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MEDICAID: PROPPED UP FOR PARALYSIS?

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Governor Michael Dukakis; advisor

“Of all forms of Inequality, injustice in healthcare is the most shocking and inhumane”

–Dr. Martin Luther King jr.

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Section I

Introduction

It is important to acknowledge the primary objectives and outcomes of what is considered to be an effective healthcare system as put forth by the World Health Organization (WHO) prior to analyzing elements of the current public health structure in the United States. In 2001, the World Health Organization (WHO) released a report that discussed three primary goals for what a good and effective healthcare system should accomplish.¹ Moreover, the WHO report specified the differences between a “good” and “fair” system. In particular, the WHO distinguished the goodness of a healthcare system as “the best attainable average level” and the fairness of a healthcare system as “the smallest feasible differences among individuals and groups.”² Thus, a healthcare system that is both good and fair would include:³

- **Good Health**: Making the healthcare status of the entire population as good as possible across the whole life cycle. A fair distribution of good health, meaning low infant mortality and long life expectancy evenly distributed across populations.
- **Responsiveness**: Responding to people’s expectations of respectful treatment and client orientation by healthcare providers.
- **Fairness in financing**: Ensuring financial protection for everyone, with costs distributed according to an individual’s ability to pay. In other words, a fair distribution of financing healthcare means that everyone is equally protected from the financial risks of illness.

For decades, politicians, policy leaders and insurance companies have all proclaimed that the United States healthcare system is by far the best in the world. However, as the system’s inadequacies become further pronounced, more and more Americans are finding it difficult to accept this particular assertion. In particular, the standards put forth by the WHO, specifically fairness in financing, remains a formidable challenge for the U.S. health structure to achieve. The estimated 46 million people residing in the United States today without health insurance clearly demonstrates that our current system is not necessarily “good” and “fair” for every individual.

¹ World Health Organization: “The World Health Report 2000; Health Systems: Improving Performance” Geneva; WHO; 2000

² WHO Ibid p-8

³ WHO Ibid pp-24-35

From an international perspective, the United States has one of the most expensive healthcare systems in the world and spends more on medical services than virtually any other country. In fact, according to the Centers for Medicare and (CMS) Medicaid Services, national health expenditures in the U.S. will reach \$2.6 trillion by FY (Fiscal Year) 2010. There are various reasons for this high spending, namely high insurance premiums and advancements in pharmaceuticals. More importantly, there is a significant dominance of the private sector over the public sector in the U.S.. However, many cannot afford this private coverage. For example, in 2003, 62 (sixty-two) percent of Americans under the age of 65 received private employer-sponsored insurance, 5 (five) percent purchased insurance on the private individual market, 15 (fifteen) percent were enrolled in public insurance programs, and 18 (eighteen) percent were uninsured.⁴ Working families, young adults and the elderly are some of the populations that tend to be most affected by the lack of a health insurance program.

It is certainly true that since 1965, enactment of the Medicare and Medicaid programs substantially extended health insurance coverage to the poor and the elderly. However, the Medicaid program, in particular, has destabilized over the past twenty years due to the grave long-term health care burden the program has inherited. This has caused a significant inability for the states to provide basic coverage for poor populations across the country. Furthermore, the Bush Administration's failure to address the long-term care burden and efforts to close regulatory loopholes, which will be discussed in a subsequent section of this paper, will undoubtedly further exacerbate the program's instability. Overall, the lack of a comprehensive long-term care insurance program in the U.S. has precipitated numerous challenges for Medicaid and has resulted in the program's inability to adequately protect poor Americans.

⁴ Kaiser Commission of Medicaid and the uninsured and Urban Institute analysis of the March 2004 Current Population Survey

Section II **The Medicaid Program**

I. Program Eligibility

Medicaid is a government health program that provides medical insurance to more than 46 (forty-six) million Americans with low incomes and no medical insurance or inadequate medical insurance. The Medicaid program primarily serves three groups of beneficiaries; women and children, the elderly and the disabled. Women and children account for about 73 (seventy-three) percent of enrollees but only utilize 27 (twenty seven) percent of actual Medicaid funding. The elderly and the disabled combined only account for around 27 (twenty-seven) percent of Medicaid enrollees, but consume about 70 (seventy) percent of total Medicaid spending.⁵

The Federal government establishes the general rules and regulations for Medicaid. Each state is responsible for establishing the specific requirements and eligibility groups for the program. Thus, a recipient's eligibility is dependent upon a state's specified regulations. A state must predicate the eligibility groups on certain types of individuals that meet a specific criterion and if a state is financially capable, they may include optional groups as well. Therefore, states eligibility groups should be characterized as one of the following as put forth by the Department of Health and Human Services (DHS):

The Categorically Needy

- Families who meet a state's Aid to Families with Dependant Children (AFDC) specified eligibility requirements.
- Pregnant women and children under age six whose family incomes are at or below 133 percent of the Federal Poverty Level.
- Children age 6 (six) to 19 (nineteen) with family incomes up to 100 percent of the Federal Poverty Level.

⁵ Ibid p-2 (Scully)

- Caretakers (those individuals who are relatives or legal guardians) who care for children under age 18 eighteen (19 if still in high school).
- Supplemental Security Income (SSI) recipient, or in certain states aged, blind, and disabled people who meet requirements that are more restrictive than the SSI program.
- Individuals and or couples who are living in medical institutions and who have monthly incomes up to a 100 (one-hundred) percent of the SSI income standard (the Federal Benefit Rate).

