Medicaid: 35 Years of Service

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On this 35th anniversary of the enactment of Medicaid, it is important to reflect on the program's role in the U.S. health care system. The Medicaid program is the third largest source of health insurance in the United States—after employer-based coverage and Medicare. The significance of Medicaid's role in providing health insurance cannot be overstated. As the largest in the Federal safety net of public assistance programs, Medicaid provides essential medical and medically related services to the most vulnerable populations in society. In 1998, the Medicaid program covered 41.4 million[1] low-income children, their families, elderly people, and individuals with disabilities—approximately 12 percent of the total U.S. population.[2]

Since its inception in 1965, Medicaid enrollment and expenditures have grown substantially. In addition, the program has evolved as Federal and State governments balance social, economic, and political factors affecting this and other public assistance programs. This article presents an overview of the Medicaid program and highlights trends in enrollment and expenditures.

OVERVIEW

Medicaid was enacted in the same legislation that created the Medicare program—the Social Security Amendments of 1965 (Public Law 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 Social Security Amendments of 1950 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 additional 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

[1] Enrollment data from HCFA Form 2082.

[2] Data from HCFA's Office of the Actuary. The percent of the population covered by Medicaid was estimated using average Medicaid enrollment data and U.S. Census Bureau estimates of the national population.

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and people with disabilities; (2) long-term care (LTC) 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.

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

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

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. Program waivers and additional mandatory eligibility groups have provided States with opportunities to extend Medicaid services to populations beyond the traditional welfare-defined groups.

Initially, eligibility for Medicaid was linked to receipt of cash assistance from 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 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 1980s in an effort to expand Medicaid coverage of pregnant women and children by delinking Medicaid eligibility from receipt of AFDC. Poverty-related groups are an increasing proportion of Medicaid eligible individuals.

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:

- *Certain low-income families*—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.
- *Poverty-related groups*—States are required to provide Medicaid to certain pregnant women and children under age 6 with incomes up to 133 percent of the Federal poverty level (FPL). States must also cover all children born after September 30, 1983, with incomes up to 100 percent of FPL. This requirement will result in the mandatory coverage of all children below 100 percent of FPL under age 19 by 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 supplementary assistance to low-income Medicare beneficiaries. All Medicare beneficiaries with incomes below the FPL 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 the FPL receive Medicaid assistance for payment of Medicare premiums. These individuals are specified low-income Medicare beneficiaries (SLMBs).

States have the option to provide Medicaid coverage to other groups. These optional groups fall within the defined categories previously mentioned 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, some States have chosen to cover pregnant women and infants with family incomes up to 185 percent of FPL or higher.
- *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.
- *LTC*—States may cover persons residing in medical institutions or receiving certain LTC services in community settings if their incomes are less than 300 percent of SSI.
- *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 project 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. This Federal matching assistance percentage 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 larger 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. Some of the mandatory services include: inpatient and outpatient hospital services, physicians' services, rural health clinic and federally qualified health center (FQHC) services, laboratory and X-ray services, and well-child services (i.e., Early and Periodic Screening, Diagnosis, and Treatment Services [EPSDT]). In addition to 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 cover under their Medicaid programs, including prescription drugs, physical therapy, dental services, and eyeglasses.

Major Legislative Milestones

Since Medicaid was enacted, the Federal Government has made significant changes in program eligibility criteria, financing, and services provided. In addition, States have used their discretion to implement their own changes in the program. 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. The following are some of the legislative changes since the Medicaid program was established in 1965.

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—EPSDT comprehensive health services benefit for all Medicaid children under age 21 is established.

1972—Medicaid eligibility for elderly, blind, and disabled residents of a State can be linked to eligibility for the newly enacted Federal SSI program if a State chooses.

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 (i.e., disproportionate share hospitals [DSH]).

1986—Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of FPL is established as a State option.

1988—Medicaid coverage for pregnant women and infants to 100 percent of FPL is mandated; special eligibility rules are established for institutionalized persons whose spouse remain in the community to prevent spousal impoverishment; QMB group is established to pay Medicare premiums and cost-sharing charges for beneficiaries with incomes and resources below established thresholds.

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

1990—Phased-in coverage of children ages 6-18 under 100 percent of FPL is established; Medicaid prescription drug rebate program established; SLMB eligibility group is established.

1991—DSH spending controls established; provider donations are banned; provider taxes are capped.

1996—Welfare Reform—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 (SCHIP) is created; limits on DSH payments are revised; new managed care options and requirements for States are established.

MEDICAID PROGRAM TRENDS

Beneficiaries

One indicator of Medicaid growth and program evolution is the trend in enrollment. In 1978, Medicaid covered approximately 9 percent of the total U.S. population. By 1998, Medicaid covered 12 percent of the total U.S. population. Many factors contribute to this increase in coverage; the most significant is the creation of new eligibility groups.

The number of individuals served by the Medicaid program remained relatively constant from 1977 to 1989. The eligibility expansions mandated in the 1980s led to significant increases among certain eligibility groups, especially pregnant women and children. Prior to implementation of these expansions, the number of persons served was approximately 23.5 million in 1989. This number reached 36.3 million in 1995 (Figure 1).

A recent decline in the number of individuals enrolled and served through Medicaid is attributed to a variety of factors including: fewer people in poverty, lower rates of unemployment, and the delinking of Medicaid and welfare assistance in 1996 (i.e., the inappropriate termination of families who lost eligibility for cash assistance but retained eligibility for Medicaid). In particular, there has been a steady decline in the number of children enrolled in Medicaid since 1996 (Figure 2).

Projections of Medicaid enrollment for the next decade show moderate growth compared with the 1990s. Total enrollment, measured in person years (i.e., full year equivalent enrollees), 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 2010. The blind and disabled population is projected to increase at twice the rate of all other eligibility groups.

Another enrollment trend is the increase in the number of non-cash beneficiaries. Non-cash beneficiaries qualify for Medicaid based solely on their income and resources (e.g., poverty-related groups). The establishment of non-cash eligibility groups allows States to provide Medicaid to low-income individuals such as the working poor whose incomes preclude them from qualifying for cash assistance. With the creation of non-cash eligibility groups, Medicaid has evolved to serve more than just welfare families. In fiscal year (FY) 1998, less than one-half (42.7 percent) of all Medicaid enrollees received some form of welfare cash assistance, and over 25 percent of beneficiaries were classified as poverty related (Figure 3).

Women and Children

Not surprisingly, females comprise a larger share of the Medicaid population (57.4 percent) than males (38.8 percent) due to their roles as mothers of children and their greater likelihood of nursing home entry (Figure 4). Medicaid provides protection for low-income women and their families from exhausting limited income and resources on LTC services. Medicaid has also had an impact on women's health.

Expansions in Medicaid eligibility coupled with presumptive eligibility for pregnant women and targeted outreach efforts (e.g., outstationed eligibility workers) have increased the availability of prenatal care services for pregnant women. The proportion of all women giving live births who started prenatal care during the first trimester increased from 75.8 percent in 1990 to 82.8 percent in 1998. Infant mortality (under 1 year of age) has decreased from 9.2 deaths per 100,000 live births in 1990 to 7.2 deaths per 100,000 live births in 1998 (National Center for Health Statistics, 2000).

Medicaid plays a prominent role in providing health insurance to low-income children. Historically, children have represented the largest eligibility group served by Medicaid. The eligibility expansions in the 1980s, coupled with a recession, contributed to the significant growth in enrollment of children throughout the early 1990s.

By the mid to late 1990s, lower unemployment rates, due to a strong economy, contributed to a decline in Medicaid enrollment. Between 1995 and 1998, the proportion of children covered by Medicaid dropped from 23.2 percent to 19.8 percent. As Medicaid enrollment has declined, the percent of uninsured children increased from 13.8 percent in 1995 to 15.4 percent in 1998 (U.S. Bureau of the Census, 2000) (Figure 5).

