Protect Medicaid – Affordability

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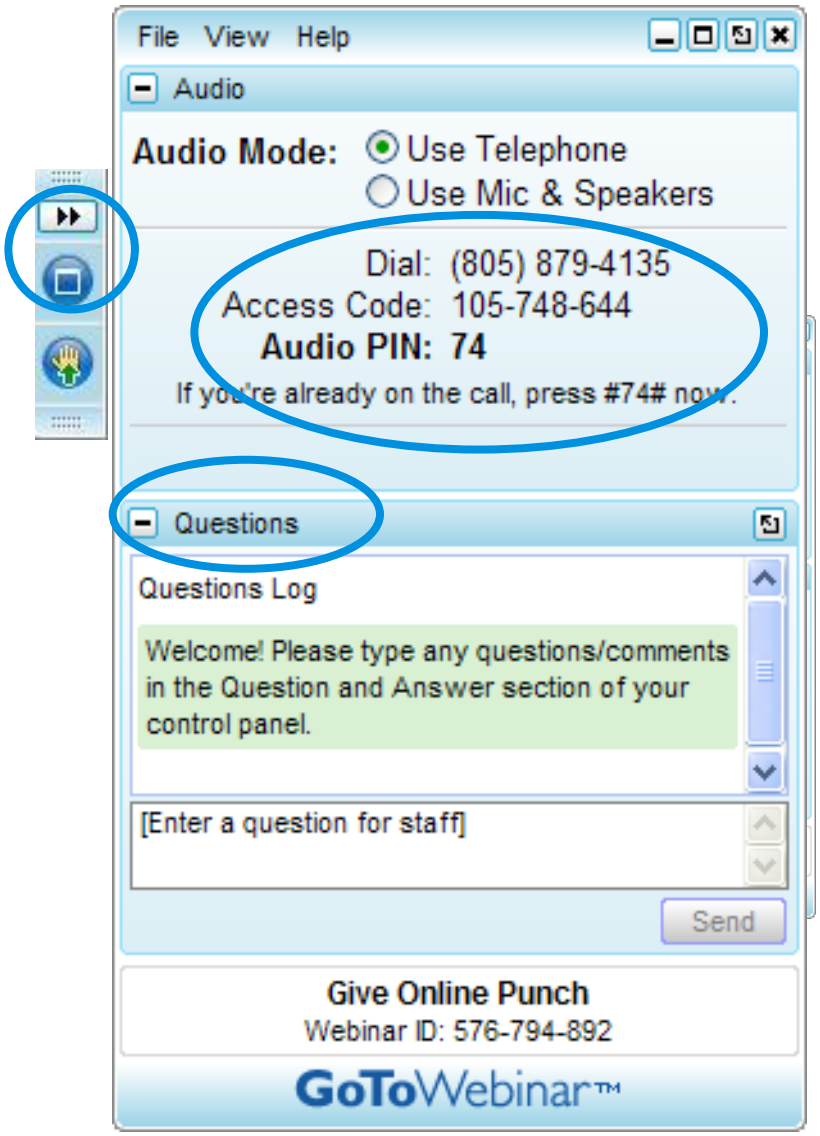
Housekeeping

GoToWebinar Interface…

- Maximize/minimize your screen with the chevron symbol
- Telephone participants need to enter their audio pin
- Please share your questions!
  - Ask a question in the questions log
  - Yes, we will make the recording, slides, and materials available



About NHeLP

- National non-profit committed to improving health care access and quality for low income and underserved individuals and families
- State & Local Partners:
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
- Offices: CA, DC, NC
- Join our mailing list at

  www.healthlaw.org
- Follow us on Twitter

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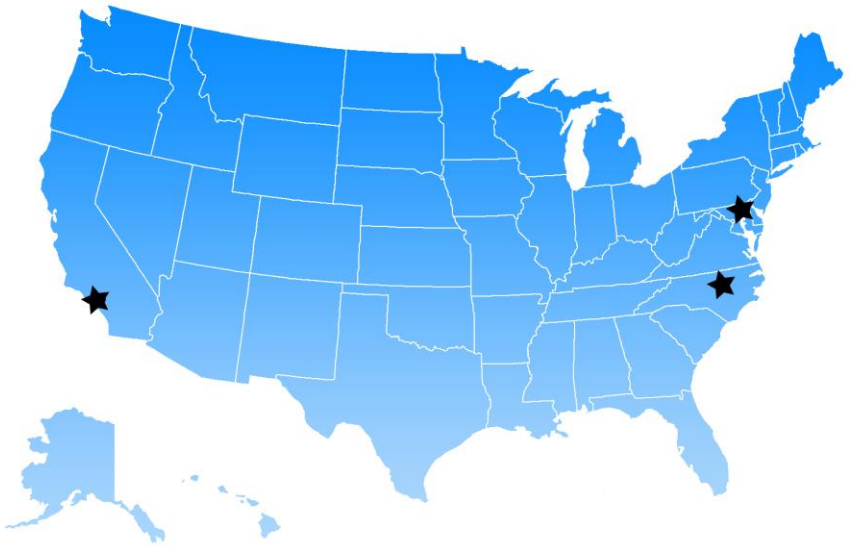

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What makes Medicaid, Medicaid?

