New Hampshire Fiscal Policy Institute

issue brief

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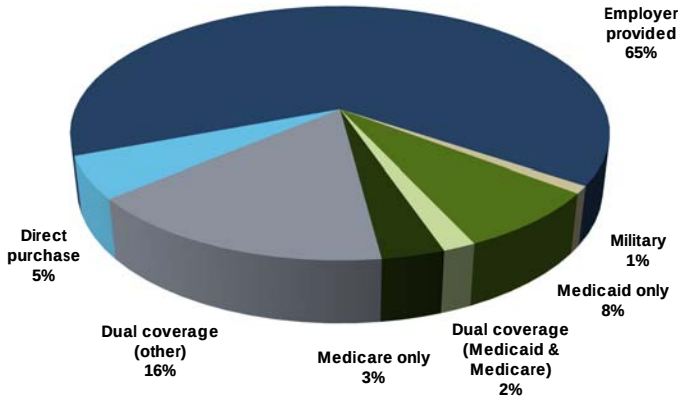
Medicaid: A Key Source of Insurance in New Hampshire

As state and federal policymakers come to grips with substantial budget shortfalls – both now and into the future – one public service that has received considerable attention is Medicaid, a decades-old program that provides health insurance coverage to low-income children and families, elders, and people with disabilities. More than 129,000 New Hampshire residents relied on Medicaid during FY 2009,[i] representing roughly one out of every ten people in the state with some form of health insurance during that time.[ii] Medicaid in New Hampshire provides its members with access to doctors' appointments, hospital care, prescription drugs, and medical equipment such as wheel chairs and insulin pumps, all of which are fundamental to success in school and work.

Medicaid is a Key Source of Health Insurance in New Hampshire
Insured Population in New Hampshire, by Source of Insurance, 2009



Source: US Census Bureau, American Community Survey, 2009

While New Hampshire administers its own Medicaid program, it shares the costs of the program with the federal government. In simple terms, for every dollar in Medicaid costs New Hampshire incurs, the federal government covers a minimum of 50 cents. As a result, reductions in Medicaid spending represent a particularly inefficient – and thus particularly damaging – method of balancing the state budget, since, in order to achieve, for instance, $10 million in state savings, New Hampshire must reduce total Medicaid spending by at least $20 million. Moreover, budget cuts to Medicaid do not erase the medical needs of Medicaid members – they shift the cost of such care to hospitals, to other medical providers, or to the privately insured. This brief seeks to answer a few basic questions about the framework of New Hampshire's Medicaid program, the families and individuals it serves, and its funding structure and explores some of the potential consequences of significant reductions to the program.

Who is Eligible for Medicaid in New Hampshire?

Medicaid Eligibility Varies by Income
New Hampshire Income Eligiblity Limits, 2011

Eligibility Category	Income Limit as Percentage of Federal Poverty Level (FPL)	Income Limit in Dollar Terms (2011)
Parents	40%	$4,356
Disabled	76%	$8,276
Seniors	76%	$8,276
Children (Ages 1-18)	185%	$20,146
Pregnant Women	185%	$20,146
Working Disabled	450%	$49,005

Source: New Hampshire Medicaid Annual Report, FY 2009

Created by federal statute in 1965, Medicaid is a means-tested, state-run health insurance coverage program for certain groups of low-income people.[iii] In general, each state designs and administers its own Medicaid program within a broad federal framework. Eligibility typically rests on the individual having a sufficiently low income and falling into one of three categories: the disabled, the elderly, or children and families.[iv] However, income eligibility levels vary across eligibility categories. The figure above shows a variety of select categorical and financial eligibility levels within the existing New Hampshire Medicaid program. It is also worth noting that even if someone meets both the financial and categorical eligibility criteria, he or she must still apply to become a Medicaid member; no one is automatically enrolled in New Hampshire Medicaid.

