THE KAISER COMMISSION ON
Medicaid and the Uninsured

August 2003

Medicaid: Fiscal Challenges to Coverage

Medicaid is a federal and state partnership providing health and long-term care coverage to 51 million low-income Americans. Medicaid plays a major role in the nation's health care system, accounting for nearly one of every five dollars of health care spending and nearly one of every two long-term care dollars; the Medicaid program is also a major engine in state economies, supporting millions of jobs across the country. Paid for jointly by federal and state governments, Medicaid is the largest source of federal support to the states. Medicaid's guarantee of federal financing that matches state spending enables states to respond to losses of private health insurance attributable to unemployment and rising premiums, increases in health care costs, emergencies and disasters, and an aging society.

- **In our fragmented health care system, Medicaid is the linchpin program that addresses the health and long-term care needs of this nation's low-income disabled and elderly populations, and families and children.** Medicaid covers more than 12 million elderly people and people with disabilities, including over 6 million Medicare beneficiaries, the "dual enrollees." Dual enrollees, for whom Medicaid fills Medicare's gaps by providing financial assistance with premiums, prescription drugs and long-term care, account for over a third of Medicaid spending.

  Medicaid is often the only source of health insurance for 38 million children and their parents. Although half of enrollees are children, 70% of Medicaid spending on services goes toward the elderly and disabled, reflecting their greater health and long-term care needs (Figure 1). Medicaid spending per enrollee is eight times greater for the elderly ($13,100) and the disabled ($11,800) than for children ($1,500) (Figure 2).

Figure 1

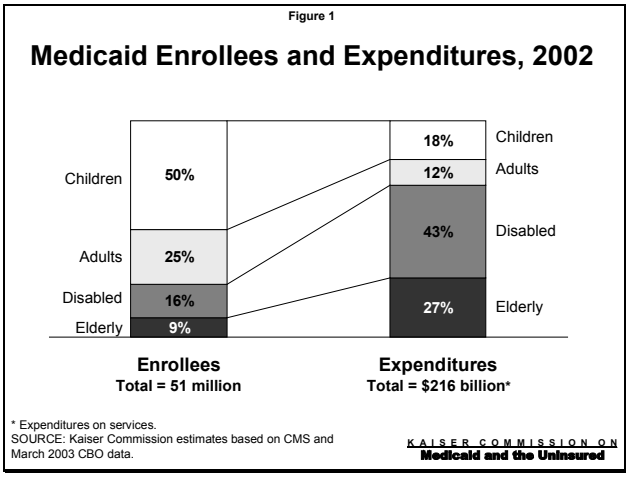
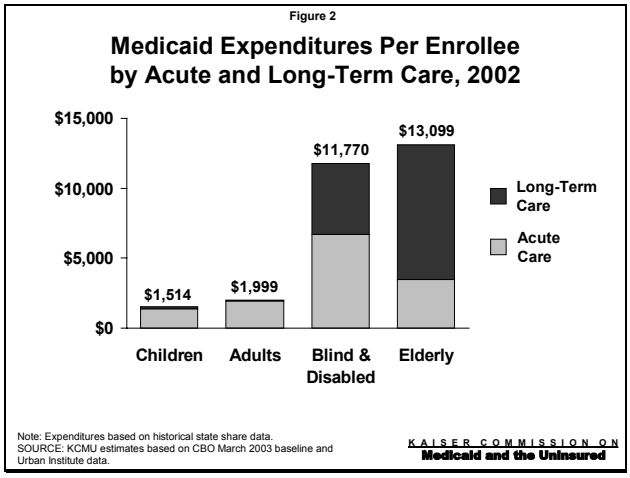


Figure 2



- **Declining state revenues threaten Medicaid's role.** Over the last two years, state revenues have fallen faster and further than anyone predicted, creating substantial shortfalls in state budgets. Worsening fiscal pressures indicate that state budget shortfalls will reach at least $70 billion in FY2004 (Figure 3). While state Medicaid spending rose in FY 2002 by $7 billion more than projected based on recent trends, this contribution to state budget deficits is modest compared to the $62 billion gap in state revenue collections relative to projections (Figure 4).

Turning first to "rainy day" and tobacco settlement funds, states have tried to preserve Medicaid and keep the associated federal dollars in their programs and state economies. But, as the sources of state funds become depleted, states face a daunting challenge in trying to forestall new or deeper cuts in Medicaid. Indeed, because Medicaid is the second largest item in most state budgets after education, cuts in the program appear inevitable – in the absence of new revenue sources – as states seek to balance their budgets.

