THE HENRY J. KAISER FAMILY FOUNDATION

State of Coverage Policy

Grantmakers In Health, Fall Forum

November 9, 2017

Karen Pollitz, Senior Fellow

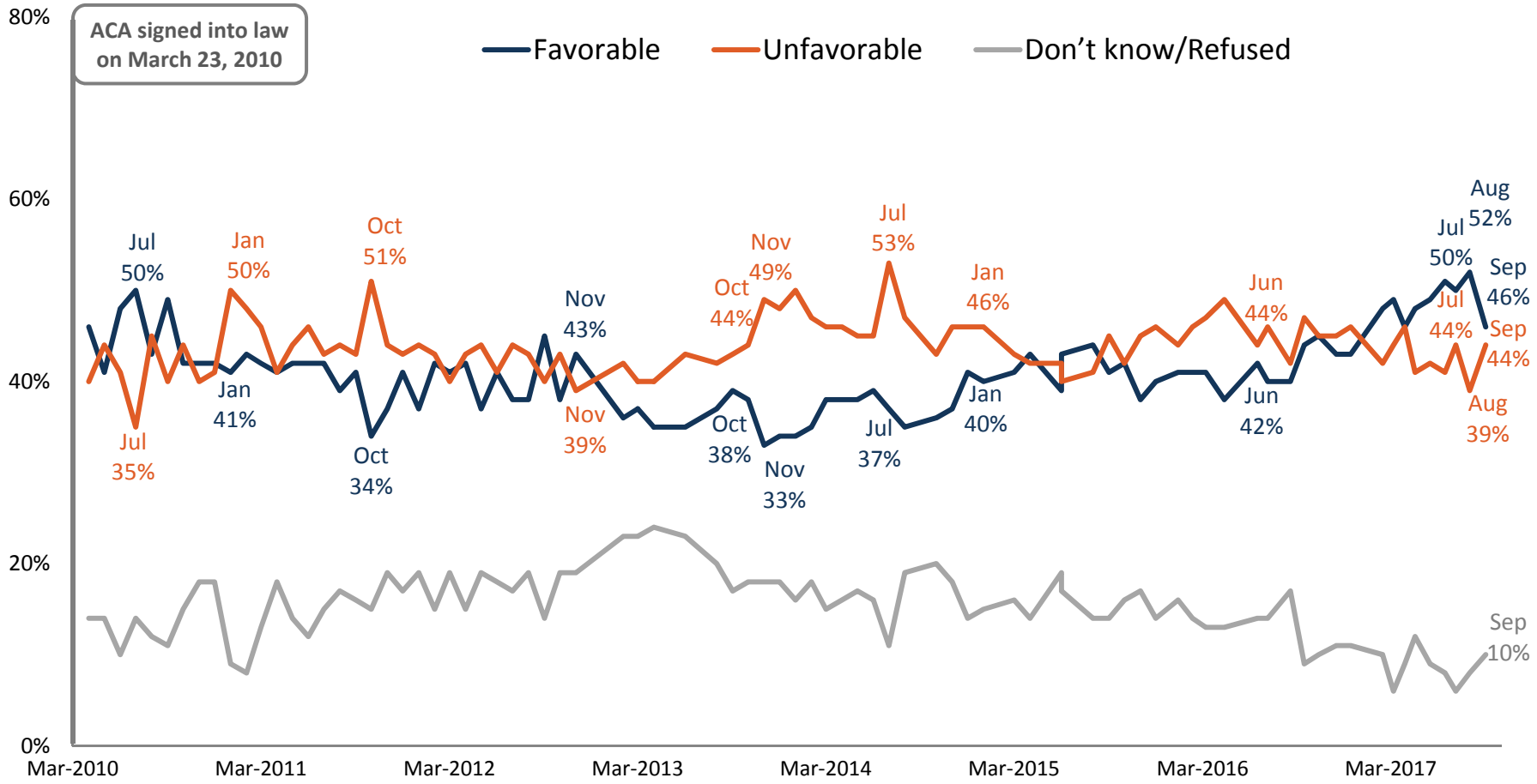
Kaiser Family Foundation

Key elements of the Affordable Care Act

- Medicaid expanded to cover adults up to 138% of poverty, which is about $17K per year for a single person and $34K for a family of four (made voluntary by the Supreme Court, with 19 states not expanding as of now).
- In insurance “marketplaces” premium tax credits are available to people with incomes of 100% to 400% of poverty (about $48K for an individual, $98K for a family of four). Low-income get additional help with cost-sharing.
- Insurers required to sell to all regardless of pre-existing health conditions. Variations in premiums limited for age and prohibited for gender & health.
- Insurance plans sold to individuals & small businesses must provide similar benefits, including preventive care, maternity, mental health, and Rx drugs.
- Employers with 50+ workers must offer affordable insurance to workers or pay a penalty.
- Parents can keep children on their insurance up to age 26.
- Most Americans required to have insurance or pay a penalty.
- Undocumented immigrants are ineligible, and authorized immigrants are ineligible for Medicaid for 5 years.

Public's view of the ACA

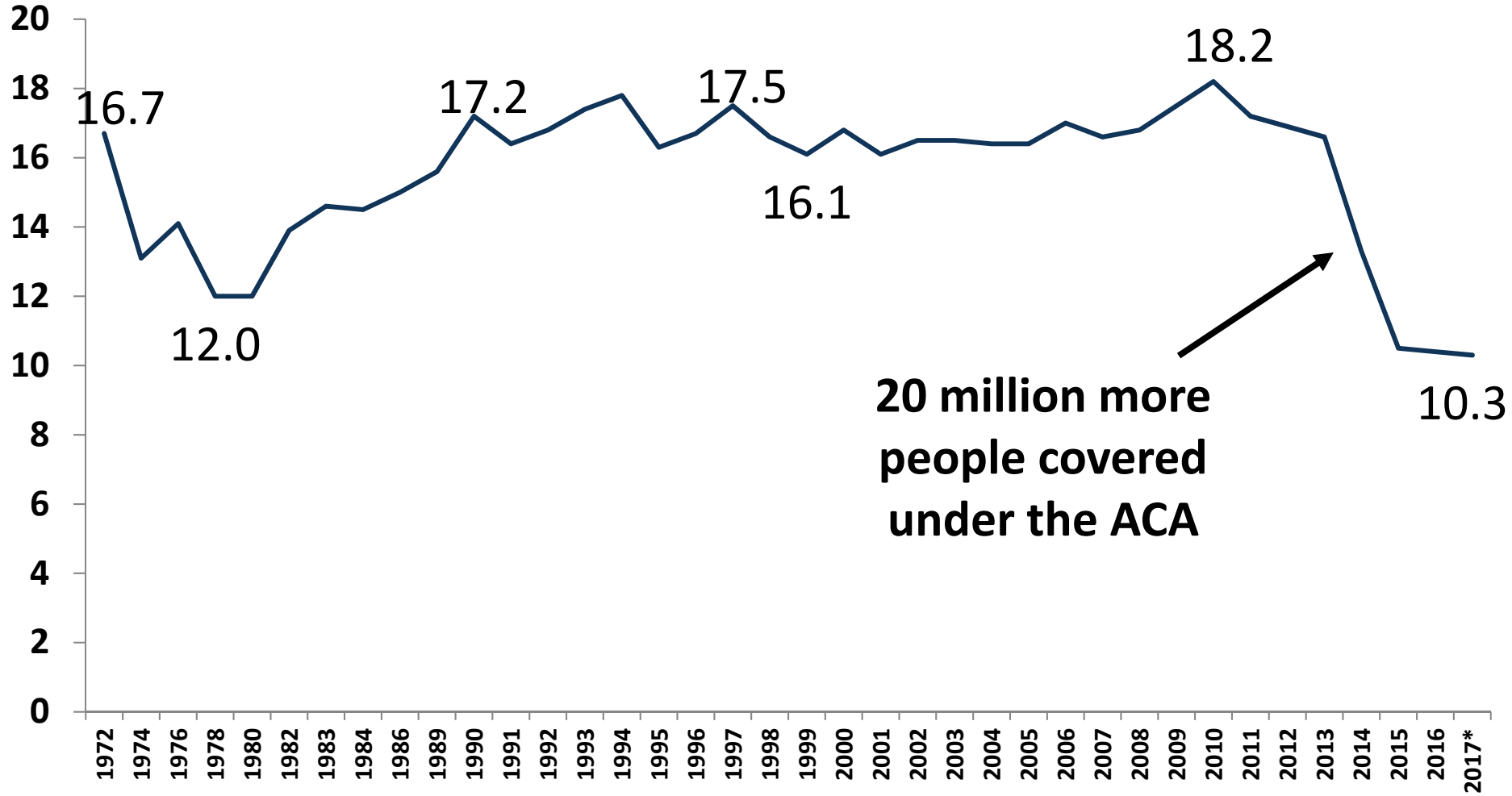
As you may know a health reform bill was signed into law in 2010, known commonly as the Affordable Care Act or Obamacare. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?



