Medicaid: A Social Safety Net in Crises

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ABSTRACT

In the United States, Medicaid is the primary social safety net that provides health care for the poor and other vulnerable populations. Interest group theory and federalism, state level sovereignty, are used to create a theoretical model that proposes factors, other than increasing health care cost, as growth determinants of Medicaid expenditure and enrollments. For over three decades driven by federalism state-level discretionary Medicaid waiver programs have been creating new and unsustainable entitlements. The role of Medicaid waivers is poorly understood and in need of scholarly attention. Due to a lack of federal oversight and other social and political factors, some of which will be discussed in this paper, it appears that discretionary Medicaid waiver programs put in place as a solution are contributing to the overall structural issues of Medicaid. The paper concludes with suggestions on needed research and some potential policy recommendations.

Keywords: Deficit, Disabilities, Entitlement, Federalism, Institutionalization, Interest Group, Long-Term Care, Medicaid, Waivers

INTRODUCTION

Medicaid, the primary social safety net for the poor and other vulnerable individuals in America, has existed for 43 years. The Affordable Care Act (ACA) of 2010 has made Medicaid a part of the national conversation on health care and some have suggested that Medicaid is broken (Lillis, 2009; Villarreal, 2006). Until recently Medicaid has generally been cast in a positive light in academic research (e.g., Anderson & Mitchell, 2004; Palmer, Parker, & Arthur, 2007). However, Medicaid expenditures have grown from $20.7 billion in 1980 to almost $400 billion in 2010. Creating a crisis that is shifting the emphasis of Medicaid state agencies from the “traditional purpose of serving eligible clients” to an emphasis on cost containment and limiting services (Kaiser Family Foundation, 2009; Lillis, 2009; Reed & Meyer, 2004, p. 236).

The number of Medicaid participants has ballooned from around 4 million beneficiaries in 1966 to almost 70 million beneficiaries in 2010. Medicaid accounted for 7% of the federal government’s expenditures in 2007 and from 15% to 40% of state expenditures (Herz, 2008; Truffer, Klemm, Hoffman, & Wolfe, 2008). In 2008, before Barack Obama took office Governors were already asking for federal help because of $40 billion in Medicaid deficits (Guarino, 2008, comments by Peter Baker). In response, the 2009 stimulus included an $87 billion increase of federal Medicaid funds; over 10%

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of the stimulus funds (Bendavid, Williamson, & Supeed, 2009).

These numbers and current Medicaid cutbacks indicate a broader discussion is needed on the financial and long-term burdens Medicaid policies have placed on US taxpayers and the vulnerable individuals served. While nursing home costs and utilization, managed care, illegal immigration and others are all factors that influence the viability of Medicaid as a social safety net, this paper concentrates on Medicaid waiver programs. Programs that are rarely mentioned in the health care debate and that are introduced by states with federal approval, as a means of improving service and reducing cost. These programs seem to be created to meet the needs of specific underserved populations that are supported by one or more interests group. However, lack of federal oversight (GAO, 2003) and other factors have made these discretionary programs as much a part of the problem as the solution. Inequalities in the services offered and the funds available across states are growing and incremental budgetary policy adds to the crisis (Villarreal, 2006). This paper builds on interest group theory to model a crisis of growing entitlements and exploding expenditures building within the Medicaid system.

This paper proceeds in four sections. The first section has two parts. Part one explains the basic structure of the Centers for Medicare and Medicaid Services (CMS). Part two provides a brief historical overview of Medicaid. The section afterwards furnishes details on state level Medicaid discretionary programs: Medicaid waivers and demonstration programs that since 1980 have grown from a few in a handful of states to at its peak over 500 programs across all 50 states (CMS, 2008). This section also provides national levels of Medicaid expenditures and the argument is made that state discretionary programs play a significant role in the growth of Medicaid spending and enrollment.

The next section builds on interest group theory to frame factors that are leading Medicaid toward a road of crisis. Paved with good intentions, three related factors fueled by interest group posturing have created a highway to the abyss: federalism, deinstitutionalization, and demographics. The argument made, with a model and examples, is that these factors combined and our legal process has created a system in crisis: a system in which the media and the legislative process are used to push for unsustainable programs and entitlements. Throughout this section comparisons are made of Medicaid services in general and of home and community based service (HCBS) expenditures using five states—California, Florida, Illinois, New York, and Texas: that account for almost 37% of the US population and over 39% of all Medicaid spending (CMS, 2008).

The final section has three parts. Part one discusses the political and financial implications of Medicaid as a social safety net. This includes a look at the political tendencies to discuss the future of Medicaid as a program that requires total federal control or total state responsibility. Part two proposes necessary research into the factors driving the growth of state discretionary programs and the effectiveness of these programs. Finally, the last part submits three steps that might be considered as a start to rebuilding a strong and viable social safety net.

This paper questions the efficacy of a state level designed, implemented, and controlled Medicaid waiver service system. Waiver and demonstration programs put into law starting in the early 1980s have been characterized as a “free-for-all” with the federal government rewarding states that spend the most (Villarreal, 2006). The suggestion is the current Medicaid structure based on incremental budget driven policies, plus interest group demands have created flagrant inefficiencies and rampant inequalities. The existing system has increased Medicaid spending and enrollment with potentially devastating consequences and current retrenchment will not solve the core problems.
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