ACA and Medicaid: Current Landscape and Future Outlook

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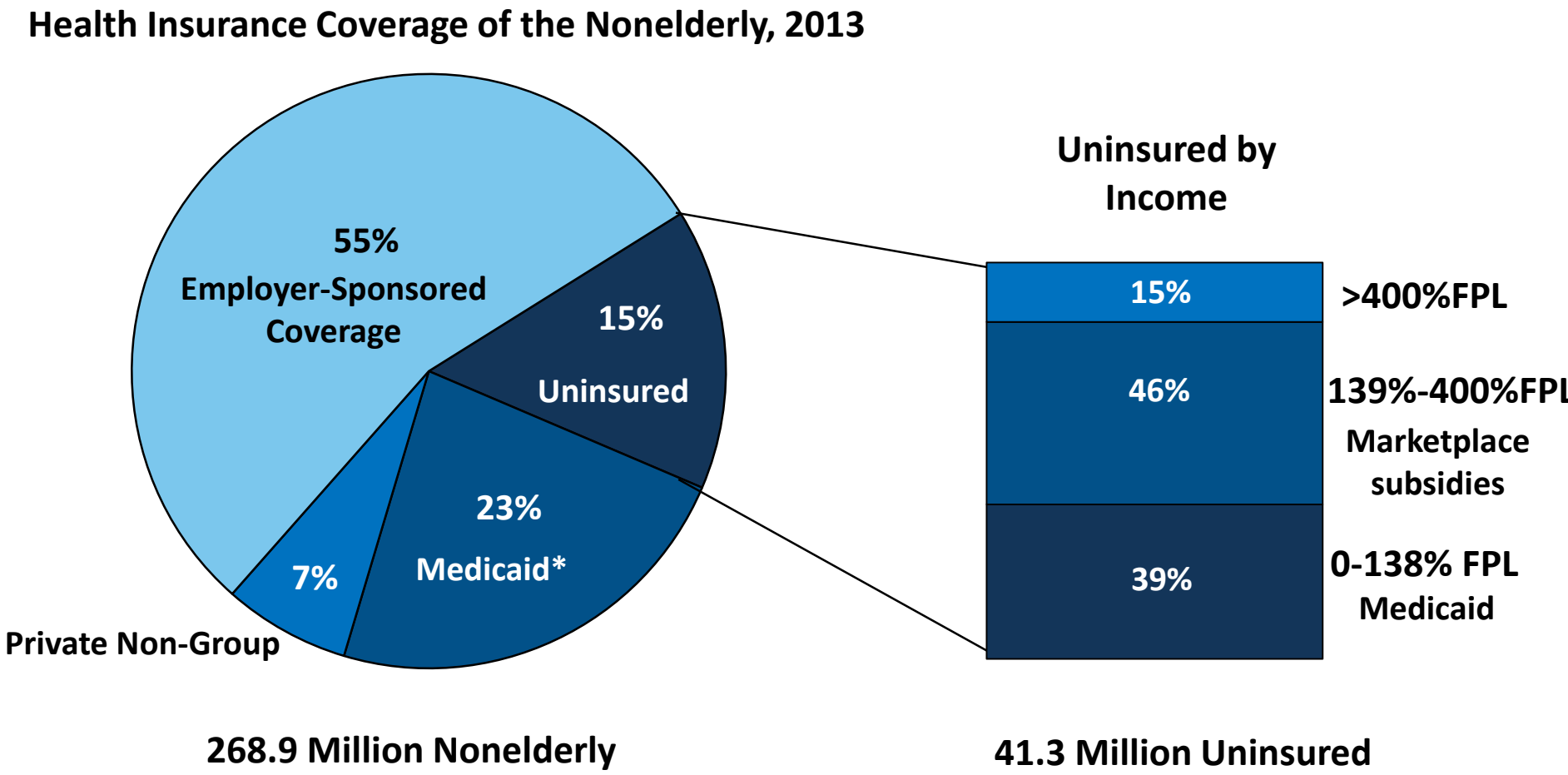
Figure 1

The ACA broadened health coverage through Marketplace subsidies and Medicaid.



