

Alternatives for Financing Medicaid Expansions in Health Reform

Prepared by:
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Prepared for:
The Kaiser Commission on Medicaid and the Uninsured

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kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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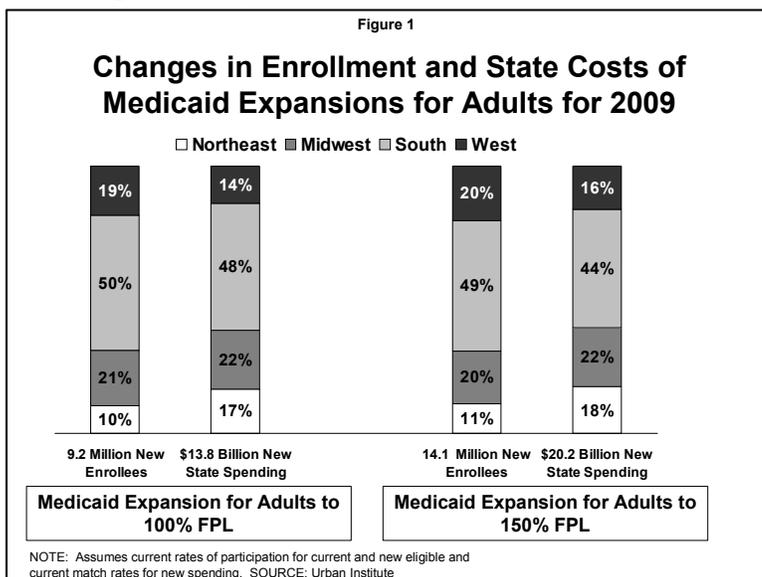


Executive Summary

Expanding Medicaid to cover low-income populations has been a fundamental component of leading health reform proposals. The House Leadership Bill would expand Medicaid to 150% of the federal poverty level (FPL) and the Senate Leadership Bill would expand Medicaid to 133% FPL. In both scenarios the federal government would finance a substantial share of costs for the expansion groups; however, this analysis shows that it is possible to distribute increased federal payments in multiple alternative ways that could be less complicated and would avoid perpetuation of inequities that would be associated with providing higher matching rates just for new eligible Medicaid enrollees.

Expanding Medicaid eligibility levels using current financing methodologies would result in higher costs and coverage in the south and west compared to the northeast and midwest.

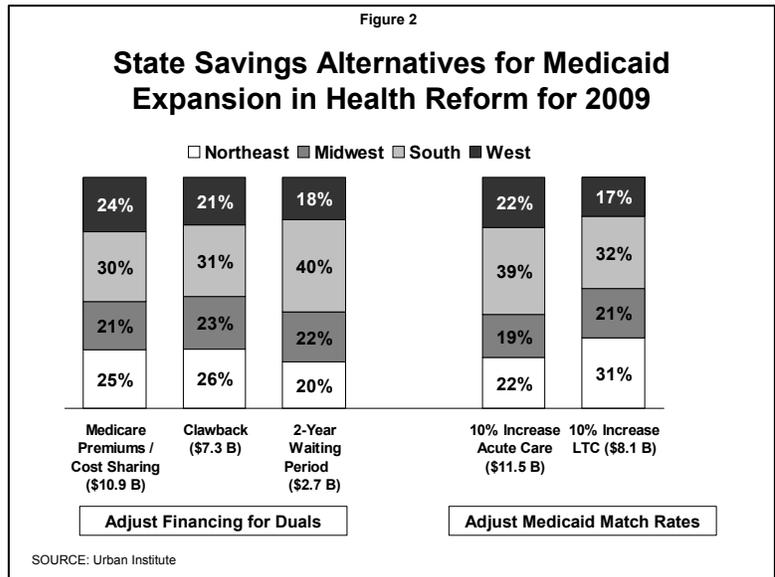
The new costs of expanding Medicaid will vary widely across states. States with low eligibility standards would have the most new eligibles (mostly states in the South and West) and other states would experience no or small expansions (like Massachusetts, Vermont, New York, Maine, Minnesota and Arizona). Figure 1 shows the distribution of new enrollees and state costs assuming current match rates assuming full phase-in of the expansion in 2009. Because of the current match rate structure, a larger share of federal dollars would go to the south and west so the share of state spending is lower than the share of new enrollees in these regions if eligibility is expanded to 100% or 150% FPL for adults. For example, in an expansion to 150% FPL, the south is expected to account for 49% of the new enrollees but 44% of the new state spending.



Current financing plans for Medicaid expansions under health reform proposals will be complex and will set up longer-term financing inequities across states.

Under both the House and Senate bills states would receive high federal match rates for new enrollees in expansion groups (and some current eligibles covered by waivers in the House) and current match rates for current enrollees and new participation of those currently eligible. So, states that have been historically generous in terms of coverage levels would receive less federal assistance because most of their new enrollees would be those that were previously eligible. These proposals introduce long-term complexity to the way Medicaid is financed as well as administrative complexity to the program.

There are alternatives to providing fiscal relief to the states that would also target funds to states with large increases in new enrollment. In this paper we examine the effects, by state and region, of alternative strategies for providing fiscal relief to states in 2009 (Figure 2). The alternative proposals include shifting Medicare related expenses to the federal government. Medicaid is now responsible for paying for Medicare premiums and cost sharing for low-income Medicare beneficiaries, wrap-around services not covered by Medicare for dual eligibles, and care for low-income individuals receiving disability payments for the 24 month waiting period before they are eligible for Medicare. In addition, while prescription drug coverage for duals was transitioned from Medicaid to Medicare in January 2006, states are still required to pay for a share of these costs through a payment referred to as the “clawback”. Shifting these costs to the federal government would disproportionately favor the south, the same region that will experience the greatest increase in new coverage. The analysis also shows the state specific effects of increasing matching rates for acute and long term care services. The savings associated with increasing the match for long-term care would be distributed among states in proportion to their current spending on long-term care and would result in higher savings to the northeast which would not meet the objective of targeting savings to states with higher enrollment from new Medicaid expansions.



