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Medicaid and Medicare

**Introduction**

Medicaid is a federally and state governed program that provides health insurance and helps with bearing the medical expenses for low-income people. Citizens who have limited resources to afford the health care receive allowances from this program. It delivers health services to the poor adults, pregnant women, children, disable and elderly adults. It is primarily administered by the states that follow the regulations and requirements defined by the federal legislations. The funding procedure is jointly-carried out by both the states and the federal government. The eligibility criteria and scope of the services is established by each state. They are also entitled to define their own rate of payment and administer Medicaid programs as per their own standards.

**Medicaid program history**

Medicaid program was initiated along with Medicare program when President Lyndon B. Johnson endorsed the Social Security Amendments on July 30, 1965. Under the Title XIX of the Social Security Act, Medicaid was approved as a joint state-federal program in United States. It was part of the social reform movement ‘Great Society’ by Johnson. Its chief purpose was eradication of poverty and providing safeguards against injustices based on race and ethnicity. The notion of national health system was proposed in the early years of the independence. The legislation that made it mandatory for the private citizens to reimburse for the public health care system was extensively supported by John Adams and Thomas Jefferson. In the 1900s, the national health programs were given their due attention and pickled up pace by the concern showed by President Harry Truman in 1940s. However, Congress failed to pass any policies on national health care plan. At the signing of the Social Security Amendment ceremony, President Johnson enrolled Truman as the first beneficiary of the Medicare (Buchmueller et al.).

The basic funding and guidelines regarding eligibility, reimbursements and costs of the services are provided by the federal government. However, states offer additional funding and have flexibility in the administration of the policy. It has been over 50 years now and the program has undergone various modifications albeit the main theme of the program remains the same. There are some mandatory actions that states must follow including the selection of individuals and the type of service that would be provided by the state. Initially, the Medicaid program was only accessible to the citizens who were the potential recipients of the financial assistance. The only eligible beneficiaries of the program were the elderly, disabled, individuals with dependent children while one parent might be absent or unemployed. With the imbursement of the Deficit Reduction Act in 1984, the requirements for membership in any of these groups were relaxed. However, upon the implementation of the Affordable Care Act (ACA), the eligibility criteria for the Medicaid was broadened to include low-income adults, parents of dependent children, disabled, elderly and pregnant women.

The history of the Medicaid program can eventually be divided into three significant periods. The first period lies between 1965 and the early years of 1980s. During this period, the eligibility criteria of the program was extremely strict as it was exclusively based on the income. The fundamental features of the program, structure and selection of services and reimbursement were enacted during this period that still persist today. The second period comprises of the time between the early 1980s and 1996. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was passed. According to this act, the definitions of the eligibility characteristics started to broaden albeit the basic route of admission to the Medicaid remained on the basis of financial aid. The last period of the program started with the approval of the PRWORA and concluded with the enactment of the ACA. Substantial changes were made during this time that were ensued in the construction of the rules that are still intact today (Koba).

**What is Medicaid?**

Medicaid is a partnership between the federal and state government to provide a series of programs for the health benefits of those who qualify. It has series of long term health care programs. Medicaid for Emergency Medical Assistance (EMA) for Non-Citizens is a program that covers various complicated and emergency medical circumstances for those who fall under the eligibility criteria but do not have American citizenship. Medicaid for pregnant Woman is a program that offers certain services for the pre-natal care for the pregnant women in need. The requirements for this program are more relaxed as compared to others. Temporary Cash Assistance (TCA) program is provided to adults who are responsible for taking care of the children under the age of 18 years old and lie under the standard income level. Anyone who qualifies for this program eventually becomes eligible for receiving Medicaid health insurance. Medicaid for Former Foster Care Children is provided to individuals until the age of 26 years old if they had received Medicaid at the time when they aged out of the foster care.

 Medicaid for Children is available for the parents, guardians and caretakers and they may receive Medicaid on the behalf of the children under their care, are below the age of 21 years old and reside with the applicant of the Medicaid. Supplementary Security Income (SSI) Related Medicaid is provided to the individuals with low income and those who qualify for the SSI. Individuals who are either 65 years old or older or have any disability inevitably qualify for the Medicaid health insurance. They can apply without having the need to file for ACCESS application unless they need long term care services. Medical Needy Program is for the individuals who do not meet the Medicaid eligibility criteria but they need financial assistance in order to pay their outstanding medical bills (Sommers and Grabowski).

