kaiser commission on
KEY FACTS
medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION
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KEY QUESTIONS ABOUT MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS AND HEALTH REFORM

1. What is Medicaid and what does it do?

Medicaid is the nation's primary health insurance program for low-income and high-need Americans. Medicaid covers 60 million low-income Americans. The program provides health coverage for low-income families who lack access to other affordable coverage options and for individuals with disabilities for whom private coverage is often not available or not adequate. Today, Medicaid does not cover all individuals with low incomes. Millions of low-income adults (particularly adults without dependent children) are uninsured because they are not eligible for Medicaid and do not have access to other coverage. Given the wide array of health needs and limited incomes of enrollees, Medicaid provides a broad range of services, with limited cost-sharing.

Medicaid is the largest source of funding for safety-net providers and the dominant payer for long-term care. Medicaid also helps to make Medicare work for low-income elderly and disabled beneficiaries. Medicaid is the largest source of funding for safety-net providers (such as community health centers and public hospitals) that serve the poor and uninsured. Many of these providers are located in low-income communities or rural areas with provider shortages. Medicaid is also the nation's largest payer for long-term care services. It helps to make Medicare work for nearly 9 million low-income elderly and disabled beneficiaries who rely on Medicaid to help pay for Medicare premiums, gaps in Medicare benefits, and long-term care needs.

States and the federal government jointly administer and finance the Medicaid program. State participation in Medicaid is optional. States that elect to participate, as all have done for the past 30 years, must meet minimum federal standards related to coverage and benefits to receive federal matching funds. States have flexibility to cover populations and services beyond federal minimums and receive federal matching funds for these costs. States generally have a great deal of flexibility to determine who is covered, what services to cover, how to deliver care and how much to pay providers. Flexibility to set eligibility levels has been limited over time by increases in federal minimum levels for children and pregnant women and more recently by eligibility protections put in place under the American Recovery and Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (ACA). However, as a result of general flexibility there is large variation from one state Medicaid program to the next. Financing for Medicaid is shared between the states and the federal government, with the federal government paying 57 percent of Medicaid costs on average across states (although this rate has been temporarily increased under ARRA). For states, Medicaid represents a major budget item and the largest source of federal revenues.

Medicaid increases access to care and limits out-of-pocket burdens for low-income people. Children and adults enrolled in Medicaid have much better access to care than those without insurance. And compared with people who do have private health insurance, Medicaid enrollees fare just as well on most measures of access to preventive and primary care, despite often cited concerns about provider participation. While there have been concerns about access to some provider types like dentists and some specialists, these issues reflect more general provider shortages as well problems with the geographic distribution of physicians that are not limited to Medicaid. Because the population covered is low-income, Medicaid does not require premiums and imposes little cost sharing, so enrollees face far fewer financial barriers to care compared to the uninsured and many with private insurance. Medicaid's extensive use of managed care arrangements has helped to improve access to care for many of its enrollees.

Most Medicaid enrollees access care through managed care plans that use private provider networks to deliver services. Nearly three-quarters (72 percent) of Medicaid enrollees are enrolled in some type of managed care (fully capitated plans or primary care case management). These plans use networks of private providers to deliver covered services to their enrollees. Medicaid managed care enrollees are largely children and families, although many states are considering enrolling elderly and disabled beneficiaries in managed care plans as well.

2. What does Medicaid cost and why?

Medicaid accounts for about one sixth of total health care spending in the country. Medicaid represents 18 percent of all hospital spending and 40 percent of all nursing home spending in the U.S. In fiscal year 2009, total federal and state Medicaid spending was $339 billion. About three-fifths of this spending was on hospital, physician, drugs, and other acute care services; about a third was on nursing home and other long-term care services.

The elderly and disabled account for the majority of Medicaid spending. While children and parents make up about 75 percent of Medicaid enrollees, they account for less than a third of the spending. In contrast, the elderly and individuals with disabilities make up about 25 percent of enrollees but about two-thirds of spending. Medicaid spending per capita in 2009 was $3,442 for families (parents and children) and more than five times higher for the elderly and disabled at $17,763. The elderly and disabled have higher utilization and intensity of use for acute care services and the elderly and disabled are more likely to use long-term care services.

