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**Medicaid: A Future Challenge For the States**

By Diane Rowland

Medicaid is a broad and multifaceted program that is jointly financed by the federal and state governments in order to address the needs of low-income families, the elderly and those with chronic, disabling health conditions. It is an essential part of the health coverage and financing system in every state and is the largest source of federal financial assistance to the states. Balancing the growing responsibilities for coverage of vulnerable populations with fiscal realities will undoubtedly be a major challenge in the years ahead.

Today, Medicaid is the primary source of health and long-term care assistance for one in 10 Americans, accounting for 16 percent of our nation’s spending on health care.¹ Jointly financed by the federal and state governments, Medicaid has evolved from a program providing medical assistance to the welfare population to a broad and multifaceted safety net addressing the needs of low-income families, the elderly and those with chronic, disabling health conditions. It is an essential part of the health coverage and financing system in every state and now represents the largest source of federal financial assistance to the states, accounting for over 40 percent of all grant-in-aid payments to states.²

Medicaid will undoubtedly remain at the forefront of state policy in the years to come. Over 40 million low-income children and adults already depend on Medicaid for assistance, and many more could potentially benefit from expansion of its safety net. Yet, as the program has grown in responsibility and scope, it has also grown as a fiscal concern for the states and federal government that share in its financing. The current economic downturn has added new pressure as high levels of unemployment propel more people to turn to Medicaid for health coverage just as state revenues are least available to expand to meet growing demand.

Balancing the growing responsibilities for coverage of vulnerable populations with fiscal realities will undoubtedly be a critical issue for both the states and federal governments in the coming years. This chapter examines Medicaid’s current role and the issues and challenges it faces in the future.

**Medicaid’s Role in the Health System**

Medicaid reaches some of the nation’s poorest and most disadvantaged populations to provide basic health insurance coverage for low-income families, acute and long-term care services for low-income people with disabling conditions, and supplemental coverage to Medicare, plus long-term care for low-income and disabled Medicare beneficiaries. The scope and composition of the program varies across states, depending on how states elect to structure their programs within federal eligibility and benefits guidelines.

From the perspective of who is served, Medicaid is predominantly a program assisting low-income families, but from the perspective of how Medicaid dollars are spent, Medicaid funds primarily serve the low-income aged and disabled populations. Adults and children in low-income families make up nearly three quarters (73 percent) of enrollees, but account for only 25 percent of spending (see Figure A).³ In contrast, the

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*Figure A: Medicaid Enrollees and Expenditures by Enrollment Group, 1998*

- **Enrollees**
  - Elderly 10.1%
  - Blind & Disabled 17.3%
  - Adults 21.4%
  - Children 51.2%
  - Total = 40.4 million people

- **Expenditures**
  - Elderly 27.1%
  - Blind & Disabled 39.4%
  - Adults 9.7%
  - Children 14.9%
  - Total = $169.3 billion

*Total expenditures exclude administrative expenses.
**Disproportionate Share Hospital payments.
Source: Urban Institute estimates, based on HCFA-2082 and HCFA-64 Reports
elderly and disabled account for 27 percent of enrollees and the majority (67 percent) of spending, largely due to their intensive use of acute-care services and the costliness of long-term care in institutional settings. In 1998, the most recent year for which detailed data is available, the average annual per capita cost for a child on Medicaid was $1,225, compared to $9,558 per disabled beneficiary and $11,235 per elderly beneficiary (see Figure B).4