- Health care access and living in poverty
- Medicaid cost sharing protections
- State flexibilities to adjust out-of-pocket costs
- Affordability under a Per Capita Cap
- Vive la résistance!

Webinar based on new paper:
What Makes Medicaid, Medicaid? Affordability

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What does it cost to live adequately? 2 adults and 1 child

Expense	Tucson, AZ	Bangor, ME	Des Moines, IA
Housing	$852	$861	$783
Food	$618	$618	$618
Child Care	$624	$708	$673
Transportation	$620	$608	$620
Other Necessities	$518	$855	$554
Taxes	$510	$672	$598
Monthly Total	**$4,452**	**$5,036**	**$4,522**
Annual Total	**$53,419**	**$60,435**	**$54,267**

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Data from Economic Policy Institute Family Budget Calculator

Adult Medicaid Expansion Eligibility

Family Size	138% FPL (2017)
1	$16,394
2	$22,108
3	$27,821
4	$33,534

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The Out-of-Pocket Costs of Care

Front End Premiums

Premiums to get in the door

Back End

Copays, Coinsurance, Deductibles to access services

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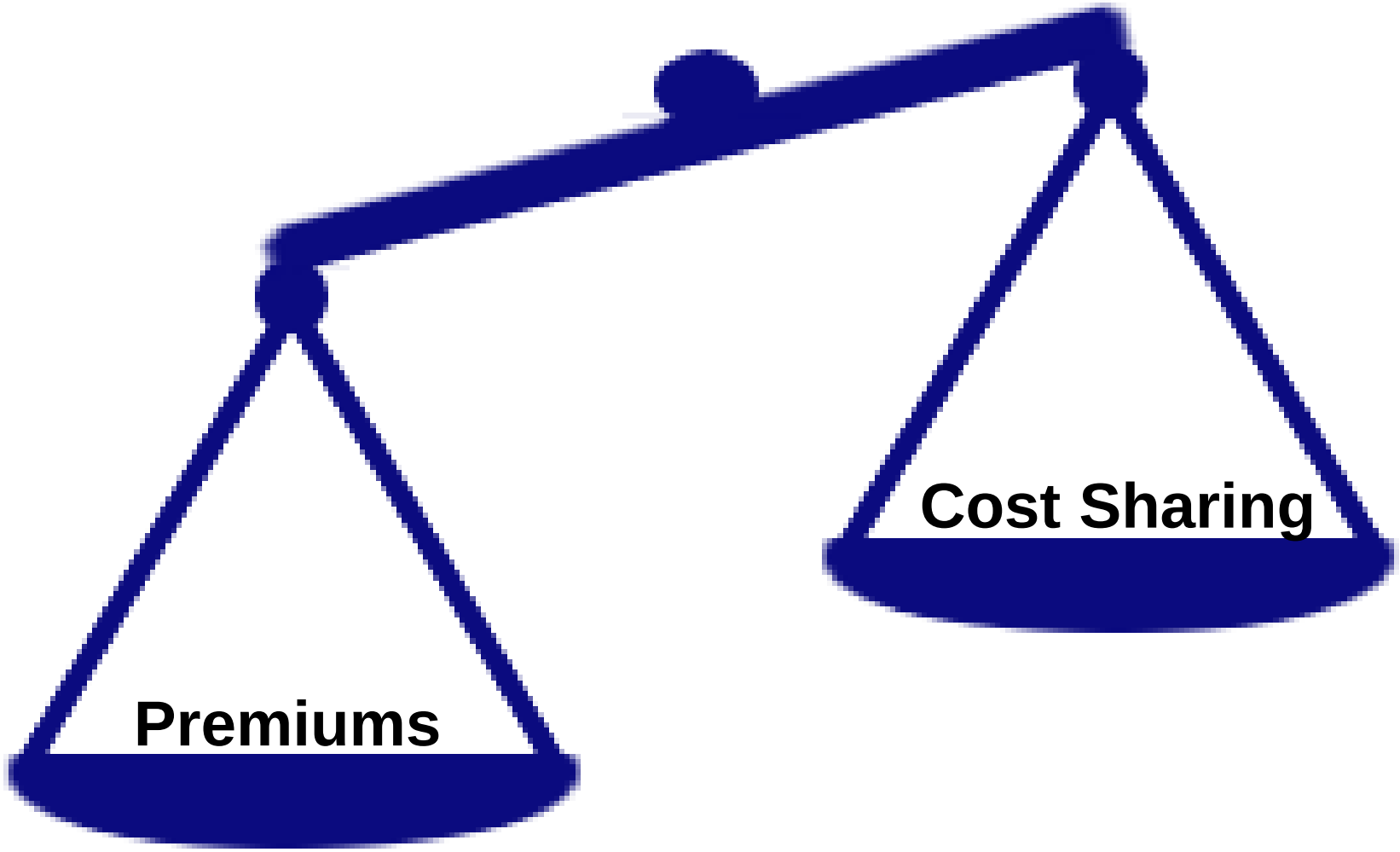

