

MEDICARE AND MEDICAID

Still Transforming Health Care

50 YEARS LATER

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.”¹

— PRESIDENT LYNDON BAINES JOHNSON



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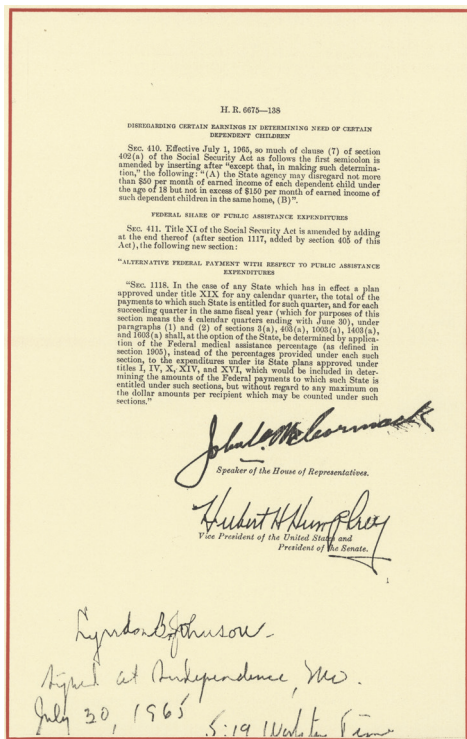
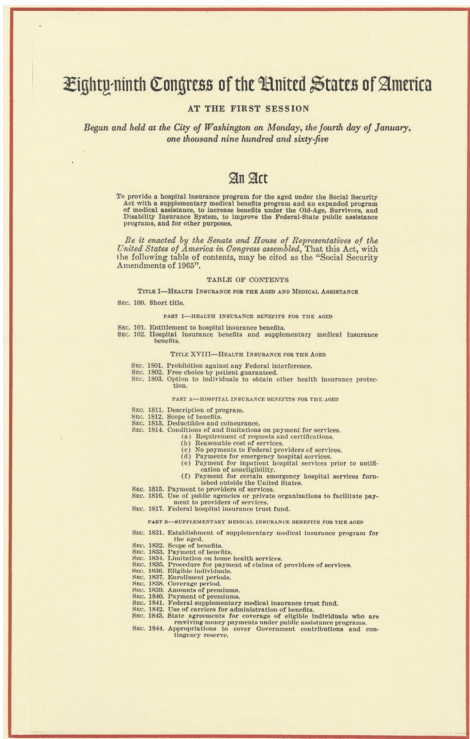
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This commentary honors and celebrates the 50th anniversary of Medicare and Medicaid, highlighting the growth, evolution, and remarkable accomplishments of two federal programs that together provide health insurance coverage to some 110 million Americans. It also recognizes President Lyndon B. Johnson, whose determination to bring these programs to life is legendary.

This was prepared as part of a commemoration sponsored by the Health, Medicine and Society Program of the Aspen Institute, the LBJ Presidential Library, and the Robert Wood Johnson Foundation. Karyn Feiden researched and wrote the commentary, on behalf of the Aspen Institute. Special thanks to the Henry J. Kaiser Family Foundation whose source material is extensively cited here.

THE GOLDEN JUBILEE

With a stroke of a pen on July 30, 1965, President Lyndon B. Johnson established the federal Medicare and Medicaid programs, and transformed access to health care for millions of Americans.² Fifty years later, the impact of these publicly funded insurance programs is greater than ever.

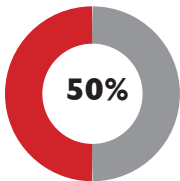
The law that amended the Social Security Act and created national health insurance for the elderly and the poor had been a long time in coming, with various approaches to health reform proposed and debated over many decades. A few modest federal statutes had passed in the 20th century, providing limited publicly funded insurance to a limited number of people, but none had a sweeping impact.

Medicare and Medicaid changed that. In 1963, about half of all Americans 65 or older had hospital insurance, but soon after Medicare’s implementation, virtually all seniors were covered.³ Fifty-four million Americans (including nine million under age 65 with permanent disabilities) received Medicare benefits in 2014.⁴ Medicaid covered almost 70 million low-income Americans, making it the largest single source of insurance in the United States.⁵

In the half-century since Medicare and Medicaid were established, they have become embedded in the nation’s social fabric. Polling consistently shows that they are enormously popular with the American public, with little support for cutbacks in either program – in 2013, 90% of those surveyed opposed major reductions in Medicare and 84% opposed major Medicaid cuts as strategies to reduce the deficit.⁶

The commentary that follows draws on anecdotes and data to look at how the programs protect the health of millions of Americans, and the challenges they face going forward.

Passing the legislation that established Medicare and Medicaid “took an extremely deft president, constantly operating the legislative machinery – while hiding his hand and deflecting the credit.” Implementing the new law was almost as challenging. “There were forecasts of disaster,” LBJ recalled, “right up to the day Medicare went into effect.”^a



IN 1963

About half of all Americans 65 or older had hospital insurance



After Medicare’s implementation, virtually all seniors were covered



MAKING HISTORY: THE BIRTH OF MEDICARE AND MEDICAID

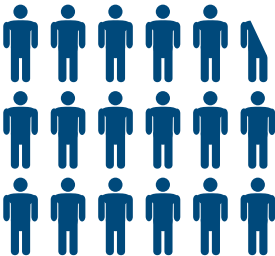
President Johnson chose the Truman Presidential Library in Independence, Missouri as the setting in which to sign the historic Medicare and Medicaid legislation. Former president Harry S. Truman was at his side, and almost immediately afterward became the first person to receive a Medicare card. His wife, Bess Truman, was the second.

That was Johnson's way of recognizing the man who first proposed a system of national health insurance in 1945 that would have covered all Americans.⁷ Truman was forced to scale back his original ambition, but under his administration Congress did consider legislation to cover the much smaller universe of Social Security beneficiaries. That, too, failed to gain traction in the face of opposition from the American Medical Association (AMA), which warned against "socialized medicine," and from the American Hospital Association, the American Bar Association, and the Chamber of Commerce, which endorsed a voluntary system of private insurance.⁸

Broad-based health reform did not return to the front burner of political debate until 1960. By then, demographic and economic realities were putting strong pressure on the system. In 1963, 17.5 million people, representing 9.4% of the American population, were 65 or older, a sharp rise from 1950, when the U.S. Census reported 12 million adults in that age group. At the same time, hospital costs were growing by 6.7% a year, far faster than either incomes or the cost of living.⁹

Soon after his inauguration, President John F. Kennedy signaled his strong support for legislation that would provide medical care to older Americans under the Social Security system. In a nationally televised address, Kennedy took on critics who claimed the bill "will sap the individual

Harry Truman became the first American to hold a Medicare card, and his wife, Bess, was the second. Truman was "the real daddy of Medicare," LBJ declared as he acknowledged his hard-fought efforts to move legislation forward almost two decades earlier.^b



1963: 17.5 million people were 65 or older



2012: 43 million people were 65 or older

Ronald Reagan suggested that “socialized medicine” could signal the twilight of American democracy.

