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
    • 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
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 eligibility for both Medicaid and Exchange, but with generous accommodations for applicants to attest to recent or anticipated changes.
Income: Recommendations

• Most statutory flexibility in the exchange income projection process.

• Critical to engage directly w/ benes to update eligibility/subsidies based on changes in family, job situations.

• Current state wage info also important.
Questions?