Medicaid–A Study Focusing on Cost Containment, Demographics, and Comparison with the Systems in Other States

Issue Memorandum **2024-07**

SOUTH DAKOTA LEGISLATURE
LEGISLATIVE RESEARCH COUNCIL

Introduction

Medicaid is a state-federal partnership to provide medical benefits to low-income people who have no medical insurance, or inadequate medical insurance, and serves about seventy-four million people in all fifty states, the District of Columbia, and the U.S. territories. The program is complex in structure and varies from state to state, but for most locales it is the single largest health program in place.

The federal role in Medicaid is limited to setting standards, issuing regulations and guidelines, and overseeing operation of the program by the states. Specific program requirements are established by each state. Whether a person is eligible for Medicaid, and what services are available, will depend on the state of residence. Because Medicaid is an entitlement, once rules for eligibility and reimbursement are set, the program cannot be terminated when funds run out without legislative action.

The costs for Medicaid are split between each state and the federal government at a percentage determined by a ratio of the per-capita income of the state and the country.[1] This is named the Federal Medical Assistance Program (FMAP). The split is adjusted every year, with the state covering a maximum of fifty percent and a minimum of seventeen percent of Medicaid costs. Congress can make exceptions, such as with Medicaid Expansion where a five percent FMAP bonus was given to states that expanded Medicaid,[2] or the 6.2 percent FMAP bonus given during the 2020-2023 pandemic.[3]

President Truman first proposed a prepaid health insurance plan on November 19, 1945, in a special message to Congress. On July 30, 1965, President Johnson signed the Medicare and Medicaid Bill (Title XVIII and Title XIX of the Social Security Act).[4] Since its enactment, Medicaid has evolved over time. In the proposed FY2025 federal budget, one in every four federal dollars will be spent for federal health programs, including Medicaid.

Which People Does Medicaid Cover?

Federal law requires state Medicaid programs to cover certain populations and allows states the option of covering others. Medicaid is an "entitlement" program, which means states may not exclude anyone who applies for coverage if an individual meets specified eligibility criteria. This provision makes budgeting for Medicaid somewhat difficult because enrollment may not be limited, and the number of eligible people fluctuates with the economy and other variables. Although seventy-four million people nationally were covered by Medicaid at some point during 2024,[5] month-by-month variations exist as people move in and out of the program.

Federal Poverty Level Guidelines

The primary determinate of eligibility for Medicaid is family household income compared to the federal poverty level (FPL) guidelines. The FPL is determined by the federal Department of Health and Human Services and is based on economic conditions as determined by the Bureau of Economic Analysis. FPL guidelines are the same for every state except for Alaska and Hawaii.

---

[1] For the exact federal law concerning the FMAP split, see 42 U.S. Code § 1396b
[2] American Rescue Plan Act of 2021 § 9814
[3] Families First Coronavirus Response Act § 6008
[4] National Archives
[5] Data collected from the Medicaid Budget and Expenditure System

The FPL guidelines for 2024 may be found in Appendix A.

Mandatory Populations

Although state participation in Medicaid is optional, states with Medicaid programs—currently, all do—must provide coverage to certain groups or "categories" of people (sometimes referred to as "categorically eligible.") Mandatory groups include the following:

- AFDC-related populations (certain parents and children).
    - Eligibility for children and parents in the former "Aid to Families with Dependent Children" (AFDC) program once automatically qualified people for Medicaid. The 1996 federal welfare reform legislation, which replaced AFDC with Temporary Assistance for Needy Families and delinked welfare from automatic Medicaid eligibility, froze Medicaid's welfare-related eligibility levels at the former AFDC eligibility levels in place on July 16, 1996.[6] The national average eligibility threshold at the time was about forty percent of the FPL guidelines, or $10,328 for a family of three in 2024. States may expand eligibility but may not reduce it.
- People who receive Supplemental Security Income (SSI), a federal cash assistance program for low-income people with disabilities who meet specified eligibility criteria.
- Pregnant women with an income at or below 133 percent of the FPL guidelines ($20,030 for a single woman in 2024).[7]
- Infants of women enrolled in Medicaid at the time of birth, or those in families with income at or below 133 percent of the FPL guidelines.
- Children under age six in families with income at or below 133 percent of the FPL guidelines.
- Children ages six through eighteen in families with income at or below the FPL.
- Children in adoption or foster care.
- Some low-income Medicare recipients (for services not covered by Medicare).

