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Strengths and Pitfalls of the U.S. Medicaid Program for the Poor

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Abstract

Medicaid is the largest program in the United States that provides medical and health-related services to the poorest people of the United States. A variety of groups of people are eligible for the mandatory Medicaid expenditure program in the United States. Some of the major recipients of the US Medicaid program include the low and medium-income people, families with disabled people, low-income children and families, low income elderly, nursing home residents, infants and pregnant women, and medically needy persons. The principal objective of this paper is to analyze the strengths and weaknesses of the Medicaid program for the poor families in the United States. In order to construe the strengths and/or efficacies of the Medicaid program expenditure this paper has explained a number of factors that favor the Medicaid expenditure for low-income poor and moderate-income families. Some key strengths of the Medicaid program comprise (1) avoidance of the cost of duplicative administrative system, (2) providing states open-ended federal matching payments and greater protection against rising health care costs, (3) offering states a more consistent level of federal matching payments over time, (4) being cost effective by offering states stronger negotiating opportunity with plans and benefit providers, and (5) providing states with options for covering low-income working patients. Different flaws of the Medicaid program include (1) failure to provide healthcare services to even very poor persons unless in one of the enlisted groups, (2) the increase of the Medicaid expenditure in different states by type of service, (3) the disparity between the growth in Medicaid and the State budgets, and so on.

I. Introduction

Medicaid is a hot and debatable issue in the arena of U.S. politics and public policy. Medicaid is a jointly operated program of the Federal and State government initiated for the poor families in the U.S. The Federal-

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State matching entitlement program, which is generally known as Medicaid program provides medical assistance to certain individuals and families with low income and resources. This Federal-State initiated Medicaid program, however, was authorized under the Title XIX of the Social Security Act in 1965, and became law as a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of more adequate medical care to eligible needy persons (Holahan, 1998). The states and the District of Columbia are responsible for administering the Medicaid program in the United States (Kaiser Family Foundation, 2005).

Although Medicaid expenditure program does not cover many poor people in the United States, it is the principal payer for health care for the poor (Bovbjerg and Holahan, 1982, pp.1-10). Medicaid is the largest program in the United States that provides medical and health-related services to the poorest people of the United States (Merlis, 1993). Medicaid is also known as a vendor-payment program operated as "third-party" coverage, which means that the state programs pay bills for services decided upon by two major parties in the transaction, patients and providers. However, federal government, which matches state expenditures for care on a percentage-of-payment basis, also faces open-ended liabilities for health care issues (Bovbjerg and Holahan, 1982, pp.2-10; Holahan and Cohen, 1986).

Medicaid spending had been increasing rapidly since the very commencement of the program, and began to grow very rapidly between 1988 and 1992, although the growth of Medicaid financing decelerated between 1992 and 1995. In 1983, a total of $37.2 billion were estimated, of which the states' share was expected to be some $17.1 billion. Medicaid expenditure increased from $53.5 billion in 1988 to $119.9 billion in 1992 (Holahan, 1998). In 1993, the federal bill for long-term care totaled $34.2 billion. Data indicate that while Medicaid provides substantial financial protections for some Medicare beneficiaries, the majority of the poor and near-poor beneficiaries do not receive these protections. As a result, many non-Medicaid beneficiaries including persons aged 65 years and over are paying substantial shares of their incomes out-of-pocket for healthcare (Lamphere and Rosenbach, 2000, pp. 207-217).

II. Research Objectives

The principal objective of this paper is to analyze the efficacy and effectiveness of the Medicaid expenditure programs of federal and state governments for the poor families in the United States. In order to

analyze the strengths and weaknesses of the Medicaid expenditure program for the poor in the United States this paper makes an effort to explore the answers to the following questions:

1. What are the effects of the Medicaid program expenditure in the United States?
2. What are the patterns of Medicaid program expenditure in the United States?
3. Are the Medicaid program expenditures for the poor families increasing or decreasing?
4. Do the majority of the poor in the United States benefit from the Medicaid expenditure program?
5. Have the numbers of enrollees for Medicaid expenditure program been increasing over the recent years? If so, what are the factors favoring the Medicaid option?