The Medically Needy

The medically needy are characterized as having too much money and in some cases too many resources to be considered categorically needy. If a state imposes a medically needy program, it must include pregnant women through a sixty day postpartum period, children under the age of 18, certain newborns for a one year period and certain protected blind persons.⁶ States may also include:

- Children under age 21 or under age 19 (nineteen) who are full time students. If a state doesn't want to cover all of these children it has the ability to limit eligibility to "reasonable groups" of such children.⁷
- Caretaker relatives, meaning relatives or legal guardians who live with and care for children.
- Individuals age 65 (sixty-five) and older.
- Blind individuals, determined by using SSI program or state standards.
- Disabled individuals, determined by SSI program or state standards.
- Individuals who would qualify if not enrolled in a health maintenance organization.⁸

Special Groups

- **Medicare beneficiaries**-Medicaid pays for Medicare premiums, deductibles, and coinsurance for Qualified Medicare beneficiaries (QMB). Such individuals must

⁶ "Medicaid at a Glance; a Medicaid Information Source." *Department of Health and Human Services, Centers for Medicare and Medicaid Services; Department for Medicaid and State Operations*; Baltimore, MD; pp-1-2

⁷ *Ibid* pp-1-2

⁸ *Ibid* p-2

have incomes that are below 100 (one-hundred) percent of the Federal Poverty line and resources that are at or below the SSI program standard. There are two additional groups that have Medicare related expenses paid for my Medicaid which are: those Medicare beneficiaries whose incomes are greater than 100 (One-hundred) percent but less than 120 (one hundred twenty) percent of the Federal Poverty line and those that have incomes at least 120 (one-hundred twenty) percent but less than 133 (one-hundred thirty-three) percent of this measure.⁹

- **Qualified working disabled individuals**-Individuals in this category have income levels below 200 (two-hundred) percent of the Federal Poverty line and resources that are double the SSI program standard. Here, Medicaid can pay for Medicare part premiums for some disabled individuals who no longer qualify for Medicare coverage because of their particular job.
- **Expanded access for the disabled**- States have the option to expand access to employment, training and placement to those disabled individuals between the ages of 16 and 65, who wish to participate through expanded Medicaid eligibility. These individuals must have income and resources greater than that allowed under the SSI program. States also have the option to extend eligibility to include working individuals who are ineligible for this group because their medical conditions improve and states can require these individuals to share in the cost of their medical care.¹⁰
- **Limited –time and TB programs**-States can include a time-limited eligibility group for women and a program for individuals with Tuberculosis (TB) under the state Medicaid program. The time-limited eligibility group for women is designed to facilitate and provide all plan services for those women who suffer from breast or cervical cancer. Under the TB program, those individuals only receive services related to the treatment of the particular TB disease.
- **1115 Medicaid Waivers**-Certain states also have the option to expand eligibility through Medicaid waivers. This expanded eligibility is typically only for people who enroll in managed care programs.

⁹ Ibid p-2

¹⁰ Ibid p-2

- **Long Term Care**-All states provide community long term care services for individuals who are Medicaid eligible and qualify for institutional care. Most states use eligibility requirements for such individuals who are more liberal than those normally used in the community.¹¹

Additionally, states also have the opportunity to request permission from the federal Government to provide other home and community-based services for individuals who would otherwise be under institutionalized care. These services can be implemented through each particular state’s Medicaid plan as a “Home and Community-Based (HCBS) waiver” which is authorized under Section 1915(c) of the Social Security Act. These waivers include a broad range of services that include the following:¹²

- Case management services
- Homemaker/home health aide services.
- Personal care services.
- Adult day health services.
- Rehabilitation services.
- Home modifications and home-delivered meals.

As of July of 2003, there were approximately 275 of these particular waivers in all states except Arizona.

II. State Children’s Health Insurance Program (SCHIP)

Since the mid-1980s, major federal and state initiatives such as the State Children’s Health Insurance Program (SCHIP) have strengthened coverage rates among lower-income children. The State Children’s Health Insurance Program (SCHIP) is a program that provides health insurance to children up to the age of nineteen within a state. The SCHIP program is designed for children whose parents have too much money to be eligible for Medicaid but not enough to invest in private health insurance. SCHIP can either be part of a state’s Medicaid program, can be separate or can be a combination

¹¹ Ibid p-3

¹² Ibid “Long-term Care-Consumer Directed Services Under Medicaid”

of both. The majority of states offer SCHIP to children in families below 200 (two-hundred) percent of the Federal Poverty line. However, because some states have different income eligibility standards, not all of the insurance programs provide the same benefits. All states' programs do, however, provide immunizations and care for "healthy babies" and children at no cost.¹³ Overall, families may be required to pay a premium or a co-payment for other services, which is dependent on their gross family income. However, today more than half of the remaining uninsured children who are eligible are still not enrolled in these types of programs.¹⁴ It is important to note that certain states have worked diligently to extend coverage to optional populations, but they have been faced with various administrative barriers to enrollment in order to limit the cost of the SCHIP and Medicaid coverage.

III Medicaid Spending

In 1989, during the first Bush Administration, total Federal and state Medicaid spending was approximately \$61.2 billion dollars. In 1993 total Federal and state Medicaid spending increased to approximately \$132 billion dollars. Last year, total Federal and state Medicaid spending rose to nearly \$304 billion dollars, meaning that total spending for Medicaid has nearly tripled over the past ten years. Furthermore, Federal funding for Medicaid over the next ten years is expected to reach \$2.6 trillion dollars and combined Federal and state spending on Medicaid during this same time period is expected to exceed \$4.5 trillion dollars.¹⁵ Therefore, Medicaid, not Medicare, is now the largest government health program in the United States.¹⁶

¹³ Ibid p-4

¹⁴ Institute of Medicine: Ibid: p-3

¹⁵ Scully, Thomas "Testimony of Thomas Scully, Administrator for the Centers for Medicare and Medicaid Services on the Challenges facing the Medicaid system in the 21st Century before the House Energy and Commerce Committee Subcommittee on Health;" CMS Office of Legislation; Centers for Medicare and Medicaid Services; Baltimore, MD; October 18, 2003; (p-1)

¹⁶ Ibid p-1 (Scully)

In Fiscal Year (FY) 2002, total Federal-state Medicaid outlays, \$259 billion, exceeded Medicare outlays, \$257 billion, for the first time by \$2 billion dollars.¹⁷ In FY 2003, Medicaid outlays, \$281 billion, exceeded Medicare outlays, \$277 billion, by \$4 billion dollars.¹⁸ During this time, Congress enacted a temporary infusion of additional Federal funds as part of the Jobs and Growth Tax Relief Reconciliation Act of 2003. This infusion began on April 1, 2003, and ended on June 30, 2004 and enabled states to receive a temporary increase in the percentage rate for Federal Medicaid matching funds (FMAP) for five calendar quarters. Therefore, in FY 2004, Medicaid outlays \$304 billion, exceeded Medicare outlays, \$289 billion, by \$26 billion dollars.¹⁹ Moreover, in FY 2004 states spent more on Medicaid than they spent on Education for the first time ever.²⁰

