New Models for Medicaid: A View from the Think-Tank Perspective

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for

The National Medicaid Congress
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Figure 1

Medicaid Today

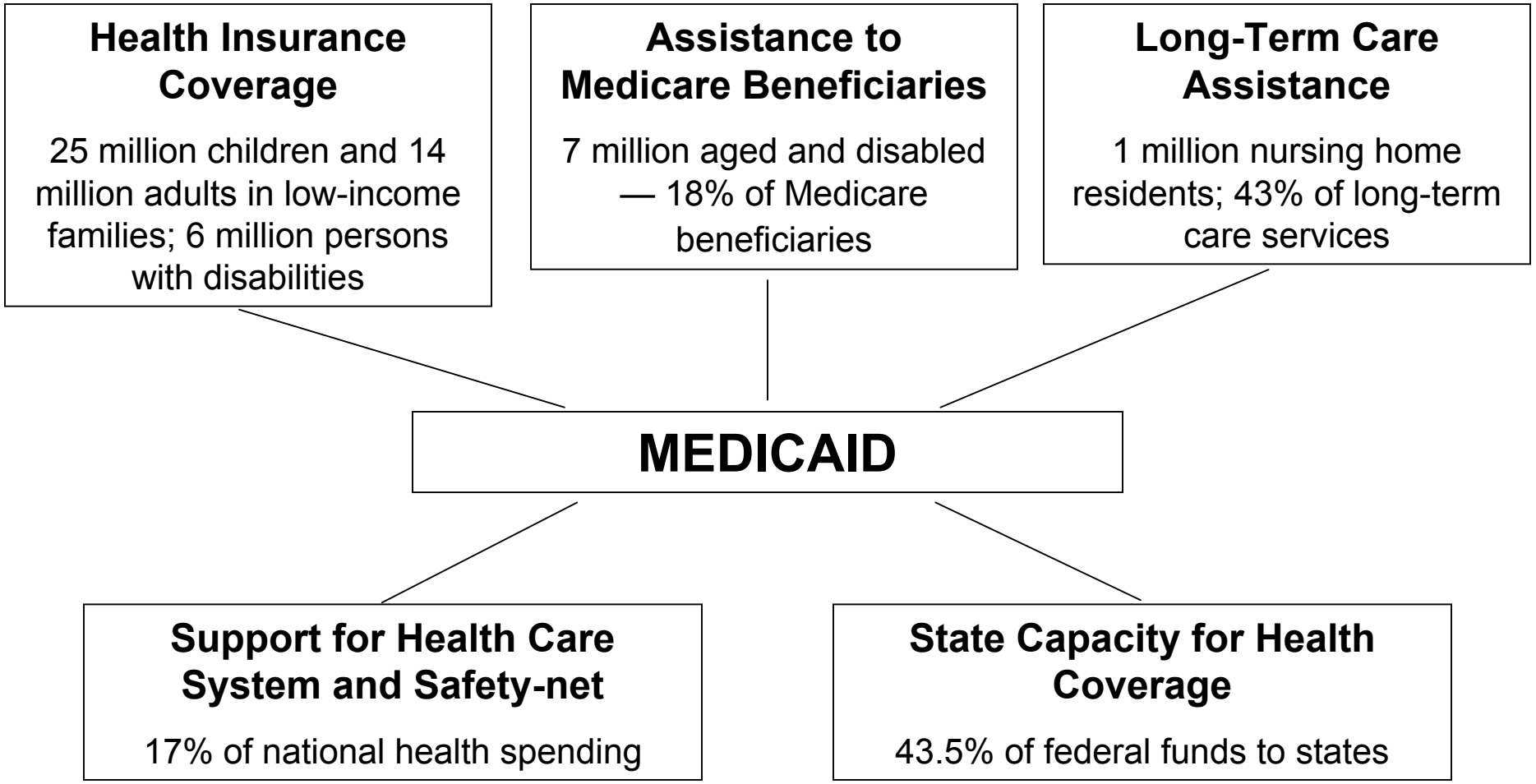
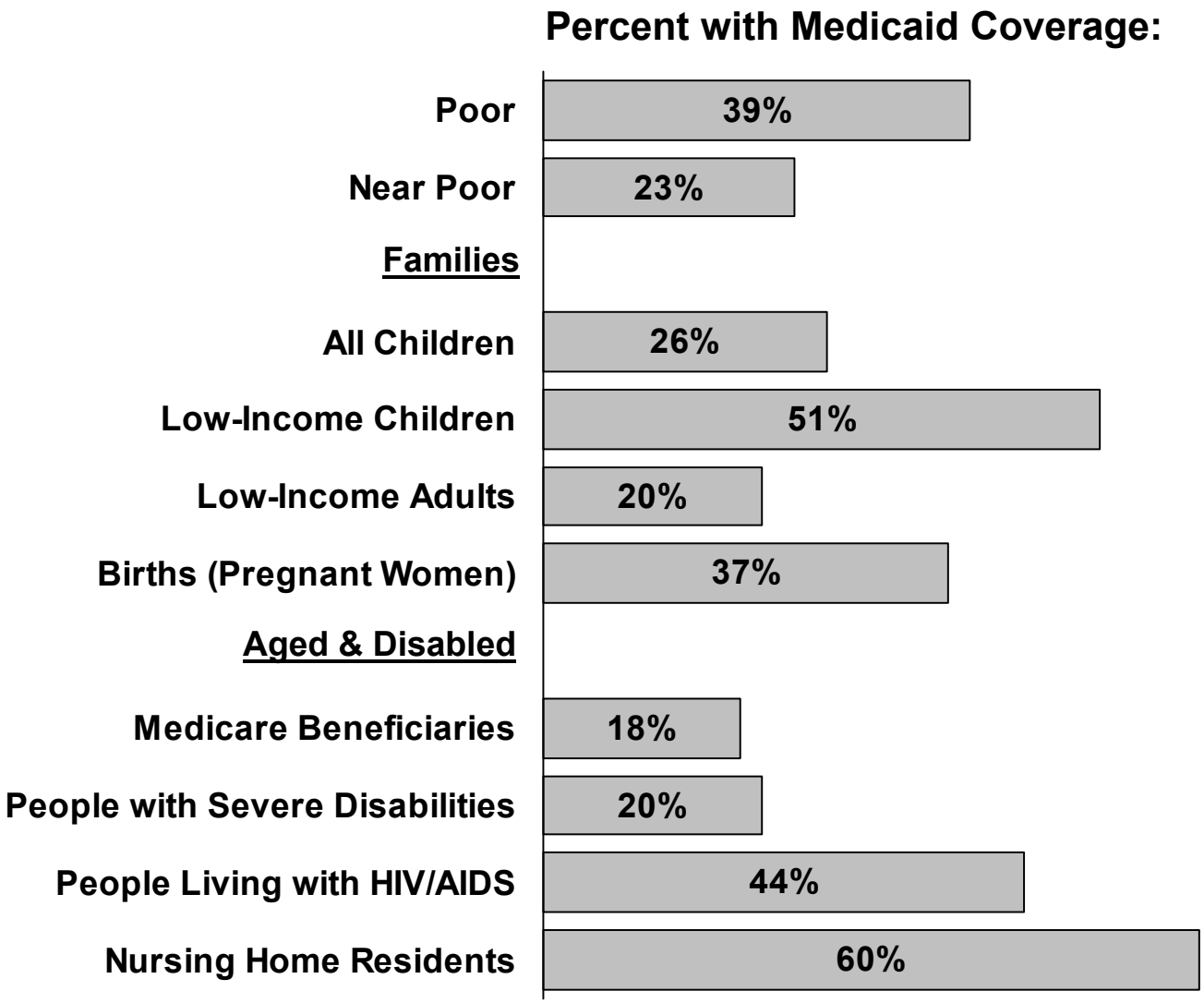


