

# Medicaid and Children: Implications of the Deficit Reduction Act and Other Policy Changes

Presented by:

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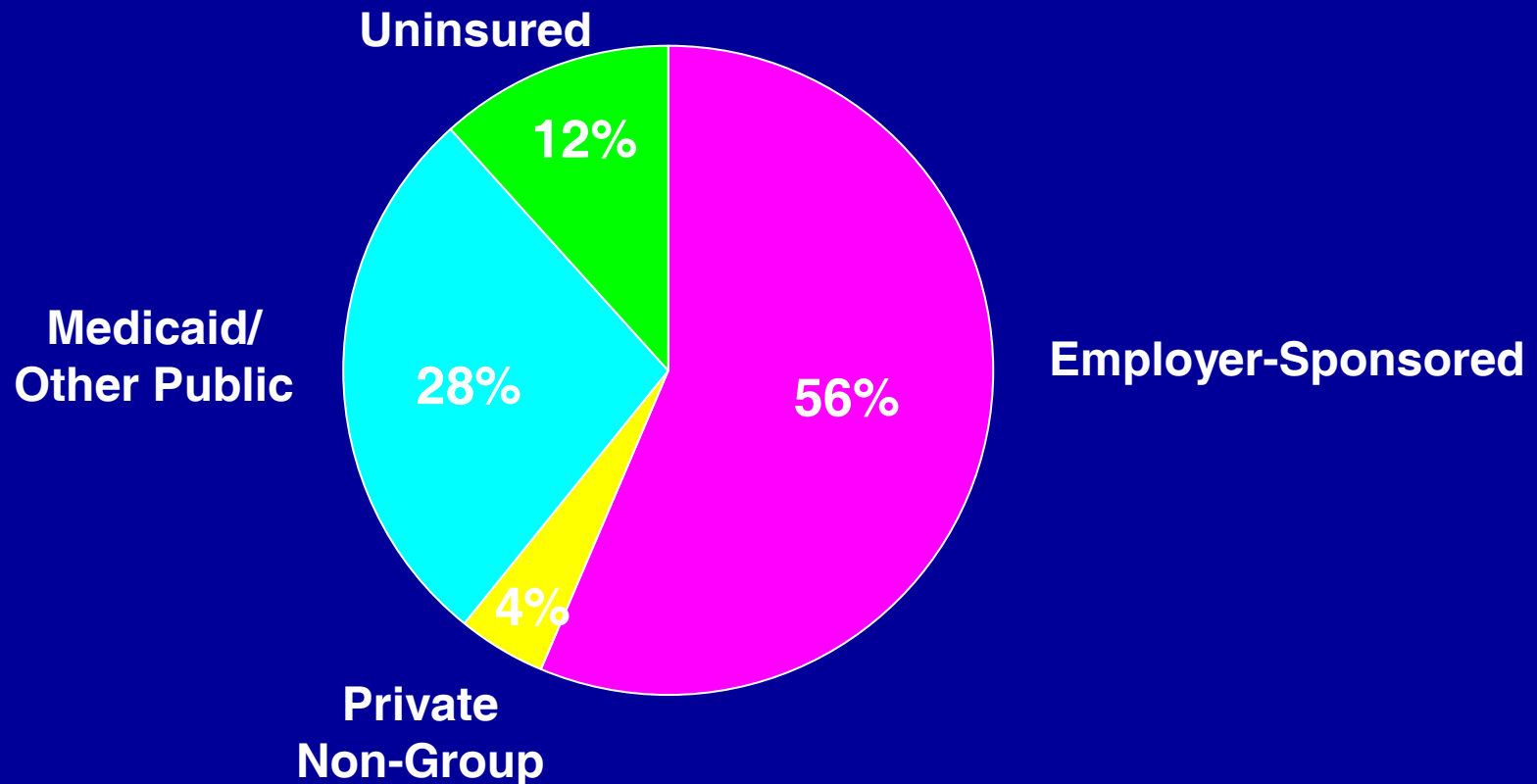
Kaiser Commission on Medicaid and the Uninsured