As mentioned earlier, while a certain amount of this fiscal growth can be attributed to expanded coverage and eligibility, the majority of the increase in Medicaid spending over the past ten years has been a consequence of the often-exorbitant costs of providing long-term care to qualified recipients. In fact, approximately one-third of all Medicaid spending is allocated to the above referenced long-term care benefits. Of this one-third, roughly 67 (sixty-seven) percent is spent on institutional care and 33 (thirty-three) percent is spent on home and community based services.²¹ From 1999 to 2003, Medicaid long-term care expenditures grew at an annual average rate of about 8 (eight) percent per year. Institutional spending, in particular, grew at an annual rate of growth of about 6 (six) percent during this same time period. However, states' efforts during this particular period to expand home and community-based benefits have resulted in a higher rate of growth for these services, increasing at an average of 17 (seventeen) percent per

¹⁷ Ibid p-1 (Scully)

¹⁸ Ibid p-1 (Scully)

¹⁹ Ibid p-1 (Scully)

²⁰ Medicaid cuts in Presidents Budget would harm states and likely increase ranks of uninsured" Center on Budget and Policy Priorities; Washington DC; March 5, 2005; (p-3)

²¹ Shaughnessy, Carl O. "Long-Term Care: What Direction for Public Policy?" Testimony Before the House Committee on Energy and Commerce; CRS Report for Congress; Washington DC; April 27, 2005 p-13

year.²² More specifically, expenditures for the Section 1915(c) waiver program increased at an average annual rate of 25 (twenty-five) percent in the states' efforts to provide expanded access to home and community-based services to those with disabilities. Thus, Medicaid, by default, has become the nation's primary source of public financing for these long-term care services. However, as a consequence, states have become financially fragmented and are now faced with the seemingly daunting task of reducing costs for standard Medicaid services and are being forced to drop optional Medicaid benefits and/or to reduce optional populations.

It is important to emphasize that there is a profound misconception by many that Medicare is the primary funder of long-term care services. In terms of long-term care, Medicare actually only offers minimal benefits and covers about 12 (twelve) percent of institutional services on an annual basis. Furthermore, as of FY 2004, Medicare beneficiaries paid over 19 (nineteen) percent of out of pocket expenses, which were primarily attributed to long-term care costs.²³ So overall, Medicare's role in long-term care is minimal at best, which is certainly paradoxical under the pretense that this program was intended for-to protect the elderly.

As a consequence of this financial strain, many states have looked to find other creative mechanisms to appropriate more money from the federal government to cover the qualified beneficiaries as mentioned above. For instance, intergovernmental transfers (IGTs) are a primary example of such a mechanism. It is important to note that it is perfectly legal for states to share costs with counties and other local government entities to regain Medicaid expenditures. However, IGT's are only supposed to provide the statutorily determined match rate for a state, meaning that the Federal government is only supposed to match real expenditures for the Medicaid population at the real matching rates. However, many states have been able to find ways to manipulate IGTs to avoid

²² Ibid p-13

²³ Ibid p-2

paying the statutory match rate and ultimately shift a larger portion of Medicaid costs to the Federal government.²⁴ In fact, according to the Bush administration, IGTs have been used to draw billions in Federal funds without any real state or local spending over the past twenty years.²⁵

Over the past five years, the Bush administration and the Department of Health and Human Services have proposed a multitude of reforms in an effort to close these mechanisms and to ensure that states receive “appropriate” matching rates.²⁶ Furthermore, the Bush administration intends to improve the “fiscal integrity” and “management” of the Medicaid program. Regardless of whether or not the Administration has legitimate legal grounds for restricting states use of these loopholes, these reforms are going to collectively precipitate some serious ramifications and consequences for the Medicaid program.

On a pragmatic level, states are already having significant difficulties in maintaining adequate financial support for Medicaid beneficiaries because of the enormity of the system. Thus, on a fundamental level, it is arguable that the states’ attempt to secure as much Federal funding as possible by utilizing these mechanisms is simply a means for providing health coverage for as many qualified recipients as possible. More importantly, the Bush Administrations reform plans would allocate a substantial portion of Medicaid costs onto the states, which would further diminish their ability to provide sufficient healthcare for qualified beneficiaries. This would significantly weaken the viability of the Medicaid program as a whole and could potentially push the financial burden for the program into the private sector, which could essentially mean considerably less medical coverage for those indigent individuals.

²⁴ Ibid p-2 (Scully)

²⁵ Ibid p-2 (Scully)

²⁶ Ibid p-2 (Scully)

Section III **“Inappropriate Funding Mechanisms”**

I. The Fiscal Relationship

To restate, Medicaid is a financial partnership between the Federal government and the states. The Federal government’s role is to provide financial support to the states and to oversee the Medicaid program overall. The states are responsible for the maintenance and the administering of each of their specified programs. The Federal government pays states a portion of their costs by matching certain spending levels, with statutory matching rates currently ranging between 50 (fifty) and 77 (seventy-seven) percent.²⁷ However, this creates an inherent tension between the states and the Federal governments and consequently states seek to maximize Federal matching dollars. Thus the Bush administration believes that the Federal government has a responsibility to ensure that funds are “matched appropriately.”

In 1985 the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), changed the regulations governing the way the Federal government provides these matching funds to states, particularly when states received private donations to help cover administrative costs. These changes were initially intended to reduce record keeping and provide states with more flexibility for accepting donations for health care costs.²⁸ Furthermore, regulations at that time allowed states to impose special taxes on specific provider groups which permitted states to impose taxes and receive donations from providers that ultimately led to new ways to finance states’ share of Medicaid expenditures.²⁹ In 1986, however, Congress became

²⁷ Scully, Thomas “Testimony of Thomas Scully, Administrator for the Centers for Medicare and Medicaid Services on the Challenges facing the Medicaid system in the 21st Century before the House Energy and Commerce Committee Subcommittee on Health;” CMS Office of Legislation; Centers for Medicare and Medicaid Services; Baltimore, MD; October 18, 2003; (p-3)

²⁸ Ibid p-3 (Scully)

²⁹ Ibid p-3 (Scully)

concerned that states were not “reimbursing” Disproportionate Share Hospitals (DSH) for their “uncompensated” health care costs.³⁰

Legislation was thus passed that eliminated any limit on DSH payments. The combination of new revenue sources from donations and taxes and the ability to pay unlimited reimbursement to Disproportionate Share Hospitals (DSH) led to a significant increase in the Medicaid expenditures claimed by states. Once these particular DHS loopholes were restricted, states pursued other alternatives. In particular, the Upper Payment Limit (UPL) mechanism was utilized more aggressively.³¹ Collectively, these specific mechanisms have provided opportunities for states to appropriate additional Federal matching funds and have generated an effective FMAP that is higher than the statutorily determined matching rates. This has created inequities among states and has caused the Bush administration to vehemently attempt to close these specific loopholes.

