

Poor Program's Progress: The Unanticipated Politics Of Medicaid Policy

Pondering the reasons why Medicaid is not so poor a program after all may clarify the debate about how to expand coverage.

by **Lawrence D. Brown and Michael S. Sparer**

PROLOGUE: The U.S. Census Bureau recently reported that the number of uninsured people topped 41.2 million in 2001—up from 39.8 million in 2000. Interestingly, Medicaid, in some ways defying its statutory history, has, together with SCHIP, emerged as a primary vehicle for the incremental extension of health care benefits to the roughly 15 percent of the population still lacking basic coverage. Within the past year the U.S. Department of Health and Human Services has built upon this tradition by allowing states even greater latitude in reconfiguring Medicaid to expand coverage eligibility among the uninsured and provide prescription drugs to low-income seniors.

In this paper Lawrence Brown and Michael Sparer trace the divergent political evolutions of the Medicaid and Medicare programs and draw lessons validating the somewhat counterintuitive notion that Medicaid, a “poor people’s program,” may ultimately hold the key to reducing the number of insured people. For example, despite Medicare’s universal coverage standards, dedicated financing stream, and “tidy” central administration, its benefits and beneficiary categories have changed little over time. In contrast, the means-tested, general revenue-financed, and decidedly “untidy” federal-state-administered Medicaid program has maintained its relatively extensive benefits in the face of economic uncertainty and greatly expanded its eligibility criteria. Moreover, although Medicare’s federal governance has administered universal coverage, it has forgone the flexibility states and localities enjoy with Medicaid in formulating creative structural solutions and implementing “reforms” such as managed care.

Both authors are well suited to lend insight into these complex issues. Brown is a professor in the Department of Health Policy and Management at the Joseph L. Mailman School of Public Health of Columbia University and a former Brookings Institution senior fellow. A political scientist, he holds a doctorate in government from Harvard. Sparer is an associate professor in that department. He holds a law degree from Rutgers and a doctorate in political science from Brandeis.

ABSTRACT: Advocates of U.S. national health insurance tend to share an image that highlights universal standards of coverage, social insurance financing, and national administration—in short, the basic features of Medicare. Such an approach is said to be good (equitable and efficient) policy and equally good politics. Medicaid, by contrast, is often taken to exemplify poor policy and poorer politics: means-tested eligibility, general revenue financing, and federal/state administration, which encourage inequities and disparities of care. This stark juxtaposition fails, however, to address important counterintuitive elements in the political evolution of these programs. Medicare's benefits and beneficiaries have stayed disturbingly stable, but Medicaid's relatively broad benefits have held firm, and its categories of beneficiaries have expanded. Repeated alarms about "bankruptcy" have undermined confidence in Medicare's trust funding, while Medicaid's claims on the taxpayer's dollar have worn well. Medicare's national administration has avoided disparities, but at the price of sacrificing state and local flexibility that can ease such "reforms" as the introduction of managed care. That Medicaid has fared better than a "poor people's program" supposedly could has provocative implications for health reform debates.

ONCE UPON A TIME, more or less everyone knew what genuine health reform meant. Affordable universal coverage would have the statutory shape of a European national health insurance law, or perhaps its closest American kin, Medicare. A federal enactment would create an entitlement to uniform medical benefits for all citizens, specify the funding sources that cover care thus rendered, set conditions for paying providers, and (perhaps) sketch variations on delivery arrangements. That Medicaid—a "poor people's program," means-tested, run by the states, replete with disparities in eligibility and payment levels and methods—might be, or point toward, a workable reform model was inconceivable. Persisting in this sentiment, many reformers await the next window of opportunity to enact the real thing.

In influential quarters, however—including the Democratic leadership of the U.S. Senate—Medicaid and the State Children's Health Insurance Program (SCHIP) are viewed as ready and able to sustain expansions of public health insurance that represent the nation's latest, best hope for reducing the number of uninsured people. Is the leading "poor people's program" enjoying a surprising reversal of political fortune, and if so, what might that mean? This paper contrasts aspects of the political evolution of Medicare and Medicaid and draws some challenging implications for reform.

Two Philosophies, Two Programs

Medicare and Medicaid, enacted in 1965 as Titles 18 and 19 (respectively) of that year's Social Security amendments, reflected two distinct political philosophies and continue to do so.¹ Medicare is a universalistic program: Its forty million beneficiaries constitute virtually all of the elderly (those age sixty-five and older), who are automatically entitled to its benefits. Medicaid's forty million-plus enrollees represent only a subset of the poor (roughly two-thirds in 2002), namely, those

who meet state-set eligibility rules (which are shaped in part by federal mandates) and can navigate state-administered enrollment processes.

