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MEDICAID: THE HEALTH CARE SAFETY NET FOR THE NATION'S POOR

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INTRODUCTION

Thank you, Mr. Chairman, for this invitation to speak before the Committee on the future of the Medicaid program. Medicaid serves as a health care safety net for 36 million of our nation's poorest and sickest people. It is vitally important to assuring that those in need of health care receive it. In a health care marketplace under intense pressure to provide care at lower cost, it is essential to assure that the most vulnerable are not excluded. As managed care plans, academic health centers, hospitals, physicians, and other health care providers respond to the demands of employers and government to provide care at lower cost, the availability of free care for those who are uninsured is increasingly jeopardized. Medicaid is the linchpin in the nation's strategy to assure access to health care for low income Americans, while using market incentives to increase the efficiency with which that care is provided.

Any changes in the Medicaid program need to be carefully considered to assure that it continues to serve its essential mission of providing health insurance coverage to low income Americans most in need of health care—women and children, disabled and elderly people. Today, I would like to review Medicaid's role as a health care safety net, describe who depends on Medicaid for health insurance coverage, outline why this coverage is vital in assuring access to needed health care services, and examine the implications of proposed changes.

MEDICAID'S ROLE IN PROVIDING HEALTH INSURANCE COVERAGE

The American economy has undergone enormous restructuring to meet the demands of an internationally competitive world. Its success in doing so has been vital to economic growth and employment. One unfortunate side effect, however, has been the loss of jobs that provide good health insurance coverage to workers—and especially to dependents. The numbers of uninsured have risen steadily since the mid-1970s—driven largely by the erosion in employment-based health insurance coverage. Today 40 million Americans are uninsured—18 percent of those under age 65.

Without Medicaid—however—this picture would be even more bleak. An ongoing study of health coverage and access in seven states by the Henry J. Kaiser Family Foundation and The Commonwealth Fund has found that almost half of families with incomes below 250 percent of the federal poverty level (approximately $35,000 for a family of four) are either uninsured or depend on Medicaid for coverage. To put it starkly—without Medicaid half of nonelderly Americans with low or modest incomes would be uninsured. Any changes to Medicaid that would result in an increase in those without health insurance coverage is of grave concern.

The Kaiser Commission on the Future of Medicaid, on which I am pleased to serve, has documented the importance of Medicaid in providing a basic safety net of health insurance coverage for the most vulnerable Americans. A recent Commission report pointed out that in 1994 Medicaid covered 33.5 million people—more than 1 in 8 Americans—including nearly 17 million children, 7.5 million parents (mostly mothers), 5.4 million blind and disabled persons, and

3.8 million elderly persons.[1] For each of these groups Medicaid covers a broad range of services to meet their complex needs.

Health Insurance for Children

The one bright note in trends of health insurance coverage is expansion of Medicaid to cover more poor children and pregnant women. These expansions, accomplished by raising income eligibility standards for young children and pregnant women, have been able to offset otherwise steep declines in private insurance coverage. As a result, forty percent of all pregnant women and infants are now covered by Medicaid, assuring financing for essential prenatal care, delivery, and well baby care.[2] Among poor families, 85 percent of pregnant women and infants are covered by Medicaid, 6 percent are privately insured, and 9 percent are uninsured. Similarly among poor children ages one to five, 88 percent are covered by Medicaid, 5 percent are privately insured, and 7 percent are uninsured.

Medicaid coverage tapers off for low income children six years or older, and the rate of uninsured children increases. Among poor children ages 6 to 12, 78 percent are covered by Medicaid, 9 percent are privately insured, and 13 percent are uninsured. As of 1994, 61 percent of poor children ages 13 to 18 were covered by Medicaid, 13 percent were privately insured, and 26 percent were uninsured. Under current law, Medicaid coverage of poor children ages 13 to 18 will be fully phased in by the year 2002.

Health Insurance Coverage for Low Income Women

Medicaid is an important source of health insurance coverage for many low income women. Twenty-two percent of women with incomes below twice the federal poverty level rely on Medicaid for assistance in paying health care bills.[3] One in five women on Medicaid is in fair or poor health, and poor health or pregnancy are major reasons women obtain Medicaid coverage.

