



THE KAISER COMMISSION ON
Medicaid and the Uninsured

Medicaid: Issues and Challenges

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for

“Challenges Facing the Medicaid Program in the 21st Century”
Committee on Energy and Commerce
Subcommittee on Health

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MEDICAID: ISSUES AND CHALLENGES

DIANE ROWLAND

Mr. Chairman and members of the Committee, thank you for inviting me to appear before the Committee today to discuss the issues and challenges facing Medicaid in providing health and long-term care coverage for the low-income population. 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.

The Kaiser Commission on Medicaid and the Uninsured is a 16 member, bi-partisan national panel established by the Kaiser Family Foundation in 1991 to serve as a source of information and analysis on the Medicaid program and health and long-term care coverage of the low-income population. I am pleased to be here today to share the work of the Commission.

Medicaid Today

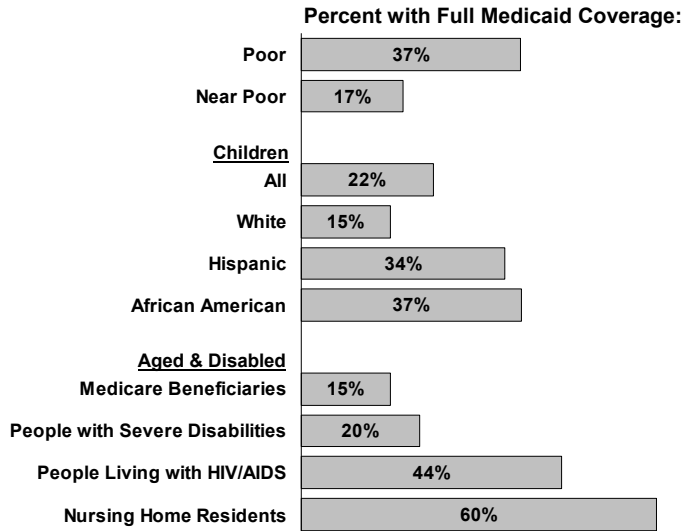
Since its enactment in 1965 as companion legislation to Medicare, Medicaid has operated as a federal and state partnership to meet the health needs of the nation's most vulnerable populations. It has evolved from a program providing federal financing to states for health coverage of their welfare population to a program that now provides health and long-term coverage to 51 million low-income Americans at an annual cost to the federal and state governments of \$205 billion in 2002. It is now the nation's largest health care program.

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 has a broad reach – it is the source of health insurance coverage for 1 in 5 American children and over a third of all Hispanic and African-American children, but it also provides health and long-term care coverage for 60 percent of nursing home residents, 44 percent of people living with HIV/AIDS, 20 percent of people with severe disabilities and 15 percent of Medicare beneficiaries (Figure 1).

In meeting these 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. Medicaid assists, on average, over one in ten state residents and is the largest source of federal support to states and a major engine for state economies, supporting millions of jobs across the country (Figure 2).

Medicaid's most widely acknowledged role is as the source of health insurance coverage for 38 million low-income children and parents. By providing fundamental health insurance protection, Medicaid keeps millions of poor children and their parents from adding to our growing uninsured population. With the enactment of the State Children's Health Insurance Program (SCHIP) in 1997 and the Medicaid expansions over the last decade, Medicaid and SCHIP now have the potential to reach all low-income children. Although more needs to be done to broaden outreach and facilitate enrollment to achieve full participation by all eligible uninsured children, the latest census numbers show that public coverage through Medicaid and SCHIP helped to offset the decline in employer coverage. While the number of uninsured grew by 2.4 million in 2002, Medicaid coverage kept another 1.6 million from being added to the uninsured and maintained coverage for children.