In a 1962 recording made on behalf of the American Medical Association, he urged citizens to write their congressional representatives opposing national health insurance.

Otherwise, he warned, “One of these days you and I are going to spend our sunset years telling our children, and our children’s children, what it once was like in America when men were free.”^c

self-reliance of Americans.” To the contrary, he said, nothing was more likely “to sap someone’s self-reliance than to be sick, alone, broke or to have saved for a lifetime and [have to] put it out in a week, two weeks, a month, two months.”¹⁰ But the legislation faced resistance from both sides of the political aisle, and was defeated in Congress. Kennedy did not live long enough to do battle again.

Just weeks after Kennedy’s assassination, President Johnson took up the cause. With more than 22 years in the U.S. Congress – five full terms in the House of Representatives and two in the Senate, where he served as Majority Whip, Minority Leader, and Majority Leader – Johnson was widely considered a master of the institution. His ability to “threaten, bully and charm members of Congress to shepherd his programs through” was legendary.¹¹

According to an analysis of archival tape recordings from the Oval Office, one of Johnson’s early strategies to promote public insurance was to make an ally of Wilbur Mills, the powerful Democratic chairman of the House Ways and Means Committee, who had helped to defeat Kennedy’s legislation.¹² Johnson let Mills know that he would get a lot of credit for a new bill, and could shape many of its details, as long as he pushed it forward. Mills agreed to do so.

But ideological opposition to government-funded health care remained strong, with Barry Goldwater giving it voice during the 1964 presidential campaign. If pensioners were entitled to medical care, he remarked, “why not food baskets, why not public housing accommodations, why not vacation resorts, why not a ration of cigarettes for those who smoke and of beer for those who drink?”¹³

Another familiar critic was the American Medical Association:

“Those doctors are awful mean,” said LBJ, referring to the AMA’s aggressive campaign against him during the presidential election.¹⁴

Johnson nonetheless won in a landslide, and moved quickly to spend his political capital. “Every day while I’m in office, I’m going to lose votes. I’m going to alienate somebody,” he warned staff members soon after the election. Medicare was one of his highest priorities. “We’ve got to get this legislation fast. You’ve got to get it during my honeymoon.”¹⁵

With Johnson guiding congressional negotiations, the proposed benefit package grew larger and more ambitious. On the Senate side, he famously “ambushed” Democrat

Harry Byrd, who opposed the initiative, putting him before television cameras without warning so that he was forced to state publicly that his Finance Committee would not delay hearings on the bill.

Johnson also made it clear that program costs were not an obstacle, telling Vice President Hubert Humphrey:

“I’ll go a hundred million or a billion on health or education. I don’t argue about that any more than I argue about Lady Bird [Mrs. Johnson] buying flour. You got to have flour and coffee in your house. Education and health. I’ll spend the goddamn money. I may cut back some tanks. But not on health.”¹⁶

Although early legislative discussions had focused on covering hospital costs for the elderly, provisions were added to pay for physicians and other outpatient medical services for the 65-and-over population, and to provide coverage for low-income individuals and families receiving public assistance. A proposal to include an outpatient prescription benefit for the elderly was dropped, however, because of concerns about unpredictable costs.¹⁷

H.R. 6675, the Social Security Amendments of 1965, passed the House of Representatives by a vote of 300 to 136 (10 members did not vote), and the Senate by 70 to 24 (6 not voting) in late July. Johnson signed the bill a few days later, and Medicare and Medicaid were born.

Victory for civil rights¹⁸

When the Medicare and Medicaid legislation was signed, segregated health care was still the norm in some parts of the country. A 1959 survey found that hospitals in most southern cities (94%) had restrictions on admitting African-American patients, as did some northern cities (17%). Black physicians faced widespread discrimination – only 25% of hospitals in the South, and 20% of hospitals in the North, had any on staff.

With the law in place, more than 7,000 hospitals were subject to Title VI of the 1964 federal Civil Rights Act, which made discriminatory practices illegal. That meant hospitals would be denied Medicare funds if they violated civil rights mandates. The federal government undertook a massive effort to certify compliance and ten months after enrollment into Medicare began, virtually every hospital in America was deemed eligible for reimbursement.

As he pursued passage of Medicare/Medicaid legislation, LBJ compared the pace of congressional activity to that of a dead cat. “It stinks. It’s just like a dead cat on the door. When a committee reports it, you better either bury that cat or get some life in it,” he warned the assistant secretary of Health, Education and Welfare.^d

“It used to be, in many places in our land, that a sick man whose skin was dark... went to the other door, he went to the other waiting room, he even went to the other hospital. Under this administration’s Medicare program, the hospital has only one waiting room; it has only one standard for black and white and brown.”^e
 – President Lyndon Baines Johnson

THE EVOLUTION OF MEDICARE AND MEDICAID

In the years since their launch, both programs have evolved considerably, with changes in eligibility standards and service coverage, and both programs have become vastly larger. The Centers for Medicare & Medicaid Services (CMS), part of the U.S. Department of Health and Human Services, administers both programs.

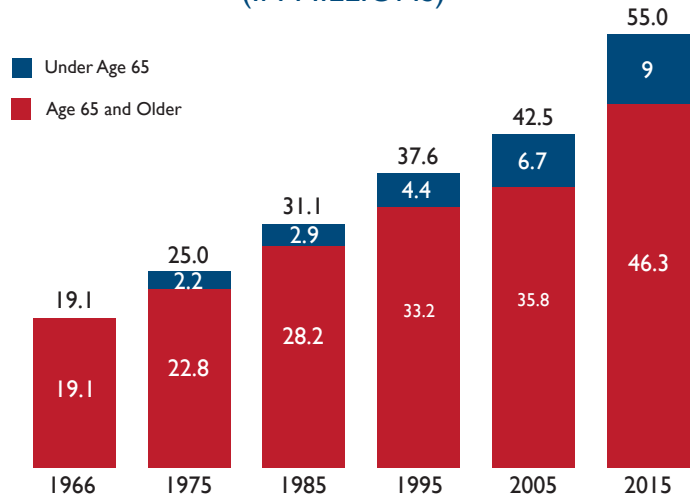
Nineteen million people were enrolled in Medicare when the first benefits became available in July, 1966. By the turn of the 21st century, that figure had climbed to almost 40 million,¹⁹ and by 2014, 54 million people were receiving benefits.²⁰

The number of Medicaid beneficiaries has also jumped. Approximately 4 million people who were already receiving aid through various other federal programs were enrolled when Medicaid began in January, 1996.²¹ States had the option of adopting a Medicaid program, and about half of them did so by the end of that first year. All states now have programs and the nearly 70 million Americans covered by Medicaid represent some 20% of the nation’s population.²²

Who is eligible for Medicare?