Medicaid spending is concentrated among a small number of high need enrollees. Individuals dually eligible for Medicare and Medicaid represent 15 percent of Medicaid enrollees and 40 percent of Medicaid spending, helping these individuals pay for Medicare premiums, and providing services and benefits that Medicare does not, including long-term care. Furthermore, only 5 percent of all Medicaid enrollees account for over half (54 percent) of Medicaid spending.

Enrollment is the dominant driver in Medicaid spending, especially during periods of economic downturn. Medicaid costs are driven largely by increases in enrollment. Inflation in the price of the health care services that Medicaid buys, and the use of services by Medicaid enrollees, also affect Medicaid spending, but enrollment is the dominant driver. This is especially true during economic downturns, when unemployment rises and incomes fall, increasing the number of low-income people eligible for Medicaid. From 2008 to 2009, total Medicaid spending grew by 8.7 percent with enrollment growing by 7.5 percent and spending per enrollee only increasing by 1.1 percent.

States have a strong incentive to manage Medicaid cost growth. Because states pay, on average, 43 percent of Medicaid costs, and because they must produce annual balanced budgets, states have a strong incentive to carefully manage program spending growth. Over the last decade, states have implemented an array of Medicaid cost containment measures as well as innovative service delivery models (including use of managed care and medical home models) to manage the growth of Medicaid costs.

On a per enrollee basis, Medicaid spending is growing more slowly than premiums for employer-sponsored insurance or national health care spending overall. On a per enrollee basis, Medicaid spending growth is lower than the growth in both employer-sponsored insurance coverage and national health expenditures overall. Over the past ten years, Medicaid spending per enrollee grew an average of 4.6 percent per year; the comparable rate of growth in the per capita costs of employer-sponsored insurance was 7.7 percent per year and in national health expenditures, 5.9 percent per year. Even though Medicaid is growing more slowly than other health programs, Medicaid still uses private providers in the private health care market, so it will take broader efforts that span all payers, both public and private, to bring overall health care costs under control.

3. What is Medicaid's role in state budgets?

Medicaid is the largest source of federal revenue for states. Medicaid funds support health care providers, jobs and state economies overall. The Medicaid program is jointly funded by states and the federal government. The federal matching percentage (FMAP) varies by state (ranging from a statutory floor of 50 percent up to 75 percent in 2011) and is based on a formula in the law that relates the FMAP to a state's average personal income. For every $2 that states pay for a Medicaid-covered service, they receive at least $1 back from the federal government. By the same token, to save just $1 in state general fund spending on Medicaid, states need to cut at least $2 in Medicaid spending. On average, states spend about 16 percent of their own funds on Medicaid, making it the second largest program in most states' general fund budgets (following elementary and secondary education, which represented 35 percent of state spending in FY 2008). Medicaid matching funds are the single largest source of federal grant support to states (45 percent in FY 2008). By bringing revenues to hospitals, nursing homes, clinics, pharmacies, and other providers, Medicaid plays an important role in supporting jobs and economic activity in urban and rural communities alike.

Enhanced Medicaid matching funds in ARRA have been critical in helping to support state budgets and Medicaid during the Great Recession. State budgets and Medicaid programs have been bolstered by temporary federal fiscal relief that was included in ARRA. That legislation, and a subsequent extension, provided states with a temporary increase in the federal share of Medicaid payments from October 1, 2008 through June 30, 2011 to help support Medicaid and state budgets during the recent recession. In periods of economic downturn, the number of low-income families rises and the need for Medicaid grows. At the same time, state revenues fall, making it more difficult for states to pay the state share of Medicaid costs. Increased federal funds with required protections for eligibility helped states to preserve coverage and avoid some program cuts that would create a further drag on state economic recovery. The expiration of the increase in federal matching payments will mean significant reductions in federal aid to states at the start of state fiscal year 2012, when many state economies and revenues are not expected to have fully recovered from the recession.

