Journal of Health Care Law and Policy

Volume 9 | Issue 1 Article 3

Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era

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MEDICAID AT FORTY: REVISITING STRUCTURE AND MEANING IN A POST-DEFICIT REDUCTION ACT ERA

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INTRODUCTION

> Medicaid is a vital program. . . . Medicaid is a huge program. . . . Medicaid is in many ways the most direct involvement with the provision of medical care undertaken by either the federal government or the states. . . . In some ways, the Medicaid program has been phenomenally successful. . . . Yet Medicaid has come under increasing fire . . . . Its cost increases, coupled with persistent budget overruns, have focused Congressional attention on rising medical prices, on inefficient program management, and on waste and sometimes deceit . . . . Medicaid has moved from a glittering symbol of the "Great Society" to a problem to be tackled by the "New Federalism." [1]

Robert and Rosemary Stevens wrote this passage over thirty years ago, ten years after Medicaid's 1965 enactment, in the prologue to their landmark *Welfare Medicine in America: A Case Study of Medicaid.* By its tenth anniversary, Medicaid already was considered "huge," accounting for some $9 billion in federal/state public spending and covering of 23 million persons.[2]

Three decades later, Medicaid expenditures stood at nearly $300 billion,[3] making it the nation's single largest insurer,[4] with enrollment ranging from 37.5 million[5] to 52 million[6] children and adults, depending on the source of data used.[7]

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1. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID xv-xvi (1974).

2. *Id.* at xv.

3. In Fiscal Year 2003, total Medicaid expenditures (state and federal) totaled $266 billion. URBAN INST. ON BEHALF OF KAISER COMM'N ON MEDICAID & THE UNINSURED, 2003 STATE AND NATIONAL MEDICAID SPENDING DATA (CMS-64), Table 1: Medicaid Expenditures By Type of Service: FFY 2003 (2005), http://www.kff.org/medicaid/upload/Medicaid-Expenditures-by-Type-of-Service-FFY-2003.pdf.

4. KAISER FAMILY FOUNDATION, CHALLENGES FACING THE MEDICAID PROGRAM IN THE 21ST CENTURY 19 (Oct. 8, 2003), *available at* http://www.kaisernetwork.org/health_cast/uploaded_files/100803_houseec_medicaid.pdf.

5. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004 60 (2005), http://www.census.gov/prod/2004pubs/p60-226.pdf. According to the Congressional Budget Office, actual federal expenditures in FY 2004 stood at $176 billion. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK:

Medicaid is the largest source of coverage for children, enrolling one in four.[8] Medicaid covers one-third of all U.S. births and is the principal source of public funding for family planning services.[9] Medicaid covers more than half of all persons living with AIDS, is the largest source of public funding for mental illness treatment, and pays for nearly half of all long-term care costs.[10] Without Medicaid revenues, the nation would witness the collapse of an already burdened system of publicly-supported clinics and public hospitals and health systems that serve the poor, including a substantial number of program beneficiaries.[11] In sum, Medicaid's role in financing health care for low-income and seriously and chronically ill and disabled populations makes it an essential part of the U.S. health care landscape.

Medicaid is also the financial platform on which rest many of states' most important health-related social welfare responsibilities in the case of children and adults with serious and long-term health care needs, such as children in foster care,[12] low-income children with educationally-related health conditions who receive special education services under the Individuals with Disabilities Education Act,[13] and adults with mental retardation, developmental disabilities, and mental illness who receive other health and supportive services through state programs.[14]

FISCAL YEARS 2006 TO 2015, at 52 (2005), *available at* http://www.cbo.gov/showdoc.cfm?index =6060&sequence=0.

6. KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER 9 (2005), *available at* http://www.kff.org/medicaid/upload/7334%20 Medicaid%20Primer_Final%20for%20posting-3.pdf [hereinafter KAISER COMM'N] .

7. Experts indicate that the enrollment data varies depending on how persons with multiple sources of insurance coverage are included in the estimates. Approximately 7 million Medicare beneficiaries, for example, are poor enough to qualify for additional coverage through Medicaid as dual enrollees. *Id.* at 4. Dual enrollment is also found among low-income or seriously ill persons with private health insurance.

8. *Id.* at 3.

9. *Id.* at 4.

10. *Id.* at 1.

11. *See* COMM. ON CHANGING MARKET, MANAGED CARE, & THE FUTURE VIABILITY OF SAFETY NET PROVIDERS, INST. OF MED., AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 21-22 (Marion Ein Lewin & Stuart Altman eds., 2000). Along with public health agencies, the Institute of Medicine (IOM) identified health centers and public hospitals as part of the "core" safety net because of their obligation to care for the poor and their significant reliance on Medicaid. *Id.*

12. *See* ROB GEEN ET AL., THE URBAN INST., MEDICAID SPENDING ON FOSTER CHILDREN 3 (2005), *available at* http://www.urban.org./UploadedPDF/311221_medicaid_spending.pdf. In FY 2001, an estimated 961,555 Medicaid-enrolled children spent some period of time in foster care. *Id.* at 2.

13. 20 U.S.C.A. § 1451-52 (West 2003 & Supp. 2005) (allotting grants to states for education of children with disabilities).

14. In 2003, 82% of the 6.9 million Supplemental Security Income (SSI) recipients qualified for coverage on the basis of disability as adults or children. OFFICE OF RESEARCH, EVALUATION, & STATISTICS, U.S. SOC. SEC. ADMIN., 2003 SSI ANNUAL STATISTICAL REPORT 1 (2004), *available at* http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2003/index.html. Approximately 60% had a mental disorder. *Id.*

In times of national crisis emanating from natural or man-made catastrophes, whether the September 11, 2001, terrorist attack on the World Trade Center or the destruction of much of the Gulf Coast by Hurricane Katrina nearly four years later to the day, the nation has turned to Medicaid to pay for essential health services—even as policymakers debate the program's future.[15]

From a structural viewpoint, Medicaid can be thought of as a logical response to the nation's market-oriented approach to health care financing and service delivery.[16] Among industrial democracies, the United States stands alone in relying on voluntary markets to insure most of the population.[17] Voluntary markets inevitably exclude persons who are unable to afford the going price or whose individual characteristics make them unattractive customers. With the cost of employer-sponsored family coverage hovering at $10,000 in 2004[18]—among employers that elect to offer any coverage[19]—private insurance is unaffordable to millions of people. Millions more find themselves either entirely or substantially barred from adequate coverage as a result of health problems that affect companies' willingness to offer coverage at any price.[20]

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15. As of September 8, 2005, as this article was being finalized, an almost surreal series of developments was taking place in Washington, D.C. The House of Representatives and the Senate were poised to consider $10 billion in reductions in Medicaid funding, as well as a series of far-reaching policy reforms, discussed later in this article. At the same moment, legislation is being introduced in the House and Senate to expand Medicaid's reach to provide a means of aiding hundreds of thousands of dislocated persons with no way to finance essential medical care and facing an unprecedented array of health problems ranging from death as a result of waterborne disease to profound mental illness associated with the loss of life and home. Temporary Medicaid Disaster Relief Act of 2005, H.R. 3698, 109th Cong. (2005); Katrina Emergency Relief Act of 2005, S. 1637, 109th Cong. (2005).

16. For a comprehensive examination of the role of competition in U.S. health care, see FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarept.pdf.

17. Medicare represents the only source of health insurance in the United States grounded in social insurance principles. *See* TIMOTHY STOLTZFUS JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 63 (2003).

18. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2004 SUMMARY OF FINDINGS 2 (2004), *available at* http://www.kff.org/insurance/7148/upload/2004-Employer-Health-Benefits-Survey-Summary-of-Findings.pdf.

19. Between 2001 and 2004, the proportion of employers offering coverage at all declined from 68% to 63%, chiefly as a result of a shrinking rate of coverage in the small employer market. *Id.*

20. *See* KAREN POLLITZ ET AL., KAISER FAMILY FOUND., HOW ACCESSIBLE IS HEALTH INSURANCE FOR CONSUMERS IN LESS THAN PERFECT HEALTH? 31 (2001), *available at* http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumers-in-Less-Than-Perfect-Health-Executive-Summary-June-2001.pdf (presenting a series of hypothetical applicants to insurance brokers around the country and finding that in certain parts of the country, even relatively healthy applicants with even mild conditions received either outright rejections or less than clean offers). In its study of the individual market, America's Health Insurance Plans (AHIP) found that 88% of applicants were offered coverage. CTR. FOR POL'Y RESEARCH, AMERICA'S HEALTH INSURANCE PLANS, INDIVIDUAL HEALTH INSURANCE: A COMPREHENSIVE SURVEY OF AFFORDABILITY, ACCESS AND BENEFITS 2 (2005), http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-

Medicaid, in short, stands as the nation's central means of compensating for the lack of a unified, population-based system of health care finance, the consequence of which is the total or partial exclusion of tens of millions of persons who tend to be poorer and sicker than the norm. Medicaid is far from perfect, but it is virtually the only national policy response to multiple problems: nearly 46 million Americans without any coverage;[21] millions more publicly and privately insured persons who nonetheless are under-insured, low-income, and unhealthy;[22] and the lack of sufficient investment in essential community health services. Medicaid can be thought of as the escape hatch, the safety valve, or whatever cliché one chooses to describe a program that buffers the United States against its own failure to come to grips with the role of government in health care. How the health care system would function without Medicaid is a question that can be answered only at our peril, and yet we seem to have arrived at a moment in time when the program's future as an elastic means of compensating for system shortcomings is under an increasing cloud.

This article explores Medicaid on its fortieth anniversary and at a pivotal moment in its history. Part One describes Medicaid's origins and evolution into a major force in U.S. health policy. Part Two examines the federal landscape for Medicaid reform and examines legislative reform proposals under consideration as of the fall of 2005, as well as parallel efforts to constrain Medicaid growth and alter the program's essential fabric through the use of federal administrative powers under section 1115 of the Social Security Act. It also focuses on the state of Medicaid in the courts. The conclusion provides a brief epilogue enacted by Congress in 2006 and reflects on Medicaid's future.

I. THE HISTORY AND EVOLUTION OF MEDICAID

The Making of a Singular Program: Medicaid's Legislative Roots and Basic Structure

Codified at Title XIX of the Social Security Act, Medicaid was a legislative culmination of one of the nation's seemingly endless cycles of national health

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2005.pdf. Average offer rates ranged from 95% for applicants under age 18 to 70% for applicants ages 60-64. *Id.*

21. DENAVAS-WALT ET AL., *supra* note 5, at 17.

22. *See generally* JOHN HOLAHAN & ARUNABH GHOSH, KAISER COMM'N ON MEDICAID & UNINSURED, DUAL ELIGIBLES: MEDICAID ENROLLMENT AND SPENDING FOR MEDICARE BENEFICIARIES IN 2003 (2005), *available at* http://www.kff.org/medicaid/upload/7346%20Dual%20Eligibles_Enrollment%20and%20 Spending_Beneficiaries_Final_revised%207_28.pdf (offering an overview of Medicaid enrollment and spending trends on dual Medicare/Medicaid enrollees).

reform debates.[23] An outgrowth of the earlier Kerr Mills grant-in-aid program,[24] which assisted states in meeting the health care costs of the elderly poor, Medicaid reflected Congress's decision to "liberalize and extend"[25] this system of federal grants to states for specific health care purposes. Although its 1965 enactment was overshadowed by the passage of more politically potent Medicare legislation that same year, Medicaid in two respects represented a fundamental philosophical breakthrough in its own right: a great broadening of national policy regarding government's role in financing health care for medically indigent persons and the codification of the concept of access by the poor to "mainstream" medical care, through "vendor payments," in lieu of reliance on a patchwork of charity care and directly-financed public health systems.[26]

In the beginning, as is true today, Medicaid rested on a financial base consisting of a shared federal/state contribution arrangement,[27] with the federal government as the senior partner.[28] As discussed in Part Two, this approach to financing has turned out to contain deep flaws that have ultimately undermined Medicaid's operational and political stability, as well as its aspirational goals. Indeed, today much (but not all) of the battle over Medicaid comes down to the question of who should bear the financial risks associated with health care financing for the sickest and poorest members of society, a sign that the federal/state deal struck forty years ago was simply not sufficiently balanced to weather extraordinary changes over four decades.

The legislative intent underlying Medicaid was evident on its face: to "undergird what was traditionally a state—indeed a local—function: taking care of the medical needs of the poor."[29] But in its essential structure, Medicaid resembled not a grant program to clinics and hospitals, but instead a "third party payment" system structured to operate like insurance, paying "participating" health care professionals and institutions for covered services furnished to enrolled persons. In this way, government financing attributable to health care for the poor would be accessible to the private sector as well.

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23. For a review of health reform efforts preceding the enactment of Medicare and Medicaid, see STEVENS & STEVENS, *supra* note 1, at 5-56 and PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 235-37, 290-95, 335-71 (1983).

24. STEVENS & STEVENS, *supra* note 1, at 51-52.

25. *Id.* at 47.

26. *Id.* at xvi.

27. *Id.* at 58.

28. In 2004, the federal government paid for approximately 57% of Medicaid program expenditures. KAISER COMM'N ON MEDICAID, KEY MEDICARE AND MEDICAID STATISTICS 8 (2005), http://www.kff.org/medicaid/upload/Key%20Medicare%20and%20Medicaid%20Statistics.pdf.

29. JOST, *supra* note 17, at 162.

From the beginning, Medicaid's sweep in relation to the more narrowly conceived Medicare program[30] was quickly evident. At least some contemporaneous analysts recognized Medicaid as the "sleeper" program of 1965, because of its potential breadth, in view of its scope and comprehensive coverage structure.[31] For some commentators, the program became the "exemplar of a national health program of the future,"[32] covering large population segments under a comprehensive scheme of government financing.[33]

Over its lifetime, Medicaid has been transformed by an astounding agglomeration of legislative provisions and interpretive guidelines and rules.[34] But it is possible to scrape away the decades of legal patchwork in the form of a litany of amendments aimed at addressing pressing problems in health policy—from the failure of the employer-sponsored market to cover low-income children, pregnant women, and workers and their families, to the lack of a national childhood immunization policy, long-term care policy, or means of financing health care for serious and life-threatening conditions with public health implications. What emerges is a remarkably elegant and simple law whose provisions illustrate why Medicaid was able to emerge as such a monumental component of health care finance.

