U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HCFA
Health Care Financing Administration

A Profile of MEDICAID

CHARTBOOK

2000

Preface

On behalf of the Health Care Financing Administration, I am pleased to present *A Profile of Medicaid*, an overview of the Medicaid program and its beneficiaries. Although the Medicaid program has been in existence for 35 years, the program is not very well understood. I hope *A Profile of Medicaid* will contribute to a better understanding of Medicaid by policy makers, analysts and the general public.

Medicaid plays a critical role in the health care system by purchasing health care for certain low-income populations; however, its impact is often overlooked. Expansions in eligibility, presumptive eligibility for pregnant women, and the provision of comprehensive preventive, diagnostic and treatment services under the EPSDT program have contributed to improved infant and maternal mortality rates. Medicaid has also provided financial protection for families with long-term care needs. As the largest payer for nursing facility services, Medicaid provides low-income elderly and individuals with disabilities and their families protection from exhausting limited income and resources on medical care.

Although the Medicaid program has been successful over the years in providing vital health care services to millions of low-income people, the program faces many challenges. Enrollment of all people eligible for Medicaid continues to be a hurdle for states, especially under the new welfare system. In addition, attention must be paid to Medicaid's fiscal integrity. The balance of federal and state funding for the program must be maintained to ensure the core mission and the broad-based support for Medicaid are not undermined.

The intricacies and importance of the Medicaid program cannot be adequately presented using only enrollment and expenditure data. However, a clearer understanding of the basic facts of Medicaid will strengthen the process of adapting the program to meet the challenges of the 21st century. I hope you find this *Profile* informative and thought-provoking.

Nancy-Ann DeParle
Administrator

September 2000

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SECTION I

MEDICAID PROGRAM OVERVIEW

The Medicaid program is the third largest source of health insurance in the United States — after employer-based coverage and Medicare. As the largest program in the federal "safety net" of public assistance programs, Medicaid provides essential medical and medically related services to the most vulnerable populations in society. The significance of Medicaid's role in providing health insurance cannot be overstated. Medicaid covered 12.0 percent of the total U.S. population in 1998, compared to 9.1 percent in 1978.[1] The Medicaid program covers millions of low-income women, children, elderly people and individuals with disabilities.

The Medicaid program was enacted in the same legislation that created the Medicare program – the Social Security Amendments of 1965 (P.L. 89-97). Prior to the passage of this law, health care services for the indigent were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and community hospitals.

Before 1965, federal assistance to the states for the provision of health care was provided through two grant programs. The first program was established in 1950 and provided federal matching funds for state payments to medical providers on behalf of individuals receiving public assistance payments. In 1960, the Kerr-Mills Act created a new program called "Medical Assistance for the Aged." This means-tested grant program provided federal funds to states that chose to cover the "medically needy" aged who were defined as elderly individuals with incomes above levels needed to qualify for public assistance but in need of assistance for medical expenses.

In 1965, Congress adopted a combination of approaches to improve access to health care for the elderly. The Social Security Amendments of 1965 created a hospital insurance program to cover nearly all of the elderly (Medicare Part A), a voluntary supplementary medical insurance program (Medicare Part B) and an expansion of the Kerr-Mills program to help elderly individuals with out-of-pocket expenses such as premiums, copayments, deductibles and costs for uncovered services. At the same time, Congress decided to extend the Kerr-Mills program – now the Medicaid program – to cover other populations including families with children, the blind and the disabled.

In general, Medicaid provides three types of critical health protection: (1) health insurance for low-income families with children and people with disabilities; (2) long-term care for older Americans and individuals with disabilities; and (3) supplemental coverage for low-income Medicare beneficiaries for services not covered by Medicare (e.g., outpatient prescription drugs) and Medicare premiums, deductibles and cost sharing. Since its inception in 1965, Medicaid enrollment and expenditures have grown substantially. In addition, the Medicaid program has evolved as federal and state governments balance social, economic and political factors affecting this and other public assistance programs. Major legislative milestones of the Medicaid program are highlighted at the end of this section.

Program Structure

Medicaid is a joint federal and state program. Each state establishes its own eligibility standards, benefits package, payment rates and program administration under broad federal guidelines. As a result, there are essentially 56 different Medicaid programs – one for each state, territory and the District of Columbia.

Eligibility

In general, Medicaid eligibility is based on a combination of financial and categorical eligibility requirements. Medicaid is a means-tested program. Beneficiaries must be low-income and meet certain resource standards. Each state determines income thresholds and resource

[1] Data from the Office of the Actuary, Health Care Financing Administration. The percent of the population covered by Medicaid was estimated using average Medicaid enrollment data and Census Bureau estimates of the national population for each year.

standards for their Medicaid program following federal guidelines. These thresholds and standards can vary by state and may differ for each Medicaid-eligible population group within a state (i.e., children, adults, elderly, individuals with disabilities.)

Financial eligibility for Medicaid was linked to receipt of federally assisted income maintenance payments such as Aid to Families with Dependent Children (AFDC) and starting in 1972, Supplemental Security Income (SSI). Over time, legislative changes to the Medicaid program and the AFDC welfare program have led to the creation of certain Medicaid groups where financial eligibility is based solely on income and resources, not receipt of cash assistance. Some of these "non-cash" groups are referred to as the "poverty-related" groups. Congress created these groups in the late 1980's in an effort to expand Medicaid coverage of pregnant women and children by delinking Medicaid eligibility from receipt of AFDC. "Poverty-related" groups, both adults and children, are an increasing proportion of Medicaid beneficiaries.

Medicaid does not provide medical assistance to all low-income individuals. Traditionally, Medicaid has been available only to persons in certain categories: members of families with children and pregnant women, and to persons with disabilities or who are aged or blind. Low-income individuals who did not fit into one of these categories, such as childless couples or adults without disabilities, typically did not qualify for Medicaid—regardless of how low their income was. The establishment of new eligibility groups in the 1980's and the approval of Medicaid program waivers have provided states opportunities to extend Medicaid services to populations beyond the traditional welfare-defined groups.

The Medicaid statute identifies certain populations that states are required to cover and other populations that states may choose to cover.

All states must provide Medicaid coverage to the following eligibility groups:

- *AFDC-eligible individuals as of July 16, 1996:* States are required to provide Medicaid to individuals who meet the requirements of the AFDC program that were in effect in their state as of July 16, 1996.[2]
- *Poverty-related groups:* States are required to provide Medicaid to certain pregnant women and children defined in terms of family income and resources. States must cover all pregnant women and children below age 6 with incomes up to 133 percent of the federal poverty level (FPL).
- *All children born after September 30, 1983 with incomes up to 100 percent FPL:* This requirement will result in the mandatory coverage of all children below 100 percent FPL under age 19 by the year 2003.
- *Current and some former recipients of SSI:* States are generally required to provide Medicaid to recipients of SSI. States, however, may use more restrictive eligibility standards for Medicaid than those used for SSI if they were using those standards prior to the enactment of SSI in 1972.
- *Foster care and adoption assistance:* States must provide Medicaid to all recipients of foster care and adoption assistance under Title IV-E of the Social Security Act.
- *Certain Medicare beneficiaries:* State Medicaid programs must provide assistance to low-income Medicare beneficiaries. All Medicare beneficiaries with incomes below the poverty level receive Medicaid assistance for payment of Medicare premiums, deductibles and cost sharing. These individuals are Qualified Medicare Beneficiaries (QMBs). In addition, individuals at the lowest income levels are entitled to full Medicaid benefits, which provide coverage for services not covered by Medicare such as outpatient prescription drugs. Medicare beneficiaries with income levels slightly higher than poverty receive Medicaid assistance for payment of Medicare premiums. These individuals are Specified Low-Income Medicare Beneficiaries (SLMBs).

[2] This date coincides with the passage of the welfare reform law creating the Temporary Assistance for Needy Families (TANF) block grant. Congress established this eligibility group to insure individuals did not lose Medicaid coverage due to TANF.

States have the option to provide Medicaid coverage to other groups. These optional groups fall within the defined categories mentioned above but the financial eligibility standards are more liberally defined. Optional eligibility groups include:

- *Poverty-related groups:* States may choose to cover certain higher-income pregnant women and children defined in terms of family income and resources. For example, states may choose to cover pregnant women and infants with family incomes up to 185 percent FPL.

- *Medically needy:* States may choose to cover individuals who do not meet the financial standards for program benefits but fit into one of the categorical groups and have income and resources within special "medically needy" limits established by the state. Individuals with incomes and resources above the "medically needy" standards may qualify by "spending down" – i.e., incurring medical bills that reduce their income and/or resources to the necessary levels.

- *Recipients of state supplementary income payments:* States have the option to provide Medicaid to individuals who are not receiving SSI but are receiving state-only supplementary cash payments.

- *Long-term care:* States may cover persons residing in medical institutions or receiving certain long-term care services in community settings if their incomes are less than 300 percent of the SSI payment level.

- *Working disabled:* States have the option to provide Medicaid to working individuals who are disabled, as defined by the Social Security Administration, who cannot qualify for Medicaid under any statutory provision due to their income. If states choose to cover this group then they may also cover individuals who lose Medicaid eligibility as a result of losing SSI due to medical improvement.

States also have the discretion to expand eligibility beyond these optional groups. Through demonstrations such as the 1115 research and demonstration authority and statutory provisions that allow less restrictive methodologies for calculating income and resources (i.e., section 1902(r)(2)), states may provide Medicaid services to individuals who do not meet standard Medicaid financial or categorical requirements. This discretion has aided states significantly in their health care reform efforts.

Financing

The Medicaid program is jointly financed by the states and the federal government. Medicaid is an entitlement program and the federal spending levels are determined by the number of people participating in the program and services provided. Federal funding for Medicaid comes from general revenues. There is no Trust Fund for Medicaid as there is for Medicare Part A or Social Security.

The federal government contributes between 50 percent and 83 percent of the payments for services provided under each state Medicaid program.[3] This federal matching assistance percentage (FMAP) varies from state to state and year to year because it is based on the average per capita income in each state. States with lower per capita incomes relative to the national average receive a higher federal matching rate. The federal matching rate for administrative costs is uniform for all states and is generally 50 percent, although certain administrative costs receive a higher federal matching rate.

Services

The Medicaid benefit package is defined by each state based on broad federal guidelines. There is much variation among state Medicaid programs regarding not only which services are covered, but also the amount of care provided within specific service categories (i.e., amount, duration, and scope of services).

Each state Medicaid program must cover "mandatory services" identified in statute. In addition to covering the mandated services, states have the discretion to cover additional services – i.e., "optional services." States may choose among a total of 33 optional services to include in their Medicaid programs. (see on following page).

[3] Certain services (i.e., family planning services) receive a larger federal match.

Mandatory Services

Inpatient hospital services;
Outpatient hospital services;
Rural health clinic and Federally Qualified Health Center (FQHC) services;
Laboratory and X-ray services;
Nurse practitioners' services;
Nursing facility (NF) services and home health services for individuals age 21+;
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21;
Family planning services and supplies;
Physicians' services and medical and surgical services of a dentist;
Nurse-Midwife services

Optional Services

Podiatrists services;
Optometrists services;
Chiropractors services;
Psychologists services;
Medical social worker services;
Nurse anesthetists services;
Private duty nursing;
Clinic services;
Dental services;
Physical therapy;
Occupational therapy;
Speech, hearing and language disorders;
Prescribed drugs;
Dentures;
Prosthetic devices;
Eyeglasses;
Diagnostic services;
Screening services;
Preventive services;
Rehabilitative services;

Optional Services (cont.)

Intermediate Care Facilities / Mentally-Retarded services (ICF/MR);
Inpatient psychiatric services for under age 21;
Christian Science Nurses;
Christian Science Sanitoriums;
Nursing facility (NF) Services for under age 21;
Emergency hospital services;
Personal care services;
Transportation services;
Case management services;
Hospice care services;
Respiratory care services;
TB-Related services;
Inpatient and NF services for 65+ in Institutions for Mental Diseases (IMDs).

History: Major Legislative Milestones

Since the Medicaid program was enacted, the federal government has made significant changes in eligibility criteria, services provided and financing of the program. In addition, states have made administrative changes (e.g., use of managed care delivery systems). Many of the changes to the Medicaid program have been in response to the growing number of low-income individuals in need of medical assistance, the need to improve access to care, and the need to contain the rising costs of providing medical assistance. Highlighted below are some of the legislative changes made to Medicaid since the program was established.

1965 The Medicaid Program, authorized under Title XIX of the Social Security Act, is enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities.

1967 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 is established.

1972 States are provided the opportunity to link Medicaid eligibility for elderly, blind and disabled residents to eligibility for the newly enacted federal Supplemental Security Income program (SSI).

1981 Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) are established; states are required to provide additional payments to hospitals treating a disproportionate share of low-income patients (DSH hospitals).

1986 Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of the federal poverty level (FPL) is established as a state option.

1988 Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent FPL is mandated; special eligibility rules are established for institutionalized persons whose spouse remains in the community to prevent "spousal impoverishment;" Qualified Medicare Beneficiary group is established (QMBs).

1989 Medicaid coverage of pregnant women and children under age 6 to 133 percent FPL is mandated; expanded EPSDT requirements are established.

1990 Phased in coverage of children ages 6 through 18 under 100 percent FPL is established; Medicaid prescription drug rebate program is established; Specified Low-Income Medicare beneficiary eligibility group is established (SLMBs).

1991 Disproportionate Share Hospital (DSH) spending controls are established; provider donations are banned and provider taxes are capped.

1996 Welfare Reform — The Aid to Families with Dependent Children (AFDC) entitlement program is replaced by the Temporary Assistance for Needy Families (TANF) block grant. Welfare link to Medicaid is severed; enrollment/termination of Medicaid is no longer automatic with receipt/loss of welfare cash assistance.

1997 Balanced Budget Act of 1997 (BBA) — State Children's Health Insurance Program (S-CHIP) is created; limits on payments to disproportionate share hospitals are revised; new managed care options and requirements for states are established.

Medicaid Populations

SECTION II

Medicaid Populations

Enrollment and Persons Served

The average length of time an individual is enrolled in Medicaid in any given year is approximately 9 months. People move on and off of Medicaid within a year for a variety of reasons, most notably due to changes in income. These recurring changes in eligibility create a challenge when determining the number of persons served through the program at any given time. Consequently, there is more than one way to count Medicaid participation.

- Medicaid participation can be counted using the unduplicated number of individuals enrolled in the program within a year (i.e., "enrollees"); the number of individuals using Medicaid services within a year (i.e., "persons served"); or the number of full-year equivalent enrollees (i.e., "person years"). The use of person years allows for determinations of expenditures per person per year and thus permits better comparisons between the Medicaid program and other programs such as Medicare. **(Figure 1.1)**

- The number of persons served through Medicaid remained relatively constant from 1977 to 1989. Eligibility expansions mandated by Congress in the late 1980s led to significant increases among certain eligibility groups, especially pregnant women and children. Prior to implementation of these expansions the number of beneficiaries was approximately 23.5 million in 1989. The number of persons served reached 36.3 million in 1995. A decline in the number of individuals served by Medicaid since 1995 is attributed to a variety of factors including fewer people in poverty and lower rates of unemployment. **(Figure 1.2)**

- An examination of recent trends in aggregate adult and child enrollment[4] indicates that Medicaid enrollment patterns vary. While many states have experienced significant decreases in adult enrollment, these declines have been masked by significant increases in a number of other states.[5] The states that have experienced significant increases in adult enrollment are states that operate statewide, comprehensive Section 1115 Research and Demonstration projects. In the case of children though, the aggregate number of children enrolled under Medicaid has steadily declined since 1996. **(Figure 1.3 & Figure 1.4)**

- Projections of Medicaid enrollment for the next decade (on a person-year basis) show moderate growth compared to the 4 percent annual average growth of the 1990's. Total enrollment is currently projected to increase at an annual average rate of about 1 percent, from 32.5 million in 1998 to 37.6 million in year 2010.[6] The average annual enrollment growth for the blind and disabled is projected to average about 2 percent while the growth rate for all other eligibility groups is forecasted to grow at 1 percent. **(Figure 1.5)**

1998 Enrollment and Persons Served Through Medicaid

In Fiscal Year[7] 1998, 41.4 million people were enrolled in the Medicaid program and 40.6 million beneficiaries accessed services, including:[8]

— 18.9 million children
— 7.9 million adults
— 3.9 million elderly
— 6.6 million individuals who were blind or disabled.

[4] There are four broad categories of Medicaid eligibility status: adults; children; the blind and disabled; and persons over the age of 65. The term adults used in the text refers to non-disabled, non-elderly adult beneficiaries. The term children used in the text will not include any children who qualified for Medicaid on the basis of a medical disability unless otherwise indicated. Children with disabilities are included in the blind and disabled eligibility category.

[5] Reports sponsored by Families USA and the Urban Institute have examined Medicaid enrollment trends in selected states. The Urban Institute report (April 2000) indicates that enrollment in the states that they examined showed increases between 1998 and 1999, after a period of declining enrollment that began in 1995.

[6] President's Fiscal Year 2001 budget. Enrollee data estimates are computed in person years; this represents the number of beneficiaries if computed in terms of 12 months of enrollment (i.e., full-year equivalents).

[7] The federal fiscal year is from Oct. 1 to Sept. 30th of the following year.

[8] During FY 1998, 3.2 million beneficiaries had an unknown basis of eligibility.

- Medicaid plays a prominent role in providing health insurance to low-income children — particularly the younger age children. Each year over one-third of all births are covered by Medicaid. In 1998, Medicaid covered 25 percent of children under age 3, 22.9 percent of children between the ages of 3 and 5, and 15.5 percent of children between the ages of 12 to 17. **(Figure 1.6)**

- Historically, children have represented the largest eligibility group. Mandatory eligibility expansions during the late 1980's contributed to the growth in Medicaid enrollment of children. **(Figure 1.7)**

- The children served by Medicaid in Fiscal Year 1998 represented one out of five children in the nation. Children (including children with disabilities) represented 54 percent of the 41.4 million individuals enrolled in Medicaid in FY 1998. The next largest group of enrollees was adults age 21 to 64 (nearly 31 percent), while the elderly, age 65 and over, accounted for the smallest group of enrollees by age (approximately 11 percent). **(Figure 1.8)**

- The proportion of Medicaid beneficiaries with disabilities has increased over time. In 1973, the blind and disabled represented 11 percent of the total Medicaid population. By 1998, the blind and disabled represented 18 percent of the total Medicaid population. In contrast, beneficiaries over the age of 65 decreased from 19 to 11 percent of the Medicaid population during the past twenty-five years.[9] **(Figure 1.9)**

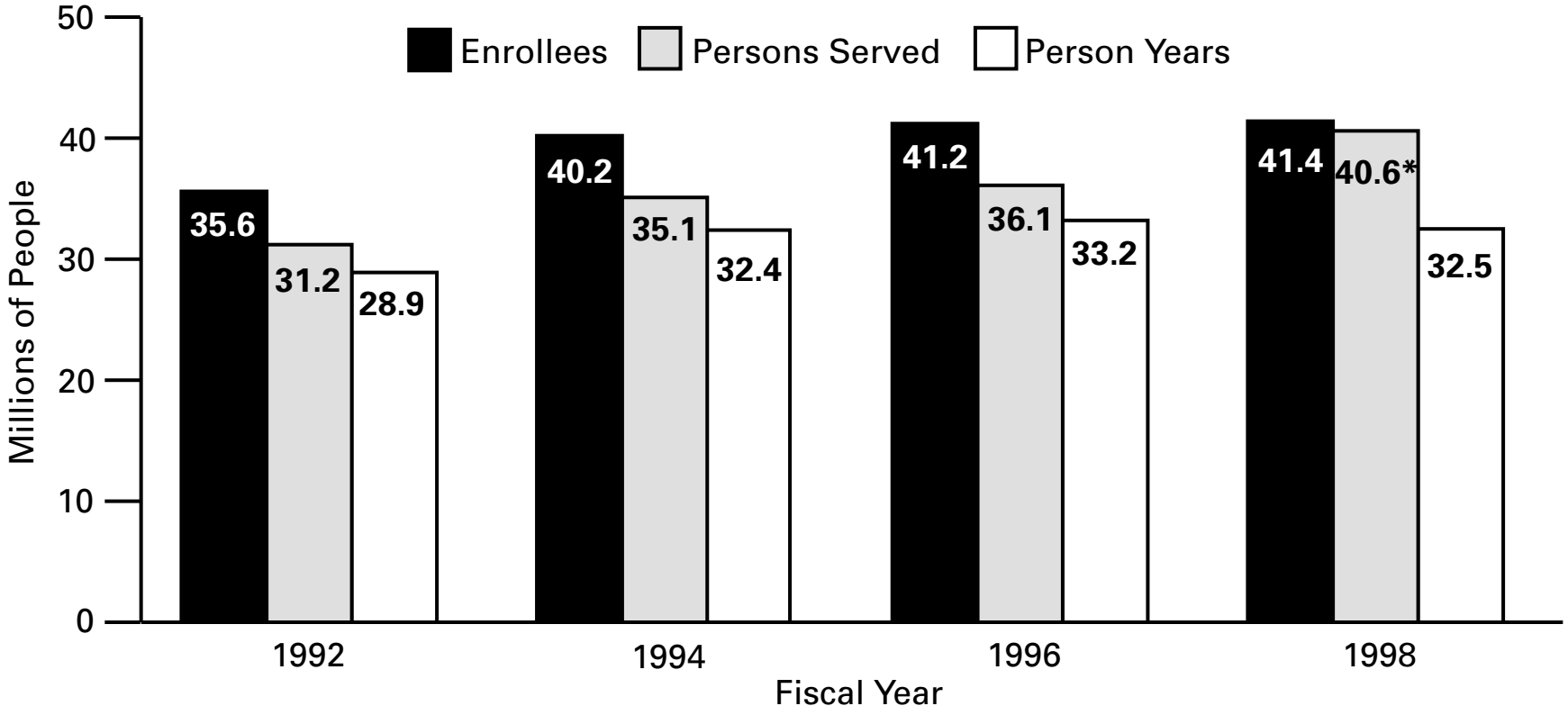
- The proportion of individuals enrolled in Medicaid who also receive federal cash assistance has declined from approximately 60 percent in FY 1992 to approximately 43 percent in FY 1998. This trend will likely continue as more future enrollees qualify for Medicaid based on their income and resources (e.g., poverty related groups, etc.). In Fiscal Year 1998 poverty related groups represented approximately one fourth of all Medicaid enrollees. **(Figure 1.10)**

- Females comprise a larger share of the Medicaid population (57 percent) than males (39 percent). Distribution of enrollment by race indicates Whites comprise 43 percent of all enrollees, while African Americans comprise almost 26 percent, and Hispanics comprise almost 17 percent. **(Figure 1.11)**

[9] Children with disabilities are included in the blind and disabled eligibility group. The term adults refers to non-disabled, non-elderly adults.

Figure 1.1 Medicaid Beneficiaries

*There are different ways to count Medicaid participation.**



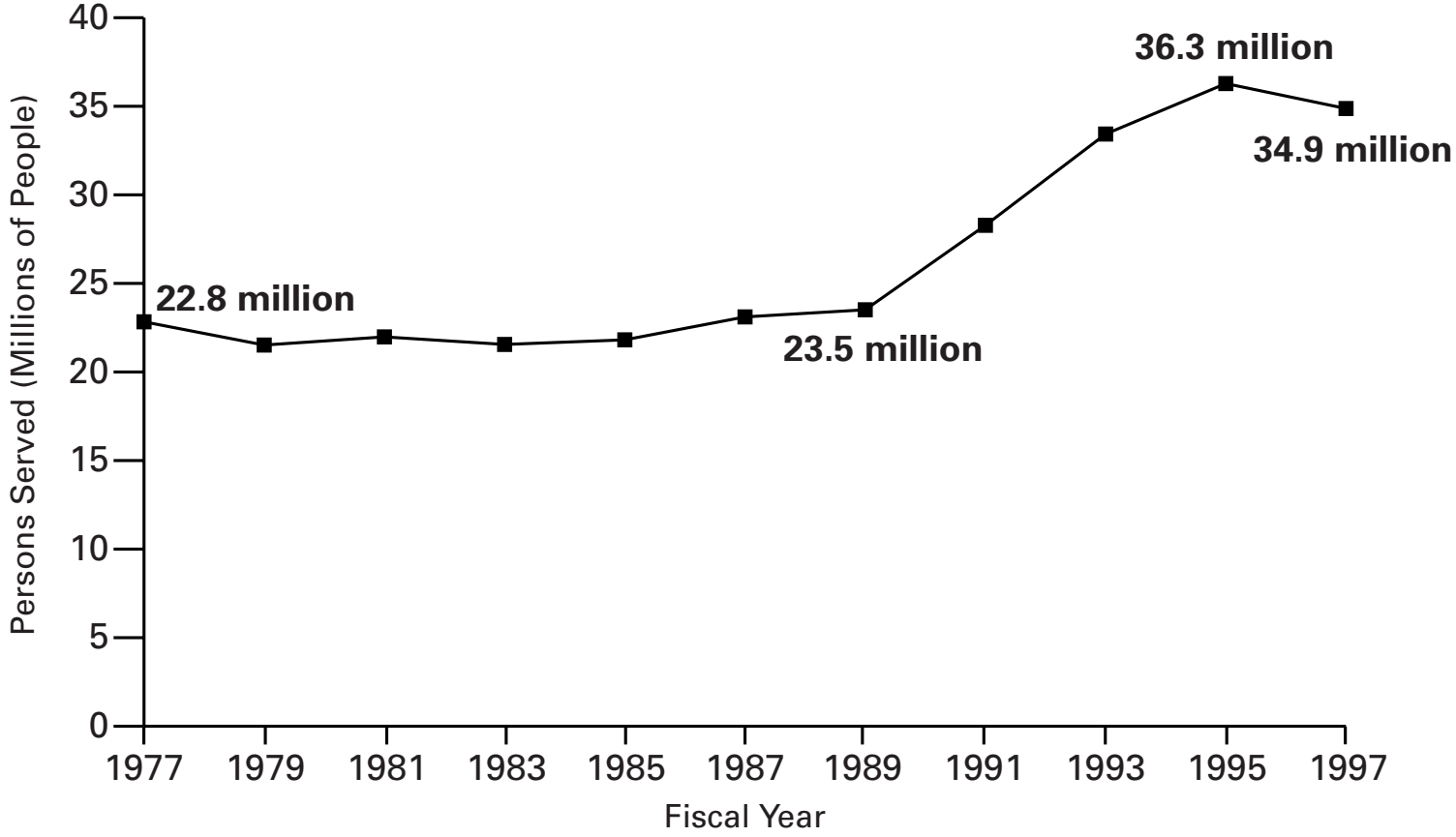
*In 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations. FY 1998 was the first year capitation payments were counted as a "service" for purposes of the HCFA 2082 reporting, and thus managed care enrollees were included in the counts of individuals receiving services through Medicaid.

Note: Enrollees are individuals enrolled in Medicaid at least one month during the year; persons served are individuals for whom a Medicaid claim was paid during the year or beginning in 1998 on whose behalf Medicaid made premium payments to managed care organizations; person years represent the number of Medicaid enrollees if computed in terms of 12 months of enrollment (i.e., full-year equivalents).

Source: HCFA Form 2082.

Figure 1.2 Persons Served Through Medicaid, Fiscal Years 1977-1997

Mandatory eligibility expansions in the late 1980s led to an increase in the number of persons served in the early 1990s.

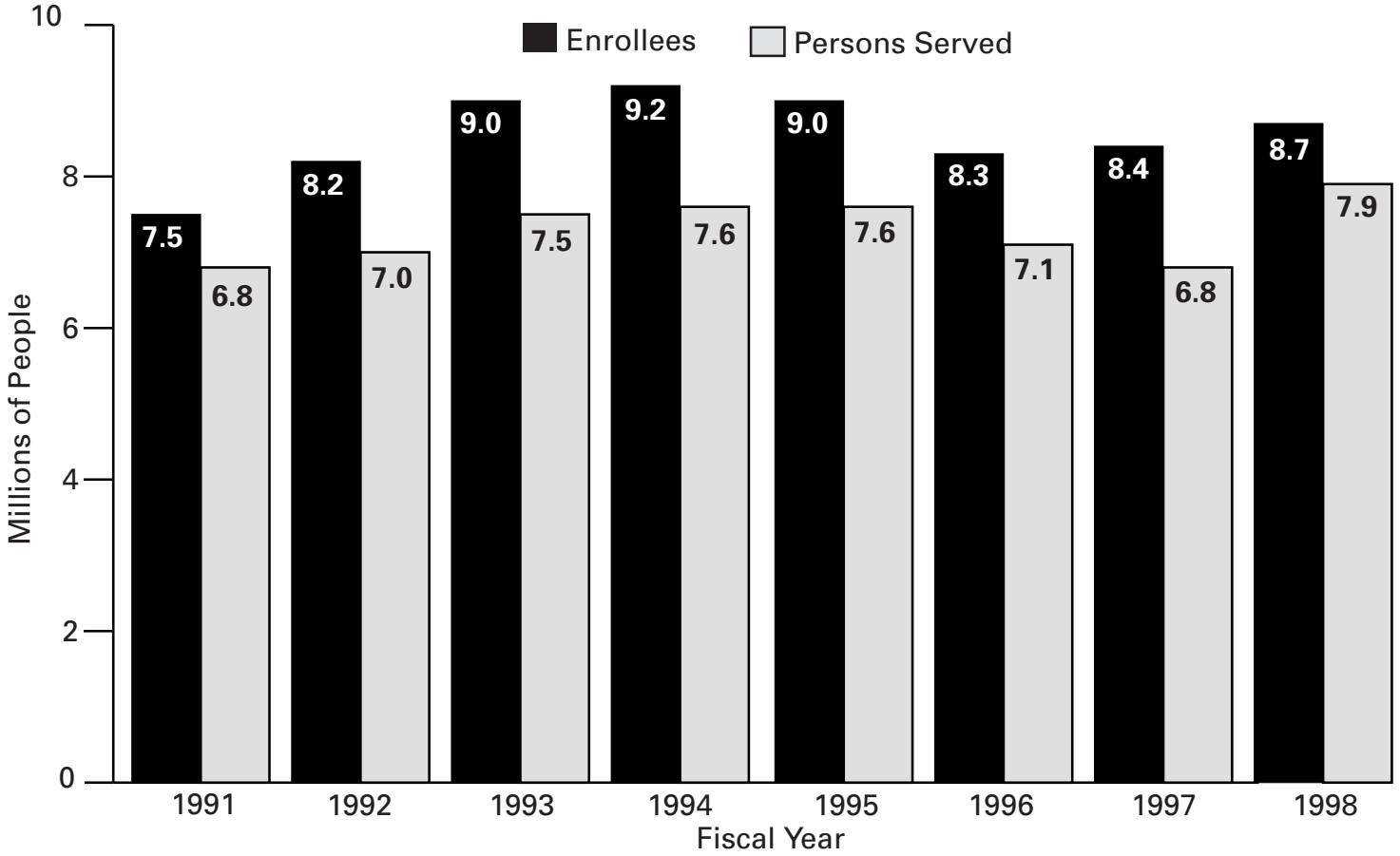


Note: (1) The trend line shown above presents a consistent time-series data set through 1997; in 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations; FY 1998 was the first year capitation payments were counted as a "service" for purposes of the HCFA 2082 reporting, and thus managed care enrollees were included in the counts of individuals receiving services through Medicaid; (2) persons served are individuals for whom a Medicaid claim was paid during the year.