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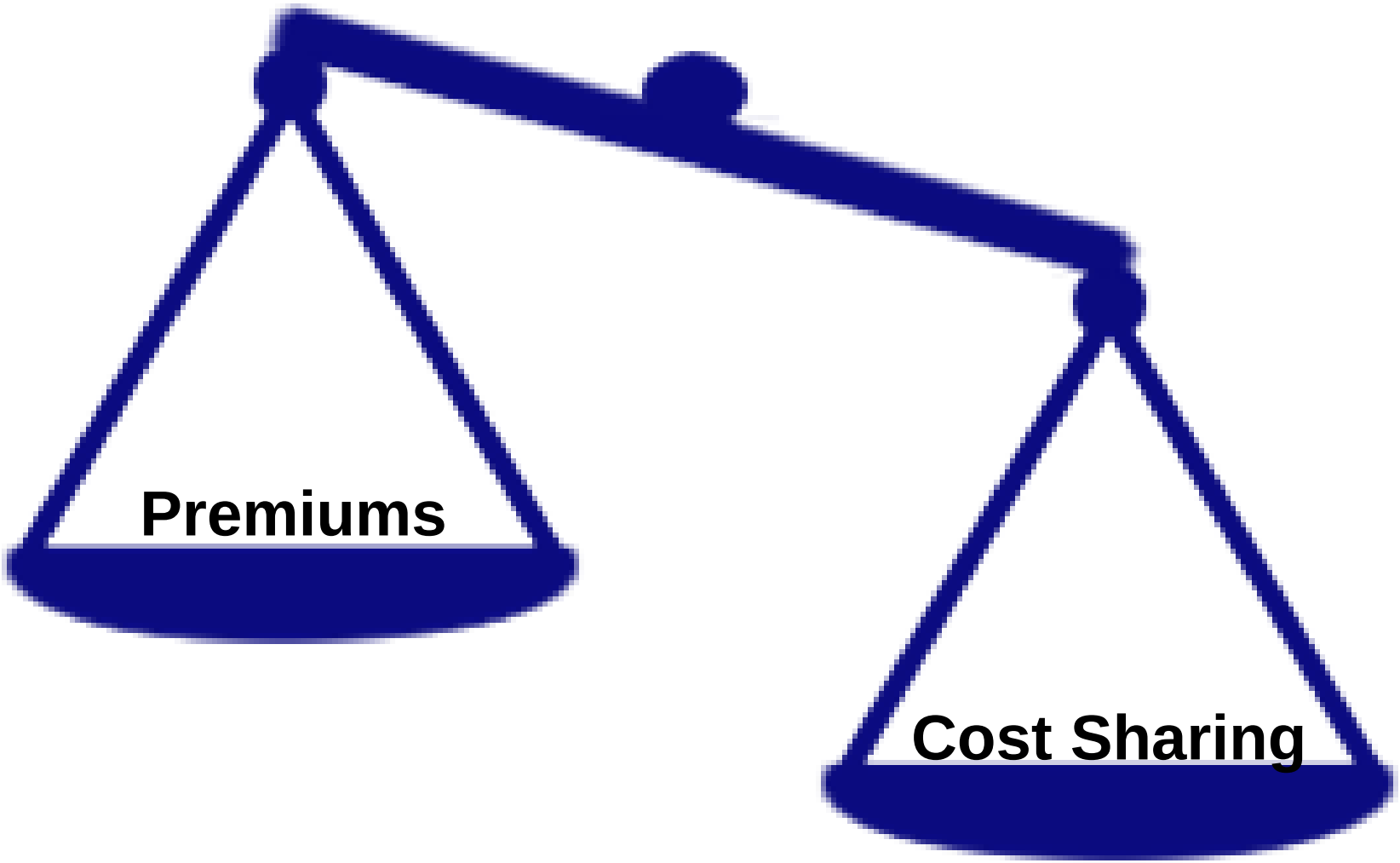

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Medical Costs and Financial Stress

One in five *insured* under 65 struggle with medical bills

How have medical bills changed your life?

"My children haven't had Christmas in two years, and some weeks we barely eat. There are holes in my roof and an entire bathroom that is unusable because I cannot afford the repairs…In addition, prescription "coverage" is a joke – a single pharmacy that rarely fills prescriptions and my out-of-pocket costs are now equal to an eighth of my monthly paycheck. I am drowning."

– J D Chastain II (from NYT survey)

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Oregon Medicaid Experiment

- More than 80% reduction in catastrophic medical expenditures
- 39% reduction in out-of-pocket spending
- 58% reduction in skipping payments or borrowing money to pay bills
- 30% relative reduction in depression
- Significantly more likely to report improved overall health

Katherine Baicker, et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013).

