

## Primer: Medicaid

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### Introduction

Medicaid is a means-tested entitlement program designed to provide low-income Americans with basic health care. Enacted in 1965 through Title XIX of the Social Security Amendment, Medicaid was created to help bridge the living standards between rich and poor as a part of President Johnson's war on poverty.

Since its enactment, Medicaid has grown to be a multi-billion dollar program, and a major portion of both state and federal budgets. In 2010, over 65 million people were covered by Medicaid for at least one month, or about one in every five U.S. citizens. The Centers for Medicare & Medicaid Services (CMS) projects that by 2020, enrollment will increase to almost 85 million<sup>i</sup>.

### Program Funding and Administration

Medicaid is funded jointly through state and the federal government. In recent decades, the states have covered about 40% of Medicaid expenditures on average.<sup>ii</sup> In 2009, this amount dropped to 33 percent of all Medicaid costs<sup>iii</sup> because the Recovery Act of 2009 shifted much of the Medicaid burden to the federal government by raising the Federal Medical Assistance Percentage (FMAP). Since this subsidy expired in 2011, state governments again bear more responsibility for funding Medicaid<sup>iv</sup>.

Medicaid is administered by each individual state, which determines eligibility requirements and the services to be provided. Consequently, the quality and quantity of what is covered can vary significantly from state to state. Services are paid for via fee-for-service (FFS), in which the state pays providers directly, or through managed care, in which benefits are subcontracted to private insurance companies such as Health Maintenance Organizations (HMOs).

### Key Takeaways

#### ***A Major provider of health care***

- Over 65 million Americans received Medicaid benefits in 2010—about one in five U.S. citizens.
- Beginning in 2014, PPACA will extend Medicaid coverage to everyone below 133 percent of the Federal Poverty Level.

#### ***The current state is unsustainable***

- The 2012 federal budget included \$269 billion for Medicaid, or 7 percent of overall spending.
- CMS estimates that by 2020, Medicaid is estimated to cost \$1 trillion.
- Medicaid has consistently grown faster than the economy; in 2010, Medicaid expenditures equaled 3 percent of GDP.

#### ***Reform is essential in order to ensure continued health care access for the needy***

- Moving from FFS to managed care saved Pennsylvania \$2.7 billion.
- Cost Sharing reduces state expenditures and may reduce moral hazard.
- FLEX Strategy: Financial Accountability, Lean Operations, Ensured Access to Care, Expanded State Ownership.
- Ryan's Plan funds Medicaid through block grants.
- RGA recommends greater state autonomy in Medicaid decisions.

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While states have a substantial degree of autonomy in determining what services their Medicaid programs will cover, the following are generally included: inpatient/outpatient hospital services, vaccines for children, pregnancy services and pediatric services. Other common services offered are optometrist services, hospice care, rehabilitation and prescription drugs<sup>v</sup>.

As part of the Patient Protection and Affordable Care Act (PPACA), Medicaid coverage will be simplified and expanded to cover those with incomes of up to 133 percent of the Federal Poverty Level (FPL) beginning in 2014. According to CMS, this expanded coverage will increase enrollment by almost 20 million and costs by over 20 percent<sup>vi</sup>.

The federal government will pay 100% of the costs of the Medicaid expansion starting in 2014. Gradually some of the cost burden will shift to the states starting in 2020 when the federal government is scheduled to decrease coverage to 90 percent<sup>vii</sup>. After the PPACA was enacted, 26 states filed lawsuits against the law's constitutionality, arguing against the Medicaid expansion among other provisions. Plaintiffs argued that the expansion was an unconstitutional use of Congress's Spending Clause powers because it coerced states to participate. The Supreme Court is expected to make a decision on the constitutionality of the PPACA provision by the end of June 2012.