Source: HFCA/Office of Information Services; HCFA Form 2082.

Figure 1.3 Medicaid Populations — Adults

Medicaid adult enrollment peaked in 1994.

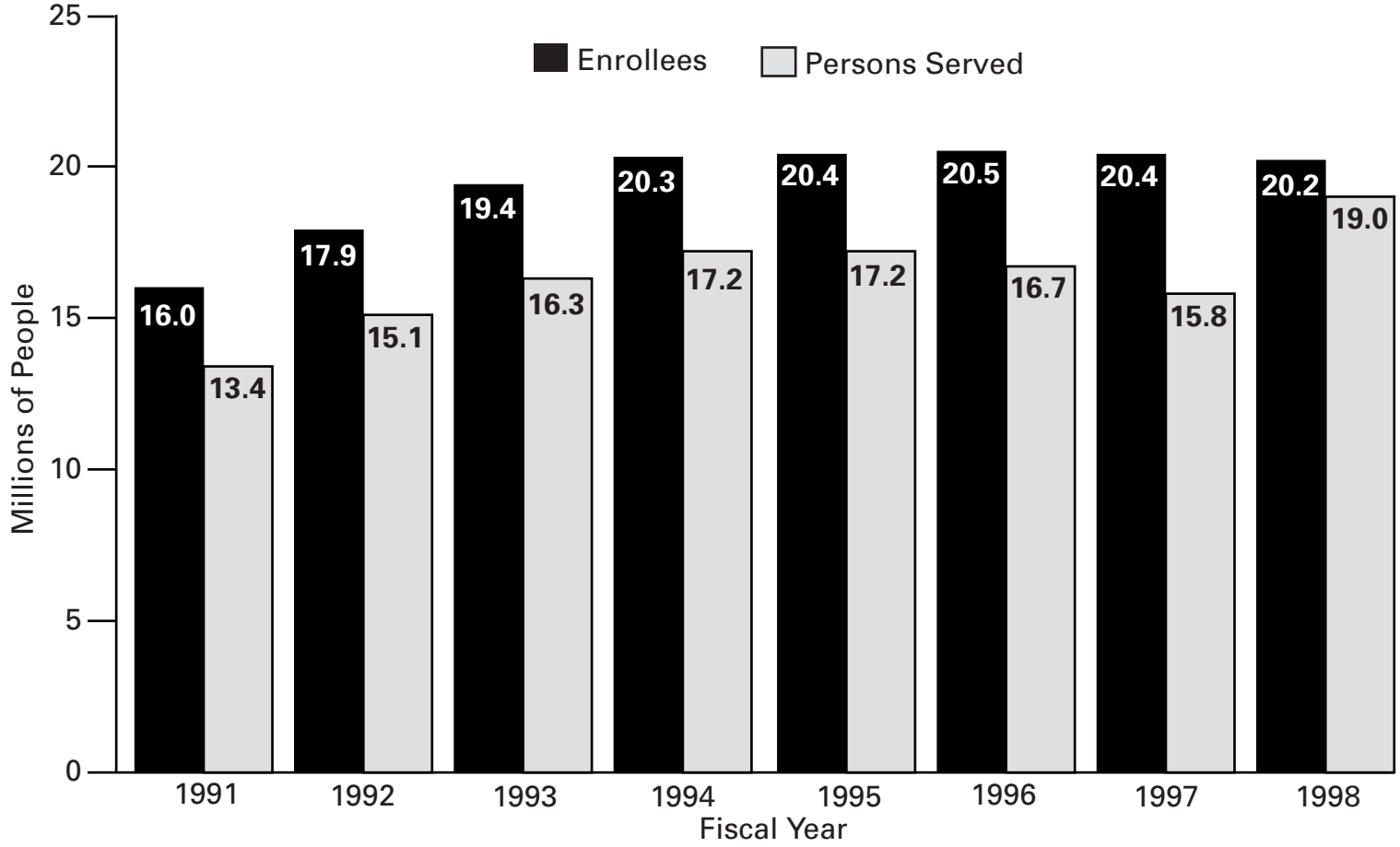


Note: (1) In 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations; FY 1998 was the first year capitation payments were counted as a "service" for purposes of the HCFA 2082 reporting, and thus managed care enrollees were included in the counts of individuals receiving services through Medicaid; (2) enrollees are individuals enrolled in Medicaid at least one month during the year; (3) persons served are individuals for whom a Medicaid claim was paid during the year or beginning in 1998 on whose behalf Medicaid made premium payments to managed care organizations.

Source: HCFA Form 2082.

Figure 1.4 Medicaid Populations — Children

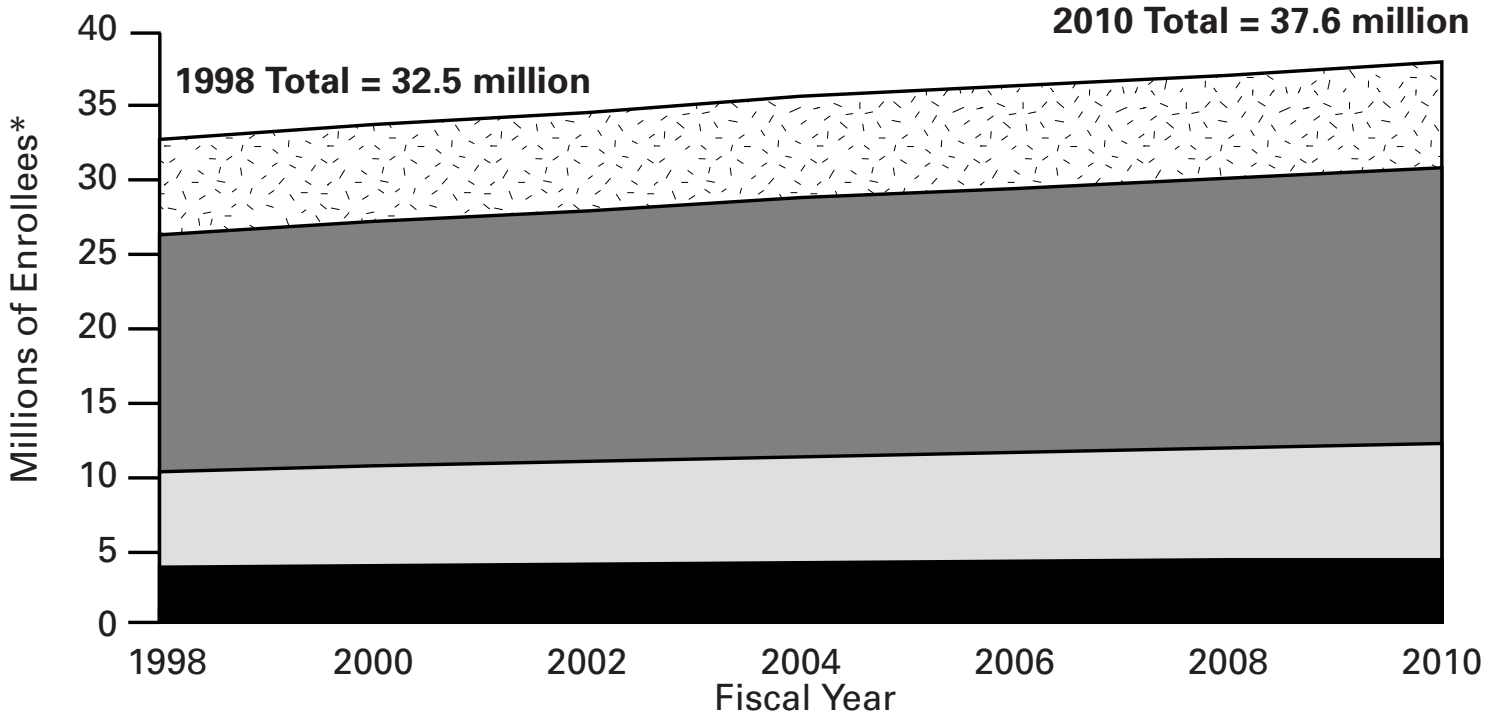
Medicaid enrollment of children peaked in 1996.



Note: (1) In 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations; FY 1998 was the first year capitation payments were counted as a "service" for purposes of the HCFA 2082 reporting, and thus managed care enrollees were included in the counts of individuals receiving services through Medicaid; (2) enrollees are individuals enrolled in Medicaid at least one month during the year; (3) persons served are individuals for whom a Medicaid claim was paid during the year or beginning in 1998 on whose behalf Medicaid made premium payments to managed care organizations.

Source: HCFA Form 2082.

Figure 1.5 Projections of Future Total Medicaid Enrollment* Fiscal Years 1998-2010



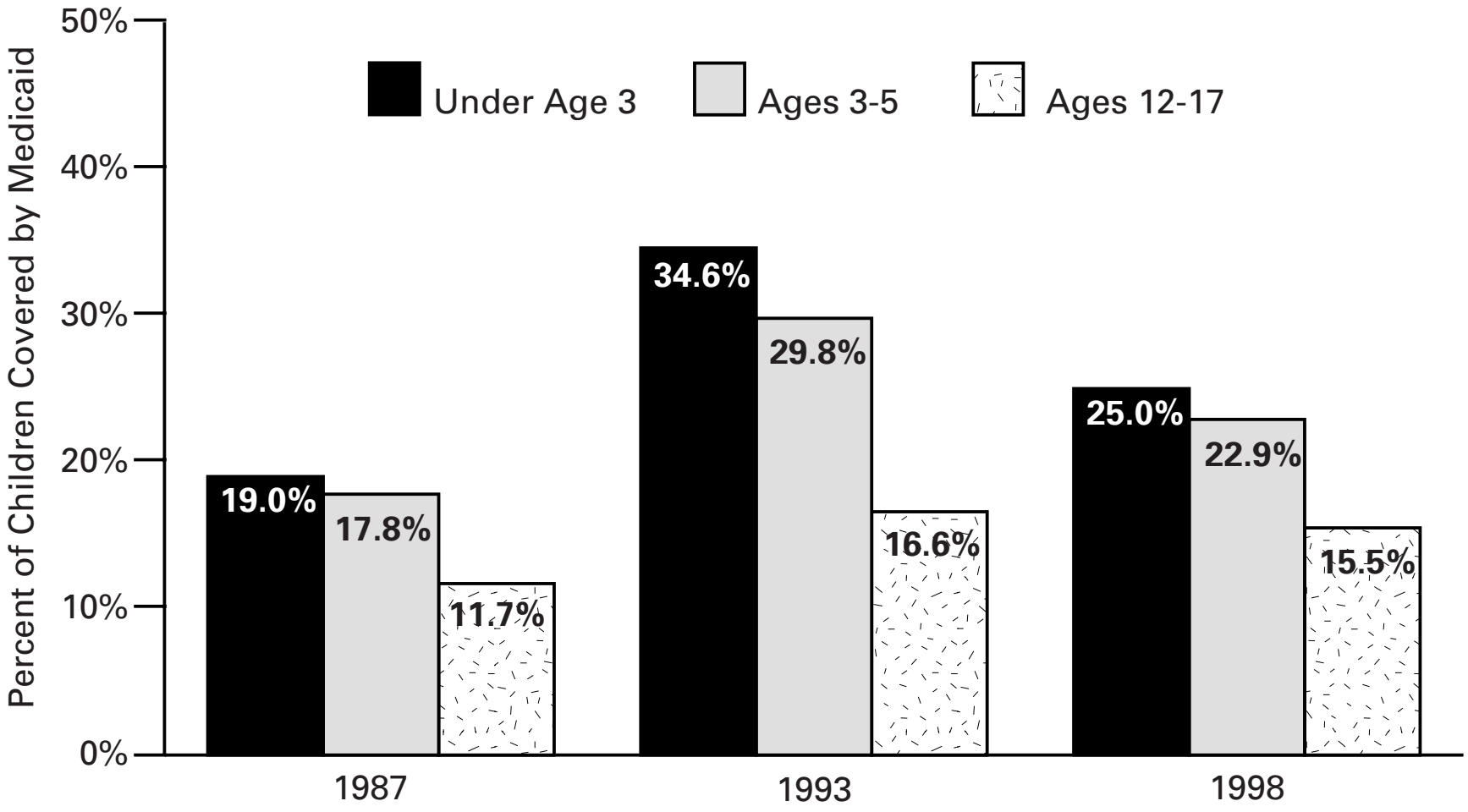
Eligibility Group	Average Annual Growth Rate
Aged	1%
Blind & Disabled	2%
Child	1%
Adult	1%
Total	**1%**

*Enrollee data estimates are computed in person-years; this represents the number of beneficiaries if computed in terms of 12 months of enrollment (i.e., full-year equivalents).

Source: HCFA/Office of the Actuary, President's Fiscal Year 2001 baseline budget.

Figure 1.6 Medicaid Health Insurance Coverage of Children, by Selected Age Groups & Calendar Years

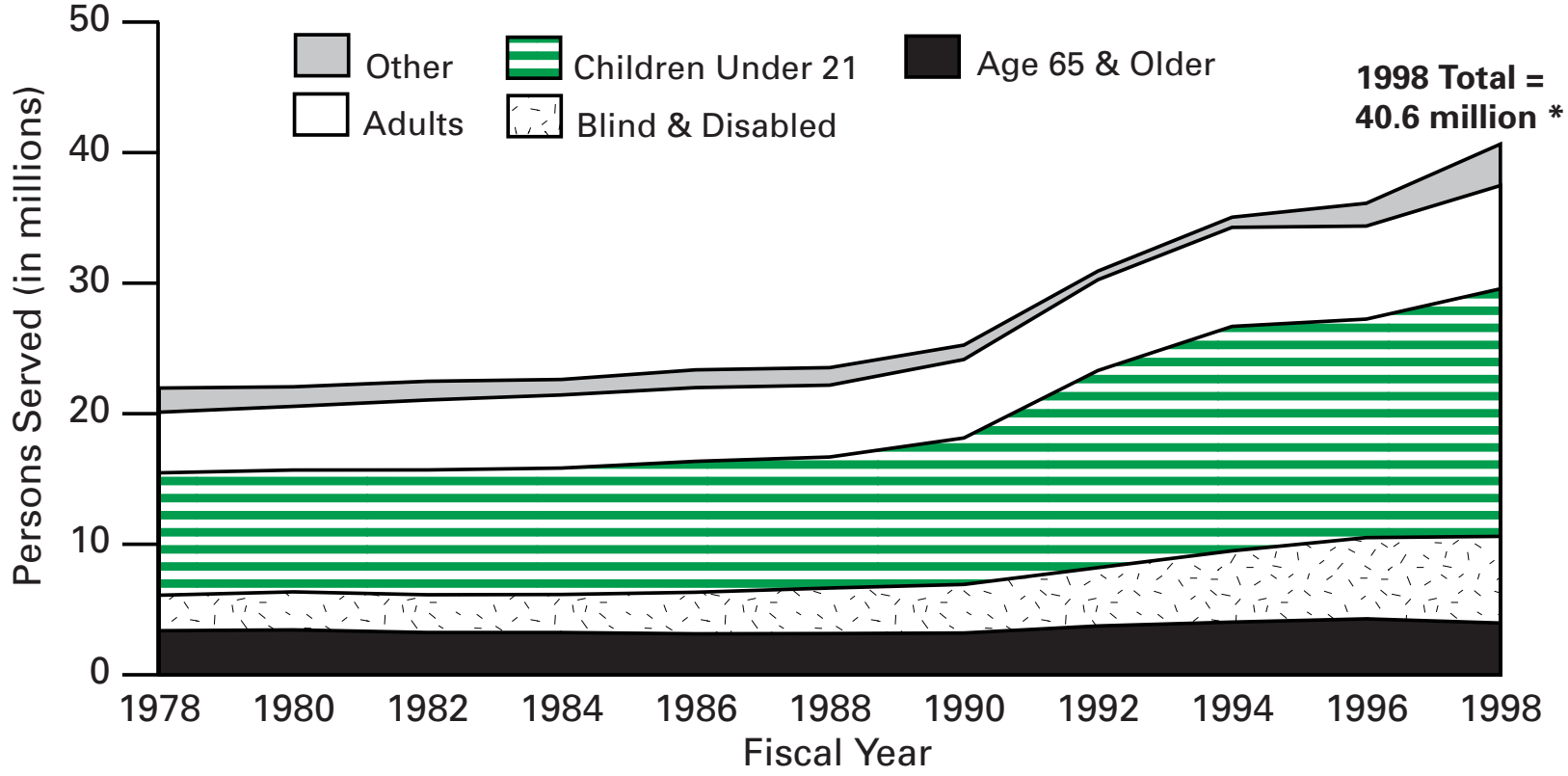
Medicaid coverage is more prevalent among younger aged children.



Source: U.S. Census Bureau, Current Population Survey.

Figure 1.7 Total Number of Persons Served Through Medicaid, by Basis of Eligibility, Fiscal Years 1978-1998

Children historically represent the largest eligibility group of Medicaid beneficiaries.

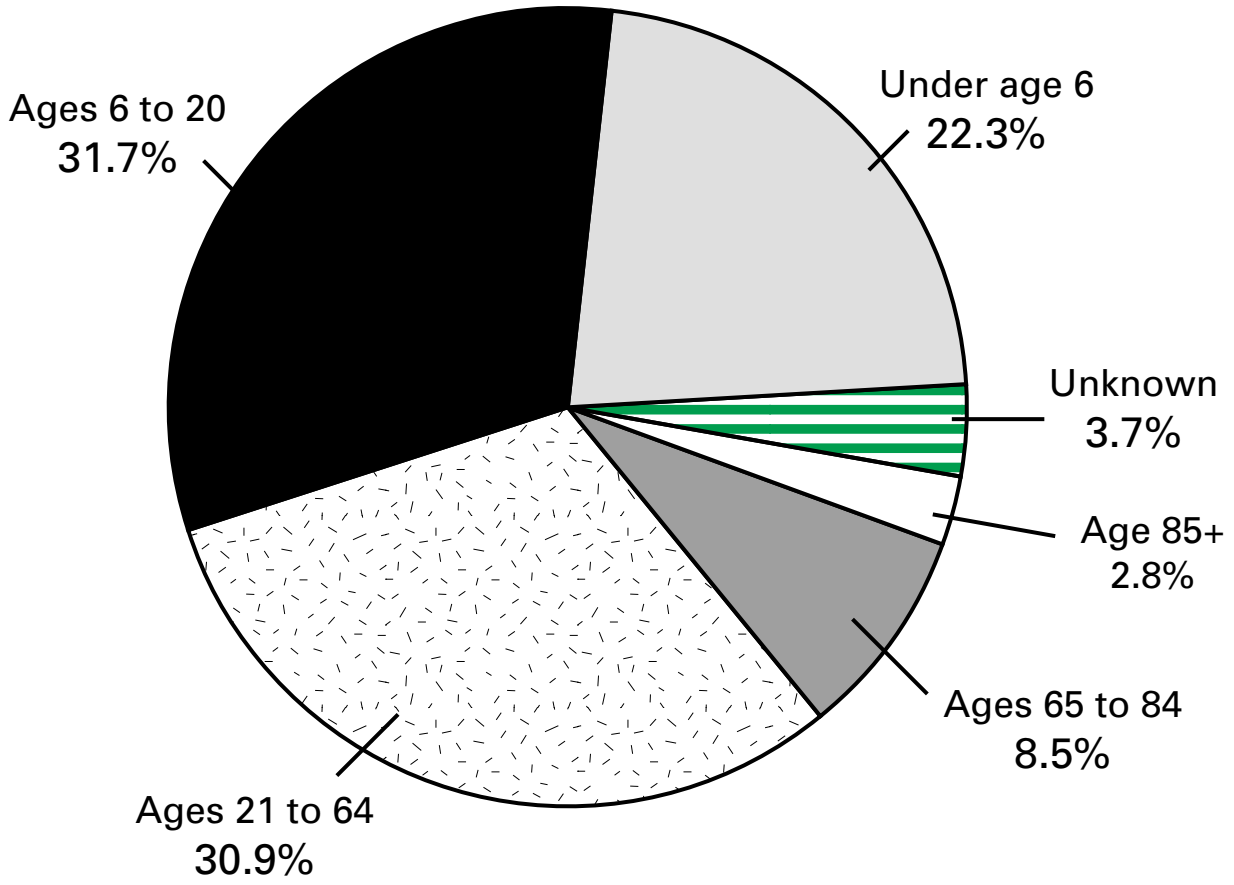


Note: *(1) In 1998, a large increase occurred in the number of persons served which is mainly the result of a new reporting methodology of classifying payments to managed care organizations; FY 1998 was the first year capitation payments were counted as a service for purposes of the HCFA 2082 reporting, and thus all managed care enrollees were counted as individuals receiving services; this new methodology probably has the greatest effect on the reported number of children; (2) the term "adults" as used above refers to non-elderly, non-disabled adults; (3) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

Figure 1.8 Medicaid Enrollees by Age, Fiscal Year 1998

Children represent over half of the Medicaid enrolled population.

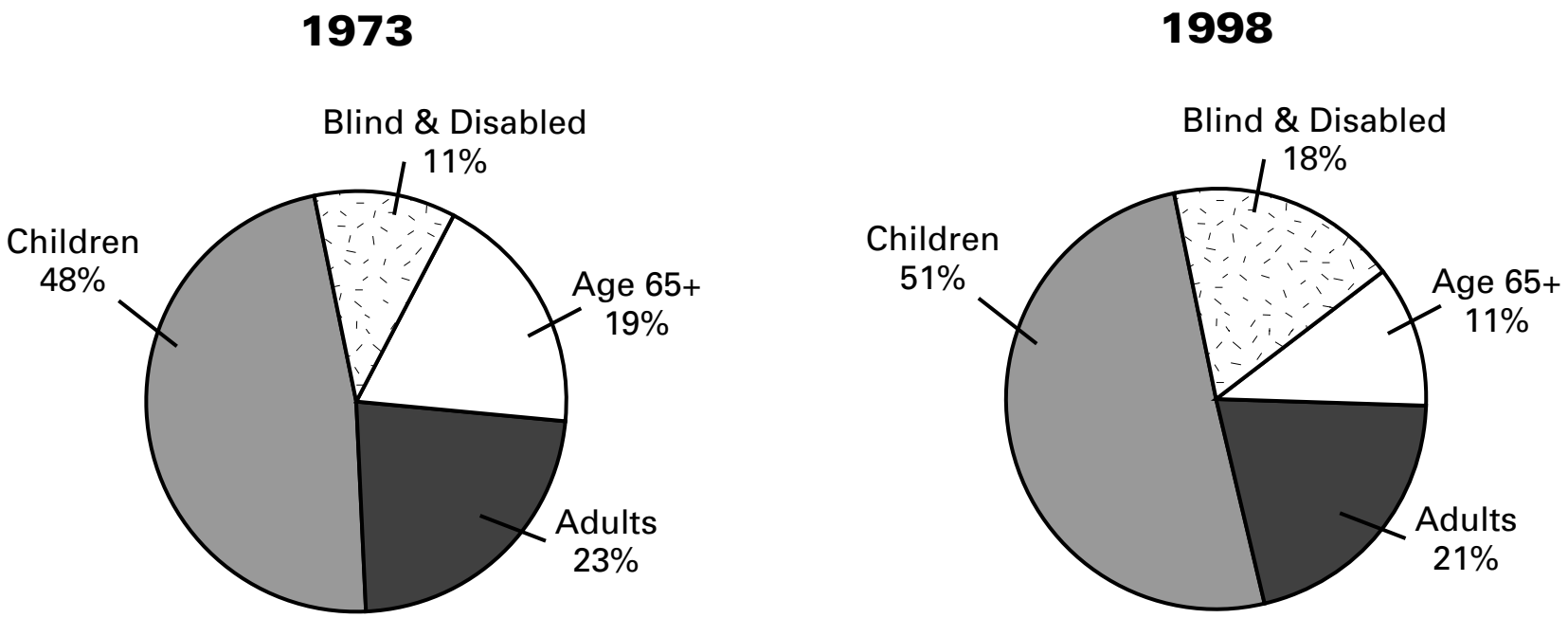


Note: Percentages may not sum to 100 due to rounding.

Source: HCFA Form 2082.

Figure 1.9 Distribution of Persons Served Through Medicaid, by Basis of Eligibility, Fiscal Years 1973 and 1998

The proportion of persons served through Medicaid with disabilities has increased while the proportion of individuals aged 65+ has decreased.

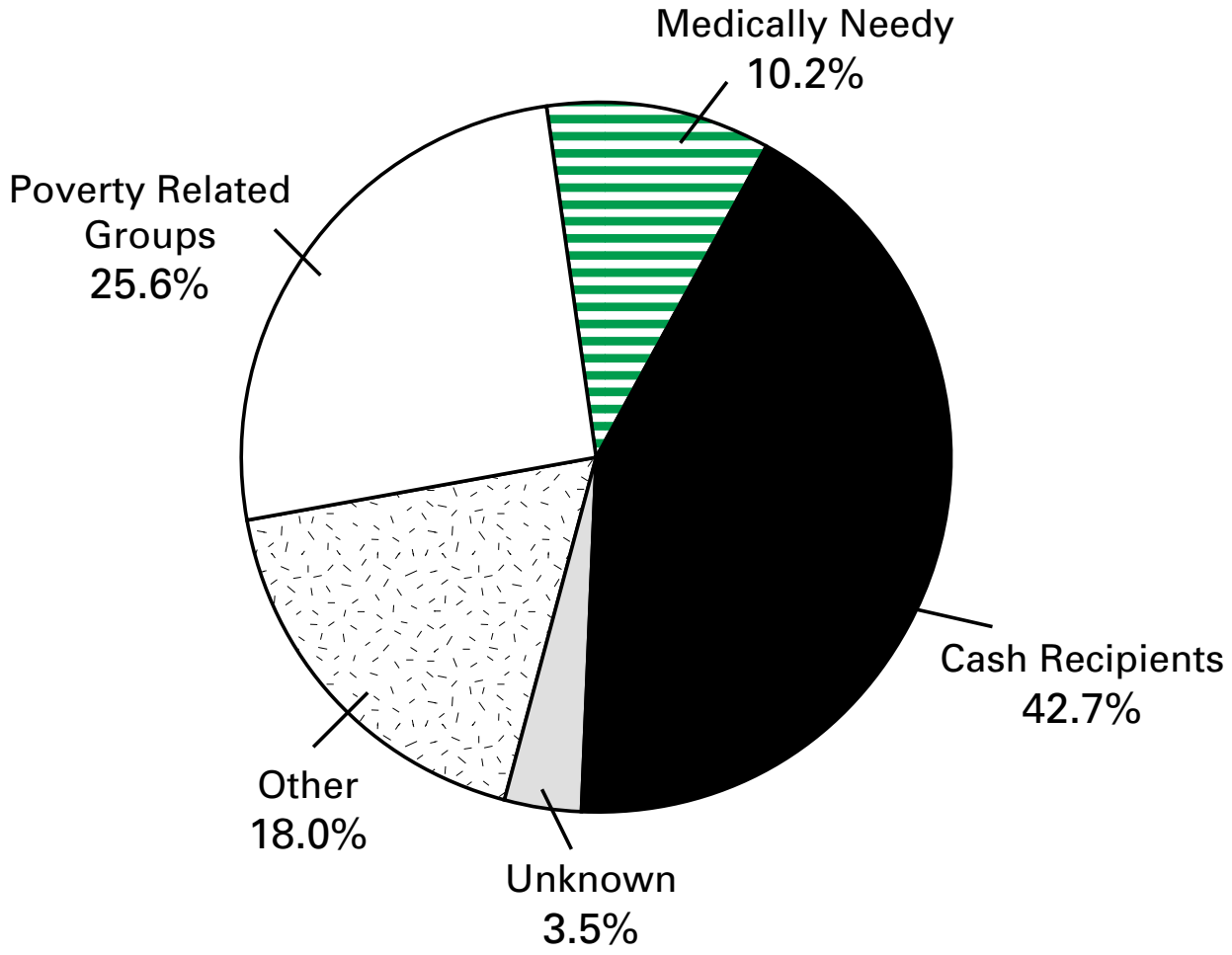


Note: (1) The percentage distribution for 1973 does not include 1.5 million persons served by Medicaid whose basis of eligibility is reported as "other," and the percentage distribution for 1998 does not include 3.1 million persons served whose basis of eligibility is unknown; (2) percentages may not sum to 100 due to rounding; (3) the term "adults," refers to non-elderly, non-disabled adults; (4) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

Figure 1.10 Medicaid Enrollees by Maintenance Assistance Status, Fiscal Year 1998

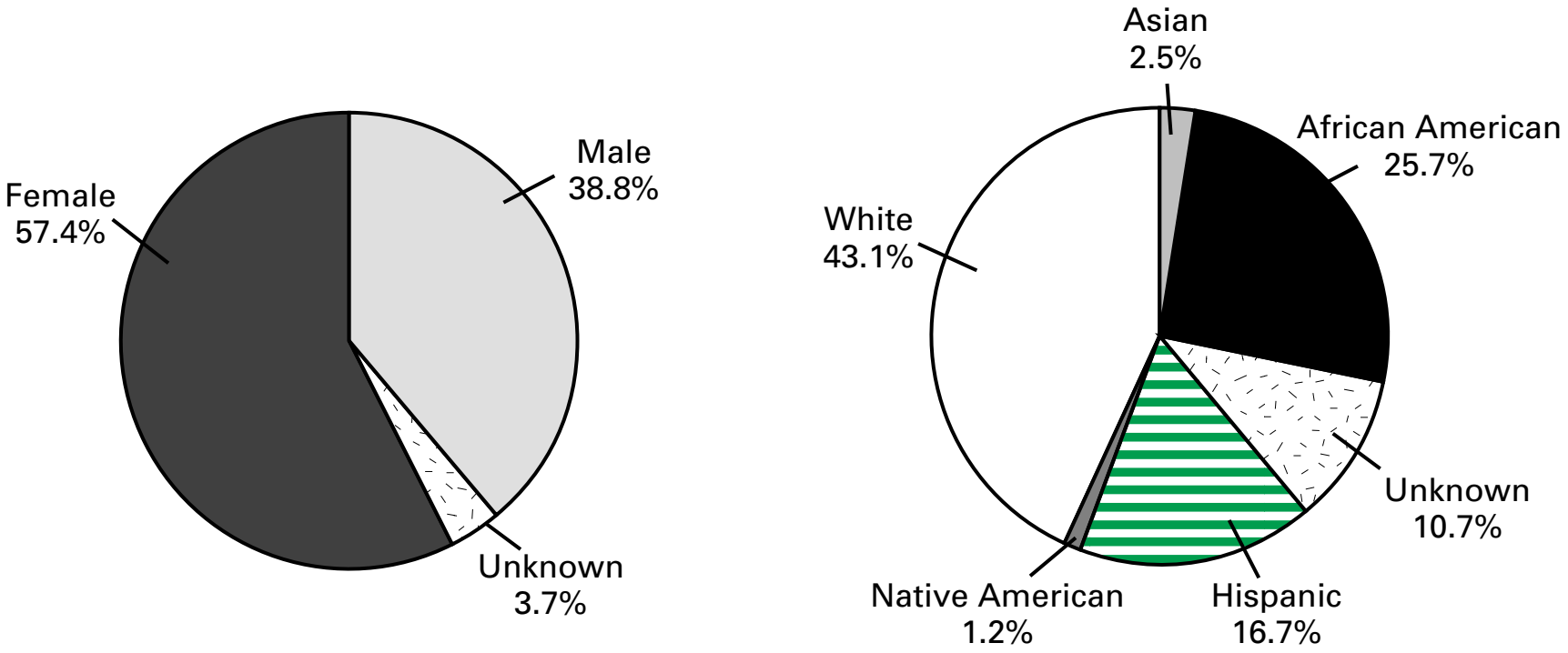
Less than half of Medicaid beneficiaries receive cash assistance.