September 15, 2006

Gainesville, FL

Figure 1

# Health Insurance Coverage of Children, 2005



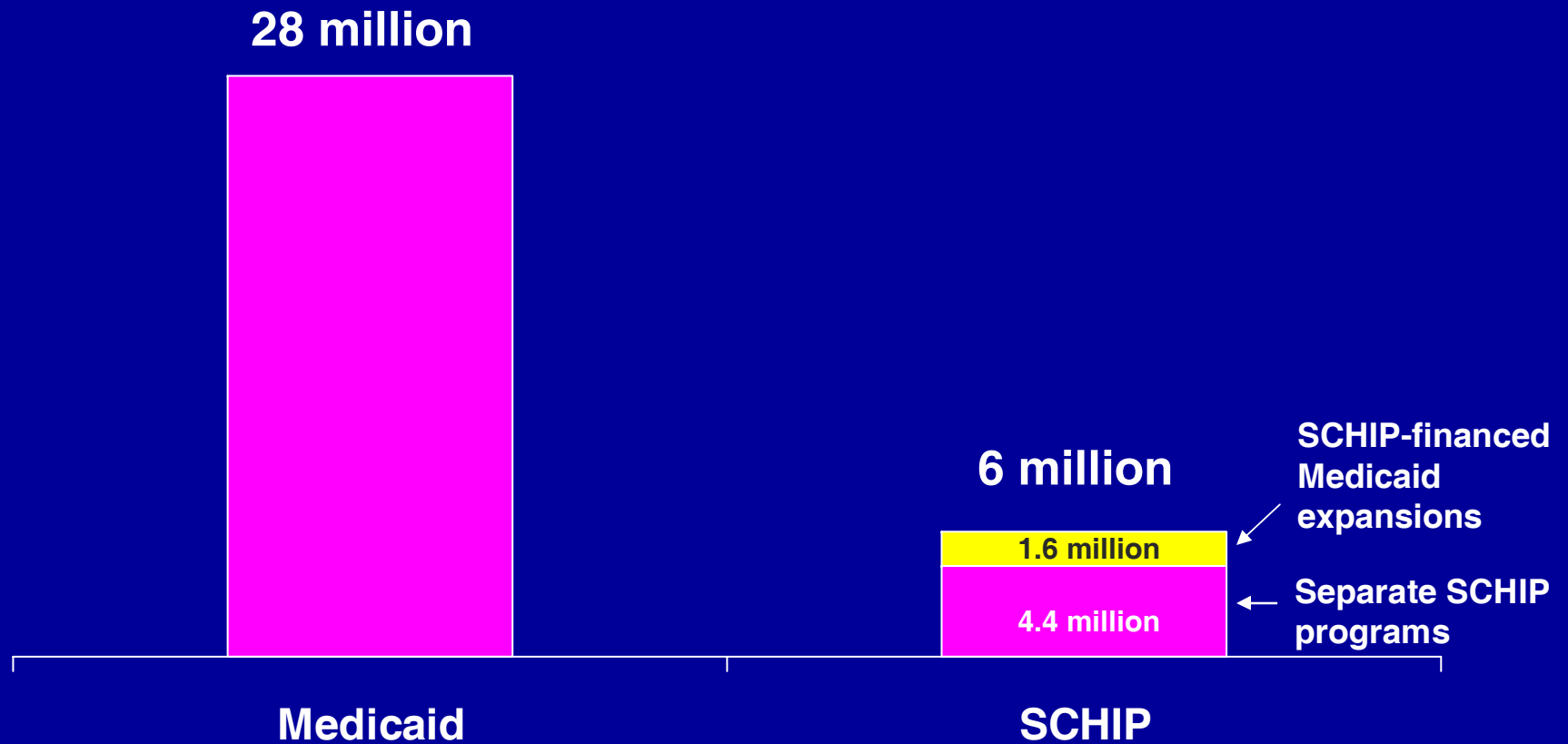
**Total = 78 Million Children**

SOURCE: PRELIMINARY Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis based on the Census Bureau's March 2006 Current Population Survey, September 2006.