Most adults are eligible for Medicare at age 65 if they have earned at least 40 credits under the Social Security system (one credit accrues for every \$1,220 of earnings, up to four credits per year). Adults can also be eligible based on a spouse’s employment record or because they have a comparable work history in a government job that does not provide Social Security benefits. Medicare is available to U.S. citizens and legal permanent residents who have lived in the country continuously for five years.

GROWTH IN MEDICARE ENROLLMENT (IN MILLIONS)



Adapted from the Henry J. Kaiser Family Foundation, “Medicare Enrollment, 1966-2013” and “A Primer on Medicare: Key Facts about the Medicare Program and the People it Covers” (March 2015). Data source: CMS and Department of Health and Human Services.

In 1972, President Richard Nixon expanded eligibility for Medicare to individuals under age 65 who also receive Social Security Disability Insurance (after a two-year waiting period) and to those with end-stage renal disease. The nonelderly disabled represent a small but growing proportion of Medicare beneficiaries. In 1975, 9% of the 25 million people enrolled in Medicare were nonelderly disabled; that figure rose to 12% of 37.6 million in 1995 and to 17% of 52 million in 2013.²³

Although the eligibility criteria for Medicare are not based on income, the program disproportionately serves people with limited resources. Half of all beneficiaries had incomes below \$23,500 and one-quarter of them earned less than \$14,400 in 2013. A much smaller percentage of beneficiaries were high earners; 5% had incomes above \$93,900 and 1% had incomes above \$171,650.²⁴

What services does Medicare cover, and who provides them?

Virtually all of the nation's hospitals, and the vast majority of health care providers, take Medicare, which means they must accept the program's fee schedule for any services they provide. Ninety-one percent of office-based physicians report they are accepting new Medicare patients, the same percentage who accept new patients with private insurance.²⁵

In 2014, about 70% of beneficiaries enrolled in "traditional" fee-for-service Medicare, which provides broad coverage for inpatient and outpatient medical costs. The remaining 30% chose private plans that operate like health maintenance organizations (HMOs) or preferred provider organizations (PPOs).²⁶

Part A covers inpatient hospital care, skilled nursing care facilities (for a limited period of time), some home health services, and hospice care. Medicare does not cover most other long-term services and supports.

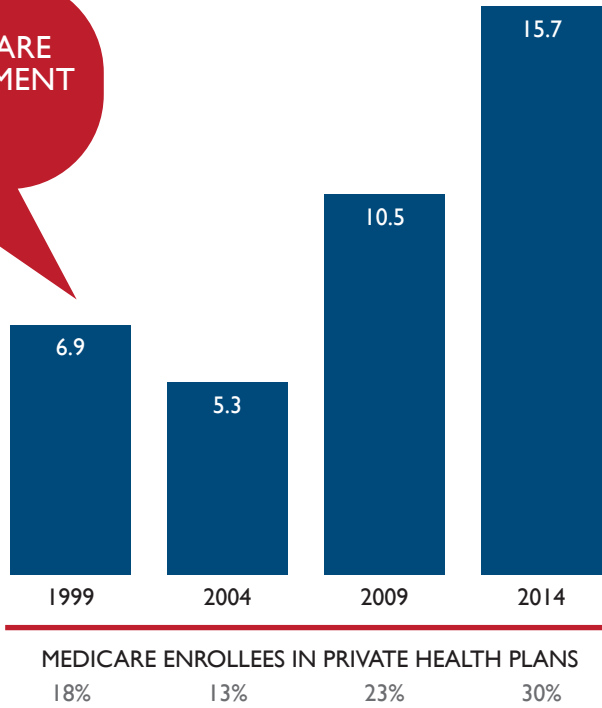
Part B covers outpatient services, including physician visits, laboratory tests, and durable medical equipment. It also pays for a variety of preventive services, including screenings for cancer, diabetes, hepatitis C, and depression; immunizations; bone mass measurements; a "welcome to Medicare" physical exam; and more. There is no coverage for routine dental or vision care, eyeglasses, or hearing aids.

Part C, originally called Medicare+Choice, was established during the Clinton Administration as part of the Balanced Budget Act of 1997.

Now known as Medicare Advantage, Part C plans provide all benefits covered under Medicare Parts A and B, generally through

Richard Nixon sang the praises of a "generous and compassionate land" when he expanded Medicare eligibility to people with disabilities. "The American way of life is the high achievement of our era and the envy of the world, and responsive and responsible legislation such as this is one major reason why," he said.^f

GROWTH IN MEDICARE ADVANTAGE ENROLLMENT (IN MILLIONS)



Adapted from the Henry J. Kaiser Family Foundation, "Medicare Advantage 2014 Spotlight." Data source: Kaiser/Mathematica Policy Research analysis of CMS data.

It took “a political shoot-out more dramatic than any ever filmed by Sergio Leone, the director of western gunslinger movies” to pass the prescription drug bill. Bipartisan wrangling, soaring drug prices, secret meetings, enraged Republicans, and infuriated Democrats all helped to move the legislation through Congress and onto George W. Bush’s desk.⁶

a network of physicians, specialists, and hospitals. When members choose “out-of-network” providers, they are typically required to pay more for their care. Most Medicare Advantage plans also provide pharmaceutical coverage, and plans may provide supplementary services, such as vision or dental care, as well.

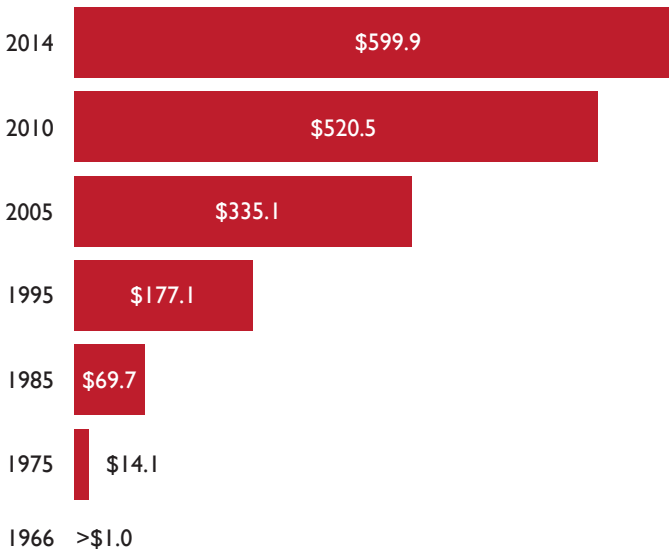
Part D provides coverage for outpatient prescription drugs, a benefit widely available only since 2006, three years after the Medicare Prescription Drug Improvement and Modernization Act was signed into law by President George W. Bush. In contrast to all other Medicare-covered benefits, the prescription drug benefit is administered by government-approved private plans through contracts with Medicare, rather than being covered directly.

Despite the increasingly central role of pharmaceuticals in medical care, previous efforts to authorize their coverage through Medicare had failed. Fears of unpredictable cost had often been a deterrent, but in at least two instances a drug benefit had been attached to a larger piece of legislation that was either repealed (the 1988 Medicare Catastrophic Coverage Act under President Reagan) or defeated (the Health Security Act under President Clinton).