III. Data Sources and Methodology for Data Analysis

This paper has been made based on the data collected from both primary and secondary sources, such as different journal articles, Internet sources, books, newspapers and government documents. Among different sources of data, the data collected from the Budget Document of Federal Government under the Department of Health and Human Services have been of great value in analyzing the Medicaid expenditure for the low-income people of the United States. The research of the Urban Institute also has provided significant insights into the analysis of the Medicaid expenditure program in the United States. Although this paper has been prepared based on data mainly collected from journal articles, Internet resources, books and government documents, some newspaper sources have also augmented the methods of data analysis by providing information about some recent trends of Medicaid program expenditure for low-income poor families in the United States. For the analysis of the data, some statistical tools also have been employed. In analyzing the data for this research paper different tables have been provided and carefully analyzed.

Table 1 of this paper exhibits total federal and state Medicaid spending and average annual growth rates of expenditures between 1988 and 1995. Table 2 presents total number of Medicaid beneficiaries and total expenditures per beneficiaries as well as average growth of beneficiaries and expenditures per beneficiaries from 1988 to 1995, while

Table 3 displays growth rate of Medicaid beneficiaries between 1988 and 1995.

IV. Data Analysis and Discussion

In the sections that follow an attempt has be made to analyze the data collected from different sources, such as government documents, journal articles, books, and Internet. In an attempt to analyze the strengths and pitfalls of the U. S. Medicaid expenditure program for the poor families a special focus has been given on the assessment of the growth (increase or decrease) of the Medicaid expenditure program for the poor, the growth rate (increase or decrease) of the number of enrollees for the Medicaid expenditure programs, and the growth rate (increase or decrease) of the cost of Medication and drug fees paid by the enrollees. However, before we proceed on to the discussion of the efficacy and effectiveness of the Medicaid program expenditures for the poor in the United States, it is imperative to discuss briefly the eligibility for Medicaid program and the services received by the recipients of the Medicaid Expenditure program.

Eligibility for Medicaid Program

Although the Medicaid program was designed to provide healthcare facilities to the low and middle-income people of the United States, it includes a variety of groups of people to be eligible for the mandatory Medicaid expenditure program. However, the following major groups are generally eligible for the inclusion of mandatory Medicaid expenditure program (HCFA, 1994; Feder, 1997; Coughlin and Holahan, 1994; Kaiser Foundation, 2005):

- Low-income children and families: These include families eligible for Aid to Families with Dependent Children (AFDC), as well as pregnant women, children up to age 6 whose family income is below 133% of the federal poverty level; and other low-income families whose eligibility is determined by the state in which they live.
- Low-income elderly: These groups for Medicaid coverage include the low-income seniors receiving Supplemental Social Security.
- Nursing home residents: The Medicaid program provides long-term coverage for the impoverished elderly and for disabled individuals.
- Recipients of adoption assistance and foster care who are under Title IV-E of the Social Security Act;

- All children born after September 30, 1983 in families with incomes at or below the FPL. They must be given full Medicaid coverage until age 19, which indicates that by the year 2002, all poor children under age 19 will be covered under the Medicaid program.
- Special protected groups that include typically individuals who lose their cash assistance from AFDC or SSI due to earnings from work or increased Social Security benefits, but who may keep Medicaid for a period of time, and certain Medicare beneficiaries.

Furthermore, states have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups shares the characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. However, the broadest optional groups that states will receive federal matching funds for coverage under the Medicaid program include (HCFA, 1995; Kaiser Foundation, 2006):

- Infants up to age one and pregnant women not covered under the mandatory rules whose family income is no more than 185% of the FPL
- Children under age 21 who meet the AFDC income and resources requirements, but who otherwise are not eligible for AFDC.
- Recipients of State supplementary income payment;
- Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL;
- Persons receiving care under home and community-based waivers;
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level;
- Institutionalized individuals with income and resources below specified limits; and
- "Medically needy" persons.

Mandated Services Covered by Medicaid

In order to provide health care facilities to the low-income poor families in the United States, Medicaid in all states covers a broad range of benefits that include the following (Rosen, 1999, p.174):

1. Inpatient and outpatient medical care
2. Laboratory and x-ray services
3. Chronic care facilities for persons over 21 years

4. Home health care for those eligible for nursing facility services
5. Services provided by a physician or nurse practitioner
6. Necessary transportation

In addition, many states provide optional service to eligible patients including prescription drugs, case management, dental care, prosthetic devices, medical transportation, intermediate care facilities, optometry and TB-related services (Rosen, 1999).

