History, Current Issues, Options: Medicaid and Medicare

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Medicaid (Medi-Cal in CA)

- Largest public insurance program for low income people
- Fills in holes –
  - 39 m children and parents, low income
  - 8 m persons with disabilities
  - 6 m low-income Medicare beneficiaries
- Financed jointly by the feds (57%) and the states, by formula based in state income

- States administer MA within broad federal guidelines – participation voluntary
  - 56 different programs
- Services purchased thru private health sector – thru FFS or managed care
- Federal waivers available – "1115 waivers"
- MA evolved – managed care, disease mgt., home and community based LTC

Medicaid: Who

1. Income requirement
2. Asset requirement
3. Must fit into a category- CA, 40+ cats

- "Mandatory" populations:
  - pregnant women & kids under 6 with incomes < 133% of poverty line, more….

- "Optional" populations:
  - Persons with disabilities
  - Seniors up to 100% of FPL
  - "Medically needy"
  - Nursing home residents with incomes up to 300% of SSI limits, more….

Medicaid: Who, Continued

- 30 m low income children and parents, 2/3 of which are in working families
- 25 m kids, 1 in 4 children. Plus SCHIP w/ 4 m additional low-income children.
- MA pays for 1/3 of all births
- Largest source of public funding for family planning
- Primary source of coverage for 8 m low income Americans with disabilities and chronic illnesses

Medicaid: Significance

- An "entitlement" program for both the states and for low income individuals
- MA enrollees:
  - Much poorer than the general population
  - Markedly worse health than the general population
  - Most enrollees' employers don't offer HI
- Many low income people don't qualify
  - 14 states: parents must be <50% of FPL
  - Adults without kids (not disabled) do not qualify
  - Immigrants – only ER for 5 years.
    - Undocumented: ER only.

Medicaid Services

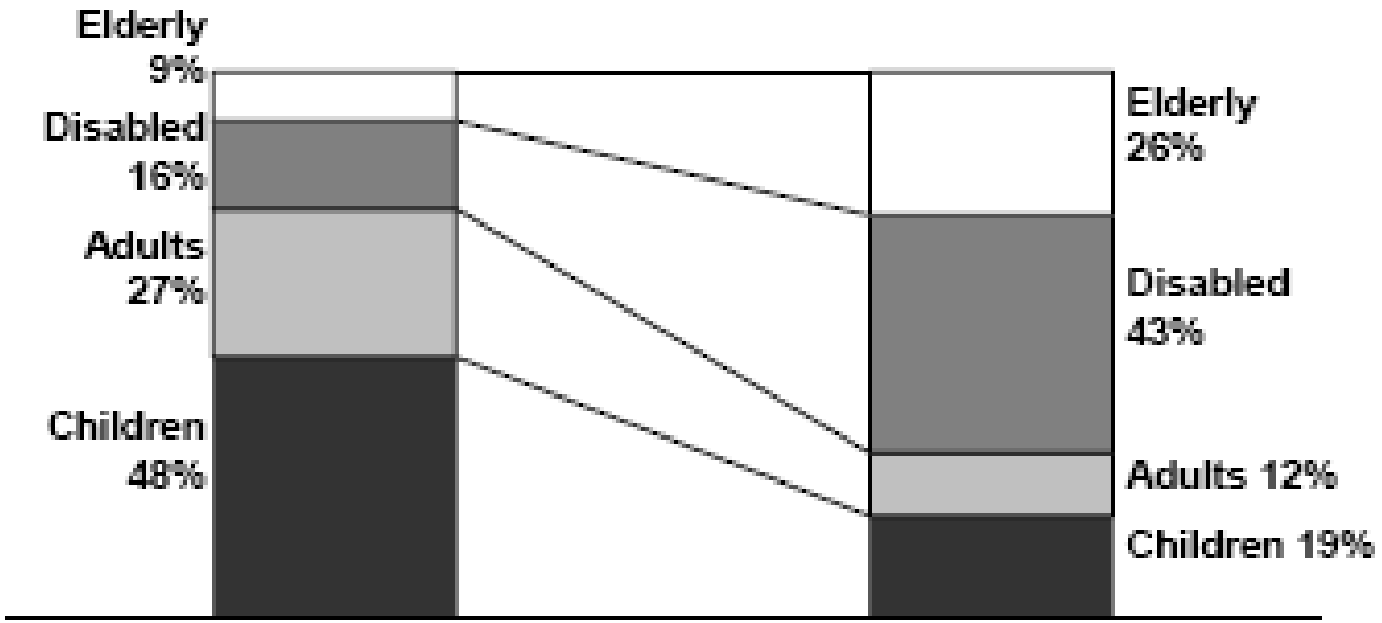
- 12 required; 30 optional (CA has 28)
- Scope of benefits varies across states
  - States can limit MD visits or drugs they cover
- MA is the major source of LTC services
  - 10 m Americans need LTC
  - MA pays 40% of the $151 b spent on LTC
- MA is the major source for mental health and substance abuse for low income people
- States can impose nominal co-payments for services