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Lessons from the Literature

Higher cost sharing reduces utilization

- Often **indiscriminate reductions** –
  - essential and less essential care
- Magnified barrier at lower incomes
- Offsetting costs – the consequences of delayed care are worse for people with chronic conditions
- Premiums reduce overall participation

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For detailed literature review, see NHeLP's *Medicaid Premiums and Cost Sharing (2014)*

Six key rules on cost-sharing and premiums in Medicaid

1. Premiums only above 150% FPL (generally)
2. Some cost-sharing generally permitted
3. Certain groups and services exempted
4. Higher limits permitted for “targeted” groups, non-emergency use of ER, and non-preferred medications
5. 5% aggregate cap on cost-sharing and premiums
6. Provider cannot deny service if enrollee cannot pay for individuals below 100% FPL

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Medicaid and Premiums

- Generally prohibited below 150% FPL
  - Limited exceptions (e.g., Medically needy, Transitional Medical Assistance)
  - No penalties beyond disenrollment for nonpayment

- Numerous demonstrations in late 1990s, early 2000s charged premiums to childless adults
  - Strong evidence of reduced participation
  - In Oregon, enrollment fell by nearly half in first year after enrollment

42 U.S.C. §1396o(a)(1); §1396o-1(b)(1); 42 C.F.R. § 447.55

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FY 2015 Maximum Allowable Cost Sharing			
Type of Service	**Household Income (% FPL)**		
	< 100%	**101-150%**	**151%+**
Institutional Care (inpatient hospital, rehab care, etc.)	**$75**	**10% total cost**	**20% total cost**
Non-institutional Care (physician visits, physical therapy, etc.)	**$4**	**10% total cost**	**20% total cost**
Non-emergency ED use	**$8**	**$8**	**No Limit***
Preferred Drugs	**$4**	**$4**	**$8**
Non-preferred Drugs	**$8**	**$8**	**20% total cost**

* Medicaid 5% aggregate cap applies

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Medicaid Cost Sharing Exemptions

Populations

- Children 0 - 18 in mandatory enrollment group
- Most children with disabilities
- Children in federally-funded foster care
- Institutionalized individuals with only a personal needs allowance
- Women eligible through Breast & Cervical Cancer Treatment Program
- Individuals receiving hospice
- Native Americans

Services

- Pregnancy-related services
- Preventive services
- Provider-preventable services
- Emergency services
- **Family planning services and supplies**

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Additional Cost Sharing Protections

1. No denying service for inability to pay
   - Optional to “enforce” cost sharing above 100% FPL
2. Provider can waive cost sharing case-by-case; agency may waive premiums
3. 5% household aggregate cap
   - monthly or quarterly
   - includes Medicaid premium costs
   - Cannot rely on enrollee accounting
   - For family of three at 138% FPL, $335/quarter

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Affordability for Older Adults: Medicare Savings Programs (MSP)

- Some Medicaid coverage provides coverage for Medicare costs
- Medicare cost sharing can be substantial
- Provide important assistance to older adults who otherwise might not be able to afford Medicare
- Multiple categories of alphabet soup: QMB, SLMB, QI-1
  - Eligibility up to 135% FPL and asset test

