

## Medicaid: Issues and Challenges for Health Coverage of the Low-Income Population

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# MEDICAID: ISSUES AND CHALLENGES FOR HEALTH COVERAGE OF THE LOW-INCOME POPULATION

DIANE ROWLAND\*

## MEDICAID TODAY

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has operated as a federal and state partnership to meet the health needs of the nation's most vulnerable populations.<sup>1</sup> It has evolved from a program providing federal financing to states for health coverage of their welfare population to a program that now provides health and long-term coverage to fifty-one million low-income Americans at an annual cost to the federal and state governments of \$258 billion in 2002.<sup>2</sup> Medicaid is now the nation's largest health care program.

In our fragmented health care system, Medicaid is the linchpin program that addresses the health and long-term care needs of this nation's low-income disabled and elderly populations, and families and children. Medicaid has a broad reach – it is the source of health insurance coverage for one in five American children and over a third of all Hispanic and African-American children.<sup>3</sup> It also

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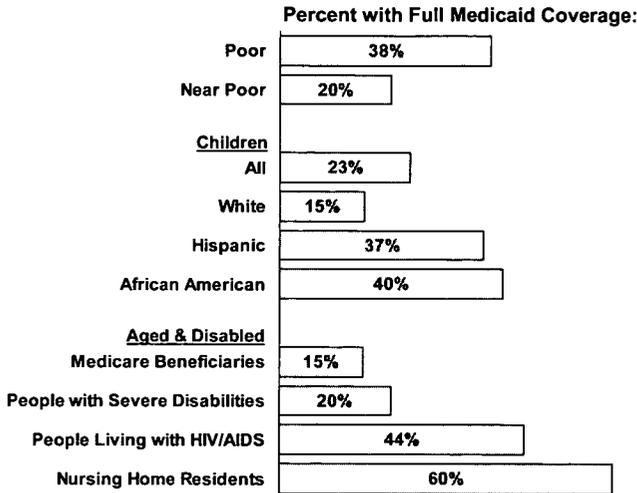
1. Alan Weil, *There's Something About Medicaid*, 22 HEALTH AFFAIRS 13, 16 (Jan./Feb. 2003). See generally, Diane Rowland & James R. Tallon Jr., *Medicaid: Lessons From a Decade*, 22 HEALTH AFFAIRS 138 (Jan./Feb. 2003) (examining the role, successes, and setbacks of the Medicaid program and arguing that, in the absence of universal coverage, it offers a vital safety net companion to Medicare).

2. THE HENRY J. KAISER FAMILY FOUND., MEDICAID: FISCAL CHALLENGES TO COVERAGE (Aug. 2003)[hereinafter MEDICAID: FISCAL CHALLENGES], available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=31732>. (last visited Feb 25, 2004); JOHN HOLAHAN & BRIAN BRUEN, THE HENRY J. KAISER FAMILY FOUND., MEDICAID SPENDING: WHAT FACTORS CONTRIBUTED TO GROWTH BETWEEN 2000 AND 2002? 1 (Sept. 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22135> (last visited Jan. 31, 2004).

3. Weil, *supra* note 1, at 13; THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE IN AMERICA, 2001 UPDATE 22 tbl.2 (Jan.

provides health and long-term care coverage for 60% of nursing home residents, 44% of people living with HIV/AIDS, 20% of people with severe disabilities and 15% of Medicare beneficiaries (Figure 1).<sup>4</sup>

**Figure 1**  
**Medicaid's Role for Selected Populations**



Note: "Poor" is defined as living below the federal poverty level, which was \$14,348 for a family of three in 2002.  
SOURCE: Poor, Near-Poor and Children: KCMU and Urban Institute analysis of the March 2003 Current Population Survey, Aged and Disabled: KCMU and Urban Institute estimates, 2002 and 2003.

In meeting these needs, Medicaid accounts for nearly one of every five dollars of health care spending, nearly one of every two dollars spent on long-term care, and over half of public mental health spending.<sup>5</sup> Medicaid assists, on average, over one in ten state residents, is the largest source of federal support to

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2003), available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14309> (last visited Jan. 31, 2004).

