Historical and Projected Trends in Medicaid
October 2006

I. Introduction

This report has been prepared to provide data on the current state of Medicaid, the nation's program providing health and long-term care services to low-income families, elderly and disabled individuals. The Centers for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing Administration, within the Department of Health and Human Services, is responsible for overseeing the Medicaid program. The report presents historical and projected future enrollment and spending trends for this vitally important program.[1] Medicaid is now the largest health insurance program in the United States, providing services to an estimated 58.6 million people and spending $298 billion in 2004. Given Medicaid's projected spending growth rate over the next ten years, questions have been raised about Medicaid's financial sustainability. Both Medicare and Social Security have annual Trustees' reports that provide both policymakers and the public with at least a partial measure of those programs financial viability. Since Medicaid does not have a group of trustees to periodically report on its status, the purpose of this report is to provide a more complete picture of the future of the Medicaid program than has been previously available.

II. Highlights

a) <u>Enrollment</u>

- Medicaid enrollment increased from 41.4 million in 1999 to 58.6 million in 2004, a 14 percent increase. Enrollment is expected to increase another 24 percent to 72.8 million by 2016.

- Among the four major categories of Medicaid enrollment (children, adults, aged, and disabled), children make up the largest number of enrollees covered under Medicaid and accounted for almost half of all enrollees in 2004.

- The number of children enrolled in Medicaid is projected to increase from 28.7 million in 2004 to 35.4 million in 2016, a 23 percent increase. The number of aged enrollees will increase by 1.7 million (5.2 million to 6.9 million), an increase of 33 percent. The share of total enrollees will remain the same for children (48.9 percent to 48.6 percent), while the share of the total for aged enrollees will slightly increase (8.9 percent to 9.5 percent).

- While varying by state, Medicaid on average covers 26 percent of all children in the U.S. and 8 percent of all nonelderly adults.

- States enroll 58 percent, on average, of their low-income children in Medicaid.

[1] ASPE has attempted to present consistent numbers throughout this report; however, some inconsistencies may appear due to the use of different sources and estimating techniques for some information.

b) Expenditures

- Overall Medicaid expenditures increased by 65 percent, from $180.5 billion to $298 billion between 1999 and 2004, a faster rate than private insurance and Medicare (51 percent and 45 percent respectively).

- Recent estimates from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) indicate total expenditures for Medicaid, both federal and state, represented 2.5 percent of the nation's Gross Domestic Product (GDP) and 15.9 percent of the nation's total health spending of $1.9 trillion in 2004. The federal share of Medicaid expenditures has averaged about 57 percent of the overall total for the past decade.

- Medicaid expenditures will continue to increase at rates exceeding overall health care spending. Projections by OACT indicate that Medicaid spending is expected to increase at a rate of nearly eight percent per year over the next ten years.

- Estimates indicate that total Medicaid spending will increase by 132 percent to $690.1 billion in 2016 and represent 3.1 percent of GDP, up from 2.5 percent in 2004.

- Children utilize fewer services than the other Medicaid enrollment groups and on average incur $1,200 in expenses annually compared to $8,600 per aged enrollee.

- The largest category of Medicaid expenditures is nursing facility costs, representing 20 percent of total expenditures in 2004. However, OACT projects that home health services will experience the fastest rise in spending between 2004 and 2016, increasing its share of total spending from 11 percent to 18 percent.

- Spending on Medicaid has increased faster than any other major spending category for states. As a percent of total state spending, Medicaid has risen from 19.5 percent in 1999 to an estimated 21.9 percent in 2004, and now surpasses spending on elementary and secondary education as the top-spending category for states.

III. Background

Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965 and is jointly funded by the Federal and state governments (including the District of Columbia and the Territories) to assist states in providing medical acute and long-term care assistance to people who meet certain eligibility criteria.[2] Medicaid is the largest source of funding for medical and health-related services for people with limited income.

[2] Public Law 89-97

The following is a brief description of the eligibility, benefits, and financing requirements for Medicaid. A more detailed description of each can be found in Appendix B.

a. Eligibility

To qualify for Medicaid, two tests must be met: an income and assets test and a 'categorical test.' Individuals must be low-income and have low assets, but they must also fall into one of the population categories that Medicaid covers. Medicaid categorical eligibility can be classified into four broad coverage groups: children, adults (specifically parents of dependent children and pregnant women), aged and disabled. Within these groups certain requirements must be met, including income, resources, and citizenship status. While operating within federal parameters, the rules for counting income and resources vary from state to state and from group to group.

Therefore, Medicaid does not provide medical assistance for all poor persons. Indeed, it is very unlikely that any non-elderly, non-disabled adult who does not have a dependent child living at home can qualify for Medicaid (unless the adult is a pregnant woman). Medicaid only provides health care services for low-income persons in one of the designated groups and low income is only one test for Medicaid eligibility for those within these groups.

The Medicaid statute requires states to cover certain groups, known as "mandatory populations," and they have the discretion to cover additional groups, known as "optional populations." States have substantial flexibility to cover optional populations by submitting State Plan Amendments (SPAs) to CMS and having them approved with whatever conditions are imposed by CMS. Similarly, states have total flexibility to discontinue coverage for optional populations through SPAs.[3] Individuals in any eligibility group that a state chooses to cover who meet the eligibility criteria for that group are eligible for Medicaid if they apply for benefits.

b. Benefits

Mirroring eligibility provisions, Medicaid also requires states to cover certain benefits for the categorically needy, known as "mandatory services," and it permits states to cover additional benefits, known as "optional services." In addition, both mandatory and optional benefits are governed by the requirement that the "amount, duration, and scope" of all services must be state-wide and comparable, which means that all Medicaid benefits must be equally available to all categorically eligible enrollees within each state.[4,5]

[3] In order for a state to receive federal matching payments, it must have in effect a state Medicaid plan approved by the Secretary. A state that wants to change the way it administers its program—for example, by adding an optional service, dropping an optional eligibility group, or changing a provider reimbursement methodology—must submit a state plan amendment (SPA) to CMS for a determination as to whether the proposed change complies with Medicaid requirements.

[4] Persons who qualify for coverage under the optional category of "medically needy" generally do so because of high medical expenses. These individuals meet Medicaid's categorical requirements— e.g., they are children or parents or aged or individuals with disabilities—but their income is too high to enable them to qualify for "categorically needy" coverage. Instead, they may qualify for coverage by "spending down"— i.e., reducing their income by their medical expenses.

Some of the mandatory services include inpatient hospital services; outpatient hospital services; physician services; medical and surgical dental services; and nursing facility services for individuals aged 21 or older.

Several of the more commonly covered optional services include clinic services; nursing facility services for the under age 21; intermediate care facility/mentally retarded services; optometrist services and eyeglasses; and prescription drugs.

c. Financing

Medicaid is financed jointly by the federal and state governments. The portion of the Medicaid program that is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each state by a formula that compares the state's average per capita income level with the national average.[6] By law, the FMAP cannot be lower than 50 percent nor greater than 83 percent. The wealthier states, as measured by per capita income, have a smaller share of their costs reimbursed. The federal government also shares in the state's expenditures for administration of the Medicaid program at generally 50 percent. Due to the entitlement nature of Medicaid, the amount of total federal outlays for Medicaid has no statutory limit.

States must establish reimbursement rates sufficient to enlist enough providers so that medical care and services are available at least to the extent that such care and services are available to the general population in that geographic area. States must also augment payment to qualified hospitals that serve a disproportionate number of Medicaid and low income patients. Each state is limited by an overall State-specific disproportionate share hospital (DSH) allotment and the amount of DSH payment may not exceed a hospital's uncompensated care regarding the provision of inpatient and outpatient services to Medicaid and uninsured patients. However, the federal government generally has little discretion over the payment rates established by states, as long as they fall within broad federal parameters to insure against excessively large or small payments.[7]

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[5] With the passage of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA), states are now allowed to provide "benchmark" or "benchmark equivalent" coverage to subpopulations of Medicaid enrollees. The statewideness and comparability rules, which required uniform coverage across all categories of enrollees and throughout each state, may no longer apply to all Medicaid covered populations. In addition, states are prohibited from covering several populations with benchmark and benchmark equivalent coverage.

[6] 1905(b) of the Social Security Act

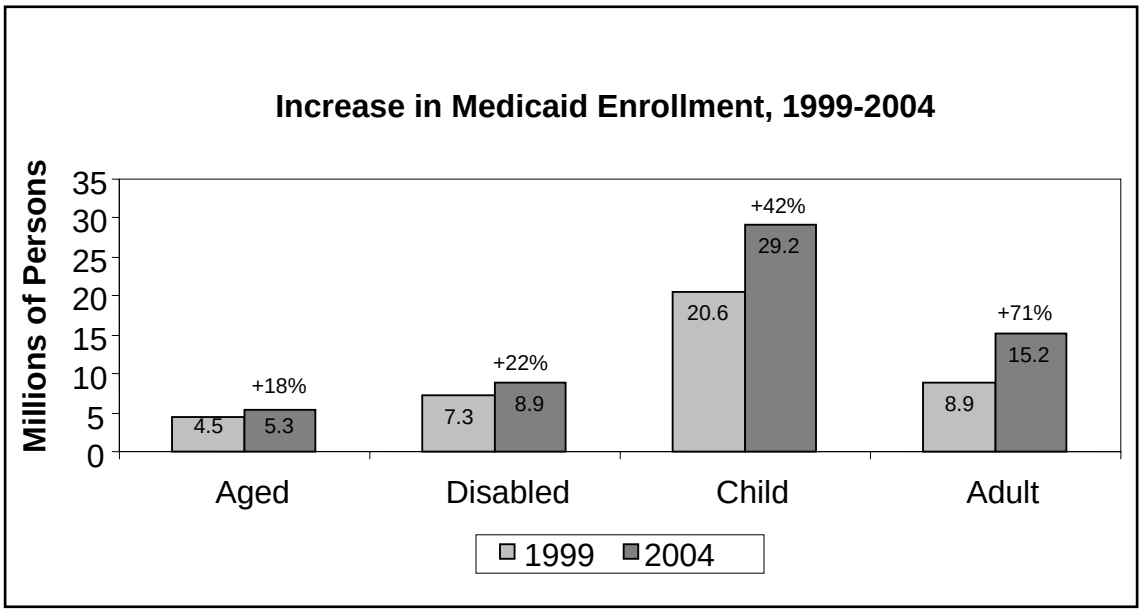
[7] One such federal parameter is the imposition of upper payment limits, or UPLs, on state Medicaid payments for hospital services. These limits are imposed in aggregate on state Medicaid payments to all hospitals based on reasonable estimates of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds.

