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

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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?
Medicaid’s Role as a Health Insurer: Major Themes
Medicaid’s Major Themes

• Markets versus social contract through direct government benefits

• Federalism

• Legal rights versus largesse
Medicaid Versus Private Health Insurance: A Conceptualization of The Social Contract Theme

<table>
<thead>
<tr>
<th>Private Health Insurance</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designed to avoid risk and engage in “fair discrimination” to avoid “moral hazard” of higher than actuarially projected use</td>
<td>Designed to insure the uninsurable (populations and services). The “non-actuarial” insurer</td>
</tr>
<tr>
<td>• Limitations on eligibility (pre-existing condition exclusions and waiting periods)</td>
<td>• Eligibility based on poverty, disability, age, pregnancy, illness, and other high risk factors considered uninsurable</td>
</tr>
<tr>
<td>• Aggressive marketing to best risks</td>
<td>• Affirmative, prompt enrollment obligations, even at the point of service; entitlement often linked to illness or medical condition</td>
</tr>
<tr>
<td>• Limitations on coverage (diagnostic-specific coverage limits, coverage exclusions, high cost sharing, stringent definitions of medical necessity)</td>
<td>• Broad defined-benefit coverage rules, limited or no cost sharing, prohibitions against diagnostic discrimination, a broad concept of medical necessity, particularly for children</td>
</tr>
</tbody>
</table>
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
Eligibility and Services
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
# 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

- Non-disabled Adult without Children, $0 Annual Income
- Pregnant, Income < 133% FPL
- Uninsured Woman < Age 65 with Breast or Cervical Cancer
- Parent Leaving Welfare, <185% FPL
- Parent with Income < ’96 AFDC level
- Adult Receiving SSI, Income < $531/month (Elderly or Disabled)
Figure 10

Sample Medicaid Eligibility Pathways for Men

- Non-disabled Adult without Children, $0 Annual Income
- Parent Leaving Welfare, <185% FPL
- Parent with Income < ’96 AFDC level
- Adult Receiving SSI, Income < $531/month (Elderly or Disabled)
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.
Figure 12

Income Eligibility Thresholds for Adults and Children Under Medicaid, 2003

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual median income eligibility threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td>$20,296</td>
</tr>
<tr>
<td>Pre-School Children</td>
<td>$20,296</td>
</tr>
<tr>
<td>School-Age Children</td>
<td>$15,260</td>
</tr>
<tr>
<td>Parents</td>
<td>$6,257</td>
</tr>
<tr>
<td>Elderly and Individuals</td>
<td>$11,292</td>
</tr>
<tr>
<td>Childless Adults</td>
<td>$0</td>
</tr>
</tbody>
</table>

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.

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)

### Required and Optional Benefits

<table>
<thead>
<tr>
<th>Required Items &amp; Services</th>
<th>“Optional” Items and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physicians services</td>
<td>• Prescription drugs</td>
</tr>
<tr>
<td>• Laboratory and x-ray services</td>
<td>• Medical care or remedial care furnished by licensed practitioners</td>
</tr>
<tr>
<td>• Inpatient hospital services</td>
<td>• Diagnostic, screening, preventive, and rehab services</td>
</tr>
<tr>
<td>• Outpatient hospital services</td>
<td>• Clinic services</td>
</tr>
<tr>
<td>• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals</td>
<td>• Dental services, dentures</td>
</tr>
<tr>
<td>under 21</td>
<td>• Physical therapy</td>
</tr>
<tr>
<td>• Family planning and supplies</td>
<td>• Prosthetic devices, eyeglasses</td>
</tr>
<tr>
<td>• Federally-qualified health center (FQHC) services</td>
<td>• TB-related services</td>
</tr>
<tr>
<td>• Rural health clinic services</td>
<td>• Primary care case management</td>
</tr>
<tr>
<td>• Nurse midwife services</td>
<td>• ICF/MR services</td>
</tr>
<tr>
<td>• Certified nurse practitioner services</td>
<td>• Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)</td>
</tr>
<tr>
<td>• Nursing facility (NF) services for individuals 21 or over</td>
<td>• Inpatient psychiatric hospital services for individuals under age 21</td>
</tr>
<tr>
<td></td>
<td>• Home health care services</td>
</tr>
<tr>
<td></td>
<td>• Respiratory care services for ventilator-dependent individuals</td>
</tr>
<tr>
<td></td>
<td>• Personal care services</td>
</tr>
<tr>
<td></td>
<td>• Private duty nursing services</td>
</tr>
<tr>
<td></td>
<td>• Hospice services</td>
</tr>
</tbody>
</table>
Figure 15
Health Status and Functional Limitations of Non-elderly Low Income Adults
Medicaid vs. Privately Insured, 1996-1998

