

Business and Health Reform – What's the Bottom Line?



Overland Park, Kansas
13 November 2019

Rosemarie Day, Founder & CEO

Day | Health | Strategies

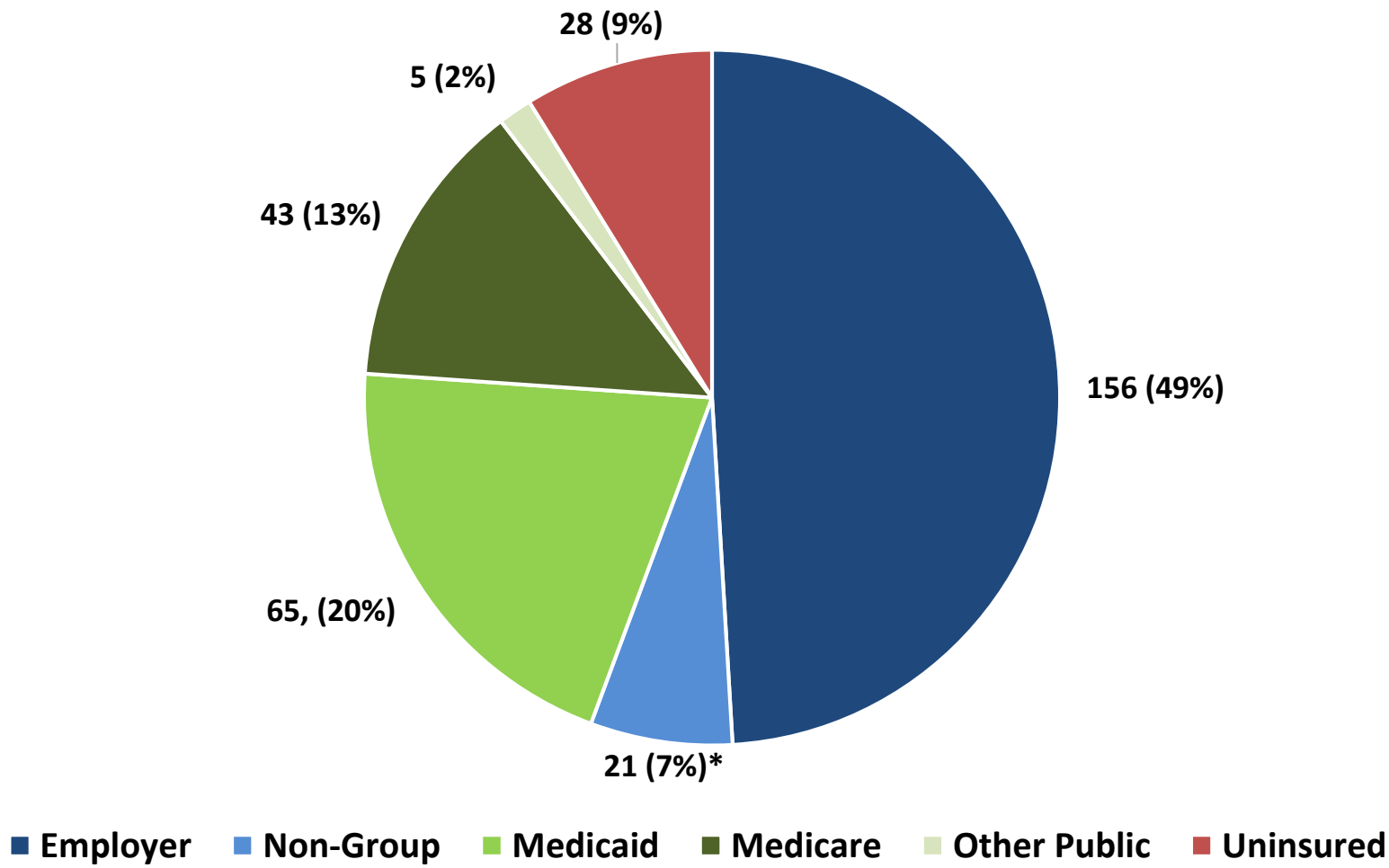
Discussion Outline

1. Setting the Context: Health Coverage and Reform in the US
2. Background on Medicaid Expansion
 - The Kansas context
 - History
 - The coverage gap
 - Facts and figures
 - Federal matching
3. Economic Impact
 - Consumers
 - State
 - Employees
4. Details of Expansion
 - Work requirements and work referrals
 - Court cases

Setting the Context: Health Coverage & Reform

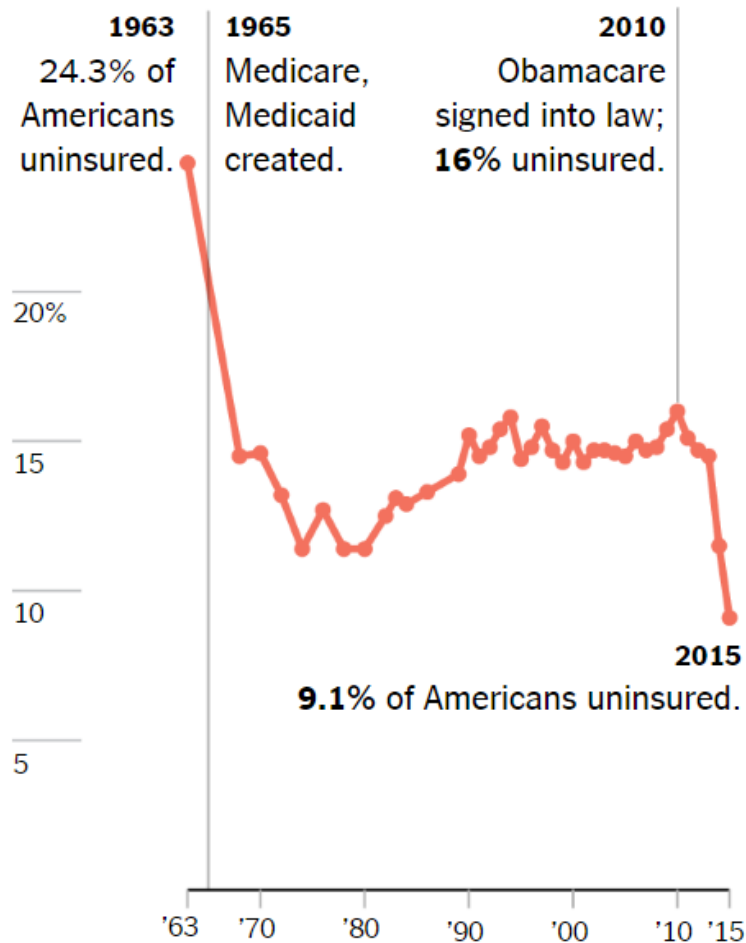
Primary Sources of Health Insurance Coverage in the US

Health Insurance Coverage Breakdown (By Millions and %)



Source: [Kaiser Family Foundation's Health Insurance Coverage of the total population, 2017](#)

