MEDICAID
A PRIMER

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THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

Medicaid: A Primer

Key Information on the Health Program for Low-Income Americans

March 2007

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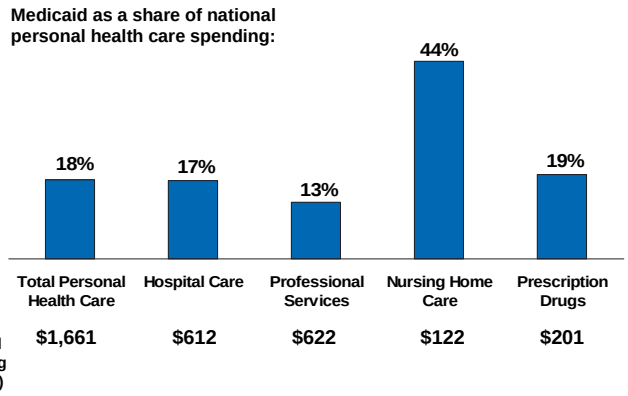
INTRODUCTION

Since Congress established the Medicaid program in 1965, it has become a linchpin in our health care system, covering health and long-term care services for many of the sickest and poorest Americans. In 2003, 55 million people were covered by Medicaid. In the absence of the program, the vast majority of its beneficiaries would join the ranks of the nearly 47 million uninsured.

Medicaid accounts for 18% of total national spending on personal health care (Figure 1). The program is the dominant source of financing for long-term care, paying over 40% of the national bill for nursing home care and for long-term care overall. It is also the largest source of public funding for mental health and substance abuse services. The Medicaid program is an essential source of financing for safety-net providers that serve the uninsured and many in the low-income population. Finally, Medicaid is a major engine in state economies, supporting millions of jobs.

Figure 1

Medicaid's Role in the Health System, 2005



SOURCE: Catlin et al, *Health Affairs*, January/February 2007. Based on National Health Care Expenditure Data, CMS, Office of the Actuary.

Medicaid operates as more than 50 separate programs – one in every state, the District of Columbia, and the U.S. Territories – each with its own policies and procedures. Although each individual Medicaid program has distinctive attributes, they all have in common fundamental elements that are defined in federal law and that account for Medicaid's key place in our national health care system. The purpose of this primer is to present basic information on Medicaid and to inform public discussion about the Medicaid program's role in providing health and long-term care coverage for millions of low-income Americans.

WHAT IS MEDICAID?

Medicaid is the nation's publicly financed health coverage program for low-income people. Enacted in 1965 under Title XIX of the Social Security Act, Medicaid was initially created to provide medical assistance to individuals and families receiving cash assistance. Over the years, Congress has incrementally expanded the scope of the Medicaid program beyond its welfare roots. Today, Medicaid is a health and long-term care program for a broad population of low-income Americans, including working families, elderly people, and individuals with diverse physical and mental disabilities. Medicaid covers many of the poorest and sickest people in the nation.

Medicaid fills in holes in our health care system. By design, Medicaid provides health coverage for millions of children and parents in low-income families who lack access to private health insurance. Medicaid is also the safety-net for millions of adults and children with severe disabilities who cannot obtain health insurance in the private market or for whom such insurance, which is designed for a generally health population, is inadequate. Finally, Medicaid supplements Medicare for over 7 million low-income Medicare enrollees known as "dual eligibles," paying Medicare's premiums and cost-sharing on their behalf and covering services that Medicare limits or does not cover.

Medicaid is the single largest source of long-term care coverage and financing in the U.S. Medicaid covers 6 of every 10 nursing home residents and finances more than 40% of nursing home and total long-term care spending in the nation. More than half of Medicaid long-term care spending is for institutional care, but an increasing share is attributable to home and community-based long-term services.

Medicaid is financed jointly by the federal government and the states. The federal government matches state spending on Medicaid. Through this partnership, the federal government and the states share the cost of providing health and long-term care assistance to the low-income population.

The states administer Medicaid within broad federal guidelines. State agencies administer Medicaid subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. Although state participation in Medicaid is voluntary, all states participate. Federal law outlines broad requirements that all state Medicaid programs must fulfill. However, states have wide discretion regarding program dimensions such as eligibility, benefits, and provider payment. As a result, Medicaid operates as over 50 distinct programs, one in each state and the District of Columbia and in each of the U.S. Territories.

Medicaid buys services primarily in the private health care sector. Medicaid is a health coverage program, not a health care delivery system. States pay health care providers for services on behalf of Medicaid beneficiaries. States may purchase services on a fee-for-service basis or by paying premiums to managed care organizations.

Medicaid is a major source of financing for health care providers and institutions that serve the low-income and uninsured populations. Medicaid is the largest source of third-party payments to community health centers, accounting for over one-

third of their operating revenues. Similarly, Medicaid provides 37% of public hospital net revenues.[1]

States may seek federal waivers to operate their Medicaid programs outside of federal guidelines. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive statutory and regulatory provisions of health and welfare programs, including Medicaid. States can apply for Section 1115 waivers to operate their Medicaid programs in ways that do not conform to federal standards. Some states have used waivers to broaden Medicaid eligibility and to adopt new models of coverage and health care delivery for the low-income population.

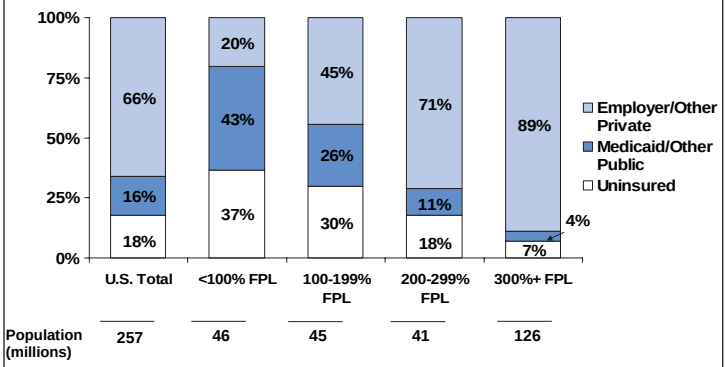
Medicaid's structure enables the program to evolve and to incorporate innovations in health care. The combination of broad state flexibility in Medicaid program design and guaranteed federal matching funds has enabled the program to respond to changing economic and demographic conditions and address emerging needs. As a major source of health care financing, the Medicaid program has leveraged improvements in health care, including new approaches to chronic care management and wider adoption of community-based alternatives to institutional long-term care.

WHO IS COVERED BY MEDICAID?

Medicaid covers more than 40% of non-elderly Americans living in poverty and about a quarter of the near-poor. Medicaid is a safety-net health coverage program for low-income individuals and families who often lack access to job-based health insurance, cannot afford the high and rising premiums for private coverage, or are excluded from private insurance based on their health status (Figure 2).

Figure 2

Health Insurance Coverage of the Non-Elderly by Poverty Level, 2005

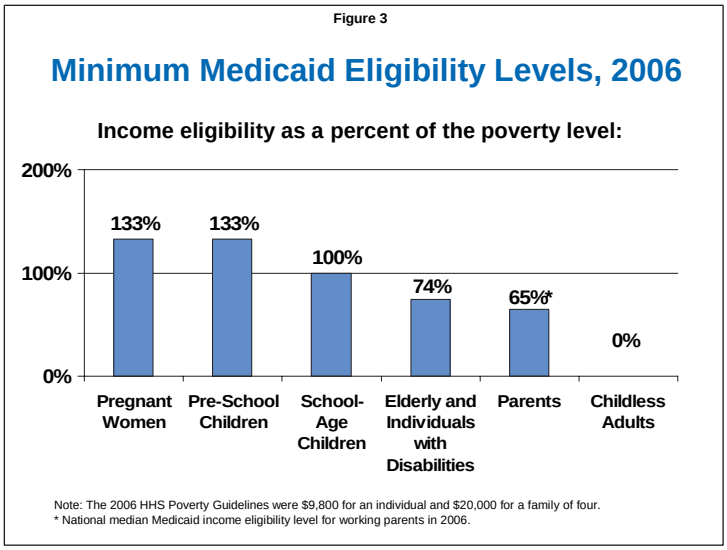


Note: Federal poverty level was $19,971 for a family of four in 2005. Sums may not equal totals and data may not total 100% due to rounding.
SOURCE: KCMU and Urban Institute analysis of the March 2006 Current Population Survey.

