kaiser commission on MEDICAID FACTS
medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION

May 2006

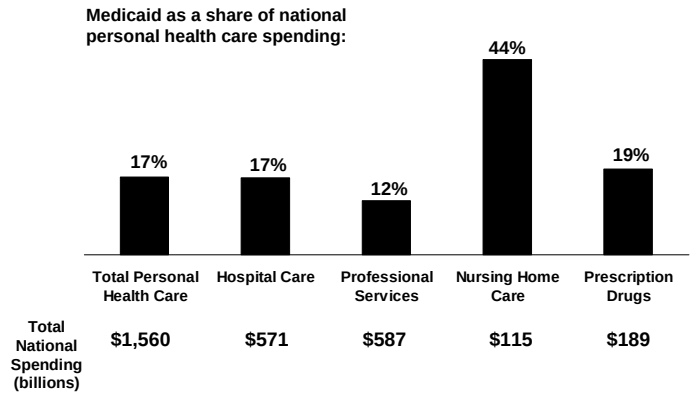
THE MEDICAID PROGRAM AT A GLANCE

Medicaid is the nation's major public health insurance program for low-income Americans, financing health and long-term care services for over 55 million people, including children and many of the sickest and poorest in our nation. In general, private health insurance is not an option for many Medicaid enrollees; low-income workers often do not have access to coverage through their employers, or cannot afford it even if it is offered, and private insurers often exclude individuals with disabilities and chronic illnesses. In the absence of the Medicaid program, the vast majority of its beneficiaries would join the ranks of the 46 million uninsured Americans.

Since its enactment in 1965, Medicaid has improved access to health care for low-income individuals, financed innovations in health care delivery, and functioned as the nation's primary source of long-term care financing. Medicaid plays a major role in the U.S. health care system, accounting for 1 of every 6 dollars spent on personal health care and more than 40% of all spending on nursing home care (Figure 1).

Figure 1

Medicaid's Role in the Health System, 2004



SOURCE: Smith, et al, 2006. Based on National Health Care Expenditure Data, CMS, Office of the Actuary.

The federal and state governments jointly finance Medicaid, and the states administer it within broad federal guidelines. The federal contribution to Medicaid spending ranges from 50% to 76%, depending on state per capita income. Overall, the federal government financed 57% of all Medicaid spending.

Who Is Covered by Medicaid?

To qualify for Medicaid, an individual must meet financial criteria and also belong to one of the groups that are "categorically eligible" for the program, including children, parents of dependent children, pregnant women, people with disabilities, and the elderly. Federal law guarantees Medicaid eligibility for individuals within these groups who fall below specified income levels. At the same time, states have broad optional authority to extend Medicaid eligibility beyond these minimum standards. States have expanded Medicaid coverage extensively, but variably; as a result, Medicaid eligibility and coverage differ widely from state to state.

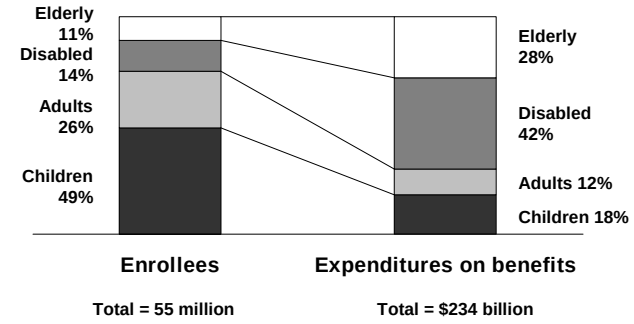
In 2003, Medicaid provided coverage to:

- 27 million children
- 14 million adults (primarily low-income working parents)
- 6 million seniors
- 8 million persons with disabilities

The majority of Medicaid spending- 70%- is attributable to the elderly and people with disabilities, who make up only one-quarter of the Medicaid population (Figure 2). In fact, the 3.6% of Medicaid enrollees with annual spending exceeding $25,000 in 2001 accounted for nearly half (48.8%) of all Medicaid spending.

Figure 2

Medicaid Enrollees and Expenditures by Enrollment Group, 2003

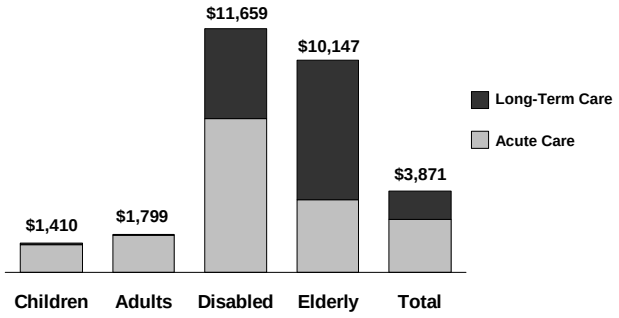


SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2003 MSIS data.

In 2003, estimated Medicaid spending per child was $1,410, compared to $11,659 per disabled enrollee and $10,147 per elderly enrollee. Higher per capita expenditures for disabled and elderly beneficiaries reflect their intensive use of costly acute and long-term care services (Figure 3).

Figure 3

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



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2003 MSIS and CMS 64 data.

