

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-03)
Medical Care for Patients with Low Incomes
(Reference Committee A)
(June 2003)

EXECUTIVE SUMMARY

Council on Medical Service Report 8 (A-03) presents the effort of the Council to pursue a new opportunity for patients with low incomes. Rather than continuing to subsidize coverage through the existing Medicaid structure, which is disliked by many patients and physicians alike, the Council proposes a model that expands upon previous AMA policy. Specifically, when the House of Delegates adopted the recommendations contained in Council on Medical Service Report 9 (A-98), it established a series of principles favoring individually owned health insurance (Policy H-165.920, AMA Policy Database). In addition, the House adopted the recommendations contained in Council on Medical Service Report 4 (A-00), which supported the principle that health insurance tax credits should be inversely related to income, so that those with the lowest incomes receive the largest subsidy of their health insurance purchases (Policy H-165.865(1c)).

The Council believes that the progressive principles embodied in AMA policy should be applied to those patients in the medical care portion of the Medicaid population. The Council envisions federally funded refundable and advanceable individual tax credits would replace Medicaid for those patients in the medical care portion of the Medicaid population, which constitutes 73% of current Medicaid enrollees, and accounts for 27% of expenses. Consistent with Policy 165.865(1c) the tax credits would be inversely related to income, with the individuals in Medicaid mandatory eligibility groups receiving tax credits that are large enough to fully subsidize the cost of health insurance. Individuals receiving tax credits would have a variety of options for purchasing private coverage.

The report also addresses Resolution 722 (I-02) because of its clear relationship to the Council's work on Medicaid reform. The resolution calls for a study of the benefits and risks of a nationalized Medicaid program. Accordingly, the report describes the urgent need for change; provides a summary of the current Medicaid program, summarizes AMA policy related to health insurance tax credits and Medicaid; describes the intense financial pressures being experienced by state governments; and proposes a new model for providing medical care for patients low incomes. The Council is well aware that the difficult issues of Medicaid funding for long-term care and disability care need to be addressed, and defers these topics for further study.

The Council understands the importance of this issue to the House of Delegates, and is presenting this report as a "blueprint" of how the Council envisions financing the care for those with low incomes. The Council intends to submit final recommendations to the House at the 2003 Interim Meeting. The Council recommends in this report that the testimony and comments in Reference Committee and House of Delegates discussions be forwarded to the Council for consideration in developing its recommendations; and that members of the House of Delegates, state medical associations, and national medical specialty societies forward any additional comments to the Council by August 1, 2003.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8 - A-03
(June 2003)

Subject: Medical Care for Patients with Low Incomes

Presented by: Cyril "Kim" Hetsko, MD, Chair

Referred to: Reference Committee A
(Kevin T. Flaherty, MD, Chair)

1 Over the years, the Council on Medical Service and the Board of Trustees have developed
2 numerous reports on the uninsured and on various aspects of the Medicaid program. Since 1996,
3 the House of Delegates has supported and reaffirmed its support for individually owned health
4 insurance, financed with individual tax credits, as preferred over both employment-based coverage
5 and public sector coverage. The Council met with many Medicaid experts over the past year as it
6 considered the broad question of Medicaid reform. Opinions vary on how to modify Medicaid, but
7 all analysts agree on this one thing: the current program is unsustainable.

8
9 The following report presents the Council's effort to craft a new opportunity for patients with low
10 incomes. The Council envisions that the proposal outlined in this report would apply to those
11 patients in the medical care portion of the Medicaid population, which constitutes 73% of current
12 Medicaid enrollees, and accounts for 27% of expenses. The Council is well aware that the difficult
13 issues of Medicaid funding for long-term care and disability care, whose recipients constitute 27%
14 of Medicaid enrollees and account for 73% of expenditures, need to be addressed in future reports.

15
16 The report also addresses Resolution 722 (I-02) because of its clear relationship to the Council's
17 work on Medicaid reform. The resolution calls for a study of the benefits and risks of a
18 nationalized Medicaid program. Accordingly, the report describes the urgent need for change;
19 provides a summary of the current Medicaid program; summarizes AMA policy related to health
20 insurance tax credits and Medicaid; describes the intense financial pressures being experienced by
21 states; and proposes a new model for providing medical care for patients with low incomes, on
22 which the Council seeks the input of the House of Delegates and the AMA Federation.

23
24 In undertaking this study, the Council is replicating the strategy that was used in the development
25 of Council on Medical Service Report 9 (A-98), "Empowering Our Patients: Individually Selected,
26 Purchased and Owned Health Expense Coverage." At the 1997 Interim Meeting, the Council
27 presented a report (Council on Medical Service Report 5, I-97) that contained a "blueprint" for how
28 the Council envisioned a system of individually selected and owned health insurance should be
29 structured. With Council Report 5 (I-97), the Council welcomed the input of the House and the
30 Federation prior developing the final recommendations contained in Council Report 9 (A-98). The
31 Council is following a similar approach with this report, and intends to submit final
32 recommendations to the House at the 2003 Interim Meeting.

