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MEDICAID OVERVIEW

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ABSTRACT

This paper provides an overview of the intent of the Medicaid program and its budgetary implications. In 1965, when Medicaid was created under Title XIX of the Social Security Act to provide health insurance for low-income individuals, the program was considered an afterthought to Medicare. Today, however, more Americans receive coverage from Medicaid than any other health insurance program, including Medicare. Today Medicaid costs nearly $500 billion annually, funded by taxpayer dollars at the state and federal levels. This paper explains the budgetary implications of Medicaid for federal and state budgets and how these obligations will grow under the Patient Protection and Affordable Care Act.

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Often called an afterthought to the Medicare program, Medicaid was signed into law under Title XIX of the Social Security Act. Unlike Medicare, which was created to provide health care coverage to those over the age of 65, Medicaid's intent was the provision of care for individuals of any age who were financially limited. In 1966, Medicaid provided health insurance to 10 million beneficiaries.[1] Currently with approximately 57 million people enrolled, Medicaid has evolved into the largest health insurance provider in the United States.[2]
This policy brief will provide an overview of the Medicaid system, its budget implications at the state and federal levels, and the implications of the Patient Protection and Affordable Care Act (ACA) for states' Medicaid programs.

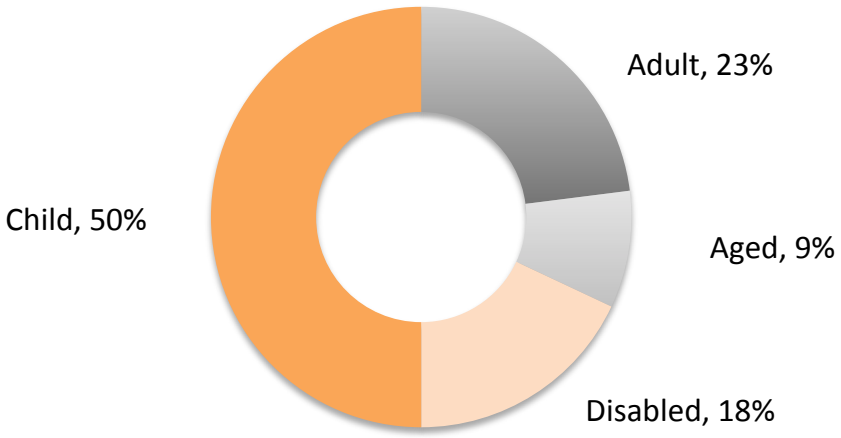
WHAT IS MEDICAID?

Medicaid is a government health insurance program providing coverage to individuals who are limited in their ability to pay for medical care. The program is run by the states using federal cost sharing dollars. Though state participation in Medicaid is voluntary, all 50 states and the District of Columbia participate. Each state, using federal matching funds, establishes and administers its own Medicaid program. As long as a state follows federal guidelines, it has the flexibility to determine the type and scope of services provided. Additionally, each state has the option of charging enrollees' premiums and establishing out-of-pocket spending requirements such as copayments, coinsurance, and deductibles.

Although Medicaid eligibility varies dramatically from state to state, in order to qualify for federal funding each state must provide coverage to limited income families with children as well as individuals who are aged, blind, or disabled (see the percentage breakdown in figure 1 on the next page).[3]

1. J. K. Iglehart, "The Dilemma of Medicaid," *New England Journal of Medicine* 348, no. 21(2003): 2140–8; Centers for Medicare and Medicaid Services, *CMS Financial Report, Fiscal Year 2010* (2010).
2. Centers for Medicare and Medicaid Services, *CMS Financial Report, Fiscal Year 2012* (2012).
3. "Eligibility," Medicaid.gov., Center for Medicaid and CHIP Services (CMCS), accessed November 19, 2013.

FIGURE 1 – FISCAL YEAR 2012 MEDICAID ENROLLEES[4]



Though the income threshold varies by state, an individual or family applying for Medicaid cannot exceed a certain income threshold, which is calculated in relation to a percentage of the Federal Poverty Level (FPL). Today, the FPL ranges from $11,490 for a family of one to $39,630 for a family of eight.[5] For example, consider a pregnant woman comprising a family of one and fitting categorically into one of Medicaid's mandatory eligibility groups. In 2013, the median (across 50 states and the District of Columbia) Medicaid threshold for this individual was 185 percent of the FPL.[6] Therefore, she would be eligible for Medicaid if she earned less than $21,257.