Medicaid coverage of children is significant among all age groups. However, coverage is more prevalent among younger aged children. From 1987 to 1993, Medicaid coverage of children under age 3 climbed from 19.0 percent to 34.6 percent. However, by 1998 the proportion of children under age 3 covered by Medicaid had dropped to 25 percent. Similar trends occurred in other age groups. In the age group 3-5, 17.8 percent of children were covered by Medicaid in 1987, increasing to 29.8 percent in 1993, and then dropping to 22.9 percent in 1998. Less dramatic changes were seen for children in the age group 12-17. In 1987, 11.7 percent of this age group was covered by Medicaid with this increasing to 16.6 percent by 1993, and decreasing slightly by 1998 to 15.5 percent (Figure 6).

Children (including children with disabilities) represent 54 percent of the 41.4 million individuals enrolled in Medicaid in FY 1998. The children Medicaid served in

FY 1998 represented one out of five children in the Nation. Over one-third of all children in the U.S. under age 6 received Medicaid services in FY 1998 (Figure 7).

Elderly

The number of Medicaid beneficiaries, age 65 or over, has grown only slightly over time. Growth in the number of elderly Medicaid beneficiaries has been much lower than the increase in the elderly U.S. population as a whole. In 1975, Medicaid covered 3.6 million older Americans or roughly 17 percent of the 21.7 million Americans age 65 or over. In 1998, Medicaid served nearly 4 million elderly beneficiaries, or 12 percent of the 32.4 million age 65 or over population (U.S. Bureau of the Census, 1999).

The elderly's representation among all Medicaid beneficiaries has actually declined over time. In 1973, the population age 65 or over represented 19 percent of all Medicaid beneficiaries. In 1998, individuals age 65 or over represented 11 percent of the Medicaid population (U.S. Bureau of the Census, 1999).

Medicaid beneficiaries age 65 or over account for a disproportionate share of total Medicaid expenditures. This is due to the high cost of services utilized by this population (e.g., LTC facilities) and not the size of the population. In 1998, elderly beneficiaries represented 11 percent of total Medicaid persons served yet they accounted for 31 percent of total Medicaid expenditures (Figure 8).

Individuals with Disabilities

The fastest growing Medicaid eligibility group is the disabled. Medicaid served approximately 6.6 million individuals with disabilities in FY 1998. The proportion of Medicaid beneficiaries with disabilities has increased over time. In FY 1973, the blind and disabled represented 11 percent of the total Medicaid population receiving services with this growing to 18 percent by FY 1998 (Figure 9).

In terms of provider payments, growth in expenditures for the blind and people with disabilities outpaced other eligibility groups. In 1978, blind and disabled individuals served through Medicaid represented 32.4 percent of total provider payments. By 1998, the blind and individuals with disabilities accounted for 43.6 percent of total provider payments (Figure 10).

One contributing factor to the growth in this eligibility group and expenditures during this time period has been the acquired immunodeficiency 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 (Health Care Financing Administration, 2000a). HCFA estimates combined Federal and State Medicaid expenditures for beneficiaries with AIDS at $4.1 billion in FY 2000.

Services

Institutional LTC Services

The most significant trend in Medicaid services is the growth in LTC expenditures. Medicaid is the primary source of LTC insurance 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 and developmentally disabled, and home and community-based services.

Medicaid's role as primary insurer for LTC has grown significantly. In 1968, Medicaid accounted for about 24 percent of total nursing home care expenditures.

In 1998, total Medicaid expenditures (State plus Federal expenditures) for nursing facility services were $44.1 billion. This accounts for almost one-half (46 percent) of all U.S. spending on nursing home care (Health Care Financing Administration, 2000b).

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 among beneficiaries. In 1998, only 4 percent (1.6 million) of all persons served by Medicaid received nursing facility services. However, the $44.1 billion spent on their service accounted for approximately 25 percent of total Medicaid expenditures.

Home and Community-Based Services

Although most LTC 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 institutionalizing Medicaid-eligible individuals. States have the flexibility to design a waiver program and select the mix of services including certain non-medical, social and supportive services 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 a diverse LTC population, including the elderly, individuals with physical and developmental disabilities, those with chronic mental illness, mental retardation, and persons with AIDS. During FY 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 (Health Care Financing Administration, 1999). Community-based LTC increased from 14.9 to 25.3 percent of LTC spending from 1992 to 1998 (Figure 11).

In 1998 Medicaid accounted for 17 percent of total spending on home health care in the U.S. (Health Care Financing Administration, 2000b). 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 LTC benefit for low-income individuals.

Medicaid Expenditures

From the inception of the Medicaid program through the late 1980s, overall Medicaid spending grew at a rate that was comparable to national health spending. Since then, however, Medicaid average annual spending growth has outpaced the rate of growth in national health spending. Medicaid expenditures have nearly tripled since the late 1980s. By FY 1998, total Medicaid program spending reached $175.1 billion. The average annual real growth rate in total spending was 5.9 percent throughout the 1980s. During the 1990s, the average annual real growth rate increased to 9.8 percent, most of which occurred in the early 1990s.

Medicaid'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 12).

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 expansions in Medicaid eligibility categories explain some of the expenditure growth. However, program spending increased the fastest between 1989 and 1992, mainly as a result of State provider tax and donation mechanisms designed to maximize Federal Medicaid payments. Several factors account for the relatively slow growth of Medicaid spending in recent years: a booming economy which has slowed enrollment growth; lower medical price inflation; the expansion of managed care and other cost containment measures; and restrictions on DSH expenditure growth (Figures 13 and 14).

Many of the factors contributing to the recent slowdown in spending growth will be temporary, producing 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. While 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 FY 2010. Case-load growth accounts for about one-sixth of the increase during this period; inflation accounts for one-third; and the balance can be explained by spending per enrollee in excess of inflation (HCFA, 2000c).

HCFA projects that total Medicaid outlays will grow at an average annual rate of about 8 percent between FYs 1998 and 2010. DSH expenditures will grow the least (a 1-percent annual average), while spending for people with disabilities and children will grow the most (9 percent annual average), followed by adults (8 percent) and the elderly (7 percent) (HCFA, 2000c).

Medicaid spending accounts for a significant portion of State budgets. In FY 1999, over 14 percent of total State general funds were spent on Medicaid. In addition, over 43 percent of total Federal funds provided to States in FY 1999 were spent on Medicaid (Figure 15).

Administrative Expenses

Medicaid administrative expenses are low compared with that of private insurance. For much of the past 30 years, Medicaid administrative expenses, as a percent of total program expenditures, have remained fairly constant—between 4.0 and 6.5 percent—compared with approximately 12 percent for major insurance plans. Overall growth rates for the most part have been relatively flat but suggest a gradual increase over the period with somewhat greater fluctuation in the past 4 years. Administrative expenses have risen by 2.5 percentage points in the past year to reach a 32-year high of 6.5 percent (Health Care Financing Administration, 2000b).

Spending By Eligibility Group

During the past two decades, Medicaid spending on behalf of the blind, individuals with disabilities and the elderly has grown significantly. This change reflects the growing Medicaid disabled population and the spiraling costs associated with institutional LTC services.

While the aged, the blind, and people with disabilities account for only 26 percent of all Medicaid persons served in FY

1998, the Medicaid payments made on their behalf account for 71 percent of program payments. The largest group, children, account for only 16 percent of all Medicaid payments (Figure 16).

This pattern in distribution of Medicaid payments by eligibility group goes back to the mid-1970s. Since 1975, Medicaid payments for the elderly and disabled have exceeded payments for adults and children. During the late 1970s and early 1980s, 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 17).

Between FYs 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 18).

Dual eligible beneficiaries are Medicare beneficiaries who also qualify for Medicaid benefits due to their low income. Medicaid spends a disproportionate share of program funds on behalf of dual eligible beneficiaries. During FY 1997, 6.4 million dual eligibles represented only 19 percent of the Medicaid population, but accounted for 35 percent of program expenditures (Clark and Hulbert, 1998).

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. Federal outlays for Medicaid premium payments to Medicaid managed care plans increased from $700 million in FY 1988 to $13.2 billion in FY 1998. State interest in pursuing Medicaid managed care initiatives began in the early 1980s 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, and achieve greater coordination and continuity of care.

Throughout the 1990s, States significantly expanded their Medicaid managed care programs. In 1991, less than 10 percent of all Medicaid beneficiaries were enrolled in managed care plans. By 1998, nearly 54 percent (16.5 million) of the Medicaid population was enrolled in managed care plans (Figure 19).

