

Medicaid and Health Reform: *Past, Present, and Uncertain Future*

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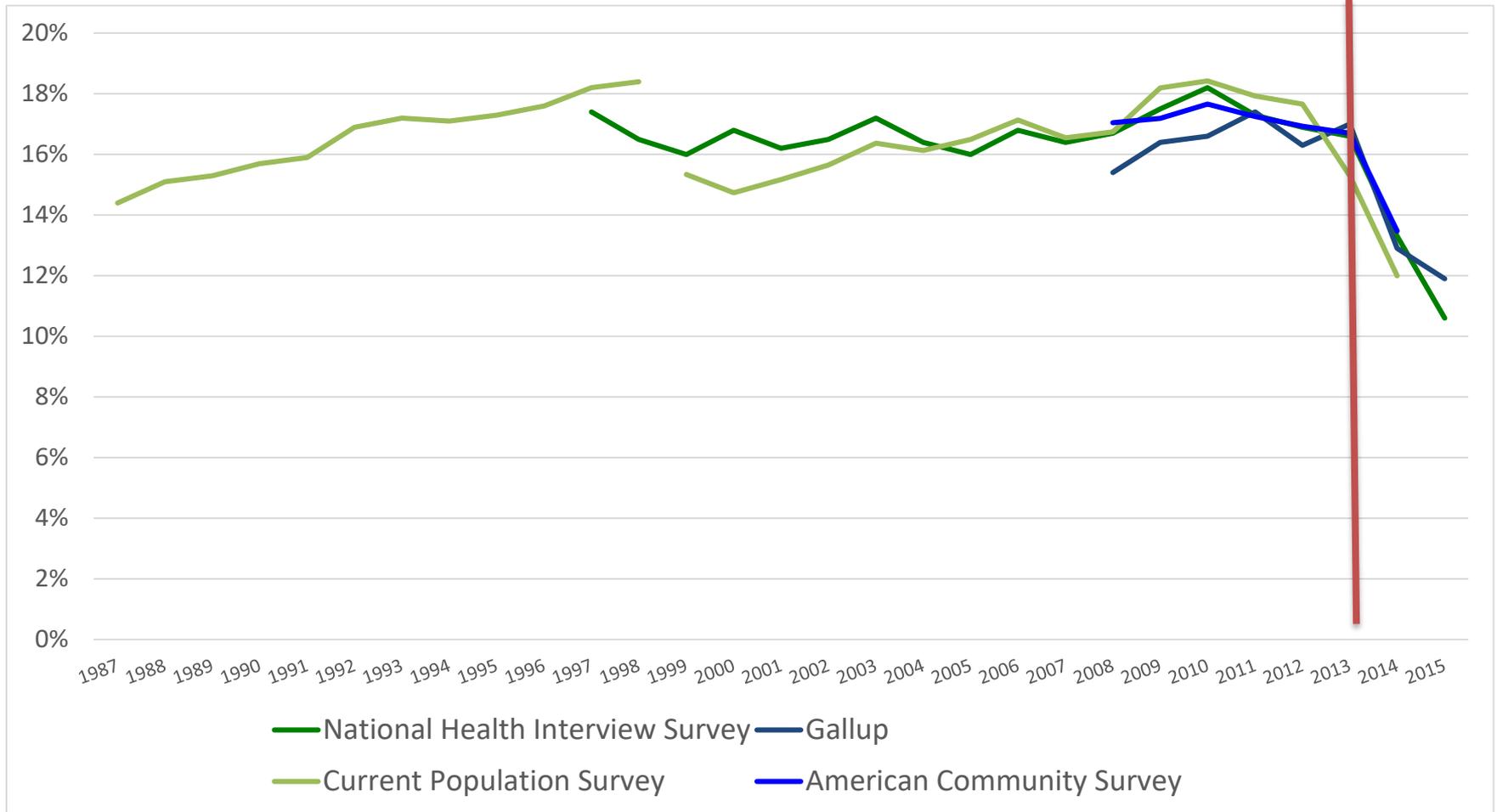


Outline for Today

- Overview of research findings from several recent or ongoing projects:
 - Disentangling ACA coverage effects
 - Medicaid impacts on patient:
 - Primary and preventive care vs. ED use
 - Chronic disease care and quality of care
 - Prescription drugs
 - State budget effects from Medicaid expansion
- Discussion of Medicaid reform proposals: Block grants & per capita allotments



ACA & the Uninsured Rate





Research To Date

- Numerous data sources show ACA associated with dramatic drop in uninsured rate
- Diffs-in-diffs analyses of Medicaid expansion show large coverage gains for low-income adults in expanding states
- But no research to date has assessed the relative contributions of the ACA's key policy tools for the nation as a whole

Sources: Clemens-Cope et al. *Urban Institute* 2014; Black & Cohen *NHIS* 2015; Sommers et al. *JAMA* 2015; Wherry & Miller *Annals Int Med* 2016; Kaestner et al *NBER* 2015; Courtemanche et al. *NBER* 2016



ACA Coverage Effects

- We attempted to provide the first comprehensive analysis to disentangle ACA coverage impacts from these key features:
 1. Medicaid expansion
 2. Premium subsidies
 3. The individual mandate



Overview of Approach

- Triple difference model, using variation over time, income group, and ACA premium rating area (which are fully contained within states)
- Incorporate three key policy measures
 - Medicaid eligibility – identified by variation across income groups and state decisions regarding 2014 expansion
 - Premium subsidies – identified by variation in effective subsidy rates by income groups and premium rating areas
 - Mandate – identified by variation in exemptions and penalty amount (based on income and family structure)



Methods: Data & Sample

- Household microdata from American Community Survey (ACS) for 2012-2015
 - Information on income, family structure, demographics, and health insurance
 - Level of analysis is the “health insurance unit” – adult, his/her spouse, and dependent children
- All non-elderly adults, 0-64 years of age (>2 million observations per year)
- Detailed within-state geography, but can't go back further than 2012