4. THE HENRY J. KAISER FAMILY FOUND., DUAL ENROLLEES: MEDICAID'S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES (Feb. 2003) [hereinafter DUAL ENROLLEES], available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14322> (last visited Jan. 31, 2004); JENNIFER KATES, THE HENRY J. KAISER FAMILY FOUND., FINANCING HIV/AIDS CARE: A QUILT WITH MANY HOLES (Forthcoming 2004); J. CROWLEY & R. ELIAS, THE HENRY J. KAISER FAMILY FOUND., MEDICAID'S ROLE FOR PEOPLE WITH DISABILITIES 10 (Aug. 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28359> (last visited Feb. 15, 2004); THE HENRY J. KAISER FAMILY FOUND., A PRESCRIPTION DRUG BENEFIT IN MEDICARE: IMPLICATIONS FOR MEDICAID AND LOW-INCOME MEDICARE BENEFICIARIES 1 (Sept. 2003) [hereinafter DRUG BENEFIT IN MEDICARE], available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22119> (last visited Jan. 31, 2004).

5. MEDICAID: FISCAL CHALLENGES, *supra* note 2; Weil, *supra* note 1, at 13.

states, and operates as a major engine for state economies by supporting millions of jobs across the country.<sup>6</sup>

Medicaid's most widely-acknowledged role is as the source of health insurance coverage for 38 million low-income children and parents.<sup>7</sup> By providing fundamental health insurance protection, Medicaid keeps millions of poor children and their parents from adding to our growing uninsured population.<sup>8</sup> With the enactment of the State Children's Health Insurance Program (SCHIP) in 1997, and the Medicaid expansions over the last decade, Medicaid and SCHIP now have the potential to reach all low-income children (low-income is defined as below 200 percent of the Federal Poverty Level or \$28,696 for a family of three in 2002).<sup>9</sup> Although more needs to be done to broaden outreach and facilitate enrollment to achieve full participation by all eligible uninsured children, the latest census numbers show that public coverage through Medicaid and SCHIP helped to offset the decline in employer coverage. While the number of uninsured grew by 2.4 million in 2002, Medicaid coverage kept another 1.6 million from being added to the uninsured population and maintained coverage for children.<sup>10</sup>

It is not, however, Medicaid's role as a health insurer of low-income families that is its most unique or costly undertaking. Medicaid's role in assisting 8 million low-income people with disabilities and 5 million low-income elderly people with both medical care and long-term care services dominates Medicaid spending.<sup>11</sup> Although children account for half of all Medicaid beneficiaries, they account for only a small share of spending. Together children and their parents represent three-quarters of all beneficiaries and 30% of all spending, while the elderly and disabled account for a quarter of beneficiaries and 70% of spending (Figure 2).<sup>12</sup> In 2002, per capita expenditures per child were \$1,500 compared to

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6. THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE IN AMERICA: 2002 DATA UPDATE 36 tbl.13 (Dec. 2003), available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29340> (last visited Feb. 25, 2004); MEDICAID: FISCAL CHALLENGES, *supra* note 2.

7. MEDICAID: FISCAL CHALLENGES, *supra* note 2.

8. See Rowland & Tallon, *supra* note 1, at 139.

9. See Cindy Mann, et al., *Historical Overview of Children's Health Care Coverage*, 13 THE FUTURE OF CHILD. 31 (2003), available at [http://www.futureofchildren.org/usr\\_doc/tfoc13-1c.pdf](http://www.futureofchildren.org/usr_doc/tfoc13-1c.pdf) (last visited Jan. 31, 2004). For 2002 Federal Poverty Thresholds, see U.S. CENSUS BUREAU, POVERTY THRESHOLDS 2002, available at <http://www.census.gov/hhes/poverty/threshld/thresh02.html> (last visited Feb. 25, 2004).

10. Calculation based upon data included in ROBERT J. MILLS & SHAILESH BHANDARI, U.S. CENSUS BUREAU, PUB. NO. P60-223, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002, CONSUMER INCOME, 4, 8 (Sept. 2003), available at <http://www.census.gov/prod/2003pubs/p60-223.pdf> (last visited Jan. 31, 2004).