Despite this important coverage, mothers of poor children are not well protected. A recent Commonwealth Fund study found that nearly a third of poor and near-poor women are uninsured. Pregnancy affords many low income women temporary Medicaid coverage; one fourth of all non-elderly women who enroll in Medicaid do so because of pregnancy. However, pregnant women qualifying for Medicaid's income standards for pregnancy are covered only for their term of pregnancy and 60 days post-partum, and then only for care related to the pregnancy. Coverage may continue after the birth of her children only if a mother qualifies for Medicaid through welfare, which has much lower income eligibility standards. For many poor women, coverage ends with the pregnancy; 15 percent of the women leaving Medicaid do so because of childbirth.

Women leaving Medicaid typically do not receive private health insurance. Among the reasons women lose Medicaid are obtaining a job (typically without private health insurance), getting a raise, becoming married, or going off welfare. Nearly two-thirds of them will become uninsured.

Any change in welfare assistance runs a risk that it will increase the numbers of uninsured women. Currently, coverage under Aid to Families with Dependent Children qualifies mothers of dependent children for Medicaid coverage. If arbitrary limits are placed on time for welfare eligibility or women move into training or employment, Medicaid coverage could be lost. Currently, Medicaid provides for continuation of coverage for one year for working women who lose AFDC because of an increase in earnings from work. Neither low income women nor their employers are likely to be able to afford coverage without subsidies.

Health Insurance for the Disabled

As a safety net for health and long-term care, Medicaid pays the cost of care for the nation's poorest and most disabled individuals. It assists individuals with the most catastrophic of illnesses—children with chronic conditions that can leave them disabled for a lifetime, trauma survivors like Christopher Reeve but without his financial resources to pay for round-the-clock care, adults with mental illness and retardation that require extensive care in the community or in an institutional setting. The average cost for a severely retarded individual on Medicaid, a population that is generally not covered by most private insurance, can exceed $50,000 per year.

Long-Term Care and Supplemental Health Insurance for Medicare's Poor

For 4 million low income elderly people and 6 million low income people with disabilities, Medicaid provides both health insurance and long-term care coverage. In its long-term care role, Medicaid pays for home- and community-based services and is the dominant source of public financing for nursing home care. In its insurance role, Medicaid is a supplementary insurance program for low income aged and disabled Medicare beneficiaries, paying Medicare's premiums, deductibles, and coinsurance and covering additional services, most notably prescription drugs.

From the perspective of how Medicaid dollars are spent, Medicaid is predominantly a program serving the low income aged and disabled population. The elderly and disabled constitute 27 percent of Medicaid beneficiaries, but account for 59 percent of spending because of their intensive use of acute care services and the costliness of long-term care in institutional settings. The per capita cost of an elderly beneficiary is eight times that for a child on Medicaid.

CONSEQUENCES OF BEING UNINSURED

The U.S. has a market-driven health care system. Those with good health insurance are increasingly viewed as "customers" whose business is sought by managed care plans and an array of health care providers. Those without health insurance or the ability to pay, however, are dependent on charity care from a limited number of public hospitals, teaching hospitals, community health centers, or other health care safety net providers. The ability of the uninsured to obtain health care has never been good, and in the future it will be increasingly scarce as financial pressures on safety net providers intensify.

Studies have documented that the consequences of being uninsured include failure to get preventive care, inadequate maintenance of chronic conditions, and adverse health outcomes. The 1993 Kaiser/Commonwealth Fund health insurance survey found that 34 percent of the uninsured failed to receive needed care, and 71 percent postponed needed care.[4]

The uninsured are much less likely to obtain preventive care. For example, 52 percent of uninsured women did not obtain a Pap smear in the last year, compared with 36 percent of insured women, and 69 percent of uninsured women ages 40 to 64 did not get a mammogram, compared with 38 percent of insured women.[5] We also know that those with chronic illnesses who are uninsured are least likely to receive proper maintenance and continuous care, with the result that untreated conditions such as hypertension or diabetes can lead to serious health consequences.

