Symposium

Insights on the dynamics of Medicaid

Introduction

by Mary S. Kenesson and Steven B. Clauser

Public policy perspective of the Medicaid program is changing. After enactment of Medicaid in 1965, public concern focused on demand for health services and patterns of growth within the program. Attention was largely placed on the extent to which the program achieved the cost, access, and quality of care objectives for the specific groups of low-income individuals and families covered under title XIX. Today's public interest in assessing Medicaid's experiences and evolution reflects a much broader perspective on the program's potential in shaping the Nation's health care system.

Symposium participants, representing a range of outlooks and viewpoints, were asked to provide insights on how the particular structure and dynamics of the Medicaid program affect its value and effectiveness, and how the Medicaid model and the program's experiences can constructively influence health policy change. We presented the following broad questions to each contributor:

- How does the Medicaid policy and operational arena foster innovative solutions to systemic problems?
- What are the opportunities and the value offered by State and local flexibility in tailoring the program to local needs and interests?
- What are the tradeoffs inherent in a climate of flexibility and innovation—e.g., difficulties in sharing and replicating successes or "lessons learned," in analyzing data and understanding a program characterized by variety and, hence, complexity?
- As broader health policy reform agendas evolve, what are the "lessons learned" from the Medicaid experience,—e.g., in structuring balanced State-Federal control, in fostering adaptability and innovation, in meeting the needs of special populations?
- Where and how has Medicaid best "worked," taking full advantage of how it's designed? Where have the tensions inherent in the program been "healthy" ones? What hasn't worked and why?

The symposium brings together three kinds of viewpoints on these issues. James R. Tallon addresses Medicaid issues based largely on his experience as a State legislator in New York and through active participation on many committees addressing national and State health policy issues. Drew Altman's article reflects his broad managerial experience with the Medicaid program in both Federal and State government and, more recently, as Director of the Health and Human Services program at the Pew Charitable Trusts, which funds research and demonstration projects related to health care for poor and disadvantaged populations. He has recently moved to Kaiser-Permanente, where he will have an opportunity to directly influence the provision of care to Medicaid beneficiaries as President of one of the Nation's largest health maintenance organizations. Altman's coauthor is Dennis F. Beatrice, who has considerable experience with the Medicaid program as a State official in New Jersey and as senior program advisor at the Pew Charitable Trusts.

Gary J. Clarke analyzes Medicaid from the perspective of a State Medicaid Director who deals with the realities of administering the Florida Medicaid program on a daily basis.

Despite the different backgrounds and viewpoints of the respondents, several broad themes and issues emerge from the articles in this symposium. The first theme is the broad diversity of the structure and administration of the Medicaid program. All of the respondents note the difficulties in understanding and analyzing a program that is not designed to address the health care needs of all poor Americans on a nationally uniform basis, but rather is uniquely molded within each State to serve distinct segments of the poor population that have very different needs. As Altman and Beatrice note: "Medicaid is really three programs in one: a program for low-income women and children; a program for the blind and disabled; and a program—really a catastrophic insurance program—for the elderly in need of long-term care." This distinction raises enormous challenges for strategic policymaking, as well as program and fiscal management.

The second major theme is the transformation of State Medicaid program management beyond essential administrative processes to proactive innovation in health policy, financing, and service delivery during the past decade. All respondents note the growing inclination of State Medicaid officials to search for and develop creative solutions to pressing issues in their States. Clarke notes that many State Medicaid programs have developed considerable expertise in critical aspects of health policy and program administration in the past decade.

Another important theme is the growing tendency to associate Medicaid with potential solutions to issues with much larger social policy significance. All respondents note the increased attention given to Medicaid in addressing the problems of the medically uninsured, chemically dependent, human immunodeficiency virus infected, and functionally and cognitively disabled segments of the population as evidence of this trend. A key issue raised by all respondents is the different strategic views of the program engendered in this debate: as a health insurance program, isolated from welfare and as a potential base for broader coverage of the medically uninsured; or as a more integral part of a comprehensive set of welfare and other social service programs to address the health-related needs of low-income individuals and their families affected by the devastation of problems such as drug addiction, acquired immunodeficiency syndrome, and Alzheimer's disease. Policy choices along each of these dimensions have potentially significant implications for the future evolution of the Medicaid program.