1 THE URGENT NEED FOR CHANGE

2
3 At the outset of this report, readers are urged to consider what the Council believes would be more
4 accurate language for describing its proposal. The Medicaid program is often described in terms
5 that evoke specific images for different people. The program title “Medicaid,” for example, may
6 convey a robust benefit package to legislators, while signaling a stigma for the patients who are
7 eligible for the program, and challenges to the physicians who provide the care. Similarly, “long-
8 term care” can mean many things to many people. The Council was particularly challenged when
9 discussing Medicaid patients classified in the category “blind and disabled,” because of the belief
10 that some of these patients, or at least some of their needs, could be appropriately insured under the
11 new medical care model being proposed by the Council. The Council has chosen to refer to its new
12 proposal as a means to provide medical care to patients with low incomes, and envisions that its
13 proposal can replace the entire medical care function of Medicaid for patients who are not blind,
14 disabled, or elderly. The Council proposes a fundamental change in how we think about health
15 insurance for the poor. It is not a way for the government to cover those with low incomes with
16 health insurance of the government’s choosing, but a way for the government to provide a funding
17 mechanism to individuals so that those with low incomes can choose and own their own coverage.
18

19 Analysts across the political spectrum agree that the current structure of Medicaid is unsustainable.
20 The Medicaid program was destined to fail, even prior to the current dismal economic outlook for
21 the states, because its objectives are no longer clear. There are as many Medicaid programs as
22 there are states and territories, each being a patchwork of a basic shell with myriad waivers and
23 varying eligibility and coverage criteria. The need for change is particularly urgent at this time,
24 however, because the economy is straining state budgets. The Kaiser Commission on Medicaid
25 and the Uninsured currently reports that 49 states plan to reduce Medicaid spending by cutting
26 benefits, limiting eligibility, requiring beneficiary cost-sharing, or reducing payments to physicians
27 and other providers. The economic outlook has stalled suggestions to expand the Medicaid
28 program, at least temporarily. The dominant discussion in early 2003 has been on a proposal of the
29 Bush Administration, which contains measures to shore up the faltering Medicaid program.
30

31 Medicaid is the largest health insurer of children and maternity care in the United States.
32 Accordingly, the Council greatly appreciates the assistance of the American Academy of Pediatrics
33 and the American College of Obstetricians and Gynecologists, which sent relevant materials for the
34 Council’s review.
35

36 A number of groups have brought lawsuits in order to obtain Medicaid-sponsored health care they
37 claim is guaranteed to them by federal statute. The plaintiffs in these actions are diverse,
38 consisting of Medicaid recipients, advocacy and professional groups, and physicians. Before
39 plaintiffs are able to bring such a lawsuit, they must demonstrate that they have the right to appear
40 before the court. This is known as “standing.” Several courts have found that Medicaid
41 beneficiaries, and more importantly, advocacy groups and physicians, have standing to challenge
42 the state’s Medicaid program. (See *Arkansas Medical Society, et al., v. Reynolds*, 6 F.3d 519 (8th
43 Cir. 1993); *Oklahoma Chapter of the American Academy of Pediatrics (OKAAP) v. Fogarty*, 205 F.
44 Supp.2d 1265 (N. D. Ok. 2002); *Westside Mothers, et al., v. Haveman*, 289 F.3d 852 (6th Cir.
45 2002); *Frew v. Gilbert*, 300 F.3d 530 (5th Cir., 2002), 8/1/02). Once past the preliminary inquiry,
46 the court will analyze the plaintiff’s claim of alleged violations of the federal Medicaid law. Courts
47 have found violations in a number of situations.

1 Patient Concerns

2
3 Patients have many reasons to be unhappy with their Medicaid programs. Patients are concerned
4 about access to physicians and other health care providers, enrollment difficulties, the welfare
5 stigma, and a lack of choice among health plans and/or physicians. Although the Medicaid
6 program ostensibly offers a rich benefits package, the benefits increasingly are elusive in many
7 regions of the country. Benefits in a program are worthless unless there are professionals who will
8 perform the services that patients can access.

9
10 In *Westside Mothers*, the lower court's dismissal of the case brought by low-income children for
11 failure to receive adequate medical screening and treatment, as the plaintiffs claim is required by
12 federal statute, was reversed and the action reinstated. This case is still pending.