Eligibility is determined both by federal requirements and by state policy choices. Federal law mandates that all state Medicaid programs cover certain eligibility groups, but also specifies additional, optional eligibility categories to which states may choose to provide coverage and for which they can receive federal matching funds. The figure at right outlines mandatory and select optional Medicaid eligibility groups and highlights some of the optional categories New Hampshire chooses to cover.

Mandatory and Select Optional Medicaid Eligibility Groups

Threshold by Eligibility Group	Mandatory (M) or Optional (O)	New Hampshire
Children		
Under age 6 up to 133% FPL	M	✓
Over age 6 up to 100% FPl	M	✓
Under age 6 over 133% FPL	O	✓
Over age 6 above 100% FPL	O	✓
Severely disabled who are cared for at home but qualify for institutional care	O	✓
Pregnant Women		
Up to 133% FPL	M	✓
Over 133% FPL	O	✓
Parents		
Up to 42% FPL	M	✓
Elderly		
SSI beneficiary under 74% FPL	M	✓
Below 100% FPL but above SSI level	O	✖
Disabled		
SSI beneficiary under 74% FPL	M	✓
Below 100% FPL but above SSI level	O	✖
Working disabled up to SSI income limit	M	✓
Working disabled above SSI income limit	O	✓
Medicare Buy In		
100-135% FPL plus asset test	M	✓

Source: New Hampshire Medicaid Annual Report, FY 2009

What Benefits Does Medicaid Provide in New Hampshire?

Federal law also requires that states provide a minimum benefit package under their Medicaid programs, but in addition to these so-called "mandatory benefits", there are a number of optional benefits states may elect to offer to their Medicaid members and for which they can receive federal matching dollars. The figure at left lists both mandatory and select optional Medicaid benefits.[v] As the figure suggests, Medicaid not only pays for traditional "doctors' appointments," but also for transportation services to providers, home and community based care for the developmentally disabled, medical equipment like wheelchairs and insulin pumps, and prescription drugs. It is unlikely that Medicaid members would be able to purchase these services and products without assistance. The absence of health care coverage for these benefits can affect the ability of members to remain well and mobile, which in turn determines the ability of members and their families to remain employed and independent.

Mandatory and Select Optional Medicaid Benefits

Mandatory Benefits	Offered in New Hampshire	Frequently offered in other states
Physician services		
Laboratory and X-rays		
Outpatient hospital		
Inpatient hospital		
Federally qualified health clinic		
Rural health clinic		
Intermediate care Facilities		
Nursing Care facility for individuals 21+		
Home health care for those entitled to nursing facility care		
Nurse midwife services		
Pediatric and family nurse practitioner services		
Family planning services and supplies		
Optional Benefits		
Prescription drugs	✓	✓
Prosthetics	✓	✓
Durable medical equipment and medical supplies (wheelchairs, insulin pumps, etc.)	✓	✓
Rehabilitative services (mental health and substance abuse)	✓	✓
Medical care by other providers (speech therapy, physical therapy, occupational therapy)	✓	✓
Intermediate care facility for mentally retarded	✓	✓
Clinic services	✓	✓
Adult dental services/dentures		
Home and community based waiver services	✓	✓

Sources: New Hampshire Medicaid Annual Report, FY 2009; Kaiser Family Foundation

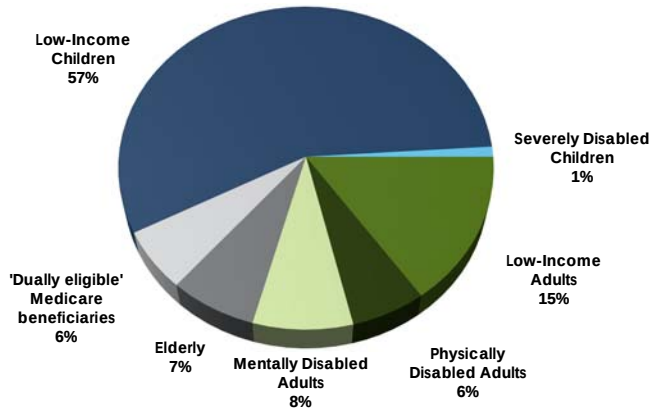
Of note, the absence of health care coverage will not alleviate the needs of Medicaid members for such services. Rather, members will still seek access to health care, albeit likely later than would otherwise be the case and therefore with more advanced conditions. Hospitals and medical providers will address these more acute health care needs, but without being reimbursed for them by the state; rather than absorb these costs directly, they will likely shift them to privately paying customers. In short, then, the cost of care for the privately insured will likely rise to cover the cost of care for the under- or uninsured, if adequate Medicaid coverage is unavailable.