4. What is Medicaid's role in the federal budget?

Medicaid is the third-largest domestic program in the federal budget. In 2010, spending from Medicaid, Medicare, and Social Security accounted for about 43 percent of all federal spending (Medicaid accounting for 8 percent of federal spending, Medicare 15 percent, and Social Security 20 percent). Compared to Medicare and Social Security, Medicaid has less impact on the federal budget because financing is shared by the federal government and the states with states paying about 43 percent of the costs.

Some deficit reduction proposals would fundamentally change the structure and financing of Medicaid. Recently, various proposals have been advanced to reduce annual federal deficits and to slow the increase in the national debt. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid. Some of the proposals relating to Medicaid would fundamentally change the structure and financing of the program, with major implications for providers and beneficiaries. One such proposal would be to convert Medicaid into a block grant, capping federal Medicaid payments to each state at a specified dollar amount, and limiting the growth in that dollar amount each year. Based on analysis of previous proposals to cap Medicaid, these dollar caps and growth limits would have to be set below the levels at which Medicaid is now expected to grow based on enrollment and health care inflation to save money. Under a block grant, costs that the federal government would otherwise have shared in would not disappear. Rather, they would be shifted to states, counties, providers, or low-income people. Some cite additional flexibility for states under capped financing, but states have a great deal of flexibility under the current program with guaranteed matching dollars. Also, these proposals will not control health care costs outside of Medicaid, so health care costs will still rise.

5. What is Medicaid's role in health reform?

Health reform builds on Medicaid as a base of coverage for low-income Americans. The Patient Protection and Affordable Care Act (ACA) will extend health insurance coverage to 32 million Americans. About 16 million of these Americans will receive their coverage through Medicaid programs administered by the states; the remainder will receive their coverage through state-operated health insurance Exchanges. The fundamental changes to Medicaid are to base eligibility on income, without regard to assets, and to set a national eligibility floor for nearly all individuals under age 65. These changes will expand Medicaid coverage for adults including parents for whom Medicaid eligibility levels are limited in many states and adults without dependent children who have been historically barred from Medicaid coverage. Beginning on January 1, 2014, Medicaid will cover nearly all individuals under age 65 up to 133 percent of poverty ($14,404 for an individual or $29,326 for a family of four in 2010). Individuals and families with incomes above those levels, but below 400 percent of poverty, will be eligible for tax credits to help with the costs of insurance premiums for coverage offered through the state-run Exchanges.

The federal government will finance about 95 percent of the costs of new Medicaid coverage over the 2014 to 2019 period. States could experience savings from reduced payments for uncompensated care and other services (like mental health services) currently provided for the uninsured. The ACA provides 100 percent federal financing for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal contribution to 90 percent by 2020. By 2019, Medicaid enrollment is expected to increase by 16 million, and on average over the 2014 to 2019 period, the federal government will finance about 95 percent of the costs of the new Medicaid coverage. From June 2001 to June 2010, enrollment in Medicaid has increased by 16 million without similar increases in federal support. All states are likely to see large declines in the numbers of uninsured for little investment of state funds. States will continue to receive their regular matching rates for individuals who qualify for Medicaid under their current eligibility rules, and some states that already cover childless adults will receive a phased-in increase in their match rate for this population. New state spending for Medicaid coverage may be offset by savings from reduced state payments for uncompensated care and other services (like mental health) currently provided for the uninsured. States that currently provide Medicaid coverage to individuals above 133 percent of poverty could experience savings if they transition these populations into the insurance Exchanges, where tax credits for coverage are funded entirely by the federal government.

Like today, most Medicaid enrollees will access care through private managed care plans. The benefits for those newly eligible for Medicaid must, at a minimum, match the essential health benefits required for coverage available through the Exchanges. This package will not include some services covered in the traditional Medicaid package like long-term care services. In an effort to boost provider participation and access, the ACA increases Medicaid payments for primary care services provided by primary care physicians to 100 percent of the Medicare payment rates for two years, with full federal financing for the increased costs. Health reform also includes significant investments in community health centers, which have long been an important source of access to care for low-income individuals, including many Medicaid beneficiaries. Because Medicaid purchases services in the private health care market, current national shortages in the supply of primary care doctors, dentists and some specialists, and problems with the geographic distribution of physicians, will affect access for individuals with Medicaid coverage as well as individuals with private coverage, as health reform is implemented.

