

Health Care Access, Medicaid, and Medicare

GLOSSARY

Categorically needy

People who qualify for Medicaid because their family is eligible to participate in certain public-assistance programs (e.g., Temporary Assistance for Needy Families).

Federal poverty level (FPL)

The minimum annual income required by a family to meet food, shelter, clothing, and other basic needs: in 2002, \$15,020 for a family of three; the figure varies by family size and is calculated by a formula established by the federal government.

Medicaid

The federal/state program that pays for health care services delivered mainly to low-income people, including many elderly, children, and pregnant women who qualify; states also may choose to cover medically needy people.

Medically needy

People who are Medicaid eligible because they have substantial medical costs and their income is too high to qualify them as categorically needy.

BACKGROUND

In regard to health care, “access” refers to the ease with which people can obtain the care they need in a timely fashion. People sometimes do not get care because

- their insurance does not cover certain services, or they do not have insurance at all;
- if they have insurance, high copayments or deductibles may discourage them from seeking necessary care;
- there are few or no providers (e.g., doctors, hospitals, clinics) within convenient distance;
- language or cultural barriers between them and their provider(s) make it hard for them to receive the care they need;
- insurance companies deny their claims; or
- they do not have transportation, cannot get time off from work, or cannot find a babysitter.

Health Care Insurance

Insurance is most often the key factor that determines whether people have access to health care services; without it, many cannot afford care. Those with no or minimum coverage often forgo preventive services or put off getting care until their problems advance and become harder (and more costly) to treat than they would have been otherwise. Many people or their dependents are without coverage because

- their employer does not provide it (employers are the greatest single source of U.S. health insurance, but some find it too expensive to carry for their workers);
- their employer covers them but not their dependents (one way that employers control costs);
- they have declined their employer’s coverage because they cannot afford their share of the premium; or
- they are not working but are ineligible for the public programs that cover some low-income adults and many low-income children (Medicaid and MICHild) or people aged 65 and over, blind, or disabled (Medicare).

In 2000 (at this writing, the latest year for which comparable data are available), one million Michiganians (10 percent of the state population) were without health insurance for the entire calendar year. Nationwide, the figure was 39 million (14 percent). Such factors as age, income, and employment status play a role in determining whether a person has coverage.

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- In Michigan and nationwide, the nonelderly (those aged 0–64) are less frequently covered by health insurance than are the elderly, mainly because Medicare covers virtually everyone aged 65 and older. A plurality of the uninsured population is aged 18–29.
- In general, nonelderly minority populations have a substantially higher uninsured rate than do whites. In Michigan, 10 percent of nonelderly whites, 14 percent of nonelderly blacks, and 32 percent of nonelderly Hispanics are uninsured. Nationally, the figures are 11 percent, 20 percent, and 34 percent, respectively.
- Despite Medicaid, 36 percent of the nation’s nonelderly poor—those with income below the federal poverty level (FPL) (in 2000, the year in which these figures were compiled, the FPL was \$13,853 for a family of three)—are uninsured. In Michigan, the number is 29 percent. Sixty percent of Michigan’s uninsured (and 64 percent of the nation’s) live in households with income below 200 percent of the FPL.
- People living in working households comprise more than 70 percent of the country’s uninsured population.
- In Michigan, health insurance is offered by 98 percent of businesses with 50 or more employees and 57 percent of businesses with fewer.

Medicare

The federal program that pays for many health care and related services for people aged 65 and older or those who are blind and/or have long-term disability. Part A (hospital insurance) is funded entirely by the government; Part B (medical insurance) must be paid for in part by the recipient.

Temporary Assistance for Needy Families (TANF)

A federal block grant; in Michigan it funds the Family Independence Program (FIP) as well as child care, transportation, and other services for people receiving public assistance.

In 2000, 68 percent of Michiganians (64 percent of Americans) were covered by private insurance either offered by their employer or union or individually purchased. Twenty-one percent (22 percent nationwide) were covered by government-sponsored health insurance, such as Medicare, Medicaid, or a military health plan.

Provider Availability

Another critical factor in accessing health care is provider availability. A person living in a rural area may have excellent insurance, but if the nearest provider is an hour’s drive away, his/her access to care suffers limits.

In 2000, according to the *Primary Health Care Profile of Michigan* (Michigan Primary Care Association), one-third of the Michigan population lived in a county with an extreme shortage of primary care physicians. In general, the population-to-physician ratio in these counties is at least 3,500:1. A ratio of 1,500:1 is the national standard.