In meeting its many responsibilities, Medicaid has become a major source of payment in the nation’s health care system. It accounts for 16.7 percent of all personal health care spending and 17 percent of hospital care expenditures.5 Because it is the only significant public program that provides financing for long-term care, Medicaid covers 70 percent of nursing-home residents and nearly half (48 percent) of nursing-home costs nationwide.6 The program also plays a vital role in covering the increasing cost of prescription medication: in 2000, Medicaid paid for over 17 percent of all prescription-drug spending in the nation.7 Because it is administered and partially financed by states, Medicaid also plays a very important role at the state level. On average, states spend 15 percent of their general-fund expenditures on Medicaid, making it the second largest budget item (after elementary and secondary education, which accounts for 36 percent of spending).8 Not only is Medicaid a significant source of state spending, it is also a key source of federal revenue for states. Medicaid is the largest source of federal funding to states, accounting for 42 percent of federal dollars to states in 2000, up from 29 percent in 1989.9 Medicaid financing not only helps states insure their vulnerable populations, but it also helps support states’ safety net of clinics and hospitals that serve low-income and uninsured populations. In addition, the program is a key third-party resource to supplement funding for state public-health efforts such as tuberculosis control and family-planning programs.

Providing Insurance to Low-Income Families

States are on the front lines in trying to provide coverage for our nation’s 38 million uninsured children and nonelderly adults. Lack of health coverage is a problem for many populations in a state, but the issue disproportionately affects low-income populations, who are most likely to work in situations where their employers do not provide health insurance. Nationwide, nearly two-thirds of the uninsured live on incomes below 200 percent of poverty (roughly $30,000 for a family of three).10 While uninsured rates vary across the country, 20 states have over 30 percent of their low-income nonelderly residents without health insurance (see Figure C and the table in this chapter entitled “Health Insurance Coverage of the Low-Income Nonelderly”).11

Medicaid plays a critical, but limited, role in helping to provide health coverage to low-income families. Today, Medicaid insures 21 million children and 8.6 million low-income adults, covering one in four American children and 40 percent of all births.12 As an insurer of low-income families, Medicaid covers 37 percent of the poor and 17 percent of the near-poor nonelderly population and helps fill the gaps in employer-sponsored coverage.13 For most of the families covered through Medicaid, private health insurance is unavailable or unaffordable; with Medicaid they gain access to a broad range of medical, dental, vision and behavioral-health services, including preventive care, acute care and long-term care, with little or no cost-sharing.

With the availability of additional resources to states to broaden coverage for low-income children through the State Children’s Health Insurance Program (SCHIP), states have additional tools that can be used to help reduce lack of insurance for low-income children. By providing states with the option (as well as increased federal matching funds) to extend coverage to all uninsured children in families with incomes up to 200 percent of poverty (or higher in some states where Medicaid eligibility levels were already high), SCHIP in combination with Medicaid now provides the foun-
dation for achieving coverage of nearly all low-income children. Currently, 40 states cover children with incomes at least up to 200 percent of the federal poverty line (see the table in this chapter entitled “Medicaid/CHIP Eligibility and Enrollment Simplification”), and, as a result, 84 percent of all low-income uninsured children are eligible for either Medicaid or a separate SCHIP program.\textsuperscript{14}

The challenge for coverage of children is how to translate eligibility into enrollment. Recognizing that the complexity of the enrollment process often deters participation, many states have moved aggressively to shorten application forms, reduce documentation requirements, simplify the process and encourage enrollment through outreach. Over 40 states have now eliminated the asset test and face-to-face interview for children, and others are renewing coverage on an annual basis (see the table entitled “Medicaid/CHIP Eligibility and Enrollment Simplification”). Due to this combination of simplification and expansion of eligibility, Medicaid now covers more than 20 million children, and another 3 million low-income children are now assisted by SCHIP.\textsuperscript{15} As states move to make enrolling children easier for working families and reach more uninsured low-income children, the recent decline in the number of uninsured children will hopefully continue.

