

Special Communication

Medicare and Medicaid at 50 Years

Perspectives of Beneficiaries, Health Care Professionals and Institutions, and Policy Makers

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IMPORTANCE Medicare and Medicaid are the nation's 2 largest public health insurance programs, serving the elderly, those with disabilities, and mostly lower-income populations. The 2 programs are the focus of often deep partisan disagreement. Medicare and Medicaid payment policies influence the health care system and Medicare and Medicaid spending influences federal and state budgets. Debate about Medicare and Medicaid policy sometimes influences elections.

OBJECTIVE To review the roles of Medicare and Medicaid in the health system and the challenges the 2 programs face from the perspectives of the general public and beneficiaries, health care professionals and health care institutions, and policy makers.

EVIDENCE Analysis of publicly available data and private surveys of the public and beneficiaries.

FINDINGS Together, Medicare and Medicaid serve 111 million beneficiaries and account for \$1 trillion in total spending, generating 43% of hospital revenue and representing 39% of national health spending. The median income for Medicare beneficiaries is \$23 500 and the median income for Medicaid beneficiaries is \$15 000. Future issues confronting both programs include whether they will remain open-ended entitlements, the degree to which the programs may be privatized, the scope of their cost-sharing structures for beneficiaries, and the roles the programs will play in payment and delivery reform.

CONCLUSIONS AND RELEVANCE As the number of beneficiaries and the amount of spending for both Medicare and Medicaid increase, these programs will remain a focus of national attention and policy debate. Beneficiaries, health care professionals, health care organizations, and policy makers often have different interests in Medicare and Medicaid, complicating efforts to make changes to these large programs.

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As the Affordable Care Act (ACA) marks its fifth anniversary, Medicare and Medicaid mark their 50th. Key milestones from enactment in 1965 to changes through 2012, including the expansion of eligibility and benefits, changes in the payment system, and stronger financial incentives to improve quality and efficiency, are shown in Figure 1. The 2 programs are constant topics of policy and political debate and, sometimes, consternation among health care professionals and health care institutions. Despite the rhetoric that sometimes surrounds both programs, polling data show that Medicare and Medicaid are very popular with the American people and the health care system could not function without them.

ACA Affordable Care Act

ACO accountable care organization

FPL federal poverty level

MCO managed care organization

SGR Sustainable Growth Rate

Together, Medicare and Medicaid provide health coverage to about 111 million people, or 1 in 3 Americans, including 10 million dual-eligible people covered by both programs (Table 1¹⁻¹⁰). That number is projected to reach 139 million people by 2025. Today, the programs constitute 39% of national health spending, account for 23% of the federal budget, and generate 43% of hospital revenues. Spending on the 2 programs for 2013 to 2023 is projected to increase at an average rate of 3.7% per year, which is slower than the projected growth for private health insurance, despite that Medicare and Medicaid generally serve populations with more illness and health problems. Table 1 summarizes the roles of the Medicare and Medicaid programs in the country and the health care system today.

Medicare, modeled on Social Security, is a national social insurance program administered by the federal government to insure Americans reaching retirement age. People pay into the program over the course of their lives and, once eligible, are entitled to

