

# TEXAS PUBLIC POLICY FOUNDATION

## Medicaid: Yesterday, Today, and Tomorrow *A Short History of Medicaid Policy and Its Impact on Texas*

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In 1989, a small group of civic-minded Texans created the Texas Public Policy Foundation to bring independent, market-based thinking to tackle problems facing state government. Through the years, the Foundation has championed solutions to the day’s pressing issues, and won support for market-based policies that have made Texas a better place to live and work.

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By refusing government funding, the Foundation maintains its independent voice on the issues important to Texas’ future.

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Director, Center for Health Care Policy Studies  
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### Executive Summary

Growing caseloads and mounting costs in the Medicaid program have left many states at a loss as to how to gain control of this politically-charged program with so much of the program's control housed in Washington. What has caused this kind of growth, both in terms of the number of people enrolled and the program's exploding costs? Looking at the program's history, its growth is clearly the result of a persistent interest in expanding the program through incremental policy changes.

This publication is not designed as a primer on the Medicaid program itself, but rather a more in-depth look at the growth of Medicaid enrollment and spending in the context of legislative changes at the federal and state level in the program's history. Medicaid data is often presented in small increments: the increase over the previous budget, caseload growth in recent years, or even a snapshot of the immediate result of a policy change, for example. However, looking more broadly over the history and the impact of legislative changes on the Medicaid program gives a more complete understanding of the program and the factors that have contributed to what it is today.

It would be impractical to offer an exhaustive treatment of each change to Medicaid policy in the more than 40 years since Congress created the program. This publication focuses on major policy changes, especially on those that have had—or would have had—a significant impact on Medicaid caseloads and cost. In creating the timeline of events to tell Medicaid's story, existing timelines published by the Texas Health and Human Services Commission and by the Kaiser Family Foundation, among others, have identified important points in the program's history. Issues like Disproportionate Share Hospital spending, the Upper Payment Limit, and Medicaid's relationship to Medicare are only briefly described, but need to be explored more fully on their own. In addition, it should be noted that waivers and lawsuits have had an undeniable impact on caseload, program structure, and benefits in Texas and around the country, but this publication does not explore in any depth the impact of administrative and judicial changes in the program.

Finally, this publication is not intended to offer public policy solutions for Medicaid, but to bring the ideas of the past 40 years to life, illustrating both the problems in past policy and the potential for future reform. Future attempts at Medicaid reform must bear in mind the victories and failures in public policy over this period, giving thoughtful consideration to the program's past in mapping its future. The historical look at the Medicaid program makes it clear that the program's growth is the result of layers of policy enacted over decades; incremental change, rather than any single act, created the program we have today.

While the magnitude of the problem may seem daunting, it is too important to be ignored. There are significant challenges that lawmakers must begin to tackle. Future publications in the Medicaid series will offer more specific recommendations for Medicaid reform in Texas; however, it must be emphasized that no amount of change on the margins will accomplish the result that the coming crisis demands. While recognizing that several million Texans have come to rely on the service that Medicaid provides, it is crucial to think critically about the role of the government in providing these services. Medicaid does not merely pay for health benefits for the most needy Texans, but has become a crutch for poor public policy in other areas of health care, while also providing benefits to a growing number of middle class people in Texas and around the country. For lawmakers and opinion leaders to craft the solutions this problem demands, there must be a clear picture of the crisis that lies ahead and the very nature of the program's growth.

The bottom line is this: the growth of Medicaid is not inexplicable; but is instead the result of decades of incremental policy changes to deliberately grow the program. Today the program covers vast numbers of people with widely varied health needs, through a generous benefits package, and with little or no regard to the cost of the program.

## Medicaid Today

In its 1965 amendments to the *Social Security Act*, the United States Congress created two sweeping new entitlement programs: Medicare and Medicaid. Forty years of amendments at both the federal and state level have fueled both increased enrollment and spending, making Medicaid a larger and more costly program than Medicare. Across the country, states have become acutely aware of the growing strain that Medicaid puts on their own budgets—committing ever more resources to fulfilling federal requirements of the Medicaid program, and often outpacing spending on historical budget priorities like education.

Medicaid, often called a federal-state partnership, today covers more than 53 million people at a price tag well over \$300 billion.<sup>1</sup> Although the program is jointly financed between the state and federal governments, much of the policy-making authority rests in Washington, though the engine for spending lies with the states. As a result, the program has created a tug-of-war between state and federal governments.

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Medicaid has proven sacrosanct (as have most entitlement programs) as caseloads have grown to serve more people—and more than just *needy* people. In 1989, approximately 23 million people received Medicaid nationwide, growing to more than 36 million people by 1995, and to around 53 million people in 2005.<sup>2</sup> The numbers are even more staggering when taken as a percentage of the total population. Today, Medicaid covers almost 18 percent of the U.S. population, up from 9 percent in 1985.<sup>3</sup> Of the average 45 million people enrolled in Medicaid each month in 2005, almost half were children.<sup>4</sup> Although children make up the largest part of the Medicaid population nationwide, they are less costly than the 14 million aged, blind, and disabled recipients in the program. In fact, Medicaid paid for nearly half of all long term care spending nationwide in 2004, whereas it accounted for less than a quarter of all nursing home costs in 1968.<sup>5</sup>

As a result of Medicaid's growth, budget writers have been left to wrestle with a program that knows no limits on cost. Though it has been argued that budget writers suffer from Medicaid's unpredictability, the truth is the program is very predictable: costs will increase. The only question is by how much?

The National Governors Association has reported that Medicaid is the largest single item in most state budgets, even surpassing spending on public education.<sup>6</sup> Left to grow unabated, Medicaid threatens state budgets today and into the future by crowding out other funding priorities. A 2005 article in the *McKinsey Quarterly* highlights the percent of new state revenue that will go to fund Medicaid in 2009. According to McKinsey, 21 states will spend more than half of every new tax dollar on Medicaid, with 10 of those states spending 75 percent or more of incremental revenues on Medicaid.<sup>7</sup> Texas isn't in either of the two highest groups, a small consolation since the McKinsey analysis projects that the Lone Star State will spend between 25 and 49 percent of new revenues on Medicaid—one of 22 states in the same bracket.

While the federal government is unencumbered by obligations to balance its budget as Texas and most other states are, many in Washington recognize the looming budget problems brought on by Medicaid and other large entitlement programs. The Congressional Budget Office (CBO) reports that Medicaid grew at slightly less than an 8 percent rate of annual growth from 1994 to 2004, followed by temporarily slowed growth in 2005, and estimates 5 percent growth in 2006 and 2007, before returning to more than 8 percent annual growth from 2007-2016.<sup>8</sup> In terms of hard dollars, that's \$182 billion in federal Medicaid spending in 2005 and \$413 billion in 2016.<sup>9</sup> These figures do not even account for the state's share of the funding, which is split by the federal and state governments at roughly 57 percent and 43 percent, respectively today.

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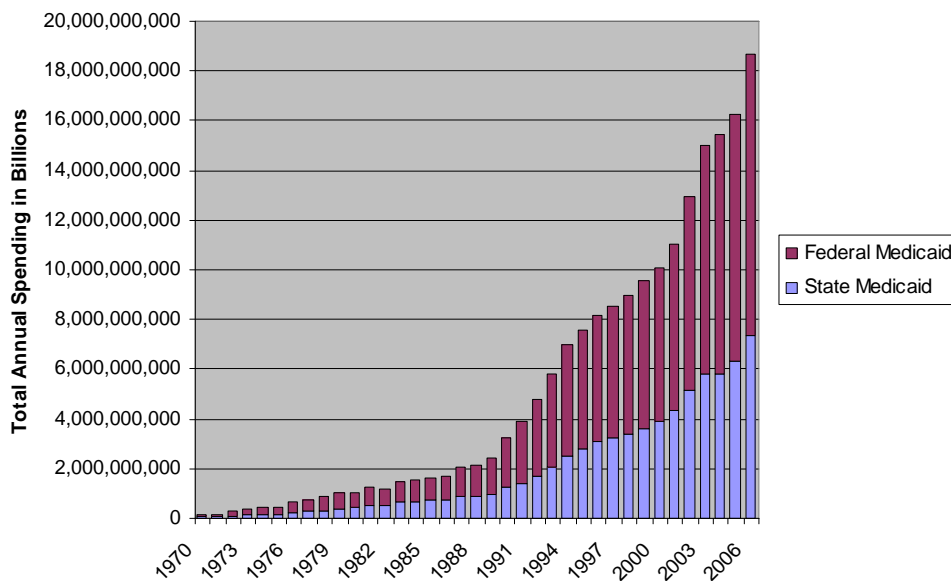
### Texas Medicaid Spending

The Texas Medicaid program has seen tremendous growth, both in terms of state revenues appropriated to the program and in federal funds that come to the state as a matching grant. Medicaid has become the single largest item in the state’s budget. Medicaid spending has surpassed public education as the state’s largest budget and arguably crowds out spending that might otherwise go to schools and classrooms around the state.

As the chart below illustrates, total Medicaid funding has continued to climb, fueled by increases in both federal and state spending. Only in 1982 did total Medicaid spending decline over the previous year, the result of a reduction in federal funding in the early 1980s (see pages 17 and 18). Texas’ General Revenue spending for Medicaid has never experienced a negative growth rate in the program’s history.

**Total Medicaid Spending in Texas 1970-2005**

\*Does not include DSH payments

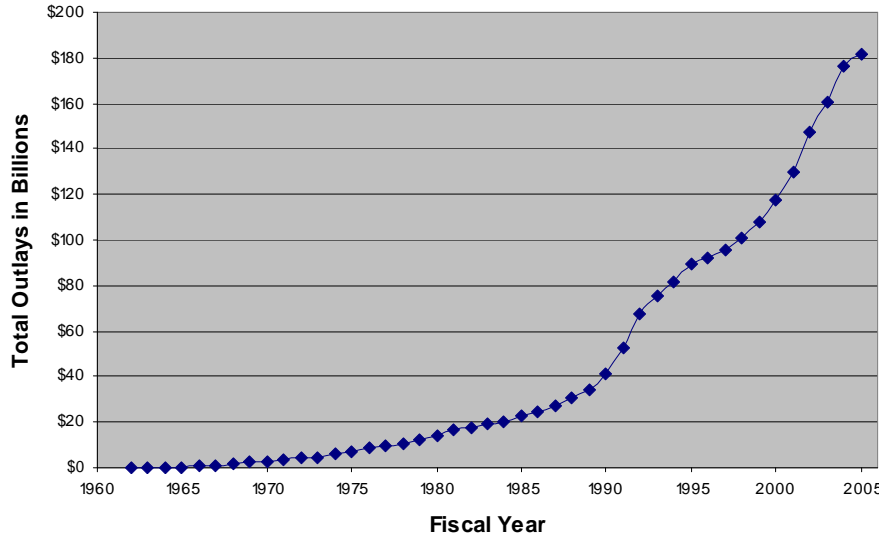


Source: Requested information, Texas Health and Human Services Commission Financial Services, Medicaid Expenditure Information FFY 1970-FFY 2006 (2006 estimated).

