THE KAISER COMMISSION ON
Medicaid and the Uninsured

Medicaid: Addressing the Future

Testimony of
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to

The U.S. Senate Special Committee on Aging

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Mr. Chairman and Members of the Committee -

I am pleased to be here today to participate in this hearing on the Medicaid program and its role for low-income Americans, especially our senior citizens. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

Medicaid is today our nation's health care safety net providing the glue to keep poor families and the elderly and people with disabilities from falling through the many cracks in our health care system. It provides health and long-term care coverage to over 53 million Americans, assisting many Americans with the most complex health care needs and the least resources to deal with these problems. It has become an especially important source of supplemental coverage, most notably for long-term care assistance and help with premiums and cost-sharing for 7 million of Medicare's sickest and poorest beneficiaries.

MEDICAID'S MULTIPLE ROLES

The Medicaid program takes on multiple roles in providing health and long-term care services to low-income families, the elderly, and people with disabilities. It is a health insurer, a supplement to fill Medicare's gaps, the nation's only program providing assistance to the aged and disabled with long-term care costs in the community and in nursing homes, and the primary financial support for our nation's safety net hospitals and clinics.

In these roles, Medicaid has a broad reach -- it is the source of health insurance coverage for 40 percent of poor Americans and one in four American children, finances health and long-term care coverage for about 20 percent of

people with severe disabilities and 44 percent of people living with HIV/AIDS, supplements Medicare for 15 percent of Medicare beneficiaries, and helps pay for the care of 60 percent of nursing home residents. In meeting these health needs, Medicaid accounts for nearly one of every five dollars of health care spending, nearly one of every two dollars spent on long-term care, and over half of public mental health spending. Jointly financed by the federal and state governments, Medicaid is now the nation's largest health care program at an annual cost of over $300 billion. The federal government covers roughly 57 percent of all Medicaid spending, making Medicaid the largest source (43 percent) of federal support to the states.

Medicaid's most widely acknowledged role as a source of health coverage for 38 million low-income children and their parents helps to keep millions of low-income families from joining the nation's growing uninsured population. However, Medicaid's role as a health insurer for low-income families is neither its most unique nor its costliest role. It is Medicaid's assistance to the 8 million low-income people with disabilities and 5 million elderly people who need both medical and long-term care services that dominates Medicaid spending. Together, children and their parents account for three-quarters of Medicaid enrollees and 30 percent of spending, while the elderly and disabled account for a quarter of beneficiaries and 70 percent of spending (Figure 1). In 2003, per capita expenditures per child were $1,700 compared to $12,300 per disabled beneficiary and $12,800 per elderly Medicaid beneficiary. This spending reflects the higher utilization of acute care services and long-term care to meet the ongoing chronic care needs of the disabled and elderly (Figure 2).

For low-income Medicare beneficiaries, Medicaid coverage is particularly important. Although Medicare provides basic medical coverage, the required premiums and cost-sharing and gaps in benefits, most notably for long-term care coverage, leave many holes to be filled by Medicaid. The 7 million elderly and disabled individuals with both Medicare and Medicaid -- the "dual eligibles" -- are among Medicare's poorest and sickest beneficiaries (Figure 3). In addition to

having low incomes, these dual eligibles are more likely than other Medicare beneficiaries to be in poor health, suffer from chronic diseases, and have limitations on their activities of daily living leading to long-term care needs. As a result, the dual eligible population accounts for 14 percent of Medicaid beneficiaries, but 42 percent of all Medicaid spending (Figure 4).

Although Medicaid is a substantial investment of federal and state dollars, it also provides an effective return on investment by improving access to care for our low-income population. Uninsured children and adults are less likely to obtain medical care and more likely to lack a usual source of care than those with Medicaid. Among the elderly and disabled with Medicare coverage, Medicaid coverage promotes access comparable to that of those with private supplemental insurance and notably better than that experienced by the population with only Medicare coverage.

Filling these multiple roles makes Medicaid both a complex and costly program. Medicaid is complex because it is not a single program, but an array of services and programs which are structured and operated somewhat differently in each of the 50 states and the District of Columbia. It is a costly program because health care, and especially long-term care, is expensive and Medicaid covers those with the most substantial health needs, including those with severe disabilities and chronic health problems requiring on-going care.

THE STRUCTURE OF MEDICAID

Medicaid is jointly financed by the federal and state governments with the federal government covering 57 percent of overall spending. The federal government matches state spending, providing 50 to 77 percent of spending, picking up a higher share in states with low per capita income (Figure 5). The structure of Medicaid provides states with federal matching funds for coverage of mandatory populations and services, but also enables states to obtain federal

matching funds for a wide range of optional services and broader population coverage. This provides states with the flexibility to obtain federal matching payments to cover a broad range of services for their low-income residents and to adjust coverage to respond to emerging health problems, but also leads to variations in the scope of coverage across states.