It is important to note that states may offer a greater number and additional types of services offered that go above and beyond what is mandated by the Department of Health and Human Services (HHS). Through Section 1115 of the Social Security Act, the federal government has encouraged states to tailor the Medicaid program to their unique political and economic environments.[7] Building upon Section 1115 of the Social Security Act, the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative gives states enhanced "waiver flexibility to streamline benefits packages, create public-private partnerships, and increase cost-sharing for optional and expansion populations covered under Medicaid."[8] Contingent on approval by the HHS Secretary, leaders are empowered to develop a unique program that meets their states needs.

4. CMS, *Financial Report*, 2012.
5. 78 Fed. Reg. 5182–3 (January 24, 2013).
6. M. Heberlein, T. Brooks, and J. Alker, "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013," The Henry J. Kaiser Family Foundation, January 2013.
7. G. Engquist and P. Burns, "Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for the States," *State Coverage Initiatives* 3, no. 2 (2002): 1–6.
8. Ibid.

HOW MEDICAID IS FUNDED

Medicaid is a matching-grant program jointly funded by federal and state governments. To determine the share of Medicaid the federal government will pay in each state, the HHS calculates the Federal Medical Assistance Percentage (FMAP):[9]

$$FMAP = 1 - 0.45 * \left[\frac{(State\ Per\ Capita\ Income)^2}{(US\ \ Per\ Capita\ Income)^2}\right]$$

Instituted in 1965, the FMAP formula ensures that the federal government pays a higher proportion of Medicaid costs in states where the average income per capita is lower relative to the national average. Using income data averaged over three years, the HHS provides an updated FMAP value every fiscal year between October 1 and November 30. For purposes of this formula, "income" represents personal income as calculated by the Bureau of Economic Analysis instead of money income as calculated by the Census Bureau. To control the amount paid by either the federal or state government, threshold limits bind the FMAP between 50 and 83 percent.[10] FMAPs as of Fiscal Year 2012 are shown in figure 2 below.

FIGURE 2 – FEDERAL MEDICAL ASSISTANCE PERCENTAGES, FISCAL YEAR 2012[11]

STATE	FMAP				
Alabama	68.62%	Kentucky	71.18%	North Dakota	55.40%
Alaska	50.00%	Louisiana	61.09%	Ohio	64.15%
Arizona	67.30%	Maine	63.27%	Oklahoma	63.88%
Arkansas	70.71%	Maryland	50.00%	Oregon	62.91%
California	50.00%	Massachusetts	50.00%	Pennsylvania	55.07%
Colorado	50.00%	Michigan	66.14%	Rhode Island	52.12%
Connecticut	50.00%	Minnesota	50.00%	South Carolina	70.24%
Delaware	54.17%	Mississippi	74.18%	South Dakota	59.13%
District of Columbia*	70.00%	Missouri	63.45%	Tennessee	66.36%
Florida	56.04%	Montana	66.11%	Texas	58.22%
Georgia	66.16%	Nebraska	56.64%	Utah	70.99%
Hawaii	50.48%	Nevada	56.20%	Vermont	57.58%
Idaho	70.23%	New Hampshire	50.00%	Virginia	50.00%
Illinois	50.00%	New Jersey	50.00%	Washington	50.00%
Indiana	66.96%	New Mexico	69.36%	West Virginia	72.62%
Iowa	60.71%	New York	50.00%	Wisconsin	60.53%
Kansas	56.91%	North Carolina	65.28%	Wyoming	50.00%

** The values for the District of Columbia in the table were set for the state plan under titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, the percentage DC is 50.00, unless otherwise specified by law.*

9. National Health Policy Forum: George Washington University, "The Basics: Medicaid Financing" (2013).
10. Ibid.
11. 75 Fed. Reg. 69082-59083 (November 10, 2010).

