The Uncertain Future of Medicaid and CHIP: Implications for Oral Health

Webinar by Children’s Dental Health Project with special guest, Genevieve Kenney, Co-Director of the Health Policy Center at the Urban Institute

March 9, 2017
Uncertain Future of Medicaid and CHIP: Implications for Oral Health

Genevieve M. Kenney
Health Policy Center
March 9, 2017
Brief Background on Medicaid

Medicaid was created in 1965 to provide health insurance coverage to families with dependent children receiving cash assistance and to cover the blind, the disabled, and the aged.

- Means tested with categorical eligibility
- Joint state-federal program
  - States work within federal guidelines to set eligibility, benefits etc.
  - Federal matching rates vary across states, over time, and across groups
  - Historically substantial variation across states in terms of eligibility, benefits, service delivery, spending per enrollee...
  - Well over 60 million nonelderly adults and children rely on Medicaid for coverage
Medicaid and CHIP for Children

- Medicaid expansions for children in the 1980s and The Children’s Health Insurance Program, added in 1997
  - designed to reduce uninsurance among poor and other low/moderate income children without affordable health insurance options
  - CHIP was reauthorized in 2009 and has received federal funding extensions in 2010 and in 2015

- Medicaid provides comprehensive benefit package, including oral health benefits for children with little or no premiums or cost sharing;

- States have more flexibility over the design of their CHIP program, but CHIP plans tend to have actuarial values close to Medicaid
Medicaid and CHIP for Children

• In 2013, Medicaid and CHIP covered 38.7 and 8.1 million children, respectively over the course of the year
  • Together, Medicaid and CHIP cover over one third of all children and over 50 percent of children who are disabled, Black Non-Hispanic, Hispanic, or in poor households

• States receive standard /enhanced match rate for covering children in Medicaid/CHIP

• The ACA included a Maintenance of Eligibility requirement thru FY 2019

• Medicaid is structured as an entitlement, but many states have chosen to cover children with incomes above the federal mandatory minimums;

• CHIP is funded as a block grant but with generous federal funds that have not been constrained to date
Income Eligibility Levels for Children in Medicaid/CHIP by State

Source: July 2016 MACStats

138% up to 200% FPL (2 states)
200% up to 250% FPL (23 states)
250% up to 300% FPL (8 states)
≥ 300% FPL (17 states)
Uninsurance Rates For Children And Nonelderly Adults, By Income, Selected Years 1984–2012

SOURCE Authors’ analysis of data from the 1984, 1989, 1992, 1996, 2000, 2004, 2008, and 2012 National Health Interview Surveys, taken from Integrated Health Interview Series. NOTES Marked data points represent the data from specific survey years; linear interpolation was used between those data points to produce the trend line. Nonelderly adults are ages 18–64; children are ages 0–17. “Poor” children and adults live in households whose incomes are less than 100 percent of poverty. “Nonpoor” children and adults live in households whose incomes are 100 percent or more of poverty.
Private And Public Coverage For Children And Nonelderly Adults, Selected Years 1980–2012

Private coverage, nonelderly adults

Private coverage, children

Public coverage, children

Public coverage, nonelderly adults

**Source** Authors' analysis of data from the 1980, 1984, 1989, 1992, 1996, 2000, 2004, 2008, and 2012 National Health Interview Surveys, taken from Integrated Health Interview Series. **Notes** Marked data points represent the data from specific survey years; linear interpolation was used between those data points to produce the trend line. Nonelderly adults are ages 18–64; children are ages 0–17. Insurance coverage is reported using the following hierarchy, so that a respondent with multiple coverage types is assigned the type that is listed first: private (including military care), public (Medicaid, Children's Health Insurance Program [CHIP], Medicare, a state-sponsored plan, or another public program), other coverage or unspecified, and uninsured.
Access to Care for Children Covered by Medicaid/CHIP

Source: Preliminary Urban Institute tabulation of 2000 and 2014 National Health Interview Surveys (NHIS)

Notes: Children defined as 0-17. Health insurance coverage is defined at the time of survey. Medicaid/CHIP is any reported Medicaid or CHIP coverage. Any unmet need includes medical care, dental care, mental health care, prescription drugs and eyeglasses. * and *** signify that point estimate for 2014 is different from 2000 at the p < 0.10 and p < .01 level, respectively.
Long Term effects of Medicaid and CHIP Expansions

