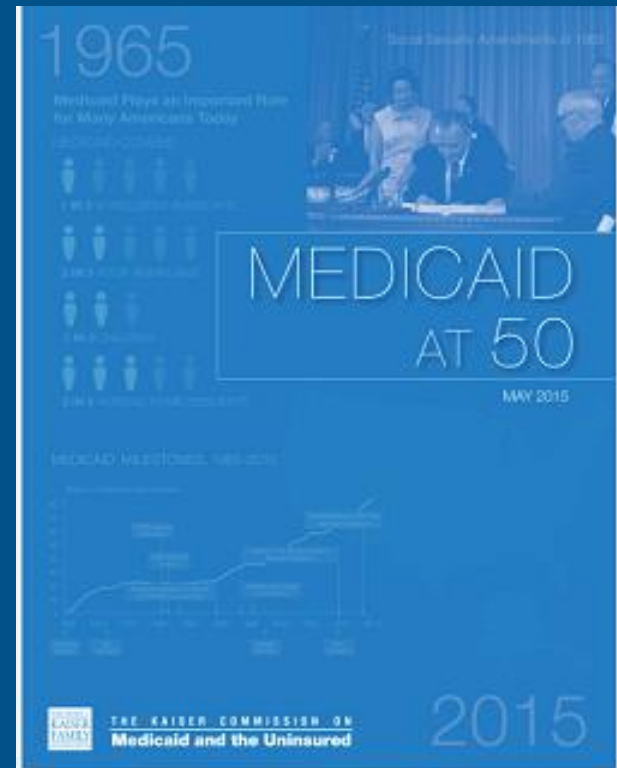


Medicaid at 50

A Look Back—And Ahead

The Kaiser Commission on
Medicaid and the Uninsured



Eighty-ninth Congress of the United States of America

AT THE FIRST SESSION

Began and held at the City of Washington on Monday, the fourth day of January,
one thousand nine hundred and sixty-five

An Act

To provide a hospital insurance program for the aged under the Social Security Act with a supplementary medical benefits program and an extended program of medical assistance, to increase benefits under the Age-Age, Survivors, and Disability Insurance System, to improve the Federal-State public assistance program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1965".

TABLE OF CONTENTS

TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE	
Sec. 101.	Short title.
PART 1—HEALTH INSURANCE FOR THE AGED	
Sec. 102.	Entitlement to hospital insurance benefits.
Sec. 103.	Hospital insurance benefits and supplementary medical insurance benefits.
TITLE XVIII—HEALTH INSURANCE FOR THE AGED	
Sec. 1001.	Prohibition against any Federal involvement.
Sec. 1002.	Plan choice by patient determination.
Sec. 1003.	Right to participate in certain other health insurance programs.
PART 2—HOSPITAL INSURANCE FOR THE AGED	
Sec. 1011.	Description of program.
Sec. 1012.	Scope of benefits.
Sec. 1013.	Exclusions and contingencies.
Sec. 1014.	Conditions of and restrictions on payment for services: <ul style="list-style-type: none"> (1) Requirement of requests and certifications. (2) Reasonable cost of services. (3) No payment for Federal provision of services. (4) Prohibition for emergency hospital services. (5) Payment for separate hospital services prior to establishment of establishment. (6) Payment for certain emergency hospital services thereafter pending the United States.
Sec. 1015.	Payment to providers of services.
Sec. 1016.	Use of public agencies or private organizations to facilitate payment to providers of services.
Sec. 1017.	Federal hospital insurance trust fund.
PART 3—SUPPLEMENTARY MEDICAL INSURANCE FOR THE AGED	
Sec. 1021.	Establishment of supplementary medical insurance program for the aged.
Sec. 1022.	Scope of benefits.
Sec. 1023.	Payment of benefits.
Sec. 1024.	Conditions on basic health services.
Sec. 1025.	Procedure for payment of claims of providers of services.
Sec. 1026.	Eligible individuals.
Sec. 1027.	Exclusionary periods.
Sec. 1028.	Coverage period.
Sec. 1029.	Amount of premium.
Sec. 1030.	Payment of premium.
Sec. 1031.	Federal supplementary medical insurance trust fund.
Sec. 1032.	Use of contracts for administration of benefits.
Sec. 1033.	State agreements for coverage of eligible individuals who are receiving money payments under public assistance programs.
Sec. 1034.	Appropriations to cover administrative, certification and non-hospitalary services.

H. R. 6675—356

REPRODUCTION OF CERTAIN SECTIONS BY DETERMINING HEAD-OF-CARETAKER DEPENDENT CHILDREN

Sec. 410. Effective July 1, 1965, so much of clause (7) of section 401(a) of the Social Security Act as follows: "except that, in making such determination," (A) the State agency may disregard not more than \$20 per month of earned income of such dependent child under the age of 18 but not in excess of \$100 per month of earned income of such dependent children in the same house, (B)";

FEDERAL SHARE OF PUBLIC ASSISTANCE EXPENDITURES

Sec. 411. Title XI of the Social Security Act is amended by adding at the end thereof (after section 1112, added by section 401 of this Act), the following new section:

"ALTERNATIVE FEDERAL PAYMENT WITH RESPECT TO PUBLIC ASSISTANCE EXPENDITURES

"Sec. 1125. In the case of any State which has in effect a plan approved under title XIX for any calendar quarter, the total of the payments in which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with June 30), under paragraphs (1) and (2) of section 1103, 401(a), 1001(a), 1001(b), and 1001(c) shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined in section 1005), instead of the percentage provided under such section, to the expenditures under its State plan approved under titles I, IV, X, XVI, and XVII, which would be included in determining the amount of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be covered under such sections."

John McCarmack
Speaker of the House of Representatives.

Hubert H. Humphrey
Vice President of the United States and
President of the Senate.

Lyndon B. Johnson
Signed at Independence, Mo.
July 30, 1965
5:19 Wichita Falls

Eighty-ninth Congress of the United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Monday, the fourth day of January,
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Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1965".

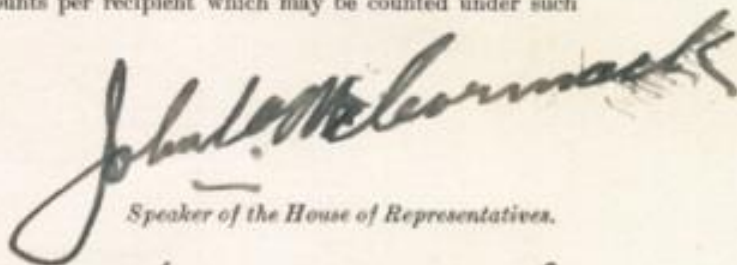
TABLE OF CONTENTS

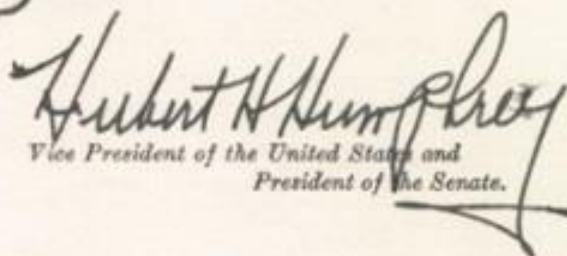
TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

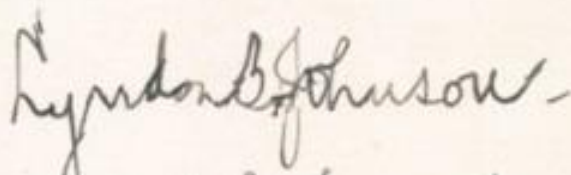
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"ALTERNATIVE FEDERAL PAYMENT WITH RESPECT TO PUBLIC ASSISTANCE
EXPENDITURES

"Sec. 1118. In the case of any State which has in effect a plan approved under title XIX for any calendar quarter, the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with June 30), under paragraphs (1) and (2) of sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined in section 1905), instead of the percentages provided under each such section, to the expenditures under its State plans approved under titles I, IV, X, XIV, and XVI, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be counted under such sections."


Speaker of the House of Representatives.