Government Health Care Coverage

The nation’s Medicare and Medicaid programs (titles XVIII and XIX, respectively, of the Social Security Act) were implemented in 1966. Medicare (a federal program) and Medicaid (a federal/state program) are intended to ensure that certain vulnerable populations have health care coverage. Today, Medicare targets mainly the elderly, and Medicaid targets mainly the poor. Over time, the two programs have become much more expensive than originally envisioned.

- From 1970 to 2000, total federal Medicare expenditures grew from \$8 billion to \$224 billion.
- From 1970 to 2000, total state and federal Medicaid expenditures grew from \$5 billion to \$203 billion.
- By 2000 Medicare accounted for 17 percent of the nation’s total health care costs, which had reached \$1.3 trillion (more than 13 percent of the gross domestic product); Medicaid (including state and federal spending) accounted for 16 percent of total health care costs.

The two programs also have become much more expansive: Since first initiated, both have undergone substantial change in regard to the people they help and the health care services they cover.

Medicare

In Medicare's first year, there were just over 19 million enrolled; by 2001—despite no major Medicare eligibility expansion since the 1970s—the number had more than doubled, to 39 million. About 87 percent of the program's enrollees are elderly (aged 65 and older); the remainder are blind or disabled. In Michigan, approximately 1.4 million people are eligible for Medicare benefits.

Today Medicare provides beneficiaries with two types of coverage: hospital insurance (Part A) and medical insurance (Part B).

- Medicare Part A reimburses participating providers for care rendered; coverage includes inpatient hospital services, care for a limited time in a skilled nursing facility, home health services, and hospice care. Part A is financed by the Medicare Trust Fund, which is funded by a 2.9 percent payroll tax that is split between employer and employee.
- Medicare Part B coverage is optional, and, to obtain it, recipients must pay a monthly premium (\$54 in 2002), which accounts for one-quarter of Part B funding; the rest is paid for by general tax revenue. Almost all people entitled to Part A choose also to enroll in Part B, which covers the following:
 - Physician services (in both hospital and nonhospital settings)
 - Clinical laboratory tests
 - Durable medical equipment
 - Flu vaccinations
 - Drugs that cannot be self-administered (except certain anti-cancer drugs)
 - Most medical supplies
 - Diagnostic tests
 - Ambulance services
 - Hospital outpatient and ambulatory surgical-center services
 - Some cancer screening and bone-mass measurement

- Some physical therapy
- Blood products not covered by Part A

Medicare does not cover routine physical examinations, most dental care and dentures, outpatient prescription drugs (except certain self-administered anti-cancer drugs), routine eye care and eyeglasses, hearing aids, and certain other services. (Some of these services may be covered under Medicare+Choice, through which qualified health maintenance organizations cover Medicare beneficiaries.) Medicare covers only 100 days of skilled nursing home care.

Medicaid and MIChild

Medicaid is a state/federal cost-shared program that provides medical assistance for certain individuals and families with low income and limited assets. The federal government has established certain parameters within which each state may establish its own eligibility standards, determine the type/amount/duration/scope of services, set payment levels for services, and administer the program.

Medicaid does not provide medical assistance for all poor people—only for designated groups (categories). Although there are only two eligible populations—the categorically and medically needy—the categories have been expanded numerous times.

Categorically Needy

Originally, this category included only families receiving cash assistance through Aid for Families with Dependent Children (AFDC) and aged, blind, and disabled people receiving Supplemental Security Income benefits. In 1997 AFDC was incorporated on the national level into Temporary Assistance for Needy Families (TANF), a federal block grant that funds Michigan's Family Independence Program (FIP), child care, transportation, and other services for people receiving public assistance. Over the years, "categorically needy" has been expanded to include

- infants, children, and pregnant women in lower-income families;
- low-income elderly and disabled persons; and
- individuals eligible for transitional Medicaid (provided for 12 months to beneficiaries who get a job or a better job and, because of the income increase, become ineligible for Medicaid).

Within the categorically needy population, there are many for whom states *must* provide Medicaid services and others for whom the state may *choose* to provide services; most states choose to extend Medicaid services to their

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most vulnerable populations who meet certain asset and income levels.

Medically Needy

States may choose, as Michigan has done, to establish programs for this category of people—those who have substantial medical costs but their income is too high for them to be eligible for Medicaid. Such people are eligible for assistance if their medical costs consume enough of their income/assets to bring the latter down to a level at which they meet Medicaid eligibility requirements.

Scope of Services

Medicaid services have expanded over time. When the Michigan Medicaid program was implemented, in 1966, it was to cover services “of a curative, not a preventive, nature,” and routine medical examinations and immunizations were excluded. Today, the program’s focus is different: For example, the Early and Periodic Screening Diagnosis and Treatment program (EPSDT) places a strong emphasis on immunization and preventing diseases among children.