Figure 2

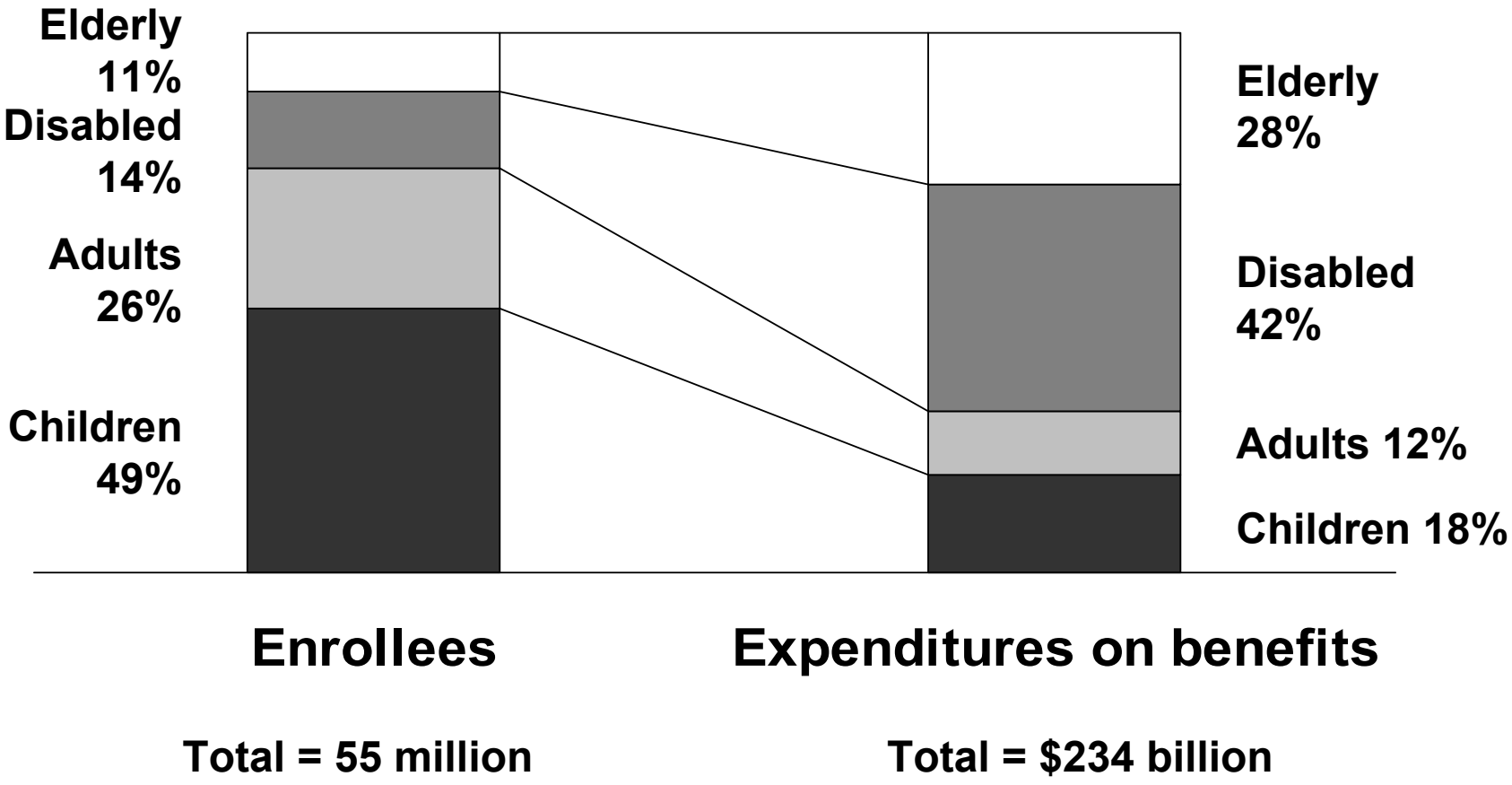
Medicaid Serves a Diverse Population



Note: “Poor” is defined as living below the federal poverty level, which was $19,307 for a family of four in 2004. SOURCE: KCMU, KFF, and Urban Institute estimates; Birth data: NGA, MCH Update.

Figure 3

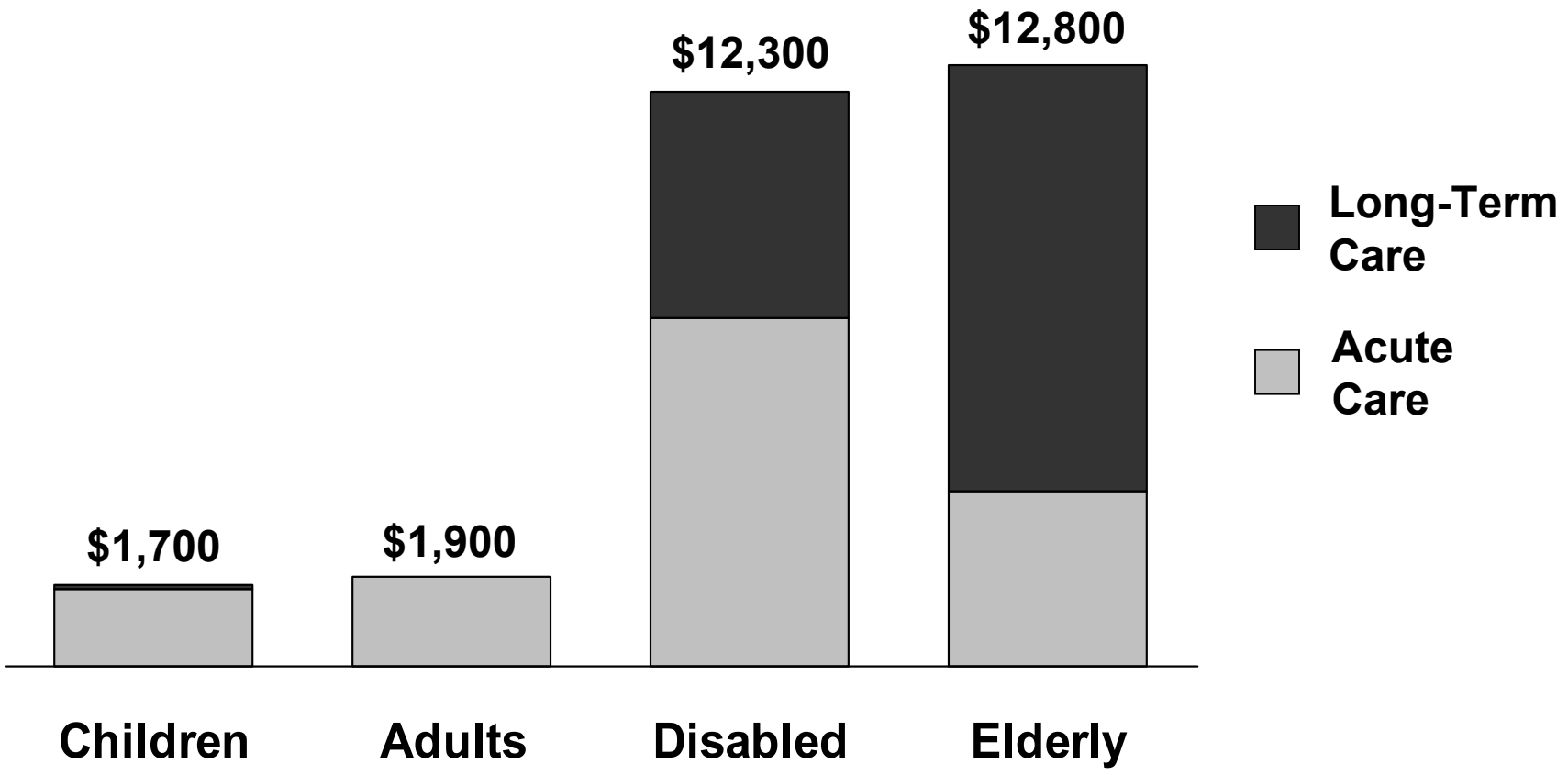
Medicaid Enrollees and Expenditures by Enrollment Group, 2003



