Dialogue on Diversity: What's at Stake for Medicaid in 2017?

Mara Youdelman
Managing Attorney (DC Office)
youdelman@healthlaw.org @marayoudelman
www.healthlaw.org @nhelp_org

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About NHeLP

- National non-profit law firm committed to improving health care access and quality for underserved individuals and families
- State & Local Partners:
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
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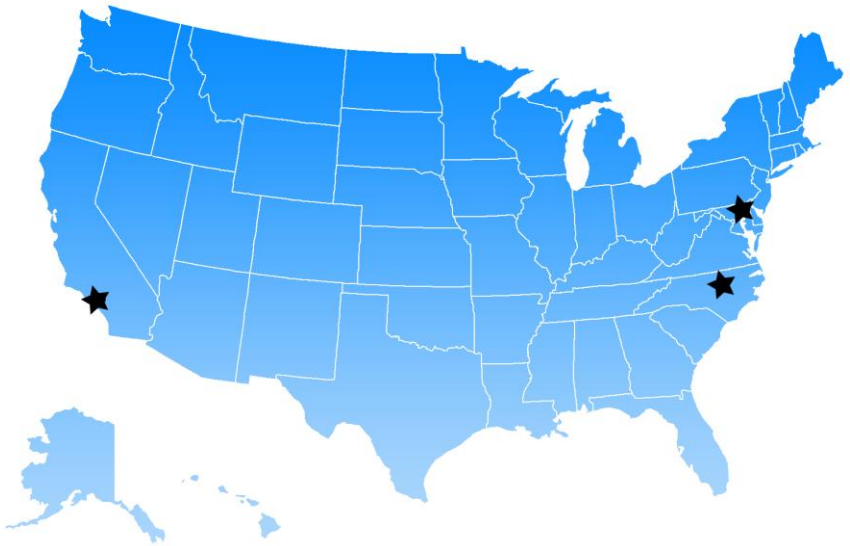

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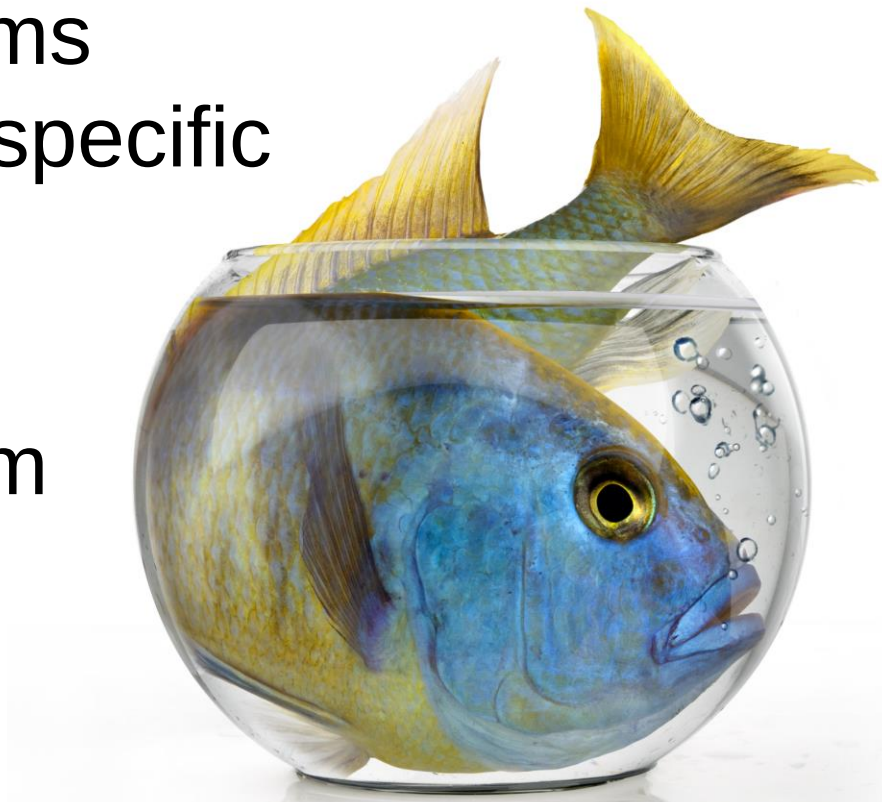
Demographics of Medicaid