A. Provider Donations

One strategy states initially used to maximize Federal Medicaid matching funds was the use of provider donations and taxes. Through this maximization strategy, states would either arrange for providers to donate funds to the Medicaid program, or would establish special taxes on certain provider groups.³² Once these funds were paid by the providers, they were then repaid to those providers through increased Federal Medicaid payments, in the form of DSH payments. Due to the states flexibility in how they made DSH payments, they were then able to raise DSH rates to compensate providers for the costs associated with the donations or taxes.³³ As the DSH payments increased, the subsequent level of Federal matching funds increased. Ultimately, the providers were repaid their donations or taxes and the state was left with the Federal matching funds to either return to the provider or to keep for whatever use it decided.

³⁰ Ibid p-3 (Scully)

³¹ Ibid p-3 (Scully)

³² Ibid p-3 (Scully)

³³ Ibid p-3 (Scully)

According to the Bush administration and the Centers for Medicare and Medicaid CMS, the Federal government was the only entity that incurred any additional costs and the consequential use of these financing mechanisms generated exorbitant increases in Federal Medicaid expenditures throughout the late 1980s and early 1990s. For instance, in 1989 CMS apparently found that three states had gained a combined total of \$23 million dollars from Federal funds through these particular provider taxes and donation mechanisms. Furthermore, in 1990, eight states achieved an additional \$300 million and by 1991 more than half of all the states had acquired nearly \$12 billion dollars through this particular maximization mechanism.³⁴

Consequently, Congress passed the “Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which imposed restrictions for states to use taxes on health care providers as part of their state dollars eligible for Federal Medicaid matching fund.³⁵ This law was enacted in 1993 and essentially laid out a process for states to request waivers of certain provisions for tax programs that were not broad based or uniform. The “hold harmless” provision, however, cannot be waived. The law also called for these taxes to be:

- Broad based, or applied to all members of a definable group. For example, they must apply to all hospitals, not just psychiatric hospitals.
- Uniform, with all providers within the group being taxed at the same rate; and not part of a “hold harmless” agreement where the funds are returned to the providers either directly or indirectly.

Furthermore, this law eliminated Federal Medicaid matching payments for provider donations, except in specified limited circumstances. In 1995, in an effort to improve state compliance with the law, CMS issued detailed regulatory guidelines explaining the Donations and Tax rules. In 1997, CMS notified states that if legislation explicitly ending the use of impermissible taxes and resolving outstanding state liabilities was not passed,

³⁴ Ibid p-4 (Scully)

³⁵ Ibid p-4 (Scully)

CMS would have no choice but to ask the Department of Justice to pursue enforcement measures to resolve states' liabilities. Also in 1997, the Balanced Budget Act (BBA) banned states from using Federal Medicaid matching funds for purchases unrelated to health care, such as building roads and bridges. In 1998, CMS proposed legislation to allow the Secretary of Health and Human Services to work with states regarding large unallowable funds they inadvertently received, rather than having to refer these cases to the Justice Department. Although this proposal never became law, due to the other restrictions discussed, it appears that today states generally have stopped attempting to exploit this particular loophole

B. Disproportionate Share Hospitals

As mentioned earlier, Disproportionate Share Hospitals (DSH) are another primary mechanism states use. In 1981, Congress realized that certain hospitals were caring for a significant amount of uninsured patients. Due to this circumstance, the hospitals Uncompensated Care Costs (UCC) increased significantly. Consequently, these particular hospitals were receiving far less revenue per patient and were struggling to remain open. In 1981, with the passage of the Omnibus Budget Reconciliation Act (OBRA), Congress allowed states to pay more to hospitals caring for a disproportionate share of uncompensated care cases as a way to encourage these hospitals to continue treating needy patients.³⁶

Initially, states didn't really embrace this program. However, a significant change to the DSH law occurred in 1986, which prohibited the Federal government from putting any limit on payments made to hospitals that serve a disproportionate number of low-income patients with special needs.³⁷ In 1987, Congress then created DSH payment rules and qualifications in the law and specifically defined Disproportionate Share Hospitals

³⁶ Ibid p-4 (Scully)

³⁷ Ibid p-4 (Scully)

and required states to pay additional funds to certain qualifying hospitals.³⁸ In 1993 Congress further restricted state use of DSH revenues by limiting the amount that states could pay to specific hospitals to 100 (one-hundred) percent of their uncompensated care costs, further limiting abusive DSH practices.³⁹

C. Intergovernmental Transfers

As this new OBRA took effect in 1993, states once again began looking for alternative ways to maximize Federal funds. They then turned to Intergovernmental Transfers IGT's, as discussed earlier. It is important to note that states are allowed to shift funds among the different levels of government to reduce administrative burdens.⁴⁰ For example, a county can transfer funds to the state, and states can subsequently use this money as their share of Medicaid expenditures.⁴¹ However, states provided DSH payments to public facilities that exceeded their Medicaid costs. This meant that states received more Federal matching funds and these facilities could then refund some of the money to the state through IGTs. To end this practice, the Balanced Budget Act of 1997 mandated state-specific caps on the total level of Federal matching payments to state DSH hospitals.⁴²

D. Upper Payment Limits

Upper Payment Limits were created by Congress in 1981 to obliterate the inherent incentive for states to overpay themselves.⁴³ However, states were still allowed to exceed these Upper Payment Limits for certain publicly owned providers. Essentially, states were able to calculate the maximum amount that Medicare would have paid to each Medicaid facility and then determined the upper limit for both public and private hospitals and nursing homes in the aggregate, rather than separating public from

³⁸ Ibid p-4 (Scully)

³⁹ Ibid p-4 (Scully)

⁴⁰ Ibid p-5 (Scully)

⁴¹ Ibid p-5 (Scully)

⁴² Ibid p-5 (Scully)

⁴³ Ibid p-5 (Scully)

private.⁴⁴ This ultimately allowed states to pay public hospitals and nursing homes more than private facilities and consequently public hospitals could return this money to the state and then the state could use these funds to obtain additional Federal matching dollars. Moreover, the state could then return a portion of its share of the money to the public facilities, and keep the Federal share for its own use.⁴⁵

During the late 1990's, CMS realized that states were manipulating these Upper Payment Limits. In 1999, CMS' employed various audits in six states that confirmed their suspicions of states use of these UPLs. Consequently, CMS imposed three regulations establishing Federal upper payment limits (UPL) that limited the ability of states to increase their share of the Federal payments under Medicaid without actually spending state funds to ultimately close this loophole.⁴⁶ These regulations now prevent states from paying each type of hospital and nursing home in Medicaid more than 100 (one- hundred) percent of what Medicare would pay for similar services.⁴⁷ All of these mechanisms have led to the Bush Administration's efforts to restrict these acts.