SOURCE: Kaiser Family Foundation Health Tracking Polls

THE HENRY J. KAISER FAMILY FOUNDATION

Uninsured rate among the non-elderly



Note: 2017 data is for Q1 only.

Source: CDC/NCHS, National Health Interview Survey.

THE HENRY J. KAISER FAMILY FOUNDATION

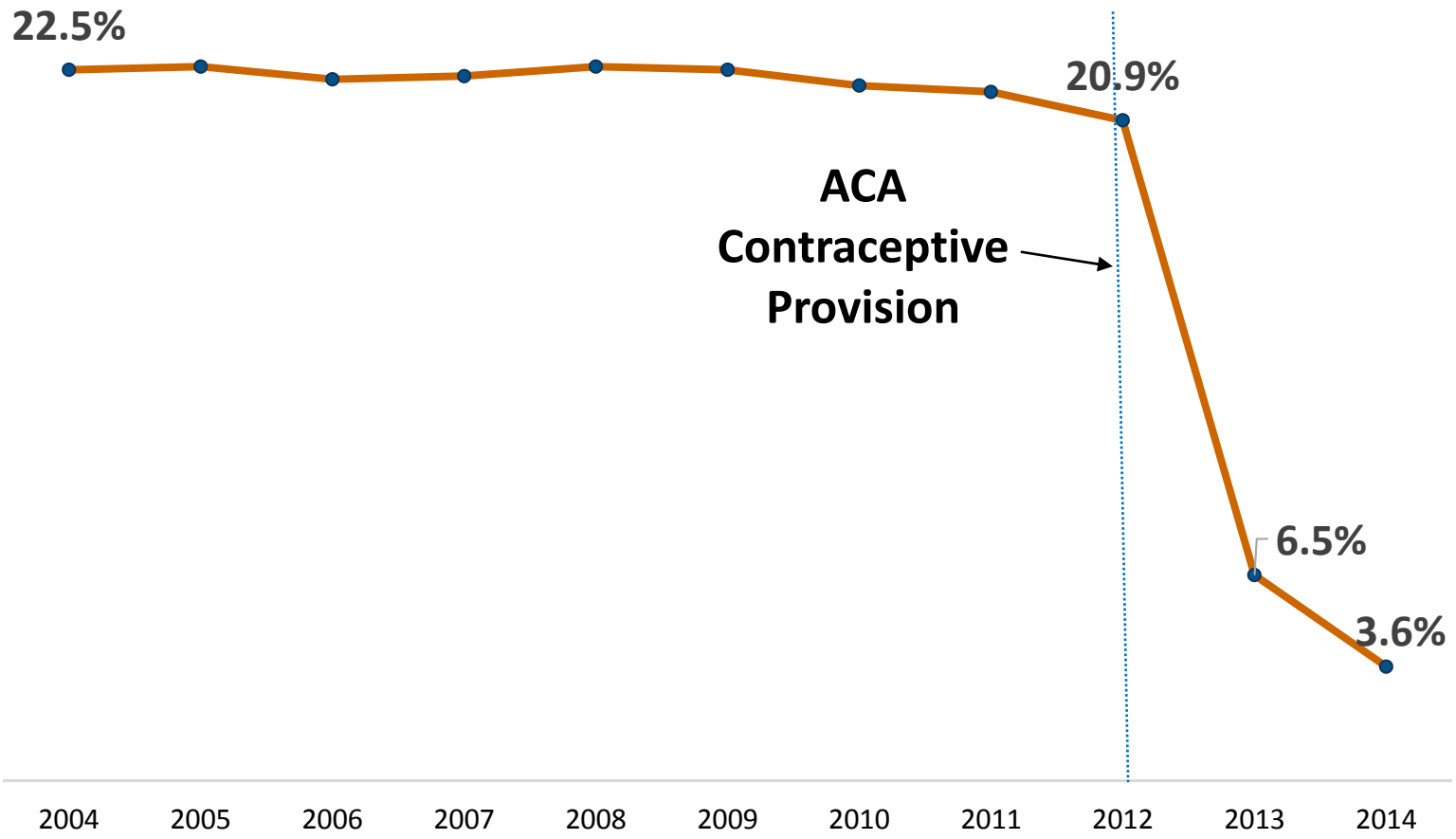
27% of non-elderly adults have a condition that would have led to an insurance denial pre-ACA

AIDS/HIV	Lupus
Alcohol abuse/ Drug abuse with recent treatment	Mental disorders (severe, e.g. bipolar, eating disorder)
Alzheimer's/dementia	Multiple sclerosis
Arthritis (rheumatoid), fibromyalgia, other inflammatory joint disease	Muscular dystrophy
Cancer within some period of time (e.g. 10 years, often other than basal skin cancer)	Obesity, severe
Cerebral palsy	Organ transplant
Congestive heart failure	Paraplegia
Coronary artery/heart disease, bypass surgery	Paralysis
Crohn's disease/ ulcerative colitis	Parkinson's disease
Chronic obstructive pulmonary disease (COPD)/emphysema	Pending surgery or hospitalization
Diabetes mellitus	Pneumocystic pneumonia
Epilepsy	Pregnancy or expectant parent
Hemophilia	Sleep apnea
Hepatitis (Hep C)	Stroke
Kidney disease, renal failure	Transsexualism

Source: KFF review of pre-ACA underwriting manuals

ACA coverage of contraceptives has dramatically reduced out-of-pocket costs for women

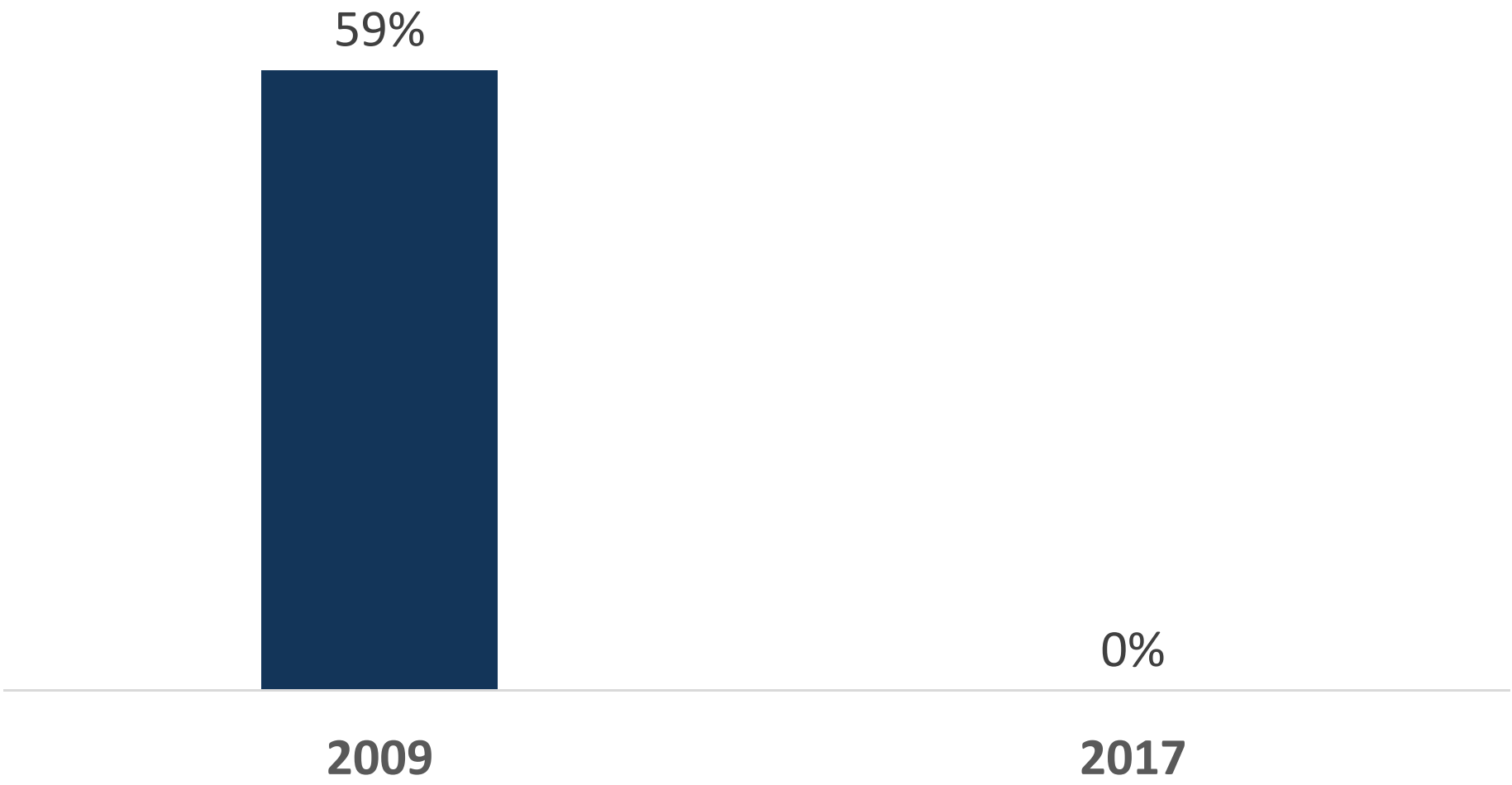
Share of women with any out-of-pocket spending on oral contraceptives:



NOTE: Share of women age 15-44 with health coverage from a large employer who have any out-of-pocket spending on oral contraceptive pills, 2004-2014.
SOURCE: Peterson-Kaiser Health System Tracker. Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004-2014.