States that elect to participate in Medicaid (currently all states do participate) are required to cover all children under the poverty level, pregnant women and children under six with incomes at or below 133 percent of the federal poverty level, and most elderly and disabled recipients of cash assistance under the Supplemental Security Income (SSI) cash assistance program. Because the federal statute requires states to cover these groups as a condition of participating in Medicaid, they are referred to as the "mandatory" eligibility groups (Figure 6). Similarly, because states are required to cover basic benefits including hospital, physician, laboratory, and nursing home services, the required services are referred to as "mandatory services".

These requirements are the minimum investment the federal government requires states to make in return for federal funds picking up 57% of overall spending. They set a national floor for coverage in all states, but states are not limited in their ability to draw additional federal matching funds to extend coverage beyond the minimum levels required.

Beyond the federal requirements, states have the option to extend coverage to children at higher incomes, their parents, and other low-income elderly and persons with disabilities in the community and in nursing homes and still receive federal matching funds for the cost of their coverage. These groups are referred to as "optional" populations because states are not required to cover them. All states extend coverage beyond the required populations and coverage varies widely across states. With regard to benefits, states also have the option to cover additional benefits above the required set for both "mandatory" and "optional" eligibility groups. Many of the "optional" benefits, such as prescription

drug coverage and intermediate care facility services for the mentally retarded (ICF/MR) are integral to Medicaid coverage and offered in all states. For both "mandatory" and "optional" benefits, States have the discretion to limit the amount, duration, and scope of coverage.

The terms "mandatory" and "optional" refer to Medicaid's statutory design and link back to its roots in 1965 as the medical coverage program for the nation's welfare population. The populations historically eligible for cash assistance are "mandatory" under Medicaid law, while most populations not eligible for cash assistance were made eligible for Medicaid through new laws enacted over the program's 40-year history. As new groups were made eligible for coverage with federal matching funds, most were offered as an option -- rather than a mandate -- to states. These options provide states with the flexibility to adopt changes and expand eligibility with federal funding support, but do not imply a lesser standard of need or worthiness than coverage for mandatory groups and services.

Eligibility

The likelihood of qualifying for Medicaid on the basis of a "mandatory" or "optional" group varies substantially by group (Figure 7). Most children (79%) qualify on the basis of "mandatory" coverage, reflecting Congressional legislative changes that have raised the minimum income eligibility threshold above cash assistance levels -- most notably, requiring states to cover all children from families with incomes below poverty and young children and pregnant women up to 133 percent of poverty. In contrast, nearly half (48%) of the elderly qualify through "optional" eligibility groups, reflecting state decisions to extend coverage to nursing home residents and the medically needy population who have incomes above SSI eligibility levels.

Coverage of the medically needy is a major state option allowing individuals to obtain help from Medicaid after “spending down” income and resources due to health care expenses. This is particularly important to elderly individuals in nursing facilities and children and adults with disabilities who live in the community and incur high prescription drug, medical equipment, or other health care expenses.

Some examples of individuals covered at state option are provided below:

- An elderly nursing facility resident whose annual income ($7,184) is just above SSI standards (74% of poverty) but below 100% of poverty $9,570 in 2005).

- A 68 year-old widow with multiple conditions, such as fibrosis of the lungs, rheumatoid arthritis, and high blood pressure, whose income ($8,400) is too high to qualify for SSI (74% of poverty of $7,082 in 2005) but qualifies for Medicaid home and community-based services, allowing her to remain in the community.

- A 22-year-old woman with disabilities who earns less than $23,925/year (250% of poverty in 2005), whose employer does not offer coverage and needs Medicaid’s coverage of physician services, personal care services, and prescription drugs.

- An 85 year-old with Alzheimer’s disease with a monthly income of $1,472 (less than 300% of SSI) qualifies for nursing facility care. She is allowed to keep $30 a month for personal needs, and the remainder of her income goes to the nursing facility to cover her medical and support needs.

- A 50-year old man who has multiple sclerosis with recurring drug and physician costs that average $750/month “spends down” to Medicaid medically needy eligibility levels (median is 55% of poverty).

Benefits

States must provide physician services, hospital care, nursing facility care, and other “mandatory” services to beneficiaries covered at state option, but they can also provide an array of “optional” services to both mandatory and

optional populations (Figures 8 and 9). Services offered at state option include prescription drugs and a broad range of disability-related services, such as, case management, rehabilitative services, personal care services, and home and community-based services. Many of these "optional" benefits provide important benefits for both Medicaid "mandatory" and "optional" beneficiaries and are particularly important for persons with disabilities and the elderly. Given the range of disabilities covered by Medicaid, many of the "optional" benefits are essential to appropriate care and management of people with disabilities on Medicaid. For the aged and disabled who rely on Medicaid to fill Medicare's gaps, "optional" benefits like prescription drugs, dental and vision care, and home and community based services are the most important gaps Medicaid fills.

