



OVERVIEW OF MEDICAID IN UNITED STATES OF AMERICA

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INTRODUCTION

The healthcare system in the United States distinguishes itself from other advanced industrialized nations. It lacks a standardized health system, universal healthcare coverage, and only recently introduced legislation making healthcare coverage mandatory for nearly all individuals. The United States allocates a higher average expenditure on healthcare services than any other nation within the Organization for Economic Co-operation and Development (OECD), exceedingly twice the amount per person [1]. Instead of having a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, the healthcare system in the United States is best characterized as a hybrid. In the mid-1960s, the U.S. introduced insurance programs, namely Medicare and Medicaid, targeting specific segments of the population, including low-income and elderly adults. Prior to the Affordable Care Act (ACA), the U.S. healthcare system was inefficient and primarily concentrated on treating chronic diseases, lacking a proactive approach to overall health management. In 2010, the Affordable Care Act, commonly known as Obamacare, represented the closest the U.S. came to a system of Universal Health Coverage (UHC). A legal mandate now compels all Americans to carry insurance or face penalties. Despite these advancements, approximately 28 million people still lack health insurance. Presently, the predominant concern in the U.S. healthcare system revolves around escalating costs [2].

Healthcare expenditures in the United States are funded through a intricate combination of public payers (including the Federal, State, and local government), private insurance, and individual payments [3]. Private insurance and social insurance initiatives like Medicare play a crucial role in pooling resources and spreading the financial risk associated with significant medical expenses across the entire population, ensuring comprehensive protection. Additionally, social welfare programs such as Medicaid and the Children's Health Insurance Program offer support to individuals who cannot afford health coverage.

The primary reliance in the United States is on employers to voluntarily provide health insurance coverage to their employees and dependents, with government programs primarily targeting the elderly, disabled, and some of the impoverished. Private and public health insurance programs vary in terms of covered benefits, funding sources, and payments to healthcare providers. Unfortunately, there is minimal coordination between private and public programs.

RESEARCH OBJECTIVES

1. To acquire a thorough grasp of the structure and operations of Medicaid.
2. To comprehend the developments and modifications in Medicaid during the year 2017.

RESEARCH METHODOLOGY

The research employed a descriptive, desk-based secondary research design within the geographical context of the United States. The study's timeframe followed a cross-sectional approach, emphasizing recent and reliable data sources. Data collection involved utilizing publicly accessible secondary research data sources, including economic indicators, national insurance statistics, details about Medicaid, and a variety of process-related materials such as flowcharts, press releases, interviews, and analyst reports. This comprehensive approach aimed to provide a detailed understanding of the subject matter through the analysis of diverse data sources, contributing to a comprehensive overview of relevant information within the specified timeframe and geographical context.

RESULTS & DISCUSSION

The implementation of the Affordable Care Act (ACA) had brought the U.S. Health Care System closer to achieving Universal Health Care Coverage. The expansion of Medicaid under the ACA indicated predominantly positive effects on aspects such as coverage, access to care, utilization, and affordability. Medicaid now covers more

than one-fifth of the U.S. population, encompassing 77 million individuals, which represents 23% of Americans. A significant portion, over 70%, of Medicaid enrollees receive care administered by Private Managed Care Organizations (MCOs). According to estimates from the Department of Health and Human Services, at least 14 million individuals have enrolled in Medicaid through the ACA expansion.

CONCLUSION

The findings of the study indicated the possibility of improvements in coverage and accessibility for consumers. Medicaid enrollment has seen a rise since the introduction of the ACA, leading to a decrease in the rate of individuals lacking insurance. However, despite these positive trends, there were still 28 million uninsured individuals in the United States. Presently, providers in states that have not yet expanded Medicaid were contemplating adopting the expansion in the future, potentially leading to a further increase in enrollment for individuals falling within the coverage gap.

REFERENCES

1. *America's Health Insurance Plans (HIAA)*, p. 232
2. Gottlieb, J. D., & Shepard, M. (2017). *Evidence on the Value of Medicaid*. Econofact. econofact.org/evidenceon-the-value-of-medicaid
3. *Medicaid General Info*. www.cms.hhs.gov.