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2003 MSIS data.

Figure 4

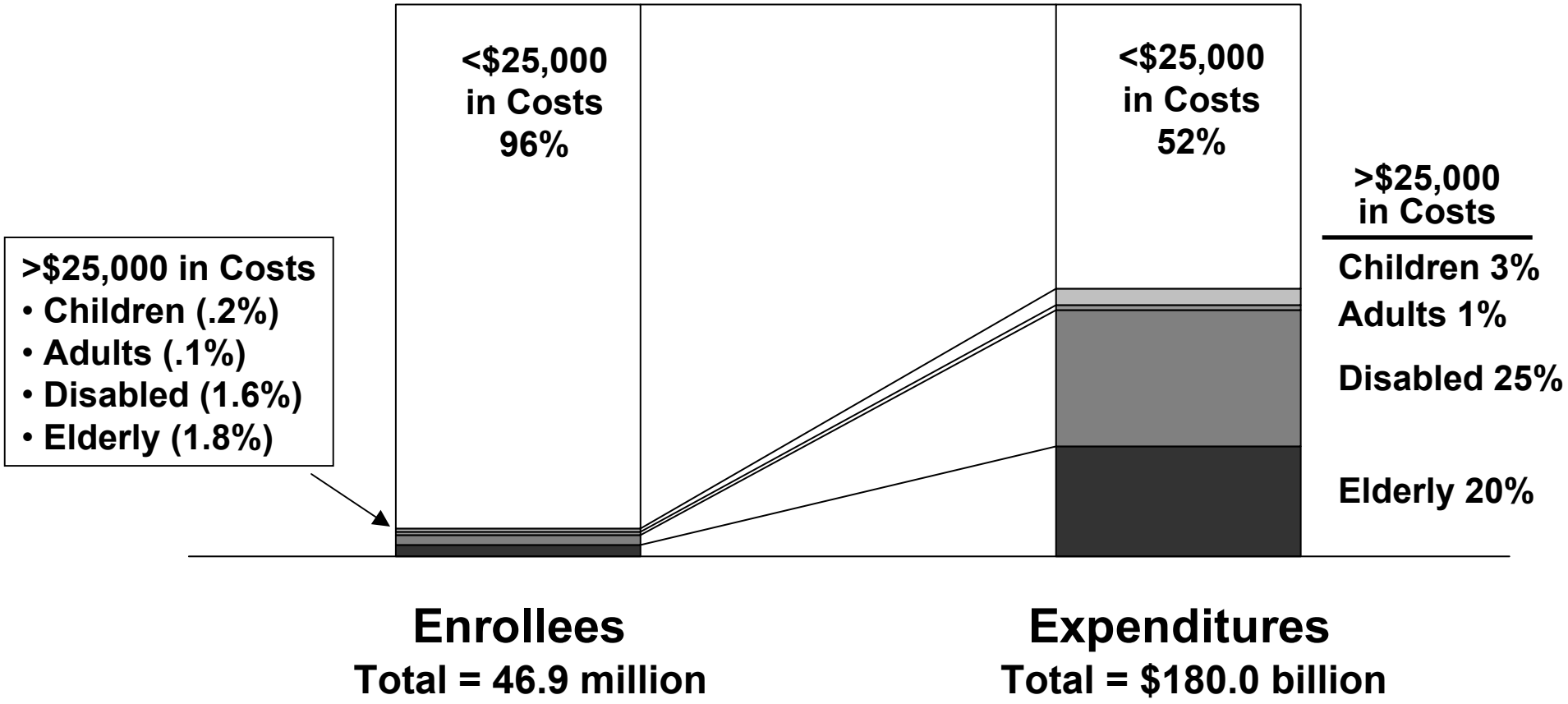
Medicaid Payments Per Enrollee by Acute and Long-Term Care, 2003



SOURCE: KCMU estimates based on CBO and Urban Institute data, 2004.

Figure 5

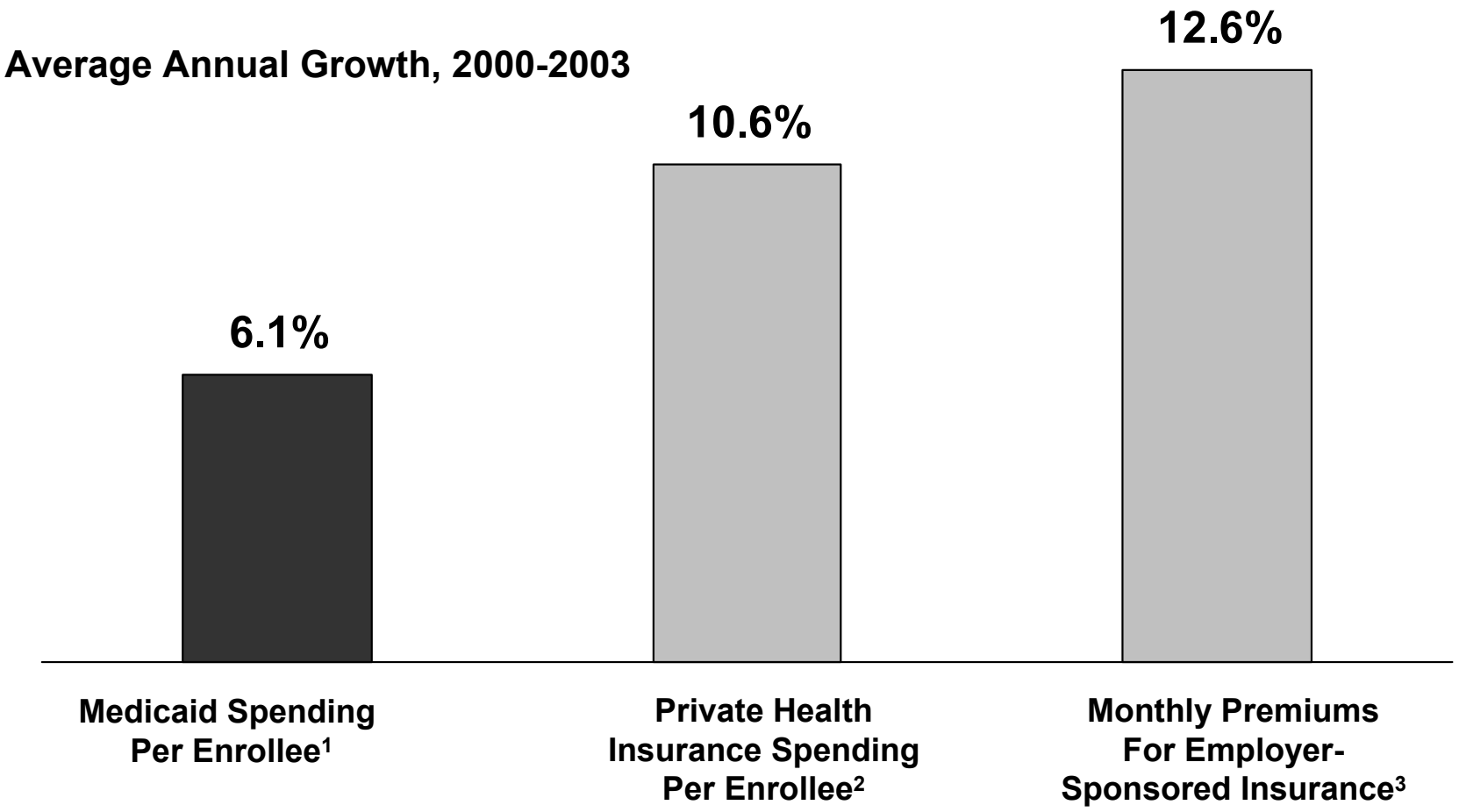
4 Percent of Medicaid Population Accounted for 48% of Expenditures in 2001



