MEDICAID & MEDICARE:

PRESCRIBED TO THRIVE

JUNE 2018

Colorado Fiscal Institute

INTRODUCTION

Health is an essential aspect of the economic well-being for our families and communities.

As renewed threats to vital social safety net programs emerge at the state and federal levels, it is more important now than ever to establish a clear and common understanding of why these programs exist, how they are funded and administered, who is eligible to enroll in them, and what the broader economic impacts of these programs are.

This brief is part of a series examining what these types of programs look like today and detailing their expansive impact. SNAP, Medicaid, Medicare, TANF, and Unemployment Insurance are often derided and debated in the context of budget cuts. Myths and misunderstandings persist about who benefits from these services and to what extent. However, at their core, they represent vital public investments that help otherwise struggling families make ends meet, help to ensure and sustain their well-being, and allow our economy to survive and provide a stabilizing effect during downturns. Without these programs in place, every downturn and every recession would have a ripple effect reaching far more families and businesses and making recoveries much more difficult.

Safety net programs exist to help families who receive services. But the safety net helps catch us all when the economy is in a free fall whether we know it or not.

MEDICAID HISTORY

Medicaid is a public health insurance program that was created in 1965 to provide health coverage to low-income individuals and families, in particular to children, pregnant women, seniors, and people with disabilities. As an alternative for people who cannot afford private health insurance, Medicaid has played a critical role in ensuring that millions of people can obtain health care coverage.

Since its creation, Medicaid has seen many iterations, the most recent of which involved expansion of the number of people who are eligible for coverage. In 2010, the Patient Protection and Affordable Care Act (most commonly referred to as the ACA or "Obamacare") was signed into law by President Barack Obama. One of the law's most prominent provisions was the expansion of Medicaid, a move aimed at decreasing the uninsured rate and expanding health care access. In 2013, SB13-200 was introduced and passed in the Colorado General Assembly, expanding Medicaid for Coloradans. Through the expansion of Medicaid, Colorado, along with 31 other states and D.C., provided health care coverage to 97 million Americans in 2015.[1]

MEDICAID FUNDING, COSTS, & ADMINISTRATION

As a joint federal and state program, Colorado Medicaid, like in other states, is paid for through the state's General Fund and through federal matching dollars. The state's Federal Medical Assistance Percentage (FMAP), or the federal matching rate, is 50 percent for traditional Medicaid and 94 percent for the Medicaid expansion. The expansion match rate will stabilize at 90 percent beginning in 2020.

In Fiscal Year 2017-2018, about 26 percent of General Fund dollars went to traditional Medicaid. Additionally, in 2009, Colorado set the Hospital Provider Fee, which allows the state to draw a dollar-for-dollar match from the federal government to help cover the costs for the Medicaid expansion and the Child Health Plan Plus (CHP+). This means the state does not have to go into its General Fund to pay for the Medicaid expansion.

The Colorado Department of Health Care Policy & Financing is responsible for overseeing and operating the Health First Colorado program (Colorado's Medicaid program) as well as the Child Health Plan Plus program.

[1] https://www.cbpp.org/research/health/policy-basics-introduction-to-medicaid

MEDICAID ELIGIBILITY

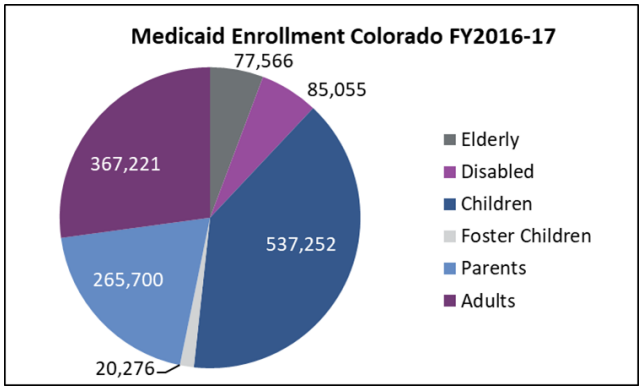
Federal law identifies population groups that states must cover and population groups that states may cover in order to receive federal Medicaid funding. Within those guidelines, each state determines which groups may be eligible for its Medicaid program. Individuals who meet the eligibility requirements have a legal right to enrollment. In Colorado, the following groups are eligible if they meet all other eligibility requirements (i.e. residency and citizenship or qualifying immigrant status):

