAGED CARE FOR THE PUBLIC GOOD 147 (Steve Davidson & Stephen Somers eds., 1998).

21. *Id.* at 162.

22. WELFARE MEDICINE, *supra* note 2, at 51-53, 57-61.

23. *Id.* at 57.

24. In its seminal study of the Medicaid program, the Congressional Research Service notes that "[t]o many the program [Medicaid] is an enigma." MEDICAID SOURCE BOOK, *supra* note 7, at vii. Medicaid has been the subject of numerous outbursts by federal courts, aghast at the complexity of the law. See, e.g., *Friedman v. Berger*, 547 F.2d 724 (2d Cir. 1976) which noted Medicaid's "statutory provisions and HEW regulations of labyrinthine complexity." *Id.* at 727. The court included the following memorable footnote in its decision: "As program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the regulations which makes them almost unintelligible to the uninitiated. There should be no such form of reference as '45 C.F.R. § 248.3(c)(1)(ii)(B)(2)' discussed below; a draftsman who has gotten himself into a position requiring anything like this should make a fresh start. Such unintelligibility is doubly unfortunate in the case of a statute dealing with the rights of poor people. An indispensable service is performed by attorneys like those representing the plaintiffs here, who advance tenable claims with clarity and courtesy even if, as in this case, not with success." *Id.* at 728 n.7.

is extraordinarily simple in structure when compared to conventional insurance. Medicaid can be thought of as a structured flow of federal funds that permits health care expenditures for populations who, because of poverty, health risks or health status, lie outside of conventional insurance.<sup>25</sup> In a real sense, Medicaid has saved the nation's market-based health system through its ability to provide generous levels of funding for national health priorities that exist beyond the furthest reaches of the market.

Moreover, Medicaid is exquisitely protean in nature. This flexibility flows from the fact that it operates outside of, and in direct contrast to, the principles and conventions of health insurance,<sup>26</sup> although individuals who are legally entitled to coverage are counted as insured for statistical purposes.<sup>27</sup> This distinction between Medicaid and health insurance shows up in three critically important ways.

The first is eligibility for coverage. Because it is not concerned with "risk," Medicaid does not restrict coverage to persons with insurable risks; indeed, it invites in the sickest and most disabled members of society. Unlike private health insurance<sup>28</sup> or Medicare,<sup>29</sup> Medicaid contains neither pre-existing condition exclusion clauses nor waiting periods.<sup>30</sup> Numerous

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25. By conventional insurance, we mean insurance products that are sold commercially and that operate on the basis of actuarial risk principles. See Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & LAW 287 (1993).

26. Deborah Stone's article, *The Struggle for the Soul of Health Insurance*, offers an excellent and succinct comparison of social versus commercial insurance and eloquently describes the conflict between the concept of actuarial fairness (also known as "fair discrimination") that underlies commercial coverage and the needs of individuals who for reasons of social and health risk factors require health care at levels greater than the norm. See *id.* at 290-94. For an additional discussion of the concept of "fair discrimination" see RAND E. ROSENBLATT, SYLVIA A. LAW & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 207-09 (David L. Shapiro et al. eds., 1997) [hereinafter LAW AND THE AMERICAN HEALTH CARE SYSTEM].

27. For example, the United States Census Bureau classifies individuals with Medicaid as insured. See, e.g., JENNIFER A. CAMPBELL, U.S. CENSUS BUREAU, U.S. DEPARTMENT OF COMMERCE, ECONOMICS AND STATISTICS ADMINISTRATION, HEALTH INSURANCE COVERAGE 1998: CURRENT POPULATION REPORTS 6 fig.6-7 (1999).

28. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limited, but did not prohibit, the use of pre-existing condition and exclusion clauses from employer-sponsored group health plans. See Pub. L. No. 104-191, 110 Stat. 1939 (codified as amended 29 U.S.C. 1181) (amending ERISA to limiting both the duration of the "look-back" period for preexisting condition exclusion clauses under group health plans as well as the allowable length of the exclusionary period).

29. The Medicare statute imposes a twenty-four-month waiting period on individuals who qualify for coverage by virtue of disability status. Social Security Act § 1811, 42 U.S.C. § 1395c (1994).

30. 42 U.S.C. § 1396a(a)(10) (1994 & Supp. IV 1998). Medicaid eligibility is conditioned solely on the criteria described in this article. The statute does not impose waiting periods or

eligibility categories are specifically designed to target persons with high health risks including children who need long-term care, persons with tuberculosis, children and women with HIV/AIDS, the frail elderly and persons with disabilities.<sup>31</sup>

The second distinction between Medicaid and insurance relates to benefits. The services and benefits made available under the program are not limited to those found in a typical commercial insurance benefit package. In contrast to conventional insurance, covered benefits extend well into the realm of long-term care and include such interventions as personal care services, respite care, home care adaptation and case management.<sup>32</sup>

The third, and perhaps most overlooked distinction has to do with the standards by which coverage decisions are made under the program. In light of the fact that its origins lie with a population of workers, conventional insurance typically limits actual coverage for enumerated benefits to items and services that are necessary to “restore normal functioning” following an “illness or injury.”<sup>33</sup> This standard, which may be appropriate for most members of working families, can fall with great harshness on children and adults with chronic illnesses and disabilities,<sup>34</sup> particularly disabilities that are tied to conditions, such as cerebral palsy or other congenital problems, that are neither an “illness” nor an “injury.” In applying this standard to persons with chronic illnesses and disabilities, insurers may deny coverage altogether because their conditions place them outside of the contractual conditions of coverage.<sup>35</sup>

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exclude coverage for certain conditions. Indeed, federal regulations expressly prohibit discrimination on the basis of a condition in coverage for required services.

31. See the categorical eligibility groupings identified in 42 U.S.C. § 1396a(a)(10)(A)(ii)(I)-(XII) (1994 & Supp. IV 1998).

32. See MEDICAID SOURCE BOOK, *supra* note 7, at vii. Federal law requires participating states to provide certain classes of “medical assistance” to individuals who are entitled to coverage and gives states the option to extend coverage for many additional classes of medical assistance. Certain types of services commonly associated with long-term care, such as nursing home services, are mandatory. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(xii)(4) (1994). Other types of services, such as the services of personal attendants and case management, are optional.

33. LAW AND THE AMERICAN HEALTH CARE SYSTEM, *supra* note 26.

34. Individuals with disabilities cannot recover from their conditions, even though they may be able to attain or maintain certain functional status or may benefit from health care in the sense that their health status does not deteriorate further. See *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149, 151 (4th Cir. 1996), for the proposition that however laudable may be the goals of functional improvement and prevention of deterioration, they lie beyond the reaches of contractual insurance limits. *Id.*

35. The impact of this standard can best be seen in *Bedrick*, in which an insurer completely denied coverage for physical therapy in the case of a child with severe cerebral palsy because in the view of the insurer there was no hope that a child with this condition could benefit from therapy. *Id.* at 151. In a remarkable opinion holding that the conduct of the insurer was arbitrary and capricious, the appeals court reversed significant portions of the decision. *Id.* at 154.



Consistent with the populations it covers and the services it furnishes, Medicaid contains no such limitations. Federal law makes it unlawful to discriminate in the provision of required services on the basis of a condition.<sup>36</sup> As a result, state Medicaid programs must adopt medically reasonable coverage limits<sup>37</sup> and must extend medically necessary services and benefits they cover to any beneficiary, regardless of whether the need for the service is related to a chronic condition or a completely correctable illness or injury.<sup>38</sup>

For these three basic reasons, Medicaid stands wholly apart from commercial insurance conventions. The result is an ability to respond to national health policy priorities whose resolution extends beyond the limits of conventional insurance. These three principal distinctions between Medicaid and insurance also underscore the implications to the entire health system were Medicaid to disappear. Although there is an enormous need to modernize Medicaid, if the program were to cease to operate in its current basic form as a legal entitlement to coverage, the number of uninsured Americans would skyrocket from forty-four million to a number approaching seventy million.<sup>39</sup> Furthermore, billions of dollars in public financing for non-insurable services, ranging from long-term nursing home care to extended community and outpatient services for children and adults with chronic illnesses and disabilities, would be at stake.<sup>40</sup>

Medicaid's importance extends far beyond the populations it covers and the services it underwrites. The program is fundamental to the economic health of state and local governments. This is because the statute entitles states to open-ended federal financing toward both the medical and administrative costs of Medicaid, with federal contribution levels for medical assistance costs that range from fifty percent to nearly seventy-seven percent of total expenditures in fiscal year ("FY") 2000.<sup>41</sup> Because Medicaid expenditures

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Because so few denials by insurers ever reach court at all, much less a federal appeals court, one can only surmise the frequency with which this type of standard is applied.

36. 42 C.F.R. § 440.230(c) (1999).

37. 42 C.F.R. § 440.230(d) (1999).

38. 42 C.F.R. § 440.230(b) (1999).

39. As of 1998, 44.3 million Americans were uninsured. THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, UNINSURED IN AMERICA: A CHART BOOK 12 (2000), available at <http://www.kff.org>. Approximately twenty-three million non-elderly Americans had Medicaid coverage in 1997. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION, HEALTH, UNITED STATES 2000, 340 tbl.128 (2000). Assuming that nearly all of these individuals would be otherwise uninsured in the absence of Medicaid, the number of uninsured would rise considerably.

40. See *infra* Figure 9, which shows that 74% of all spending under Medicaid is for services and benefits that are other than preventive and acute care services for non-disabled working age adults and non-disabled children.

41. ANDY SCHNEIDER & DAVID ROUSSEAU, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID FINANCING 19 (2000), available at <http://www.kff.org>.

comprise the majority of total state spending on health care, this level of federal financial participation provides major aid to states in meeting the overall cost of medical care, which is by far the fastest growing portion of their public welfare budgets.<sup>42</sup> To be sure, states must comply with extensive federal requirements as a condition of receiving federal payments, the most important of which relates to their obligations toward program beneficiaries.<sup>43</sup> At the same time, federal Medicaid payments are so substantial that Medicaid funding has evolved into one of the essential pillars of states' economies. Even the lure of a 1995 Congressional proposal, as part of welfare reform, to "block grant" Medicaid and strip out all legal requirements and protections in exchange for an aggregate fixed upper limit on federal contributions to state programs pegged to the general inflation rate, failed in the end and was removed from the final legislation.<sup>44</sup>

Medicaid is essential to a triumvirate of stakeholders, including the states that are entitled to federal payments on an open-ended basis, participating health care providers that are entitled to payment for the covered services they furnish to program beneficiaries, and the individuals who have an enforceable legal entitlement to coverage.<sup>45</sup> Although their interests frequently tend to sharply diverge, particularly in the case of initiatives to mandate coverage expansion or payment reforms, this group of stakeholders has coexisted for thirty-five years. Historically, this core Medicaid stakeholder group has been supplemented, at least informally, by considerable public support for the program by the commercial health insurance industry<sup>46</sup> as well as by

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42. Over the past decade, state spending on public welfare services has grown faster than the gross domestic product (GDP) or the rate of growth in per capita revenues. While the entire public welfare component grew by seventy-one percent, vendor payments to health care providers grew by 111% over the same time period. DAVID MERRIMAN, THE URBAN INSTITUTE, WHAT ACCOUNTS FOR THE GROWTH OF STATE GOVERNMENT BUDGETS IN THE 1990s? 1, 3 tbl.2 (Series A No.39) (2000), available at <http://www.urban.org>.

43. See generally MEDICAID SOURCE BOOK, *supra* note 7, at 1-20 (summarizing the basic requirements of the program).

44. The Medicaid block grant legislation was originally a part of the same legislative vehicle that contained the welfare reform legislation. 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, 1443 (1999) [hereinafter *The Law of Unintended Consequences*].

45. While decisions by the Supreme Court have in recent years limited the ability of individuals to claim an enforceable right to benefits under various Social Security Act programs, as a general rule the federal courts have continued to recognize the enforceability of the Medicaid statute. LAW AND THE AMERICAN HEALTH CARE SYSTEM, *supra* note 26, at 253-62 (1999-2000 Supp.).

46. For example, the Health Insurance Association of America (HIAA) has traditionally called for Medicaid expansions as part of its national health reform proposals. HIAA's current proposal contains Medicaid expansions. HIAA Press Releases, *HIAA Is Fortune's Top Health*

employers and insurance purchasers. While the support of insurers and employers has been valuable to the success of the program and the enactment of specific legislative reforms,<sup>47</sup> their interest in a strong Medicaid program has not been purely altruistic. Were Medicaid not to exist, private interests conceivably could face a far more difficult policy and regulatory environment in the absence of a program that is capable of absorbing the billions of dollars in annual health care expenditure responsibilities that lie outside of the marketplace.

At the same time that Medicaid enjoys both explicit and tacit support, it is precisely this sea of interest that makes it so difficult to achieve structural improvements in light of the divergent views regarding the wisdom or value of program modification. The cost of modernizing Medicaid would be relatively significant. As a result, the constraints of the federal budget process itself create additional impediments to reform. Finally, the obvious need, for the reasons stated above, for a health care financing mechanism that operates outside the principles of insurance, expanding and strengthening Medicaid can be viewed as tantamount to an admission of “market failure.” For those who advocate a pure market approach to health reform, for example the use of vouchers or tax credits to aid in the purchase of private insurance or the greater deductibility for out-of-pocket expenditures on health care, a Medicaid expansion would be precisely the wrong remedy. For all of these reasons, Medicaid struggles forward, long on achievements but burdened by serious deficiencies that significantly hamper the program’s effectiveness.