*Medicaid also includes other public programs: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of three in 2013 was $19,530.
Numbers may not add to 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2014 ASEC Supplement to the CPS.

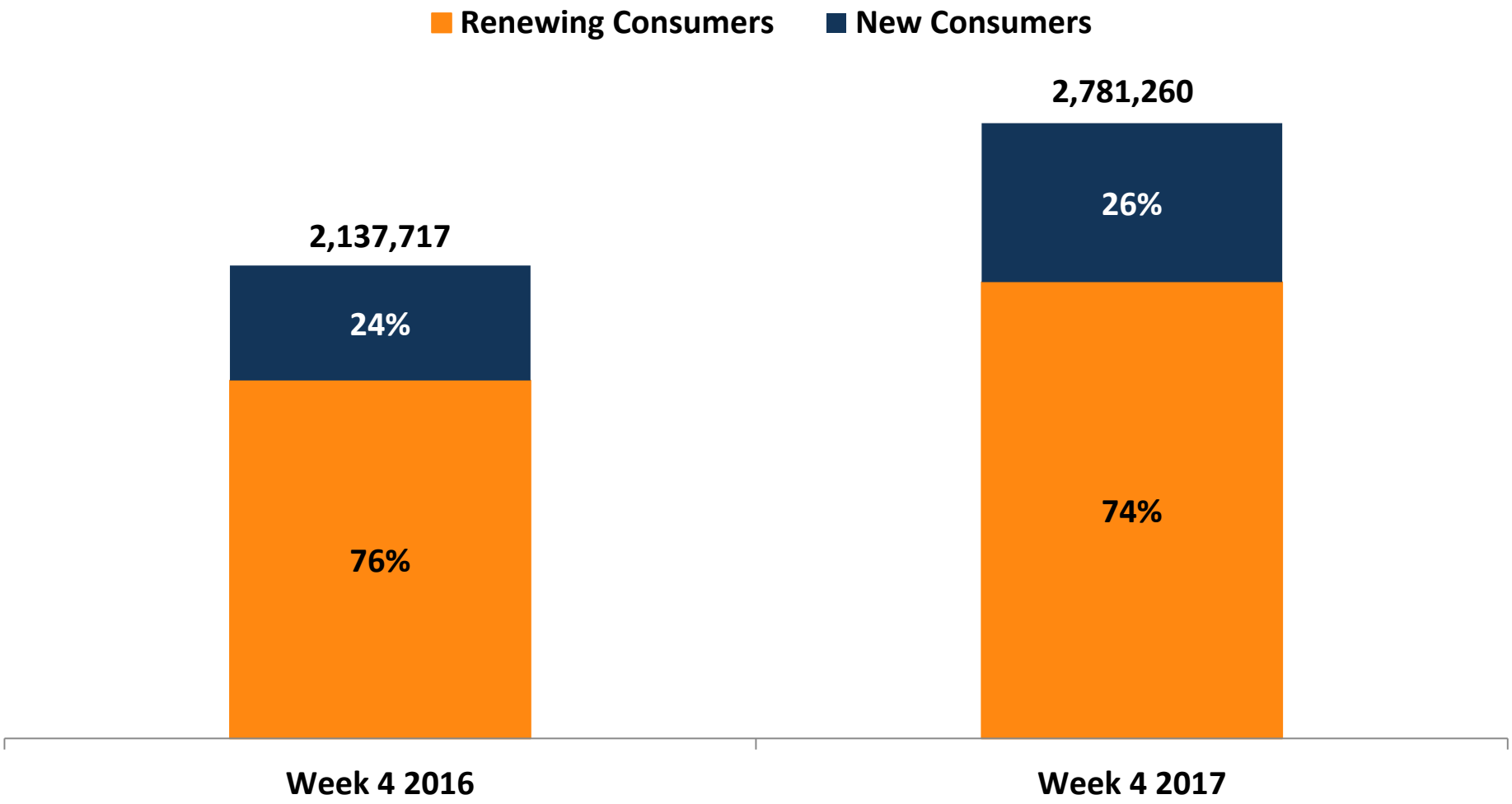
Figure 2

Events over the past year have created uncertainty over the future of ACA and Medicaid coverage.

