The Role of Medicaid & CHIP in Health Reform

Answering the Affordability Question

A Utah Health Policy Position Paper

May 27, 2009

Summary

Medicaid and the Children's Health Insurance Program (CHIP) have been central players in the health reform discussion taking place in Congress this year. Deliberations have been heavily focused on understanding and improving these programs, and this is for three reasons:

1. Medicaid and CHIP provide health coverage to nearly one-sixth of the nation's non-elderly (under 65) population; quite simply, these programs are too large to ignore if we are going to reform our health care system.

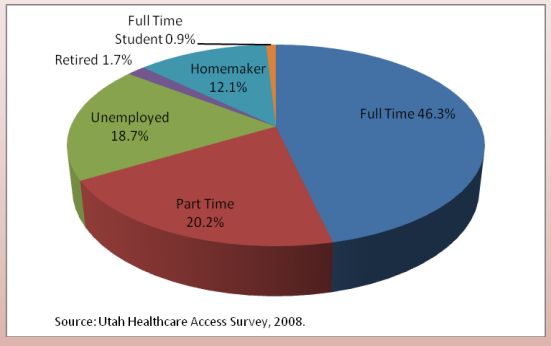
2. Private health insurance is increasingly expensive! Even in a reformed health care system it is unlikely that many low-income uninsured families will be able to afford private health coverage and all of the associated cost sharing obligations.

3. Given Medicaid and CHIP's historical role in providing health coverage to populations least able to afford health coverage or care on their own, these programs are a natural starting place to address problems with affordability in a reformed health care system.

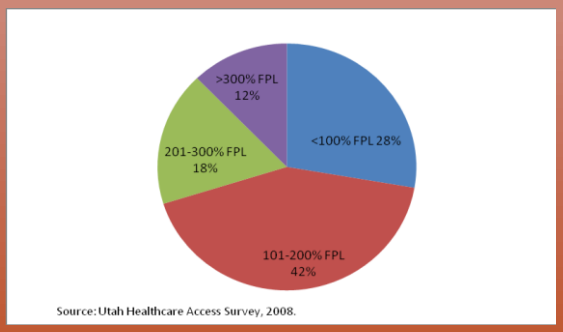
Who Are Utah's Uninsured?

Utah's uninsured are generally low-income working adults. Unfortunately, they cannot afford the premiums and cost-sharing associated with private health care coverage.

Most Uninsured Adults are Working



70% of Utah's Uninsured are in Families Earning Less than 200% FPL



Millions of Americans already rely on Medicaid and CHIP for their health coverage

With nearly 60 million enrollees, 190,000 in Utah alone, Medicaid is the largest single health plan in the country, providing health care coverage to 14% of the non-elderly population.[i] Nearly half of these enrollees are children. When combined with CHIP, which provides coverage to an additional 7 million children, 25% of the nation's children receive coverage through either public program.[ii] Because of this size, Medicaid and CHIP must receive as much attention as employer sponsored insurance, individual market insurance, and Medicare in the reform discussion. The same cost-containment measures and quality improvements under consideration in the broader health system (electronic medical records, provider payments around episodes of care, incentives for primary care, wellness care, and medical homes) must also be applied to Medicaid and CHIP. If not, reforms will not be sustainable.

Private health care coverage is out of reach for most low-income people

66% of the nation's uninsured are in families earning less than 200% FPL.[iii] Utah's uninsured are even more likely to come from low-income families, with 71% of Utah's uninsured living below 200% FPL.[iv] It is therefore unlikely that these low-income uninsured individuals will be able to afford coverage in the private market. Nationwide, just 39.8% of workers with family income below 100% FPL were eligible for employer-sponsored health insurance, and 60.3% of workers with family income between 100 and 200% FPL were eligible.[v] An offer of coverage at the workplace is thus not enough—especially if the employee cannot afford his or her share of the premium. In the U.S. the average employee's share of employer-sponsored group premiums was $3,354 in 2008. Tragically, the cost sharing obligations imposed on workers earning less than 200% FPL are even more onerous.[vi]

But the premium obligations tell only one part of the story. Low-income families who *do* have employer sponsored insurance often are unable to afford the cost sharing associated with that coverage. Uninsured low-income adults can have significant health care needs. For example, 36% of low-income adults have a chronic physical and mental health need.[vii] Because of this, many low-income families with private coverage often face unaffordable cost sharing. In the Western states region, families with incomes below 100% FPL with private insurance spent almost twice their income (190%), on premiums, deductibles, copayments, and other health-related expenses.[viii]

Medicaid & CHIP are key to solving the affordability equation for low-income families

Thanks to their built-in protections around cost sharing, Medicaid and CHIP provide a natural starting point for addressing the affordability challenges for low-income families. Both programs have been designed to meet the health needs of low-income, high-need populations, populations for whom private coverage is often not available, not affordable, or inadequate. However, it is important to note that Medicaid is *not* available to all low-income individuals. In Utah and most other states, for example, adults without children, regardless of income level, are not eligible for Medicaid. Further, minimum income guidelines vary depending on the population. For example, in Utah only parents

For more information please contact Lincoln Nehring, JD: lincoln@healthpolicyproject.org (801) 638-7695

earning less than 50% of the federal poverty level (FPL) are eligible for Medicaid, but pregnant women earning up to 133% of poverty can enroll.