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

In an attempt to increase the number of Medicaid recipients, the ACA as it was originally written created a new category of individuals eligible for Medicaid. Without noting the specific caveats, this category extended coverage to all individuals whose incomes fell below 133 percent of the FPL (accounting for a 5 percent federal income exclusion, this threshold effectively increases to 138 percent of the FPL) who were not previously eligible for Medicaid.[12,13] Based on an estimate from the Centers for Medicare and Medicaid Services, this coverage expansion was estimated to increase total projected Medicaid enrollment by 14.9 million people in 2014 and 25.9 million people by 2020.[14]

Under current law, the HHS Secretary is permitted to withhold federal funding if a state fails to comply with the minimum benefit and eligibility requirements established by the federal government. Originally, the ACA stipulated that states that failed to expand their Medicaid coverage would be considered noncompliant. In its review of the ACA's constitutionality, the Supreme Court held that the Medicaid expansion clause in the ACA was unconstitutionally coercive.[15] Chief Justice John Roberts's opinion held that the mandatory expansion of Medicaid coupled with the HHS secretary's authority to withhold funding for noncompliance is a "gun to the head" because the "threatened loss of 10 percent of a State's overall budget is economic dragooning that leaves the States with no real option but to acquiesce."[16] To allow the provisions set forth in the ACA to remain intact while providing a remedy for the coercion inherent in the act, the Supreme Court precluded the HHS Secretary's ability to withhold existing Medicaid funds for failing to comply with the Medicaid expansion requirements, leaving only the "carrot" of increased funding to encourage states to expand Medicaid eligibility.[17] For newly eligible individuals, the federal government will pay 100 percent of the costs for the first three years. Starting in 2017, the percentage paid will decrease and ultimately settle at 90 percent in 2020.[18]

MEDICAID AND THE COST IMPLICATIONS OF THE ACA

The Supreme Court's ruling effectively relegates the choice to expand Medicaid to the states. From a state's perspective, the decision to expand coverage depends on two competing values. Charles Blahous, a public trustee for Social Security and Medicaid, recently analyzed the incentives facing states under the ACA. He finds that a state governor faces an incentive to "maximize the health benefits his own

12. National Conference of State Legislatures. "The Affordable Care Act: A Brief Summary" (March 2011).
13. CMS, *Financial Report*, 2011.
14. Ibid.
15. The Henry J. Kaiser Family Foundation, "A Guide to the Supreme Court's Affordable Care Act Decision" (July 2012).
16. National Federation of Independent Business v. Sebelius, 567 U. S. ____ (2012), at 51.
17. Ibid.
18. National Health Policy Forum, "Medicaid Financing," 2013.

FIGURE 3 – PROJECTED MEDICAID EXPENDITURES (ASSUMES UNIVERSAL PARTICIPATION)[21]