IV. Historical Trends

The Medicaid program, as the safety net for much of the nation's low-income population, bears an increasing responsibility for providing health coverage for this segment of the nation's population. For the five year period from 1999 to 2004, total enrollment in the program increased by 42 percent. This growth coincides with an erosion of employer-sponsored health benefits. Private insurance has become less available and more costly for employees as employers shift more of the plan costs (coinsurance and copays) to their employees. And though the percent of premiums paid for by the employee has remained unchanged, the cost for their share of the premium continued to rise at a faster rate than income over the past decade. While median family income increased by 46 percent from 1993 to 2003, the average monthly worker contribution for family premiums increased 74 percent.[8]

Non-aged and non-disabled adults show the largest percentage increase in enrollment of the four major eligibility categories, growing from 8.9 million to 15.2 million between 1999 and 2004, an increase of 71 percent. Children experienced the largest numerical change from 20.6 million to 29.2 million, increasing by 42 percent.[9] The disabled increased by 22 percent, while the aged increased 18 percent.[10]

Figure 1



Source: Office of the Actuary, CMS

Consistent with the rapid rise in enrollment, Medicaid expenditures increased at a faster rate than other insurance coverage types between 1999 and 2004. Overall Medicaid expenditures increased by 56 percent from $180.5 billion to $281.8 billion, with spending on adults increasing by 68 percent, the greatest increase among all enrollment categories.

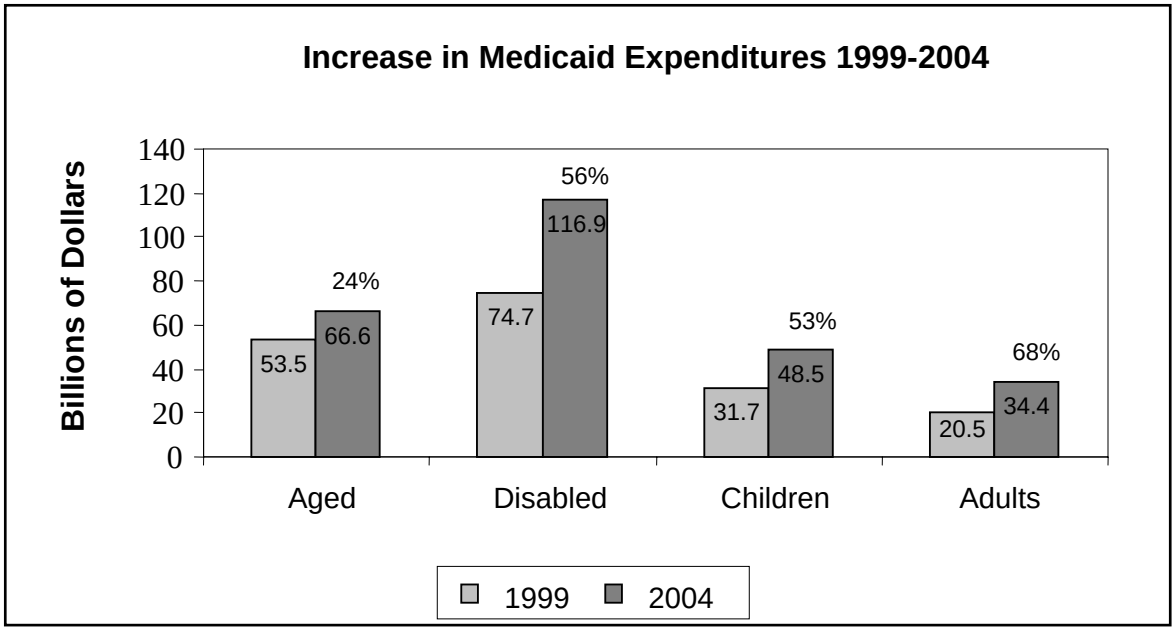
[8] ASPE calculations based on U.S. Census Bureau, Current Population Survey and KFF/HRET *Survey of Employer Health Benefits, 2005*

[9] Some of the increase in the number of children covered under the Medicaid program may be due in part to outreach and educational efforts conducted under SCHIP enacted in 1997(PL 105-33).

[10] Historical and projected information presented for Medicaid in this report exclude data from the SCHIP Program. Additionally, historical information excludes Puerto Rico and the Virgin Islands beyond 2001.

These increases compare to increases of 51 percent for private insurance expenditures and 36 percent for Medicare over the same time period.

Figure 2



Source: Office of the Actuary, CMS

Medicaid spending has risen faster than the rate of growth in the nation's Gross Domestic Product. Consequently, Medicaid's proportion of GDP had risen from 2.0 percent of GDP in 1999 to 2.5 percent in 2004.

V. Current Medicaid Data

a. Federal/State Spending

Medicaid expenditures continue to rise along with health care spending in general. The total expenditures for Medicaid by both federal and state sources were $298 billion in 2004. This represents 2.5 percent of the nation's Gross Domestic Product (GDP) and 15.9 percent of the nation's total health spending of $1.9 trillion. The federal share of Medicaid expenditures has averaged 57 percent of the overall total for the past decade.

Table 1

	Federal	State	Total
2004 Medicaid (billions)	$176.40	$121.60	$298.00
Medicaid Spending as % of GDP	1.5%	1.0%	2.5%

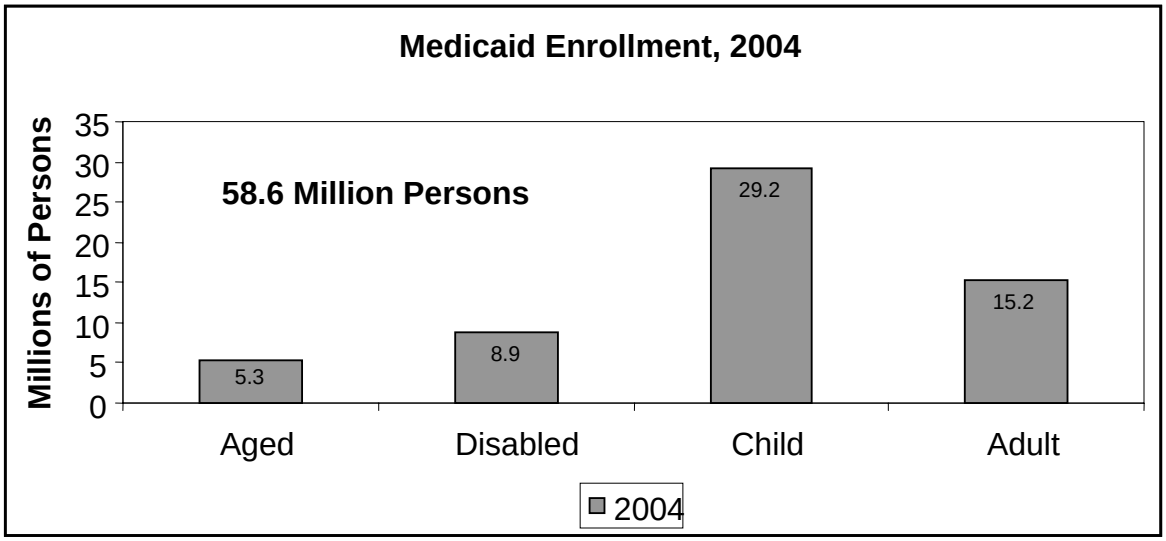
Source: President's FY 2007 Budget Baseline for Medicaid Program, CMS

b. Enrollment

The CMS Office of the Actuary's (OACT) most recent report estimates the number of Medicaid enrollees at 58.6 million for 2004.

As shown in Figure 3, children are the largest segment of Medicaid enrollees. Of the four major categories of individuals covered under Medicaid, children numbered 29.2 million in 2004. There were 15.2 million adults enrolled in Medicaid, 8.9 million disabled and 5.3 million aged.

Figure 3

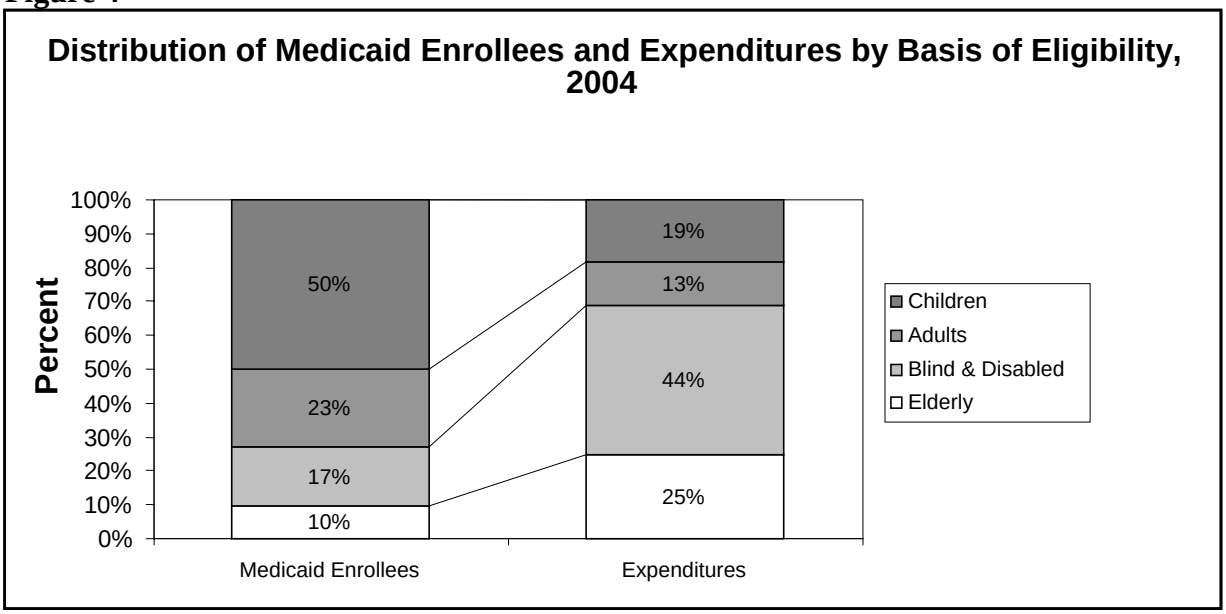


Source: President's FY 2007 Budget Baseline for Medicaid, CMS

The proportion of total enrollment that each category represents is very different from the proportion of expenditures paid on behalf of each category. This discrepancy can be seen in the distributions presented in Figure 4.

Children make up the largest number of enrollees covered under Medicaid, but utilize a much smaller relative amount of services as measured by dollars expended on their behalf. As shown in Figure 4 below, children represent half of all enrollees, but only 19 percent of total expenditures, whereas the aged represent only ten percent of enrollees but consume 25 percent of total expenditures. Similarly, the blind and disabled represent only 17 percent of Medicaid enrollment but represent 44 percent of Medicaid expenditures. The discrepancy between enrollment and expenditures is dramatically reflected in the different federal per capita costs for the four groups. OACT estimates that per capita expenditures for these categories range from a low of $1,200 per child in 2004 to a high of $8,600 per aged enrollee.

Figure 4



Source: President's FY 2007 Budget Baseline for Medicaid, CMS
Note: Total expenditures on benefits exclude DSH payments.

