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Medicaid at 50:

The Program's Evolution and Future

Cindy Mann, Partner
Deborah Bachrach, Partner
Elizabeth Osius, Manager

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Introduction

Born as an afterthought to Medicare five decades ago, Medicaid has evolved from an adjunct to state welfare programs to the nation's largest health insurer. The occasion of Medicaid's 50th birthday is a fitting time to consider that evolution, not to reminisce, but to help chart the path forward. Medicaid is a complex program with a complex history, and understanding its role in the U.S. health system is essential to ensuring that it is performing at optimal levels for its beneficiaries, as well as for states, taxpayers, and the myriad healthcare providers, health plans, and others touched by the program. In a four-part series supported by The Commonwealth Fund, Cindy Mann, Deborah Bachrach and Elizabeth Osius of Manatt Health Solutions examine Medicaid's evolution and consider its role in the new coverage paradigm established by the Affordable Care Act (ACA). To access The Commonwealth Fund Blog, click here.

Medicaid as Health Insurer: Evolution and Implications

On January 1, 2014, a new healthcare coverage paradigm took hold in the nation. A transformed Medicaid program became, along with the insurance marketplaces and the Children's Health Insurance Program, one of three programs offering a continuum of subsidized coverage for people who lack affordable insurance through the workplace.

The Affordable Care Act (ACA) solidified Medicaid's health insurance credentials, moving it farther along a path it had been traveling for three decades—from its origins in the welfare system to the nation's largest health insurer. And yet, efforts to bring Medicaid back to its welfare roots continues to haunt the program—as evidenced by recent proposals by some states to impose work requirements and eligibility time limits and to resist expanding eligibility to cover so-called "able-bodied" adults. Medicaid is a complex program that has looked different at different times in its history; appreciation of its role today has implications for Medicaid and the entire healthcare system.

Medicaid started out in 1965 primarily covering people receiving welfare. It didn't have its own eligibility rules or application process. If you qualified for cash assistance, you received a Medicaid card. Its reach was limited; the nation's welfare system—and therefore Medicaid—confined its support to the so-called deserving poor: children and their parents and the elderly, blind, and disabled. And in keeping with operative welfare principles and budget considerations, enrollment was not encouraged. Most low-income families remained uninsured.

In the late 1980s, concerns about infant mortality and children's health prompted Congress to extend Medicaid coverage to children and pregnant women whose earnings put them above welfare eligibility levels. This striking expansion of coverage reflected an equally striking though less noted break in the relationship between Medicaid and welfare. Medicaid had begun its steady march to becoming a health insurance program for low-income individuals.

The year 1996 was the year of welfare reform. The Aid to Families with Dependent Children program was replaced by the Temporary Assistance for Needy Families block grant to states, with the goal of reducing reliance on welfare by ending the entitlement to cash aid and imposing work requirements and time limits.

But health coverage was seen as different—something that ought to be available to people even if they were no longer (or never were) cash assistance recipients. And so the same law that revamped welfare further severed the ties between it and Medicaid by ensuring that very-low-income parents could enroll in Medicaid regardless of their eligibility for cash assistance.

The enactment of the Children's Health Insurance Program, or CHIP, in 1997 prompted the next round of changes. CHIP triggered further expansions in eligibility for children in Medicaid and CHIP, and brought about a wholesale overhaul of the way children

Medicaid's Transformation into a Health Insurance Program

1965

Medicaid established to primarily cover very low-income **People Receiving Welfare**

The new program lacks its own eligibility rules and application process.

Late 1980s

Congress extends coverage to **Children and Pregnant Women** whose earnings put them above welfare eligibility levels.

1996

Welfare reform enables very-low-income **Parents** to enroll in Medicaid regardless of eligibility for welfare.

1997

Enactment of the Children's Health Insurance Program, or CHIP, triggers **Further Expansions In Eligibility** for public coverage. The application process for children is simplified.

Today

In **2010**, the Affordable Care Act, or ACA, completes Medicaid's transformation by making Medicaid coverage available to

All Adults in All States, Based on Income.

Expansion becomes optional for states, however, following a 2012 Supreme Court ruling.

The ACA also creates a streamlined application process that aligns with the new health insurance marketplaces; there is one application, one set of rules and a simplified process for people enrolling in Medicaid, CHIP or marketplace plans.

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enrolled in coverage. The Medicaid application process for children was simplified: families didn't have to come into the welfare office to apply, asset tests were dropped, and unnecessary verification burdens were lifted. The explicit goal of promoting coverage was a marked departure from the objectives that had characterized the administration of welfare and, derivatively, Medicaid. These efforts have had a lasting impact for kids and provided a blueprint for the ACA. Driven largely by public program coverage, uninsured rates for children dropped from a high of 15 percent in 1994 to 7 percent in 2013.

