

Chicago Fed Letter

Medicaid expansion and the Affordable Care Act: A fiscal checkup

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On April 4, 2016, the Federal Reserve Bank of Chicago and the Civic Federation held a conference to examine how states are lowering the ranks of the uninsured under the Affordable Care Act (ACA)—by expanding Medicaid and through other strategies. The conference also looked at the ACA's impact on delivering health care to traditionally underserved populations.

One of the primary goals of the ACA,¹ passed in 2010, has been to expand health care coverage to previously uninsured populations. However, the particular mechanisms for achieving this goal have been largely left up to the states to develop and execute, especially following the Supreme Court's 2012 ruling, which upheld the law's constitutionality but made its provision to expand Medicaid optional.² Besides discussing how states are implementing the ACA with or without Medicaid expansion, the policymakers, academics, and other experts at the conference focused on the associated challenges of containing health care costs, developing new payment and delivery systems, and reaching traditionally underserved populations, such as low-income people with mental illness or substance abuse problems.

Opening remarks

Trish Riley, executive director, National Academy for State Health Policy, provided an overview of the benefits and challenges for states using Medicaid expansion to meet the goals of the ACA. Riley noted that since the enactment of the ACA, 20 million Americans have gained health care

Some materials presented at the conference are available at <https://www.chicagofed.org/events/2016/medicaid-expansion>.

coverage, lowering the share of the uninsured to roughly 10%. A significant portion of these gains in health care coverage has been due to Medicaid expansion. Although expanding Medicaid under the ACA is no longer mandatory, 31 states and the District of Columbia have chosen to do so in order

to provide coverage to many who were historically ineligible for Medicaid (such as low-income childless adults³). Medicaid now accounts for roughly 17% of U.S. health care expenditures and enrolls nearly 65 million Americans. Many states have chosen Medicaid expansion because of the financial incentives provided by the federal government: The cost of each new enrollee will be fully reimbursed over the period 2014–16, and then the reimbursement rate will be gradually reduced to 90% by 2020.⁴ These reimbursement rates are substantially higher than those offered by the federal government for traditional Medicaid programs.

Riley reported that under the ACA, the pace of health-care-related costs for the nation has slowed (achieving another goal of the act, at least over the short term): They grew by 3.6% in 2013. However, these costs accelerated to 5.6% in 2014 and are projected to grow 6% annually over the period 2015–23, she said. Focusing on the act’s impact at the state level, Riley noted that states that have opted to expand Medicaid have seen more financial benefits relative to states that have opted not to—such as slower growth in state Medicaid spending (3.4% versus 6.9% in fiscal year 2015) and a greater reduction in uncompensated care (26% versus 16% in 2014). States that have decided to expand Medicaid eligibility have also reduced their spending on the uninsured and gotten more tax revenues from health care insurers and providers than they would have otherwise.

Despite these benefits of Medicaid expansion, it is not without its challenges, Riley remarked. Perhaps the most challenging part of Medicaid expansion has been devising new payment and delivery systems. State governments are experimenting with several approaches (73% of them are using four or more types of reforms at once). Most of these approaches focus on managed care,⁵ chronic disease prevention, and payments based on health outcomes in order to reduce costs and increase accountability among patients and providers.

To close, Riley expressed some concerns about the current landscape of health care provision. For one, in an effort to improve efficiency, many health care insurers and providers have been encouraged to consolidate their operations, but this may make the markets for their products and services less competitive, ultimately driving up costs for patients. For another, the administrative capacity of Medicaid programs is significantly challenged, often not keeping pace with the rapidly rising number of enrollees. The average tenure of a state Medicaid director is under two years, and job vacancies in Medicaid programs are quite common. Given these trends, states have increasingly relied on contractors to administer these programs.

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To expand Medicaid or not: Midwest choices

In the first panel, speakers representing Illinois, Michigan, Indiana, and Wisconsin explained the mechanisms each of their respective states is using to expand health care coverage. These midwestern states have elected to 1) expand Medicaid coverage as the ACA originally stipulated; 2) expand it, but with federal waivers for features differing from the standard formulas or criteria for expansion;⁶ or 3) not expand it and forgo federal funding.

