

What's at Stake in Medicaid: A Voter Guide

Medicaid is financed and administered through a federal-state partnership. The federal government matches state Medicaid spending based on a statutory formula. States have flexibility in how they structure and provide benefits, but federal law specifies core requirements that all states must meet as a condition of receiving federal funding. Medicaid is an important source of health care for 12 million people with Medicare, helping to pay for costs and services that Medicare does not, including nursing home care and personal care services. Medicaid also makes Medicare more affordable by helping low-income beneficiaries pay their premiums and cost-sharing.¹

In recent years, there have been efforts by some in Washington to significantly restrict Medicaid funding and eligibility in ways that would put millions at risk of being un- or under-insured. As the coronavirus pandemic has shown, Medicaid's affordable, comprehensive health coverage is more important than ever. For 2020, voters should pay close attention to candidates' statements about Medicaid, including their vision for the future of the program. To help voters weigh in, below are a few proposals to keep an eye out for that would transform the program for the worse.

“Block Grants” or “Per-Capita Caps”: Some policymakers support fundamentally restructuring and severely cutting Medicaid by turning the program into a block grant or a per-capita cap system. Typically, these reforms are designed to produce large federal savings over time by shrinking federal funding for state Medicaid programs. This would shift significant costs to states and almost certainly lead to reduced services and eligibility.

- **Block Grant.** Under a block grant, states would receive a fixed amount of federal funding each year to operate their Medicaid programs. To achieve federal savings, the amount provided to states would be less than what is expected under current law. Further, the federal share would not automatically adjust in times of need or keep pace with inflation, as do today's Medicaid rates. For example, during economic downturns, or health events like the coronavirus public health emergency, enrollment in Medicaid grows, increasing state Medicaid costs at the same time that state tax revenues are declining.² Under a block grant, states would be responsible for all costs that exceed the federal amount.

¹ Centers for Medicare & Medicaid Services, “People Enrolled in Medicare and Medicaid” (March 2019), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

² Robin Rudowitz, et al., “Medicaid Financing: The Basics,” Kaiser Family Foundation (March 21, 2019), <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/>.

- **Per-Capita Cap.** A per-capita cap sets a limit on the amount the state receives for each Medicaid enrollee. These caps could be determined for all enrollees or separate caps could be calculated based on broad Medicaid coverage groups. In either case, to generate federal savings, per-enrollee spending would be indexed to grow more slowly than is expected under current law. While under this approach federal funding would respond to population changes, it would still not address changes in health costs, like those associated with a natural disaster like a hurricane, an epidemic like coronavirus, or expensive new therapies like those for hepatitis C.

Elimination of Medicaid Expansion: Other threats to Medicaid include efforts to roll back or dilute the Affordable Care Act’s (ACA) Medicaid expansion. The health care law gave states the option to expand their Medicaid programs to include coverage for low-income, non-elderly adults (ages 19-64) without dependent children. Studies indicate this has led to historic coverage gains, improved enrollee health and financial security, and generated economic benefits for states and providers.³ The ACA’s future is uncertain, as the U.S. Supreme Court is set to consider the law’s constitutionality this fall in *California v. Texas* (known as *Texas v. U.S.* in the lower courts).⁴ The appeal before the Court stems from a Texas district court decision that held (1) the ACA’s individual mandate is unconstitutional because Congress reduced the penalty to zero in the 2017 tax bill; and (2) therefore, the entire ACA is invalid. The plaintiffs—which include 18 Republican attorneys general and the Trump administration—maintain their support of the lawsuit and its goal of eliminating the entire ACA, including Medicaid expansion, despite the risks of tearing away coverage during a pandemic. The Supreme Court will hear the case on November 10. A decision would then be expected in 2021.⁵

“Work requirements,” “Healthy Adult Opportunity,” “Able-bodied adults,” or “Community Engagement”:

Increasingly, states are seeking federal approval for waivers to their Medicaid programs that condition eligibility (generally, but not exclusively, for expansion Medicaid) on compliance with monthly employment and reporting rules. This is despite the overwhelming evidence that most Medicaid adults are already working; among those who are not, most report barriers to work—such as illness or disability and caregiving requirements. Additionally, many Medicaid adults do not use computers, the internet or email, which could be a barrier in finding a job or complying with policies to report work or exemption status.⁶ Older adults face particular challenges in complying, and the health consequences if they lose Medicaid coverage are likely to be especially severe.⁷ Research has shown that for people with serious health needs, coverage interruptions lead to increased emergency room visits and hospitalizations, admissions to mental health facilities, and health care costs.⁸ When such requirements were put in place in Arkansas, thousands of enrollees lost access to

³ Larisa Antonisse, et al., “The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review,” Kaiser Family Foundation (March 28, 2018), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

⁴ No. 19-840, <https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-840.html>. The case has been consolidated with *Texas v. California*, No. 19-1019, <https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-1019.html>.

⁵ See Amici Curiae Brief of AARP, AARP Foundation, Center for Medicare Advocacy, and Justice In Aging Supporting Intervenor Defendants-Appellants Urging Reversal (April 1, 2020), <https://www.medicareadvocacy.org/wp-content/uploads/2019/04/Fifth-Circuit-FINAL-ACA-brief-4-1-2019.pdf>.

⁶ Rachel Garfield, et al., “Understanding the Intersection of Medicaid and Work: What Does the Data Say?” Kaiser Family Foundation (August 8, 2019): <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/>.

⁷ Center on Budget and Policy Priorities, “Taking Away Medicaid for Not Meeting Work Requirements Harms Older Americans” (Updated March 14, 2019), <https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-older-americans>.

⁸ Leighton Ku, et al., “Bridging the Gap: Continuity and Quality of Coverage in Medicaid,” George Washington University (September 10, 2013), <http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%202019-10-13.pdf>.

Medicaid, many because they were unable to find work or adhere to the state's onerous reporting standards.⁹ Where challenged, federal courts to date have consistently declared work requirements invalid because they contradict the Medicaid statute. But these rulings cannot retroactively address the harms the waivers caused to enrollees and their families.

Premiums and Cost Sharing, Rapid-Fire Redeterminations, and “Lockouts”: Medicaid rules allow states to impose limited premiums and cost-sharing amounts, which cannot exceed five percent of an enrollee's family income. But states can seek waivers to charge enrollees more,¹⁰ which can have detrimental effects on an enrollee's ability to keep coverage¹¹ and willingness to seek treatment.¹² States can also make eligibility redeterminations more frequent, which can cause eligible enrollees to lose coverage simply because they did not receive mailed notices or could not prove their financial status in time. Currently, if someone loses Medicaid, they can generally reapply and avoid coverage gaps. However, several states are attempting to disenroll people who cannot pay Medicaid and refuse to allow them to re-enroll for a set time no matter their need for care and coverage.¹³ Such lock-outs create disruptions in care¹⁴ that lead to poor health outcomes and increased costs for individuals, providers, and state and local governments.¹⁵

Elimination of Retroactivity: Upon application, states are required to provide qualifying Medicaid enrollees with three months of retroactive Medicaid coverage. This prevents enrollees from shouldering unaffordable medical bills they incurred before applying and gives providers an incentive to treat uninsured Medicaid-eligible individuals, because they know they will be reimbursed for the services once the person is enrolled. Several states have waived retroactive coverage—exposing Medicaid enrollees to overwhelming medical debt,¹⁶ reducing provider assurances, and increasing hospitals uncompensated care burden.¹⁷

Elimination of Non-Emergency Medical Transportation: Medicaid has long required states to provide non-emergency medical transportation (NEMT), which facilitates access to medical services for low-income beneficiaries who have no other means of transportation—helping them receive the care they need to manage their conditions and improve their outcomes. However, some states have sought waivers to eliminate this benefit. This would leave many enrollees in need—including those for whom health and affordability

⁹ Robin Rudowitz, et al., “February State Data for Medicaid Work Requirements in Arkansas,” Kaiser Family Foundation (March 25, 2019),

<https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/>.