An interesting point raised by all respondents is the importance of maintaining and enhancing the basic infrastructure of health facilities and health professionals whose participation is essential for achieving program objectives. In this regard, all respondents draw special attention to the need for more initiative in the areas of

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primary care and obstetrics. Altman notes that ". . . one way to begin to address this problem without substantial new expenditures (is to) get serious about expanding managed care."

Finally, all respondents emphasize the difficulties confronting both the States and the Federal Government in addressing Medicaid policy issues alone. The growing demands placed on Medicaid resources in the coming years require a strengthened State-Federal partnership to marshal program resources effectively within current Federal and State fiscal realities. Tallon's article, in particular, outlines the multiple views currently under debate for repositioning Medicaid in the search for solutions. Whether program changes are incremental or systemic, and occur slowly or rapidly, Clarke emphasizes the need to build on the States' Medicaid management expertise, their demonstrated capacity for innovation, and their ability to work directly with local agencies and providers in balancing State and Federal fiscal and policymaking responsibilities.

Perspectives on the Medicaid program

by Drew Altman and Dennis F. Beatrice

Introduction

Viewed from one vantage point, Medicaid has been one of the most successful social programs this country has launched. It represents a dramatic achievement in providing access to care for low-income people and stands in sharp contrast not only to the situation that existed prior to the passage of the Medicaid program, but also to the plight of the uninsured today. Medicaid also serves some of the Nation's neediest and most vulnerable groups, especially low-income women and children, the elderly, and the blind and disabled. It provides coverage to more than 25 million people, many of whom would otherwise be added to the ranks of the uninsured.

Yet, despite its important contributions to access to health care for the poor, Medicaid has never been a popular program. Indeed, it is the health care program everyone loves to hate. Governors and State administrators see it as the "Pac Man" of State budgets, eating up a substantial share of available increases every year. Providers believe Medicaid pays them too little and too slowly. Federal executives see a constant stream of State Medicaid waiver requests, with tortuous arguments for budget neutrality, that seek to raid the Federal treasury. And clients view Medicaid as a mixed blessing: It offers a vital health benefits life line, but they view it as stigmatizing, and obtaining care is often frustrating.

Both sides of the ideological aisle also have their reasons to dislike the Medicaid program. Liberals view Medicaid as diverting the Nation's attention from the need for national health insurance. They are troubled by the fact that the program covers less than one-half the Nation's poor and that there are substantial variations in State Medicaid programs. Conservatives view Medicaid as "just another welfare program," this time hiding in health care clothes. Their view is that welfare programs, including Medicaid, have caused more harm than good by promoting dependency and using taxpayer dollars unwisely.

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Not surprisingly, given these perceptions, Medicaid has not built a strong constituency and has received only a fraction of the analytical attention devoted to Medicare. Another reason for this lack of affection and focus is the complexity and diversity of the program. As is well known by the readership of this journal, Medicaid is really three programs in one: a program for low-income women and children; a program for the blind and the disabled; and a program—really a catastrophic insurance program—for the elderly in need of long-term care. Remembering that each of these 3 programs looks a little different in every State, one realizes that Medicaid is really 150 different programs spread across the 50 States. It is difficult to comprehend, analyze, or mobilize support for a program this diverse. The result is that Medicaid plays its role as payer of last resort and provides care to the most vulnerable populations without much fanfare or support.

As Human Services Commissioner and Associate Commissioner in New Jersey, and long-time advocates for Medicaid, we sometimes even found ourselves losing our affection for the Medicaid program, as annual Medicaid increases consumed funds needed for other priority areas. In any given year, the increase in Medicaid necessary just to maintain current services consumed about one-half of all the new funds available for our department. This left the homeless, the mentally ill, the elderly, the developmentally disabled, veterans, welfare recipients, and other needy groups to fight for the leftovers after Medicaid had taken its share.

The last 10 years

In recent years, Medicaid has gone through some important changes. With State and national economies faltering, the early eighties saw a period of cost containment in the Medicaid program. During this time, the States and the Federal Government faced a common challenge: how to control Medicaid expenditures without hurting needy clients. The specific challenge Medicaid faced was how to limit expenditures without resorting to the traditional, quick-fix Medicaid cuts—reducing eligibility, eliminating benefits, or reducing payments to providers. Although Federal policy changes in the early eighties reduced Medicaid eligibility for some groups (Omnibus Budget Reconciliation Act of 1981, Public Law 97-35), by and large, States worked hard to avoid