A principal goal of the national reform process is to extend access to affordable health care and coverage to all citizens. To this end, Medicaid must be restructured to serve *all* low-income individuals who do not have a reasonable offer of coverage in the workplace. With these goals in mind, the first step is to bring Medicaid eligibility levels up to a uniform level for all adults. To help offset the considerable expense to the Federal government and states, robust measures must be taken to contain costs and improve the quality of care through payment reforms and better alignment of treatment and financing decisions with evidence-based medicine. The crisis of access to primary care, wellness care, and care coordination should also be addressed by requiring all Medicaid beneficiaries to have a medical home; Medicaid mandatory and optional benefit packages must be re-evaluated to ensure that beneficiaries are able to receive the most appropriate and cost effective care for their needs; and, finally, provider reimbursement payments must be closely examined to make sure providers can participate in the program and so that costs that are not shifted to other payers.

In Summary: What changes should be made to Medicaid as part of health reform?

Eligibility Changes

1. Medicaid eligibility categories should be eliminated, and eligibility should be based solely on income. Categorical Medicaid is administratively burdensome to administer and does not recognize how, at certain income levels, like 100% of poverty level, health coverage is unaffordable regardless of whether you are a child, parent, person with disability, senior, or a childless adult.

2. Medicaid and CHIP should serve all families without a reasonable offer of health care coverage. In regions like Utah, Medicaid coverage should be expanded to at least 100% FPL. Regions with higher cost of living should have higher income thresholds.

3. Remove harmful barriers to enrollment like the Medicaid asset test. Low-income families do not have assets to speak of, thus the test serves only as a barrier to eligibility and cost-effective care.

Quality Improvements

1. Require a benefit package that emphasizes care coordination, primary care and wellness care through a medical home.

2. Scrap the current mandatory and optional benefit distinction and create a basic benefit package that is responsive to individual differences in the need for specialty care and other medically necessary services. A well designed medical home program could help to orchestrate a more nimble and strategic approach to meeting the needs of patients.

Medicaid Financing

1. To ensure stability and fiscal integrity of Medicaid programs, apply an automatic *countercyclical stabilizer* to the Federal Medical Assistance Percentage (FMAP) increases for states. For example, when the state or regional economy slows down, the FMAP would automatically increase.

2. Expanding Medicaid is an expensive proposition. Most states, including Utah, are not financially in a position to pay for *any* Medicaid expansion under the existing state-federal match formula. The federal government must therefore provide sufficient resources to states to extend coverage to these new populations.

Conclusion

The majority of Utah's uninsured come from families earning less than 200% FPL. These same families are also least likely to receive an offer of employer sponsored health insurance or be able to afford the cost-sharing associated with such insurance. Because of Medicaid and CHIP's historical role in providing health coverage to low-income families in need, as a first step in health system reform, these programs should be expanded to provide coverage to everyone living under poverty. However, reform must not stop with just expanding these programs. In order to contain costs, the quality of coverage Medicaid and CHIP provide must also be improved.

ENDNOTES

[i] The Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer, Key Facts About Americans Without Health Insurance," (October 2008)
[ii] Families USA, "Estimated Number of Children Enrolled in Medicaid and the State Children's Health Insurance Program (CHIP)," July 2008.
[iii] The Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer, Key Facts About Americans Without Health Insurance," (October 2008)
[iv] Utah Department of Health, "2008 Utah Health Status Survey," (2008).
[v] Clemans-Cope, Lisa and Matthew Pantell, Cynthia D. Perry, "Access to Employer-Sponsored Health Insurance among Low-Income Families: Who Has Access and Who Doesn't," *The Urban Institute* (2007).
[vi] *Id.*
[vii] Kaiser Commission on Medicaid and the Uninsured, "Expanding Health Coverage for Low-Income Adults: Filing the Gaps in Medicaid Eligibility," (May 2009)
[viii] Agency for Healthcare Research and Quality. 2006 Medical Expenditure Panel Survey – Household Component.

For more information please contact Lincoln Nehring, JD: lincoln@healthpolicyproject.org (801) 638-7695