

MEDICAID AS A PLATFORM
FOR BROADER HEALTH REFORM:

Supporting High-Need
and Low-Income Populations

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THE KAISER COMMISSION ON
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Medicaid As A Platform For Broader Health Reform: Supporting High-Need and Low-Income Populations

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Executive Summary

As debate on national health reform moves forward, expanding coverage to the uninsured as well as addressing health care cost and quality issues have emerged as the dominant drivers for system reform. Extensive research shows that coverage is key to securing access to needed health care services. Leading health reform proposals rely on a combination of public and private approaches to expand coverage, control costs and improve quality with shared responsibilities across employees, employers, government, consumers and insurance markets.

What problems do low-income individuals face in today's health care system?

- Two-thirds of the 45 million uninsured are low-income individuals (below 200% of the poverty level or \$36,620 for a family of three in 2009), and many have significant health needs.
- Many low-income individuals do not have access to employer coverage and cannot afford or access private coverage through the individual market.

Why build on Medicaid?

- Medicaid already serves 60 million Americans and provides a base of affordable and comprehensive coverage that is well suited for low-income and high-need populations. The costs of private health care and Medicare premiums are lessened by having Medicaid insure these high-need populations and provide key services not covered by private plans or Medicare.
- Most Medicaid enrollees receive care through private managed care plans that are designed to promote access to care, enhance quality and control costs. Medicaid also helps support community health centers and other safety-net providers in medically underserved areas.
- Medicaid enrollees fare as well as the privately insured populations on important measures of access to primary care even though they are sicker and more disabled. Accounting for the health needs of its beneficiaries, Medicaid is a low-cost program with lower per capita spending than private insurance; thus covering Medicaid enrollees in private coverage would be more costly.
- Medicaid has a well developed administrative structure in every state that has enabled it to be a cornerstone in federal and state efforts to expand coverage. Medicaid plays an important role for some disadvantaged populations and the program has broad public support.

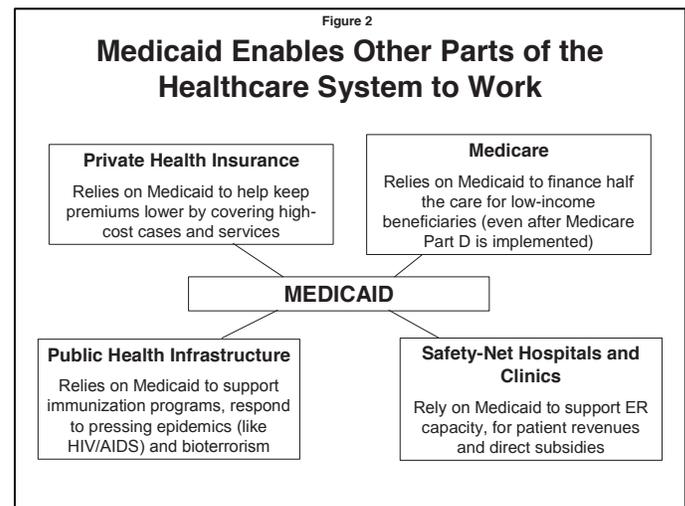
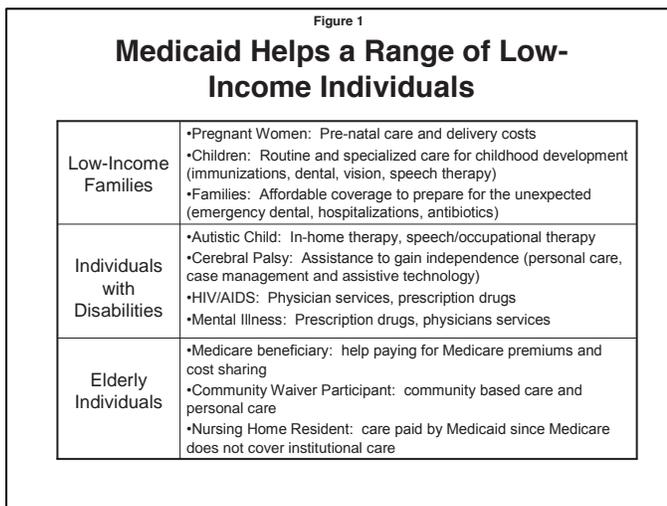
How can Medicaid be a stronger platform for health reform?

- Expand Medicaid's reach to more low income individuals by basing eligibility on income alone with federal minimum standards and making additional progress to increase participation rates.
- Ensure that current and new enrollees receive Medicaid's benefit and cost-sharing protections, and promote better access by addressing payment rates to help boost provider participation.
- Provide adequate Medicaid financing by having the federal government assume the costs of expanding Medicaid coverage or by shifting some current Medicaid costs to the federal government; and provide stable financing by establishing a countercyclical financing mechanism during economic downturns.
- Bolster Medicaid with broader efforts to contain costs across the health system (public and private) to help ensure long term sustainability; develop strategies to expand the primary care workforce to provide better access to primary and preventive care, and establish system-wide quality standards along with the implementation of health information technology to promote an efficient health care system based on positive outcomes.

Health reform will not address all the gaps in the health care system that Medicaid now helps to fill such as providing long-term care and helping to sustain the health care safety-net and covering many of the supportive services that the chronically ill and disabled need. As we move forward, Medicaid offers a strong foundation on which broader health reforms can be built by providing coverage for the high-need and low-income populations and providing a vehicle to reach more low-income uninsured with affordable coverage. This strong foundation will help to assure the success of larger health reform efforts.

INTRODUCTION

Over the last 45 years, Medicaid has been on the frontline providing health coverage to many of the poorest, sickest, and most disabled among us – a large low-income population with multiple and complex health needs. Medicaid is a fundamental part of our health care system covering 60 million low-income Americans and financing 16 percent of national health spending, including 40 percent of spending on long-term care services. It serves as the nation’s health care safety net providing health coverage to one in four of America’s children and many of their parents --- 30 million low-income children and 15 million adults who generally have no access to job-based coverage. It is also a particularly important source of coverage for both acute and long-term care for 8 million non-elderly people with disabilities and 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. Medicaid financing provides states with the capacity to extend coverage to low-income families and helps to support safety net providers that serve the poor and uninsured (Figures 1 and 2).



Medicaid is the centerpiece of coverage for the low-income population with incomes below 200 percent of poverty or \$36,620 for a family of three in 2009. For most low-income families, health coverage through the workplace is not available. Medicaid and the Children’s Health Insurance Program (CHIP) have helped fill the coverage gap for children. Federal law currently requires states to provide Medicaid coverage to all children in families with incomes below poverty and young children and pregnant women at 133 percent of poverty and gives states the option of extending coverage to children at higher income levels through Medicaid and CHIP. Children are now covered at 200 percent of poverty or higher in 43 states and the District of Columbia. However, 34 states set Medicaid eligibility for parents at levels below poverty, leaving many parents of covered children uninsured. Under current federal rules, adults without dependent children are ineligible for Medicaid unless they qualify on the basis of a disability or are added through a state waiver provision. As a result, Medicaid now provides coverage to half of all low-income children, but nearly half of poor and a third of near-poor adults are left uninsured.

