Medicaid and Retiree Health: Issues and Challenges

Diane Rowland, Sc.D.
Executive Director
Kaiser Commission on Medicaid and the Uninsured
and
Executive Vice President, Kaiser Family Foundation

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Figure 1

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**

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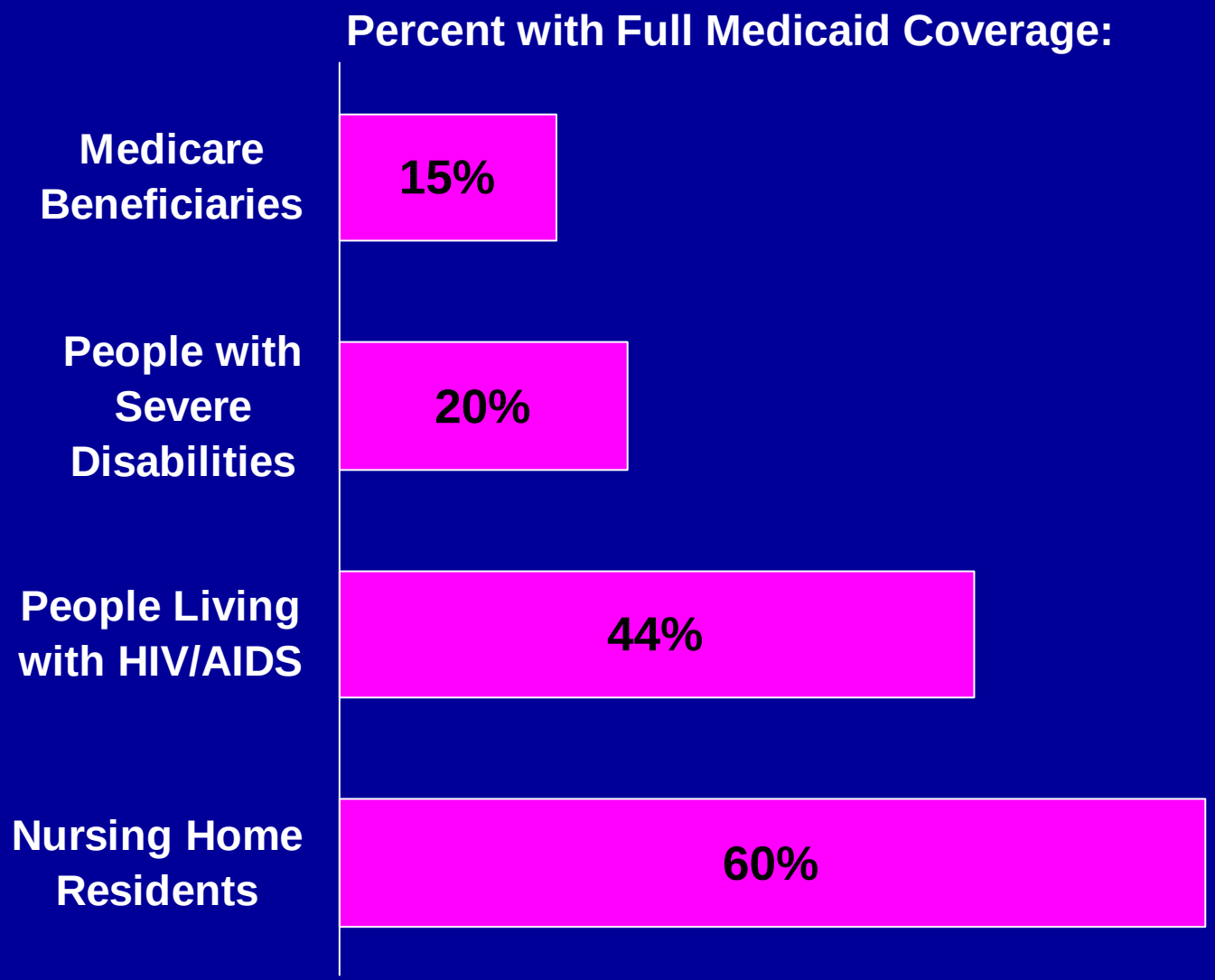
Figure 2