*Vice President of the United States and
President of the Senate.*



*Signed at Independence, Mo.
July 30, 1965 5:19 Western Time*

Figure 2


Medicaid's Origins

- Enacted in 1965 as title XIX of the Social Security Act
- Means-tested; originally focused on the public assistance population

Entitlement

Eligible Individuals are entitled to a defined set of benefits

States are entitled to federal matching funds



Federal

Sets core requirements on eligibility and benefits



State

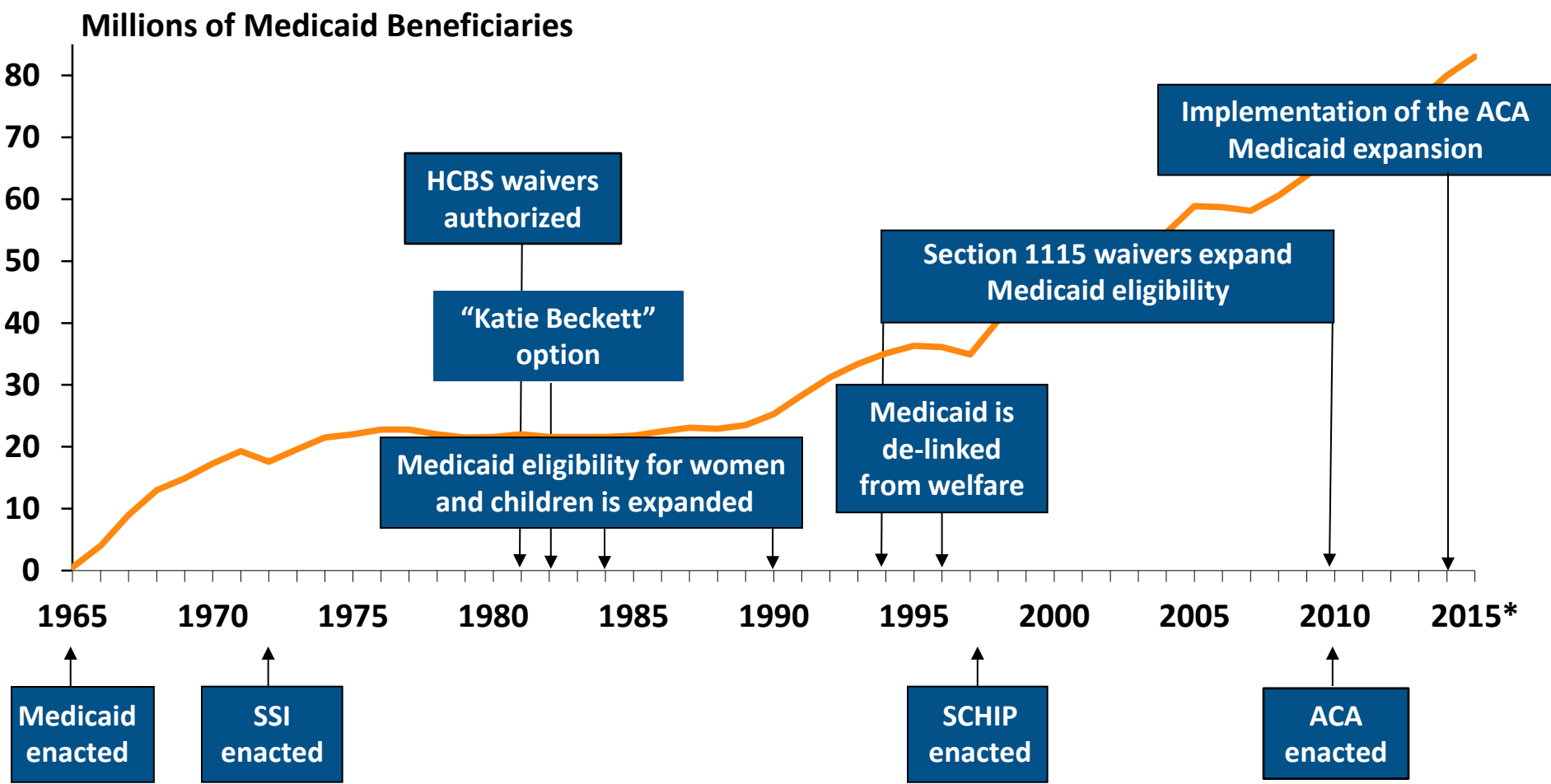
Flexibility to administer the program within federal guidelines

partnership

Mean
welfa
-single
child
-aged,

Figure 3

Medicaid has evolved over time to meet changing needs.



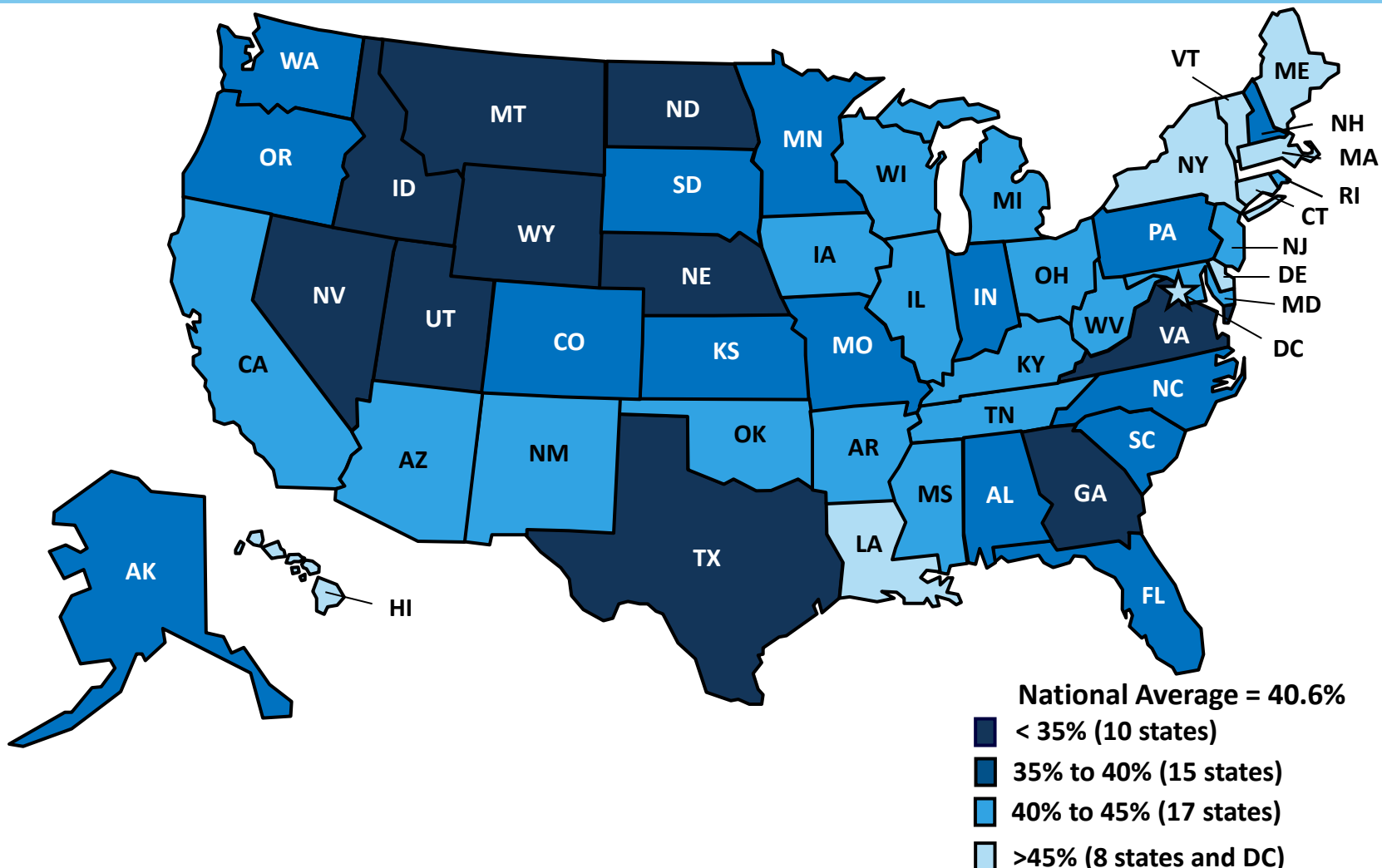
NOTE: *Projection based on CBO March 2015 baseline.

SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2011, as well as March 2015 CBO baseline ever-enrolled counts.



Figure 4

Medicaid's coverage of the non-elderly, low-income population varied by state in 2013.

