MEDICAID: THE SHIFTING PLACE OF THE OLD IN A NEEDS-BASED HEALTH PROGRAM

BY ELIZABETH A. KUTZA

While Medicare dominates discussion as regards healthcare and the elderly, the importance of Medicaid to older people should not be underestimated. Medicaid (Title xxx of the Social Security Act) is a matching entitlement program that provides medical assistance for certain individuals and families with low income and few resources. Funding is shared by the federal and state governments, although the states have wide latitude in establishing eligibility standards, type and scope of services, and rate of payment to providers. As a result, the Medicaid program varies considerably from state to state. Total outlays for the Medicaid program were $125.8 billion for 1993 ($72.3 billion in federal and $53.5 billion in state funds), plus administrative costs (Social Security Administration, 1994).

Under federal guidelines, some elderly—those who are receiving federal Supplemental Security Income (SSI) cash benefits—must be covered under the Medicaid program. States have the option of covering other categorically needy groups, including older people who have incomes above SSI eligibility but below the federal poverty guidelines and those institutionalized individuals with incomes and resources below specified limits. And, finally, states also have the option of extending eligibility to those who are "medically needy," that is, to those who have too much income to qualify under the mandatory or optional categorically needy levels. This option allows the individuals to "spend down" to Medicaid eligibility and has been an especially important source of funding for middle-class older Americans who are institutionalized in nursing facilities.

Another way that the Medicaid program serves older people is through its relationship to the Medicare program. While people who have insured status under Social Security receive Medicare hospital insurance (HI) benefits automatically, they must pay a monthly premium for coverage under Medicare's Supplemental Medical Insurance (SMI) provisions. The state Medicaid agency may pay those premiums for Medicaid recipients entitled to Medicare. For certain Qualified Medicare Beneficiaries (those Medicare-entitled people with resources at or below twice the standard allowed under the SSI program and with incomes below the federal poverty guidelines), the state pays all the premiums and cost-sharing expenses for HI and SMI.

Altogether, those provisions in 1993 allowed 3.86 million persons aged 65 or older to participate in the Medicaid program. With older people representing 11.5 percent of all beneficiaries, vendor payments on behalf of this age...
group totaled $31.5 billion in 1993, or 3.9 percent of total outlays. Disabled people, too, receive substantial benefit from Medicaid. They represent 14.6 percent of beneficiaries and 37.3 percent of total vendor payments are to them (Social Security Administration, 1994). A look at vendor payments by type of medical service shows distinctions between these two groups, however. Table 1 displays these differences.

<table>
<thead>
<tr>
<th>Percent Distribution of Medicaid Payments</th>
<th>AGED</th>
<th>DISABLED</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>67.3</td>
<td>12.4</td>
</tr>
<tr>
<td>ICF/MR</td>
<td>1.7</td>
<td>25.4</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>6.4</td>
<td>26.0</td>
</tr>
<tr>
<td>Home Health</td>
<td>8.0</td>
<td>6.8</td>
</tr>
<tr>
<td>Other</td>
<td>16.2</td>
<td>29.4</td>
</tr>
</tbody>
</table>


As illustrated in Table 1, the dominant benefit under Medicaid for older people is for payment of nursing facility care. For the disabled, institutional care both in nursing facilities and in intermediate care facilities for the mentally retarded (icf/mrs) represents over one-third of expenditures, followed by inpatient hospital care (a benefit that Medicare provides for the aged), and other medical expenses (e.g., physician and other provider services, outpatient care, laboratory and drug expenses).

Thus, the importance of Medicaid to both the poor and the medically needy aged is clear. They rely upon it as a supplement to Medicare and a significant source of funding for nursing home care.

NEEDS-BASED PROGRAMS AND THE AGED

In the debate surrounding age versus need as a criterion for benefit eligibility, it is often asserted that needs-based programs will stigmatize older people and place them at a disadvantage. Whether this is the case in large part depends upon how "need" is defined. Typically, in American social policy, need is defined as "financial need" and is determined by income and asset eligibility standards. Such standards or "means tests" can serve one of two functions. They can screen clients in or out of a service program, or they can be taken into considera-

fairsness, advocates for the elderly also object to means-tested programs because of the stigma associated with their receipt. Declaring oneself to be impoverished in order to receive benefits from a program like Medicaid is assumed to be demeaning to the individual.

But in programs that provide health or social services, "need" can be defined as the "need for service"—for example, illness in the case of a health service, functional disability in the case of a long-term-care service. In such a scenario, "in or out" income and asset rules can be avoided, and new rules that essentially provide for cost-sharing can be implemented. Such a system is more equitable among individuals because public support for service is based upon need for service, qualified by the individual's ability to share in those costs. Cost sharing is also less stigmatizing for beneficiaries.

Two recent policy initiatives proposed such a change in our long-term care system but were given very scant hearing within Congress. In 1990, the U.S. Bipartisan Commission on Comprehensive Health Care, more commonly referred to as the "Pepper Commission," made its report on Access to Health Care and Long-Term Care for All Americans. The report recommended a social insurance program for home- and community-based care under which eligibility would be determined by functional status, not age or income. Cost sharing was to be required, but generous income and asset protection also was to be in place. For example, full protection of income and assets was proposed for all nursing home users during the first three months of care.

Three years later, President Clinton put forward his American Health Security Act, which also recommended a new long-term-care program. As in the Pepper Commission proposal, eligibility for services was based on functional status, not income or age. Eligible individuals were expected to pay a coinsurance amount, according to a sliding scale, to cover a portion of the cost of all services they would receive.
Neither of these proposals was enacted, however, because universal entitlement proposals that base receipt of service on need are a departure from our current approach of either categorical or means-tested eligibility. For that reason, they have not succeeded in the political marketplace.

