kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

August 2012

A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage

Key Findings in Brief

Effective January 2014, the ACA establishes a new minimum Medicaid eligibility level of 138% FPL for adults who were not previously eligible for the program.

- The expansion provides states four years lead time to plan for implementation and is 100% federally funded for the first three years (2014-2016) and at least 90% federally funded thereafter.
- The Supreme Court ruling maintains the Medicaid expansion for adults, but limits the Secretary's authority to enforce it.

Past experience shows that the availability of federal funds has served as an effective incentive for states to provide health coverage to meet the health and long-term care needs of their low-income residents despite state budget pressures.

- More than half of states implemented a Medicaid program within the first year federal funding became available, and nearly all states were participating in Medicaid within four years, even though participation required substantial state investment.
- Over time, states have met new federal requirements to extend Medicaid coverage and expanded beyond minimum coverage levels at the regular federal matching rate.
- States have also expanded Medicaid and CHIP coverage for children at an enhanced federal matching rate.

The ACA Medicaid expansion provides states a significantly higher share of federal funding for state dollars invested in the program than for previous Medicaid or CHIP coverage as well as lead time and federal support to prepare for the expansion.

- Implementation of the expansion will result in significant returns in federal revenues for the state's investment as well as increased coverage for low-income individuals, declines in uncompensated care costs, and improved health care access and outcomes.

Introduction

One of the key goals of the Affordable Care Act (ACA) is to significantly reduce the number of uninsured by providing a new continuum of affordable coverage options. Beginning in 2014, the ACA provides for a Medicaid expansion to 138% of the federal poverty level (FPL) ($15,415 for an individual or $26,344 for a family of three in 2012) to nearly all individuals to serve as the foundation of health coverage. This expansion will build on the 40 years of experience that states have in providing health coverage to their low-income residents through Medicaid and will improve access to health care and health outcomes for millions of currently uninsured adults. The Medicaid expansion is 100% federally funded for the first three years (2014-2016) and at least 90% federally funded thereafter.

The Supreme Court ruling on the ACA maintains the Medicaid expansion but limits the Secretary's enforcement authority for the expansion. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds. To provide greater insight into how this change in enforcement authority may impact state implementation of the Medicaid expansion, this brief provides an overview of previous state responses to available federal funding for health coverage expansions.

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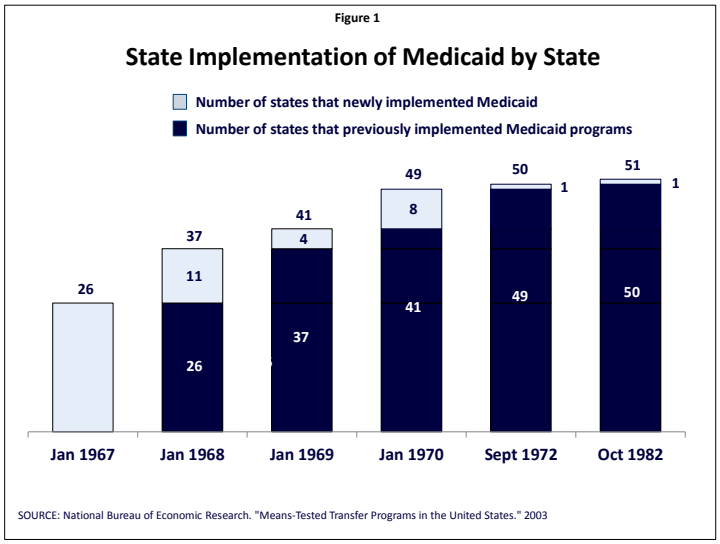
State Implementation of Medicaid

Nearly all states implemented a Medicaid program within the first four years after federal funding became available, even with a substantial state investment. Medicaid was originally enacted in July 1965 as a federal-state partnership in which voluntarily participating states receive federal funds for eligible individuals to access a defined set of medical and long-term care benefits. In exchange for receiving federal funds to match state spending, states must meet certain federal core requirements, which include covering certain groups and benefits. States also can expand coverage to additional groups and services at their option. Participating states receive federal matching payments based on a formula related to state per capita income. Federal matching funds first became available to states in January 1966, six months after the program's enactment, and ranged from 50% to 83% across states.[1] Even though participation in the program required states to establish a new program and substantial state investment, more than half of the states (26) implemented Medicaid within the first year federal funds became available, and 37 states were participating in the program within two years.[2] Nearly all states were participating within four years (as of January 1970), with the exception of Alaska, which joined in 1972, and Arizona, which implemented Medicaid through a waiver program in 1982 (Figure 1 and Appendix Table A).[3]