⁴⁴ Ibid p-5 (Scully)

⁴⁵ Ibid p-5 (Scully)

⁴⁶ Ibid p-5 (Scully)

⁴⁷ Ibid p-6 (Scully)

Section IV

The Bush Administration Themes of Reform

I. 2003 Medicaid Reform Plan

Proponents of the Bush Administration's healthcare reform plans contend that the Medicaid program is currently outdated and that the "spiraling costs" and "straitjacket rules" are forcing states into no-win situations where they need to reduce coverage and have little opportunity to expand coverage.⁴⁸ Specifically, in 2003 almost two-thirds of states were forced to reduce some Medicaid benefits due to the severe budget crisis. This precipitated the Bush administration to propose an optional Medicaid reform plan that the Administration believed would potentially make Medicaid more effective, protect and cover more people and provide better health care delivery.

This 2003 proposal allowed the Federal Government to "frontload" Medicaid spending, meaning the first year (FY 2004) states would receive an additional \$3.25 billion dollars in "new money" for 2004 and it would collectively add \$12.7 billion dollars in over a full seven year period. By employing this frontloading method, the Bush administration believed, would help prevent people from losing coverage and would provide opportunities for states to extend health care to more qualified beneficiaries. Furthermore, this plan would give each state flexibility in targeting its resources to better serve Medicaid beneficiaries. For example, states would have the flexibility to expand coverage to the mentally ill, the chronically ill, those with HIV/Aids virus, those with substance abuse issues and childless adults without seeking a federal waiver.⁴⁹ States could also impose long term care for seniors and those with disabilities. Overall, this plan placed the emphasis on providing health coverage for entire families. The Administration's rationale for this was that to provide coverage to parents would attract more children into the program because parents are generally more inclined to include the

⁴⁸ Ibid p-7

⁴⁹ "HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan" Kaiser Network, Health Policy as it Happens; Washington DC; January 31, 2003; (p-5)

entire family in a healthcare plan. Under this new flexibility (flexibility meaning cost sharing and co-pays) states would be able to tailor their program so there would be one doctor, one clinic and/or one hospital for the entire family.

This new plan was based upon the SCHIP model. Proponents of this plan maintain that SCHIP allowed states to have greater flexibility in providing adequate and cost effective care to its beneficiaries. In other words, these same principles should be applied throughout the Medicaid program as well. If states were to take advantage of this plan, they would only have to contribute the additional amount of money for the inflationary amount of medical costs, which would essentially mean a reduction in the expenditures for the state.⁵⁰ They would ultimately get more flexibility, less funds out of their treasury and essentially more money coming in from the Federal government.

It is important to note that this plan would mean voluntary participation for a state. Currently, HHS distributes checks in quarterly installments for SCHIP, Medicaid and disproportionate use and a check for management of the programs.⁵¹ This plan would reduce this current payment system into two checks, one for acute care and one for long-term care. In addition, states would have transferability of up to ten percent from one program to another and fifteen percent of this deducted for management.⁵²

II. 2004-2005 Medicaid Reform Plan

One of the primary reforms the administration proposed in 2004, was to cap the reimbursement level to individual state and local government providers to no more than the cost of providing services to Medicaid beneficiaries and to restrict the use of intergovernmental transfers that are used to “recycle” Medicaid payments through government providers.⁵³ The administration contends that this proposal would not affect legitimate intergovernmental transfers that are intended to raise funds for the states share

⁵⁰ Ibid p-6 (2003-Thompson)

⁵¹ Ibid p-11(2003-Thompson)

⁵² Ibid p- 11 (2003 Thompson)

⁵³ Thompson, Tommy G. “Statement before the U.S. Senate Committee on the Budget” Department of Health and Human Services; February 12, 2004; (p-12)

of Medicaid costs.⁵⁴ Moreover, several other reforms were put forth during this particular time period.

A. Extension of the Qualified Individual (QI) Program

Under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), the Medicaid program paid for Medicare Part B Premiums for qualifying individuals (QI) through September 2004. Qualified Individuals are identified as Medicare beneficiaries with incomes of 120 (one-hundred and twenty) percent to 133 (one-hundred and thirty-three) percent of the Federal Poverty Level with minimal assets. HHS continued this premium service for one additional year.⁵⁵

B. Extension of Transitional Medical Assistance

Transitional Medical Assistance (TMA) is a program that was created to provide healthcare insurance for former welfare beneficiaries after they entered the workforce. TMA provided a one year extension of health coverage for those families who lose eligibility for Medicaid because of their income. However, this provision expired in March of 2004. Consequently, the Bush Administration proposed a five year extension of TMA with "statutory modifications to simplify the administration of the program for the states."⁵⁶ Under this new provision, states would have the option to eliminate TMA reporting requirements, provide twelve months of continuous eligibility and would allow for a potential waiver from providing the mandatory TMA program to their Medicaid program if the eligibility income level for families is set at 185 (one-hundred eighty-five) percent of the poverty level.⁵⁷

C. Partnership for long-term care (LTC)

The Partnership for long term care was formed as an attempt to find alternatives for current long-term care (LTC) financing by "blending" public and private insurance

⁵⁴ Ibid p-12 (Thompson 2004)

⁵⁵ Ibid p-13 (Thompson 2004)

⁵⁶ Ibid p-13 (Thompson 2004)

⁵⁷ Ibid p-13 (Thompson 2004)

together. There are four states that currently have private insurance cover the initial costs of LTC. Participants of these partnership-approved insurance policies could potentially become eligible for Medicaid services after their private insurance was utilized, without shifting all of their assets, which is typically a requirement to meet Medicaid eligibility standards.⁵⁸

