



MEDICAID WORKS:

A Review of How Public Insurance Protects the Health and Finances of Children and Other Vulnerable Populations

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Executive Summary

This report briefly reviews the evidence about the effectiveness of Medicaid and the Children's Health Insurance Program (CHIP) in addressing the health and financial needs of vulnerable Americans, including children and other vulnerable populations, including low-income parents, pregnant women, seniors and people with disabilities.

The importance of Medicaid and CHIP to low-income children and adults is well understood; less evident is the extent to which Medicaid and CHIP protect populations with serious health problems. Children covered by Medicaid or CHIP are more likely than their privately-insured counterparts to be in poorer health status and to have serious health conditions, as are publicly-insured adults. Almost all elderly Americans are covered by Medicare, but low-income seniors who are also enrolled in Medicaid (sometimes called dual eligibles) tend to have substantially worse health than those with Medicare alone or with private coverage. The benefit structure of Medicaid is particularly designed to help address the serious health needs and low incomes of its beneficiaries. Children covered by Medicaid have comprehensive services under its Early Periodic Screening, Diagnosis and Treatment policies.

A substantial body of research, conducted across the nation, indicates that Medicaid and CHIP have been successful in attaining their primary goals, including:

- Increasing health insurance coverage among children and protecting coverage for adults,
- Strengthening access to health care services and medications,
- Safeguarding the finances of low-income families and individuals, and
- Protecting the health of children and adults.

Medicaid and CHIP give states considerable flexibility in administering their programs to meet local conditions within a broad framework of federal guidance (and with a majority of funding provided by the federal government). Using this state flexibility, Medicaid programs have served as pioneers and innovators in numerous areas, such as payment reform, managed care, patient-centered medical homes, quality measurement, and home- and community-based care, paving the way for the rest of the nation and the health care system.

Finally, Medicaid and CHIP are already extremely lean programs that provide care at a much lower per-person cost than private health insurance. Because states share in program financing, they have a strong incentive to keep costs low. Although total Medicaid spending has risen because the number of people who need its benefits has increased, Medicaid per-capita expenditures have grown much less than private health insurance premiums and more slowly than overall health care cost growth.

Major cuts in Medicaid could seriously endanger the health and finances of millions of children and other vulnerable beneficiaries, including the elderly and disabled. The budget developed by Congressman Paul Ryan and passed by the House of Representatives would reduce federal funding by \$1.4 trillion over the next decade and transform the program into a block grant. Under a block grant with such major reductions in funding, states would inevitably be forced to take drastic actions, including reducing enrollment, limiting benefits, cutting provider payments or shifting more costs onto beneficiaries and their families. To give a sense of the potential impact of the House proposal, about 31 to 44 million fewer people, including millions of children and others, would be covered by Medicaid a decade from now than under current law. The progress that has been made in improving health insurance coverage and health access for children and other vulnerable populations should not be reversed.

Introduction

Jointly administered by the federal and state governments, Medicaid offers health insurance coverage to many of the nation's neediest individuals, including low-income children, pregnant women, parents with dependent children, the elderly, those with permanent disabilities and, in some states, adults without dependent children. Its sister program, the Children's Health Insurance Program or CHIP, was designed to offer insurance coverage to uninsured children in families whose incomes are just above the Medicaid income criteria. States that elect to participate in Medicaid receive federal matching funds to administer their programs and meet the cost of medically necessary care without caps on federal funding levels, so that the level of federal funding automatically adjusts to the level of need.

This report refers to "the Medicaid program," but Medicaid has many faces and, in reality, embodies a myriad of related programs. Because Medicaid is a joint federal-state program, states enjoy substantial flexibility in how they design and administer the program. States can tailor the program to their needs and markets within a broad federal framework and with the majority of funding provided by the federal government.

To many, Medicaid is a source of preventive health care, such as immunizations, preventive health care for children, comprehensive prenatal care and screening for cancer or other serious illnesses. For millions of others, Medicaid is a lifeline to affordable health care to treat serious physical and mental health conditions that can strike children and adults alike, such as asthma, serious emotional disorders and mental illnesses, diabetes or cardiovascular disease, as well as accidents or trauma. For others who have

developmental disabilities such as cerebral palsy, autism or Downs Syndrome, Medicaid can offer the only support available for the home- and community-based services that can keep them at home with their families and in the community in which they live and attend school. Finally, unlike medical insurance and Medicare, Medicaid provides coverage for long-term care services for children, adults, and the elderly with severe disabilities, who require a broad range of services to improve the quality of life and enable the fullest possible community integration. These services include home- and community-based care, the services of personal attendants, and when necessary, the services of long term care institutions such as nursing facilities and intermediate care facilities for children and adults with mental retardation and developmental disabilities.

In 2010 Medicaid served about 53 million people in any given month. Because people enter and exit from enrollment over the year, the total number of people enrolled in Medicaid over the year was closer to 67 million. In 2008, Medicaid served more than 28 million children over the course of the year. In 2010, CHIP served 5 million beneficiaries at any point in time and about 8 million over the course of 2010.¹

Enrollment in Medicaid has grown in recent years for a number of reasons. Most important, when the economy stumbles, more people lose their jobs and their families become impoverished and income-eligible for Medicaid (see Figure 1). However, even as the economy gradually strengthens, certain long term factors will continue to push Medicaid enrollment upward. An aging population is increasing the number of people who are eligible based on age or disability. As private health insurance coverage erodes, the number of people who must instead seek public insurance coverage steadily rises.

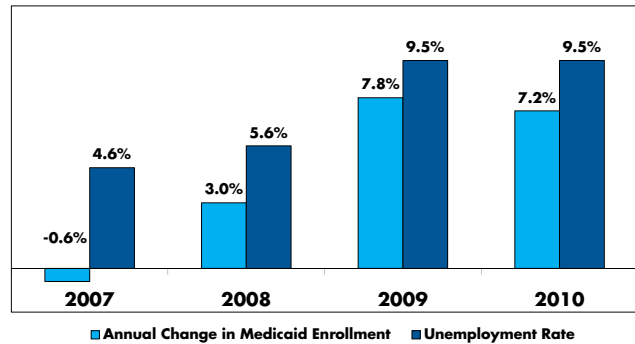
Medicaid Protects Children and Adults with Serious Medical Problems

Medicaid and CHIP serve populations who face elevated health risks. On average, Medicaid enrollees are much less healthy and have heavier disease burdens than those covered by private health insurance. Because of the combination of serious health problems and low incomes, Medicaid enrollees often require more comprehensive benefits than those offered by regular private health insurance. A broader range of services, including preventive care and special services needed by those with disabilities or other chronic conditions, are necessary to address their health care needs. In addition, low cost-sharing requirements used in Medicaid and CHIP are critical so that low-income enrollees and their families can afford care.

Children. Table 1 compares the health status and health conditions of children covered by Medicaid or CHIP, compared with those covered by private health insurance. Data comes from the 2008 Medical Expenditure Panel Survey (MEPS), a nationally representative survey of non-institutionalized persons conducted by the Agency for Healthcare Research and Quality and the 2007 National Survey of Children's Health (NSCH) a nationally representative survey of non-institutionalized children under 18, conducted by the Centers for Disease Control and Prevention with support from the Maternal and Child Health Bureau of the Health Resources and Services Administration.² (All analyses presented in this report are appropriately weighted and adjusted for sampling and complex survey design concerns.)