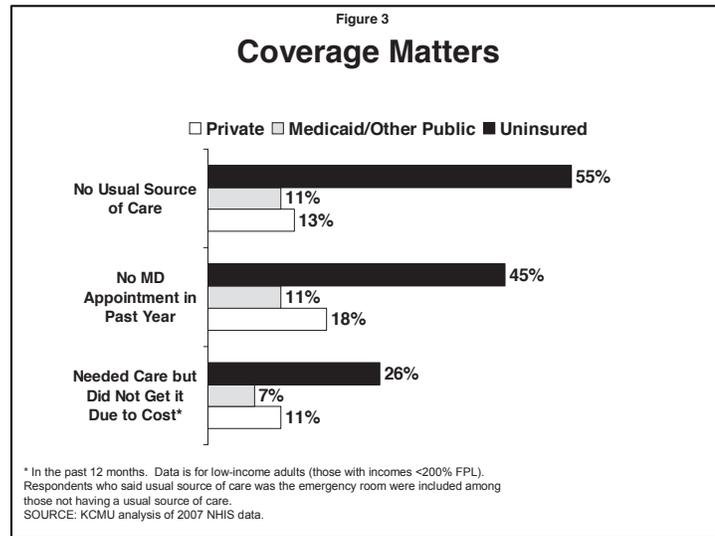
Medicaid provides access to a comprehensive scope of benefits with limited cost-sharing that is geared to meet the health needs and limited financial resources of the beneficiaries the program serves. For these low-income and high-need populations, private coverage options are often not available, not affordable or inadequate. The costs of private and Medicare premiums are lessened by having the public sector insure these populations.

Years of research and analysis conducted by the Kaiser Commission on Medicaid and the Uninsured, demonstrate that Medicaid's experience in covering the low-income population provides a logical and operational framework on which to build broader coverage of the low-income uninsured. With a focus on addressing the issues of the poorest and sickest individuals, this brief examines 4 key questions related to Medicaid and health reform:

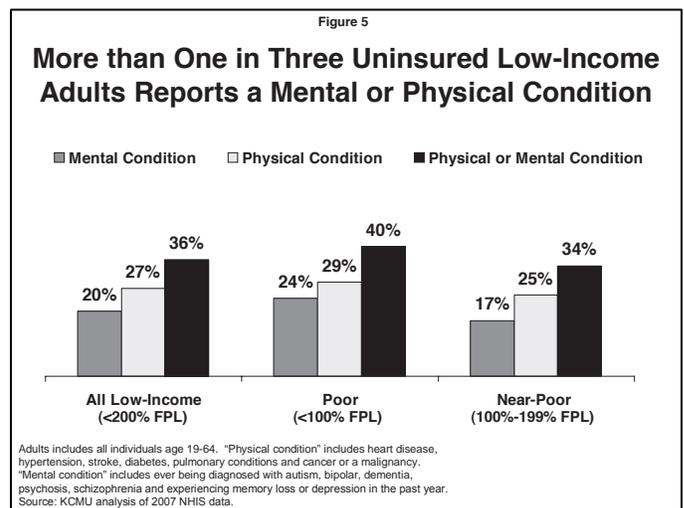
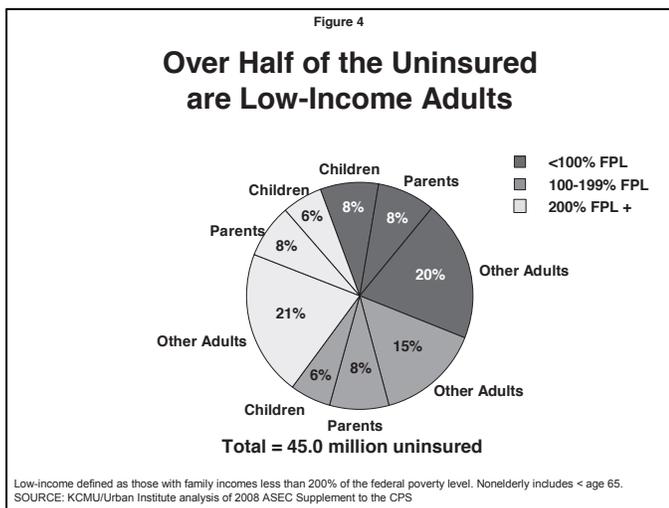
1. What problems do low-income individuals face in today's health care system?
2. What approaches can be used to expand coverage?
3. Why build on Medicaid?
4. How can Medicaid be a stronger platform for health reform?
 - o Expand Medicaid's reach and integrate Medicaid with broader health system changes
 - o Provide access to adequate and affordable coverage and needed health care
 - o Provide adequate and stable financing for Medicaid
 - o Bolster Medicaid efforts with broader reform efforts

1. What Problems do Low-Income Populations Face in Today's Health Care System?

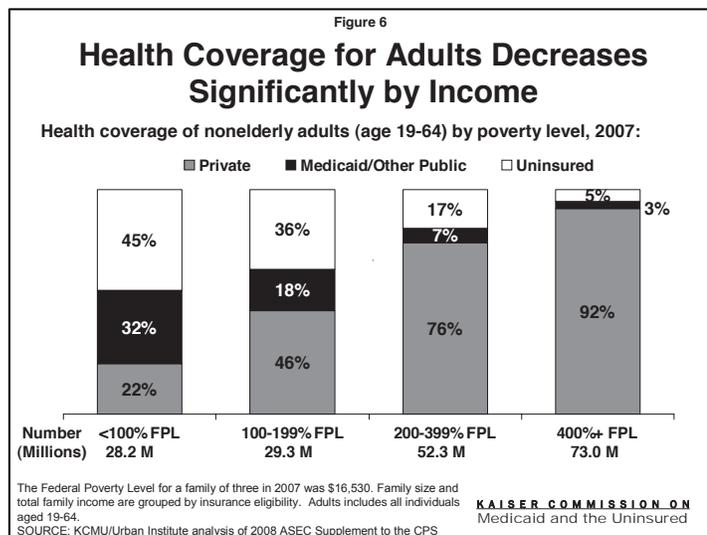
The current health care system leaves many uninsured which results in serious access problems for millions of Americans. In 2007, 45 million individuals were uninsured and millions of others were underinsured meaning their insurance was not adequate or left them vulnerable due to high out of pocket costs. These problems have gotten more severe as the number of uninsured has climbed by eight million since 2000. Individuals without insurance face more significant barriers in accessing care compared to those with private or public coverage and also are vulnerable to the financial consequences of the high costs of health care (Figure 3). Many with inadequate private coverage face similar access barriers to needed care and high out of pocket costs as those who are uninsured.