Originally, the federal government required states to cover only five Medicaid services. Since 1966 the list has expanded substantially and now includes the following:

- Inpatient and outpatient hospital services
- Services provided at rural health clinics and federally qualified health centers
- Laboratory and x-ray services
- Nursing home services
- Physicians’ services, including medical and surgical services provided by a dentist
- Services provided by a nurse midwife, certified pediatric nurse, and certified family nurse practitioner
- Home health services
- EPSDT for youth under age 21
- Family-planning services and supplies
- Necessary medical transportation

Michigan’s Medicaid program also covers numerous optional services (for some, the state may require recipients to make a copayment), including the following:

- Prescribed drugs
- Clinic services
- Dental services and dentures

- Physical, occupational, and speech therapy
- Podiatry, optometry, and chiropractic services
- Hospice care
- Inpatient psychiatric services for people aged 21–65 and intermediate-care-facility services for persons with mental retardation
- Eyeglasses, hearing aids, and prosthetic devices

Eligible Populations

Currently, Michigan’s Medicaid program serves numerous eligible populations that fall roughly into the following categories:

- Family Independence Program participants
- Supplemental Security Income recipients
- Infants and pregnant women in families who have annual income under 185 percent of the poverty level
- Children older than one year but younger than 18 in families with income below 150 percent of the FPL
- Elderly and disabled persons with income below the poverty level
- Former FIP recipients whose cases were closed due to employment but who do not have health insurance (this is referred to as the transitional Medicaid population)
- Medically needy

In Michigan approximately 1.2 million people are enrolled in Medicaid. In 2001 the state’s total spending (including state and federal funds) on Medicaid totaled \$7.9 billion, including about \$3.5 billion in state funds. Of the people who receive Medicaid services in Michigan,

- 42 percent are children,
- 31 percent are low-income adults,
- 20 percent are blind or disabled, and
- 7 percent are elderly.

Although more than 40 percent of Michigan’s Medicaid population are children, nearly three-quarters of the program’s spending goes to the elderly, disabled, and blind.

- 13 percent of Medicaid spending is for children (averaging \$907/child/year),
- 13 percent is for low-income adults (\$1,242),
- 50 percent is for persons who are blind or disabled (\$7,113), and

- 24 percent is for the elderly (\$9,615).

Nationwide, only 10 million people were enrolled in the program in 1960; now more than 41 million are served. Nationally, in 2000, Medicaid financed health care for approximately

- 21 million children,
- 9 million adults in low-income families,
- 7 million people who are blind and disabled, and
- 4 million elderly.

Almost 14 percent of the American population is eligible to receive Medicaid benefits—up more than 35 percent from 1990.

MiChild

In 1997 Congress enacted the State Children's Health Insurance Program (SCHIP) to supplement existing Medicaid coverage of low-income children. Michigan's SCHIP program is called MiChild, and coverage is almost identical to Medicaid. As is the case in other states, Michigan receives a greater percentage of its funding for MiChild from the federal government than it does for Medicaid.

MiChild covers children (1) aged under one living in a household with income of 185–200 percent of the FPL and (2) aged 1–18 in a household with income of 150–200 percent of the FPL. MiChild enrollment was 26,331 as of February 2002.

DISCUSSION

For the large majority of people, health insurance—provided through an employer or government plan—covers a large portion of their health care costs. If the plan does not pay the entire bill, the individual must pay the balance out-of-pocket. For many, the out-of-pocket portion imposes a manageable burden, but for others it can be considerable. Those without health insurance must pay for all treatment out-of-pocket, and this can mean financial ruin. If a person simply is unable to pay his/her health care bill, s/he either must forgo treatment, or the provider(s) must absorb much—and sometimes all—of the expense (this means higher health care bills and restricted access for others).

Federal law requires providers to render emergency care to everyone who needs it, regardless of ability to pay, but it does not require providers to give preventive care (e.g., regular checkups) to those who cannot pay.

Proponents of the current U.S. health care delivery system contend that it ensures that virtually everyone has access to medical services: Most families have private coverage; millions of elderly, disabled, and low-income Americans are covered by Medicare, Medicaid, and other government programs; and the uninsured are able to receive critically needed care on a charity basis.

Critics argue that the system, as good as it is, has serious flaws. They point out, for example, that people can amass ruinous health care bills even if they are insured, because a plan may not cover or may cover only part of needed services. Critics also believe that the system reduces health care to a commodity that is provided as charity to the poor but enjoyed at will by the more affluent. They contend that access to basic health care is a privilege that should be equally available to all.