Financing alternatives would not be as complex and would also address long-standing Medicaid financing issues. Alternative Medicaid financing options allow the current matching rate structure to stay in place and would not introduce new disparities in matching rates across populations that are included in the Senate and House proposals. These differential match rates for expansion groups compared to current eligibles could require continuation of complex eligibility determination systems to determine whether new enrollees are eligibles under previous or new eligibility standards. In addition, shifting Medicare related costs to the federal government could potentially help efforts to coordinate care for high-cost populations that has been difficult with two funding streams. Under these alternatives, the targeting of funds to states with the most new enrollees is not perfect and some additional transition funds may be necessary for states with very large increases in enrollment. But in most cases, states with the greatest expansions would receive a substantial influx of new federal dollars, with \$2-\$3 in federal funds for every dollar of new state spending.

Introduction

Expanding Medicaid to cover low-income populations has been a prominent component of health reform proposals. The Senate Leadership bill would expand Medicaid to 133% of the federal poverty level (FPL) and House Leadership bill to 150% FPL. Both would have the federal government pay a substantial share of the new expenditures. The House bill would have the federal government paying 100% of the cost of new eligibles (and some currently eligible through waivers) in 2013 and 2014 and 91% thereafter. In the Senate proposal, the federal government would pay 100% of the cost of new eligibles for 2014 through 2016. In 2017 and 2018 the percentage point increase in the federal matching assistance percentage (FMAP) would be 30.3 and 31.3 for states that already cover adults with incomes above 100% FPL and 34.3 and 33.3 percentage points for other states. These percentage point increases would be adjusted so that by 2019, all states would receive an increase of 32.3 percentage points for the newly eligible, not to exceed 95% in any year. The increased federal share does not apply to those currently eligible in the Senate bill.

The House proposal would require that states continue to provide coverage to those eligible on June 16th 2009. Thus states that have expanded coverage voluntarily would find that voluntary effort turned into a mandate. The Senate proposal has a maintenance of eligibility for children in Medicaid and CHIP through 2019 and for adults through 2014, when the state exchanges are expected to be operational.

The problem with these approaches to paying for the new or marginal costs of Medicaid expansions is that current coverage in Medicaid varies greatly among states. As shown in Table 1, some states cover far more low-income people than others. Two states, Massachusetts and Vermont, would have no new eligibles if Medicaid coverage is extended

to 133% of FPL. Other states, like New York, Maine, Minnesota, and Arizona, would experience only small expansions. (The House bill would provide an enhanced match for those states that have already extended coverage for non-disabled childless adults and some parents through waivers. In contrast there are a significant number of states particularly in the south and west that would have major expansions of health insurance coverage and would potentially face large increases in expenditures. These states would have most of the new spending borne by the federal government. Thus, states with low eligibility standards would have the most new eligibles and for these new eligibles they would receive a very high federal match.

States would be likely to also experience an increase in participation among those currently eligible. Under both the House and Senate bills (and in the House bill those covered through a 1931 state plan amendment as opposed to a waiver), states would receive their current matching rate for those currently eligible. The problem is that in some states, most of the new enrollees would be from among the ranks of the previously eligible. Thus not only are there likely to be fewer new enrollees in high coverage states, but more new enrollees are likely to come from the previously eligible because eligibility standards have been broader. Therefore (with the exception in the House where enhanced federal financing also applies to states that have expanded through waivers) states that have been historically generous are in effect penalized - they would receive less federal assistance because most of their new enrollees would be those that were previously eligible. Moreover, states would continue to receive their current Medicaid match for those that are currently enrolled. The opposite is true in less generous states. States that have fewer current enrollees and fewer previously eligible but unenrolled but many new eligibles would in effect receive a significantly higher

average matching rate than is true today, again with some exceptions for those currently covered through waivers in the House bill.

These proposals will therefore introduce extraordinary complexity to the way Medicaid is financed that, absent substantial changes, would remain in place in perpetuity. A related problem is that there will be enormous administrative complexity (as well as incentives for gaming) in that states will have to determine, for each new enrollee, whether they would be eligible for coverage through old or new rules, a calculation that will affect their federal matching funds.

Meanwhile, there are a number of problems in Medicaid financing that would remain unaddressed. For example the federal government now pays for Medicare premiums and cost sharing for dual eligibles. Thus states must pay for some of the costs for this population while it has little control over their ultimate expenditures. Second, when the Medicare drug benefit was enacted states were required to continue to pay an amount equal to a high share of their estimated expenditures had there been no change in legislation. This provision, known as the clawback, requires states to continue making payments, potentially forever, that are based on the prescription drug policies they enacted years earlier¹. Third, there are a large number of individuals who are not eligible for Medicare until they have been receiving disability payments for 24 months. During this period they can receive Medicaid benefits which mean that states must pay for Medicaid benefits in a period in which arguably these individuals should be eligible for Medicare.

Finally, a strong argument can be made that care for dual eligibles should be financed by the federal government². At present, Medicaid has primary responsibility for long-term care as well as for Medicare premiums and cost-sharing obligations. Medicare has primary

responsibility for acute care services. There is a substantial need for coordination in the care provided to these populations. This is made very difficult when two major programs, operated by different levels of government with different revenue streams, share responsibilities for the same population. Though the amount spent on dual eligibles is considerable and would represent a major increase in federal spending, clearly an argument could be made that shifting all of the care for dual eligibles to the federal government could yield efficiencies from vastly improved care coordination.

In this paper we examine the effects, by state and region, of alternative strategies for providing fiscal relief to states. All estimates assume full phase in of the Medicaid expansion in 2009. The goal is to show that there are alternative ways to provide support to states that would actually target funds reasonably well to states with large increases in new enrollment. We include shifting some or all of the costs of dual eligibles to the federal government, eliminating the clawback payment, and ending the two year waiting period. The implications of the federal government assuming all costs of dual eligibles are also shown. We also examine the state specific effects of increasing matching rates for acute and long term care services. These policies would not target federal funds as effectively as the Senate and House proposals on the newly eligible but would be easier to implement and would generally distribute most funds to states that face large new incremental costs. Some supplemental short term transfers to large expansion states may still be needed. In addition to addressing some cumbersome features of current Medicaid financing, these alternatives would help avoid the problem of creating an inequitable system that would potentially be in place for a very long period of time.