- People of color represent 58% of all non-elderly Medicaid enrollees
  - African-Americans comprise 22 percent of Medicaid enrollment
  - Hispanics comprise 25 percent
- Over 10 million people with disabilities on Medicaid
- Many LGBTQ gained coverage through Medicaid Expansion because previously didn't fit into a traditional eligibility category
- Gains still need to be made:
  - Racial and ethnic minorities are more likely than White non-Hispanics to lack insurance and fall in the Medicaid gap.
  - Lack of Medicaid expansion disproportionately affects African Americans and women who make up the majority of poor uninsured adults in states that did not expand Medicaid

Medicaid is not “Discretionary”

- Discretionary programs are funded yearly at specific levels by legislative action
- Discretionary program funding can be cut and they can run out of money



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Medicaid is an "Entitlement"

- Mandatory programs are automatically funded at open-ended levels based on need
  - Can not run out of money

Current Medicaid financing

If a state wants to. . .	Does it get more federal $?
add more enrollees e.g. expansion, natural disasters, economic downturns	✓
add more services e.g. HCBS, ABA therapy, adult dental, family planning	✓
cover new Rx e.g. Solvaldi, Zika vaccine	✓
increase provider reimbursement	✓

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Other Medicaid features

- As an “entitlement,” Medicaid is a “property interest” under the Constitution and can’t be taken away without due process
- No waiting lists (except for some waiver programs)
- Federal-state partnership –
  - states pay part of the costs
  - on average 63% paid by the federal government but up to 75% in states with lowest per capita income
  - enhanced federal match for systems upgrades, services for newly eligible adults, family planning, preventive services

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Block grants

- Block grants eliminate the budgetary entitlement by setting a fixed allotment for each state
- Block grants put states at heavy risk for enrollment increases

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Per capita caps

- Theoretically, per capita caps solve the enrollment problem, by setting the cap per enrollee
- But per capita caps still leave states fully at risk for numerous other cost drivers

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Cost drivers PCCs do not address

- $ Medical innovations (ex. new Rx)
- $ New health conditions or pandemics (ex. HIV)
- $ Outbreaks (ex. Zika/flu)
- $ New health trends (ex. obesity, SUDs)
- $ Shifts in health demographics (ex. more aging enrollees)
- $ Natural disaster health impacts (ex. hurricane Katrina)
- $ Up-front investments that save $ over long term

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Current financing v. block grants & per capita caps (in theory)*

If a state wants to. . .	Does it get more federal $?		
	Current Structure	Block Grant	Per Capita Cap
add more enrollees	✓	✗	✓
add more services	✓	✗	✗
cover new Rx	✓	✗	✗
increase provider reimbursement	✓	✗	✗

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*This is theoretical since any proposal can alter a state's ability to add more enrollees or other features of the Medicaid program.

Design a PCC: Details

- Singular, combined cap creates issues because of varied spending – e.g. “healthy” child v. person with HIV/AIDS
- Five caps design creates other issues – e.g. determining who is in which group

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A word about "flexibility"

- Medicaid is flexible
  - Optional services and eligibility
  - Sec. 1115 waiver/demonstration projects
  - 60% of Medicaid spending is on optional services and eligibility – inc. Rx, HCBS
- Per capita caps/block grants shift costs onto states above the cap
- Cutting billions means less flexibility