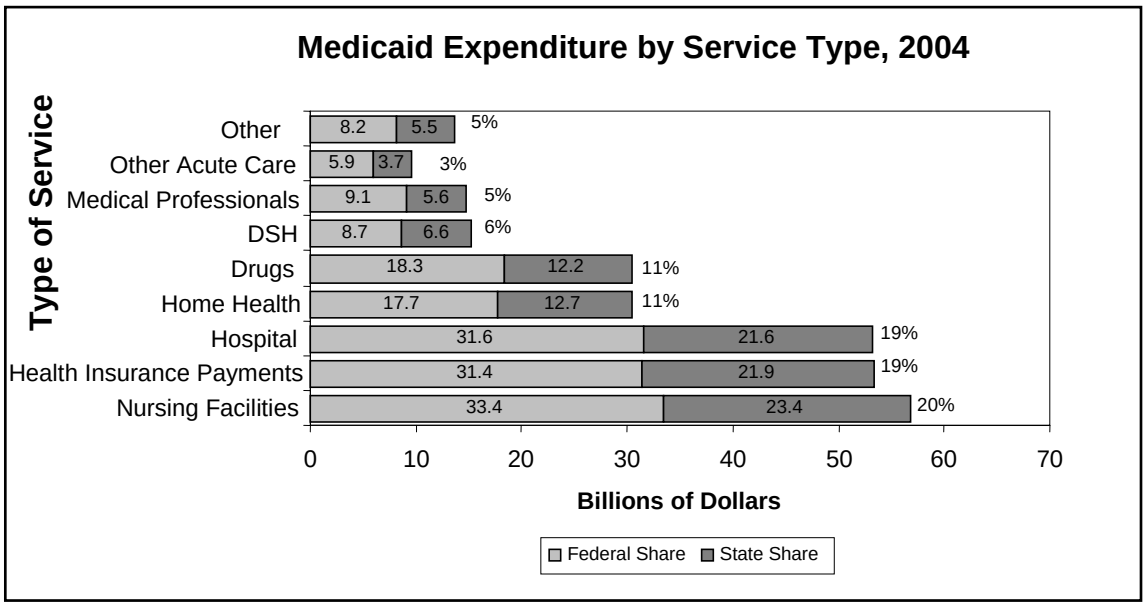
c. Expenditures by Service Type

When looking at Medicaid expenditures by service type (see Figure 5), the largest category of spending is for nursing facility costs. Individuals receiving these services are mainly the aged and disabled, but may also include some children and adults.

Health insurance payments and hospitals represent the next largest categories of expense. Health insurance payments include payments to Medicare for the low-income elderly's premiums, coinsurance and deductibles; premiums to group and pre-paid health plans (including HMO capitation and Medicaid managed care payments); premium assistance programs on behalf of low-income workers toward their share of employer plan premiums; and other premium payments. Hospital care includes both inpatient and outpatient care, as well as mental health hospital care.

Other major categories of expense include home health services and prescription drugs.

Figure 5



Source: President's FY 2007 Budget Baseline for Medicaid, CMS

d. Distribution of Enrollees by Age

As displayed in Table 2, half of all persons enrolled in Medicaid are under age 18. For the year 2003, the latest year available with detailed age data, one-fifth of all Medicaid eligibles were age 5 and under. Another 22 percent were between ages 6 and 14, and 8 percent between ages 15 and 18. Together, children account for half of all eligibles. Adults ages 19 to 64 and the elderly age 65 and over, represent 39 percent and 10 percent, respectively.

Table 2

Medicaid Eligibles - Fiscal Year 2003		
By Age Group – All States		
Age Group	**Eligibles**	
	Number	Percent
UNDER 1	2,078,549	4%
AGE 1-5	9,067,236	16%
AGE 6-14	12,104,360	22%
AGE 15-18	4,525,249	8%
AGE 19-20	1,923,773	3%
AGE 21-44	14,132,129	26%
AGE 45-64	5,317,461	10%
AGE 65-74	2,457,045	4%
AGE 75-84	2,124,726	4%
AGE 85 >	1,299,393	2%
UNKNOWN	127,854	0%
TOTAL	**55,157,775**	**100%**

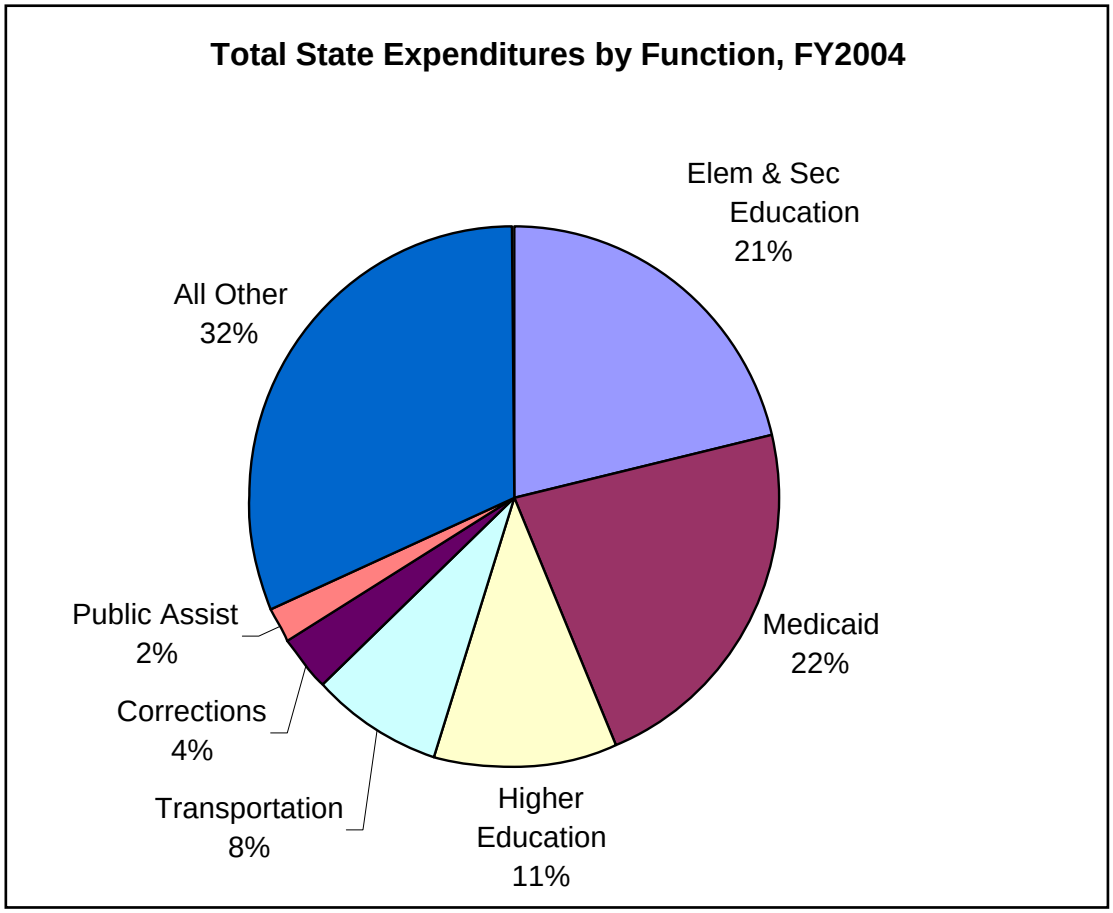
Source: Medicaid Eligibles, FY 2003, MSIS,
(http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/MSISTables2003.pdf)

VI. State Demographics

a. Distribution of State Expenditures

State spending on Medicaid has increased faster than any other major spending category over the past five years. Medicaid spending as a percent of total state spending has risen from 19.5 percent in 1999 to an estimated 21.9 percent in 2004, now surpassing spending on elementary and secondary education as the top expenditure category for states.

Figure 6



Source: State Expenditure Report, 2004, National Association of State Budget Officers

The percent of total expenditures spent on Medicaid by state can be seen in Figure A2 of the Appendix. Tennessee had the highest percent of its state expenditures going toward Medicaid at 35.2 percent and Wyoming had the lowest at 4.6 percent.

Medicaid per capita expenditures by state averaged $4,072 in 2003, the most recent year available (see Appendix Figure A3). New York had the highest per capita spending at $7,583 and California had the lowest at $2,520.

b. Percent of State Populations Covered by Medicaid

Medicaid, on average, now covers 26 percent of all children and 8 percent of all non elderly adults. These figures vary by area with states such as Arkansas, New Mexico, and the District of Columbia covering at least 40 percent of their children, and states such as Vermont, Maine and the District of Columbia covering at least 13 percent of their adult populations (see Table 3).

Low-Income Populations

States have a great degree of flexibility to set income eligibility levels at higher amounts than the federal minimum requirements. As a result, there is wide variation in the extent to which states cover their low-income populations. On average, states enroll 58 percent of their low-income children in Medicaid. Enrollment percentages range from 35 percent to 75 percent. Several states, such as Maine, Vermont, Arkansas, and the District of Columbia enroll over 70 percent of their low-income children in Medicaid (see Figure 7).[11] Other states, such as Colorado and Nevada have less than 40 percent enrolled.

The lower percentage of low-income adults enrolled in states' Medicaid programs reflects the fact that most childless adults, regardless of income level, are not eligible. States on average enroll 27 percent (ranging from 14 to 48 percent) of their low-income adults in Medicaid. Maine, Tennessee, Vermont, Rhode Island, Massachusetts, and the District of Columbia enroll over 40 percent of this population (see Figure 8), while Nebraska, Utah, Colorado, Texas, New Hampshire, Virginia, and Nevada enroll less than 20 percent.

Elderly individuals are covered by the Medicare program, but are also eligible for coverage under Medicaid if they are low-income. These individuals are called dual eligibles, being covered under both programs.[12] States on average enroll 25 percent (ranging from 5 to 44 percent) of their low-income elderly individuals in Medicaid (see Figure 9). Tennessee, Mississippi, and Vermont enroll over 40 percent of this population, while New Hampshire, Illinois, Indiana, Nebraska, and Wisconsin enroll less than 15 percent.

[11] For this analysis the low-income level was set at 100 percent of the FPL.

[12] There are various categories of dual eligibles (QMB, SLMB, QI, QWD), having some of their Medicare premiums and/or cost sharing requirements paid by Medicaid depending on their income level. Additionally, as specified under the MMA of 2005, Medicare now pays for the prescription drug expenses of the elderly, previously paid for by the Medicaid program.