Medicaid's Role for the Aged and Disabled



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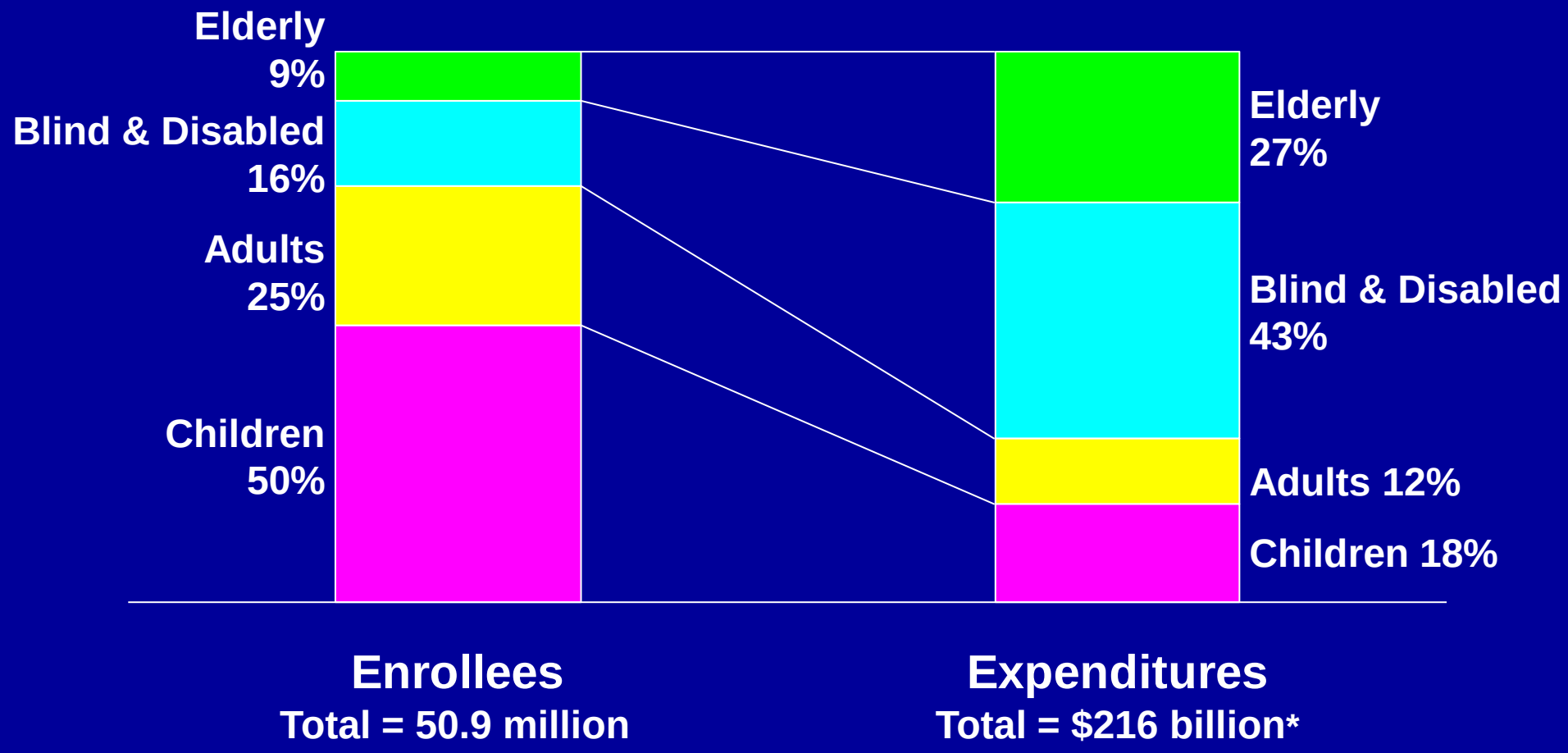
SOURCE: KCMU and Urban Institute estimates, 2002.

Figure 3

Medicaid Enrollees and Expenditures by Enrollment Group, 2002



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

SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2003.

