

# The Current Health Care Debate: What's Next?

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Figure 1

# ACA Framework

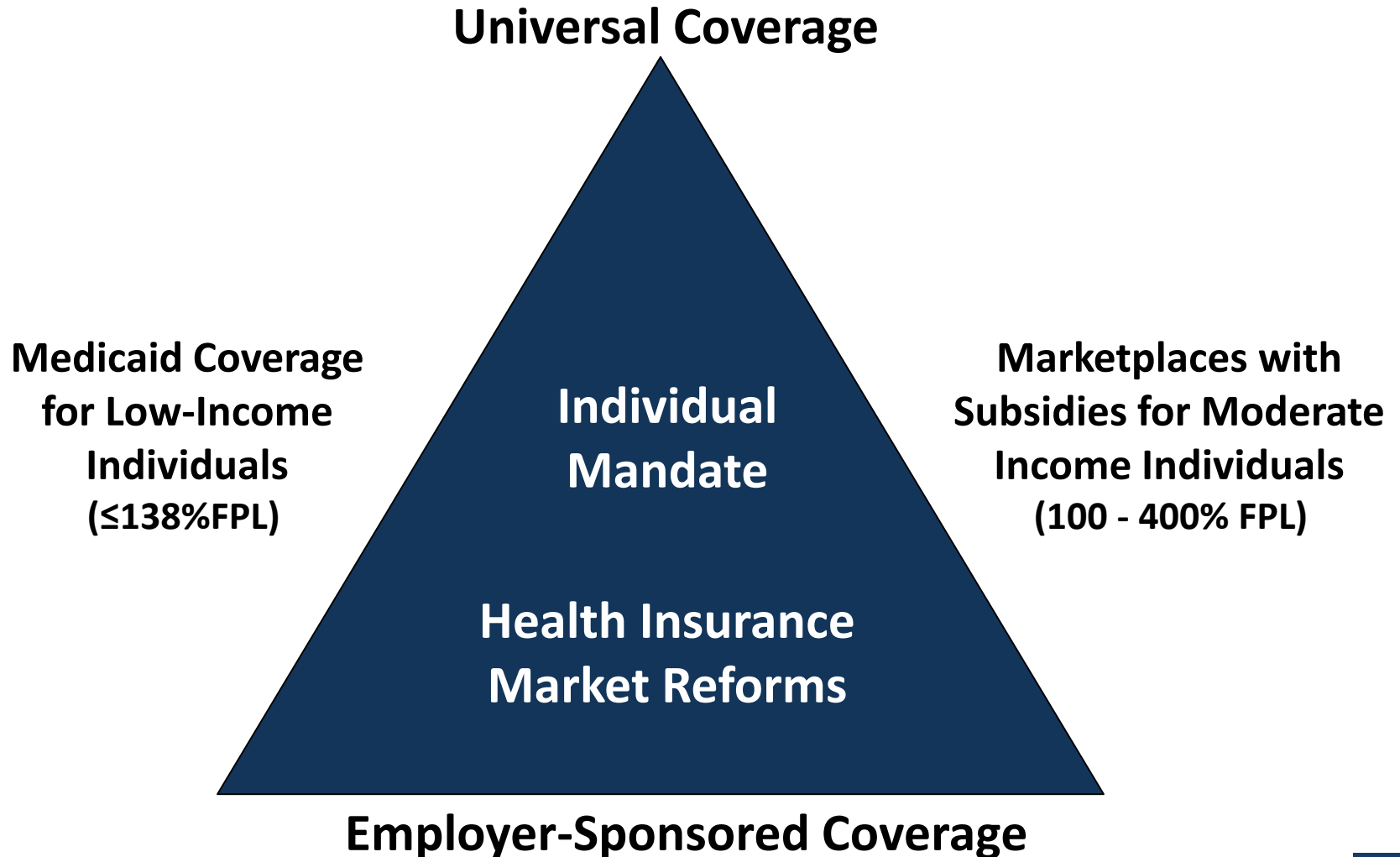
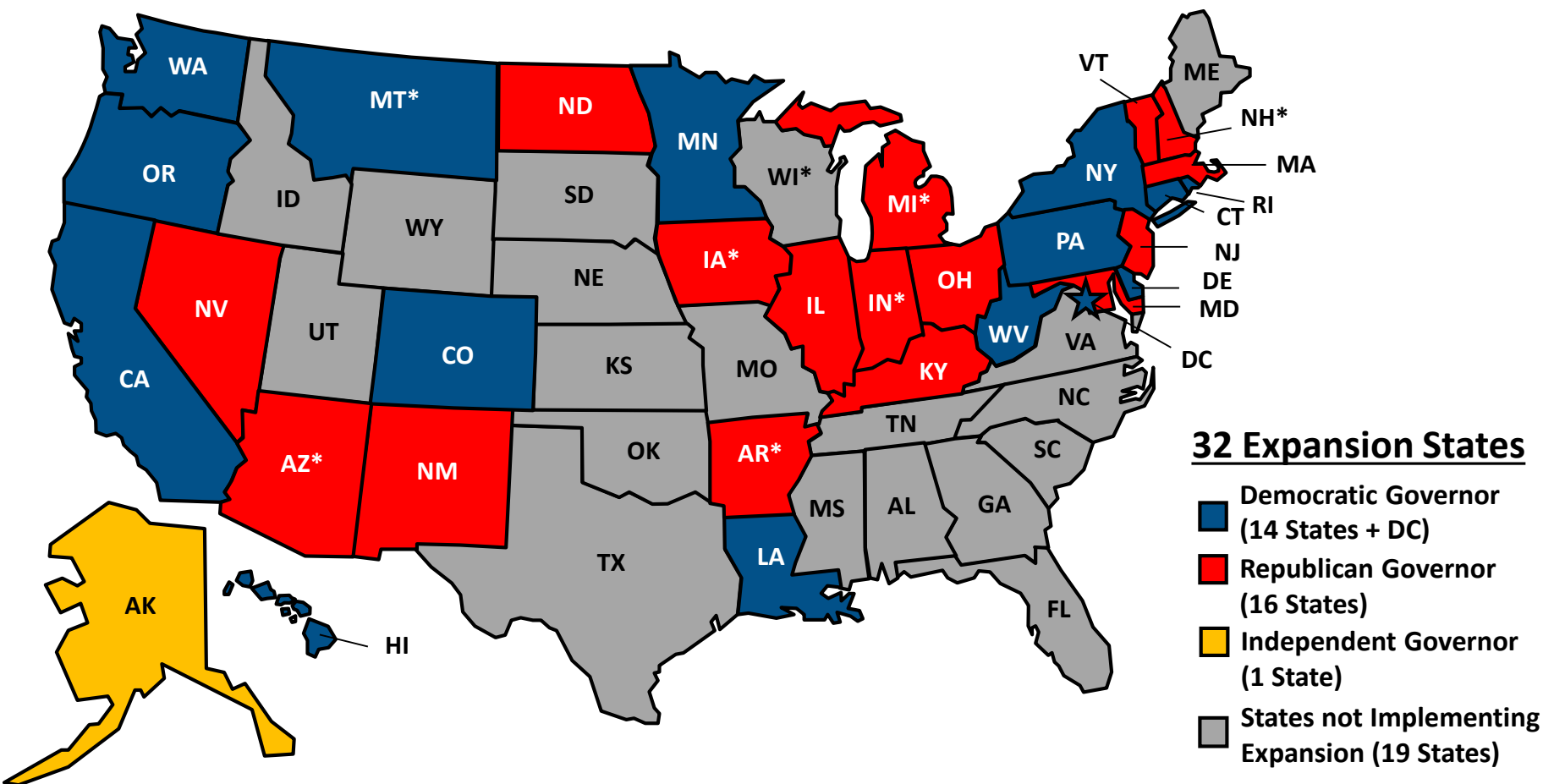