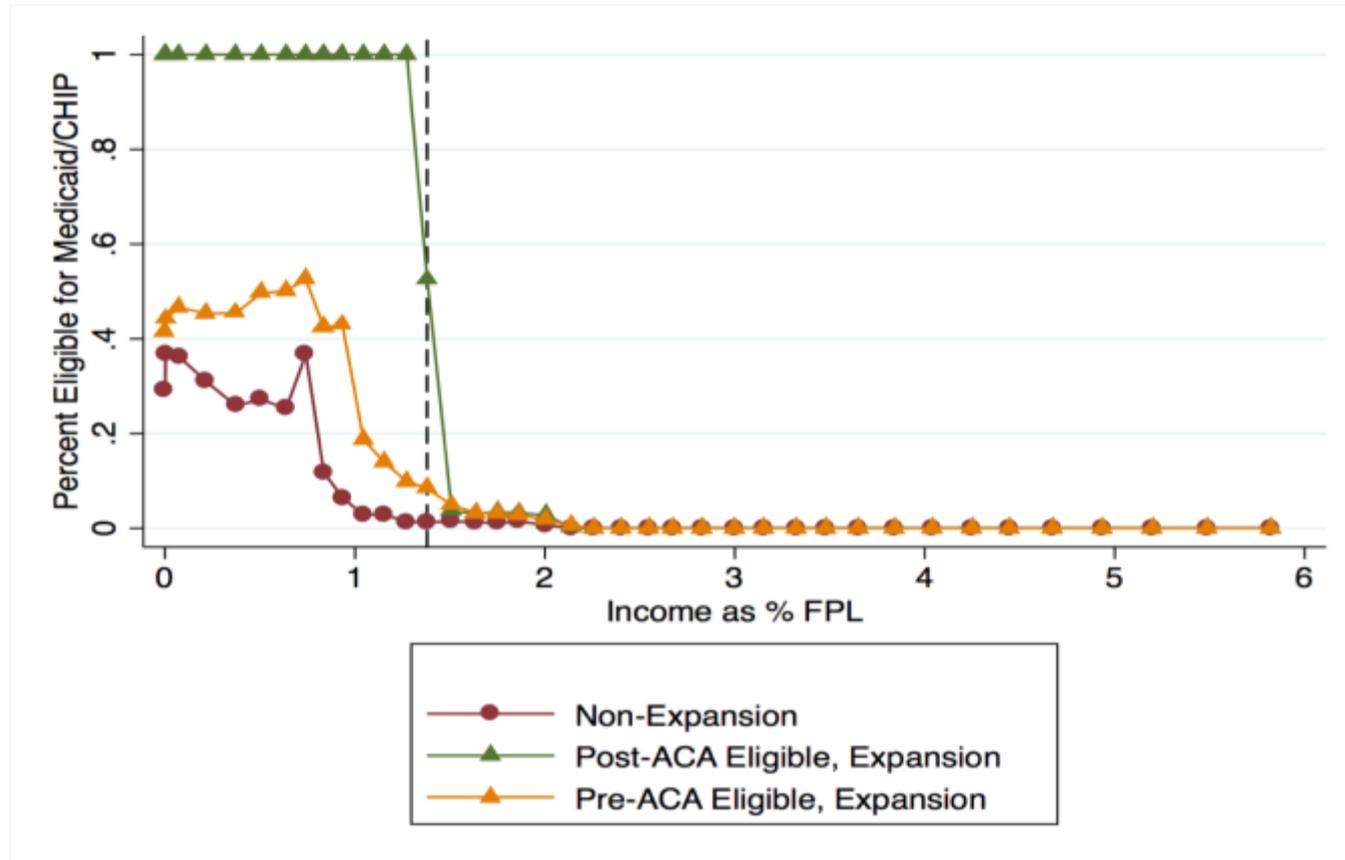


Policy Measures: Medicaid

- **Medicaid eligibility** from CMS, Kaiser Foundation, and state sources
- Based on age, income, disability and family structure
- We distinguish between:
 - Existing Medicaid eligibility as of 2010 (“previously eligible”)
 - Early ACA eligibility in six states that expanded 2011-2013
 - New Medicaid eligibility in 2014 or 2015



Medicaid Eligibility: Adults



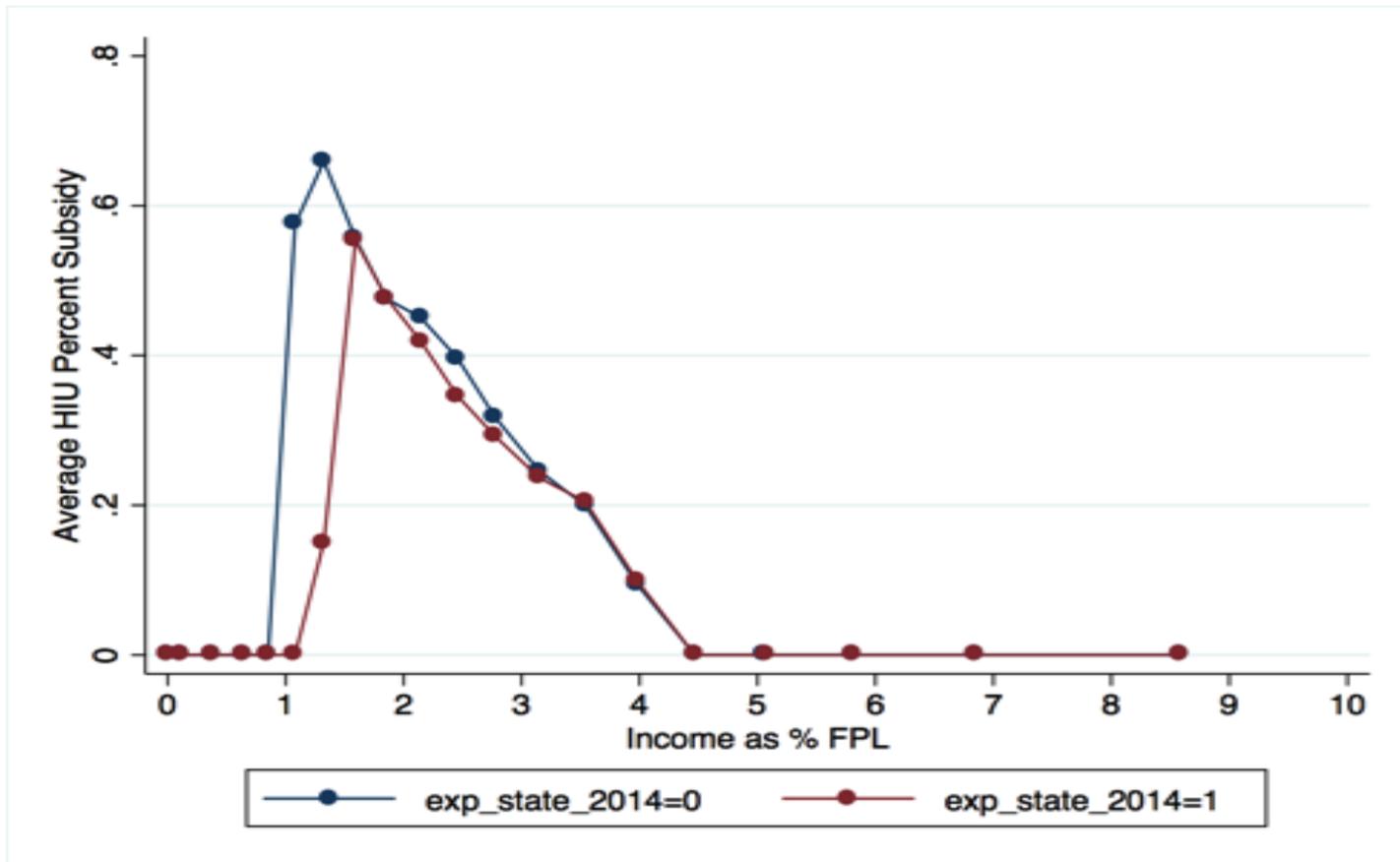


Policy Measures: Premiums

- **Marketplace premiums** by rating area from Robert Wood Johnson Foundation - mapped onto 2,350 ACS “public use microdata areas” (PUMAs):
 - Using 2nd-lowest cost silver plan in each rating area
 - Age-specific using CMS age-rating curves
 - Subsidy amount based on ACA provisions: family size, family income (between 100/138% and 400% FPL)
- We calculate percent subsidy (0-100%) for each household, which captures info on both costs and value of coverage



