

# Attending to Medicaid

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*[P]layers line up in a long line and hold hands. The player at the front of the line is the 'head' and the player at the end of the line is the 'tail'....The game begins when the head begins to run wildly in any direction, making sharp turns and quick double-backs....The force created by the twists and turns will often send the tail of the whip flying....It may be best for the tail to hold on with both hands to keep from flying off the end. Sometimes, however, the tail will go flying no matter how hard they hold on...Be prepared to get dirty if you play this game!*

—"Crack the Whip," *Party Game Central*<sup>1</sup>

If the evolution of American health policy (in both its purposeful and its accidental forms) is compared to the children's game of Crack the Whip,<sup>2</sup> then there is no question that the Medicaid program is the tail of the line. When those at the head of the line (e.g., employer-based insurance, Medicare, managed care plans, and pharmaceutical companies) start to move, Medicaid receives whatever shocks and unintended consequences result, and when the line "begins to run wildly in any direction," it receives them faster and harder than the players at the center.

Shocks also come from other sources. When the economy slumps, an epidemic arises, or a path in another part of the system becomes a cul-de-sac, new twists and turns occur, with Medicaid absorbing much of the change.

Given all this activity and change, Medicaid has filled its various roles well. Medicaid works – not only for its original beneficiaries but also for almost every group, purpose, and problem with which it has been charged over the years. Despite some creaks and considerable stress, it has proven surprisingly resilient and even supple as the line has gone flying.

But as we discuss and plan the next round of health reform (be it tax-based, employer-based, or public; be it incremental or systemic), we should do so with Medicaid in mind. Medicaid deserves more attention and intention. Rather than leaving it as an afterthought at the tail, we should plan affirmatively for Medicaid improvements so that Medicaid is stronger and more able to absorb the shocks and do its job. To the extent possible, we should work to ensure that Medicaid fits the system and the system fits Medicaid. Doing so will improve the strength of the whole line and make it less likely that any part will fly off the end.

This paper is organized into three parts. The first is a discussion of the current role of Medicaid. The second is a brief description and history of the evolution of the program. Finally, the paper concludes with a discussion of Medicaid's likely role in a reformed system, and with proposals that address some of the tensions in the present system as well as the need to expand and simplify Medicaid in order to cover more of the uninsured. Each of these sections is necessarily brief, building upon more extensive writings by others.<sup>3</sup> Together, they underscore the extent to which Medicaid is intertwined with other parts of the health care system and how important it will be – not just for Medicaid, but for the entire system – to give Medicaid due consideration as system-wide reform moves forward.

## The Current Role of Medicaid: Where Are We Now?

Medicaid is now the largest single insurer in the United States in terms of the number of beneficiaries enrolled and dollars spent. It

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covers more than fifty million people (while Medicare covers forty-one million),<sup>4</sup> and total (state and federal) expenditures are projected to reach \$305 billion in 2004 (in contrast to \$278 billion for Medicare).<sup>5</sup> Medicaid accounts for seventeen percent of all U.S. health expenditures.<sup>6</sup>

Medicaid is also the most heterogeneous insurance program in the country.

- Its beneficiaries are extraordinarily diverse: It is the largest insurer of children<sup>7</sup> and of people with disabilities,<sup>8</sup> and also includes a large number of elderly people.<sup>9</sup>
- Its services are also varied (reflecting the needs of its beneficiaries): It is the largest single provider of maternity care,<sup>10</sup> the largest single purchaser of prescription drugs,<sup>11</sup> and the largest financier of nursing home care.<sup>12</sup>
- Its institutional dependents are wide-ranging: By all reckonings, public hospitals<sup>13</sup> children's hospitals<sup>14</sup> community health centers,<sup>15</sup> and public clinics<sup>16</sup> depend on Medicaid to stay afloat.

Moreover, Medicaid has served as a stopgap for other public programs, picking up beneficiaries here, providing wrap-around benefits there, and filling in holes in other places. For example, the more prominent Medicare program has eligibility limitations (such as the twenty-nine month waiting period for people with disabilities and the minimum number of quarters of work requirement) that keep many disabled and elderly people from qualifying. In addition, those who are enrolled in Medicare have significant gaps in coverage (most notably long-term care and – at least until 2006 and perhaps beyond – prescription drugs). Similar observations might also be made about the limited availability and usefulness of other sources of coverage and health-related services (such as veterans' health benefits, the Ryan White program, the Maternal and Child Health Block Grant, and COBRA continuation benefits). In one way or another, Medicaid fills in some of the gaps in each of these programs.

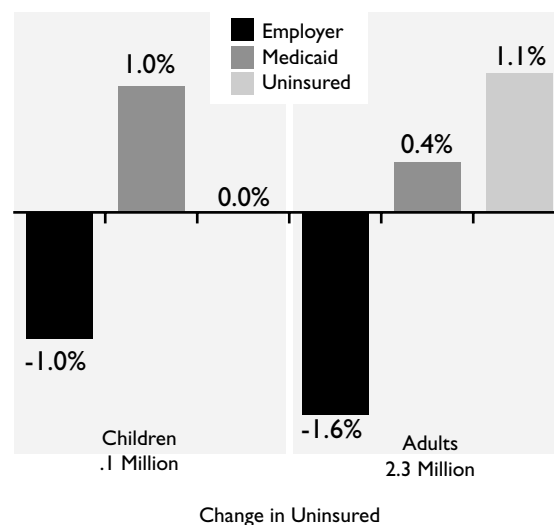
Medicaid is also the health policy tool that has proven most immediately responsive to social change and to newly recognized health and health-systems-delivery problems.<sup>17</sup> It responds in the event of both mass recessions and individual job losses, providing assistance for whole regions in economic downturn as well as to discrete families in transition.<sup>18</sup> It has proven to be the health-finance first-responder to public health problems and even disaster situations.<sup>19</sup>

Medicaid's strength for the populations it serves and the providers who serve them is its entitlement to affordable coverage for a broad range of services. The entitlement is a legal requirement that directs states, as a condition of receiving federal Medicaid funds, to enroll all eligible people who apply.<sup>20</sup> There are many facets of the entitlement – consequences that flow from the simple directive that all eligible people must be enrolled. Most notable, perhaps, is Medicaid's open-ended financing structure, which is tied closely to the entitlement. The longstanding arrangement under Medicaid is that in exchange for taking on the obligation to serve all eligible people, states are guaranteed funding for the federal share of all costs that flow from that obligation. If enrollment rises, so does federal financial participation. It is difficult to imagine how an entitlement program the size of Medicaid could be maintained by the states without the open-ended federal commitment of federal funds and, at the same time, it is difficult to imagine that the federal government would continue to provide open-ended financing to states if states were not obligated to serve all eligible people.

The entitlement also has the effect of keeping the program honest – it ensures coverage to all those who qualify by giving its intended beneficiaries the ability to enforce that promise and to guard against arbitrary (intentional or unintentional) delays or denials of coverage or services. In addition, the entitlement undergirds Medicaid's counter-cyclical role: Medicaid is the only source of health coverage

Figure 1

**Changes in Health Insurance Coverage Rates, Children vs. Adults, 2001-2002 (Percentage Point Differences)**



Source: "Health Insurance Coverage in America: 2002 Data Update," Kaiser Commission on Medicaid and the Uninsured, December 2003.

that expands when the economy contracts. In its 2003 annual release of insurance data, the U.S. Census Bureau identified Medicaid as the major reason why many more people did not become uninsured during the 2001-2002 economic downturn.<sup>21</sup> In that year, Medicaid enrollment growth more than offset the sharp decline in employer-based coverage for children and partially offset those declines for adults. It was the entitlement nature of the program – the legal requirement for states to enroll all those who are eligible and who apply – that allowed (indeed required) the program to expand in response to greater need.

Uninsured people are not the only beneficiaries of the entitlement. Health care providers, particularly those who depend on Medicaid for a large share of their revenues, would suffer serious consequences if Medicaid payments for services could be turned on and off depending on how many people had enrolled that year or the cost of the services provided to those enrollees. No major health insurer – whether it operates in the public sector (like Medicaid and Medicare) or in the private sector – could function for long without providing a legal guarantee of coverage and payment for services.<sup>22</sup>

## The Evolution of Medicaid: How Did We Get Here?

Altogether, Medicaid is now large, varied, vital, and remarkably adaptable. But this central role of Medicaid in the midst of health financing is largely a policy accident, and would probably be quite a surprise to its original authors. No one ever sat down to design a big, heterogeneous, responsive, "last-ditch" insurance program. Rather, the major health debates and changes have primarily focused on such high-profile programs and policies as Medicare, commercial insurance regulation, competition, and managed care, leaving Medicaid – sometimes by design and often by default – to take up the slack.