### III. A LEGAL AND STATISTICAL OVERVIEW OF MEDICAID

In order to understand Medicaid’s role, it is necessary to have a basic understanding of program structure and design, and to be familiar with at least basic statistical data illustrating the program’s operations in the areas of enrollment coverage and program expenditures. Even the limited overview of Medicaid presented in this article underscores its complexity, size and potential impact on health care.

#### A. *Program Structure*

Medicaid, the largest of all means-tested entitlement laws, is a federal grant-in-aid program that entitles individuals who meet its eligibility

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*Insurance Trade Assn. for 3rd Consecutive Year* (Nov. 15, 1999), at <http://www.hiaa.org/news/news-current/press-releases/release110.html>.

47. Professor Rosenbaum notes that in her previous position as director of the Health Division at the Children’s Defense Fund (“CDF”) in Washington D.C., CDF routinely sought and received the enthusiastic support of insurers and employer organizations for a wide variety of Medicaid initiatives over the years to improve coverage for women and children.

requirements to a defined set of benefits known as “medical assistance.”<sup>48</sup> The law also affords participating states the right to federal contributions toward the cost of both the medical assistance and program administration.<sup>49</sup> In FY year 1997, the latest year for which final data are available, total federal and state Medicaid spending stood at \$161.2 billion.<sup>50</sup>

Medicaid is voluntary for states which, as a condition of participation, must agree to administer their programs in accordance with a series of federal requirements set forth in both the statute and regulations.<sup>51</sup> Participating states must administer their programs through a “single state agency” which may be any agency (for example a unit of the state welfare or public health agency).<sup>52</sup> Regardless of which part of state government serves as the single state agency, federal law requires that eligibility for Medicaid be determined by the state welfare agency.<sup>53</sup> Federal law also requires states to supplement this basic eligibility determination function with outstationed enrollment activities for certain populations in order to improve case-finding and applicants with the enrollment process.<sup>54</sup> Federal Medicaid administrative payments are available to support the cost of the enrollment process, including outstationing.<sup>55</sup>

All discussions of Medicaid begin with the question: who is eligible? Medicaid eligibility requirements are notoriously complex. Eligibility for

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48. Social Security Act § 1905(a), 42 U.S.C. § 1396d(a) (1994).

49. Social Security Act § 1903(a), 42 U.S.C. § 1396b (1994 & Supp. IV 1998).

50. Data from the Health Care Financing Administration; calculations by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured. *See infra* Figure 10.

51. Social Security Act § 1902 et seq., 42 U.S.C. § 1396a, et. seq. Federal regulations are codified as part of Chapter 42 of the Code of Federal Regulations. The Health Care Financing Administration also issues extensive informal program guidance, which can be found at its website, *Health Care Financing Administration*, <http://www.hcfa.gov>.

52. Social Security Act § 1902(a)(5), 42 U.S.C. § 1396a(a)(5) (1994). State Medicaid plans identify a range of state agencies as the Medicaid agency. Katie Tedrow, *Organizing Medicaid Responsibilities: A Look at Current State Agency Structure*, 12 AM. PUB. HUM. SERVS. ASS’N. WASH. MEMO 21 (2000).

53. Social Security Act § 1902(a)(5), 42 U.S.C. 1396a(a)(5) (1994). In the case of applicants for the federally administered Supplemental Security Income (SSI) program, which is administered by the Social Security Administration, states may enter into agreements with SSA under which the federal government determines Medicaid eligibility as part of the SSI application process. *Id.*

54. Social Security Act § 1902(a)(5), 42 U.S.C. § 1396(a)(5) (1994).

55. Outstationed enrollment is mandatory for children and pregnant women and must be provided at federally qualified health centers and disproportionate share hospitals. At their option, states may conduct outstationing and outreach activities in any location. Outstationing is relatively common in the case of children, in the wake of the enactment of the State Children’s Health Insurance Program of 1997 (SCHIP) which operates as a companion program to the basic Medicaid structure and which serves as a catalyst for the identification of eligible children. *See* LYNDIA FLOWERS & TRISH RILEY, NATIONAL ACADEMY FOR STATE HEALTH POLICY, AN ANALYSIS OF POLICY ISSUES IN SCHIP AND MEDICAID IMPLEMENTATION 3 (2000).

federally assisted Medicaid benefits<sup>56</sup> depends on an individual's ability to satisfy several basic eligibility criteria, the principal ones are categorical eligibility, financial eligibility, state residency and citizenship/legal residency requirements.<sup>57</sup> We focus here on categorical and financial eligibility, although failure to satisfy residency or legal status requirements<sup>58</sup> will be equally disqualifying.

Medicaid requires that in order to be eligible for federally assisted coverage, an applicant must fall into one of the federally recognized eligibility categories. As of 1993, the federal statute contained over fifty separate coverage categories,<sup>59</sup> and more have been added since then.<sup>60</sup> Medicaid's principal mandatory coverage categories, that is, the categories of beneficiaries whom all state plans must cover as a condition of participation are pregnant women, children born after September 30, 1983 and under age nineteen, individuals who meet states' July, 1996 eligibility criteria for Aid to Families with Dependent Children,<sup>61</sup> certain qualified severely impaired individuals and recipients of Supplemental Security Income (SSI).<sup>62</sup> In addition, states must

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56. States may of course extend Medicaid to any individual regardless of whether federal eligibility criteria are met if they are willing to bear financial responsibility for total program costs. With limited exceptions states restrict coverage to individuals and services for whom federal financial participation is available.

57. An individual must be a resident of the state in which he applies for benefits. Special residency rules have been developed to determine residency in the case of persons institutionalized outside of the state, children living in out-of-state foster care and adoption arrangements, and migrant agricultural workers. 42 C.F.R. § 403 (1994). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 established a legal presumption against coverage of individuals who are legal residents but not citizens, although the law contains numerous exceptions. SARA ROSENBAUM, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID ELIGIBILITY AND CITIZENSHIP STATUS: POLICY IMPLICATIONS FOR IMMIGRANT POPULATIONS 1 (2000) [hereinafter IMMIGRANT POPULATIONS], available at <http://www.kff.org>.

58. For a complete discussion of Medicaid and legal status requirements, see generally *id.*

59. MEDICAID SOURCE BOOK, *supra* note 7, at 3.

60. Coverage categories added in recent years include vaccine eligible children, Social Security Act § 1927, 42 U.S.C. § 1396s (1994); optional targeted low income children, Social Security Act, § 1902(a)(10)(a)(ii)(VII), 42 U.S.C. § 1396a(a)(10)(a)(ii)(VII) (1994); employed individuals with medically improved disabilities, Social Security Act § 1902(a)(10)(A)(ii)(XVI), 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVI) (1994 & Supp. IV 1998); and independent foster care adolescents, Social Security Act, § 1902(a)(10)(A)(ii)(XVII); 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVII) (1994 & Supp. IV 1998).

61. Personal Responsibility and Work Opportunity Act, Pub. L. 104-193, 110 Stat. 2105 (1996). For a discussion of the welfare reform and its implications for Medicaid eligibility, see generally *The Law of Unintended Consequences*, *supra* note 44.

62. Social Security Act § 1902(a)(10)(A)(i)(II), 42 U.S.C. § 1396a(a)(10)(A)(i)(II) (1994).

furnish cost-sharing assistance to certain low income Medicare beneficiaries.<sup>63</sup> Optional coverage categories include numerous additional categories of families, and elderly and disabled persons,<sup>64</sup> and medically needy individuals.<sup>65</sup> Medically needy persons are individuals who fall into one of the federally recognized coverage categories, but whose incomes and resources exceed “categorically needy” eligibility levels. As a result, they spend down to eligibility by personally incurring medical care costs, a process that can be thought of as a deductible.<sup>66</sup> Figure 2 sets forth Medicaid’s principal categorical “eligibility pathways.”

Medicaid also requires that applicants satisfy the program’s financial eligibility rules. All participating states must adopt certain mandatory minimum financial eligibility guidelines, but with the notable exception of children, pregnant women, and certain workers with disabilities, these standards are notoriously strict. An applicant’s financial eligibility depends on both income and assets, although states have the authority to waive or liberalize asset tests in the case of certain applicants and recipients who do not receive cash assistance.<sup>67</sup> Federal law also contains complex standards for calculating family income, which vary by coverage group.<sup>68</sup> As Figure 2 illustrates, the minimum income eligibility standards vary by group and range from slightly above the federal poverty level in the case of pregnant women, infants and young children<sup>69</sup> to state-set standards that average well below the federal poverty level in the case of most non-disabled, non-elderly adults.<sup>70</sup>

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63. Low income Medicare beneficiaries whose incomes exceed Medicaid eligibility levels qualify for cost-sharing assistance for Medicare premiums, deductibles and coinsurance. Social Security Act § 1905d(p), 42 U.S.C. § 1396d (1994).

64. Social Security Act § 1902(a)(10)(A)(ii)(I)-(XII), 42 U.S.C. § 1396a(a)(10)(A)(ii)(I)-(XII) (1994).

65. Social Security Act § 1902(a)(10)(C).

66. These individuals effectively “spend down” to Medicaid coverage by spending their “excess” income and resources on medical care. MEDICAID SOURCE BOOK, *supra* note 7, at 12. The program primarily is a means for financing high cost long-term institutional care such as nursing home care. *See* 42 C.F.R. § 435.300-350 (1999).

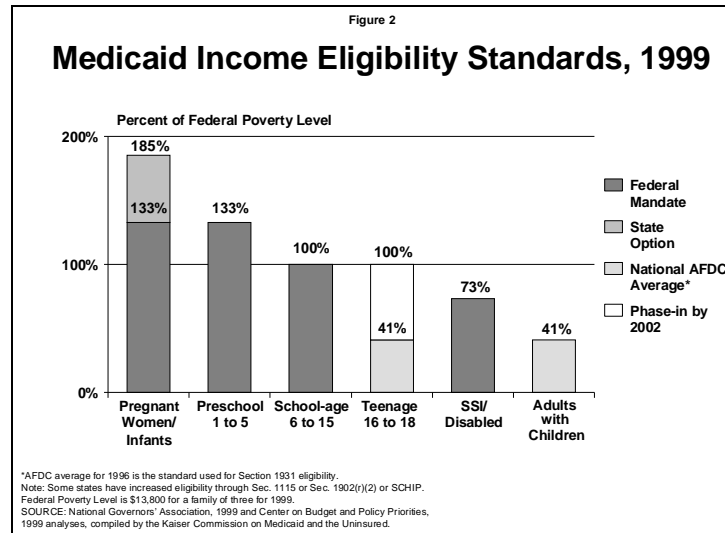
67. Social Security Act §§ 1902(r)(2), 1931.

68. Social Security Act § 1902(a)(17), 42 U.S.C. § 1396a(a)(17) (1994); 42 C.F.R. § 435.600-640 (1999).

69. In 2000, the federal poverty level for a family of three was \$14,150 in the forty-eight contiguous states and the District of Columbia. OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING & EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE 2000 HHS POVERTY GUIDELINES 1 (2000), available at <http://www.aspe.hhs.gov/poverty/00/poverty.htm>.

70. The standard for non-disabled, non-elderly adults must be tied to the most closely associated “welfare category” which, in this case, would be the AFDC program. Social Security Act, § 1902(a)(17), 42 U.S.C. § 1396a(a)(17). Furthermore, federal law generally limits the maximum income standard for beneficiaries to 133% of the AFDC payment level for a family of

The effect of these standards on eligibility is so enormous that in 1999 a mother working full-time at the minimum wage would not be able to qualify for coverage for herself, although she could secure it for her children.<sup>71</sup>



States have significant latitude to establish financial eligibility conditions for all categorical groups. In the case of children, pregnant women, and families with children, persons with disabilities, and the elderly, states may liberalize the standards and methodologies beyond those that are used to determine eligibility for cash assistance.<sup>72</sup> As a result, a state could, for example, extend coverage to all families with children where family incomes are at or below twice the federal poverty level, regardless of work status.<sup>73</sup>

Individuals who meet program eligibility requirements are entitled under federal law to a defined set of benefits.<sup>74</sup> Federal law lists numerous benefit

that size with no other income. Social Security Act § 1903(f)(1)(B), 42 U.S.C. § 1396b(f). There are numerous exceptions to this rule, however.

71. *The Law of Unintended Consequences*, *supra* note 44, at 1470.

72. Social Security Act §§ 1902(r)(2) & 1931.

73. *The Law of Unintended Consequences*, *supra* note 44, at 1470. The District of Columbia, for example, covers all resident families with children with family incomes at or below 200% of the federal poverty level.

