

KEY FACTS:

- Medicaid's rising costs have imposed real challenges on state budgets.
- These cost increases must be understood within the broader context of rising health care costs in general.
- In the debate about how to rein in Medicaid spending, basic facts tend to get lost.
- Medicaid is a cost-effective way to serve very low-income seniors, adults, children and people with disabilities who would otherwise not be able to access affordable insurance in the private market.

Community Action Project

4606 S. Garnett Road, Suite 100

Tulsa, OK 74146

www.okpolicy.org

918 382.3200

F/918 382.3213

publicpolicy@captc.org

Issue Brief

January 25, 2006

Medicaid Basics: Facts to Keep Straight in the Reform Debate

By *Monica Barczak, Senior Research Analyst*

In the halls of federal and state government, policymakers have spent months talking about Medicaid reform. The President appointed a task force to deal with the issue, the National Governor's Association put together a set of recommendations, and here in Oklahoma the House of Representatives created a state-level task force. What's driving all the attention on the nation's main health care program for the poor is that rapidly escalating program costs are putting a real and significant strain on the federal and state budgets.

While it is easy to look at Medicaid's growing budget and conclude that the program needs to be "wrestled under control" by any means necessary, it is important that policymakers and advocates proceed based on a clear grasp of how the program works, who it serves, and why its costs have been growing. In reality, Medicaid serves as America's main safety net health insurer, providing health care for millions of Americans who lack affordable access to employer-sponsored insurance, such as very low-income seniors, adults, children and people with disabilities. Rising Medicaid costs are symptomatic of rising health care costs in general, as well as Medicaid assuming the burden for the growing number of employees and dependents who are not offered or cannot afford private coverage. The lion's share of the Medicaid budget is devoted to providing long-term and acute care for seniors and the disabled, not for children. Among non-disabled adults and children, Medicaid provides health care at a lower cost than does private insurance.

This paper is an effort to dispel some common Medicaid myths and to inform the ongoing discussions about Medicaid in Oklahoma. While continued debate about how to operate Medicaid in a more effec-

tive and cost-efficient manner is necessary and appropriate, policymakers need to be very careful lest "reforms" cut off access to care for the most medically and economically vulnerable populations. Such an outcome would only add new burdens to the overall health care system.

Medicaid Is a Shared State-Federal Program

Medicaid is an extremely complex program that provides vital health care services to certain low-income populations. The federal and state governments fund the program together, but states oversee the provision of services. In Oklahoma, the Oklahoma Health Care Authority (OHCA) is the designated state Medicaid agency and it administers the bulk of the program. The federal government has defined certain mandatory populations that states must cover and certain mandatory services that states must provide. Beyond that, states have flexibility in setting eligibility thresholds and offering optional services.

In recent years, states have successfully secured permission from the federal government to customize their Medicaid programs through the use of *waivers*. Oklahoma's Premium Assistance program, for example, which uses Medicaid dollars to help small employers purchase health insurance for low-wage workers, was made possible through a federal waiver.

Medicaid is the Nation's Major Safety Net Health Care Provider

Medicaid was created in 1965 primarily to provide health care coverage to people who qualified for cash assistance. Since then, Medicaid has evolved into a broad safety net addressing the needs of low-income families, the elderly, and individuals with disabilities. Today, Medicaid provides health and long-term care ser-



vices to more than 47 million individuals, most of whom could not be served by the private health care market.¹

The majority of people in the United States do in fact access private health insurance through an employer. Medicaid beneficiaries, however, typically lack this access or cannot afford the coverage offered. In recent years, the number of people covered by employer-sponsored insurance (ESI) has shrunk. Between 2000 and 2004, for example, the percentage of non-elderly individuals covered by ESI fell by 4.9 points nationwide while the percentage covered by Medicaid grew by 2.7 points. Seniors, who are covered by Medicare, can also qualify for Medicaid when their income and assets fall below a certain level. In 2003 Medicaid provided health care for nearly 7.5 million seniors.²

Not All Poor People Receive Medicaid

Despite being the major safety net health care provider, Medicaid does not provide coverage to all poor people. In addition to meeting income eligibility criteria, potential beneficiaries must meet certain categorical criteria, resource eligibility limits, immigration criteria, and state residency requirements.

A common misconception about Medicaid involves categorical eligibility. The Medicaid program classifies five categories of people as “deserving” of assistance, including children, pregnant women, parents of dependent children, individuals with disabilities, and the elderly. Even the extremely poor will not qualify for Medicaid if they do not fit into one of these categories. Thus in Oklahoma, healthy working-age adults without children are

category. The federal government sets minimum standards, but states can choose to cover people at higher income levels. Oklahoma’s eligibility thresholds and asset limits appear in Table 1. For 2005, the federal poverty level (FPL) for a family of three is \$16,090; for a family of four it is \$19,350. With eligibility at 185% of FPL, a child from a family of three will qualify for Medicaid if the family income is at or below \$29,766.

