STRENGTHENING MEDICAID

Building on a Solid Foundation: Medicaid's Role in a Reformed Health Care System

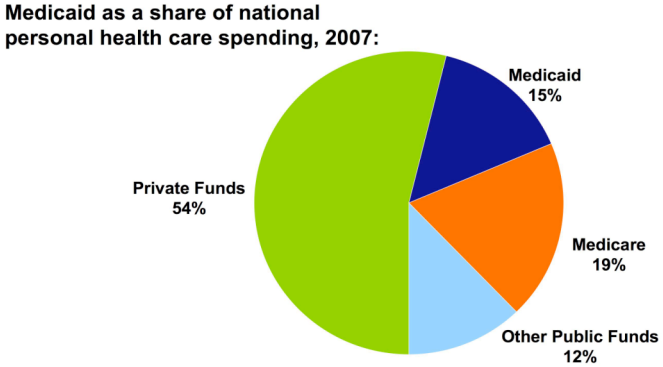
Executive Summary

Health care reform is once again a front and center issue – at the White House and in the halls of Congress, in state capitols and corporate boardrooms, and around kitchen tables across America. Covering the uninsured, reigning in health care costs, and obtaining better quality and value for our health care dollars are goals that have sweeping public and policymaker support. While the policy debates are just beginning, broad consensus exists that a newly reformed system ought to build on the components of the current system, including the Medicaid program. This means that a central question underlying health care reform is: How can each of those components be strengthened and work together to meet national health care reform goals? This question raises many important issues, including how to best build on and strengthen Medicaid, which has long been a foundation of our health care system. This paper considers ways of doing this, focusing on three key areas: Medicaid eligibility and access, cost and efficiencies, and financing.

Why Medicaid?

Medicaid is a cornerstone of the nation's health care infrastructure, accounting for about one in every six health care dollars spent in the U.S. (Figure 1). This year, it will cover nearly 68 million children, parents, pregnant women, seniors, and people with disabilities. It covers almost two-thirds of all poor children, more than four out of ten births, and helps pay nursing home costs for almost two-thirds of all nursing home residents (Figure 2, next page). Medicaid's contribution, however, extends well beyond the numbers of people it serves. Medicaid covers, with remarkable success, people who have the greatest needs: including children in families whose financial means are very modest and people with significant disabilities or multiple, chronic conditions. Special features of the program that distinguish it from typical commercial insurance allow Medicaid to take on this unique coverage role. In so doing, Medicaid relieves other insurers and payers of the responsibility of covering a population whose health care needs can be complex and costly and who have little or no ability to purchase care that is not covered.

Figure 1:
Medicaid is a Major Purchaser of Health Care



Note: Medicaid spending includes both the federal, the state, and the local portion of Medicaid, but does not include spending in SCHIP. Source: M. Hartman, *et al.*, "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," *Health Affairs*, 28(1): 246-261 (January/February 2009).

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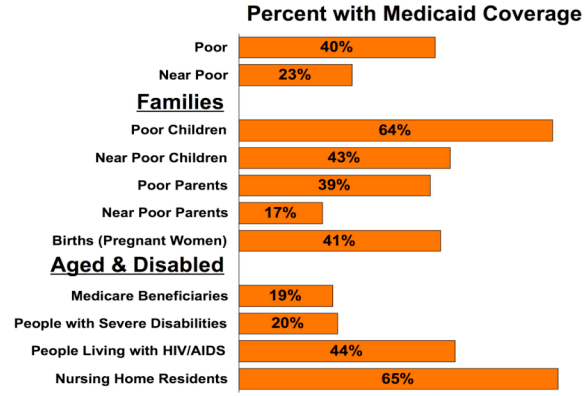
The current economic crisis also reminds us of Medicaid's important "countercyclical" coverage role. Along with the much smaller Children's Health Insurance Program (CHIP), Medicaid buffers the falloff in private, employer-based health insurance that accompanies economic downturns, preventing many children and adults who are losing their private insurance from becoming uninsured.[1] Even with the gaps in Medicaid's current eligibility structure, Medicaid reduces, by nearly one-half, the rise in the number of people without insurance that would otherwise result from growing unemployment (Figure 3).

