Medicaid Overview

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CSG Policy Academy

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The basic foundations of Medicaid are related to the entitlement and the federal-state partnership.

**Entitlement**
- **Eligible Individuals** are entitled to a defined set of benefits.
- **States** are entitled to federal matching funds.

**Federal**
- Sets core requirements on eligibility and benefits.

**State**
- Flexibility to administer the program within federal guidelines.

**Partnership**
Medicaid plays a central role in our health care system.

- Health Insurance Coverage For 1 in 5 Americans
- Assistance to 10 million Medicare Beneficiaries
- > 50% Long-Term Care Financing

Support for Health Care System and Safety-Net

State Capacity to Address Health Challenges
Figure 3

Medicaid is a budget item and a revenue item in state budgets.

- **Total State Spending (State & Federal Funds):** $1.85 Trillion
  - Medicaid: 52.3%
  - Elementary & Secondary Education: 59.6%
  - Other: 34.4%
  - Federal Funds: 56.8%

- **State Funds (General & Other Funds):** $1.24 Trillion
  - Medicaid: 19.5%
  - Elementary & Secondary Education: 24.8%
  - Other: 15.6%

SOURCE: Kaiser Family Foundation estimates based on the NASBO’s November 2016 State Expenditure Report (data for Actual FY 2015.)
Figure 4

Medicaid spending is mostly for the elderly and people with disabilities, FY 2014.

Enrollees
Total = 80.7 Million

Expenditures
Total = $462.8 Billion

NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.
Figure 5

Nationally, Medicaid covers 44% of children with special health care needs.

U.S. = 44%

NOTE: Medicaid/CHIP also includes Medicare and Medigap. Includes children with special health care needs with Medicaid/CHIP only and Medicaid/CHIP and private insurance.

Between 2005 and 2015, national opioid death rate increased from 5.1 to 10.4 per 100,000, with the highest increases in a few states (CT, DE, MS, NH, NY, OH and WV).

NOTE: Data for AK, ND, and WY are not available.

SOURCE: Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2015 on CDC WONDER Online Database
The Medicaid expansion was designed to fill the gaps in Medicaid coverage.

NOTE: The June 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius maintained the Medicaid expansion, but limited the Secretary's authority to enforce it, effectively making the expansion optional for states. 138% FPL = $16,643 for an individual and $28,180 for a family of three in 2017.
NOTES: Coverage under the Medicaid expansion became effective January 1, 2014 in all but seven expansion states: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2016), and Louisiana (7/1/2016).

Seven states that will have Republican governors as of January 2017 originally implemented expansion under Democratic governors (AR, IL, KY, MA, MD, NH, VT), and one state has a Democratic governor but originally implemented expansion under a Republican governor (PA). *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers.

To date, 32 states have implemented the Medicaid expansion.
The uninsured rate has decreased everywhere, but especially in Medicaid expansion states.

NOTE: Uninsured rates for 2016 are as of June 2016.

Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.

Percent reporting in the last year:

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid</th>
<th>ESI</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Checkup</td>
<td>85%</td>
<td>86%</td>
<td>53%</td>
</tr>
<tr>
<td>Doctor Visit Among Adults</td>
<td>74%</td>
<td>69%</td>
<td>36%</td>
</tr>
<tr>
<td>Specialist Visit Among Adults</td>
<td>30%</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>Adults Satisfied With Their Health Care</td>
<td>85%</td>
<td>87%</td>
<td>44%</td>
</tr>
</tbody>
</table>

NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care.

SOURCE: KCMU analysis of 2015 NHIS data.
### How the BCRA changes key elements of Medicaid:

<table>
<thead>
<tr>
<th></th>
<th>Current Law</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACA Medicaid Expansion</strong></td>
<td>Expands adult coverage to 138% FPL</td>
<td>Makes expansion population a state option</td>
</tr>
<tr>
<td></td>
<td>• Provides enhanced federal matching dollars for newly eligible (90% by 2020)</td>
<td>• Phases out the enhanced match beginning 1/1/2021 for newly enrolled expansion adults</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Guarantees federal matching dollars with <strong>no cap</strong></td>
<td><strong>Caps federal matching dollars in 2020:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establishes per enrollee spending caps by eligibility group – <strong>limits growth to inflation (CPI-U)</strong> by 2025</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• States have option for block grant for children and adults</td>
</tr>
</tbody>
</table>
Figure 12
The ACA expanded Medicaid coverage and financing.