Optional Populations

For many years, states had little discretion to cover additional people under Medicaid. The program was mainly designed to assist very low-income, welfare-related populations. However, the program expanded over time, most notably for children and pregnant women. The most common additional populations that states may choose to cover in their Medicaid programs include the following:

- Infants and pregnant women with family incomes at or below 185 percent of the FPL guidelines.
- Additional families, by disregarding a portion of family income, eliminating asset tests, raising income levels to adjust for inflation, or extending benefits to two-parent working families.
- Additional Medicaid recipients by increasing income eligibility levels.
- "Medically needy" people (individuals who do not meet income criteria, but who have large medical expenses in proportion to their income).
- People with disabilities who would lose eligibility because of higher income, who may buy Medicaid coverage under a sliding-scale premium (the "Ticket to Work" initiative).
- Low-income uninsured women with breast or cervical cancer who have been diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.
- Children in the State Children's Health Insurance Program (SCHIP). Under federal SCHIP legislation passed in 1997, states may extend Medicaid coverage to children through age eighteen with family

[6] Bipartisan Welfare Reform Act of 1996 § 421

[7] Appendix A

incomes at or below two hundred percent of the FPL guidelines (or they may create a non-Medicaid insurance option).

Medicaid Expansion

In 2009, Congress passed the Affordable Care Act as a reform measure for the United States healthcare system. As part of the reform, states were given the option to expand the population which could be eligible for Medicaid. In return for expanding coverage, the federal government would cover the cost of expanding Medicaid to a flat rate of ninety percent of costs, with the states covering the remaining ten percent. To date, forty states have expanded their Medicaid programs, including South Dakota.

In 2022, South Dakota voters approved Amendment D.[8] This amendment expanded Medicaid to include all adults between the ages of eighteen to sixty-four and required the state to provide Medicaid services for this group the same as the traditional Medicaid group.

To be eligible for the Medicaid Expansion group, an individual must meet the following qualifications:

- Be a resident of South Dakota.
- Be between the ages of eighteen to sixty-four.
- Have an income at or below 138 percent of the FPL.
- Not be eligible for any other Medicaid coverage group.

At the end of FY2024, 24,241 people were enrolled as part of the Medicaid Expansion group, or roughly eighteen percent of the enrollment into medical services in South Dakota. The total cost to cover this group in FY2024 was $186,232,846. The federal government covered $167,609,561 of the cost, with the state covering the remaining $18,623,285.[9]

Most states have expanded Medicaid either through legislative action or by popular referendum. Some states have expanded through a private-public partnership with a health insurance firm, such as in Montana and Arkansas. The federal government, through the Department of Health and Human Services, regulates who must be covered and what must be covered for states to receive the ninety percent FMAP for Medicaid Expansion enrollees.

Waiver programs

Section 1115 of the Social Security Act[10] provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute. Such waivers, usually five-year demonstration projects, must be "cost neutral" over the life of the waiver, meaning states must achieve savings in some program areas to cover additional people.

South Dakota currently uses four waivers as part of their Medicaid program.

- CHOICES (Community, Hope, Opportunity, Independence, Careers, Empowerment, Success) Waiver[11]— This waiver focuses on adults and children with intellectual and developmental disabilities, with the goal of getting them as close to independent living as possible. Services provided by this waiver include

[8] South Dakota General Canvass Report 2022 – Pages 45 - 46
[9] Data collected from the June 2024 Medical Services Report
[10] 42 U.S. Code § 1315
[11] DHS – CHOICES Waiver

assistive technology, residential services, employment support, career exploration, and day services to develop living skills. The services provided by this waiver are overseen by the Department of Human Services.

