THE KAISER COMMISSION ON
Medicaid and the Uninsured

April 2006

WHO NEEDS MEDICAID?

Medicaid, the nation's major public health insurance program for low-income Americans, covers over 52 million people in the United States, many of whom would otherwise be uninsured. Over the last several years, Medicaid has played an increasingly large role in our health insurance system, filling widening gaps – especially for children – left by the steady erosion of employer-sponsored insurance (ESI). Still, the number of uninsured non-elderly Americans reached almost 46 million in 2004. More than one-third of the uninsured are poor and another 28% are near-poor. Nearly three of every four low-income uninsured Americans come from working families.[1]

Medicaid's growing role highlights the program's importance as a safety-net insurer, while its rising state and federal costs have also made it a target for cuts. Declining private health insurance coverage, the lack of alternatives for long-term care coverage, increasing numbers of uninsured Americans, and pressures to control public spending frame a fundamental question: Who needs Medicaid? This brief reviews Medicaid's current eligibility structure and the health needs of the people covered by Medicaid. In view of limited and declining access to private health coverage in the low-income population and the growing health and long-term care demands of an aging population, a broader model for Medicaid eligibility is considered and the implications of recent legislative and policy developments for coverage are assessed.

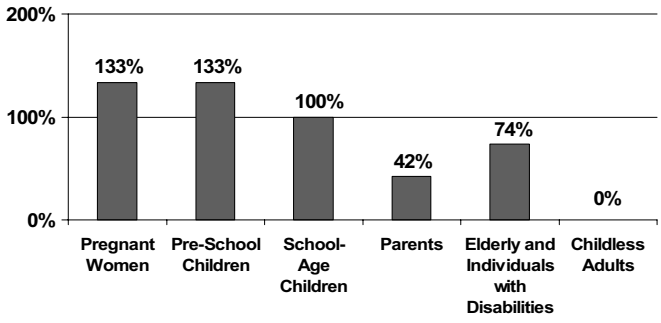
WHO DOES MEDICAID COVER TODAY?

Medicaid covers specific categories of people. Under current law, Medicaid eligibility is limited to individuals who fall into specified categories named in the federal Medicaid statute. These categories are tied to Medicaid's early roots as a welfare-related assistance program. Four main categories of individuals are eligible for Medicaid under federal law: children, adults with dependent children, people with disabilities, and the aged. Included in the latter two groups are millions of very low-income Medicare beneficiaries eligible for supplemental assistance from Medicaid. States cannot receive federal Medicaid matching funds for individuals who do not fit one of the statutory Medicaid categories – no matter how poor they may be – except under a federal waiver.

Federal law sets minimum income standards. In states that elect to have a Medicaid program, which all states do today, federal law guarantees Medicaid to categorically eligible people with income and resources below specified thresholds (Figure 1). Thus, state Medicaid programs must cover: pregnant women and children under age 6 with family income at or below 133% of the federal poverty level (FPL); school-age children at or below 100% FPL; parents with income below states' 1996 welfare eligibility levels (often at or below 50% FPL); and most seniors and people with disabilities who receive cash assistance. The 2006 FPL is $16,600 for a family of three.

Figure 1

Minimum Medicaid Eligibility Levels, 2005



Note: The federal poverty level was $9,750 for a single person and $16,090 for a family of three in 2005.
SOURCE: Cohen Ross and Cox, 2005 and KCMU, Medicaid Resource Book, 2002.