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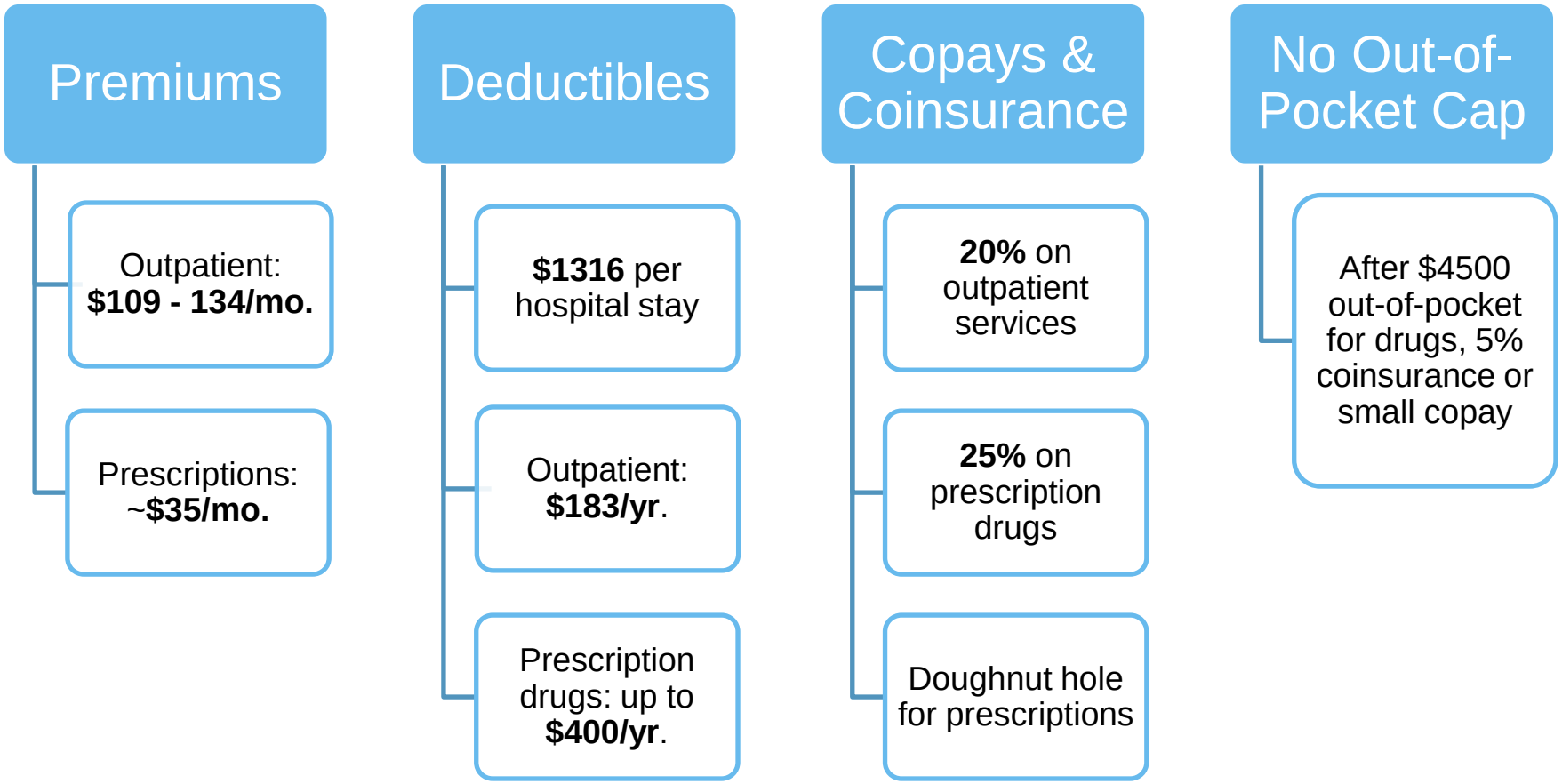
Traditional Medicare Affordability



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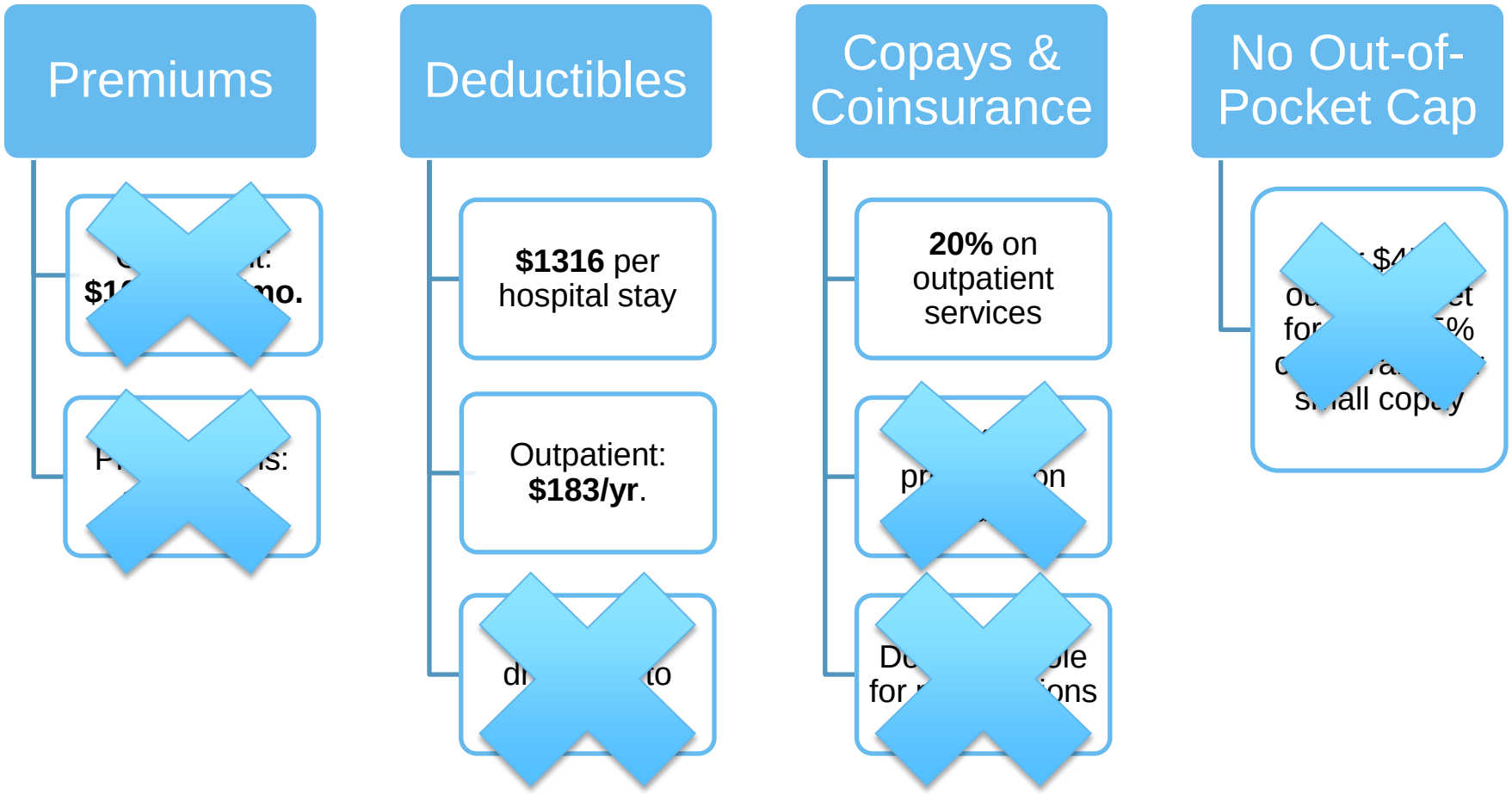
Note: This list is not comprehensive of all Medicare premiums & cost sharing.