Figure 1. Key Milestones in Medicare and Medicaid

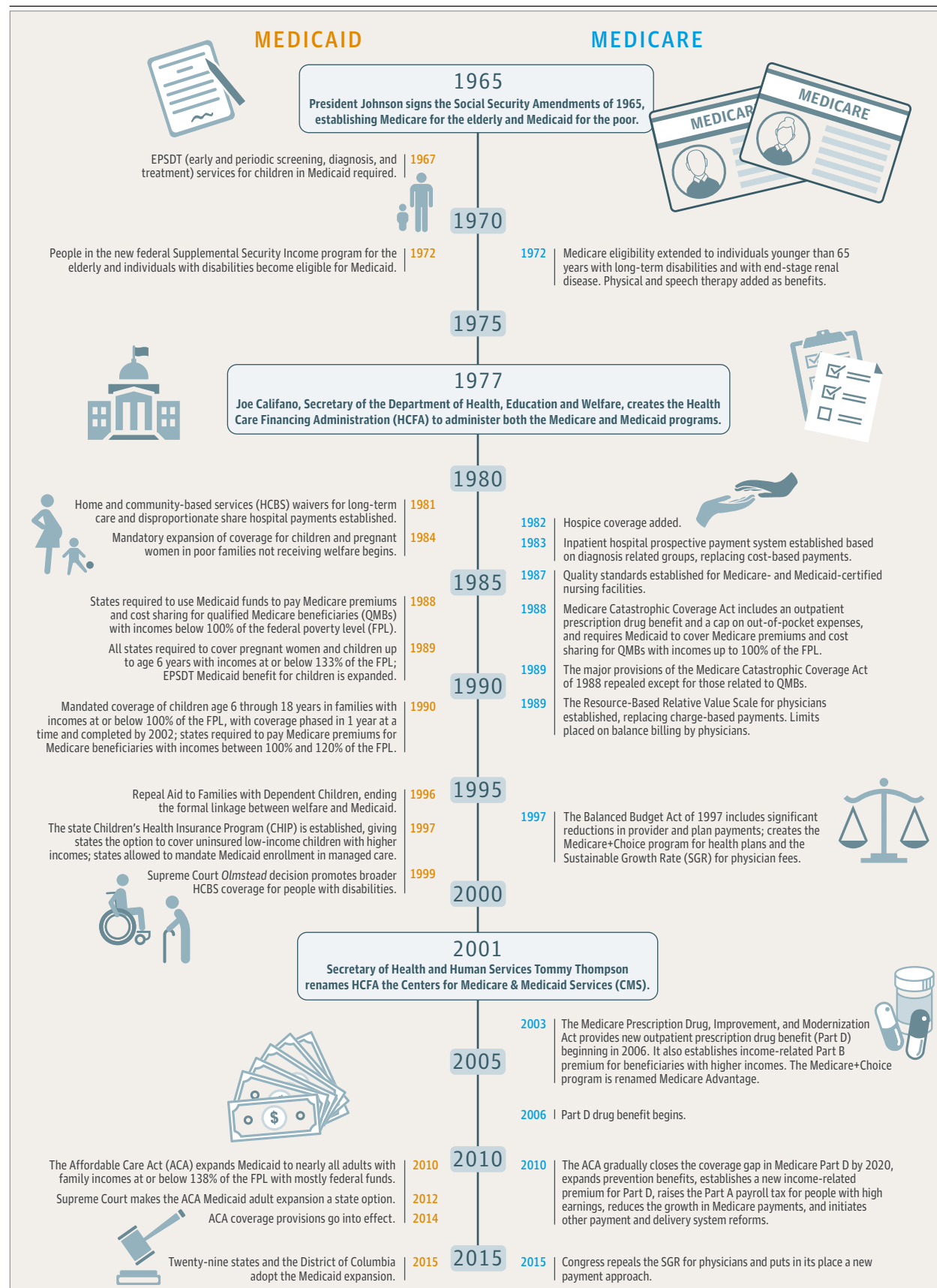


Table 1. Medicare and Medicaid at a Glance

	Medicare	Medicaid	Medicare and Medicaid
No. of beneficiaries, 2015, in millions ^{1,a}	55 (Part A)	66	111 ^b
No. of beneficiaries, 2025, in millions ^{1,a}	74 (Part A)	77	139 ^b
Share of US population covered by program, 2015, % (No./total, in millions)	17 (55/320)	21 (66/320)	35 (111/320)
Total spending, 2013, \$, in billions ²	585.7 ^c	449.4	1035.0
Federal spending on program as a share of the federal budget, 2014, % ¹	14 ^d	9	23
Federal spending on program as a share of gross domestic product, 2015, % ¹	2.9	1.9	4.8
Spending as a share of provider revenues, 2013, % ²			
Total national expenditures	22	17	39
Hospitals	26	17	43
Physicians	22	9	31
Nursing homes	22	30	52
Prescription drugs	28	8	35
Per capita spending, 2013, \$ ²	11 581	7748	9541.4 ^e
Increase in per capita spending, 2013–2023, % ²	3.4	4.1	3.7 ^e
Financing, 2013, % ^{3,4}			
General revenues	41		
Payroll tax revenue	38		
Premiums	13		
Other ^f	7		
Federal funds		57	
State funds ^g		43	
Share of beneficiaries receiving care in managed care plans, % ^{5,6}	30 ^h	67 ⁱ	
Share of physicians who say they accept new Medicaid/Medicare patients, % ^{7,8}	91 ^j	70	
No. of people covered by both programs (dual-eligible beneficiaries), in millions ⁹	9.6	9.6	9.6
Median yearly income of beneficiaries, \$ ^{10,k}	23 500	15 000 (Nonelderly adults)	

^a Data reported are average monthly enrollments published in the Medicare and Medicaid baselines.

^b Data combine average monthly enrollment projections for Medicare and Medicaid published in the Medicare and Medicaid baselines, adjusted to account for dual-eligible beneficiaries (which are assumed to grow at the same rate projected for elderly Medicaid beneficiaries).

^c Medicare amount reflects gross outlays, not excluding premiums and other offsetting receipts.

^d Medicare spending as a share of the federal budget is total net outlays, excluding premiums and other offsetting receipts.

^e Calculated as a weighted average based on per-enrollee spending for Medicare and Medicaid (weighted by program enrollment).

^f Includes state payments, taxation of Social Security benefits, interest, and other sources.

^g Includes all nonfederal sources (state funds as well as some local funds.) The Congressional Budget Office projects this to increase up to 60% to 62% in 2015 and later years because of the Affordable Care Act-enhanced match for the expansion.

^h Medicare estimate is for 2014.

ⁱ These data reflect the share of Medicaid beneficiaries in 19 states reporting data for September 2014.

^j Medicare rate excludes pediatricians.

^k Authors' analysis of the US Census Bureau's 2014 Annual Social and Economic Supplement to the Current Population Survey.

coverage without regard to income or health status. Today, Medicare covers more than 55 million Americans. Most are aged 65 years or older, but 9 million are younger adults with permanent disabilities. In contrast, Medicaid is a joint state and federal program (unlike with Medicare, states must contribute some proportion of the cost of Medicaid, ranging from 26% to 50%) providing need-based insurance to about 66 million Americans with low incomes in any given month. Roughly 10 million of those individuals are dual eligible, receiving assistance from both Medicare and Medicaid. Medicaid primarily provides coverage to low-income children and adults but also provides services to people with disabilities and elderly individuals. It is the primary source of public funding for long-term care.

Medicare and Medicaid account for \$1 trillion in federal spending, so it is no surprise that these programs are at the forefront of

policy discussions about federal and state spending and that there are partisan and ideological differences about the future of the 2 programs. Democrats often favor a continued or expanded role for public entitlement programs, whereas Republicans frequently advocate reducing federal spending and transitioning to privatization. This partisan divide exemplifies the fundamental differences in the way the 2 parties approach health care reform. The Democrats have traditionally favored guaranteed benefits and using the government's purchasing power to leverage reform. Alternatively, the Republicans have advocated for privatization of insurance and switching to a defined contribution system to limit spending and encourage consumer choice and cost sharing.

Because both programs affect so many Americans and are the subject of sharp partisan disagreement, they have the potential to

figure prominently in elections. This is especially true of Medicare, which influences older adults, a demographic group with a high voter turnout rate in both general and midterm elections.

Medicare and Medicaid are quite different today than 50 years ago, a potentially important lesson for the current debate over the ACA. Medicare has changed its payment system for clinicians and health care organizations, expanded eligibility, added new benefits such as drug coverage, and included private plans, known as Medicare Advantage plans. Medicare is now changing again to create stronger financial incentives to improve the quality and efficiency of care. Medicaid has changed over the years to expand eligibility to cover more low-income Americans, provide coverage for 1 in 3 of the nation's children, fill gaps in Medicare coverage for elderly and disabled people, facilitate development of long-term care services and supports in the community, and introduce delivery system reforms.¹¹

A short video documentary featuring the perspectives of many of the individuals and stakeholders involved in the formation of the 2 programs can be found at <http://kff.org/medicare/video/medicare-and-medicare-at-50/>.

In this Special Communication, we provide a comprehensive review of Medicare and Medicaid from the perspectives of 3 different groups of stakeholders: beneficiaries and the public; health care professionals and health care institutions; and policy makers. Their perspectives and interests can be varied, and reconciling the goals of these different stakeholders is one factor making reform of these programs so challenging.

