Teaching Medicaid: A Tool for Health Law Teachers (2004 Update)

Prepared for the 2004 Health Law Teachers Conference

(available electronically at http://www.gwhealthpolicy.org/news.htm)

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Figure 1

Topics

- **Medicaid's role as a health insurer: major themes**
- **Eligibility and services**
- **Where do Medicaid expenditures go and how important are they to the health care system?**
- **Medicaid as health care payer and its role in supporting the health care safety net**
- **Medicaid's role in state financing**
- **Medicaid's role as a legal entitlement**
- **Does Medicaid need reform and if so, what should reform accomplish?**

Figure 2

Medicaid's Role as a Health Insurer: Major Themes

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Figure 3

Medicaid's Major Themes

- Markets versus social contract through direct government benefits
- Federalism
- Legal rights versus largesse

Figure 4

Medicaid Versus Private Health Insurance:
A Conceptualization of The Social Contract Theme

Private Health Insurance

Designed to avoid risk and engage in "fair discrimination" to avoid "moral hazard" of higher than actuarially projected use

- Limitations on eligibility (pre-existing condition exclusions and waiting periods)
- Aggressive marketing to best risks
- Limitations on coverage (diagnostic-specific coverage limits, coverage exclusions, high cost sharing, stringent definitions of medical necessity)

Medicaid

Designed to insure the uninsurable (populations and services). The "non-actuarial" insurer

- Eligibility based on poverty, disability, age, pregnancy, illness, and other high risk factors considered uninsurable
- Affirmative, prompt enrollment obligations, even at the point of service; entitlement often linked to illness or medical condition
- Broad defined-benefit coverage rules, limited or no cost sharing, prohibitions against diagnostic discrimination, a broad concept of medical necessity, particularly for children

Figure 5

The Themes of Federalism, Social Contract, and Largesse

- **Federalism**
  - Federal requirements versus state flexibility over coverage design, coverage decisions, provider payment, and administration

- **Private enforceability**
  - Can individuals be said to have “rights” under Medicaid?
  - Are these rights enforceable against state and federal defendants and if so, under what circumstances?
  - Unlike Medicare and employee benefits, no clear legislative provision within the “four corners” of the Medicaid statute authorizing private enforcement of federal rights

Figure 6

Eligibility and Services

Figure 7

Basic Elements of Eligibility

- Connection to one or more federally enumerated, recognized eligibility categories (e.g., age, disability, pregnancy, child <18, parent of child < 18)
- Financial eligibility (income and assets, with complex valuation tests)
- Satisfaction of applicable citizenship or legal residency status
- Satisfaction of federally defined state residency standards

Figure 8

Medicaid Beneficiary Groups

Mandatory Populations

- Children below federal minimum income levels
- Adults in families with children (Section 1931 and TMA)
- Pregnant women ≤133% FPL
- Disabled SSI beneficiaries
- Certain working disabled
- Elderly SSI beneficiaries
- Medicare Buy-In groups (QMB, SLMB)

Optional Populations

- Children above federal minimum income levels
- Adults in families with children (above Section 1931 minimums)
- Pregnant women >133% FPL
- Disabled (above SSI levels)
- Disabled (under HCBS waiver)
- Certain working disabled (>SSI levels)
- Elderly (>SSI; SSP-only recipients)
- Elderly nursing home residents (>SSI levels)
- Medically needy

Figure 9

Sample Medicaid Eligibility Pathways for Women

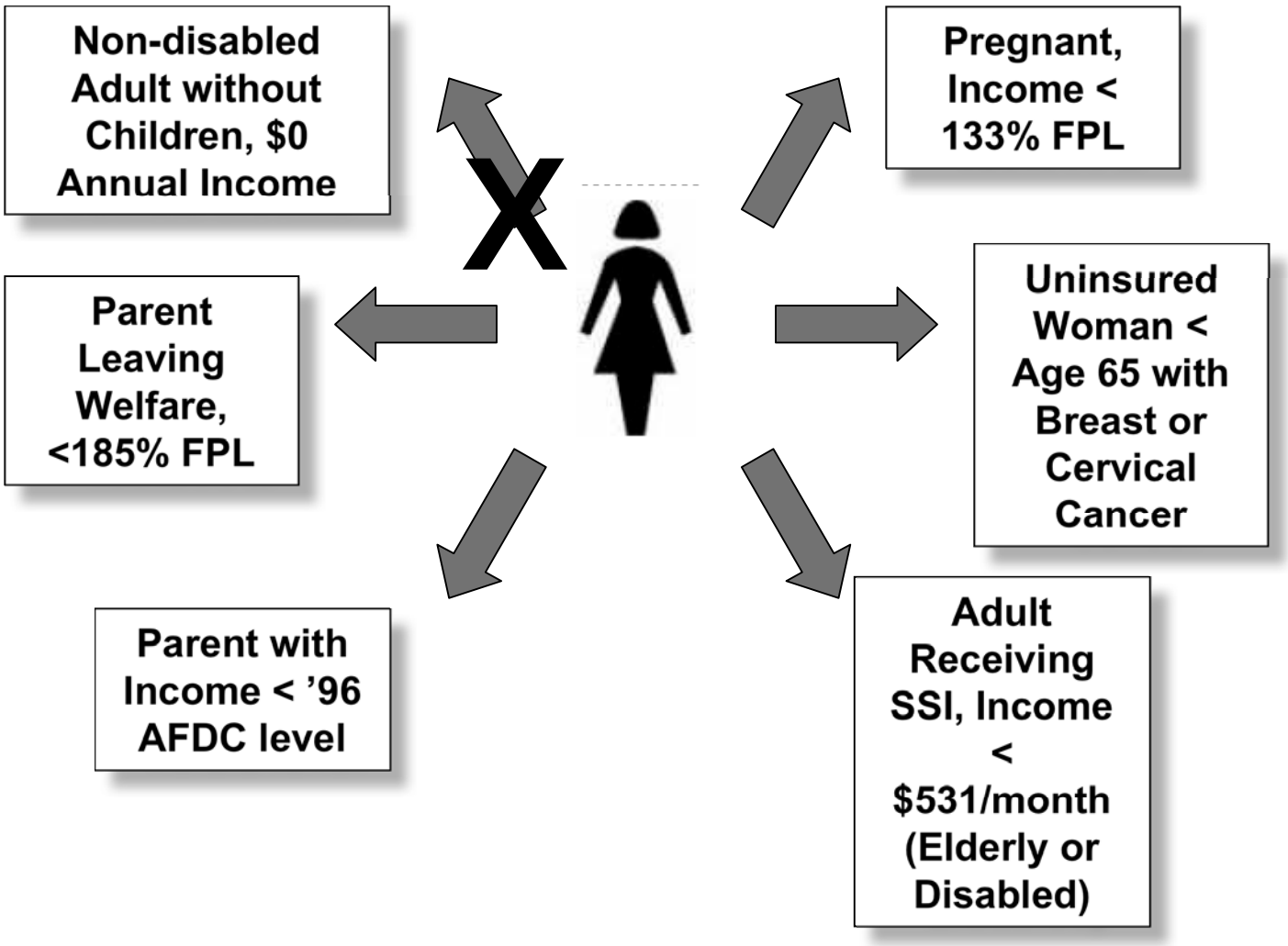

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Figure 10

Sample Medicaid Eligibility Pathways for Men

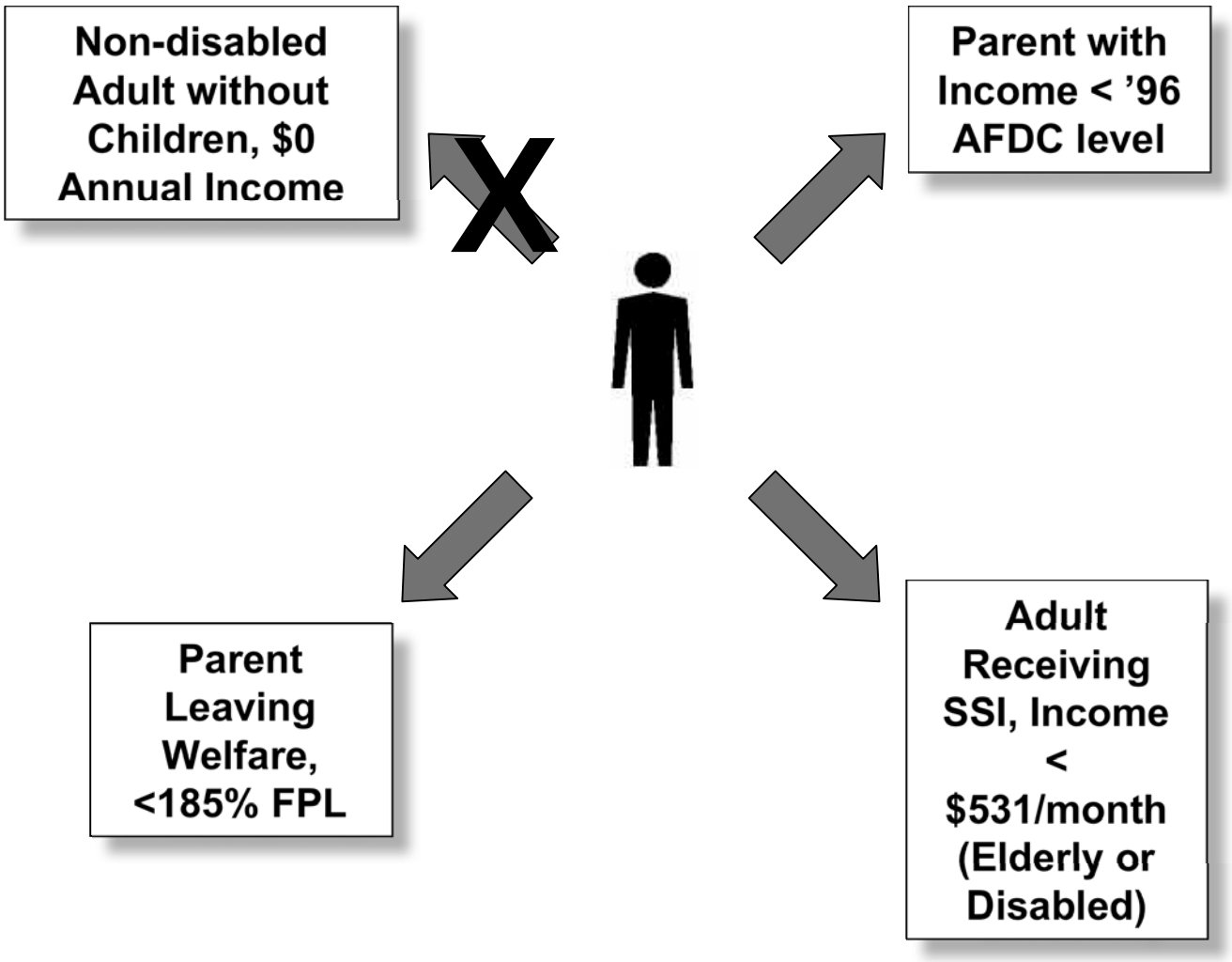
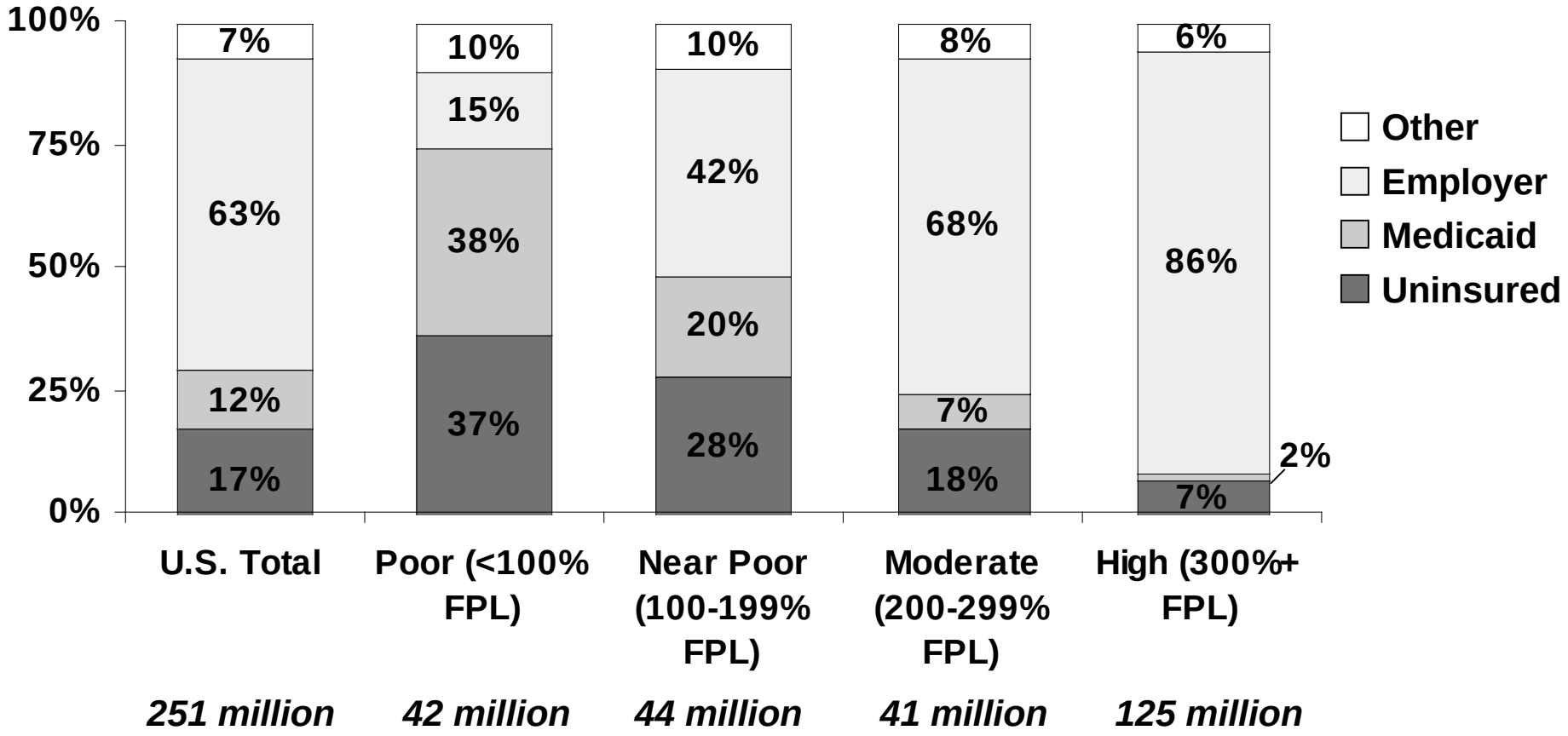


Figure 11

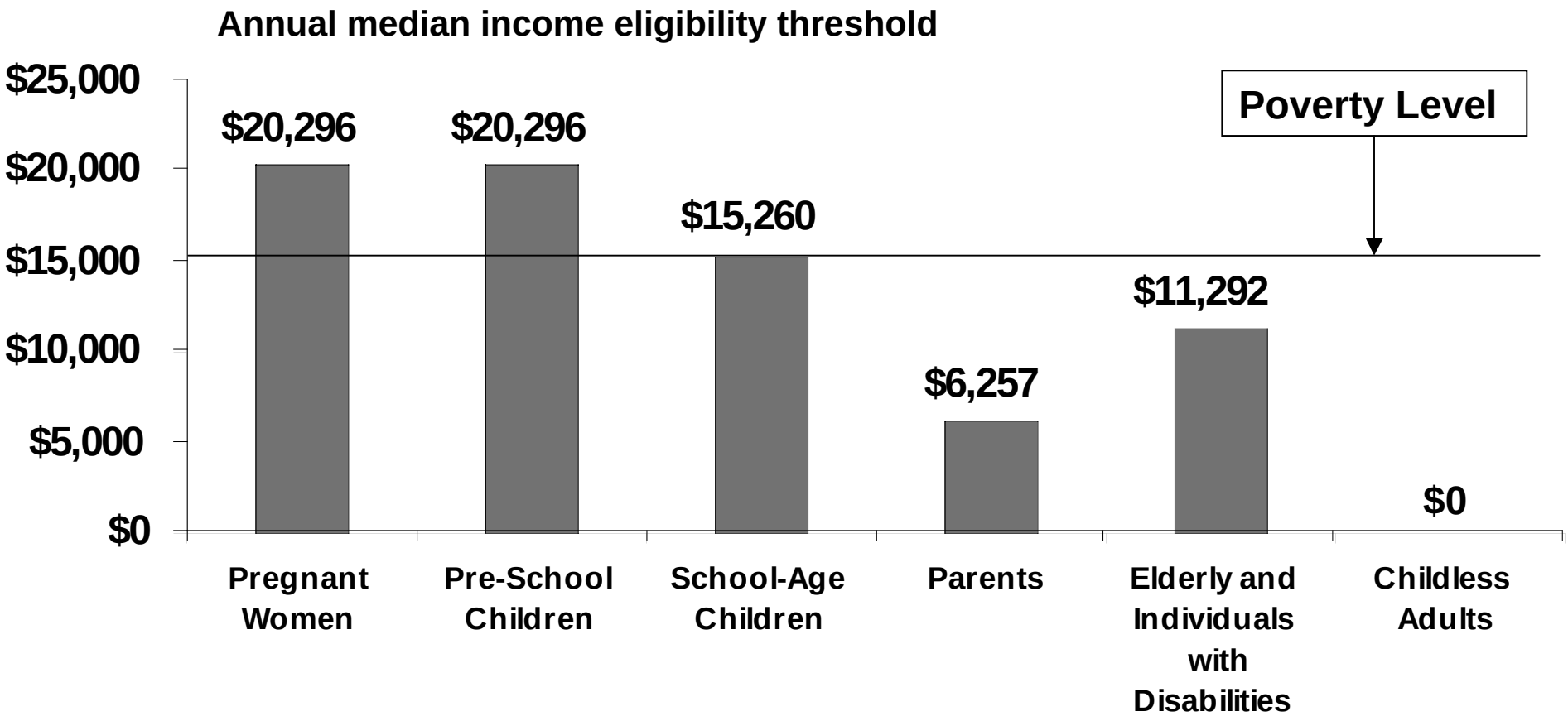
Health Insurance Coverage of Nonelderly Persons by Poverty Level, 2002



Notes: The federal poverty level was $14,348 for a family of three in 2002.
Percentages may not total 100% due to rounding.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of the 2003 Current Population Survey.

Figure 12

Income Eligibility Thresholds for Adults and Children Under Medicaid, 2003



NOTE: Based on a family of three. The federal poverty level was $8,980 for a single person and $15,260 for a family of three in 2003.
Source: Kaiser Commission on Medicaid and the Uninsured, 2004.