Cost and Coverage Estimates of Various Expansions

Earlier this year we published estimates of the coverage and cost impacts of expanding Medicaid³. We found that extending Medicaid to adults to 100% of FPL would cost \$61.5 billion dollars in 2009. Further, a policy that would extend coverage to adults to 150% FPL would cost \$78.4 billion. These estimates assume close to full participation (about 90%) which is consistent with not covering undocumented immigrants and somewhat less than 100% participation. If we assume participation rates are closer to current experience the cost would fall to \$30.2 billion and \$43.7 billion respectively. The Congressional Budget Office has projected Medicaid coverage increases that are consistent with the lower estimates, believing that it would be difficult to enforce a mandate for low income people who pay little or no income taxes. But the key point for this paper is not the overall cost but the distribution of the new spending among states.

We showed that a large share of the new coverage and expenditures would be in southern states (Table 2). A policy that extended coverage to adults to 100% FPL, the South would see 51.9% of the increased expenditures (without a change in matching rates). The northeastern states would only experience a 13.9% increase in spending, the Midwest 21.7%, and the West 12.5%. A similar picture emerges for an expansion to 150% FPL. Table 3 shows that because of the more favorable matching rates now in place, 54.9% of federal spending is in the South but only 47.5% of state spending. This means that a large share of the new federal dollars in Medicaid would go to southern states that have large low income populations and limited Medicaid coverage currently, even without an increase in federal matching rates. The House and Senate bills would dramatically increase federal matching rates for new eligibles, meaning that these states would experience a very high federal match

potentially indefinitely. This would only change if the distribution of federal matching funds was revisited at some point in the future.

In the next section, we examine a number of alternatives that would relieve some of the financial costs that states now bear for Medicaid. Most of these alternatives would do so in a way that would provide a disproportionate share of the benefits to states in the South, thus offsetting most of the cost of new enrollees. These alternatives would not target funds as effectively as proposals in the House and Senate. But neither would they have the inequities and administrative complexities of differential matching rates for new and previous eligibles.

Shifting Some Medicaid Responsibilities to the Federal Government

In this section, we discuss alternatives that would shift some Medicaid financing responsibilities to the federal government. The intent is to show that new state expenditures from new enrollment can be offset in other ways. Under current law, Medicaid pays for a variety of Medicare related expenses for 17% of Medicare beneficiaries. The dual eligibles are substantially poorer and sicker than other Medicare beneficiaries and their costs account for over 40 percent of overall Medicaid spending⁴. Medicaid pays for premiums and cost-sharing for low-income Medicare beneficiaries and additional services not covered by Medicare, including long-term care. Medicaid also provides coverage during the two-year Medicare waiting period for low-income people with disabilities under age 65 and helps finance Medicare coverage of prescription drugs for dual eligibles through a “clawback” payment to the federal government.

Many have argued that the current split between Medicare and Medicaid in financing care for low income, aged and disabled individuals is highly inefficient from both a quality and payment perspective. The federal government pays for a higher share of acute care costs

but states are required to pay Medicare premiums for Part B and cost sharing for services (the Medicare Savings Programs) used by low-income Medicare beneficiaries although they have no control over acute care payment policies or levels. The policy requiring Medicaid programs to make premium payments to Medicare was established decades ago when Medicare did not provide additional financial assistance to low-income beneficiaries. More recently, with the implementation of the Medicare Part D benefit low-income subsidy benefit, the federal government has adopted mechanisms to provide financial help to low-income Medicare beneficiaries and may now be a more efficient vehicle to provide this assistance.

Many dual eligibles have multiple chronic physical and mental conditions and are more likely than other Medicare beneficiaries to be high utilizers of acute and long-term care services⁵. Navigating health needs across these two programs is difficult and creates challenges in coordinating care for a particularly vulnerable and high cost population. Moreover, the split of services between the programs, with Medicare responsible primarily for acute care services, while Medicaid pays for virtually all long-term care services, creates incentives for cost-shifting, rather than cost-efficient care, between the two programs. Consolidating these costs and care responsibilities to the federal government would reduce state Medicaid costs and provide an incentive for investment in care coordination programs because the benefits of the coordination would return to the level of government that is making the investment.

Below we explore four alternative ways responsibilities for financing care for dual eligibles can be shifted to the federal government: shifting acute care services for dual eligibles, eliminating the clawback payment for prescription drugs, eliminating the two year

waiting period for Medicare for those with disabilities, and shifting all costs for dual eligibles to the federal government.

Federal assumption of the cost of Medicare premiums and cost sharing on Medicare services. Under current law, Medicaid pays Part B premium and cost sharing for low-income Medicare beneficiaries. Making these costs the full responsibility of the federal government through Medicare would have provided \$10.9 billion in relief to states in 2009 (Table 4). In this option, states would remain responsible for all other benefits, e.g. long term care and acute care services, not covered by Medicare for dual eligibles. This change would also be consistent with the way that the low-income subsidy is provided for the Medicare Part D prescription drug benefit where Medicare is responsible for the premium cost.

The results by state and region are shown in Table 4. The results show that states in the Northeast would have saved \$2.7 billion (25.3%), the Midwest \$2.3 billion (21.0%), and the West \$2.6 billion (23.6%). The South would have the largest savings at \$3.3 billion, or 30.1% of the savings. The South receives the largest share of funds because it has large numbers of older and disabled individuals who are low-income and are therefore dual eligibles.

Eliminate the current clawback payment for prescription drugs. As part of the Medicare Modernization Act, prescription drug coverage for the duals was transitioned to the Medicare Part D program on January 1, 2006; however, states are now obligated to finance a portion of this Medicare coverage through a payment referred to as the “clawback” to the federal government. The clawback payment is based on the projection of what the prescription drug spending for these dual eligibles would have been in the absence of the shift. States were

required to pay 90% of estimated state savings in 2006 with the share dropping to 75% after 10 years⁶. Relieving states of their clawback obligations would save \$7.3 billion in 2009. Ending the clawback payment would distribute savings fairly evenly throughout the country. The Northeast would receive \$1.9 billion, or 25.7% of the savings, and the Midwest \$1.7 billion or 22.9%. The South would receive \$2.3 billion (30.8%) and the West \$1.5 billion (20.6%).