- Debate over Affordable Care Act repeal ended with no legislation enacted, but efforts may continue
- Changes to open enrollment and resources for outreach and consumer assistance may suppress enrollment in the marketplaces
  - 2018 Open Enrollment shortened to 6 weeks in many states
  - 90% reduction in federal funding for advertising
  - 41% reduction in federal navigator grants; varying effects by states and programs
- Termination of cost-sharing reduction (CSR) payments to insurers contributing to marketplace premium increases
- Recent Medicaid guidance signals a shift in view of Medicaid's role

Figure 3

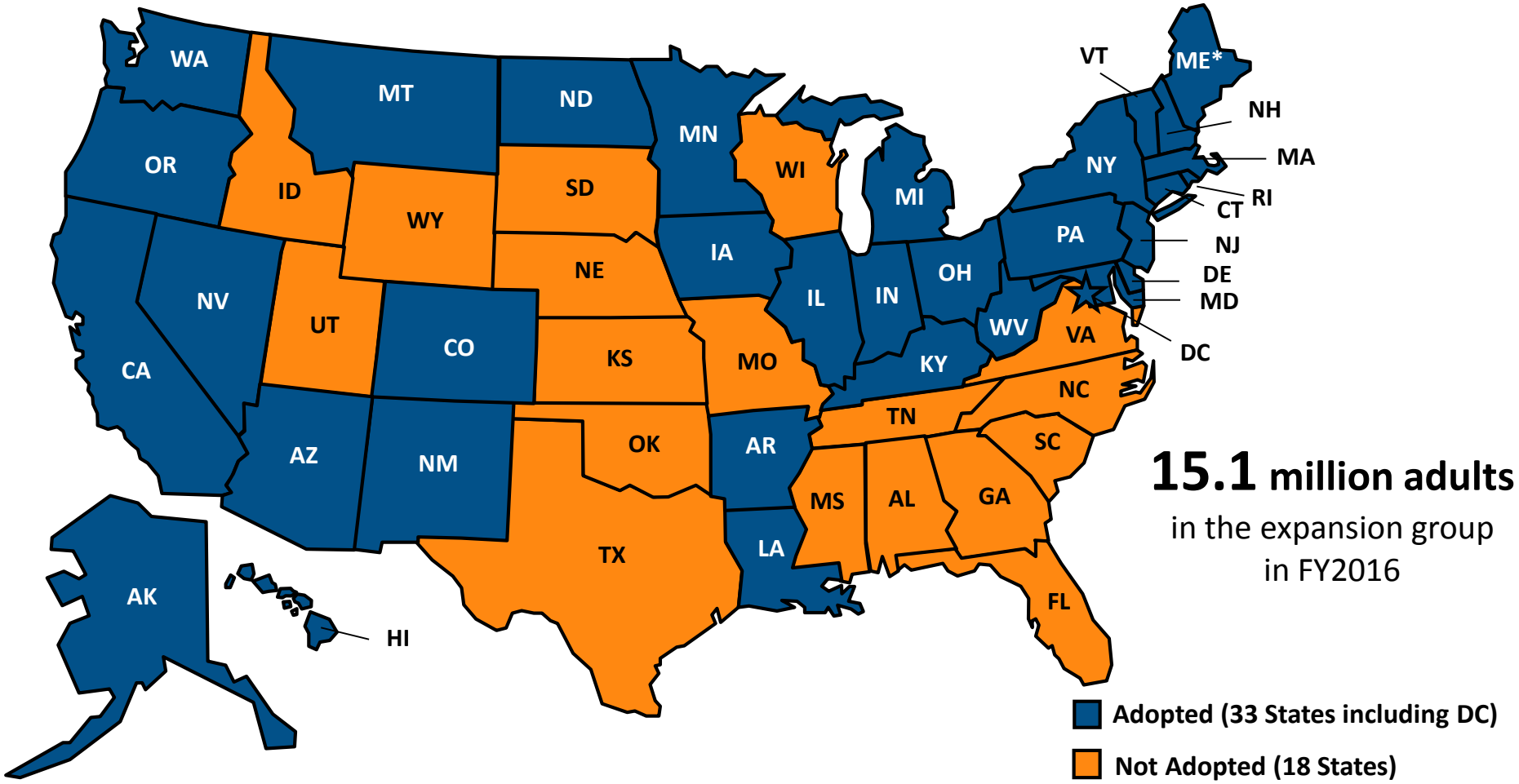
Signups in 2017 are outpacing 2016, but will it be enough?



