CHAPTER 1

Context and Overview of Medicaid and CHIP

Section 1900(b)(1)(D) of the Social Security Act - [MACPAC shall] submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

Chapter Summary

Medicaid and the State Children's Health Insurance Program (CHIP) are sources of health coverage for 76 million people, almost one quarter of the population. Those served by these programs include one-third of all children, many low-wage workers and their families, persons who have physical and mental disabilities, and seniors with Medicare. Medicaid has evolved from welfare-based coverage to a central component of our health care system while CHIP provides coverage to children in low-income, mostly working families. Together, these joint federal-state programs account for 15 percent of total U.S. health care spending.

Medicaid's role in our health care delivery system is unique: the program covers the diverse health needs of enrollees; directly supports safety-net providers; complements Medicare for low-income beneficiaries; and reduces the burden of uncompensated care. Incremental additions and changes have been layered on top of Medicaid's original foundation, expanding the scope of whom the program serves, what it provides, and how much it costs. Today, Medicaid is a source of coverage for millions of low-income Americans.

CHIP is structured differently from Medicaid and at the time of its creation it was uncertain whether states would respond to the new federal funding opportunity to extend health care coverage to more uninsured children. Within three years of enactment, though, all states and territories had children enrolled in CHIP-financed coverage.

Federal and state Medicaid officials are responsible for administering Medicaid and CHIP, including providing enrollees appropriate access to care, maintaining coverage of people and benefits during economic downturns, ensuring adequate provider participation, coordinating care with Medicare for low-income seniors and persons with disabilities, and containing costs while meeting diverse, complex and costly health care needs. At the same time, program managers must maintain program integrity and fiscal accountability.

In recognition of the programs' significance as sources of health coverage and long-term care assistance for low-income populations, and the complex needs of many Medicaid and CHIP beneficiaries, the Congress established the Medicaid and CHIP Payment and Access Commission (MACPAC) as a nonpartisan advisor to provide technical and analytical assistance and to be a source of current, reliable information to guide policies related to these programs. In our first report to the Congress, the Commission provides baseline information about Medicaid and CHIP, including key policy and data questions that need to be addressed. We also establish an analytic framework that serves as the foundation for our future work.

This chapter briefly describes Medicaid and CHIP, the history of health care coverage and these programs, and situates them in the context of the U.S. health care system.

CHAPTER 1

Context and Overview of Medicaid and CHIP

Medicaid and the State Children's Health Insurance Program (CHIP) are joint federal-state programs that provide health care coverage to millions of Americans—more than one-third of all children and 16 percent of Medicare beneficiaries, among many others (Table 1-1, MedPAC 2010a). As major payers in our health care system, they account for over 15 percent of total U.S. health care spending (Figure 1-1).

Medicaid and CHIP provide coverage for medical and medically related services for the most economically disadvantaged populations: low-income children and their families, low-income seniors, and low-income persons with disabilities. These populations are unique in terms of the breadth and intensity of their health needs, the impact of poverty and unemployment on their ability to obtain health care services, and the degree to which they require assistance in paying for care.

Medicaid's Unique Role

Medicaid was enacted as part of the same legislation that created Medicare—the Social Security Amendments of 1965 (P.L. 89-97). Like Medicare and employer-sponsored insurance (ESI), Medicaid is a major source of coverage for health care. Medicaid accounts for 15 percent of U.S. health spending while Medicare and private insurance (including ESI) account for 20 percent and 32 percent, respectively (Figure 1-1).

Medicaid provides coverage for a range of medical services and supports that goes beyond the benefits provided under Medicare or ESI. Medicaid benefits include acute care services that are typical of Medicare and ESI; however, Medicaid benefits also include services not covered by Medicare or ESI such as long-term services and supports, rehabilitative services and therapies, assistive technology (e.g., communication

BOX 1-1. Key Medicaid and CHIP Facts

People

Medicaid provided health care coverage for 68 million low-income people during FY 2010 including (OACT 2011a):

- 33 million children;
- 11 million persons with disabilities;
- 17 million non-disabled adults (e.g., pregnant women, parents of Medicaid enrolled children);
- 6 million seniors; and
- 1 million people in the U.S. territories.

CHIP covered 8 million children in FY 2010 (Table 3 in MACStats).

90 percent of CHIP children have family incomes below 200 percent of the federal poverty level ($37,060 for a family of 3) (Table 4 in MACStats).

Expenditures

Medicaid federal and state expenditures were over $400 billion in FY 2010 (Table 6 in MACStats) and account for:

- 8.1 percent of total federal outlays (OMB 2011);
- 33 percent of all nursing home expenditures (Figure 1-2);
- 36 percent of all home health care expenditures (Figure 1-2); and
- 25 percent of all mental health and substance abuse treatment spending (Mark et al. 2007).

CHIP federal and state expenditures in FY 2010 were $11 billion (Table 8 in MACStats).

devices), and non-emergency transportation services. Medicaid also pays for Medicare premiums and cost sharing for over 9 million seniors and persons with disabilities who are eligible for both Medicare and Medicaid (Table 2 in MACStats). Medicaid serves many people who have high levels of need for services and high health care costs, including the frail elderly, young persons with physical disabilities, and developmentally or intellectually challenged persons residing in long-term care facilities or living in the community. Many of the people who rely on Medicaid to pay for health care services are unable to work at all or are low-wage workers who are not offered ESI or cannot afford ESI. The gap in the availability of insurance coverage for low-income families would be larger if Medicaid were not present. In addition, many Medicaid enrollees would be uninsurable in the individual private health insurance market.

