

CRS Report for Congress

Received through the CRS Web

Medicaid: A Fact Sheet

Jean Hearne
Domestic Social Policy Division

Medicaid is the largest of the joint federal/state entitlement programs. The program provides payments for health care for certain groups of low-income individuals. Medicaid can be thought of as three distinct programs — one program funds long-term care for the chronically ill, disabled, and aged; another program provides comprehensive health insurance for low-income children and families; and the disproportionate share (DSH) program assists hospitals with the cost of uncompensated care. Preliminary estimates for FY1999 (based on state reports) from the Center on Medicare and Medicaid Services (CMS) reveal Medicaid enrollment of 42.1 million persons at a total cost of almost \$190 billion. The federal share of the cost for FY1999 was \$108 billion.

Table 1. Federal Share and Total Medicaid Spending, 1994-2000
(\$ in billions)

Year	Total Medicaid spending	Federal share	Percentage change in federal share
1994	\$143.8	\$82.0	—
1995	\$159.5	\$89.1	8.7%
1996	\$159.6	\$92.0	3.3%
1997	\$167.4	\$95.6	3.9%
1998	\$177.0	\$100.0	5.6%
1999	\$190.0	\$107.6	7.7%
2000	\$206.7	\$117.4	9.2%

Sources: Historical tables of The Budget of the United States Government, Fiscal Year 2002, HCFA 64 Financial Management Reports,

Each state establishes its own eligibility within broad federal guidelines. States must cover certain population groups such as recipients of Supplemental Security Income (SSI), i.e., the aged, blind and disabled, and have the option of covering others. Historically, Medicaid eligibility for poor families (generally women with dependent children) was linked to receipt of cash welfare payments. In recent years, Medicaid's ties to welfare benefits have been loosened. The trend culminated in the creation of the Temporary Assistance for Needy Families (TANF) program in 1996. The new welfare law included provisions severing the automatic link with Medicaid but allowed states to maintain the link as an option. The federal government shares in a state's Medicaid costs by means of

CRS-2

a statutory formula designed to provide a higher federal matching rate to states with lower per capita incomes. The federal medical assistance percentage (FMAP) is the percentage of Medicaid benefit costs paid for by the federal government. In FY1999, FMAPs ranged from 50% to 77%.

Medicaid does not cover everyone who is poor, reaching only 40.3% of persons in poverty in 1998. Eligibility is also subject to "categorical" restrictions; benefits are available only to members of families with children, pregnant women, persons who are aged, blind, or disabled or who belong to a group that has been specifically identified in the law such as those with tuberculosis or breast and cervical cancer. Beginning in 1984, Congress expanded eligibility for pregnant women and children. Partly as a result of that expansion, the number of beneficiaries grew by 60% over the next 10 years. Enrollment in Medicaid declined following welfare reform in 1996. Recently, Medicaid enrollment has begun to rise again as the economy slows. Combined with a quickly rising prices for health insurance and a continuing economic slowdown, Medicaid enrollment is expected by many to be heading upward.

Special eligibility rules apply to persons receiving care in nursing facilities and other institutions. Many of these persons have incomes well above the poverty level but qualify for Medicaid because of the high cost of their care. Medicaid has thus emerged as the largest source of third-party funding for long-term care. It is also a major source of federal support for programs to serve the mentally retarded and developmentally disabled. In FY1998, the latest year for which per capita spending data is available, the aged, blind and disabled represented 26% of Medicaid enrollment but accounted for 60% of program spending. Poor families, in contrast, comprised 72% of enrollment but only 26% of spending.

The State Child Health Insurance Program (SCHIP), created in 1997, is closely related to Medicaid. SCHIP provides federal matching funds for states to expand health benefits coverage for modest income children through Medicaid, through a separate state program, or through a combination of both. The federal matching percentage for SCHIP children, whether covered through Medicaid or a separate program is between 65% and 85%. In 2000, 3.3 million children were covered under state SCHIP programs.

Each state defines its own package of Medicaid covered medical services. Federal law mandates some, such as hospital, nursing facility, and physician care; others, such as prescription drugs and dental care, are at state option. States also set their own reimbursement rules. Many states pay considerably less under Medicaid than providers' costs or customary charges. As a result, many medical care providers refuse to accept Medicaid patients or limit the number of such patients they will treat. Still, Medicaid beneficiaries appear to have significantly better access to care than comparable uninsured individuals.

Before 1990, most Medicaid services were provided on a fee for service basis by any health care practitioner who was willing to accept Medicaid. By 1997, almost half of Medicaid recipients were enrolled in some kind of pre-paid managed care organization (MCO). This shift to managed care provided the impetus for a set of laws passed as part of the Balanced Budget Act of 1997. Among other things, they make mandatory enrollment into MCOs easier for states and establish quality and other standards for Medicaid MCOs.