Medicare and Medicaid

BACKGROUND

The nation's Medicare and Medicaid programs (titles XVIII and XIX, respectively, of the Social Security Act) were created in 1965 as part of the so-called Great Society legislation. The programs were enacted at the same time that comprehensive private health insurance coverage was becoming available to most of the nation's population. Congress enacted Medicare (a federal program) and Medicaid (a state and federal program) to ensure that certain vulnerable populations had access to health care coverage. Today, Medicare targets mainly the elderly, and Medicaid targets mainly the poor.

Over time, the two initiatives have become much more expensive than originally envisioned.

- From 1970 to 1996, total federal expenditures for Medicare grew from $8 billion to $203 billion.
- From 1970 to 1996, total state and federal expenditures for Medicaid grew from something over $5 billion to almost $148 billion.
- By 1996 Medicare alone accounted for almost 20 percent of total health care costs, which had reached $1 trillion (more than 14 percent of the gross domestic product); Medicaid (including state and federal spending) accounted for more than 14 percent of total health care costs.

The two initiatives 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

As originally enacted, a person's eligibility for Medicare was determined by his/her eligibility for Supplemental Security Income (SSI). In 1966 this meant that a person had to

- be a U.S. citizen,
- meet certain asset and income requirements,
- be aged 65 or older, and
- in many cases, have paid a certain amount in payroll taxes (into the Social Security Trust Fund).

As eligibility requirements for SSI expanded, so did those for Medicare. In the 1970s Congress extended access to the program to those who

GLOSSARY

Aid to Families with Dependent Children (AFDC)
A state/federal initiative that provides cash assistance to impoverished families. Nationally, AFDC has been incorporated with Supplemental Security Income into a single program known as Temporary Assistance for Needy Families. In Michigan, AFDC now is the Family Independence Program.

Benefit period
Starts when a Medicare beneficiary first enters a health care facility and ends when there has been a 60-day break in care.

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

Dual eligible
A person eligible for both Medicare and Medicaid services.

Federal poverty level (or guideline)
The minimum annual income required by a family to meet food, shelter, clothing, and other basic needs: in 1998, $13,650 for a family of three (varies by family size); set according to formula by the federal government.

Fee-for-service
A health care payment system in which patients obtain care at the facility or from the provider of their choice, and their health plan pays a fee each time a service is used.

Managed care
A broad term for any comprehensive approach to health care delivery that (1) coordinates patient care and (2) routinely monitors and measures the health provider's performance; capitated managed care *entails a fixed monthly amount per beneficiary being paid to the health insurance carrier or provider.*

- are blind and/or severely disabled, and
- suffer from end-stage renal disease.

In Medicare's first year, there were just over 19 million enrolled; by 1997—despite there not having been a major Medicare eligibility expansion since the 1970s—the number had doubled, to 38 million. About 87 percent of the program's enrollees are elderly (aged 65 or older); the remainder are blind or disabled. In Michigan, approximately 1.3 million people are eligible for Medicare benefits.

Today, for its beneficiaries, Medicare provides two types of health care coverage: hospital insurance (Part A) and medical insurance (Part B).

- Medicare Part A is provided automatically to qualified people aged 65 and over and to most who are severely disabled and entitled to SSI benefits. It reimburses participating institutional providers for care rendered; coverage includes inpatient hospital services, care given in skilled nursing facilities, 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 benefits also are available to almost all citizens aged 65 and over, certain aliens aged 65 and over (even those not entitled to SSI benefits), and blind or disabled people entitled to Part A. Part B coverage is optional and to obtain it, recipients must pay a monthly premium, which accounts for one-third of Part B funding; the rest is paid for by general tax revenue. Almost all people entitled to Part A choose to enroll in Part B, which covers
  - physician services (in both hospital and nonhospital settings),
  - clinical laboratory tests,
  - durable medical equipment,
  - flu vaccinations,
  - drugs that cannot be self-administered (except certain anticancer drugs),
  - most medical supplies,
  - diagnostic tests,
  - ambulance services,
  - hospital outpatient and ambulatory surgical center services,
  - some therapy, and
  - blood products not covered by Medicare Part A.

Medicare generally will not cover any service unless it is medically necessary, nor does it cover dentures, dental care, prescription drugs (except certain self-administered anti-cancer drugs), eyeglasses, hearing aids, and certain other services (some of these services may be covered under certain managed-care arrangements).

Medicaid

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

Medicaid
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 necessary
Needed to save or protect a patient's life or health.