The uninsured population is predominantly low-income and many have significant health care needs. Two-thirds of the uninsured have incomes below 200 percent of poverty (\$33,200 for a family of three in 2007) and over half of the uninsured are low-income adults (Figure 4). Low-income individuals and families often struggle to meet basic needs, are in poorer health and have higher rates of chronic disease and disability than those with higher incomes. More than one in four uninsured low-income adults (27%) reports a chronic physical condition, such as hypertension, diabetes, or heart disease; one in five (20%) reports a mental health problem, such as depression, bipolar disorder, autism, dementia, schizophrenia or psychosis; and more than one in three (36%) reports either a chronic physical or mental health problem (Figure 5).

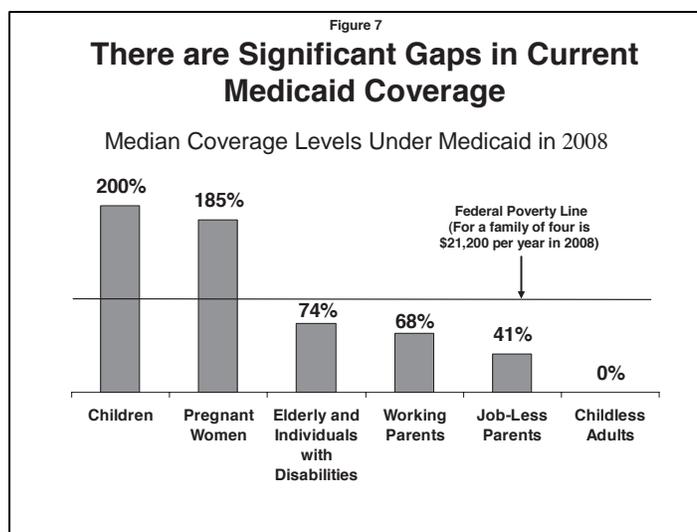


The low-income population has little access to affordable private health coverage. The high uninsured rate among low-income adults is primarily driven by a low rate of private coverage. Low-income adults, particularly those below poverty, are significantly less likely to have private coverage than those at higher incomes. Only about one in five (22%) poor adults has private coverage compared to more than nine in ten with incomes at or above 400% of poverty (Figure 6). This leads to much higher uninsured rates for poor and near-poor adults. Over half (53%) of low-income adults are in families with at least one full-time worker, but they tend to be employed in low-wage positions and in firms and industries that often do not provide coverage to their workers. Even when coverage is offered by an employer, it has become increasingly unaffordable for low-income adults.



Coverage that is available is expensive, especially for low-income individuals. The average premiums for employer-sponsored coverage in 2008 were \$4,704 for single coverage and \$12,680 for family coverage. These costs are out of reach for low-income individuals without financial assistance. Although current premiums for nongroup coverage can be less expensive than group premiums, individuals and families must bear the full cost of the premiums. For those with pre-existing conditions, if they are offered coverage (many are denied coverage on the basis of their pre-existing condition), the premiums are likely to be much higher than group premiums. This raises the question of whether the out-of-pocket liability associated with current nongroup coverage would provide sufficient financial protection and access to services for the low and moderate income families reform proposals are trying to reach.

Medicaid provides a base for extending coverage, but many low income individuals are not eligible for Medicaid under current law. Reflecting the program's historic ties to welfare, states can only cover certain groups of people through Medicaid including children, pregnant women, parents, the elderly and disabled individuals. States must cover these groups to federal minimum levels and have the option to expand eligibility to higher incomes. Today 44 states have set the Medicaid/CHIP income-eligibility level for children at or above 200 percent of the federal poverty level, but 34 states limit the Medicaid income eligibility for parents to below 100 percent of the federal poverty level. Under federal law, states cannot cover adults without dependent children under Medicaid (Figure 7).

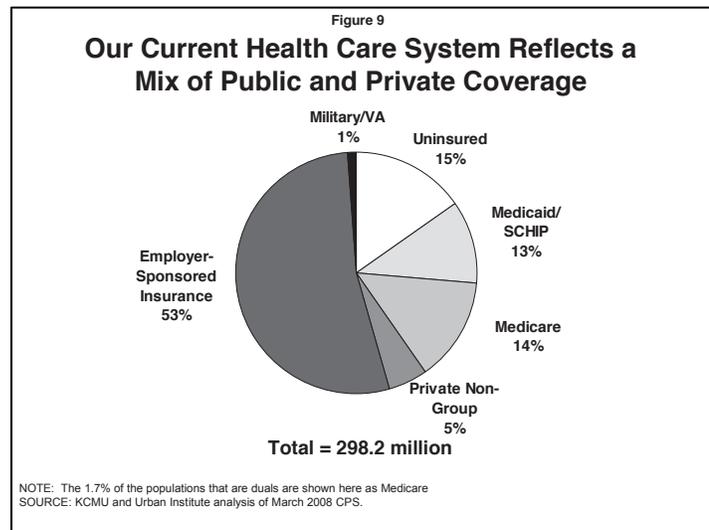


Beyond Medicaid, there are systemic issues in the US health system including rising costs, lack of primary and preventive care and lack of adequate quality measures that are critical for broader health reform. Health care costs have far outpaced inflation and increases in workers wages, making health care increasingly unaffordable for individuals, employers and consumers. Rising health care costs are the primary reason for cost growth for public and private insurers. While concerns have been raised about access to care under Medicaid, access to primary care, specialists and dentists are problems for those with private coverage as well. Current payment policies do not adequately reimburse for primary care or prevention services which has resulted in a general shortage of primary care doctors across the entire health system. In addition, system-wide quality measures, accepted practice guidelines for care delivery, and mechanisms (like electronic health records) to help improve quality and coordinate care do not exist in the current health care system.

Two major pieces of legislation signed by President Obama have already made some important down-payments for broader health reform efforts. The reauthorization of the Children's Health Insurance Program (CHIP) is expected to reach 4.1 million children through Medicaid and CHIP who otherwise would have been uninsured over the next five years. The American Reinvestment and Recovery Act (ARRA) makes substantial investments to help develop health information technology, expand the primary care workforce and conduct research on comparative effectiveness for health care treatment options. Focusing on expanding coverage to address the growing uninsured as well as addressing health care cost and quality issues remain the dominant issues for the larger health reform debate.