Medicare's hospital insurance program (Part A) is financed by a social insurance trust fund. As in Social Security, employers and workers pay contributions into the trust fund over time and then (theoretically) recoup their contributions after they enter the program and start using covered services. (Medicare Part B, which covers physician services, draws on a combination of federal general revenues and premium payments by beneficiaries.) Medicaid runs on general revenues, federal and state. As in "welfare," taxpayers' dollars are collected by government and then redistributed to needy "recipients" of the public largesse.

Medicare is administered by the federal government. Not only eligibility criteria and financing policy but also the benefit package, policies governing payments to providers, and decisions about the delivery system (for instance, fee-for-service versus managed care) are determined in Washington, D.C., with no direct participation by the states. (The program delegates important decisions about coverage and payments to third-party insurers—fiscal intermediaries and carriers—and thus these national determinations do not preclude considerable regional variations that reflect local differences in wage costs and other factors).² Medicaid is managed by the states. Although a framework of federal rules constrains state program administrators, they retain wide, and widening, discretion on all of the basic issues: eligibility, benefits, payments, and organization of care.

■ **Reflections of a political philosophy.** That these legislative twins are so decidedly unidentical is no accident. The programs' antipodal character reflected tenets of political philosophy that were widely shared among health reformers of the day (a "day" that stretched more or less seamlessly from the New Deal to the Great Society and is by no means over yet). Medicare is the preferred reform model because, so the axiom held, poor people's programs are poor programs—not only inequitable but also politically precarious. As Wilbur Cohen and his colleagues worked to whittle down national health insurance (postponed under Roosevelt, stalemated under Truman, and snubbed under Eisenhower) into passable legislative shape, they sought to make Medicare both fair and formidable. Universalism promised broad, strong political support: a constituency of the elderly and their offspring that spanned social classes and income groups. Social insurance funding conferred legitimacy. Medicare was a social contract between the state and contributing citizens, who later reaped what they had sowed, not a handout.

The contractarian connotations of the trust fund carried distinct political implications: Immune from the vagaries of annual appropriations that allocated general revenues in a budget process stamped by partisan and ideological fads and shifts, Medicare's resources would enjoy a stability toward which a poor people's program could never hope to aspire. Federal administration of Medicare also secured equity. States that looked askance at the elderly, government programs, or higher taxes did not get to cover fewer people and services than more "progres-

sive” states. As befits a universal entitlement, one set of national standards applied to all major facets of Medicare in all fifty states.

■ **Legislative beginnings.** The passage of Medicare crowned many years of patient effort to customize national health insurance as understood elsewhere to fit the stubborn exceptionalism of American politics. The enactment of Medicaid was near-serendipitous, an afterthought. Wilbur Mills (then chair of the House Ways and Means Committee, which controlled the Social Security amendments), persuaded by the election of many new liberal Democrats to Congress in 1964 that new public health insurance legislation was inevitable, “proceeded to astonish policy observers” by synthesizing the existing Kerr-Mills program of federal payments to states for medical care for the poor with “Eldercare,” the American Medical Association’s preferred, means-tested variation on Medicare, and morphing the concoction into something called “Medicaid.”³ Reformers admired the fancy footwork and concurred that more was better, but the politics of social programs being what they were, Medicare appeared to be poised for stability and growth, while Medicaid seemed fated for chaos and perhaps retrenchment.

The evolution of the two programs over nearly four decades shows that the conventional wisdom about the political inferiority of poor people’s programs—at least in the health policy arena—misses much. Medicare has indeed been stable and politically successfully, but the program has seen very little expansion, whereas Medicaid has enjoyed more stability and growth than “theory” predicted.

Universalism Versus Incrementalism

■ **Medicare coverage.** Political calculations limited Medicare to coverage for hospital and physician services for the elderly. These constrictions were supposedly at once necessary—to assuage opposition and get enough votes to win the hard-fought legislative battle—and transitory—once the barrier to federal financing of care was breeched, additional public coverage, straight through into national health insurance, was surely imminent. The latter prognosis proved faulty, however: Medicare’s benefit package remains substantially what it was in 1965 and indeed is “considerably less comprehensive than packages offered by the better employer plans.”⁴ Neither protracted debate nor energetic lobbying has filled such important lacunae as coverage for prescription drugs and long-term care. In 1972 the disabled and people with end-stage renal disease were made eligible for Medicare, but no comparable expansion has occurred since.