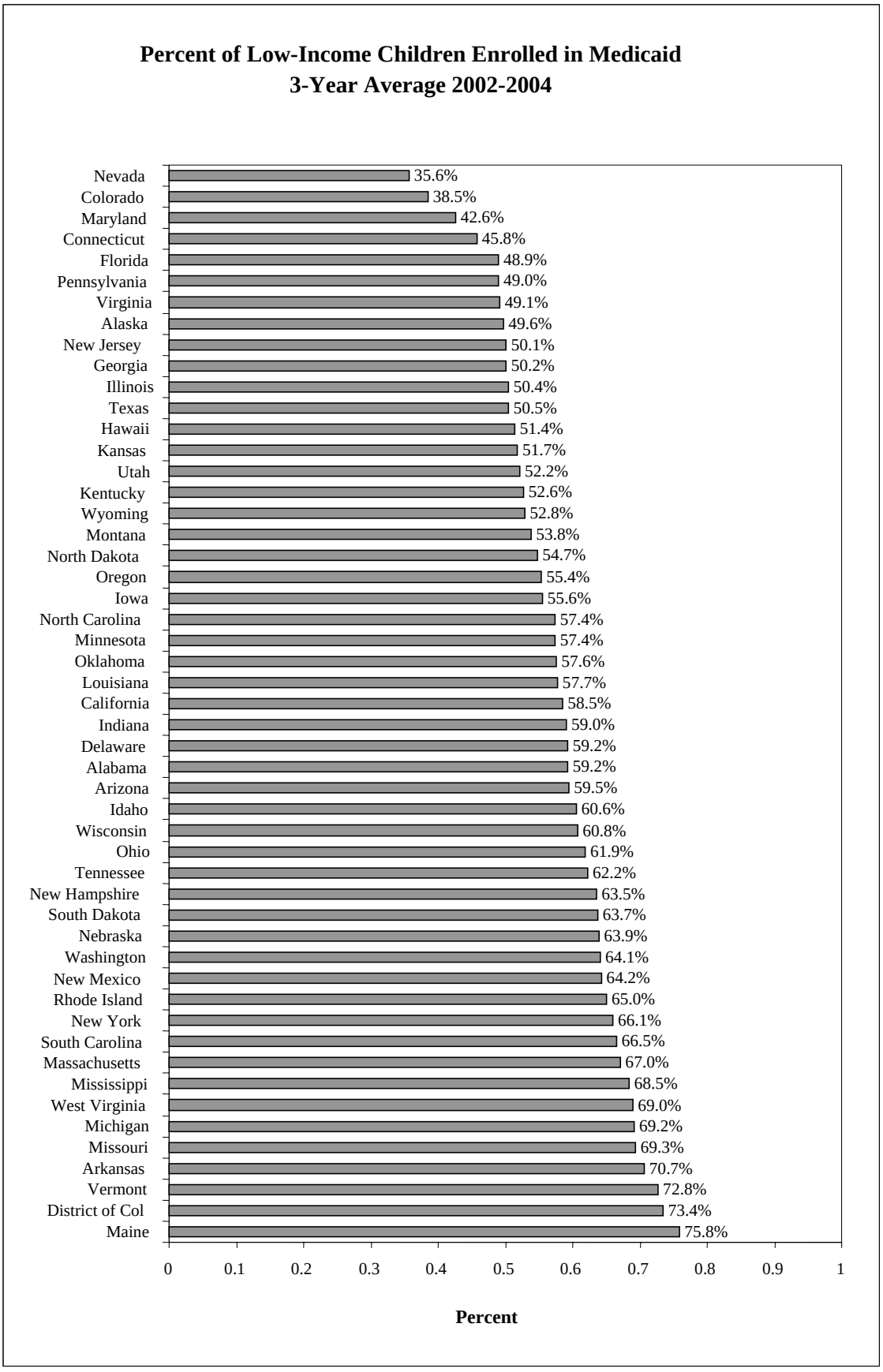
Table 3

Nonelderly with Medicaid

	Child 0-18	Adult 19-64	Child 0-18	Adult 19-64
	number	number	percentage	percentage
United States	20,514,050	13,754,300	26	8
Alabama	344,190	218,620	30	8
Alaska	60,040	31,470	30	8
Arizona	462,600	320,150	29	10
Arkansas	283,830	117,280	40	7
California	3,057,610	2,030,100	30	9
Colorado	184,980	125,920	15	4
Connecticut	174,920	170,420	20	8
Delaware	44,200	36,310	21	7
Dist of Columbia	50,000	48,550	43	13
Florida	1,100,030	588,690	26	6
Georgia	722,280	324,540	30	6
Hawaii	67,960	47,310	22	6
Idaho	110,220	45,980	27	6
Illinois	682,200	435,860	20	6
Indiana	399,770	220,300	24	6
Iowa	151,020	99,850	20	6
Kansas	148,680	82,800	20	5
Kentucky	298,860	230,820	29	9
Louisiana	435,160	183,300	35	7
Maine	104,070	125,790	34	16
Maryland	274,380	125,640	19	4
Massachusetts	334,100	419,110	21	10
Michigan	711,200	484,850	27	8
Minnesota	223,350	199,450	17	6
Mississippi	312,380	174,140	39	10
Missouri	404,390	263,490	27	8
Montana	65,360	38,760	29	7
Nebraska	109,970	47,400	23	5
Nevada	97,960	53,000	15	4
New Hampshire	52,750	18,130	16	2
New Jersey	363,580	259,840	16	5
New Mexico	219,830	102,410	42	9
New York	1,521,090	1,407,830	31	12
North Carolina	586,860	344,300	26	7
North Dakota	28,090	22,090	18	6
Ohio	695,400	470,130	23	7
Oklahoma	256,250	97,740	28	5
Oregon	209,900	151,000	24	7
Pennsylvania	648,660	516,660	21	7
Rhode Island	74,450	77,450	28	12
South Carolina	333,380	208,540	31	9
South Dakota	53,540	26,090	26	6
Tennessee	392,350	463,070	27	13
Texas	1,868,510	719,120	28	5
Utah	133,450	70,010	17	5
Vermont	54,870	48,440	38	13
Virginia	335,110	158,010	17	3
Washington	487,750	288,540	31	8
West Virginia	142,430	98,580	34	9
Wisconsin	357,240	236,150	25	7
Wyoming	33,180	14,610	26	5

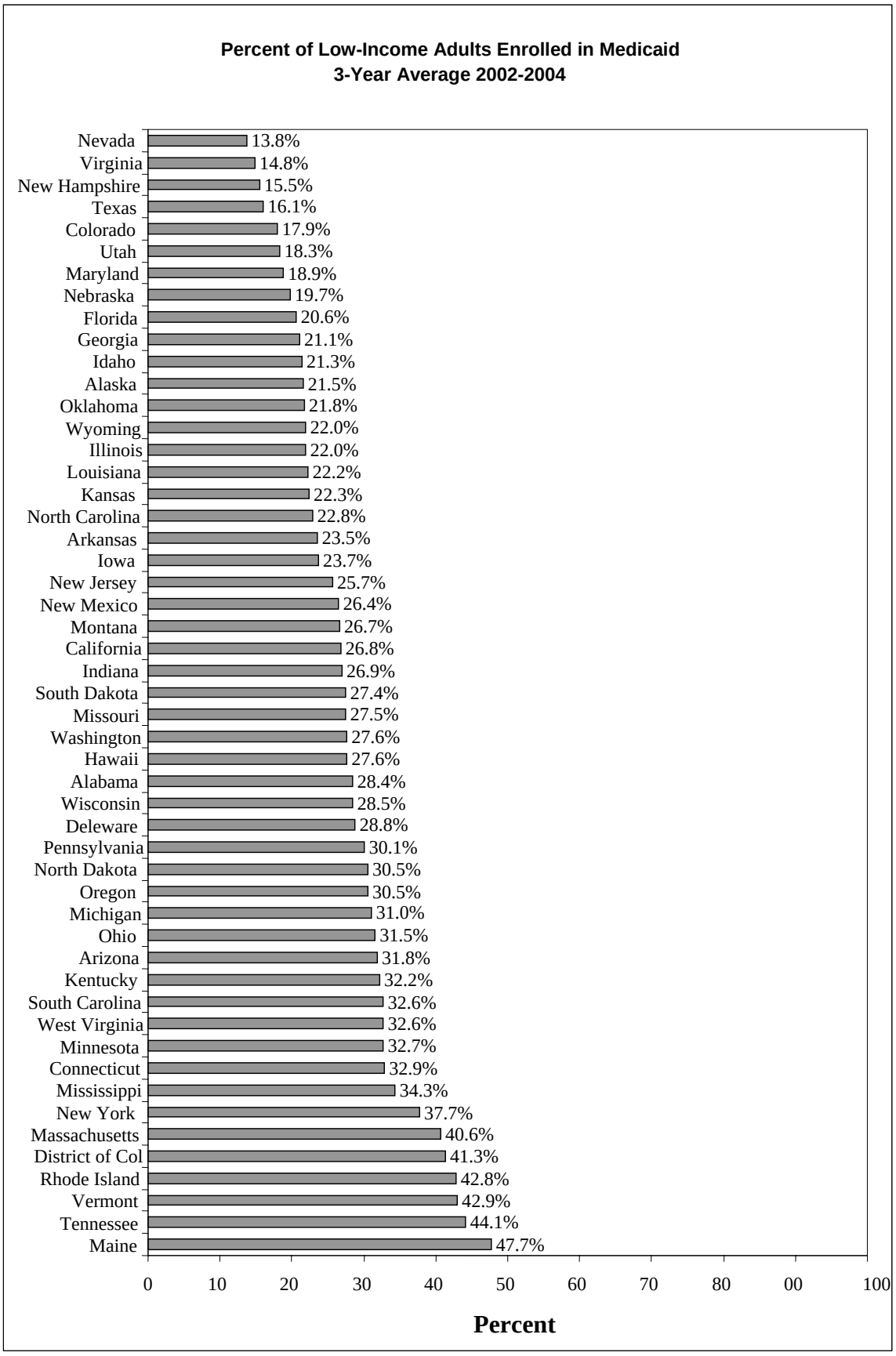
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2004 and 2005 Current Population Surveys. Total US numbers are based on March 2004 estimates.