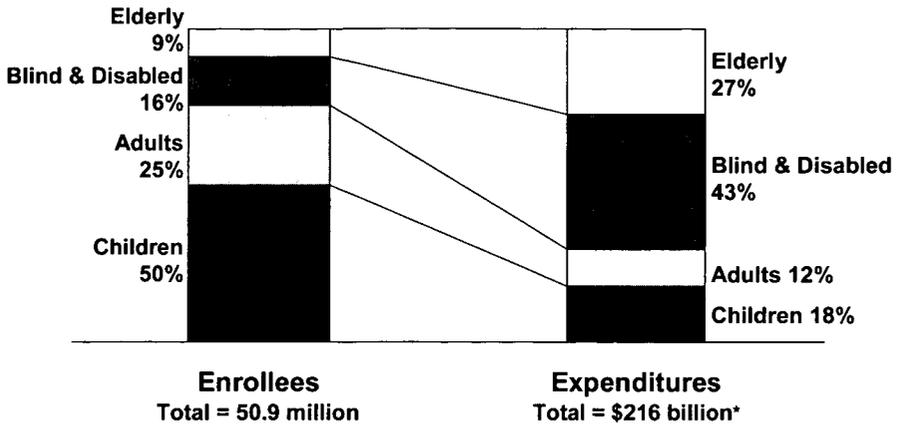
11. THE HENRY J. KAISER FAMILY FOUND., THE MEDICAID PROGRAM AT A GLANCE (Jan. 2004), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30463> (last visited Feb. 25, 2004).

12. *Id.*; MEDICAID: FISCAL CHALLENGES, *supra* note 2.

\$11,500 per disabled beneficiary and \$12,800 per elderly Medicaid beneficiary.<sup>13</sup> Higher utilization of acute care services coupled with long-term care spending for the elderly and disabled account for the difference.

Figure 2

### Medicaid Enrollees and Expenditures by Enrollment Group, 2002



Expenditure distribution based on CBO data that includes only spending on services and excludes DSH, supplemental provider payments, vaccines for children, and administration.  
SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2003.

For low-income Medicare beneficiaries Medicaid coverage is particularly important. Although Medicare provides basic medical coverage, the required cost-sharing and gaps in benefits, most notably lack of prescription drug or long-term care coverage, leave many holes to be filled by Medicaid. The 7 million individuals with both Medicaid and Medicare – the “dual eligibles” – are among Medicare’s poorest and sickest beneficiaries.<sup>14</sup> In addition to having low incomes, these dual eligibles are also more likely than other Medicare beneficiaries to be in poor health, suffer from chronic diseases, and have limitations on their activities of daily living leading to long-term care needs (Figure 3).<sup>15</sup> As a result, the dual eligible population accounts for 14% of Medicaid beneficiaries but for 42% of all Medicaid spending (Figure 4).<sup>16</sup> Spending on prescription drug coverage alone for

13. THE MEDICAID PROGRAM AT A GLANCE, *supra* note 11.

14. DRUG BENEFIT IN MEDICARE, *supra* note 4, at 1-2.

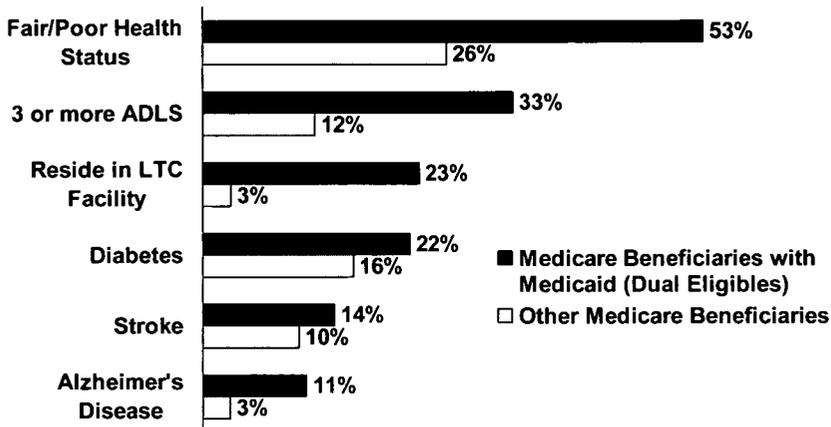
15. DUAL ENROLLEES, *supra* note 4.