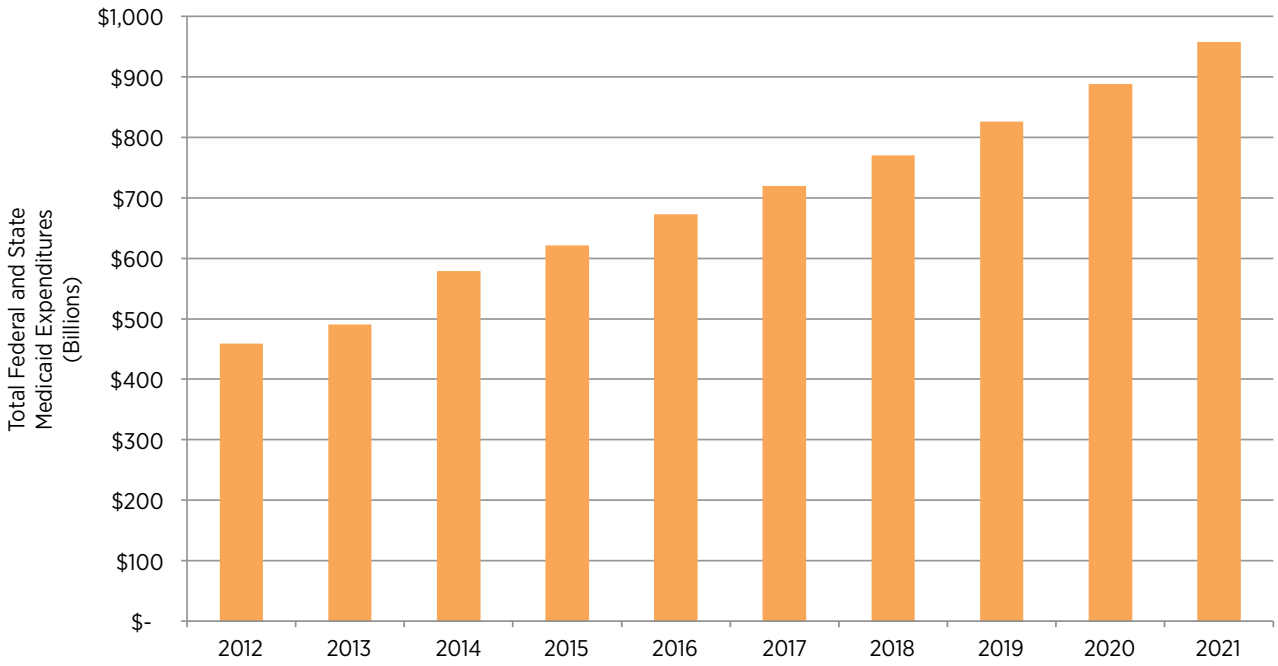
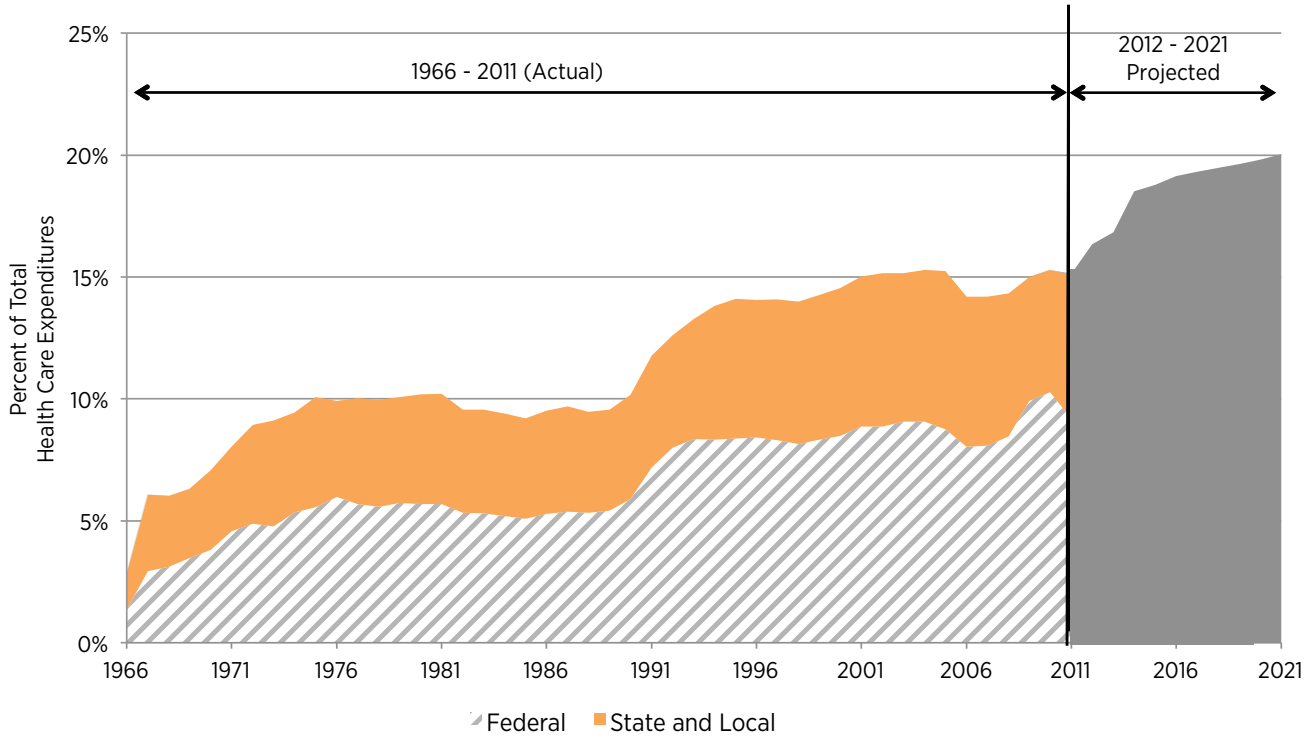


FIGURE 4 - MEDICAID EXPENDITURES AS A PERCENTAGE OF TOTAL US HEALTH CARE EXPENDITURES[23]



state's citizens receive that are financed by entities outside of the state, while also minimizing his state's budgetary exposure."[19] From state policymakers' perspectives, the decision to expand coverage is complex. Though the federal government agreed to cover a significant portion of associated expenses in order to influence states to expand Medicaid, each state must project how the Medicaid expansion will impact its current and future budgets. Considering Medicaid represented less than three percent of total state and local expenditures in 1967, whereas in fiscal year 2012 it represents an estimated 24 percent of total expenditures, it is unlikely expenditures will decrease in the foreseeable future.[20] The trend is clearly visible in figure 3 below.