• Expanded childhood/prenatal Medicaid/CHIP eligibility improves health in adulthood
  • Reduces hospitalizations and ED use
  • Lowers incidence of hypertension, obesity, and oral health problems in early adulthood

• Expanded childhood/prenatal Medicaid eligibility improves education and economic outcomes in adulthood:
  • Improves reading test scores later in childhood
  • Increases high school/college completion
  • Increases earnings in adulthood
  • Increases intergenerational mobility
  • Decreases reliance on public assistance in adulthood
ACA Medicaid Expansion for Non-Elderly Adults

- Supreme Court Decision of June 2012 made Medicaid expansion an option for states

- As of October 2016, AK, AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, IN, KY, LA MD, MA, MI, MN, MT, NH, NV, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV have implemented the expansion

- Pre ACA Median Medicaid Eligibility Thresholds (Comprehensive Benefits)

  - Pregnant Women: 185% of FPL
  - Working and non-working Parents: at 64% and 38 %FPL, respectively
  - Childless Adults: 0% of FPL
  - Children: 255 percent of the FPL
Medicaid Eligibility for Adults under the ACA

- Intended to introduce a uniform Medicaid floor of at least 138 percent FPL for adults beginning Jan 2014

- States could expand Medicaid in advance of that date (CA, CT, DC, MN, NJ, and WA took that option)

- 100 percent federal matching funds available for newly eligible adults for three years; 95 match percent in 2017 shifting to 90 percent in 2020 (compared to matching rates of between 50 and 75 percent—for higher income and lower income states, respectively) for other adults covered in Medicaid

- Dental is not an Essential Health Benefit and is optional in Medicaid for adults
Medicaid Dental Benefits for Non-Pregnant, Non-Disabled Adults, 2015

Source: MACPAC June 2015 Report
States Can Leverage Federal Funds for the Medicaid Expansion Population under the ACA

- **State Funds**
- **Federal Funds**

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<td>$2,000</td>
<td>$1,900</td>
<td>$1,872</td>
<td>$1,849</td>
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The American Health Care Act

Fundamental Changes to Medicaid

- Moves Medicaid from its federal/state matching structure to per capita caps in 2020 which limit federal spending on a per enrollee basis
  - Five Separate Groups: Blind/Disabled, elderly, children, non expansion adults, expansion adults
    - Locks in substantial state variation in per enrollee Medicaid spending
    - New federal funding limited to growth in medical care component of the consumer price index
    - FY 2016 is base year trended forward using medical CPI
- Eliminates enhanced match for “new/returning” expansion enrollees in 2020
- Loss of Medicaid Eligibility for so-called Stair-step kids
Other Potential Federal Policy Changes Affecting Medicaid and CHIP Eligibility for Children

• Discontinuation of CHIP (MACRA included funds for CHIP through FY 2017)
  • Changes in federal matching rate for CHIP

• Discontinuation of Medicaid MOE for children
  • MOE provision in the ACA extends through FY 2019
Number of Uninsured Children under Four Scenarios, 2019

Thousands of children

<table>
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<tr>
<th>Scenario</th>
<th>Uninsured under the ACA</th>
<th>Difference from ACA scenario</th>
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<td>ACA</td>
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<td>Reconciliation bill</td>
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<td>Reconciliation bill and no MOE</td>
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Notes: ACA = Affordable Care Act; ESI = employer-sponsored insurance; MOE = maintenance of eligibility. Children are ages 18 and younger, following Medicaid/CHIP guidelines. Medicaid/CHIP eligibility under "Reconciliation Bill and No MOE" scenario is at federal minima for all states: 138 percent of the federal poverty level for children younger than 6 and 100 percent of the federal poverty level for children ages 6 to 18. If the MOE provision is eliminated, states would decide whether to reduce eligibility levels for children.
Selected References


Report to Congress on Medicaid and CHIP. June 2015. MACPAC.

Report to Congress on Medicaid and CHIP. March 2015. MACPAC.
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Current Oral Healthcare Coverage and What’s at Stake?