Who is Enrolled in Medicaid in New Hampshire?

More than 129,000 Granite Staters relied on Medicaid services in FY 2009 – representing almost 1 in 10 New Hampshire residents with some form of health insurance.[vi]

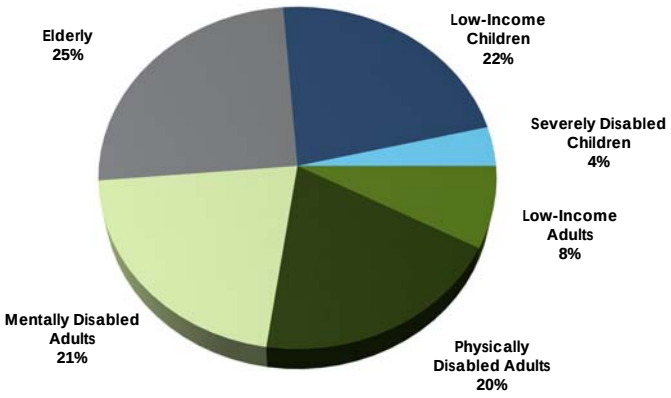
Children Make Up Most of the Medicaid Membership…

New Hampshire Medicaid Membership, by Eligibility Group, FY 2009



… but Costs are Concentrated Among Elderly, Disabled

New Hampshire Medicaid Provider Expenditures, by Eligibility Group, FY 2009



Source: New Hampshire Medicaid Annual Report, FY 2009

As the figure at left shows, children made up 58 percent of the New Hampshire Medicaid population in FY09. Adults aged 19 to 64 represented 29 percent of Medicaid members, while 7 percent were aged 65 or older.[vii] Slightly more than half of all Medicaid members were women and girls.

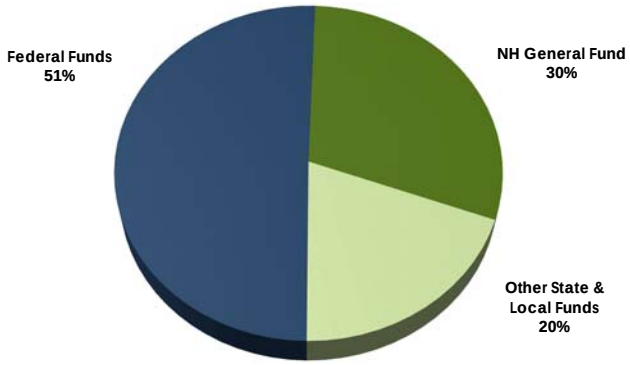
As seen at left, the disabled and elderly – that is, people with significant and long-lasting health care needs – comprised only 22 percent of Medicaid membership, but accounted for 70 percent of program expenditures, due to such needs.[viii] National research suggests that Medicaid is becoming one of the primary sources of extended long-term care, a trend that may be reflected here and that bears monitoring as the baby boomer generation begins to enter retirement.[ix]

How is Medicaid Financed?