Based on preliminary estimates from the Centers for Medicare and Medicaid Services (CMS), Medicaid expenditures per year are expected to increase by approximately $500 billion between 2012 and 2021—roughly a 108 percent increase.[22] (See figure 4 below.) It is important to note that CMS assumes universal expansion of the Medicaid program to include the ACA intended beneficiary group. While one may argue that it is incorrect to assume universal participation, the issue of increasing Medicaid expenditures has plagued the health insurance program since its inception.

The amount of money spent on Medicaid continues to represent a significant portion of total health care expenditures in the United States. It is important to note that projections are not allocated between federal and state & local governments. The problems associated with Medicaid expenditures are further evidenced in figure 5 on the next side.

Adjusting for inflation, the amount of money spent on Medicaid has significantly increased since the program was first adopted. While one may be tempted to argue that this increase can be solely attributed to rising health care costs, research shows that this increase can be primarily attributed to "changing demographics, increased access and eligibility, service expansions, and waste."[25] Regardless of the cause, Medicaid continues to become a larger share of state budgets. (See figure 6 on the next page.) For fiscal year 2012, Medicaid represented roughly 24 percent of state budgets.

To reflect the likelihood that not every state in the country will expand Medicaid eligibility, the Congressional Budget Office (CBO) released a revised report in June

19. Charles Blahous, "The Affordable Care Act's Optional Medicaid Expansion: Considerations Facing State Governments" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, March 2013) 20.
20. National Association of State Budget Officers, *The Fiscal Survey of States, 2012* (2012); US Department of Commerce. *Statistical Abstract of the United States*, 90th ed. (1969).
21. CMS, *National Health Expenditure Data* (2012)..
22. Ibid.
23. Ibid.
24. bid.
25. Scott Beaulier and Brandon Pizzola, "The Political Economy of Medicaid: Evidence from Five Reforming States" (Mercatus on Policy, Mercatus Center at George Mason University, Arlington, VA, April 2012).

FIGURE 5 – HISTORICAL FEDERAL AND STATE MEDICAID SPENDING[24]