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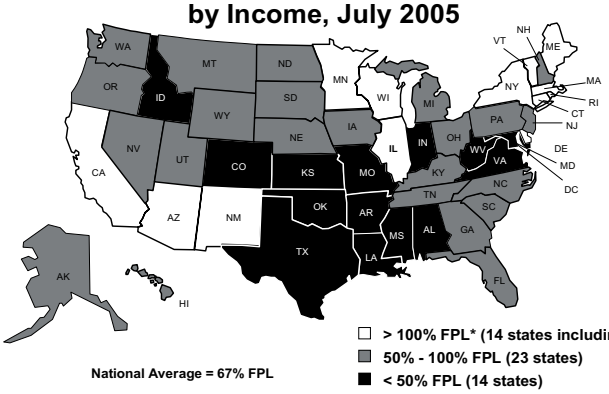
State policy varies widely. Under Medicaid's federal-state partnership, states have broad authority to raise Medicaid income eligibility levels above federal minimums. States have used this authority extensively, but variably. To illustrate, while working parents up to 157% FPL are eligible for Medicaid in Maine, only those with income up to 30% FPL can qualify for Medicaid in Texas (Figure 2).

Public coverage of children is much more uniform, as state Medicaid programs are required to cover all poor children, and most states cover children up to 200% FPL through

Medicaid or the State Children's Health Insurance Program (SCHIP).

Figure 2

Medicaid Eligibility for Working Parents, by Income, July 2005



National Average = 67% FPL

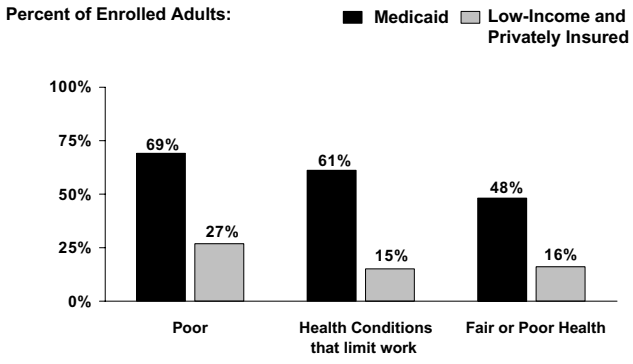
* Federal Poverty Level (FPL) refers here to HHS Poverty Guidelines, $16,090 for a family of three in 2005.
SOURCE: Center on Budget and Policy Priorities for KCMU, 2005

Many people who qualify for Medicaid or SCHIP have not enrolled and remain uninsured. Research shows that lack of knowledge about public programs and burdensome enrollment and recertification procedures are important barriers to participation. Many states have simplified Medicaid enrollment and recertification, primarily for children, taking steps such as minimizing the documentation required and using mail-in and telephone applications. However, under fiscal pressures stemming from Medicaid enrollment growth during the recession, some states have reinstituted procedures that dampen participation.

Medicaid serves a diverse population that has little income and high health needs. The population Medicaid serves is diverse, poor, and sick (Figure 3). Medicaid beneficiaries, nearly all of whom are poor or near-poor, include infants, children and parents, pregnant women, people with severe mental or physical disabilities or chronic conditions, and seniors (Figure 4).

Figure 3

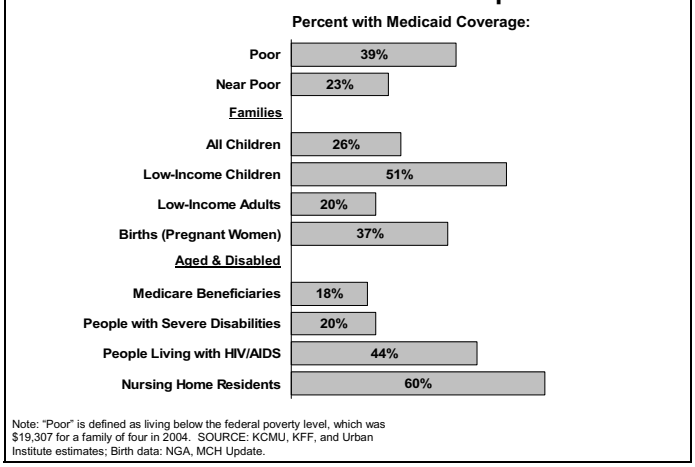
Medicaid Enrollees are Poorer and Sicker Than the Low-Income Privately Insured Population



SOURCE: Coughlin et. al, 2004 based on a 2002 NSAF analysis for KCMU.