Medicaid followed the tradition of federal grant-in-aid programs, enacted pursuant to Congress's spending clause powers, which condition the receipt of federal funds by states that elect to participate on compliance with a series of structural and operational conditions of participation.[35] Unlike other grant programs such as the State Children's Health Insurance Program[36] or the Title V Maternal and Child Health Services Block Grant,[37] Medicaid is structured as an open-ended legal entitlement for participating states with approved plans. As such, Medicaid is the single largest source of direct federal revenue transfer to state

30. Medicare and Medicaid were both signed into law in the Social Security Amendments of 1965. However, Medicare was originally drafted to address more limited segments of the population, types of health care covered, and available payment options. STEVENS & STEVENS, *supra* note 1, at 51-52.

31. *Id.*

32. *Id.* at 52.

33. Benjamin Werne, *Medicaid: Has National Health Insurance Entered Through the Back Door?*, 18 SYRACUSE L. REV. 49, 49 (1966).

34. For a comprehensive review of all aspects of the program, the most usable tool is probably the Commerce Clearing House Medicare and Medicaid Guide. The Kaiser Commission on Medicaid and the Uninsured publishes voluminous and relatively simple to follow materials on the program. ABOUT US: KAISER COMM'N ON MEDICAID & THE UNINSURED, http://www.kff.org/about/kcmu.cfm (last visited Apr. 11, 2006). There is a relatively extensive legal literature on Medicaid, although much of it addresses the program's jurisprudential aspects rather than its systemic and operational characteristics and impact.

35. 42 U.S.C. § 1396a (2000).

36. *Id.* §§ 1397aa-jj.

37. *Id.* §§ 701-10.

governments, representing 40% of all federal funds received.[38] While these state plan requirements have grown over the years, it is possible to describe Medicaid's ground rules relatively succinctly; a comparison of current provisions with the terms of the original statute indicates that much of its original structure remains unchanged.[39]

A right to apply for assistance and receive it. Although Medicaid eligibility is limited to only certain categories of persons,[40] any individual is entitled to apply and, if eligible, must be furnished medical assistance with reasonable promptness.[41] As a result, states cannot queue applicants or refuse to take applications, an option under non-entitlement programs such as SCHIP.[42]

Health care coverage and finance without the constraints of health insurance. In subtle yet powerful ways, Medicaid represents a total departure from health insurance coverage design principles. Although Medicaid functions like health insurance from a vendor payment perspective for purposes of statistical studies of

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38. Bipartisan Commission on Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005).

39. In this regard, the CCH Medicare/Medicaid Guide is an indispensable guide to the evolution of each statutory provision.

40. 42 U.S.C.A. § 1396a(a)(10) (West 2003 & Supp. 2005). *See generally* ANDY SCHNEIDER ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE MEDICAID RESOURCE BOOK 8-38 (2002) (identifying twenty-five different categories of eligibility, including pregnant women, children, and the elderly).

41. 42 U.S.C.A. § 1396a(a)(8) (West 2003 & Supp. 2005). The concept of "medical assistance" has been interpreted by courts to cover both the provision of evidence of coverage (i.e., an actual insurance card) and provision of covered services. On the latter question, courts are divided on "reasonable promptness," which has tended to arise in the context of individuals who need long-term care services. *See, e.g.*, Doe v. Chiles, 136 F.3d 709, 715 (11th Cir. 1998) (interpreting reasonable promptness provision as prohibiting the use of long-term waiting lists for intermediate care facilities). *But see* Bruggeman v. Blagojevich, 324 F.3d 906, 910 (7th Cir. 2003) (interpreting prompt assistance to refer to financial assistance, not actual services).

42. Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMED. L. 1, 18 (2004). For a study of SCHIP enrollment waiting lists, see DONNA COHEN ROSS & LAURA COX, KAISER COMM'N ON MEDICAID & THE UNINSURED, OUT IN THE COLD: ENROLLMENT FREEZES IN SIX STATE CHILDREN'S HEALTH INSURANCE PROGRAMS WITHHOLD COVERAGE FROM ELIGIBLE CHILDREN (2003), *available at* http://www.kff.org/medicaid/upload/Out-in-the-Cold-Enrollment-Freezes-in-Six-State-Children-s-Health-Insurance-Programs-Withhold-Coverage-from-Eligible-Children.pdf. This is not to say that states and counties do not try to control Medicaid caseload by limiting or discouraging applications. Anyone familiar with Medicaid's complex eligibility determination system can attest to long waits, limited entry points, the use of procedural barriers such as unnecessary written verification requirements, and other techniques that slow down or discourage persons who seek assistance. The "slow-walking" of the Medicaid application process is a long-standing issue that has received enormous attention over the years. *See, e.g.*, DONNA COHEN ROSS & LAURA COX, KAISER COMM'N ON MEDICAID & THE UNINSURED, BENEATH THE SURFACE: BARRIERS THREATEN TO SLOW PROGRESS ON EXPANDING HEALTH COVERAGE OF CHILDREN AND FAMILIES 1, 19 (2004), *available at* http://www.kff.org/medicaid/uplaod/Beneath-the-Surface-Barriers-Threaten-to-Slow-Progress-on-Expanding-Health-Coverage-of-Children-and-Families-pdf.pdf (concluding that simplified enrollment and renewal procedures have been recently retracted, barring individuals from obtaining coverage, particularly in SCHIP programs).

coverage, it bears little resemblance to insurance in terms of its inner workings. Indeed, Medicaid's coverage rules give it the power to finance significant health needs left unaddressed by insurance markets. Medicaid is not structured on a "moral hazard" principle; indeed, the program encourages individuals to apply at the point of (or even following), in particular, catastrophic costs assoicated with hospital emergency care, nursing home care, and other services for which individuals "spend down" to eligibility.[43] Individuals thus can apply at the point of service, when their health is at its worst and costs are higher; indeed, by law, states must outstation the application process at certain types of health care providers.[44] Coverage can actually begin up to three months prior to the date of application for qualified persons.[45] Unlike private health insurance, Medicaid contains no pre-existing condition exclusions and no waiting periods.[46] Medicaid contains no provision that permits "refusal to offer" or "conditional offer," meaning that any individual who meets program eligibility rules must be accepted and covered, regardless of health status.

In sum, the law obligates states to receive and process all applications and to furnish medical assistance promptly to persons found eligible. Any individual who meets federal eligibility standards is entitled to coverage regardless of—and indeed, often because of—disability and illness.

Minimum coverage groups and eligibility standards. All states must cover certain "mandatory" groups[47] of state residents, which consist of persons identified by certain personal characteristics and low family income: low-income children and pregnant women,[48] persons who receive Supplemental Security Income,[49] children who receive federal foster care or adoption assistance,[50] and certain other groups.[51] Furthermore, in determining eligibility for and furnishing medical

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43. "Spending down" is the concept that individuals whose incomes would normally disqualify them from receiving Medicaid services effectively qualify for Medicaid because the amounts in health care costs that they have already incurred are calculated as deductions from their total incomes. SCHNEIDER ET AL., *supra* note 40, at 6.

44. 42 U.S.C. § 1396a(a)(55) (2000) (mandating enrollment at places other than Medicaid offices for certain classes of beneficiaries at federally-qualified health centers and hospitals serving a disproportionate percentage of publicly insured and low income persons).

45. *Id.* § 1396a(a)(34).

46. Rosenbaum et al., *supra* note 42, at 10. A pre-existing condition exclusion is an exclusion from coverage that "limits or denies benefits for a medical condition that existed before the date of coverage began." Ctrs. for Medicare & Medicaid Servs., HIPAA Keyword Menu, http://www.cms.hhs.gov/hipaa/hipaa1/phig_Includes/023.asp (last visited Apr. 11, 2006). A waiting period is "the time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts." Ctrs. for Medicare & Medicaid Servs., General Glossary, http://www.cms.hhs.gov/glossary/ (last visited Apr. 11, 2005).

47. 42 U.S.C. § 1396a(a)(10)(A)(i) (2000).

48. *Id.* § 1396a(10)(A)(i)(III).

49. *Id.* §§ 1381-83f.

50. *Id.* § 1396a(10)(A)(ii)(VIII).

51. *Id.* § 1396a(a)(10)(A)(i) (identifying mandatory coverage groups).

assistance, states must adhere to certain "reasonable" budgeting methodologies in valuing family income and resources.[52] These "reasonable" methodologies include prohibitions against the "deeming" of income and resources from non-financially responsible household members, as well as between spouses under certain circumstances.[53]

A minimum, reasonable, and non-discriminatory set of defined benefits. Participating states must cover a minimum level of "medical assistance" to program enrollees.[54] The term "medical assistance" is defined as "payment of part or all" of the cost of a statutorily-defined list of medical benefits and services,[55] some of which are required while others are optional.[56] States may impose only limited premium and cost-sharing obligations, and certain populations are exempted from cost-sharing entirely.[57]

Coverage under Medicaid is comprehensive. States must operate their programs consistent with principles of reasonableness,[58] equality, and comparability in "amount, duration and scope"[59] and medical necessity.[60] Together, these statutory provisions have been interpreted not only as requiring reasonable standards and decision-making around any particular case, but also reasonableness in program *design,* a concept that is completely unknown in commercial insurance markets, which are free to set arbitrary limits on coverage unrelated to either fairness and comparability among covered groups or the level of medical need for care.[61]

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52. *Id.* § 1396a(a)(17).

53. *Id.* §§ 1396a(a)(17)(D), 1396a(a)(51). States' flexibility to deem income and resources between spouses is limited. *See* SCHNEIDER ET AL., *supra* note 40, at 36-37 (providing an explanation of special "spousal impoverishment" rules for spouses of institutionalized recipients).

54. 42 U.S.C. §§1396a(a)(10)(A)-(C) (2000).

55. *Id.* §1396d(a).

56. *Id.* §§ 1396a(a)(10), 1396d(a). There is no particular rhyme or reason to mandatory versus optional coverage; for example, prescription drugs are an "optional" service. *Id.* § 1396d(a)(xiii)(12). As discussed below, in the case of children, all services and benefits falling within the definition of "medical assistance" are considered required as a result of special coverage rules for individuals under age twenty-one. *Id.* §§ 1396d(a)(4)(B), 1396d(r).

57. *Id.* §§ 1396a(a)(14), 1396(o). Children, pregnant women, and institutionalized patients are completely exempt, for example, as are emergency care, family planning services, and supplies. *Id.* U.S.C. §1396o(a)(2).

58. 42 U.S.C.A. §§ 1396a(a)(17) (West 2003 & Supp. 2005).

59. *Id.* §§ 1396a(a)(10)(B), (C)(i).

60. *Id.* § 1396a(a)(30)(A).

61. *See, e.g.*, Doe v. Mutual of Omaha, 179 F.3d 557 (7th Cir. 1999) (holding that the Americans with Disabilities Act (ADA) Title III does not regulate the content of private health insurance and that, therefore, an insurer's stipulated lack of any actuarial evidence to justify severe and discriminatory limits on coverage of HIV/AIDS and related conditions is not unlawful under the ADA), *cert. denied.* In most states, insurance laws are so weak that even with respect to state-regulated coverage arrangements, laws do little to set reasonable coverage standards or prohibit discrimination against conditions. *See*

Interpretive guidelines, published coterminous with Medicaid's enactment[62] and now relegated to history,[63] established unsurpassed requirements for reasonable program design. While some of the passages in these original standards are remarkably aspirational, the guidelines on coverage live on in the rules today.[64] The guidelines set the following conceptual framework for coverage under Medicaid:

> The passage of title XIX marks the beginning of a new era in medical care for low income families. The potential of this new title can hardly be over-estimated, as its ultimate goal is the assurance of complete, continuous, family centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of medical bills, and states, in order to achieve its high purpose, will need to assume responsibility for planning and establishing systems of high quality medical care, comprehensive scope and wide in coverage.[65]
>
> In a well-balanced program, whether or not the scope of services is comprehensive, institutional and non-institutional care should be mutually supportive, allowing the patient to move into the institution and back to the community according to his medical needs. A variety of non-institutional services is needed to assure continuity of care. A system which provides the patient with appropriate care when and where needed not only promotes quality but is also economical. For example, to provide physicians' services, but not drugs, is self defeating and costly in both human and fiscal terms.[66]

Under this broad goal, standards of coverage for enumerated medical and remedial services were to be "sufficient in amount, duration and scope reasonably to achieve their purpose,"[67] and states were prohibited from setting program limitations "by eliminating certain groups of patients or certain diagnoses from coverage."[68] These concepts of reasonableness, non-discrimination, and comparability, along with the law's "statewideness" provisions,[69] set the stage for a

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RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 142-47 (1997) (discussing state insurance law and regulation).

62. U.S. DEP'T OF HEALTH, EDUC. & WELFARE, HANDBOOK OF PUB. ASSISTANCE ADMIN., SUPPLEMENT D (1966) [hereinafter HANDBOOK SUPPLEMENT D].

63. In 1981, the Reagan Administration notified the public that the Handbook would no longer serve as a valid interpretation of the program.

64. 42 C.F.R. §§ 440.230 (a)-(d) (2004).

65. U.S. Dep't of Health, Educ., and Welfare, Handbook of Public Assistance Administration, Supplement D, § D-5140.

66. *Id.*

67. *Id.* at § D-5130(1).

68. *Id.* at § D-5140.

69. Under Title XIX, state plans for medical assistance "shall be in effect in all political subdivisions of the state." 42 U.S.C. § 1396a(a)(1) (2000).

health care financing scheme of unprecedented range and breadth, particularly in relation to both the commercial market as well as Medicare, whose design resembled commercial insurance in terms of scope of benefits covered and underlying principles of coverage.[70] Under these rules, state programs, unlike private insurers, could select neither their coverage groups nor their geographic markets.