THE HENRY J. KAISER FAMILY FOUNDATION

Share of covered workers in employer health plans with a lifetime limit on coverage

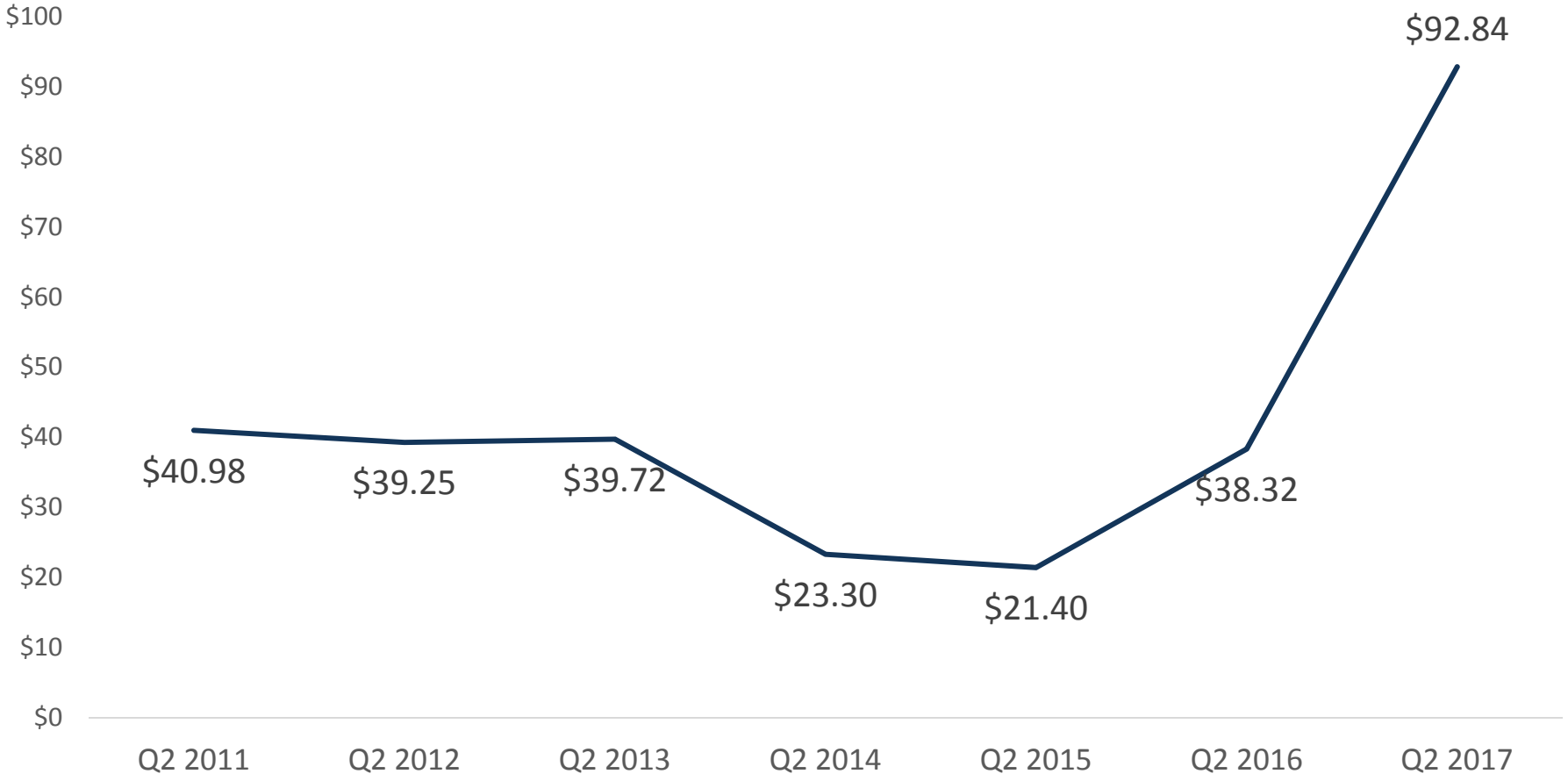


Source: Kaiser-HRET Employer Health Benefits Survey, 2009.

THE HENRY J. KAISER FAMILY FOUNDATION

Financial condition of non-group market health insurers stabilized with 2017 premium increases

Average Individual Market Gross Margins Per Member Per Month, 2011 - 2017

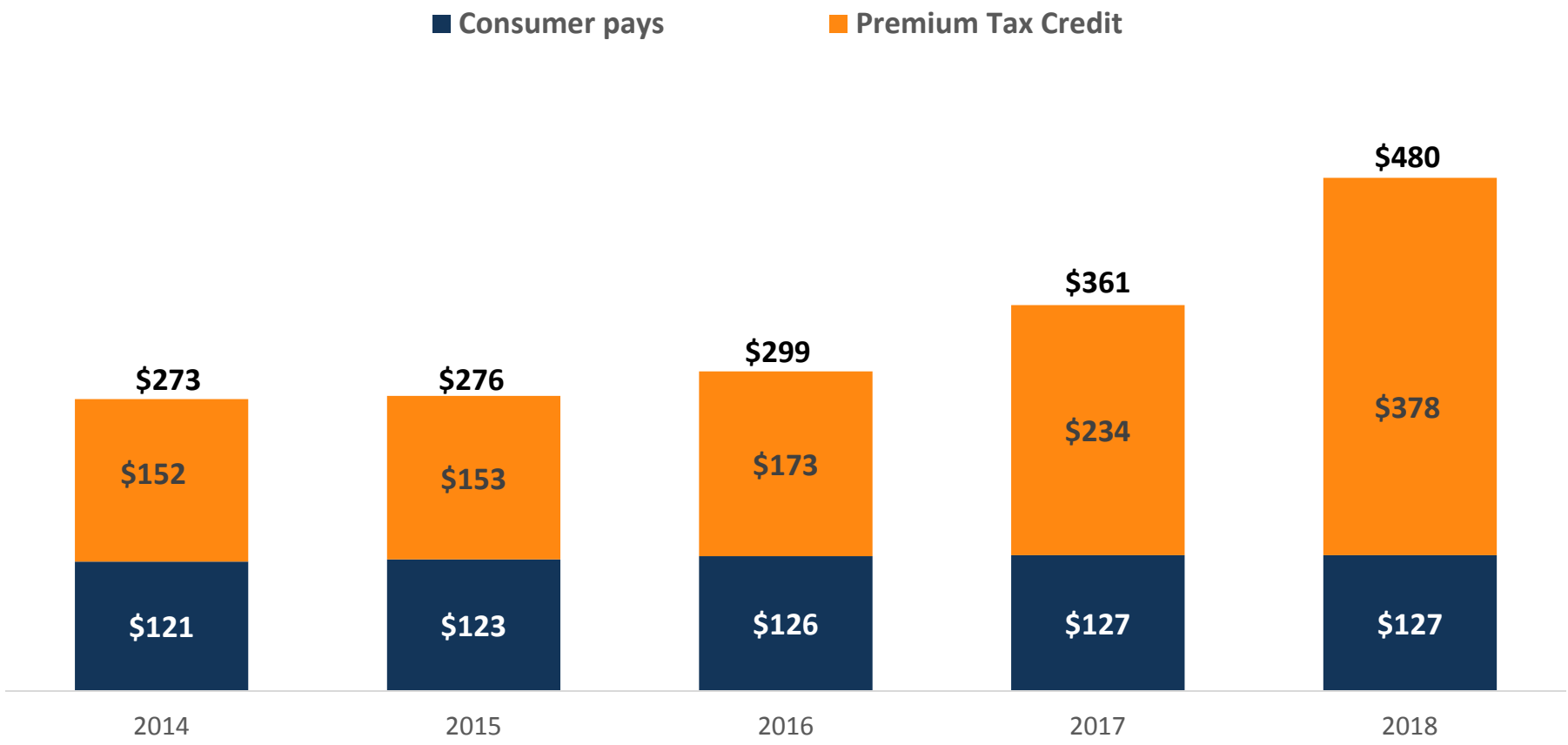


Note: Q2 data is year-to-date from January 1 – June 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