13
14 A 2002 study conducted by the University of California-San Francisco and published by the
15 California HealthCare Foundation (CHCF) found that physicians who were not board certified
16 were more likely to treat Medi-Cal patients, which the study's authors suggested may raise
17 questions about whether Medicaid beneficiaries have access to the same quality of physicians as
18 patients with private insurance. A 2002 study of rural Minnesota Medicaid beneficiaries published
19 in the *Journal of Rural Health* found that beneficiaries faced high levels of unmet need for care,
20 with more than a third reporting unmet need for primary physician, specialist, or hospital care.

21
22 In March 2003, the U.S. Supreme Court agreed to review a decision that ordered the Texas
23 Medicaid program to correct serious flaws in how it administered preventive health services to
24 children. The ruling resulted from a class-action lawsuit filed in 1993 on behalf of Texas children
25 eligible for Medicaid. The ruling focused on the Early Periodic Screening, Diagnostic and
26 Treatment program, covered by Medicaid. The state had been found to have failed to educate
27 families about treatment options, and to have contracted with managed care plans that have not
28 provided appropriate care.

29
30 In 1999, the Health Care Financing Administration (HCFA, now the Centers for Medicare and
31 Medicaid Services or CMS) ordered hospitals and physicians to stop demanding cash payments for
32 childbirth pain management. HCFA officials contended that the federal law requires states to cover
33 the prenatal, delivery, and other medical services related to delivery. HCFA officials did not know
34 how widespread the problem of access to anesthesia was. An article in the *New York Times* on the
35 inadequacy of Medicaid payment for managing the pain of labor cited claims that Medicaid pays
36 10% or 20% of what private insurers would pay for the same procedure. The article reported that
37 in some states Medicaid patients were being inappropriately required to pay with their own money,
38 with cash in advance, for epidural blocks because of the inadequacy of Medicaid payments.

39
40 Physician Concerns

41
42 The federal Medicaid statute requires that all participating states ensure beneficiaries' access to
43 medical care equal to that of the general population. This "equal access" requirement was violated
44 by the Arkansas Medicaid program's failure to consider the effect of reduced physician
45 reimbursements on the quality of care received by beneficiaries (*Arkansas Medical Society*). In
46 *OKAAP*, the defendant's motion to dismiss the plaintiff's case was denied. Thus, the trial on the
47 issue of whether low-income citizens were deprived of medical care in violation of the federal
48 Medicaid statute will begin in 2004. However, in *Tennessee Medical Association v. Corker*, 1995

1 Tenn. App. LEXIS 243 (Ct. of App. Tenn. 1995), the court held that neither the association nor the
2 physicians had the requisite standing to bring an action because neither of these groups could allege
3 any personal injury traceable to the Medicaid program's actions.
4

5 Although some states have improved their Medicaid programs by adjusting their payment rates,
6 and allowing innovations in how the program is administered, physicians in most states continue to
7 be unhappy with Medicaid payment rates and paperwork demands. The Medicaid programs in
8 most states are plagued with costs that outstrip the benefits mandated by federal law. Physicians
9 have cited inadequate payment and burdensome paperwork as deterrents to seeing Medicaid
10 patients. Several state medical associations have considered filing lawsuits against their Medicaid
11 programs. For example, in 1992, the Arkansas Medical Society sued its state department of human
12 services for violating federal law when it reduced Medicaid payment to physicians and other health
13 care practitioners by 20%. In 1994, the Tennessee Medical Association sought an injunction to
14 block enrollment of an additional 400,000 uninsured individuals in the failing TennCare program,
15 but the suit was dismissed.
16

17 A 2002 study of 3,773 primary care pediatricians, entitled "Factors that Influence the Willingness
18 of Private Primary Care Pediatricians to Accept More Medicaid Patients" found that low payment,
19 capitation, and paperwork all relate to low Medicaid participation (Berman, et al., *Pediatrics*,
20 August 2002).
21

22 The 2002 CHCF study found that 45% of California's primary care physicians and 43% of its
23 specialists say they do not have any patients covered by Medi-Cal, the state Medicaid program. An
24 analysis by the Center for Health System Change (HSC), completed in 2002, found much higher
25 participation rates in the 12 nationally representative communities in which HSC surveys were
26 completed. The report said that the proportion of physicians serving Medicaid patients decreased
27 from 87.1% in 1997 to 85.4% in 2001. HSC found that the level of physician participation was
28 sensitive to the physician payment levels, noting that payment cuts may trigger access problems.
29 The Council is greatly concerned that such access will become more problematic as Medicaid
30 programs are forced to reduce their spending. HSC also found that physicians with a large amount
31 of managed care contracts are increasingly likely to refuse to accept new Medicaid patients.
32

33 The House of Delegates has repeatedly voiced concern about poor physician payment rates under
34 Medicaid. For example, Policy H-290.980 (AMA Policy Database) was adopted as an amendment
35 to Council Report 5 (I-99), and states that the AMA continues to advocate for appropriate payment
36 to physicians under the Medicaid program. Policy H-290.982 favors an array of possible
37 mechanisms to increase patient choice and improve Medicaid budgets, and Policy H-290.997
38 supports increased uniformity across states with regard to eligibility, benefits, and payment.
39 Several policies also ask the AMA to secure "adequate" or better payment under Medicaid,
40 including Policies H-165.895(1), H-290.976(2), and H-290.997(4).
41

42 In addition, the paperwork burden associated with the Medicaid program can be very onerous. The
43 CHCF study found that most physicians had negative opinions about the Medi-Cal program.
44 Among those who participated in the program, 94% said payment rates were inadequate and 87%
45 said the program's paperwork requirements are burdensome.