Free choice of health care providers and equal access to services. With the exception of certain situations involving the use of managed care arrangements or competitive purchasing systems, state programs must give eligible beneficiaries free choice of providers participating in the program.[71] States also must permit participation by all "qualified providers."[72] Furthermore, although states are given broad latitude in establishing provider qualification standards and payment structures, states' payment levels must ensure that covered services are at least as available to beneficiaries as they are to the general population in the geographic areas in which beneficiaries reside.[73] This requirement has come to be referred to as the "equal access" provision.[74]

In sum, in its original structure, and throughout its forty-year history, Medicaid was designed to run counter to the basic rules of health insurance. Although the pressure for retrenchment at the federal and state level of government began shortly after the program's enactment and has never diminished,[75] Medicaid's essential design has survived. Indeed, its reach has grown with each public health crisis, from a collapsing employment-based health insurance system, to communicable disease threats and acts of terrorism or natural disasters.[76]

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70. *See* JOST, *supra* note 17, at 63-64, 162-83 (discussing the historical foundations of health care entitlements and how their devolution led to the development of health insurance for the poor). For example, Medicare uses arbitrary limits on coverage (e.g., more limited coverage of mental illness) and applies a lengthy waiting period to persons whose eligibility is based on their receipt of Social Security Disability Insurance.

71. 42 U.S.C. §1396a(a)(23) (2000).

72. *Id.*

73. *Id.* § 1396a(a)(30)(A).

74. *Id.* § 1396a(a), n.222.

75. *See* STEVENS & STEVENS, *supra* note 1, at 129.

76. In 2001, following the terror attacks on the World Trade Center, New York instituted a disaster relief Medicaid program that set aside normal eligibility restrictions and assisted survivors to widespread acclaim. United Hospital Fund: Disaster Relief Medicaid Fact Sheet (10/01), http://www.uhfnyc.org/homepage3219/homepage_show.htm?doc_id=103951. By September 10, 2005, four years to the day after the attacks, as the nation was attempting to recover from the loss of hundreds of Gulf Coast communities, policy makers again turned to Medicaid. In the case of the Bush Administration, the Medicaid response has been through the issuance of emergency policies, authorized under §1135(b) of the Social Security Act, and designed to expedite Medicaid coverage to legislation aimed at broadening the program. *See* Press Release, Dep't of Health & Human Serv., Waiver Under Section 1135 of the Social Security Act (Sept. 4, 2005), http://www.hhs.gov/katrina/sswaiver/html. A full list of the federal agency response can be seen at the Centers for Medicare and Medicaid Services website, http://www.cms.hhs.gov/katrina/. The CMS response focuses on the coordination of out-of-

It would be a serious mistake, however, to view Medicaid as a monolith of federal requirements. States have significant discretion over the range of beneficiary groups and services they cover,[77] and an estimated 60% of all state program expenditures are for optional services and beneficiaries, 80% of which are expended on services to elderly and disabled persons.[78] Nonetheless, Medicaid is a program that places great demand on federal and state budgets, because it operates as an interlocking web of legal entitlements that reflect a balance of interests. States are entitled to federal contributions for covered medical assistance expenditures, based on a statutory formula that varies with state wealth.[79] The effective *quid pro quo* for this open-ended financing scheme is an individual legal entitlement among eligible persons to carefully designed medical assistance and an entitlement among qualified and participating providers for payment when covered services are furnished to enrolled persons.

Medicaid's Evolution

A full accounting of the extent to which Medicaid has been restructured over four decades to respond to pressing social and public health programs would occupy a book in its own right.[80] The evolution of Medicaid's legislative architecture can be classified as a series of distinct categories of reform, and the illustrative examples offered below are meant to give a flavor of the nature of program change.

Expansion of populations eligible for assistance. Perhaps the principal and best-known program response over the years has been expansion of populations eligible for assistance on either a mandatory or optional basis. These expansions read like a litany of social problems. The best known, perhaps, have been a series of incremental mandatory coverage reforms adding full coverage for "poverty

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state coverage for displaced survivors from the stricken states. Federal legislation introduced on September 8, 2005, would have taken an alternative approach, creating in-state coverage in evacuees' state of temporary residence and would assure host states complete federal financing for aid furnished to short term residents. *See* Temporary Medicaid Disaster Relief Act of 2005, H.R. 3698, 109th Cong. §3 (2005); Hurricane Katrina Medicaid and SCHIP Relief Act of 2005, S. 1688, 109th Cong. § 3 (2005).

77. SCHNEIDER ET AL., *supra* note 40, at 5, 59-63.

78. KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: AN OVERVIEW OF "MANDATORY" VS. "OPTIONAL" POPULATIONS AND SERVICES 1, 6 (2005), *available at* http://www.kff.org/medicaid/upload/ Medicaid-An-Overview-of-Spending-on.pdf.

79. ANNA SOMMERS ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID ENROLLMENT AND SPENDING BY "MANDATORY" AND "OPTIONAL" ELIGIBILITY AND BENEFIT CATEGORIES 1 (2005), *available at* http://www.kff.org/medicaid/upload/Medicaid-Enrollment-and-Spending-by-Mandatory-and-Optional-Eligibility-and-Benefit-Categories-Report.pdf.

80. In this regard, the Medicaid Resource Book, *supra* note 40, offers helpful guidance. Interested persons also can view a simple but effective interactive Medicaid reform timeline developed by the Kaiser Family Foundation, http://www.kff.org/medicaid/medicaid_timeline.cfm (last visited Feb. 24, 2006).

level" children and pregnant women[81] and limited coverage for premiums, deductibles, and cost-sharing for poverty-level Medicare beneficiaries not eligible for full assistance.[82] Expansion options also have been adopted for working families with children,[83] adolescents in foster care who have achieved independence,[84] persons with disabilities who are workers,[85] uninsured women with breast or cervical cancer,[86] persons with tuberculosis infections,[87] and persons with disabilities who would qualify for Medicaid if institutionalized and who instead receive "home or community-based services."[88] In the wake of Hurricane Katrina, members of Congress once again turned to Medicaid through the introduction of legislation to provide Medicaid coverage for thousands of displaced and impoverished hurricane victims.[89]

The dynamics of Medicaid eligibility expansion have been the dynamics of incrementalism; that is, with sometimes pinpoint precision,[90] optional groups have

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81. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401, 100 Stat. 1084, 2050-52 (codified as amended at 42 U.S.C. §§ 1396a(a)(10)(A)(III) (2000)).

82. *Id.* § 9403, 100 Stat. 1084, 2053-56 (codified as amended at 42 U.S.C. §1396a(a)(3)(E) (2000)). For purposes of statutory structure, "qualified Medicare beneficiaries" and related categories of low-income Medicare recipients are not treated as an eligibility category within (a)(10)(A), but rather as a group of persons that receives mandatory financial support, in order to signify their lack of eligibility for full "medical assistance." 42 U.S.C. §§ 1396a(a)(10)(A)(III), (10)(E) (2000).

83. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 114, 110 Stat. 2105, 2177-80 (1996) (codified as amended at 42 U.S.C. §1396u-1 (2000)).

84. Foster Care Independence Act of 1999, Pub. L. No. 106-169, § 121(c)(4), 113 Stat. 1822, 1829-30 (codified as amended at 42 U.S.C. §1396a(a)(10)(A)(ii)(XVII) (2000)).

85. Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. No. 106-170, § 201(a)(2)(A), 113 Stat. 1860, 1892 (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVI) (2000)).

86. Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, § 2, 114 Stat. 1381, 1381-1384 (codified as amended at 42 U.S.C. §1396a(a)(10)(A)(ii)(XVIII) (2000)).

87. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13603, 107 Stat. 312, 619-20 (codified as amended at 42 U.S.C.§1396a(a)(10)(A)(ii)(XII) (2000)).

88. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 411 (K)(17)(B), 102 Stat. 683 (codified as amended at 42 U.S.C. §1396a(a)(10)(A)(ii)(VI) (2000)).

89. Temporary Medicaid Disaster Relief Act of 2005, H.R. 3698, 109th Cong. § 3 (2005); Hurricane Katrina Medicaid and SCHIP Relief Act of 2005, S. 1688, 109th Cong. § 3 (2005). For a history of Medicaid's role in Congress's response to Katrina, see Sara Rosenbaum, *U.S. Health Policy in the Aftermath of Hurricane Katrina*, 295 JAMA 437 (2006).

90. Studying any of the expansions in detail reveals the absurd lengths to which Congress will go to describe the individuals to be assisted. *See, e.g.*, Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, § 2(a)(2), 114 Stat. 1381 (codified as amended at 42 U.S.C.A. § 1396a(aa)(1-4)) (providing a highly specific definition of coverage group under the benefit plan as only covering uninsured women diagnosed with breast or cervical cancer *only if* their breast or cervical cancer has been diagnosed through a cancer screening program under the Public Health Service Act, 42 U.S.C.A. § 300k(a)(1) (2000)). This type of precision can be attributed to several factors: the desire to control the estimated expansion costs in order to stay within pre-set spending limits that frequently have no real relationship to an expansion's costs, the lobbying power of certain interests, and the desire not to "crowd out" private health insurance markets, even when the notion that a robust private health insurance market exists is laughable. *See* Jeanne M. Lambrew, *Numbers Matter: A Guide*

been added in response to evidence of a lack of insurance and access to health care, as well as evidence that states would respond with additional coverage were the federal government to come to the table as a partner. Expansion of coverage for persons with disabilities can be seen as evidence of an emerging understanding on the part of federal policymakers of Medicaid's role in achieving the community integration aims of the Americans with Disabilities Act. Program expansions have made it possible for persons with disabilities to return to work without the loss of coverage and have increased the availability of community services to persons at risk for institutionalization.[91]

Compensating for Medicare's limitations. Medicare's premium and cost sharing structure leaves many low income beneficiaries unable to either properly afford or utilize the coverage to which they are entitled. Medicaid covers millions of Medicare beneficiaries whose incomes are sufficiently low to make them dually eligible. Medicaid also pays Medicare premiums, deductibles, and coinsurance for low-income Medicare beneficiaries whose incomes are too high to qualify for full coverage.[92]

In the case of Medicaid for low income Medicare beneficiaries, more than beneficence is at work. In effect, Congress has used Medicaid to compensate for Medicare's weaknesses in the areas of coverage limits and premium and cost sharing structure as applied to low income persons. Indeed, even as Congress moved to rectify Medicare's coverage limits through enactment of prescription drug coverage,[93] it simultaneously took the unprecedented step of forcing states to help pay for the benefit from savings realized as prescription drug coverage for dual enrollees was shifted from Medicare to Medicaid.[94]

Broadening the reach of health care finance through an expansion of "medical assistance." Over Medicaid's life, Congress has repeatedly expanded the definition of "medical assistance" in response to the health care needs of

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to Cost and Coverage Estimates in Health Reform Debates, 32 J.L. MED. & ETHICS 446 (2004); Judy Feder, *Crowd-out and the Politics of Health Reform*, 32 J.L. MED. & ETHICS 359 (2004).

91. Sara Rosenbaum & Joel Teitelbaum, Kaiser Comm'n on Medicaid & the Uninsured, Olmstead at Five: Assessing the Impact 17-21 (2004), *available at* http://www.kff.org/medicaid/upload/Olmstead-at-Five-Assessing-the-Impact.pdf.

92. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9403, 100 Stat. 1874, 2053 (codified as amended at 42 U.S.C.§1396a(a)(10)(E) (2000)).

93. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 103, 117 Stat. 2066, 2154 (codified at 42 U.S.C.A.§ 1396u-5(c) (West 2003 & Supp. 2005)) (establishing special provision related to the Medicare Prescription Drug Benefit).

94. 42 U.S.C.A. § 1935(b)(2) (West 2003 & Supp. 2005). As one might guess, states ardently oppose this deal as well as the elimination of federal contributions for Medicaid prescription drug payments for drugs covered under Medicare Part D. Medicaid expansion legislation for Hurricane Katrina victims introduced in September 2005 would both suspend implementation of the new benefit for dually-enrolled Medicare/Medicaid beneficiaries as well as state obligation to pay for the service. Temporary Medicaid Disaster Relief Act of 2005, H.R. 3698, 109th Cong. § 3 (2005); Hurricane Katrina Medicaid and SCHIP Relief Act of 2005, S. 1688, 109th Cong. § 3 (2005).

distinct sub-populations. Perhaps the single most far-reaching example of this Congressional response to the health needs of specific subgroups was the addition in 1967 of early and periodic screening diagnosis and treatment services (EPSDT) for children under age twenty-one.[95] This remarkable benefit, which was revised and further expanded in 1989, consists of a service bundle encompassing broad preventive health services as well as all forms of coverage recognized under the federal definition of medical assistance.[96] In other words, no form of federally defined medical assistance is optional for enrolled children, other than those whose enrollment is based on medically needy spend-down status.[97]

Other subsequent coverage reforms, such as coverage of comprehensive and voluntary family planning services[98] and federally qualified health center services,[99] served explicitly to link Medicaid coverage and financing to critical health care safety net providers for low income persons. This is particularly true in the case of federally-qualified health centers, which encompass both federally-funded community health centers as well as health centers receiving state, local, and private grant support but meeting federal standards.[100] This use of Medicaid as an express means of financing publicly-supported clinics also underscores the extent to which the program's original mainstreaming vision faltered over time and the use of Medicaid to support public systems quickly re-emerged as a viable—and in many underserved communities virtually the only—option for health care delivery.

Additional Medicaid reforms in coverage have extended the program's reach far into the system of community-based health services for persons with severe and chronic conditions requiring long-term care. Case management services,[101] respiratory care,[102] home and community based services[103] and personal care[104] have become core Medicaid financed services, with no market-based counterpart.

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95. Pub. L. 90-248, 81 Stat. 929 (codified as amended at §1396d(a)(4) (2000)).

96. *Id.*

97. The vast majority of children are eligible as categorically needy individuals who meet pre-set financial eligibility rules. Sara Rosenbaum, et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMED. L. 1, 22 (2004).

98. 42 U.S.C. § 1905(a)(4)(C) (2000).

99. *Id.* §§ 1396d(a)(2)(B)-(C).

100. *Id.* § 1396d(l)(2)(B).

101. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13603, 107 Stat. 312, 620-21 (codified as amended at 42 U.S.C. § 1396d(a)(19) (2000)).

102. Omnibus Budget and Reconciliation Act of 1986, Pub. L. No. 99-509, § 9408, 100 Stat. 1874, 2060-61 (codified as amended at 42 U.S.C. §1396d(a)(20) (2000)).

103. *Id.* § 9411, 100 Stat. 1874, 2061 (codified as amended at 42 U.S.C. §1396n(c)(1)) (2000).

104. Omnibus Budget and Reconciliation Act of 1993, Pub. L. No. 103-66, § 13601, 107 Stat. 312, 612-13 (codified as amended at 42 U.S.C. §1396d(a)(24) (2000)).

Shoring up the health care safety net. Medicaid is the source of 33-40% of the funds required to operate federally-qualified health centers[105] and public hospitals and health systems,[106] as well as nearly two-thirds of publicly financed family planning services, much of it delivered through publicly supported clinics.[107] Medicaid supports these entities through explicit coverage of their services (as in the case of "federally qualified health center services"[108]), through broad general coverage rules (as is the case with family planning services and supplies[109]), through favorable payment rules in the case of federally qualified health centers (which receive "cost-related" payments for their services (as opposed to low, flat fees unrelated to the cost of service delivery[110]), and through special supplemental allotments to hospitals serving a disproportionate number of low income and publicly insured patients.[111]

In its provisions structured to support the health care safety net through both coverage and preferred payment rules, Medicaid ironically stands as a testament to the degree to which its original goal of "mainstream care" has fallen short. To be sure, hundreds of thousands of private health professionals and health care institutions participate in Medicaid. Yet the dependence on public services remains enormous; in 2004 for example, approximately 800 federally assisted health centers served approximately 10% of all beneficiaries.[112] Whether the cause of Medicaid's mainstreaming failure is low provider payment rates, the residential segregation of the poor, or the general unwillingness of private providers to treat large numbers of low income and disproportionately minority persons—or some combination of all three—probably cannot be definitively known. In any event, Medicaid participation among "mainstream" health care providers and institutions remains low, and Medicaid revenues for medical and hospital care flow disproportionately to traditional community health systems serving the poor and underserved.

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105. Sara Rosenbaum et al., Kaiser Comm'n on Medicaid & The Uninsured, Economic Stress and the Health Care Safety Net 1 (2004), *available at* http://www.kff.org/uninsured/upload/Economic-Stress-and-the-Safety-Net-A-Health-Center-Update.pdf.

106. Marsha Regenstein & Jennifer Huang, Kaiser Comm'n on Medicaid & the Uninsured, Stresses to the Safety Net: The Public Hospital Perspective 1 (2005), *available at* http://www.kff.org/medicaid/upload/Stresses-to-the-Safety-Net.pdf.

107. Rachel Benson Gold et al., Kaiser Comm'n on Medicaid and the Uninsured & The Alan Guttmacher Inst, Medicaid: A Critical Source of Support for Family Planning in the United States 5 (2005), *available at* http://www.kff.org/womenshealth/upload/Medicaid-A-Critical-Source-of-Support-for-Family-Planning-in-the-United-States-Issue-Brief-UPDATE.pdf.

108. 42 U.S.C. §§ 1396d(a)(24)(B)-(C) (2000).

109. *Id.* § 1905(a)(4)(C).

110. *Id.* §1396.

111. *Id.* §1396a(h).

112. Rosenbaum et al., *supra* note 105, at 2, 4.

Medicaid's support for the health care safety net appears to be essential to health care access for low income populations generally. In the absence of special federal waivers, Medicaid does not provide coverage for non-disabled, working age adults without children.[113] Furthermore, other than for medical emergencies, Medicaid is unavailable to undocumented persons or recent legal immigrants.[114] Even in the case of populations who qualify for Medicaid, coverage can fluctuate wildly with changes in income or as a result of interstate movement, as in the case of migrant and seasonal farm workers and itinerant laborers, who face major barriers in a state-based program structured for long-term state residents.[115] A health care safety net remains essential for all of these persons; in view of the highly limited nature of other sources of public support, Medicaid payments have become critical to maintaining the scale of operations that make it possible to keep these hospitals and clinics functioning.

The managed care transformation of the health care system. The original Medicaid statute is a reflection of its times, grounded in a notion of fee-for-service care and free choice of providers. In the wake of the HMO Amendments of 1973,[116] Congress passed reforms aimed at allowing the development of Medicaid managed care systems.[117] In 1981, federal reforms gave states the power to mandate managed care enrollment under certain circumstances.[118] Fifteen years of state efforts to broaden use of compulsory managed care arrangements (through their federal statutory authority as well as special federal demonstration authority under §1115 of the Social Security Act, discussed at greater length in Part Two) culminated in the 1997 passage of amendments that further expanded the power to

113. *See* 42 U.S.C. § 1396 (2000) (listing eligible groups covered by Medicaid).

114. Ross & Cox, *supra* note 42, at 7.

115. *See generally* Sara Rosenbaum & Peter Shin, Kaiser Comm'n on Medicaid & the Uninsured, Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care (2005), *available at* http://www.kff.org/uninsured/7314.cfm. The impact of interstate movement on access to continuous Medicaid coverage had received little attention until Hurricane Katrina. The Centers for Medicare and Medicaid Services has suggested requiring beneficiaries' home states to remain responsible for coverage and for payment to out-of-state providers. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, KATRINA WAIVERS, *available at* http://www.cms.hhs.gov/MedicaidStWaivProg DemoPGI/07_KatrinaWaivers.asp. Some members of Congress would address portability by requiring the temporary resident state to issue a temporary in-state card, with the costs of coverage to be subsidized by the federal government. Temporary Medicaid Disaster Relief Act of 2005, H.R. 3698, 109th Cong., §§ 4, (3)(b)(c) (2005); Katrina Emergency Relief Act of 2005, S. 1637, 109th Cong. (2005) §§ 104, 103(b)(B)(C) (2005).

116. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. § 300e(a) (2000)).

117. For a history of Medicaid and managed care from 1973 through 1995, see ROSENBLATT ET AL., *supra* note 61, at 528-644.

118. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2161 (codified as amended at 42 U.S.C. § 1396n(b) (2000)).

compel managed care enrollment.[119] Medicaid managed care today parallels the use of network-style insurance coverage found in the employer-sponsored market, which condition some or all contractual coverage on use of specified provider networks.[120]

Cost containment. Finally it is important to note that cost containment has received little direct federal legislative attention in Medicaid, a reflection of policymakers' failure to come to confront health care costs generally and the law's emphasis on state design and administration. The only real intervention on Congress's part has been several attempts to limit federal exposure to program costs. In 1981, Congress enacted temporary reductions in federal contributions to state expenditures.[121] In 1996, legislation to essentially "block grant" the program as part of welfare reform, which would have placed aggregate limits on federal expenditures and explicitly terminated Medicaid as a federal legal entitlement,[122] narrowly failed only when President Clinton refused to sign a welfare reform bill containing such provisions.[123]

Over the years, Congress's main response to spiraling Medicaid costs has paralleled its response to escalating costs in the employer-sponsored market, generally: reliance on the sponsor (state governments in the case of Medicaid, employers in the case of employee health benefits) to trim spending. With the exception of Medicare (where decades of reform generally have failed to head off financial stress),[124] Congress has done virtually nothing to address the larger cost drivers in American health care; the preferred option for federal policy making has been to leave the tough task of cost containment responsibility in the hands of employers and state agencies, while trying to limit its own financial exposure. This federal non-response also has included an utter failure to help states weather Medicaid's costs during economic downturns.[125] Congress has on occasion stepped in with a temporary increase in federal financial assistance levels, in order to aid states whose own economies are under such serious stress that they cannot

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119. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 489 (codified as amended at 42 U.S.C. § 1996u-2(a) (2000)). For a thoughtful assessment of Medicaid managed care, see Sidney D. Watson, *Commercialization of Medicaid,* 45 ST. LOUIS U. L.J. 53 (2001).

120. ROSENBLATT ET AL., *supra* note 61, at 552. Of course, a key difference is that unlike their more affluent counterparts, Medicaid managed care enrollees cannot pay extra to go out-of-network. As a result, Medicaid managed care systems may offer both a floor and ceiling on health care access.

121. Omnibus Reconciliation Act of 1981, Pub L. No. 97-35, § 2161, 95 Stat. 803 (1982).

122. Welfare and Medicaid Reform Act of 1996, H.R. 3734, 104th Cong. § 1508(a) (1996). *Id.* at § 1511(a)(4)(A).

123. Rochelle L. Stanfield, *Kids on the Block*, NAT'L J., Feb. 3, 1996, at 247.

124. As of this year, reports continue to surface of dire financial straits for the Medicare program. Jonathan Weisman, *Report Emphasizes Shortfall in Medicare*, WASH. POST, March 24, 2005, at A1 (noting a report by two independent trustees that Medicare's financial outlook is "deteriorating dramatically").

125. John Holahan et al., *Which Way For Federalism and Health Policy?*, HEALTH AFF. - WEB-EXCLUSIVE W3-317, W3-324 (July 16, 2003).

meet their normal expenditure obligations.[126] These federal measures have been short-lived however, resulting in no long term change in Medicaid's financial landscape.

Despite its struggles with access and costs, Medicaid has been a remarkably successful program. Its impact on the health of the poor has been extensively documented, as has its impact on health care access.[127]

As Medicaid's importance grew, and as impact of landmark judicial rulings related to the individual enforceability of welfare rights began to be felt,[128] the courts became a central focus of interpretation of Medicaid program requirements. By the 1970s, states were actively resisting individual legal actions on grounds of sovereign immunity and the absence of enforcement rights.[129] Early congressional efforts at this time to clarify state Medicaid participation as a waiver of sovereign immunity for purposes of monetary relief were subsequently repealed,[130] but the ability of individuals to secure prospective relief through the private enforcement of federal statutory rights conferred under the program, through the use of 42 U.S.C. §1983, was definitively established in *Wilder v. Virginia Hospital Ass'n.*[131] Thus, although Medicaid contains no independent federal right of action, as in the case of other federal laws governing insurance and health benefits such as Medicare and ERISA,[132] individual enforcement of federal rights under Medicaid is achieved through the "borrowed" right of action for state violations of federal rights, which is contained in the Civil War Amendments.[133] As discussed below,

126. KENNETH FINEGOLD ET AL., URBAN INST., SOCIAL PROGRAM SPENDING AND STATE FISCAL CRISES, 11-21 (2003), *available at* http://www.urban.org/uploadedPDF/310888_OP70.pdf.

127. *See, e.g.*, KAREN DAVIS & CATHY SCHOEN, THE BROOKINGS INST., HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL 32-25 (1977) (tracing Medicaid's implementation to a decline in national infant mortality rates through improved access to pregnancy care). For an overview of Medicaid's impact on health care access, see Kaiser Comm'n on Medicaid & the Uninsured, Medicare and Medicaid, Key Statistics (2005), http://www.kff.org/medicaid/40years.cfm (attributing improvements in health care access to Medicaid program). Additionally, Medicaid has a significant impact on women's access to health care. Alina Salganicoff & Roberta Wyn, *Access to Care for Low Income Women: The Impact of Medicaid*, 10 J. HEALTH CARE FOR POOR & UNDERSERVED 453, 453-67 (1999).

128. *See* ROSENBLATT ET AL., *supra* note 61, at 422-24.

129. *E.g.*, Boaz Nursing Home Inc. v. Recovery Inns of Am., 266 So. 2d 588 (Ala. 1972) (holding that garnishee could claim sovereign immunity as agent of state in action for recoupment of Medicaid funds).

130. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 512-17 (1990).

131. *Id.* (holding that Congress did not foreclose a private judicial remedy under 42 U.S.C. § 1983).

132. *See* Sara Rosenbaum, George Wash. Univ. Ctr. for Health Servs. & Research Policy, Issue Brief #14: An Overview of Legal Developments in Managed Care Case Law and Selected Case Studies of Legal Developments in State Contracting for Managed Behavioral Health Services 2 (2001), 4 http://www.treatment.org/topics/word/Legaloverviewarticle2.doc (describing the legal actions brought by Medicaid recipients compared to ERISA and Medicare recipients).

133. *Eg.*, U.S. CONST. AMEND. XIV, § 1 ("No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny any person within its

with every ensuing year the Supreme Court and the lower courts seemingly have raised the bar on federal Medicaid enforcement litigation, and today, the right to seek individual redress for violation of statutory obligations is increasingly confined to selected program elements.

A final observation is important before turning to the current policy, political, and legal climate in which Medicaid labors to survive, and this observation has to do with program financing. Medicaid's very existence as a bulwark of the American health care system rests on a financial arrangement whose limits have become increasingly evident over decades, as states, straining under the cost of health care, have turned to important ambiguities in the law's federal payment rules in order to meet their own expenditure obligations. As the federal government has begun to resolve these federal funding ambiguities in its own favor, states' already palpable disenchantment with Medicaid has grown exponentially. Indeed, political ideology regarding entitlements for the poor may appear to lie at the heart of the latest Medicaid backlash, the current climate simply cannot be understood without considering the program's underlying financing dilemma.[134]

II. THE LEGAL AND POLITICAL LANDSCAPE OF MEDICAID REFORM IN 2005

Setting the Stage

By 2004, Medicaid had emerged as a program that, in size and cost, eclipsed any other single source of coverage (unless one treats as a single category the thousands of separate employer-sponsored health plans offered by public and private employers). Its growth in recent years has been particularly striking. Between 2000 and 2003, Medicaid expenditures increased by one-third, fueled by a combination of factors: rising health care costs that affected the public and private sectors alike; the cumulative impact of previous reforms; relatively rapid growth in enrollment among both elderly and disabled populations; enrollment growth attributable to the displacement of working-age persons and their families from private coverage as a result of the economic downturn; and states' use of

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jurisdiction the equal protection of the laws."); Timothy Stoltzfus Jost, *Health Care Rationing in the Courts: A Comparative Study*, 21 HASTINGS INT'L & COMP. L. REV. 639, 698 (1998).