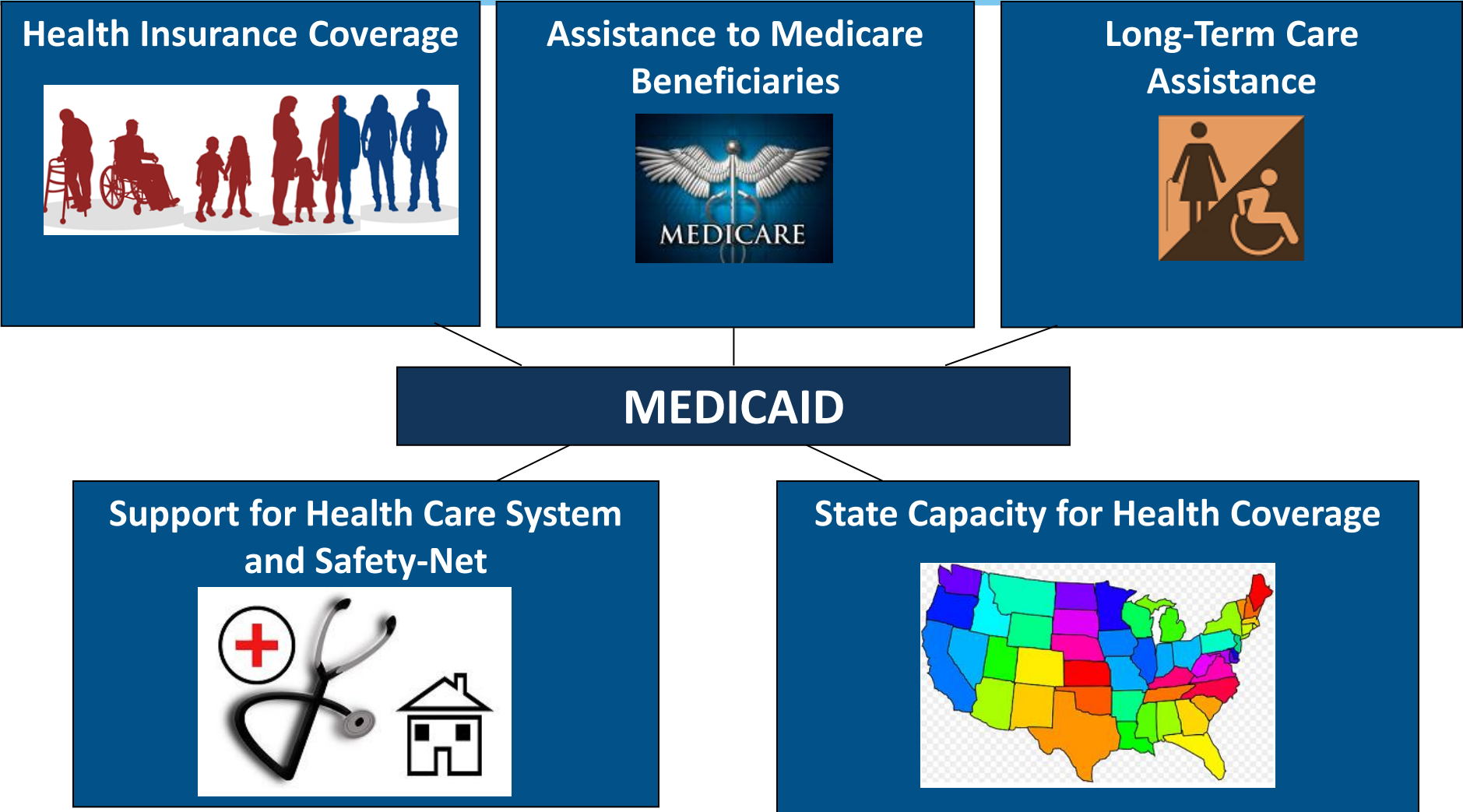


NOTE: Low-income refers to the population with incomes up to 200% FPL.
SOURCE: Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS: Annual Social and Economic Supplements).



Figure 5

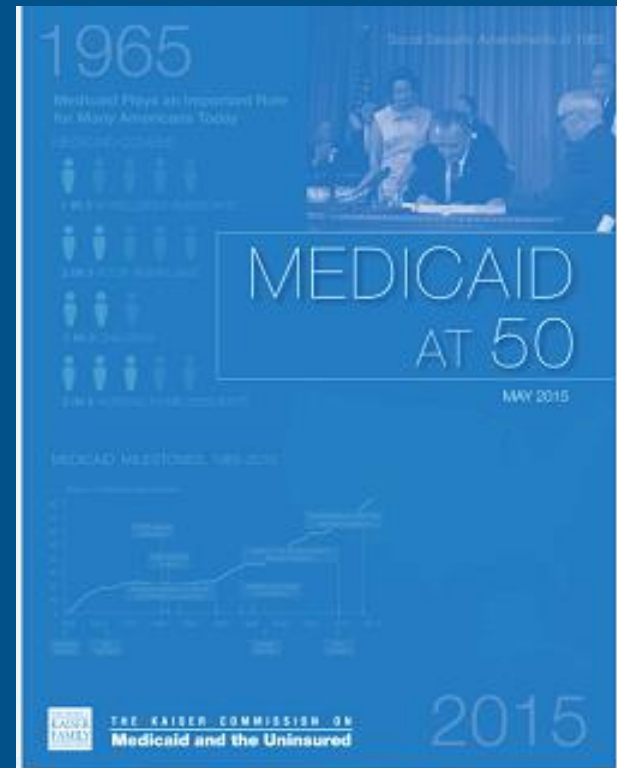
Medicaid plays a central role in our health care system.



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Medicaid and the Uninsured



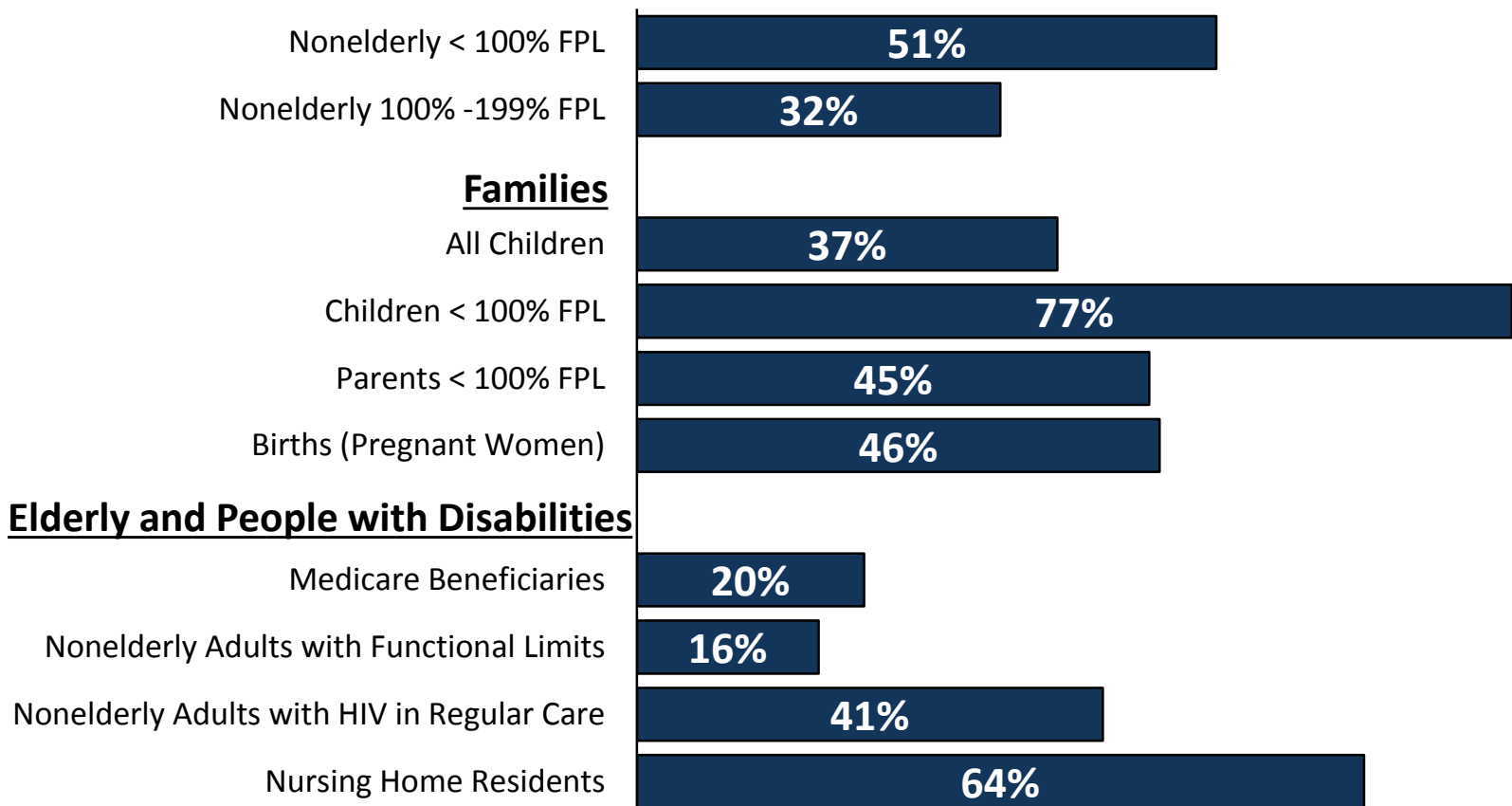
Medicaid's Role for People, Access and the Safety Net

The Kaiser Commission on Medicaid and the Uninsured

Figure 7

Medicaid covers a large share of certain populations.