Mounting stresses on safety net health care providers—public hospitals, teaching hospitals, community health centers, and others that have traditionally served poor and uninsured people—are rapidly eroding the capacity and willingness to provide uncompensated care. These stresses include: cutbacks in state and local government funding, the diversion of Medicaid revenues to managed care organizations, proposed reductions in disproportionate share funding under Medicare and Medicaid, and reduced ability to cross-subsidize care as managed care plans demand reduced payment rates as the price of entry into networks. As financial pressures on hospitals and other health care providers mount, the health consequences for the uninsured are likely to intensify.

MEDICAID SUBSTITUTE: A HOLLOW PROMISE

Financial pressures on the federal government and on state governments of financing health care for low income Americans have led to an understandable desire to replace the current Medicaid program with a block grant and achieve budgetary savings. But the numbers of low income Americans in need of health insurance coverage can not be wished away. The disabled will not become well. Nursing home patients with Alzheimer's or other disabling conditions will continue to need round-the-clock care. Employers of low-wage workers are not spontaneously going to begin paying for health insurance. Nor is it easy to find savings in a program that has always tried to purchase health care at a lower rate than that paid by private insurers or Medicare. Certainly, changes that would improve efficiency, reduce fraud and abuse, and encourage employers to cover the working poor should be pursued—but state and federal policy makers have strived for over two decades to identify and implement such changes with only modest success. The reality is that providing health insurance to the sickest and poorest Americans is a costly undertaking, and as good a case could be made that we are spending too little as that we are spending too much.

Concerns raised by the Medicaid substitute proposal under consideration by the Committee include: 1) the change from an entitlement program to a modified block grant; 2) lack of guaranteed benefits; 3) lack of federal managed care standards and safeguards; and 4) lack of enforcement.

Entitlement to Health Insurance

Entitlement has become a maligned term. But all health insurance is by its nature entitlement. Employers entitle workers to a set of health benefits which they obtain through fee-for-service health insurance plans or through managed care plans. Essential to the nature of health insurance coverage is that it defines who is covered, what is covered, and how providers will be paid.

Under the Medicaid substitute proposal "eligibility" would be retained for:

- pregnant women and children up to age 6 up to 133 percent of poverty;
- children age 6 to 12 up to 100 percent of poverty;
- recipients of AFDC below national average of those covered by a new welfare program defined by the state;
- the disabled as defined by the state or the disabled on SSI;
- the elderly meeting SSI income and asset standards; and
- Medicare cost sharing for Qualified Medicare Beneficiaries (Medicare beneficiaries up to 100 percent of poverty).

States would have great flexibility to define income and assets potentially resulting in loss of coverage for many of those now covered. States would have the option of covering other individuals currently covered by Medicaid and anyone with income under 275 percent of poverty, but without additional federal matching funds to meet the cost of this expanded coverage.

Some people now covered by Medicaid would no longer be entitled to health insurance coverage. Under current law, children ages 13 to 18 in families with incomes up to the poverty level would be phased in by the year 2002. No provision is included for their coverage—reducing Medicaid coverage for 3 million adolescents by 2002. States could define disability to exclude people with HIV disease, substance abuse, mental illness, or any other disability without support at the state level. Many elderly poor could also lose coverage. No provision is made for picking up Medicare premiums, as current law does for Medicare beneficiaries with incomes up to 120 percent of poverty. Low income elderly now covered at the option of a state by virtue of spend-down or medically needy provisions would also appear to be excluded.

Guaranteed Benefits

But the real problem with the proposal is not only who would be covered, but what they would be covered for. The proposal does not require that beneficiaries receive health insurance coverage or coverage under a managed care plan. States could simply reimburse selected providers for bad debts incurred rendering health care services to eligible groups, rather than provide health insurance coverage. Or, the state could use federal funds to cover the budgets of state psychiatric facilities. The difference between insurance and payments to providers is an important distinction. Studies show that the uninsured who rely on free sources of care systematically receive less care.

