

Medicaid work requirements

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Abstract

Medicaid in the United States is a federal and state program that helps with healthcare costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, including nursing home care and personal care services. The main difference between the two programs is that Medicaid covers healthcare costs for people with low incomes while Medicare provides health coverage for the elderly. There are also dual health plans for people who have both Medicaid and Medicare.[1] The Health Insurance Association of America describes Medicaid as "a government insurance program for persons of all ages whose income and resources are insufficient to pay for health care." [2]

Medicaid is the largest source of funding for medical and health-related services for people with low income in the United States, providing free health insurance to 74 million low-income and disabled people (23% of Americans) as of 2017,[3][4][5] as well as paying for half of all U.S. births in 2019.[6] It is a means-tested program that is jointly funded by the state and federal governments and managed by the states,[7] with each state currently having broad leeway to determine who is eligible for its implementation of the program. As of 2017, the total annual cost of Medicaid was just over \$600 billion, of which the federal government contributed \$375 billion and states an additional \$230 billion.[6] States are not required to participate in the program, although all have since 1982. In general, Medicaid recipients must be U.S. citizens or qualified non-citizens, and may include low-income adults, their children, and people with certain disabilities.[8] Along with Medicare, Tricare, and ChampVA, Medicaid is one of the four government sponsored medical insurance programs in the United States. Medicaid, along with Medicare, are administered by the U.S. Centers for Medicare & Medicaid Services in Baltimore, Maryland.[9]

Keywords: sport

Introduction

Medicaid is the nation's publicly financed health and long term care program that currently covers over 70 million people, including low-income children and adults, the elderly and disabled. Jointly funded by states and the federal government, Medicaid fills gaps in the US health system for those that lack access to private insurance and covers more than 2/3 of all nursing home residents. Medicaid is the largest payer for births, mental health, and long term care in the United States. Medicaid enrollment has increased considerably with the Affordable Care Act (ACA) Medicaid expansion and will continue in the coming years. Health reform and state and federal budget deficits are driving significant change in the Medicaid program, and the need for research informed policy decision-making has never been greater.

The United States stands on the verge of a dramatic expansion in health insurance coverage, unprecedented since the creation of Medicare and Medicaid in 1965. Starting in January 2014, coverage through expanded Medicaid eligibility and subsidies for health insurance purchases through Marketplaces¹ will extend coverage to tens of millions of Americans (Elmendorf, 2012). In the face of daunting implementation challenges, early lessons about such expansions would be valuable to federal and state policymakers, as well as numerous stakeholders. Since the passage of the Affordable Care Act (ACA) in March 2010, six states or jurisdictions—California, Connecticut, the District of Columbia, Minnesota, New Jersey, and Washington—have enacted Medicaid expansions that include some or all of the low-income adults who will become eligible for Medicaid, starting in 2014, under the ACA (The Henry J. Kaiser Family Foundation, 2012a).

The ACA offered states the opportunity to expand eligibility to low-income adults at or below 133% of the federal poverty level (FPL) before the national 2014 expansion. Unlike the 2014 expansion, these early expansions were subject to the state's baseline match rate (Federal Medical Assistance Percentage, or FMAP), rather than the 100% initial federal funding (and 90% in the long-run) offered by the ACA for newly-eligible

adults in 2014 (The Henry J. Kaiser Family Foundation, 2013b). In these early expansions, states also had the flexibility to choose an eligibility threshold below 133% of FPL, expanding coverage to only a subset of the ACA's ultimate target Medicaid population.

In either case, these early expansions were generally considered a bridge to 2014, at which point eligibility will be expanded to 133% of FPL (138%, when including a 5% income disregard), with the FMAP for these individuals rising to 100%.

The impending 2014 Medicaid expansion features numerous policy challenges and unanswered questions. We conducted in-depth interviews with high-ranking Medicaid officials in these six early expanding states (for brevity, we hereafter refer to the District of Columbia as a "state") to glean important lessons from their experiences.

