



Medicaid at 50 — From Welfare Program to Nation's Largest Health Insurer

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HEALTH POLICY REPORT

Mary Beth Hamel, M.D., M.P.H., *Editor***Medicaid at 50 — From Welfare Program to Nation's Largest Health Insurer**

John K. Iglehart and Benjamin D. Sommers, M.D., Ph.D.

Over its 50-year history, the federal–state Medicaid program has evolved from a neglected stepchild of Medicare to the nation's largest health care program, providing coverage to tens of millions of persons and families of limited means. Withstanding perpetual challenges along a contentious political path, Medicaid expanded steadily and proved to be adaptable as demands for change arose. In the most sweeping change since the creation of the program in 1965, the Affordable Care Act (ACA) essentially completed Medicaid's transformation from a welfare-style program that served certain categories of low-income persons — namely, those with disabilities, the elderly, pregnant women, parents of dependent children, and children 18 years of age or younger — to one in which any American with a family income at or below 138% of the federal poverty level (just under \$28,000 for a family of three) is eligible to enroll. A Supreme Court ruling in 2012 effectively gave states the option of whether to expand their Medicaid programs under the ACA, and thus far, 29 states and the District of Columbia have decided to do so.¹ As of December 2014, the end of the first year of the ACA expansion, 9.7 million more persons were enrolled in Medicaid and its allied program, the Children's Health Insurance Program (CHIP), than during the year before the ACA expansion went into effect. This influx of enrollees has brought the total number of beneficiaries to about 69 million, as compared with 52 million beneficiaries in Medicare as of 2012.² Because Republicans have assumed control of the 114th Congress in Medicaid's 50th anniversary year, the program may well face new efforts to restrain its growth and grant greater flexibility to states as the GOP pursues its more conservative policy agenda.

In this article, which recognizes Medicaid's golden anniversary, we will cover key developments in the program's history and its current, if un-

settled, state as the ACA is implemented, along with providing an overview of some of the most important highlights and policy debates.³⁻⁹

EARLY HISTORY AND PROGRAM DESIGN

Medicaid and Medicare were created as part of the Social Security Amendments of 1965, which Congress approved overwhelmingly — 307 to 116 in the House and 70 to 24 in the Senate. These programs were enacted in an era when American liberalism was at a high tide under President Lyndon B. Johnson, who launched an array of “Great Society” programs in 1964 that included a “War on Poverty.” But Medicaid was essentially a creature of Congress, led by Representative Wilbur Mills (D-AR), chairman of the House Ways and Means Committee and coauthor of the earlier Kerr–Mills Act, which provided medical assistance to older persons and became a template for Medicaid.⁴ Wilbur Cohen, a close advisor to Mills, was also a major force in winning enactment of these programs, in part because legislators found his formula favoring incremental change more attractive than approaches to universal coverage. Cohen later became secretary of the Department of Health, Education, and Welfare, the precursor to today's Department of Health and Human Services.

Medicaid is an exemplar of federalism, a defining feature of American government in which power is shared between the federal and state governments. In the American model, ambiguity is built in because it “embodies a national-state balance in sovereignty that can be structured in different ways, at different times, by different actors, and for direct activities.”⁹ As one former Medicaid director put it, “No state has structured its program exactly like any other state. Benefits, payment rates, and eligibility have always varied,

reflecting state-specific traditions, politics, budgets, and health care systems” (Smith V: personal communication).

