NHeLP
NATIONAL HEALTH LAW PROGRAM

Protect Medicaid Funding

Older Adults and Individuals with Disabilities

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A personal story from a family in California:

Sandra's son Sean, who is 23 years old and has Down Syndrome requires much prompting and support for his activities of daily living. Medicaid helps Sandra's son Sean live independently. He is a people person and he loves interacting with others on a consistent basis. Sean has a live-in aid and support staff six days a week. Sean also has a job coach that helps him search for, apply, interview, and keep jobs that work well for his bright personality. Without Medicaid, Sean would not be able to receive the support that he needs to live and thrive independently.

A personal story from a family in Colorado:

Julie was diagnosed with Multiple Sclerosis in the late 80s at age 20. Over the next several years, she had more than a dozen hospitalizations with no way to pay for them, even though she was working. After almost dying from being uninsured and uninsurable, she was able to get coverage through Medicaid Home and Community Based Services (HCBS). In more than 20 years on Medicaid HCBS, she has not been in a hospital at all.

To get on Medicaid, Julie had to stop working for pay and go on Social Security Disability. In late 2012, Colorado created a Medicaid Buy-In for Working Adults with Disabilities. As a result, she was able to start working for pay, with her salary ranging from $10,000 to $50,000 over the past few years. She was able to give up Social

Security Disability and now receives only Medicaid and happily pays a premium. Medicaid provides her personal care, including a high quality wheelchair for both indoors and outdoors which is not available through Medicare or most insurance companies. She also requires more than $1000 a month of medications and supplies. Because she can work, she is able to give back to the community personally and through her job as the director of a nonprofit organization, the Colorado Cross-Disability Coalition.

Without Medicaid, Julie fears she would be unable to function enough to work and certainly cost the system more via inability to meet needs causing illnesses that require hospital visits that she cannot afford. She says that making changes to Medicaid, such as block granting would be devastating. Julie says, "Those of us with disabilities are always blamed for costing the most in the system---but prevention with us costs more. Instead of a $30 vaccination preventing $1000 ER visit for the flu, it might be a $15,000 wheelchair with complex rehab seating systems preventing $1 million in pressure sores. People with disabilities are the canaries in the coal mines of health care."

Older Adults and Individuals with Disabilities

Medicaid provides a long-term investment in health that helps people succeed. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, and reduces health care disparities.[1] Medicaid coverage is tailored to the unique needs of low-income individuals and families, but still costs less per enrollee than employer-based insurance.[2] Despite Medicaid's proven success and efficient use of funds, opponents repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 97 million people who benefit from Medicaid each year.[3] Medicaid's core consumer protections make the program work for enrolled populations, including children, parents, pregnant women, low-income workers, older adults, and people with disabilities. This fact sheet examines why Medicaid is important for older adults and people with disabilities and how they would be harmed by funding caps.

Why Medicaid is important for older adults and individuals with disabilities:

- **Medicaid provides health coverage to 16 million older adults and people with disabilities.**[4] Medicaid requires all states to cover low-income older adults and people with disabilities.[5] States also have the flexibility to expand coverage to additional populations of older adults and persons with disabilities, such as those who need home support services. In addition, 32 states (including D.C.) have implemented the Affordable Care Act's Medicaid expansion, which covers many low-income individuals with disabling conditions who could not otherwise qualify because they do not have an officially recognized

"disability."[6] Medicaid provides states guaranteed federal funding to help cover the actual cost of providing care to these populations regardless of how health care costs change.

- **Medicaid helps older adults and individuals with disabilities receive vital health care services, including long-term care.** Medicaid is tailored to meet the needs of low-income populations and thus covers many vital services *not* covered by Medicare or most other insurance, most notably long-term care (including nursing homes). In fact, Medicaid pays for approximately two-thirds of the country's long-term services and supports.[7] Medicaid is also a pioneer in creating home care options that allow individuals to stay out of nursing homes, which also improves outcomes and costs less.[8] For individuals with both Medicare and Medicaid, Medicaid supplements Medicare, helping to fill in coverage gaps and ensure that older adults and people with disabilities have access to comprehensive care. Medicaid also offers a range of other key services, including non-emergency medical transportation (not covered by Medicare) and extensive coverage of mental and behavioral health services.

- **Medicaid makes coverage affordable for program beneficiaries.** Key protections in Medicaid limit cost sharing such as copays, premiums, and deductibles for all program enrollees.[9] Medicaid also makes Medicare coverage more affordable for lower-income individuals through "Medicare Savings Programs," where *Medicaid* pays for some or most of an individual's *Medicare* out-of-pocket costs.