Medicaid covers more than 7 million of Medicare's almost 44 million enrollees. Medicare is a federal health insurance program that covers 37 million elderly Americans and 7 million non-elderly individuals with permanent disabilities. About 1 in 6 Medicare beneficiaries, based on their low income, are also covered by Medicaid. Compared with other Medicare enrollees, these "dual eligibles" are much poorer and in worse health. Medicaid provides financial protection for dual eligibles by covering Medicare's premiums and cost-sharing. Medicaid also covers important services that Medicare limits or does not cover, especially long-term care, improving access to needed care for these low-income and high-need seniors and people with disabilities. Medicaid finances close to 40% of the total expenditures associated with dual eligibles.

To qualify for Medicaid, individuals must meet income and asset requirements and also fall into one of the categories of eligible populations. In order to receive federal matching funds, state Medicaid programs must cover certain "mandatory" populations, including pregnant women and children under age 6 with family income below 133% of poverty (the poverty level was $20,000 for a family of four in 2006), school-age children (age 6-18) with family income below 100% of poverty, parents with income below states' July 1996 welfare eligibility levels (often below 50% of poverty), and most elderly and persons with disabilities receiving Supplemental Security Income (SSI), for which the income eligibility standard is 74% of the poverty level (Figure 3).

Figure 3



States have broad flexibility to expand Medicaid eligibility beyond federal minimum standards to cover additional "optional" groups. Optional eligibility groups include pregnant women, children, and parents with income exceeding the mandatory thresholds; persons with disabilities and the elderly up to 100% of poverty; persons residing in nursing facilities with income below 300% of the SSI standard, and "medically needy" individuals who have high health expenses relative to their income. States have expanded Medicaid to optional groups extensively, but variably. As a result, Medicaid eligibility above the federal minimum levels varies widely from state to state.

All individuals who qualify for Medicaid are guaranteed coverage. Medicaid is an entitlement program. Therefore, all low-income individuals who meet their state's Medicaid eligibility criteria have a legal right to enroll in Medicaid and to obtain coverage for medically necessary services that are included in their state's Medicaid benefit package. A state cannot cap enrollment in Medicaid unless the state obtains a federal waiver exempting it from federal Medicaid program rules.

Medicaid covers over 40 million low-income children and parents, most of whom are in working families. Medicaid is the largest source of health insurance for children in the U.S., covering 28 million in 2005, or 1 in every 4.[2] The State Children's Health Insurance Program (SCHIP) builds on Medicaid, providing coverage for 6 million children in low-income families who have too much income to qualify for

Medicaid but lack access to private insurance. Many low-income workers have no access to private insurance and among those who do, affordability is a major barrier. Without Medicaid, most of children and parents covered by the program would be uninsured.

Medicaid has extended health coverage to more children as job-based health insurance has eroded. Between 2000 and 2004, both children and adults experienced steady declines in job-based coverage, but due to Medicaid and SCHIP coverage for children, all of the growth in the number of uninsured was attributable to adults. Between 1997 and 2004, the percentage of children without health coverage fell by about one-third from 23% to 15%, due largely to improved access to Medicaid and the implementation of SCHIP. In 2005, Medicaid and SCHIP enrollment did not rise and eroding employer-based coverage left more adults and low-income children uninsured.[3]

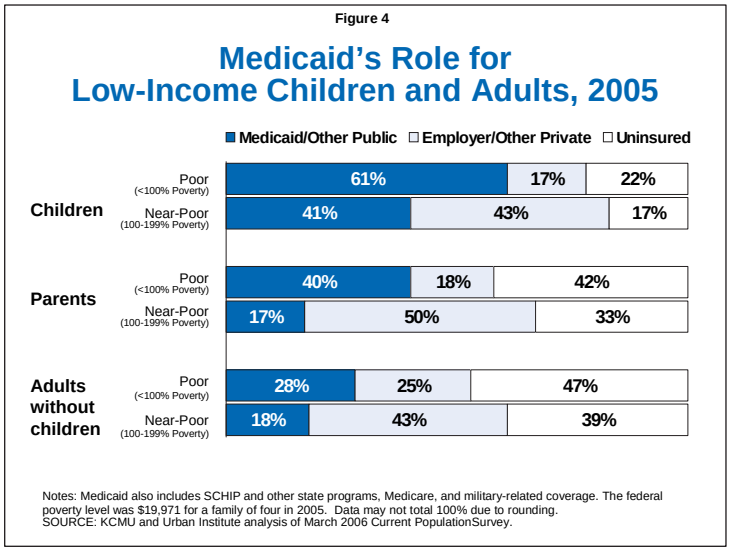
Medicaid is a key source of coverage for low-income pregnant women. Many states have expanded coverage of pregnant women beyond the federal minimum income eligibility level of 133% of poverty. Medicaid improves access to prenatal care and neonatal intensive care for low-income pregnant women and their babies, respectively, helping to improve maternal health and reduce infant mortality, low-weight births, and avoidable birth defects.[4] Medicaid funds more than one in three births in the U.S. and is the nation's largest source of public funding for family planning.[5]

Medicaid provides health and long-term care coverage for 8 million low-income Americans with disabilities and chronic illnesses. Medicaid covers a broad set of acute and long-term services designed to meet the diverse and extensive needs of people with disabilities and chronic illnesses. These individuals often cannot obtain coverage in the private market. Medicaid's comprehensive benefits enable low-income adults with disabilities to obtain a fuller range of the services they require, helping to maximize their independence and, in some cases, to support their participation in the workforce. Medicaid covers a large majority of all poor children with disabilities.

Overall, Medicaid enrollees are much poorer and in markedly worse health than the privately insured population. Compared even with the low-income privately insured population, Medicaid beneficiaries are more likely to have income below the poverty level, to have health conditions that limit work, and to be in fair or poor health.

Medicaid coverage is not available to all in the low-income population. Although Medicaid covers millions of poor and near-poor Americans, it is not a universal source of coverage for those with low income. Partly because income and categorical requirements restrict eligibility for Medicaid, a substantial share of non-elderly Americans below or near poverty remain uninsured (Figure 4).

Figure 4



Notes: Medicaid also includes SCHIP and other state programs, Medicare, and military-related coverage. The federal poverty level was $19,971 for a family of four in 2005. Data may not total 100% due to rounding.
SOURCE: KCMU and Urban Institute analysis of March 2006 Current PopulationSurvey.

- **Parents.** While all poor children are eligible for Medicaid, many of their parents are not. Most States apply much lower income eligibility thresholds for parents than for children. In 14 states, working parents with income equal to 50% of poverty earn too much to qualify for Medicaid. In nearly half the states (24), a parent in a family of three working full-time at the federal minimum wage cannot qualify.

- **Adults without children.** States cannot receive federal matching funds to extend Medicaid to adults under age 65 without children, unless they are pregnant or disabled. As a result, over 40% of low-income adults without children are uninsured,[6] and these low-income adults account for over one-third of the 46 million non-elderly Americans who lack insurance.

- **Immigrants.** Generally, legal immigrants, including children, are eligible only for Emergency Medicaid during their first five years in the U.S., provided they meet Medicaid's financial and categorical requirements. After five years, under federal law, legal immigrants are eligible for Medicaid on the same basis as U.S. citizens, although states can further delay their eligibility. Regardless of their length of residence in the U.S., undocumented immigrants can obtain only Emergency Medicaid.

Some low-income Americans who are eligible for Medicaid are not covered. It is estimated that nearly three-quarters of uninsured children are eligible for Medicaid or SCHIP but are not enrolled.[7] In the mid- to late-1990s, many states improved outreach, simplified their Medicaid enrollment and renewal procedures, and expanded eligibility, resulting in significant increases in enrollment. During the economic downturn, many states under difficult budget pressures reversed these efforts to promote participation. As their economies have begun to recover,

numerous states have again taken steps to broaden access to Medicaid and SCHIP. However, a recently-enacted federal requirement that citizens applying for or renewing their Medicaid coverage supply documents to prove their citizenship and identity is likely to impede Medicaid enrollment and retention.[8] [9]

WHAT SERVICES DOES MEDICAID COVER?