1 SUMMARY OF THE MEDICAID PROGRAM

2
3 In 1965, amid the highly public debate over the establishment of Medicare, the Medicaid program
4 was enacted as Title 18 of the Social Security Act (SSA) as an afterthought as a means to provide
5 medical care to the poor and indigent. The Medicaid program was established as a joint
6 federal/state venture, rather than strictly a federal program like Medicare, thus preserving the
7 historic control states had had over programs for the poor. In order to receive federal matching
8 funds of at least half their program costs through the federal medical assistance percentage
9 (FMAP), states are required to provide a set of mandatory benefits to a mandatory group of
10 beneficiaries. The FMAP, also known as the "Medicaid match," determines the proportion of
11 federal funding each state receives, with states receiving at least 50% of the funding for their state
12 Medicaid programs from the federal government and poorer states receiving more generous
13 matches, up to 83%. States can also receive the federal matching funds if they expand coverage to
14 federally allowed optional categories of individuals or expand benefits with federally allowed
15 optional services.

16
17 In 1962, prior to the enactment of the Medicaid program, Section 1115 of the SSA gave the
18 Secretary of Health, Education and Welfare (the predecessor of Health and Human Services or
19 HHS) the authority to approve demonstration projects, or waivers, that promote any grant program
20 under SSA. The Secretary of HHS now has that authority. Once Medicaid became a part of the
21 SSA, it was subject to the demonstration authority. Section 1115 demonstrations have never been
22 subject to formal rulemaking or design standards. In a thorough examination of how Section 1115
23 waivers have been used in the Medicaid program, a Kaiser Family Foundation analysis found that
24 Section 1115 has been used as a means to achieve general program changes outside of the
25 legislative process, blurring the line between Congressional and Administration control over the
26 program.

27
28 In 1997, with passage of the Balanced Budget Act (BBA, P.L. 105-33), the State Children's Health
29 Insurance Program or SCHIP was created to extend coverage to children in families with incomes
30 too high for Medicaid eligibility, but too low to purchase their own coverage. SCHIP provides
31 states with a more generous match, but was designed as a block grant to states, so that states are not
32 required to adhere to the Medicaid benefits package. The average matching rate for SCHIP is 70%,
33 whereas the average matching rate for Medicaid is 57%. Soon after its enactment, SCHIP was
34 modified through Section 1115 waivers to cover children at higher levels of income (six states
35 cover children at or above 300% of the federal poverty level), and now several states also use
36 SCHIP funds to provide coverage to the parents of eligible children.

37
38 In 2001, HHS granted states even broader waiver authority using Health Insurance Flexibility and
39 Accountability (HIFA) waivers to modify state programs, with explicit permission to restrict some
40 benefits in order to expand others. In 2002, the General Accounting Office criticized aspects of the
41 HIFA waiver process for circumventing the opportunity for public input into proposals, and for
42 failing to ensure that approved waivers are consistent with the goals and fiscal integrity of
43 Medicaid and SCHIP.

44
45 The Office of Management and Budget has estimated that total Medicaid spending for 2003 will be
46 \$280 billion for its nearly 40 million beneficiaries. Medicare also has some 40 million
47 beneficiaries, with projected spending for 2003 to be \$230 billion. In 2003, the Medicaid program
48 continues to spend more than the Medicare program, a trend that began only in 2002. As illustrated

1 in Table 1, care for the elderly and care for the blind and disabled account for \$112,695,595,547
2 (73%) of Medicaid expenditures, although the elderly, blind and disabled constitute just 27% of
3 Medicaid enrollees. In 1998, the most recent year for which detailed data on both expenditures and
4 enrollees are available, Medicaid expenditures totaled \$169 billion for 40 million enrollees

5
6 Table 1

7
8 Medicaid Expenditures and Enrollees, by Group, 1998

9

	Expenditures	Enrollees	Average Spending per Enrollee by Group
11 Children	\$25,308,460,014	20,664,617	\$1,225
12 Adults	\$16,349,616,638	8,642,895	\$1,892
13 Blind & Disabled	\$66,747,165,968	6,983,562	\$9,558
14 Elderly	\$45,948,429,579	4,089,805	\$11,235
15 Total*	\$154,353,672,199	40,380,879	\$3,822

16 *Excludes Disproportionate Share Hospitals payments, which totaled \$14,961,831,256 in
17 1998. Source: KFF, State Health Facts Online: Medicaid Enrollment, Distribution by
18 Enrollment Group and Medicaid Spending, Distribution of Spending by Enrollment Group,
19 and KFF Fact Sheet “Medicaid Enrollment and Spending Trends,” February 2001.