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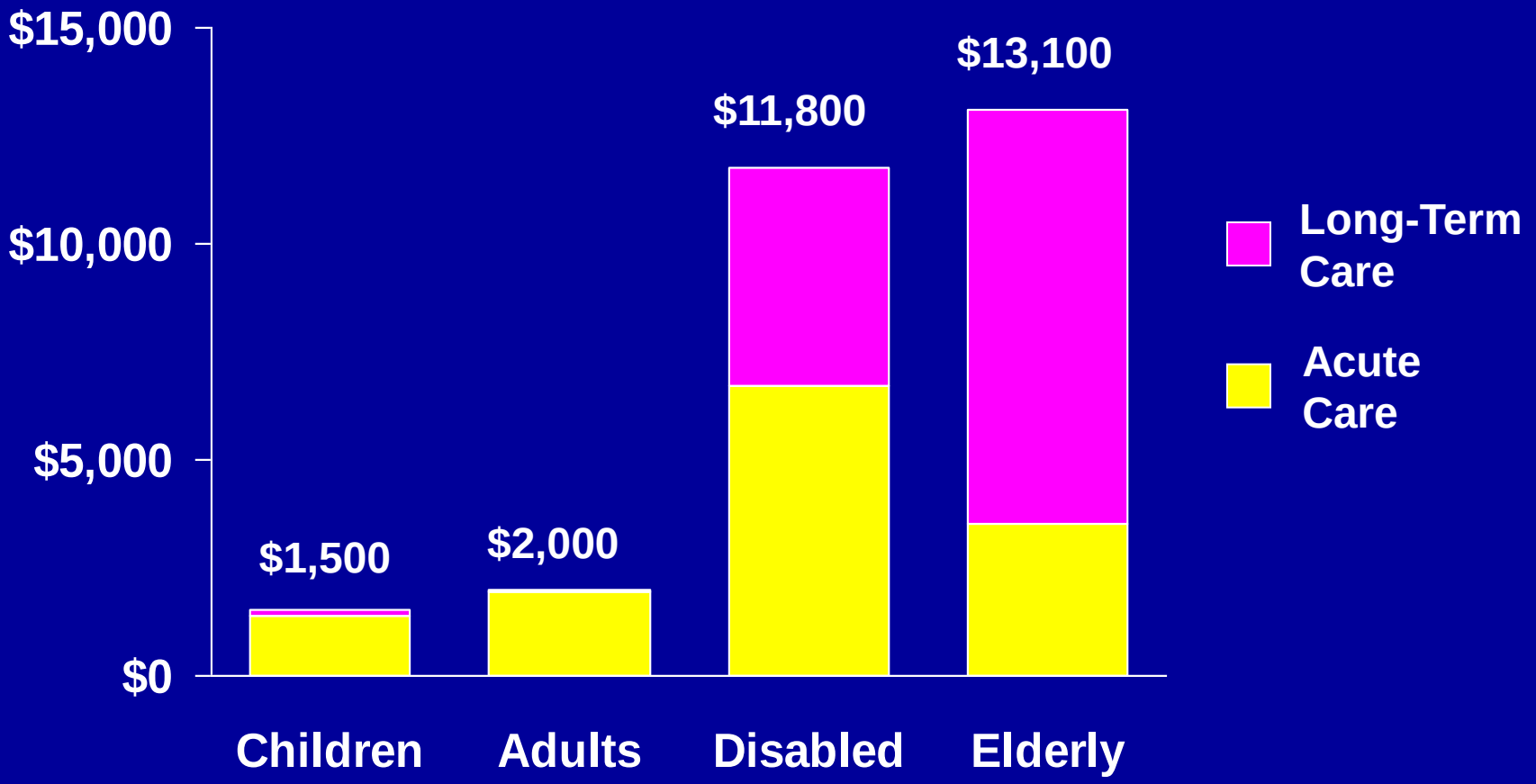
Figure 4

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



SOURCE: KCMU based on CBO and Urban Institute estimates, 2003.