Medicare

From the beginning, Medicare helped make health care more affordable and improved access to health care for older persons. Prior to 1965, roughly half of older adults in the United States lacked health insurance, but with the launch of Medicare, coverage became nearly universal.¹² Since Medicare's inception, life expectancy has increased,¹³ at least in part related to expanded access for older persons. Implemented after the enactment of the Civil Rights Act of 1964, Medicare also played an important role in desegregating hospitals, many of which had previously denied care to African Americans or had segregated waiting rooms and wards.¹⁴ Medicare's coverage has also played a role in reducing disparities in health care.¹⁴

Medicare, Its Beneficiaries, and the Public

Medicare beneficiaries are a fast-growing age group with a strong voting record in both general and midterm elections.¹⁵ Even with health care coverage, many Medicare beneficiaries live modestly and have high medical costs. In a survey conducted before the 2012 election, registered voters aged 65 years or older identified Medicare as the second most important issue to their vote behind the economy, ahead of the federal deficit, taxes, military spending, the ACA, and immigration.¹⁶

The Medicare population includes 46 million older adults and 9 million younger adults with permanent disabilities. Forty-five percent of Medicare beneficiaries have 4 or more chronic conditions, 34% have a functional impairment, 31% have a cognitive or mental impairment, and 26% assess their health as fair or poor.¹⁷ Similar to trends in overall health care demographics, 10% of the Medicare population accounts for 59% of Medicare spending.¹⁷

Most Medicare beneficiaries live on fairly limited incomes and have modest assets. In 2013, half of Medicare beneficiaries reported an income of less than \$23 500 per person, including 25% who had incomes of less than \$14 400, and half had savings at or less than \$62 000 per person—not enough to pay for 1 year in a nursing home. Few older persons would have the ability to pay for health care without Medicare, and many struggle to pay medical bills even with assistance.¹⁰

In 2013, Medicare spending totaled \$585.7 billion. Medicare provides coverage for inpatient hospital stays; physician, outpatient, and preventive services; postacute care; and, as of 2006, outpatient prescription drugs. However, traditional Medicare has high cost sharing and has no limit on out-of-pocket spending. Medicare also does not cover dental care, hearing aids, or long-term services and supports, which are important resources for much of the Medicare population. Most Medicare beneficiaries (86%) fill these gaps with supplemental insurance, either purchasing it themselves or obtaining it through an employer, Medicaid, or a Medicare Advantage plan (by which private insurers offer coverage to Medicare beneficiaries).¹⁷ However, even with supplemental insurance, Medicare households spend nearly 3 times more than households without Medicare coverage on out-of-pocket health expenses.¹⁸

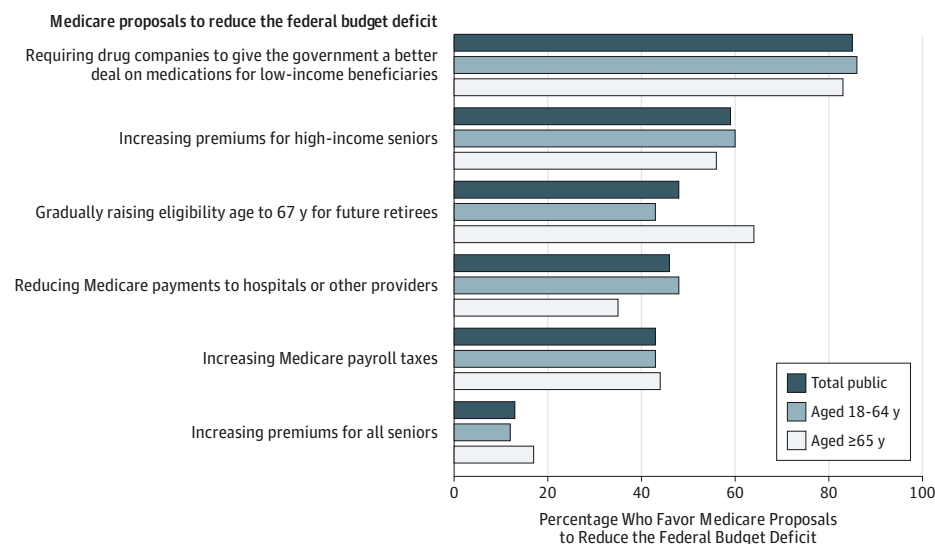
Between 2010 and 2050, the number of Americans older than 80 years will nearly triple and the number older than 90 years will quadruple.^{19,20} Median income and savings are projected to be modestly higher for the next generation of Medicare beneficiaries, but wealth will continue to be unevenly distributed.¹⁰ Over time, a smaller share of retirees will have employer-sponsored retiree health benefits or defined-benefit pension plans. Additionally, health-conscious baby boomers (born 1946-1964) may cross the Medicare threshold and have more years of good health than their predecessors. However, gains in longevity are likely to lead to more people living longer with multiple chronic conditions, which will have cost implications for families and Medicare alike.

Despite the high cost sharing, Medicare is incredibly popular among Americans. Among the general public, 72% have a favorable view of Medicare (based on 1253 respondents in a Harvard School of Public Health poll conducted May 13-26, 2013) and 6 in 10 report that the program is working well for most seniors (based on 1347 respondents in a Kaiser Family Foundation/Harvard School of Public Health/Robert Wood Johnson Foundation poll conducted January 3-9, 2013²¹). Among adults aged 65 or older, nearly 9 in 10 (based on 501 respondents) have a favorable view of Medicare and 8 in 10 (based on 315 respondents) say it is working well.²²

Given the popularity and importance of Medicare to families, older adults are resistant to proposals that would increase their costs, such as higher premiums, higher deductibles, or new co-payments. There is less resistance to proposals that would require higher premiums of wealthier beneficiaries or affect only younger adults, such as raising the age of Medicare eligibility. There is strong support among people of all ages for proposals requiring drug companies to provide the government with lower drug prices for lower-income beneficiaries, with 86% of adults aged 18 to 64 years and 83% of those aged 65 years or older supporting such a plan (Figure 2).²¹

Given this resistance and the known voting record of Medicare beneficiaries, most recent Medicare reform proposals focus on future beneficiaries. Congressman Paul Ryan, for example, proposed to shift Medicare to include a defined contribution approach, which

Figure 2. Public Support for Various Deficit-Reducing Changes to Medicare



Data are from a Kaiser Family Foundation/Harvard School of Public Health/Robert Wood Johnson Foundation poll conducted January 3-9, 2013.²¹ The survey interviewed 1347 adults in English and Spanish via land-line and cellular telephone, including 1026 adults aged 18 to 64 years and 315 aged 65 years or older. The response rate calculated based on the American Association of Public Opinion Research's Response Rate 3 formula was 18% for the land-line telephone sample and 16% for the cellular telephone sample.