ACA provides new options to expand community-based long-term care and to coordinate care for high cost populations. ACA also includes a number of other changes to Medicaid including new options to expand community-based long-term care, new funding for demonstration programs, and new opportunities for states to test innovative payment and delivery systems and to coordinate care for dual eligibles. These new opportunities build on current Medicaid efforts and may help to implement reform and provide some additional means to achieve cost savings and improve care in the near-term as well as over the long-term.

See attached data sheet for additional state by state information about key Medicaid statistics.

States	Medicaid Enrollees			Medicaid Service Delivery & Spending			Medicaid Funding		
	Total # Medicaid Enrollees	% Residents Covered by Medicaid	Children as a % of Total Medicaid Enrollees	% of Medicaid Enrollees		% Medicaid Spending on Long-Term Care	Regular FMAP 2010	Medicaid as % of	
				Managed Care	Elderly and Disabled			General Fund Spending	Federal Funds to States
United States	**58,106,000**	**19%**	**50%**	**72%**	**67%**	**34%**	**56%**	**16%**	**45%**
Alabama	918,800	20%	48%	66%	66%	33%	68%	3%	44%
Alaska	120,800	18%	60%	0%	54%	38%	51%	8%	34%
Arizona	1,455,800	23%	47%	90%	29%	24%	66%	13%	56%
Arkansas	692,300	24%	54%	79%	72%	36%	73%	14%	50%
California	10,511,100	29%	41%	52%	69%	32%	50%	12%	43%
Colorado	553,800	11%	60%	95%	70%	37%	50%	17%	35%
Connecticut	530,300	15%	53%	75%	74%	52%	50%	21%	48%
Delaware	184,900	21%	43%	74%	57%	31%	50%	14%	44%
District of Columbia	164,900	28%	47%	98%	70%	27%	70%	NA	53%
Florida	2,842,400	16%	51%	66%	69%	29%	55%	16%	41%
Georgia	1,685,000	18%	58%	92%	54%	26%	65%	12%	39%
Hawaii	216,600	17%	44%	97%	58%	34%	54%	9%	41%
Idaho	212,500	14%	62%	84%	69%	34%	69%	13%	43%
Illinois	2,322,500	18%	56%	55%	60%	27%	50%	20%	39%
Indiana	1,022,700	16%	59%	74%	65%	32%	66%	12%	45%
Iowa	470,000	16%	48%	83%	74%	45%	64%	11%	40%
Kansas	352,900	13%	57%	87%	71%	41%	60%	14%	40%
Kentucky	833,900	20%	47%	83%	67%	28%	71%	12%	49%
Louisiana	1,096,500	25%	57%	69%	71%	31%	68%	8%	43%
Maine	350,100	27%	36%	64%	73%	33%	65%	19%	57%
Maryland	753,100	13%	51%	79%	71%	35%	50%	18%	43%
Massachusetts	1,402,500	22%	32%	60%	70%	29%	50%	28%	53%
Michigan	1,855,500	18%	56%	89%	67%	24%	63%	23%	43%
Minnesota	785,600	15%	50%	63%	73%	42%	50%	18%	49%
Mississippi	750,400	26%	50%	76%	70%	32%	76%	7%	50%
Missouri	1,001,800	17%	55%	99%	63%	25%	65%	15%	50%
Montana	110,800	12%	55%	67%	69%	42%	67%	9%	33%
Nebraska	240,900	14%	59%	84%	68%	44%	61%	20%	39%
Nevada	247,000	10%	56%	84%	67%	30%	50%	11%	31%
New Hampshire	143,500	11%	61%	78%	69%	43%	50%	31%	40%
New Jersey	954,000	11%	53%	75%	76%	39%	50%	14%	40%
New Mexico	501,300	25%	60%	74%	55%	26%	71%	12%	51%
New York	4,954,600	26%	40%	66%	72%	43%	50%	16%	55%
North Carolina	1,645,900	18%	53%	70%	65%	30%	65%	14%	52%
North Dakota	69,400	11%	50%	68%	78%	64%	63%	16%	29%
Ohio	2,067,300	18%	51%	70%	74%	41%	63%	36%	47%
Oklahoma	719,200	20%	59%	88%	61%	36%	64%	17%	44%
Oregon	512,600	14%	52%	88%	65%	37%	63%	13%	44%
Pennsylvania	2,090,200	17%	46%	82%	74%	40%	55%	24%	48%
Rhode Island	195,400	19%	46%	62%	72%	32%	53%	26%	47%
South Carolina	891,600	20%	51%	100%	62%	26%	70%	13%	48%
South Dakota	122,700	15%	60%	80%	63%	41%	63%	23%	33%
Tennessee	1,447,100	23%	49%	100%	61%	27%	66%	22%	51%
Texas	4,170,100	17%	64%	65%	57%	24%	59%	14%	40%
Utah	291,000	11%	55%	86%	55%	26%	72%	6%	37%
Vermont	157,600	25%	42%	88%	70%	40%	59%	16%	47%
Virginia	863,300	11%	54%	64%	71%	39%	50%	18%	37%
Washington	1,163,300	18%	54%	86%	64%	33%	50%	20%	45%
West Virginia	392,300	22%	47%	46%	72%	40%	74%	10%	48%
Wisconsin	990,000	18%	43%	60%	77%	36%	60%	12%	45%
Wyoming	78,100	15%	65%	0%	67%	48%	50%	8%	26%