Source: HCFA Form 2082.

Figure 1.11 Medicaid Enrollees by Sex and Race, Fiscal Year 1998

Females and White Americans comprise the largest demographic groups of Medicaid enrollees.



Note: Percentages may not sum to 100 due to rounding.

Source: HCFA Form 2082.

Medicaid Expenditures

SECTION III

Medicaid Expenditures[10]

From the inception of the Medicaid program through the late 1980's, overall Medicaid spending grew at a rate that was comparable to national health spending. Since the late 1980's, however, Medicaid spending growth has outpaced national health spending. Medicaid expenditures have nearly tripled since 1989.

- The Medicaid program's share of national health spending has increased over the past three decades. In 1966, Medicaid spending accounted for only 2.9 percent of total national health expenditures. By 1998, Medicaid as a share of health care spending had risen to 14.8 percent, approximately a 5-fold increase over the 32-year period. The total public sector portion of national health care expenditures increased from 30.2 percent in 1966 to 45.4 percent in 1998. **(Figure 2.1)**

- Total Medicaid program spending reached $175 billion during Fiscal Year 1998. The average annual real growth rate in total spending was 5.9 percent throughout the 1980's. During the 1990's, the average annual real growth rate increased to 9.8 percent; most of this growth occurred in the early 1990's. For much of the past 30 years, Medicaid administrative expenses as a percent of total program expenditures have ranged between 4.0 and 6.5 percent. **(Figure 2.2)**

- A variety of factors contribute to the annual growth rate in Medicaid program expenditures. Changes in federal and state policy, for example, have a significant impact on spending. Congressionally mandated eligibility expansions explain some of the expenditure growth. Program spending increased the fastest between 1989 and 1992, mainly as a result of state provider tax and donation mechanisms and disproportionate share hospital payments.[11] These payment mechanisms were designed to maximize federal disproportionate share payments without additional state expenditures. **(Figure 2.3)**

- Several factors account for the relatively slow growth of Medicaid in recent years such as slower enrollment growth; lower medical price inflation; the expansion of managed care and other cost containment measures; and restrictions on DSH expenditure growth. **(Figure 2.4)**

Many of the factors contributing to the recent slowdown in growth are temporary and there will likely be a gradual return to future higher growth rates. For example, the projected rate of DSH spending will slow considerably in the near term as a result of reductions in annual allotments.[12] Disproportionate share hospital (DSH) payments account for a large part of the increased spending during the past decade. HCFA estimates that Medicaid expenditures on behalf of children and individuals with disabilities will drive future spending: both groups have the highest expenditure growth rates and the disabled account for the largest share of Medicaid expenditures.

- Total Medicaid spending is currently projected to reach $444 billion in Fiscal Year 2010.[13] Case load growth accounts for about one-sixth of the increase during this period. Inflation accounts for one-third of projected spending growth and the balance of the increase can be explained by spending-per-enrollee in excess of inflation. **(Figure 2.5)**

[11] Expenditure data presented in this chapter are aggregate data for all states and territories. Expenditures attributed to specific Medicaid services and providers, or presented on a per capita basis are solely based on state classification of expenditures reported in the HCFA 64 form and 2082 form. The expenditures in the charts may include enhanced payments made by certain states to specific providers under 42 CFR 447.272.

[11] Letsch, Suzanne W., Lazenby, Helen, Levit, Katherine R., Cowan, Cathy A., "National Health Expenditures, 1991", Health Care Financing Review (Volume 14, Number 2, Winter 1992):13-17.

[12] The Balanced Budget Amendment of 1997 reduced annual allotments of DSH expenditures.

[13] President's Fiscal Year 2001 budget.

- HCFA projects that total Medicaid outlays will grow at an average annual rate of about 8 percent between Fiscal Years 1998 and 2010. DSH expenditures will grow the least (1 percent), while spending for people with disabilities and children will grow the most (9 percent), followed by adults (8 percent) and the elderly (7 percent). **(Figure 2.6)**

Federal and State Funding

The federal government funds a significant portion of the Medicaid program. The Federal Medical Assistance Percentage, or FMAP, represents the percentage of total Medicaid program spending paid for by the federal government. The federal government also shares in the state Medicaid administrative expenditures. The basic federal matching rate for administrative costs is 50 percent but higher ("enhanced") matching rates apply for certain functions (e.g., 75% for automated claims processing systems, 75% for skilled professional medical personnel).

- The FMAP for each state is generated using a formula that compares the state average per capita income with the national average. By law, the FMAP cannot be lower than 50 percent or greater then 83 percent. **(Figure 2.7)**

- Medicaid spending accounts for a significant portion of state budgets. In Fiscal Year 1999, over fourteen percent of total state general funds were spent on Medicaid. In addition, over forty-three percent of total federal funds provided to states in Fiscal Year 1999 were spent on Medicaid. **(Figure 2.8)**

Disproportionate Share Hospital Payments

States must augment payment to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries or other low-income persons. During 1998, Disproportionate Share Hospital (DSH) payments totaled $15 billion, of which the federal government provided $8.5 billion (57 percent). DSH accounted for 9 percent of total Medicaid spending in Fiscal Year 1998. These payments help support health care safety net providers, such as public hospitals, which are under financial pressure from the rising number of uninsured and changes in Medicaid policies (e.g., managed care).[14]

- Annual federal DSH payments grew from $400 million in Fiscal Year 1989 to over $11 billion by Fiscal Year 1992. During the late 1980's there was significant concern in Congress regarding how states used DSH funds and the magnitude of DSH expenditures. Legislation passed in 1991 curtailed states' DSH payments.[15] The Balanced Budget Act of 1997 further curtailed DSH payments.[16] **(Figure 2.9)**

Medicaid Eligibility Groups

During the past two decades, Medicaid spending on behalf of the blind, individuals with disabilities and the elderly has grown significantly. Two distinct factors contribute to this trend; (1) the increasing size of the Medicaid disabled population; and (2) the spiraling costs associated with institutional long-term care services.

- While the aged, the blind and people with disabilities accounted for only 26 percent of all persons served through Medicaid in Fiscal Year 1998, the Medicaid payments made on their behalf accounted for 71 percent of program payments. These payments measure payments directly to providers and payments to managed care organizations; they exclude DSH payments. The largest

[14] Institute of Medicine, America's Health Care Safety Net: Intact but Endangered, March 2000.

[15] Public Law 102-234, The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, limited total DSH program expenditures to 12 percent of expenditures for medical assistance. Starting in Fiscal Year 1993, state base allocations were held constant with certain adjustments and supplemental payments, as determined through a statutory formula. Actual state-level DSH expenditures may differ from the state-specific DSH allocation during a fiscal year, for reasons such as disallowed provider-related donations or health care taxes collected by a state.

[16] The BBA specified DSH allotments by state from Fiscal Year 1998 through Fiscal Year 2002. After Fiscal Year 2002, federal government DSH expenditures may increase by the change in inflation (CPI-U)—but are subject to a ceiling of 12 percent of each state's total annual Medicaid expenditures.

group of persons served through Medicaid, children, accounted for only 16 percent of all Medicaid program payments. **(Figure 2.10)**

- This pattern in distribution of Medicaid payments by eligibility group goes back to the mid-1970's. Since 1975, Medicaid payments for the elderly and disabled have exceeded payments for adults and children. During the late 1970's and early 1980's, payments for the elderly and the disabled have generally been similar, with payments for the elderly slightly higher. Starting in 1987, however, payments for individuals with disabilities began to surpass payments for the elderly. Furthermore, since 1992, there has been a dramatic growth in spending for the disabled. **(Figure 2.11)**

- Between the Fiscal Years 1978 and 1998, real, per capita spending for elderly Medicaid beneficiaries grew the fastest among all eligibility groups (an average annual growth rate of 4.9 percent). Per capita program payments on behalf of the blind and disabled grew somewhat slower (a 3.7 percent average annual increase). In contrast, spending for children and adults grew at more modest rates (average annual growth rates of 2.8 and 2.2 percent, respectively). **(Figure 2.12)**

- Dually enrolled beneficiaries[17] are Medicare beneficiaries who also qualify for Medicaid benefits on the basis of financial need. Medicaid spends a disproportionate share of program funds on behalf of dual eligible beneficiaries. During Fiscal Year 1997, 6.4 million dual beneficiaries represented only 19 percent of the Medicaid population, but accounted for 35 percent of program expenditures. **(Figure 2.13)**

[17] These individuals are also referred to as "dual eligibles."

Medicaid Services

- In Fiscal Year 1998, prescription drugs exceeded physician services as the most utilized Medicaid service, based on the number of Medicaid beneficiaries (over 19.3 million) accessing the service. Over 12 million beneficiaries received inpatient hospital services and over 4 million received outpatient hospital services. Nursing facility services were the least utilized service among the Medicaid population, with 1.6 million beneficiaries accessing nursing facility services. **(Figure 2.14.)**

- In terms of total Medicaid expenditures, however, nursing facility services were the highest. During Fiscal Year 1998, Medicaid spent over $44 billion on institutional long-term care services (nursing homes and intermediate care facilities for the mentally retarded). Also, the program purchased $11.5 billion of home and community-based long-term care services. Medicaid spent $28.9 billion on hospital services (excluding DSH), $6.6 billion on physician services and purchased $6.4 billion of other forms of acute care services (e.g., lab and x-ray, as well as services provided through clinics). The Medicaid program spent $11.7 billion on prescription drugs.[18] The program also spent $27.5 billion on health insurance (including the cost of Medicaid program expenditures for Medicare premiums on behalf of the dually-enrolled and Medicaid premiums paid to primary care case management groups, HMO's, and pre-paid health plans). **(Figure 2.15)**

- Medicaid has traditionally played an important role in paying for acute care services. The largest expenditure categories within Medicaid acute care spending are hospital services (approximately 40 percent) and DSH program payments (approximately 21 percent). Medicaid is an important source of revenue for safety net providers. One-third or more of the patients served by public hospitals and community health centers are Medicaid

[18] The expenditure amounts cited above (except for the payments to managed care organizations) represent fee-for-service payments.

beneficiaries.[19] Prescription drug expenditures (approximately 16 percent) account for the third largest category of acute care spending. **(Figure 2.16)**

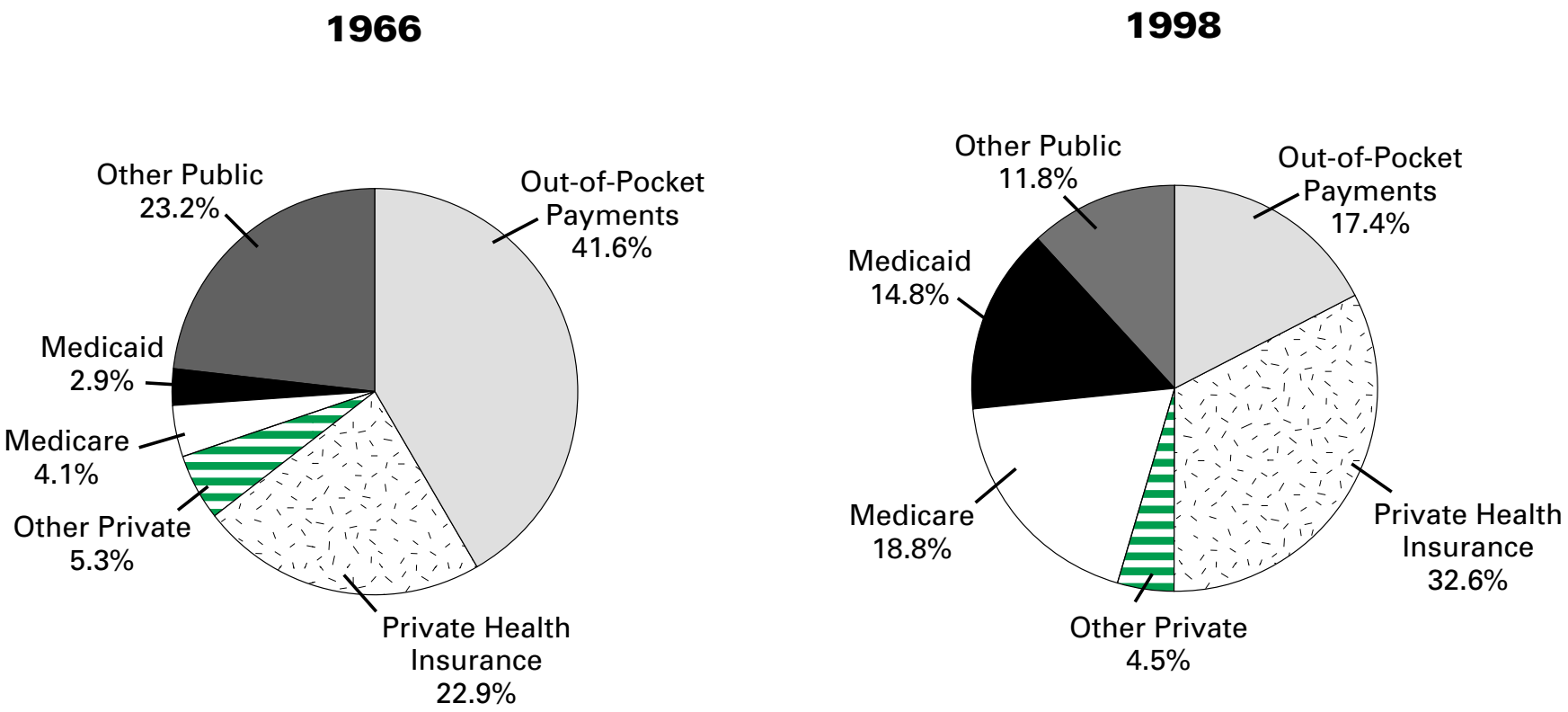
- In 1998, Medicaid spent $44 billion on institutional long-term care services. The vast majority, 77.7 percent, of these funds went to nursing homes, while 13.6 percent went to public intermediate care facilities for the mentally retarded and another 8.7 percent went to private intermediate care facilities for the mentally retarded. **(Figure 2.17)**.

- In 1998, the average state Medicaid per capita expenditure was $4,307 per person served. The average FMAP was 57%. When DSH funds are excluded from spending, the average per capita expenditure decreases to $3,939. Northeastern states (e.g., New York, New Hampshire, Connecticut) tended to have the highest per capita expenditures, excluding DSH payments. Two of the states with the lowest per capita levels, excluding DSH payments, also had the highest levels of managed care penetration (Tennessee and Washington). **(Figure 2.18)**

[19] Institute of Medicine, America's Safety Net: Intact but Endangered, March 2000.

Figure 2.1 Medicaid Expenditures as a Percent of All National Health Expenditures, Calendar Years 1966 and 1998

Medicaid's share of national health spending increased from 2.9 to 14.8 percent between 1966 and 1998.

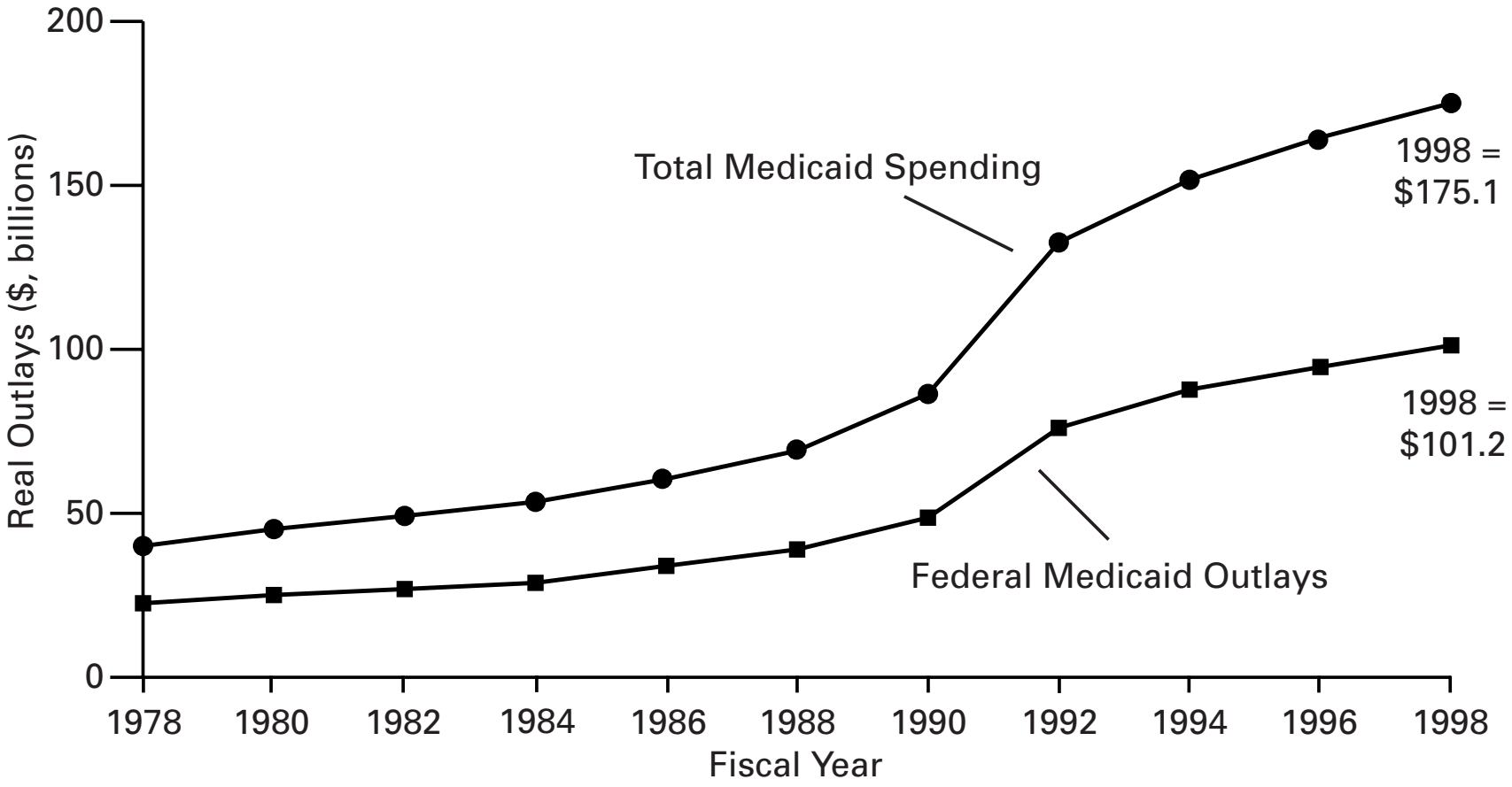


Note: Percentages may not sum to 100 due to rounding.

Source: HCFA's Office of the Actuary, National Health Statistics Group.

Figure 2.2 Medicaid Expenditure Trends, in Real Terms, Fiscal Years 1978-1998

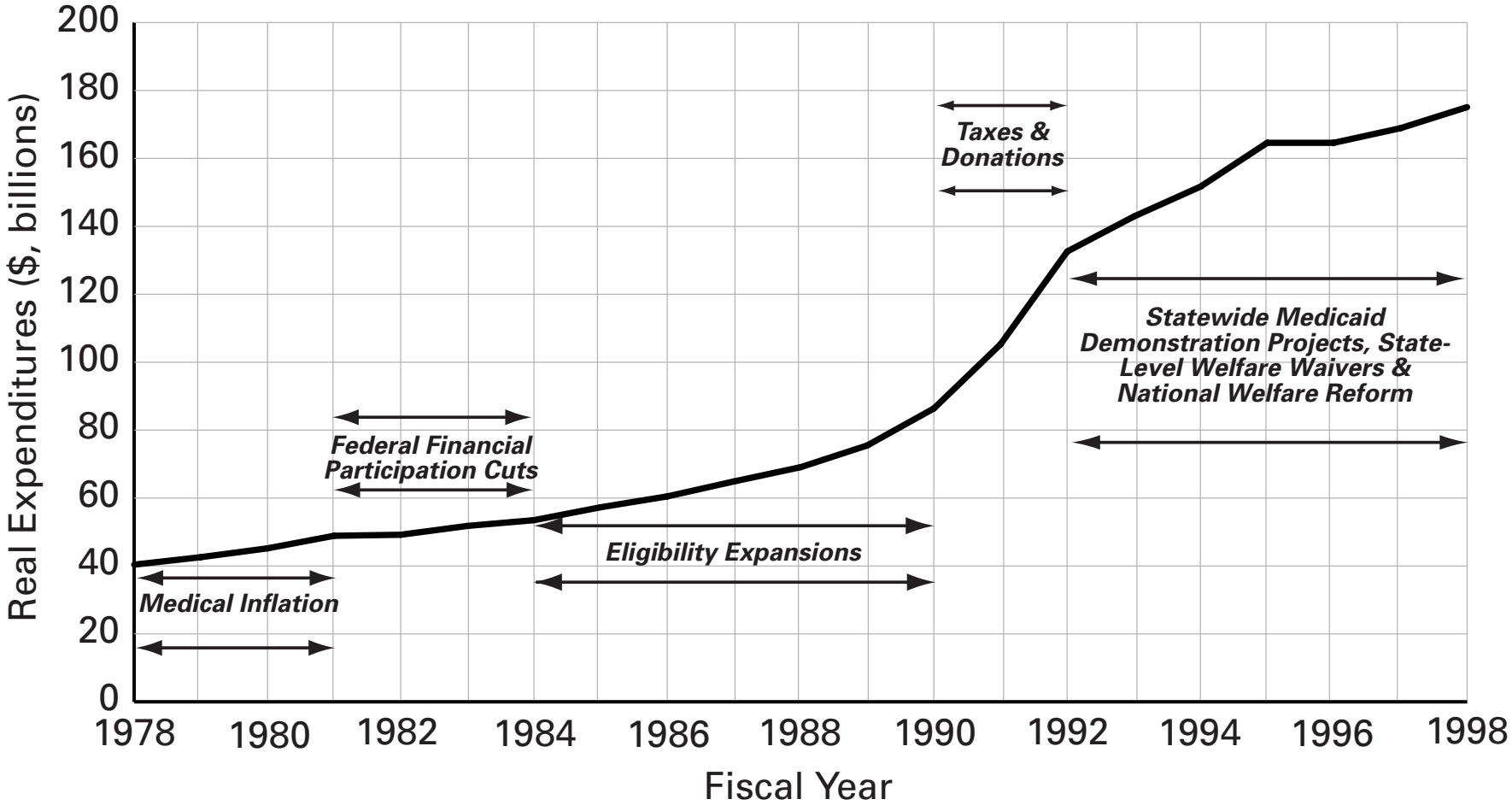
Spending grew at an annual average rate of 5.9 percent throughout the 1980s, but increased to 9.8 percent on average during the 1990s.



Note: The data shown above are expressed in 1998 dollars.

Source: HCFA/Office of the Actuary, Medicare and Medicaid Cost Estimates Group.

Figure 2.3 Total Medicaid Spending by "Era," Fiscal Years 1978-1998

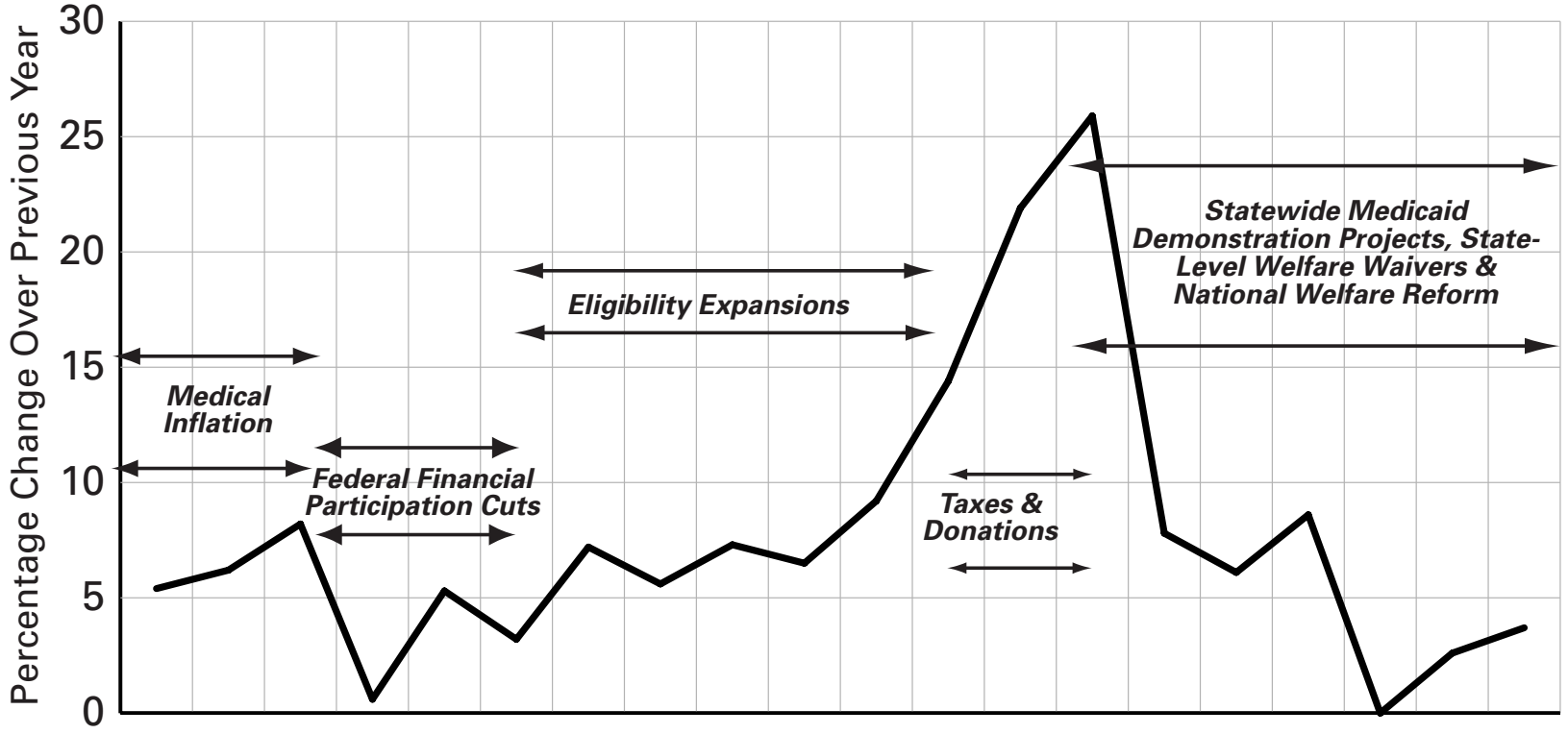


Note: The data shown above are expressed in 1998 dollars.

Source: HCFA/Office of the Actuary, Medicare and Medicaid Cost Estimates Group.

Figure 2.4 Percent Change in Total Medicaid Spending in Real Terms by "Era," Fiscal Years 1978-1998

Spending grew most quickly between 1990 and 1992.



	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Percent Change	5.4	6.2	8.2	0.6	5.3	3.2	7.2	5.6	7.3	6.5	9.2	14.4	21.9	25.9	7.8	6.1	8.6	0	2.6	3.7

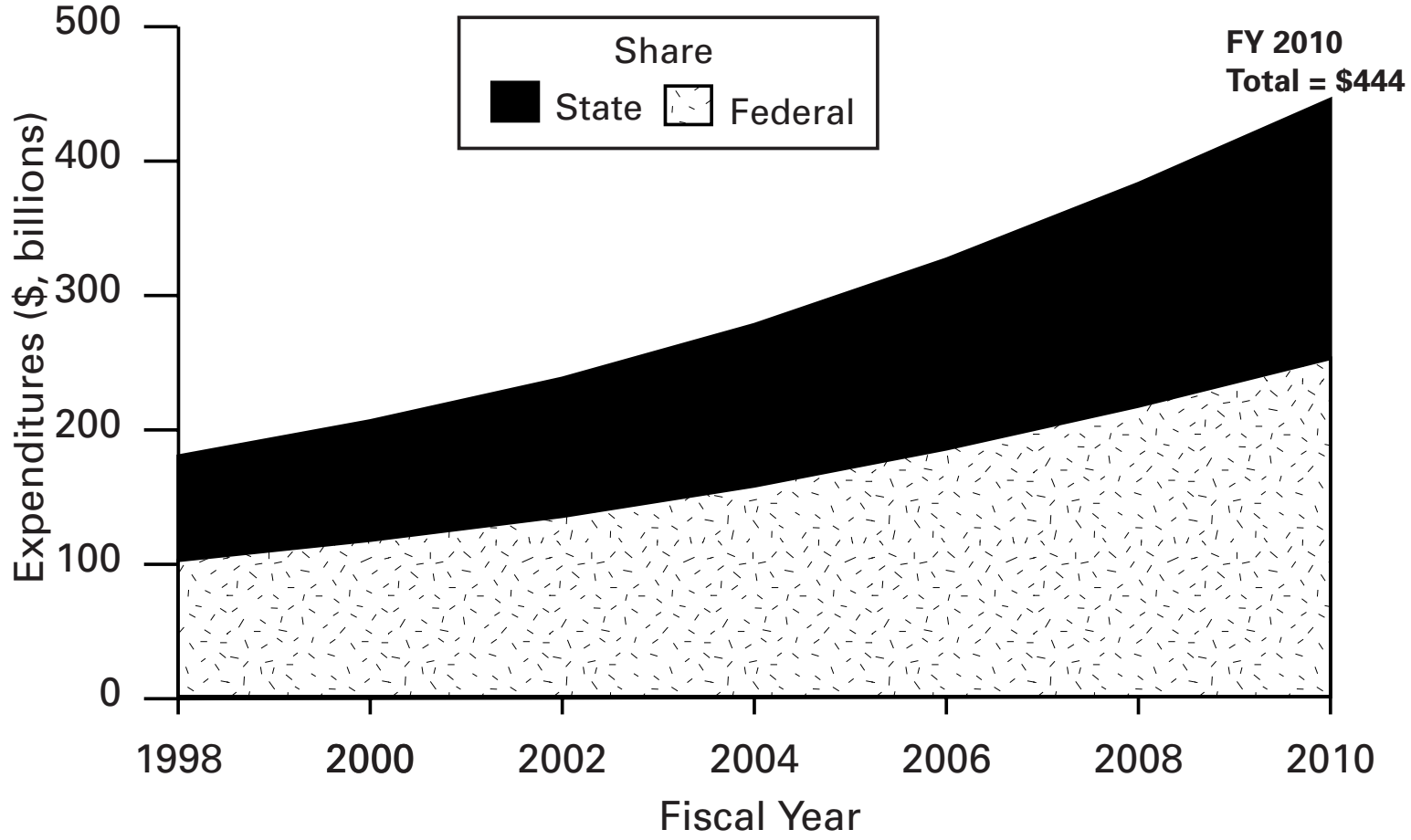
Fiscal Year

Note: The data shown above are expressed in 1998 dollars.

