Industry Snapshot Newsletter

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Understanding the Issue: Medicaid 101

By Gallagher Student Health & Special Risk

Medicaid has been in existence for over half a century and remains one of the largest health insurance coverage programs (even when compared to the individual marketplace) since the passing of the Affordable Care Act (ACA). Yet there are still millions of Americans admittedly unclear on the structure of the program, how it works and who it serves. We recognize that it's a complicated topic to navigate, especially considering the various angles of debate over recent attempts to repeal and replace the ACA, including potential major Medicaid changes on the horizon. However, its level of complexity should not overshadow its vast significance in American society.

- Approximately 68 million U.S. citizens were enrolled in Medicaid as of January 2018
- The biggest overall expenditure for state governments in this fiscal year is approximated at $658 billion for health care, mainly on Medicaid and related programs partially funded by the federal government
- Medicaid finances almost 45% of all U.S. births annually

Regardless of the structural and legislative intricacies, it's important that the higher education community educate themselves on this topic, as we have seen state Medicaid programs become the top alternative to college and university student health insurance plans (SHIPs) in recent years.

To help simplify the concept of the Medicaid structure, key objectives, trends and possible changes on the horizon, we will be breaking this Newsletter edition into two parts:

Part 1 (June 2018): "Medicaid 101" - Recapping the program's fundamental building blocks, expansion under the ACA and recent trends to ensure basic stakeholder understanding of funding, coverage requirements, administration and delivery

Part 2 (Sept/Oct 2018): "Medicaid on the Horizon" - Exploring potential Medicaid changes in the near future (at both the federal and state level), a partnership through SHIP Premium Assistance and possible implications for the higher education student health insurance industry

In order to examine the key evolving Medicaid topics inevitably making an impact on the SHIP world, we should begin with a brief history lesson on this publicly supported healthcare program.

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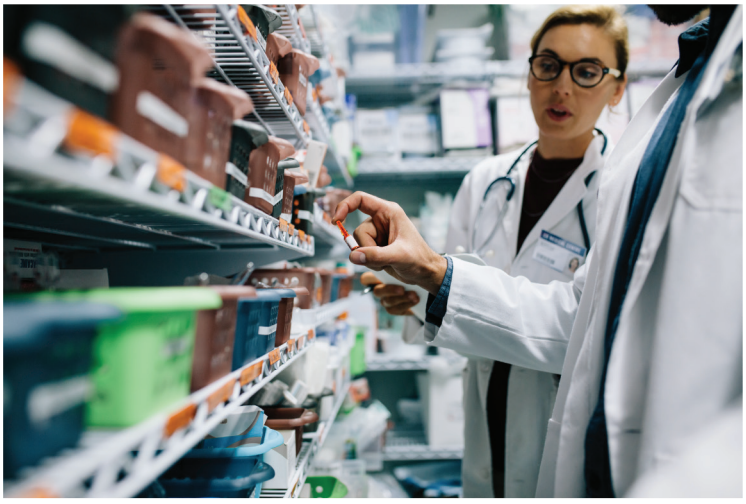
The Basics

Originally referred to as "Medical Assistance" when signed into law in 1965, Medicaid is a joint federal/state program designed to provide health coverage to low-income families and individuals. The foundation of the program is joint funding by both the states and the federal government - designated agencies in Washington D.C. pay states a specified percentage towards Medicaid expenditures, called the Federal Medical Assistance Percentage (FMAP), and states must ensure they can fund their share of program expenditures for the care and services available under their unique state program. So, although Medicaid is administered by individual U.S. states, it must be administered in accordance with all federal requirements in order to receive federal funds.



Funding

This may contribute to the general public's challenges with comprehending the program – the fact that although the federal government establishes Medicaid guidelines and shares in the cost, it's actually run by the states themselves. In the simplest of terms, the federal government contributes a significant portion of states' Medicaid costs and sets several governing rules for the entire country. States are required to pick up the difference in cost after receiving assistance from Washington, and in turn, they are allowed to make a number of rules and choices for their individual populations' coverage guidelines.

