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MEDICAID 101: The Federal-State Health Care Partnership

What is Medicaid?

Medicaid is the largest source of health care funding for the poor in the U.S., serving one in six Americans or close to 53 million people.[1] Medicaid guarantees eligible individuals coverage for primary, acute and long-term care services. The program is run jointly by the federal and state governments, with each state administering its own Medicaid program under federal guidelines, and the federal government contributing more than half of the program's costs.[2]

Medicaid is an entitlement program, which means that ***anyone who meets the stringent eligibility requirements can enroll in the program*** and there is no limit on the number of people allowed into the program.

There are five main categories of eligible people: (1) Children, (2) Parents, (3) Pregnant Women, (4) People with Disabilities, and (5) the Elderly. Beyond these categories, eligibility is determined based on financial considerations, with a federally defined income threshold for each group and a limit on assets.[3] States may seek approval through an application to the federal government called a "waiver" if they want to alter their program in any way that would not meet federal Medicaid requirements.

What is Covered by Medicaid?

Since its early years, the Medicaid program has guaranteed its beneficiaries access to key health services, including physician services, laboratory and x-ray services, inpatient and outpatient hospital care, nursing home care and family planning supplies and services.[4] Many states have opted to go beyond federal requirements and provide coverage of "optional" services, such as coverage for prescription drugs.[5] Unfortunately, the recently passed budget law called the Deficit Reduction Act (DRA) allows states to replace even the traditional Medicaid package with reduced benefit packages for certain groups.[6]

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[1] IssuesPA, *Medicaid 101 – An Overview of a Federal-State Partnership.* at http://www.issuespa.net/articles/10933/ (accessed June, 2005).

[2] National Health Policy Forum, *The Basics: Medicaid Financing*. The George Washington University, September 14, 2004. at http://www.nhpf.org/pdfs_basics/Basics_MedicaidFinancing.pdf

[3] Almanac of Policy Issues, *Medicaid: A Program Overview*. U.S. Department of Heath and Human Services, Health Care Financing Administration – *A Profile of Medicaid: 2000 Chartbook,* Section 1, September 2000.

[4] For a comprehensive list of all mandatory services, refer to Centers for Medicare & Medicaid Services, *Medicaid – A Brief Summary,* http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp (accessed August 29, 2005).

[5] "In addition to the mandated benefits packages, states may provide additional "optional" services. All fifty states do." Anna Sommers, Ph.D., Arunabh Gosh, B.A., The Urban Institute and David Rousseau, M.P.H., The Kaiser Commission on Medicaid and the Uninsured. *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefits Categories.* June 2005.

[6] For more information about what services could be lost under the DRA, please see *Medicaid Cuts: Benefits May Be Reduced for Women Under the DRA* at http://www.nwlc.org/pdf/FSMedicaidandtheDRA_04.21.06.pdf

Who Pays for Medicaid?
Medicaid was created in 1965 to serve as the primary health care program for the poor. A partnership was created between the state and federal governments to allow both to share the financial burden of the program and to provide health care to the most vulnerable Americans. ***Because the federal government commits to paying at least half the cost of Medicaid, the program has a fiscal incentive for states to extend health care coverage to their low-income residents.***

Costs for the program are divided between the federal and state governments based on a matching rate, called the federal medical assistance percentage or "***FMAP***." The FMAP is calculated based on a formula that uses each state's per capita income to account for varying degrees of poverty among the states.[7] Wealthier states, which have higher per capita incomes, receive less federal support than poorer states. Currently, FMAPs range from a minimum of 50% in states like California and New York to a maximum of 76% in Mississippi.[8]

States generally may charge a co-payment or insurance premium, known as ***cost-sharing,*** to beneficiaries for the care they receive, including prescription medication. However, traditionally, some groups and services were exempt from cost-sharing in order to ensure their use of needed health care.[9] Unfortunately, the DRA now allows states to impose new or higher cost sharing on most Medicaid beneficiaries. States may not require cost-sharing for services for mandatory children and pregnant women. Very significantly, the DRA grants providers the right to *deny* services or drugs if a beneficiary cannot pay the cost-sharing amount at the point of service. This individual then not only faces a loss of care for a particular health need, but also faces the loss of his/her health insurance all together.