Our analysis builds on a conceptual model and recent empirical research on challenges facing the Medicaid expansion. Our conceptual model came from Eisenberg and Power's description of access to care in the U.S. health care system. In their seminal paper (Eisenberg & Power, 2000), the authors describe how multiple barriers to effective health care exist in the U.S., pre-ACA system, each one a "voltage drop" that may lead to the loss of potential for better care. In particular, our analysis focused on the following voltage drops identified in that model: (1) insurance availability, (2) enrollment in insurance, (3) provider and services covered, (4) choice of plans and providers, (5) consistent source of primary care available, and (6) referral services accessible.

States have the option to establish a "medically needy program" for individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups. Medically needy individuals can still become eligible by "spending down" the amount of income that is above a state's medically needy income standard. Individuals spend down by incurring expenses for medical and remedial care for which they do not have health insurance. Once an individual's incurred expenses exceed the difference between the individual's income and the state's medically needy income level (the "spenddown" amount),

the person can be eligible for Medicaid. The Medicaid program then pays the cost of services that exceeds the expenses the individual had to incur to become eligible.

In addition to states with medically needy programs, 209(b) states also must allow a spenddown to the income eligibility levels eligibility groups based on blindness, disability, or age (65 and older), even if the state also has a medically needy program. Thirty-six states and the District of Columbia use spenddown programs, either as medically needy programs or as 209(b) states.

Research aims :

Learn about the concepts of the Medicaid health care program, its requirements and how to obtain it

A statement that the program is valid for all patients and that they have access to the necessary health insurance services

Clarify that the program includes health care for the elderly and children in public and private hospitals

Reducing the lack of awareness of the Medicaid health program among community members

Research problem :

Dealing with the costs of a serious or chronic disorder can be as daunting as dealing with the disorder itself—the costs often exceed most people's personal resources. For older people, most health care

Expenses are paid for by:

Medicare: Helps people age 65 or older who have a disability, who need dialysis, or who have amyotrophic lateral sclerosis.

Medicaid: Helps some poor or disabled patients.

Other government programs, such as the Department of Veterans Affairs: The Department of Veterans Affairs provides health care to honorably discharged veterans who meet certain eligibility requirements.

Private insurance

Payments are not covered by insurance

In addition, many states provide health-related benefits and programs for seniors, such as subsidies for transportation, housing, utilities, telephone, and food expenses, as well as home assistance and nutrition services.

Understanding how Medicare, Medicaid, or other government programs work is complex; what is paid in full, how much is paid in part, who pays how much, and how payments are arranged is difficult to understand. Programs change frequently, and for Medicaid, regulations and legislation differ state to state. But part of the problem is the complexity and fragmented nature of the health care system in the United States and the health care payment system.

Search terms:

Medicaid is a program funded by the federal and state governments to help pay for health care costs. It is intended for people of all ages who have very low incomes and few assets. Medicaid eligibility requirements vary from state to state. People who enroll in Medicare may be eligible Also for Medicaid, which helps pay for some expenses that Medicare doesn't cover.

Requirements:

A requirement is a statement of how the system should behave. Defines what the system must do in order to meet the user's needs or expectations. Requirements can be thought of as user-discovered features. They differ from non-functional requirements, which specify how the system should work internally (eg, performance, security, etc.).

Requirements consist of two parts:

function and behaviour. A function is what the system does (eg, "calculate sales tax"). The behavior is how the system does it (eg, "The system should calculate sales tax by multiplying the purchase price by the tax rate").

The research sample :

The random sample included a number of health practitioners and eligible patients for the Medicaid program at King Khalid Hospital in Hafr Al-Batin.

Search tools :

Personal interviews and closed and open questionnaires were used to collect data on the research sample and information about the research topic

Search dimensions:**First: the social dimension:**

Health programs are influenced by the nature of society in its general philosophy, vision, and perception of what the health process should be in religious and spiritual beliefs and in its culture that it inherited from the relationship, with what it embodies in terms of values, trends, ways of thinking, behavioral patterns, customs and traditions, and way of life. They satisfy it for themselves, and other moral values, then link it to what it uses, and the community employs it as an element of guidance and guidance for its members; It helps them to adapt to the rest of the society, linking them with aspirations and hopes, and uniting their attitudes towards other societies.