Figure 2:
Medicaid's Role in Coverage

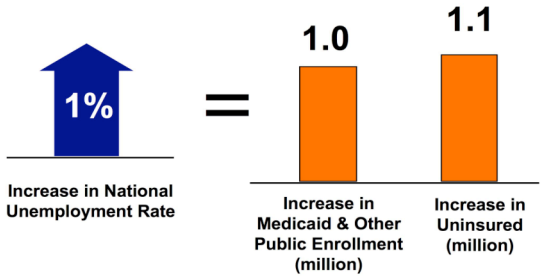


Note: "Poor" is defined as living below the federal poverty level (FPL), which was $17,600 for a family of 3 in 2008. "Near poor" is defined as income between 100% and 199% of FPL. Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates of March 2008 CPS; and National Governor's Association, "Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007" (November 25, 2008).

Medicaid's Challenges

While Medicaid has many strengths and enjoys strong public support, it has gaps and faces challenges that will need to be addressed for it to function as needed in a reformed health system. First, is that while Medicaid is a major source of coverage for poor and near-poor people, not all low-income people—not even all very poor people—qualify for Medicaid under current rules. To make significant progress in covering the uninsured, these eligibility gaps must be filled. At the same time, it will be important to ensure that current as well as newly eligible Medicaid beneficiaries have appropriate access to health providers. Second, building on progress achieved over the last decade, more can be done to make sure that Medicaid purchases care in cost-effective ways aimed at assuring high quality care. Finally, aspects of Medicaid's financing system need re-examination to ensure that the program can sustain its countercyclical coverage role and to address the heavy burden Medicaid bears filling in for gaps in the Medicare program. This report offers recommendations in each of these three areas.

Figure 3:
Medicaid Reduces the Impact of Unemployment on Uninsurance by Nearly One Half



Note: a 1% increase in unemployment also equals a 3-4% decline in state revenues. Source: S.Dorn, *et al.*,"Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses," Kaiser Commission on Medicaid and the Uninsured (April 2008).

Recommendations

1) Establish a national minimum Medicaid coverage standard to assure coverage to low-income people across the nation.

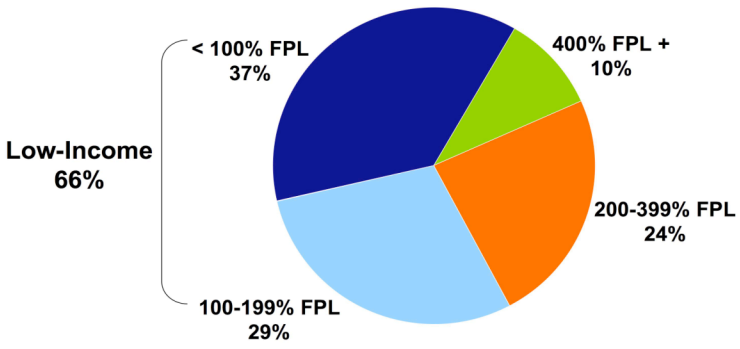
Medicaid covers different groups of people at different

income levels, a pattern shaped by the combination of federal rules and state options. The result is that eligibility varies by group (e.g., children, parents, pregnant women) and by state. These gaps and variations will need to be addressed in order to provide a consistent coverage guarantee as a base for health reform.

The coverage gap is most pronounced for adults who are not caring for children and who are not elderly, disabled, or pregnant. This group of people is not eligible for Medicaid, regardless of income, which helps explain why 45 percent of non-elderly adults living below the poverty level are uninsured.[2] Even within eligibility categories covered through Medicaid, wide state-to-state variations lead to substantial inequities in who gets coverage. Parents in Arizona are eligible for Medicaid if their income is below twice the poverty level (equivalent to about $3,000 in monthly earnings for a family of three), while a parent with the same household size living in neighboring Colorado is "over income" for Medicaid if he or she earns just 66 percent of the poverty level, or $970 a month.[3]

Medicaid needs a national uniform coverage standard. With two out of every three uninsured Americans living in low-income families, eliminating these disparities is a key priority for health care reform that would accomplish multiple objectives. A national minimum coverage standard would target coverage to where the need for it is greatest (Figure 4), and it is the most logical way to set a uniform base for coverage upon which other federal reforms can be built. In addition, a national uniform standard would dramatically simplify Medicaid's complex maze of eligibility categories. Simplification would make the program easier for the public to understand and navigate and simpler for states to administer.