While the President and members of Congress have made efforts to achieve a small measure of cost containment in the Medicaid program, it is arguable that the states wield the greatest power in determining Medicaid’s annual bill. The matching arrangement, whereby states use state funds to leverage additional federal funding, drives up total spending. Without limitation on the amount of federal funds available to them, states make extraordinary efforts to leverage as much federal money as possible with state general revenue. This financing arrangement necessarily leads to mushrooming costs for the federal government, as states attempt to maximize their funds. Ultimately, as states push their budgets to the brink in order to meet Medicaid’s promises, the federal budget also experiences dramatic growth.



### Total Federal Outlays for Medicaid



Source: United States Congressional Budget Office, “The Budget and Economic Outlook: Fiscal Years 2007 to 2016,” January 2006: 148.

Also contributing to the growing budgetary pressure are the nation’s changing demographics, which will drive much of the growth in the future. Over the next 50 years the number of people age 65 or older will double and the number of people under age 65 will increase by only 12 percent.<sup>10</sup> Since the aged, blind, and disabled make up a disproportionately large share of Medicaid’s costs relative to their portion of the Medicaid population today, an aging population will only further exacerbate the program’s existing budget difficulties. In particular, Medicaid and other entitlement programs that primarily serve the elderly will be strained as health care costs are expected to grow faster than the economy, while at the same time the number of people receiving benefits increases.<sup>11</sup>

In March of 2005, David Walker, Comptroller General of the U.S. Government Accountability Office, testified before the U.S. House Committee on Ways and Means and delivered a bleak forecast for an aging nation that will increasingly rely on Social Security, Medicare, and Medicaid for support. Both Walker’s data and recent CBO data highlight the crippling impact of entitlement programs on the federal budget. In 2006, total federal outlays will be about \$2.6 trillion, with Medicaid, Medicare, and Social Security making up 43 percent of the total, jumping to 56 percent by 2017.<sup>12</sup> The funding demands of these entitlement programs will likely put a squeeze on discretionary items in the federal budget, just as Medicaid has already begun to do in most states.

Almost every expert agrees that Medicaid’s growth will continue; the question is at what rate? Medicaid costs have been greatly underestimated—a problem that has plagued both Medicaid and Medicare since their beginnings. A 2000 publication from the Health Care Financing Administration (HCFA) predicted that Medicaid enrollment nationwide would increase at an average rate of about

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In 2005, total federal outlays were slightly less than \$2.5 trillion, with Medicaid, Medicare, and Social Security making up more than \$1 trillion of the total, or approximately 42 percent of federal spending.

1 percent, growing from 32.5 million enrollees in 1998 to only 37.6 million in 2010.<sup>13</sup> However, in reality, both average monthly enrollment and an unduplicated count of all enrollees show that the program served 44.7 million and 53 million, respectively, in 2005. This far exceeds the HCFA projections made in 2000.<sup>14</sup> There is no doubt that assumptions can change, making it difficult to compare the predictions and the results. In Texas, budget estimates are based on predicted caseloads that prove to be as much about the art of politics as they are science, often changing during the course of budget deliberations and making comparisons difficult in hindsight.

Texas, as well as the nation, should consider the history of the Medicaid program, including its originally established obligations, legislative expansions, and cost containment efforts since the program's beginning. The bottom line is this: the growth of Medicaid can be explained as the result of decades of incremental policy changes to deliberately grow the program. Today the program covers vast numbers of people with widely varied health needs, through a generous benefits package, and without regard to the cost of the program.

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## Medicaid's Early Days

The period following World War II saw significant advances in medicine and changed the way Americans—even the world—thought about health care. In the U.S., government imposed wage controls in the 1940s made it difficult for employers to compete for labor, ultimately leading employers to offer health insurance benefits as a way to circumvent the wage controls through the tax code's favorable treatment of employer provided health insurance. Not only did the health insurance market grow, there became two increasingly distinct tiers of people: the young workers who received health insurance through their employer, and the elderly who did not have the benefits of subsidized health insurance through an employer. This disparity contributed to an increasing interest in creating a health care system to provide services to older Americans.

In 1960, the Kerr-Mills Act created the "Medical Assistance for the Aged" program, a means-tested program that used federal matching funds to cover the "medically needy," loosely defined as elderly individuals who made too much to qualify for public assistance<sup>i</sup> but who still could not pay for their medical expenses.<sup>15</sup> Under Kerr-Mills, the federal matching funds came to the state through a formula wherein the federal government paid between 50 and 80 percent of the cost—a sliding scale based on the state's per capita income.<sup>16</sup> Author of the legislation, Congressman Wilbur Mills of Arkansas, was looking for a way to target help to the poorer Southern states in particular, and designed the matching percentage to favor those states. Yet a 1962 report from Arizona Congressman Morris K. Udall pointed out that only 26 states had put the program into action and that almost all of the money went primarily to New York and to other large states. According to Udall, in 1961 "92 percent of all federal money

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<sup>i</sup>An earlier program, created in 1950 gave federal matching funds to states to pay medical providers on behalf of people receiving public assistance. Kerr-Mills expanded on this previous program and created a new program, extending benefits to people who were not eligible for public assistance.

expended went to the states of New York, Massachusetts and Michigan,” and, highlighting the disparity in per recipient spending, added that “the average payment per recipient in Illinois was \$506.86, whereas the average payment in Kentucky was \$15.62.”<sup>17</sup>

Kerr-Mills failed to provide the intended relief to Southern states, and pressure grew to expand the program even more.

In 1965, following some 15 years of debate, the U.S. Congress created the Medicare and Medicaid programs through an amendment to the *Social Security Act*. Some have said that Medicaid was the afterthought of the legislation, an easily argued assertion given little Congressional debate on the creation of the Medicaid program. However, the structure of the Medicaid program has deeper roots than its description as an “afterthought” would imply. In fact, much of the structure of the two grant programs delivering assistance to older Americans from 1950 to 1965 was eventually incorporated into the Medicaid and Medicare programs. Medicare Part A and Part B were created to provide a hospital insurance program for almost all older Americans, and a supplemental insurance program, respectively. In addition, Congress expanded the Kerr-Mills program, creating the Medicaid program and extending medical assistance to certain families with children, the blind, and disabled.<sup>18</sup>

Medicaid retained the joint federal-state funding structure, with the federal share coming through a matching percentage based on the state’s per capita income, which was again designed to favor Southern states with a comparatively lower per capita income. Today, Mississippi has the highest matching percentage in the country, an arrangement that still reflects the financing structure created by Congressman Mills to deliver assistance to poorer (Southern) states; though despite Mississippi’s high matching rate, the state still spends less per recipient than New York.

Although participation was voluntary, states agreeing to participate would be required to meet federally established minimum requirements regarding populations served and services provided. In addition to the mandatory populations and services, states could choose to include certain “optional” populations and services.

As created in 1965, Medicaid’s mandatory populations included those receiving assistance under Aid to Families with Dependent Children (AFDC, later changed to Temporary Assistance for Needy Families, TANF),<sup>19</sup> as well as other recipients of cash assistance. Medicaid’s mandatory services included: physician services, inpatient and outpatient hospital services, laboratory and x-ray services, and services through a skilled nursing facility. Finally, Medicaid would also be required to cover non-Medicare services through supplemental coverage to low-income Medicare enrollees.<sup>20</sup>

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<sup>19</sup>At the time Medicaid was created, states established eligibility for welfare. According to the *National Journal’s* article “Balancing Act” from August 2005, most states granted eligibility to people living on incomes above 20 or 30 percent of Federal Poverty Level (FPL).

## Medicaid An Afterthought?

Although conventional wisdom points to Medicaid as an afterthought given the limited—if non-existent—debate over the creation of the program, such a characterization deserves closer inspection. Arguably Medicaid was not an afterthought, but the natural outgrowth of a practice of incrementalism.

In fact, there is little doubt that the creation of the Medicare program was largely due to a slowly growing interest in a universal national health insurance program. In its early years, the issue was mired in concerns over states' rights, with the earliest concepts giving states the option to participate in medical assistance programs. However, advocates of the national model were dismayed with the states' seeming disinterest in creating expansive programs, so they turned to Social Security as the vehicle for adding a universal health benefit.

Although President Roosevelt had shown an interest in a national health insurance system, it had not been included in the creation of the Social Security program. Not until President Truman asked Congress in 1945 to pass a national health program had a President taken such a visible stand on the issue. Truman called for expanding hospitals, increasing support of maternal and child health services, providing federal funds to subsidize medical research and medical education, and an insurance system that would include everyone—without limitation on need or receipt of Social Security benefits. Truman also tried to lure the doctors into supporting the plan by expanding the health care infrastructure and resources, and by promising increased earnings.

Indeed, what began as a debate on a universal national health insurance system two decades earlier resulted in a major expansion of social insurance—a compromise favoring a policy of incrementalism to gradually reach the desired result. There can be little doubt that the creation of Medicare was an intentional step in building the case for a nationalized system. While it may be true that going the next step and creating Medicaid in *this* same piece of legislation was an “afterthought,” the intention of creating a far flung government program to cover all Americans was an issue of *when*, not *if*. Once created, Medicare and Medicaid offered a foothold from which to expand the programs to achieve those larger ends—an expansion that continues today. Robert Ball, Social Security Commissioner under Presidents Kennedy, Johnson, and Nixon has since said, plainly:

For persons who are trying to understand what we were up to, the first broad point to keep in mind is that all of us who developed Medicare and fought for it had been advocates of universal national health insurance. We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically. Although the public record contains some explicit denials, we expected Medicare to be a first step toward universal national health insurance, perhaps with ‘Kiddicare’ as another step... President Franklin Roosevelt feared that health insurance was so controversial, because of doctors’ opposition, that if he included it in his program for economic security he might lose the entire program.<sup>19</sup>

Perhaps it is easiest to think that Medicaid was an “afterthought,” but the fact that it was put into law on Medicare’s coattails does not make it so. The structure of Medicaid was clearly patterned on earlier government grant programs for delivering assistance, and the expansion of Kerr-Mills was entirely in keeping with the overall direction of national insurance proponents. Medicaid was born out of a clear interest in a national system, with the intent that incremental expansion would eventually cover more people and more services than thought politically palatable in 1935, 1945, or 1965.

*Sources: Paul Starr, The Social Transformation of American Medicine: 278-291 and President Lyndon B. Johnson’s Remarks With President Truman at the Signing in Independence, Missouri of the Medicare Bill, July 30, 1965 available at <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp>.*

In addition, states were given the option to extend coverage to certain “medically needy” people with high medical expenses, but who were ineligible for AFDC or other cash assistance. States could also elect to cover optional services: prescription drugs, clinic services, home health care services, dental care, and physical therapy, as well as certain diagnostic, preventive, and rehabilitative services.<sup>21</sup>

Importantly, the amendment also solidified Medicaid as an entitlement program, under which participating states would guarantee benefits to anyone who is eligible, without the ability to limit enrollment or overall cost. As a result, states electing to participate in the Medicaid program, as all states in the country have decided to do since the early 1980s, must comply by covering the federally mandated populations and services. As an entitlement, states forecast their Medicaid caseload and costs, but must pay for services that are covered under the program and enroll all eligible applicants even when funding is not sufficient to meet the demands. This arrangement, as discussed later, has led to considerable budget pressure on all states, both within and between fiscal years. In addition, there is no cap on the federal share of Medicaid funds, resulting in significant growth in total Medicaid spending.