Felicia Norwood, director, Illinois Department of Healthcare and Family Services, said that Illinois has opted to expand Medicaid eligibility, more or less, as originally specified in the ACA. The initial projection was for Illinois to enroll 342,000 low-income people through Medicaid expansion, but as of January 2016, 622,000 were enrolled. For the sake of cost containment, the new Medicaid recipients are required to enroll in risk-based managed care, she pointed out. In January 2015, 50% of the Illinois Medicaid population was in managed care, but that share has risen to 62% today. As the ranks of Illinois’s Medicaid recipients swell, coordinating the actions of multiple health care providers has become a major challenge: Norwood said that the original group of 30 providers was too large, but it has since been reduced to 13—which has helped improve provider accountability. Moreover, Norwood said the state is in the process of setting up a medical payment and delivery system that rewards healthy outcomes to improve patient accountability. Norwood emphasized that the state’s costs for its new Medicaid enrollees due to ACA reform are projected to grow to \$60 million in 2017 and \$130 million in 2018, as the federal reimbursements decrease.

Chris Harkins, director, Office of Health and Human Services, Michigan State Budget Office, explained that lawmakers in his state initially balked at a straightforward ACA Medicaid expansion,

like the one in Illinois. They argued that enrollees in expanded Medicaid should have more “skin in the game,” so they required the state’s executive branch to come up with a plan that incorporated modified eligibility requirements, enrollee cost sharing, rewards for healthy behavior, and limits on how long certain enrollees can keep Medicaid coverage without facing increases in cost sharing. Under the ACA, all of these adjustments to standard Medicaid expansion required the state to obtain waivers from the federal government before receiving federal funding.

Harkins noted that under this plan, dubbed the Healthy Michigan Plan (HMP),⁷ new Medicaid enrollees with incomes between 100% and 138% of the federal poverty level (FPL) have some cost sharing in the form of premium payments and copayments, albeit with reductions in the latter for healthy behaviors. Moreover, such enrollees must transition out of Medicaid after 48 months to federally subsidized private insurance or face an increase in cost-sharing requirements (of up to 7% of their income) for keeping Medicaid coverage. Individuals with incomes at or below 100% of the FPL do not pay premiums but must pay some copayments, again with reductions for healthy behaviors. As in Illinois, Medicaid enrollments far exceeded projections, Harkins indicated. Michigan’s initial estimate was for 322,000 low-income enrollees. Presently, the number of enrollees has stabilized at around 600,000 (notably, among the adult enrollees, 47% are under the age of 35 and 80% have incomes below 100% of the FPL; about one-sixth of all new enrollees live in rural areas). Implementing the HMP has helped Michigan’s uninsured rate decline from 12.5% in 2013 to 8.5% in 2015, said Harkins. The state’s rate of uncompensated care at hospitals has also moved down over this span.

Harkins concluded by discussing the impact of implementing the HMP on the state budget. For fiscal year 2017, Michigan will not be fully reimbursed by the federal government for expanding Medicaid. The governor has proposed apportioning \$108 million in general funds to cover the difference. Harkins emphasized that by state law, the costs of the HMP must be covered by the savings generated from it; however, a broad base is used for determining the savings—they include not only reductions in uncompensated hospital care and similar benefits, but also reductions in costs to other departments of the state, such as its corrections department, resulting from the HMP.

Seema Verma—president of SVC Inc. and a consultant to the State of Indiana—discussed the Healthy Indiana Plan (HIP) 2.0,⁸ which is similar in some respects to the HMP. She began by arguing that traditional Medicaid was not designed to meet the needs of the uninsured population targeted by the ACA. Originally, Medicaid was intended for the aged, blind, disabled, children, and pregnant women, so it required limited cost sharing and did little to encourage healthy lifestyles or discourage undesirable behaviors. Thus, Indiana developed its own approach to extending Medicaid coverage, she said. Relying on a private-market-style model for health plans, this approach requires HIP 2.0 enrollees to make contributions toward coverage, and promotes healthy lifestyles and chronic disease prevention. The state costs for HIP 2.0 are supported by a cigarette tax (and Indiana hospitals will start supporting these costs in 2017).

Verma said a key feature of HIP 2.0 coverage is the Personal Wellness and Responsibility (POWER) accounts. These are personal health savings accounts, to which the state and individuals contribute. Members must make monthly contributions (set at 2% of monthly income) to their POWER accounts or face penalties (e.g., loss of coverage). Additionally, the HIP 2.0 program provides members monthly statements that allow them to monitor and manage their own health care spending, thereby increasing member engagement (statements also improve the transparency of charges for medical services rendered). If money from the member contribution is still in the account at year-end, it can be rolled over to reduce the required contribution in the following year. (Completing preventative care services will double this reduction.⁹)