74. Social Security Act § 1902(a)(10)(A), 42 U.S.C. § 1396a(a)(10)(A) (1994). As noted previously, following the Supreme Court's decision in *Suter v. Artist M*, 503 U.S. 347 (1992), the question of whether Medicaid creates legally enforceable entitlement rights has become somewhat unsettled. Courts have tended to take a case-by-case approach to the issue, ruling on

groupings, some of which participating states are required to furnish to “categorically needy” beneficiaries<sup>75</sup> (i.e., beneficiaries who do not qualify for Medicaid as medically needy persons). Other benefits are optional in the care of adults.<sup>76</sup> Required benefits consist of inpatient hospital care, outpatient hospital care, nursing facility care, physician services, laboratory and x-ray services, services of federally qualified health centers and rural health clinics, family planning services and supplies for individuals of childbearing age (including sexually active minors), early and periodic screening diagnostic and treatment (EPSDT) services for individuals under age twenty-one, and nurse midwife and nurse practitioner services.<sup>77</sup> Optional benefits are extensive and range from basic preventive services to advanced long-term care benefits.<sup>78</sup> Most states cover most classes of benefits, although with limitations.<sup>79</sup>

Regardless of whether benefits are covered under a state plan on a mandatory or optional basis, federal law sets minimum standards for determining the reasonableness of coverage.<sup>80</sup> Although states have discretion to set limits on coverage, coverage limits must be reasonable;<sup>81</sup> in the case of required services, states may not discriminate on the basis of diagnosis or

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the enforceability of the statute in light of the specific provisions of law that plaintiffs seek to enforce. *See supra* text accompanying note 45. Thus, for example, beneficiaries with disabilities are generally accorded a legal right to enforce the requirement that services be furnished with “reasonable promptness.” *See Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998); *Cramer v. Chiles*, 33 F. Supp. 2d 1342 (D. Fla. 1999); *Lewis v. New Mexico Dep’t. of Health*, 94 F. Supp. 2d 1217 (D. N.M. 2000); *Sobky v. Smoley*, 855 F. Supp. 1123 (9th Cir. 1994); *Rodriguez v. City of New York*, 197 F.3d 611 (2d Cir. 1999). Similarly, children are considered to have an enforceable right to early and periodic screening diagnostic and treatment benefits (EPSDT). *See Frew v. Gilbert*, No. 3:93CA65, 2000 U.S. Dist. Lexis 12410 (E.D. Tex. Aug. 14, 2000), *Salazar v. District of Columbia*, 954 F. Supp. 278 (D. D.C. 1996); *Pittman v. Florida Dep’t of Health and Rehab. Serv.*, 998 F.2d 887 (11th Cir. 1993); *Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993); *Hunter v. Chiles*, 944 F. Supp. 914 (S.D. Fla. 1996).

75. Social Security Act § 1902 (a)(1)(A), 42 U.S.C. § 1396a(a)(10)(A) (1994).

76. *Id.*

77. *Id.*

78. Social Security Act § 1905(a), 42 U.S.C. § 1396d(a) (1994). The most prominent optional benefit is prescribed drugs.

79. In the case of children entitled to EPSDT services, all service limitations that otherwise would be permissible for adults are prohibited, both with respect to classes of benefits and the amount, duration and scope of coverage that is required. Social Security Act § 1905(r)(5), 42 U.S.C. § 1396d(r)(5) (1994).

80. *Chiles*, 136 F.3d at 715.

81. 42 C.F.R. § 440.230(a) (2000). The reasonableness test is measured against the total beneficiary population rather than subclasses of beneficiaries. Thus, for example, where a state uses a 3-physician-visit limit per month and permits additional visits with prior authorization, the limitation is sufficient to satisfy the needs of more than 95% of all beneficiaries and is considered reasonable. *Curtis v. Taylor*, 648 F.2d 946 (5th Cir. 1980).



condition.<sup>82</sup> States may use appropriate coverage criteria based on medical necessity.<sup>83</sup>

In the case of children under age twenty-one, Medicaid coverage is the broadest of any public or private health coverage arrangement in the U.S. States must, in the case of children and as part of the EPSDT program, cover all federally recognized categories of benefits and services that are determined to be medically necessary, regardless of whether in the case of the over-twenty-one population otherwise applicable across-the-board limitations would be considered reasonable.<sup>84</sup> In addition, EPSDT covers a broad range of preventive health services.<sup>85</sup>

The breadth of Medicaid's benefit entitlement extends beyond amount, duration and scope considerations. The program also prohibits virtually all patient cost sharing, including premiums, deductibles and coinsurance.<sup>86</sup> Thus, with the exception of the medically needy, who as noted "spend down" to financial eligibility,<sup>87</sup> recipients may be charged only nominal amounts for coverage and services.<sup>88</sup>

While federal requirements are stringent in the case of coverage, they afford states considerable latitude in the areas of provider qualification, participation and compensation. States also have broad discretion with respect to service delivery.<sup>89</sup> Only qualified providers are permitted to participate in Medicaid;<sup>90</sup> however, with certain exceptions,<sup>91</sup> states have significant flexibility to set provider participation standards.<sup>92</sup> In the case of certain groups of providers, including federally qualified health centers, rural health clinics, hospice programs and disproportionate share hospitals, the statute

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82. 42 C.F.R. § 440.230(b), (c) (1999).

83. 42 C.F.R. § 440.230(d) (1999).

84. Social Security Act § 1905(r)(5), 42 U.S.C. § 1396d(r)(5) (1994). *Pittman*, 998 F.2d at 892; *Miller*, 10 F.3d at 1320; *Hunter*, 944 F. Supp. at 920.

85. Social Security Act § 1905(r). Preventive services include periodic assessments of growth and development, all age appropriate immunizations recommended by the Advisory Committee on Immunization Practice (ACIP) and complete vision, dental and hearing care.

86. Social Security Act §§ 1902(a)(14), 1916, 42 U.S.C. §§ 1396a(a)(14), 1396o (1994 & Supp. III 1997). Cost-sharing is prohibited in the case of children under eighteen, pregnant women and nursing facility residents. States do have the option to impose more substantial cost sharing on certain groups of individuals, including former persons with disabilities who qualify for Medicaid on the basis of their work status but whose income is moderate. The premiums must be income related. SCHNEIDER & ELLBERGER, *supra* note 9.

87. 42 C.F.R. § 435.800-843 (1999).

88. *See* Social Security Act § 1902(a), 42 U.S.C. § 1396a (1994 & Supp. IV 1998).

89. *Id.*

90. Social Security Act § 1902(a)(23), 42 U.S.C. § 1396a(a)(23) (1994 & Supp. IV 1998).

91. States must cover the services of federally qualified health centers, rural health clinics, nurse midwives, and nurse practitioners. Social Security Act § 1902(a)(2)(C), (17), (21), 42 U.S.C. § 1396a(a)(2)(C), (a)(17), (a)(21) (1994).

92. *Id.*

contains certain required payment methodologies.<sup>93</sup> With respect to health centers, which as a matter of law serve large numbers of uninsured patients,<sup>94</sup> federal law prohibits Medicaid programs from demanding deep compensation discounts and requires agencies to pay health centers the reasonable cost of care; this policy is designed to assure that cost-shifting onto grant funds designed to care for the uninsured does not result.<sup>95</sup> Similarly, states must maintain a formula to define and furnish supplemental payments to hospitals that serve a disproportionate number of low income and Medicaid insured patients.<sup>96</sup> In the case of other providers, states have broad discretion to set payment rates.<sup>97</sup> However, in setting rates for hospitals and nursing facilities, states must adhere to certain procedural notice and comment requirements.<sup>98</sup> Furthermore, payments must be consistent with “efficiency, economy and quality of care and . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic service area.”<sup>99</sup>

In addition to establishing provider qualification standards, Medicaid agencies have the option to use various forms of managed care arrangements to provide covered services to program enrollees.<sup>100</sup> Under federal law, state agencies can condition coverage for most groups of beneficiaries on mandatory enrollment in some form of managed care arrangement<sup>101</sup> and may contract with either comprehensive managed care organizations or with primary care

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93. Social Security Act § 1902(a)(13), 42 U.S.C. § 1396a(a)(13) (1994 & Supp. III 1997).

94. The Public Health Service Act § 330, 42 U.S.C. § 254c (Supp. III 1997), authorizes the establishment and operation of federally funded health centers. As a condition of funding, health centers must offer certain services, serve populations and communities designated as medically underserved, and prospectively adjust their charges in accordance with a fee schedule that reflects family income.

95. *Id.* A similar cost-related payment policy applies to the Medicare program. Social Security Act § 1832(a)(2)(D), 1833(a)(3) (1999).

96. Social Security Act § 1902(a)(13)(C), 42 U.S.C. § 1396a(a)(23) (1994 & Supp. IV 1998).

97. Social Security Act § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A) (1994).

98. *Id.* These procedural requirements take the place of the Boren Amendment, which required states to pay hospitals and nursing homes in accordance with cost-related principles and which was repealed by the Balanced Budget Act of 1997. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251 (1997).

99. Social Security Act § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A) (1994).

100. For a comprehensive review of state managed care purchasing practices see NEVA KAYE & CYNTHIA PERNICE, NATIONAL ACADEMY FOR STATE HEALTH POLICY, MEDICAID MANAGED CARE: A GUIDE FOR STATES (4th ed. 1999), available at <http://www.nashp.org/pubs/medicaid.htm>; SARA ROSENBAUM ET AL., THE GEORGE WASHINGTON UNIVERSITY, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES, NEGOTIATING THE NEW HEALTH SYSTEM: A NATIONWIDE STUDY OF MEDICAID MANAGED CARE CONTRACTS (3d ed. 1999).

101. Social Security Act § 1932(a)(1)(A), 42 U.S.C. 1396n(a)(1)(A) (1994).

case managers, who offer a more limited form of managed care.<sup>102</sup> As of 1998, more than half of all beneficiaries were enrolled in some form of managed care arrangement<sup>103</sup> and thirty-eight states made at least some use of managed care for persons with disabilities.<sup>104</sup>

Medicaid's status as a legal entitlement has resulted in countless lawsuits by beneficiaries who have challenged both individual and across-the-board denials and reductions in eligibility and services, as well as violations of procedural due process safeguards. In addition, providers, who are entitled to payment for the covered care and services they furnish to enrollees, have mounted extensive litigation against state agencies over both the issue of payment, as well as the level of payment.<sup>105</sup> In addition, providers have successfully challenged on due process grounds their exclusion from the Medicaid program without prior notice and hearing.<sup>106</sup> This extensive litigation has continued into the present time, with legal challenges to virtually all aspects of state administration, ranging from the adequacy of enrollment

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102. *Id.*

103. Data from the Health Care Financing Administration; calculations by the Kaiser Commission on Medicaid and the Uninsured, at <http://www.kff.org>.

104. MARSHA REGENSTEIN & CHRISTY SCHROER, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID MANAGED CARE FOR PERSONS WITH DISABILITIES: STATE PROFILES 5 (1998).

105. Provider litigation against Medicaid agencies over payment rates culminated with the Supreme Court's decision in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990) (holding that under Medicaid's "Boren Amendment," hospitals had an enforceable legal right to payment levels that reflected the cost of care incurred by efficient and economically operated institutions). The Boren Amendment, which was repealed in 1997 by the Balanced Budget Act, covered both hospitals and nursing facilities and was long criticized by states as a source of mandatory and excessive program expenditures. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4712(c), 111 Stat. 509 (1997). The language that replaced the Boren Amendment requires states to establish and adhere to a public process for determination of rates, but with the exception of payments to disproportionate share hospitals, removes any rate standard. In addition to the Boren Amendment, the statute requires that state Medicaid payments be sufficient to ensure that care is accessible. Social Security Act § 1902(a)(30), 42 U.S.C. § 1396a(a)(30) (1994). The adequacy of payment provisions of the law have resulted in separate and extensive litigation. *See, e.g.*, *Clark v. Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990) (challenging the sufficiency of dental payments).

106. In *MedCare HMO v. Bradley*, a virtually non-functional HMO successfully obtained a ruling enjoining the state from removing its Medicaid members and assigning them to other functional plans on the ground that it was being deprived of property without due process. 788 F. Supp. 1460 (N.D. Ill. 1992). The *MedCare* ruling, which considered the interests of the HMO, without concern for the beneficiaries, was codified into the Medicaid statute as part of the Balanced Budget Act of 1997. Social Security Act § 1932(f)(4), 42 U.S.C. § 1396u-2(f)(4) (Supp. IV 1998), prohibits the termination of managed care entity contracts without prior notice and hearing. States may, at their discretion, notify enrollees that termination hearings are under way and permit members to switch plans. *Id.*

protections and benefit levels to the operation of managed care and long-term care systems, as well as other aspects of the modern Medicaid program.<sup>107</sup>

Given the legal exposure that state Medicaid programs incur, the obvious question is “what is in it for a state?” The answer lies in the states’ legally enforceable entitlement to federal financial assistance on an open-ended basis for the medical assistance and administrative service costs they incur.<sup>108</sup> Indeed, while the nominal level of states’ entitlement is considerable (at a minimum Medicaid reimburses states for half of all federally recognized costs and in the case of poorer states and certain administrative services, the level of federal contribution is considerably higher), over the years states have done a remarkable job at manipulating the federal Medicaid contribution formula to create actual federal contribution levels far higher than the level to which they might therefore be entitled under the nominal statutory formula.<sup>109</sup> Therefore, while legal exposure may create a disincentive for state Medicaid programs, it is offset by the extensive reimbursement for medical assistance they receive.

#### *B. Trends in Coverage and Expenditures*

While it is possible to gain a technical understanding of Medicaid through a legal overview, for broad policy analysis purposes examination of Medicaid recipient and expenditure data is essential to understanding program trends and identifying major and emerging policy issues. Therefore, this section of the article examines Medicaid statistics. Unless otherwise noted, all of the data presented has been prepared for the Kaiser Commission on Medicaid and the Uninsured<sup>110</sup> and employs a variety of governmental data sources. Data on Medicaid coverage and expenditures are from 1997, the latest year for which final statistics on coverage and expenditures were available as of the summer of 2000.

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107. A complete review of all Medicaid litigation would be so vast that it lies well beyond the scope of this article. Individuals interested in gaining a clearer sense of the level of litigation that has transpired need only examine the United States Code Annotated. Readers may wish to visit the website of the National Health Law Program, at <http://www.healthlaw.org>, which specializes among other matters in Medicaid legal advocacy.

108. Social Security Act § 1903(a), 42 U.S.C. § 1396b (1994).

109. For a particularly clever state federal contribution strategy that has resulted in the payment of billions of dollars in federal Medicaid funding beyond the amount nominally specified under the statutory formula, see Letter from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations, to State Medicaid Director 1 (July 26, 2000) (regarding states “upper payment limit” activities) at <http://www.hcfa.gov/medicaid/smd72600.htm>. Proposed rules to stop this practice were promulgated in October 2000. 65 Fed. Reg. 60,151 (Oct. 10, 2000).