Figure 2

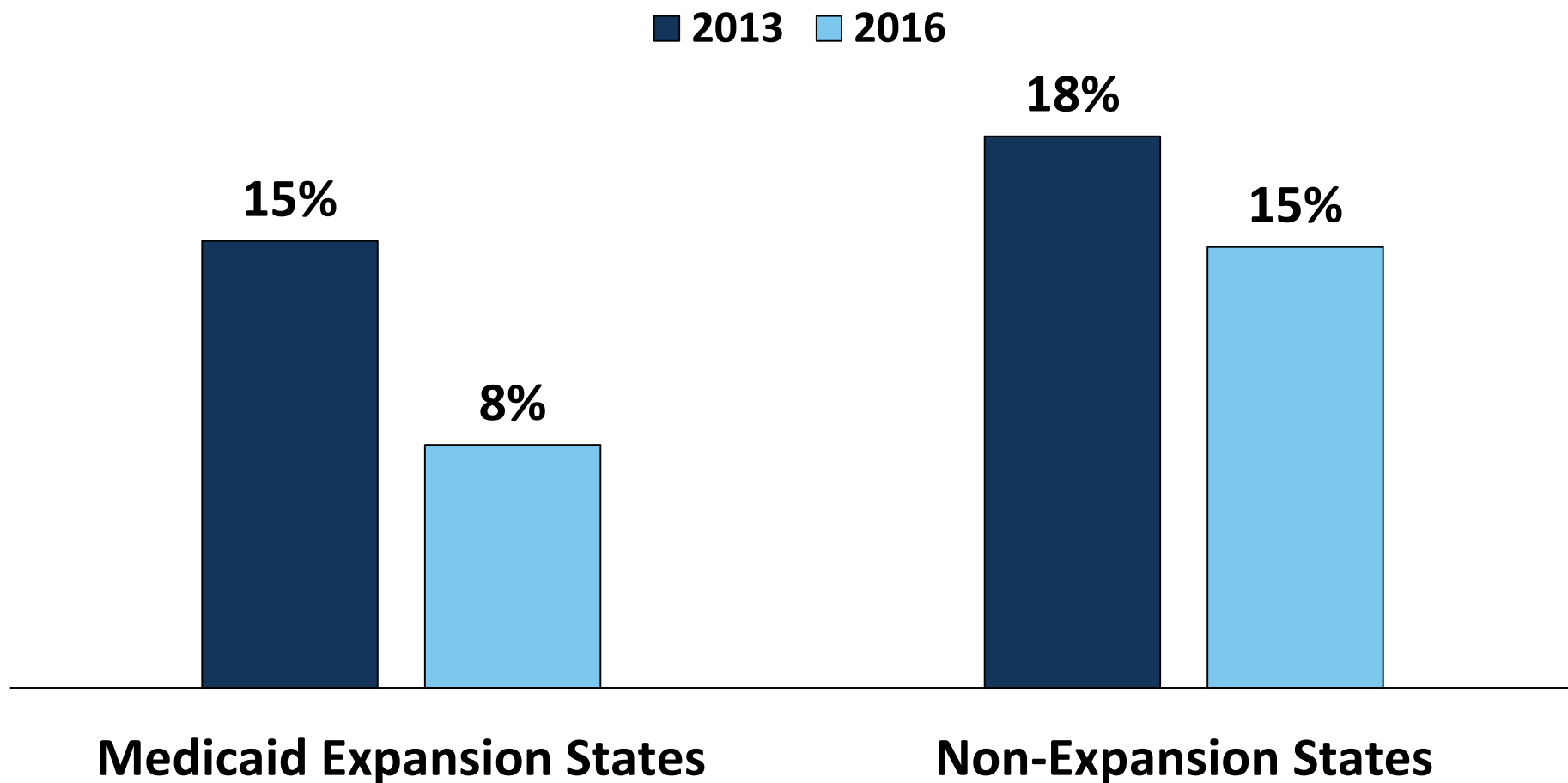
# To date, 32 states have implemented the Medicaid expansion.



NOTES: Coverage under the Medicaid expansion became effective January 1, 2014 in all but seven expansion states: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2016), and Louisiana (7/1/2016). Seven states that will have Republican governors as of January 2017 originally implemented expansion under Democratic governors (AR, IL, KY, MA, MD, NH, VT), and one state has a Democratic governor but originally implemented expansion under a Republican governor (PA). \*AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers.

Figure 3

## The uninsured rate has decreased everywhere, but especially in Medicaid expansion states

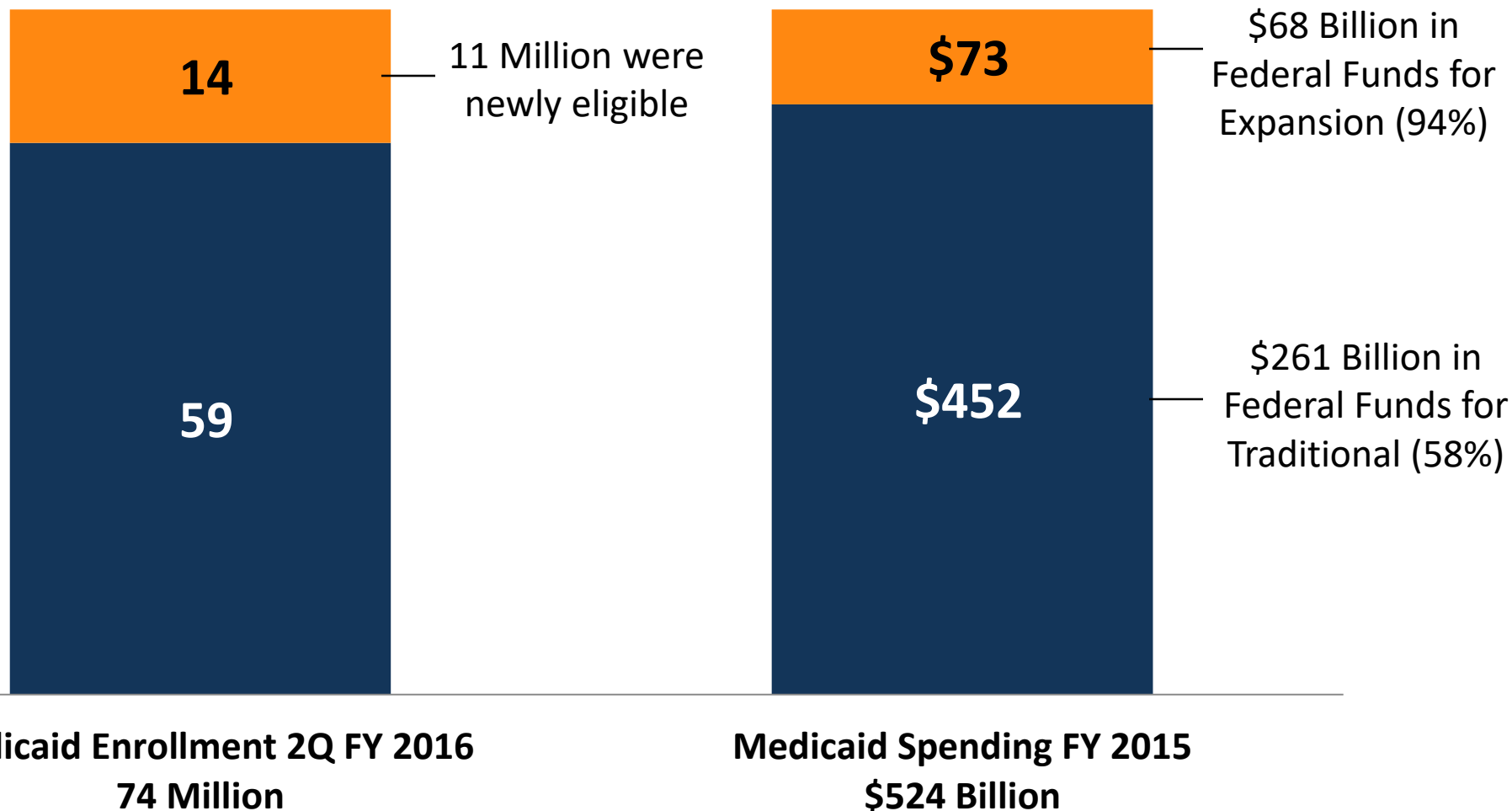


SOURCE: Robin A Cohen, Emily P Zammiti, and Michael E Martinez, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016, (Hyattsville, MD: National Center for Health Statistics, May 2017), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf>.

