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EXPANDING COVERAGE TO ADULTS THROUGH MEDICAID UNDER HEALTH REFORM

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA), into law. The new law requires most U.S. citizens and legal residents to have health coverage and provides assistance to individuals up to 400% of the federal poverty level (FPL) by expanding Medicaid to a national floor of 133% FPL and providing premium tax credits for coverage through new Health Insurance Exchanges for those between 133–400% FPL. States will be largely responsible for implementing the Medicaid expansion and will assume new roles establishing Exchanges and coordinating Medicaid and Exchange coverage. When the new coverage goes fully into effect in 2014, states will face one of the largest enrollment efforts in the Medicaid program's history. It is estimated that some 17.1 million uninsured adults have family income at or below the new Medicaid eligibility floor of 133% FPL ($14,404 for an individual in 2009).

The Kaiser Commission on Medicaid and the Uninsured convened a roundtable on June 23, 2010 with a group of federal and state officials and experts to discuss key issues related to reaching, enrolling and delivering care to adults in Medicaid under reform, particularly non-disabled adults without dependent children (often referred to as "childless adults") who have historically been ineligible for the program. Key issues identified included the following:

Updating eligibility systems is essential for the success of the Medicaid expansion to adults and to effectively coordinate coverage between Medicaid and the new Exchanges. Roundtable participants emphasized that no amount of outreach will be able to overcome the enrollment barriers that will exist if eligibility and enrollment systems are not updated and prepared for the expansion. Many states have antiquated systems and will likely need significant upgrades to timely process a large amount of new enrollees and develop integrated systems that can coordinate with Exchanges. There was general agreement among participants that it is unlikely states will be able to update their systems to meet the new roles required of them under reform by 2014 without federal assistance. Participants stressed that having the federal government develop prototypes of eligibility systems and processes that states could adopt would help states move forward and avoid duplicative efforts. Further, the federal government is considering whether a 90% federal match (rather than the traditional 50% administrative match rate) could be applied for updating eligibility systems; this additional financing would provide key support to bolster states' capacity to conduct system upgrades.

Providing simple and seamless enrollment, renewal, and coverage transition processes, as required by the ACA, is fundamental for enrolling individuals and maintaining continuous coverage over time. Participants emphasized that simple and easy enrollment and renewal processes will be key for reducing enrollment barriers and minimizing gaps in coverage. They also highlighted the law's requirement that there be "no wrong door" for individuals coming in to apply for coverage and the importance of coordinating enrollment in and transitions between Medicaid and Exchange coverage. Discussion further focused on the potential benefits and challenges of integrating Medicaid enrollment with other social service programs, such as food stamps (SNAP). This integration would help link some individuals to a wider array of services; however, participants also commented that it would be difficult to create these linkages by 2014, when integrated systems for Medicaid and the Exchange must be operational. It was suggested that systems could be built with the capacity to link to other programs over a longer timeline and that, as an interim step, Medicaid systems could transfer data to other programs.

Transitioning to a standard eligibility methodology using Modified Adjusted Gross Income (MAGI) greatly simplifies eligibility but also creates new challenges. Under reform, eligibility for Medicaid and subsidies in the Exchange will be based on MAGI without an asset test. Having a national standard is a major simplification from today where each state Medicaid program has its own methodology for counting income and resources. However, moving to MAGI changes the rules about which income counts and how households are defined. Further, the Departments of the Treasury and Health and Human Services will need to reconcile the use of MAGI, which is collected when individuals file taxes and may have lagged data, with Medicaid rules that base eligibility on current income. This issue is particularly important since many low-income individuals do not file tax returns and/or have fluctuating incomes. Participants also noted that there are non-MAGI groups (including the elderly and disabled) for which states must continue to use current Medicaid eligibility methodologies and that states must track "current" versus "new" eligibles, since the federal government will pay the majority of costs for individuals newly eligible for coverage under reform. It was noted that it will be important for states to be able to meet these requirements in a way that will not hinder broad efforts to simplify enrollment.

