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Monday Morning Medicaid Must Reads

Helping you consider differing viewpoints. Before it's illegal.

January 7th, 2019

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In this issue...

Article 1: *Healthy and Working: Benefits of Work Requirements for Medicaid Recipients, Buckeye Institute*, December 2018

Clay's summary: Beware the red pill.

Key Excerpts from the Article:

Extending Medicaid benefits to individuals who are able to work may reduce their lifetime earnings over the long-term and adversely affect their consumption patterns in the short-term. Although households may benefit in the short-term from Medicaid coverage through little- or no-cost health care, the ACA's Medicaid expansion does not promote individual long-term earnings growth or wealth accumulation. Workers have less incentive to invest in their human capital than if they were required to work in order to receive benefits.

To address this concern, states that have participated in the ACA's Medicaid expansion are now considering—or have already begun to impose—work requirements for some new Medicaid enrollees. Work and "community engagement" requirements, such as education and job training, tend to keep benefits recipients participating in the work force, helping them to gain valuable work experience and generate higher earnings and income over the long-term.
Using publicly available economic data, this report reveals the potential impact of imposing work requirements on healthy, single individuals with no children. We study how eligibility work requirements may affect the lifetime earnings of some Medicaid enrollees and find that Medicaid work requirements could:

** • Increase lifetime earnings by $212,694 for women and $323,539 for men—even assuming that the individual remains on Medicaid for their entire working life; and*

** • Raise the hours worked per week by 22 hours for women (from 12 hours to 34 hours per week), and by 25 hours for men (from 13 hours to 38 hours per week), bringing Medicaid recipients well above the typical 20 hours per week requirement.*

We also find that the financial prospects look even brighter for individuals who transition off of Medicaid; they may earn close to $1 million more over the course of their working years.

Requiring labor force participation for benefits eligibility creates an incentive for individuals to increase human capital investment through the labor market. We show that there is a significant potential economic benefit for those able-bodied adults who would change their work effort in response to a work requirement for Medicaid eligibility.

Read full article in packet or at links provided

Article 2: *State Trends and Analysis*, Pew Trusts, November 2018

Clay's summary: Turns out you do have to choose between healthcare and education. Until we find where the unicorns are hiding the magic wands, that is.

Key Excerpts from the Article:

Medicaid's claim on each revenue dollar affects the share of state resources available for other priorities, such as education, transportation, and public safety. Because Medicaid is an entitlement program, states must provide certain federally required benefits for any eligible enrollee, even during times of sluggish revenue growth. So policymakers have less control over growth in states' Medicaid costs than they do with many other programs.

Read full article in packet or at links provided

Article 3: *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, KFF, October 2018

Clay's summary: The potential safety net costs for newly arriving Americans may be getting more attention if the rule is passed.