134. *See* Holahan et al., *supra* note 125, *Which Way For Federalism and Health Policy?*, HEALTH AFF.- WEB-EXCLUSIVE, July 16, 2003, at W3-317, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.317v1.pdf (offering an excellent overview of Medicaid's most pressing policy problems and pointing out the fundamental flaws of the current financing arrangement). Over the 1990-2000 time period, state per capita Medicaid spending grew by 88% while real state spending net of inflation increased by only 32%. *Id.* at W3-323. Medicaid by 2002 accounted for 12% of state budgets, crowding out other essential investments. *Id.*

specific strategies aimed at meeting their state expenditure obligations in order to maximize federal payments for their health care programs.[135]

Although the rate of spending growth was already showing signs of slowing by 2004,[136] the last factor—state revenue maximization efforts—assumed increasing importance as a policy justification for program reform in a political environment poised to curb federal entitlement spending for the poor.[137] As previously noted, Medicaid growth rates coincided with a series of reports identifying state efforts to manipulate Medicaid's state expenditure requirements to create the appearance of state spending when in fact there was none.[138] This manipulation had the effect of elevating the federal share of state spending to levels well above the federal medical assistance percentage rate to which states are entitled by law.[139] States achieved this result by using the law's flexibility to generate the requisite state share of program expenditures first through special provider contributions rather than through state tax levies, as well as through local government payments. Medicaid permits states to derive up to 60% of all state expenditures through local revenues,[140] a financing structure that harkens back to the history of indigent health care as a city and county activity.[141] This provision also underscores the potential for downstreaming Medicaid costs to small units of government without the economic base to generate financial support for the program. Had local expenditures involved cash payments from municipalities, the program probably would have become quickly and obviously unworkable from a fiscal point of view. The response to this obvious structural problem came to be

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135. John Holahan & Arunabh Ghosh, *Understanding the Recent Growth in Medicaid Spending*, HEALTH AFF. W5-52 (2005).

136. *Id.*

137. It is worth noting that tax expenditures related to the exclusion of employer-paid premiums from the taxable income of working persons fortunate enough to have health insurance exceed federal Medicaid expenditures. In FY 2004, estimated federal expenditures for Medicaid stood at $172 billion. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2004-2013, at 84 (2003), *available at* http://www.cbo.gov/ftpdocs/40xx/doc4032/EntireReport_WithErrata.pdf. That year, federal tax losses for employer-sponsored premiums were estimated to surpass $188 billion, and these losses disproportionately could be attributed to the most affluent wage earners. The highest 14% of wage earners accounted for more than 26% of all tax expenditures. John Sheils and Randall Haught, *The Cost of Tax Exempt Health Benefits in 2004*, HEALTH AFF. – WEB EXCLUSIVE, Feb. 25, 2004, at W4-106, W4-108 tbl.3, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.

138. KATHRYN G. ALLEN, U.S. GEN. ACCOUNTING OFFICE, MEDICAID: INTERGOVERNMENTAL TRANSFERS HAVE FACILITATED STATE FINANCING SCHEMES 1-5 (2004), *available at* http://www.gao.gov/new.items/d04574t.pdf.

139. The GAO notes that as of 2002, federal contributions to Medicaid in the aggregate represented 57% of total program spending, with variations based on state income. *Id.* at 3. Often, state "creative financing arrangements" are due to exploitation of Medicaid's upper payment limit (UPL) regulations. *Id.* at 1.

140. 42 U.S.C. § 1396a(a)(2) (2000).

141. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (providing a historical perspective of when indigent health care was supported by local communities).

known as intergovernmental transfers (IGTs), a process that allowed states to certify the portion of local expenditures on indigent health care attributable to covered services furnished to Medicaid enrollees by qualified providers.[142] Prior to 1965 of course, the bulk of local spending on indigent health care took the form of direct investments in health care facilities such as public hospitals and clinics.[143] Thus, the IGT process, while making Medicaid affordable, also incentivized retention of public facilities, not only in order to preserve public systems capable of serving all poor persons, but also, as it turned out, to generate revenue for municipalities and states, which frequently rewarded their institutions with high paper payments and then siphoned off the funds.[144] The more Medicaid patients served, the more revenues public facilities yielded for local budgets that retained responsibility for the millions of poor persons excluded from the program, not to mention an obligation to address other local needs.[145]

State revenue maximization arrangements not only did not go away over the years, they grew bolder as the gap between Medicaid costs and state and local budgets increased. States had attempted various approaches to generating federal payments beyond the statutory levels to which they were entitled. Factors included excessive payments to state facilities, extensive use of targeted provider taxes and donations that were then recycled back to providers, excessive payments under the Medicaid disproportionate share payment system, and excessive payments to state mental facilities.[146] Another strategy for generating high federal contributions, which many states were emboldened to use as the Medicaid financial burden grew, involved an obscure federal rule known as the Upper Payment Limit (UPL) Rule.[147] The rule is designed to limit Medicaid payment levels in order to maintain alignment with Medicare;[148] at the same time, it has historically contained an exemption for public health care providers and systems operated by local units of government.[149] Using this exemption, states and counties artificially inflated

142. Kaiser Comm'n on Medicaid & the Uninsured, Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity (2005), http://www.kff.org/medicaid/upload/Medicaid-Financing-Issues-Intergovernmental-Transfers-and-Fiscal-Integrity-Fact-Sheet.pdf.

143. *See generally* STEVENS & STEVENS, *supra* note 1.

144. Robert and Rosemary Stevens vividly describe the impact of Medicaid's financing scheme on the willingness of localities to give up their separate systems with a discussion of New York's use of federal payments as a windfall to its general fund in great part to help support its "massive public hospital system." *Id.* at 98.

145. *See generally* DAVID ROUSSEAU & ANDY SCHNEIDER, KAISER COMM'N ON MEDICAID & THE UNINSURED, CURRENT ISSUES IN MEDICAID FINANCING: AN OVERVIEW OF IGTS, UPLS, AND DSH (2004), http://www.kff.org/medicaid/7071.cfm.

146. ALLEN, *supra* note 138, at 4.

147. *Id.* at 5.

148. *Id.* Ironically of course, Medicaid payments lag well behind those made by Medicare in the case of private health care providers, a fact that at least in part explains the shortage of private providers in the program.

149. ALLEN, *supra* note 138, at 6-7.

payments to county- and city-owned and operated health care providers such as nursing homes and hospitals.[150] As states received federal payments in return for their combined state and IGT expenditures, they would repay themselves and their localities.[151] However, only a portion of the funds would be passed along to the public facilities, whose budgets generated the IGT and which, in reality, frequently operated under dire financial shortfalls.[152] The Laguna Honda case offers an extravagantly horrible case. The facility, a public nursing home, was used to return millions of dollars to San Francisco while its 1400 mentally disabled residents were left to endure terrible conditions. Essentially, local public facilities were used to launder funds.

Congress attempted to close the UPL loophole in 2000, and CMS further tightened allowable payment levels to local public facilities in 2002 by regulation.[153] This strategy of over-payment from local governments violated federal law in two ways. First, states were able to meet their own expenditure obligations by putting up less than the required minimum 40% state share and by downstreaming an excessive obligation onto localities and their health care systems.[154] Second, this under-expenditure by states effectively boosted federal medical assistance payment levels above the statutory formula to which states were entitled.[155]

State manipulation of Medicaid expenditure rules of course is disturbing, not merely because of the federal payment overage such practices generate, but because the funds received were in many instances diverted away from struggling and under-funded public health care systems to other purposes that did not necessarily have anything to do with health care. But perhaps even more fundamentally, state revenue maximization efforts serve to underscore what has been obvious even to a casual observer from the outset: the Medicaid funding formula has resulted in an unworkable distribution of financial obligations, devolving too much responsibility to states, whose economies are relatively ill-equipped to withstand the punishment of rapidly rising health care costs, particularly in the care of the poorest and sickest persons.[156] States could, in turn, further devolve their obligations to cities and counties, which ultimately had nowhere to turn for their obligations but their own struggling health care systems.

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150. *Id.*

151. *Id.* at 5-7.

152. *Id.* For a truly depressing look at one particularly distressing revenue maximization arrangement, read the decisions connected with the HHS Office of Civil Rights investigation into the nursing home. http://www.usdoj.gov/crt/split/documents/laguna_honda_hosp.pdf (Letter to San Francisco City Attorney); http://www.justice.gov/crt/split/documents/laguna_honda_findlet_aug3.pdf (Letter to Governor Schwarzenegger).

153. ALLEN, *supra* note 138, at 4.

154. *Id.* at 7.

155. *Id.* at 10-12.

156. Holahan et al., *supra* note 125, at W3-331.

Local governments could, of course, close their hospitals and clinics; indeed, many have done so over the past four decades because of the difficulty of sustaining health care providers for the poor, even with Medicaid's financial contributions.[157] But many attempted to maintain their health services, while simultaneously using their local health care budgets to meet their Medicaid obligations through the IGT process. In many cases, states employed the special federal demonstration process under §1115 of the Social Security Act, which permits the Secretary to waive federal Medicaid statutory requirements in order to conduct demonstrations,[158] in order to create Medicaid financing arrangements that favor public facilities and restrict or steer Medicaid beneficiaries to managed care systems built on these facilities. The need to shore up large public hospital systems lies at the heart of some of the nation's most prominent §1115 Medicaid reform demonstrations, such as those found in Massachusetts, New York, and California, which struggled to sustain their public health networks in order to meet extensive need among low-income publicly insured and uninsured persons.[159]

In sum, the weak financial base on which Medicaid rests inevitably has led to enormous problems: an undermining of a central program goal of mainstreaming as a result of the pressure to save local health care systems in order to maintain

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157. *See* Sarah Webster, *Care Suffers, More Die in Wake of Health Cuts; Closings Give Detroit Poor Few Options*, DETROIT NEWS, June 25, 2000, at 1A (citing cutbacks in funding as reason for faltering health care programs for poor and uninsured patients); Laurie Abraham, *Summit Tackles Chicago's Crumbling Health System*, THE CHICAGO REPORTER, April 1990 (attributing hospital closings in poor Chicago communities to low Medicaid rates).

158. For a discussion of section 1115, see Sara Rosenbaum, *Mothers and Children Last: The Oregon Medicaid Experiment*, 18 AM. J.L. & MED. 97, 110-17 (1992); Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545 (1995); Samantha Artiga & Cindy Mann, Kaiser Comm'n on Medicaid & the Uninsured, New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity (2005), http://www.kff.org/medicaid/upload/New-Directions-for-Medicaid-Section-1115-Waivers-Policy-Implications-of-Recent-Waiver-Activity-Policy-Brief.pdf. For an excellent analysis of the impact of Section 1115 on the basic protections afforded beneficiaries under Medicaid, see Jonathan R. Bolton, *The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of 1115 Waivers to Restructure the Medicaid Program*, 37 COLUM. J.L. & SOC. PROBS. 91 (2003).

159. The Centers for Medicare and Medicaid Services does not make these negotiations public, but persons involved in waiver negotiations in states with large public hospital systems explicitly point to the need to save public hospital systems as the core issue in waiver negotiations. The most striking example of the willingness of states to agree to sweeping terms in order to maintain Medicaid demonstration programs that favor public hospital payments may be the CMS renewal of the California demonstration during the summer of 2005, which explicitly conditioned the continued waiver on the state's agreement to force more than a half million Medicaid recipients with severe disabilities into compulsory managed care arrangements. (CMS did not have to push the state too hard; Governor Schwarzenegger in fact had sought just such a change as part of his own budget proposals.) The legislature slowed down the deal in September 2005, finding other funds for the hospitals and in all likelihood forfeited federal payments as a result, but the demonstration is expected to move forward in 2006. Sara Rosenbaum et al., The California Endowment, Achieving "Readiness" in Medi-Cal's Managed Care Expansion for Persons with Disabilities: Issues and Process (2005), http://www.calendow.org/reference/publications/pdf/npolicy/TCE0930-2005_Achieving_Read.pdf.

some semblance of access for the uninsured poor; an undermining of federal confidence in the integrity of state programs; and desperate state unhappiness with legal health care entitlements for the poor because of their impact on state and local budgets. All of these problems in turn further served to legitimize the antipathy toward the program on the part of persons who are simply ideologically opposed to entitlements for low income persons. The problems associated with Medicaid financing "scandals" have served to feed Medicaid's image as a bloated entitlement and a source of seemingly endless financial fraud; this imagery in turn helped obscure a totally alternative theory, namely, that Medicaid is an essential program in great need of modernization with respect to whom it covers and how it is financed. Today half the poor still are ineligible for Medicaid simply because they do not fall into a federally recognized coverage category.[160] Health services that should be part of every state's program, such as community living arrangements for children and adults with physical and mental disabilities, are frequently sorely lacking. Reforms aimed at supporting states grappling with the problem of countercyclical need are nowhere in evidence. Despite these shortfalls in coverage and federal financial support, the legislative proposals that emerged in 2005 all focused on reducing federal payments and permitting states greater latitude to reduce their programs.[161]

The welling opposition to Medicaid—from federal policymakers ardently opposed to legal entitlements and incensed over the IGT incidents, and from state policymakers unwilling to continue to support Medicaid without fundamental changes in the program's financing arrangement—fueled increasingly anti-Medicaid rhetoric. A Google search combining the terms "Medicaid" and "unsustainable" turned up 33,700 hits as of September 3, 2005.[162] A comparable search linking "Medicaid" and "scam" turned up 832,000 hits.[163] State governors

160. STAN DORN, ECONOMIC & SOCIAL RESEARCH INST., MEDICAID COVERAGE FOR POOR ADULTS: A POTENTIAL BUILDING BLOCK FOR BIPARTISAN HEALTH REFORM 7 (2004); *see* AMY DAVIDOFF ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH COVERAGE FOR LOW-INCOME ADULTS: ELIGIBILITY AND ENROLLMENT IN MEDICAID AND STATE PROGRAMS (2005), http://www.kff.org/uninsured/upload/Health-Coverage-for-Low-Income-Adults-Eligibility-and-Enrollment-in-Medicaid-and-State-Programs-2002-Policy-Brief.pdf (noting that "adults without dependent children are generally precluded from Medicaid coverage, unless pregnant or disabled").