Without guaranteed health insurance coverage, the uninsured put off obtaining care, go without preventive services, and do not receive ongoing medical attention to chronic conditions such as hypertension and diabetes—with life-threatening consequences. There is a world of difference between insurance coverage and limited subsidies to health care providers to care for the poor.

Even if a state decides to continue providing health insurance coverage to beneficiaries, there is no guaranteed benefit package. The proposal indicates that the following benefits remain guaranteed for core covered populations: inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening Diagnosis and Treatment Services (redefined so that a state need not cover all Medicaid optional services for children). Other benefits are optional including after two years community health centers and rural health clinics, and long term care options are broadened (presumably including room and board residential care facilities not meeting nursing home standards).

What really matters, however, is that states would have complete flexibility in defining amount, duration, and scope of services. States, for example, could limit hospital days to five days of coverage or require beneficiaries to pay substantial cost sharing for covered services. Benefits could be different in different areas of the state and for different population groups. Current provisions that require hospitals, physicians, and other Medicaid health care providers to accept Medicaid as payment in full would be repealed—leaving beneficiaries vulnerable to supplemental charges by providers. Nor would the federal government provide any standards or oversight regarding the level of provider payments. A list of services, without any guarantee of how many services from what providers at what cost to beneficiaries, is a hollow promise of coverage.

Managed Care

One strategy states have increasingly used to contain the growth in Medicaid outlays is enrollment of Medicaid beneficiaries in managed care plans. Today, most states are aggressively moving low income beneficiaries, especially children and adults, from fee-for-service care into managed care plans. This year, 30 percent of Medicaid enrollees nationwide will be enrolled in Medicaid managed care plans. Many states are planning to expand managed care enrollment to disabled beneficiaries, although there is only limited experience in managed care for this population.

However, many states have wanted to move more swiftly, rely more heavily on Medicaid-specific plans, restrict the freedom of choice of beneficiaries to be cared for by their own physician, and require mandatory enrollment in state-selected managed care plans. Under current law, such proposals must be reviewed and approved under a waiver authority. Under the proposal states could pursue managed care without the need for federal approval and without safeguards that guarantee beneficiaries choices of enrolling in quality managed care plans or staying in traditional Medicaid.

States' experiences with managed care to date have been quite variable. Where quality plans exist and states have moved in a gradual carefully planned way toward expanding the

choices available to beneficiaries, Medicaid beneficiaries have had wider access to primary care.[6] When implemented without sufficient planning and quality standards, the move to managed care has been at best chaotic and at worst destabilizing to current systems of care in low income communities.

Legal Recourse

The proposal would repeal Title XIX of the Social Security Act. Current protections in the law would be lost, including limits on cost-sharing, mandatory assignment by providers, enforcement of nursing home quality standards, and prohibitions against discriminating against certain groups of beneficiaries based on their age or medical condition or geographic location. Individuals could only bring law suits with regard to eligibility, not benefits, and through state courts not federal courts. Providers and health plans are specifically excluded from the right to bring suit.

State Fiscal Capacity

The fiscal capacity of states to finance health care for the poor is quite variable. Poor states have always had poorer programs. States that have higher health care costs are hard hit. No state can risk having a more generous Medicaid program, and higher state tax rates, without fear of either attracting low income families with serious health problems to the state or more to the point, discouraging business from locating and remaining in the state.

Nor with state constitutions requiring balanced budgets can states afford to expand coverage in times of economic recessions. States are thrown into fiscal crisis when the business cycle slumps—sales tax revenues decline and unemployment compensation increases. Yet it is also the time that jobs are lost, including jobs with health insurance coverage, poverty increases, and the need for publicly funded health insurance coverage for low income people increases. A federal umbrella fund would assist states fiscally in times of economic downturn, but there would appear to be no guarantee that the unemployed and poor would get the health insurance coverage they need.

Health insurance coverage for the poor, disabled, frail elders, and unemployed is clearly a national responsibility—not an individual or local community responsibility. It is not a problem that markets or individual responsibility can solve. Nor is it strictly a local matter. All Americans should be concerned with assuring that a baby gets a healthy start in life—not just the residents of the state in which that child is born. It is a national concern—and we should be examining options for moving toward uniform national standards of eligibility, benefits, and quality standards—not dismantling the nation's most important health safety net for the poor.