Policy Measures: Premiums



% Subsidy per Family

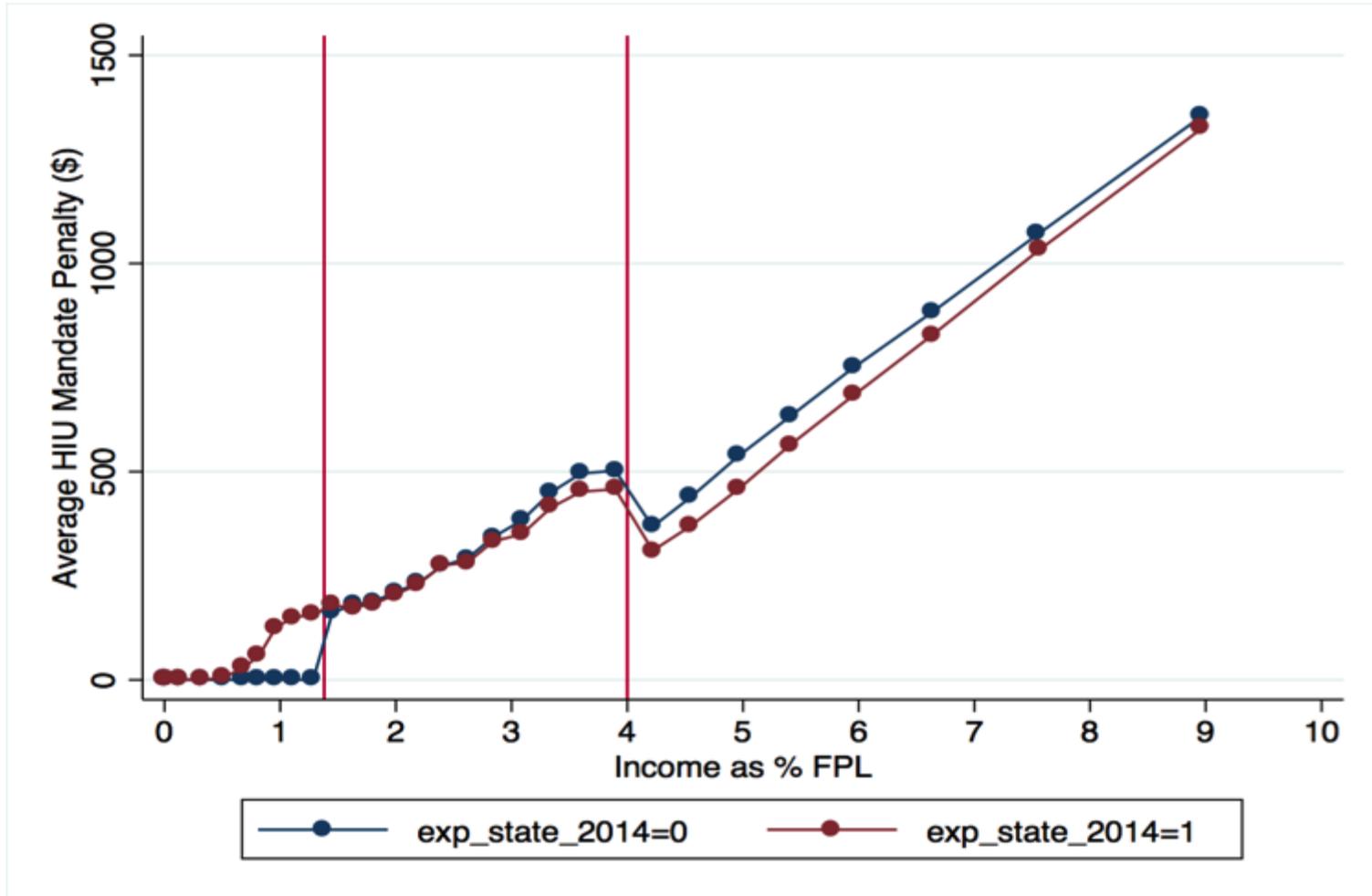


Policy Measures: Mandate

- **Exempt from Mandate (38%):**
 - Those below tax filing threshold (21% of sample)
 - Those in Medicaid gap in non-expansion states (6%)
 - Native Americans (1%)
 - Affordability exemption, based on lowest cost bronze plan > 8% of family income (10%)
- **Mandate Penalty for Non-Exempt (62%):**
 - 2014: \$95 per uninsured adult or 1% of taxable income, whichever is greater
 - 2015: \$325 per uninsured adult or 2% of taxable income
 - Capped at national average bronze premium



Policy Measures: Mandate





Regression Model

$$\begin{aligned} \%Uninsured_{ijt} = & \beta_0 + \Omega Area_j * Income_i * HIU_Type_i + \delta Year_t * HIU_Type_i \\ & + \pi AreaUnemploymentRate_{jt} + \beta_x X_{ijt} + \\ & + \beta_1 PercentSubsidy2014_{ij} * Yr2014_t \\ & + \beta_2 MandatePenalty2014_{ij} * Yr2014_t \\ & + \beta_3 McaidEligiblePreACA_{ij} * Yr2014_t \\ & + \beta_4 McaidEarlyExpansionEligible_{ij} * Yr2014_t \\ & + \beta_5 McaidNewlyEligible2014_{ij} * Yr2014_t \\ & + \beta_6 PercentSubsidy2015_{ij} * Yr2015_t \\ & + \beta_7 MandatePenalty2015_{ij} * Yr2015_t \\ & + \beta_8 McaidEligiblePreACA_{ij} * Yr2015_t \\ & + \beta_9 McaidEarlyExpansionEligible_{ij} * Yr2015_t \\ & + \beta_{10} McaidNewlyEligible2015_{ij} * Yr2015_t + \varepsilon_{ijt} \end{aligned}$$

Fixed effects & controls

2014 D-in-D-in-D estimators

2015 D-in-D-in-D estimators

- Fixed effects for Area * Income measure direct effect of the policy measures, and policy measures separately identify 2014 and 2015 effects
- Dep Vars: uninsured, Medicaid, ESI, non-group coverage



Results: Uninsured

Variable	2014 Effect	2015 Effect
Percent Subsidy	-0.051***	-0.089***
Family Mandate Penalty (\$100s)	0.0004***	0.0003**
Previously Medicaid-Eligible	-0.026***	-0.046***
Early Expansion Medicaid-Eligible	-0.107***	-0.197***
Newly Medicaid-Eligible	-0.089***	-0.137***

Notes: ***p<0.01, **p<0.05, *p<0.10

Models include demographic controls, state and year fixed effects, with robust SE clustered at PUMA level.



Decomposing the ACA's Policy Effects

Policy Variable	2015 DDD Effect	Population Mean	Implied Percentage Point Change	% of ACA-Related Change
Percent Subsidy	-0.089	0.161	-1.43%	40%
Family Mandate Penalty (\$100s)	0.0003	9.56	0.29%	N/A
Previously Medicaid-Eligible	-0.046	0.227	-1.04%	29%
Early Expansion Medicaid-Eligible	-0.197	0.019	-0.37%	10%
Newly Medicaid-Eligible	-0.137	0.055	-0.75%	21%



Results: Type of Coverage

Policy Variable, 2015	Uninsured	Medicaid / “State- Subsidized Coverage”	Employer Coverage	Non- Group Private
Percent Subsidy	-0.091***	0.040***	0.011***	0.048***
Family Mandate Penalty (\$100s)	0.0003***	-0.0001	-0.00004	-
Previously Medicaid-Eligible	-0.045***	0.038***	0.008***	0.005**
Early Expansion Medicaid-Eligible	-0.196***	0.210***	-0.000	-0.001
Newly Medicaid-Eligible	-0.137***	0.148***	0.002	0.002

Notes: ***p<0.01, **p<0.05, *p<0.10

Models include demographic controls, state and year fixed effects, with robust SE clustered at PUMA level.



Coverage: Implications

- 20% of ACA's 2014-2015 coverage gains due to new Medicaid expansion, and 10% due to "early expansions" in 2011-2013 in 6 states
- 30% due to "woodwork" effect
 - Streamlined application, navigators, and publicity (all states)
 - Includes ~1 million children
- No crowd-out from Medicaid once we model premium subsidies



Coverage: Implications

- 20% of ACA's 2014-2015 coverage gains due to new Medicaid expansion, and 10% due to “early expansions” in 2011-2013 in 6 states
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 - Streamlined application, navigators, and publicity (all states)
 - Includes ~1 million children
- No crowd-out from Medicaid once we model premium subsidies
- *Some have been using these results to suggest that ACA repeal won't be so bad*



ACA Repeal Not So Bad?