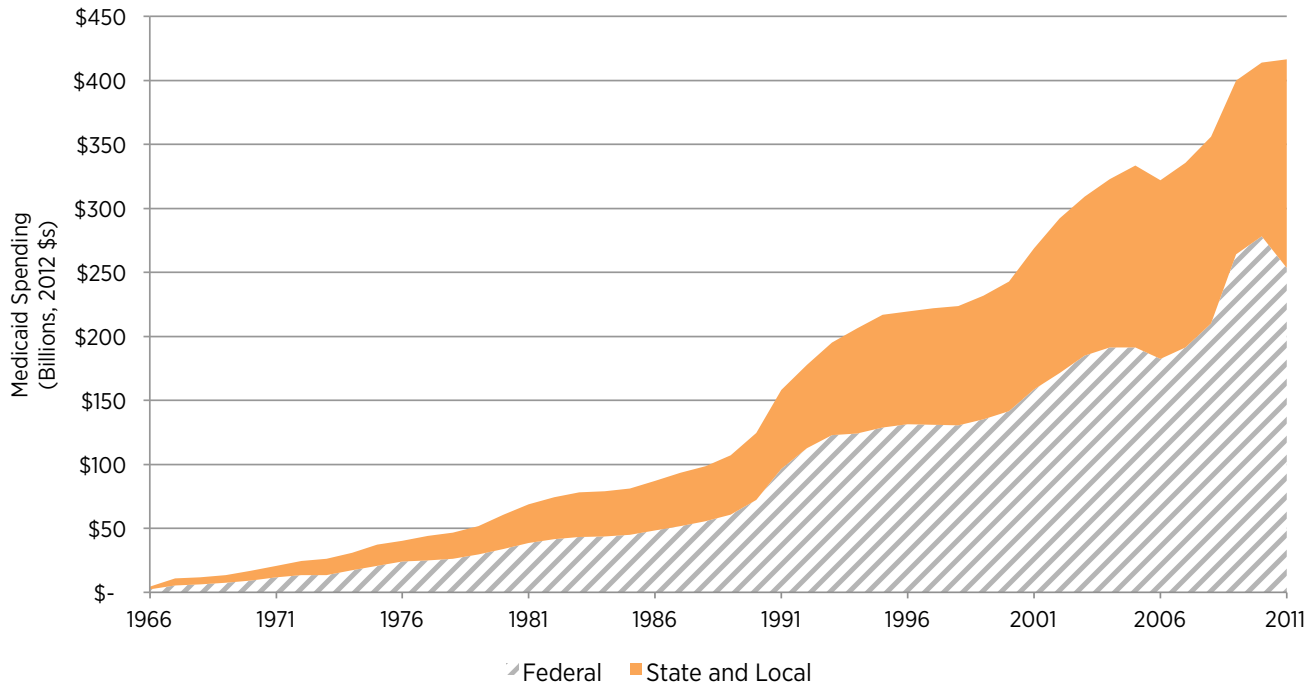
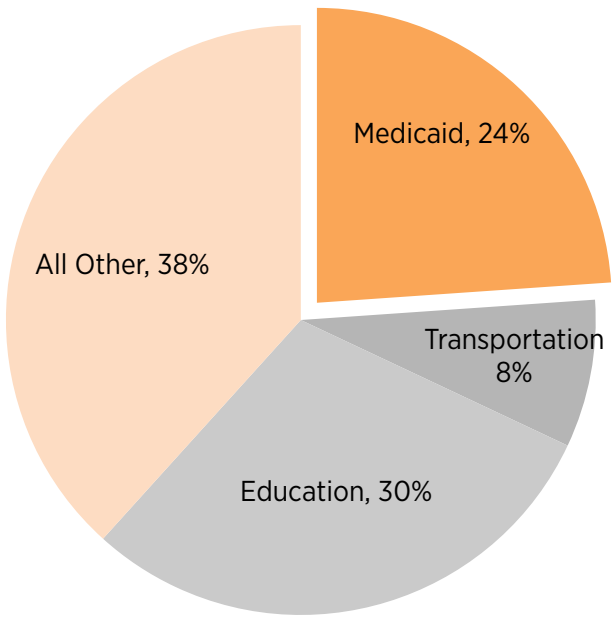


FIGURE 6 - MEDICAID EXPENDITURES AS A SHARE OF TOTAL STATE BUDGETS[26]



2012 with updated cost estimates. Though the revised estimate suggests that the total Medicaid outlays between 2012 and 2022 will be approximately $289 billion less than originally planned, it projected that federal government exchange subsidies and related spending will increase by $209 billion.[27] This revised estimate warrants further clarification.

To this point, this report has focused solely on the expansion of the Medicaid program. Though no state is required to expand eligibility, every state is required to establish a health insurance exchange (hereafter cited in text as exchange). In its simplest form, an exchange is a virtual marketplace where qualified individuals and small businesses can purchase health insurance. The exchange will help facilitate the purchase of a health insurance plan by allowing individuals and businesses the ability to compare benefits and prices of different plans. In implementing the mandated exchanges, each state has the option to either operate its own exchange (assuming approval by the HHS Secretary) or opt for a federally facilitated exchange.[28]

Though numerous stipulations exist, an applicant in the exchange may be eligible for federal subsidies to help pay for an insurance policy offered through the exchange. To be considered for such subsidies, an applicant must not be eligible for "minimum essential coverage" except through the individual health insurance market or an employer-sponsored plan that is either deemed unaffordable or does not provide an ACA-mandated minimum value. The applicant's income must fall between 100 and 400 percent of the FPL.[29] Minimum essential coverage is defined as coverage under: (1) a government-sponsored plan; (2) an employer sponsored plan; (3) plans in the individual market; (4) grandfathered health plans; (5) or any other health benefits coverage recognized by the HHS Secretary.[30]

It is important to highlight the threshold established by the ACA because it creates a new incentive for state governments. The ACA effectively created a new beneficiary group characterized by individuals who were previously ineligible for Medicaid and whose income fell below 133 percent. For states that opt to expand coverage, research suggests coverage will only be expanded for individuals making below 100 percent of the FPL. For a state governor who values maximizing externally financed health benefits while minimizing exposure to the state's budget, this type of expansion would allow citizens to experience higher quality health care at no additional cost to the state.[31]

26. NASBO, *Fiscal Survey of States*, 2012.
27. Congressional Budget Office. "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision" (2012).
28. Bernadette Fernandez, and Annie L. Mach, "Health Insurance Exchanges under the Patient Protection and Affordable Care Act (ACA)," *Congressional Research Service*. R42663 (2013).
29. Ibid.
30. Annie L. Mach, M. Scales, and J. Mulvey, "Individual Mandate and Related Information Requirements under ACA," *Congressional Research Service* R41331 (July 22, 2013).
31. Blahous, "ACA's Optional Medicaid Expansion," 2013.