Figure 3

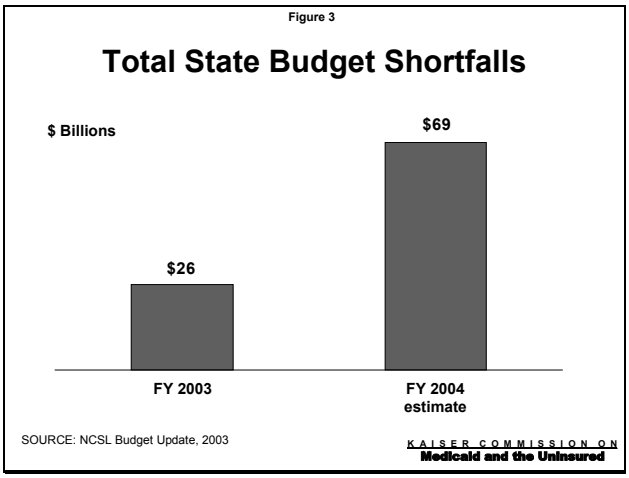
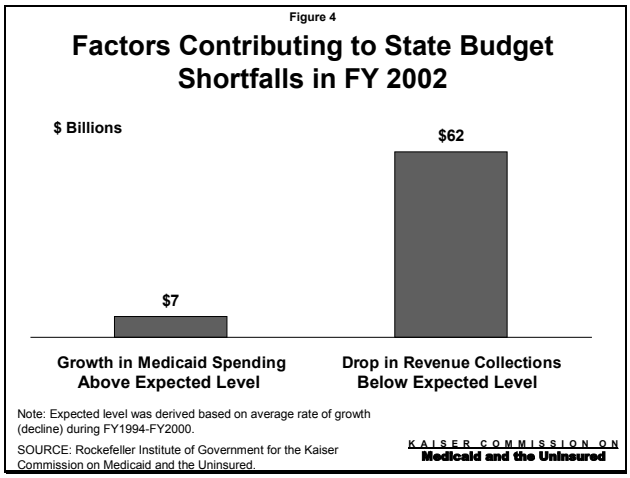


Figure 4



- **Medicaid expenditures are growing, primarily due to increases in the price of medical and long-term care services, but these spending increases are modest compared to the revenue declines that states are experiencing.** As overall health care costs rise, Medicaid spending is forced upward, as states seek to maintain access to care for beneficiaries. Nevertheless, the rate of growth in Medicaid per capita spending has remained lower than the rate of increase in private insurance premiums – despite the considerably worse health of the Medicaid population. Most (77%) of the growth in Medicaid spending on services last year was attributable to elderly and disabled beneficiaries, reflecting their high use of prescription drugs – the fastest-growing component of Medicaid spending -- and long-term care services (Figures 5 and 6).

Figure 5

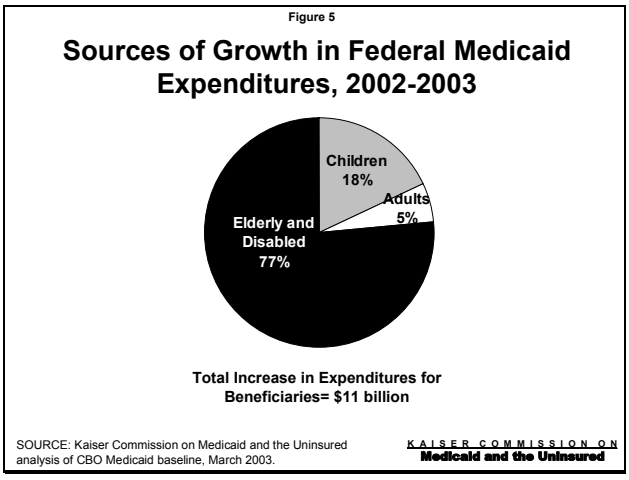
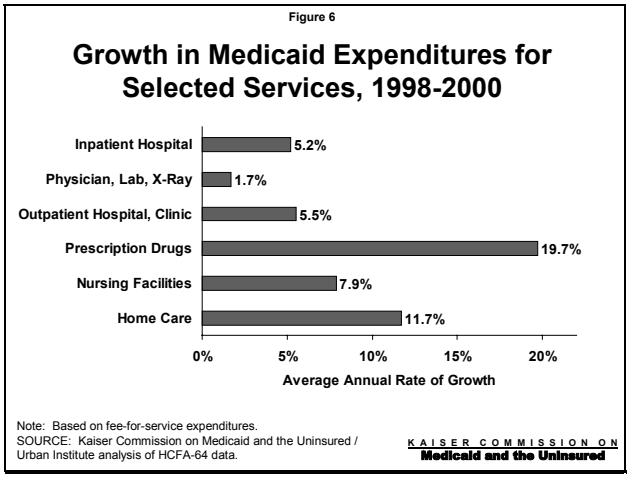