OPINION 11/27/2016 @ 11:14PM | 10,967 views

New Gruber Study Raises Major Questions About Obamacare's Medicaid Expansion



Brian Blase, Contributor



Anna Galland, Executive Director of MoveOn.org stands with supporters after a court session on April 2, 2014 in Baton Rouge, Louisiana. MoveOn pledges to continue medicaid fight after billboard ruling in Louisiana. (Tyler Kaufman/Getty Images for MoveOn)

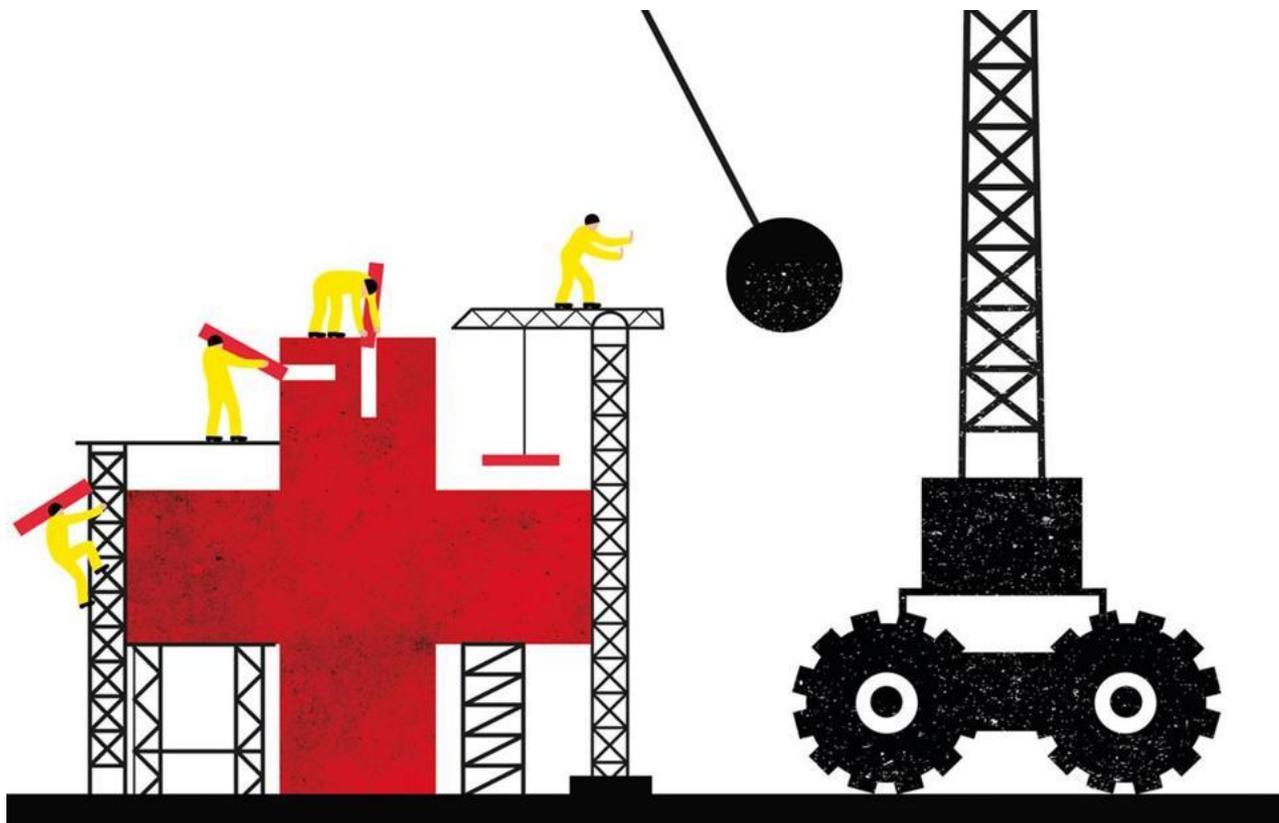
If Gruber's estimates are correct, then a far lower percentage of people added to Medicaid over the past three years were made eligible by the ACA than states are reporting to Washington. This means that the federal government has likely paid billions more each year than the law allows for the expansion population while states have spent billions less.

Repealing the Medicaid expansion would likely not result in nearly as much coverage loss as expected

A new [study](#) by Jonathan Gruber, one of the Affordable Care Act's (ACA) chief economic architects, suggests that roughly two-thirds of new Medicaid enrollees in 2014 were eligible for the program under previous state eligibility criteria—meaning that they were not made eligible by the ACA. If accurate, then a much smaller share of new Medicaid enrollees were made eligible for the program by the ACA than Washington experts commonly believe. For example, the Congressional Budget

OPINION | JONATHAN GRUBER AND BENJAMIN SOMMERS

Repealing the Affordable Care Act — fact vs. fiction

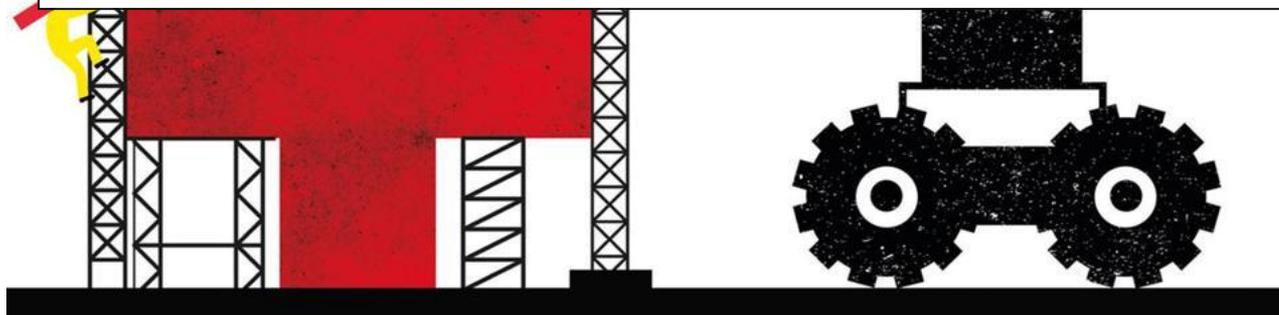


VERONICA GRECH FOR THE BOSTON GLOBE

By Jonathan Gruber and Benjamin Sommers | DECEMBER 08, 2016

Repealing the Affordable Care Act — fact vs. fiction

Critics of the law have recently used our results to argue that since only one-third of the Medicaid coverage gains arose from the new expansions, a repeal would have limited effects on overall coverage rates. This is wrong on many counts.



VERONICA GRECH FOR THE BOSTON GLOBE



Effects of Medicaid Expansion

- Basic study design: Diffs-in-diffs
- Expansion States vs. Non-Expansion
 - Some variability about treatment of early expanders or states like Massachusetts
- Variable Data Sources
 - Telephone Survey (AR, KY, TX)
 - Prescription Claims Data
 - Surgery Registry Data



Medicaid Expansion: *Better Access & Affordability*

Changes from 2013 to 2015 after Medicaid expansion in two states (KY and AR), compared to no expansion (TX)



Source: Commonwealth Fund, "In the Literature,"
Adapted from Sommers et al., *JAMA Int Med* 2016



Types of Health Care Use

Table 2. Changes in Coverage, Access to Care, Utilization, and Health after the ACA Medicaid Expansion^a

Outcome	Mean in Expansion States, 2013	Net Change After Expansion (Arkansas and Kentucky vs Texas) ^b			
		2014 Net Change, vs 2013 % (95% CI)	P Value	2015 Net Change, vs 2013 % (95% CI)	P Value
Any office visits in past year	55.5	2.5 (-3.4 to 8.4)	.41	3.0 (-3.8 to 9.7)	.38
Any ED visits in past year	21.0	-1.9 (-7.6 to 3.8)	.51	-6.0 (-11.7 to 0.3)	.04
No. office visits in past year	2.80	0.54 (-0.33 to 1.40)	.22	0.69 (0.05 to 1.33)	.04
No. ED visits in past year	1.16	-0.12 (-0.45 to 0.21)	.48	-0.09 (-0.45 to 0.27)	.62
Any hospitalization in past year	16.9	-1.5 (-6.8 to 3.7)	.57	2.1 (-3.1 to 7.3)	.43
ED is usual location of care ^c	9.6	-5.2 (-10.5 to 0.1)	.06	-6.1 (-10.1 to 2.2)	.003
Glucose check in past year	43.0	2.3 (-5.2 to 9.8)	.54	6.3 (0.0 to 12.6)	.05
Glucose check among those with diabetes ^f	86.2	4.3 (-7.5 to 16.1)	.47	10.7 (1.2 to 20.2)	.03
Regular care for chronic condition ^g	65.7	11.6 (2.0 to 21.2)	.02	12.0 (3.1 to 21.0)	.008

- *More office-based care, preventive care, and chronic disease management*
- *Less reliance on the Emergency Department*