For example, the limitations of the coverage of nursing home services under Medicare (which generally pays for such care only after hospitalization and, then, only for a short time) led – not by design but largely by default – to Medicaid picking up much of this large and growing responsibility. Similarly, the narrowness and cost of COBRA

continuation benefits, when combined with the lengthy waiting period for Medicare, have resulted in Medicaid becoming a primary payer for workers (and their families) who become disabled.<sup>23</sup> In these instances federal law was not affirmatively amended to have Medicaid take on these roles; Medicaid was a programmatic “Good Samaritan,” providing assistance just because it was there. The list of programs and services that Medicaid has come to prop up is long and varied.

Even when Medicaid has been affirmatively addressed with legislation, its expansion has been geological, growing by accretion as layers of beneficiaries, benefits and providers dealt with poorly by other parts of the system have been added or assisted. Sometimes this has occurred through the adoption of new federal mandates but more often (and particularly recently) growth has occurred when states have taken advantage of new or longstanding program options.

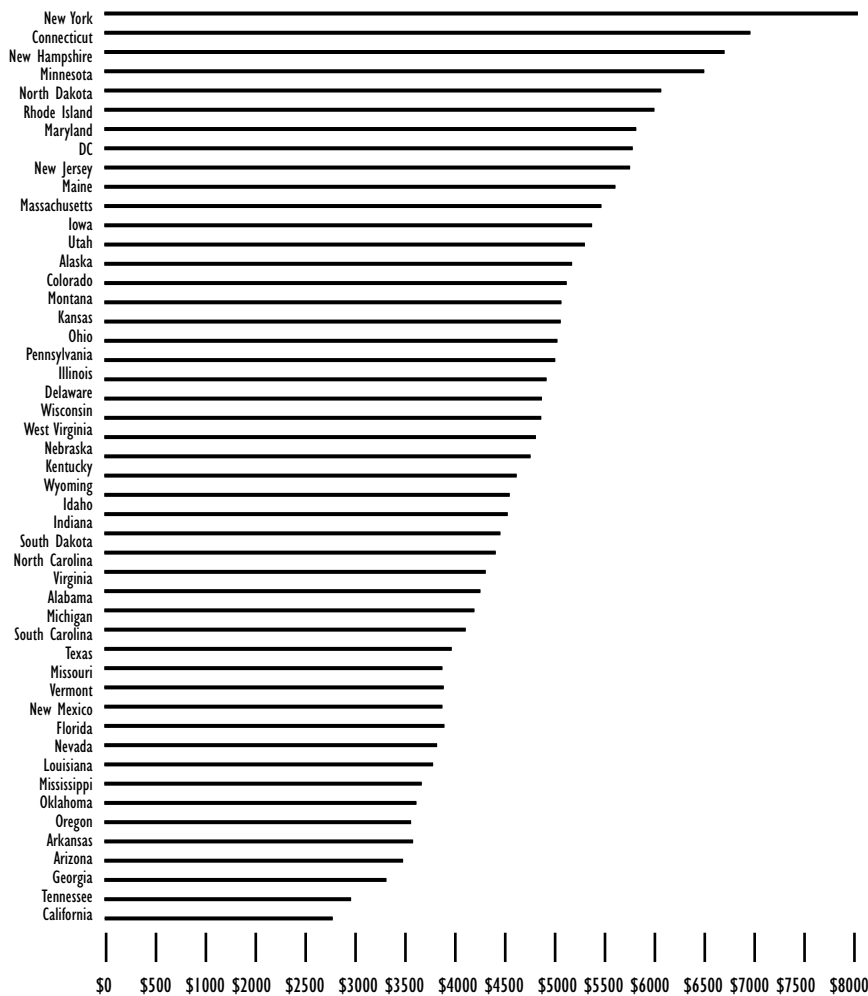
From its inception in 1965, the program has been jointly funded and administered by the federal government and the states. The statute has balanced the federal interest in having some minimum national standards and accountability for the substantial amount of fed-

**Medicaid is now large, varied, vital, and remarkably adaptable.**

eral dollars spent with a recognition that states need flexibility to design their programs in light of local conditions and to have some control over costs. The balance struck sets minimum federal standards with respect to eligibility, benefits, and beneficiary costs, but allows states to decide whether to expand coverage and benefits beyond the statutory minimums. States also have broad discretion to design their service delivery systems and to set provider rates.

The extent of the discretion is evident from many perspectives. Nationwide, Medicaid covered forty percent of the low-income population who were not covered by private insurance (in 1998-2000), but the variation across states is considerable and due largely to state policy choices. Among the thirteen states studied through the Urban Institute’s Assessing the New Federalism program, Medicaid penetration among the low-income uninsured ranged from a low of 27.9 percent in Colorado to a high of fifty-nine percent in Massachusetts.<sup>24</sup> Another indication of the flexibility within the program is the difference in levels of spending per beneficiary. In 2001, New York spent \$7,749 per beneficiary compared to only \$2,334 in California.<sup>25</sup> It is often said that if you have seen one state Medicaid program, you have seen one state Medicaid program.

Figure 2  
Total Medicaid Expenditures per Beneficiary, FY 2001



Source: Georgetown Health Policy Institute analysis based on MSIS 2001 data. No data available for Hawaii or Washington State.

*Medicaid’s Geological Evolution*

The Medicaid program began by focusing narrowly on people receiving welfare: children, their “caretaker relatives”, and the “aged, blind, and disabled” – all persons deemed too vulnerable to provide insurance for themselves.<sup>26</sup> Beginning in 1984, the general requirement of a link between federal cash assistance and Medicaid began to wither away, although Medicaid still focused on people too poor to insure themselves.<sup>27</sup> Required coverage was extended to children and some pregnant women who met the welfare eligibility standards (but who might not actually be receiving it). In 1986, an option was created for states to enlarge voluntarily their coverage to include all pregnant women and infants below the poverty level (regardless of their receipt of welfare)<sup>28</sup> and, by 1988, such coverage was required.<sup>29</sup> Likewise, in 1986, states were allowed to include some low-income people on Medicare (the so-called “Qualified Medicare Beneficiaries,” or QMBs) to pay for the out-of-pocket costs imposed by Medicare,<sup>30</sup> and in 1988 such coverage was required.<sup>31</sup> The next year, minimum eligibility was expanded to include pregnant women and young children up to 133 percent of poverty.<sup>32</sup> In 1990, the gradual phase-in of coverage for poor children up to age eighteen was begun (completed recently in 2002), and another group of low-income people on Medicare (the “Specified Low-Income Medicare Beneficiaries,” or SLMBs) was added and given some help with Medicare cost-sharing.<sup>33</sup>

By 1996, with the repeal of the federal welfare program for children and their families, Aid to Families With Dependent Children (AFDC), the link between cash

assistance for poor families and Medicaid was broken entirely (although the old AFDC income thresholds were retained as the federal floor on eligibility). Family coverage must now be provided regardless of eligibility for welfare, although the minimum income eligibility standards for parents remain quite low.<sup>34</sup>

In all cases where coverage is required under Medicaid (i.e., for infants, pregnant women, older children, parents, the elderly, and people with disabilities), states have the option to expand their program to cover people in these groups at higher income levels. Most have done so to some degree for some groups of beneficiaries.

In 1997, the State Child Health Insurance Program (SCHIP) was created, giving states even more options with respect to children's coverage. SCHIP encourages states (through higher federal matching payments) to provide insurance for children whose family income is higher than pre-SCHIP state Medicaid levels.<sup>35</sup> At state option, SCHIP funds can be used to finance a stand-alone, non-Medicaid program or to expand Medicaid.