The ACA completed Medicaid's evolution from an adjunct to welfare programs to an insurance program for low-income Americans, at least on paper. It eliminated the carryover from welfare of covering only certain groups of low-income adults. For the first time, Medicaid coverage was to be available to all adults in all states based on their income, whether or not they had children. Expansion, however, became optional after the 2012 Supreme Court ruling and 20 states have yet to expand the program.

But perhaps just as significant, the ACA established new Medicaid eligibility rules and processes aligned not with welfare but with the marketplace. It called for one application, one set of eligibility rules, and one simplified process for enrolling in the appropriate health coverage program. Though these changes are not yet fully mature, one year after implementation, the national uninsured rate has dropped to a record low, with rates falling most sharply in states taking up the Medicaid expansion.

So far, 30 states and D.C. have chosen to expand Medicaid eligibility. A handful of these states have done so by adopting alternative expansion policies requiring federal waivers. Some of the states now considering expansion and some that have already expanded are proposing welfare-style work or eligibility time limits.

Medicaid's transformation is an important lens through which to consider current as well as the next generation of policies. For example, will the state expansion proposals requiring work or time limits strengthen Medicaid's ability to function as a cost-effective, high-quality insurer aligned with other parts of the healthcare system, or do they harken back to a different era and a different program? Important work remains to be done to track these and other policies, and a clear-eyed vision of Medicaid's role is essential to accomplish the work ahead.

New Eligibility and Enrollment Rules and Practices for a Revamped Program

Medicaid's evolution from a small program linked to welfare to a major health insurer occurred over many years, but sweeping changes were needed for the new coverage paradigm established by the Affordable Care Act (ACA) to take hold.

Eligibility for Medicaid had long ago been "delinked" from welfare, but until the ACA, Medicaid eligibility was still constrained by the old welfare-based eligibility "categories," such as children, parents caring for children, and pregnant women. With the goal of near-universal coverage, the ACA ended these eligibility silos, extending Medicaid to all low-income adults and making tax credits available through the new insurance marketplaces to those with incomes above Medicaid levels and below 400 percent of the federal poverty level ($47,080 for an individual). To accomplish the level of coordination with the marketplace envisioned by the ACA, the law also revamped Medicaid's eligibility and enrollment process. These changes positioned Medicaid as the foundation of a coordinated set of health insurance programs that make affordable coverage available to nearly all Americans.

While the decision to expand Medicaid to all low-income adults now resides with the states, the changes in how people apply and how eligibility is determined is the law of the land in all states, regardless of whether a state has taken up the Medicaid expansion. To appreciate the extent of the change that has occurred, it's helpful to compare the old and the new eligibility and enrollment processes.

Even after Medicaid eligibility had been delinked from welfare, but before the ACA, the Medicaid application process for adults looked a lot like the welfare application process. That process was designed for a different purpose and a different population, and not necessarily to encourage enrollment. For example, in 1997, 29 states required a face-to-face interview as a condition of Medicaid eligibility, a carryover from the welfare process. This required health insurance applicants to take a day off of work and spend an afternoon in the local welfare office to obtain coverage. While applying, and at least once a year and usually more often, consumers were required to demonstrate their eligibility for Medicaid by producing reams of documents proving their income, assets (or lack thereof), residence, date of birth, and other eligibility factors. These requirements resulted in depressed coverage rates and high rates of churning on and off insurance. But practices that effectively kept eligible people out of coverage had no place in the system envisioned by the ACA, where coverage is both a key goal and the starting point for the delivery of cost-effective, quality care.

To effectuate the new coverage continuum, the ACA requires a single application and uniform income-counting rules (based on modified gross income as defined by the tax code) for all of the insurance affordability programs (Medicaid, the Children's Health Insurance

Program, and the marketplaces). There are no interview requirements for any of the programs, and to the maximum extent possible, information provided through the application is verified through the use of electronic data sources, so that consumers need not compile and submit paper documents to prove information readily available in electronic databases. The law similarly streamlined and coordinated the renewal process. So today there is one application, one eligibility determination process, and then enrollment in the appropriate program. For Medicaid, these changes are nothing short of transformative.

Effective implementation of these new rules was a massive undertaking requiring a modern IT infrastructure. When the ACA passed, most state Medicaid agencies were relying on antiquated information systems—some using computer language dating back to the 1950s—that had proven an enduring barrier to developing a consumer-friendly enrollment system. Moreover, the system was often shared with and owned by the welfare agency, which meant the Medicaid agency often had to wait for essential eligibility and enrollment modifications.