The analyses demonstrate that children covered by Medicaid and CHIP tend to have poorer health status and tend to be more likely to have a history of serious health disorders than children who have private

FIGURE 1. Annual Change in Medicaid Enrollment (June to June) and June Unemployment Rates, 2007-2010



Source: Kaiser Commission on Medicaid and the Uninsured and Bureau of Labor Statistics

TABLE 1. Comparison of Health Status and Conditions for Children Under 18 with Medicaid/CHIP or Private Insurance

	Medicaid or CHIP	Private Insurance	
From 2008 Medical Expenditure Panel Survey (a) General Health Status Measures			
Any Serious Limitations (b)	4.6%	1.8%	*
Health Fair or Poor	4.0%	1.4%	*
Mental Health Fair or Poor	3.7%	1.3%	*
From 2007 National Survey of Children's Health (c) Health Conditions			
Child with Special Health Needs	23.6%	18.1%	*
Asthma	16.8%	12.5%	*
Two or More Dental Problems	12.3%	5.9%	*
Attention Deficit Hyperactivity	11.7%	7.0%	*
Developmental Delays	8.2%	3.6%	*
Anxiety Disorder	6.7%	3.7%	*
Depression	6.1%	2.6%	*
Bone, Joint, Muscle Problems	3.9%	2.8%	*
Hearing Problems	3.3%	2.8%	*
Autism	2.5%	1.4%	*
Vision Problems (Not Corrected with Glasses or Contact Lenses)	2.0%	1.3%	*
Brain Injuries, Concussion	1.8%	1.9%	
Seizure Disorder, Epilepsy	1.6%	0.8%	*
Diabetes (Juvenile)	0.7%	0.5%	

* Differences are statistically significant with $p < .05$

a. Covered by Medicaid/CHIP vs. private health insurance on Dec. 31, 2008.

b. Serious limitations include functional, cognitive, sensory or activity-limiting conditions, such as difficulty walking, work- or school-related limitations, difficulty remembering, blindness, etc.

c. Covered by Medicaid/CHIP vs. private health insurance at time of interview

Source: GW analyses of 2008 Medical Expenditure Panel Survey and 2007 National Survey of Children's Health

insurance. Data from the 2008 MEPS show that the publicly-insured children are almost three times as likely to have a serious limitation, such as problems walking, hearing or seeing or other functional, cognitive or sensory problems that make it difficult for a child to function in school or other settings, than privately-insured children and almost are three times as likely to be reported by their parent or caretaker as being in fair or poor health.

Data from the 2007 NSCH provide more detail about histories of specific health problems for publicly- and privately-insured children. Almost one-quarter (24 percent) of Medicaid/CHIP children can be considered children with “special health needs” -- meaning that they have a chronic health problem, such as asthma, developmental difficulties or other conditions that may require more intensive health, educational or social services – compared with 18 percent of privately insured children. A large number of serious health problems are more common among the publicly-insured children than privately-insured children, including: asthma, autism, dental problems, attention deficit hyperactivity disease, developmental delays, anxiety, depression, vision problems and seizure disorders/epilepsy.

Many of these problems, such as autism or developmental delays or mental health/behavioral problems are areas which private health insurance often does not cover very well. Moreover, private medical insurance often excludes coverage of non-medical services, like dental or vision services. Given the prevalence of serious health problems among children, it is fortunate that Medicaid coverage provides additional services under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) component of the program. EPSDT helps ensure that low-income children can get preventive, screening and diagnostic

services to help prevent and detect developmental and other health problems and to treat them when they are found. For example, under EPSDT, children covered by Medicaid are assured they can get dental, vision and behavioral services (even if they are not offered to adult Medicaid beneficiaries) and more specialized developmental services, such as those appropriate for autistic children or other children with developmental delays.

Adults. Table 2 shows that non-elderly adults enrolled in Medicaid or CHIP are three to five times more likely than those covered by private insurance to report serious functional, activity, cognitive or sensory limitations, such as difficulty walking, blindness or Alzheimer’s disease. They are also far more likely to report being in fair or poor physical or mental health

TABLE 2.
Comparison of Health Status and Diagnoses for Non-elderly Adults(18-64) with Medicaid/CHIP or Private Insurance, 2008. (a)

	Medicaid or CHIP	Private Insurance	
General Health Status Measures			
Any Serious Limitations (b)	46.7%	16.7%	*
Fair or Poor Health Status	32.3%	7.7%	*
Fair or Poor Mental Health Status	21.7%	3.9%	*
Specific Diagnoses			
High Blood Pressure	33.5%	24.6%	*
High Cholesterol	27.3%	27.6%	*
Coronary Heart Disease	6.6%	2.5%	*
Angina	3.5%	1.5%	*
Heart Attack	5.2%	1.8%	*
Other Heart Disease	13.1%	7.5%	*
Stroke	5.6%	1.2%	*
Emphysema	5.9%	1.1%	*
Asthma	18.3%	8.5%	*
Diabetes	12.6%	6.7%	*
Arthritis	25.4%	17.7%	*
Cancer	6.9%	6.8%	*
Pregnant in 2008 (Females Only)	19.3%	6.6%	*

* Differences are statistically significant with p < .05
a. Covered by Medicaid/CHIP vs. private health insurance on Dec. 31, 2008.
b. Serious limitations include functional, cognitive, sensory or activity-limiting conditions, such as difficulty walking, work- or school-related limitations, difficulty remembering, blindness, etc.

Source: GW analyses of 2008 Medical Expenditure Panel Survey

status. Their health status profile is paralleled by their health histories, which reveal two to five times higher rates of diagnoses of cardiovascular health problems, diabetes, stroke, asthma, and arthritis. Because Medicaid offers particularly generous coverage during pregnancy (most states cover pregnant women with incomes up to 185 percent of the poverty line), and providers have an incentive to enroll pregnant women, it is not surprising that about one-fifth of Medicaid-enrolled women reported being pregnant in the preceding year, about three times the rate among privately-insured women. (The data for non-elderly adults and the elderly are drawn from the 2009 MEPS.)

Elderly. For Medicare beneficiaries whose incomes are low enough to qualify for Medicaid (a group often referred to as “dual eligibles”), Medicaid covers long-term care and other services that are not part of the Medicare benefit package. Medicaid also pays Medicare deductibles and coinsurance to assure better financial access to care.

Table 3 compares Medicare beneficiaries with and without dual Medicaid coverage. (Those who are not dual eligibles may have Medicare alone or have Medicare supplemented with additional private coverage.) Dual eligibles experience particularly severe health problems. About four out of every five elderly Medicaid enrollees report serious health limitations and about two-fifths are reportedly in fair or poor health. Dual eligibles also experience a greater severity of specific illnesses and conditions than individuals enrolled in Medicare alone.