Figure 1
Medicaid's Role for Selected Populations

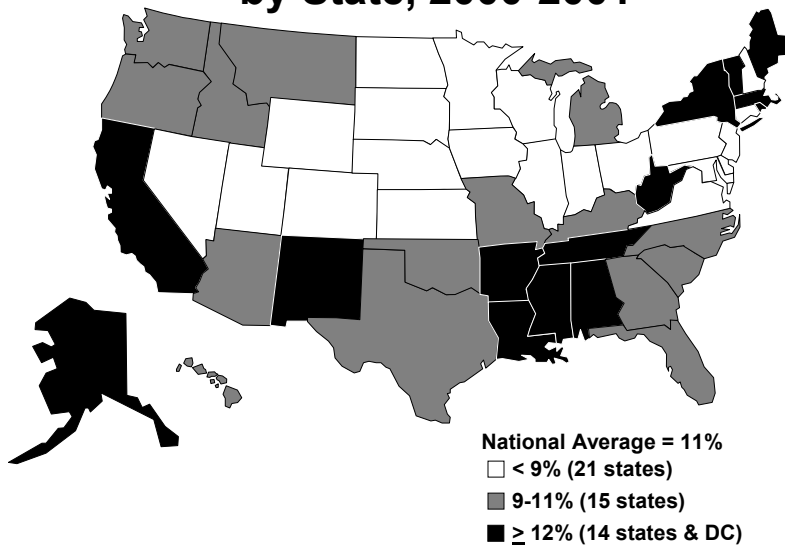


Note: "Poor" is defined as living below the federal poverty level, which was \$14,128 for a family of three in 2001.

SOURCE: KCMU and Urban Institute estimates, 2002.

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Figure 2
**Percent of Residents Covered by Medicaid,
 by State, 2000-2001**



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of 2 year-pooled data from March 2001 and 2002 Current Population Survey, 2002.

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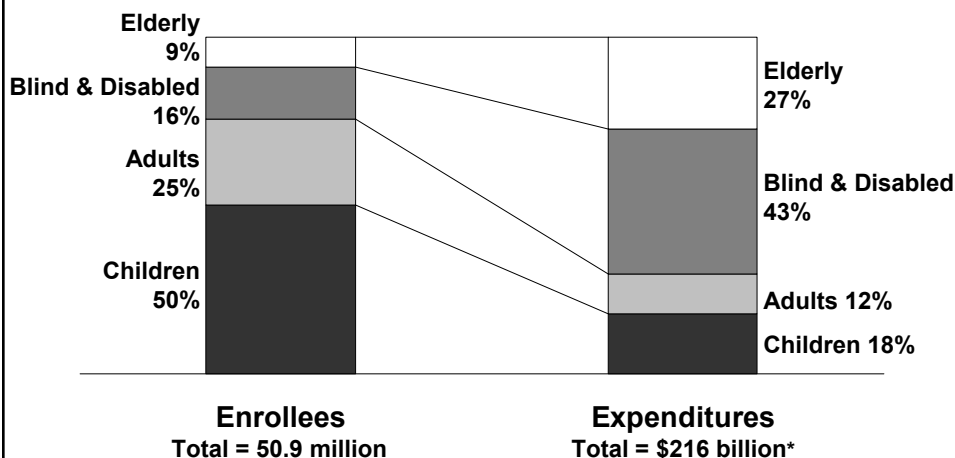
It is not, however, Medicaid's role as a health insurer of low-income families that provides Medicaid's most unique or costly undertaking. Medicaid's role in assisting 8 million low-income people with disabilities and 5 million low-income elderly people with both medical care and long-term care services dominates Medicaid spending. Although children account for half of all Medicaid beneficiaries, they account for only a small share of spending. Together children and their parents represent three-quarters of all beneficiaries and 30 percent of all spending, while the elderly and disabled account for a quarter of beneficiaries and 70 percent of spending (Figure 3). In 2002, per capita expenditures per child were \$1,500 compared to \$11,800 per disabled beneficiary and \$13,100 per elderly Medicaid beneficiary. Higher utilization of acute care services coupled with long-term care spending for the elderly and disabled account for the difference (Figure 4).

For low-income Medicare beneficiaries Medicaid coverage is particularly important. Although Medicare provides basic medical coverage, the required cost-sharing and gaps in benefits, most notably lack of prescription drug or long-term care coverage, leave many holes to be filled by Medicaid. The 7 million individuals with both Medicaid and Medicare – the “dual eligibles” – are among Medicare's poorest and sickest beneficiaries. In addition to having low-incomes, these dual eligibles are also 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 (Figure 5). As a result, the dual eligible population accounts for 14 percent of Medicaid beneficiaries, but for 42 percent of all Medicaid spending (Figure 6). Spending on prescription drug coverage alone for the dual eligible population represents 6 percent of total Medicaid spending – \$13.4 billion in 2002 – and represents approximately half of all Medicaid spending on prescription drugs.