In a different vein of policy development, recent moves have been made to use Medicaid for coverage of people with disabilities who are not, by any routine standard, low-income but who are, nonetheless, effectively priced out of the private market because of its targeted risk underwriting for all but the largest group insurance plans. In 1997, states were allowed to include working people with disabilities with income up to 250% of poverty<sup>36</sup> and, in 1999, even that limit was removed.<sup>37</sup> Most recently, legislation has come near passage to make a similar provision for children with disabilities who are part of non-poor families.<sup>38</sup>

Parallel to these incremental expansions of eligibility were gradual legislative extensions of assistance to certain providers of services to low-income people. In 1981, states were required to make special payments to Disproportionate Share Hospitals (DSH).<sup>39</sup> In 1989 guarantees of Medicaid coverage and payment floors for community health centers and other poverty clinics, the Federally Qualified Health Centers (FQHCs), were enacted.<sup>40</sup>

Beyond this gradual broadening, Medicaid has also been enlarged through legislation to ensure that children received the scope of coverage they needed. In 1989, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit (which was originally established in 1967) was strengthened. Medicaid law now guarantees children coverage for regular health visits and dental, hearing, and vision screenings, as well as for any treatment found to be medically necessary.

Congress and the states have also regularly turned to Medicaid as an ad hoc response to certain health problems. In 1993, after tuberculosis outbreaks occurred in the late 1980s, states were allowed to extend eligibility for Medicaid to people who test positive for TB.<sup>41</sup> Also, in an effort to increase pediatric immunization rates, Medicaid was expanded to pay for vaccine for uninsured and underinsured children who are not themselves Medicaid beneficiaries.<sup>42</sup> In 2000, states were allowed to open eligibility to uninsured women who are diagnosed with breast or cervical cancer in a screening program supported by the Centers for Disease Control and Prevention.<sup>43</sup>

### *Progress and Tension*

And Medicaid has worked. All states have implemented the program, many have taken advantage of program options, and enrollment has increased dramatically for all groups of people.<sup>44</sup> The breadth of benefits available for children with disabilities is far more

medically appropriate than any other insurance package.<sup>45</sup> Cost-sharing generally has been held to a level that does not impede access by low-income people. And, most important, study after study has shown that people covered by Medicaid have better access to care and better health outcomes than people without insurance.<sup>46</sup> Observing it at a distance, far enough from the daily cracks of the whip, shows that, even as the perennial tail of the health policy process, Medicaid has held on and made remarkable contributions.

This is not to say that Medicaid's growth and development has always been easy. While Medicaid's unique brand of federalism has helped keep the program in balance and lend it the flexibility to evolve, it has also been a breeding ground for tensions. These tensions have sometimes compromised Medicaid's ability to do its job and have, on occasion, pushed the program into crisis. The tugs and pulls play out on two different levels: between and among states, local government, providers and beneficiaries ("To serve or not to serve"); and between states and the federal government ("Your money, my rules").

**In hindsight, one could have predicted that Medicaid would become central in health financing. Other public and private programs are intended for "average people," i.e., people with "average income" generally sufficient to pay for health insurance and people with "average health care needs."**

### **To Serve or Not to Serve**

States are responsible for twenty-three to fifty percent of Medicaid benefit costs.<sup>47</sup> Any new person covered, any new outbreak of disease, and any new medical advance achieved will affect a state's bottom line. As Medicaid has grown, so has its influence on state budgets. Nationwide, Medicaid accounts for about sixteen percent of state general-fund spending, second only to education.<sup>48</sup> Whatever its benefits may be to

states, Medicaid represents a significant financial undertaking for them.

The tensions created by state budget pressures play out in a number of ways. Over the years, the lack of outreach, as well as complicated and sometimes stigmatizing application and renewal procedures, have dampened participation (and damaged the reputation of the program).<sup>49</sup> These practices have their roots in the program's historic ties to welfare, but states have long had the flexibility under federal law to simplify the process. Many chose not to do so, largely due to the costs associated with more robust participation. And, of course, states were right about the relationship between barriers, participation rates, and costs. When states simplified enrollment procedures for children in Medicaid after the enactment of SCHIP made covering children a valued goal, enrollment – and costs – rose.<sup>50</sup> In the wake of state budget shortfalls, several states have rolled back their simplification measures.<sup>51</sup>

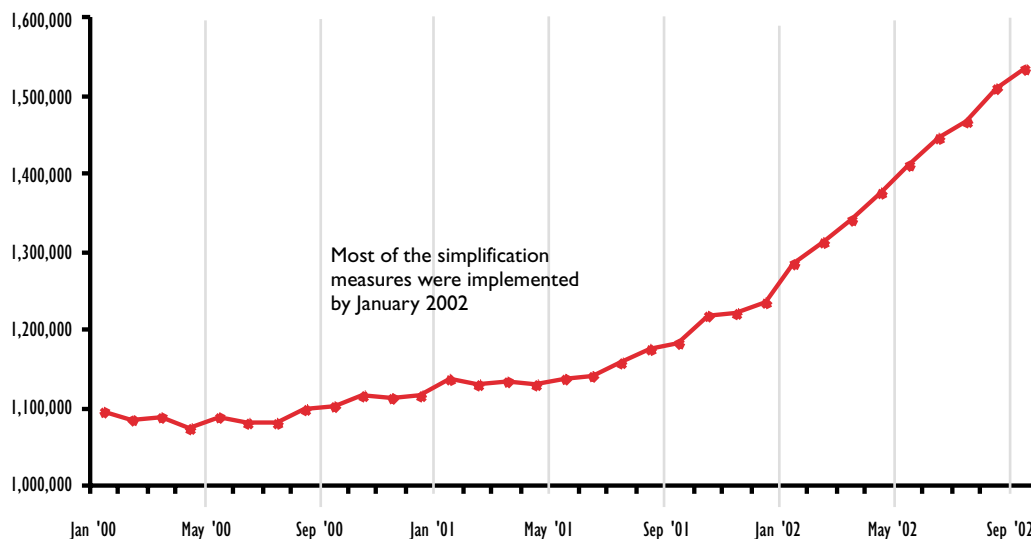
Low provider payment rates have also been used to keep Medicaid costs down. Lower-than-market rates generally contribute to Medicaid's ability to deliver services at a lower cost than private insurance.<sup>52</sup> While, in most cases, people still have access to care at levels comparable to private insurance,<sup>53</sup> in some places at some times, low rates have compromised Medicaid's ability to assure access to care.<sup>54</sup> This is a problem: The entitlement is little more than a hollow promise if providers are not willing to serve.

Budget constraints also deter some eligibility and benefit improvements. Another remnant of Medicaid's historic ties with welfare is that there is no eligibility category for childless adults.<sup>55</sup> This group of people cannot be covered under Medicaid (without a waiver), no matter how poor they may be. In large part, this problem has not been fixed because of the reluctance on the part of states and the federal government to assume the cost of extending coverage.

Similarly, the lack of community-based long-term care services funded by Medicaid is a consequence of funding pressures and priorities. Medicaid law requires states to offer nursing home services

Figure 3

**Texas Child Medicaid Enrollment Before and After Simplification** Monthly average, January 2000 to September 2002



to eligible beneficiaries, but home- and community-based long-term care services are not required. This imbalance between institutional and community-based services is not an oversight. It is a reflection that states believe they cannot afford the costs if these services were opened up to all who qualify.<sup>56</sup>

### My Rules, Your Money

Some of the tensions in the program play out mainly between the states and the federal government. As noted above, both levels of government share responsibility for program costs and program rules.

Even though about two-thirds of all spending under the Medicaid program is optional (either for optional services for mandatory beneficiaries or for all services provided to optional beneficiaries),<sup>57</sup> not surprisingly – and, from their perspective, understandably – states would like more authority over program rules. During the past decade, the program has moved in this direction,<sup>58</sup> although the principle that Medicaid should operate according to minimum federal standards in the areas of eligibility, benefits and beneficiary costs has remained intact, at least as a matter of federal law. The Bush Administration's aggressive promotion of waivers, however, has put many of these basic statutory standards in question through the section 1115 waiver process.<sup>59</sup>

The tugs and pulls between the states and the federal government over financing have been even more intense. Medicaid's financing structure is designed to assure that federal funds increase when costs rise and to encourage states to take advantage of options to improve coverage. States (understandably) work the system, looking for ways within the rules to maximize their federal payments. At times, states have taken these measures to extremes and, in effect, distorted the statutorily established matching rate.<sup>60</sup> Some have found ways to use federal Medicaid dollars to fund other state priorities or reduce state taxes. When this happens, the federal government typically takes steps to close down the practice, although not always completely or in an even-handed or transparent way.<sup>61</sup> During the early 1990s and again in 1999 and 2000, the struggle between states and the federal government over whether and to what extent certain financing mechanisms would be permitted dominated Medicaid debates.