In the years since Medicaid was created, Congressional and state actions have gradually expanded the program to widen eligibility and cover more services. These changes have led to marked increases in the scope of the program and its costs.

## Medicaid Timeline: 1967-1969

In 1967, less than two years after Medicaid was created, Congress enacted the first changes to the Medicaid program. These changes simultaneously expanded the benefits package for children and created restrictions on eligibility in response to mounting federal costs.

President Johnson sent a new package of children’s health programs to Congress, aiming to expand the nascent Medicaid program. Most notably, he proposed the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) amendment to provide definition to the package of health benefits required for children. Under the amendment, EPSDT services became mandatory for children under age 21, requiring the identification and treatment of physical and mental health needs.

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While President Johnson proposed expanding the scope of services provided to children under the Medicaid program, Congress grew increasingly concerned about the mounting cost to the federal government. New York became the symbol of liberalized state Medicaid policy and was recognized for its almost singular role in increasing total Medicaid outlays by extending Medicaid coverage to 40 percent of the state's total population.<sup>22</sup> It has since been observed that "New York State policy makers seem to have envisioned Medicaid as the stepping stone to universal health care for its residents."<sup>23</sup> Congressman Stratton of New York addressed these concerns on the floor of the U.S. House in early 1967, saying:

Under the original law we left a good deal of freedom to the individual States, assuming that they would exercise a measure of caution and discretion in implementing this program within their own boundaries. But the experience of a number of States, most particularly my own State of New York, has demonstrated that we need to be more explicit ourselves in determining guidelines for State Medicaid programs if the ultimate costs of this title are to remain within reasonable limits of the kind which we had assumed would develop when Congress passed the initial legislation.

As it is now, the cost of the program in New York State, for example, is estimated to run on an annual basis almost twice the amount which we had originally anticipated and set aside for title 19 programs in all 50 states. Clearly this is out of line with what we had in mind, even if our own original legislation may have been at fault in not defining our purposes more exactly. If all 50 States were to follow the lead of the New York program without any further guidelines from us, therefore, we would certainly find the overall costs of implementing Medicaid far exceeding the costs of the basic program of Medicare.<sup>24</sup>

In an effort to control the spiraling costs, Congress placed restrictions on the eligibility for "medically needy" individuals. When Medicaid was originally passed, states set the income eligibility limits for cash assistance through the AFDC, receipt of which also entitled a person to Medicaid benefits. In addition, states had been responsible for determining eligibility limits for those qualifying for Medicaid coverage as "medically needy." The growth in cost, even in the two short years since its inception, prompted Congress to limit Medicaid eligibility for the "medically needy" to 133.33 percent of a state's eligibility level for cash assistance.<sup>25</sup>

By the end of the 1960s, states had already begun to exploit Medicaid's incentives for generous spending. Congress had underestimated the states' interest in the program and in covering optional populations, which resulted in higher enrollment and higher costs. Entering the 1970s, Medicaid spending had crept to slightly less than \$87 billion and enrollment exceeded 16 million people nationwide.<sup>26</sup>

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From the *Rochester (N.Y.) Times-Union*, August 15, 1967, as printed in the Congressional Record.<sup>27</sup>

## Good Check on Medicaid Costs

At long last, there is a solid chance that Congress will rescue the taxpayers from the folly of runaway Medicaid.

The powerful House Ways and Means Committee has just approved an omnibus package of Social Security amendments. Among them is a sensible ceiling on federal aid to states like New York which have established Medicaid eligibility standards at unreasonably high levels.

Some 30 states now have set up Medicaid programs under Title 19 of the 1965 Social Security Act, which also authorized Medicare for the elderly.

‘While most of the state plans raise no questions at this time,’ the committee reported with an accusing finger leveled between the lines at New York, ‘a few go well beyond... what the committee believes to have been the intent of Congress.’

The committee deplored the effects of such generosity with taxpayers’ money in supplanting private health insurance and reimbursing medical expenses of ‘a considerable portion of the adult working population of moderate income.’

As the highly respected committee chairman, Wilbur D. Mills (D-Ark.), put it:

‘Because the states are projecting programs that will ultimately cost the federal government around \$3 billion a year, we think it’s high time for us to get a degree of reasonableness into the law.’

The committee would achieve this, basically, by limiting the 50 percent federal reimbursement of state-local Medicaid spending only to those families whose incomes are no more than one-third above the average state welfare payment under Aid to Dependent Children programs.

The committee figures this income maximum in New York at about \$4,400 annually for a family of four,

after taxes and any payments for health insurance premiums. New York now sets the maximum at \$6,000 for a family of four.

To ease the transition in states like New York which have set higher income eligibility standards, the limit on federal aid would start at a slightly higher level for them and drop to the basic standard in 1970.

Opinions differ on the effect of this limitation on New York’s Medicaid spending, which now is figured at a whopping \$738 million for the current fiscal year.

The total saving might run to \$50 million annually at the outset for federal, state and local governments. Most important, however, it would put a checkrein on Medicaid costs, which could skyrocket as more persons sign up for the program or if the New York legislature liberalized it.

The purpose of these amendments is not to deny government medical assistance to the poor, as critics will charge. They will be fully aided, and states would still retain flexibility to devise program to meet special needs. Low-cost private health insurance still will be available to everyone.

Rather, the bill’s aim is to stop a trend under Medicaid to ‘blanket in’ as much as half of a state’s population under a program verging on socialized medicine.

Even if that were a good idea in principle, which it is not, an America inundated by high government spending and high taxes because of the Vietnam war and domestic programs simply can’t afford so big a hand-out.

The House committee...deserves the taxpayers’ thanks for devising a program which protects them as well as the poor. Congress should not fail to approve it.

## Medicaid Timeline: 1970-1979

The early 1970s saw significant changes in the benefits for the aged, blind, and disabled. The Social Security Amendments of 1967 authorized Medicaid coverage for Intermediate Care Facilities (ICFs): facilities that provide “custodial care” for individuals who do not need care around the clock. However, the definition of an ICF was so broadly written that states channeled patients into these facilities to receive federal funds for their treatment, using the ICF as a “catch-all for any nursing home unable to meet other standards.”<sup>28</sup>

When the Secretary of the Department of Health, Education and Welfare (HEW) attempted to pass rules more clearly defining the role of ICFs, the states opposed the changes and forced the proposed rules to be withdrawn. The standards for ICFs were not agreed upon until 1971, when Congressional amendments to Title XIX also allowed states to provide Medicaid coverage for services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).<sup>29</sup>

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Between 1972 and 1976, total Medicaid enrollment grew an average of 5 percent each year, reaching 20.7 million people by 1976.

In 1972, Congress created the Supplemental Security Income (SSI) program, combining state-run cash assistance programs for the aged, blind, and disabled, and creating a new, federal program to cover the same. A 2003 study in the *Journal of Health Politics, Policy and Law* stated that the creation of SSI was a “crucial early development that led to significant downstream consequences,” and pointed to a “bifurcation among Medicaid beneficiaries...the elderly, blind, and disabled—who tended to be viewed as highly sympathetic groups—gained Medicaid eligibility based on a federal eligibility standard,” while mothers and children were eligible for the program based on a state eligibility standard.<sup>30</sup> Indeed, a bifurcation in Medicaid beneficiaries exists today, where it is particularly noticeable that different members of the same family may qualify for Medicaid assistance under different standards of eligibility, or may be ineligible altogether, as is the case with male heads of household.

At the national level, the creation of SSI had an almost immediate impact on the Medicaid program, increasing enrollment an average of 8 percent between 1971 and 1972, and contributing to an 18 percent growth in expenditures between 1972 and 1976.<sup>31</sup> In addition, spurred by an enrollment increase in disabled recipients, total Medicaid enrollment grew an average of 5 percent each year, reaching 20.7 million people by 1976.<sup>32</sup>

## Medicaid Timeline: 1980-1989

### The Early 1980s

In the early years of President Reagan’s first term, the cost increases in Medicaid presented the Administration with considerable challenges. While Medicaid enrollment nationwide had declined by an average of .7 percent a year between 1976 and 1981, Medicaid expenditures increased on average more than 15 percent a year.<sup>33</sup> The Reagan Administration spent the first few years of the term searching for ways to increase flexibility and control spending through unprecedented, if not controversial, reform proposals, while halting the program’s expansion.



In 1981, President Reagan proposed funding Medicaid through a block grant. Under the proposal, federal Medicaid funds would have been capped, allowing for a 5 percent increase in Fiscal Year 1982, and limiting future increases to the rate of inflation only.<sup>34</sup> As it was originally floated, the plan would have reduced the total grant by \$100 million in Fiscal Year (FY) 1981 and by \$1 billion in 1982.<sup>35</sup> The reductions, the *New York Times* explained, would force states to “make up the difference, either by changing eligibility requirements, reducing payment rates or increasing efficiency.”<sup>36</sup> The proposal made overtures about giving states additional flexibility in return for the reduction in federal funds, but was unpopular with governors nonetheless.

Reagan’s proposal for a block grant made it through the Senate with a 9 percent increase for FY 1982, but it was ultimately dropped in Congressional negotiations on the budget.<sup>37</sup> Undeterred, in 1982, Reagan proposed a swap that would have turned over welfare programs to the state and all Medicaid costs over to the federal government. The administration estimated Medicaid costs for FY 1983 to hit \$19 billion, with welfare costs running slightly less at \$16 billion.<sup>38</sup> However, many states worried that growing welfare rolls and federal changes to Medicaid might increase the uninsured, making the states’ exposure more significant than the Administration had estimated.<sup>39</sup> Again, the proposal failed.

Despite the failed attempts to block grant Medicaid or swap responsibility for the welfare and Medicaid programs, the early 1980s did see modest reductions in federal Medicaid funding, changes in financing and cost sharing, as well as opportunities for state flexibility.

The *Omnibus Budget Reconciliation Act* of 1981 (OBRA-81) included a reduction in federal matching rates of 3 percent for FY 1982, 4 percent for FY 1983, and 4.5 percent for FY 1984.<sup>40</sup> In addition, OBRA-81 also established a standard asset limit across all the states, and eliminated or reduced the earnings disregard and certain deductions, ultimately removing an approximated 408,000 families from the welfare rolls nationwide and cutting \$4 billion from the program.<sup>41</sup> Since the receipt of welfare benefits also entitled individuals to Medicaid benefits, the reduction in welfare rolls nationwide also impacted the number of individuals receiving Medicaid benefits.<sup>42</sup>

Also in 1981, Congress repealed requirements that states follow the reimbursement system under Medicare, but required states to make additional payments to hospitals seeing disproportionate numbers of low income and special needs patients, in order to prevent states from cutting reimbursement rates and hurting these hospitals.<sup>43</sup> These Disproportionate Share Hospital payments (DSH), however, did not become a major source of funding until the late 1980s and early 1990s.<sup>44</sup> More than two decades after it was created, DSH has now become a source of payment that providers rely upon, proving to be a different hurdle in reform discussions in Texas and in other states.