The structure of Medicaid provides states with federal matching funds for coverage of mandatory populations and services, but also enables states to

Figure 3

Medicaid Enrollees and Expenditures by Enrollment Group, 2002



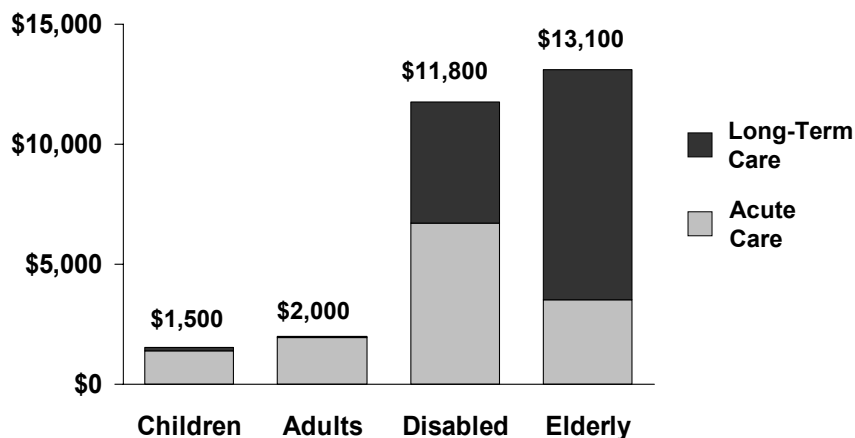
Expenditure distribution based on CBO data that includes only spending on services and excludes DSH, supplemental provider payments, vaccines for children, and administration.

SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2003.

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Figure 4

Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 2002

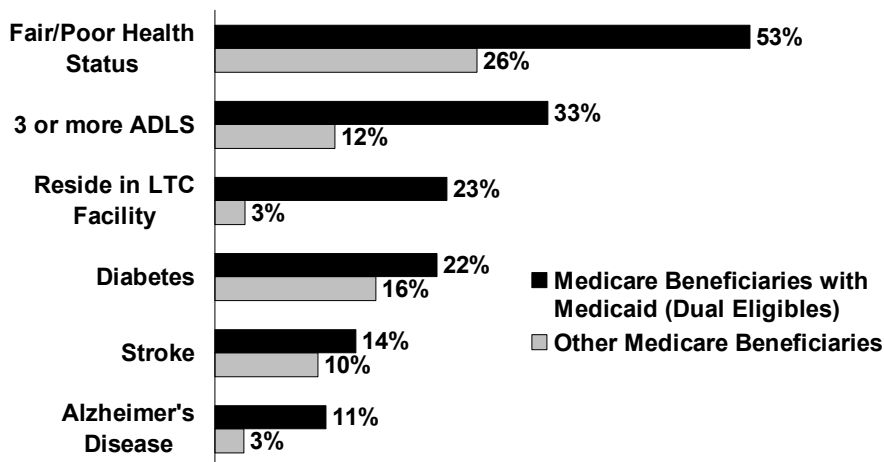


SOURCE: KCMU based on CBO and Urban Institute estimates, 2003.

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Figure 5

Characteristics of Dual Eligibles Compared to Other Medicare Beneficiaries, 1999

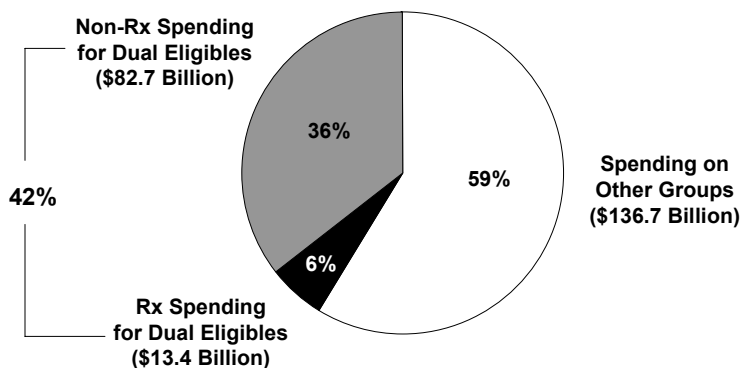


Note: ADLS = Number of limitations in Activities of Daily Living
 SOURCE: 1999 Medicare Current Beneficiary Survey.

