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Coverage for Lower-Income Adults: Exchange versus Medicaid

Prepared By: David Machledt
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States that refuse to implement the Affordable Care Act's (ACA) Medicaid expansion will short shrift many low-income adults. Those in the lowest-income brackets will undoubtedly be worst hit as many will continue without any affordable coverage option and remain uninsured. Their plight has been widely acknowledged, but they are not the only ones who stand to lose in states that refuse expansion. Though adults with slightly higher incomes – between 100% and 133% of the Federal Poverty Level (FPL) – will gain access to federally subsidized private coverage in the health insurance Exchanges, this group of lower-income adults would likely fare better with Medicaid coverage, which generally provides more comprehensive benefits at lower cost.[1] Further, coverage of this population through the Exchanges is more expensive system-wide and the added influx of low-income adults would likely increase risk (and premiums) for both Exchange and private individual market insurance.[2]

Impacts on Low-Income Adults

States that refuse to implement the Medicaid expansion would generate a "coverage gap" for the lowest-income adults. Lower-income adults earning at least 100% FPL ($11,490 individual; $23,550 family of four) would qualify for subsidized coverage – Advanced Premium Tax Credits and cost-sharing reductions – but many childless adults and parents earning *less* would be left with no viable coverage option.[3] Since Congress expected these individuals to receive Medicaid, it provided no additional alternative coverage option in the ACA. Thus, a state's decision not to implement the Medicaid expansion creates a profoundly unfair gap that contradicts the ACA's goal of a seamless system of affordable Medicaid coverage for the lowest income Americans.

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[1] The Federal Poverty Level (FPL) for the contiguous 48 states in 2013 is $11,490 for an individual, $23,550 for a family of four.

[2] Risk pooling to set premiums includes individuals both inside and outside the Exchanges, so an increased risk for Exchange participants will also affect the private individual market. See Am. Acad. of Actuaries, *Implications of Medicaid Expansion Decisions on Private Coverage*, 2, (September 2012), http://www.actuary.org/files/Medicaid_Considerations_09_05_2012.pdf.

[3] The ACA allows lawfully present immigrants below 100% FPL to receive subsidized Exchange insurance if they are ineligible for Medicaid due to their immigration status. Legislators intended this for lawfully present immigrants subject to a five-year Medicaid eligibility bar. If a state refuses the Medicaid expansion, these immigrants may no longer be eligible for Exchange subsidies.

For lower-income adults between 100% and 133% FPL, private insurance premiums through the Exchange will likely be unaffordable. Individuals earning just over the poverty level still live on a shoestring budget, often scraping by paycheck to paycheck. Low-income individuals regularly have to decide between filling a prescription or paying the electricity bill, going to the doctor or paying rent. Even a relatively small added financial burden has a magnified impact on people with little or no disposable income.[4]

Cost-sharing on the Exchange leaves lower-income adults at substantial risk of major out-of-pocket expenses. Cost-sharing subsidies in the Exchange reflect *average* spending across a population. Individuals who use more services, perhaps due to a chronic condition or an expensive hospitalization, will face higher expenses, potentially into the thousands of dollars. Others may have to pay their out of pocket share up front as a deductible, which research shows to discourage access to all healthcare services, needed or not.[5] Medicaid forbids premiums for individuals below 150% FPL ($16,755 for an individual), allows only nominal cost-sharing and sets tight limits on maximum out-of-pocket expenses.[6] Additionally, certain services, like emergency and pregnancy-related services, and populations, such as individuals in hospice care, are exempt from cost-sharing in Medicaid. Furthermore, in most states Medicaid providers may not refuse to provide a service if the individual is unable to pay the cost-sharing, a consumer protection that does not exist in the Exchanges.[7] Even the healthiest lower income individuals could incur potentially crippling expenses in the Exchanges if they have a serious accident or medical trauma.

Medicaid specifically designs its coverage to meet the needs of very low-income adults. Health status decreases with income.[8] Benefit packages in the private market are tailored to healthier populations who are less likely to have disabilities, chronic conditions, or developmental illnesses. Some lower-income adults will get a Medicaid benchmark benefit that includes moderate extra protections not usually included in