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), 12 States have penetration rates between 76 and 100 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 and South Carolina. During 1998, South Carolina enrolled 4 percent of beneficiaries in managed care while North Carolina had a 69-percent managed care penetration rate (Figure 20).

Most State Medicaid managed care enrollment consists of children and non-disabled adults. In 1998, individuals under age 21 represented over 55 percent of all Medicaid managed care enrollees, while adults age 21-64 represented nearly 29 percent of total managed care enrollment (HCFA Form 2082).

The elderly and the disabled are not traditionally pursued for managed care enrollment due to the challenge of delivering comprehensive services to these high need populations while controlling costs. Several States, however, have started to move non-elderly, disabled Medicaid beneficiaries into managed care. In 1998, approximately 1.6 million persons with disabilities were enrolled in Medicaid managed care programs operated by 36 different States (Regenstein and Schroer, 1998).

Managed Care Waivers

Medicaid program waivers play a significant role in the delivery of Medicaid services. Medicaid program waivers have allowed States to test Medicaid program innovations. The two primary mechanisms used for this are section 1915(b) Freedom of Choice waivers, and section 1115 research and demonstration projects.

Section 1915(b) waivers are used to mandatorily enroll beneficiaries in managed care programs; provide additional services via savings produced from managed care, create a carve-out delivery system for specialty care (e.g., behavioral health, etc.), and/or create programs that are not available statewide.

Section 1115 research and demonstration projects provide States with the flexibility to test substantially new ideas of policy merit. Under 1115 research and demonstration projects, States are testing programs that range from small-scale pilot projects testing new benefits or financing mechanisms, to major restructuring of State Medicaid programs. In 1998, 19 States had approved section 1115 research and demonstration projects, 17 of which were operating statewide.

LTC

States are increasingly interested in providing LTC services in a managed care environment. In addition to providing traditional LTC 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. Currently, Texas and Michigan are operating concurrent 1915(b) and 1915(c) waivers.

SCHIP

In order to further address the problem of uninsured children, the SCHIP was created by BBA 1997. Designed as a State/Federal partnership, SCHIP was appropriated $24 billion over 5 years and $40 billion over 10 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 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 FPL or 50 percentage points above the State's Medicaid eligibility threshold. Most States have an upper eligi-

bility limit of 200 percent of FPL, however, some States have amended their SCHIP plans to expand coverage to more children.

SCHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. When enacted, the goal of BBA was to cover one-half of the 10 million uninsured children through Medicaid outreach and SCHIP expansions. It has provided States with 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 FY 1999.

The SCHIP law offers States three options for covering uninsured children. States can use SCHIP funds to provide coverage through separate children's health insurance programs, expand coverage available under Medicaid, or combine both strategies. States are using all three options for implementation.

Although most States use a Medicaid expansion as part of their SCHIP plan—either separately or in combination with a separate program—two thirds of all SCHIP children are being served through separate SCHIP programs. In FY 1999, nearly 2 million children were enrolled in the SCHIP program. States reported that over 1.2 million children were in new State-designed children's health insurance programs and almost 700,000 were enrolled in Medicaid expansion plans in FY 1999 (Figure 21).

Note on Data Sources

A majority of the information presented in this article is based on State-reported program data collected by HCFA (HCFA-2082 and HCFA-64). Each figure cites reference sources as well as notes to clarify the data.

Terminology

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

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

Data Caveats—HCFA-2082 and HCFA-64

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 gross domestic product chain-type price index (1996=100). The chain-type price indexes used for these adjustments were published by the U.S. Bureau of Economic Analysis (2000).

Apparent inconsistencies in financial data are due to the difference in the information captured on the HCFA-2082 and HCFA-64. 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 and do not reflect payment adjustments or deductions. States claim the Federal match for payments to DSHs on the HCFA-64. Payments to DSHs 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 this report is collected from State Medicaid agencies and HCFA. Data is presented for all States, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico.

Current Population Survey (CPS)

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.

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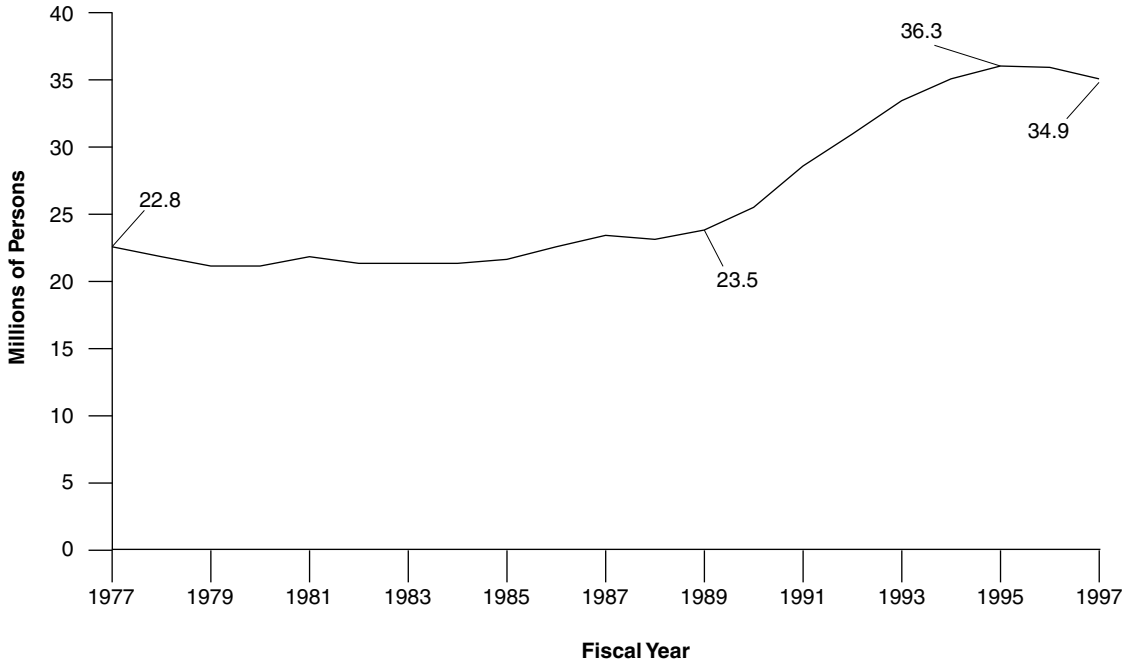
Reprint Requests: Christie Provost, M.P.P., Health Care Financing Administration, Room 325-H, Hubert H. Humphrey Building 200 Independence Avenue, SW., Washington, DC. E-mail: cprovost@hcfa.gov

Figure 1

Persons Served Through Medicaid, Fiscal Years 1977-1997

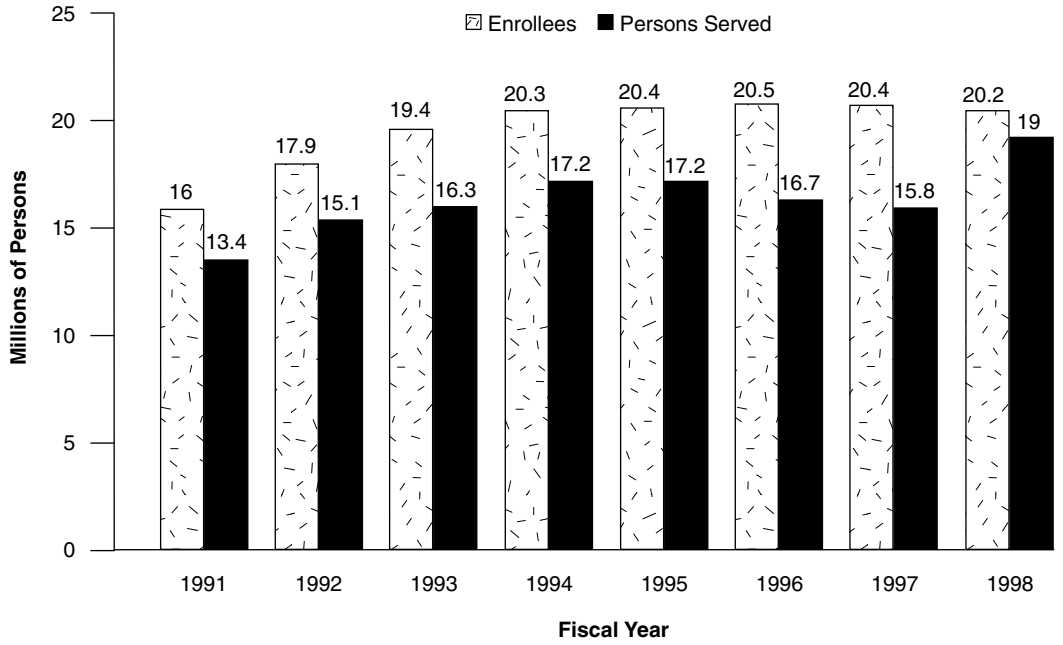


NOTES: The trend line presents a consistent time-series data set through 1997. In 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations. FY 1998 was the first year 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. Persons-served are individuals for whom a Medicaid claim was paid during the year.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from the 1977-1997 HCFA Form 2082, 2000.