Quality of Care and Health

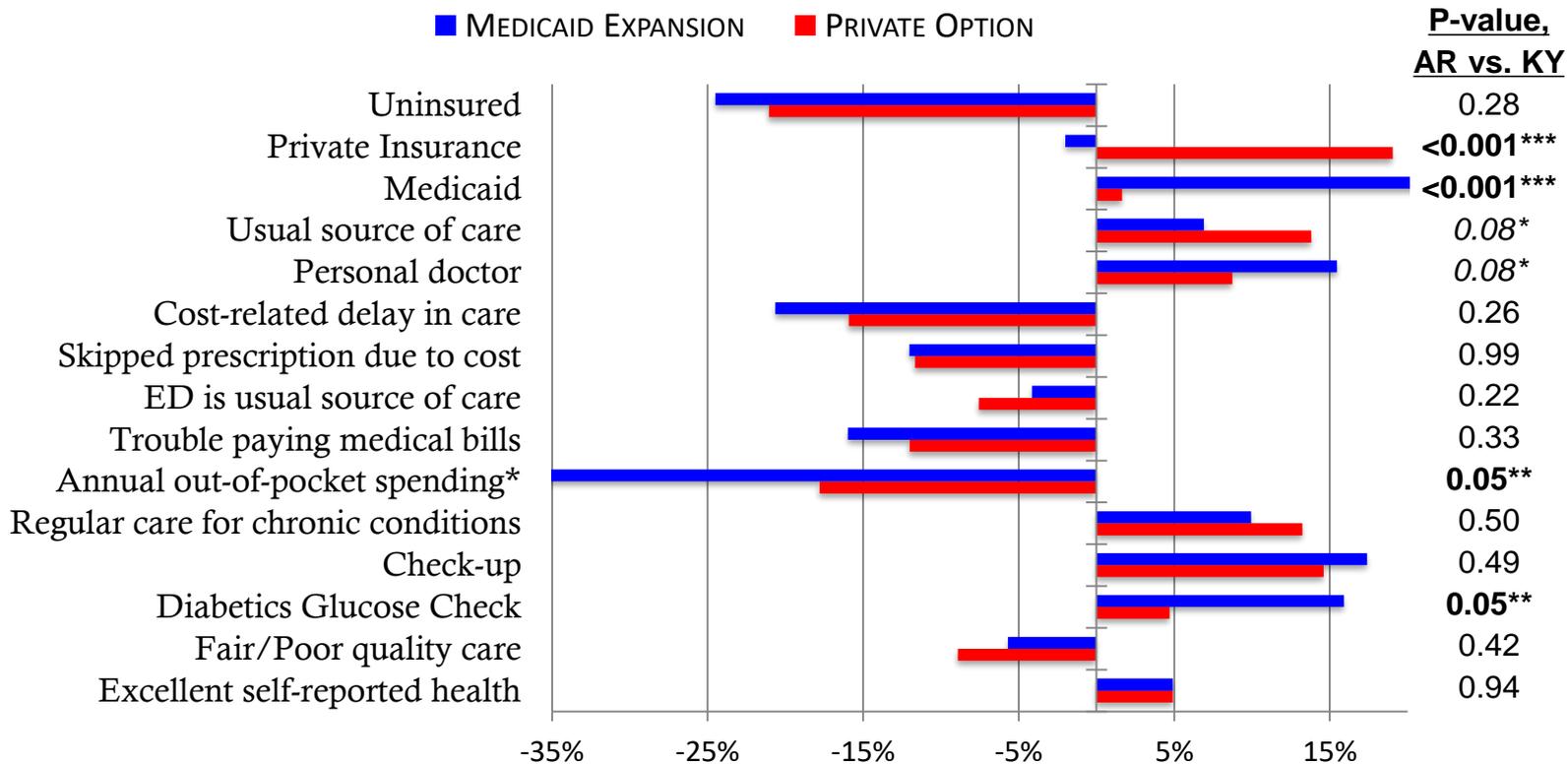
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		2014 Net Change, vs 2013 % (95% CI)	P Value	2015 Net Change, vs 2013 % (95% CI)	P Value
Excellent quality of care	28.1	-2.7 (-10.8 to 5.5)	.52	2.2 (-5.2 to 9.5)	.56
Fair/poor quality of care	19.9	-2.5 (-8.9 to 3.9)	.45	-7.1 (-13.6 to -0.6)	.03
Health status					
Excellent self-reported health	12.2	2.4 (-2.3 to 7.1)	.32	4.8 (0.3 to 9.3)	.04
Fair/poor self-reported health	39.6	0.9 (-6.7 to 8.4)	.82	-3.2 (-11.1 to 4.7)	.43
Positive depression screen, PHQ2 score ≥ 2	47.5	2.0 (-5.5 to 9.4)	.60	-6.9 (-14.6 to 0.8)	.08

Source: Sommers, Orav, Blendon, & Epstein, JAMA Internal Medicine, 2016



Private Option vs. Medicaid: *Both Beneficial, Few Differences*



Notes: Bars show difference-in-differences comparison, relative to non-expansion (Texas).

* Outcome is Log(Spending), with estimate reported as percent change. All other estimates are percentage-points.

Source: Sommers, Orav, Blendon, & Epstein, JAMA Internal Medicine, 2016

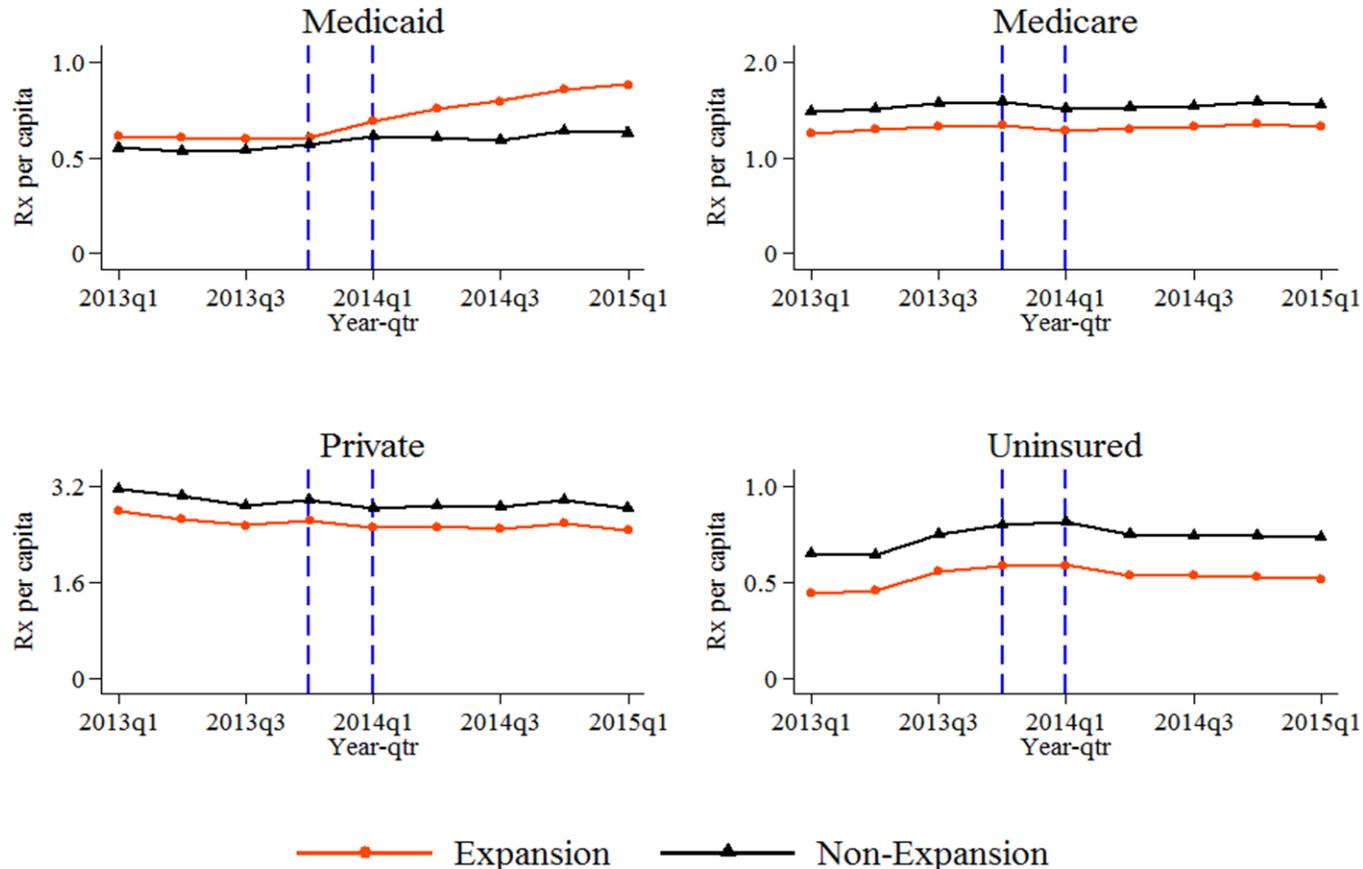


Medicaid Effects: Administrative Data

- Ongoing study analyzing administrative data and Medicaid expansion
- State-level prescription drug claims from a national claims aggregator
- Standard diffs-in-diffs with regression adjustment for demographics, clustered-standard errors, etc...



