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MEDICAID EXPANSION UNDER THE AFFORDABLE CARE ACT

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On June 28, 2012, the Supreme Court rendered an opinion on the constitutionality of the Affordable Care Act (ACA). One major outcome of the Supreme Court's decision was to give states the ability to opt out of the Medicaid expansion while not jeopardizing current federal funding levels for existing Medicaid programs. The original text of the ACA would have taken federal Medicaid support away from those states that did not expand enrollment eligibility, but the Supreme Court decision ruled that the ACA violated the prohibition of federal coercion upon states. As of July 2013, 23 states plus the District of Columbia are moving forward with Medicaid expansion, 21 states are not moving forward, and six states are still debating the option.[1] The impact on existing state Medicaid programs will vary by state, regardless of whether or not a state chooses to expand enrollment in 2014.

The ACA expanded Medicaid eligibility to 133 percent of the federal poverty level (FPL) for parent and childless adult populations. However, the eligibility level is often referred to as 138 percent because of a 5 percent income disregard. The expansion will significantly change the population demographics of the current Medicaid program. Table 1 illustrates the fiscal year 2009 enrollment distribution by general eligibility groupings.[2]

Table 1: 2009 Medicaid Enrollment by Eligibility Group

Eligibility Group	Enrollees (millions)
Aged	6.1
Disabled	9.5
Adults	16.2
Children	30.7
Total	62.5

The current adult population includes primarily individuals that are eligible either as pregnant women or parents/caretakers of children. Most state Medicaid programs will cover pregnant women up to 185 percent FPL; however, many states limit the parent's eligibility to 20 percent to 50 percent FPL. A few states provide coverage to childless adults through section 1115 demonstration waivers or other waiver programs. Medicaid expansion will primarily extend eligibility to parents and childless adults. Table 2 summarizes the number of individuals that meet the new Medicaid eligibility threshold. We have separately illustrated the populations by current insurance status, either uninsured or currently insured.[3]

Table 2: Individuals Newly Medicaid Eligible under ACA Provisions (as of 2010)

Eligibility Group	Uninsured (millions)	Currently Insured (millions)
Parents	6.7	3.5
Childless Adults	14.9	9.2
Total	21.6	12.7

The introduction of the parents and childless adult populations will have a significant impact on the demographic profile of the current Medicaid population. Based on self-reported health status, the currently uninsured adult population, in aggregate, may have a lower risk profile than the current parent population. Table 3 illustrates a relative morbidity distribution based on self-reported health status of the current Medicaid parent population and the uninsured parent and childless adult populations. The relative morbidity is shown in relation to a commercially insured adult member. The relative morbidity was developed by fitting the commercially insured reported health status information from the current population survey to the Milliman Individual Underwriting Guidelines.

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Table 3: Relative Morbidity Comparison of Adult Populations

Health Status	Relative Morbidity	Employer Sponsored	Medicaid – Parents Only	Uninsured
Excellent / Very Good	0.60	70%	47%	55%
Good	1.30	23%	32%	32%
Fair / Poor	4.10	7%	21%	13%
Composite Morbidity		1.00	1.56	1.28

Source: (3), Health status distribution by population only

Table 4: Population Report Fair/Poor Health Status by FPL

Federal Poverty Level	Fair / Poor Health Status
Below 100%	20.9%
100% - 199%	15.2%
200% - 399%	8.3%
400% +	4.3%

While the overall uninsured population has a relative morbidity lower than the current Medicaid parent population, the expected average morbidity is 28 percent greater than the average commercial insurance morbidity. Further, the percentage of the population reporting fair or poor health status varies significantly by income level. Table 4 compares the percentage of the population that report fair or poor health status by federal poverty level. The populations include those that are fully insured, receiving public health care, or are uninsured.[4]

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Medicaid expansion provides eligibility for the parent and childless adult populations up to 133 percent FPL. If a state does not expand Medicaid, a person may receive federally subsidized health insurance through the health insurance exchanges if their income is between 100 percent and 400 percent of the federal poverty level. With the higher morbidity of the population in the lower income levels, the exchange based population's relative morbidity may increase under a no Medicaid expansion scenario. In a state that does not expand the Medicaid program, the population between 100 percent and 133 percent FPL will not be eligible for Medicaid but will be eligible for the advanced premium tax credits and cost-sharing subsidies in the exchange.

In the states that expand Medicaid eligibility, the state Medicaid programs will face various issues related to the new population base.