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Figure 2

# Children's Enrollment in Medicaid and SCHIP, 2003

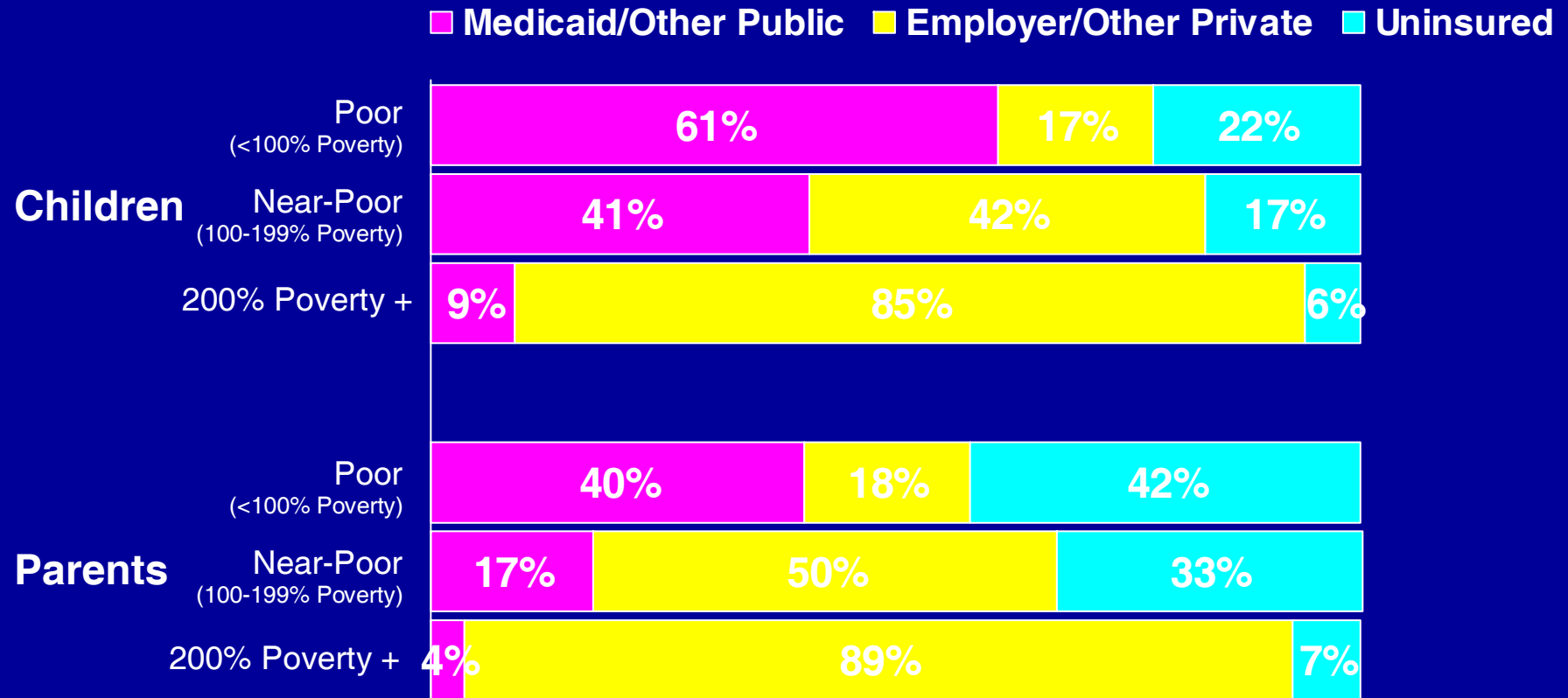


Source: Center for Children and Families Analysis of FY 2003 Medicaid Statistical Information System (MSIS) and SCHIP enrollment data.

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Figure 3

# Medicaid's Role for Children and Parents, 2005



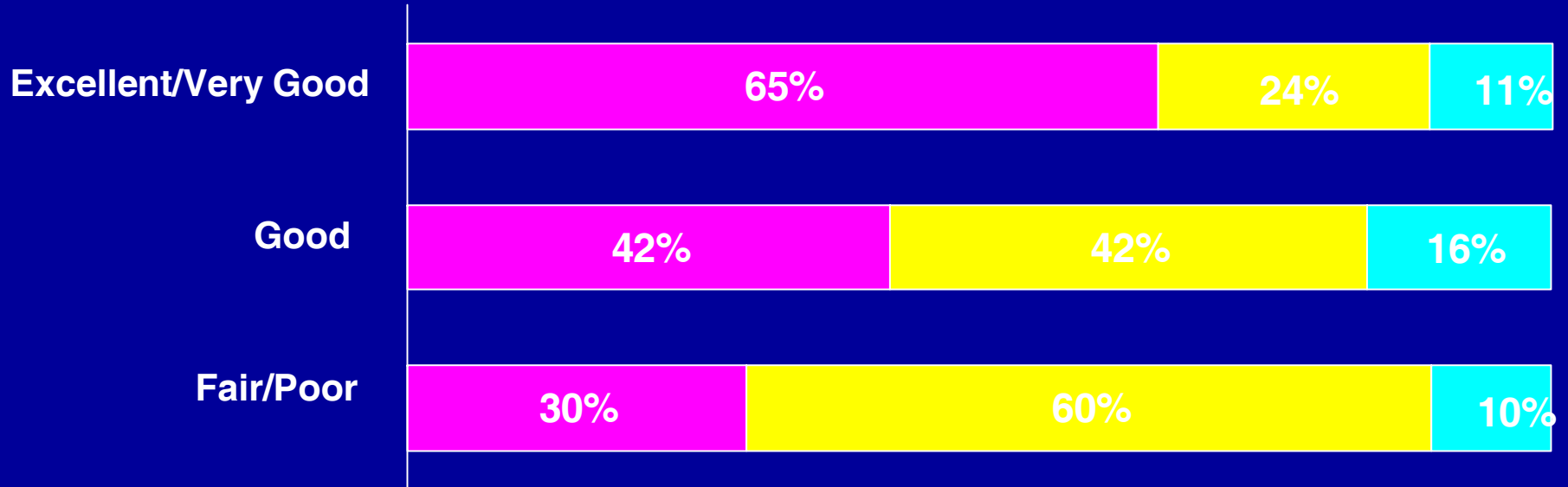
Notes: Medicaid also includes SCHIP and other state programs, Medicare and military-related coverage. The federal poverty level was \$19,350 for a family of four in 2005.

SOURCE: PRELIMINARY KCMU and Urban Institute analysis of March 2006 Current Population Survey.