State Medicaid programs must cover certain "mandatory services" enumerated in federal law in order to receive federal matching funds. Most Medicaid beneficiaries are entitled to receive the following services if they are determined to be medically necessary by the state Medicaid program or a managed care organization with which the state contracts:

- Physician services
- Hospital services (inpatient and outpatient)
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Medical and surgical dental services
- Rural and federally-qualified health center services
- Family planning
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health care for persons eligible for nursing facility services

States can choose to cover certain additional services and are entitled to receive federal matching funds for these "optional" services. Commonly offered optional services include:

- Prescription drugs
- Clinic services
- Dental and vision services and supplies
- Prosthetic devices
- Physical therapy and rehab services
- TB-related services
- Primary care case management
- Nursing facility services for individuals under 21
- Intermediate care facilities for individuals with mental retardation (ICF/MR) services
- Home- and community-based care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice services

Through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, Medicaid provides comprehensive health coverage for children with a broad range of health needs. Under the federal requirements pertaining to EPSDT, children enrolled in Medicaid are entitled to receive all services authorized by federal law, including optional services. EPSDT approximates a uniform federal benefit package for children, covering screening and early intervention services to promote children's healthy development, as well as vision, dental, and hearing services, and the diagnostic and treatment services typical of private insurance.

Many of the benefits offered at state option are particularly important for persons with disabilities and the elderly. The term "optional services" is a statutory designation that reflects Medicaid services covered at state option rather than by

federal mandate. However, many optional services are important to meet the diverse and complex health needs of the program's enrollees, who include many with severe physical and mental disabilities. All state Medicaid programs cover prescription drugs and certain other optional services, and a large share of Medicaid spending is associated with services provided at state option. States have a variety of administrative tools for managing utilization, such as prior authorization and case management.

The scope of Medicaid benefits varies considerably across the states. States have substantial discretion in designing their Medicaid benefit packages.[10] [11] While federal law requires that Medicaid benefits are covered subject to medical necessity, the definition and application of this standard varies from state to state. States also define the amount, duration, and scope of coverage for each benefit. For example, states can limit the number of physician visits or prescription drugs they will cover.

Until recently, federal law required that states offer the same Medicaid benefits to all enrollees statewide. Under provisions enacted in the Deficit Reduction Act of 2005 (DRA), states now have authority to replace their Medicaid benefits (including mandatory services) with a "benchmark" package for most children and certain other groups. Benchmark packages include the standard Blue Cross Blue Shield Plan offered to federal employees, the benefits offered to state employees, the coverage offered by the largest commercial HMO in the state, and any coverage approved by the HHS Secretary. States using benchmark coverage must provide EPSDT as a wrap-around for children. Most groups, including mandatory pregnant women and parents, individuals with disabilities or special medical needs, dual eligibles, and people with long-term care needs, cannot be required to enroll in benchmark coverage, but states can provide for voluntary enrollment. States cannot offer benchmark coverage to any "expansion" groups to whom eligibility was extended after the DRA was enacted.

Medicaid is the nation's major source of coverage and financing for long-term services and supports. Nearly 10 million Americans, primarily the elderly and people with severe disabilities, need long-term care.[12] However, neither Medicare nor private insurance covers substantial long-term care benefits; Medicaid is generally the sole source of assistance for these high-cost services. In 2004, Medicaid financed more than 40% of the estimated $158 billion spent nationally on long-term care.[13] In recent years, both state initiatives and federal legislation have emphasized increasing the availability and use of home and community-based alternatives to institutional long-term care.

Medicaid is a major source of coverage for low-income individuals who need mental health services and substance abuse treatment. Many state Medicaid programs cover mental and behavioral health services that are often not available under other sources of health insurance. Eleven percent of Medicaid enrollees use mental health and/or substance abuse services.[14] Medicaid is a major payer in the mental health system, accounting for 44% of public mental health spending.[15]

States can charge premiums and cost-sharing in Medicaid, subject to some federal limitations. Historically, federal Medicaid law sharply limited the use of premiums and cost-sharing in the program, but the DRA expanded states' discretion in this regard. States are prohibited from charging premiums to Medicaid beneficiaries

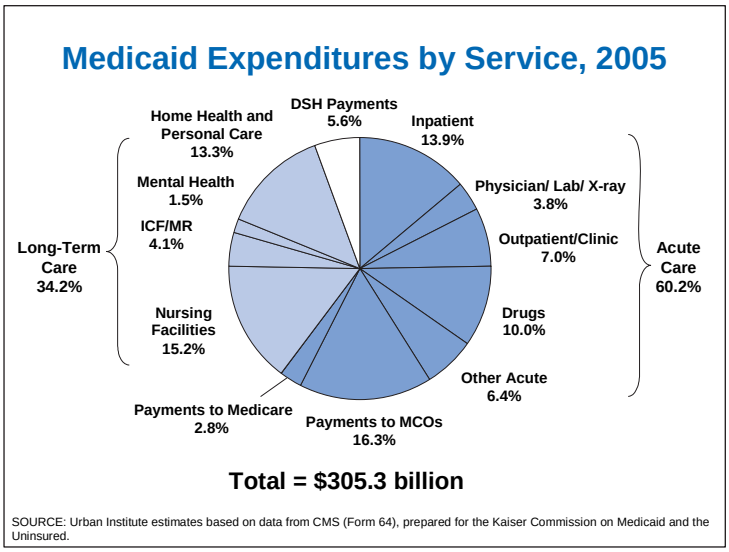
below 150% of poverty and other specified groups (e.g., mandatory children and pregnant women, foster care children, terminally ill individuals). Otherwise, premiums are allowed. Cost-sharing is largely prohibited for mandatory children, and certain services are also exempt, regardless of a beneficiary's income (e.g., preventive services for children, pregnancy-related care, emergency services, family planning, care provided to institutionalized individuals and those in hospice). For others below poverty, cost-sharing remains limited to nominal levels, but the DRA permits higher cost-sharing for those above poverty (including children). Cost-sharing and premiums combined cannot exceed 5% of family income for any family.

HOW MUCH DOES MEDICAID COST?

In 2005, total federal and state Medicaid spending was $316.5 billion. More than 96% of total Medicaid spending is for benefits and supplemental payments to hospitals serving a disproportionate share of low-income or uninsured patients (DSH). [16] Medicaid provides a substantial share of health care financing in the U.S. [17] In 2005, Medicaid accounted for:

- 18% of total national spending on personal health care
- 17% of national spending on hospital care
- 13% of national spending on professional services
- 44% of national spending on nursing home care
- 19% of national spending on prescription drugs

Medicaid expenditures are distributed across an array of acute and long-term care services, DSH payments, and administrative expenses. In 2004, Medicaid spending on services and DSH totaled $288.1 billion. Almost 60% was attributable to acute care, about 35% to long-term care, and 6% to DSH (Figure 5).



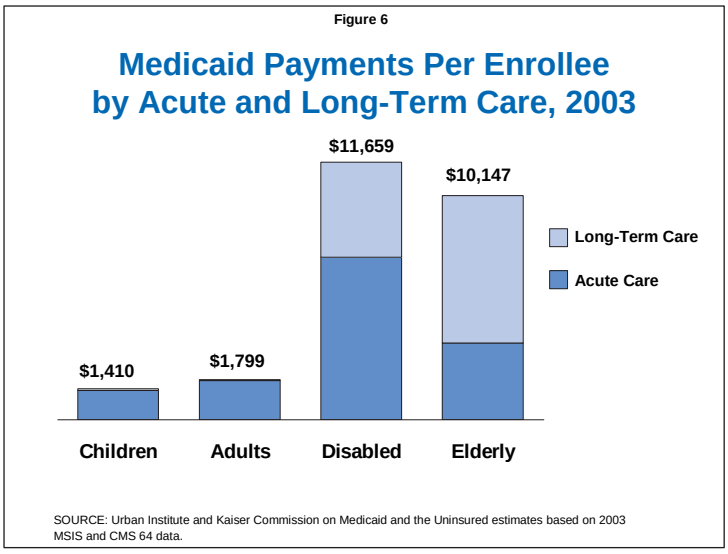
Medicaid is a comparatively low-cost health insurance program, once the health status of Medicaid beneficiaries is taken into account. [18] Because the Medicaid population is in markedly worse health than the privately insured population, per capita spending under Medicaid is higher than under private insurance. However, if adjusted for health status to make the Medicaid and privately insured populations more comparable, both adult and child per capita spending is lower under Medicaid than under private insurance.