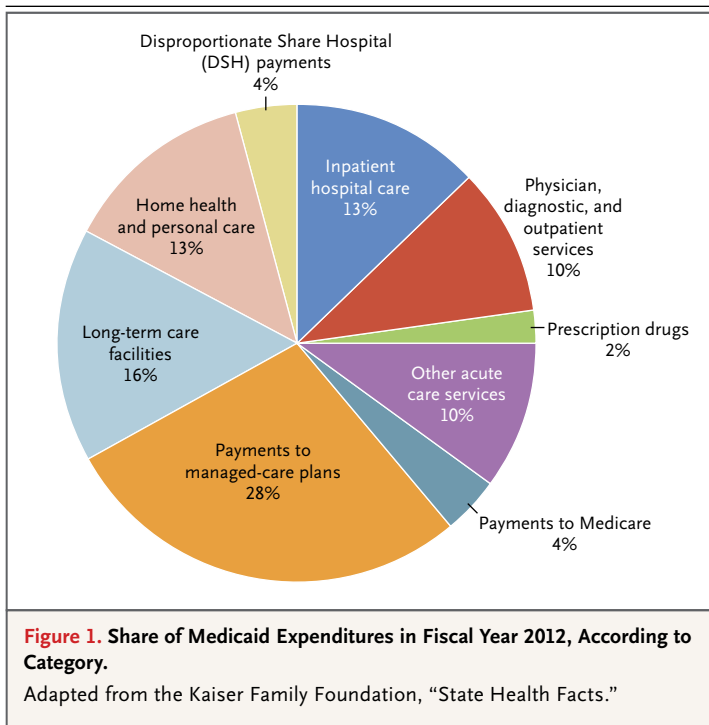
At its outset, Medicaid eligibility for persons without disabilities was directly linked to the welfare system, known then as Aid to Families with Dependent Children. In the 1980s and 1990s, a series of eligibility expansions — some implemented by states at their discretion and others required by Congress — brought Medicaid coverage to broader swaths of children in low-income families, pregnant women, and parents, and the formal tie with welfare eligibility was eventually severed in 1996.^{10,11} Over this time, Medicaid has grown to occupy a larger percentage of state budgets, though more than half of state spending on Medicaid is reimbursed by the federal government. At Medicaid’s creation in 1965, health programs received 6% of all federal grants that flowed to state and local governments. By 2010, health-related activities accounted for 58% of all federal grants-in-aid to state and local governments, with Medicaid alone spending about 95% of these health-related federal grants and squeezing competing claims for resources such as education, income security, and social services.⁵

Medicaid expenditures in 2014 totaled nearly \$475 billion, with the federal government contributing approximately 60% of that amount and states paying the bulk of the rest; in a few states, counties also support the program. The amount that states contribute is based on the per capita income of each state’s population. The match rate (the federal share of Medicaid spending) currently ranges from a federal floor of 50% in 13 states with the highest per capita incomes to 73.6% in Mississippi, the nation’s poorest state.¹² Under the ACA, the match rate for adults who are newly eligible for Medicaid is 100% for 2014–2016 and decreases gradually to 90% in 2020 and beyond. During recessionary periods, Medicaid enrollments increase as some workers are laid off and thus lose their employer-sponsored coverage and more families meet income criteria for the program; at the same time, state budgets are typically reeling from the loss of tax revenue. Three times during recessions — in 2003, over the opposition of President George W. Bush, and again in 2009 and 2010 — Congress temporarily increased the federal share of Medicaid’s costs to help alleviate this budget crunch in states.

In recent decades, as the politics surrounding

federalism moved to favor greater devolution of authority to states, the federal grip on Medicaid has loosened — driven particularly by presidents who served previously as governors. Though Medicaid has always featured substantial state-level flexibility, the drumbeat in support of such efforts has intensified over time. President Ronald Reagan, a conservative Republican, was a champion of devolution but so was Bill Clinton, a moderate Democrat. In a 1993 speech, Clinton told an assembly of governors that, for many years, “governors had been screaming for relief from a cumbersome process by which the federal government had micromanaged the health care system affecting poor Americans.”¹⁵ Clinton directed the Health Care Financing Administration, since renamed the Centers for Medicare and Medicaid Services (CMS), to streamline the process by which the agency considered state proposals to waive selected federal rules that states deemed too restrictive. But Clinton and his fellow Democrats drew the line when it came to accepting Republicans’ favored reform of Medicaid — converting federal support to capped block grants. Research suggests that in both wealthier and poorer states, a block granting of Medicaid would require either increased state spending or reduced benefits. In one analysis, economists wrote, “We would expect a conversion to block grants to result in very substantial and widespread reductions in Medicaid benefits.”¹⁶

Because of the diverse and complex needs of Medicaid’s population, the program covers a broad range of both health and long-term care benefits — well beyond those included in most private insurance plans. Medicaid is the primary payer for long-term services and supports (LTSS), accounting for 61% of the national spending on LTSS in 2012, which totaled \$134.1 billion. As the population ages, Medicaid’s provision of LTSS is certain to increase, although currently only about half the users of these services are 65 years of age or older. In 2010, about 6% of Medicaid beneficiaries used LTSS, and total Medicaid spending on these beneficiaries accounted for almost half of all Medicaid spending.¹³ States also have the flexibility to cover many additional services that federal law designates as optional, such as prescription drugs, dental services, and home and community-based services. Figure 1 shows the breakdown of program expenditures, with payments to Medicaid managed-care plans, inpatient hospital care, and



long-term institutional care making up the three largest sources of costs in Medicaid.