Some policymakers favor a universal (covers everyone) delivery system that would ensure at least certain health care benefits for everyone, regardless of employment status or income. A universal plan receives most support from those who believe that access to basic health care is a right; they argue that it is government's responsibility to guarantee people's rights, and, therefore, it should make sure that health care coverage is provided for all citizens. Opponents argue that the law already ensures people's access to care by requiring providers to render emergency service. They maintain that it should not be government's responsibility to guarantee health care. If it were, the government would have to tax heavily and limit its provision of numerous other non-health (e.g., education, defense, foreign aid) services.

Although most Americans are satisfied with the current care delivery system, many also believe that it needs substantial repair. Rather than revamp the entire system, policymakers are focusing on reforms that will extend health care access, either in the form of coverage or in coverage of more benefits (e.g., prescription drugs). The following summarizes the major national and state policy initiatives to improve access to care.

Tax Incentives to Purchase Health Insurance

State and federal legislation has been proposed to give employers and individuals tax incentives to purchase health insurance. The most prominent of these initiatives currently is the president's FY 2002–03 budget proposal to offer \$89 billion in tax credits to individuals not covered by employer-sponsored insurance: Families with two or more children and annual household income under \$25,000 could obtain up to \$3,000 in tax credits for health insurance costs.

Proponents of such tax breaks for *individuals* point out that businesses are allowed to deduct all costs in providing health insurance to their employees, and they argue that workers also should be permitted deductions. They contend that tax breaks will encourage more people to buy into health insurance plans and also provide relief to insureds who incur substantial medical expenses despite their coverage.

Those who support additional *employer* tax breaks (that is, tax credits and not just tax deductions) argue that many firms do not offer health insurance to their workers, and they should be encouraged as much as possible to offer at least basic coverage.

Others contend that tax breaks alone are insufficient to encourage people to buy health coverage themselves or employers to purchase it for them: Even with the proposed deductions and credits, individuals and employers still must assume a great majority of the cost themselves.

“One-Third Share” and Other County Programs

Several Michigan counties have stopgap programs that offer some health benefits to the uninsured. These programs usually offer a low-cost alternative, covering fewer benefits, to private and public health insurance. A few offer or are considering “one-third share” plans for uninsured workers and their dependents, under which employers, county and/or state government, and the workers each contribute one-third of the premium for a low-cost policy.

Several other counties have community programs that cover some residents who are ineligible for Medicaid and do not have private insurance. These programs rely on funding from county, state, federal, and sometimes private sources, and they offer limited benefits—inpatient hospital care usually is excluded—to qualified individuals. Unlike the one-third share plans, these programs are not employer based.

In two locations—the City of Detroit and Ingham County—the W.K. Kellogg Foundation has funded Community Voices (CV) projects, expansive efforts to improve residents’ access to health coverage and care. The project brings together residents, neighborhood groups, community-based nonprofit organizations, care providers, public health departments, and others in a coordinated effort that addresses not only coverage but also barriers to access such as provider-availability problems, cultural and ethnic issues, and transportation needs.

Medicaid and Medicare

In America and the states, Medicaid and Medicare have been the primary means by which access to health care

has been extended to a larger share of the population. The most recent significant expansion, SCHIP, for children, is basically a Medicaid expansion even though some states (like Michigan) have chosen to create new programs under the SCHIP banner. As health care costs continue to rise, Medicaid and Medicare struggle to balance cost control and expansion of access. The recent economic downturn and the attendant shortfalls in federal and state budgets have exacerbated this struggle. Policymakers face a difficult question: How do we expand access (or even protect the access that we have now) in the face of budget problems?

The Medicaid and Medicare programs have grown substantially, and federal and state spending for them soon will be unable to keep pace with the demand for services. The Medicare program is in particular jeopardy: In 2000 there were only 34 million American elderly, but by 2025 there will be almost 61 million. Additional utilization and spending because of this population’s growth is expected to push the program’s cost beyond \$500 billion by 2008. Costs will accelerate even more when the babyboomers begin retiring, around 2010.

Current demographic trends portend a considerable problem for Medicaid as well. Although the elderly (aged 65 and over) account for the smallest segment of this program’s population, their care is the most expensive. In Michigan, annual Medicaid services cost \$907 per child but \$9,615 per elderly adult. As the number of elderly who qualify for the program grows, so will the cost.

To address access and cost, state and local policymakers are considering several proposals, the most prominent of which are MIFamily (a Michigan initiative) and an outpatient prescription-drug benefit for Medicare (a federal initiative).