Medicaid Covers More People (and Costs More) When the Economy Is Weak
Medicaid is *counter-cyclical,* meaning that it expands to cover more people when weak economic times lead more individuals to become eligible for the program.[10] Therefore, as the need grows and more enter the program, federal financial support also grows. The fact that Medicaid is an entitlement program has ensured the program's ability to cover more uninsured, low-income people when the economy suffers a downturn.[11] ***If the federal government were to provide funding for Medicaid only through limited amounts of money rather than providing matching funds for all state expenditures as it does through the FMAP, states would come up short during hard times, and they would not be able to meet the growing demands during an economic slump.***[12]

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[7] Glossary of Home Health Care and Health Care Terms, "FMAP is a percentage of Federal matching dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capital income." at
http://www.healthcarewebdesign.com/glossary_healthcare_homecare_terms/glossaryF.php (accessed July 2005)
[8] *Federal Financial Participation in State Assistance Expenditures*, FY 2006 Federal Register: November 24, 2004 (Volume 69, Number 226).
[9] For more information on the effects of cost-sharing on low-income populations, please see *Increased Cost-Sharing in Medicaid Hurts Women and their Families* at http://www.nwlc.org/pdf/6-2005MedicaidCost-Sharing.pdf.
[10] Leighton Ku, *CDC Date Show Medicaid and SCHIP Played A Critical Counter-Cyclical Role In Strengthening Health Insurance Coverage During Economic Downturn*. The Center on Budget and Policy Priorities, Revised October 8, 2003.
[11] *Id.*
[12] *Id.*

Ways to Expand Medicaid Coverage
States can expand Medicaid coverage in various ways. One way is to raise the income at which people are eligible.[13] States must cover eligible populations (known as mandatory populations) up to a certain percentage of the federal poverty level. But states can go beyond this level and cover individuals at higher incomes. Currently, all states go above some federal minimums to cover portions of these so-called "optional" populations. Another way to expand coverage is to streamline the enrollment process by eliminating the asset test. Even when their income meets eligibility criteria, many individuals do not enroll because they encounter barriers to enrollment. One such barrier is the asset test, which counts parents' ownership of certain assets when determining the family's eligibility for Medicaid. Removing this test eases the application process, streamlines and reduces administrative costs and increases the pool of eligible individuals. In 2004, 21 states had eliminated the asset test for parents.

States may also allow working individuals with disabilities the option of *buying into Medicaid*. Under this option, working individuals with disabilities, who because of their earnings cannot qualify for Medicaid, can pay a monthly premium in an amount equal to the difference between their income and the maximum income eligibility level set by their state.[14] In total, 31 states allow certain populations to utilize the buy-in option to receive benefits.[15]

States also may seek permission through *a waiver* to use federal Medicaid funds to cover more categories of people then those required by federal law.[16] Waivers were designed to let states try "research and demonstration" to institute projects that "further the objectives of the [Medicaid] program."[17] Unfortunately, in an attempt to contain costs, many states are now using these waivers to limit Medicaid enrollment and benefits while increasing the cost to recipients rather than using the waivers to expand coverage.

Cutting Medicaid Severs the Federal-State Partnership and Hurts Beneficiaries
Recent efforts to cut federal funding to Medicaid could have dire consequences for the program's beneficiaries, the majority of whom are women. An inadequate federal commitment exposes these women and their families to inevitable cuts in coverage or a reduction in benefits at the state level. As health care costs continue to rise and access to employer-sponsored insurance decreases, the federal government must continue to carry its fair share of the Medicaid financing burden and stay true to its historical commitment to this health insurance safety net.

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[13] 42 U.S.C. §§ 1396-1396v; 42 C.F.R. Ch. IV; 45 C.F.R. Subtitle A.

[14] *Medicaid Eligibility*, Centers for Medicare & Medicaid Services. at http://www.cms.hhs.gov/eligibility/criteria.asp (accessed June 2005)

[15] Allen Jensen, *Variables Impacting Participation in a State's Medicaid Buy-In Program: Medicaid Eligibility "Starting Points" and Restrictions in Medicaid Buy-In Program*. Draft, September 4, 2003. at http://www.uiowa.edu/~lhpdc/work/III_Framework/2003_TablesA_B_StartPoints.doc

[16] *Medicaid Section 1115 Waivers: Current Issues*, Kaiser Commission on Medicaid and the Uninsured. Key Facts, January 2005.

[17] *Id.*