One of Medicaid's most widely embraced roles has been its ambitious expansion of coverage for children, a priority established by Congress that took effect in two waves — 1984–1990 and again in 1997–2009.⁴ In 1967, Congress also established the Early and Periodic Screening, Diagnostic, and Treatment Program, which initiated Medicaid's dual role as a financier of medical services and source of comprehensive care and prevention for America's poorest children. In the Balanced Budget Act of 1997, Congress created CHIP, which provides coverage for children in families with incomes that exceed the Medicaid eligibility threshold, with some states now covering children with family incomes as high as 300% of the federal poverty level.¹⁴

For several decades, states have been moving away from fee-for-service payment and encouraging or requiring Medicaid recipients to enroll in managed-care plans in hopes of decreasing or at least stabilizing their program costs. Under this model, states contract with managed-care plans that agree to provide all covered health care services in return for fixed (usually monthly) payments, thus making state outlays more predictable.

Although about two thirds of Medicaid beneficiaries were receiving services through managed-care plans by 2010, less than 30% of Medicaid dollars flowed to such plans because their enrollees were typically parents and children, who are less expensive to cover than other Medicaid beneficiaries. Increasingly, states are requiring disabled and elderly beneficiaries with more expensive conditions to enroll in managed-care plans, despite the lack of experience of such plans in serving these high-risk populations. In a related development, the nation's largest private insurers are moving aggressively into the Medicaid marketplace.¹⁵ Despite the growing enthusiasm for managed care in Medicaid, evidence is mixed on whether such programs actually save money or improve the quality of care.¹⁶

MEDICAID'S EFFECTIVENESS

Following on the heels of Medicaid's rapid expansion from 1980 into the 2000s, the ACA placed the program squarely in the national spotlight as one of the law's two main approaches (along with subsidies for coverage through federal and state exchanges) to expanding health insurance coverage to millions of previously uninsured Americans. In addition to expanding eligibility dramatically, the ACA also aimed to streamline the Medicaid application process and eliminate financial asset tests for many applicants in order to improve the participation rate among eligible adults — which was roughly 60% before passage of the ACA, owing to cumbersome enrollment and renewal procedures, variable program quality, stigma, and lack of awareness.^{17–19}

Given the dramatic increase in the number of Medicaid enrollees and the contentious divide that separates the political parties over the ACA, there has been growing interest in evaluating the program's successes and failures and how it is perceived by the public. Cross-sectional studies have noted that Medicaid beneficiaries have worse health outcomes than those with private insurance and, in some cases, than persons without any insurance. This finding has been used by some observers to make the claim that Medicaid is worse than no coverage at all, though these studies are limited in their ability to draw any true cause-and-effect conclusions.²⁰ It is simply not possible to compare beneficiaries of Medicaid — by con-

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struction, the insurer of last resort for many of society's sickest and poorest members who cannot obtain private coverage — with beneficiaries of private insurance or even patients without insurance.²¹

Rigorous evidence on the effects of Medicaid have come from quasi-experimental studies and the landmark Oregon Health Insurance Experiment, which was a randomized, controlled trial of Medicaid coverage on the basis of a waiting-list lottery that was conducted in Oregon in 2008. The Oregon study, which compared persons who were randomly selected to be offered Medicaid coverage with those on a waiting list who were not selected for coverage, showed convincing evidence of major improvements in the lives of low-income adults who received coverage, with better access to primary care and recommended preventive services, improved mental health, better self-reported physical health, and reduced risk of medical debt. But the Oregon researchers did not detect a statistically significant improvement in blood-pressure, cholesterol, or diabetes control during an 18-month follow-up period.^{22,23} In a larger but nonrandomized, quasi-experimental study, major Medicaid expansions in three states in the early 2000s were associated with significant gains in access to care and self-reported health and a 6% decline in mortality during a 5-year period, as compared with states not expanding Medicaid.²⁴ These findings echo the results of previous studies on the effect of Medicaid expansions on pregnant women and children in low-income families in the 1980s and 1990s, which showed a range of health and economic benefits.²⁵⁻²⁸

