Enacted in 1965
Largest source health insurance coverage America's poorest
A means tested eligibility program.
The Federal government establishes general guidelines but program requirements are established by each State.
Eligibility standards, type, amount, and scope, payment rates, and administration
Limitations may not cause insufficient levels of care
Limitations may not cause discrimination
Medicaid Coverage

- Under the broadest provisions of the Federal statute, eligibility depends on membership in a designated groups.

- Low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels.

Mandatory “categorically needy” groups

1. Those eligible for AFDC (Aid to Families with Dependent Children)
   - Now TANF
   - Eligibility determined at the state level
   - Mainly for pregnant women and children 6 and under
2. Supplemental Security Income (SSI) recipients
3. Adopted or foster care children
4. Special protected groups
5. All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL

Covered Services

<table>
<thead>
<tr>
<th>Mandatory</th>
<th>Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inpatient Hospital Services</td>
<td>1. Prescription drugs</td>
</tr>
<tr>
<td>2. Outpatient Hospital Services</td>
<td>2. Medical or remedial care</td>
</tr>
<tr>
<td>3. Laboratory and X-Ray Services</td>
<td>3. Private duty nurse</td>
</tr>
<tr>
<td>4. Family Planning</td>
<td>4. Clinic services</td>
</tr>
<tr>
<td>5. Early &amp; Periodic Screening, Diagnosis, and Treatment (EPSDT)</td>
<td>5. Services for persons with speech, hearing, and language disorders</td>
</tr>
<tr>
<td>6. Physician Services</td>
<td>6. Physical therapy</td>
</tr>
<tr>
<td>7. Medical &amp; surgical services furnished by dentists</td>
<td>7. Dental services</td>
</tr>
<tr>
<td>8. Nurse-Midwife services</td>
<td></td>
</tr>
</tbody>
</table>
Medicaid’s Roles

Health Insurance Coverage
- 23 million children & 14 million adults in low-income families
- 6 million persons with disabilities

Assistance to Medicare Beneficiaries
- 7 million aged and disabled—18% of Medicare beneficiaries

Long-Term Care Assistance
- 1 million nursing home residents—47% of long-term care services

Support for Health Care System and Safety-net
- 17% of national health spending

State Capacity for Health Coverage
- 43.5% of federal funds to states

MEDICAID

Medicaid’s Role for Selected Populations
Percent with Medicaid Coverage:

- Poor
- Near Poor
- Families
- All Children
- Low-Income Children
- Low-Income Adults
- Births (Pregnant Women)

- Aged & Disabled
- Medicare Beneficiaries
- People with Severe Disabilities
- People Living with HIV/AIDS
- Nursing Home Residents

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

Medicaid Member Characteristics
Payment for Medicaid Services

- Medicaid operates as a vendor payment program.
  - FFS or Prepaid
    - Method of payment is state determined
- Considerations relevant to payment rates
  - Sufficient to enlist enough providers
  - Assure access to services.
  - Providers must accept payment in full

More on Medicaid Payments

- The "disproportionate share hospital" (DSH) adjustment.
- Deductibles, coinsurance, or co-payments must be kept low
  - Cost sharing arrangement are not allowed for:
    - Pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care.
    - Emergency services and family planning services.

What the Medicaid Dollar Buys

- What the Medicaid Dollar Buys
  - Physician services
  - Dental services
  - Prescribed drugs
  - WIC services
  - Home health services
  - Other practitioner services
  - PCCM services
  - Mental health services
  - Nursing facility services
  - Other care
  - Inpatient hospital services
  - Lab and X-ray services
  - Residential health services
  - Unknown
  - Other services

- What the Medicaid Dollar Buys
  - Capitated care
  - Clinic services
  - Dental services
  - Physician services
  - Personal support services
  - Sterilizations
  - Unknown

- What the Medicaid Dollar Buys
  - Home health services
  - ICF/MR services
  - Inpatient hospital services
  - Lab and X-ray services
  - Mental health facility services
  - Nursing facility services
  - Other care
  - Outpatient hospital services
  - Other practitioner services
  - PCCM services
  - Prescribed drugs

- What the Medicaid Dollar Buys
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  - Dental services
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  - PCCM services
  - Prescribed drugs
Medicaid Spending: 2000-2006, in billions

Federal Share in Medicaid
- The Federal Government's share
- The FMAP is determined based on a state's average per capita income level
- States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent.
- In 2002, the FMAPs varied from 50 percent in eleven states to 76.09 percent in Mississippi, and averaged 57 percent overall.