Figure 4:
Two-Thirds of the Uninsured are Low-Income



Source: Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer" (October 2008).

Setting the eligibility standard. A number of issues will influence the decision of where to set the level for a new national standard. The standard should assure coverage to people who are least likely to have access to private coverage and who, as a result of their low incomes, will need a full subsidy to access care, and the level selected needs to fit well within the larger structure of any health care reform plan of which it is part. A standard pegged at 150 percent of poverty represents a reasonable starting point, particularly given that the federal minimum coverage standard in Medicaid for young children and pregnant women is already at 133 percent of the poverty level. A new standard could be phased in over time, and states could maintain current eligibility categories for groups that exceed the income standard and have higher public program coverage standards for children through CHIP.

Related reforms. A new national Medicaid standard will need to be coupled with new enrollment procedures that would streamline enrollment and coordinate Medicaid enrollment with enrollment for subsidies or other new options for people with incomes above the Medicaid standard. In addition, issues relating to Medicaid provider payment levels and access to care will need to be addressed, and, as will be the case with any significant expansion in coverage, steps will need to be taken to ensure access to care for those who become newly eligible. While there are many options for how best to finance expansions of Medicaid coverage, given structural state fiscal constraints, the federal government rather than the

states, should be primarily responsible for added costs, although maintaining state investment in Medicaid coverage is also critical.

2) Controlling costs and improving efficiency.

Because Medicaid accounts for such a large part of the health care system, it can play a significant role in helping to control health care costs and assuring better value for the dollars spent. For many years, Medicaid has helped spur and test new approaches to managing costs and improving efficiency, but Medicaid – like other large purchasers of health care – could be doing more to help maximize value. In addition, while many states already have Medicaid quality initiatives in place, more can be done to develop a core set of quality measures, focus quality measures on services for which Medicaid plays an especially large role, and collect and report quality data. The law reauthorizing CHIP includes a new initiative to develop quality standards for all children, whether they are privately or publicly insured. This initiative should be extended beyond children.

Prescription drug policies. Medicaid is a major purchaser of prescription drugs. Given that drugs are a vital part of meeting the health care needs of Medicaid beneficiaries and others, additional attention to the management and purchase of prescription drugs is warranted. Initiatives that rely on clinical effectiveness reviews, including evidence-based formularies, and managing care for high-cost users can help maintain beneficiary access to needed drugs *and* control costs. These tools can also help states avoid blunt and often harmful cost containment policies that can impede beneficiary access to medically necessary drugs, like limiting the number of prescriptions a beneficiary can obtain. At the same time, Medicaid needs to get the best possible price for the drugs it purchases by increasing the program's drug rebate and improving administration of the rebate program, saving money both for the federal government and for states. Significant rebate proposals have been included in President Obama's Fiscal Year 2010 budget proposal, with the savings directed into a fund for health reform.

Health information technology and quality improvements. Medicaid should also expand the use of health information technology to improve care and increase efficiency in the health care system. Tools ranging from electronic prescribing to electronic medical records facilitate coordination of care, minimize unnecessary procedures, and reduce administrative costs. The American Recovery and Reinvestment Act of 2009 (ARRA) included significant new resources to promote implementation of electronic health records in Medicaid and Medicare. In addition, improvements to basic management of the Medicaid program will help to ensure that enrollees obtain the health and long-term care services they need, providers offer high quality care in a system that operates efficiently, enrollment is coordinated with other system components, and public resources are spent well.

3) Assuring that the Medicaid program is on sound fiscal footing.

