NATIONAL ACADEMY OF·SOCIAL INSURANCE

Medicaid's Role in Our Health Insurance System

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JUNE 22, 2017

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
- Thanks to Alexandra L. Bradley, Sara Rosenbaum, and Debra J. Lipson for their research and work on this project.

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)

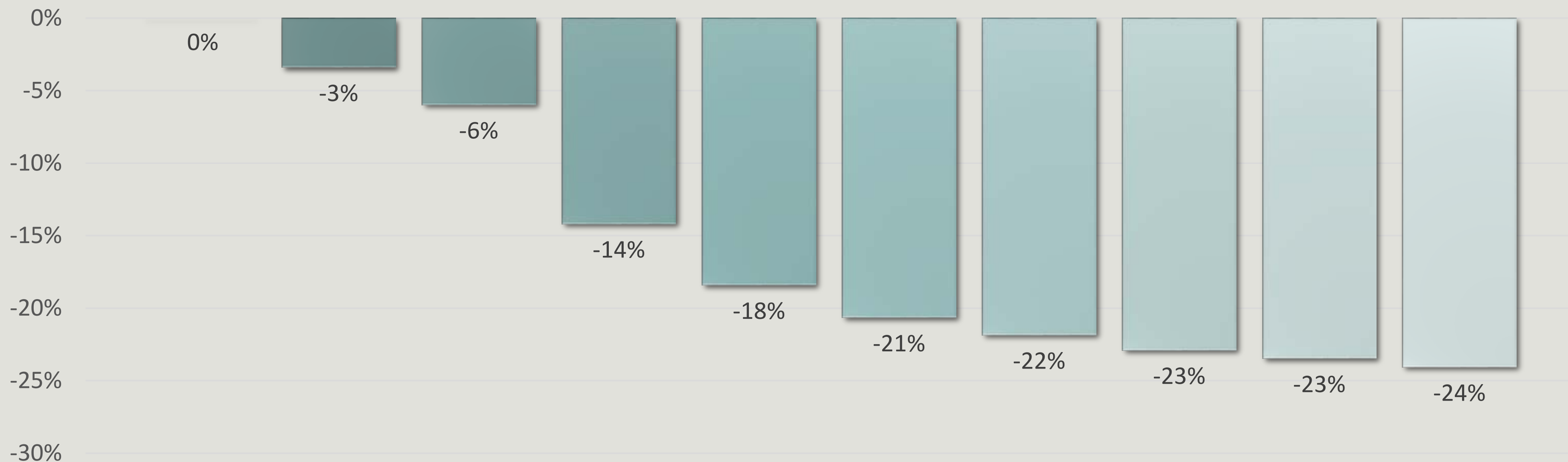
Per Capita Caps in the AHCA

- 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)



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