Medicaid is an important payer of care delivered by providers such as hospitals and nursing homes. Along with CHIP, the program accounted for approximately 18 percent of total hospital expenditures and 33 percent of total nursing home expenditures in 2009 (Figure 1-2). In addition, Medicaid directly supports safety net providers such as hospitals receiving disproportionate share payments,[1] community health centers, school-based

[1] Disproportionate share hospital (DSH) adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients; eligible hospitals are referred to as DSH hospitals.

health centers, and mental health clinics. These are the providers who consistently see and treat uninsured patients as well as Medicaid enrollees. Medicaid is a substantial payer for these providers.

For low-income Medicare beneficiaries Medicaid's benefit package "wraps around" Medicare coverage, filling in benefit limitations and gaps (e.g., long-term nursing home care) and paying premiums and cost-sharing. Medicaid also covers people who might otherwise be uninsured, thus reducing the burden of uncompensated care. Although Medicaid was designed to play a supporting role for Medicare from the beginning, its importance to federal and state efforts to address social and economic challenges has evolved as the program has changed over time.

Medicaid has faced a variety of issues since its inception. Just as for Medicare and ESI, ensuring program efficiency and quality of services is a perennial issue for Medicaid. Federal and state Medicaid officials are responsible for providing enrollees appropriate access to care, maintaining coverage of people and benefits during economic downturns, ensuring adequate provider participation, coordinating care with Medicare for low-income seniors and persons with disabilities, and containing costs while meeting diverse, complex and costly health care needs. At the same time, program managers must maintain program integrity as well as fiscal accountability for federal and state tax dollars.

Brief History of Medicaid, CHIP, and Other Health Coverage

Early Employer-Sponsored Insurance

The modern approach to health care coverage came about in the 1920s as health care became more sophisticated and expensive. The first Blue Cross plan began in 1929 in Texas when the Baylor University Hospital agreed to provide 1,500 school teachers with up to 21 days of hospital care a year for $6.00 per person. The first Blue Shield plan designed for coverage of physician services began in 1939. The success of "the Blues" persuaded commercial insurers to enter the field and private insurers accelerated these efforts in the 1940s when businesses, seeking ways to bypass wartime wage controls, began to compete for labor by offering health insurance (Starr 1982). About 12 million people were covered by private health insurance in 1940—less than 10 percent of the population. In 1950, 75 million people, about 49 percent of the population, were covered by private health insurance (Fronstin 1998). Today over 194 million people, about 64 percent of the population, are covered by private health insurance (Table 1-1).

Public Funds for Health Care

Around the time the Blue Cross and Blue Shield programs started, health care services for indigent persons were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and community hospitals. Federal financial assistance to states for

the costs of these services was provided through grant programs. The Social Security Act of 1935 included Title V, now the Maternal and Child Health (MCH) Block Grant, which was designed to support state efforts to extend health and welfare services for mothers and children, in particular children with special health care needs. This resulted in the establishment of state departments of health or public welfare in some states, and facilitated the efforts of existing agencies in others.

The Social Security Amendments of 1950 provided federal matching funds for state payments to medical providers on behalf of individuals receiving public assistance payments (i.e., welfare). In 1960, the Kerr-Mills Act created a new program, Medical Assistance for the Aged. This means-tested grant program provided federal funds to states that chose to provide health care services to seniors with incomes above levels needed to qualify for public assistance but nonetheless in need of assistance for medical expenses. These individuals were referred to as the "medically needy aged."

In 1965 the Congress legislated a combination of approaches to improve access to health care for seniors and other populations. The Social Security Amendments of 1965 created a national hospital insurance program to cover nearly all of the elderly (Medicare Part A), a national voluntary supplementary medical insurance program (Medicare Part B), and an expansion of the Kerr-Mills federal grant program to help elderly individuals with out-of-pocket expenses, such as premiums, copayments, deductibles, and costs for uncovered services. At the same time, the Congress decided to extend the Kerr-Mills program to cover additional populations including families with children, the blind, and the disabled. This new program, called Medicaid, retained the Kerr-Mills structure of a federal and state partnership for administration and funding for health care services for the indigent. Thus Medicaid became the partner legislation to Medicare.

Medicaid's Evolution and the Introduction of CHIP

Since its inception in 1965, the Medicaid program has evolved substantially from welfare-based coverage to a major payer in our health care system. The federal government has made significant changes in eligibility criteria, covered services, and financing of the program over the years. In addition, states have made a variety of changes to their programs, such as covering optional populations and incorporating home and community-based services in their systems of long-term services and supports. One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery model. States have explored various managed care approaches over the years, pursuing such arrangements mostly for children and non-disabled adults. Today almost 50 percent of Medicaid enrollees are enrolled in risk-based arrangements (Box 2-2).