20
21 As reported in Council Report 10 (A-02), Table 1 provides evidence that it may cost less to buy
22 coverage on the individual market than it would cost to enroll a person in Medicaid: The table
23 shows annual Medicaid spending per child in 1998 of \$1,225, while spending per nondisabled and
24 nonelderly adult was \$1,892. Thus, the average cost to Medicaid for two children and two
25 nondisabled and nonelderly adults was \$6,234. For one nondisabled and nonelderly adult and three
26 children the average cost to Medicaid was \$5,567. A private sector family policy costing \$5,500 to
27 \$6,200 would assure access to high-quality health care.

28
29 As previously indicated, states must provide “mandatory” eligibility groups with a mandatory level
30 of coverage in order to receive federal matching funds. States may also elect to cover “optional”
31 eligibility groups and optional services. According to the Kaiser Commission on Medicaid and the
32 Uninsured, 65% of Medicaid spending is for optional services. More than half (58.4%) of optional
33 spending in 1998 was spent on long-term care.

34
35 Mandatory populations include children through age 5 at or below 133% of the federal poverty
36 level (FPL), children aged 6-19 in families with incomes at or below 100% of FPL, certain adults
37 in families with eligible children, pregnant women with incomes at or below 133% of FPL,
38 disabled and elderly social security income (SSI) beneficiaries, certain working disabled, and
39 Medicare buy-in groups. States also receive matching funds if they provide coverage to any of the
40 federally determined “optional” eligibility groups. Optional populations include infants under age
41 1 in families with incomes at or below 185% of FPL, older children in families with incomes above
42 the mandatory poverty levels, pregnant women at higher levels of poverty, certain disabled and
43 elderly individuals whose incomes exceed SSI limits, and individuals deemed “medically needy”
44 and able to “spend down” because of their high medical expenses Mandatory Medicaid benefits
45 include, but are not limited to, physician services; x-ray and laboratory services; hospital services;
46 nursing facility and home health services for individuals 21 and older; and early and periodic
47 screening, diagnostic and treatment services for individuals under 21. Optional benefits include
48 prescription drugs; intermediate care facilities for individuals with mental retardation (ICFs/MR);

1 personal care services authorized by a physician; and targeted case management services. States
2 have wide discretion to determine which benefits to offer Medicaid beneficiaries, and they can
3 institute nominal cost-sharing for certain beneficiaries for certain benefits. Federal law prohibits
4 states from requiring cost-sharing from eligible children under age 18; pregnant women with
5 respect to pregnancy-related services; terminally ill patients receiving hospice care; and inpatients
6 of hospitals, nursing homes, and ICFs/MR who became eligible as a result of “spending down.”
7

8 AMA POLICY RELATED TO HEALTH INSURANCE TAX CREDITS

9
10 The development of a Medicaid reform model that enables the low-income population to purchase
11 their own health insurance coverage aligns AMA policy toward the medical portion of the
12 Medicaid program with the coverage envisioned in the AMA’s private sector reform proposal,
13 articulated in Policies H-165.920, H-165.882, H-165.865, and H-165.867.
14

15 Policy H-165.920 provides a broad summary of the proposal favoring individually owned health
16 insurance over public sector and employment-based coverage. The policy supports the use of
17 income-related individual tax credits, financed in part by revoking the subsidy for employment-
18 based coverage. Policy H-165.882 supports market innovations to make individual ownership of
19 health insurance affordable, as well as the formation of small employer and other collective groups.
20 Policies H-165.865 and H-165.867 outline principles by which tax credit proposals should be
21 structured.
22

23 Taken as a whole the policies support individually owned health insurance financed by a system of
24 refundable and advanceable tax credits that are inversely related to income, thereby being a useful
25 model to subsidize those with little or no tax liability. AMA policy recognizes that the current
26 individual market can and will be transformed by the influx of dollars earmarked for individual
27 health insurance policies. Council on Medical Service Report 7 (A-03), also being considered at
28 this meeting, analyzes ways to address legislative and regulatory barriers to the formation and
29 operation of alternative group purchasing arrangements.
30