110. See generally THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, at <http://www.kff.org>.

As noted previously, Medicaid law contains more than fifty separate eligibility groups.<sup>111</sup> Nonetheless, for health services research and policy analysis purposes, these groupings can be collapsed into four “macro” categories: children; non-disabled, non-elderly adults; persons with disabilities; and the elderly. Within these four groupings, a further broad distinction can be made between those who receive both Medicaid and cash welfare assistance, and those who do not receive cash assistance. This collapsing of eligibility groupings creates certain anomalies (for example, disabled children are grouped within the disabled persons category rather than within the children’s category). However, experts do not consider these peculiarities to adversely affect the accuracy of broad policy analysis.

Medicaid data tell policy makers much about the program. First and foremost, children dominate Medicaid;<sup>112</sup> in 1997, children accounted for fifty-two percent of all beneficiaries.<sup>113</sup> Non-disabled, non-elderly adults accounted for twenty-one percent of program beneficiaries,<sup>114</sup> while disabled, non-elderly persons accounted for seventeen percent of enrollees.<sup>115</sup> The elderly comprised ten percent of all program beneficiaries.<sup>116</sup> The predominance of children in the program is a testament to childhood poverty in America; in 1996 nearly twenty percent of all American children were poor.<sup>117</sup>

While children comprise the majority of beneficiaries, Figure 3 shows that between 1990 and 1997, the number of Medicaid-enrolled children actually declined slightly, as did the number of non-disabled, non-elderly adults.<sup>118</sup> Figure 4 shows that between 1995 and 1997, enrollment for children and adults dropped by 1.4% and 5.4% respectively after growing significantly during the first part of the decade.<sup>119</sup> The number of elderly enrollees grew and then stabilized, while the number of persons with disabilities showed growth throughout this time period.<sup>120</sup>

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111. See MEDICAID SOURCE BOOK, *supra* note 7, at 3.

112. See *infra* Figure 8.

113. *Id.*

114. *Id.* Because poor adults are not recognized as an independent eligibility category under federal law, one can presume that these adults are overwhelmingly pregnant women or caretakers of children.

115. *Id.*

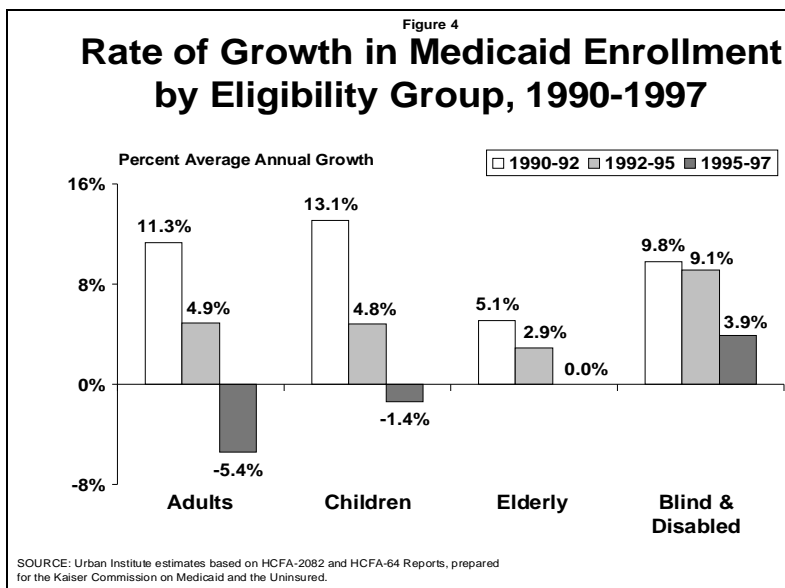
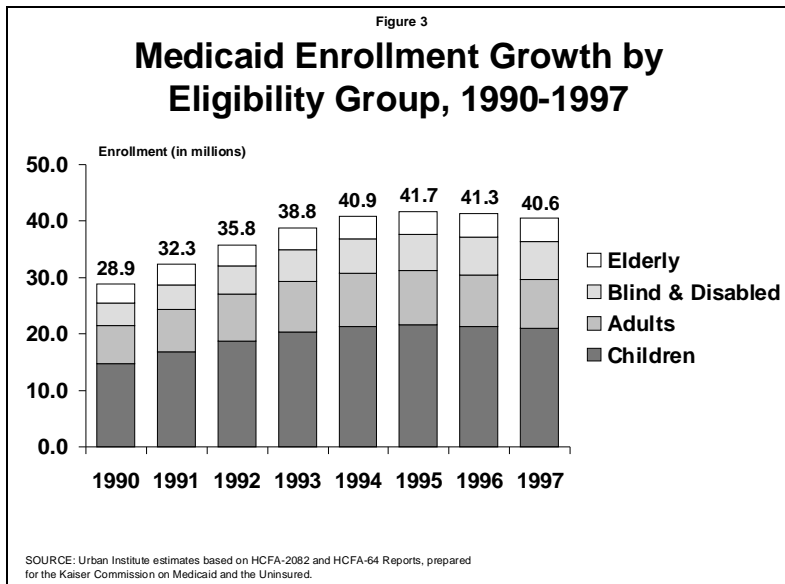
116. *Id.*

117. In 1996 the figure stood at 19.8%. ANNIE E. CASEY FOUNDATION, KIDS COUNT DATA BOOK 22 (1998).

118. See *infra* Figure 3.

119. See *infra* Figure 4.

120. *Id.*



The seeds of decline in Medicaid coverage of children and non-disabled adults probably began as a result of federally supported welfare reform experiments begun by the Clinton Administration in 1993, which introduced time limits and enhanced work requirements into the AFDC program.<sup>121</sup> With

121. See Figure 4.

the enactment of federal welfare reform legislation in 1996, this decline may have actually increased, since the new legislation permitted far more aggressive efforts to terminate welfare and prevent enrollment than those sanctioned by the Administration as part of its earlier demonstrations.<sup>122</sup> As women and children were removed from welfare rolls, state welfare agencies (which as noted administer the eligibility component of Medicaid as a matter of federal law) failed to draw a distinction between welfare eligibility (which ended) and Medicaid eligibility (which continued).<sup>123</sup>

The growth in the number of persons with disabilities in the early part of the decade can be attributed to an expansion of coverage for disabled children,<sup>124</sup> as well as more aggressive efforts on the part of states to design home and community service programs for persons with disabilities.<sup>125</sup> The continued growth in the latter part of the decade probably is a result of a continuation of these factors, as well as greater awareness of the availability of Medicaid for persons with disabilities.

Depending on the regulation sub-group, the importance of Medicaid varies significantly by population sub-category. In 1997, forty-four percent of all poor persons (i.e., individuals with family incomes below the federal poverty level) were enrolled in Medicaid; among the near poor the number dropped to sixteen percent.<sup>126</sup> Medicaid is of profound importance to American pediatrics. As noted, children comprise the largest single group of beneficiaries;<sup>127</sup> furthermore, in 1997 more than twenty percent of all American children received Medicaid.<sup>128</sup> The program is twice as important for women as men (nine percent of all women received Medicaid in 1997 compared with five percent of men).<sup>129</sup> This greater level of enrollment is

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122. See Personal Responsibility and Work Opportunity Act, Pub. L. No. 104-193, §§ 701-42, 801-16, 110 Stat. 2287-2318 (1996).

123. *The Law of Unintended Consequences*, *supra* note 44.

124. This expansion undoubtedly came to a halt with the enactment of the 1996 welfare reform legislation, which, among other provisions, sharply curtailed coverage for children with mental and developmental disabilities. The Supreme Court's decision in *Sullivan v. Zebley*, which overturned the standards and procedures used by the federal government to determine children's eligibility for SSI, resulted in an overhaul of eligibility criteria that had its greatest impact on children with mental and developmental conditions. 493 U.S. 521 (1990). In 1996, federal legislation expressly reversed *Zebley*. Personal Responsibility and Work Opportunity Act, Pub. L. No. 104-193, tit. I, 110 Stat. 2105 (1996).

125. As a result of the Supreme Court's decision in *Olmstead v. L.C.*, this expansion may continue as states attempt to remove institutional bias from their state health programs through restructured Medicaid programs that emphasize the eligibility of persons with disabilities for services in the community. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

126. The 1997 poverty level for a family of three was \$13,300.

127. See *supra* Figure 3.

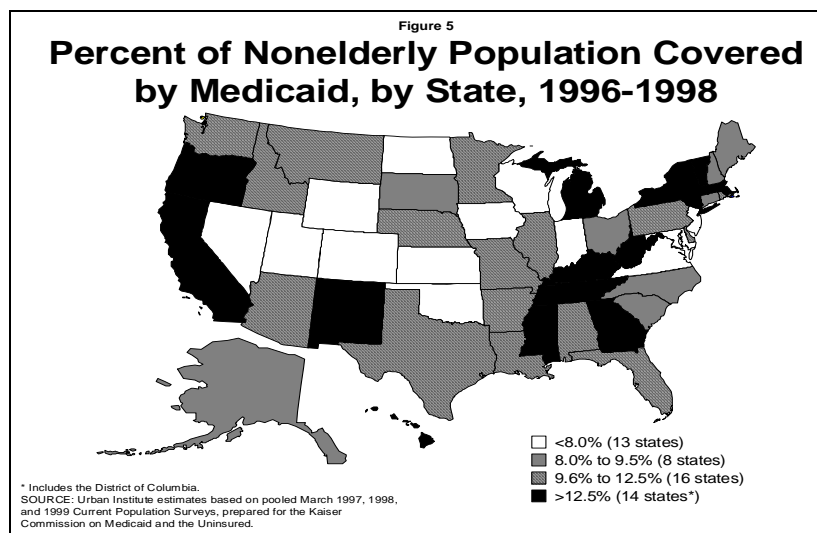
128. *Id.*

129. See *infra* Figure 16.

undoubtedly a result of women's higher poverty rates, the existence of female-specific eligibility categories (i.e., pregnancy), and the fact that women are more likely to show up as caretaker relatives of children in poor households.<sup>130</sup>

Minority Americans are also disproportionately likely to be enrolled in Medicaid.<sup>131</sup> In 1997, twenty-two percent of all African Americans, and nineteen percent of all Hispanic and Native Americans were enrolled in Medicaid, compared with eight percent of white Americans.<sup>132</sup> Studies suggest that adults with activity limitations are nearly seven times as likely as those without limitations to be enrolled in Medicaid.<sup>133</sup> Finally, while fourteen percent of all Medicare beneficiaries receive Medicaid,<sup>134</sup> when disabled beneficiaries are considered separately, this figure skyrockets to thirty-six percent.<sup>135</sup>

As noted, states have considerable power over Medicaid eligibility levels. The state role in establishing Medicaid eligibility is underscored by data on state-level variation in eligibility. Figure 5 shows that during the 1996-1998 time period, twelve states maintained sufficiently restrictive eligibility standards to maintain coverage at under eight percent of their state populations, while fourteen states covered more than 12.5% of their populations.<sup>136</sup>



130. *Id.*

131. *Id.*

132. *Id.*

133. Dennis McCarty & Helen Levine, *Needs of People with Chronic and Disabling Conditions*, in ACCESS TO HEALTH CARE: PROMISES AND PROSPECTS FOR LOW-INCOME AMERICANS 61, 66 (Marsha Lillie-Blanton et al. eds., 1999).

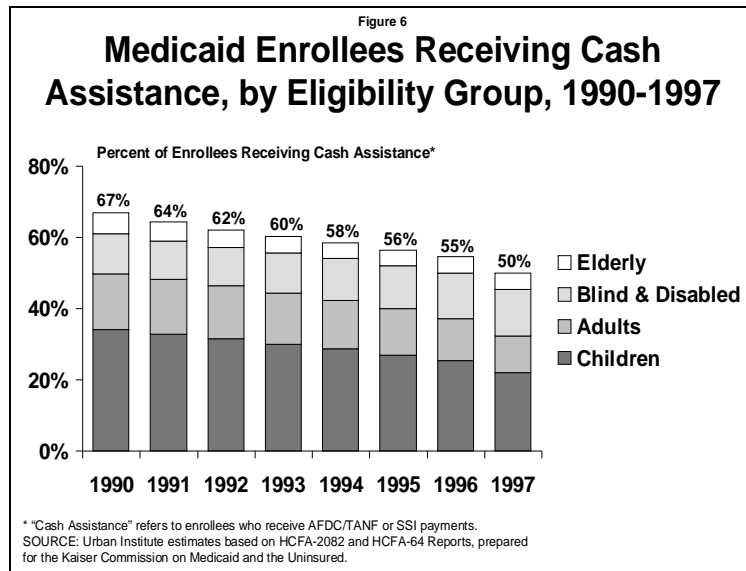
134. See *The Law of Unintended Consequences*, *supra* note 44.