161. Temporary expanded Medicaid relief for Hurricane Katrina victims notwithstanding, some lawmakers were insisting when they returned from August 2005 recess that they could reduce Medicaid spending even as they extended coverage to those with disaster-related needs. Emily Heil, *Moderates Hold Medicaid Key*, CONGRESSDAILYAM, Oct. 18, 2005, *available at* http://nationaljournal.com/members/news/2005/hilloutlook/medicaid.htm.

162. Search conducted by the author. http://www.google.com/search?hl=en&q=Medicaid+and+unsustainable&btnG=Google+Search (Sept. 3, 2005).

163. Search conducted by the author. http://www.google.com/search?hl=en&lr=&q=Medicaid+and+scam&btnG=Search (Sept. 3, 2005). It should be noted that a Google search of Medicaid and "safety net" turns up 655,000 hits. http://www.google.com/search?hl=en&lr=&q=Medicaid+and+safety+net&btnG=Search (Sept. 3, 2005).

and legislatures, faced with the potential loss of flexibility over how state expenditures, and thus federal payments, would be calculated as well as the financial impact of the Medicare "clawback" provisions related to the new Part D benefit,[164] inevitably sought to shield themselves against financial catastrophe by calling for a significant rollback in the program.[165]

Visions of Reform

By September 2005, two schools of thought had emerged regarding Medicaid reform: the first reflected Bush Administration priorities, while the second mirrored the view of state officials. The two positions bore some similarity, but they also underscored the fundamental differences that flow from the federalism-driven political schism that has characterized the program.

The Bush Administration

The essential thrust of the Administration's proposals involved curbing federal financial support, accompanied by a relaxation of requirements, in particular where coverage design was concerned. This essential thrust can also be seen in federal Medicaid demonstrations approved by the Administration officials acting under the broad powers bestowed by §1115 of the Social Security Act.

The legislative front. The principal legislative proposals advanced by the Administration employed a variety of strategies to limit federal exposure to Medicaid program costs, as well as constrain states in their ability to generate revenues to support state expenditures that would in turn obligate federal payment. Thus, for example, the Administration proposed to further limit state authority to generate Medicaid expenditure revenues through broad-based health care provider taxes, a common source of financing for indigent health care programs.[166] The proposal would tighten already existing limits on state taxing authority enacted in 1990.[167]

The Administration also proposed far reaching reforms aimed at curtailing state incentives to support safety net providers. This recommendation took the form of a proposal to disallow state Medicaid payments to public providers. The

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164. *See* discussion *infra* note 226 and accompanying text.

165. THE KAISER FAMILY FOUND., KAISER NETWORK, *Daily Health Policy Report* (July 18, 2005), at http://www.kaisernetwork.org/daily_reports/rep_hpolicy_recent_rep.cfm?dr_cat=3&show=yes&dr_DateTime=07-18-05#31443.

166. On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005, which cut state Medicaid spending through 2011. Peter Baker, *Medicaid, Medicare Growth to Slow; Bush Signs Republican Spending Bill, Citing 'Fiscal Sanity,'* WASH. POST, Feb. 9, 2006, at A4. Furthermore, one of the landmark ERISA cases focuses on whether or not ERISA preempts just such a state tax. N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

167. 42 U.S.C. §1396a(o) (2000).

immediate impact of this change would have disincentivized money laundering through public health care systems.[168] On a longer term basis, the proposal, which received no hearing, could have disincentiviezed state investment in public systems generally, at least in states in which public support derived purely from these systems' role in state economies. On the surface the proposal could be viewed as an effort to avert more Laguna Hondas.[169] In the long term, however, the impact of the proposal could have been the further destabilization of public facilities.

The Administration also proposed to significantly narrow the range of benefits and services for which public providers (as well as other providers) would be able to generate federal contributions, especially in the case of seriously and chronically ill children and adults. The proposal sought to achieve this end through indirect means, by narrowing the definition of rehabilitation services and case management services, which are optional for adults and required for children under EPSDT.[170] Federal law defines "case management" as a form of medical assistance, whose purpose is to assist eligible individuals to obtain necessary medical, social, educational, and other services,[171] while rehabilitation services encompass services that assist individuals to regain functioning.[172] The Administration proposed to disallow federal medical assistance payments for rehabilitation and case management services when the service is also an "intrinsic element" of another program.[173] This change, if adopted, potentially could lead to the ultimate withdrawal of large amounts of federal payments to public agencies and public and private provider systems responsible for the care and management of Medicaid-enrolled special needs children and adults. In effect, the Administration's proposal would have withdrawn federal Medicaid funds in the case of chronically ill children and adults served by multiple federal social welfare programs with shared missions, even though these other programs have been structured to rely on Medicaid for the financing of health care services. Particularly at risk were other programs essential to state social service infrastructure: child welfare programs; programs that arrange for special education services for children with educationally related needs under the Individuals with Disabilities Education Act; and programs for adults with mental illness, mental retardation, and developmental disabilities. All of these programs share Medicaid's mission of case management and rehabilitation where persons with disabilities are concerned; as a result, the Administration's "mission" definition for

168. *Id.*

169. *See* Letter to San Francisco City Attorney, *supra* note 152.

170. 42 U.S.C.A. § 1396d(r) (West 2003 & Supp. 2005)

171. *Id.* § 1396n(g)(2).

172. 42 C.F.R. § 440.130(d) (2005).

173. New Freedom Initiative Medicaid Demonstrations Act of 2005 (proposed), http://www.cms.hhs.gov/faca/mc/Medicaid_Pharmacy_Payments.pdf.

this new payment exclusion potentially would result in a dramatic downturn in Medicaid's role in social welfare financing. As of August 2005, the Congressional Budget Office (CBO), which develops cost estimates for Congress to use when it deliberates changes in federal tax and spending policies, was unable to develop a reliable cost estimate for the change because of its ambiguity and magnitude. Finally, the Administration proposed to place aggregate limits on federal administrative payments to states in order to eliminate the state entitlement to assistance in financing Medicaid administration.[174]

None of these proposals was publicly deliberated in Congressional hearings. Furthermore, nowhere in its proposals did the Administration place its proposals in the context of the Medicare Modernization Act, which imposes major obligations on states and requires their financial support for program benefits.

In sum, the central thrust of the Administration's policy recommendations focused on reducing federal outlays and curbing states' ability to generate federal Medicaid revenues to support indigent care activities. As has been the case with past reform proposals offered by the Reagan Administration in 1981 and a Republican-controlled Congress in 1995, the current Administration effectively sought the freedom to walk away from—as well as new curbs on states' ability to rely on—Medicaid.

Section 1115 demonstrations. The Administration's proposals occurred simultaneously with a strategy of constraining federal cost exposure through the use of §1115. The §1115 process is a longstanding tool for reforming Medicaid. It was used sporadically during the 1970s and 1980s, but came into vogue under the Clinton Administration as a means of spurring Medicaid coverage for otherwise ineligible low income persons[175] and expanding the use of compulsory managed care systems for families with children prior to 1997, when compulsory emrollment was authorized as a state plan option.[176] The Bush administration has made particularly aggressive use of its demonstration authority, using this authority as well as §1115's budget neutrality requirement to secure deep financial concessions from states to operate their programs under aggregate funding limits in order to gain freedom from federal constraints.[177]

174. CALIFORNIA HEALTHLINE, *Bush Administration Sends Congress Draft Medicaid Reform Legislation*, Aug. 11, 2005, http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=113287.

175. Sara Rosenbaum, *Health Policy Report: Medicaid*, 346 NEW ENG. J. MED. 635, 639 (2002).

176. *See supra* note 125 and accompanying text.

177. Artiga & Mann, *supra* note 158, at 7.

The States

For their part, the governors, who generally are recognized as the leading state lawmakers on the subject of Medicaid,[178] adopted a distinctly different approach to Medicaid reform. Not surprisingly, the governors did not echo the Administration's recommendations for limitations on either federal Medicaid payments or state taxing authority to generate state expenditures. States' legislative proposals called for broad authority to redesign coverage standards for optional beneficiary categories along with significantly greater use of cost sharing. Indeed, state officials sought to maintain at least the existing level of federal/state financial relationship while simultaneously relaxing federal benefit mandates, coverage standards, and cost-sharing rules.[179] In effect, the governors sought the financial wherewithal to maintain Medicaid but as a program that, for certain populations, resembled private insurance in design and market thrust, except for beneficiary subgroups—selected at state option—who in the judgment of states, merited deeper coverage. The concept of discrimination in coverage design, long a structural feature of the commercial market, was laid squarely on the table.

The governors' proposal took aim at many of the basic dimensions of Medicaid described in Part Two, primarily in their application to optional enrolled beneficiary population groups. For optional populations, the governors call for the elimination of both comparability and statewideness.[180] They also sought the authority to replace the defined benefits that currently comprise Medicaid coverage with a form of "premium support" that would provide beneficiaries with a premium for "benchmark" coverage to be defined by the state.[181] Rather than mandated benefits subject to rules of reasonableness and non-discrimination, coverage would be in the form of "premium support" for a coverage "benchmark" to be set by the states.[182] For optional populations, required comprehensive benefits such as EPSDT would be eliminated in favor of a premium support approach. In other words, persons other than those for whom coverage is mandatory would have seen a defined benefit with modest cost sharing replaced by a premium support system. In the case of mandatory coverage groups, furthermore, the governors called for flexibility to use this same premium support approach for benefits considered "optional."[183]

Finally, the governors also sought "judicial reform," stating as follows:

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178. While the National Conference of State Legislatures also has an articulated Medicaid position, it is the NGA which is typically seen as the major negotiator of state policy in Washington.

179. NAT'L GOVERNORS ASS'N, SHORT-RUN MEDICAID REFORM 4 (2005), http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF (articulating the NGA's Medicaid reform position).

180. *Id.* at 6.

181. *Id.* at 7.

182. *Id.*

183. *Id.*

> The right of states to locally manage the optional Medicaid categories is clearly defined in policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. Also, U.S. Department of Health and Human Services officials should have to stand by states when one of their [§1115] waivers or state plans is questioned in the judicial system and should work with states to define for the judiciary system that any state has a fundamental right to make basic operating decisions about optional categories of the program.[184]

This passage effectively demanded a diminution of benefit and coverage rights not only as a means of controlling program costs but also as a deeper strategy for shielding states from enforcement actions. In addition, the governors implicitly endorsed legislation introduced in the 109th Congress by Tennessee Senator Lamar Alexander, whose state has been embroiled in Medicaid enforcement litigation for years as a result of a controversial Section 1115 demonstration known as Tenncare.[185] The Lamar bill proposed to curb the power of federal courts to enter and maintain consent decrees in federal rights litigation.[186] In sum, the governors sought both design flexibility and a statutory restructuring that would ultimately shield states against judicial enforcement of coverage rights.

In the context of enforceability, it would appear that the judiciary is rapidly moving away from Medicaid enforceability rights on its own. The decades-long judicial "backstory" to Medicaid has, over a number of years, grown increasingly attenuated as a result of an progressively more restrictive interpretation by the courts of which provisions of Medicaid enforceable rights. Following its landmark decisions in *Wilder v. Virginia Hospital Association*, which clarified the applicability of 42 U.S.C. § 1983 to federal actions to enforce Medicaid rights,[187] the Court has grown increasingly hardened in the tests that it imposes in measuring when a right may be said to exist.[188] As the mountains that private litigants have

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184. *Id.* at 9.

185. The program's constant turmoil was intensified in 2004 when Governor Bredesen called for the elimination of over 300,000 enrollees and a dramatic curtailment of coverage, including the use of a medical necessity definition that effectively leaves the state free to deny any coverage for which no "scientific" evidence of efficacy exists. SCHNEIDER ET AL., *supra* note 40, at 61-62.

186. This legislation would put term limits on federal court consent decrees and cause them to be more narrowly drawn, thereby putting Medicaid issues back in the hands of state officials. Federal Consent Decree Fairness Act, S. 489, 109th Cong. §§ 2-3 (2005) (finding that "consent decrees should be structured to give due deference to the policy judgments of State and local officials as to how to obey the law").

187. 496 U.S. 498, at 513 (holding that there is a binding obligation on states to adopt "reasonable and adequate rates," enforceable by health care providers under 42 U.S.C. § 1983).

188. Gonzaga Univ. v. Doe, 536 U.S. 273, 276 (2002) (limiting the circumstances under which a § 1983 action may be brought to those where statute explicitly creates such a right); *see* Sanchez v.

had to scale have grown ever higher, the lower courts have, with growing frequency, concluded that key elements of the Medicaid statute previously considered privately enforceable no longer meet the current test.

In August 2005, the United States Court of Appeals for the Ninth Circuit ruled in *Sanchez v. Johnson,*[189] that certain private litigants could not enforce the Medicaid "equal access" provision. In its ruling, the court not only reviewed the similar evolution of equal access litigation in other circuits, but also surveyed enforceability generally in the wake of the Supreme Court's pronouncements in *Gonzaga University v. Doe*[190] and concluded that *Wilder* could perhaps best be thought of as an "aberration" in the line of decisions dealing with services and benefits conferred under federal spending clause statutes.[191] Thus, the governors' demand for a fundamental redefinition of coverage rights coincided with a shifting judicial landscape.

The Deficit Reduction Act of 2005

Signed into law in February 2006,[192] the Deficit Reduction Act of 2005[193] (DRA) marks a new chapter in the life of the Medicaid program by introducing certain fundamental changes into program design; these changes in turn hold the potential for a far-reaching re-formulation of the rules of coverage and state plan administration and, as a result, legal duties and rights. The Medicaid amendments achieve over $28 billion in estimated 10-year net savings.[194] Although this figure is modest from a financial viewpoint when compared to projected Medicaid outlays of $3 trillion over the 2007-2016 time period,[195] the legal changes that contribute to these savings carry implications that extend beyond the types of effects that financial savings alone might have produced. Indeed, the DRA presents

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Johnson, 416 F.3d 1051, 1056-62 (9th Cir. 2005) (documenting the evolution of the § 1983 legal theory).