Over the last several years, Medicaid per capita costs have grown more slowly than health spending for the privately insured. Between 2000 and 2002, the rate of growth in Medicaid spending increased, driven by rising enrollment due largely to the recession, declines in employer-based coverage, and health care cost inflation. The rate of growth in Medicaid spending slowed from 2002 to 2004 as the economy improved. Over the entire 2000-2004 period, Medicaid acute care spending per

enrollee grew at an average annual rate of 6.4%. Over the same period, spending per person with private coverage grew at an average annual rate of 9.5% and monthly premiums for employer-sponsored insurance grew at an average annual rate of 12.2%.[19] [20]

Medicaid spending per enrollee varies considerably by eligibility group. In 2003, the per capita cost for children covered by Medicaid was $1,400, compared to $1,800 per adult, $12,000 per disabled enrollee and $10,000 per elderly enrollee (Figure 6). Higher per capita expenditures for disabled and elderly beneficiaries reflect their intensive use of acute and long-term care services.

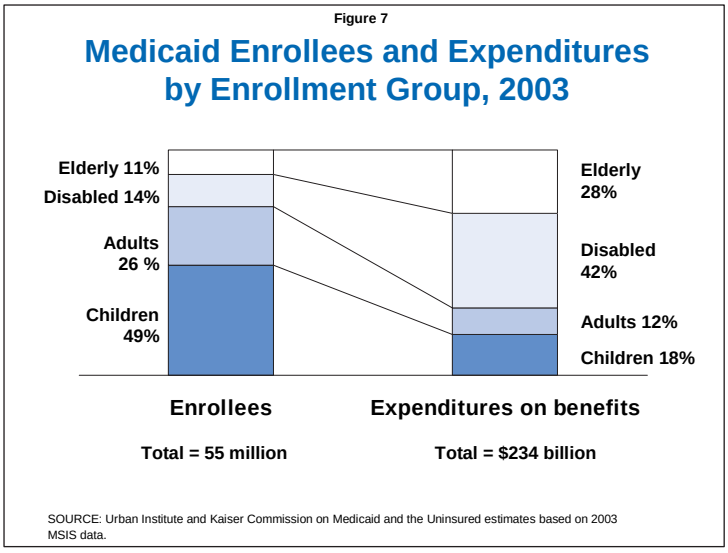
Figure 6



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2003 MSIS and CMS 64 data.

Children and their parents make up the majority of the Medicaid population, but the lion's share of Medicaid spending goes toward services for the elderly and people with disabilities. Children, parents, and pregnant women make up three-quarters of the Medicaid population but account for 30% of Medicaid spending on services. The elderly and disabled, who make up the remaining quarter of the Medicaid population, account for about 70% of Medicaid spending on services (Figure 7).[21]

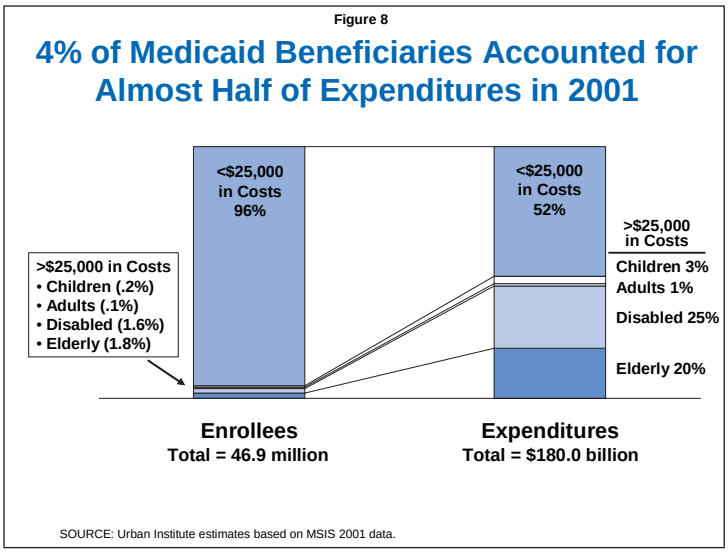
Figure 7



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

Nearly half of Medicaid spending is attributable to 4% of Medicaid beneficiaries. Medicaid enrollees who, due to their health care needs and utilization incur very high costs, account for a large share of total Medicaid spending. In 2001, the 4% of Medicaid enrollees with costs exceeding $25,000 accounted for 48% of total Medicaid spending (Figure 8). Disabled beneficiaries with costs at this level alone accounted for one-quarter of Medicaid spending. This pattern holds in each major eligibility group: a small share of enrollees account for a very large share of spending.

Figure 8



A significant share of Medicaid spending is attributable to dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicare and Medicaid. While dual eligibles make up 14% of the Medicaid population, their health and long-term care costs accounted for 40% of Medicaid spending on services in 2003. Most Medicaid spending on behalf of dual eligibles is for long-term care. Historically, Medicare had no outpatient prescription drug benefit and Medicaid provided drug coverage for dual eligibles. Beginning January 2006, Medicare covers outpatient prescription drugs under a new Part D. Although dual eligibles now receive their outpatient prescription drugs through Part D of Medicare, states are required to help to finance the benefit by making a monthly "clawback" payment to the federal government.

Long-term care users account for half of Medicaid spending. Only 7% of Medicaid beneficiaries use long-term care services, but these enrollees account for 52% of Medicaid spending because of their high of both acute and long-term care services.

Medicaid finances 18% of total national spending on personal health care. Medicaid pays almost one-fifth of the national bill for personal health spending, and it is a key source of financing for major categories of services. The Medicaid program is by far the largest funding source for nursing home care in the nation.

Medicaid makes supplemental payments to hospitals that serve a disproportionate share of low-income or uninsured patients (DSH). For many safety net hospitals, DSH payments represent a critical source of financing for uncompensated care provided to low-income and uninsured patients. The amount of

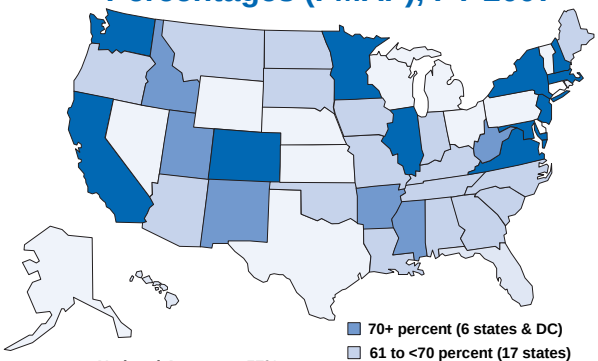
federal matching funds that a state can use to make DSH payments in any given year is capped at a level specified in the federal Medicaid statute, and these capped amounts vary widely across the states.

WHO PAYS FOR MEDICAID?

Medicaid is financed jointly by the federal government and the states. The federal government matches state Medicaid spending at least dollar for dollar. The federal share of Medicaid spending is determined by the Federal Medical Assistance Percentage (FMAP), which varies by state, based on state per capita income relative to the national average. The FMAP is at least 50% in every state and is higher in relatively poor states, reaching 76% in the poorest state (Figure 9) Consistent with the federal guarantee of Medicaid coverage for all eligible individuals, federal Medicaid matching dollars are guaranteed to states as needed, on an uncapped basis. This approach directs funding based on actual, rather than predicted, need.

Figure 9

Federal Medical Assistance Percentages (FMAP), FY 2007



SOURCE: www.statehealthfacts.org; data from Federal Register

The federal government funds about 57% of all Medicaid spending. The Medicaid program accounts for 8% of total federal outlays and 44% of all federal grants to state and local governments.[22] Federal matching dollars support states' ability to meet the health needs of the low-income population.

States commit substantial resources to Medicaid. On average, states spend about 18% of their general funds on Medicaid, making it the second largest item in state budgets, following elementary and secondary education.[23] Medicaid costs are a recurrent issue at the state level, as states have a limited fiscal capacity, strain during economic downturns to meet increased demands for Medicaid coverage with declining state revenues, and must balance their budgets.

Medicaid is a major engine in state economies. The infusion of federal matching dollars into state economies generates economic activity, including the creation of jobs and additional income and state tax revenues. According to one study, total state Medicaid spending generated nearly 3 million new jobs and over $100 billion in wages in FY 2001.[24] The Medicaid program also supports the low-wage employment sector and the private insurance market by providing health insurance coverage to the lowest-income working families and individuals with extensive health needs.

Medicaid's current financing structure, with uncapped federal matching funds, gives states flexibility to respond to changing and emerging health care needs. Federal matching dollars increase to match increased state spending to address the challenges of rising health care costs, increasing enrollment, growing demand for costly long-term care, and public health crises such as the HIV/AIDS pandemic. Because of states' access to matching funds as needed, Medicaid was able absorb a substantial share of the decline in employer-sponsored coverage during the recent economic downturn, thereby stemming the increase in the number of uninsured.[25] The Medicaid Integrity Program, established by the DRA, focuses resources on activities to detect and prevent inappropriate Medicaid payments, to assure sound stewardship of state and federal funds.