Rapid Increase of Medicaid Growth Expenditure, 1988-92

While Medicaid program expenditures were slowed down, and enrollment had remained roughly constant nationwide since 1970s till 1987, Medicaid expenditure expanded rapidly between 1988 and 1992. In fact, the reasons for remaining Medicaid enrollment constant between 1970s and late 1987 was due to the increasing number of poor people in the United States that was responsible for the stagnation of the Medicaid program during that period (Committee on Health Care for Homeless People, 1988). However, both the Medicaid enrollment and expenditures increased between 1988 and 1992. Between 1988 and 1992, Medicaid expenditure rose on average by 22.4 % per year, increasing from $53.5 billion in 1988 to $119.9 billion in 1992 (Holahan, 1998, p. 67). It is important to note that in 1991, the total cost of caring for the 30 million poorest people in the United States was almost $90 billion of which, about $50.8 billion came from the federal government, and the remaining $30 billion was spent by the states.

Table 1
Total Medicaid Expenditures, 1988-1995
Federal and State Medicaid Expenditures, 1988-1995

	Spending ($ billions)			Average Annual Growth (%)	
Expenditures	1988	1992	1995	1988-1992	1992-1995
Total	$53.5	$119.9	$157.3	22.4	9.5
Benefits	50.6	98.5	132.8	18.1	10.5
				Benefits By Service	
Acute Care	25.4	55.5	80.4	21.6%	13.1
Long-term Care	25.1	42.9	52.3	14.3%	6.8
				Benefits By Group	
Elderly	18.1	31.4	39.4	14.7%	7.9
Blind and Disabled	19.3	36.2	49.9	17.0%	11.3
Families	13.1	30.9	43.5	23.9%	12.1
DSH Payments	0.4	17.5	19.0	149.9	2.7
Administration	2.4	3.9	5.5	12.2%	12.6

Source: Holahan and Liska 1997, Coughlin and Liska, Urban Institute, 1997

Table 1, however, indicates that expenditures on the elderly and disabled grew each year by an average of 14.7% and 17.0%, respectively. Spending on adults and children grew from $13.1 billion to $30.9 billion, an average annual increase of 23.9%. However, spending on adults and children grew more rapidly than those of spending on the elderly and disabled (Holahan, 1998).

Table 2, however, presents that Medicaid enrollment increased from 22.0 million to 29.8 million Americans since 1988 to 1992. Rather, increases in the enrollment of the elderly were relatively small. Table 2 shows that the enrollment of the beneficiaries increased from 3.1 million in 1988 to 3.5 million in 1992, or 3.2% per year. From the table it is also obvious that there was a significant growth in coverage of the disabled, with enrollment increasing from 3.4 to 4.5 million, or by 6.7% per year. The high annual cost of covering the disabled means that this expansion has been extremely important to the cost of the program (Holahan, 1998; Coughlin and Liska, 1997). The number of low-income adults and children, however, increased from 15.4 to 21.8 million, which was an average annual increase of 9.0%.

In actual practice, a number of factors were responsible for the growth in Medicaid during 1988-92. The most important reason was, however, the increase in enrollment. A bunch of legislative mandates extended Medicaid coverage to pregnant women and children and to the elderly and disabled. In the late 1980s, Medicaid ended the link between the participation in the aid to families with Dependent Children (AFDC) program and Medicaid coverage (Holahan, 1998). By 1990, federal law required the coverage of all pregnant women and infants and children under age six with incomes below 133 percent of the federal poverty level. Under federally Medicaid program states are given the option to extend coverage to program women and infants up to 185 percents of the poverty level with federal matching payments (Holahan, 1998; Coughlin and Liska, 1997). One of the significant strengths of the Medicaid expenditure program was that between 1988 and 1992, 4.5 million pregnant women and poor children were covered through the mandates of the Medicaid expenditure program because of the fact that these new eligible groups of Medicaid program composed approximately 50% of the total increase in enrollment, although they accounted for a substantially lower share of total growth of expenditures (Holahan, 1998).