Table 2. Percentage of Personal Health Expenditures Accounted for by Medicare, 1970-2010^a

	1970	1980	1990	2000	2010
Personal health care	12	17	17	19	22
Total home health care expenditures	27	27	26	26	45
Total prescription drug expenditures	0	0	0	2	23
Total hospital expenditures	20	26	27	30	27
Total physician and clinical expenditures	11	17	19	20	22
Total nursing care facilities and continuing care retirement communities	4	2	4	13	23

^a All data are percentages. Data are from the Centers for Medicare & Medicaid Services.²

would not take effect for another 10 years.²³ President Obama's most recent budget proposal would increase deductibles and impose new home health co-payments for new enrollees only.²⁴

Medicare, Health Care Professionals, and Health Care Institutions

There is an adage in health care that "when Medicare sneezes, health care catches cold." Health care professionals and institutions pay attention to Medicare because it is a major source of revenue, covers a large proportion of high health care users, and is a significant driver of change in health care. Some have suggested that Medicare drives innovation more than the private sector because it is such a major source of revenue. Currently, the Centers for Medicare & Medicaid Services Innovation Center has a budget of more than \$1 billion per year to stimulate innovation.²⁵

Medicare's share of total personal health expenditures has increased from 12% in 1970 to 22% today.² This growth is attributable to a number of factors, including changes in demographics (more people receiving Medicare), changes in Medicare coverage (such as the new prescription drug benefit), and an increase in use (driven in part by more clinicians and health care organizations, such as home health agencies). Medicare's share of health spending has increased over time across all types of practitioners and health care organizations (Table 2). For example, Medicare's share of spending for physician services and clinical services increased from 11% in 1970 to 22% in 2010, and its share of spending on hospitals increased from

20% to 27% over the same period.² In addition to paying for patient care and supplies, Medicare provides additional support to clinicians and institutions, with payments for graduate medical education and care provided in hospitals serving large proportions of low-income and uninsured patients.

Initially, Medicare's system of payments to health care professionals and hospitals was modeled on practices used by private insurers (mainly Blue Cross/Blue Shield plans), which based payment on reasonable and customary charges. Over time, Medicare shifted its payment policy, developing the diagnosis related group classification for hospitals, which has become a model for many private insurers. Since 1992, Medicare payments to physicians and other health care professionals have been set according to a fee schedule, known as the Resource-Based Relative Value Update Scale. This schedule is based on the relative average cost of providing services to Medicare patients, adjusted for other costs such as malpractice insurance. The schedule is based on recommendations by physicians working in their respective fields appointed to special committees.

Medicare also has introduced payment and delivery system reforms such as accountable care organizations (ACOs) and stronger incentives for quality improvements like readmission penalties. This January, Health and Human Services Secretary Sylvia Mathews Burwell announced new goals for traditional Medicare to tie 50% of payments to alternative payment models—ACOs, patient-centered medical homes—by 2016, and 90% of payments to quality or value measures.²⁶ Although it is too soon to tell, these changes

could have far-reaching effects for clinicians and health care entities in the years ahead.

Another significant change is the long-anticipated repeal of the Sustainable Growth Rate (SGR). Since 1998, physician payments have been subject to a formula, known as the SGR, which was created to help control total spending on physician services. However, with the exception of 4 years since its inception, the SGR calculation has required a reduction in physician fees. To avoid reductions, Congress has passed 17 amendments or “fixes” to the SGR in the last 11 years. Because of these avoided reductions, the total reduction due in 2015 would have been 24%. However, in April Congress succeeded in passing a permanent replacement for the SGR. Moving forward, Medicare will freeze payments for 3 months, increase payments by 0.5% per year through 2019, and maintain that payment level through 2025, subject to adjustments. Beginning in 2019, physicians who participate in a merit-based incentive program will begin to receive payment adjustments (positive or negative) based on their performance. Physicians who receive a substantial portion of their revenue from alternative payment models (such as ACOs or bundled payments) will receive a 5% increase based on their payments from Medicare in the previous year.

Insurers also pay close attention to Medicare because Medicare has become a significant source of revenue through administration of Medicare Advantage plans, prescription drug plans, and Medigap plans. While 70% of Medicare beneficiaries receive coverage under traditional Medicare, an increasing number are enrolling in Medicare Advantage.²⁷ Medicare Advantage plans are operated by private health insurers, which receive capitated payments from Medicare to administer the plan. Payments to Medicare Advantage plans have doubled as a share of total Medicare spending from 13% in 2004 to 26% in 2014 (eFigure 1 in the [Supplement](#)).^{28,29}

Medicare, Policy Makers, and Elected Officials

Medicare accounts for 14% of the federal budget, and any effort to slow the growth in federal spending invariably addresses Medicare spending.

For now, the momentum to move forward with fundamental Medicare changes has subsided somewhat, presumably because of the overall slowdown in the growth of expenditures for Medicare and in total health care spending. Between 2009 and 2012, Medicare per capita spending increased by about 2% annually, and the growth rate was virtually flat in 2013, compared with 6% average annual per capita growth between 2000 and 2008.³⁰ Medicare spending in 2014 was \$1200 less per person than the Congressional Budget Office projected in 2010 after the ACA spending reductions were enacted.³¹ Over the next decade, Medicare spending is projected to grow more slowly than private health insurance on a per capita basis—3.4% from 2013 to 2023 vs 4.8% for private insurance.³² The Medicare Hospital Trust Fund, once projected to be insolvent by 2001, is now projected to be solvent for the next 15 years through 2030.³

Even in the absence of a budget-driven push for fundamental change, Medicare will be on the policy agenda in the coming years because of its importance to valued constituents, including beneficiaries, health care professionals and institutions, suppliers, drug companies, and other medical care entities. However, because Medicare can be a volatile election issue, it is unclear to what extent policy makers will consider major changes to the program until after the 2016 election. To date, neither Democrats nor Republicans have

made a serious attempt to broach the inevitable but difficult question of how the nation will finance medical care for an aging population or address the looming issue of paying for long-term care.