- HOPE (Home and Community-Based Options and Person-Centered Excellence) Waiver[12]—This waiver focuses on older adults and adults with specific disabilities, with the goal of preventing premature nursing home admissions. This waiver may be used for family members providing support to the Medicaid eligible patient. The waiver may also be used for alternatives to nursing homes, such as an assisted living home, adult day care, or a community living home.
- Family Support 360[13]—This waiver focuses on "people with intellectual and developmental disabilities and their families," with the goal of helping families live as "independently as possible." This waiver may be used for modification of homes and vehicles to provide mobility for the patient. These modifications may include handrails and wheelchair ramps. Specialized therapy treatments may also be covered by this waiver. The services in this waiver are generally provided by a third-party provider in partnership with the state.
- ADLS (Assistive Daily Living Services) Waiver[14]—This is a waiver provided to individuals who have quadriplegia due to a birth defect, illness, or injury, and need a level of care requisite of a nursing home. Services provided by this grant include hygiene, medication, and housekeeping. Qualified friends and family may receive this grant under certain conditions. The waiver may also be used for specialized medical equipment, a personal emergency response device, and paying for respite care. The overall goal is to allow the individual to live in a normal home or in a community-assisted living home.

What Services Are Covered?

Similar to mandatory and optional populations for Medicaid eligibility, federal Medicaid law requires states to cover certain services and allows states to select from a menu of other optional services. Because Medicaid covers so many low-income, elderly people, and people with serious disabilities who cannot obtain private sector coverage, its benefits package reflects these special needs. For example, Medicaid covers some services that most private insurance plans do not cover, such as nursing home and other long-term care services, which can be especially expensive.

Covered services must be available statewide, must be comparable (equal for all in a group), and must be sufficient in "amount, duration and scope"[15] to achieve their purpose. States retain considerable flexibility in defining certain services and setting coverage guidelines.

States can, and have, set "appropriate"[16] limits on both mandatory and optional services, such as the number of prescriptions, or the number of visits to a particular type of provider. In practice, with the exception of required services for children, states have exercised wide discretion in the amount, duration, and scope of services they cover.

The South Dakota Constitution[17] requires all people in the Medicaid Expansion group receive the same coverage as other groups under Medicaid.

---

[12] DHS – HOPE Waiver
[13] DHS – Family Support 360
[14] DHS – ADLS Program
[15] 42 CFR § 440.230 (b)
[16] 42 CFR § 44.230 (d)
[17] *See* S.D. Const., Art. XXI, § 10 ("Such person shall receive coverage that meets or exceeds the benchmark or benchmark-equivalent coverage requirements, as such terms are defined by federal law….")

What Affects State Medicaid Costs?

The state's Medicaid costs depend on how many people receive care, what care they receive, who provides it, what the provider is paid, and the basis for the payment. When unemployment went up, more individuals qualified for Medicaid coverage as incomes declined and access to employer-sponsored insurance became more limited. Similarly, when unemployment went down, more people received employer-sponsored insurance and moved above the FPL guideline for eligibility.

Among the more expensive groups covered under Medicaid are individuals with developmental disabilities, chronic and severe mental illnesses, and the frail elderly. These groups depend on the state to act as their advocate and to fund their care. This situation can place state agencies in conflicting roles, with one agency having protective responsibility for the vulnerable patients while another must manage budgetary demands. Legislators face both responsibilities.

As baby boomers approach retirement age, more stress will be put on Medicaid. In 1960, shortly before the Medicaid system was enacted, the over sixty-five population in South Dakota was 71,513. According to the United States Census, there are an estimated 165,909 people over the age of 65 in South Dakota as of 2022. As a percentage of South Dakota's total population of 909,824, this represents about eighteen percent.[18]

Since the passage of the Affordable Care Act, the priority of the federal government has been maintaining coverage. An example of this was the recent 2020-2023 COVID-19 pandemic. During the pandemic, the Department of Health and Human Services declared a public health emergency. States were then allowed to enroll people on Medicaid, but could not disenroll them, even if they were otherwise unqualified. In exchange, the federal government provided a five percent FMAP bonus to all FMAP programs. This bonus continued until the end of 2023 when the public health emergency ended, and states were allowed to disenroll people off Medicaid.

The federal government continues to offer incentive to states to expand their Medicaid programs and keep people enrolled in Medicaid. When South Dakota expanded their Medicaid program, the federal government provided a five percent FMAP bonus for two years. This bonus is separate from the five percent FMAP bonus provided during the public health emergency.

Challenges

The most obvious ways for states to trim Medicaid costs involve cutting program eligibility, services, or payments to service providers. However, each of these options has its drawbacks.