Figure 1: Distribution and Payments by Enrollment Group, 2009<sup>viii</sup>

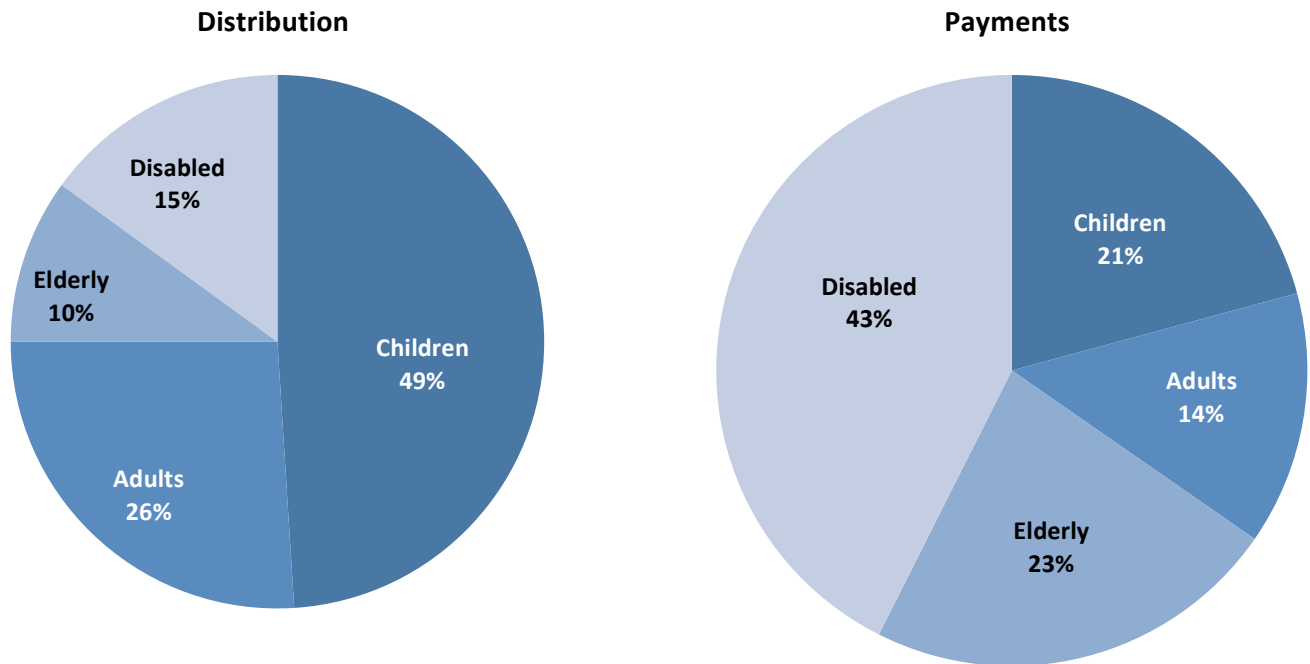