2008 FMAP
State Characteristics

- Total income
- Per Capita Income
- Per Capita Disposable Income
- Poverty Level (Individuals and Families)
- Percent not insured (all and children)
- Aids Cases
- Spending per recipient
Personal Income (Constant 2000 Dollars)

2006 Per Capita Income (2000 Dollars)

2006 Disposable Income Per Capita (2000 Constant Dollars)
### Total Spending Per Medicaid Child

<table>
<thead>
<tr>
<th>State</th>
<th>Total Spending Per Medicaid Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>$3,000</td>
</tr>
<tr>
<td>Maine</td>
<td>$4,000</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$5,000</td>
</tr>
<tr>
<td>DC</td>
<td>$6,000</td>
</tr>
<tr>
<td>New York</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

### Total Spending Per Medicaid Non-Elderly Adult

<table>
<thead>
<tr>
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<th>Total Spending Per Medicaid Non-Elderly Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>$3,000</td>
</tr>
<tr>
<td>Connecticut</td>
<td>$4,000</td>
</tr>
<tr>
<td>North Dakota</td>
<td>$5,000</td>
</tr>
<tr>
<td>New York</td>
<td>$6,000</td>
</tr>
<tr>
<td>Ohio</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

### Total Spending Per Medicaid Elderly Adult

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</table>
Florida’s Medicaid Burden

State Children’s Health Insurance Program (SCHIP)
The Balanced Budget Act of 1997 establishes the State Children’s Health Insurance Program (SCHIP).

Similar to Medicaid, adding many important consumer protections while putting other protections at risk.

Grants to cover uninsured children up to 200% FPL.

State Options
- Expanding Medicaid
- Expanding or creating a separate SCHIP program

Eligibility is determined at the state level.

The extent of the program depends in part on availability of federal funds which are capped.

Who is eligible?
- not eligible for Medicaid
- under age 19; and
- at or below 200% of the federal poverty level (FPL).
SCHIP - Program Structure

- State discretion
- Implementation
  - expand Medicaid;
  - create or expand a state program; or
  - a combination of both
- States can also spend up to 10% of the funds to provide coverage through a community-based health delivery system or by purchasing family coverage.
- Cost-sharing
  - Premiums, deductibles, copays, fees

SCHIP - Cost Sharing for Families

States can impose the following:

- Premiums: $15-19 per family per month
- Deductibles: $2 per family per month
- Co-insurance: 5% of non-institutional costs
- Co-payments: range from $.50 to $3.00 per service
- Institutional care: 50% of the first day’s costs.
- For children above 150%, states can impose premiums, deductibles or other cost-sharing on a sliding scale not to exceed 5% of the family’s income.

SCHIP - State matching Requirements

- Federal matching funds must be preceded by state expenditures
- Enhanced FMAP
  - 30% higher than the state’s regular FMAP
  - Maximum federal match is 85%.
- For example: if a state’s FMAP is 50% the federal government will match funds under the SCHIP program at 65% [(.30 x 50%) = 15% and 50% + 15% = 65%].
• At Federal level: Expenses offered through
  – Department of defense
  – Veteran Affairs
  – National Institute of Health
• Non-Federal:
  – Public Health activities expenses by state and local governments
  – Workers’ compensation program
  – School Health Clinics (subsidized / fully funded)
  – Health Services for Migrant Workers
Two main sources of private health care expenditures

1. Individuals receiving treatments
2. Private insurer payments

In 1965, prior to the advent of Medicare and Medicaid, private expenditure accounted for 76.9% of all personal health care expenditures; in 1935, 82.4%; in 1929, 88.4%

