Disability Policy Seminar: 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
- Offices: CA, DC, NC
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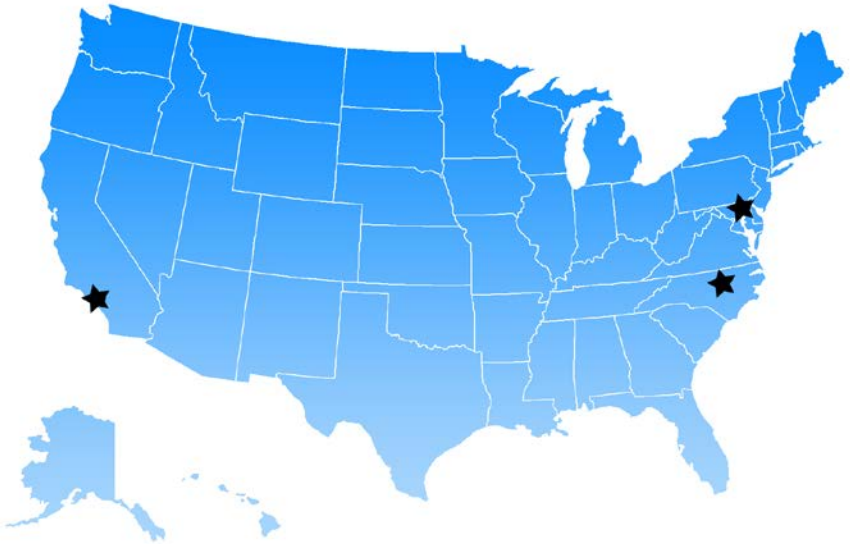

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Medicaid is not “Discretionary”

- 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)

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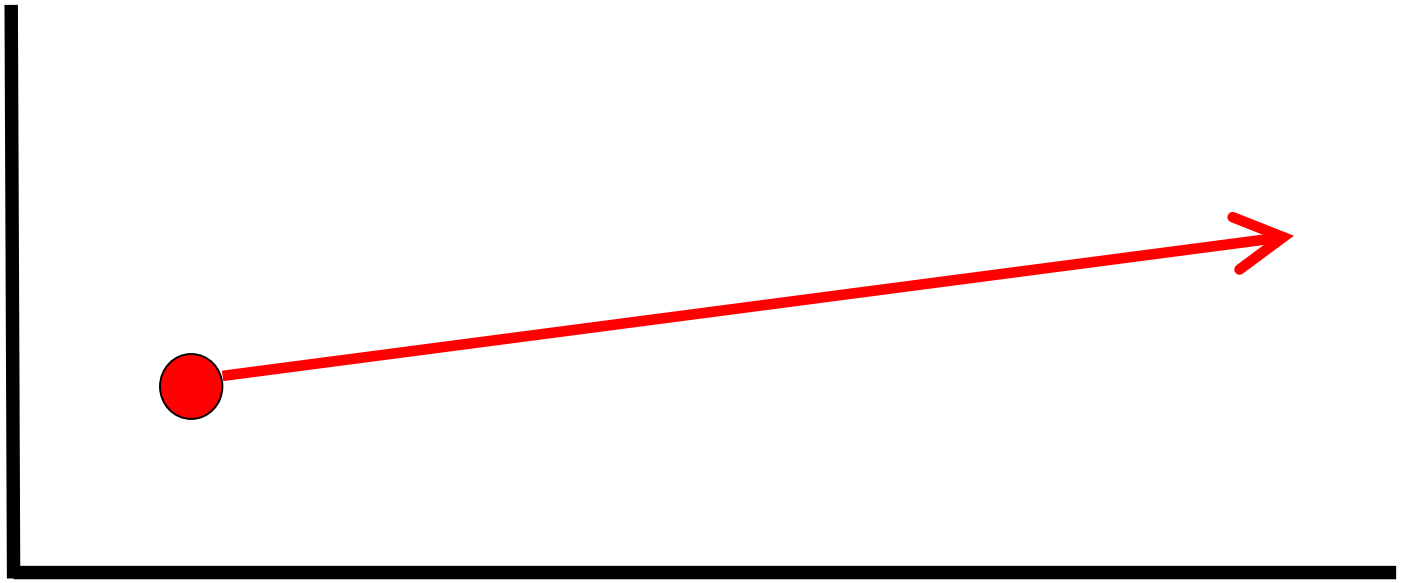
*This is theoretical since any proposal can alter a state's ability to add more enrollees or other features of the Medicaid program.