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[4] For estimates of basic budget needs for low-income families, see the National Center for Children in Poverty's Basic Needs Budget Calculator: http://www.nccp.org/tools/frs/budget.php.
[5] Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcome*, Robert Woods Johnson Found., Research Synthesis Report #20, 4 (December 2010), http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html.
[6] For Medicaid beneficiaries between 100-150% FPL, cost-sharing may not exceed 10% of the cost for most services and copays for pharmaceuticals cannot exceed $3.90. The maximum out-of-pocket expense is capped at 5% of monthly or quarterly income. For details on other limitations, see 42 U.S.C. §§ 1396o and 1396o-1(b)(1). See also, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing.html.
[7] 42 U.S.C. § 1396o(e). The Deficit Reduction Act of 2005 allows states to waive this requirement, but only seven states reported making cost-sharing enforceable on a particular group in FY 2012. See Vernon K. Smith et al, Kaiser Family Foundation, *Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends*, at 42, (October 2012), http://www.kff.org/medicaid/upload/8380.pdf.
[8] Nancy E. Adler and Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, 21(2) Health Affairs 60-76, (2002) available at: http://content.healthaffairs.org/content/21/2/60.full.pdf+html.

private coverage.[9] Other more vulnerable populations, such as the medically frail, will have access to traditional Medicaid coverage that includes robust behavioral health services and services that reduce access to care barriers, like non-emergency medical transportation.[10] Medicaid law also grants protections for beneficiaries' freedom to choose between qualified family planning providers—a protection not commonly found private insurance.[11]

Impacts on the Health System

Covering low-income individuals through the Exchange is much more costly for the Federal government than covering them through Medicaid. Medicaid delivers far more cost-efficient health care than private insurance.[12] Private insurance has overall higher administrative costs, including marketing, profit margins and executive salaries. The Congressional Budget Office (CBO) estimates that the federal government will spend an additional $3,000 for every individual who, as a result of a state refusing the Medicaid expansion, enrolls in an Exchange (and receives APTCs and cost-sharing assistance) instead of Medicaid.[13]

Adding lower-income adults to the Exchange insurance pool will increase the risk profile and raise premiums for privately insured individuals. Health status decreases with income. The least healthy lower-income adults are also *most* likely to sign up for coverage. This influx of generally less healthy enrollees will raise insurance costs across the Exchange. Furthermore, added uncertainty due to churning on and off coverage around the minimum eligibility limit will increase uncertainty, encouraging insurers to build in a risk premium that further inflates costs for everyone. Finally, hospitals and other providers will likely shift costs to compensate for remaining uninsured individuals who fall in the coverage gap. The CBO estimates that average individual market and Exchange premiums will rise 2 percent across the country because some states will refuse Medicaid expansion.[14] Factoring out the many states that do expand (and have no spike in premiums), those refusing states will see premium hikes well above 2 percent.

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[9] For example, benchmark plans must ensure beneficiary access to Federally-Qualified Health Centers and Rural Health Clinics. 42 C.F.R. § 440.365. Secretary-approved benefit plans, the benchmark option most states have used to this point, must provide "appropriate coverage to meet the needs of the population provided that coverage." 42 C.F.R. § 440.330(d).
[10] States must ensure that beneficiaries receive necessary transportation to and from providers. 42 C.F.R 431.53. CMS recently proposed a clarification of its broad definition of medically frail to explicitly include all people with disabilities. See 78 Fed. Reg. 4631, 4700 (Jan 22, 2013).
[11] 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(3). Some states have received CMS permission to waive this requirement.
[12] National Academy of Public Administration and the National Academy of Social Insurance, *Administrative Solutions in Health Reform*, 45-47, (July 2009), available at: http://www.napawash.org/wp-content/uploads/2009/09-14.pdf. Note also that the ACA funds system reforms that should lower per capita Medicaid administrative expenses.
[13] Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, 4, (July 2012), available at http://www.cbo.gov/publication/43472.
[14] *Id*, at 15.

If a state refuses the Medicaid expansion, churning on and off health insurance will increase and lead to interrupted and delayed care. Low-income individuals have fluctuating income, due to part-time jobs with varying hours, seasonal employment, and other factors. The coverage gap for individuals below 100% FPL will create a new eligibility threshold. Instead of the seamless system envisioned by the ACA, which promotes regular preventive care and helps manage chronic illness, low-income adults will regularly drop in and out of coverage as their incomes rise and fall. This will cause individuals to delay needed care for financial reasons and increase the likelihood of more serious health problems.

Next Steps

Given the implications for lower-income adults, it is difficult to overstate the importance for states to fully implement the Medicaid expansion. The benefits accrue to individuals across the income spectrum. Low-income adults receive access to comprehensive and cost-effective Medicaid coverage, while the Expansion reduces uncompensated care costs and keeps premiums on the private market in check, which benefits those at higher incomes. In short, the Medicaid expansion preserves the ACA's goal of seamless affordable coverage across income groups and increases efficiency across the income spectrum.