Despite Medicaid's contentious political status,²⁹ public opinion surveys find that the program is quite popular among the low-income persons who are its primary beneficiaries³⁰ and the general public as well. One national poll showed that half of Americans had a personal connection to the program through coverage for themselves, family members, or friends, and the majority oppose any budget cuts in Medicaid to reduce the deficit.³¹ However, this does not mean that there is no support for reform. Although the public is generally opposed to substantial cuts in Medicaid or state block grants, the majority favor granting states more flexibility in administering their programs.³²

The Supreme Court's 2012 decision changed the nature of federalism when it ruled that, unlike previous federal expansions of Medicaid, the ACA's expansion was unconstitutionally coercive toward states. The result has been a number of contentious debates carried out in state governments over whether to expand Medicaid under the health reform law. Initially, the debates followed party lines, with most states that were controlled by Democrats favoring expansion and Republican states strongly opposed because of the long-term budget implications of expansion and general opposition to the ACA. However, in recent months, the tables have turned in an increasing number of states. Republican governors in states including Indiana, Utah, Wyoming, and Tennessee have come out in support of expansion, although in the last three states, opposition from state legislators remains an obstacle.¹ In Florida and Texas, two of the states with the largest numbers of uninsured Americans, most Republican leaders have remained opposed to expanding Medicaid, but hospital and private business communities are putting heavy pressure on policymakers to reconsider.³³ Acknowledging the law's potential benefit to low-income Americans, Ohio's Republican Governor John Kasich surprised many conservatives with his impassioned defense of expanding Medicaid: "For those that live in the shadows of life, those who are the least among us, I will not accept the fact that the most vulnerable in our state should be ignored."³⁴

In some instances, Republican governors opted for expansion after negotiating program changes with Barack Obama's administration that more nearly matched their more conservative policy paths. The past 2 years have seen a proliferation of proposals for alternative approaches in Medicaid. These proposals include the so-called private option in Arkansas, in which Medicaid funds are being used to purchase private insurance for low-income adults in the ACA's insurance marketplace,³⁵ and plans in states such as Michigan, Indiana, and Montana requiring greater use of cost-sharing, premiums, and financial incentives to promote healthy behaviors.³⁶ Thus, although the ACA initially was

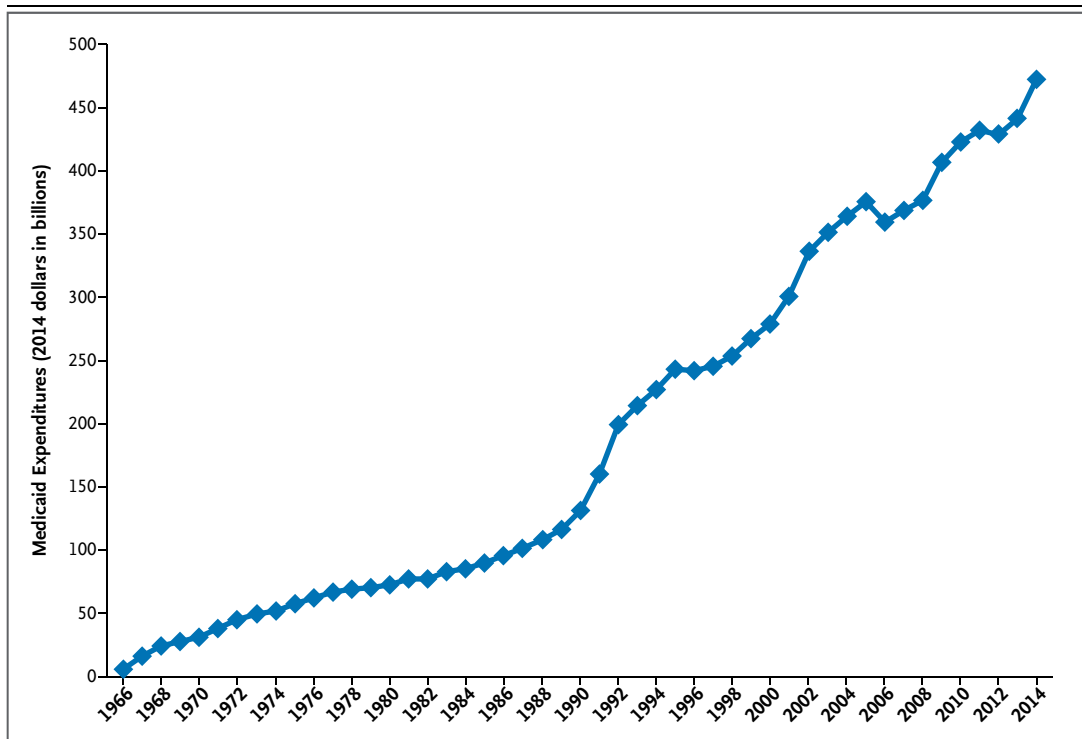


Figure 2. Medicaid Inflation-Adjusted Total Expenditures (State and Federal), 1966–2014.