Medicaid Expansion: *Increased Prescription Drug Use*



Notes: "Rx per capita" is per non-elderly adult in the state (not just Medicaid beneficiaries).
Source: Ghosh, Simon, and Sommers 2017 NBER Working Paper



Prescription Drugs: *More for Chronic Conditions*

- Overall Effect: *19% increase* in Medicaid prescription drug utilization by mid-2015
- Largest Gains by Drug Class
 - Diabetes Medications: 24%
 - Birth Control: 22%
 - Cardiovascular Medications: 21%
 - Mental Health medications: 19%
 - Antibiotics: 17%



State Medicaid Costs

- ACA expansion covers newly-eligible at 100% FMAP until 2016, 90% in long-run
- Traditional Federal Medical Assistance Percentage (FMAP) range of 50-83% per state continues for those eligible by pre-ACA criteria
- GOP proposals would change all of this to a per capita allotment (and/or block grant) going forward



Data Source

- National Association of State Budget Officers (NASBO)
- Annual state expenditure reports, FY 2010-2015 (fiscal year is July-June for 46 states)
- Outcomes:
 - Total spending
 - Spending by funding source (state vs. federal)
 - Spending categories:
 - Medicaid, K-12 education, Higher education, Transportation, Corrections, Public Assistance, and Other



Statistical Analysis

- Log-spending as outcome
- State-Year level dataset (n=300), robust clustering at state level
- Adjusting for state-year unemployment and per capita income, from Bureau of Labor Statistics, year, and state fixed effects
- Accounts for timing of expansion for later-expanders

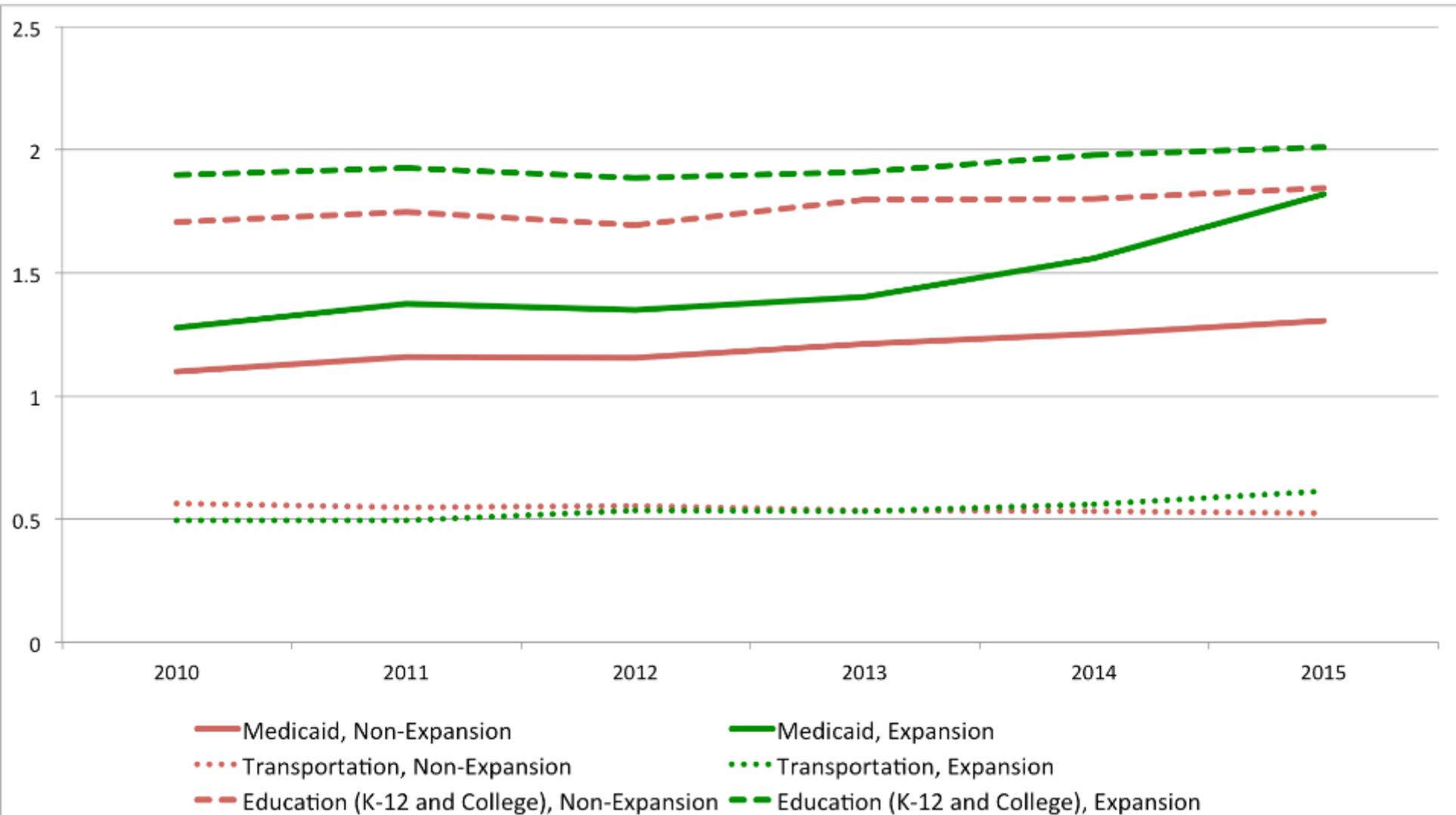


Additional Budget Models

- In addition to the simple D-in-D, we parameterized “Medicaid expansion” with *% newly eligible* – measures scope of the expansion in each state
- We also conducted a simultaneous model comparing predicted vs. actual costs for states submitting separate numbers (n=45)
 - Same as main model, but with 2 observations per state year, with a flag indicating “*Predicted*”
 - Test whether “*Medicaid Expansion * Actual*” coefficient = “*Medicaid Expansion * Predicted*”



Expansion Budget Effects





Budget Effects, FY 2010-2015

OUTCOME	MEDICAID EXPANSION EFFECT		% NEWLY-ELIGIBLE EFFECT	
	Percent Change from Expansion	p-value	Change per 1% Newly-Medicaid Eligible	p-value
Total Spending	5.8%	.002	0.32%	.048
<i>Source of Funds</i>				
Federal Funds	12.2%	.006	0.51%	.016
State Funds	2.4%	.24	0.17%	.32
--State General Revenue	2.9%	.35	-0.04%	.81
--Other State Funds	3.1%	.54	0.39%	.28
<i>Category of Spending</i>				
Medicaid	11.7%	<0.001	0.86%	<0.001
K-12 Education	-0.9%	.76	-0.08%	.70
Higher Education	-5.0%	.25	-0.66%	.15
Transportation	8.0%	.062	0.42%	.20
Corrections	-0.4%	.88	-0.17%	.35
Public Assistance	3.6%	.60	-0.21%	.67
Other	10.1%	.057	0.62%	.13