SOURCE: Urban Institute estimates based on MSIS 2001 data.

Figure 6

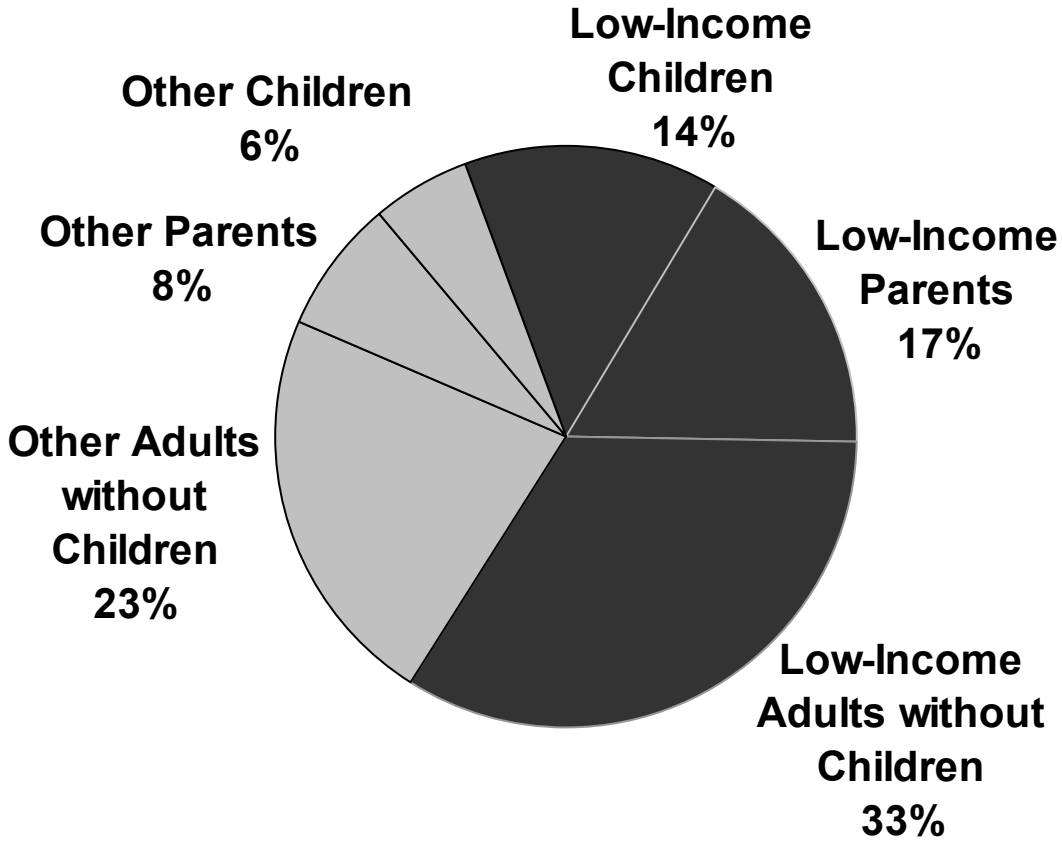
Medicaid Acute Care Spending Per Person Grew More Slowly than Spending Under Private Insurance, 2000 - 2003



[1] Holahan and Ghosh, *Health Affairs*, 2005.
[2] CMS Office of the Actuary, National Health Accounts, 2005.
[3] Kaiser/HRET Survey, 2003.