Figure 4

# Health Insurance Coverage of Children by Health Status, 2005

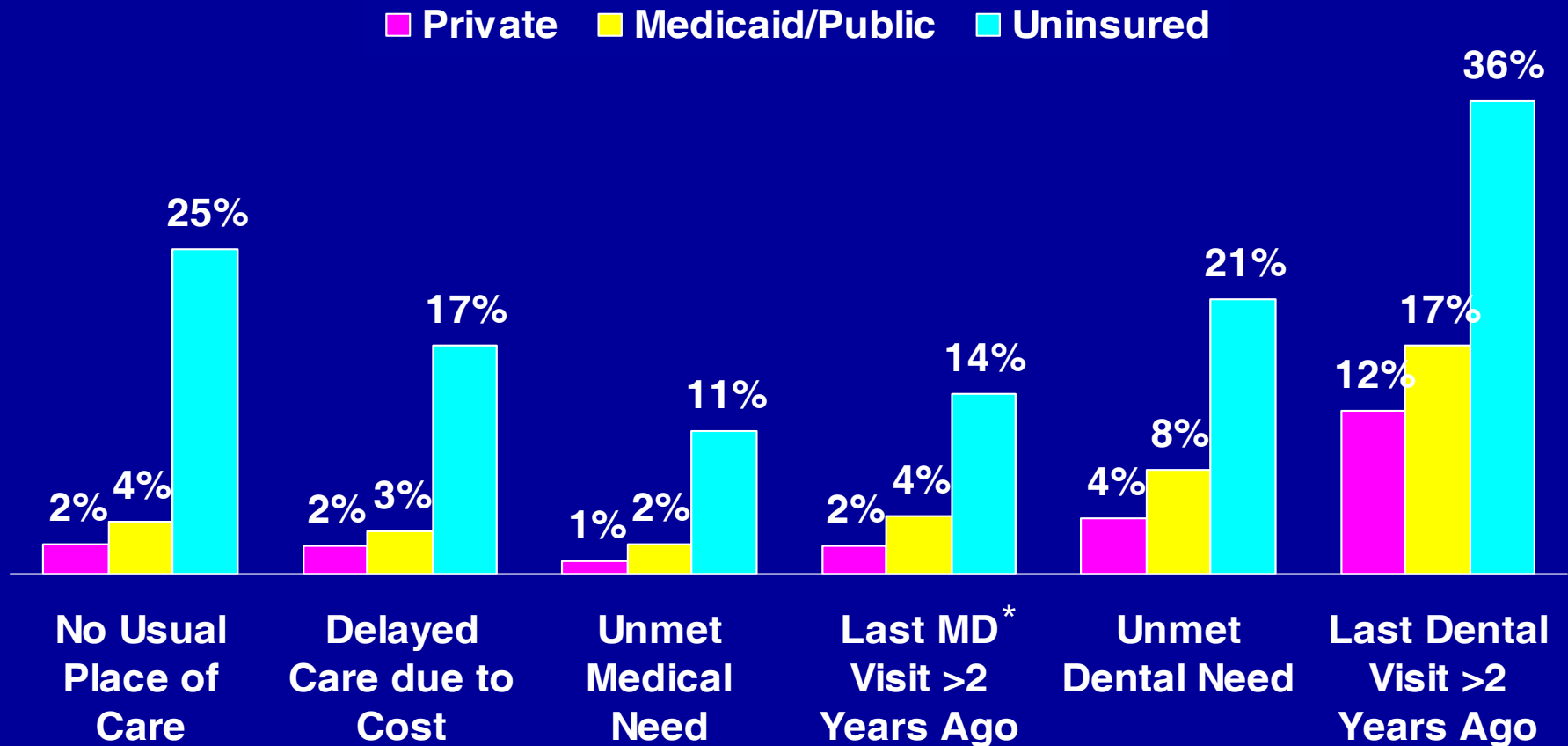
Employer/Other Private    Medicaid    Uninsured



Medicaid also includes S-CHIP, other state programs, Medicare, and military-related coverage. Data may not total 100% due to rounding.  
Source: PRELIMINARY KCMU/Urban Institute analysis of 2006 March CPS

Figure 5

# Children's Access to Care, by Health Insurance Status, 2004



\* MD or any health care professional, including time spent in a hospital. All estimates are age-adjusted.

Source: National Center for Health Statistics, CDC. 2006. Summary of Health Statistics for U.S. Children: National Health Interview Survey, 2004

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Figure 6

## **DRA Requires Proof of Citizenship for Medicaid**

- **Prior to the DRA**
  - 47 states allowed applicants to self-declare citizenship status
- **DRA requires all Medicaid enrollees to document proof of citizenship starting July 1, 2006**
- **HHS rules provide a “documentation hierarchy” where individuals must use passport or birth certificate before non-government documents and affidavits**
- **HHS rules also**
  - Exempt dual eligibles and SSI recipients; foster children not exempted
  - Allow states to conduct upfront data matches to obtain birth certificates
  - Allow current beneficiaries a “reasonable opportunity” to obtain documents but delays enrollment for new applicants without documentation

Figure 7

# Cost Sharing Provisions in the DRA

- **Prior to DRA states could impose nominal cost sharing to certain Medicaid beneficiaries but could not impose premiums**
- **Cost sharing and premiums changes:**
  - States may impose higher or new cost sharing and premiums
  - States may make cost sharing “enforceable”
  - Maintains exemption for mandatory children and pregnant women (except for non-preferred prescription drugs)
  - Allows variation in benefits and cost sharing across groups and geographic areas
- **CBO estimates:**
  - 80% of the savings would be attributable to decreased utilization

Figure 8

## Benefit Provisions in the DRA

- **Prior to DRA, states were required to cover mandatory services; could receive federal match for optional services**
- **New Benefit Flexibility**
  - Allows states to use “benchmark” plans or Secretary-approved coverage for certain groups
  - Maintains current benefits for individuals with disabilities or long term care needs (can be enrolled on voluntary basis)
  - Maintains EPSDT coverage as wrap-around for children
  - Does not apply to expansion populations
  - Allows variation across groups and geographic areas

Figure 9

# Health Opportunity Accounts in the DRA

- **Up to 10 state demonstrations**
- **Allows high deductible coverage in Medicaid combined with health opportunity account**
- **Account up to \$2,500 per adult and \$1,000 per child per year to pay for health care services**
- **Deductible set by state**
  - Can be up to 10% higher than the account
  - If account runs out, must pay out-of-pocket for care until deductible is met
- **Individuals maintain access to accounts even if Medicaid eligibility ends, could increase state costs**

Figure 10

## **Latest State DRA Developments: West Virginia**

- **Creates Basic and Enhanced benefit plans for children and parents**
- **Parents must sign a “member agreement” to access “Enhanced” benefits for themselves and their children, including mental health services, diabetes care, and drugs beyond a four-drug limit**
- **State must continue to provide EPSDT services to children**
- **HMOs and providers will report patient status with regard to the member agreement to the state**

