



EXPLAINING HEALTH CARE REFORM: What is Medicaid?

Expanding coverage to the uninsured is a key issue in health reform. A number of leading proposals rely on a combination of public and private approaches to achieve broader coverage with shared responsibilities across employees, employers, government, consumers and insurance markets. In health reform, policy makers will debate the right mix of public and private coverage and how to integrate these systems. Medicaid is the nation's primary health coverage program for low-income and high-need populations. Given that two-thirds of the 45 million uninsured have incomes below twice the rate of poverty (\$36,620 for a family of three in 2009) and many have significant health needs, Medicaid is a logical platform to extend coverage to more uninsured.

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

This brief explains the how Medicaid works in today's health care system and answers some of the key questions as policy makers look to use Medicaid as part of broader health reform efforts.

How Medicaid Works Today

Medicaid is the nation's primary health insurance program for low-income and high-need Americans. Medicaid covers 60 million low-income American including nearly 30 million low-income children and 15 million adults and 8 million non-elderly people with disabilities. Given the wide health needs and limited incomes of enrollees, Medicaid provides a broad range of services, with limited cost-sharing. The federal government sets minimum eligibility levels for coverage and then states 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 Medicaid coverage for parents is more limited with 34 states setting levels below 100 percent of the federal poverty level. Under federal law, states generally cannot cover adults without dependent children under Medicaid. Low-income and high-need individuals covered by Medicaid generally do not have access to employer based or other private coverage.

Medicaid provides financing capacity to states to support coverage. Medicaid financing is shared across the 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, like those in Massachusetts, to fund health services for low-income individuals and to expand health coverage more broadly.

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

Medicaid provides assistance to low-income Medicare beneficiaries. Medicaid is an essential adjunct to Medicare for the nearly 9 million low-income elderly and disabled Medicare beneficiaries who depend on Medicaid to help with premiums, gaps in Medicare benefits, and long-term care needs. While these "dual eligibles" represented 15 percent of all Medicaid enrollees, they accounted for 40 percent of all Medicaid expenditures in 2006. Medicaid also provides coverage for low-income people with disabilities in the two-year Medicare waiting period.

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

KEY QUESTIONS

1. Who should be eligible for Medicaid?

To serve more uninsured, coverage needs to be extended to childless adults who are currently categorically excluded from Medicaid and more uniform eligibility for the program needs to be established. To level the playing field across states, national minimum eligibility floors could be set based on income. A critical issue in health reform is what level to set nationwide. To assure that eligible individuals obtain coverage, it will also be necessary to conduct outreach and make enrollment and renewal processes in Medicaid as simple as possible. In addition, requiring more stable coverage (for 12 months) would mirror more closely how coverage works in the private sector, would help to prevent multiple transitions across coverage type in one-year and reduce some administrative burdens associated with frequent renewals.

2. What benefits should Medicaid cover?

Compared to private insurance Medicaid has more comprehensive benefits that have been designed to meet the needs of low-income and high-need populations served by Medicaid. For example, 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 are often not covered by private insurance plans. In addition, Medicaid 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. The uninsured population is similar to the current Medicaid population in that two-thirds are low-income and many have significant health needs so a Medicaid benefits package would be appropriate for the majority of uninsured Americans. Medicaid provides an integrated and comprehensive benefit

package that meets the complex health needs of low-income enrollees; supplementing a more limited private health insurance plan with wrap-around benefits is potentially more costly and administratively challenging.

3. How much should individuals pay for Medicaid?

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. Medicaid provides protections against high out-of-pocket expenses for health care unlike many private plans. 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.

4. Can Medicaid enrollees obtain health care services?

Medicaid's enrollees fare as well as those with private insurance on measures of access, even though they are sicker and more disabled and despite often cited concerns about provider participation. For both children and adults, Medicaid, like private insurance, 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. Despite low payment levels for physicians, Medicaid's extensive use of managed care arrangements has helped to assure access for enrollees.

KEY QUESTIONS (continued)

5. How do Medicaid costs compare to private health insurance?

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. Most Medicaid spending is attributable to the program’s elderly and disabled enrollees, who have extensive needs for both acute and long-term care. Low provider payment in some states and lower administrative costs contribute to Medicaid’s lower overall costs. Given these lower costs, comparable private coverage would be much more costly than Medicaid coverage; even if Medicaid payments were adjusted to Medicare rates.

6. How could Medicaid coverage expansions be financed?

Paying for the additional costs of coverage and dealing with significant variation in potential costs of Medicaid expansions across states might be the biggest challenge in health reform. Given state balanced budget requirements and limited fiscal resources, especially given the devastating current status of state economies, expanding

coverage to additional low-income populations will require greater federal financing responsibility to moderate the impact of federal health reform expansions on states. This could be achieved by the federal government picking up the cost of Medicaid expansions to the low-income uninsured or to help offset state costs reallocating the share of responsibility that Medicaid provides to the federal government to support Medicare (such as having the federal government finance premium and cost sharing payment for low-income Medicare beneficiaries) or increasing the federal share of overall Medicaid spending for program responsibilities (such as acute or long-term care).

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

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.

Conclusion

Medicaid has diverse roles in today’s health care system, and many of these roles will continue beyond health reform. The program already provides a base of affordable and comprehensive coverage that is well-suited for low-income and high-need populations. Medicaid compares favorably to private insurance in terms of access to care and compared to private insurance, Medicaid is a low cost program. Among the financing challenges for health reform will be finding ways to pay for coverage of the low-income population through Medicaid and other subsidies to make health insurance more affordable.

Resources

Kaiser Commission on Medicaid and the Uninsured – Medicaid: A Primer:
<http://www.kff.org/medicaid/7334.cfm>

Kaiser Commission on Medicaid and the Uninsured - Medicaid as a Platform for Broader Health Reform:
Supporting High-Need and Low-Income Populations: <http://www.kff.org/medicaid/7898.cfm>

Kaiser Commission on Medicaid and the Uninsured - Low-Income Adults Under Age 65 – Many are Poor, Sick,
and Uninsured: <http://www.kff.org/healthreform/7914.cfm>

Kaiser Commission on Medicaid and the Uninsured – Expanding Health Coverage for Low-Income Adults:
Filling the Gaps in Medicaid Eligibility: <http://www.kff.org/medicaid/7900.cfm>

Kaiser State Health Facts: <http://www.statehealthfacts.org/>

Rowland, D. – Testimony before the Senate Finance Committee: Medicaid and Health Reform:
<http://www.kff.org/healthreform/hr050509tst.cfm>

Rowland, D. – Testimony before the House Energy and Commerce Subcommittee on Health: Medicaid and
Access to Care: <http://www.kff.org/healthreform/7880.cfm>

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