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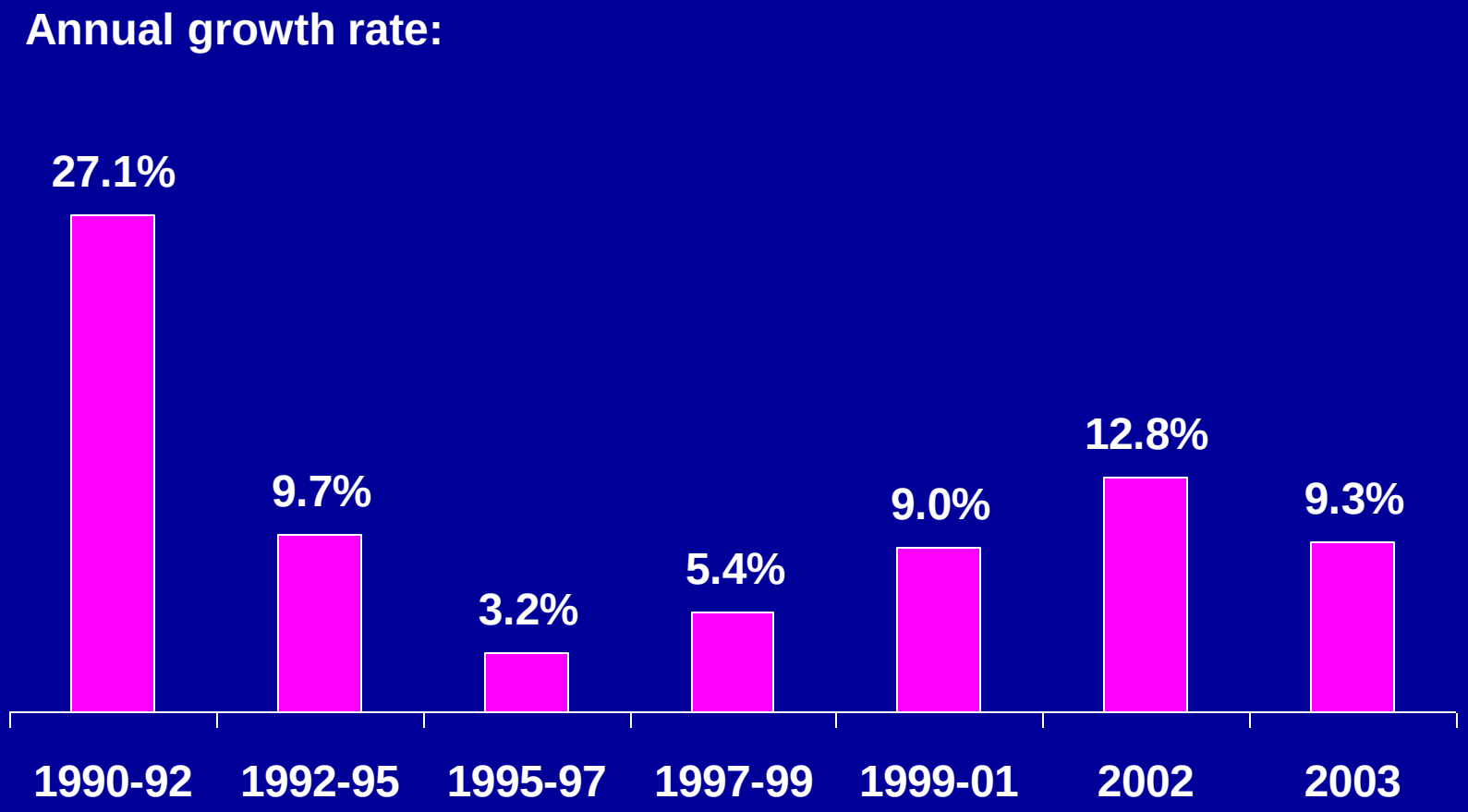
Figure 5

Change in State Tax Revenue Collections, 1995-2003

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



SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 2001-2003: Health Management Associates, for the Kaiser Commission on Medicaid and the Uninsured.