Figure 11

# Latest State DRA Developments: Kentucky

- **Creates 4 Targeted Benefits Packages:**
  - Family Choices (most kids), Optimum Choices (MRDD), Comprehensive Choices (Nursing Home Care), Global Choices (remaining enrollees)
  - Family Choices and Global Choices plans do not cover long-term care services
- **New cost sharing requirements and service limits**
  - copays of \$1-\$50, 4 prescription limit per month
  - \$225 annual out of pocket limit for medical services and \$225 annual out of pocket limit for prescription drugs
- **Emphasis on disease management, Get Healthy Benefit Accounts, and premium assistance**
- **Expanded access to community based long-term care services**

## Florida: Key Changes in Coverage

- **State will allot risk-adjusted premiums for beneficiaries as payment to plans**
- **Beneficiaries choose among managed care plans or “opt-out” to employer sponsored insurance**
- **New authority for plans to set benefits for adults**
- **New overall annual maximum benefit limit for adults**
- **No benefit limit for children, continuation of EPSDT**
- **Individuals can earn “Enhanced Benefits” by engaging in healthy activities**

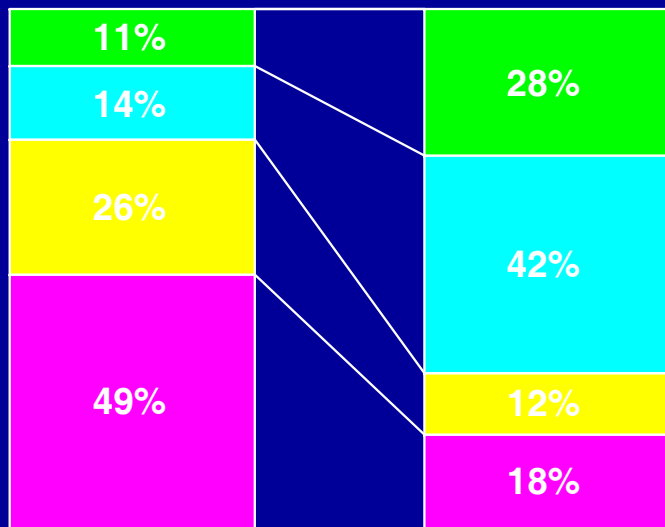
## **New Directions in Medicaid**

- **Emphasis on personal behavior and responsibility**
  - “Consumer choice” of plans / Long-term care services
  - Increased premiums and/or cost sharing
  - Behavior modification through incentives
- **“Tailored” benefits**
  - Variation in benefit packages across groups or geographic areas
- **Increased role of private marketplace**
  - Increased control to plans to determine benefit packages
  - Emphasis on premium assistance
  - Public/private long-term care partnerships
- **Restricting spending/increasing spending predictability**
  - Defined contribution approaches
  - Aggregate cap on federal funding