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Figure 6

Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FFY2002



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

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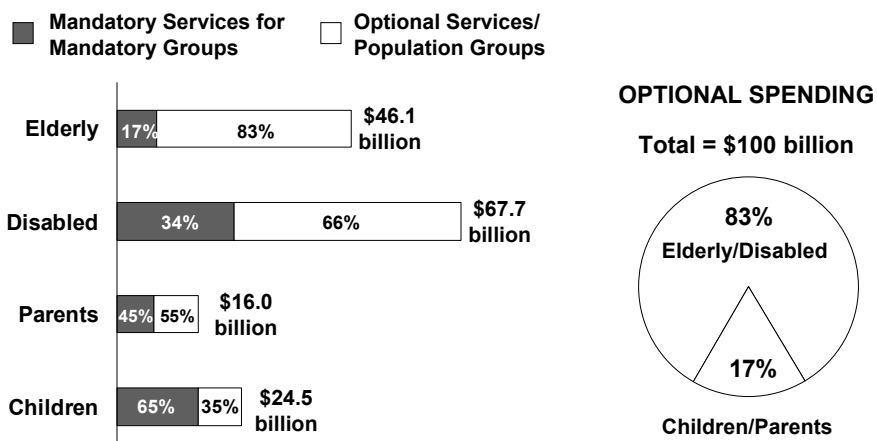
obtain federal matching funds for a wide range of optional services and broader population coverage. Most notably, states are required to cover all children under the poverty level and most aged and disabled recipients of cash assistance under the Supplementary Security Income (SSI) program and have the option to cover children at higher income levels, their parents, and other low-income elderly and people with disabilities in the community and in nursing homes. However, coverage of non-disabled childless adults is not an optional category for coverage. With regard to benefits, states must cover basic physician, laboratory, and hospital services, but many benefits, including prescription drug coverage and community-based long-term care are covered at state option.

Although the configuration varies from state to state, about 65 percent of all program spending is at state option. However, in meeting the health and long-term care needs of the low-income population, the legislative language of “State Option” hardly applies to the population’s need for the services covered—83 percent of optional spending is for the aged and disabled population and the bulk is for long-term care and prescription drug coverage (Figure 7). Without these “optional” services and the broadened coverage at state option of the aged and people with disabilities, millions of America’s poorest and sickest people would be without essential health and long-term care services.

Moreover, despite its comprehensive coverage of services and limited cost-sharing, Medicaid is in reality a low-cost program when compared with other health care spending. Among children, per capita expenditures for those in Medicaid are significantly lower than for their privately insured counterparts (Figure 8). While per capita expenditures for adults in Medicaid are higher than the corresponding amounts for low-income adults who have private coverage, this is due to the much poorer health status of the adult population enrolled in Medicaid. When adults with disabilities are excluded from the analysis of both Medicaid and private insurance, per capita expenditures are significantly lower

Figure 7

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

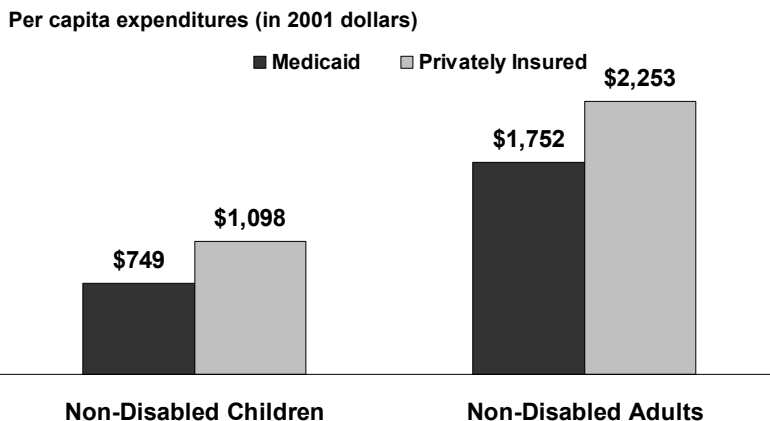


Note: Expenditures on services.
 SOURCE: Urban Institute estimates, 2001.

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Figure 8

Per Capita Expenditures for Non-Disabled Low-Income Children and Adults



Note: "Low income" defined as those with incomes less than 200% of the Federal Poverty Level. "Non-disabled" defined as those not reporting any limitations.
 SOURCE: Holahan and Hadley analysis of MEPS data from 1996, 1997, 1998, and 1999, prepared for the Kaiser Commission on Medicaid and the Uninsured.

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for Medicaid adults than for the privately insured. Medicaid spends more because it covers a sicker population.

Although Medicaid is a substantial investment of federal and state dollars, it also provides an effective return on that investment in terms of improving access to care for our low-income population. Medicaid does a particularly good job in helping low-income populations close the gap in access to care and in connecting people to the health system. Uninsured children and adults are less likely to obtain medical care and more likely to postpone needed care and lack a regular source of care than those with Medicaid coverage (Figure 9). Among the elderly and disabled with Medicare coverage, Medicaid supplements Medicare coverage and provides access comparable to those with private supplemental insurance and notably better than that experienced by the population covered with Medicare only (Figure 10).