Figure 7

Non-Elderly Uninsured, by Age and Income Groups, 2004



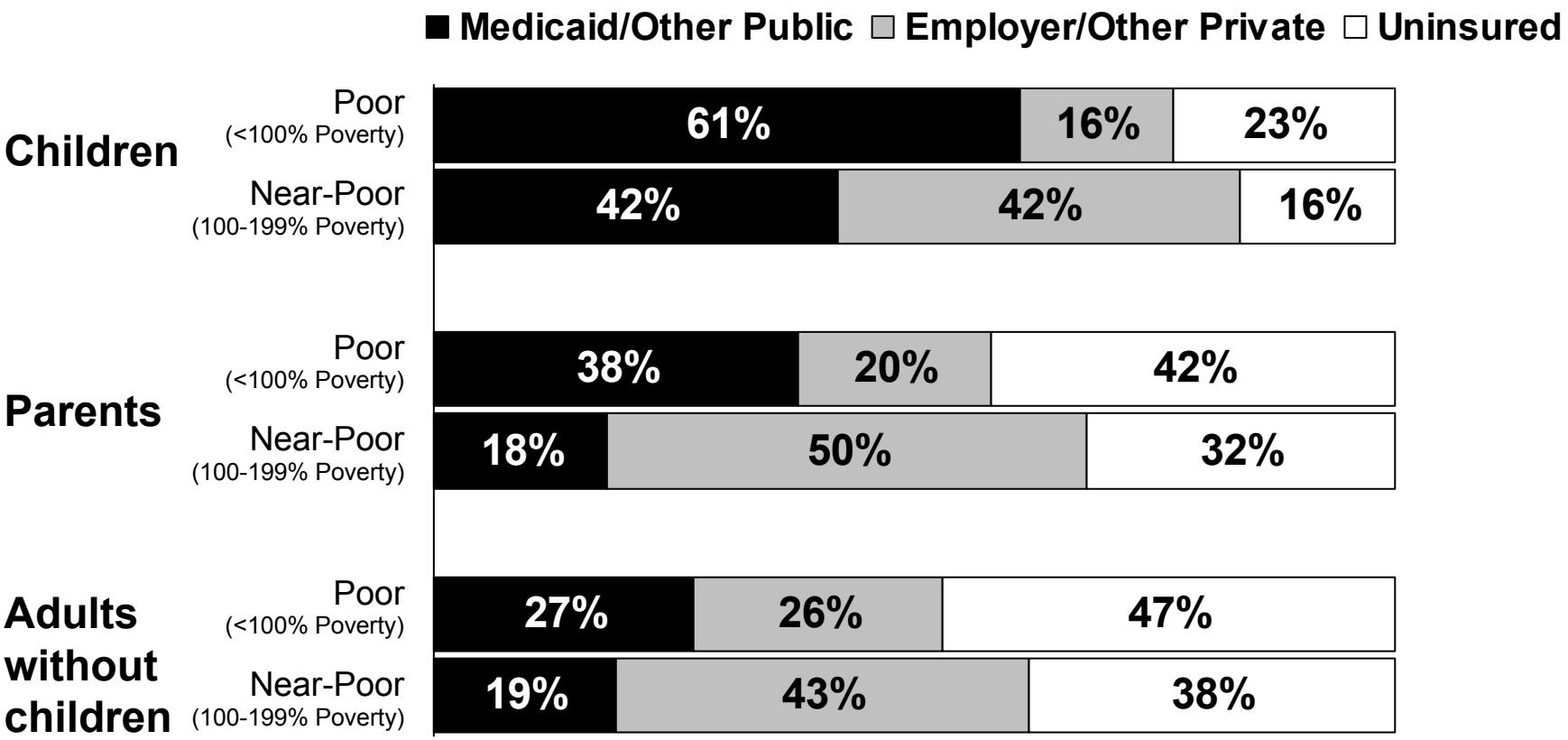
Total = 45.5 Million Uninsured

NOTES: Low-income is <200% of the federal poverty level ($30,134 for family of three in 2004). Parents of dependent children under age 19. Adults without children also include parents whose children are no longer dependent.

SOURCE: *Health Insurance Coverage in America, 2004 Data Update*, KCMU.

Figure 8

Medicaid's Role for Children and Adults, 2004

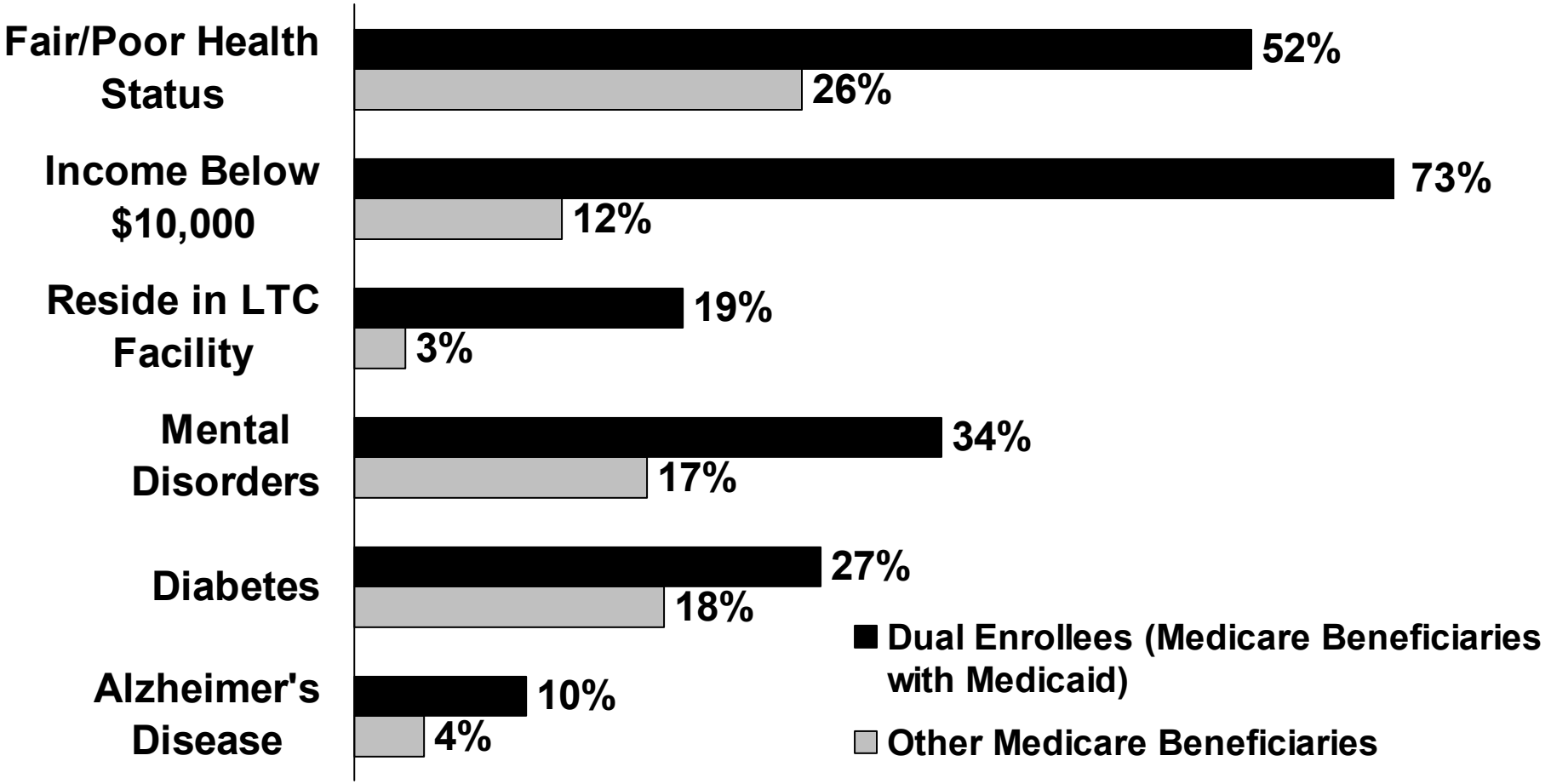


Notes: Medicaid also includes SCHIP and other state programs, Medicare and military-related coverage. The federal poverty level was $19,307 for a family of four in 2004.

SOURCE: KCMU and Urban Institute analysis of March 2005 Current Population Survey.

Figure 9

Dual Enrollees are Poorer and Sicker Than Other Medicare Beneficiaries

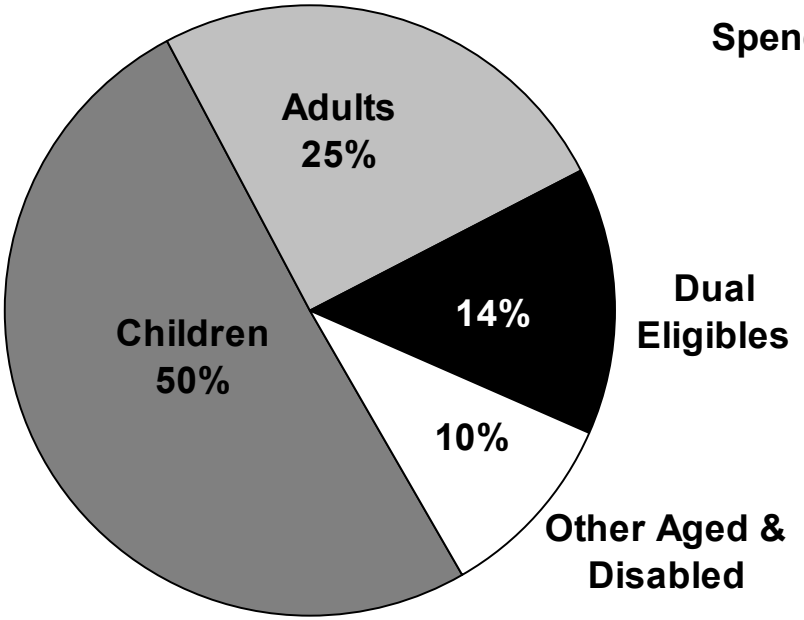


SOURCE: KFF estimates based on the Centers for Medicare and Medicaid Services Medicare Current Beneficiary Survey 2002 Access to Care File.

