



# Comments on Your Government

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## Medicaid Expansion in Rhode Island

*This RIPEC issue brief provides an overview of the state-administered Medicaid program, including current levels of coverage and enrollment. Medicaid expansion, a provision of the Affordable Care Act (ACA), will impact Rhode Island's current scope of care and expenditure, although the magnitude of the impact is difficult to measure. The report concludes with issues to consider in preparing the state for Medicaid expansion.*

### Introduction

A primary objective of the Patient Protection and Affordable Care Act (ACA) is to expand health insurance coverage. To this end, federal law both creates a mechanism for the purchase of insurance through exchanges, providing an individual and employer mandate for the purchase or provision of health insurance, and includes the ability for states to expand Medicaid to childless adults up to 138.0 percent of the federal poverty level (FPL). Extending Medicaid to this new population will impact the way eligible individuals access health insurance, the flow of federal funding, state budgets, and the viability of health benefits exchanges.

Medicaid expansion is federally funded in full through 2016, and then the share drops to a floor of 90.0 percent by 2020 and thereafter. At the state level, some savings may be realized from transitioning certain Rhode Islanders from state-sponsored benefit programs to Medicaid. Additionally, Rhode Island's Medicaid program covers certain optional populations who could be transitioned from Medicaid to the state's health benefits exchange. Moreover, increased access to health care could generate additional economic activity in that sector, and higher numbers of insured persons could promote improved health status and worker productivity.

**Table 1**  
**2013 Federal Poverty Guidelines**

Household Size	Percent of Federal Poverty Line						
	100%	138%	150%	185%	200%	300%	400%
One	\$11,490	\$15,856	\$17,235	\$21,257	\$22,980	\$34,470	\$45,960
Two	15,510	21,404	23,265	28,694	31,020	46,530	62,040
Three	19,530	26,951	29,295	36,131	39,060	58,590	78,120
Four	23,550	32,499	35,325	43,568	47,100	70,650	94,200
Five	27,570	38,047	41,355	51,005	55,140	82,710	110,280
Six	31,590	43,594	47,385	58,442	63,180	94,770	126,360

For each additional person, add \$4,020/year for families at 100% of poverty

However, uncertainty about the number of Rhode Islanders eligible for Medicaid through the new expansion will impact out-year budgets as the state's share of financial responsibility increases. Furthermore, the outreach and promotion related to the implementation of the ACA could induce Rhode Islanders who are currently eligible, but unenrolled in Medicaid, to apply for benefits.

## Medicaid Overview

Medicaid is a health and long-term care coverage program administered by states and financed jointly by federal and state governments. There are mandatory federal parameters for eligible populations, including qualifying low-income parents, children, and pregnant women, children in foster care or receiving adoption assistance, and recipients of Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). While the federal level dictates a standard level of benefits, states can choose to augment the federal mandates with optional populations and services.

Medicaid benefits include acute care (inpatient hospital, diagnostic, outpatient, and other services; prescribed drugs, payments to Medicare; and managed care and health plans), as well as long-term care (nursing facilities, intermediate care facilities, mental health facilities, home and community care, and other personal care, e.g. hospice). In addition to these services, states may offer a number of optional services, such as eyeglasses, dental care, prosthetic limbs, speech/physical therapy and case management. Specific mandatory services under Medicaid include, but are not limited to:

- Physician/nursing services;
- Laboratory and x-ray services;
- Inpatient/outpatient hospital services;
- Selected screenings for children under 21;
- Family planning; and
- Nursing facility/home health care services for those 21 and over.<sup>1</sup>

Providers are compensated by a combination of state and federal funding. Rhode Island