Share with Medicaid Coverage



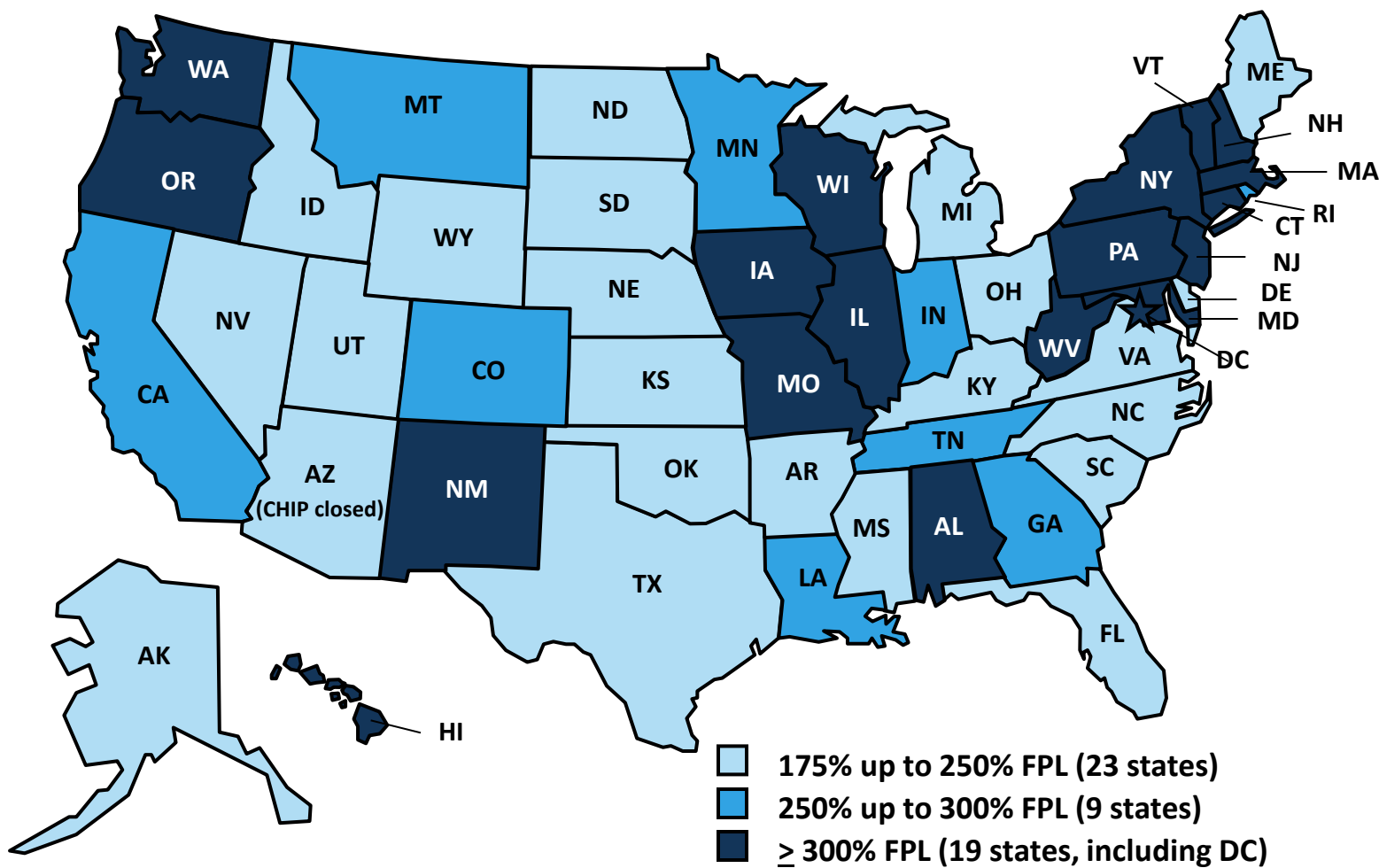
NOTE: FPL means federal poverty level. 100% FPL was \$19,530 for a family of three in 2013.

SOURCES: Kaiser Commission on Medicaid and the Uninsured (KCMU) and Urban Institute analysis of 2013 CPS/ASEC Supplement; Birth data - Maternal and Child Health Update, National Governors Association, 2012; Medicare data - Medicare Payment Advisory Commission, Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid (January 2015), 2010 data; Functional Limitations - KCMU Analysis of 2012 NHIS data; Nonelderly with HIV - 2009 CDC MMP; Nursing Home Residents - 2012 OSCAR data.



Figure 8

Medicaid/CHIP eligibility for low-income children is broad.



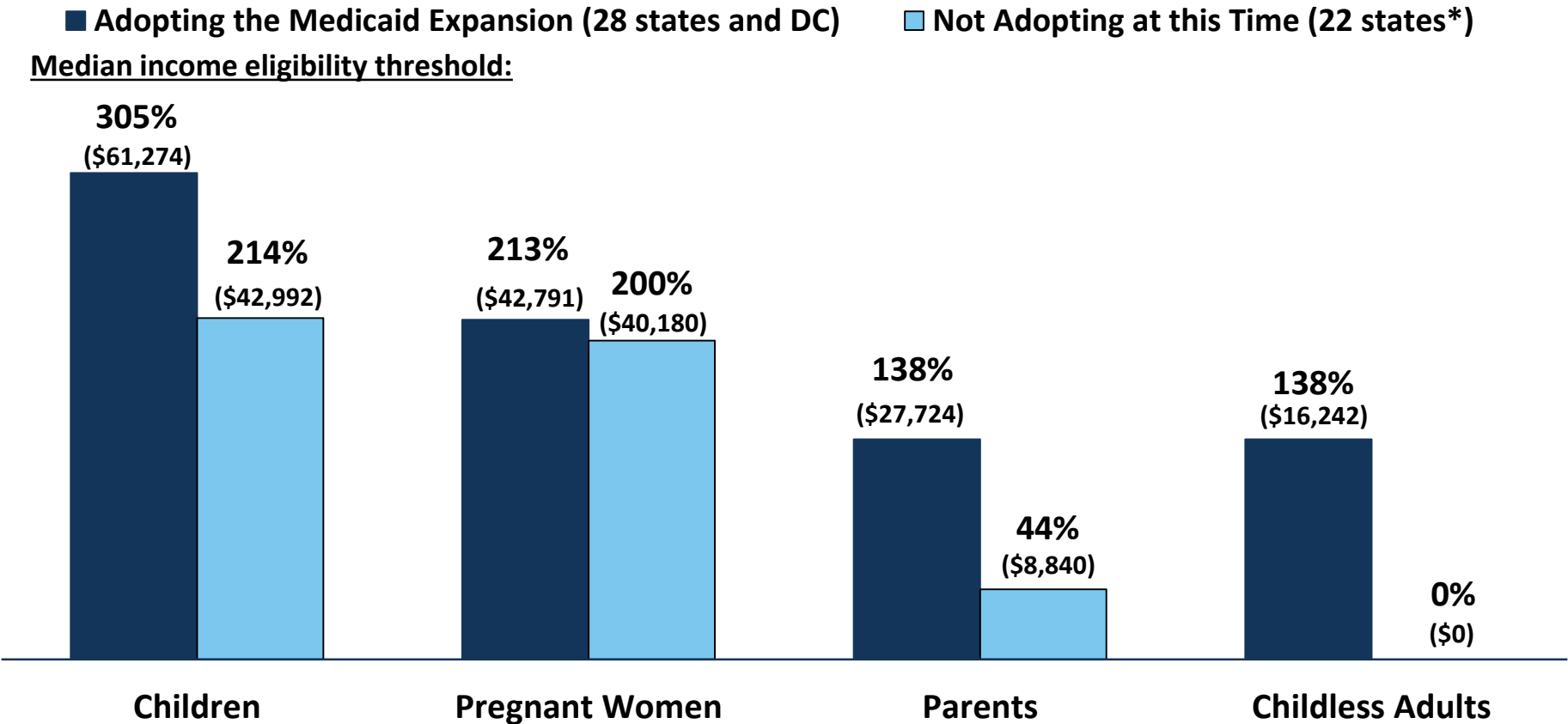
NOTE: The federal poverty level (FPL) for a family of three in 2015 is \$20,090. Thresholds include an income disregard equal to five percentage points of the FPL.

SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.



Figure 9

Medicaid eligibility for adults is higher in expansion states compared to non-expansion states.