Many of the changes to the Medicaid program have been in response to the growing number of low-income individuals in need of medical assistance, the need to improve access to care, and the need to contain the rising costs of providing medical assistance. Some changes have been made to enhance state flexibility for program administration, such as the establishment of managed care program waivers. Other changes, like the disproportionate share hospital

(DSH) spending controls and the addition of the prescription drug rebate program, were implemented by the Congress for fiscal integrity reasons: to limit what funds states can use to draw their federal share so an appropriate federal and state financial partnership is maintained and to help lower total Medicaid spending on prescription drugs, respectively. CHIP was enacted in 1997 in response to the then 10 million uninsured children (Martinez and Cohen 2010). Many of these children resided in families who could not afford to purchase employer-sponsored or private insurance coverage, and had incomes too high to qualify for Medicaid. CHIP has undergone several changes since its inception, particularly with respect to coverage for adults and financing.

Box 1-2 highlights selected federal legislative milestones of the Medicaid and CHIP programs since their enactment. Subsequent chapters in this Report discuss some of these changes in more detail.

Program Basics

Medicaid

Medicaid is inherently a complex program. Like Medicare, Medicaid is an entitlement program. Eligible individuals have federal rights, protected by federal courts, to payment for medically necessary health care services defined in statute and the federal government is obligated to funding a share of the outlays for those services. Medicaid is a means-tested program and federally financed with general revenues; there is no federal trust fund or dedicated tax revenues to finance federal Medicaid expenditures. Medicaid spending is driven by enrollment growth, inflation, and policy changes. Generally, it is more variable from year to year than Medicare (Holahan 2009). A key factor driving federal Medicaid expenditures is state coverage and payment decisions. Typically, the federal share of total Medicaid expenditures nationally is 57 percent and the state share is 43 percent.[2]

Medicaid is a program where variability is the rule rather than the exception. As a federal-state program, states establish their own Medicaid eligibility standards, benefits packages, payment rates, and administration policies under broad federal guidelines, effectively establishing 56 different Medicaid programs—one for each state, territory, and the District of Columbia.

Although there is a basic core of Medicaid coverage, populations and benefits included in one state may not be covered or have limited coverage in others. Provider payment methods, standards, and rates vary from state to state as well. Individual state use of managed care, home and community-based services, and other options also vary. This variability is driven by the program's inherent flexibility with state options regarding whom is covered, what is covered, and how services are paid. Medicaid has never been a "one size fits all" program. Another driver of program variability is federal matching fund rates for states. States receive federal matching funds for at least half of their Medicaid spending; most states, however, receive more. Federal matching rates, called federal medical assistance percentages (FMAPs), range from

[2] In response to the recent recession, the Congress provided states with a temporary increase in Medicaid federal medical assistance percentages (FMAPs) that has increased the federal share of total Medicaid expenditures. The increase will end in June 2011, at which point the federal and state shares of expenditures nationally are anticipated to return to 57 percent and 43 percent, respectively.

BOX 1-2. Selected Federal Legislative Milestones

1965	The Medicaid program is established to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind and individuals with disabilities.
1967	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for all Medicaid children under 21 is established.
1971	States are allowed to cover services in intermediate care facilities (ICFs) and in facilities for the mentally retarded (ICFs/MR).
1972	States are allowed to link Medicaid eligibility for elderly, blind and disabled residents to eligibility for cash assistance under the newly enacted federal Supplemental Security Income program (SSI) or keep Medicaid eligibility criteria separate.
1981	Medicaid freedom of choice waivers (1915(b)) and home and community-based care waivers (1915(c)) are established; states are required to provide additional payments to hospitals treating a disproportionate share of low-income patients (DSH) but allowed to set their own payments for hospitals separate from Medicare.
1988	Medicaid coverage for pregnant women and infants (up to age one) to 100 percent of the federal poverty level (FPL) is mandated; special eligibility rules are established for institutionalized persons whose spouse remains in the community to prevent "spousal impoverishment;" Qualified Medicare Beneficiary (QMB) group is established.
1990	Phased-in Medicaid coverage of children ages 6 –18 in families with incomes up to 100 percent of FPL is mandated with states required to cover a new age cohort each year until 18 year olds are covered in 2002. Prescription Drug Rebate Program is established; Specified Low-Income Medicare Beneficiary (SLMB) eligibility group is established.
1991	Disproportionate Share Hospital (DSH) spending controls are established in Medicaid; provider donations are banned and provider taxes are capped.
1996	Medicaid's link to welfare benefits is severed; enrollment/termination of Medicaid is no longer automatic with receipt/loss of welfare cash assistance.
1997	State Children's Health Insurance Program (CHIP) is created; new managed care options and requirements for states are established.
1999	States are permitted to provide Medicaid coverage to working disabled individuals with incomes above 250 percent FPL and impose income-related premiums on such individuals.
2000	Health Insurance Flexibility and Accountability (HIFA) waivers are established to increase health insurance coverage for non-traditional groups of Medicaid beneficiaries via premium assistance.
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BOX 1-2, Continued

2005	States are permitted to use "benchmark" coverage in lieu of Medicaid benefits package for adult enrollees and to increase copayments for non-emergency services; increased penalties are imposed for assets transferred at less than fair market value to qualify for nursing home care; prescription drug payment policies are changed. CHIP coverage for childless adults is eliminated effective in 2009.
2009	CHIP is reauthorized through FY 2013; coverage for parents is phased out by 2014; MACPAC is established.
2010	Beginning in 2014, Medicaid eligibility is expanded to include all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133 percent FPL based on modified adjusted gross income; increase in primary care services payments rates to 100 percent of the Medicare payment rates for 2013 and 2014.