Figure 4

Medicaid's Role for Selected Populations



Note: "Poor" is defined as living below the federal poverty level, which was $19,307 for a family of four in 2004. SOURCE: KCMU, KFF, and Urban Institute estimates; Birth data: NGA, MCH Update.

Among the low-income individuals Medicaid serves are 8 million people with disabilities who are living in the community – 1 in every 5 of such Americans. Medicaid's disabled beneficiaries have a wide range of physical and mental conditions, including blindness, quadriplegia, mental illness, HIV/AIDS, cerebral palsy, mental retardation, cystic fibrosis, and Down Syndrome.

Medicaid also fills major gaps in Medicare for almost 7.5 million low-income Medicare beneficiaries, known as "dual eligibles." Medicaid subsidizes Medicare premiums and cost-sharing for dual eligibles and covers services that Medicare excludes or limits, including long-term care, and dental and vision services. Reflecting the lack of other substantial private or public sources of long-term care insurance, Medicaid covers 60% of persons residing in nursing homes today.

Reflecting their diverse health needs, Medicaid beneficiaries use a broad spectrum of services. Medicaid spending is widely distributed across Medicaid-covered benefits, which include a broad range of acute and long-term care services. Some services are mandated by federal law and some are offered at state option. Over half of Medicaid spending is for optional services.

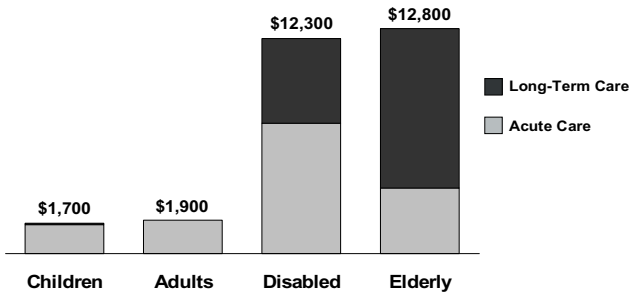
Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children provides comprehensive coverage that has no counterpart in the private insurance market.[2] Under EPSDT, states must provide a broad set of prevention-oriented services in addition to more traditional primary and acute care services. Also, the definition of medical necessity that applies under EPSDT is broad, providing children with access to services

that can help them maintain or maximize their level of function. EPSDT helps to meet the health needs of low-income children in general, but it is especially important for children with special health needs, who use many more services than other children. For example, special needs children use at least five times more inpatient hospital care, services of non-physician health professionals, prescriptions, and home health care than other children.[3]

Disabled and elderly beneficiaries have the highest needs. Reflecting the much greater acute care needs of the disabled and elderly and their needs for long-term care, Medicaid spending per capita is notably higher for these groups than it is for children and non-elderly adults (Figure 5). This higher per capita spending for disabled and elderly Medicaid beneficiaries explains the skewed distribution of Medicaid spending at the aggregate level. Nationally, low-income children and families, who make up three-quarters of Medicaid enrollment, account for just 30% of program spending. The vast majority (70%) of Medicaid spending is attributable to the elderly and disabled (Figure 6).

Figure 5

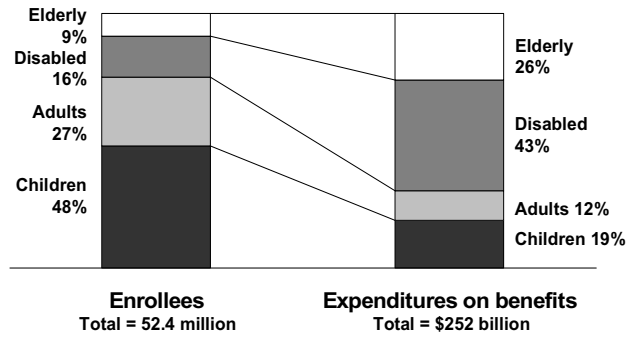
Medicaid Payments Per Enrollee by Acute and Long-Term Care, 2003



SOURCE: KCMU estimates based on CBO and Urban Institute data, 2004.