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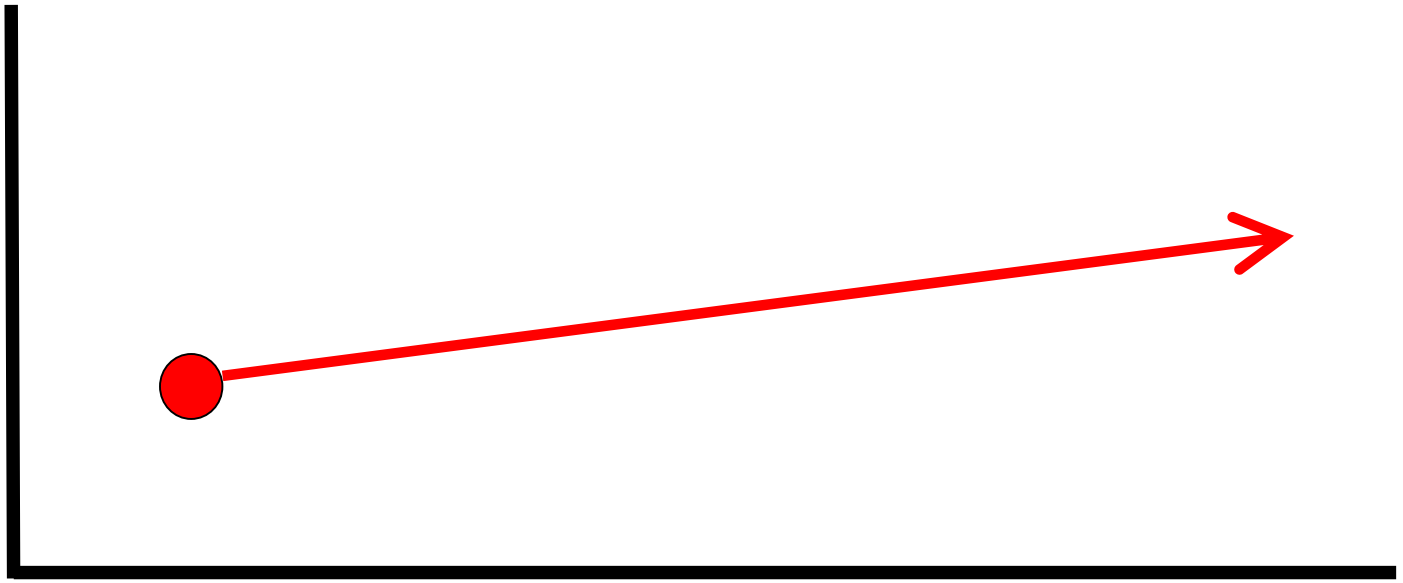
American Health Care Act (AHCA) & Medicaid

- Passed by the House on 5/4
  - Implements a per capita cap on Medicaid – 5 “buckets” (elderly; people who are blind or have disabilities; children; Medicaid expansion adults; other adults)
  - Index is CPI-M
  - Repeals Medicaid expansion enhanced funding after 1/1/2020 (except for individuals enrolled before 1/1/2020 and who don’t experience > 1 month gap in coverage)
- AHCA also restructures private marketplaces

Designing a PCC

- First, a base year spending level is set
- Second, an index is used to set the yearly growth rate for the base spending level