2. What Approaches Can be Used to Expand Coverage?

The current health care coverage structure represents a mixture of private and public insurance. The majority of non-elderly Americans receive health insurance through their or a family member's employer. Most of the elderly are covered by Medicare while Medicaid and CHIP are the primary public health programs for low-income individuals (especially children). There is a small individual health insurance market, which is typically used by those without access to employer-provided coverage. Gaps in the current system leave 15% of the population, or 45 million nonelderly uninsured (Figure 9).



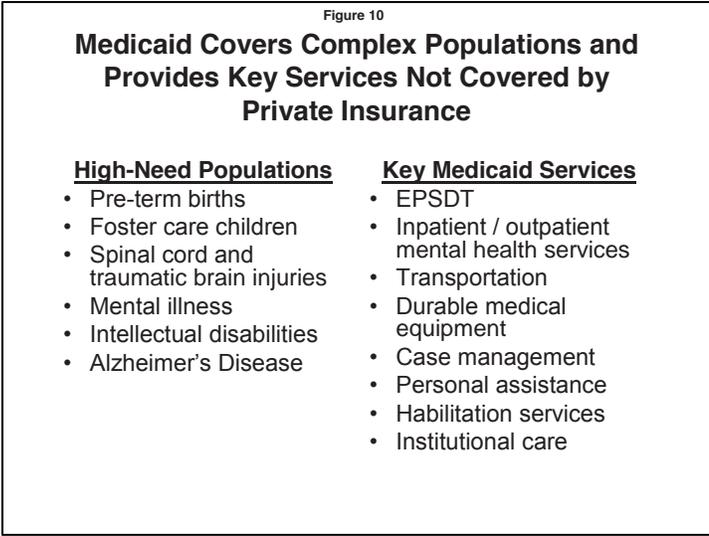
Expansion of both public and private coverage can help address the problem of the uninsured. While there is general agreement that the problem of the uninsured needs to be addressed, there is not always agreement about how to best expand coverage. Approaches to covering the uninsured may: strengthen current coverage arrangements (both public and private), improve the affordability of coverage, improve the availability of coverage or change the tax treatment and financing of health insurance. These approaches can be combined in various ways to achieve broader coverage similar to the Massachusetts reform model, President Obama's approach and a white paper issued by Senator Baucus. These plans all rely on a combination of approaches with shared responsibilities across employees, employers, government, consumers and insurance markets.

Different coverage strategies may be more or less effective depending on the characteristics of the target populations. For example, low-income individuals need financial assistance to afford health care and high-need populations generally need access to benefits not typically covered by private insurance. Under the current health system public coverage now assumes the costs for many low-income and high-need individuals (through both Medicaid and Medicare) which helps the private market work by removing these risks from the private insurance risk pool.

In a system of shared responsibilities, finding the right mix of public and private coverage and how to integrate these systems generates debate. Ideological, political and fiscal concerns are the cause of debate about how far to extend public coverage. The debate over the reauthorization of the Children's Health Insurance Program highlighted the issues around public coverage: how high up the income scale should eligibility be raised, which groups should be covered, how does public coverage expansions affect private coverage, how much should individuals contribute and how should public coverage be financed. These same issues are magnified when discussing broader health reform. If there is some agreement that low-income individuals need assistance paying for health coverage, there is debate over whether to enroll these individuals in public coverage programs or whether to rely on public subsidies for individuals to purchase private coverage.

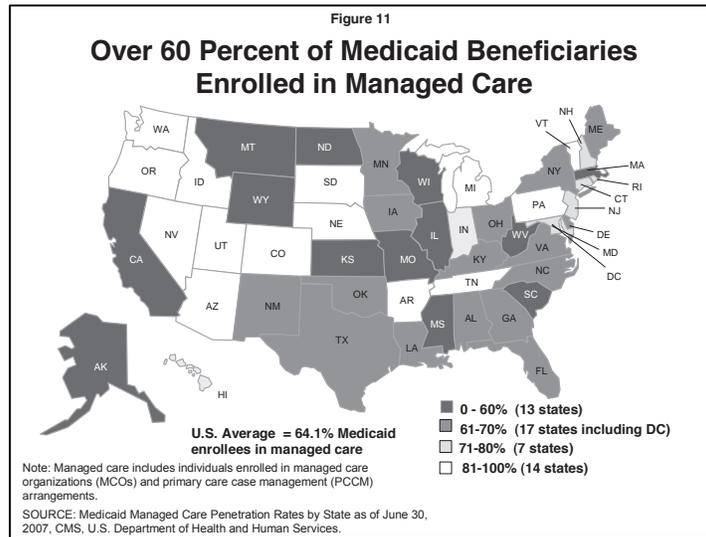
3. Why Build on Medicaid?

Medicaid already provides a base of affordable and comprehensive health coverage that is well suited for low-income and high-need populations. Medicaid is the workhorse of the U.S. healthcare system providing coverage for almost 60 million Americans left out of private health insurance including low-income pregnant women, children, families, individuals with disabilities, and seniors. Medicaid's comprehensive scope of benefits and limited cost-sharing is geared to meet the complex health needs and limited financial resources of the population that the program serves. More specifically, Medicaid covers an array of supportive and enabling services for high-need populations such as transportation, durable medical equipment, case management and habilitation services that private plans do not typically cover now nor are they likely to cover under a reformed health system (Figure 10). Unlike some private coverage, Medicaid does not have any pre-existing condition exclusions so individuals with health needs are not turned away from coverage.

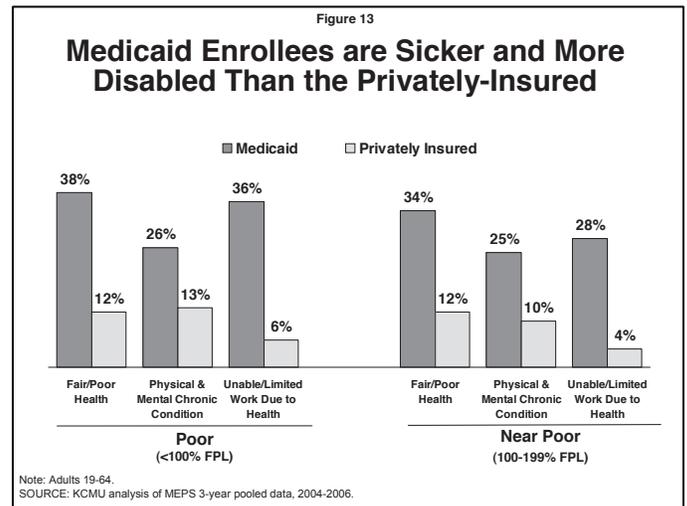
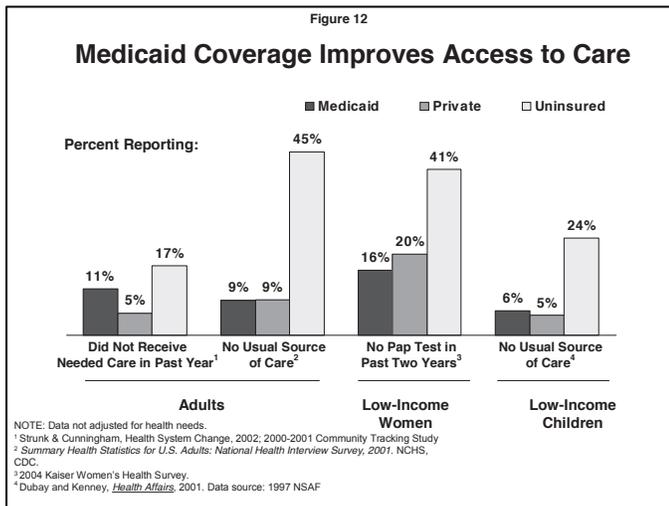