16. BRIAN BRUEN & JOHN HOLAHAN, THE HENRY J. KAISER FAMILY FOUND., SHIFTING THE COST OF DUAL ELIGIBLES: IMPLICATIONS FOR STATES AND THE FEDERAL GOVERNMENT 5 tbl. 2, 6

the dual eligible population represents 6% of total Medicaid spending, \$13.4 billion in 2002, and represents approximately half of all Medicaid spending on prescription drugs.<sup>17</sup>

Figure 3

## Characteristics of Dual Eligibles Compared to Other Medicare Beneficiaries, 1999



Note: ADLS = Number of limitations in Activities of Daily Living  
SOURCE: 1999 Medicare Current Beneficiary Survey.

The structure of Medicaid provides states with federal matching funds for coverage of mandatory populations and services, but also enables states to obtain federal matching funds for a wide range of optional services and broader population coverage.<sup>18</sup> Most notably, states are required to cover all children under the poverty level and most elderly and disabled recipients of cash assistance under the Supplementary Security Income (SSI) program.<sup>19</sup> States also have the option to cover children at higher income levels, their parents, and other low-income elderly and people with disabilities in the community and in nursing

(Nov. 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=27097> (last visited Feb. 25, 2004); DRUG BENEFIT IN MEDICARE, *supra* note 4, at 3.

17. DRUG BENEFIT IN MEDICARE, *supra* note 4, at 3.

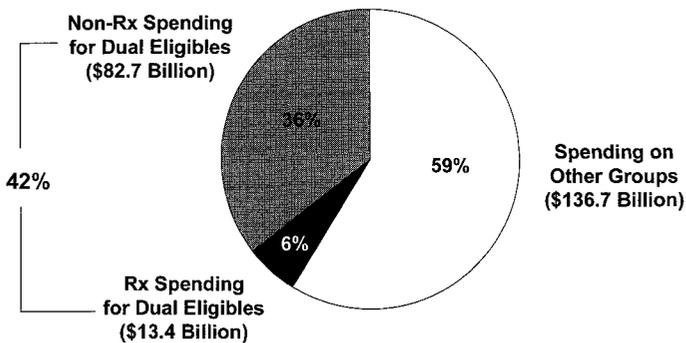
18. THE HENRY J. KAISER FAMILY FOUND., THE MEDICAID RESOURCE BOOK 55 (July 2002) [hereinafter MEDICAID RESOURCE BOOK], available at <http://www.kff.org/medicaid/2236-index.cfm> (last visited Jan. 31, 2004).

19. See THE HENRY J. KAISER FAMILY FOUND., MEDICAID "MANDATORY" AND "OPTIONAL" ELIGIBILITY AND BENEFITS 2, 4 (July, 2001) [hereinafter "MANDATORY" AND "OPTIONAL" ELIGIBILITY], available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13767> (last visited Jan. 31, 2004).

homes.<sup>20</sup> However, coverage of non-disabled childless adults is not an optional category for Medicaid coverage.<sup>21</sup> With regard to benefits, states must cover basic physician, laboratory, and hospital services, but many benefits, including prescription drug coverage and community-based long-term care are covered at the option of the state.<sup>22</sup>

Figure 4

## Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FFY2002



**Total Spending on Benefits = \$232.8 Billion**

NOTE: Due to rounding, percentages do not total 100%.

SOURCE: Urban Institute estimates prepared for KCMU based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.

Although the configuration varies from state to state, about 65% of all program spending is at state option.<sup>23</sup> However, in meeting the health and long-term care needs of the low-income population, the legislative language of “State Option” hardly applies to the population’s need for the services covered: 83% of optional spending is for the aged and disabled population and the bulk is for long-term care and prescription drug coverage.<sup>24</sup> Without these “optional” services and the broadened coverage of the elderly and people with disabilities at state option, millions of America’s poorest and sickest people would be without essential health and long-term care services.

20. *Id.*

21. *Id.*

22. *Id.* at 7 fig.7.

23. MEDICAID RESOURCE BOOK, *supra* note 18, at 55.

24. “MANDATORY” AND “OPTIONAL” ELIGIBILITY, *supra* note 19, at 12 fig.12, 13 fig.13.