- Medicaid Enrollment 2Q FY 2016: 74 Million
- Medicaid Spending FY 2015: $524 Billion

- 11 Million were newly eligible
- $68 Billion in Federal Funds for Expansion (94%)
- $261 Billion in Federal Funds for Traditional (58%)

NOTES: Enrollment data for 2 quarters FY 2016 (maximum for the time period) or 31 states that implemented the Medicaid expansion as of January 2016 (Louisiana expanded Medicaid on 7/1/16 and has no data reported. SOURCE: KCMU analysis of data from Medicaid Budget and Expenditure System (MBES).
The Medicaid expansion has coverage and fiscal implications for states beyond Medicaid.

**Federal + State Funds**

**Increased Economic Activity**
- ↑ General fund revenue and GDP
- ↑ or neutral effects on employment

**Reduction in the Number of Uninsured**

**Increased Access to Care and Service Utilization**
- ↑ Affordability and Financial Security

**Increased State Savings**
- ↓ Uncompensated care costs
- ↓ State-funded health programs (e.g. behavioral health and corrections)

Medicaid block grants or per capita caps are designed to cap federal spending.

- **Current law**: Reflects increases in health care cost, changes in enrollment, and state policy choices.
- **Block grant**: Does not account for changes in enrollment or changes in health care costs.
- **Per capita cap**: Does not account for changes in health care costs.
Reducing and capping federal Medicaid funds could:

- Shift costs and risks to states, beneficiaries, and providers if states restrict eligibility, benefits, and provider payment.
- Lock in past spending patterns:
  - If expansion funding is cut, the impact could be even greater for the 32 states that expanded Medicaid.
- Limit states’ ability to respond to rising health care costs, increases in enrollment due to a recession, or a public health emergency such as the opioid epidemic, HIV, Zika, etc.
Other Key Medicaid Provisions in the BCRA

- Makes adjustments to states that spend 25% above or below mean per enrollee amounts
- Limits states’ ability to use provider taxes to finance their share of Medicaid
- Allows states to impose a work requirement
- Makes changes to enrollment processes to make it more difficult to obtain and maintain coverage
- Provides funds for a Safety Net Pool ($10 billion for 2018-2022) and eliminates DSH cuts for non-expansion states
- Repeals enhanced match for Community First Choice
- Eliminates Medicaid funding for Planned Parenthood for one year
NOTES: Includes Medicaid provider taxes as reported by states. It is possible that there are other sources of revenue from taxes collected on health insurance premiums or health insurance claims that are not reflected here. *ME did not report whether its provider taxes exceeded 3.5% or 5.5%.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016.
<table>
<thead>
<tr>
<th>Year</th>
<th>Reduction in Federal Medicaid Spending (in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>-$12</td>
</tr>
<tr>
<td>2018</td>
<td>-$23</td>
</tr>
<tr>
<td>2019</td>
<td>-$52</td>
</tr>
<tr>
<td>2020</td>
<td>-$70</td>
</tr>
<tr>
<td>2021</td>
<td>-$87</td>
</tr>
<tr>
<td>2022</td>
<td>-$103</td>
</tr>
<tr>
<td>2023</td>
<td>-$124</td>
</tr>
<tr>
<td>2024</td>
<td>-$143</td>
</tr>
<tr>
<td>2025</td>
<td>-$158</td>
</tr>
<tr>
<td>2026</td>
<td></td>
</tr>
</tbody>
</table>

**In 2026**
- 15 million ↓ Medicaid enrollees
- 26% ↓ in federal funds
- 22 million ↑ in uninsured → 49 million uninsured

Certain characteristics put some states at higher risk than others under federal Medicaid cuts and caps.

