inSocialWork Podcast Series

Episode 131 - Dr. Toni Miles: Health Care Policy: Medicaid Expansion and the Affordable Care Act

[00:00:08] Welcome to in social work podcast series of the University at Buffalo School of Social Work at www.insocialwork.org. We're glad you could join us today. The purpose of social work is to engage practitioners and researchers and lifelong learning and to promote research to practice and practice to research. We're in social work. Hello and welcome to social work. I'm Charles Syms your host for this episode. It is not a surprise to anyone to hear about rising health care costs. The PBS NewsHour reported in October of 2012 that the American health care costs were about 18 percent of the total gross domestic product. That translated to over two and a half trillion dollars. With that costs continuing to rise another worrisome statistic was reported in September 2013. A New York Times article reported that some 48 million Americans or about 15 and a half percent of the U.S. population were without health insurance in 2012. These numbers highlight a disquieting reality and give light to why it is important that social workers understand health care policy and its impact on those we serve. Created in 1965 Medicaid was developed to address the health care needs of low income families as well as individuals who had a disability were blind or aged. While often described as an entitlement. Medicaid is a form of health insurance ensuring that those who are in need of healthcare and are eligible have access to it. Following the commercial market this form of health insurance underwent changes in the 90s to include a more managed care model. More recently Medicaid is again undergoing change with the Affordable Care Act.

[00:02:14] Medicaid offers the opportunity for expanded eligibility and thus coverage to people who were previously ineligible. Dr Toni P. Miles is the director of the Institute of Gerontology and Professor of Epidemiology and Biostatistics in the College of Public Health at the University of Georgia Athens. She is also the founding director of the Pennsylvania State University's Center for special populations and health and has previously served as a Health and Ageing policy fellow in the United States Senate Finance Committee with more than 125 publications. Dr. Miles recent scholarship includes articles on the aging Healthcare Workforce physical problems shaping transitions of care and the application of ethics to the analysis of health care policy in this podcast Dr. Miles helps the listener understand key provisions of Medicaid expansion and the Affordable Care Act. Dr. Miles was interviewed by Nancy Kusmaul a licensed Master social worker and Ph.D. candidate at the School of Social Work at the University at Buffalo. This interview was recorded in April 2013. My name is Nancy Kusmaul and I'm a doctoral candidate at the University of Buffalo School Social Work. I'm joined today by Dr. Toni Miles who's a professor of epidemiology and biostatistics and the director of the Institute of Gerontology at the University of Georgia School of Public Health. Thank you for joining us Dr. Miles. Thank you for having me. So when you think about health care policy what do you think are really the big issues that social workers need to know about. That's an excellent question.

[00:04:06] I think the first thing that social workers need to really drill into are the details surrounding whether or not there are local areas are going to participate in the Medicaid expansion. And I'd say Medicaid not Medicare Medicaid of course is the federal state partnership that provides health care for people with low incomes. Mothers and children and long term care and it's complicated and it's called something different in every area. So that's probably the biggest challenge first in terms of understanding what's going on with the Affordable Care Act. Can you tell us a little more about what makes up Medicaid and then what you mean by the expansion what that looks like in the states that are participating. Okay so Medicaid is a state federal partnership. It is a health insurance. Most people don't realize that if a health insurance just like every other health insurance is just administered either by your state or by a company that your state contracts with. And basically those contracts cover three distinct populations. The first population are pregnant

women and children under the age of 19 and the eligibility for those two groups are mandatory populations meaning if they're limited Medicaid dollars those people have to be for first and the eligibility criteria is based on income. So in most places it's now 133 percent of poverty. So this a set income for poverty and if you make up to 133 percent of that you're in as an expectant mother or a member of a family. Now the children in the family will be covered under Medicaid under those conditions but their parents won't be which is something a lot of people are stunned by when they encounter it. So the mothers receive Medicaid when they're pregnant but once they deliver then just the children are covered. That's right.