What do we spend on Medicare, and who pays?

- Costs when the program launched:** In 1967, its first full year of operations, Medicare paid out \$4.6 billion in benefits.²⁷ Hospital coverage (Part A) at that time was funded by a payroll tax on employees and employers (0.35% apiece, up to a wage maximum of \$6,600), and provided without a premium to those 65 or older (with a \$40 deductible). Outpatient medical insurance (Part B) cost beneficiaries \$3 a month in premiums, with a \$50 deductible, and was designed to cover half the price of the benefits, with the federal government paying for the rest.²⁸
- Costs today:** In 2014, mandatory Medicare outlays totalled nearly \$600 billion (not taking into account offsetting revenue, such as premiums paid by beneficiaries).²⁹ Medicare accounted for 14% of the total federal budget (factoring in revenue offsets) in 2013, with the largest single source of financing coming from general revenues (41%). Most of the rest came from payroll taxes (38%) and premiums (13%).³⁰
 - The Part A payroll tax is currently 1.45% of wages (apiece for employees and employers), and there is no cap on earnings. Beneficiaries must also meet a \$1,260 deductible, and pay a daily coinsurance rate after 60 days in the hospital or 20 days in a skilled nursing facility.

GROWTH IN MEDICARE SPENDING (IN BILLIONS)



Mandatory Medicare outlays (excludes offsetting receipts)

Adapted from Congressional Budget Office, "The Budget and Economic Outlook: 2015 to 2025."

Gail Wilensky, CMS director under George H.W. Bush: "We will do better if people are more involved in making health care choices. There are few people who are more price sensitive than seniors."

Bruce Vladeck, CMS director under Bill Clinton: "We have 30 years of data... Out-of-pocket payments reduce utilization. Most Medicare beneficiaries are below median income and need more health care services than privately insured people."^h

“Tens of thousands of complaints,” a flawed government website, delays in access to a promised public benefit – and a pledge to “fix every problem as quickly as possible.” It might describe the rollout of the Affordable Care Act under Barack Obama, but the words were actually spoken shortly after Medicare Part D was launched under George W. Bush. “This is a huge undertaking and there are going to be glitches,” said Representative Joe Barton of the new prescription drug benefit.ⁱ

- For Part B, most beneficiaries pay a monthly premium of \$105, a \$147 annual deductible, and 20% coinsurance for the Medicare-approved fees. In contrast to most private plans offered by large employers, traditional Medicare does not have a limit on out-of-pocket expenses.³¹
- Higher earners pay a higher Part A payroll tax and a surcharge for Part B coverage. Beneficiaries with low incomes and modest assets may qualify for help in paying their premiums and meeting cost-sharing requirements through Medicaid and the Medicare Savings Programs.
- For Medicare Advantage (Part C), the federal government pays a capitated rate per enrollee through contracts with private insurers, at a cost that has historically been higher, on average, than coverage for beneficiaries under traditional Medicare.³² Under the payment methodology dictated by the Patient Protection and Affordable Care Act (ACA), Medicare is reducing these so-called overpayments to Medicare Advantage plans across the country.

Individuals who opt for Medicare Advantage are still subject to the payroll tax, but their premiums, deductibles, and other cost-sharing requirements vary by plan. In general, these plans are less costly to beneficiaries than traditional Medicare and have caps on annual out-of-pocket expenses.

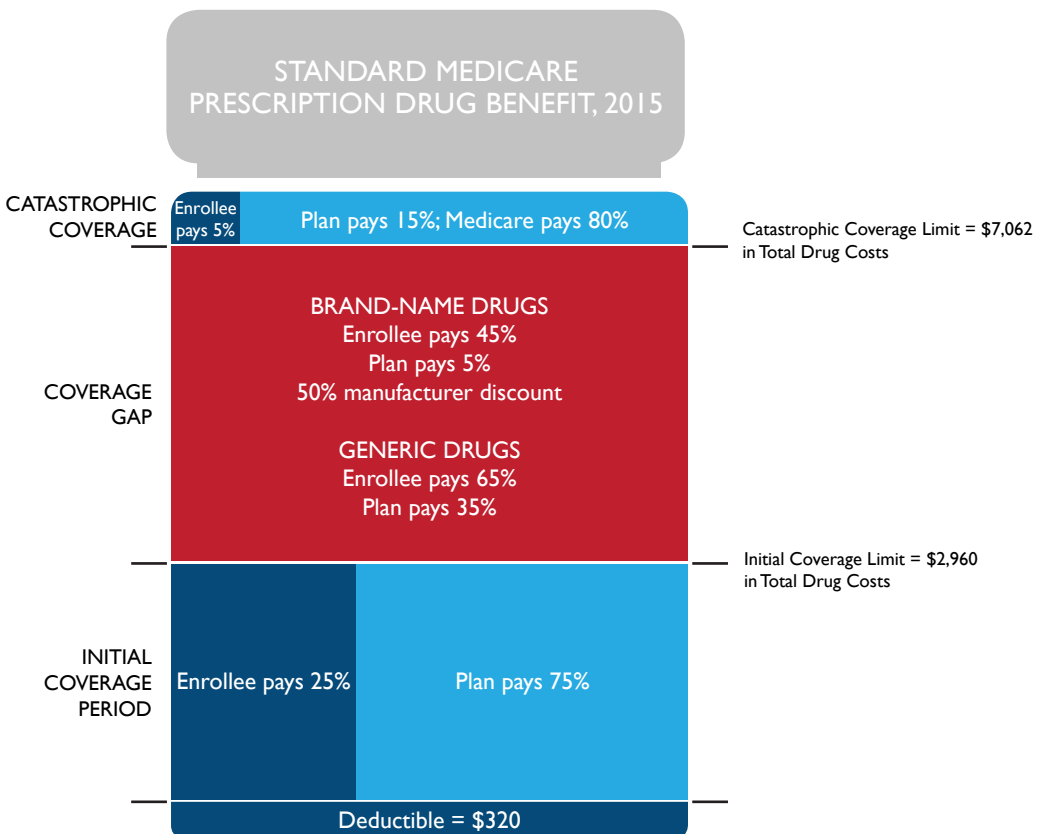
- Prescription drug benefits under Part D also vary by plan, as do premiums and other cost-sharing, although CMS defines a minimum level of coverage. Medicare offers Part D premium and cost-sharing assistance to individuals with low incomes and modest assets, the first time Medicare itself has provided such support.

In 2015, the premium for the standard Part D benefit costs \$33.13 a month (again with a surcharge for high earners), plus a \$320 deductible. Enrollees then pay 25% of their drug costs up to \$2,960 in total costs (calculated as the sum of enrollee and insurer payments).