Eliminate the two year waiting period for Medicare. Under current law individuals who become eligible for the Supplementary Security Disability Income program receive income benefits immediately upon the eligibility determination but must wait two years to become eligible for Medicare benefits. During this two year period many receive Medicaid benefits, but will eventually become dual eligibles. Eliminating the two-year waiting period of Medicare could lead to more consistent care management with other nonelderly dual eligibles and could save states \$2.7 billion in 2009⁷. Ending the two year waiting period would provide the greatest benefit to the South, again because of the large number of aged and disabled individuals. The South would receive \$1.1 billion, or 39.8% of the savings. The remaining outlays would be split fairly evenly with the Northeast receiving 20.1% of the savings, the Midwest 21.8%, and the West 18.3%.

Full federal financing for all spending on dual eligibles. If the federal government assumed all costs of dual eligibles, including premiums, cost-sharing and other services not covered by Medicare, states would save \$69.8 billion. This would mean shifting long term care as well as acute care services for dual eligibles to the federal government. Long-term care spending is far more variable across states than acute care services. If long-term care services were shifted to the federal government, more uniform standards would need to be

established. Thus, this option would provide opportunities for better care coordination and more uniform long-term care service options, but would likely also add substantially to the overall cost of long term services. Table 4 shows that if all of the cost for dual eligibles were shifted to the federal government savings would be heavily tilted toward states in the northeast that have had more generous coverage of long term care services for dual eligibles. As a result the Northeast would receive \$26.0 billion or 37.4% of the savings. Of the other regions, the Midwest would receive \$14.4 billion (20.6% of the savings), and the West \$13.2 billion, or 19.0%. The South would see savings of only \$16.0 billion (23.0%) because of less current coverage of long term care services. Thus while having other merits, this policy would not be well targeted to offset new expenditures by states with the greatest increase in enrollment.

While shifting all of the costs of dual eligibles to the federal government would not be well targeted, the other three policies would shift costs of the federal government in a way that would disproportionately favor the South, the same region that will experience the greatest increase in new coverage. These shifts would not only address awkward provisions of the current law and a problem that has plagued states for several years but would also allow the current matching rate structure to stay in place and avoid the distortions that are present in the Senate and House proposals.

Increase the Federal Share of Medicaid Spending for Program Responsibilities

Another set of options to realign the federal and state roles for financing Medicaid would be to increase the federal match or the share that the federal government pays for certain services (or alternatively certain populations). Increasing the federal share would free up state resources that could be put toward coverage expansions. There are a number of options to increase federal matching rates. The first option is to increase matching rates on acute care services for all but dual eligibles. This policy might be attractive if combined with another policy that affected dual eligibles such as shifting the cost of acute care services for dual eligibles to the federal government. Alternatively, increasing matching rates for all acute care services or all long term care services could be adopted. And finally matching rates could be increased on both acute and long term care services. It is assumed, but not shown, that matching rates would be increased on new enrollees by the same percentage. The results are shown in Table 5.

Increase matching rates on acute care services for non- dual eligibles by 10%. Increasing matching rates for acute services would provide benefits to many low income states because it would offset the cost of current coverage. Increasing matching rates for acute care services by 10% would provide savings to states of \$11.5 billion. A very high share of savings would go to states in the south. This occurs because while eligibility standards are not as extensive as elsewhere, these states have large low income populations and end up covering large numbers of people. The result is that southern states would receive \$4.2 billion or 36.7% of the benefits. Of the remainder, the Northeast would receive \$2.6 billion (22.6%), the Midwest \$2.2 billion (19.1%), and the West \$2.5 billion (21.7%). This policy would thus distribute benefits much in line with the cost of new enrollees. Thus a policy that increases

matching rates on acute care services for new enrollees as well as all current enrollees whether they are previously eligible or newly eligible, would result in most of the benefits going to the states with the largest increases in coverage but would change the distribution of federal matching funds among states.

Increase matching rates for all acute care services by 10%. An alternative would be to simply increase the matching rates on all acute care services including dual eligibles, as well as all new enrollees. The effects would be similar to those in the previous option. The savings to states would be \$14.5 billion. Of this \$5.2 billion would be in the South, 35.9% of the savings from the higher federal matching rates. This occurs once again because the Southern states serve a large number of low income individuals, despite more limited Medicaid eligibility standards. The Northeast would receive \$3.2 billion in savings or 22%, the Midwest \$3.0 billion or 20.5%, and the West \$3.1 billion or 21.6%.

Increase matching rates on long-term care services by 10%. A less costly option for the federal government would be to increase the matching rate on spending on long-term care by 10%, together with a policy to provide incentives for states to work with the federal government in developing new models for chronic care management. If matching rates were increased on all long term care spending for all populations, states would save \$8.1 billion. This would address states concerns with the looming problem of an aging population. The savings however would be distributed among states in proportion to their current spending on long-term care. As a result the states in the Northeast would see savings of 30.5%; the South simply because of its large population would receive savings of 31.6%. The remaining savings would be 21.2% in the Midwest, and 16.8% in the West. Thus because the Northeast has provided a broader range of long term care services the distribution of savings would

tend to favor states in this region. While an argument could be made for providing additional support to the northeastern states because of the long-term care systems they support, the distribution of funds would not be in line with the distribution of new enrollees because of the Medicaid expansion.

Increase in matching rates for acute and long-term care services by 5%. Another alternative is to simply increase matching rates across the board for acute and long term care services. A 5% increase in the matching rates would provide states with savings of \$11.3 billion. Of this amount, states in the Northeast would receive 25.1% of the benefits, the Midwest 20.7%, the South 34.3%, and the West 18.9%.

Thus it is possible to distribute increased federal payments in multiple alternative ways that do not result in an unwieldy federal matching system. These policies could address current problems in Medicaid financing structure and avoid perpetuation of inequities that would be associated with providing higher matching rates just for new eligible Medicaid enrollees.

Conclusion

In this brief, it is argued that the approaches to financing the Medicaid expansions that are being proposed in the House and the Senate raise some extremely difficult issues that, unless addressed, are likely to plague Medicaid financing for a long time period of time. Essentially both the House and Senate have made major proposals to extend coverage - in the House to 150% FPL and in the Senate to 133% FPL. This would result in large increases in eligibles in most states and many new enrollees. Not only would eligibility standards be extended but the individual mandate, though somewhat difficult to enforce at these income levels, will mean that large numbers of both previously eligible and newly eligible people will enroll. Both the House and the Senate propose to make rather generous federal matching payments available to states experiencing increased enrollment among newly eligibles and some current eligibles covered through waivers in the House. In the Senate and House bills states would not receive enhanced assistance for new enrollment among those who are currently eligible (with some exceptions in the House bill).