Over half of the U.S. states require that counties fund a portion of the state's share of Medicaid, by covering the costs of specific services for Medicaid recipients (i.e. long-term care or mental health). The states also often delegate certain administrative duties to the counties for the delivery of many social and health services to low-income and uninsured individuals.

Expansion

We saw this dynamic of state autonomy strategically exercised with the passage of the ACA in 2010. "Obamacare" proposed more lenient Medicaid eligibility standards, allowing coverage for any adult with income up to 138% of the Federal Poverty Level. Although the intention of the ACA was to mandate this expansion to cover almost all U.S. citizens earning up to 138%, a number of states argued that they shouldn't be forced to expand due to the future liability of funding a larger (more needy) group. As a result, the Supreme Court ruling in 2012 made Medicaid expansion optional. It's important to note that the states who chose to expand their programs received an incentive of increased federal funding. Prior to the ACA, federal funding of state Medicaid programs averaged 57%. To entice states to expand, Washington promised to contribute 100% of the cost for the Medicaid expansion population in the initial years.

As of May 2018, all but 17 states have chosen to implement the expansion of Medicaid eligibility. In those states that expanded, millions gained coverage, and the uninsured rate dropped significantly. However, in the states that have not implemented expansion, eligibility is based on the original requirements. The average income limit for parents in these states is just 44% of the poverty level (or an annual income of $8,985 a year for a family of three in 2017), and in nearly all "non-expansion" states, childless adults are still ineligible. And because the ACA envisioned most low-income families receiving coverage through Medicaid, it does not offer financial assistance to those below the poverty level for other subsidized coverage options through the marketplace. This leaves millions of uninsured adults unable to benefit from the ACA and with limited options for affordable health coverage.

Currently, the federal government is picking up about 94% of the cost for the expansion of Medicaid eligibility, with a plan in place to phase down to 90% of expansion population costs by 2020. An increase in states' funding responsibilities by 4% may not sound like much, but when you consider the hundreds of billions of dollars funding U.S. Medicaid, that percentage begins to sound a lot more significant within a state's budgeting plan.

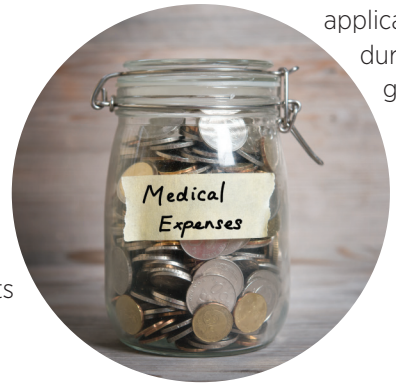
With the majority of states choosing to expand the Medicaid 'safety net,' the program's nationwide coverage has grown to an approximated 68 million people (according to The January 2018 Medicaid and Children's Health Insurance Program (CHIP) Application, Eligibility, Determinations, and Enrollment Report), including pregnant women, children, elderly and disabled people under certain income levels, as long as they meet residency and immigration requirements and are documented U.S. citizens. 74 million enrollees are expected by the end of this year, equating to roughly one in five Americans covered, including more than a third of the nation's children, and almost two thirds of nursing home residents (many of whom fall into the middle class, and spent their savings on care before becoming eligible).

Determining Eligibility & Applying

Generally, beneficiaries must be residents of the state in which they are receiving Medicaid and they must either be U.S. citizens or certain qualified non-citizens, such as lawful permanent residents. In addition, some eligibility groups are limited by age, pregnancy or parenting status.

Financial Eligibility

The ACA established a new approach to determining income eligibility for Medicaid, based on Modified Adjusted Gross Income (MAGI). MAGI is the foundation used to determine Medicaid income eligibility for most children, pregnant women, parents and adults. Its methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. MAGI not only outlines what income is/is not "countable," but also how to compose a household to determine whose income is attributable to whom within that particular family. All state Medicaid programs (expansion or no expansion) are now subject to MAGI.