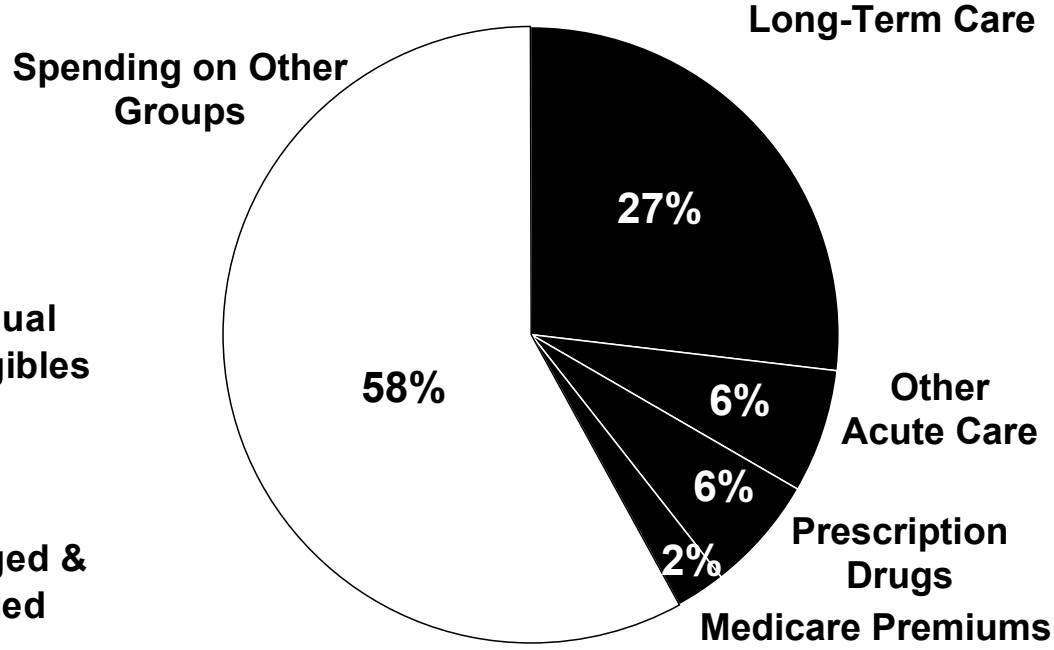
Figure 10

Medicaid Dual Eligibles: Enrollment and Spending

Medicaid Enrollment



Medicaid Spending



Total = 51 Million

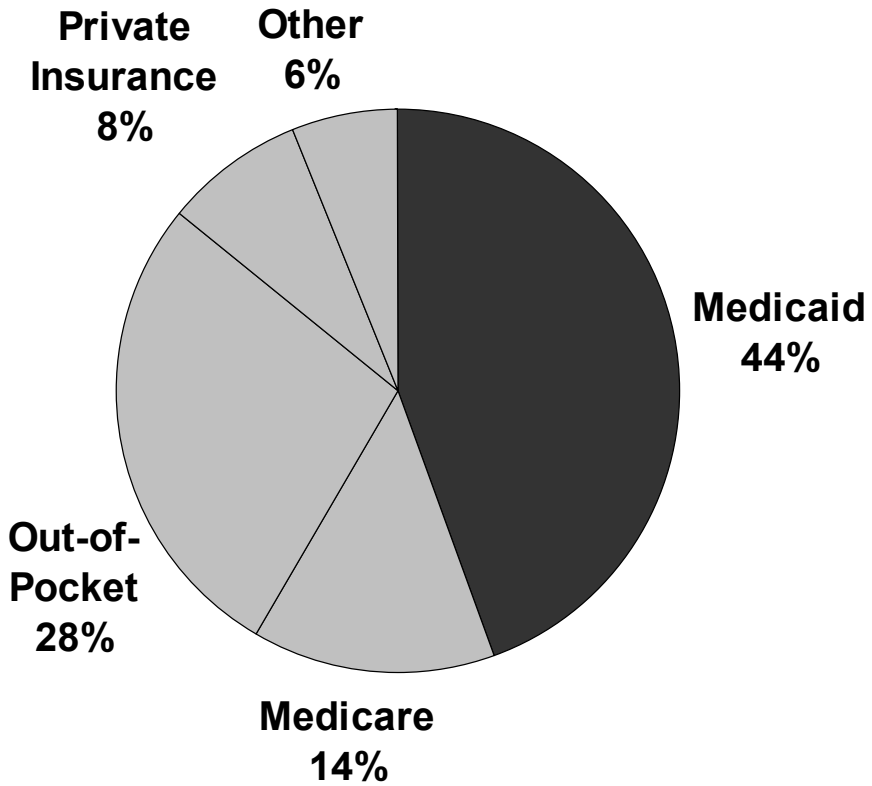
Spending on Benefits = $232.8 Billion (42% on Duals)

SOURCE: KCMU estimates based on CMS data and Urban Institute analysis of data from MSIS.

Figure 11

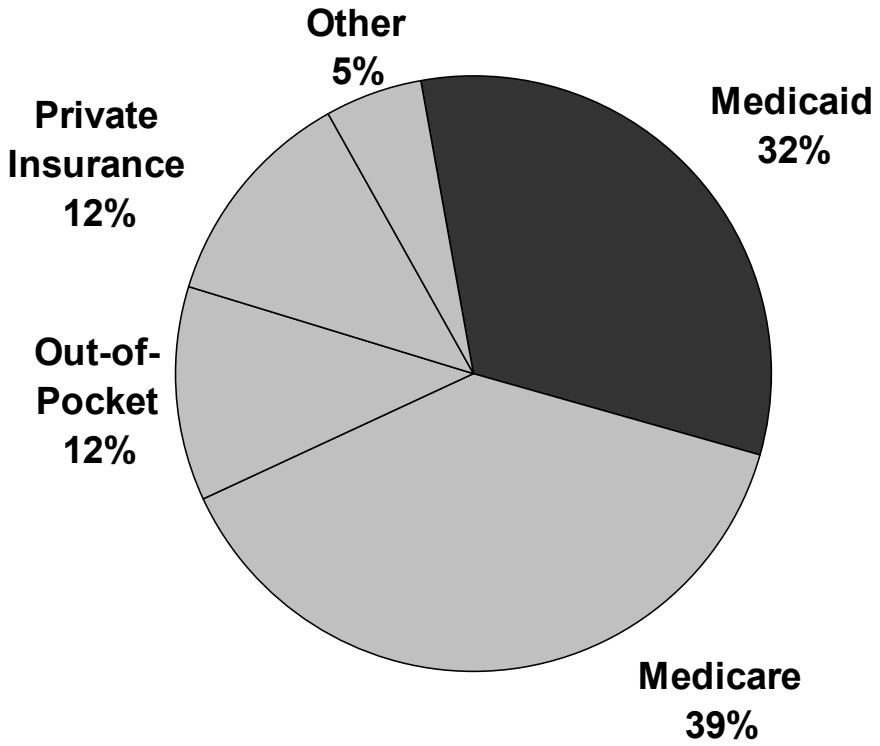
National Spending on Nursing Home and Home Health Care, 2004