The nature of society, in many of its manifestations, may be subject to change, due to the social changes that occur, and the development of science and technology. Health builders must keep abreast of these changes and developments, benefit from them, and employ them to achieve the aspirations and interests of society, and the happiness and freedom of its members.

Second: the psychological dimension:

Societies are moving according to their vision and perception of what health programs should be like in all their dimensions, their data in a serious and scientific manner, through scientific research; to conduct a number of different studies on health practitioners and patients; To explore

how they think, what they want, what their interests, desires, inclinations and needs are, what their potential, abilities, physical and mental energies are, and how they can then be put to good use; To develop and develop health work for the benefit of the beneficiary and his community.

Those psychological dimensions collectively or individually are important dimensions that clearly and prominently affect the process of building and designing the Medicaid program, building health goals, choosing appropriate implementation methods, choosing aids for health work, and other things related to the health process and its goals that it seeks. to be achieved.

Third: Scientific and Technical Dimension:

Our era is the impact of the knowledge and technology explosion, and the massive, rapid, and broad development in technical sciences. Health work must keep pace with these data and health programs, and they must be built and designed in a way that is based on its foundation and is based on scientific studies and research within a framework through which the individual is prepared; In order to deal with and confront scientific and technical developments, there is no sovereignty in our present era except for science and technology and the achievement of new discoveries that benefit humanity.

research assumes :

Health care can be paid for in two ways

Service Expenses: Practitioners and health institutions pay for each hospital stay, each practitioner visit, each test, and each treatment.
fare p vice (POS) plans or a combination of both.

search limits :

Spatial limitations: The research was conducted in the city of Hafar Al-Batin - King Khalid General Hospital.

Temporal boundaries: During the second semester of the year 1444 AH

Human Limits: The category of elderly, young and children eligible patients for the Medicaid program.

Theoretical framework and previous studies

Medicaid and patient care

It is a program funded by the federal and state governments to help pay for health care costs. It is intended for people of all ages who have very low incomes and few assets. Medicaid eligibility requirements vary from state to state.

People who enroll in Medicare may also be eligible for Medicaid, which helps pay for some expenses not covered by Medicare.

If people have very low incomes but have certain assets such as home or stock investments, they may not qualify for Medicaid. In order to qualify, they may have to spend, that is, they may have to sell their stocks and other assets and use the money to pay for health care. until their income plus assets is low enough to qualify.

To avoid having to spend, some patients give their assets to others, or sell them at below market value, often to family members. However, to qualify for Medicaid, they must not have given those assets within 5 years of needing care. In some States, patients may be able to keep their home so that some family members can stay there.

But also under certain circumstances, Medicaid is entitled (and sometimes required to) recover long-term care expenses, and sometimes the regular costs of Medicaid, from the estate of deceased Medicaid recipients. The assets that can be claimed vary by state; Some states home the family from Medicaid claims.

If people qualify for Medicaid and Medicare, most health care costs are covered.

Medicaid is the main public driver of long-term care, such as skilled nursing care (including care in a nursing home).

For seniors, Medicaid often pays for home care. Medicaid is required to provide long-term care to eligible people age 21 or older who participate in Medicaid.

Part A helps pay for the following:

- hospital care
- Medical tests (such as blood and urine tests)
- Diagnostic tests (such as x-rays)
- Doctor visits
- Skilled nursing care
- Vaccines
- Home health care

Since each state operates its own medical treatment program, the services covered vary from state to state. In some states, Medicaid helps pay for other items, such as prescription drugs, dental care, eyeglasses, and mid-level nursing care.

Mid-level nursing care involves less care than skilled nursing, but more care than personal care. Its purpose is to maintain and, if possible, improve a person's condition.