Medicaid's Costs

- $300 b in FY 2004, 90% for services.
- Relatively low cost per person, once you consider health status of MA bennies
- Spending (FY 03)
  - Children: $1,700 -Adults: $1,800
  - Disabled: $12,300 -Seniors: $12,800
- Adults and children are 75% of bennies, but cost only 31% of the total. Seniors/disabled are 25% of the beneficiaries, but use 60% of the funds

Figure 6

Medicaid Enrollees and Expenditures by Enrollment Group, 2003



Note: Total expenditures excludes DSH payments.
SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates based on CBO and OMB data, 2004.

Medicaid reform is on the agenda

- Congressional demand to cut $10 b over 5 yrs.
- Responses:
  - Secretary's Medicaid Commission
  - National Governors Association (NGA)
  - National Conference of State Legislatures (NCSL)
- Context:
  - Dramatic decline in state revenues 2001-2005
  - High MA cost growth – enrollment & health $
  - Health care costs continue to climb
  - Hurricanes Katrina and Rita

Practical reforms…

- Pay drug companies less for their drugs
  - Currently: discount off Avg Wholesale Price (AWP)
  - Alternative: Avg. Mfgs Price (AMP) or Avg. Sales Price
- Asset transfer restrictions
  - Now: $2,000 in assets allowed, excluding home, 1 car, life insurance <$1,500, and misc.
  - Community spouses have special rules
  - Proposals: change look-back period….

More Medicaid reforms….

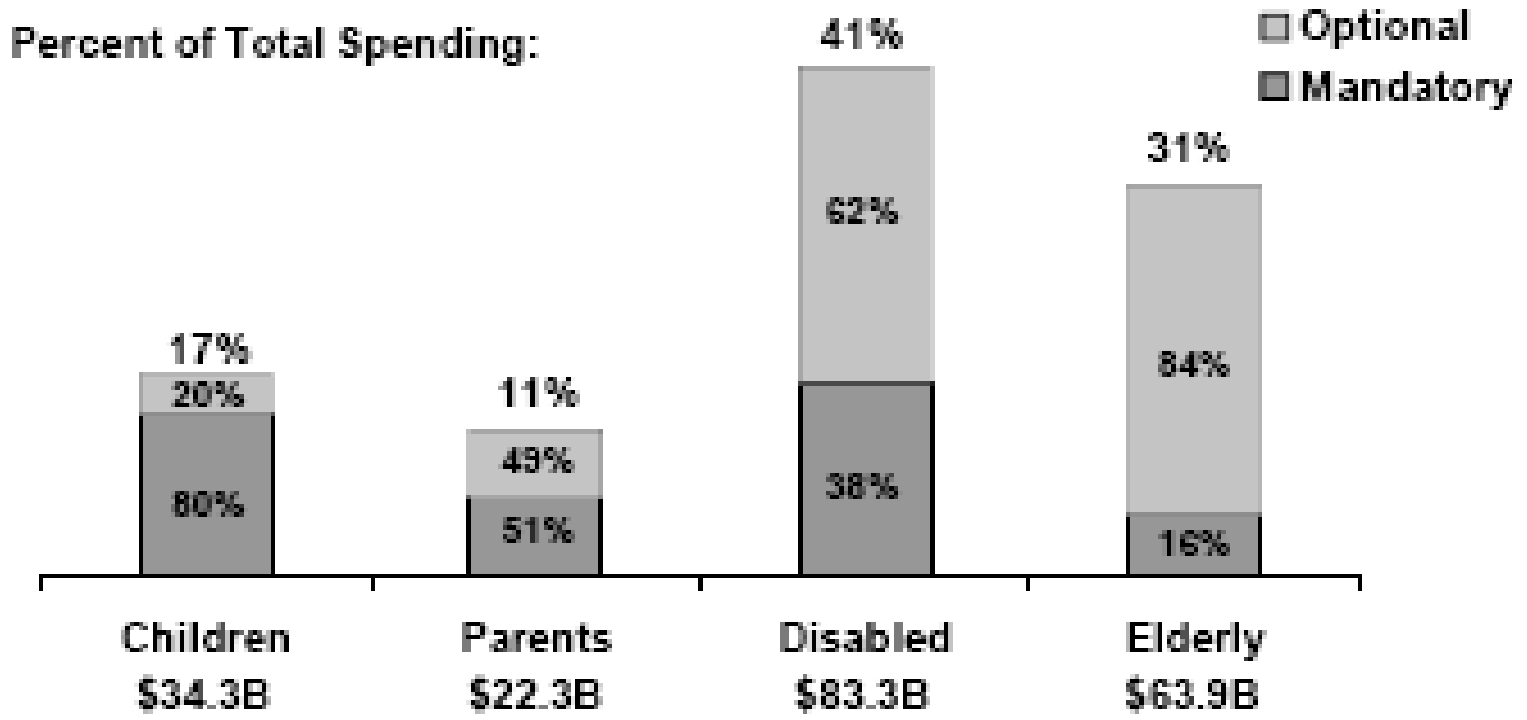
- Premiums and cost-sharing
  - Now: states can't charge premiums
  - Proposed: higher co-pays and premiums for some groups, tiered co-pays for drugs
  - Make not paying co-pays "enforceable" – no pay, no service
- Allow states to cut "optional" services
  - Optional eligibility groups: very poor seniors, disabled adults….

