Where Medicaid Stands: From the AHCA to State Waivers

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The basic foundations of Medicaid are related to the entitlement and the federal-state partnership.

**Entitlement**
- **Eligible Individuals** are entitled to a defined set of benefits
- **States** are entitled to federal matching funds

**Federal**
- Sets core requirements on eligibility and benefits

**Partnership**
- Flexibility to administer the program within federal guidelines

**State**
- Flexibility to administer the program within federal guidelines
Medicaid plays a central role in our health care system.

Health Insurance Coverage For 1 in 5 Americans

Assistance to 10 million Medicare Beneficiaries

> 50% Long-Term Care Financing

Support for Health Care System and Safety-Net

State Capacity to Address Health Challenges
NOTE: The June 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius maintained the Medicaid expansion, but limited the Secretary's authority to enforce it, effectively making the expansion optional for states. 138% FPL = $16,643 for an individual and $28,180 for a family of three in 2017.
NOTES: Coverage under the Medicaid expansion became effective January 1, 2014 in all but seven expansion states: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2016), and Louisiana (7/1/2016). Seven states that will have Republican governors as of January 2017 originally implemented expansion under Democratic governors (AR, IL, KY, MA, MD, NH, VT), and one state has a Democratic governor but originally implemented expansion under a Republican governor (PA). *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers.
Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.

Percent reporting in the last year:

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid</th>
<th>ESI</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Checkup</td>
<td>85%</td>
<td>86%</td>
<td>53%</td>
</tr>
<tr>
<td>Doctor Visit Among Adults</td>
<td>74%</td>
<td>69%</td>
<td>36%</td>
</tr>
<tr>
<td>Specialist Visit Among Adults</td>
<td>30%</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>Adults Satisfied With Their Health Care</td>
<td>85%</td>
<td>87%</td>
<td>44%</td>
</tr>
</tbody>
</table>

NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care.

SOURCE: KCMU analysis of 2015 NHIS data.
**How the ACHA changes key elements of Medicaid:**

<table>
<thead>
<tr>
<th>ACA Medicaid Expansion</th>
<th>Current Law</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expands adult coverage to 138% FPL</td>
<td>Makes expansion population a state option</td>
<td></td>
</tr>
<tr>
<td>• Provides enhanced federal matching dollars for newly eligible (90% by 2020)</td>
<td>• Ends enhanced match 1/1/2020 for newly enrolled expansion adults</td>
<td></td>
</tr>
</tbody>
</table>

**Financing**

<table>
<thead>
<tr>
<th>Current Law</th>
<th>American Health Care Act (AHCA)</th>
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</thead>
<tbody>
<tr>
<td>Guarantees federal matching dollars with no cap</td>
<td>Caps federal matching dollars in 2020:</td>
</tr>
<tr>
<td>• Establishes per enrollee spending caps by eligibility group based on 2016 spending</td>
<td></td>
</tr>
<tr>
<td>• States have option for block grant for children and adults</td>
<td></td>
</tr>
</tbody>
</table>
Figure 7

The ACA expanded Medicaid coverage and financing.

- Medicaid Enrollment 2Q FY 2016: 74 Million
- Medicaid Spending FY 2015: $524 Billion

NOTES: Enrollment data for 2 quarters FY 2016 (maximum for the time period) or 31 states that implemented the Medicaid expansion as of January 2016 (Louisiana expanded Medicaid on 7/1/16 and has no data reported. SOURCE: KCMU analysis of data from Medicaid Budget and Expenditure System (MBES).
The Medicaid expansion has coverage and fiscal implications for states beyond Medicaid.

**Figure 8**

- **Federal + State Funds**
- **Increased Economic Activity**
  - ↑ General fund revenue and GDP
  - ↑ or neutral effects on employment
- **Increased State Savings**
  - ↓ Uncompensated care costs
  - ↓ State-funded health programs (e.g. behavioral health and corrections)
- **Increased Access to Care and Service Utilization**
  - ↑ Affordability and Financial Security
- **Reduction in the Number of Uninsured**

Medicaid block grants or per capita caps are designed to cap federal spending.

- **Current law**: Reflects increases in health care cost, changes in enrollment, and state policy choices.
- **Block grant**: Does not account for changes in enrollment or changes in health care costs.
- **Per capita cap**: Does not account for changes in health care costs.
Reducing and capping federal Medicaid funds could:

- Shift costs and risks to states, beneficiaries, and providers if states restrict eligibility, benefits, and provider payment.

- Lock in past spending patterns
  - If expansion funding is cut, the impact could be even greater for the 32 states that expanded Medicaid.

- Limit states’ ability to respond to rising health care costs, increases in enrollment due to a recession, or a public health emergency such as the opioid epidemic, HIV, Zika, etc.
In 2026
14 million ↓ Medicaid enrollees
24% ↓ in federal funds
24 million ↑ in uninsured → 52 million uninsured

Certain characteristics put some states at higher risk than others under federal Medicaid cuts and caps.

- Limited Medicaid Programs
- Challenging Demographics
- Poor Health Status
- High Cost Health Markets
- Low Spending and Low Tax Capacity
Figure 13

33 states have 41 approved Section 1115 Medicaid demonstration waivers in place as of February 2017.

Landscape of Current Section 1115 Medicaid Waivers

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery System Reform Waivers</td>
<td>16</td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td>7</td>
</tr>
<tr>
<td>Managed Long-Term Services and Supports</td>
<td>12</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>12</td>
</tr>
<tr>
<td>Other Targeted Waivers</td>
<td>15</td>
</tr>
</tbody>
</table>

More states are seeking waivers to condition Medicaid on work requirements, but most not working face barriers to work.

Main Reasons for Not Working

- Ill or disabled, 35%
- Taking care of home or family, 28%
- Going to school, 18%
- Could not find work, 8%
- Retired, 8%
- Other, 3%
- Not Employed = 9.8 Million Medicaid Adults

Own Work Status, 24 Million Medicaid Adults

- Not Employed = 9.8 Million Medicaid Adults
- Part-Time = 41%
- Full-time = 41%

States are also seeking waivers to impose premiums and cost sharing, but research shows negative effects of policies for low-income populations.

**New/increased premiums**
- Decreased enrollment and renewal in coverage
- Largest effects on lowest income
- Many become uninsured and face increased barriers to care and financial burdens

**New/increased cost-sharing**
- Even small levels ($1-$5) decrease use of services, including needed services
- Increased use of more expensive services (e.g., ER)
- Negative effects on health outcomes
- Increased financial burdens for families

- States savings are limited
- Offset by disenrollment, increased costs in other areas, and administrative expenses
More than half of Americans say that Medicaid is important to them and their family.

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 13-19, 2017)
There are many “Faces of Medicaid”.