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# IMPROVING MEDICAID AS PART OF BUILDING ON THE CURRENT SYSTEM TO ACHIEVE UNIVERSAL COVERAGE

by January Angeles

The U.S. health care system suffers from a number of problems. Almost 46 million individuals were uninsured in 2007, an increase of 6 million people since 2001. Employer-based coverage, the primary source of health insurance across the nation, continues to erode. Costs continue to rise and bear primary responsibility for the nation's bleak long-term fiscal outlook. While the United States spends more on health care than any other country, it falls short of other industrialized nations on key dimensions of care such as quality, access, and efficiency.[1]

Against this backdrop, there is broad agreement that comprehensive health care reform is essential and that ensuring access to affordable health insurance for all Americans, while containing costs and improving quality, is a top priority. But there is less agreement about the appropriate path to universal coverage. Some have suggested replacing the current mix of employer-sponsored insurance and public programs with a universal public health insurance system (a "single-payer" system). Others would rely heavily on the non-group private insurance market.[2]

Alternatively, several leading proposals favor building on the strengths of the current system — preserving what works and improving the current framework of employer-sponsored insurance and public programs in an attempt to achieve a seamless, integrated health care system. Senator Max Baucus, Chairman of the Senate Finance Committee, has proposed extending Medicaid to cover

## KEY FINDINGS

- As the source of comprehensive, affordable coverage for more than 50 million low-income Americans, Medicaid can be a building block of a health care reform initiative that achieves universal coverage by strengthening both the private and public health insurance systems and better coordinating them.
- Policymakers can help Medicaid fill this role effectively by making several improvements in the program:
  - ✓ facilitating enrollment by modernizing eligibility rules and procedures;
  - ✓ improving access to care by increasing payments to health care providers;
  - ✓ putting the program on a more stable financial footing; and
  - ✓ integrating Medicaid into broader efforts to improve the quality and cost-effectiveness of health care.

[1] Karen Davis, "Closing the Quality Chasm: Opportunities and Strategies for Moving Toward a High Performing Health System," testimony before the Senate Committee on Health, Education, Labor and Pensions, January 29, 2009.

[2] For example, some have proposed eliminating the tax exclusion for employee health care benefits and replacing it with tax credits for individuals to secure private health coverage on their own in the individual health insurance market. See Nina Owcharenko, "Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage," *Backgrounder #1895*, The Heritage Foundation, November 8, 2005.

everyone below a certain income level, noting that those with low incomes are least likely to be able to afford and purchase coverage on their own. President Obama's health care reform proposal during the presidential campaign would expand eligibility for Medicaid and the Children's Health Insurance Program (CHIP). Similarly, researchers from the Commonwealth Fund argue that Medicaid should be one of the "building blocks" in developing a system that provides seamless coverage to all Americans.[3]

Currently, Medicaid covers many low-income individuals but leaves many others out. It does not cover childless adults unless they are pregnant, over the age of 65, or have serious disabilities.[4] While it covers all children up to age six with family incomes below 133 percent of the poverty line, and all poor children aged six to 19, the income eligibility standards for *parents* are much lower, leaving many families with only partial coverage.[5]

In a reformed system that builds on employer-sponsored and public programs to achieve universal coverage, Medicaid should be expanded so that any American below a certain income level can qualify for benefits regardless of age or disability status. Since Medicaid provides more comprehensive and affordable coverage than other insurance options, it is an attractive vehicle for extending coverage to low-income Americans who cannot afford to pay premiums, cost-sharing, or deductibles. For Medicaid to serve as a base for expanding coverage, however, it needs to be strengthened and integrated into a broader system of coverage.

## Expanding Medicaid an Effective Way to Cover Low-Income, Uninsured Americans

Medicaid's proven success at providing comprehensive, affordable coverage to tens of millions of low-income children, parents, seniors, and people with disabilities makes it an excellent option for expanding coverage to a broader group of low-income, uninsured Americans. A substantial portion of uninsured people have characteristics that are similar to current Medicaid beneficiaries: two-thirds of them are poor or near-poor, 10 percent are in fair or poor health, and almost half suffer from a chronic condition.[6] Medicaid's benefit package and cost-sharing structure are well-matched to this population's needs.

### Medicaid's Benefits Are Suited to the Needs of Low-Income Populations

Medicaid provides an array of services and supports that private health insurance generally does not. Because many Medicaid beneficiaries have disabilities or chronic health conditions, these services are critical to maintaining and improving their health. For example, Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit guarantees low-income children coverage for any service needed to treat any diagnosed health condition they have, even if it is not otherwise covered by a state's Medicaid program. These include, among other things, physical and speech therapies, hearing services, and vision exams and eyeglasses. The EPSDT benefit is more comprehensive than the comparable children's benefit under most

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[3] Senator Max Baucus has proposed broadening Medicaid so it covers everyone living below the poverty line. Researchers from The Commonwealth Fund propose using a threshold of 150 percent of poverty. See Max Baucus, "Call to Action: Health Reform 2009," November 2008, available at http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf. See also and Cathy Schoen, Karen Davis and Sara Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, Vol 27, No 3, May/June 2008.