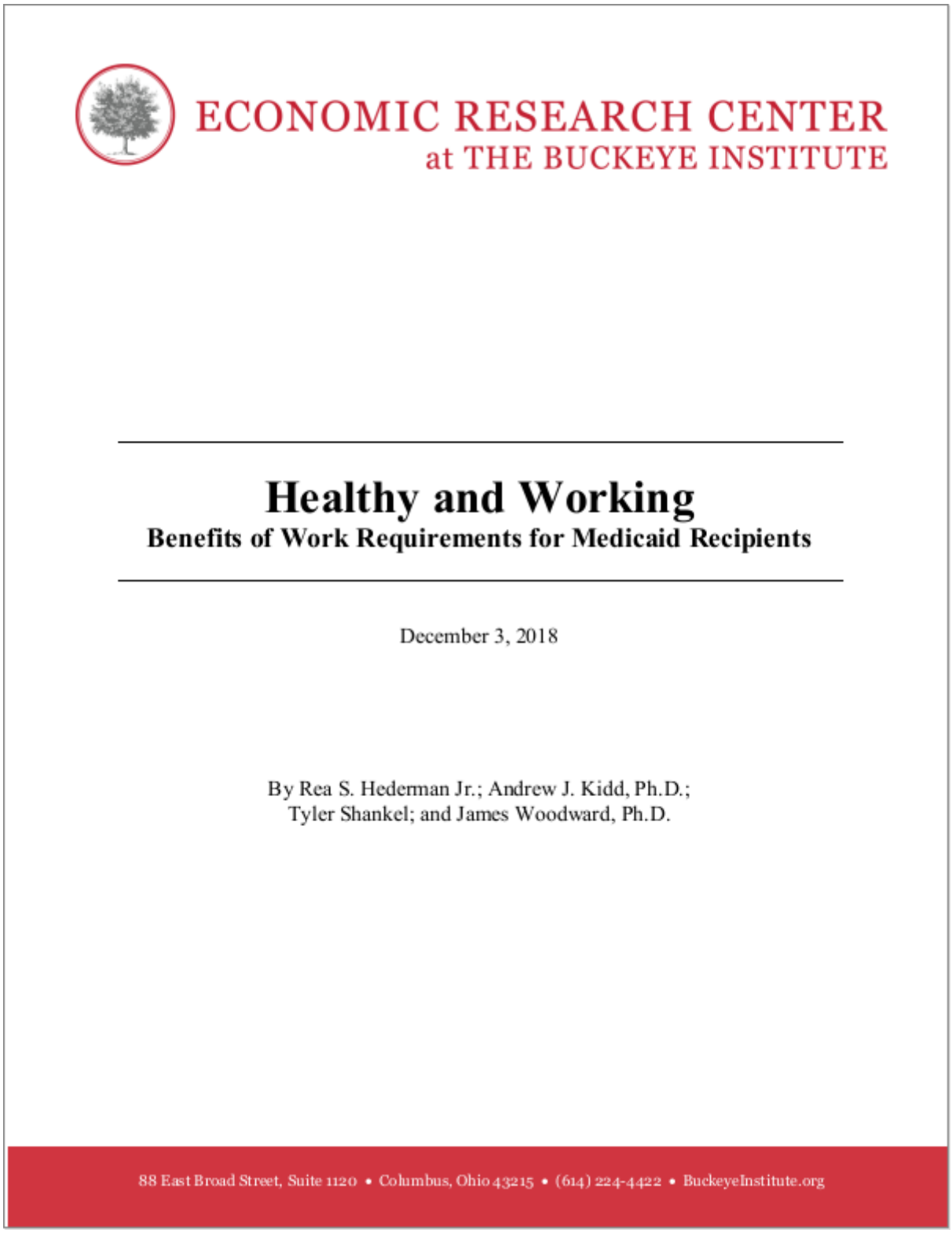
Key Excerpts from the Article:

On October 10, 2018, the Trump administration released a proposed rule to change "public charge" policies that govern how the use of public benefits may affect individuals' ability to obtain legal permanent resident (LPR) status. The proposed rule would expand the programs that the federal government would consider in public charge determinations to include previously excluded health, nutrition, and housing programs, including Medicaid. It also identifies characteristics DHS could consider as negative factors that would increase the likelihood of someone becoming a public charge, including having income below 125%

of the federal poverty level (FPL) ($25,975 for a family of three as of 2018). This analysis provides new estimates of the rule's potential impacts. Using 2014 Survey of Income and Program Participation data, it examines the (1) share of noncitizens who originally entered the U.S. without LPR status who have characteristics that DHS could potentially weigh negatively in a public charge determination and (2) number of individuals who would disenroll from Medicaid under different scenarios:
Nearly all (94%) noncitizens who originally entered the U.S. without LPR status have at least one characteristic that DHS could potentially weigh negatively in a public charge determination. Over four in ten (42%) have characteristics that DHS could consider a heavily weighted negative factor and over one-third (34%) have income below the new 125% FPL threshold.

Read full article in packet or at links provided

SourceURL: https://www.buckeyeinstitute.org/library/docLib/2018-12-03-Healthy-and-Working-Benefits-of-Work-Requirements-for-Medicaid-Recipients-policy-report.pdf



SourceURL: https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2014/fiscal-50?utm_campaign=2018-11-05+SW&utm_medium=email&utm_source=Pew#ind7

State Trends and Analysis

Every state spent a larger share of its own dollars on Medicaid in 2016 than in 2000, and percentages in 18 states reached a new high. The increases varied widely, however, from less than 1 cent more per state-generated dollar in Hawaii and New York to nearly 14 cents more in Louisiana.