Source: Sommers & Gruber, Health Aff 2017



Budget: Predicted vs. Actual

OUTCOME	PERCENT CHANGE FROM EXPANSION		Difference (Actual – Projected)	p-value for Difference
	Projected Spending	Actual Spending		
Total Spending	6.1%	6.9%	0.8%	0.64
<i>Source of Funds</i>				
Federal Funds	17.0%	13.5%	-3.5%	0.42
Spending from Bonds	0.1%	31.8%	31.7%	0.18
State Funds	1.0%	3.6%	2.6%	0.30
--State General Revenue	3.3%	3.5%	0.2%	0.90
--Other State Funds	0.5%	4.3%	3.8%	0.43
<i>Category of Spending</i>				
Medicaid	9.7%	12.6%	2.9%	0.31
K-12 Education	-1.0%	-1.0%	0.0%	0.98
Higher Education	-10.1%	-5.1%	5.0%	0.15
Transportation	12.3%	9.4%	-2.9%	0.34
Corrections	1.1%	-0.2%	-1.3%	0.75
Public Assistance	2.5%	3.8%	1.3%	0.93
Other	11.3%	11.3%	0.0%	0.99

Source: Sommers & Gruber, Health Aff 2017



Budget Implications

- Through the first 18 months of expansion, large increases in Medicaid spending in expansion states that was almost entirely from federal funds
- No significant change in spending from state funds
 - Reconciling this with woodwork effect: It doesn't depend on the expansion decision
- No crowding out of non-Medicaid spending by states
- Predictions were reasonably accurate in the aggregate, though of course individual states varied – error rates for Medicaid ranged from -26% to +46%.



Summary of Findings

- ACA has produced historic drop in the uninsured rate, ~60% of it via Medicaid
- Medicaid expansion – both public and “private option” – has improved access for chronic conditions, quality of care, and self-reported health
- Medicaid expansion has increased drug treatment rates for diabetes, heart disease, mental illness
- Costs of expansion so far have been paid by fed gov’t, without significant state increases or squeezing out of other state priorities



So What's Next for Medicaid?

- GOP “Better Way” Proposal, partially adapted to recent AHCA:
 - States get a choice between block grants and per capita allotment instead of current match-rate system
 - Caps federal commitment to Medicaid and gives states much more autonomy
- What are the basic economics of these proposals?



The Devil in the Details

- **2 Key Choices:**
 1. How much do states get in their allotment?
 2. How will that allotment change over time?



The Devil in the Details

- **2 Key Choices:**
 1. **How much do states get in their allotment?**
 2. How will that allotment change over time?
- GOP block grant proposal eliminates Medicaid expansion funding entirely from baseline allotment
- Per capita allotment grandfathers in expansion states as of Jan. 2016, but scales FMAP down from 90% to old rate (50-75%) for anyone who has not been continuously enrolled prior to 2019.

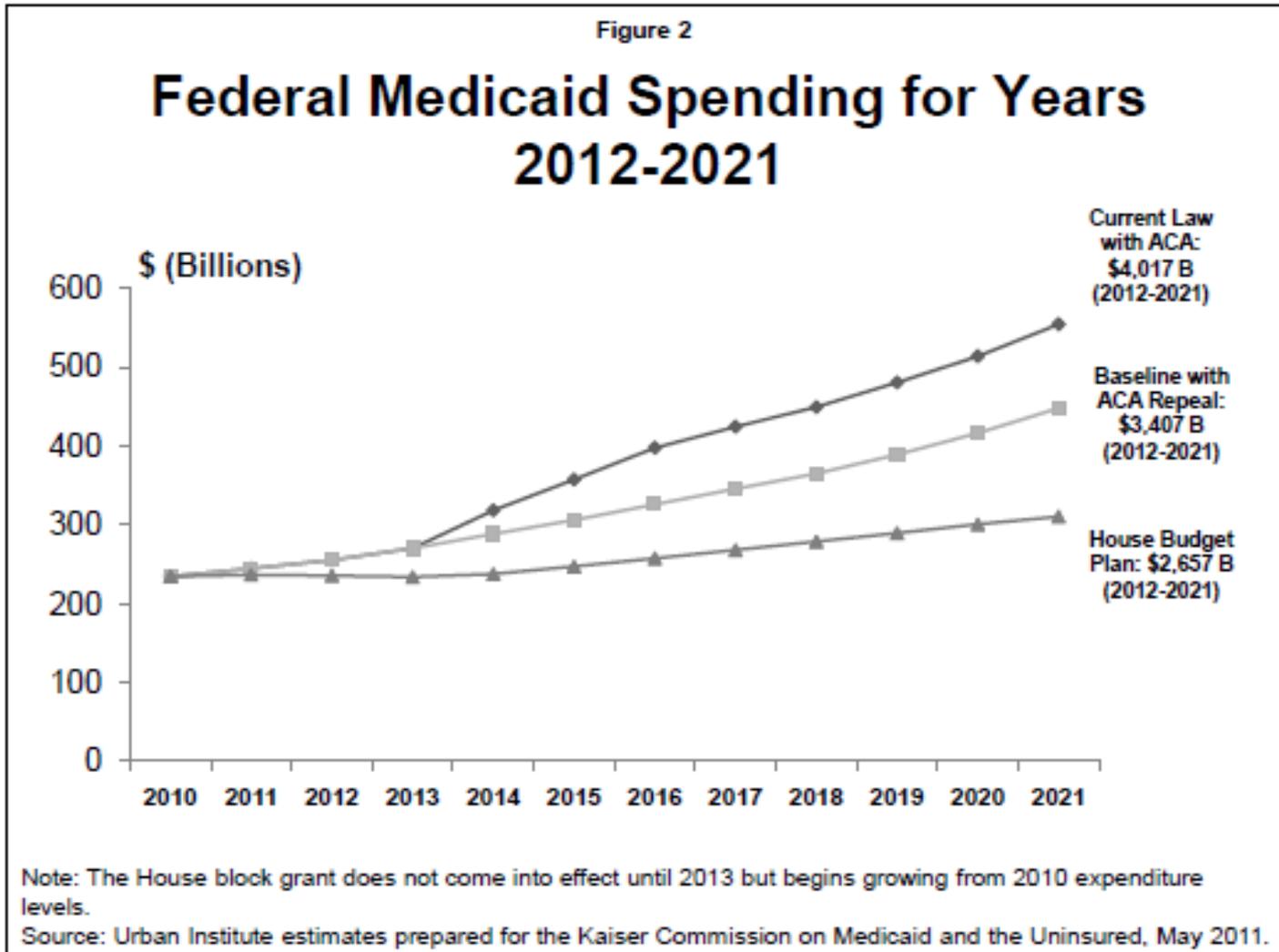


The Devil in the Details

- **2 Key Choices:**
 1. How much do states get in their allotment?
 2. **How will that allotment change over time?**
- Ryan plan ties the allotment growth to inflation and population growth; AHCA suggests medical inflation
- Historically, health care costs always outpace inflation, and generally medical inflation too (though by a smaller margin)



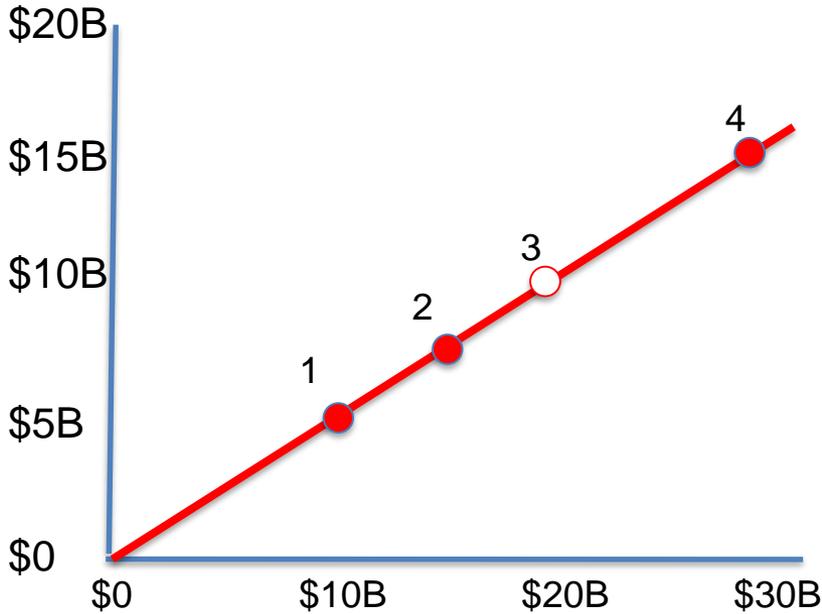
The Devil in the Details





State Spending

FMAP (50% Match)