Figure 6

Medicaid Enrollees and Expenditures by Enrollment Group, 2003

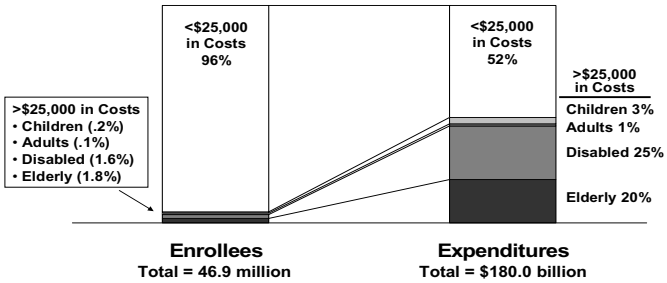


Note: Total expenditures on benefits excludes DSH payments.
SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates based on CMS, CBO, and OMB data, 2004.

A small minority of very high-need enrollees drive Medicaid costs. At the same time that Medicaid spending is spread widely across benefits, it is highly concentrated from an enrollee perspective. A minority of beneficiaries – just 4% – with very high costs generate nearly half of all Medicaid expenditures (Figure 7). In 2001, disabled enrollees with costs over $25,000 accounted for 25% of total Medicaid spending, and elderly enrollees with costs at that level accounted for another 20%. Medicaid's high costs reflect the very high needs and costs of a small minority of predominantly disabled and elderly enrollees. The majority of Medicaid enrollees have relatively low per capita costs, but with enrollment exceeding 50 million, the program is expensive.

Figure 7

4% of Medicaid Enrollees Accounted for 48% of Medicaid Expenditures in 2001



SOURCE: Urban Institute estimates based on MSIS 2001 data.

Medicaid enrollees struggle to afford basic needs and often face high health care costs. Research shows that families living in or near poverty strain to meet their costs for housing, transportation, and food, and have little income for other needs, including health care.[4 5] They are much more likely than other families to face high out-of-pocket health costs relative to their income. Health problems, which occur at higher rates in the low-income and Medicaid populations, further increase the risk of high health cost burdens.[6]

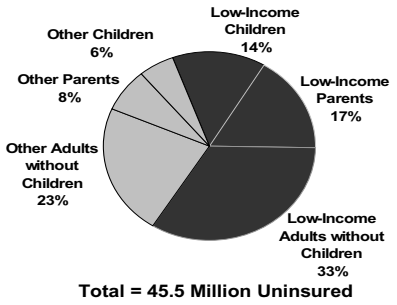
WHO COULD BENEFIT FROM MEDICAID COVERAGE?

Nearly 30 million low-income Americans are uninsured. Low-income people – those in families with income below 200% FPL ($33,200 for a family of three in 2006) – make up nearly two-thirds of the uninsured. Low-income adults alone account for half of all Americans without health insurance (Figure 8).

Low-income adults are much more likely to be uninsured than low-income children. While virtually all low-income children are eligible for Medicaid or SCHIP, eligibility for these coverage programs is extremely limited for adults.

Figure 8

Non-Elderly Uninsured, 2004 by Income and Dependent Status



Total = 45.5 Million Uninsured

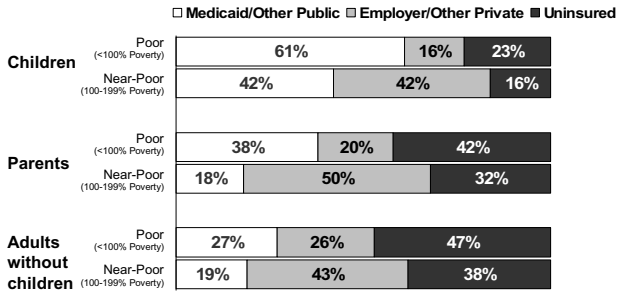
NOTES: Low-income is <200% of the federal poverty level ($30,134 for family of three in 2004). Parents of dependent children under age 19. Adults without children also include parents whose children are no longer dependent.
SOURCE: *Health Insurance Coverage in America, 2004 Data Update*, KCMU.

