Medicaid’s Role in Our Health Insurance System

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Overview

• Medicaid’s role in the health care system
• Medicaid’s financing structure
• Capping federal spending vs. controlling health costs
• Medicaid reform proposals (AHCA)
• Effects of capping federal spending on access to care

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Medicaid’s Role in the Health Care System
Medicaid’s Role in the Health Care System

• Covers roughly 69 million people
• Finances nearly half of all births in the U.S.
• 1 in 10 low-income working-age adults
• 1 in 5 low-income Medicare beneficiaries
• Primary insurer for long-term services and supports
Medicaid’s Role in the Health Care System

• Challenge of balancing purpose and budget

• U.S. health care system
  • Unusually high costs
  • Lack of comprehensive approach to cost management
Medicaid’s Role in the Health Care System

• Funding shared by federal and state governments
  • Reductions in federal funding → larger cost burden on states

• States required to balance budgets annually

• Potential for shifting costs between states
  • Raising taxes → high-earners moving out
  • Higher coverage or benefits → attract new enrollees from neighboring states
Medicaid’s Role in the Health Care System

• Nation’s largest public insurance program and largest social program targeted at low-income Americans
  • $553.8 billion total spending, 63% federal
• Per capita cost growth lower than or comparable to other health insurance
• Less expensive per-enrollee than Medicare, private insurance
  • CBO estimates 50% higher cost under private coverage
Medicaid’s Financing Structure
Medicaid’s Current Financing Structure

• States are paid a percentage of qualifying expenditures for health care / admin costs
• Rate of federal share inversely related to state per capita income
• States must comply with minimum eligibility / coverage requirements; otherwise have substantial flexibility in determining the size and scope of their programs
Medicaid’s Predecessor

• Federal grant-in-aid program
  • Funding for state health care programs covering low-income individuals

• Subject to per capita limits → limited coverage
  • A dozen states excluded all children
  • Other states restricted coverage for hospital care (outside of life-threatening emergencies) and/or most prescription drugs
  • Less than 2% of population was covered
Medicaid’s Current Financing Structure

• Current program uses open-ended financing structure
  • Strong enrollment growth over time
  • Growth in per-beneficiary spending
  • Reflects actual costs of a reasonable level of coverage

• Medicaid covers broad range of services, such as:
  • Preventive primary care
  • Health and long-term care for seniors / individuals with disabilities
  • Services to manage serious and chronic health conditions
Disadvantages of Open-Ended Financing Structure

• Potential disincentive for states to deliver care more efficiently
  • Increased efficiency difficult for vulnerable populations
  • Easier strategies include restricting enrollment, cutting benefits, and/or expanding cost sharing

• States shifting cost burden onto federal government
  • Funds from providers can be used to raise federal contributions
  • Federal share grew from 2008-2012, while state funds decreased.
Capping Federal Spending vs. Containing Health Care Costs
Cost Control Dilemma

• U.S. health care costs highest in the world
• Controlling costs and capping spending are fundamentally different
  • *Controlling costs* requires health care financing and delivery system reforms that hold down the rate of spending growth
  • *Federal spending caps* simply shift costs from to other payers (e.g., states, local governments, other insurers, providers, beneficiaries)
Approaches to Cost Control

• Rising Medicaid costs primarily driven by enrollment

• Opportunities for cost control:
  • Managed care
  • Price negotiation for prescription drugs, devices, and assistive technology
  • Global budgeting
  • Increased use of home and community-based services (HCBS)
  • Value-based care
Social Determinants of Health as Cost Control

• Enlightened cost control strategy—not just for Medicaid, but health care system overall
• Increase efficiency while also improving health of enrollees
• Interventions for targeted populations have demonstrated cost savings, such as:
  • Intensive case management for super-utilizers
  • Coordinating access to safe, affordable housing for individuals who are homeless or housing-insecure
Capping Federal Spending

- Shifts responsibility for cost containment onto states
- Fundamentally differs from managed care capitation and global budgeting
  - Managed care capitation rates must be *actuarially sound*
  - Managed care capitation rates are annually adjusted to reflect changes in cost of health care and long-term services and supports (LTSS)
  - Global budgeting (internationally) co-exists with programs that already ensure virtually universal coverage, typically have a floor for covered benefits
  - Future legislation could erode mandatory populations and benefits required under current Medicaid law
Medicaid Reform Proposals
How Would Per Capita Caps Work?

• Per capita caps place a fixed limit on federal Medicaid spending

• Federal payments would grow or shrink with the changing number of enrollees but would not account for:
  • Changes in the volume or intensity of care
  • The introduction of new technologies / pharmaceuticals
  • Demographic changes, such as aging of the Boomer generation into years of higher care needs
How Would Per Capita Caps Work?