Figure 14

# Medicaid Enrollees and Expenditures by Enrollment Group, 2003

## United States

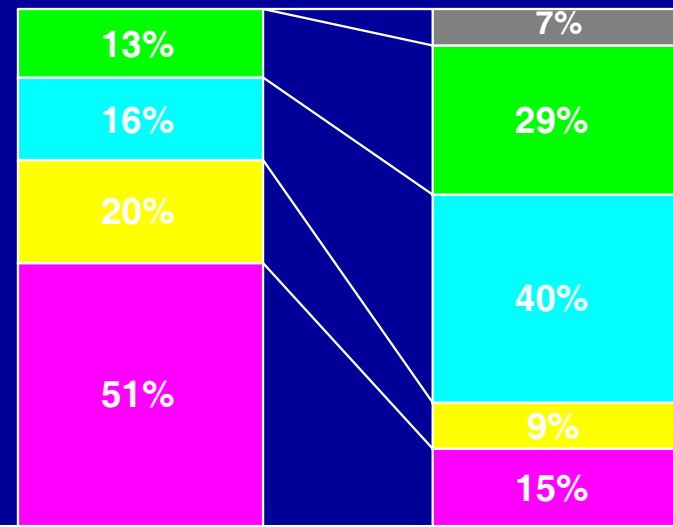


**Enrollees**  
55 Million

**Expenditures**  
\$234 Billion

- Unknown
- Aged
- Disabled
- Adult
- Children

## Florida



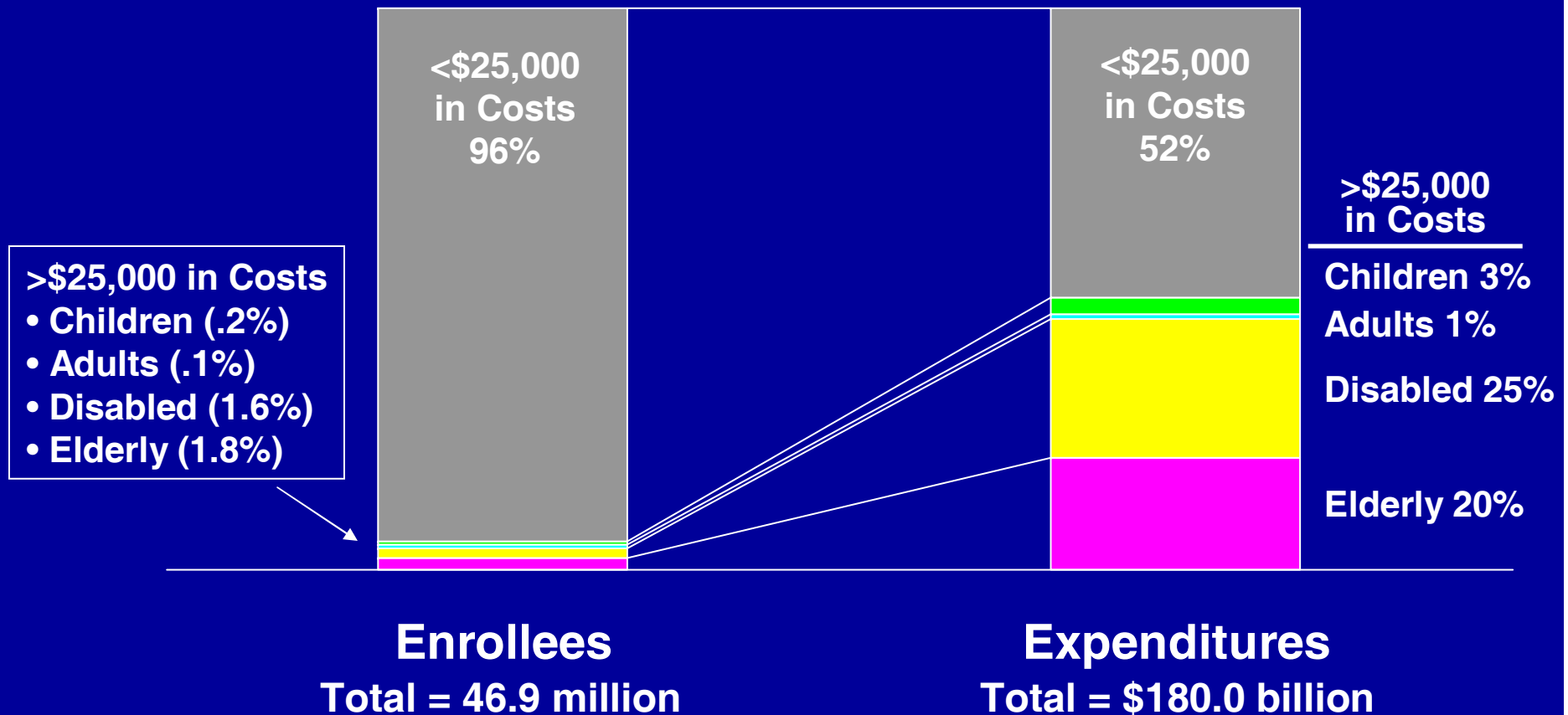
**Enrollees**  
2.8 Million

**Expenditures**  
\$11.1 Billion

Note: Total expenditures on benefits excludes DSH payments.  
SOURCE: KCMU and Urban Institute estimates based on the Centers for Medicare and Medicaid Services' Medicaid Statistical Information System (MSIS).