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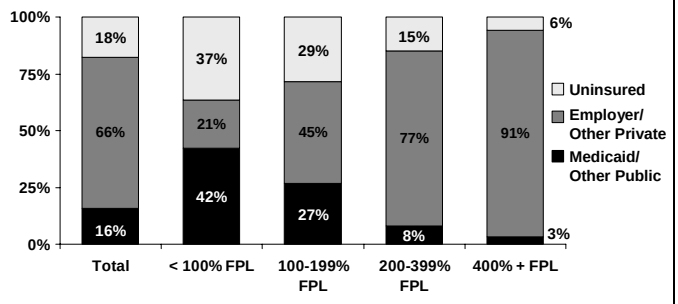
Over the last several years, average annual increases in per capita Medicaid costs have been substantially lower than increases in private health insurance premiums.

A large share of Medicaid spending (40%) is attributable to "dual eligibles," low-income Medicare beneficiaries who are also enrolled in Medicaid. Dual eligibles rely on Medicaid to pay for Medicare premiums and cost-sharing and to cover important services that Medicare does not cover, such as long-term care. As of January 2006, drug coverage for dual eligibles shifted from Medicaid to Medicare Part D prescription drug plans. Some states offer wrap-around coverage for drugs not covered or pay for new cost sharing amounts, but these expenses are not eligible for federal matching funds.

Medicaid is also a key source of coverage for low-income working families, who often do not have access to health insurance through their jobs (Figure 4). More than one in four children in America relies on Medicaid for coverage, and two-thirds of all Medicaid enrollees are in low-wage working families.

Figure 4

Health Insurance Coverage of the Nonelderly by Poverty Level, 2004



Medicaid also includes S-CHIP, other state programs, Medicare, and military-related coverage. The federal poverty level (FPL) was $15,670 for a family of three in 2004. Data may not total 100% due to rounding.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of the March 2005 Current Population Survey.

The 2001 recession caused more families to qualify for Medicaid when their income fell. With rates of employer-sponsored coverage dropping, Medicaid and the State Children's Health Insurance Program (SCHIP) have stemmed the increase in the number of uninsured. However, eligibility restrictions, particularly for adults and recent immigrants, and enrollment obstacles continue to limit Medicaid's reach.

What Services Does Medicaid Cover?

Medicaid uses public dollars to buy services, often in the private health care system. The program covers a variety of benefits to meet the complex needs of the diverse populations it serves. State Medicaid programs are generally required to cover:

- inpatient and outpatient hospital services
- physician, midwife, and certified nurse practitioner services
- laboratory and x-ray services
- nursing home and home health care for individuals aged 21 years and older
- early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- family planning services and supplies
- rural health clinic/ federally qualified health center services

States have the option of covering additional services with federal matching funds. Commonly covered optional services include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care, and intermediate care facilities for the mentally retarded (ICF/MR). The majority of state spending on optional services goes toward elderly and disabled beneficiaries.

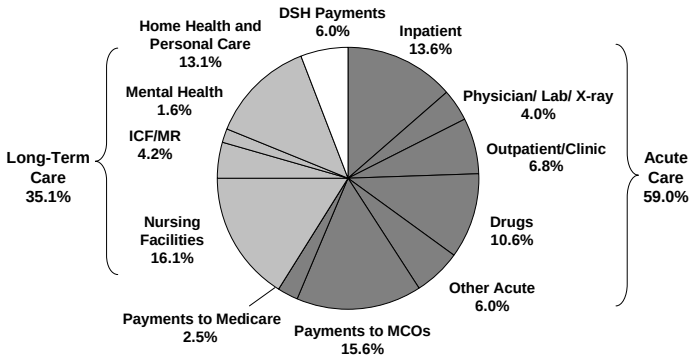
In addition to matching state Medicaid spending for services, the federal government also matches the supplemental payments that states make to hospitals serving a disproportionate share of indigent patients (DSH) up to federal caps.

Of the $288 billion in total Medicaid spending in 2004 (Figure 5):

- Acute-care services comprised over half (59%)
- Long-term care services made up 35%
- Payments for Medicare premiums accounted for about 2%

Figure 5

Medicaid Expenditures by Service, 2004



Total = $288.1 billion

SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

Medicaid accounts for nearly half of total long-term care spending and finances care for 60% of nursing home residents. While more than half of Medicaid long-term care spending goes toward institutional services, home and community-based services account for a growing proportion of Medicaid spending on long-term care.

Future Challenges Affecting Medicaid

As expected, Medicaid enrollment and spending growth spiked during the 2001 recession. As the economy recovers, Medicaid enrollment and spending growth is starting to slow, but state and federal pressure to limit and/or increase the predictability of Medicaid spending remains high. The recent passage of the Deficit Reduction Act of 2005 (DRA) is expected to reduce Medicaid spending and gives states new flexibility to limit benefits and impose premiums and cost sharing. The new law also provides options focused on expanding community based long-term care, requires states to make changes to the asset transfer rules that affect eligibility for Medicaid nursing home services, and requires states to obtain proof of citizenship for Medicaid enrollees. Beyond these changes, some states are pursuing major and fundamental program reforms through Medicaid waivers.

Many of these recent changes could create financial barriers for Medicaid beneficiaries and make it more difficult to obtain and maintain Medicaid coverage. Going forward it will be important to evaluate and monitor the implications of these program changes for program spending as well as for the availability and affordability of coverage for the low-income beneficiaries the program serves.

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