THE HENRY J. KAISER FAMILY FOUNDATION

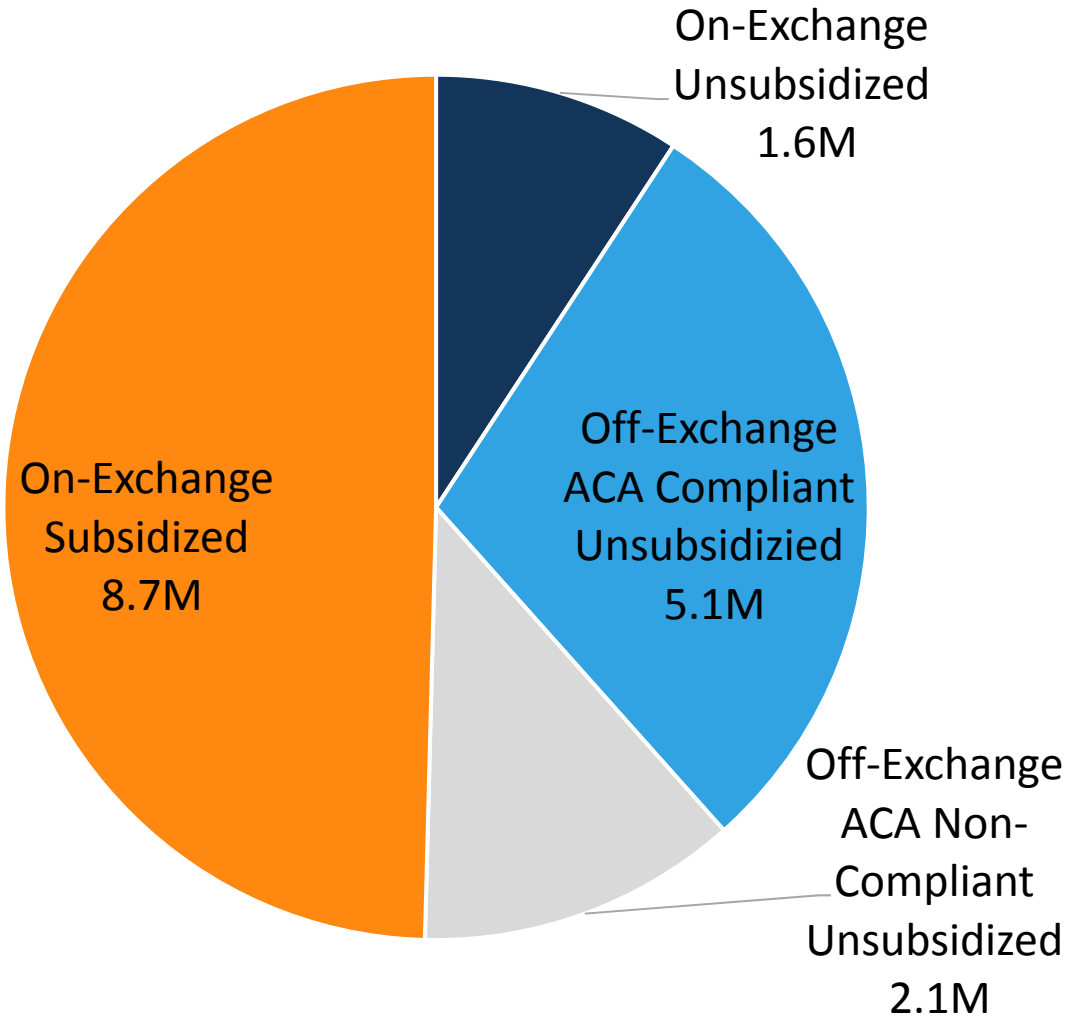
Average marketplace benchmark premium for a 40-year-old has increased, but so have premium tax credits

Advance premium tax credit amounts and consumer share of premiums for 40-year old with income at 200% FPL



SOURCE: KFF Subsidy Calculators, 2014-2018

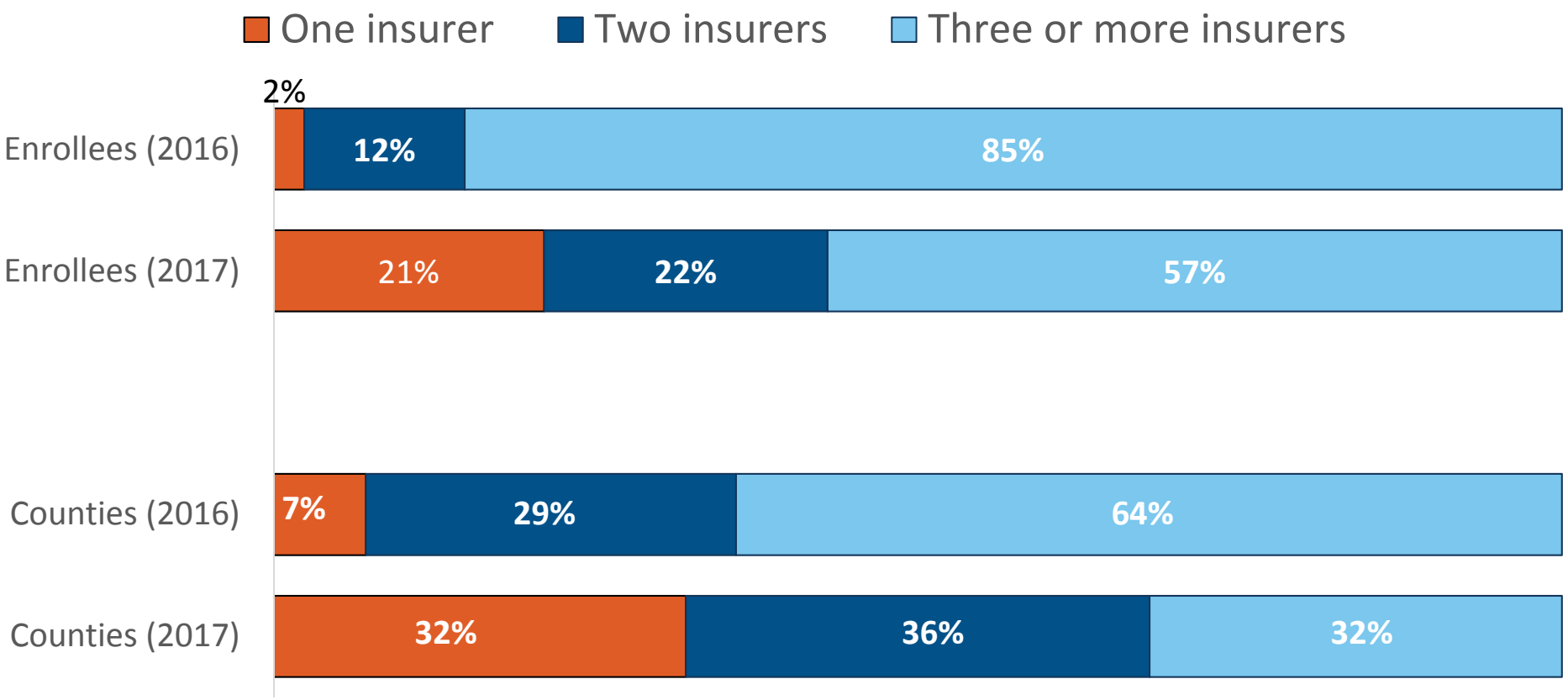
Most in ACA-compliant plans are protected from rate increases by premium subsidies



Kaiser Family Foundation analysis of data from Mark Farrah Associates, Healthcare.gov, and KFF Survey of Nongroup Health Insurance Enrollees. Note: People enrolled in off-exchange ACA non-compliant plans are not part of the same risk pool as those in ACA compliant coverage and pay different premiums.