How funding caps would harm older adults and persons with disabilities:

- **Funding caps threaten Medicaid eligibility.** Funding caps reduce federal funding for states and shift costs onto states. This would likely lead states to cut Medicaid eligibility to recoup losses. States might target coverage for older adults and people with disabilities for cuts, since they are populations with higher needs and higher costs and much of that coverage is optional. Funding caps may also discourage states from adopting Medicaid expansion and may even cause some states to eliminate their completed expansions.

- **Funding caps would lead to services cuts.** Because services for older adults and individuals with disabilities tend to be expensive, these services would be significantly at-risk for cuts. States would likely target a wide-range of critical yet optional home care support services that are extremely important to older adults and persons with disabilities, such as home attendants or incontinence supplies. States would also likely place strict limits on the amount and frequency of services these enrollees could access.

- **Funding caps would make coverage less affordable.** Under a funding cap policy, states facing budget shortfalls would have strong incentives to shift costs to enrollees. States would likely add premiums, copayments, and other costs that would reduce access to

necessary services and supports.[10] Further, many states might tighten their eligibility standards for Medicare Savings Programs, making it harder for older adults and persons with disabilities to become eligible and thus dramatically increasing their Medicare costs.

- **Funding caps put state budgets at risk.** Medicaid is currently a guaranteed funding stream, helping states finance health care regardless of how costs and needs change. Under funding caps, states lose the certainty of funding and are financially exposed. For example, the health care costs for the older adult population increase sharply as an increasing proportion of older adults surpass age 80. Under funding caps, federal funding is locked-in ahead of time, and states might not get additional support to address an increase in costs as the elderly population lives longer.[11]

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[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes among Medicaid Patients in 2015 within Medicaid Expansion States under the Affordable Care Act*, 38 DIABETES CARE 833 (2015) (Medicaid coverage improves diabetes screening and treatment initiation); DAVID W. BROWN ET AL., NAT'L BUREAU OF ECON. RESEARCH, MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS? 20 (2015), http://www.nber.org/papers/w20835 (Medicaid improves long-term outcomes for children); Thomas C. Buchmeuller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage* 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (Medicaid expansion reduced health care disparities).

[2] TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Employer-based coverage would cost 28% more than covering the same low-income individual with Medicaid).

[3] CONG. BUDGET OFFICE, DETAIL OF SPENDING AND ENROLLMENT FOR MEDICAID FOR CBO'S MARCH 2016 BASELINE (2016), https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf. Though 97 million individuals enrolled in Medicaid over the course of 2015, the average monthly enrollment was 76 million. *Id*. This underscores the importance of Medicaid as a source of coverage for individuals who temporarily lose coverage, such as individuals between jobs.

[4] JULIA PARADISE, BARBARA LYONS, AND DIANE ROWLAND, KAISER FAMILY FOUND., MEDICAID AT 50 (2015), http://kff.org/medicaid/report/medicaid-at-50/.

[5] *See* KAISER FAMILY FOUND., MEDICAID: AN OVERVIEW OF SPENDING ON "MANDATORY" VS. "OPTIONAL" POPULATIONS AND SERVICES (2005), http://www.kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-an-overview-of-spending-on.pdf.

[6] MARYBETH MUSUMECI, KAISER FAMILY FOUND., THE AFFORDABLE CARE ACT'S IMPACT ON MEDICAID ELIGIBILITY, ENROLLMENT, AND BENEFITS FOR PEOPLE WITH DISABILITIES (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/04/8390-02-the-affordable-care-acts-impact-on-medicaid-eligibility.pdf.

[7] NAOMI FREUNDLICH, ROBERT WOOD JOHNSON FOUND., LONG-TERM CARE: WHAT ARE THE ISSUES? (2014) http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf410654

[8] CAROL V. IRVIN ET AL., MATHEMATICA POLICY RESEARCH, MONEY FOLLOWS THE PERSON 2013 ANNUAL EVALUATION REPORT, 28 (2015).

[9] DAVID MACHLEDT, NAT'L HEALTH LAW PROGRAM, MEDICAID AND MEDICARE: AGING, ACCESS AND AFFORDABILITY, ISSUE 3 (2014) http://www.healthlaw.org/issues/medicaid/dual-eligible-beneficiaries/medicaid-medicare-aging-access-affordability-issue-3#.VN5cpfnF9Zu.

[10] DAVID MACHLEDT & JANE PERKINS, NAT'L HEALTH LAW PROGRAM, MEDICAID PREMIUMS AND COST SHARING (2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

[11] CONG. BUDGET OFFICE, OPTIONS FOR REDUCING THE DEFICIT: 2014-2023, 187 (2013), https://www.cbo.gov/budget-options/2013/44687.