31 AMA POLICY RELATED TO MEDICAID

32
33 Although the AMA has developed numerous policies regarding the Medicaid program, such policy
34 lacks a coherent direction. Policy H-290.982, in particular, favors a wide array of possible
35 mechanisms to increase patient choice and improve Medicaid budgets. Policy H-290.997 supports
36 increased uniformity across states with regard to eligibility, benefits, and payment. As previously
37 noted, several policies ask the AMA to secure “adequate” or better payment under Medicaid.
38

39 For the most part, the Council would leave the Medicaid policies intact while the House considers
40 whether to move in the direction outlined in this report. Indeed, even if the House agrees to the
41 proposal outlined in this report, the Council believes that the AMA should retain the bulk of its
42 Medicaid policies, disjointed as they are, until such time as the current Medicaid program ceases to
43 operate.
44

45 The one Medicaid policy that the Council believes should be modified at this time is
46 Policy H-290.982(1), which urges that Medicaid reform not be undertaken in isolation, but rather in
47 conjunction with Medicare reform, in order to ensure that the delivery and financing of care
48 through both programs result in appropriate access and level of services for patients. The Council
49 believes this policy should be modified to urge that Medicaid reform be undertaken in conjunction
50 with broader health insurance reform.

1 STATES UNDER PRESSURE

2
3 In February 2003, amid continuing news of state fiscal crises, HHS Secretary Tommy Thompson
4 attended a meeting of the National Governors Association (NGA) seeking support for the
5 Administration's Medicaid proposal, which was to offer states a temporary infusion of money, and
6 greater flexibility with respect to benefit design for optional eligibility categories. A number of
7 groups in attendance at the meeting, including AIDS organizations, the Children's Defense Fund,
8 the National Women's Law Center, and AARP, asked the governors to reject efforts to reduce
9 benefits and enrollment eligibility, and to seek more federal financial assistance for state Medicaid
10 programs. The governors took no position on the Administration proposal, but did agree to
11 establish an NGA task force on Medicaid reform and asked for additional information.

12
13 In 2002, the federal government closed a loophole that some states used to boost their share of
14 federal Medicaid contributions. The loophole, made possible by creative state accounting with
15 respect to Medicaid's upper payment limit rules, occurred when states made excessive Medicaid
16 payments, financed jointly by states and the federal government, to certain facilities and then were
17 refunded the over-payment by those facilities. The upper payment limit regulation simply sets
18 ceilings on the amount of Medicaid payments that can be made to providers. Some states made
19 payments far in excess of the costs of treating Medicaid patients to certain public hospitals and
20 nursing homes, while keeping the aggregate payment to all such facilities below the upper payment
21 limit. The federal match was applied to the inflated payments. The excess payment to facilities
22 were then returned to the state treasuries with no provision to assure that the additional dollars
23 would be spent on Medicaid services. The 2002 regulation closing the loophole is being
24 implemented in phases, to slowly transition states that had become dependent upon the loophole.

25
26 MEDICAL CARE FOR PATIENTS WITH LOW INCOMES

27
28 The Council believes that the only equitable and logical proposal for the Medicaid program is to
29 dismantle it, at least for those patients who use Medicaid solely for medical care, and to replace the
30 medical care function with federally financed tax credits. By completely federalizing the financing
31 of care for the 73% of Medicaid beneficiaries (children and non-disabled, non-elderly adults), who
32 account for 27% of Medicaid expenditures, states will be freed of a large financial obligation.
33 When the Council looks at how to improve the care provided to the elderly, blind and disabled, it is
34 possible that additional funding from states will be necessary.

35
36 People with low incomes do not benefit from the separate and unequal health care delivery system
37 that has developed as a result of excessive and unfocused Medicaid administration. The Council
38 proposes a system aligned with the AMA private sector reform proposal as follows:

- 39
40 (1) Finance the medical care portion of the Medicaid program with federally issued tax credits
41 that are refundable, advancable, and inversely related to income, and not in a shared
42 federal/state partnership.

43
44 Rationale: Medicaid beneficiaries will be able to purchase the same individual health
45 insurance available to individuals of all income categories. Although some states have
46 succeeded in making changes that improve access for Medicaid beneficiaries, most have
47 not. Poor access to mainstream medical care is a recurring problem of the Medicaid
48 program, which promises a generous benefit package but cannot assure that there will be
49 physicians and other health care practitioners who can afford to provide those services.