Health Reform's Results



20 million insured

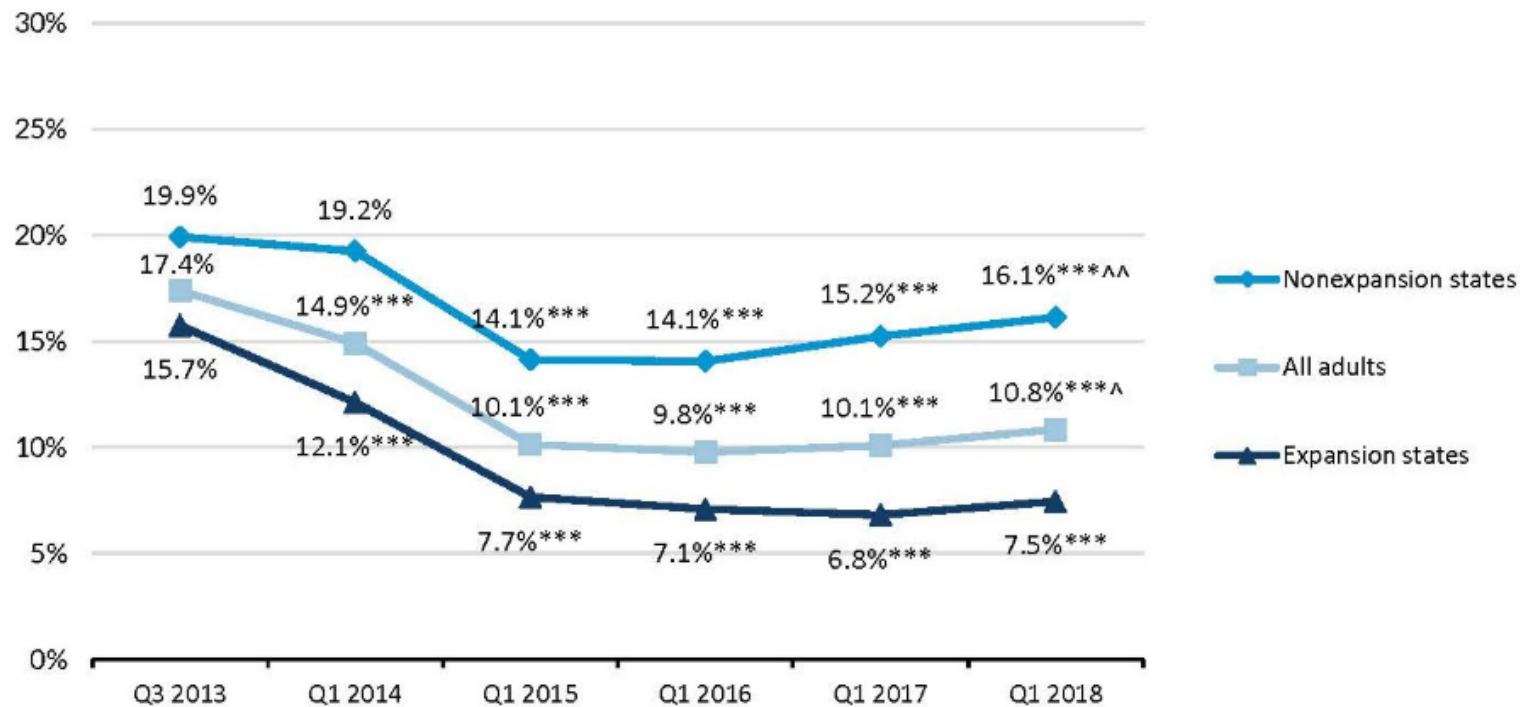
9.1% uninsured

Source: National Health Interview Survey and earlier surveys

By The New York Times

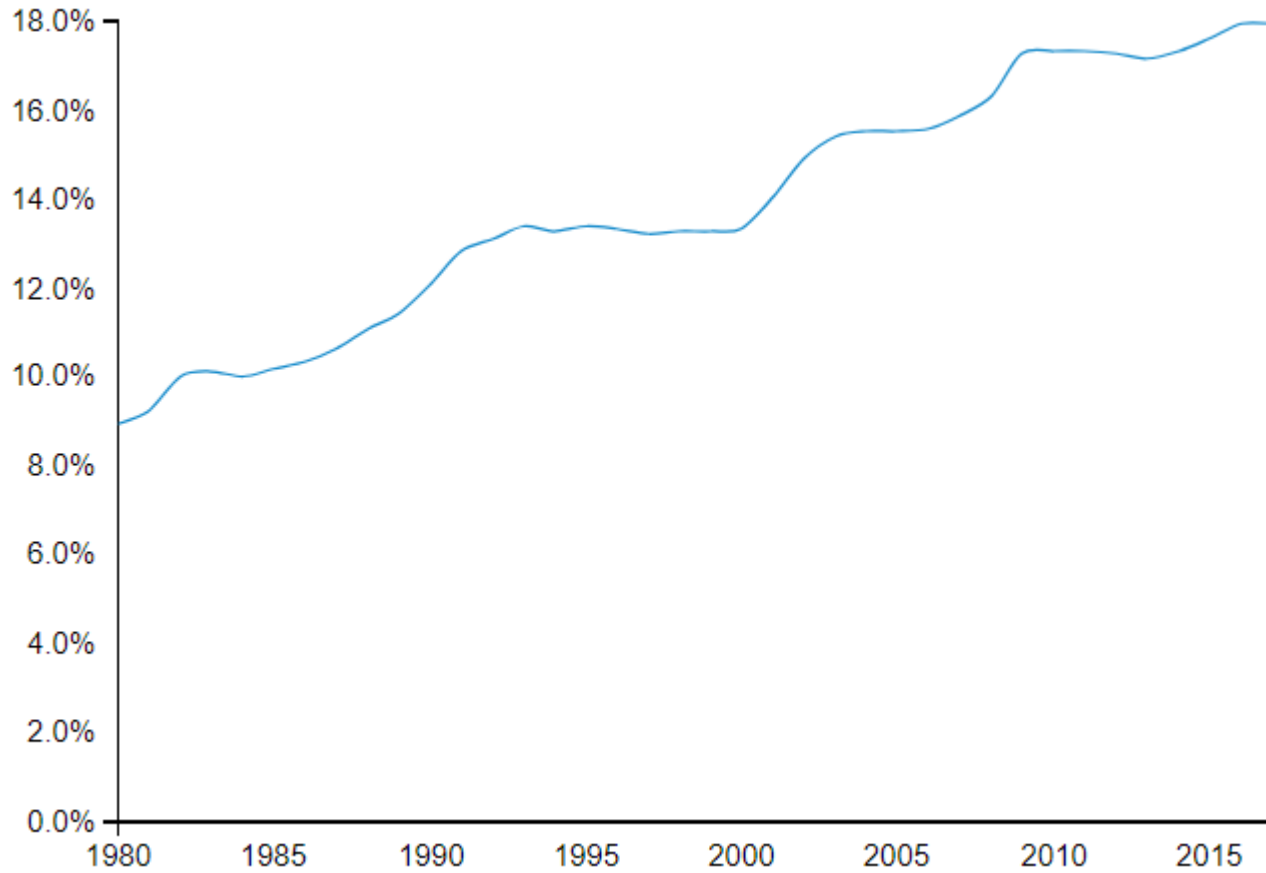
Gains in Coverage Rates from ACA are Reversing

Exhibit 1: Trends in Uninsurance Among Adults Ages 18 to 64, by 2018 State ACA Medicaid Expansion Status, Quarter 3 2013 to Quarter 1 2018



The Growing Share of Health Care in the Economy

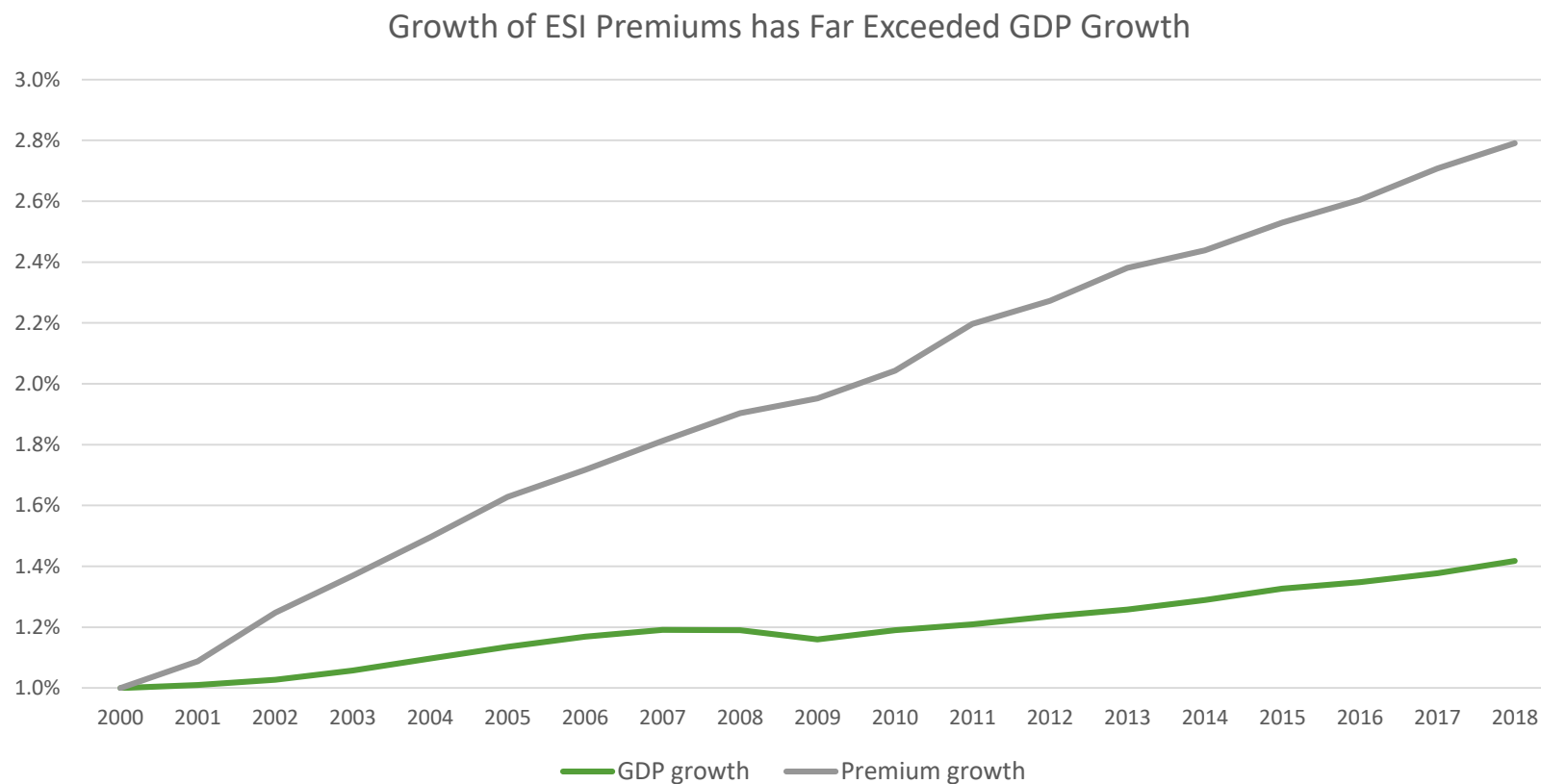
Health spending as a % of GDP has doubled since 1980



Employers are Feeling the Cost Crunch

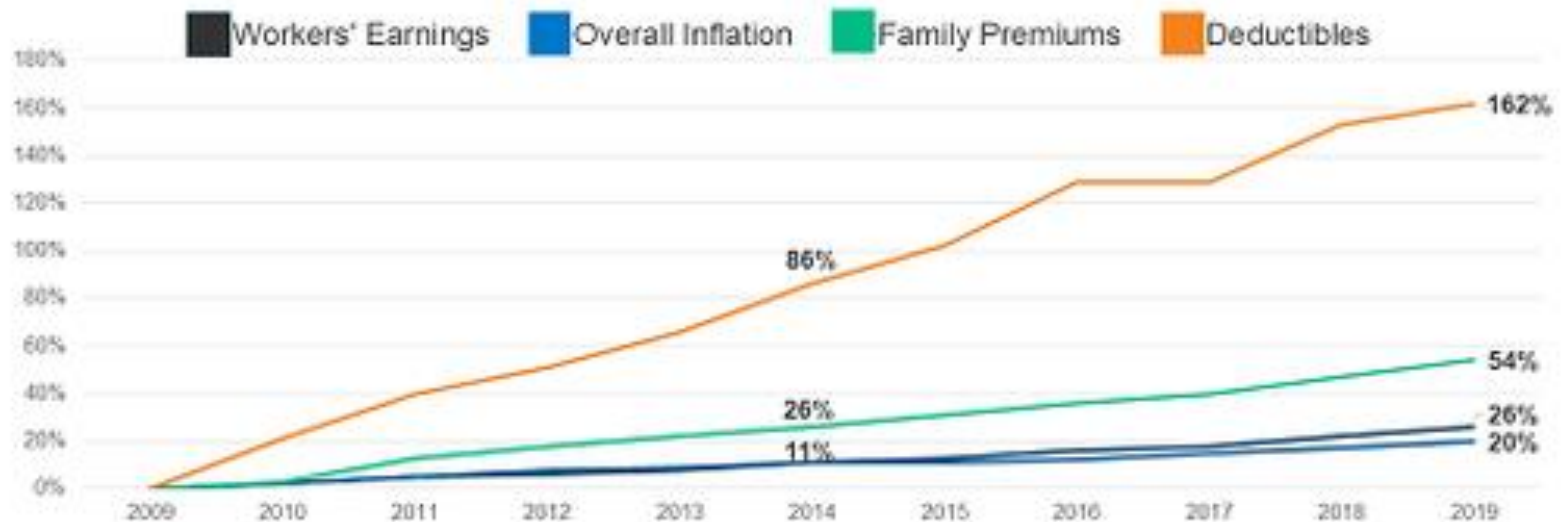
Historical growth of ESI premiums: 2001 - 2017

