Spillover Benefits of Medicaid Expansion for Older Adults With Low Incomes

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Medicaid plays an important role in providing health insurance coverage to more than 75 million people in the US with low incomes, including children, pregnant individuals, nonelderly and older adults, and people with disabilities. Approximately 12 million older adults and other qualifying individuals are dual-eligible beneficiaries concurrently enrolled in both Medicare and Medicaid; this dual enrollment enables Medicaid to pay for premiums and other out-of-pocket expenses that beneficiaries only covered by Medicare would otherwise encounter. The Centers for Medicare & Medicaid Services (CMS) limits the amount of cost sharing that Medicaid beneficiaries can incur to no more than 5% of family income, which offers greater financial protections than many private health plans.

Older adults with supplemental Medicaid coverage thus benefit from reduced out-of-pocket spending and fewer cost-related barriers to medical care and prescription medication use compared with near-poor older adults (those with incomes more than 100% but less than 200% of the federal poverty level) who are not dual eligible. State Medicaid programs frequently cover a broader array of services than other payers, including dental and vision care and health-related social needs, such as transportation to medical appointments and home and community-based services. The combination of Medicaid's low caps on cost sharing and generous covered benefits can facilitate improved access to care for older adults with low incomes, particularly those with chronic health conditions.

The expansion of Medicaid approved by 38 states and the District of Columbia under the Affordable Care Act (ACA) has been associated with improved coverage, access to care, and health for many nonelderly adults newly eligible for coverage, including reduced mortality among middle-aged adults. But Medicaid expansion has also had spillover or “welcome mat” effects on many people who were previously eligible but only enrolled in coverage after the ACA’s implementation and outreach efforts.

Earlier studies of pre-ACA insurance coverage expansions have also demonstrated spillover benefits to insured older adults. In a study of Massachusetts state health reform, a multipayer approach to expanded insurance coverage targeted to previously uninsured nonelderly adults was associated with reductions in preventable hospitalizations among older adults with Medicare coverage. Similarly, a study of pre-ACA state Medicaid expansions found that expanded eligibility for working-age adults was associated with reduced spending for older adults covered by Medicare; these reductions in spending were most prominent among dual-eligible beneficiaries. Studies of coverage expansions under the ACA have primarily focused on potential benefits for nonelderly adults. Scant attention has been focused on potential spillover benefits for older adults, with the exception of a recent study that found no significant spillover changes in Medicare beneficiaries’ primary care utilization during the first 2 years of the ACA Medicaid expansion.

In this issue of JAMA Health Forum, McInerney and colleagues present a cross-sectional study of nearly 22,000 low-income adults 65 years and older who participated in the National Health Interview Survey during 2010 through 2017. With incomes below the federal poverty level ($11,756 for an older adult in 2017), these individuals were likely dually eligible for both Medicare and Medicaid. Using rigorous difference-in-difference methods, the authors compared older adults with low incomes in states that expanded Medicaid for nonelderly adults during 2014 to 2017 with similar older adults in states that did not expand Medicaid during this period. They further stratified their study cohort into those with limitations related to a chronic health condition (arthritis, heart or lung problems, hypertension, diabetes, stroke, or cancer), representing one-third of the overall cohort.
the remaining two-thirds of the cohort, 45% had a chronic condition without limitations in activity, and the other 22% did not report one of these chronic conditions.

Among older adults with chronic condition limitations, the study had 3 main findings. First, in states that expanded Medicaid for younger adults, older adults were significantly more likely to be covered by Medicaid after age 65 years—by nearly 5 percentage points—relative to nonexpansion states. Second, these older adults in expansion states were significantly more likely—also by about 5 percentage points—to have had an office visit with a physician in the prior 2 weeks, particularly by the third and fourth year after Medicaid expansion. Third, no difference was evident between expansion and nonexpansion states in the likelihood that these older adults had been hospitalized in the past year. For the two-thirds of older adults without chronic condition limitations, no significant differences were noted between expansion and nonexpansion states in any of these 3 study outcomes.

These findings indicate that Medicaid expansion since 2014 has been associated with significant spillover benefits in insurance coverage and access to care for older adults with low incomes who were not the intended beneficiaries of Medicaid expansion focused on younger adults. Furthermore, these benefits were concentrated among older adults with the greatest health limitations. This finding is consistent with prior longitudinal research indicating that the greatest health benefits of gaining Medicare coverage for uninsured adults at age 65 years are experienced by those with major chronic health conditions, such as cardiovascular disease or diabetes. In short, health insurance matters most for those with the most substantial health needs.

Because older adults with low incomes often experience the most pressing health needs, policies are needed to coordinate benefits and care more effectively between Medicare and Medicaid. Both CMS and state Medicaid agencies play a role in improving care for older adults with low incomes. For example, enhanced funding from CMS and increased efforts by state Medicaid agencies to offer navigation assistance to older adults may be beneficial while they are transitioning into myriad new coverage options at age 65 years. Because eligibility criteria differ between Medicaid expansion coverage and dual Medicare-Medicaid coverage, older adults with low incomes may or may not remain eligible for Medicaid at age 65 years. Thus, those with the lowest incomes may enroll in Medicare with supplemental Medicaid coverage (dual-eligible), those with slightly higher near-poor incomes may enroll in Medicare with a general cost-sharing assistance program (Medicare Savings Programs) or with prescription drug cost-sharing assistance (Part D Low-Income Subsidy), and those with higher incomes may only be eligible to enroll in Medicare alone with its full cost sharing. However, many older adults who are eligible for Medicaid, Medicare Savings Programs, or the Low-Income Subsidy never enroll, underscoring the importance of navigation assistance during this critical transition.

Additionally, formal care coordination or integrated care programs for dual-eligible older adults could be expanded, including the Program of All-Inclusive Care for the Elderly (PACE), Medicare Advantage special needs plans, and other state-based models for integrated care, though evidence is currently mixed on the effectiveness of these programs for improving health outcomes. Several states have pursued demonstration programs to improve coordination of care between Medicare and Medicaid for dual-eligible individuals, as encouraged by the Medicare-Medicaid Coordination Office created by the ACA. However, preliminary evaluation has found that few beneficiaries were aware of these care coordination efforts, and evidence is still emerging on the effectiveness of these programs. Improved financial incentives and technical support to monitor plan performance on the quality of care coordination may improve beneficiaries’ perceived benefits for their health and quality of life. To build on the spillover benefits of Medicaid expansion demonstrated by McInerney and colleagues for older adults with low incomes and chronic condition limitations, more effective strategies for care navigation and coordination are needed to bridge Medicare and Medicaid for dual-eligible beneficiaries.
ARTICLE INFORMATION
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