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AN INTRODUCTION TO MEDICAID

What Is Medicaid?

Created by Congress in 1965, Medicaid is a public insurance program that provides health coverage and long-term care coverage to low-income families and individuals, including children, parents, the elderly, and people with disabilities. Medicaid is funded jointly by the federal government and the states.

Each state operates its own Medicaid program within federal guidelines. Because the federal guidelines are broad, states have a great deal of flexibility in designing and administering their programs. As a result, Medicaid eligibility and benefits can and often do vary widely from state to state.

Today, Medicaid helps nearly 60 million low-income Americans, including:

- 28 million children;
- 16 million adults (mostly low-income working parents);
- 6 million seniors; and
- 10 million persons with disabilities.

Children account for about half of all Medicaid enrollees but less than one-fifth of Medicaid spending. Only about one-quarter of Medicaid enrollees are seniors or persons with disabilities, but because these beneficiaries need more (and more costly) health-care services, they account for over two-thirds of all Medicaid spending.

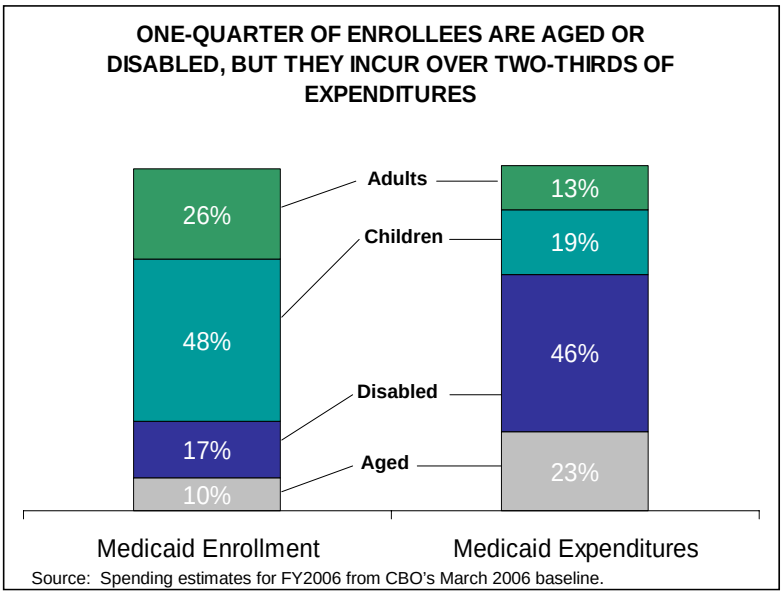
Medicaid is sometimes confused with Medicare, the federally administered, federally funded health insurance program for people aged 65 and over. Unlike Medicaid, Medicare is not limited to those with low incomes and resources. About 7 million low-income elderly and disabled Americans — so-called "dual eligibles" — are enrolled in both Medicare and Medicaid.

Who Is Eligible for Medicaid?

Medicaid is an "entitlement" program, which means that anyone who meets federal and state eligibility rules has a right to receive Medicaid coverage. It also means that states have guaranteed federal financial support for part of the cost of their Medicaid programs.

In order to receive guaranteed federal funding, states must cover certain "mandatory" populations:

- children under age 6 with income below 133 percent of the federal poverty line (in 2006, the poverty line is $16,600 for a family of three);
- children aged 6-18 with income below the poverty line;
- pregnant women with income below 133 percent of the poverty line;



- parents whose income is within the state's eligibility limit for cash assistance through the Temporary Assistance for Needy Families (TANF) program; and
- most elderly persons and persons with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

States may also receive federal Medicaid funds for the costs of covering additional, "optional" populations, including:

- pregnant women, children, and parents with income above "mandatory" coverage income limits;
- elderly persons and persons with disabilities with income below the poverty line; and
- "medically needy" people — those whose income exceeds the state's regular Medicaid eligibility limit but who have high medical expenses (such as for nursing-home care) that reduce their disposable income to below the eligibility limit.