These tensions become all the more acute when Medicaid costs are rising relative to available state revenues. This is one of those times. As a result of state budget pressures, states are cutting optional cov-

erage and benefits, eliminating many of the simplification measures that had been adopted to promote participation, and freezing or reducing provider payment rates in ways that could jeopardize access to care.<sup>62</sup> Some states have also secured a "waiver" of federal minimum standards, permitting them to cap enrollment (i.e., end the entitlement), increase beneficiary costs, and eliminate coverage for mandatory services (such as hospital care).<sup>63</sup>

The Bush administration has generally welcomed a shift in the paradigm towards fewer federal programmatic standards,<sup>64</sup> but it has taken the opposite approach on fiscal matters. In 2003, the Administration proposed legislative changes that would cap federal Medicaid payments to states and, in 2004, it proposed to close down financing mechanisms it believes are abusive (including some that it re-opened the door to in the past).<sup>65</sup> Even without new legislation, HHS is engaging in new levels of fiscal review,<sup>66</sup> adding to state fiscal woes and the acrimony between state and federal administrators.

So far, the Congress has largely stayed out of the recent skirmishes, although it did recently take action having a significant fiscal impact. Legislation adopted in 2003 temporarily shifted some state Medicaid costs to the federal government through an 18-month increase in the federal Medicaid matching rate.<sup>67</sup> The matching rate change helped states avert eligibility rollbacks and other reductions in coverage and benefits.<sup>68</sup> Fiscal relief has not been sufficient, however, to forestall significant retrenchments.<sup>69</sup> Continuing budget pressures have prompted many states to take action or to consider taking action that will have large, negative long-term consequences on the program's ability to fulfill its mission.<sup>70</sup>

Medicaid is always under some stress. But some have identified this period in the life of the program – a time of weak state revenue growth, rising health costs, and demographic shifts – as "the perfect storm."

### The Future of Medicaid: Where Should We Go From Here?

In hindsight, one could have predicted that Medicaid would become central in health financing. Other public and private programs are intended for "average people," i.e., people with "average income" generally sufficient to pay for health insurance and people with "average health care needs." Private sector insurance is not designed for people who cannot afford to pay premiums or for people with a predictable need for chronic care. If there was to be coverage for these peo-

ple and payment to their providers, then some other mechanism for providing coverage and financing had to be invented. Without Medicaid, some people would not receive the care they need and, to the extent that they did receive care, then states, localities, providers, and (through cost-shifting) other payers would be stuck with the bill.

Recognizing the need for a program like Medicaid, most health care reform proposals contemplate some combination of public programs and private coverage.<sup>71</sup> As long as the nation continues to rely primarily on private insurance, it is difficult to imagine how the system could function effectively without Medicaid.

A reformed system will continue to need Medicaid to occupy a central role for four main reasons. First, Medicaid will be needed to provide coverage to those priced out of private insurance. The breadth of this group will depend on the extent and nature of other reforms and whether reform is intended to ensure universal coverage. Currently, a high portion of low-wage workers are uninsured either because they are not offered work-place coverage or their employer's contribution toward the cost of the premium is too low to make the product affordable.<sup>72</sup> Some reform proposals would require employers to offer coverage or to contribute toward the cost of coverage. Others would offer tax credits to help low-income people purchase private insurance. The level of financial support available, either through an employer or a public subsidy, and the structure of that subsidy will affect the scope of Medicaid's role insuring low-wage workers and their families. It seems unlikely (in part for the reasons discussed below) that any new approach could be sufficient to reach all low-income people at its outset.

Second, by taking responsibility for many of the people eschewed by private insurance no matter what their ability to pay, Medicaid essentially functions as a high-risk pool. Without significant insurance reforms, Medicaid will still be needed to provide coverage to people with chronic illnesses and disabilities.

A third reason for continuing Medicaid under a reformed system is that Medicaid generally serves the people left out of private insurance – whether due to price or medical condition – better than private insurance. A publicly-funded coverage program is uniquely suited to provide full financial support (i.e., with no or very limited premiums, no deductibles, and only nominal cost-sharing) for a broad array of benefits to people with little or no means to purchase those benefits on their own; to respond promptly to changes in families' financial needs and circumstances; and to help those who fall between the cracks due to frequent job transitions, immigration status, and other factors.<sup>73</sup> And it does all this at a relatively low cost.<sup>74</sup>

Finally, Medicaid's role as a major financier of the system cannot be ignored. In 2004, Medicaid pumped over \$300 billion into the health care system. Nearly half (43 percent) of that amount comes from states and would be hard to capture and redirect in a reformed system.<sup>75</sup> The absence of these funds would leave a gaping financing hole not just for so-called safety-net institutions but also for many providers with a mixed-payer base.

Medicaid's role will vary and adjust depending on the extent of the broader reforms that might be adopted, but inevitably there will be a need for an efficient, publicly funded partner for coverage and financing. With apologies to Voltaire,<sup>76</sup> if Medicaid did not exist, it would be necessary to invent it. The program, however, is under considerable stress, in part because it has grown to meet myriad needs without the benefit of system-wide planning.

Whatever the design of comprehensive system reform may be, it

should be made with Medicaid's unique mission in mind and, moreover, in concert with a number of changes to Medicaid itself. While the "crack the whip" approach does not do justice to Medicaid or its mission, neither does an approach to reform that focuses exclusively on the current tensions in the program and that ignores Medicaid's relationship with other parts of the system and the need for broader system-wide reform, and, most fundamentally, the need to reach many more of the currently uninsured. With this caveat in mind, four areas for potential Medicaid reforms are discussed below.

**We can continue to shortchange Medicaid and its beneficiaries, react to the crisis of the moment, and let the key elements of the program unravel under multiple points of pressure; or we can take advantage of the interest in system-wide reform and take the steps necessary to help Medicaid achieve its objectives well.**

### *Financing*

First and foremost, Medicaid needs a financing method that provides a reliable and adequate source of funds that can adapt to changing needs or rising costs without sending the program (and its beneficiaries and providers) into crisis.<sup>77</sup> Maintenance of open-ended federal financing is, therefore, critical. Moreover, the mismatch between health care costs and state financing capacity, the important national interests underlying the program, and the aging population point to the need for even greater federal financial responsibility. This could be accomplished by shifting a greater share of the cost of the program onto the federal government, for example, through a higher across-the-board matching rate. Alternatively (or in addition), certain policies

could be adopted that would increase the federal government's fiscal responsibility in more specific ways. Two changes deserve particular attention.

Federal Medicaid matching rates should adjust automatically so that the federal government assumes a larger share of costs during an economic downturn. Medicaid's entitlement prompts the program to do more when the economy sours, but states' capacity to absorb added costs in these times is limited. Because of its broader tax authority and its abilities to borrow, the federal government is in a better position to take on these costs and to ensure that Medicaid coverage remains intact when it is needed most.

The federal government also should assume more responsibility for the impact of the aging population and the burgeoning cost of serving people who are receiving both Medicare and Medicaid. Medicaid's responsibility for these individuals has been growing steadily over the years.<sup>78</sup> In 2001, their costs accounted for more than forty percent of all Medicaid spending.<sup>79</sup> Among the many concerns regarding Medicaid's responsibilities for Medicare beneficiaries, perhaps the most significant are the growing cost of long-term care and the lack of community-based long-term care services. While Medicaid has become the principle financier of long-term care, state revenue systems are ill-equipped to handle this large and growing responsibility or to assume a major role in financing the modernization of the long-term care benefit. With the aging of the baby boomers and the contraction of private retiree coverage, cost pressures will become more extreme.

### *Eligibility Rules and the Systems for Accessing Coverage*

A national income eligibility floor now exists for children; however, minimum income standards for children still vary by age, and much lower eligibility standards for their parents leave many families with only partial coverage.<sup>80</sup> Eligibility "cliffs" also exist, for example when a child becomes an adult and after a pregnant woman gives birth, often leading to the loss of coverage. And, as discussed above, childless adults are not eligible at any income level (without a waiver).