1 The Medicaid program is also marked by a welfare stigma that will be greatly diminished
2 by converting to a federal individual tax credit for eligible individuals.
3

- 4 (2) Mandatory Medicaid eligibility groups should receive tax credits that are large enough to
5 enable individuals in those groups to purchase coverage individually, through programs
6 modeled after the state employee purchasing pool, or the Federal Employee Health
7 Benefits Program (FEHBP), with no cost-sharing obligations.
8

9 Rationale: This recommendation would leave intact the premise of the Medicaid program
10 that there are some low-income individuals whose medical care should be subsidized
11 completely. Allowing individuals to use their tax credit to “buy in” to state or federal
12 employee pools is consistent with Policy H-165.995(3).
13

- 14 (3) Optional Medicaid eligibility groups should receive tax credits that are large enough to
15 enable them to purchase coverage individually, through programs modeled after the state
16 employee purchasing pool, or the FEHBP, with limited cost-sharing.
17

18 Rationale: AMA policy advocates that tax credits be inversely related to income, and
19 states that tax credits must be large enough to entice recipients to purchase coverage, but
20 does not define “large enough.” In order to be a practical option for Medicaid
21 beneficiaries, the cost-sharing would have to be minimal.
22

- 23 (4) Individuals with incomes up to a certain level, yet to be determined, should receive tax
24 credits to cover a substantial portion of individually purchased coverage, or coverage
25 through programs modeled after the state employee purchasing pool or the FEHBP, with
26 moderate cost-sharing.
27

28 Rationale: The intent is to integrate SCHIP, which provides coverage to higher income
29 children and some parents, and to enable families to purchase family coverage where there
30 are children receiving a subsidy. Medicaid does not cover all poor persons, but the Council
31 believes it is sound policy to provide coverage to parents of currently eligible children.
32 Such a subsidy would not amount to an expansion of current eligibility. Rather, it would
33 be an expansion of coverage with tax credits to the uninsured, consistent with AMA Policy
34 H-165.920.
35

- 36 (5) In order to assure continuity of care, there should be a mechanism to quickly reassess the
37 eligibility group and amount of tax credit with changes in income and family.
38

39 Rationale: Under the current Medicaid program, individuals gain and lose coverage as
40 their income changes. The portability of individually owned health insurance is assured
41 because the size of the tax credit will only decrease as income increases.
42

- 43 (6) Medicaid beneficiaries should be given choices of where to purchase coverage. A
44 mechanism should be developed to administer a process by which those who do not choose
45 will be assigned a health plan in their geographic area until the next enrollment
46 opportunity.
47

48 Rationale: Some beneficiaries may never have had private coverage and may be
49 uncomfortable choosing their own health insurance. Although proactively changing the
50 coverage of a Medicaid beneficiary who has not chosen to do so may cause some

1 confusion, doing so may be necessary to eliminate the joint federal/state Medicaid
2 partnership that maintains contracts with health plans. The proposed change would be
3 financed solely by the federal government, and health plan contracts would be with
4 patients rather than a government entity.
5

6 CARE FOR THE ELDERLY, BLIND AND DISABLED
7

8 The Council recognizes that it needs to do further study to address the complex needs of the
9 elderly, blind, and disabled, which are separate populations from those of the Medicaid population
10 who receive Medicaid services primarily for acute and preventive medical care. In addition, the
11 Council believes that relieving states of their financial obligations for financing the medical care of
12 low income patients does not mean that states should be free to use that funding on expenses
13 unrelated to health. In fact, the Council anticipates that as it further studies care for the elderly,
14 blind, and disabled, it will take into consideration the financial “windfall” that will result from
15 states no longer being obligated to finance the medical care of 73% of Medicaid enrollees.
16 As previously noted, the 27% of the Medicaid population that consists of the blind, disabled and
17 elderly, have needs that account for 73% of program expenses. For these Medicaid beneficiaries,
18 with known high expenses, as with the segment of the non-Medicaid population whose health
19 would make their individual coverage problematic, some form of subsidized high-risk pool may
20 need to be created to serve as a safety net, with potentially shared federal and state financing. The
21 problem of obtaining health insurance coverage for chronically ill Medicaid patients is really no
22 different than the problem for high-health expense individuals in general. Therefore, there is a
23 consistency and simplicity in modeling Medicaid reform in a way in which everyone whose
24 income is below a certain level receives a tax credit for the purchase of health insurance, and those
25 whose health is so bad that they cannot purchase coverage would be allowed into some special
26 high-risk pool or other mechanism, along with the general population. Further study may offer
27 ways in which some disabled patients might be appropriately covered under the medical care
28 model of tax credits for health insurance.
29

30 With respect to long-term care, states may be much better equipped to handle long-term care
31 because waiver initiatives can be used appropriately to explore alternatives to custodial care, such
32 as day care centers and home health options, including vouchers, respite care, and pharmaceutical
33 programs. The Council is committed to further study of the best policies for providing care for the
34 elderly, blind, and disabled.
35

36 POLITICAL FEASIBILITY
37

38 The Council believes that the proposal outlined in this report has considerable political merit. In
39 general, support for tax credits for the purchase of individual health insurance is gaining viability.
40 For example, as described in Council on Medical Service Report 11 (A-03), also being presented at
41 this meeting, the U.S. Department of the Treasury is currently developing a method for
42 administering health coverage tax credits that were approved in the Trade Act of 2002 for certain
43 uninsured individuals.
44