Medicaid is most states' biggest expense after K-12 education. States and the federal government share costs for the safety-net program, which provides medical coverage for eligible groups of children, adults, people with disabilities, and the elderly.

The costs borne by states surged in the wake of the Great Recession, after the expiration of federal economic stimulus dollars that had helped cover a spike in Medicaid enrollment during the downturn. As a share of own-source revenue, states' collective costs have plateaued at roughly 17 cents of each revenue dollar since 2012, even with the Affordable Care Act's (ACA) optional expansion of Medicaid coverage beginning in 2014. Costs for newly eligible low-income adults were fully reimbursed by the federal government in the 31 states that chose to expand their Medicaid programs through 2016.

This state Medicaid spending indicator excludes federal support, examining only the cost to states because that spending—and increases relative to revenue—exerts pressure on their operating budgets, which rely on state-generated revenue.

Medicaid's claim on each revenue dollar affects the share of state resources available for other priorities, such as education, transportation, and public safety. Because Medicaid is an entitlement program, states must provide certain federally required benefits for any eligible enrollee, even during times of sluggish revenue growth. So policymakers have less control over growth in states' Medicaid costs than they do with many other programs.

State highlights

A comparison of states' Medicaid spending relative to their own resources in 2000 and 2016 shows:

- Louisiana's share rose the most since 2000. In 2016, the state spent 24.3 percent of its own revenue on Medicaid, 13.7 percentage points higher than

in 2000—equivalent to 13.7 cents more of each state-generated dollar.
- The next-largest hikes per revenue dollar were in Alaska (11.8 cents) and Texas (10.5 cents). These three states were the only ones with increases of more than 10 cents per state-generated dollar.
- The slowest growth was in five states with increases of 1.5 cents or less per own-source dollar: New York (0.5), Hawaii (0.9), Michigan (1.1), Tennessee (1.3), and Utah (1.4).
- The 18 states where Medicaid in 2016 was at its highest level since 2000 were Alaska, Colorado, Florida, Iowa, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Vermont, Virginia, and Wyoming. Participation in the optional Medicaid expansion was split almost evenly among this group, with 10 participating as of 2016 and eight not. Virginia elected to expand in June 2018.
- Eight states spent more than one-fifth of their own revenue on Medicaid in 2016: New York (27.0 percent), Louisiana (24.3 percent), Rhode Island (23.1 percent), Pennsylvania (21.9 percent), Massachusetts (21.8 percent), Texas (21.8 percent), Missouri (21.7 percent), and Tennessee (20.2 percent). New York spent the largest share of its own revenue on Medicaid in every year of the study period. Texas joined this group for the first time since at least 2000.
- The states that spent the lowest share of own dollars on Medicaid in 2016 were Utah (5.8 percent), Hawaii (8.1 percent), Nevada (9.1 percent), North Dakota (9.4 percent), and Wyoming (9.9 percent).

Trend drivers

States in 2016 collectively spent $220.4 billion of their own resources to provide health benefits for eligible low-income Americans. This was $8.8 billion more than in 2015, a 4 percent rise—the second-slowest annual rate in six years. Because state revenue rose even more slowly (2.0 percent), the slice of state dollars devoted to Medicaid coverage expanded from 16.8 percent in 2015 to 17.1 percent in 2016.

Higher enrollment has been one of the major drivers of growth in Medicaid spending, with more than twice as many people enrolled in 2016 than in 2000. From 2000 to 2013, a number of factors drove up enrollment, including two economic downturns—which caused people to lose jobs and associated health insurance—and a gradual erosion of employer-sponsored insurance. From 2014 to 2016, millions more joined the program as the optional expansion under the

ACA was implemented by 31 states, but the federal government agreed to absorb the first three years of all related expenses for newly eligible enrollees. Future enrollment growth could be curbed because of low unemployment and federally approved actions by some states to require work or other community engagement as a condition of eligibility for certain adults.

Influence of federal policy changes

Medicaid is a state-administered program, but the federal government covered from 50 to 78 percent of states' bills for the program in 2016, for a total of 62.1 percent of costs. Spending by the federal government on Medicaid rose 5 percent that year, from $344.2 billion in 2015 to $360.5 billion.