Health care practitioners who provide care for people covered by Medicaid must accept what Medicaid pays as full compensation.

However, because this rate is often low, some practitioners choose not to provide care for people covered by Medicaid. Also, some nursing homes do not accept Medicaid.

What does the program cover?

- Hospital services for inpatients and outpatients
- Clinic services
- Early screening, diagnosis and treatment of children under the age of 21 under the Health Teen/Child Program
- Medicines, supplies, medical equipment and other equipment such as wheelchairs, etc.
- Laboratory services and x-ray imaging services
- Preventive health and dental care and treatment provided by doctors and dentists
- Care provided in nursing homes
- Care provided through home health and personal care agencies
- Treatment provided in psychiatric hospitals for persons under the

age of 21 or those aged 65 or older and in mental health and designated facilities

- For those with developmental disabilities
- Family planning services
- Go to appointments for medical visits, including methods
- Public transportation and vehicle mileage
- Transportation to hospital in emergency ambulances
- Smoking cessation products such as gum and patches

How much does Medicaid cost?

Monthly Installments: There is no monthly premium for Medicaid.

Cost Sharing: Some Medicaid services require a small copayment, but sometimes it isn't needed.

The maximum co-payment you will make under Medicaid in one year is \$200.

Previous studies

1- An analytical study of the health insurance market in the Kingdom of Saudi Arabia

Dr.. Hussein bin Muhammad Barai: Associate Professor - Department of Health Services and Hospitals Management - College of Economics and Administration, King Abdulaziz University. Jeddah, Saudi Arabia.

The study focused on health insurance because of its great importance in all parts of the world, as it aims to provide health care services to a segment of the population, and in some countries it reaches the coverage of the entire population under the umbrella of health insurance. in all countries of the world. The importance of health insurance is growing in the Kingdom of Saudi Arabia, due to the Kingdom's uniqueness in the presence of a large number of residents working and living with their families within it. At the end of 2014, the

Kingdom's population reached 8.30 million, and the number of residents reached about 10 million, representing a third of the population.

Health insurance is implemented in the Kingdom through a cooperative system managed by insurance companies under the Ministry of Health

Supervision of the Cooperative Health Insurance Council, and this system is applied to the targeted subscribers

All private sector workers and their families are compulsory, and this system bears the burden of providing care health of more than half of the population.

Hence, it is necessary to conduct an analytical study of the health insurance market in the Kingdom of Saudi Arabia in the light of the actual application experience during a time series that extends for ten years, during which it was possible to collect audited data on it through official statistical reports.

2- Ali, Muhammad Awad Al-Karim Al-Mubarak. Medical Insurance and its Role in Improving the Health Sector: A Case Study of Ahmed Qasim Hospital - Khartoum State / Muhammad Awad Al-Karim Al-Mubarak Ali; Babiker Al-Faki Al-Mansour. - Khartoum: Sudan University of Science and Technology, Commercial Studies, 2013. - 107 p.: Also; 28 cm. - Master.

This study dealt with medical insurance and its role in improving the health sector. The problem of the study was the low level of quality of the medical services provided and the high costs of obtaining them under the medical insurance system, the absence of the supervisory role of the insurance companies over the institutions providing health care, in addition to the inappropriate place and time of providing medical services. The study followed the descriptive and inferential analysis methods. The study aimed to: identify the role of medical insurance in improving the quality of medical care services in Sudan. Identifying the role of medical insurance in improving the techniques of medical care services. Identifying the role of medical insurance in advancing the health sector and its contribution to the establishment of health care centers and

hospitals. To achieve the objectives of the study, a number of hypotheses were tested: There is no statistically significant effect of the medical insurance system on improving the quality of health services. There is no statistically significant effect of the medical insurance system on the cost of health care services. There is no statistically significant effect of the medical insurance system on expanding the options of beneficiaries of health services. The study reached a set of results, the most important of which are: The medical staff in the centers and hospitals that provide health care services have the necessary competence and skill, and the beneficiaries get good treatment from the working staff. The medical insurance system provides many advantages at a low cost with the reasonableness of the subscription amount that they pay. medical insurance system. The study recommended several recommendations, the most important of which are: Work to settle the treatment inside the country by benefiting from insurance funds in purchasing modern devices and equipment to create psychological stability for the beneficiaries and improve the work environment to limit the migration of medical talent abroad in search of a better environment. Developing strict legislation to supervise and technically control health service providers and insurance companies, and focus on quality standards for health service providers.

