

Chapter 8

Safety Net Programs: Medicare, Medicaid, and SCHIP (CHIP)

In the previous chapter, we discussed access to health care services in the United States, and critically examined the disparities in the accessibility of health services and in some health measures among the country's different ethnic and racial groups. We concluded Chap. 7 by noting that the identified differences in uninsurance rates and in health disparities among segments of the population would probably have been worse were it not for the safety net programs that have been funded to provide insurance coverage and health care services for the poor, elderly, disabled, and pregnant women and their children.

The review of the history of the evolution of the health care system undertaken in Chap. 2 shows that the health expansions put in place during the postindustrial period, such as passage of the Hill-Burton program and massive investments in biomedical research, did not curtail the perceived inequities in the distribution of health services. At the same time, the prices charged for medical services increased significantly, thereby putting severe strains on the elderly and the needy. It was in response to these concerns about inequity in the distribution of health services and the inability of some people to pay for care that led to the passage of the Kerr-Mills Act of 1960, the predecessor to Medicare and Medicaid. In 1965, 6 years after the launching of the Kerr-Mills program, Medicare and Medicaid were passed. Consequently, this chapter is devoted to examining Medicare, Medicaid, and the changes that were made to Medicaid in 1997 that resulted in the State Children's Health Insurance Program (SCHIP), simply called Children's Health Insurance Program (CHIP) since March 2009. We begin by examining Medicare.

Medicare

Medicare, Title XVIII of the *Social Security Act* (SSA) or Health Insurance for the Aged and Disabled, is a federal program for financing hospital, physician, and other acute care and prescription drug services for the elderly and disabled. The disabled

became eligible for Medicare in July 1973 (Davis et al. 1990, p. 16), and the prescription drug program started on January 1, 2006.

The passage of Medicare, which came about after many unsuccessful attempts to enact a national health insurance program for the country, ushered in a new era for the federal government's role in health care. Medicare was expected to be the first step toward the enactment of a national health insurance plan.

The History of Medicare

As we discussed in Chap. 2, political discontent led to the introduction of social insurance in almost all of the major European countries on the eve of World War I. But unlike in Europe, there was no significant threat to the United States' political system and governing arrangements during the period. In addition, labor unions, employers, and the then powerful AMA were opposed to national health insurance. As a result, the Progressive Movement's proposal for national health insurance did not make any headway in the early 1920s.

Furthermore, the linking of social insurance to Nazi Germany effectively ensured that the idea would not enjoy strong public support in the United States. In addition, the Great Depression changed the order of social reform in the country by placing unemployment insurance on top of the social policy agenda. It was out of this environment that the Roosevelt administration decided, on coming into office in 1932, not to push the national health insurance idea. In other words, President Roosevelt and his advisers decided to invest their political capital in promoting and seeking passage of the SSA in 1935 (Marmor 2000, p. 6). For example, the original language in the draft Social Security legislation, which authorized the federal government to study the concept of health insurance, was removed from the final legislation on the orders of President Roosevelt and his top advisers (Oberlander 2008, p. 311).

President Harry Truman and his advisers, who succeeded Roosevelt, were very open to the idea of a national health insurance program. The President openly and formally endorsed a national health insurance plan for the country. However, the new Administration was not successful in pushing the idea to the policy formulation and legitimation phases. The AMA coined the phrase "socialized medicine" to attack the Truman administration's proposal. This opposition led Truman and his advisers to adopt an entirely new approach, incrementalism.

The incremental approach, drafted by Truman advisers Wilbur J. Cohen and I. S. Falk, limited health insurance to the beneficiaries of the Old Age and Survivors Insurance (OASI) program, the national, contributory, earnings-related pension program for the retired aged and their survivors, established by the SSA of 1935 (Marmor 2000, p. 9). In 1951, a new plan to insure the seven million aged social security beneficiaries for 60 days of hospital care per year was announced. By focusing on social security beneficiaries whose medical and financial deprivations were due to the natural process of aging, and who had paid their dues during their productive working years, the new proposal sought to avoid the pitfalls of the earlier proposals that could not be enacted.

A new and modest Medicare proposal covering only hospital costs for the elderly on Social Security was introduced in 1958 by Aime Forand, a congressman from Rhode Island. As in the past, the AMA opposed the plan, but the linking of the proposal to the aged poor resulted in what Starr (1982, p. 368) calls “a groundswell of grassroots support” for the proposal. Congress responded to these pressures by passing the *Kerr-Mills Act* in 1960. The Kerr-Mills program extended federal support for indigent medical care programs in the country; between 50 and 80% of the funding for the program was borne by the federal government.

Liberal members of Congress were unhappy with the means-tested nature of the Kerr-Mills program, which was thought to be a source of humiliation for the aged. In addition, the program was said to be an insufficient response to the medical and financial needs of the elderly. Furthermore, it was argued that state governments would not move vigorously to take advantage of the program. This latest fear was validated by a report in 1963 which found that only 32 of the 50 states had programs in effect to take advantage of the provisions of the Kerr-Mills legislation (Marmor 2000, p. 29; Harris 1966, p. 110, 144). Many states had not acted at all, and five industrial states, with one third of the nation’s population, were receiving 90% of the Kerr-Mills funds.

The 1964 general elections, in which Lyndon Johnson won the presidency in a landslide and Democrats gained wide majorities in both Houses of Congress, broke the power of the conservative coalition that was successful in blocking previous health care legislative proposals. Ironically, the AMA introduced its own “Eldercare” plan that promised the elderly more generous benefits, including payment for physician services. Similarly, the senior Republican member of the House Ways and Means Committee also introduced a voluntary insurance plan, subsidized out of government revenues, which would cover major medical and doctors’ services and drugs. The elderly share of the costs of the proposal was to be scaled to their Social Security benefits (Starr 1982, p. 369).

The AMA and Republican Medicare proposals exposed the limitations of the Democratic proposal. Therefore, convinced that the public wanted a more generous plan, Representative Wilbur Mills decided to expand the Democratic proposal. He proposed combining the Democratic and Republican proposals and adding a third program to provide medical services for the poor, for a total of three distinct components.

The first component of Rep. Mills’ proposal was the Democratic compulsory hospital insurance program under Social Security. The second component was a revised Republican proposal of a government-subsidized voluntary insurance program to pay for physicians’ services; and the third component provided expanded assistance to the states for medical care for the poor. The three components became Medicare Parts A, B, and Medicaid. These programs were enacted without serious difficulty and signed into law by President Johnson in July 1965. The combination of three distinct proposals sponsored by different interest groups to form the Medicare and Medicaid programs supports the assertion we made when discussing advocacy coalitions in Chap. 1 that the initial Medicare and Medicaid legislations were the result of the equilibrium that was reached among the competing groups that took part in designing the programs.

The threat by some physicians to organize a boycott of Medicare did not materialize when the medical profession discovered, after the program went into effect, that the indirect benefits to them were substantial. However, as we shall soon discuss, Medicaid was not widely accepted by the medical profession (Starr 1982, p. 370). These differences in acceptability of Medicare and Medicaid were partly due to the differences in their organization, financing, and goals.

Medicare Financing, Organization, and Goals

Medicare is a federal program financed through a combination of payroll taxes. The program was intended to provide health insurance coverage to elderly retirees who were no longer eligible for employer-sponsored insurance (ESI). Its design was based on the argument that to correct the insurance problems the elderly experienced, government should provide some assistance through a universal entitlement—the provision of aid without regard to personal income or means, but based on some more or less objective indicator of need, in this case, age and previous work record (Aaron and Reischauer 1995, p. 9).

Since Medicare is a form of universal entitlement, it is solely financed by the federal government and involves the same eligibility standards and benefit levels throughout the country. Accordingly, the program covers everyone aged 65 and older who has worked in a job subject to payroll deduction, or a spouse of an entitled worker, including the relatively recent addition of the disabled and persons with end-stage renal disease (ESRD). The program is structured to achieve specific goals related to hospitalizations, physician and laboratory services, and prescription drugs.

Program Structure and Benefits

Medicare comprises four parts, A, B, C, and D, which are discussed in detail below.

Part A: Hospital Insurance

Medicare Part A is a hospital insurance (HI) program that covers inpatient hospital stays (including semiprivate room, food, and medical tests), skilled nursing facility (SNF) (noncustodial), hospice, and home health care. The inpatient hospital stay is covered when a doctor says it is needed to treat a beneficiary's illness or injury. Recipients are covered for up to 90 days per benefit period plus a lifetime reserve of 60 hospital days. Covered hospital services include a semiprivate room, meals, general nursing, and other hospital services and supplies. The services covered do not include private-duty nursing, a television or telephone in a beneficiary's room, and personal care items, such as razors or slipper socks. Private rooms are also not covered, unless medically necessary.

In 2011, a Medicare Part A recipient pays the following for each benefit period: \$1,132 for the first 60 days of inpatient hospital stay; \$283 coinsurance for each day from days 61 to 90; \$566 coinsurance for each “lifetime reserve day” after 90 days during each benefit period; all costs incurred after exhausting all the lifetime reserve days. Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime (Medicare.gov. 2011a, p. 30).