It is also important to mention that total Medicaid payments, increased from $12.2 billion to $77.0 billion between 1975 and 1991 that showed an increase of more than 500%. The Average rate of growth during this period was 12.2% per year (Pine, Clause and Baugh, 1992). However, Medicaid program growth was not uniform over the entire period. Data from a study by Pine, Clause and Baugh indicate that from 1975 through 1981, program payments grew rapidly at an average annual rate of 14.2%. Moreover, payment growth slowed down considerably from 1975 to 1988. This study further indicates that the rapid growth in Medicaid payments from 1988 to 1991 largely reflected the Medicaid program expansions (Pine, Clause and Baugh, 1992).

In order to explain the growth of Medicaid expenditure and the trends of Medicaid enrollment it is essential to mention that the Omnibus Budget reconciliation Act of 1990 required Medicaid programs to cover Medicare costs for low-income elderly people not eligible for cash assistance. However, the Medicare Catastrophic Coverage Act of 1988 that was revoked in 1990 involved qualified Medicare beneficiaries (QMBs), and required states to cover Medicare Premiums and cost sharing for all Medicare-eligible persons with incomes below the federal poverty level. This requirement was expanded in 1995 to require states to provide the Part B premiums for Medicare eligibles between 100 and 120 percent poverty (Holahan, 1998). Although it is difficult to know the exact enrollees covered by these provisions, it is estimated that there were 1.3 million low-income elderly and disabled who received coverage of Medicare in 1995 through this so-called QMB legislation (Holahan, 1998).

Factors Favoring the Medicaid Expenditure Option

An extensive study of Medicaid expenditure program indicates that a number of factors influence the Medicaid expenditure program for the low-income poor and moderate-income families. The first factor as identified by Cyndy Mann is that the Medicaid option avoids the need for, and cost of duplicative administrative system. More than 22 million children already have been receiving health care coverage under state Medicaid programs. Secondly, Medicaid option provides states open-ended federal matching payments and greater protection against rising health care costs. Under the Medicaid option, if a state's new federal child health block grant funds are exhausted before the end of the fiscal year, the state can still draw down federal dollars at the regular Medicaid matching rate to help cover the cost of serving additional eligible children (Mann, 1997).

The Medicaid option also offers states a more consistent level of federal matching payments over time. Furthermore, the Medicaid option can be cost-effective by offering states a stronger negotiating advantage with plans and providers. However, with one of every four children in the United States covered under Medicaid, states were supposed to spend about $27 billion during fiscal year 1998 purchasing coverage for children through their Medicaid programs. This huge purchasing power offers states a significant bargaining advantage in negotiations with health plans and providers, and in the end can help states get the most value for their child health dollars (Mann, 1997).

Another important factor favoring the Medicaid option is that Medicaid provides states with options for covering low-income working patients. However, according to Census Bureau data, some 43% of all parents in working poor families with children were uninsured during the mid-1990's, which was partly because of the fact that only small portion of low-wage workers have employer based coverage (Purcell, 1997).

Slowdown of Medicaid Expenditure Growth

Although Medicaid expenditure program grew rapidly between 1988 and 1995, the growth declined to a considerable extent after 1992 (Holahan, 1998). While the average annual growth rate of Medicaid was 22.4% between 1988 and 1992, Medicaid spending grew only on average by 9.5% per year between 1992 and 1995. Table 1 also indicates that Medicaid spending increased from $119.9 billion in 1992 to $157.3 billion in 1995. Rather, annual increases in spending remained higher for needy families (12.1%) than for disabled (11.3%) or for the aged elderly (7.9%). Data indicate that this slowdown in Medicaid expenditure growth also began to continue since 1995. While Medicaid spending slowed to 9-10% annually between 1992 and 1995, Medicaid expenditure grew by less than 3% between 1996 and 1997 (Adams and Wade, 2001; Bruen and Holahan, 1999).

Table 2 clearly demonstrates that the increases in Medicaid enrollment slowed substantially. This table also shows that, while Medicaid enrollment increased by 7.9% annually between 1988 and 1992, enrollment growth fell to 5.3% per year in the following three years till 1995. However, Table 3 exhibits that the rate of growth of Medicaid beneficiaries declined between 1991 and 1995. While Medicaid enrollment growth increased by 11 percent in 1992, the growth of enrollment increased by only 1.8% in 1995. It is also ostensible from

Table 3 that enrollment growth among the elderly fell from 7.2% in 1992 to 4.0% in 1994 and 1.2% in 1995.