Figure 1



SOURCE: National Bureau of Economic Research. "Means-Tested Transfer Programs in the United States." 2003

Over time, states have met new federal requirements to extend Medicaid coverage, despite tight state budget constraints. For example, all states met new requirements established in 1972 to extend eligibility to elderly and disabled individuals that were tied to the establishment of the federal Supplemental Security Income (SSI) program (Table 1).[4] Moreover, states met subsequent requirements to expand coverage to pregnant women and children with incomes up to 100% FPL, and all but five states took up options to expand to these groups before the requirement went into place.[5] A larger number of states (32 states) had to expand their eligibility levels to meet the later requirements to extend coverage to pregnant women and children up to age six with incomes up to 133% FPL and coverage for older children up to 100% FPL. Amidst difficult budget situations, governors placed a high priority on extending coverage to low-income children. All states met the new requirements for pregnant women and children, and many extended beyond them even though additional state dollars were required to draw down federal funds for expanded coverage.[6]

Table 1:
Key Expansions in Medicaid Coverage for Non-Elderly Groups

Social Security Amendments of 1972	• Required states to extend Medicaid to Supplemental Security Income (SSI) recipients or elderly and disabled individuals meeting state 1972 eligibility criteria
Omnibus Reconciliation Act of 1986	• Provided a new option for states to cover pregnant women and children up to age 5 with incomes at or below 100% FPL
Omnibus Reconciliation Act of 1987	• Provided a new option for states to cover pregnant women and infants with incomes at or below 185% FPL • Provided a new option for states to cover children up to age 8 with incomes below 100% FPL
Medicare Catastrophic Coverage Act of 1988	• Required states to phase in coverage of pregnant women and infants with incomes up to 100% FPL
Omnibus Budget Reconciliation Act of 1989	• Required states to cover pregnant women and children up to age 6 with incomes at or below 133% FPL
Omnibus Budget Reconciliation Act of 1990	• Required states to phase in coverage of children ages 6 through 18 with incomes at or below 100% FPL
Source: Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book," July 2002, Appendix 1: Medicaid Legislative History, 1965-2000, pp. 175-177, available at: http://www.kff.org.	

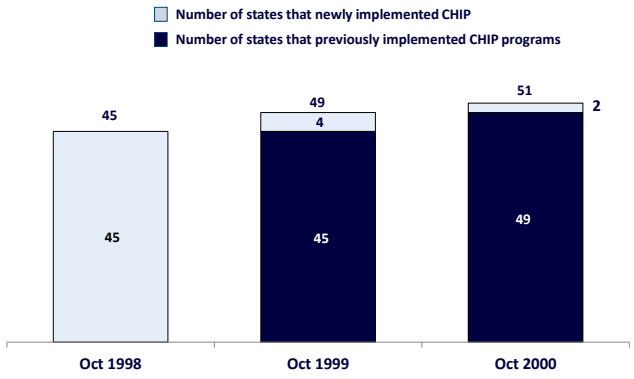
States have also expanded Medicaid beyond minimum coverage levels. For example, most states (45 states, including DC) have expanded Medicaid coverage for pregnant women beyond the federal minimum.[7] Many states also have expanded eligibility for parents but, overall, eligibility limits for parents remain low, reflecting the very low minimum coverage requirements for parents.[8] States also have utilized options to expand coverage for seniors and individuals with disabilities. As of 2010, 23 states, including DC, had increased eligibility for seniors and individuals with disabilities above the minimum Supplemental Security Income (SSI) assistance level (75% FPL); 32 states, including DC, offered medically needy coverage to individuals with high medical expenses; and 43 states allowed people in need of nursing home care to qualify with incomes up to 300% of the SSI assistance level.[9] Many states also allow working individuals with disabilities to buy into Medicaid, and some extend this option to children with disabilities with family incomes above eligibility limits.[10] Prior to the enactment of the ACA, states were not permitted to provide Medicaid coverage to non-disabled adults without dependent children unless they obtained a waiver. The ACA provided states a new option to expand early to these adults in preparation for the 2014 expansion. As of July 2012, nine states provide full Medicaid coverage to adults under a waiver or through the new early expansion option and 17 states provide more limited coverage to adults under a waiver.[11]