The federal government matches state spending on allowable Medicaid administrative costs at a matching rate of 50% for most types of costs. Federal matching payments for administrative costs are open-ended and the matching rates are uniform across all states.[26]

CONCLUSION

Medicaid is an integral component of the nation's health care system, covering almost 1 in every 5 Americans and financing almost 1 in every 5 dollars of personal health care spending. The program's 55 million diverse beneficiaries include children and parents in low-income working families, low-income adults and children with disabilities, and low-income seniors. Most non-elderly Medicaid beneficiaries lack access to other coverage. They work in jobs that don't offer insurance, or they are not eligible for it, or they can't afford private insurance premiums. Most Medicaid enrollees with disabilities also lack access to private insurance or have health and/or long-term care needs that commercial insurance cannot adequately meet. Dual eligibles rely on Medicaid to pay their Medicare premiums and cost-sharing and to cover expensive gaps in Medicare benefits, especially for long-term care. Without Medicaid, the vast majority of the program's beneficiaries would join the ranks of the 47 million uninsured or would be under-insured for services and supports that are essential to meet their needs.

Medicaid was established to fill distinct gaps in the private health insurance system – gaps that left those with the least income and the most extensive health needs without access to coverage and care. Expansions of Medicaid since then have occurred as needs for safety-net coverage have grown, primarily due to economic and labor force dynamics, rising health care costs, and aging and disability trends.

As declines in job-based health insurance continue and the uninsured count rises, initiatives to expand coverage of the uninsured are taking shape in a growing number of states and at the federal level. While the plans vary in scope and approach, most of them build on Medicaid coverage and financing to provide broader coverage of the uninsured. At the same time, as the baby-boomers age and financing long-term care becomes a more pressing issue, the dominant role of Medicaid in supporting the long-term care needs of low-income Americans is also likely to receive more attention. Understanding Medicaid and the needs of the low-income people it serves helps to assure that in the coming years, public policy affecting the Medicaid program will be formulated soundly to meet the opportunities, issues, and challenges ahead.

[1] National Association of Public Hospitals and Health Systems Annual Survey 2002 and Center for Health Services Research and Policy analysis of 2002 UDS data. Also see Rosenbaum S et al. 2004. *Economic Stress and the Safety Net: A Health Center Update*. Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7122.
[2] Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2006 Current Population Survey.
[3] Holahan J and A Cook. 2006. *Why Did the Number of Uninsured Continue to Increase in 2005?* Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7571.
[4] Wachino V et al. 2004. *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*. Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7000.
[5] Gold RB et al. 2005. *Medicaid: A Critical Source of Support for Family Planning in the United States.* The Henry J. Kaiser Family Foundation and The Alan Guttmacher Institute. Pub.No. 7064. Also see *MCH Update: State Coverage of Pregnant Women and Children*. *2006*. National Governors' Association Center for Best Practices.
[6] Kaiser Commission on Medicaid and Urban Institute analysis of 2006 Current Population Survey.
[7] Urban Institute analysis of 2005 Current Population Survey for Kaiser Commission on Medicaid and the Uninsured.
[8] Cohen Ross D and L Cox. 2004. *In a Time of Growing Need: States Choices Influence Health Coverage Access for Children and Families.* Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7191.
[9] Cohen Ross D et al. 2007. *Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*. Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7608.
[10] Schneider A and R Garfield. 2003. *Medicaid as a Health Insurer: Current Benefits and Flexibility*. Kaiser Commission on Medicaid and the Uninsured. Pub.No. 4150.
[11] Schneider A and R Elias. 2003. *Medicaid as a Long-Term Care Program: Current Benefits and Flexibility.* Kaiser Commission on Medicaid and the Uninsured. Pub.No. 4149.
[12] Georgetown University Health Policy Institute Analysis of the 2000 National Health Interview Survey; Jones A. 2002. "The National Nursing Home Survey: 1999 Summary." *Vital Health Statistics* 13(152).
[13] Centers for Medicare and Medicaid Services, 2006 National Health Accounts.
[14] Buck J et al. 2003. "Use of Mental Health and Substance Abuse Services Among High-Cost Medicaid Enrollees." *Administration and Policy in Mental Health* 31(1).
[15] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. 2005. *National Expenditures for Mental Health Services and Substance Abuse Treatment 1991-2001*. DHHS Pub.No. SMA 05-3999.
[16] statehealthfacts.org. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, October 2006.
[17] Catlin A et al. 2007. "National Health Spending In 2005: The Slowdown Continues." *Health Affairs*, January/February. Based on National Health Care Expenditure Data, CMS, Office of the Actuary.
[18] Hadley J and J Holahan. 2004. "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40(4).
[19] Holahan J and M Cohen. 2006. *Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004*, Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7499.
[20] Kaiser Family Foundation and Health Research and Educational Trust. 2004. *Employer Health Benefits Annual Survey 2004*. Pub.No. 7148.
[21] Kaiser Commission on Medicaid and the Uninsured estimates based on Congressional Budget Office and Office of Management and Budget data, 2004.

[22] National Association of State Budget Officers, *2004 State Expenditure Report*. 2005.
[23] Office of Management and Budget. 2004. Analytical Perspectives, Budget of the United States Government, Fiscal Year 2005.
[24] Families USA. 2003. *Medicaid: Good Medicine for State Economies*. Also see *The Role of Medicaid in State Economies: A Look at the* Research. 2004. Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7075.
[25] Holahan J and A Ghosh. 2004. *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003*. Kaiser Commission on Medicaid and the Uninsured. Pub.No. 7174.
[26] Schneider A et al. 2002. *The Medicaid Resource Book*. Kaiser Commission on Medicaid and the Uninsured. Pub.No. 2236.

Tables

Table 1

Medicaid Expenditures by Type of Service, FFY 2005

	Expenditures (in millions)						
	Total	Acute Care		Long-Term Care		DSH Payments*	
State	$	$	%	$	%	$	%
United States	**$305,337**	**$182,604**	**60%**	**$105,644**	**35%**	**$17,089**	**6%**
Alabama	3,864	2,133	55%	1,323	34%	409	11%
Alaska	987	628	64%	340	34%	20	2%
Arizona**	5,734	4,231	74%	1,361	24%	141	2%
Arkansas	2,844	1,754	62%	1,052	37%	38	1%
California	33,983	20,114	59%	11,354	33%	2,514	7%
Colorado	2,816	1,644	58%	999	35%	173	6%
Connecticut	4,112	1,790	44%	2,048	50%	274	7%
Delaware	869	564	65%	301	35%	4	0%
District of Columbia	1,277	914	72%	310	24%	52	4%
Florida	13,375	9,226	69%	3,815	29%	333	2%
Georgia	7,818	5,435	70%	1,970	25%	412	5%
Hawaii	1,044	710	68%	335	32%	0	0%
Idaho	1,023	656	64%	353	35%	14	1%
Illinois	10,937	7,451	68%	3,136	29%	349	3%
Indiana	5,268	2,834	54%	2,156	41%	278	5%
Iowa	2,419	1,319	55%	1,068	44%	32	1%
Kansas	1,981	1,080	54%	838	42%	64	3%
Kentucky	4,300	2,847	66%	1,256	29%	196	5%
Louisiana	5,470	2,954	54%	1,485	27%	1,031	19%
Maine	2,249	1,553	69%	631	28%	64	3%
Maryland	5,269	3,481	66%	1,695	32%	93	2%
Massachusetts	9,710	5,711	59%	3,299	34%	699	7%
Michigan	8,710	5,865	67%	2,417	28%	428	5%
Minnesota	5,608	2,800	50%	2,751	49%	57	1%
Mississippi	3,375	2,110	63%	1,082	32%	183	5%
Missouri	6,601	4,127	63%	1,782	27%	692	10%
Montana	704	390	55%	305	43%	9	1%
Nebraska	1,409	688	49%	701	50%	19	1%
Nevada	1,186	752	63%	356	30%	78	7%
New Hampshire	1,261	475	38%	513	41%	273	22%
New Jersey	7,619	3,887	51%	2,706	36%	1,026	13%
New Mexico	2,371	1,665	70%	689	29%	16	1%
New York	43,428	22,346	51%	18,081	42%	3,001	7%
North Carolina	9,315	5,915	64%	2,975	32%	424	5%
North Dakota	515	213	41%	300	58%	2	0%
Ohio	11,836	6,268	53%	5,475	46%	94	1%
Oklahoma	2,817	1,757	62%	1,028	37%	31	1%
Oregon	2,851	1,863	65%	949	33%	39	1%
Pennsylvania	15,873	8,313	52%	6,745	42%	815	5%
Rhode Island	1,691	1,024	61%	556	33%	111	7%
South Carolina	4,203	2,674	64%	1,088	26%	441	11%
South Dakota	615	371	60%	243	40%	1	0%
Tennessee	7,601	5,934	78%	1,667	22%	0	0%
Texas	18,446	12,135	66%	4,818	26%	1,494	8%
Utah	1,366	978	72%	372	27%	16	1%
Vermont	868	556	64%	277	32%	35	4%
Virginia	4,475	2,566	57%	1,768	40%	141	3%
Washington	5,745	3,615	63%	1,783	31%	348	6%
West Virginia	2,230	1,341	60%	807	36%	82	4%
Wisconsin	4,859	2,731	56%	2,086	43%	43	1%
Wyoming	410	216	53%	194	47%	0	0%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS (Form 64).
Note: Does not include administrative costs, accounting adjustments, or the U.S. Territories. Total Medicaid spending including these additional items was $316.5 billion in FFY 2005. Figures may not sum to totals due to rounding.
*"DSH" refers to disproportionate share hospital payments.
**Of $4.8 billion in prepaid/managed care expenditures reported by Arizona, 72% was assumed to pay for acute care and 28% was assumed to pay for long-term care. These proportions are based on data from the "2005 AHCCCS Overview" (http://www.ahcccs.state.az.us/publications/overview/2005/contents.asp).