Source: HCFA/Office of the Actuary, Medicare and Medicaid Cost Estimates Group.

Figure 2.5 Projected Medicaid Expenditures, Fiscal Years1998-2010

Spending is projected to grow to $444 billion in FY 2010.

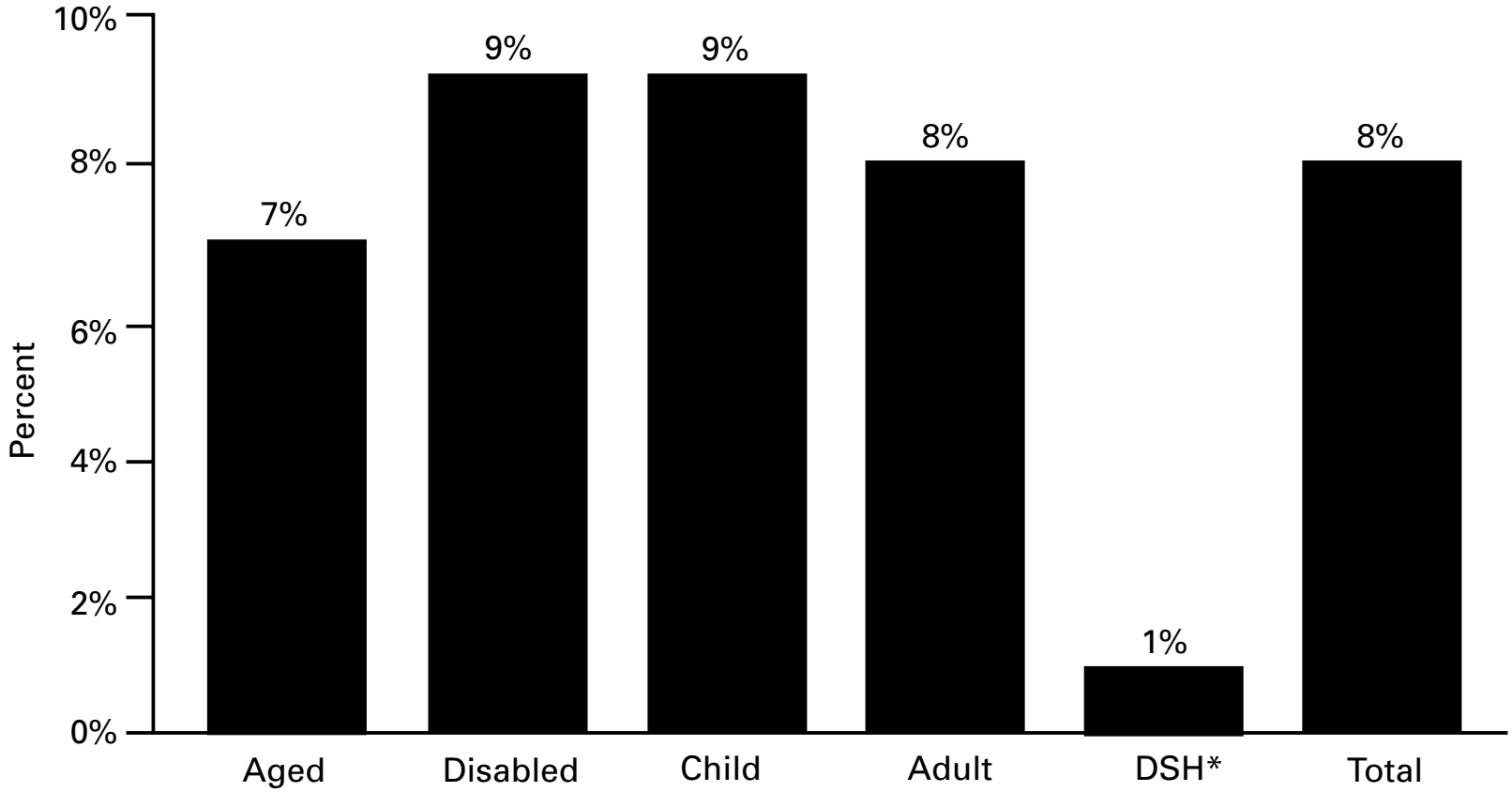


Note: (1) The projected increase in Medicaid expenditures can be explained by the following factors — case load accounts for about one-sixth of the increase, inflation one third, and the balance can be explained by spending-per-enrollee in excess of inflation; (2) data shown above are expressed in nominal terms.

Source: HCFA/Office of the Actuary, President's Fiscal Year 2001 baseline budget.

Figure 2.6 Projected Average Annual Expenditure Growth Rates, Fiscal Years 1998-2010

People with disabilities and children are projected to have the highest increase in Medicaid expenditures.



*DSH refers to Disproportionate Share Hospitals which receive higher Medicaid reimbursement than other hospitals because they treat a disproportionate share of low-income individuals.

Note: Data shown above are expressed in nominal terms.

Source: HCFA/Office of the Actuary, President's Fiscal Year 2001 baseline budget.

Figure 2.7 Federal Medical Assistance Percentage Matching Rates, by State, For Selected Fiscal Years

State	FY80-81	FY84-85	FY89	FY90	FY95	FY2000
Alabama	71.3%	72.1%	73.1%	73.2%	70.5%	69.57%
Alaska	50.0%	50.0%	50.0%	50.0%	50.0%	59.80%
Arizona	59.9%	61.2%	62.0%	61.0%	66.4%	65.92%
Arkansas	72.9%	73.7%	74.1%	74.6%	73.8%	72.85%
California	50.0%	50.0%	50.0%	50.0%	50.0%	51.67%
Colorado	53.2%	50.0%	50.0%	52.1%	53.1%	50.00%
Connecticut	50.0%	50.0%	50.0%	50.0%	50.0%	50.00%
Delaware	50.0%	50.0%	52.6%	50.0%	50.0%	50.00%
District of Columbia	50.0%	50.0%	50.0%	50.0%	50.0%	70.00%
Florida	58.9%	58.4%	55.2%	54.7%	56.3%	56.82%
Georgia	66.8%	67.4%	62.8%	62.1%	62.2%	59.88%
Hawaii	50.0%	50.0%	54.0%	54.5%	50.0%	51.01%
Idaho	65.7%	67.3%	72.7%	73.3%	70.1%	70.15%
Illinois	50.0%	50.0%	50.0%	50.0%	50.0%	50.00%
Indiana	57.3%	59.9%	63.7%	63.8%	63.0%	61.74%
Iowa	56.6%	55.2%	63.0%	62.5%	62.6%	63.06%
Kansas	53.5%	50.7%	54.9%	56.1%	58.9%	60.03%
Kentucky	68.1%	70.7%	72.9%	73.0%	69.6%	70.55%
Louisiana	68.8%	64.5%	71.1%	73.1%	72.7%	70.32%
Maine	69.5%	70.6%	66.7%	65.2%	63.3%	66.22%
Maryland	50.0%	50.0%	50.0%	50.0%	50.0%	50.00%
Massachusetts	51.8%	50.1%	50.0%	50.0%	50.0%	50.00%
Michigan	50.0%	50.7%	54.8%	54.5%	56.8%	55.11%
Minnesota	55.6%	52.7%	53.1%	52.7%	54.3%	51.48%
Mississippi	77.6%	77.6%	79.8%	80.2%	78.6%	76.80%

Source: HCFA/Office of the Actuary, Medicare and Medicaid Cost Estimates Group.

Figure 2.7 Federal Medical Assistance Percentage Matching Rates, by State, For Selected Fiscal Years *(continued)*

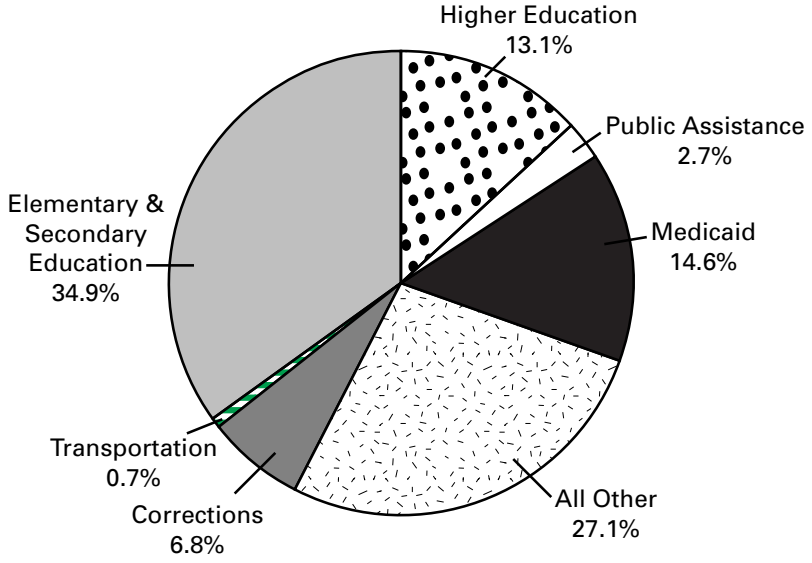
State	FY80-81	FY84-85	FY89	FY90	FY95	FY2000
Missouri	60.4%	61.4%	60.0%	59.2%	59.9%	60.51%
Montana	64.3%	64.4%	70.6%	71.4%	70.8%	72.30%
Nebraska	57.6%	57.1%	60.4%	61.1%	60.4%	60.88%
Nevada	50.0%	50.0%	50.0%	50.0%	50.0%	50.00%
New Hampshire	61.1%	59.5%	50.0%	50.0%	50.0%	50.00%
New Jersey	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
New Mexico	69.0%	69.4%	71.5%	72.3%	73.3%	73.32%
New York	50.0%	50.0%	50.0%	50.0%	50.0%	50.00%
North Carolina	67.6%	69.5%	68.0%	67.5%	64.7%	62.49%
North Dakota	61.4%	61.3%	66.5%	67.5%	68.7%	70.42%
Ohio	55.1%	55.4%	59.0%	59.6%	60.7%	58.67%
Oklahoma	63.6%	58.5%	66.1%	68.3%	70.1%	71.09%
Oregon	55.7%	57.1%	62.4%	63.0%	62.4%	59.96%
Pennsylvania	55.1%	56.0%	57.4%	56.9%	54.3%	53.82%
Rhode Island	57.8%	58.2%	55.9%	55.2%	55.5%	53.77%
South Carolina	71.0%	73.5%	73.1%	73.1%	70.7%	69.95%
South Dakota	68.8%	68.3%	71.0%	70.9%	68.1%	68.72%
Tennessee	69.4%	70.7%	70.2%	69.6%	66.5%	63.10%
Texas	58.4%	54.4%	59.0%	61.2%	63.3%	61.36%
Utah	68.1%	70.8%	73.9%	74.7%	73.5%	71.55%
Vermont	68.4%	69.4%	63.9%	62.8%	60.8%	62.24%
Virginia	56.5%	56.5%	51.2%	50.0%	50.0%	51.67%
Washington	50.0%	50.0%	53.1%	53.9%	52.0%	51.83%
West Virginia	67.4%	70.6%	76.1%	76.6%	74.6%	74.78%
Wisconsin	58.0%	56.9%	59.3%	59.3%	59.8%	58.78%
Wyoming	50.0%	50.0%	62.6%	66.0%	62.9%	64.04%

Source: HCFA/Office of the Actuary, Medicare and Medicaid Cost Estimates Group.

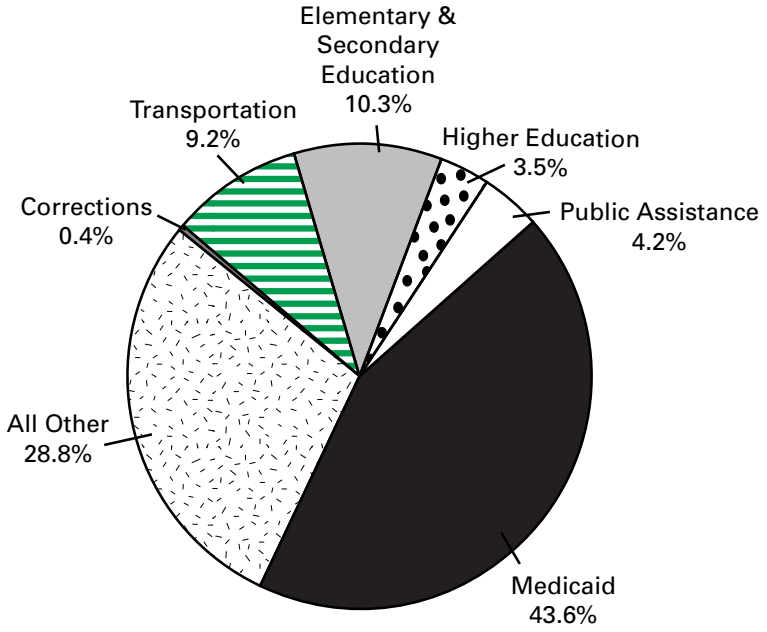
Figure 2.8 State Medicaid Spending Compared to Other Expenditures, By Fund Sources, Fiscal Year 1999

Over fourteen percent of state general funds and over forty-three percent of total federal funds provided to states were spent on Medicaid.

State Spending: General Funds

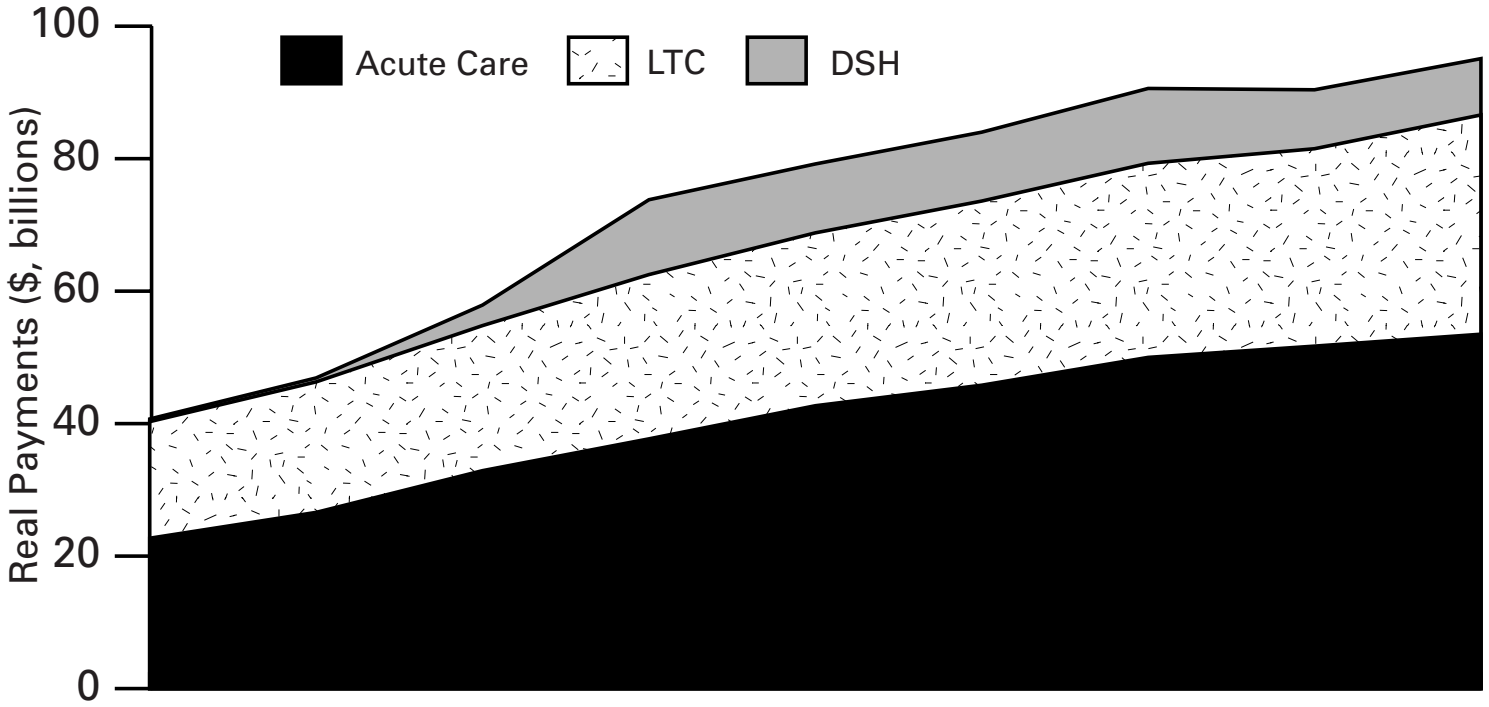


State Spending: Federal Funds Provided to States



Source: National Association of State Budget Officers, *1999 State Expenditure Report.*

Figure 2.9 Federal Medical Assistance Payments, by Category, Fiscal Years 1989-1998



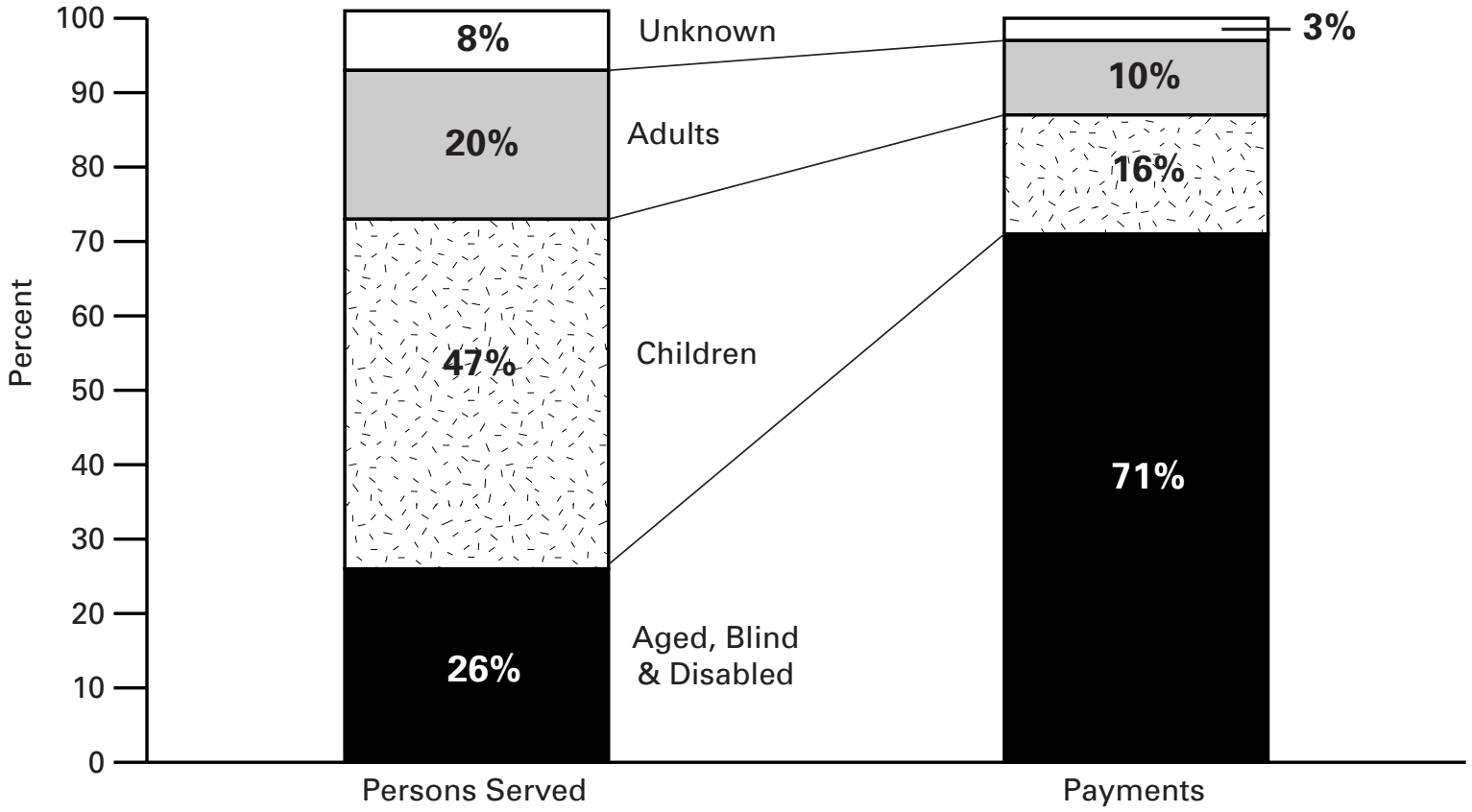
Fiscal Year ($, billions)	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Acute Care	$22.7	$26.6	$32.9	$37.7	$42.7	$45.8	$50.0	$51.7	$51.0	$53.5
LTC	17.6	19.7	21.9	24.8	26.1	27.8	29.3	29.8	31.9	33.1
DSH	0.4	0.6	3.1	11.3	10.4	10.4	11.3	8.9	9.1	8.5

Note: (1) LTC refers to Medicaid Long-Term Care spending; (2) DSH refers to Disproportionate Share Hospitals which receive higher Medicaid reimbursement than other hospitals because they treat a disproportionate share of low-income individuals; (3) the data shown above are expressed in 1998 dollars.

Source: HCFA/Office of the Actuary, Medicare and Medicaid Cost Estimates Group.

Figure 2.10 Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 1998

Payments for the elderly, blind and disabled account for 71 percent of total payments.

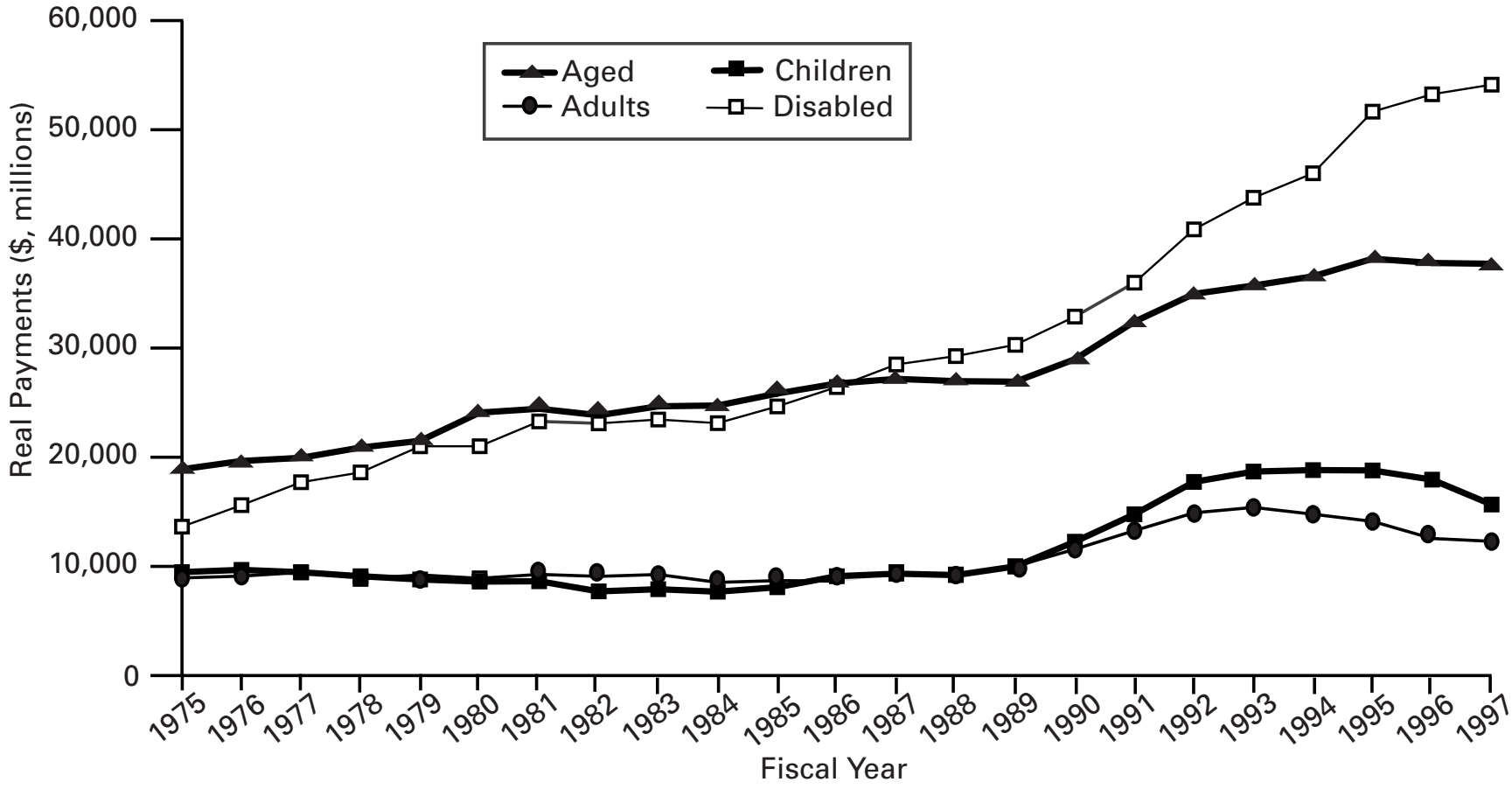


Note: (1) Totals may not equal 100% due to rounding; (2) "Payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare); (3) disabled children are included in the aged, blind & disabled category shown above.

Source: HCFA-2082.

Figure 2.11 Medicaid Payments, by Eligibility Group: Fiscal Years 1975-1997

Since 1992, there has been a dramatic growth in spending for the disabled.

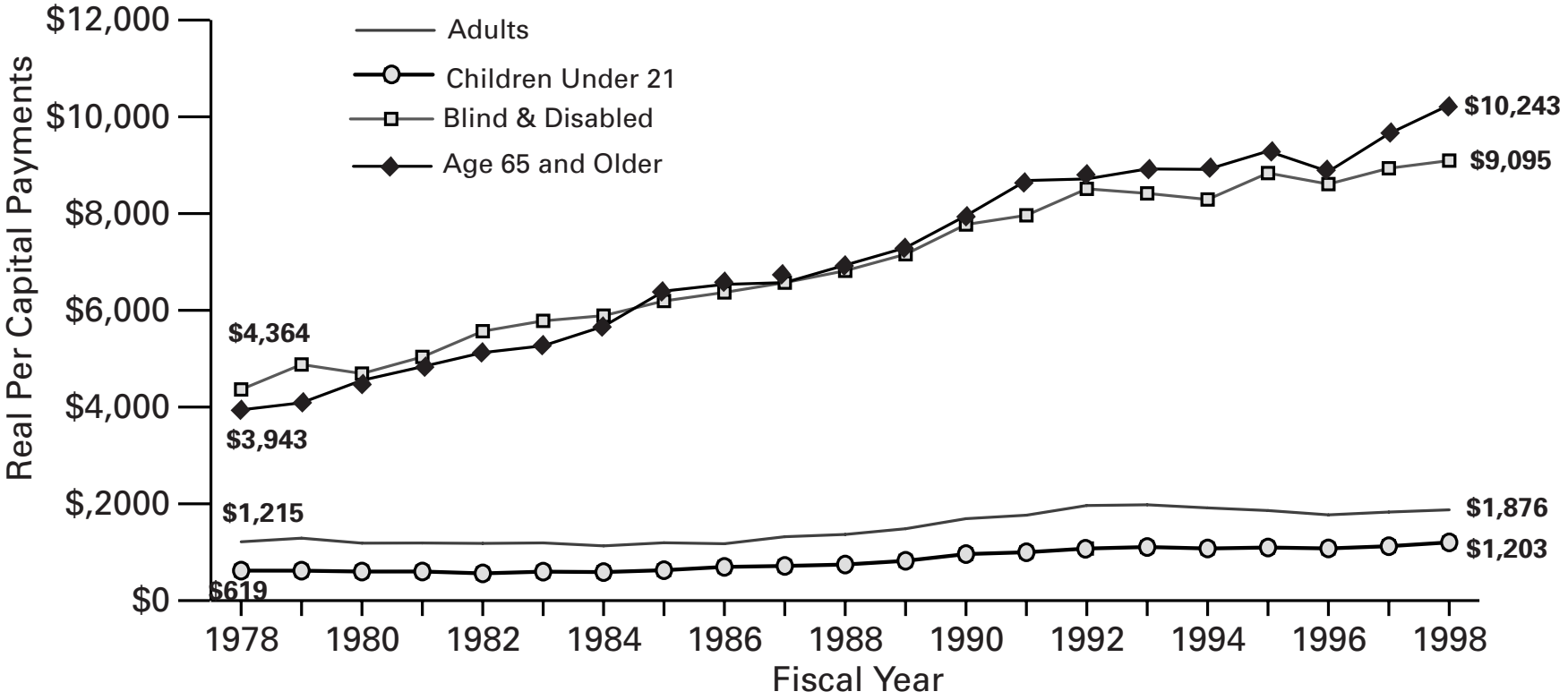


Note: Expenditures are expressed in 1997 dollars.

Source: HCFA Form 2082.

Figure 2.12 Average Real Medicaid Payments per Person Served, Fiscal Years 1978-1998

Per capita payments for the elderly, blind and individuals with disabilities more than doubled while per capita payments for children and adults had modest growth rates.