Self-Reported Health Status

Percentage Reporting:

- **Fair or Poor**
  - Medicaid: 11%
  - Privately Insured: 2%
- **Excellent**
  - Medicaid: 14%
  - Privately Insured: 28%

Limitations

- **Fair or Poor Mental Health**
  - Medicaid: 5%
- **Social or Cognitive Limitations**
  - Medicaid: 21%
  - Privately Insured: 4%
- **Difficulty Lifting, Walking, or with Steps**
  - Medicaid: 16%
  - Privately Insured: 3%
- **Unable to Perform Activity of Daily Living**
  - Medicaid: 18%
  - Privately Insured: 2%
- **Any Limitations**
  - Medicaid: 9%
  - Privately Insured: 3%

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.

Figure 16

Medicaid’s Role for Selected Populations

Percent with Full Medicaid Coverage:

Nonelderly Americans 12%

Poor 38%

Near Poor 20%

Children

All 23%

White 15%

Hispanic 37%

African American 40%

Aged & Disabled

Medicare Beneficiaries 15%

People with Severe Disabilities 20%

People Living with HIV/AIDS 44%

Nursing Home Residents 60%

Note: “Poor” is defined as living below the federal poverty level, which was $14,348 for a family of three in 2002.


K A I S E R  C O M M I S S I O N O N
Medicaid and the Uninsured
Figure 17

Medicaid’s Role for Selected Populations

Percent with Medicaid coverage:

- Nonelderly Americans: 10%
- Poor: 37%
- Near Poor: 17%
- Poor Children: 52%
- Poor Pregnant Women: 53%
- Poor Parents: 34%
- Poor Disabled Adults: 41%
- Poor Medicare Beneficiaries: 56%
- People Living with HIV/AIDS: 44%
- Nursing Home Residents: 60%

Note: “Poor” defined as living below the federal poverty level.
Figure 18
Trends in the Uninsured Rate of Children, by Income Level

Uninsured Rate

Children with incomes below 200% of poverty

Children with incomes above 200% of poverty

SOURCE: Center on Budget and Policy Priorities analysis of NHIS data.
Figure 19

Medicaid’s Impact on Access to Health Care

Percent Reporting

- Did Not Receive Needed Care
  - Adults: 30%
  - Medicaid: 13%
  - Private: 7%

- No Pap Test
  - Women: 53%
  - Medicaid: 28%
  - Private: 33%

- Did Not See a Doctor
  - Children: 39%
  - Medicaid: 16%
  - Private: 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

- Spending on Dual Eligibles: 42% ($82.7 Billion)
- Prescription Drugs: 6% ($13.4 Billion)
- Non-Prescription: 36% ($82.7 Billion)
- Spending on Other Groups: 59% ($136.7 Billion)

NOTE: Due to rounding, percentages do not total 100%.
Figure 22

National Spending on Nursing Home and Home Health Care, 2002

**Nursing Home Care**
- Medicaid: 50%
- Medicare: 12%
- Out-of-Pocket: 26%
- Private Insurance: 7%
- Other Private: 3%
- Other Public: 2%