The coverage for convalescence in a SNF is subject to certain conditions. First, a preceding hospital stay must be at least 3 days, 3 midnights, not counting the discharge date. Second, the skilled nursing home care must be for illness diagnosed during the hospital stay or for the main diagnosis that led to the hospital stay. Third, if the patient is not undergoing rehabilitation, there must be some other acceptable condition that requires skilled nursing care. And fourth, the care given in the SNF must indeed be skilled, and not involve custodial, nonskilled, or long-term care (LTC) activities, including moving around the house, toileting, cooking, cleaning, eating, etc.

The maximum length of stay that Medicare Part A will cover in a SNF per ailment or episode of illness is 100 days. The first 20 days would be paid for in full by Medicare, while the remaining 80 days would require a copayment. As of 2011, the copayment is about \$141.50 per day. If a recipient uses some portion of their Part A SNF benefit and then goes at least 60 days without receiving facility-based skilled nursing services, the 100-day clock is reset and the person qualifies for a new 100-day benefit period (Wikipedia 2011a, p. 1; Medicare.gov. 2011a, p. 43).

Part B: Medical Insurance

Part B is medical insurance that helps pay for some services and products that Part A does not cover, mostly services that are provided on an outpatient basis. This benefit is optional and may be deferred to a later date or time if the beneficiary or their spouse is still working and receiving ESI.

Part B coverage starts once the beneficiary meets his or her deductible. After that, Medicare covers 80% of approved services, while the beneficiary pays the remaining 20%. There is a lifetime penalty of about 10% per year if an eligible individual who is not actively working fails to enroll in Part B.

Medical insurance coverage includes physician and nursing services, X-rays, medical laboratory and diagnostic tests, influenza and pneumonia vaccinations, blood transfusions, renal dialysis, outpatient hospital procedures, limited ambulance transportations, immunosuppressive drugs for patients receiving organ transplants, chemotherapy for cancer patients, hormonal treatments, and other doctor office outpatient medical treatments, including medication administration.

Medicare Part B also covers durable medical equipment, such as canes, walkers, wheelchairs, and mobility scooters for those the device has been prescribed by a licensed physician. Artificial limbs, breast prosthesis following mastectomy, one pair of eyeglasses following cataract surgery, and oxygen for home use are covered. Periodic coverage advisories known as National Coverage Determinations (NCDs) are issued by the CMS. Local Coverage Determinations (LCDs) apply within the multistate area managed by a specific regional Medicare Part B contractor (Wikipedia 2011a, p. 6).

Part C: Medicare Advantage

The *Balanced Budget Act* (BBA) of 1997 (PL 105-33) made significant and broad policy changes to Medicare and children's health insurance. The legislation, signed into law by President Clinton on August 5, 1997, gave Medicare beneficiaries the option of receiving their Medicare benefits through private health insurance plans, rather than getting benefits through the original Medicare Parts A and B. The new private health insurance plans that Medicare beneficiaries could receive services from were known as "Medicare+Choice" or "Part C" plans. The *Medicare Prescription Drug, Improvement, and Modernization Act* of 2003 (MMA 2003) attempted to make Part C plans more attractive to Medicare beneficiaries by adding prescription drug coverage and renaming the plans "Medicare Advantage" (MA) plans.

In addition to the changes made to Medicare, the BBA of 1997 also made available nearly \$13 billion in federal money to provide health insurance coverage to children who lost coverage as a result of the 1996 federal welfare reform legislation (National Association of Social Workers (NASW) 1997, p. 1). This provision essentially established SCHIP, which is discussed more fully under Medicaid.

Medicare Part C or Medicare Advantage is essentially an attempt to introduce managed care into Medicare. Unlike the traditional Medicare program which has a standard package of benefits that members can receive from any hospital or physician in the United States, under Medicare Advantage plans a fixed or capitated amount is paid per enrollee per month. Enrollees typically also pay a monthly premium in addition to the Medicare Part B premium to cover services not covered by traditional Medicare (Parts A and B). These additional services may include prescription drugs, dental and vision services, catastrophic coverage, and exercise or health club memberships. These additional services give enrollees "advantage" over traditional Medicare enrollees. However, Advantage Plans' enrollees may be subject to gatekeeping practices, such as a limited network of providers or extra fees for using nonpanel or nonnetwork providers.

Similar to the different types of managed care plans discussed in Chap. 4, there are equally different types of Medicare Advantage Plans. These include HMO Plans, PPO Plans, Private Fee-for-Service (PFFS) Plans, and Special Needs Plans (SNP) which, as the name suggests, are designed for people with special medical needs. In addition, other less common types of plans may be available, such as Health Maintenance Organization Point of Service (HMOPOS) Plans, Medical Savings Account (MSA) Plans, and Prescription Drug Plans (PDP) or MA-PDs (Medicare.gov. 2011b).

Since the payment formulas established by the MMA of 2003 overpay MA plans compared to traditional Medicare, in 2006 enrollees in Medicare Advantage PFFS plans were offered more benefits than enrollees in traditional Medicare (Merlis 2008). However, some concerns have been raised about the quality of care received by minorities and older, poorer, and sicker persons in MA plans (Trivedi et al. 2006, p. 1998; Hellinger 1998, p. 833). These concerns may cause minorities and the older and sicker MA enrollees to drop their enrollments in MA plans and to reenroll in traditional Medicare, resulting in adverse selection within the traditional program.

Additionally, the Government Accountability Office (GAO) reported in 2008 that the administrative costs of private Medicare Advantage plans for 2006 were much higher than those of traditional fee-for-service Medicare. In that year, the plans earned profits of 6.6%, had overhead of 10.1%, and provided 83.3% of the revenue dollar in medical benefits (GAO-09-132R).

In fairness, it must also be noted that an analysis of the AHRQ data published by America's Health Insurance Plans (AHIP) found that Medicare Advantage enrollees spent fewer days in the hospital than FFS enrollees, were less likely to have "potentially avoidable" admissions, and had fewer readmissions. The comparisons among MA and FFS enrollees adjusted for age, sex, and health status using the risk score used in the MA risk adjustment process (Chovan et al. 2009; Chovan and Chen 2009).

Part D: Prescription Drugs

Medicare insurance drug coverage made possible by the passage of the MMA of 2003 became effective on January 1, 2006. Prescription drug coverage is insurance run by an insurance company or other private company approved by Medicare. In order to get the prescription drug benefit, a Medicare beneficiary must either enroll in a Medicare PDP, or enroll in a Medicare Advantage (MA) Plan. PDPs add prescription drug coverage to original Medicare, Medicare Cost Plans, Medicare PFFS Plans, or to Medicare MSA Plans; MA Plans, which were described under the previous sub-heading, offer all Medicare Parts A and B services, along with prescription drug benefits. Those who do not join a Medicare drug plan when they first become eligible and who have no other credible prescription drug coverage at the time they fail to enroll are likely to pay a late enrollment penalty when they finally decide to enroll.

Unlike the original Medicare program (Parts A and B), Part D coverage is not standardized. Each plan can vary in drugs covered and cost. In other words, the plans choose the drugs they cover, the level (tier) of coverage, and are free to choose not to cover some drugs at all. The exceptions to these are the drugs that Medicare specifically excludes from coverage, such as benzodiazepines, cough suppressants, and barbiturates. If a drug plan chooses to cover the Medicare-excluded drugs, their costs cannot be passed on to Medicare. However, Medicaid may pay for drugs not covered by Medicare Part D on behalf of dual eligibles (those eligible for both Medicare and Medicaid).

Just as Part D plans may vary in costs and drugs covered, the monthly premiums paid by enrollees may also vary based on income. The monthly premium cost is determined by comparing beneficiaries' average modified adjusted gross incomes from the previous 2 years' tax records to a certain predetermined amount. Those with higher average modified adjusted gross incomes from the previous 2 years pay higher premiums than those with lower average modified adjusted gross incomes for the same period. In that sense, the premium costs among beneficiaries are progressive in nature, with higher income earners paying higher premiums than lower income earners.

As was stated during our discussion of Medicare Part A, Medicare recipients are covered for 90 days of hospital stay per benefit period plus a lifetime reserve of 60 hospital days. Similarly, Part B also has deductibles that the elderly must pay. Therefore, neither Part A nor Part B pays for all the medical costs of the elderly. These limitations or gaps in Parts A and B coverage are out-of-pocket costs that must be borne by program beneficiaries. Some people elect to purchase a type of supplemental coverage, called a Medigap policy, to help cover the gaps in original Medicare Parts A and B.

Medigap Policies

Medicare supplemental insurance or Medigap policies are sold and administered by private insurance companies, but are standardized by the CMS in order to minimize variations in the policies sold to the elderly. Policy holders pay the full costs of this additional insurance coverage. Some Medigap policies sold before 2006 could include coverage for prescription drugs, but after the MMA came into force on January 1, 2006, Medigap policies are prohibited from covering drugs. Similarly, Medicare regulations prohibit a Medicare beneficiary from having both a Medicare Advantage Plan and a Medigap Policy.