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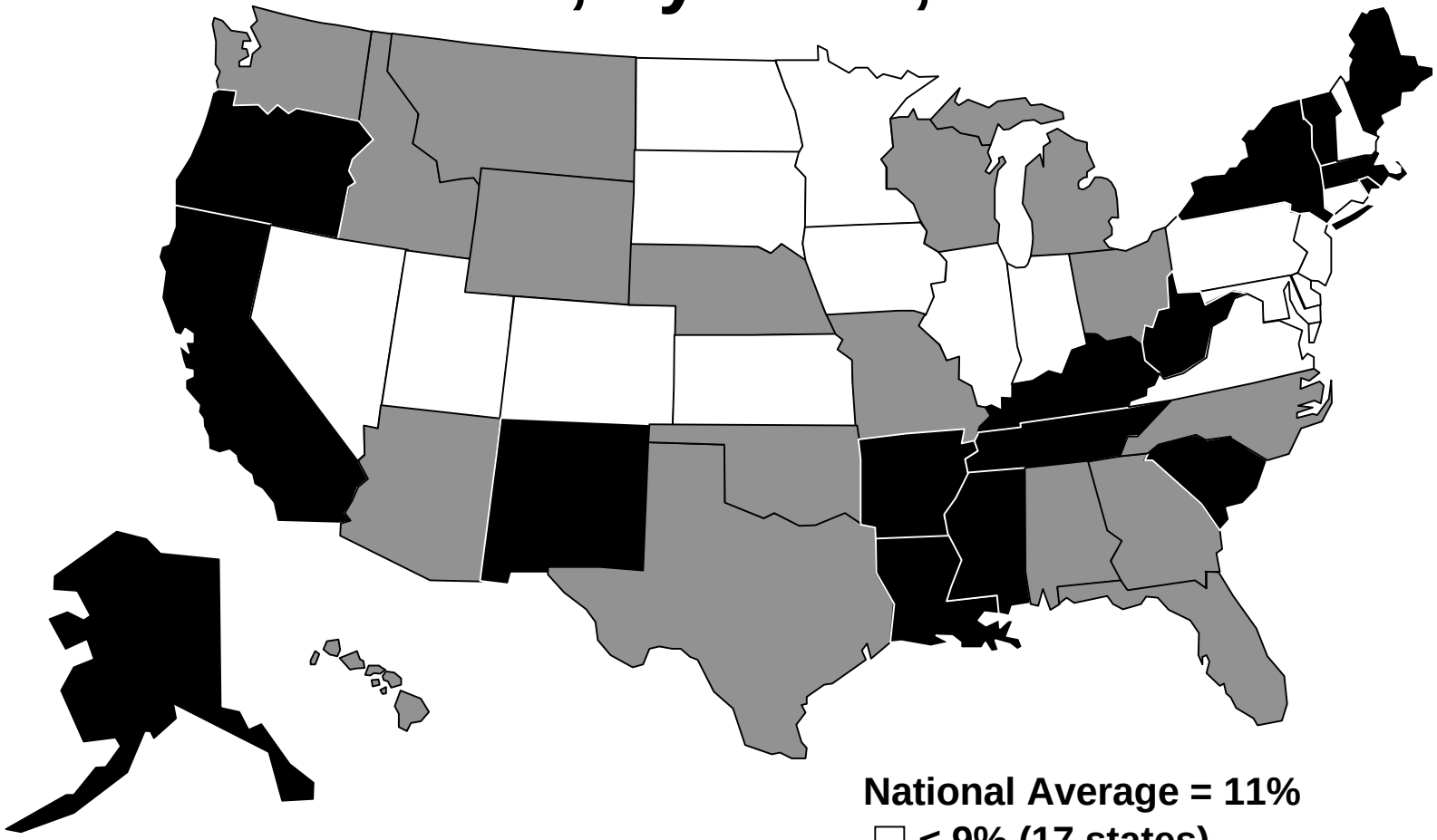
Figure 13

Percent of Residents Covered by Medicaid, by State, 2001-2002



National Average = 11%

- **< 9% (17 states)**
- **9- < 12% (17 states)**
- **≥ 12% (16 states & DC)**

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of two-year pooled data from March 2002 and 2003 Current Population Survey, 2003. Based on total population.

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Figure 14

Required and Optional Benefits

Required Items & Services

- Physicians services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Nursing facility (NF) services for individuals 21 or over

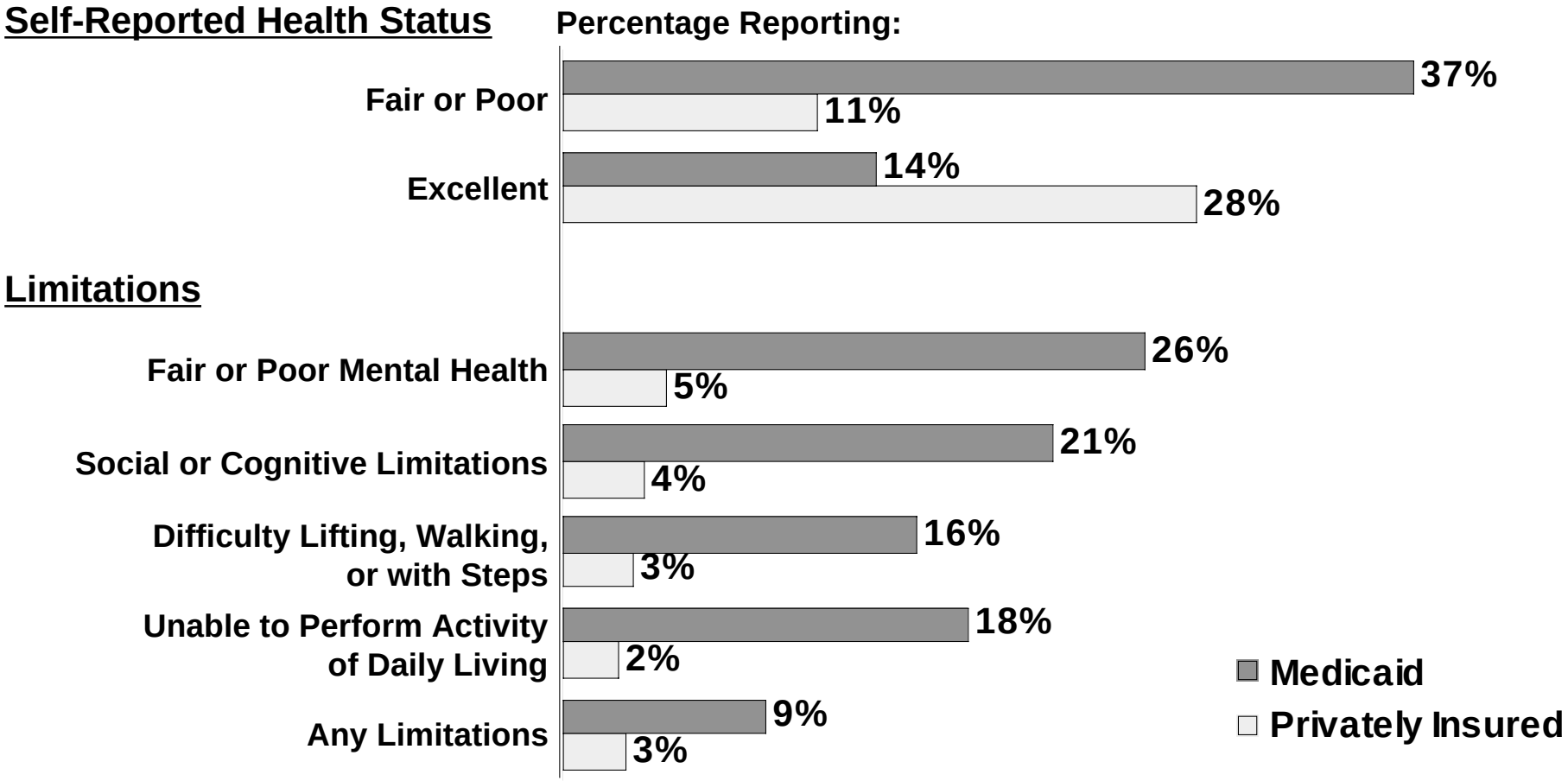
"Optional" Items and Services

- Prescription drugs
- Medical care or remedial care furnished by licensed practitioners
- Diagnostic, screening, preventive, and rehab services
- Clinic services
- Dental services, dentures
- Physical therapy
- Prosthetic devices, eyeglasses
- TB-related services
- Primary care case management
- ICF/MR services
- Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
- Inpatient psychiatric hospital services for individuals under age 21
- Home health care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Private duty nursing services
- Hospice services

Figure 15

Health Status and Functional Limitations of Non-elderly Low Income Adults

Medicaid vs. Privately Insured, 1996-1998



Note: All differences are statistically significant at the 5% level. Low income defined as those with incomes less than 200% of the Federal Poverty Level. Adults defined as age 19-64.

SOURCE: Holahan and Hadley analysis of MEPS data from 1996, 1997, and 1998, prepared for the Kaiser Commission on Medicaid and the Uninsured.

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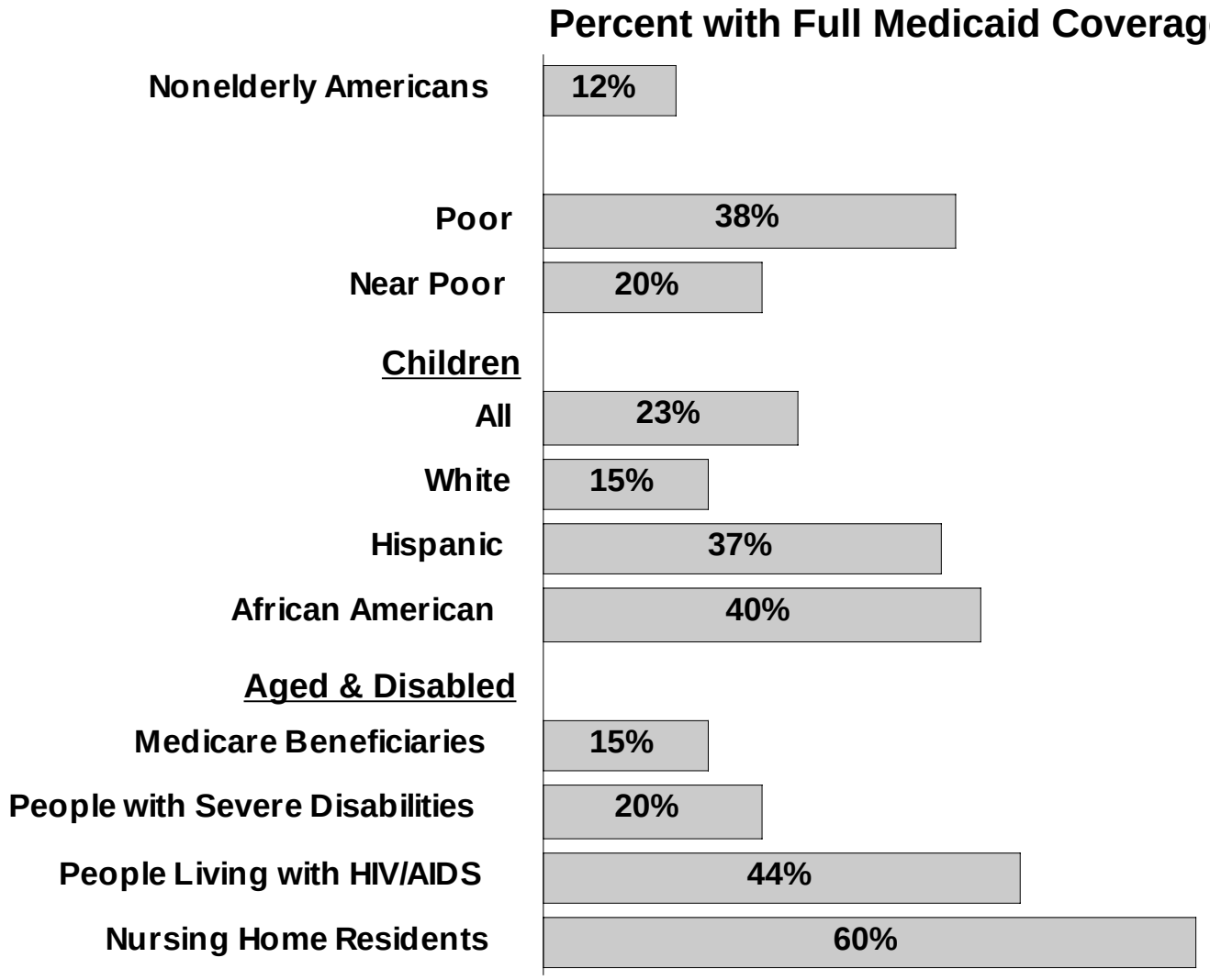
Figure 16

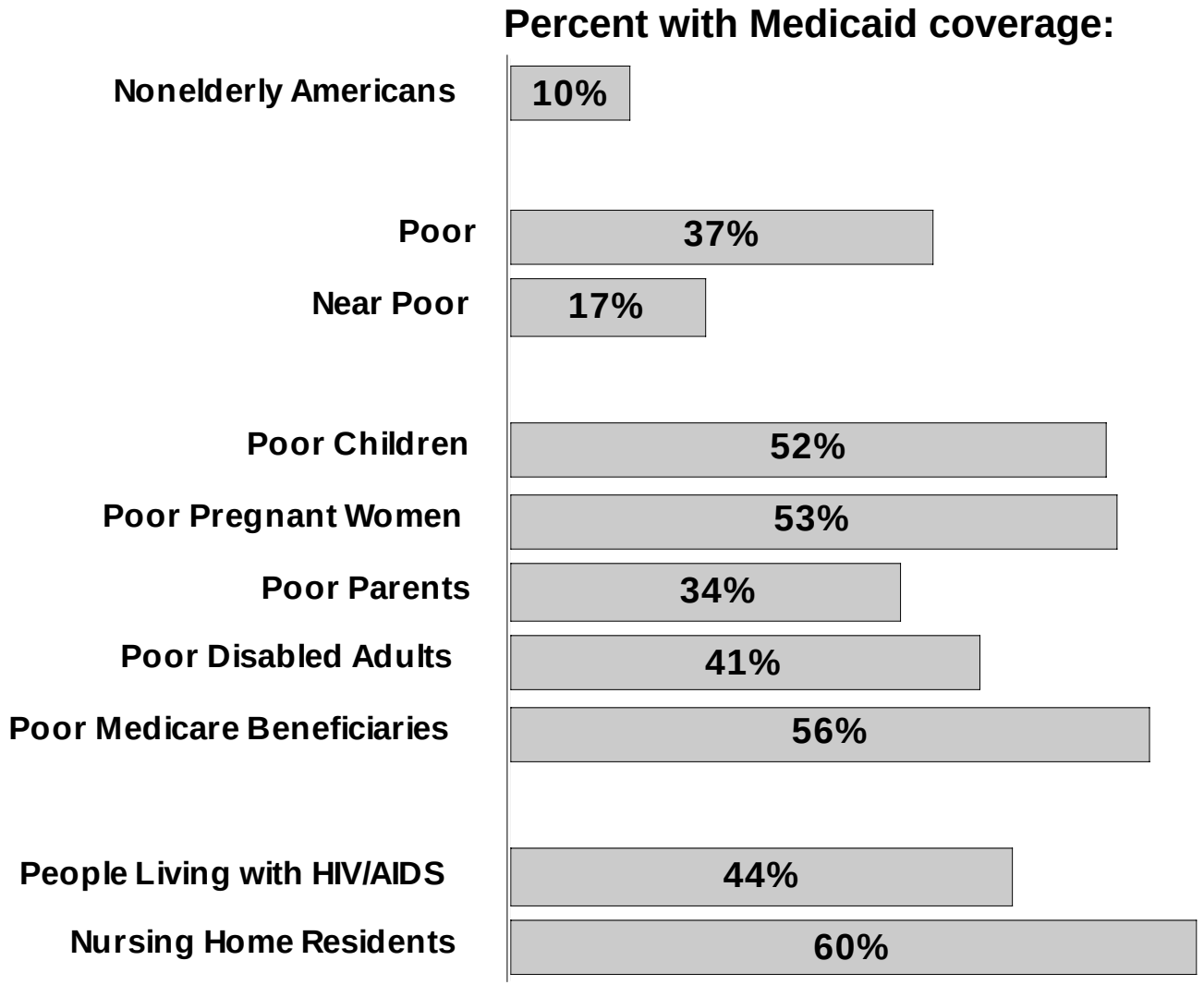
Medicaid's Role for Selected Populations



Note: "Poor" is defined as living below the federal poverty level, which was $14,348 for a family of three in 2002.
SOURCE: Nonelderly, Poor, Near-Poor and Children: KCMU and Urban Institute analysis of the March 2003 Current Population Survey; Aged and Disabled: KFF, KCMU and Urban Institute estimates, 2002 and 2003.

Figure 17

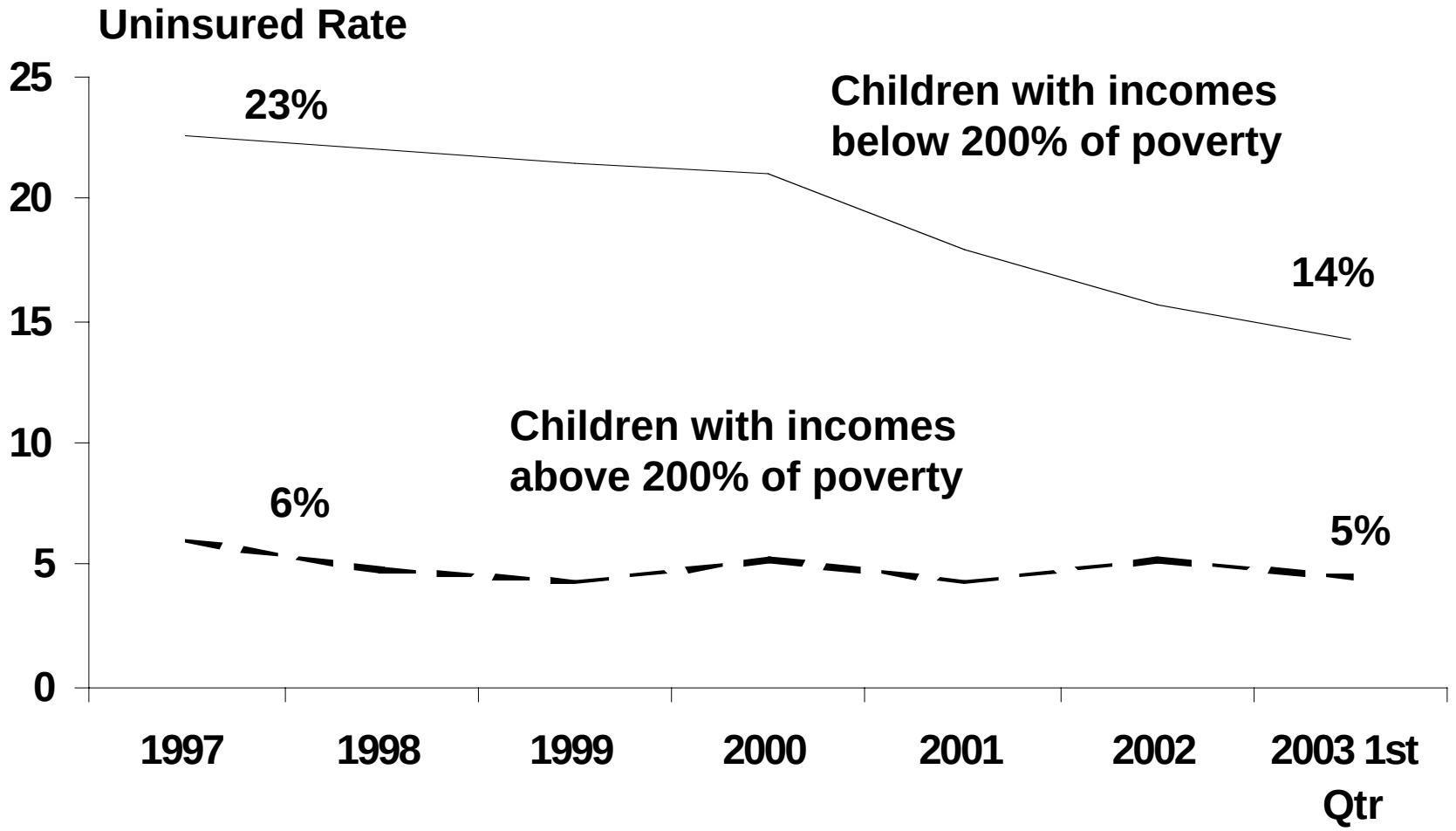
Medicaid's Role for Selected Populations



Note: "Poor" defined as living below the federal poverty level.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, estimates based on the March 2001 Current Population Survey; Thorpe, et al. 1999; Meyer and Zeller, 1999; Kates, 2002; Urban Institute analysis of MCBS, 2002.