Impact on Spending

Overall, individuals covered at state option account for 29 percent of Medicaid enrollees and 60 percent of all Medicaid expenditures for both "mandatory" and "optional" populations are "optional." The majority of "optional" spending (86%) pays for services to the elderly and disabled. Some of the sickest and poorest Medicaid beneficiaries are considered "optional" and many of the "optional" benefits provided under Medicaid, such as prescription drugs and rehabilitation services, often are integral to appropriate care and functioning for the population Medicaid serves.

As shown in Figure 10, "optional" populations account for about 42 percent of all Medicaid spending and of this spending, 70 percent is for "mandatory" services and 30 percent is for "optional" services. Spending is not evenly distributed among the "optional" populations. As shown in Figure 11, the elderly and disabled represent 29 percent of the "optional" populations covered but account for 83 percent of Medicaid spending on "optional" populations.

Although three fifths of total Medicaid spending is "optional", the share of spending that is "mandatory" or "optional" varies substantially across beneficiary

groups (Figure 12). Only 20 percent of spending on children is “optional” while 84 percent of spending on the elderly is “optional.” “Optional” spending is driven in large part by coverage of long-term care services for the elderly and persons with disabilities for nursing facility care, ICF/MR services, and home and community-based services. As a result of state decisions to cover these services, over half (57%) of total “optional” spending is for long-term care services (Figure 13). Eighty-five percent of Medicaid spending on long-term care is “optional” (Figure 14) and two thirds of that is for institutional care. While one in five optional long-term care dollars is for home and community-based waiver services and other home care, only 4 percent of total long-term care spending is for “mandatory” home health services and 11 percent for required institutional coverage.

Most optional spending is devoted to the frailest and most vulnerable Medicaid beneficiaries, including many elderly people. These populations rely on Medicaid for help with long-term care needs, including nursing home and community-based services. These services are not available through Medicare or private insurance and therefore, Medicaid’s coverage provides an essential safety net; most frail elderly and disabled could not function without this help.

Providing more options in the community for the elderly and people with disabilities is a national priority and will be even more important as the population ages. Today, there is wide variation in the availability of home and community-based care across the states. While 11 states, including Oregon and Washington, spend more than half of their long-term care dollars in community settings, 16 states spend less than one-third of their long-term care dollars on non-institutional options.

State Flexibility

While the framework of Medicaid provides states with considerable flexibility over the design and scope of their Medicaid programs, states, under

increasing fiscal pressure, are asking for additional flexibility to alter federal coverage rules without waivers. Giving states more flexibility to impost cost-sharing or scale back benefits that restrict coverage for working families could reduce program costs but also shift costs to the poor and their providers and add to administrative burdens for providers. Those on Medicaid are generally sicker with more chronic conditions and less income than the privately insured. Imposing additional financial requirements on families, most with incomes of less than $300 a week, is likely to result in delayed of foregone care leading to the negative health consequences we find among the uninsured. Given the extremely limited incomes of most Medicaid beneficiaries, nominal co-payments and cost-sharing are likely to lead to reduced access to early care and potentially more costly hospitalizations for untreated conditions. Imposing premiums on people with incomes below the poverty level may bring in limited revenue, but, as the Oregon experience shows, mostly reduces Medicaid costs by reducing enrollment and adding to the growing uninsured population. Tightening eligibility for long-term care in the community or nursing home to reduce Medicaid costs leaves an elderly couple of modest means facing nursing home costs averaging $70,000 a year with no help until destitute.

State flexibility without additional federal resources does not provide a painless solution to the fiscal pressures facing Medicaid. These short-term strategies will not achieve significant savings for states or facilitate Medicaid's ability to meet the health needs of the low-income population and adequately pay their providers nor will they help address the increasing long-term care needs of an aging population. Instead they will further increase the number of uninsured Americans and shift more costs to doctors and other health care providers who care for Medicaid patients. Long-term strategies that invest in Medicaid to promote better management of chronic illness, disease prevention, and coordination with Medicare to more effectively address the needs of the high costs enrollees who rely on both programs offer a better and more humane alternative for containing costs.

LOOKING AHEAD

Medicaid's role in providing health and long-term services to our nation's most vulnerable people and its widening safety net responsibilities have brought notable improvements in coverage of low-income families and assistance to the elderly and individuals with disabilities. As the primary source of financing and coverage for the low-income population, Medicaid has been a critical force in moderating the growth in America's uninsured population over the last three decades. Without Medicaid, millions of our nation's poorest children would be without health insurance.

Medicaid continues to provide coverage beyond that of private insurance or Medicare to the most vulnerable and frail in our society - acute and long-term care services for persons with chronic mental illness and retardation; medical and long-term care services and drug therapy for those with AIDS; assistance with Medicare's premiums and cost-sharing and prescription drug coverage for poor Medicare beneficiaries; and home-based and institutional care for those with severe physical and mental disabilities that require long-term care. In the absence of Medicaid, it is hard to envision how these enormous societal needs would be met.

