Medicaid: Apples and Oranges

by Barbara J. Culliton

Now that Medicaid has become a bill paying reality in 25 of the 50 states, people are lining up by the thousands to show their willingness to participate; and before the ink is even dry on some of the states' programs, Congress is going to try to shorten the lines.

Officially known as title 19 of the Social Security Amendments of 1965, Medicaid is the very controversial and very expensive companion to Medicare. The latter is the federal health insurance plan that covers all persons over 65, regardless of income. Its rapidly growing brother, Medicaid, is a plan to meet the costs of health for the medically indigent of any age, and is jointly financed by federal and state money.

When Congress wrote Medicaid into law it obviously thought it was a good idea, but now that states' plan for implementing that law have been turned into Washington for approval, Congress is having doubts about the wisdom of its benevolence. It seems that nobody appreciated how much this would cost, and everybody wishes it would cost less than it does.

Medicaid might cost state and federal treasuries together up to $6 billion a year; Medicare has an estimated price tag of $3.3 billion, financed largely out of Social Security funds.

In New York anyone who can prove that his medical bills are beyond his means can call on the state for Medicaid, and get it. The total cost of this generosity is expected to pass $500 million, with Washington slated to pay almost half.

In Maine, only those eligible for public assistance can receive free health care, but Washington must pay 70 percent of the tab, and Maine's needy will draw about $5.5 million in Medicaid from the federal treasury in fiscal 1967.

California has set $3,800 as the ceiling for families of four and will split a $666 million bill with Congress for care of its medically indigent citizens.

Every state legislature has a different opinion about where medical indigence leaves off and self-sufficiency begins, and this includes a fairly broad range of opinion. For a family of four, for example, the ceiling is $2,448 in Oklahome, $2,640 in Utah, $3,000 in Minnesota, $3,800 in California and $4,000 in Pennsylvania.

New York's program seems to have triggered much of the furor over Medicaid, although it alone is not responsible for pushing the projected costs sky high. New York took literally the Congress' intention to encourge the states to extend or otherwise improve existing programs under the new law. It was an easy step, therefore, to raise the basic level of eligibility for a family of four from $5,200, which it already was under the state's extensive health care plan, to $6,000 where it now stands. Other states set their sights much lower, but they were not already spending over $400 million yearly to cover medical bills for the needy, as was the Empire State.

New York's concept of need helps explain what some consider its fabulously broad definition of indigence. State aid is offered to people between the ages of 21 and 64, as well as to children and older people, on the theory that it is sensible and less expensive in the long run to assist persons in the productive segment of society in order to maintain productivity.

George K. Wyman, New York's Commissioner of Social Welfare put it this way: "We know the dimensions of the problem: either we pay for short-term medical care to protect and promote the health of our people and save them from being pauperized by overwhelming medical bills—or we pay the higher, long-term financial and social costs of a permanent—but—avoidable public welfare burden."

In direct opposition to this position, House Ways and Means Committee chairman Wilbur D. Mills (D-Ark.) introduced a bill last October that would limit the use of federal funds to persons under 21 or over 65, and to the blind or disabled. The Mills bill would also provide that funds from Medicare and private insurance policies be used before any money be appropriated for an individual under Medicaid. The limitations, as set down by Mills, would cut the estimated cost of Medicaid to the federal government by half—from $3 billion to $1.5 or $2 billion annually.

Though no action was taken on the proposed changes in the law by the last Congress, it is expected that legislation will be reintroduced early in the new Congress. Evaluation of state programs already in operation may influence the course of any new amendments.

New York is prepared to maintain the scope of its health care programs regardless of any financial barriers Congress may decide to put in its way. In Michigan, however, Governor George Romney two weeks ago ordered a cutback and in some areas a halt to his state's Medicaid program. Mushrooming costs that could create an enormous hole in the state budget, and a lack of federal guidelines to establish realistic cost figures earlier, were cited as the major reason for the unforeseen financial problem.

Unrealistic early cost estimates seem to be a major source of trouble to federal and state planners alike.

Little or no coordination of basic social security programs is partly responsible for the present unfortunate state of affairs, according to Thomas B. Curtis (R-Mo.), a member of the Ways and Means Committee.

Only so much money can be spent by governments on health care, Rep. Curtis said, and the failure to recognize that there are two types of medical bills, "as distinct as are apples and oranges," is what is getting us into such an expensive predicament, he believes. Apples, or routine medical bills, should present no significant problem because they can be foreseen and budgeted, by low-income families and by welfare agencies. Oranges, or unexpected and staggeringly high bills, on the other hand, do not occur frequently but can wipe a family out when they do. "Apples have been mixed with oranges" in our health coverage, he said, thus taking public funds to pay bills an individual family might well be expected to meet, and burdening everyone when it comes time to pay the whoppers.