Medicaid Spending

These roles make Medicaid both a complex and costly program. Medicaid is complex because it is not a single program, but an array of services and programs under a single name, 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, in America is expensive and Medicaid covers those with among the most substantial health care needs – including those with severe disabilities and chronic health problems requiring on-going care.

Medicaid spending is determined by the number of people covered, the cost of their medical and long-term services and the amount of services used. During the early 90s, Medicaid spending growth was particularly high, largely due to the use of provider taxes and donations and other financing mechanisms used by states to gain additional federal matching funds (Figure 11). Once these

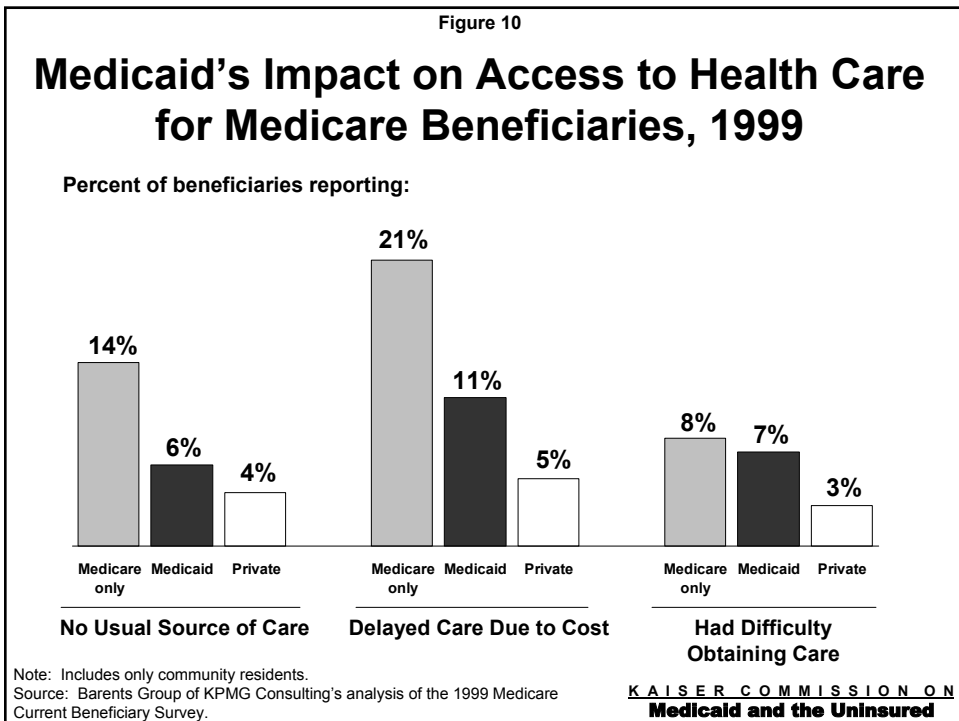
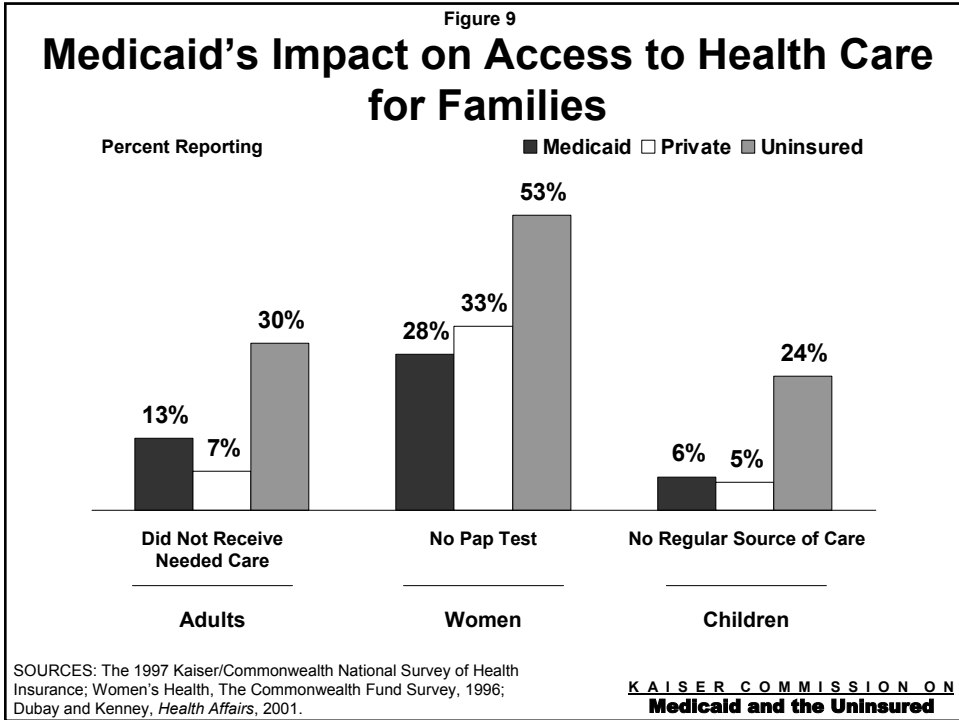
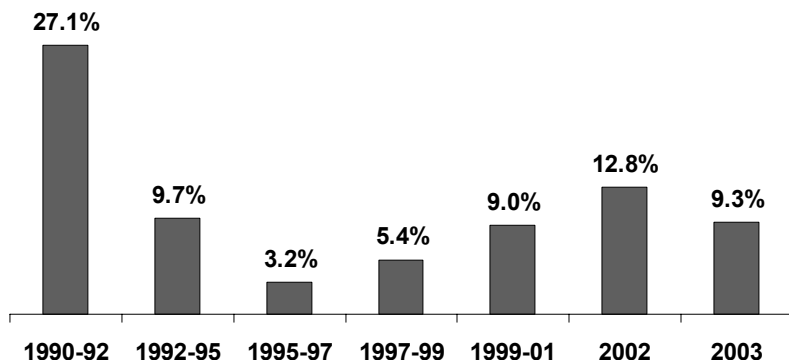


