

How Will Repealing the ACA Affect Medicaid? Impact on Health Care Coverage, Delivery, and Payment

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ABSTRACT

ISSUE: The Affordable Care Act enhanced Medicaid's role as a health care purchaser by expanding eligibility and broadening the range of tools and strategies available to states. All states have embraced delivery and payment reform as basic elements of their programs.

GOAL: To examine the effects of reducing the size and scope of Medicaid under legislation to repeal the ACA.

FINDINGS AND CONCLUSIONS: Were the ACA's Medicaid expansion to be eliminated and were federal Medicaid funding to experience major reductions through block grants or per capita caps, the effects on system transformation would be significant. Over 70 percent of Medicaid spending is driven by enrollment in a program that covers 74 million people; on a per capita basis Medicaid costs less than Medicare or commercial insurance. States would need to absorb major financial losses by reducing the number of people served, reducing the scope of services covered, introducing higher cost-sharing, or further reducing already low payments. Far from improving quality and efficiency, these changes would cause the number of uninsured to rise while depriving health care providers and health plans of the resources needed to care for patients and invest in the tools that are essential to system transformation.

KEY TAKEAWAYS

- ▶ By eliminating the expansion of Medicaid eligibility and capping federal funding for the traditional program, the American Health Care Act would lead some states to eliminate Medicaid coverage for certain populations, restrict or eliminate access to specific services, and introduce barriers to enrollment.
- ▶ The large federal funding losses also would mean fewer state resources for health care delivery reform efforts.
- ▶ Paradoxically, states that have managed to reduce their per capita Medicaid spending may be especially hard hit by a block-granting or per capita caps.



BACKGROUND

Medicaid has taken center stage in ongoing policy discussions about “repealing and replacing” the Affordable Care Act (ACA). In addition to eliminating health insurance coverage for millions, reducing the size and scope of Medicaid could hinder efforts to transform the program into a more efficient health care purchaser. These concerns have come into clear focus under legislation now pending in the U.S. House of Representatives that would transform Medicaid, not only by eliminating enhanced federal funding for eligibility expansion but also by reducing the amount of funding states receive to run their traditional programs. The Congressional Budget Office (CBO) estimates that, combined with other provisions aimed at reducing eligibility and access to certain services, the bill would reduce federal Medicaid payments by \$880 billion over the coming decade, triggering major enrollment declines and threatening the scope of coverage available to those who remain enrolled.

Medicaid has tested delivery and payment reform models for decades. The original Medicaid statute allowed states to offer enrollment into prepaid group health plans.¹ Later amendments, enacted on a bipartisan basis over many decades, have allowed states to broaden their use of managed care and to require beneficiaries to use designated providers, including provider networks offered by insurers that participate in the Medicaid program.² Additionally, through Section 1115 (of the Social Security Act) waivers, states have tested delivery and payment reform for key populations, including beneficiaries with serious and chronic health conditions, using managed care demonstrations.³

Delivery and Payment Reform Models Under the ACA

Medicaid’s efforts to improve the quality and efficiency of care have taken on added importance because of the ACA’s eligibility expansion, now under threat. According to government statistics, as of October 2016, Medicaid enrollment surpassed 74 million. More than 17 million people—an increase of 30 percent—gained eligibility since October 2013, just before full implementation of the ACA. Although 19 states have not yet chosen to adopt the ACA’s adult Medicaid eligibility expansion, virtually all have embraced the idea of using Medicaid to promote

health system transformation as a program goal.⁴ By 2014, in the first year of full ACA implementation, over 76 percent of all Medicaid beneficiaries were enrolled in some form of managed care.⁵ Today, 21 states have introduced accountable care organizations into their Medicaid programs, 46 rely on comprehensive managed care programs for at least a portion of their population, 20 have developed health homes, and 49 have introduced some type of payment reform.