Yet, one of the most daunting challenges facing Medicaid's future is how to meet the growing need for health and long-term care coverage within the constraints of federal and state financing. The fiscal situation in the states, coupled with the growing federal deficit, makes assuring adequate financing and meaningful coverage for low-income families, the elderly, and people with disabilities a growing challenge. Yet, it is a challenge that should be met with responsible proposals that assure that the most frail and vulnerable among us are protected and able to obtain the health and long-term services they need.

Underlying the debate over who pays for Medicaid is thus a more fundamental debate about we as a nation fill the gaps in our health care system

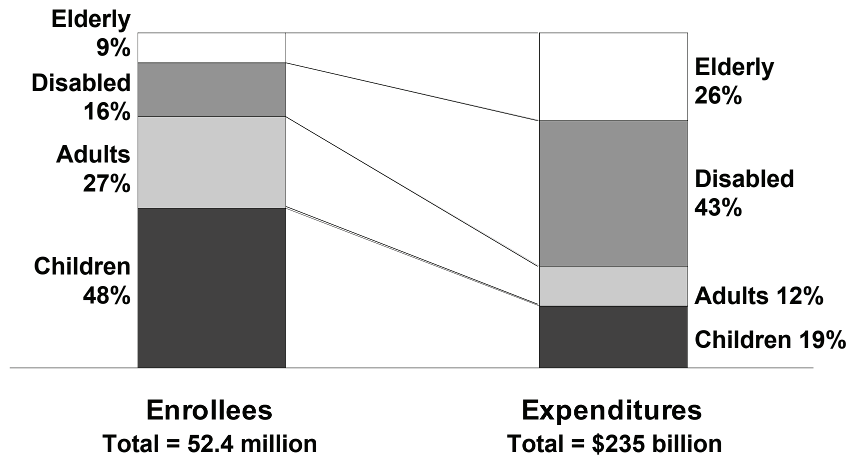
to provide and finance care for the poorest and sickest among us (Figure 15). The solution to making Medicaid more sustainable is to make it less necessary. If we had universal health coverage and assistance with the high cost of long-term care, the future sustainability of Medicaid would not be a question. But, in the absence of broader solutions, policymakers need to find ways to maintain - not shred - the Medicaid safety net because without Medicaid millions more would be uninsured and many of our poorest and sickest citizens would be unable to obtain or afford the care they need.

There are no easy answers to reducing the cost of providing care to the over fifty million Americans who now depend on Medicaid for health and long-term care assistance - the poorest, oldest, frailest, and most disabled of our population. The high cost of caring for this population is reflective of their serious health problems, not excessive spending by the program. Program costs grow in response to downturns in the economy, rising health care costs, the needs of an aging population, and emerging public health crises and emergencies. Efforts at reform should be directed at finding ways to support and maintain the coverage the program offers while balancing the responsibilities for coverage and financing between the federal and state governments. Assuring that financing is adequate to meet the needs of America's most vulnerable and addressing our growing uninsured problem should be among our nation's highest priorities.

Thank you for this opportunity to share this information with the committee.

Figure 1

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,

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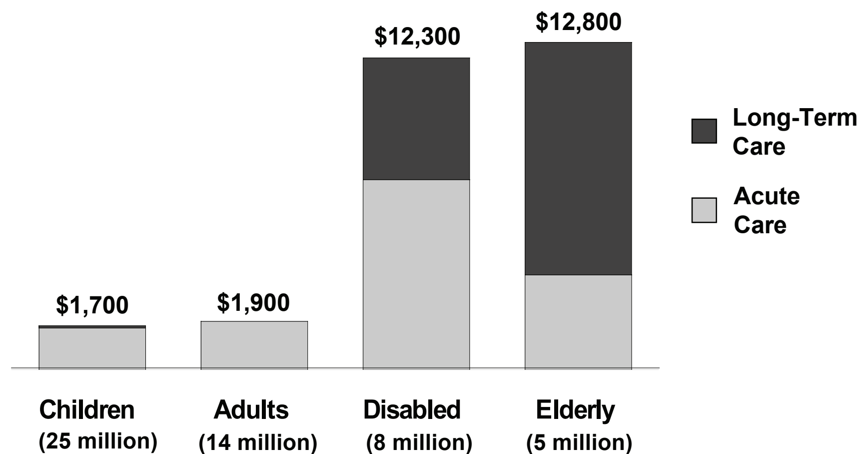
Figure 2

Medicaid Payments Per Enrollee by Acute and Long-Term Care, 2003



SOURCE: KCMU estimates based on CBO and Urban Institute data, 2004.