■ **Higher-than-expected costs and attempted remedies.** No sooner did implementation of Medicare commence than federal budgetmakers complained that its costs were running far higher than expected, a complaint reinforced by the high costs (“unexpected,” of course) of the beneficiaries admitted in 1972. Critics of the program have cited the combination of demographic and technological trends—a steadily growing elderly population of Medicare beneficiaries lays claim to an ever-expanding array of more costly and complex medical benefits—as evidence

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 that the program is “an out-of-control entitlement that consumes too much of the federal budget and obstructs deficit reduction,” that the value of the program’s (stable) benefit package for the elderly has grown greatly over time, and that these endogenous forces of expansion preclude fiscally responsible additions to the current package of benefits and the corps of beneficiaries.⁵

Medicare’s alleged uncontrollability is highly exaggerated. In 1983 and 1989 the program changed its methods for paying hospitals and physicians, respectively, and produced savings that eluded the private sector, a record all the more impressive because Medicare covers an older, sicker population in need of more specialized and technologically intensive services than is the case for the population at large. Between 1970 and 1998 private health insurance spending increased by a per capita average of 11 percent annually; Medicare’s rate of growth was 10.2 percent.⁶ More recently, provisions in the Balanced Budget Act (BBA) of 1997 sharply cut payments to hospitals, nursing homes, and home health agencies, but the howling that ensued dramatized the intensity of the cost pressures under which the program labors more than its success at holding the line.

The main exception to this pattern—the addition of catastrophic coverage to Medicare in 1988—ended as brutal proof of the rule. When the Reagan administration proposed new coverage for Medicare beneficiaries who bore exceptionally high medical expenses out of pocket, congressional Democrats “perfected” the measure by adding prescription drug benefits and other new provisions. Aiming to fund the new package without adding to the federal budget, political leaders enacted an income-related premium “surcharge” to be borne by more-affluent beneficiaries. Amazed lawmakers were soon bombarded by letters and calls from angry seniors whose wrath had been stirred by organizations other than the AARP, whose soundings of constituent opinion failed to detect the danger in advance. Memorable television footage of aged protesters shouting insults and pounding on the car of Daniel Rostenkowski (then chair of the House Ways and Means Committee) generated no end of post-traumatic stress in Washington. Indeed, Ronald Vogel opined that “perhaps no other Medicare event in its 30-year history threatened members of Congress as much as the advent and demise” of the Medicare Catastrophic Coverage Act.⁷ Political lessons proliferated: Sizable new benefits, if universal, were budget-busting; “responsible” budgeting and “equitable” financing meant some measure of means testing, which was a political minefield; the elderly were unreasonable and volatile; the “responsible” organizations that speak for them could not always read the political cards accurately. In 1989 Congress undid its handiwork of the year before, repealing most provisions of the new program. Ironically, much of what survived expanded Medicaid.⁸

■ **Medicaid coverage and eligibility.** Medicaid, which bore fewer marks than did Medicare of its creators' strategic calculations and philosophical convictions, emerged as comprehensive health coverage for people who could not afford to buy care through private means. The program has contrived to stabilize its benefits and expand its number of beneficiaries with success that is surprising in a poor people's program. The number of Medicaid clients has grown from twenty million during the 1980s to roughly forty million in 2002.

Lacking a universalistic mandate, the program's leaders could and did consider tightening eligibility when costs rose too fast or state revenues sank too low. In the late 1960s and the 1970s, for example, both the feds and states adopted various cutting and tightening measures to cope (as in Medicare) with surprisingly rapid growth in spending. In the mid-1980s, however, the picture changed, and (in Jean Gilman's terms) the political stepchild began to emerge as Cinderella. Reductions in eligibility were seldom adopted, and most states worked to expand the ranks of eligibles. One explanation is that more penurious states could not race much farther to the bottom and more generous ones had that status because their politics made and kept them that way. But fiscal federalism was also a factor, prompting coverage expansions during good times (the feds paid most of the bill) and deterring cutbacks even in bad times (every state dollar saved meant two or three federal dollars lost).

The federal government also required expanded Medicaid coverage, demanding that states give eligibility to poor women and children at more inclusive income and age limits.⁹ States duly protested these mandates, but Washington turned a deaf ear.¹⁰ In 1996 the feds authorized Medicaid enrollment for former welfare beneficiaries, further severing Medicaid's traditional connection with welfare.