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

Medicare
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 provided entirely by the government; Part B (medical insurance) must be paid for in part by the recipient.

Provider-sponsored organization (PSO)
An affiliation of health care providers that contracts with purchasers (including employers and government agencies) to deliver health care services to a specified group of people.

Severe disability
A disability expected to (1) keep a person from doing "substantial" work (earning $500 or more a month) for at least a year or (2) result in death.

Supplemental Security Income (SSI)
A federal assistance program for people aged 65 and older who meet certain asset and income requirements; also assists the blind or extremely visually impaired and those suffering from severe physical or mental disability; SSI has been incorporated (with Aid to Families with Dependent Children) into Temporary Assistance for Needy Families.

Temporary Assistance for Needy Families (TANF)
A federal government program into which the Aid to Families with Dependent Children and Supplemental Security Income programs have been incorporated.

- establish its own eligibility standards,
- determine the type, amount, duration, and 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 and so have the services offered.

Categorically Needy

Originally, "categorically needy" 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 and SSI were incorporated on the national level into a single program—Temporary Assistance for Needy Families (TANF). Over the years, categorically needy has been expanded to include the following:

- Infants, children, and pregnant women in lower-income families
- Low-income elderly and disabled persons
- 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)
- Certain low-income Medicare beneficiaries

Within the categorically needy population, there are many for whom states *must* provide Medicaid services and many for whom the state may *choose* to provide the services; most states choose to extend Medicaid services to their most vulnerable populations who meet certain asset and income levels.

Medically Needy

States may choose, as Michigan has done, also to establish programs for the "medically needy"— people who have substantial medical costs, but their income is too high for them to be eligible for Medicaid. Such people must "spend down" their income until it reaches a level at which they meet Medicaid's income and asset requirements. States that establish a medically needy program must serve children aged under 18 and pregnant women from low-income families.

Services

Medicaid services have expanded over time. When the Michigan Medicaid program was implemented, in 1966, the state indicated that "the medical services are of a curative, not a preventive, nature. Thus, routine medical examinations and immunizations are not covered." Today, the program's focus is different: For example, the Early and Periodic Screening Diagnosis and Treatment program (EPSDT) for children places a strong emphasis on disease prevention and immunization for children.

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

- inpatient and outpatient hospital services,
- services provided at rural health clinic and federally qualified health centers,
- laboratory and x-ray services,
- nursing home services,
- physicians' services, including medical and surgical services provided by a dentist,
- home health services,
- EPSDT for youth under age 21,
- family planning services and supplies,
- necessary medical transportation, and
- services provided by a nurse midwife, certified pediatric nurse, and certified family nurse practitioner.

Michigan's Medicaid program also covers 24 of 33 optional services (for some, the state may require recipients to make a copayment), including

- 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 the mentally retarded, and
- eyeglasses, hearing aids, and prosthetic devices.

Eligible Populations

Currently, Michigan's Medicaid program serves 25 eligible populations, which fall roughly into the following seven categories:

- Family Independence Program (FIP) participants (Michigan's name for its AFDC program)
- SSI recipients
- Infants and pregnant women in families who have annual income under 185 percent of the federal poverty level (the 1998 FPL for a family of three is $13,650)
- Children older than one year but younger than 16 in families with income below 150 percent of the FPL
- Elderly and disabled persons with income below the FPL
- Former FIP recipients whose cases were closed due to employment but do not have health insurance coverage (this is referred to as the transitional Medicaid population)
- Medically needy

In Michigan approximately 1.1 million people are eligible to receive Medicaid. In 1997 the state's total spending (including state and federal funds) on the Medicaid program totaled almost $5 billion, including about $1.3 billion in state general funds. Of the people who receive Medicaid services in Michigan,

- 46 percent are children,
- 25 percent are low-income adults,
- 21 percent are blind or disabled, and
- 8 percent are elderly.

Although almost half of Michigan's Medicaid population are children, three-quarters of the program's spending goes to the elderly, disabled, and blind. Of total spending,

- 50 percent goes to the blind and disabled;
- 25 percent to the elderly;
- 13 percent to children; and
- 12 percent to adults.

Nationwide, only 10 million people were enrolled in the program in 1960; now more than 38 million are served, nearly four times as many as in the beginning. Nationally, in 1997, Medicaid financed care for approximately

- 18 million children,
- 8 million adults in low-income families,
- almost 7 million people who are blind and disabled,
- almost 5 million elderly, and
- others.

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

DISCUSSION

Since their inception, the Medicare and Medicaid programs have grown substantially.