All states have expanded coverage for children through Medicaid and CHIP. CHIP was enacted in August 1997 to provide coverage to uninsured children in low- and moderate-income working families who earn too much to qualify for Medicaid but not enough to afford private insurance. Similar to Medicaid, under CHIP, the federal government provides federal matching funds to states for providing coverage that meets certain requirements. However, the federal government pays a greater share of costs compared to Medicaid, and, unlike Medicaid, federal funding for CHIP is subject to an overall cap. Federal CHIP funds first became available to states in October 1997, soon after the program's enactment. Most states (45) implemented the program within the first year that funding became available, and most of the earliest states to implement the program did so by expanding their Medicaid programs.[12] Nearly every state implemented a CHIP program within two years of the funding becoming available, and all states had implemented a program by early 2000 (Figure 2 and Appendix Table B).[13] Today, all states have expanded coverage for children well above minimum levels through Medicaid and

CHIP. As of January 2012, 47 states covered children with family incomes up to at least 200% FPL, with 18 states covering children with family incomes at or above 300% FPL (Figure 3).[14]

Figure 2

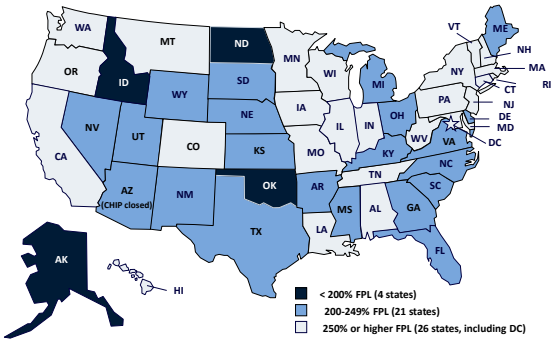
State Implementation of CHIP by Date



SOURCE: National Governors' Association and National Conference of State Legislatures. State Children's Health Insurance Program: Annual Report. 1999

Figure 3

Children's Eligibility for Medicaid/CHIP by Income, January 2012



NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment. IL is waiting for approval for federal funding of its state-funded coverage between 200% and 300% FPL.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Implications

Historically, the opportunity to access federal funds has served as an effective incentive for states to provide health coverage to meet the health and long-term care needs of their low-income residents. Although Medicaid requires state funding in return for federal matching dollars, states quickly implemented Medicaid and CHIP programs when federal funds became available and also took up options to expand beyond federal minimum requirements. While states have made different policy choices on the scope of their programs, today, Medicaid and CHIP play a key role for the low-income population, enabling them to access needed care and providing protection from high medical costs. In the absence of this coverage, millions of individuals would not have any affordable coverage available to them and would face the health and financial consequences of being uninsured.

The federal funds that flow to states have not only enabled states to expand coverage, but also play an integral role in state economies. Medicaid funding plays a substantial role in health care spending, providing a revenue stream for hospitals and other providers and helping to reduce the burden of uncompensated care costs on employers and localities. Moreover, though Medicaid requires state dollars be invested in the program, analysis suggests that federal Medicaid matching dollars have broader multiplier effects on the state economy, with positive impacts on jobs and revenues.[15] In fact, in 2009 and 2010, when several states analyzed the potential impacts of opting out of the Medicaid program, they identified far reaching and significant coverage and fiscal impacts, including significant increases in the uninsured and uncompensated care costs; revenue losses for providers and hospitals; cost shifting to private insurers in the form of higher premiums; and loss of federal revenues that support other state agencies, such as mental health departments.[16] They further noted that there are likely even broader economic impacts on jobs and businesses.