The ACA encouraged states to view Medicaid as a vehicle for health care transformation in other ways. “Health homes,” for example, represent an explicit effort on the part of Congress to give states additional improvement tools for their most vulnerable patients.⁶ Additionally, many of the ACA’s delivery and payment reforms—initially targeted chiefly at Medicare—were incorporated into Medicaid through regulations that gave states additional flexibility. These reforms include: promoting payment reform;⁷ promoting use of integrated delivery and accountable care models⁸ that already have begun to show measurable savings;⁹ establishing a “state innovation model” initiative within the Center for Medicare and Medicaid Innovation;¹⁰ and establishing a Medicaid Innovation Accelerator program, which aims to ensure that innovations in care are more rapidly disseminated to all states, with technical support available.¹¹ The ACA also acted to promote Medicaid managed care plans to better care for high-need, high-cost beneficiaries and to improve health care quality, efficiency, and health outcomes for people eligible for both Medicare and Medicaid.^{12,13}

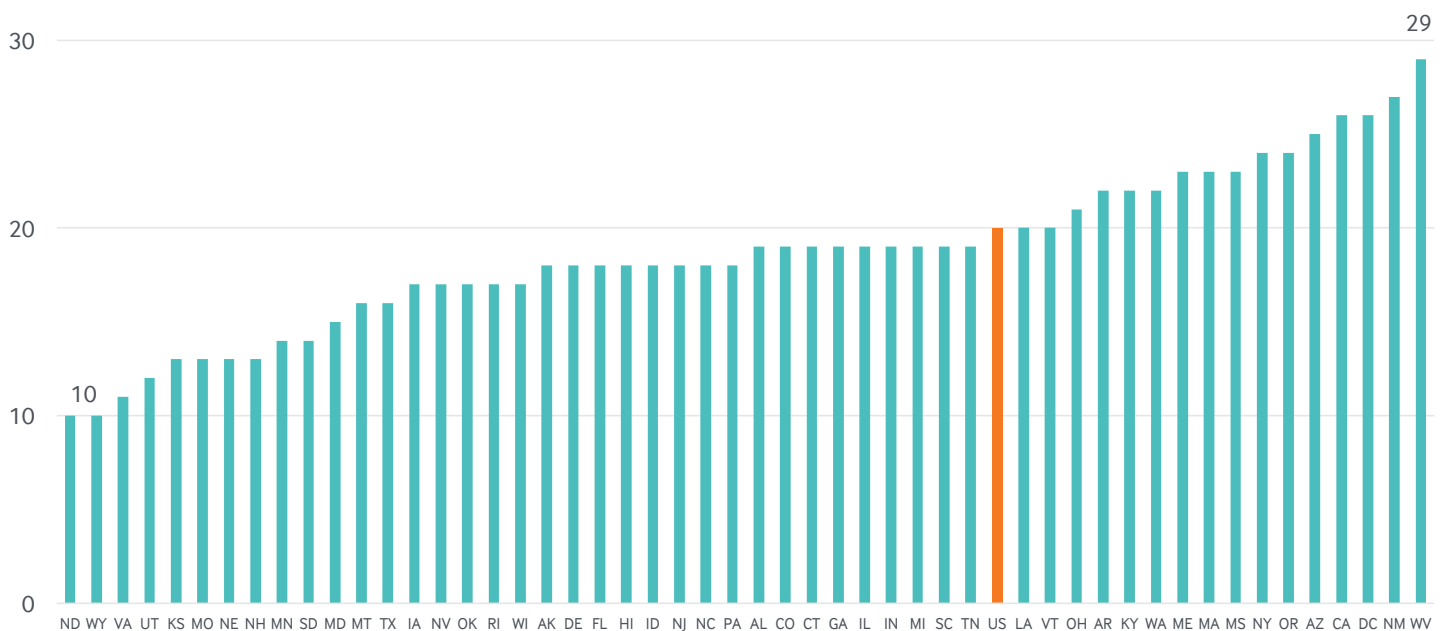
Medicaid’s Impact on Coverage and Spending

Nationwide, Medicaid now covers 20 percent of the population; in expansion states with exceptionally large poor populations, such as West Virginia or California, Medicaid insures 25 percent or more of the total population (Exhibit 1).¹⁴ At this rate, Medicaid can be expected to have considerable impact on health care. This is especially true for services for which Medicaid is the largest and most influential payer, like maternity and pediatric care, long-term services and supports, and services to treat mental illness and addiction disorders.