Figure 4

# The ACA expanded Medicaid coverage and financing.

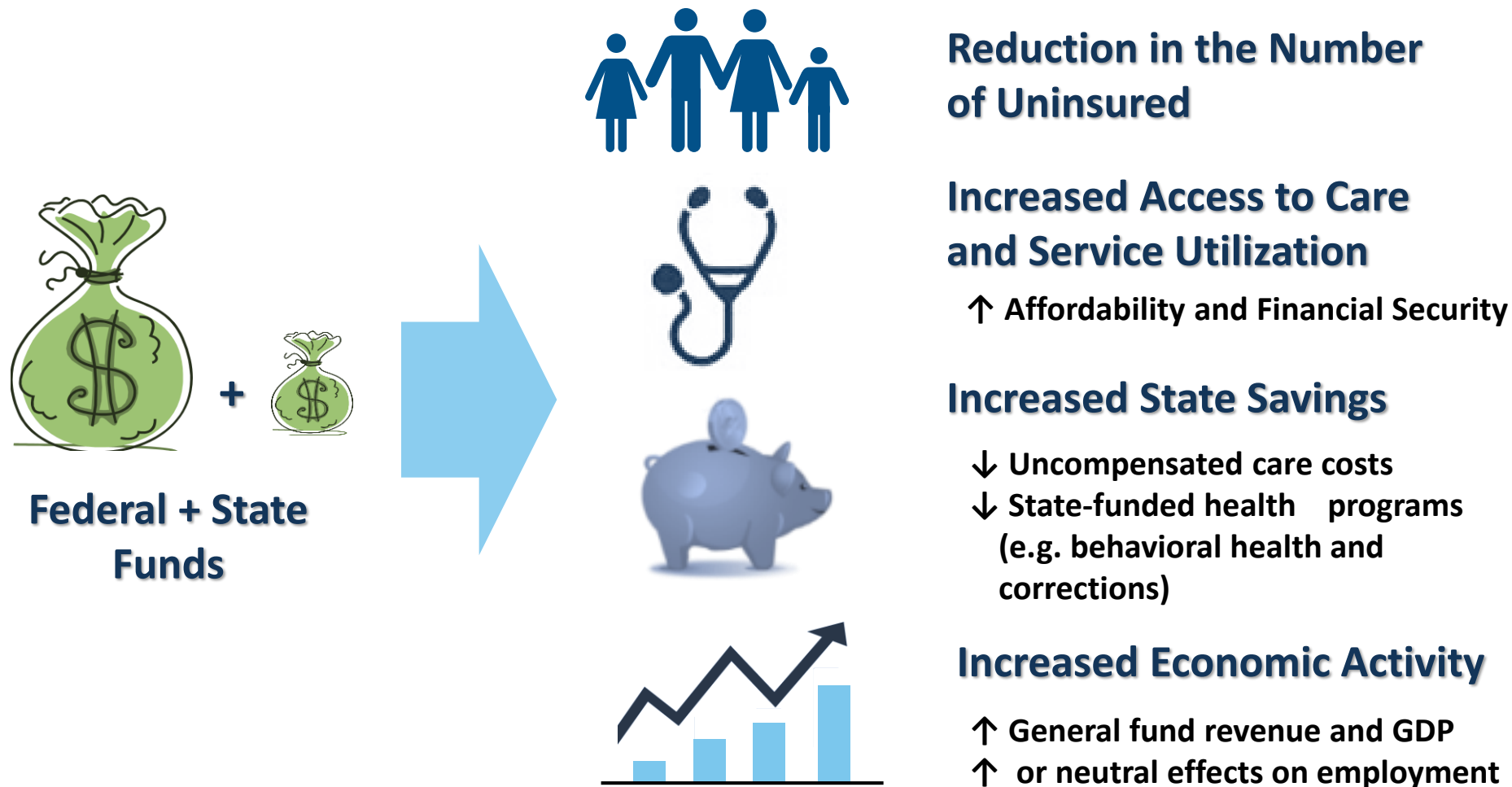
■ Traditional ■ Expansion Group



NOTES: Enrollment data for 2 quarters FY 2016 f(maximum for the time period) or 31 states that implemented the Medicaid expansion as of January 2016 (Louisiana expanded Medicaid on 7/1/16 and has no data reported. SOURCE: KCMU analysis of data from Medicaid Budget and Expenditure System (MBES).

Figure 5

# The Medicaid expansion has coverage and fiscal implications for states beyond Medicaid.



SOURCE: L. Antonisse, R. Garfield, R. Rudowitz, and S. Artiga, *The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2016), <http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/>

Figure 6

# ACA transformed the non-group health insurance market.

- Discrimination based on health status prohibited
  - Pre-ACA, insurers denied coverage, charged more based on health status, excluded coverage for pre-existing conditions
- Policies redefined to provide major medical coverage (EHB, OOP limits)
  - Pre-ACA, insurance defined as anything sold by licensed health insurer; exclusions, coverage limits, “mini-meds” were common
- Individual mandate
  - Pre-ACA, voluntary coverage made insurers fear adverse selection
- Subsidize premiums (to 400% FPL) and cost sharing (to 250% FPL)
  - Pre-ACA, non-group coverage unsubsidized. 90% of uninsured had income <400% FPL; 75% of uninsured had income  $\leq$ 250% FPL
- New Marketplaces deliver subsidies, provide standard comparison info and in-person help to consumers
  - Pre-ACA, lack of transparency in insurance, help through brokers/insurance sales force.

Figure 7

## **The transition to a reformed market was challenging for insurers through 2016.**

- With implementation of ACA, insurers adopted an entirely new business model, faced new competition
- Many insurers underpriced policies in early years to gain market share
  - Average 2014 premiums were much lower than predicted
  - 2017 premium increases largely corrected for previous underpricing
- Most marketplace enrollees are eligible for subsidies and shielded from 2017 rate increases, but others face rising premiums
- Market enrollment grew 50% from pre-ACA and is holding steady
- The ACA individual market is not in a "death spiral"



Figure 8

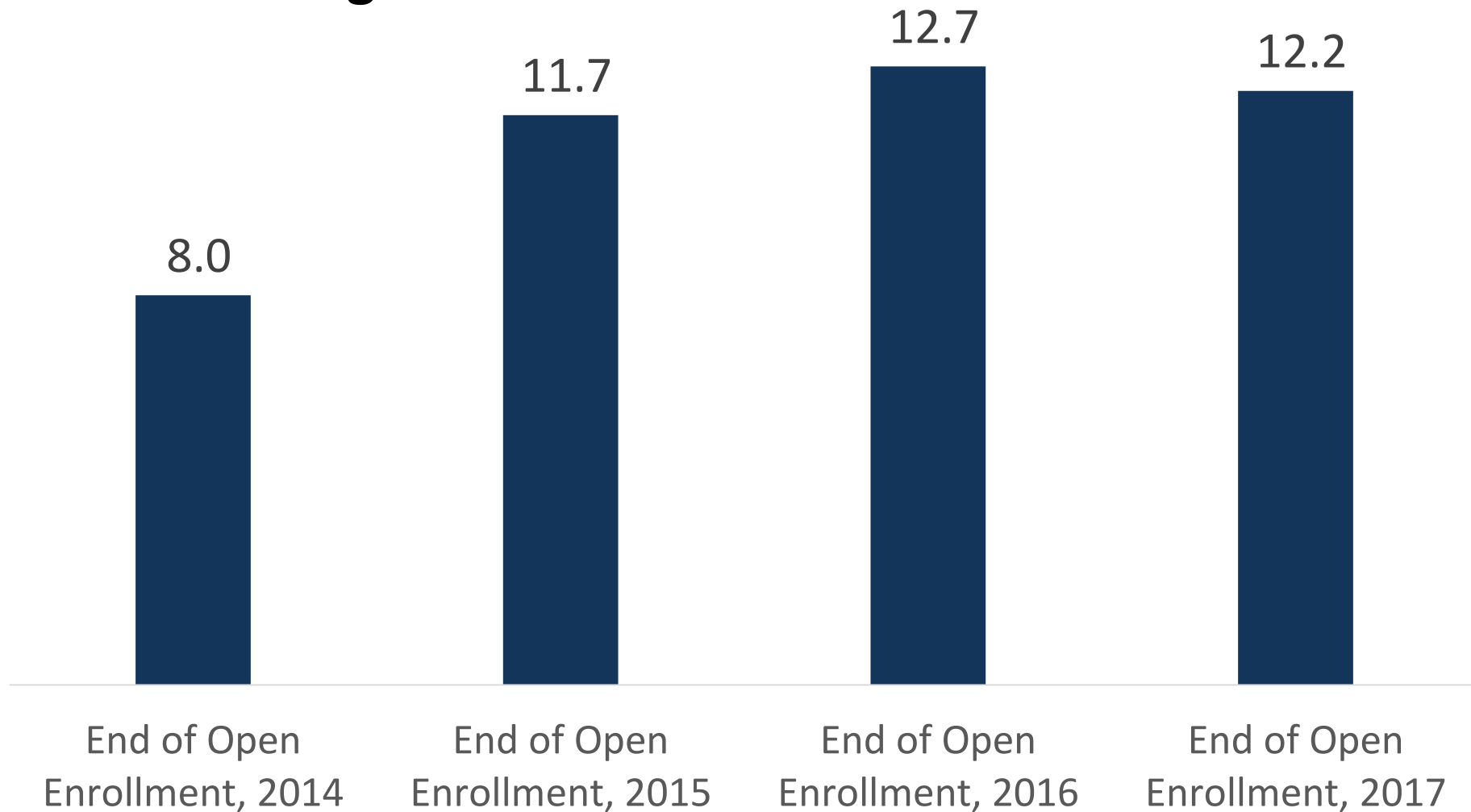
## Recent financial data suggest insurer profits are increasing and individual market is stabilizing.