Medicaid

Medicaid has evolved substantially since enactment 50 years ago. This program was designed to cover the elderly, those who are blind, people with disabilities, and parents and dependent children receiving public assistance³³ but now serves nearly 70 million people per year, or 1 in 5 Americans.¹¹ This makes the joint federal-state partnership the nation's largest public health insurance program. Medicaid spending totaled \$449.4 billion in 2013, of which 43% is from states, accounting for a significant share of overall health spending, particularly for long-term services and supports.²

Medicaid Beneficiaries and the Public

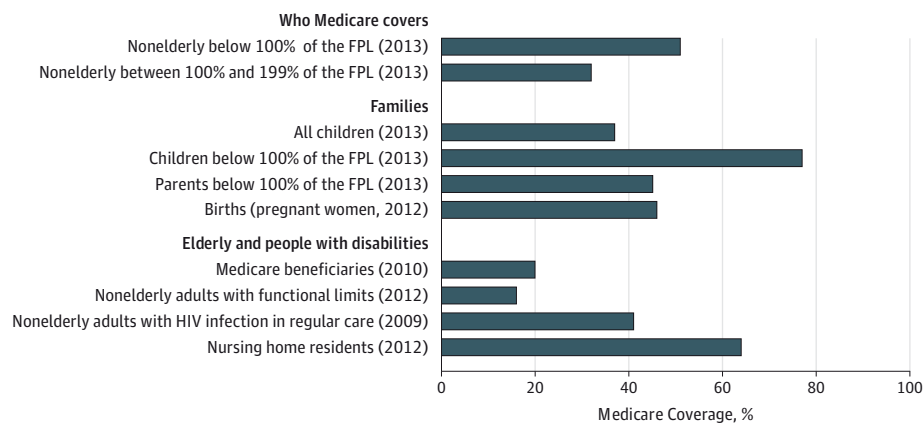
Medicaid is the nation's main source of health coverage for low-income people. Before the ACA, Medicaid eligibility was based on need plus a categorical qualification: income-eligible children, pregnant women, parents of dependent children, individuals with disabilities, and people aged 65 years or older all qualified. States were required to cover individuals in these groups up to federal minimum income thresholds but also had the option to expand coverage to people at higher income levels.³⁴

Over the last 5 decades, Congress and the states have expanded Medicaid to reach more low-income people who would otherwise not be able to access coverage, especially children and pregnant women. States are required to cover all children and pregnant women up to at least 138% of the federal poverty level (FPL). However, all states have expanded coverage for children well above federal requirements, and 28 states (including the District of Columbia) currently cover children living in households with incomes at or above 250% of the FPL through Medicaid or the Children's Health Insurance Program.³⁵ Today, Medicaid provides coverage to more than one-third of all children and more than three-fourths of children living in households below 100% of the FPL.¹¹ Medicaid also covers nearly half of all births ([Figure 3](#)).³⁶ Of the almost 70 million people covered by Medicaid, 33 million are children.⁴

Medicaid also provides coverage for elderly people and individuals with disabilities. States generally must provide Medicaid to older adults and people with disabilities who receive Supplemental Security Income benefits. States have the option to cover older individuals and people with disabilities who have more income or high medical expenses relative to their income.³⁸ Medicaid provides assistance to low-income Medicare beneficiaries by helping to pay premiums, reducing cost sharing, and covering specific benefits (primarily long-term services and supports) that are not covered by Medicare.³⁹ As a result, Medicaid covers 1 in 5 Medicare beneficiaries and almost two-thirds of all nursing home residents ([Figure 3](#)).¹¹

Coverage for adults through Medicaid has historically been much more limited. Prior to the ACA, low-income adults without dependent children (“childless adults”) were largely excluded, and most states limited coverage for parents to levels well below the poverty level. The ACA changed Medicaid by establishing eligibility for non-elderly adults and setting a national minimum income eligibility threshold at 138% of the FPL (\$16 242 for an individual or \$27 724

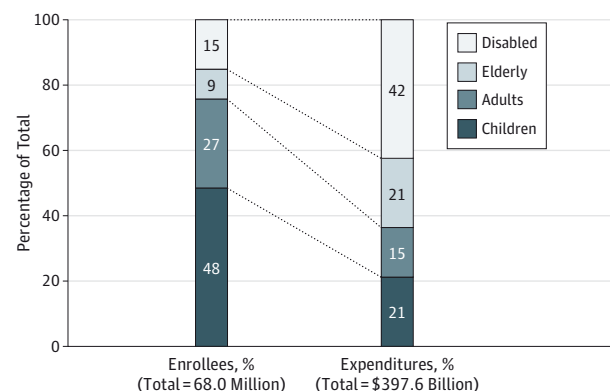
Figure 3. Individuals Covered by Medicaid



HIV indicates human immunodeficiency virus. The federal poverty level (FPL) was \$19 530 for a family of 3 in 2013. Data are from a Kaiser Commission on Medicaid and the Uninsured (KCMU)/Urban Institute analysis of the 2013 Annual Social and Economic Supplement to the Current Population Survey, the 2012 Maternal and Child Health Update (birth data),³⁶ the Data Book:

Beneficiaries Dually Eligible for Medicare and Medicaid (Medicare data),³⁷ a KCMU analysis of 2012 National Health Interview Survey data (functional limitations data), the 2009 Centers for Disease Control and Prevention Medical Monitoring Project (nonelderly with HIV data), and 2012 Online Survey, Certification and Reporting data (nursing home resident data).

Figure 4. Medicaid Enrollees and Expenditures, 2011



Data are from Kaiser Commission on Medicaid and the Uninsured/Urban Institute estimates based on data from the fiscal year 2011 Medicaid Statistical Information System (MSIS) and Centers for Medicare & Medicaid Services (CMS) Form 64 (Medicaid Financial Management Reports). Fiscal year 2010 data from MSIS were used for Florida, Kansas, Maine, Maryland, Montana, New Mexico, New Jersey, Oklahoma, Texas, and Utah but adjusted to 2011 CMS Form 64.

for a family of 3 for 2015) for all individuals younger than 65 years. Although Medicaid expansion was intended to be national, the Supreme Court ruling⁴⁰ on the ACA in June 2012 made it effectively optional for states.⁴¹ As of May 2015, 29 states and the District of Columbia had adopted expansion, 3 states were considering it, and 18 states had opted out (eFigure 2 in the Supplement).⁴²