Medicaid MSPs: QI & SLMB-only



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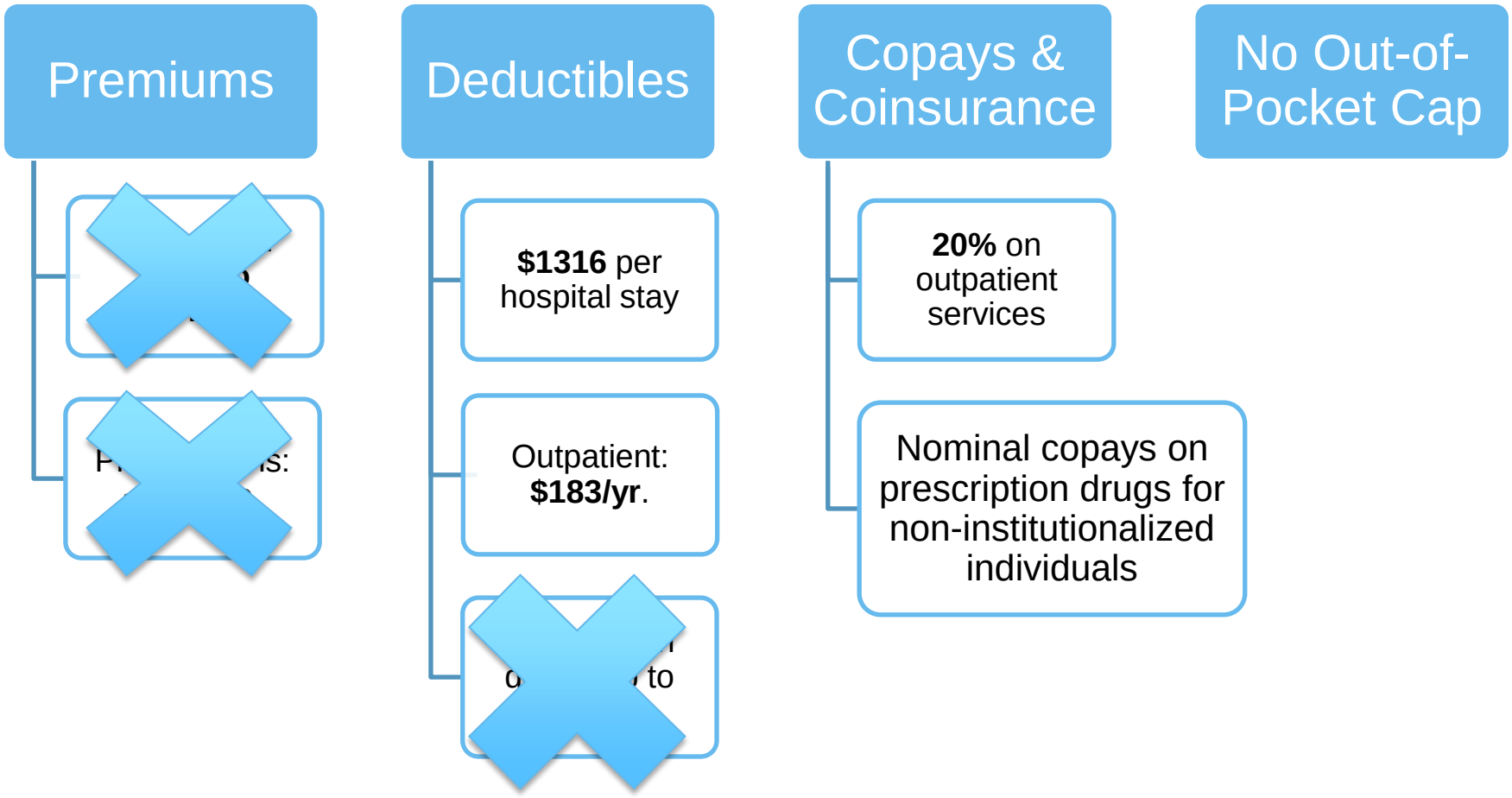