Arcane and inequitable eligibility categories and income stan-

dards ought to be replaced with a national minimum income floor for all people based on their ability to purchase insurance that addresses their medical needs. How high these income standards should be and the pace of implementation will depend in part on other reforms that might be undertaken and the amount of resources that will be devoted to reform.

More uniform minimum eligibility standards should be coupled with measures that would simplify program administration and boost participation rates. Approaches could be adopted that make signing up for coverage easier and more automatic (as it is for employer-based coverage). People should be able to apply by mail, by phone and online, and at a variety of sites. (This is the practice now for some groups of people in some states). Another promising approach is linking enrollment to other programs and services. People could sign up for coverage when they pay their taxes, enroll their child in school, or when a member of the family applies for Social Security, or unemployment insurance benefits. Enrollment could be stabilized and costly churning<sup>81</sup> reduced through more streamlined renewal systems and measures, such as “continuous eligibility,” that prevent minor fluctuations in income from resulting in coverage gaps. In short, mechanisms that make it difficult for eligible families to enroll and stay enrolled should be dropped.<sup>82</sup>

#### *Linkage with the Employer-Based System*

As Medicaid has expanded to cover more families and individuals with ties to the workplace, systems are needed to help smooth the transition between private and public insurance (in both directions). A number of changes could help, but first, the ambivalence about public programs reaching out to cover low-wage workers and their families needs to be resolved. Concerns about public coverage programs “crowding out” or replacing employer-based coverage have kept policies muddled at best and counterproductive at worst. (For example, one commonly-used policy to prevent crowd out requires that a person remain uninsured for a period of time before qualifying for public coverage.)

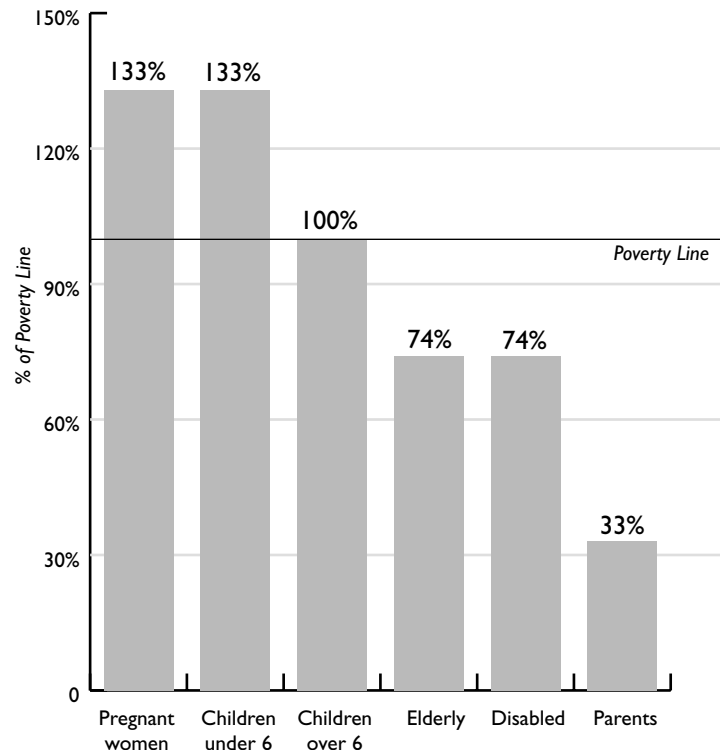
Publicly funded coverage can do a better job filling this gap if coverage policies are encouraged in a more considered and consistent way. For example, states would be more likely to extend coverage to low-wage earners if they were permitted to pool state resources with those of employers. One way to do this is to allow states to treat employer contributions toward the cost of coverage as part of a state’s payments that could be matched with federal funds. To the extent that Medicaid reached up the income ladder and covered families with somewhat higher incomes, modest premiums and cost sharing might be permitted as well.<sup>83</sup>

In another vein, to the extent that the tax system is used to promote coverage among more moderate-income households, it might be appropriate to consider aligning the methodology to calculate any tax-based relief with the methodology to calculate Medicaid financial eligibility (for example, by using adjusted gross income in both contexts). The current system is a crazy quilt in terms of the treatment of income and assets. Alignment would facilitate transitions between programs for providing financial support for coverage.

Additionally, disruptions in care that arise when people move in and out of Medicaid could be avoided if private insurance and public programs relied on many of the same health plans and providers. Plans and providers might be required to participate in Medicaid in order to operate in the state or as a condition of contracting with the state or a local unit of government. (For example, plans that sign up to offer coverage to state employees and retirees could be required to also open their doors to Medicaid beneficiaries).

Figure 4

#### Minimum Income Eligibility Standards for Medicaid by “Eligibility Group”



Note: The income level for parents varies by state; 33% is the mandatory minimum income level for a family with no earnings in the median state, relative to the 2004 federal poverty line. Families with earnings in some states are eligible at modestly higher income levels due to “earnings disregards.”

#### *Waivers*

Last but far from least, there are waivers. Over the past few years, the Administration has actively encouraged states to restructure their programs through broad-based “section 1115” waivers.<sup>84</sup> These waivers allow states to use federal Medicaid and SCHIP funds in ways that do not conform to federal law. Waivers can help states expand coverage or they can give states new ways to restrict coverage. Either way, they have resulted in significant programmatic and financing changes without open debate or much deliberation.

Waivers were originally intended to promote discrete “research and demonstration” projects, but they have long since lost that characterization. Little research or study is expected or conducted, and “copy-cat” waivers are common. In addition, waivers offer states only a limited ability to expand coverage and can push states into compromising financing arrangements (i.e., per-person or, in some cases, global caps on federal payments) because of a longstanding federal policy (not required in statute) that waivers be “budget neutral” to the federal government.<sup>85</sup>

Waivers should not become a substitute for rulemaking or a way to circumvent the law.<sup>86</sup> If the statutory or regulatory provisions that govern the program are out of date or inappropriate, they should be debated and changed. Far too many people and far too much money are at stake for these decisions to be delegated to back-room negotiations. On the other hand, waivers that are truly of a research and experimental nature and that promote the objectives of the program have a value, if conducted within clear bounds and with study and

analysis. In fact, federal funds should be available for such efforts as a way to promote new ways to deliver services, measure quality, promote participation, and contain costs without compromising care.

## Conclusion

Medicaid's ability to operate effectively and efficiently is notable given how much it has been asked to do. Like almost all aspects of the American health care system, however, the program is at a crossroads and is likely to change. There is a choice on how to proceed: we can continue to shortchange Medicaid and its beneficiaries, react to the crisis of the moment, and let the key elements of the program unravel under multiple points of pressure; or we can take advantage of the interest in system-wide reform and take the steps necessary to help Medicaid achieve its objectives well. If we make the system fit Medicaid and Medicaid fit the system, we can transform the evolution of American health policy from Crack the Whip to a team sport.