189. 416 F.3d at 1056-62.

190. 536 U.S. at 273.

191. *Sanchez,* 416 F.3d at 1056-62.

192. The budget reconciliation measure reported by the Finance Committee and passed by the Senate contained modest changes in Medicaid and SCHIP, with savings of slightly more than $4 billion over five years. CONG. BUDGET OFFICE, ESTIMATED BUDGETARY IMPACT OF S. 1932, THE DEFICIT OMNIBUS RECONCILIATION ACT OF 2005, *available at* http://www.cbo.gov/showdoc.cfm?index=6886&sequence=0. Required savings under reconciliation instructions related to the FY 2006 budget would instead have been achieved through Medicare reductions aimed at Medicare Advantage plans (managed care plans participating in Medicare) as well as other changes related to provider payments. Deficit Reduction Act of 2005, S. 1932, 109th Cong. (2005).

193. Pub. L. No. 109-171, 120 Stat. 4 (2006) (to be codified in scattered sections of the U.S.C.).

194. CONG. BUDGET OFFICE, COST ESTIMATE, S. 1932, DEFICIT REDUCTION ACT OF 2005 36, t. 15 (2006) [hereinafter CBO COST ESTIMATE], *available at* http://www.cbo.gov/showdoc.cfm?index=7028&sequence=0.

195. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: 2007-2016, t. 3.3 (2006), *available at* http://www.cbo.gov/showdoc.cfm?index=7027&sequence=0.

one of those legislative situations in which dollar calculations do an injustice to the nature of the financial reform under consideration; ironically, in fact, certain amendments that on their face appear to be the most far-reaching also carry CBO cost-estimates that would seem absurdly low on their face.[196] To illustrate how dollar savings can be misleading, consider that Congress could have achieved the same 10-year savings by simply enacting a fractional reduction in federal contribution levels to state Medicaid programs over a 10-year time period. Such an approach, identical to one taken in 1981,[197] could have produced the requisite financial contribution to deficit reduction without altering program structure. But twenty-five years later, in an age of dramatically altered public policy visions regarding the role of government in the lives of the poor and medically vulnerable, such an approach would have been philosophically and politically unthinkable.

The DRA reforms were the result of a bitter legislative battle over the future of Medicaid. The fight began with a battle over whether to include any Medicaid savings at all into the FY 2006 federal budget blueprint or instead defer to a Congressionally appointed commission (the cuts were included, the commission was not).[198] The battle continued with a decision by the administration to appoint a commission of its own, headed by HHS Secretary Michael Leavitt, whose recommendations,[199] along with those offered by the nation's governors,[200] included calls for significant reforms in coverage and cost sharing (the governors' recommendations actually surpassed those offered by the Medicaid Commission). The fight culminated with enactment of the DRA, which was controversial

196. For example, the Congressional Budget Office estimates that changes related to citizenship proof changes would save $735 million over 10 years and result in the removal of only about 35,000 persons. *Id.* An estimate by the Center on Budget and Policy Priorities however, which is based on actual data gleaned from a telephone survey of beneficiaries, concluded that the changes would lead to the elimination of as many as 5 million children and adults who lack citizenship proof.

197. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97- 35, § 2301, 95 Stat. 357. The reductions were repealed three years later.

198. Revising the concurrent resolution on the budget for fiscal year 2006, H.R. Con. Res. 214, 109th Cong. (2005).

199. The Medicaid Commission, popularly known as the Leavitt Commission, resulted from Congressional Medicaid budget negotiations as part of the first Budget Resolution for FY 2006. THE KAISER FAMILY FOUND., KAISER NETWORK, *Daily Health Policy Report* (May 23, 2005), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=30259. The Commission had controversial roots, formed by HHS after the Senate's efforts to delay any Medicaid cuts until a Congressionally appointed commission had studied the program and reported to Congress was rebuffed in conference. *Id.* The Commission released a report on September 2, 2005, calling for certain changes in beneficiary cost sharing, nursing home asset transfer policies, and prescription drug pricing. As of March 16, 2006, the Centers for Medicare and Medicaid Services had relocated the report to an undisclosed website location. http://www.cms.hhs.gov/faca/mc/090105rpt.pdf. A summary of the report can be viewed at THE KAISER FAMILY FOUND., KAISER NETWORK, *Daily Health Policy Report* (Sept. 2, 2005), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID= 32380.

200. The NGA position statement on Medicaid can be found at http://www.nga.org/portal/site/nga/menuitem.8358ec82f5b198d18a278110501010a0/?vgnextoid=e5ff0640e8e34010VgnVCM1000001a01010aRCRD (last visited Apr. 2, 2006).

virtually in its entirety,[201] and whose enactment spilled over into 2006. With respect to Medicaid, the final legislation goes well beyond changes recommended by either the governors or the commission.

A full examination of the Medicaid provisions in the DRA is beyond the scope of this article; indeed, many may prove to be subject matter for lengthy articles in their own right. The focus here instead is on provisions that directly reduce eligibility as well as the nature, structure, and extent of coverage among eligible and enrolled persons. Several important amendments are excluded: expanded state options to liberalize eligibility and/or coverage rules for certain children and adults with disabilities,[202] revision in payment methods for the outpatient prescription drugs,[203] limitations and exclusions on federal payments to states for certain administration and medical assistance services for children and adults with special health care needs (especially children in foster care placements),[204] changes in federal standards governing the prevention of fraud and abuse,[205] "Health Opportunity Account" reforms to encourage state demonstrations establishing "health savings account"-type insurance for Medicaid beneficiaries comprised of high deductible plans linked to health savings accounts,[206] and other amendments related to federal funding and state program administration.[207]

Many of these statutory changes carry substantial cost estimates (for example, the prescription drug amendments alone account for more than $12.5 billion of the net 10-year savings).[208] But it is the reductions directly affecting eligibility and coverage that proved to be the most controversial and that carry the most immediate and powerful implications for affected beneficiaries. Indeed, the DRA achieves nearly $11 billion of total net estimated Medicaid 10-year savings—more than a third of the total—through changes explicitly aimed at removing individuals from the rolls or reducing benefits and coverage.[209] Yet even as the ramifications of some of the most legally significant provisions become clearer, the Act's provisions aimed at program performance for children and adults with severe

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201. Robert Pear, *Domestic Spending Squeezed Throughout the Government*, N.Y. TIMES, Feb. 7, 2006, at A14.

202. DRA §§ 6062-71.

203. *Id.* §§ 6001-63.

204. *Id.* § 6052.

205. *Id.* § 6034.

206. *Id.* § 6082.

207. *Id.* §§ 6001-202 represent all amendments to Medicaid, including both changes to the statute as well as "outside the quotes" revisions to Medicaid operations at the federal level. An example of such "outside the quotes" changes that affect federal Medicaid operations but do not make permanent changes in the statute is Subtitle C of Title VI, related to special Medicaid payments to locales affected by Hurricane Katrina. For a discussion of Medicaid policy and Hurricane Katrina, see Sara Rosenbaum, *U.S. Health Policy in the Aftermath of Hurricane Katrina*, 295 JAMA 437 (2006).

208. CBO COST ESTIMATE, supra note 194, at t. 15.

209. *Id.*

disabilities offer at least a faint outline of an emerging consensus regarding Medicaid's structural importance in developing and supporting community-based systems of care for persons with disabilities.

Reductions in eligibility

Written proof of citizenship

Medicaid eligibility hinges a series of criteria, one of which is citizenship or legal residency satisfying a minimum durational test.[210] Prior to the DRA, federal law required no written proof of citizenship at the time of application or redetermination, although legal residents were required to submit written proof of legal status.[211] Citizenship was verified simply through oral affirmation.

The DRA modifies current law by requiring individuals seeking Medicaid coverage to furnish written proof of citizenship in the case of individuals other than dual Medicare/Medicaid enrollees, recipients of Supplemental Security Income, and others granted an exemption by the Secretary.[212] At least one analysis based on actual interviews with beneficiaries concludes that this change alone will result in an estimated loss of between 3 and 5 million children and adults because of a pervasive lack of written documentation of citizenship and a financial inability to secure required proof. It is not possible to know whether states will cover the cost of securing documentation as a program administration cost or even whether the Centers for Medicare and Medicaid Services will permit it. The citizenship requirements take effect for calendar quarters beginning on July 1, 2006, and the requirements are applicable at both the initial eligibility determination and redetermination stages.[213] Thus, rather than being applied on a going-forward basis, the new proof requirement applies to current beneficiaries as they reach their date of eligibility redetermination for continued assistance.[214] In recent years, states have attempted to streamline the application, eligibility determination, and redetermination processes by reducing paperwork submission requirements and permitting "passive redetermination" for certain population groups (i.e.,

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210. CENTERS FOR MEDICARE & MEDICAID SERVICES, STATE MEDICAID MANUAL §§ 3210-3256, *available at* http://www.cms.hhs.gov/Manuals/ (last visited Apr. 4, 2006). Otherwise eligible undocumented persons and legal residents who entered the country within the past seven years are eligible for emergency coverage only. For an excellent overview of Medicaid eligibility, see SCHNEIDER ET AL., supra note 40, at Ch. 1.

211. LEIGHTON KU ET AL., CTR. ON BUDGET AND POL'Y PRIORITIES, SURVEY INDICATES BUDGET RECONCILIATION BILL JEOPARDIZES MEDICAID COVERAGE FOR 3 TO 5 MILLION U.S. CITIZENS (Feb. 17, 2006), http://www.cbpp.org/1-26-06health.pdf.

212. DRA § 6037 (to amend 42 U.S.C. §1396b).

213. *Id.* § 6036 (to amend section 1903 of the Social Security Act, 42 U.S.C. 1396(b)(i)).

214. Medicaid eligibility is both need-based and tied to the ability to satisfy certain categorical status attributes (e.g., pregnancy, disability). As a result, states are required to periodically redetermine eligibility, at least every twelve months. 42 C.F.R. § 435.916.

continuation of enrollment upon affirmation that no changes have occurred).[215] The citizenship proof requirements would appear to have an enormous impact on such systems.

Expanded eligibility prohibitions linked to asset transfers

Prior to the DRA, federal Medicaid law provided for the disqualification of individuals who transferred assets for less than fair market value; the period of disqualification could be as long as thirty-six months and commenced on the date of the asset transfer.[216] The disqualification applied primarily to elderly persons who transferred assets (or, more accurately probably, to people whose adult relatives relieved them of their assets) for less than fair market value in order to qualify for long term care assistance, either in institutions or in community settings under so-called "home and community based care waivers.[217] Studies of elderly persons at risk for long term care suggest that few in fact possess assets of any significant value,[218] although one of the more commonly told fables in Washington Medicaid policy circles is a tale of millionaires who give away their property in order to qualify for Medicaid-financed long term care.[219]

The DRA makes numerous changes in asset valuation and penalty rules as well as in methodologies for calculating penalty periods. Most significantly perhaps, the legislation lengthens the period of disqualification to sixty months, a change that by itself is serious but perhaps not profoundly worse in terms of "real-world" impact than the already-existing thirty-six-month disqualification period. In addition however, the DRA re-classifies the period of disqualification as commencing *either* from the date of the transfer *or* from the date on which eligibility otherwise would begin, whichever occurs later.[220] Thus, an individual whose assets were transferred sixty-five months prior to the date of application (and thus outside of the new, lengthened transfer window) nonetheless still would

215. For a discussion of enrollment simplification, see DONNA COHEN ROSS AND LAURA COX, KAISER COMM'N ON MEDICAID & THE UNINSURED, MAKING IT SIMPLE (2000), *available at* http://www.kff.org/medicaid/2191-index.cfm.

216. 42 U.S.C. §1396p (discussed in CCH Medicare/Medicaid Guide, ¶14,311).

217. *Id.*

218. Evidence regarding the limited number of individuals with significant assets to transfer holdings to qualify for Medicaid can be found in KAISER COMM'N ON MEDICAID & THE UNINSURED, FRONTLINE PERSPECTIVES ON LONG-TERM CARE FINANCING DECISIONS AND MEDICAID ASSETS (Feb. 2006) [hereinafter FRONTLINE PERSPECTIVES], http://www.kff.org/medicaid/7458.cfm.

219. Anyone who has spent any amount of time in a Medicaid-participating long term care facility (many of the best facilities do not participate in Medicaid or severely limit their participation to individuals who converted from private pay patients) quickly would know just how apocryphal such a story is. But there was just enough anecdotal evidence of Medicaid's use as an estate planning device to lend credibility to the claims and to support legislation carrying severe penalties. See the discussion of estate planning and Medicaid in FRONTLINE PERSPECTIVES, *supra* note 218.

220. 42 U.S.C. §§ 1396p(c)(1)(B)(i) & 1396p(c)(1)(D) (as amended by DRA §6011).

face a period of exclusion commencing on the date of eligibility. The DRA places the burden of proof on the individual to demonstrate a level of "hardship"[221] sufficient to overcome the disqualification period.

Reductions in coverage and out-of-pocket payment protections

"Benchmark" coverage

In what may be the most far-reaching change from a structural and legal perspective, the DRA gives states the option to alter the definition of medical assistance for certain population groups, specifically low income children and their parents.[222] The legislation adds a new section to the Medicaid statute, which provides in pertinent part as follows:

> Sec. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—
>
> (I) AUTHORITY.—
>
> (A) IN GENERAL.— Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals specified by the State through enrollment in coverage that provides—
>
> (i) benchmark coverage . . . or benchmark equivalent coverage . . . ; and
>
> (ii) for any child under 19 years of age who is covered under the State plan . . . , wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).[223]

Translated into understandable terms, this section authorizes, for affected children and adults, a shift from the "defined benefit" approach to coverage that historically has characterized Medicaid to a "defined contribution" system under which a state program would pay premium support for a coverage product, with almost no specifications regarding the terms of coverage. Significantly, this new flexibility in coverage design applies to currently eligible populations but not to new populations whom states might add to their state plans, although at a reduced level of coverage.[224] In other words, states can use their new flexibility to reduce, but not expand, coverage.