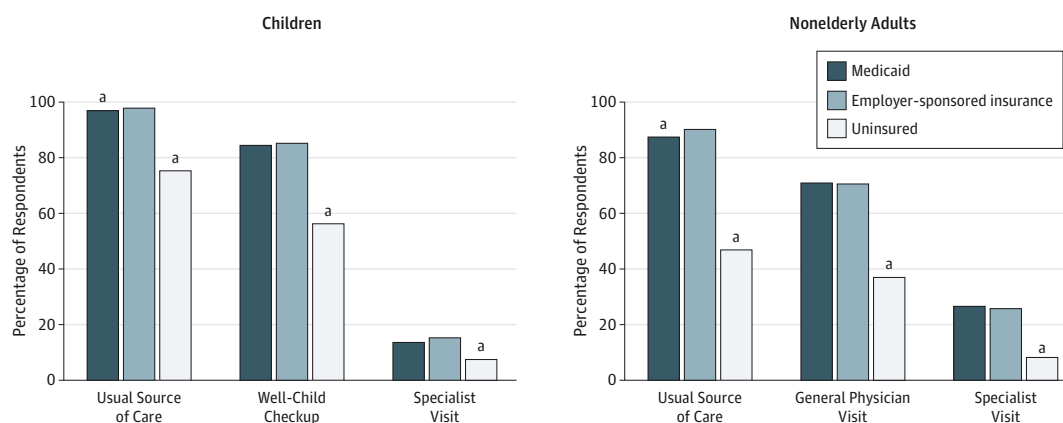
A number of states have implemented Medicaid expansion through waivers approved by the federal government, and many states "considering" expansion may request waivers as well. The waivers authorize program additions such as requiring the use of premium assistance to purchase private coverage, sometimes called the "private option"; healthy behavior incentive programs; monthly contributions or premiums, which are not common in Medicaid; and waivers of certain benefits (primarily nonemergency medical

transportation).⁴³ In states not implementing Medicaid expansion, median eligibility levels for parents are 44% of the FPL, or \$8840 per year, and childless adults are generally not eligible at all.³⁵ This leaves 3.7 million adults in the "coverage gap," meaning they do not qualify for Medicaid nor do they meet income requirements to qualify for tax credits to purchase coverage in the new marketplaces. Nine in 10 adults in this coverage gap live in southern states and 62% are in just 4 states (Texas, Florida, North Carolina, and Georgia) (eFigure 3 in the Supplement).⁴⁴

As with most of the health care sector, a small percentage of enrollees account for a large amount of costs. Children and nonelderly adults make up three-quarters of enrollees, but older persons and individuals with disabilities account for almost two-thirds of spending.⁴ For example, children accounted for 48% of the enrollees but only 21% of the cost. These populations have complex health care needs and higher utilization of acute services as well as long-term services and supports (Figure 4). In fiscal year 2010, the dual-eligible population, those being covered by both Medicare and Medicaid, totaled 14% of all Medicaid beneficiaries at 9.6 million. This includes older individuals and younger people with disabilities, and together they account for 36% of Medicaid spending.⁹

People with Medicaid coverage fare better than those who are uninsured on key measures of access to care, use, unmet needs, and financial security (Figure 5). For example, 87% of adults with Medicaid report that they have access to a usual source of care other than an emergency department, similar to 90% of adults with employer-sponsored coverage and far higher than 47% of uninsured adults.¹¹ Most Medicaid beneficiaries are also more likely to see a physician regularly compared with the uninsured population. Research based on national surveys shows that both children and adults enrolled in Medicaid have access to and use primary and preventive care at rates comparable with their counterparts with employer-sponsored insurance.⁴⁵ The recent Oregon Health Insurance Experiment, a randomized trial that received wide attention, compared newly covered Medicaid beneficiaries with cohorts without coverage. The study found that improvements in physical health were not statis-

Figure 5. Self-reported Access to Care—Medicaid, Private Insurance, and Uninsured, 2013



Data are from a Kaiser Commission on Medicaid and the Uninsured analysis of 2014 National Health Interview Survey data. The "usual source of care" measure reflects respondent self-report of having a general source of care. Well-child checkups, specialist visits for both children and adults, and general physician visits for adults reflect self-reported experiences in the past 12 months.

Respondents who said their usual source of care was the emergency department were not counted as having a usual source of care.

^a Difference from employer-sponsored insurance is statistically significant ($P < .05$).

tically significant. However, the study did show increased health care use, improved self-reported health, a substantial reduction in depression, and near elimination of catastrophic medical costs in the newly insured population.⁴⁶

Today, 51% of Americans report a "connection" to the Medicaid program because they or a friend or family member have or had health insurance through the program. Others are connected to the program because they received assistance with Medicare premiums or help paying for nursing home care for themselves or a friend or family member. Eight in 10 enrollees rate their experiences with the program positively, citing problems gaining access to clinicians as their most significant negative experience.⁴⁷

Medicaid, Health Care Professionals, and Health Care Institutions

The Medicaid program provides \$1 of every \$6 spent on health care in the United States, but Medicaid's share of spending varies substantially depending on the type of service, ranging from 8% for prescription drugs to 30% of nursing home care (eFigure 4 in the Supplement).² Medicaid revenues account for 35% of safety-net hospital revenues⁴⁸ and 40% of health center revenues (eFigure 5 in the Supplement).⁴⁹

States have increasingly been using managed care organizations (MCOs) to deliver Medicaid services.⁵⁰ Thirty-nine states now contract with MCOs to serve at least some Medicaid beneficiaries.⁵¹ Nationally, more than half of all Medicaid beneficiaries, primarily children and parents, receive their care through these plans.⁵² States pay MCOs a monthly premium for each enrolled beneficiary, and 6 multistate, private MCOs account for more than one-third (36%) of Medicaid MCO enrollees.⁵³ States are also increasingly using MCOs to provide care for higher-need Medicaid populations, such as people with disabilities and the dual-eligible population.⁵⁴

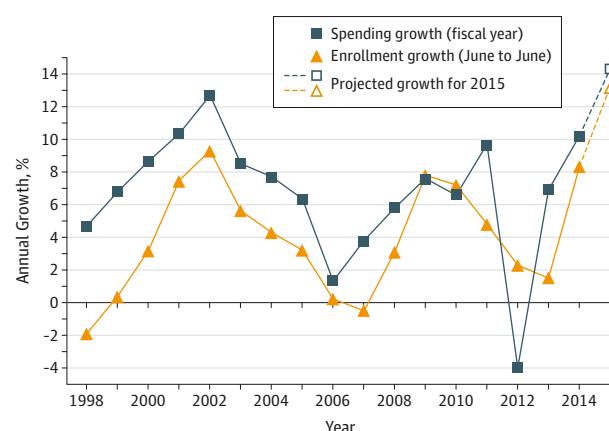
Many Medicaid beneficiaries who are not in risk-based MCOs are enrolled in primary care case management programs, in which states pay on a fee-for-service basis but also pay contracted primary care practitioners an additional small monthly fee to coordinate care for

their Medicaid patients. The ACA includes a variety of provisions designed to promote health care delivery and payment system reforms in Medicaid. These have accelerated implementation of patient-centered medical homes and ACOs, which involve a more central role for preventive and primary care, increased care coordination, and expanded financial incentives linked to performance. For example, in fiscal year 2015, 40 states implemented some type of delivery system reform within Medicaid (eFigure 6 in the Supplement).⁵¹