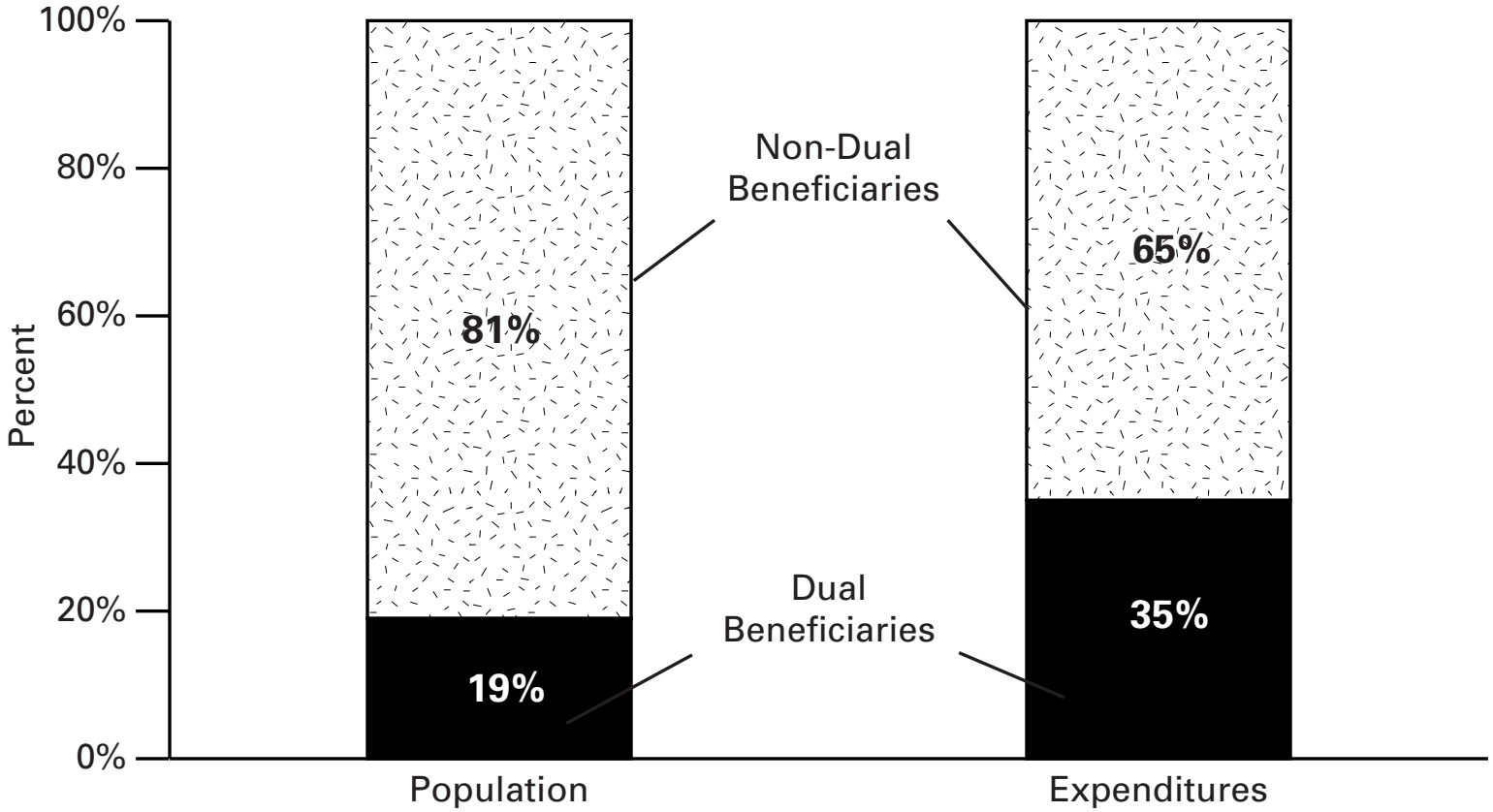


Note: (1) Data shown above are expressed in 1998 dollars; (2) for FY 1998 "payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare), while data from previous years only include direct vendor payments; (3) the term "adults" as used above refers to a category of non-elderly, non-disabled adults; (4) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

Figure 2.13 Medicaid Expenditures for Beneficiaries "Dually" Enrolled in Medicaid and Medicare, Fiscal Year 1997

The estimated 6.4 million dually enrolled beneficiaries in Medicaid and Medicare account for approximately 35 percent of total Medicaid spending in 1997.

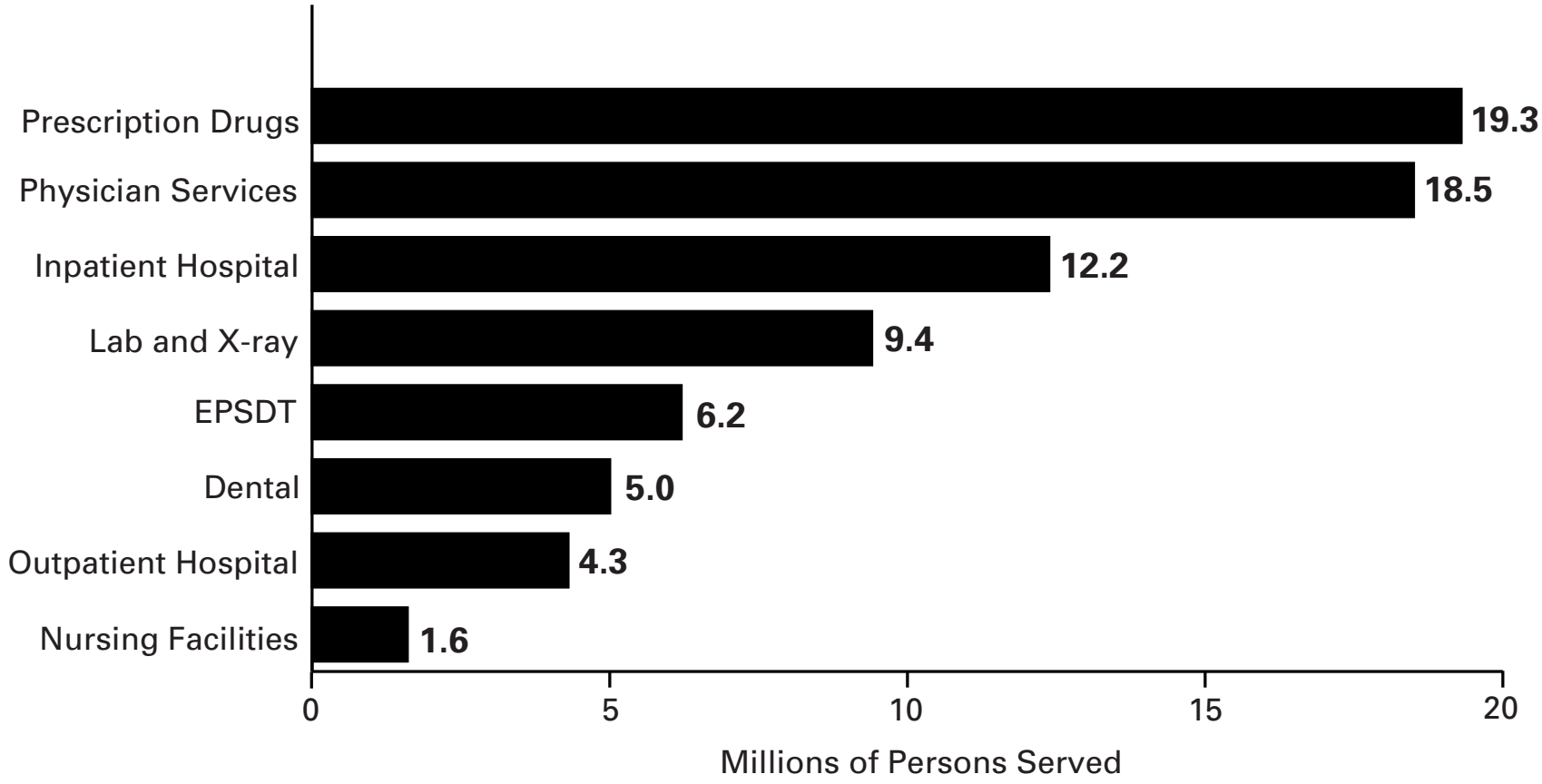


Note: Medicaid estimates are based on federal fiscal year 1997 Health Care Financing Administration 2082 reports actuarially adjusted to represent person years of enrollment and approximate the average monthly or April 1 enrollment.

Source: Clark, W.D. and Hulbert, M.M., "Research Issues: Dually Eligible Medicare and Medicaid Beneficiaries, Challenges and Opportunities," *Health Care Financing Review* Winter 1998, Volume 20, Number 2.

Figure 2.14 Utilization of Certain Medicaid Services, Fiscal Year 1998

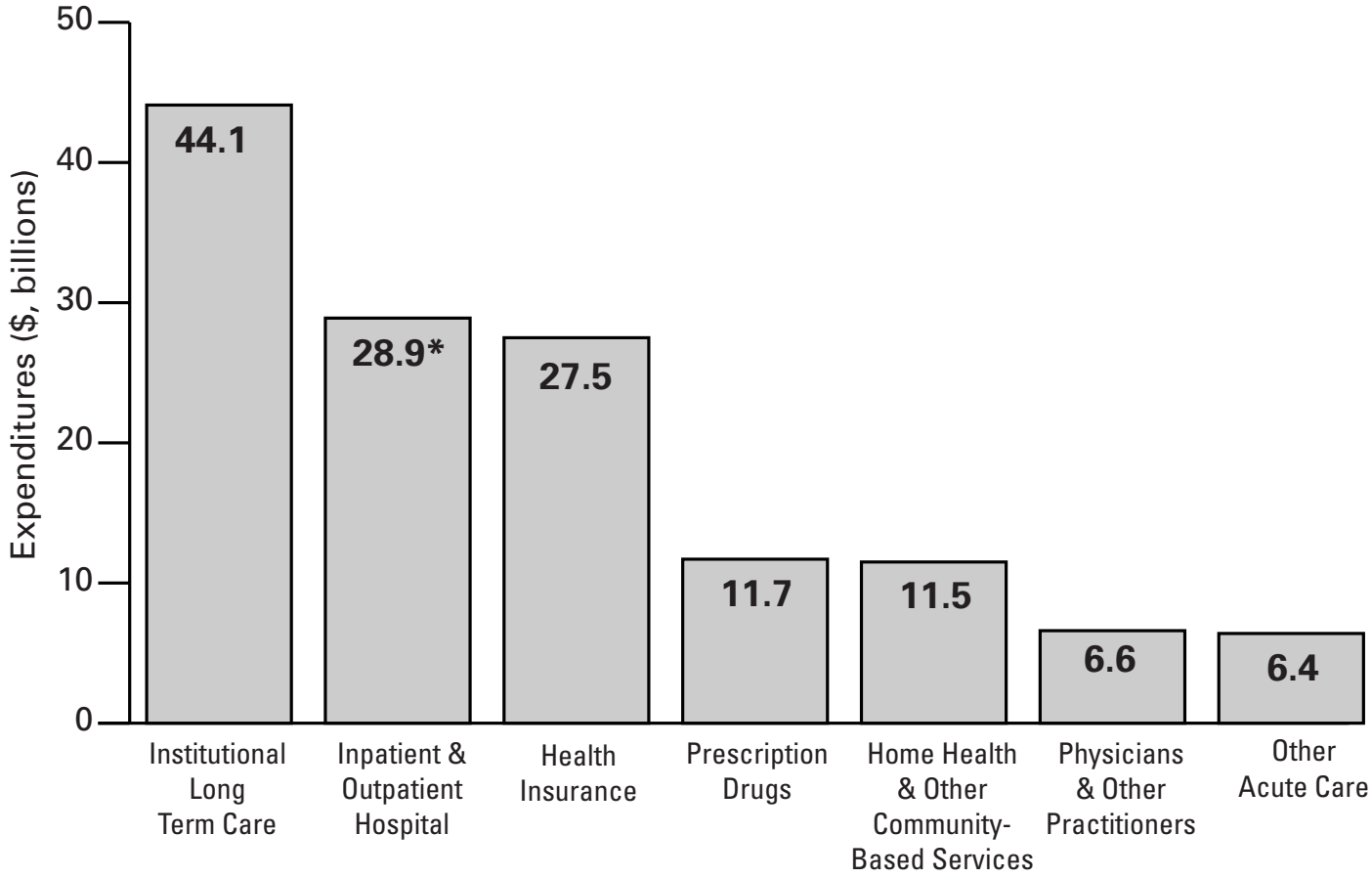
Prescription drugs were the most utilized Medicaid service in Fiscal Year 1998.



Note: The data cited above do not include beneficiaries receiving services from managed care organizations. Persons receiving services through Medicaid may be counted in more than one type of service. EPSDT refers to Early and Periodic Screening, Diagnosis, and Treatment services for individuals under the age of 21.

Source: HCFA Form 2082.

Figure 2.15 Total Medicaid Expenditures by Type of Service, Fiscal Year 1998



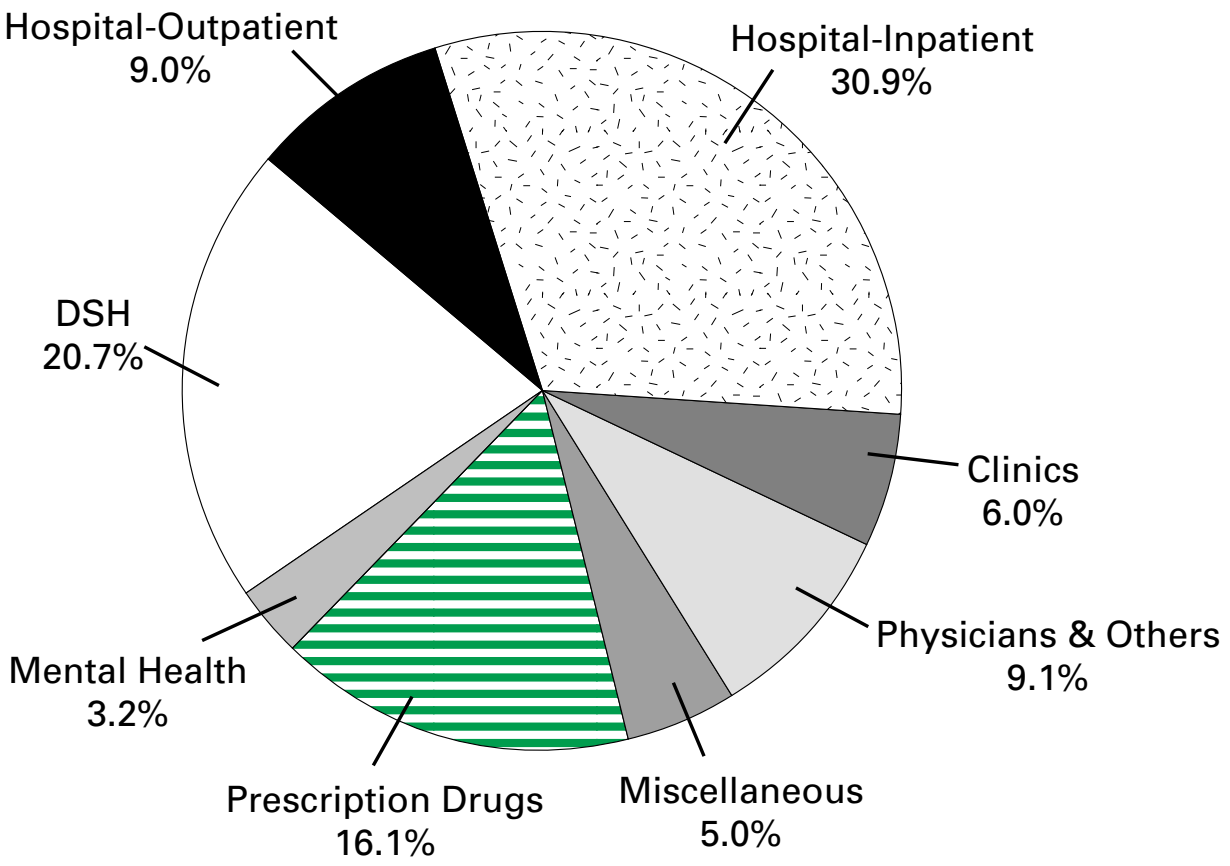
*DSH expenditures are not included; $22.4 billion inpatient hospital expenditures, $6.5 billion outpatient hospital expenditures.

Note: (1) "Health Insurance" refers to Medicaid program expenditures for Medicare premiums (on behalf of dual beneficiaries), as well as Medicaid premiums paid to primary care case management groups, HMOs and pre-paid health plans; (2) "Home Health & Other Community-Based Services" includes four categories found on the HCFA Form 64 (home health, personal care, home and community, and home and community-based disabled-elderly); (3) "Other Acute Care" includes clinics, Federally Qualified Health Centers, lab & x-ray and Early and Periodic Screening, Diagnosis and Treatment services.

Source: HCFA Form 64, total computable expenditures.

Figure 2.16 Medicaid Acute Care Expenditures, Fiscal Year 1998

Hospitals and DSH account for the majority of acute care spending.



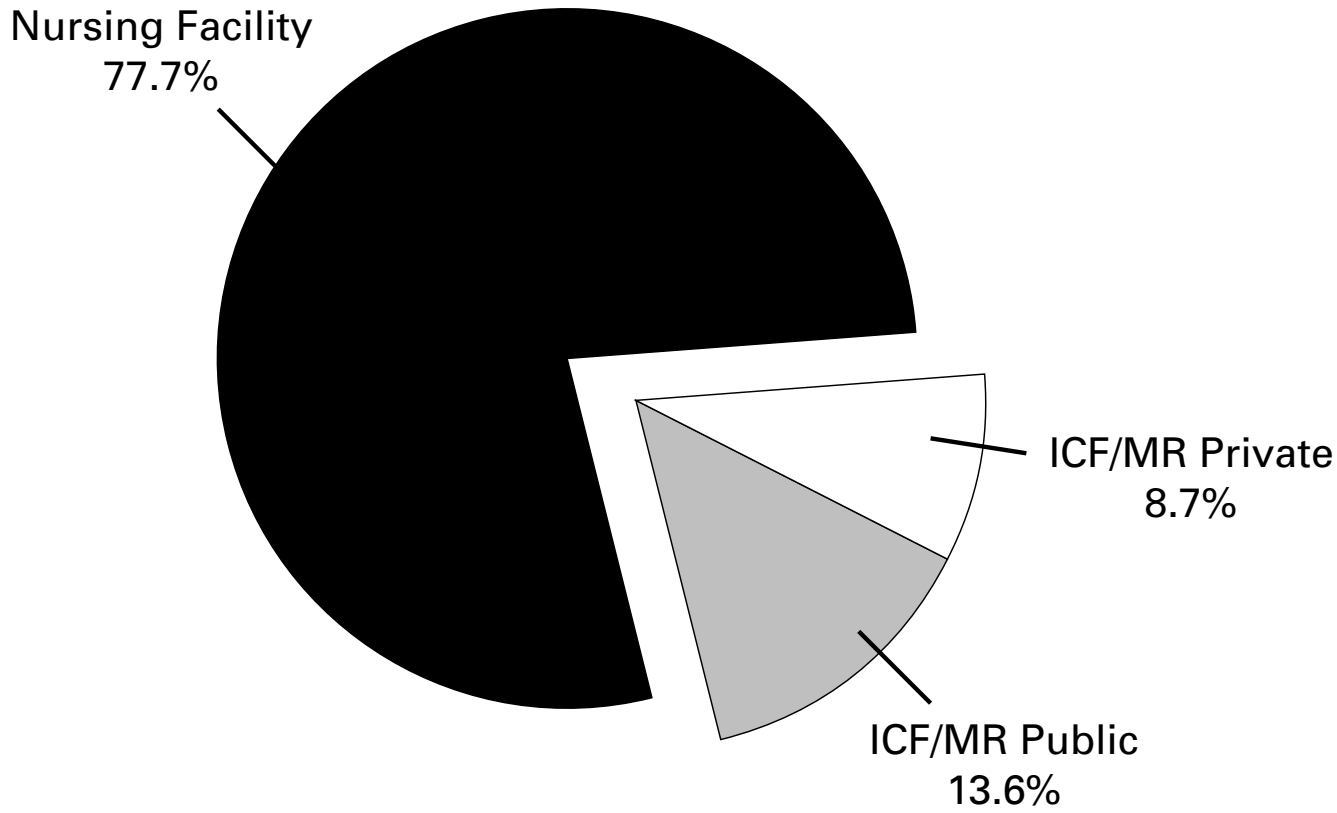
1998 Total Acute Care Expenditures = $65.8 billion

Note: (1) The data presented above describe fee-for-service spending; (2) the category labeled "prescription drugs" represents net expenditures, after accounting for drug rebates; (3) the category labeled "miscellaneous" includes Federally Qualified Health Center services, Early and Periodic Screening, Diagnosis and Treatment services and targeted case management services.

Source: HCFA Form 64, total computable expenditures.

Figure 2.17 Medicaid Institutional Long-Term Care Expenditures, Fiscal Year 1998

Nursing homes account for the majority of Medicaid institutional long-term care spending.



Note: ICF/MR refers to Intermediate Care Facility for the Mentally Retarded.

Source: HCFA Form 64.

Figure 2.18 State-by-State Comparisons of Medicaid Expenditures, Fiscal Year 1998

	Medicaid Expenditures	Federal Medical Assistance Percentage (FMAP)	Medicaid DSH Payments	Average $ Payment per Person Served	Average $ Payment per Person Served (w/out DSH)
All Jurisdictions	$175,065,785,063	57%	$14,961,830,000	$4,307	$3,939
Alabama	2,386,960,623	69.3%	393,725,550	4,529	3,782
Alaska	404,349,539	59.8%	15,359,184	5,427	5,221
Arizona	1,995,647,195	65.3%	123,400,100	3,931	3,688
Arkansas	1,503,143,348	72.8%	1,656,113	3,539	3,535
California	16,900,135,806	51.2%	2,450,659,581	2,386	2,040
Colorado	1,655,158,031	52.0%	139,080,856	4,799	4,395
Connecticut	2,984,090,391	50.0%	370,130,367	7,828	6,857
Delaware	450,384,207	50.0%	8,000,000	4,440	4,361
District of Columbia	776,545,565	70.0%	32,857,143	4,674	4,476
Florida	6,869,451,090	55.7%	370,501,877	3,607	3,412
Georgia	3,845,448,072	60.8%	409,567,607	3,147	2,812
Hawaii	624,947,036	50.0%	0	3,385	3,385
Idaho	505,050,782	69.6%	2,150,130	4,100	4,083
Illinois	6,693,269,901	61.4%	196,878,426	4,435	4,111
Indiana	1,516,260,653	63.8%	19,837,645	4,815	4,752
Iowa	7,050,809,934	50.0%	269,569,794	5,170	4,972
Kansas	1,131,055,936	59.7%	45,012,596	4,675	4,489
Kentucky	2,696,929,368	70.4%	194,685,201	4,185	3,883
Louisiana	3,298,850,530	70.0%	738,261,750	4,578	3,553
Maine	1,160,312,323	66.0%	122,431,837	6,807	6,089

Sources: FY 1998 HCFA Form 64, and FY 1998 HCFA Form 2082.

Figure 2.18 State-by-State Comparisons of Medicaid Expenditures, Fiscal Year1998 *(continued)*

	Medicaid Expenditures	Federal Medical Assistance Percentage (FMAP)	Medicaid DSH Payments	Average $ Payment per Person Served	Average $ Payment per Person Served (w/out DSH)
Maryland	2,858,399,994	50.0%	135,983,963	5,094	4,852
Massachusetts	6,240,026,597	50.0%	497,279,716	6,870	6,323
Michigan	6,124,381,104	53.6%	319,344,308	4,494	4,259
Minnesota	3,133,340,561	52.1%	56,255,876	5,820	5,715
Mississippi	1,748,939,562	77.1%	183,879,961	3,600	3,222
Missouri	3,441,932,848	60.7%	666,056,976	4,689	3,782
Montana	429,924,141	70.6%	220,049	4,267	4,265
Nebraska	897,652,159	61.2%	5,922,068	4,250	4,222
Nevada	557,205,936	50.0%	73,559,997	4,348	3,774
New Hampshire	898,041,296	50.0%	128,411,171	8,493	7,126
New Jersey	6,675,476,319	50.0%	1,020,399,407	6,856	5,601
New Mexico	1,077,359,070	72.6%	9,407,934	3,270	3,242
New York	27,539,936,152	50.0%	1,860,442,452	8,961	8,356
North Carolina	4,872,406,054	63.1%	354,104,750	4,172	3,868
North Dakota	356,138,657	70.4%	1,194,829	5,718	5,699
Ohio	6,900,675,153	58.1%	657,034,743	5,346	4,837
Oklahoma	1,458,029,874	70.5%	22,722,398	4,257	4,191
Oregon	1,866,822,080	61.5%	27,047,133	3,652	3,599
Pennsylvania	8,846,726,699	53.4%	546,328,751	5,808	5,450
Puerto Rico	334,000,000	50.0%	0	346	346

Sources: FY 1998 HCFA Form 64, and FY 1998 HCFA Form 2082.

Figure 2.18 State-by-State Comparisons of Medicaid Expenditures, Fiscal Year1998 *(continued)*

	Medicaid Expenditures	Federal Medical Assistance Percentage (FMAP)	Medicaid DSH Payments	Average $ Payment per Person Served	Average $ Payment per Person Served (w/out DSH)
Rhode Island	1,011,108,624	53.2%	55,985,976	6,603	6,237
South Carolina	2,429,333,787	70.2%	445,678,485	4,083	3,334
South Dakota	371,532,790	67.8%	1,074,213	4,149	4,137
Tennessee	3,826,379,693	63.4%	0	2,075	2,075
Texas	10,272,990,955	62.3%	1,438,878,261	4,419	3,800
Utah	740,413,343	72.6%	4,133,372	3,431	3,412
Vermont	434,561,127	62.2%	22,260,838	3,505	3,325
Virgin Islands	10,381,533	50.0%	0	525	525
Virginia	2,443,379,308	51.5%	160,677,775	3,740	3,494
Washington	3,622,166,158	52.2%	332,814,161	2,563	2,328
West Virginia	1,328,062,888	73.7%	21,883,410	3,876	3,812
Wisconsin	2,830,114,783	58.8%	11,177,687	5,457	5,436
Wyoming	213,767,800	63.0%	122,769	4,635	4,632

Note: (1) The Medicaid Expenditures cited above are fiscal year 1998 total computable current expenditures (including administrative costs) from the HCFA Form 64; (2) DSH refers to Disproportionate Share Hospitals which receive higher Medicaid reimbursement than other hospitals because they treat a disproportionate share of Medicaid patients.

Sources: FY 1998 HCFA Form 64, and FY 1998 HCFA Form 2082.

Medicaid Managed Care

SECTION IV

Medicaid Managed Care

One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery method. Medicaid's premium payments to Medicaid managed care plans rose from $700 million in 1988 to $13.2 billion in 1998. State interest in pursuing Medicaid managed care initiatives began in the early 1980's when a combination of rising Medicaid costs and the national recession put pressure on states to control spending growth.

Since then, states have continued to experiment with various managed care approaches in their efforts to reduce unnecessary utilization, contain costs, improve access to services, and achieve greater coordination and continuity of care.

- Throughout the 1990's states significantly expanded enrollment in Medicaid managed care programs. In 1991, less than 10 percent of all Medicaid enrollees were covered under managed care plans. By 1998, nearly 54 percent (16.5 million) of the Medicaid population was enrolled in some type of managed care plan. These numbers include those in plans that are not at full risk or that provide less than a full range of health care services. **(Figure 3.1)**

- Although Medicaid managed care enrollment has grown rapidly in the aggregate, wide variation in penetration rates exists among the states. Two states have no managed care enrollment (Alaska and Wyoming), while twelve states have penetration rates over 75 percent (Arizona, Colorado, Delaware, Georgia, Hawaii, Iowa, Montana, New Mexico, Oregon, Tennessee, Utah and Washington). The contrasts can even be observed between neighboring states such as North Carolina and South Carolina. During 1998, South Carolina served only 4 percent of its Medicaid population through managed care while North Carolina had a 69 percent managed care penetration rate. **(Figure 3.2)**

- In 1998, Medicaid managed care contractors included 283 comprehensive HMO plans, 136 Medicaid-only HMO plans, 91 prepaid health plans (PHPs) and 58 primary care case management plans (PCCMs). Individuals can be enrolled in more than one type of plan. The most common type of plan used in Medicaid managed care delivery systems is the health maintenance organization (HMOs). In 1998, over half of all Medicaid managed care enrollees were enrolled in HMO/Health Insuring Organization (HIO) type plans.[20] **(Figure 3.3)**

- Most state Medicaid managed care enrollment consists of children and non-disabled adults. In 1998, individuals under the age of 21 represented over 55 percent of all Medicaid managed care enrollees, while adults age 21 to 64 represented less than 29 percent of total managed care enrollment. **(Figure 3.4)**

The elderly and individuals with disabilities have not yet been enrolled in large numbers in managed care. The inherent challenge of controlling costs and delivering comprehensive services to these high need populations have deterred states as yet from mandatorily enrolling these populations in risk-based plans. In addition, for individuals who are dually enrolled in both Medicare and Medicaid,

[20] The Medicaid Program defines MCOs in the following manner.

- A Health Insuring Organization (HIO) is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.
- A Heath Maintenance Organization (HMO) is a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services.
- A Prepaid Health Plan (PHP) is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.
- Primary Care Case Management (PCCM) is a program where the state contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid beneficiaries under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to reimbursing services on a fee-for-service (FFS) basis.

Medicare is the primary payer for covered services. Several states, however, have started to move non-elderly, disabled Medicaid enrollees into managed care. In 1998, roughly 1.6 million persons with disabilities were enrolled in Medicaid managed care programs operated by 36 different states.[21]

Managed Care Waivers

Medicaid program waivers play a significant role in the delivery of Medicaid services. Waivers allow states to test innovative approaches to certain program aspects such as benefit design and service delivery. The two primary mechanisms used for this experimentation are Section 1915(b) "Freedom of Choice" waivers and Section 1115 Research and Demonstration Projects.

- Section 1915(b) "Freedom of Choice" waivers are used to mandatorily enroll beneficiaries in managed care programs; provide additional services via savings produced from managed care; create a "carveout" delivery system for specialty care (e.g., behavioral health, etc.); and/or create programs that are not available statewide. During Fiscal Year 1998, 35 states and the District of Columbia operated 84 Section 1915(b) waivers. **(Figure 3.5)**

- Section 1115 Research and Demonstration Projects provide states with the flexibility to test substantially new ideas with potential policy merit. Under 1115 demonstrations, states are permitted to test programs that range from small-scale pilot projects testing new benefits or financing mechanisms, to major restructuring of state Medicaid programs. In 1998, 17 states operated statewide, comprehensive Section 1115 demonstrations. **(Figure 3.6)**

[21] Marsha Regenstein and Christy Schroer, Medicaid Managed Care for Persons with Disabilities:State Profiles, Economic and Social Research Institute/Kaiser Commission on Medicaid and the Uninsured, December 1998.