New Hampshire and the federal government share in the cost of Medicaid, with the federal government paying a fixed percentage, at least 50 percent of the total cost, for Medicaid members' care. For New Hampshire, the base federal matching rate is 50 percent. (New Hampshire's matching rate may be lower than other states because it is calculated based on a state's

Medicaid Jointly Financed by New Hampshire & Federal Governments

Composition of NH Medicaid Funding, FY 2009



Source: NH Office of Medicaid Budget and Policy

per capita income.) Therefore, for every dollar New Hampshire spends on Medicaid, the federal government contributes another dollar toward our Medicaid costs.

In FY 2009, total spending on New Hampshire's Medicaid program was approximately $1.36 billion. However, due in part to such shared responsibility for the program, only about 30 percent of those costs – or roughly $400 million – were borne by the state's General Fund. Federal funds covered slightly more than 50 percent of program expenditures, while other state and local funds - primarily a tax on hospitals and county reimbursements for nursing home care - covered the remainder.[x] In other words, New Hampshire covers 129,000 people in its Medicaid program, but pays for as little as 30 percent of their care.

Provider payments constituted approximately 77 percent of total Medicaid expenditures in FY 2009. Put another way, Medicaid directed $1.05 billion to New Hampshire health care providers (such as hospitals, physicians, and care facilities) to reimburse them for health care services provided to Medicaid members. This amount is equivalent to approximately 9.8 percent of personal health care expenditures for all of New Hampshire in 2008.[xi] Personal health care expenditures consists of payments for all services and products purchased for the health care of individuals and includes hospitals, nursing homes, prescriptions, medical equipment, physician care, surgeons, and other medical supplies.[xii] Health care expenditures represent a growing share of New Hampshire's economic activities. Medicaid, in turn, is a vital component of that economic activity.

What are Some of the Consequences of Reducing Medicaid Expenditures?

Due to the fifty percent federal match involved in funding Medicaid, to achieve General Fund savings through Medicaid reductions, lawmakers would have to cut 2 dollars from the Medicaid program in order to reduce General Fund spending by 1 dollar. This financing dynamic could produce particularly severe consequences not only for Medicaid members, but for the New Hampshire economy as well.

New Hampshire's hospitals provide one potential illustration of such outcomes. At present, New Hampshire has 26 hospitals, 13 of which are known as Critical Access Hospitals (CAHs). Critical Access Hospitals are rural hospitals with 25 or fewer beds that are designated by Medicare - due in part to their small sizes and rural locations - to receive cost-based reimbursement. In New Hampshire, CAHs tend to have higher proportions of publicly financed patients than non-critical access hospitals; thus, Medicaid funds are a critical element of their total stream of revenue.[xiii]

At the same time, Critical Access Hospitals are frequently significant employers in their respective parts of the state, generating both primary and secondary jobs. In fact, a 2009 study estimates that, on their own, Critical Access Hospitals produce 10,300 jobs (both primary and secondary), which, in turn, represent some $469 million worth of income in the state of New Hampshire.[xiv] Consequently, significant reductions in Medicaid funding may mean reducing access to health care and a primary source of regional employment, as well as impairing those industries and services that develop in response to the demands of a large employer and its personnel.[xv] For the 13 other non-rural acute care hospitals, which serve significant Medicaid patient caseloads as

well, reductions in Medicaid funding foster health care cost increases because hospitals and providers cost-shift to avoid absorbing losses related to care for the uninsured and underinsured.

Reducing or eliminating particular Medicaid services may also reduce Medicaid-driven revenue streams. For instance, prescription drug expenditures provide a revenue stream to the state through Medicaid pharmacy rebates. More specifically, under the federal Omnibus Budget Reconciliation Act of 1990, pharmaceutical manufacturers must rebate to the federal and state governments a portion of their revenues from sales to Medicaid patients, a requirement that has yielded at least $13 to $15 million per year for the state.[xvi] Reducing or eliminating prescription drug expenditures would decrease the pharmacy rebate revenue generated, thereby increasing the extent of General Fund reductions necessary to balance the budget.