Figure 11

Average Annual Growth Rates of Total Medicaid Spending

Annual growth rate:

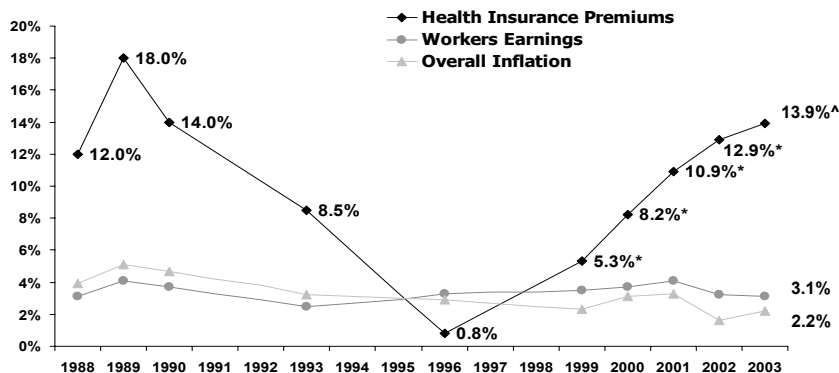


SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, 2000. For 2001-2003: Health Management Associates, for the Kaiser Commission on Medicaid and the Uninsured.

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Figure 12

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four.

* Estimate is statistically different from the previous year shown at $p < 0.05$: 1996-1999, 1999-2000, 2000-2001, 2001-2002.

^ Estimate is statistically different from the previous year shown at $p < 0.1$: 2002-2003.

SOURCE: KFF/HRET Survey of Employer-Sponsored Health Benefits; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1989, 1990, 1993, 1996.

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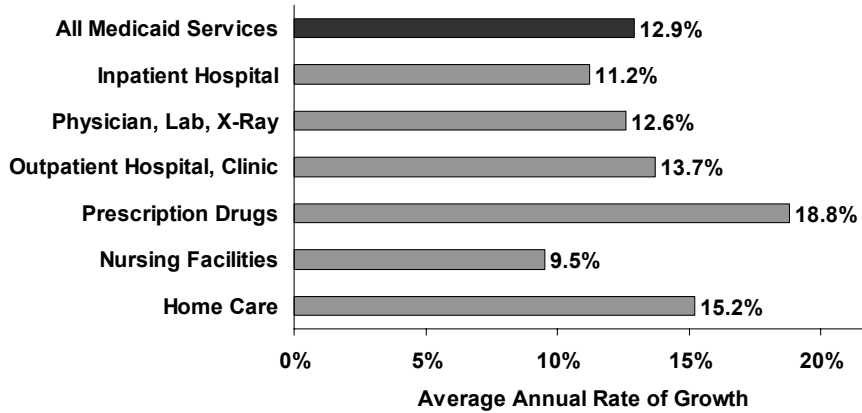
practices were curbed, Medicaid spending growth returned to levels more consistent with private spending and reflective of expanding coverage. A notable drop occurred in the period surrounding welfare reform, largely due to individuals losing Medicaid coverage during the welfare reform transition. This was also a time when cost increases for the private health insurance were at an all-time low (Figure 12). In recent years, Medicaid spending has increased as enrollment has grown and the cost of medical care has risen for both the public and private sectors.