Eligibility Changes: Under the ACA, many of the current Medicaid eligible populations will have different eligibility rules regarding income and assets. Income will be converted to a Modified Adjusted Gross Income (MAGI) standard for all states. Medicaid eligibility for the children, parent and childless adult populations will no longer have an asset test. In addition, the Medicaid program will receive referrals from the health insurance exchanges. All of these eligibility changes may create enrollment delays as individuals are navigating the new eligibility rules.

Presumptive Eligibility: Many current Medicaid programs provide presumptive eligibility for pregnant women. Presumptive eligibility provides immediate coverage based on the individual meeting certain criteria. Under the ACA, presumptive eligibility is expanded beyond the pregnant women population. Hospitals may provide presumptive eligibility for individuals that meet certain eligibility criteria. The expansion of the presumptive eligibility provision may increase the average health care costs for the Medicaid populations since individuals will be receiving eligibility at the point of care.[5]

Pent-up Demand for Services: Individuals that are currently uninsured may have pent-up demand for health care services. In 2008, the State of Indiana implemented a Medicaid expansion program, the Healthy Indiana Plan. The Healthy Indiana Plan provided expanded Medicaid eligibility for parents and childless adults through an 1115 waiver. During the first year of the program, it was observed that individuals incurred overall health care costs 20 percent greater during the first three months of enrollment in the program, with hospital inpatient and outpatient services 20 percent to 40 percent higher. Pharmacy expenditures tended not to be greater during the earlier months of enrollment; however, the pharmacy expenditures increased after six months of enrollment.[6]

Access to Providers: On a national basis, the average physician reimbursement rate under the Medicaid program is approximately 60 percent of the Medicare reimbursement rate. Physician reimbursement varies significantly on a state-by-state basis. The ACA provides for increased physician reimbursement to qualifying primary care physicians for evaluation and management services during calendar years 2013 and 2014. While this provides for short-term enhanced funding to primary care physicians, the long-term funding issue remains for physicians under Medicaid. The newly eligible population may encounter issues related to physician access, especially as the newly eligible population ramps up into the system and more people seek care.

Take-Up Rates: Outreach by the state, the exchange and others will impact the percentage of those newly eligible for coverage that actually enroll. The current Medicaid program illustrates that not all of those eligible for coverage choose to engage in the process. We know those with higher perceived needs will be more likely to sign up for coverage, and those that actually seek care will likely be assisted in the enrollment process by their providers. This leads to a less healthy enrolled risk pool than what the survey data on all uninsured would lead one to believe.

Welcome Mat Effect: It is anticipated that significant publicity will occur in late 2013 and early 2014 regarding enrollment into Medicaid, health insurance exchanges, and employer-sponsored insurance plans. This may encourage those currently eligible for Medicaid but not enrolled to enroll in the program. The impact of this population may lower the average cost per person if these individuals are lower cost healthier lives, although the aggregate spending will increase with greater enrollment.

For the six states that are still debating legislatively or in discussions with CMS regarding the Medicaid expansion, it may be expected that the expansion may not be able to be implemented with an effective date of Jan. 1, 2014. Under the delayed expansion scenario, individuals may temporarily qualify for the subsidies offered through health care exchanges and then subsequently qualify for the Medicaid program. If a state implements a mid-year expansion, the integration of the population that qualified for the health care exchanges will create pricing issues for both calendar year 2014 and 2015 as population eligibility shifts during these periods.

During the next several years, the Medicaid expansion population will change the face of the current Medicaid program. The Medicaid program will reflect more parents and adults, with enrollment potentially growing to the levels of the children population. The enrollment growth will put pressure on the demand for health care services and access to providers. Many states may turn to enrollment into risk-based managed care programs. With or without the expansion, state Medicaid programs will need to determine how to integrate eligibility data and information with the health care exchanges. The Medicaid program will continue to evolve as the option to expand coverage has been given to the state legislators, governors, and state Medicaid agencies to decide.

[1]"Analyzing the Impact of State Medicaid Expansion Decisions," Kaiser Commission on Medicaid and the Uninsured, Issue Brief, July 2013.

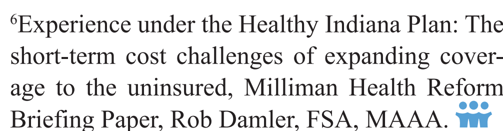
[2]Statehealthfacts.org, FY 2009 Medicaid enrollees by enrollment group.

[3]"The Uninsured A Primer, Key Facts About Americans Without Health Insurance," October 2011, The Henry J. Kaiser Family Foundation.

[4]Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, Health, United States, 2011, Table 56.

[5]42 CFR 435.1110.

[6]Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured, Milliman Health Reform Briefing Paper, Rob Damler, FSA, MAAA.



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