Figure 15

# Small Share of Medicaid Population Accounts for Large Share of Expenditures

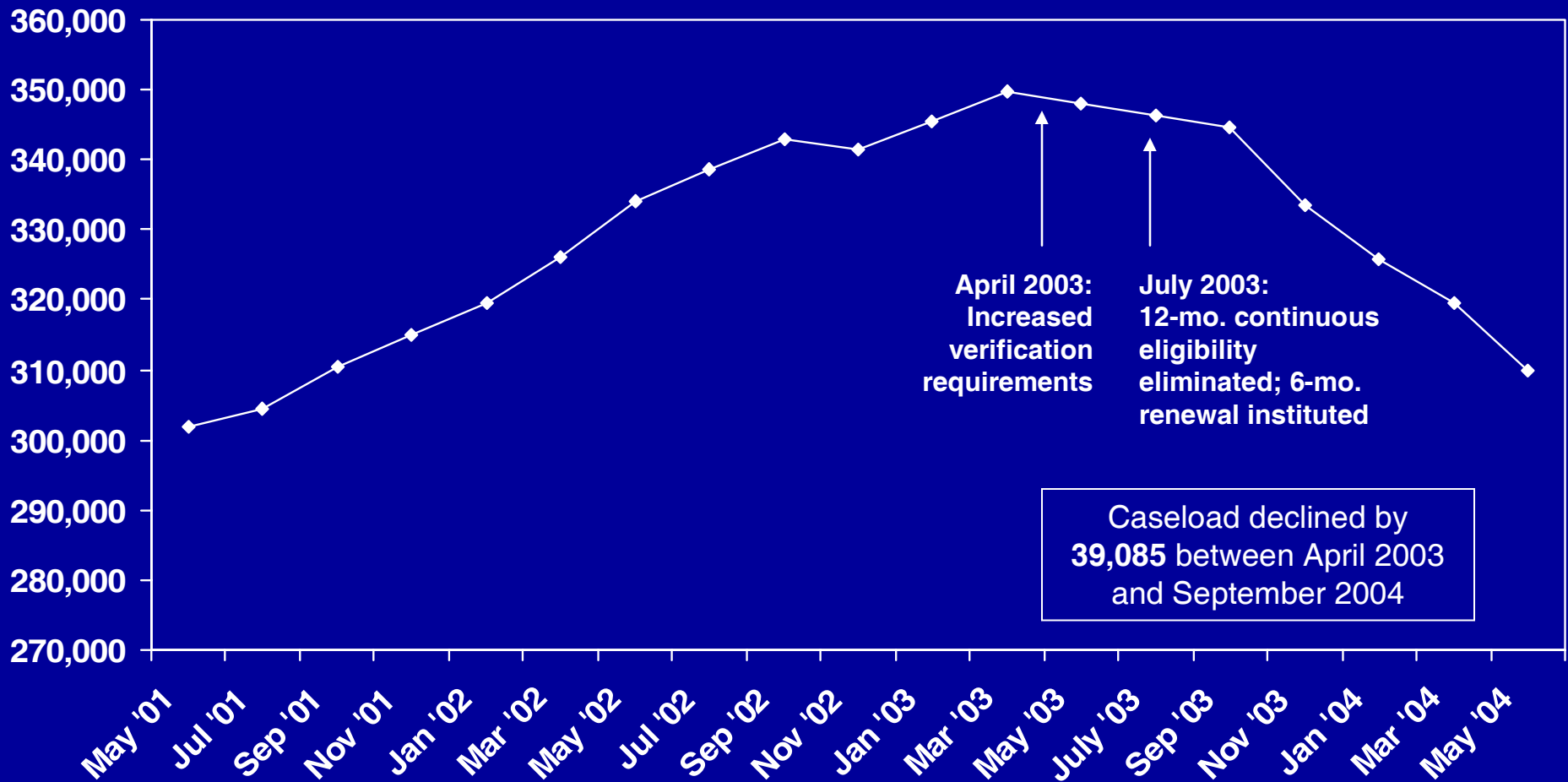


SOURCE: Urban Institute estimates based on MSIS 2001 data.

Figure 16

# Washington State Medicaid Enrollment of Low-Income Children\*

Number of Children



\*Children under 200% of the Federal Poverty Line (FPL) who are not eligible for TANF or SSI.

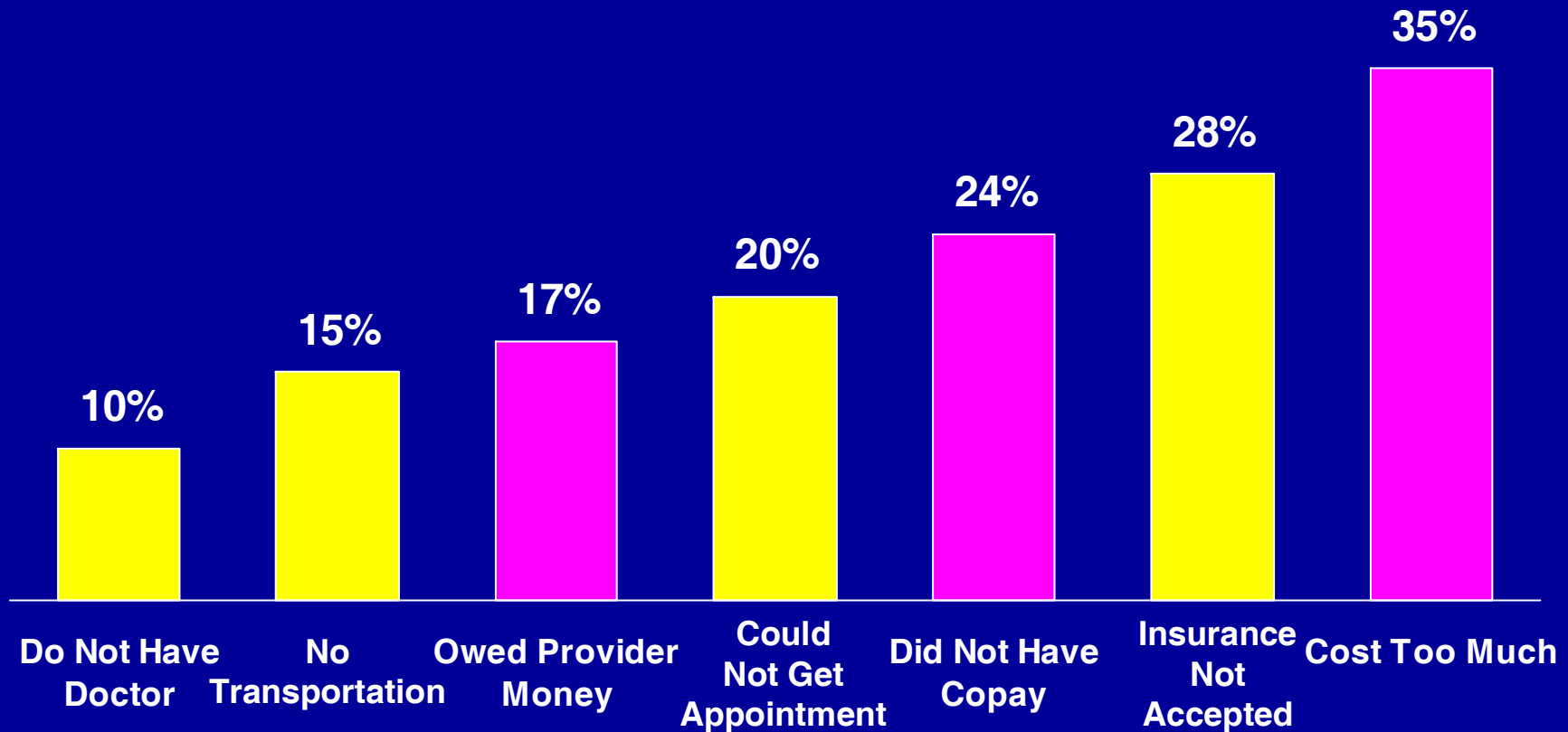
SOURCE: Data from Washington's Caseload Forecast Council website

