

# Medicaid

## **What is Medicaid?**

Medicaid is joint federal-state program of health and long-term care coverage for people with low incomes or very high medical bills. The federal government provides matching funds for state funds at percentages tied to each state's per capita income. For Washington the federal match rate is a little over 50 percent.

Eligibility for Medicaid depends on age, disability or family status *and* on an individual's (or family's) income and assets. The federal government establishes minimum eligibility standards and services that must be covered, along with rules to which states must adhere, and then each state develops its specific program within these federal parameters. Nationally, it was estimated in 2001 that optional populations and benefits accounted for 60 percent of Medicaid expenditures. States often also seek and receive federal waivers to allow them to provide and cover groups of individuals that would otherwise be excluded from Medicaid.

*Note: The federal government has strict citizenship requirements, and will only provide Medicaid payment for U.S. citizens or legal immigrants. Some states, including Washington, have chosen to cover illegal immigrants under programs similar to Medical Assistance using state-only money.*

Medicaid is really three programs in one:

- ◆ A health insurance program for low-income parents (mostly mothers) and children— Nationally, more than one-third of all births are covered by Medicaid.
- ◆ A long-term care program for the elderly. Nearly 60 percent of nursing home residents are Medicaid beneficiaries
- ◆ A funding source for services to people with disabilities, paying for about one-third of the nation's bill for this population.

To qualify for Medicaid, an individual must meet financial criteria and belong to a "category" that is eligible for the program, mainly children, parents of dependent children, pregnant women, people with disabilities and the elderly.

In addition to paying for more medical and long-term care, Medicaid also pays for a significant amount of mental health and chemical dependency services for eligible populations, as well as for some Special Education services for children in public schools.

For more specific Medicaid (and other Medical Assistance programs) Eligibility information, see DSHS's Medical Assistance Eligibility Overview at: [www.dshs.wa.gov/pdf/Publications/22-315.pdf](http://www.dshs.wa.gov/pdf/Publications/22-315.pdf).

## **Is Medicaid different from Medicare?**

**Yes. Medicare** is a **federal** health insurance program for which almost anyone age 65 and older qualifies, along with certain people on Social Security disability and some people with permanent kidney failure. Medicare eligibility depends on age or disability only (*not* income or assets). Some individuals qualify for both Medicaid and Medicare. They are referred to as **dual-eligibles**. (*See Medicare 101 for more information on Medicare*).

## **If an individual is not eligible for Medicaid, are there other public programs for which they may qualify?**

**Yes.** In addition to Medicaid, there are several public programs that provide health coverage through DSHS's Medical Assistance Division. Individuals who do not qualify for Medicaid due to citizenship status or income may qualify for other programs that are often funded by state-only dollars. *Information on these programs is available in "DSHS's Medical Assistance Eligibility Overview" at: [www.dshs.wa.gov/pdf/Publications/22-315.pdf](http://www.dshs.wa.gov/pdf/Publications/22-315.pdf)*

The Basic Health Plan also provides health care coverage for individuals under 200% FPL who are not eligible for Medicaid. *See the Basic Health Plan Issue 101.*

## **Medicaid and the Budget**

Medicaid plays a major role in the nation's health care system, funding an estimated \$320 billion in services in 2006, including nearly half the cost of nursing home care.

Medicaid is one of the major drivers of state budget growth. It is difficult to obtain a total for Medicaid expenditures in our state because they are distributed across DSHS programs, including Medical Assistance, Mental Health, Aging and Adult Services, and Economic Services.

Although the Medical Assistance program includes more than Medicaid, its budget and caseload growth are good indicators of the growth in the state Medicaid spending. In fiscal year 2009 Medical Assistance will account for a budgeted \$2.1 billion in Near General Fund spending, with an average monthly caseload of 947,424. In fiscal year 2000 Near General Fund expenditures for Medical Assistance were about \$1.0 billion, with an average caseload of 746,748. This is a spending increase of *106 percent* over this period. By comparison, total Near General Fund spending increased by about 59 percent over that same time.

**\*\*See Long Term Care 101 for additional information on Medicaid spending on long-term care.\*\***

## **Current Issues**

**Access to Physicians** - Many people think that the answer to increasing access to health care is enrolling more people in government sponsored health care, such as Medicaid; however, many physicians (primary and specialists) have stopped or limit the number of Medicaid, SCHIP and/or Medicare patients they will see because reimbursement rates don't cover their costs. For example, during the 2007 rural health care tour it was noted that only 12 percent of physicians in the Vancouver area will see fee-for-service Medicaid children (i.e. non-managed care).

**Cost Shifting** - There is a perception that privately insured individuals are subsidizing the uninsured through higher premiums. While this may happen to some extent, two recent studies found that the privately insured are heavily subsidizing the cost of care of individuals enrolled in public health care programs, such as Medicaid.

- Findings from a 2007 study published by Stanford University, “Cost shifting in California Hospitals: What is the effect on private payers?:
  - If revenues for every California hospital's Medicare and MediCal patients would have been sufficient to cover these patients' costs, then private patients' revenue-to-cost ratio would have declined by 10.8 percent; however, if revenues for every California hospital's indigent patients would have been sufficient to cover these patients' costs, then private-payer patients' revenue-to-cost ratio would have declined by only 1.4 percent.
- Findings of a 2006 study conducted by Milliman, Inc. at the request of Premera Blue Cross, “Payment Level Comparison Between Public Programs and Commercial Health Plans for Washington State Hospitals and Physicians”:
  - In order for Medicaid and Medicare to cover their share of expenses of care in hospitals, they would have to increase their rates by 18.5 percent and 18.2 percent respectively, and private insurers expenses would be decreased by 14.3 percent. The cost shift is estimated to amount to 4.8 percent of private insurance premiums, which would equate to \$490/yr. on an \$850/month family plan premium.