Colin Reusch
Senior Policy Analyst
March 9, 2017
Medicaid and CHIP

As of December 2016, Medicaid and CHIP cover over 74 million people – that’s about 1 in 5 people in the country

Oral health at stake: Medicaid for Kids

- EPSDT dental care minimum standard: “relief of pain and infections, restoration of teeth, and maintenance of dental health”
- Generally a comprehensive package including check ups and preventive care and treatment
- Designed to respond to individual needs
- State variability in periodicity schedules, payment policies, provider types, reimbursable services, prior approval, etc.
Oral health at stake: CHIP for Kids

- Created in 1997, CHIP did not require a dental benefit until 2010 (CHIPRA 2009) – which made the benefit vulnerable to being cut in difficult budget years.
- States determine the structure and benchmarks that meet the basic benefit standards.
  - States may provide expanded Medicaid program.
  - In general, provides comprehensive coverage but does allow for dollar limits, cost-sharing & premiums.
- Limits out-of-pocket costs (medical & dental) to 5% of family income.
- The program was reauthorized in ACA until 2019, however funding ends Sept. 2017.
Oral health at stake: Medicaid for Adults

- Eligibility ranges from 13% FPL in Alabama to 150% FPL in Connecticut (parents/caregivers)
- Pregnant women eligibility ranges from 138% to 301% FPL
- ACA expansion for childless adults to 138% FPL (all but 19 states)
- **Dental coverage remains optional for all adult enrollees**
- Most states cover “emergency dental services”
  - Extractions, pain medication, etc.
- Dental reimbursement rates and programs are often some of the first programs cut during fiscal challenges¹

Oral health at stake: Major gains in coverage

Children

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<tr>
<th>Year</th>
<th>Private</th>
<th>Public</th>
<th>Public (with dental benefits)</th>
<th>Public (without dental benefits)</th>
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<td>2011</td>
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<td>2012</td>
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<td>2014</td>
<td>50.3%</td>
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Adults

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<tr>
<th>Year</th>
<th>Private</th>
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<th>Public (with dental benefits)</th>
<th>Public (without dental benefits)</th>
<th>Uninsured</th>
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<td>2008</td>
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<td>2014</td>
<td>58.1%</td>
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Source: American Dental Association Health Policy Institute analysis of MEPS data.
Oral health at stake: Marketplace coverage

- ACA established pediatric dental as Essential Health Benefit
- Required health plans to cover certain preventive oral health services at no cost
- Premium tax credits up to 400% FPL
- Out-of-pocket limits & cost-sharing reductions
- Further integration of dental into health insurance
- Bonus: more than 1 million adults purchased dental plans on marketplaces
The American Health Care Act (House Bill)

- Keeps aspects of ACA (for now)
  - Essential Health Benefits (outline what insurance should cover)
  - Discrimination protections
  - Protects those with pre-existing conditions
  - Parents insurance for children up to age 26

- Changes insurance markets
  - Removes individual mandate to purchase coverage – but other policies also deter younger and healthier individuals from getting insurance:
    - Tax credits based solely on age - likely to hurt poorer individuals
    - Pricing protections changed – companies can charge older populations more
    - “Continuous coverage” clause
      - individuals who go too long without coverage are charged a penalty

- Changes to Medicaid
  - Switches Medicaid to per capita caps system – cuts federal funding to states and removes certain care requirements
  - Rolls back Medicaid expansion (starting in 2020)
The American Health Care Act (House Bill)

- Hurts state Medicaid programs
  - Pushes costs to states – fewer dollars could mean less coverage and/or fewer people covered
  - Loosens benefit requirements
- Removes cost protections and reduces tax credits for private coverage
  - Could mean higher costs with less support for working class Americans
- Less incentive for young, healthy people to get insured (and stabilize the insurance market)
  - With fewer healthy people, insurance prices go up – hurting the sickest people
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The Politics, the Process, and Strategies for Effective Outreach

Libby Mullin

Children’s Dental Health Project
March 9, 2017
Current Climate in Congress

• GOP plan to repeal/repair the ACA
  – Moving at an absurd clip, using a process called “budget reconciliation” to avoid a filibuster and allows for a simple majority
    • For reference: Before passage of the ACA, there were 179 hearings, 121 witnesses and the Democrats accepted 121 amendments, 25 days of debate on the chamber floor over a 2 year period
  – The GOP plan was released on Monday (March 6), with no hearings, went straight to mark ups in Energy and Commerce and Ways and Means Committees
  – Bill is not really an ACA repeal as much of a massive gutting of Medicaid, and destabilizing of marketplace