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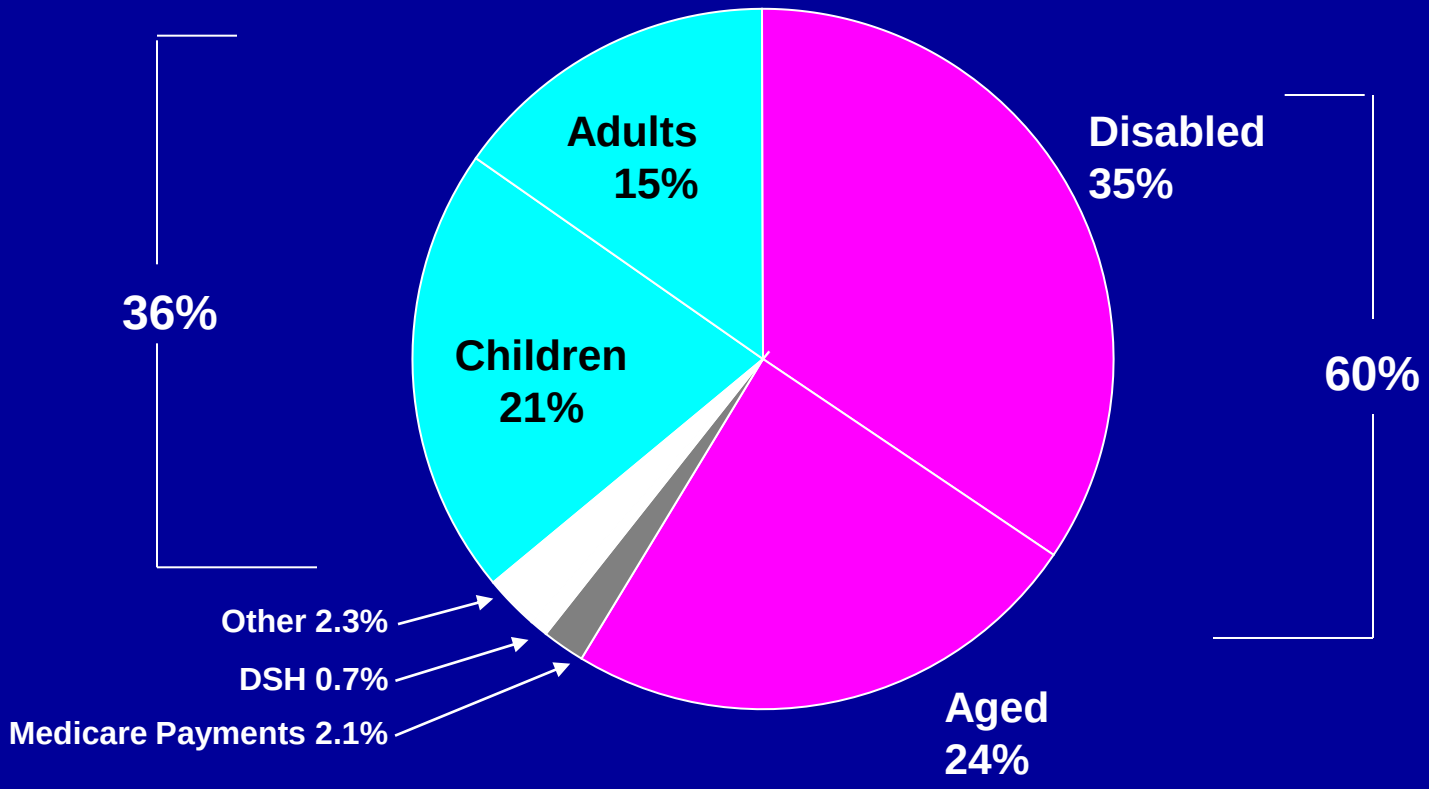
Figure 7

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



Total = $48.2 Billion

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SOURCE: Estimates for KCMU prepared by the Urban Institute, 2003.

