Health Advocate

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Key Resources

NHeLP's Protect Medicaid Series

50 Reasons Why States Should Take Up the Medicaid Expansion

Coming in December Health Advocate: Litigation Round-up

The Post-Election State of Our Health

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Starting the day after the election, the questions began – what will happen to Obamacare? What will happen to Medicaid and CHIP? The president-elect's mantra "We will repeal Obamacare" puts many of the gains we have achieved through Obamacare, including the lowest uninsurance rate in 50 years, at risk. Obamacare also improved health equity by leading to the largest declines in uninsurance for blacks and Hispanics, down 10.4% and 9.5%, respectively.

On November 10, President-elect Donald Trump's transition website posted a document about health care. It mentions allowing the purchase of health insurance across state lines, re-establishing high-risk pools, and using Health Savings Accounts as alternatives to Obamacare.

What happens to Obamacare?

Over 25 million individuals gained coverage since Obamacare was signed into law on March 23, 2010. More than 12 million of those enrolled in private insurance through the state and federal marketplaces.

Repealing Obamacare is not as simple, however, as getting rid of the marketplaces and rolling back Medicaid eligibility to 2010 levels. A lot of Obamacare's changes are now entwined in the fabric of the provision of health insurance and may be harder to repeal. Think about policies providing free preventive care including contraception, allowing children up to age 26 to remain on their parents' health insurance plans, prohibiting annual and lifetime limits, capping yearly out-of-pocket costs, and prohibiting the denial of insurance due to pre-existing conditions. Think also about the progress achieved from enacting a broad nondiscrimination protection, which included prohibitions against sex discrimination in health care for the first time; prohibiting most age rating; reforming Medicare; and many of the provisions advancing public health and supporting training in the health professions.

While many have argued that the health plans offered through the marketplaces did not meet expectations – sometimes due to limited networks, rising prices year-over-year, or high deductibles – millions of previously uninsured consumers enrolled and were able to obtain health care for the first time in years or even decades. It will be difficult to take away or change health insurance for over 12 million individuals. Health savings accounts – as mentioned by the president-elect – likely will be insufficient for lower and moderate income individuals to buy health insurance. Health savings accounts benefit those who have high enough incomes to withhold part of their salary pre-tax and use that money to buy health insurance. Many low and moderate income workers, already struggling to pay their bills, will not have disposable income to withhold about $237

per month (the average cost of a monthly premium on the individual market), not to mention the additional costs of co-pays, co-insurance and deductibles. Remember that most people can purchase a private insurance plan on the federal marketplace for under $75/month (after tax credits). The marketplaces' efficiencies of scale, guaranteed access, tax credits and cost-sharing reductions, and requirements for providing essential health benefits mean that millions can afford insurance and many insurers are willing to participate to gain enrollees. Putting all these individuals back into an unregulated individual market will leave them to the vagaries of researching plans and costs themselves. This will occur as insurers will not have the same constraints to provide comprehensive, affordable insurance.

The president-elect's other component for a replacement – high-risk pools – were tried both before the ACA and after the ACA was enacted but before the marketplaces launched. In general, these pools were very costly and many individuals who needed care did not meet the eligibility requirements. State high risk pools prior to Obamacare generally had higher premiums than standard non-group markets, exclusions for pre-existing conditions, annual and lifetime limits, and high deductibles. Some states capped enrollment to limit their costs. As noted by the Kaiser Family Foundation, "Even with these limitations, the government subsidies required to cover losses in these high-risk pools were substantial – over $1 billion per year in the state pools and about $2 billion in the final year of PCIP [Pre-existing Condition Insurance Plan]. A high-risk pool that had minimal barriers to enrollment could cost substantially more."

Timing is also a question. Most of the current discussion around repeal envisions at least a two-step process – repeal immediately with a 2-year transition period to determine how to replace the law. Thus, we expect that anyone who enrolls in a 2017 plan will have coverage at least through 2017. But repealing without replacing provides further instability to consumers and the insurance market due to the inability to plan and implement a transition. It has taken most of the past six years to put Obamacare into place and even if a replacement were to be enacted in two years, implementation cannot be done in the blink of an eye, even with a willing administration.

What happens to Medicaid?

Medicaid expansion was an integral part of Obamacare, to ensure that individuals would have access to health insurance if their incomes were below 133% of the Federal Poverty Level (FPL, about $32,319 for a family of four). To date, 32 states and the District of Columbia have expanded Medicaid. Medicaid is extremely cost-effective, with spending per enrollee averaging only $3,247 per year for adults and $2,463 for children (compared to a cost of $5,963 in premiums – not actual spending – per enrolled employee for employer-based insurance).