Despite these reforms, a significant issue for Medicaid continues to be access to physicians. The majority of primary care clinicians (67%) report accepting new Medicaid patients, but 33.2% do not, and acceptance rates are lower among some specialists.⁸ Overall, physician participation is more limited in Medicaid than in Medicare or private insurance.⁵⁵ This is related to the relatively low reimbursement rates in many states. For 2013 and 2014, the ACA provided federal financing to increase Medicaid fees for most primary care physician services to Medicare fee levels.⁵⁶ As a result, Medicaid fees for these services increased by an average of 73%,⁵⁷ but with the withdrawal of federal funds in 2015, many states reduced fees.⁵⁸ Access to and participation of primary care practitioners in Medicaid is stronger than for specialists, where there are more gaps. Particular areas of concern for low participation include psychiatrists⁸ and substance abuse treatment professionals because of the high prevalence of behavioral health conditions among Medicaid beneficiaries.⁵⁹ Even so, Medicaid is the largest single source of behavioral health spending (26%).⁶⁰ Access to dental services is another reported problem for adults, when it is covered, as well as for children.⁶¹

An area of special focus in Medicaid is long-term services and supports. Medicaid accounts for more than half of all spending in this area, which includes institutional care as well as services in the community.⁶² Medicare and other private coverage generally do not provide coverage for these services. Over time, the share of Medicaid long-term care spending has increased but also shifted from institutional-based care to community-based care. In fiscal year 2013, home- and community-based services accounted for 46% of total

Figure 6. Medicaid Spending and Enrollment



Data are from *Medicaid Enrollment: June 2013 Data Snapshot*.⁶⁷ Spending data are from a Kaiser Commission on Medicaid and the Uninsured (KCMU) analysis of Centers for Medicare & Medicaid Services Form 64 data for historic Medicaid growth rates. Fiscal year 2014 and 2015 data are based on a KCMU survey of Medicaid officials in 50 states and the District of Columbia conducted in October 2014.⁵¹ Enrollment percentage changes from June to June of each year. Spending growth percentages are for states' fiscal years.

Medicaid long-term care spending, up from 32% in fiscal year 2002, and represented \$57 billion of a total of \$123 billion in expenditures on long-term care.¹¹

Medicaid, Policy Makers, and Elected Officials

Medicaid is the third largest domestic program in the federal budget, accounting for 9% of spending following Social Security (24%) and Medicare (14%) (eFigure 7 in the Supplement).¹ Defense and nondefense discretionary spending accounts for 34% of the federal budget. The federal government provides federal matching dollars for allowable state spending on individuals eligible for Medicaid on an open-ended basis. States make payments for eligible services for qualified enrollees and then are able to draw down federal matching dollars for these services. The joint federal and state financing structure means that Medicaid is both a source of expenditures and a source of revenues for states.⁶³ Medicaid is both the largest source of federal funds for a state and a significant share of state spending, representing about 18% of most state spending. Because Medicaid is typically the second largest item in state budgets (35%, including the federal contribution) behind elementary and secondary education (47%), efforts to control increases in Medicaid spending play a major role in state Medicaid politics and state budget deliberations (eFigure 8 in the Supplement).⁶⁴

The federal medical assistance percentage is determined by a statutory formula based on state per capita income, which varies across states and adjusts over time. On average, the federal government pays 57% of program costs, but matching rates across states range from 50% to 74% in 2015, with poorer states receiving more federal assistance.⁶⁵

This financing model means that federal funds are distributed to states based on actual costs and needs. If medical costs increase, more individuals enroll in Medicaid because of an economic downturn, a state increases payment rates, or an epidemic occurs (such as HIV/AIDS), federal payments automatically adjust to

reflect the added costs.⁶⁶ Because Medicaid is a countercyclical program, enrollment and spending increase during economic downturns as incomes decline and more people become eligible for the program (Figure 6). For example, Medicaid enrollment increased 7.8% in 2009 during the Great Recession but grew just 1.5% in 2013 as the economic recovery took hold.⁶⁷ The federal government has twice temporarily increased the matching rate to provide fiscal relief to states during economic downturns because program spending increased simultaneously with a depression in state revenues. States under recessionary pressures have frequently sought to constrain their own Medicaid spending through actions such as reducing payment rates to clinicians and health care organizations or reducing benefits. When economic conditions improve, states sometimes restore cuts imposed during the downturns.

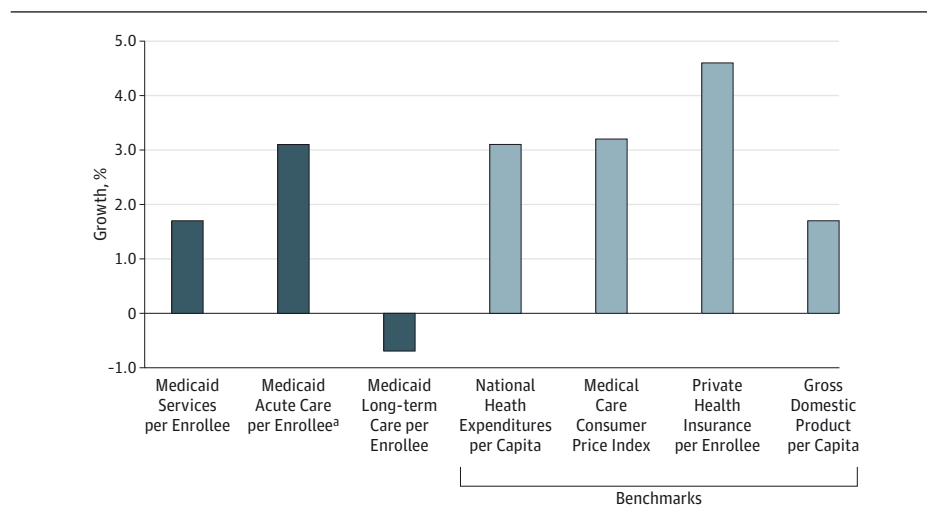
Enrollment growth is generally the primary driver of overall Medicaid spending growth. Nationally, Medicaid spending per enrollee has been increasing at a slower rate than private insurance. The acute care portion of Medicaid (including all services other than long-term care) increased by 3.1% on average per enrollee from 2007 to 2013 compared with 4.6% for private health insurance (Figure 7).⁶⁸ Although the program is structured to operate under federal rules, states have a degree of flexibility to administer programs to meet state needs and priorities.⁶⁹ The use of Section 1115 waivers in Medicaid provides additional flexibility to make program changes for research and demonstration purposes. To grant these waivers, the federal government determines if the initiative would "promote the objectives" of the program. Throughout the history of the program, states have used waivers to implement managed care, extend coverage to populations not otherwise eligible,⁴³ and pursue delivery system reforms.⁵⁴ The federal government has varied with each administration as to its willingness to deviate from federal rules and for what types of changes they will grant waivers.