MIFamily Initiative

In his FY 2002–03 budget, the governor proposed MIFamily, a program to cover more low-income people not currently eligible for Medicaid. A federal waiver will be required and, if approved, will allow the state to cover these adults under Medicaid although with fewer benefits than current Medicaid eligibles receive.

Proponents of this Medicaid expansion argue that it will help uninsured adults. Others are wary, contending that the viability of Michigan’s Medicaid program has been in question for years because the state does not pay health plans and providers enough to cover their costs to deliver care. Another Medicaid expansion, they say, will make this situation worse, especially if funded in part by payment cuts to plans and providers. Health plans and pro-

viders further argue that inadequate payments threaten access to care for those who are already on Medicaid, because more doctors and others may decide that they cannot accept Medicaid patients. Defenders of the current Medicaid program counter that the state has controlled Medicaid spending without jeopardizing access. They cite independent quality-review studies in support of their position. In addition, they point out that Michigan has used special financing mechanisms to obtain over \$1 billion in additional federal funds for Medicaid, while other states have to operate without the additional monies.

Medicare Proposals

Balancing access and cost is no less difficult with Medicare. In recent years, there have been proposals to lower the Medicare-eligibility age and allow others—the uninsured and those aged 55–64—to buy into the program with a \$300–400 monthly premium. Others have proposed raising the eligibility age, from 65 to 67, but many believe that the idea failed because it is unpopular with the elderly, who are a powerful lobbying force and tend to vote regularly and in great number.

Rather than raise the eligibility age, Congress has considered requiring the affluent to pay a higher Medicare premium. Opponents argue that people aged 65 and over already paid for their Medicare services through the payroll taxes that fund the program. Supporters argue that those who can afford to pay more out-of-pocket for their health care ought to do so and that the elderly receive much more in benefits than they contributed in payroll taxes.

The Medicare initiative currently receiving the most attention pertains not to extending Medicare to more beneficiaries but to improving current beneficiaries' access to a benefit (outpatient prescription drugs). Before the events of September 11, 2001, and the economic downturn, which reordered federal budget priorities and left less money to fund this expansion, the addition of an outpatient prescription-drug benefit to Medicare seemed likely. Policymakers and advocates agreed that prescriptions are essential to managing many illnesses and conditions; the obstacles were cost and benefit design: Which drugs would Medicare cover and how much in deductibles and copayments would beneficiaries have to pay?

In his FY 2002–03 budget, the president proposed \$190 billion over 10 years to fund a drug benefit, but as yet there are no specifics on how the benefit would be structured. Some critics say this is far too little to be much help. Other critics, including many provider and health plan groups, contend that any expansion of Medicare benefits is likely to come at a cost in access. They fear that funding for a drug benefit will come from payments to

providers for other Medicare services, and this will compromise access.

Access to Providers

Although discussion about public and private health insurance seems to monopolize the access debate, also important to patients is doctor/hospital availability. In some places there is an oversupply, while in many others there is a shortage. The latter is a pressing matter in many communities, but it is difficult to address directly—lawmakers cannot require a hospital to locate in a particular area or force doctors or nurses to practice in one place rather than another.

To address this problem, Michigan and many other states allow doctors and nurses to reduce or eliminate their student-loan burden by agreeing to practice for a given number of years in a rural community or underserved inner city, and many patient advocates are encouraging funding for clinics that serve as hospital outposts in such locations. With the nursing shortage worsening in Michigan and across the nation, policymakers are considering numerous initiatives to attract people to nursing, provide financial assistance for schooling, and help keep nurses in the profession.

Conclusion

Today's policymakers have the unenviable task of maintaining, if not improving, vulnerable populations' access to health care and, at the same time, managing the cost of doing so. This tension pinpoints the tradeoffs involved with access to health care: Given finite funding for government programs, policymakers must balance (1) the number and kind of people covered (recognizing that some need more services than others), (2) the services/benefits covered, and (3) the payments to health plans and providers for delivering the covered benefits. Any increase or decrease in any of these factors affects spending on behalf of and access for some people. Any significant decrease in any of these will severely compromise access for many people. As a state or a country, we could choose to provide everyone with public or private health insurance, but to do so would mean that we would have to offer fewer benefits or pay providers less for the services we use.

The only way to avoid trading off among these three factors is for policymakers to expand significantly the funding for health care, which, given other priorities—e.g., education, defense, corrections—is no simple task. The biggest question for state and federal officials is whether (1) the responsibility for access to health care should continue to be government's, or (2) a greater share should be assumed by the private sector—employers and individuals.

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See also Aging; Health Care Costs and Managed Care; Immigrants: Human Services Benefits; Long-Term and Related Care; Mental Health Funding and Services; Substance Abuse; Tobacco Settlement; Youth at Risk.

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