REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-99)
Status Report on the Medicaid Program
(Reference Committee A)

EXECUTIVE SUMMARY

Council on Medical Service Report 5 provides an overview of the Medicaid program and summarizes extensive AMA policy related to Medicaid financing, long-term care financing, and access to health care coverage for the uninsured. In particular, the report addresses the following areas:

- Medicaid program authority and state eligibility expansion efforts.
- Expenditures per key Medicaid beneficiary group, including the disabled, the elderly, and children. The report includes an update of the Children's Health Insurance Program.
- Medicaid financing with projected program expenditures through next year and a discussion of Medicaid managed care.
- Trends in long-term care financing, including alternatives to Medicaid financing of long-term care through expanded use of medical savings accounts and private long-term care insurance.

The report finds that although the elderly account for a minority of Medicaid beneficiaries, their expenses for long-term care consume a disproportionate share of Medicaid dollars. With an almost certain increase in the demand for long-term care services, the report contains recommendations that address anticipated growth in long-term care financing needs. In addition, the Council affirms its continued support for private sector reforms that have the potential for increasing access to health insurance, but also notes that public sector expansions may be necessary in the absence of private sector reforms.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - I-99

Subject: Status Report on the Medicaid Program

Presented by: Eugene Ogrod, MD, Chair

Referred to: Reference Committee A
(Jerome Bobruff, MD, Chair)

At the 1997 Interim Meeting, the House of Delegates adopted the 21 recommendations contained in Board of Trustees Report 31 related to Medicaid financing (Policy H-290.982, AMA Policy Compendium). Board Report 31 (I-97) presented the findings of the AMA Inter-Council Medicaid Task Force, which advocated that the Medicaid program be viewed and treated as three separate programs because the needs and attendant costs of one group of beneficiaries may overwhelm those of another group of beneficiaries. In particular, the Task Force noted the intensive use of both long-term and acute care services among the elderly, blind, and disabled, although these populations account for a minority of the Medicaid beneficiary population.

In its ongoing study of mechanisms for increasing health care coverage for the uninsured, the Council on Medical Service believes these issues must be addressed with a comprehensive understanding of the Medicaid program and its beneficiaries. The Council presents this report in its effort to evaluate and present information related to the future viability of the Medicaid program.

THE MEDICAID PROGRAM

Medicaid was authorized in 1965 by Title XIX of the federal Social Security Act as a federal-state matching entitlement program that pays the medical care for certain vulnerable and needy individuals and families with low income and assets. Medicaid is the largest source of health care funding for the country's poorest people.

States are given broad discretion in determining eligibility standards, payment rates, and scope of services. There is no requirement that all low-income individuals be eligible for Medicaid. The federal government does, however, require that states cover certain low-income population groups that are considered "categorically needy." These include pregnant women and children under the age of six who are in families at or below 133% of the federal poverty level; children under the age of 19 who were born after September 30, 1983, and whose family income is at or below 100% of the federal poverty level; recipients of federal adoption or foster assistance; the aged, blind and disabled who receive benefits under the Supplemental Security Income Program (SSI); individuals who meet what on July 16, 1996 had been the income and related standards of Aid to Families with Dependent Children (AFDC, the former cash benefit program); special protected groups, such as those who lost cash assistance due to earnings income or increased Social Security benefits), and certain Medicare beneficiaries who have low incomes and limited resources.

In addition to the "categorically needy," states have the option of providing Medicaid coverage for other groups that share some characteristics of the mandatory groups, but with more liberally defined eligibility criteria. For example, states may choose to cover infants up to age one and pregnant women whose family income is at or below 185% of the federal poverty level; as well as individuals who would be eligible if institutionalized, but who are receiving care under home or community-based services. A significant optional coverage group includes "medically needy" persons who would be eligible for Medicaid under one of the categorical or optional groups, except that they exceeded the income or asset limits. In order to qualify for Medicaid coverage, this group of individuals must "spend down" by incurring medical expenses that reduce their income and assets to or below their state's level.

Some states have used their discretionary eligibility authority to address the problem of the uninsured by developing programs to expand Medicaid coverage to low-income (up to 150% of the federal poverty level) and non-elderly adults, who are not disabled and who have no children. In the absence of private sector reforms that would enable persons with low-incomes to purchase insurance, the Council supports such Medicaid expansion efforts to provide coverage to the otherwise uninsured.