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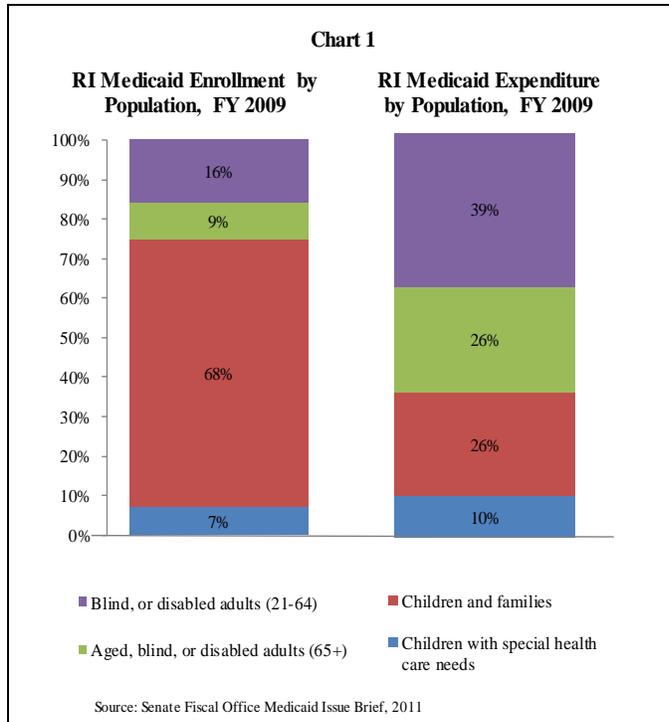
<sup>1</sup> Recipients must meet the required level of care to qualify for these services.

Medicaid services are paid through fee-for-service or contracted through managed care. Fee-for-service is the primary payment method for most long-term care services and some acute treatments wherein the providers bill the state Medicaid program directly for services rendered. Managed care caters to most children and families and adults with disabilities. Under this arrangement, a contracted health insurer (Neighborhood Health Plan of Rhode Island or United Healthcare of New England) is paid a monthly fee for each beneficiary. More than three-quarters of all Rhode Island Medicaid beneficiaries were enrolled in a managed care plan in state fiscal year (SFY) 2011, but account for about half of Medicaid expenditures.

## Eligible Populations

Medicaid programs are required to cover certain low-income populations, including children and their parents, pregnant women, elderly and disabled adults. Eligibility for adults varies nationally, but there is no federal mandate to provide Medicaid to adults without dependent children. Although the ACA allows for the possibility of expansion to this population, states may opt out of expansion without penalty per the Supreme Court decision in June 2012. Children from families that are low-income but above the Medicaid income threshold are also eligible for Medicaid benefits, through the Children's Health Insurance Program (CHIP).

As shown in Chart 1, low-income children and their families represented roughly two-thirds of Rhode Island's Medicaid population in state fiscal year (SFY) 2011, the most recent year for which data is available, but account for a quarter of the state's Medicaid expenditures. Conversely, blind, disabled or aged adults (aged 21+)



who were recipients of Medicaid were a quarter of the SFY 2011 enrollment, but accounted for about 65 percent of total Medicaid spending in that year. Children with special health care needs represented the remainder of the Medicaid enrollment population (7.0 percent), and the expenditure (10.0 percent). Although there is no exactly comparable data nationally, an analysis of Medicaid spending by the Kaiser Family Foundation for federal fiscal year (FFY) 2009 indicates that the trend is similar at the national level.

State-administered Medicaid programs can also cover optional populations beyond federal guidelines. Optional populations generally cover the mandatory populations listed above, but with higher income thresholds. In SFY 2011, Rhode Island’s Medicaid program served about 224,000 individuals, with optional populations accounting for roughly half of the state’s \$1,824.0 million in total Medicaid expenditures.

### Adults

Mandatory populations under federal law include those who would have been considered eligible under the Aid to Families with Dependent Children (AFDC) program, which preceded the current Temporary Aid to Needy Families (TANF) program. Included in this population are pregnant women up to 185.0 percent of FPL, as well as low-income individuals with dependent children.<sup>2</sup> Additionally, low-income Medicare beneficiaries up to 135.0 percent of FPL are also eligible for Medicaid, a population known as “dual eligibles”, as are individuals who receive SSI, or SSDI.

In Rhode Island, Medicaid services have also been extended to adults meeting the following criteria:

- Low income elderly adults or adults with disabilities up to 100.0 percent of the FPL;
- Parents up to 175.0 percent of FPL;
- Individuals eligible for home- and community-based services waiver programs;
- Women eligible for the Breast and Cervical Cancer Program; or
- Individuals determined to be “medically needy” due to high medical expenses.