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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Base year spending level

- Some PCC proposals start with a base spending level below the current need
- State variability makes it hard to pick a base criteria that is fair to all
- Using past data to set base is problematic, but using future data could let states add spending before the base year
- Will baseline be with or without Medicaid Expansion

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Design a PCC: Details

- Singular, combined cap creates issues because of varied spending – e.g. “healthy” child v. person with HIV/AIDS
- Four 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

- Introduced in the House on March 6, passed by both House Energy & Commerce and Ways & Means Committees
  - 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

Index for growth

- Prior PCC proposals used growth indexes based on objective factors (such as CPI) that increase much more slowly and predictably than Medicaid spending
- They are also not counter-cyclical
- Ultimately they make the federal funding gap *grow* every year

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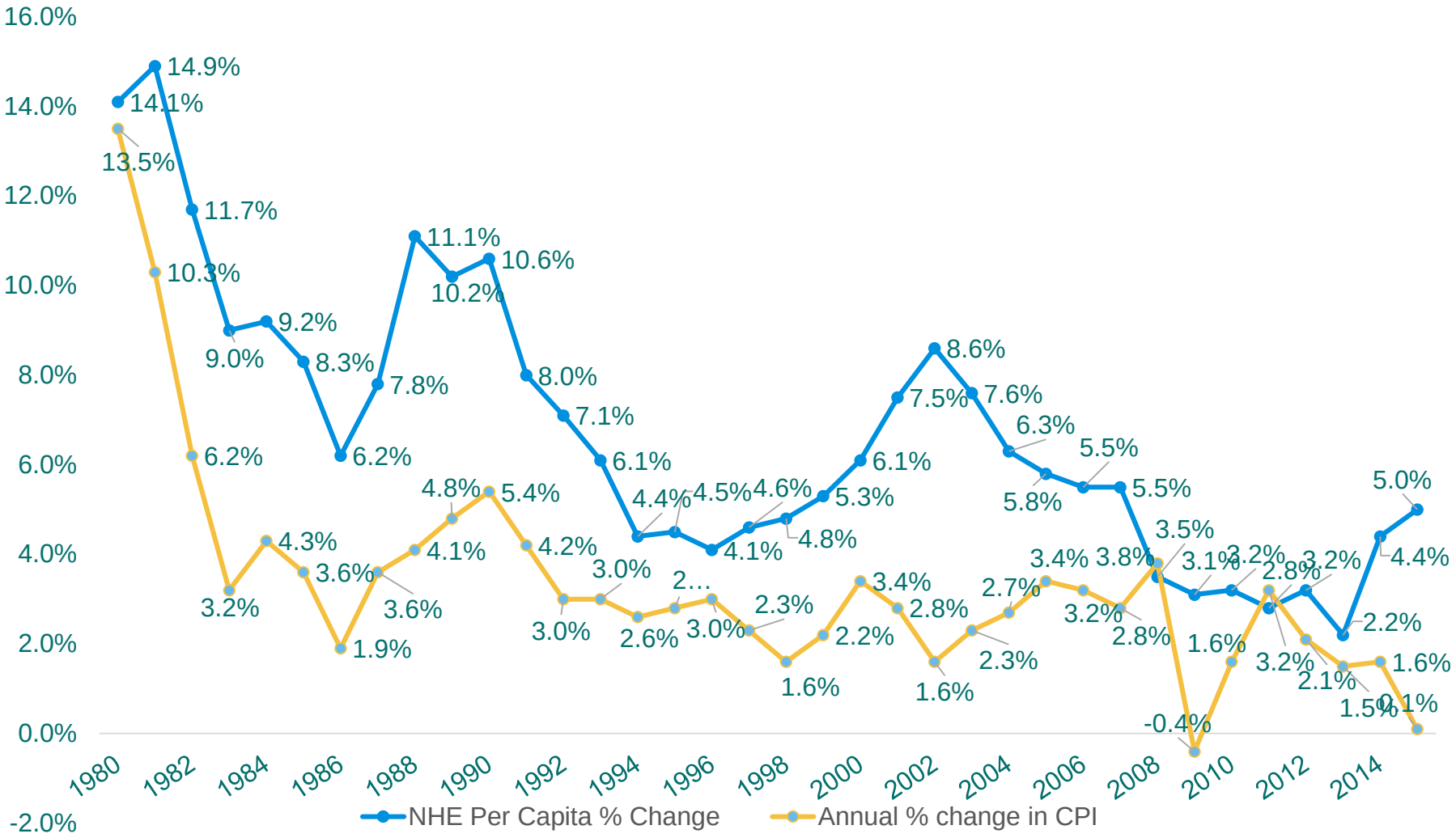
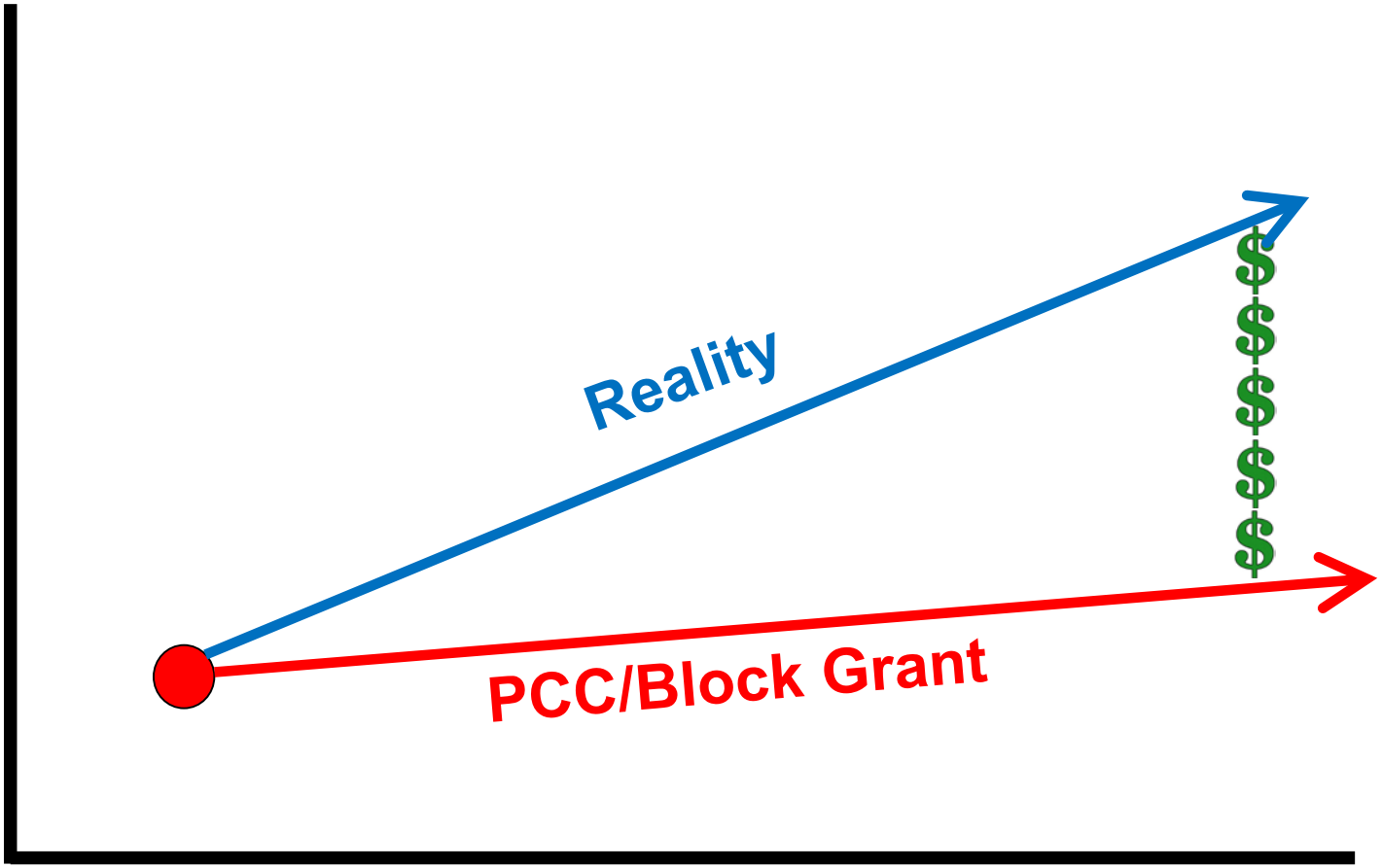
Growth in per capita health spending has consistently been higher than overall economic growth

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).

Escalation of the Funding Gap



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CBO/JCT “Score”

- Estimate on AHCA released 3/13/17
  - Cuts $880 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

Next Steps

- House floor vote scheduled for 3/23 (ACA anniversary)
- Expect “Manager’s amendment” before House floor vote re: work requirements, block grant option
- Senate floor vote could occur week of 4/3
- 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
- Goal is to slash **billions** of dollars from Medicaid, not to make it more flexible
- 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
- Medicaid is different than CHIP

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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