- Children through age 18 with a household income at or below 142% of the Federal Poverty Level (FPL); for a family of four that is $2,971 per month in 2018;
- Pregnant women with a household income at or below 195% FPL, for a family of four that income is $4,079 per month in 2018;
- Parents and caretakers up to 68% FPL or $1,423 per month for a family of four
- Adults up to 133% FPL or $2,782 per month for a family of four; and
- People with disabilities and seniors (there are various Medicaid programs for these populations and income eligibility depends on the program)

In 2013, through the adoption of the Medicaid expansion, Colorado's program was expanded to adults without children and parents up to 138 percent of the FPL. Prior to 2014, only very low income parents could qualify for Medicaid. Adults without dependent children, no matter how low income, could not qualify unless they had been determined disabled by Medicaid or by the federal Social Security Administration. As a result of the Medicaid expansion passed in 2013, all adults with a household income up to 133% FPL can now qualify for Medicaid coverage.

In Fiscal Year 2016-2017, children made up the largest percentage of Medicaid enrollees at 41.2 percent, but only accounted for 18 percent of the costs, while seniors and people with disabilities only made up 12 percent of total enrollees, but accounted for 40 percent of the cost.

Undocumented immigrants are ineligible for enrollment in the Medicaid program and only have access to emergency Medicaid services. It is important to note that people with certain legal immigrant statuses can access Medicaid services if they meet all eligibility requirements. Immigrants who have their green card are barred from the program during their first five years in the United States, but this bar does not apply to pregnant women and children.



MEDICAID FUNDED SERVICES

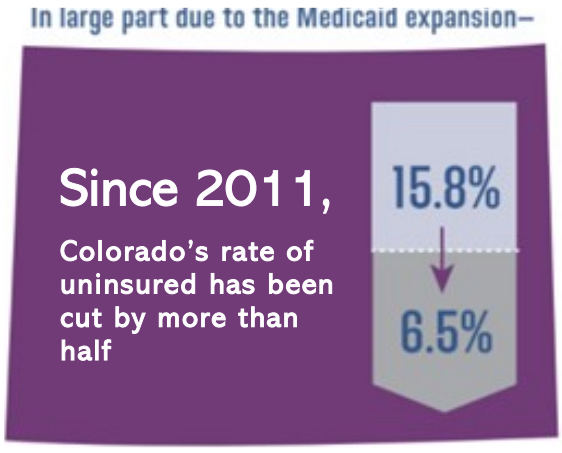
Along with mandatory populations, federal law also requires states to offer certain services including, but not limited to:

- Physician
- Midwife
- Certified nurse practitioner services
- Inpatient and outpatient hospital services
- Rural health clinic and federally qualified health center services
- Nursing facility and home health care for adults over age 21

States also have the discretion to offer additional services like dental and vision workers. However, due to the flexible nature of federal guidelines, states have the ability to set the terms for the amount, duration, and scope of the services they offer. For instance, states can limit the number of hospital stays or the number of physician visits. Nationally, about 75% of all Medicaid spending goes to pay for acute care services, such as hospital care, physician services and prescription drugs, while the remainder pays for nursing homes and long -term care.[2]

WHAT DOES MEDICAID LOOK LIKE IN COLORADO

In large part due to the Medicaid expansion in Colorado, the uninsured rate has decreased by more than 50 percent since 2011. Today, one in four Coloradans is insured through the Medicaid program and more than 500,000 Coloradans now have regular access to health care because of this expansion. Among the groups who saw the greatest benefits in Colorado were young adults, low-income people and rural Coloradans. [3]



[2] Ibid
[3] http://www.coloradofiscal.org/wp-content/uploads/2017/06/Urban-Tax-Cuts-Rural-Health-Cuts-Final.pdf