Oklahoma’s Last Major Medicaid Expansion Occurred in 1997

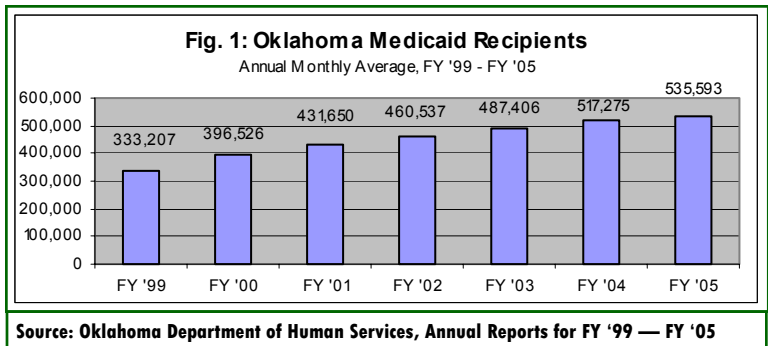
States have flexibility in defining the population eligible for Medicaid, subject to certain minimum requirements. The last time Oklahoma significantly expanded eligibility was in 1997, when children and pregnant women up to 185% of the federal poverty level were included in the program.

Shortly thereafter, the federal government began offering states an enhanced federal Medicaid matching rate to cover these children through the State Children’s Health Insurance Program, or SCHIP. Subsequent expansions have targeted small populations such as low-income women with breast or cervical cancer and low-income women and men needing family planning services.

The enrollment effects of the 1997 population expansion were still being felt

ling under the eligibility thresholds, and employers dropping private coverage – not of changing definitions of eligibility. **Medicaid Covers Basic Services For Acute and Long-Term Care – Not Fancy “Extras”**

The federal government requires that states provide a minimum set of benefits, beyond which states may cover additional optional services. Required services include inpatient and outpatient hospital care, nursing home care, physician services, laboratory and X-ray services, family planning services, health centers and rural health clinics, nurse midwife and nurse practitioner services, and early and periodic screening, diagnostic, and treatment (EPSDT) services for children. States have some discretion to set the amount, duration and scope of covered services.



For example, states may limit the number of days of inpatient hospital services or the number of visits to physicians, provided the amount is “sufficient” for the purpose of the service.

Oklahoma has chosen to cover a range of additional services, including case management, prescription drugs (with some limitations), home health care services, and intermediate care facilities for the mentally retarded, among others. With the exception of prescription drugs, however, expenditures for these optional services do not constitute the largest budget items. OHCA data show that in FY '05 the largest expenses were for hospital services, followed by prescription drugs and nursing facilities, with payments to physicians coming in a distant fourth.

Medicaid Recipients Contribute to the Cost of Their Health Care

Among the many state and federal level Medicaid reform proposals under consideration are several that would require

POPULATION	INCOME ELIGIBILITY	ASSET LIMIT
Children up to age 19	185% of FPL	None
Pregnant Women	185% of FPL	None
Parent of dependent child	Approx. 37% of FPL	None
Single parent transitioning from welfare to work	185% of FPL (eligible for up to 12 months)	None
Aged, Blind, and Disabled (ABD)	100% of FPL	\$2,000 ind.; \$3,000 couple
Specified Low-income Medicare Beneficiaries	120% of FPL; covers Medicare Part B Prem.	\$4,000 ind.; \$6,000 couple
ABD in institution or Home-and-Community based waiver program	300% of SSI	\$2,000 ind.; \$3,000 couple

never eligible for Medicaid.

Categorical eligibility could be considered the first “screen” through which Medicaid eligibility is determined. After that, income limits and asset tests vary by

into FY '00, as seen in Figure 1. After that, enrollment continued to grow modestly, albeit steadily, each year. Enrollment in the most recent years has been largely a function of outreach efforts, families fal-