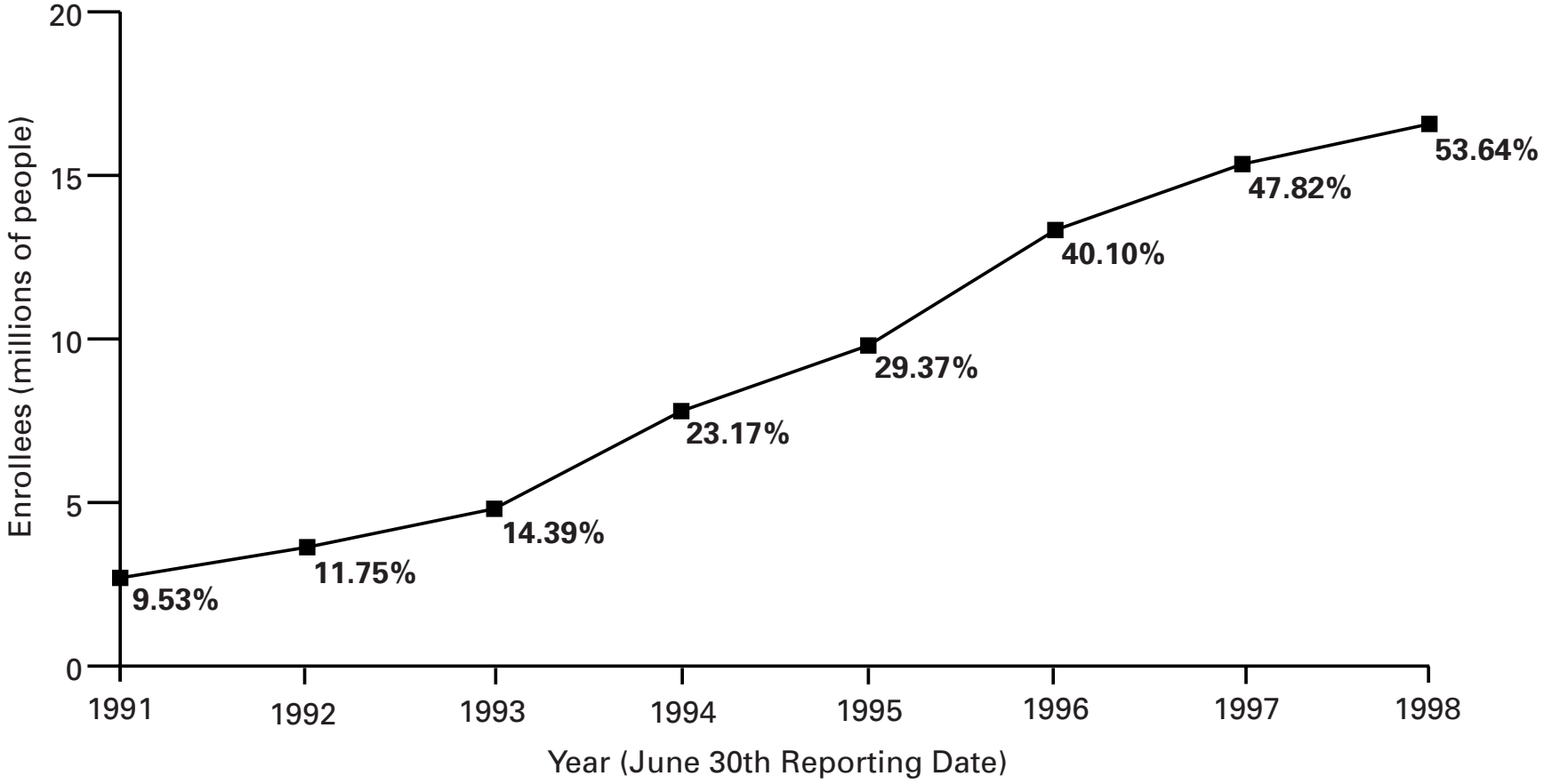
Long-Term Care

States are increasingly interested in providing long-term care services in a managed care environment. In addition to providing traditional long-term care services (e.g., home health, personal care, institutional services, etc.), states are interested in providing non-traditional home and community-based services (e.g., homemaker services, adult day care, respite care, etc.) in their managed care programs as well. To achieve this, some states simultaneously utilize authorities under 1915(b) and 1915(c) to limit freedom of choice and provide home and community-based services.

The states of Texas and Michigan are two prominent examples of states operating these concurrent waivers. The Texas STAR+PLUS program serves disabled and elderly beneficiaries in Harris County (Houston) by integrating acute and long-term care services through a managed care delivery system consisting of three MCO's and a primary care case management system. Michigan's program carves out specialty mental health, substance abuse and developmental disabilities services and supports, and provides these services under a prepaid shared risk arrangement.

Figure 3.1 Number and Percent of Medicaid Beneficiaries Enrolled in Managed Care During the 1990s

By 1998 over 50 percent of Medicaid beneficiaries were enrolled in managed care health plans.

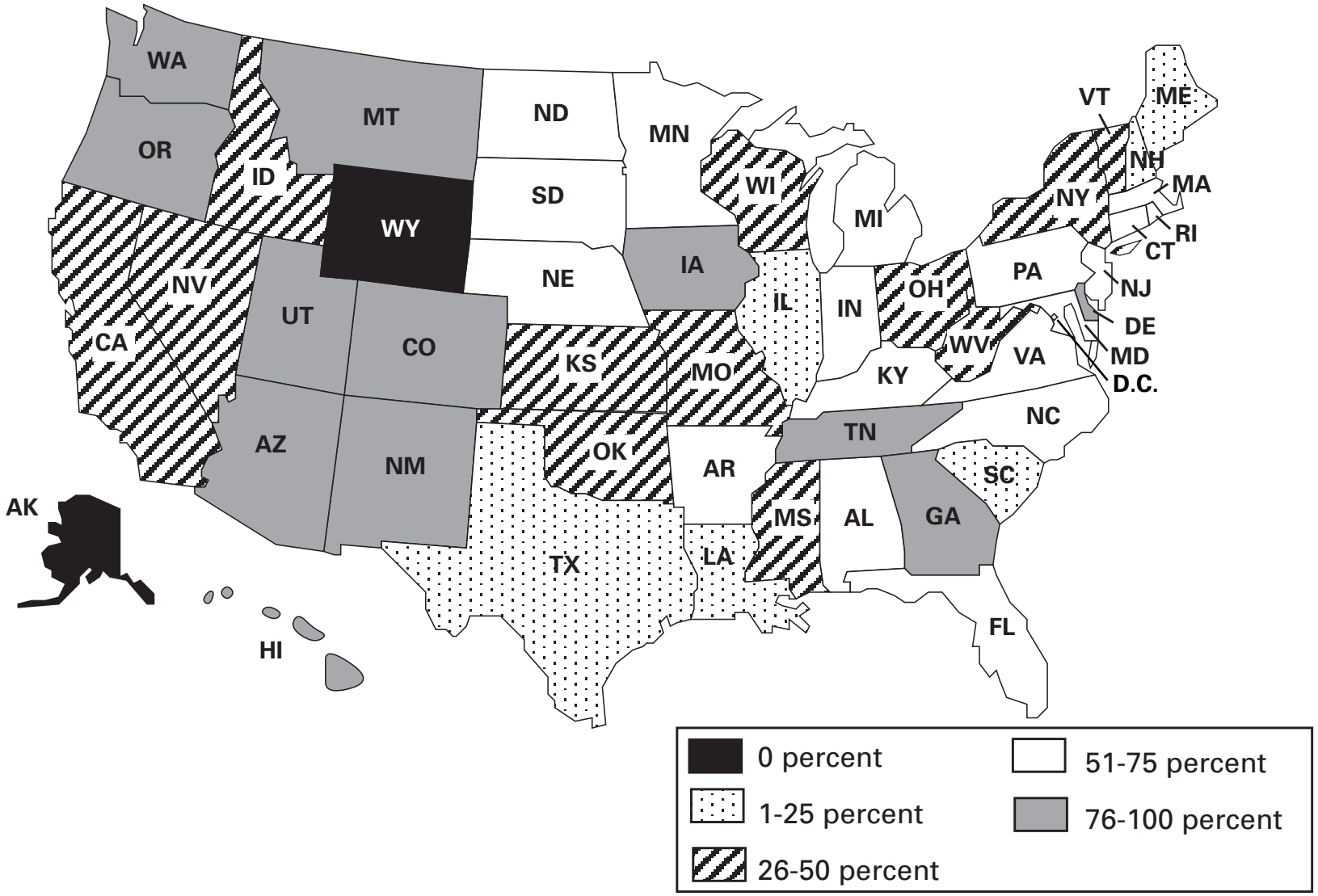


Note: State reported managed care data prior to 1996 may include duplicated enrollment.

Source: HCFA/Center for Medicaid & State Operations, Medicaid Managed Care Enrollment Report.

Figure 3.2 Medicaid Managed Care Penetration, 1998

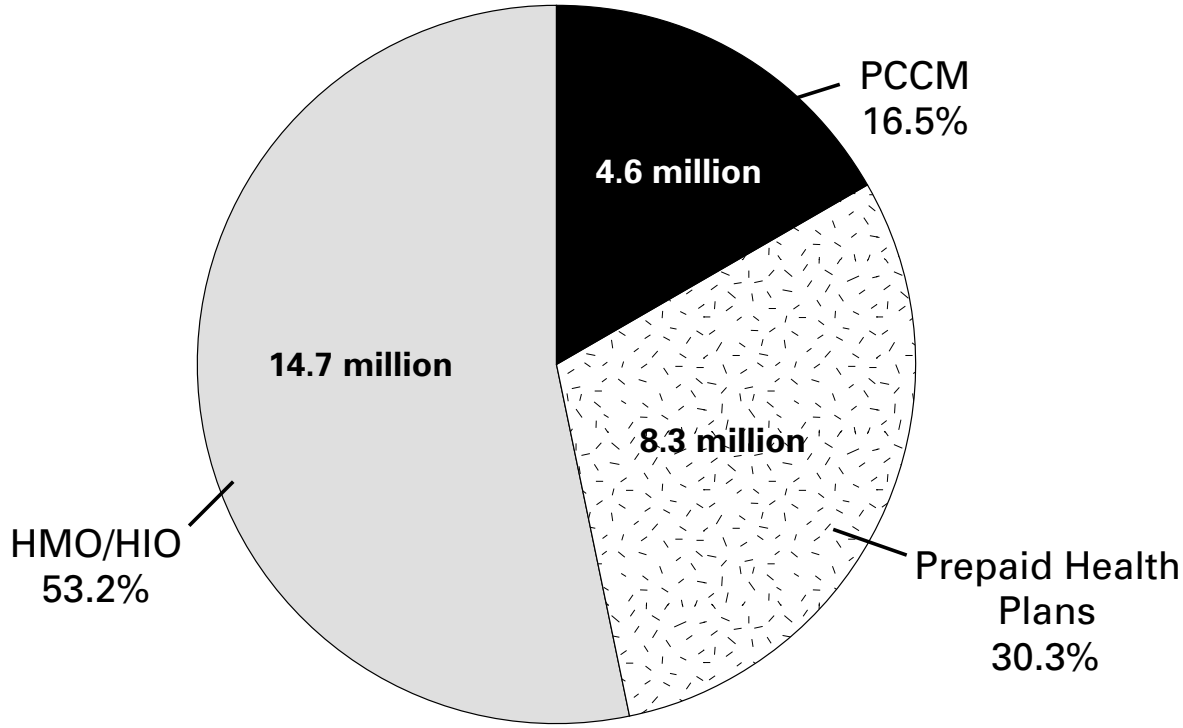
Most states have more than 25 percent of their Medicaid population in managed care.



Source: HCFA/Center for Medicaid & State Operations Medicaid Managed Care Report.

Figure 3.3 Medicaid Managed Care Enrollment Distribution by Type of Plan, Fiscal Year 1998

Over half of all Medicaid managed care enrollees are in HMO/HIO type plans.

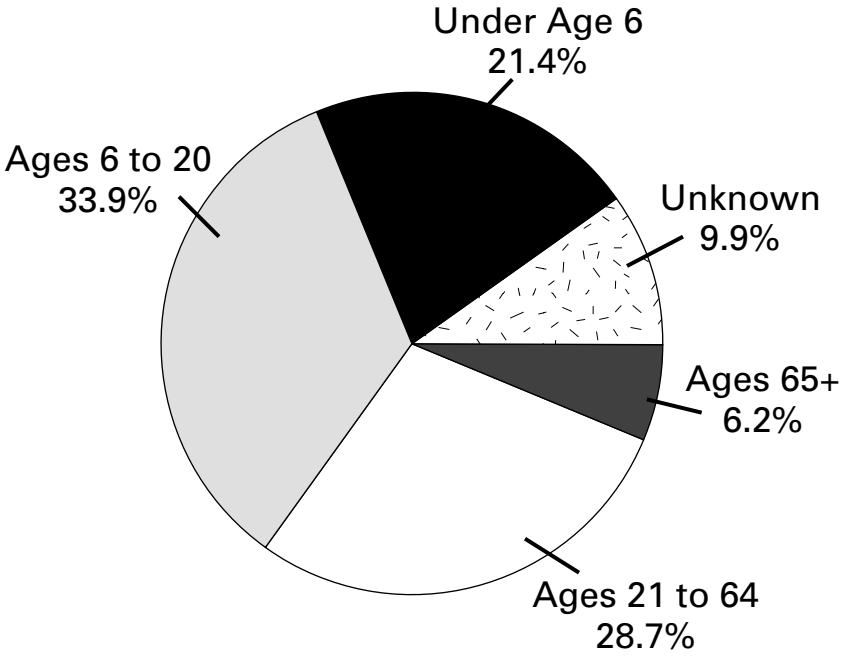


Note: (1) Some managed care enrollees are enrolled in more than one plan (e.g., an HMO and a prepaid health plan); (2) a Health Maintenance Organization (HMO) is a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services; a Health Insuring Organization (HIO) is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services; (3) a Prepaid Health Plan is an entity providing less than comprehensive services on an at-risk basis or one that provides any benefit package on a non-risk basis; (4) Primary Care Case Management (PCCM) groups contract to locate, coordinate, and monitor covered primary care.

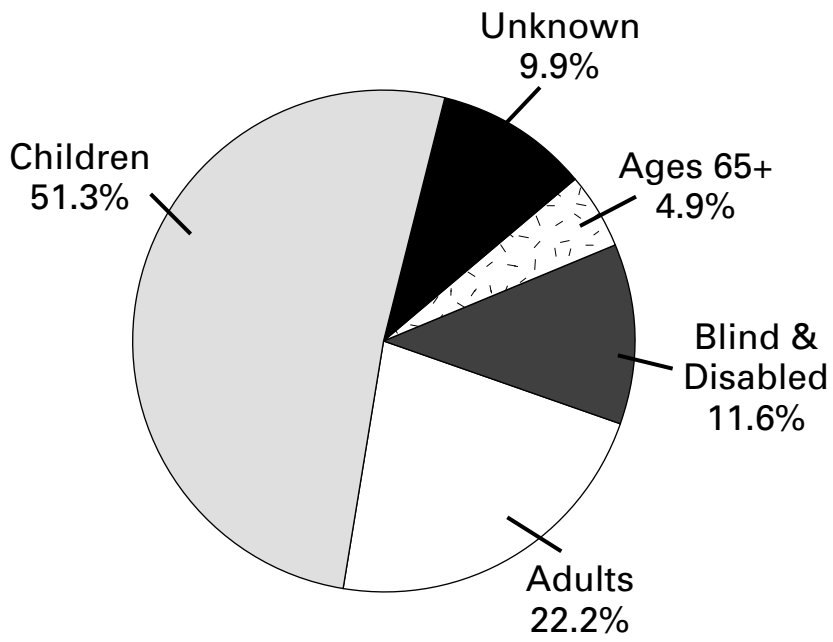
Source: HCFA Form 2082.

Figure 3.4 Medicaid Managed Care Enrollment, by Age & Basis of Eligibility, Fiscal Year 1998

Children and non-disabled, non-elderly adults are an overwhelming majority of Medicaid managed care enrollees.



Age Group



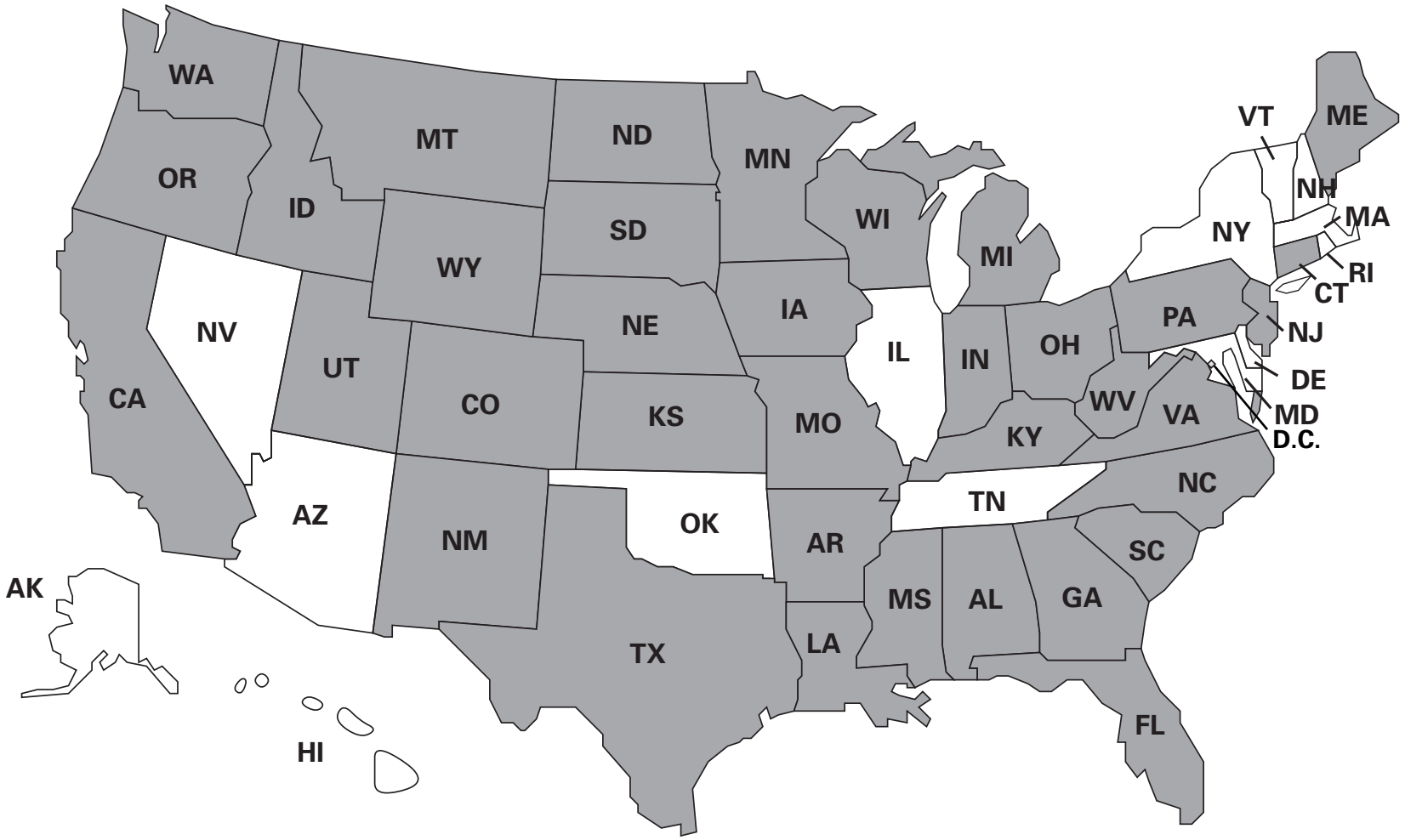
Basis of Eligibility

Note: Data includes only enrollees served by HMOs, HIOs and pre-paid health plans; it does not include primary care case management enrollees. Percentages may not sum to 100 due to rounding. Disabled children are included in the blind and disabled eligibility category.

Source: HCFA Form 2082.

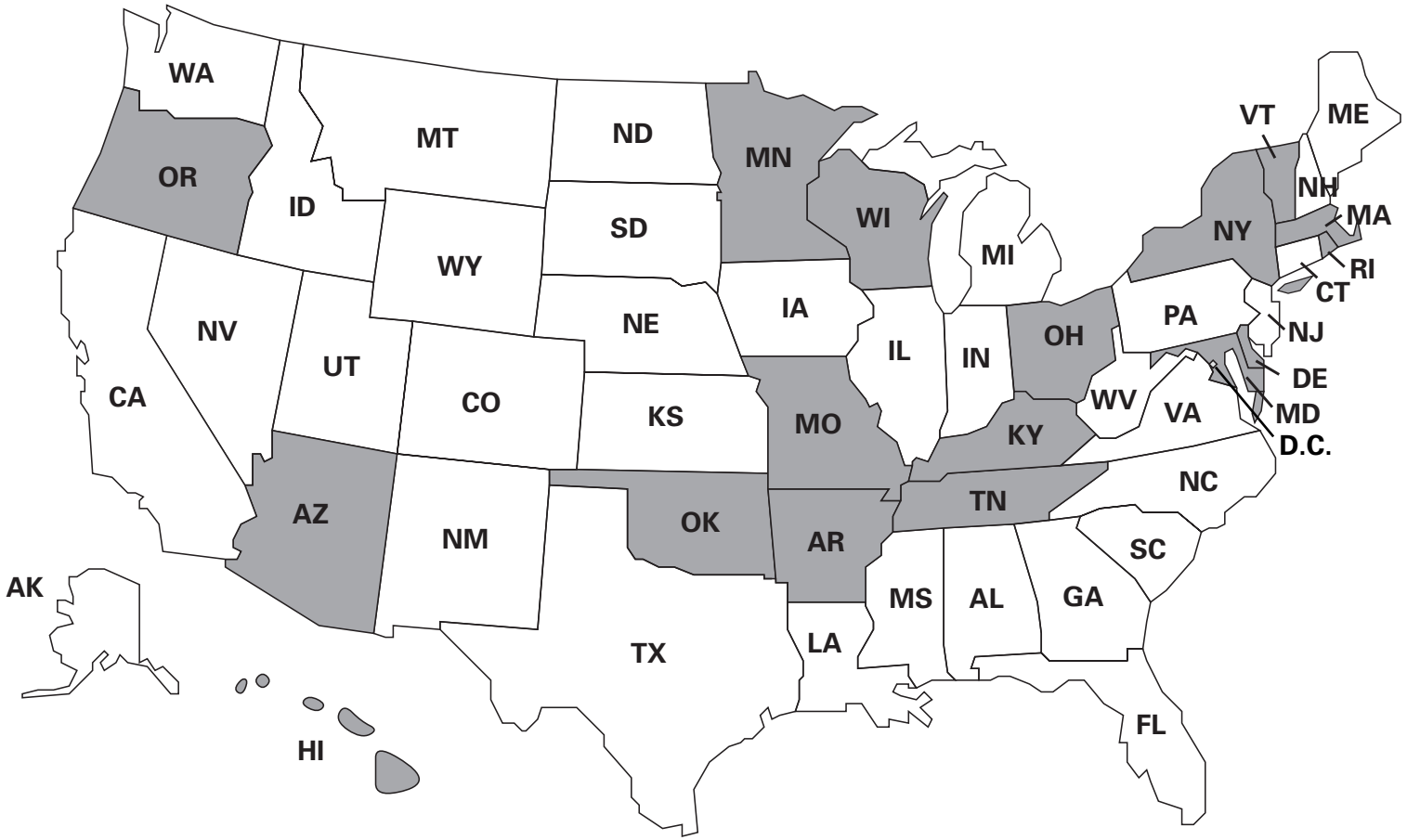
Figure 3.5 Medicaid 1915(b) Waivers in Fiscal Year 1998

Thirty five states and the District of Columbia operate 84 managed care waivers.



Source: Center for Medicaid and State Operations/HCFA.

Figure 3.6 Statewide, Comprehensive Section 1115 Waivers Operating in Fiscal Year 1998



Section 1115 Waivers **17** AR, AZ, DE, HI, KY, MA, MD, MN, MO, NY, OH, OK, OR, RI, TN, VT, WI.

Note: Additional states (AL and CA) have comprehensive demonstrations that are not statewide.

Source: Center for Medicaid and State Operations/HCFA.

The Elderly and Individuals with Disabilities

SECTION V

The Elderly and Individuals with Disabilities

Elderly

Since the 1970's, elderly Americans have experienced an increase in wealth. This has resulted in a decline in the proportion of the 65 and older population enrolled in Medicaid. In 1975, Medicaid enrolled 3.6 million older Americans, roughly 17 percent of the 21.7 million Americans age 65 and older. In 1998, Medicaid enrolled nearly 4 million elderly individuals, or 12 percent of the 32.4 million population age 65 and older.

- Medicaid beneficiaries age 65 and over (65+) account for a disproportionate share of total Medicaid expenditures. This is due to the high cost of services utilized by this population (e.g., long-term care services) and not the size of the population. In 1998, elderly beneficiaries represented 11 percent of total Medicaid beneficiaries[22], yet they accounted for 31 percent of total Medicaid expenditures. **(Figure 4.1)**

- The number of Medicaid beneficiaries age 65 and older has grown only slightly over time. In addition, growth in the number of elderly Medicaid beneficiaries has been much lower (11 percent from 1975 to 1998) compared to the increase (50 percent) in the elderly U.S. population as a whole. **(Figure 4.2)**

- The elderly as a proportion of all Medicaid beneficiaries has declined over time. In 1973, the population age 65 and older represented 19 percent of all Medicaid beneficiaries. In 1998, the same population represented 11 percent of the total Medicaid population. **(See Figure 1.9)**

Individuals with Disabilities

People with disabilities are the fastest growing Medicaid eligibility group. Medicaid provided services to 6.6 million individuals with disabilities in FY 1998.

- The proportion of Medicaid enrollees with disabilities has increased over time. In 1973, the blind and disabled represented 11 percent of the total Medicaid population. By 1998, the blind and disabled represented 18 percent of the total Medicaid population. **(See Figure 1.9)**

- In terms of provider payments, growth in expenditures for the blind and disabled outpaced other eligibility groups. In 1978, blind and disabled persons served through Medicaid represented 32 percent of total provider payments. By 1998, the blind and individuals with disabilities accounted for almost 44 percent of total provider payments. **(Figure 4.3)**

There are many factors contributing to the growth of this eligibility group and expenditures during this time period. One contributing factor is Acquired Immune Deficiency Syndrome (AIDS). Medicaid is the largest single payer of direct medical services for persons living with AIDS. Medicaid serves over 50 percent of all persons living with AIDS and up to 90 percent of all children with AIDS.[23] HCFA estimates combined federal and state Medicaid expenditures for beneficiaries with AIDS will be $4.1 billion for Fiscal Year 2000.

[22] HCFA 2082 data presents classification of individuals according to their original basis of eligibility; the blind and disabled includes individuals age 65 and over.

[23] Department of Health and Human Services, Health Care Financing Administration's Center for Medicaid and State Operations, Fact Sheet. "Medicaid and Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection," April 2000.

Institutional Long-Term Care Services

Medicaid is the primary source of long-term care coverage for the elderly and people with disabilities, including middle income individuals who spend down their financial resources. Medicaid covers skilled nursing facility care, intermediate care facilities for the mentally retarded, home health care, and home and community-based services.

- Medicaid's role as primary insurer for long-term care has grown significantly. In 1968, Medicaid accounted for 24 percent of total nursing home care expenditures. In 1998, total Medicaid expenditures (state plus federal expenditures) for nursing facility services were $40.6 billion. This accounts for almost half (46 percent) of all U.S. spending on nursing home care. **(Figure 4.4)**

The magnitude of Medicaid's nursing facility expenditures reflects the high cost of these services as well as the limited coverage under Medicare and private insurance. Nursing facility expenditures also drive the distribution of Medicaid spending across enrollee groups with the elderly and disabled populations receiving the largest share of Medicaid expenditures.

Home and Community-Based Services

Although most long-term care spending is for institutional care, Medicaid has made great strides in shifting the delivery of services to home and community-based settings.

Medicaid's home and community-based services waiver program (i.e., "1915(c) waivers") affords states the flexibility to develop and implement creative alternatives to institutionalization. States have the flexibility to design a waiver program and select the mix of services including certain nonmedical, social and supportive services such as homemaker services, adult day care services, etc. to best meet the needs of the population they want to serve in the home or community.