ECONOMIC IMPACT OF MEDICAID

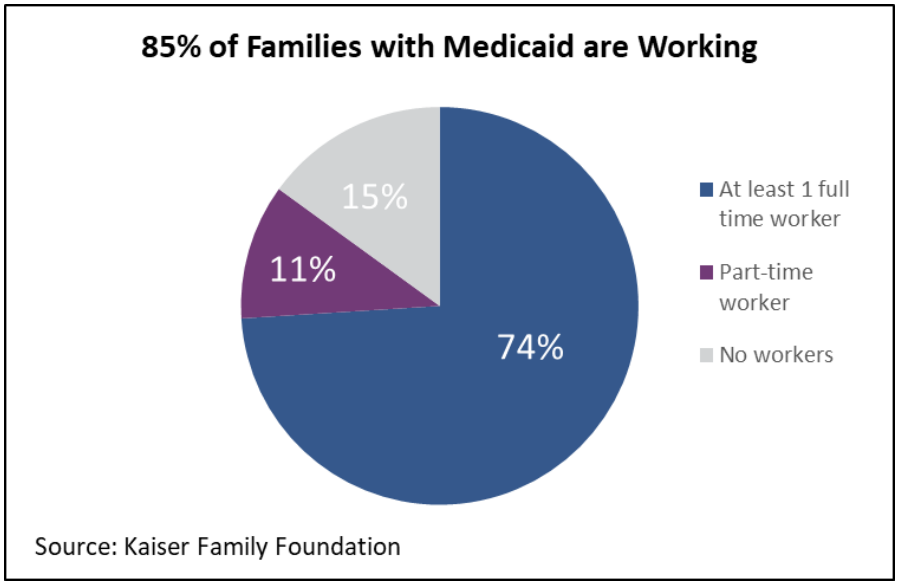
Medicaid has played a critical role in helping children, adults and the elderly to have regular access to health care and its short and long-term benefits. Positive health outcomes associated with Medicaid coverage include decreases in child and infant mortality rates, long-term health and education gains and long-term financial security. Countless studies, including a landmark study of Oregon's Medicaid program, show its effects on health outcomes, financial strain and the well-being of low-income adults. The study found that people who have health care coverage under Medicaid are more likely to use preventative care, receive diagnosis and treatment of depression and diabetes and are less likely to incur high out-of-pocket medical expenses.[4] According to the Center on Budget and Policy Priorities, adults with Medicaid have more access to health care than adults who are uninsured. In particular, they report adults on Medicaid are twice as likely to have visited a doctor in a given year and recieved a usual source of care than uninsured adults.

Investments in Medicaid also bring high returns, particularly when looking at the benefits of providing healthcare for children. A 2015 report [5] by Georgetown University's Health Policy Institute summarized the research that exists showing the long-term benefits to children as well as to the economy when they have access to healthcare coverage. The research shows that kids who are covered through Medicaid have better health outcomes, greater academic achievement and greater economic success as adults. For instance, kids who are eligible for Medicaid are also more likely to finish high school, graduate from college and pay more taxes. They also exhibit lower rates of death by treatable diseases as well as lower blood pressure rates as adults. In Colorado, two in five children are currently covered through Medicaid. However, an estimated 52,000 Colorado kids - 4.2 percent - are still uninsured.[6]

Medicaid matters to Colorado's many diverse local economics. The federal government pays 50 cents for every dollar for regular Medicaid and 94 cents of every dollar for the Medicaid expansion, pumping about $5.8 billion a year into Colorado's economy. Medicaid is a major source of funding for safety-net hospitals and nursing homes, particularly in rural areas. Federal funds flowing into every part of the state spur local economic activity and create jobs.

[4] http://www.nber.org/oregon/
[5] https://ccf.georgetown.edu/2015/07/28/medicaid-provides-excellent-long-term-return-investment/
[6] https://www.aap.org/en-us/Documents/federaladvocacy_medicaidfactsheet_colorado.pdf

Individuals and families with Medicaid are also working families. Contrary to messaging around the need for Medicaid work requirements, 85 percent of adult and child Medicaid enrollees in the state are in families with a worker, and 74 percent contain a full-time worker. [7] Medicaid is a particularly important economic safety net in places where jobs are scarce and wages are lower. Colorado counties with higher unemployment rates rely more heavily on Medicaid and expanded Medicaid.