Medigap policies follow Federal and State laws. The standardized Medigap policies that insurance companies sell are required to provide the same benefits, with the only difference between them being the costs. In most states, except Massachusetts, Minnesota, and Wisconsin, insurance companies can only sell standardized policies identified by letters A through N. Plans M and N were new as of June 1, 2010. Plans E, H, I, and J are no longer sold, but people who had those plans prior to the change in policy on June 1, 2010, can keep them (CMS 2011a). Additionally, one may be able to buy Medicare Select policies, variants of managed care plans, which may limit enrollees to a select group of physicians and hospitals. In return for subjecting enrollees to gatekeeping practices, select plans may be cheaper than other plans.

Table 8.1 summarizes the standardized Medigap Plans currently available. Insurance companies that sell Medigap policies are required to make Plan A, the most basic coverage, available. If they offer any plan, they must also offer either of the two most popular plans, Medigap Plan C or Plan F.

As we noted earlier, Medigap policies are standardized in different ways in Massachusetts, Minnesota, and Wisconsin, than shown in Table 8.1. In Massachusetts, the basic benefits include: coverage of the Medicare Part A coinsurance plus coverage for 365 additional days after Medicare coverage ends; coverage of the Medicare Part B coinsurance, generally 20% of the Medicare-approved amount; coverage of the first three pints of blood each year; coverage of Part A Hospice coinsurance or copayment; coverage of 60 days of care per Calendar Year in inpatient mental health hospitals; and coverage of some state-mandated benefits, such as annual pap tests and mammograms. Additional benefits are available under a supplemental plan.

Minnesota's Medigap basic benefits include: coverage of the Medicare Parts A and B coinsurance; coverage of the first three pints of blood each year; coverage of

Table 8.1 Standardized Medigap plans

Medigap benefits	Medigap plans										
	A	B	C	D	F ^a	G	K	L	M	N	
Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	X	X	X	X	X	X	X	X	X	X	X
Medicare Part B coinsurance or copayment	X	X	X	X	X	X	50%	75%	X	X ^b	
Blood (first three pints)	X	X	X	X	X	X	50%	75%	X	X	
Part A hospice care coinsurance or copayment	X	X	X	X	X	X	50%	75%	X	X	
Skilled nursing facility (SNF) care coinsurance			X	X	X	X	50%	75%	X	X	
Medicare Part A deductible		X	X	X	X	X	50%	75%	50%	X	
Medicare Part B deductible			X		X						
Medicare Part B excess charges					X	X					
Foreign travel emergency (up to plan limits)			X	X	X	X				X	
Out-of-pocket limits ^c							\$4,640	\$2,320			

^aPlan F also offers a high deductible plan. Those enrolled in this plan must pay for Medicare-covered costs up to the deductible amount of \$2,000 in 2011 before the Medigap plan pays anything

^bPlan N pays 100% of the Medicare Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to \$50 copayment for emergency room visits that result in an inpatient admission

^cAfter enrollees meet their out-of-pocket yearly limit and their yearly Part B deductible (\$162 in 2011), the Medigap policy pays for 100% of covered services for the rest of the calendar year

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (2011a), p. 11

Medicare Part A Hospice and respite, as well as the home health services and supplies’ cost sharing; coverage of 100 days of Medicare Part A SNF Coinsurance, Medicare-covered preventive care, specified payments for foreign travel emergencies, outpatient mental health, and physical therapy; and coverage of State-mandated benefits, such as diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations. Additional benefits are available under the Extended Basic Plan.

In Wisconsin, the Medigap basic benefits include: coverage of the Medicare Part A coinsurance for inpatient hospital care, as well as the Medicare Part B coinsurance, usually 20% of the Medicare-approved amount; coverage of the first three pints of blood each year, as well as the Part A Hospice coinsurance or copayment; 175 days inpatient mental health coverage per lifetime in addition to Medicare’s mental health benefit; and 40 home health care visits in addition to those paid by Medicare. Furthermore, insurance companies are allowed to offer additional specified riders to a Medigap policy, plans known as “50 percent and 25 percent Cost-Sharing Plans,” and a high deductible plan (\$2,000 in 2011) (CMS 2011b).

Buying Medigap Policies

Medigap insurance companies use medical underwriting to decide who to insure and how much to charge for a policy. However, applicants who elect to buy policies during their open enrollment period may not be subjected to medical underwriting. In other words, applicants who elect to buy coverage during their open enrollment period may buy any Medigap policy the insurance company sells, even if they have health problems or preexisting conditions, for the same price as people in good health or without preexisting conditions. Only those who meet limited specified conditions may buy Medigap policies outside of their open enrollment periods. In addition, insurance companies are required to offer a 30-day “free look” period for Medigap plans, during which people who buy policies can cancel for a full refund.

In addition to the Medicare direct benefits identified in the course of our discussion of the program’s financing, organization, and goals, Medicare confers additional important indirect benefits on society and the families of Medicare beneficiaries. According to Gusmano and Schlesinger (2001, p. 37), since its inception, the Medicare program has addressed needs beyond those of its titular beneficiaries. It has also provided some services that are only loosely related to insuring beneficiaries against the costs of medical care. Both the direct and indirect benefits have significantly increased the costs of the program, leading to cost controls. In the following pages, we examine Medicare’s indirect benefits, program costs, and the strategies that have been employed to contain program costs. We begin with the program’s indirect benefits.

Medicare’s Indirect Benefits

The number and scope of Medicare’s indirect benefits have increased significantly since the program’s inception in 1965 (Gusmano and Schlesinger 2001, p. 38). The costs of the indirect benefits, in association with the perception that Medicare faces serious financial problems in the years to come, have made the indirect benefits more controversial (Altman et al. 1997; Institute of Medicine 1997). The Medicare program’s indirect benefits include support for graduate medical education or residency training, subsidies to insurance company intermediaries and health care providers, various forms of information collection and dissemination, support for health services research, beneficiary education programs, and financial and psychological relief for the families of the elderly who would have had to pay their loved one’s medical bills if the program was not in place.

Support for Graduate Medical Education

Medicare has supported the residency training functions or graduate medical education of teaching hospitals since its enactment in 1965 (Altman et al. 1997; Institute of Medicine 1997). These support activities include payments for the so-called

direct medical education (DME) costs, including stipends paid to residents and their trainers. The program also pays teaching hospitals for the indirect costs of graduate medical education (IME payments). Both the DME and IME payments run into billions of dollars annually (Gusmano and Schlesinger 2001, p. 41).

Subsidies to Intermediaries and Providers

The political struggle for the passage of Medicare that we discussed under the history of the program caused supporters to adopt strategies that would lessen interest groups' opposition to the legislation. To ensure the support of the AMA, the Medicare legislation avoided prescribing a fee schedule for physicians and stipulated instead that physicians treating Medicare patients would be paid their "usual and customary fee," provided the fee was also "reasonable" (Marmor 2000, p. 61). Furthermore, physician fees were decoupled from hospital fees, and it was not required that the physician directly charge the insurance company intermediaries that were enlisted to handle the government payments. Rather than directly charging the insurance company, the physician could bill the Medicare patient, who would pay the bill and present the receipt to the insurance intermediary for reimbursement. Based on this provision, the physician could bill the Medicare patient for more than the government would be willing to pay.

Furthermore, the Medicare legislation used a generous cost-based or retrospective payment method for hospital services provided to Medicare beneficiaries. This initial hospital payment method also included a 2% bonus payment to cover capital costs (Oberlander 2008, p. 314). In addition, the utilization of insurance intermediaries that typically enjoyed close relationships with hospitals and doctors to fulfill the program's payment functions ensured that Medicare would not be used to regulate the practice of medicine. It also caused significant increases in the program's overhead costs. Therefore, those who were initially bent on blocking the Medicare legislation became prominent indirect beneficiaries of the program—they made large sums of money from the programs.

As was discussed in Chap. 7 under access to health care services, the characteristics of patients affect their access to health care services. Specifically, predisposing factors, such as race, level of education, and gender, may influence the care physicians provide their patients and the patients' ability to access necessary health care services. For example, because some providers either do not accept Medicaid or limit their Medicaid caseloads, Medicaid beneficiaries and other poor patients are very likely to use public facilities and emergency rooms for their health care needs. These public and institutional settings, especially those located in large urban areas and in inner cities, tend to see a disproportionate proportion of the poor and uninsured than their counterparts in affluent middle-class areas. Disproportionate share adjustments are available to disproportionate share hospitals (DSHs) under both Medicare and Medicaid.

The Medicare-DSH adjustment provision was enacted by Section 9105 of the *Consolidated Omnibus Budget Reconciliation Act* (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986. Hospitals can qualify

based on a complex statutory formula that yields a DSH patient percentage, or by demonstrating that more than 30% of their net inpatient revenues come from State and local governments for indigent care, excluding Medicare and Medicaid. The payments are meant to compensate DSHs both for higher average Medicare patient costs and higher costs associated with providing care to indigent patients (Gusmano and Schlesinger 2001, p. 41; CMS 2011b).