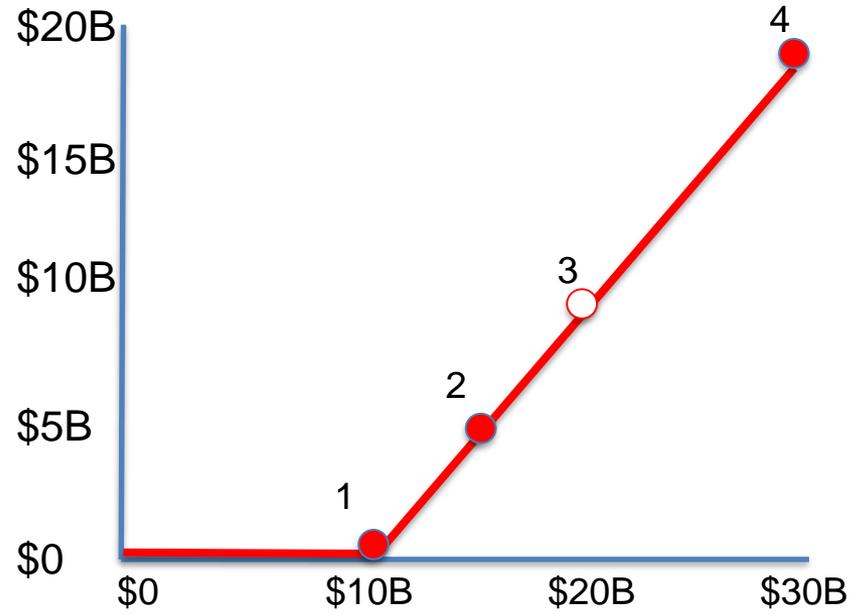


TOTAL Medicaid Spending

- 1) Spend \$5B for a \$10B program
- 2) Spend \$7.5B for a \$15B program
- 3) Spend \$10B for a \$20B program
- 4) Spend \$15B for a \$30B program

Block Grant (\$10B)

State Spending



TOTAL Medicaid Spending

- 1) Spend \$0 for a \$10B program
- 2) Spend \$5B for a \$15B program
- 3) Spend \$10B for a \$20B program
- 4) Spend \$20B for a \$30B program



What Happens?

- So for three reasons, Medicaid spending will contract significantly:
 - Medicaid expansion dollars shrink or go away entirely
 - Health care costs far exceed the growth in federal funding
 - States have no obligation to spend any of their own money in order to receive federal Medicaid dollars



What Happens?

- So for three reasons, Medicaid spending will contract significantly:
 - Medicaid expansion dollars shrink or go away entirely
 - Health care costs far exceed the growth in federal funding
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BOTTOM LINE:

- Block grants will likely produce large reductions in Medicaid eligibility (i.e. enrollment), covered benefits, or provider payment rates – and likely all three.
- Per capita allotment would put less pressure on eligibility, but likely still produce the other effects.



What Happens?

Mike Keefe THE DENVER POST 04/20/07



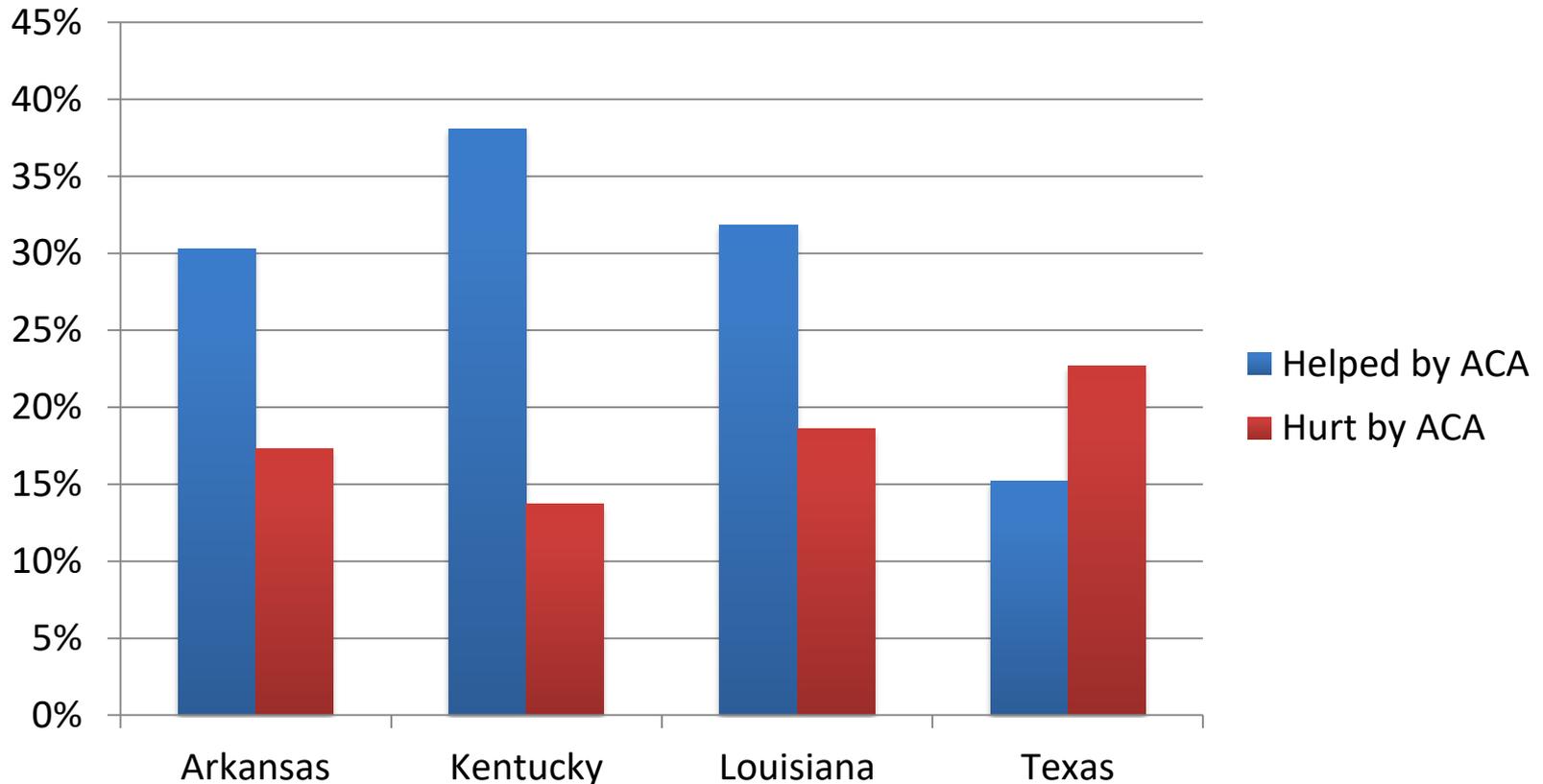


ACA Repeal – Dead or Alive?

- Unclear if House majority has time and ability to get a bill passed... *But this was never the hard part!*
- Higher hurdle is whether GOP could get 51 votes in the Senate for a repeal.
- Medicaid expansion has been a more bipartisan effort than other parts of the law:
 - 14 states with current GOP governors expanded Medicaid
 - 13 states that voted for Trump have expanded, with a 4.2 million increase in Medicaid enrollment since 2013
 - National Governors’ Association: “strong bipartisan consensus” for maintaining federal funding to states



Red States and Repeal



1,570 adults 19-64 with incomes < 138% of poverty were asked in Nov-Dec 2016: *“So far, would you say the health care law has directly helped you, directly hurt you, or has it not had a direct impact?”* **Source:** Sommers & Epstein, NEJM 2017



Questions & Comments?

Thanks for having me!

Ben Sommers

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