Effectively reaching eligible adults will entail careful consideration of messages, program names, and terminology as well as both broad and targeted outreach efforts. Participants pointed to the importance of messaging used to reach newly eligible adults. Some suggested that renaming Medicaid would help promote enrollment, reinforce a culture of coverage and overcome any previously held negative associations with the program. It was also noted that messaging could focus on the broad continuum of assistance available up to 400% FPL. Further, participants agreed that the term "childless adults" is a misnomer and a new name is needed to refer to this group. Many "childless adults" are non-custodial parents or parents of adult children, including some who may have had Medicaid coverage before their children turned 18. With regard to outreach, participants commented that it will be key to include both broad and targeted efforts, particularly for hard-to-reach groups, such as young and healthy adults and adults with complex needs including serious mental illness.

Connecting newly eligible adults who have diverse characteristics and health needs to medical homes and access to needed care is imperative. Participants agreed that states should expect wide variation in demographic characteristics and health needs among the expansion population. Some will be relatively healthy while others will have significant needs including physical and mental health issues. The overall case mix and costs for the group will depend on participation rates and patterns when the expansion is initially implemented and over the longer term. Participants stressed the importance of aligning enrollment in coverage with enrollment in a managed care plan or connection to a medical home to help new enrollees access needed care. However, it was noted that many states would need to take significant steps and make investments to develop the infrastructure needed to provide a medical home model of care. Federal support will be important to promote the development of new systems of care and provider workforce development. Participants also noted that, given overall national shortages in primary care physicians, expanding the roles of providers such as nurse practitioners and physician assistants may be important to meet primary care needs.

In summary, the Medicaid expansion in reform creates a historic new opportunity to expand coverage to millions of currently uninsured low-income adults. The roundtable discussion made clear that while the expansion does not go fully into effect until 2014, it is imperative for states to begin preparing and making the necessary upgrades to their eligibility systems now. Although states are starting from different places, they must meet the same requirements in the same timeframe. Recognizing this, a key point stressed throughout the discussion was the importance of federal leadership, guidance, and assistance. In particular, developing prototypes of eligibility and enrollment systems and processes that states could adopt was viewed as key for helping states navigate their options and preventing duplicative efforts.

INTRODUCTION

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA), into law. The new law requires most U.S. citizens and legal residents to have health coverage and provides assistance to individuals up to 400% of the federal poverty level (FPL) by expanding Medicaid to a national floor of 133% FPL and providing premium tax credits for coverage through new Health Insurance Exchanges for those between 133-400% FPL. The Medicaid expansion and tax credits will create new coverage pathways for millions of currently uninsured individuals, particularly low-income non-disabled adults.

Prior to reform, Medicaid eligibility for non-disabled adults under age 65 was limited. States were required to cover certain groups through Medicaid, including children, pregnant women, elderly and disabled individuals, and parents, to federal minimum levels and had the option to expand eligibility to higher incomes. Some states expanded eligibility to parents above minimum levels; however, overall, parent eligibility remained limited.[1] Adults without dependent children—oftentimes referred to as "childless adults"—were were not included in the categories of people states could cover through Medicaid and receive federal matching funds, regardless of their income. States could only cover these adults through a waiver or fully state-funded program. Reflecting these limitations, more than half of states did not provide any coverage to low-income childless adults in 2009.[2]

Overall, an estimated 17.1 million uninsured adults have family income at or below the new Medicaid eligibility floor of 133% FPL ($14,404 for an individual in 2009).[3] States will be largely responsible for conducting outreach and enrolling newly eligible adults as well as for establishing Exchanges and developing integrated eligibility systems that coordinate with new Health Insurance Exchanges. Moreover, as adults are enrolled in coverage it will be important to connect them to care and facilitate their access to needed services. These issues are complex, costly and require significant lead time, so it will be important to begin to planning for the expansion today to be ready and prepared for 2014.

The Kaiser Commission on Medicaid and the Uninsured convened a roundtable on June 23, 2010 with a group of federal and state officials and experts to discuss key issues related to reaching, enrolling and delivering care to adults in Medicaid under reform, particularly childless adults who have historically been ineligible for the program. This roundtable and brief builds on research conducted by KCMU drawing on key lessons learned about reaching, enrolling and delivering care to childless adults in Medicaid from states and national experts.[4] The key issues identified during this roundtable are discussed in this report.