■ **SCHIP expansion.** Medicaid served as a model, moreover, for the nation's largest publicly funded health insurance expansion since the Great Society. SCHIP, enacted in 1997, follows the Medicaid template: federal matching funds for programs in which states have wide discretion. SCHIP also allows states to reach the program's target, uninsured children who do not qualify for Medicaid, by making SCHIP an "add-on" to their Medicaid programs. These expansions may be read as no small vote of confidence in a program that has meanwhile committed growing shares of its budget to long-term care services for the indigent elderly, thus meeting needs that policymakers fear to assign to Medicare. At the end of the 1990s Medicaid and SCHIP accounted for 16 percent of the nation's health spending, pulling almost even with Medicare's share (18 percent).¹¹

■ **Maneuvering at the margins.** The despised categorical character of Medicaid invites incremental adjustments and extensions in criteria of eligibility. The feds and states alike can raise income thresholds a little here, a bit more there, as political support and financial resources permit. Such maneuvering at the margins entices and rewards policy entrepreneurs (Henry Waxman is the quintessential example), working quietly within the intricacies of the budget process to add a new group

now, another benefit next time. In Waxman's own words, "Incrementalism may not get much press, but it does work."¹²

Universalism may indeed confer the power that follows the political law of large numbers, but that very fact, understood ruefully and well by policymakers, itself raises political barriers to laws incorporating further large numbers into a program whose costs are deemed uncontrollable. The vices that taint Medicaid—invidious moralism and means testing—have a virtuous correlate of no small value: strategic flexibility.

Social Insurance Versus General Revenues

■ **Medicare: social insurance and fiscal integrity.** Medicare's social-insurance financing has doubtless enhanced the program's legitimacy, but it has not sufficed to protect it from periodic alarms about its fiscal integrity or from intermittent "crises" over its allegedly impending bankruptcy. As Jon Oberlander points out, the trust fund mechanism makes Medicare's perceived sustainability a function of complex calculations by officially empaneled actuaries, whose computations and pronouncements cater to political Cassandras hoping to advance their agendas for change (for instance, more aggressive introduction of market forces into Medicare) by trumpeting the program's impending collapse.¹³ The coalition of critics is broad indeed—"anti-government conservatives," self-styled advocates of generational equity, and ardent anti-redistributionists, conjuring up "hordes of voracious Medicare beneficiaries feasting on the hard-gotten gains of struggling, virtuous investment bankers" and the ensuing "pundit consensus" registered forcefully in public opinion.¹⁴ In a 1995 survey only 41 percent of respondents knew that Medicare failed to cover prescription drugs for the elderly, but fully 70 percent "knew" that the program was, and had long been, in danger of bankruptcy.¹⁵

Over time, the opacity of the actuarial tea leaves and the opportunistic rhetorical uses to which they were put have damaged the political legitimacy that social insurance was supposed to secure. For example, pollster Celinda Lake found that people often assumed that Medicare, like Social Security, was not part of the federal budget and thus took the talk of fiscal doom as evidence that politicians were "moving money that ought to be sacrosanct and in a trust fund," that a "rotten political system...has raided a trust."¹⁶ When everyone knows that Medicare is about to go broke, expansion looks utopian. When everyone accepts that its plight can be fixed only by higher taxes or more competition, deadlocks between left and right are hard to break.

■ **Medicaid: general revenues and political heat.** In theory, Medicaid's reliance on general revenues ("the taxpayers' dollars") should make it a political football, and "soaring" rates of Medicaid spending have indeed generated considerable heat. This heat was most intense between 1988 and 1992, when state Medicaid budgets were rising at an average of 20.9 percent annually. Several variables explained these increases, including rates of medical inflation in general, the costs of absorbing

newly mandated clients, increased services for people with AIDs, rising immigration, and a national economic downturn. In part, however, these rates reflected an aggravated case of the logic of expansion: State policymakers had become more aggressive than usual in laying plans to increase their federal matching shares.¹⁷

Managed care to the rescue. Once the dust settled—in part because Congress pulled the plug on excessively creative “scams” but also because medical inflation slowed, managed care began to yield savings in Medicaid, the economy revived, and Medicaid rolls fell—annual spending increases returned to “normal” (single-digit) figures, and Medicaid regained its status as a big-ticket state budget item that was, however, neither so vexing nor so vulnerable as to justify major reductions in eligibility and services or to derail the incremental expansions under way since the late 1980s. Medicaid rolls fell sharply in the late 1990s, to be sure, but mainly as a consequence of events external to the program itself—namely, a strong economy and, most important, welfare reform legislation of 1996, which sowed confusion by ending the automatic enrollment of public-assistance clients in Medicaid, thus obliging these clients to navigate social services bureaucracies and prove their eligibility for Medicaid.

