



EXPLAINING HEALTH CARE REFORM: Questions About Medicaid's Role

Medicaid plays a major role in covering more of the uninsured under the new health reform law. The new law includes a significant expansion of Medicaid, an individual requirement to obtain health insurance, and subsidies to help low-income individuals buy coverage through newly established Health Benefit Exchanges.

Today, Medicaid is the nation's primary health coverage program for low-income and high-need populations and the program serves as the foundation for coverage of the low-income population under health reform. Prior to health reform, Medicaid, together with the Children's Health Insurance Program, offered broad based coverage to children with median eligibility levels up to 235% of poverty. However, Medicaid coverage for parents was much more limited and federal law generally prohibited Medicaid coverage for adults without dependent children. The new law bases eligibility for Medicaid on income without categorical restrictions for individuals under age 65 and establishes a national floor for Medicaid coverage at 133% of poverty (\$14,404 for an individual or \$29,326 for a family of four in 2009).

Since Medicaid was established in 1965, the program has gradually expanded in scope and has helped to stem greater increases in the uninsured especially among children and some parents in low-income families. Beyond coverage, Medicaid has multiple and diverse roles in today's health care system providing health coverage to people with disabilities, long-term care coverage and financing, support to safety-net providers, and assistance to low-income Medicare beneficiaries. Medicaid is jointly funded by state the federal government.

This brief explains the how Medicaid works today and answers some key questions about Medicaid's role in health reform.

How Medicaid Works Today

Medicaid is the nation's primary health insurance program for low-income and high-need Americans. Medicaid covers 60 million low-income American including nearly 30 million low-income children, 15 million adults and 8 million non-elderly people with disabilities. Given the wide health needs and limited incomes of enrollees, Medicaid provides a broad range of services, with limited cost-sharing. Today, the federal government sets minimum eligibility levels for coverage and then states have the option to expand eligibility to higher incomes. Currently, 47 states set the Medicaid/CHIP income-eligibility level for children at or above 200 percent of the federal poverty level, but Medicaid coverage for parents is more limited with 39 states setting levels below 133 percent of the federal poverty level. Prior to reform, states generally could not cover non-disabled adults without dependent children under Medicaid. Low-income and high-need individuals covered by Medicaid generally do not have access to employer based or other private coverage.

Medicaid provides financing capacity to states to support coverage. Medicaid financing is shared across the states and the federal government. On average, the federal government pays for 57 percent of Medicaid costs, but this varies across states based on per capita income ranging from a floor of 50 percent to 76 percent. Federal financing for Medicaid is guaranteed with no set limits. Federal Medicaid financing has been critical in helping to support state efforts, like those in Massachusetts, to fund health services for low-income individuals and to expand health coverage more broadly. The American Recovery and Reinvestment Act provided states with a temporary increase in the federal share of Medicaid payments from October 1, 2008 through December 31, 2010 to help support Medicaid and state budgets during the recession when demand for programs increases and states have less ability to finance care. To be eligible for these increased funds, states could not restrict eligibility levels or make it more difficult for individuals to apply for coverage.

Medicaid supports the health care safety-net. Medicaid is the largest source of funding (from patient revenues and supplemental payments) for community health centers and public hospitals, the nation's safety-net providers that serve the poor and uninsured. Many of these entities are located in poor or rural areas with provider shortages.

Medicaid provides assistance to low-income Medicare beneficiaries. Medicaid is an essential adjunct to Medicare for the nearly 9 million low-income elderly and disabled Medicare beneficiaries who depend on Medicaid to help with premiums, gaps in Medicare benefits, and long-term care needs. While these "dual eligibles" represented 18 percent of all Medicaid enrollees, they accounted for nearly half (46 percent) of all Medicaid expenditures in 2005. Medicaid also provides coverage for low-income people with disabilities in the two-year Medicare waiting period.

Medicaid is dominant source of coverage and financing for long-term care. Medicaid is this nation's only source of significant long-term care financing. Medicaid covers 6 of every 10 nursing home residents and finances more than 40 percent of nursing home and total long-term care spending in the nation. For people with disabilities and the elderly, Medicaid is a growing source of financing for home and community based long-term care services.

KEY QUESTIONS ABOUT CHANGES UNDER HEALTH REFORM

1. Who is eligible for Medicaid under health reform?

The new law bases eligibility for Medicaid on income without categorical restrictions for individuals under age 65 and establishes a national floor for Medicaid coverage at 133% of poverty (\$14,404 for an individual or \$29,326 for a family of four in 2009) in 2014. This will reduce state-by-state variation in eligibility for Medicaid and also include adults under age 65 without dependent children who are currently not eligible for the program. These changes help to provide the base of seamless and affordable coverage nationwide through Medicaid for those with incomes up to 133% of poverty. Subsidies for coverage are available through state-based Health Benefit Exchanges for individuals with incomes above Medicaid levels between 133% and 400% of poverty. The new law requires coordination between Medicaid and the Exchanges to promote new coverage. Individuals eligible for Medicaid will not be eligible for subsidies in the state exchange. For most Medicaid enrollees, income would be based on modified adjusted gross income without an assets test or resource test.¹ Those currently eligible for Medicaid as of March 23, 2010 would continue to be eligible for coverage. This maintenance of eligibility for individuals with income above 133 percent of poverty would extend through 2014 for adults and through 2019

for children. The new law allows states the option to expand coverage to childless adults starting April 1, 2010 at their regular Medicaid match rate (FMAP), the higher match rate for coverage of the new groups begins in 2014.