Figure 18

Trends in the Uninsured Rate of Children, by Income Level



SOURCE: Center on Budget and Policy Priorities analysis of NHIS data.

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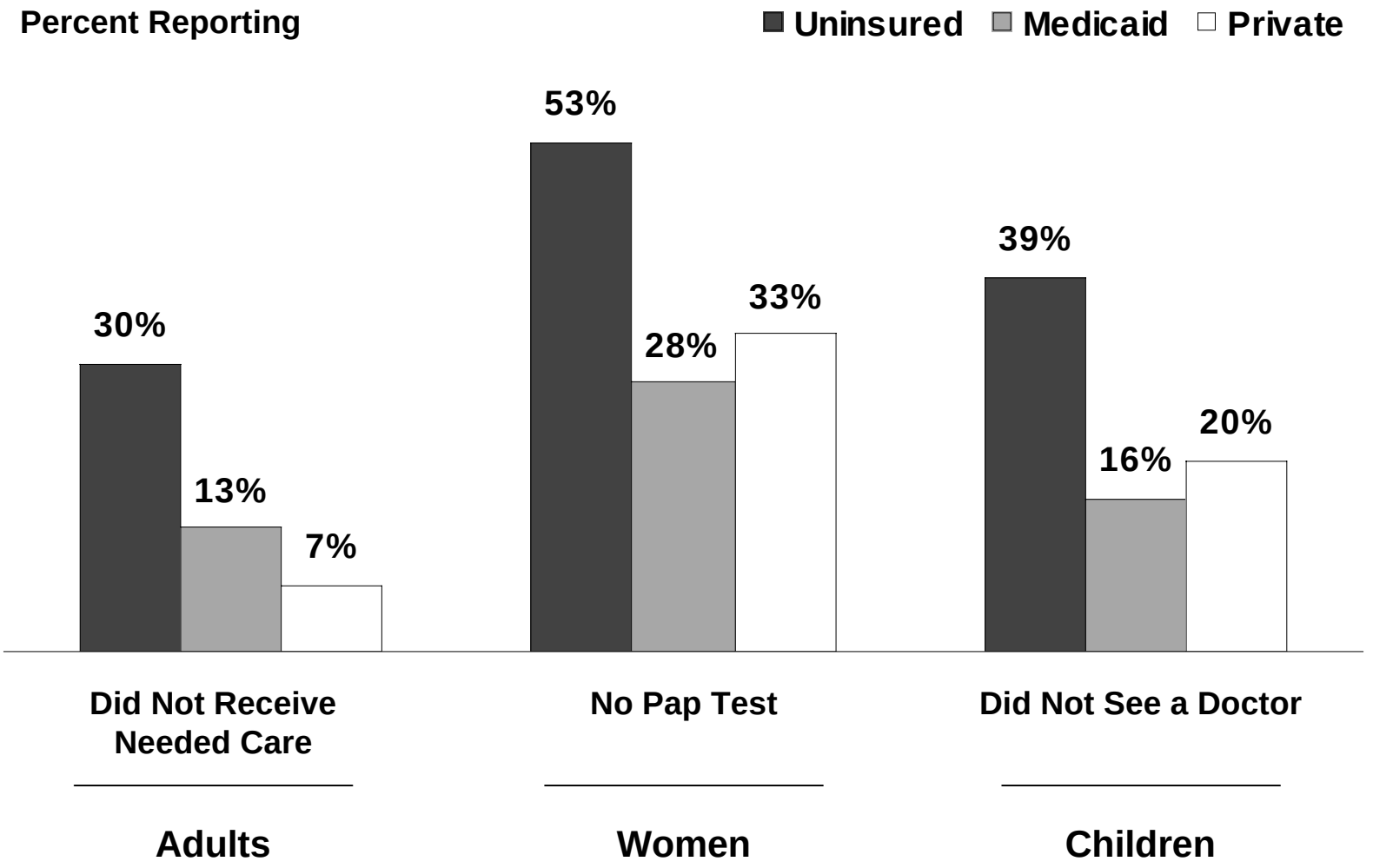
Figure 19

Medicaid's Impact on Access to Health Care



SOURCES: The 1997 Kaiser/Commonwealth National Survey of Health Insurance; Women's Health, The Commonwealth Fund Survey, 1996.

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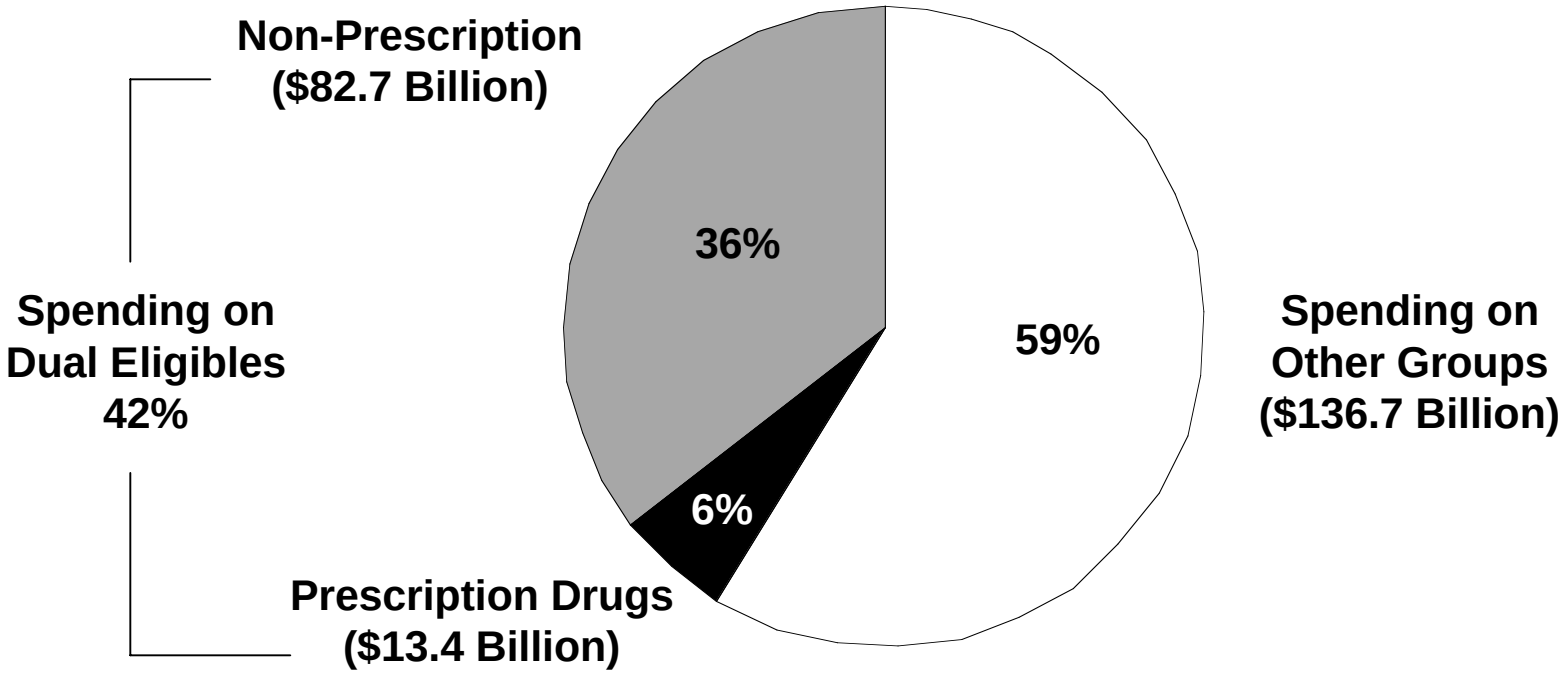
Figure 20

Medicaid's Relationship to Medicare

Figure 21

Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FY2002



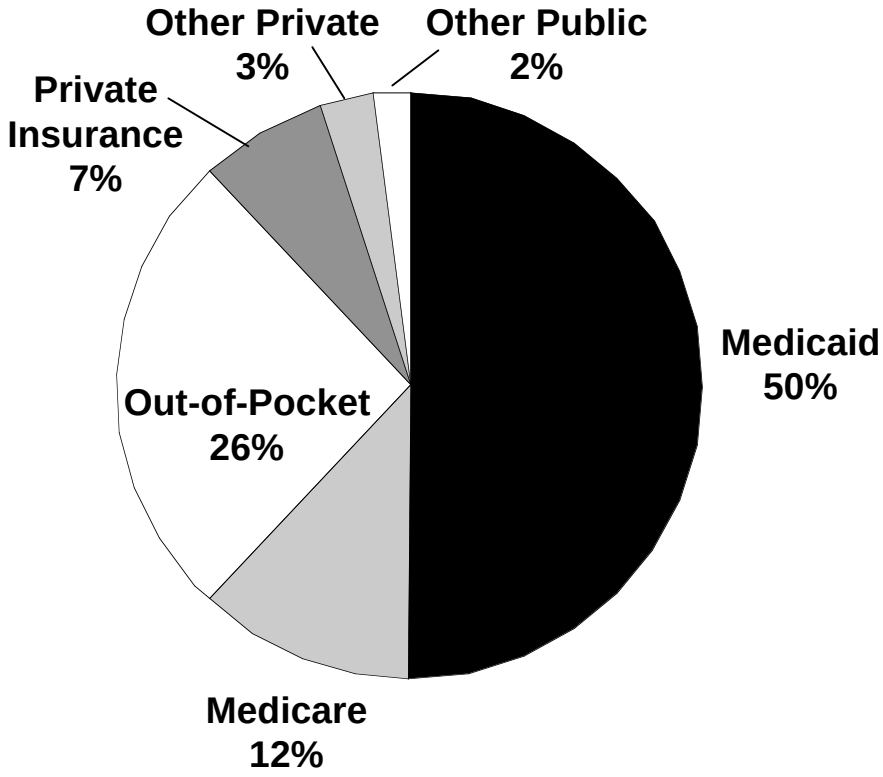
Total Spending on Benefits = $232.8 Billion

NOTE: Due to rounding, percentages do not total 100%.
SOURCE: Urban Institute estimates prepared for KCMU based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.

Figure 22

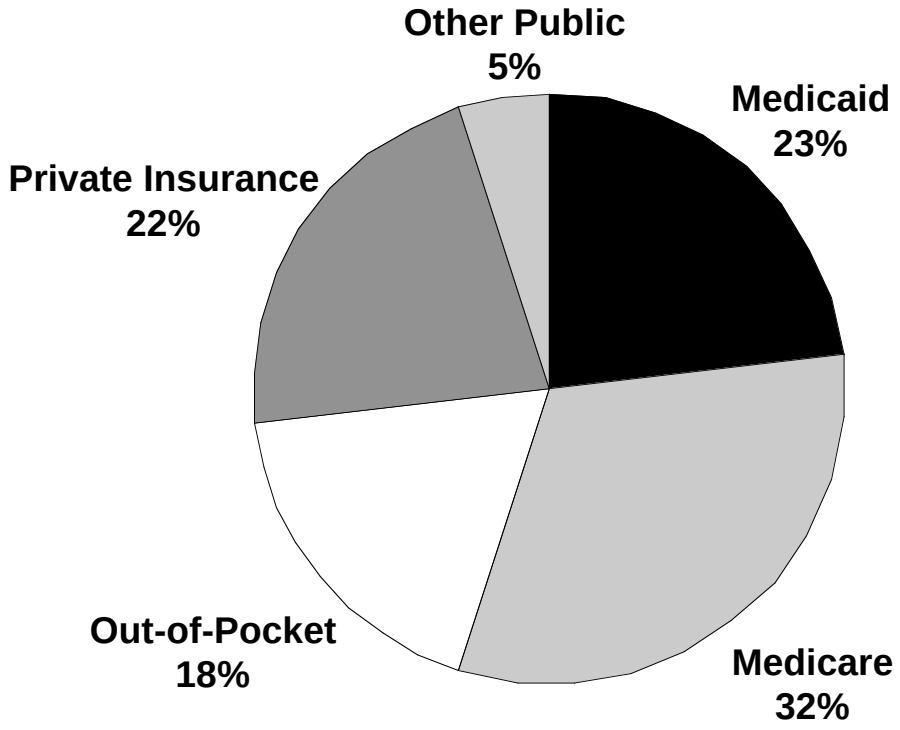
National Spending on Nursing Home and Home Health Care, 2002

Nursing Home Care



Total = $103.2 billion

Home Health Care



Total = $36.1 billion

SOURCE: CMS, National Health Accounts, 2004.

Figure 23

Implications of Provisions in the New Medicare Bill for States

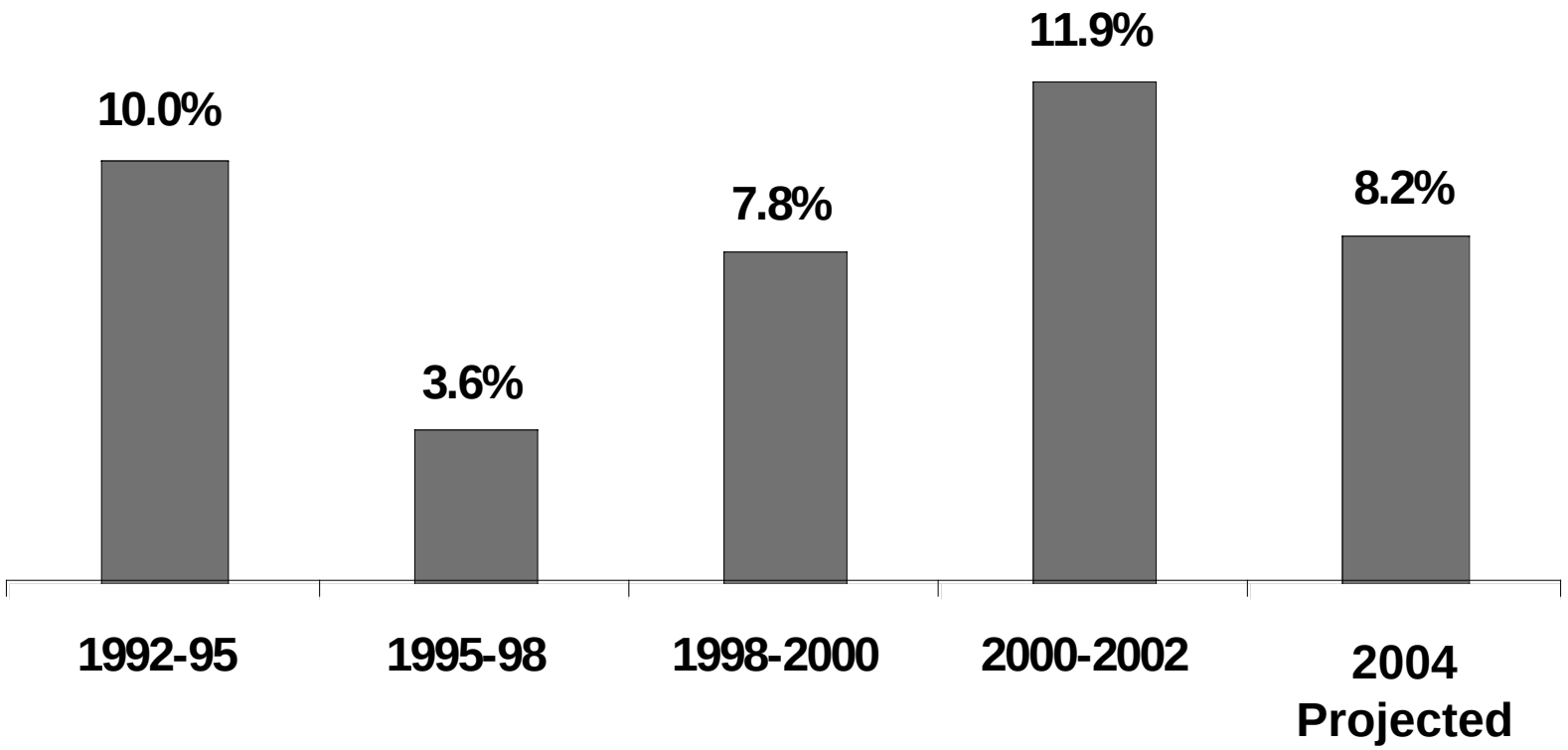
- **Medicare will provide prescription drug coverage to Medicaid beneficiaries who are also enrolled in Medicare (the "dual eligibles")**
  - However, states may not supplement the Medicare prescription drug benefit for dual eligibles through Medicaid. They must instead use state general revenue funds
- **States will be required to make payments to the federal government totaling $115 billion over the next 10 years**
  - Payments are designed to offset the fiscal relief states will receive as a result of no longer providing prescription drugs to dual eligibles under Medicaid
  - Between 2004 and 2006, this provision will cost states $1.2 billion more than they would have otherwise spent. Over 10 years, states will save a total of about $17 billion.
- **States will assume new responsibilities for administering the Medicare prescription drug card in 2004 and the low-income subsidy in 2006**

Figure 24

Where Do Medicaid Expenditures Go, and How Important are They to the Health Care System?

Figure 25

Average Annual Growth Rates of Total Medicaid Spending

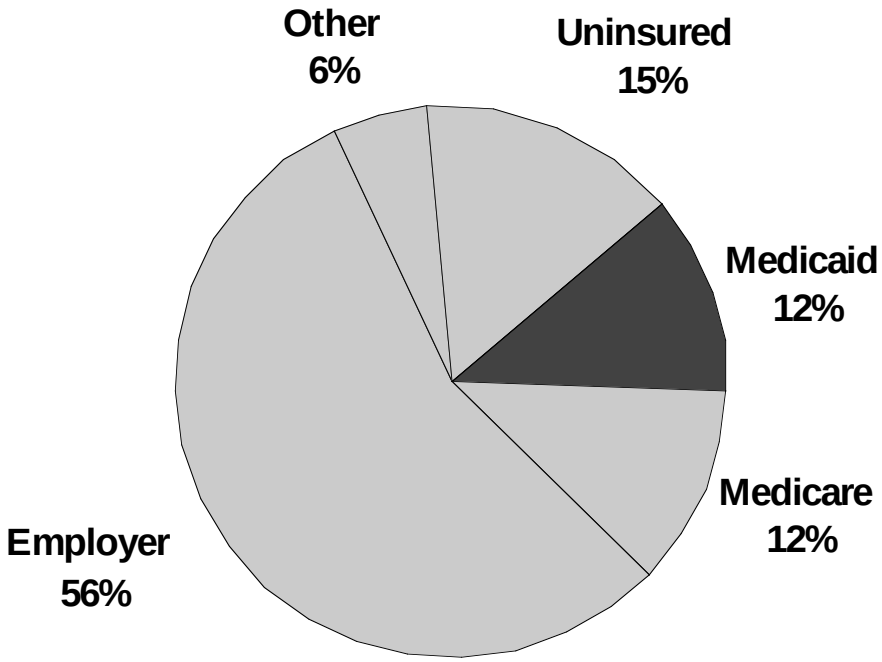


SOURCE: For 1992-2002: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64); For 2003-2004: Health Management Associates estimates based on estimates provided by state officials. FY 2004 estimate is based on state officials' projections for FY 2004.