Table 2
Medicaid Beneficiaries and Expenditures per Beneficiary, 1988-1995

	1988	1992	1995	1988-1992	1992-1995
	Beneficiaries (millions)			Average Growth (%)	
Beneficiaries (Total)	22.0	29.8	34.8	7.9%	5.3%
Elderly	3.1	3.5	3.9	3.2	3.0
Blind and Disabled	3.4	4.5	5.7	6.7	8.7
Families	15.5	21.8	25.1	9.0	4.9
	Dollars			Average Growth (%)	
				Expenditures per Beneficiary	
(Federal and State)	$2,298	$3,303	$3816	9.5%	4.9%
Elderly	5,794	8,848	10,166	11.2	4.7
Blind and Disabled	5,619	8,099	8,685	9.6	2.4
Families	848	1,416	1,728	13.7	6.8

Source: Holahan, 1998; Coughlin and Liska, Urban Institute 1997

While the Medicaid enrollment growth among the blind and disabled increased by 10.7% and 11.6% in 1992 and 1993, respectively, the enrollment increased only by 6.8% in 1995, showing a noticeable decrease from 1992 and 1993, respectively. Furthermore, the Medicaid enrollment growth among the adults and children of low-income families increased by 11.7% and 9.1% in 1992 and 1993, respectively, while the enrollment growth of these groups increased by 5.1% in 1993, and by only .08% in 1995 (Holahan, 1998; Coughlin and Liska, 1997).

Table 3

Medicaid Beneficiaries, 1991-1995

Medicaid Beneficiaries, 1991-1995					
	1991	1992	1993	1994	1995
Total (millions)	26.9	29.8	32.4	34.2	34.8
Elderly	3.3	3.5	3.7	3.8	3.9
Blind and Disabled	4.0	4.5	5.0	5.4	5.7
Families	19.5	21.8	23.8	25.0	25.2
Annual Growth		11.0%	8.8%	5.4%	1.8%
Elderly		7.2	3.7	4.0	1.2
Blind and Disabled		10.7	11.6	7.8	6.8
Families		11.7	9.1	5.1	0.8

Source: Holahan, 1998; Coughlin and Liska, Urban Institute, 1997.

Causes of the Slowdown of Medicaid Expenditures

There are several reasons responsible for the decline of Medicaid enrollment growth. The first reason was due to the decline in AFDC enrollment in the recent years because of the improved economy, as well as efforts in many states to reduce welfare program participation, particularly through tougher work requirements. Second reason was due to the decline of growth in coverage for children and pregnant women. Third, the growth in enrollment of the blind and disabled population has begun to slowdown during the last several years. However, the enrollment among the blind and disabled population in the early 1990s grew due to courts decisions, which mainly resulted in dramatic increases in enrollment of disable children. Another, slowdown in enrollment occurred among the elderly, which was due to the introduction of the QMB program. Another cause in the slowdown of Medicaid growth rates has been identified as the reduced spending per enrollee. Spending per enrollee in Medicaid, however, declined to 4.9% between 1992 and 1995, compared to an average annual growth rate of 9.5% between 1988 and 1992 (Holahan , 1998, pp.67-85).

One important cause of the slowdown of the Medicaid enrollment was due to the rapid growth in managed care. In the last few years there has been a rapid expansion of mandatory Medicaid managed care through Section 1915 (b) and Section 1115 waiver programs that are more limited and typically restricted to a geographic area within a state. Another significant reason for the decline of Medicaid expenditures is because of 1991 and 1993 legislation affecting the use of DSH payments (Holahan, 1998; Fedler, 1997).

Huge Growth in Medicaid Prescription Drug Costs

It is important to mention that the increase of the cost of caring for the poor is also a significant loophole of the Medicaid expenditure program. It goes without saying that a large number of low-income poor families cannot afford to pay the high cost of medication. Due to the high cost of spending for medication, such as high cost of spending for nursing care services, physician prescription fees, hospital in and out service payments, and drugs many low-income families had not been afforded to enroll for Medicaid expenditure program. Many of these uninsured are low-income and homeless people the majority of whom live in rural areas (Committee on Healthcare for Homeless People, 1988, pp.138-139). However, according to John Holahan and David Liska, medical price inflation accounted for about one-third of Medicaid spending growth

between 1988 and 1992. Furthermore, over the past few years the costs of hospitals and nursing homes have clearly increased with inflation as a direct result of wage costs and other factors (Holahan and Liska, 1997; pp. 157-163).