Recognizing that Medicaid's systems had to be modernized, the Centers for Medicare and Medicaid Services provided states 90 cents on the dollar for the development of new systems. Funding was conditioned on full integration or a seamless interface with the marketplace and the ability to connect with the newly established federal data services hub, enabling states to electronically verify key elements of eligibility.

In the five years since the ACA became law, states and the federal government have been working on these systems. IT-related problems have impeded progress for some, but even with those challenges, today, in every state, the new taxed-based rules are being used to determine eligibility and people can apply using a single online application that allows them to enroll in the insurance affordability program for which they are eligible. Data-driven verification is also in place in all states, although modernization of the renewal process has lagged in some states.

The federally run marketplace and a growing number of state marketplaces also are making the application process highly efficient by using dynamic, online applications that narrow the questions asked based on previous answers and by verifying information against electronic sources all during one application sitting. Some states report that the majority of new applications or renewals can be processed through the online, data-driven system without any delay caused by paperwork requirements. To date, the connection between the federally run marketplace and state Medicaid agencies has not achieved the same level of integration as the state-based marketplaces. However, the ACA's goal of a coordinated eligibility and enrollment process has been realized to a large extent. Enrollment data confirm that the new eligibility and enrollment systems are—again, to varying degrees—helping to drive uninsurance down to record lows.

While federal rules permit and encourage flexibility and state innovation, the critical advance has been to set a floor that ensures that all states move forward with improvements to enrollment in coordination with the marketplace. Achieving the level of simplification and coordination envisioned by the ACA cannot be taken for granted, however, and the new federal IT funding rules require ongoing testing and accountability so that systems continue to improve and don't slide back to the condition they were pre-ACA. Taken together, the single application, the simplified, uniform rules for determining eligibility, and the modernized electronic eligibility and enrollment and renewal systems provide the backbone of a transformed Medicaid program and the foundation of the new coverage paradigm.

Balancing State and Federal Responsibilities

As we consider what it means for Medicaid to have evolved from a welfare-based program to a large health insurer, it's important to take into account the balance of responsibilities between states and the federal government. Federalism—shared authority between states and the federal government—has always been a defining characteristic of Medicaid.

The Affordable Care Act (ACA) imposed greater uniformity in certain aspects of Medicaid—chiefly around eligibility and enrollment—to make the continuum of subsidized public and private coverage work. At the same time, the evidence shows that federalism remains firmly in place. Far from diminishing the importance of states, Medicaid's key position in the healthcare system both enables and requires state-driven efforts to devise value-based, integrated models for delivering and paying for quality care in Medicaid and beyond.

For the past five years, the Centers for Medicare and Medicaid Services (CMS) has been supporting states' efforts to test new approaches to the delivery of care. There are extensive and diverse changes under way: states are leading the way, leveraging their purchasing power in Medicaid and requiring their contracted providers and health plans to become more accountable for the costs and quality of care.

For example, states are experimenting with health homes to coordinate care for chronically ill beneficiaries and developing new integrated care models for all beneficiaries, supported by new provider payment models. Aiming to align with other payers, including Medicare and commercial insurers, states are working with health plans and providers to: drive better value through provider incentives and the use of quality metrics; reduce unnecessary hospital admissions and emergency department use; improve coordination between physical and mental health services; and in some states, bring long-term services and supports into managed care. In short, states' interest in improving care and lowering costs, coupled with a rapidly changing healthcare system, has triggered far-reaching innovations.

States have implemented many such payment and delivery initiatives without special authority, but some have sought to transform their delivery systems under initiatives established by CMS's new Innovation Center or with funding and authority granted through a Section 1115 demonstration waiver. Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services to allow and fund policies that are not otherwise permitted by federal law if she determines they "promote the objectives of the [Medicaid] program." The Medicaid programs in Oregon, New York, and Texas are examples of these delivery system reform waivers.

In addition, several states have secured 1115 waivers to test alternative expansion

models. As has been true with demonstrations in the past, each of the five alternate expansion demonstrations approved and in effect (in Arkansas, Iowa, Michigan, New Hampshire, and Indiana) has broken new ground. Two will test access to coverage and care when Medicaid enrollees receive services through qualified health plans doing business in the health insurance marketplace; four will test the impact of new premiums; one imposes higher copayments aimed at deterring inappropriate use of emergency department services; several seek to encourage healthy behaviors; and three set up different versions of health savings accounts.