Finally, OBRA-81 sought to fulfill Reagan’s interest in giving states greater flexibility to manage their Medicaid programs by creating two new kinds of

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In 1981, President Reagan proposed funding Medicaid through a block grant

### Snapshot: Texas Medicaid in the 1980s

In 1987, the Texas Medicaid program crossed the \$2 billion mark in total annual expenditures—20 years after Texas Medicaid began.<sup>45</sup> Though the early 1980s held few changes in the Texas Medicaid program, expansions enacted at the federal level were soon followed by the Texas Legislature’s decision to expand the state program as well.

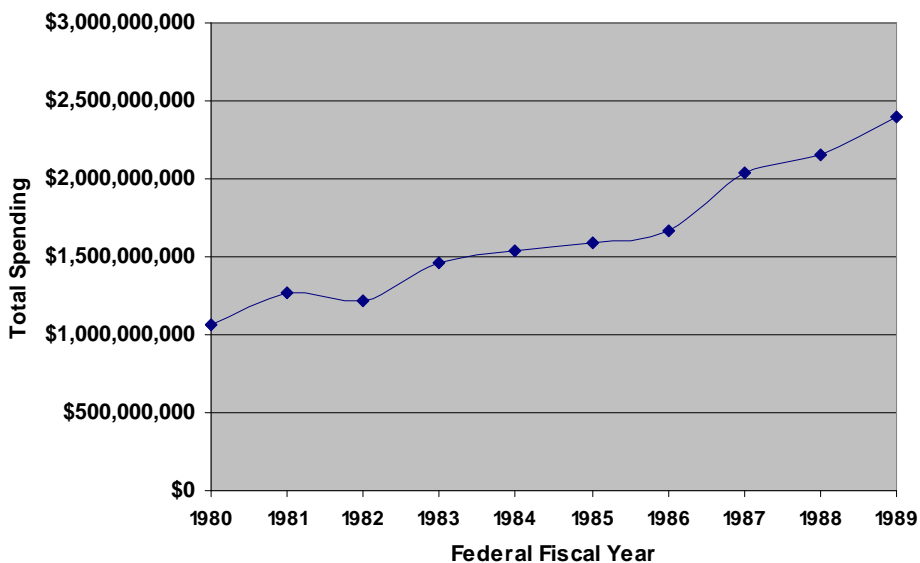
Texas implemented its Medically Needy program on January 1, 1985.

In September of 1988, Texas expanded Medicaid services to cover pregnant women and children under age two with a family income less than 100 percent of the Federal Poverty Level (FPL).<sup>46</sup> Congress had first given states the option to add such coverage in the budget reconciliation of 1986; and, through the same vehicle in 1987, Congress raised the eligibility ceiling again up to 185 percent of FPL. Effective January 1, 1989, House Bill 1345 increased income eligibility for pregnant women and children under age one to 130 percent of FPL, and increased the age of eligibility to 100 percent of FPL for children up to age four.<sup>47</sup>

The Texas Medicaid spending and caseload graphs show similar growth through the decade, including the obvious drop in both spending and caseload from 1981 to 1982. These changes also reflect many of the changes in the program at the federal level. In particular, the overall caseload reduction as a result of OBRA-81, and the reduction in matching rates for FY 1982, FY 1983, and FY 1984 coincided with a drop in the Texas Medicaid caseload, as did the declining or slowed growth rate in spending for the same years.

**Texas Medicaid Spending in All Funds 1980-1989**

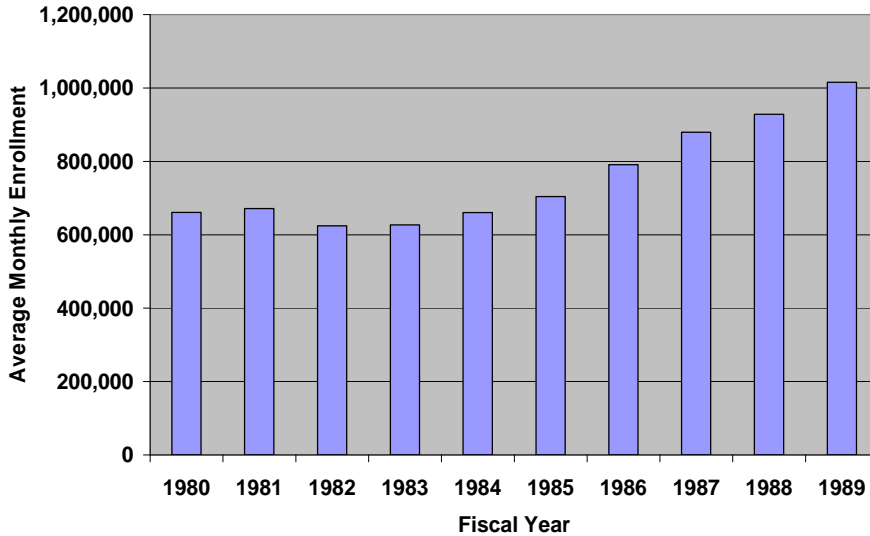
\*Does not include DSH payments



Source: Requested information, Texas Health and Human Services Commission Financial Services, Medicaid Expenditure Information FFY 1970-FFY 2006 (2006 estimated).

**Snapshot: Texas Medicaid in the 1980s—continued**

**Texas Medicaid Caseload 1980-1989**



Source: Requested information, Texas Health and Human Services Commission, Fall 2005 Forecast.

waivers: Freedom-of-Choice waivers and Home and Community-Based Services waivers.<sup>48</sup> The waivers were intended to allow states to expand managed care participation, in addition to providing greater flexibility in services to the elderly and disabled at risk for institutional care.

In 1982, Reagan’s interest in reform continued in the *Tax Equity and Fiscal Responsibility Act* (TEFRA), which gave states additional room to use cost-sharing with certain Medicaid recipients for certain services.<sup>49</sup> This idea of “nominal” cost sharing has continued until recently, when Congress authorized states to pursue higher levels of cost sharing. Finally, TEFRA allowed states to waive SSI income restrictions to cover disabled children under age 18 who require institutional care but can live at home. This group is often referred to as “Katie Beckett” children, named after the little girl who served as an example of this situation.<sup>50</sup> President Reagan introduced Katie Beckett to the country and highlighted her story in a 1981 news conference:

We just recently received word of a little girl who has spent most of her life in a hospital. The doctors are of the opinion that if she

could be sent home and receive her care at home, it would be better for her; this spending most of her life there and away from the home atmosphere is detrimental to her. Now, it would cost \$1,000 a month for her particular ailment to send her home. Her parents have no way that they can afford that, and the regulations are such that Medicaid now cannot pay for that if she goes home. The alternative is Medicaid continues to pay \$6,000 a month to keep her in a hospital, when the doctors say she would receive better treatment and be better off at home. But her parents can't afford to have her taken off Medicaid.

Now, by what sense do we have a regulation in government that says we'll pay \$6,000 a month to keep someone in a hospital that we believe would be better off at home, but the family cannot afford one-sixth of that amount to keep them at home?<sup>51</sup>

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Beginning in 1984, Congress undertook a major expansion of Medicaid every year through 1990.

Also in 1982, Arizona became the last state to establish a Medicaid program,<sup>52</sup> while being the first state to receive an 1115 Research and Demonstration waiver that has allowed Arizona to operate a statewide waiver program using a Medicaid Managed Care model.

### The Late 1980s

Although the early 1980s saw few changes in Medicaid, the late 1980s were marked by frequent program expansion and increasing costs. Beginning in 1984, Congress undertook a major expansion of Medicaid every year through 1990. From 1981 to 1984, Medicaid expenditures grew less than an average rate of 8 percent, with nationwide enrollment holding steady at approximately 20 million.<sup>53</sup> The slowed increase over this period is particularly notable as it followed on the heels of double digit increases in Medicaid spending of 18 percent and 15 percent per year from 1972-1976 and from 1976-1981, respectively.<sup>54</sup> Improved economic conditions and political pressure to soften the effect of Medicaid policies of the early 1980s, led to a seeming reversal in public policy.

Presiding over much of this expansion was California Congressman Henry Waxman, then-chairman of the Commerce Health and Environment Subcommittee in the U.S. House. Congressman Waxman drove much of Medicaid's expansion, directing any available federal funds to this purpose, with particular interest in covering pregnant women and children.<sup>55</sup> Indeed, Congressman Waxman put the policy of incrementalism into practice, as evidenced by serial Medicaid expansion in the later part of the decade. *National Journal* explained the approach in a 2005 article by saying, "the strategy was to first allow states to cover a group of people as optional Medicaid beneficiaries, and then come back later and require states to cover those people." And if there was any doubt as to the deliberate and incremental expansion of the program, Congressman Waxman put those doubts to bed when quoted as saying, "I always thought the Medicaid program was trying to help low-income people get access to health care, and that it was a program we needed until such time as we have national health insurance."<sup>56</sup>

In 1984, the *Deficit Reduction Act* mandated the coverage of children born after September 30, 1983, up to age five for families receiving cash assistance, as well as coverage of first-time pregnant women receiving cash assistance and pregnant women in two-parent unemployed families.<sup>57</sup> One year later, coverage for all pregnant women receiving cash assistance became mandatory in the *Consolidated Omnibus Budget Reconciliation Act* of 1985.<sup>58</sup>

In 1986, Congress gave states the option to cover pregnant women and infants (up to 1 year of age) with incomes up to 100 percent of the federal poverty level (FPL).<sup>59</sup> It also required states to cover emergency medical conditions for illegal immigrants, as though they were otherwise eligible for Medicaid.<sup>60</sup>

OBRA-87 raised the ceiling on optional coverage for pregnant women and infants, giving states the option of covering women and children up to age one with an income of up to 185 percent of FPL.<sup>61</sup>

The *Medicare Catastrophic Coverage Act* of 1988 (MCCA) impacted the Medicaid program by requiring states to cover Medicare premiums and cost-sharing for low-income Medicare beneficiaries with incomes below 100 percent FPL (known as Qualified Medicare Beneficiaries, QMBs).<sup>62</sup> In 1989, however, Congress repealed most of MCCA, but left the Medicaid coverage for QMBs in effect.<sup>63</sup>

By the late 1980s, states were beginning to feel considerable pressure brought on by years of policies to expand Medicaid, though their pleas for help were only beginning. During the U.S. House debate to repeal the MCCA provisions, a letter and resolution from the National Governors Association (NGA) was printed in the record and conveyed the states' growing concern over the unsustainable growth in Medicaid at the hands of Congress. The August 1, 1989 letter read, in part:

Dear Member of Congress: Today the nation's Governors took action calling on Congress and the White House to adopt a two year freeze on the enactment of further Medicaid mandates. Our Resolution was based on our increasing concern with the impact of the last three years of Medicaid mandates on our budgets, and consequently, on our ability to properly fund education and other important services.<sup>64</sup>

The "Resolution on Health Care" accompanying the NGA's letter stated that "the accelerating costs of Medicaid, Medicare, and other health programs argue for a new look at health care financing options, including federalization of Medicaid or an aggressive effort to restructure the system."<sup>65</sup> Despite the governors' interest in a two year "freeze" on further expansions, the Congress enacted another round of program expansions in 1989.