Medicaid also provides protections against high out-of-pocket expenses for health care unlike many private plans. Even with premium supports, cost-sharing and deductibles (even at low levels) can adversely affect access to care for low-income people. Average premium costs for workers have increased by 78 percent since 2001, a growing number of individuals are in plans with deductibles of at least \$1,000 and many private policies have lifetime caps on spending. Even under health reform, it is unlikely that private coverage would be structured in a way to make it affordable for low-income individuals. For example, in Massachusetts, low-income individuals (under 300% of poverty) have access to comprehensive and affordable coverage under Commonwealth Care. Commonwealth Care plans do not have deductibles or co-insurance and the copayments enrollees face are modest. In contrast, private plans in the state are subject to minimum creditable coverage standards which allow deductibles of \$2,000 for individuals and \$4,000 for families. Consequently, even if premium subsidies were available, out-of-pocket expenses could be unaffordable for low-income individuals.

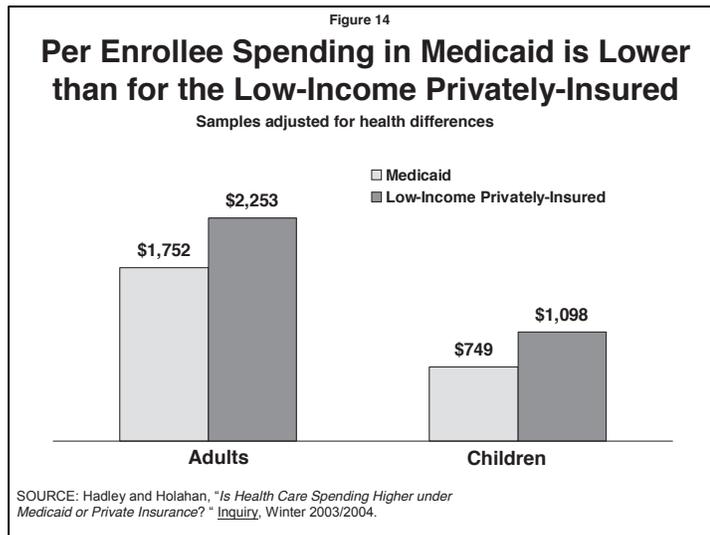
Medicaid is a leader in developing models to manage care, enhance quality and control costs. The majority of low-income families on Medicaid receive their health coverage through private managed care organizations under contract with the state to provide comprehensive services and a provider network for beneficiaries (Figure 11). Through managed care arrangements and primary care case management states have moved to both secure better access to primary care services and restrain costs. Many states have used managed care and pay-for-performance programs as a vehicle to improve the quality of services provided to Medicaid beneficiaries. Community Care of North Carolina (CCNC) is an enhanced medical home model of care that goes beyond linking individuals to a medical home by incorporating a heavy emphasis on care coordination, disease management and quality improvement. This program has documented cost savings and quality improvements for high-need populations (such as diabetes and asthma patients) which could be replicated in other states and applied to larger health reform efforts.



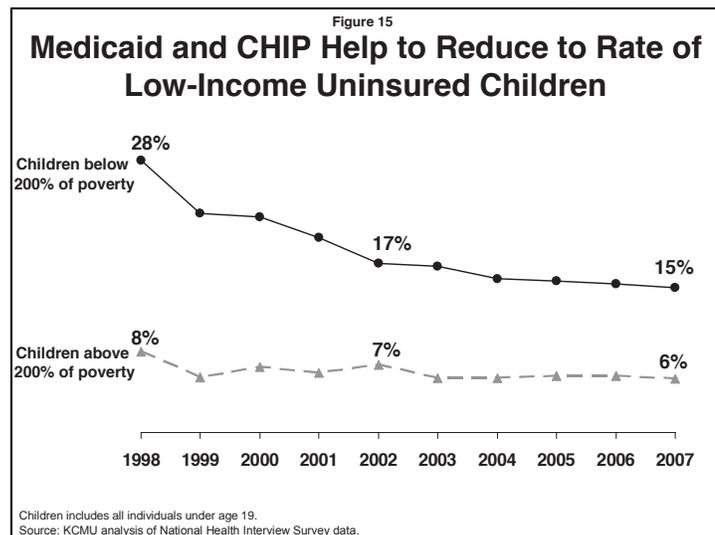
Medicaid's enrollees fare as well as those with private insurance on measures of access, even though they are sicker and more disabled. Medicaid's success in improving access to care for the low-income population is reflected in the comparability of Medicaid to private insurance on the many access measures where the uninsured fall far behind, despite often cited concerns about provider participation. For both children and adults, Medicaid, like private insurance, links families to a usual source of care -- the key entry point into the health care system. With Medicaid coverage, children utilize the health system similarly to those privately insured and face far fewer financial and access barriers to care than the uninsured. For those with serious health problems, poor adults with chronic conditions and disabilities with Medicaid coverage fare better than those with private insurance and substantially better than the uninsured on access to medical services (Figure 12). Medicaid's extensive use of managed care arrangements has helped to assure access for enrollees. The comparability of Medicaid's access to private coverage is especially notable given that the Medicaid population is both poorer and more disabled than those who are low-income and privately insured (Figure 13).



Medicaid is a low-cost program when the health needs of its beneficiaries are taken into account, Medicaid beneficiaries overall are in significantly worse health than the low-income privately insured population, and they are much more likely to have disabilities and chronic conditions. When these differences are controlled to make the Medicaid and privately insured populations more comparable, both adult and child per capita spending is lower in Medicaid than under private insurance (Figure 14). Most Medicaid spending is attributable to the program's elderly and disabled enrollees, who have extensive needs for both acute and long-term care. Medicaid's lower spending levels are due mostly to its lower provider payment rates. Medicaid administrative costs are also lower than costs in the private sector. Given the lower provider payments and lower administrative costs, comparable private coverage would be much more costly than Medicaid coverage.