Healthcare, and access to it, is a fundamental basic need that allows children, adults and seniors to lead a healthy life. As previously stated, access to Medicaid means people are more likely to visit a doctor and children and families have long-term gains in their health and education. Further research shows that healthy individuals are more productive workers which is better for the economy. Investments in Medicaid also lead to savings down the road when compared to the economic loss incurred when employees miss work days due to illnesses.[8] When we invest in healthcare it means we are prioritizing the health of Coloradans around the state.

[7] http://files.kff.org/attachment/fact-sheet-medicaid-state-CO
[8] http://www.gradingstates.org/the-real-path-to-state-prosperity/healthy-workers-are-more-productive/

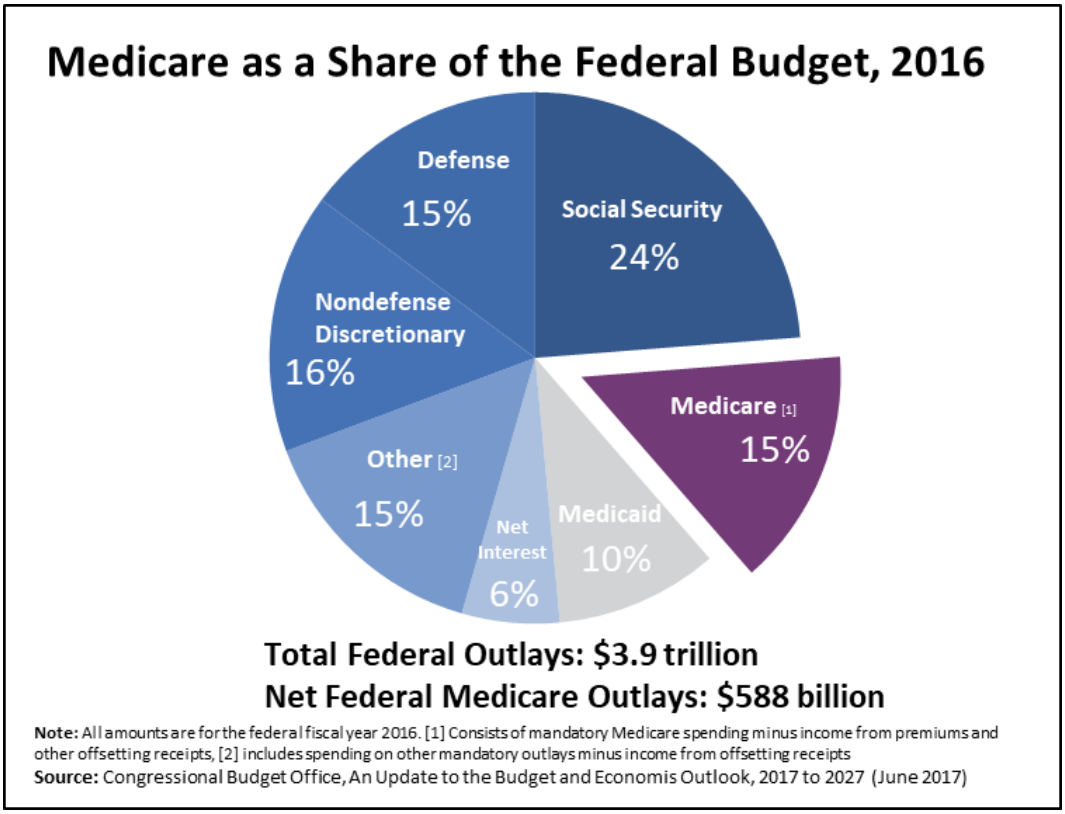
MEDICARE HISTORY

Medicare is a federal health insurance program created in 1965 for people 65 and over. In 1972, the program was expanded to cover people under the age of 65 with certain lifelong disabilities.[9] Medicare helps offset certain health care costs, but it does not cover all medical expenses, nor does it cover the costs of long-term care.

