

# Expert Voices

## In Health Care Policy

### MEDICAID EXPANSION: STATE OF PLAY AND WHAT'S TO COME

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Since the 2012 Supreme Court decision making it optional for states to implement the Affordable Care Act's expansion of Medicaid to cover non-elderly adults with incomes below 138 percent of the poverty line, 30 states and the District of Columbia have chosen to expand eligibility (Figure 1). In this essay I describe current data on the impact of these expansions and the alternative approaches adopted by some states and consider how the landscape may evolve in coming years.

#### THE IMPACT OF MEDICAID EXPANSION

The ACA coverage provisions are reducing uninsurance rates nationwide, with the biggest gains occurring in states that have expanded Medicaid. New data from the American Community Survey show that between 2013 and 2014 the overall uninsurance rate fell by 3.4 percentage points in expansion states vs. 2.3 percentage points in non-expansion states.<sup>1</sup> Likewise, the latest Health Reform Monitoring Survey pegs the declines in uninsurance rates for working age adults at 8.5 and 5.2 percentage points, respectively, for expansion vs. non-expansion states in the two years since the start of the 2013 open enrollment period.<sup>2</sup> With non-expansion states, as a group, starting off with higher uninsurance rates and seeing less improvement, their coverage disparity relative to expansion states has worsened.

Expansion states are also reporting positive budget impacts. States can reduce their Medicaid program costs when enrollees who had been receiving services under special targeted programs, such as medically needy beneficiaries, are moved to the expansion

program with its higher federal match. Expansion states have also been able to use federal Medicaid dollars instead of state general funds for uncompensated care programs and certain other services to the uninsured. And states that tax health plans or providers are seeing higher revenue as the Medicaid expansion increases plan and provider income.

These fiscal impacts are substantial, with one study estimating savings and revenue of \$1.8 billion by the end of 2015 across the eight expansion states it examined.<sup>3</sup> Furthermore, in three states making such projections, these newfound gains are expected to more than offset new state expenditures associated with the expansion through at least 2021, after the federal match rate for the expansion population has declined to its long-term level of 90 percent.<sup>3,4</sup> Numerous other studies are showing the large benefits to hospitals, which now have to provide much less uncompensated care, while others are documenting significant positive indirect impacts on state economies.<sup>5,6</sup>

Early evidence on access to care for newly enrolled beneficiaries is also encouraging. In Michigan, despite a rapid influx of well over 600,000 newly insured people, Medicaid appointment availability improved significantly and new appointment wait times did not increase. Kentucky has reported dramatic gains in the number of its Medicaid beneficiaries receiving physical exams, cancer screenings and other preventive services. Nationally, 78 percent of new Medicaid enrollees who have obtained care said they would not have been able to afford or access this care prior to gaining Medicaid coverage.

#### **EXPANSION THROUGH WAIVERS**

Five states—Arkansas, Indiana, Iowa, Michigan and New Hampshire—are currently operating their Medicaid expansions through an approved demonstration project or "waiver" authorized under section 1115 of the Social Security Act, and Montana is now enrolling people for 2016 coverage under its new waiver (Figure 1). Conversely, under a new governor, Pennsylvania reversed its approved waiver and is now proceeding with a traditional expansion.

Section 1115 waivers give states added flexibility in running their Medicaid program, but within limits. States must show that their demonstrations promote Medicaid's objectives of delivering health and long-term care services and other needed supports to vulnerable low-income populations. Some provisions of Medicaid law, most notably the rules limiting out-of-pocket costs such as copayments, cannot be waived under section 1115.

Arkansas broke new ground as the first state to receive an expansion waiver, gaining permission to use federal Medicaid funds to purchase private coverage on the health insurance exchange for most newly eligible adults. Since that time, lowa and New Hampshire adopted this approach for some or all of their expansion populations, although lowa now plans to transfer its enrollees to traditional Medicaid managed care plans. Other common features in approved expansion waivers include premiums, incentives for healthy behavior, and HSA-like accounts used to pay co-pays or deductibles.<sup>10</sup>

While section 1115 does not permit states to waive Medicaid's cost-sharing protections,

a separate authority does allow cost-sharing waivers in limited circumstances. This authority was used for the first time in Indiana. where beneficiaries will be charged \$25 for the second time they use an emergency room for a non-emergency purpose. Indiana is also the only state with permission to charge premiums to people in deep poverty—those with incomes below 50 percent of the poverty line. To date, no state has been allowed to drop coverage for people in poverty who don't pay their premiums, but Indiana puts these enrollees in a plan that charges the maximum co-pays allowed under Medicaid. The state also has a six-month lock out period for people with incomes above poverty who fail to pay their premiums.

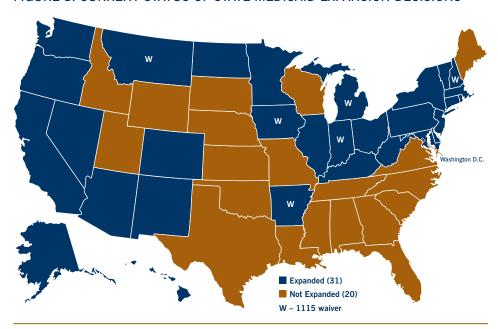
#### WHAT'S NEXT?