Medicaid has a well developed administrative structure in every state that has enabled it to be a cornerstone in federal and state efforts to expand coverage. Great gains in reducing the share of low-income children who are uninsured have been made through the expansion of Medicaid /CHIP, demonstrating that public programs provide a solid platform from which to expand coverage. Between 1998 and 2007, the uninsured rate among low-income children fell by almost half (Figure 15). Beyond coverage for children, states have relied on Medicaid for larger reform efforts to leverage additional federal dollars and use the existing administrative infrastructure to help achieve broader coverage goals. For example, Medicaid coverage expansions and financing were key components in achieving near universal coverage in Massachusetts.



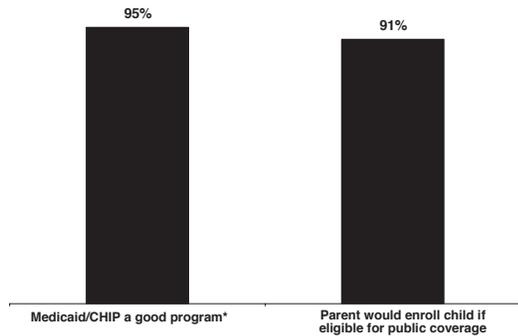
Medicaid plays an important role for some disadvantaged populations and the program has broad public support. Medicaid helps to address racial and ethnic disparities in access to care. Because minority Americans are more likely than Whites to be low-income and uninsured, Medicaid provides an important safety net for about 1 in 4 non-elderly African Americans, American Indians/Alaska Natives, and Latinos, and about 1 in 10 Asian/Pacific Americans and Whites. Medicaid covers over a quarter of all children in the U.S., including nearly 1 of every 5 White children, but roughly 2 of every 5 African American and Hispanic children. By providing health insurance coverage Medicaid promotes improved access to care that can help to narrow disparities in access to care. Medicaid also plays an important role as a

source of coverage in rural areas. In rural areas there is less employer-sponsored coverage and higher poverty rates than in urban areas. Nearly a fifth of poor children live in rural areas. As a result, about a third (32%) of rural children compared to a quarter (26%) of urban children have Medicaid and CHIP for their health insurance coverage. As Medicaid promotes access to care for the low-income rural population enrolled, it also serves as a major source of payment for rural providers, and helps fill the gap left by the low level of private insurance in rural areas. By enabling hospitals, doctors, and clinics to get financing support for their services, Medicaid helps maintain the availability of health services for all rural residents and helps sustain rural economies.

Medicaid has broad public support. In surveys of low-income families, over 90% of parents with an uninsured child view Medicaid / CHIP as good programs and say they would enroll their child if eligible for public coverage (Figure 16). Public opinion surveys have consistently shown broad support for public coverage programs with 74% ranking Medicaid as a very important program compared to 83% for Medicare in a 2005 survey of the general public. When asked about approaches to expanding coverage nationally, 70% of the public say they favor expanding Medicaid / CHIP as one way to achieve broader coverage (Figure 17).

Figure 16

Medicaid Has High Public Support

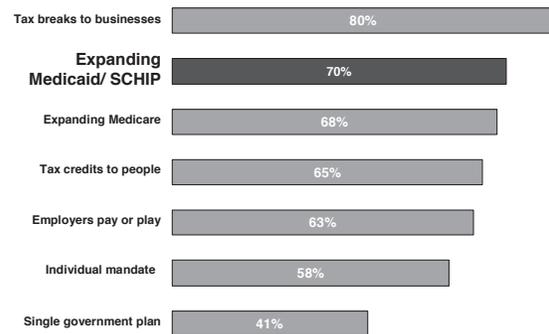


*Based on those who have heard of Medicaid/SCHIP
 SOURCE: Kaiser Survey of Children's Health Coverage, 2007.

Figure 17

Public Favors Using Medicaid/SCHIP to Expand Coverage

Percent of registered voters who favor each way to expand coverage:



Note: Not exact wording of options
 Source: Kaiser Health Tracking Poll: Election 2008 (conducted Sep. 8 -13, 2008).

4. How Can Medicaid be a Stronger Platform for Health Reform?

Expand Medicaid's Reach and Integrate Medicaid with Broader Health System Changes

Basing Medicaid eligibility on income alone. To make Medicaid a more effective platform for extending coverage to the low-income population, policy makers could set national minimum floors for eligibility based on income without regard to assets. This would mean eliminating the current categorical eligibility criteria for Medicaid. These changes would remove current coverage barriers and help to eliminate the large variation in eligibility levels that currently exist across states. The impact of setting national eligibility floors will vary significantly across states depending on a state's current eligibility levels. In general, the South and the West tend to have lower Medicaid eligibility levels and more uninsured residents, so these changes would have a larger impact in these regions.

Transform the enrollment and renewal process. To assure that individuals obtain coverage, it will also be necessary to make enrollment and renewal processes in Medicaid as simple as possible. After the enactment of the Children's Health Insurance Program in 1997, a focus on outreach and enrollment simplification efforts, combined with eligibility expansions, were critical to boost enrollment for children in these programs. Over time states have adopted a variety of strategies to simplify the enrollment and renewal process and the CHIPRA law encourages states to adopt more simplifications. In addition to efforts already in place, focusing on new ways to ease the enrollment process such as on-line income verification or data-matching, setting up multiple locations or options to enroll (such as provider-based or on-line enrollment) and elimination of the assets test will help integrate Medicaid enrollment with a reformed health system. Additionally, requiring more stable coverage (for 12 months) would mirror more closely how coverage works in the private sector and would help to prevent multiple transitions across coverage type in one-year and reduce some administrative burdens associated with more frequent renewals. Finally, conducting extensive outreach to inform individuals of new coverage options and how to apply is essential to ensuring participation. While all of these measures will yield significant results in covering more individuals, achieving near universal coverage may ultimately require stronger incentives related to enrollment efforts or mandates that individuals obtain coverage.

Ensure a seamless transition between public, subsidized and private coverage options. In a reformed health system with a goal of universal coverage, aligning the rules, verification systems and application processes between public, subsidized and private options will help assure that individuals are enrolled in the correct program and do not experience gaps in coverage as income changes. Under current law, many states have simplified enrollment processes between Medicaid and CHIP programs to ensure that applicants are enrolled in the right program even as family incomes change. Essentially, regardless of where individuals apply they are automatically enrolled in the correct program based on their income levels. Using comparable eligibility rules and allowing individuals to enroll in public or subsidized coverage at multiple locations would simplify the application process, ease administrative hurdles, and help achieve an integrated system. For example, under the Massachusetts health reform plan, MassHealth (Medicaid) also determine eligibility for Commonwealth Care (subsidized coverage) and individuals can apply for coverage through various entry points.