The so-called Sole Community Hospitals (SCH) Program, established under amendments to the SSA in 1972, resulted in the Health Care Financing Administration (HCFA), and now the CMS, subsidizing the SCHs. Similarly, as a result of the introduction of the Medicare prospective payment system (PPS) in 1983, rural hospitals received lower base payments because they had lower average patient care costs, and many of them had to close their doors. The Medicare PPS was blamed for these rural hospital closings, and Congress reacted by instructing the HCFA to eliminate the distinction between rural and “other urban” hospitals (Gusmano and Schlesinger 2001, p. 42). This policy change had the effect of subsidizing rural hospitals in order to improve their financial fortunes.

As we discussed in Chap. 4, the total amount of money raised in any given year to pay for health care is the product of the quantities of health care services provided during the period and their average prices, which in turn are the product of the average incomes of health workers and the hours they expend to provide care. It then follows that when Medicare payments are cut or frozen, providers lay off employees, especially nonphysician employees, or cut their work hours, or both.

This author was a medical technologist in Wichita, Kansas, at the time of the implementation of the Medicare PPS in 1983. The decline in hospital revenues caused by the PPS resulted in layoffs of nurses and other hospital personnel and in a decline in the volume of laboratory tests physicians ordered for Medicare patients. The point, therefore, is that providers, their employees, equipment manufacturers, and the localities where the health providers that participate in Medicare are located are some of the indirect beneficiaries of the Medicare program. These indirect benefits are substantial and have important economic consequences.

Support for Health Services Research

The CMS provide grants and access to data to health policy researchers to conduct meaningful research and disseminate the research findings. Separately, the CMS conduct in-house research and demonstration projects that seek to improve health care financing. In addition, Medicare makes other indirect contributions to biomedical and health services research through its support of teaching hospitals and other federal agencies and their researchers.

Information Collection and Dissemination

The CMS collect large quantities of data regarding the costs of medical services provided to Medicare and Medicaid beneficiaries, utilization patterns, providers’

profiles, and total public and private health care expenditures. For example, a large part of the information presented in this chapter, and throughout the book, is acquired from the CMS website. The CMS database is beneficial to health care researchers, Medicare and Medicaid beneficiaries, state and local governments, and the general population. Those who use the data are continuously asked to participate in surveys that are designed to gather the information necessary to make the database more user-friendly.

Beneficiary Education Programs

From my personal observation and experience while working in government, not many redistributive programs make the effort to contact potential beneficiaries and advise them of their eligibility for benefits. But Medicare administrators and, perhaps, the Department of Veterans Affairs, do a good job of being client-centered. The CMS try to provide Medicare beneficiaries with better information about benefits, insurance plan options, copayments and deductibles, and treatment options (McMullan 1996, p. 9). For example, the Medigap policies, benefits, and guidelines referenced earlier in this chapter were developed for Medicare beneficiaries jointly by the CMS and the National Association of Insurance Commissioners (NAIC).

Financial and Psychological Relief for Families

This last category of indirect benefits is not frequently talked or written about, but is nonetheless very important. While Medicare has alleviated the elderly's fear and anxiety of growing old without care and opened the door to greater economic security for the nation's elderly and disabled populations (Frist 1995, p. 82; Moon and Davis 1995, p. 31), it has at the same time alleviated the families of elderly and disabled persons the burden and anxiety of worrying about how to provide and pay for their loved ones' health care services. This benefit, which can be substantial if quantified in monetary terms, allows the family members to focus their energies and resources on other important needs, such as the education of their children.

As was discussed earlier, the direct and indirect benefits of the Medicare program have resulted in significant expenditures. As shown in Table 8.2, in Calendar Year 2006, there were a total of 43.2 million disabled and aged Medicare Parts A, B, and D enrollees, a total expenditure of \$408.3 billion, and an average benefit of \$10,221 per enrollee. By contrast, in Calendar Year 2010, there were a total of 47.5 million aged and disabled Medicare Parts A, B, and D enrollees, a total expenditure of \$522.8 billion, and an average benefit of \$11,762 per enrollee. Therefore, between 2006 and 2010, the total number of Parts A, B, and D enrollees increased by about 10%, total expenditures increased by about 28%, and average benefits per enrollee increased by about 15%.

Another important lesson that can be learned from Table 8.2 is that in both 2009 and 2010, total Medicare Parts A, B, and D expenditures exceeded incomes.

Table 8.2 Growth in Medicare enrollees and expenditures, 2006–2010

Year	Variables	Part A	Part B	Part D	Total
2010	Aged enrollment (millions)	39.2	36.7	N/A	39.6
	Disabled enrollment (millions)	7.9	7.1	N/A	7.9
	Total enrollment (millions)	47.1	43.8	34.5	47.5
	Total income (billions)	215.6	208.8	61.7	486.0
	Total expenditures (billions)	247.7	212.9	62.0	522.8
	Average benefit per enrollee	\$5,187	\$4,786	\$1,789	\$11,762
2009	Aged enrollment (millions)	38.3	36.0	N/A	38.7
	Disabled enrollment (millions)	7.6	6.8	N/A	7.6
	Total enrollment (millions)	46.0	42.8	33.4	46.3
	Total income (billions)	225.4	221.9	60.9	508.2
	Total expenditures (billions)	242.5	205.7	60.8	509.0
	Average benefit per enrollee	\$5,205	\$4,728	\$1,810	\$11,743
2008	Aged enrollment (millions)	37.5	35.2	N/A	36.9
	Disabled enrollment (millions)	7.4	6.6	N/A	7.2
	Total enrollment (millions)	44.9	41.7	32.3	44.1
	Total income (billions)	230.8	200.6	49.4	480.8
	Total expenditures (billions)	235.6	183.3	49.3	468.1
	Average benefit per enrollee	\$5,179	\$4,322	\$1,517	\$11,018
2007	Aged enrollment (millions)	36.6	34.6	N/A	36.9
	Disabled enrollment (millions)	7.2	6.4	N/A	7.2
	Total enrollment (millions)	43.8	40.9	30.9	44.1
	Total income (billions)	223.7	188.7	49.5	461.9
	Total expenditures (billions)	203.1	178.9	49.5	431.5
	Average benefit per enrollee	\$4,573	\$4,312	\$1,575	\$10,460
2006	Aged enrollment (millions)	35.9	34.1	N/A	36.3
	Disabled enrollment (millions)	7.0	6.1	N/A	7.0
	Total enrollment (millions)	42.9	40.3	27.9	43.2
	Total income (billions)	211.5	177.3	48.2	437.0
	Total expenditures (billions)	191.9	169.0	47.4	408.3
	Average benefit per enrollee	\$4,410	\$4,121	\$1,690	\$10,221

Totals do not necessarily equal the sums of rounded components

N/A indicates that data are not available

Source: 2006–2010 Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

The 2010 expenditures were \$36.8 billion, or about 7.6% above income. Similarly, except in 2006 when Part D total income was \$0.8 billion above expenditures, Part D incomes and expenditures were about the same between 2007 and 2009, and Part D income was below expenditures in 2010. These trends are justifications for the concerns expressed by the Medicare Board of Trustees about the long-term financial health of the program.

In their 2010 Calendar Year report, the Medicare Board of Trustees notes that while the lower expenditures and additional tax revenues instituted by the PPACA of 2010 have substantially improved the financial status of the Health Insurance (HI) trust fund, the fund is still not adequately financed over the next 10 years. Furthermore, the

Board notes that Part B costs have been increasing rapidly and are likely to continue to increase. The improvements that the Medicare Board of Trustees expects in the HI trust fund are likely to evaporate if the PPACA is repealed and steps are not taken to retain the financial benefits it confers on the HI trust fund.

Similar to other health insurance programs, Medicare administrators and policy-makers have taken various steps to contain program expenditures. Since most of the measures employed to contain Medicare expenditures (prospective payment based on DRGs, health planning, PSROs, PROs, RBRVS used to pay for physician services, Medicare Part C or managed care in Medicare) have already been discussed in this and previous chapters, the discussion that follows is brief and merely summarizes materials that have already been presented in the book.

Medicare Cost Containment

Since the United States relies on a pluralistic system of public and private financing of health services, the approaches employed to contain costs have equally been fragmented. In other words, responsibility for cost containment has been shared by both the public and private sector. Following the design of Medicare and Medicaid, efforts to contain Medicare costs have been applied uniformly throughout the country, while Medicaid cost containment approaches vary from state to state.

Once the Medicare program was enacted, the most serious and persistent of its problems involved the methods and costs of paying doctors and hospitals. According to Theodore Marmor (2000, p. 89), in the year between the enactment of the Medicare legislation and its initial operation, the rate of increase in physician fees more than doubled. Similarly, hospital price increases presented the most intractable political problem for the Johnson administration. For example, in the first year of Medicare's operation, the average daily service charge in American hospitals was reported to increase by as much as 21.9% (Marmor 2000, p. 89).

As shown in Table 8.2, reimbursement for services and the population of Medicare beneficiaries continue to increase. Therefore, Medicare cost containment began just as soon as the program went into effect. Additionally, throughout the late 1960s, the debate on reforming Medicare and the rising cost of care continued (Davis et al. 1990, p. 16).