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## References

- Party Game Central, *Crack the Whip*, at <<http://www.partygamecentral.com/pgcstandard/gametmpstd.asp?gn=CRACK+THE+WHIP>> (last visited June 23, 2004).
- "Sharp turns and quick double-backs" is a fair description of the past 20 years of health policy.
- See especially, A. Schneider, et. al., *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured Website [hereinafter, "The Yellow Book"] available at <<http://www.kff.org/medicaid/2236-index.cfm>> (last visited July 1, 2004).
- Congressional Budget Office, *Baseline for Medicaid and the State Children's Health Insurance Program and Medicare*, March 2004. Total spending for Medicaid is computed off the baseline (which reports federal spending only) by assuming that federal spending represents fifty-seven percent of total Medicaid spending.
- Id.*
- K. Levit, et. al, "Health Spending Rebound Continues in 2002," *Health Affairs* 23, no. 1 (2004): 147-159.
- Key Facts: Health Coverage for Low-Income Children* (May 2002), Kaiser Commission on Medicaid and the Uninsured Website, at <<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14044>> (last visited July 1, 2004).
- J. Crowley and R. Elias, *Medicaid's Role for People with Disabilities* (August 2003), Kaiser Commission on Medicaid and the Uninsured Website, at <<http://www.kff.org/medicaid/4027.cfm>> (last visited July 1, 2004); J. Meyer and P. Zeller, *Profiles of Disability: Employment and Health Coverage* (September 1999), Kaiser Commission on Medicaid and the Uninsured Website, at <<http://www.kff.org/medicaid/2151-index.cfm>> (last visited July 1, 2004).
- Issue Paper: Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps* (March 2004), Kaiser Commission on Medicaid and the Uninsured Website, at <<http://www.kff.org/medicaid/7058.cfm>> (last visited July 1, 2004).
- Health Insurance is a Family Matter* (September 2002), Institute of Medicine of the National Academies, at <<http://www.iom.edu/report.asp?id=4356>> (last visited July 1, 2004).
- J. Stone and H. Yacker, *Prescription Drug Coverage for Medicare Beneficiaries* (Washington, D.C.: Congressional Research Service, 2002).
- Long Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, 108th Cong., Senate Special Committee on Aging, March 21, 2002 (statement of David Walker, Comptroller General of the United States), at <<http://www.gao.gov/new.items/d02544t.pdf>> (last visited July 1, 2004).
- America's Health Care Safety Net: Intact but Endangered*, Institute of Medicine Website, at [hereinafter America's Safety Net] <<http://www.iom.edu/Object.File/Master/4/118/0.pdf>> (last visited June 23, 2004).
- K. Cordero, "Medicaid Cuts Endanger Health Care for All Children," *Children's Hospitals Today* (Spring 2003), National Association of Children's Hospitals and Related Institutions (NACHRI) & National Association of Children's Hospitals (N.A.C.H.) Website, at <[http://www.childrenshospitals.net/Content/ContentGroups/Publications/Childrens\\_Hospitals\\_Today/Articles/200311/Medicaid\\_Cuts\\_Endanger\\_Health\\_Care\\_for\\_All\\_Children.htm](http://www.childrenshospitals.net/Content/ContentGroups/Publications/Childrens_Hospitals_Today/Articles/200311/Medicaid_Cuts_Endanger_Health_Care_for_All_Children.htm)> (last visited July 1, 2004); see also, C. Kelly, "Introduction to Medicaid Mission Impossible?" *Children's Hospitals Today* (Spring 2002), at National Association of Children's Hospitals and Related Institutions (NACHRI) & National Association of Children's Hospitals (N.A.C.H.) Website, at <[http://www.childrenshospitals.net/Content/ContentGroups/Publications/Childrens\\_Hospitals\\_Today/Articles/200211/Introduction\\_to\\_Medicaid\\_Mission\\_Impossible\\_.htm](http://www.childrenshospitals.net/Content/ContentGroups/Publications/Childrens_Hospitals_Today/Articles/200211/Introduction_to_Medicaid_Mission_Impossible_.htm)> (last visited July 1, 2004).
- America's Safety Net*, *supra* note 13.
- See, e.g., R. Martinez and E. Closter, *Public Health Departments Adapt to Medicaid Managed Care*, Issue Brief 16 (November 1998), Center for Studying Health System Change Website, available at <<http://www.hschange.com/CONTENT/65/?topic=topic01#care>> (last visited July 1, 2004).
- See A. Weil, "There's Something About Medicaid," *Health Affairs* 22, no. 1 (2003): 13-30.
- See R.J. Mills and S. Bhandari, *Health Insurance Coverage in the United States: 2002* (Washington, D.C.: U.S. Census Bureau, 2003); *Medicaid Matters: Hearing from Families*, produced by Kaiser Commission on Medicaid and the Uninsured, 9 min. (2003), at <<http://www.kff.org/medicaid/mm-index.cfm>> (last visited July 1, 2004).
- T. Bauer and J. Fuld, "Remove Barriers and Eligible New Yorkers Will Enroll: Lessons From DRM," *New York Forum for Child Health: Forum Update #7* (New York: The New York Academy of Medicine, 2002).
- There is no single provision in federal law that concisely sets forth the entitlement to coverage. Judicial interpretations of the federal Medicaid law have generally grounded the entitlement in section 1902(a) (8), Title XIX of the Social Security Act, 42 USC.1396(a)(8).
- Health Insurance Coverage in the United States: 2002*, *supra* note 18.
- By contrast, smaller public coverage programs (for example, separate, non-Medicaid, SCHIP programs) and other public programs that help pay for medical services (such as the Ryan White program, the Maternal and Child Health block grant program, and various pharmacy benefit programs) do not extend a legal entitlement to coverage. B. Smith and S. Rosenbaum, *State SCHIP Design and the Right to Coverage*, Center for Health Services Research (Washington, D.C.: George Washington University, 2001). As a result, the number of people provided services under these programs can be capped, waiting lists can be formed, and enrollment can be closed for budget or other reasons.
- S. Dale and J. Verdier, "Issue Brief: Elimination of Medicare's Waiting Period for Seriously Disabled Adults," *Commonwealth Fund* 660 (2003), available at <[http://www.cmf.org/programs/medfutur/dale\\_waitingperiod\\_ib\\_660.pdf](http://www.cmf.org/programs/medfutur/dale_waitingperiod_ib_660.pdf)> (last visited July 1, 2004).
- J. Holahan, *Variations Among States in Health Insurance Coverage and Medical Expenditures: How Much is Too Much* (June 2002), Urban Institute, at <<http://www.urban.org/url.cfm?ID=310520>> (last visited July 1, 2004) [Low-income is defined as having income below 200 percent of the federal poverty line].
- Authors' analysis of MSIS 2001 data submitted by states to the Centers for Medicare and Medicaid Services. Data do not include Washington or Hawaii, neither of which have submitted data to CMS as of April 19, 2004.
- Social Security Amendments of 1965, Pub. L. 89-97, 79 Stat. 286 (July 30, 1965) (codified as amended in scattered sections of 42 U.S.C.).
- Deficit Reduction Act of 1984, Pub. L. 98-369, 98 Stat. 494 (July 18, 1984) (codified as amended in scattered sections of 42 U.S.C.).
- Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-509, 100 Stat. 1874 (Oct. 21, 1986), 42 U.S.C. § 1396a (2004) [hereinafter OBRA 1986].
- Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, 102 Stat. 683 (July 1, 1988), 42 U.S.C. § 1396a (2004) [hereinafter MCCA 1988].
- OBRA 1986, *supra* note 28, 42 U.S.C. § 1396a, 1396d.
- MCCA 1988, *supra* note 29, 42 U.S.C. § 1396d(p).
- Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, 103 Stat. 2106 (Dec. 19, 1989), 42 U.S.C. § 1395 et. seq. (2004) [hereinafter OBRA 1989].
- Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, 104 Stat. 1388 (Nov. 5, 1990), 42 U.S.C. § 1396a (2004).
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193, 110 Stat. 2105, Aug. 22, 1996), 42 U.S.C. § 602 (2004).
- Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251 (Aug. 5, 1997), 42 U.S.C. § 1397aa (2004) [hereinafter BBA 1997].
- Id.*
- Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. 106-170, 113 Stat. 1860, (Dec. 17, 1999), 42 U.S.C. § 1396o.
- S. Rep. No. 265, 107th Cong., (2002), at <[http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107\\_cong\\_reports&docid=fsr265.107.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_reports&docid=fsr265.107.pdf)> (last visited July 1, 2004).
- Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, 92 Stat. 357 (Aug. 13, 1981), 42 U.S.C. § 1396uu (2004).
- OBRA 1989, *supra* note 32, at 42 U.S.C. § 1396a (2004).
- Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, 107 Stat. 312, (Aug. 10, 1993), 42 U.S.C. § 1396a(a)(10)(A)(ii) (2004) [hereinafter OBRA 1993].
- Id.*, at 42 U.S.C. § 1396v.
- Breast and Cervical Cancer Treatment and Prevention Act of 2000, Pub. L. 106-354, 113 Stat. 1381 (Oct. 24, 2000), 42 U.S.C. § 1396r-1b.
- For example, federal program data show that there were 13 million beneficiaries in 1968; program data for 2001 show enrollment above 47 million.