50 to 75 percent in FY 2011; states are currently receiving a temporary increase through June 2011 (Table 14 in MACStats).

Medicaid's complexity has increased over the years with the addition of new eligibility groups, benefits, and payment policies as federal and state governments balance social, economic, and political considerations affecting public assistance. Growing numbers of people without health insurance, public health crises, natural disasters, and economic downturns have all led to temporary or permanent changes to Medicaid. Incremental additions and changes to the program have been layered on top of Medicaid's original foundation, expanding the scope of whom the program serves, what it provides, and how much it costs. As a result, Medicaid is a very large program in terms of enrollment, expenditures, and as a share of federal and state budgets.

State Children's Health Insurance Program (CHIP[3])

Like Medicaid, CHIP is a federal and state partnership in which states opt to participate in order to receive federal funds for health care coverage. Unlike Medicaid, CHIP is not an entitlement. Compared to Medicaid, which is a $406 billion program that covers 68 million people, including 33 million children, CHIP is an $11 billion program that covers approximately 8 million children (Box 1-1). Together, the programs provide health care insurance to over one-third of all children. Because of its size and interactions with Medicaid in many states, it is often difficult to separate CHIP statistics from Medicaid.

Enacted in 1997, CHIP is designed to provide health insurance coverage for children in families who have too much income to qualify for Medicaid. Federal funding for CHIP is divided

[3] Initially referred to as SCHIP, the acronym was changed to CHIP when the program was reauthorized in 2009.

among the states in the form of capped federal allotments which are provided to the states on a matching basis. The federal CHIP match is an enhanced FMAP and like Medicaid, the federal CHIP matching rate varies by state, with states being responsible for 30 percent of national CHIP expenditures, and the federal government financing the remaining 70 percent. CHIP is currently federally funded through FY 2015.

States have three options for designing their CHIP programs: (1) expand their existing Medicaid program, (2) create a separate child health insurance program, or (3) use a combination of the two approaches. In separate CHIP programs, benefits, premiums, and cost-sharing requirements differ from Medicaid; however, states choosing to use the Medicaid expansion approach for CHIP must provide full Medicaid benefits and adhere to Medicaid cost-sharing rules. Most states began by expanding their existing Medicaid programs but over time more states have elected to design separate programs that operate in combination with the Medicaid program.

The CHIP program allows states to experiment with providing health insurance coverage that more closely resembles what might be available in the commercial health insurance market. This flexibility was eventually applied to Medicaid as well, with the allowance of benchmark benefit packages (as discussed in Chapter 2).[4]

Picture of Coverage Today

According to the most recent survey estimates of the non-institutionalized population (e.g., excluding individuals in nursing homes) 34.4 percent of children were enrolled in Medicaid or CHIP and 8.8 percent were uninsured; among adults aged 19-64, 8.5 percent were enrolled in Medicaid or CHIP and 22.4 percent were uninsured. (See Table 1-1.)

Nearly all seniors—94.4 percent of those age 65 and older—have Medicare; only 1 percent are uninsured (Table 1-1). The standard Medicare benefits package is not as extensive as Medicaid's and its cost-sharing requirements are greater than most other health insurance (Peterson 2009). For example, the Medicare deductible for a hospitalization in 2011 is more than $1,100. Sixteen percent of all Medicare beneficiaries, including those in nursing facilities and other institutions, are "dual eligibles." These people are eligible and enrolled in both Medicare, which is their primary source of coverage, and Medicaid. Medicaid pays Medicare premiums, deductibles and cost-sharing for dual eligibles and covers long-term services and supports, as well as other services not covered or limited by Medicare. While most dual eligible are seniors, 41 percent are persons with disabilities under age 65 (MedPAC 2010b).

[4] As first authorized by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), states may amend their Medicaid state plans to provide benefit packages other than the minimum standard benefits identified in the definition of "medical assistance" in 1905(a). These benchmark benefit packages or benchmark-equivalent packages are allowed for certain populations. The benchmark benefit packages for states to choose from are the Blue Cross and Blue Shield standard option available to federal employees, a plan available to state employees, and coverage offered by the HMO plan in the state with the largest commercial, non-Medicaid enrollment. In addition, states may design their own benefit package and obtain approval from the Secretary of the U.S. Department of Health and Human Services (HHS), if the Secretary determines the coverage is appropriate for the population.

TABLE 1-1. Sources of Health Insurance by Age, 2010

	Total (millions)	Private	Medicaid/ CHIP	Medicare	Uninsured	
					Percent	Millions
All ages	303.4	60.8%	15.1%	14.0%	16.2%	49.1
0-18	78.8	54.4%	34.4%	0.2%	8.8%	7.0
19-64	186.1	64.9%	8.5%	3.1%	22.4%	41.8
65+	38.5	54.1%	7.8%	94.4%	1.0%	0.4

Note: Coverage status and type is measured at the time of the survey among civilian, non-institutionalized population. Percentages within each age group may sum to more than 100 percent because people can have multiple sources of health insurance.
Source: Analysis of National Health Interview Survey, by the National Center for Health Statistics, Centers for Disease Control and Prevention for MACPAC.