Over the 2000-2002 period, Medicaid expenditures for services grew by 12.9 percent overall—a rate comparable to the increases seen for private health insurance premiums. Although Medicaid is historically a low-paying purchaser of health care services, there is continual pressure on the program to keep pace with payment rates in the private sector in order to maintain access to care for Medicaid beneficiaries. As a result, the spiraling costs for health care also impact Medicaid. Just as for private insurance, prescription drugs costs had the highest rate of growth among Medicaid services, increasing 18.8 percent from 2000 to 2002 (Figure 13). However, after several years of rapidly accelerating Medicaid spending growth, in FY 2003 the rate of growth in Medicaid spending fell by nearly a quarter, to 9.3 percent. This rate of growth, which is still substantial, stands in marked contrast to growth trends for employer-sponsored health insurance, which continue to increase and reached 13.9 percent that year.

The rapid Medicaid spending growth has been driven, in part, by enrollment increases resulting from the loss of income and private insurance coverage during the current economic downturn, together with continued increases in hospital and prescription drug costs that have affected the entire health care sector. Yet, Medicaid spending increases on a per capita basis remained substantially lower than increases in per capita spending in the private sector – from 2000 to 2002, Medicaid per capita spending increased on average 8.6 percent compared to over 12 percent increases in private insurance

Figure 13

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



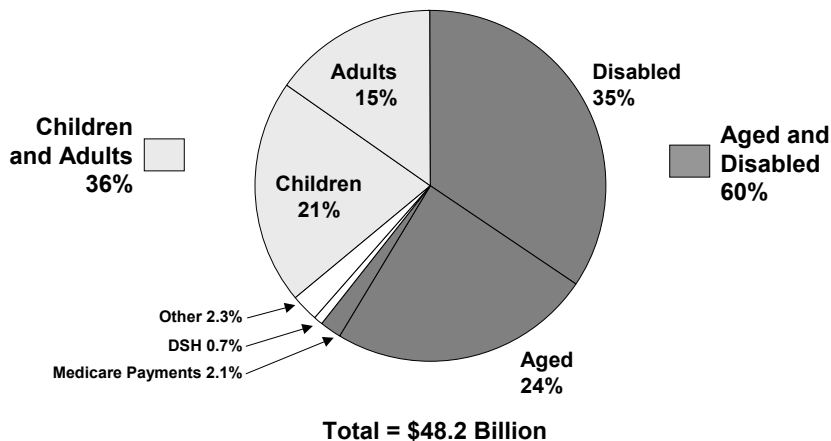
Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed.

SOURCE: Kaiser Commission on Medicaid and the Uninsured / Urban Institute analysis of HCFA-64 data.

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Figure 14

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



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

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premiums per person. Moreover, Medicaid enrollment growth also helped to soften the recession's effects, stemming further increases in the number of uninsured. However, the increased enrollment of low-income children and parents is not the major driver of Medicaid spending increases---it is the cost of care for the elderly and disabled who depend on Medicaid to fill Medicare's gaps and provide assistance with both acute and long-term care needs. The elderly and individuals with disabilities accounted for almost 60 percent of the \$50 billion growth in Medicaid spending from 2000 to 2002 due to their extensive need for health service and their use of costly long-term care coverage (Figure 14).