135. *Id.*

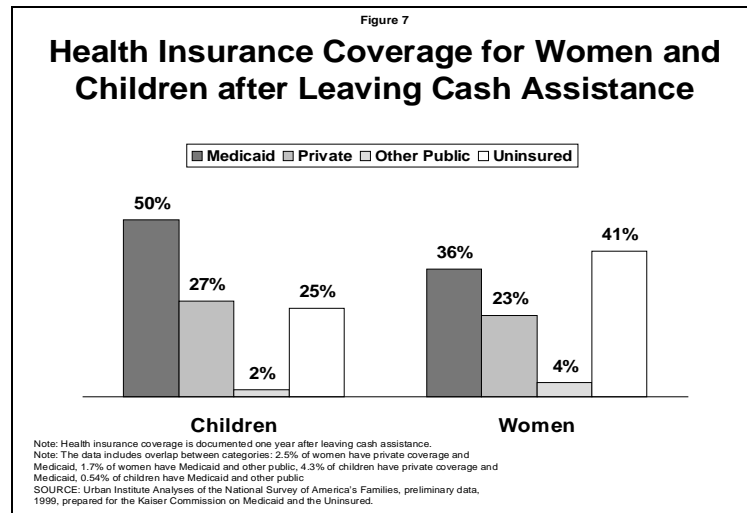
136. *Id.*



The impact of the 1996 welfare reform legislation can be seen in the declining proportion of Medicaid enrollees who receive cash assistance.<sup>137</sup> Figure 6 shows that the proportion of Medicaid enrollees who also receive cash assistance fell from sixty-seven percent in 1990 to fifty percent in 1997.<sup>138</sup> These declines occur even among individuals who, following the loss of cash assistance, remain eligible for Medicaid.<sup>139</sup> Figure 7 shows the impact of the loss of welfare on Medicaid enrollment.<sup>140</sup> Within a year of leaving cash assistance, only fifty percent of children retain Medicaid (even though virtually all remain entitled to coverage as low income children), while Medicaid enrollment drops to thirty-six percent in the case of women despite their eligibility for transitional benefits.<sup>141</sup> Figure 7 also underscores that former welfare recipients do not substitute private insurance for Medicaid.<sup>142</sup> Only twenty-seven percent of children and only twenty-three percent of women were privately insured at the end of the time period in question.<sup>143</sup>



137. See Figure 6.  
 138. *Id.*  
 139. *The Law of Unintended Consequences*, *supra* note 44.  
 140. See *infra* Figure 7.  
 141. *The Law of Unintended Consequences*, *supra* note 44.  
 142. See *infra* Figure 7.  
 143. *Id.*



In sum, data on Medicaid enrollment shows a high dependence on the program among the poor, persons with disabilities, members of racial and ethnic minority groups, and children and women of childbearing age,<sup>144</sup> who otherwise would be without access to health insurance.<sup>145</sup> Women and children appear to be experiencing a decline in enrollment owing to the advent of welfare reform and states' failure to implement aggressive outreach and case-finding efforts or formal procedures for ensuring the retention of Medicaid coverage during the welfare disenrollment process.<sup>146</sup> While the Health Care Financing Administration has taken action to require states to put safeguards into place, these efforts occurred only years after large-scale disenrollment had begun<sup>147</sup> and prospects for finding and re-enrolling the thousands of women and children who incorrectly lost benefits are limited at best.<sup>148</sup>

The enrollment data underscore Medicaid's significant and growing role for persons with disabilities, among whom enrollment has shown steady increases throughout the decade.<sup>149</sup> Underlying factors include greater levels of state investment in the provision of home and community services for

144. *See supra* Figures 2, 3 and 7.

145. *Id.*

146. *See supra* Figures 2, 3, 4 and 7.

147. Westmoreland, *supra* note 109.

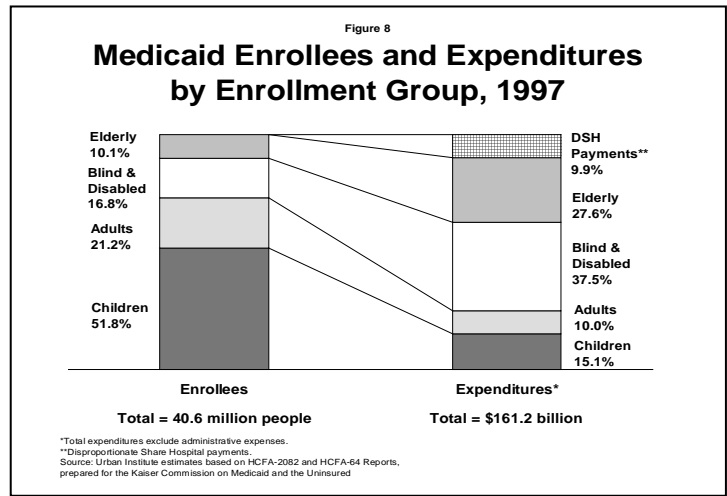
148. *Id.*

149. *See supra* Figure 3.

persons with serious disabilities, as well as changes in eligibility criteria that have resulted in enhanced coverage levels.<sup>150</sup>

1. Expenditures by population sub-group

Spending by population sub-group is an important means for gauging the relative and absolute importance of the program where different sub-populations are concerned. Figure 8 shows the difference between enrollment and expenditures. In 1997, although non-disabled adults and children comprised nearly seventy-five percent of program beneficiaries, they accounted for only twenty-five percent of program spending.<sup>151</sup> Sixty-five percent of all program expenditures were made for elderly and disabled individuals who together accounted for only slightly more than one quarter of all enrollees.<sup>152</sup> Figure 9 presents an alternative means of looking at expenditures. This figure shows that in 1997, only one quarter of all Medicaid expenditures could be attributed to “acute care” services (i.e., services other than long-term care) for families.<sup>153</sup> Thus, of the \$161 billion in Medicaid spending that year, only one quarter is in fact associated with the types of expenditures that one might find under a standard commercial insurance plan for working age adults and their children.<sup>154</sup> The vast majority of program spending was made on behalf of populations who overwhelmingly exist outside of the conventional insurance market and where needs would in significant measure be considered uninsurable.<sup>155</sup>



150. See, e.g., Social Security Act § 1902(a)(10)(A)(ii), 42 U.S.C. § 1396 (a)(10)(A)(ii) (1994 & Supp. III 1997).

151. See Figure 8.

152. *Id.*

153. See *infra* Figure 9.

154. *Id.*

155. *Id.*

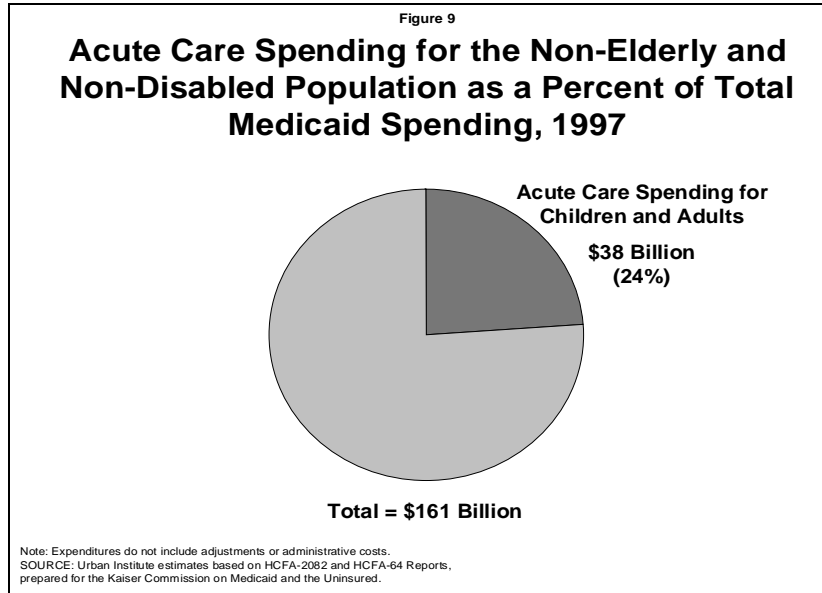
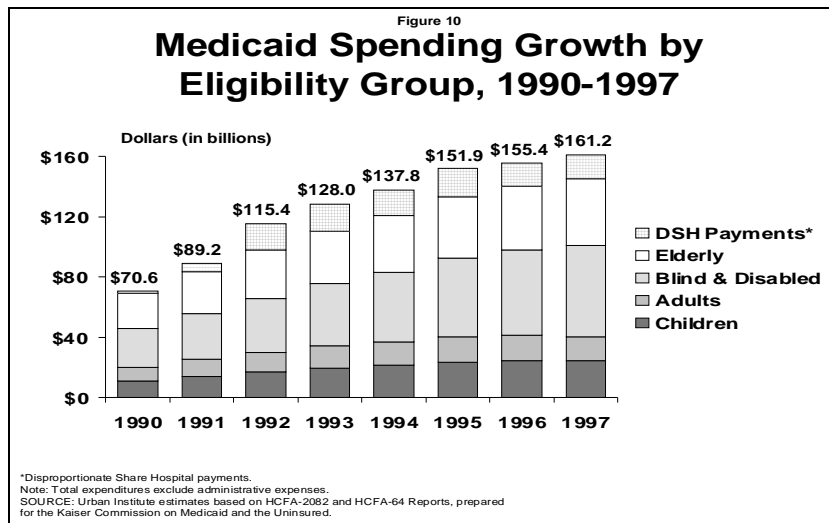
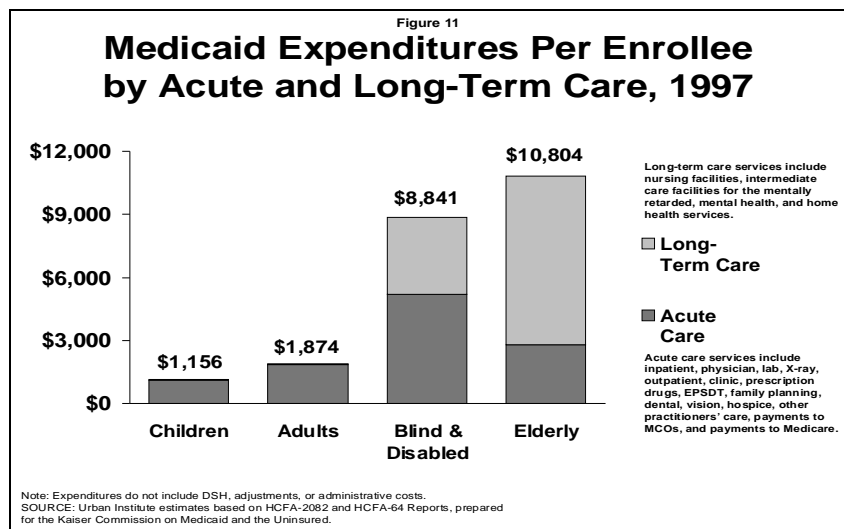


Figure 10 shows the growth in expenditure by population group between 1990 and 1997. While spending on children and non-disabled adults grew slightly over this time period, spending on persons with disabilities increased dramatically.<sup>156</sup> These figures are consistent with those related to enrollment growth and show Medicaid's growing importance for this population.



156. See Figure 10.

The significance of Medicaid expenditure figures for persons with disabilities is further heightened by statistics that disaggregate these expenditures into their acute and long-term components for each population sub-group, as illustrated by Figure 11.<sup>157</sup> The pattern that emerges for beneficiaries with disabilities is extremely important to understand. When acute and long-term spending are separated, it becomes evident that, perhaps contrary to popular expectations, the majority of the more than \$8,000 in annual expenditures for this population in 1997 were for acute care services (e.g., outpatient care, community services, prescribed drugs), rather than institutional long-term care.<sup>158</sup> It is also possible to see the very high average annual cost of acute care spending for persons with disabilities, with expenditures levels that vastly exceed those that would be anticipated under a standard commercial policy.



This high level of acute care spending on persons with disabilities underscores the shift in care and services away from institutional settings and toward community services. It also is a strong indicator of just how far beyond the conventional insurance market beneficiaries with disabilities lie. This figure suggests the limited potential for applying “market” strategies to improve coverage of persons with disabilities.<sup>159</sup>

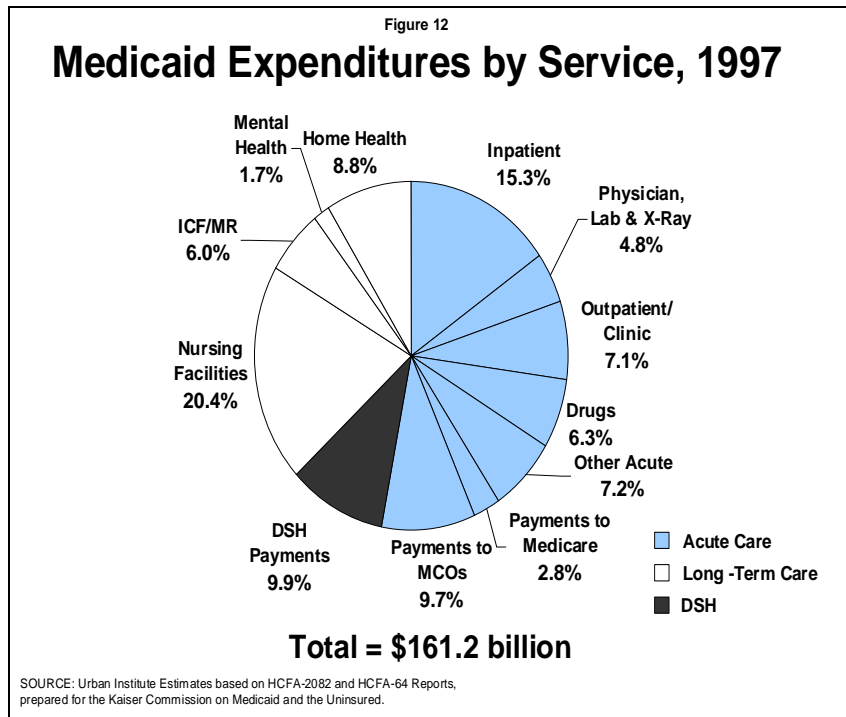
157. See Figure 11.

158. Were it not for the fact that Medicare is the first payer for dually eligible beneficiaries, this same pattern also undoubtedly would have been in evidence for the elderly.

