Medicaid Today and Under the ACA

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for
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Washington, DC
June 20, 2013
Medicaid has many vital roles in our health care system.

**Health Insurance Coverage**
31 million children & 16 million adults in low-income families; 16 million elderly and persons with disabilities

**Assistance to Medicare Beneficiaries**
9.4 million aged and disabled — 20% of Medicare beneficiaries

**Long-Term Care Assistance**
1.6 million institutional residents; 2.8 million community-based residents

**Support for Health Care System and Safety-net**
16% of national health spending; 40% of long-term care spending

**State Capacity for Health Coverage**
For FY 2013, FMAPs range from 50 – 73.4%
Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues. Kaiser Commission on Medicaid and the Uninsured, April 2011

### States have flexibility to administer core Medicaid programs.

<table>
<thead>
<tr>
<th>Core Requirements</th>
<th>State Options</th>
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<tbody>
<tr>
<td>Eligibility and Enrollment&lt;br&gt;• Federal minimum coverage of certain low-income groups (pregnant women, children, elderly and disabled, parents)&lt;br&gt;• Maintenance of Eligibility (MOE)&lt;br&gt;• Streamlined and simplified enrollment procedures</td>
<td>• Coverage beyond federal minimum levels&lt;br&gt;• ACA early expansion option for childless adults&lt;br&gt;• ACA Medicaid Expansion to 138% FPL (requirement with limited authority to enforce)&lt;br&gt;• Additional enrollment simplifications (e.g., ELE, 12-month continuous eligibility)</td>
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<tr>
<td>Benefits and Cost Sharing&lt;br&gt;• Required benefits set in statute</td>
<td>• Optional benefits&lt;br&gt;• Cost sharing within federal rules</td>
</tr>
<tr>
<td>Care Delivery and Provider Payments&lt;br&gt;• Payments must be “consistent with efficiency, economy, quality and access”&lt;br&gt;• Some requirements for specific providers/services (FQHCSs, MCOs, etc.)</td>
<td>• Delivery systems (FFS, MCOs, PCCM, combination)&lt;br&gt;• New ACA options (CMMI, new grants)&lt;br&gt;• Premium assistance options</td>
</tr>
<tr>
<td>Long-Term Services and Supports&lt;br&gt;• Nursing home coverage and quality standards&lt;br&gt;• Olmstead&lt;br&gt;• Resource and asset tests</td>
<td>• Level of need determinations&lt;br&gt;• Community-based care options (HCBS and new ACA requirements)&lt;br&gt;• Duals demos</td>
</tr>
</tbody>
</table>
Medicaid plays a critical role for selected populations.

- Poor: 42%
- Near Poor: 24%
- All Children: 30%
- Low-Income Children: 56%
- Low-Income Adults: 21%
- Births (Pregnant Women): 41%
- Medicare Beneficiaries: 17%
- People with Severe Disabilities: 20%
- People Living with HIV/AIDS: 44%
- Nursing Home Residents: 70%

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 ASEC Supplement to the CPS; Birth data from Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007, National Governors Association, 2008; Medicare data from USDHHS.
Medicaid eligibility is more limited for adults than for children.

Median Medicaid/CHIP Eligibility Thresholds, January 2013

Minimum Medicaid Eligibility under Health Reform - 138% FPL ($24,344 for a family of 3 in 2012)

- Children: 235%
- Pregnant Women: 185%
- Working Parents: 61%
- Jobless Parents: 37%
- Childless Adults: 0%

SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.
Most Medicaid enrollees receive care through private managed care.

NOTE: Includes enrollment in MCOs and PCCMs. Most data as of October 2010.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

U.S. Overall = 65.9%
Medicaid provides access to care that is comparable to private insurance and better than access for the uninsured.

NOTES: In past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).
SOURCE: KCMU analysis of 2011 NHIS data.
Figure 7

The elderly and disabled account for the majority of Medicaid spending.

<table>
<thead>
<tr>
<th>Enrollees Total = 62.7 Million</th>
<th>Expenditures Total = $346.5 Billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 49%</td>
<td>Disabled 15%</td>
</tr>
<tr>
<td>Adults 26%</td>
<td>Elderly 10%</td>
</tr>
<tr>
<td>Elderly 23%</td>
<td>Disabled 42%</td>
</tr>
<tr>
<td>Disabled 42%</td>
<td>Adults 14%</td>
</tr>
<tr>
<td>Children 20%</td>
<td>Elderly 23%</td>
</tr>
</tbody>
</table>

NOTE: Percentages may not add up to 100 due to rounding.

SOURCE: KCMU/Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64, 2012. MSIS FFY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.
Figure 8

Duals Account for 38% of Medicaid Spending, FFY 2009

Medicaid Enrollment

- Children: 49%
- Adults: 26%
- Other Aged & Disabled: 10%
- Dual Eligibles: 15%

Total = 62.7 Million

Medicaid Spending

- Non-Dual Spending: 62%
- Dual Spending: 38%
  - Medicare Acute: 7%
  - Long-Term Care: 25%
  - Prescribed Drugs: 0.4%
  - Other Acute: 2%
  - Premiums: 3%

Total = $358.5 Billion

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. 2008 MSIS data was used for PA, UT, and WI, because 2009 data were unavailable.
Figure 9

NOTE: Spending includes both state and federal payments to Medicaid. These figures represent the average (mean) level of payments across all Medicaid enrollees. Spending per enrollee does not include disproportionate share hospital payments (DSH). Some enrollees are only eligible for a limited set of benefits. A small fraction of elderly and disabled enrollees in every state qualify only for assistance with their Medicare premiums and coinsurance.