- GDP grew **42%**
- Individual premiums grew **179%**



Growing Health Expenditures for Workers

Premiums and Deductibles Rise Faster than Worker's Wages Over Past Decade



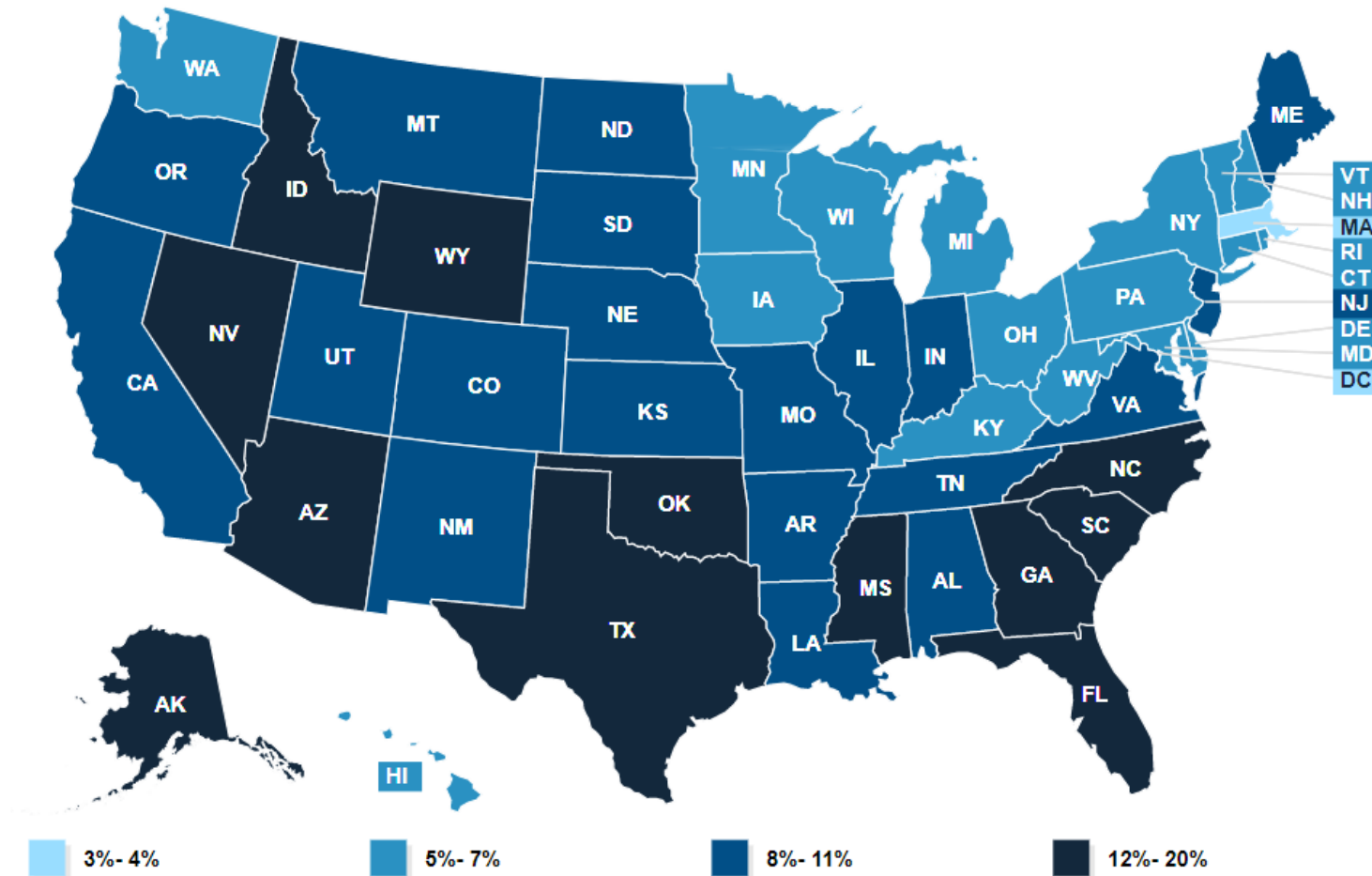
SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017.
Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2009-2019.
Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2009-2019 (April to April)



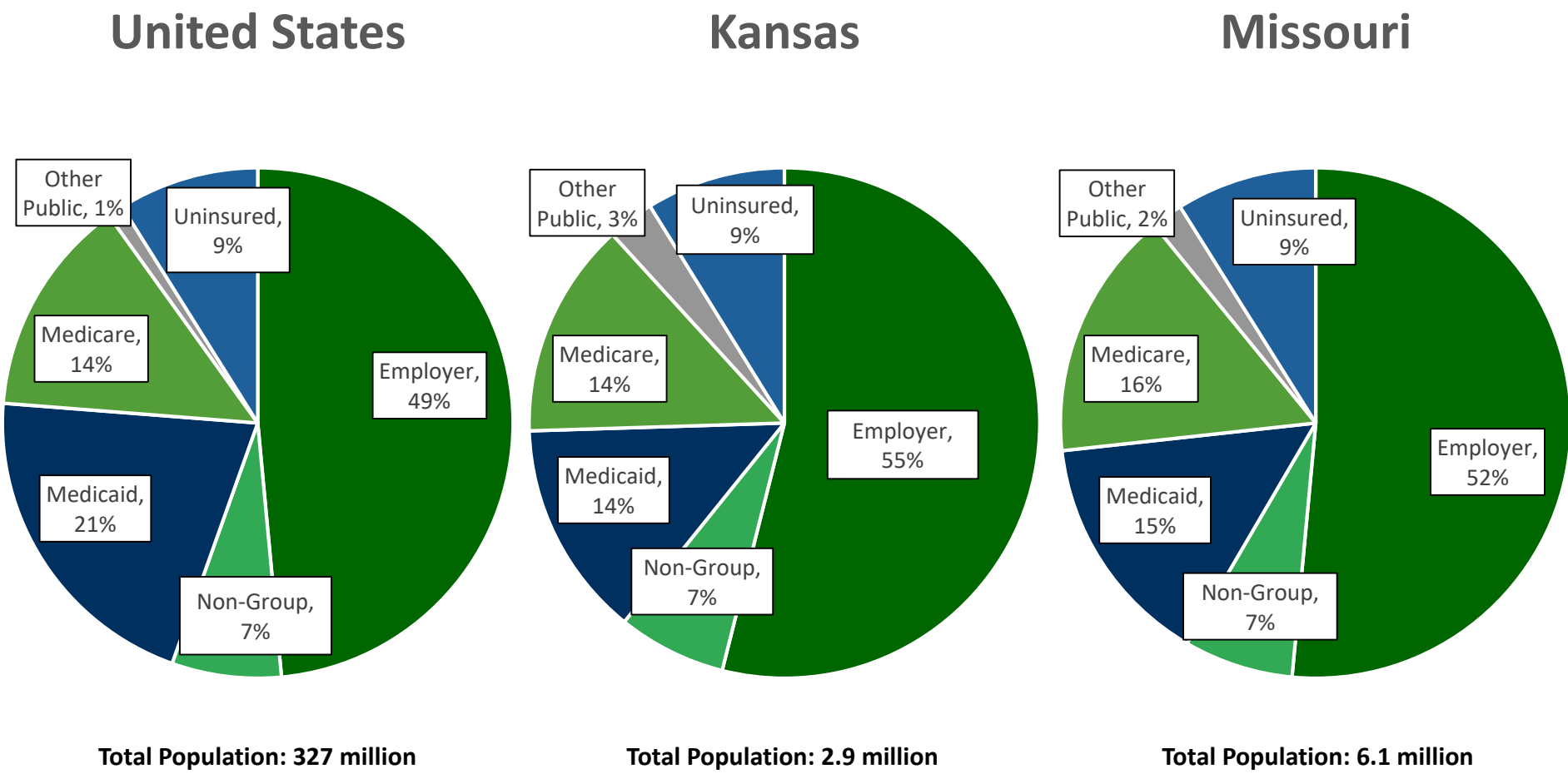
Background on Medicaid Expansion

Uninsured: Majority in States Without Expanded Medicaid

Uninsured Rates Among the Nonelderly, 2017



Kansas and Missouri, Despite Lower Medicaid Coverage, Have Similar Insured Rates as the US Overall Because of Employer-Sponsored Insurance



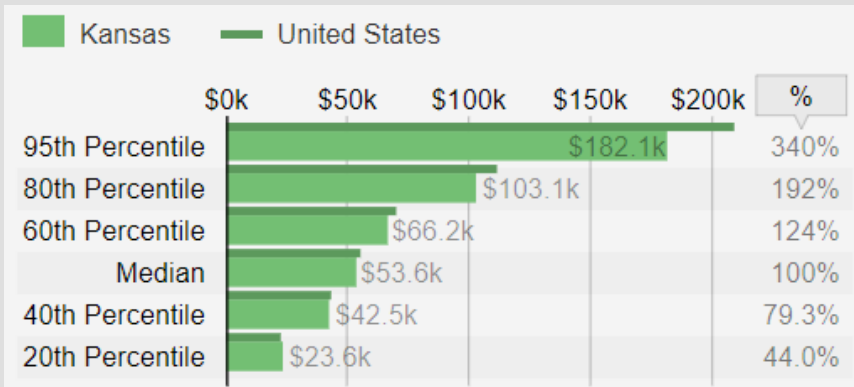
Kansas Economic Profile

Unemployment: 3.2% (U.S. 3.7%)

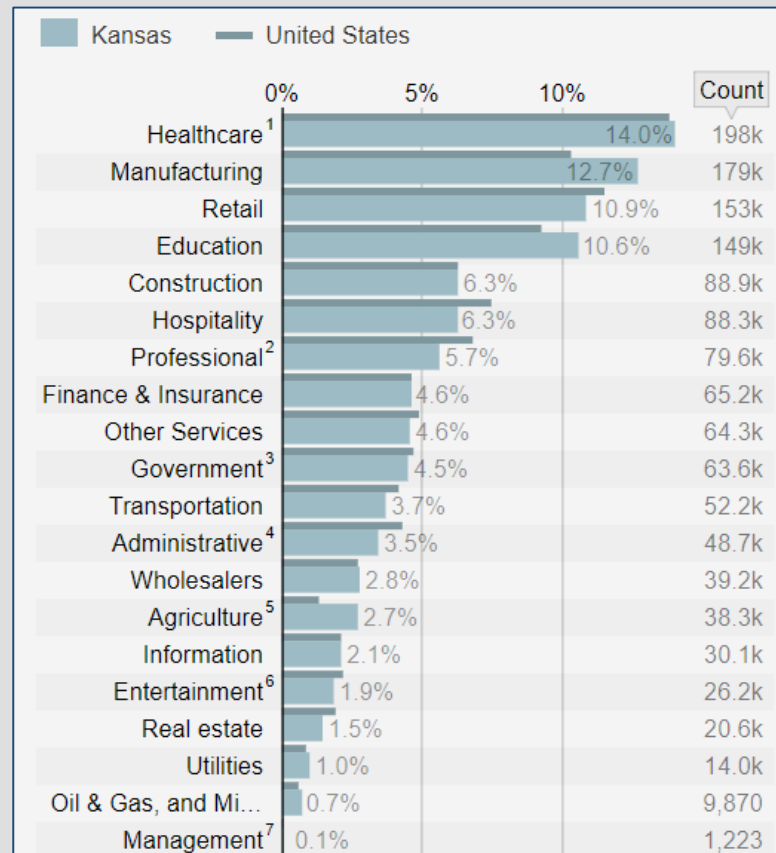
On healthcare.gov: 89,993
...and receive subsidies: 75,625

Uninsured: 240,000

Income distribution:



Major Industries:



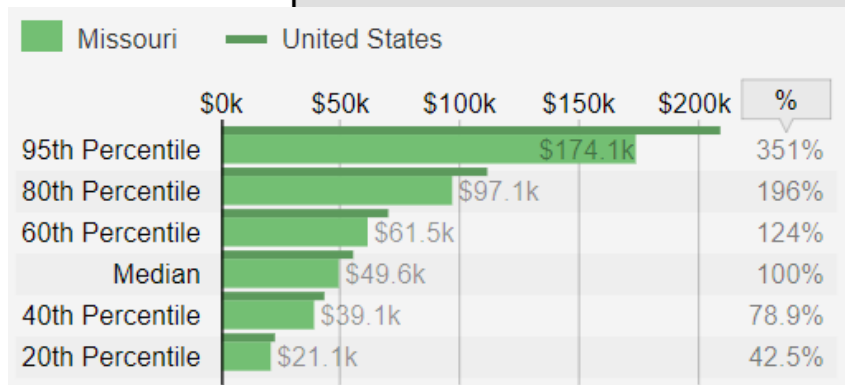
Missouri Economic Profile

Unemployment: 3.1% (U.S. 3.7%)