The outcome will be a matching rate structure that has little rational basis. The current structure already favors low income states. Average matching rates would be increased substantially more, particularly for those states that are experiencing many new eligibles. States for whom most of the increase in enrollment would be among those who were previously eligible would receive no increase in federal matching support for this new enrollment.

Thus both bills in effect impose a penalty for having been previously generous. The penalty comes in the form of locking in lower matching rates for states that have more extensive coverage today. Not only is there less new enrollment in states with more generous

coverage but the ratio of new enrollment among those previously eligible and newly eligible varies considerably among states. Almost all new enrollment in a state such as Alabama will be among those newly eligible. In states like Massachusetts and Vermont there will be no newly eligibles and all of the increased enrollment will be among previously eligibles. Furthermore, groups that are currently enrolled in some states would be new enrollees in other states.

There are several alternative ways to address this problem that have discussed above. A policy that would have the federal government pay for Medicare premiums and for cost sharing for acute care services, eliminate the prescription drug clawback payment, and end the 24 month waiting period for Medicare enrollment of disabled individuals would provide considerable financial support to all states. Somewhat surprisingly, it would provide a disproportionate share of these funds to states in the south, states that will experience the greatest increase in enrollment. The result of adopting a policy that shifted these costs entirely to the federal government would mean that the current matching rate structure could stay in place and the inequities we discussed above would not exist. Shifting all of the costs of dual eligibles would have many advantages in terms of providing greater support for care coordination but would not distribute dollars to the states that would experience most of the new enrollment.

We also found that increasing matching rates for acute care services either for non duals or for all Medicaid eligibles would largely redistribute funds to southern states that would experience most of the new enrollment. This is because these states have large low income populations that are current enrollees in Medicaid, despite lower eligibility levels; thus increasing matching rates provides benefits to those states that would help offset the

costs of new enrollment. Increasing matching rates on long term care services as with policies that affect all services for dual eligibles would not be as well targeted. Whatever other merits such policies might have they do not help address the incremental cost of new enrollees.

Clearly the policies adopted by the House and the Senate target funds well to new enrollees. But they create enormous inequities in the process. Adopting policies such as those discussed in this brief could result in a more equitable outcome, though it would target somewhat less to states experiencing the most new enrollment. While these states—those with the most new enrollees—would have to spend more with these policies than they would under the House and Senate proposals, there would be a huge influx of new federal money into these states even with current matching rates. For every dollar of new state spending in most of the states with new enrollees, there would be 2-3 dollars of new federal money. The increase in state spending could also be avoided if the federal government simply bore a higher share of the new expenditures. Fairness in the treatment of states is extremely important. The options presented here would both be more equitable and introduce less administrative complexity than the House and Senate proposals.

Notes

¹ Andy Schneider, “The Clawback: State Financing of Medicare Drug Coverage” Kaiser Commission on Medicaid and the Uninsured, June 2004

² John Holahan, Dawn M. Miller and David Rousseau, “Rethinking Medicaid’s Financing Role for Medicare Enrollees,” Kaiser Commission on Medicaid and the Uninsured, February 2009

³ Bowen Garrett, John Holahan, Allison Cook, Irene Headen and Aaron Lucas, “The Cost and Coverage Impacts of Expanding Medicaid,” Kaiser Commission on Medicaid and the Uninsured, May 2009

⁴ John Holahan, Dawn M. Miller and David Rousseau, “Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005,” Kaiser Commission on Medicaid and the Uninsured, February 2009

⁵ Teresa Coughlin, Timothy Waidmann and Molly O’Malley Watts, “Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligibles,” Kaiser Commission on Medicaid and the Uninsured, April, 2009

⁶ Andy Schneider, *op. cit.*

⁷ Stacy Berg Dale and James M. Verdier, “Elimination of Medicare’s Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs,” The Commonwealth Fund, July 2003

Table 1. Medicaid/CHIP Eligibility					
	Eligibility as a Percent of the Federal Poverty Level, December 2009				Percent of Non-Elderly with Medicaid/CHIP**, 07-08
	Children	Working Parent*	Childless Adults*	Pregnant Women	
United States	235%	64%	NA	185%	17.7%
Alabama	300%	24%	NA	133%	17.9%
Alaska	175%	81%	NA	175%	18.6%
Arizona	200%	106%	110%	150%	20.9%
Arkansas	200%	17%	NA	200%	22.8%
California	250%	106%	NA	200%	18.1%
Colorado	205%	66%	NA	200%	12.1%
Connecticut	300%	191%	NA	250%	14.5%
Delaware	200%	121%	110%	200%	16.5%
District of Columbia	300%	207%	NA	300%	23.1%
Florida	200%	53%	NA	185%	14.3%
Georgia	235%	50%	NA	200%	16.7%
Hawaii	300%	100%	100% (closed)	185%	17.7%
Idaho	185%	27%	NA	133%	13.3%
Illinois	200%	185%	NA	200%	15.9%
Indiana	250%	25%	NA	200%	15.9%
Iowa	300%	83%	NA	300%	14.4%
Kansas	241%	32%	NA	150%	15.6%
Kentucky	200%	62%	NA	185%	20.7%
Louisiana	250%	25%	NA	200%	19.0%
Maine	200%	206%	NA	200%	23.6%
Maryland	300%	116%	NA	250%	12.3%
Massachusetts	300%	133%	NA	200%	20.2%
Michigan	200%	64%	NA	185%	16.7%
Minnesota	275%	215%	NA	275%	14.5%
Mississippi	200%	44%	NA	185%	24.8%
Missouri	300%	25%	NA	185%	17.7%
Montana	250%	56%	NA	150%	17.5%
Nebraska	200%	58%	NA	185%	13.7%
Nevada	200%	88%	NA	185%	10.4%
New Hampshire	300%	49%	NA	185%	9.7%
New Jersey	350%	200%	NA	200%	11.3%
New Mexico	235%	67%	NA	235%	21.4%
New York	400%	150%	100%	200%	21.6%
North Carolina	200%	49%	NA	185%	18.9%
North Dakota	160%	59%	NA	133%	11.5%
Ohio	200%	90%	NA	200%	16.2%
Oklahoma	185%	47%	NA	185%	20.3%
Oregon	300%	40%	NA	185%	14.1%
Pennsylvania	300%	34%	NA	185%	15.9%
Rhode Island	250%	181%	NA	250%	17.8%
South Carolina	200%	89%	NA	185%	17.5%
South Dakota	200%	52%	NA	133%	15.0%
Tennessee	250%	129%	NA	250%	21.9%
Texas	200%	26%	NA	185%	17.0%
Utah	200%	44%	NA	133%	10.1%
Vermont	300%	191%	160%	200%	22.3%
Virginia	200%	29%	NA	200%	14.4%
Washington	300%	74%	NA	185%	17.5%
West Virginia	250%	33%	NA	150%	20.8%
Wisconsin	300%	200%	NA	300%	16.2%
Wyoming	200%	52%	NA	133%	14.1%