Recent budget woes. Over the past year or so Medicaid enrollment trends have shifted again, and the number of enrollees is rising dramatically, prompted by a combination of aggressive outreach and education and a weakened economy. As Medicaid costs rose 13 percent in 2002 while state tax revenues (in April–July 2002) fell by 10 percent, states put expansion on hold and worried anew about cost controls. The Kaiser Commission on Medicaid and the Uninsured reported in 2002 that forty states had imposed controls on drug costs, twenty-eight had reduced or frozen provider payments, fifteen had increased copayments on items other than drugs, and eighteen had cut eligibility in some form.¹⁸

Cuts are never minor to the cuttees or to those who advocate for them, but the “news” is, arguably, how marginal the contractions are, given the magnitude of the fiscal challenge. Protracted budget woes may of course call the question and test the hypothesis proffered here—namely, that Medicaid has developed constituencies of sufficient, breadth, depth, and clout to protect the program in hard times and to enlarge it when the clouds lift.

Fiscal creativity. Medicaid’s reliance on general revenues raised by both states and the feds has encouraged strategic improvisations to which trust funding has been less conducive. States spending as little as twenty-three cents and no more than fifty cents of their own funds in each Medicaid dollar find that it pays to be creative in the search for disproportionate-share hospital (DSH) payments, federal waivers, upper payment limits, and other pots of gold. Fiscal federalism encourages “catalytic federalism”: For example, states enact a small program of new coverage for non-Medicaid-eligible children and then seek a federal waiver (and accompanying federal funds) to expand it. The feds authorize Medicaid matching monies for new categories of the poor, hoping that states will find the offer too

good to refuse.¹⁹ Beyond the halcyon expansionary years of 1984–1990, moreover, lay rising reliance on federal waivers for states seeking to innovate within their Medicaid programs. Waiver politics were, and remain, a classic bargaining game in which greater state discretion is traded for enhanced public coverage and is customized, state by state, in ways Medicare cannot easily emulate.

■ **Medicare’s endlessly anticipated insolvency.** Meanwhile, Medicare’s trust fund, cloaked in the supposedly impregnable legitimacy that inheres in an entitlement grounded in a social contract, may be losing legitimacy because its endlessly anticipated insolvency contradicts official mythology and has no clear and acceptable explanation. If Medicare is social insurance, then why do the demographics—fewer current workers making the contributions that cover the costs of the growing ranks of beneficiaries using more costly medical care over time—set the program on a road to fiscal doom from which there is (supposedly) no exit save draconian extractions from current and future workers? That Social Security itself is sometimes said to require a comparably redistributive intergenerational rescue only underscores how politically threadbare have become the contractarian arguments for social insurance in the United States.

Fee-For-Service Versus Managed Care

Medicare suffers from a challenge its creators could not have foreseen in 1965: While the U.S. medical world has shifted massively to managed care arrangements, Medicare remains centered on a fee-for-service, third-party payment model that was mainstream, indeed near ubiquitous, thirty-five years ago. (Whether it may have retained the “right” model after all is of course an important question that cannot be pursued here.) This large antiquarian island in a sea of market forces offends conservatives who equate competition with smaller government and also troubles liberals who never liked the traditional arrangements beloved by organized medicine and want Medicare to be no less modern and innovative than the private sector. (This sense that the program is badly behind the times was one reason why the Clinton reform plan bypassed Medicare-for-all—“about 180 degrees removed from Clinton’s thinking,” as Ira Magaziner put it—in favor of an employer-funded system predicated on managed competition.)²⁰

■ **Medicare’s foray into managed care.** Once both houses of Congress came under Republican control in 1996, the rush to infuse market forces and competition into Medicare soon yielded legislation (Medicare+Choice) that stepped up federal encouragement (on the books, to little avail, since the early 1980s) for the elderly to join health maintenance organizations (HMOs). The project soon became a fiasco: HMOs sought to build market share in this revitalized market by promising elderly members benefits (prescription drug coverage in particular) absent from traditional Medicare but soon fell to quarreling with federal payers over fair payment for covering an unexpectedly expensive population. When the feds held firm (the plans were selecting preferred risks, said officials from the Centers for Medicare and Medicaid