Figure 26

Medicaid's Role in the U.S. Health System

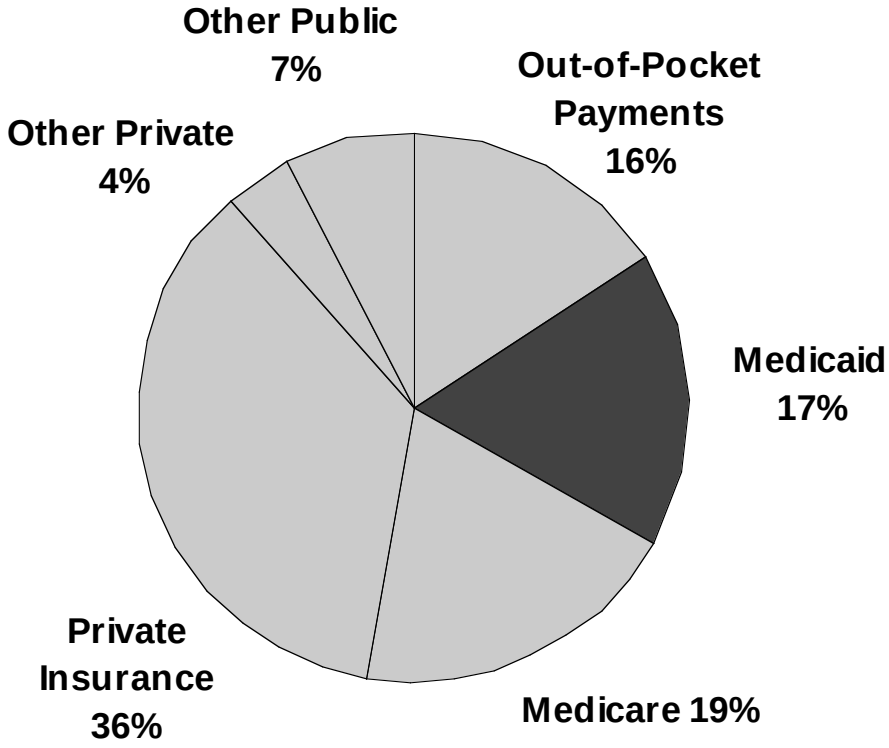
Health Insurance Coverage, 2002



Total Population = 285 Million

Note: Excludes active military members
SOURCE: Urban Institute and Kaiser Commission estimates based on the March 2003 Current Population Survey.

Personal Health Spending, 2002



Total = $1,340 Billion

SOURCE: Levit et al, 2004 based on National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary.

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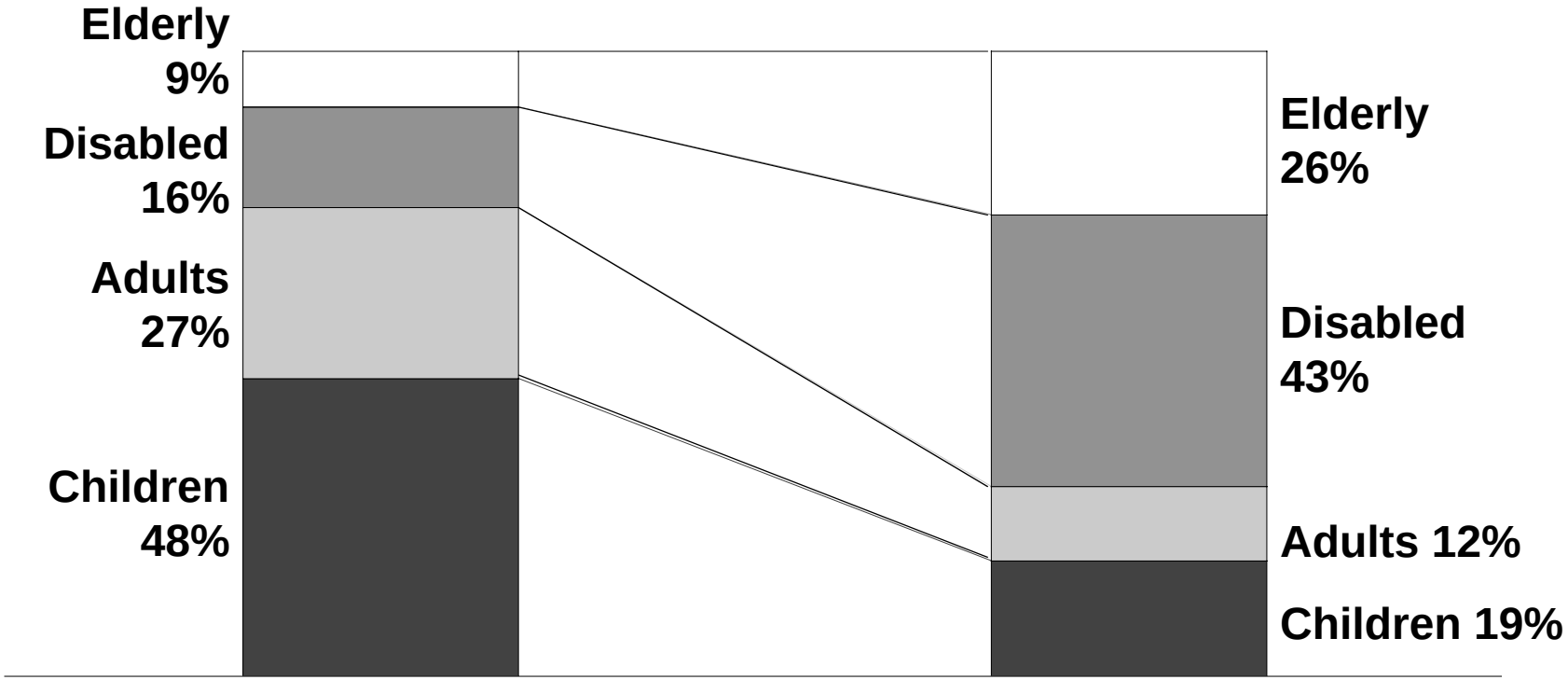
Figure 27

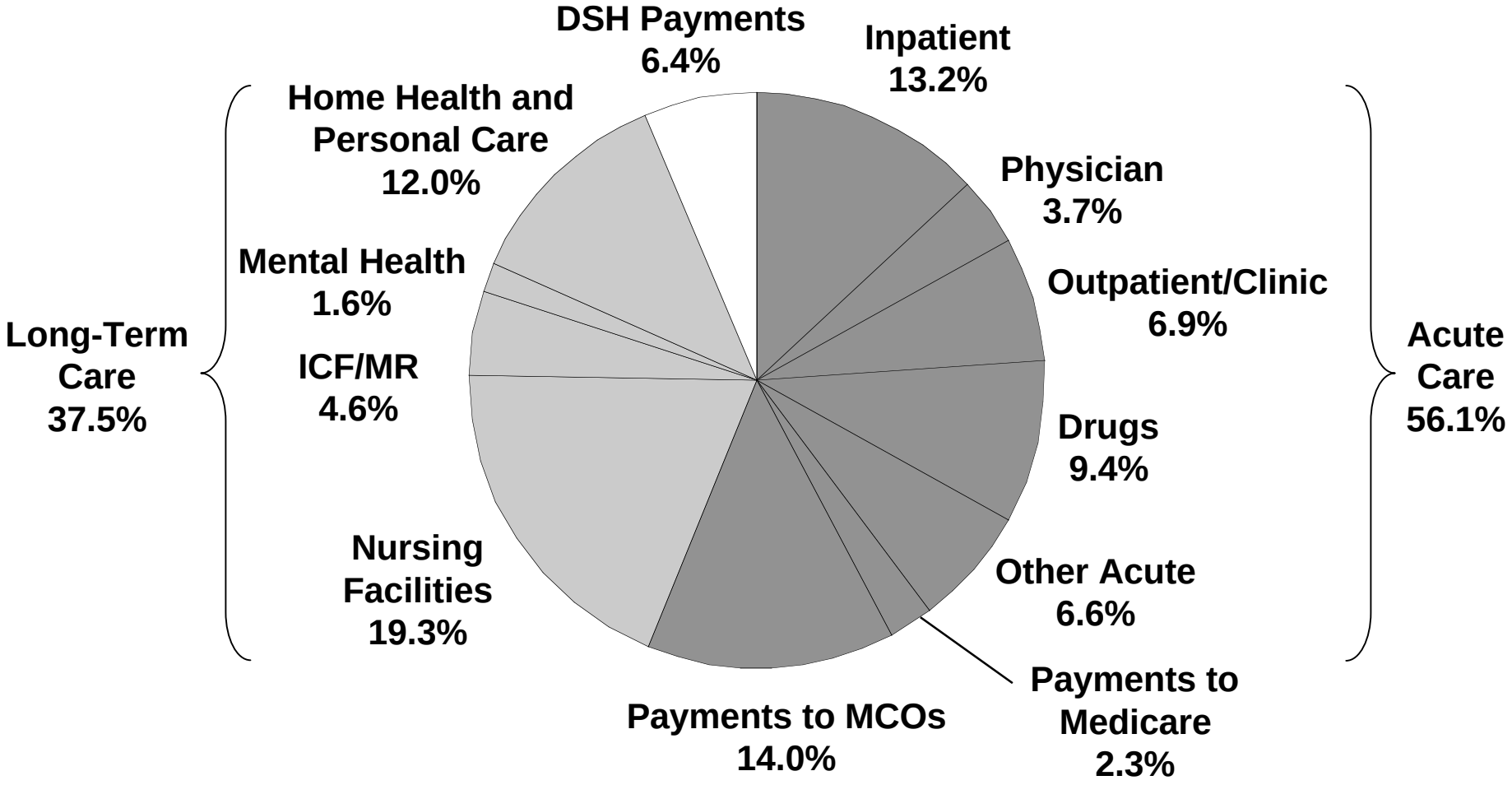
Medicaid Enrollees and Expenditures by Enrollment Group, 2003



Expenditure distribution based on CBO data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.
SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2004.

Figure 28

Medicaid Expenditures by Service, 2002

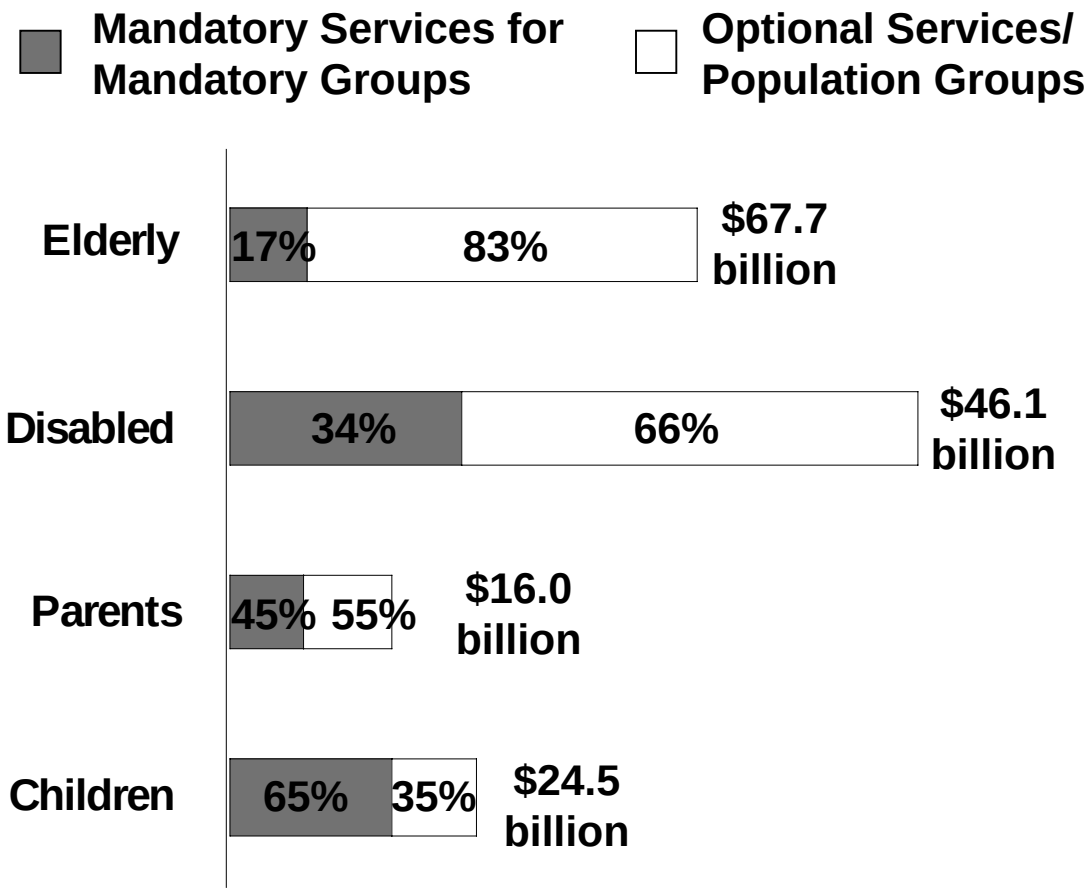


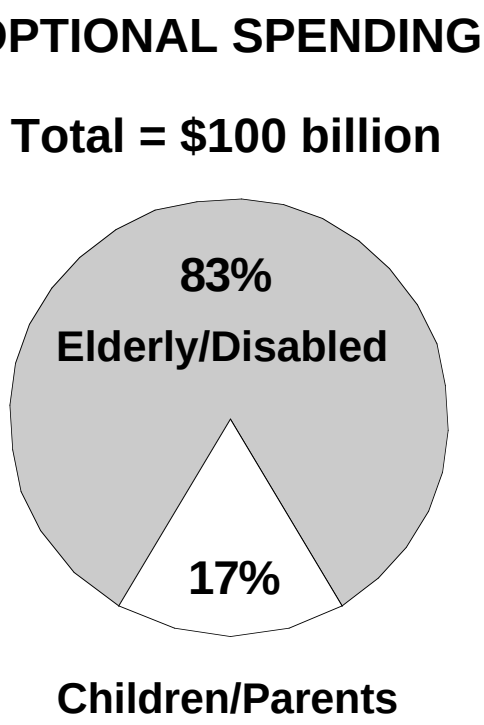
Total = $248.7 billion

SOURCE: Urban Institute estimates based on data from CMS (Form 64).

Figure 29

Distribution of Medicaid Spending by Eligibility Group and Type of Service, 1998

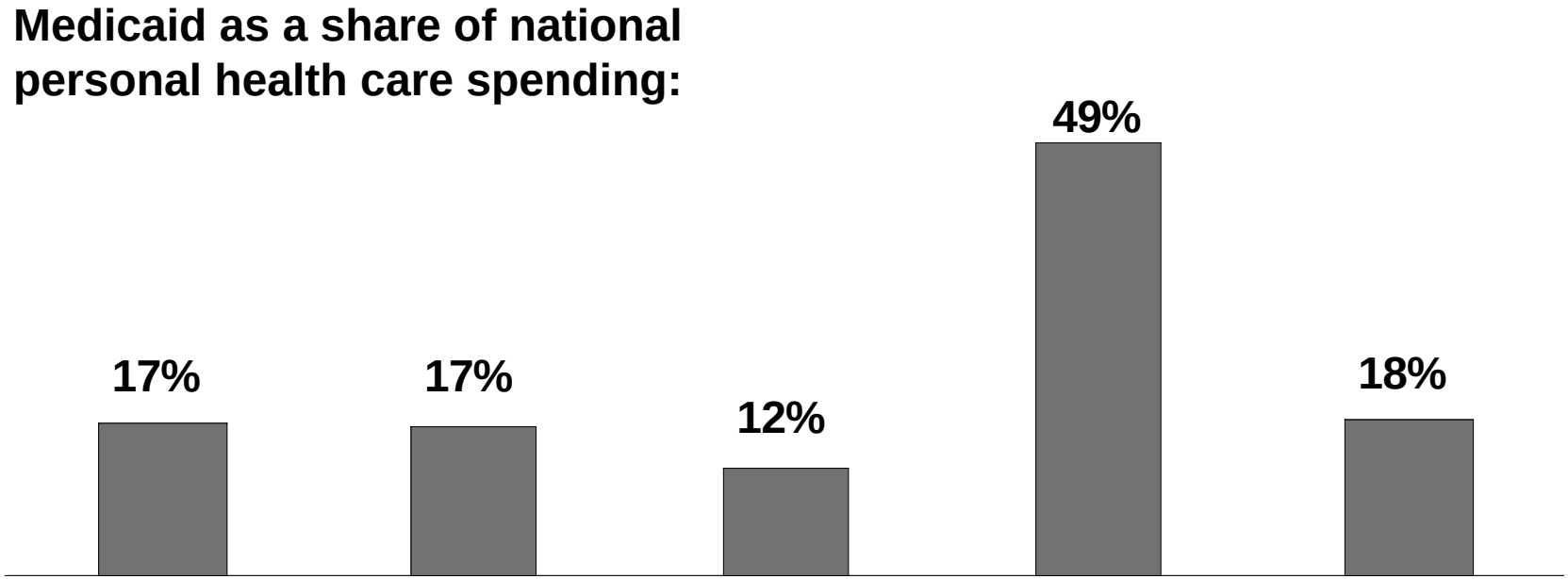




Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 30

Medicaid's Role in the Health System, 2002

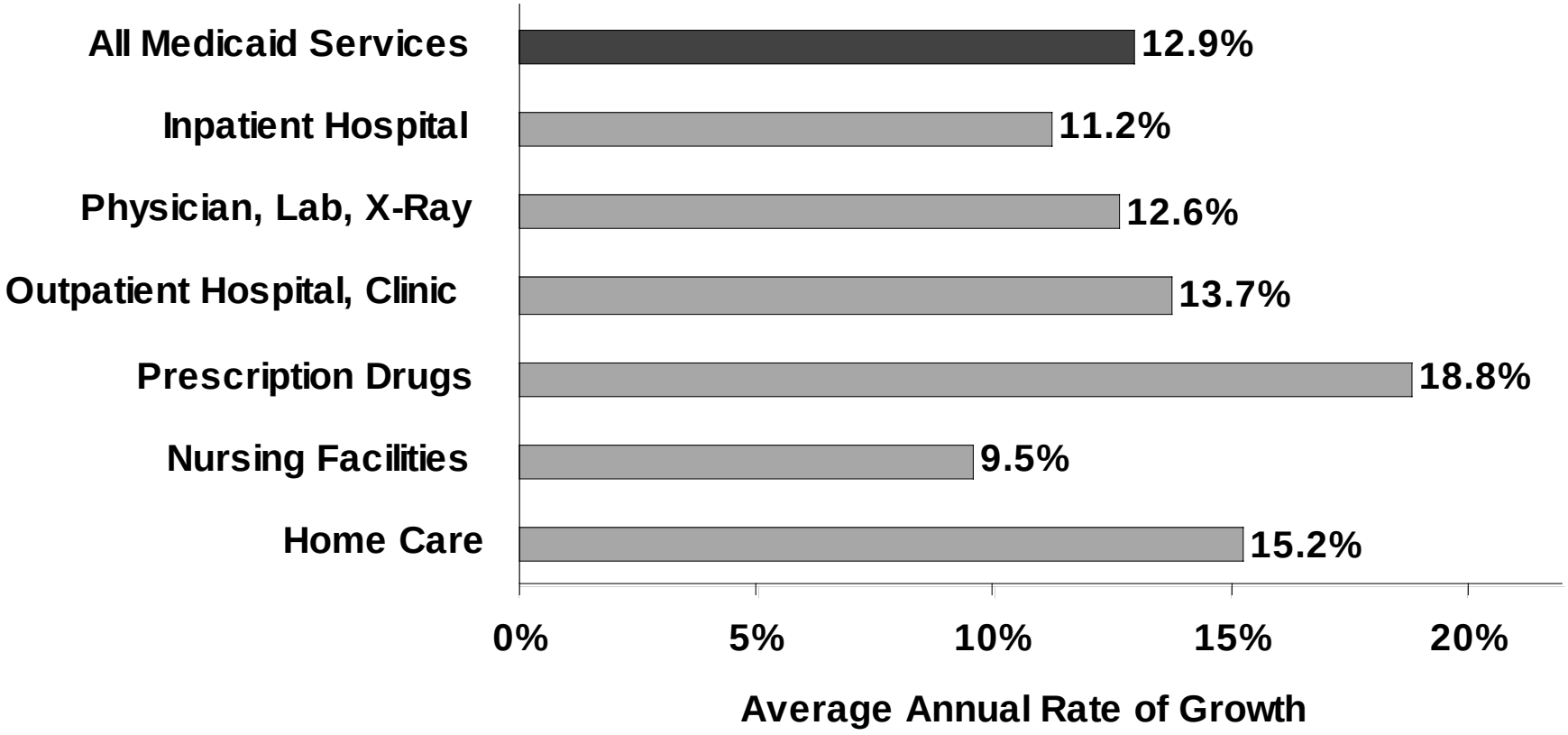


	Total Personal Health Care	Hospital Care	Professional Services	Nursing Home Care	Prescription Drugs
Total National Spending (billions)	$1,340	$486.5	$501.5	$103	$162

SOURCE: Levit, et al, 2004. Based on National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary.