¹⁰ The Secretary of Health and Human Services can waive cost-sharing rules if the requirements of sections 1916 and 1916A of the Social Security Act are met. In practice, this means state must seek a 1916 waiver (in addition to an 1115 waiver) in order to charge cost sharing above nominal Medicaid amounts set out in Medicaid law. A 1916 waiver has its own set of detailed required protocols and documentation. Few states have approved 1916 waivers for the adult Medicaid population to date.

¹¹ Bill J. Wright, et al., “Raising Premiums and Costs for Oregon Health Plan Enrollees Drove Many to Drop Out,” Health Affairs (December 2010),

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0211>.

¹² Michael Chernew, et al., “Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care,” J Gen Intern Med. (June 14, 2008),

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517964/pdf/11606_2008_Article_614.pdf.

¹³ Andis Robeznieks, “Medicaid ‘lockout’ provisions hurt most vulnerable patients” (June 13, 2018), <https://www.ama-assn.org/delivering-care/patient-support-advocacy/medicaid-lockout-provisions-hurt-most-vulnerable-patients>.

¹⁴ Jacob Dreier, et al., “The association between continuity of care in the community and health outcomes: a population-based study,” Isr J Health Policy Res. (May 23, 2012) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3424831/>.

¹⁵ Teresa A. Coughlin, et al., “Uncompensated Care for the Uninsured in 2013: A Detailed Examination,” Kaiser Family Foundation (May 30, 2014),

<https://www.kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-sources-of-funding-for-uncompensated-care/>.

¹⁶ David U. Himmelstein, et al., “Medical Bankruptcy in the United States, 2007: Results of a National Study,” The American Journal of Medicine (2009),

http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

¹⁷ Amendment to Arkansas Works Section 1115 demonstration, as submitted to HHS Secretary Thomas E. Price on June 30, 2017,

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-pa2.pdf>.

issues may make it impossible for them to drive a car, use public transit, or pay for a ride, as well as those who live in rural areas and may have limited public transportation options and face long travel times—unable to get appropriate care at the appropriate time¹⁸ Without NEMT, Medicaid enrollees are likely to miss necessary appointments, potentially leading to worse health outcomes and higher health care costs down the road.¹⁹

Failing to Meet Growing Demand for Long-Term Care: Many people with Medicare rely on Medicaid for long-term care, and demands are likely only to grow as the population ages, exacerbating existing problems:

- Extensive Waiting Lists for Home- and Community-Based Services (HCBS). Already, many people who are dually eligible for Medicare and Medicaid face long wait times in accessing HCBS.²⁰ If demographic and economic trends continue, more people will need such services and state budgets will be less able to provide them.
- Health Care Workforce. As more dually eligible beneficiaries require long-term care or HCBS, the need for a competent, reliable workforce grows. But already there are too few workers, with too few protections.²¹

¹⁸ Paul T. Cheung, et al., “National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries,” *Annals of Emergency Medicine* (July 2012), <https://www.ncbi.nlm.nih.gov/pubmed/22418570>.

¹⁹ TRB’s Transit Cooperative Research Program, “Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation” (October 2005), <http://www.trb.org/Publications/Blurbs/156625.aspx>.

²⁰ MaryBeth Mesumuci, et al., “Key Questions About Medicaid Home and Community-Based Services Waiver Waiting Lists” (April 4, 2019), <https://www.kff.org/report-section/key-questions-about-medicaid-home-and-community-based-services-waiver-waiting-lists-appendix-tables/>.

²¹ Bob Woods, “America’s \$103 billion home health-care system is in crisis as worker shortage worsens” (April 9, 2019), <https://www.cnn.com/2019/04/09/us-home-healthcare-system-is-in-crisis-as-worker-shortages-worsen.html>.