THE BENEFICIARY TRIAD

The Medicaid program is often thought of as providing medical coverage for three distinct beneficiary groups: children, the blind and disabled, and the elderly. The common thread among all Medicaid beneficiaries is that they are in families with very low incomes. Table 1 summarizes the 1997 Medicaid beneficiary population.

Table 1: Medicaid Enrollees and Expenditures by Group, 1997

	Enrollees		Direct Expenditures	
	Thousands (or 000)	% of Total	$ Millions (or 000,000)	% of Total
All Enrollees	40,570	100.0	145,282	100.0
Nondisabled Children	21,019	51.8	24,301	16.7
Nondisabled Adults	8,604	21.2	16,122	11,1
Aged	4,114	10.1	44,450	30.6
Blind and Disabled	6,833	16.8	60,409	41.6

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports, 1999. Data are provided in cooperation with the Kaiser Commission on Medicaid and the Uninsured.

Notes: Data are for federal fiscal year 1997. Does not include $15.9 billion in disproportionate share hospital payments, administrative costs, accounting adjustments, or expenditures in the U.S. territories; total expenditures with all of these inclusions are $165.9 billion. Enrollees are defined as individuals who sign up for the Medicaid program for any length of time during the federal fiscal year–these people may never actually use medical services.

In addition, to beneficiary groups included in the triad, nondisabled, low-income pregnant women and other adults with children receiving cash assistance account for roughly a fifth of Medicaid recipients. Although the elderly and disabled account for less than a third of Medicaid recipients, 60% of total program expenditures go to these groups. Prior to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, the "Welfare Reform Act"), people who received cash assistance were automatically enrolled in Medicaid. As

reported in CMS Report 2 (A-99), the Welfare Reform Act administratively disconnected the link between receiving cash assistance and Medicaid enrollment so that an additional effort must now be made to enroll those in families receiving cash benefits. In addition, although the Welfare Reform Act of 1996 was specifically intended to allow those who left the welfare rolls for work to keep their Medicaid coverage, several thousand Medicaid-eligible low-income workers have lost their coverage. Because many former welfare recipients took low-wage jobs that offer no health benefits, the result has been an increase in the number of people without health insurance.

Children and the elderly are characterized in the Medicaid beneficiary population by virtue of their age. Table 2 summarizes the age of Medicaid beneficiaries in 1997. According to unpublished 1997 data provided by HCFA, 66% of Medicaid recipients in the 45 to 64 age group were disabled.

Table 2: Medicaid Enrollees by Age, 1997

	Enrollees	% of Total
Total enrollees	40,344,493	100.0
under 1 year old	2,112,346	5.2
1-5 years old	7,531,010	18.7
6-14 years old	9,108,943	22.6
15-20 years old	3,977,133	9.9
21-44 years old	9,486,692	23.5
45-64 years old	3,308,820	8.2
65-74 years old	1,964,608	4.9
75-84 years old	1,603,379	4.0
85 years old and over	1,143,560	2.8
Age unknown	92,568	0.2

(Source: HCFA-2082 Report, Table 28)

The Disabled

In 1997, approximately 73% of disabled Medicaid recipients were nonelderly adults aged 21 to 64 years old. The disabled accounted for 16.8% of Medicaid beneficiaries and 41.6% of direct Medicaid expenditures, making the disabled the most costly beneficiary group. The relatively high expenditures for the disabled reflects their substantial health care needs and the very nature of their Medicaid eligibility. Of total Medicaid expenditures for care of the disabled, 41.3% went to finance long-term care (see Table 4). With the discussion of long-term care to follow, it is relevant to note that in 1995, only 10.9% of nursing facility residents were under age 65, which indicates that the disabled are underrepresented in the nursing home population relative to the elderly—the other significant nursing home population. In 1997, long-term care expenses for the disabled consisted of 36.6% for care in an intermediate care facilities for the mentally retarded, 36.7% for home health care, and 23.5% for care in skilled nursing facilities.