Medicaid eligibility restrictions for adults are of two kinds. In the case of parents, most states apply very restrictive income criteria. Adults without dependent children are categorically excluded from the program unless they are pregnant or severely disabled, except in states that obtain federal waivers. In 2002, only a third of low-income adults were eligible for Medicaid or other public coverage; even among adults below 100% FPL, fewer than half qualified.[7]

Poor adults have the highest risk of being uninsured. In 2004, adults below 100% FPL accounted for more than one-fourth of all Americans without health insurance. Because private insurance plays a limited role below the poverty level and many poor adults cannot qualify for public coverage, a large share of poor adults is uninsured. More than 40% of poor parents were uninsured in 2004. The uninsured rate was the highest among poor adults without dependent children – 47% (Figure 9).

Figure 9

Insurance Coverage of Low-Income Children and Adults, 2004

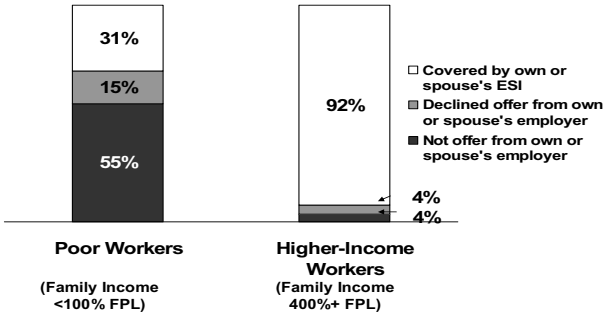


Notes: Medicaid also includes SCHIP and other state programs, Medicare and military-related coverage. The federal poverty level was $19,307 for a family of four in 2004.
SOURCE: KCMU and Urban Institute analysis of March 2005 Current Population Survey.

Access to private employer-based insurance is limited for poor Americans. While job-based insurance is offered to nearly all higher-income workers, less than half of poor workers are offered it (Figure 10).

Figure 10

Access to Employer-Sponsored Insurance in Working Families, by Family Income, 2005

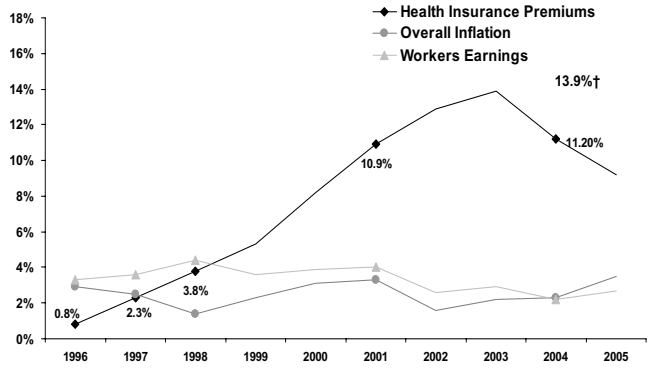


SOURCE: Garrett B, Urban Institute analysis for Kaiser Commission on Medicaid and the Uninsured, April 2006.

Affordability of premiums is a large and worsening problem for workers with access to ESI. Despite their limited income and the high cost burden of premiums, two-thirds of poor workers with access to job-based coverage take it up. However, since the late 1990s, premium growth has sharply outpaced wage growth (Figure 11), and some who are offered coverage cannot afford the premiums.