OBRA-89 expanded eligibility by requiring Medicaid coverage for pregnant women and children under age six in families with incomes at or below 133 percent of FPL and regardless of receipt of cash assistance.<sup>66</sup> In addition, OBRA-89 expanded the Early and Periodic Screening, Diagnostic and Treat-

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In 1989, the National Governors Association asked for a freeze on Medicaid mandates.

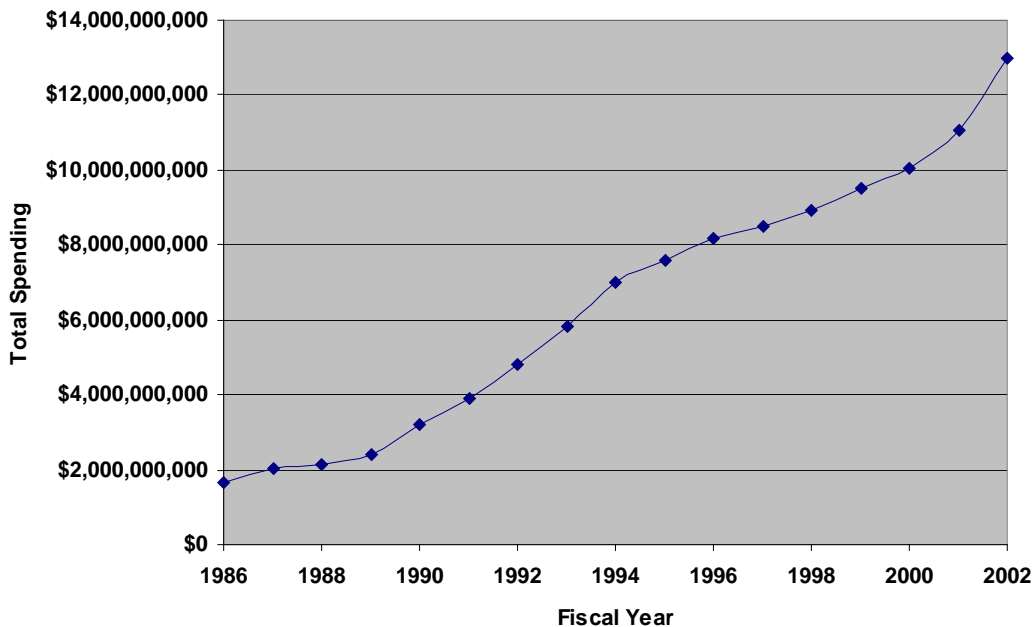
### Texas Medicaid Growth from 1986-2002

Federal Medicaid policy from the late 1980s through the early 1990s fueled the growth of the Medicaid program by expanding eligibility to include more people, particularly pregnant women and infants, and children. In addition, federal policy placed greater responsibility on the state to assist Medicare recipients, contributing to both significant long term costs and caseload growth.

In 1990 Congress expanded eligibility for children ages six through 18, increasing the maximum age of eligibility by one year, each year until completely phased in. During this period, Texas Medicaid enrollment tripled and caseload grew by as much as 19 and 21 percent a year in the early 1990s. Nationwide caseloads surged by an average growth rate of 12 percent in 1991 and 1992. In addition, total Medicaid spending grew from less than \$2 billion in 1986 to almost \$13 billion in 2002.

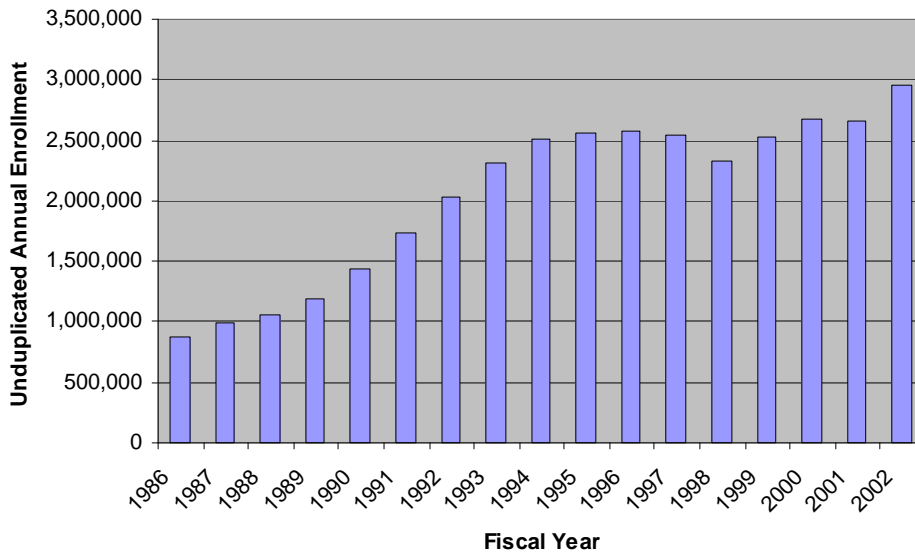
### Texas Medicaid Spending in All Funds 1986-2002

\*Does not include DSH payments



Source: Requested information, Texas Health and Human Services Commission Financial Services, Medicaid Expenditure Information FFY 1970-FFY 2006 (2006 estimated).

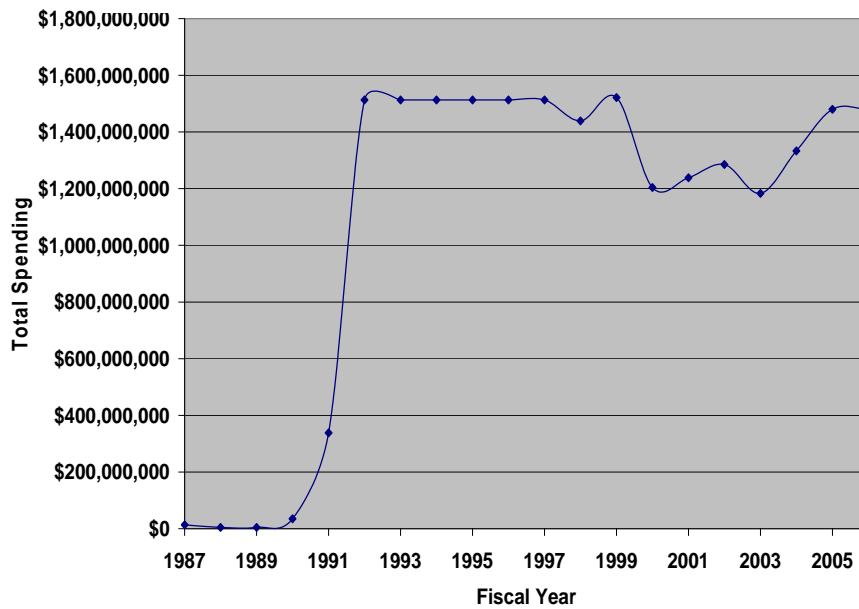
### Texas Medicaid Enrollment 1986-2002



Source: Compiled data, Texas Health and Human Services Commission, "Texas Medicaid In Perspective," Ed. 2, 3, 4.

As spending and caseloads grew, so did payments for Disproportionate Share Hospitals (DSH). The graph below illustrates the explosive growth in the DSH program in the early 1990s.

### Total Spending: Disproportionate Share Hospital Payments



Source: Requested information, Texas Health and Human Services Commission Financial Services, Medicaid Expenditure Information FFY 1970-FFY 2006 (2006 estimated).

ment program's benefits to children under 21 (established in 1967) to include needed diagnostic and treatment services, regardless of whether they are otherwise available in the Medicaid program.

In the late 1970s nationwide enrollment declined slightly, while expenditures grew by 15 percent. By the early 1980s, enrollment was holding steady at slightly less than 20 million people and the growth in expenditures had slowed to 8 percent.<sup>67</sup> Yet those trends began to change dramatically with the expansions of the mid to late 1980s. Between 1984 and 1990 average annual caseload growth ran 2.5 percent jumping to 12 percent annual growth in the early 1990s, while growth in Medicaid expenditures ran almost 12 percent a year from 1984-1990.<sup>68</sup> Despite this growth, the expansions of the late 1980s would continue into the 1990s and drive both caseloads and expenditures.

### Medicaid Timeline: 1990-1999

It took well into the 1990s for the full impact of the 1980s expansions to become visible. The effects of many of the 1980s expansions were not immediately recognizable, in part because of the incremental policy changes that slowly brought more people into the program, many as optional populations first, and later as mandatory populations.

Just as it had done in 1984 to boost coverage for children up to age 5, in 1990 Congress again expanded coverage to children through a phased-in approach. Through OBRA-90, Congress mandated Medicaid coverage of children ages six through 18 in families with incomes up to 100 percent FPL.<sup>69</sup> The legislation again phased in the coverage according to birth date, increasing the maximum age for Medicaid eligibility by one year, each year, such that the full effect of this expansion would not be felt until 2002 when the first of the phased-in children reached age 18.