The Elderly

In 1997, the elderly accounted for 10.1% of the Medicaid population and 30.6% of direct Medicaid expenditures. Medicaid beneficiaries over the age of 65 are also eligible for coverage under the Medicare program, making them “dual eligibles.” Long-term care costs for the elderly accounted for 74.1% of total Medicaid expenditures for the elderly. Within long-term care, 82.1% of expenditures for the elderly were for care in nursing facilities. Like the disabled, the high costs

associated with elderly Medicaid beneficiaries represent the substantial health care needs of this group.

Children

In 1997, 51.8% of Medicaid beneficiaries were nondisabled children, who accounted for 16.7% of direct program expenditures. Thus, children comprise the largest category of Medicaid beneficiaries, but receive a relatively small portion of Medicaid resources. The great medical and social value of ensuring access for children is fortuitously combined with the relatively low cost of their health care. The Council continues to strongly support Policy H-165.882(1), which places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for children.

CMS Report 2 (A-99) provided an overview of the State Children's Health Insurance Program, commonly referred to as CHIP, which was authorized by the Balanced Budget Act of 1997 (P.L. 105-33, "BBA"). All states and six U.S. territories have approved CHIP programs, which provide health insurance coverage to low-income children who are ineligible for Medicaid. Although CHIP programs can be structured as either Medicaid expansions or as separate programs, eligibility criteria for CHIP can be characterized as including an income cap that is higher than that allowed for Medicaid eligibility.

As of June 1999, 1.3 million children were enrolled in state CHIP programs. In May 1999, two comprehensive reports were issued that provide updates on CHIP: one by the U.S. General Accounting Office (GAO) and the other by the Department of Health and Human Services Office of the Inspector General (OIG). The GAO reported that a growing number of states are exploring statutory options under CHIP for including family coverage and subsidizing employer-sponsored coverage. Such innovations are consistent with Policy H-165.882[8], which calls for alternative sources of financing premium subsidies for children's private coverage. The 15 states included in the GAO's analysis had all developed innovative outreach strategies. The OIG report focused on enrollment processes and recommended shorter and multi-lingual enrollment applications, which are consistent with the recommendations in CMS Report 2 (A-99) (Policy H-290.982[17 and 18]).

On October 12, 1999, President Clinton announced a multi-agency plan to increase federal efforts to enroll more children in Medicaid and CHIP. The plan will attempt to reach children through school-based programs and through their grandparents by informing seniors about the programs in Social Security notices. In addition, the plan includes private sector initiatives such as placing enrollment information on grocery bags. Furthermore, HCFA has awarded a five-year, $4.2 million contract to Mathematica Policy Research, Inc. to conduct a five-year study of CHIP success toward expanding access to health insurance to children in low-income families.

RELEVANT AMA POLICY

The AMA has established comprehensive policy concerning the financing of Medicaid, which includes policy on long-term care financing and improving access to health care coverage for the otherwise uninsured. In addition, AMA policy on the uninsured favors private over public coverage as a means of increasing access, and provides a detailed policy for achieving privately and individually owned insurance (Policy H-165.920).

Policy H-290.982(1) advocates that Medicaid reform not be undertaken in isolation, but rather in conjunction with Medicare reform, in order to ensure that the delivery and financing of care through both programs result in appropriate access and level of services for patients; (2) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (3) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (4) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (5) urges states to administer their Medicaid and SCHIP programs through a single state agency; (6) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (7) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of tax credits; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (8) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (9) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (10) calls for HCFA to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (11) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (12) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care; (13) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term

care needs; (14) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (15) supports efforts to assess the needs of mentally retarded individuals and, as appropriate, shift them from institutional care in the direction of community living; (16) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (17) urges HCFA to require states to use its simplified four-page combination Medicaid/CHIP application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (18) urges HCFA to ensure that Medicaid and CHIP outreach efforts are appropriately bilingual and culturally sensitive in states or localities with large uninsured ethnic populations.

Policy H-280.991 establishes guidelines for long-term care financing proposals. Among the comprehensive list of principles in this policy are the following key recommendations: (7) provide sliding scale subsidies for the purchase of long-term care insurance coverage for individuals with incomes between 100-200 percent of the poverty level; (8) encourage private sector coverage through an asset protection program; equivalent to the amount of private coverage purchased; (9) create tax incentives to allow individuals to deduct the cost of coverage from income tax, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of long-term care insurance premiums and expenses; (10) authorize a tax deduction or credit to encourage family care giving; and (10,a) provide an environment that permits states to develop innovative financing and delivery arrangements.