*Note: This column includes states that provide coverage comparable to the state's full Medicaid coverage for parents. Additional states provide more limited coverage to childless adults.

**Note: Medicaid/CHIP includes dual eligibles and individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE (formerly CHAMPUS) as well as some non-elderly Medicare enrollees.

Sources:
Children's Eligibility and Pregnant Women Eligibility: Based on a national survey conducted by KCMU and the Center on Budget and Policy Priorities, 2009.
Working Parent and Childless Adults: Based on Where Are States Today: Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults, Kaiser Commission on Medicaid and the Uninsured analysis of state policies through program websites and contacts with state officials, December 2009. Available at: <http://www.kff.org/medicaid/upload/7993.pdf>.
Public Coverage: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements). Data are for states (2007-2008) and U.S. (2008).

Table 2
Change in Medicaid Enrollment and Expenditures
by Region in 2009
Current Participation Rates

	Public Expansion: Adults to 100% FPL				Public Expansion: Adults to 150% FPL			
	Enrollment	% of US Enrollment	Expenditures (in millions)	% of US Spending	Enrollment	% of US Enrollment	Expenditures (in millions)	% of US Spending
US	9,190,970	100.0%	\$33,707	100.0%	14,148,503	100.0%	\$49,045	100.0%
Northeast	955,248	10.4%	\$4,691	13.9%	1,550,715	11.0%	\$7,288	14.9%
Midwest	1,894,049	20.6%	\$7,324	21.7%	2,795,767	19.8%	\$10,732	21.9%
South	4,630,362	50.4%	\$17,488	51.9%	6,932,190	49.0%	\$23,831	48.6%
West	1,711,311	18.6%	\$4,204	12.5%	2,869,831	20.3%	\$7,195	14.7%

Table 3
Federal and State Share of Spending on New Medicaid Expenditures
by Region in 2009
Current Participation Rates

	Public Expansion: Adults to 100% FPL					Public Expansion: Adults to 150% FPL				
	Total Expenditures (in millions)	Federal Spending	% of Federal Spending	State Spending	% of State Spending	Total Expenditures (in millions)	Federal Spending	% of Federal Spending	State Spending	% of State Spending
US	\$33,707	\$19,901	100.0%	\$13,806	100.0%	\$49,045	\$28,818	100.0%	\$20,227	100.0%
Northeast	\$4,691	\$2,407	12.1%	\$2,284	16.5%	\$7,288	\$3,739	13.0%	\$3,549	17.5%
Midwest	\$7,324	\$4,281	21.5%	\$3,044	22.0%	\$10,732	\$6,272	21.8%	\$4,460	22.0%
South	\$17,488	\$10,917	54.9%	\$6,571	47.6%	\$23,831	\$14,877	51.6%	\$8,954	44.3%
West	\$4,204	\$2,296	11.5%	\$1,907	13.8%	\$7,195	\$3,930	13.6%	\$3,265	16.1%