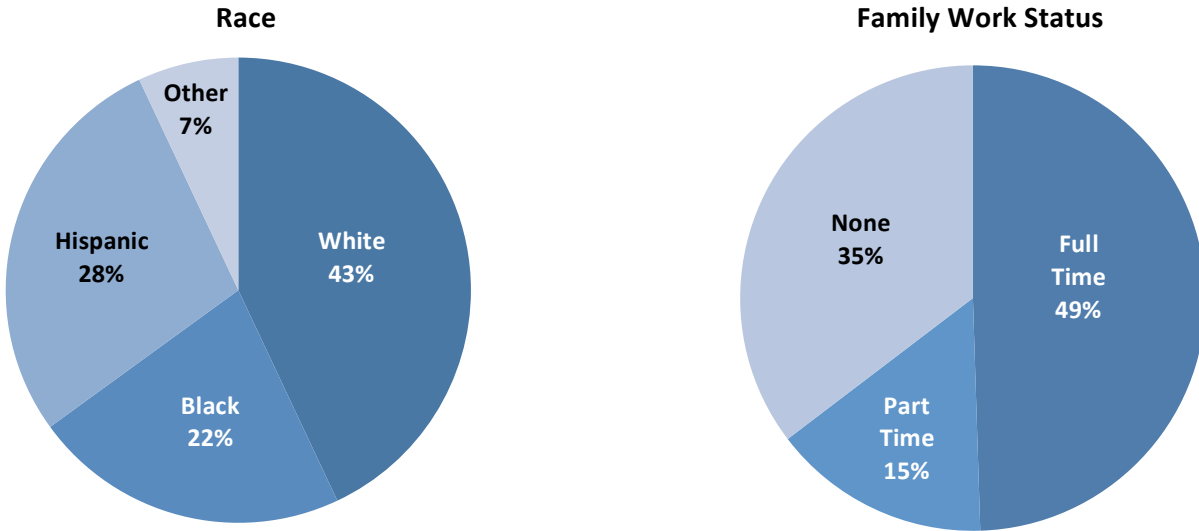
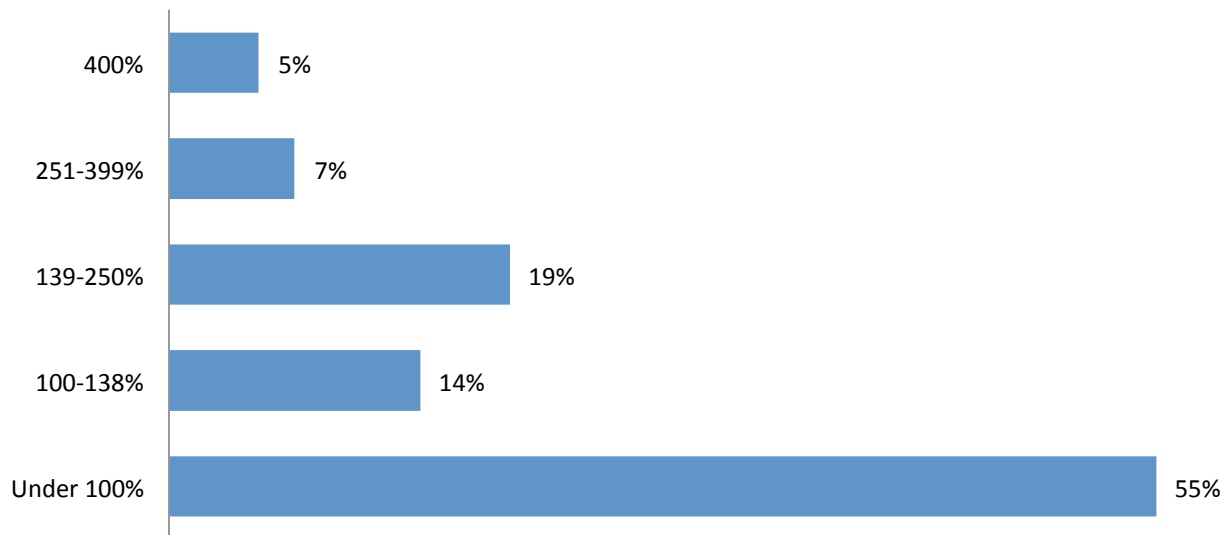