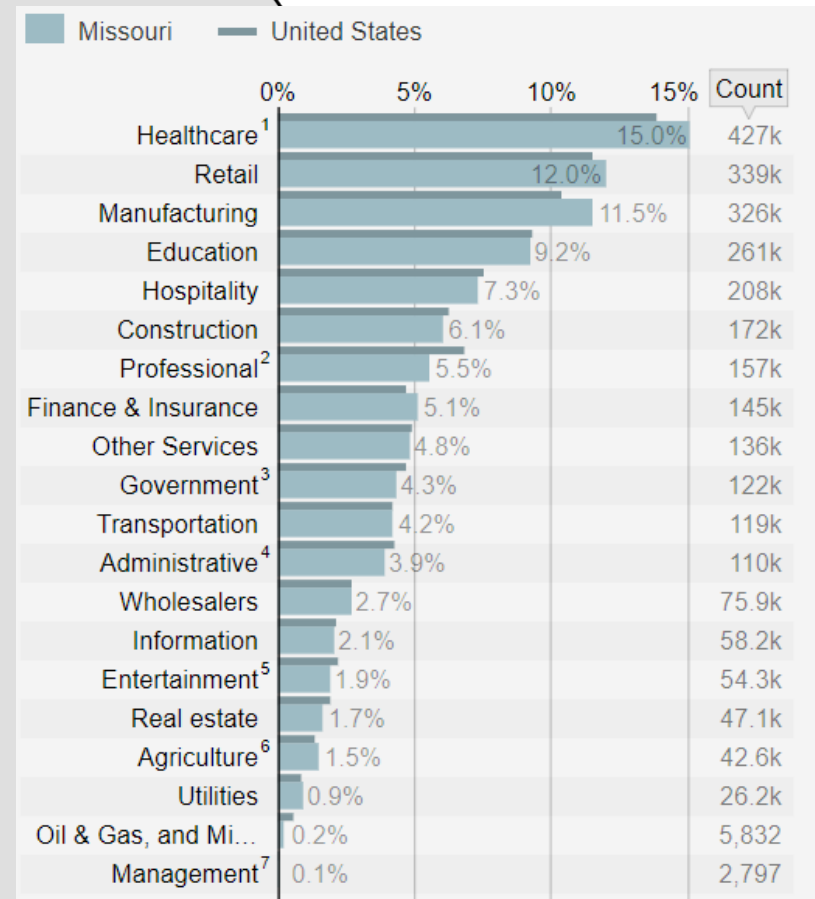
On healthcare.gov: 220,461
...and receive subsidies: 177,258

Uninsured: 536,500

Income distribution:



Major Industries:



A Brief History of Medicaid

Legal background

- Social Security Act of 1965 created Medicaid and Medicare
 - Medicaid run by states, Medicare run by federal government
 - Medicaid: Income-based eligibility: Federal Poverty Level (FPL)
 - Additional eligibility factors (maternal status, age)
- The Affordable Care Act (“Obamacare”) expanded to 138% FPL in all states
- Supreme Court decision *NFIB v Sebelius* decided expansion is optional

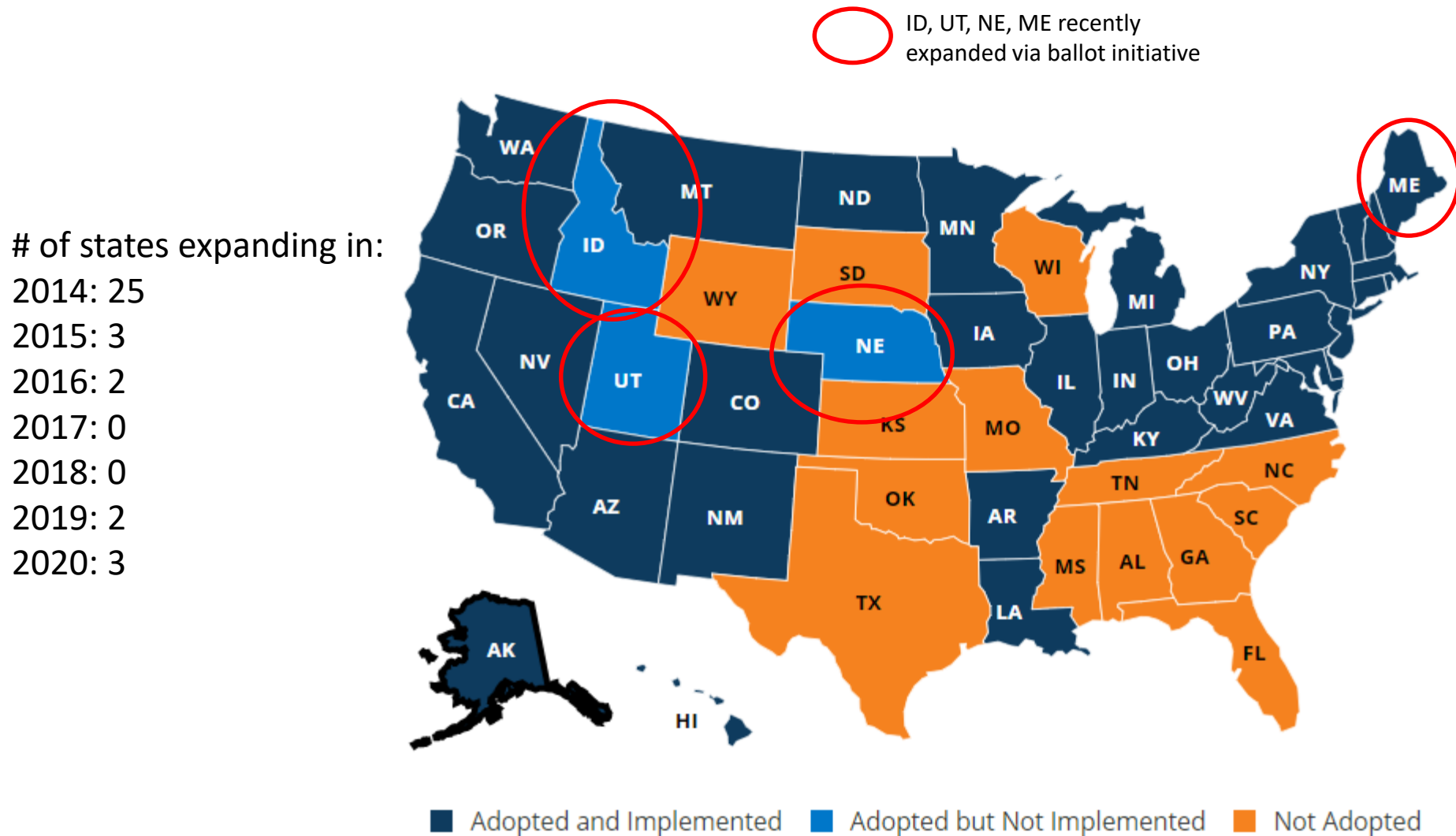
FPL cutoffs

- Expansion states:
138% FPL
- Non-expansion
states: various

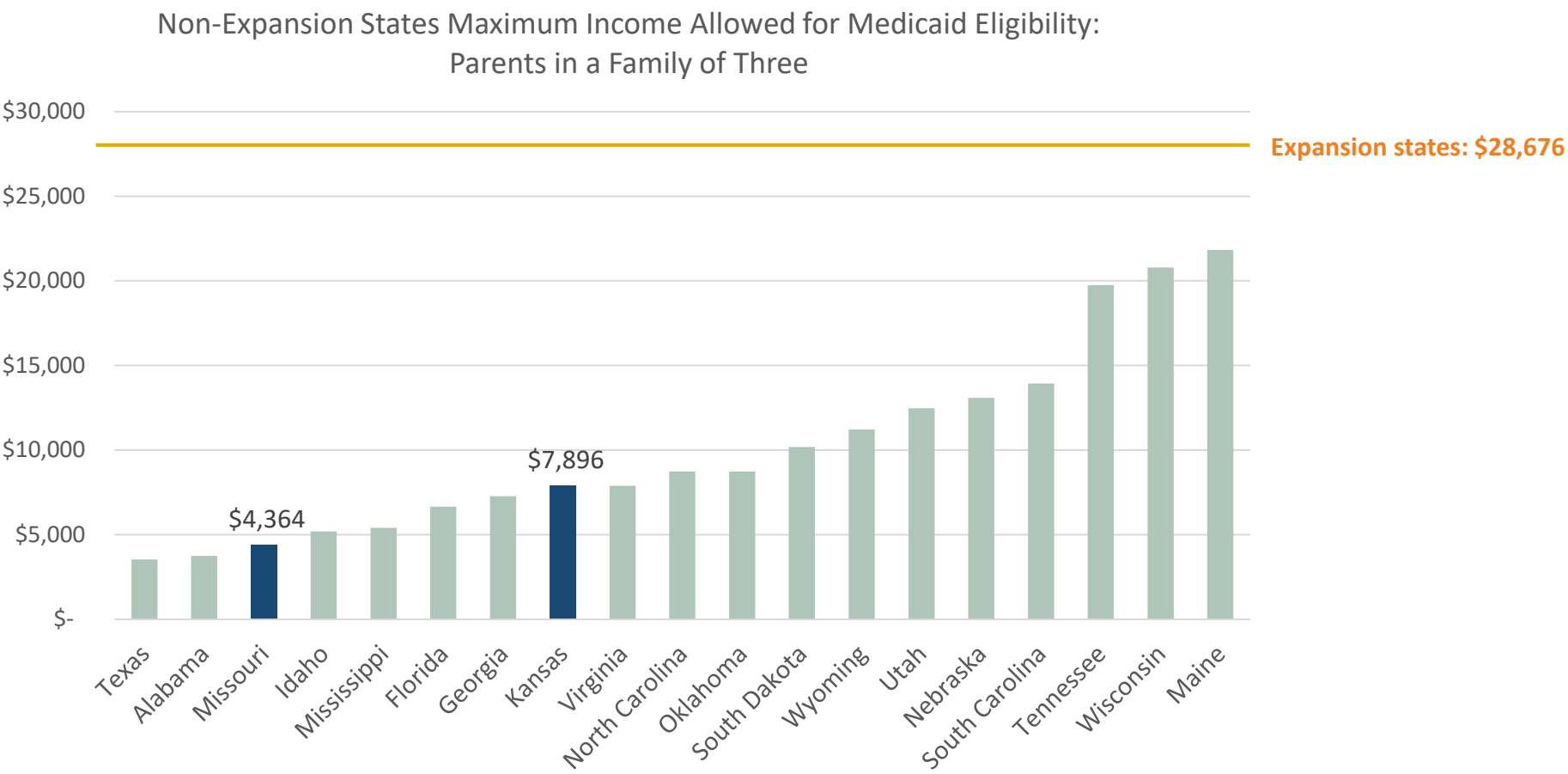
Persons in Household	100% FPL	138% FPL
1	\$12,140	\$16,753
3	\$20,780	\$28,676