OBRA-90 also expanded the state's responsibility to share in the cost of Medicare coverage for certain Medicare beneficiaries, and created the Medicaid prescription drug rebate program requiring pharmaceutical manufacturers to give the "best price" to the government.<sup>70</sup>

In 1991 and 1992, national caseloads grew at an average rate of 12 percent, up from 2.5 percent growth in the years immediately before, while expenditures grew by 27 percent each year from 1990-1992.<sup>71</sup> In addition, increased budget pressures from a recession left many states to find ways to shift some of the mounting cost to the federal government. Accordingly, the federal government clamped down on state accounting practices that increased DSH payments. At the time, federal limits on Medicaid reimbursements did not apply to DSH payments, allowing states to increase DSH payments to a provider, and then collect the increased payment, as a donation or tax on the provider, to leverage federal DSH funds.<sup>72</sup> As a result, federal DSH payments had skyrocketed from less than \$1 billion in FY 1990, to more than \$17 billion in FY 1992.<sup>73</sup> (See page 23 for Texas DSH spending.) The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 limited the use of donations and health care

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In 1991 and 1992, national caseloads grew at an average rate of 12 percent, up from 2.5 percent growth in the years immediately before, while expenditures grew by 27 percent each year from 1990-1992.



taxes to “draw down” federal funds, and capped the amount of money that provider-specific taxes could raise for state spending on Medicaid.<sup>74i</sup> DSH payments would be capped at 12 percent of Medicaid spending, and frozen at 1992 levels for states that were already exceeding the 12 percent threshold.<sup>75</sup>

Yet, despite efforts to control the states’ ability to shift costs to the federal government and rein in spending, Congress tackled DSH spending again less than two years later. OBRA-93 took the ceiling on DSH payments to the states a step further and established limits on the DSH payments that an individual hospital could receive, as well as standards for designating a DSH hospital.<sup>76</sup> The ceiling on DSH payments to hospitals was phased in to become fully effective in FY 1995, which a publication from the Congressional Research Service links to the drop in total payments in FY 1996.<sup>77</sup>

In addition to further limits on DSH payments, OBRA-93 required states to implement a Medicaid estate recovery plan. Although the original Medicaid statute allowed states the option to recover its costs from the estate of certain deceased Medicaid recipients, only 12 states had an estate recovery program in place before 1990.<sup>78</sup> The results of an aggressive estate recovery program in effect in Oregon since the 1940s suggested that the federal government, as well as states, could realize significant savings if estate recovery plans were put into place.<sup>79</sup> OBRA-93 outlined the state’s responsibility to recover certain Medicaid costs from certain recipients. Until 2003, Texas had avoided implementing an estate recovery program, despite direction from federal law to do so. In 2003, the 78<sup>th</sup> Legislature passed House Bill 2292, directing the Health and Human Services Commission to comply with federal requirements to establish an estate recovery program, which subsequently became effective on March 1, 2005.

In 1995, Congressional Republicans were actively campaigning for dramatic reforms in the nation’s welfare programs, including the use of a block grant for both welfare and Medicaid programs. Republican governors had worked with Congress to develop a Medicaid block grant proposal that would loosen the strings that came with federal funding, an interesting twist considering the objections from many governors when President Reagan proposed the system of block grants in the early 1980s. Under the 1995 proposal, Medicaid funds were to be cut by more than \$180 billion over seven years.<sup>80</sup> As passed by the House Commerce Committee, the so-called “MediGrants” would have come to the states free of almost all of the federal rules, but with a requirement that states spend 40 percent of their grant on certain needy populations.<sup>81</sup>

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In 1995, Congressional Republicans were actively campaigning for dramatic reforms in the nation’s welfare programs, including the use of a block grant for both welfare and Medicaid programs.

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<sup>i</sup>Other state accounting practices had a similar impact, including the use of intergovernmental transfers, but the Voluntary Contribution and Provider-Specific Tax Amendments protected these transfers. Intergovernmental transfers were not widely used at the time, but have since become a major issue in Washington as the federal government looks to curb state practices to shift costs to the federal government and increase federal spending on Medicaid.

### Snapshot: Texas Medicaid in the 1990s

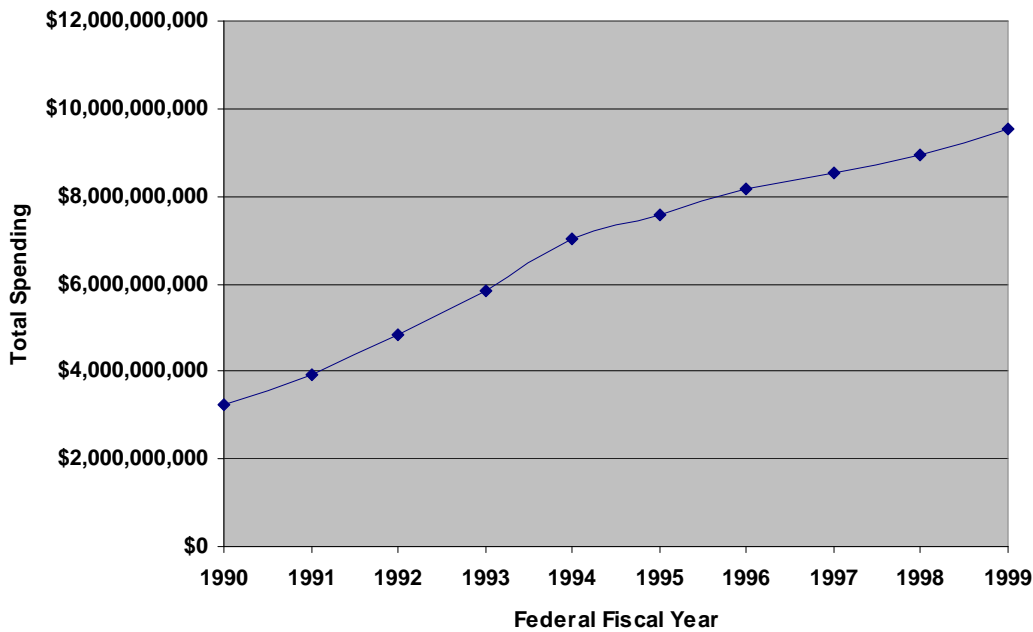
Rapidly changing policy at the federal level drove several state level changes in the early 1990s.

In April of 1990, Texas expanded Medicaid coverage for pregnant women and children under age six in families with incomes below 133 percent of FPL, as required in the federal budget reconciliation bill of 1989.<sup>82</sup> In December of 1991, the Texas Legislature boosted income eligibility limits up to 185 percent of FPL for pregnant women and children under the age of one. Except for a brief period from 2003 to 2004, eligibility for pregnant women and children under age one has remained unchanged and exceeds the federally mandated eligibility level of 133 percent FPL.<sup>83</sup>

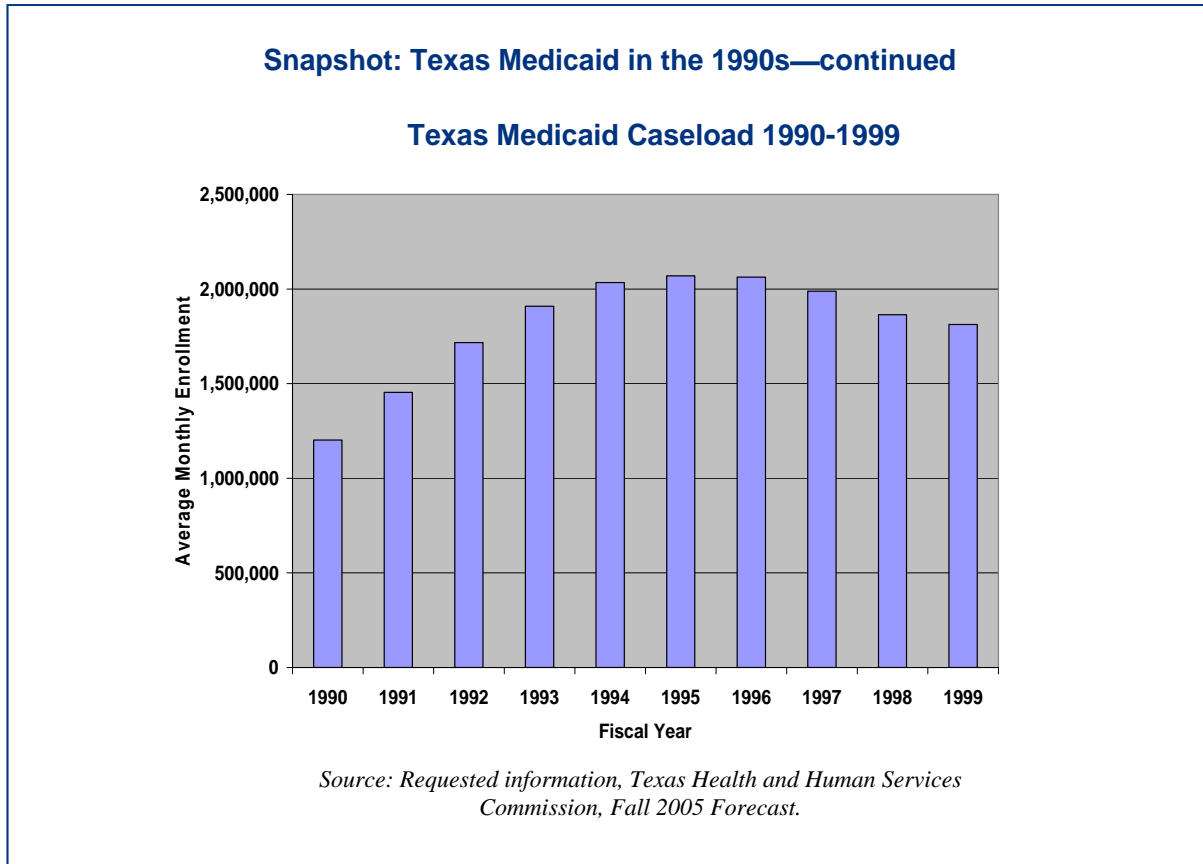
Texas Medicaid grew by more than one million people between 1990 and 1995 with steady enrollment growth throughout most of the decade.<sup>84</sup> Texas' caseloads increased by as much as 21 percent in the early part of the 1990s, with a noticeable decline in 1997 and 1998. Texas created the CHIP program in 1999, which also increased the number of children on the Medicaid rolls as a result of outreach and enrollment efforts in CHIP.

#### Texas Medicaid Spending in All Funds 1990-1999

\*Does not include DSH payments



Source: Requested data, Texas Health and Human Services Commission Financial Services, Medicaid Expenditure Information, FFY 1970-FFY 2006 (2006 estimated).



In a showdown with the Republican-controlled Congress over balanced budget proposals, along with Medicare, Medicaid, welfare, and tax cuts, President Clinton made it clear that he would veto legislation that cut such assistance.<sup>85</sup> President Clinton’s stance drew praise in a letter sent to the President from U.S. Senate Democrats in 1995 expressing their pleasure “to hear Chief of Staff Panetta relay your commitment to veto any budget not containing a fundamental guarantee to Medicaid for eligible Americans.”<sup>86</sup> When the legislation landed on the President’s desk in early 1996, President Clinton made good on his veto promise.

Overall, Medicaid expenditures grew by an average of 27 percent annually from 1990 to 1992, dropping to an average of 8 percent annually until the 1995 block grant proposal gained popularity and states increased spending in an effort to raise their grant amount in preparation for the possible financing change.<sup>87</sup> As a result of the growth in 1995 expenditures, the rate of growth for 1996 reached an all-time low of less than 2 percent nationally.<sup>88</sup>

In President Clinton’s 1997 State of the Union Address, he emphasized expanding children’s health insurance, calling for a \$3 billion increase in funds to insure uninsured children and pledging to expand coverage to an additional 5 million uninsured children by 2000.<sup>89</sup> President Clinton’s budget called for further expansions in the Medicaid program, primarily through an emphasis on out-

reach to enroll eligible children who were not participating in the program, and a requirement for states to guarantee children continuous eligibility in Medicaid for a full year.<sup>90</sup> However, Congressional Budget Office estimates projected that mandating a full year of continuous eligibility for children would increase Medicaid costs by \$14 billion over five years, an increase that Congressional Republicans would not support.<sup>91i</sup>

The *Balanced Budget Act* of 1997 created the State Children’s Health Insurance Program (SCHIP or CHIP) in an effort to address growing concern over the number of uninsured children. Under the new program, states could extend coverage to children who were ineligible for Medicaid but whose families make less than 200 percent FPL. As an incentive states would receive a larger share of the program’s funding from the federal government than they received under Medicaid. President Clinton promoted the idea of an expanded health insurance program for children in his State of the Union address in 1997, and characterized the plan as the “opportunity of a generation,” placing the nation “on the verge of enacting the single largest investment in health care for children since Medicaid was passed in 1965.”<sup>92</sup>

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The Balanced Budget Act of 1997 created the State Children’s Health Insurance Program (SCHIP or CHIP) in an effort to address growing concern over the number of uninsured children.