- States are using these programs to provide services to diverse groups of enrollees, many of whom would be institutionalized without these waivers including the elderly, individuals with physical and developmental disabilities, those with chronic mental illness, mental retardation, and persons with AIDS. During Fiscal Year 1998, home and community-based waivers served over 467,000 beneficiaries. As of April 1999, 240 1915(c) waiver programs were operating in 49 states[24]. Community-based long-term care increased from 14 to 25 percent of long-term care spending from 1991 (earliest available data) to 1998. **(Figure 4.5)**

- In 1998 Medicaid accounted for 17 percent of total spending on home health care in the U.S., up from 12 percent in 1978. Unlike the home health benefit under Medicare, Medicaid does not require individuals to have a need for skilled care in order to qualify for services. Medicaid home health generally is a long-term care benefit. **(Figure 4.6)**

Program of All-Inclusive Care for the Elderly

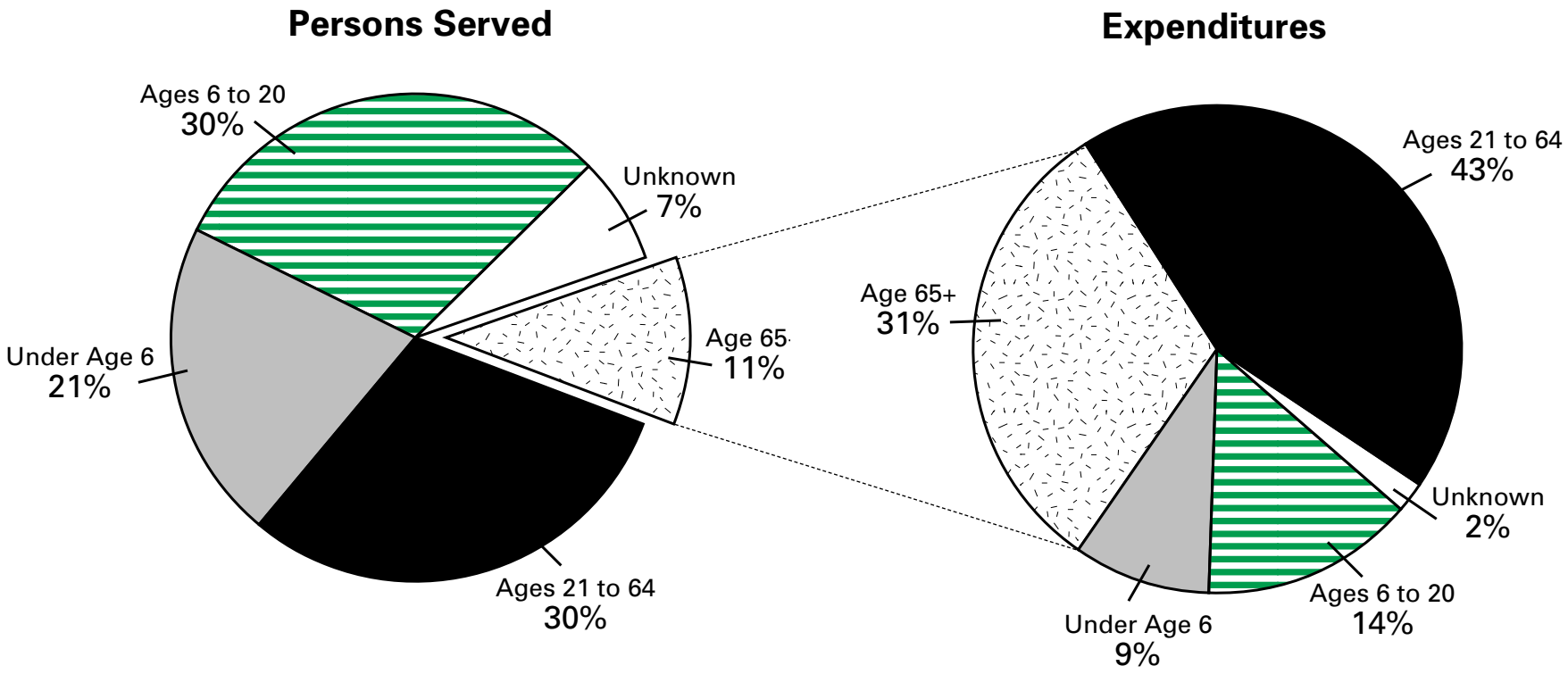
A new option for states in the delivery of home and community-based services for the frail elderly is the Program of All-Inclusive Care for the Elderly (PACE). PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive medical and social service delivery system and integrated Medicare and Medicaid funding. For most participants, the comprehensive service package permits them to continue living at home and receive services rather than enter an institution. The use of capitated payments for PACE allows providers to deliver all services participants need, including social services, rather than limiting services to those only reimbursable under the Medicare and Medicaid fee-for-service systems.

- Based on a model of care initially developed as a demonstration project, the BBA established the PACE program as a permanent entity under Medicare. The program enables states to provide PACE services to Medicaid beneficiaries as a state option. The BBA restricts annual growth of the PACE program by limiting the number of program agreements that states and the Secretary of the U.S. Department of Health and Human Services can enter into with PACE providers. Currently there are 14 states with 26 approved demonstration sites and 8 states that have included PACE as an option in their state plans. Although 8 states have elected PACE as a Medicaid state plan option, currently there are no approved PACE program agreements. **(Figure 4.7)**

[24] HCFA HCBS Waivers Summary Report; Arizona provides home and community-based services through its 1115 program waiver.

Figure 4.1 Persons Served Through Medicaid and Expenditures by Age, Fiscal Year 1998

Beneficiaries age 65 and older account for a disproportionate share of Medicaid expenditures in comparison to their share of persons served.

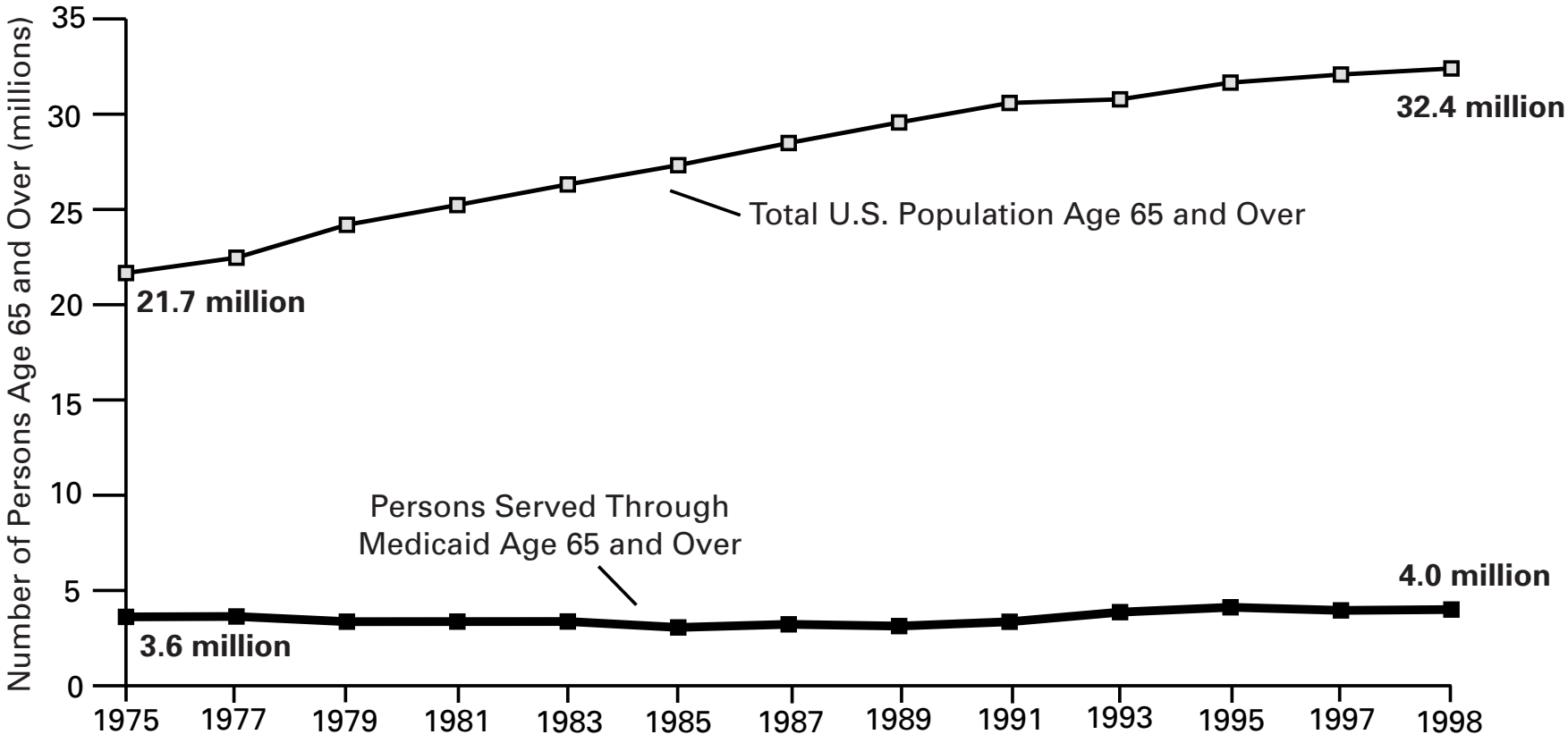


Note: Percentages do not sum to 100 due to rounding.

Source: HCFA Form 2082.

Figure 4.2 Individuals Age 65 and Over: U.S. Population and Persons Served Through Medicaid,* 1975-1998

While the number of individuals age 65 and over increased steadily since 1975, the number of elderly Medicaid beneficiaries increased only slightly.

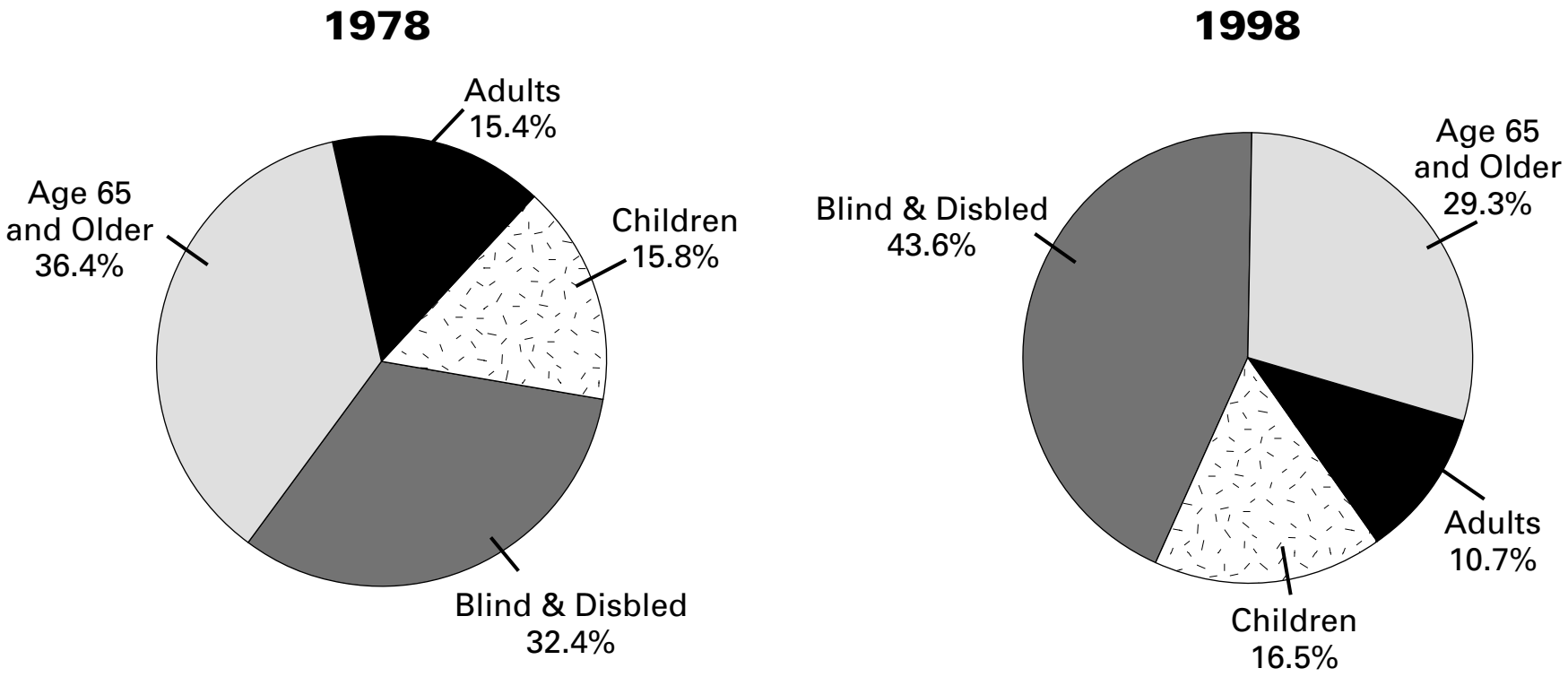


*Medicaid data are for beneficiaries in the 65 and older eligibility group as reported in the HCFA 2082. Data do not include individuals age 65 and older counted in other eligibility groups (e.g., disabled).

Source: Population age 65 and over: U.S. Census Bureau. Persons age 65 and older, served through Medicaid: HCFA 2082 report.

Figure 4.3 Distribution of Medicaid Payments by Eligibility Group, Fiscal Years 1978 and 1998

The proportion of Medicaid provider payments attributed to the blind and disabled individuals has increased significantly since 1978.

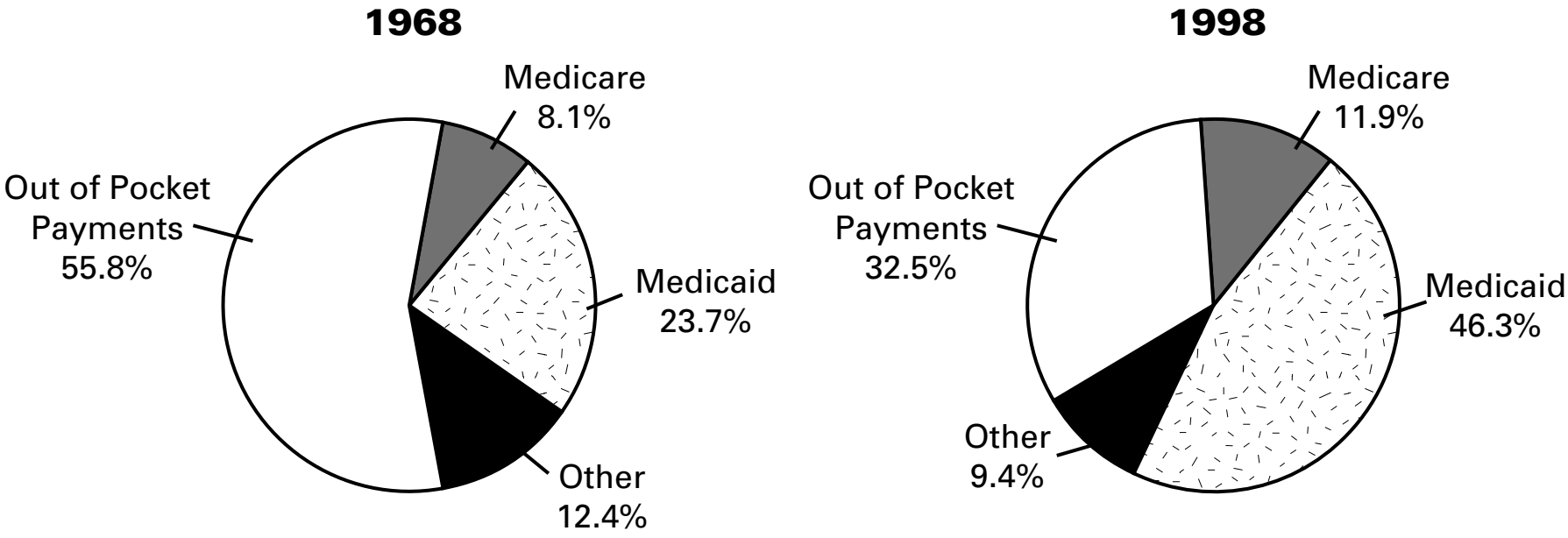


Note: (1) The percentage distribution for 1978 does not include $1.4 billion of payments (in 1998 dollars) on behalf of 1.9 million persons served by Medicaid whose basis of eligibility is reported as "other," and the percentage distribution for 1998 does not include $3.7 billion on behalf of 3.1 million persons served whose basis of eligibility is unknown; (2) percentages may not sum to 100 due to rounding; (3) "payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of dual beneficiaries); (3) the term "adults" as used above refers to non-elderly, non-disabled adults; (4) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

Figure 4.4 Medicaid Nursing Home Expenditures as a Percent of Total U.S. Nursing Home Care Expenditures, Calendar Years 1968 and 1998

Medicaid now accounts for nearly half of all U.S. spending on nursing home care.

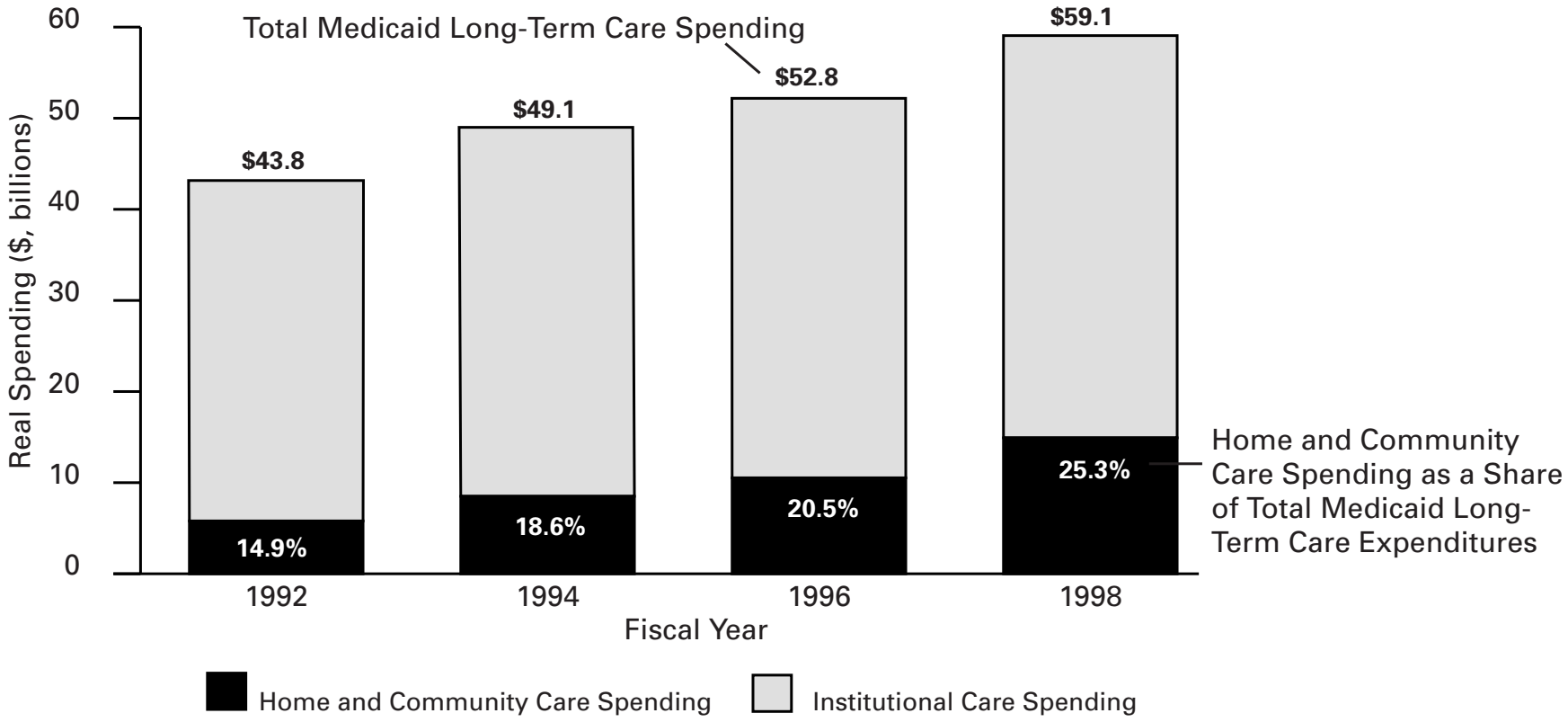


Note: Medicaid spending includes the state and federal shares. Total U.S. spending on nursing home care was $87.8 billion in 1998 compared to $2.9 billion in 1968. The 1998 "other" expenditures primarily consists of private health insurance and Veteran's Administration spending. The 1968 "other" consisted largely of non-Medicaid general funds from state/local and federal governments. Percentages may not sum to 100 due to rounding.

Source: HCFA/Office of the Actuary, National Health Statistics Group.

Figure 4.5 Medicaid Spending for Institutional Long-Term Care and Home and Community Care

Spending on home and community care as a share of total Medicaid long-term care expenditures has increased over time.

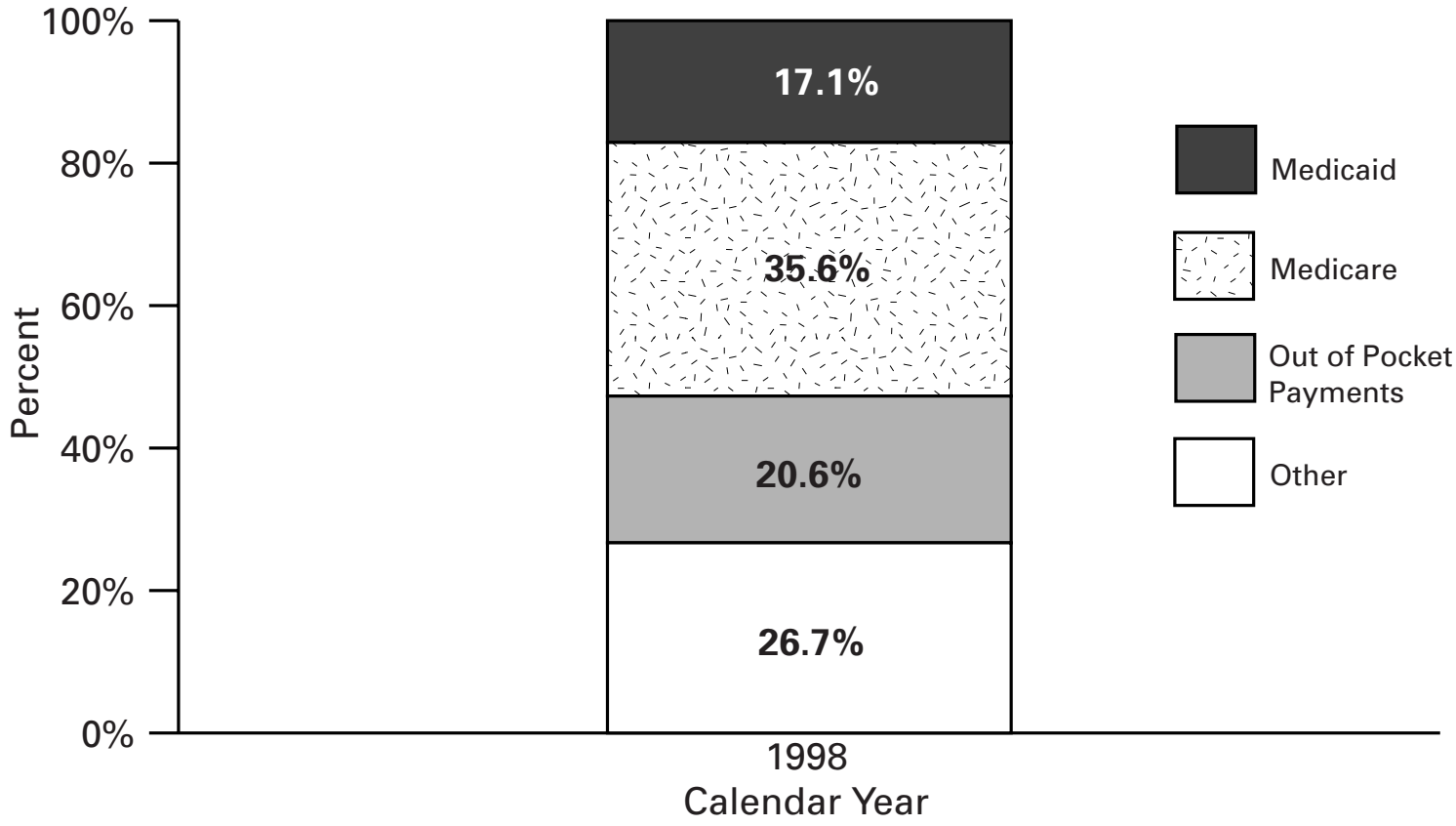


Note: (1) The data shown above are expressed in 1998 dollars; (2) Total Medicaid long-term care expenditures consists of spending on institutional long-term care and home and community care. Institutional long-term care spending includes expenditures for nursing facilities, and public and private ICF/MR facilities. Home and community-care spending consists of expenditures for personal care, home health, and home and community-based waivers.

Source: HCFA Form 64.

Figure 4.6 Medicaid Spending as a Percent of Total U.S. Home Health Care Expenditures, 1998

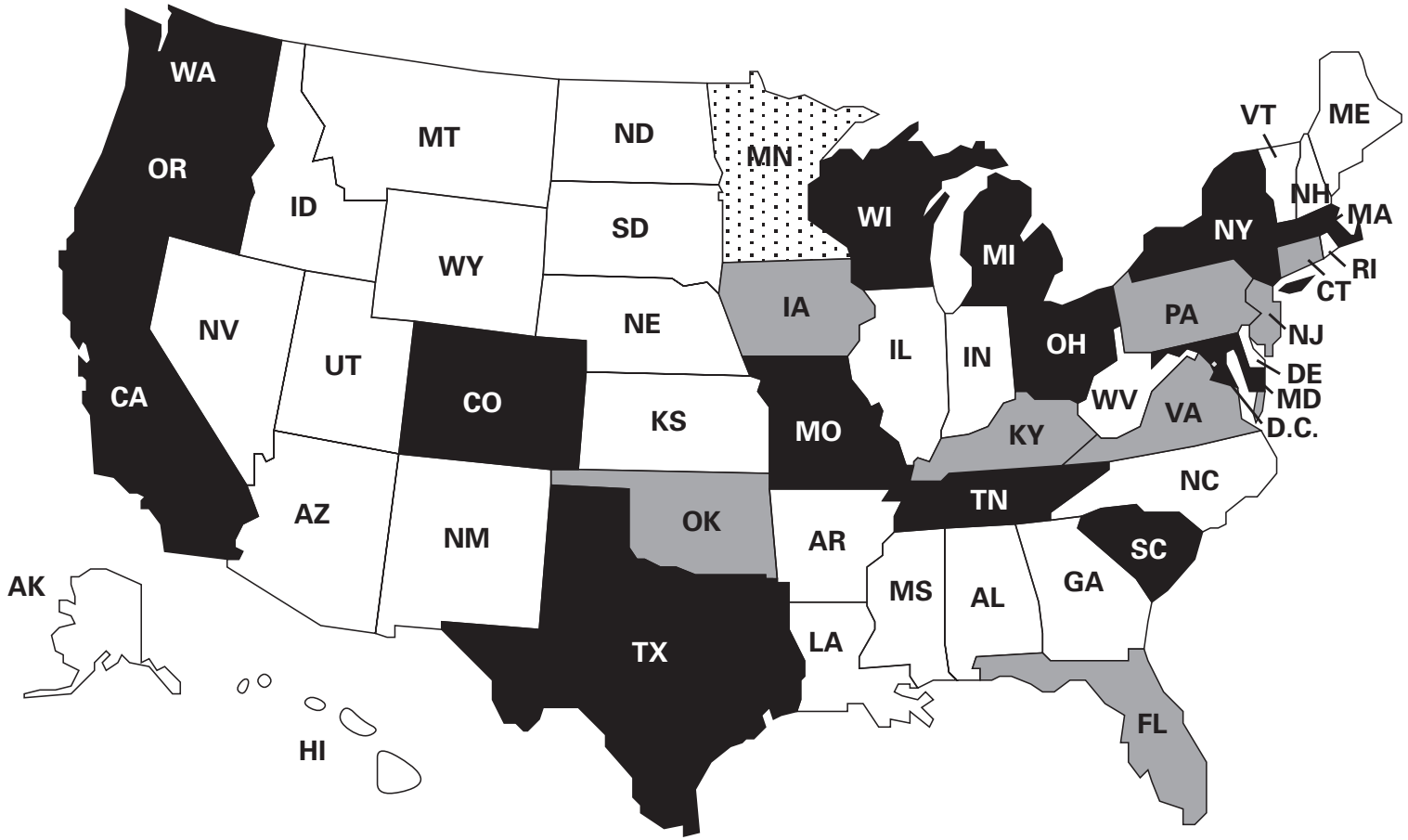
Medicaid expenditures account for 17 percent of total home health spending.



Note: Medicaid spending includes the state and federal share. Total U.S. spending on home health care was $29.3 billion in 1998. The "other" largely consists of private health insurance and revenues for which no direct patient care is furnished, such as philanthropy. Percentages may not sum to 100 due to rounding.

Source: HCFA/Office of the Actuary, National Health Statistics Group.

Figure 4.7 Nationwide Activity on Program of All-Inclusive Care for the Elderly (PACE)



Source: HCFA

The State Children's Health Insurance Program (SCHIP)

SECTION VI

The State Children's Health Insurance Program (SCHIP)

Although Medicaid has made great gains in enrolling low-income children, significant gaps in insurance coverage still exist. In 1988, Medicaid provided health insurance for 15.6 percent of all children. By 1993, Medicaid coverage of children grew to 23.9 percent. During this same time period, however, employer-sponsored insurance coverage for children under age 18 declined from approximately 64 percent to 57 percent. As a result, many children residing in families with incomes too high to qualify for Medicaid were left uninsured.

- From 1988 to 1998 the proportion of children who were uninsured increased from 13.1 percent to 15.4 percent. Medicaid coverage increased from 15.6 percent to 19.8 percent. **(Figure 5.1)**

In 1997, Congress created The State Children's Health Insurance Program (SCHIP) program to address the growing number of uninsured children. SCHIP was created by the Balanced Budget Act of 1997 (BBA). Designed as a state/federal partnership, SCHIP was appropriated $24 billion over five years and $40 billion over ten years to help states expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance.

SCHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. It has provided states a historic opportunity to reduce the number of uninsured children.

As of January 1, 2000, each of the states and territories had an approved SCHIP plan in place. Of the 56 approved plans, 53 were implemented and operational during Fiscal Year 1999.