[00:06:09] There's about a 60 day tale for covering the pregnant woman postpartum but then that goes away. So if you can imagine all the different scenarios under which that would create a lot of complexity. The second group of people that are mandatory coverage populations are impoverished elders. So that's a piece. Blind people and disabled people. And again the states used to control their Medicaid budgets by moving the income eligibility bar around. So what the Affordable Care Act did was if they wanted to get some enhanced federal funding they had to set that bar 133 percent of poverty for everybody for the new enrollees. And so those groups get covered too as well as the pregnant women and the children. So those are all the mandatory populations that drive the state Medicaid budgets. So the federal government mandates those populations when they give the money to the states. Is that how that works. Correct. And so that is all in place or has been in place prior to the Affordable Care Act the Medicaid budgets for impoverished elders also covers long term care. So these are people who require home and community based services in some states. Delivery of the support services has to be done within an institutional stirring so skilled nursing all the different ways you can think about people getting long term care elders getting long term care. Medicaid covers them if they are an impoverished elder are the criteria for long term care. The same as the criteria for the low income elders that you mentioned in the other group. That's correct.

[00:08:02] And just to give you the big picture if most states the largest number of people on Medicaid are younger sample. So children and low income adults the disabled and blind. But the biggest chunk of their spending for the states is long term care because that's going to have an important when we get into the discussion of what the Affordable Care Act is. That's going to be an important thing to keep in mind so how has all this changed now with the Affordable Care Act. OK so what the Affordable Care Act is trying to do is by making Medicaid available to a broader group of low income people. And you know as I've said nothing about many lower income men men who are unemployed here are probably the most disadvantaged in our population right now from a health insurance perspective if they work a low wage job and they don't have insurance they're not eligible for Medicaid. There are very few avenues for them to get health insurance. And I think that contributes somewhat to our understanding of the differences between men and women in health and longevity. So what the Affordable Care Act does is it stabilizes eligibility sets the bar at 133 percent of poverty for everyone and then opens it up to the groups that have been basically labeled as eligible. So a man who is a low income person can get eligible for Medicaid if his state participates in the expansion. And what the Spanton basically does for the states is it says for the first three years of participation the federal government will pay the premiums of the newly included. So those populations that they're adding like low income men. That's right. Now the federal government define who it has to expand to. OK.

[00:10:03] And this new definition includes all of the populations not previously included that are below that income bar. Correct. So what do you think this does for the states who opt out of this Medicaid expansion. Does it change their Medicaid picture at all. No they'll still operate under the old rules. That was the heart of the Supreme Court ruling was that the states that opt not to participate will basically continue the way things always were. They will be able to move their eligibility criteria up and down they just won't get any enhanced funding for newly eligible people. So whatever problems they have with people not being insured will persist and the states that do opt

to do this expansion after that third year do the states then become responsible for those expenses for those new populations they pick up 10 percent of the premiums. Keep in mind what we're talking about here is not the cost of care per se. We're talking about health insurance premiums. Medicaid is an insurance program just like everybody else is insurance. The states pay premiums to have an absurd amount of money to companies that manage them. They are very much an insurance program for what happens after the first three years. Is the feds will pay 90 percent of the premiums of the newly enrolled and the states now have to pick up 10 percent. Now the thing about Medicaid is probably the group that stays on it for a prolonged period is people in long term care because they are at that stage of life where their incomes are not going to get any better.

[00:11:41] But everybody else pregnant women children and families and even these newly eligible men will probably cycle off as the overall economy improves. So that's one way to think about it is that they're still in the system and so how often does a person who's on Medicaid recertify or report their incomes that when their income changes or is there a defined period where they would do that. Well now that varies from state to state there are some states that require them to recertify every six months. That's probably the most aggressive recertification requirement. And some states have a four year. Are there any specific pieces of the Medicaid and the Medicaid expansion that you think are really important for social workers to know about if you've got a client and it's important to them. I guess it's often that you need to do. From my perspective as a gerontologist the long term care piece I think moving forward in time is going to become more and more important for social workers to be aware of because that's the group long term care particularly home and community based services versus institutional care is going to be an issue. It is an issue now in the States a retirement destination states states like Florida which are seeing an influx of people who are retirement age who come in with resources. But somewhere about 80 85 a lot of them their resources run out. I mean how many people can plan the fund 40 years worth of retirement. That's a new thing for our culture. So the states are seeing their support for long term care funding.