THE CHALLENGE AHEAD

Medicaid is indisputably our nation's most important health care safety net for low income Americans. At a time of great stress in our health care system, rising numbers of uninsured, and stresses on public hospitals, teaching hospitals, and other sources of care for the uninsured, we should be expanding Medicaid funding—not repealing it, substituting a block grant, and achieving federal budget savings of $72 billion over the next six years.

Rather than increasing the fragility of our safety net, we need to reengage the issue of expanding health insurance coverage. Modest, pragmatic steps should be explored. Medicaid has proven a successful vehicle for insuring low income children and pregnant women. We need to explore ways of continuing coverage for low income mothers who work. We need to accelerate, not repeal, expanded coverage for poor children ages 13 to 18. We need to expand Medicaid eligibility and provide federal matching for low income working families—perhaps starting by making such coverage optional for states with matching federal funds.

But this coverage needs to guarantee vulnerable Americans access to quality health care. For some Americans, a high quality managed care plan is an attractive option, providing a regular place to turn for preventive and primary care. Others, however, need complex care for serious illnesses and disabilities. Care must be taken to assure that Medicaid beneficiaries can enroll in a system that best meets their needs. The recent experience of states point to the need for federal quality standards, safeguards, and oversight as Medicaid changes with the changing health care system.

As this evolution takes place, Medicaid should strive to become a model program for both poor and working families, for healthy babies and disabled seniors. It should become a vehicle for expanding coverage to the nation's uninsured—not shrunk at a time of great vulnerability. It deserves our attention and support. Thank you.

ENDNOTES

[1] The Kaiser Commission on the Future of Medicaid, *The Medicaid Program at a Glance*, December 1995.

[2] John Holahan and Shruti Rajan, *Medicaid Coverage of Low Income People*, prepared for the Kaiser Commission on the Future of Medicaid, March 1996, and special tabulations from the Current Population Survey requested by the author.

[3] Pamela Farley Short, *Medicaid's Role in Insuring Low-Income Women*, The Commonwealth Fund, May 1996. Based on analysis of the 1990 panel of the Survey of Low Income and Program Participation.

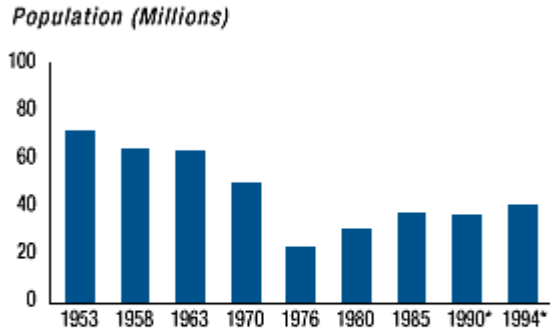
[4] Davis et al., "Health Insurance: Size and Shape of the Problem," *Inquiry*, Volume 32, Number 2, Summer 1995.

[5] E. Richard Brown et al., *Women's Health-Related Behaviors and Use of Clinical Preventive Services*, The Commonwealth Fund, October 1995.

[6] "Managed Care and Low Income Populations: A Case Study of Managed Care in Minnesota" and "Managed Care and Low Income Populations: A Case Study of Managed Care in California" prepared by Mathematica Policy Research, Inc., for The Henry J. Kaiser Family Foundation and The Commonwealth Fund, May 1996.

THE UNINSURED: 1953-1994

Erosion of Employer Coverage Takes its Toll in Last 15 Years



**Survey questions change in 1988 and 1994, lowering the number of uninsured.*

Source: USDHEW, Health Interview Survey 1953-76. CPS Survey 1980-93. 1980-85 Health Care Financing Review 1994; 1989-93, EBRI, 1996.