Total = $103.2 billion

**Home Health Care**
- Medicaid: 22%
- Medicare: 32%
- Out-of-Pocket: 18%
- Private Insurance: 22%
- Other Public: 5%
- Other Private: 3%
- Other Public: 2%

Total = $36.1 billion

Medicaid and the Uninsured

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
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

Annual growth rate:

- 1992-95: 10.0%
- 1995-98: 3.6%
- 1998-2000: 7.8%
- 2000-2002: 11.9%
- 2004 Projected: 8.2%

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

Health Insurance Coverage, 2002

- Employer: 56%
- Medicare: 12%
- Medicaid: 12%
- Private Insurance: 36%
- Other Private: 4%
- Other Public: 7%
- Uninsured: 15%
- Other: 6%

Total Population = 285 Million

Note: Excludes active military members

Personal Health Spending, 2002

- Medicare: 19%
- Medicaid: 17%
- Private Insurance: 36%
- Other Public: 7%
- Out-of-Pocket Payments: 16%
- Other: 6%

Total = $1,340 Billion

Enrollees
Total = 52.4 million

Expenditures
Total = $235 billion

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.

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

<table>
<thead>
<tr>
<th>Menuary Services for Mandatory Groups</th>
<th>Optional Services/Population Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>17%</td>
</tr>
<tr>
<td>Disabled</td>
<td>34%</td>
</tr>
<tr>
<td>Parents</td>
<td>45%</td>
</tr>
<tr>
<td>Children</td>
<td>65%</td>
</tr>
</tbody>
</table>

Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

Figure 30

Medicaid’s Role in the Health System, 2002

Medicaid as a share of national personal health care spending:

<table>
<thead>
<tr>
<th>Category</th>
<th>Medicaid Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Personal Health Care</td>
<td>17%</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>17%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>12%</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>49%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>18%</td>
</tr>
</tbody>
</table>

Total National Spending (billions):

- Total Personal Health Care: $1,340
- Hospital Care: $486.5
- Professional Services: $501.5
- Nursing Home Care: $103
- Prescription Drugs: $162

Figure 31

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

- All Medicaid Services: 12.9%
- Inpatient Hospital: 11.2%
- Physician, Lab, X-Ray: 12.6%
- Outpatient Hospital, Clinic: 13.7%
- Prescription Drugs: 18.8%
- Nursing Facilities: 9.5%
- Home Care: 15.2%

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

- Disabled: 35%
- Children: 21%
- Adults: 15%
- Aged: 24%
- Other: 2.3%
- DSH: 0.7%
- Medicare Payments: 2.1%

Total = $48.2 billion

Figure 34

Medicaid as a Health Care Payer and Supporter of the Health Care “Safety Net”
Figure 35

Medicaid Provider Participation

- 47% Accept ALL New Medicaid Patients
- 28% Accept NO New Medicaid Patients
- 25% Accept SOME New Medicaid Patients

Hospital Payment-to-Cost Ratios, 2000

Figure 37
Growth in Medicaid Long-Term Care Expenditures, 1991-2001

In Billions:

1991: $34
- Institutional care: $4.54 (14%)
- Non-Institutional care: $29.46 (86%)

1996: $52
- Institutional care: $2.14 (21%)
- Non-Institutional care: $50.86 (79%)

2001: $75
- Institutional care: $53.91 (71%)
- Non-Institutional care: $21.09 (29%)

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).
Medicaid’s Role in State Financing
Figure 40

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

- Medicaid: 16%
- Elementary & Secondary Education: 35%
- Higher Education: 13%
- Transportation: 1%
- Corrections: 7%
- All Other: 26%
- Public Assistance: 2%

Total State General Fund Spending = $496 billion


K A I S E R C O M M I S S I O N O N
Medicaid and the Uninsured
Figure 41

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

- Medicaid: 44%
- Elementary & Secondary Education: 10%
- Transportation: 10%
- All Other: 27%
- Higher Education: 5%
- Public Assistance: 4%
- Corrections: 0.3%

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.