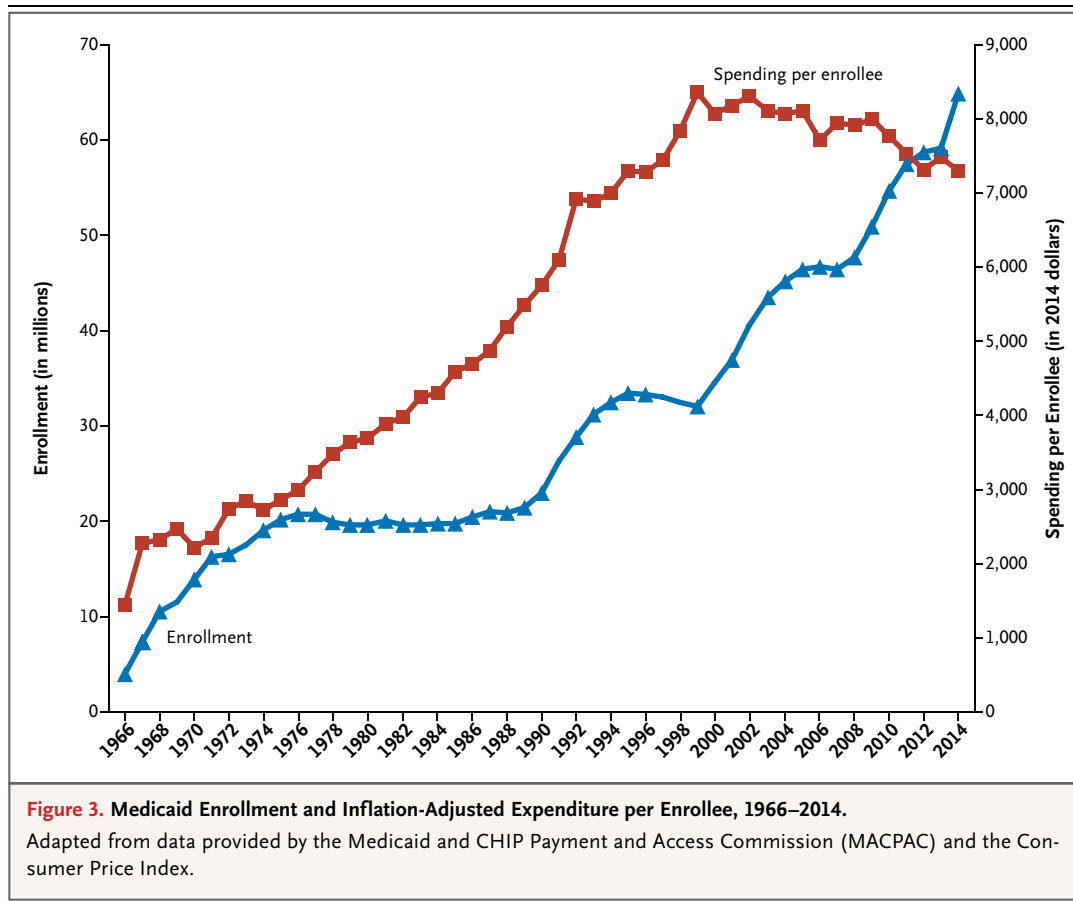
Adapted from data provided by the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Consumer Price Index.

seen by many of its opponents as a centralizing force, the Supreme Court ruling has, in many ways, ushered in a new era of federalism. As Health and Human Services Secretary Sylvia Mathews Burwell stated, “We’re eager and willing to work with states that have yet to expand. . . . My message to governors is, ‘If you’re interested in expanding, call me.’”³⁷