THE HENRY J. KAISER FAMILY FOUNDATION

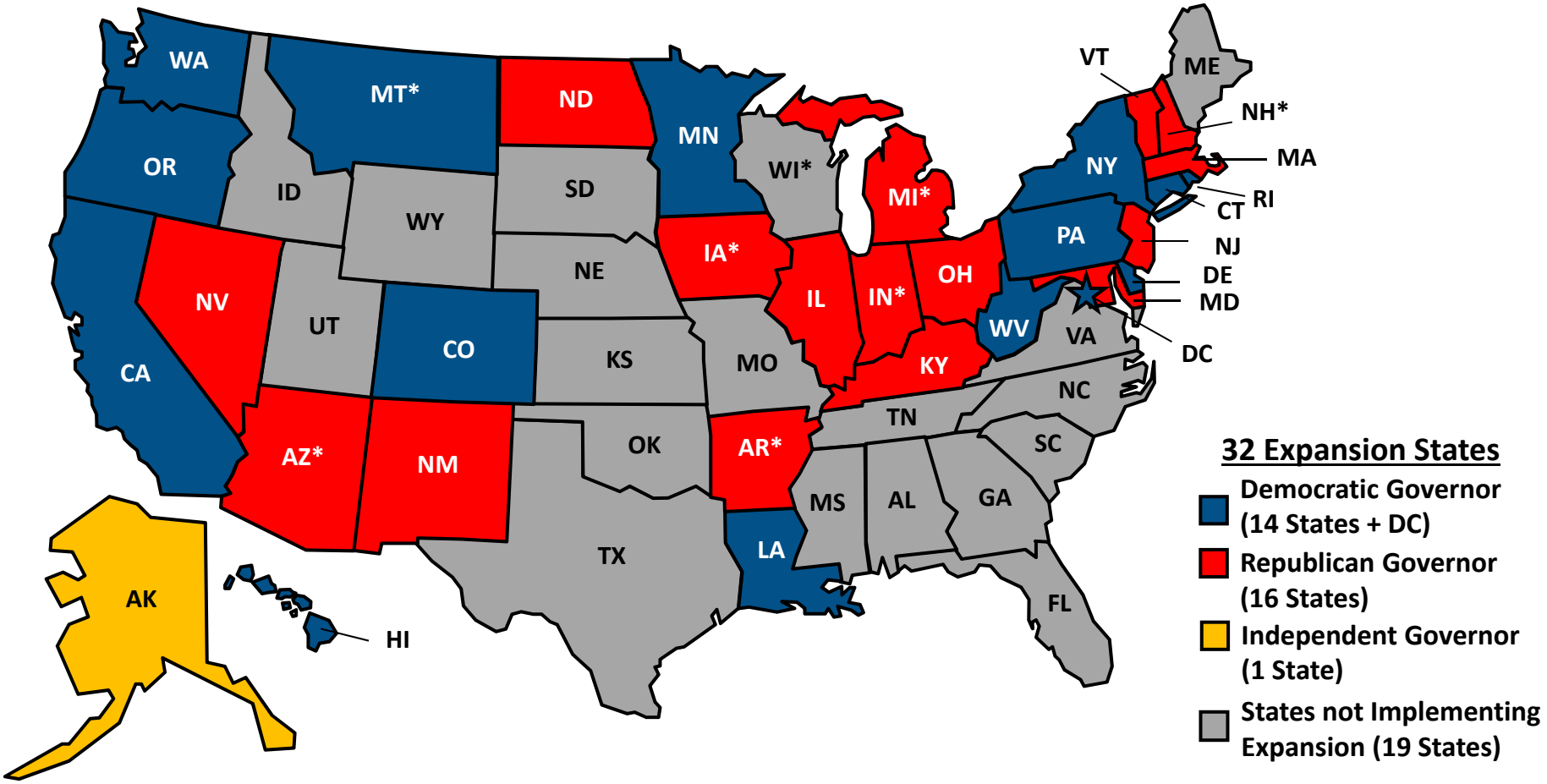
21% of marketplace enrollees have access to one exchange insurer in 2017 vs. 2% in 2016



Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups.

THE HENRY J. KAISER FAMILY FOUNDATION

12 million have been made newly eligible by the ACA's Medicaid expansion, but not in all states



More than 2.6 million poor, nonelderly uninsured adults in the Medicaid coverage gap

THE HENRY J. KAISER FAMILY FOUNDATION

Even before this year, there were many challenges to ACA from the outset

- More than 50 Congressional repeal votes 2011-2016
- Congressional cuts to market stabilization funding
- State-level actions
  - Oppose expansion of Medicaid eligibility
  - Oppose establishment of State-operated exchanges
  - Oppose enforcement/implementation of insurance market regulations
  - Oppose/inhibit operation of in-person consumer assistance
- Significant implementation mishaps also occurred
  - HealthCare.gov (and some state marketplace) functionality problems
  - “If you like what you have you can keep it”
  - Limited development of standards, oversight for network adequacy
- Other, underlying issues unaddressed
  - Adequacy of subsidies
  - Family glitch

Key themes in the 2017 repeal and replace debate

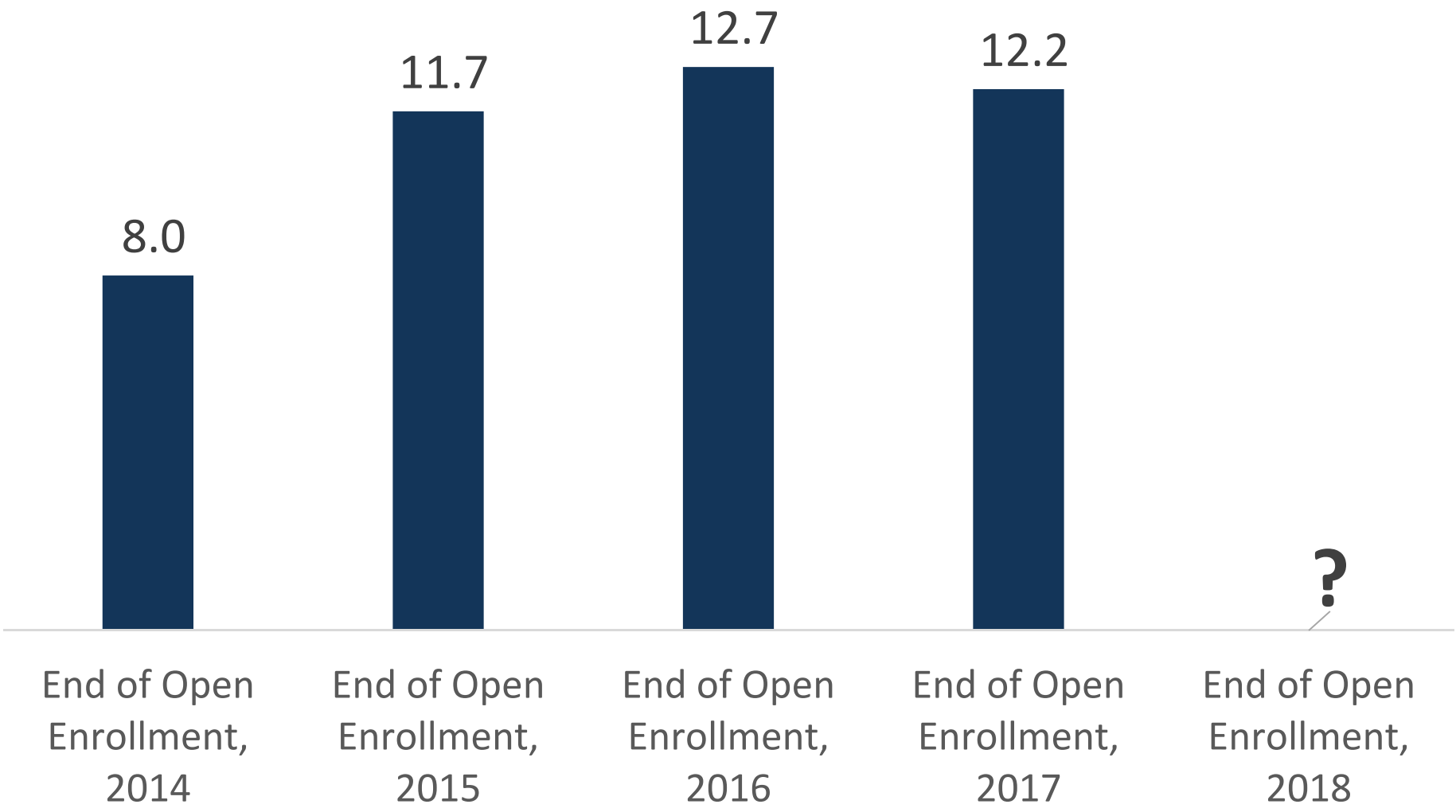
- Repeal the individual and employer mandates, effective retroactively
- Scale back regulation and consumer protections
- Phase out the Medicaid expansion
- Shift premium subsidies away from older and lower-income people to younger and higher-income people, and from high-cost areas to low-cost areas
- Restructure, reduce federal Medicaid funding
  - Per capita cap, or block grant
  - Graham-Cassidy proposal block granted Medicaid expansion and marketplace subsidies, reduced and redistributed
- Eliminate funding for Planned Parenthood
- Repeal many or all of the ACA's tax increases
- CBO estimated tens of millions would lose coverage by 2026
- The process in many ways drove the outcome:
  - Use of budget reconciliation
  - No "regular order"

