Medicaid, Income and the ACA

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Conceptual Overview of ACA

- Largest coverage expansion in a generation.
- Designed as a package of reforms to extend coverage to ~30-33m uninsured, while leaving current system in place.
- Three-legged stool
  - Medicaid to 138% FPL
  - Exchange tax credits and subsidies 100-400% FPL.
  - Individual and group insurance market reforms, incl. mandate.

Conceptual Overview of ACA

- $1 trillion gross cost largely the coverage expansions.
  - $500b: **Medicaid** – financed 100% by feds for first 3 years; financed up to 10% by states after 2017.
  - $500b: **Exchange Tax Credits and Subsidies**
  - Offset predominately by $700b in lower Medicare spending.
    - 1/3: **Reductions in reimbursement to hospitals**
    - 1/3: Reductions in Medicare Advantage reimbursement.
    - 1/3: **Other stuff (e.g., DSH payment reductions).**
    - Key assumption is that *lots* of uninsured will be covered.

Conceptual Overview of ACA

- Additional revenues (investment taxes on high-income earners, Snooki tax, mandate penalties, Cadillac tax on high cost plans) to fully offset cost of coverage expansion.
- Additional package of delivery system reforms (ACOs, IMPAC, comparative effectiveness research, innovation grants)
  - Each could lower level and growth in health care costs, but unproven.

Medicaid: Key Issues

- Key dimension is income: exchange subsidies & tax credits, Medicaid eligibility, employer plan affordability, mandate exemptions.
  - Law aligns *components* that define income under MAGI.
  - But time-horizons ("budget periods") may differ.
  - Sets up concerns of "seams" & churning between programs, stratification of family members across programs.

Medicaid: Key Issues

- Supreme court added a new and unexpected twist:
  - Medicaid expansion optional.
  - Premium tax credits start at 100% FPL; no subsidies under 100% FPL.
  - Most stakeholders keeping powder dry until after Nov. elections.
    - I will try to fill in some gaps.

Issue #1: Medicaid Expansion

- Options
  - No expansion
  - Expand to poverty line* (guidance forthcoming from HHS)
  - Full expansion
- Questions:
  - How much will newly insured cost?
  - Woodwork effect: how many currently eligible will enroll (at regular FMAP)?

Medicaid Expansion: Key Issues

- Keep in mind: ACA designed as a joint package of reforms.
  - No exchange subsidies <100% FPL
  - Budget offsets premised on assumption that large #s of low-income uninsured would be covered.
- Why does this matter? The dog that is not (yet) barking:
  - Medicaid and Medicare Disproportionate Share Hospital Payments
  - Hospitals will see large reductions in reimbursements and DSH – even if a state doesn't expand Medicaid.

Medicaid Expansion: Key Issues

- Medicaid DSH
  - Statutory reductions: $18b between 2012-2020.
    - HHS Sec. has discretion on how distributed across states.
    - Hospitals in low-DSH states see lower cuts.
- Medicare DSH
  - 75% cut from initial levels.
  - Additional dollars restored based on % declines in state uninsured rate.
  - Why does this matter?

Medicare DSH

- 45% of uninsured have income *above* Medicaid expansion level.
  - A state at U.S. average could cover *no* uninsured <138% FPL, and just half above, and still reduce its uninsured rate by nearly a quarter.
  - Triggers 17% cut in Medicare DSH from current levels.
  - Woodwork effect: even under no expansion, some current eligibles will enroll, reducing uninsured rate further.

DSH: Estimates

- Graves, 2012 (forthcoming)
  - Total reductions of $51b (2012-2020) under full expansion.
  - If *no* state expands, DSH still declines by $29b ($18b Medicaid; $11b Medicare).
  - Results by state very striking: of top 5 most affected states, 3 have already signaled they won't expand.