III. 2006 Proposed Medicaid Reform and Spending Cuts

Bush's 2006 proposed budget called for a \$45 billion dollar net reduction in Federal funding for Medicaid over the next ten years. The Administration is proposing to reduce Medicaid funding by roughly \$60 billion dollars with \$15 billion in new Medicaid-related spending between fiscal years 2006 and 2015, for a net reduction in federal funding of \$45 billion over the next ten years.⁵⁹ This new Medicaid related spending would have generated \$15 (fifteen) billion dollars in new funding for Medicaid and SCHIP. This included \$1 billion dollars for a new outreach initiative. This initiative was intended to potentially enroll more children in Medicaid and SCHIP. Additionally, the Administration's budget called for \$10 billion dollars, as a consequence of this new outreach initiative, for the federal share of the costs of covering the children whom the budget assumes would newly enroll in Medicaid. However, the administration is still maintained that there should be a cap on at least part of Federal Medicaid funding as well as various other spending cuts, which they are attempting to employ through five different methods over the next ten years. First, the Administration is proposed to reduce Medicaid federal expenditures by \$15 (fifteen) billion dollars by reducing the amount that Medicaid pays pharmacists for prescription drugs to approximate what pharmacists pay wholesalers for the drugs they dispense.⁶⁰ The Administration also proposed to "strengthen" the existing requirements for questionable asset transfers" by individuals

⁵⁸ Ibid p-13 (Thompson 2004)

⁵⁹"Medicaid cuts in Presidents Budget would harm states and likely increase ranks of uninsured" Center on Budget and Policy Priorities; Washington DC; March 5, 2005; (p- 1)

⁶⁰ "Major Savings and Reforms in the President's 2006 Budget" US Office of Management and Budget; Washington DC; February 11, 2005.) (p-70)

seeking Medicaid coverage for nursing home care.”⁶¹ The Administration maintains that by doing so, would generate \$4.5 billion dollars in savings over the next ten years.

The third method the Administration proposed is to generate a \$23 (twenty-three) billion dollar reduction in Medicaid’s financing rules. Fourth, to employ \$12 billion in savings from reducing the matching rate for targeted case management, which is designed to assist individuals in securing needed medical services and related social services?⁶² By limiting this service, the Administration believes, would reduce the likelihood of states inappropriately shifting more funds to the Federal Government. Lastly, Medicaid spending should be reduced by \$6 (six) billion dollars by capping the federal share of the administrative costs that states gain. Currently, the federal government and the states each pay half of most state Medicaid administrative costs, such as the cost of making eligibility determinations, conducting outreach, and paying claims.⁶³ The federal government pays 75 (seventy-five) percent of a small number of state administrative costs, such as monitoring the quality of nursing homes and prosecuting fraud and abuse. As an alternative measure, the Administration’s budget proposes to replace these specific matching arrangements with fixed federal “allotments” to each state for administrative costs. Thus means that there would essentially be a block grant for federal funding for these administrative costs. This is one of the proposals that would reduce federal funding for state Medicaid programs without lowering the costs that states incur.

The 2006 s budget also proposed to “modernize” Medicaid and the SSCHIP program to give states more “flexibility” to restructure coverage in addition to these other various appending cuts. However, all this proposal called for was a change that results in

⁶¹ Wachino, Victoria; Schneider, Andy; Leighton, Ku “Medicaid Budget Proposals will shift costs to states and be likely to cause reductions in Health Coverage.” Center for Policy and Budget Priorities; Washington DC; *February 18, 2005*; (p-2)

⁶² Ibid p-2 (Wachino)

⁶³ Ibid p-2 (Wachino)

no additional federal cost.⁶⁴ According to the Centers on Budget and Policy Priorities, this essentially meant that the Administration would likely invoke a cap on part or all of Medicaid funding. As a consequence of this cap, the Federal Government's share of Medicaid costs could significantly decrease over time and would again shift a larger substantial share of Medicaid costs onto the states. Furthermore certain low-income children, parents, seniors, and individuals with disabilities would no longer have an entitlement to Medicaid coverage and could potentially be turned away or put on a waiting list, despite their eligibility and need for insurance.⁶⁵

Overall, the federal government's share of Medicaid administrative costs is an essential source for maintaining and administering the Medicaid program. As clearly emphasized, states are already cutting back Medicaid coverage because of their consequential struggle to produce their share of Medicaid costs, which has a great deal to do with the long-term care burden. Despite this, the Administration is still attempting to employ these various reforms that would further shift costs to states. This is undoubtedly going to further exacerbate the states current fiscal predicament. In particular, the same Center for Budget and Policy Priorities report showed that this reduction would undoubtedly lead to increases in the number of the uninsured and the underinsured for Americans by significantly weakening the states ability to provide long-term health care to low-income recipients, particularly under the already stained financial circumstance. All of the Bush Medicaid reforms thus far, fail to address the real underlying issue-the long-term care burden.

⁶⁴ Ibid p-2 (CHPP)

⁶⁵ Ibid pp-2-3 (CBPP)

Section V

Long-term Care in the United States

I. LTC Recipients: Who are they and who cares for them?

It is estimated that roughly 8 million individuals receive long-term care services that include nursing home, assisted living and home care in the United States today.⁶⁶ Of this figure, roughly 56 (fifty-six) percent are over the age of 65, and about 44 (forty-four) percent are under the age of 65. Moreover, the vast majority of these adults, about 80 (eighty) percent, receive care in home and community settings and about 1.8 million adults, roughly 20 (twenty) percent require institutionalized treatment.⁶⁷ Thus, the primary source of long-term care assistance generates from informal caregivers, meaning families and friends of people with disabilities who provide this assistance without financial compensation. Even more specifically, about two-thirds of the functionally impaired elderly require care for impairments with *Instrumental Activities of Daily Living* (ADL) and about 71 (seventy-one) percent of these individuals age 18-64, rely exclusively on this informal, unpaid assistance. Overall it is estimated that a minimum of about 13 million people care for these particular individuals with moderate to severe disabilities in the United States today.