- Medicaid Expansion Decision / Limited Medicaid Programs
- Challenging Demographics
- Poor Health Status
- High Cost Health Markets
- Low Spending and Low Tax Capacity

Figure 20

States that adopted the Medicaid expansion could lose more financing and coverage with changes to the ACA enhanced match rate; non-expansion states would lose the option to finance new coverage.

High Share Expansion Enrollees as % of Total
- Oregon
- New York
- Arkansas
- West Virginia
- Kentucky

High Share of Federal Expansion Funding as % of All Federal Medicaid
- Washington
- Oregon
- Nevada
- Kentucky
- Hawaii

Largest Percentage Point Reduction in Uninsured
- Nevada
- Kentucky
- California
- New Hampshire
- Arkansas

Highest Uninsured Rate
- Texas
- Georgia
- Florida
- Mississippi
- Oklahoma

Largest Number of People in the Coverage Gap
- Texas
- Florida
- Georgia
- North Carolina
- South Carolina

NOTE: States in multiple categories are shown in orange.
States with certain demographic and health status characteristics are at higher risk with federal Medicaid cuts or caps.

- **High Projected Growth 85+**
  - Alaska
  - Nevada
  - Arizona
  - New Mexico
  - Wyoming

- **High Share of Population in Rural Areas**
  - Montana
  - North Dakota
  - Wyoming
  - South Dakota
  - Vermont

- **High Share of New HIV Cases**
  - District of Columbia
  - Louisiana
  - Georgia
  - Florida
  - Maine

- **High % Reporting a Disability**
  - West Virginia
  - Arkansas
  - Alabama
  - Kentucky
  - Maine

- **High Opioid Death Rate**
  - West Virginia
  - New Hampshire
  - Ohio
  - Rhode Island
  - Massachusetts

NOTE: States in multiple categories are shown in orange.

33 states have 41 approved Section 1115 Medicaid demonstration waivers in place as of February 2017.

Landscape of Current Section 1115 Medicaid Waivers

- Delivery System Reform Waivers: 16
- Medicaid Expansion: 7
- Managed Long-Term Services and Supports: 12
- Behavioral Health: 12
- Other Targeted Waivers: 15

More states are seeking waivers to condition Medicaid on work requirements, but most not working face barriers to work.

Main Reasons for Not Working

- Ill or disabled, 35%
- Taking care of home or family, 28%
- Going to school, 18%
- Could not find work, 8%
- Retired, 8%
- Other, 3%

Not Employed = 9.8 Million Medicaid Adults

Own Work Status, 24 Million Medicaid Adults

- Not Employed = 9.8 Million
- Part-Time = 41%
- Full-time = 59%

States are also seeking waivers to impose premiums and cost sharing, but research shows negative effects of policies for low-income populations.

**New/increased premiums**
- Decreased enrollment and renewal in coverage
- Largest effects on lowest income
- Many become uninsured and face increased barriers to care and financial burdens

**New/increased cost-sharing**
- Even small levels ($1-$5) decrease use of services, including needed services
- Increased use of more expensive services (e.g., ER)
- Negative effects on health outcomes
- Increased financial burdens for families

- States savings are limited
- Offset by disenrollment, increased costs in other areas, and administrative expenses
Majorities across political parties say Medicaid is working well for most low-income people covered by the program.

Would you say the current Medicaid program is working well for most low-income people covered by the program, or not?

<table>
<thead>
<tr>
<th></th>
<th>Working well</th>
<th>Not working well</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>...in the nation, overall?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>61%</td>
<td>26%</td>
</tr>
<tr>
<td><strong>...in your state?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>67%</td>
<td>23%</td>
</tr>
</tbody>
</table>

**By Political Party ID**

<table>
<thead>
<tr>
<th></th>
<th>Working well</th>
<th>Not working well</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Democrats</strong></td>
<td>68%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Independents</strong></td>
<td>62%</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Republicans</strong></td>
<td>52%</td>
<td>35%</td>
</tr>
</tbody>
</table>

NOTE: Don’t know/Refused responses not shown. Question wording abbreviated. See topline for full question wording.

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted June 14-19, 2017)
There are many “Faces of Medicaid”.