The extension of coverage to low-income adults is more complex. The increases in coverage for children resulting from expansions and improvements in Medicaid and enactment of SCHIP do not extend to the low-income parents of these children or other childless adults. Parents can qualify for Medicaid if their income falls below levels set by the state, but in most states these levels are exceedingly low. In 31 states, parents are ineligible for Medicaid if their income exceeds the poverty level, and in about half of these states, parents are not eligible if their income is more than half the poverty line, which was just over $7,000 per year for a family of three in 2001.\textsuperscript{16}

States have the ability to broaden Medicaid coverage of parents through the more liberal accounting of income permitted as part of welfare reform (under Section 1931 of the Social Security Act) or through the

\begin{figure}[h]
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\includegraphics[width=\textwidth]{Figure_C.png}
\caption{Uninsured Rates Among the Nonelderly Low-Income Population by State, 1999-2000}
\end{figure}

\textsuperscript{14} Note: Low-income defined as < 200\% of poverty level, or $27,476 for a family of three in 2000.
use of waivers. Use of these options is a key component of improving insurance coverage of the low-income population and has also been demonstrated to improve outreach and enrollment of children. However, states that did not take advantage of these options in times of economic growth may be even less likely to do so in times of budget crises. Providing full-family coverage for low-income children and their parents is likely to remain a major policy debate as most states struggle to reduce their uninsured population while balancing their budgets.

However, even extending coverage to all low-income parents leaves a substantial share of the low-income uninsured population without coverage. Among the low-income uninsured adult population, less than six million are parents, but over 13 million are childless adults.\textsuperscript{17} In general, Medicaid does not provide coverage for childless adults unless they are aged, blind or disabled. Although a few states have waivers to extend some coverage to this group, financing care for childless adults is likely to remain outside the purview of most Medicaid programs for the near future.

As we enter 2002, states have clearly been trying to reach out and insure more low-income children through Medicaid and SCHIP and, in several states, to broaden coverage to more parents. These efforts have helped to simplify program enrollment and contribute to a modest decline in the number of uninsured Americans. There will be pressure to do more in the future, but the goal of improving coverage is now facing a new pressure from the slowing of the economy and the rising number of unemployed workers who are losing their employer coverage.

### Meeting the Health Needs of the Disabled and Elderly

Just as the economic downturn places new stress on state efforts to extend health-insurance coverage to more low-income families, Medicaid’s growing role as the health and long-term care safety net for low-income disabled and elderly people is also a future challenge to states. Medicaid now assists nearly seven million disabled and five million elderly low-income people, and changes in the population and patterns of health care delivery are likely to increase the program’s responsibility in caring for these vulnerable groups. Most of Medicaid’s elderly and about a third of disabled beneficiaries also have Medicare coverage; Medicaid’s continuing role as a supplement to Medicare for these individuals is therefore also intertwined with broader policy debates over Medicare reform.

Medicaid provides a crucial acute and long-term care support system for low-income people with severe disabilities, ranging from people with physical impair-
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ments to those with severe mental or emotional conditions to those with specific disabling conditions, such as HIV/AIDS. For many disabled Americans, private-insurance coverage does not cover necessary services, is not available due to pre-existing condition exclusions, or is simply prohibitively expensive. Medicaid coverage provides an essential link to a broad array of services in the community or in institutions. Currently, Medicaid is the source of coverage for one in five nonelderly persons with a specific, chronic disability who live in the community and the single largest source of public financing for HIV/AIDS-related care.18

The complex and often intense health needs of the disabled population, coupled with greater use of community-based or institutional long-term care services, make the disabled more expensive on a per capita basis than children or non-disabled adults. The disability population accounts for 17 percent of Medicaid enrollees, but nearly 40 percent of all spending (see Figure A).19 Many of the Medicaid services that the disabled population requires are among the most costly. For example, as shown in Figure D, in 1998, they accounted for 55 percent of all Medicaid prescription-drug spending, with per capita annual drug expenses of $1,133 compared to $81 for children and $893 for the elderly.20

Medicaid also plays a vital role in filling gaps in the Medicare program for low-income elderly and disabled Medicare beneficiaries. Thirty-seven percent of elderly and nearly 60 percent of disabled Medicare beneficiaries live on incomes below twice the poverty level.21 Medicare’s benefits gaps and financial obligations can impose significant financial burdens on low-income beneficiaries, many of whom have more extensive health care needs than the average beneficiary but cannot afford costly private coverage to supplement Medicare. For 4.6 million elderly and two million disabled Medicare beneficiaries, Medicaid serves as a supplementary insurance program,22 providing additional coverage for services not covered by Medicare (notably, prescription drugs and long-term care) and helping to cover Medicare’s Part B premiums and cost-sharing requirements.