As we discussed in Chap. 4, the first major attempt to minimize health care costs came with the Nixon administration's 1971 Economic Stabilization Program (ESP). The ESP put a freeze on wages and prices in the entire economy, including the hospital industry. But following the lifting of the ESP controls, Medicare hospital and other health expenditures increased much faster than was the case prior to the imposition of controls.

Following the lifting of the ESP controls, Section 223 of legislation passed by the Congress in 1972 to amend the original 1965 Medicare legislation gave program administrators the authority to disallow costs that were deemed unnecessary to the efficient provision of care. The Section 223 regulations, first implemented in July 1974,

applied to routine costs, or specifically, it applied only to hospital costs associated with room and board and nursing services; it did not include ancillary services, special care units, or outpatient care. The Section 223 regulations were continually refined to account for new knowledge about the factors that affected hospital costs. For example, the original proxy for hospital input costs, county per capita income, was soon replaced by a wage index for hospital workers in an area (Davis et al. 1990, p. 19).

In order to respond to increases in Medicare utilization rates that were not anticipated at the time of the initial debate over the Medicare legislation, PSROs were created by the 1972 Medicare amendments to ensure efficiency and economy in federally funded health care services. Similarly, the 1972 amendments encouraged state government to develop other approaches to cost containment, such as incentive reimbursement demonstrations, voluntary and mandatory rate-setting programs, alternative care delivery methods, and other innovations that were deemed effective in controlling expenditures. By 1976, Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington had established mandatory rate-setting programs (Biles et al. 1980, p. 664).

In addition to attempts to directly control costs, other attempts were made in the 1970s to increase the supply of health providers, especially physicians. The *Emergency Health Personnel Act* of 1970 established the National Health Service Corps to furnish physicians and other providers to the underserved areas of the country. Similarly, the *Health Manpower Training Act* of 1970 further encouraged the training of physicians, more especially primary care physicians (PCPs). Furthermore, HMOs were promoted by the HMO Act of 1973, while the *National Health Planning and Resources Development Act* of 1974 (PL 3-641) attempted to make group practice and alternative health care delivery systems important objectives of federal health policy (U.S. Department of Health, Education, and Welfare (U.S. DHEW) 1971; Ubokodom 1998, p. 59; Davis et al. 1990, p. 25).

President Carter and his advisers made attempts to control hospital costs that were still on the rise when they assumed office in 1977. The Carter Administration argued that costs should be controlled before attempting to expand insurance coverage to all Americans. In response to the Carter administration's legislative proposals to control hospital costs, the industry responded by forming a coalition of providers and payers called the Voluntary Effort (VE) in December 1977. The VE was temporarily effective in controlling some hospital costs, but costs went up as soon as the Carter legislative proposal failed and the threat of regulation was gone. Next, it was up to the Reagan Administration to do something about high health care costs.

The Reagan administration and Republican members of Congress preferred market-based approaches to health care cost containment (Oberlander 2008, p. 316). Congressional efforts were driven by the desire to frustrate Reagan's efforts to cut the benefit and eligibility standards in the Medicare and Medicaid programs. In order to reduce the size of government, the Reagan administration was forced to support more federal regulations to contain spending. Legislators worked to institute cuts to providers' reimbursements rather than cuts in benefits and eligibility standards.

The OBRA of 1981 tightened the limits on Medicare reimbursement under Section 223 of the Medicare Amendments of 1972 in order to generate additional

savings. It also required the Secretary of the DHHS to develop a new method of hospital reimbursement under Medicare and Medicaid and to report to Congress on the new system by July 1982. States were also allowed the flexibility to design and implement their hospital payment arrangements for Medicaid.

The *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982 made significant changes in the existing hospital payment methods in order to control Medicare hospital expenditures (Iglehart 1982, p. 1288). For example, the rates of growth in Medicare hospital payments per admission were curtailed. Additionally, Section 223 of the 1972 Medicare amendments was modified to incorporate a case-mix index based on DRGs and to provide incentive payments to hospitals that were deemed efficient. TEFRA applied only to hospital care provided Medicare beneficiaries. It mandated that limits be set on Medicare hospital payments per discharge using case-mix indexes based on DRGs developed at Yale University.

TEFRA did little to change the variability in payment rates across hospitals, because it granted the same rate of increase in payments to all hospitals, whether they initially had high or low costs. Therefore, it relied on a methodology that did not fully acknowledge and reward efficient hospitals. In October 1982, the DHHS announced plans to switch to prospective payment based on DRGs as mandated by the TEFRA.

As was discussed briefly in Chap. 1, the prospective payment legislation was attached to another more popular legislation that was designed to ensure the solvency of the Social Security program in order to guarantee its passage. It was passed in March 1983 and quickly signed into law.

The PPS was limited to hospitals. Following its successful adoption, Congress enacted the Medicare Fee Schedule for Physicians based on the resource-based relative value scale (RBRVS) in 1989. The RBRVS, also discussed in Chap. 4, is a method of paying physicians based on the time, skill, and effort involved with different health care services. This new methodology replaced the customary, prevailing, and reasonable slogan on which the initial physician reimbursement method was based. The RBRVS was followed about 8 years after by the enactment of Medicare Part C or managed care in Medicare.

Favorable risk selection has made the Medicare managed care strategy less successful than anticipated. Medicare actually lost money on beneficiaries enrolled in private managed care plans, spending more for their HMOs than it would have spent if they had remained in traditional Medicare (Oberlander 2008, p. 320). Therefore, the quest to contain Medicare costs continues. At the time of this writing, Medicare cost containment and overall federal expenditure levels are generating heated debates among the two major political parties.

Medicare and Long-Term Care

As was noted in the preceding discussion, Medicare focuses on acute or short-term care for the elderly 65 years of age and above and the disabled. It provides limited

coverage for skilled nursing home care after a Medicare patient has experienced an episode of illness that requires hospitalization. But since age is one of the determinants of the need for LTC services, one would have expected that Medicare, a program designed to provide medical services to the elderly population, would also cover the LTC needs of the elderly. That is, however, not the case. The designers of the Medicare program did not intend for it to cover beneficiaries' custodial LTC needs. Consequently, the institutional LTC needs of the elderly have to be met elsewhere.

The bulk of LTC services for the elderly are provided by family members or the so-called informal long-term caregivers, and by institutional providers, such as nursing homes. Medicaid, passed at the same time as Medicare, pays for most of the institutional LTC services used by the elderly. In order to further address the Medicare LTC gap, Congress, in the doomed *Medicare Catastrophic Care Act* (MCCA) of 1988, raised the amount of money seniors could retain for themselves when their spouses received Medicaid nursing home benefits. According to Grogan and Patashnik (2003, p. 51), the adoption of the spousal impoverishment provision reflects the emergence of Medicaid as the nation's de facto LTC program.

Given the nation's budget problems and high deficits, it is not likely that Medicare will be expanded to cover custodial LTC services. Rather, Medicaid, which is facing its own budget pressures from state governments, will continue to be both the de facto LTC program and the vehicle for providing health services to the poor. Therefore, our discussion now shifts to Medicaid, its organization and goals, benefits and beneficiaries, expenditures, and its cost containment strategies.

Medicaid

Medicaid (Title XIX of the SSA) is a joint federal and state program that provides medical assistance for certain individuals and families who meet eligibility criteria and assets requirements. Each state establishes its own Medicaid eligibility standards within broad federal guidelines; determines the type, amount, duration, and scope of services; establishes the rates that will be paid for the services provided to program beneficiaries; and administers its program (Klees et al. 2010, p. 3).

As was noted while discussing Medicare, Medicaid grew out of the struggle to improve access to health care for the elderly. In 1964, there were three specific proposals to improve access to health care for American senior citizens, namely: a universal hospital insurance program based on Social Security (the King-Anderson bills of 1963 and 1964, named after Senator Clinton Anderson of New Mexico and Representative Cecil King of California, high-ranking members of the Senate Finance Committee and the House Ways and Means Committee, respectively); a voluntary program to finance physician services that was to be supported by beneficiary premiums; and an expansion of the Kerr-Mills program, which, as we have already discussed, offered a range of health care benefits to the low-income elderly (Grogan and Patashnik 2003, p. 824; Grogan 2008, p. 331; Marmor 2000, p. 51).

The Social Security Amendment of 1965 combined the above three approaches into a single package consisting of three parts. As we have already discussed, the first and second parts were Medicare Parts A and B, while the third part became the Medicaid program, originally called Medicare Part C. Medicaid liberalized the Kerr-Mills means test so as to cover additional elderly citizens. Similarly, eligibility among the poor was broadened to include the blind, the permanently disabled, and recipients of Aid to Families with Dependent Children (AFDC).

Like the Kerr-Mills program, Medicaid financing was to be shared by federal general revenues and state funds. Exceptions were made to the age restriction of the Medicare program. The original legislation authorized comprehensive health benefits for all persons who, regardless of age, qualified for public assistance.