Though the plan passed through Congress with relative ease, not everyone shared the President’s enthusiasm for a new program to cover additional children. The *New York Times* pointed out that the Republicans in Congress were not “rushing to take credit for the new health insurance program that they are creating under pressure from the President,” and quoted then-Oklahoma Senator Don Nickels as saying that he had reservations about creating another federal program, noting that the recipients would be in families making well above the poverty level.<sup>93</sup> Yet, increased flexibility for states, allowing states to use CHIP funds to either expand Medicaid programs for children or create an entirely new program, along with the latitude to establish benefit packages, charge premiums and copayments, along with the preferential match from the federal government, helped to satisfy Congressional Republicans and appeal to state legislatures in the end.

In addition, the *Balanced Budget Act* of 1997 required states to again pay Medicare premiums for certain additional elderly and disabled individuals, allowed states to increase the use of managed care plans without obtaining a waiver, and further reduced ceilings on payment adjustments in the DSH program.

By the end of 1997, Clinton administration officials expressed frustration that states were not enrolling more children, despite the President’s efforts to heighten awareness and offer tools to help enroll more children in public insurance programs. In response, President Clinton ordered greater efforts to get children enrolled through increasing the presence of eligibility workers, as well as “reminding [states] that they can accept Medicaid applications by mail and do not have to verify the financial assets of families who would otherwise qualify because of their low incomes.”<sup>94</sup>

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<sup>i</sup>States have the option to offer 12 months of continuous eligibility.

## Medicaid Timeline: 2000-2005

From 2000 to 2003, nationwide Medicaid expenditures grew by about one-third, as total costs shot up from just over \$200 billion to \$276 billion.<sup>95</sup> The economic downturn and resulting tightening of state budgets forced many states to pursue policy changes and cost containment measures to mitigate the impact of revenue shortages and high enrollment.

The enrollment increases from 2000 to 2003 are often branded as the result of increased need in the down economy, but this explanation fails to recognize the growth in the program resulting from 15 years of policy changes to deliberately liberalize eligibility. For example, by 2002 the eligibility increases for children through OBRA-90 had taken full effect with under 12 percent enrollment growth for families from 2000-2002 and 7 percent from 2002-2003, compared with about 3 percent growth each year from 2000-2003 for the aged and disabled.<sup>96</sup> Although, the slowed economy may have contributed to the peak in enrollment, the trends in growth and expanded eligibility would have reflected higher enrollment regardless of the economy.

In 2000, Congress took action to expand services as well as control state maneuvering to get additional federal funds. First, Congress passed the *Breast and Cervical Cancer Treatment and Prevention Act* of 2000 to give states the option of providing services to women regardless of their income. In an effort to encourage state participation, federal funds would match state funds at the more generous SCHIP matching rate, rather than at the Medicaid matching level.

Second, Congress responded to states' increasing use of the upper payment limit (UPL) to leverage additional federal funding. The UPL calculation allowed states to pay facilities (primarily nursing homes and hospitals) up to the amount Medicare would pay, but paying more to facilities that have a higher cost than other facilities due to difference in patient population and insurance status. This method attempted to better reimburse facilities according to their cost, rather than applying a single standard to all providers. However, the federal government grew concerned that loopholes in the law were allowing states to use "excessive payment rates" to draw down the federal funds and recapture them at the state level rather than fully reimburse providers. These concerns about UPL echoed the issues surrounding DSH payments years before where the federal government held that states were getting more federal money without having to commit additional state money to the program. Testifying before the U.S. Senate Finance Committee, Timothy Westmoreland, Director of the Center for Medicaid and State Operations, illustrated the "rapid increases" in federal Medicaid spending as a result of states' practices with UPL, saying:

The practical outcome is that the States using this financing mechanism actually gain Federal matching payments without any new State financial contribution. In fact, through these practices, it is possible for a State that should receive \$1 in federal funds for every State dollar spent on Medicaid to instead receive \$5 or more in federal funds for every State dollar spent. In addition, if a State requires county or municipal facilities to

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From 2000 to 2003, nationwide Medicaid expenditures grew by about one-third, as total cost shot up from just over \$200 billion to \$276 billion.

refund its own Medicaid contribution, the practice also effectively undermined the requirement that a State share in the funding for its Medicaid program.<sup>97</sup>

As Westmoreland points out, state gamesmanship in drawing down these existing federal funds not only shifts a greater financial burden to the federal government, but to the local level as well. In response to these concerns, Congress directed the Secretary of Health and Human Services to better control the states' use of UPL funds through federal regulations.

Since 2001, the Bush Administration has put its efforts into allowing states better flexibility to manage their Medicaid programs through Health Insurance Flexibility and Accountability (HIFA) waivers. The HIFA waivers emphasize state flexibility with the goal of expanding coverage to new populations, adding a caveat that the waiver must be revenue neutral.

In 2003, Congress gave states temporary relief from high caseloads and the budget shortfalls impacting most states by increasing Medicaid matching rates for a short window of time through June 2004. The Congressional Budget Office points to the expiration of these "enhanced matching rates" as a factor in slower cost growth in 2005 than in the years before and in future projections.<sup>98</sup>

Also in 2003, President Bush created the largest new entitlement since the creation of the Medicare and Medicaid programs in 1965. The *Medicare Prescription Drug, Improvement, and Modernization Act* of 2003 created a new prescription drug benefit for Medicare recipients, requiring states to make a monthly payment to the Medicare program. This "clawback" mechanism was designed to recover what would otherwise be a savings to the state budget from the enrollment of dual eligibles in Medicare Part D drug coverage.

In 2005, President Bush signaled an interest in Medicaid reform with the Secretary of Health and Human Services appointing members of the Medicaid Commission to recommend \$10 billion in short-term budget savings, and long-term reforms by the end of 2006. In addition, over the course of 2005, both the President and his new Health and Human Services Secretary Mike Leavitt, talked openly about the need to reform Medicaid. In February 2005, Secretary Leavitt signaled the federal government's particular focus on state accounting "gimmicks" and Medicaid loopholes, saying that reforms that close those loopholes and prevent cost shifting to the federal government could save \$60 billion over 10 years.<sup>99</sup>

Most recently, the *Deficit Reduction Act* of 2005, signed by President Bush in February 2006, reduced domestic spending by almost \$40 billion over five years, with savings of almost \$5 billion in the Medicaid program between 2006 and 2010.<sup>100</sup> Among the largest items of savings were amendments to allow states to require cost sharing and reduce certain aspects of coverage.<sup>106</sup> U.S. House and Senate leaders have noted that the Act merely slows the growth of Medicaid by less than one half of 1 percent.<sup>107</sup>

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Most recently, the Congressional budget resolution for 2006, signed by President Bush, reduced domestic spending by almost \$40 billion over five years, with savings of almost \$5 billion in the Medicaid program between 2006 and 2010.

### Snapshot: Texas Medicaid 2000-2006

Following more than a decade of extraordinary growth in caseloads and expenditures, Texas Medicaid was running at all time highs entering into the new century. Since then, the program has continued to grow, though with a modest rein on spending stemming from the state's budget shortfall in 2003. Despite this growth, however, a number of policy changes have been implemented at the direction of the Legislature.

Among the notable changes made in the Texas Medicaid program from 2000-2006:

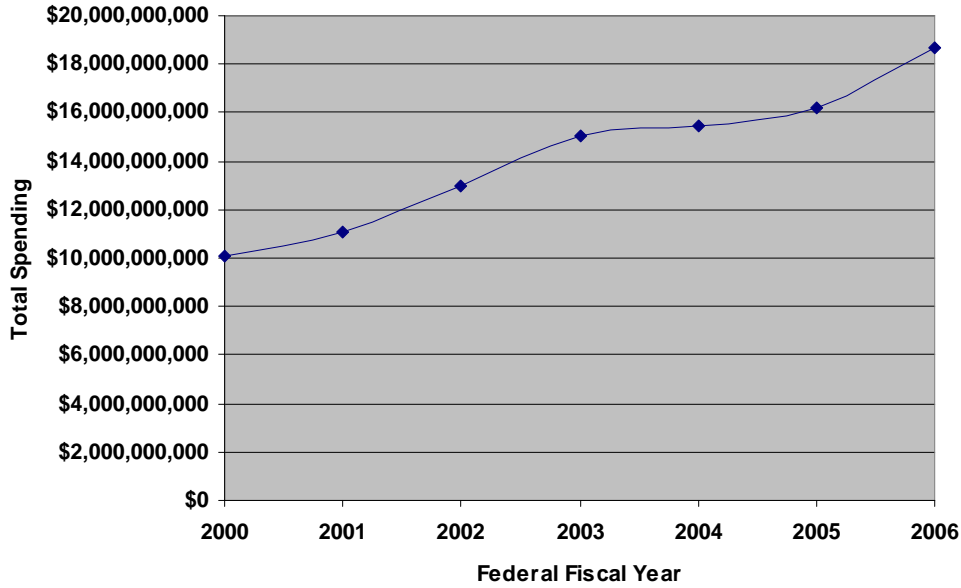
- January 1, 2002, Senate Bill 51 took effect, providing Medicaid coverage to foster youth age 18-20 after aging out of the foster care system, and with an income of less than 400 percent of FPL.<sup>101</sup>
- Also effective January 1, 2002, were provisions for simplified Medicaid eligibility enacted by the 77<sup>th</sup> Texas Legislature. Senate Bill 43 eliminated face-to-face interview requirements for application and recertification of children's Medicaid benefits in an effort to ensure that "Texas Medicaid eligibility verification procedures will be no more difficult than those of the Children Health Insurance Program."<sup>102</sup>
- On December 1, 2002, Texas began offering women coverage for breast and cervical cancer screening through the Breast and Cervical Cancer Control Program passed in Senate Bill 532.<sup>103</sup>
- In 2003, the Texas Legislature faced an almost \$10 billion budget shortfall that was eventually balanced through the reduction of programs and agencies across the state budget. While much of House Bill 2292 made organizational changes to consolidate the state's health and human services enterprise from 12 agencies down to five, there were two notable Medicaid policy changes. First, HB 2292 lowered the income eligibility for pregnant women age 19 and older from 185 percent of FPL to 158 percent of FPL, a reduction in the optional eligibility level that was restored in September 2004.<sup>104</sup> Second, the state budget did not include funds for the "medically needy," narrowing the "medically needy" to only pregnant women and children.<sup>105</sup>

The two graphs on the following page, illustrate spending and caseload growth and show consistent increases in the average monthly enrollment on Medicaid throughout the period, as well as a steady—but slowed—growth in spending following the budget shortfall in 2003. Importantly, the average monthly enrollment in Medicaid shows lower enrollment numbers than an unduplicated count for the same period. Note that the unduplicated count more accurately measures the number of individuals receiving Medicaid during the year, while the average monthly count is a better indication of the enrollment at any given time. As an example, the average monthly enrollment for 2001 and 2002 was about 1.8 million and 2.1 million, respectively. The unduplicated count, according to Health and Human Services Commission published data, is approximately 2.6 million and 3 million for the same years.