159. In theory, applying risk adjustment principles to insurance premiums (i.e., paying more for certain enrollees based on health status) might be a means of better matching premium revenues to health care spending expectations. However, the current science of risk adjustment

2. Expenditures by service type

In addition to considering Medicaid’s relative importance for specific population sub-groups, policy analysts also examine expenditures for different classes of services. Figure 12 shows Medicaid expenditures by service type. In 1997, more than one third of all program spending entailed the purchase of long-term care services (i.e., home health care, mental health services, the services of intermediate care facilities for persons with mental retardation and related conditions, and nursing facility services).<sup>160</sup> Figure 13 illustrates Medicaid’s extraordinary role in the case of long-term care. In 1997, Medicaid accounted for thirty-eight percent of all long-term care expenditures among all payers and forty-seven percent of all expenditures for nursing home care.<sup>161</sup> The long-term care system is effectively dependent on Medicaid (and to a lesser extent Medicare).<sup>162</sup>

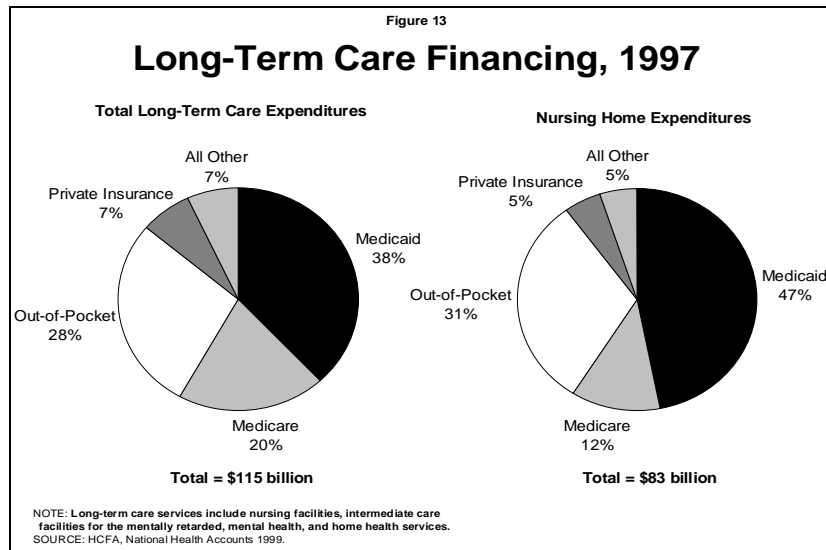


appears to be sufficiently under-developed at this point in time to prevent this approach from being feasible.

160. See Figure 12.

161. See *infra* Figure 13.

162. *Id.*



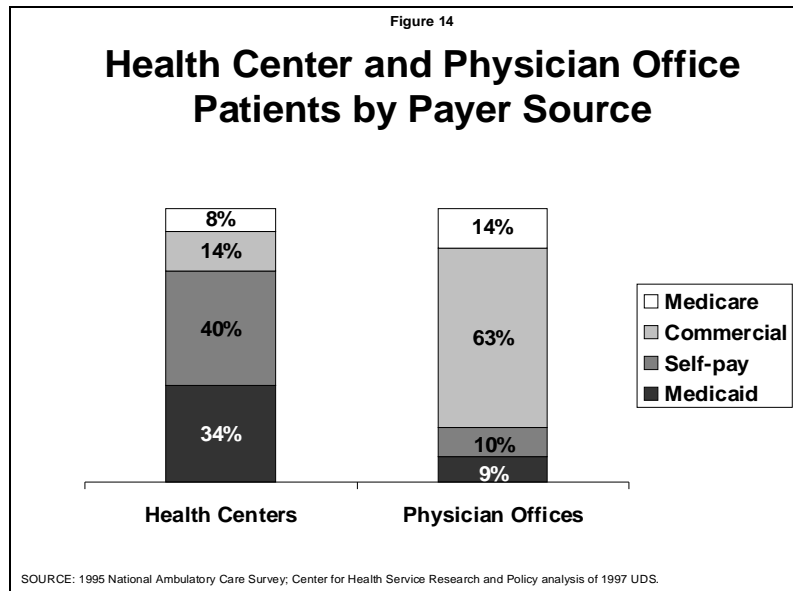
Finally, Medicaid's major role in the support of the safety net can be seen in Figure 14, which compares Medicaid patients as a percentage of total patients for primary physician practices and practices of federally supported community health centers, which furnish comprehensive primary health services to low income and medically underserved communities.<sup>163</sup> Figure 14 shows that in a standard physician practice, Medicaid comprises nine percent of all patients served.<sup>164</sup> In the case of health centers, Medicaid patients account for thirty-four percent of all patients.<sup>165</sup> Revenue numbers are consistent with patient load: in 1997, Medicaid accounted for more than one third of all health center revenues.<sup>166</sup>

163. See *infra* Figure 14.

164. *Id.*

165. *Id.*

166. SARA ROSENBAUM ET AL., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HEALTH CENTERS' ROLE AS SAFETY NET PROVIDERS FOR MEDICAID PATIENTS AND THE UNINSURED 13 (2000), available at <http://www.kff.org>.



In sum, Medicaid program expenditure data demonstrate the extraordinary level of dependence among various sub-population groups on the program in both absolute and relative dollar levels. Medicaid spending on elderly persons and persons with disabilities is extremely high on a per capita basis. These high spending levels, particularly in the case of persons with disabilities, reflect high levels of expenditures not only for long-term care services but for acute care services as well, in amounts that extend well beyond those levels that would be anticipated under conventional insurance. Expenditures on working age adults and children are low and account for a minority of total program spending, yet as the enrollment data suggest, these populations are extremely reliant on the program to meet their insurance needs.<sup>167</sup>

The expenditure data also underscore the central role that Medicaid plays in the nation's long-term care system, accounting for the largest single share of overall national spending.<sup>168</sup> In the absence of any other third party financing mechanism, Medicaid has filled the financial void where both institutional and community-based long-term care services are concerned. Were Medicaid to disappear, not only would millions of individuals be left without coverage but the long-term care system in the United States would virtually collapse.

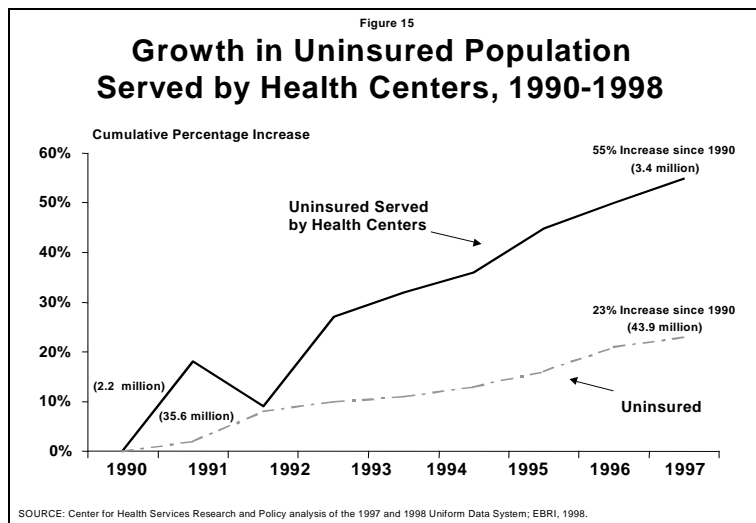
Similarly, in light of Medicaid's role as an underwriter of safety net providers (i.e., health care providers that treat high volumes of both uninsured and Medicaid-sponsored patients such as public hospitals, health centers, and

167. *See supra* Figure 8.

168. *See supra* Figure 13.



public health agencies), the loss of Medicaid funds could be expected to significantly adversely affect the ability of the safety net to absorb growing numbers of uninsured patients. As Figure 15 shows, between 1990 and 1997, when the number of uninsured Americans grew by twenty-three percent, the number of uninsured patients served by health centers grew by fifty percent.<sup>169</sup> Much of this capacity within health centers to absorb so many uninsured patients can be attributed to a significant increase in overall revenues, fueled by broader Medicaid coverage and better Medicaid rates paid to health centers over the decade.<sup>170</sup>



#### IV. MODERNIZING MEDICAID: MAJOR CHALLENGES AND PROSPECTS FOR REFORM

Despite Medicaid's enormous role in the modern health system, the program suffers from a series of major problems tied to its basic federal design compounded by federal and state administrative choices over the years. Over the course of three and a half decades, legislative changes have been heaped on changes (sometimes with duplicative or contradictory results).<sup>171</sup> The result is

169. ROSENBAUM, *supra* note 166, at 11. See also Figure 15.

170. DANIEL R. HAWKINS JR. & SARA ROSENBAUM, *The Challenges Facing Health Centers in a Changing Healthcare System*, in *THE FUTURE U.S. HEALTHCARE SYSTEM: WHO WILL CARE FOR THE POOR AND UNINSURED?* 99 (Stuart H. Altman et al. eds., 1998).

171. For example, the optional categorically needy children whose coverage was added to Medicaid in 1997 as part of the State Children's Health Insurance Program (SCHIP) legislation already could be covered as optional categorically needy children under §1902(r)(2) of the Act, which had been added a decade earlier. SARA ROSENBAUM & COLLEEN SONOSKY, *THE URBAN INSTITUTE, CHILD HEALTH IN A CHANGING POLICY ENVIRONMENT: THE ROLES OF CHILD*

a horribly complicated law that leaves out nearly as many poor people as it covers, makes coverage of the near-poor feasible but only on terms that most states reject (very broad eligibility and no cost-sharing), supports coverage of long-term care services but with significant lapses in the adequacy of that coverage and the ability to furnish coverage in community settings, and underwrites the safety net through antiquated payment mechanisms that no longer work as they should in the modern health care environment. The question thus becomes Medicaid's prospects for reform.

For a number of reasons, in the absence of comprehensive national reform, a strong case can be made for the systematic and thoughtful modernization of Medicaid. First, the process already has begun. As this article points out, over the past decade, Medicaid has been altered in certain basic respects to take into account the needs and pressures created by the modern health system and emerging health needs. Eligibility standards were revised as part of the 1996 welfare reform legislation to make possible the coverage of all families with children on the basis of financial need alone (as defined by the states), without regard to welfare receipt or categorical relationship to the AFDC program.<sup>172</sup> This reform, which states have begun to use, permits a federally assisted response to the problem of the working uninsured, which is concentrated in lower income working families (i.e., families with incomes at or below two-hundred percent of the federal poverty level).<sup>173</sup> As Figure 16 illustrates, in 1998 more than three-quarters of uninsured non-elderly Americans were members of working households, and more than half of these individuals were members of families with incomes at or below two-hundred percent of the federal poverty level.<sup>174</sup> It is unlikely that these families will be able to secure access to employer-sponsored coverage; indeed, firms that offer no coverage employ the majority of uninsured workers.<sup>175</sup> In the absence of an alternative

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ADVOCACY ORGANIZATIONS IN ADDRESSING POLICY ISSUES (1999). In federal Medicaid policy, duplication is a serious problem, since under the federal budget process, each addition to Medicaid results in financial obligations which must be paid for through tax increases or offsetting program reductions.

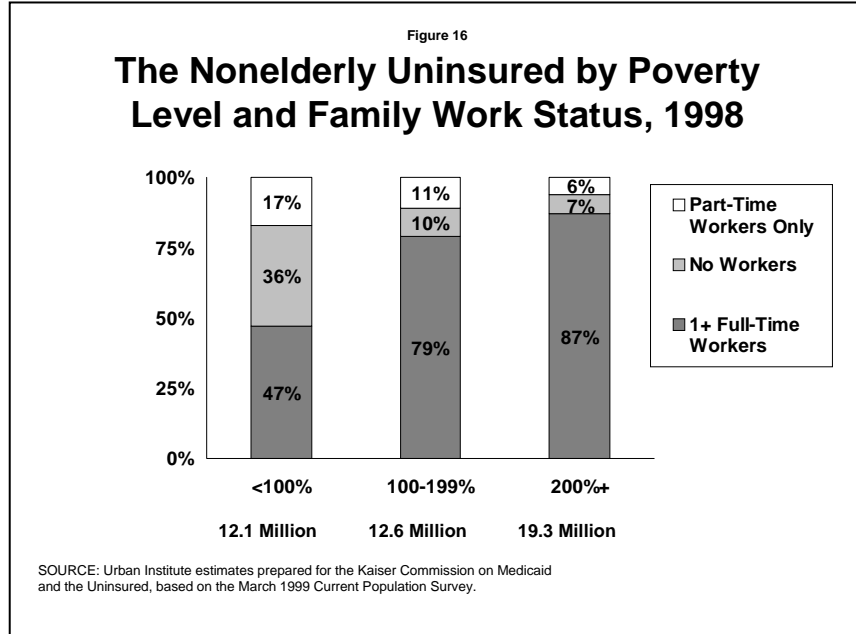
172. See The Personal Responsibility and Work Opportunity Reconciliation Act § 103, (codified at 42 U.S.C. § 601 (Supp. III. 1997)). The Personal Responsibility and Work Opportunity Reconciliation Act was the repeal of AFDC and replaced it with Temporary Assistance to Needy Families. Pub. L. No. 104-193, 110 Stat. 2105, 2210 (1996).

173. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, UNINSURED IN AMERICA 11 (2000). In 1998, when eighteen percent of all non-elderly persons were uninsured, thirty-six percent of the poor and thirty-one percent of the near-poor were uninsured.

174. See *infra* Figure 16.

175. ELLEN O'BRIEN & JUDY FEDER, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HOW WELL DOES THE EMPLOYMENT-BASED HEALTH INSURANCE SYSTEM WORK FOR LOW-INCOME FAMILIES? (1998), available at <http://www.kff.org/content/archive/2107/lowincome3.html>. Only forty-three percent of low wage workers were even offered coverage by their employers in 1996, compared to ninety-three percent of higher wage workers.

source of affordable coverage, it is likely that many will remain uninsured, as the welfare transition statistics presented in the previous section suggest.