Figure 2: Demographics of Non-Elderly Medicaid Recipients, 2010<sup>ix</sup>

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**Distribution by Federal Poverty Level**



## Factors Determining Eligibility

Although Medicaid is designed to help those of lower income, low income by itself does not guarantee eligibility. Other determining factors in Medicaid eligibility include age, disability, non-income assets and immigration status<sup>x</sup>. The majority of Medicaid beneficiaries are children, though the elderly also make up a significant portion of recipients. Medicare does not cover long-term care such as nursing homes, but seniors with lower incomes can qualify for both Medicare and Medicaid to help pay for such services; these seniors are also known as “dual-eligibles.” Because of the high costs associated with long-term care, the elderly receive a greater proportion of Medicaid payments relative to children and adults (Figure 1). The high cost of treatments for disabled individuals

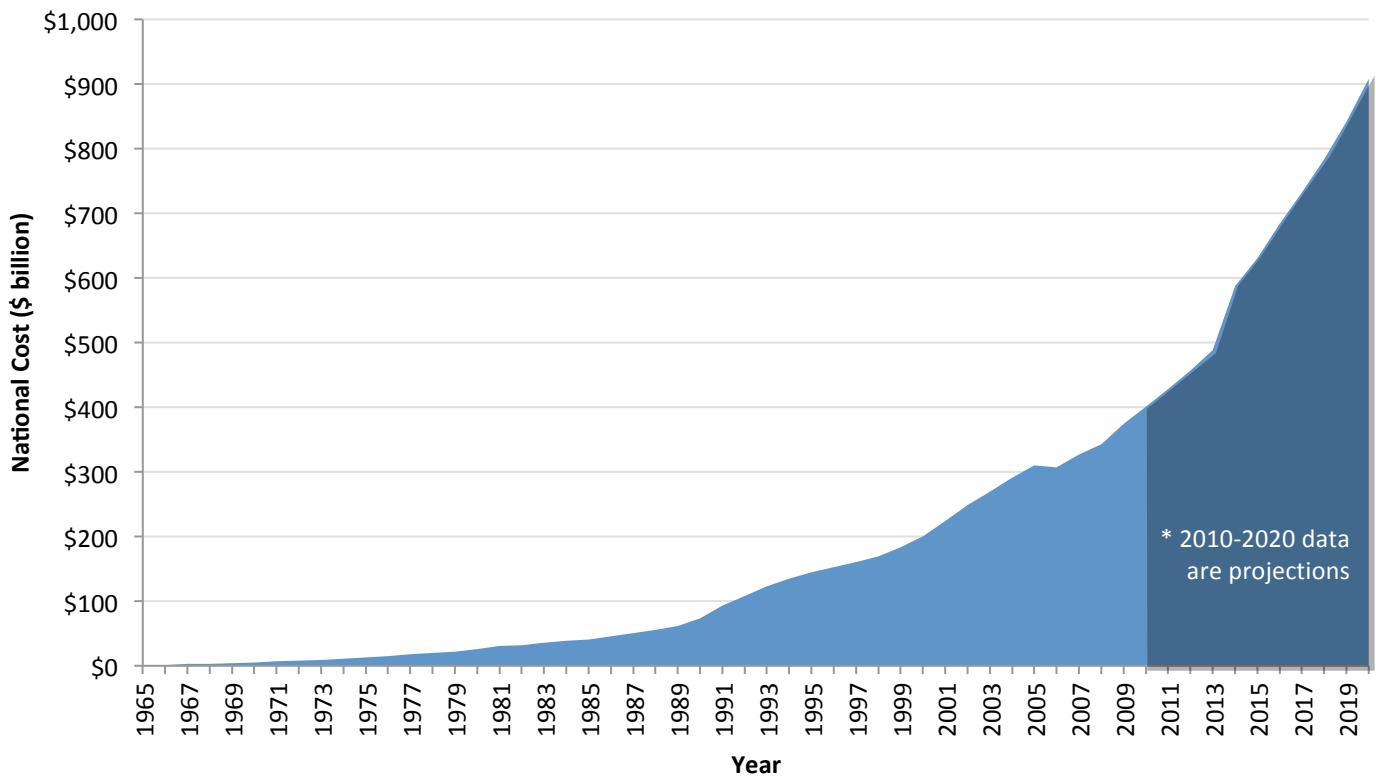
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creates a similar disproportionate payment profile. Figure 2 highlights the demographics of Medicaid recipients by race, work status of family members and federal poverty level.

## Rising Costs and Other Concerns

Medicaid's costs have increased dramatically since its inception. In 1970, Medicaid expenditures amounted to 0.4 percent of GDP; in 2010 they were 2.7 percent of GDP<sup>xi</sup>. Medicaid is the largest source of expenditures for most states, and such rapid growth puts heavy pressure on state budgets. Figure 3 shows the growth in spending on the Medicaid program since 1965. In 2010, Medicaid expenditures were estimated to be \$432 billion. By 2020, Medicaid costs will approach \$800 billion<sup>xii</sup>. The 2012 federal budget allots 13 percent of mandatory spending to Medicaid (7 percent of overall spending), a total of \$269 billion<sup>xiii</sup>.

**Figure 3: Historical and Projected State and Federal Cost of Medicaid<sup>\*xiv</sup>**



Doctors are increasingly reluctant to accept Medicaid patients. Low reimbursements, capitation<sup>1</sup> and paperwork concerns are de-incentivizing doctors to accept new Medicaid patients<sup>xv</sup>. In 2005, 21 percent of doctors were not accepting any new Medicaid patients, and 14 percent of doctors received no revenue from Medicaid<sup>xvi</sup>. By 2010, the proportion of doctors who had stopped accepting new Medicaid patients had risen to 50 percent<sup>xvii</sup>.

As the Medicaid system expands, fraud becomes an ever greater concern. Common schemes include billing for services not provided, double billing, substitution of generic drugs, billing for unnecessary services, kickbacks and false cost reports<sup>xviii</sup>. In June of 2011, Senator Coburn (R-OK) and Senator Carper (D-DE) introduced legislation to

<sup>1</sup> Fixed compensation per patient.

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help fight waste, fraud and abuse of both Medicare and Medicaid<sup>xix</sup>. Their legislation highlighted the extent of fraud by citing over 20 examples of Medicaid fraud cases reported in 2010-11 alone, ranging from \$12,000 to over \$4 million<sup>xx</sup>. In FY 2008, State Medicaid Fraud Control Units recovered more than \$1.3 billion in court-ordered restitution, fines and settlements<sup>xxi</sup>.