Figure 31

Average Annual Rate of Expenditure Growth for Medicaid Services, 2000-2002



Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed.
SOURCE: Kaiser Commission on Medicaid and the Uninsured / Urban Institute analysis of HCFA-64 data.

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Figure 32

Sources of Medicaid Expenditure Growth

- **Keeping pace with health care inflation**
  - Pressure to increase provider payments
  - Escalating costs for prescription drugs

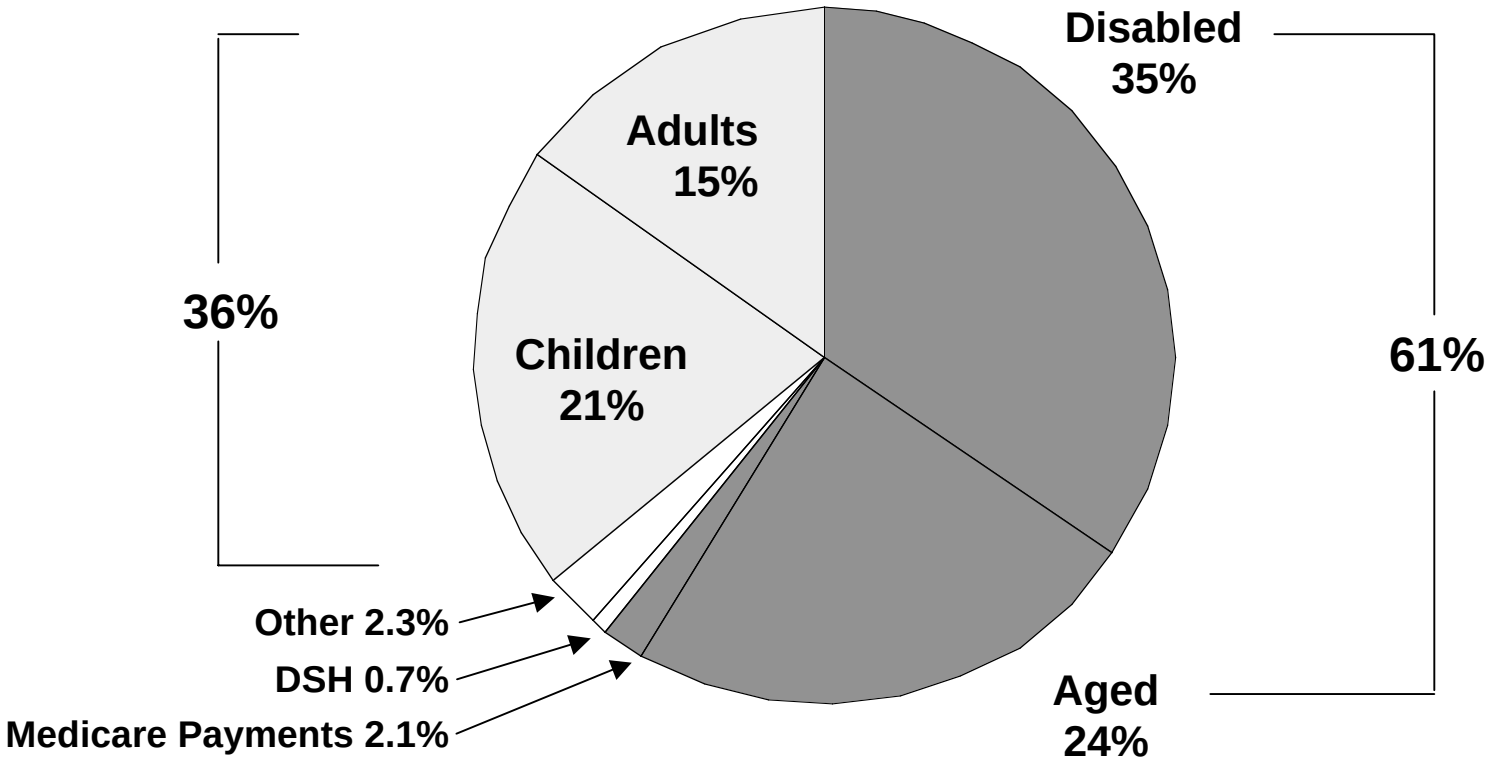
- **Changing patterns of health care utilization**
  - Expanding home- and community-based services
  - Increase in prescription drug utilization

- **Expanding enrollment**
  - Economic downturn
  - Growth of the disabled population in Medicaid

- **Use of "Medicaid maximization" arrangements** which increase federal contributions to state programs above legal levels permitted under "federal medical assistance percentage (FMAP)" law

Figure 33

Contributors to Medicaid Expenditure Growth by Enrollment Group, 2000-2002



Total = $48.2 billion

SOURCE: Estimates for KCMU prepared by the Urban Institute, 2003.

Figure 34

Medicaid as a Health Care Payer and Supporter of the Health Care "Safety Net"

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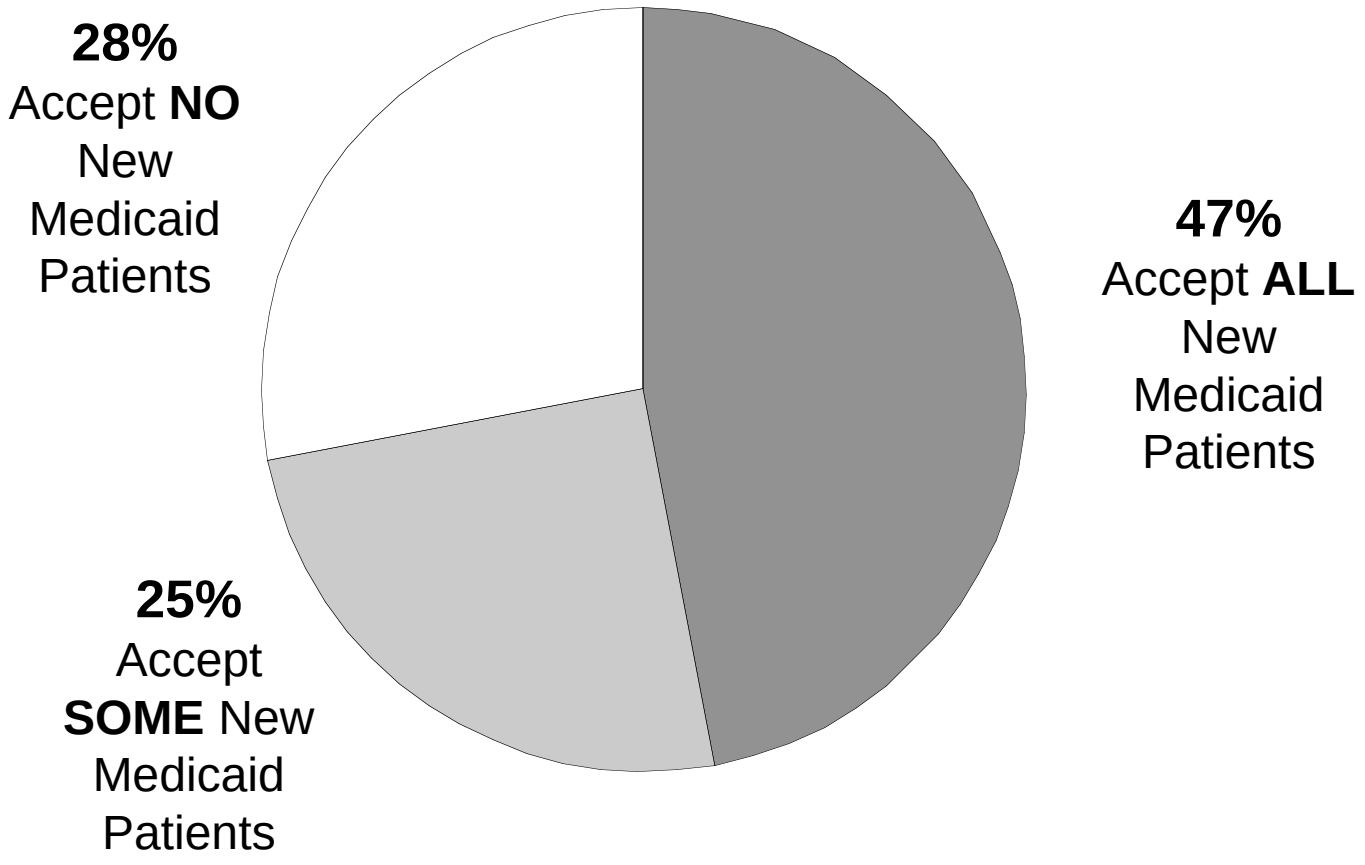
Figure 35

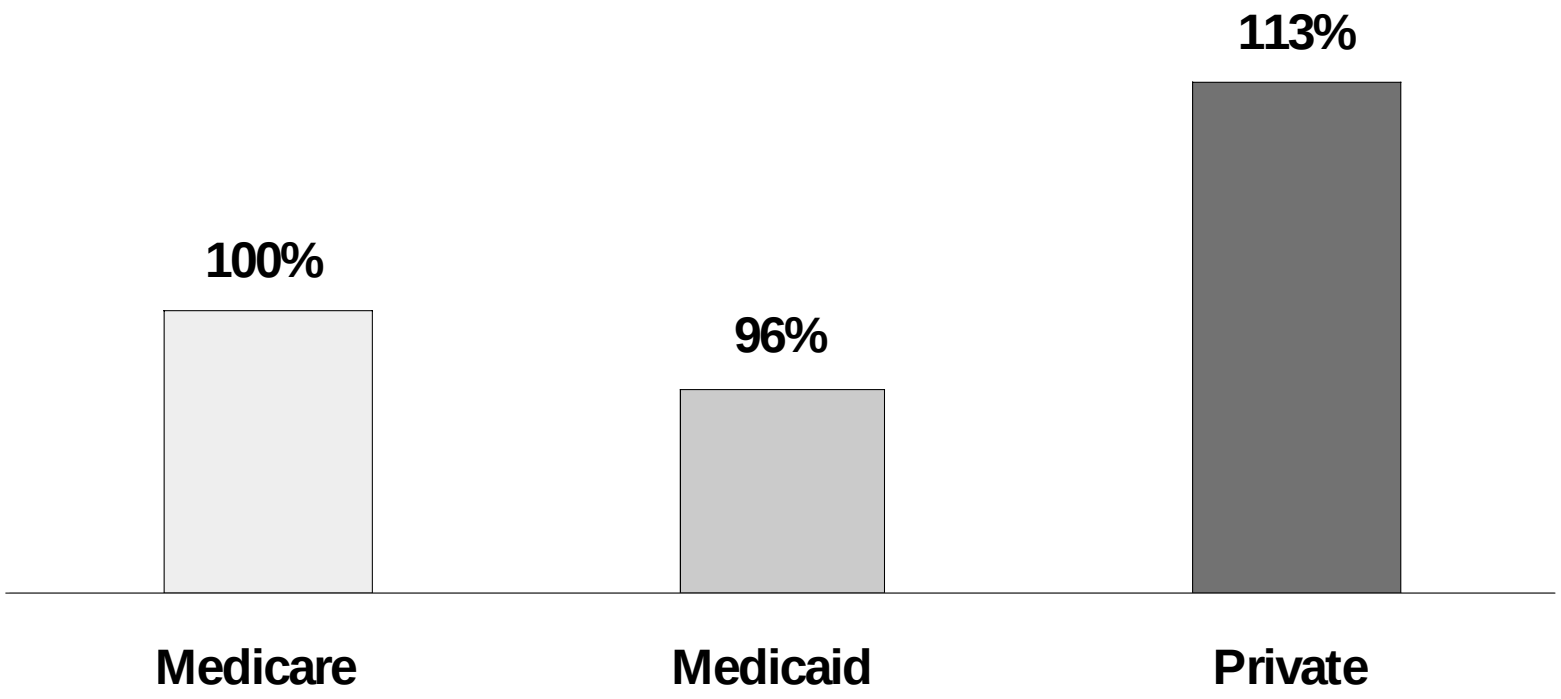
Medicaid Provider Participation



SOURCE: Medicare Payment Advisory Commission, 1998-1999 survey of physicians.

Figure 36

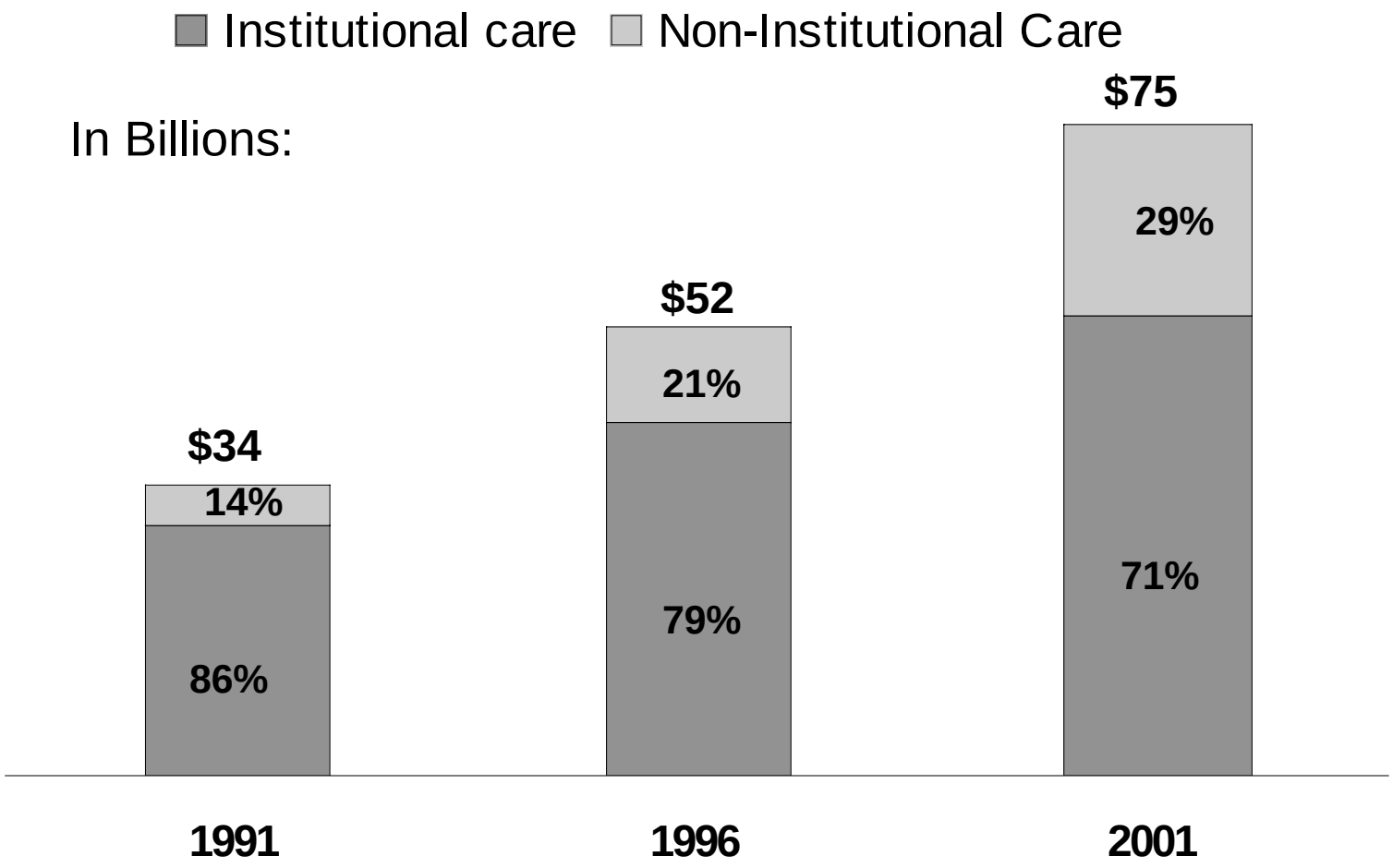
Hospital Payment-to-Cost Ratios, 2000



SOURCE: Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy", March 2002, p. 156.

Figure 37

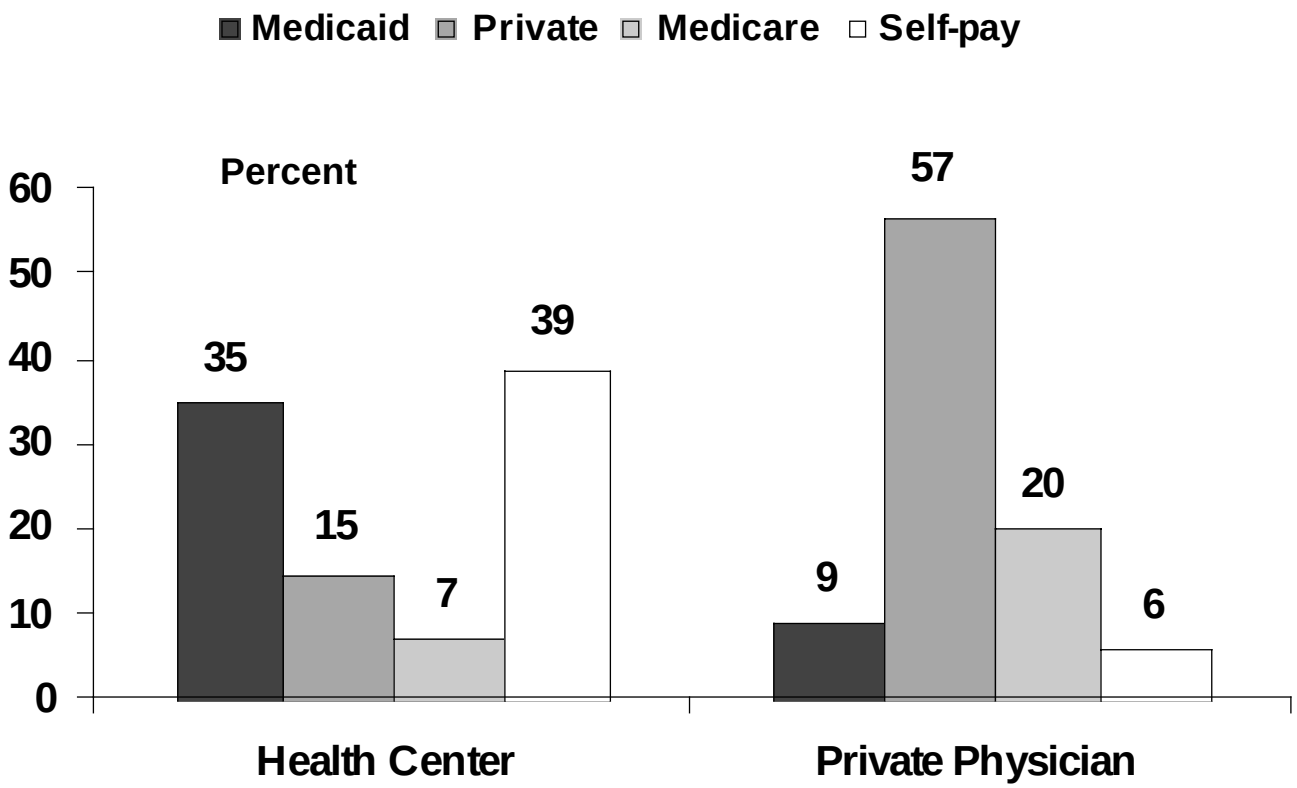
Growth in Medicaid Long-Term Care Expenditures, 1991-2001



Source: Burwell et al. 2002, HCFA-64 data.