Medicaid and CHIP in the Context of U.S. Health Care Spending

Combined federal and state expenditures for Medicaid and CHIP accounted for over 15 percent of U.S. health care spending in 2009, the most recent year for which historical data are available (Figure 1-1). In comparison, Medicare and private insurance accounted for about 20 percent and 32 percent, respectively.

For certain types of care, Medicaid and CHIP account for a substantially larger portion of the U.S. total than other payers.[5] In 2009, Medicaid financed 36 percent of home health care, 33 percent of nursing home care, and 53 percent of other health, residential, and personal health care (Figure 1-2). For other services, Medicaid and CHIP account for a smaller share than might be expected based on enrollment. Lower payment rates, differing coverage policies (e.g., Medicaid provides dental for children but generally not adults), and different groups' proportionate use of services (e.g., people over age 65 use more services than younger enrollees) offer a partial explanation.[6]

As Figure 1-3 indicates, Medicaid is the dominant source of payment for long-term services and supports (LTSS), followed by out-of-pocket payments by individuals and families. Medicaid accounted for 48 percent of all long-term care spending in 2009, $127 billion out of a total $264 billion.[7] The program also financed one-quarter of mental health and substance abuse spending in 2003, the most recent year for which data are readily available (Mark et al. 2007).

Unlike Medicare, for which a substantial portion of federal spending is financed by dedicated revenue sources that include payroll taxes and enrollee premiums, federal spending for

[5] Although amounts cited here include CHIP, it accounts for no more than 3 percent of total Medicaid and CHIP spending.
[6] As described in more detail in Chapters 2 and 3, states are required to cover certain benefits while others are optional.
[7] MACPAC analysis of unpublished NHE detail from the Office of the Actuary, Centers for Medicare and Medicaid Services.

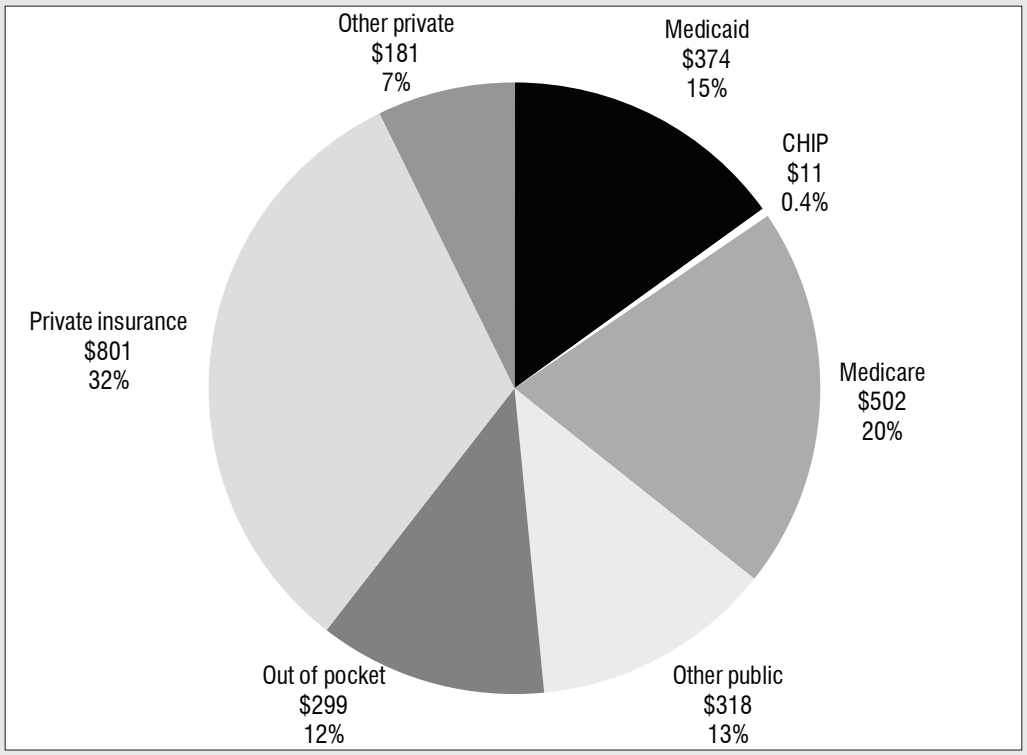
Medicaid and CHIP is financed by general revenues (OACT 2010). The programs represent a growing portion of the federal budget, having increased from 1.4 percent of federal outlays in FY 1970 to 8.1 percent in FY 2010; in comparison, Medicare increased from 3.0 percent of federal outlays to 12.3 percent (OMB 2011).

Medicaid and CHIP have increased as a share of U.S. health care spending over time, along with Medicare and private insurance; in contrast, out-of-pocket and other public spending shares have decreased (Figure 1-4).[8] In addition, as health care has consumed a growing share of the nation's economy, so have Medicaid and CHIP. Between FY 1970 and FY 2009, total U.S. health care spending increased from 7.2 percent of gross domestic product (GDP) to 17.6 percent. Over the same period, Medicaid and CHIP spending increased from 0.5 percent of GDP to 2.7 percent (OACT 2011b).