45 Republicans have long supported privatization and individual ownership of health insurance
46 coverage. Democrats have long supported public financing of health care for those with low
47 incomes. Refundable and advanceable individual tax credits are a means of public financing
48 private and individually owned health insurance. At a health care reform hearing of the Senate
49 Special Committee on Aging in March 2003, Senator John Breaux (D-LA) advocated a system of
50 refundable and advanceable tax credits for low- and middle-income Americans. In addition, during

1 “Covering the Uninsured Week,” also in March 2003, the Democratic Leadership Council issued a
2 statement that “the basic principles for expanding coverage should be to emphasize public
3 financing through refundable tax credits for the purchase of private health insurance coverage; to
4 give all Americans the kind of real choices of health care plans enjoyed by members of Congress
5 and other federal employees through the Federal Employee Health Benefit Plan (FEHBP); and to
6 set up the system so that employer-provided coverage is reinforced, not supplanted.”
7

8 CONCLUSIONS

9
10 According to a recent study completed by researchers at the Urban Institute for the Kaiser
11 Commission on Medicaid and the Uninsured, \$35 billion was spent on caring for the uninsured in
12 2001, with \$31 billion of that amount funded by the government (Hadley and Holahan, *Health*
13 *Affairs*, February 2003). As the authors conclude, the money spent on providing services to the
14 uninsured could be spent on premiums.
15

16 The outline to Medicaid reform presented by the Council in this report would fully implement the
17 AMA’s support for individual insurance using tax credits inversely related to income, so that the
18 proposal would broadly support health insurance reform instead of solely “private sector reform.”
19 The subsidization as outlined by the Council would apply to the provision of medical care services
20 for Medicaid’s current mandatory and optional categories, as well as to all individuals at or below
21 an income threshold. The Council does not view this proposal as an expansion of Medicaid, but as
22 an expansion of coverage in a manner consistent with existing policy supporting individual tax
23 credits and individually owned health insurance. Eighty-five percent of the uninsured live in
24 families headed by workers, and are therefore contributing, through income taxation, to the
25 financing of Medicaid, Medicare, and the nearly \$100 billion subsidization of employment based
26 coverage. Accordingly, these uninsured families are spending more on health insurance for others
27 than for their own families. The Council continues to believe that it is unconscionable to continue
28 to deprive low-income individuals of any health insurance subsidy simply because their employers
29 do not offer coverage or because their incomes, while low, are too high for Medicaid.
30

31 In response to Resolution 722 (I-02), as this report demonstrates, the Council believes there is
32 considerable merit in federalizing the medical care portion of the Medicaid program. The Council
33 initially believes that long-term care may best be handled by states, whereas care for the disabled
34 and chronically ill may be appropriately financed with additional subsidy to participate in the
35 private market with the healthier general population.
36

37 The Council is seeking the advice and suggestions of members of the House of Delegates, state
38 medical associations, and national medical specialty societies. The Council is interested in
39 knowing if there are elements that have been left out and need to be considered, or whether there
40 are elements that are included and should be deleted. In addition, the Council is seeking
41 recommendations for the optimal financial threshold with respect to the third eligibility group,
42 which is discussed as the fourth item under the section of this report entitled “Medical Care for
43 Patients with Low Incomes.” Generally, at higher levels of income, individuals are more likely to
44 have employment-based coverage. On the other hand, the long-term vision of the AMA is to
45 replace the employment-based exclusion with tax credits. The Council also welcomes input on the
46 how to address care for elderly, blind and disabled Medicaid beneficiaries. Once state
47 governments are freed of the financial responsibility for the medical care of low income residents,
48 perhaps they should be expected to increase their financial commitment to the elderly, blind, and
49 disabled within their states.

1 RECOMMENDATIONS

2

3 The Council on Medical Service recommends that the following be adopted and the remainder of
4 the report be filed:

5

6 1. That Policy H-290.982(1) be amended by insertion and deletion to read as follows:

7

8 AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation,
9 but rather in conjunction with ~~Medicare~~ broader health insurance reform, in order to ensure that
10 the delivery and financing of care ~~through both programs~~ results in appropriate access and level
11 of services for low-income patients. (Modify HOD Policy)

12

13 2. That the testimony and comments in reference committee and House of Delegates discussions
14 regarding the model outlined under the heading “Medical Care for Patients with Low Incomes”
15 in this report be forwarded to the Council on Medical Service for consideration in developing
16 its recommendations. (Directive to Take Action)

17

18 3. That members of the House of Delegates, state medical associations, and national medical
19 specialty societies be encouraged to forward any additional comments on the model outlined
20 under the heading “Medical Care for Patients with Low Incomes” in this report to the Council
21 on Medical Service by August 1, 2003. (Directive to Take Action)