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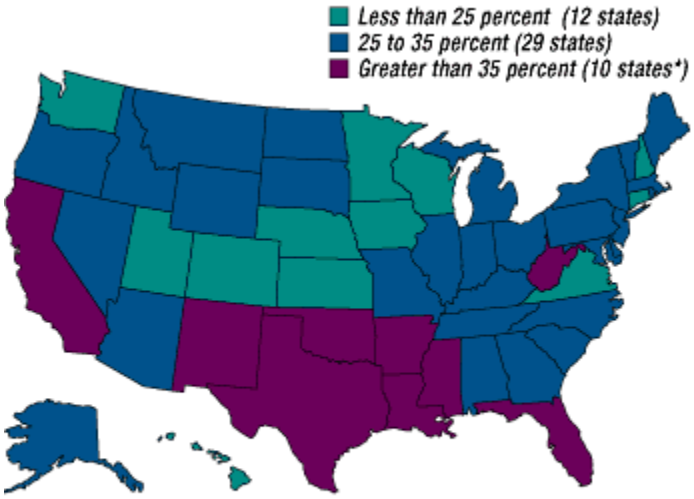
At-Risk Population Under Age 65 as a Percent of Total Population, by State, 1993

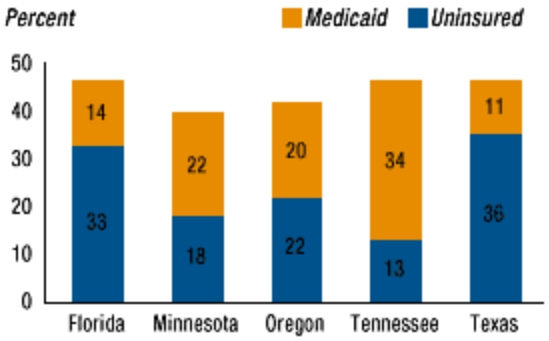


Note: 'At-risk' is defined as either uninsured or on Medicaid.
Estimates for ND and WY based on 1990-1992 average.
**Includes the District of Columbia*

Source: EBRI, 1995; Winterbottom, et al., 1995

The Kaiser Commission on THE FUTURE OF MEDICAID

Low Income Populations at Risk



"Low income" includes individuals with incomes below 250% of the poverty level

Kaiser/Commonwealth Low Income Survey, 1995-1996, Louis Harris and Associates, Inc.

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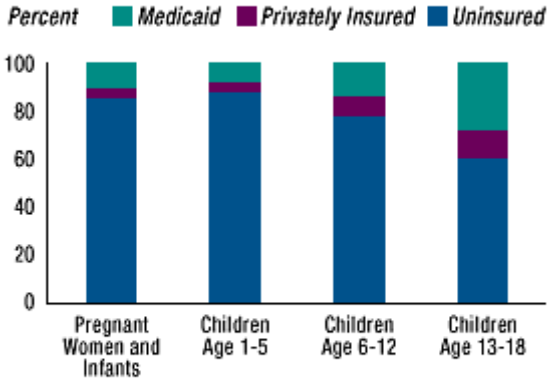
Insurance Coverage of Low Income Pregnant Women and Children, 1994



Source: Urban Institute Tabulations From the 1994 March Current Population Survey, February, 1996

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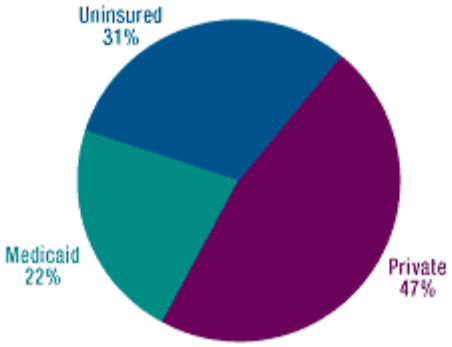
Health Insurance Coverage of Low Income Women

Percent Distribution by Insurance Group



Source: Pamela Farley Short, 1996, based on Survey of Income and Program Participation, 1990 Panel

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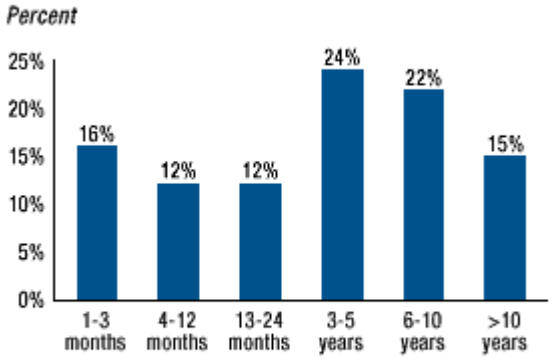
Time on Medicaid