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Figure 17

# Impact of Increased Cost Sharing in Oregon

Reasons for not obtaining care among those who reported unmet need:

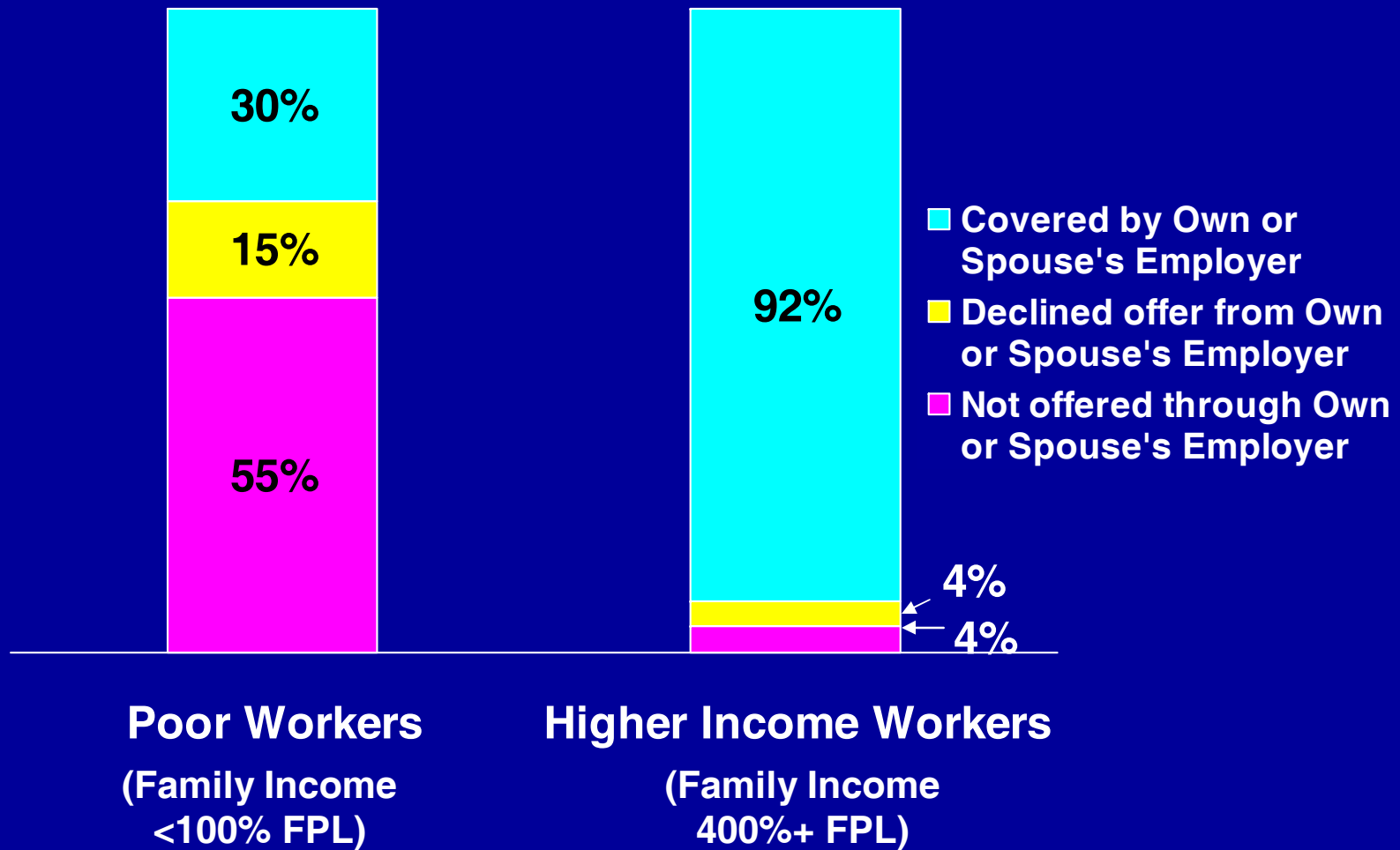


Note: Includes adults subject to benefit, premium, and cost sharing changes who were continuously enrolled for six months following the changes. Categories are not mutually exclusive; will not sum to 100%.

Source: Carlson, M. and B. Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization, in the Oregon Health Plan Standard Population," March 2005.

Figure 18

# Access to Employer-Based Coverage by Family Income, 2005



SOURCE: Garrett and Clemens-Cope, *Changes in Employer-Sponsored Health Insurance, 2001-2005*, KCMU report forthcoming.

Figure 19

# Medicaid Services Typically Not Covered Or Limited By Private Insurance for Children\*

## Services Not Covered

- EPSDT Services
- FQHC/RHC Services
- Nursing Facility Services
- Intermediate Care Facility for Individuals with Mental Retardation
- Personal Care Services
- Case Management Services
- Home and Community-based Services

## Services with Limits

- Physical Therapy Services
- Occupational/Speech Therapy Services
- Transportation Services
- Home Health Services

\*Private insurance benefits based on Blue Cross/Blue Shield Standard PPO offered under the Federal Employees Health Benefit Program for 2001.

Figure 20

# Potential Impact of Medicaid Policy Changes on Children

- Medicaid plays an extremely important role in covering low-income children and families, many of whom have chronic conditions with multiple health needs
- New documentation requirements will lead to coverage losses
- Changes in cost sharing and benefits could create barriers to care and increase unmet health needs
- “Tailoring” of benefits introduces complexity that could make access to needed care more difficult