Medicaid Expansion Status

* As of Sept 20, 2019



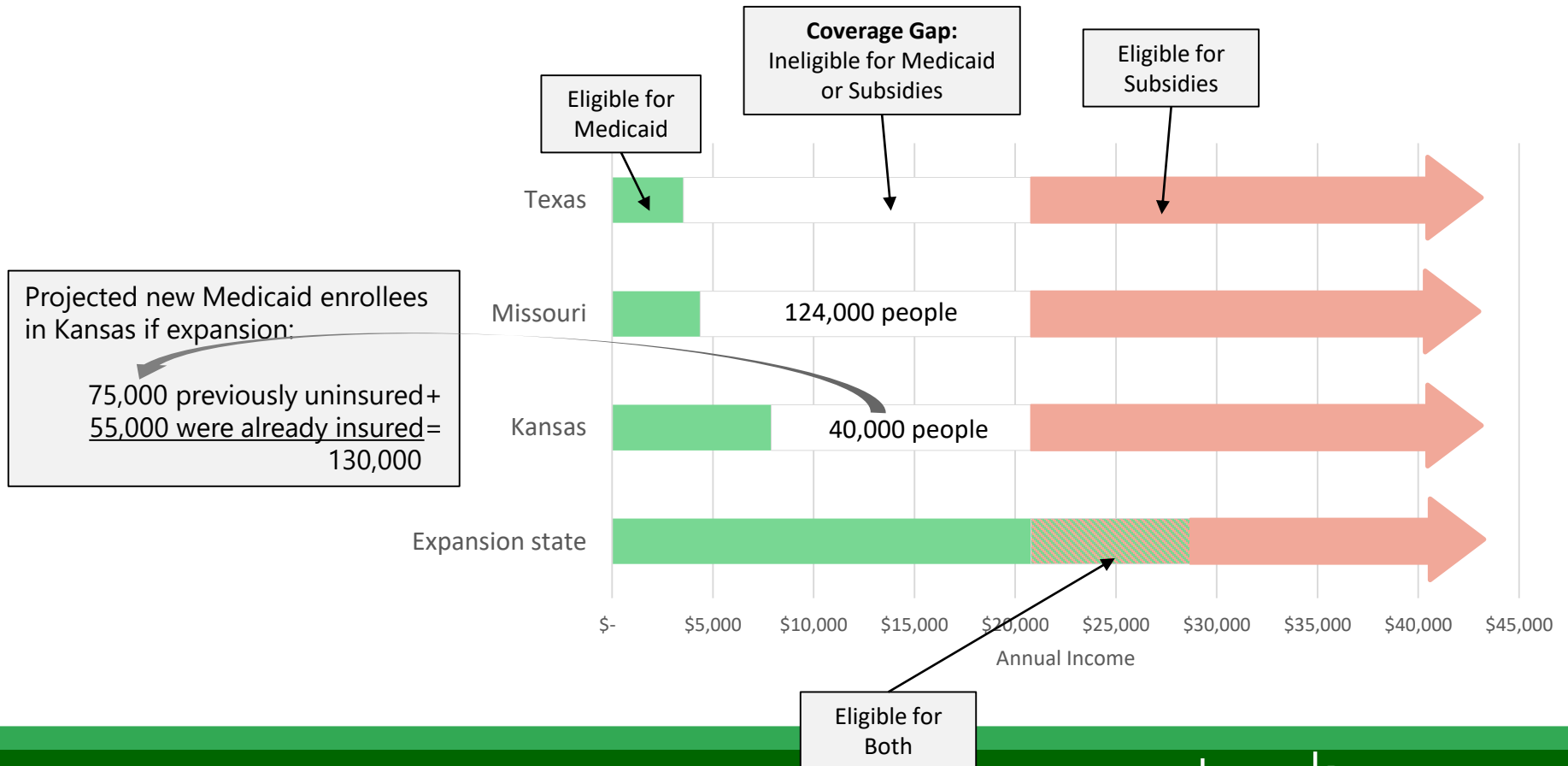
Missouri and Kansas Require a Very Low Income to be Medicaid Eligible, Even Compared to Other Non-Expansion States



The Coverage Gap

46,000 people in Kansas who make less than 100% FPL are **ineligible for subsidies** on the individual market and ineligible for Medicaid

- **Why?** The drafters of the ACA did not anticipate Supreme Court decision (*NFIP v. Sebelius*) and thought everyone with incomes up to 138% FPL would be covered by Medicaid
- **As a result neither Medicaid (ineligible) nor individual marketplace coverage (impossible to afford without subsidies) are viable options** for people who fall in the coverage gap



Medicaid Expansion has Generous Federal Funding

The percentage the federal government contributes to Medicaid varies from state to state.

Federal Matching Funds:

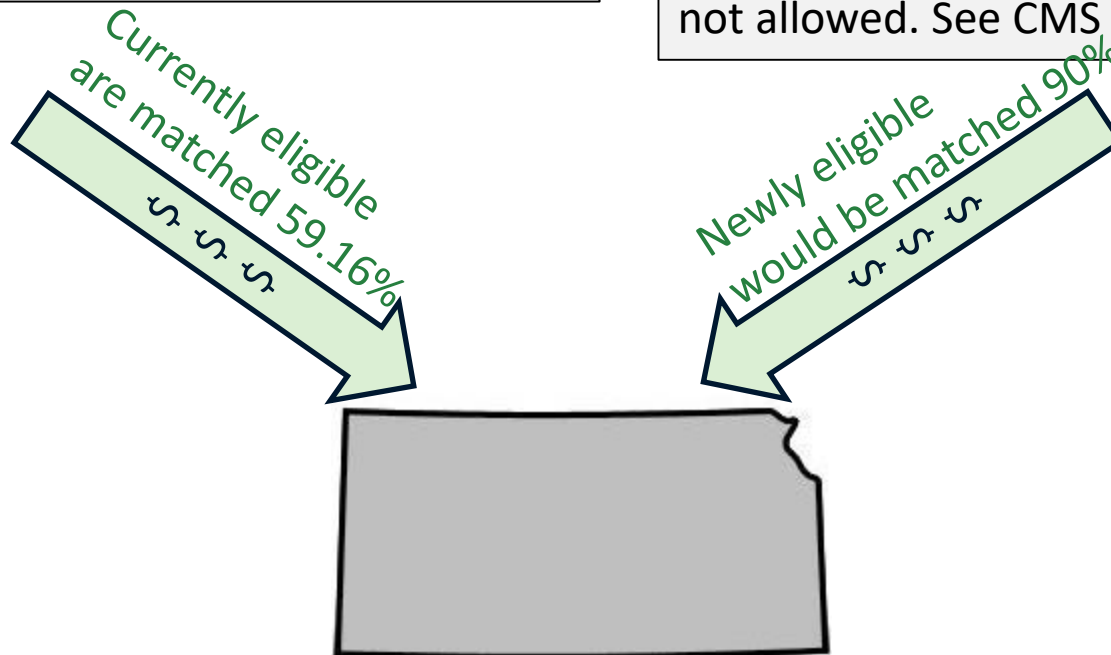
Based on state's per capita income (the lower the income, the higher the federal match). Range from 50% to 74%.

Currently **59.16%** in Kansas, 65.65% in Missouri

Expansion:

90% across the board starting in 2020
(used to be 100%, phased down over time)

*Partial expansion (for example, up to 100% FPL instead of 138%) has been attempted by AR, MA and UT but CMS has not allowed. See CMS letter [here](#).



The Economic Impact of Medicaid Expansion

The following slides cover economic analyses of the effects of Medicaid expansion on:

- Financial health and household consumption of state residents
- GDP
- State budget
- State medical system
- Offer and take-up of Employer-sponsored insurance
- Health and productivity of Medicaid-enrolled workers

Effects of Expansion on Consumer Financial Health and Household Consumption

- Individuals who gained Medicaid coverage were **13 percent less likely to have medical debt** and approximately **80 percent less likely to have experienced catastrophic medical expenses**
- Medicaid coverage at different points during the lifespan has been tied to **economic mobility across generations** and **higher educational attainment, income, and taxes paid** as adults
- Medicaid is associated with household **reductions in quarterly health spending of about \$60**, freeing up cash for low-income households.



Effects of Expansion on State Economies

Estimates suggest that a one percentage point increase in public coverage of the working-age population **increases annual real GDP growth** by 0.08 percentage points and **increases employment growth** by the same 0.08 percentage points



Arkansas: 0.41% increase in GDP and growth of GDP and state employment

Analysis: Regional Economic Analysis



Kentucky: state benefits by \$919.1 million FY 2014 – FY 2021 (*projection*)

Analysis: Deloitte Development, LLC



Maine: 6,000 new jobs (*projection*)

Analysis: The Real Impact of Medicaid Expansion in Maine



Pennsylvania: 15,500 new jobs and increased state tax revenue of \$53.4 million

Analysis: Pennsylvania Department of Human Services




Montana: 5,000 new jobs (2,000 in healthcare and 3,000 in other), increases personal income by \$280 million

Analysis: Bureau of Business and Economic Research, University of Montana


Effects of Expansion on State Budgets


Savings from using Medicaid Expansion's high federal match to replace existing state-funded (or less than 90% state-funded) programs




 In SFY 2015, Arkansas saved


- **\$15.2 million** by accessing federal matching funds for pregnant women
- **\$17.1 million** in spending on disabled who no longer had to pursue disability determinations, and
- **\$6.4 million** through reduced spending on community health centers who received more Medicaid payments

 Kentucky saved **\$14 million** in SFY 2015 by accessing federal funds for medically needy

 Michigan saved **\$19 million** in SFY 2015 as Medicaid replaced expenditures for health needs of the Medicaid-eligible incarcerated