Current share of private expenditures: 55%
Definitions of Methods of Payment

1. Fee-For-Service Reimbursement
   • The unit of payment is the visit or procedure, and the provider is paid for each individual component

2. Episode of illness (or care)
   • One payment for all services during episode

3. Per Diem Payments to Hospitals
   • A flat fee for all services during 1 day

4. Capitation Payments
   • A per time period per member
   • PMPM (per member per month)

5. Payments for all services delivered to all patients

Managed Care Plans and Reimbursements

- Managed care plans tend to change payment methods to control costs
- There are three major forms of managed care organizations
  1. Fee-for-service practice with utilization review
  2. Preferred provider organization (PPOs)
  3. Health maintenance organizations (HMOs)

Reimbursement Mechanisms Managed Care

1. FFS with utilization review
   • Traditional type of reimbursement but 3rd party payer assumes the power to authorize or deny payment

2. Preferred provider organization (PPOs)
   • Loose-knit organizations between insurers and providers who agree to a discounted FFS with utilization review

3. Health maintenance organizations (HMOs)
   • Members are required (except in emergencies) to receive their care from providers within that HMO.
**World Snapshot: Healthcare Spending**

- There were more than 6 billion people in 2002 across 200 countries.
- Healthcare expenditure for 6 billion people totaled $3.5 trillion (WHO).
- The 285 million people in the U.S. represented 5% of the worldwide total population, but U.S. healthcare expenditure, $1.5 trillion, accounted for more than 40% of total spending.
- China, with 1.3 trillion population, accounted for less than 0.3 trillion in health care spending.
- Health expenditure per person in the U.S. were 10 times the worldwide average in 2002.

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**Comparison of Health Expenditure Across Nations: 2002**

![Diagram showing distribution of private vs. public expenses across countries, with data for World, U.K., Canada, Japan, Germany, and U.S.]


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**Comparison of Health Expenditure Across Nations: 2002**

![Diagram showing out of pocket expenses across countries, with data for World, U.K., Canada, Japan, Germany, and U.S.]

Comparison of Health Expenditure Across Nations: 2002


German System

- Mandatory contributions by employers and employees to non-profit (private) regulated "sickness funds."
- Strict separation of ambulatory care physicians and hospital based-physicians.
- Ambulatory care physicians operate with a global budget based on a detailed fee schedule
- Coverage
  - 90% of the population belong to the mandatory sickness fund system
  - 8% opt for private insurance
  - 2% receive medical care as members of the armed forces or police
  - Less than 0.2% (all wealthy) have no coverage

German Organization

- Sickness Fund 1-700+
- Regulated Rates to Hospitals
- Global Budget for Physicians
- Regionally organized
- Efforts to Determine Delivery and Reimbursement
Canadian System
- Tax-financed, public, single-payer
- Universal coverage
- Primary care focus
  - Canadians have free choice of physicians
- Physician reimbursement is FFS
  - Fee levels negotiated between provincial governments and provincial medical associations
- Canadian hospital reimbursement is based on annually negotiated global budgets

Canadian Reimbursement
- General Tax
- Provincial (or territory) Health Plans
  - Global Budgets for Hospitals
  - FFS for Primary and Specialist Physicians

U.K. (British) System
- 82% of funding comes from taxes
- 13% employer-employee contribution
- 4% from user charges
- Separation of health insurance from employment
- Reimbursement
  - Capitation for British GPs
  - Some fee-for-service for certain preventive services and home visits during nights and weekends.
  - Salaries for consultants (specialists)
  - FFS for some in case of privately insured patients
**U.K. Reimbursement**

- General Tax
- National Health Service
- Global Budgets for Hospitals
- Capitation for General Practitioners
- Salaried / Employee Specialists

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**Conclusions**

- The U.S. spends comparatively more on health care:
  - In total
  - On a per capita basis
- A balancing act:
  - Avoid both “over-treatment” and “under-treatment”
- Evolution from FFS (set by providers) to negotiated fee schedules
- Other systems also use managed care principles such as capitation