Medicaid and Retiree Health: Issues and Challenges

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Medicaid’s Role

• Provides health and long-term care coverage for over 50 million people
  – Finances care for over 12 million elderly and persons with disabilities, including over 6 million Medicare beneficiaries
  – Provides comprehensive, low-cost health insurance for 38 million people in low-income families, reducing the number of uninsured

• Improves access to care and reduces disparities

• Guarantees entitlement to individuals and federal financing to states

• Provides $160 billion in federal and $120 billion in state and local funding for coverage of low-income populations

• Pays for nearly 1 in 5 health care dollars; 1 in 2 long-term care dollars in the U.S.; and over half of public mental health spending
Medicaid’s Role for the Aged and Disabled

Percent with Full Medicaid Coverage:

- Medicare Beneficiaries: 15%
- People with Severe Disabilities: 20%
- People Living with HIV/AIDS: 44%
- Nursing Home Residents: 60%

Expenditure distribution based on CBO data that includes only spending on services and excludes DSH, supplemental provider payments, vaccines for children, and administration.

Figure 4

Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 2002

<table>
<thead>
<tr>
<th>Category</th>
<th>Expenditures Per Enrollee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>$1,500</td>
</tr>
<tr>
<td>Adults</td>
<td>$2,000</td>
</tr>
<tr>
<td>Disabled</td>
<td>$11,800</td>
</tr>
<tr>
<td>Elderly</td>
<td>$13,100</td>
</tr>
</tbody>
</table>

Long-Term Care
Acute Care

Figure 5

Change in State Tax Revenue Collections, 1995-2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>7%</td>
</tr>
<tr>
<td>1996</td>
<td>5.4%</td>
</tr>
<tr>
<td>1997</td>
<td>6.2%</td>
</tr>
<tr>
<td>1998</td>
<td>6.9%</td>
</tr>
<tr>
<td>1999</td>
<td>5.7%</td>
</tr>
<tr>
<td>2000</td>
<td>8.7%</td>
</tr>
<tr>
<td>2001</td>
<td>4.7%</td>
</tr>
<tr>
<td>2002</td>
<td>-5.9%</td>
</tr>
<tr>
<td>2003</td>
<td>0%</td>
</tr>
</tbody>
</table>

SOURCE: Rockefeller Institute of Government, Fiscal Year 2002 Tax Revenue Summary, May 2003. Changes are shown in nominal terms and are not adjusted for tax-related legislative changes.
Figure 6

Average Annual Growth Rates of Total Medicaid Spending

Annual growth rate:

- 27.1% (1990-92)
- 9.7% (1992-95)
- 3.2% (1995-97)
- 5.4% (1997-99)
- 9.0% (1999-01)
- 12.8% (2002)
- 9.3% (2003)

Figure 7

Contributors to Medicaid Expenditure Growth by Enrollment Group, 2000-2002

- Disabled: 35%
- Aged: 24%
- Children: 21%
- Adults: 15%
- Other: 2.3%
- Medicare Payments: 2.1%
- DSH: 0.7%

Total = $48.2 Billion

State Actions Affecting Persons with Disabilities and Seniors: Selected Examples

• Scaling back eligibility, especially for those who qualify because of high medical bills
  – 3 states eliminated or restricted their “medically needy” programs
  – Several states reduced spend-down period and changed asset rules

• Changes to home and community-based waivers
  – While many states are expanding home and community-based care, others are reducing enrollment and benefits

• Benefit reductions for optional services
  – Several states chose to eliminate or restrict occupational, physical and speech therapies as well as chiropractic, dental and podiatry services. Other restrictions include new limits on long-term care home therapies and limits on personal care hours

• Impact of new and increased cost-sharing
  – Few states are exempting seniors or people with disabilities from co-payments; potential impact is large because these groups use health care services, including prescription drugs, intensively

Figure 9

Expenditures for Dual Eligibles, FY2002

Total Spending = $91.3 billion

- Long-Term Care: 65%
- Medicare Acute: 11%
- Prescribed Drugs: 14%
- Other Acute: 4%
- Medicare Premiums: 6%

Figure 10

Implications of Provisions in the New Medicare Bill for States

• Medicare will provide prescription drug coverage to Medicaid beneficiaries who are also enrolled in Medicare (the "dual eligibles")
  – However, states may not supplement the Medicare prescription drug benefit for dual eligibles through Medicaid. They must instead use state general revenue funds

• States will be required to make payments to the federal government totaling $115 billion over the next 10 years
  – Payments are designed to offset the fiscal relief states will receive as a result of no longer providing prescription drugs to dual eligibles under Medicaid
  – Between 2004 and 2006, this provision will cost states $1.2 billion more than they would have otherwise spent. Over 10 years, states will save a total of about $17 billion.

• States will assume new responsibilities for administering the Medicare prescription drug card in 2004 and the low-income subsidy in 2006
Medicaid Policy Concerns

• The state budget outlook is not yet improving and an aging population will provide additional stress

• Cost-cutting could erode coverage, increasing the number of uninsured and compromising the affordability and availability of health care for low-income groups

• Policy proposals to restructure Medicaid could further compromise coverage

• Assuring adequate financing and meaningful coverage for the elderly and disabled is a growing challenge