Figure 2

Medicaid Populations – Children, Fiscal Years 1991-1998

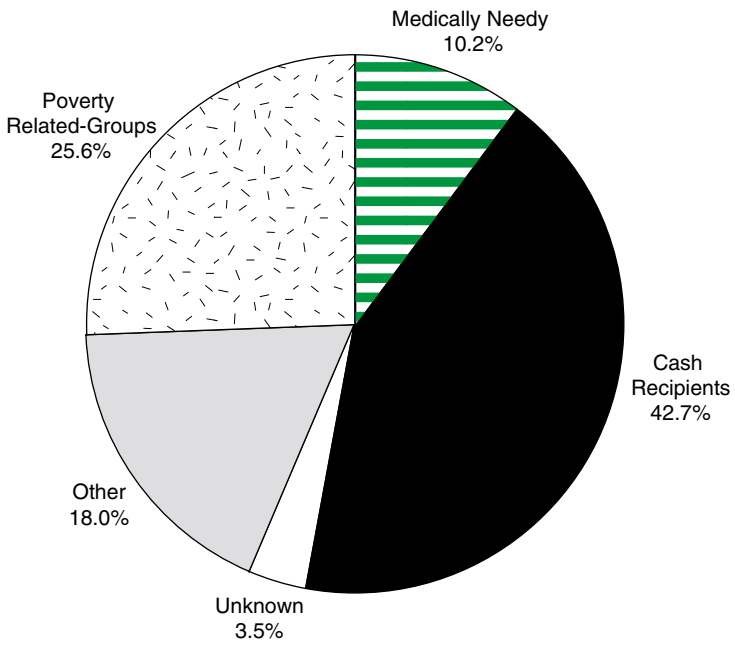


NOTES: In 1998, a large increase occurred in the number of persons served through Medicaid, which is mainly the result of a new reporting methodology of classifying payments to managed care organizations. FY 1998 was the first year capitation payments were counted as a service for purposes of the HCFA-2082 reporting, and thus managed care enrollees were included in the counts of individuals receiving services through Medicaid. Enrollees are individuals enrolled in Medicaid at least 1 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.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1991-1998 HCFA 2082, 2000.

Figure 3

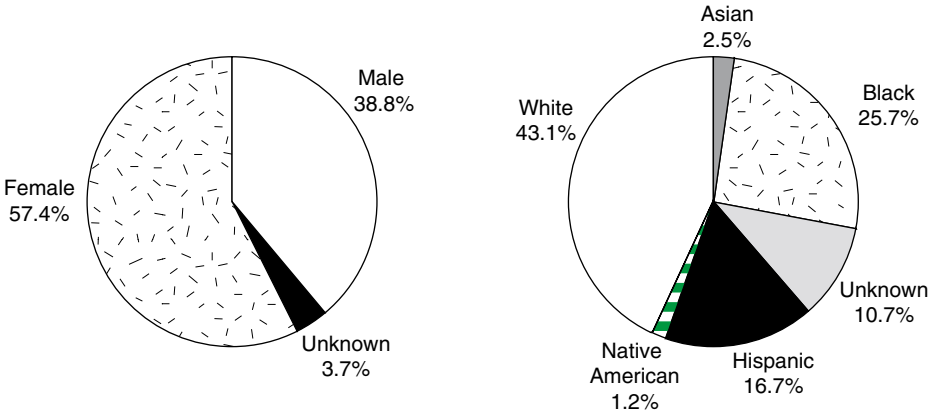
Medicaid Enrollees, by Maintenance Assistance Status: Fiscal Year 1998



SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 4

Medicaid Enrollees, by Sex and Race: Fiscal Year 1998

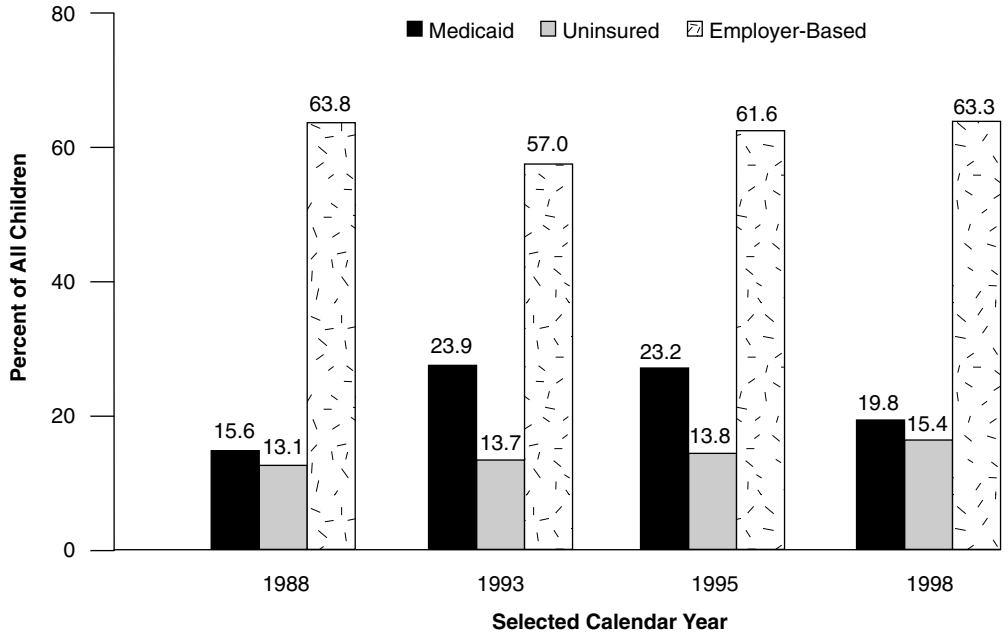


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 5

Percent of Insurance Children, by Type of Coverage: Selected Calendar Years

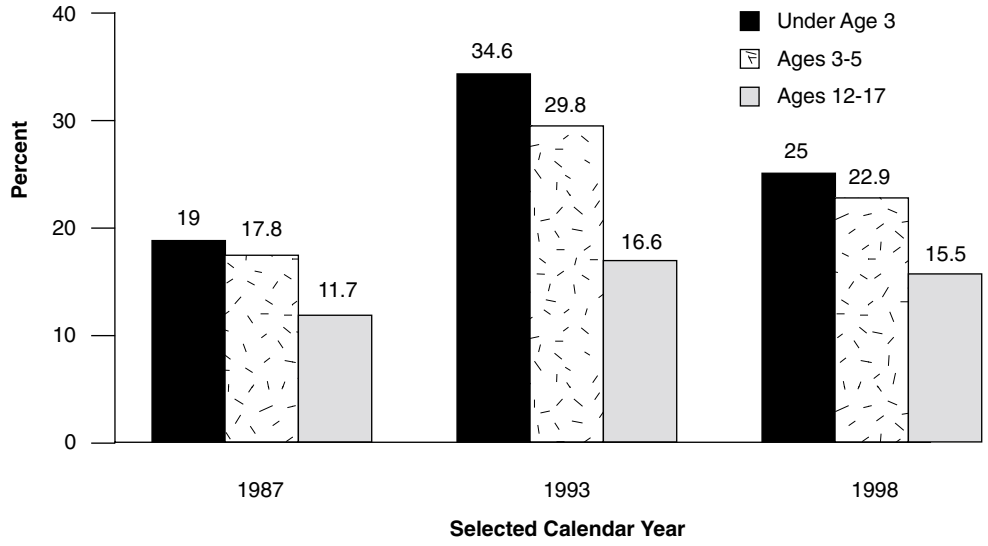


NOTES: Children refers to all people under the age of 18. The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of insurance during the year. In 1994, health insurance questions on the *Current Population Survey* were redesigned; increases in estimates of employment-based coverage may be partially due to questionnaire changes; overall coverage estimates were not affected.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1988, 1993, 1995, and 1998 U.S. Bureau of the Census, March *Current Population Survey*, U.S. Government Printing Office. Washington, DC. 2000.