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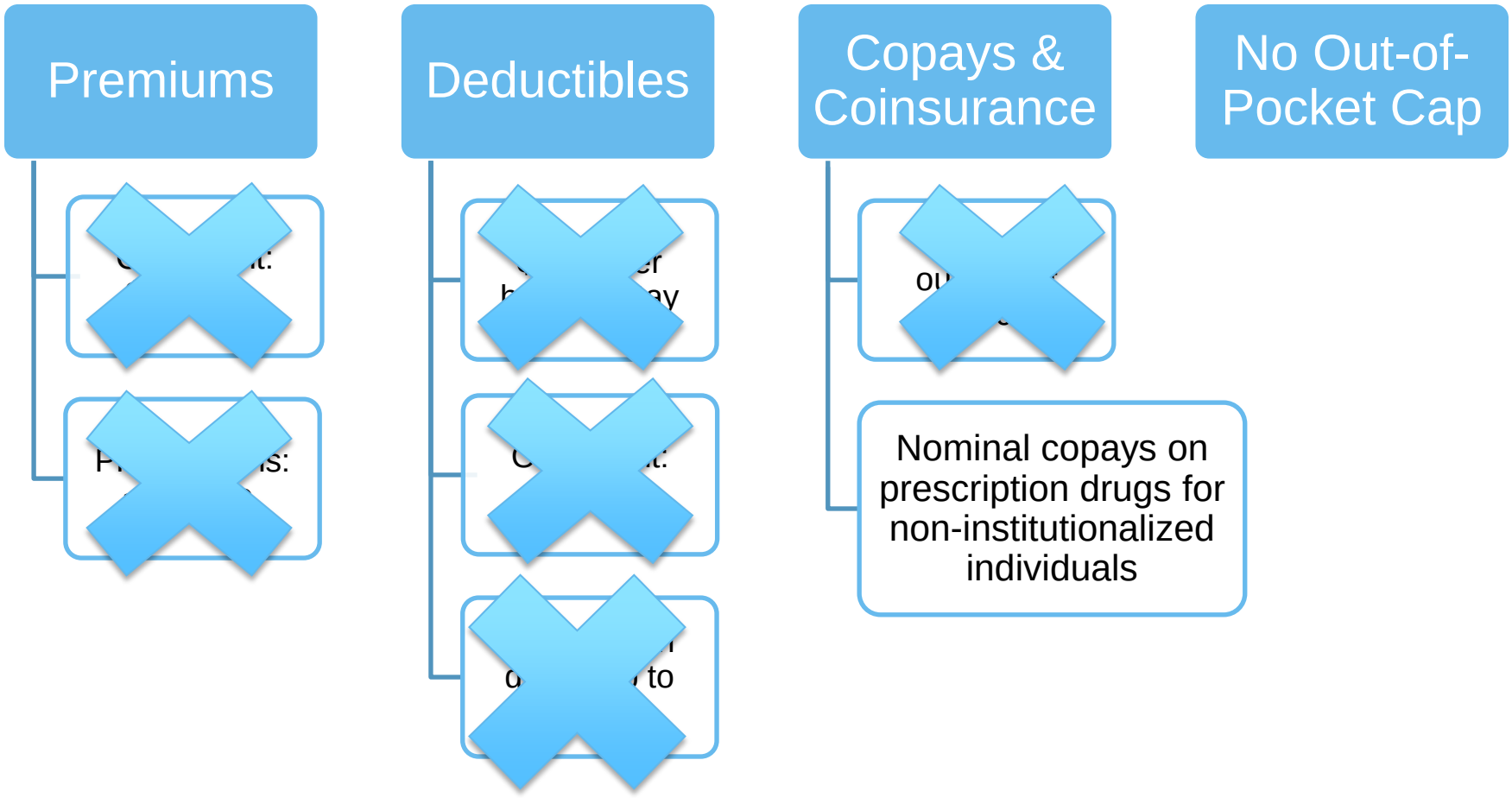

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State flexibility

- Set cost sharing limits
- Targeting cost sharing to enrollees above 100% FPL
- Enforceable cost sharing above 100% FPL
- 1115 demonstration waivers

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1115 Demonstrations: A different world

- Despite limitations, waivers of premium and cost-sharing have been approved in several Medicaid expansion demonstrations
- Usual § 1115 rules and limitations apply
- Statute allows waivers for cost-sharing demonstrations that meet conditions in § 1916(f)
  - Fairly stringent requirements
  - Approved in Indiana for first time for ED copay

Healthy Indiana Plan (HIP) 2.0

Plus Plan

- Premiums (2% FPL)
- No copays except non-emergency ED
- Dental and Vision
- For those over 100% FPL
  - Nonpayment = 6 mo. lockout
- Under 100% FPL
  - Nonpayment sends you to Basic