Moreover, despite its comprehensive coverage of services and limited cost-sharing, Medicaid is in reality a low-cost program when compared with other health care spending.<sup>25</sup> Among children, per capita expenditures for Medicaid enrollees are significantly lower than for their privately insured counterparts.<sup>26</sup> While per capita expenditures for adults in Medicaid are higher than the corresponding amounts for low-income adults who have private coverage, this is due to the much poorer health status of the adult population enrolled in Medicaid. When adults with disabilities are excluded from the analysis of both Medicaid and private insurance, per capita expenditures are significantly lower for Medicaid adults than for the privately insured.<sup>27</sup> In other words, Medicaid spends more than private insurance because it covers a sicker population.

Although Medicaid is a substantial investment of federal and state dollars, it also provides an effective return on that investment by improving access to care for our low-income population. Medicaid does a particularly good job helping low-income populations close the gap in access to care and connecting people to the health system. For example, uninsured children and adults are less likely to obtain medical care than those without Medicaid coverage, are more likely to postpone needed care, and lack a regular source of care than those with Medicaid coverage (Figure 5).<sup>28</sup> Among the elderly and disabled with Medicare coverage, Medicaid supplements Medicare coverage and provides access comparable to those with private supplemental insurance.<sup>29</sup> This dual coverage is notably better than that experienced by the population covered with Medicare only.<sup>30</sup>

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25. J. Holahan & J. Hadley, *Is Health Care Spending Higher under Medicaid or Private Insurance?*, INQUIRY, (forthcoming 2004).

26. *Id.*

27. *Id.*

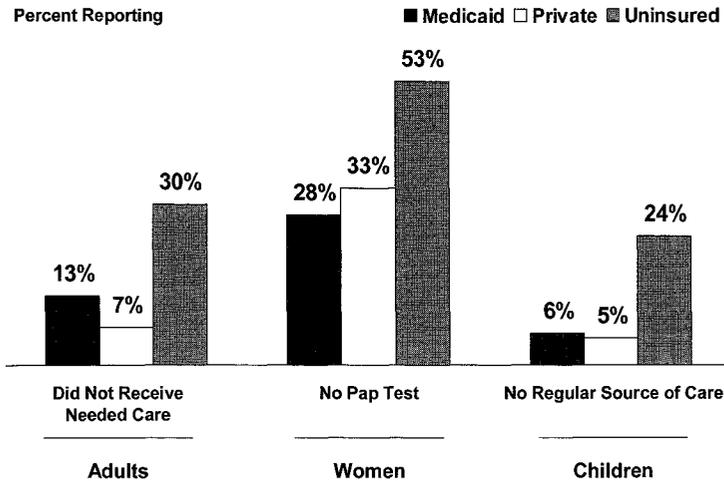
28. THE HENRY J. KAISER FAMILY FOUND., ACCESS TO CARE FOR THE UNINSURED: AN UPDATE 2-3 (Sept. 2003), available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=23628> (last visited Jan. 31, 2004).

29. THE HENRY J. KAISER FAMILY FOUND., MEDICARE CHARTBOOK, 36 (2001) available at <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13598> (last visited Jan. 31, 2004)

30. *Id.* at 44.

Figure 5

## Medicaid's Impact on Access to Health Care for Families



SOURCES: The 1997 Kaiser/Commonwealth National Survey of Health Insurance; Women's Health, The Commonwealth Fund Survey, 1996; Dubai and Kenney, *Health Affairs*, 2001.

### MEDICAID SPENDING

These roles make Medicaid both a complex and costly program. Medicaid is complex because it is not a single program, but an array of services and programs under a single name, which are structured and operated somewhat differently in each of the fifty states and the District of Columbia. It is a costly program because health care, and especially long-term care, in America is expensive and Medicaid covers those with the most substantial health care needs, including those with severe disabilities and chronic health problems requiring on-going care.