Figure 43

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

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.

Figure 46

State Variation in Medicaid Spending Growth Rates, 1991 - 2001

Average Annual Rate of Medicaid Spending Growth, 1991-2001

Lowest State: 6.9%
Median State: 11.5%
Highest State: 15.7%

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

KAISER COMMISSION ON Medicaid and the Uninsured
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.

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Adults</th>
<th>Disabled</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term Care</td>
<td>$1,700</td>
<td>$1,900</td>
<td>$12,300</td>
<td>$12,800</td>
</tr>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
States’ Medicaid Response to the Current Fiscal Crisis
Figure 49

Underlying Growth in State Tax Revenue
Adjusted for Inflation and Legislative Changes, 1997-2004


5.0% 5.9% 5.0% 4.9% 1.0% -6.8% -3.3% 1.5%

**Figure 50**

**Sources of Growth in Federal Medicaid Expenditures, 2002-2003**

```
Total Increase in Expenditures for Beneficiaries = $11 billion

- Children: 18% ($2.0 billion)
- Adults: 5% ($0.6 billion)
- Elderly and Disabled: 77% ($8.4 billion)

Factors Behind Expenditure Growth

- Services-related: 53% ($8.4 billion)
- Enrollment-related: 47% ($2.0 billion)
```

Figure 51

Total Reduction in Medicaid Spending Resulting from State Budget Cuts

Medicaid spending reduction if states cut Medicaid budgets:

- **State Funds Saved**
- **Federal Dollars Lost**

<table>
<thead>
<tr>
<th>FMAP</th>
<th>State Funds Saved</th>
<th>Federal Dollars Lost</th>
<th>Total Reduction in Medicaid Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMAP = 50%</td>
<td>$100</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>FMAP = 65%</td>
<td>$100</td>
<td>$186</td>
<td>$286</td>
</tr>
<tr>
<td>FMAP = 70%</td>
<td>$100</td>
<td>$233</td>
<td>$333</td>
</tr>
</tbody>
</table>

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)

- Controlled Drug Costs: 50
- Reduced or Froze Provider Payments: 50
- Reduced or Restricted Eligibility: 34
- Reduced Benefits: 35
- Increased Co-Payments: 32

Does Medicaid Need Federal Reform?
What Should Federal Reform Accomplish?
Figure 54

Number of Nonelderly Uninsured Americans, 1994-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>Previous Method</th>
<th>Revised Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>39.8</td>
<td>39.6</td>
</tr>
<tr>
<td>1995</td>
<td>40.6</td>
<td>40.0</td>
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<tr>
<td>1996</td>
<td>41.7</td>
<td>40.9</td>
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<tr>
<td>1997</td>
<td>43.1</td>
<td>43.3</td>
</tr>
<tr>
<td>1998</td>
<td>43.9</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>42.1</td>
<td></td>
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<tr>
<td>2000</td>
<td>39.6</td>
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<tr>
<td>2001</td>
<td>40.9</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>43.3</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>Poor (&lt;100 Poverty)</th>
<th>Near-Poor (100-199% Poverty)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>25%</td>
<td>17%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>56%</td>
<td>36%</td>
</tr>
<tr>
<td>Employer</td>
<td>14%</td>
<td>41%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor (&lt;100 Poverty)</td>
<td>43%</td>
<td>31%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>34%</td>
<td>13%</td>
</tr>
<tr>
<td>Employer</td>
<td>15%</td>
<td>49%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Adults without children</td>
<td>46%</td>
<td>37%</td>
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<tr>
<td>Poor (&lt;100 Poverty)</td>
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<tr>
<td>Medicaid</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Near-Poor (100-199% Poverty)</td>
<td>37%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Notes: Adults age 19-64. Data may not total 100% due to rounding.
Figure 56
Projected Annual Rate of Federal Medicaid Spending Growth v. Other Federal Spending, 2003-2013

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
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.
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