Table 4								
Savings By State and Region From Realignment of Medicaid Responsibility								
State	MEDICARE PAYMENT For Premiums and Cost Sharing: Projected States' Share of Medicaid Spending 2009 Baseline (in millions)	Percent of US Total	Projected Part D Clawback Expenditures, 2009 (in millions)	Percent of US Total	Ending the Two Year Medicare Waiting Period (in millions)	Percent of US Total	DUAL ELIGIBLES Projected States' Share of Medicaid Spending 2009 Baseline (in millions)	Percent of US Total
United States	10,862	100.0%	7,304	100.0%	2,700	100.0%	69,605	100.0%
Northeast	2,745	25.3%	1,875	25.7%	543	20.1%	26,010	37.4%
Maine	50	0.5%	38	0.5%	18	0.7%	390	0.6%
New Hampshire	31	0.3%	30	0.4%	13	0.5%	392	0.6%
Vermont	11	0.1%	24	0.3%	7	0.2%	248	0.4%
Massachusetts	357	3.3%	246	3.4%	64	2.4%	2,531	3.6%
Rhode Island	80	0.7%	37	0.5%	13	0.5%	438	0.6%
Connecticut	194	1.8%	125	1.7%	32	1.2%	1,630	2.3%
New York	1,470	13.5%	897	12.3%	188	7.0%	13,398	19.2%
New Jersey	284	2.6%	251	3.4%	80	3.0%	2,893	4.2%
Pennsylvania	267	2.5%	226	3.1%	130	4.8%	4,091	5.9%
Midwest	2,280	21.0%	1,673	22.9%	588	21.8%	14,350	20.6%
Ohio	340	3.1%	278	3.8%	97	3.6%	2,666	3.8%
Indiana	162	1.5%	125	1.7%	59	2.2%	1,284	1.8%
Illinois	397	3.7%	419	5.7%	99	3.7%	2,435	3.5%
Michigan	290	2.7%	220	3.0%	102	3.8%	1,559	2.2%
Wisconsin	151	1.4%	165	2.3%	44	1.6%	1,406	2.0%
Minnesota	410	3.8%	96	1.3%	39	1.5%	1,962	2.8%
Iowa	101	0.9%	64	0.9%	26	0.9%	645	0.9%
Missouri	254	2.3%	191	2.6%	71	2.6%	1,167	1.7%
North Dakota	12	0.1%	10	0.1%	4	0.2%	160	0.2%
South Dakota	18	0.2%	13	0.2%	6	0.2%	139	0.2%
Nebraska	71	0.7%	43	0.6%	15	0.6%	396	0.6%
Kansas	74	0.7%	49	0.7%	25	0.9%	532	0.8%
South	3,270	30.1%	2,251	30.8%	1074	39.8%	16,010	23.0%
Delaware	32	0.3%	17	0.2%	9	0.3%	244	0.4%
Maryland	197	1.8%	104	1.4%	44	1.6%	1,094	1.6%
District of Columbia	21	0.2%	11	0.1%	5	0.2%	140	0.2%
Virginia	196	1.8%	150	2.1%	72	2.7%	1,371	2.0%
West Virginia	68	0.6%	36	0.5%	31	1.1%	316	0.5%
North Carolina	250	2.3%	255	3.5%	105	3.9%	1,604	2.3%
South Carolina	163	1.5%	101	1.4%	55	2.0%	515	0.7%
Georgia	204	1.9%	171	2.3%	86	3.2%	1,082	1.6%
Florida	724	6.7%	464	6.3%	161	6.0%	2,854	4.1%
Kentucky	107	1.0%	88	1.2%	61	2.2%	590	0.8%
Tennessee	197	1.8%	210	2.9%	73	2.7%	886	1.3%
Alabama	150	1.4%	67	0.9%	69	2.6%	667	1.0%
Mississippi	109	1.0%	68	0.9%	44	1.6%	401	0.6%
Arkansas	134	1.2%	32	0.4%	38	1.4%	395	0.6%
Louisiana	114	1.0%	97	1.3%	45	1.7%	591	0.8%
Oklahoma	94	0.9%	52	0.7%	36	1.3%	547	0.8%
Texas	511	4.7%	330	4.5%	140	5.2%	2,713	3.9%
West	2,567	23.6%	1,505	20.6%	495	18.3%	13,236	19.0%
Montana	22	0.2%	10	0.1%	8	0.3%	140	0.2%
Idaho	25	0.2%	20	0.3%	12	0.4%	155	0.2%
Wyoming	13	0.1%	8	0.1%	4	0.1%	137	0.2%
Colorado	78	0.7%	63	0.9%	27	1.0%	805	1.2%
New Mexico	36	0.3%	18	0.2%	16	0.6%	320	0.5%
Arizona	100	0.9%	29	0.4%	49	1.8%	220	0.3%
Utah	24	0.2%	24	0.3%	12	0.4%	177	0.3%
Nevada	78	0.7%	22	0.3%	19	0.7%	257	0.4%
Washington	179	1.6%	148	2.0%	54	2.0%	1,334	1.9%
Oregon	51	0.5%	47	0.6%	33	1.2%	601	0.9%
California	1,882	17.3%	1,075	14.7%	247	9.2%	8,683	12.5%
Alaska	25	0.2%	16	0.2%	5	0.2%	171	0.2%
Hawaii	55	0.5%	24	0.3%	10	0.4%	236	0.3%

State	ACUTE CARE NON-DUAL ENROLLEES Projected States' Share of Medicaid Acute Care Spending 2009 Baseline (in millions)		ACUTE CARE ALL ENROLLEES Projected States' Share of Medicaid Spending 2009		LONG-TERM CARE Projected States' Share of Medicaid Spending 2009		ACUTE CARE and LONG-TERM CARE Projected States' Share of Medicaid Spending 2009	
	Medicaid Savings Assuming 10% Increase (in millions)	Percent of US Savings	Medicaid Savings Assuming 10% Increase (in millions)	Percent of US Savings	Medicaid Savings Assuming 10% Increase (in millions)	Percent of US Savings	Medicaid Savings Assuming 5% Increase (in millions)	Percent of US Savings
United States	11,479	100.0%	14,527	100.0%	8,080	100.0%	11,303	100.0%
Northeast	2,556	22.3%	3,201	22.0%	2,464	30.5%	2,832	25.1%
Maine	74	0.6%	109	0.8%	66	0.8%	87	0.8%
New Hampshire	21	0.2%	31	0.2%	33	0.4%	32	0.3%
Vermont	25	0.2%	67	0.5%	13	0.2%	40	0.4%
Massachusetts	354	3.1%	469	3.2%	209	2.6%	339	3.0%
Rhode Island	61	0.5%	66	0.5%	40	0.5%	53	0.5%
Connecticut	77	0.7%	107	0.7%	148	1.8%	127	1.1%
New York	1,239	10.8%	1,492	10.3%	1,280	15.8%	1,386	12.3%
New Jersey	183	1.6%	254	1.8%	232	2.9%	243	2.1%
Pennsylvania	522	4.5%	605	4.2%	444	5.5%	525	4.6%
Midwest	2,180	19.0%	2,974	20.5%	1,710	21.2%	2,342	20.7%
Ohio	412	3.6%	536	3.7%	423	5.2%	479	4.2%
Indiana	223	1.9%	289	2.0%	160	2.0%	224	2.0%
Illinois	373	3.2%	525	3.6%	197	2.4%	361	3.2%
Michigan	403	3.5%	524	3.6%	178	2.2%	351	3.1%
Wisconsin	132	1.1%	213	1.5%	137	1.7%	175	1.5%
Minnesota	131	1.1%	236	1.6%	192	2.4%	214	1.9%
Iowa	82	0.7%	105	0.7%	103	1.3%	104	0.9%
Missouri	270	2.4%	353	2.4%	148	1.8%	250	2.2%
North Dakota	12	0.1%	14	0.1%	27	0.3%	21	0.2%
South Dakota	25	0.2%	29	0.2%	21	0.3%	25	0.2%
Nebraska	48	0.4%	58	0.4%	53	0.7%	56	0.5%
Kansas	69	0.6%	91	0.6%	72	0.9%	82	0.7%
South	4,217	36.7%	5,214	35.9%	2,549	31.6%	3,882	34.3%
Delaware	40	0.4%	47	0.3%	22	0.3%	34	0.3%
Maryland	189	1.6%	225	1.6%	124	1.5%	175	1.5%
District of Columbia	80	0.7%	88	0.6%	34	0.4%	61	0.5%
Virginia	147	1.3%	186	1.3%	135	1.7%	160	1.4%
West Virginia	98	0.9%	116	0.8%	83	1.0%	100	0.9%
North Carolina	420	3.7%	527	3.6%	256	3.2%	391	3.5%
South Carolina	208	1.8%	243	1.7%	105	1.3%	174	1.5%
Georgia	349	3.0%	395	2.7%	162	2.0%	278	2.5%
Florida	491	4.3%	638	4.4%	316	3.9%	477	4.2%
Kentucky	238	2.1%	276	1.9%	123	1.5%	200	1.8%
Tennessee	351	3.1%	394	2.7%	162	2.0%	278	2.5%
Alabama	158	1.4%	177	1.2%	121	1.5%	149	1.3%
Mississippi	168	1.5%	208	1.4%	120	1.5%	164	1.5%
Arkansas	128	1.1%	173	1.2%	106	1.3%	139	1.2%
Louisiana	208	1.8%	277	1.9%	170	2.1%	223	2.0%
Oklahoma	134	1.2%	179	1.2%	105	1.3%	142	1.3%
Texas	809	7.0%	1,066	7.3%	406	5.0%	736	6.5%
West	2,525	22.0%	3,138	21.6%	1,357	16.8%	2,247	19.9%
Montana	30	0.3%	34	0.2%	29	0.4%	31	0.3%
Idaho	54	0.5%	66	0.5%	37	0.5%	52	0.5%
Wyoming	12	0.1%	16	0.1%	15	0.2%	15	0.1%
Colorado	91	0.8%	112	0.8%	75	0.9%	94	0.8%
New Mexico	153	1.3%	204	1.4%	70	0.9%	137	1.2%
Arizona	572	5.0%	624	4.3%	4	0.0%	314	2.8%
Utah	93	0.8%	100	0.7%	36	0.4%	68	0.6%
Nevada	36	0.3%	47	0.3%	27	0.3%	37	0.3%
Washington	203	1.8%	244	1.7%	132	1.6%	188	1.7%
Oregon	119	1.0%	147	1.0%	97	1.2%	122	1.1%
California	1,071	9.3%	1,457	10.0%	788	9.7%	1,122	9.9%
Alaska	38	0.3%	34	0.2%	21	0.3%	28	0.2%
Hawaii	52	0.5%	52	0.4%	28	0.3%	40	0.4%