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*SSI is a federal income support program that provides basic cash assistance to individuals 65 or older. SSDI serves the same purpose for adults and children with serious disabilities.*

*Qualifying for SS(D)I also makes an individual eligible for Medicaid and SNAP.*

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<sup>2</sup> In Rhode Island, the mandatory coverage for low-income parents is about 50 percent of the FPL, meeting the 1996 threshold.

### Children

The federal minimum threshold for children's Medicaid benefits is a family income below 100.0 percent FPL, though all states have extended coverage beyond this mandate through CHIP. Additionally, a federal Medicaid mandate extends the provision for children under age six in families earning at or below 133.0 percent FPL. Infants born to Medicaid-enrolled pregnant women also automatically qualify for the benefit. Lastly, children receiving adoption assistance or in foster care qualify for Medicaid. In Rhode Island, children's health coverage, partially funded through CHIP, is available for families with incomes up to 250.0 percent FPL, as well as children under 19 with a disability warranting institutional care, but who remain at home.

### Spending

The ratio of federal to state spending for Medicaid generally varies as a function of each state's per capita income. While the federal match, referred to as the Federal Medical Assistance Percentage (FMAP), is set at a minimum of 50.0 percent, federal matches for FFY 2013 average 59.2 percent of total Medicaid expenditures. Rhode Island's FMAP for FFY 2013 is 51.3 percent, leaving the state responsible for the remaining 48.7 percent of Medicaid expenditures.<sup>3</sup> Across the country, FMAP rates range between the minimum threshold of 50.0 percent in 14 states to a high of 73.4 percent in Mississippi. Between FFY 2009 and FFY 2011, states received an enhanced FMAP rate through the American Recovery and Reinvestment Act (ARRA) that was primarily determined by each state's unemployment rate. During this time, the federal floor was set at 56.2 percent, and

<sup>3</sup> An enhanced matching rate is applied to the Children's Health Insurance Program (CHIP). Rhode Island's enhanced rate for 2013 was 65.9 percent.

Rhode Island's FMAP increased to 63.9 percent.

In federal fiscal year (FFY) 2010, the most recent year for which complete data is available, Medicaid spending totaled \$389.1 billion nationally while Rhode Island Medicaid spending totaled \$1,926.2 million. This total represents the amount contributed by the federal government as well as all state spending.<sup>4</sup> It should, however, be noted that table 2 reflects spending under the enhanced FMAP during ARRA.

	<b>Federal</b>	<b>State</b>	<b>Total</b>
United States	\$263,376.8	\$125,707.5	\$389,084.3
Connecticut	\$3,506.9	\$2,237.6	\$5,744.4
Maine	1,713.8	582.1	2,295.9
Massachusetts	7,256.0	4,525.1	11,781.2
New Hampshire	793.5	538.2	1,331.7
<b>Rhode Island</b>	<b>1,217.1</b>	<b>709.1</b>	<b>1,926.2</b>
Vermont	870.7	379.7	1,250.5

Excludes administrative costs, accounting adjustments and expenditures in US territories  
SOURCE: Kaiser Family Foundation State Health Facts

According to the Kaiser Family Foundation State Health Facts, the majority of spending was for acute care, both nationally and across the majority of New England. Of the spending on acute care, managed care accounted for the highest share of spending nationally, and in Connecticut, Massachusetts and Vermont. In Rhode Island, "other services", which primarily encompass optional services under Medicaid such as dental care, prosthetic devices, and physical/speech therapy, represented the

<sup>4</sup> Excludes administrative costs, accounting adjustments and spending in US territories.

highest share of the \$1.5 billion in acute care spending (40.3 percent). However, managed care was the second-highest share, accounting for 38.0 percent of acute care spending.

Long-term care represented 31.5 percent of all Medicaid spending in FFY 2010 nationally, compared to 16.8 percent in Rhode Island. Of this share, nursing facilities accounted for the vast majority of Rhode Island's long-term care expenditures (94.2 percent), more than double the national average of 41.2 percent.