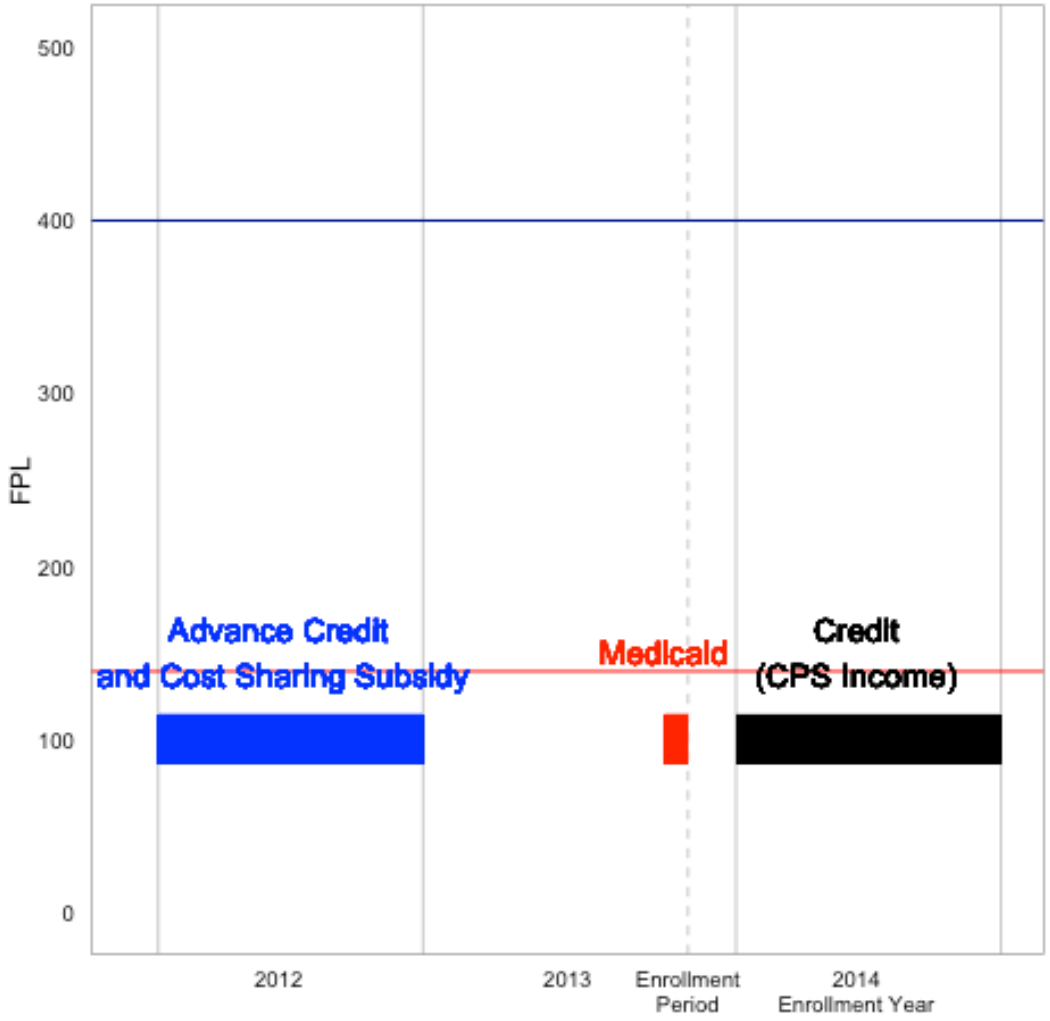
Medicaid Expansion

- Woodwork effect: How can we think about fiscal impact? What about fiscal impact of new eligibles?
- “conditionally” insured, presumptive eligibility suggests that some share of their health care needs already covered.
- Oregon health insurance experiment: 25% increase in total spending (+1 office visit, no change ER, 30% increase in hospitalizations)