Conclusion

Medicaid is a key source of health insurance in New Hampshire, ensuring access to critical medical services for thousands of New Hampshire's children, elderly, and disabled. It also plays an important role in the state's economy, due, in part, to the joint state and federal relationship in funding the program that brings hundreds of millions of dollars into New Hampshire each year. Policymakers weighing options for addressing the fiscal challenges before New Hampshire should be aware, therefore, not only of the difficulty of achieving budgetary savings through reductions in Medicaid spending, but of the ramifications of those reductions both for vulnerable residents and for workers in the health care industry.

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[i] Office of Medicaid Budget and Policy, "New Hampshire Medicaid Annual Report, SFY 2009," December 30, 2010, p. 8.

[ii] "Chart B27010 Types of health insurance coverage by age - universe: civilian non-institutionalized population," 2009, American Community Survey, 1 Year Estimates.

[iii] Medicaid is distinct from Medicare, the federal health insurance program for retirees and the disabled.

[iv] Some states do cover adults who are low-income without any other qualifying categorical membership, but they are considered an expansion population and not one of the traditional groups of Medicaid eligibility.

[v] Kaiser Family Foundation, *Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services*, June 2005, http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf. Approximately 30 percent of Medicaid spending is spent on optional benefits, nationally. New Hampshire's expenditures are roughly consistent with this figure.

[vi] Medicaid enrollees, as a proportion of the population, vary by location with penetrations exceeding 15 percent of the population in some towns.

[vii] There is an overlapping population of individuals who are eligible for both Medicaid and Medicare, commonly referred to as "dual eligibles." Some Medicare beneficiaries are eligible for Medicaid to help with their cost sharing. In other instances the Medicaid program supplements Medicare coverage by providing services and supplies that are available under a state's Medicaid program. Services that are covered by both programs are paid first by Medicare and the difference by Medicaid, up to the states payment limit.

[viii] Office of Medicaid Budget and Policy, "New Hampshire Medicaid Annual Report, SFY 2009," December 30, 2010, p. 10-13. Kaiser Family Foundation, *Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services*, June 2005. http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf

[ix] Feder, et. al., "Long-Term Care Financing: Policy Options for the Future," Long Term Care Financing Project, Georgetown University, June 2007.

[x] Office of Medicaid Budget and Policy, "New Hampshire Medicaid Annual Report, SFY 2009," December 30, 2010, p. 6.

[xi]Based on Norton, Stephen, et. al., *What is New Hampshire? A Collection of Data for Those Seeking Answers*, New Hampshire Center for Public Policy Studies, September 2010, p. 75-79. Total health expenditures for New Hampshire include all spending on personal health care (which includes hospitals, physicians services, nursing homes, prescription drugs, home health care, medical equipment, etc.) as well as spending on health care research, health facility construction, and public health services.

[xii] Norton, Stephen, et. al., *16 Cents of Every Dollar: Health Care Costs in New Hampshire (2004-2005)*, New Hampshire Center for Public Policy Studies, February 2007, p. 2-4.

[xiii] In fact, all but three critical access hospitals had a majority of their gross charges produced by Medicare and Medicaid patients, rather than from privately insured patients in 2009. Norton, Stephen, et. al., *Health System Cost-Shifting in New Hampshire*, New Hampshire Center for Public Policy Studies, February 2011, p. 12-24.

[xiv] Foundation for Healthy Communities, NH Hospital Association with National Center for Rural Health Works, "The Economic Impact of Hospital Systems in New Hampshire," December 2009, p. iii.

[xv] In recognition of the potential for such consequences, the version of HB 1 approved by the New Hampshire House of Representatives on March 31 reduced Medicaid disproportionate share hospital (DSH) General Funds by a total of $115 million over the biennium, but preserved approximately $50 million in General Funds for Critical Access Hospitals.

[xvi] US Congressional Budget Office, *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry*, January 1996, available at http://www.cbo.gov/doc.cfm?index=4750; State Department of Health and Human Services, "Unrestricted Revenue Summary," p. 2-5, January 13, 2011.