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Services [CMS, formerly known as HCFA], and falling short on the management of care to boot), plans began abandoning the Medicare market. Many seniors found themselves without the promised extras, indeed without HMO coverage at all, and the well-publicized upheavals added fuel to a growing backlash that did nothing to endear managed care to Medicare’s many stakeholders.²¹ Between 1998 and 2001 the number of managed care plans participating in Medicare+Choice (M+C) dropped roughly by half (from 346 to 179), and managed care penetration among beneficiaries fell to 14 percent—a rate that the Congressional Budget Office forecasts will hit a mere 18 percent of beneficiaries in 2011.²²

■ **Medicaid’s more successful managed care venture.** Medicaid has, for better or worse, modernized itself into managed care more adroitly than has Medicare. One possible explanation, of course, is that poor people, who do not vote much and lack AARP-like organizations to defend them, are easier to “force” into managed care than are the elderly. States had to win federal waiver authority to proceed with Medicaid managed care, however, and, under intense scrutiny from HCFA/CMS, state policymakers averred that they were designing managed care that would expand access and improve quality even as it slowed the growth of costs. States did not (for the most part) slash payment rates dramatically in anticipation of imminent savings, although they did impose potent regulatory controls on health plans entering the Medicaid market.

Nowhere has Medicaid managed care been an easy ride, and the misadventures of M+C—the plans’ rush to sew up market share, the misrepresentations in marketing to befuddled enrollees, indignation over the more-expensive-to-serve-than-predicted clientele, battles between plans and government over fair rates, the huffy exits of aggrieved plans, and jilted enrollees scrambling for new plans or providers—have all surfaced, in varying degrees, in Medicaid managed care programs. On the whole, however, the interplay of the feds and states in Medicaid has more successfully installed midcourse corrections into managed care for the 56 percent of clients who are in it than has the stalemated byplay between the feds and plans that governs managed care for its 14 percent of Medicare beneficiaries.

The difference derives precisely from Medicaid’s initially suspect character as a joint federal-state endeavor. Medicaid combines a framework of federal rules and guidance with fifty varieties of state-plan relations. Medicare combines voluminous rules with much more constricted responsiveness to variations in state politics and regional markets. Moreover, having moved down the road to managed care for their Medicaid clients, states, unlike the feds, cannot call the plans’ bluff, knowing that a fee-for-service sector stands ready to accept refugees. Medicaid managed care arose from the conviction that the fee-for-service system gave inade-

quate access and quality at excessive cost. If states cannot after all buy good care cheaply, they must either go back to painful wrestling with fee-for-service, raise rates (and refine regulations) sufficiently to make the managed care market work, or—the emerging strategy of choice—negotiate acceptable arrangements with managed care plans formed by safety-net institutions that have long served as providers of last resort for the poor.

Medicare beneficiaries, unique among insured U.S. citizens (although entirely typical of citizens covered by the national health insurance systems of other Western nations), can fall back on yesterday's mainstream should modernization by means of managed care flop. Having acknowledged that yesterday's mainstream had grown indefensible for Medicaid's patients and purchasers alike, states have little choice but to contrive somehow to manage the care of the poor.

The Poor People's Program And Policy Reform

Few would deny that Medicare is a great and good program or that Medicaid retains both a weighty cultural burden of welfare medicine and disturbingly low adult eligibility levels in many states. The point of this comparative sketch of the political evolution of the two programs is not to bury Medicare or praise Medicaid as public programs but rather to challenge inherited reform models.

The perpetual perils of comprehensive health reform, reenacted vividly a decade ago by the Clinton health plan, suggest that the universalism in affordable coverage may lie beyond the polity's capacity any time soon: Eighty-five percent of the population has coverage; the 15 percent that lack it are unorganized and uncohesive; redistributive politics are tough in the best of times; the lingering antigovernmental ethos that set in thirty-five years ago continues to make the going that much rougher; and the consoling myth that the safety net provides all of the care that those without coverage really need stifles any sense of popular urgency around the issue.

The fabled connections between universalism and strong political constituencies have, furthermore, grown strained and murky. The political strength of the nation's elderly, their offspring, health care providers, medical suppliers, and other Medicare contractors registers far more potently in defensive maneuvers to block threatening changes than in expansions of benefits or beneficiaries.²³

■ **Medicaid's broad constituency.** Meanwhile, and contrary to first impressions, Medicaid's constituency has grown well beyond the nation's welfare poor. In 1974 Robert Stevens and Rosemary Stevens regretted "a lack of clarity about what Medicaid was and for whom it was created" but added that this "catch-all program" with ambiguous boundaries had expansionary potential that might yield a constituency "at least as wide as that of Medicare."²⁴ This forecast has proved prescient: A sizable corps of physicians, hospitals, community health centers, and public health clinics, including but not limited to those that constitute the safety net, have tangible interests not only in what Medicaid pays but also in whom it covers and thus