Medicaid spending is determined by the number of people covered, the cost of their medical and long-term services and the amount of services used. During the early 1990s, Medicaid spending growth was particularly high, largely due to the use of provider taxes and donations and other financing mechanisms used by states to gain additional federal matching funds.<sup>31</sup> Once these practices were curbed, Medicaid spending growth returned to levels more consistent with

31. John Holahan et al., *Understanding the Recent Growth in Medicaid Spending*, in *MEDICAID FINANCING CRISIS: BALANCING RESPONSIBILITIES, PRIORITIES, AND DOLLARS 23* (Diane Rowland et al. eds., 1993); *MEDICAID RESOURCE BOOK*, *supra* note 18, at 92.

private spending and reflective of expanding coverage.<sup>32</sup> A notable drop occurred in the period surrounding welfare reform, largely due to individuals losing Medicaid coverage during the welfare reform transition.<sup>33</sup> This was also a time when cost increases for private health insurance were at an all-time low.<sup>34</sup> In recent years, Medicaid spending has increased as enrollment has grown and the cost of medical care has risen for both the public and private sectors.

Over the 2000-2002 period, Medicaid expenditures for services grew by 12.9% overall - a rate comparable to the increases seen for private health insurance premiums.<sup>35</sup> Although Medicaid is historically a low-paying purchaser of health care services, there is continual pressure on the program to keep pace with payment rates in the private sector in order to maintain access to care for Medicaid beneficiaries. As a result, the spiraling costs for health care also impact Medicaid. Just like private insurance, prescription drugs costs had the highest rate of growth among Medicaid services, increasing 18.8% from 2000 to 2002 (Figure 6).<sup>36</sup> However, after several years of rapidly accelerating Medicaid spending growth, in FY 2004 the rate of growth in Medicaid spending fell from nearly 12% in FY 2002 to 8.2%.<sup>37</sup> This rate of growth, which is still substantial, stands in marked contrast to growth trends for employer-sponsored health insurance premiums, which continue to increase and reached 13.9% in 2003.<sup>38</sup>

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32. JOHN HOLAHAN & DAVID LISKA, THE HENRY J. KAISER FAMILY FOUND., WHERE IS MEDICAID SPENDING HEADED? (Dec. 1996), available at <http://www.kff.org/medicaid/2074-forecast.cfm> (last visited Feb. 25, 2004).

33. See HOLAHAN & BRUEN, *supra* note 2, at 4.

34. Jon Gabel et al., *Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing*, 22 HEALTH AFFAIRS 117, 119 exhibit 1 (Sept./Oct. 2003).

35. HOLAHAN & BRUEN, *supra* note 2, at 2, 10.

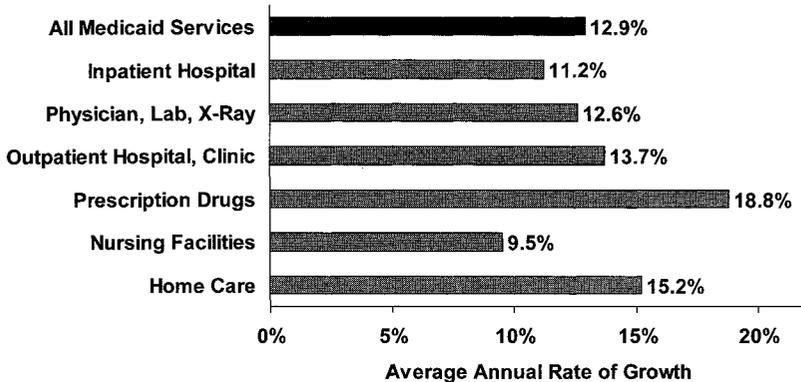
36. HOLAHAN & BRUEN, *supra* note 2, at 7 tbl.4.

37. VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUND., STATES RESPOND TO FISCAL PRESSURE: A 50-STATE UPDATE OF STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT ACTIONS 1 (Jan. 2004), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30453> (last visited Feb. 25, 2004).

38. Jon Gabel et al., *supra* note 34, at 117.

Figure 6

## Average Annual Rate of Expenditure Growth for Medicaid Services, 2000-2002



Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed.  
 SOURCE: Kaiser Commission on Medicaid and the Uninsured / Urban Institute analysis of HCFA-64 data.