Total # of Medicaid Enrollees - FY 2007 figures. http://www.statehealthfacts.org/comparemaptable.jsp?typ=1&ind=200&cat=4&sub=52.
% of Residents Covered by Medicaid - FY 2007 figures. http://www.statehealthfacts.org/comparemaptable.jsp?ind=199&cat=4.
Children as a % of Total Medciaid Enrollees - Generally age 17 and under. FY 2007 figures. http://www.statehealthfacts.org/comparemaptable.jsp?typ=1&ind=200&cat=4&sub=52.
Managed Care - % of Medicaid enrollment in managed care, June 30, 2009. http://www.statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4.
Elderly & Disabled - % of Medicaid payments spent on the elderly and disabled, FY 2007. http://www.statehealthfacts.org/comparemaptable.jsp?ind=858&cat=4.
Long-Term Care - % of Medicaid payments spent on Long Term Care Services, FY 2008. http://www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4.
Regular FMAP 2010 - Federal Register, Vol. 75 No. 209. http://www.statehealthfacts.org/comparemaptable.jsp?ind=695&cat=4.
General Fund Spending - % of State General Fund Expenditures directed to Medicaid, SFY 2008. http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=33&cat=1&sub=10.
Federal Funds to States - FY 2009 figures, Tables 17-23 and 17-4,FY 2011 Federal Budget. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2011/assets/topics.pdf.