**Average First Quarter Individual Market Gross Margins  
Per Member Per Month, 2011 - 2017**



Figure 9

## Marketplace enrollment slipped slightly in 2017, but remains strong.

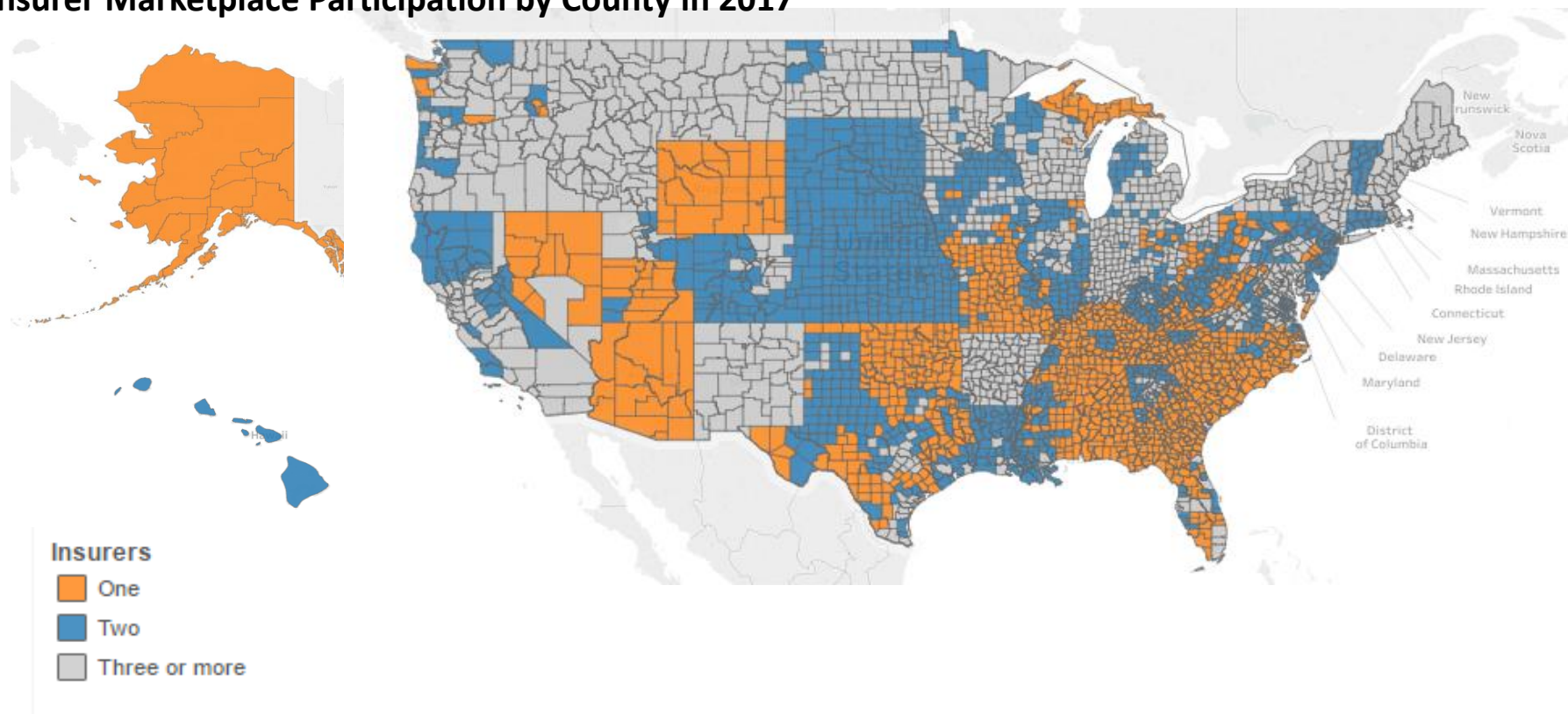


Source: <http://kff.org/health-reform/state-indicator/total-marketplace-enrollment/?activeTab=map&currentTimeframe=0&selectedDistributions=number-of-individuals-who-have-selected-a-marketplace-plan>

Figure 10

# 21% of marketplace enrollees have access to only one insurer in 2017, up from 2% in 2016.

## Insurer Marketplace Participation by County in 2017



Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: We define the number of insurers in a single county as the number of insurers (grouped by parent company or group affiliation) that offer at least one silver plan in the county. For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. States that do not use healthcare.gov in 2017 are: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington. See the interactive map here:

<https://public.tableau.com/profile/kaiser.family.foundation#!/vizhome/InsurerParticipationinthe2017IndividualMarketplace/2017InsurerParticipation>

Figure 11

## For 2018, new uncertainty worries insurers in all states.

- “Every time something new (and potentially disruptive) is thrown into the works, it impedes the individual market's path to stability.”\*
- Anthem BCBS of Ohio recently announced exiting 20 counties in 2018
  - “A stable insurance market is dependent on products that create value for consumers through the broad spreading of risk and a known set of conditions upon which rates can be developed...Today, planning and pricing for ACA-compliant health plans has become increasingly difficult due to the shrinking individual market as well as continual changes in federal operations, rules and guidance.”
- Will cost sharing reduction (CSR) payments continue?
  - Estimated cost is \$10 billion in 2018; To recoup losses and remain in marketplace, insurers would need to increase premiums 19%
- Will the individual mandate be enforced?
  - CBO estimates repeal of mandate, alone, could increase premiums 20%
- How will the next Open Enrollment Period be conducted?
  - Administration cancelled outreach, advertising for final days of OE4
  - OE5 will be shortened from 12 weeks to 6 weeks
  - ACA described as “horrible health care,” “collapsing,” “a disaster”

\* S&P Global, “The US ACA Individual Market Showed Progress in 2016, but Still Needs Time to Mature,” April 7, 2017

Figure 12

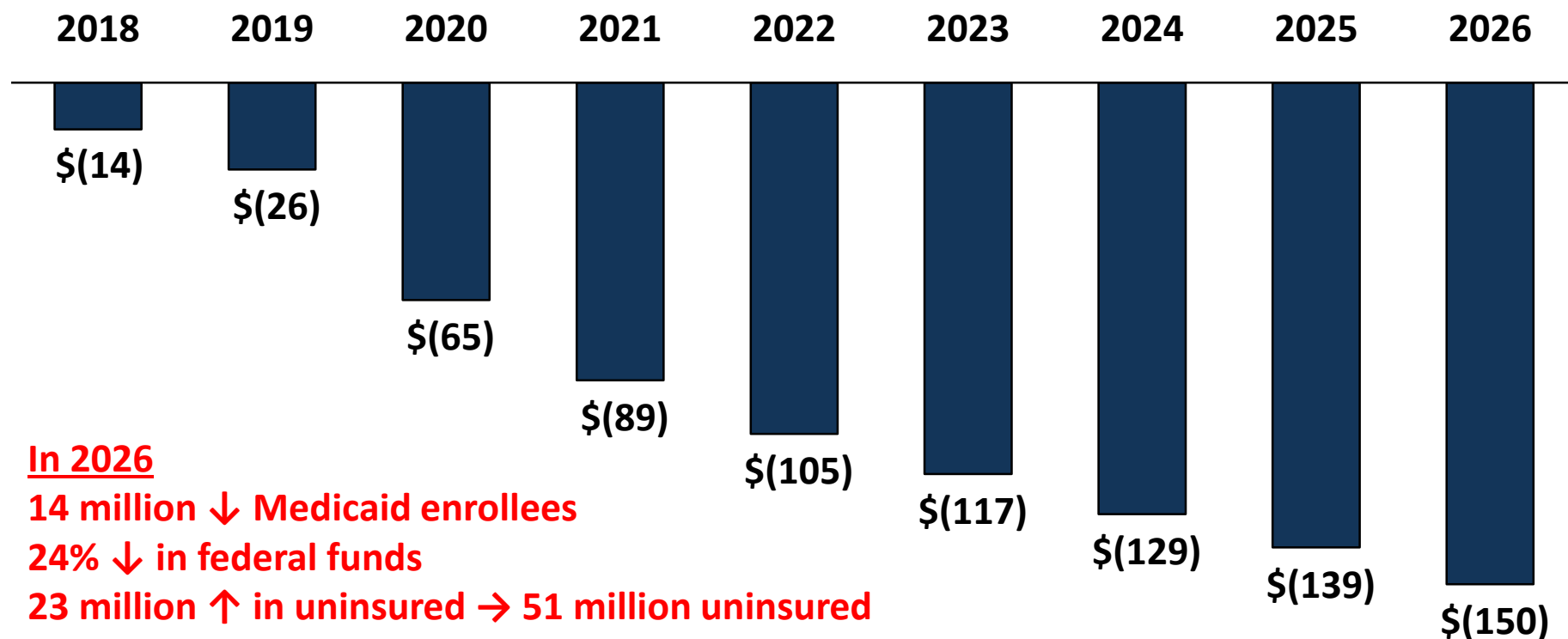
## Senate bill was similar to House bill with some key differences.