KEY ISSUES

1. Updating eligibility systems is essential for the success of the Medicaid expansion to adults and to effectively coordinate coverage between Medicaid and the new Health Insurance Exchanges.

Participants emphasized that no amount of outreach will be able to overcome the enrollment barriers that will exist if eligibility systems are not updated and prepared for the expansion. The updated systems will need to process a substantial number of new enrollees when the expansion goes into effect. Further, the systems will need to handle new roles associated with coordinating Medicaid enrollment with Exchange coverage, as required by the ACA. In addition, under the ACA, states must operate Web portals, utilize data exchanges to support eligibility determinations and develop processes to apply for health coverage through multiple avenues including on-line.

There currently is wide variation across states in terms of the status of their Medicaid eligibility systems—some have made significant strides in moving to online systems with automated processes, while many others remain antiquated, paper-based systems. As of 2009, 47 states had applications available on-line, but only 25 states allowed applicants to complete and submit an application on-line; in the other states the application still needs to be downloaded, printed and mailed.[5] Further, in some states that allow electronic submission of the application,

applicants still need to mail in paper documentation.[6] Given the current status of eligibility systems, a number of states will need significant upgrades to their systems to process the volume of new enrollments likely to occur following the expansion in a timely manner, particularly since many states have been experiencing reductions in administrative staff due to the current budget situation.

Further, participants pointed out that as states move forward to comply with the new requirements to coordinate enrollment systems with the Exchanges, they will need to address a number of threshold questions that may impact the development of their systems. For example, where will eligibility for Medicaid and the Exchange be determined (at the state or county level and by the Medicaid agency, another agency, or a private contractor), will the state opt to run its own Health Insurance Exchange or have the federal government operate the Exchange, what will the federal Exchange look like, and will the state opt to have its Medicaid agency determine eligibility for subsidies in the Exchange.

There was general agreement that it is unlikely states will be able to update their systems to meet the new roles required of them under reform by 2014 without federal assistance, particularly given the current budget situation and the long lead-time often associated with the system upgrades. Participants noted that states are specifically interested in having access to prototypes of eligibility systems and processes that they could adopt and tailor to meet their states' needs and receiving direct technical assistance. Having the federal government develop system prototypes would help states move forward more quickly and avoid unnecessary duplication of state efforts. Further, the federal government is considering whether a 90% federal match could be applied for updating eligibility systems. Currently, states receive a 90% match for development of claims processing systems but states have only been able to receive the traditional Medicaid administrative match rate of 50% for eligibility system upgrades. Additional federal financing in terms of a higher match rate would provide important support to bolster states' capacity to conduct system upgrades.

2. Providing simple and seamless enrollment, renewal, and coverage transition processes, as required by the ACA, is fundamental for enrolling individuals and maintaining continuous coverage over time.

Health reform envisions a system of coverage where nearly all individuals have simple and easy access to affordable coverage. To this end, the law includes provisions requiring consumer-friendly, coordinated, simplified, and technology-enabled enrollment systems.[7] Participants emphasized that making the enrollment and renewal processes as simple and automated as possible will be critical for reducing enrollment barriers and preventing gaps in coverage. Discussion further highlighted the importance of creating a fully integrated eligibility and enrollment system for Medicaid and Exchange coverage. Participants pointed out that the law requires that there be "no wrong door" for individuals coming in to apply for coverage and that the steps to determine which coverage a person should be enrolled in or to transition a person from one program to another should occur behind the scenes and be essentially invisible to the individual.

Facilitating seamless transitions between the coverage types is important because lower-income individuals often have fluctuating incomes and family circumstances that may cause their eligibility to change over time. For example, it was noted that, in Massachusetts, large numbers of people move between Medicaid and Exchange coverage each month. However, most of these transfers occur with no action by beneficiaries or eligibility workers, and beneficiaries maintain continuous coverage despite the shift in financing of their coverage.