Once costs exceed \$2,960, enrollees enter the coverage gap, often called the “doughnut hole.” When the Part D legislation was first passed, this coverage gap made Medicare beneficiaries responsible for the entire cost of their drugs within a certain range (in 2006, beneficiaries paid everything once total drug costs reached \$2,250, until they hit a “catastrophic” threshold of \$5,100).³³

Under the ACA, the doughnut hole has been getting smaller, with beneficiaries paying a shrinking portion of their total drug costs. In 2015, after reaching the \$2,960 threshold, they pay 65% of generic drug costs and 45% of brand-name therapies; once total drug costs reach \$7,062, they become responsible for 5% of further costs. Those discounts are scheduled to increase so that by 2020, the doughnut hole will close. At that point, beneficiaries will have to meet their deductible and then pay 25% of brand-name and generic drug costs until reaching a catastrophic threshold, when their share will be reduced to 5%.³⁴

In contrast to Part A and Part B, where Medicare determines provider reimbursement, the government has no direct role in setting prices for prescription drugs covered under Part D plans, and is explicitly prohibited from negotiating with pharmaceutical companies for lower prices.



Adapted from the Henry J. Kaiser Family Foundation.

Arizona was the last state in the union to participate in Medicaid, and the first to mandate managed care for all eligible beneficiaries. In 1982, a decade after the rest of the country put programs in place, Arizona signed on to Medicaid.^j

- **Supplemental coverage:** Traditional Medicare beneficiaries often have supplemental insurance to limit their out-of-pocket expenses. Many people purchase policies to wrap around traditional Medicare (known as “Medigap” coverage); others have health plans through current or previous employers to fill the gap.

On average, Medicare beneficiaries spent \$4,734 in out-of-pocket medical expenses in 2010. Of that total, 42% was spent on premiums and 58% on services, with long-term services and supports representing the largest single cost.³⁵

Medicaid: A Federal/State Partnership³⁶

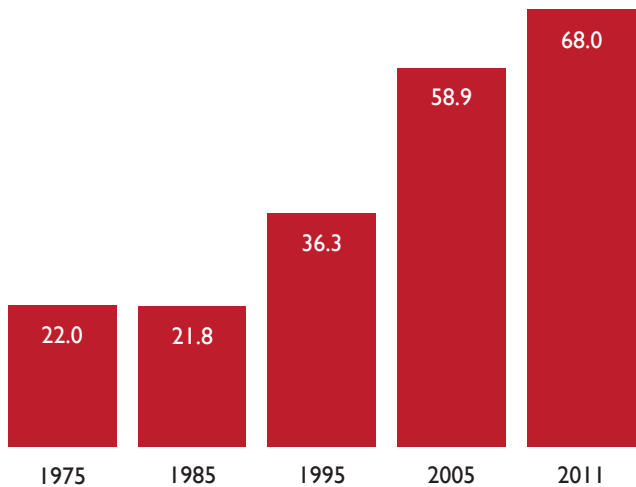
While Medicare is financed entirely by the federal government and beneficiary contributions, Medicaid is structured as a federal/state partnership. Historically, states have differed significantly in their eligibility criteria and the extent of the services they cover, and those differences have widened considerably since the passage of the ACA.

Who is eligible for Medicaid?³⁷

In contrast to Medicare’s uniform and relatively straightforward eligibility requirements, the federal government establishes a floor for Medicaid eligibility, allowing the states to decide who else will be covered.

Prior to the passage of the ACA, Medicaid was available to low-income people within certain specific categories: children, parents of dependent children, pregnant women, individuals

**GROWTH IN MEDICAID ENROLLMENT
(PERSON-YEARS, IN MILLIONS)**



Adapted from Green Book, U.S. House Ways and Means Committee (1975 to 1995) and Kaiser Commission on Medicaid and the Uninsured analysis (2005 and later). Data source: CMS.

with disabilities, and people age 65 or older. Under federal law, most adults under 65 without dependent children were ineligible for Medicaid, and states offered coverage only to very low-income parents of working age – the median eligibility threshold for this group in 2013 was 61% of the federal poverty level.³⁷ (FPL in 2013 was \$11,490 for a single person, and \$23,550 for a family of four.)

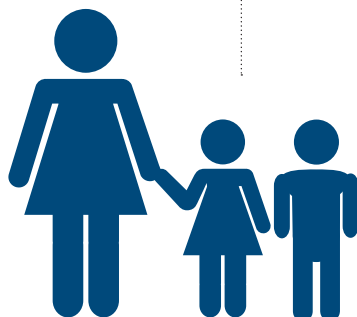
The health reform law was designed to reach more low-income adults by requiring Medicaid eligibility for most Americans under 65 who had an income at or below 138% of FPL. However, a 2012 U.S. Supreme Court ruling effectively made the coverage expansion for adults optional for states. As of March 2015, 28 states plus Washington, D.C. had expanded their Medicaid programs, and others were discussing that possibility.

A significant coverage gap remains in states that have not raised their income threshold. About four million adults earn too much to qualify for the Medicaid coverage available in their state and too little to afford insurance through health exchanges, which were established under the ACA to provide quality, affordable group coverage. (While the exchanges provide subsidized insurance at certain income levels, the subsidies are not available to adults with incomes below 100% of FPL; the law had intended universal expansion of Medicaid to be the coverage mechanism for that group.)

Children are generally more fully covered, in part because family income cut-offs are higher. Even if they are not expanding their programs, states are required to provide Medicaid to children up to at least 133% of the federal poverty level, but all states have long chosen to cover them at higher income levels through Medicaid or the Children's Health Insurance Program (CHIP). As of January 2015, the median eligibility level for children in Medicaid or CHIP was 255% of FPL.³⁸ Twenty-eight million children were covered through Medicaid³⁹ and an additional 5.8 million children were enrolled in CHIP in December 2013.⁴⁰

At the 2012 National Governors Association meeting, Department of Health and Human Services officials sat down with the governors who had not yet expanded Medicaid to talk about what they needed to move forward. “They’ve got a lot of coffee and a lot of water upstairs, and I think they’re meeting with almost every governor,” said Idaho governor C. L. “Butch” Otter.^k