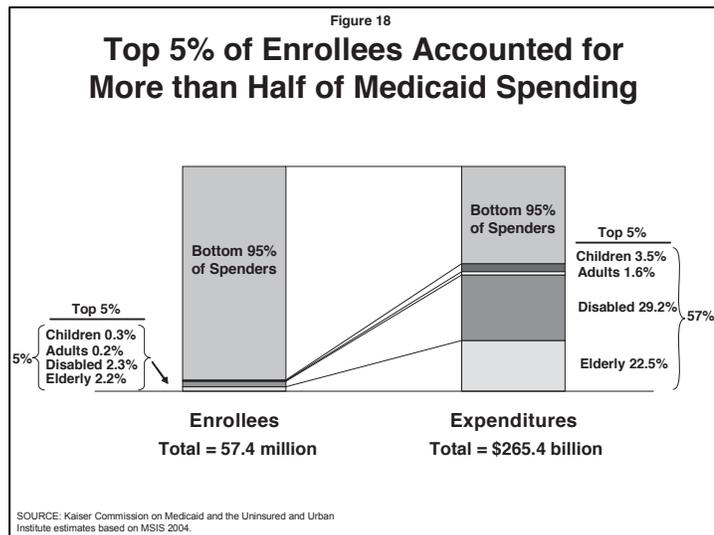
Provide Access to Appropriate and Affordable Coverage and Care for Low-Income Americans

Protect access by maintaining benefit and cost-sharing protections. The current Medicaid benefits package and minimal cost sharing requirements have been designed to meet the needs of low-income and high-need populations. These same protections are important if Medicaid is expanded to additional low-income individuals, many of whom have significant health care needs. An integrated and comprehensive benefit package can help promote coordinated care efforts, improve quality and reduce administrative burdens and costs compared to a system where beneficiaries need to navigate a system for wrap around coverage for needed benefits that may be excluded from a private coverage plan. For example, it is difficult to coordinate care, implement quality initiatives and control costs for the duals because they are enrolled in both Medicare and Medicaid. Within Medicaid, the program has a history of including providers (such as safety-net clinics and school-based health providers) that have experience in meeting the needs of low-income populations. Low-income individuals also need protections against high out of pocket costs. Even with health reform and a premium support system, private plans may have high copayments and deductibles that can adversely affect access to care and financial security.

Reform Medicaid payment policy. Even with a broad set of comprehensive benefits, access to services can vary across states and geographic areas based on provider participation. Low payment and other administrative burdens are cited as key factors influencing provider participation in the Medicaid program. The Medicaid and CHIP Payment and Access Commission was recently established as part of the CHIP reauthorization bill to study these issues and report back to Congress with an evaluation and recommendations. This Commission could be expanded in scope to study more than children. Policy makers could consider setting federal standards for access or Medicaid provider rates (such as linking Medicaid provider rates to Medicare rates).

States have also been exploring initiatives to better link payment rates to performance and quality. In 2008, the majority of states reported that they were using some type of pay-for-performance, particularly for managed care. Other states have had success in working to eliminate administrative burdens associated with participating in Medicaid and removing payment delays for submitted claims. Efforts beyond Medicaid to expand the health care work force and better align the geographic distribution of providers are also critical for access. Overall, access to primary care, certain specialists and dentists can also be problematic due to limited numbers of providers. Expanding the health care workforce to meet demands in these critical health areas is essential for Medicaid and across the entire health care system. Incentives to also help match the geographic distribution of the health care work-force to the areas in need is also essential.

Promote additional efforts to enhance quality and manage health care costs for high cost populations. With five percent of Medicaid beneficiaries accounting for nearly half of all Medicaid costs it is critical to focus on high cost populations to ensure quality care and to manage costs of care. Better ways to integrate delivery systems for acute and long-term care, Medicaid and Medicare for those dually eligible for both programs, institutional and community based, and mental and physical health issues could be examined. For long-term care services, policy makers can consider changes that would better support community living (and not institutional care) by promoting rehabilitation services that have been used to help deliver community mental health services, targeted case management, day habilitation, adult day services, community-based attendant services and personal care. Greater access to routine counseling and testing could help promote early treatment and prevent late and more costly diagnoses (including early testing for HIV).

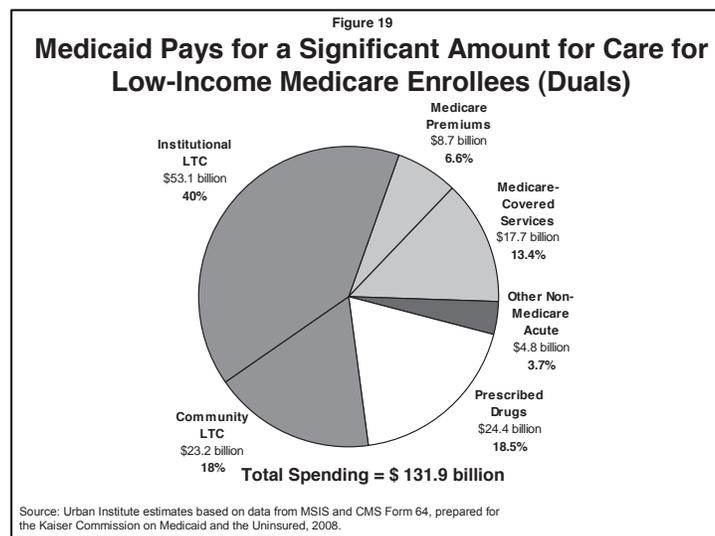


Provide Adequate and Stable Financing for Medicaid

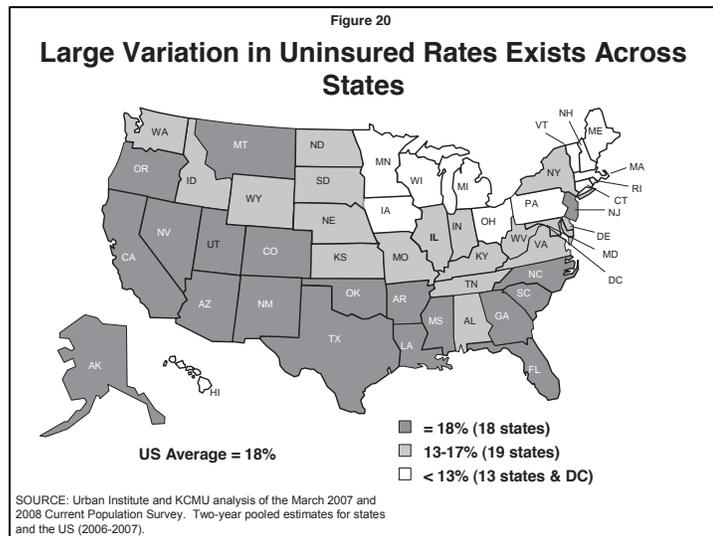
Provide additional federal support to expand coverage. Medicaid financing is shared across the state and federal governments. On average, the federal government pays for 57 percent of Medicaid costs, but this varies across states ranging from a floor of 50 percent to 76 percent. Federal financing for Medicaid is guaranteed with no set limits. Federal Medicaid financing has been critical in helping to support state efforts to fund health services for low-income individuals and to expand health coverage more broadly (like in Massachusetts). Given state balanced budget requirements and limited fiscal resources, expanding coverage to additional low-income populations will require that the federal government assume a greater share of the financing or shift some current Medicaid costs to the federal government.