Policy H-165.920(7) strongly supports legislation promoting the establishment and use of medical savings accounts and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

Policies H-165.882 and Policy H-165.920(2) related to improving access for the uninsured, recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access. The former policy includes 11 recommendations for increasing access for children including a recommendation to place particular emphasis on expanding insurance coverage to uninsured children and placing a preference on enabling children to obtain private insurance rather than being placed in Medicaid (Policy H-165.882[1]). In addition, Policy H-165.882[8] advocates other sources of financing premium subsidies for children's private coverage.

MEDICAID FINANCING

The HCFA Office of the Actuary estimates that 1999 federal and state Medicaid expenditures will total $181 billion, covering 34.9 million individuals, or about 13 percent of the United States population. For 2000, budgeted projections estimate that 35.4 million individuals will be covered at a cost of $192 billion. State Medicaid programs operate by making "vendor" payments, with vendors being physicians and other health care practitioners as well as health care facilities. Table 3 includes a summary of overall 1997 Medicaid expenditures as expressed in terms of vendor payments.

Table 3: Medicaid Vendor Payments, 1997

Vendor Type	Dollar Amount	% of Payments
General and mental inpatient hospital	$25 billion	20.2%
Outpatient hospital	$6.2 billion	5.0%
Clinic services	$4.3 billion	3.5%
Lab and X-ray services	$1 billion	0.8%
Nursing facility services	$30.5 billion	24.7%
Home health services	$12 billion	9.7%
Intermediate care facilities	$9.8 billion	7.9%
Physician services	$7 billion	5.7%
Dental services	$1 billion	0.8%
Other practitioner services	$979 million	0.8%
Prescription drugs	$12 billion	9.7%
Family planning	$400 million	0.3%
EPSDT	$1.6 billion	1.3%
Rural health	$308 million	0.2%
Other care	$11 billion	8.9%
Service unknown	$2 million	0.0%

(Source: HCFA-2082 Report, Table 10)

States may pay vendors directly or pay for Medicaid services through various prepayment strategies. The BBA cleared the way for states to require Medicaid beneficiaries to enroll in managed care plans. The AMA expressed strong opposition to the mandatory enrollment procedure, citing the difficulties of Medicare+Choice implementation as evidence of an unstable market and the subsequent threat to the public health safety net. The Council also developed a comprehensive series of principles to guide the development and implementation of Medicaid managed care plans (Policy H-290.985). As of July 1999, Medicaid managed care programs were operating in 38 states. Consistent with the AMA's expressed concern with the precedence of Medicare+Choice, some Medicaid managed care plans have withdrawn, reduced services, or limited enrollment of Medicaid beneficiaries in their plans, citing low payment rates and a high degree of administrative requirements.

The BBA eliminated the requirement that Medicaid managed care plans maintain a minimum of 25% private sector enrollees, which served as an indirect quality assurance measure based on the presumption that plans with private sector enrollees would maintain a competitive quality standard. Following the enactment of the BBA, states may now enroll beneficiaries established solely to serve the Medicaid population. With the elimination of the private sector in managed care plans enrollee requirement, HCFA has identified numerous quality and patient protection measures that plans must meet. In addition, a June 1999 OIG report found that Medicaid managed care plans lack guidelines to detect fraud and abuse. The report specifically found that Medicaid managed care plans were particularly susceptible to fraudulent enrollment processes and withholding covered services from beneficiaries.

It is too early to know whether the savings to the Medicaid program with mandatory managed care enrollment will be substantial. There is reason to believe, however, that any savings will be diminished because Medicaid fee-for-service payment rates were already very low. In addition, the beneficiaries enrolled in the managed care plans tend to be generally healthy adults and children who have accounted for a minority of Medicaid expenditures. Moreover, managed care can be a

risky option for the disabled and others with significant health care needs. Inadequate panels of specialists and other measures that trim services that may be infrequently used for the general population, can have a profound impact on meeting the needs of persons with disabilities.