As was the case with the Kerr-Mills program, the federal share of Medicaid was increased to an open-ended commitment to pay for an established set of services. But even with the federal commitment to pay for an established set of services, estimates of Medicaid's future budgetary outlays assumed that the program would not lead to a dramatic expansion of health care coverage (Stevens and Stevens 1974). For example, it was assumed that even if all the 50 states implemented the Medicaid program, Medicaid expenditures would be no more than \$238 million per year above what was being spent on medical welfare programs (Grogan and Patashnik 2003, p. 826).

The health programs of the 1960s were intended to reduce the exclusion from medical care of the poor and the aged, people who were marginal to the core sectors of the economy where health insurance was available as a fringe benefit (Starr 1982, p. 373). The available evidence showed that these goals were greatly impacted. For example, the decade after 1965 witnessed a measurable increase in the use of medical services by the poor. Davis and Schoen (1978, p. 164) write that in 1964 the nonpoor saw physicians about 20% more frequently than the poor; by 1975, the poor visited physicians 18% more often than the nonpoor. Similarly, in 1964, whites saw physicians 42% more often than blacks; by 1973, the difference between white and black physician visits had narrowed to 13%.

Additionally, in 1963 those who earned less than \$2,000 per year had only half as many surgical procedures per 100 people as those who earned \$7,500 or more; by 1970, the surgical rate for the low-income group was 40% higher than the rate for the high-income group. Furthermore, 1969 data showed that for every level of health status, public assistance beneficiaries eligible for Medicaid used medical care much more often than other poor people who were not eligible for Medicaid. It follows, therefore, that some or most of the reported increases in the utilization of medical services were likely due to Medicare and Medicaid.

Another reason that was suggested for the increased use of medical care reported above was the change in the composition of poor people. As the poverty population dropped following the enactment of the Great Society redistributive programs, there was a higher proportion of chronically ill and disabled people among the poor relative to the rest of the population (Starr 1982, p. 374). These chronically ill and disabled people are likely to be in poorer health than the rest of the members of the population. Obviously, those in poor health are likely to use more health care services than those in good health.

Medicaid Beneficiaries

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, particularly dependent children and their mothers, the disabled, and the elderly (Klees et al. 2010, p. 28). Since the initial enactment, Medicaid eligibility has been slowly expanded beyond its original association with persons eligible for cash assistance programs. Although states generally have broad discretion in determining who their Medicaid programs will cover, to be eligible for the Federal Medical Assistance Percentage (FMAP) or matching funds, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, some States have additional “State-only” medical assistance programs that target specified poor persons who do not qualify for Medicaid. However, federal monies are not provided for State-only programs.

Medicaid beneficiaries for which the federal government provides matching funds to state governments are divided into mandatory and nonmandatory or optional categories.

Mandatory Beneficiaries

The mandatory category includes the following: limited-income families with children, as described in Section 1931 of the SSA, who meet the requirements for the AFDC program that was in effect in their State on July 16, 1996; children under age 6 whose family income is at or below 133% of the federal poverty level (FPL); pregnant women whose family income is below 133% of the FPL, who receive pregnancy-related services, and complications of pregnancy, delivery, and postpartum care; infants born to Medicaid-eligible mothers, for the first year of life with certain restrictions; Supplemental Security Income (SSI) recipients in most States, or aged, blind, and disabled persons in States that use more restrictive Medicaid eligibility requirements that predate SSI; recipients of adoption or foster care assistance under Title IV-E of the SSA; special protected groups, typically people who lose their cash assistance under Title IV-A or SSI due to earnings from work or from increased Social Security payments, but who are allowed to keep their Medicaid for a period of time; all children under age 19, in families with incomes at or below the FPL; and dual Medicare-Medicaid-eligible persons, who are usually referred to as Qualified Medicare Beneficiaries (QMBs), as well as the so-called Specified Low-Income Medicare Beneficiaries (SLMBs).

To elaborate further, QMBs are Medicare beneficiaries who have financial resources at or below twice the standard allowed under the SSI program, and incomes at or below 100% of the FPL. For QMBs, Medicaid pays the Medicare Parts A and B premiums and coinsurance and deductibles, subject to any limits imposed by their States.

SLMBs are Medicare beneficiaries who have resources similar to QMBs, but with incomes that are higher, though still less than 120% of the FPL. Medicaid pays only the Medicare Part B premiums for SLMBs. Similar to QMBs and SLMBs, employed disabled individuals who previously qualified for Medicare due to their disability, but who lost entitlement because of their return to work despite the disability, are allowed to purchase Medicare Parts A and B coverage. If they have incomes below 200% of the FPL and do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums under a category called Qualified Disabled and Working Individuals (QDWIs).

In addition to QMBs and SLMBs, the federal government provides States with a capped amount of funds to pay Medicare Part B premiums for Medicare beneficiaries with incomes above 120% and less than 135% of the FPL. These beneficiaries, who are called Qualifying Individuals (QIs), cannot be otherwise eligible for medical assistance under a State Medicaid plan. The QI benefit is 100% federally funded, up to the State's allowed amount. Established by the BBA of 1997 to take effect during Fiscal Years 1998 through 2002, the QI benefit has been extended several times. The most recent extension continued the program through December 2011 (Klees et al. 2010, p. 30).

Nonmandatory or Optional Beneficiaries

States have the option of providing Medicaid coverage for other categorically defined or optional groups. Whereas the optional groups share characteristics of the mandatory groups discussed earlier, the eligibility criteria for the optional groups are more liberally defined (Klees et al. 2010, p. 23). States can receive FMAP or matching funds under the Medicaid program for coverage of the following optional groups: infants up to age 1 and pregnant women not covered under the mandatory rules, whose family income is no more than 185% of the FPL, with the exact percentage determined by each State; children up to age 21 who meet criteria more liberal than the AFDC income and assets requirements that were in effect in their States on July 16, 1996; persons in institutions and those in home and community-based waiver programs, who are eligible under a special income level set by each State, and which may be up to 300% of the SSI Federal benefit rate; persons who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers; certain aged, blind, or disabled persons who have incomes above those requiring mandatory coverage, but below the FPL; aged, blind, or disabled recipients of State supplementary income payments; certain working-and-disabled individuals with family income less than 250% of the FPL, who would be eligible for SSI if they did not work; TB-infected individuals who would be financially eligible for Medicaid at the SSI income level if they were in a Medicaid-covered category, with coverage limited to TB-related ambulatory services and TB drugs; some uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the CDC, as required by the *Breast and Cervical Cancer Prevention and Treatment Act* of 2000 (PL 106-345); optional

targeted low-income children included in the CHIP; and “medically needy” persons whose incomes and resources are above the Medicaid eligibility level set by their State, or who spend down by incurring medical bills that reduce their incomes to or below their State’s medically needy income level.

Medicaid eligibility and benefit levels for the medically needy may be more restrictive than what is available for mandatory beneficiaries. The federal government provides matching funds for medically needy programs. If a State elects to have a medically needy program, federal rules require the coverage of certain groups of people and the provision of certain services. For example, children under age 19 and pregnant women who are medically needy must be covered. Similarly, prenatal and delivery services for pregnant women, as well as ambulatory care for children, must be made available. Furthermore, a State may decide to provide medically needy coverage to certain additional groups and may elect to provide certain additional services under its medically needy program.

While the expectation that Medicaid would reduce the exclusion from medical care of the poor, the aged, and the disabled was met, the expectation that the program would not lead to a dramatic expansion in health care coverage and costs was not borne out. It turned out that the anticipated \$238 million annual expenditure above what was spent on medical welfare programs around 1965 was reached only after six States had implemented their Medicaid programs (Grogan 2008, p. 332). The Congressional Research Service (1993, p. 30) reported that by 1967, 37 states were implementing Medicaid programs, and that spending was going up by 57% annually. Before looking at the measures that have been employed to contain these expenditures, we briefly look at the expenditure trends between 1975 and 2008.

Medicaid Expenditures

The early expenditure growth in the Medicaid program was attributed to the establishment of generous eligibility standards under states’ medically needy programs. For example, New York is reported to have enrolled families with incomes of up to \$6,000 per year (four person family income) in 1966. Congress responded by passing legislation in 1967 that lowered the medically needy eligibility level to 133.33% of a State’s AFDC means-tested level (Grogan 2008, p. 332). But in spite of this effort by the Congress to curtail program costs, Medicaid expenditures continued to increase.