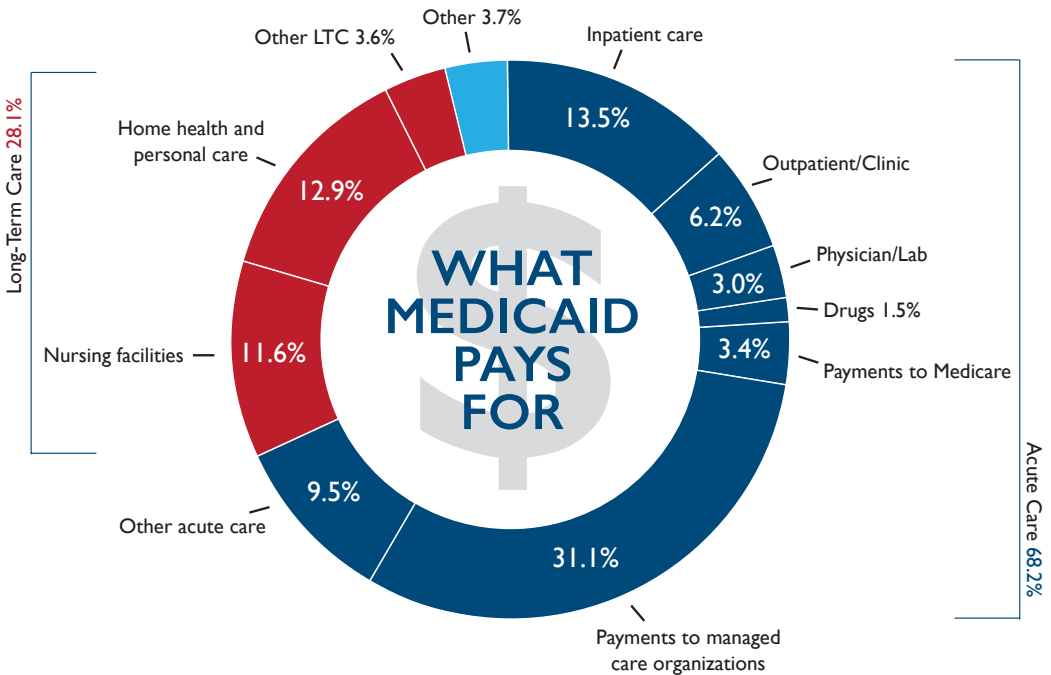
28,000,000
CHILDREN
WERE COVERED THROUGH
MEDICAID IN 2013



What services does Medicaid cover, and who provides them?

Under Medicaid, the federal government requires states to provide a core set of services and gives them the option of providing others. Required benefits include most hospital and clinical care, physician services, and laboratory testing, as well as the comprehensive services for children up to age 21 known as Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). Federally mandated benefits for the Medicaid expansion group under the ACA differ slightly from traditional Medicaid benefits, mostly to match the standards established for the private insurance market.

Coverage for nursing facilities, as well as for home health services to individuals who would be eligible for those facilities, is also mandatory. All states provide at least some benefits for prescription drugs, and many do so for dental care, durable medical equipment, and other services, but these are not required. Medicaid-reimbursable care can be provided in a variety of settings, including private physician offices, clinics, and hospitals.



FY 2013.

Adapted from the Henry J. Kaiser Family Foundation "Medicaid Expenditures by Service, FY 2013." Data Source: Urban Institute estimates based on CMS data.



Through the ACA, waivers of traditional Medicaid rules, and other mechanisms, the federal government is encouraging widespread experimentation with new models of care. In general, these reflect a broad consensus that providers should be paid for value, rather than for volume, and have the goals of better coordinating care, improving quality, and reducing costs.

More than half of all Medicaid beneficiaries are now served by managed care organizations (MCOs) that charge a flat, risk-adjusted monthly fee per enrollee under contracts with state governments. Another structure in use is Primary Care Case Management, which couples traditional fee-for-service reimbursement with additional payments to promote care coordination. The ACA also provides funds to significantly expand community health centers, which have long operated in areas with large populations of Medicaid beneficiaries.

Better and more cost-effective strategies for delivering long-term services and supports are also being developed with incentives through the ACA. In particular, additional financial incentives are being provided for states to continue shifting the locus of care from institutional to home and community-based settings, with increased funding available for home health, case management, personal care, caregiver support, and rehabilitation.

What do we spend on Medicaid, and who pays?

Medicaid expenditures were just under \$1 billion in 1966, when the program was being phased in. By 2013, they had grown to more than \$454 billion.⁴¹ Medicaid represents about 17% of the nation's total personal health spending⁴² and 8% of the federal budget⁴³ and has steadily increased as a share of Gross Domestic Product (GDP) – from 0.1% (1966) to 2.2% (1995) to a projected 3.1% (2015) – reflecting increased enrollment and the rising cost of health care.⁴⁴

Medicaid expenses are split between the federal and state governments through a formula known as the Federal Medical Assistance Percentage (FMAP), which is based on per-capita income in each state. On average, the federal government has paid about 57% of the total cost of Medicaid, with the states picking up most of the rest.⁴⁵ Those proportions are shifting under the ACA since the federal government will pay 100% of the costs for those newly eligible under the Medicaid expansion through 2016. The federal share of the expansion then drops slowly to 90% by 2020, and remains there indefinitely.

Medicaid is the largest single source of funding for long-term services and supports, financing 51% of the nation's total spending (almost \$158.6 billion of the \$310 billion spent in 2013). Highlighting the shift away from institutional care, 46% of the Medicaid dollars spent on long-term services and

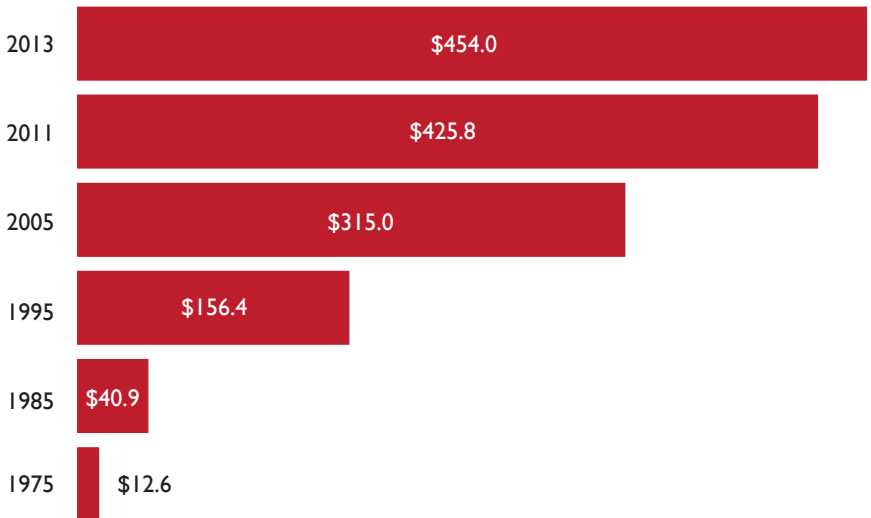
supports went to home and community-based services in 2013, compared to 20% in 1995.⁴⁶

Medicaid beneficiaries have limited responsibilities for premiums, deductibles and co-payments. Under federal regulations, no premiums can be charged to beneficiaries living at or below 150% of FPL and total cost-sharing can not exceed 5% of a family’s income. There are also cost-sharing exemptions for certain populations (*e.g.*, pregnant women, children who meet mandatory eligibility requirements, and disabled people) and for certain services (including family planning, emergency care, and, preventive services for children). For beneficiaries with incomes below 100% of FPL, the ACA caps copayments for outpatient services at \$4 and inpatient hospital admissions at \$75.

Who receives both Medicare and Medicaid services? What does it cost?

Nearly ten million Americans are enrolled in both Medicare and Medicaid. About 61% of these “dual-eligible” beneficiaries qualify for Medicare because they are 65 or older, while the rest are eligible because they receive Social Security Disability Insurance.⁴⁷ All qualify for Medicaid on the basis of their low incomes.