While these demonstrations move state policy in new and sometimes controversial directions, they all test new ways to provide health insurance and potentially improve care. The Department of Health and Human Services has signaled that some proposed policies, such as conditioning coverage on the payment of premiums by those with very low incomes, caps on the number of people enrolled, and work requirements that base eligibility for coverage on job search or other work-related activities, will not be approved because they don't fit with Medicaid's objectives. The law requires that demonstration waivers "promote the objectives" of the Medicaid program. Enrollment caps, costs that exceed people's ability to pay, and work requirements are incompatible with a health insurance model and impede Medicaid's coverage goals.

The flexibility debate—and to some degree the tension between federal and state roles inherent to federalism—will continue. It's a valuable debate, helping to draw lines as to which level of government drives which decisions and figure out what "shared responsibility" really means. But the ACA's changes to Medicaid, which cemented its place in the coverage continuum, underscores the importance of considering state experimentation in the context of the program's core objectives: providing coverage, access to care, and payment for services for a low-income population; aligning with other health insurers to promote quality, person-centered care; and driving value for the dollars spent.

What's Next?

The changes to Medicaid that have taken hold over the past five years through a combination of federal legislation and regulation, states' actions, and market forces are unprecedented. They include: broad-based eligibility expansions in 29 states and the District of Columbia; a complete revamping of the rules and processes for determining eligibility for most Medicaid enrollees; a new streamlined, data-driven application process married to marketplaces; and in almost all states, significant delivery and payment reforms.

With new roles come new responsibilities and challenges. Four key, and closely related, areas of focus lie ahead.

First, states that have not yet expanded Medicaid must address the resulting hole in the coverage continuum. Without coverage, people don't get the care they need at the right time, the right place, or at all. And by not expanding Medicaid, states and healthcare providers are missing out on the substantial economic benefits that other states and providers have begun to realize. Not expanding Medicaid also handicaps healthcare delivery and payment reform efforts. There is no "one way" to expand Medicaid. Regardless of how it is done, Medicaid expansion is an essential component of the coverage continuum and the foundation of healthcare reform.

Second, Medicaid must continue to make progress as a strategic, value-based purchaser of coverage and services. The tools to do so are there, informed by the experimentation and learning going on around the country in, for example, integrating behavioral and physical health; reducing preventable hospitalizations and emergency department visits; supporting (in the most appropriate and least restrictive setting) individuals who need long-term services and supports; ensuring effective systems of care for children with complex medical needs; coordinating care with and for people with chronic illnesses and disabilities; and holding health systems—often acting in partnership with social services and community-based supports—accountable not only to cure the sick but to help people in the communities stay or become healthy. This is hard work, and in many cases it will require major restructuring of how states finance their programs as well as how they manage and pay for care, with equally significant restructuring for health plans and providers.

Third, Medicaid needs to be a strong partner—and, in some cases, a leader—in the broader systemwide efforts to improve health and healthcare and lower costs. At the outset, as discussed in our earlier blogs, Medicaid's first job is to modernize and rationalize its own delivery system and payment policies so that alignment across payers is even possible. Because it is often the dominant payer, Medicaid can have tremendous leverage with respect to services for children, pregnant women, and people with chronic illnesses or disabilities. For these populations and these areas of care, Medicaid can shape practices and markets in ways that drive improvements in care, health, and cost.

At the same time, Medicaid should seek to advance marketwide delivery system and payment reforms. The unique circumstances of Medicaid's

enrollees, most notably their very low incomes, mean that to do its job well Medicaid must sometimes attend to its business in unique ways. Still, coordinating with other insurers and payers on delivery system and payment reforms should be the general rule, not the exception.

Fourth, the IT infrastructure enabling the gains in coverage and improvements in consumer experience achieved to date needs to be completed in some states and at the federal level, and kept current with new technologies and efficiencies. Prior to the ACA, state Medicaid enrollment systems had become woefully out of date. We can't let that happen again, and with ongoing enhanced federal financing coupled with accountable standards for such systems, improvements are likely to continue. Along with enabling electronic verification of personal information and integrating with the insurance marketplaces' data, Medicaid's IT infrastructure also must produce the medical encounter, cost, and quality data states and the public need to ensure that the program is operating effectively and efficiently. It's not flashy stuff, but it is vital to all the rest.

As all of this occurs, it will be essential to stay focused on Medicaid's mission to ensure access to quality and affordable care for the lowest-income Americans, people with disabilities, and the elderly. It also will be important to consider Medicaid's role and responsibilities, not as a public assistance program or an afterthought in the healthcare system, but as one of the most important health insurance programs in the nation.

For more information, contact:

Cindy Mann
Partner
202.585.6572
cmann@manatt.com

Deborah Bachrach
Partner
212.790.4594
dbachrach@manatt.com

Elizabeth Osius
Manager
202.585.6582
eosius@manatt.com

manatt

Albany
Los Angeles
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Orange County
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Sacramento
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Washington, D.C.