Because providers are paid at a lower rate, Medicaid programs are able to furnish coverage to beneficiaries

Exhibit 1. Proportion of State Population Covered by Medicaid, 2015

Percent



Data: Henry J. Kaiser Family Foundation, *State Health Facts: Health Insurance Coverage of the Total Population, 2015*, available at <http://kff.org/other/state-indicator/total-population/?currentTimeframe=0>.

with lower cost-sharing and annual per capita spending that is significantly lower than comparable coverage through employer-sponsored health plans.¹⁵ But the low spending levels create other challenges for states.

One is relatively low provider participation rates among medical specialists.¹⁶ This is a particularly serious problem for beneficiaries who experience both physical and behavioral health needs—a phenomenon considerably more likely to occur among the Medicaid population.¹⁷ States have sought to overcome this problem by investing in care delivery arrangements like accountable care organizations designed to make more efficient use of specialty care while broadening the role of comprehensive primary care.

The health care safety-net—community health centers, women’s health clinics, public hospitals, and hospitals that function as sole providers in remote communities—is essential to transforming care for low-income populations. But the safety-net providers on which Medicaid programs heavily depend—especially in areas with concentrated poverty and limited access to health care resources—lack

resources to invest in tools like enhanced information systems, new and more accessible service delivery sites, and affiliations or relationships with other providers. Medicaid can play a critical role through expanded eligibility and by payment enhancements that incentivize quality, which can help providers gain access to revenues needed to transform their practices.¹⁸ Further, in recent years some Medicaid agencies themselves have become directly involved in capacity-building critical to long-term success through initiatives like the Delivery System Reform Incentive Payment program, a special 1115 demonstration launched by the Obama administration to ensure that state Medicaid programs and their key providers have access to transformation investment funding.¹⁹

WHAT MIGHT REPEAL AND REPLACE MEAN FOR MEDICAID TRANSFORMATION?

Impact on Coverage

The American Health Care Act, reported by the House Energy and Commerce and Ways and Means committees in March 2017, would eliminate the ACA’s enhanced

funding to support the expansion population, among other changes. The bill also would cap the amount paid by the federal government to states to support their overall Medicaid program, setting the cap at an amount below actual annual program growth costs, even though per person Medicaid spending is lower than that of either Medicare or private health insurance. The Congressional Budget Office has concluded that the loss of Medicaid funds at the enhanced rate for the expansion population (100% in 2014–2016, declining to 90% in 2020) to states' normal federal Medicaid matching rates (ranging from 50% to 75%) would lead a number of states to eliminate coverage for the expansion population.²⁰ By 2026, less than one-third of all people eligible for coverage through the ACA expansion would live in a state that offers such coverage. The House measure also reduces Medicaid spending for community-based long-term services and supports and introduces new barriers to eligibility and enrollment.²¹

The bill also introduces a complete replacement of the federal Medicaid financing structure that has sustained the program for a half-century. Under the bill, the federal government would no longer pay its share in accordance with the actual cost of coverage but instead would limit its contribution to state programs to a fixed annual per person amount that would be permitted to grow only by the rate of medical inflation. The legislation would effectively limit annual payments to estimated enrollment, with no real-time adjustment for actual and sudden changes in the number of people covered or the intensity of care required.

The Effect of Lowered Spending

At least in theory, fixed limits on per person Medicaid funding could help foster innovation by encouraging strategies that substitute less costly but equally appropriate care, reduce excessive use of services of questionable value, or lower the price paid for care. But despite its size, Medicaid does not spend excessively in terms of the amount or intensity of care it purchases or the prices it pays. As a result, innovations that maintain good coverage while supporting quality and efficiency would be difficult to achieve.