SOURCE: CMS, Weekly Enrollment Snapshots

Figure 4

33 states including DC have expanded Medicaid through the ACA.



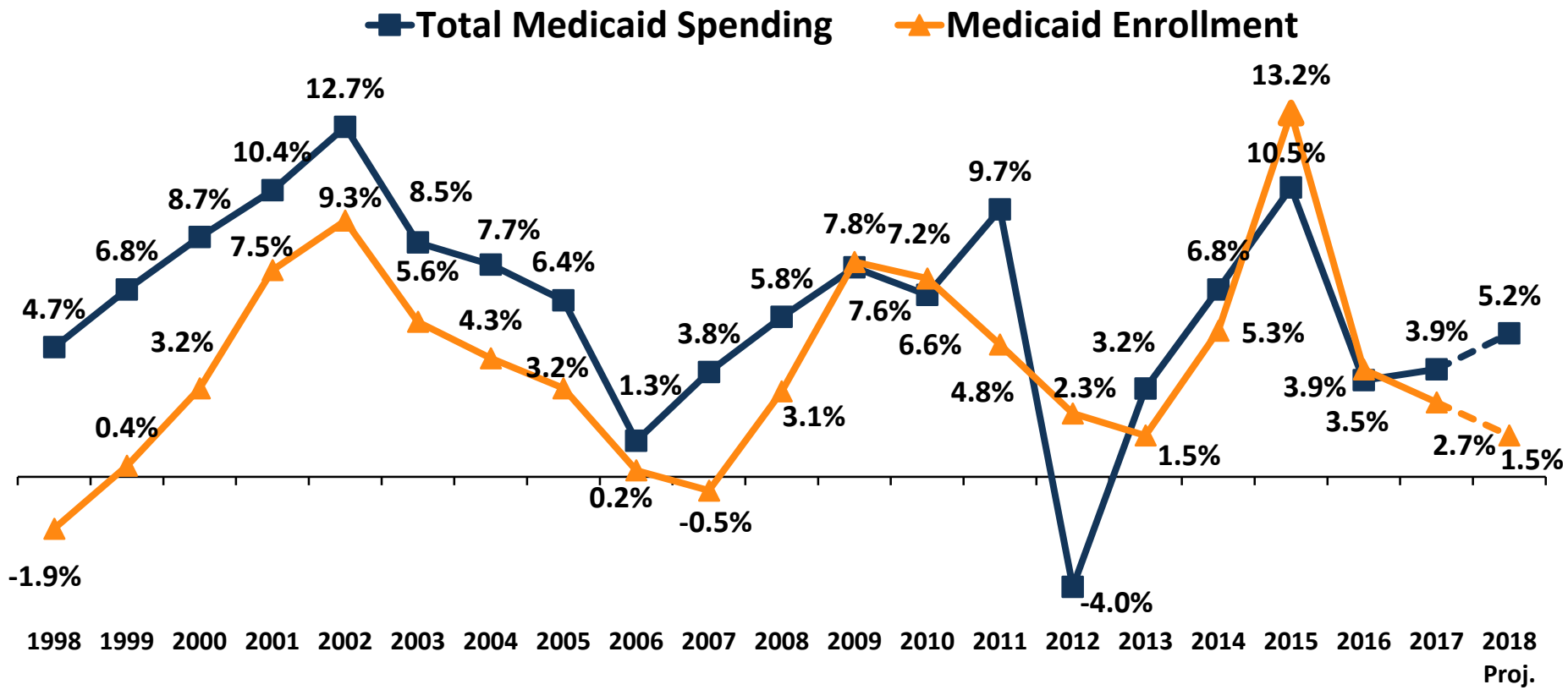
NOTES: Current status for each state is based on KFF tracking and analysis of state executive activity. *ME adopted the Medicaid expansion through a ballot initiative in November 2017, but has not yet been implemented. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated November 8, 2017. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Figure 5

Medicaid enrollment continues to slow in FY 2017 and FY 2018; however, states project an uptick in spending in FY 2018.