Figure 38

Comparison of Health Center and Physician Office Patients by Payor Source



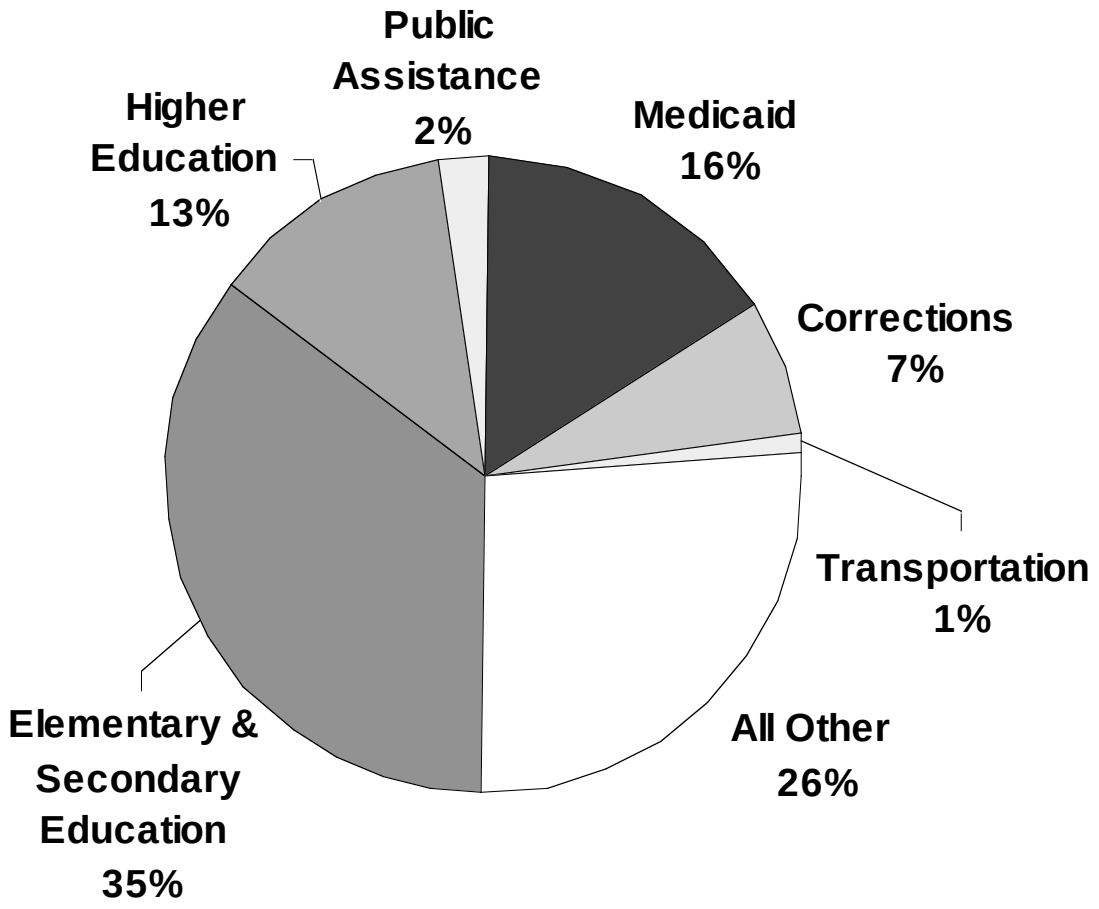
Source: 2000 National Ambulatory Medical Care Survey (visits);
Center for Health Services Research and Policy Analysis of 2001 UDS (patients).

Figure 39

Medicaid's Role in State Financing

Figure 40

State Medicaid Spending as a Percent of General Fund Expenditures, 2002

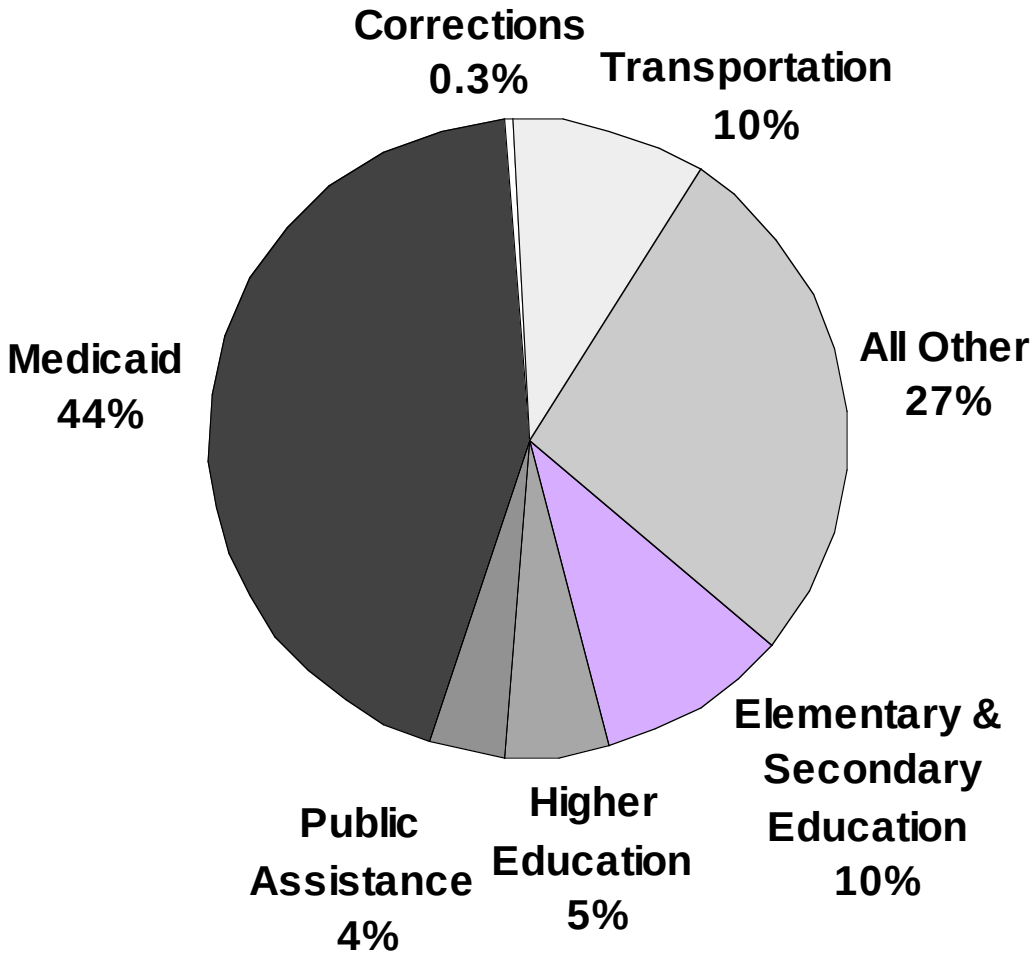


Total State General Fund Spending = $496 billion

SOURCE: National Association of State Budget Officers, 2002 State Expenditure Report, November 2003.

Figure 41

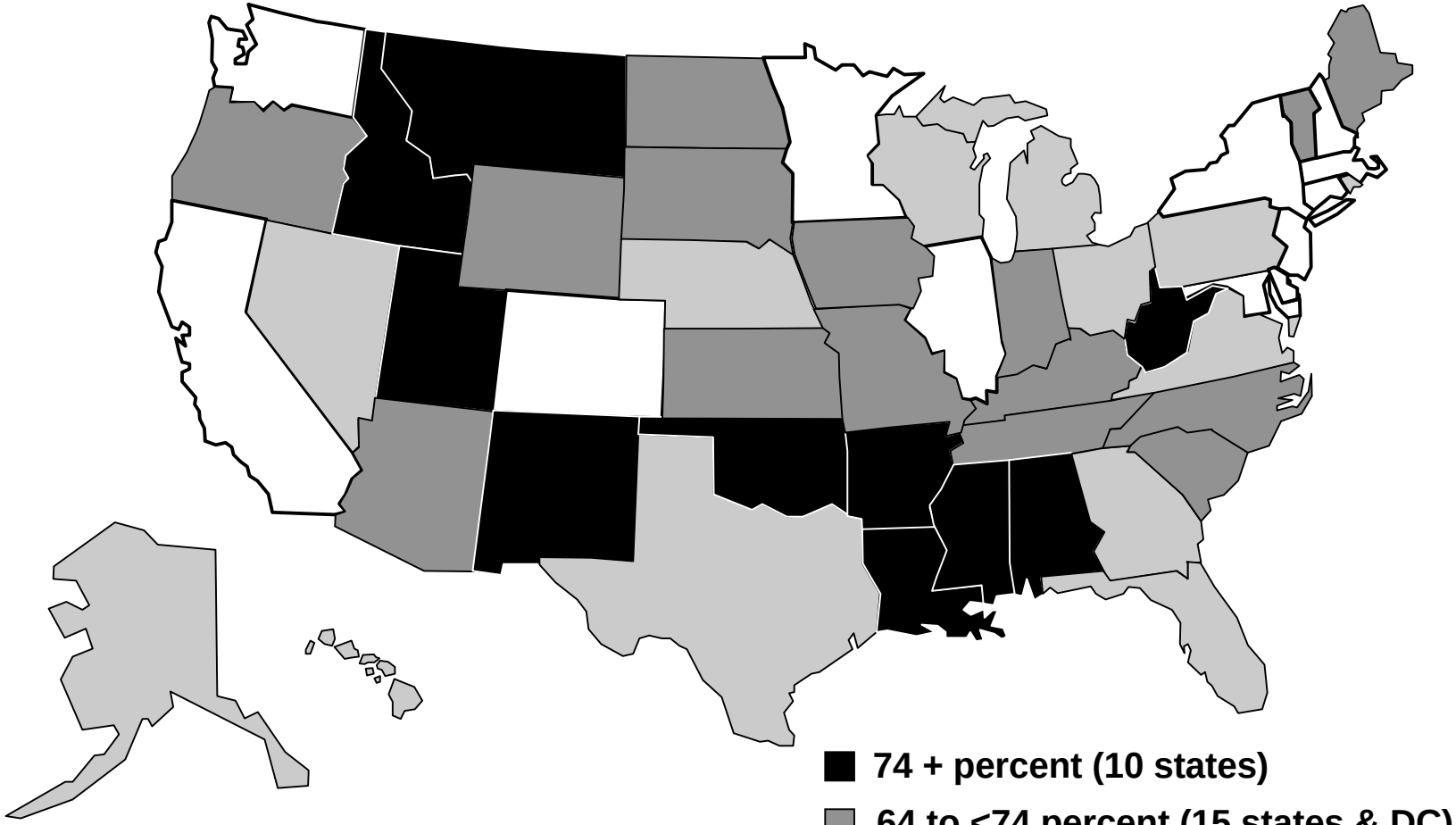
Medicaid As a Percent of Federal Grant Funding to States, 2001



SOURCE: National Association of State Budget Officers, 2001 State Expenditure Report, Summer 2002.

Figure 42

Federal Medical Assistance Percentages (FMAP), FY 2004, Including Temporary Fiscal Relief



NOTE: The percentages listed reflect the temporary increase in federal Medicaid matching rates enacted in the Jobs and Growth Tax Relief Reconciliation Act of 2003, which is effective for the first 3 calendar quarters of FY 2004.
SOURCE: Federal Register, June 17, 2003.

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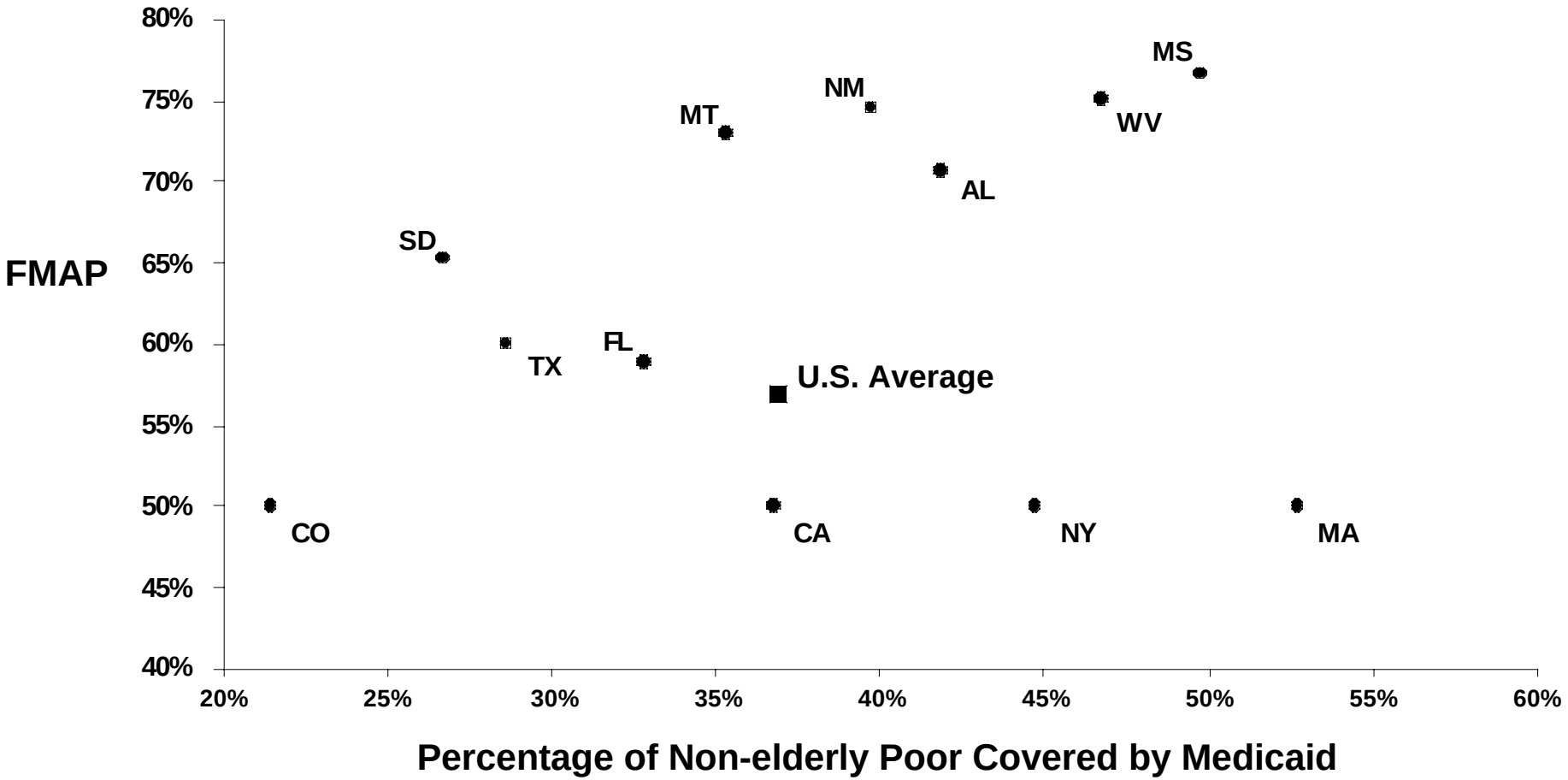
Figure 43

Federal Share of Medicaid Financing (FMAP) v. Percentage of Poor Covered by Program



SOURCE: Coverage data from Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of 2 year-pooled data from March 2000 and 2001 Current Population Survey, 2001. FMAP data from http://aspe.hhs.gov/health/fmap03.htm

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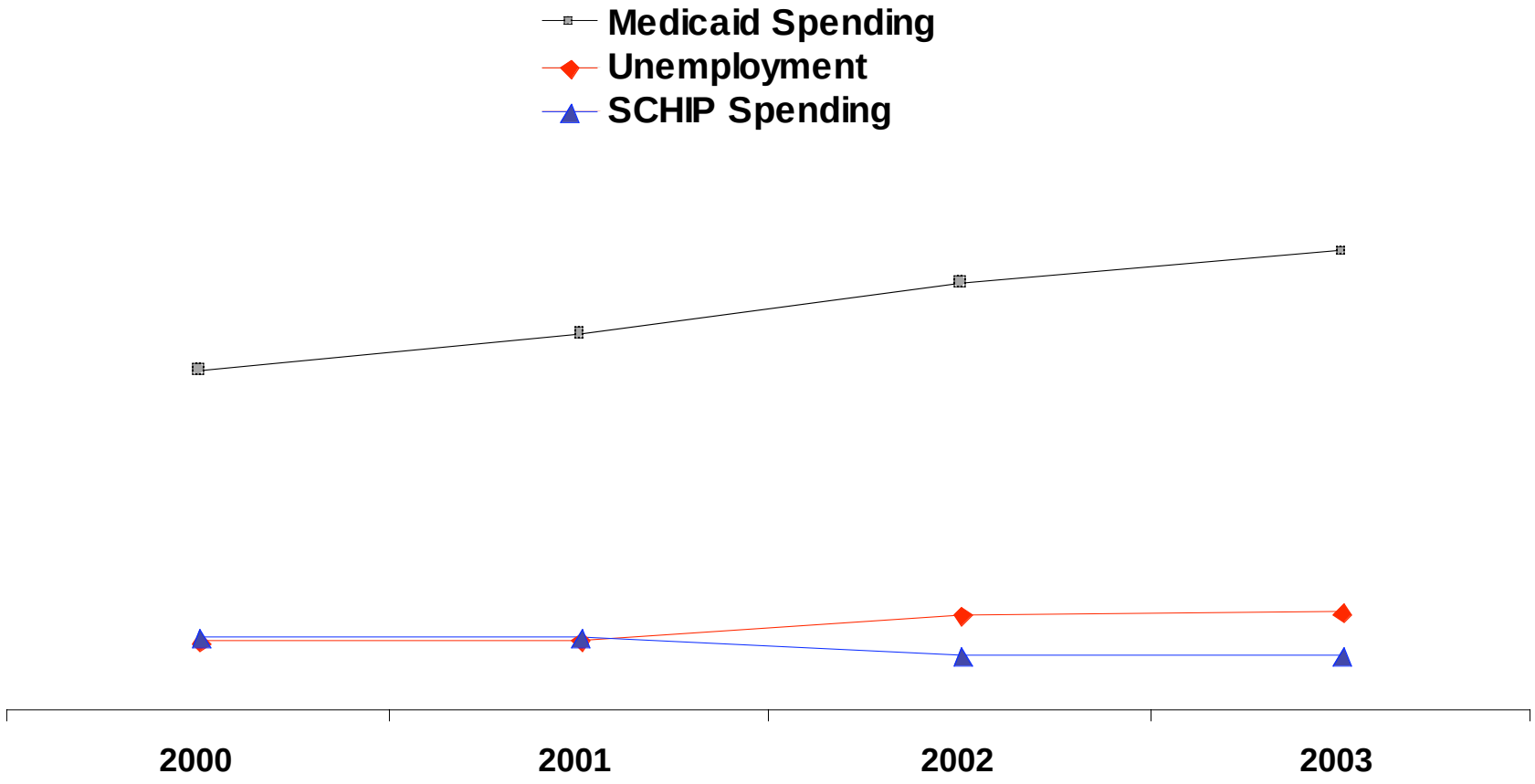
Figure 44