- Cutting eligibility may shift costs elsewhere, such as to other state or locally funded programs, to emergency rooms, to private insurance plans in the form of higher premiums, and to providers in the form of bad debt or charity care. These alternatives are less desirable, and without the generous federal cost sharing.
- Imposing overly stringent restrictions on services, such as prescription drugs, may result in higher costs associated with sicker patients, including expensive hospital or nursing home care.
- Paying less can have unexpected effects on the rest of the healthcare system, as the excess costs are absorbed by other payers. Underpaid providers may shift costs to private insurance, or refuse to treat Medicaid patients altogether. If providers and plans find lower payments unacceptable, paying less can reduce access as well. An example of this is in the nursing homes. If the payments to nursing homes are too low, the nursing homes will offer less beds to Medicaid patients in favor of more profitable privately insured patients.

[18] Data obtained from the United States Census – ACS Survey

Several trends can be misleading as to their impact on the entire system. Rapid growth in one category of spending is not necessarily bad because increasing the use of some services may decrease the use of more expensive services and lower costs over time.

- Outpatient and physicians' office visits increased a decade ago due to a shift from inpatient to less expensive outpatient care.
- Pharmaceutical spending has swelled alarmingly in recent years; however, it is not clear this is undesirable. For at least some conditions, such as chronic mental illness, pharmaceuticals are an alternative to more expensive care or procedures and may slow the costly progression of disease and disability.
- Home and community-based care have been growing at double-digit rates, encouraged by the view that it is often less expensive than institutional alternatives. New community-based services create budget problems if they are not offset by decreased use of nursing facilities. More than half of Medicaid long-term care spending goes to nursing homes, although the proportion varies from state to state.

Conclusion

Medicaid provides vital, life-giving-services to the most vulnerable populations. Since its enactment, Medicaid has evolved from a program providing federal financing to states to support health coverage for their welfare population into a federal and state partnership that now provides health and long-term coverage to millions of low-income Americans. It has become the nation's largest health care program, both in terms of enrollment and spending, with children and families making up the vast majority of program enrollment and the elderly and disabled accounting for the bulk of program spending.

Underlying factors point to continuing growth in Medicaid enrollment and costs adding further pressure to state budgets. Although states receive at least half their program costs from the federal government, Medicaid still accounts for a substantial portion of state budgets. Ideally, costs are saved by giving care more efficiently, eliminating unnecessary and wasteful systems, and keeping people well by preventing rather than treating illnesses.

The Legislative Research Council provides nonpartisan legislative services to the South Dakota Legislature, including research, legal, fiscal, and information technology services. This issue memorandum is intended to provide background information on the subject. This issue memorandum was written for the Legislative Research Council in April 2005 by Sue Cichos, and revised by Bill Douglas in November 2024. For more information, please contact Bill Douglas, Position (Fiscal Analyst).

Appendices

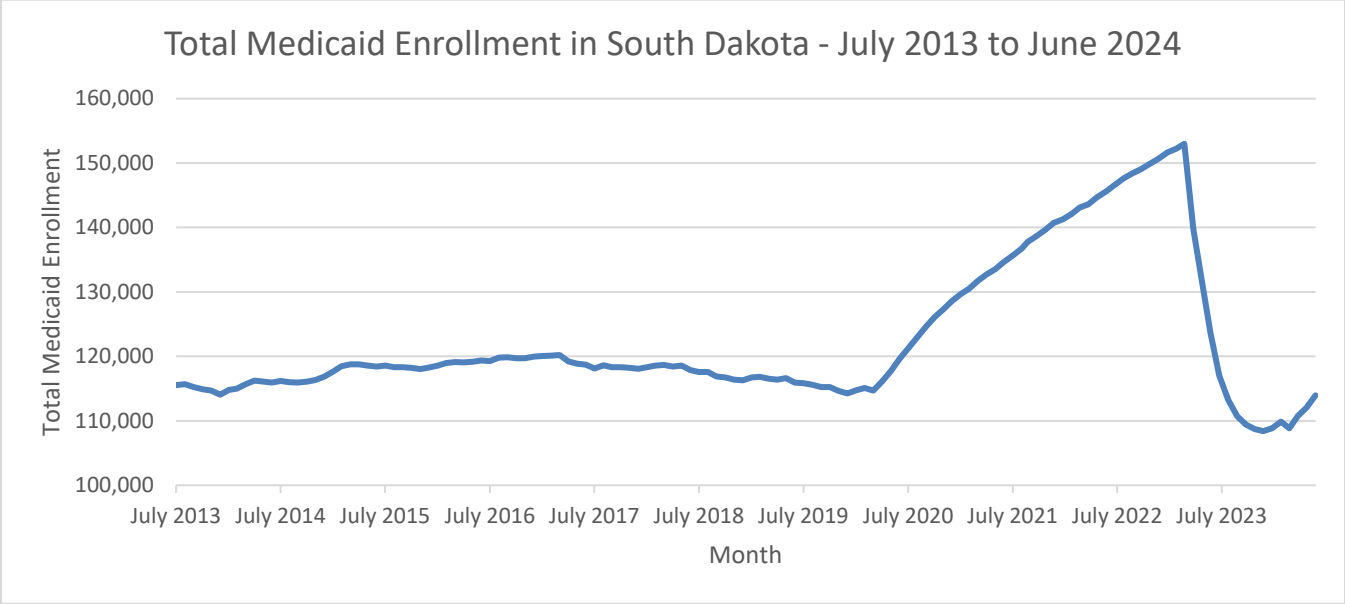
Appendix A: 2024 Federal Poverty Level (FPL) Guidelines[19]