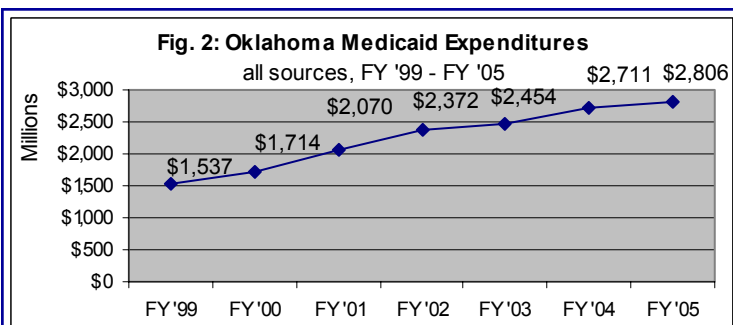
¹Figure from FFY '01. The Kaiser Commission on Medicaid and the Uninsured, State Medicaid Fact Sheets, <http://www.kff.org/mfs/medicaid.jsp?rl=OK&r2=US&x=9&y=7>

² Ibid

Medicaid beneficiaries to contribute to the cost of their health care through monthly premiums, co-payments for doctors' visits and prescription drugs, deductibles, and co-insurance. These proposals are often justified on the grounds that they would make beneficiaries more responsible in their use of health care.

While federal law currently protects many beneficiaries from premiums and cost-sharing, other Medicaid recipients

budget than the budget of a higher-income adult with private insurance.⁴ This is because a Medicaid beneficiary will have a considerably smaller income – about one-ninth the size – than an adult with private insurance. Non-disabled adult Medicaid recipients, with an average annual income of \$8,846, spent an average of \$210, or 2.4% of income, in out-of-pocket health care costs in 2002. Adults with private insurance, with an



Source: Oklahoma Health Care Authority Annual Reports for FY '99 — FY '05.

already pay for part of their health care. Moreover, states can secure permission to impose premiums and cost-sharing on certain optional populations – such as pregnant women above 150% of FPL – through the waiver process. In Oklahoma, non-institutionalized seniors and adults with disabilities enrolled in Medicaid face co-payments of \$3 per day of inpatient or outpatient hospital care, \$1 per physician visit, and \$1 or \$2 per prescription drug.³ In addition to these costs, all Medicaid beneficiaries must pay for services Medicaid doesn't cover and for services that exceed the amount, duration, or scope of covered services.

A study by the Center on Budget and Policy Priorities shows that out-of-pocket medical expenses eat up more of a non-disabled adult Medicaid beneficiary's

costs.

Recent actions by the federal government will likely make it much easier for states to impose premiums and cost-sharing on previously protected populations and to raise costs for beneficiaries already making these payments. The FFY '06 budget bill allows states to charge recipients 10% of the cost of any

item or service if they have incomes between 100% and 150% of FPL. Recipients at higher incomes could be charged 20% of cost.⁵ Studies of states that already have premiums and cost-sharing provisions in their Medicaid programs show that such provisions can force beneficiaries to drop out and thus lose coverage.⁶

Medicaid Costs Are Rising, But Less Than General Health Care Costs

At root, most Medicaid reform efforts are being driven by the escalating costs associated with Medicaid. There is no doubt that these costs have been rising. Figure 2 shows that Medicaid spending in Oklahoma, from all sources including state and federal funds, grew 82.6% from \$1.5 billion in FY '99 to \$2.8 billion in FY '05. State appropriations to

OHCA, the designated Medicaid agency, grew 44.6% from \$321.7 million to \$482.3 million over the same period. Over the past five years OHCA has been one of the fastest-growing agencies in the state.

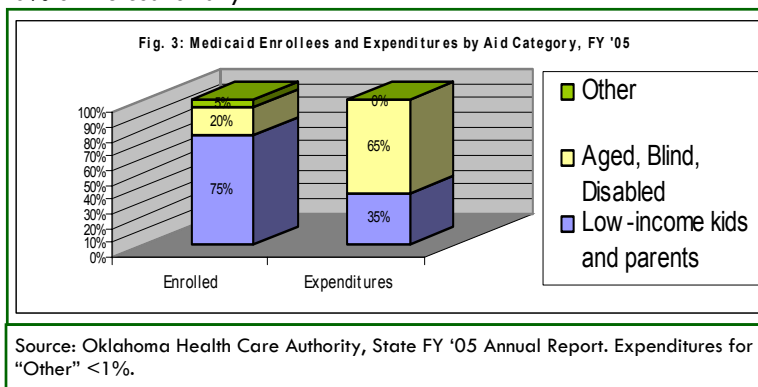
The growing cost of Medicaid, however, must be understood within the context of growing health care costs in general. Employer health plan premiums, for example, rose 8.2% in 2000, 10.9% in 2001, 12.9% in 2002, 13.9% in 2003, and 11.2% in 2004.⁷

average income of \$80,325, spent an average of \$548, or 0.7% of income, on health care. Disabled Medicaid recipients pay an even greater percentage of their incomes in out-of-pocket medical