In addition to this informal care, the long-term care services system also includes a variety of formal providers. These include nursing and residential care facilities for people with mental retardation and developmental disabilities and various other agencies and programs that provide a wide range of home and community-based services for beneficiaries. Additionally, assisted living facilities, adult foster care and other group homes provide room and board as well as personal care and other assistance, to individuals who have lost the capacity to live independently in their own home environment. Furthermore, researchers predict that the increased numbers of individuals

⁶⁶ Shaughnessy, Carl O. "Long-Term Care: What Direction for Public Policy?" Testimony Before the House Committee on Energy and Commerce; CRS Report for Congress; Washington DC; April 27, 2005 p-4

⁶⁷ Ibid p-4

reaching age 65 in conjunctions with the increasing life expectancy rate, will undoubtedly affect future demand for formal providers. In fact, according to a report entitled “*New Estimates of Lifetime Nursing Home Use: Have Patterns Changed?*,” 44 (forty-four percent) of those individuals who turned age 65 in FY 2000 will enter a nursing home during their remaining lifetime, almost one-third will have nursing home stays of three months or longer, and almost one fourth will have stays of one year or longer.⁶⁸ This report also predicts that the number of individuals aged 65 and older who will need institutionalized care will more than double, 891,000 to 1.8 million, between 2000 to 2020.

A. Costs of LTC

According to the *AARP Public Policy Institute*, the average cost of a nursing home stay is roughly \$55,000 per year and can exceed \$100,000 in some urban areas.⁶⁹ The average retiree has roughly \$30,000 in retirement savings, which is clearly insufficient to self-fund even a relatively short stay in a nursing facility. Home care can cost around \$1,000 per month and hourly home care agency rates average from \$18 for a home health aide to about \$37 for a licensed practical nurse. The average fee for assisted living services often exceeds \$2000 per month. Moreover, projected spending just on nursing home care alone will increase from the current \$94.1 billion to roughly \$125 billion a year by the end of this FY 2005 and could potentially surpass \$330 billion by FY 2030.

B. Fiscal Spending for LTC

Of the \$1.44 trillion spent on all U.S. personal health care services, roughly \$181.9 billion, or about 12.6 percent, are currently spent on long-term services. In FY 2000, total spending for long-term healthcare services was approximately \$140.7 billion

⁶⁸ Brenda C. Spillway and James Lubitz, “New Estimates of Lifetime Nursing Home Use: Have Patterns Changed?,” *Medical Care*, vol. 40, no. 10, 2002.

⁶⁹ Enid Kassner, “Long-term Care Insurance Fact Sheet” AARP Public Policy Institute; September 2004

dollars, excluding the cost of informal care giving by families.⁷⁰ This amount includes spending on services in *Institutions for Individuals with Mental Retardation* (ICF/MR)), and a wide range of home and community-based services. In FY2003, spending for long-term care increased to about \$181.9 billion. Of this figure, Medicaid financially contributed approximately \$86.3 billion, 47.4 percent, of all long-term care spending, and Medicare contributed \$32.4 billion, 17.8 percent of this proportion. Private out-of pocket spending accounted for \$37.5 billion, 20.6 percent, and private insurance accounted for about \$15.7 billion, 8.7% of this figure. To demonstrate this in an alternative context, Medicaid and Medicare combined financially contribute roughly 65 (sixty-five) percent of all long-term care spending in the United States today, which clearly substantiates the significant burden that these services have bestowed on Medicaid, in particular.

C. LTC in the Private Sector

The number of private long-term care insurance policies has significantly increased over the past twenty years. In particular, between 1987 and 2002, the market for private long-term care policies increased by 18 (eighteen) percent for each year during that time period. As of FY 2002, approximately 80 (eighty) percent of all private long-term care insurance policies were sold through the individual market, and approximately 28 (twenty-eight) percent were sold in either the employer-sponsored or life insurance markets.⁷¹ Even more specifically, a report published by *America's Health Insurance Plans 2004* (AHIP) showed that in FY 2002 more than 104 companies sold more than 900,000 long-term care policies. This same report also showed that a total of 9.16 million policies were sold in the overall private sector during this same period and that roughly 6.4 million of these insurance plans have remained active.⁷² These plans included individual, group association, employer-sponsored policies, and riders to life

⁷⁰Shaughnessy, Carl O. Lyker, Bob and Storey James R." Long-Term Care: What Direction for Public Policy?" CRS Report for Congress; Washington DC; December 18, 2002

⁷¹ Enid Kassner, "Long-term Care Insurance Fact Sheet" AARP Public Policy Institute; September 2004 p-11

⁷² Coronel, Susan: "Long-term Care Insurance in 2002" *Americas Health Insurance Plans (AHIP)*; Washington DC; June 2004

insurance policies that accelerate the death benefit for long-term care.⁷³ It is important to note, however, that although the individual and employer-sponsored markets have experienced substantial growth in recent years, the long-term care life insurance rider market has remained stagnant since 1996.⁷⁴ In fact, according to this AHIP report, 68 (sixty-eight) percent of the FY2002 increase can be attributed to the individual and group association markets. Furthermore, this study showed that the total premium volume for the individual and group association policies sold in 2002 exceeded \$1 billion.⁷⁵

The average cost of private long-term care insurance is high and varies dramatically with the consumer's age, the amount of coverage and other policy content. The majority of the private policies sold do cover nursing home, assisted living and home care services and generally reimburse the insured for long-term care expenses up to a fixed amount, such as \$100 or \$150 per day.⁷⁶ According to the AHIP report, the base plan average annual premium in FY 2002 for a policy providing \$150 per day for an individual age 65 cost \$1,337 and with a 5 (five) percent compounded inflation protection, rose to \$2,346 that year. For a person aged 79 and older, the average annual premium for a base long-term care plan increased to \$5,330, and with a 5 (five) percent compounded inflation protection, exceeded \$7,572 during this same time period.⁷⁷ So I would hope that you would agree with me that irrespective of any surge in the private market, very few Americans actually have the financial capability to invest in this private insurance, particularly middle and lower class Americans, given these high costs. To further validate this notion, the Long-Term Care Financing Strategy Group's *Index of long-term care Uninsured* recently reported that only 9 (nine) percent of all individuals above the age of 65 have private LTC insurance and 14 (fourteen) percent of this

⁷³ Enid Kassner, "Long-term Care Insurance Fact Sheet" AARP Public Policy Institute; September 2004 p-11

⁷⁴ Ibid p-11

⁷⁵ Ibid p-11

⁷⁶ Ibid p-11

⁷⁷ Ibid ; p-11

population have public LTC coverage.⁷⁸ This means that approximately 77 (seventy-seven) percent of all individuals above the age of 65 are without any form of long-term care insurance in the United States today.

