# Issue Brief

## *Medicaid*

**March 2005**

The Medicaid program provides services to over 52 million people, including children and many of the sickest and poorest people in our nation. The Kaiser Family Foundation reports that Medicaid plays a major role in our health system, accounting for 1 out of every 6 dollars spent on personal health care and nearly half of all spending on nursing home care. In general, private health insurance is not an option for those on Medicaid since low-income workers often do not have access to coverage through their employers, and if it is offered they cannot afford it. Private insurers often exclude people with disabilities and chronic illnesses. Nearly 1 in 4 children relies on Medicaid for coverage and two-thirds of all Medicaid enrollees are in low-wage working families.

The Medicaid program is financed jointly by the federal and state governments but states administer the program within broad federal guidelines. In 2003 the federal government financed 57 percent of the $266 billion in total Medicaid spending. Federal spending on Medicaid ranges by state from 50 to 77 percent depending on state per capita income.

Medicaid eligibility is determined by income and by belonging to one of the groups that are "categorically eligible", which includes children, parents of dependent children, pregnant women, people with disabilities, and the elderly. Federal law guarantees Medicaid eligibility for people within these groups who fall below certain income levels. States have broad optional authority to extend Medicaid coverage beyond these minimum standards and as a result coverage varies from state to state.

The Medicaid program provided services to 25 million children, 14 million adults who were primarily working parents, 5 million seniors and 8 million people with disabilities in 2003. Although seniors and people with disabilities make up only one-quarter of the Medicaid population, they account for the majority of spending – 69 percent. Low-income children and parents make up three quarters of the Medicaid population and account for only 31 percent of Medicaid spending.

In 2003, Medicaid spending per child was $1,700 compared to $12,300 per disabled enrollee and $12,800 per elderly enrollee. Costly acute and long term care services account for the higher expenditures for disabled and elderly beneficiaries.

Forty-two percent of Medicaid spending targets "dual eligibles", low-income Medicare beneficiaries who are also enrolled in Medicaid. Dual eligibles rely on Medicaid to pay for Medicare premiums and co-payments and to cover services that Medicare does not cover, such as long-term care and prescription drugs. Starting in January 2006, dual eligibles will lose prescription drug coverage and will instead be offered drug coverage under the new Medicare Part D prescription drug program.

Medicaid spending has increased substantially in recent years due to growth in enrollment as a result of the economic downturn. It is important to note that average annual increases in Medicaid have been substantially lower than increases in private health insurance premiums.

State budgets are expected to continue to struggle with Medicaid spending as a result of increasing health care costs and demographic trends. Between Fiscal Years 2002 and 2005, all states reduced provider rates and placed controls on prescription drugs and 38 states reduced eligibility and 34 reduced benefits.

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States that choose to participate in Medicaid must cover minimum benefits for some groups. States must cover the following benefits if they are medically necessary: hospital care; nursing home and home health care; physician services; laboratory and x-ray services; immunizations and other early and periodic screening, diagnostic, and treatment (EPSDT) services for children; family planning services; rural health clinic and health center services; and nurse midwife and nurse practitioner services. States have the option of covering these additional services: prescription drugs; institutional care for individuals with mental retardation; home- and community-based care for the frail elderly including case management; personal care and other community-based care for individuals with disabilities; and dental care and vision care for adults.

Elderly and disabled beneficiaries receive the majority of state spending on optional services. Long-term care and prescription drugs account for over two-thirds of optional spending.

## Bush Administration Proposal

The Bush Administration's FY 2006 budget request would cut federal funding to states for the Medicaid program by $60 billion over 10 years. The gross reduction of $60 billion would be offset by $15 billion in new Medicaid-related initiatives for a net reduction of $45 billion over 10 years.

The Bush proposal would change the payment for drugs resulting in $15 billion in savings and close loopholes on asset transfers for $4.5 billion in savings. The proposal would also restrict Inter-Governmental Transfers (IGTs) for a savings of $11.9 billion and limit provider payment to "actual costs" for a savings of $3.3 billion. A total of $6.2 billion would be saved from reducing the allowable provider tax rate from 6 percent to 3 percent of total revenue. Requiring taxes on managed care would result in $1.4 billion of savings. The Bush proposal would also narrow the definition of targeted case management and reduce the federal match on targeted case management to 50 percent. Administrative costs would be block granted to states for a savings of $6 billion.

All or part of the Bush proposal will be discussed as part of the budget reconciliation process. It is anticipated that the proposal could also include caps on services and eligibility as it moves through the legislative process.

Advocates have embraced three principles with Medicaid reform:

- Any proposal must not harm Medicaid recipients and should not impede access to care;
- Savings must accrue to the federal and state government, not simply shift costs to the states; and
- Legitimate savings in the Medicaid program should be reinvested in the program.

## Legislation

Legislation has been introduced in the House and Senate that would create a bipartisan commission on Medicaid to study and make recommendations for the program improvement. The Bipartisan Commission Medicaid Act, S. 338 and H.R. 985, was introduced in the Senate by Senators Bingaman (D-NM) and Smith (R-OR) and introduced in the House by Representative Wilson (R-NM).

**Action Needed!** Advocates are encouraged to contact their Senators and Representative and ask them to co-sponsor S. 338 or H.R. 985. Tell your elected officials that Medicaid reform should be conducted separate from the budget process and with a clear understanding of the impact changes would have on beneficiaries, providers and states. For information about your Senators and Representative, go to www.lutheranservices.org or call the capitol switchboard at 202-224-3121.