HPAM 7660 Case Study: Reforming the Medicaid Program

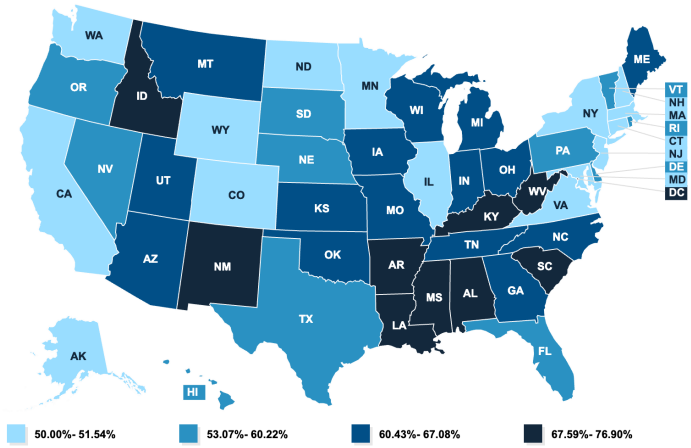
Background[1]

Medicaid is the nation's public health insurance program for people with low income. The Medicaid program covers 1 in 5 Americans, including many with complex and costly needs for care. Additionally, the program is the principal source of long-term care coverage for Americans.

The vast majority of Medicaid enrollees lack access to other affordable health insurance. Medicaid covers a broad array of health services and limits enrollee out-of-pocket costs. Medicaid finances nearly a fifth of all personal health care spending in the U.S., providing significant financing for hospitals, community health centers, physicians, nursing homes, and jobs in the health care sector. Title XIX of the Social Security Act and a large body of federal regulations govern the program, defining federal Medicaid requirements and state options and authorities. The Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) is responsible for implementing Medicaid.

Federal-State Partnership
Subject to federal standards, states administer Medicaid programs and have flexibility to determine covered populations, covered services, health care delivery models, and methods for paying physicians and hospitals. States can also obtain Section 1115 waivers to test and implement approaches that differ from what is required by federal statute but that the Secretary of HHS determines advance program objectives. Because of this flexibility, there is significant variation across state Medicaid programs. The Medicaid entitlement is based on two guarantees: first, all Americans who meet Medicaid eligibility requirements are guaranteed coverage, and second, states are guaranteed federal matching dollars without a cap for qualified services provided to eligible enrollees. The match rate, called the Federal Medical Assistance Percentage (FMAP), is determined by a formula in the law that provides a federal match of at least 50% and provides a higher federal match rate for states with lower per-capita incomes (see Figure 1).

Figure 1: FY 2025 FMAP Rates by State



Source: KFF estimates of increased FY 2025 FMAPs and the multiplier based on Federal Register, November 21, 2023 (Vol 88, No. 223), pp 81090-81093.

[1] Excerpted from Rudowitz et al. (2019) "10 Things to Know about Medicaid: Setting the Facts Straight".

Coverage and Coverage Expansions

Under the original 1965 Medicaid law, Medicaid eligibility was tied to cash assistance (either Aid to Families with Dependent Children (AFDC) or federal Supplemental Security Income (SSI) starting in 1972) for parents, children and the poor aged, blind and people with disabilities. States could opt to provide coverage at income levels above cash assistance. Over time, Congress expanded federal minimum requirements and provided new coverage options for states especially for children, pregnant women, and people with disabilities. Congress also required Medicaid to help pay for premiums and cost-sharing for low-income Medicare beneficiaries and allowed states to offer an option to "buy-in" to Medicaid for working individuals with disabilities. Other coverage milestones included severing the link between Medicaid eligibility and welfare in 1996 and enacting the Children's Health Insurance Program (CHIP) in 1997 to cover low-income children above the cut-off for Medicaid with an enhanced federal match rate. Following these policy changes, for the first time states conducted outreach campaigns and simplified enrollment procedures to enroll eligible children in both Medicaid and CHIP. Expansions in Medicaid coverage of children marked the beginning of later reforms that recast Medicaid as an income-based health coverage program.