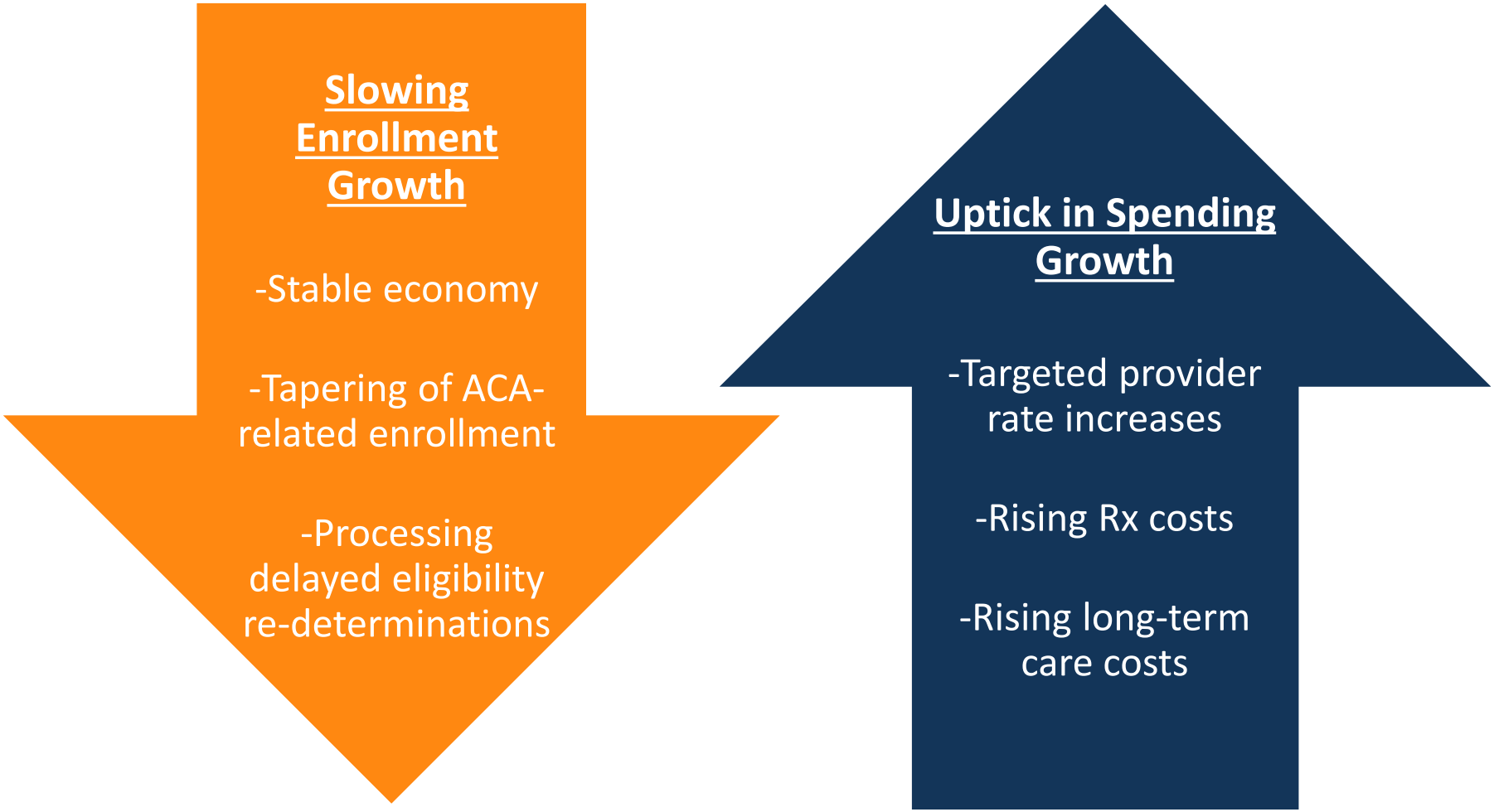
Annual Percentage Changes, FY 1998 – FY 2018