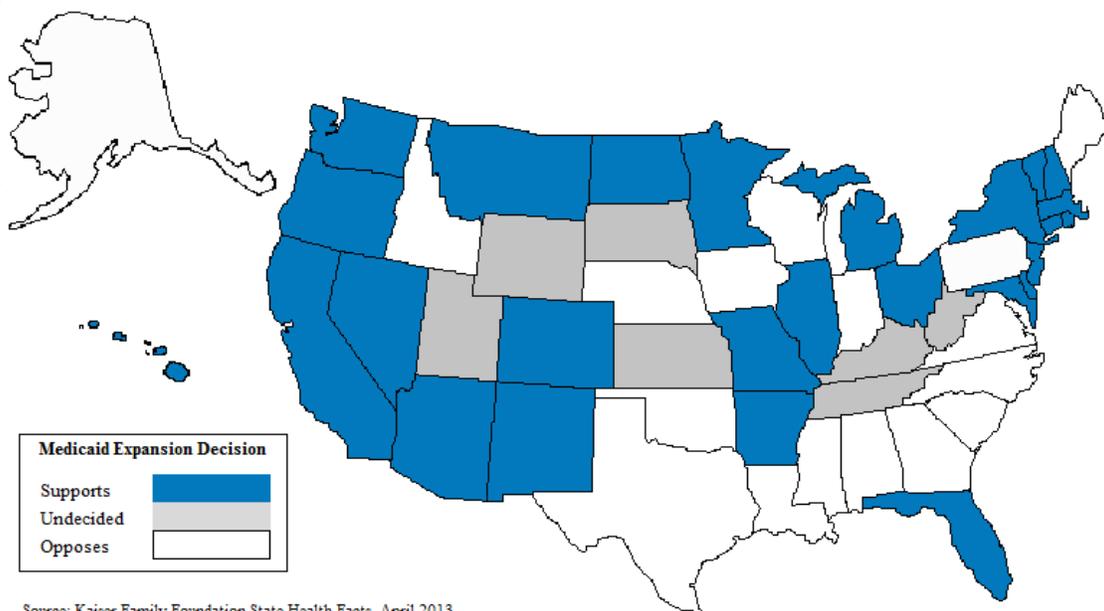
The last category of spending – disproportionate share hospital (DSH) payments – was 4.5 percent of Medicaid spending nationally. Although Rhode Island's DSH payments were the second-highest in New England at 6.5 percent, they were almost a third of DSH payments in New Hampshire (17.3 percent). Of note, Massachusetts did not have any DSH payments in FFY 2010.

**Medicaid Expansion**

Beginning in January 2014, a provision in the ACA grants states the ability to qualify childless, non-disabled adults up to 138.0 percent FPL for Medicaid (includes the 5.0 percent income disregard). As of April 2013, this optional provision has been supported by 26 states and the District of Columbia, rejected by 17 states, and is still under consideration in seven as shown in figure 1.

Estimates by The Kaiser Commission on Medicaid and the Uninsured suggest that Rhode Island's Medicaid expenditures will increase by 2.7 percent between 2013 and 2022, a net difference of about \$450.0 million compared to expenditures without Medicaid expansion. The total incremental increase in general fund spending in Rhode Island resulting from Medicaid expansion (including uncompensated care costs) between 2013 and 2022 is estimated at \$199.0 million.

**Figure 1**  
**State Medicaid Expansion Decisions, as of April 2013**



The study projects that \$254.0 million of this new spending would be for currently eligible (taking into account current benefits and medical inflation), while \$196.0 million would be allocated to the expansion population during this period. Individuals qualifying through Medicaid expansion would account for 82.7 percent of the roughly 40,000 new enrollees through 2022. This state share would be met with an increase of \$3,152.0 million from the federal government. Without the ACA and consequent Medicaid expansion, the state’s Medicaid expenditures would be expected to increase by 1.2 percent between 2013 and 2022.

**Impact of Medicaid Expansion in Rhode Island**

Medicaid expansion aims to give states an opportunity to provide wider health insurance coverage to low-income residents. Initially, the federal government guarantees that states will have no financial responsibility for this population. In Rhode Island, the Governor’s proposed budget projects \$4.2 million in general revenue savings through shifting costs to federal sources for the second half of FY 2014 by transitioning eligible populations in state-funded programs to Medicaid with commensurate benefits. Additional savings could be achieved by moving optional populations currently enrolled in Medicaid into the exchange, eliminating the state’s share of the spending related to their benefits. At the same time, Medicaid expansion, coupled with the individual mandate, could reduce the state’s share of

uncompensated care costs to hospitals for care provided to the uninsured.