2. How will Medicaid be financed under health reform?

The new law provides full federal financing (100% federal) for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal contribution to 90% by 2020. States will receive their current match rates for individuals currently eligible for Medicaid. However, states that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in their FMAP for non-pregnant childless adults currently eligible for Medicaid. These states will receive the same federal financing for this population as states that had to expand by 2019.²

3. What benefits will Medicaid cover?

The new law provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent that at least meets the minimum essential health benefits available in the Exchanges for coverage. It appears that states also have the option to define a benchmark plan that would cover a more comprehensive benefits package, similar to what is currently offered through Medicaid. Medicaid covers an array of supportive and enabling services for high-need populations such

KEY QUESTIONS (continued)

as transportation, durable medical equipment, case management and habilitation services that might not be covered by a typical private or benchmark plan. The elderly and individuals with disabilities will continue to receive the broader Medicaid package that also includes long-term care benefits. The new law also includes financial incentives through a higher matching rate to encourage states to offer prevention services with no cost sharing, to “provide “health home” services” to better help coordinate care for individuals with chronic conditions and to take advantage of new options to expand community based long-term care.

4. Will Medicaid enrollees be able to access health care services?

Today, Medicaid’s enrollees fare as well as those with private insurance on most measures of access, even though they are sicker and more disabled and despite often cited concerns about provider participation. For both children and adults, Medicaid, like private insurance, provides access to a usual source of care — the key entry point into the health care system and individuals with Medicaid face far fewer financial and access barriers to care than the uninsured. Medicaid’s extensive use of managed care arrangements has helped to assure access for enrollees. In an effort to boost provider participation and access, the health reform law increases Medicaid payments for primary care physicians and services to 100% of the Medicare payment rates for 2013 and 2014 with full federal financing for the increased costs. Health reform includes significant investments in community health centers that have traditionally been places where low-income individuals have been able to access care and Medicaid contracts with these clinics to deliver care. The new law also funds the Medicaid and CHIP Payment and Access Commission (MACPAC) to monitor and evaluate these issues. However, the general supply of primary care doctors, dentists and some specialists, and problems with the distribution of physicians geographically will affect both individuals with private as well as public insurance coverage as health reform is implemented.

5. What roles will Medicaid continue to fill beyond health reform?

Medicaid will continue to fill gaps in the health care system by providing coverage for many long-term and supportive services for individuals with disabilities that are not covered in the private insurance market. Medicaid will also continue to provide assistance to low-income Medicare beneficiaries with help paying for premiums and cost-sharing. The new health reform law includes provisions to encourage states to further develop community based long-term care options and a new office to help coordinate care for individuals dually eligible for Medicare and Medicaid. The duals often have complex health needs and high costs for both Medicare and Medicaid. The health reform law also establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Over time, this program is expected to help reduce Medicaid costs for nursing home care.

6. What happens to the Children’s Health Insurance Program under health reform?

The new law provides funding for CHIP through 2015 (an additional two years compared to current law), continues the authority for the program through 2019 and requires states to maintain eligibility standards for children in Medicaid and CHIP through 2019. CHIP eligible children who cannot enroll in the program due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan that is certified by the Secretary by April 2015 to be comparable to CHIP in the exchange. Medicaid and CHIP together have been responsible for helping to cut the uninsurance rate for low-income children in half over the last decade. CHIP reauthorization provided states with new tools and financing to achieve broader coverage for children in Medicaid and CHIP. In advance of the new coverage requirements for adults taking effect in 2014, states can continue to make strides to cover uninsured children, most of whom are currently eligible for coverage and not enrolled.

Conclusion

Medicaid is the foundation for health coverage for low-income individuals under health reform. The program is expected to cover another 16 million people by 2019, half of the reduction in the uninsured by that time. The new law provides a national floor for coverage, eliminates the exclusion of childless adults from coverage under the program and provides states with significant new federal resources to fund the expansion. In addition to new coverage, Medicaid will continue to fill gaps in the health care system by providing long-term services and supports, assistance to low-income Medicare beneficiaries, and general support for the health care system.

¹ There is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty. The legislation maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI)).

² It appears that AZ, DE, HI, ME, MA, NY and VT are eligible for the phased in match rate for current coverage of childless adults below any enrollment caps that may be in place.

Resources

Medicaid and Children's Health Insurance Program Provisions in the New Health Reform Law
<http://www.kff.org/healthreform/7952.cfm>

Medicaid and CHIP Health Reform Implementation Timeline
<http://www.kff.org/healthreform/8064.cfm>

Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty
<http://www.kff.org/healthreform/8052.cfm>

Where Are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults
<http://www.kff.org/medicaid/7993.cfm>

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