Balancing Federal and State Interests

Part of the challenge in setting policies for Medicaid and CHIP is balancing federal and state interests. Both the federal and state governments have a financial stake in the programs and

FIGURE 1-1. U.S. Health Care Spending by Source, 2009 (billions)

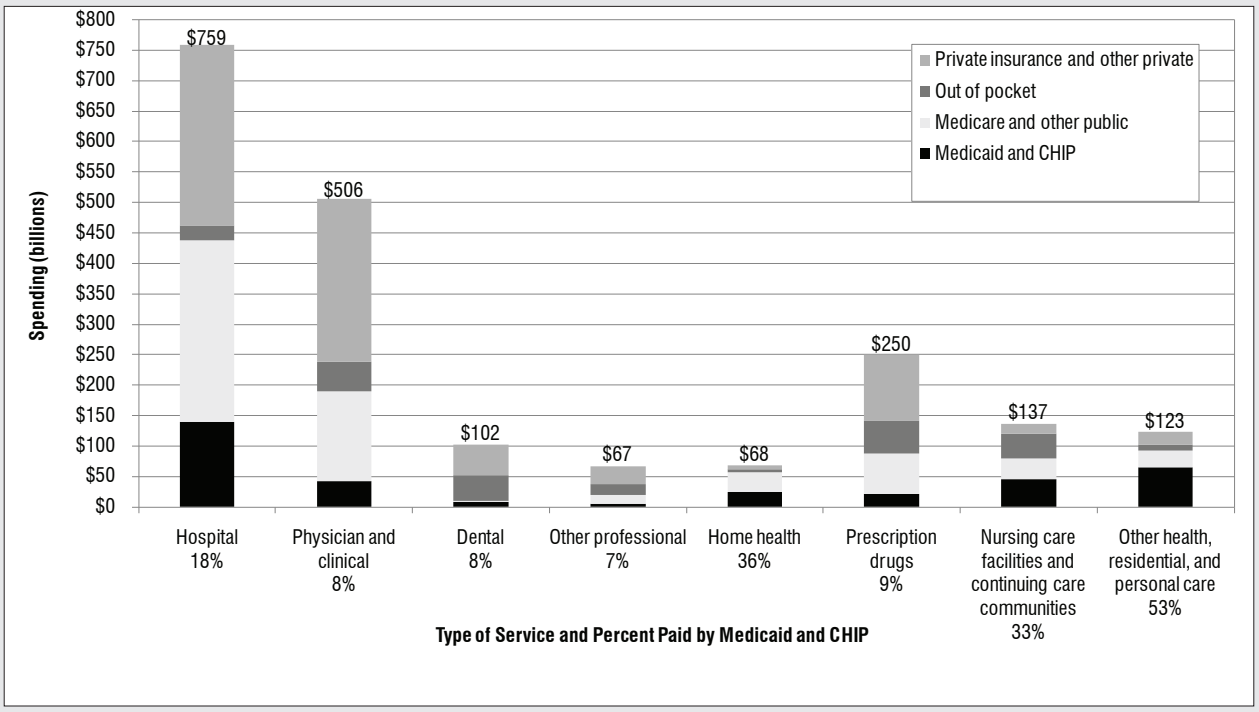


Note: Total spending is $2.486 trillion.

Source: See Table 16 in MACStats

[8] Although amounts cited here include CHIP, it accounts for no more than 3 percent of total Medicaid and CHIP spending.

FIGURE 1-2. U.S. Health Care Spending on Selected Services by Source, 2009



Note: Services not shown are non-prescription drugs and non-durable medical products ($43 billion, nearly all of which is out of pocket) and durable medical equipment ($35 billion, primarily out of pocket and Medicare). Nursing/continuing care and other care categories reflect new data and methods as of 2011. In prior releases, Medicaid accounted for about 40% of nursing home expenditures and about three-quarters of other personal health care expenditures.

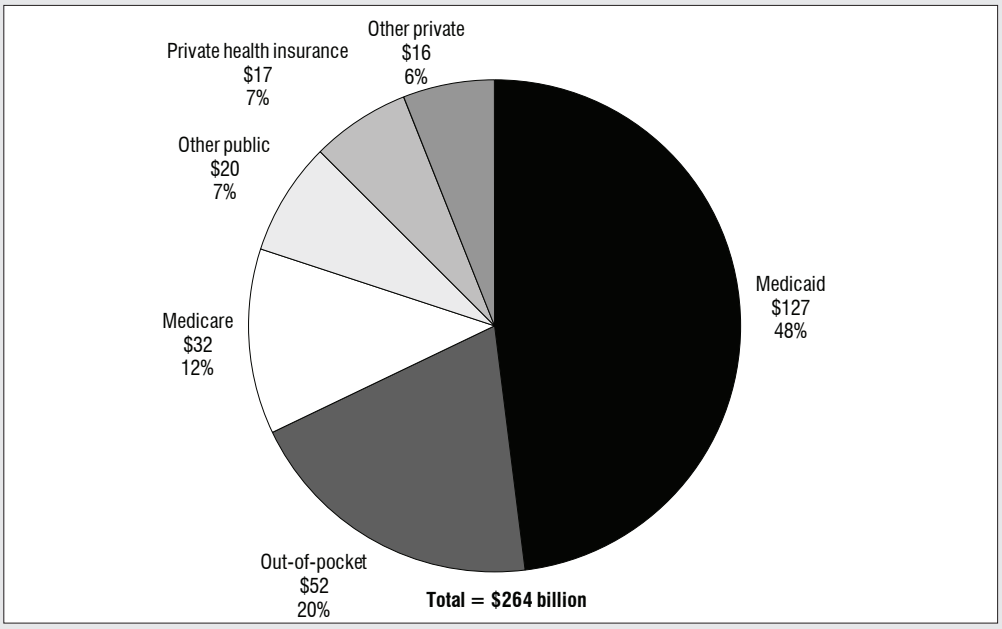
Source: See Table 16 in MACStats

reconciling their often different, sometimes conflicting priorities can be difficult, particularly under stressful fiscal circumstances such as during a national and/or state recession.