MEDICARE FUNDING, COSTS, & ADMINISTRATION

Medicare is federally administered through the Centers for Medicare & Medicaid Services (CMS). Funding for the program comes from taxes levied on employees and employers. The Federal Insurance Contributions Act, commonly known as FICA, includes two taxes that are withheld from employees' paychecks, while employers pay them in addition to any other taxes they owe. The first is a 12.4 percent Social Security Tax that is evenly split between employers and employees and the second is a 2.9 percent Medicare tax, also evenly split between employers and employees. Revenue collected from taxes levied on employees' wages, employers, and self-employment income are all used to fund Medicare expenses. [10]

In fiscal year 2016, Medicare spending accounted for 15 percent of total federal spending, with most funds going to pay for Medicare Advantage, hospital care, and prescription drugs.[11]



[9] https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/
[10] https://www.cbpp.org/research/federal-tax/policy-basics-federal-payroll-taxes?fa=view&id=3853
[11] *Ibid*

MEDICARE ELIGIBILITY

Like Medicaid, by law, individuals who qualify for Medicare are guaranteed enrollment. However, unlike Medicaid, individuals who are 65 and older are eligible to receive Medicare coverage regardless of income, medical history, or health issues. People under the age of 65 qualify for coverage if they are receiving Social Security Disability Insurance (SSDI) and have been receiving these benefits for more than twenty-four months. Finally, individuals under the age of 65 who have been diagnosed with End-Stage Renal Disease, commonly known as kidney failure, are also eligible to receive Medicare coverage.[12] Additionally, low-income people over age 65 can qualify for both Medicaid and Medicare benefits to help offset financial hardship associated with health care costs; these individuals are considered "dual-eligible."

Again, it is important to note that eligibility requirements for non-U.S. citizens is restricted. Individuals who are not U.S. citizens can qualify for Medicare if they are eligible to receive Social Security, Railroad Retirement, or disability benefits. However, if someone does not qualify for these benefits they must have permanent legal status and have lived in the U.S. for 5 continuous years before they can qualify for Medicare coverage.[13] Undocumented immigrants do not qualify for Medicare benefits.

MEDICARE FUNDED SERVICES

- Medicare can be divided into two programs, Original Medicare and Medicare Advantage Plan. Original Medicare consists of Parts A and B, while Medicare Part C refers to the Medicare Advantage plans. Medicare Part D refers to Medicare drug coverage. Each plan covers specific health care needs and they vary in their eligibility requirements.

- Medicare Part A, also referred to as hospital insurance, is available to adults 65 and older, people with disabilities, and people with End-Stage Renal Disease (ESRD). Services covered under Part A include: inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care. It is free for people if they or their spouse are eligible to receive social security or railroad retirement benefits, if they or their spouse worked in a government job and paid Medicare taxes, or they are dependent parents of a fully insured deceased child.[14] If requirements are not met for free coverage of Part A, coverage can be purchased and paid via a monthly premium charge.

[12] https://www.medicareinteractive.org/get-answers/introduction-to-medicare/medicare-eligibility/am-i-eligible-for-medicare-if-i-am-under-65
[13] *Ibid*
[14] https://www.ssa.gov/pubs/EN-05-10043.pdf

- Medicare Part B is free for individuals who are eligible for Part A at no extra cost. Services covered under Part B include physician visits, outpatient services, preventative services, and some home health visits. On the other hand, individuals who have to pay for Part A coverage also have to purchase Part B coverage and must be 65 years or older, be a U.S. resident, and a U.S. citizen or lawful permanent resident.[15]

- Medicare Part C refers to the Medicare Advantage plan. Unlike Part A and Part B coverage, which are benefits that come from the government, Part C is private health insurance that is administered by a Medicare Advantage company. Beneficiaries of Medicare Part C are entitled to all covered services in Part A and B as well as Medicare coordinated-care plans and Medicare specialty plans, among others. Medicare Part A and B beneficiaries may join a Medicare Advantage plan at an extra monthly premium cost.

- Finally, Medicare Part D covers outpatient prescription drugs. People who qualify for Medicare Part A and B are also eligible for Part D coverage. Medicare recipients can choose whether to enroll in Part D coverage and they must pay a monthly premium if they do.