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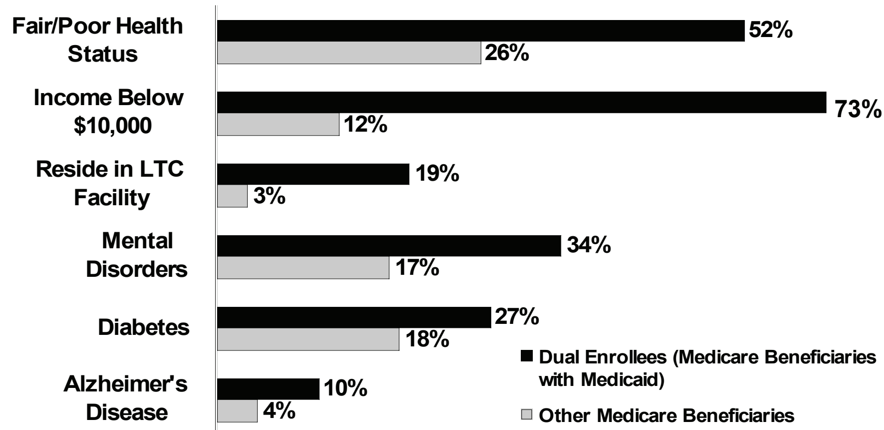
Figure 3

Dual Enrollees are Poorer and Sicker Than Other Medicare Beneficiaries



SOURCE: KFF estimates based on the Centers for Medicare and Medicaid Services Medicare Current Beneficiary Survey 2002 Access to Care File.

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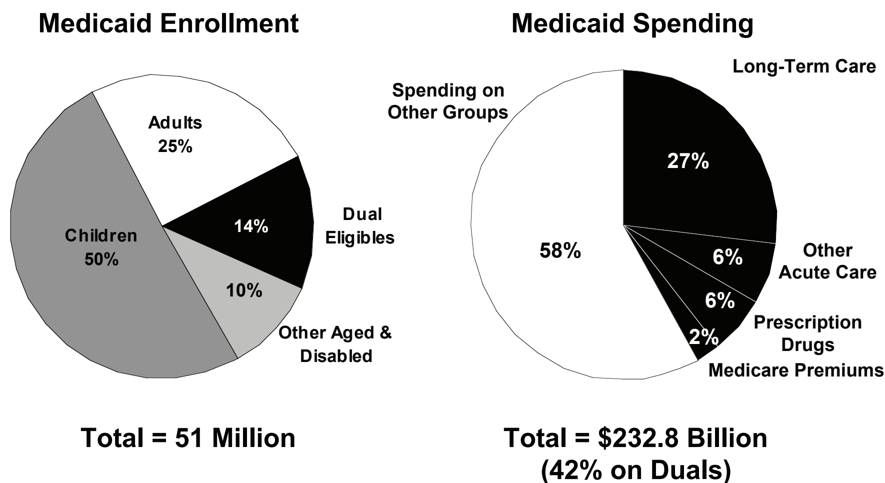
Figure 4

Medicaid Dual Eligibles: Enrollment and Spending



SOURCE: KCMU estimates based on CMS data and Urban Institute analysis of data from MSIS.

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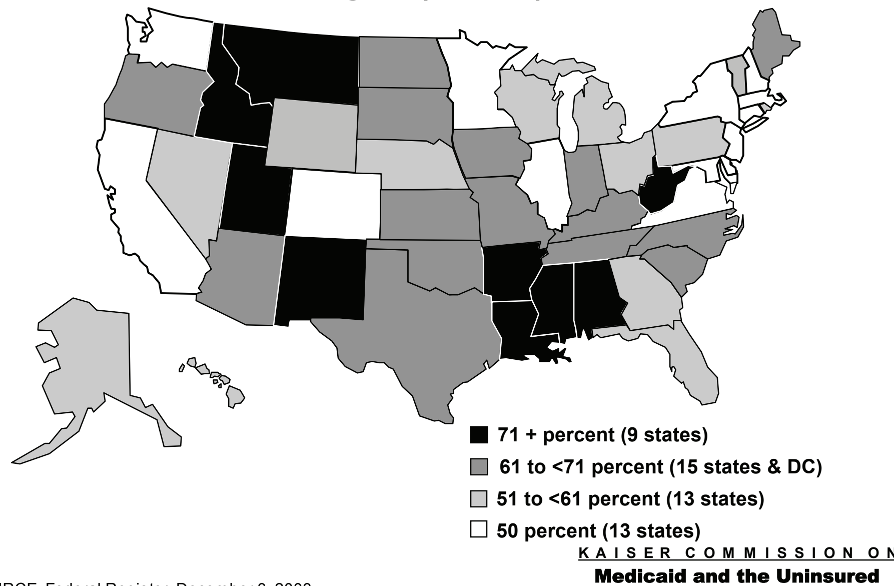
Figure 5

Federal Medical Assistance Percentages (FMAP), FY 2005



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SOURCE: Federal Register, December 3, 2003

Figure 6

Medicaid Beneficiary Groups

Mandatory Populations

- Children age 6 and older below 100% FPL ($15,670 a year for a family of 3)
- Children under age 6 below 133% FPL ($20,841 a year for a family of 3)
- Parents below state's AFDC cutoffs from July 1996 (median = 42% FPL)
- Pregnant women ≤133% FPL
- Elderly and disabled SSI beneficiaries with income ≤ 74% FPL ($6,768 a year for an individual).
- Certain working disabled
- Medicare Buy-In groups (QMB, SLMB, QI)