Nursing Home Care



Total = $115.2 billion

Home Health Care

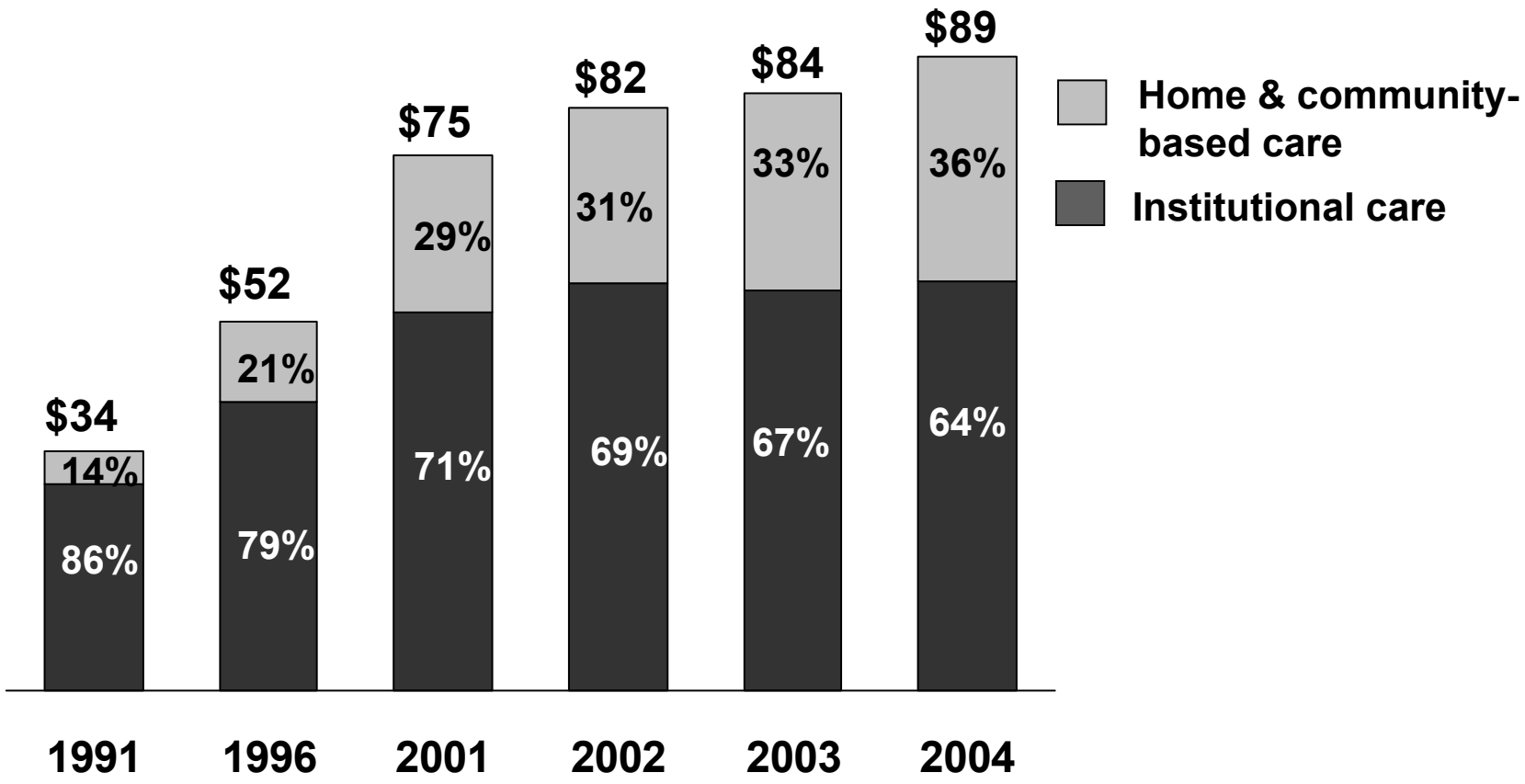


Total = $43.2 billion

Note: Medicaid percentage includes spending through SCHIP
SOURCE: CMS, National Health Accounts, 2006.

Figure 12

Growth in Medicaid Long-Term Care Expenditures, 1991-2004



Note: Home and community-based care includes home health, personal care services and home and community-based service waivers.
SOURCE: Burwell et al. 2005, CMS-64 data.

Figure 13

Why is Medicaid at the Center of State and Federal Budget Debates?

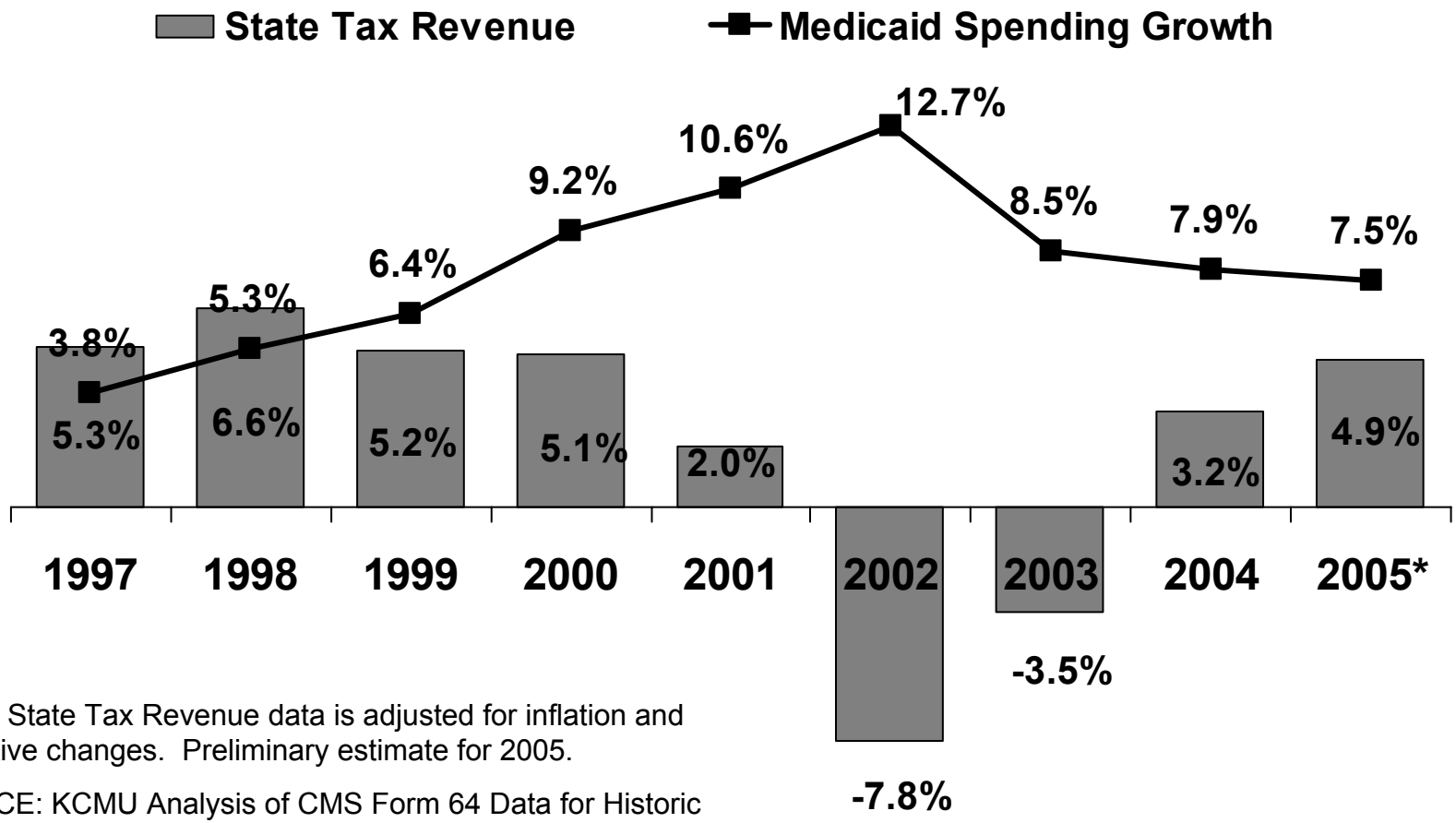
- Pressures in health care system
  - Rising health care costs
  - Rising numbers of uninsured
  - Aging population