Participants pointed out that one key issue that is being discussed with regard to the development of enrollment systems is the extent to which Medicaid eligibility and enrollment should be integrated with other social service programs, such as food stamps (SNAP). Most public assistance programs are targeted to individuals with incomes at or below the poverty level; however the income, resource and documentation requirements often vary across programs. Many states offer a combined application that allows families to apply for Medicaid (and sometimes CHIP) at the same time as other public assistance programs. However, the extent to which enrollment in Medicaid has been integrated with other programs varies widely across states.

The discussion among participants highlighted both the potential benefits and challenges of integrating health coverage enrollment with other social service programs under reform. On one hand, the need to upgrade systems to support the Medicaid expansion in health reform can be viewed as an opportunity to facilitate upgrades for other public assistance programs. Further, integrating enrollment in health coverage with other programs would help low-income individuals access a wider array of benefits and services.

On the other hand, given the variation in eligibility requirements across programs and in current practices across states, integrating these systems would be complex and developing systems that would create such linkages could take significant time. Several participants remarked that achieving integration between Medicaid and Exchange eligibility and enrollment systems by 2014 will be difficult on its own, let alone considering extended integration across other programs. Further, with eligibility for Medicaid or subsidized coverage in the Exchange reaching individuals and families up to 400% FPL, participants noted that only a small portion of this group will be eligible for benefits in other programs. Given these challenges, it was suggested that the eligibility and enrollment systems could be designed with the capacity to integrate other programs over a longer timeline and that, in the interim, the systems could transfer data to other programs.

3. Transitioning to a standard eligibility methodology using Modified Adjusted Gross Income (MAGI) greatly simplifies eligibility but also creates new challenges.

Under health reform, eligibility for both Medicaid and subsidies in the Exchange will be based on Modified Adjusted Gross Income (MAGI). Having a national standard for eligibility with no asset and resource test that is consistent across Medicaid and the Exchanges is a major simplification from today where each state has its own methodology for counting income and resources. However, transitioning to this new methodology raises policy issues as well as systems issues that were identified by participants. In terms of policy issues, moving to MAGI for determining income for Medicaid changes the rules about which income counts and also how households are defined and family size is calculated. For example, current Medicaid income counting rules include income from death benefits, Veterans benefits, IRA, transportation benefits, and child-support income, which are not included in MAGI. However, Medicaid often excludes step-parent and grandparent income that would be counted in the MAGI household definition of income.

In addition, MAGI is defined by the Internal Revenue Code and is captured through the Internal Revenue Service when individuals file income taxes. This information will be lagged, sometimes by as much as two years, in terms of evaluating eligibility for coverage and for determining the levels of subsidies for individuals in the Exchange, whereas the law still requires that Medicaid eligibility be based on current income data or point-in-time income. The Departments of Treasury and Health and Human Services will need to develop rules and processes to reconcile the use of MAGI and point-in-time income determinations and to determine income for individuals who do not file a tax return. These issues are particularly relevant for the low-income population since many do not file tax returns and/or have fluctuating incomes.

Another issue raised was that there will be groups eligible for Medicaid who will continue to rely on current Medicaid eligibility methodologies—i.e., non-MAGI populations. Given that non-MAGI groups include the elderly and disabled it will be important to ensure that these eligibility determinations are also coordinated with the MAGI process so that individuals can access appropriate Medicaid coverage and benefits even if they come into coverage through the Exchange. Further, participants also pointed to issues related to states being required to track "current eligibles" versus "new eligibles," since the federal government will pay the majority of costs for individuals who become newly eligible for coverage as a result of reform. Questions were raised about how states would continue to determine eligibility for non-MAGI groups and distinguish between "new" versus "current" eligibles and whether they would need to maintain existing eligibility systems or processes to meet these requirements. It was recognized that increased federal guidance is needed around these issues and that it will be important for states to be able to meet these requirements in ways that will not hamper broad efforts to simplify enrollment.

4. Effectively reaching eligible adults will entail careful consideration of messages, program names, and terminology and both broad and targeted outreach efforts.