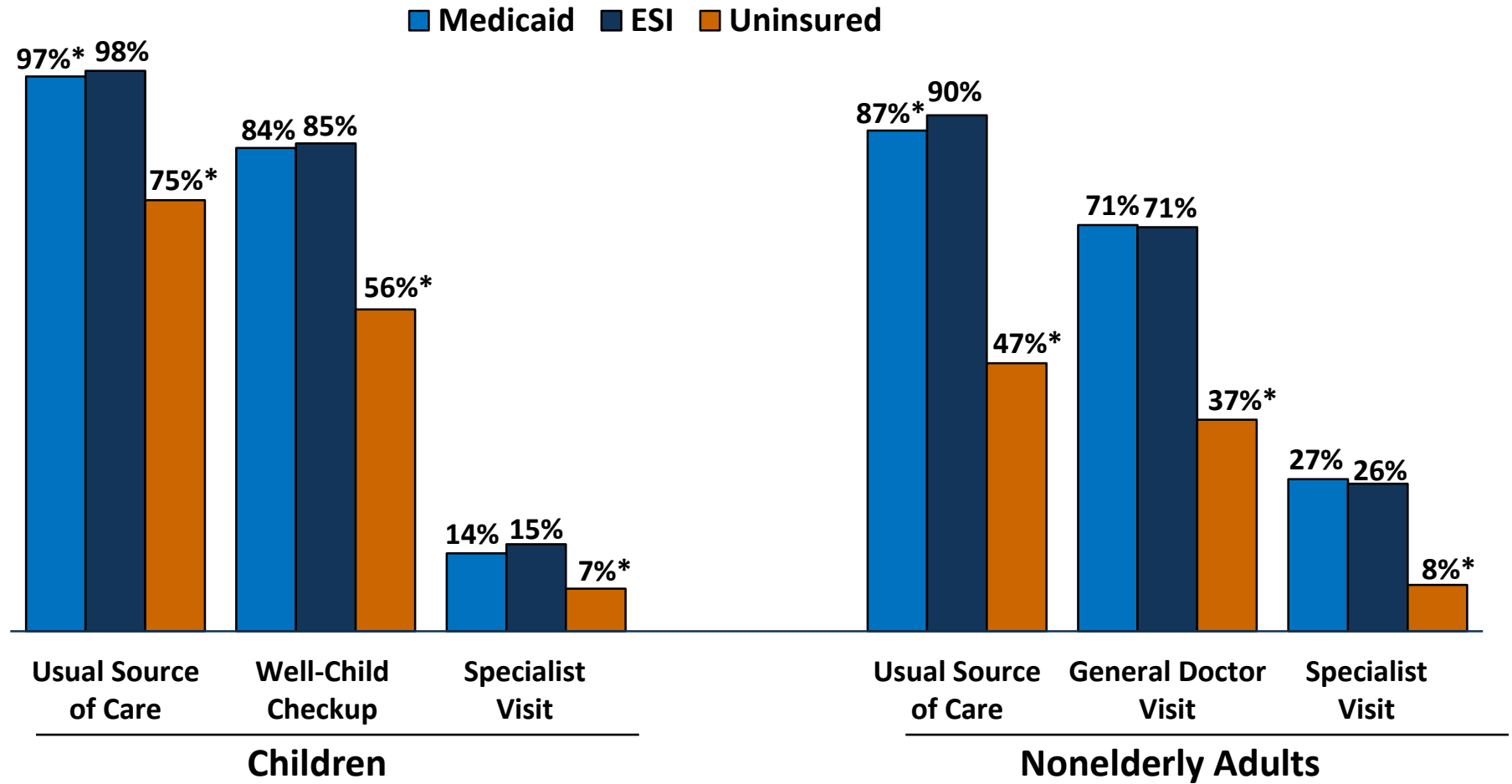
NOTE: State-reported eligibility levels as of January 2015, updated to reflect Medicaid expansion decisions as of April 2015. Eligibility levels are based on 2015 federal poverty levels (FPL) for a family of three for children, pregnant women, and parents, and for an individual for childless adults. In 2015, the FPL was \$20,090 for a family of three and \$11,770 for an individual. Thresholds include the standard 5 percentage point of FPL disregard. *Montana has adopted the Medicaid expansion but implementation is pending waiver approval.

SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.



Figure 10

Medicaid and private insurance provide similar access to care – the uninsured fare far less well.



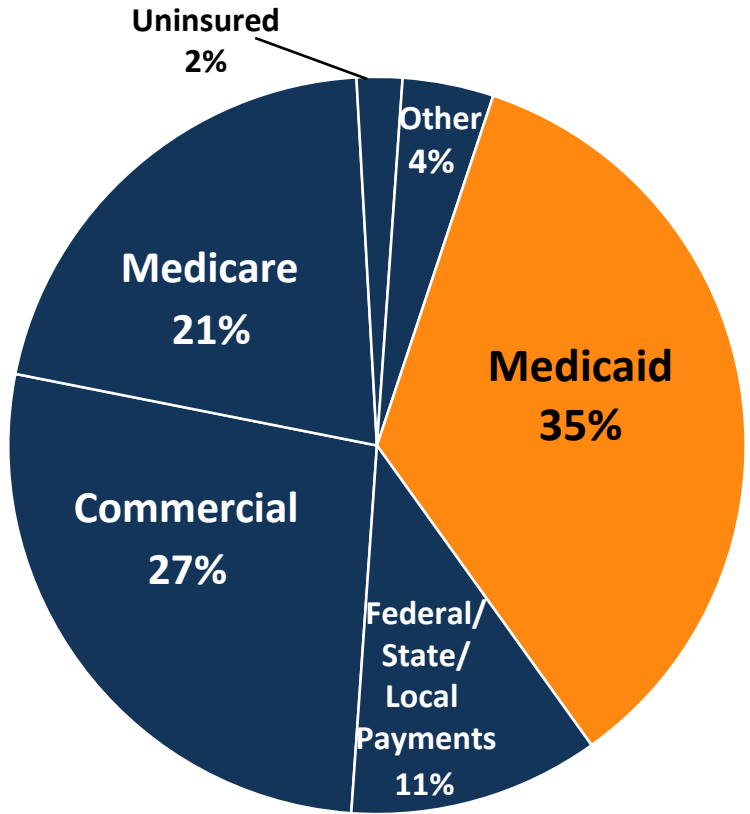
NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care. *Difference from ESI is statistically significant (p<.05)
 SOURCE: KCMU analysis of 2014 NHIS data.



Figure 11

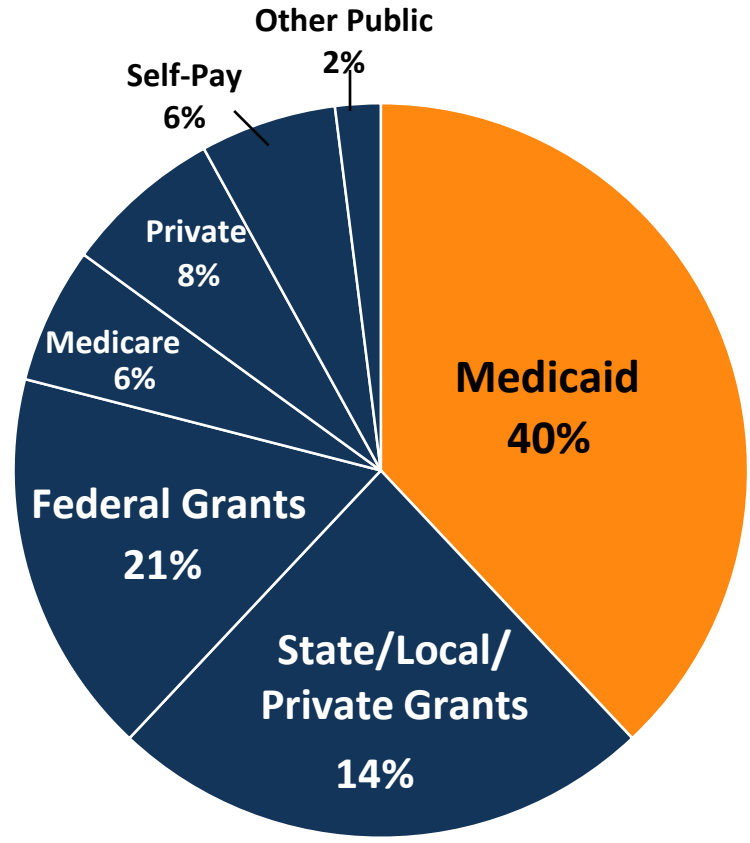
Medicaid and safety-net providers are important to each other.

Safety-Net Hospital Revenues, by Payer



Total = \$47 Billion

Health Center Revenues, by Payer



Total = \$15.9 Billion

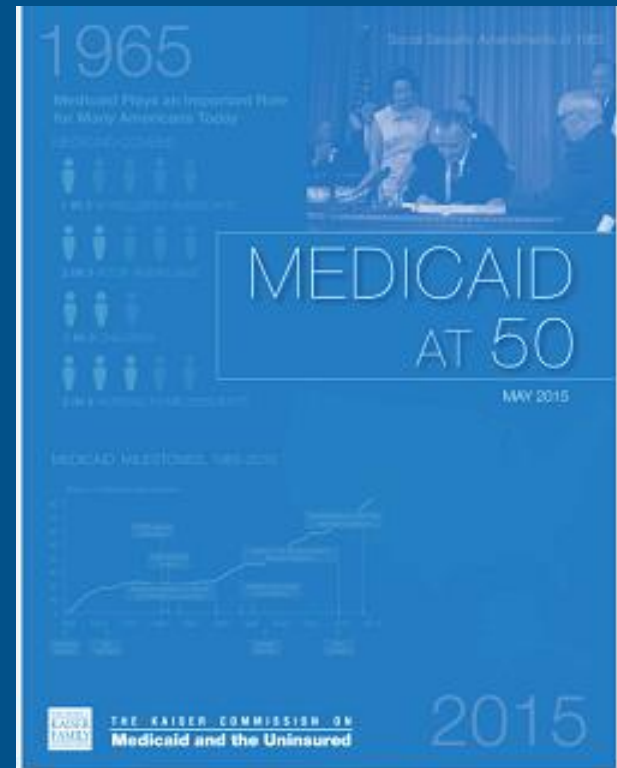
SOURCES: *America's Safety Net Hospitals and Health Systems, 2010*, National Association of Public Hospitals and Health Systems, May 2012. National Association of Community Health Centers analysis of the 2013 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services, Special Data Request, February 2015.