Percent Distribution of Adult Women with Medicaid



Source: Pamela Farley Short, 1996, based on Survey of Income and Program Participation, 1990 Panel

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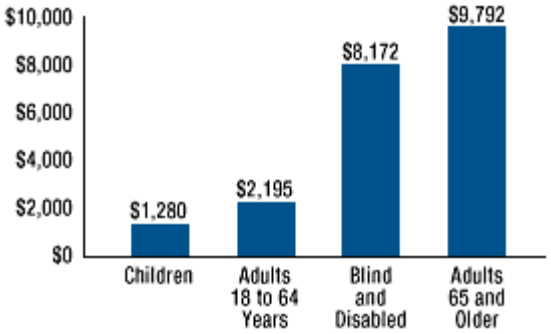
Medicaid Expenditures Per Beneficiary, 1994



Source: The Kaiser Commission on the Future of Medicaid; The Urban Institute analysis of HCFA 2082 and HCFA 64 date, 1995.

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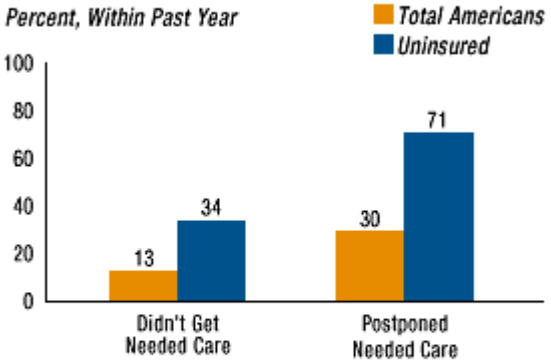
Uninsured Most Likely to Go Without Needed Care



Kaiser/Commonwealth Fund Health Insurance Survey, 1993
Louis Harris & Associates, Inc.

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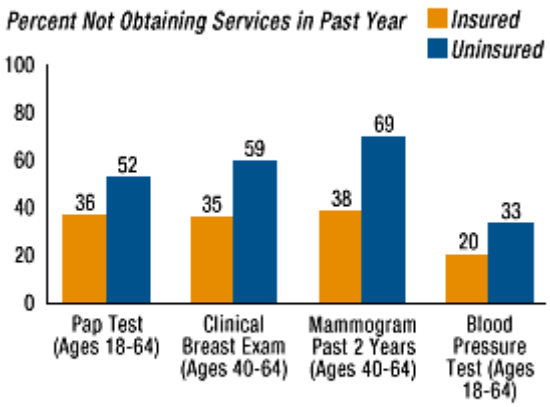
Women Without Selected Clinical Preventive Services by Insurance Status, 1991



Source: Brown, et al., Women's Health-Related Behaviors and Use of Clinical Preventive Services, October, 1995

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Medicaid Substitute

- Entitlement to Health Insurance
- Guaranteed Benefits
- Managed Care
- Legal Recourse
- State Fiscal Capacity

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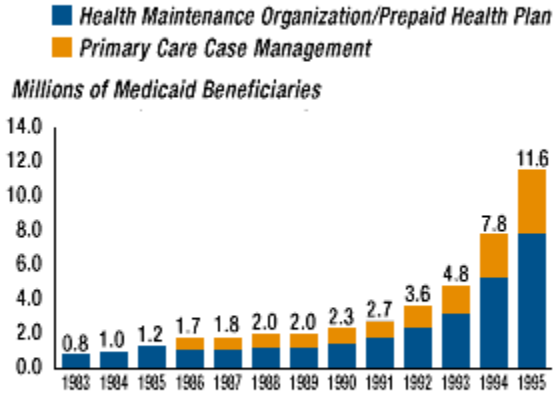
Growth in Medicaid Managed Care Enrollment, 1983-1995



SOURCE: Health Care Financing Administration, 1992 and 1995

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