Table 2

Federal Medical Assistance Percentages, FY 2004-2007

State	FY 2004	FY 2005	FY 2006	FY 2007	Federal Funds Sent to State for Each Dollar in State Medicaid Spending, FY 2007
Alabama	70.8%	70.8%	69.5%	68.9%	$2.21
Alaska	58.4%	57.6%	57.6%	57.6%	$1.36
Arizona	67.3%	67.5%	67.0%	66.5%	$1.98
Arkansas	74.7%	74.8%	73.8%	73.4%	$2.76
California	50.0%	50.0%	50.0%	50.0%	$1.00
Colorado	50.0%	50.0%	50.0%	50.0%	$1.00
Connecticut	50.0%	50.0%	50.0%	50.0%	$1.00
Delaware	50.0%	50.4%	50.1%	50.0%	$1.00
District of Columbia	70.0%	70.0%	70.0%	70.0%	$2.33
Florida	58.9%	58.9%	58.9%	58.8%	$1.42
Georgia	59.6%	60.4%	60.6%	62.0%	$1.63
Hawaii	58.9%	58.5%	58.8%	57.6%	$1.36
Idaho	70.5%	70.6%	69.9%	70.4%	$2.37
Illinois	50.0%	50.0%	50.0%	50.0%	$1.00
Indiana	62.3%	62.8%	63.0%	62.6%	$1.67
Iowa	63.9%	63.6%	63.6%	62.0%	$1.63
Kansas	60.8%	61.0%	60.4%	60.3%	$1.52
Kentucky	70.1%	69.6%	69.3%	69.6%	$2.29
Louisiana	71.6%	71.0%	69.8%	69.7%	$2.30
Maine	66.0%	64.9%	62.9%	63.3%	$1.72
Maryland	50.0%	50.0%	50.0%	50.0%	$1.00
Massachusetts	50.0%	50.0%	50.0%	50.0%	$1.00
Michigan	55.9%	56.7%	56.6%	56.4%	$1.29
Minnesota	50.0%	50.0%	50.0%	50.0%	$1.00
Mississippi	77.1%	77.1%	76.0%	75.9%	$3.15
Missouri	61.5%	61.2%	61.9%	61.6%	$1.60
Montana	72.9%	71.9%	70.5%	69.1%	$2.24
Nebraska	59.9%	59.6%	59.7%	57.9%	$1.38
Nevada	54.9%	55.9%	54.8%	53.9%	$1.17
New Hampshire	50.0%	50.0%	50.0%	50.0%	$1.00
New Jersey	50.0%	50.0%	50.0%	50.0%	$1.00
New Mexico	74.9%	74.3%	71.2%	71.9%	$2.56
New York	50.0%	50.0%	50.0%	50.0%	$1.00
North Carolina	62.9%	63.6%	63.5%	64.5%	$1.82
North Dakota	68.3%	67.5%	65.9%	64.7%	$1.83
Ohio	59.2%	59.7%	59.9%	59.7%	$1.48
Oklahoma	70.2%	70.2%	67.9%	68.1%	$2.14
Oregon	60.8%	61.1%	61.6%	61.1%	$1.57
Pennsylvania	54.8%	53.8%	55.1%	54.4%	$1.19
Rhode Island	56.0%	55.4%	54.5%	52.4%	$1.10
South Carolina	69.9%	69.9%	69.3%	69.5%	$2.28
South Dakota	65.7%	66.0%	65.1%	62.9%	$1.70
Tennessee	64.4%	64.8%	64.0%	63.7%	$1.75
Texas	60.2%	60.9%	60.7%	60.8%	$1.55
Utah	71.7%	72.1%	70.8%	70.1%	$2.35
Vermont	61.3%	60.1%	58.5%	58.9%	$1.43
Virginia	50.0%	50.0%	50.0%	50.0%	$1.00
Washington	50.0%	50.0%	50.0%	50.1%	$1.00
West Virginia	75.2%	74.7%	73.0%	72.8%	$2.68
Wisconsin	58.4%	58.3%	57.7%	57.5%	$1.35
Wyoming	59.8%	57.9%	54.2%	52.9%	$1.12

Source: Kaiser Commission on Medicaid and the Uninsured calculations based on FFY 2004-2007 FMAPs as published in the Federal Register as follows: FY 2004 FMAP Vol. 67, No. 221, pp. 69223-69225; FY 2005 FMAP Vol. 68, No. 232, pp. 67676-67678; FY 2006 FMAP Vol. 69, No. 226, pp. 68370-28373; FY 2007 FMAP Vol. 70, No. 229, pp. 71856-71857.

Note: FY2006 and FY2007 for Alaska are from Federal Register, May 15, 2006 (Vol. 71, No. 93), pp. 28041-28042.