Participants pointed to the importance of messaging used to reach newly eligible adults, particularly given childless adults' historic exclusion from the program. Some of these adults may have tried to enroll in Medicaid before, so it will be important to convey their new eligibility for the program and that Medicaid is really a "new program." Some suggested that renaming Medicaid would help to promote enrollment and overcome any previously held negative associations with the program; however, participants also cautioned that such renaming should go hand-in-hand with making sure that that the program provides a simple, user-friendly enrollment process for individuals. Further, participants agreed that the term "childless adults" is a misnomer and a new name was needed to refer to this population. Many "childless adults" are non-custodial parents or parents of adult children, including some who may have previously been covered by Medicaid before their children turned 18.

In terms of outreach strategy, participants commented that marketing will need to include both broad and targeted efforts. It was suggested that broad-based marketing strategies that focus on new coverage opportunities overall will be one important component for facilitating enrollment in Medicaid and new Exchanges. Health reform changes the coverage landscape and Medicaid is one component in a new continuum of coverage options. There is a significant demand for affordable and comprehensive coverage, so many individuals will be eager to take advantage of new coverage options. Further, the mandate for coverage under reform may contribute to a new culture of coverage.[8] However even with broad-based marketing, targeted messaging and outreach will be important, particularly for difficult-to-reach subgroups. Specific messaging is essential because there is a lot of diversity among this group of adults. Some are young and relatively healthy while at the other end of the spectrum there are older adults with significant health needs. This group also includes some individuals with complex needs, including homeless individuals, those with substance abuse problems, and individuals with serious mental illness.

In addition, it was suggested that it will be important for messages to come through multiple pathways and for efforts to occur on an ongoing basis. Oftentimes, an individual needs to hear a message multiple times through multiple avenues before taking action to sign up for coverage. Participants also stressed the importance of using community-based organizations, providers and other entities that may have contact with newly eligible adults to assist in communicating information about new coverage options and completing the enrollment process. The role of providers and organizations will be particularly important for some individuals, particularly those with complex needs. For example, mental health providers will likely play a key role in helping individuals with serious mental illness complete the enrollment process. Similar, homeless shelters could serve as a vital point of contact for enrolling homeless individuals. Further, it was noted that it will be important to ensure that the information individuals receive is objective, accurate, and easily understood and to provide a multitude of options for individuals to apply including on-line, in-person, by phone, mail, etc. In particular, having easy, on-line applications will help promote coverage among young and healthy adults.

5. Connecting newly eligible adults who have diverse characteristics and health needs to medical homes and access to needed care is imperative.

Participants agreed that states should expect wide variation in demographic characteristics and health needs among the expansion population. Some will be relatively healthy while others will have significant health needs including physical and mental health issues. However, the overall case mix and costs for the new Medicaid expansion group will depend on participation rates and patterns when the expansion is initially implemented and over the longer term. Understanding the health needs and costs of the expansion population has important implications for designing appropriate benefit packages and delivery systems, particularly since under reform newly eligible adults receive a "benchmark benefit package" that may be more limited that a state's full Medicaid benefit package. Understanding their needs and costs will also be important for setting capitation rates if states opt to use managed care arrangements as a primary care delivery model for the population.

There was a general consensus that newly eligible individuals who are the sickest will likely be among the first ones to enroll under the expansion creating adverse selection and higher initial costs.[9] These individuals will seek out coverage or seek care at a provider site that will help facilitate enrollment, or some states may transfer individuals currently enrolled in state-only or local programs for the low-income uninsured (such as General Assistance programs). In these cases, states may see high levels of pent-up demand for services. However, over time, the mix of health needs among enrollees will likely even out as more healthy adults also come into the program. Some participants noted that the new mandate for coverage, simplified enrollment processes and broad based outreach could promote enrollment and mitigate problems with adverse selection. More young and healthy individuals are likely to enroll if there is broad outreach and an easy enrollment process.