Under current law, Medicaid pays for a variety of Medicare related expenses (Figure 19).

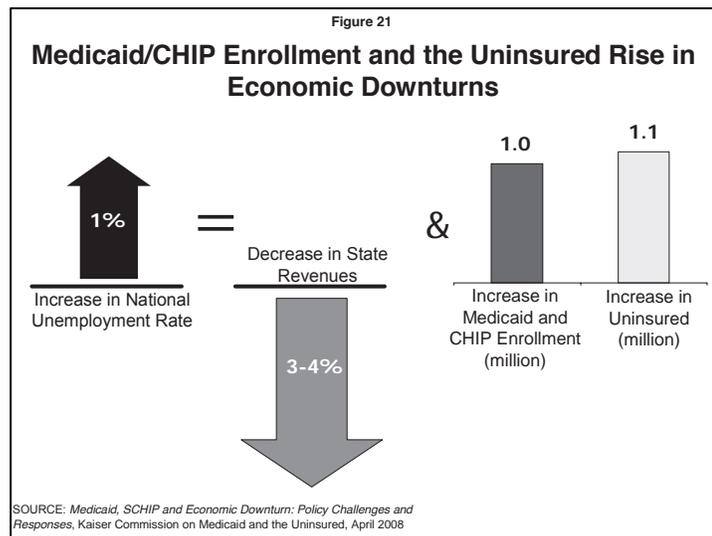
Medicaid pays for premiums and cost sharing for low-income Medicare beneficiaries; provides coverage during the 29-month waiting period for low-income individuals with disabilities under age 65 to receive Medicare, and finances a portion of Medicare coverage for prescription drugs for individuals who are dually eligible for Medicare and Medicaid through a payment to the federal government referred to as the “clawback”. Shifting these costs to the federal government could reduce current barriers that make it difficult for Medicare and Medicaid to develop effective care coordination models for this expensive population.



It is important to understand that establishing federal minimum floors for coverage will have very different effects across states. In general, the South and the West tend to have lower Medicaid eligibility levels, higher rates of poverty and more uninsured residents, so national minimum eligibility standards would have larger impact in these regions (Figure 20). Even with additional federal resources or shifting expenditures from the states to the federal level, it will be difficult to avoid any new costs to the states. One key challenge for health reform will be how to move to more national standards and maintain a fair balance of state and federal financing.



Provide for an automatic adjustment to the Medicaid match rate during an economic downturns. During economic downturns, Medicaid enrollment and spending rise as state revenues fall (Figure 21). In 2003 and again in 2009, Congress enacted legislation to help states by having the federal government pay a larger share of Medicaid costs to help meet rising demand and shrinking resources during an economic downturn. In exchange for the enhanced federal support, states were required to maintain eligibility levels. Fiscal relief helped states to address budget shortfalls, avoid making deeper reductions in their Medicaid programs and preserve eligibility in 2003-2004. Legislation could be crafted to provide an automatic adjustment to the federal matching rate (FMAP) triggered by economic conditions. Additional federal resource could help states when they face fiscal stress during an economic downturn. Such an adjustment was included in Senator Baucus' "A Call to Action: Health Reform 2009" based on the number of states experiencing an increase in unemployment and the magnitude of that increase.



Bolster Medicaid Efforts with Broader Health Care Reforms

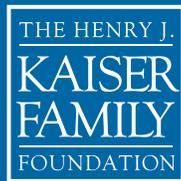
System-wide efforts (across private insurers, Medicare and Medicaid) to contain costs can help ensure that the health care system is sustainable over the long-term. Increasing costs are the dominant drivers for private health care premiums as well as Medicare and Medicaid costs. Focus on efforts to develop the primary care workforce will help ensure that individuals have access to better primary and preventive care. The development of system-wide quality standards will help to promote a health care system based on positive outcomes and help improve the efficiency of the current system. Implementation of health information technology can help achieve some of these quality goals. While the Medicaid program is a critical component in helping to control health care costs, promote primary care and improve quality, these efforts must be more broad-based than Medicaid to be effective.

CONCLUSION

Medicaid serves a population that is not just low-income but also includes many with complex health needs. The comprehensive benefits and limited cost sharing requirements have been designed to meet the needs of the populations served by the program. Over the last 45 years, Medicaid has proven to be cost effective, an important lever to help improve access to health services and narrow racial and ethnic disparities in access to care and a cornerstone in both state and federal efforts to expand coverage. In addition, Medicaid fills gaps in the health care by providing states with the capacity to extend coverage to their low-income families, helping to sustain the health care safety-net and covering many long-term and supportive services that the chronically ill and disabled need. Health reform will not address all the gaps in the health care system that Medicaid now helps to fill. For example, in Massachusetts, following health care reform demand for services from safety net providers increased as low-income individuals gained coverage and sought needed medical services, particularly primary care. These providers continue to rely on Medicaid financing support to be able to play a critical role in serving those who remain uninsured.

Medicaid with its experience in covering the low-income population provides a logical and operational framework on which to build broader coverage of the low-income uninsured. Medicaid has an established track record in providing the scope of benefits and range of services to meet the health needs of a low-income population that includes many with chronic illness and severely disabling conditions. By covering these high-need populations, Medicaid helps to lower the cost premiums for private insurance and for Medicare. Medicaid offers an appropriate starting point for extending coverage to the low-income uninsured population through health reform with the least disruption in care for the most vulnerable.

As the nation moves forward to consider health care reform, strengthening the base that Medicaid provides for the low-income population and those with special health needs will help to provide the foundation on which broader health reforms can be built and will provide time to develop and implement the many other elements required to move to universal coverage. As a building block in the broader reform effort, Medicaid can provide a stable base to protect the health care of the poor and the sick while providing a vehicle to reach low-income adults with affordable coverage during the transition to a reformed system. This strong foundation will help to assure the success of larger health reform efforts.



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