### Texas Medicaid 2000-2006—continued

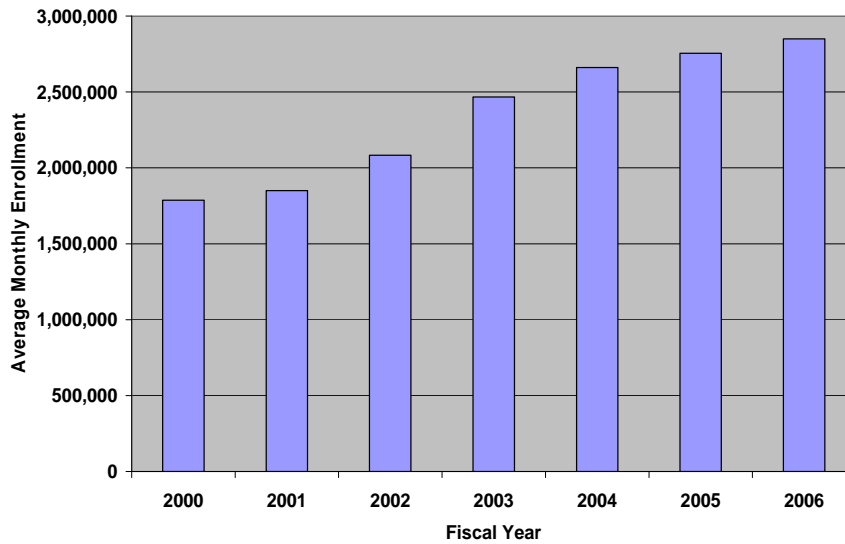
#### Texas Medicaid Spending in All Funds 2000-2006

\*Does not include DSH payments



Source: Requested information, Texas Health and Human Services Commission Financial Services, Medicaid Expenditure Information, FFY 1970-FFY 2006 (2006 estimated).

#### Texas Medicaid Caseload 2000-2006



Source: Requested information, Texas Health and Human Services Commission, Fall 2005 Forecast (2006 estimated).



## Conclusion

No single event in the more than 40 years since Medicaid was created drove the program to become the largest and most expensive government health program in the country's history. Instead, a series of incremental policy changes to expand Medicaid have driven the program to the brink of collapsing state budgets and crowding out other state priorities. Furthermore, reforms passed by the Texas Legislature in 2003, and the modest reforms passed by the Congress and signed by the President in 2006, will not be enough to stave off a budgetary crisis.

While some may have intended for Medicaid to remain a narrowly crafted program providing only a safety net for the country's most needy, the policy of incremental expansion has clearly won out. The percent of the population enrolled in Medicaid has grown to almost 18 percent and will continue to grow in the years ahead as aging baby boomers become eligible for Medicare and Medicaid services to meet their health and long-term care needs. The almost three million Texans who will make up the state's Medicaid caseload over the next two years will represent everyone from the most truly needy, to the growing middle class relying on Medicaid for long-term care.

As lawmakers contemplate reforms and likely proposals for expansion in the coming years, it is imperative that Medicaid be seen as a safety-net, rather than a catch-all for the health care needs of a growing number of Texans. In almost every instance, attempts to regain control of the program have been unsuccessful due to the program's inherent design to cover as many people as possible without regard to cost. Medicaid's problems are systemic. Change on the margins will not arrest the growth of the program, nor improve its chances of solvency in the future. Consequently, it is imperative that all sides recognize that Medicaid has been stretched to accommodate disparate health needs at unsustainable cost, and the status quo will not be an acceptable alternative in the future. Texas lawmakers and opinion leaders must aggressively push Washington to fundamentally restructure the Medicaid program and give states more autonomy in running the Medicaid program.

Future publications on Medicaid will explore opportunities for state and national reform, but understanding the history of the program and its incremental expansion is critical to avoiding the same mistakes again. The system needs wholesale changes, and incremental reforms will do little to put off the impending financial crisis.

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## Reference Timeline

### 1965

- Medicare and Medicaid are created.

### 1967

- Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) mandatory for children under age 21
- Limits eligibility for “medically needy” to 133 1/3 percent of the eligibility level for Aid to Families with Dependent Children

### 1971

- Optional coverage for services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

### 1972

- Supplemental Security Income program created, extends Medicaid eligibility to SSI recipients

### 1981

- Reagan present block-grant proposal for Medicaid funding (fails)
- Omnibus Budget Reconciliation Act of 1981 (OBRA 81) reduces federal matching rates in FY 1982, FY 1983, and FY 1984; sets standard asset limit for welfare benefits that reduced the number of welfare enrollees and, as a result, Medicaid enrollees; repeals requirements for reimbursement under Medicare system, requiring states to make additional payments to hospitals seeing disproportionate numbers of low income and special needs patients (DSH); establishes 1915(b) waivers, or freedom-of-choice waivers, and 1915(c) waivers, or Home and Community Based Care waivers

### 1982

- Reagan offers a swap: states take over welfare programs, federal government takes over Medicaid (fails)
- Tax Equity and Fiscal Responsibility Act (TEFRA) allows states more opportunities for cost sharing; allows states to cover “Katie Beckett” children by waiving the family’s SSI income requirement for coverage
- Arizona becomes last state to begin a Medicaid program

### 1984

- Deficit Reduction Act mandated coverage of children born after September 30, 1983 up to age five for families receiving cash assistance; mandates coverage for first-time pregnant women receiving cash assistance and for pregnant women in two-parent unemployed families.

### 1985

- Consolidated Omnibus Budget Reconciliation Act of 1985 makes coverage for all pregnant women receiving cash assistance mandatory.
- Texas implements Medically Needy program.

### 1986

- Omnibus Budget Reconciliation Act of 1986 makes coverage for pregnant women and infants up to age one with income up to 100 percent of the federal poverty level (FPL) optional for states; requires coverage for emergency medical conditions for otherwise Medicaid eligible illegal immigrants.

**1987**

- Omnibus Budget Reconciliation Act of 1987 allows states to cover pregnant women and infants up to an income of 185 percent of FPL.

**1988**

- Medicare Catastrophic Coverage Act of 1988 (MCCA) requires states to cover Medicare premiums and cost-sharing for low-income Medicare beneficiaries (QMBs) with incomes below 100 percent FPL. MCCA was repealed in 1989, but left this required Medicaid coverage in place.
- Texas adopts optional coverage for pregnant women and children under age two with a family income below 100 percent FPL.

**1989**

- The Omnibus Budget Reconciliation Act of 1989 mandates Medicaid coverage for pregnant women and children under age six in families with incomes at or below 133 percent of FPL; expands EPSDT benefits to include diagnostic and treatment benefits even if they are not otherwise available in the Medicaid program.
- Texas increased income eligibility for pregnant women and children under age one to 130 percent of FPL; covers children up to age four in families making up to 100 percent of FPL.

**1990**

- The Omnibus Budget Reconciliation Act of 1990 mandates Medicaid coverage of children born after September 30, 1983 up to age 18 in families with incomes up to 100 percent FPL (fully phased in by 2002); requires state to pay Medicare premiums for special low-income Medicare beneficiaries (SLMBs) with incomes between 100 and 120 percent of FPL; requires pharmaceutical manufacturers to give the government “best price” for prescription drugs.
- Texas expands Medicaid coverage for pregnant women and children with incomes below 133 percent of FPL.

**1991**

- Medicaid Voluntary Contribution and Provider-Specific Tax Amendments limit use of donations and provider taxes to “draw down” additional federal funds; caps DSH payments at 12 percent of Medicaid spending.
- Texas boosts income eligibility limits for pregnant women and children under age one to 185 percent FPL

**1993**

- The Omnibus Budget Reconciliation Act of 1993 sets a ceiling on the amount of DSH payments than an individual hospital can receive, as well as standards for designating a DSH hospital; requires states to establish an estate recovery plan.

**1995**

- Congress passes block grants for Medicaid, President Clinton vetoes.

**1996**

- Congress passes welfare reform.

**1997**

- The Balance Budget Act of 1997 creates the State Children’s Health Insurance Program (CHIP); requires states to pay Medicare premiums for qualified individuals with incomes between 120 and 135 percent FPL.

**2000**

- Congress passes the Breast and Cervical Cancer Treatment and Prevention Act allowing states to provide services to women regardless of income, and at the CHIP matching rate.

- Congress directs the Secretary of Health and Human Services to use federal regulations to control the states' use of upper payment limit (UPL) funds.

**2001**

- Bush administration offers Health Insurance Flexibility and Accountability (HIFA) waivers to emphasize state flexibility to expand Medicaid coverage, but requiring budget neutrality.
- Texas Legislature passes simplified eligibility requirements for Medicaid, implemented January 1, 2002.
- December 1, 2002 Texas begins the Breast and Cervical Cancer Control program.

**2003**

- Congress passes temporary relief for states through enhanced matching rates for Medicaid through June 2004.
- Congress passes the Medicare Modernization Act to create a new prescription drug benefit in Medicare and requires states to make payments to the federal government to cover the state's savings through the enrollment of dual eligibles in the Medicare prescription drug plan.
- The Texas Legislature passes the largest reorganization of the health and human services enterprise; temporarily reduces eligibility for pregnant women age 19 and older to those with an income below 158 percent of FPL; medically needy program becomes a program for pregnant women and children.

**2005**

- Medicaid Commission created.
- House passes budget resolution with reductions in growth in Medicaid spending, signed by President Bush in 2006.

## About This Report

Medicaid's incremental expansion since its inception in 1965 has resulted in the largest government health program in the country's history—even larger and more expensive than Medicare. Decades of expansion have resulted in more than 53 million people on Medicaid nationwide at a price tag of well over \$300 billion for 2005.

In Texas, Medicaid is the largest single item in the state's budget, providing services to roughly 3 million people. Expansions at the federal level have led to expansions at the state level, gradually covering more people each year. The growth of Texas Medicaid is the direct result of these incremental expansions over many years, not any single act by the federal or state government.

Projections through 2016 show that federal Medicaid costs will increase by 8 percent each year. Without serious reforms, Medicaid spending will occupy much of the state and federal budgets, edging out other budget priorities.