Medicaid has been praised for its administrative efficiency: some private sector health organizations have administrative overhead up to 20 percent of total expenditures, while Medicaid overhead is approximately 4 to 6 percent of claims paid<sup>xxii</sup>. This comparison however, is misleading. The main administration cost for private health organizations is premium collection, and because Medicaid does not collect premiums, its administration costs are lower due to the structure of the program, not its administrative efficiency.

## Reform Strategies

- **Managed Care vs. Fee for Service (FFS):** Evidence shows that moving to managed care can significantly reduce costs. According to a Lewin Group study from 2005, HealthChoices, Pennsylvania's managed care program, saved the state \$2.7 billion over five years<sup>xxiii</sup>. Opponents claim that managed Medicaid saves money but decreases quality of care. However, evidence shows that managed care is just as effective as FFS. One study finds that children with special disabilities are more likely to be in compliance with American Academy of Pediatrics guidelines when enrolled in a managed care program<sup>xxiv</sup>. Another study found that the shift toward managed Medicaid has benefitted minorities by reducing racial disparity in doctor visits<sup>xxv</sup>.
- **Cost Sharing:** Federal law currently allows states to charge up to 5 percent of personal income in Medicaid copayments, and many states are considering introducing or raising such copayments. Cost sharing both alleviates burden on state budgets, and may help reduce moral hazard by giving Medicaid recipients incentive to stay healthy<sup>xxvi</sup>. Opponents claim that charging copayments would significantly reduce the amount of enrollees in Medicaid and increase the number of uninsured. A 2011 study by Georgetown's Health Policy Institute found that a 3-4 percent increase in premiums would decrease Medicaid participation by 49,000-87,000, and that emergency room usage would increase as a result<sup>xxvii</sup>.
- **FLEX Strategy:** Research by the American Action Forum produced a four-fold strategy to make Medicaid more reliable and efficient. A 2011 report written by Michael Ramlet and Douglas Holtz-Eakin outlines the FLEX strategy, which involves:
  - 1) Greater financial accountability through federal block grant funding.
  - 2) Intensified anti-fraud operations and other immediate cost-saving options.
  - 3) Increased managed Medicaid to ensure access to care.
  - 4) Expanded state ownership: flexibility with long-term care, dual-eligibles and managed care decisions<sup>xxviii</sup>.
- **The Ryan Plan:** Under Rep. Ryan's (R-WI) health care reform plan, Medicaid would be funded through state block grants<sup>2</sup>. Proponents claim that block grants would not only simplify funding, but also end the "blank-check" mentality in Congress and force states to be more responsible and efficient in their Medicaid programs<sup>xxix</sup>. Opponents contend that the plan will ultimately fail to deliver services to the enrollees who need

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<sup>2</sup> Pre-determined sums of money distributed to states by the federal government, with few requirements for how it is to be spent

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them most. However, a report published by the Center for American Progress argues that the grants, adjusted for inflation, would not be able to cover rapidly rising health care costs<sup>xxx</sup>.

- **RGA Recommendations:** In August 2011, the Republican Governor's Association (RGA) published a report on Medicaid outlining recommendations for Medicaid reform from the states' perspective. While states are responsible for administering Medicaid, they have recently been excluded from health policy debates, according to the report. The RGA called for more state involvement in policy-making, more state autonomy in administering Medicaid and for the Federal government to be responsible for illegal immigrants who enroll in Medicaid<sup>xxxi</sup>.