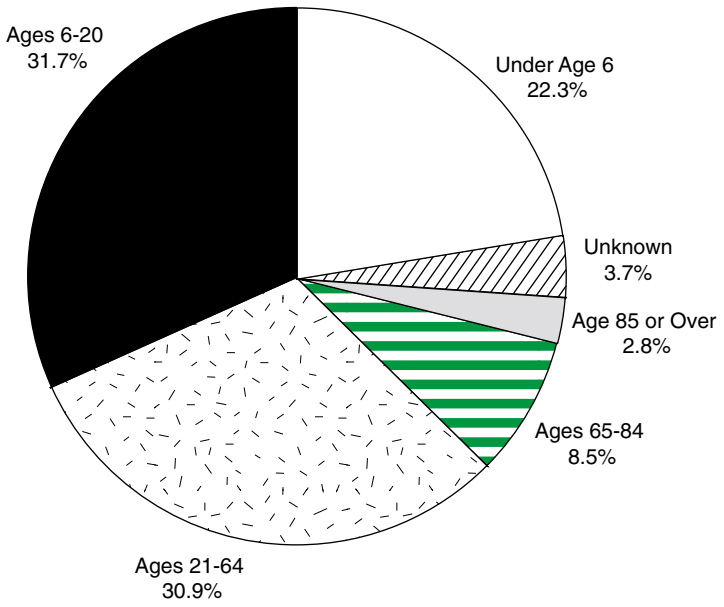
Figure 6

Percent of Children With Medicaid, by Age Groups: Selected Calendar Years



SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1987, 1993, and 1998 U.S. Bureau of the Census, March *Current Population Survey*, U.S. Government Printing Office. Washington, DC. 2000.

Figure 7
Medicaid Enrollees, by Age: Fiscal Year 1998

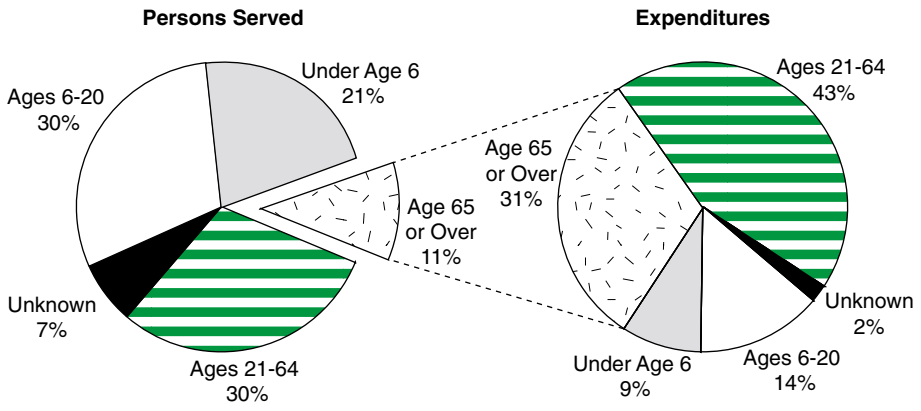


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 8

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

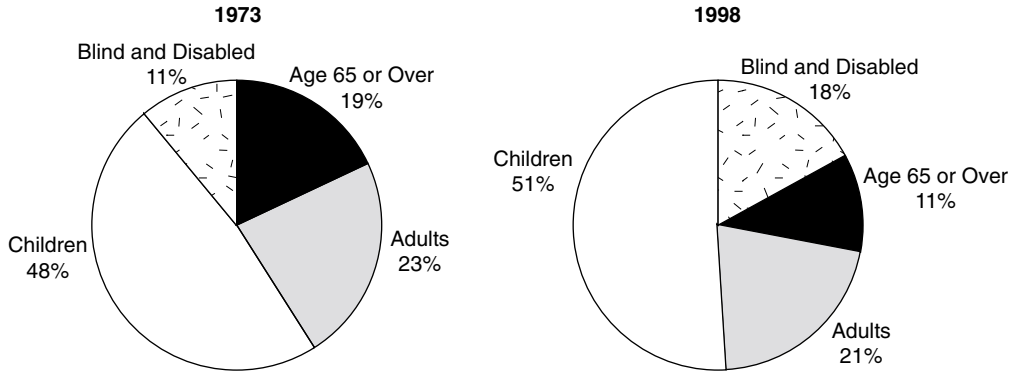


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 9

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

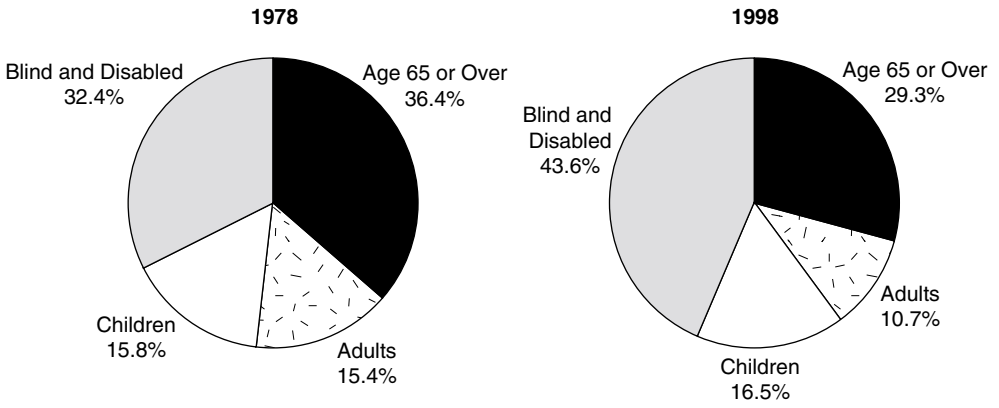


NOTES: The percentage distribution for 1973 does not include 1.5 million persons served by Medicaid whose basis of eligiblity is reported as other, and the percentage distribution for 1998 does not include 3.1 million persons served whose basis of eligibility is unknown. Percentages may not sum to 100 because of rounding. The term adults, refers to a category of non-elderly, non-disabled adults. Disabled children are included in the blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from the 1973 and 1998 HCFA 2082, 2000.