LONG-TERM CARE FINANCING

In 1997, nursing facility services accounted for 76.5% of Medicaid's long-term care expenses. At the same time that demand for long-term care increases, the nation is seeing what may become a shortage of services. Nursing homes, in particular, are under intense scrutiny following well-publicized cases of patient negligence as well as fraud and abuse. In 1998, expenses for nursing facility residents were principally covered by Medicaid (67.6%). Private insurance paid for 23.2% of nursing facility expenses and Medicare covered 9.3%. Although Medicare does not cover "long-term care," it does cover acute care services that may be provided in settings where long-term care is provided, such as skilled nursing facilities, for up to 100 days.

Table 4 summarizes Medicaid expenditures in long-term care by beneficiary group. Costs incurred by the elderly for care in nursing facilities are significant. The disabled are more likely to be represented in alternatives to nursing facility care, such as in home health and intermediate care facilities for the mentally retarded.

Table 4: Medicaid Expenditures on Long-Term Care by Enrollee Group and Type of Service
(Millions of Dollars or 000,000)

		Long Term Care				
	All Services	Total LTC (% of all svcs)	Nursing Facilities (% of LTC)	ICF-MR (% of LTC)	Mental Health (% of LTC)	Home Health (% of LTC)
Total	145,282	59,621	32,944	9,732	2,798	14,148
		(41.0)	(55.3)	(16.3)	(4.7)	(23.7)
Nondisabled Children	24,301	1,487	46	37	1,028	376
		(6.1)	(3.1)	(2.5)	(69.1)	(25.3)
Nondisabled Adults	16,122	243	25	4	82	132
		(1.5)	(10.3)	(1.6)	(33.7)	(54.3)
Aged	44,450	32,922	7,017	551	877	4,477
		(74.1)	(82.1)	(1.7)	(2.7)	(13.6)
Blind and Disabled	60,409	24,969	5,856	9,141	810	9,162
		(41.3)	(23.5)	(36.6)	(3.2)	(36.7)

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports, 1999. Data are provided in cooperation with the Kaiser Commission on Medicaid and the Uninsured.

Notes: Data are for federal fiscal year 1997. Does not include administrative costs, accounting, adjustments, or the U.S. territories; total expenditures with these inclusions are $165.9 billion. ICF-MR refers to intermediate care facilities for the mentally retarded.

Whereas the long-term care expenses for the disabled can be presumed to remain relatively stable, similar expenses for the elderly are expected to soar in the coming decades. The U.S. population is aging, with mortality and fertility rates both declining, and the baby boom generation beginning to reach age 65 in 2011. In 1999, 14% of the U.S. population is age 65 or older, and long-term care accounts for one-tenth of total health care spending. By 2030, 20% of the population will be 65 or older. In March 1999, the Congressional Budget Office estimated that national expenditures for long-term care services for people aged 65 and older would grow each year through 2040. Because of the strain on public financing sources, 1999 has seen considerable federal debate on financing long-term care.

Costs of Nursing Care

The average annual charge for nursing home care is nearly $50,000 and patient choice of nursing homes is sharply curtailed under Medicaid. Many residents pay out-of-pocket for their nursing home costs, at least for the initial few months of residency. Some nursing homes restrict the number of new residents covered by Medicaid, or require proof that new residents will be able to pay out-of-pocket for a specified time, such as one year.

In a study of innovative long-term care alternatives, the American Association of Retired Persons found that most states regulated the growth of nursing home beds either through a certificate of need process, a moratorium, or both; and many states restricted rate reimbursement increases and controlled access to nursing home care. Policy H-290.982(12) encourages the development of alternative long-term care options.

MSAs and Long-Term Care

AMA policy on individual health insurance (H-165.920) strongly supports legislation promoting the establishment and use of medical savings accounts (MSAs). The policy supports the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as essential for expanding coverage and increasing patient choice of health insurance. However, the current tax code limits the use of MSAs to the self-employed and individuals who work for companies with 50 or less employees. CMS Report 10 (I-99), which is before the House of Delegates at this meeting, discusses AMA advocacy of MSA expansion efforts.