This dual eligible population – elderly and disabled individuals covered by both Medicare and Medicaid – includes many of Medicare and Medicaid’s most vulnerable beneficiaries. These dual eligibles account for a disproportionate share of spending under Medicaid due to their use of costly long-term care services and prescription drugs.

As health costs – and especially prescription-drug spending – rise, expenditures for the disabled and elderly can be expected to grow as well. Increases in per capita spending, as well as increases in the number of disabled enrollees on Medicaid and the aging of the population, will push spending upward. As shown in Figure E, annual per capita spending for the disabled is expected to increase from $10,000 to over $15,000 during the next five years, and annual per capita spending for the elderly is expected to increase from $12,000 to over $17,000.23 Growth in prescription-drug spending and pressure to expand home and community-based care for the disabled (prompted by the recent Olmstead Supreme Court decisions) are major contributors to this projected increase.

Growth in the disabled population, coupled with the aging of our population, will particularly put pressure on Medicaid’s role as the primary source of long-term care coverage. In the next 30 years, the elderly population is expected to nearly double, with major increases in the population over 85 – those at greatest risk of needing long-term care. In the absence of long-term care reform to replace Medicaid’s role in financing home and institutional care, Medicaid’s responsibility for financing and assuring quality of care in nursing homes and residential facilities is likely to continue to grow.

Medicaid’s future role in coverage of the disabled and elderly populations also will be largely shaped by future Medicare policy. Proposals to restructure Medicare or rely more heavily on Medicare managed care have important implications for beneficiaries with Medicaid and the state programs that serve them. Most notably, enactment of a prescription-drug benefit under

![Figure E: Projected Total Medicaid Spending Per Enrollee, 2001-2006](image_url)

Note: Includes federal and state spending on benefits.
Medicaid could have a substantial impact on state Medicaid spending if Medicare takes over some responsibility for prescription-drug coverage of the six million Medicare beneficiaries who are dual eligibles. Alternatively, if no action is taken on this issue, more elderly and disabled Medicare beneficiaries may look to Medicaid for needed assistance.

**Rising Costs and Fiscal Pressures**

One of the biggest challenges facing the Medicaid program is how to meet the growing need for health and long-term care coverage at a time when health care costs are rising and state and federal fiscal resources are constrained. Health-care costs, particularly those for prescription drugs, have begun to rise more rapidly than in past years: in 2000, national health expenditures for prescription drugs increased over 17 percent from the previous year, and hospital and physician services increased 5 and 6 percent, respectively. These rising costs are reflected in increases in health insurance premiums for employers, which are now rising rapidly again after moderating in the mid-1990s (see Figure F). From 2000 to 2001, premiums rose 11 percent, and increases this year are expected to be even higher.

Cost increases in the private market put pressure on Medicaid programs to keep pace as a major purchaser of care. In order to maintain access to care for its beneficiaries, Medicaid programs are being pushed to raise payment rates for health plans and providers and pay for the escalating cost of prescription drugs.

For example, in a recent survey, state Medicaid officials reported that the top reasons for Medicaid expenditure growth in FY2001 were pharmacy costs (48 states); provider rate increases (31 states); enrollment increases from eligibility expansions and growth of the disabled population (27 states) and increased costs for long-term care (24 states). Many states indicated that these cost increases are due to the need to increase provider rates in a competitive labor market to assure participation and maintain access to care. Evolving patterns of health-care utilization — with greater reliance on prescription drugs and home and community-based services for long-term care — mean these cost pressures are likely to continue.

The return of rising health-care costs and upward pressure on Medicaid budgets comes at a time when the downturn in our nation’s economy has left many states fiscally constrained. In the summer of 2001, many states were reporting that projected expenditure growth for Medicaid was exceeding state revenue growth. After September 11 and the economic slowdown, the situation has worsened. By the end of December 2001, 39 states were reporting budget shortfalls for fiscal year 2002.