- The Congressional Budget Office projects that enrollment will reach 52.4 million in 2004. Health Care Financing Administration (HCFA) data for 1968 provided by the Kaiser Commission on Medicaid and the Uninsured; 2001 data from Georgetown University Health Policy Institute's analysis of the 2001 Medicaid Statistical Information System (MSIS) data; 2004 data from Congressional Budget Office's March 2004 Medicaid Baseline.
45. Crowley and Elias, *supra* note 8.
  46. See, e.g. Key Facts: Children's Health – Why Health Insurance Matters (May 2002), Kaiser Commission on Medicaid and the Uninsured Website, at <<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14132>> (last visited July 1, 2004); see generally, *Consequences of Uninsurance*, Institute of Medicine Website, at <<http://www.iom.edu/project.asp?id=4660>> (last visited June 23, 2004).
  47. This is based on the "regular" matching rates in effect in fiscal year 2004. Enhanced rates, which ended as of June 30, 2004, lowered state contributions to twenty to forty-seven percent. The federal matching rate varies by state, with poorer states having a lower state spending requirement. See, *Federal Medical Assistance Percentages*, United States Department of Health and Human Service Website, at <<http://aspe.os.dhhs.gov/health/fmap.htm>> (last visited June 23, 2004).
  48. National Association of State Budget Officers (NASBO), *2002 State Expenditure Report* (Washington, D.C.: NASBO, 2003).
  49. D. Cohen-Ross and L. Cox, "Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2000); General Accounting Office (GAO), *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries*, GAO-04-363, March 26, 2004; M. Perry, S. Kannel, R. Valdez and C. Chang, "Medicaid and Children: Overcoming Barriers to Enrollment," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2000); GAO, *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, GAO/HEHS-00-86, April 2000; V. Smith, E. Ellis and C. Chang, "Eliminating the Medicaid Asset Test for Families: A Review of State Experiences," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2001); GAO, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*, GAO/HEHS-98-93, March 1998; P. Cunningham, "Targeting Communities With High Rates of Uninsured Children," *Health Affairs* Web Exclusive (July 25, 2001), at <[http://content.healthaffairs.org/cgi/content/full/hlthaff.w1.20v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Targeting+Communities&andorexactfulltext=and&searchid=1088433853632\\_786&stored\\_search=&FIRSTINDEX=0&resource-type=1&journalcode=healthaff](http://content.healthaffairs.org/cgi/content/full/hlthaff.w1.20v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Targeting+Communities&andorexactfulltext=and&searchid=1088433853632_786&stored_search=&FIRSTINDEX=0&resource-type=1&journalcode=healthaff)> (last visited July 1, 2004); G. Kenney, J. Haley and L. Dubay, "How Familiar Are Low-Income Parents with Medicaid and SCHIP?" *New Federalism Series B. No.B-34* (Washington, D.C.: Urban Institute, 2001); L. Summer, S. Parrot and C. Mann, *Millions of Uninsured and Underinsured Children are Eligible for Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, 1997).
  50. A. Dunkelberg, "Simplified Eligibility for Children's Medicaid in Texas: A Status Report at Nine Months," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); C. Mann, et. al., "Reaching Uninsured Children Through Medicaid: If You Build it Right, They Will Come," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2002).
  51. V. Smith, et. al., "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2004); National Conference of State Legislators (NCSL), *State Medicaid Actions: A Two-Year Review of State Actions as a Result of the States' Fiscal Crisis* (Washington, D.C.: NCSL 2003); L. Ku and S. Nimalendran, *Losing Out: States are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs*, (Washington, D.C.: Center on Budget and Policy Priorities, 2003).
  52. J. Hadley and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (2003/2004): 323-342.
  53. See *Challenges Facing the Medicaid Program in the 21st Century: Hearing Before the Subcommittee on Health of the House Committee on Energy and Commerce*, 108th Cong., October 8, 2003 (statement by Diane Rowland, Executive Director of the Kaiser Commission on Medicaid and the Uninsured).
  54. GAO, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, GAO-01-883, September 2001; The problem has been particularly severe with respect to dental services, prompting the agency that oversees the Medicaid at the federal level (the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration) to issue a directive to states to take steps to examine whether low provider rates might be affecting children's ability to obtain Medicaid-financed dental services; see Letter from T. Westmoreland, Director, to State Medicaid Directors (January 18, 2001), at <<http://www.cms.hhs.gov/states/letters/smd118a1.pdf>> (last visited July 1, 2004).
  55. As discussed above, originally, Medicaid eligibility was linked to welfare eligibility and childless adults did not fit under either of the two major welfare programs – the Aid to Families with Dependent Children program and the Aid to Aged, Blind and Disabled program (the precursor to the federal Supplemental Security Income, or SSI, program). Under the law, states can cover adults who are pregnant, living with a child, elderly or disabled.
  56. This imbalance is mirrored at the Federal level in the consideration of legislation to require States to offer home- and community-based care. The Medicaid Community-based Attendant Services and Support Act (Mi-CASSA) has been introduced and re-introduced in the Congress for many years, but its consideration has been haunted by cost-estimates that are predicated on an assumption that more people would use such care than use institutional services. See R. Glazier, "The Re-invention of Personal Assistance Services," *Disability Studies Quarterly* 21, no. 2 (2001), available at <[http://63.240.118.142/\\_articles\\_html/2001/Spring/dsq\\_2001\\_Spring\\_12.html](http://63.240.118.142/_articles_html/2001/Spring/dsq_2001_Spring_12.html)> (last visited July 1, 2004).
  57. Based on data analyzed by J. Holahan and B. Bruen, "Policy Brief, Medicaid Mandatory and Optional Eligibility and Benefits," *The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2001).
  58. For example, in 1997, federal law was amended to provide states more authority to set rates for institutional providers (nursing homes and hospitals) and to require Medicaid beneficiaries, under certain conditions, to enroll in managed care. In that same year, states were allowed new options to presumptively enroll children in Medicaid and to keep children enrolled for up to twelve months regardless of changes in financial circumstances; See Yellowbook, *supra* note 3.
  59. Since August 2002, the Bush Administration has released three major waiver initiatives: the Health Insurance Flexibility and Accountability (HIFA) initiative, see, Centers for Medicaid and Medicare Services Website, at <<http://www.cms.hhs.gov/hifa/>> (last visited June 24, 2004); Pharmacy Plus, at <[http://www.cms.hhs.gov/medicaid/1115/pharmacy\\_plus.asp](http://www.cms.hhs.gov/medicaid/1115/pharmacy_plus.asp)> (last visited June 24, 2004); and Independent Plus, at <<http://www.cms.hhs.gov/independenceplus/>> (last visited June 24, 2004). Each encourages states to submit section 1115 demonstration waiver requests that meet the guidelines set forth in these initiatives. The Administration has consistently cited waivers as a key policy tool to provide states greater programmatic flexibility; See, U.S. Department of Health and Human Services, News Releases, *Statement By Tommy G. Thompson, Secretary of Health And Human Services Regarding "Insuring America's Health" Report* (January 14, 2004), at <<http://www.hhs.gov/news/press/2004pres/20040114.html>> and *HHS Secretary Urges Congress To Approve Uninsured Package* (September 30, 2003), at <<http://www.hhs.gov/news/press/2003pres/20030930b.html>> (last visited July 1, 2004).
  60. D. Rousseau and A. Schneider, "Current Issues in Medicaid Financing- An Overview of IGTs, UPLs, and DSH," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2004); GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes is Needed*, GAO-04-228, February 2004; T. Coughlin, et. al., "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23, no. 2 (2004): XX-XX; GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101, January, 2003; GAO, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133, August 1, 1994.
  61. See *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes: Testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives*, 108th Cong. Committee on Energy and Commerce, March 18, 2004 (statement by Kathryn G. Allen, Director, HealthCare, General Accounting Office); 10; GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228, February 13, 2004; GAO, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*, GAO-02-147, October 30, 2001.
  62. V. Smith, et. al., *supra* note 51; NCSL, *supra* note 51; Ku and Nimalendran, *supra* note 51.
  63. S. Gill, J. Guyer, C. Mann, "Section 1115 Medicaid and SCHIP Waivers: Policy Implications of Recent Activities," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2000); For state-specific waiver fact sheets, see <<http://www.kff.org/medicaid/waivers-index.cfm>> (last visited June 24, 2004).
  64. See discussion of waivers and waiver initiatives, *supra* note 59.
  65. *Budget of the United States Government, Fiscal Year 2005: Department of Health and Human Services*, Office of Management and Budget (OMB) Website, Executive Office of the President Website, at <<http://www.whitehouse.gov/omb/budget/fy2005/hhs.html>> (last visited June 24, 2004).
  66. See *Inter-governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?* Hearing Before the Subcommittee on Health of the House Committee on Energy and Commerce," 108th Cong., April 1, 2004 (statement by Dennis Smith, Director, CMS, Center for Medicaid and State Operations).