Disability. Disability status represents a major Medicaid eligibility pathway; millions of beneficiaries are eligible for Supplemental Security Income (SSI). Administrative data show that in FY 2008, approximately one-sixth of Medicaid beneficiaries were

TABLE 3.
Comparison of Health Status and Diagnoses for Elderly (65 or Older) Who Are Dual Eligibles and Medicare without Medicaid, 2008(a)

	Dual Eligibles	Medicare (no Medicaid)	
General Health Status Measures			
Any Serious Limitations(b)	79.1%	55.2%	*
Health Fair or Poor	43.9%	20.4%	*
Mental Health Fair or Poor	23.6%	9.3%	*
Specific Diagnoses			
High Blood Pressure	78.9%	66.6%	*
High Cholesterol	60.5%	62.5%	
Coronary Heart Disease	28.9%	21.3%	
Angina	16.3%	9.7%	
Heart Attack	15.8%	12.3%	
Other Heart Disease	31.3%	27.3%	*
Stroke	17.5%	12.7%	*
Emphysema	11.7%	6.4%	*
Asthma	14.6%	7.3%	*
Diabetes	35.3%	21.0%	*
Arthritis	64.7%	59.8%	
Cancer	20.9%	30.5%	

* Differences are significant with $p < .05$
 a. Covered by Medicaid and Medicare (dual eligibles) vs. those covered by Medicare, but not also enrolled in Medicaid, on Dec. 31, 2008.
 b. Serious limitations include functional, cognitive, sensory or activity-limiting conditions, such as difficulty walking, work- or school-related limitations, difficulty remembering, blindness, etc.

Source: GW analyses of 2008 Medical Expenditure Panel Survey

classified as disabled. Because of the complexities of the disability determination process, which typically requires medical examinations, it is not possible to use survey data to emulate those who would be determined as disabled on a programmatic basis, but MEPS data provides some insight.

Table 4 presents findings on individuals with serious health limitations or who report having poor health or mental health status (the most severe category); these individuals are described as “appear disabled.” As seen in Table 4, only half of those who appear to be disabled are SSI recipients. The other half of the apparently disabled people covered by Medicaid did not enroll through SSI and often entered under poverty- or welfare-related eligibility categories. A large share of those in Medicaid who are not considered “disabled” under SSI categories nonetheless have very serious health limitations that render them unable to function in the normal daily activities of life and work.

TABLE 4.
Measures of Disability Among Medicaid Enrollees, 2008

	Non-elderly Adults	Children	Elderly
Receive SSI Benefits	28.3%	3.0%	36.9%
Appear Disabled: Have a Serious Health Limitation or Report Poor Health or Mental Health Status	47.9%	5.1%	79.1%
Share of Those Who Appear Disabled Who Receive SSI Benefits	42.4%	58.9%	46.6%

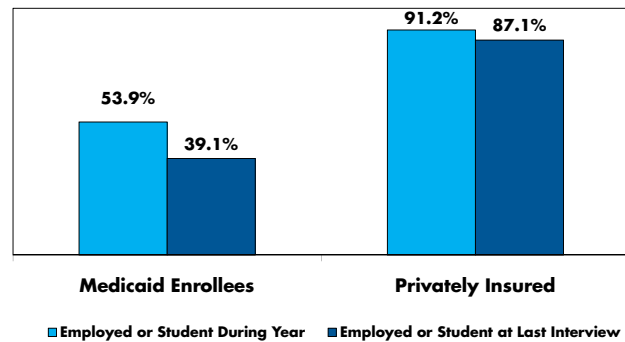
Source: GW analyses of 2008 Medical Expenditure Panel Survey. See notes for Tables 1-3 for criteria used.

Medicaid Helps Those Battered by the Recession

By its nature, Medicaid is a counter-cyclical program, intended to help more people when times are hard. The recent increases in Medicaid enrollment are testimony to the importance of Medicaid as a source of insurance coverage when unemployment is rising and private health coverage is falling. MEPS data also show that low-income Medicaid/CHIP recipients are more vulnerable to job loss than those with private insurance. A recession affects both people who are privately-insured and those enrolled in Medicaid, but it takes a much greater toll on Medicaid enrollees, who reside closer to the edge of an economic cliff.

As seen in Figure 2, while 54 percent of adult Medicaid enrollees either worked or were students for some period of 2008, only 39 percent were employed or a student at the date of their last interview. (Student status is only counted for those 18 to 23 years old.) More than *one-quarter* of Medicaid enrollees who were working or students had lost their jobs or schooling by the year's end. In contrast, the levels of job or school loss were much smaller among those privately-insured. Although 91 percent of the privately-insured either worked or were in school during the year, only 4 percent -- less than one-fifth as many -- had lost that

FIGURE 2.
Employment and Student Status for Non-elderly Adults Over the Year and at Last Interview, 2008



Source: GW analyses of 2008 Medical Expenditure Panel Survey

status by their last interview. The level of job loss was far smaller for those with private insurance than those covered by Medicaid.

These data are from 2008, the year in which the recession began. The seasonally-adjusted unemployment rate rocketed from 5.0 percent in January 2008 to 8.2 percent by January 2009 and peaked at 10.1 percent in October 2009. The data about job loss shown in Figure 2 illustrates that the recession had a strong impact on the number of people enrolled in Medicaid. Researchers at the Urban Institute estimated that a one percentage point increase in the unemployment rate increases the number of Medicaid enrollees by about one million, while

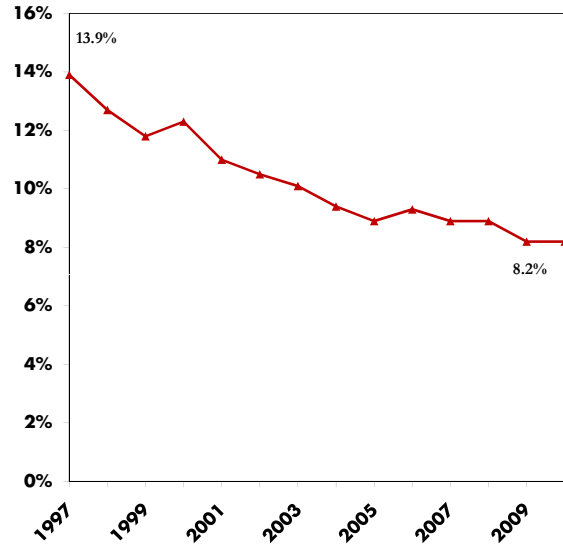
also increasing the number of uninsured people an equivalent amount.³

Medicaid and CHIP Reduce the Ranks of the Uninsured

A major goal of Medicaid and CHIP is to reduce the number of uninsured low-income people. The United States has been particularly successful in reducing the uninsurance rate among children, particularly because of the implementation in 1997 of CHIP and related expansions in Medicaid. These efforts included both eligibility expansions and innovative approaches to simplify enrollment and retention to increase participation of eligible children.⁴ Figure 3 shows the percentage of American children who are uninsured has fallen by almost half between 1997 and the first three quarters of 2010 (the most recent data reported by the National Center for Health Statistics' National Health Interview Survey, NHIS).⁵ Other analyses indicate that most of the decline occurred among low-income children who are the target populations for Medicaid and CHIP. The reduction in children's uninsurance occurred because of the growth in enrollment of children in Medicaid and CHIP and took place despite the erosion of private health insurance over this period.