Discussion

States have been moving toward increased delivery of LTSS through HCBS. In addition, PPACA provides states with additional opportunities to provide access to HCBS services for Medicaid-only beneficiaries and dual eligible with LTSS needs. Policymakers investing funds in these innovations hope that they can reduce the challenges beneficiaries with LTSS needs experience in obtaining the services they need while maximizing their choice of providers and remaining in home and community-based settings. Policymakers also hope that such investments will contain Medicaid and Medicare spending growth in the face of growing pressure on these programs to deliver services to an aging population.

Unlike traditional source of demand, government-sponsored Medicaid LTSS programs represent coverage-by-necessity whereby individuals must demonstrate their need for coverage through income requirements and/or disability. As fiscal pressures rise, there is principally only one way to reduce cost; that is by reducing waste and non-productive expenses.

Medicaid work requirements

One significant impact the Trump administration has had on Medicaid is the encouragement of states to implement work requirements for enrollees. Medicaid is the government-funded health insurance program that provides free or low-cost health coverage for eligible low-income adults. It also provides free or low-cost coverage for some children, pregnant women, seniors, and people with disabilities. Medicaid is administered jointly by state governments and the federal government—specifically, the Centers for Medicare and Medicaid Services (CMS).

Work requirements for Medicaid typically take the form of waivers. These waivers require Medicaid beneficiaries to verify that for a given number of hours a week they are either employed, actively job hunting, or enrolled in a job training program. If otherwise qualified Medicaid applicants can prove this, they can then enroll or or retain their coverage

But many experts believe that these work requirements are redundant at best and detrimental to the Medicaid program at worst, keeping people who are already actively employed from receiving benefits for which they already qualify.

If you're looking to see if you're eligible for Medicaid or subsidized Marketplace health insurance (aka Obamacare or Affordable Care Act health insurance), enter your zip code below.

What is the difference between Medicare and Medicaid?

Medicare

Medicare is an insurance program. Medical bills are paid from trust funds which those covered have paid into. It serves people over 65 primarily, whatever their income; and serves younger disabled people and dialysis patients. Patients pay part of costs through deductibles for hospital

and other costs. Small monthly premiums are required for non-hospital coverage. Medicare is a federal program. It is basically the same everywhere in the United States and is run by the Centers for Medicare & Medicaid Services, an agency of the federal government.

Medicaid

Medicaid is an assistance program. It serves low-income people of every age. Patients usually pay no part of costs for covered medical expenses. A small co-payment is sometimes required. Medicaid is a federal-state program. It varies from state to state. It is run by state and local governments within federal guidelines. To see if you qualify for your state's Medicaid (or Children's Health Insurance) program .

What does this research mean for Medicaid work requirements?

The body of literature summarized above includes several notable caveats and conclusions to consider in applying findings to a work requirement in Medicaid.

Limitations and implications that are particularly relevant include:

Effects found for the general population may not apply to Medicaid, as the link between work and health is not universal across populations or social contexts. In general, the studies examined above analyze the relationship between work and health among broad populations of all income levels. However, several authors suggest that population differences may modify the relationship between work and health. A 2003 study found that nationally, older adults, women, blacks, and individuals with low education levels were more likely to be employed in jobs viewed as “barely adequate” or “inadequate” (the types of jobs that the study found to be independently associated with poorer physical health and higher rates of depression) compared to other populations.⁷⁹ Authors of a 2006 literature review qualify their broad findings on the work/health relationship with the proviso that the social context must be taken into account (particularly social inequities in health and regional deprivation), and also cite evidence that the strong association between socioeconomic status and physical and mental health and mortality likely outweighs (and is confounded with) all other work characteristics that influence health.⁸⁰