American Health Care Act	Better Care Reconciliation Act
Phase out Medicaid expansion in 2020	Phase out Medicaid expansion 2020-2024
Convert Medicaid funding to per capita cap; growth rate: CPI-M+1% and CPI-M	Convert Medicaid funding to per capita cap; growth rate: CPI-M, then CPI-U starting 2025
Repeal individual and employer mandates	Repeal individual and employer mandates
Late enrollment penalty	6-month waiting period
Keep ACA insurance market rules, but <ul style="list-style-type: none"><li>• Increase age rating to 5:1</li><li>• States can waive essential benefits rules</li><li>• States can waive rating rules</li></ul>	Keep ACA insurance market rules, but <ul style="list-style-type: none"><li>• Increase age rating to 5:1</li><li>• States can waive essential benefits rules</li><li>• Loosen 1332 waiver authority</li></ul>
Replace income-based premium subsidy with flat tax credit based on age	Income- and age-based tax credits (0-350% FPL); older adults pay more
Repeal cost sharing subsidies in 2020; no provision to fund in 2018 and 2019 Deductibles will increase	Repeal cost sharing subsidies in 2020; fund through 2019 Deductibles will increase
New State Stability Fund \$138 billion/9 years; Invisible reinsurance program	New State Stability Fund \$112 billion/9 years; reinsurance required component

Figure 13

## CBO estimated declines in Federal Medicaid spending under the American Health Care Act (AHCA).

Change in Federal Dollars in Billions (Total 2018-2026 = \$834 billion)



NOTE: Includes manager's amendments.

SOURCE: CBO Estimate of H.R. 1628, the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25. March 23, 2017.

Figure 14

# Medicaid block grants or per capita caps are designed to cap federal spending.

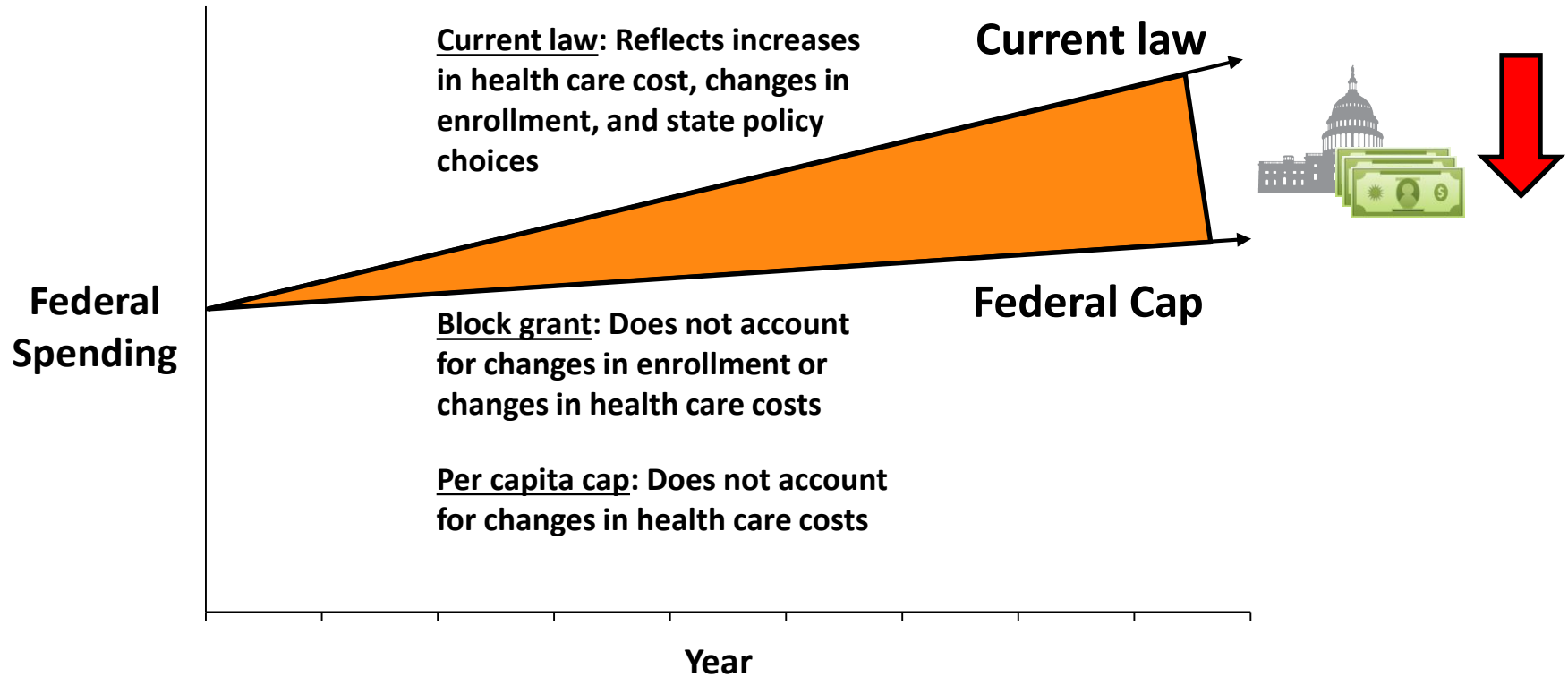
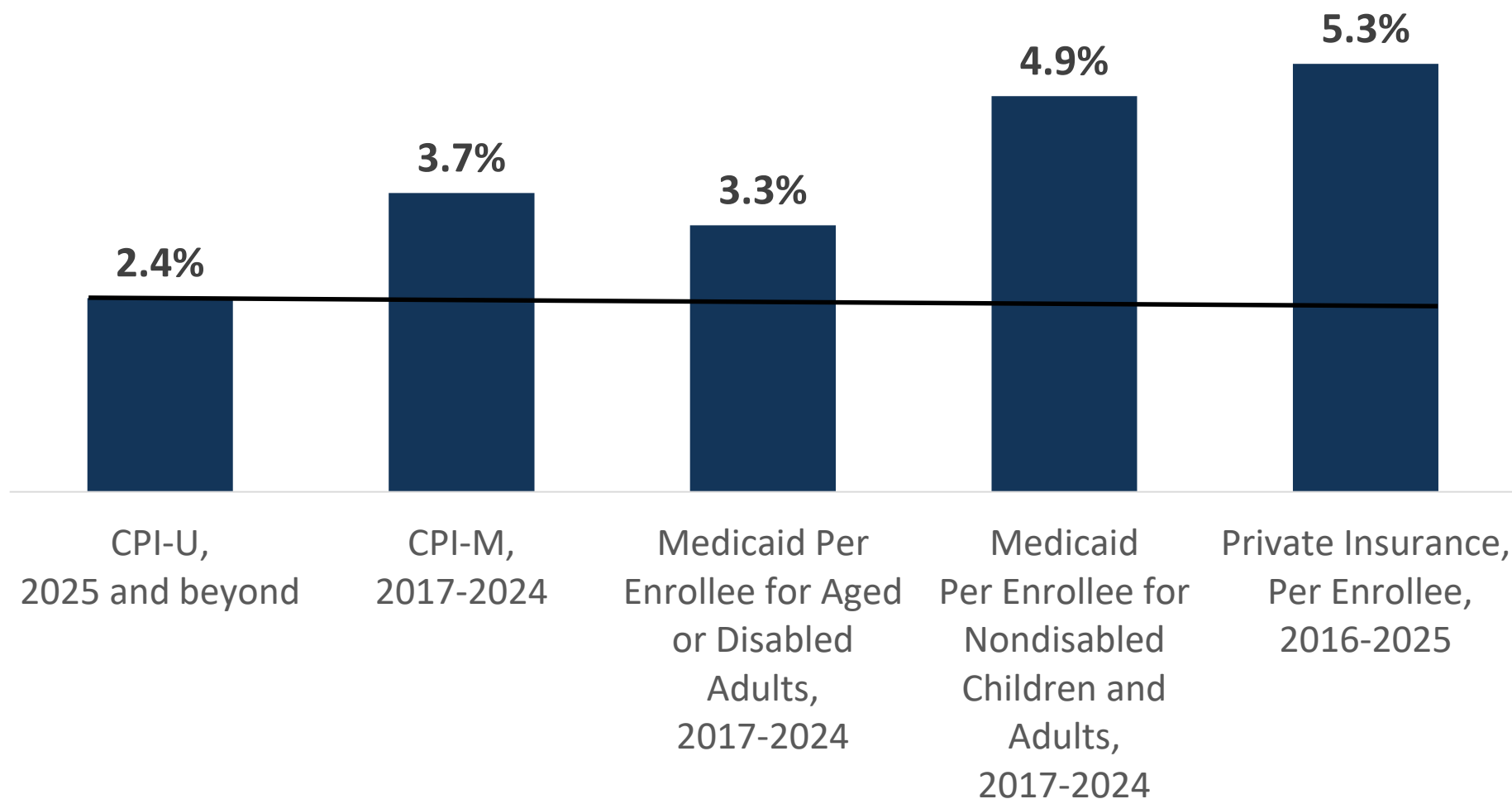