New Administration challenges to ACA in 2017

- Enrollment period shortened from 12 weeks to 6 weeks in most states
- Federal investment in marketing reduced 90%
- Federal support for navigators reduced 41% on average
  - ≥ 60% in Georgia, Indiana, Iowa, Louisiana, Michigan Missouri, Nebraska, New Jersey, North Dakota, Ohio, South Carolina, South Dakota, Wyoming
- CSR reimbursement to insurers terminated, prompting high, unusual premium increases

- Public uncertainty, lack of awareness is high
  - Most don't know Open Enrollment deadlines,
  - Most concerned about affordability
  - Many think ACA mandate was repealed or are unsure

ACA marketplace signups (millions)



Source: http://kff.org/health-reform/state-indicator/total-marketplace-enrollment/?activeTab=map&currentTimeframe=0&selectedDistributions=number-of-individuals-who-have-selected-a-marketplace-plan

THE HENRY J. KAISER FAMILY FOUNDATION

What's next?

- Open enrollment – outcome could affect future of the ACA
- Further Administration actions pending:
  - Further cuts/changes to in-person consumer assistance
    - Current 3-year grants end in 2018
    - Proposed end to rule that navigators be physically located in state
  - Changes to EHB standard
  - Executive order on association health plans, short term policies, other changes to lessen regulation/enforcement of market rules
  - State waivers (1332 and Medicaid)
- Weakening or repeal of ACA mandates?
- Potential bipartisan market stabilization legislation?
- Potential further legislative efforts to repeal/replace ACA
- Reauthorize funding of other core programs (CHIP, CHCs)
- Single payer?

Role of Foundations?

- Add/retain “health coverage” on the agenda
- Support for in-person consumer assistance/advocacy
  - Help navigating, applying for health coverage
  - Help resolving coverage problems
- Support for direct patient care, financial assistance
- Policy analysis on key coverage issues
- Support for health journalism/public education

THE HENRY J. KAISER FAMILY FOUNDATION

State of Coverage Policy

Grantmakers In Health Fall Forum
November 9, 2017

Trish Riley, Executive Director
National Academy for State Health Policy
10 Free Street
Portland, ME 04101
Triley@NASHP.org

Cost & Coverage Post-ACA

- Lowest Uninsured Rate – 10.4%
- Coverage Gains – 20.M via ACA – Most via Medicaid
  - 31 States & DC Expand Medicaid
- Coverage Gap
  - < 138% FPL (54%)
  - Most in Family with Worker
  - Ineligible Immigrants

Medicaid as a Major Payer

Medicaid vs Medicare FY 2014

- Total Medicaid expenditures: $475 Billion
- Total Medicare expenditures: $ 618.7 billion
- Total Medicaid Enrollees: 64.8 Million
- Total Medicare Enrollees: 54.1 Million
- Nearly half of births in the United States were covered by Medicaid
- 1:5 Americans covered by Medicaid (over 70M 2017)

National Health Expenditures 2014 Highlights. Centers for Medicare and Medicaid Services. Accessed March 21, 2016 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf

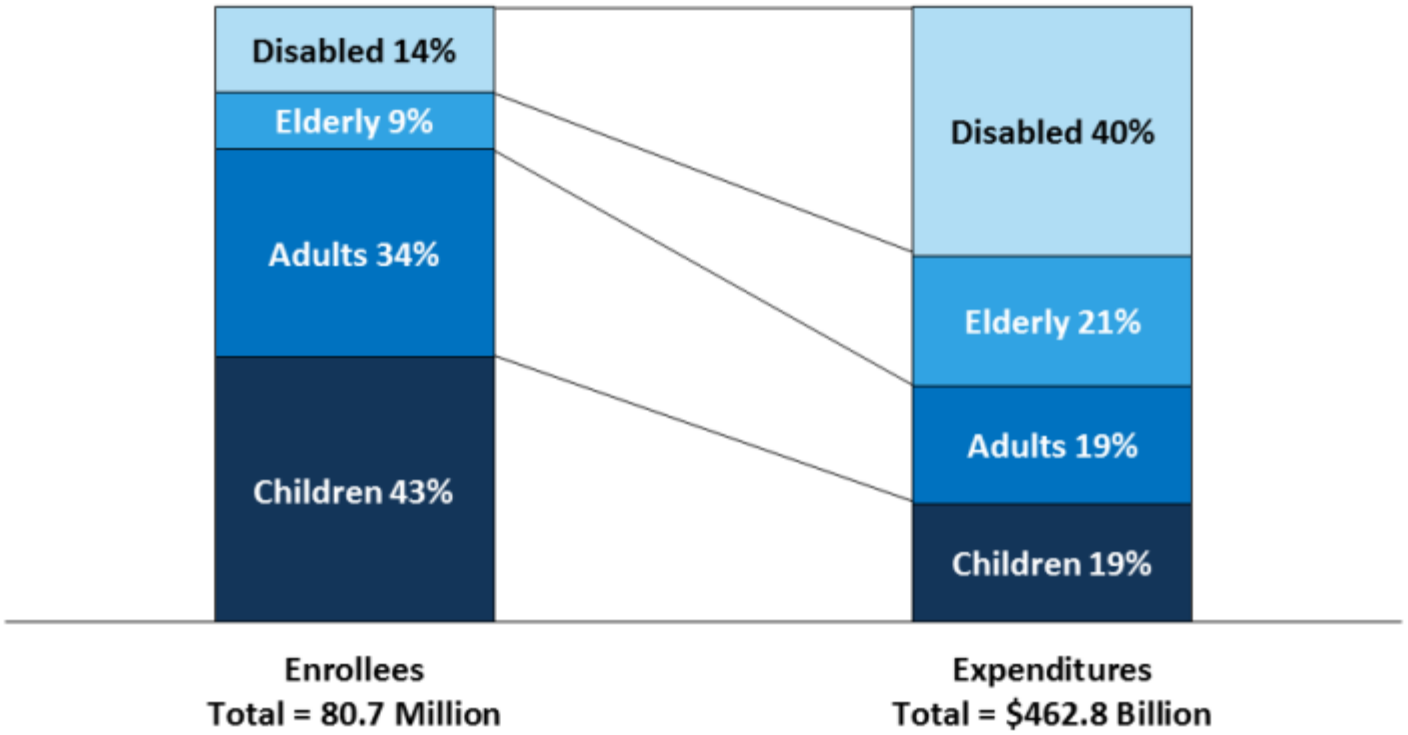
Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1966-2014. Medicaid and CHIP Payment and Access Commission. Accessed March 21, 2016 at https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-10.-Medicaid-Enrollment-and-Total-Spending-Levels-and-Annual-Growth-FYs-1966%E2%80%932014.pdf

Medicare Enrollment Dashboard. Centers for Medicare and Medicaid Services. Accessed March 21, 2015 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html

Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform. *Women's Health Issues*. October 2013. Accessed March 21, 2016 at http://www.whijournal.com/article/S1049-3867(13)00055-8/fulltext