Authors of a 2005 review on unemployment and health found a strong association between deprived areas, poor health, poverty and unemployment (although the exact relationship is not clear), and highlight the need for more research on the geographical dimension on unemployment and health.⁸¹ These findings imply that the work/health relationship may differ significantly for the low- income Medicaid population, who report worse health status compared to the total US population and often face more significant challenges related to housing, food security, and other social determinants of health.^{82,83,84} In addition, some volunteerism research suggests that the association between volunteerism and improved health outcomes may be limited to older volunteers, yet approved and pending Section 1115 Medicaid work requirement waiver requests all include exemptions for individuals above a certain age (which varies by state but ranges from 50 to 65 years

What states have Medicaid work requirements?

Right now, there are six states that have approved work requirement waivers for their Medicaid programs:

- Arizona (approved, but not implemented)
- Indiana (approved and implemented)
- Ohio (approved, but not implemented)
- South Carolina (approved, but not implemented)
- Utah (approved and implemented, but currently on hold due to COVID-19)
- Wisconsin (approved, but not implemented)

If you have Medicaid and live in one of these states, check with your state Medicaid office to make sure you've completed all required documentation.

There are an additional ten states with pending work requirement waivers for their Medicaid programs:

- Alabama
- Georgia
- Idaho

- Mississippi
- Montana
- Nebraska
- Oklahoma
- South Dakota
- Tennessee
- Virginia

And four states have had their work requirement waivers set aside by the federal court system:

- Arkansas
- Kentucky
- Michigan

New Hampshire

What do we know about workforce participation of Medicaid recipients?

According to the Kaiser Family Foundation,

- 63% of non-dual, non-SSI, non-elderly adults with Medicaid already work full- or part-time
- 12% reported not working due to caregiving responsibilities at home
- 11% reported not working due to disability or illness
- 7% reported not working due to school attendance
- 7% reported not working due to retirement, inability to find work, or another reason.

In other words, the overwhelming majority of Medicaid recipients are already working or in school. A small percentage are not working because of their role as caregivers in their family or an inability to work because of disability. And an even smaller percent — the most small percentage of all Medicaid recipients — are simply not working, for a number of reasons.

Health and education are key factors in determining Medicaid recipients' ability to work. 69% of recipients who report their health as being excellent or good are currently working. Same goes for 64% who report their health as being good. Likewise, 72% of those with a Bachelor's

degree or higher are working. Over 60% of those with some college or a high school diploma are working, and over half of those with some high school are working.

How would work requirements impact Medicaid recipients?

It is predicted that between 1.5 to 4.1 million people could lose their Medicaid coverage if work requirements were implemented nationwide.

While the majority of Medicaid recipients already work full-time (35 hours a week or more) for the entire year (at least 50 weeks), many Medicaid adults do not use the computer, the internet, or email. This could be a major barrier for reporting work, even among those already working. Considering that there are high rates of functional disability and serious medical conditions among adults on Medicaid, especially among those not working, losing Medicaid coverage because of the inability to access a computer or internet could be devastating.

And considering that the implementation of work requirements in state Medicaid programs is now shown to increase employment rates or the availability of employer-based health coverage, loss of coverage because of work requirements could actually result in an increased inability to work — and increased uncompensated healthcare by providers.

Conclusion

This paper argues that if medical education journals are to continue developing academic legitimacy, the discipline must be able to engage in epistemological discussions about the nature of the knowledge medical education research seeks to create. Developing an increased awareness of the paradigms in use within the field is important because we need to demonstrate that significant decisions regarding the provision of medical education and health care are based on a critical understanding of the nature of knowledge itself. The paper argues that research methodology is not simply about data collection strategies, but, more importantly, that it addresses the philosophical beliefs that determine the nature of the research design. Articulating these underlying assumptions is central to the research task if we are to be able to critically engage with the findings.