Figure 15

**Limiting Medicaid spending growth to CPI-U would mean significant reductions compared to current law for all groups.**



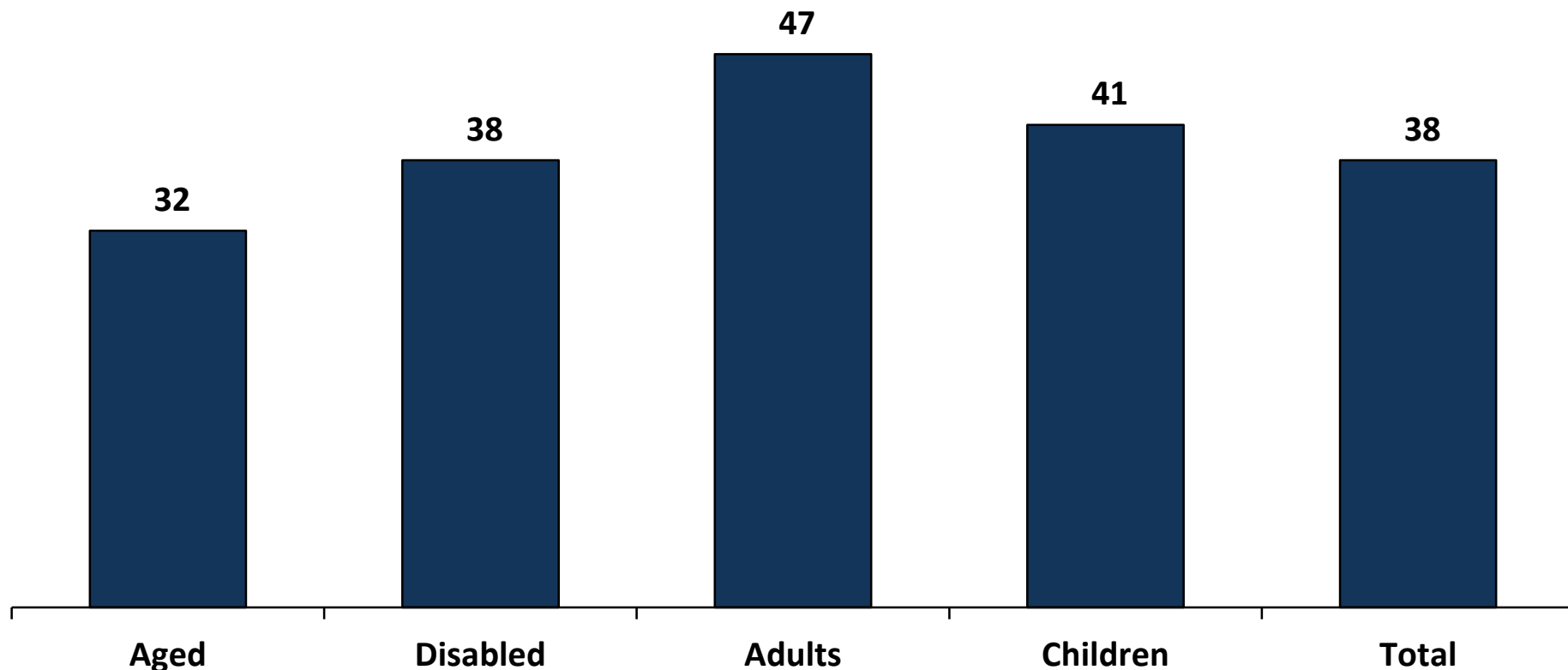
SOURCES: CPI-U, CPI-M, Medicaid Per Enrollee: Congressional Budget Office estimate of H.R. 1628, Better Care Reconciliation Act of 2017, June 26, 2017, <https://www.cbo.gov/publication/52849>.

Private Insurance Per Enrollee: Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65, 2016 to 2026*, March 2016, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-healthinsurancebaseline.pdf>.



Figure 16

**Most states would have experienced declines in federal spending if per enrollee spending growth by group had been limited to medical-CPI from 2001-2011.**



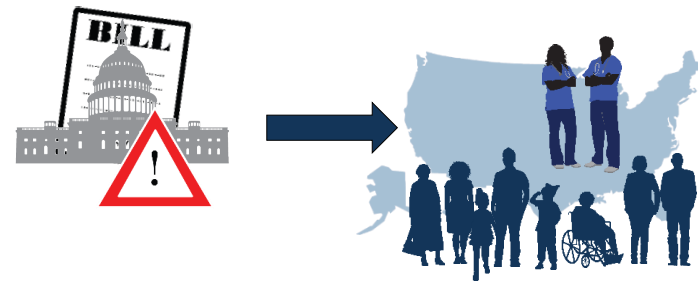
NOTE: Includes full-benefit enrollees only. Spending for the Aged excludes prescription drug spending due to shift in these costs from Medicaid to Medicare Part D in 2006. See Methods in full report for additional detail.

SOURCE: Kaiser Family Foundation and Urban Institute analysis of 2000-2011 MSIS data.

Figure 17

# Reducing and capping federal Medicaid funds could:

- Shift costs and risks to states, beneficiaries, and providers if states restrict eligibility, benefits, and provider payment
- Lock in past spending patterns
  - If expansion funding is cut, the impact could be even greater for the 32 states that expanded Medicaid
- Limit states' ability to respond to rising health care costs, increases in enrollment due to a recession, or a public health emergency such as the opioid epidemic, HIV, Zika, etc.



# What's next for Medicaid?

- ACA repeal and replace efforts may return
- Will more states expand Medicaid?
- Administration has signaled increased flexibility on Medicaid 1115 waivers
  - Focus among states on work requirements and premiums/cost sharing
  - May enable some non-expansion states to adopt the expansion
  - Continued delivery system reform
- Medicaid changes may be included as part of Children's Health Insurance Program (CHIP) reauthorization legislation
  - CHIP funding is due to expire on September 30, 2017