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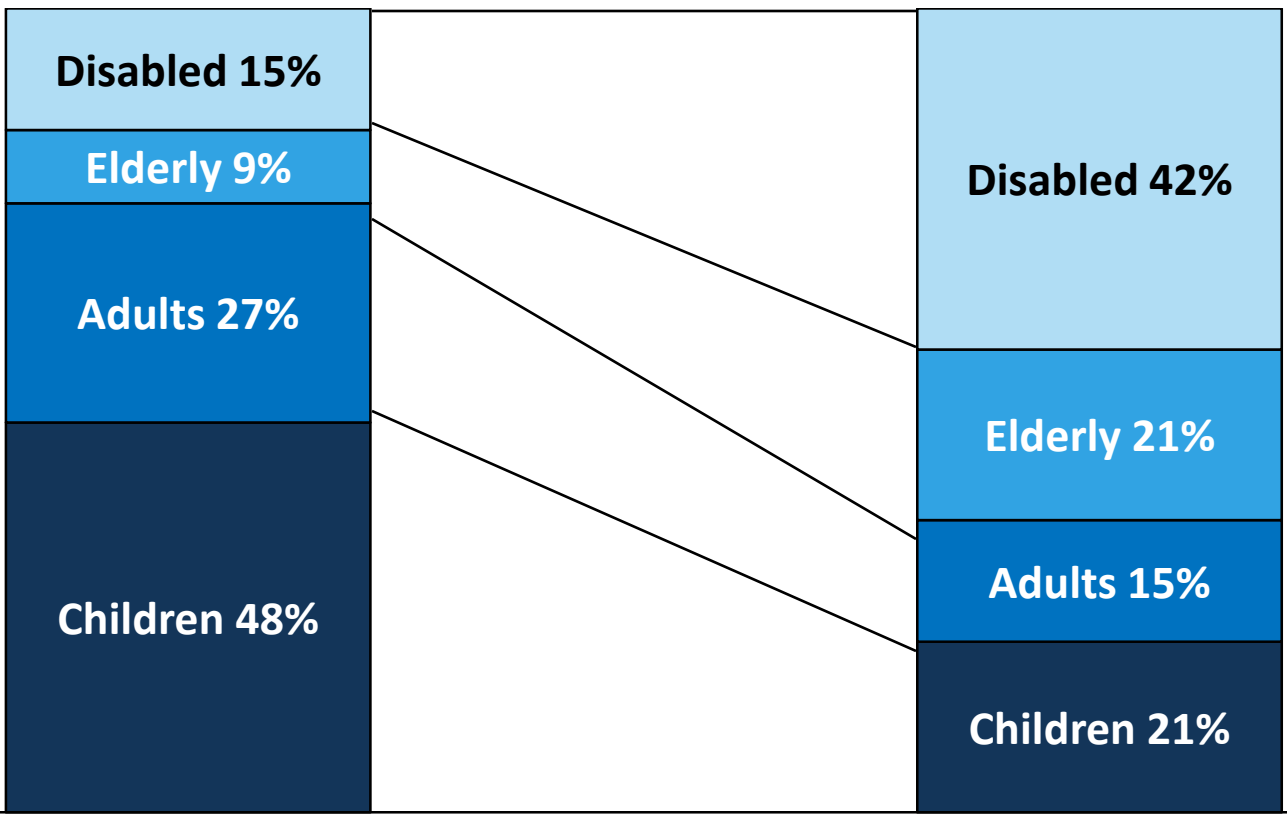


Medicaid's Role in the Health Care System

The Kaiser Commission on Medicaid and the Uninsured

Figure 13

Medicaid spending is mostly for the elderly and people with disabilities, FY 2011.



Enrollees
Total = 68.0 Million

Expenditures
Total = \$397.6 Billion

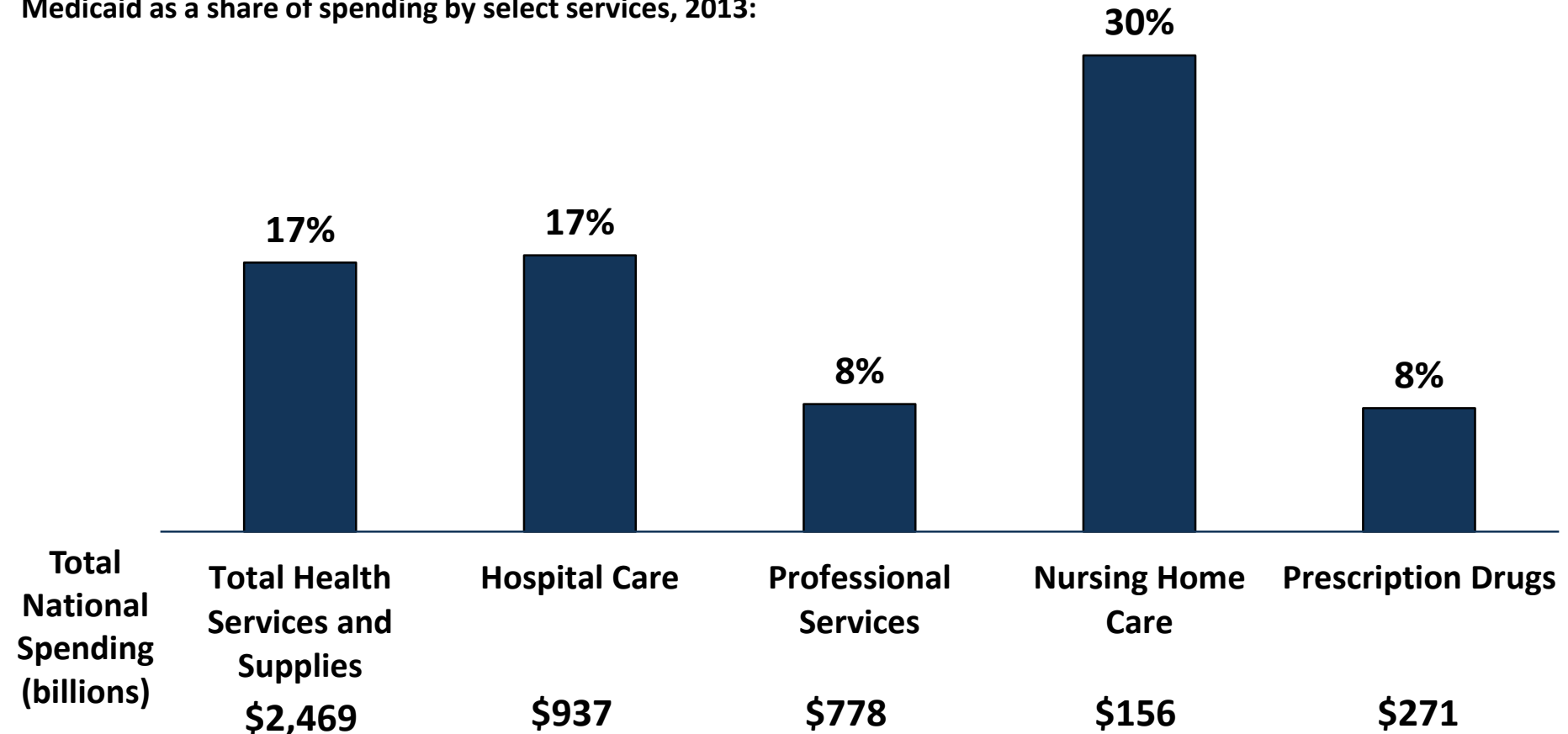
SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.



Figure 14

Medicaid provides support for providers and services in the health care system.

Medicaid as a share of spending by select services, 2013:



NOTE: Includes neither spending on CHIP nor administrative spending. Definition of nursing facility care was revised from previous years and no longer includes residential care facilities for mental retardation, mental health or substance abuse. The nursing facility category includes continuing care retirement communities.