According to Holahan and Bruen, the “[r]apid Medicaid spending growth has been driven, in part, by enrollment increases resulting from the loss of income and private insurance coverage during the current economic downturn, together with continued increases in hospital and prescription drug costs that have affected the entire health care sector.”<sup>39</sup> Yet, Medicaid spending increases on a per capita basis remained substantially lower than increases in per capita spending in the private sector from 2000 to 2002: Medicaid per capita spending increased on average 8.6% compared to over 12% increases in private insurance premiums.<sup>40</sup> Moreover, Medicaid enrollment growth also helped to soften the recession’s effects, stemming further increases in the number of uninsured. However, the increased enrollment of low-income children and parents is not the major driver of Medicaid spending increases---it is the cost of care for the elderly and disabled who depend on Medicaid to fill Medicare’s gaps and provide assistance with both acute and long-term care needs. The elderly and individuals with disabilities accounted for almost 60% of the \$50 billion growth in Medicaid spending from 2000 to 2002 due to their extensive need for health service and their use of costly long-term care coverage (Figure 7).<sup>41</sup>

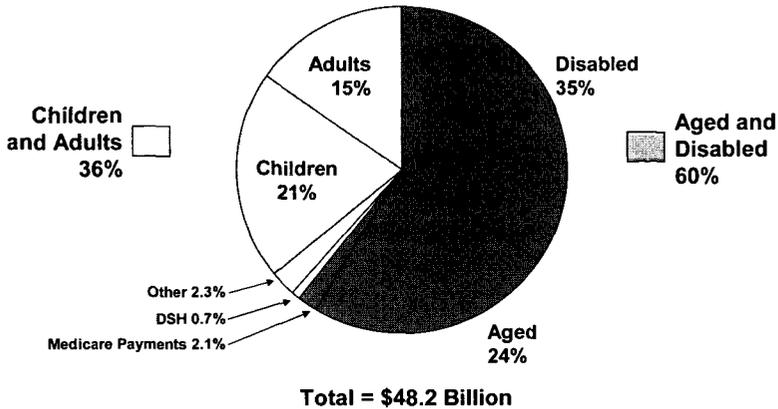
39. HOLAHAN & BRUEN, *supra* note 2, at 1.

40. HOLAHAN & BRUEN, *supra* note 2, at 10.

41. HOLAHAN & BRUEN, *supra* note 2, at 2.

Figure 7

## Contributors to Medicaid Expenditure Growth by Enrollment Group, 2000-2002



SOURCE: Estimates for KCMU prepared by the Urban Institute, 2003.

### THE STATE FISCAL CHALLENGE

Meanwhile, as these pressures push Medicaid spending up, states are facing extremely challenging fiscal conditions and have been for several years. State tax revenues declined significantly in 2002 and remained at low levels throughout 2003.<sup>42</sup> The recent falloff in state tax revenue is large even by the standards of recent history, and the decline in state tax revenue is twice as big as it was in either of the two most recent recessions.<sup>43</sup> Moreover, it is this revenue falloff, not the recent increase in Medicaid spending that has been by far the major contributor to state budget shortfalls, which reached more than \$80 billion in FY 2003.<sup>44</sup>

As states have grappled with the challenge of balancing their budgets in the face of declining revenues, most have devoted significant attention to

42. DONALD BOYD & VICTORIA WACHINO, THE HENRY J. KAISER FAMILY FOUND., IS THE STATE FISCAL CRISIS OVER? A 2004 STATE BUDGET UPDATE 2-4 (Sept. 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30459> (last visited Feb. 25, 2004).

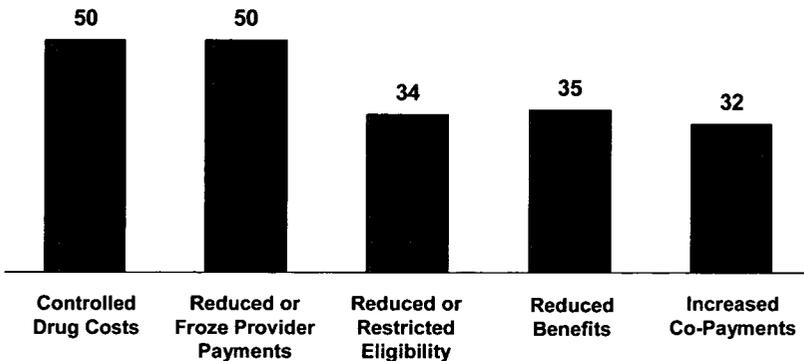
43. DONALD BOYD, THE HENRY J. KAISER FAMILY FOUND., THE CURRENT STATE FISCAL CRISIS AND ITS AFTERMATH 1 (Sept. 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22130> (last visited Feb. 25, 2004).