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## References

- <sup>i</sup> Office of the Actuary, "[2011 Actuarial Report on the Financial Outlook for Medicaid](#)," *Centers for Medicare and Medicaid Services*, March 16, 2012, Accessed May 10, 2012.
- <sup>ii</sup> "[An Overview of Changes in the Federal Medical Assistance Percentages \(FMAPs\) for Medicaid](#)" *Kaiser Family Foundation*, Accessed May 10, 2012.
- <sup>iii</sup> "[State Health Facts: Medicaid & CHIP](#)," *Kaiser Family Foundation*, Accessed May 10, 2012.
- <sup>iv</sup> "[Medicaid Cost-Saving Opportunities](#)." *U.S. Department of Health and Human Services*, February 3, 2011.
- <sup>v</sup> Barbara S. Klees, Christian J. Wolfe, and Catherine A. Curtis, "[Medicaid Program Description and History](#)," *Centers for Medicare and Medicaid Services*, November 1, 2010.
- <sup>vi</sup> Office of the Actuary. Op cit.
- <sup>vii</sup> "Focus on Health Reform" *Kaiser Family Foundation*, Accessed May 14, 2012.
- <sup>viii</sup> "[State Health Facts: Medicaid & CHIP](#)," *Kaiser Family Foundation*, Accessed May 10, 2012.
- <sup>ix</sup> Ibid.
- <sup>x</sup> Barbara S. Op cit.
- <sup>xi</sup> Office of the Actuary. Op cit.
- <sup>xii</sup> Office of the Actuary. Op cit.
- <sup>xiii</sup> Office of Management and Budget, "[Fiscal Year 2012 Budget of the U.S. Government](#)," February 14, 2011.
- <sup>xiv</sup> National Health Expenditures Data. NHE Historical and Projections, 1965-2020.  
[https://www.cms.gov/nationalhealthexpenddata/03\\_nationalhealthaccountsprojected.asp](https://www.cms.gov/nationalhealthexpenddata/03_nationalhealthaccountsprojected.asp).
- <sup>xv</sup> Steve Berman, et al. "Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics*, August 1, 100:2 (2002): 239-248.
- <sup>xvi</sup> Peter Cunningham & Jessica May, "[Medicaid Patients Increasingly Concentrated Among Physicians](#)" *Center for Studying Health System Change*, August 2006.
- <sup>xvii</sup> "[Medicare/Medicaid Acceptance Trends Among Physicians](#)," *Amerimed Consulting*, June 2010.
- <sup>xviii</sup> "[What is Medicaid Fraud?](#)" *National Association of Medicaid Fraud Units*, 2011, accessed September 19, 2011.
- <sup>xix</sup> "Sens. Carper and Coburn Lead Bipartisan Legislation to Combat Billions of Dollars in Waste, Fraud and Abuse in Medicare and Medicaid," Press Release, June 22 2011, at [http://coburn.senate.gov/public/index.cfm/pressreleases?ContentRecord\\_id=aa4a3979-df58-42ca-acb3-b4c5fbff139d](http://coburn.senate.gov/public/index.cfm/pressreleases?ContentRecord_id=aa4a3979-df58-42ca-acb3-b4c5fbff139d)
- <sup>xx</sup> "Medicaid Fraud in the News," at [http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File\\_id=e04f42d4-7f4c-468b-b57a-b957501b9d1d](http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=e04f42d4-7f4c-468b-b57a-b957501b9d1d).
- <sup>xxi</sup> Office of Inspector General, "[Annual Report](#)," *Department of Health and Human Services*, 2008.
- <sup>xxii</sup> Tim Henderson, "[State-By-State Comparisons: Administrative Costs](#)," *American Academy of Family Physicians*, December 2005.
- <sup>xxiii</sup> "[Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program](#)," *The Lewin Group*, May 2005.
- <sup>xxiv</sup> Jean M. Mitchell, Darrell J. Gaskin and Chahira Kozma, "[Health Supervision Visits Among SSI-Eligible Children in The D.C. Medicaid Program: A Comparison of Enrollees in Fee-For-Service and Partially Capitated Managed Care](#)," *Inquiry*, June 2008, 45:2: 198-214.
- <sup>xxv</sup> Benjamin Le Cook, "[Effects of Medicaid Managed Care on Racial Disparities in Health Care Access](#)," *Health Services Research*, October 9, 2008.
- <sup>xxvi</sup> Peter Zweifel and Willard Manning, "[Moral Hazard and Consumer Incentives in Health Care](#)," *Science Direct*, February 8, 2005.

# AMERICAN ACTION FORUM

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<sup>xxvii</sup> Joan Alker, Martha Heberlein, & Wesley Prater, "[The Impact of Premiums on Families in BadgerCare Plus](#)," *Georgetown University Health Policy Institute Center for Children and Families*, May 23, 2011.

<sup>xxviii</sup> Douglas Holtz-Eakin and Michael Ramlet, "[A New Vision For Medicaid: Developing the FLEX Strategy to Strengthen the Social Safety Net](#)," *American Action Forum*, April 13, 2011.

<sup>xxix</sup> Ibid.

<sup>xxx</sup> Scott Lilly, "[The Ryan Medicaid Plan: A Threat to Middle Class Security](#)," *Center for American Progress*, July 8, 2011.

<sup>xxxi</sup> "[A New Medicaid: A Flexible, Innovative and Accountable Future](#)," *Republican Governors Public Policy Committee*, August 31, 2011.