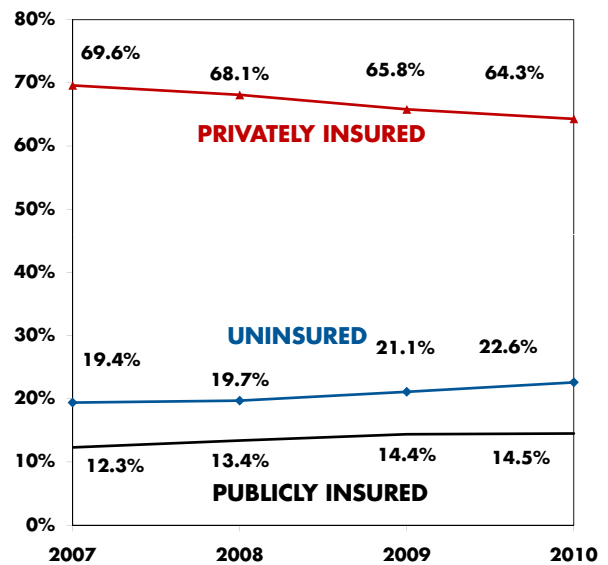
For non-elderly adults, there were no major national expansions of Medicaid eligibility over this time period. (Some states expanded coverage under so-called "waiver" programs during this period, although some later scaled back their expansions). Over the past few years, the principal factor that drove adults' Medicaid enrollment has been the weak economy, as discussed earlier. Figure 4 shows NHIS data from for 2007 through the first three-quarters of 2010 (again the most recent data available).⁶ The percent of non-

FIGURE 3.
Changes in the Percent of Children Who Are Uninsured, 1997 - 2010



Source: National Health Interview Surveys (2011)
The final point is for Jan-Sept. 2010.
In 2004, the methodology changed, slightly reducing the percent estimated as uninsured.

FIGURE 4.
Changes in Health Insurance Coverage for Non-elderly Adults, 2007- 2010



Source: National Health Interview Surveys (2011)
The final point is for Jan.-Sept. 2010.

elderly adults covered by public insurance (mostly Medicaid) rose from 12.3 percent to 14.5 percent, but these gains were not large enough to offset the steeper reduction in private insurance coverage from 69.4 percent to 64.3 percent. As a result, the percent of uninsured adults rose from 19.4 percent to 22.6 percent. Private health insurance coverage has been steadily eroding for many years, in large measure because of the high costs of health care. Increases in Medicaid and CHIP enrollment helped to stem these losses and keep the number of uninsured from rising at an even steeper pitch.

Medicaid and CHIP Improve Access to Health Care

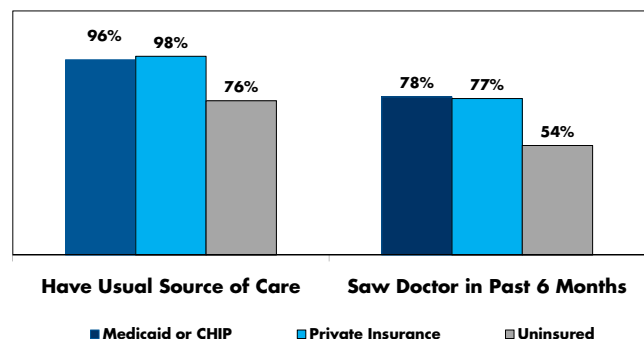
Medicaid and CHIP help ensure that low-income families have access to affordable health care. The actual benefits provided vary from state to state and differ for Medicaid and CHIP, but generally include a comprehensive array of preventive and acute care medical services, including physician and clinic services, inpatient hospital care, prescription drugs and laboratory and diagnostic services. In Medicaid, services for children are particularly comprehensive; under the Early, Periodic Screening, Diagnosis and Treatment component of Medicaid, children are eligible for a broad array of preventive services and for any care that is necessary to treat problems diagnosed, including dental and vision care. Medicaid also covers long-term care services, including home- and community-based services as well as nursing home care, for those who need them. In light of the low incomes of Medicaid and CHIP beneficiaries, cost-sharing levels (e.g., copayments, deductibles and premiums) are generally nominal.

To help keep the cost of Medicaid coverage affordable,

the amount Medicaid pays physicians is often lower than private insurance payments and some physicians are unwilling to care for Medicaid patients. Some critics therefore conclude that Medicaid patients are unable to get access to medical care.⁷ However, evidence suggests that Medicaid and CHIP improve overall access to care at levels that are broadly comparable to access provided under private health insurance and far better than access available to the uninsured. It is worth remembering that even when Medicaid patients are unable to get care from private physicians' offices, they can often secure quality care from safety net providers, such as community health centers, who serve all patients regardless of their ability to pay, and who therefore serve a disproportionate share of Medicaid and uninsured patients. Research shows that community health centers provide good quality primary care, which can, in turn, result in improved health and lower overall medical costs.^{8,9}

Children. Figure 5 shows two basic measures of health care access for children: having a usual source of care – a medical home where they can get routine medical care – and seeing a physician in the past six months. We present data from the 2009 National Health Interview Survey, a nationally representative survey conducted by the Centers for Disease Control

FIGURE 5.
Percent of Children (Age-Adjusted) Who Have a Usual Source of Care or Saw a Doctor in the Last Six Months, 2009



Source: 2009 National Health Interview Survey

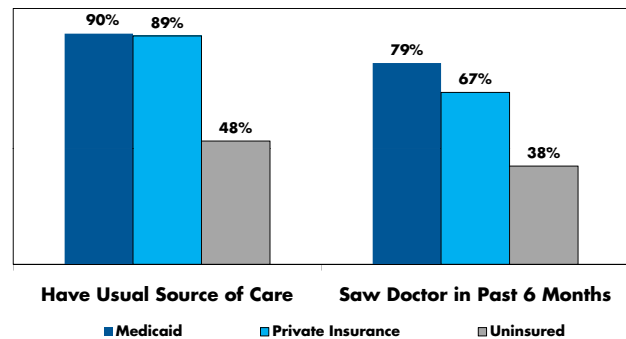
and Prevention.¹⁰ Almost all children covered by Medicaid or CHIP children have a usual source of care, as do almost all children with private insurance. Both groups are more likely to have a place to get medical care than uninsured children. Similarly, slightly more than three-quarters of publicly-insured and privately-insured children have seen a physician (or other health professional) in the last six months, while just about half of uninsured children received a doctor's care.

Adults. Figure 6 presents similar data for adults, also based on the same survey.¹¹ About nine out of ten publicly- and privately-insured adults had a usual source of care, compared to less than half of uninsured adults. A somewhat higher share of Medicaid covered adults (79 percent) saw a doctor (or other clinician) in the past six months than privately-insured adults (67 percent), compared to 38 percent of uninsured adults.