Medicaid and CHIP provide an important source of revenue for the health care industry that affects economic activity throughout the nation. They are major sources of federal financing for costs that might otherwise be borne by state and local governments, and by individuals and providers. Enrollment in the program has grown steadily, particularly in times of economic downturns, which exacerbate the pressure on federal and state budgets. States are subject to the same underlying medical cost drivers that other payers struggle to control, such as changing medical practice patterns and high-cost technological innovations. These cost drivers, along with state needs to balance budgets, and federal interests for fiscal accountability, are a few of the factors that contribute to tension between the federal and state partners in administering Medicaid and CHIP.

The individual entitlement of Medicaid, coupled with the longstanding FMAP formula determining the level of federal support for each state program, creates incentives for states to maximize or

FIGURE 1-3. Spending for Long-term Services and Supports by Source, 2009 (billions)



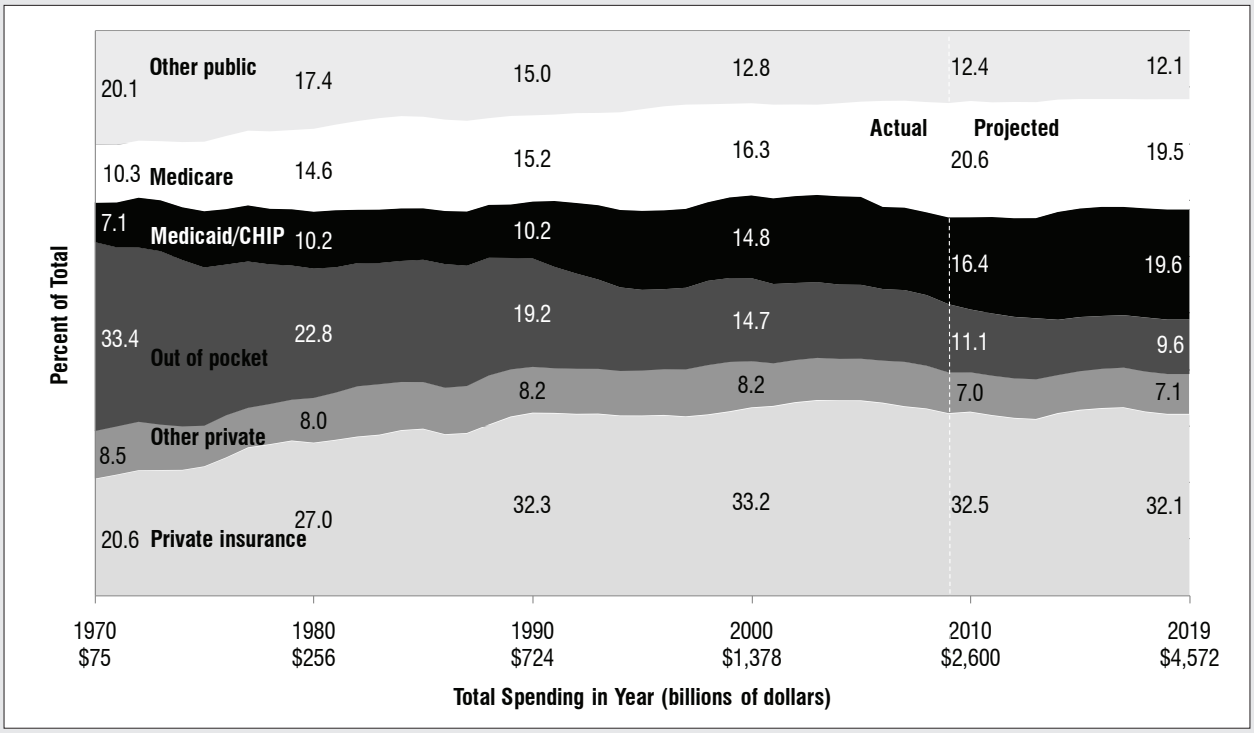
Note: Includes nursing care facility and continuing care retirement community (with the exception of Medicare, which only pays for these services on a short-term basis), home health (all payers), residential care for individuals with intellectual disabilities and for mental health and substance abuse (all payers), and home and community-based waiver (for which Medicaid is the only payer) expenditures. Includes Medicaid hospital-based nursing/continuing care and Medicaid and Medicare home health expenditures that are categorized as hospital expenditures in published national health expenditure (NHE) estimates. Estimates may differ from those published elsewhere due to variation in the treatment of Medicare, residential care, and hospital-based expenditures, as well as from those published earlier due to a comprehensive revision of NHE estimates released in 2011.