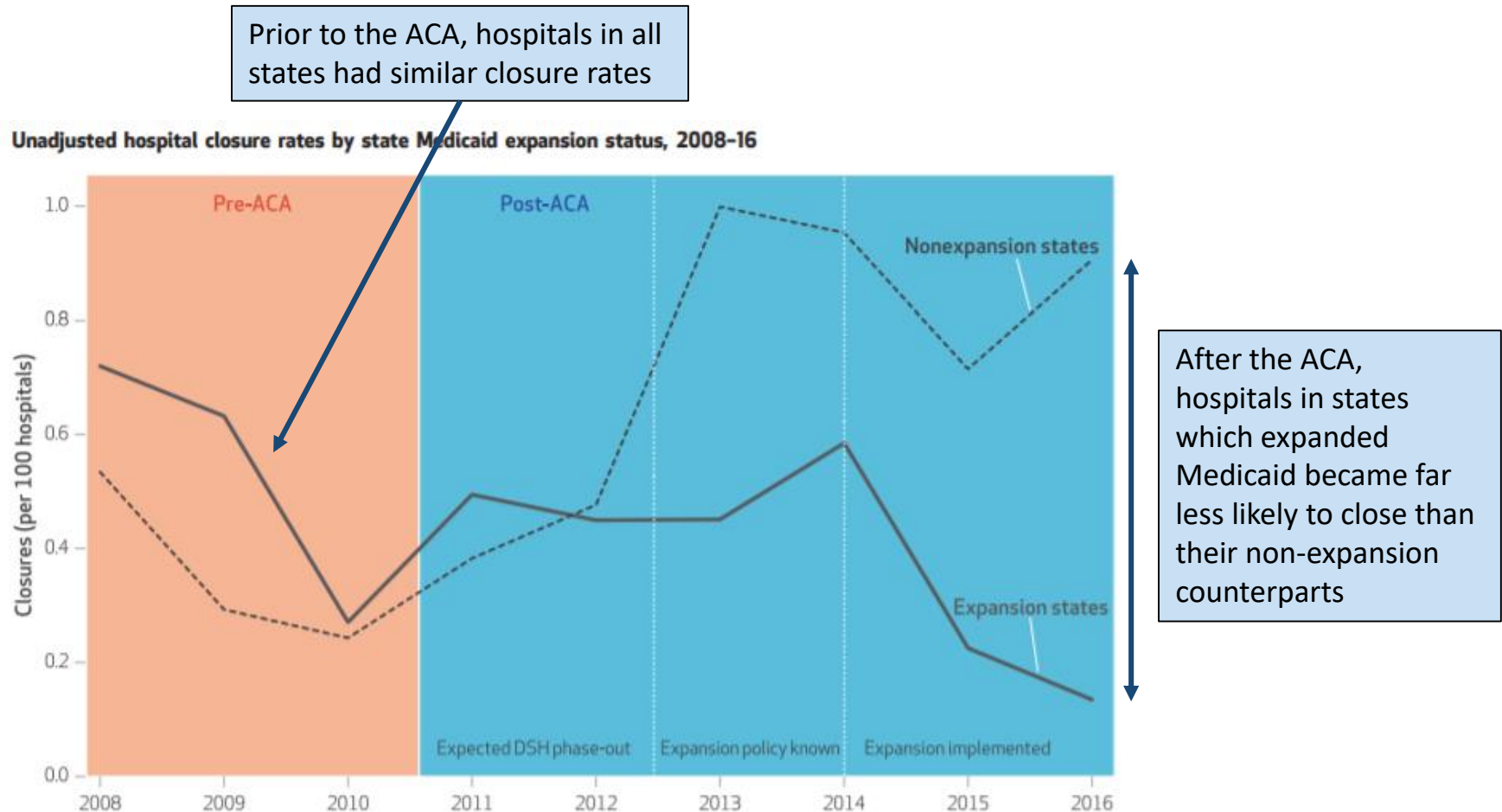
Revenue Gains: Nearly all states raise revenue through assessments or fees on providers and/or health plans. As provider and health plan revenues increase with expansion, this translates into additional revenue for states.

 New Mexico's 2014 premium tax revenues increased by **\$30 million** due to expansion adults

 Michigan gained **\$26 million** in SFY 2015 revenue from the state's Health Insurance Claims Assessment

Effects on Hospital Viability

- Overall, hospitals in non-expansion states are over **six times as likely to close**. Results are similar for urban and rural hospitals.
- An increase in childless adults' Medicaid eligibility threshold of 100 percent of poverty made a hospital about **2.5 times less likely to close** than a hospital in a non-expansion state, with other factors held constant



Will Employees Drop their ESI to go onto Medicaid?

Potential reasons to switch:

1. Avoid premium contributions
2. Obtain better financial protection through the low cost-sharing public program

Medicaid expansion has been shown to have little effect on ESI offer, take-up, and coverage rates overall, however...

...There is evidence of switching among younger, healthy age groups

Connecticut: ESI among age 19-35 dropped **5.6%**. Those who dropped ESI also were more likely to be **male**. Estimation that **30%** of new Medicaid enrollees had previously held employer-sponsored coverage.

Washington DC: ESI among age 19-35 dropped 2.6%, not statistically significant.



Effects of Medicaid Expansion on the Workforce

Effect on worker productivity:

- Michigan Survey (of newly enrolled after expansion):
 - Employed: **69%** reported being able to **do a better job** at work
 - Unemployed: **54%** reported being **better able to look for a job**
- Some evidence of reduction in **absenteeism**

Effects on worker health:



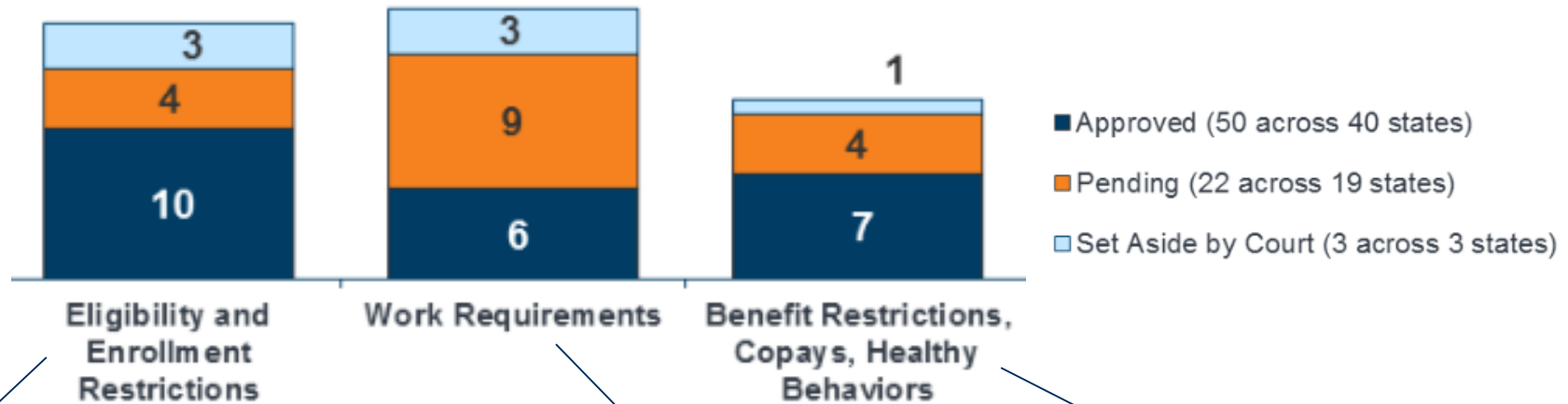
- More **behavioral health** treatment
 - More **opioid addiction** treatment
- Better measures of **self-reported health**
- Lower **cardiovascular mortality** rates
- Lower **kidney disease mortality** rates



Details of Medicaid Expansion

Federal Law (Sec. 1115) Waivers

These waivers allow states to modify their Medicaid programs. Medicaid Expansion does not require an 1115 waiver but CMS published guidance encouraging work requirements.



Includes but not limited to:

Premiums State must build infrastructure to collect premiums and tie to eligibility

Tobacco surcharges to discourage smoking

Lock-out periods for program violations

Expansion eligibility limitations e.g. to 100% FPL

Requirement to report work, school or other activities. Systems and requirements vary.

Can include healthy behavior incentives, fees for missed appointments, restrictions on provider choice, or higher copays

Expanding Medicaid, Contingent Upon Work Requirement (aka “conditional enrollment”)

Health and Human Services department under President Trump has encouraged states to impose work requirements using 1115 Waivers (for restructuring Medicaid programs)

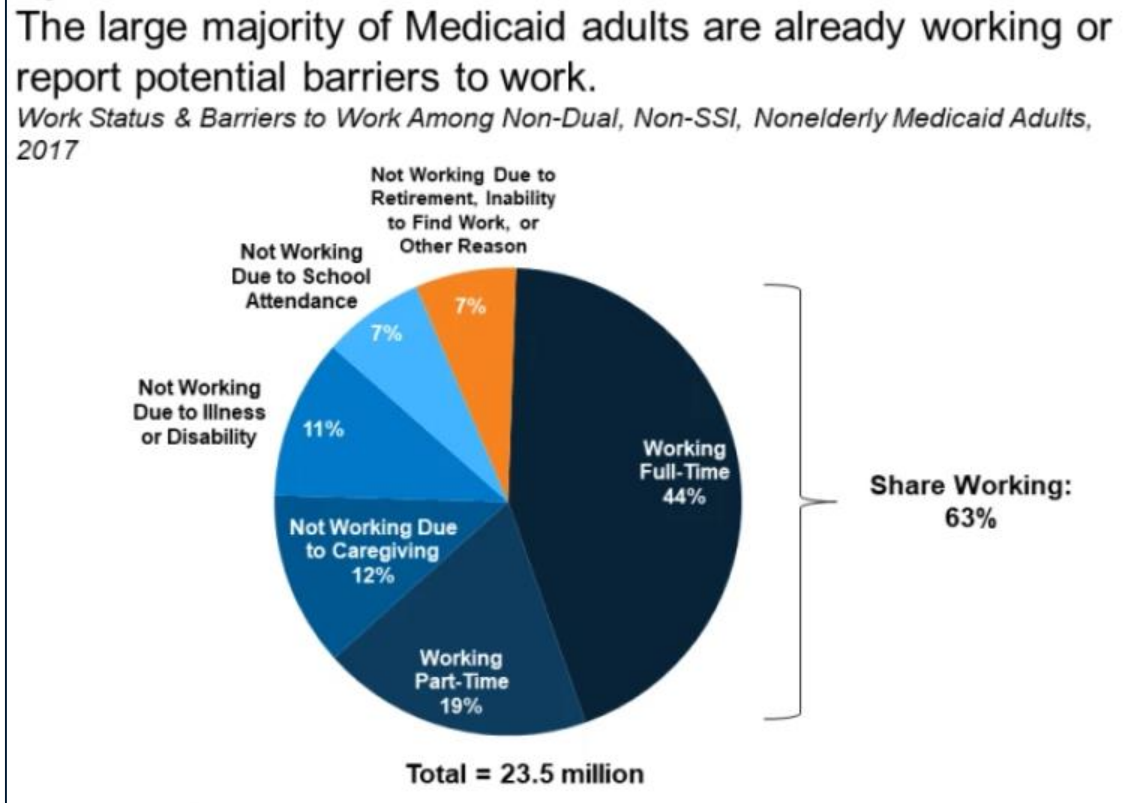
Typical work requirement policies:

1. Enrollees must be qualified for work requirements program
 - Federal gov’t requirements: non-pregnant, non-elderly, non-disabled adults
 - Additional state requirement examples (can vary by state): Age 19-49, expansion population only
2. Those in the work requirement program must:
 - Work at least 80 hours each month
 - Be engaged in job search or volunteer work, or
 - Be exempt because of medically frailty, pregnancy, or parenthood
3. Those who do not comply lose Medicaid coverage, often after three months

Work Requirements

Work requirements programs have had expensive implementations and adverse affects on those already working

- The employed, students, and ill/disabled have new reporting **burden**
 - ↓
- 18,000 Medicaid enrollees lost coverage in Arkansas, nearly all due to confusion rather than not working
 - Over 75% of those required to report worked hours failed to do so
- Kentucky: Work requirements program **cost state \$271.6 million** and is currently on hold, being decided in US Circuit Court of Appeals



Case: Montana

2015

Medicaid expanded (with June 2019 sunset)

Nov 2018

Extension ballot initiative narrowly defeated

- Paid with tobacco tax: tobacco industry outspent proponents 7:1 to defeat
- Business groups and Hospital Association were key supporters

May 2019

Extension passes legislature 61-35

- Republican majorities in Senate + House
- Dems wanted a straight expansion, but Republicans passed a version with work requirements and premiums

August 2019

1115 Waiver submitted to CMS (pending)

- Premiums up to 5% of income
- Work requirements, but not stringent because of operational difficulties in state:
 - Many independent workers (ranching, farming)
 - Internet access issues
 - Cyclical work
 - Areas with high unemployment

Key Takeaways:

- Legislature expanded despite failed ballot initiative a few months earlier because most opposition was to Tobacco tax, not expansion itself
- Republicans wanted a work requirement, but understood the burdens it could pose to Montana's economy so they made it fit

Work Referrals:

Montana's Health and Economic Livelihood Partnership Link (HELP-Link) program

HELP-Link has helped thousands of Montanans obtain skills for and find work. However, this program is expecting significant budget cuts to pay for Montana's new work requirements program.