In 2010, as part of a broader health coverage initiative, the Affordable Care Act (ACA) expanded Medicaid to nonelderly adults with income up to 138% FPL with enhanced federal matching funds (100% FMAP rate for the first three years and 90% FMAP rate thereafter for the Medicaid expansion population). Prior to the ACA, individuals had to be categorically eligible and meet income standards to qualify for Medicaid leaving most low-income adults without coverage options as income eligibility for parents was well below the federal poverty level in most states and federal law excluded adults without dependent children from the program no matter how poor. The ACA changes effectively eliminated categorical eligibility and allowed adults without dependent children to be covered; however, as a result of a 2012 Supreme Court ruling, the ACA Medicaid expansion is effectively optional for states. Under the ACA, all states were required to modernize and streamline Medicaid eligibility and enrollment processes. Expansions of Medicaid have resulted in historic reductions in the share of children without coverage and, in the states adopting the ACA Medicaid expansion, sharp declines in the share of adults without coverage.

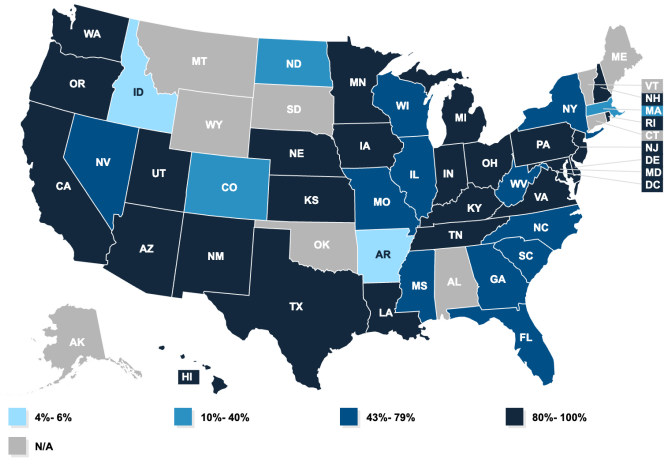
Medicaid covers a broad range of services to address the diverse needs of the populations it serves. In addition to covering the services required by federal Medicaid law, many states elect to cover optional services such as prescription drugs, physical therapy, eyeglasses, and dental care. Coverage for Medicaid expansion adults contains the ACA's ten "essential health benefits" which include preventive services and expanded mental health and substance use treatment services. Medicaid plays an important role in addressing the opioid epidemic and more broadly in connecting Medicaid beneficiaries to behavioral health services. Medicaid provides comprehensive benefits for children, known as Early Periodic Screening Diagnosis and Treatment (EPSDT) services. EPSDT is especially important for children with disabilities because private insurance is often inadequate to meet their needs. Unlike commercial health insurance and Medicare, Medicaid also covers long-term care including both nursing home care and many home and community-based long-term services and supports. More than half of all Medicaid spending for long-term care is now for services provided in the home or community that enable seniors and people with disabilities to live independently rather than in institutions.

Given that Medicaid and CHIP enrollees have limited ability to pay out-of-pocket costs due to their modest incomes, federal rules prohibit states from charging premiums in Medicaid for beneficiaries with income less than 150% FPL, prohibit or limit cost sharing for some populations and services, and limit total out-of-pocket costs to no more than 5% of family income. Some states have obtained waivers to charge higher premiums and cost sharing than allowed under federal

rules. Many of these waivers target expansion adults but some also apply to other groups eligible through traditional eligibility pathways.

Managed Care
Over two-thirds of Medicaid beneficiaries are enrolled in private managed care plans that contract with states to provide comprehensive services, and others receive their care in the fee-for-service system (see Figure 2). Managed care plans are responsible for ensuring access to Medicaid services through their networks of providers and are at financial risk for their costs. In the past, states limited managed care to children and families, but they are increasingly expanding managed care to individuals with complex needs. Close to half the states now cover long-term services and supports through risk-based managed care arrangements. Most states are engaged in a variety of delivery system and payment reforms to control costs and improve quality including implementation of patient-centered medical homes, better integration of physical and behavioral health care, and development of "value-based purchasing" approaches that tie Medicaid provider payments to health outcomes and other performance metrics.