Figure 7



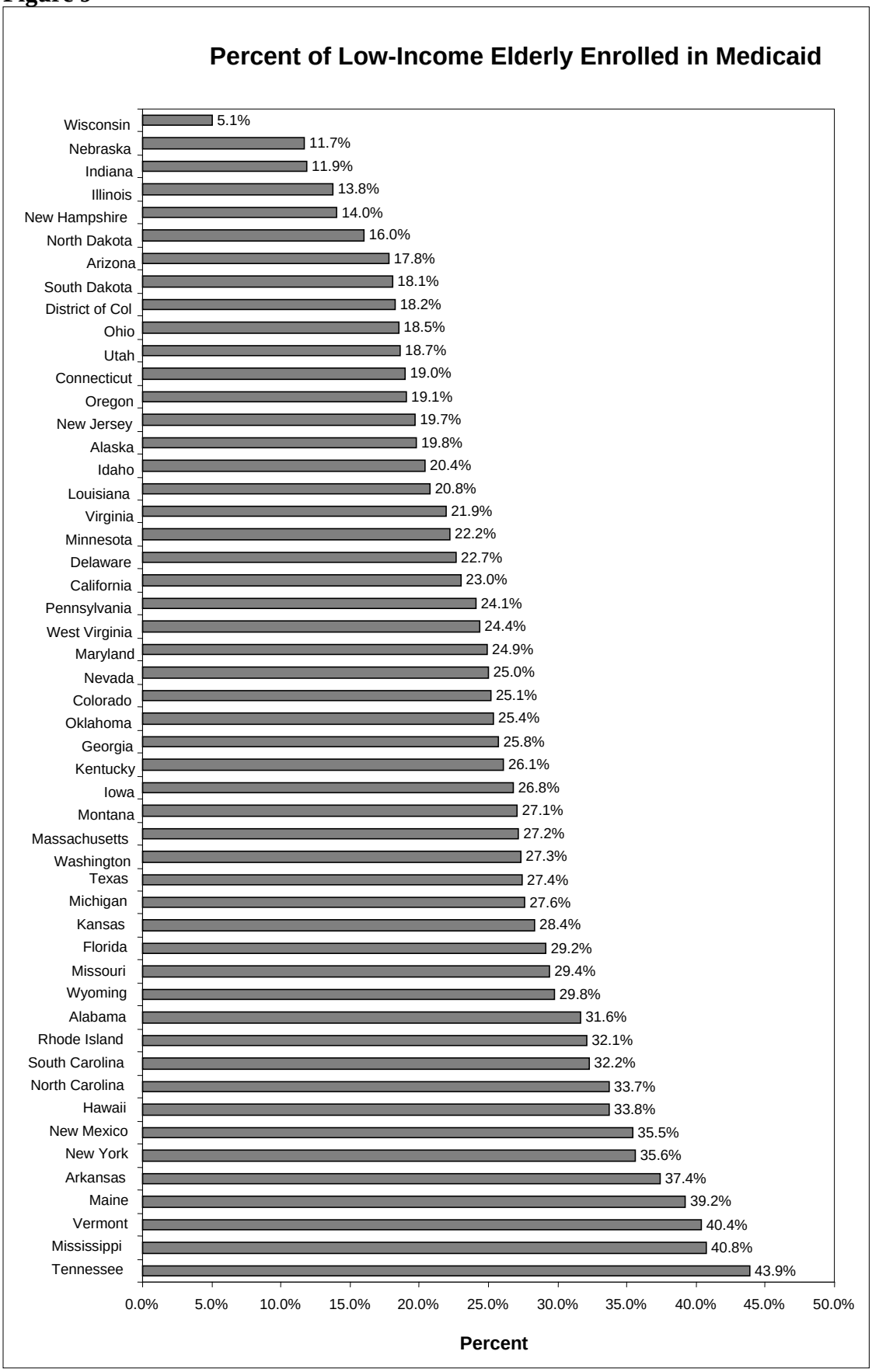
Source: ASPE Tabulations of the Census Bureau's Current Population Survey, 2003-2005.

Figure 8



Source: ASPE Tabulations of the Census Bureau's Current Population Survey, 2003-2005.

Figure 9



Source: ASPE Tabulations of the Census Bureau's Current Population Survey, 2003-2005.

VII. Projections of Enrollment and Spending[13]

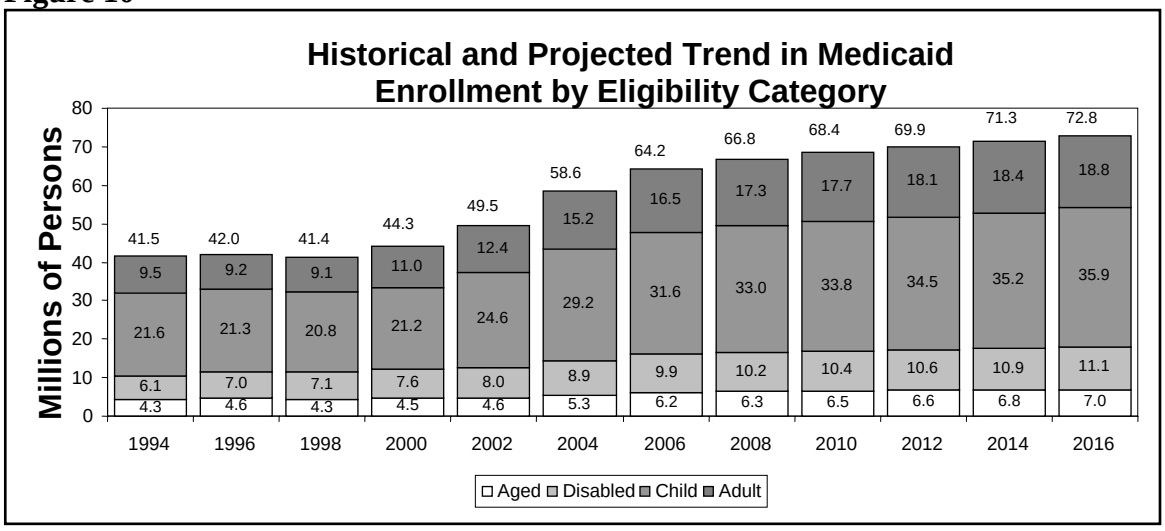
a. Enrollment Trends and Projections

Enrollment growth in the Medicaid program will play a large part in determining future spending. According to figures presented by OACT in the President's FY 2007 Budget, Medicaid enrollment is expected to increase from 47.2 million enrollees in 2004 to 58.6 million in 2016, a 24 percent increase (see Figure 10).

The growth in enrollment will vary by eligibility category, affecting the share of total enrollees in each of the four general categories. The number of children enrolled in Medicaid is projected to increase from 29.2 million in 2004 to 35.9 million in 2016, an increase of 6.7 million children (23 percent). However, the percent of total enrollees that children represent will have slightly declined from 49.8 percent to 49.3 percent. Conversely, while the number of aged enrollees will have increased by only 1.7 million (5.3 million to 7.0 million), this is a 32 percent increase in the number of aged in Medicaid. The aged's share of total Medicaid enrollment will have increased from 9.0 percent to 9.7 percent.

This uneven growth by eligibility category will affect spending trends. The increase in enrollment is estimated to be disproportionately larger for categories of enrollees that have higher per capita spending.

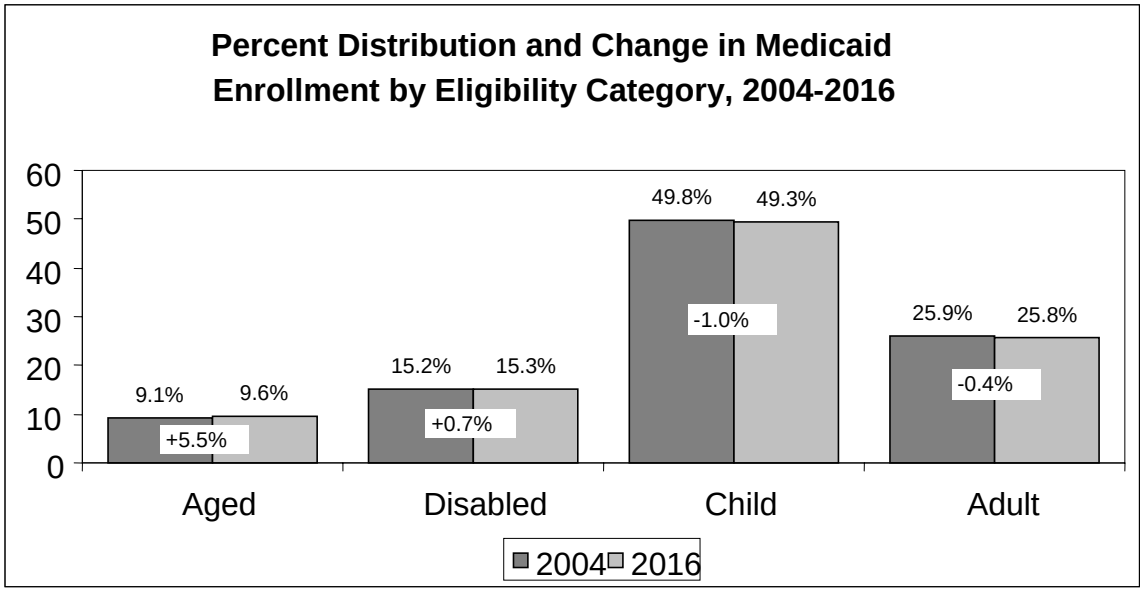
Figure 10



Source: President's FY 2007 Budget and CMS Office of the Actuary historical data.

13 OACT projections use OMB pricing assumptions, SSA wages and market basket trends, and state budget projections, among other factors, to adjust trends from historical bases.

Figure 11



Source: President's FY 2007 Budget Baseline for Medicaid, CMS

b. Medicaid Trends in Comparison to General Health Care Spending Trends

Spending on health care under public programs increased at rates greater than spending from private sources from the late 1990s to early 2000s. According to earlier estimates from OACT, the federal share of Medicaid spending had increased from $76.8 billion to $162.5 billion from 1993 to 2003, a 112 percent increase in total spending, or an average annual rate of increase of 10.3 percent; higher than the total expenditure rate of 8.2 percent (see Table 4).

Table 4

Current and Projected Health Care Spending
Billions of Dollars

Source of Funds	1993	2003	2004	2015	Average Annual Percent Change 1993-2003	2003-2004	2004-2015
Total Expenditures	$916.5	$1740.6	$1877.6	$4031.7	8.2	7.9	7.0
Private	514.2	957.2	1030.3	2116.4	8.6	7.6	6.5
Public	402.3	783.4	847.3	1915.3	7.8	8.2	7.5
Total Medicaid	122.4	271.2	292.7	669.7	8.6	8.3	8.3
Federal	76.8	162.5	173.1	384.4	10.3	6.6	8.2
State	45.6	108.7	119.6	285.3	6.9	10.0	8.3

Source: "Health Spending Projections Through 2015: Changes on the Horizon," OACT, *Health Affairs*, February 22, 2006

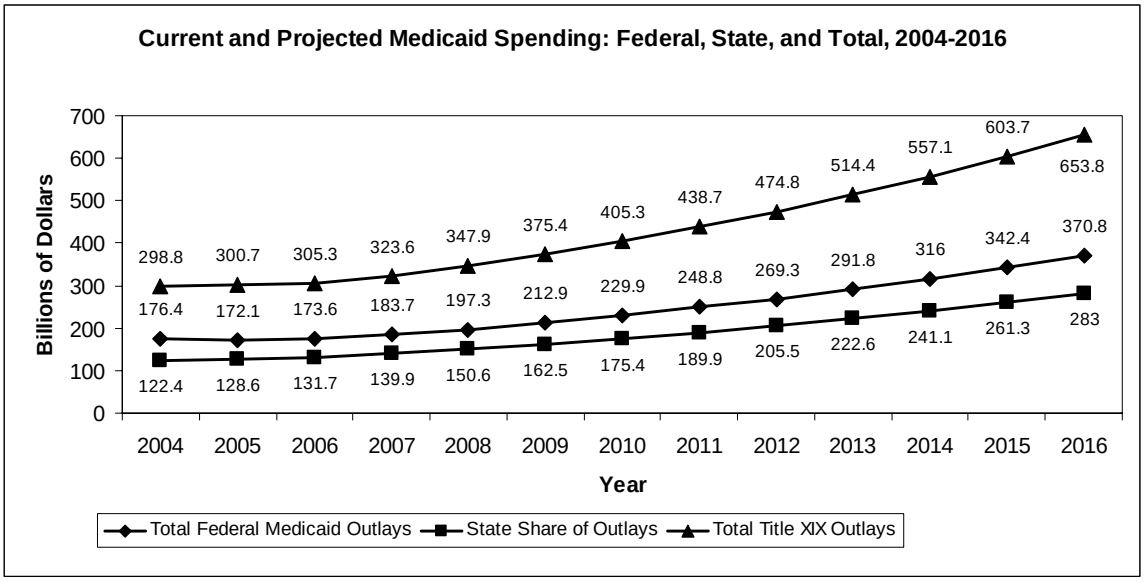
IN 2004, the rate of increase in public spending was 8.2 percent, compared to an overall increase of 7.9 percent and a private spending increase of 7.6 percent. Medicaid, in particular, among other public programs, increased spending by 8.3 percent between

2003 and 2004. The federal share of Medicaid spending increased by 6.6 percent while the state share increased by 10 percent.