NOTE: For FY 1998-2013, enrollment percentage changes are from June to June of each year. FY 2014-2017 reflects growth in average monthly enrollment. Spending growth percentages refer to state fiscal year. FY 2018 data are projections based on enacted budgets.
SOURCE: Enrollment growth rates for FY 1998-2013 are as reported in *Medicaid Enrollment June 2013 Data Snapshot*, KCMU, January 2014. FY 2014-2017 are based on KFF analysis of CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports, accessed September 2017. Historic Medicaid spending growth rates are derived from KCMU Analysis of CMS Form 64 Data. FY 2017-2018 data are derived from the KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2017.

Figure 6

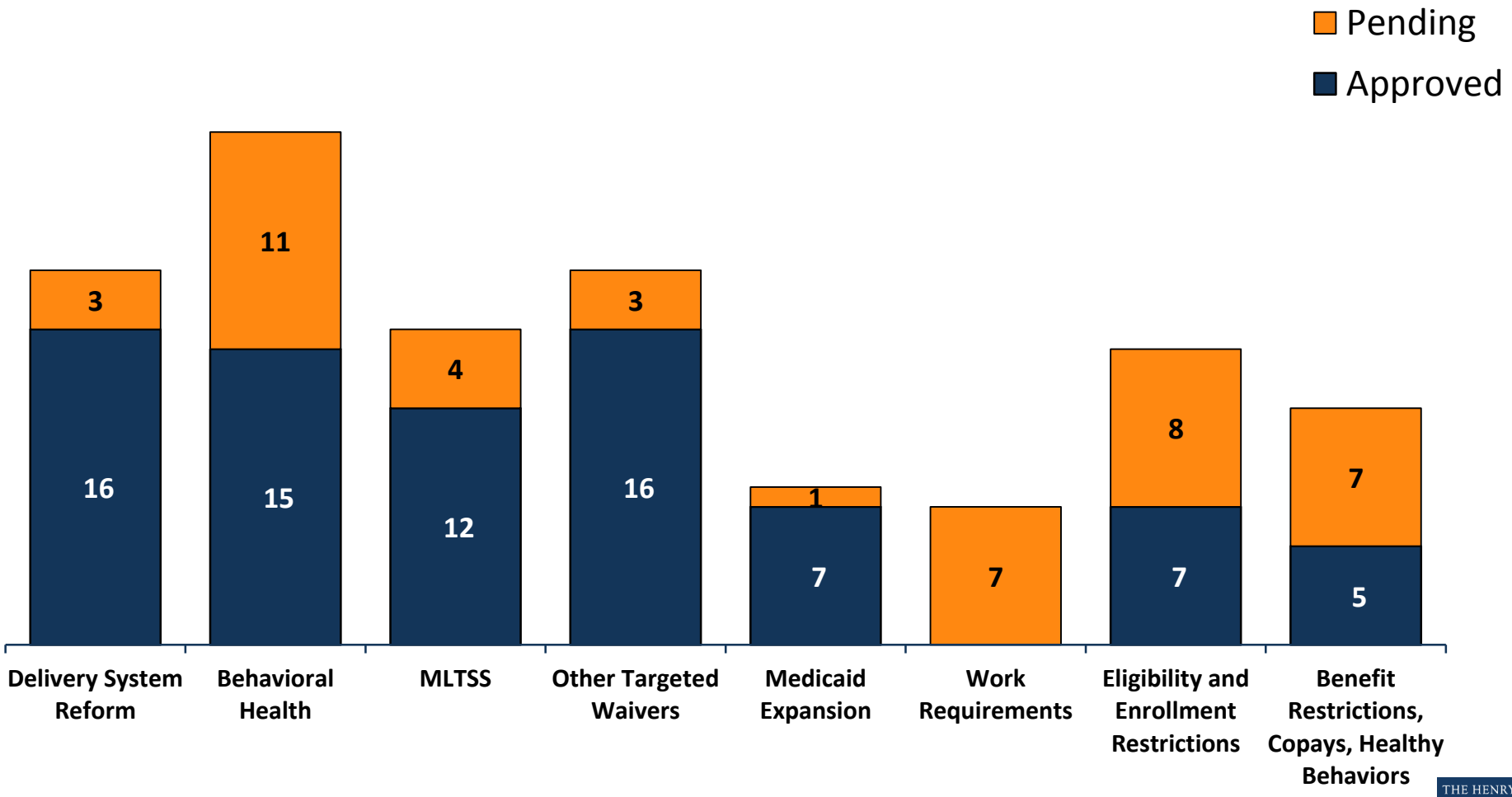
For FY 2018, states project that a number of factors will contribute to slowing Medicaid enrollment growth and an uptick in spending growth.