Figure 2: Total Medicaid Managed Care Enrollment, 2022



Source: KFF analysis of the Centers for Medicare and Medicaid Services' 2022 Medicaid Managed Care Enrollment Report, 2024.

Medicaid Spending
Seniors and people with disabilities make up 1 in 4 Medicaid beneficiaries but account for almost two-thirds of Medicaid spending, reflecting high per enrollee costs for both acute and long-term care. Medicaid is the primary payer for institutional and community-based long-term services and support – as there is limited coverage under Medicare and few affordable options in the private insurance market. Over half of Medicaid spending is attributable to the highest-cost five percent of enrollees. However, on a per-enrollee basis, Medicaid is low-cost compared to private insurance, largely due to lower Medicaid payment rates for providers. Medicaid spending per enrollee has also been growing more slowly than private insurance premiums and other health spending benchmarks.

The 2024 Elections and Health Policy[2]

Following the November 5, 2024 election, Republicans retained control of the House of Representatives (219 to 215) and gained control of the Senate (53 to 47). Given the narrow

Republican margins in the House and Senate, critical health policy issues will face a sharply divided Congress, which is likely to hinder their resolution.

Reflecting the attitudes of their own parties' voters, Republican and Democratic members of the U.S. Senate and House differ not only in terms of support for specific policies, but also in underlying values. For instance, in a November 2024 poll of the general public, 90% of Democrats said it is the responsibility of the federal government to make sure all Americans have health care coverage, as compared with only 32% of Republicans. Likewise, approval of the ACA varies widely among the general public by political party, with 94% of Democrats approving compared to only 19% of Republicans.

Given the importance of inflation as an issue for voters in the 2024 elections and their general resistance to enhanced safety-net spending, Republicans in Congress are likely to oppose any major expansion in domestic expenditures. Most Republicans believe the major domestic spending bills signed into law under the Biden administration have been inflationary and have ballooned the deficit, while most Democrats disagree and point to high levels of domestic spending under the previous Trump administration.

Although Republicans in Congress are likely to make substantial efforts to reduce government spending, major changes in Medicare from the perspective of beneficiaries are unlikely because of the program's popularity. In a 2019 poll, 83% of Republicans and 84% of Democrats expressed a favorable opinion of Medicare. Notably, this newfound hesitancy on the part of Republicans to propose cuts to Medicare does not extend to the Medicaid program. On February 1, 2025, House Republicans passed a Budget Resolution that called for the Energy and Commerce Committee, which has jurisdiction over the Medicaid program, to cut spending by $880 billion over the next ten years. And while the Budget Resolution did not explicitly mention Medicaid, the Energy and Commerce Committee has few other viable alternatives to meet their spending reduction target. The goal for Congressional Republicans would be to pass these spending cuts through a process known as budget reconciliation in order to avoid facing a filibuster in the Senate.

We do not yet know the exact cuts facing the Medicaid program, but the House Budget Committee has circulated a preliminary list of targeted changes to Medicaid that would result in approximately $2 trillion in savings over the next 10 years.

Scenario to Consider

Your task is as follows: Suppose you and your team are health policy analysts for Representative Brett Guthrie from Kentucky, the chair of the House of Representatives Energy and Commerce Committee, which has jurisdiction over the Medicaid program. Your task is to present a package of reforms to the chair that would meaningfully lower federal spending on Medicaid. The legislative plan you propose should be developed considering positioning vis-à-vis various stakeholders, including demands of the House Freedom Caucus and the growing influence of hardline right-wing thought-leaders, and the public, which generally has a favorable view of the Medicaid program. You should also consider the eventual give and take of the legislative process including political practicalities, like the need for some degree of bipartisan support, and potential obstacles to your approach. Your proposed reforms **DO NOT** need to generate the full $880 billion in spending cuts to Medicaid. However, a plan that only nominally reduces Medicaid spending will not be embraced by House Republicans.

Resources that might be helpful:

- CBO Options for Reducing the Deficit: 2025 to 2034

- KFF Strategies to Reduce Medicaid Spending: Findings from a Literature Review
- KFF Summary of the American Health Care Act