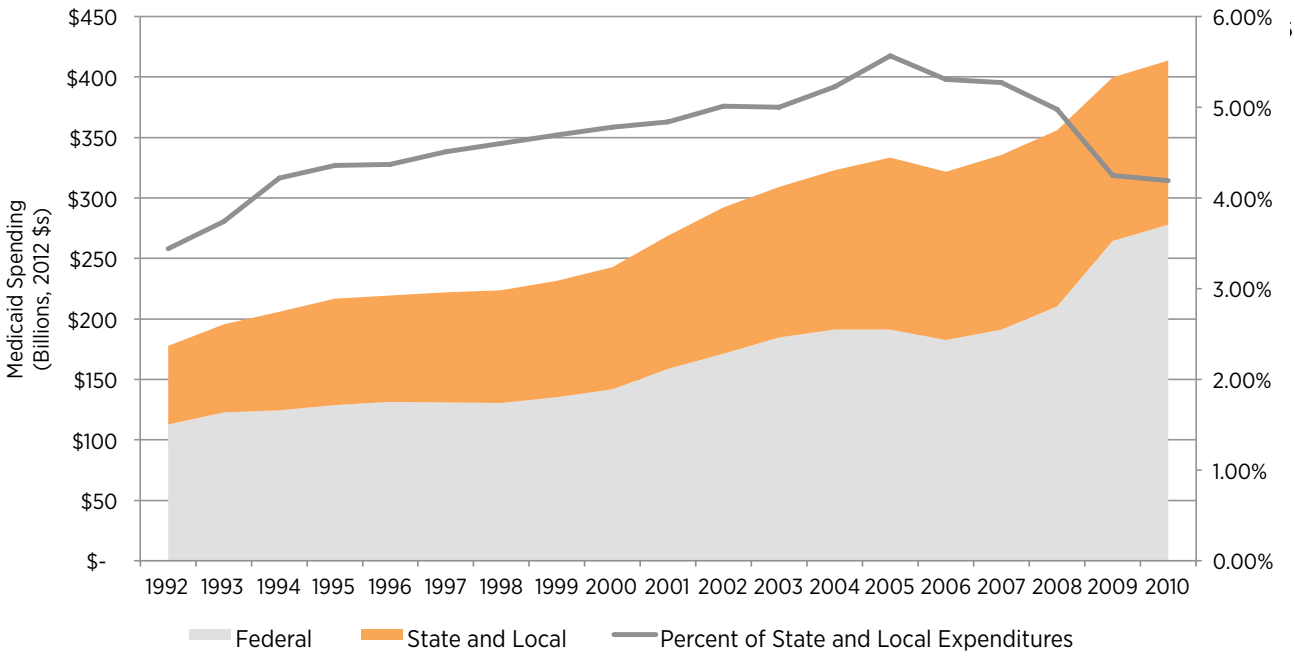
Unfortunately, this incentive is likely to have a significant impact on the federal government's budget between now and 2022. Assuming that the HHS Secretary allows partial expansion, CBO revised estimates suggest that exchange insurance subsidies and other related spending are expected to cost $1.017 trillion between now and 2022—with costs starting to gradually increase in 2014.[32]

CONCLUSION

Given that the ACA is still in its infancy, it is imperative to consider how this significant change will affect state and federal budgets and the economy at large. To emphasize this point, consider figure 7.

Examining the data between 2000 and 2036, it is clear that the two largest government health care programs in the country are slowly beginning to represent a larger share of Gross Domestic Product (GDP). With non-interest spending at 22 percent of GDP, it is clear that government health care spending is at unprecedented levels. With or without Medicaid eligibility expansion, Medicaid is on a trajectory to require increasing resources at state and federal levels of government, creating difficult budgetary tradeoffs for both.

FIGURE 7 – HEALTH EXPENDITURES AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT[33]



32. Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (2012).
33. Congressional Budget Office. *The 2012 Long-Term Budget Outlook* (2012).