Beginning in 2004 it is projected that the rate of increase in Medicaid spending will again exceed the rate of increase in overall health care spending. Projections by OACT indicate that total health care spending will continue to increase at over seven percent per year for the next ten years while Medicaid spending is expected to increase at a rate of nearly eight percent per year.

More recent estimates from OACT indicate that total Medicaid spending will increase from $298 billion in 2004 to $690 billion in 2016 (see Figure 12), an overall increase of almost 131 percent (10.1 percent per year). Federal spending will have increased from $176 billion to $387 billion and state spending from $122 billion to $303 billion, increases of approximately 9.2 percent per year and 11.4 percent per year respectively.

Figure 12



Source: President's FY 2007 Budget Baseline for Medicaid, CMS

c. Spending Trends by Service Type

While overall Medicaid spending is expected to increase by 132 percent between 2004 and 2016, spending for different services will experience strikingly different rates. With rates of spending similar between state and federal expenditures, Table 5 uses federal spending as an example of variation in rates of spending by type of service.

The most visible variance from the overall rate of increase is the much smaller spending increase for prescription drugs due almost entirely to the shifting of coverage of low-income elderly prescription drug spending from Medicaid to Medicare. Between 2005 and 2007 federal Medicaid spending on drugs is expected to decrease from $20 billion to $9 billion. After 2007, the increase in spending on drugs will continue at an annual rate near the overall rate of increase. Because of this shift in coverage from Medicaid to Medicare, federal Medicaid spending on drugs will comprise about 5.9 percent of total spending in 2016, down from 11.4 percent in 2004.

Spending on nursing facilities comprises the largest dollar category of spending in 2004 with $33.5 billion and 20.8 percent of total spending. Its growth rate at 8.3 percent annually will cause spending on nursing facilities to remain the largest spending category of Medicaid at 23.5 percent of total spending in 2016. Home health spending will also increase at a larger rate than other categories, increasing its total share of spending to 18 percent in 2016.

Federal Medicaid spending on home health services will experience the fastest rise in expenditures at 63.2 percent in this time period. Its share of total spending will increase from 11.0 percent in 2004 to 18 percent in 2016.

Table 5

Change in Amount and Distribution of Federal Medicaid Expenditures By Type

	2004		2016		Percent Change*	
	$$ Bil	%	$$ Bil	%	% $$	%
Nursing facility	33.5	20.8%	86.9	23.5%	159.4	12.8%
Health Ins Payments	27.7	17.2%	61.6	16.6%	122.4	-3.3%
Hospital	31.6	19.7%	66.6	18.0%	110.8	-8.7%
Drugs	18.3	11.4%	21.7	5.9%	18.6	-48.6%
Home Health	17.7	11.0%	66.5	18.0%	275.7	63.2%
Other	8.3	5.2%	22.5	6.1%	171.1	16.8%
Medical Prof	9.1	5.7%	18.3	4.9%	101.1	-13.3%
DSH	8.7	5.4%	11.6	3.1%	33.3	-42.0%
Other Acute	5.9	3.7%	14.7	4.0%	149.2	7.3%
Total	**160.8**	**100**	**370.4**	**100**		

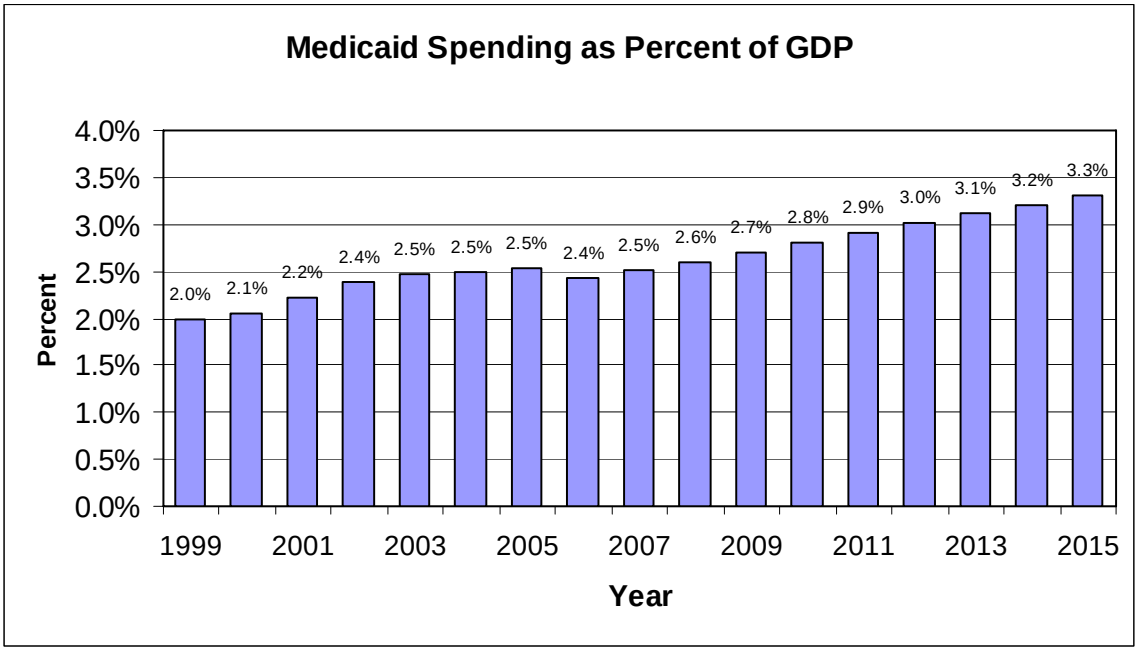
*Numbers in these columns represent the change in dollars and the percent distribution for each spending category. For example, the percent of total expenditures that drugs represent decreased by over half (48.6%) from 11.4 percent of total expenditures to 5.9 percent of the total.

Source: President's FY 2007 Budget Baseline for Medicaid, CMS

d. Medicaid and GDP

Medicaid spending will exceed the rate of growth of other economic indicators. GDP is expected to rise by about five percent per year toward the latter half of the next decade, while Medicaid spending is predicted to rise by 8.5 percent. As a result, Medicaid is predicted to consume a greater percent of GDP by 2015, rising from 2.5 percent in 2003 to 3.3 percent in 2015 (see Figure 13).

Figure 13

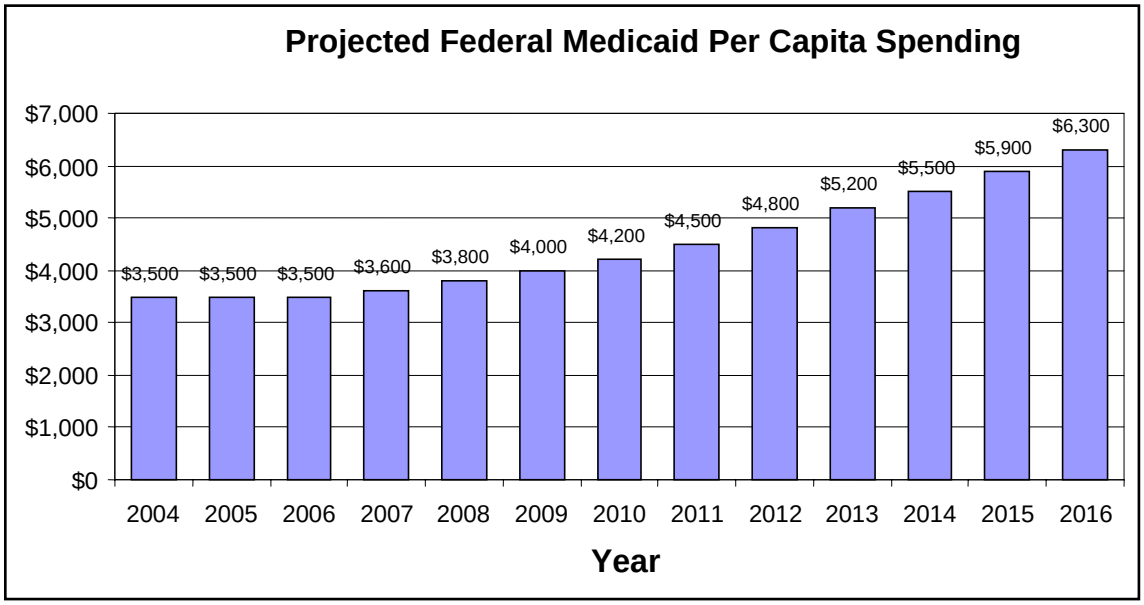


Source: CMS, OACT (http://www.cms.hhs.gov/NationalHealthExpendData) and "Health Spending Growth Slows in 2003," Cynthia Smith et al, CMS, *Health Affairs*, January/February 2005.

e. Per Capita Spending Trends

Because of the increasing cost of care covered by the Medicaid program, per capita spending will increase over the next decade. Per capita spending by Medicaid will continue to rise, doubling from $3,500 per person in 2004 to $6,300 in 2016 (see Figure 14).

Figure 14



Source: President's FY 2007 Budget Baseline for Medicaid, CMS

VIII. Summary

Government and health industry experts agree that over the next decade spending on health care services by both public and private sources will continue to increase at rates above the rate of overall consumer spending.

Medicaid, the shared federal and state program that pays for medical assistance for certain individuals and families with low incomes, is expected to increase its spending on health services above the rates of spending of both Medicare and private health care spending.

Medicaid is particularly vulnerable to factors affecting health care spending because of its role as the safety net program for low-income populations. In fact, the number of Medicaid enrollees has increased by 14 percent since the year 1999 with spending by both federal and state sources increasing by more than 65 percent. The problem of increased spending on Medicaid is particularly difficult for states who must administer the program and for which Medicaid has now exceeded other state programs as the largest category of states' budgets, surpassing spending on elementary and secondary education.