It is challenging to accurately predict the impact of Medicaid expansion, however, because of the uncertainties surrounding:

- Enrollment among newly eligible childless adults at or below 138.0 percent FPL;
- Health status of enrollees;
- Enrollment among previously eligible, but unenrolled Rhode Islanders; and
- Timing of enrollment.

Without a precise count of individuals newly qualifying for Medicaid, or those currently eligible, but unerolled, who may join the program, a phenomenon termed the “woodwork effect”, the budgetary implications range widely. Of note, individuals between 100.0 and 138.0 percent FPL would also qualify for a subsidy through the state’s health benefits exchange as shown in table 3.

Regardless, although the magnitude of the impact is unknown, the increase in Medicaid enrollment, especially related to the currently eligible, but unenrolled, will affect the state’s out-year Medicaid budgets. By 2020, the federal government’s enhanced match for the expansion population will decline to 90.0 percent, with the state responsible for the remaining 10.0 percent of an unknown total. Similarly, while much of the increase in Medicaid expenditures

**Table 3**  
**Access to Health Insurance for Childless Adults**

State Status	# of States*	Percent of FPL			
		< 100%	100% - 138%	139% - 400%	> 400%
Medicaid Expansion	26	Medicaid	Medicaid	Exchange Subsidy	No subsidy
No Medicaid Expansion	17	No subsidy	Exchange Subsidy	Exchange Subsidy	No subsidy

\*As of April 2013. Excludes DC, which has opted to expand Medicaid. The expansion decision remains under consideration in 7 states.

will be paid by the federal government, previously eligible, but unenrolled Rhode Islanders seeking Medicaid will be matched at the current FMAP. There is also the potential that the federal government will reduce its share of Medicaid reimbursement in the future, shifting more of the cost to states.

While the direct impact of Medicaid expansion on the state's out-year budget will depend on enrollment, access to insurance that leads to improved health status could also impact the state's economic activity. Preparing for the budgetary impacts of Medicaid expansion requires coordination, particularly between departments responsible for enrollment and the medical community. The state must first ensure that individuals seeking enrollment have adequate access to the system, and then that providers can accommodate the increase in demand for primary care and other services. Outreach for providers is also necessary to accommodate this new demand for health care services.

The actual multiplier effect of federal dollars to the state's Medicaid program could prove to be one of the most significant elements of expansion. For example, the potential growth of the state's health care sector, through the increased flow of federal funding and demand for access to care among the presently uninsured could generate positive economic activity. Additionally, improved health status, and, consequently, worker productivity, among the affected population could also prove beneficial to the state's economy.

### **Considerations**

Medicaid expansion, as part of the Affordable Care Act, functions as a tool to extend health insurance coverage to low-income childless adults. The impact of this

policy will be determined by the take-up rate of the newly eligible, the previously eligible but unenrolled, and the timing of enrollment. These factors will ultimately dictate the cost associated with Medicaid expansion for Rhode Island. Although precisely anticipating the out-year impact of the expanded program poses a challenge, developing a range of possible scenarios and allocating funding accordingly would be a prudent measure in preparation.

The benefit of the predominately federally-funded increased access to health insurance must be weighed against the potential externalities of Medicaid expansion. Once a state commits to Medicaid expansion, the new population must be covered for three years. If the state is prepared for Medicaid expansion, it could be better positioned to capture the benefits from increased federal funding, improved health status, and productivity. As such, the state should consider several questions with implementation:

- How will Medicaid expansion impact out-year budgets as the FMAP declines?
- How will the woodwork effect simultaneously impact Medicaid enrollment?
- How would Rhode Island integrate cost-sharing (RIte Share) into the Medicaid expansion model for the newly eligible with private insurance?
- Can the state's health care providers accommodate the increased demand for care?
- How will Medicaid expansion affect the population of Rhode Island's health benefits exchange?