MEDICAID

INTRODUCTION

Begun in 1965 as one of President Johnson's "Great Society" initiatives, Medicaid finances health care—including nursing home coverage—for more than 1 in 10 Americans.[1] It is the major public health insurance program for low-income Americans and, increasingly, a safety net for former middle- and working-class individuals whose assets have been depleted by the high cost of long-term care. Though funded jointly between the federal government and the states, the states administer the program pursuant to federal regulations, resulting in widely differing coverage and eligibility criteria across the country.

Despite eligibility freezes, benefit cuts, a cost-per-patient growth rate nearly 50% lower than private insurance,[2] and substantially lower costs per patient than those for private health insurance, Medicaid costs continue to grow.[3] Costs have increased partly due to the rise in unemployment and, for those employed in low-paying jobs, the lack of affordable health insurance. Increasing health care costs and the aging Baby Boomers guarantee that Medicaid's financial burden will only get heavier. The question of who will pay for it remains in debate.

The single largest cut in the President Bush's 2006 budget was a proposal to reduce Medicaid spending by about $60 million over the next decade.[4] He proposed a trade-off whereby states would be given more freedom to administer Medicaid in exchange for accepting a cap on federal spending for all but the poorest participants. The Administration hoped to save money by cracking down on middle-class and wealthy seniors who transfer their assets to qualify for Medicaid.[5] Critics argue that a federal spending cap would force states to cut benefits, prevent the states from responding to the health crisis, and result in higher state and local taxes as well as higher insurance premiums.

MEDICAID: PARTICIPANTS AND BENEFITS

To receive Medicaid payments, participants must (1) meet financial criteria and (2) be a member of one of the "categorically eligible" groups: children, parents of dependent children, pregnant women, or the elderly. Today, 53 million people participate in Medicaid. Nearly one in four children in America relies on Medicaid for health coverage. Two-thirds of Medicaid enrollees are members of low-wage working families.[6]

Though children represent the largest number of beneficiaries, the majority of Medicaid funds are spent on seniors and the disabled, primarily for long-term nursing care. The following table shows the breakdown of Medicaid expenditures to beneficiary group:[7]

	% of Total Enrollment	% of Total Expenditures
Children	48%	19%
Adults	27%	12%
Disabled	16%	43%
Elderly	9%	26%

The elderly and disabled represent such large percentages because of gaps in Medicare coverage. For example, Medicare–the government's medical assistance plan for the elderly–usually does not cover

nursing home costs. This forces Medicaid to pay the nursing home costs for the large number of elderly and disabled people who deplete their assets in paying for nursing home care, fall into poverty after entering a nursing home, and qualify for Medicaid from that time forward.[8,9] Medicaid currently pays between 46 – 60% of the nation's spending on nursing home costs.[10] (In comparison, Medicare pays for just 5% of all nursing home costs.)[11] Care for seniors and the disabled averages more than $12,000 per person annually; caring for a child or young adult costs less than $2,000.[12]

FUNDING

Medicaid represents the largest source of federal revenue to the states.[13] The federal contribution comes from general revenue funds (contrast Social Security and Medicare payments, which come from special trust funds) and matches state spending. Thus, when states reduce state Medicaid spending, they lose federal revenue. The matching formula is based on the relative per capita income in each state. States with higher per capita income contribute more than those states with lower per capita income. On average, the federal government provides 57% of Medicaid funds.[14] To put federal Medicaid spending in context, in FY 2004, Medicaid represented 8% of federal outlays, while Medicare accounted for 12% and Social Security, 21%. Over the next decade, Medicaid is expected to increase from 1.5% of the GDP to 2%.[15]

States often fund their Medicaid share through intergovernmental transfers ("IGTs") – transfers of public funds between governmental entities. IGTs, though legal, can be used in creative, and often problematic, ways. For example, prior to March 13, 2001, federal regulations permitted payments to individual hospitals and nursing homes that exceeded the cost of providing services, provided the aggregate payments did not exceed Medicaid's upper payment limit ("UPL"). The excess payments were then returned to the state treasury via an IGT.[16] Legislation has been enacted to curtail these practices.

In response to budget challenges, all states reduced provider rates and implemented prescription drug cost controls, 38 states reduced eligibility, and 34 states reduced benefits between FY 2004 and 2005.[17]

CRITICS OF BUSH'S PROPOSED CUTS AND FEDERAL CAP

In addition to the obvious deleterious effects on the poor, critics argue that the Administration's proposal to cap the amount of the federal contribution would raise state and local taxes and private insurance costs. Left to foot a growing bill with fewer federal dollars, states would be forced to raise taxes, or maintain current levels of coverage at the expense of other programs, such as education, or cut back on coverage and increase the ranks of the uninsured and the under-insured.[18] If hospitals and clinics see an increase in uncompensated cases, they will likely shift the cost by raising the amount they charge to private insurers—resulting in higher private insurance premiums. The federal government's guaranteed matching payments currently creates incentives for states to invest in health care and resist reductions in coverage. Absent the incentive provided by matching funds, states may be inclined to cut Medicaid services or to reduce the amount of Medicaid payments to providers. Reduced Medicaid payments would likely increase the number of providers who refuse to accept Medicaid patients.

