**New Directions in Health Care: The Commonwealth Fund Podcast**

**Medicaid's Latest Successes and Challenges**

This is New Directions in Health Care, the Commonwealth Fund's podcast, and today we offer an update on Medicaid—how the program has changed under the Affordable Care Act and what reforms we may see in the months and years to come.

When signed into law in 2010, the Affordable Care Act directed states to expand their Medicaid programs to include people who earned up to 138 percent of the poverty level—now $16,000 for an individual and $33,000 for a family of four. People making more than that but less than 400 percent of the poverty level could qualify for federal subsidies to buy private insurance policies through the marketplaces.

Then in 2012, the Supreme Court ruled that states did not have to expand Medicaid, and Sara Collins, Vice President for Health Care Coverage and Access at The Commonwealth Fund, says that created a problem. In the 22 states that have so far not expanded Medicaid, nearly four million people have fallen into a coverage gap.

"Their incomes aren't high enough to apply for subsidies through the marketplaces, and they're too high to qualify for their state's existing Medicaid program, which in most states includes only children and very low income parents."

That's unfortunate, because The Commonwealth Fund Affordable Care Act Tracking Survey and Biennial Health Insurance Surveys suggest the new law is working well for people with both Medicaid and marketplace coverage.

"We found that 68 percent of people enrolled in either Medicaid or marketplace plans had used their plans to visit a doctor or a hospital or fill a prescription, and of those who got care, 78 percent of those who were newly enrolled in Medicaid and about half of those with marketplace plans said they would not have been able to access or afford this care prior to getting their new health insurance."

What's more, most people who now have Medicaid are happy with their care. Again, The Commonwealth Fund's Sara Collins.

"Adults with Medicaid coverage in our survey were just as likely as those with private insurance to have a regular doctor and to be able to get same or next day appointments when they were sick. Enrollees in Medicaid plans were just as likely to rate the quality of the health care they receive as excellent or very good as those adults who were enrolled in plans through their employer or plans they purchased in the individual insurance market. And we also found that adults who had Medicaid coverage appeared to be better protected from out-of-pocket health care costs than privately insured adults. For example, Medicaid enrollees were significantly less likely to tell us, compared to privately insured adults, that they'd experienced difficulty paying their medical bills or paying off medical debt over time."

What's more, adults with Medicaid were less likely than people without health insurance to skip doctor visits or medical tests when they were sick, or to forego treatment and follow-up visits because of cost. Still, 25 million adults remain without insurance and the failure to expand Medicaid is not the only reason. Fewer than half know they might be eligible for financial assistance to purchase a plan, and only 47 percent know the Affordable Care Act might make them eligible for Medicaid.

"People are somewhat uncertain whether they can afford their plans if they were to go into the marketplaces. There also is some uncertainty among people who are still uninsured whether or not they would be eligible for the coverage that's available to them, so I think this really does underscore a couple of major policy implications for both federal and state policymakers. Number one, it's clearly going to be important for these 22 states to go ahead and find a way to expand eligibility for Medicaid, so that people who are the poorest and the most likely to be without coverage can reap the benefits of people in their income ranges in other states are enjoying, and then the other thing that's critical will be significant outreach efforts targeted at people who are most at risk of being uninsured, so people who are younger, poorer and in racial and ethnic minorities."

There is one other way in which coverage is likely to expand to some of the four million Americans stuck in the gap between private, subsidized insurance policies and Medicaid. Since 1965, section 1115 of the Social Security Act has allowed states to apply for a waiver from the rules in order to experiment with social welfare programs—making modifications that could further their original goals. Sara Rosenbaum is Professor of Health, Law, and Policy at George Washington University.

“What we’ve seen over the past three years now is sort of this dance between the federal government and state governments to test out the limits of what the federal government will allow in the way of departures from traditional Medicaid principles. There has to be a hypothesis. There has to be an evaluation, and most importantly, it has to be a demonstration that the secretary finds furthers the objectives of the Medicaid program. So, for example, a demonstration program that would enable more people to get covered through Medicaid, even if the terms of that coverage are slightly different from what normally would be the case, might further the objectives of the program, right? Because the purpose of the program is to cover poor people. On the other hand, a demonstration that gives the coverage but also applies onerous conditions on newly eligible people, might be deemed not to further the objectives of Medicaid, because the objectives of Medicaid are to make coverage more available to people.”

Arkansas, for example, does not have its own Medicaid managed care market, so it asked the federal government if it could use Affordable Care Act money to buy private insurance for people who made too much to get Medicaid and too little to receive subsidies in the health insurance marketplace.

“Well that makes sense, because this brings a whole lot of people into the Arkansas exchange. Most of them are healthy people. The ones who are medically frail would not go into the exchange. They would stay in traditional Medicaid, and it’s had the effect of bringing hundreds of thousands of people in and helping jump start the exchange as well as giving people good, basic insurance coverage.”

Other states have proposed a work requirement for people to get Medicaid, but the Department of Health and Human Services has rejected that idea. Again, Sara

Rosenbaum, Professor of Health, Law and Policy at George Washington University.

Medicaid historically has excluded working-aged people who have some income coming in but are poor, and so a job requirement just becomes sort of an added burden of enrollment as opposed to accomplishing anything, and so HHS's position has been, 'Look, if you want to give new applicants access to purely voluntary job search programs, that's okay, but we are not going to allow a work condition, because it's not necessary, and it doesn't further the objectives of the program. These people are already in working families overwhelmingly."

The Secretary of Health and Human Services has, however, allowed several states to charge premiums for Medicaid coverage or to require an upfront fee, and Indiana has taken things one step further.

"It was sort of understood that those payments would be collected, but if they didn't get paid, they didn't get paid. Indiana got permission to actually lock people out of Medicaid if they're over the poverty level for non-payment of a premium subsidy. Indiana says, 'Look, we are testing out the theory that it's good for poor people to have skin in the game,' and the Secretary went along with it."

Rosenbaum worries about that, because the concept has been tested before.

"If you impose anything over the tiniest amount on poor people, they just won't use services. Even if you look at something like a community health center – community health centers greatly reduce their fees if you're poor, but often there are still some nominal fees, and the utilization rates among the uninsured is lower, so we know that other than in dire emergencies, poor people just don't have disposable income, and they will forego necessary care."

She's also dismayed by states testing the impact of denying certain traditional Medicaid benefits.

"One state's waiver tests taking dental benefits away from 19 and 20-year-olds. Normally that's a required service for any child or adolescent under 21. What the

state hopes to prove by taking away dental benefits from 19 and 20-year-olds I'm not sure, but HHS allowed it."

She and Commonwealth Fund Vice President Sara Collins agree that the Affordable Care Act is working well so far and hope all states will move to make coverage available to more of the 25 million adults who still have no insurance.

The Affordable Care Act's coverage expansions—Medicaid and the subsidized marketplace plans—are making a major difference in people's lives by helping them access and afford the care that they need, and it will be very important that people in all states to be able to benefit from this new coverage either through Medicaid or the marketplaces.

You've been listening to New Directions in Health Care, The Commonwealth Fund's podcast. To see results from The Commonwealth Fund's latest Affordable Care Act Tracking Survey and Biennial Heath Insurance Survey, visit our website, commonwealthfund.org.