Optional Populations

- Low-income children above 100% FPL who are not mandatory by age (see column on left).
- Low-Income parents with income above state's 1996 AFDC level.
- Pregnant women >133% FPL
- Disabled and elderly below 100% FPL ($9,310 a year for an individual), but above SSI level.
- Nursing home residents above SSI levels, but below 300% of SSI ($1,692 a month).
- Individuals at risk of needing nursing facility or ICF-MR care (under HCBS waiver)
- Certain working disabled (>SSI levels)
- Medically needy

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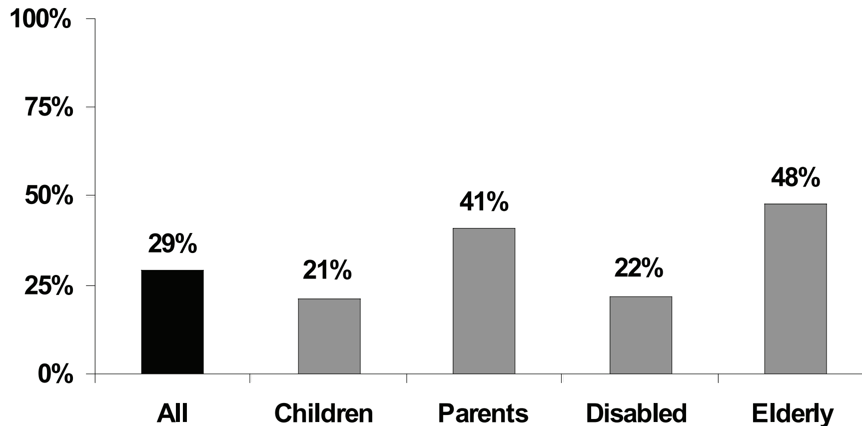
Figure 7

Percent of Medicaid Beneficiaries with Optional Eligibility, 2001



SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

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Figure 8

Medicaid Acute Care Benefits

"Mandatory" Items and 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 pediatric and family nurse practitioner services

"Optional" Items and Services*

- Prescription drugs
- Medical care or remedial care furnished by other licensed practitioners
- Rehabilitation and other therapies
- Clinic services
- Dental services, dentures
- Prosthetic devices, eyeglasses, durable medical equipment
- Primary care case management
- TB-related services
- Other specialist medical or remedial care

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Figure 9

Medicaid Long-Term Care Benefits

“Mandatory” Items and Services	“Optional” Items and Services*
Institutional Services	
• Nursing facility (NF) services for individuals 21 or over	• Intermediate care facility services for the mentally retarded (ICF/MR) • 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 & Community-Based Services	
• Home health care services (for individuals entitled to nursing facility care)	• Home- and community-based waiver services • Other home health care • Targeted case management • Respiratory care services for ventilator-dependent individuals • Personal care services • Hospice services • Services furnished under a PACE program

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis, with the exception of Home and Community-based waiver services.

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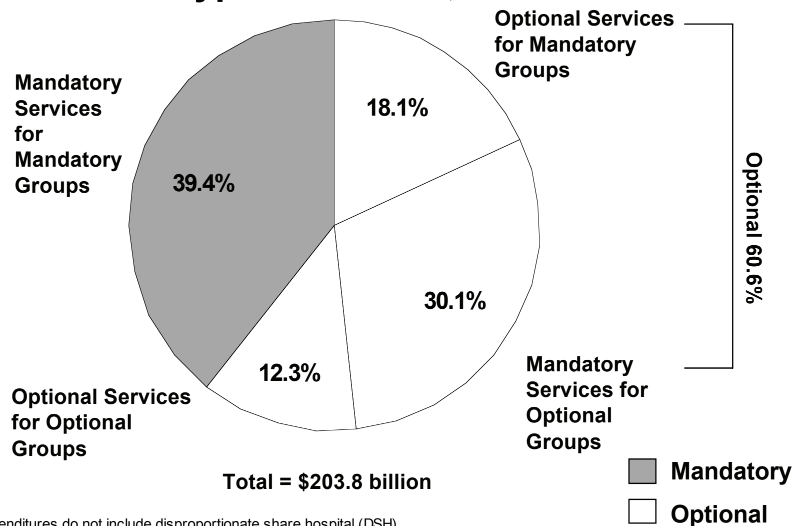
Figure 10