[4] Some states have expanded Medicaid to cover low-income childless adults through Section 1115 waivers.

[5] Donna Cohen Ross and Caryn Marks, "Challenges of Providing Health Coverage for Parents and Children in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009," Kaiser Commission on Medicaid and the Uninsured, January 2009.

[6] Henry J. Kaiser Family Foundation, "The Uninsured: A Primer, Key Facts About Americans Without Health Insurance," October 2008.

private insurance plans.[7] This is especially important, since poor families whose children are covered through Medicaid generally would not be able to afford to purchase health care services that their children needed but their insurance did not cover.

Medicaid also provides a number of health services not offered by private insurance that are tailored to meet the particular needs of low-income people who have serious disabilities, chronic illnesses, or other complex health conditions. For beneficiaries with serious disabilities, for example, Medicaid covers services and supports to facilitate independent living and to help them function at the highest level possible. In contrast, private insurance tends either to cover services such as physical therapy only to the extent that they meet a narrow definition of medical necessity — when a condition can actually be ameliorated and normal functioning restored — or not to cover such services at all.[8]

The Kaiser Commission on Medicaid and the Uninsured has noted, "Medicaid plays a critical role in providing health care services to people with disabilities — both filling in the gaps in Medicare and in private health insurance and . . . offer[ing] the broad array of services needed by people with severe disabling conditions."[9]

## Medicaid Improves Beneficiaries' Health

Almost all children in Medicaid and CHIP have a usual source of care, i.e., a regular place where they receive preventive care or treatment when they are sick. Having a usual source of care generally increases the quality of care a person receives. Children served by Medicaid and CHIP are much more likely than uninsured children to obtain important preventive services, for example, and they have checkups at rates similar to privately insured children.[10]

Better health care, in turn, contributes to better health. Studies have shown that low-income children's health status improved after one year of enrollment in Medicaid or CHIP. In California, children in poor health showed improvements both in their health and in their ability to function socially after two years of coverage through CHIP.[11] Children with chronic illnesses showed similar kinds of improvements after enrolling in CHIP.[12]

## Medicaid Is Affordable for Beneficiaries

Medicaid's premiums and cost-sharing are well below those that private insurance plans charge. Medicaid generally does not charge premiums and requires only small co-payments of approximately $3 per service.[13]

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[7] "Comparing EPSDT and Commercial Insurance Benefits," The Commonwealth Fund, September 2005.

[8] See, for example, "Comparing EPSDT and Commercial Insurance Benefits," The Commonwealth Fund and George Washington University, September 2005.

[9] Diane Rowland, "Medicaid's Role for People with Disabilities," testimony before the House Energy and Commerce Committee, Kaiser Commission on Medicaid and the Uninsured, January 16, 2008.

[10] Leighton Ku, Mark Lin and Matthew Broaddus, "Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP," Center on Budget and Policy Priorities, January 2007.

[11] "The Healthy Families Program: Health Status Assessment (PedsQL) Final Report," California Managed Risk Medical Insurance Board, 2004.

[12] Amy Davidoff et al, "Effects of the State Children's Health Insurance Program Expansions on Children With Chronic Health Conditions," *Pediatrics*, 2005.

[13] The Deficit Reduction Act of 2005 gave states greater flexibility to charge certain Medicaid populations higher premiums and cost-sharing, as long as aggregate premiums and cost-sharing do not exceed 5 percent of a family's income.

In contrast, many private plans charge co-payments of $15 to $25 per office visit to primary care physicians, and $20 to $30 for specialty care physicians within the plan network.[14]

For low-income populations, this protection against high out-of-pocket costs is essential. Research shows that even modest premiums can make it difficult for low-income people to enroll in Medicaid and keep their coverage. Higher co-payments also tend to cause low-income individuals to use less primary and preventive care.[15] Low-income people may not seek care they need if they are charged the high co-payments that are typical in most private plans. This could lead to complications that eventually require more expensive forms of care, such as emergency room treatment or hospitalization.

## A Stronger Medicaid Could Play an Essential Role in a Reformed Health System

For Medicaid to serve effectively as the foundation for expanding coverage to low-income Americans, however, it needs to be strengthened as part of a comprehensive reform that builds on the current system of private insurance and public programs. Four particularly important steps are outlined below.