HELP-Link Process



Identify need

Newly eligible Medicaid beneficiaries are surveyed about their employment and barriers to work



Outreach

State workers analyze the surveys and make outreach calls to offer personalized assistance based on the barriers and needs



Connect to resources

Beneficiaries are connected to:

- Career counseling
- On-the-job training programs
- Subsidized employment

And other state agency services like:

- Home health aides
- Child care
- Housing

Nearly 3,000 services were rendered through HELP-Link in 2018

Information Services		
	One Stop Delivery System Info & Services	1,296
	Workforce & Labor Market Information	2,605
	Referral to Federally Funded Training Programs	1,706
Wagner-Peyser Staff Assisted Services		
	Career Assessment/Diagnostic Testing	953
	Career Counseling	281
	Client Intake	2,138
	Employment Counseling	1,068
	Employment Plan	75
	Interviewing Skills	422
	Job Search Assistance	2,594
	Placement Assistance	510
	UI Assistance	53
Program Appointments		
	HELP-Link	2,816
	RESEA	1,232
	100% / Montana Way	511
Total		2,968

Court Cases

Texas v. Azar

Case: Does elimination of the tax penalty mean that the entire ACA should be struck down as unconstitutional?

Status: Case currently in Circuit Court. Ruling expected within a month. If goes to Supreme Court, will be decided June 2020 or later.

Likelihood: Most legal experts think the legal challenge will fail (and the ACA will stand):

“the penalty tax is simply lying dormant until a future Congress (and future President) officially amends the law”

–Chris Condeluci, former counsel to Senate Finance Committee

“With a zero tax, individuals are wholly free of any requirement to be insured so there is no constitutional problem.”

–Timothy Jost, law professor and ACA expert

“O’Connor also ignored settled law on “severability” of unconstitutional provisions of a law.”

–Timothy Jost, law professor and ACA expert



Stewart v. Azar & Gresham v. Azar

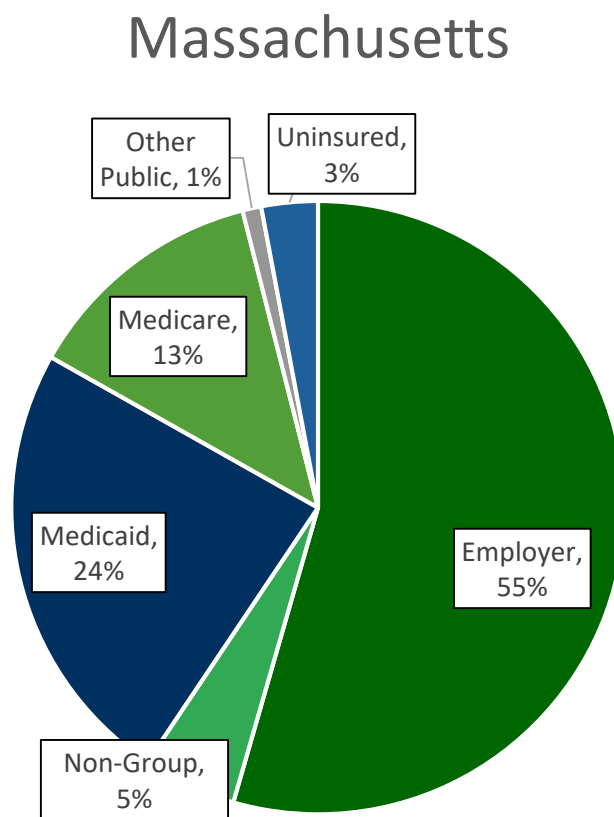
Case: Stewart (Kentucky) and Gresham (Arkansas) challenged work requirements laws.

Status: Hearing arguments in circuit court.

Likelihood: Circuit court will likely rule against requirements, and case will go to Supreme Court

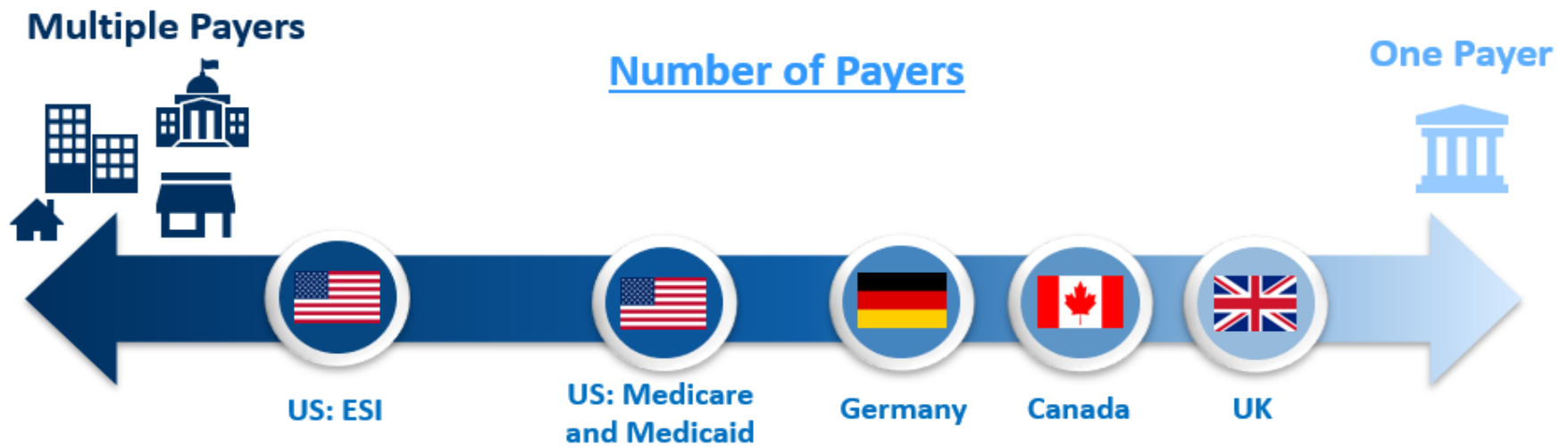
Appendix

Massachusetts has a Very Low Uninsured Rate Compared to Other States

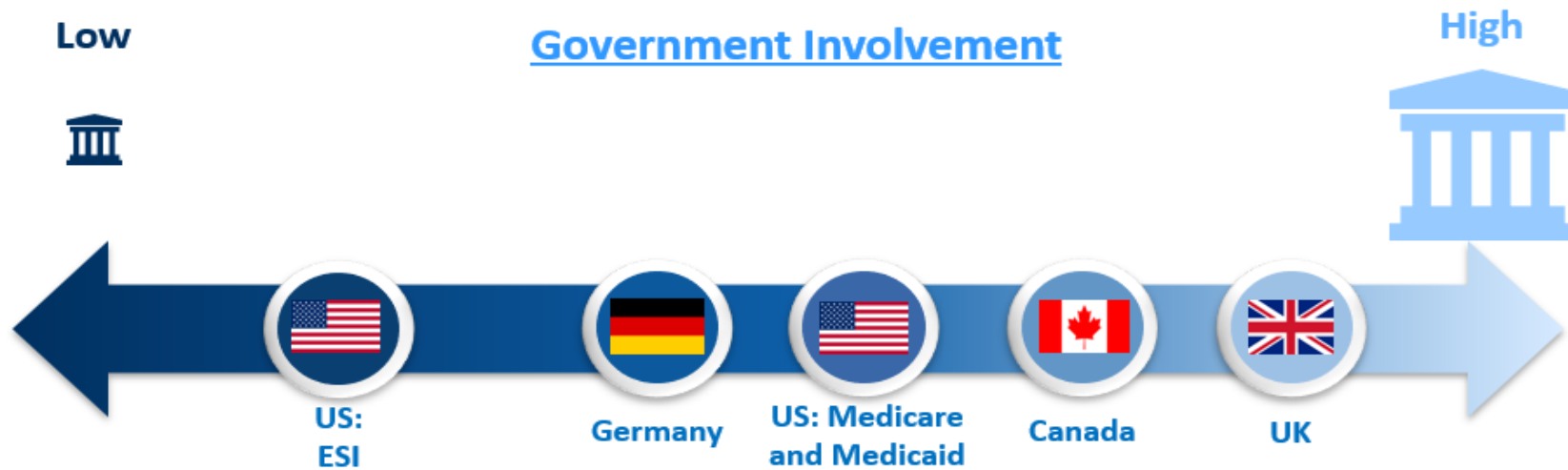


Total Population: 6.9 million

The US has Many More Payers than other Countries, But no Country has a True Single Payer System



The United States has Significantly Less Government Involvement in Healthcare than other Developed Countries



Medicare for All

Features of the most liberal Medicare for All proposals from Democratic presidential candidates:

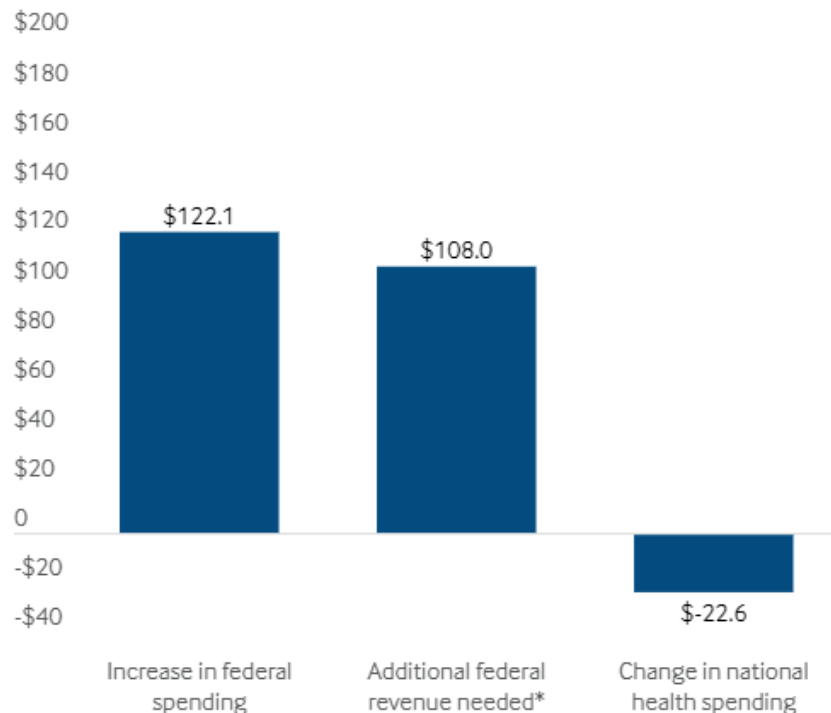
- Government plan with broad benefits, including
 - adult dental
 - vision
 - hearing
 - home- and community-based long-term services and supports
- No premiums or cost-sharing
- Includes all U.S. residents
- Private insurance prohibited