Beyond coverage, major concerns remain about the program’s low payment rates to providers, a major driver behind the decision by some physicians not to participate in Medicaid.^{38,39} One recent study showed that 69% of physicians nationally are willing to accept new Medicaid patients, as compared with 82% for private insurance and 83% for Medicare.³⁸ In the closing days of the 113th Congress, legislators potentially exacerbated the problem by not extending a 2-year increase in Medicaid fees for primary care services that had expired. The federally funded fee bump increased fees on average by 73% for services provided by family physicians, primary care internists, and pediatricians,⁴⁰ and recent evidence

suggests that the policy succeeded in expanding the willingness of some physicians to see new Medicaid patients.⁴¹ As of April 2015, a total of 15 states had indicated their intent to maintain higher Medicaid fees with the use of state funds, 23 states had said that they did not intend to continue the fee increase, and 13 states were undecided.⁴⁰ California, which is among states paying the lowest Medicaid fees to physicians, has announced that it does not plan to raise its program’s fees. In a related development, the Supreme Court recently ruled that providers do not have a legal right to sue states in federal court over Medicaid reimbursement levels, instead leaving those decisions to the Department of Health and Human Services for administrative oversight.⁴²

Financial compensation is not the only issue.^{43,44} Among physicians who decline to accept Medicaid patients or limit the number they will treat, 76% cite onerous paperwork requirements and 60% cite the clinical complexity of patients enrolled in Medicaid.⁴⁵ Although reducing paperwork burdens and offering more support for those



caring for patients with complex medical conditions could produce increased provider participation in the program, some observers have suggested that an ethic of professionalism alone should lead all physicians to treat at least some Medicaid patients.⁴⁶ Despite the unwillingness of some providers to care for Medicaid enrollees, previous expansions have offered strong evidence that acquiring coverage through this program gives previously uninsured persons markedly enhanced access to needed medical care.²²⁻²⁴

The final major challenge facing the program is a budgetary one. As a former state Medicaid director put it, “The big issue for Medicaid has always been about the money. From the opening bell, governors, budget directors, and legislators have expressed concern about the long-term fiscal sustainability of Medicaid” (Smith V: personal communication). As shown in Figure 2, growth in Medicaid spending has been steep, particularly during recessions, and this growth already began to accelerate in 2014 under the

ACA. CMS is projecting that Medicaid spending will double to about \$919 billion by 2023.⁴⁷ However, Figure 3 shows that this spending increase in recent years has been entirely due to increased enrollment, whereas per-enrollee spending has leveled off since 1998. In this area, there is an asymmetry between whom Medicaid covers and whom it spends its money on: although 75% of Medicaid enrollees are children and working-age adults, nearly two thirds of Medicaid dollars go toward care for the program’s elderly and disabled beneficiaries.⁴⁸ Key to managing Medicaid’s budget pressures will be improving what is often a fragmented system of care for patients with chronic medical problems, many of whom are dually enrolled in Medicare and Medicaid or receive long-term care services. Efforts to design more coordinated care for such patients, including several state demonstration programs to improve quality and reduce the costs of care for dual-eligibles, will be central to the program’s long-term financial health.⁴⁹

As the 114th Congress takes shape and 2016 presidential contenders emerge, there are signs that some Republicans are looking for ways to “emphasize policy prescriptions to address concerns of the poor and middle class.”⁵⁰⁻⁵² Another political challenge that faces the new Congress is whether legislators can reduce, if not muzzle, the toxic partisanship that has greatly reduced progress in recent sessions. In announcing his retirement after 40 years, Rep. Henry A. Waxman (D-CA), one of the most successful legislators of modern times and a tenacious champion of Medicaid, emphasized that reaching out to Republicans was a key to his success. “Many times they would make criticisms or proposals that improved the legislation, and I welcomed that. . . . Every bill that I authored that became law had Republican support of one sort or another except for one, and that was the Affordable Care Act.”⁵³

Hubert Humphrey, vice president under Lyndon Johnson when Medicaid was first enacted, once said, “The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and the handicapped.” Those words are inscribed on the wall of the Humphrey Building in Washington, home to the Department of Health and Human Services, which oversees Medicaid. As policymakers continue to debate the proper size, oversight, and design of the program, what is clear is that the ACA has ushered in a new era for Medicaid, in which Humphrey’s “moral test” has expanded its scope far beyond the children, the elderly, and the disabled. Now at the age of 50 years, Medicaid faces a future filled with numerous challenges but also opportunities to improve health care — and health — for tens of millions of Americans.

Disclosure forms provided by the authors are available with the full text of this article at [NEJM.org](http://nejm.org).

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