Basic Plan

- No Premiums
- Maximum allowable copays
- Waiting period up to 60 days (under 100% FPL);
- No vision and dental

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Healthy Indiana Plan (HIP) 2.0

Evaluations raising concerns:

- Sharp increase in disenrollment in 2016
- Complicated incentive structure and widespread confusion
- Incongruous data
- Members with copays display lower use of primary and preventive care

For more information, see NHeLP's *Indiana Medicaid Demonstration Raises Concerns*

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Current Medicaid structure vs. block grants & per capita caps

If your state wants to. . .	Do you 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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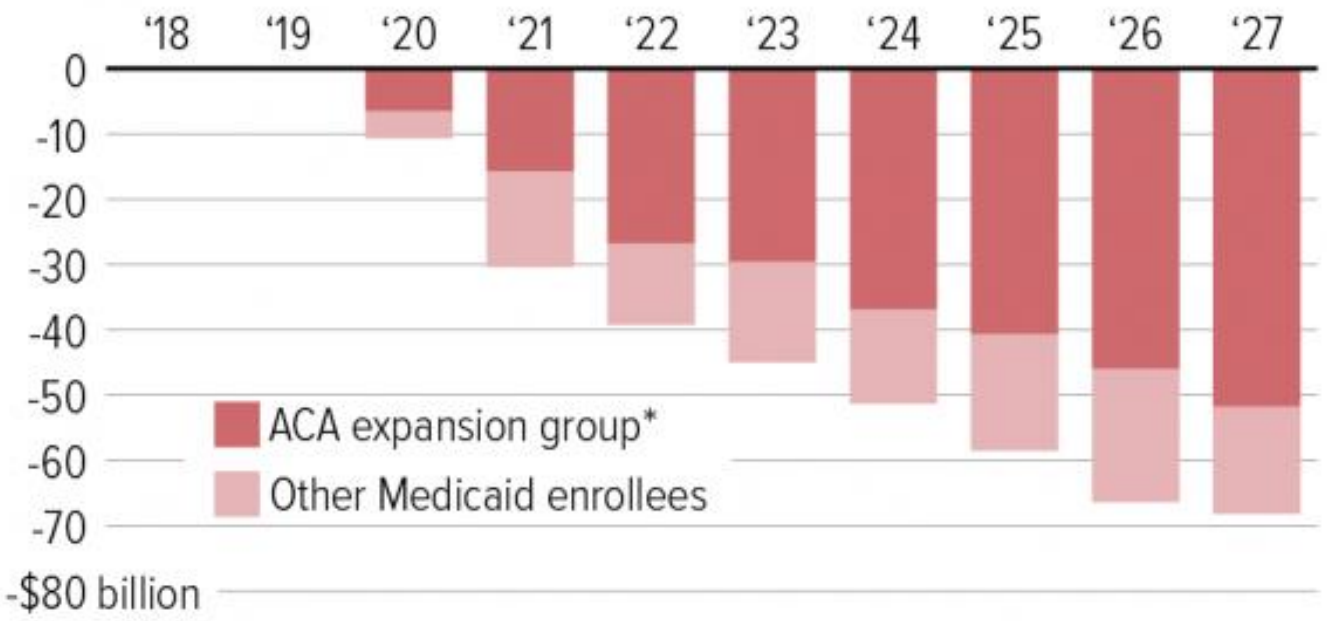
Medicaid Cost Shifts in House GOP Plan Would Total an Estimated $370 Billion Over 10 Years and Grow Over Time

Cost shifts to states, relative to current law



*Enrollees under the Affordable Care Act's Medicaid expansion

Source: CBPP analysis using Jan. 2017 Congressional Budget Office Medicaid baseline and inflation estimates from CBO and the Centers for Medicare and Medicaid Services

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Cost Sharing and State Budgets

No state collects significant revenue from Medicaid cost sharing or premiums;

BUT…

- Premiums depress participation ($$$)
- Cost sharing reduces utilization ($$$)

….So expect to see more in context of PCC.

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Key takeaways

- **Cost sharing creates a substantial barrier to care that typically increases as income decreases**
- **Medicaid has robust cost sharing and premium protections to preserve access to care.**
- **States may impose limited cost sharing in Medicaid**
- **Medicaid premiums have been shown to reduce participation in the past**
- **Per capita caps and block grants on Medicaid would shift costs to the states and likely lead to more premiums, lockouts, and higher cost sharing**

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What you can do

- Contact your elected representatives
- Work with state coalitions
- Prepare fact sheets and other materials (NHeLP is here to help!)
- Story collection – Medicaid works!
- Mobilize, organize, resist!

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Now @ NHeLP

The president and his allies are pushing policies to trample the health rights of our most vulnerable. We need your help. **Share your stories** about the importance of health care coverage. Your stories will help us fight to protect health care for millions of Americans. And **join the effort** to #ProtectMedicaid and #SaveHealthCare.

- Click here to share your story about Medicaid and the ACA
- Comparta su historia con nosotros aquí!

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THANK YOU

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