Other Research. Many other studies clearly demonstrate that Medicaid and CHIP strengthen access to care. Some of the best information in this area is based on studies conducted when states expanded or contracted health insurance eligibility, including cutbacks that occurred due to budget problems. Four examples:

- A study of Tennessee's Medicaid expansion in the mid-1990s involved a rigorous comparison of newly covered adults and children with an uninsured comparison population, statistically controlling for differences in health status, gender, race/ethnicity, family structure, income and other factors, such as attitudes toward health care. The study found that newly enrolled adults and children were far more likely to have a usual source of care, to get an appointment the same day or the next day after they called, and to always see the same

FIGURE 6.
Percent of Adults (Age-Adjusted) Who Have a Usual Source of Care or Saw a Doctor in the Last Six Months, 2009



Source: 2009 National Health Interview Survey

provider than the uninsured comparison group. The newly covered adults and children also were likely to receive care they needed (i.e., had fewer unmet medical needs or service delays) and to get medications. Substantially more women received Pap smears and more children received well-child visits when they were newly insured than the uninsured comparison group.¹²

- In contrast, another set of studies evaluated changes in Oregon's Medicaid program made in 2003-4 when the state raised cost-sharing and reduced benefits for adult beneficiaries in the Oregon Health Plan Standard program due to budget concerns. After the changes, almost half of the enrollees lost coverage and most of them remained uninsured for a protracted period. Those who lost coverage were subsequently less likely to use primary care, more likely to turn to emergency departments for care and more likely to have unmet health care needs, such as being unable to see a doctor or to get medications because of cost than those who remained covered.^{13 14} Those with chronic illnesses and lost coverage were the most likely to experience problems getting the health care services or medications they needed and incurred greater medical debt.¹⁵

- Insurance coverage can help reduce health care disparities. For example, in New York State, African-American or Hispanic children had higher levels of unmet medical needs than white, non-Hispanic children before CHIP began. After the children had been enrolled in CHIP for a year, the levels of unmet need fell for all the children and the gaps between African-American, Hispanic and white children disappeared.¹⁶
- Even if people who lose Medicaid can continue to get primary care at community health centers, the loss of insurance can lead to problems. A study in Massachusetts examined the consequences of losing Medicaid after welfare reform on patients receiving care at community health centers. Federally-funded health centers provide primary care to patients regardless of their insurance status, so they continued to serve the patients even when they lost insurance. While most of those losing Medicaid still had a usual source of care (the health center), they were less likely to get their prescribed medications and were more likely to forego care due to cost than patients who retained their coverage.¹⁷ While health centers provide primary care services, they cannot always assure that uninsured patients get prescription drugs or specialty medical care.

A host of other research also finds that the public insurance programs improve access to health care services and to medications for low-income populations:

- An analysis of the National Survey of America's Families found that 74 percent of children enrolled in Medicaid or CHIP had a preventive well-child visit in the past year, compared with 59 percent of privately-insured children and 41 percent of uninsured children. The study also found that

Medicaid and CHIP children were more likely to have seen a physician or health professional in the last year than privately insured or uninsured children.¹⁸

- Children with chronic health problems, such as developmental disabilities, autism, asthma, diabetes, mental retardation or attention deficit disorder, often called “children with special health needs,” have particular needs for health care services, so that they can function better, go to school and play with other children. Analyses of the National Health Interview Survey found that the CHIP expansions helped reduce unmet needs, such as problems getting medical care or medications, for children with special health needs.¹⁹
- Many children have mental or behavioral health problems too, but their needs often go unmet. Analyses of the National Survey of Children with Special Health Needs found that publicly-insured children were less likely to have unmet needs for behavioral health services than privately-insured or uninsured children.²⁰
- Many chronic health conditions can be effectively treated with proper medications and proper use can help prevent more severe problems that lead to emergency department use or hospitalization. Analyses of the California Health Interview Survey have found that adult Medicaid enrollees with chronic diseases were more likely to be taking appropriate medications than privately insured or uninsured adults with these conditions. Medicaid enrollees with heart disease were about two-thirds more likely to take appropriate medications than privately-insured adults and about twice as likely as uninsured adults. There were similar findings for Medicaid adults with high blood pressure or asthma.²¹

- Research also shows that Medicaid’s effectiveness can improve over time. For example, one study examined the adequacy of prenatal care for California women. The study found that the percent of pregnant women with an adequate number of prenatal visits was 62 percent for Medicaid women vs. 79 percent in 1980. But by 1999, the gap had virtually closed to 81 percent for Medicaid women and 85 percent for the privately-insured.²²
- An econometric study sought to control for any underlying differences (sometimes called “selection bias”) among mothers who have Medicaid versus other types of insurance. The study found that Medicaid improved access for care, compared to uninsured mothers, and brought access to levels comparable to those for privately insured women. The researchers found that controlling for selection bias often strengthened the impact of Medicaid on health access.²³

Medicaid Protects the Finances of Poor Families

While the most important purpose of Medicaid and CHIP is to increase access to health care and improve health, another fundamental purpose of any insurance plan – whether public or private – is to protect the finances of the beneficiaries. These cost-sharing limits are particularly important for low-income families and individuals, who have very limited disposable incomes. For a middle- or upper-income person, a \$100 payment for a medical visit or prescription drug is inconvenient but is likely affordable. For a low-income person, that same \$100 payment could require making a painful choice between medical care, eating, or paying the rent.

Public insurance programs, particularly Medicaid, have relatively low cost-sharing levels – that is, low out-of-pocket copayments, deductibles or premiums – compared to private insurance. Children with incomes below the poverty line are not charged any copayments. In many cases these days, the private health insurance that low-income families can afford has high deductibles (e.g., \$2,000) or high coinsurance levels (e.g., 30 percent or more). A substantial body of research has demonstrated that low-cost sharing is particularly important to preserve access to care for low-income beneficiaries.²⁴

Research consistently shows that that Medicaid protects the finances of low-income people:

- Low-income families of children with special health needs can face serious financial difficulties meeting the costs of their children’s health care, which may in some cases consume more than a fifth of their family incomes. Analysis indicates that families of children with special health needs who are covered by Medicaid or CHIP have lower financial burdens than families of children covered by private insurance.
- The elderly are also at particularly high risk of heavy financial burdens for medical care. Although almost all American seniors have Medicare coverage, cost-sharing levels can be substantial and some benefit gaps exist. Analyses of the Medical Expenditure Panel Survey have shown that seniors enrolled in both Medicaid and Medicare have substantially better financial protection than seniors with Medicare alone.²⁶
- A national study compared the relative financial burdens for non-elderly adults who had Medicaid, employer-sponsored coverage, or private non-group coverage. For those with incomes below

200 percent of the poverty line, those covered by Medicaid had lower financial burdens than those with employer-sponsored insurance; those with private non-group insurance had the highest out-of-pocket costs.²⁷ Non-group private insurance has particularly high burdens because the family must pay both the insurance premiums as well as out-of-pocket deductibles and copayments.