Figure 11

Increases in Health Insurance Premiums vs. Other Indicators, 1996-2005



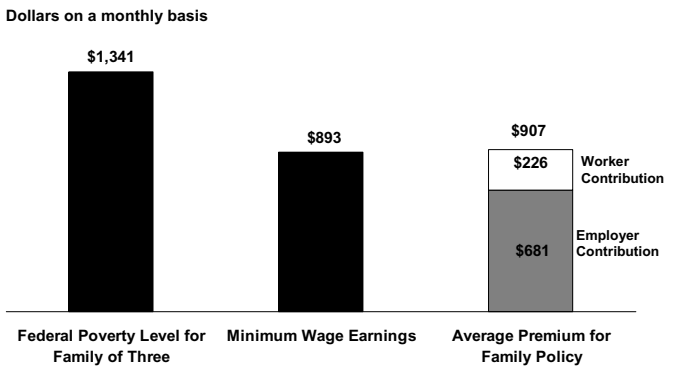
* Estimate is statistically different from the previous year shown at p<0.05. No statistical tests were conducted for years prior to 1999.
† Estimate is statistically different from the previous year shown at p<0.1. No statistical tests were conducted for years prior to 1999.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation (April to April), 1988-2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2005.

In 2005, the average premium for a family policy was $907 per month – more than the monthly earnings of a full-time minimum-wage worker (Figure 12). The worker's share of the average premium, $226 per month, was equivalent to a quarter of his or her earnings, or to 17% of the income of a family of three living at the federal poverty level. Premium levels for non-group coverage are often higher.

Figure 12

Federal Poverty Level, Minimum Wage, and Worker Contribution for Family Insurance, 2005



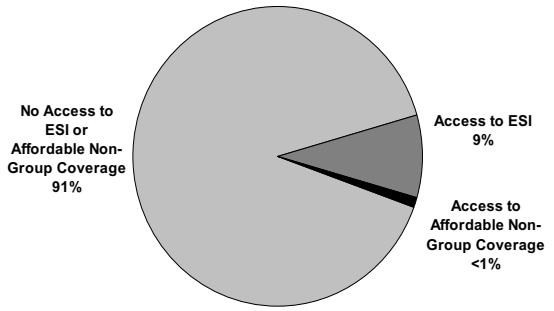
SOURCES: 2005 HHS Poverty Guidelines; U.S. Department of Labor; *Employer Health Benefits, 2005 Annual Survey*, KFF/HRET.

Individuals with disabilities face barriers to private insurance apart from its premiums. Private health insurance products often exclude coverage for pre-existing conditions and limit or exclude core disability benefits, such as rehabilitation services, mental health care, personal care services, and others.

In combination, the lack of availability of ESI in the low-income population and the high cost of premiums relative to income limit the potential of job-based health insurance as a source of coverage for the low-income uninsured population (Figure 13).

Figure 13

Access to Employer-Sponsored Insurance Among Low-Income Adults, 2002



Note: Analysis based on 2002 National Survey of America's Families; low-income defined as less than 200% of the federal poverty line; affordable coverage defined as less than 5% of income.

SOURCE: Long S and J Graves, KCMU, January 2006, publication #7449.

OUTLOOK

Growing ranks of low-income uninsured

Declining insurance coverage is primarily affecting low-income individuals. The ranks of low-income uninsured Americans, who now number 30 million, continue to grow. Low-income people make up the majority of all uninsured Americans, and they are also the fastest growing segment of the uninsured. Of the 6 million people added to the ranks of the uninsured between 2000 and 2004, 3.8 million, or two-thirds, came from low-income families.

Private market approaches to expanding health insurance appear to have a limited ability to reach low-income Americans. As ESI rates continue to decline, due largely to rising costs, high-deductible health plans and health savings accounts have attracted interest as a possible mechanism for reducing health care costs and expanding access to coverage. Experience with these arrangements is limited, but available data suggest that, even with refundable tax credits to reduce the burden of premiums, low-income people, particularly those who are not young and healthy, are still unlikely to be able to afford such plans in the individual insurance market. Moreover, low-income individuals and families have few funds available to cover the higher out-of-pocket costs they are likely to face in these arrangements. The tax-deductibility of personal contributions to health savings accounts offers low-income people little financial benefit.