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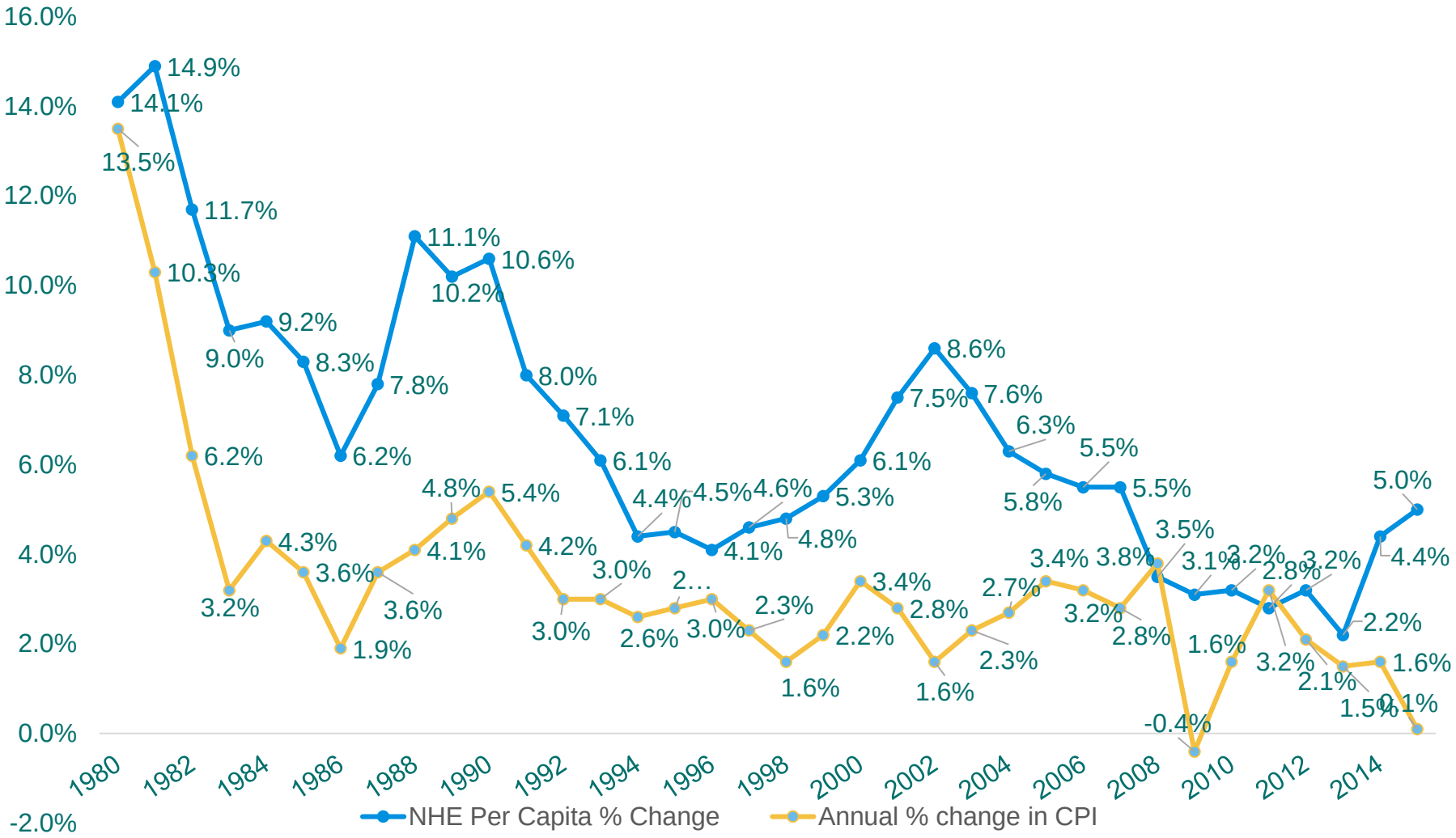
AHCA baseline

- Uses state's 2016 spending – locks in historical anomalies inc. high v. low spending states
- Increases 2016 by CPI-M for until 2019
  - CPI-M is based on out-of-pocket health care spending and not actual health care cost growth
- After 2019, increases annual spending by CPI-M for kids/adults and CPI-M + 1% for elderly and people with disabilities

Growth in per capita health spending has consistently been higher than overall economic growth

Percent change in total health expenditures per capita, 1980-2015, Consumer Price Index 1980-2015



Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group and CPI data from Bureau of Labor Statistics at https://data.bls.gov/pdq/SurveyOutputServlet (All Urban Consumers, All Items, 1982-1984=100, Not Seasonally Adjusted, U.S. city average).