SOURCE: Kaiser Family Foundation survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2017.

Figure 7

There are 42 approved Medicaid waivers in 34 states and 22 pending waivers in 20 states as of November 2017.



NOTE: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas.

Figure 8

New waiver approval criteria does not focus on coverage and quality.

2015 Waiver Approval Criteria:

- **Increase and strengthen overall coverage** of low-income individuals in the state;
- Increase access to, stabilize and strengthen providers and **provider networks** available to serve Medicaid and low-income populations in the state;
- Improve **health outcomes** for Medicaid and other low-income populations in the state, or
- **Increase the efficiency** and **quality of care** for Medicaid and other low-income populations through invitations to transform service delivery networks.

New Criteria: November 2017

- **Improve access** to high-quality, person-centered services that produce positive **health outcomes** for individuals;
- **Promote efficiencies** that ensure Medicaid's sustainability for beneficiaries over the long term;
- Support coordinated **strategies to address certain health determinants** that promote upward mobility, greater independence, and improved quality of life among individuals;
- **Strengthen beneficiary engagement** in their personal healthcare plan, including incentive structures that promote responsible decision-making;
- **Enhance alignment between Medicaid policies and commercial health insurance** products to facilitate smoother beneficiary transition; and
- Advance innovative delivery system and payment models to strengthen provider **network capacity** and drive greater value for Medicaid.

Figure 9

Medicaid block grants or per capita caps are designed to cap federal spending.