Although the growth of Medicaid expenditures has slowed down since 1992, the average monthly Medicaid expenditure by major types of service has continued increasing. Data indicate that in the State of Idaho, the average monthly Medicaid expenditure by nursing home, physician services, hospital in-and-out service payments, and drug costs increased by about $5.25 million, $0.4 million, $2.5 million, and $0.4 million, respectively in 1988 to about $12.8 million, $2.5 million, $8.25 million, and $6 million, respectively in 1999 (Idaho Department of Health Welfare, 1999).

In the state of Florida the spending for Medicaid prescription drug is also growing, averaging 21% annual increases over the past five fiscal years. For Fiscal Year 1999-2000, expenditures for prescription drugs exceeded all Medicaid services except for nursing home care. In the 1999-2000 fiscal year, spending for prescription drugs reached $1.3 billion, comprising 17% of the total spending for Medicaid services. Rather, in fiscal year 2000-2001, prescription drug expenditures in Florida were expected to grow to about $1.5 billion (OPPAGA, 2001, pp. 2-19).

The rapid growth in spending for prescription drugs is, however, viewed as an important factor contributing to deficits in Medicaid budget. Data suggest that Medicaid experienced an estimated $78.7 million deficit in Florida in Fiscal Year 1999-2000. During this fiscal year, the Medicaid program overspent its prescription drug allocation by $68.8 million. Prescription drug costs in the state of Florida are expected to contribute to Medicaid deficit that may put a burden over the enrollees, especially over the low-income poor people (OPPAGA, 2001). However, Florida’s Social Service Consensus Estimating Conference projects a Medicaid deficit of $640.6 million in Fiscal Year 2001-2002, while prescription drug spending has been projected to account for 21% and 37% of these deficits, respectively. In fact, several factors have been identified as the reasons for rapid growth in Medicaid spending for prescription drugs, which include a) doctors prescribing more expensive dosage forms of existing drugs or switching to other more expensive existing drugs; b) doctors prescribing new drugs which are typically more expensive than existing drugs; and c) annual price increases for existing drugs (OPPAGA, 2001).

However, Florida's Medicaid pharmacy program had taken several steps to help control prescription drug costs. The more important news in this respect is that in Fiscal Years 1998-99 and 1999-2000, the state legislature of Florida directed Agency for Health Care Administration (AHCA) augmented its pharmacy fraud detection activities, which resulted in recoveries and cost avoidance of $43.4 million. In Fiscal Year 1999-2000, the Legislature also directed the agency to profile and evaluate doctors' prescribing patterns through peer review. As a result of new measures of drug cost control, the state Legislature of Florida reduced the Fiscal Year 1999-2000 appropriations for prescription drugs by $40.7 million. Furthermore, the 2000 Florida Legislature expanded its efforts to control drug costs by enacting a drug cost control program that are expected to reduce recurring prescription drug expenditures by an estimated $231.2 million (OPPAGA, 2001, pp. 1-5).

President George W. Bush in his presidential election campaign in Orlando in October 2000 pledged to deliver a prescription drug benefit very soon to "low-income and moderate-income seniors" in Medicare. In an interview with the AARP Bulletin President George W. Bush vowed for reducing prescription drug cost for Medicaid beneficiaries saying, "I will tell you, the prescription drug issue is a huge issue." President Bush further said, "Prescription drug coverage is a priority of mine." However, President Bush's proposed wider Medicare reform and all out-of-pocket payment for Medicaid expenses over $6,000 a year was a good initiative for providing Medicaid benefits to low-income elderly population (Carlson, 2000).