Table 3

Medicaid Enrollment by Group, FFY 2003

	Enrollment (rounded to nearest 100)								
	Total	Aged		Disabled		Adult		Children	
State	Number	Number	%	Number	%	Number	%	Number	%
United States	**55,071,200**	**5,871,700**	**11%**	**7,679,200**	**14%**	**14,257,300**	**26%**	**27,263,000**	**50%**
Alabama	892,800	126,800	14%	175,300	20%	152,300	17%	438,400	49%
Alaska	126,500	7,500	6%	12,400	10%	27,600	22%	79,000	62%
Arizona	1,278,900	79,600	6%	102,700	8%	502,100	39%	594,500	46%
Arkansas	675,600	64,600	10%	108,200	16%	159,200	24%	343,600	51%
California	10,042,800	872,400	9%	872,800	9%	4,376,800	44%	3,920,800	39%
Colorado	473,700	49,900	11%	64,900	14%	99,200	21%	259,700	55%
Connecticut	502,100	64,700	13%	60,600	12%	107,700	21%	269,200	54%
Delaware	156,700	12,000	8%	18,400	12%	57,100	36%	69,200	44%
District of Columbia	157,100	14,200	9%	26,300	17%	38,000	24%	78,500	50%
Florida	2,841,100	356,600	13%	443,400	16%	578,300	20%	1,462,800	51%
Georgia	1,638,500	164,300	10%	248,400	15%	284,000	17%	941,800	57%
Hawaii	216,100	22,400	10%	23,100	11%	72,400	34%	98,300	45%
Idaho	208,700	13,100	6%	28,500	14%	32,000	15%	135,200	65%
Illinois	2,177,300	374,100	17%	265,800	12%	375,200	17%	1,162,100	53%
Indiana	945,000	81,300	9%	131,800	14%	170,800	18%	561,000	59%
Iowa	378,700	41,800	11%	62,700	17%	75,200	20%	199,000	53%
Kansas	325,100	32,700	10%	52,800	16%	55,200	17%	184,400	57%
Kentucky	809,900	94,800	12%	198,000	24%	120,900	15%	396,200	49%
Louisiana	1,054,100	108,900	10%	184,400	17%	122,800	12%	638,000	61%
Maine	378,200	75,900	20%	98,200	26%	88,600	23%	115,600	31%
Maryland	752,000	67,800	9%	109,600	15%	142,000	19%	432,600	58%
Massachusetts	1,193,500	146,200	12%	228,000	19%	338,200	28%	481,200	40%
Michigan	1,572,400	132,100	8%	275,400	18%	280,300	18%	884,500	56%
Minnesota	729,900	90,600	12%	99,100	14%	169,100	23%	371,100	51%
Mississippi	731,000	97,100	13%	145,000	20%	91,100	12%	397,700	54%
Missouri	1,157,200	102,000	9%	166,100	14%	264,700	23%	624,400	54%
Montana	110,400	10,900	10%	17,300	16%	23,100	21%	59,100	54%
Nebraska	269,200	23,800	9%	30,300	11%	50,500	19%	164,700	61%
Nevada	236,200	22,600	10%	33,600	14%	52,800	22%	127,200	54%
New Hampshire	129,700	14,400	11%	17,400	13%	18,100	14%	79,800	62%
New Jersey	974,500	141,900	15%	152,900	16%	197,700	20%	482,000	49%
New Mexico	492,600	32,100	7%	48,700	10%	108,300	22%	303,500	62%
New York	4,583,000	500,000	11%	603,400	13%	1,452,500	32%	2,027,200	44%
North Carolina	1,450,200	178,800	12%	244,500	17%	275,400	19%	751,500	52%
North Dakota	76,700	10,200	13%	10,000	13%	19,600	26%	36,900	48%
Ohio	1,938,800	161,600	8%	307,400	16%	432,000	22%	1,037,800	54%
Oklahoma	666,500	65,800	10%	83,900	13%	91,300	14%	425,500	64%
Oregon	625,600	50,800	8%	73,100	12%	237,400	38%	264,200	42%
Pennsylvania	1,786,300	218,100	12%	408,100	23%	299,800	17%	860,300	48%
Rhode Island	210,900	25,000	12%	36,800	17%	53,300	25%	95,800	45%
South Carolina	992,000	137,600	14%	130,500	13%	228,500	23%	495,400	50%
South Dakota	119,700	12,400	10%	14,800	12%	19,200	16%	73,300	61%
Tennessee	1,651,500	166,900	10%	284,500	17%	476,000	29%	724,100	44%
Texas	3,660,700	400,800	11%	419,300	11%	589,100	16%	2,251,500	62%
Utah	278,000	13,900	5%	29,000	10%	82,400	30%	152,700	55%
Vermont	159,700	21,100	13%	18,300	11%	51,400	32%	69,000	43%
Virginia	736,500	100,300	14%	134,400	18%	96,500	13%	405,300	55%
Washington	1,160,600	82,000	7%	151,900	13%	305,800	26%	621,000	54%
West Virginia	366,400	33,700	9%	92,700	25%	60,700	17%	179,300	49%
Wisconsin	903,700	148,000	16%	125,900	14%	239,900	27%	389,900	43%
Wyoming	76,800	5,500	7%	8,700	11%	15,400	20%	47,300	62%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS, 2006.

Table 4

Medicaid Payments by Group, FFY 2003

	Payments (in millions)											
	Total	Aged		Disabled		Adult		Children		Unknown	
State	$	$	%	$	%	$	%	$	%	$	%
United States	**$232,920**	**$63,325**	**27%**	**$93,860**	**40%**	**$26,717**	**11%**	**$40,006**	**17%**	**$9,012**	**4%**
Alabama	$3,118	$949	30%	$986	32%	$148	5%	$698	22%	$336	11%
Alaska	$836	$134	16%	$291	35%	$122	15%	$277	33%	$12	1%
Arizona	$3,285	$599	18%	$1,122	34%	$649	20%	$858	26%	$56	2%
Arkansas	$2,212	$642	29%	$912	41%	$140	6%	$480	22%	$39	2%
California	$25,812	$6,995	27%	$10,016	39%	$3,560	14%	$4,743	18%	$499	2%
Colorado	$2,269	$613	27%	$905	40%	$243	11%	$416	18%	$92	4%
Connecticut	$3,359	$1,304	39%	$1,276	38%	$246	7%	$517	15%	$17	1%
Delaware	$750	$175	23%	$286	38%	$152	20%	$133	18%	$5	1%
District of Columbia	$1,200	$256	21%	$505	42%	$124	10%	$218	18%	$97	8%
Florida	$11,104	$3,205	29%	$4,406	40%	$981	9%	$1,697	15%	$815	7%
Georgia	$5,358	$1,206	23%	$1,844	34%	$740	14%	$1,227	23%	$341	6%
Hawaii	$753	$226	30%	$227	30%	$156	21%	$139	18%	$5	1%
Idaho	$867	$188	22%	$421	48%	$86	10%	$165	19%	$7	1%
Illinois	$9,391	$1,777	19%	$3,476	37%	$885	9%	$1,594	17%	$1,659	18%
Indiana	$3,951	$1,005	25%	$1,693	43%	$377	10%	$787	20%	$89	2%
Iowa	$1,996	$560	28%	$917	46%	$177	9%	$307	15%	$35	2%
Kansas	$1,615	$459	28%	$729	45%	$114	7%	$276	17%	$36	2%
Kentucky	$3,558	$903	25%	$1,560	44%	$320	9%	$731	21%	$44	1%
Louisiana	$3,615	$835	23%	$1,678	46%	$316	9%	$582	16%	$204	6%
Maine	$2,074	$384	19%	$899	43%	$319	15%	$458	22%	$14	1%
Maryland	$4,466	$973	22%	$1,869	42%	$566	13%	$1,007	23%	$52	1%
Massachusetts	$6,392	$2,054	32%	$2,967	46%	$554	9%	$767	12%	$51	1%
Michigan	$6,479	$1,533	24%	$2,876	44%	$559	9%	$914	14%	$597	9%
Minnesota	$4,702	$1,267	27%	$2,138	45%	$413	9%	$836	18%	$47	1%
Mississippi	$2,570	$791	31%	$1,034	40%	$243	9%	$487	19%	$15	1%
Missouri	$4,407	$1,162	26%	$1,774	40%	$475	11%	$969	22%	$28	1%
Montana	$536	$148	28%	$189	35%	$66	12%	$112	21%	$21	4%
Nebraska	$1,283	$361	28%	$405	32%	$112	9%	$291	23%	$113	9%
Nevada	$881	$166	19%	$371	42%	$109	12%	$179	20%	$57	6%
New Hampshire	$786	$252	32%	$301	38%	$47	6%	$183	23%	$3	0%
New Jersey	$6,030	$2,113	35%	$2,516	42%	$463	8%	$843	14%	$94	2%
New Mexico	$2,033	$382	19%	$697	34%	$236	12%	$579	28%	$140	7%
New York	$35,207	$10,952	31%	$15,020	43%	$4,967	14%	$3,823	11%	$445	1%
North Carolina	$6,521	$1,695	26%	$2,826	43%	$794	12%	$1,157	18%	$50	1%
North Dakota	$445	$172	39%	$171	38%	$37	8%	$57	13%	$8	2%
Ohio	$10,235	$3,206	31%	$4,572	45%	$1,022	10%	$1,408	14%	$28	0%
Oklahoma	$2,129	$582	27%	$823	39%	$147	7%	$561	26%	$15	1%
Oregon	$2,116	$492	23%	$746	35%	$433	20%	$423	20%	$22	1%
Pennsylvania	$9,450	$3,152	33%	$3,981	42%	$747	8%	$1,531	16%	$39	0%
Rhode Island	$1,338	$401	30%	$598	45%	$123	9%	$208	16%	$8	1%
South Carolina	$3,642	$674	19%	$1,221	34%	$352	10%	$704	19%	$691	19%
South Dakota	$542	$152	28%	$207	38%	$50	9%	$124	23%	$9	2%
Tennessee	$5,459	$1,220	22%	$2,095	38%	$1,265	23%	$842	15%	$38	1%
Texas	$12,525	$3,143	25%	$4,444	35%	$1,425	11%	$3,327	27%	$185	1%
Utah	$1,201	$143	12%	$406	34%	$116	10%	$243	20%	$292	24%
Vermont	$642	$166	26%	$238	37%	$88	14%	$144	23%	$5	1%
Virginia	$3,181	$909	29%	$1,422	45%	$227	7%	$565	18%	$58	2%
Washington	$4,524	$766	17%	$1,249	28%	$575	13%	$652	14%	$1,282	28%
West Virginia	$1,830	$438	24%	$786	43%	$131	7%	$277	15%	$197	11%
Wisconsin	$3,921	$1,373	35%	$1,627	41%	$483	12%	$420	11%	$20	1%
Wyoming	$325	$72	22%	$142	44%	$38	12%	$72	22%	$1	0%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS, 2006.
Note: The basis of eligibility for some enrollees and the payments made on their behalf is reported as "unknown" in MSIS. For more information on MSIS eligibility groups, see http://www.kff.org/medicaid/kcmu031104pkg.cfm

