Health Care Reform in the Balance: What’s at Stake for California?

Repeal of the ACA

Medicaid per capita caps and block grants

Edwin Park
March 2, 2017
CBO Estimates of 2016 Vetoed ACA Repeal Bill

Repealing Affordable Care Act Means Millions More Uninsured, Higher Premiums

Increases in uninsured and individual-market premiums compared to current law

- First year after bill enacted
- Three years after bill enacted
- End of decade (2026)

Uninsured:
- 18 mil.
- 27 mil.
- 32 mil.

Premiums:
- 20%
- 50%
- 100%

Source: Congressional Budget Office, Jan. 2017
Likely House GOP ACA Repeal Plan and Update on Timing

• Eliminate individual and employer mandates immediately

• Phase out enhanced matching rate for Medicaid expansion to regular matching rate

• Delay repeal of marketplace subsidies for 2-3 years, though some immediate changes to existing subsidies

• Repeal all or much of the ACA revenues

• Leave most but not all of the market reforms/consumer protections in place

• Leave ACA Medicare/Medicaid savings in place
Increase in State Expansion Costs

2019, state spending in $billions

$37.8

Expansion FMAP

Regular FMAP

$5.9

Expansion states

$10.9

California

$1.5

Source: CBPP analysis using CMS historical and projected Medicaid spending data.
GOP Health Plans Won’t Replace ACA Coverage

Congressional Republicans want to only ensure “universal access”
Likely House GOP “Replacement” Provisions

• Flat tax credit
• Continuous coverage with late enrollment penalty
• Elimination of EHBs, age rating
• Grants to states for innovation, stability
• HSAs
• Medicaid per capita cap or block grant
• Cap on tax exclusion for ESI
ACA Repeal Places Medicaid at Risk

Total savings, 2016-2025: roughly $1 trillion

68% of savings pay for tax cuts

Note: Figure uses Congressional Budget Office definition of coverage provisions except for excise tax on high-premium health plans, which we treat as a revenue provision.
Source: Congressional Budget Office, CBPP calculations
Medicaid is the Primary Source of Federal Funds to States

Share of total federal funds to state budgets, 2015

- **56%** Medicaid
- **9%** Elem. and Sec. Education
- **7%** Transportation
- **4%** Higher education
- **2%** Public assistance
- **22%** Other

Source: NASBO, 2015.
Medicaid Is Already Efficient

**Medicaid costs less than private insurance.**

2009 costs per enrollee, adjusted for health status

- Medicaid: $6,052
- Employer-sponsored coverage: $7,752

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<thead>
<tr>
<th>Health care spending (excluding OOP)</th>
<th>Medicaid</th>
<th>Employer-sponsored coverage</th>
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<td>$6,052</td>
<td>$7,752</td>
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<th>Out-of-pocket spending (OOP)</th>
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<th>Private insurance</th>
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<td>$257</td>
<td>$784</td>
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**Medicaid spending has grown more slowly than private**

Growth in per-enrollee spending since 2007

- Medicaid: 1.2%
- Private insurance: 4.1%

**Medicaid's administrative costs are low.**

- Administrative costs: 5%
- Health care services: 95%

Medicaid’s administrative costs are less than half those of private insurers.
Federal government pays state-specific share of total Medicaid costs (FMAP).

- FMAP higher for poorer states, lower for wealthier states.
- 50% minimum and 83% maximum.
- Some Medicaid costs not matched at standard FMAP.

Mandatory entitlement funding.

Source: CMS, 2017
Medicaid Cuts Would Grow Over Time Under Last Year’s House GOP Budget Plan Block Grant/Cap

Percent cut in federal Medicaid funds, relative to current law

Source: CBPP analysis using Jan. 2016 Congressional Budget Office Medicaid baseline and House Budget Committee documents.
Impact of Unanticipated Costs and Aging

• Overall health care cost growth
• Unanticipated health care costs
• Demographic changes, aging of the population
The onset of the HIV/AIDS epidemic in the 1980s and early 1990s led to unexpected Medicaid costs.

Anti-retroviral prescriptions increased from 170,000 to 3 million from 1991 to 2005.

Anti-retroviral prescription spending increased from $31 million to $1.6 billion.

Medicaid Block Grants and Per Capita Caps: Shift Costs and Risks to States

Current Medicaid Financing System VS Capped Federal Medicaid Funding

50% FMAP State

Higher spending (unexpected cost growth)

Federal Share

State Share

$100

$50

$60

$50

$100

$50

$60

$80

Federal cap

50% FMAP State

Expected spending with cap

Higher spending (unexpected cost growth)

Federal Share

State Share

$100

$40

$100

$40

$100

$40

$120
State Choices to Compensate for Federal Cuts

- Raise taxes and contribute more state general revenues
- Cut education, social services, other parts of budget
- Cut Medicaid spending

State General Fund Expenditures

- K-12 Education: 35%
- Medicaid: 19.3%
- Corrections: 6.9%
- Transportation: 0.8%
- All Other: 26.9%
- Public Assistance: 1.4%

Source: NASBO State Expenditure Report, FY 2014.
Most Likely: Medicaid Cuts

- Cut Medicaid benefits, eligibility and provider payment rates.
• About 20 percent of Medicaid enrollment is among seniors and people with disabilities.

• But they account for 50 percent of federal spending.

Source: Congressional Budget Office.
New Medicaid Flexibility: Flexibility to Cut

• Individual entitlement
• Eligibility
• Benefits
• Work requirements
• Premiums and cost-sharing
Caps Impede Innovation

• Innovation, delivery system reforms, transition to HCBS all require upfront investment

• Blunt cuts vs. reforms that may improve quality and lower costs over time
Long-Term Harm from Medicaid Cuts

- Research shows long-term benefits of Medicaid coverage for children:
  - Do better in school,
  - Miss fewer school days due to illness or injury,
  - Are more likely to finish high school, attend college, and graduate from college,
  - Have fewer emergency-room visits and hospitalizations as adults, and
  - Earn more as adults.