As Verma explained, HIP 2.0 offers three options for gaining health care coverage to low-income people aged 19–64 (with incomes at or below 138% of the FPL). HIP Plus is the baseline plan (which

covers almost all copayments), while HIP Basic provides coverage to those with incomes at or below 100% of the FPL (with no member contributions to POWER accounts required, but with no copayments covered). Both HIP Plus and HIP Basic feature a high deductible (\$2,500), which is paid with funds accrued in the POWER accounts. The third option, HIP Link, provides public assistance for premium payments (via the POWER accounts) for employer-sponsored plans registered with the state.¹⁰

Verma concluded by highlighting some of HIP 2.0's successes. For instance, since HIP 2.0 started, 5,300 new providers have signed up to serve Medicaid and HIP enrollees. And for individuals who moved from traditional Medicaid to HIP 2.0, there was a 42% decline in emergency room visits. HIP 2.0 also has received high member satisfaction ratings—with 87% of members indicating they are satisfied or very satisfied with their coverage, 83% indicating they would pay more to be in the program, and 94% indicating they would enroll again.

Kevin Moore, Medicaid director, Wisconsin Department of Health Services, noted his state has elected not to expand its Medicaid program as the ACA stipulates or otherwise, forgoing federal funding. Prior to the ACA, Wisconsin obtained a federal waiver to operate its Medicaid program in ways not otherwise permitted under federal rules. Dubbed BadgerCare Plus,¹¹ this new approach to Medicaid extended coverage to childless adults (starting in 2009) with incomes up to 200% of the FPL (among other uninsured populations) without taking any additional federal funds (beyond the normal amount for traditional Medicaid). But an enrollment cap was applied, which resulted in a long waiting list. Rather than expanding Medicaid to cover all adults with incomes at or below 138% of the FPL under the ACA, Wisconsin officials decided to roll back the income threshold for Medicaid coverage for almost all adults (with or without children) to 100% of the FPL, but with no enrollment cap. Those losing coverage (with incomes above 100% of the FPL) are eligible for tax credit subsidies to help buy insurance through the health care exchanges established by the ACA. State officials reasoned that the federal government would not be able to maintain its level of funding for ACA Medicaid expansion, and instead opted to make adjustments to the state's existing Medicaid program to ensure its long-run fiscal sustainability while maintaining coverage to those who need it most.

The ACA's impact on mental health and substance abuse treatment

The second panel looked at how Medicaid expansion under the ACA has made treatment possible for more low-income people with mental illness or substance abuse issues. These groups have often lacked access to adequate health care.

Chuck Ingoglia, senior vice president, National Council for Behavioral Health, explained that because of Medicaid expansion, 2.7 million low-income, previously uninsured individuals who need substance abuse or mental health treatment are now eligible for care. Ingoglia contended it was a positive development that Medicaid was used as the vehicle for expanding health care coverage because Medicaid has better benefits for treating mental health and substance abuse problems than most private insurance plans. It also keeps cost sharing down, which helps to ensure access to care for those with less means. However, he noted, the different ways in which states have been experimenting with expanding Medicaid coverage have, in some cases, led to payment delays for treatment or done very little to assist those with serious mental illness.

Jay Shannon, CEO, Cook County Health and Hospitals System (CCHHS) in Illinois, described the extraordinary impact that Medicaid expansion under the ACA has had on the system's financial viability and its ability to care for Cook County residents with mental health or substance use disorders. The expansion of Medicaid eligibility has changed the system's payer mix from 32% with Medicaid and 55% with no insurance in 2013 to 50% with Medicaid and 33% with no insurance in 2016.¹² This change has, in turn, generated enough funding to significantly reduce the taxpayer subsidy to CCHHS—from \$481 million in 2009 to \$121 million in 2016.

Shannon said that CCHHS treats nearly 3,000 patients with mental health or substance abuse issues every month, including patients at the Cook County Jail. Prior to the ACA, many low-income people with these issues only received care while they were in jail, but that should change now that more of them are gaining access to care outside of jail. Shannon then reviewed the many programs CCHHS is pursuing—including a new 24/7 triage center treating people at risk of incarceration or hospitalization due to mental illness or substance abuse. By improving the delivery of care through such initiatives, CCHHS will improve its own fiscal sustainability, Shannon said.

Mark Ishaug, CEO, Thresholds, presented a mental health care provider's perspective on ACA Medicaid expansion. Thresholds is one of the oldest and largest providers of community-based health care for persons with mental illnesses in Illinois. Ishaug said that while the ACA has been helpful in expanding Thresholds' ability to provide care to a larger population, Illinois's move toward managed care has helped even more by allowing for treatment that better integrates mental health care with physical health care.