Source: MACPAC analysis of unpublished NHE detail from the Office of the Actuary, Centers for Medicare & Medicaid Services

augment the federal share of Medicaid costs. In addition, virtually all states have requirements to balance their budgets; measures they take to meet that requirement often include cuts in Medicaid that affect providers and beneficiaries. Finally, fiscal stresses are compounded by the rising cost of health care and the fact that Medicaid is designed to be countercyclical. Medicaid enrollment and spending increase when there is a downturn in the economic cycle and there is growth in the low-income population as unemployment, and loss of employer-sponsored insurance increase. Without Medicaid and CHIP, uninsurance would be more prevalent during economic downturns. Because of the underlying dynamics of this enrollment growth, however, Medicaid often struggles to meet its multiple federal and state responsibilities and interests under difficult fiscal conditions. During robust economic times, on the other hand, management of federal and state interests can be easier.

As federal and state Medicaid officials move forward and continue to shape Medicaid, understanding the scope and role of the program in context of the health care system as a whole, the people it serves, and the providers and programs it supports, is essential. The following two chapters describe Medicaid and CHIP, their roles in delivering and financing health care services, and their impact on people and providers. Current data on program enrollment, expenditures, and financing are also provided.

FIGURE 1-4. Distribution of U.S. Health Care Spending by Source, 1970–2019 (billions)



Source: See Table 17 in MACStats

MACPAC

In recognition of the programs' significance as sources of health coverage and long-term care assistance for low-income populations, and the complex needs of many Medicaid and CHIP beneficiaries, the Congress established the Medicaid and CHIP Payment and Access Commission (MACPAC) as a nonpartisan advisor to provide technical and analytical assistance and to be a source of current, reliable information to guide policies related to these programs.

MACPAC was authorized in the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), and was later expanded in the Patient Protection and Affordable Care Act (P.L. 111-148) in 2010. MACPAC's responsibilities are to advise the Congress on Medicaid and CHIP program policies including access, payment, eligibility, enrollment and retention, coverage, and quality. MACPAC also is responsible for advising the Congress on interactions of Medicaid and CHIP payment policies with health care delivery and Medicare. Furthermore, the Commission is to develop an early-warning system to identify provider shortage areas and other factors that adversely affect access to care by Medicaid and CHIP beneficiaries.

MACPAC's objective is to create an independent analytic base of information integrating both data and policy analysis to support nonpartisan recommendations to the Congress and also to the Secretary of the Department of Health and

Human Services (HHS) and the states. In order to fulfill our mandate to develop an independent capacity to serve the information and analytic needs of policymakers, the Commission must work with its partners—the Congress, the Secretary of HHS, the Centers for Medicare & Medicaid Services (CMS), and the states to improve the quality, depth, and transparency of data, information, and dialogue about Medicaid and CHIP.

The purpose of this first report to the Congress is to contribute to a better understanding of the Medicaid and CHIP programs, their roles in the U.S. health care system, and key policy and data issues that need to be addressed. In addition, this Report outlines MACPAC's approach to developing its independent analytic base necessary to meet its mandate advising the Congress. Future Commission work, including technical assistance and mandated reports to the Congress, will rely on this base of research, data, and policy analysis.

References

Fronstin, P. 1998. *Features of employment-based health plans*. Issue brief no. 201. Washington, DC: Employee Benefit Research Institute. September. http://www.ebri.org/pdf/briefspdf/0998ib.pdf.

Holahan, J. 2009. *Medicaid and entitlement reform*. Washington, DC: Urban Institute. http://www.urban.org/UploadedPDF/901200_medicare_entitlement_reform.pdf.

Mark, T., K. Levit, and R. Coffey, et al. 2007. *National estimates of expenditures for mental health and substance abuse treatment, 1993-2003*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA). http://www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf.

Martinez, M.E., and R. A. Cohen. 2010. *Health insurance coverage: early release of estimates from the national health interview survey,* January–June 2010. Hyattsville, MD: National Center for Health Statistics. http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201012.html.

Medicare Payment Advisory Commission (MedPAC). 2010a. *Aligning incentives in Medicare*. Washington, DC: MedPAC. http://www.medpac.gov/documents/Jun10_EntireReport.pdf.

Medicare Payment Advisory Commission (MedPAC). 2010b. *Dual-eligible beneficiaries*. In *A data book: Healthcare spending and the Medicare program, section 3*. http://www.medpac.gov/chapters/Jun10DataBookSec3.pdf.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services. 2011a. Communication with MACPAC.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2011b. *National Health Expenditures Summary and GDP: Calendar Years 1960-2009*.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services. 2010. *Actuarial report on the financial outlook for Medicaid*.

Office of Management and Budget. 2011. *Historical tables, budget of the United States government, fiscal year 2012*. http://www.gpoaccess.gov/usbudget/fy12/.

Peterson, C.L. 2009. *Setting and valuing health insurance benefits*. Report R40491. Washington, DC: Congressional Research Service (CRS). May.

Starr, Paul L. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.

U.S. Department of Health and Human Services (HHS). 2011. *Justification of Estimates for Appropriations Committees, FY 2012*. http://www.cms.gov/PerformanceBudget/Downloads/CMSFY12CJ.pdf.

U.S. Department of Health and Human Services (HHS). 2009. Federal financial participation in state assistance expenditures; federal matching shares for Medicaid, the Children's Health Insurance Program, and aid to needy aged, blind, or disabled persons for October 1, 2010 through September 30, 2011. *Federal Register* 74, no. 227 (November 27): 62315-62317. http://aspe.hhs.gov/health/fmap11.htm.