44. BOYD & WACHINO, *supra* note 42.

implementing new measures to control their Medicaid spending growth. For fiscal year 2003, every state and the District of Columbia has put in place some Medicaid cost containment mechanism.<sup>45</sup> Over the past three years, thirty-four states have reduced eligibility for Medicaid and even more have restricted health care benefits (Figure 8).<sup>46</sup> These strategies appear to have been successful in reducing the rate of Medicaid spending growth, but they also raise real questions about how the program will be able to meet the health care needs of low-income people, whose numbers are growing.

Figure 8

### Number of States Implementing Medicaid Cost Containment Strategies Over the Past Three Years (FY 2002 – FY 2004)



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September 2003.

The outlook for state budgets in FY 2004 and 2005 remains challenging, and although states project slight revenue growth in 2004, spending pressures continue to build.<sup>47</sup> States have exhausted a lot of one-time measures they have previously used to balance their budgets.<sup>48</sup> Medicaid expenditure assumptions in FY 2004 appear optimistic, and Medicaid budget shortfalls are likely in a majority of states.

45. VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUND., STATES RESPOND TO FISCAL PRESSURE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2003 AND 2004 2 (Sept. 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=22126> (last visited Feb. 25, 2004).

46. *Id.* at 3.

47. BOYD & WACHINO, *supra* note 42, at 8.

48. BOYD & WACHINO, *supra* note 42, at 8.

Finally, the federal fiscal relief enacted in May 2003, which helped states avoid making additional and deeper changes to their Medicaid programs this year, expires at the end of fiscal year 2004.<sup>49</sup> This, along with present expectations of low revenue growth, will leave states with significant gaps in their budgets for FY 2005. As states enter another year of Medicaid cost containment, they will continue to struggle to balance the health needs of their low-income citizens with the need to close what are for many states gaping holes in their overall state budgets.

#### LOOKING AHEAD

Medicaid's role in providing health and long-term services to our nation's most vulnerable people and its widening safety net responsibilities have brought notable improvements in coverage of low-income families and assistance to the elderly and individuals with disabilities. As the primary source of financing and coverage for the low-income population, Medicaid has been a critical force in moderating the growth in America's uninsured population over the last three decades. Without Medicaid, millions of our nation's poorest children would be without health insurance. Medicaid continues to provide coverage beyond that of private insurance or Medicare to the most vulnerable and frail in our society - acute and long-term care services for persons with chronic mental illness and retardation; medical and long-term care services and drug therapy for those with AIDS; assistance with Medicare's premiums and cost-sharing and prescription drug coverage for poor Medicare beneficiaries; and home-based and institutional care for those with severe physical and mental disabilities that require long-term care. In the absence of Medicaid, it is hard to envision how these enormous societal needs would be met.

Yet, one of the most daunting challenges facing Medicaid's future is how to meet the growing need for health and long-term care coverage within the constraints of federal and state financing. The fiscal situation in the states, coupled with the growing federal deficit, makes assuring adequate financing and meaningful coverage for low-income families, the elderly, and people with disabilities a growing challenge. Yet, it is a challenge we must meet with responsible proposals that assure that the most frail and vulnerable among us are protected and able to obtain the health and long-term care services they need.

There are no easy answers to reducing the cost of providing care to the over fifty million Americans who now depend on Medicaid for health and long-term care assistance - the poorest, oldest, frailest, and most disabled of our population. The high cost of caring for this population is reflective of their serious health problems, not excessive spending by the program. Program costs grow in response

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49. SMITH ET AL., *supra* note 37, at 9.

to downturns in the economy, the needs of an aging population and emerging public health crises and emergencies. Efforts at reform should be directed at finding ways to support and maintain the coverage the program offers while balancing the responsibilities for coverage and financing between the federal and state governments. Assuring that financing is adequate to meet the needs of America's most vulnerable and addressing our growing uninsured population must to be among our nation's highest priorities.