- The BBA offers states three options for covering uninsured children through the SCHIP program. States can use SCHIP funds to provide coverage through separate child health programs, expand coverage available under Medicaid, or combine both strategies. States are using all three options for implementation. **(Figure 5.2 and Figure 5.3)**

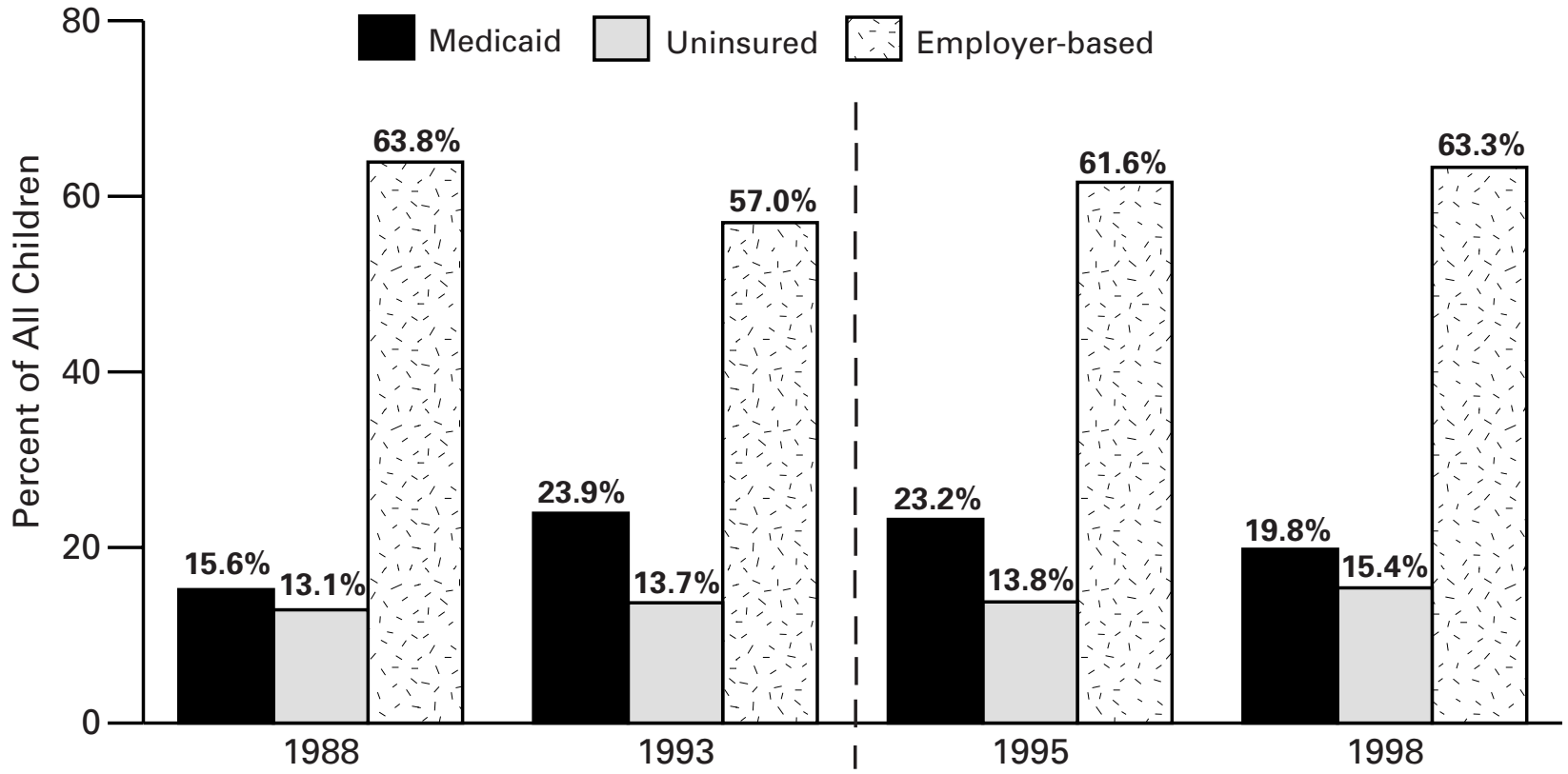
- Although most states use a Medicaid expansion as part of their SCHIP plan — either solely or in combination with a separate program — two thirds of all SCHIP children are being served through separate SCHIP programs. In Fiscal Year 1999, nearly two million children were enrolled in the State Children's Health Insurance Program. States reported that over 1.2 million children were in new state-designed child health programs and almost 700,000 were enrolled in Medicaid expansion plans in Fiscal Year 1999. **(Figure 5.4).**

- The three states which have the largest enrollment of SCHIP children have structured SCHIP to work in combination with Medicaid. The distribution of SCHIP enrollment by state is provided in **Figure 5.5.**

- SCHIP is designed to provide health insurance coverage to "targeted low-income children" who are not eligible for Medicaid or other health insurance coverage. A "targeted low-income child" is one who resides in a family with income below the greater of 200 percent of poverty or 50 percentage points above the state's Medicaid eligibility threshold. Most states have an upper eligibility limit of 200 percent of the federal poverty level, however, some states have amended their SCHIP plans to expand coverage to include children with family incomes above 200 percent FPL. **(Figure 5.6)**

Figure 5.1 Health Insurance Status of Children by Type of Coverage, Selected Years

The proportion of children who were either covered by Medicaid or uninsured was higher during the 1990s than the late 1980s.

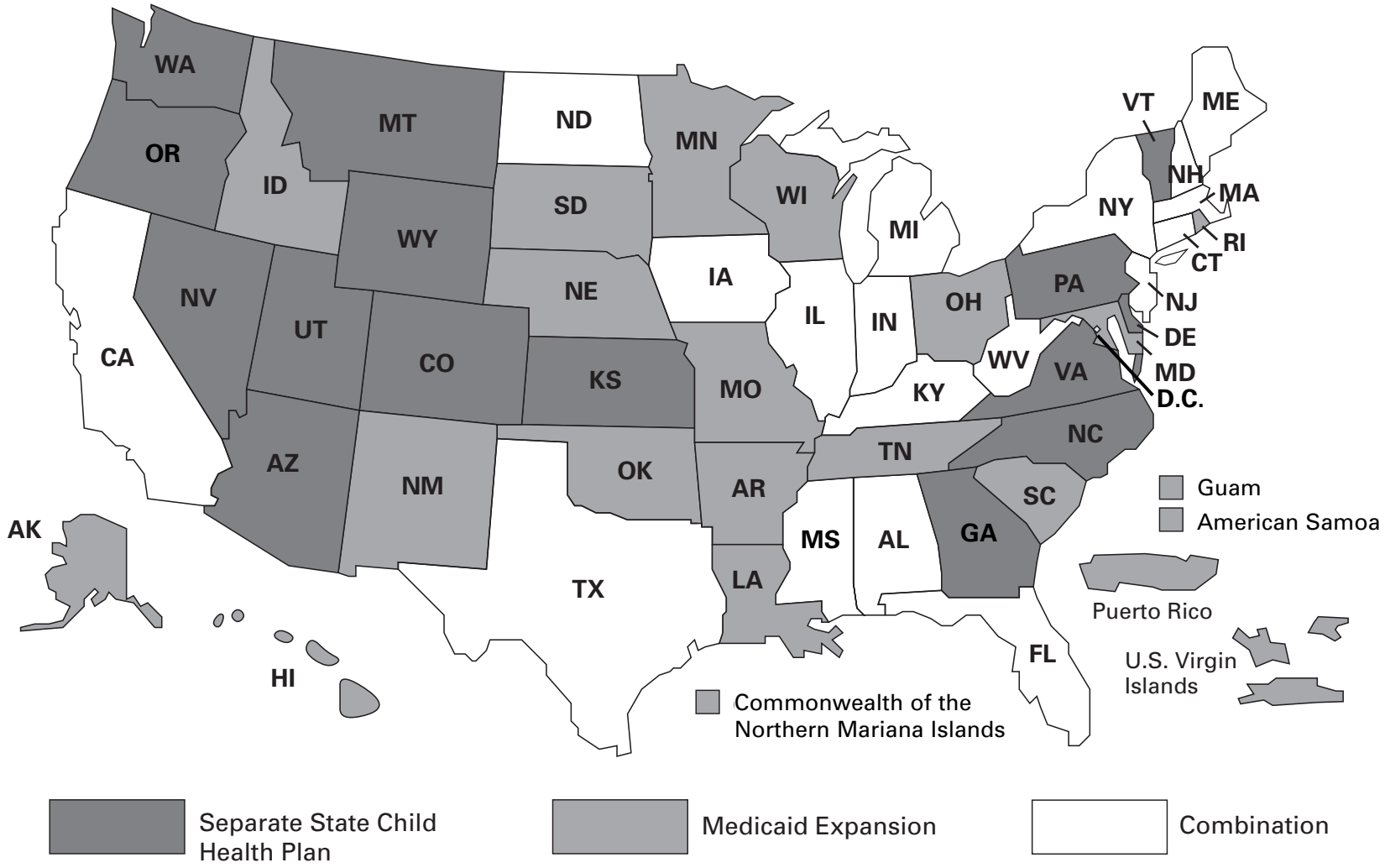


Note: (1) Children refers to all people under the age of 18; (2) the estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of insurance during the year; (3) the dotted line delineates methodological change; in 1994, health insurance questions on the CPS were redesigned; increases in estimates of employment-based coverage may be partially due to questionnaire changes; overall coverage estimates were not affected.

Source: U.S. Census Bureau, Current Population Survey.

Figure 5.2 State Children's Health Insurance Program

Plan activity as of June 26, 2000

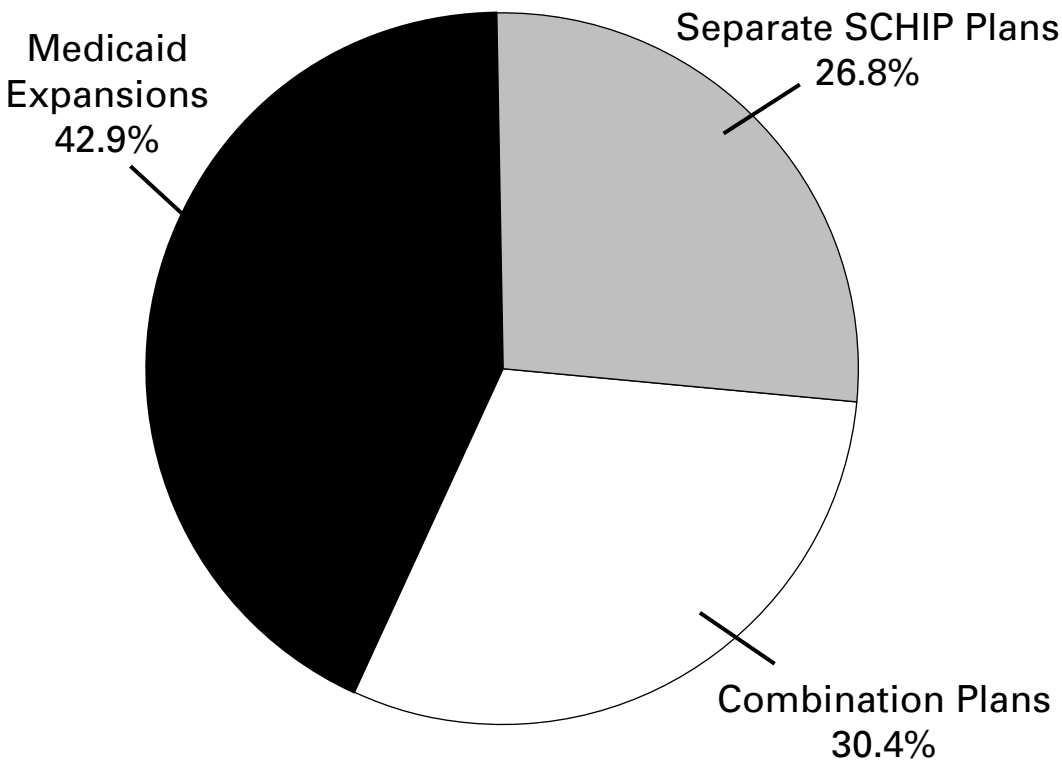


Summary Information (in order of submission/approval)

Number of Approved Separate State Child Health Plans: 15 (CO, PA, OR, NV, UT, MT, NC, GA, VA, AZ, DE, KS, VT, WA, WY)
Number of Approved Medicaid Expansions: 23 (SC, OH, MO, RI, OK, ID, WI, PR, MN, MD, DC, AR, NE, NM, SD, VI, LA, AK, HI, GU, AS, CNMI, TN)
Number of Approved Combination Plans: 18 (FL, CA, MA, CT, NJ, ME, NH, KY, MI, AL, MS, WV, IA, TX, NY, ND, IN, IL)

Figure 5.3 State Children's Health Insurance Plans — Percentage of States Using Each Design Option

States are utilizing all three options for implementing SCHIP plans.

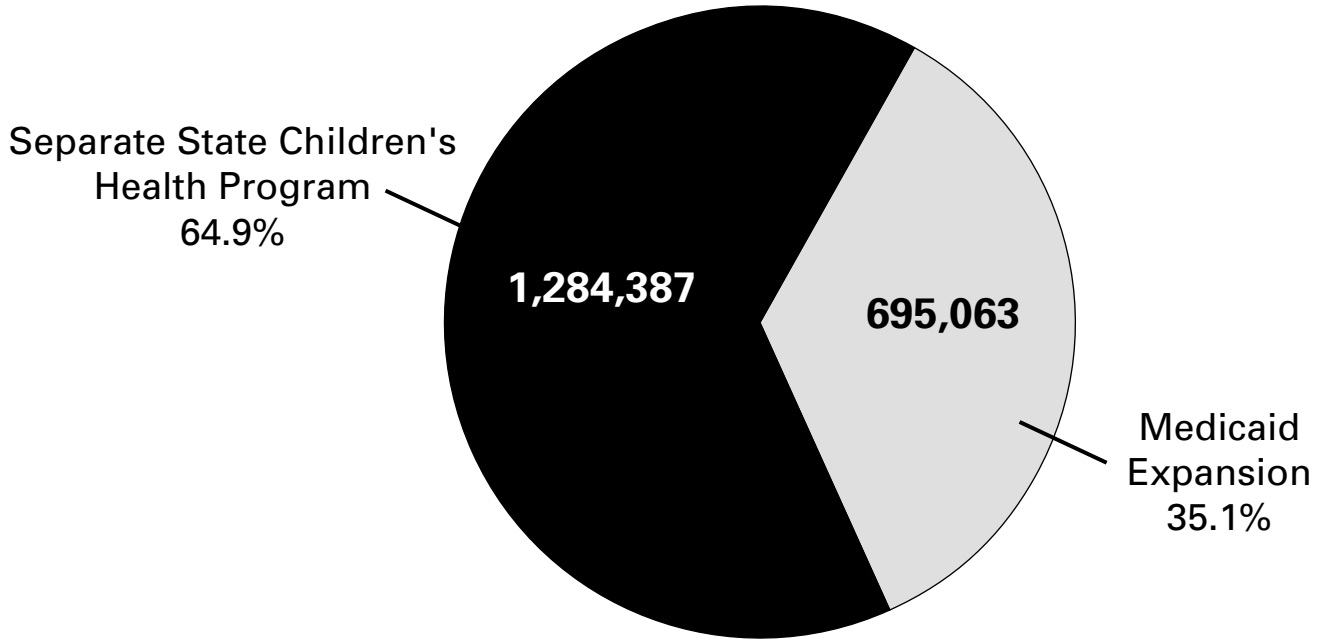


Note: The percentages may not sum to 100 due to rounding.

Source: HCFA — The State Children's Health Insurance Program Annual Enrollment Report Oct. 1, 1998 - Sept. 30, 1999.

Figure 5.4 State Reported Fiscal Year 1999 SCHIP Enrollment

Most of the 2 million SCHIP beneficiaries served in FY 1999 received services through a separate State Children's Health Insurance Program.



Source: HCFA — The State Children's Health Insurance Program Annual Enrollment Report Oct 1, 1998 - Sept. 30, 1999.

Figure 5.5 State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for FY 1999

State	Type of SCHIP Program	Date Implemented	State Reported FY '99 SCHIP Enrollment[3] *(Total children ever served in FY '99)*		FY 1999 Total SCHIP Enrollment
			Separate Program	Medicaid Expansion	
TOTAL: 56 Plans			1,284,387	695,063	1,979,450
Alabama[4]	Combo	02/01/98	25,738	13,242	38,980
Alaska	Medicaid	03/01/99		8,033	8,033
American Samoa[~]	Medicaid	04/01/99			0
Arizona	Separate	11/01/98	26,807		26,807
Arkansas	Medicaid	10/01/98		913	913
California	Combo	03/01/98	187,854	34,497	222,351
Colorado	Separate	04/22/98	24,116		24,116
CNMI[~,+]	Medicaid	10/01/97			0
Connecticut	Combo	07/01/98	5,277	4,635	9,912
Delaware	Separate	02/01/99	2,433		2,433
District of Columbia	Medicaid	10/01/98		3,029	3,029
Florida[#]	Combo	04/01/98	116,123	38,471	154,594
Georgia	Separate	11/01/98	47,581		47,581
Guam[~,+]	Medicaid	10/01/97			0
Hawaii[^]	Medicaid	07/01/00		N/I	N/I
Idaho	Medicaid	10/01/97		8,482	8,482

Figure 5.5 State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for FY 1999 *(continued)*

State	Type of SCHIP Program	Date Implemented	State Reported FY '99 SCHIP Enrollment[3] *(Total children ever served in FY '99)*		FY 1999 Total SCHIP Enrollment
			Separate Program	Medicaid Expansion	
Illinois[5]	Medicaid	01/05/98	7,567	35,132	42,699
Indiana^	Combo	10/01/97	N/I	31,246	31,246
Iowa	Combo	07/01/98	2,694	7,101	9,795
Kansas	Separate	01/01/99	14,443		14,443
Kentucky**,^	Combo	07/01/98	N/I	18,579	18,579
Louisiana	Medicaid	11/01/98		21,580	21,580
Maine	Combo	07/01/98	3,786	9,871	13,657
Maryland	Medicaid	07/01/98		18,072	18,072
Massachusetts	Combo	10/01/97	24,408	43,444	67,852
Michigan	Combo	05/01/98	14,825	11,827	26,652
Minnesota**	Medicaid	10/01/98		21	21
Mississippi^	Combo	07/01/98	N/I	13,218	13,218
Missouri	Medicaid	09/01/98		49,529	49,529
Montana	Separate	01/01/99	1,019		1,019
Nebraska	Medicaid	05/01/98		9,713	9,713
Nevada	Separate	10/01/98	7,802		7,802
New Hampshire	Combo	05/01/98	3,700	854	4,554
New Jersey	Combo	03/01/98	43,824	31,828	75,652
New Mexico**	Medicaid	03/31/99		4,500	4,500
New York[6,#]	Combo	04/15/98	519,401	1,900	521,301

Figure 5.5 State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for FY 1999 *(continued)*

State	Type of SCHIP Program	Date Implemented	State Reported FY '99 SCHIP Enrollment[3] *(Total children ever served in FY '99)*		FY 1999 Total SCHIP Enrollment
			Separate Program	Medicaid Expansion	
North Carolina**	Separate	10/01/98	57,300		57,300
North Dakota^	Combo	10/01/98	N/I	266	266
Ohio	Medicaid	01/01/98		83,688	83,688
Oklahoma**	Medicaid	12/01/97		40,196	40,196
Oregon	Separate	07/01/98	27,285		27,285
Pennsylvania#	Separate	05/28/98	81,758		81,758
Puerto Rico[7]	Medicaid	01/01/98		20,000	20,000
Rhode Island[8]	Medicaid	10/01/97		7,288	7,288
South Carolina[9]	Medicaid	10/01/97		45,737	45,737
South Dakota	Medicaid	07/01/98		3,191	3,191
Tennessee**	Medicaid	10/01/97		9,732	9,732
Texas^	Combo	07/01/98	N/I	50,878	50,878
Utah[10]	Separate	08/03/98	13,040		13,040
Vermont**	Separate	10/01/98	2,055		2,055
Virgin Islands[11,~]	Medicaid	04/01/98		120	120
Virginia	Separate	10/22/98	16,895		16,895
Washington^	Separate	02/01/00	N/I		N/I
West Virginia	Combo	07/01/98	6,656	1,301	7,957
Wisconsin	Medicaid	04/01/99		12,949	12,949
Wyoming^	Separate	12/01/99	N/I		N/I

Figure 5.5 State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for FY 1999 *(continued)*

Notes:

1999 Caveats and Data Limitations:

(Note: FY 1999 enrollment statistics reflect unedited, unduplicated data as submitted by states to HCFA)

[1]Implementation date of the initial SCHIP plan as reported by states. In some states the initial SCHIP plan involved a modest expansion of coverage and was followed by a plan amendment to further expand coverage. As of January 1, 2000, there are 37 states with approved amendments, and another 13 states have pending state plan amendments.

[2]Reflects upper eligibility level of SCHIP plans and amendments approved as of January 1, 2000. Upper eligibility is defined as a percent of the Federal poverty level (FPL). In 1999, FPL was $16,700 for a family of 4. In general, states with Medicaid expansion SCHIP programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP programs can establish their upper eligibility levels on a gross income basis or net of income disregards. Puerto Rico defines the upper eligibility limit as 200 percent of Puerto Rico's poverty level.

[3]State reported enrollment in FY 1999 reflects formal state quarterly electronic statistical data submissions and estimates by states in cases where electronic state quarterly data submissions were not available.

[4]Alabama's enrollment for Medicaid expansion SCHIP is estimated.

[5]Illinois is covering children under its proposed separate SCHIP program; although the amendment is pending.

[6]New York's enrollment for Medicaid expansion SCHIP is estimated.

[7]Puerto Rico's SCHIP allotment funded 20,000 children; another 44,324 children were funded with Territorial funds.

[8]Rhode Island has implemented their program to 250 percent FPL. In addition, Rhode Island has an approved amendment (February 5, 1999) to further expand the program to 300 percent FPL.

[9]South Carolina's enrollment for SCHIP reflects estimated enrollment from October 1998 - July 1999.

[10]Utah SCHIP enrollment for FY1999 reflects the total number of children ever enrolled in the fourth quarter.

[11]Virgin Island's SCHIP enrollment reflects the number of children for which health care claims were paid during the period from July 1998 through April 1999.

[^]These states have plans or amendments approved, but these programs were not implemented as of September 30, 1999. Therefore, the enrollment counts do not correspond fully to the upper eligibility levels reported in this table since these eligibility levels reflect plans and plan amendments approved as of January 1, 2000.

[**]State reported SCHIP enrollment is estimated.

N/I "Not Implemented" denotes states with approved SCHIP plans or amendments with implementation dates after FY 1999.

[~]Due to the unique nature of their SCHIP plans, these U.S. Territories and Jurisdictions may cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.

[+]Guam and the Commonwealth of the Northern Mariana Islands (CNMI) did not exceed their Medicaid funding caps, and therefore could not claim any SCHIP funding in FY 1999.

[#]Florida, New York and Pennsylvania had state-funded programs prior to SCHIP. Title XXI permitted children previously in the state-funded program to be covered under SCHIP and requires these states to maintain at least the previous levels of spending.

Figure 5.6 Eligibility Standards in States with Approved Title XXI Plans

(By Percentage of the Federal Poverty Level)

State[1]	Medicaid standards in effect 3/31/97[2] (lower income boundary for SCHIP)				Medicaid SCHIP-Expansion Approved as of 01/01/00	Separate SCHIP Program Approved as of 01/01/00[3]
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Alabama	133%	133%	100%	15%	100%	200%
Alaska	133%	133%	100%	100%	200%	N/A
Arizona	140%	133%	100%	30%	N/A	200%
Arkansas[4]	133%	133%	100%	18%	100% (born after 9/3/82 and before 10/1/83)	N/A
California	200%	133%	100%	82%	100%	250%
Colorado	133%	133%	100%	37%	N/A	185%
Connecticut	185%	185%	185%	100%	185%	300%
Delaware	133%	133%	100%	100%	N/A	200%
District of Columbia	185%	133%	100%	50%	200%	N/A
Florida[5]	185%	133%	100%	28%	100%	200%
Georgia	185%	133%	100%	100%	N/A	200%
Hawaii	185%	133%	100%	100%	185% (ages 1 thru 5)[7]	N/A
Idaho	133%	133%	100%	100%	150%	N/A
Illinois	133%	133%	100%	46%	133%	N/A
Indiana	150%	133%	100%	100%	150%	200%[7]

Figure 5.6 Eligibility Standards in States with Approved Title XXI Plans *(continued)*

(By Percentage of the Federal Poverty Level)

State[1]	Medicaid standards in effect 3/31/97[2] (lower income boundary for SCHIP)				Medicaid SCHIP-Expansion Approved as of 01/01/00	Separate SCHIP Program Approved as of 01/01/00[3]
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Iowa	185%	133%	100%	37%	133%	185%
Kansas	150%	133%	100%	100%	N/A	200%
Kentucky	185%	133%	100%	33%	150%	200%[7]
Louisiana	133%	133%	100%	10%	150%	N/A
Maine	185%	133%	125%	125%	150%	185%
Maryland	185%	185%	185%	100%	200%	N/A
Massachusetts	185%	133%	114%	86%	150%	200%
Michigan	185%	133%	100%	100%	150%	200%
Minnesota	275%	275%	275%	275%	280% (below age 2)	N/A
Mississippi	185%	133%	100%	34%	100%	200%[7]
Missouri	185%	133%	100%	100%	300%	N/A
Montana	133%	133%	100%	40.50%	N/A	150%
Nebraska	150%	133%	100%	33%	185%	N/A
Nevada	133%	133%	100%	31%	N/A	200%
New Hampshire	185%	185%	185%	185%	300% (ages 0-1)	300% (ages 1-18)

Figure 5.6 Eligibility Standards in States with Approved Title XXI Plans *(continued)*

(By Percentage of the Federal Poverty Level)

State[1]	Medicaid standards in effect 3/31/97[2] (lower income boundary for SCHIP)				Medicaid SCHIP-Expansion Approved as of 01/01/00	Separate SCHIP Program Approved as of 01/01/00[3]
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
New Jersey	185%	133%	100%	41%	133%	350%
New Mexico	185%	185%	185%	185%	235%	N/A
New York[5]	185%	133%	100%	51%	100%	192%
North Carolina	185%	133%	100%	100%	N/A	200%
North Dakota	133%	133%	100%	100% (thru age 17)	100% (18 year olds)	140%
Ohio	133%	133%	100%	33%	150%	N/A
Oklahoma	150%	133%	100%	48%	185% (thru age 17)	N/A
Oregon	133%	133%	100%	100%	N/A	170%
Pennsylvania[5]	185%	133%	100%	41%	N/A	200%
Rhode Island	250%	250%	100%	100% (ages 8 thru 14)	300%[8]	N/A
South Carolina	185%	133%	100%	48%	150%	N/A
South Dakota	133%	133%	100%	100%	140%	N/A
Tennessee[6]	—	—	—	16%	100%	N/A
Texas	185%	133%	100%	17%	100%	200%[7]
Utah	133%	133%	100%	100% (thru age 17)	N/A	200%

Figure 5.6 Eligibility Standards in States with Approved Title XXI Plans *(continued)*

(By Percentage of the Federal Poverty Level)

State[1]	Medicaid standards in effect 3/31/97[2] (lower income boundary for SCHIP)				Medicaid SCHIP-Expansion Approved as of 01/01/00	Separate SCHIP Program Approved as of 01/01/00[3]
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Vermont	225%	225%	225%	225%	N/A	300%
Virginia	133%	133%	100%	100%	N/A	185%
Washington	200%	200%	200%	200%	N/A	250%[7]
West Virginia	150%	133%	100%	100%	150% (ages 1 thru 5)	150% (ages 6 thru 18)
Wisconsin	185%	185%	100%	45%	185%	N/A
Wyoming	133%	133%	100%	55%	N/A	133%

Notes

[1]The Territories are not included in this table. Due to the unique nature of their SCHIP plans, the U.S. Territories and jurisdictions may cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.

[2]Title XXI contains a provision that a child's family income must exceed the Medicaid income level that was in effect on March 31, 1997 in order for that child to be eligible for SCHIP-funded coverage.

[3]Reflects upper eligibility level of SCHIP plans and amendments approved as of January 1, 2000. Upper eligibility is defined as a percent of the Federal Poverty Level (FPL), which, in 1999, is $16,700 for a family of 4. In general, states with Medicaid expansion SCHIP programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP programs can establish their upper eligibility levels on a gross income basis or net of income disregards.

[4]Arkansas increased Medicaid eligibility to 200% FPL effective September 1997 though section 1115 demonstration authority.

[5]These states had state-funded programs that existed prior to SCHIP. Title XXI permitted children previously in these state-funded programs to be covered under SCHIP and requires these states to maintain their previous level of state spending.

[6]Under its section 1115 demonstration, Tennessee has no upper eligibility level. The currently approved title XXI plan covers children born before October 1, 1983 in the expansion group and who enrolled in TennCare on or after April 1, 1997.

[7]Approved but not implemented as of January 1, 2000.

[8]Rhode Island has implemented their program to 250 percent of the FPL. The state also has an approved amendment (February 5, 1999) in place to further expand the program to 300 percent of the FPL.

Data Notes

Note on Data Sources

A majority of the information presented in this chart book is based on state reported program data collected by the Health Care Financing Administration (HCFA). Each figure cites reference sources as well as notes to clarify the data. The comments below further supplement the notes.

HCFA Sources

Terminology

The terms "enrollees" and "beneficiaries," as used in the chart book, refer to individuals who are enrolled in Medicaid, including individuals enrolled in Medicaid managed care plans. Medicaid data (i.e., HCFA-2082 report) refers to these individuals as "eligibles."

The term "persons served," as used in the chart book, refers to individuals for whom Medicaid program payments are made. Medicaid data (i.e., HCFA 2082-report) refers to these individuals as "recipients." Starting in FY 1998 "recipient" data included individuals for whom managed care premium payments were made.

HCFA-2082 report

The HCFA-2082 is an annual report submitted by states to HCFA. This report provides statistical data on persons enrolled in Medicaid; persons receiving Medicaid services; Medicaid fee-for-service utilization and expenditures during the federal fiscal year (October 1-September 30). The expenditure and payment data represent claims paid during the fiscal year for fee-for-service utilization. Starting in FY 1998, HCFA-2082 data on Medicaid vendor (i.e., provider) payments include capitation payments made to managed care organizations, and the data on persons served (i.e., "recipients") include individuals for whom managed care premium payments were made.

HCFA-64 report

The HCFA-64 is a product of the financial budget and grants system. The report is a quarterly accounting statement of actual expenditures made by states for which they are entitled to receive federal reimbursement under Title XIX. The amount claimed on the HCFA-64 is a summary of expenditures derived from invoices and cost reports.

Data Caveats – HCFA-2082 and HCFA-64 reports

Where "real" spending data is shown in the charts, adjustments have been made for inflation using the U.S. Bureau of Economic Analysis' estimates of the GDP chain-type price index (1996=100). The chain-type price indexes used for these adjustments were published by the Bureau of Economic Analysis on January 28, 2000.

Apparent inconsistencies in financial data are due to the difference in the information captured on the HCFA-2082 and HCFA-64 reports. Adjudicated claims data are used in the HCFA-2082; actual payments are reported in the HCFA-64. The data presented within the figures showing total spending refers to the "Current Expenditure" line from the HCFA-64 reports and do not reflect payment adjustments or deductions. States claim the federal match for payments to disproportionate share hospitals on the HCFA-64. Payments to disproportionate share hospitals do not appear on the HCFA 2082 since States directly reimburse these hospitals. Finally, the HCFA-64 includes data from Guam, Commonwealth of the Northern Mariana Islands, and American Samoa.

Medicaid Managed Care Enrollment Report

Data from the Medicaid Managed Care Enrollment Report is collected from state Medicaid agencies and HCFA. Data is presented for all states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Current Population Survey (CPS)

The Current Population Survey (CPS) is a monthly survey of approximately 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The Annual Demographic Survey or March CPS supplement is the primary source of detailed information on income and work experience in the United States. The CPS sample is scientifically selected to represent the civilian, non-institutional population.

The March 1995 CPS adopted new and revised health insurance questions. Caution should be used when comparing March 1995 estimates with earlier estimates. Generally, the changes in health insurance questions did not have a noticeable effect on overall health insurance estimates. However, there is an impact for estimates regarding specific types of coverage. For example, employer provided health insurance estimates increased significantly from 57 percent in 1993 to 61 percent in 1994. This increase is probably the result of a more straightforward set of private health insurance questions.