Figure 19

**33 states have 41 approved Section 1115 Medicaid demonstration waivers in place as of February 2017.**

### Landscape of Current Section 1115 Medicaid Waivers

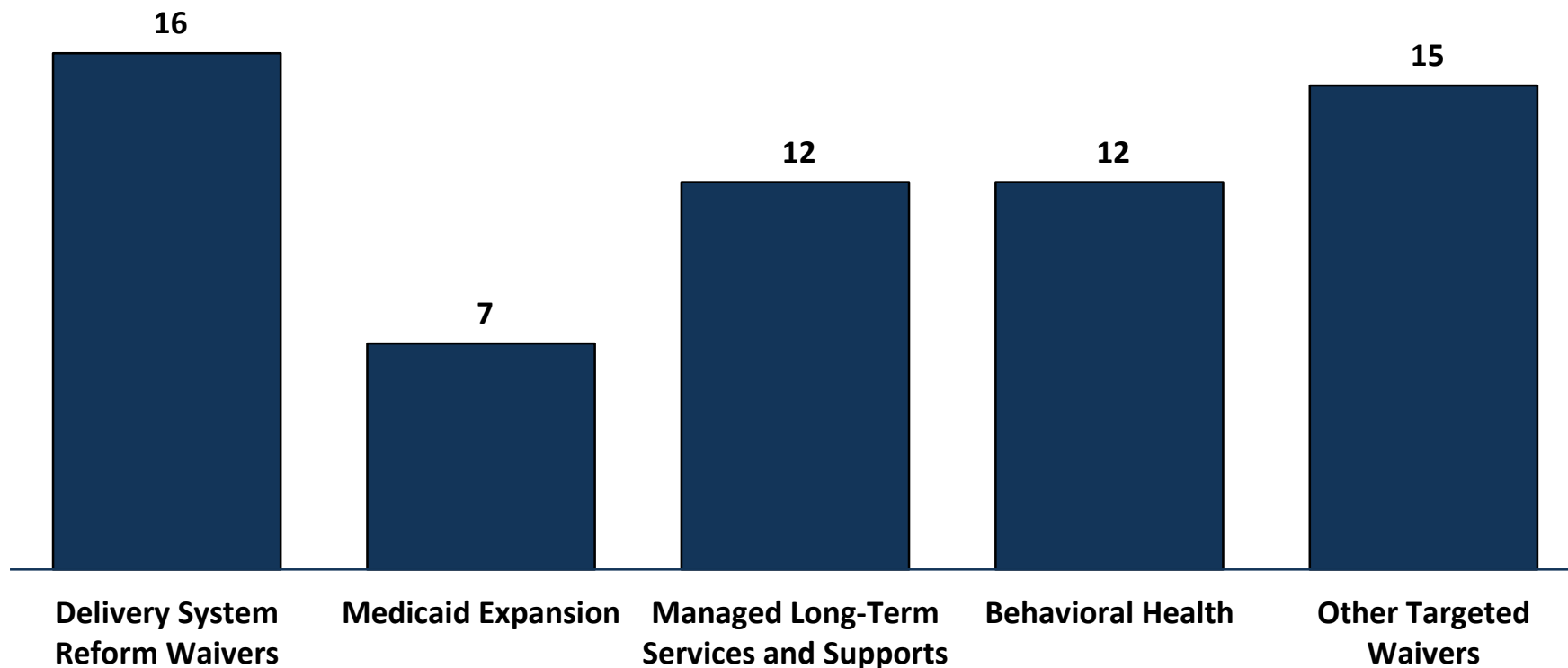
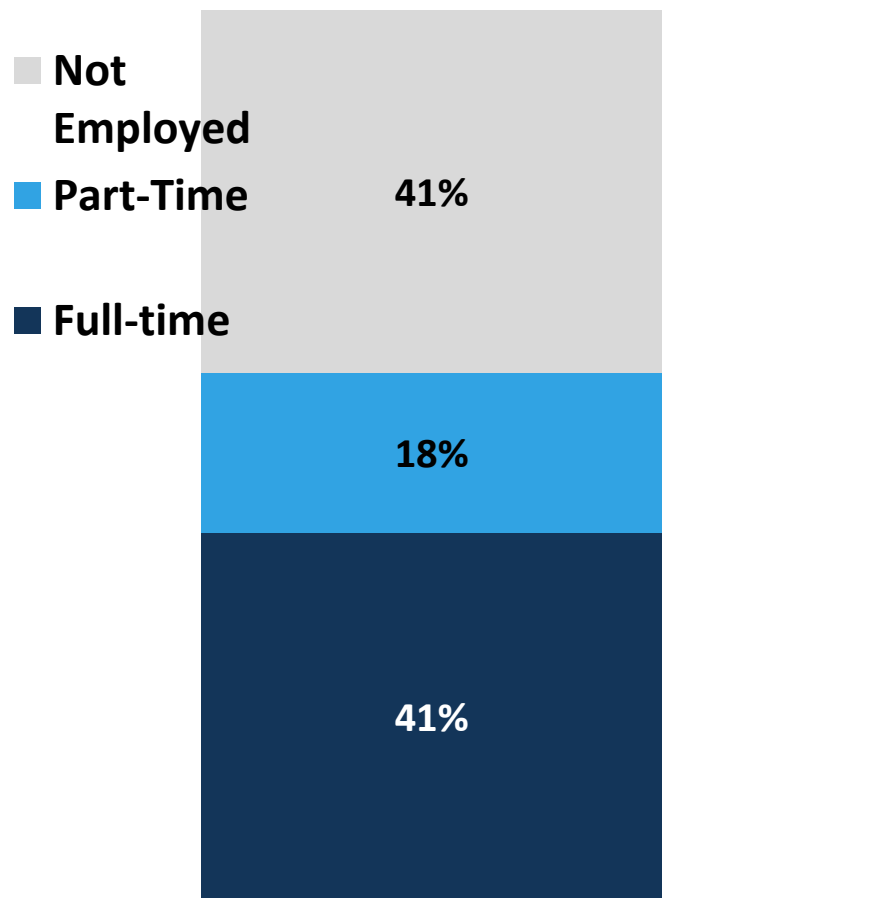
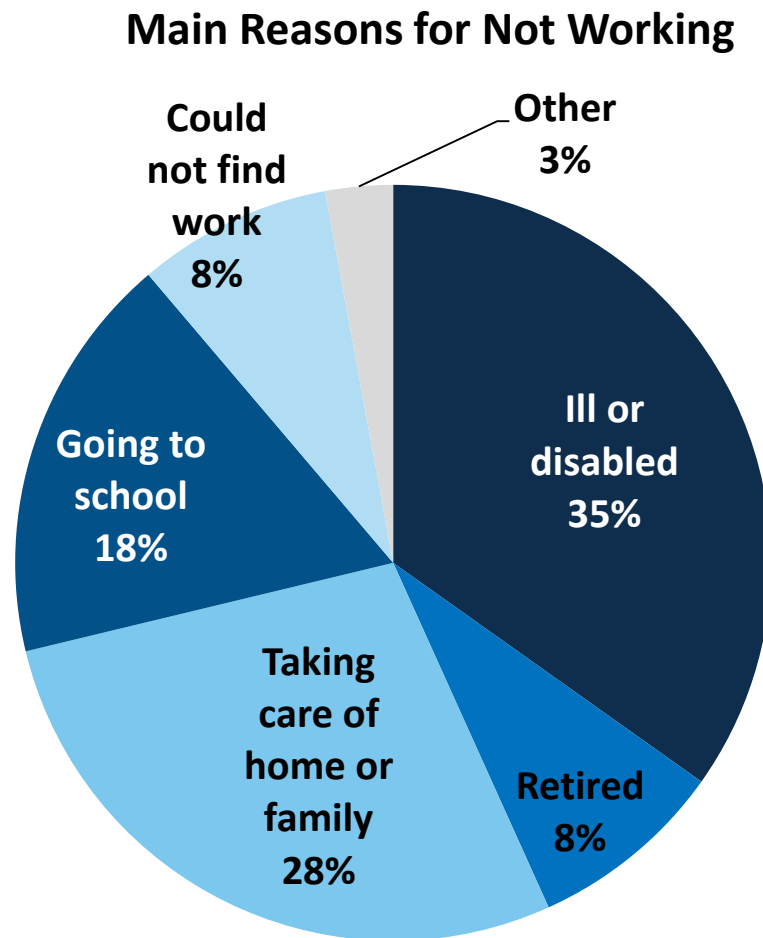


Figure 20

# More states are seeking waivers to condition Medicaid on work requirements, but most not working face barriers to work.