Medicaid and CHIP Can Improve Health

By improving low-income Americans' access to health care in an affordable fashion and financing care for those with serious medical problems, Medicaid and CHIP can improve the health of millions of Americans. A number of studies indicate the positive effects of Medicaid and CHIP on health. The evidence is clearest for child health, in part because of evidence accumulated during program expansions from the 1980s through the early 2000s:

- A recent Urban Institute study examined the relationship of Medicaid and CHIP expansions for children and child mortality (death rates) from 1986 to 2003. It examined mortality associated with illnesses or “external” causes (e.g., accidents, homicide, etc.). Because children tend to be healthy, mortality from external causes is somewhat higher than from illness. The expansion of Medicaid and CHIP eligibility was significantly associated with reduced external cause mortality. The evidence about effects on illness-related mortality was equivocal. The reductions in childhood mortality appeared to hold true for both black and white children.²⁸
- During the late 1980s and early 1990s, there were major expansions of Medicaid eligibility for low-income children and pregnant women. A key

study found that Medicaid expansions for children in the late 1980s and early 1990s contributed to a 5.1 percent reduction in childhood mortality.²⁹ Other research indicated that the Medicaid expansions led to an 8.5 percent reduction in infant mortality and a 7.8 percent reduction in the incidence of low birth weight.³⁰

- Researchers in New York studied the health of asthmatic children when they enrolled in CHIP and after they had been covered for one year. Children had fewer asthma attacks after being enrolled in CHIP for a year and the average number of attacks per year fell from 9.5 to 3.8. In addition, the proportion of children who were hospitalized due to asthma fell by roughly three-fourths.³¹
- Research conducted in Iowa, Kansas and California found that children who enrolled in CHIP tended to be healthier after being in the program for a year or more.^{32 33 34}

A variety of research studies also demonstrate the importance of Medicaid for adults' health:

- A federal study found that when areas had broader Medicaid eligibility, they had lower average rates of preventable hospitalizations for disorders such as diabetes or asthma. This held true for younger and older adults, as well as children.³⁵ A likely explanation is that Medicaid increases access to primary care services, which in turn may help people manage chronic diseases, so that they are less likely to be hospitalized.
- A study found that seniors with high blood pressure (hypertension) were more likely to have their blood pressure under control if they were on Medicaid than if they were uninsured or on Medicare without Medicaid.³⁶

- Research by Nicole Lurie and her colleagues found that after low-income adults lost their Medicaid coverage their health status deteriorated, compared to those who retained coverage. In particular, those with hypertension were less able to control their blood pressure than those who remained insured.³⁷
- Research using the National Health and Nutrition Examination Survey found that Medicaid patients were more likely to have their blood pressure controlled than uninsured patients and as likely to be controlled as privately insured patients.³⁸

A more definitive study of the effects of Medicaid on adults' health status is now being conducted. In 2008, the state of Oregon found that it had funds to restore Medicaid (Oregon Health Plan) coverage to a limited number of people and decided to restore benefits using a lottery process. This creates the opportunity for a randomized experiment, one of the most rigorous research methods, to assess the impact of insurance for low-income adults' access to care, health status and other outcomes. The study is being conducted by researchers from a number of universities with cooperation from the state.³⁹

Nonetheless, this does not mean that the quality of care provided under Medicaid could not be improved. It could be and should be. A landmark study by RAND researchers found that only 55 percent of adult Medicaid enrollees received recommended medical care services; while this indicates gaps that need to be addressed in Medicaid, results were identical for those with private insurance.⁴⁰ The Children's Health Insurance Program Reauthorization Act and the Affordable Care Act establish processes to more carefully measure and monitor the quality of care for children and adults, which contribute to improving the quality of care in Medicaid.

Does Medicaid Lead to Worse Outcomes?

Some critics, such as the American Enterprise Institute's Scott Gottlieb, observe that in some studies Medicaid participation is associated with worse outcomes, such as higher mortality, than those with private insurance or even those who are uninsured.⁴¹ They therefore conclude that Medicaid may be *causing* worse outcomes and is worse than being uninsured.

Such a conclusion is unwarranted. It fails to distinguish between causation and correlation, between Medicaid being a cause of poorer outcomes and Medicaid simply being a marker of other underlying problems. This fallacy has been long understood. The Institute of Medicine and researchers at the American Cancer Society have explained that a critical flaw in viewing Medicaid as a cause of poor outcomes is that patients often become eligible for Medicaid as a result of being sick.^{42 43} *It is not that Medicaid enrollment causes ill health, but that ill health leads to Medicaid enrollment.* This confusion can cause a spurious correlation between Medicaid and poor outcomes. A recent commentary in the *New England Journal of Medicine* also concluded that the analyses that Medicaid increases mortality are flawed.⁴⁴ Gottlieb even cited a recent paper about higher mortality among patients with head and neck cancer as evidence of Medicaid's harmful effects, but failed to disclose that the authors of the paper also explained that "Medicaid enrollment often happens for an uninsured patient at time of diagnosis...introducing some misclassification in the statistical analysis."⁴⁵

Consider the case of a person with an incurable disease. This person may initially have employer-sponsored insurance, but because of illness loses his job or retires and loses private insurance. He is then uninsured for a spell. In the final stages of disease

progression, he enters a hospital, which diagnoses the disease. In order to collect insurance reimbursement, the hospital also helps him apply for Medicaid and he is enrolled. He eventually dies while covered by Medicaid. In an observational study, he would be counted as a Medicaid patient, even though at earlier stages this person could also have been considered a privately insured or an uninsured patient. Medicaid was not the cause of his death, but instead helped support care and comfort for a dying patient.

Medicaid patients are often diagnosed with cancer in late stages of the disease, which increases the risk of poor outcomes. When patients are enrolled in Medicaid for a longer time (and at an earlier stage of the disease), better outcomes are possible. One study found that female breast and cervical cancer patients enrolled in Medicaid for longer periods of time had less severe cancers than those enrolled for shorter periods.⁴⁶ Another study found that cancer patients enrolled in Medicaid *before* their cancer diagnoses lived longer than those who enrolled only *after* diagnosis.⁴⁷ In fact, being enrolled in Medicaid in advance can help promote screening and earlier detection of cancers.⁴⁸ The policy goal should not be to eliminate Medicaid, but to try to ensure longer and more continuous insurance coverage, before people get sick, to give them the best chance to get preventive, primary and specialty health services to help them avoid becoming sicker, as well as to support the best care when they are sick.

Another problem is that it is difficult for studies to adequately control for all the risk factors that may lead to poorer outcomes. As demonstrated earlier in this paper, Medicaid patients tend to have poorer health than those with private insurance and are, thus, prone to greater co-morbidities. Medicaid enrollees often face other serious hardships that make it harder

to cope with their daily needs. Poor families, such as those on Medicaid, often have multiple problems, such as crowded or insecure housing, food insecurity/hunger, and utility terminations, such as loss of electricity, gas or telephone service.^{49 50} Problems of low education or literacy, inadequate social supports or limited transportation are also common. Taking medications regularly can be harder if a person cannot afford the copayment for the prescription, does not have transportation to get to the pharmacy or must worry about how to eat or where to sleep. Maintaining a healthy diet to reduce risks of diabetes or heart disease can be a challenge if a person lives in a “food desert” where grocery stores are scarce or over-priced. The additional hardships faced by many Medicaid enrollees also place their health at risk and are not caused by Medicaid, but may be correlated with its presence.

The bottom line is that evidence clearly demonstrates that people have better access to health care services and to medications when they have Medicaid than when they are uninsured. It is difficult to conceive of a mechanism by which *better* access to health care can lead to *worse* health outcomes on a broad basis. It is possible to imagine individual cases where mishaps, such as hospital-acquired infections or medical errors, lead to poorer health outcomes, but it is almost impossible to describe a plausible mechanism by which Medicaid could make health worse on a broad basis. The more reasonable reading of the evidence is that conclusions about the harmful effect of Medicaid are flawed because of misclassification of cases or spurious correlations.