Medicaid as a Legal Entitlement

Figure 45

The States' Legal Entitlement: Unemployment, Medicaid, and SCHIP Trends 2000-2003

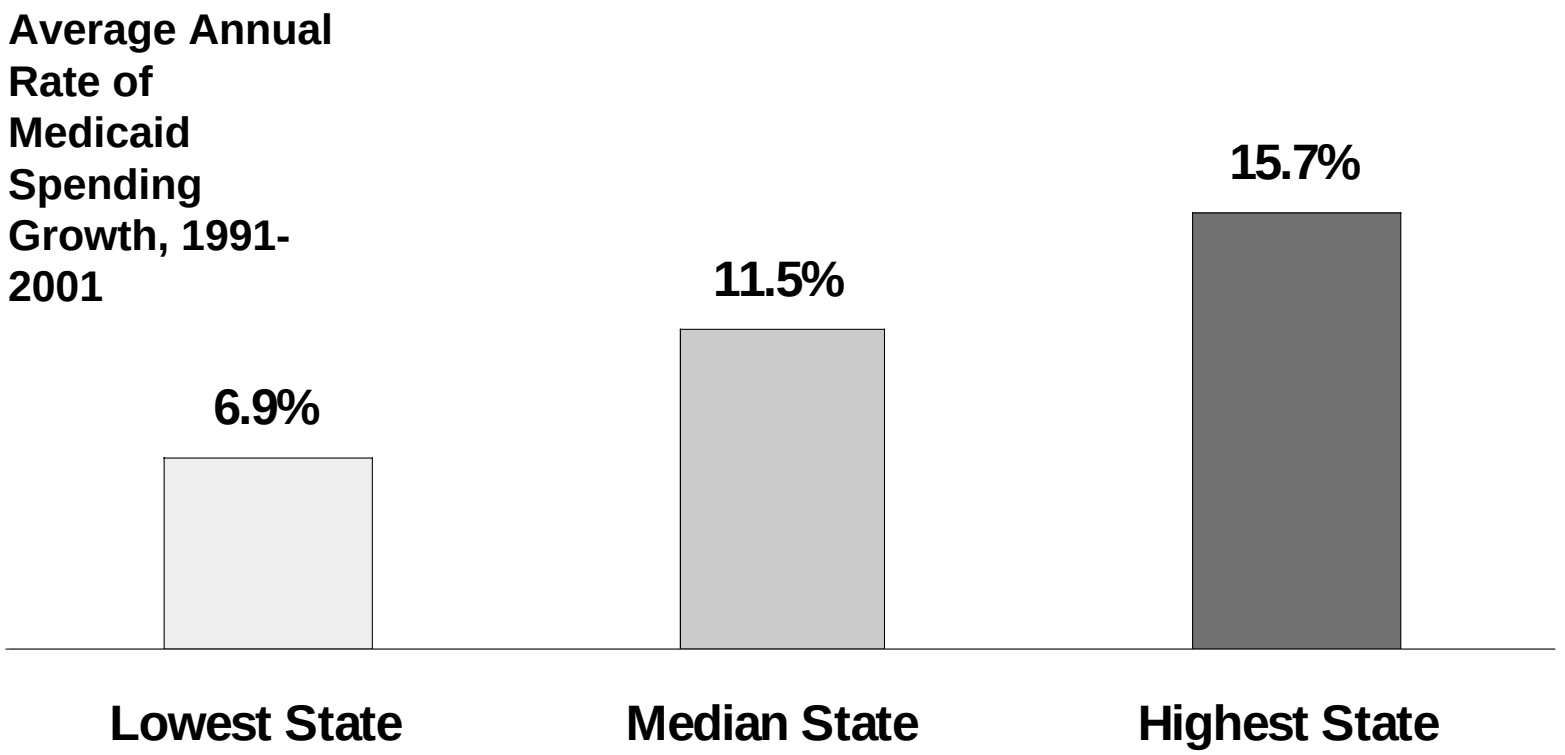


NOTE: Trend lines are in tens of billions of dollars for Medicaid spending, billions of dollars for SCHIP spending, and unemployment rate for unemployment data.

SOURCE: Kaiser Commission analysis of CMS, OMB, and BLS data, 2003.

Figure 46

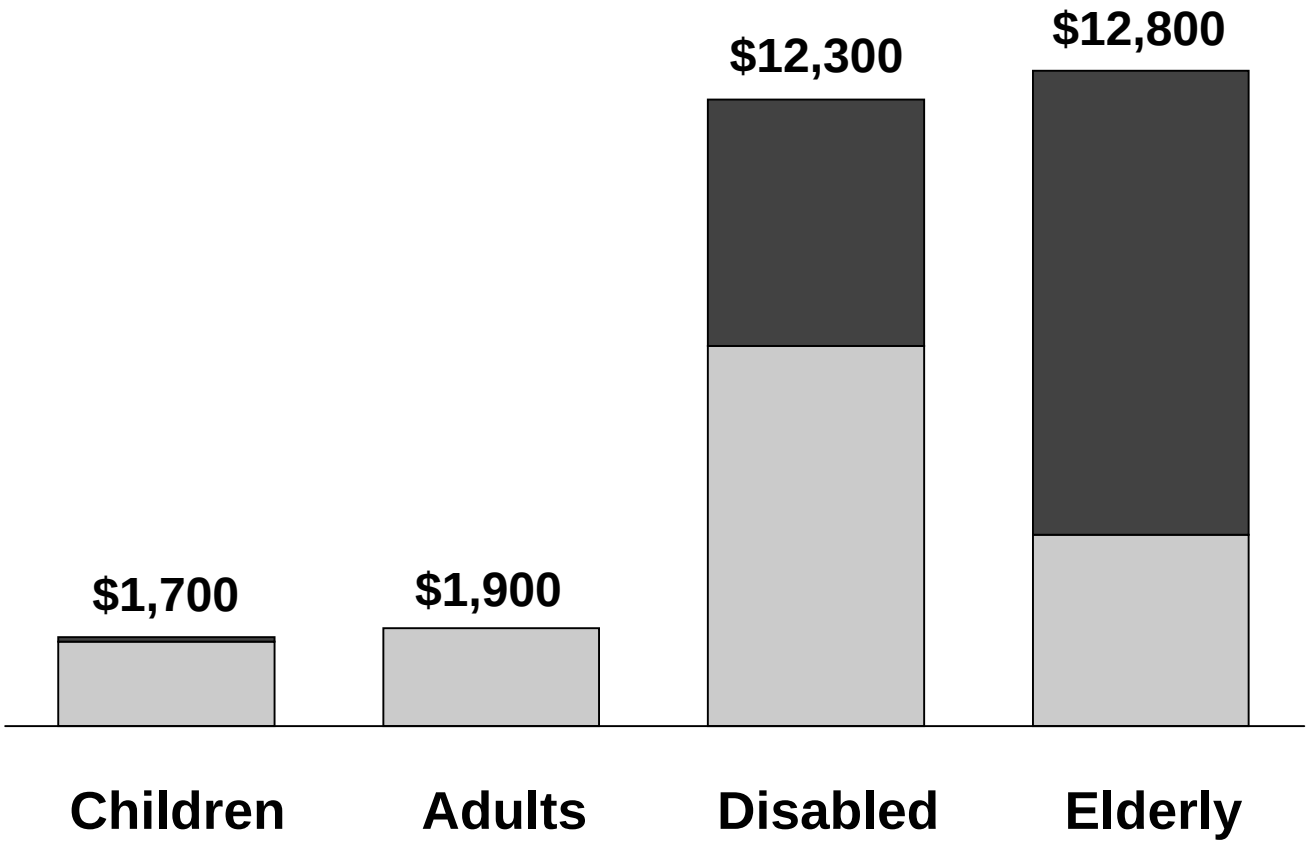
State Variation in Medicaid Spending Growth Rates, 1991 - 2001



SOURCE: Data provided by the Urban Institute based on Form 64. Data include expenditures on DSH, but excluded administrative costs and accounting adjustments.

Figure 47

The Individual Legal Entitlement: Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 2003



Long-Term Care

Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, and home health services.

Acute Care

Acute care services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to MCOs, and payments to Medicare.

Note: Expenditures do not include DSH, adjustments, or administrative costs.
SOURCE: CBO Baseline; KCMU and Urban Institute estimates based on HCFA-2082 and HCFA-64 Reports.

Figure 48

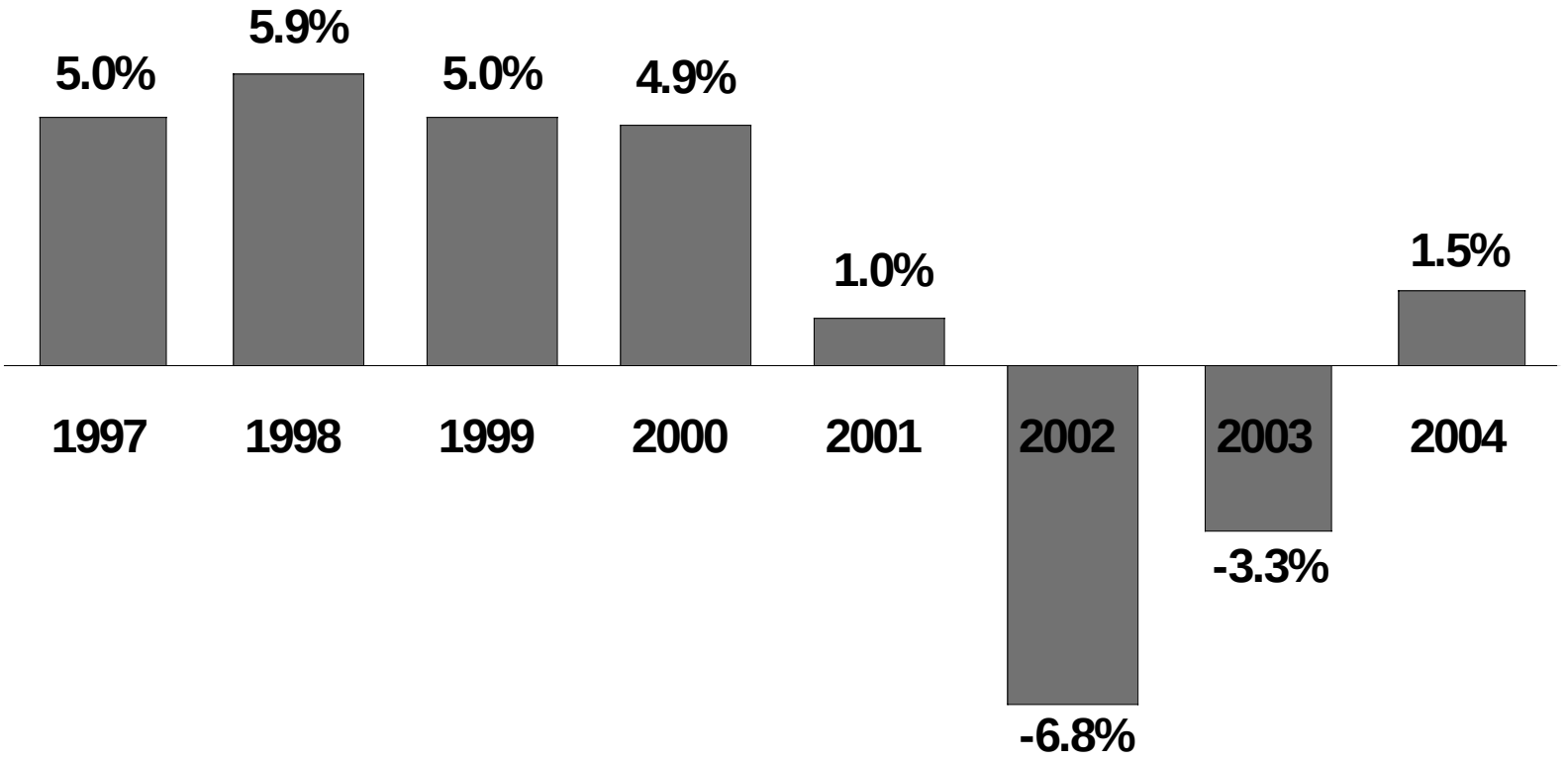
States' Medicaid Response to the Current Fiscal Crisis

KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 49

Underlying Growth in State Tax Revenue

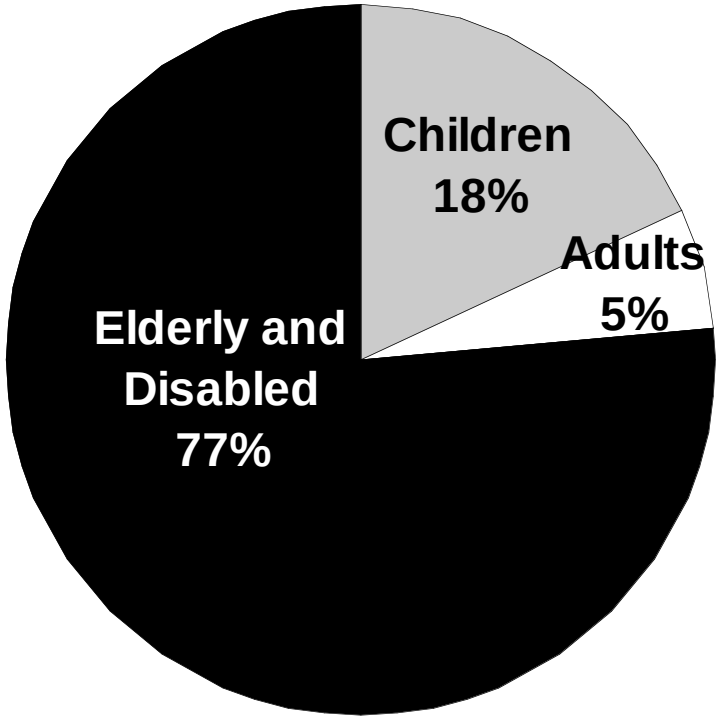
Adjusted for Inflation and Legislative Changes, 1997-2004



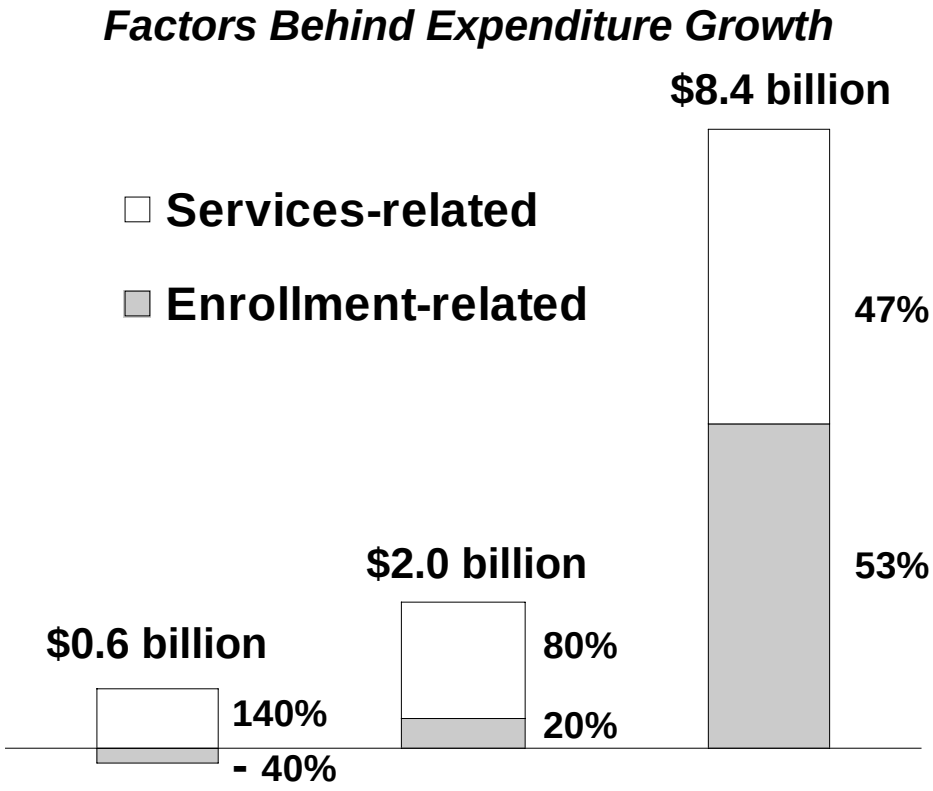
SOURCE: Analysis by the Rockefeller Institute of Government of data from the Bureau of the Census, Bureau of Economic Analysis and the National Association of State Budget Officers.

Figure 50

Sources of Growth in Federal Medicaid Expenditures, 2002-2003



Total Increase in Expenditures for Beneficiaries= $11 billion



SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Medicaid baseline, March 2003.