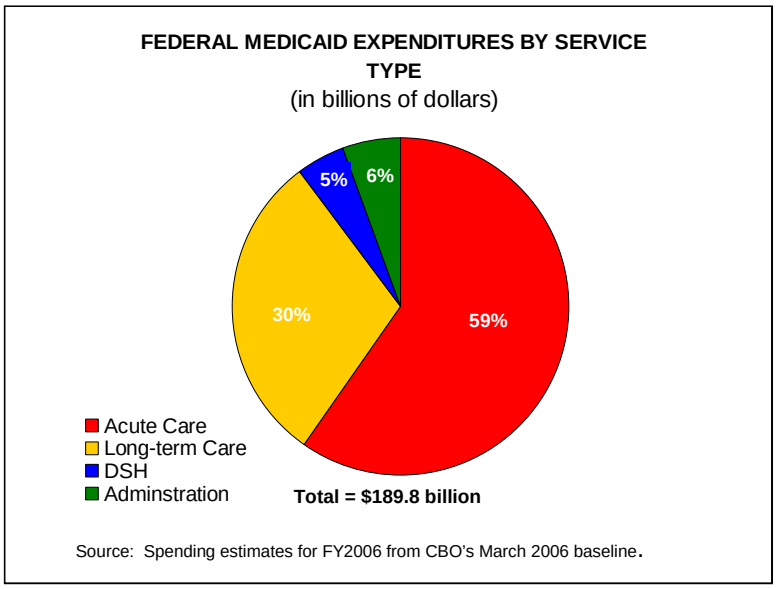
Every state covers at least one of these "optional" groups. Because states have such broad flexibility to determine which groups they will cover and at what income levels, Medicaid eligibility varies significantly from state to state.

Not all low-income Americans are eligible for Medicaid. In particular, childless adults — that is, those over 21 who are not disabled, not pregnant, and not elderly — are generally not eligible for Medicaid, no matter how poor they are. In addition, legal immigrants are barred from Medicaid for their first five years in this country, even if they meet all of the program's eligibility requirements.

Medicaid is a "counter-cyclical" program. In other words, its enrollment expands to meet rising needs during an economic downturn, when people lose their jobs and their job-based health coverage. That is what happened during the last recession: if Medicaid enrollment had not

increased in response to the loss of employer-based coverage, more than 1 million additional adults would have become uninsured.

What Services Does Medicaid Cover?



Medicaid is an insurance program. It pays hospitals, physicians, nursing homes, and other health-care providers for covered services that they deliver to eligible patients; it does not provide health care directly.

About 60 percent of all Medicaid spending pays for acute-care services such as hospital care, physician services, and prescription drugs; another 30 percent pays for nursing home and other long-term care services. More than half of all nursing-home residents are covered by Medicaid, which pays nearly half of the nation's total costs for long-term health care.

Medicaid also reimburses certain hospitals for the uncompensated costs they incur when they care for uninsured patients. These payments, known as disproportionate share hospital (DSH) payments, account for about 5 percent of Medicaid spending. Finally, about 5 percent of Medicaid spending reflects administrative costs.

Federal rules require state Medicaid programs to cover certain "mandatory" services, such as: physician, midwife, and certified nurse-practitioner services; in-patient and out-patient hospital services; laboratory and x-ray services; family-planning services and supplies; nursing home and home health care; and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21. EPSDT guarantees that enrollees under age 21 have access to medically necessary services, regardless of whether the state's Medicaid program covers these services for other populations.

States can — and all states do — cover certain additional services as well. Common examples include prescription drugs, dental care, vision services, hearing aids, and personal-care services for the frail elderly or others with long-term care needs. These services, though listed as "optional" because states are not required to provide them, are critical to meeting the health needs of Medicaid beneficiaries.

States have flexibility to determine the amount, duration, and scope of the services they provide under Medicaid. For example, states must cover hospital and physician services, but they can limit the number of hospital days or physician visits they pay for. As a result of this flexibility, Medicaid benefits packages vary substantially from state to state.

The recently enacted Deficit Reduction Act of 2005 (DRA) gave states even more flexibility, permitting them to replace the existing Medicaid benefit package for some children and adults with scaled-back benefits. However, states still must follow traditional Medicaid coverage rules for certain populations, such as the disabled.

The DRA also weakened the protections built into Medicaid to ensure that low-income beneficiaries can afford health care. Historically, federal rules have barred states from imposing co-payments (fees that beneficiaries pay in exchange for health-care services) on certain beneficiaries, such as children; federal rules also strictly limited the amount of co-payments that states could impose on other beneficiaries. The DRA, however, allows states to increase co-payments substantially and to impose co-payments on certain populations previously exempt from them. The DRA also allows states to permit health-care providers to deny services to beneficiaries who cannot pay the required co-payments. The Administration is encouraging states to use the new DRA flexibility, and a number of states have done so.

Hospitals, physicians, and other health-care providers are not required to participate in Medicaid, and not all do so. State Medicaid programs each have their own way of reimbursing providers for services. Some states pay providers directly for the services they furnish, while others contract with managed plans, which in turn pay the hospitals, physicians, and other providers in their networks. (Some states do both.) Nationally, over half of all Medicaid beneficiaries, mostly children and parents, are enrolled in managed-care plans.

How Is Medicaid Financed, and How Much Does It Cost?