Medicaid and Continuity of Coverage

Another issue associated with health outcomes is discontinuity of coverage. Because Medicaid has strict income limits and there can be cumbersome paperwork procedures for periodic reenrollment, Medicaid beneficiaries often “churn” off and on coverage, insured for several months, followed by a spell without insurance, then back on again. Medicaid beneficiaries tend to have less stable insurance coverage than those with employer-sponsored coverage or Medicare, which do not generally have income limits or require periodic reapplications.⁵¹ Even brief insurance gaps can disrupt the continuity of medical care and make it harder for patients to get effective preventive and acute care, which can increase the risk that they become sicker and need expensive emergency or hospital care. Studies in California have shown that when Medicaid enrollees have longer, more continuous coverage, they are less likely to be hospitalized for preventable causes like conditions like diabetes or asthma, also called “ambulatory care sensitive” conditions.^{52 53} Research in Utah found that schizophrenic patients were more likely to be hospitalized after interruptions in Medicaid coverage, suggesting that more stable Medicaid coverage helps them avoid hospitalization.⁵⁴

Changes enacted in the Affordable Care Act should improve coverage, which could lead to improved continuity and quality of care. First of all, the Affordable Care Act will expand adults’ Medicaid eligibility to 133 percent of the poverty level. One of the factors that promotes churning in Medicaid is the restrictive income eligibility levels that are common. For example, a parent in Texas is eligible for Medicaid only if her income is below 26 percent of the poverty line (less than \$100 per week for a family of three).⁵⁵ With such a narrow income limit, even a slight change in earnings can cause a person to become ineligible.

By broadening the income levels up to 133 percent of poverty, fewer people should lose eligibility because of minor fluctuations in income. In addition, the health reform law also calls for coordinated and simplified enrollment procedures for Medicaid, CHIP and the affordability credits (tax subsidies) available for the health insurance exchanges. A broader, simpler and better coordinated process for these major insurance programs should also promote more continuous coverage. Moreover, this change should also promote better coordination with private insurance, so when people gain income and lose Medicaid, they will be better able to transition smoothly into private insurance and continue to have access to care. These changes will promote greater continuity of insurance coverage and better outcomes.

Medicaid, Flexibility and Innovation

Some governors have complained that Medicaid is inflexible and that states need greater authority over Medicaid, such as through block grants.^{56 57} Congressman Paul Ryan, Chairman of the House Budget Committee, described Medicaid as an “onerous one-size-fits-all approach.”⁵⁸ In fact, Medicaid provides considerable flexibility to states, which administer the program with federal funding support and broad federal guidelines. States enjoy substantial flexibility about eligibility, what benefits to provide, how to structure their programs and how to pay health care providers. States may customize their policies using a variety of state plan amendments and waivers from standard federal requirements.

States are particularly concerned about Medicaid because of budgetary worries. State revenues and budgets are still weak because of lingering effects of the recession and they are facing mounting state

Medicaid costs; they remain in the midst of the worst fiscal crisis in decades. Their financial problems have been compounded by the premature termination of federal fiscal relief, which provided additional federal Medicaid matching funds from October 2008 to June 2011. The 2009 Recovery Act increased the federal Medicaid matching rate on a targeted basis among states, based on their current economic situation and the effort was temporarily renewed, but ends after June 2011, even though states are still having severe budget problems. The result is that, effective July 2011, states will have to shoulder a much larger share of total Medicaid costs, despite their continuing economic problems. The U.S. Government Accountability Office has noted that it is possible to revise the Medicaid matching rate system to include targeted, counter-cyclical changes, akin to the approach used recently, but on a permanent basis, so that states know they can always get some additional federal support when their economies sour.⁵⁹

It is important to remember that Medicaid is already a very low-cost system for providing health care – much less expensive than private insurance – and that Medicaid per capita costs are rising slower than private health insurance costs, as will be discussed in more depth in the next section. The major force driving Medicaid costs up now is rising enrollment, which is primarily caused by the recession, as previously discussed in this report. On a longer term basis, the aging of the baby boomers will add to the number of elderly and disabled beneficiaries, who are the most costly component of Medicaid. Block granting Medicaid may allow states to stop enrolling low-income people, but it will not resolve these underlying macroeconomic forces. If the number of people who are uninsured rises appreciably, they will delay care until they are sicker and eventually be forced to use more expensive forms of care such as emergency rooms or

hospitalization. Frail seniors or those with disabilities who require long-term care services, whether in their homes or in a nursing home, would be left unable to care for themselves and would experience major health problems and reductions in the quality of their remaining lives.

Because of the joint federal-state role in financing Medicaid, both the federal government and states pay for a portion of Medicaid and both have an incentive to see that total program costs are held down. One of the consequences of the combination of economic incentives and structural flexibility is that Medicaid has been one of the most innovative forces in the American health care system for many years.

State Medicaid programs have served as pioneers in reforming the health care system for many years. As Steve Somers and Michael Sparer have noted: “These are heady times for big concepts for transforming health care delivery, but there is not always an obvious, real-world mechanism for implementing these innovations at scale. Just look more closely at many of the most-favored concepts of the day: covering the uninsured; accountable care entities; patient-centered medical homes; public reporting and performance measurement; pay-for-performance; health information technology for meaningful uses; reducing racial and ethnic disparities; and integrated preventive care for patients with multiple chronic conditions. For each of these innovations, somewhere across the country — and in some cases, in many places — Medicaid is in fact already doing it.”⁶⁰

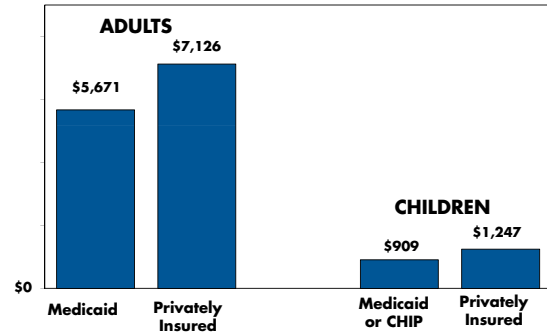
Medicaid Is Already Very Lean

Perhaps the most serious complaint about Medicaid is that it is expensive and its costs are rising quickly. While there is some validity to these concerns, it is critical to remember that this is true not just for Medicaid, but for health care in general, whether public or private. A fundamental goal of the Affordable Care Act was to make health care more rational, transparent and equitable, broadening health coverage to insure more people, but also to help bend the cost curve over time and to do so, while reducing overall federal costs. The non-partisan Congressional Budget Office found that the Affordable Care Act reduced overall federal expenditures substantially over the next decade and beyond.⁶¹

Medicaid is already an exceptionally low cost insurance program compared to private insurance. Analyses of the Medical Expenditure Panel Survey found that, after controlling for health status, age, gender, income, and other factors, the average per person annual cost of serving an adult on Medicaid was 20 percent less than under private insurance and the annual cost of serving a child on Medicaid or CHIP was 27 percent less than under private insurance (Figure 7). In addition, because Medicaid and CHIP have lower cost-sharing levels, the out-of-pocket costs that beneficiaries must bear was several times lower than the amounts required under private insurance.⁶² That is, Medicaid costs less overall and creates less of a financial burden for low-income families. Medicaid is a very cost-effective way to provide coverage for low-income people.