In this kind of health care environment, it is actually less costly in many cases to provide health care under Medicaid than under private insurance. A recent study found spending per non-disabled adult was \$1,752 for patients on Medicaid compared to \$2,253 for patients with private insurance between 1996 and 1999. Children, including children with disabilities, were also found to be less expensive to cover under Medicaid compared to private insurance. In fact, if an average Medicaid beneficiary were moved into private insurance, annual per capita spending would increase an estimated \$1,265 for an adult and \$76 for a child.⁸

High-Cost, Long-Term Care Services Consume Majority of Medicaid Budget

The basic fact about Medicaid costs is that nearly two-thirds of the program's



Source: Oklahoma Health Care Authority, State FY '05 Annual Report. Expenditures for "Other" <1%.

budget in Oklahoma is spent on services – including long-term care and prescription drugs – for the elderly and people with disabilities. Children and pregnant women, who represent three-quarters of the program's population, consume only about one-third of the budget (See Figure 3).

National data on expenditures per enrollee verify this observation. Table 2 (on page 4) reports national Medicaid cost data. On a per person basis, individuals with disabilities and the elderly cost over six times more to care for than children and adults on Medicaid.

³ General Accounting Office, "Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries," March 2004.

⁴ Leighton Ku and Matthew Broaddus, "Out-of-Pocket Medicaid Expenses for Medicaid Beneficiaries are Substantial and Growing," Center on Budget and Policy Priorities, May 31, 2005.

⁵ Robert Pear, "Budget Accord Could Mean Payments by Medicaid Recipients," *The New York Times*, December 20, 2005. Both the House and Senate approved the budget bill in December 2005, but a small change made in the Senate means that final approval is not likely until late January or early February.

⁶ Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured, May 2005.

⁷ *Trends and Indicators in the Changing Health Care Marketplace*, Kaiser Family Foundation.

⁸ "Medicaid: A Lower-Cost Approach to Serving a High-Cost Population," Kaiser Commission on Medicaid and the Uninsured Policy Brief, March 2004.

Undocumented Immigrants Are Not A Main Driver of Higher Medicaid Costs in Oklahoma

The welfare reform legislation of 1996 prohibited states from using federal

Table 2: Medicaid Payment per Enrollee, 2003

Medicaid Recipient	Payment
Children	\$1,700
Adult	\$1,900
Disabled	\$12,300
Elderly	\$12,800

Source: *Trends and Indicators in the Changing Health Care Marketplace*, Kaiser Family Foundation.

funds to provide new immigrants, whether documented or not, with basic Medicaid services. The law imposes a five-year waiting period on documented immigrants before they can apply for Medicaid (assuming they meet all other eligibility requirements). States can use *state dollars only* to care for documented immigrants not covered by federal funding, to cover undocumented immigrants who are children or pregnant, and to provide prenatal care regardless of the immigration status of the mother. Oklahoma has not taken advantage of any of

these provisions. Federal law does require that *any* immigrant meeting all of the other Medicaid requirements be able to receive treatment for medical emergencies that place the individual's health in serious jeopardy. Hospitals must also screen and stabilize immigrants who seek care in their emergency room.

Conclusion

As the Medicaid reform debate has gathered steam, it has become increasingly critical to ensure that policymakers have a clear grasp of how the program works today. Starting with an accurate picture of who benefits, what the benefits look like, what is happening with enrollment, and why costs are increasing is important for finishing with good policy outcomes. Fundamentally, it should be acknowledged that many of Medicaid's problems stem not so much from the way the program operates as from the larger issues affecting health care more generally. Seen in that light, Medicaid is actually a cost-effective way to insure low-income children and adults.

Recent Congressional actions to impose premiums and cost-sharing arrangements on Medicaid beneficiaries, however, threaten the ability of the program to continue providing basic needed services to

vulnerable populations. With employers increasingly dropping private health care coverage, and with continued increases in the price of private health insurance, it seems highly unlikely that people who get priced out of Medicaid will be able to access any coverage at all. That is an outcome that Oklahoma cannot afford.‡

Community Action Project (CAP) is a Tulsa-based comprehensive anti-poverty agency whose mission is to help individuals and families in need achieve self-sufficiency. CAP's public policy department aims to promote policies that will benefit low- and moderate-income Oklahomans through research, education and advocacy. Visit us on the web: www.okpolicy.org.



Community Action Project
of Tulsa County Inc.

4606 S. Garnett Rd., Suite 100 • Tulsa, OK 74146

**NON PROFIT
ORGANIZATION
US POSTAGE
PAID
TULSA OK
PERMIT NO. 2266**