[00:13:30] It's unstable and they have no real way to make an estimate right now because we haven't given a lot of thought to social workers as they work with families that are taking care of older adults. They're going to have to really get on this and it's going to change year to year. Every six months something new is happening and people are trying to experiment. So the states are making changes to try different ways to save money or expand services. And so it's important for the social workers to keep up with those changes that are happening in their state. Yes. So for example there's a big experiment right now called Money Follows the Person I think it may be 24 states in both. But this targets is people who are already in institutional settings because their state in the past required that they be institutional setting in order to get Medicaid support. This experiment helps them move out of the institutions and back into the communities which is good from the standpoint of people want to be in communities they want to not be in institutions is the thought that this will save the state money in the long term. It costs half what it does to keep somebody in the community even if you're paying the rent on the apartment and you're bringing all this stuff in for them. It's half what it cost in an institutional setting. So there's an immediate savings for the state. So that's one experiment that's ongoing. And if you go to the Medicare Web site and type in money files the person you can get the details and they report on it every six months about how it's going.

[00:15:06] So in a place like Texas which has probably done the most work to get people back into the community they have things like home repair services that are covered under those Medicaid dollars because it's still again like you said cheaper to keep the person at home in a repaired home than it is to put them in an institution. Exactly. So that's one experiment the other experiment comes at the front end. And it's called a Community First Choice Option. So at the moment when there's a decision being made about this issue there's an incentive to help people stay in the community longer before making that transition. And what the state forget is enhanced federal funding. I think

it's up to five percent more. But don't quote me on that I mean you can quote me on that one but I would encourage people who are listening to the podcast to look at their local. These are all local issues so you really do have to follow the local environment. But the state of residence gets enhanced Medicaid funding for participating in this community first choice option. OK. And so that puts in services at the front end to keep somebody from going to an institution. That's correct. And are these all changes that have come as part of the Affordable Care Act specifically or are they part of a broader look at health care policy and health care expenditures. Money Follows the Person actually started before the Affordable Care Act. But what the Affordable Care Act and I'm going to call it ACA for sure it does is it enhances those programs adds more resources to make those programs available to a broader array of states.

[00:16:45] So what are some other changes that have come about kind of from a national perspective from the Affordable Care Act that will impact the people that social workers are working with on a daily basis. There's a group of people out there for working but they're either working in jobs that don't offer them health insurance at all. And their income is too high. Even with the enhanced eligibility criteria for Medicaid the Affordable Care Act through its health insurance exchanges which become viable in 2014 the ACA offers health insurance premium support for that group of workers. So the person who fell in that income category would apply for assistance with their premium through the Affordable Care Act also part of the details are being enacted they have to apply. What's happening now is there was some wrangling over what they call the individual mandate but what people will have to do on their taxes is report whether or not they have health insurance plans in 2014 will all be required to people whose income is at a certain level. We'll have a way. This was my last understanding of it of directing the dollars to support their premiums to an agency that's connected to this exchange so they can buy their insurance through the state health insurance exchange and there will be a framework and you make ten dollars an hour 10 12 hours and hours. Fourteen thousand a year something in the neighborhood that those people particularly if they have a family. There'll be a policy in the exchange that gives them the minimum coverage they need. Basically health insurance inpatient outpatient preventive services. That's what they call it a bronze policy.

[00:18:41] And the feds will pay the premiums for the policy that they select. So it's not like you get a check and it's not like you have to go through some agency that reviews your qualifications it's not done that way. Lisa last time I saw it discussed it wasn't. It's streamlined so that you pick the policy and the feds will send a check on your behalf to that company that you're being covered by. And all the policies are through private insurance companies. That's right. This is part of the private market. And so those private insurance companies will decide what the policy actually looks like what it actually covers what. No no no. OK. That's the other thing about the Affordable Care Act before the Affordable Care Act was enacted. Yeah the insurance companies could decide whatever they wanted and charge accordingly. Under the Affordable Care Act there are 12 specific benefits that must be in any policy that is available through the exchange. So one example I can give you a lot of the private insurance companies had gotten out of the business of providing maternity care. So a lot of folks particularly young workers would get a policy and start their families only to find out that there was no coverage for that. Well that can't happen anymore. That will be illegal. So that is one of the essential components of these policies has to include. Yes. And you said the bronze level so that sounds like that these policies have to provide a basic level of certain services but if people had the funds and wanted to purchase more services they could. That's right. That's exactly right.

[00:20:24] So what other changes have come to private insurance companies as a result of all this. So from a company perspective they are now required to pay at least 80 percent of their premium dollars in benefits for people who are purchasing their policies with them. And that's significantly different than what had been happening before. Oh yeah. There was no I could sell you a policy and I could use only 50 percent of the dollars that you gave me for providing you benefits and the other

50 percent is profit. There was no regulation on that. And so when an insurance company does not hit that mark they have to send the people who own policies with the check and there are people who have already gotten those checks. And that's across the board. Every state there are required to do that. What other changes have come in the private sector. So one of the ways before I did the work on Senate Finance Committee one of the things that was always a mystery to me was how premiums got set. Why do I have to pay in my case. Two thousand dollars a month for a family policy part of the way that insurance companies would set those rates. Well they could use all kinds of criteria they could use criteria that define the health experience of the community that you live in.