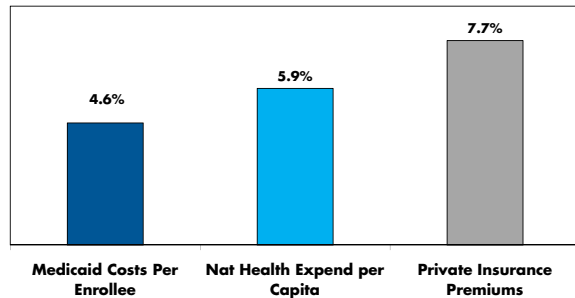
In addition, Medicaid’s per person costs have risen at a slower pace than private health insurance premiums. As seen in Figure 8, between 2000 and 2009, the annual growth rate for private insurance premiums was about two-thirds higher than for Medicaid. Medicaid

FIGURE 7.
Estimated Costs per Person, if Covered by Medicaid vs. Private Insurance (Adjusted for Health and Other Factors, 2005)



Source: Ku and Broaddus (2009)

FIGURE 8.
Changes in Medicaid Costs Per Enrollee Compared to National Health Expenditures per Capita and Private Health Insurance Premiums, 2000-2009



Source: Kaiser Commission on Medicaid and the Uninsured (2011)

has also held cost growth much lower than overall growth in national health care costs per capita.⁶³

Medicaid is already an extraordinarily lean program, especially given its important role in providing coverage for a low-income, high risk population. Because there is little “fat” in Medicaid, major cutbacks in funding must almost certainly cut into muscle, blood and bone instead. It is unrealistic to expect that a block grant would enable states to become substantially more efficient without leading to major reductions in either the number of people served, the scope of benefits provided or the amount paid to healthy care providers or increases in costs shifted to low-income beneficiaries.

Conclusions

The evidence presented in this analysis shows that Medicaid and CHIP are effective and efficient health insurance programs that meet the health and financial needs of tens of millions of low-income children, adults, seniors and people with disabilities, many of whom have serious health problems. Like other insurance, Medicaid and CHIP would benefit from certain improvements, most significantly, continuity of coverage guarantees greater incentives to providers to integrate their clinical care activities in order to improve health care quality and efficiency. At the same time, even a brief review underscores the role played by Medicaid and CHIP in responding to a broad range of health system needs that private health insurance lacks the flexibility to accommodate: unemployment and poverty, an aging population, and serious health conditions that require long term care and that commercial insurance is not designed to cover. There have been – and probably will continue to be – a number of proposals to reshape Medicaid and CHIP

in the future. The U.S. House of Representatives recently passed a federal budget resolution, crafted by House Budget Committee Chairman Paul Ryan, that proposes to cut Medicaid by \$1.4 trillion (compared to current law, as estimated by the Congressional Budget Office) over the next decade, both by cancelling the expansions enacted under the Affordable Care Act as well as by cutting another \$771 billion in the rest of the program. Ryan proposed to replace Medicaid with a block grant to states.⁶⁴ It appears that this proposal also calls for the termination of the CHIP program. As with any budget resolution, the budget outlines funding limits for various committees of Congress, but the final decisions would need to be made by subsequent legislation. Both President Obama and Senate leadership have expressed their opposition to this budget.

A number of analyses have already discussed potential impacts of such major changes under this proposal. The Congressional Budget Office (CBO), for example, noted: “Chairman Ryan’s proposal would shift some of the burden of Medicaid’s growing costs to the states.” It went on to explain, “because of the magnitude of the reduction in federal Medicaid spending under the proposal, however, states would face significant challenges in achieving sufficient cost savings through efficiencies to mitigate the loss of federal funding.” They could be forced to cut spending for other programs, increase revenues or make significant cuts in Medicaid, such as by limiting eligibility and enrollment, reducing benefits, further lowering how much is paid to health care providers, or raising cost-sharing levels for low-income beneficiaries.⁶⁵

If such a tremendous reduction in federal support occurs, most states would have little recourse but to adopt massive cuts in services. Over the past several years, states have repeatedly scoured their Medicaid

programs and sought to find ways to make the program more efficient or more effective; it seems hard to believe that a block grant will suddenly enable them to be more efficient, although it could give them authorization to substantially reduce services, cut enrollment or increase the amount that low-income beneficiaries must pay for services.

The scope of cutbacks could be enormous. To illustrate the potential impact of the House proposal, we can compare the number of people who might be served with the planned level of federal Medicaid funding, compared to CBO's estimate of the number who would be served under current law.⁶⁶ Since the Ryan proposal would create a block grant, it is not possible to be certain of how much money states would contribute, nor how much the cost per enrollee would be. A recent report by the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured estimated the potential impacts of the House budget plan on a state-by-state basis.⁶⁷ The report illustrated three scenarios about the impact on enrollment under the House budget plan:

1. If cuts made were distributed evenly across the caseload, 36 million fewer people would be covered by 2021;
2. If states can modestly reduce per person cost growth, 31 million fewer would be enrolled;
3. If states modestly reduce per person cost growth, but focus cuts on adults and children (as compared to the elderly or people with disabilities), 44 million fewer individuals would be covered.

Our independent estimates confirm the potential range of the impacts. Our scenario assumed that the states continued to contribute the historical

average share of total costs (43 percent) and had

costs per enrollee that are equivalent to the current projections. We estimated that by 2021 Medicaid would serve about *40 million fewer people* over the course of the year than are currently projected by the CBO.⁶⁸ Such a loss exceeds the total population of 23 states combined. Since children constitute slightly less than half of current Medicaid beneficiaries, it is reasonable to expect that a large share of those losing coverage would be children, but the actual number and mix of those who would lose coverage would depend on actual state policies under a block grant. These are conservative estimates, since it is plausible that many states would contribute less than the historical average share and because the future caseloads might be even tilted toward high cost elderly or disabled enrollees. CBO also compared Medicaid expenditures, excluding the amounts that are expected for the Medicaid expansion included in the Affordable Care Act; it projected that Ryan's proposal would cut Medicaid funding by 35 percent by 2022 and 49 percent by 2030.⁶⁹

The evidence reviewed in this report demonstrates that Medicaid has been a vital and effective program in addressing the health and financial needs of millions of children and other vulnerable Americans. The nation has made great strides improving health insurance coverage and health care access for millions of children and protecting the health and finances of families, the elderly, and people with disabilities and we should avoid taking actions that will cause this progress to be reversed. While the government must periodically review the costs and scope of public programs and policies, it is important to understand that Medicaid has been a cost-effective, vital lifeline to tens of millions of children, their families and other needy populations.

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68 This estimate is based on the estimated federal cost per enrollee (as measured over the course of a year), based on the CBO's March 2011 Medicaid baseline. It assumes that states continue to contribute 43 percent of the total cost of care (the historical average match rate, excluding adjustments for fiscal relief and changes under the Affordable Care Act such as the expansion for adults). Using an adjusted cost per enrollee and the level of federal funding under the Ryan proposal, we estimate that about 55 million people would be served in 2021, as compared to the 95 million projected under current law by CBO. This is a conservative estimate of the reduction, since CBO's current law estimate assumes that a lower share of enrollees in 2021 are elderly or people with disabilities; without the planned Medicaid expansion, actual adjusted costs would be higher. In addition, it is plausible that, under a block grant, states would contribute less than the historical average of 43 percent of total costs. For example, if we used CBO's March 2010 baseline (which did not include the impact of Affordable Care Act), the caseload reductions would be much deeper than described above.

69 Letter to Paul Ryan, *op cit*.

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