Appendix A Additional Tables and Charts

Table A1

Medicaid Expenditures in $$ Millions
Actual Fiscal 2004

State	General Fund	Federal Funds	Other State Funds	Total
Alabama	326	2,731	716	3,773
Alaska	230	669	83	982
Arizona	674	2,781	359	3,814
Arkansas	459	2,101	150	2,710
California*	11,009	15,459	3,018	29,486
Colorado	1,127	1,442	148	2,717
Connecticut	2,849	1,938	692	5,479
Delaware	346	384	0	730
Florida*	3,711	8,330	1,038	13,079
Georgia	1,716	3,669	53	5,438
Hawaii	322	530	8	860
Idaho	225	650	77	952
Illinois	3,277	5,539	1,684	10,500
Indiana*	1,488	2,808	11	4,307
Iowa	332	1,509	556	2,397
Kansas	549	1,103	80	1,732
Kentucky	740	3,003	377	4,120
Louisiana	723	3,614	541	4,878
Maine	529	1,454	64	2,047
Maryland	2,142	2,432	0	4,574
Massachusetts	2,908	2,908	0	5,816
Michigan*	1,960	4,803	1,492	8,255
Minnesota	2,341	2,831	0	5,172
Mississippi	258	2,674	541	3,473
Missouri*	1,097	3,691	957	5,745
Montana	127	493	20	640
Nebraska	457	895	25	1,377
Nevada	524	624	86	1,234
New Hampshire	374	599	168	1,141
New Jersey	3,556	4,023	50	7,629
New Mexico	418	1,886	34	2,338
New York	6,061	18,729	2,772	27,562
North Carolina	1,983	5,163	235	7,381
North Dakota	136	356	0	492
Ohio*	9,858	1,702	934	12,494
Oklahoma	596	1,852	125	2,573
Oregon	731	1,731	262	2,724
Pennsylvania*	5,054	8,441	1,553	15,048
Rhode Island	592	845	0	1,437
South Carolina	487	2,868	602	3,957
South Dakota	169	410	0	579
Tennessee*	2,108	4,857	666	7,631
Texas*	5,811	9,631	0	15,442
Utah*	192	915	163	1,270
Vermont	60	439	191	690
Virginia	1,812	1,977	37	3,826
Washington	2,420	2,750	0	5,170
West Virginia	228	1,554	211	1,993
Wisconsin	778	2,728	1,291	4,797
Wyoming	36	64	0	100
All States	**85,906**	**154,585**	**22,070**	**262,561**

Source: National Association of State Budget Officers, 2004 State Expenditure Report

Table A2

Medicaid Expenditures as a Percent of Total Expenditures

State	Fiscal 2003	Fiscal 2004	Fiscal 2005
Alabama	23.6	23.5	20.8
Alaska	12.7	12.8	10.0
Arizona	17.5	17.6	19.5
Arkansas	19.5	19.8	19.0
California	19.2	18.8	20.2
Colorado	17.3	19.9	20.8
Connecticut	26.4	27.0	27.8
Delaware	15.5	15.6	15.4
Florida	24.0	25.2	24.5
Georgia	18.4	19.0	19.1
Hawaii	10.7	10.8	10.0
Idaho	19.6	20.8	20.6
Illinois	23.7	20.9	25.5
Indiana	20.5	20.0	21.5
Iowa	18.3	17.8	15.1
Kansas	17.6	17.0	18.8
Kentucky	20.8	21.7	20.9
Louisiana	23.6	24.1	20.6
Maine	28.5	31.3	33.3
Maryland	27.0	27.1	27.6
Massachusetts	20.8	22.6	23.2
Michigan	20.0	20.8	20.9
Minnesota	20.1	22.0	20.1
Mississippi	31.1	32.2	32.5
Missouri	32.6	32.0	34.4
Montana	15.6	16.2	14.9
Nebraska	18.9	19.4	17.4
Nevada	18.6	18.2	16.9
New Hampshire	21.7	26.4	28.0
New Jersey	22.0	20.6	19.3
New Mexico	22.1	24.4	22.0
New York	28.4	28.3	29.2
North Carolina	23.4	23.0	25.6
North Dakota	15.8	16.8	16.0
Ohio	23.1	25.9	23.1
Oklahoma	18.4	19.7	19.1
Oregon	17.7	15.9	16.4
Pennsylvania	29.8	31.3	32.1
Rhode Island	26.2	24.9	24.0
South Carolina	23.0	24.9	26.3
South Dakota	21.1	21.8	21.1
Tennessee	34.2	35.2	35.2
Texas	24.7	24.3	23.4
Utah	14.5	16.1	17.0
Vermont	21.4	21.5	20.5
Virginia	13.5	13.6	13.6
Washington	22.2	19.9	20.2
West Virginia	11.0	12.0	12.3
Wisconsin	12.6	14.6	14.3
Wyoming	4.6	4.6	4.5
All States	**22.0**	**22.3**	**22.5**

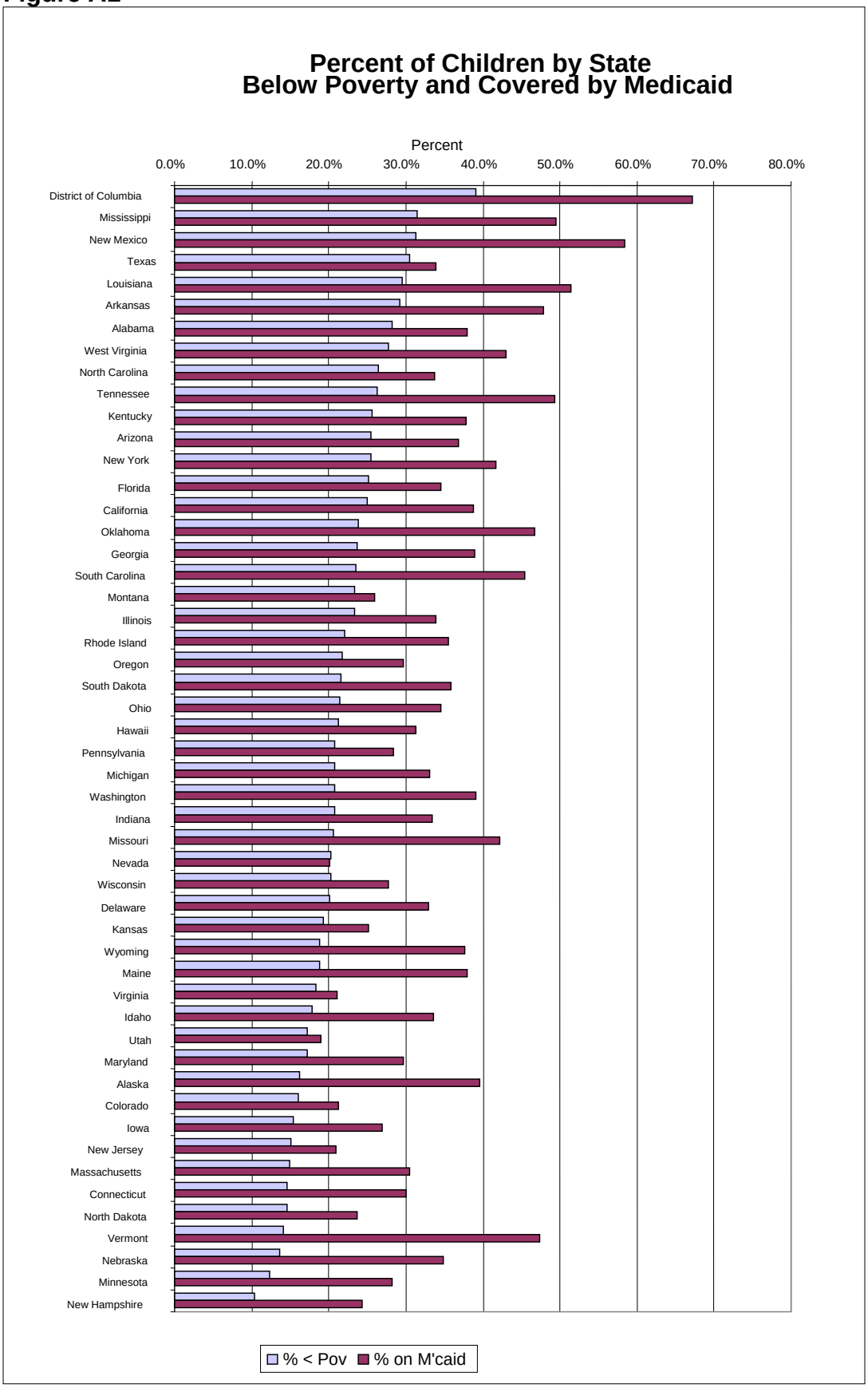
Source: National Association of State Budget Officers, 2004 State Expenditure Report

Table A3

Medicare Payments Per Enrollee by Enrollment Group, FY 2003					
	Children	Adults	Elderly	Disabled	Average
United States	1,467	1,872	10,799	12,265	4,072
Alabama	1,595	989	7,485	5,623	3,119
Alaska	3,504	4,443	17,921	23,402	6,512
Arizona	1,443	1,293	7,531	10,924	2,525
Arkansas	1,396	879	9,919	8,420	3,215
California	1,210	813	8,016	11,475	2,520
Colorado	1,603	2,447	12,290	13,932	4,595
Connecticut	1,920	2,281	20,158	21,050	6,657
Delaware	1,887	2,661	14,524	15,535	4,738
Dist of Col.	2,775	3,255	18,038	19,176	7,020
Florida	1,160	1,696	8,986	9,938	3,621
Georgia	1,302	2,606	7,336	7,421	3,061
Hawaii	1,413	2,163	10,102	9,835	3,462
Idaho	1,220	2,698	14,368	14,759	4,119
Illinois	1,372	2,359	4,749	13,077	3,552
Indiana	1,402	2,206	12,360	12,843	4,087
Iowa	1,540	2,358	13,351	14,611	5,169
Kansas	1,499	2,058	14,027	13,823	4,856
Kentucky	1,844	2,651	9,526	7,878	4,339
Louisiana	912	2,572	7,671	9,100	3,236
Maine	3,961	3,606	5,054	9,155	5,445
Maryland	2,327	3,984	14,345	17,053	5,870
Massachusetts	1,593	1,637	14,052	13,012	5,312
Michigan	1,033	1,993	11,601	10,446	3,741
Minnesota	2,254	2,440	13,977	21,583	6,376
Mississippi	1,225	2,664	8,142	7,132	3,495
Missouri	1,552	1,794	11,386	10,676	3,784
Montana	1,888	2,858	13,591	10,942	4,664
Nebraska	1,768	2,222	15,166	13,382	4,344
Nevada	1,409	2,059	7,336	11,033	3,491
New Hampshire	2,292	2,606	17,442	17,338	6,039
New Jersey	1,749	2,345	14,983	16,456	6,091
New Mexico	1,907	2,176	11,701	14,180	3,818
New York	1,885	3,418	21,903	24,888	7,583
North Carolina	1,540	2,884	9,478	11,558	4,463
North Dakota	1,537	1,879	16,966	17,195	5,702
Ohio	1,357	2,364	19,843	14,873	5,265
Oklahoma	1,319	1,608	8,847	9,808	3,171
Oregon	1,598	1,823	9,689	10,196	3,345
Pennsylvania	1,780	2,491	14,452	9,756	5,268
Rhode Island	2,175	2,301	16,045	16,262	6,308
South Carolina	1,421	1,538	4,901	9,352	2,974
South Dakota	1,688	2,601	12,259	14,014	4,451
Tennessee	1,163	2,658	7,307	7,361	3,283
Texas	1,478	2,419	7,842	10,599	3,371
Utah	1,591	1,413	10,295	13,983	3,286
Vermont	2,095	1,713	7,849	12,970	3,977
Virginia	1,393	2,354	9,065	10,585	4,241
Washington	1,050	1,880	9,347	8,223	2,793
West Virginia	1,545	2,166	13,001	8,480	4,456
Wisconsin	1,076	2,012	9,272	12,922	4,317
Wyoming	1,517	2,476	13,118	16,377	4,220

Source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2006

Figure A1



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2004 and 2005 Current Population Surveys. Total US numbers are based on March 2004 estimates.