Losers and More Losers

- Funding is locked in to 2016 spending
- Indexes are not counter-cyclical while current Medicaid funding is
- Ultimately the indexes make the federal funding gap *grow* every year
- State variability makes it hard to pick a base criteria that is fair to all
  - Some states have higher spending
  - Some states have higher federal match rates
- Over time, all states lose because index is lower than actual growth in health care costs

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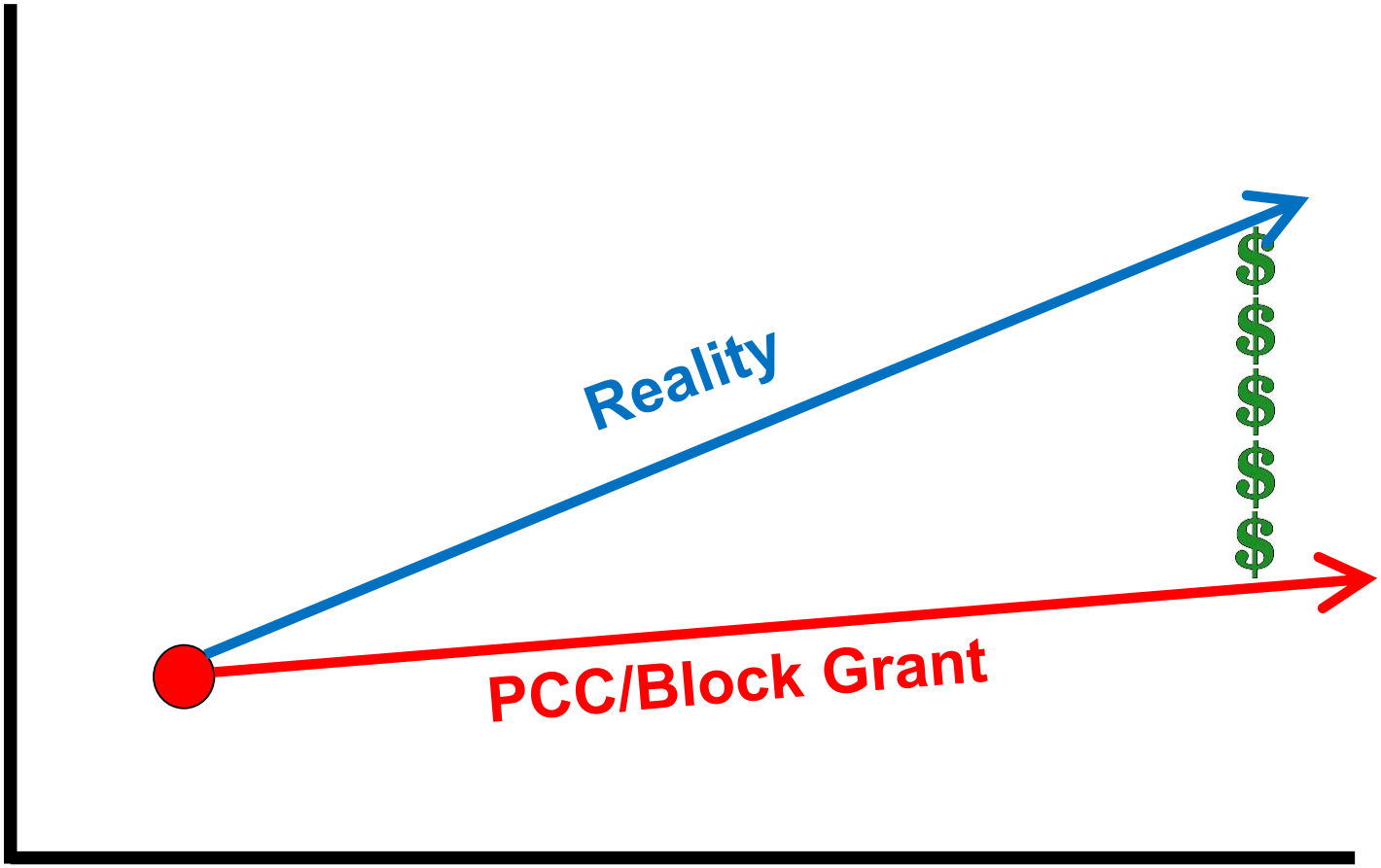
Escalation of the Funding Gap