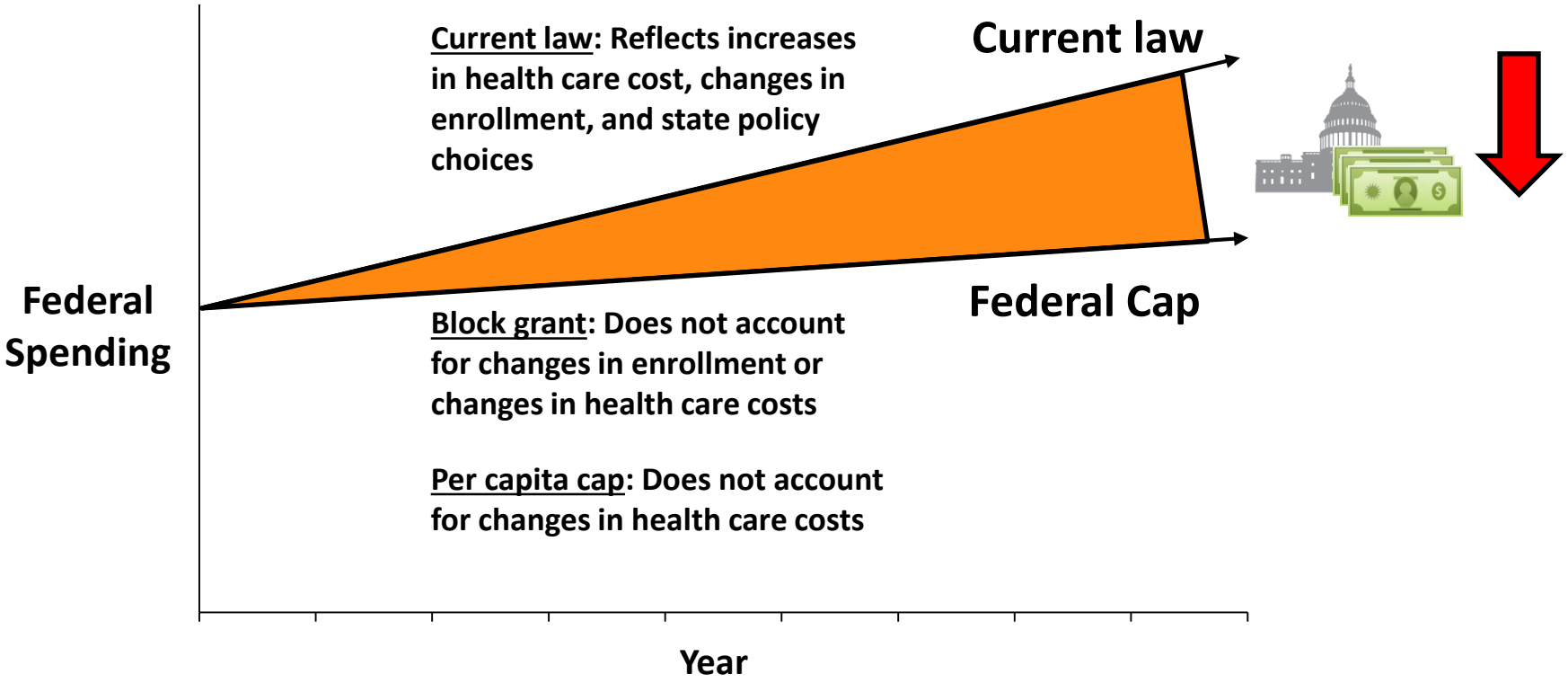
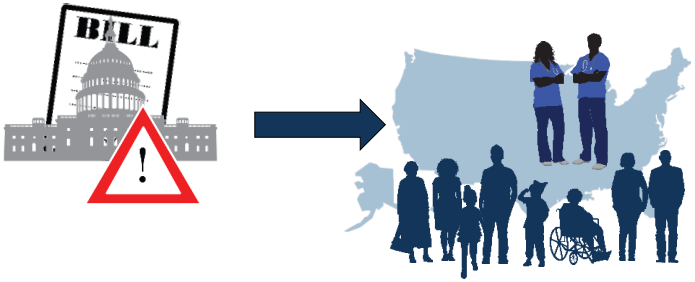


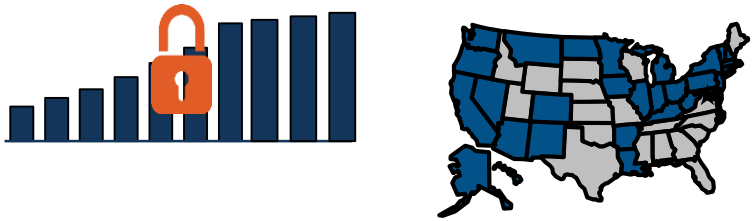
Figure 10

Reducing and capping federal Medicaid funds could:

- Shift costs and risks to states, beneficiaries, and providers if states restrict eligibility, benefits, and provider payment



- Lock in past spending patterns
  - If expansion funding is cut, the impact could be even greater for the states that expanded Medicaid



- Limit states' ability to respond to rising health care costs, increases in enrollment due to a recession, or a public health emergency such as the opioid epidemic, HIV, Zika, etc.

Figure 11

Key Medicaid challenges in FY 2018 and beyond:

- What is the trajectory for Medicaid enrollment and spending? Will demographics and health care costs continue to put pressure on Medicaid spending?
- How and when will Congress reauthorize CHIP?
- Will Congress renew debate on Medicaid financing?
  - For the expansion?
  - For the whole program through a per capita cap or block grant?
- With significant uncertainty about Medicaid at the federal level, will states continue to invest in payment and delivery system reforms that may require upfront investments but yield longer-term savings?
- How will new flexibility through waivers affect Medicaid costs?