- From 1970 to 1996, total federal Medicare spending rose nearly 24-fold.
- From 1970 to 1996, total federal and state Medicaid spending rose nearly 29-fold.
- From 1966 to 1997, Medicare enrollees increased by 100 percent.
- From 1966 to 1997, Medicaid enrollees increased by 280 percent.

Very soon, federal and state spending on these programs will not able to keep pace with the demand for their services. The Medicare program is in particular jeopardy: In 1995 there were only 34 million

American elderly, but by 2025 the number is projected at almost 61 million—a 79 percent increase. Additional utilization and spending because of this population's growth is expected to push the program's cost beyond $447 billion by 2008. Although the Medicare-spending growth rate has subsided somewhat in recent years, policymakers expect it to increase in the future. In fact, Congress estimates that Medicare will become bankrupt by 2010, just as the first wave of babyboomers begins retiring.

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, Medicaid services cost about only about $790 per child but $9,400 per elderly adult. As the number of elderly who qualify for the program grows, so will the cost.

To address Medicare and Medicaid's financial future, policymakers are debating changes in the way in which health care services are delivered to beneficiaries. Managed care is seen as a way to substantially reduce costs. Federal officials are addressing Medicare costs also by considering changes to eligibility standards and requiring recipients to pay more for the care.

Managed Care

One way that the federal government and the states hope to save Medicare and Medicaid dollars is by switching from fee-for-service to managed care. Managed care is an approach to health care that (1) coordinates patient care so as to ensure that services are appropriately utilized (that is, care is not unnecessarily rendered), and (2) routinely monitors and measures provider performance so as to control cost and maintain or improve the quality of care.

Medicare

Today only 13 percent of the entire Medicare population receives health care through a managed-care system, but this soon will change. In 1997 Congress voted to extend this option to Medicare recipients. The federal plan allows managed-care organizations other than health maintenance organizations (HMOs)—for example, provider-sponsored organizations—to compete to give care to Medicare beneficiaries. The plan, known as Medicare+Choice, also establishes payment incentives that will encourage MCOs to provide services in rural areas, which usually are considered a less lucrative market than others. The federal government will begin a marketing campaign to encourage (but not require) senior citizens to enroll in MCOs.

Medicaid

Michigan is one of many states that to reduce program costs and improve health care access and quality has adopted a *mandatory* Medicaid managed-care strategy. In 1997 several HMOs and clinic plans were selected through a competitive bid process to begin providing comprehensive, capitated managed-care services to recipients in five southeast Michigan counties; officials expect to have statewide managed care in place by mid-1998. Under the plan, enrollment in a managed-care organization (either an HMO or other preferred-provider arrangement) will be mandatory for all but a few Medicaid recipients for whom the state is devising separate managed-care plans. (Excepted from the mandatory managed care requirements will be those needing mental health and substance abuse services, those needing long-term care, and children with special health care needs.) Michigan officials expect total Medicaid managed-care savings to reach nearly $120 million.

Although Michigan officials are confident that the Medicaid managed-care initiative will be a great success, many observers are concerned about some of its potential effects. Opponents of the program fear that consumers will have to leave their regular physician to select one who has agreed to participate in a managed-care plan, and this affects continuity of care. Others worry that because capitation limits the amount that carriers are paid to cover health care services, some managed-care organizations, to save money, may deny Medicaid managed-care enrollees medical services they need or limit their access to them.

Other Changes

Managed care is not the only answer to Medicare and Medicaid's future financial concerns; other op-

tions are to limit program eligibility and require beneficiaries to contribute more out of pocket.

Medicare

As Congress considered whether to expand Medicare managed care, many lawmakers argued that a more economical course would be to raise the age—from 65 to 67—at which a person becomes eligible to receive benefits. Although the Senate approved the initiative, the House defeated it. Many believe that the idea failed because it is unpopular with the elderly (a national poll conducted before the vote on the issue showed 65 percent of Americans opposed to it), who tend to vote more regularly and in greater number than younger people.

Rather than raise the eligibility age, Congress considered requiring the affluent to pay a higher Medicare premium. Although this option was not adopted, its supporters argued that those who can afford to pay more out of pocket for their health care ought to be required to do so. Opponents argued that people who are aged 65 and over already have paid for their Medicare services: For years they paid payroll taxes that fund the program. Others contend that the elderly receive much more in benefits than they contributed in payroll taxes.

In their effort to control Medicare spending, policymakers also have adopted policies to

- restrain the growth in Medicare payments to providers,
- impose fees on physicians who violate certain Medicare standards, and
- eliminate spending fraud and abuse.