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shelters from the rolls of charity care patients. The indigent elderly (and those in the process of spending down to become so) plus the nursing homes and home health agencies that serve them fight contractions in America's major long-term care program. A range of managed care plans has joined (and then sometimes left) the crowd of Medicaid's stakeholders. Fifty states, and the elected officials who enjoy showering federal benefits on them, perpetually ponder the seductions of fifty or more federal cents on each Medicaid dollar (half the states get a federal match of 60 percent or more, while ten, including the District of Columbia, get upward of 70 percent). Medicaid permits members of Congress “to claim credit for providing benefits while shifting half of the cost to the states.”²⁵ Political liberals see realized in Medicaid the powerful (albeit nonuniversalistic) principle of targeting: to each according to his or her needs.

The needs Medicaid meets have steadily expanded and now stretch well beyond the impoverished women and children with whom the program is popularly identified. Roughly two-thirds of Medicaid spending serves the aged, blind, and disabled, who are about one-quarter of its beneficiaries. The equation of poor people's programs with poor programs failed to capture how heterogeneous and capacious the categories of entitlement would become as the politics of social policy played on.

■ **Universalism and U.S. political culture.** A glance at national health insurance in other nations suggests that universalism has crucial moral underpinnings. Other Western societies accept as a kind of normative axiom that care is not enough, that basic human dignity would be offended if any citizen declined to seek medical care for fear of the financial consequences of doing so or faced financial stress as a consequence of getting care. This simple but indispensable conviction has so far failed to register strongly in U.S. political culture, and there are no current signs that it is beginning to do so. A massive political and ideological shift like those of 1932 and 1964 could change this prognosis overnight, but in the meantime sustaining and stretching incremental extensions of coverage to means-tested categories of the uninsured may be the nation's best bet for shrinking the number of uninsured Americans to the point at which employer buy-ins and kindred measures may supply coverage for those nonpoor uninsured whom Medicaid may never reach.

■ **Stigma of social insurance.** Even if the political stars aligned to produce a universal, national entitlement to health coverage, social insurance financing is unlikely to confer the social legitimacy and political insulation the founders of Social Security and Medicare cherished. Social insurance has served this and other countries very well for many years, and if magic wands were available, what rational actor would not cheerfully install the French or German health care system in place of the

U.S. status quo? Years of apocalyptic predictions that Medicare (like Social Security) totters near bankruptcy, will not “be there” when today’s contributors retire, and can be salvaged only by Sisyphean lifting by current workers have, however, stigmatized social insurance along with the “t” word (“taxes”) in general. Although no single source—employer mandates, social insurance, or general revenues—will do the whole job, the latter will probably have to supply much of the money needed to cover forty million uninsured people. (The French, for example, have steadily supplemented their “Bismarckian” social insurance–funded health regime with infusions of general revenues that tap a broader range of wealth.) Reformers might want to scrutinize more closely than is customary how the feds and states combine to steer the political economy of fiscal federalism in Medicaid, which runs entirely on taxpayers’ closely watched dollars.

■ **Universal entitlement with regional variations.** Even if a universalistic entitlement and social insurance funds proved to be politically feasible, a centrally run program with uniform national rules is unlikely to be the preferred administrative vehicle. The states have grown too prominent and too powerful not to insist on wide spheres of discretion, and managed care’s sensitivity to local market settings precludes dispelling all disparities. For public managers the trick will be to fashion a set of national rules that protects the interests of the insured without proscribing state and regional variations (in organizational arrangements, payment provisions, perhaps supplemental benefits, and more) that do not cross the line into objectionable inequities. Canadian federalism offers one instructive approach: ten distinct provincial systems linked by acceptance of a short list of national principles that set conditions for the sharing of provincial costs with the central government. The accumulation of federal-state accommodations in Medicaid, and especially the long yet underexamined saga of federal waivers to support state innovations in that program, doubtless suggest further lessons.

HEALTH REFORM IN THE TWENTY-FIRST CENTURY will not resemble the New Deal or Great Society Oldsmobile, much less their Cadillac. Pondering the surprising evolution of Medicaid and the reasons why it is not so poor a program after all may help reorient a policy debate that risks losing its way within nostalgic mists. The succinct “lessons” are these: add groups by raising income thresholds incrementally; use federal-state matching to catalyze creative use of general revenues; experiment with managed care (and then labor to get it out of the theoretical clouds and onto firm institutional ground); try to get rates of uninsurance among children down to low single digits; try to add family coverage; seek political openings to narrow eligibility gaps; and work harder to enroll eligible people. Might one see coming into view, albeit dimly, a model of universal coverage—inelegant, impure, and replete with disparities to be sure—that may be sufficiently distinct to fit America’s stubborn exceptionalism?