For many programs, the federal government issues a poverty test criterion to determine eligibility. This table shows the current (2024) poverty guidelines:

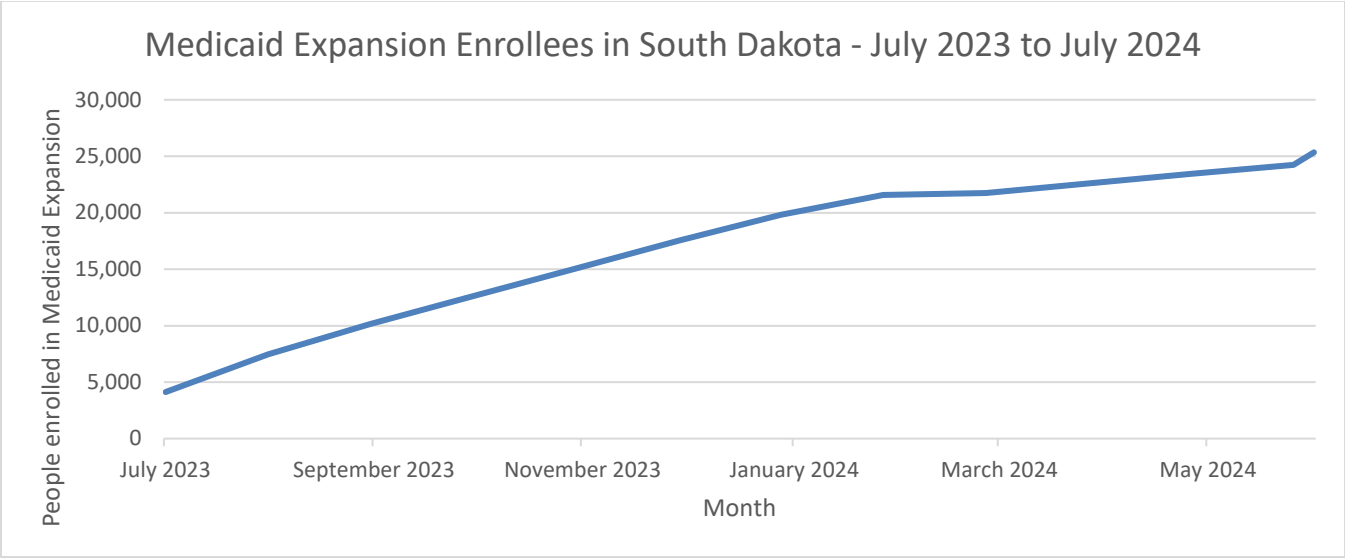
Persons in household	Household Income
1	$15,060
2	$20,440
3	$25,820
4	$31,200
5	$36,580
6	$41,960
7	$47,340
8	$52,720
For each person above 8, add:	$5,380

[19] As published by the Office of the Assistant Secretary for Planning and Evaluation

Appendix B: Medicaid Enrollment in South Dakota from July 2013 to June 2024[20]



Appendix C: Medicaid Expansion Enrollment in South Dakota from July 2023 to June 2024[21]



[20] Data obtained from South Dakota Medical Services Reports from July 2013 to June 2024
[21] Data obtained from South Dakota Medical Services Reports from July 2023 to July 2024