The federal government contributes at least $1 in matching funds for every $1 a state spends on its Medicaid program. The federal matching rate varies from state to state, with poorer states receiving larger federal amounts for each dollar they spend than wealthier states. In the poorest states, the federal government pays 77 percent of all Medicaid costs; the national average is about 57 percent.

Together, states and the federal government are projected to spend about $330 billion on Medicaid in fiscal year 2006. State policies have a large impact on the amount the federal government spends on Medicaid, not only because states are guaranteed federal Medicaid matching funds for the costs of covered services furnished to eligible individuals, but also because states have broad discretion to determine who is eligible, what services they will cover, and what they will pay for covered services.

Medicaid spending is projected to increase 7 percent per year over the next decade. Medicaid costs are growing primarily because the number of low-income Americans eligible for the program is growing and because inflation is driving up the cost of the services Medicaid buys, especially hospital care and prescription drugs. Medicaid, however, has been more effective than private health insurance companies at controlling costs. Studies show that in recent years, costs per beneficiary have been rising less rapidly in Medicaid than in private insurance.

Medicaid's Partner: The State Children's Health Insurance Program (SCHIP)

SCHIP gives states matching federal funds to provide health coverage to children in families whose income is modestly above Medicaid limits, typically up to 200 percent of the poverty line (or roughly $33,000 for a family of three). About 4 million children receive health coverage through SCHIP. Some states also use SCHIP funds to cover low-income adults, such as parents or pregnant women.

Between 1998 and 2004, the percentage of children who are uninsured fell from 15.4 to 10.8 percent, even though the percentage of children with private health coverage *declined* during this period. The reason for this progress was the increased enrollment of low-income children in SCHIP and Medicaid.

States can use SCHIP funds to create or expand a separate health insurance program for children and/or to provide coverage to additional children within their Medicaid program. Eighteen states use SCHIP funds solely to operate separate SCHIP programs, 11 states plus the District of Columbia use SCHIP funds solely to expand Medicaid, and 20 states rely on a combination approach.

To encourage states to take full advantage of federal SCHIP funds and provide low-income children with needed health coverage, SCHIP's matching rate is more favorable to states than the Medicaid rate is. The federal government pays 70 percent of states' SCHIP-related costs, on average, compared to 57 percent of states' Medicaid costs.

However, federal SCHIP funds, unlike federal Medicaid funds, are capped; they do not rise automatically to help states compensate for increases in health-care costs or caseloads. As a result, in fiscal year 2007 an estimated 17 states will have insufficient SCHIP funds to sustain their existing programs. If Congress does not act to add more funds, states may be forced to deal with shortfalls by closing new enrollment or cutting some people off the program (unlike Medicaid, SCHIP is not an entitlement program) or by scaling back benefits significantly.

SCHIP is also unlike Medicaid in that it is not part of permanent law; it will expire at the end of fiscal year 2007 if Congress does not reauthorize it. As Congress considers reauthorization, it will be important to ensure that the program is sufficiently funded to allow children currently enrolled in SCHIP to retain coverage as well as to allow states to cover more uninsured children.

How Effective Is Medicaid?

Medicaid pays for over one-third of all births in the United States each year and provides health coverage to one in every four American children. Medicaid also covers 20 percent of low-income adults and 60 percent of all nursing-home residents.

Medicaid has greatly reduced the number of Americans without health insurance. If Medicaid did not exist, most of the more than 50 million Americans whose health coverage comes solely through Medicaid would join the ranks of the 47 million Americans who are uninsured. This is because private health insurance is generally not an option for Medicaid beneficiaries: many low-income workers do not have access to coverage through their jobs, and people with disabilities or chronic illnesses are often unable to obtain private coverage at any price because of their pre-existing medical conditions.

Medicaid coverage provides low-income Americans with access to needed preventive services and medical care. For example, studies have shown that Medicaid helps patients with chronic diseases such as heart disease, diabetes, and asthma receive medical care that can prevent their condition from worsening. People who have lost Medicaid coverage are two to three times more likely than Medicaid beneficiaries to report going without medical care because they cannot afford it.

Numerous studies also show that by improving access to preventive and primary care and by protecting against (and providing care for) serious diseases, Medicaid has helped make millions of Americans healthier. For example:

- Expansions of Medicaid eligibility for low-income children in the late 1980s and early 1990s led to a 5.1-percent reduction in childhood deaths.

- Expansions of Medicaid coverage for low-income pregnant women led to an 8.5-percent reduction in infant mortality and a 7.8-percent reduction in the incidence of low birth weight.

For more information about Medicaid, including state-by-state information on benefits, eligibility, and spending, see http://www.kff.org/medicaid/index.cfm.