67. Title IV, Jobs and Growth Tax Relief Reconciliation Act of 2003. Pub. L. 108-27.
68. V. Smith, et. al., *supra* note 51.
69. T. Boyd and V. Wachino, "Is the State Fiscal Crisis Over? A 2004 State Budget Update," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2004).
70. For example, Oregon, has adopted a series of very deep reductions in coverage; it eliminated the portion of its program that covered people impoverished by their medical expenses and instituted new premium policies for poor adults that have caused about half of those adults to drop out of the program. See Oregon Health Research & Evaluation Collaborative Website, at <<http://www.ohpr.state.or.us/OHREC%20welcome2.htm>> (last visited June 24, 2004). Several states, including Florida and California, are considering major waiver initiatives that could affect the entitlement, benefits, cost-sharing and financing for everyone covered under their Medicaid programs. A. Ulferts "Bush Strives to Rein in Medicaid," *St. Petersburg Times*, February 22, 2004; A. Ulferts, "Medicaid Records Hard to Come By," *St. Petersburg Times*, March 31, 2004; For California, see Medi-Cal Redesign Website, at <<http://www.medi-calredesign.org/overview.aspx>> (last visited June 24, 2004).
71. All of the presidential candidates who had a broad-based health care reform proposal included a substantial role for Medicaid (or a program with similar elements), with some anticipating a considerably expanded role as compared to today, see, "Side-by-Side Summary of Presidential Candidates' Proposals for Expanding Health Insurance Coverage," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); S.R. Collins, K. Davis, and J. Lambrew, "Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals," *Commonwealth Fund* 671(2004): 7-10.
72. S.R. Collins, et. al, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage*, *Commonwealth Fund* 626 (2003); This study found that fifty-three percent of workers making less than ten dollars an hour were eligible for their employer's health plan, as compared to eighty-seven percent of workers making more than fifteen dollars an hour.
73. Tax credits have been advanced as one possible way to help low-income people afford private coverage, and refundable tax credits have been proposed as a way to extend this subsidy to the millions of Americans whose incomes are too low to owe income tax (or to owe an amount of tax that would exceed the potential subsidy amount). A number of structural issues would have to be resolved for a refundable tax credit system to work well as a way to finance health insurance for low-income people; see L. Blumberg, *Health Insurance Tax Credits: Potential for Expanding Coverage* (Washington, D.C.: The Urban Institute, 2001). To date, the refundable tax credit created under the recent Trade Act has had limited take up, in part due these structural problems; as of the end of 2003, only about 3.6 percent of the workers who were potentially eligible had enrolled in the advance credit. S. Dorn and T. Kutyla, "Issue Brief: Health Coverage Tax Credits Under the Trade Act of 2002," *Commonwealth Fund* 721 (2004): 3; see also, R. Pear, "Sluggish Start for Offer of Tax Credit for Insurance," *New York Times*, January 25, 2004.
74. J. Hadley and J. Holahan, *supra* note 52.
75. Congressional Budget Office (CBO), *March 2004 Medicaid Baseline* (Washington, D.C., United States Government Printing Office, 2004); Center for Medicare and Medicaid Services (CMS), *National Health Care Expenditures Projections: 2003-2013* (Washington, D.C.: CMS, 2004).
76. "If God did not exist, it would be necessary to invent him," *Epitre a l'Auter du Livre des Trois Imposteurs*, November 10, 1770, quoted in J. Bartlett, *Bartlett's Familiar Quotations* 15th ed. (Boston: Little, Brown, 1980): 344.
77. Some new tools could help states contain Medicaid costs without compromising the quality of care; for example, disclosure to state Medicaid agencies of drug pricing that would allow states to improve their ability to set drug prices. Some changes would need to occur within the Medicaid program while other measures go beyond Medicaid and would help Medicaid as well as other payers contain costs.
78. L. Ku, *The Medicaid-Medicare Link: State Medicaid Programs Are Shouldering a Greater Share of the Costs of Care for Seniors and People with Disabilities*, (Washington, D.C.: Center on Budget and Policy Priorities, 2003).
79. B. Bruen and J. Holahan, "Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003).
80. Federal minimum income eligibility standards for parents vary by state; for parents with no earned income, they range from thirteen percent of the federal poverty line in Alabama to sixty-seven percent of the federal poverty line in Connecticut (based on the 2004 Federal poverty line). Authors' calculations based on data on July 1996 eligibility levels from U.S. House of Representatives, Committee on Ways and Means, 104th Cong., *Background Material And Data On Programs Within The Jurisdiction Of The Committee On Ways And Means (Green Book)*, Table 8-12: 437.
81. "Churning" refers to loss of coverage, often due to administrative requirements, followed by re-enrollment in the program. This not only disrupts coverage and care, but also results in added costs. G. Fairbrother, H.L. Park and A. Haidery, *Policies and Practices That Lead to Short Tenures in Medicaid Managed Care*, Draft, (Princeton, NJ: Center for Health Care Strategies, 2003); P.F. Short, D.R. Graefe, and C. Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," *Commonwealth Fund* 688 (2003): 9-10.
82. States should, of course, be permitted to adopt procedures that assure program integrity. States have generally found that streamlined processes do not interfere with states' ability to take a variety of measures (including data matches, using information from other state programs, and random audits) to assure that people who are enrolled are eligible for the program. D. Cohen-Ross and L. Cox, "Preserving Recent Progress in Health Coverage for Children and Families: New Tensions Emerge," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003).
83. Research has repeatedly shown that premiums and cost sharing, if set too high, will deter low-income people from enrolling in coverage and accessing necessary care; See, J. Hudman and M. O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); L. Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid*, (Washington, D.C.: Center on Budget and Policy Priorities, 2003); R. Tamblin, et. al., "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons," *Journal of the American Medical Association* 285, no. 4 (2001): 421-429; HRSA State Planning Grant Consultant Team, *Income Adequacy and Affordability of Health Insurance in Washington State* (University of Washington Health Policy Analysis Program, Rutgers University Center for State Health Policy, RAND, William M. Mercer, Inc., The Foundation for Health Care Quality, 2002). The recent experience in Oregon where more than half of the poor adults who were subject to premiums dropped out of the program shows that even relatively modest premiums (in this case, premiums ranged from six dollars to twenty a month) can be too high for poor people; J. McConnell and N. Wallace, *Impact of Premium Changes in the Oregon Health Plan (February 2004)*, Oregon Health Research & Evaluation Collaborative, at <[http://www.ohpr.state.or.us/OHREC%20welcome2\\_files/Reports%20and%20Briefs/Impacts%20of%20Premiums%20-%20FINAL.pdf](http://www.ohpr.state.or.us/OHREC%20welcome2_files/Reports%20and%20Briefs/Impacts%20of%20Premiums%20-%20FINAL.pdf)> (last visited July 1, 2004).
84. For the list of HHS waiver initiatives, see *supra* note 59. For a description of the new Health Insurance Flexibility and Accountability waiver initiative and some of the implications of the new waivers, see C. Mann, "The New Medicaid and SCHIP Waiver Initiatives," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2002); C. Mann, S. Artiga and J. Guyer, "Assessing the Role of Waivers in Providing New Coverage," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); S. Artiga, J. Guyer and C. Mann, *supra* note 63; and other waiver reports and fact sheets prepared by and for the Kaiser Commission on Medicaid and the Uninsured, at <<http://www.kff.org/medicaid/waivers.cfm>> (last visited June 24, 2004).
85. J. Guyer, "The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003).
86. Recently the far-reaching nature of waiver activity has attracted critical attention from the Congress as well. See, Letter from Senators Charles Grassley and Max Baucus to CMS Director Mark McClellan, June 16, 2004.