Figure 10

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

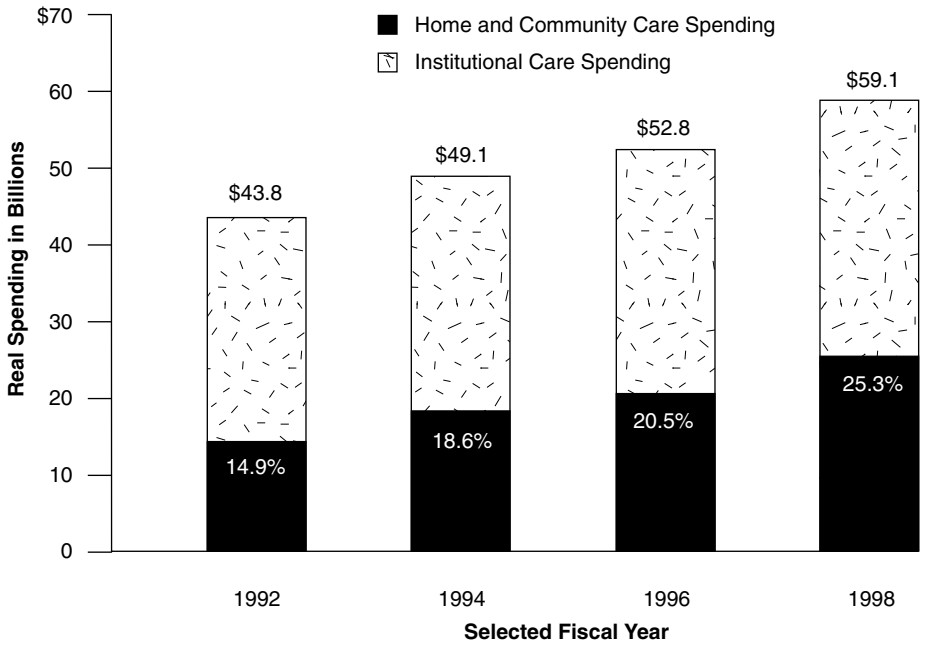


NOTES: The percentage distribution for 1978 does not include $1.4 billion of payments (in 1998 dollars) on behalf of 1.9 million persons served by Medicaid whose basis of eligibility is reported as other, and the percentage distribution for 1998 does not include $3.7 billion on behalf of 3.1 million persons served whose basis of eligibility is unknown. Percentages may not sum to 100 because of rounding. Payments describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude disproportionate share hospital payments, Medicare premiums, and cost sharing on behalf of dual beneficiaries). The term adults as used refers to non-elderly, non-disabled adults. Disabled children are included in the blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from the 1978 and 1998 HCFA 2082, 2000.

Figure 11

Medicaid Spending for Institutional Long-Term Care (LTC) and Home and Community Care, by Selected Fiscal Years

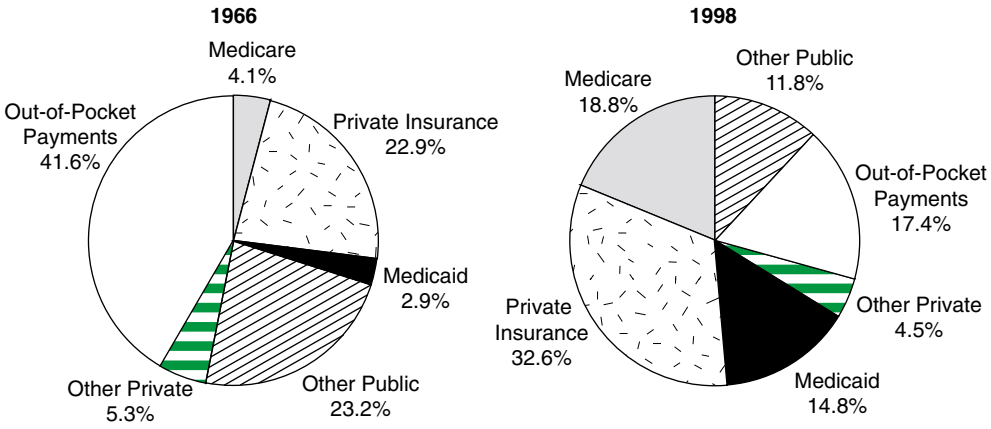


NOTES: The data are expressed in 1998 dollars. Total Medicaid LTC expenditures consist of spending on institutional LTC and home and community care. Institutional LTC spending includes expenditures for nursing facilities, and public and private intermediate care facilities for the mentally retarded. Home and community care spending consists of expenditures for personal care, home health, and home and community-based waivers. The percentages (e.g., 14.9 percent, 18.6 percent, etc.) represent the proportion of total Medicaid LTC spending that is home and community care spending.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1992, 1994, 1996, and 1998 HCFA 64, 2000.

Figure 12

Medicaid Expenditures as a Percent of All National Health Expenditures: Calendar Years 1966 and 1998

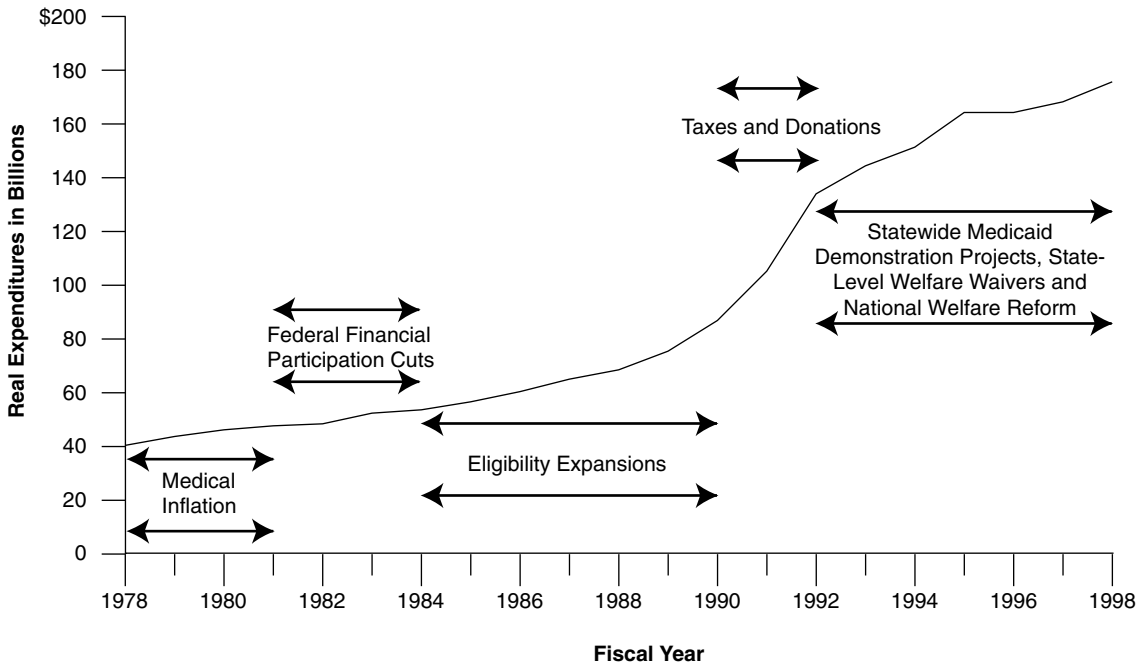


NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the National Health Statistics Group, 2000.

Figure 13

Total Medicaid Spending, by Era: Fiscal Years 1978-1998

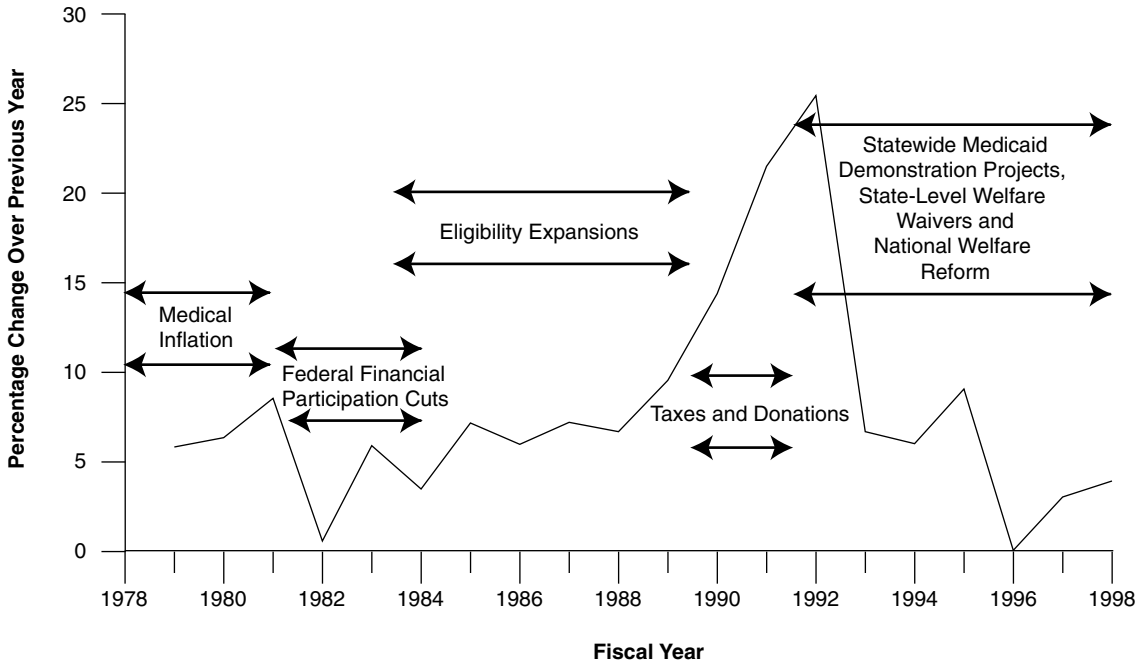


NOTE: The data are expressed in 1998 dollars.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 14