Appendix B – Medicaid Program Requirements

The Medicaid program is a joint federal/state partnership that provides health coverage to low-income families, children and pregnant women, aged, blind and disabled individuals and certain other special categories of individuals, such as Qualified Medicare Beneficiaries. In order to receive federal Medicaid funds, states must comply with federal laws and regulations. For example, to receive federal funds, states are required to provide Medicaid to individuals who fall into a mandatory eligibility group, and cover services for all Medicaid eligible individuals.

Eligibility

The most basic principle of Medicaid eligibility is that an individual must fit into a Medicaid eligibility group. A Medicaid eligibility group consists of people who share specific common characteristics and who meet specific eligibility requirements. There are three broad classifications of Medicaid eligibility groups:

1. Mandatory categorically needy:
2. Optional categorically needy: and
3. Medically needy.

These classifications are further explained below.

To be eligible under a given group, an individual must meet both the financial and non-financial criteria for that group. Non-financial conditions of eligibility may include some or all of the following: age, disability status, state residency, U.S. citizenship or satisfactory immigration status, provision of the applicant's Social Security Number, cooperation with paternity requirements, and mandatory assignment of rights to payments for medical support and medical care from any liable third party. Financial eligibility requires that an individual meet specified income and/or resource standards for the eligibility group in question. The non-financial conditions of eligibility generally are the same in all states. Each state, however, has the flexibility in establishing its own income and resource tests. Therefore, financial eligibility for Medicaid benefits varies from state to state.

Historically, eligibility for Medicaid was tied to receipt of cash assistance – Aid to Families with Dependent children (AFDC) for children, pregnant women, parents and caretakers; Supplemental Security Income (SSI) for aged, blind and disabled individuals. Over the years, Congress added various other coverage groups for individuals who are not receiving cash assistance – e.g., children in families whose income is too high to receive cash assistance. Then, in 1996, the historic link between eligibility for Medicaid and AFDC was broken with the passage of welfare reform (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) when Congress replaced AFDC with Temporary Assistance for Needy Families (TANF). Thus, eligibility for TANF does not automatically confer Medicaid eligibility. In establishing financial eligibility for families, children and pregnant women, however, many of the rules followed under AFDC are still used for determining Medicaid eligibility for families, children and pregnant women today. For this reason, the eligibility groups for families, children and pregnant women often are referred to as "AFDC-related groups."

In many states, eligibility for aged, blind and disabled individuals' remains directly linked to eligibility for SSI. A few states have adopted more restrictive Medicaid eligibility criteria for aged, blind and disabled individuals than SSI, but SSI eligibility rules serve as the starting point. Congress also has added additional eligibility groups for aged, blind and disabled individuals who are not actually receiving SSI, and many of the rules used by SSI also are used for determining eligibility for these groups. For this reason, eligibility groups for aged, blind and disabled individuals often are referred to as "SSI-related groups."

To receive federal matching funds under Medicaid, states are required to provide coverage to individuals who meet the eligibility requirements for specified eligibility groups, referred to as the mandatory categorically needy groups. Examples of mandatory categorically needy groups include:

- Low-income pregnant women with income below 133% FPL;
- Low-income infants with income below 133% FPL;
- Low-income families who meet certain pre-welfare reform AFDC eligibility requirements (e.g., income and resources);
- Low-income children aged 1-5 with income below 133% FPL;
- Low-income children aged 6-18 with income below 100% FPL;
- Aged, blind and disabled individuals receiving SSI;
- Aged, blind and disabled individuals who are deemed to be receiving SSI.

A listing of all the mandatory categorically needy eligibility groups with accompanying statutory citations can be found on page 14 of the document entitled "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources" on the CMS Website.

States have the option, but are not required, to provide Medicaid coverage for certain other categorically needy eligibility groups. These optional groups generally share the "categorical" characteristics of the mandatory categorically needy groups –i.e. they cover pregnant women, children or families or aged, blind or disabled individuals – but either has less restrictive income and resource standards than those of the mandatory groups, or is less restrictive than the mandatory groups in some way.

Examples of optional eligibility groups include:

- Individuals under age 21 who meet the income and resource requirements of the AFDC program;
- Individuals age 65 and over who would be eligible for SSI if they were not in a medical institution;
- Disabled individuals or individuals age 65 and over who have been in a medical institution for at least 30 consecutive days and whose gross income does not exceed 300% of the SSI income standard;
- Disabled individuals or individuals 65 and over who are receiving a state supplement payment, or who would be receiving such a payment if they were not in a medical institution;
- Individuals screened for breast or cervical cancer under the CDC program.

A listing of the most commonly used optional categorically needy eligibility groups with accompanying statutory citations can be found on page 18 of the document entitled "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources" on the CMS Website.

States also can, but are not required to, cover "medically needy" individuals. This option allows states to provide Medicaid to individuals who meet the non-financial eligibility requirements of one of the mandatory or optional categorically needy groups, but whose income exceeds the income standard for the group in question. Under this option, an individual can meet the income standard for a medically needy eligibility group by incurring medical and/or remedial care expenses equal to the difference between their income and the relevant income standard. This process commonly is referred to as "spenddown." States also can give individuals the option to spenddown to the medically needy income standard by making a lump sum of monthly installment payments to the state totaling the difference between their income and the income eligibility standard.

If a state elects to provide coverage to medically needy individuals, it must cover medically needy children under age 18 and pregnant women. States may also choose to provide coverage to other groups of medically needy individuals, including aged, blind and/or disabled individuals; certain specified relatives of dependent children; and children up to age 21.

It is important to note that any individual who is described in one of the mandatory or optional categorically needy groups cannot be eligible under a medically needy group. This is the case whether or not the state has elected to cover a particular optional categorically needy group in which an individual is described. For example, there is an optional categorically needy group for individuals under age 21 who meet the income and resource requirements of the former AFDC program. Therefore, a 20-year old with income and resources below the standards of the state's former AFDC program cannot be eligible for medically needy coverage because such individual is described in this optional group, even if the state has not actually adopted this optional group.

Benefits

Medicaid is a state administered program. Each state determines their program's benefit and service provisions, subject to federal rules and guidelines. Certain services must be covered by the states in order to receive federal funds. Other services are optional and are elected by states. Title XIX of the Social Security Act requires that in order to receive Federal matching funds, certain mandatory services must be offered to the categorically needy population in any state program[14]:

- Inpatient hospital services;

[14] With the passage of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA), states are now allowed to provide "benchmark" or "benchmark equivalent" coverage to subpopulations of Medicaid enrollees. The statewideness and comparability rules, which required uniform coverage across all categories of enrollees and throughout each state, may no longer apply to all Medicaid covered populations. In addition, states are prohibited from covering several populations with benchmark and benchmark equivalent coverage.

- Outpatient hospital services;
- Physician services;
- Medical and surgical dental services performed by a dentist when under state law that service could be performed by a physician;
- Nursing facility (NF) services for individuals aged 21 or older;
- Home health care for persons eligible for nursing facility services;
- Family planning services and supplies;
- Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the state plan;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Federally-qualified health center services and any other ambulatory services offered by a federally-qualified health center that are otherwise covered under the state plan;
- Nurse-midwife services (to the extent authorized under state law); and
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21.

If a state chooses to include the medically needy population, the state plan must provide, as a minimum, the following services:

- Prenatal care and delivery services for pregnant women;
- Ambulatory services to individuals under age 18 and individuals entitled to institutional services;
- Home health services to individuals entitled to nursing facility services; and
- If the state plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded (ICF/MRs), it must offer either of the following to each of the medically needy groups: the services contained in 42 CFR sections 440.10 through 440.50 and 440.165 (to the extent that nurse-midwives are authorized to practice under state law or regulations); or the services contained in any seven of the sections in 42 CFR 440.10 through 440.165.

States may also receive Federal funding if they elect to provide other optional services. The most commonly covered optional services under the Medicaid program include:

- Clinic services;
- Nursing facility services for the under age 21;
- Intermediate care facility/mentally retarded services;
- Optometrist services and eyeglasses;
- Prescribed drugs;
- TB-related services for TB infected persons;
- Prosthetic devices; and
- Dental services.

States may provide home and community-based care waiver services to certain individuals who are eligible for Medicaid. The services to be provided to these persons may include case management, personal care services, respite care services, adult day

health services, homemaker/home health aide, habilitation, and other services requested by the state and approved by CMS.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPT) gives states the option to provide medical services to certain women who have been found to have breast or cervical cancer or precancerous conditions. For further information, see the Medicaid BCCPT information website. States may also receive enhanced funding for this new option.

Within broad Federal guidelines, states determine the amount, duration, and scope of services offered under their Medicaid programs. The amount, duration, and scope of each service must be sufficient to reasonably achieve its purpose. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, states may place a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained prior to service delivery.

Health care services identified under the EPSDT program as being "medically necessary" for eligible children must be provided by Medicaid, even if those services are not included as part of the covered services in that state's plan.

With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers participating in Medicaid. States may provide and pay for Medicaid services through various prepayment arrangements, such as a health maintenance organization (HMO). In general, states are required to provide comparable services to all categorically needy eligible persons.

There is an important exception related to home and community-based services "waivers," under which states offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers so long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients).

States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such co-payments. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care.

Financing

Medicaid is financed jointly by the Federal and state government. The portion of the Medicaid program which is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each state by a formula that compares the state's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent nor greater than 83 percent. The wealthier states have a smaller share of their costs reimbursed. The Federal government also shares in the state's expenditures for administration of the Medicaid

program. Most administrative costs are matched at 50 percent for all states. However, higher matching rates (75, 90 and 100 percent) are authorized by law for certain functions and activities.

The amount of total Federal outlays for Medicaid has no set limit; rather, the Federal government must match whatever the individual state decides to provide, within the law, for its eligible recipients. However, reimbursement rates must be sufficient to enlist enough providers so that medical care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area.

States must also augment payment to qualified hospitals that serve a disproportionate number of Medicaid and low income patients under what is known as the disproportionate share hospital (DSH) program. Each state is limited by an overall State-specific DSH allotment and the amount of DSH payment may not exceed a hospital's uncompensated care regarding the provision of inpatient and outpatient services to Medicaid and uninsured patients. The federal government generally has little discretion over the payment rates established by states, as long as they fall within broad federal parameters to insure against excessively large or small payments, such as imposed upper payment limits or UPLs.