Pre-Obamacare, many low-income individuals were ineligible for Medicaid due to the program's income limits, asset tests, and categorical requirements (that the applicant be a low-income child, pregnant woman, person with a disability, or older adult). Parents of children and childless adults were often excluded from Medicaid or only the lowest income individuals in these categories were eligible. For example, Alabama (which has not expanded Medicaid under Obamacare) only covers parents of children if they earn less than 18% of the Federal Poverty Level and does not cover childless adults at all. The purpose of Obamacare's Medicaid expansion was to equalize eligibility limits for parents and childless adults across the U.S. and provide a baseline of insurance for all low-income individuals (at a cost less than providing insurance through the marketplaces). While the Supreme Court effectively made this expansion optional for states, states that adopted the Medicaid expansion saw their Medicaid rolls increase and uninsurance rates decrease. Even states that did not technically expand Medicaid eligibility often saw more eligible individuals enroll as they learned about the availability of health insurance.

Notably, several Republican governors adopted Medicaid expansion because they understood the benefits not only for their residents but also to their state's hospitals from lowering uncompensated care costs, to their budgets with the 100% federal match for the expansion population (through 2016 and then tapering to 90% by 2020) and to their ability to transfer some fully funded state health care costs to Medicaid (for example, some costs related to public health and mental health). These expansions also provided tens of thousands of individuals with a lifeline of health insurance. One politician who campaigned on rolling back its state's Medicaid expansion – Governor Bevin in Kentucky – eventually backed down from this pledge once elected (although he is seeking changes to the expansion coverage).

Medicaid serves as an important anti-poverty and economic security measure by providing health care with very low premiums and no deductibles but also because it allows low-income to use their limited incomes to pay for housing, food, transportation and other necessities. In addition to serving as a safety net for low-income individuals, Medicaid provides a significant source of health insurance for people of color. According to the Kaiser Family Foundation, African-Americans comprise 22% of Medicaid enrollment; Hispanics, 25%. Medicaid insures one of every five individuals in the U.S. and one of every three children. Medicaid also covers nearly half of all births in the U.S.

But this is not only about low-income individuals. Medicaid is an economic stimulus for states, funding job creation and supporting hospitals, physicians, nursing homes and other health services. For example, hospitals have significantly benefitted from having fewer uninsured patients which helps them stay afloat.

Over the past twenty-five years, numerous attempts have been made to cut Medicaid spending. One proposal, back on the table again, is to block grant the Medicaid program. A block grant would provide states with a set amount of money to provide health care to their low-income populations. The problem with a block grant is that is does not account for fluctuations in enrollment such as increases due to economic recessions, natural disasters such as hurricanes (for example, hundreds of thousands of individuals needed health insurance after Hurricane Katrina), or even medical advances.

Medicaid was designed as an entitlement program such that any individual eligible would receive it. Turning it into a block grant puts much more financial burden on states to come up with extra funding when more individuals need health insurance, or cut benefits and enrollees, right when people may need help the most. Another recent suggestion – per capita caps – may address the issue of limited funding somewhat by allowing all those eligible to enroll but limiting the amount the federal government pays per individual. However, unless the caps yearly adjust congruently with actual increases in health care costs and development of new medications and technologies, and do not clamp down on funding by artificial increases (e.g. tying increases to the consumer price index instead of health care cost indexes), states will feel the financial squeeze as well. Unfortunately, past proposals to change Medicaid into a block grant or per capita caps were focused on cutting federal spending rather than identifying a feasible method of paying for all needed medical care. As one conservative consultant said recently, "If we do not have fewer people in Medicaid in four years, then we have not reformed health policy in a good direction." The odds are that this Congress and President would not develop a per capita cap in a way that supports the provision of quality health care. The guise of greater flexibility, but coupled with less money, will not offer states the solution they think they want.

The Children's Health Insurance Program (CHIP) is also facing extinction if Congress does not act to provide funding by September 30, 2017 (the program is authorized through Fiscal Year 2019 but only funded through 2017). It is unclear if Congress will act expeditiously to provide states the needed clarity to plan for continuation of the program past September 30. And repealing Obamacare also affects CHIP since Obamacare required states to maintain their pre-ACA funding levels in CHIP.

Conclusion

While it seems a repeal of Obamacare is almost certain when the new Congress convenes in January, what it will be replaced with, how it will impact access to affordable coverage, and whether the Medicaid entitlement financing mechanism is changed are all questions that will likely drag out through 2017 and 2018. We must, however, remember that it is not just about dollars and cents but that the lives of more than 25 million individuals lie in the balance. We owe it to them to ensure that they do not lose access to quality, comprehensive, affordable coverage.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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