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

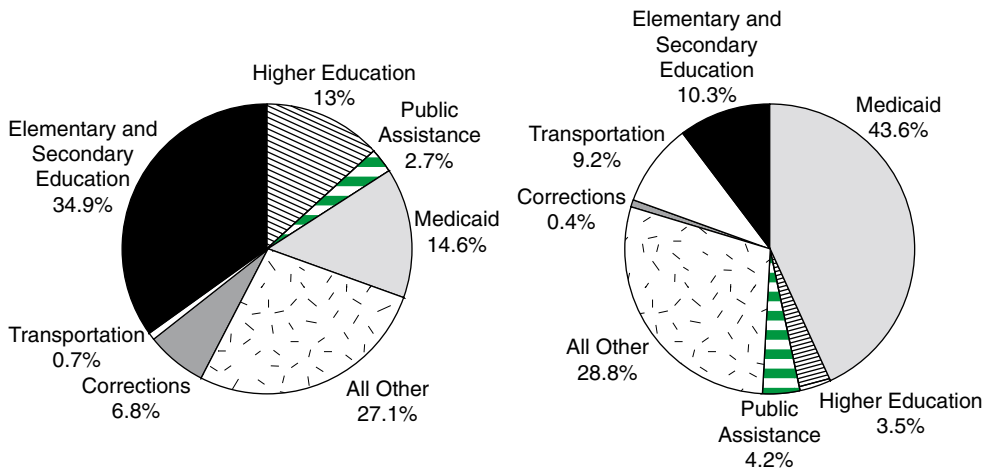


NOTE: The data are expressed in 1998 dollars.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare and Medicaid Cost Estimates Group, 2000.

Figure 15

State Medicaid Spending Compared With Other Expenditures, by Fund Sources: Fiscal Year 1999



State Spending: General Funds

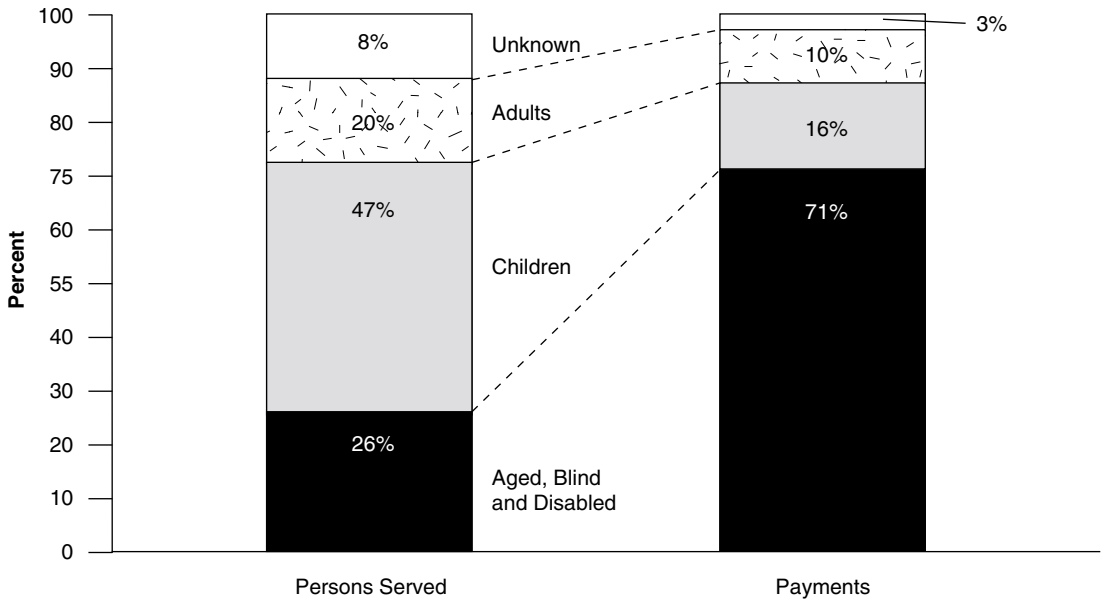
State Spending: Federal Funds Provided to States

NOTE: Percentages may not sum to 100 because of rounding.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from the National Association of State Budget Officers, 1999 State Expenditure Report, 2000.

Figure 16

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

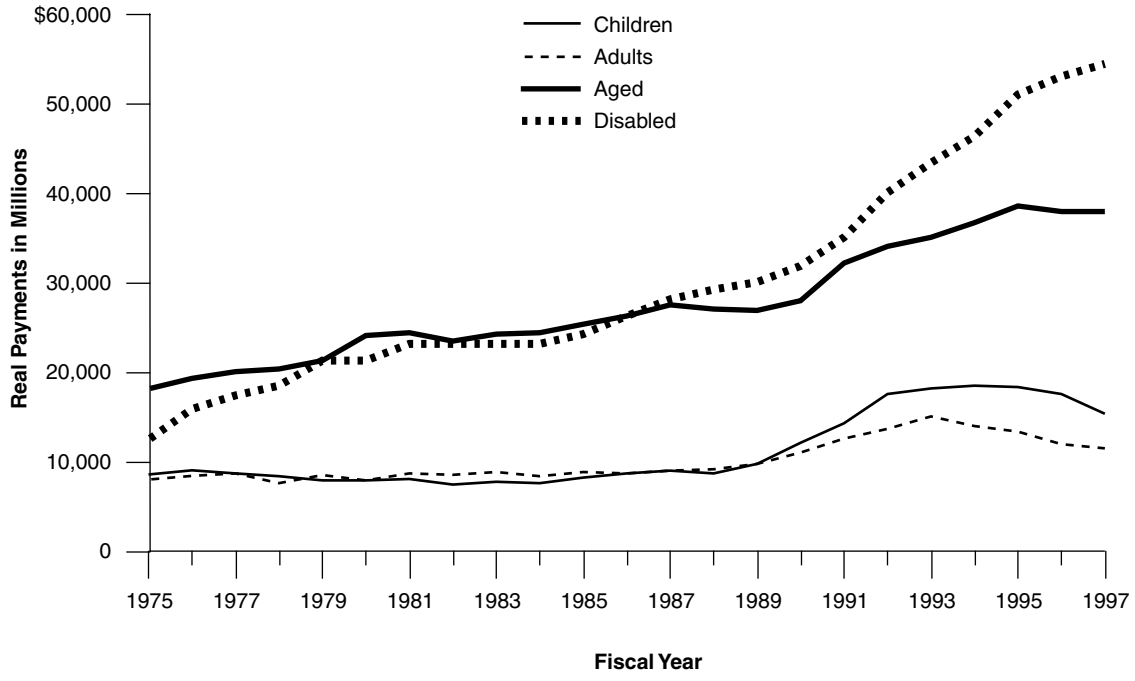


NOTES: Totals may not equal 100 percent because of rounding. Payments describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude disproportionate share hospital payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare). Disabled children are included in the aged, blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from 1998 HCFA 2082, 2000.