On a per capita basis, Medicaid is significantly less costly than comparable coverage purchased in the employer

market. Even without the introduction of federal spending caps, experts had projected that future Medicaid per person spending would be lower than spending for comparable services under either Medicare or private insurance. Medicaid spending is largely explained by enrollment. From 1975 to 2012, over 70 percent of Medicaid spending growth was linked to enrollment rather than rising costs per enrollee; since 2012, Medicaid spending growth has been spurred by a 30 percent increase in program enrollment coupled with enhanced funding for the expansion population.²²

Going forward, even if greater health care efficiencies can be identified, such efficiencies will not be able to offset the loss of federal funding under the House bill. The CBO notes if per capita caps fail to keep up with actual costs, states will either have to increase their own spending or eliminate optional populations and services.²³ Current initiatives—like the Medicare Shared Savings Program or financial incentive arrangements under Medicaid managed care—project savings of about 5 percent through delivery reform and payment efficiencies typically. This is far below what would be required to absorb the type of large-scale decline in federal funding under Medicaid repeal-and-replace plans.

Cuts of the type contained in the House bill carry major implications for payment and delivery reform. First and foremost, the CBO projects that elimination of enhanced funding for the ACA expansion population would lead states to roll back their expansions or forgo expansion in the first place, ultimately reducing the number of people covered by 17 percent by 2026—14 million fewer people annually. Without coverage there can be no delivery and payment reform.

How Will States Get by with Less?

Even with coverage maintained for some, it is likely that states' efforts at large-scale delivery and payment reform would be hindered. The number of uninsured will rise as a result of the bill's Medicaid cutbacks and its major reduction in the amount of financial assistance given to low-income people to buy subsidized private health insurance. The rise in the number of uninsured patients that would accompany large federal funding losses

would place enormous pressure on safety-net providers and delivery systems, meaning that there would be less capacity and resources for delivery reform efforts. The loss of coverage also would reduce insurance revenues that help providers and health plans show the type of future revenue that in turn would make them attractive to private lenders and investors, thereby gaining access to public and private investment funding. This loss of capital would impede the kind of large-scale system transformation efforts under way in states like California, Massachusetts, New York, and Texas.

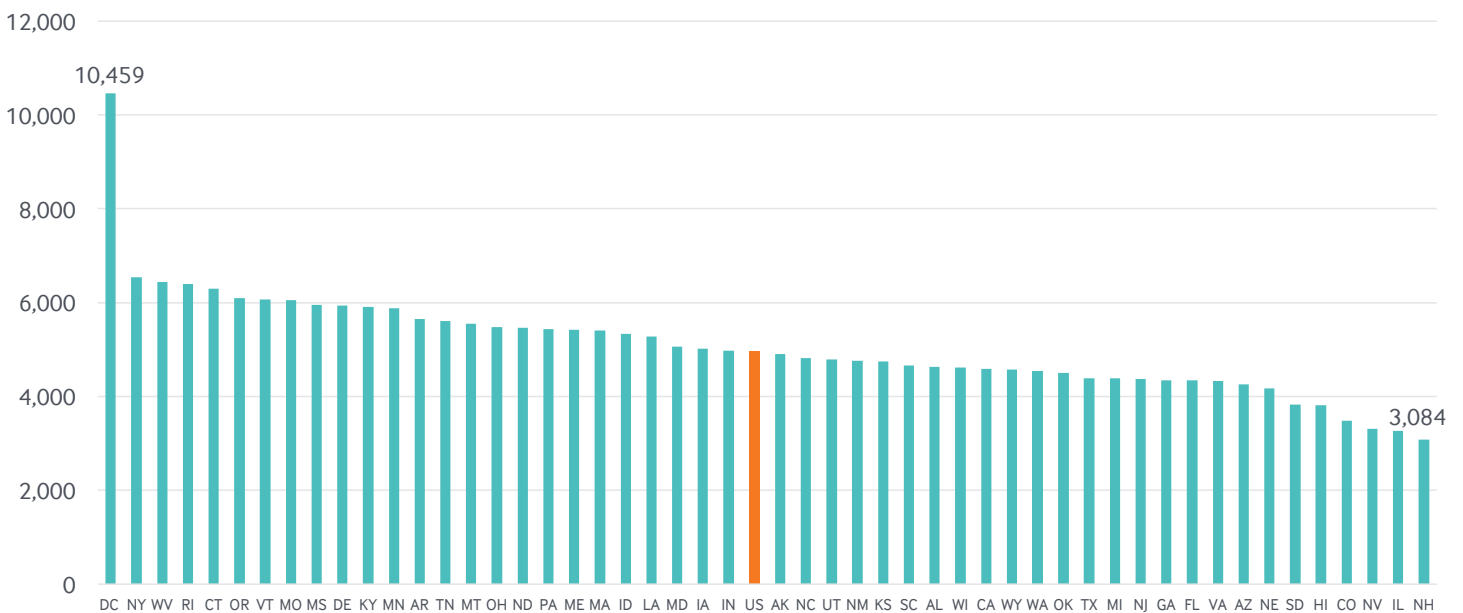
As the CBO notes, states could attempt to preserve some level of coverage for their populations by steeply scaling back the scope of covered services as well as the rate at which they pay for care. Under repeal, it is likely that the federal Medicaid requirement that payments to risk-based managed care contractors be actuarially sound—that is, that payment reflect the reasonable cost of furnishing covered services to a defined population—would be relaxed or eliminated. Under such a scenario, there could be a decline in the number of managed care plans either