Medicaid has been effective in expanding coverage to many who lack access to private insurance. Medicaid program expansions over the last 40 years have provided coverage to millions in the low-income uninsured population. Most recently, Congress has looked to Medicaid as a means of expanding access to coverage for disabled children. The "Family Opportunity Act" provisions enacted in the Deficit Reduction Act of 2005 (DRA) authorize states, at their option, to allow parents of disabled children to "buy in" to the Medicaid program if they have family income below 300% of the federal poverty level. This new option helps to address the lack of access to adequate insurance for children with disabilities by making Medicaid available to the families of such children in higher-income families, at state prerogative and subject to a premium.

However, if Medicaid is to be used as a vehicle for extending coverage to more poor Americans, the program's long-standing categorical barriers to eligibility will have to be eliminated. Removing the categorical requirements would simplify Medicaid's eligibility structure and provide a source of coverage for all Americans living below the federal poverty level or another specified income threshold.

Broadening Medicaid to reach all those in poverty would substantially reduce the number of uninsured Americans and ameliorate the exceptionally high uninsured rate experienced by poor adults, in particular. Estimates indicate that aligning

parents' eligibility for Medicaid with children's eligibility would provide health insurance to over half of all uninsured parents.[8] Evidence that children whose parents are insured are more likely to be insured themselves suggests that expanding Medicaid to cover parents could also reduce the number of uninsured children.

Keeping the enrollment process simple and accessible is essential to improving participation in Medicaid. The DRA adds a new documentation burden for low-income families, requiring most U.S. citizens who are newly applying or re-applying for Medicaid to document their citizenship by showing a passport, or a combination of a birth certificate and an identifying document, like a driver's license. This new requirement complicates states' efforts to simplify and promote participation in Medicaid and, based on past program experience, Medicaid coverage losses seem likely to result.

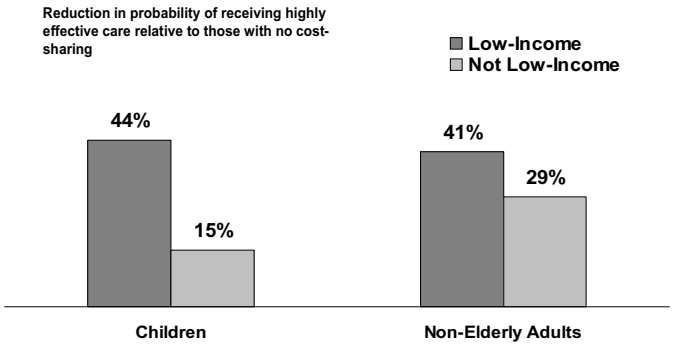
New policy directions

New state flexibility to redefine Medicaid benefits and cost-sharing could compromise coverage and access. State fiscal pressures created by the recession have begun to ease, but systemic health care inflation, the aging of the population, and eroding private coverage continue to increase Medicaid's costs. In efforts to reduce Medicaid costs, federal legislative changes in DRA and a number of new waivers permit states to increase premiums and cost-sharing and limit benefits for Medicaid beneficiaries.

DRA grants states expanded authority to reduce Medicaid benefits and increase their use of premiums and cost-sharing, using private health insurance as a model. Official estimates project that these provisions will generate $3.2 billion in federal Medicaid savings over the next five years and $16 billion over the next ten. The savings are expected to derive primarily from reduced utilization due to premiums and cost-sharing, and from reduced spending for those affected by benefit cuts. Coverage losses among children as well as adults are also projected. These expected impacts are consistent with research showing that premiums reduce participation in public coverage and that, among low-income people, cost-sharing – even at nominal or modest levels – leads to reduced use of effective medical care (Figure 15), unmet medical need, and financial stress.[9 10 11]