The ACA Medicaid expansion provides states a significantly higher share of federal funding than available for previous Medicaid or CHIP coverage and lead time and federal support to prepare for the expansion. Effective January 2014, the ACA establishes a new minimum Medicaid eligibility level of 138% FPL for nearly all individuals, which will provide a coverage pathway for millions of currently uninsured adults in states that implement the expansion. The ACA Medicaid expansion provides a

significantly higher share of federal funding than available for previous Medicaid and CHIP coverage, with 100% federal funding for the first three years (2014-2016) and at least 90% federally funding thereafter, and four years of lead time for states to prepare for the expansion. Moreover, significant federal support has been provided to support states' preparations through technical assistance and the availability of a 90% federal match to upgrade their Medicaid eligibility systems. State implementation of the ACA Medicaid expansion will require some state investment but will result in significant returns on federal revenues and a decline in uncompensated care costs borne by the state, localities, and employers as well as an increase in coverage for low-income adults that will result in better access to health care and improved health outcomes.

Appendix Table A:
State Medicaid Implementation Dates

State	Medicaid Implementation Date
Hawaii	Jan-66
Illinois	Jan-66
Minnesota	Jan-66
North Dakota	Jan-66
Oklahoma	Jan-66
Pennsylvania	Jan-66
California	Mar-66
New York	May-66
Connecticut	Jul-66
Idaho	Jul-66
Kentucky	Jul-66
Louisiana	Jul-66
Maine	Jul-66
Maryland	Jul-66
Nebraska	Jul-66
Ohio	Jul-66
Rhode Island	Jul-66
Utah	Jul-66
Vermont	Jul-66
Washington	Jul-66
West Virginia	Jul-66
Wisconsin	Jul-66
Massachusetts	Sep-66
Delaware	Oct-66
Michigan	Oct-66
New Mexico	Dec-66
Kansas	Jun-67
Iowa	Jul-67
Montana	Jul-67
Nevada	Jul-67
New Hampshire	Jul-67
Oregon	Jul-67
Wyoming	Jul-67
Texas	Sep-67
Georgia	Oct-67
Missouri	Oct-67
South Dakota	Oct-67
District of Columbia	Jul-68
South Carolina	Jul-68
Colorado	Jan-69
Tennessee	Jan-69
Virginia	Jul-69
Alabama	Jan-70
Arkansas	Jan-70
Florida	Jan-70
Indiana	Jan-70
Mississippi	Jan-70
New Jersey	Jan-70
North Carolina	Jan-70
Alaska	Jul-72
Arizona	Oct-82

SOURCES: United States Advisory Commission on Intergovernmental Relations. "Intergovernmental problems in Medicaid." Washington, D.C.. UNT Digital Library. September 1968. Available at: http://digital.library.unt.edu/ark:/67531/metadc1397/.
Gruber, J. "Means-Tested Transfer Programs in the United States." National Bureau of Economic Research. 2003. Robert A. Moffitt, editor. Available at: http://www.nber.org/chapters/c10254