The continuing economic downturn is likely to exacerbate this situation. Medicaid is a means-tested health program - as more people lose their jobs and health insurance and experience reductions in their incomes, more people qualify for Medicaid assistance. Thus, in the absence of changes in state eligibility policy, rising unemployment increases Medicaid enrollment; for each one percent increase in the unemployment rate, an additional 1.6 million people can be expected to enroll in Medicaid. At the same time, ris-

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**Figure F: Health Insurance Premium Increases Compared with other Indicators, 1989-2001**

The challenge for states and their Medicaid programs is how to meet the growing demand for coverage when fiscal resources are constrained. Some states are attempting to hold the line and not reduce funding this year, but others have already initiated budget-reduction actions for fiscal 2002. States are considering, and some have implemented, reductions in provider payments, eligibility and/or benefits; capping enrollment in the SCHIP program; or putting planned expansions on hold. Others are planning to use the new waiver authority (the Health Insurance Flexibility and Accountability Demonstration Initiative, or HIFA) to alter eligibility and benefits under Medicaid to address budget problems.

Because states make different decisions about what populations to cover, what benefits to provide and what amounts to pay for services, the scope and cost of the program and the nature of the responses to fiscal pressure will continue to vary widely across the states. In the past, budget constraints led many states to employ creative financing mechanisms that allowed them to draw down more federal matching funds without commensurate increases in state matching funds. Many of these approaches have now been curtailed by federal regulation and legislation, but we may see new schemes develop as states try to balance their budgets.

Facing the Future and Balancing Priorities
As a safety net for the most vulnerable and needy Americans, Medicaid has faced the daunting challenge of serving low-income people whose health and social needs are extremely complex. This charge catapults Medicaid into many of our country's most difficult health and social issues - urban violence, teen pregnancy, substance abuse and HIV/AIDS. In the face of these challenges, Medicaid has done a remarkable job to improve health care for millions of low-income Americans.

Medicaid has demonstrated the importance of health care coverage and has achieved remarkable success in helping to close gaps in access to care and improve health status and satisfaction with the health care system among the poor. The value of Medicaid is underscored by the contrast in outcomes between the poor with Medicaid and the uninsured poor, where studies consistently show that the uninsured lag well behind those with Medicaid, while those with Medicaid fare comparably to the privately insured. For the elderly and disabled, Medicaid has provided an essential safety net, both filling gaps in acute-care coverage and being the major support for long-term care services and in institutions.

The challenge for the future is how to maintain and build on these achievements in light of the downturn in the economy. Obviously, the length and depth of the recession will affect the priorities and responses of the states. Medicaid is a vital and important program for millions of low-income Americans, assisting our nation’s poorest and most vulnerable populations. It provides a solid building block on which to expand coverage for low-income families and helps reduce the number of uninsured while providing coverage to low-income elderly and disabled individuals who rely on the program for long-term care and to fill in Medicare’s gaps. However, these priorities must be balanced against the pressure from growing health care costs and the difficulty of trimming spending for the elderly and disabled and long-term care. Given Medicaid’s role as our health and long-term care safety net, it is essential that attempts to constrain costs not compromise the care available to the poorest and sickest people in our nation.

Notes
3 Urban Institute, unpublished estimates based on HCFA-2082 and HCFA-64 reports.
4 Urban Institute, unpublished estimates.
5 K. Levit et al.
7 K. Levit et al.
8 National Association of State Budget Officers.
9 National Association of State Budget Officers.
15 Urban Institute, unpublished estimates based on HCFA 2082 and HCFA 64 reports, 2000; V. Smith, D. Rousseau and J. Geyer, CHIP Program Enrollment: December 2000 (Washington, D.C.: The
19 Urban Institute, unpublished estimates based on HCFA-2082 and HCFA-64 reports.
24 K. Levit et al.

About the Author

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