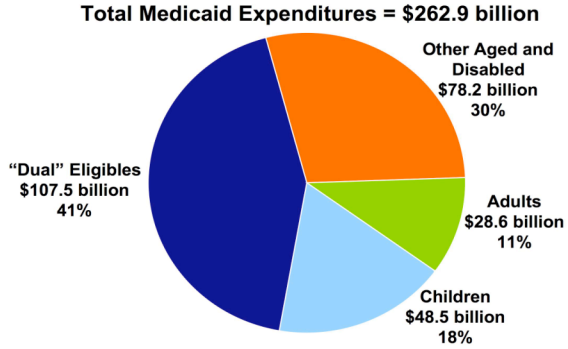
The fundamentals of Medicaid's financing system are strong and have allowed the program to serve its mission well. However, growth in health care costs, the decline in employer-based health coverage, and the aging of the population pose fiscal challenges for states that pay, on average, 47 percent of Medicaid costs.

Protecting coverage in downturns. Stabilizing Medicaid coverage during recessions is a key goal for reform. Relief to states was provided as part of the ARRA, as it was on a more modest scale during the 2003 recession. But Medicaid needs a built in financing stabilizer that automatically boosts the share of federal funding during economic downturns without the need for new federal legislation. This would provide predictable financial support to states to help them maintain coverage during downturns - an essential element if national health reform is to be built upon a reliable base of coverage.

Realigning fiscal responsibilities. More fundamentally, some realignment of the fiscal responsibilities assigned to the states and the federal government for providing health and long-term care for people who are enrolled in both Medicaid and Medicare (the "dual" eligibles) is in order. Medicaid pays the cost of services, such as long term care, that Medicare does not cover. It also pays the Medicare premiums and cost sharing on behalf of low-income Medicare beneficiaries and fills in the coverage gap for many people with disabilities who must wait two years to qualify for Medicare. These Medicare gaps drive Medicaid spending to a significant degree, with services for "dual" eligibles accounting for more than 40 percent of all Medicaid spending (Figure 5). Some realignment of Medicare's and Medicaid's financing responsibilities will ensure that the nation is better prepared to handle long-term fiscal challenges, including the health and long term care needs of an aging population.

Different options for realigning responsibilities could be considered. Increasing the federal matching rate for the services Medicaid provides to "dual" eligibles, shifting or reducing the responsibility for paying Medicare premiums and cost-sharing for low-income Medicare beneficiaries from state Medicaid programs to Medicare, and eliminating the two-year Medicare waiting period for people with disabilities are all viable options for strengthening health coverage and Medicaid's long-term financial health. As with the national coverage standard, these measures could be calibrated and phased in to align with broader policy goals and accommodate budgetary constraints.

Figure 5:
"Dual" Eligibles Accounted for More Than 40% of Medicaid Spending in 2005



Note: Spending on prescription drugs for dual eligibles, which became a Medicare responsibility in 2006, is excluded in order to approximate the share of post-2005 Medicaid spending that is attributable to duals. However, because this amount also excludes "clawback" payments states began paying the federal government in 2006, this estimate is probably conservative. Source: J. Holahan, D. Miller, & D. Rousseau, "Rethinking Medicaid's Financing Role for Medicare Enrollees," Kaiser Commission on Medicaid and the Uninsured (February 2009).

Conclusion

As the nation turns its attention to health care reform, Medicaid will be integral to efforts to cover the uninsured, better control costs, and assure quality care. Medicaid, employer-sponsored insurance, and Medicare are the three linchpins of our health care system. In light of Medicaid's large and unique role and its success in covering people with the greatest needs, most health reform plans contemplate that Medicaid will be a key component of a reformed system. If the goals of health reform are to be met, Medicaid will not only need to be maintained, it must be strengthened and well integrated with the other components of the system. It's time to give Medicaid the attention and support it needs.

Endnotes

[1] L. Arjun, J. Guyer, & M. Heberlein, "Keeping the Promise to Children and Families in Tough Economic Times," Center for Children and Families (November 2008). S. Dorn, *et al.*,"Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses," Kaiser Commission on Medicaid and the Uninsured (April 2008).
[2] Elderly adults are generally eligible for Medicare. Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America, 2007" (October 2008).
[3] Center for Children and Families analysis of D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009).

Acknowledgements

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