States	Health Costs Per Enrollee		Estimated Change in Coverage and Spending Under Health Reform			
				% Change over Baseline		
	Medicaid Acute Care Per Capita (Adults)	Average Single Premium ESI	Uninsured Adults (19-64) Eligible for Medicaid Expansion	Reduction in Uninsured Adults <133% FPL in 2019	Increase in State Medicaid Spending 2014-2019	Increase in Federal Spending 2014-2019
United States	**$2,541**	**$4,669**	**21,103,788**	**45%**	**1%**	**22%**
Alabama	$1,709	$4,647	317,149	53%	4%	36%
Alaska	$5,108	$6,047	47,215	48%	2%	37%
Arizona	$3,164	$4,358	511,439	14%	0%	4%
Arkansas	$982	$3,717	237,217	48%	5%	39%
California	$969	$4,631	2,991,141	42%	2%	23%
Colorado	$2,583	$4,570	268,423	50%	2%	37%
Connecticut	$2,615	$4,909	125,642	48%	1%	21%
Delaware	$3,667	$4,955	35,639	16%	0%	6%
District of Columbia	$4,396	$5,082	28,336	49%	1%	8%
Florida	$2,854	$4,488	1,443,634	44%	2%	24%
Georgia	$3,773	$4,692	837,078	49%	3%	29%
Hawaii	$3,308	$4,116	45,517	50%	-1%	47%
Idaho	$3,678	$4,248	96,949	54%	3%	27%
Illinois	$3,242	$4,725	723,859	43%	2%	26%
Indiana	$2,839	$4,849	364,304	44%	3%	23%
Iowa	$1,941	$4,453	117,815	44%	1%	16%
Kansas	$2,861	$4,236	148,903	51%	2%	24%
Kentucky	$3,831	$4,336	330,169	57%	4%	32%
Louisiana	$3,262	$4,861	343,666	51%	2%	22%
Maine	$1,618	$5,119	43,881	47%	-2%	13%
Maryland	$3,216	$4,870	285,397	46%	2%	30%
Massachusetts	$3,506	$5,268	114,901	10%	-2%	4%
Michigan	$3,036	$4,916	599,888	51%	2%	22%
Minnesota	$3,008	$4,600	146,057	44%	1%	22%
Mississippi	$2,410	$4,469	227,828	55%	5%	37%
Missouri	$3,370	$4,393	346,062	46%	2%	20%
Montana	$3,544	$4,546	49,407	50%	4%	40%
Nebraska	$2,604	$4,315	72,428	54%	2%	24%
Nevada	$2,192	$4,627	179,441	47%	3%	50%
New Hampshire	$3,165	$5,227	42,525	49%	1%	21%
New Jersey	$4,312	$4,901	425,709	45%	1%	21%
New Mexico	$3,356	$4,535	179,081	53%	2%	21%
New York	$3,897	$5,121	974,312	15%	0%	3%
North Carolina	$3,466	$4,676	691,411	47%	3%	29%
North Dakota	$2,940	$4,127	24,091	45%	1%	17%
Ohio	$2,844	$4,261	645,268	50%	2%	19%
Oklahoma	$2,716	$4,243	216,775	53%	4%	48%
Oregon	$3,873	$4,680	281,175	57%	4%	51%
Pennsylvania	$3,414	$4,749	486,447	41%	1%	18%
Rhode Island	$3,869	$5,059	47,945	51%	1%	15%
South Carolina	$2,224	$4,503	304,482	56%	4%	36%
South Dakota	$3,367	$4,262	41,166	52%	1%	16%
Tennessee	$4,097	$4,549	439,559	43%	3%	20%
Texas	$3,185	$4,499	2,389,889	49%	3%	39%
Utah	$2,940	$4,257	119,806	53%	4%	35%
Vermont	$2,124	$5,001	14,715	10%	-1%	2%
Virginia	$2,962	$4,590	369,399	51%	2%	35%
Washington	$2,741	$4,923	308,589	52%	1%	26%
West Virginia	$2,713	$4,700	117,706	57%	2%	20%
Wisconsin	$2,123	$5,132	200,692	51%	1%	13%
Wyoming	$3,326	$4,703	25,056	53%	1%	27%

Medicaid Per Capita - Average level of payment across all Medicaid enrollees, including both state and federal payments. Data based on MSIS data and CMS-64 reports, 2010. http://www.statehealthfacts.org/comparemapreport.jsp?rep=50&cat=17.
Average Single Premium ESI - AHRQ. 2009 Medical Expenditure Panel Survey (MEPS) -Insurance Component. Tables II.C.1, II.C.2, II.C.3
Uninsured Adults (19-64) <139% FPL - Urban Institute and KCMU estimates based on the March 2009 and 2010 CPS: Annual Social and Economic Supplements. http://www.statehealthfacts.org/comparetable.jsp?ind=779&cat=3.
All Change Over Baseline Figures - http://www.statehealthfacts.org/comparereport.jsp?rep=68&cat=4.

This publication (#8139) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.