V. Conclusions

In light of the previous discussion about the growth of Medicaid program expenditures, enrollment, cost of Medicaid services, and other related issues it is obviously understood that Medicaid expenditure program possesses both some strengths and weaknesses in providing health care services to the low-income poor families in the United States. One major problem or pitfall of the U. S. Medicaid program is that Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the federal law, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups mentioned earlier. Rather, a large number of the U. S. population is uninsured most of whom are poor. These large numbers of the uninsured low-income poor people are not receiving health care facilities from Medicaid expenditure program (Rowland, Feder, and

Keenan, 1998, pp. 25-41). A study conducted by Gross, Alecxih, Gibson and Corea indicates that almost 60% of beneficiaries with incomes below the poverty level did not receive Medicaid assistance. The study also found that 75% of the beneficiaries with incomes between 100 and 125 percent of the poverty level who were not enrolled in Medicaid spent an estimated 30% of their income out-of-pocket on health care if they were in the traditional program, and about 23% of their income if they were enrolled in Medicare HMO (Gross, Alecxih, Gibson and Corea, 1999, pp. 241-254).

Another loophole of the Medicaid program expenditures is the increase of the Medicaid expenditure in different states by type of service, such as nursing home, physician services, in-and-out service payments increased to a considerable extent. The rapid increase of the drug costs in different states, including the state of Florida is an example of the weakness of Medicaid program expenditure in the United States. Rapid growth in spending for prescription drug is, however, an important factor that contributes to deficit budget (OPPAGA, 2001). The disparity between the growth in Medicaid and that of State budgets is also a major problem facing different states over time (Tudor, 1995, pp. 1-11).

Although the Medicaid expenditure program is not immune from setback, its role in the U. S. society in improving the health condition of the low-income poor families cannot be denied. There are several factors that favor the Medicaid expenditure program for low-income poor and near-poor people in the United States. One of the important strengths of the Medicaid expenditure program is that it avoids the need for and cost of duplicative administrative system (Mann, 1997). Rather, Medicaid expenditure program option provides states open-ended federal matching payments and greater protection against rising health care costs (Mann, 1997).

Another advantage of the Medicaid expenditure program is that Medicaid option can be cost effective by offering states stronger negotiating opportunity with plans and benefit providers. Another significant strength of the Medicaid expenditure program is that it provides states with options for covering low-income working patients (Purcell, 1997). Overall, Medicaid expenditure program covers a wide variety of low-income poor and near poor people in the United States by providing health care services (Mann, 1997).

If we compare the total amount of Medicaid expenditures and the enrollments between the late 1970s and late 1980s or 1990s, we see that both amount of Medicaid expenditures and numbers of enrollees have

increased to a significant extent which indicates that Medicaid expenditure program has gained popular supports for providing health care services to the low-income poor and near-poor people. While Medicaid expenditures in 1975 were $12.6 billion, the expenditure increased by about tenfold to $141 billion in 1993 (Holahan, 1998).

However, Medicaid program expenditure growth increased rapidly between 1988 and 1992. During this period, Medicaid increased by 22.4% from $53.5 billions in 1988 to $119.9 billions in 1992, while the Medicaid expenditure increased to $157.3 billions by 9.5% between 1992 and 1995, and total growth of enrollment increased by 7.9% between 1988 and 1992, and 5.35 between 1992 and 1995 (Holahan, 1998; Coughlin and Liska, 1997). Although both the growth of Medicaid expenditures and enrollments slowed down after 1992, and even after 1995, it does not indicate the failure of Medicaid program. Because due to good economic conditions of the United States, and the reduction of unemployment the numbers of low-income poor families have decreased to a considerable extent in the 1990s. The dramatic court decisions in the early 1990s were also responsible for increasing the growth in enrollment among the blind and disabled (Holahan, 1998).

Despite the slow growth of Medicaid expenditure since 1992, Medicaid has played an important role in improving the health status of the poor people in the United States. Although the quality of care received by the poor from Medicaid is some times questioned in terms of the quality of care by private Medication, it bears some evidence that the health of the poor has improved since the very inception of Medicaid. Finally, regarding the success of the Medicaid expenditure program in the United States Rebecca Blank rightly says, “Because of the introduction of the Medicaid infant mortality rates among poor mothers have declined, life expectancies have grown, and the incidence of a variety of infectious diseases has gone down, although it remains true that poor persons are still at higher risk of medical problems than persons living in higher-income families” (Blank, 1997, p.165; also see Rosen, 1999, pp.174-175).

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