[00:21:45] So if you live in a community where there were a lot of healthy people you might pay a lower premium for the same set of benefits than somebody who lives in a place where there's a lot of sick people because the policies sold in other place is just going to have to pay out more for health care and that will persist. But what has changed is first of all they can no longer charge you more if you're a woman that used to be one of the ways premium rates were set a postmenopausal woman in the United States couldn't buy a health insurance policy as an individual because it was just prohibitively expensive. And that was different than for a man of a similar age. Right. That's right. And if you had a history of cancer getting a policy was practically impossible or if you were diabetic at all or particularly if you had a history of diabetic complications people would ask as much as 25000 a year for an individual policy which is prohibitive prohibitive for most people. Yes. Yes. So the pricing ban it used to be the older you got the more you paid. And there was no limit on how big that aid Span's could be. And we know that the older you are the more likely you are to have health issues and you're going to need insurance. But what happened was you could set a rate for someone who's 25 and then someone who is 55 could pay ten times that rate or 15 times that rate. Well that again is prohibitive. So now the rape ban can be no more than three to five times what a 25 year old would pay. So now with the Affordable Care Act any uninsured individual who's not getting coverage to their employer can go to a private insurance company and get coverage at a rate comparable to the next person of the similar age irrespective of their health conditions.

[00:23:41] Yeah and more importantly we are all required to have insurance. That's the only way it's going to be cost effective across the board. But that insurance has to be purchased through the exchange. And so let's talk about these things for a second. These exchanges are like shopping mall for health insurance and a state can run one some places are experimenting with a regional exchange so multiple places are trying to band together to do one of these a state once again can opt out of participating in the exchange. So if you live in a state that doesn't have an exchange there will be a federal one. And the federal law will cover all of those states that don't have their own. Yes. So if you want to see one in action you go to the Massachusetts Connector Web site the state of Massachusetts has had a health insurance exchange up and running for a while. And in Massachusetts I think it's like ninety four ninety five percent of all people are covered because the only way to make it financially feasible is that everyone participates. And so what you have is a pool of dollars because basically we're self-financing our health care that pool of dollars from people who don't need a lot of health care at this point in time pay for their health care by people who do. And we make decisions with that pool about what we think is important. So one of the things that we've made a decision about is that women and children should always get coverage. And right now or before the Affordable Care Act that wasn't a decision we all made.

[00:25:21] So it was women and children first and then everybody else kind of mentality for health care. So are there any other overall changes to the Affordable Care Act that you really think will have a day to day impact on the people the social workers interact with. Let's talk a little bit about people who are not citizens by birth. So people come to the United States under different pathways. Let's start with the worst case scenario. There's nothing in the Affordable Care Act that acknowledges the existence of people who come here without documentation. Some people call them illegal immigrants or aliens or people whose derogatory terms. So those people have no

recourse under the Affordable Care Act is no federal dollars allocated to their care. None of that. So the way ACA works right now for that group is that they will still be a little bit of money that goes to the hospitals that are caring for them because we recognize there are some communities with high rates of caring for people who have nothing and that those dollars are called a disproportionate share dollars. But the size of that pool because more people will have health insurance is going to get smaller. So it will really be targeted to those communities who serve a disproportionate number of undocumented or uninsured party. That's right. That's right. But there's no specific language for people who are illegal. OK. The next step up though is people who come here. Students who come to study here or the medical side we bring in residents who do our medical training under the age visa system.

[00:27:07] Before we had laws on the books that their children if they couldn't get health insurance and a lot of times they don't because universities still have different policies about health care. Their children had to wait five years before they would be eligible for any of our public programs if they were sick. There had been this pool of children who were uncovered because of their parents status. Exactly exactly. And five years as you know a child's life is huge. And so that five year waiting period has been removed. So through the Affordable Care Act the parents that we bring here to do the work that we need to do in the United States their kids can now get some kind of coverage from their. The other thing though I think social workers are uniquely positioned to be aware of. One of the ways that we are lowering our healthcare costs is being more cognizant of fraud and abuse. This is particularly a problem for beneficiaries who are cognitively impaired or frail and any social worker who is in a position to observe that their client is not getting care that's been set up I think should ask themselves. Am I observing fraud. If they think they are there is now Medicare maintains a hotline that you can call because it's been estimated that maybe 15 20 percent of our expenditures are from fraud. And you define fraud as being billing for care that's not being delivered. That's definitely one piece of it. Do you have that number. Do you have a resource that our listeners can find that information. Yes.