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CBO/JCT "Score"

- Estimate on AHCA released 3/13/17 (earlier version of bill)
  - Cuts $839 B from Medicaid over 10 years
  - 14 million would likely lose Medicaid coverage, 17% less than current law
  - By 2024, only 5% of Medicaid expansion population would remain with enhanced funding
- Full report available here
- Revised estimate expected 5/24 but don't expect major changes re: Medicaid

So in summary, AHCA would. . .

- Cut $839 B from program in 10 years
- Cut 14 million people from Medicaid coverage
- Put Medicaid at risk in every budget cycle and make it easy to continue making more cuts but dialing down the index
- Shift burden to states to make difficult decisions about cutting eligibility, services and provider rates
- Roll back gains in coverage for people of color and LGBTQ
- Use savings from Medicaid cuts to pay for tax cuts for wealthy

Other AHCA Medicaid changes

- Cuts eligibility for children age 6-19 to pre-ACA levels
- Cuts HCBS attendant supports after 1/1/2020
- Eliminates enhanced match for Medicaid Expansion (up to 138% FPL) after 12/31/2019; prohibits Medicaid expansion for individuals over 138% FPL; and grandfathered MedEx enrollees only get enhanced match if no more than 1 month loss in coverage
- Sunsets EHB in Medicaid after 12/31/2019
- Repeals retroactive eligibility
- Reduces exclusion for home equity
- Excludes Planned Parenthood from Medicaid for 1 year
- And much, much more. . .

Next Steps

- Senate developing its own bill
  - But AHCA seen as a start
  - “Gang of 13” is taking leadership
  - Vote could occur in June

- If House & Senate bills differ, will need to either send Senate bill back to House for acceptance or convene a “Conference Committee” to resolve the differences
  - After Conference Committee, would have to pass both House and Senate again

Conclusions

- Changing financing to Medicaid radically alters the entitlement of the program
- Medicaid is a critical safety net to address health disparities and ensure people of color, people with disabilities and LGBT individuals can access health care
- Burden shifts to states to make tough decisions about eligibility, services, etc.
- States won't be able to be flexible if they don't have the $ to do it
- Affects enrollees, hospitals, insurers and providers – no one is safe

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Resources

- NHeLP -- http://www.healthlaw.org/issues/medicaid
  - Top 10 Changes to Medicaid Under House Republicans' ACA Repeal Bill
  - Medicaid Expansion and the Republicans' ACA Repeal bill
  - Medicaid - Fast Facts
- CBO -- https://www.cbo.gov/publication/52486
- Kaiser Family Foundation – Insurance Coverage Changes for People with HIV Under the ACA
- AHCA legislative text –
  - Energy & Commerce bill (Medicaid provisions)
  - Ways & Means bill (private market provisions)

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THANK YOU

Washington DC Office

1444 I Street NW, Suite 1105
Washington, DC 20005
ph: (202) 289-7661
fx: (202) 289-7724
nhelpdc@healthlaw.org

Los Angeles Office

3701 Wilshire Blvd, Suite #750
Los Angeles, CA 90010
ph: (310) 204-6010
fx: (213) 368-0774
nhelp@healthlaw.org

North Carolina Office

200 N. Greensboro St., Ste. D-13
Carrboro, NC 27510
ph: (919) 968-6308
fx: (919) 968-8855
nhelpnc@healthlaw.org

www.healthlaw.org @nhelp_org