**What is Medicare?**

Medicare is a federal health insurance program for people who are 65 years old or older, young people with certain disabilities and individuals with End-Stage Renal Disease. It is the permanent kidney failure and the patients are required to have dialysis or even a transplant in some cases. Other than these eligibility criterion, there are no income limits or any other requirements. Medicare has different parts in order to cover specific health care services. Medicare Part A is the ‘Hospital Insurance’ and covers the inpatient hospital stays, care delivery in the skilled nursing facilities and some health care services at home. Medicare Part B is the ‘Medical Insurance’ and it deals with the doctor’s services, outpatient care, certain medical supplies and preventive care services such as flu shots etc. it is imperative to keep it in consideration that none of these plans offer complete coverage of the patient’s care services. Medicare has several premium and co-insurance policies that are to be paid by the patients themselves.

 Medicare Part D is the ‘Prescription Drug Coverage’ and it offers the original Medicare services, several cost plans, private fee for service plans and the medical savings account procedures. This part was introduced in 2006 when the Medical Prescription Drug, Improvement, and Modernization Act was passed. It helps to move some expenses of the prescription drugs to the patients through the domain of the coverage gap. In order to be able to avail the Part D, an individual with Medicare should be enrolled in either a separate Prescription Drug Plan or the Medicare Advantage Plan along with the drug coverage. These plans are monitored by the Medicare, however, are designed and administered by the private health insurance companies. These plans may cover the costs of certain drugs while may not provide any coverage for certain drugs at all. Medicare Part C or the Medicare Advantage Plan is applicable when an individual has both Part A and Part B. The Medicare plans deliver all services in the Part A and Part B with some additional services. The Part C subscribers have to pay monthly premium along with copayments, however, they are less as compared to the coinsurance and deductibles as per the Original Medicare (*What’s Medicare? | Medicare*).

**Difference between Medicare and Medicaid**

Medicare and Medicaid are two different state-run programs. They are administered and funded by different organizations of the government and provide services to various groups. Medicare is the federally run program and it provides health coverage programs to individuals who are 65 years old or older. It may also be given to people who are young but have physical or mental disabilities. It is not based on the income of the individuals applying for the program. Medicaid, on the other hand, is a joint program run by the federal as well the state governments to provide the health coverage in case the individuals lie below the standard income level. If any individual fulfils the eligibility requirements for both the programs, they can receive both. Medicare and Medicaid in this case will work together in order to provide health coverage along with lowering the expenses of the health care services. Albeit, both programs are run by the government and are health insurances, the main difference lies in the covered services and the plans related to the cost sharing.

 In a Medicare program, the medical bills are covered by the trust funds. Patients only have to pay some part of the total expenses by some deductibles from the hospital and other service costs. However, small premiums on monthly basis are needed for non-hospital coverage. As it is run entirely by the federal government, it is similar in all over the United States. It is administered by the Centers for Medicare and Medicaid Services which is a federal government agency. Medicaid, on the other hand, is as assistance program in which patients do not have to pay any part in the costs to cover the total medical expenses. Sometimes, small copayments are required for the services coverage. As governments of the states are also involved in the regulation of the program, it may vary state to state. However, they are bound to follow the set guidelines by the federal government (Medicare et al.).

**Services provided by the Medicaid**

The services to be provided via the Medicaid program are primarily dependent on the decisions by the states. However, there are certain mandatory requirements by the federal government that are needed to be fulfilled by the state departments. Federal government only releases enough funds based on the services provided by the organizations in the state and. Some of those compulsory services include; in-patient and out-patient hospital services, pre-natal care, vaccination for the adolescents, nursing facilities for the individuals who are older than 21 years, family planning and complementary supplies. It also includes the provision of rural health care clinic services, home based health care services, certain laboratory services including X-rays, pediatrics and family nursing services, nurse and midwifery services and the diagnostic, screening and treatment services for people under the age of 21 years old.

**Role of Federal and State Governments**

The major role of the federal governments is in the regulation of the financial matters of the delivery of national health programs. It is made efficient by the mandatory health insurance programs and several other social insurances while ensuring the service quality and patient safety. These agencies also take into consideration the proper regulation of the pharmaceuticals and the medical devices. It is also the responsibility of the federal government to device the health policies and guidelines for the national health programs. The federal government oversees the care programs in all states of the United States via the Centers for Medicare and Medicaid Services. It is a federal agency and its responsibility is to ensure the regulation of all the policies and the federal principles in the states. It also manages the financial aspect of the programs. It establishes certain partnership contracts with the agencies of the states in order to administer the Medicare and Medicaid programs. The states, however, device the plans according to their needs, population health index, financial policies and other such agendas. They are responsible to decide the kinds of services to be provided through these programs and the people who might be eligible for being administered into certain programs. States decide these matters on the basis of the public health records, initiatives taken by the state agencies in order to promote health and other short and long term care services.

**Works Cited**

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