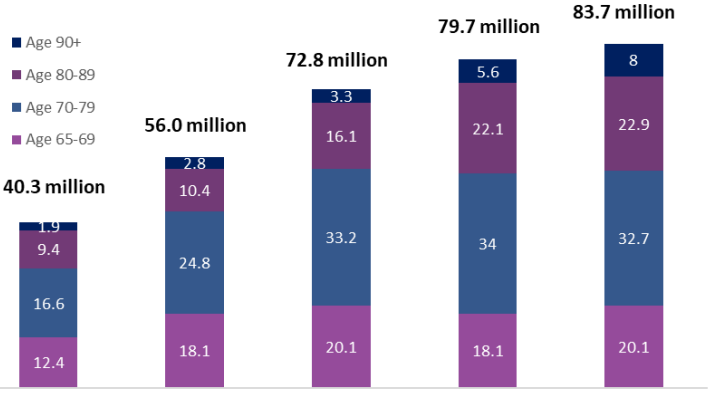
[15] *Ibid*

ECONOMIC IMPACT OF MEDICARE

Medicare plays an important role in providing health insurance for older adults and people with disabilities. Today, the program supports 57 million beneficiaries with their health care costs. Nonetheless, with the growing population 65 and older in Colorado and nationally, Medicare spending also continues to grow. According to the Kaiser Family Foundation, Medicare per capita spending rises with age, and with the number of adults ages 80 and older nearly tripling in the coming years, total and per capita Medicare spending will see tremendous demand.[16]

The aging of the population and rising health care costs are contributing to the growth in Medicare spending over time.

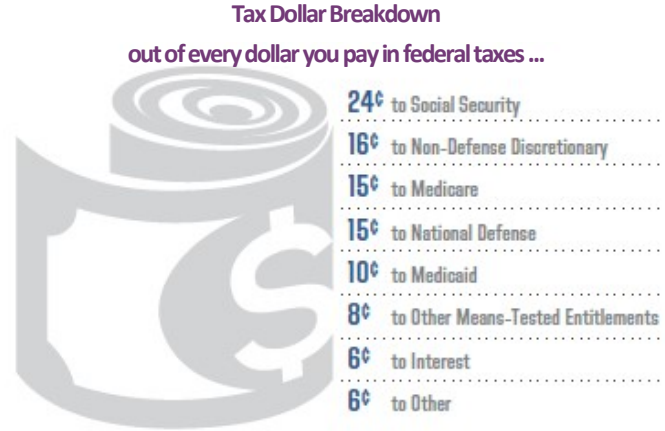
U.S. population ages 65 and older, 2010-2050



Source: Kaiser Family Foundation

Colorado's aging population is expected to grow 120 percent between 2010 and 2030 as reported by the State Demographer's Office. Between 2010 and 2015, Colorado had the third-fastest growing population over age 65. The state was home to 785,389 Medicare beneficiaries in 2015, 87 percent of whom were 65 and older.[17] This growth will continue to place pressure on federal health care programs as well as Medicare beneficiaries who spend a substantial portion of their income on health care costs. A 2018 report found that health care related expenses accounted for 14 percent of a Medicare household's spending in 2016, more than double the average spending of a non-Medicare household.[18] The costs further increase with age as long-term healthcare needs also increase. Colorado had the eighth highest average annual percentage growth in Medicare spending between 1991-2014.

Healthcare costs are especially burdensome for people with low incomes and people with poor health conditions. Today, a number of older adults are spending most of their Social Security income on health related expenses. The average Social Security income for all Medicare beneficiaries in 2013 was $13,375 (in 2016 dollars) and out of pocket costs consumed 41 percent of this per capita income as recently reported by Kaiser. Additionally, out of pocket costs are expected to absorb half of Social Security income by 2030. These distressing figures are a clear indication that any future changes to health care policy and Social Security must consider the expanding senior population and their growing heath needs and the costs associated with this growth.



[16] https://www.kff.org/medicare/issue-brief/10-essential-facts-about-medicares-financial-outlook/
[17] https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22colorado%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[18] https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care-spending-larger-for-medicare-households-than-for-non-medicare-households/

The Colorado Fiscal Institute provides credible, independent and accessible information and analysis of fiscal and economic issues facing Colorado. We work for a Colorado where responsible fiscal and budget policies advance equity and widespread economic prosperity.

Contact us 720.379.3019 or visit www.coloradofiscal.org. Our offices are located at 1905 Sherman St., Suite 225, Denver, CO, 80203.