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

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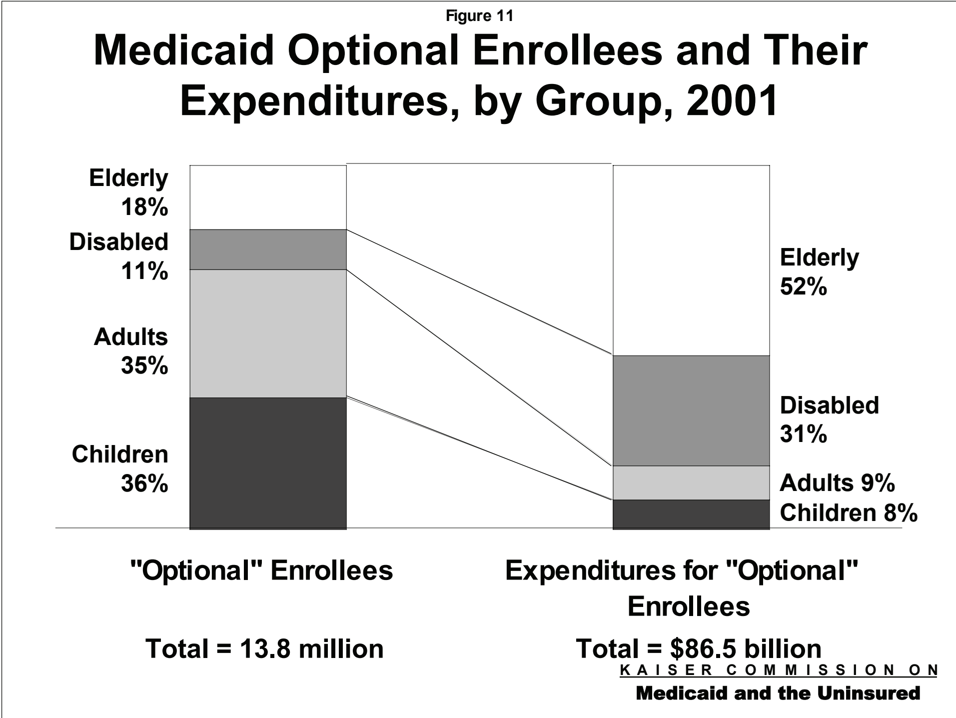
Figure 11
Medicaid Optional Enrollees and Their Expenditures, by Group, 2001
Elderly 18%
Disabled 11%
Adults 35%
Children 36%
Elderly 52%
Disabled 31%
Adults 9%
Children 8%
"Optional" Enrollees
Expenditures for "Optional" Enrollees
Total = 13.8 million
Total = $86.5 billion
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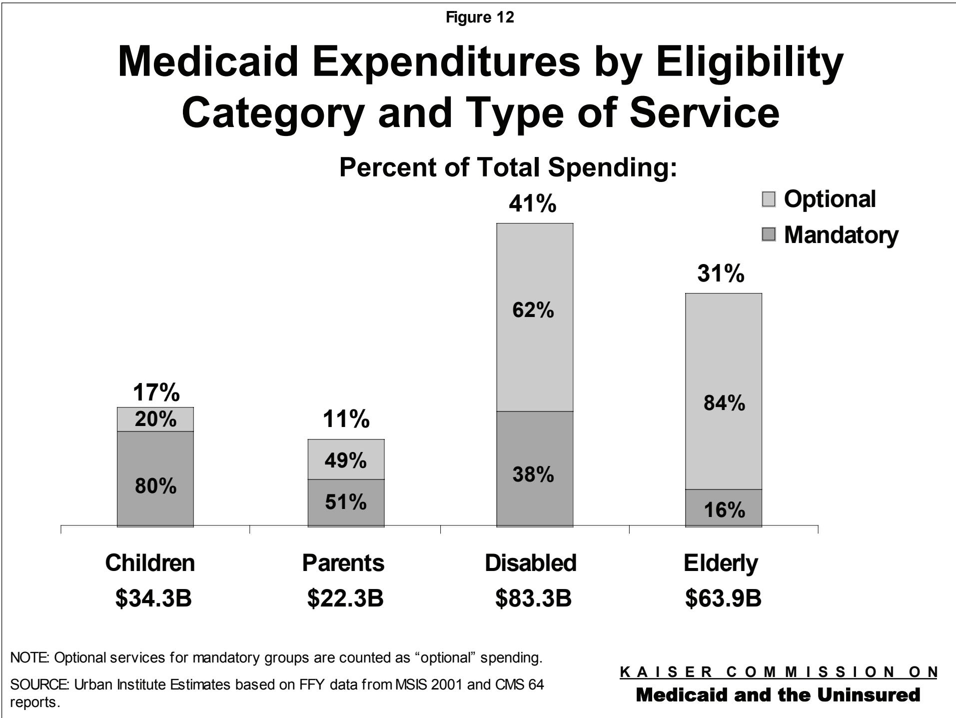
Figure 12
Medicaid Expenditures by Eligibility Category and Type of Service
Percent of Total Spending:
Optional
Mandatory
17%
20%
80%
11%
49%
51%
41%
62%
38%
31%
84%
16%
Children
$34.3B
Parents
$22.3B
Disabled
$83.3B
Elderly
$63.9B
NOTE: Optional services for mandatory groups are counted as "optional" spending.
SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.
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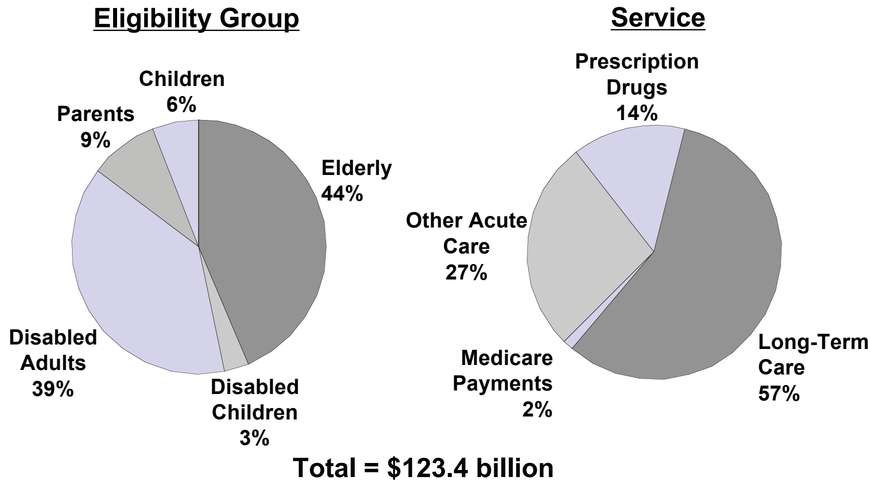
Figure 13