Table 8.3 is a tally of Medicaid recipients and expenditures for selected years between 1975 and 2008. The data show that the most dramatic increases in program beneficiaries and expenditures occurred between 1985 and 2004. For example, total Medicaid recipients and expenditures increased by about 152 and 587% points, respectively, between 1985 and 2004 (there were 21.8 million total beneficiaries in 1985, and about 55 million total beneficiaries in 2004; there were total expenditures of about \$37.5 billion in 1985, and about \$257.7 billion in total expenditures in 2004). These sharp increases in recipients and expenditures between 1985 and 2004 were attributed to Congressional action which expanded Medicaid between 1984

Table 8.3 The distribution of Medicaid expenditures and recipients, 1975–2008

Recipients (thousands)	1975	1980	1985	1990	1995	2000	2004	2008
Total	22,007	21,605	21,814	25,255	36,282	42,763	55,002	58,771
Children ^a	9,598	9,333	9,757	11,220	17,164	19,723	26,459	28,071
Adults	4,529	4,877	5,518	6,010	7,604	8,750	12,244	12,947
Aged	3,615	3,440	3,061	3,202	4,119	3,371	4,318	4,147
Disabled	2,464	2,911	3,012	3,718	5,858	6,889	7,933	8,864
Other/unknown	1,801	1,044	466	1,105	1,537	3,671	4,048	4,912
Recipients (%)								
Total	100	100	100	100	100	100	100	100
Children ^a	43.6	43.2	44.7	44.4	47.3	46.1	48.1	47.8
Adults	20.6	22.6	25.3	23.8	21.0	20.5	22.3	22.0
Aged	16.4	15.9	14.0	12.7	11.4	8.7	7.9	7.1
Disabled	11.2	13.5	13.8	14.7	16.1	16.1	14.4	14.8
Other/unknown	8.2	4.8	2.1	4.4	4.2	8.6	7.4	8.4
Expenditures (millions) ^b								
Total	12,242	23,311	37,508	64,859	120,141	168,307	257,748	296,830
Children	2,186	3,123	4,414	9,100	17,976	26,775	44,205	57,137
Adults	2,062	3,231	4,746	8,590	13,511	17,763	30,721	37,698
Aged	4,358	8,739	14,096	21,508	36,527	44,503	59,541	61,131
Disabled	3,145	7,621	13,452	24,404	49,418	72,742	111,614	129,040
Other/unknown	491	597	800	1,257	2,709	6,524	11,667	11,824
Expenditures (%) ^c								
Total	100	100	100	100	100	100	100	100
Children	17.9	13.4	11.8	14.0	15.0	15.9	17.1	19.2
Adults	16.8	13.9	12.6	13.2	11.2	10.5	11.9	12.7
Aged	35.6	37.5	37.6	33.2	30.4	26.4	23.1	20.6
Disabled	25.7	32.7	35.9	37.6	41.1	43.2	43.3	43.5
Other/unknown	4.0	2.5	2.1	1.9	2.2	3.9	4.5	4.0

^aIncludes nondisabled children and foster care children

^bExpenditures for the “other/unknown” category were not reported separately by the CMS; rather, they were lumped together in the “total” category. Amounts shown are nominal dollars

^cThe sum of the percentages for the separate categories may not add up to 100 because of rounding

Source: Centers for Medicare and Medicaid Services Health Care Financing Review, (2010), Tables 13.4 and 13.10

and 1990, and to economic slowdown. Both of these factors resulted in additional individuals qualifying for Medicaid coverage (Letsch et al. 1992, p. 1). On the other hand, Medicaid expenditures increased at a much slower rate in the early 1980s due to reductions in the FMAP or matching rates and other cuts instituted by the *Omnibus Budget Reconciliation Act* of 1981 (OBRA-81) (Holahan and Cohen 1986).

In addition to the total number of beneficiaries and the total expenditures for each of the years shown in Table 8.2, analyses of the categories of recipients incurring the least and most expenditures reveal additional interesting trends. When children, adults, disabled, and the aged are compared, the data show that since 1975, children outnumber each of the other groups, but account for the least expenditures.

Additionally, while children were about three times more than disabled beneficiaries in each of the years reported in Table 8.2, the total expenditures for disabled beneficiaries during the period were about 2.5 times more than those of children.

In 2008, the disabled accounted for 14.8% of the Medicaid population and incurred about 43.5% of the total Medicaid expenditures for that year. Similarly, the aged accounted for 7.1% of the Medicaid population in 2008 and incurred about 20.6% of the total expenditures for the year. The aged and disabled, who together made up about 22% of the Medicaid population in 2008, accounted for about 64% of the expenditures for the year.

To further elaborate on the Medicaid costs for specific population groups, the national data for 2008 demonstrate that Medicaid payments for health services for children averaged \$2,035 per child. The 2008 payments for adults averaged \$2,912 per adult; payments for the elderly averaged \$14,742 per person; and payments for the disabled averaged \$14,558 per person (CMS 2010). These trends are certainly due to the creation in 1972 of the SSI program that conferred Medicaid eligibility to the elderly, blind, and disabled, and the fact that the aged and disabled are far more expensive to insure than adults and children.

Similar to Medicare, increased Medicaid expenditures has raised serious concerns among State and Federal policy makers. Therefore, shortly before 1980 till now, one of the primary goals of Federal and State lawmakers and Medicaid administrators has been efforts to control the growth in program expenditures. Therefore, in the next few pages, we examine the approaches and measures that have been utilized to contain Medicaid expenditures.

Medicaid Cost Containment

The quest for Medicaid cost control began in the 1970s during the Nixon administration. The 1972 amendments to the SSA provided the first major changes in the direction of Medicaid coverage. The amendments eliminated Medicaid's goal of comprehensive health care coverage for the poor in response to state governments' concerns about Medicaid expenditure growth. This quest for Medicaid cost control became more intense after President Reagan assumed office in January 1981, with a public mandate to cut federal spending and curtail federal regulations.

The budget President Reagan submitted to the Congress in 1981 proposed to put a limit or cap on how much the federal government would spend on Medicaid in any given year. If the cap had been implemented, the proposal would have cut about \$9 billion in federal Medicaid spending from 1981 to 1985 (Iglehart 1985, p. 59). The proposal was not adopted by the Congress, but other spending proposals were on the way.

The *Omnibus Budget Reconciliation Act* of 1981 (OBRA-81) imposed a temporary reduction in the federal matching rate for Medicaid in each State of 3% in 1982, 4% in 1983, and 4.5% in 1984 (Davis et al. 1990, p. 73). In addition, the legislation allowed state governments to experiment with new approaches to control Medicaid costs, such as innovative new provider payment methods and other approaches to

Table 8.4 Medicaid managed care trends^a

Year	Total Medicaid population	Managed care population	Other population	Percent managed care enrollment
2009	50,471,859	36,202,281	14,269,578	71.73
2008	47,142,791	33,427,582	13,715,209	70.91
2007	45,962,271	29,463,098	16,499,173	64.10
2006	45,652,642	29,830,406	15,822,236	65.34
2005	45,392,325	28,575,585	16,816,740	62.95
2004	44,355,955	26,913,570	17,442,385	60.68
2003	42,740,719	25,262,873	17,447,846	59.11
2002	40,147,539	23,117,668	17,029,871	57.58
2001	36,562,567	20,773,813	15,788,754	56.82
2000	33,690,364	18,786,137	14,904,227	55.76

^aThe figures represent point-in-time enrollment as of June 30 for each reporting year. The unduplicated managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits, as well as individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards. The national figures for the Total Medicaid population and Other population are unduplicated

Source: CMS (2011c)

curtail health care utilization by beneficiaries. Under the law, states were given the authority to determine Medicaid hospital payment levels and methods and to find alternatives to the fee-for-service physician payment model. These innovations centered on case management, capitated reimbursement practices, and gatekeeping.

State governments responded to the new authority granted them under OBRA-81 and to increased local pressures to contain expenditures, by limiting Medicaid income eligibility standards, limiting coverage of the optional groups discussed earlier, finding new ways to pay for hospital care, such as rate setting and selective contracting, devising alternative delivery systems, or by doing all of those things. The waiver application process for alternative delivery plans was streamlined and simplified in order to make it faster and easier to implement.

The authority granted to states by the OBRA-81 generated interest in the managed care option within the Medicaid program. Managed care, discussed in greater detail in Chap. 4, was expected to contain program costs, curtail Medicaid beneficiaries' use of hospital emergency rooms for routine care, and to minimize the relatively high inpatient hospital admission rates and lengths of stay among the Medicaid population. Therefore, since the early 1980s, significant growth occurred in the enrollment of Medicaid beneficiaries in managed care plans.

As shown in Table 8.4, as of June 30, 2009, about 36.2 million Medicaid beneficiaries, or 72% of the 2009 Medicaid population of about 50.5 million people, were enrolled in managed care plans throughout the 50 states, the Virgin Islands, and the District of Columbia. Additionally, except between 2006 and 2007, managed care enrollment has grown steadily between 2000 and 2009. While the Medicaid population grew by 50% between 2000 and 2009, the Medicaid managed care population grew by about 93% during the same period (CMS 2011c).

The growth in Medicaid managed care enrollment documented above has been facilitated by the authority granted to state governments under OBRA-81, as well as the grant of waiver authority to make it easier to implement managed care programs. Waiver authority under Sections 1915(b), 1915(c), and 1115 of the SSA is an important part of the Medicaid program.

Medicaid Waivers

As was discussed earlier, States design and operate their Medicaid programs under broad federal guidelines. These federal guidelines specify what they can or cannot do. For example, while the BBA of 1997 allows States to implement primary care case management services without the need for a waiver, there are generally three major federal limitations. First, under the freedom of choice provision of the Medicaid law, States are required to allow Medicaid beneficiaries to choose their medical providers. Second, the comparability requirement mandates that States offer the same benefit packet to all mandatory groups. And, third, the statewideness provision mandates that every managed care program must be statewide and not confined to a small area of the State.