Critics also point out that the President's promise that states would benefit with more flexibility in implementing Medicaid rings hollow. States already have enough flexibility to respond to changes in demographics, economic conditions, and heath crises under the existing funding structure. In contrast, critics point to the inflexibility of the State Children's Health Insurance Program ("SCHIP"). Under SCHIP, the federal government provides a capped entitlement to the states to cover children in low-

income working families who are ineligible for Medicaid. During the first years of the program, the federal spending allotments exceeded costs. Now, however, many states are expecting funding shortfalls.[19]

GENERAL CONVENTION RESOLUTIONS RELATED TO MEDICAID

- 1976-C044 – Support and Fund the Mission to the City Through Urban Churches.
- 1985-A088 – Encourage National and Congregational Support of Community Health Services.
- 1985-A086 – Express and Encourage Support for Ministry and Services to the Aging.
- 1991-A010 – Advocate Legislation for Comprehensive Health Care.
- 1994-A057 – Adopt Church Principles on Access to Health Care.
- 2000-A078 – Call on Lawmakers and Physicians to Provide Adequate and Comprehensive Hospice and Palliative Care.

EXECUTIVE COUNCIL RESOLUTIONS RELATED TO MEDICAID

- NAC 024 – In Support of Protection of Medicaid and Medicare as part of America's Social Safety Net.

OTHER RESOURCES

- U.S. Social Security Administration - http://www.ssa.gov/
- The Henry J. Kaiser Family Foundation - http://www.kff.org/medicare/index.cfm
- Employee Benefits Research Institute - http://www.ebri.org/

ENDNOTES

[1] The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Issues in Restructuring Federal Financing*, Jan. 2005. Available at <http://www.kff.org/kcmu> (last visited on 18 May 2005).
[2] Robert Kuttner, *Taming the Medicaid Monster*, The Boston Globe, Feb. 16, 2005 (citing a study by the Kaiser Family Foundation that 23 states have taken actions to freeze enrollment or cut benefits, and a study by the Urban Institute finding that actual Medicaid per-patient costs are growing at only about half the rate of private insurance).
[3] Center for Budget and Policy Priorities, *Future Medicaid Growth is Not Due to Flaws in the Program's Design, but to Demographic Trends and General Increases in Health Care Costs*, Feb. 4, 2005. Available at <http://www.cbpp.org/2-4-05health.htm> (last visited on 24 May 2005).
[4] Gleckman, Howard and Ann Therese Palmer, *The New Face of Medicaid*, Business Week, Feb. 21, 2005, p. 58.
[5] *Id.* at p. 59.
[6] The Henry J. Kaiser Family Foundation, *The Medicaid Program at a Glance*, publication no. 7235, Jan., 2005. Available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50450> (last visited on 24 May 2005).
[7] Howard Gleckman and Ann Therese Palmer, *The New Face of Medicaid*, at p. 58.
[8] Center on Budget and Policy Priorities, *Future Medicaid Growth Not Due to Flaws in the Program's Design, but to Demographic Trends and General Increases in Health Care Costs*.
[9] Though not specific to nursing home residents or Medicaid recipients, a Harvard study demonstrates how expensive health care can be. It examined causes of personal bankruptcy in 2001 and found that half

of the filers cited medical reasons as a cause. David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, Health Affairs-Web Exclusive, Feb. 2, 2005. Available at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63> (last visited on 18 May 2005).

[10] Some state that the figure is over 60%. *See* Howard Gleckman and Ann Therese Palmer, "The New Face of Medicaid," at p. 58. Others have found the figure to be around half. *See* Center on Budget and Policy Priorities, *Future Medicaid Growth Not Due to Flaws in the Program's Design, but to Demographic Trends and General Increases in Health Care Costs*. ("Medicaid foots the bill for "nearly half—46 percent—of all costs of nursing home care in the country.").

[11] *See* Howard Gleckman and Ann Therese Palmer, *The New Face of Medicaid*, at p. 58.

[12] *Id.*

[13] The Henry J. Kaiser Family Foundation, *Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity*, publication no. 7282, Feb., 2005. Available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51132> (last visited on 24 May 2005).

[14] The Henry J. Kaiser Family Foundation, *Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity*.

[15] The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Issues in Restructuring Federal Financing*, Jan. 2005. Available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50205> (last visited on 24 May 2005).

[16] The Henry J. Kaiser Family Foundation, *Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity*.

[17] The Henry J. Kaiser Family Foundation, *The Medicaid Program at a Glance*, publication no. 7235, Jan., 2005.

[18] Center on Budget and Policy Priorities, *Future Medicaid Growth Not Due to Flaws in the Program's Design, but to Demographic Trends and General Increases in Health Care Costs*, Feb. 4, 2005.

[19] The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Issues in Restructuring Federal Financing*, Jan., 2005. Available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50205> (last visited on 24 May 2005).