Discussion

While public attention has focused on the ACA, Medicare and Medicaid remain the core of the nation's public health insurance system. Together these programs serve more than a hundred million of the nation's most vulnerable people—low-income children and adults, people with disabilities, and older persons. Because beneficiaries, health practitioners and organizations, and policy makers all have different interests in these programs, it is difficult to reconcile their conflicting perspectives and priorities and enact large-scale program changes. Few policies can simultaneously constrain spending, improve reimbursement rates, and protect and strengthen benefits. Reaching bipartisan agreement on policy change is especially challenging in the current polarized political environment. However, it is not impossible, as witnessed by the recent repeal of the SGR formula.

Although Medicare and Medicaid differ in many respects, there are common questions about the future of both programs. The most fundamental question is whether the programs should remain entitlements. Should Medicare stay a guaranteed set of benefits or be transformed into a program providing a defined contribution through premium supports or vouchers? Should Medicaid remain an entitlement with matching dollars or transition into a block grant that states administer with greater flexibility and, in most proposals, less money? In

Figure 7. Growth in Average Annual Medicaid Spending on Medical Services vs Growth in Other Indicators, 2007-2013



Medicaid estimates are from an Urban Institute analysis of data from the Medicaid Statistical Information System, Centers for Medicare & Medicaid Services (CMS) Form 64 (Medicaid Financial Management Reports), and Kaiser Commission on Medicaid and the Uninsured and Health Management Associates data. National health expenditure and private health insurance data are from the CMS Office of the Actuary, National Health Statistics Group. Medical care consumer price index data are from the Bureau of Labor Statistics Consumer Price Index Detail Report Tables. Gross domestic product data are from the Bureau of Economic Analysis.

^a Acute care includes payments to managed care plans.

both cases, advocates have multiple goals, but limitation of future financial risk for the federal government, ensuring the future solvency of Medicare, and promotion of choice of private insurance options for beneficiaries are the primary focus. The effect of these changes on stakeholders and federal spending depends on the details of policy proposals, and these ideas are always intensely debated.

The degree to which both programs should be privatized in the future is another common question. Today, almost a third of Medicare beneficiaries are enrolled in private plans via Medicare Advantage, and the number is expected to increase. Similarly, more than half of Medicaid beneficiaries are enrolled in a private managed care arrangement, and some states are now testing a private insurance alternative through federal waivers. These "private option" Medicaid demonstrations to be tested in Arkansas, Iowa, and New Hampshire are notable because while premium supports and vouchers have been debated for years, this is the first time the concept has been put into practice. In the future, how "public" will health care's 2 giant public health insurance programs actually be?

A third common question is how much cost-sharing structures for beneficiaries should change. Will Medicare beneficiaries pay even more out of pocket in the future, and how will older adults living on fixed incomes afford this change? Will recent efforts to institute premium payments and more cost sharing for low-income Medicaid beneficiaries take hold on a wider scale? Research over many years has established that cost sharing can be a barrier to care for low-income people, and experience shows that it can be an administrative burden for clinicians and health care organizations to collect nominal cost-sharing amounts from low-income populations. The question of how much cost sharing is appropriate to eliminate unnecessary, expensive care, for which services, and at what income levels must be answered for both programs but is especially pressing for the low-income Medicaid population.

As states try different approaches to Medicaid through waivers or other means, will the increasing variation in Medicaid across states be a positive development, enabling states to customize Medicaid to their own circumstances, or a negative one, resulting in even greater inequity in coverage of the low-income population across the country?

Given the size of both programs, despite reforms, Medicare and Medicaid will continue to be a focus in annual budget deliberations. Typically, at the federal and state levels, policy makers choose to make selected spending reductions in many areas rather than major reductions in one area. When they can, policy makers prioritize reductions that affect the health care industry over those that directly affect beneficiaries. However, in both programs, and especially for Medicaid, in which payment rates are lower, much of the lower-hanging fruit may already have been picked. Reductions typically affect the rate of increase in payments while absolute cuts are rare. The scope and depth of reductions depend on how sharply and quickly spending accelerates and whether broader economic conditions put added pressure on policy makers to reduce spending. In any scenario, it is virtually guaranteed that both Medicare and Medicaid will be central to state and federal budget discussions every year.

Finally, both Medicare and Medicaid are changing their roles in the health care system to become more proactive forces for payment and delivery reform. Since 1983, when Medicare switched to the diagnosis related group system for hospital reimbursement, the program has sought to become a smarter bill payer. The goal of moving 90% of traditional Medicare reimbursements to alternative value-based payment arrangements by 2016 signals a new effort to use Medicare's purchasing power to promote quality and reform the delivery of care. While it gets less attention, payment and delivery reform in Medicaid is also under way in virtually every state. Medicaid programs have also been increasingly aggressive purchasers of drugs. Although the 2 programs are housed in the same federal cabinet department, Health and Human Services, and the same agency, the Centers for Medicare & Medicaid Services, they have seldom coordinated purchasing and payment reform efforts. Together they have more than \$1 trillion a year in purchasing power, and they are now pursuing common strategies in the form of ACOs, medical homes, managed care for chronically ill persons, and a variety of value-based payment options. A new Center for Medicare & Medicaid Innovation is now responsible for coordinating demonstration efforts in both programs.

Which of these delivery and payment changes will have staying power remains unknown. In general, these changes impose

overall incentives to meet targets but do not necessarily change the underlying fee-for-service system. A great deal about the potential benefits of these changes will be learned through the independent evaluations being sponsored by the federal government. The private sector is generally regarded as the engine of

innovation in the United States, but on the 50th anniversary of Medicare and Medicaid, health care's 2 largest public health insurance programs are playing a much larger role in innovation in payment and delivery reform and reshaping the delivery of care for the future.

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Study concept and design: Altman, Frist.

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Drafting of the manuscript: Altman.

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