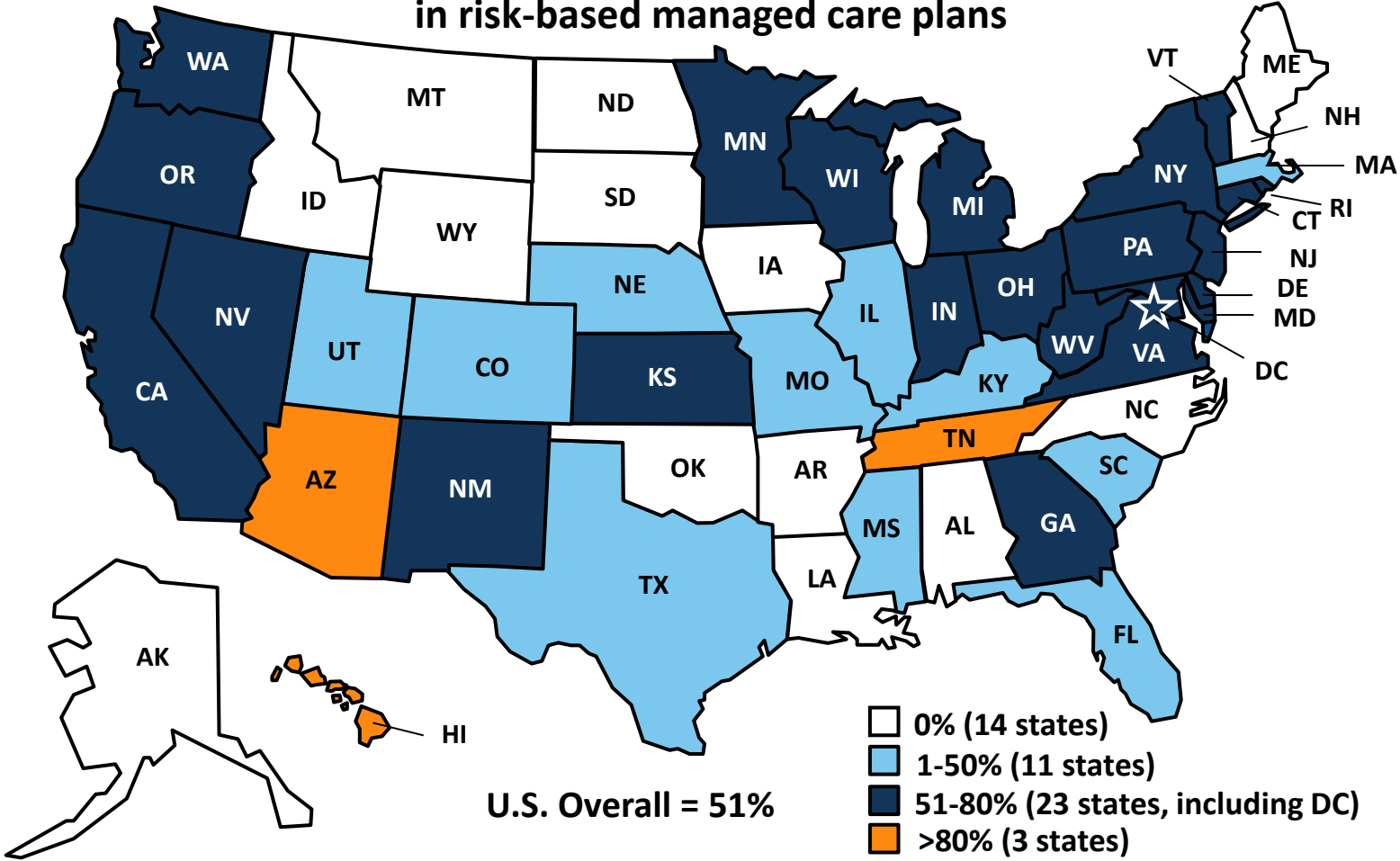
SOURCE: CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditure Accounts, 2015. Data for 2013.



Figure 15

Over half of all Medicaid beneficiaries receive their care in comprehensive risk-based MCOs.

Share of Medicaid beneficiaries enrolled in risk-based managed care plans

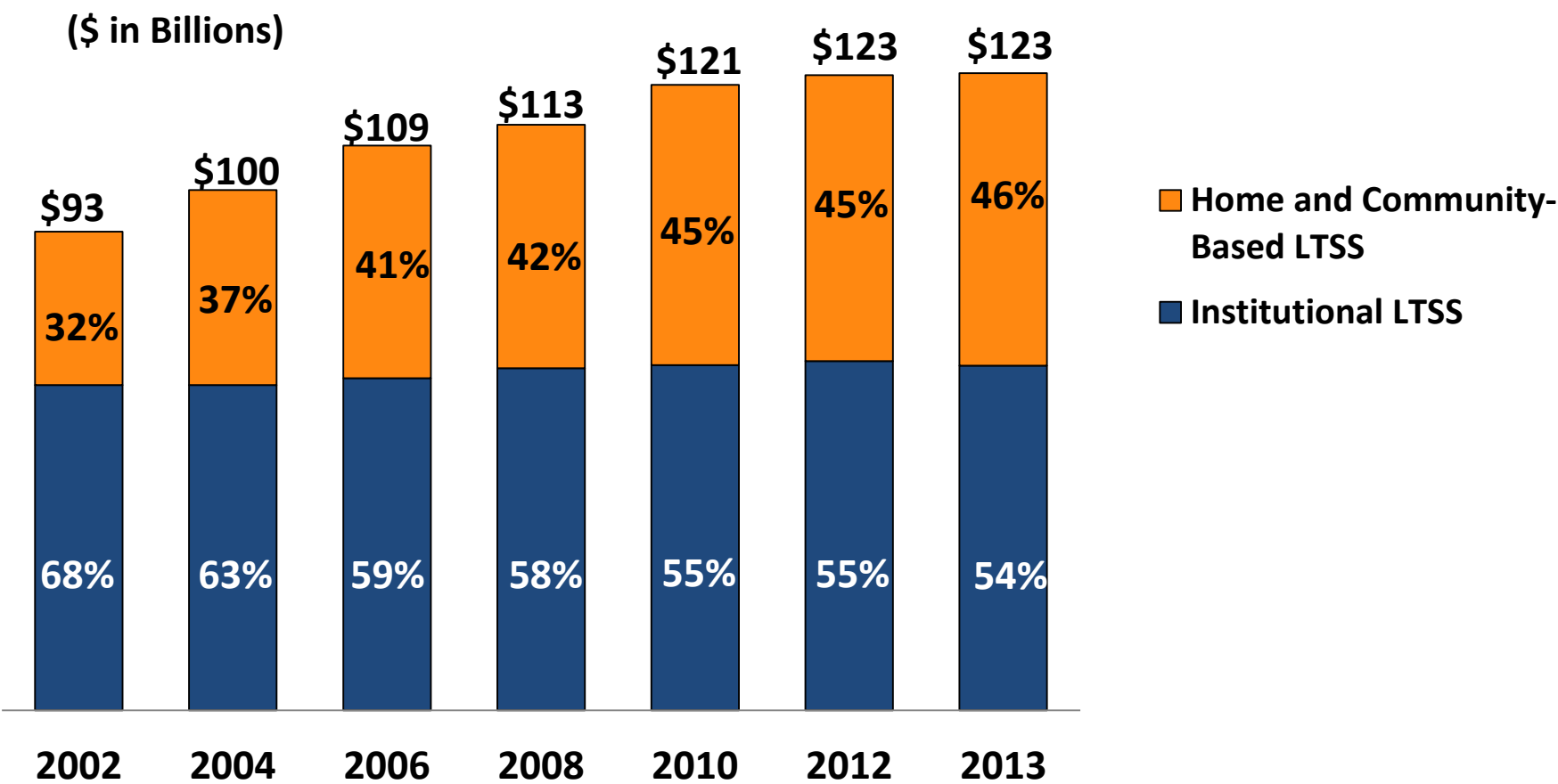


SOURCE: Medicaid Managed Care Enrollment Report, Summary Statistics as of July 1, 2011, CMS, 2012.



Figure 16

Over time, the share of Medicaid long-term care spending going to home and community-based settings has increased.