Medicaid Optional Spending by Eligibility Group and Service, 2001



Total = $123.4 billion

NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports

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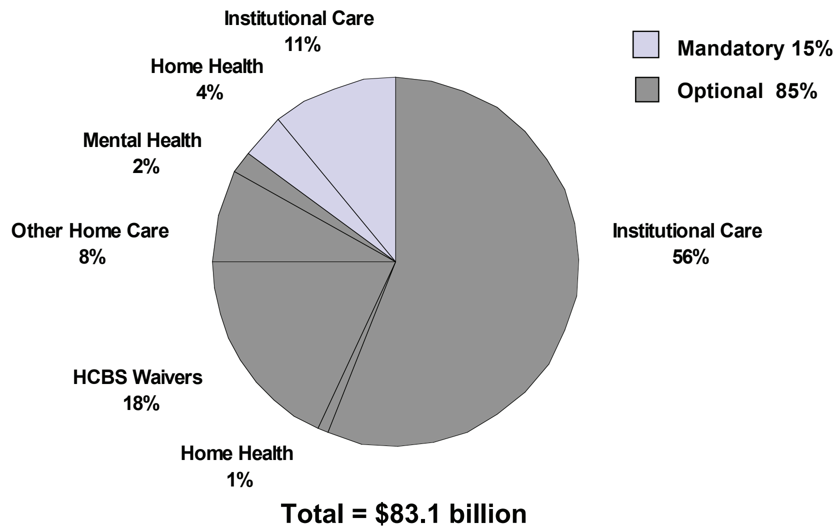
Figure 14

Medicaid Spending on Long-Term Care, by Optional and Mandatory Services



Total = $83.1 billion

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports

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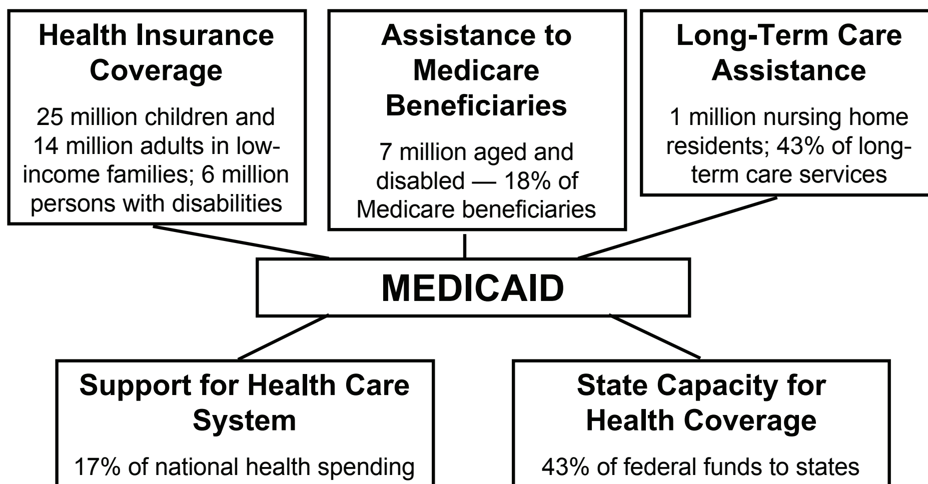

Figure 15
What's at Stake in Medicaid Reform
Health Insurance Coverage
25 million children and 14 million adults in low-income families; 6 million persons with disabilities
Assistance to Medicare Beneficiaries
7 million aged and disabled — 18% of Medicare beneficiaries
Long-Term Care Assistance
1 million nursing home residents; 43% of long-term care services
MEDICAID
Support for Health Care System
17% of national health spending
State Capacity for Health Coverage
43% of federal funds to states
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