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221. *Id.*

222. §1937(a)(2) of the Social Security Act (as added by §6044 of the DRA).

223. §1937 (a)(1) of the Social Security Act (as added by § 6044 of the DRA).

224. §1937(a)(1)(B) of the Social Security Act (as added by §6044 of the DRA).

The shift in benefit design has the potential to affect not only the structure of Medicaid but the nature of the entitlement itself. Under a defined benefit approach, the entitlement consists of an entitlement to coverage encompassing a broad array of specified benefits; indeed, the detailed nature of benefit specification is such that much of the Medicaid litigation that has taken place over the past four decades has focused on the enforcement of federal coverage rights in terms of benefit class and amount, duration, and scope.[225]

A premium support approach, on the other hand, entitles individuals to, at most, a defined contribution toward health coverage, with almost total discretion over actual benefit design left to insurer discretion rather than legally enforceable standards; under this approach, legal provisions related to enumerated benefits and tests of reasonableness would no longer apply. The Medicare Part D outpatient prescription drug program represents a version of this defined contribution, premium support approach to coverage, entitling eligible persons to subsidized enrollment in plans rather than defined drug benefits. [226]

The DRA applies this approach to Medicaid, permitting states as a matter of routine program design and administration to eliminate specific coverage rights for certain classes of beneficiaries, specifically low income children and their parents. For these two populations states could substitute a contribution toward coverage meeting "benchmark" or "benchmark equivalency" standards.[227] Benchmark equivalency, which represents the coverage floor under the law, consists in its entirety of inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, and "well-baby and well-child" care (undefined), including age-appropriate immunizations.[228] This standard is identical to that used in the State Health Insurance Program (SCHIP)[229] program, which furnishes premium support assistance to certain low income but Medicaid-ineligible children.[230]

The one notable limitation on coverage discretion in benchmark states is the requirement that benchmark states furnish children under nineteen with enrollment in coverage that "provides for wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r)." Legislative history concurrent to final passage, including the conference agreement,[231] CBO cost estimates accompanying the final legislation[232] and statements issued by the

225. *See* Jost, *supra* note 17, at 32; ROSENBLATT ET AL., *supra* note 61, at 410-66.

226. 42 U.S.C. § 1860D-1(a) (2000).

227. *Id.* § 1937(a)(1).

228. *Id.* § 1937(b)(2) (as added by § 6044 of the DRA).

229. 42 U.S.C. §1397cc(a) (2000).

230. *See* Rosenbaum et al., *supra* note 42, 1-47.

231. H.R. Rep. No. 109-362 (2005).

232. CBO COST ESTIMATE, *supra* note 194.

Administration[233] and Chair of the House Energy and Commerce Committee (which has jurisdiction over Medicaid)[234] indicate that Congress intended to preserve EPSDT coverage, at least for children under nineteen. But the legislative language that describes what might be characterized as an EPSDT "savings clause" is vague, and therefore, the risk of state confusion over the extent of children's rights and states' duties, is extremely high.[235] The provision offers no definition of "wrap-around" (a term that never before appeared in the context of ESPDT law), and offers no direction regarding how the broad language of the benchmark is to be reconciled with EPSDT coverage rights. Whether courts can navigate the morass of this example of legislative drafting at its absolute worst is not clear.

The ambiguities over the EPSDT savings clause are further complicated by the opening clause of §1937 itself, which provides that its terms apply "notwithstanding any other provision of this title." Such breathtakingly broad language never has been used to introduce an amendment into this notoriously complex law. Whether courts will interpret the language as permitting benchmark states to disregard all aspects of the statute—including the legal right to coverage itself among eligible persons[236]—remains to be seen. Nothing in either the benchmark section or its history suggests that Congress intended to supersede any provision of law other than those that pertain directly to the definition of medical assistance, but the highly textual approach taken by the United States Supreme Court in recent years to the interpretation of Spending Clause statutes alleged to create legal rights leaves the future of the Medicaid entitlement in benchmark states uncertain.[237]

Although the legal outcome of the benchmark amendment is uncertain, its practical effects are not. Table 1 compares the federal EPSDT benefit against a legally acceptable "benchmark) (in this case, an insurance plan offered to federal employees) and illustrates the potential magnitude of coverage loss for children if state benchmark systems fail to effectively ensure children access to both "benchmark coverage" and EPSDT.

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233. Letter from Dr. Mark B. McClellan, CMS Administrator, to the U.S. Senate, Dec. 19, 2005.

234. Statement by Rep. Joe Barton, Chairman, House Committee on Energy and Commerce, June 15, 2005, *available at* http://energycommerce.house.gov/108/Hearings/06152005hearing1550/The_Honorable_Joe_Barton.htm.

235. The risk may be heightened by the fact that the governors in their 2005 position statements recommended elimination of EPSDT rights for some or most children, and the benchmark provision itself alludes to "well-baby and well-child" care. NAT'L GOVERNORS ASS'N , *supra* note 179, at 7.

236. Courts continue to find a legal entitlement to coverage as defined in § 1902(a)(10) of the Social Security Act even as they find numerous other provisions of the statute non-enforceable. *See, e.g.*, Sanchez v Johnson, 415 F.3d 1051, 1056 (9th Cir., 2005); Watson v. Weeks, 436 F.3d 1152, 1157 (9th Cir. 2006).

237. Gonzaga v Doe, 536 U.S. 273, 284-91 (2002).

Table 1. A Comparison of EPSDT and the FEHBP Standard PPO

BENEFIT	MEDICAID EPSDT PROGRAM	FEHBP STANDARD PPO OPTION BLUE CROSS/BLUE SHIELD PLAN
Comprehensive assessment of physical and mental growth and development (developmental assessments)	Covered	Limited to "healthy newborn visits," "routine screening," "routine physical examinations," "neurological testing," and initial examination of a newborn needing "definitive treatment," when the infant is covered under a family enrollment.
Anticipatory guidance	Covered	Silent [Not covered]
Physical, speech, and related therapies	Covered without limitations other than medical necessity; no "recovery" requirements; therapy covered for conditions identified through early intervention and child care programs.	Limited to inpatient coverage. "Maintenance therapy" expressly excluded. Also excluded are "recreational and educational" therapy and "any related diagnostic testing except as provided by a hospital as part of a covered inpatient basis." All services billed by schools or a member of school staffs are excluded.
Hearing services	Covered without limitations, including tests, treatment, hearing aids, and speech therapy related to hearing loss and speech development.	Testing covered only when "related to illness or injury." Routine hearing tests excluded other than as standard part of "routine" screening for children; hearing aids excluded along with testing and examinations for the prescribing or fitting of hearing aids.
Eye examinations and eyeglasses	Covered without limitations, as medically necessary.	One pair of eyeglass replacement lenses or contact lenses to "correct an impairment directly caused by a single instance of accidental ocular injury or intraocular injury;" eye examinations for specific medical

BENEFIT	MEDICAID EPSDT PROGRAM	FEHBP STANDARD PPO OPTION BLUE CROSS/BLUE SHIELD PLAN
		conditions; nonsurgical treatment for amblyopia and strabismus from birth through age 12. Eyeglasses and routine eye examinations specifically excluded, as are eye exercises, visual training and orthoptics except in connection with the specific diagnosis of amblyopia or strabismus.
Durable medical equipment (DME)	Covered without limitations, as medically necessary.	Certain DME covered but only if prescribed for the treatment of "illness or injury."
Home nursing	Covered without limitations, as medically necessary; home visits can cover health educators, therapists, health aides, and others.	Covered for 2 hours per day, 25 visits per year, when furnished by a nurse or licensed practical nurse and under a physician's orders.
Other medically necessary care	Covered (and covered in greater amount, duration, and scope) if recognized under §1905a of the Social Security Act	No supplemental coverage
Medical necessity standard	Early care to correct or ameliorate conditions	BCBS determines "whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are: 1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury; 2. Consistent with standards of good medical practice in the United States; 3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider; 4. Not part of or associated with scholastic education or vocational training of the patient; and

BENEFIT	MEDICAID EPSDT PROGRAM	FEHBP STANDARD PPO OPTION BLUE CROSS/BLUE SHIELD PLAN
		5. In the case of inpatient care, cannot be provided safely on an outpatient basis. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan."

Sources: §1905(r) of the Social Security Act, 42 U.S.C. 1396d(r); Part 5, Section 5122 of the State Medicaid Manual; Office of Personnel Management, FEHBP Blue Cross and Blue Shield Service Benefit Plan, 2005. Comparisons by George Washington University (author and Dr. Anne Markus).

Cost sharing and premiums

The DRA[238] modifies federal law regarding the use of premiums and cost sharing under Medicaid, amending the statute to provide states with considerable flexibility to require beneficiaries to contribute toward coverage, particularly in the case of persons with family incomes above the federal poverty level. The law further permits states to redefine the meaning of poverty, in order to reclassify the poor as near-poor.[239] The flexibility to expand financial contribution requirements for the near-poor was recommended by both the governors and the Medicaid Commission, although neither recommended giving states the power to redefine the meaning of poverty for premium and cost sharing purposes. In addition, the law is silent with respect to cost sharing for the poor, leaving open to doubt whether the distinction between poor and near-poor in fact has any meaning at all.

The DRA amendments continue certain prior cost sharing protections and add several: children whose coverage is mandatory, pregnant women, certain elderly and disabled persons, and persons with certain conditions. For affected populations, however, the extent of permissible cost-sharing is quite significant. The DRA recognizes the use of not only copayments, but also co-insurance, which can amount to up to 20% of the cost of services in the case of non-exempt individuals and families.[240] The DRA also permits states to expose the poor to cost sharing requirements established for the near-poor by giving them the power to

238. DRA §§ 6041-43.

239. 42 U.S.C. § 1916A(b)(3)(B) (as added by § 6043 of the DRA).

240. *Id.* § 1916A(b)(2).

treat as available family income that is, by law, disregarded during the eligibility determination phase. Because eligibility-related disregards tend to recognize subsistence costs other than health care (e.g., work-related expenses, shelter), this authority to treat post-eligibility income as available for health care expenditure purposes has the potential to create significant new financial burdens especially with respect to the use of premiums or the imposition of new cost sharing responsibilities in the case of families with extensive health care needs.

The size of the potential cost sharing burden in out-years also rises under the terms of the DRA. The amendments require the Secretary of HHS to annually adjust cost-sharing levels to take into account the rate of medical inflation,[241] an annual rate of increase far surpassing any possible annual increase in enrollee income.[242] Furthermore, although the legislation establishes certain aggregate upper limits on families' total exposure to premiums and cost sharing in relation to family income, this aggregated exposure level is steep: 5% of aggregate family income on a quarterly or monthly basis. Thus, in the out-years the aggregate burden also will rise steeply in relation to family income. Combined with state power to redefine the poor as not poor, the potential impact of the premium and cost sharing rules is truly significant.

Finally, the DRA gives states the option to permit providers (including hospital emergency departments) to make premiums and cost-sharing requirements "enforceable." Prior to the DRA, participating physicians and hospitals were obligated to furnish care to patients regardless of their ability to satisfy applicable cost sharing rules. The DRA permits states to allow participating providers to require payment of any allowable cost sharing before providing care, including payments for services sought in emergency departments, while also authorizing providers to waive advance payment on a case-by-case basis.[243] How this "enforceability" clause will be understood and administered in hospital emergency department settings, given the prohibition against demanding payment for services required under the Emergency Medical Treatment and Women in Labor Act (EMTALA),[244] is unclear.

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241. *Id.* § 1916A(d)(2)(b).

242. For an excellent illustration of medical costs compared to family income, see KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2005 ANNUAL SURVEY, Chart 1, *available at* http://www.kff.org/insurance/7315/sections/upload/7375.pdf. According to the study, health insurance premium costs run annually at more than twice the general inflation rate and worker premiums.

243. § 1916A(d)(2) of the Social Security Act.

244. 42 U.S.C. §1396dd(h) provides that "a participating hospital may not delay provision of an appropriate medical screening examination . . . or further examination and treatment . . . in order to inquire about the individual's method of payment or insurance status."

CONCLUSION

Medicaid's fortieth anniversary came in a year of significant program alteration. How these changes are interpreted and applied in the context of state program administration and judicial settings is a question that may require years to answer. Taken together the reforms send certain strong messages about government's evolving role in making health care for the poor financially accessible, about the extent to which those who can least afford it will be shielded from the dramatic reforms in coverage that are taking place within the private insurance sector, and about the economic relationship between state and federal governments. The new face of Medicaid is one in which the federal government seeks actively to reduce its contribution levels to state programs in exchange for greater state flexibility to trim help to the poor. From a broad perspective, the DRA represents an about-face to four decades of federal Medicaid policy. In effect, the message of the legislation is that the federal government will continue to help states in their efforts to meet the cost of health care for their poorest residents, but that this help will come at a high price for certain populations, health care providers, and states interested in maintaining a broad program. The price to be paid includes new standards that clamp down harshly on the classes of persons entitled to receive help, states' ability to help the near-poor with at least moderate coverage, and place pressure on states to cut benefits through the creation of "flexibility options" that invite enthusiastic enactment by political and ideological foes of extensive assistance to low income populations.

How the courts view Medicaid in the wake of the DRA is a matter to watch carefully. With each passing year, the status of Medicaid coverage as a legally enforceable federal right grows increasingly precarious. Structural legislative changes as broad as those in the DRA lead one to envision, down the road, the emergence of one of those magical "tipping points" when the law ceases to be one thing and becomes another in the eyes of courts. In this case, the tipping point may be the extent to which the DRA is considered to be a new vision for Medicaid, no longer as a legally enforceable right to coverage akin to insurance, but as a vast source of federal revenue sharing for states, with accompanying program and expenditure obligations so broad as to eviscerate any notion of entitlement. This tipping point finds its expression in the DRA's use of dramatic legislative language to express the new state flexibility. One cannot imagine that in the ideologically charged atmosphere of Washington D.C., this extravagant approach to expressing states' option to change the meaning of coverage was the product of a simple error. The question is whether the nation is ready for an additional 50 million uninsured persons, who can join the ranks of the nearly 50 million today who hope for some health care.