Figure 15

Impact of Cost-Sharing on Likelihood of Receiving Highly Effective Medical Care, by Income



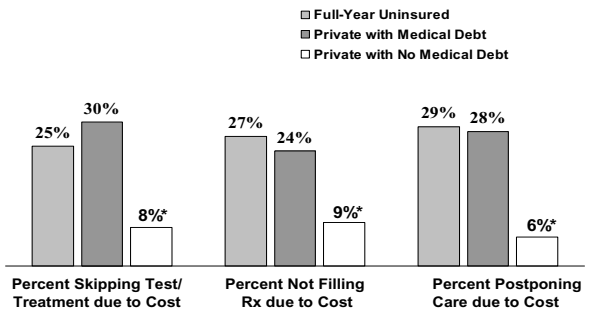
Note: Low-income defined as lowest third of income distribution, which is roughly equivalent to <200% of the poverty level.
SOURCE: Lohr et al, "*Effect of Cost-Sharing on Use of Medically Effective and Less Effective* Care," Medical Care, 24(9), September 1986.

Under federal law, only medically necessary services can be paid for by Medicaid, making it difficult to limit the benefit package without restricting access to services that beneficiaries need. Experience from several states that have cut optional Medicaid services or obtained waivers to provide limited Medicaid benefits for some groups suggests that these measures can diminish access to care, worsen health problems, and increase financial hardship among those affected.[12 13 14 15]

Other study findings indicate that the insured with high medical costs experience financial barriers to care that are similar in many ways to those facing the uninsured (Figure 16). This result raises concerns about the implications of growing under-insurance, particularly among low-income people, for whom the margins for out-of-pocket spending are so narrow.[16]

Figure 16

Access Problems Among Uninsured and Privately Insured Adults: The Impact of Medical Debt



* Significantly different from Private with Medical Debt (95% CI).
Rates adjusted for age, education, income, race, health status, and employment - as categorized in Table 1.
SOURCE: Hoffman et al, *Medical Debt and Access to Care*, KCMU, September 2005.

Mounting demographic pressures

Demographic trends portend growing needs for Medicaid. The aging of the population can be expected to increase demands on Medicaid, as health care needs and costs are highest among the elderly and people with disabilities. Americans age 65 and older, who comprise 12.5% of our population today, are expected to make up 21% of the nation by 2050.

While Medicare pays for most of the acute care costs of the elderly, the program's coverage of long-term care is extremely limited. Because it is unaffordable for most, private insurance plays a small role, covering only 4% of long-term care costs. Medicaid, which covers long-term care for low-income Medicare beneficiaries, is the single largest source of financing for long-term care today, assisting 60% of all nursing home residents and paying for close to half of national spending on long-term care services.

As long-term care demands increase, and community-based alternatives to nursing home care develop further, the nation's long-term care costs can be expected to rise. DRA provisions tighten eligibility for Medicaid long-term care coverage but, without significant changes in long-term care financing, Medicaid is likely to remain the major source of long-term care coverage in the coming years.

CONCLUSION

Today, the Medicaid program provides a safety-net of coverage, reaching 40% of poor Americans and almost a quarter of the near-poor. However, 30 million low-income Americans remain uninsured. For most of this population, the private health insurance market is not a realistic source of coverage, as they lack access to it altogether or cannot afford it. This fact, along with the record of the Medicaid program in extending coverage of the uninsured, suggests that a targeted and effective approach to covering the poorest uninsured Americans – primarily, parents and other adults – would be to broaden Medicaid to reach them.

As states wrestle with the competing pressures to cover the low-income uninsured and contain Medicaid costs, it will be important to monitor the implementation of the DRA provisions regarding citizenship documentation, benefits, and premiums and cost-sharing in Medicaid, and to evaluate their impact on coverage, access to care, financial burden, and health outcomes for low-income Americans.

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[2] Rosenbaum et al, "*Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*," Journal of Health & Biomedical Law, 2004.
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