These, combined with the federal government's recently adopted managed-care initiatives, are expected to save $115 billion over five years. Despite this, Congress estimates that Medicare faces bankruptcy as early as 2010.

Despite Medicare's financial difficulties, President Clinton met lawmakers' proposal to raise the Medicare eligibility age with a proposal to lower it. Under the president's plan, able-bodied adults aged 55–64 could buy into Medicare with a $300–400 monthly premium. Supporters argue that the extension will pay for itself; detractors contend that it will not.

Medicaid

Most states, including Michigan, are deferring a decision on narrowing Medicaid eligibility limits or requiring additional patient out-of-pocket contributions until the results are in on the managed-care initiatives.

Michigan policymakers, however, dealt with a new Medicaid question: How should health care services be extended to uninsured children? In 1997 Congress appropriated $24 billion to help states to do just that, and of this money, the State of Michigan will receive $467 million over five years. (This is a textbook example of "devolution," the shift from a higher to a lower level of government the responsibility for decision-making in regard to government services.) The states are permitted to (1) expand their existing Medicaid program or (2) create an entirely new children's health care program; Michigan lawmakers opted for a combined approach.

Originally, the Michigan Department of Community Health (MDCH) proposed a new health insurance program for uninsured children who (1) are aged under 19, (2) live in a family having income at or below 200 percent of the federal poverty level, and (3) are ineligible for any other health insurance program, including Medicaid.

Although legislators, children's advocates, and others agreed that coverage should be extended to this uninsured population, many disagreed with the decision to create a new, state-run health plan. Opponents of the MDCH initiative argued instead for expanding Medicaid, contending that this would avoid having to allocate limited state and federal resources to developing a *separate*

- health care benefits package for children;
- health care provider network to deliver those benefits; and

- administrative system, including information technology, to monitor the results of the program and coordinate children's health care.

After much debate, legislators adopted and the governor signed a plan (Public Act 54 of 1998) that supersedes the MDCH proposal. It both expands Medicaid *and* creates a new program: Uninsured children in families with income under 150 percent of FPL will become eligible for Medicaid, while children in families with income of 150–200 percent of FPL shall obtain coverage through the new plan, called *MIChild*. NOTE: Many people may refer to both the Medicaid expansion and the new program as the MIChild initiative.

Opponents of the combined approach argue that it will be difficult to administer, but supporters contend that provisions in the plan allowing families to apply simultaneously for the new program and Medicaid will save them from having to apply for Medicaid, then, if denied, go though another application process for MIChild, or vice versa.

Conclusion

Those who created Medicare and Medicaid could not have envisioned the programs' present cost and scope. Today's policymakers have the unenviable legacy of having to maintain, if not improve, vulnerable populations' access to health care, while at the same time manage the cost of doing so. The biggest question for state and federal officials, however, is whether the responsibility should continue to be government's or whether a greater share should be assumed by the private sector—employers and individuals.

See also Child and Family Services; Devolution; Early Childhood Development; Health Care Access; Health Care Costs and Managed Care; Long-Term and Related Care; Substance Abuse.

FOR ADDITIONAL INFORMATION

American Association of Retired Persons
309 North Washington Square, Suite 110
Lansing, MI 48933
(517) 482-2772
(517) 482-2794 FAX
www.aarp.org

Families USA
1334 G Street, N.W.
Washington, DC 20005
(202) 628-3030
(202) 347-2417 FAX
www.familiesusa.org

Family Independence Agency
235 South Grand Avenue
P.O. Box 30037
Lansing, MI 48909
(517) 373-2000
(517) 335-6101 FAX
www.mfia.state.mi.us

Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244
(410)786-3000
(410)786-3252 FAX
www.hcfa.gov

Medical Services Administration
Michigan Department of Community Health
400 South Pine Street
P.O. Box 30479
Lansing, MI 48909
(517)335-5501
(517) 335-5007 FAX
www.mdch.state.mi.us/MDCH2/index_j.htm

Medicare/Medicaid Assistance Program
6105 West St. Joseph Street, Suite 209
Lansing, MI 48917
(517) 886-0899
(517) 886-1305 FAX

Michigan Council for Maternal and Child Health
318 West Ottawa Street
Lansing, MI 48933
(517) 482-5807
(517) 482-9242 FAX

Michigan League for Human Services
300 North Washington Square, Suite 401
Lansing, MI 48933
(517) 487-5436
(517) 371-4546 FAX