[00:28:50] There's an online piece if you want to go out online see and contact the office of the inspector general that if you type in report space fraud space online that takes you to that Web site or you can call 800 4 4 7 8 4 7 7 Okay that's one place. The other place is you can call the Centers for Medicare and Medicaid Services. And that's where 800 6 3 3 4 2 2 7 so these are definitely some good ways that social workers can be directly engage in the cost savings on an individual level on them broader sense. What would you like to see change about health care policy. What is number one on your wish list of what needs to change in healthcare policy. Right now the Affordable Care Act. Tell me a little bit of history in the book. I do talk about the context. Most of us don't understand why these changes were necessary or the history of health care in this country. So most people don't understand that Medicare achieve two goals. One was getting rid of barriers to health care for the elderly before was enacted. Older people could not get access to hospital because most of them had any money. The other thing that Medicare did which is also not widely discussed is the segregated U.S. healthcare. The hospitals could not get Medicare dollars unless they admitted everybody. We talk about health disparities but as late as 1970 in this United States we had segregated hospitals and separate but equal never works. So the next say frontier in healthcare disparities is language. We need to deliver health care in a language that everybody can understand. And there are strategies to do that and not break the bank.

[00:30:54] It is no longer legal for example to use family members as the primary translators in a health care setting and too often that happens. You have 10 year olds translating for people in their 70s right. And all the issues around culture and not wanting to share certain parts of care with other family members. So information not getting through. That's right. And there are companies now you can put a phone in every exam room call up the company they will provide a native speaker in the language that you are attempting to communicate and who's also trained in healthcare and you

get much better quality of conversation. I used to live in Louisville Kentucky where 77 language was spoken in the community. And the community health centers which are sort of our public health equivalent in healthcare. That's a technique that they use to muscle Satisfact for both the providers and the patients. So what do you think is the best way for a social worker who's out there in the field to stay engaged in health policy. What's our best source for knowing about changes at some of the detail that you shared with us today. Find out who in your state is responsible for setting the regulations for Medicaid. And I would consult that on a regular basis because sometimes I'm going to just lay it out there. You will find that some people who are delivering care to the communities that you're serving will lie about what the policy is. I've come across examples of that and the social workers were not aware that they were being lied to. This is a very political issue.

[00:32:31] We're talking about as much as health care and so implementing these components of the Affordable Care Act will be important but so find out who in your state is responsible for doing implementation. Get to know them and find out what is the next best thing. What's the next biggest thing. That's a state level but it's always really important to go to the CMF dot gov and find out what CMFs have to say about what's going on. So knowledge is power and social workers as knowledge for the people that they work with and take care of. Yes I had a part time faculty appointment at the school social work at University of Louisville and part of what we trained our people to do was to be advocates and so in your role as an advocate and it'll be frustrating. I'm not going to say you're going to be successful every time but part of your role as an advocate is to ensure that the laws that we have on the books get implemented because ACA is not perfect but it sure fixes a lot of things. Like I said for young people 18 to 34 that's a group that basically has been going make it. When it comes to health care will now get it pregnant women have been losing coverage. Most of us didn't realize it helping the states balance their budgets and do this transition being able to offer smart solutions in your local area will be an important point. I'm excited about the future for those of you under 30.

[00:34:02] Health care will be so much better when it finally work out all the details and if you have clients that are 50 and older encourage them to eat your vegetables and go to the gym. Thank you so much for being with us today for sharing your knowledge for the work that you do in the areas of health policy. Thank you Nancy hello again. This is Charles Syms and you have been listening to a discussion with Dr. Toni Miles on health care policy Medicaid expansion and the Affordable Care Act. I hope you found it informative and will join us again in social work. Hi I'm Nancy Smyth professor and dean of the University at Buffalo School of Social Work. Thanks for listening to our podcast. We look forward to your continued support of the series. For more information about who we are as a school our history our programs and what we do and by to visit our Web site at www.socialwork.buffalo.edu.