Figure 3

Distribution of Medicaid Spending by Eligibility Group, FY 2014

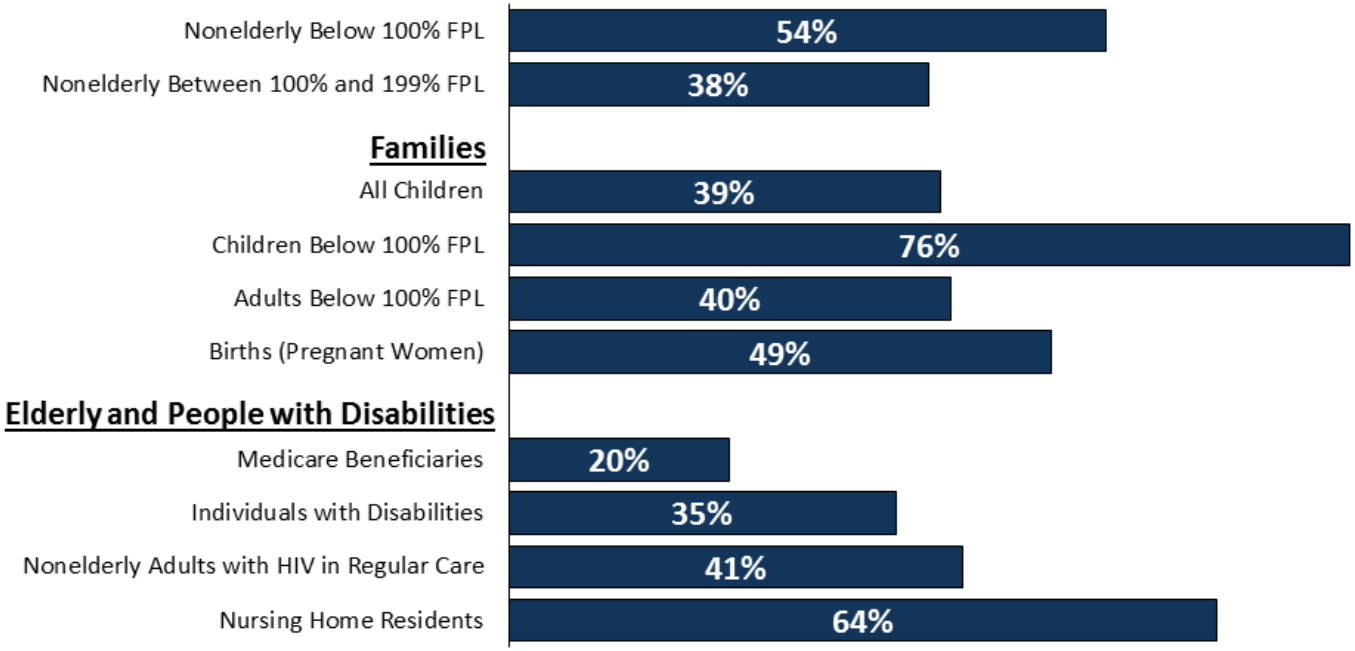


NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.

Figure 1

Medicaid's Role for Selected Populations

Percent with Medicaid Coverage



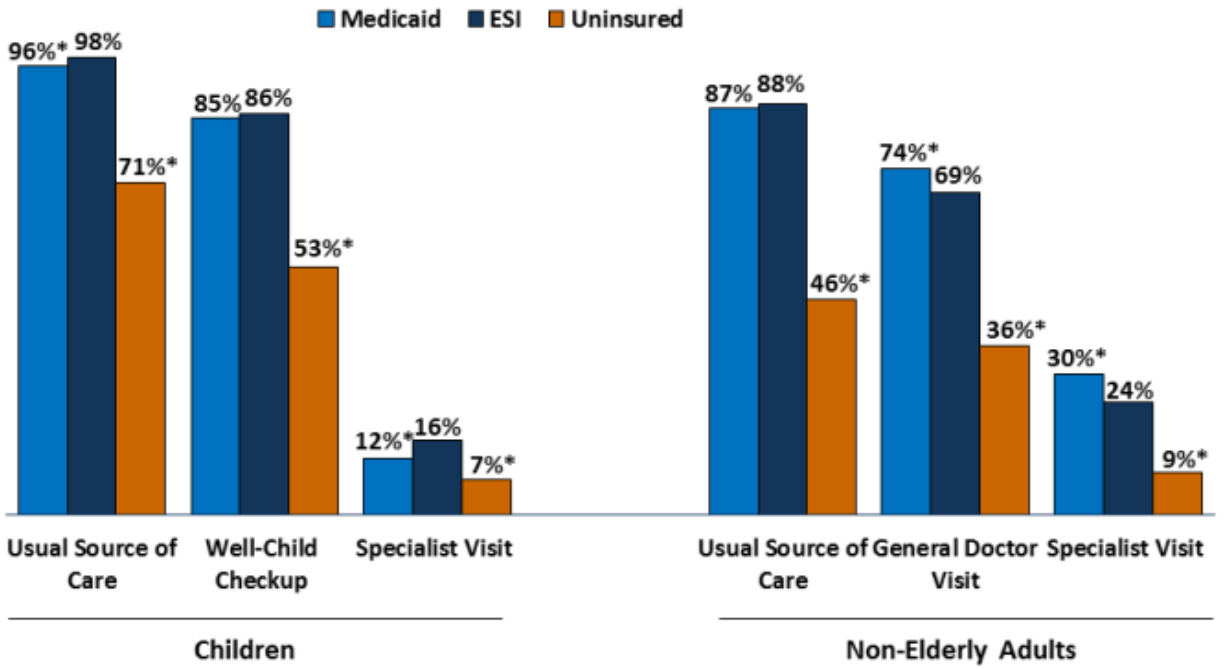
NOTE: FPL-- Federal Poverty Level. The FPL was $20,160 for a family of three in 2016.

SOURCES: Kaiser Commission on Medicaid and the Uninsured (KCMU) analysis of 2016 CPS/ASEC Supplement; Birth data - Kaiser Family Foundation Medicaid Budget Survey, 2016 (median rate shown); Medicare data - Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (January 2016), 2011 data; Disabilities - KCMU Analysis of 2015 NHIS data; Nonelderly with HIV - 2009 CDC MMP; Nursing Home Residents - 2012 OSCAR data.

THE HENRY J. KAISER FAMILY FOUNDATION

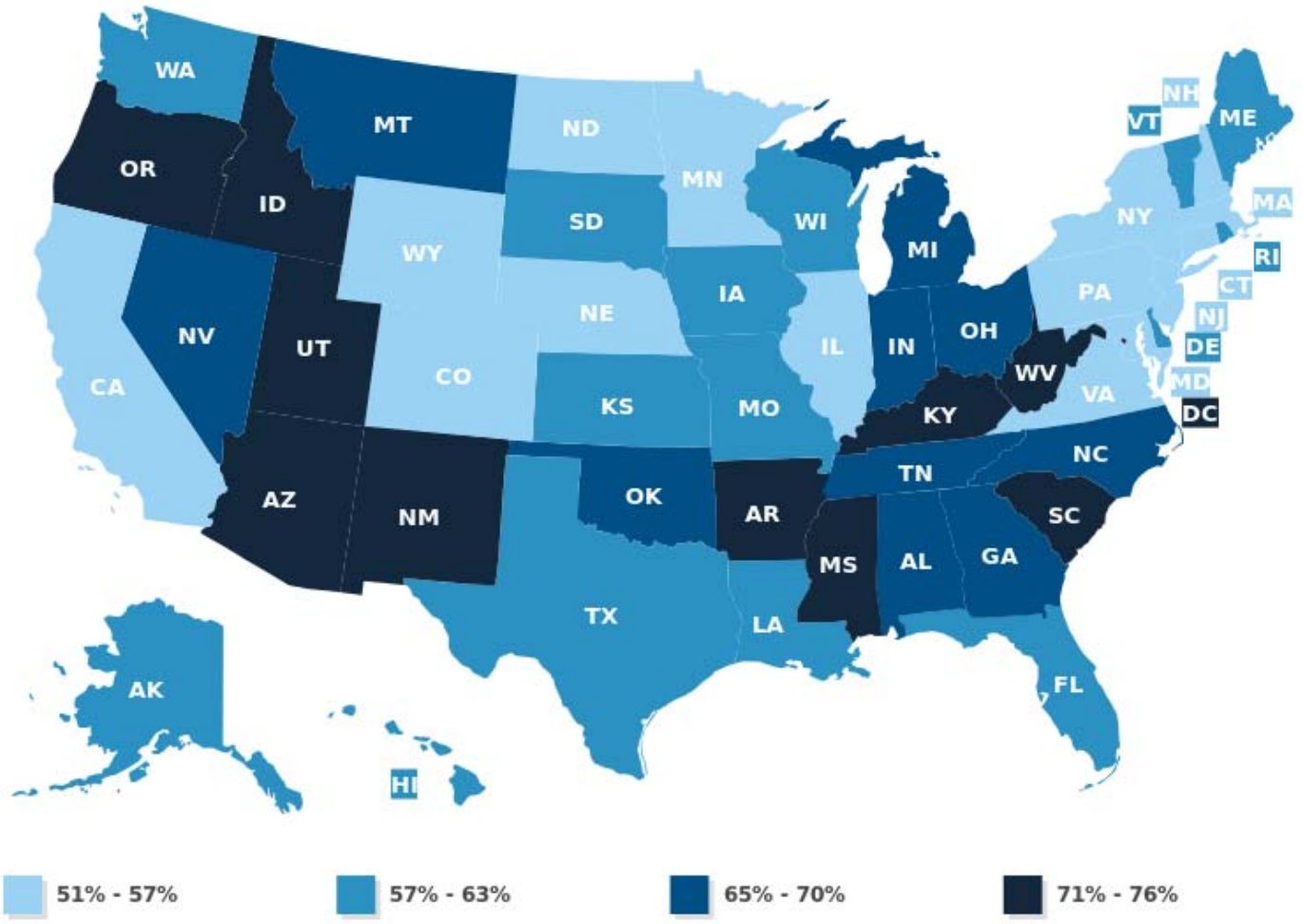
Figure 2

Access to Care among Medicaid Enrollees Compared to Privately Insured and Uninsured



NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care. *Difference from ESI is statistically significant (p<.05)
SOURCE: KCMU analysis of 2015 NHIS data.