### 1. Modernizing Eligibility Rules and Processes

An estimated one-quarter of all uninsured individuals, and about three-quarters of uninsured children, are eligible for public programs like Medicaid and CHIP but remain unenrolled.[16] Many low-income parents are unaware that they qualify for these programs due to complicated eligibility rules. (Some working-poor parents mistakenly assume that these programs are not for working families and that their earnings are too high to qualify for benefits, for example.) In addition, administrative barriers such as burdensome documentation and face-to-face interview requirements have sometimes prevented eligible families from completing the eligibility process.[17]

Moreover, Medicaid and CHIP beneficiaries often have difficulty retaining coverage. Many of the beneficiaries who are "disenrolled" during the renewal period lose coverage because of procedural problems, such as failing to renew their eligibility within a certain timeframe or not having complete documentation. Only a small portion of disenrollments are actually the result of changes in eligibility. As a result, many families end up losing coverage at renewal, subsequently reapplying for benefits, and getting re-enrolled a few months later.[18] This "churning" unnecessarily increases administrative costs, leads to disruptions in coverage, and adds to the ranks of the uninsured.

Making Medicaid available to everyone below a certain income threshold would go a long way toward simplifying and increasing the effectiveness of outreach and enrollment efforts. It would eliminate much of the uncertainty about who is eligible and would allow all members of a family to be covered under the same

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[14] "Employer Health Benefits: 2008 Annual Survey," Kaiser Family Foundation and Health Research Educational Trust, September 2008.

[15] The research on cost-sharing and premiums is summarized by Julie Hudman and Molly O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and The Uninsured, March 2003.

[16] Kaiser Commission on Medicaid and the Uninsured, "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?" February 2007.

[17] Michael Perry and Julia Paradise, "Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents," Kaiser Commission on Medicaid and the Uninsured, May 2007.

[18] Victoria Wachino and Alice Weiss, "Maximizing Kids Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling, and Retaining Eligible Children," the Robert Wood Johnson Foundation and National Academy for State Health Policy, February 2009.

program, a particularly important reform. Research has shown that expanding Medicaid and CHIP to cover low-income parents raises participation rates among eligible children significantly and improves continuity of coverage. Family coverage also increases the likelihood that enrolled children actually receive health care services they need.[19]

More uniform eligibility standards should be accompanied by measures to simplify enrollment and renewal processes. Since CHIP was established in 1997, states have made significant strides in enrolling eligible children in both CHIP and Medicaid; most states have eliminated the asset test and done away with face-to-face interviews, for example. Many states, however, have not applied these same simplification measures to *parents* who apply for Medicaid. Aligning the rules and procedures for children and parents would represent a significant first step in reducing barriers to enrollment.

More progress also is needed in other areas. For example, fewer than half of the states provide 12 months of "continuous eligibility" for children, which allows them to retain coverage for a full year regardless of changes in family income or circumstances during that period.[20] Continuous eligibility prevents disruptions in care and the negative health consequences these disruptions can cause. In addition, by modernizing state Medicaid eligibility systems (such as by using data from other public programs to verify family income and other information), states could make it easier for families to obtain coverage.[21] Measures like these would improve efficiency and decrease administrative costs.

Finally, since Medicaid would only be one component of a broader system of universal coverage, it is important to coordinate the eligibility rules for Medicaid and other subsidy programs so that people can easily move from one program to another if their circumstances change. One strategy for doing so involves using the same rules across all of the programs for counting income and verifying eligibility.

## 2. Increasing Provider Payments

Medicaid beneficiaries are more likely than other individuals to need services because of difficult health and social problems, but the program generally pays health care providers at much lower rates than private insurance or Medicare.[22] In addition, Medicaid provider payments are often the first to be cut when states reduce spending due to an economic downturn.[23]

In a reformed system where Medicaid serves as a foundation for universal coverage, it is essential that payment rates be brought up to levels sufficient to encourage more providers to participate in the program.[24] This is critical to ensuring access to necessary services, since in a system of universal coverage, Medicaid will cover more people than it does now. The Children's Health Insurance Program Reauthorization Act of 2009 established the Medicaid and CHIP Payment Access Commission (MACPAC) to review policies affecting

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[19] Leighton Ku and Matthew Broaddus, "Coverage of Parents Helps Children Too," Center on Budget and Policy Priorities, October 2006.

[20] Donna Cohen Ross and Caryn Marks, *op cit.*

[21] The new Express Lane Eligibility option under CHIP, enacted as part of CHIP legislation that became law on February 4, will allow states to rely on information previously collected by public agencies that determine eligibility for other public programs, such as the school lunch program, in order to facilitate enrollment in Medicaid and CHIP.

[22] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman, December 2008.

[23] Vern Smith *et al.*, "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004: Results from a Fifty-State Survey," Kaiser Commission on Medicaid and the Uninsured, September 2003.