Long-term care insurance premiums are considered an acceptable MSA expense so that for those eligible to invest in MSAs, the purchase of long-term care insurance is a prudent option. However, it would not be an optimal choice to accumulate a large MSA balance in anticipation of long-term care costs because unspent MSA balances are subject to taxation if the beneficiary of the MSA is anyone other than the spouse of the policy holder. Insurance is usually the best way to plan for a contingency that has a relatively small likelihood of realization but a very high potential cost, such as the need for long-term care.

Private Long-Term Care Insurance

AMA policy H-280.991 supports a variety of alternatives for privatizing responsibility for long-term care needs. There has been considerable public debate on how best to encourage individuals to purchase private long-term care coverage. In recent years, the availability of insurance for long-

term care has greatly increased so that a variety of products are available. Because Medicaid eligibility is income and asset dependent, those who need long-term care, but who lack long-term care insurance, often find that they must "spend down" their assets in order to qualify for Medicaid coverage. The Robert Wood Johnson Foundation has developed demonstration projects linking Medicaid to private long-term care insurance. The demonstrations allow those who purchase private long-term care insurance to protect some or all of their assets from eligibility consideration in the event they exhaust their long-term care insurance and need to apply for Medicaid coverage.

Long-term care proposals that were generally consistent with AMA policy were discussed during the 1999 session of Congress. One bill would have provided a refundable tax credit to cover long-term care expenses, consistent with Policy H-280.991(10). A separate proposal would have made long-term care insurance premiums fully deductible, consistent with Policy H-280.991(9).

CONCLUSION

As suggested by the AMA Inter-Council Medicaid Task Force in Board Report 31 (I-97), the Council on Medical Service considered both the positive and negative implications of treating the Medicaid program as three separate programs with separate beneficiary needs. For purposes of better understanding the financial strains of the Medicaid program, however, the Council believes that the most useful initial step is to look at the expenditures associated with the various beneficiary groups relative to the overall program costs. At this time, the Council believes that any effort to separate the program for purposes other than analyzing its components could inadvertently harm those groups for which such a separation would intend to protect. For example, the health care access interests of children may be better served by their remaining in the same entitlement program as elderly people who have a stronger political base.

Nonetheless, the Council is greatly concerned about the impending surge in long-term care expenditures and is encouraged that some federal legislators are responding for the need to address this issue. The Council believes that AMA policy on Medicaid and long-term care financing continues to be pertinent to ongoing advocacy efforts. The Council notes that long-term care insurance should receive the same tax treatment as health insurance, because it is used to cover expenses related to maintaining health. Whereas AMA Policy H-165.920(20) supports a tax credit for the purchase of individual health insurance, and Policy H-280.991(9) supports a tax deduction for the purchase of long-term care insurance, the Council recommends that advocacy for individually owned insurance apply also to long-term care insurance so that a tax credit would be provided for the purchase of long-term care insurance.

Furthermore, the Council believes that improving health care access for the poor, regardless of age or disability, is a key national priority, and the most appropriate framework for improving access was developed in Council Report 9, A-98 (Policy H-165.920), which supports a refundable tax credit for the purchase of individually owned insurance. Under the current insurance market, however, the disabled would have difficulty obtaining affordable individually owned insurance and the Council recognizes the critical role of Medicaid as a safety net for the poorest elderly and disabled who have enormous health care needs. Therefore, in the absence of private sector reforms to enable the poor and uninsured to purchase coverage, the Council would support eligibility expansions in Medicaid and CHIP.

RECOMMENDATIONS

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

1. That the AMA reaffirm Policy H-165.882(1), which places particular emphasis on advocating policies and proposals designed to expand coverage for uninsured children and recommends that the funding for this coverage should preferably be used for the selection of private insurance rather than placement in the Medicaid program.

2. That, in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, the AMA support eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups.

3. That the AMA reaffirm Policy H-165.920(12), which encourages the replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with a tax credit for individuals equal to a percentage of the total amount spent for health expense coverage by the individual's employer.

4. That the AMA advocate that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance.

5. That the AMA urge Congress and the Administration to develop proposals and enact solutions to address the pending growth of long-term care needs of the American population.

6. That the AMA continue to advocate for appropriate payment to physicians under the Medicaid program.