**GROWTH IN MEDICAID SPENDING
(IN BILLIONS)**



Adapted from Green Book, U.S. House Ways and Means Committee (1975 to 1995) and Kaiser Commission on Medicaid and the Uninsured analysis (2005 and later). Data source: CMS

Dual-eligible beneficiaries typically have more complex health care needs than the rest of the Medicare population. Nearly half rate their health status as fair or poor, 70% have three or more chronic conditions, more than half (56%) have a cognitive or mental impairment, and more than half (55%) live with one or more functional impairments in activities of daily living.⁴⁸

Unsurprisingly, they are also among the costliest users of publicly funded health care, with spending across both Medicare and Medicaid exceeding \$300 billion:

- Per-capita Medicare and Medicaid costs for dual-eligible beneficiaries approach \$30,000 a year, compared to just over \$8,000 for people eligible only for Medicare.⁴⁹
- 20% of the Medicare population also receives Medicaid – but account for 34% of Medicare’s total costs.⁵⁰
- 14% of the Medicaid population also receives Medicare – but account for 36% of total Medicaid costs.⁵¹

Providing well-integrated health care for dual-eligible beneficiaries is complicated not only by the intensive needs of the population, but also by differing administrative structures and reimbursement mechanisms. For example, Medicaid pays for community-based services that Medicare does not, and when a patient moves from one care setting to another (e.g., a hospital to a long-term-care facility) responsibility for reimbursement shifts. The result is often fragmented care for a population least able to manage it, according to CMS:

“The majority of Medicare-Medicaid enrollees must navigate three sets of rules and coverage requirements (original Medicare, a Medicare prescription drug plan, and Medicaid) and manage multiple identification cards, benefits, and plans.”⁵²

Under the Affordable Care Act, CMS established the Center for Medicare and Medicaid Innovation to test and promote new approaches to seamless, cost-effective care. In partnership with the Medicare-Medicaid Coordination Office, also under the CMS umbrella, the new office is guiding *State Demonstrations to Integrate Care for Dual Eligible Individuals* and *Financial Alignment Demonstrations*, among other initiatives.

Strategies of interest include “medical homes” and accountable care organizations; coordinated primary, acute, behavioral, and long-term services and supports; certification of integrated care organizations; targeted interventions for high-risk individuals; new payment incentives for improving care coordination; and many others.

Medicaid expansion offered Ohio an opportunity “to treat the mentally ill, to get them across the bridge so they can get employment. The same for the drug addicted and you know drug addiction is in every demographic, every income, every community.... And also to make sure the working poor have a system that makes sense, instead of showing up and getting their healthcare... in emergency rooms.”¹
– Ohio governor John Kasich

“The virtual dismantling of segregation of hospitals, physicians’ offices, nursing homes, and clinics,” was one of the paramount contributions of the legislation. “If Medicare and Medicaid had not made another single contribution, this result would be sufficient to enshrine it as one of the most significant social reforms of the decade.”^m
 – Wilbur Cohen, former U.S. Health, Education and Welfare Secretary

FACING THE FUTURE

The 50th anniversary of Medicare and Medicaid is a time of opportunity and challenge, as the growth of both programs stimulates innovation while demographics, cost, and ideology pose inevitable complications.

Meeting new demands

One of the significant stressors on the system is certain to be the aging of the Baby Boom generation (those born from 1946 to 1964). In 2010, 13% of all Americans were age 65 or older, but when the last of the cohort reaches 65 in 2030, that figure will rise to 19%, according to U.S. Census projections.⁵³

Because Medicare is funded partly by payroll taxes, a further demographic hurdle is emerging. While there were four workers for every Medicare beneficiary in 2000, there will be only 2.3 workers per beneficiary by 2030.⁵⁴

But Medicare is not running out of money. The 2014 report of the Medicare trustees predicts the trust fund that finances hospital coverage will remain solvent until 2030 – four years beyond its 2013 projections. In part, this reflects slowing in its rate of growth. Since 2010, the average annual rise in Medicare spending has been well below the average annual growth

5 MYTHS 5 FACTS

1 MYTH: Medicare is an inefficient government program with high overhead.

FACT: Medicare’s administrative costs (Parts A and B) represent about 2% of the program’s total spending, compared to an estimated 17% in the private sector.ⁱ

2 MYTH: Medicare will go bankrupt as increasing numbers of Baby Boomers become eligible for coverage.

FACT: The trust fund that finances hospital coverage under Medicare will remain solvent at least until 2030.ⁱⁱ

3 MYTH: Medicare spending grows faster than private insurance, per beneficiary, year after year.

FACT: Medicare spending has grown more slowly than private insurance since 2000 and will likely continue doing so. The per-capita growth rate for Medicare has been estimated at 3.7% from 2014-2023, compared to 4.7% for private insurance.ⁱⁱⁱ

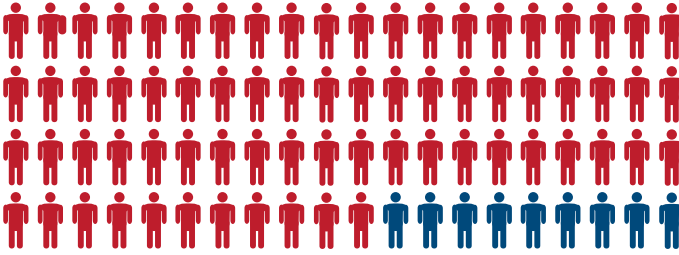
4 MYTH: Medicaid spending is mostly for low-income families.

FACT: Nearly two-thirds of Medicaid spending is for the elderly and those with disabilities (who represent one-quarter of Medicaid enrollment). Only 20% of Medicaid spending is for children (who make up nearly half of Medicaid enrollment).^{iv}

5 MYTH: The Affordable Care Act’s Medicaid expansion will strain state budgets past the breaking point.

FACT: The federal government pays all costs for those newly eligible under the Medicaid expansion through 2016, and most costs after that – by 2020, it will cover 90% of costs indefinitely. Early evidence suggests that some states are seeing budget savings and increased revenues from their expansions.^v

80 MILLION PEOPLE WILL BE ELIGIBLE FOR MEDICARE IN 2030⁵⁵



9 MILLION WILL BE 85 OR OLDER⁵⁶

in GDP, and that trend will continue, according to CMS.⁵⁷ Medicare spending represented about 3% of total GDP in 2014 and is expected to rise only slightly to 3.3% in 2024.⁵⁸

Nonetheless, controlling costs is a vigorous focus of policy discussions. In what the Department of Health and Human Services called an “historic announcement” in January 2015, Secretary Sylvia Burwell unveiled a plan to increase Medicare’s use of alternative payment models. The goal is to tie 30% of traditional, fee-for-service Medicare payments to quality measures by 2016 through new formulas that give health care providers incentives to coordinate care and meet quality standards. By the end of 2018, half of these payments would be linked to quality. This use of alternative payment models was virtually non-existent as recently as 2011.⁵⁹

Other strategies under discussion to strengthen Medicare’s bottom line include increasing premiums, restructuring beneficiary contributions, raising the age of eligibility, adjusting payments to health plans and providers, and implementing a “premium support” model that would rely on private insurance, with the government making a defined benefit contribution.