• Purpose of a per capita cap system is to save money for the federal government

• Savings generated by setting slower growth rate for federal spending than actual growth of program costs

• Funding gap will fall to states

• States will likely require additional flexibility to limit mandatory coverage and benefits
The American Health Care Act (AHCA)

• Passed the House of Representatives: May 4, 2017
• Introduces fundamental change of Medicaid’s structure from an open-ended entitlement → per capita caps
• Also allows for state option for a block grant instead of per capita caps
• Senate has not yet introduced their version of the bill
Per Capita Caps in the AHCA

- Per capita caps take effect in 2020
- Caps are set for five beneficiary categories:
  - Children
  - Seniors
  - People with disabilities
  - Low-income adults covered under ACA expansion
  - Other low-income adults previously eligible (e.g., pregnant women, parents)
Per Capita Caps in the AHCA

- Caps are based on the lower of two options:
  - Actual 2019 spending for the 5 beneficiary categories
  - Actual 2016 spending, trended forward through 2019 using the medical component of the Consumer Price Index (CPI-M)
Per Capita Caps in the AHCA

• States receive an aggregate sum of money annually starting in 2020
  • Multiply each beneficiary group cap by number of enrollees in that beneficiary group
  • Sum the products for all five beneficiary groups

• Growth rate for each beneficiary group after 2020 differs
  • Seniors and people with disabilities: CPI-M + 1
  • Children, ACA expansion, and other adults: CPI-M
CBO Estimates for Medicaid under the AHCA

• The CBO estimates that the proposed reforms would reduce federal spending over 10 years by $834 billion

• Reductions minimal in the first few years following implementation, but grow in later

• Congress could lower per capita growth rate to increase federal savings at any point in time
AHCA Cuts in Federal Medicaid Payment to States, 2017-2026 (CBO estimate)

Figure 1. AHCA Cuts in Federal Medicaid Payments to States, 2017-26 (percent)

Other Federal Spending Reduction Estimates

• CMS actuary estimates a reduction of $383.2 billion in Medicaid spending under the AHCA

• Trump Administration’s FY18 budget uses slower growth rate for per capita caps than AHCA

• CBO estimates Administration’s FY18 budget would cut Medicaid by $1.3 trillion between 2017-2026
Effects of Capping Federal Spending on Access to Care
State Responses to Capping Federal Spending

• States could respond in a variety of ways, with or without additional flexibility to reduce program size and scope
• Most states already do a great deal to control costs
• Options are limited for increasing efficiency to this magnitude at the state level
State Responses to Capping Federal Spending

States essentially have two options:

• Raise funds to compensate
  • Increase taxes
  • Cut funds from other programs (e.g., education, infrastructure, safety)
  • Increase cost sharing for beneficiaries

• Scale back on coverage
  • Restrict enrollment
  • Cut benefits
  • Cut already-low payments to providers
Health Care and Long-Term Services & Supports

• Under fiscal pressure, states are most likely to cut/reduce populations and services that are most costly, such as:
  • LTSS for individuals earning income above SSI level
  • Adult dental care or vision care
  • Home and community-based services (HCBS)
  • Personal care services
  • Rehabilitative services
  • Could also opt to put non-mandatory populations on wait lists
Long-Term Services & Supports

• Individuals requiring LTSS are generally expensive to serve and so could be acutely targeted

• Seniors and individuals with disabilities represent 1/4 of beneficiaries, but 2/3 of total spending

• As Boomers grow older, cost of coverage for their health care and LTSS needs will increase

• HCBS are optional; institutional care is mandatory
Dual-Eligibles and Medicare’s Finances

• Medicare’s finances could be negatively affected
• 1 out of 5 Medicare beneficiaries also covered by Medicaid
• 15% of Medicaid beneficiaries, but 1/3 of spending
• If cuts are made to their coverage, many will likely forgo or delay care
• Saves Medicaid $$ short term; cost Medicare $$ long term
  • Increased preventable hospitalizations and emergency care drive up costs
Responsiveness to Population Health Threats

• Medicaid acts as “first responder” for health care system
• Program can respond quickly to crises (e.g., HIV/AIDS, Hurricane Katrina)
• Opioid epidemic—many states have expanded coverage for intensive inpatient/outpatient rehabilitation
• Adaptable to sudden spikes in health care costs due to innovation (e.g., Hepatitis-C drug)
Innovation and the Flexibility Paradox

• Innovation in current environment can be challenging
  • Waiver application process is burdensome
  • Long lag time

• But, opportunities for flexibility and innovation are uncertain under a per capita cap structure
  • Innovation often requires up-front investment
  • Challenging for states to front cash for measures to improve health
  • Could lead to increases in financial burden on beneficiaries
Conclusion
Conclusion

• Policymakers constantly seeking strategies for lowering health care costs while maintaining—or improving—quality of care
• Medicaid cost growth predominantly driven by enrollment
• Reductions in federal Medicaid spending likely to lead to reductions in coverage, not increased efficiency
Conclusion

• Medicaid is foundational to American health care system
• Program’s strength is its flexibility to grow and adapt to unpredictable factors
  • Economic downturns
  • Elevated poverty
  • Shifts in labor force dynamics
  • Demographic changes
  • Medical advancements
  • Population health threats
Conclusion

• Capped federal funding divorces program from real world of health and health care
  • Eliminates significant share of funding for vulnerable populations
  • Threatens beneficiaries with the highest health needs
  • Dampens capacity to respond to health crises
  • Hinders investment in innovation and technology
Conclusion

• States will face a difficult choice:
  • Maintain existing program and fill gap in funding; or
  • Substantially scale back funding for health care and LTSS

• Either option carries substantial implications for:
  • State and local economies
  • Beneficiaries
  • Health care system
  • Jobs
  • Population health