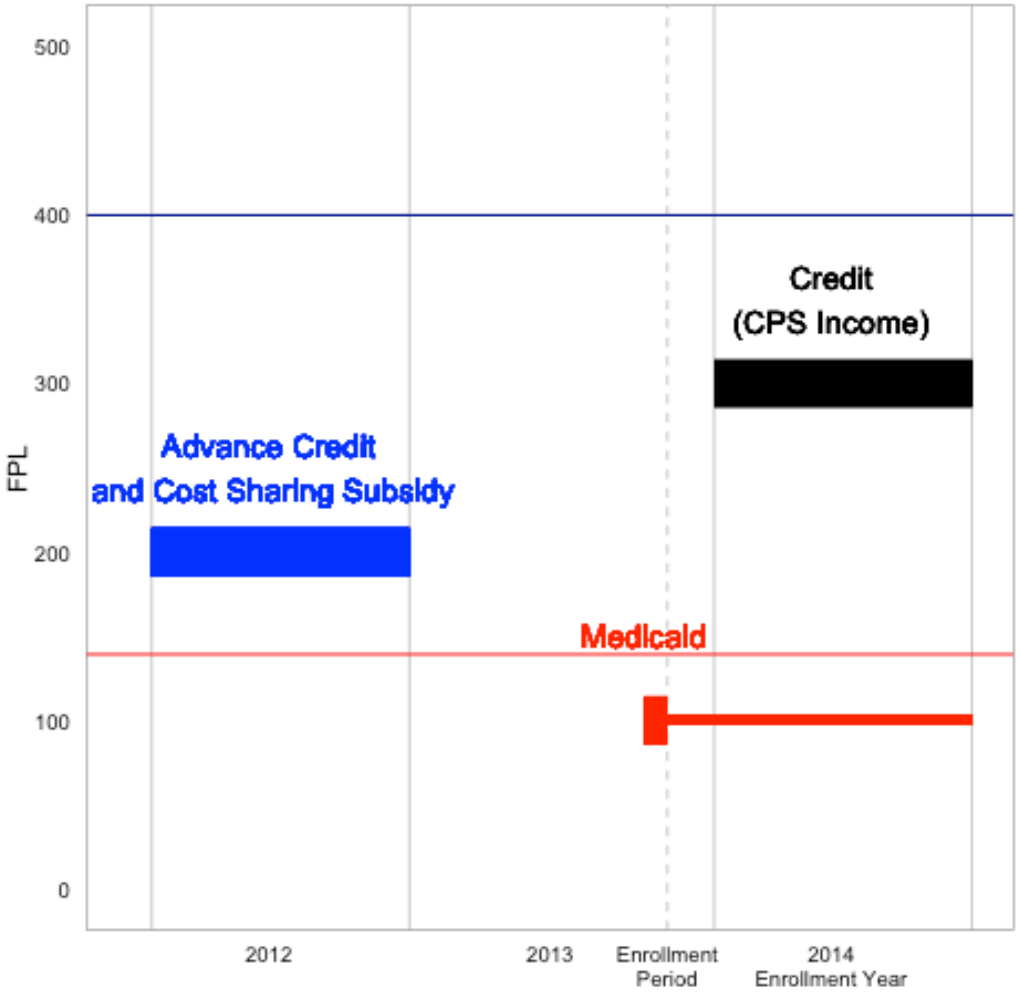
MAGI: Key Issues

- Both Medicaid and Exchange (largely) use the same components to define total income.
  - Simplification from current Medicaid policies
- Components are aligned, but time horizons aren't.
  - Medicaid: Current Monthly MAGI
  - Advance Tax Credit and Cost-Sharing Subsidy: MAGI from most recent tax return
  - Final Tax Credit: MAGI from enrollment year tax return.

An “Ideal” World:



Reality


500
400
300
200
100
0
FPL
Credit
(CPS Income)
Advance Credit
and Cost Sharing Subsidy
Medicaid
2012
2013
Enrollment
Period
2014
Enrollment Year

Income: Key Issues

- What are the implications?
  - Inherent tension between minimizing applicant and administrative burdens and collecting data for an accurate projection of income
  - Adopting a single monthly income test that has greater variability relative to other income measures will increase state Medicaid costs and churning.
  - See Graves (July 2012 *Health Affairs)* for detailed simulation results.

Income: Recommendations

- Better alignment of Exchange and Medicaid income budget periods can actually reduce state costs through better targeting.
- Simulation evidence indicates that “optimal” approach is to use tax returns + state wage data to set initial eligibilty for both Medicaid and Exchange, but with generous accomodations for applicants to attest to recent or anticipated changes.

Income: Recommendations

- Most statutory flexibility in the exchange income projectionprocess.
- Critical to engage directly w/ benes to update eligibility/subsidies based on changes in family, job situations.
- Current state wage info also important.

Questions?