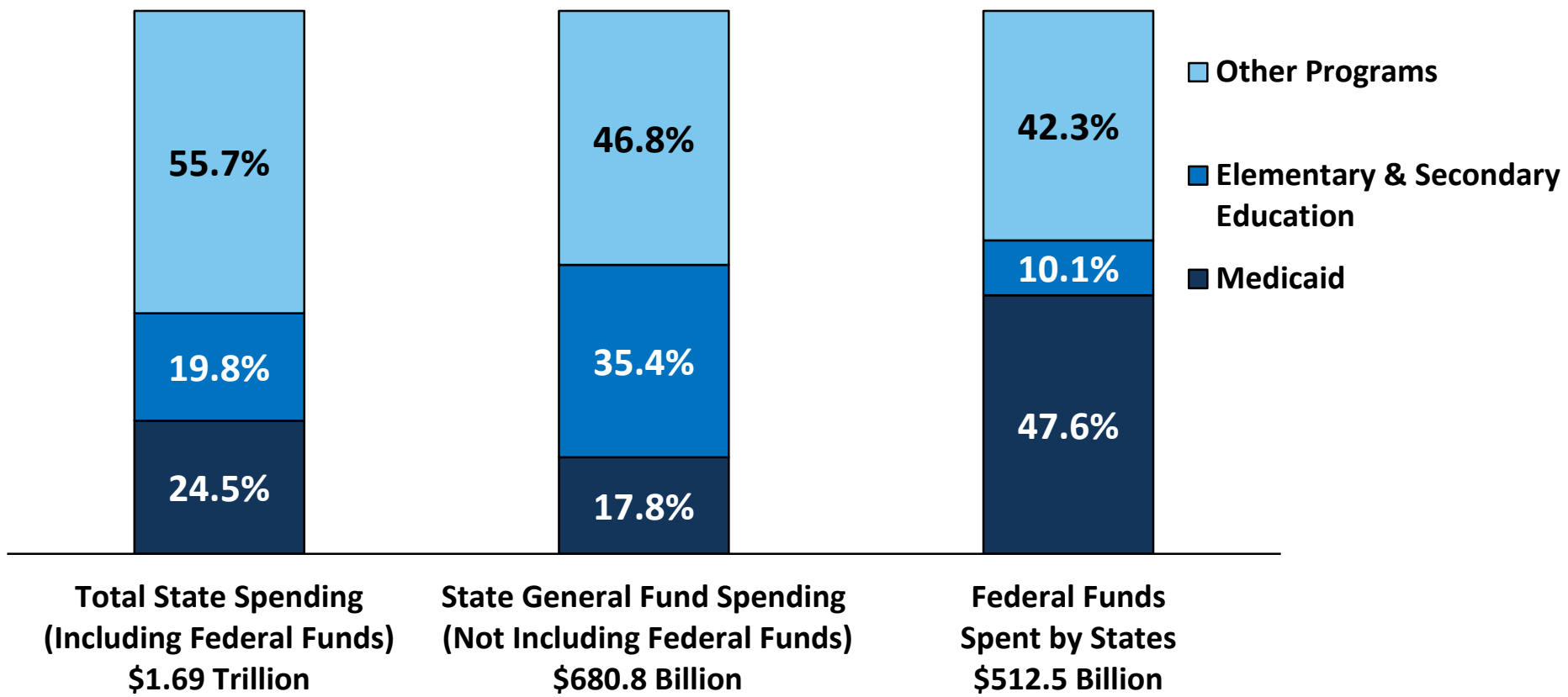


NOTE: LTSS means long-term services and supports. Home and community-based LTSS includes state plan home health, state plan personal care services and section 1915(c) HCBS waivers. Institutional LTSS includes intermediate care facilities for individuals with intellectual/developmental disabilities, nursing facilities, and mental health facilities.

SOURCE: KCMU and Urban Institute analysis of Centers for Medicare & Medicaid Services (CMS)-64 data.

Figure 17

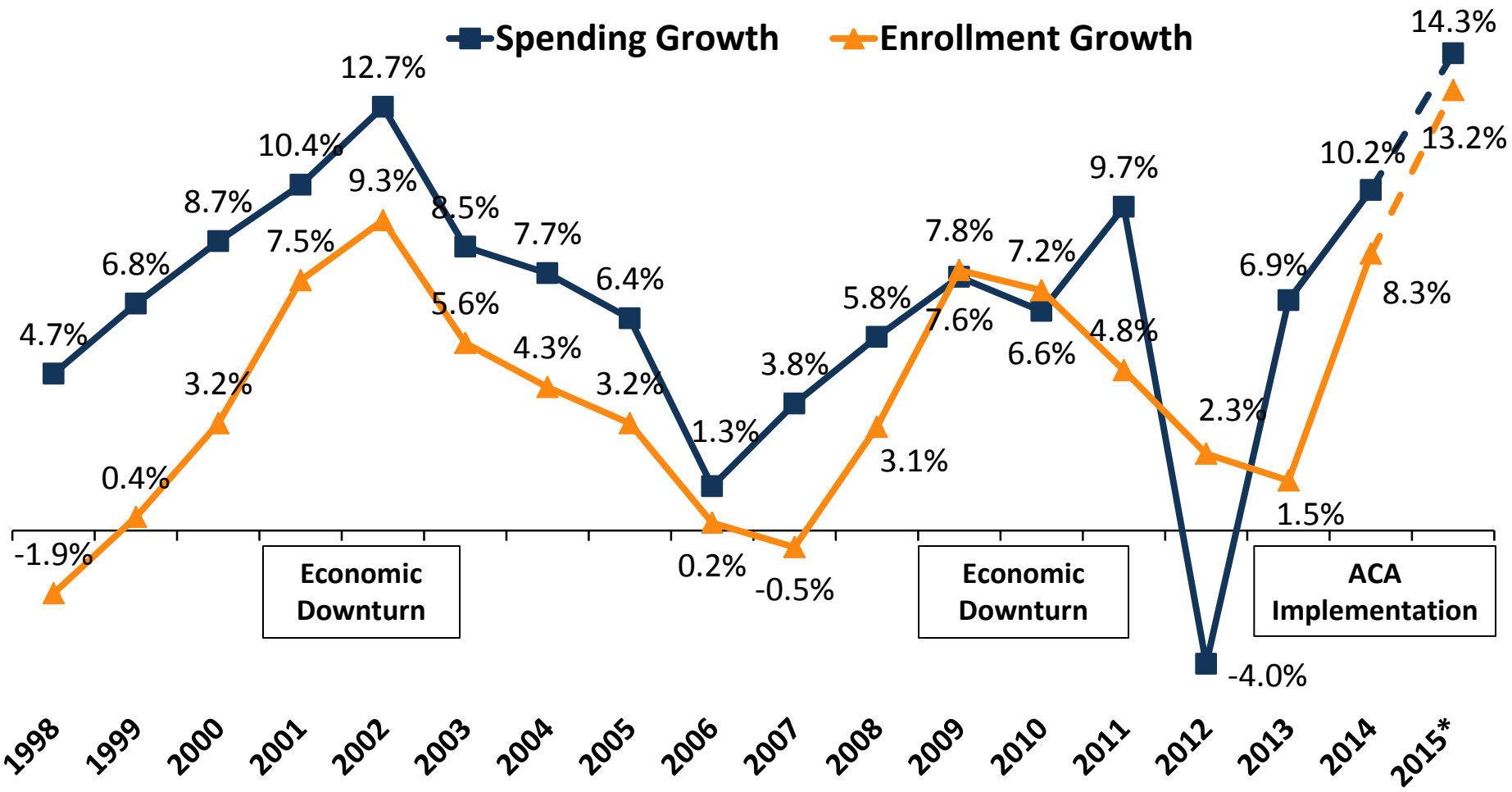
Medicaid is both a spending item and a source of federal revenue in state budgets.



SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates based on the NASBO's November 2014 State Expenditure Report (data for Actual FY 2013).

Figure 18

Medicaid spending and enrollment are affected by changes in economic conditions and policy.



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

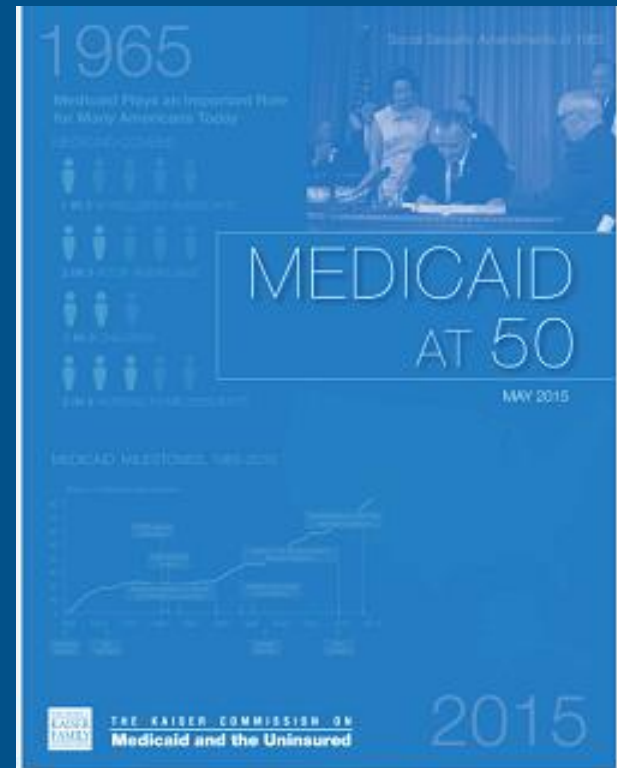
SOURCE: Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015



Medicaid at 50

A Look Back—And Ahead

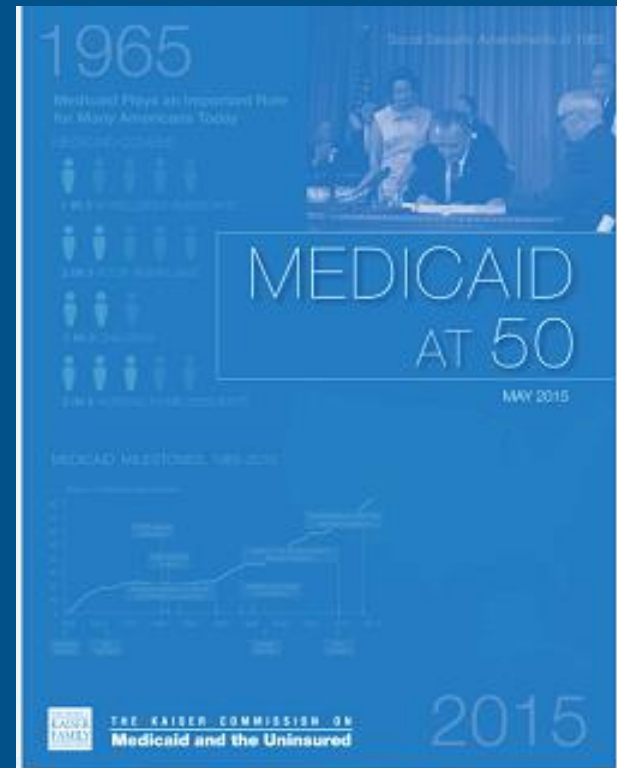
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