The reform process also has grown for persons with disabilities. Legislation enacted in 1999 further extends existing provisions of law that permit states to provide Medicaid to persons with severe disabilities who, if they were to return to work, would risk the loss of coverage or who, in the absence of Medicaid coverage, would be unable to work.<sup>176</sup> These expanded benefits assist workers with disabilities in two ways. First, because of the potential impact on insurance costs, employers might resist hiring individuals with disabilities or else may impose long waiting periods for benefits. Second, persons with disabilities who believe that they can work, and wish to do so, nonetheless may fail to pursue employment opportunities in the absence of Medicaid benefit protections. The 1999 reforms create additional incentives to work without fear of major health consequences and remove a possible barrier to employment.

Reforms also have occurred in the context of the organization and administration of Medicaid. Medicaid has been modernized over the past two

*Id.* at fig.5. As equally important, when offered coverage low-wage workers are surprisingly responsive to the offer, suggesting that employment-based health coverage is an extremely high priority. *Id.* at fig. 6.

176. Ticket to Work and Work Incentives Improvement Act of 1999 § 201(a), Pub. L. No. 106-170 (codified as amended in scattered sections of 42 U.S.C. and 26 U.S.C.).

decades in the area of managed care. The Balanced Budget Act of 1997 and its precursor managed care “waiver” program dating back to 1981,<sup>177</sup> permit states to take their programs through the same fundamental type of managed care conversion that employer-sponsored coverage has undergone over the past two decades.<sup>178</sup> It is now possible to establish both basic and specialty mandatory managed care programs for Medicaid beneficiaries, and many state agencies are highly sophisticated purchasers of complex managed care products.<sup>179</sup>

A second reason to invest in the modernization of Medicaid has to do with its amenability to change and the existence of an administrative infrastructure to implement change. Were Congress to initiate entirely new programs to address the problems identified in this article, a completely new infrastructure would have to be put into place, a process that would push the cost of reform up dramatically and add years to the implementation timetable.

The most important reason to modernize Medicaid is that the program is an enormously expensive investment with vast promise but in need of a lot of attention. Most pointedly, if Medicaid’s problems are not addressed, then ultimately one can expect to see greater efforts to bypass Medicaid altogether in an effort to address emerging health issues. This already has happened once, with the 1997 enactment of the State Children’s Health Insurance Plan (SCHIP).<sup>180</sup> The SCHIP program can be operated as either a part of Medicaid or else as a separate block grant program that contains nominal federal standards and virtually no federal beneficiary protections.<sup>181</sup> Even more significantly perhaps, SCHIP is utterly duplicative of Medicaid in its most fundamental respects, thereby underscoring the fact that, rather than being an affirmative addition to the pantheon of federal interventions to emerging public health problems, SCHIP is a “non-Medicaid” law that creates a legal mechanism for bypassing the requirements and safeguards of the Medicaid statute.<sup>182</sup> All the children whom SCHIP makes eligible could already be covered under an expanded Medicaid.<sup>183</sup> The services SCHIP supports are

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177. Social Security Act § 1915(b), 42 U.S.C. § 1396n(b) (1994).

178. *Id.*

179. Sara Rosenbaum, *Approaches to Assuring Quality Health Care Through State Contracts with Managed Care Plans*, in ACCESS TO HEALTH CARE 223, 234 (Marsha Lillie-Blanton et al. eds., 1999).

180. 42 U.S.C. § 1397.

181. Sara Rosenbaum et. al., *The Children’s Hour: The State Children’s Health Insurance Program*, HEALTH AFF., May-June 1998, at 75.

182. The price that states paid for this flexibility was a capped federal financial contribution of \$40 billion over ten years, a price that they presumably might be less willing to pay in the case of the \$100 billion per year Medicaid program.

183. SCHIP makes “targeted low-income” children eligible for assistance. Social Security Act § 2110(b), 42 U.S.C. § 1397jj(a) (Supp. IV 1998). Under freestanding SCHIP programs, these are children who are ineligible for Medicaid and whose family incomes are at or below

federally recognized services under Medicaid. Already there have been calls at the highest levels<sup>184</sup> to continue this path of duplicative health care spending by expanding SCHIP to cover parents.<sup>185</sup> As with the children, parents of low-income children already can be covered under Medicaid.

What explains the enactment of SCHIP? At its core, SCHIP reflects a desire on the part of Congress not to create new entitlement programs.<sup>186</sup> However, the bigger question is why Congress created a new program rather than modify Medicaid for the near poor. The answer lies in the fact that most federal lawmakers, simply refused at the time and under the hurried circumstances in which SCHIP was enacted, to address the deep structural issues that must be dealt with in order to Medicaid to the near-poor. State officials concluded that since the children targeted for assistance were near-poor, their families could afford modest cost-sharing; furthermore, since the program was designed to create a proxy for employer coverage,<sup>187</sup> the benefit package should be more limited than the extensive coverage available to the poorest children under Medicaid. Neither of these options—using modest cost sharing or offering a streamlined benefit package—is possible under the traditional Medicaid program.

Whatever one's view of Medicaid for the poor, these concerns about Medicaid coverage of the near poor are legitimate, yet the issue was never debated. As a result, lawmakers opted for a duplicative new program rather than to rethink certain basic aspects of Medicaid.<sup>188</sup>

Rather than spawning more SCHIP substitutes that not only diminish protections for vulnerable populations but also entail duplicative governmental spending,<sup>189</sup> the wiser course may be to thoughtfully attempt Medicaid

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twice the federal poverty level. Social Security Act § 2110(b), 42 U.S.C. § 1397jj(b) (Supp. IV 1998).

184. President Clinton proposed a SCHIP expansion in the fiscal year 2001 budget and Vice President Gore proposed SCHIP expansions as part of his Presidential campaign.

185. *Id.*

186. SARA ROSENBAUM & COLLEEN SONOSKY, URBAN INSTITUTE, CHILD HEALTH IN A CHANGING POLICY ENVIRONMENT: THE ROLES OF CHILD ADVOCACY ORGANIZATIONS IN ADDRESSING POLICY ISSUES (1999).

187. The SCHIP statute even speaks in terms of “benchmark coverage” which is to be calibrated under SCHIP programs to one of several alternative employer-sponsored benefit plans. Social Security Act § 2103(b), 42 U.S.C. § 1397cc (Supp. IV 1998).

188. Added to the philosophical resistance to Medicaid reform, one of two prime sponsors of SCHIP was Senator Edward Kennedy, who is not a member of the Senate Finance Committee, which has jurisdiction over Medicaid. He thus had limited interest in introducing a bill that his committee (the Senate Labor Committee) could not consider. *See generally* <http://www.senate.gov> (listing all members of the United States Senate Committees).

189. Because each new initiative must be paid for under the Federal Budget Act, the fact that Medicaid already includes these potential expenditures in its budgetary “baseline” does not mean that the Congressional Budget Office would recognize possible Medicaid savings as a cost offset to new outlays under a separate SCHIP program. Thus, Congress effectively paid twice for

restructuring. Rather than letting a nearly two-hundred billion dollar program continue to lurch along under the accumulated burdens of thirty-five years of policy “wear and tear,” there ought to be a real effort at program reform.

The areas that cry out for repair span the entire program, and the list of items that need attention is long. But the essential thing to remember is that while addressing these matters is complicated, Medicaid is a program of demonstrated resilience, and none of the issues raised here is beyond thoughtful attention and reform.

A logical place to start the Medicaid “litany of horrors” is with eligibility. The program’s basic financial eligibility levels are extremely restrictive; furthermore, because they are absolute, they create a steep “cliff” effect and thus represent enormously regressive social policy. In the case of categorically needy persons (virtually all of the expansion groups discussed in this article fall into this classification), the fixed financial standards mean that individuals qualify or do not qualify. With very limited exceptions, there is no income-related premium option under Medicaid, nor are there sufficient flexible cost-sharing options for near-poor families and individuals that would help states maintain some control over program costs. While care must be taken in the design of premiums and cost sharing in order to avoid creating of barriers to coverage of lower income plans,<sup>190</sup> modest premium contributions and cost sharing would appear to be preferable to no coverage at all.

Not only are the financial eligibility levels low in relation to need, but the standards and methodologies used to evaluate income and resources, determine family size, and make other financial adjustments necessary to the determination of financial eligibility are frightfully complex. They create an unnecessarily heavy administrative burden on state and local agencies and above all, on applicants and recipients. Additionally, they vastly increase the potential for erroneous denials and major delays in assistance. Anyone who has spent even a scintilla of time around the Medicaid program probably believes that were administration made simpler, more people could be assisted for roughly the same amount of money.

One logical response might be to permit states to adopt more generous financial eligibility standards for all populations that at the same time permit the use of income related premiums and modest cost sharing in the case of

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SCHIP: once in the new tax revenues that were needed to support the program (in the case of SCHIP, a tobacco tax was used) and once in the form of a Medicaid expenditure baseline that already allowed for these outlays.

190. There is a sizable body of literature on cost-sharing and its effects on the poor that suggests that cost sharing beyond modest levels acts as a strong deterrent to enrollment. Nonetheless, some cost sharing undoubtedly is feasible. SARA ROSENBAUM ET AL., *CHIP HEALTH INSURANCE PREMIUMS AND COST SHARING: LESSONS FROM THE LITERATURE* (1998). See also SARA ROSENBAUM ET AL., *AN ANALYSIS OF IMPLEMENTATION ISSUES RELATING TO CHIP COST SHARING PROVISIONS FOR CERTAIN TARGETED LOW INCOME CHILDREN* (1999).

near-poor individuals and families. Another option would be to allow states to measure eligibility in accordance with simplified methodologies that lend themselves to short applications, a limited amount of personal information, and quick and accurate calculations. Also essential are annual enrollment periods,<sup>191</sup> so that Medicaid coverage is stabilized and the need for frequent eligibility reviews is eliminated.<sup>192</sup> The annual enrollment concept, which was introduced into the statute for children in 1997,<sup>193</sup> is more consistent with the notion of Medicaid as insurance rather than welfare. With simpler methodologies, states could be expected to take far more aggressive steps to design enrollment systems that are accessible in communities and that avoid using welfare offices. Even if welfare offices were to remain responsible for the final “stamp of approval,” their role as the site of application for assistance should be ended.

Beyond the financial eligibility problems lie the categorical eligibility problems. To begin with, there is no federal coverage category for non-disabled working age adults without children, a problem that has plagued states for years. The statute cries out for the addition of an optional coverage category that would recognize adults who are neither elderly, persons with disabilities, or parents. The data on the working uninsured and the reality of limited employer participation in insurance plans when the workforce is predominantly low income more than justify this response.

The bar to categorical eligibility in the case of non-disabled adults is by no means the only problem. Persons with disabilities face serious problems of their own that are increasingly coming to light in the wake of the Supreme Court’s decision in *Olmstead v. L.C.*,<sup>194</sup> which declared the unnecessary institutionalization of persons with disabilities a form of discrimination under the Americans with Disabilities Act.<sup>195</sup> Given the importance of Medicaid in financing long-term care, states naturally have begun to reconsider how their Medicaid programs will need to be amended or revised to promote greater availability of community services. Under existing Medicaid law, states can offer expanded services and benefits using liberalized eligibility standards for institutionalized persons as well as for persons who, but for these services, would require institutional services covered under the state plan.<sup>196</sup> However,

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191. Under federal law, eligibility must be redetermined whenever personal circumstances change, thereby leading many states to adopt short periods of coverage and frequent redetermination cycles. 42 C.F.R. § 435.916(c) (1999).

192. The statute already permits twelve months continuous enrollment in the case of children, an option to which many states have responded. Social Security Act § 1902(e)(12), 42 U.S.C. § 1396a(e)(12) (1994 & Supp. IV 1998).

193. *Id.*

194. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

195. *Id.* at 600.

196. Social Security Act § 1915(c), 42 U.S.C. § 1396n(c) (1994).

this test creates two problems. First, persons with physical disabilities either must go into an institution or be on the verge of doing so before they can qualify for an alternative program.<sup>197</sup> States would have to literally expand their institutional coverage standards in order to qualify more persons for community services, a step that few officials want to take. Second, persons with mental illnesses are completely unaided by this standard, since Medicaid excludes coverage for individuals with mental diseases. As a result, persons with mental illnesses cannot meet a test that requires that they demonstrate that they would reside in a Medicaid covered institution without broader community care.

A possible option would be to allow states to set liberalized eligibility standards for persons with disabilities who reside in communities. Costs could be controlled through the use of case planning and active care management. The elimination of a risk of institutionalization test would not only expand options for aiding persons with physical disabilities but would also make assistance more readily available to those with mental disabilities. Furthermore, this change would appear to be enormously important in light of the *Olmstead* decision, in order to minimize the potential for institutional bias in Medicaid.

Medicaid's extraordinary benefit package creates problems of its own. One of the great strengths of Medicaid is its benefit structure. At the same time, as it is currently configured, the benefit package has major drawbacks for states that engage in large-scale managed care purchasing. Under law, all categorically needy persons are entitled to all benefits with either nominal or no cost sharing. While the scope of the entitlement is vital to the program's mission, it makes managed care purchasing and administration difficult, because it extends so far beyond the scope of conventional managed care products. Consequently, as states have begun to purchase managed care products, it is clear that virtually no vendors sell products as broad as Medicaid coverages either requires or permits. States have pursued a logical tactic of effectively breaking up their state plans into two components: one consisting of the managed care contract and the other consisting of residual benefits that remain directly administered by the state.<sup>198</sup> The result has been a hodgepodge of state managed care agreements that vary enormously in what lies "inside" the agreement and what lies "outside" the scope of the contract and, thus remains a direct responsibility of the state agency.