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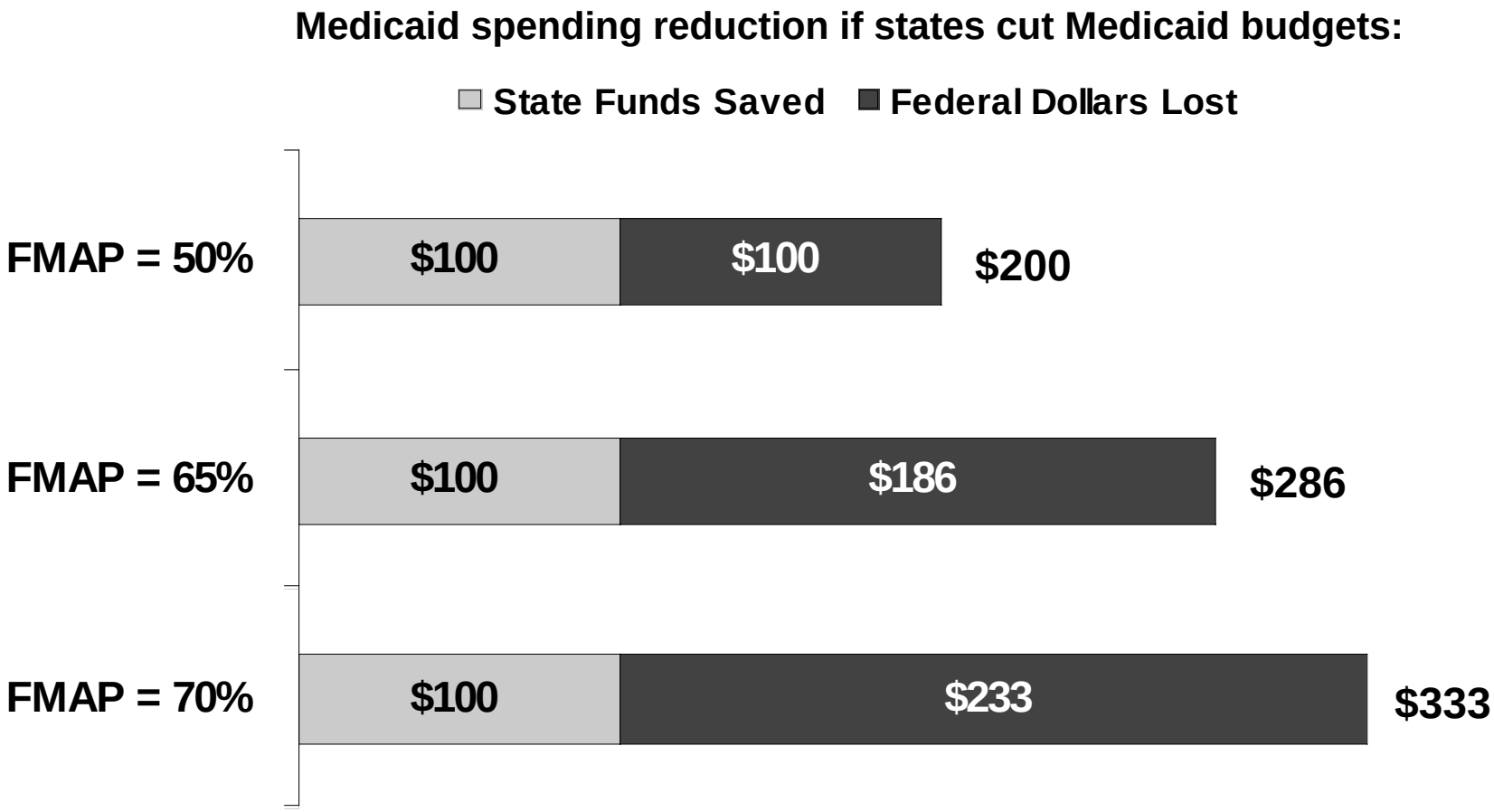
Figure 51

Total Reduction in Medicaid Spending Resulting from State Budget Cuts

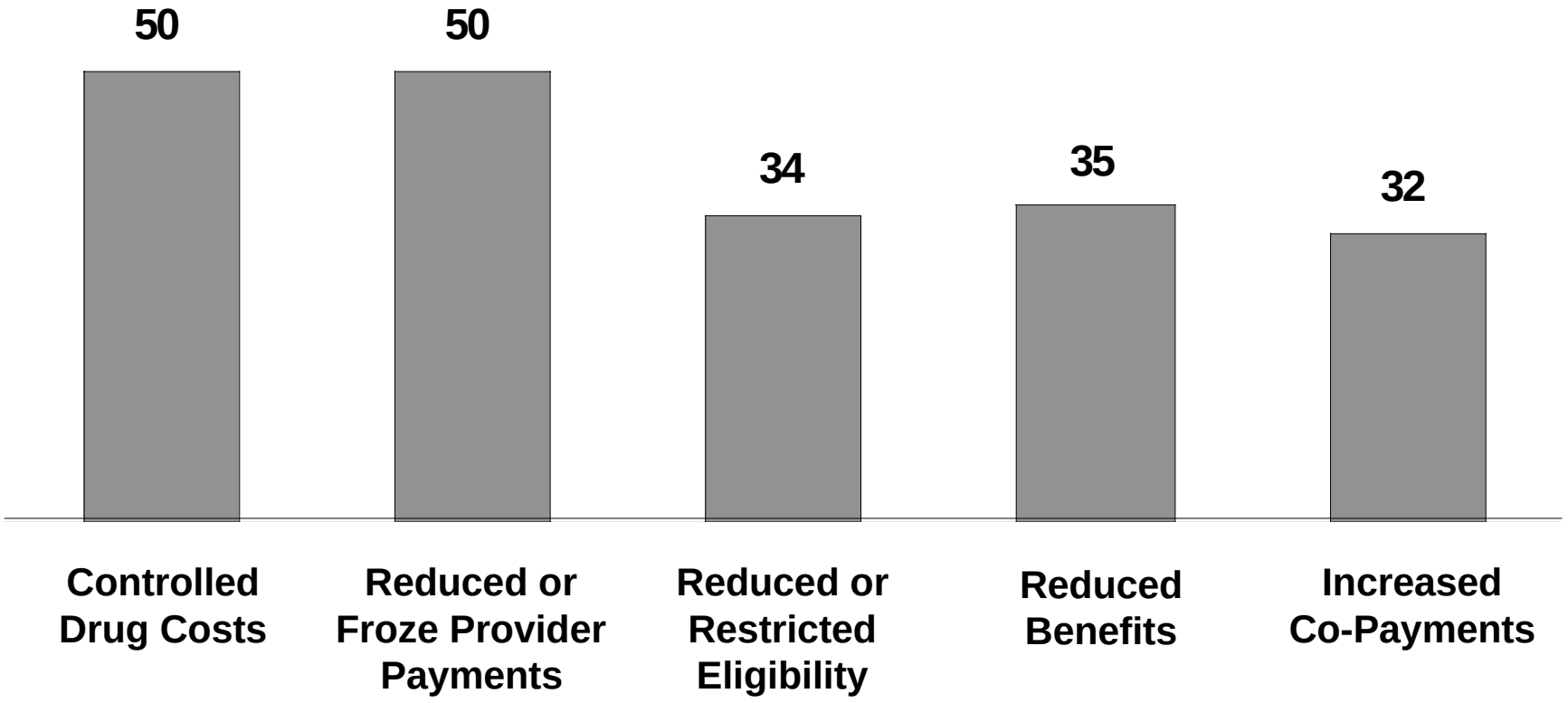


SOURCE: Kaiser Commission on Medicaid and the Uninsured.

Figure 52

Number of States Implementing Medicaid Cost Containment Strategies Over the Past Three Years

(FY 2002 – FY 2004)



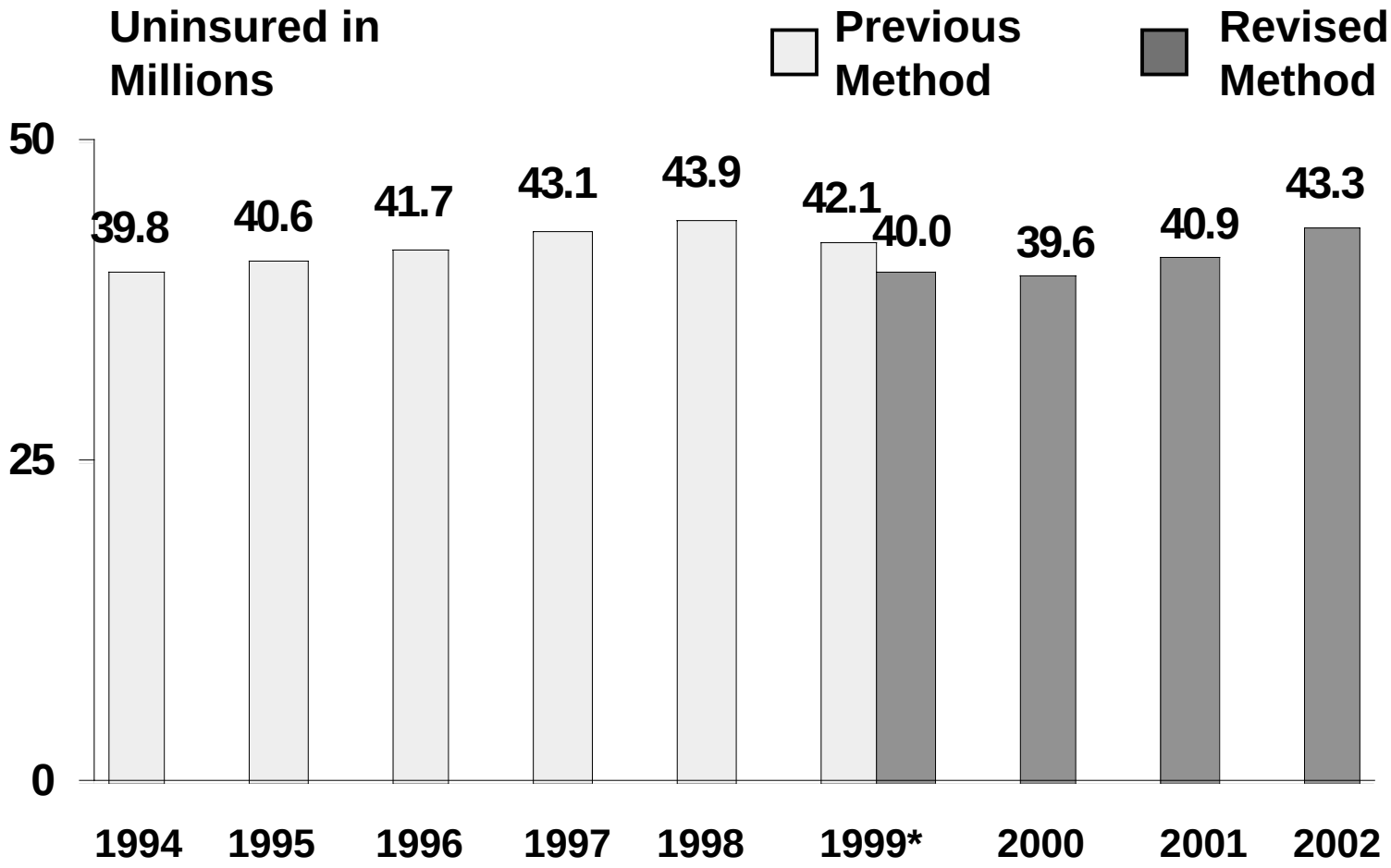
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September 2003.

Figure 53

Does Medicaid Need Federal Reform? What Should Federal Reform Accomplish?

Figure 54

Number of Nonelderly Uninsured Americans, 1994-2002



*Revised method estimates for 1999 are comparable to later years, except they are based on a smaller sample.

SOURCE: KCMU and Urban Institute analysis of March Current Population Survey data.

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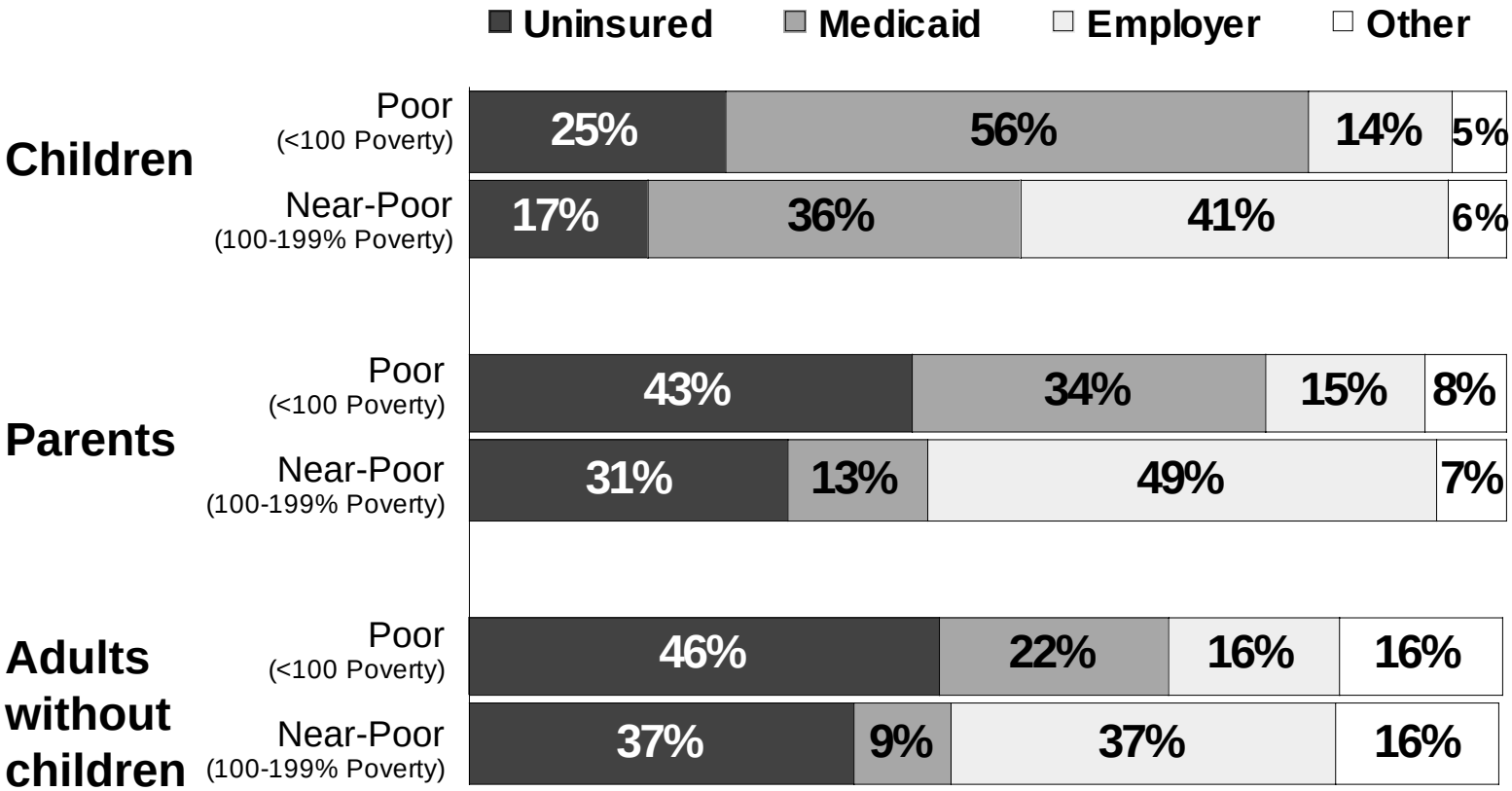
Figure 55

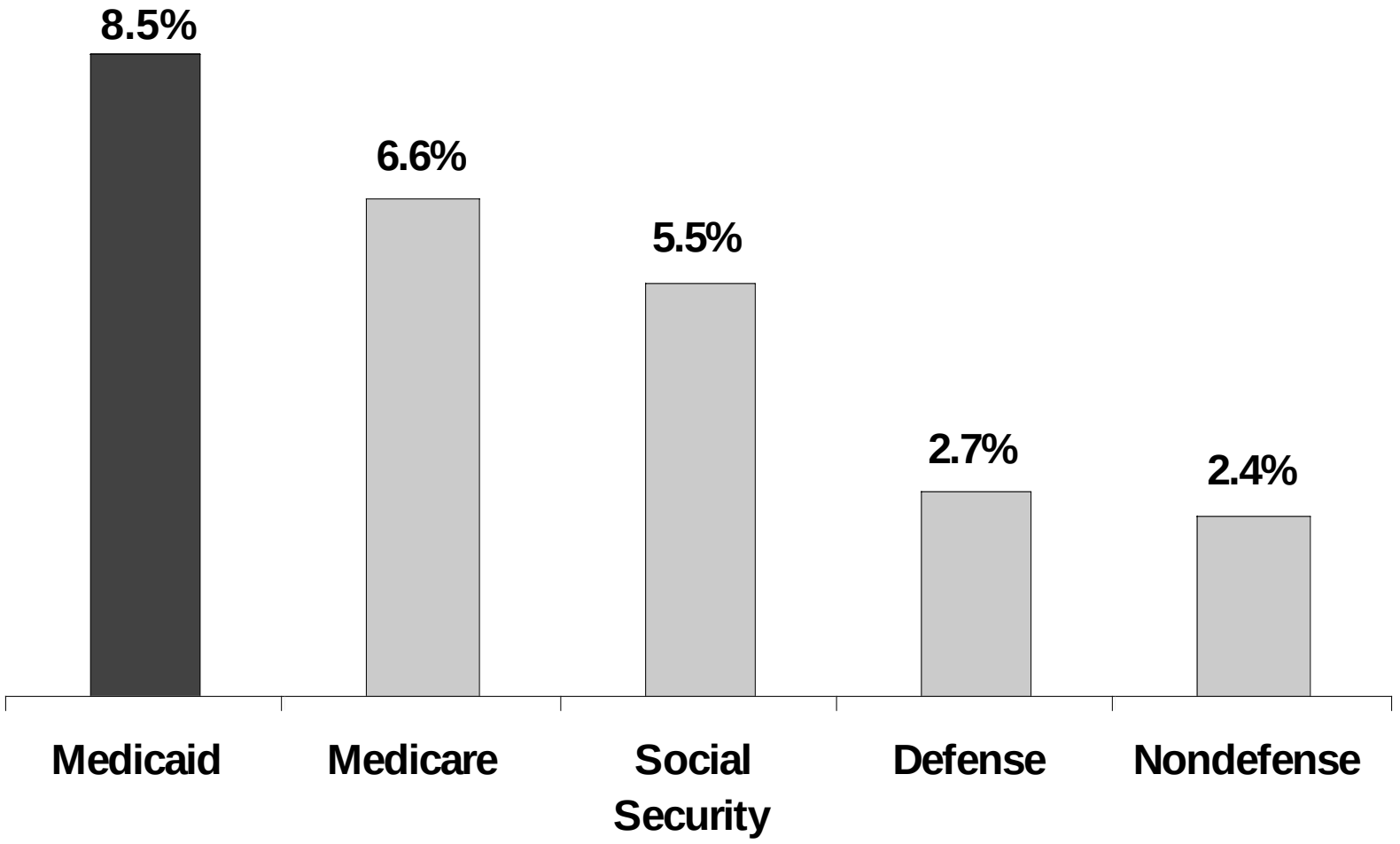
Health Insurance Coverage of Low-Income Adults and Children, 2002



Notes: Adults age 19-64. Data may not total 100% due to rounding.
SOURCE: KCMU and Urban Institute analysis of March 2003 Current Population Survey.

Figure 56

Projected Annual Rate of Federal Medicaid Spending Growth v. Other Federal Spending, 2003-2013



SOURCE: Congressional Budget Office, January 2003.

Figure 57

What Ought to Drive Reform?

It depends on one's point of view:

- The cost of the program and state manipulation of FMAP rates, *OR*
- The rising number of uninsured people, the need to finance uninsurable and higher cost health services for persons with chronic and serious health conditions, and the need to relieve state fiscal burdens, *OR*
- Both

Figure 58

Reforming Medicaid

- How one approaches reform depends on how one defines the problem to be addressed.
  - An essential program which, in its current form, is inadequate to deal properly with various problems: a voluntary employer-based insurance system; insurers and employer sponsored health plans that operate on market (versus social contract) principles and seek to limit financial exposure to chronic illness and higher costs; the heavy burden of health spending that falls on state governments; and inadequate funding for broader population health programs

OR

  - A program that is unaffordable, a tremendous drain on state and federal budgets, susceptible to state “scams,” and economically inefficient and antiquated in its continued provision of comprehensive and essentially free services to eligible persons while leaving out millions of others.

Figure 59

Two Visions of Federal Medicaid Reform

- Retain basic program structure while making certain reforms
  - Alter the federal/state financial partnership by increasing the FMAP and retaining the state entitlement
  - Close the categorical coverage gaps (e.g., low income adults without children)
  - Increase financial eligibility standards
  - Eliminate the “institutional bias” by augmenting coverage of community services
  - Improve provider payment levels and support for the safety net
- Shield the federal government from excessive and inefficient spending
  - Place an aggregate cap on federal contributions to state budgets
  - Eliminate the legal entitlement in states to open-ended financing
  - Eliminate the legal entitlement in individuals and providers
  - Eliminate some, most, or all eligibility and benefit rules to allow reductions in coverage and slimmer services
  - Eliminate provider payment rules