Figure 17

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

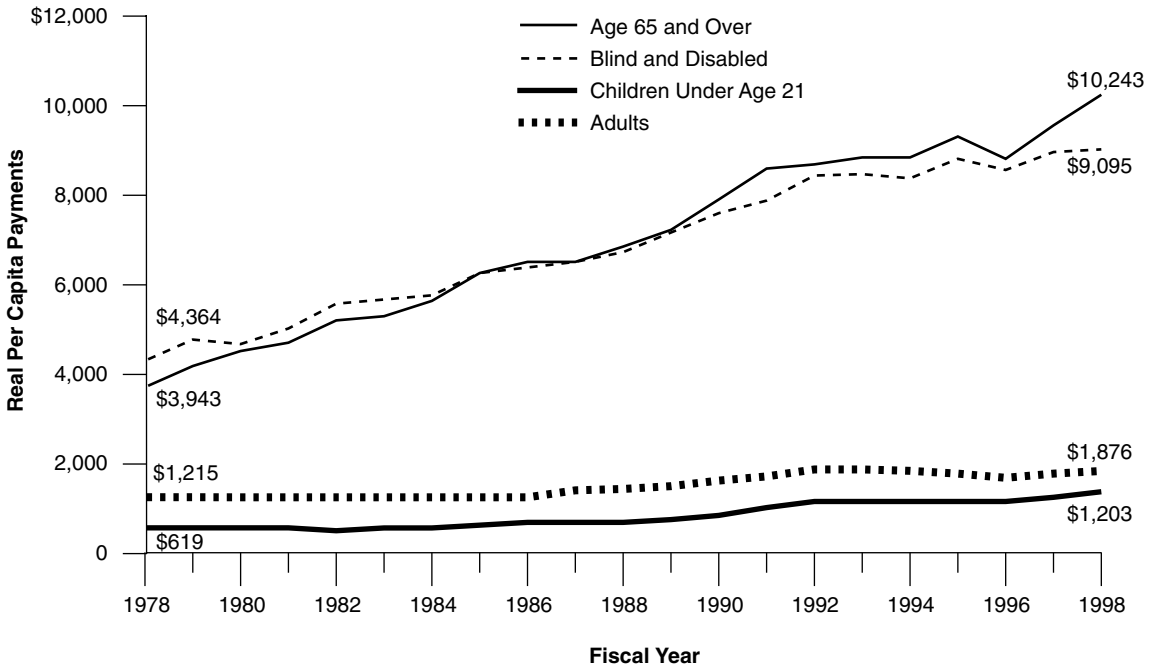


NOTE: Expenditures expressed in 1997 dollars.

SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Division of Beneficiary Research, data from 1975-1997 HCFA 2082, 2000.

Figure 18

Average Real Medicaid Payments per Person Served: Fiscal Years 1978-1998

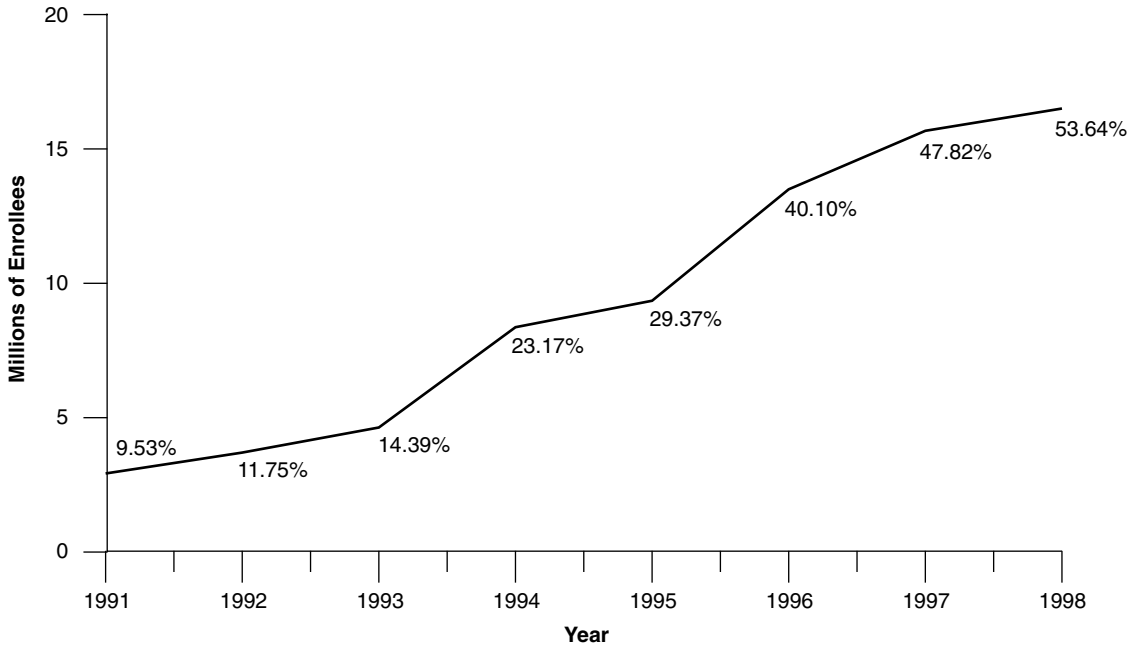


NOTES: Data shown expressed in 1998 dollars. For fiscal year 1998 payments describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude disproportionate share hospital payments, Medicare premiums, and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare), while data from previous years only include direct vendor payments. The term adults as used refers to a category of non-elderly, non-disabled adults. Disabled children are included in the blind and disabled category.

SOURCE: Health Care Financing Administration, Office of Information Services: Data development by Enterprise Databases Group, data from 1978-1998 HCFA 2082, 2000.

Figure 19

Number and Percent of Medicaid Beneficiaries Enrolled in Managed Care, by Year[1]: 1991-1998



[1] June 30 reporting date.

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

SOURCE: Health Care Financing Administration, Center for Medicaid and State Operations: Data from the 1998 Medicaid Managed Care Enrollment Report, 2000.

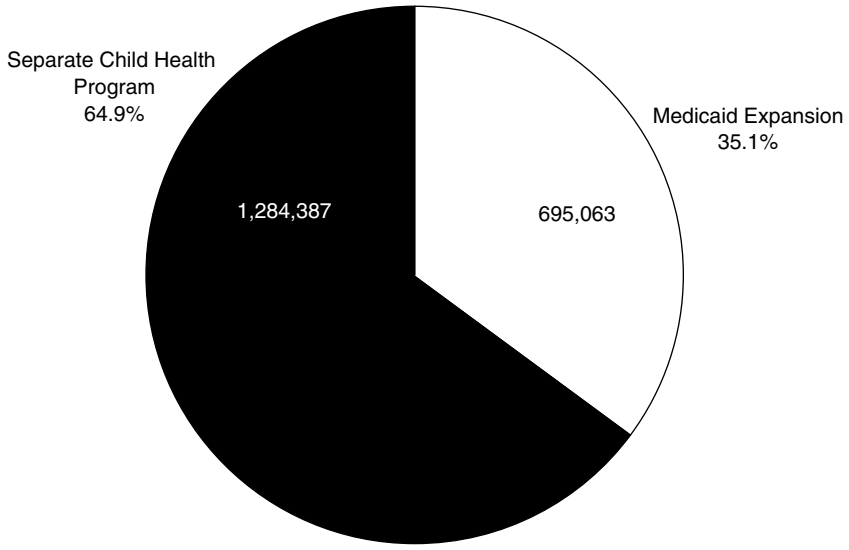
Figure 20
Medicaid Managed Care Penetration, 1998

0 Percent	1-25 Percent	26-50 Percent	51-75 Percent	76-100 Percent
Alaska	Illinois	California	Alabama	Arizona
Virgin Islands	Louisiana	Distict of Columbia	Arkansas	Colorado
Wyoming	Maine	Idaho	Connecticut	Delaware
	New Hampshire	Kansas	Florida	Georgia
	South Carolina	Mississippi	Indiana	Hawaii
	Texas	Missouri	Kentucky	Iowa
		Nevada	Maryland	Montana
		New York	Massachusetts	New Mexico
		Ohio	Michigan	Oregon
		Oklahoma	Minnesota	Puerto Rico
		Vermont	Nebraska	Tennessee
		West Virginia	New Jersey	Utah
		Wisconsin	North Carolina	Washington
			North Dakota	
			Pennsylvania	
			Rhode Island	
			South Dakota	
			Virginia	

SOURCE: Health Care Financing Administration, Center for Medicaid and State Operations: Data from the 1998 Medicaid Managed Care Enrollment Report, 2000.

Figure 21

State Children's Health Insurance Program Enrollment: Fiscal Year 1999



SOURCE: Health Care Financing Administration, Office of Strategic Planning: Data development by Planning and Policy Analysis Group, data from fiscal year 1999 State Children's Health Insurance Program Annual Enrollment Report, 2000.