Medicaid spending varies across states.

**Available Revenue:** per capita income, total taxable resources, tax collections

**Demand for Public Services:** poverty, unemployment, need for health services (coverage, age, disability, chronic conditions)

**Health Care Markets:** employer premiums, Medicare spending per enrollee, primary care shortage areas, supply of providers and health facilities

**Medicaid Policy Choices:** eligibility levels, benefits, payment and delivery system choices, long-term care delivery systems

**Budget and Policy Process:** political affiliation of Governor and legislature, legislative sessions, state budget process

Figure 12

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Medicaid</th>
<th>Elementary &amp; Secondary Education</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total State Spending</td>
<td>23.7%</td>
<td>48.2%</td>
<td>56.1%</td>
</tr>
<tr>
<td>$1.66 Trillion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Funds</td>
<td>16.7%</td>
<td>35.1%</td>
<td>43.8%</td>
</tr>
<tr>
<td>$635.5 Billion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Funds</td>
<td>12.5%</td>
<td>43.7%</td>
<td>43.8%</td>
</tr>
<tr>
<td>$565.9 Billion</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Shares of state general fund spending for Medicaid and education have remained fairly stable over time.

**Figure 13**

**SOURCE:** State Expenditure Report. NASBO, December 2012.
Medicaid enrollment and spending growth is accelerated during economic downturns.

NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: Medicaid Enrollment June 2011 Data Snapshot, KCMU, June 2012. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 and FY 2013 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.
State budget pressures have resulted in Medicaid cost containment efforts, but eligibility is protected.

NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. Survey was conducted in July and August 2012.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.
States are also moving ahead with initiatives to better coordinate care, especially for more complex populations.

**Figure 16**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>FY 2012</th>
<th>Adopted FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Managed Care Expansions or Initiatives</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Any Care Coordination Initiatives</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Any Dual Eligible Initiatives</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.
Expanding Medicaid is a key element in health reform

- Universal Coverage
  - Medicaid Coverage For Low-Income Individuals
  - Exchanges With Subsidies For Moderate Income Individuals
  - Health Insurance Market Reforms
  - Employer-Sponsored Coverage
  - Individual Mandate
The ACA Medicaid expansion fills current gaps in coverage.

Medicaid Eligibility Today
Limited to Specific Low-Income Groups

Medicaid Eligibility in 2014
Extends to Adults ≤138% FPL*

Elderly & Persons with Disabilities
Children
Pregnant Women
Parents
Adults

*138% FPL = $15,856 for an individual and $26,951 for a family of three in 2013.
The ACA transforms the Medicaid enrollment experience, regardless of whether states expand.

Multiple Ways to Enroll

Single Application for Multiple Programs

Use of Electronic Data to Verify Eligibility

Real-Time Eligibility Determinations

Dear _____,
You are eligible for...

Data Hub

$ #
Over half of today’s uninsured have incomes below the new Medicaid expansion limit.

Income:

- ≤138% FPL: Medicaid (51%)
- 139-399% FPL: Subsidies (39%)
- ≥400% FPL: (10%)

Total: 47.5 Million Nonelderly Uninsured
Figure 21

As of June 17, 2013 24 states are moving forward with the ACA Medicaid expansion.

NOTES: 1 - Exploring an approach to Medicaid expansion likely to require waiver approval.  2 - Discussion of a special session being called on the Medicaid expansion.

SOURCES: Based on KCMU analysis of recent news reports, executive activity and legislative activity in states. Data reported here are as of June 17. It is important to note that per CMS guidance, there is not deadline for states to implement the Medicaid expansion. Requirements for legislation to implement the Medicaid expansion vary across states.
The Medicaid expansion will significantly increase eligibility for parents in many states.

NOTE: Eleven states (CT, HI, IL, MA, ME, MN, NJ, NY, RI, VT, WI) and DC already offer coverage to parents at or above 133% FPL; under the ACA an income disregard of 5 percentage points will be applied to this limit increasing the effective income limit to 138% FPL.

SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.
Coverage gains for childless adults under the Medicaid expansion would be even larger.

Medicaid Coverage of Low-Income Adults, January 2013

NOTE: Map identifies the broadest scope of coverage in the state.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.
If all states expand Medicaid.

Expanding Medicaid would affect individuals’ health and personal lives.

- Enable individuals to obtain needed care and utilize physicians rather than delaying care and relying on the emergency room.
- Provide financial protection from the cost of care and alleviate stress and worry.
- Help individuals get their health under control so they can focus on other priorities and goals, including employment.

Key Issues to Watch

• Affordable Care Act
  – How many states implement the Medicaid expansion? What will decisions mean for coverage and costs?
  – How will Medicaid enrollment systems be transformed over the next year?

• Delivery System Reform
  – How will managed care and other care coordination initiatives continue to develop?
  – Will these initiatives improve care and save money?
  – How many more states will move forward with initiatives for dual eligibles?

• State and Federal Fiscal Issues
  – What Medicaid policy changes will be included in state budgets for SFY 2014?
  – How will federal deficit reduction efforts affect Medicaid and states?