II. Long-Term Care Reforms

To restate, irrespective of the extensive spending on long-term care, the United States still lacks a comprehensive policy for providing such services. It is fair to argue that the complexity of financing and delivering adequate care to recipients has been an intricate challenge for both federal and state governments for the past 35 years. In fact, the last time Congress made a systemic change in federal long-term care policy was in 1981 when it created the Medicaid Section 1915(c) home and community-based waiver program for persons with disabilities under Medicaid as discussed earlier. Other minor alterations have included changes in Medicaid eligibility rules for long-term care services such as financial protections for spouses of persons needing nursing home care and other Medicaid services, which were imposed by Congress in 1988. In 2000, Congress authorized a caregiver support program under the *Older Americans Act for Friends/Family of long- Term Care Recipients* and also established a voluntary long-term care insurance program for federal employees, retirees, and family members. Moreover, the last time that Congress proposed policy options for long-term care reform was in 1990 under the *U.S. Bipartisan Commission on Comprehensive Health Care*, also referred to as the *Pepper Commission*.⁷⁹

There have certainly been a variety of proposals contemplated by policy makers for the past two decades. Certain proposals advocate for relying on payments from individuals through cost-sharing, premiums and deductibles, rather than means-testing and spend-down requirements under Medicaid. Others promote the private sector for

⁷⁸ Long-Term Care Financing Strategy Group's *Index of long-term care Uninsured*; 2004 p-1

⁷⁹ Shaughnessy, Carl O. "Long-Term Care: What Direction for Public Policy?" Testimony Before the House Committee on Energy and Commerce; CRS Report for Congress; Washington DC; April 27, 2005 p-14

long-term care insurance, with the rationale that the nation cannot afford the additional tax burden of another entitlement program. In FY2001 President Bush set forth the following initiatives for long-term care legislation, known as the “freedom Initiative:”

- A \$3,000 Income tax credit, when fully phased in, for those individual in need of long-term care services.
- \$125 million dollars for caregiver services under the *Older Americans Act*.
- A group long-term insurance program for federal employees.
- An option for states to liberalize Medicaid income eligibility for persons who are in need of home and community based care.
- Steps to improve the quality of care in nursing facilities.
- \$100 million for capital grants and operating subsidies for Assisted Living Housing Units administered by the *Department of Housing and Urban Development* (HUD)

The most significant component of Bush’s long-term care proposals is the tax credit element for individuals and families in need of such services. Specifically, the individual’s spouse or someone who can claim the elder person as their dependent could qualify for the tax credit. The maximum credit allotted would be \$3,000 per individual and would be phased in starting at \$2,000 and would increase until the \$3,000 is reached thereafter. However, this would not be available to lower income tax payers with no tax liability.⁸⁰ For the \$125 million for caregivers, the services provided would include adult day care, home care services and others validated by state and area agencies on aging. As for Medicaid home and community based services, Bush has proposed legislation that would permit states to expand home and community based services to those individuals with incomes up to 300 percent of the poverty line who are determined to need institutional care. As for nursing home quality of care improvements, Bush’s initiatives include: imposing immediate sanctions on homes that are found to have deficiencies that

⁸⁰Carol O’Shaughnessy, Bob Lyke and Carolyn Merck: “Long Tem Care: The President’s FY2001 Budget Proposals and Related Legislation” CRS Report for Congress; August 21, 2000

effect patient care, conducting weekend inspections, increasing numbers of patients evaluated to determine facilities ability to detect and prevent bed oars and more frequent inspections for those facilities with recurring violations.

Various Congressional and Senatorial representatives have also proposed legislation in conjunction with the Bush Administration's platform. However, Congress and the Senate have showed minimal endorsement, at best, of Bush's proposals over the past five years. Overall, the current Administration's underlying political philosophy, in terms of tax credits relative to healthcare policy, is both ineffective in the long-term and does not adequately support the most vulnerable population with the lowest incomes who are need of this type of insurance.

III. Recommendations

The Social Security-LTC Insurance Program

Although this is a thesis and the hypothesis is that the long-term care burden has been the underlying factor that has destabilized the Medicaid program, it is important to provide a solution for the lack of a comprehensive long-term care program in the United States. I will provide a brief description for a plan but a more in-depth analysis can be found in a subsequent paper I have written on this particular proposal.

In 1993, Yung Ping Chen introduced a comprehensive long-term care proposal known as "A Three Legged Stool: A New Way to Financing Long-Term Care" The central theme in this particular plan is to invoke a tradeoff principle in which individuals aged 65 and older would shift 5 (five) percent of their social security cash benefits into a public trust fund account that would thus guarantee a basic level of long-term care protection under Medicare. For those individuals with the lowest income levels predicated upon the standards put forth by the Federal Poverty Line (the bottom ten percent), there will be an exemption with coverage. Under this plan, the basic level of protection would guarantee recipients 1 (one) year of nursing home care, 1 (one) and a

half years of assisted living and 2 (two) years of home care. This basic protection could then be supplemented, on a voluntary basis, by some personal savings, private insurance or perhaps by earmarking the estate tax funds to further ensure that the Social Security-LTC program remains financially viable. The funds for this program would be collected and administered by the government.

The Social Security-LTC plan is going to be phased in within five to six years with part of the cost of living increases. The exact time is contingent upon the rate of inflation, which is currently under 3 (three) percent. For the first year, Social Security beneficiaries would pay 1 (one) percent of their cash benefits into the Social Security-LTC trust fund. This premium would increase by one percentage point annually until the 5 (five) percent was met and beneficiaries would then continue to pay the annual 5 (five) percent transfer thereafter. Recipients would be automatically enrolled in this program at age 65. Based upon Chen's preliminary projections, a five percent transfer of Social Security benefits would generate nearly 15 (fifteen) billion dollars, which would be substantial enough to facilitate a basic protection for long-term care. However, this estimate is dependant upon the rate of inflation and the number of years it would take to achieve 1 (one) percentage point per year. Thus, the allure of this program is that it would essentially be self ensured by this 5 (five) percent transfer.

VI. Conclusion

It is certainly true that since 1965, enactment of the Medicare and Medicaid programs substantially extended health insurance coverage to the poor and the elderly. However, the Medicaid program, in particular, has destabilized over the past twenty years due to the grave long-term health care burden the program has inherited. This has caused a significant inability for the states to provide basic coverage for poor populations across the country. Furthermore, the Bush Administration's failure to address the long-term care

burden and their consequential efforts over the past four years to close regulatory loopholes, as discussed in a subsequent section of this paper, will further exacerbate the program's instability. Overall, the lack of a comprehensive long-term care insurance program in the U.S. has precipitated numerous challenges for Medicaid and has resulted in the program's inability to adequately protect poor Americans.

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