Haberkorn, Jennifer (2017, February 27) Obamacare repeal-replace effort begins to jell. *Politico*
Current Climate in Congress (cont’d)

– Just 3 months ago, talk was of straight repeal and a replace package just a promise of a better plan on the horizon

– House committee consideration began yesterday (3/8)
  • Included hundreds of amendments, much political theater, acrimony, division
  • Passed committee this morning (March 9) at 4:15am

– Senate consideration unclear but Senate Majority Leader McConnell is committing to floor consideration during last week of March (ACA anniversary)

– Despite holding a majority in both chambers of Congress, Republicans are split on a number of the proposed changes:
  • repealing Medicaid expansion
  • per capita caps
  • allowing any subsidies

– Opposition fierce- Republicans cannot lose more than 2 Senators
Compounding the Politics

• Timing: Compressed by a 2 week April recess period which bumps up against 4/28 expiration of CR
  – Recess for “district work” scheduled for 04/10/2017 – 04/21/2017
• Debt Ceiling: (remember when that was the big story?) - 3/16 law to suspend expires, so gov’t in breach
• Nomination hearings: Supreme Court (Gorsuch) beginning 3/20, Ag and Labor Secretaries still left to confirm
• Must pass reauthorizations
  – Prescription Drug User Fee Act (authorized through Sept 2017)
  – CHIP (funding runs out in Sept 2017)
Politics of CHIP

- CHIP is currently enjoying unprecedented bipartisan lip service
  - Outspoken endorsement has not been this solid perhaps since its enactment in 1997

- Given the current climate, it will be challenging to ensure a clean extension of the program
  - During nomination hearing, Sec. Price suggested 8 year extension
  - MACPAC recommended 5 year extension in 2016

- Risk of CHIP being thrown into larger structural changes of Medicaid

Important Factions in Healthcare Debates

• Democrats:
  – Taking a hard, party-line not to lose ACA gains
  – Aggressive advocacy launched in December to generate grassroots to protect the ACA is allowing Democrats to be more unified and consistent about not just fighting repeal but about holding Americans harmless

Divisions within the GOP

• A growing number of Moderate Republicans:
  – Support substantial continuation of expanded benefits, particularly those representing states that have already expanded Medicaid
  – Called for replacement program to be included in repeal legislation

• More Conservative lawmakers
  – Support outright repeal of ACA with limited to no replacement of the current subsidies.

• Republican leadership in a very challenging position to reach middle ground and get a majority, particularly in the Senate
Medicaid changes divide Congress and States

- Capping spending at 2016 levels will harm all Medicaid beneficiaries and squeeze spending for states but some states will be more than others. States that have reigned in spending loose the most (i.e.: Florida) as their baselines will be lower.

- Changes to the Medicaid expansion statute may be the most dicey piece of the proposal, but “repeal” will not be able to pass without addressing the issue as it is cost saver.
  - 20 Republican senators represent states that expanded Medicaid eligibility vs 32 Republican senators in states that did not expand
Medicaid Expansion by State

Current Status of State Medicaid Expansion Decisions

Adopted (32 States including DC)
Not Adopting At This Time (19 States)

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
What can you do?

- Levers of Influence
  - Direct Outreach to Governors
    - Congressional leadership looking to governors to understand impact at state level
  - Direct Outreach to Congressional representatives
    - Calls/emails/letter campaigns NOW
    - Visiting offices with resources - during Congressional district work periods or during April district work period (esp. April 10 – 21)

- Attend Congressional town halls

- Sign-on Letters
  - CDHP, ADA, and a number of oral health organizations sent a letter to Congressional Leadership about oral health
  - Letter can serve as a template for a letter to Governor or Congressional delegation
  - Leverage coalitions
Messaging Best Practices

• Gratitude
  – “Thank you for your hard work and …”

• Start with an emphasis on gains and innovation
  – Under ACA Americans have more access to dental health coverage and care than ever – highlight what that looks like in your state or district
  – Emphasize that you don’t want to lose these gains but BUILD off of them

• Information
  – Many elected officials uninformed about oral health access issues (not just prevalence of problems but impact on education, military readiness, employability, etc.)
  – Resources: CDHP Fast Facts or ADA State Sheets

• Legislative Tool Kit available at cdhp.org (including links to items mentioned here and access to recording of this Webinar)