Figure 6

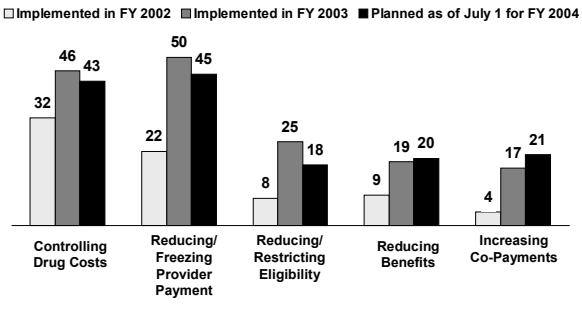


- **While states have aggressively adopted a wide variety of cost-containment strategies, no magic bullet can close budget shortfalls of this magnitude.** States have reduced provider payments, placed new limits on prescription drug use and payments, and continue to adopt disease management strategies and better manage high-cost cases. However, the pressure to reduce Medicaid spending further has led many states to turn now to eligibility and benefit reductions (Figure 7). Adult enrollment is projected to fall, reflecting state cutbacks in parent eligibility.

Eligibility and benefit cuts are difficult to make because, although close to two-thirds of Medicaid spending is at state option, the lion's share (83%) of this optional spending pays for essential care for the elderly and disabled – primarily, long-term care and prescription drugs (Figure 8). Medicaid reductions are likely to lead simply to greater numbers of uninsured, diminished community options for people with disabilities, and loss of assistance for people with significant medical and long-term care expenses.

Figure 7

States Undertaking Medicaid Cost Containment Strategies FY 2002 - FY 2004

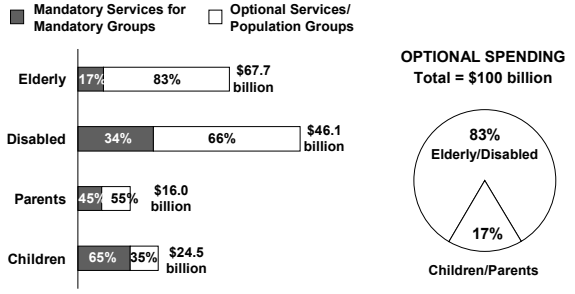


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and forthcoming September 2003.

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 8

Distribution of Medicaid Mandatory and Optional Spending, 1998



Note: Expenditures on services.
SOURCE: Urban Institute estimates, 2001.

KAISER COMMISSION ON Medicaid and the Uninsured

- **Loss of Medicaid coverage leads to increased numbers of uninsured.** As the single largest source of health insurance for the low-income population, including millions of workers and their families, Medicaid coverage strongly affects the number of uninsured in the U.S. When Medicaid eligibility is restricted and hurdles to enrollment are raised, the number of uninsured grows because people who lose Medicaid usually cannot obtain employer-based coverage. Lack of coverage can result in serious consequences for individuals and families and wreak havoc on the nation's safety net providers as reliance on emergency rooms increases and levels of uncompensated care rise.

- **Increasingly, states are considering limiting Medicaid options that help families when conditions, such as Alzheimer's disease or a stroke, render a parent or spouse incapable of living independently.** High medical or long-term care bills can quickly drain the financial resources of families who are solidly middle-class. As virtually the only source of financial assistance for nursing home care, Medicaid is the backbone of our nation's long-term care system. Constrained Medicaid spending will leave the nation hard-pressed to meet the growing needs of our elderly and disabled populations.

Medicaid has promoted a wide spectrum of national objectives, including health coverage of low-income families, quality standards for nursing home care, and greater access to community-based care for the elderly and people with disabilities. These and other core elements of our health and long-term care system are now in jeopardy as cash-strapped states seek to hold their programs together. In May, Congress enacted $20 billion in state fiscal relief, including an estimated $10 billion through a temporary increase in the federal Medicaid matching rate. States have utilized this fiscal relief to soften or avoid cuts in Medicaid and other programs in FY 2003 and FY 2004, but remain concerned about FY 2005 when the temporary relief expires and continue to express an interest in the federal government taking greater fiscal responsibility for dual enrollees. While the evident strains on our system highlight the need to examine options for change, assured and adequate Medicaid financing and meaningful benefits remain essential if Medicaid is to continue to meet the health and long-term care needs of low-income families and children, seniors and people with disabilities.