[24] Studies have shown greater Medicaid participation among physicians in states where fee levels are higher. See Stephen Zuckerman *et al.*, "Changes in Medicaid Physician Fees, 1998-2003," *Health Affairs* (Web Exclusive), June 23, 2004.

children's access to services and other issues affecting Medicaid and CHIP. MACPAC can be set up to operate like the Medicare Payment Advisory Commission, an independent entity that advises Congress on payment and related Medicare issues, and to make recommendations on provider payment rates in Medicaid.

### 3. Strengthening Medicaid Financing

Medicaid needs a reliable and adequate source of funds if it is to serve as a base for a reformed health care system. The financing mechanism must allow Medicaid to adapt to changing needs and economic circumstances without putting beneficiaries or services at risk.

In a reformed health care system, Medicaid would play a larger role in covering the uninsured. New federal resources would be needed to ensure that states have the capacity to cover those who enter the program as a result of eligibility expansions and improved enrollment and renewal procedures. States would also need financial assistance to raise payment rates for providers.

There are a number of ways to provide additional federal support. One option is to increase the Medicaid federal matching rate for all states to help offset costs stemming from increased enrollment. Another is to shift more of Medicaid's financial responsibilities for "dual eligibles" — individuals who are eligible for both Medicaid and Medicare — to the federal government.[25]

In addition, to ensure that Medicaid is stable and secure during bad economic times as well as good ones, federal support should increase automatically during recessions. In a recession, Medicaid enrollment increases as people lose their jobs and job-based health coverage; at the same time, rising unemployment shrinks state tax revenues, limiting the state's ability to finance the program just when it is most needed.[26] These pressures place Medicaid at risk for significant cuts, particularly because states are required to balance their budgets each year, even in recessions.

The recent economic stimulus package temporarily increases the percentage of state Medicaid costs that the federal government pays, in order to help states maintain their Medicaid programs during the current downturn. Such adjustments should be made automatic in recessions, through the creation of a trigger that increases federal matching rates during economic downturns, based on changes in a combination of economic indicators at both the national and state levels.

### 4. Integrating Medicaid into Broader Efforts to Improve the Quality and Efficiency of Care

Health reform needs not only to expand coverage; it also must address the quality and costs of health care. It is evident that the current health care delivery system contains inefficiencies and excesses and does not always lead to appropriate care. Moreover, without fundamental changes in the way care is provided, health care costs will rise to unsustainable levels.

Medicaid has strong incentives to "bend the trend" in health care spending by improving the quality and efficiency of care. Fewer than one-quarter of all Medicaid beneficiaries account for *70 percent* of program spending; these beneficiaries, many of whom have chronic conditions and disabilities and require social supports to help them deal with their health or other issues, are also the patients who would benefit most

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[25] See, for example, John Holahan and Alan Weil, "Toward Real Medicaid Reform," *Health Affairs* (Web Exclusive), February 23, 2007.

[26] A one percentage point increase in the national unemployment rate results in 1 million new Medicaid enrollees and a 3 to 4 percent decline in state revenues. See "Impact of Unemployment Growth on Medicaid and SCHIP and the Number Uninsured," Henry J. Kaiser Family Foundation, April 2008.

from care and disease management programs and other efforts to improve service delivery.[27] Focusing on improving care for this segment of the Medicaid population may allow states and the federal government ultimately to contain costs.

Medicaid should be an integral part of broader efforts to improve the quality and efficiency of health care, such as initiatives that promote access to appropriate care, advance the use of information technology, and emphasize prevention and disease management. Many states are already engaged in these activities; Medicaid can be a leader in these efforts. For example, North Carolina's Medicaid program is a pioneer in implementing the "medical home" concept: Medicaid patients in the state have a usual source of care, and primary care physicians manage patient care on an ongoing basis. As a result, the state has demonstrated savings by preventing hospitalizations and reducing unnecessary care.[28]

## Conclusion

Medicaid plays a critical role in providing needed and affordable health care to tens of millions of low-income Americans, particularly those with disabilities and special health care needs. It is difficult to imagine how a reformed system would function without it.

If Medicaid is to serve as a foundation for a reformed health care system that builds on the existing base of employer-sponsored insurance and public programs, it will need to be strengthened so it can work effectively in concert with other parts of the reformed system to ensure seamless coverage. By streamlining Medicaid enrollment, enhancing beneficiaries' access to providers, putting the program on a sounder financial footing, and improving the quality and efficiency of health care services, policymakers can help Medicaid fulfill this essential task.

[27] "Medicaid Enrollees and Expenditures by Enrollment Group, 2005," Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, May 19, 2008.

[28] Thomas Ricketts *et al.*, "Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000 – December 2002," The Cecil G. Sheps Center for Health Services Research, April 15, 2004.