States that already cover childless adults have had varying experiences in terms of the cost of covering these adults. This reflects variations in the income groups covered by state programs, the scope of benefits provided, and the case mix of enrollees.[10] Individuals with the lowest income (under 50% FPL) are likely to have the most extensive health needs and the highest costs.[11] Overall, research and state experience suggest that coverage for the adult expansion population is expected to be less expensive than that for disabled adults currently covered by Medicaid.[12] How health needs and costs for expansion adults will compare to non-disabled adults already covered by Medicaid will ultimately depend on participation rates and levels of adverse selection, which will be impacted by state outreach and enrollment efforts. However, research indicates that after the initial start-up period, on balance, new Medicaid enrollees are not likely to be markedly different from current non-disabled adult enrollees.[13]

Consistent with these research findings, New York's experience covering childless adults revealed that very low-income childless adults in Medicaid who receive cash assistance were significantly sicker and more costly than those at relatively higher incomes who do not receive cash assistance. Among the somewhat higher-income non-cash group covered by the state's Family Health Plus waiver program, there were very limited differences between childless adults and parents in terms of severity of illness or expenditures per member per month (PMPM).

Participants stressed the importance of aligning enrollment in coverage with enrollment in a managed care plan or connection to a medical home to help new enrollees access needed care. If states plan to use managed care to provide services to this population, it will be important to ensure that the plans can meet the needs of those with complex medical issues as well as those who may be relatively healthy. Further, since some individuals may have fluctuating incomes that would move them in and out of eligibility for Medicaid, having some Medicaid managed care plans that also participate in the Exchange would facilitate coordination of care when they transition between coverage.

States may also use medical home models of care and case managers to help coordinate care, particularly for individuals who may be new to coverage and unfamiliar with the health care system. These individuals may have significant pent-up demand for services and need help navigating the health care system. Further, the expansion population might require more integration of mental and behavioral health services, as some will have significant mental health needs, including serious mental illness and substance abuse problems. Team-based care that includes a broad range of professionals and linkages to other social service supports may also be useful for high-need cases.

It was noted that many states would need to take significant steps and make investments to develop the infrastructure needed for appropriate delivery systems including medical home models of care. While the ACA provides a 90% match rate for "health home" services designed to help coordinate care for individuals with chronic conditions, this higher match rate is time-limited and many states will likely also need technical assistance to move forward with these new models.[14] Further, with millions of individuals newly enrolling in coverage, federal efforts will be needed to address shortages in primary care physicians and some specialists in Medicaid and across the health care system. It was suggested that it will be important to ensure adequate payment rates for providers and to consider expanding the role of providers such as nurse practitioners and physician assistants to meet primary care needs.

CONCLUSION

In summary, the Medicaid expansion in reform creates a historic new opportunity to expand coverage to millions of currently uninsured low-income adults. The roundtable discussion made clear that while the expansion does not go fully into effect until 2014, it is imperative for states to begin preparing and making the necessary upgrades to their eligibility systems now. Although states are starting from different places, they must meet the same requirements in the same timeframe. Recognizing this, a key point stressed throughout the discussion was the importance of federal leadership, guidance, and assistance. In particular, developing prototypes of eligibility and enrollment systems and processes that states could adopt was viewed as key for helping states navigate their options and preventing duplicative efforts.

ENDNOTES

[1] Cohen Ross, D., Jarlenski, M., Artiga, S., and Marks, C. "A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009," Kaiser Commission on Medicaid and the Uninsured, December 2009.

[2] "Where are States Today?" Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults," Kaiser Commission on Medicaid and the Uninsured, December 2009.

[3] Schwartz, K. and A. Damico, "Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty," Focus on Health Reform, The Henry J. Kaiser Family Foundation, April 2010.

[4] "Reaching, Enrolling and Delivering Care for Low-Income Childless Adults in Medicaid: Key Lessons Learned from National Experts and State Experiences," Kaiser Commission on Medicaid and the Uninsured, June 2010.

[5] Unpublished data from Cohen Ross, D., op cit.

[6] Ibid.

[7] Morrow, B. and J. Paradise, "Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges," Focus on Health Reform, The Henry J. Kaiser Family Foundation, August 2010.

[8] "Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform," Kaiser Commission on Medicaid and the Uninsured, April 2010.

[9] Somers, S. and Hamblin, A. "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States," Center for Health Care Strategies, August 2010.

[10] Ibid.

[11] Ibid.

[12] Ibid.

[13] Holahan, J., Kenney, G, and J. Pelletier, "The Health Status of New Medicaid Enrollees Under Health Reform, The Robert Wood Johnson Foundation and The Urban Institute, August 2010.

[14] The 90% match is limited to eight consecutive fiscal quarters.

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