Federal & State Share of Medicaid Spending 2014

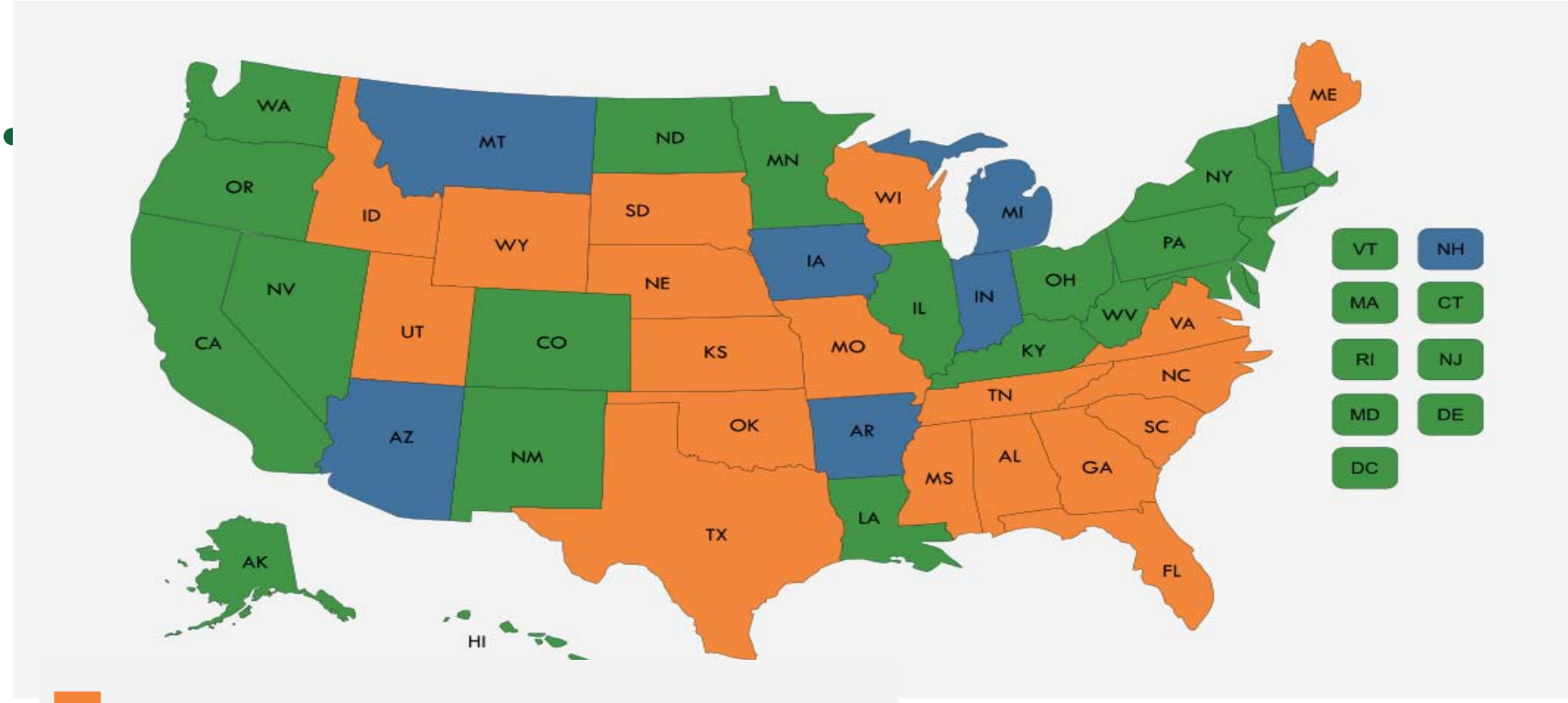


Federal and State Share of Medicaid Spending 2014. The Henry J Kaiser Family Foundation. June 2015. Accessed March 22, 2016 at http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/#map

The "Flexibility" Issue – It's about the Money.

- President's budget - $1 Trillion Medicaid cut over 10 years.
- State budgets
  - Brinksmanship / shut-downs
  - FY18 smallest revenue growth since 2011
  - 11 states enacted tax cuts since 2011
    - Conformity with Federal tax reform?
  - Rating agency concerns
- Flexibility / block grants / waivers
  - Block grant – not a new idea
  - Issue:
    - Entitlement
    - Money
  - CHIP – Canary in the coal mine

Status of State Medicaid Expansion Decisions



19 states are not expanding Medicaid

25 states (count includes the District of Columbia) are expanding Medicaid

7 states are expanding Medicaid, but using an alternative to traditional expansion

*Kentucky has submitted an 1115 waiver to move from traditional Medicaid expansion to a waiver model

Key Aspects of Currently Approved ACA Medicaid Expansion Waivers

	AR	AZ	IA	IN	MI	MT	NH	State Totals
Premiums/Monthly Contributions	X	X	X	X	X	X		6
Premium Assistance	QHP & ESI		ESI	ESI	QHP*		QHP	5
Healthy Behavior Incentives		X	X	X	X			4
Waive Retroactive Eligibility	X			X			X	3
Waive Required Benefits (NEMT)			X	X				2
Waive Reasonable Promptness				X				1
Co-payments Above Statutory Limits				X**				1
12-Month Continuous Eligibility						X		1

*MI'S premium assistance provisions are effective in April 2018
**IN's cost-sharing waiver approved under Section 1916(f), not Section 1115

Information adapted from Kaiser Family Foundation brief, "Section 1115 Medicaid Expansion Waivers: A Look at Key Themes and State Specific Waiver Provisions."

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Potential New Types of Medicaid Proposals

- In March 2017, CMS indicated a willingness to consider Medicaid waiver applications that include programs to connect individuals to employment or incorporate features of private market coverage

- Some common themes in new waiver requests include:
  - Dis-enrolling individuals for non-payment of premiums
  - Work requirements as a condition of eligibility
  - Time limits on coverage

Pending ACA Medicaid Expansion Waiver Provisions Not Yet Approved

	AR	AZ	IN	KY	State Totals
Work Requirement	X	X	X	X	4
Lock-out for Failure to Timely Renew Eligibility			X	X	2
Time Limit on Coverage		X			1
Limit Expansion Eligibility to 100% FPL	X				1
Monthly Income Verification/Renewals		X			1
Tobacco Surcharge			X		1

*AR's provisions would apply to expansion adults; all other states' provisions would affect both expansion and traditional, able-bodied adults, with the exception of IN's lock-out provision applying only to expansion adults
**KY's waiver application also seeks to impose sliding-scale premiums for most non-disabled adults, have coverage start upon premium payment, implement a healthy behavior incentive account, expand premium assistance for adults with access to ESI, waive retroactive eligibility for most adults, and waive NEMT for expansion adults.
***AZ state law requires the Medicaid agency to annually request from CMS the ability to implement certain eligibility requirements for able-bodied adults; public comments on the current draft waiver were accepted through March 2017 and the state is anticipated to submit the proposal to CMS soon.
****Although the state has expanded Medicaid without a waiver, in September 2017, MA submitted an amendment to its existing MassHealth 1115 waiver to enroll non-disabled adults with income above 100% FPL into exchange plans, along with other changes.

Information adapted from Kaiser Family Foundation brief, "Section 1115 Medicaid Expansion Waivers: A Look at Key Themes and State Specific Waiver Provisions."

Proposed Medicaid Section 1115 Waivers in Maine & Wisconsin

Key Pending Waiver Requests for Non-Medicaid Expansion Eligibility Groups

- Seeking to add premiums:
  - Maine ($14-$66/month)
  - Wisconsin (Depending on income, none or $8/month)
- Seeking to add work requirements:
  - Maine (20 hours/week, averaged monthly)
  - Wisconsin (80 hours/month)
- Seeking to add time limits on coverage:
  - Maine (No more than 3 months in a 36-month time period, unless work requirements are met)
  - Wisconsin (48-month time limit that can be extended if work requirements are met; disallow reenrollment for 6 months)
- Seeking to add drug screening and testing:
  - Wisconsin

Philanthropy?

- Support Medicaid staff – average E.D. tenure 19 months.
- Civil discourse/ evidence
- Test ideas

  e.g., Medicaid buy-in