- **Optional services**: prescription drugs, clinic services, dental, vision, prosthetic devices, PT, TB-related services, nursing facilities (<21 years old), intermediate care facilities/individuals with mental retardation, home and community-based care, respiratory care for those who are ventilator dependent, personal care, hospice services
- Many of these are important to seniors and disabled individuals

- Proposals: vary services for diff populations
  - More limited package for some groups
  - BUT – either you cut adults/kids deeply or you cut seniors/disabled – really hard to do

Figure 8

Medicaid Expenditures by Eligibility Category and Type of Service



NOTE: Optional services for mandatory groups are counted as "optional" spending.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

KAISER COMMISSION ON
Medicaid and the Uninsured

Medicaid reform – only 5 ways

1. Curtail services
2. Buy services more cheaply or use them more efficiently
3. Private LTC insurance
4. Reduce fraud
5. Shift costs to the states
   - Change from open-ended entitlement program to block grant.
   - Governors unanimously opposed!

Medicare

- The world's 2nd largest HI program – next to Medicaid:
  - 41m seniors and disabled persons (2003)
  - Admin. cost: 2%-3% of program expenditures
- Established in 1965, along with Medicaid
- Incredible complexity….
- Politically – more difficult than SS. Why?
  - Cost growth
  - Dependence of seniors on the program

The Program

- A: Hospital Insurance (HI) – inpatient + short-term SNFs, HH, Hospice
- B: Supplementary Medical Insurance (SMI) – doctors, outpatient hospital services, HH not in A, tests, DME, ambulances
- C: Medicare Advantage – was Medicare + Choice – HMO, other options
- D: the new Drug plan

Eligibility

- A: everyone with 40 quarters of "insurance" with SS.
  - Disabled on SSDI for 2 years.
  - ESRD
- B: voluntary, but 95% of those on A are in. Costs ~$78.20 in 2005 per month
- C: voluntary, replaces A and B (11-15% of the population)
- D: voluntary

History

- 1965-enacted
- 1972-eligibility extended to SSDI recipients and ESRD persons
- 1982 – managed care plans (HMOs) could participate with risk-based option (not FFS)
- 1983 – inpatient hospital prospective payment system introduced
- 1988 – Medicare Catastrophic Coverage Act

History

- 1989 – MCCA repealed!
- 1997 – Balanced Budget Act of 1997:
  - Establishes Part C as Medicare+Choice
  - New payment systems (HH prospective pmt)
  - R&D for other approaches (PPO)
  - Expanded preventive benefits (mammograms)
- 2003 – Medicare Modernization Act

Patterns

- 24% - A, B, + Medigap plan
- 33% - A, B, employer supplemental plan
- 11% - A, B + Medicaid – (the "dual eligibles"
- 17% - MR+Choice (=HMOs, MR-HSAs)
- 12% - A, B = old Fee For Service (FFS)
- 2% - "other public" (military….)
- 100% - Total 34.6m non-institutionalized MR beneficiaries….

What's right with Medicare

- Covers millions who would not have health insurance otherwise
- Improves quality of life for them
- Popular
- Controls costs better than the private sector
- Administrative costs are low
- Supports teaching hospitals, urban/rural hospitals, isolated hospitals

What's wrong with Medicare

- Benefits limited, but a lot better than <1997
- HI trust fund will run short in ~2030
- Reforms needed to accommodate baby boom
- Some MR spending is wasted
- Costs increasing faster than economic growth
- Costs containment strategies – mixed success

Reforms

- Increased age of eligibility
- Increased cost sharing
  - Relate premiums to beneficiary income
- Increase revenues through payroll tax
- Defined contribution plan – no standard benefit package
- Premium support – w/standardized benefit package – like Federal employee plan
- Tax the value of Medicare

Expanding coverage

- Drug benefit – expand it?
- Allow those 55-64 to buy in
- Long-term care benefit