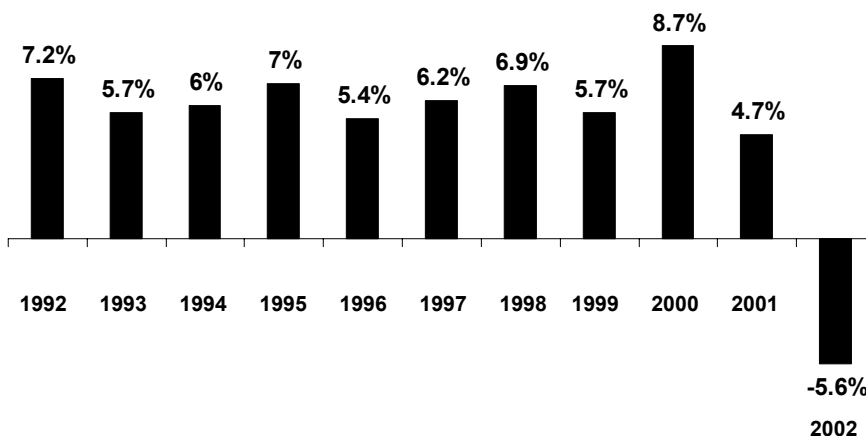
The State Fiscal Challenge

At the same time as these pressure push Medicaid spending up, states are facing extremely challenging fiscal conditions, and have been for several years. State tax revenues declined significantly in 2002 and remained at that low level throughout 2003 (Figure 15). The recent falloff in state tax revenue is large even by the standards of recent history---the decline in state tax revenue is twice as big as it was in either of the two most recent recessions. Moreover, it is this revenue falloff, not the recent increase in Medicaid spending, that has been by far the major contributor to state budget shortfalls, which reached more than \$70 billion this year.

As states have grappled with the challenge of balancing their budgets in the face of declining revenues, most have devoted significant attention to implementing new measures to control their Medicaid spending growth. For fiscal year 2003, every state and the District of Columbia has put in place some Medicaid cost containment mechanism. Over the past three years, 34 states have reduced eligibility and even more have restricted health care benefits (Figure 16). These strategies appear to have been successful in reducing the rate of Medicaid spending growth, but they also raise real questions about how

Figure 15

Change in State Tax Revenue Collections, 1992-2002

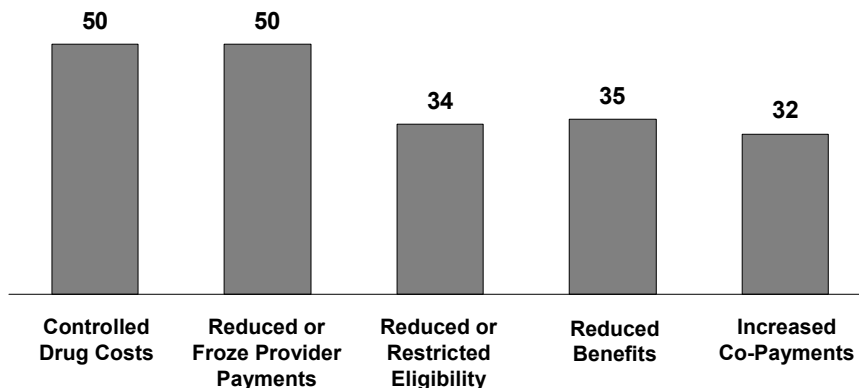


SOURCE: Rockefeller Institute of Government, Fiscal Year 2002 Tax Revenue Summary, May 2003. Changes are shown in nominal terms and are not adjusted for tax-related legislative changes.

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Figure 16

Number of States Implementing Medicaid Cost Containment Strategies Over the Past Three Years (FY 2002 – FY 2004)



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

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the program will be able to meet the health care needs of low-income people, whose numbers are growing.

The outlook for state budgets in FY 2004 and 2005 remains challenging. The state revenue picture remains depressed. Spending pressures continue to build. States have exhausted a lot of one-time measures they have used to balance their budgets. Medicaid expenditure assumptions in FY 2004 appear optimistic, and Medicaid budget shortfalls are likely in a majority of states. Finally, the federal fiscal relief Congress provided in June, which helped states avoid making additional and deeper changes to their Medicaid programs this year, expires at the end of fiscal year 2004. This, along with present expectations of low revenue growth, will leave states with significant gaps in their budgets for FY 2005. As states enter another year of Medicaid cost containment, they will continue to struggle to balance the health needs of their low-income citizens with the need to close what are for many states gaping holes in their overall state budgets.

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. And, 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 we must meet with responsible proposals that assure that the most frail and vulnerable among us are protected and able to obtain the health and long-term care services they need.

There are no easy answers to reducing the cost of providing care to the over 50 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 cost of caring for this population is high, reflective of their serious health problems, not excessive spending by the program. Program costs grow in response to downturns in the economy, 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 population ought to be among our nation's highest priorities.

Thank you for the opportunity to testify today. I welcome your questions.