Table 5

Medicaid Payments Per Enrollee by Group, FFY 2003

State	Payments per Enrollee				
	Total	Aged	Disabled	Adult	Children
United States	**$4,072**	**$10,799**	**$12,265**	**$1,872**	**$1,467**
Alabama	$3,119	$7,485	$5,623	$989	$1,595
Alaska	$6,512	$17,921	$23,402	$4,443	$3,504
Arizona	$2,525	$7,531	$10,924	$1,293	$1,443
Arkansas	$3,215	$9,919	$8,420	$879	$1,396
California	$2,520	$8,016	$11,475	$813	$1,210
Colorado	$4,595	$12,290	$13,932	$2,447	$1,603
Connecticut	$6,657	$20,158	$21,050	$2,281	$1,920
Delaware	$4,738	$14,524	$15,535	$2,661	$1,887
District of Columbia	$7,020	$18,038	$19,176	$3,255	$2,775
Florida	$3,621	$8,986	$9,938	$1,696	$1,160
Georgia	$3,061	$7,336	$7,421	$2,606	$1,302
Hawaii	$3,462	$10,102	$9,835	$2,163	$1,413
Idaho	$4,119	$14,368	$14,759	$2,698	$1,220
Illinois	$3,552	$4,749	$13,077	$2,359	$1,372
Indiana	$4,087	$12,360	$12,843	$2,206	$1,402
Iowa	$5,169	$13,351	$14,611	$2,358	$1,540
Kansas	$4,856	$14,027	$13,823	$2,058	$1,499
Kentucky	$4,339	$9,526	$7,878	$2,651	$1,844
Louisiana	$3,236	$7,671	$9,100	$2,572	$912
Maine	$5,445	$5,054	$9,155	$3,606	$3,961
Maryland	$5,870	$14,345	$17,053	$3,984	$2,327
Massachusetts	$5,312	$14,052	$13,012	$1,637	$1,593
Michigan	$3,741	$11,601	$10,446	$1,993	$1,033
Minnesota	$6,376	$13,977	$21,583	$2,440	$2,254
Mississippi	$3,495	$8,142	$7,132	$2,664	$1,225
Missouri	$3,784	$11,386	$10,676	$1,794	$1,552
Montana	$4,664	$13,591	$10,942	$2,858	$1,888
Nebraska	$4,344	$15,166	$13,382	$2,222	$1,768
Nevada	$3,491	$7,336	$11,033	$2,059	$1,409
New Hampshire	$6,039	$17,442	$17,338	$2,606	$2,292
New Jersey	$6,091	$14,893	$16,456	$2,345	$1,749
New Mexico	$3,818	$11,701	$14,180	$2,176	$1,907
New York	$7,583	$21,903	$24,888	$3,418	$1,885
North Carolina	$4,463	$9,478	$11,558	$2,884	$1,540
North Dakota	$5,702	$16,966	$17,195	$1,879	$1,537
Ohio	$5,265	$19,843	$14,873	$2,364	$1,357
Oklahoma	$3,171	$8,847	$9,808	$1,608	$1,319
Oregon	$3,345	$9,689	$10,196	$1,823	$1,598
Pennsylvania	$5,268	$14,452	$9,756	$2,491	$1,780
Rhode Island	$6,308	$16,045	$16,262	$2,301	$2,175
South Carolina	$2,974	$4,901	$9,352	$1,538	$1,421
South Dakota	$4,451	$12,259	$14,014	$2,601	$1,688
Tennessee	$3,283	$7,307	$7,361	$2,658	$1,163
Texas	$3,371	$7,842	$10,599	$2,419	$1,478
Utah	$3,268	$10,295	$13,983	$1,413	$1,591
Vermont	$3,977	$7,849	$12,970	$1,713	$2,095
Virginia	$4,241	$9,065	$10,585	$2,354	$1,393
Washington	$2,793	$9,347	$8,223	$1,880	$1,050
West Virginia	$4,456	$13,001	$8,480	$2,166	$1,545
Wisconsin	$4,317	$9,272	$12,922	$2,012	$1,076
Wyoming	$4,220	$13,118	$16,377	$2,476	$1,517

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS, 2006.
Note: Data in this table do not include spending when the service or basis of eligibility of the enrollee is unknown; national per capita spending amounts shown elsewhere in this report are adjusted to include this unknown spending and differ slightly from the totals shown here.

Table 6

Medicaid Income Eligibility as a Percent of Federal Poverty Level (FPL), 2006

State	Infants	Children 1-5	Children 6-19	Pregnant Women	Parents	
					Non-Working	Working
Alabama	133%	133%	100%	133%	12%	26%
Alaska	175%	175%	175%	175%	76%	81%
Arizona	140%	133%	100%	133%	200%	200%
Arkansas	200%	200%	200%	200%	15%	18%
California	200%	133%	100%	200%	100%	107%
Colorado	133%	133%	100%	200%	60%	67%
Connecticut	185%	185%	185%	185%	150%	157%
Delaware	200%	133%	100%	200%	100%	107%
District of Columbia	200%	200%	200%	200%	200%	207%
Florida	200%	133%	100%	185%	22%	58%
Georgia	200%	133%	100%	200%	31%	55%
Hawaii	300%	300%	300%	185%	100%	100%
Idaho	133%	133%	100%	133%	23%	43%
Illinois	200%	133%	133%	200%	185%	192%
Indiana	150%	150%	150%	150%	21%	27%
Iowa	200%	133%	133%	200%	31%	77%
Kansas	150%	133%	100%	150%	29%	36%
Kentucky	185%	150%	150%	185%	38%	66%
Louisiana	200%	200%	200%	200%	14%	20%
Maine	200%	150%	150%	200%	200%	207%
Maryland	200%	200%	200%	250%	31%	38%
Massachusetts	200%	150%	150%	200%	133%	133%
Michigan	185%	150%	150%	185%	38%	61%
Minnesota	280%	275%	275%	275%	275%	275%
Mississippi	185%	133%	100%	185%	27%	33%
Missouri	300%	300%	300%	185%	21%	40%
Montana	133%	133%	100%	133%	35%	62%
Nebraska	185%	185%	185%	185%	46%	58%
Nevada	133%	133%	100%	185%	25%	86%
New Hampshire	300%	185%	185%	185%	45%	56%
New Jersey	200%	133%	133%	200%	115%	115%
New Mexico	235%	235%	235%	185%	28%	65%
New York	200%	133%	100%	200%	150%	150%
North Carolina	200%	200%	100%	185%	39%	54%
North Dakota	133%	133%	100%	133%	38%	65%
Ohio	200%	200%	200%	150%	90%	90%
Oklahoma	185%	185%	185%	185%	34%	43%
Oregon	133%	133%	100%	185%	100%	100%
Pennsylvania	185%	133%	100%	185%	30%	61%
Rhode Island	250%	250%	250%	250%	185%	192%
South Carolina	185%	150%	150%	185%	48%	97%
South Dakota	140%	140%	140%	133%	58%	58%
Tennessee	185%	133%	100%	185%	70%	80%
Texas	185%	133%	100%	185%	14%	29%
Utah	133%	133%	100%	133%	42%	49%
Vermont	300%	300%	300%	200%	185%	192%
Virginia	133%	133%	133%	166%	24%	31%
Washington	200%	200%	200%	185%	39%	79%
West Virginia	150%	133%	100%	150%	18%	36%
Wisconsin	185%	185%	185%	185%	185%	192%
Wyoming	133%	133%	100%	133%	43%	57%

Source: "Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2007. Available at http://www.kff.org/medicaid/7608a.cfm.

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The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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