The Medicaid program is the medical care subsidy for low-income persons. It was legislated in 1965 at about the same time as the Medicare program, which is the medical care subsidy for the aged—those persons over 65 irrespective of income level. However, because Part B of the Medicare program (which covers medical services other than inpatient hospital services) requires a monthly premium as well as deductibles and copayments, low-income elderly may have such payments made through the Medicaid program. Thus, there is some overlap of beneficiaries in the two programs. From an economic perspective both programs can be categorized as in-kind demand subsidies.

The implicit assumption of the two programs are these: (1) that improving the health of low-income persons and the elderly benefits society as well as the individual, i.e., there are externalities in the consumption of medical services; (2) that the major barriers to access to medical care services for the elderly and the poor are financial.

Medicare and Medicaid are basically health insurance subsidies. The government does not provide directly nor does it guarantee provision of services. Medicare and Medicaid eligibles seek medical care in the private health care sector along with all other consumer/patients, the government will then pay for the services obtained. Thus a third assumption of the two programs is that the private health care market as it is currently constituted is adequate to meet the health needs of low income and elderly persons. Before addressing the validity of these assumptions, it is important to note a major difference between these two medical care subsidies.

Medicare is a totally federal program with homogeneous eligibility requirements and service coverage across states and socioeconomic
status. Medicaid, by contrast, is financed jointly with state and federal funds and is administered by each state within broad federal guidelines. Each state determines its own eligibility criteria, the benefits covered, and provider reimbursement methods. The amount of variation among the states is enormous as far as who is covered, what is covered, and how it is paid for. Consequently, it is more appropriate to speak of State Medicaid Programs and more importantly to note that horizontal inequities have resulted from state administration of the program. However, this paper will not present a detailed analysis of each state Medicaid program. Instead, it will focus on some of the major commonalities and differences that exist and their impact on the total low income population. Secondly, this paper will discuss the results of an empirical research project designed to determine what difference Medicaid programs have made on the health status of low-income populations and the policy implications of the findings. Lastly, this paper will offer some insights on the ability of a health insurance subsidy to adequately address the health needs of non-white populations.

Medicaid programs were legislated to service low-income persons; however, low income is an insufficient condition for Medicaid eligibility in almost all of the 50 states. In addition to being poor, one must also be aged, blind, disabled, or a member of a household with dependent children where one parent is absent, incapacitated or unemployed. Until 1974 these conditions were necessary and sufficient for automatic Medicaid eligibility. However, in 1974 when welfare programs for the aged, blind, and disabled were federalized as the Supplemental Security Income (SSI) program, states were given the right to exclude SSI cash assistance recipients from automatic Medicaid eligibility if Medicaid eligibility requirements were more liberal than those previously utilized by the state. But it was also legislated that states may provide Medicaid to persons considered "medically needy." The medically needy are defined as persons who fit into one of the categories covered by the cash welfare programs who have enough income to pay for their basic living expenses and so are not recipients of welfare but do not have enough to pay for their medical care.

What all this means is that Medicaid does not necessarily provide medical assistance to all of the poor because they are poor. In 1970 the percent of the federally defined U.S. poverty population that were Medicaid recipients was 55%. By 1975 this figure had improved greatly to approximately 90%. However, the U.S. average hides the extremes which exist in individual states (see Table 1). Medicaid recipients totalled