While it is probably not possible to arrive at a single standard plan and supplemental coverage arrangement under Medicaid that would fit all state

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197. This is the practical import of the statutory test under § 1915(c) of the Social Security Act. 42 U.S.C. § 1396n (1994).

198. SARA ROSENBAUM ET AL., *NEGOTIATING THE NEW HEALTH SYSTEM: A NATIONWIDE STUDY OF MEDICAID MANAGED CARE CONTRACTS* (3d ed. 1999).



needs, it might be possible to devise several different basic and supplemental coverage packages, much like “standard” and “high option” health plans in the private sector. States that wished to contract with managed care vendors could buy a standard package of primary, preventive, acute, and limited long-term services for enrollees, while state agencies, in their insurer roles, would retain direct responsibility for “high option” services (i.e., the remainder of the Medicaid entitlement). Those vendors who can demonstrate added capabilities in the provision and management of persons with long-term health service needs could expand their contracts to include some or all of these residual “high option” services. At the same time, the separation of the Medicaid entitlement into its two basic coverage components (acute and long-term) might help encourage the emergence of a more stable, better priced, national Medicaid market that in turn would yield more products, better pricing techniques (including tiered pricing for special populations), greater ability to develop common data systems, and mechanisms for measuring and achieving quality improvement.

An additional problem that would require statutory restructuring is the issue of aid to low income Medicare beneficiaries. Under federal law, Medicare recipients with low incomes who do not qualify for Medicaid receive premium and cost sharing assistance only.<sup>199</sup> Pending Medicare drug reform proposals would extend additional coverage for prescribed drugs as well.<sup>200</sup> An additional policy option would be to extend to low income Medicare beneficiaries coverage for other necessary services and benefits excluded from Medicare, particularly hearing aids and eyeglasses. If Medicare is not expanded to cover prescribed drugs, then Medicaid coverage extension to all lower income Medicare beneficiaries becomes particularly important.

The problem of managed care pricing puts a spotlight on providers generally. Since Medicaid’s inception, one of its greatest problems has been low participation by private providers, a situation fueled at least in part by low payment levels. While it is not at all clear that better rates would bring a multitude of providers into the program, payment reforms fashioned after those used in Medicare and designed to bring Medicaid payments up to at least Medicare levels might create at least modest program participation incentives, particularly as eligibility expands.

It is also clear that in light of continuing high levels of uninsurance, it is important to address the needs of safety net providers. Federally funded community health centers, public hospitals, and local public health agencies that furnish medical care are facing a huge rise in the number of uninsured

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199. *See supra* text accompanying note 63.

200. THE HENRY J. KAISER FAMILY FOUNDATION, PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: A SIDE-BY-SIDE COMPARISON OF SELECTED PROPOSALS (2000), available at <http://www.kff.org>.

patients they treat. As noted previously, between 1990 and 1997, the proportion of uninsured patients treated at health centers rose at a rate twice that for the non-elderly uninsured population as a whole.<sup>201</sup> While Medicaid typically pays steeply discounted rates to health providers,<sup>202</sup> Medicaid's disproportionate share ("DSH") payment policy for high volume indigent care hospitals and the cost-related payment policy for health centers have at least in theory averted the imposition of such steep discounts in the case of safety net providers which cannot absorb the impact of deeply discounted payments without cutting into other funds intended for care of the uninsured.<sup>203</sup> Unfortunately, neither policy is working well.<sup>204</sup>

In the case of DSH, the current formula is so loose that states can divert much of the DSH funding they receive to hospitals with modest indigent care burdens, leaving highly stressed facilities with only limited aid. In the case of health centers, the cost based payment system is set to sunset in FY 2004<sup>205</sup> and many states have resisted adherence to the policy.<sup>206</sup> Moreover, both health centers and public hospitals actively participate in managed care and, like other providers, have had to provide steep discounts to companies as a condition of network participation. Thus, the combination of these three factors—the rising number of uninsured, the effects of a competitive health system, and only limited relief under Medicaid's special payment rules—have combined to create serious problems for the safety net.<sup>207</sup>

One logical step might be creation of federalized Medicaid payment policies for safety net providers that offset managed care discounts and ensure that revenues meant for the care of the uninsured are not diverted into Medicaid revenue offsets. A federally funded annual payment supplement could be allocated directly to institutions and clinics whose uninsured patient caseloads exceed specified minimum standards. Another option would be to continue, expand, and refine the existing policy of mandatory state payment supplements to safety net institutions, although such an option probably would be the less attractive because of state resistance to federally mandated payment

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201. See *supra* Figure 15.

202. MEDICAID SOURCE BOOK, *supra* note 7, at 20 (reporting that in 1989 Medicaid payments to physicians averaged 73.7% of Medicare payment rates).

203. See *supra* text accompanying notes 89-99. For a comprehensive review of the problems that safety net providers face under Medicaid, see COMM. ON THE CHANGING MARKET, MANAGED CARE, AND THE FUTURE VIABILITY OF SAFETY NET PROVIDERS, INSTITUTE OF MEDICINE, AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED (Marion Ein Lewind & Stuart Altman eds., 2000) [hereinafter INTACT BUT ENDANGERED].

204. *Id.*

205. Social Security Act § 1902(a)(13)(C), 42 U.S.C. § 1396(a) (1994).

206. See, e.g., Letter from National Governor's Association, to Congress (July 2000) (opposing continuation of special payment policies for federally qualified health centers).

207. INTACT BUT ENDANGERED, *supra* note 203, ch. 3. For a synopsis of these findings see the Executive Summary. *Id.* at 1.

levels. The federal government has a history of providing financial support for the provision of health services in underserved communities,<sup>208</sup> a federally administered system of direct payment supplements is consistent with this history and has been recommended by at least one national study.<sup>209</sup>

A final issue that needs to be addressed is the federal/state allocation of financial responsibilities. This issue has been debated in one form or another since Medicaid's enactment. Currently the federal government bears approximately fifty-five percent of the financial responsibility for the program.<sup>210</sup> The issue is whether this level of financial contribution should be increased, either by some percentage, or to a level needed to fully underwrite the cost of one or more aspects of the program. Arguments for expanded federal financial role relate to the question of which part of government—the federal government or state governments—is in the best position to bear the burden of social welfare expenditures (in this case, health care) that rise more rapidly than the general inflation rate. Given the limited ability of state governments to respond to rapid escalations in health costs, the most logical step might be to have the federal government assume responsibility for a significantly higher share of Medicaid program costs, while leaving states with reduced financial exposure but a sufficient investment to continue to play a partnering role in service delivery, program design, and quality improvement. This expanded federal financial role also might encourage states to support those restructuring costs that entail significant outlays.

Beyond the issue of sorting out financial responsibilities, several other matters affect the prospects for resolution of these major Medicaid reform issues. There are three major issues. The first is finding the money and dealing with the federal budget process. The second is addressing the ideological opposition to strengthening and modernizing an entitlement program. The third is opposition to strengthening a direct government benefit program rather than using market solutions such as tax credits for the purchase of private insurance.

The 1974 Budget Act imposes a series of conventions on Congressional deliberations of budgetary matters that fall with particular harshness on general

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208. Examples of this tradition are the health centers program as well as other programs authorized and funded under the Public Health Service Act and Social Security Act, including the Title V Maternal and Child Health Services Block Grant, (Title V of the Social Security Act); the Ryan White Care Act (Title XXIII of the Public Health Service Act); and the National Health Service Corps (Title III of the Public Health Service Act).

209. INTACT BUT ENDANGERED, *supra* note 203.

210. The federal medical assistance percentage may not be less than fifty percent nor higher than eighty-three percent. Social Security Act § 1903(a), 42 U.S.C. § 1396(b) (1994 & Supp. IV 1998).

revenue entitlement programs such as Medicaid.<sup>211</sup> Entitlement spending reforms cannot proceed unless paid for. This means that Congress must, as part of a budget resolution, approve significant new levels of Medicaid spending before debate on the matter can proceed and legislation can be enacted. As of summer 2000, the projected federal surplus over the next ten years exceeded four trillion dollars.<sup>212</sup> However, nearly half that amount would be dedicated to the Social Security system or debt reduction, and calls for tax relief, Medicare drug reform, and other national priorities may leave little money for other activities.<sup>213</sup> It is impossible to say what the ten-year cost of the Medicaid reforms discussed in this article would amount to, but it is evident that the cost could be significant. This is particularly true for reforms aimed at expanding and simplifying eligibility (the managed care-related benefit and safety net reforms probably would carry relatively minor price tags, because the reforms primarily involve restructuring the manner in which existing funds are spent).

The second and third problems—opposition to entitlements and preference for tax solutions—are intertwined. It is clearly the entitlement nature of the program that gives Medicaid its basic stature as “insurance.” The legal entitlement is what permits the Census Bureau to count recipients as “insured,” since the essence of insurance is the ability to enforce individual contractual expectations (or in this case, statutory entitlements). Otherwise the benefits amount to simple largesse.<sup>214</sup>

It is true that with entitlements come enforceable legal expectations (and ultimately lawsuits). But this is no different from the legal expectations that privately insured individuals have. Were one to count all of the insurance lawsuits ever brought, they would probably dwarf those brought under Medicaid. The fact is, if the nation wants to “insure” people, then it needs to give individuals the legal tools they need to secure the services and benefits they are promised.

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211. 2 U.S.C. § 900. For a brief explanation of the Budget Enforcement Act of 1990, which tightened up on entitlement budgeting procedures and its “paygo” requirements (which preclude expansion of direct spending programs such as Medicaid without identified sources of revenue), see <http://www.usbr.gov/laws/bea.html>.

212. Richard W. Stevenson, *Bush Tax Plan: The Debate Takes Shape*, N.Y. TIMES, August 26, 2000, at A1.

213. *Id.*

214. In that vein, we think that it is worth pointing out that it is not at all clear that children enrolled in freestanding SCHIP programs can be counted as insured or simply as recipients of subsidized health care, since as a matter of law the federal SCHIP statute specifies that it creates no individual entitlement. The George Washington University Center for Health Services Research and Policy, which Professor Rosenbaum directs, is currently in the process of examining the legal documents for freestanding state SCHIP programs to determine whether they create enforceable legal rights under state law.

Furthermore, a tax credit is as much an entitlement as Medicaid. Extending tax credits to lower income individuals would create a tax entitlement. In the case of health care, it is not at all clear that tax entitlements are less expensive.<sup>215</sup> Furthermore, using the tax code as a mechanism for achieving better health coverage of lower income families and persons with disabilities creates additional problems. Such an approach would leave beneficiaries without a program administration mechanism and would by definition rely on the market for millions of individuals who, as this article points out, either work for employers that do not participate in the health market or else fall outside of the market. Finally, the issue of Medicaid versus tax credits may also be a distinction without a difference today, since in the case of working age adults and their children, so many states purchase managed care products.

Some may see a problem of private insurance “crowd out”<sup>216</sup> (that is, substituting public benefits for private benefits) in expanding Medicaid to cover greater numbers of working families. This option already exists in Medicaid; the question is whether it should be expanded. Furthermore, whether or not the “crowd-out” phenomenon is real (some research suggests that very little substitution actually occurs), the problem is no less present for tax expansions than is the case for direct expenditure reforms.<sup>217</sup> Moreover, were government to provide the health coverage subsidy for lower income workers, employers that now subsidize coverage might in fact invest savings in greater levels of wages and compensation, a not unwelcome outcome.

Finally, there are those who would object to Medicaid expansion on the ground that it stigmatizes the poor. Despite concerns about the “stigma” of Medicaid, two recent studies suggest that the opposite may be true.<sup>218</sup> When asked about Medicaid, lower income families consistently cite its value and desirability.<sup>219</sup> Moreover, when the real barriers to Medicaid enrollment are explored in detail, at least one study suggests that the true problems lie in how states administer their programs, not how people view themselves for being enrolled in Medicaid.<sup>220</sup>

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215. Jonathan Gruber & Larry Levitt, *Tax Subsidies for Health Insurance: Costs and Benefits*, HEALTH AFF., Jan.-Feb. 2000, at 75.

216. Lara Shore-Sheppard et al., *Medicaid and Crowding Out of Private Insurance: A Re-examination Using Firm Level Data*, 19 J. OF HEALTH ECON. 61 (2000).

217. *Id.*

218. MICHAEL PERRY, ET AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID AND CHILDREN OVERCOMING BARRIERS TO ENROLLMENT: FINDINGS FROM A NATIONAL SURVEY (2000), available at <http://www.kff.org>.

219. *Id.*

220. JENNIFER STUBER ET AL., BEYOND STIGMA: WHAT BARRIERS ACTUALLY AFFECT THE DECISIONS OF LOW INCOME FAMILIES TO ENROLL IN MEDICAID? (2000).

In the end, Medicaid reform is a matter of political consensus and will. The changes set forth in this article are modest in cost next to that which would form the establishment of an entirely new program were to be launched. Each proposed reform is logical in that it builds on existing aspects of the program and could be enacted with relative ease. Given the importance of Medicaid for uninsurable populations and services, it is virtually impossible to conceive of the American health system without the program, unless vast new economic investments and extensive regulation of the private insurance market are adapted. These are most unlikely events. Concerns about entitlement expansion, crowd-out, and government intrusion could just as easily be raised about tax proposals. With respect to the concern about entitlements, there is little that can be done to avoid this problem if the goal of the reform exercise is insurance or its equivalent. Whatever the outcome, it is evident that in the absence of a unified national system, the modernization of Medicaid will be a dominant theme in the next phase of health reform.