- State fiscal pressures
  - Slow revenue growth in recovery
  - Medicaid spending increases outpacing revenue growth
  - Intense focus on Medicaid cost containment for several years
  - Response: Cost containment and Waivers

- Federal fiscal pressures
  - Growing federal deficit
  - Pressure to cut deficit and extend tax cuts
  - Interest in reducing federal spending on Medicaid
  - Response: DRA, President's FY 2007 proposals, Secretary's Medicaid Commission

Figure 14

Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2005

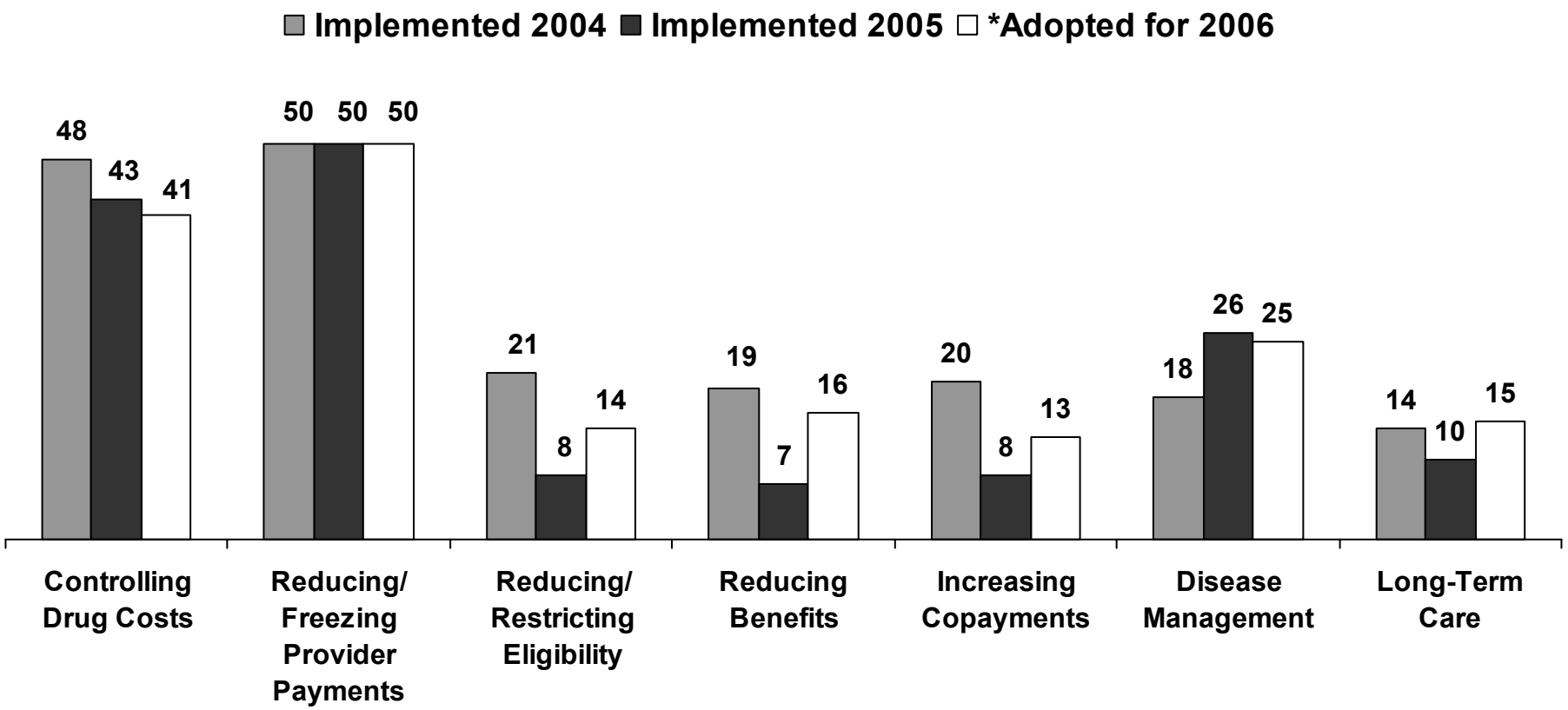


NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. Preliminary estimate for 2005.

SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU / HMA Survey for 2005 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

Figure 15

States Undertaking New Medicaid Cost Containment Strategies FY 2004 – FY 2006



NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004 and October 2005.

Figure 16

Medicaid Provisions in DRA

- **Savings Provisions in Deficit Reduction Act ($11.5B)**
  - Premiums and cost sharing ($1.9B)
  - Benefit flexibility ($1.3B)
  - Prescription drug payment reform – pricing and rebates ($3.9B)
  - Reforms to asset transfer laws ($2.4B)
  - Other changes ($2B)

- **Spending Provisions in Deficit Reduction Act ($6.8B)**
  - Katrina-related assistance to affected states ($2.1B)
  - Home and community-based services ($1.1B)
  - Family Opportunity Act ($1.5B)
  - Health Opportunity Accounts ($64M)
  - Cash and counseling ($100M)
  - TMA and abstinence education ($760M)
  - Medicaid integrity ($529M)
  - Other ($536M)

Figure 17

Emerging Trends in Medicaid

- Emphasis on personal behavior and responsibility
  - "Consumer choice" of plans
  - Increased premiums and/or cost sharing
  - Behavior modification through incentives
  - Increased beneficiary autonomy over long-term care services
- "Tailored" benefits
  - Variation in benefit packages across groups or geographic areas
- Increased role of private marketplace
  - Increased control to plans to determine benefit packages
  - Emphasis on premium assistance
  - Public/private long-term care partnerships
- Restricting spending/increasing spending predictability
  - Defined contribution approaches
  - Aggregate cap on federal funding
  - Increased ability to limit/reduce coverage
  - Tightening eligibility for long-term care

Figure 18

Future Directions and Challenges

- National coverage for low-income population
- Adequate coverage for high cost chronically ill or disabled individuals
- Countercyclical federal financing during economic downturns
- Increased Medicare responsibility for 6 million dual eligibles
- Broader-based financing for long-term care