Medicaid is also experiencing sweeping growth, powered by the ACA, its critical role in providing coverage to children, and the aging of the population. CMS projects that almost 81

*“Keep your government hands off my Medicare,” a South Carolina man demanded of Congressman Bob Inglis.” The remark, made during the heated debate that accompanied Barack Obama’s health reform proposals, was not fully informed, but it did suggest that Medicare has been broadly embraced, even by those who vigorously resist many other publicly funded programs.”*ⁿ

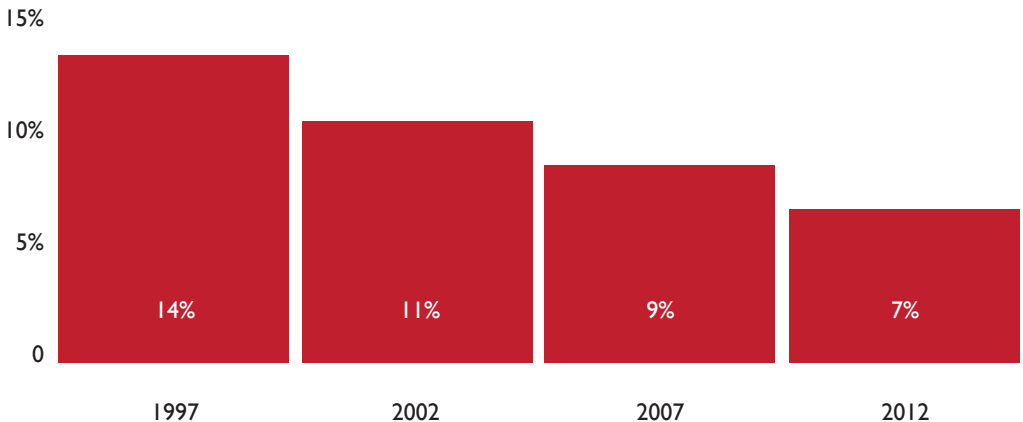
Six in ten Americans say Medicaid is important to their own families, with 38% calling it “very important.”^o After the Supreme Court made the Medicaid coverage expansion optional for states, 68% of Americans said their own state should make it more available to residents.^p

million people will be enrolled by 2022, with costs rising at an annual average rate of 7.1% to reach \$854 billion.⁶⁰ (These baseline estimates assume a high take-up rate across the states; other sources make lower projections.)

Over the past two decades, Medicaid and the Children’s Health Insurance Plan have achieved stunning success in increasing access to care for children, cutting the uninsurance rate from 14% to 7% between 1997 and 2012 by expanding eligibility, using effective outreach techniques, and simplifying enrollment. More than one in three children is now covered through these programs. However, more than seven million remain uninsured even though most are eligible for public insurance.⁶¹ Meeting the nation’s commitment to give all kids a healthy start in life is an ethical imperative and the ACA offers a number of additional mechanisms to do it. That will have to be one of the health system’s priorities moving forward.

The steady increase in people living to 85 and beyond will put further demands on the system, as many spend down their resources and require the long-term services and supports that are heavily funded by Medicaid.

REDUCING UNINSURANCE AMONG CHILDREN



Adapted from the Henry J. Kaiser Family Foundation, “Children’s Health Coverage: Medicaid, CHIP and the ACA,” March 2014. Data source: National Health Interview Survey.

Promoting value

With its vast investment in health care, the federal government is the inevitable leader of widespread efforts to establish value – defined essentially as patient outcomes relative to their cost – as the watchword throughout the health care sector. The ACA dictates a number of delivery and payment reforms intended to better integrate care and focus Medicare, Medicaid, and the broader health system on quality.

Significant new resources have been dedicated to prevention. Medicare provides first-dollar coverage for more services and states are required to pay for preventive services without cost-sharing for those covered under the Medicaid expansion. Medicaid also offers financial incentives to encourage all states to reduce any of their remaining cost-sharing requirements related to prevention.

CMS is moving aggressively to encourage far-reaching experiments and innovations in the delivery of care through Medicaid. Managed care is the most common strategy for promoting access and quality at a predictable cost and it is helping to drive reforms designed to align payment and delivery systems. States are also experimenting with other pay-for-performance models and expanding their use of accountable care organizations and medical or health homes designed to make the patient the locus of care.⁶²

The incentives to shift Medicaid-funded long-term supports and services to home and community-based care represent a further attempt to serve beneficiaries in the settings most appropriate to their needs. They also respond to requirements that people with disabilities be served in the least restrictive setting possible, which fortunately tends to be the most cost-effective approach.

Under the ACA, most states are testing ways to improve access and service delivery – such as the Money Follows the Person demonstration, which provides federal matching funds to help Medicaid beneficiaries move out of institutions, and the Balancing Incentive Program, which rewards structural reforms designed to improve access to community-based services. There is also increasing state interest in various approaches to managed long-term care, either through a capitated model or a managed fee-for-service approach.

As well, there is a strong emphasis on improving care for dual-eligible beneficiaries. CMS is working to reduce fragmentation across Medicare and Medicaid through its “Alignment Initiative”; increasing state access to data about their service populations (essential to reducing duplication of services); and funding other innovative pilot programs.

On average, nursing facilities and other institutional settings cost more than \$90,000 a year, compared to annual costs of \$22,000 for home health services (20 hours a week) or \$18,000 for adult day care (5 days a week).⁹

*“Coverage matters....
There is a chasm between
the health care needs of
people without insurance
and access to effective
health care services.
This gap results in
needless illness, suffering,
and even death.”⁷¹
– Institute of
Medicine report*

Medicare and Medicaid have made America healthier

In a sense, all of this began as LBJ’s signature was drying on the bill that established Medicare and Medicaid. The fundamental principles of that law remain intact, but other presidents and legislators have added their imprints in response to shifts in the American population and advances and upheavals in the health care system.

Amidst the blizzard of data that describes the vast apparatus of Medicare and Medicaid, and the rancor that characterized efforts to overhaul the health care system 50 years ago and continues to do so today, one incontrovertible fact should not be obscured: the two federal health insurance programs that together cover some 110 million Americans have made the United States a healthier place to live.

As the Institute of Medicine declares, “a robust body of well-designed, high-quality research provides compelling findings about the harms of being uninsured and the benefits of gaining health insurance for both children and adults.” From cancer, heart disease and stroke, to diabetes, hypertension, and injuries, the IOM cites overwhelming evidence that having health insurance produces better health outcomes.⁶³

The tradition LBJ spoke of that July day in Independence, Missouri remains a worthy one:

*It calls upon us never to be indifferent toward despair.
It commands us never to turn away from helplessness.
It directs us never to ignore or to spurn those who suffer
untended in a land that is bursting with abundance.⁶⁴*

Medicare and Medicaid will continue to evolve, as they have since their launch, but their central role in the American health care system seems assured.

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