EQUITY CONSIDERATIONS IN THE DEFINITION OF NEED

Of course, moving away from “means-tested” eligibility standards to “need for service” eligibility standards in public programs does not exempt us from concerns about equity; it only presents us with different equity considerations depending upon how “need for service” is defined. In the two examples cited above, “need” would have been defined in eligibility rules as need for hands-on or supervisory assistance with three or out of five activities of daily living or severe cognitive or mental impairment. By these criteria, many elderly would qualify for service. But perhaps a clearer illustration of the equity challenges faced by shifting criteria of need is a recent policy change in the state of Oregon.

In 1987, Oregon legislators faced with budget constraints decided not to pay for transplants for Medicaid patients, but instead to fund basic healthcare and other social services. The public became aware of the trade-off with the death of a 7-year-old boy who otherwise might have been eligible for a state-financed transplant. Despite considerable public and media pressure, the lawmakers kept to their earlier legislative decision, but the case was the beginning of a foundation for significant healthcare reform.

During its 1989 and 1991 sessions (Oregon has a biennial legislative session), the Oregon legislature passed six laws that began incremental reform of the healthcare system. The most widely publicized was Senate Bill 27 (1989), which extended Medicaid coverage to every Oregonian with income below the federal poverty level and provided a basic benefit package. SB 27 also created the Oregon Health Services Commission to rank medical services from most to least important to the entire population. The 1989 reforms also included bills that would require employers to cover all “permanent” employees and their dependents and a bill to fund the Oregon Medical Insurance Pool, which offers health insurance to people who cannot buy conventional coverage because of preexisting medical problems. In 1991, other bills created the Small Carrier Advisory Committee to design a basic benefit package for small businesses and required the Health Services Commission to integrate mental health and chemical dependency services into future priority lists as well as begin the process of offering the standard benefit package to seniors and persons with disabilities. Essentially, the Oregon health plan attempted to respond to the estimated 450,000 Oregonians uncovered by any health plan.

What captured national attention was SB 27 and its priority ranking of services, “rationing” as it was called in the media. From the state’s point of view, however, SB 27 provided for a process to develop a social and political consensus on what an “adequate” or “basic” package of benefits was to be. The bill established an eleven-member health services commission made up of consumers and providers who, through a very public and open process, were to prioritize healthcare services from the most important to the least important based on the beneficial effect each service has on the entire population being served, as opposed to an individual within that population. Panels of medical experts looked at the medical effectiveness of each treatment intervention to maintain life. A series of public meetings and community forums solicited expressions of community values regarding healthcare. Oregonians said they wanted healthy mothers and babies, comfort care, and general preventive services. Prevention was ranked higher than treatment. Oregonians considered as less important treatment for conditions that get better on their own, cosmetic services, and experimental services.

All of these inputs ultimately led to a list of 688 “condition/treatment pairs” that were grouped into seventeen categories and three groupings. Categories 1-9 were considered essential services; 10-13 were very important; and 14-17 were services valuable to certain individuals. After the list was generated, actuarial costs of each intervention were computed. The state legislature, which had no power to alter any ranking, then examined how much money was available under the Medicaid program and established a cut-off point of affordability. The state said that of the 688 conditions on the list, only 568 could be afforded in the following biennium. Each biennium, the cut-off would be reconsidered in light of available resources. Treatment for all conditions that ranked below the cut-off would not be reimbursed. For the most part, these were conditions for which treatment was considered ineffective, where the condition would run its course regardless of treatment, or which were considered cosmetic.

In early 1995, older people and people with disabilities started to be enrolled in the Oregon health plan. In anticipation of this enrollment, the Oregon Health Services Commission began examining the list of condition/treatment pairs to see whether “need” as defined by the list was responsive to the needs of the elderly. The exercise has provided a living example of the equity considerations that face policymakers even if “need” for service is used as an eligibility criterion. An examination of the list found that many of the diseases experienced by the elderly were already ranked quite high, e.g., eye diseases, cancers. An example of conditions that were not ranked high but were reconsidered were those resulting from relaxation of the sphincter muscle, i.e., incontinence or impaction. Clearly, these conditions affect the elderly and disabled more than other people.

Perhaps most interesting was the addition of five “dysfunction lines”
that were to be considered with the condition/treatment pairings. Consideration for treatment was given if there was dysfunction in (1) respiration, eating, or elimination; (2) posture and movement; (3) respite care; (4) communication; or (5) chronic mental illness or dementias. Thus, for the treatment of a person with Alzheimer’s disease, payment would be allowed for respite of a caregiver to compensate for the dysfunction associated with Alzheimer’s. Similarly, the dysfunction lines allowed for equity among conditions that are frequently not considered equitably in health insurance plans. For example, if a person is dependent on a wheelchair because of a stroke, insurance usually fully covers the person’s care needs, but if a person must use a wheelchair because of a birth defect like cerebral palsy, the person is frequently uncovered. Under the Oregon health plan, consideration under the dysfunction line of posture and movement makes the CP patient eligible for the full range of ancillary services that a person with a stroke may have.

CONCLUSION

All programs require rules of participation and eligibility. Critics of eligibility rules that are means tested, like those in Medicaid, cite equity considerations as paramount. Unfortunately, such critics also frequently imply that these equity considerations are the exclusive domain of selective programs. In fact, concern for fairness among program participants like the elderly does not disappear if the rules are based on a need standard other than financial. The Oregon example shows how programs like Medicaid can remain sensitive to fairness issues as they refer to the special needs of older people and alerts us to the fact that irrespective of the need standard used, we must always remain vigilant to the special circumstances that aging brings to the lives of individuals.

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REFERENCE