Source Data for Tables 4 and 5

2008 CMS Medicaid Financial Management Reports (form CMS-64); 2001, 2002, 2003, and 2006 Medicaid Statistical Information System (MSIS) data; Congressional Budget Office (CBO) January 2009, March 2007, 2008, and 2009 Baseline Projections for Federal Medicaid Outlays; and 2006, 2008 and 2009 Federal Medicaid Assistance Percentages from the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2003 to 2009 National Health Expenditure historical estimates and projections on total prescription drug spending per capita

Methodological Appendix

Projecting Medicaid Expenditures for 2009

For acute care, long-term care, and DSH spending, we calculate projections by applying estimated 2009 growth rates for the benefit categories to 2008 spending in each category. Growth rates for 2009 were calculated using CBO's March 2009 Medicaid Baseline Projections. 2008 Medicaid spending comes from the CMS-64 Medicaid Financial Management Report data.

Projections for Medicare payments include estimates of payments for Medicare premiums and Medicare-covered acute care services provided to dual eligibles. These services include hospital inpatient and outpatient services; physician, nurse practitioner, and other practitioner services; laboratory tests and x-rays; rehabilitation services; physical, occupational, and speech therapy; hospice care; and other non-medical religious services. We created projections for these two components separately and then summed together. Medicare premium projections were calculated using the method described above. We estimated dual eligibles' spending on acute care services by taking this population's 2006 MSIS spending total for these services and trending it forward to 2009 using growth rates for Medicare Part A and Part B spending from CBO's March 2007, 2008, and 2009 Baseline Projections.

We project total dual eligible spending by using 2006 MSIS spending data trended forward to 2009 using the weighted average growth rates in spending for the aged and disabled populations from CBO's March 2007, 2008, and 2009 Medicaid Baseline Projections. The weights equal the percentage of a state's 2006 total dual spending represented by the aged and disabled populations. We project non-dual eligible acute care spending using the same method except we use the weighted average growth rates in spending for the aged, disabled, non-disabled, non-aged adult, and non-disabled child populations. Here, the weights equal the percentage of a state's 2006 total non-dual acute care spending represented by each of these populations.

For all FMAP projections, we used the 2009 FMAP values to project the states' share under the base and alternative FMAP scenarios.

Estimating 2009 Clawback Payments

The formula used for clawback projections is as follows:

$$\text{Claw} = \text{RXPC} * \text{DUAL_ENROLL} * \text{PD}$$

where

RXPC = 2003 MSIS state share of dual RX expenditures per dual enrollees trended forward to 2009 using the growth rates for National Health Expenditure (NHE) historical estimates and projections of total prescription drug spending per capita. The method used to project this component of the formula is taken from Miller (2009). Using 2006 and 2007 estimates as an example, the calculations are as follows:

$$\text{RXPC}_{2006} = \text{RXPC}_{2003} * \left(\frac{((5/12)*\text{NHE}_{2004}) + ((7/12)*\text{NHE}_{2005})}{((5/12)*\text{NHE}_{2003}) + ((7/12)*\text{NHE}_{2004})} \right)$$

$$\text{RXPC}_{2007} = \text{RXPC}_{2006} * \left(\frac{((5/12)*\text{NHE}_{2005}) + ((7/12)*\text{NHE}_{2006})}{((5/12)*\text{NHE}_{2004}) + ((7/12)*\text{NHE}_{2005})} \right)$$

The 2003 MSIS prescription drug spending totals were aligned to the CMS-64 prescription drug spending data to ensure that Medicaid prescription drug rebates were reflected in the total.

DUAL_ENROLL = 2006 number of duals in the state, trended forward to 2009 based on weighted average of CBO projected enrollment growth rate for the aged and disabled populations. Growth rates are weighted by the percentage of a state's 2006 total dual enrollment each population represented.

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