Several waiver proposals from current expansion states will be considered by CMS over the coming months and all contain components that push the limits of what has been allowed previously. Michigan is seeking to modify its waiver to require beneficiaries above the poverty line to choose between enrolling in private coverage on the exchange and remaining in Medicaid with higher cost sharing and premiums of up to 7 percent of income after four years in the program. Arizona's recent waiver application would implement targeted cost sharing and require premium contributions to an HSA, with a sixmonth lock out for nonpayment for those above the poverty level. The state legislature also has required the state to submit new requests annually seeking a work requirement and fiveyear lifetime enrollment limit. And Ohio's state budget compels its Medicaid agency to seek a waiver requiring expansion beneficiaries at all income levels to contribute up to 2 percent of income to an HSA in order to stay enrolled.

HHS is unlikely to approve onerous premiums in combination with co-pays, time limits, or work requirements. Recent research shows that cost sharing can deter both new and ongoing treatments and may be hard for low-income patients to understand,11 that copays for non-emergency use of the emergency room did not change ER use,12 and that even modest premiums reduce Medicaid participation.<sup>13</sup> Time limits have never been approved for Medicaid, and HHS has rejected all prior proposals to condition Medicaid eligibility on participation in work-related activities. HHS has, however, allowed states to refer beneficiaries to employment or work search programs with no impact on eligibility.

Even beyond these pending waivers, the current expansion landscape is not indelibly fixed. Existing waivers may be amended and

FIGURE 1. CURRENT STATUS OF STATE MEDICAID EXPANSION DECISIONS



all will expire in the next few years, requiring a renewal application if the state wishes to continue and introducing opportunities for further changes in approach. Alaska's recent expansion by the governor's executive action could be undone by the pending legal challenge from the state legislature, and the newly elected governor in Kentucky seems likely to seek a waiver to change that state's expansion approach. Likewise, some non-expansion states have made serious runs at expansion in the past and may eventually find an acceptable path to this end. Louisiana, South Dakota and Alabama are states to watch on this front.

Meanwhile, in the 20 non-expansion states, an estimated 3.1 million adults are too poor to qualify for subsidized private coverage on the exchange but not poor enough to qualify for their state's existing Medicaid coverage. <sup>14</sup> These individuals can almost certainly not afford unsubsidized coverage and few have access to employer-provided coverage even when working. Uninsured, they will remain highly reliant on safety net providers, when they are able to access the health care system at all, leaving them at risk of poorer health outcomes due to postponed or intermittent care and resulting in higher spending on uncompensated care.

#### **ENDNOTES**

- Smith JC, Medalia C. "Health Insurance Coverage in the United States: 2014," U.S. Census Bureau Report P60-253, Sept 2015.
- 2 Karpman M, Long SK. "Taking Stock: Gains in Health Insurance Coverage under the ACA Continue as of September 2015, but Many Remain Uninsured." Urban Institute. Nov 4, 2015.

- 3 Bachrach D, Boozang P, Glanz D. "States Expanding Medicaid See Significant Budget Savings and Revenue Gains." State Health Reform Assistance Network Issue Brief. April 2015.
- 4 Kaiser Family Foundation. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." Issue Brief. March 2015.
- 5 Bachrach D, Boozang P, Lipson M. "The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States." State Health Reform Assistance Network Issue Brief. June 2015.
- 6 Assistant Secretary for Planning and Evaluation. "Economic Impact of the Medicaid Expansion." March 23, 2015
- 7 Tipirneni R, Rhodes KV, Hayward RA, et al. "Primary Care Appointment Availability for New Medicaid Patients Increased After Medicaid Expansion in Michigan." Health Affairs, 34(8):1399-1406. Aug 2015.
- 8 Ungar L, "Preventive Care Rises among Kentucky Medicaid Patients." *The Courier-Journal*, Aug 5, 2015.
- 9 Collins SR, Rasmussen PW, Doty MM, Beutel S. "Americans' Experiences with Marketplace and Medicaid Coverage: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March-May 2015." June 2015.
- 10 Cross-Call J, Solomon J. "Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid Through Waivers." Center on Budget and Policy Priorities, March 4, 2015.
- 11 Powelll V, Saloner B, Sabik LM. "Cost Sharing in Medicaid: Assumptions, Evidence and Future Directions." Med Care Res Rev. Published online Nov 24, 2015.
- 12 Siddiqui M, Roberts ET, Pollack CE. "The Effect of Emergency Department Co-payments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005," JAMA Intern Med, 175(3):393-8, March 2015.
- 13 Dague L. "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach." J Health Econ, 37:1-12. Sept 2014.
- 14 Garfield R, Damico A. "The Coverage Gap": Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update." Kaiser Family Foundation. Oct 23, 2015.