Financial Impact of Health Reform Proposals

Typical “buy-in” reform proposal:

- Universal coverage attained
- Continuous autoenrollment
- Public option
- Cost-sharing
- Employer-sponsored insurance remains

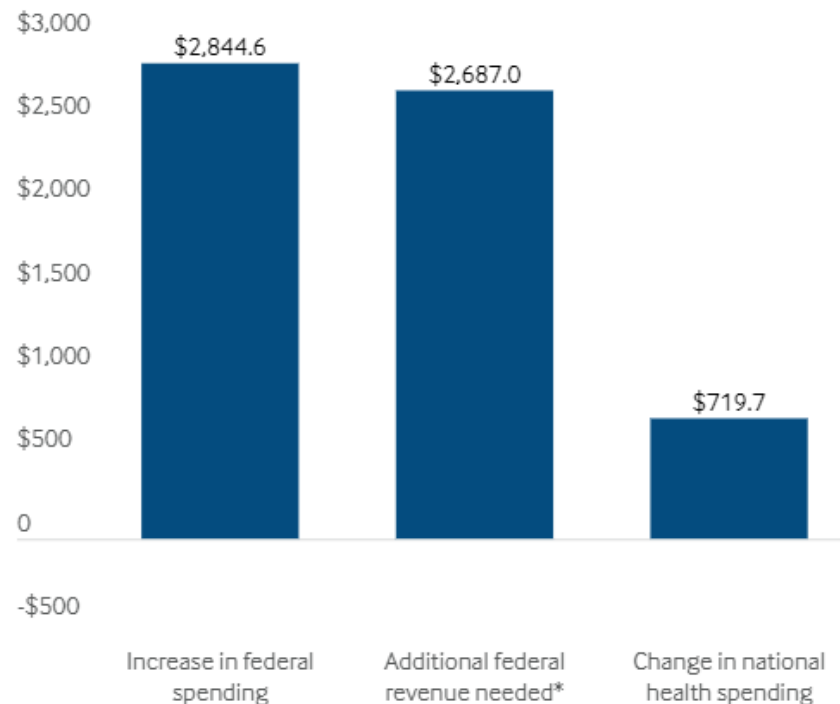
Billions of dollars



“Medicare for all” proposal:

- Government plan with broad benefits
- No premiums or cost-sharing
- Includes all U.S. residents
- Private insurance prohibited

Billions of dollars



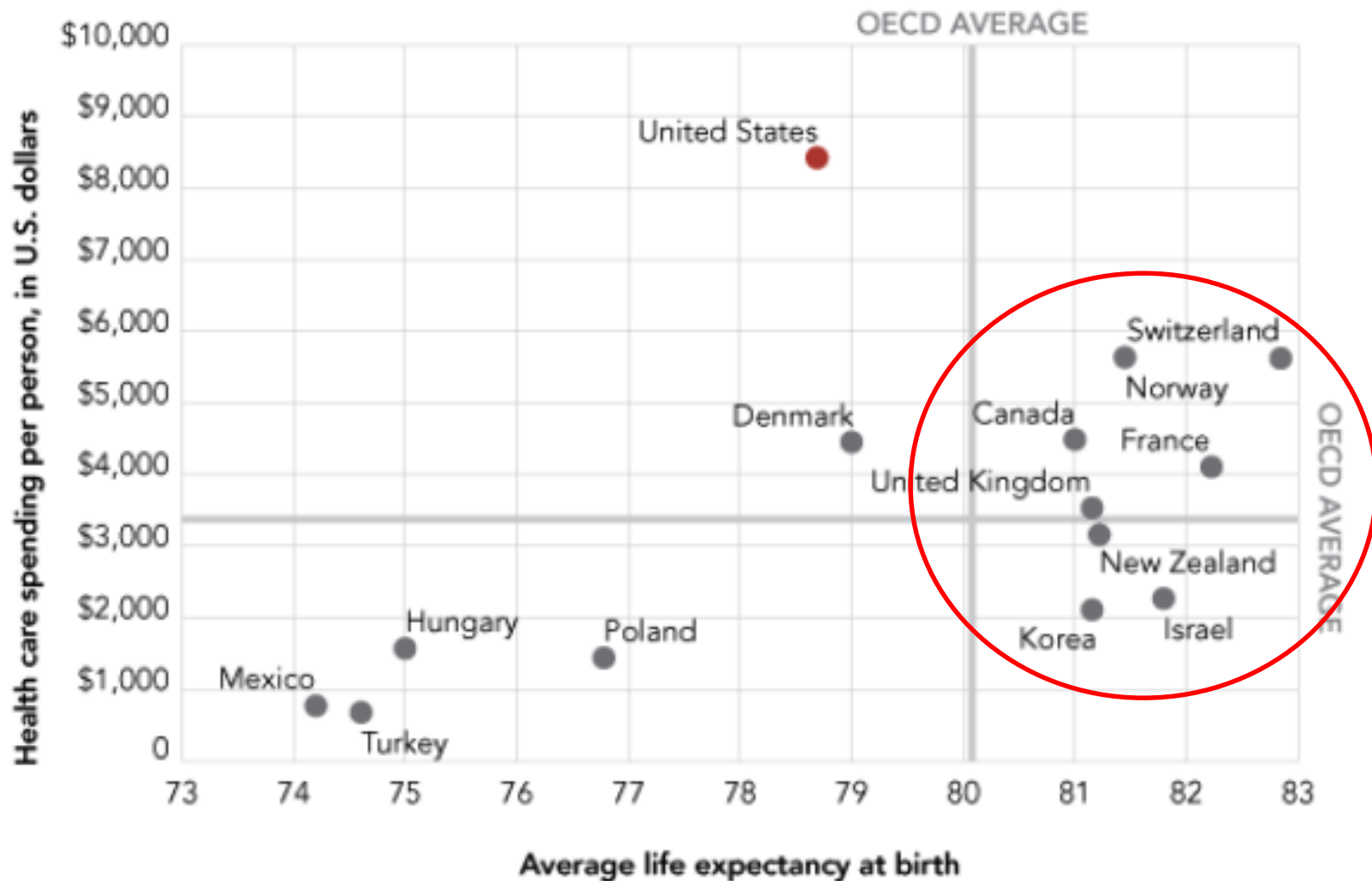
Elizabeth Warren's Proposed Pay-Fors

Elizabeth Warren's plan for a budget-neutral Medicare for All program

- 6% wealth tax on >\$1b net worth individuals
- Employer tax roughly equivalent to gov cost of insuring their employees
- Lower reimbursement for physicians and hospitals to 100%/110% current Medicare rates
- Tax evasion and fraud enforcement
- Taxes on financial industry and on bond, stock and derivative sales
- Changes to corporate tax structure
- Tax on foreign earnings, including US companies which offshore
- Cut military spending

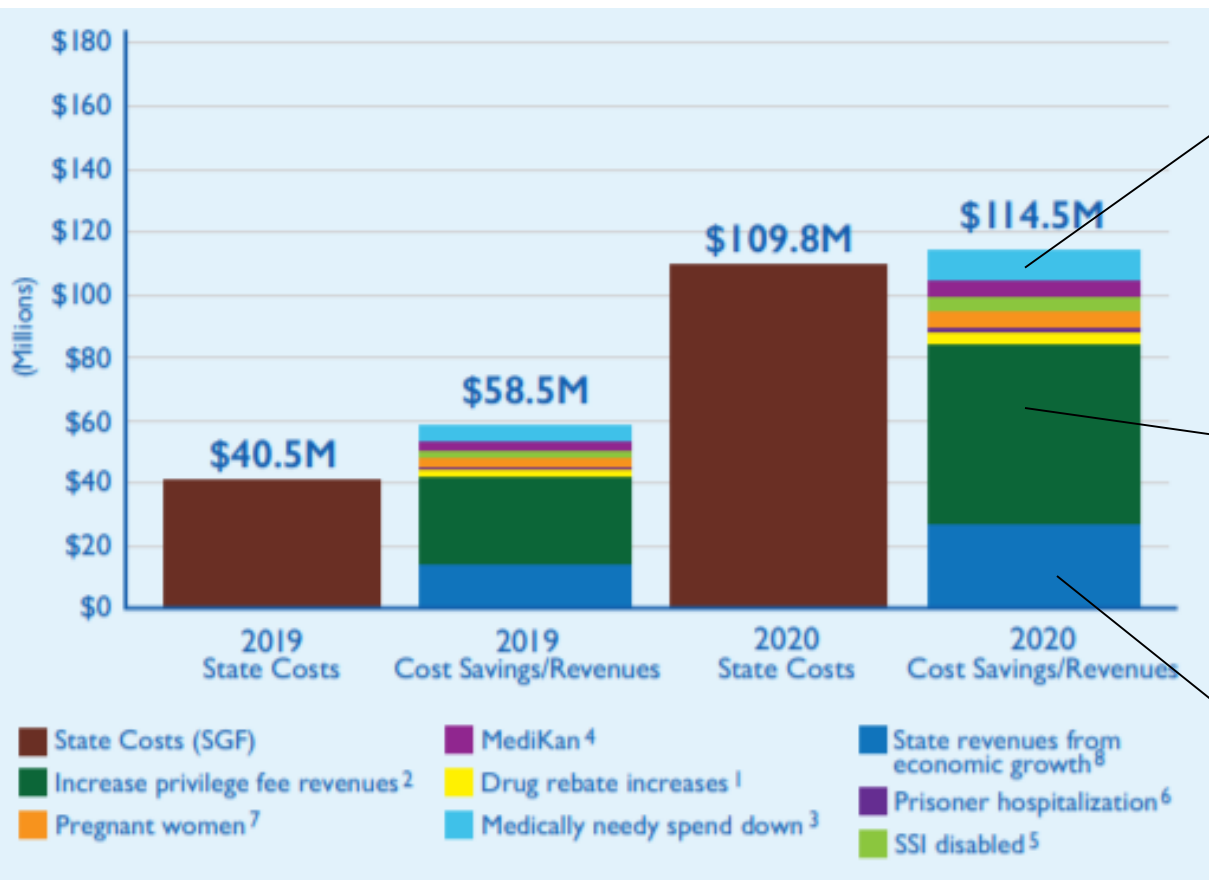


Americans Don't Live Longer than People in Countries that Spend Much Less on Health Care



Bridge to a Healthy Kansas Bill: Projected Effects on State Budget

“Bridge to a Healthy Kansas” was a Medicaid expansion bill introduced in January 2019



Kansas residents who “spend down” to be eligible will stop

Increased “privilege fees” from Managed Care Companies: fee revenue rises in tandem with enrollment

Tax revenues from growth of KanCare MCOs and ripple effect spending

Sources: 1. Kansas Legislative Research Department; 2. Kansas Department of Health and Environment (KDHE) estimate of KanCare Expansion costs and Senate Sub. HB 2281; 3. KDHE; 4. KDHE Medical Assistance Report; 5. KDHE Medical Assistance Report; 6. Kansas Department of Corrections; 7. KDHE; 8. Health Affairs, March 2016.