Perhaps most importantly, the study advances the field of LTSS program evaluation by providing a tool to policy makers to monitor the relative efficiency of various LTSS programs. The study shows that it is possible to measure and compare the efficiency of Medicaid provided LTSS across states and over time. This is particularly important as the US implements health system reforms. We intend to extend this analysis with finer grained data on beneficiary characteristics and quality outcomes, as such data become available. We hope that this study encourages state Medicaid agencies to invest in the development of improved data sources and estimation methods, with the overall objective to stimulate action that will improve the performance of LTSS systems and contribute to improving the welfare of people.

Research Results

The research reached several conclusions:

Health care costs in the United States are disproportionately high for many reasons.

Many factors, especially new and expensive diagnostic tests and treatments, contribute to rising health care costs.

Using these new tests and treatments may not necessarily improve health.

In the United States, administrative costs, mostly related to private insurance, account for between 20% and more than 30% of healthcare costs.

Reducing physician fees is not likely to reduce healthcare costs much.

Perhaps the increasing age of the population of the United States of America did not contribute much to the increase in material health burdens, but it may increase these burdens as children born in the baby boom period reach old age.

The use of new types of diagnostic tests and treatments may contribute to health care costs more than any other factor. The use of these

procedures or treatments can be justified or not, but either way it increases health care costs.

Because drug development costs a lot of money, drug companies are discouraged from developing less profitable drugs, such as vaccines, drugs used to treat rare disorders, or even antibiotics. This can negatively affect public health by limiting the number of drugs and vaccines available to prevent types of infection. Serious infections and their treatment.

The provision of care by specialists is increasing, partly because the number of primary care physicians is declining, and partly because more and more patients are seeking to consult a specialist directly.

Specialty care is often more expensive than primary care. Specialist doctors are paid more and may order tests that primary care doctors are not.

On the other hand, patients with more than one medical condition may need more than one specialist doctor to evaluate and treat their conditions, while a single primary care physician may be able to do all of this alone.

It is estimated that administrative costs range from 20 to 30% of the total healthcare cost. Most of these costs come from private insurance companies. But the Affordable Care Act now limits the amount that private insurers can spend on administration. Private insurers also spend a lot of money on marketing and evaluating policy applicants to identify those with pre-existing or potential future disorders. Of course. However, these measures do not improve health care. Having patients deal with numerous private insurance programs increases administrative costs for health care providers by making processes (such as filing claims and coding) more complex and time-consuming.

Tests and procedures that are taken to protect a doctor against lawsuits for malpractice and do not have a direct impact on the patient's health (called defensive medicine)

Physicians and other health care providers and organizations, drug companies, and medical device manufacturers pay premiums to insurance companies for malpractice insurance. These premiums cover claims

settlements, overheads, and profits for malpractice insurance companies. Ultimately, these costs are passed, at least in part, to the government and/or healthcare beneficiaries.

The total money spent on malpractice insurance premiums each year is only about 0.3% of total health care costs. Also, the total money spent on malpractice compensation is a smaller proportion of health care costs. Thus, any significant reduction Medical malpractice compensation will not reduce health care costs significantly, although it may be of great benefit to some physicians.

Defensive medicine refers to tests or treatments that a doctor performs to protect himself and other health care providers from prosecution for malpractice. These tests or treatments may not be justified based on the patient's condition. For example, a doctor may admit a patient to the hospital Even if it can be treated well on an outpatient basis.

It is difficult to determine the total cost of defensive medicine. Few well-designed studies have been conducted to estimate these costs, and their estimates vary widely. The difficulty in determining costs is partly because defensive medicine is known to be biased. In other words, it depends on the clinician's decision as to whether Whether or not a test is necessary Doctors can differ widely, medically or legally, in making a decision for a particular patient. There are only a few cases in which clear rules for testing can be followed.

It is also not clear whether reducing the amount of compensation paid to patients who sue doctors for medical errors will reduce the costs of treatments.

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