NOTES

1. See T.R. Marmor, *The Politics of Medicare*, 2d ed. (New York: Aldine de Gruyter, 2000) (a modestly dubbed “second edition” that adds to the first several new chapters indispensable for understanding the program); and J. Oberlander, *Medicaid and American Politics* (Chicago: University of Chicago Press, forthcoming). Our main sources for Medicaid are R. Stevens and R. Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974); M. Sparer, *Medicaid and the Limits of Health Reform* (Philadelphia: Temple University Press, 1996); and J.D. Gilman, *Medicaid and the Costs of Federalism, 1984–1992* (New York: Garland, 1998). Gilman admirably addresses, from a different slant, many of the questions we tackle here.
2. See B.C. Vladeck, “The Political Economy of Medicare,” *Health Affairs* (Jan/Feb 1999): 22–36.
3. E.D. Berkowitz, *America’s Welfare State: From Roosevelt to Reagan* (Baltimore: Johns Hopkins University Press, 1999), 173.
4. R.M. Ball, “Reflections on How Medicare Came About,” in *Medicare: Preparing for the Challenges of the Twenty-first Century*, ed. R.D. Reischauer et al. (Washington: National Academy of Social Insurance, 1998), 36.
5. See Marmor, *The Politics of Medicare*, 96, 127.
6. *Ibid.*, 128; and Henry J. Kaiser Family Foundation, *Medicare Chart Book*, 2d ed. (Menlo Park, Calif.: Kaiser Family Foundation, Fall 2001), 30.
7. R.J. Vogel, *Medicare: Issues in Political Economy* (Ann Arbor: University of Michigan Press, 1999), 75.
8. R. Himelfarb, *Catastrophic Politics: The Rise and Fall of the Medicare Catastrophic Coverage Act of 1988* (University Park, Pa.: Pennsylvania State University Press, 1995); and Marmor, *The Politics of Medicare*, 110–113.
9. See Gilman, *Medicaid and the Costs of Federalism*, 59–72, for measures expanding eligibility and benefits.
10. *Ibid.*, 103–104.
11. Kaiser Family Foundation, *Medicare Chart Book*, 23.
12. Gilman, *Medicaid and the Costs of Federalism*, 141.
13. Oberlander, *Medicare and American Politics*, chap. 4.
14. T. Skocpol, “Pundits, People, and Medicare Reform,” in *Medicare*, ed. Reischauer et al., 23, 25; Marmor, *The Politics of Medicare*, 124; and Vladeck, “The Political Economy of Medicare,” 26.
15. F.E. Mebane, *Medicare Politics: Exploring the Roles of Media Coverage, Political Information, and Political Participation* (New York: Garland, 2000), 45.
16. “View by Celinda Lake,” in *Medicare*, ed. Reischauer et al., 308, 312.
17. For a discussion of state financing stratagems, see Gilman, *Medicaid and the Costs of Federalism*, 155–183.
18. Kaiser Commission on Medicaid and the Uninsured, “State Budgets under Stress: How Are States Planning to Reduce the Growth in Medicaid Costs?” (Washington: Kaiser Commission, 30 July 2002); and *Medicaid Spending Growth: Results from a 2002 Survey* (Washington: Kaiser Commission, September 2002).
19. L.D. Brown and M.S. Sparer, “Window Shopping: State Health Reform Politics in the 1990s,” *Health Affairs* (Jan/Feb 2001): 50–67.
20. H. Johnson and D.S. Broder, *The System: The American Way of Politics at the Breaking Point* (Boston: Little, Brown, 1996), 398.
21. N.M. DeParle, “As Good as It Gets? The Future of Medicare+Choice,” *Journal of Health Politics, Policy and Law* (June 2002): 495–512.
22. Kaiser Family Foundation, *Medicare Chart Book*, 51–52.
23. Vladeck, “The Political Economy of Medicare,” 26–31.
24. Stevens and Stevens, *Welfare Medicine*, 349, 51–52. On the breadth of Medicaid’s coalition, also see Gilman, *Medicaid and the Costs of Federalism*, 95, 146.
25. Gilman, *Medicaid and the Costs of Federalism*, 188.