The MAGI-based methodology does not allow for income disregards that vary by state or by eligibility group, and does not allow for an asset or resource test. Some individuals are exempt from the MAGI-based income counting rules, including those whose eligibility is based on blindness, disability or age (65 and older). Certain Medicaid eligibility groups do not require a determination of income by the Medicaid agency. This coverage may be based on enrollment in another program, for example a Supplemental Security Income (SSI) recipient.

Medically Needy Eligibility

Medicaid eligibility is not always based solely on financial need. States have the option to establish a "medically needy" program for those with significant health needs and income too high to otherwise qualify for Medicaid. Medically needy individuals can become eligible by "spending down" the amount of income above a particular state's medically needy standard. As they incur expenses for uninsured medical, remedial care and exceed the difference between their income and the state's medically needy income level, they may become eligible for the program. Medicaid then pays the cost of services exceeding what that individual incurred in order to become eligible.

Effective Date of Coverage

Once an individual is determined eligible for Medicaid, coverage is effective either on the date of application or the first day of the month of application. Benefits may also be covered retroactively for up to three months prior to the month of application, if the individual would have been eligible during that period had he or she applied. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility. The eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months (and no more frequently).

Applying for Medicaid

In order to determine eligibility and apply for Medicaid, individuals must fill out an application. They may learn more about how to fill out an application in one of the two ways below:

1. The health insurance marketplace – an online application is completed; if anyone in the household qualifies for Medicaid, then the individual's information is sent to the designated state agency and that agency will contact you about enrollment.

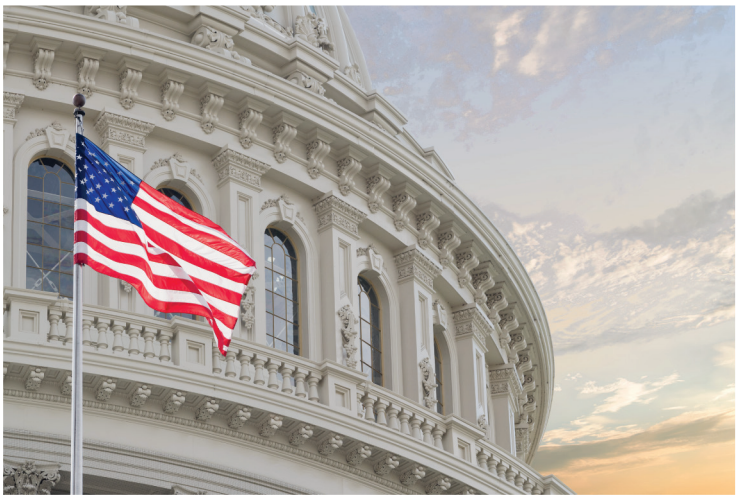
OR

2. The state Medicaid agency – the applicable state is chosen from a dropdown menu on www.healthcare.gov and the individual is directed to their state's Medicaid agency website

Flexibility Among States

Administration

Just like any government-sponsored assistance program, federal Medicaid rules and requirements do exist. However, as previously alluded, U.S. states retain a certain amount of



independence surrounding how they choose to administer their Medicaid programs. For example, although the ACA broadened individual Medicaid eligibility, a state may also use a Section 1115 Waiver to expand coverage to additional groups, such as low income working adults, children and pregnant women whose household incomes are higher than the federal thresholds or young adults attending college.

Coverage Requirements

This level of autonomy has resulted in a fair amount of flexibility in each state's Medicaid "profile." Minimum federal care standards are imposed nationwide, meaning that under federal law, certain mandatory benefits must be provided to all Medicaid enrollees (i.e. hospitalization and physician visits). There is also a list of optional benefits (i.e. prescription drugs and hospice) that states may or may not choose to cover on an individual basis. For this reason, Medicaid benefits can and do vary across state lines.