Under the Medicaid waiver program, States can apply for and use the 1915(b) waiver authority to limit Medicaid beneficiaries' freedom to choose their providers. This allows the State to assign Medicaid recipients specific PCPs in order to curtail the inappropriate utilization of specialists and other higher levels of care. Similarly, Section 1115 waivers allow states to implement experimental, pilot, or demonstration projects that may not be statewide in nature.

Flexibility under Section 1115 waivers is broad enough to allow states to test substantially new ideas of policy merit that have not been demonstrated on a widespread basis. Projects are usually approved for an initial 5-year period, with the option to submit renewal requests to continue the project for additional periods of time. Section 1115 waiver proposals must be approved by the CMS, the Office of Management and Budget (OMB), and the DHHS and may be subject to site visits and evaluations before implementation.

Section 1915(c) waivers allow states to provide HCBS to their disabled and elderly populations. Additionally, States may opt to simultaneously use Section 1915(b) and 1915(c) program authorities to offer a range of services to disabled and elderly Medicaid populations. By this method, states can offer traditional LTC services, such as home health, personal care, and institutional services, as well as the nontraditional services, such as homemaker and adult day care services, and respite care.

States implementing 1915(b) and 1915(c) concurrent waivers must meet the federal requirements for both programs. Accordingly, when applying for the concurrent waiver authority, states are required to submit a separate application for each waiver type and to satisfy all the applicable requirements, such as the neutrality requirement of the 1915(c) waiver, the cost-effectiveness requirement of the 1915(b)

waiver, as well as the separate reporting requirements for each waiver. According to the CMS (2011d), while meeting the separate requirements for a 1915(b) and 1915(c) concurrent waiver authority can be a potential impediment to States considering such a program, the ability to develop an innovative managed care program that integrates HCBS with traditional state plan services is appealing enough to some states to outweigh the potential impediments.

Public perceptions of different groups affect their likelihood of getting Medicaid benefits and the generosity of the benefits they receive. As our discussion so far has shown, children and the elderly fare better than able-bodied unemployed and poor employed citizens, who fare better than noncitizens and illegal immigrants. For example, the *Deficit Reduction Act* (DRA) of 2005 (PL 109-171) refined eligibility requirements for Medicaid beneficiaries by tightening standards for citizenship and immigration documentation, thereby making it harder for noncitizens and both legal and illegal immigrants to qualify for Medicaid. On the other hand, as the following discussion about the plight of children under welfare reform demonstrates, efforts have always been made to maintain or expand Medicaid eligibility for poor children who are perceived to have no control over their socioeconomic conditions.

The Repeal of the AFDC Program and the Creation of SCHIP

As a result of the fear that the repeal of the AFDC program would result in more uninsured children, the SCHIP, now simply called the CHIP, was implemented in 1997.

The *Personal Responsibility and Work Opportunity Reconciliation Act* of 1996 (PL 104-193), also known as the “welfare reform” bill, created the block grant program, Temporary Assistance for Needy Families (TANF), to replace the AFDC program on which Medicaid eligibility for dependent children was based. TANF generally limits a family’s lifetime cash welfare benefits to a maximum of 5 years and permits States to impose other wide-ranging requirements related to employment.

Under welfare reform, people who would have been eligible for AFDC under the program requirements in effect on July 16, 1996, are generally still eligible for Medicaid. In other words, welfare reform cut Medicaid’s longstanding tie to AFDC, but kept Medicaid intact. Therefore, a large number of families and children continued to be eligible for Medicaid, but not TANF. But the problem was how to keep track of the Medicaid-eligible children who were, until welfare reform, tracked through the AFDC program. This concern generated the fear that many of the untracked children would go without Medicaid coverage. Congress created the SCHIP in 1997 to address these concerns.

SCHIP was authorized under Title XXI of the SSA. At its creation in 1997, it was the largest expansion of taxpayer-funded health insurance coverage for children in the United States since the passage of Medicaid in 1965 (Wikipedia 2011b). Similar to Medicaid, the program is jointly funded by the federal and state governments.

States administer the program according to guidelines set by the CMS. The federal government allows States the option of designing their SCHIP independent of Medicaid (separate child health programs), or using SCHIP funds to expand their Medicaid programs (SCHIP Medicaid expansion programs), or combining the two approaches (SCHIP combination programs). Separate child health programs have a lot more flexibility than Medicaid programs. Overall, federal matching rates for SCHIP are more generous than the regular Medicaid match. To qualify for these enhanced SCHIP funds, states must submit their coverage expansion plans to the CMS.

The SCHIP was initially authorized for 10 years. In order to continue to receive funding after federal fiscal year 2007, a reauthorization bill had to be passed. Two reauthorization bills, which also expanded the scope of the program, were vetoed by President George W. Bush. However, a 2-year reauthorization bill that did not involve any program expansion was signed by President Bush in December 2007. When Democrats gained majorities in both Houses of Congress following the 2008 Presidential and Congressional election cycles, SCHIP was reauthorized (PL 111-3) in January 2009. President Obama signed the reauthorization legislation on February 4, 2009, and SCHIP was simply called CHIP with effect from March 2009. Therefore, we have been using SCHIP and CHIP interchangeably throughout the book.

As of 2010, about 7.7 million American children were enrolled in CHIP. The results of studies conducted to evaluate the impacts of the program are mixed. For example, Rimsza et al. (2007, p. 1026) have found that children who drop out of SCHIP cost states more money because they shift away from using routine care to more frequent emergency care use. The CBO, in a 2007 study, concludes that “for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children,” possibly because of the desire to remain in the public programs that offer better benefits at lower costs than private programs. Similarly, Kenney and Chang (2004, p. 51) argue that while SCHIP has improved children’s access to health care and sparked innovation in program design and improvements in Medicaid, the program has added to the complexity of the insurance system and introduced new inequities in access to insurance. For example, they argue that SCHIP is imperfectly targeting eligible children who are uninsured, and its financing is problematic because of the block grant funding structure and the use of program funds to cover adults.

As we noted at the beginning of this chapter, the health disparities among different population groups in the United States would have been worse had it not been for the creation of the safety net programs of Medicare, Medicaid, and CHIP. These programs have improved access to health care for the elderly, the poor, the disabled, and children. However, at a time of changing beliefs about the role of government, serious economic problems, and large public debts, serious concerns are raised about the survivability of the safety net programs. The supporters of the PPACA argue that the legislation is necessary to address these concerns and to expand insurance coverage to the large population of the uninsured. As would be expected, the opponents of the PPACA disagree. Therefore, it is important to devote the next chapter to the health care reform legislation and its likely impacts, perceived or real, on Medicare, Medicaid, CHIP, and the uninsured.

Conclusion

The health expansions put in place during the postindustrial period of the evolution of the health care system did not curtail inequities in the distribution of health services. At the same time, the prices of medical care increased significantly, causing serious problems for the poor and elderly. Consequently, Medicare, Medicaid, and more recently, CHIP, were created to provide health insurance coverage to the nation's vulnerable population groups. Medicare finances hospital, physician, other acute care, and prescription drug services for the elderly and disabled. Medicaid is a joint federal-state program that provides medical assistance to certain individuals and families who meet income criteria and asset requirements, including the poor, elderly, disabled, and children. CHIP was established by the BBA of 1997 to provide health insurance coverage to children who were likely to lose Medicaid coverage because of welfare reform. All these safety net programs are being questioned and seriously scrutinized in the present environment characterized by calls for smaller governments and low debts and taxes; and by slow economic growth. Proponents of the PPACA of 2010 argue that the legislation has addressed some of the uncertainties associated with these safety net programs, while opponents vehemently disagree. Therefore, the next chapter is devoted to examining health care reform.

Review Questions

1. What impressions did the phrase, socialized medicine, coined by the AMA to attack President Harry Truman's proposal for a national health insurance program create in the minds of the public about the proposal?
2. Why did limiting the Medicare proposal to aged Social Security beneficiaries lead to what Paul Starr describes as "a groundswell of grassroots support" for the proposal?
3. What significant changes did the BBA of 1997 make to the Medicare program? What are the significance and implications of the changes?
4. What are the implications of Medigap insurance companies using medical underwriting to decide who to insure and how much premium to charge?
5. What are the indirect benefits of the Medicare program? How significant are these indirect benefits?
6. How did Medicare try to restrain its costs in the 1970s and 1980s?
7. What population groups receive health insurance coverage under Medicaid?
8. How well has Medicaid reduced the exclusion from medical care of the poor and the aged?
9. Why is it that even though children on Medicaid outnumber the program's aged and disabled beneficiaries, they, the children, account for the least expenditures under the program?
10. What measures has Medicaid employed to restrain its costs since the early 1980s?

11. Distinguish between Section 1115, 1915(b), and 1915(c) waivers. What effects have these waivers had on the Medicaid program and program beneficiaries?
12. How do the perceptions of different needy groups impact their likelihood of getting government assistance and the generosity of the assistance they receive? Cite some specific examples where possible.

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