Keynote address

Vikki Wachino—director of the Center for Medicaid and CHIP¹³ Services (CMCS) within the Centers for Medicare & Medicaid Services (CMS)—shared the federal government's vision for how Medicaid's transformation under the ACA will continue to 1) expand coverage, 2) simplify eligibility requirements, and 3) reform how health care is delivered.

According to Wachino, after the ACA's implementation, the uninsured rate for 18–64 year olds had fallen significantly, to around 12% by the end of 2015. Wachino highlighted research that shows how in Medicaid expansion states there is now greater access to primary care, higher rates of preventative visits, and increased rates of diabetes diagnosis relative to before expanded coverage. In addition, she said because of Medicaid expansion, hospitals reduced the costs of uncompensated care by an estimated \$7.4 billion in 2014.

Wachino explained that under the ACA, eligibility standards for Medicaid have been transformed to align with those for coverage that can be purchased (with tax credit subsidies) in the health care exchanges. This allows eligibility for all insurance affordability programs to be determined via a single process (thereby reducing administrative costs). Because of this change and some functional support the federal government has provided with data analytics, Medicaid eligibility can be determined for children and nondisabled adults in near real time in 37 states. Innovations like this allow Medicaid to function more like a modern health insurance program and make it more consumer-friendly.

As Wachino noted, CMS is encouraging states to experiment with different kinds of reforms that continue to move Medicaid away from paying for volume of care toward paying for value of care. For instance, currently, 58% of Medicaid beneficiaries are enrolled in capitated, risk-based managed care instead of less efficient fee-for-service care; and this percentage is expected to rise. A majority of states are testing out this model and other reforms. In sum, Wachino said the federal government, in cooperation with the states, is seeking to build a stronger Medicaid program while improving the U.S. health care system as a whole.

Conclusion

State strategies to expand health care coverage to previously uninsured populations have varied following the passage of the ACA. While many states have opted to expand Medicaid as originally stipulated by the ACA, others are implementing Medicaid expansion in unconventional ways. Still others are devising their own policy strategies to extend health insurance coverage to certain segments of their populations without expanding Medicaid coverage. However, what most states have in common in an era of tight state budgets is a willingness to experiment with policies that may contain costs and improve health outcomes.

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- ¹ The ACA refers to the Patient Protection and Affordable Care Act of 2010, which was amended by the Health Care and Education Reconciliation Act of 2010. For further details, see <http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html> and <https://www.medicaid.gov/affordablecareact/affordable-care-act.html>.
- ² See <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/>. For an overview of Medicaid, which is a federal–state partnership, see <https://www.medicaid.gov/medicaid-chip-program-information/medicaid-and-chip-program-information.html>. For more on the current status of Medicaid expansion under the ACA, see <http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx>.
- ³ More specifically, standard expansion of Medicaid under the ACA extends coverage to all adult citizens under age 65 whose household income falls at or below 138% of the federal poverty level (FPL); see <https://www.ncsl.org/documents/health/HRMedicaid.pdf>. New coverage for immigrants depends on their legal status and state policies; see <https://www.nilc.org/issues/health-care/immigrantsshr/>.
- ⁴ <https://www.ncsl.org/documents/health/HRMedicaid.pdf>.
- ⁵ For more on Medicaid managed care, see <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.
- ⁶ For more on ACA Medicaid expansion waivers, see <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>.
- ⁷ For more details, see <https://www.michigan.gov/healthymiplan>.
- ⁸ Established in 2007, HIP 1.0 was in place before the ACA; for HIP 1.0, the state obtained a federal waiver to expand Medicaid coverage and run its Medicaid program in ways that would normally not be allowed under federal rules; see <http://kff.org/medicaid/fact-sheet/healthy-indiana-plan-and-the-affordable-care-act/>. For more details on HIP 2.0 (which required an amendment to the previous waiver), see <http://www.in.gov/fssa/hip/index.htm>.
- ⁹ <http://www.in.gov/fssa/hip/2452.htm>.
- ¹⁰ <http://www.in.gov/fssa/hip/2491.htm>.
- ¹¹ For more details on BadgerCare Plus, see <https://www.dhs.wisconsin.gov/badgercareplus/index.htm>. For details on its evolution, see <http://kff.org/medicaid/fact-sheet/wisconsins-badgercare-program-and-the-aca/>.
- ¹² The remaining payers had Medicare or private insurance; their respective shares of the payer mix did not change very much between 2013 and 2016.
- ¹³ CHIP stands for Children’s Health Insurance Program.

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