Appendix Table B:
CHIP Implementation by State

State	State Plan Effective Date	Age Group Included in Earliest Expansion	Highest Eligibility Limit at Implementation	Eligibility Limit as of January 2012
Arizona	Oct-97	0-19	150%	200% (enrollment closed)
Connecticut	Oct-97	14-18	185%	300%
Idaho	Oct-97	0-19	160%	185%
Indiana	Oct-97	14-18	100%	250%
Massachusetts	Oct-97	0-19	200%	300%
Missouri	Oct-97	0-19	300%	300%
Rhode Island	Oct-97	0-19	250%	250%
South Carolina	Oct-97	0-18	150%	200%
Tennessee	Oct-97	0-18	100%	250%
Alabama	Nov-97	0-19	100%	300%
Oklahoma	Dec-97	0-18	185%	185%
Illinois	Jan-98	6-18	133%	200%
Ohio	Jan-98	0-19	150%	200%
New Jersey	Feb-98	0-19	133%	350%
Colorado	Apr-98	0-18	185%	250%
Florida	Apr-98	0-19	185%	200%
Montana	Apr-98	0-19	150%	250%
New York	Apr-98	0-19	185%	400%
Arkansas	May-98	0-19	100%	200%
Michigan	May-98	0-19	200%	200%
Nebraska	May-98	15-18	100%	200%
New Hampshire	May-98	0-19	300%	300%
Pennsylvania	Jun-98	0-19	200%	300%
California	Jul-98	1-19	200%	250%
Iowa	Jul-98	6-18	133%	300%
Kansas	Jul-98	0-19	200%	238%
Kentucky	Jul-98	14-19	100%	200%
Maine	Jul-98	1-19	185%	200%
Maryland	Jul-98	0-19	200%	300%
Minnesota	Jul-98	0-2	280%	275%
Mississippi	Jul-98	15-19	100%	200%
Oregon	Jul-98	0-19	170%	300%
South Dakota	Jul-98	6-19	133%	200%
Texas	Jul-98	15-19	100%	200%
West Virginia	Jul-98	1-6	150%	300%
Alaska	Aug-98	0-19	200%	175%
Utah	Aug-98	0-18	200%	200%
Georgia	Sep-98	0-18	200%	235%
Delaware	Oct-98	0-19	200%	200%
District of Columbia	Oct-98	0-19	200%	300%
Nevada	Oct-98	0-18	200%	200%
North Carolina	Oct-98	0-19	200%	200%
North Dakota	Oct-98	18	100%	160%
Vermont	Oct-98	0-18	300%	300%
Virginia	Oct-98	0-19	150%	200%
Louisiana	Nov-98	6-19	133%	250%
New Mexico	Mar-99	0-18	235%	235%
Wyoming	Apr-99	0-18	133%	200%
Wisconsin	Jul-99	15-18	185%	300%
Hawaii	Jan-00	1-6	185%	300%
Washington	Jan-00	0-19	250%	300%

SOURCE: CMS. CHIP State Plan Information.

ENDNOTES

[1] United States Advisory Commission on Intergovernmental Relations, "Intergovernmental problems in Medicaid," Washington, D.C., UNT Digital Library, September 1968, pp 15-16, available at: http://digital.library.unt.edu/ark:/67531/metadc1397/.
[2] United States Advisory Commission on Intergovernmental Relations, op cit., p. 19 and Gruber, J. , "Means-Tested Transfer Programs in the United States," National Bureau of Economic Research, 2003, Robert A. Moffitt, editor, pp. 17-20, available at: http://www.nber.org/chapters/c10254 .
[3] Ibid.
[4] States were required to extend Medicaid eligibility to SSI recipients or could elect to maintain their 1972 eligibility criteria. If they elected to maintain their 1972 criteria, they were also required to extend eligibility to individuals who spend-down to the federal SSI level There are eleven states 209(b) states that retained their state's 1972 eligibility criteria; Medicaid and CHIP Payment and Access Commission, Report to the Congress on Medicaid and CHIP, March 2011, Table 11, available at: http://www.macpac.gov/reports/.
[5] National Governors' Association, "State Coverage of Pregnant Women and Children," MCH Update, January 1991, available at http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/maternal-and-child-health-mch-up.html.
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Medicaid and CHIP Payment and Access Commission, op cit.
[10] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010, available at: http://www.kff.org/medicaid/8048.cfm.
[11] Kaiser Commission on Medicaid and Uninsured, "How will the Medicaid Expansion for Adults Impact Eligibility and Coverage," July 2012, available at: http://www.kff.org/medicaid/8338.cfm.
[12] Analysis of CHIP State Plans.
[13] Ibid.
[14] Heberlein, M., et al, "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012," Kaiser Commission on Medicaid and the Uninsured, January 2012, Table A, pg. 28, available at: http://www.kff.org/medicaid/8272.cfm.
[15] Marks, C. and R. Rudowitz, "The Role of Medicaid in State Economies: A Look at the Research," Kaiser Commission on Medicaid the Uninsured, January 2009, available at: http://www.kff.org/medicaid/7075a.cfm; Chodorow-Reich, G., et al. "Does State Fiscal Relief during Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act." *American Economic Journal: Economic Policy*, 4(3): 118–45. 2012
[16] Texas Health and Human Services Commission, "Impact on Texas if Medicaid is Eliminated," December 2010; Wyoming Department of Health, "Medicaid Opt-Out Impact Analysis," September 2010; Nevada Department of Health and Human Services and the Division of Health Care Financing and Policy, "Medicaid Opt Out, White Paper," January 22, 2010.

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.