willing or able to participate in Medicaid. Health care providers that treat high volumes of both uninsured and Medicaid patients would be forced to scale back services. This would be especially true for those services that are no longer covered or paid for, like oral health care, services to treat chronic behavioral health conditions, and treatments that depend on combining ongoing clinical care with costly prescription drug treatment regimens. The gap between patient need and coverage and payment would be particularly wide for high-cost, high-need patients who need care that is intense and costly. It is extremely difficult to create financial incentives that move health care delivery toward quality and efficiency if the starting point is underfinanced care and eliminated coverage.

Finally, states that have achieved greater program efficiencies and thus reduced their per capita spending may be especially hard hit by a block grant or per capita caps. A 2016 analysis of state variation in federal Medicaid funding found a variation of 11-to-1 in spending per low-income person and as much as a 3-to-1 variation in spending on program enrollees (Exhibit 2).²⁴ Greater

Exhibit 2. Federal Per Capita Medicaid Enrollee Spending by State, 2017

Dollars



Data: J. Holahan and M. Buettgens, *Block Grants and Per Capita Caps: The Problem of Funding Disparities Among States*, Urban Institute, Sept. 2016, available at <http://www.urban.org/research/publication/block-grants-and-capita-caps>.

efficiencies achieved by certain states have reduced the amount of funds needed to appropriately care for affected populations. Thus, caps applied either at the per-beneficiary or aggregate level could have the paradoxical effect of disadvantaging states that have been the most efficient while rewarding those with the highest underlying health system costs. In other words, rather than encouraging innovation and efficiency, capping spending could trigger higher state spending to increase allotments.

CONCLUSION

“Repeal and replace” will certainly have an enormous impact on the private insurance market, particularly the market for individual insurance. The same is true for Medicaid. For a half-century, the federal and state governments have partnered to improve the accessibility and quality of care for tens of millions of low-income and medically vulnerable children and adults and have shared in the cost of this undertaking. If repeal-and-replace efforts curtail this partnership, consequences could include the loss of coverage for millions, but also a dismantling of transformation endeavors or removing incentives from future progress. Medicaid already is a comparatively efficient means of insuring the population; the CBO has estimated that Medicaid coverage costs one-third less than comparable coverage bought on the individual market using tax subsidies.²⁵ Efforts to reduce federal funding will serve only to impede further payment and delivery reforms.

NOTES

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