Figure 8

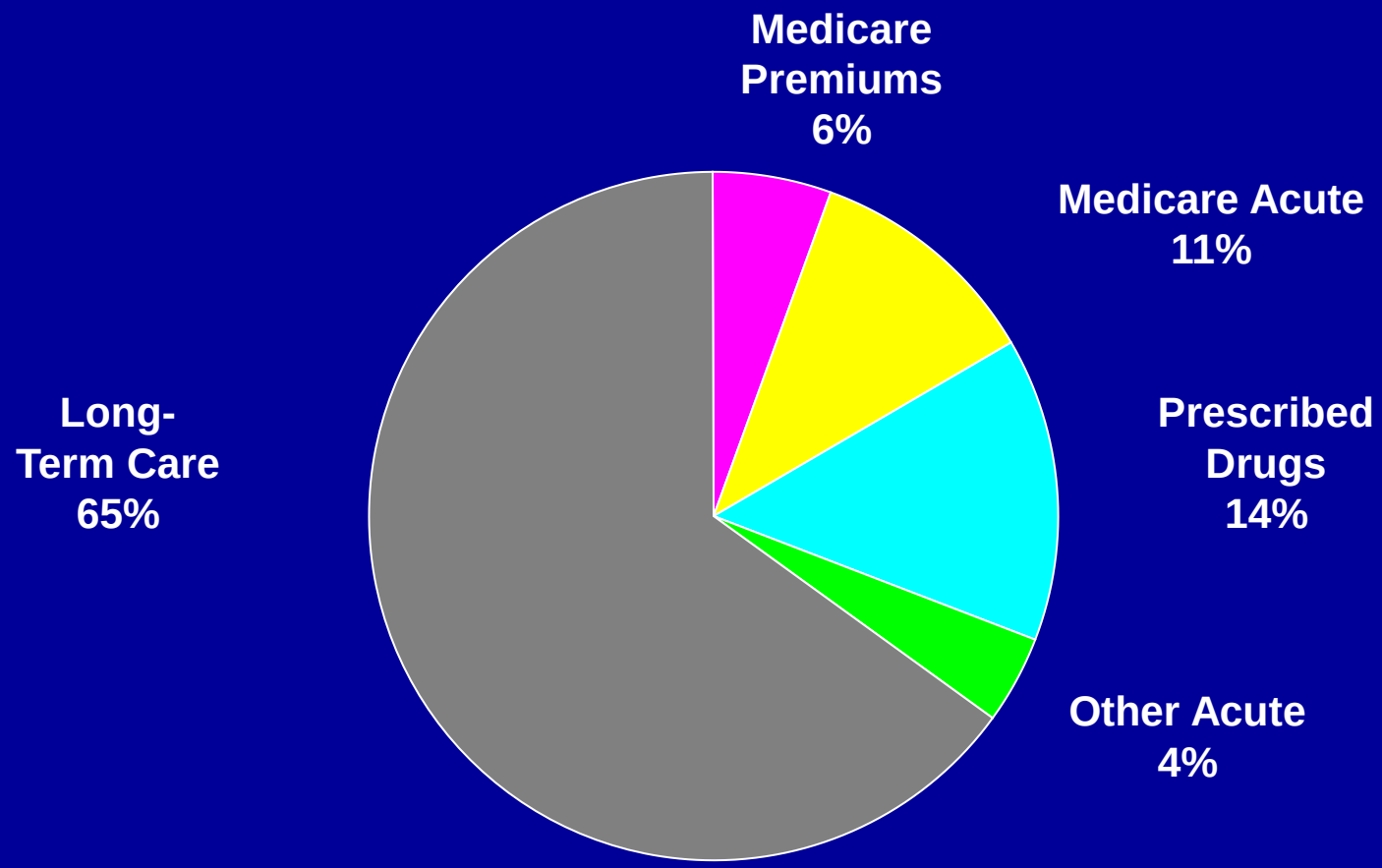
State Actions Affecting Persons with Disabilities and Seniors: Selected Examples

- **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

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2003 and September 2003.

Figure 9

Expenditures for Dual Eligibles, FY2002



Total Spending = $91.3 billion

SOURCE: Urban Institute estimates for KCMU based on an analysis of MSIS and Financial Management reports (CMS Form 64).

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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**

Figure 11

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