Own Work Status, 24 Million Medicaid Adults

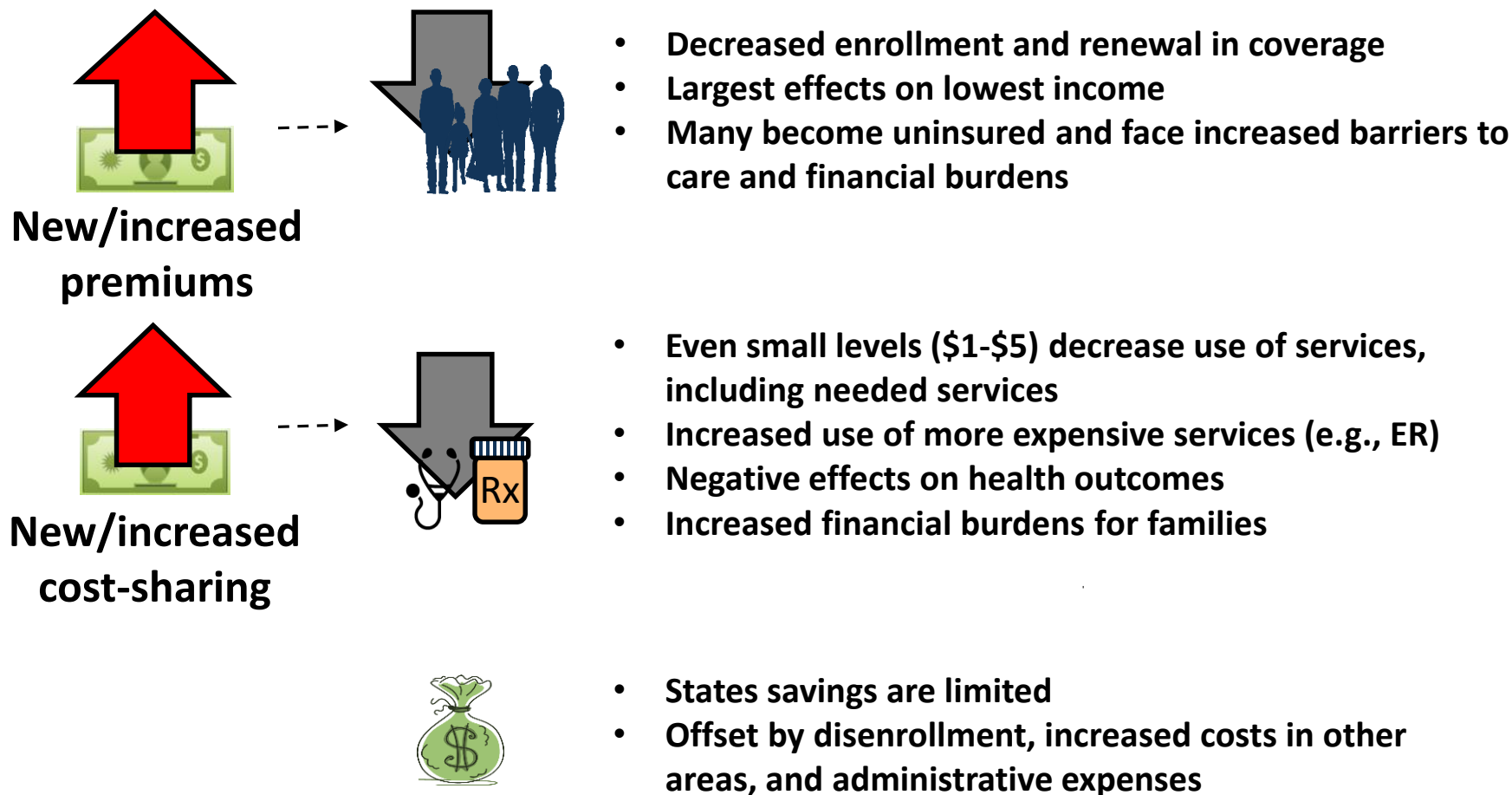


Not Employed = 9.8 Million Medicaid Adults

NOTE: Totals may not add due to rounding. Includes nonelderly Medicaid adults who do not receive Supplemental Security Income (SSI), 2015. SOURCE: Kaiser Family Foundation analysis of March 2016 Current Population Survey.

Figure 21

**States are also seeking waivers to impose premiums and cost sharing, but research shows negative effects of policies for low-income populations.**



SOURCE: The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings, Kaiser Family Foundation, June 2017. <http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>

# What's next for the Marketplaces?

- ACA repeal and replace efforts may return
- Options for stabilizing insurance markets
  - Funding of cost sharing reductions
  - Federal reinsurance program
  - Invest in outreach efforts to increase enrollment
  - Strategies for rural areas needed
- 1332 waivers
  - Statutory requirements remain, but Administration may interpret more loosely
  - Reinsurance model: Alaska waiver was approved; Minnesota, New Hampshire have submitted applications for similar reinsurance programs
- Broader strategies needed to address long-term affordability

Figure 23

# Majorities across political parties say Medicaid is working well for most low-income people covered by the program.

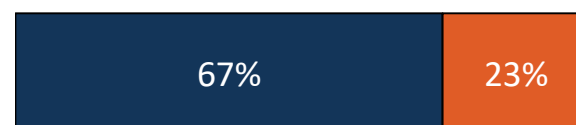
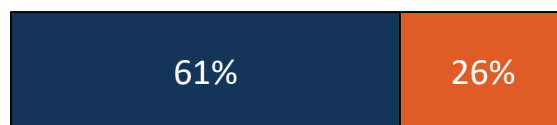
Would you say the current Medicaid program is working well for most low-income people covered by the program, or not?

■ Working well ■ Not working well

...in the nation, overall?

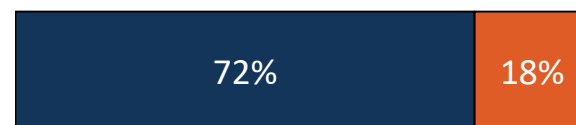
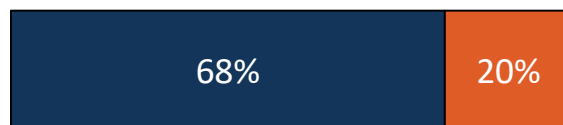
...in your state?

Total

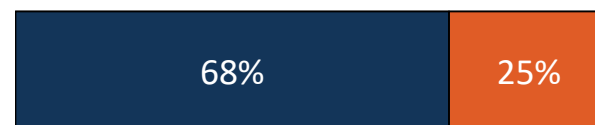
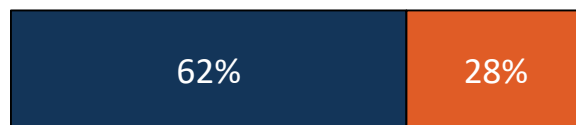


By Political Party ID

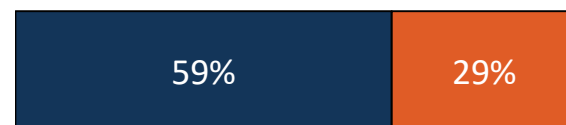
Democrats



Independents



Republicans



NOTE: Don't know/Refused responses not shown. Question wording abbreviated. See topline for full question wording.

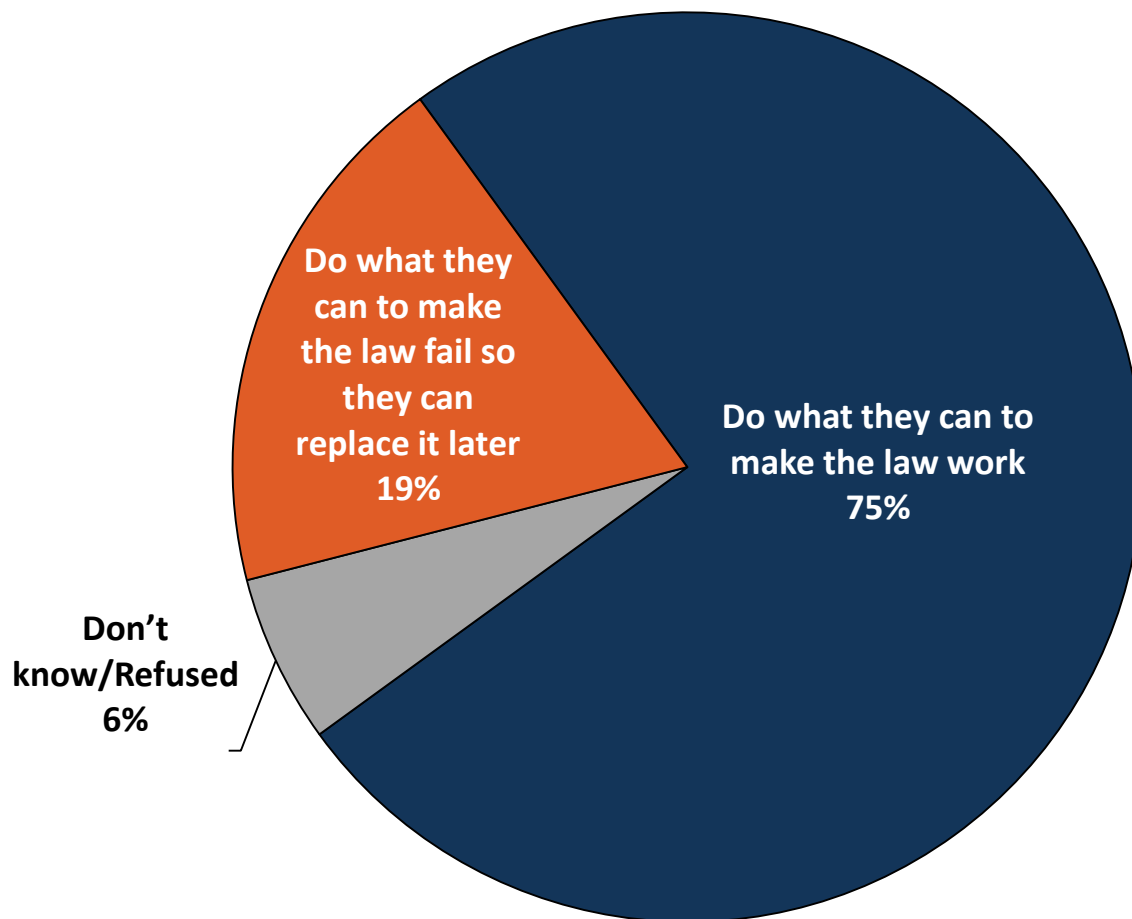
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted June 14-19, 2017)



Figure 24

# A Majority of Americans Say President Trump and his Administration Should Do What They Can to Make ACA Work

Moving forward, do you think President Trump and his administration should do what they can to make the current health care law work or should they do what they can to make the law fail so they can replace it later?



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted March 28 – April 3, 2017)