Delivery of Benefits

State program variations extend beyond coverage requirements and benefits. Each state may also establish its own Medicaid provider payment rates and methods (within federal requirements). In general, state Medicaid services are paid for through one of two delivery of care methods:

1. Fee-for-service – Enrollees may use any provider that accepts the state's Medicaid program

OR

2. Managed care organization arrangements – For example, enrollees are assigned to a Health Maintenance Organization (HMO) and are limited to using a provider within that specific network

As can be expected, most states choose option number two, as it allows them to better manage program spending. If a state wishes to modify their method of paying Medicaid providers or eligibility, it must submit a State Plan Amendment (SPA) and/or Section 1115 Waiver for the Centers for Medicare and Medicaid Services' (CMS) review and approval.

Benefits & Challenges

As with any government program, there are a variety of individuals, demographics, interests, benefits, intricacies and challenges to be taken into consideration when exploring Medicaid's place (and future) in American society. Key considerations include:

Benefits

- Promotes equal access to subsidized healthcare, decreasing the uninsured rate
- Offers coverage that meets and exceeds federal ACA standards
- Improves public health
- Lowers state cost for individuals to be enrolled with enhanced federal match/FMAP
- Coverage is usually provided with no cost-sharing responsibility, limiting out-of-pocket cost

Challenges

- Increases federal/state debt, and may lead to increased taxes
- Lacks centralization across state lines, causing coverage gaps
- Coverage outside of the issuing state extremely limited (emergency care only)
- Limits provider networks and specialists (i.e. behavioral health) accepting Medicaid
- Increases the need for more primary care providers (PCPs) to manage care

We strongly encourage all industry partners to familiarize themselves with the Medicaid topic, and to contact us with any outstanding questions for further clarification.

Additional Relevant Publications

As research best practices indicate, multiple sources/opinions should be evaluated in any major change or decision-making process. To that end, below is a list of scholastic and media publications examining the topic of Medicaid, its current trends and their potential impact on the healthcare industry:

1. This is how the U.S. has become a Medicaid nation
2. Mainers voted to expand Medicaid last year. Could these states be next?
3. MassHealth restructured, begins student loan repayment program for health care providers
4. Kentucky's Medicaid requirements hurt more than help
5. Payer Roundup—Mississippi gets 10-year Medicaid waiver extension; A third of Americans believe ACA is repealed
6. Battles over single-payer healthcare, drug pricing and Medicaid loom for California in 2018
7. Arizona Supreme Court upholds state's Medicaid expansion
8. States Moving More Medicaid Patients to Managed Care

Appendix:

- Chantrill, Christopher. "What is the Total US Government Spending?" US Government Spending, 2018.
- "Current Status of State Medicaid Expansion Decisions." Kaiser Family Foundation, 31 May 2018
- Garfield, Rachel, and Damico, Anthony. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid." Kaiser Family Foundation, 1 Nov. 2017.
- Goodnough, Abby, and Zernike, Kate. "How Medicaid Works, and Who It Covers." The New York Times, 23 June 2017.
- Luthra, Shefali. "Medicaid payments allow struggling hospitals to maintain vital costly services such as maternity care." Kaiser Health News, 12 Mar. 2018.
- "Medicaid Eligibility." Medicaid.gov
- "Projected total Medicaid expenditure from 2018 to 2025 (in billion U.S. dollars)." Statista, 2018.
- Risch, James E., and Ron Johnson. "Johnson Leads Senate Letter Urging More Consumer Choice in Health Insurance Markets." U.S. Senator for Idaho, 7 June 2017.
- Rosenbaum, Sara. "The American Health Care Act And Medicaid: Changing A Half-Century Federal-State Partnership." Health Affairs Blog, 10 Mar. 2017.
- Rudowitz, Robin. "Medicaid: What to Watch in 2018 from the Administration, Congress, and the States." Kaiser Family Foundation, 17 Jan. 2018.
- Soffen, Kim. "There's One Obamacare Repeal Bill Left Standing. Here's What's in It." The Washington Post, 25 Sept. 2017.
- The Editorial Board. "A Short-Term ObamaCare Fix." The Wall Street Journal, 14 Aug. 2017.
- The Kaiser Commission on Medicaid and the Uninsured. "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)." Kaiser Family Foundation, Sept. 2012.
- "Understanding Medicaid." Medical Billing & Coding Certification, 2018.