Changes in federal policies have helped shape states' financial responsibilities for Medicaid. Most recently, the ACA provided an opportunity for states to expand their programs with enhanced federal support. The latest 50-state data reflect nearly three years—11 quarters—of the ACA's Medicaid expansion, which took effect in January 2014. The law expanded Medicaid eligibility to all adults under age 65 who earn up to 138 percent of the federal poverty level, a change that the U.S. Supreme Court later ruled was optional for states. The U.S. government agreed to reimburse 100 percent of expansion costs through 2016 for states that chose to extend health coverage to newly eligible low-income adults, dropping to 95 percent in 2017 and ultimately to 90 percent by 2020. As of the federal fiscal year ending Sept. 30, 2016, the timeframe for this analysis, 31 states had expanded their programs in accordance with the ACA, with Louisiana and Montana participating for part of the fiscal year. As of June 2018, 33 states had agreed to expand eligibility for Medicaid, though Maine and Virginia, the most recent adopters, had not started implementation.

In response to the 2001 and 2007-09 recessions, as state tax revenue fell, the federal government sent extra dollars to states to help cover the increased costs associated with higher Medicaid enrollment. When enhanced federal aid from the Great Recession tapered off between December 2010 and June 2011, states' share of the costs spiked while their tax revenue was still recovering.

In 2006, the federal government began relieving states of prescription drug costs for "dual eligibles," people who qualify for both Medicaid and the federal Medicare program. In return, states are required to share some of their savings with the federal government through annual "clawback" payments, which are included in this analysis as part of state Medicaid spending.

The proportion of federal reimbursement that states receive is one of several factors that influence the wide range in the share of their own revenue spent on Medicaid. This variation is attributable not only to state Medicaid policy decisions —the breadth of health care services covered, eligible populations, and provider payment rates—but also to tax and other policy decisions that determine state revenue. Variation also is driven by factors outside of policymakers' direct control, such as state economic performance, demographics, resident health status, and regional differences in health care costs and practices. (For more information, see "State Health Care Spending on Medicaid.")

Analysis by Matt McKillop and Jessica Carges

Click here for a printable version of this analysis.

SourceURL: https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/

Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid

Samantha Artiga, Rachel Garfield, and Anthony Damico
Published: Oct 11, 2018

On October 10, 2018, the Trump administration released a proposed rule to change "public charge" policies that govern how the use of public benefits may affect individuals' ability to obtain legal permanent resident (LPR) status. The

proposed rule would expand the programs that the federal government would consider in public charge determinations to include previously excluded health, nutrition, and housing programs, including Medicaid. It also identifies characteristics DHS could consider as negative factors that would increase the likelihood of someone becoming a public charge, including having income below 125% of the federal poverty level (FPL) ($25,975 for a family of three as of 2018). This analysis provides new estimates of the rule's potential impacts. Using 2014 Survey of Income and Program Participation data, it examines the (1) share of noncitizens who originally entered the U.S. without LPR status who have characteristics that DHS could potentially weigh negatively in a public charge determination and (2) number of individuals who would disenroll from Medicaid under different scenarios:

Nearly all (94%) noncitizens who originally entered the U.S. without LPR status have at least one characteristic that DHS could potentially weigh negatively in a public charge determination. Over four in ten (42%) have characteristics that DHS could consider a heavily weighted negative factor and over one-third (34%) have income below the new 125% FPL threshold. Under the proposed rule, individuals with lower income, a health condition, less education, and/or who use or are likely to use certain health, nutrition, and housing programs, including Medicaid, would face increased barriers to adjusting to LPR status because DHS could consider these characteristics as negative factors.

If the proposed rule leads to Medicaid disenrollment rates ranging from 15% to 35% among Medicaid and CHIP enrollees living in a household with a noncitizen, between 2.1 to 4.9 million Medicaid/CHIP enrollees would disenroll. These estimates reflect disenrollment among noncitizens without LPR status who would disenroll because participation in the program could negatively affect their chances of adjusting to LPR status as well as disenrollment among a broader group of enrollees in immigrant families, including their primarily U.S. born children, due to increased fear and confusion. The disenrollment rates draw on previous research on the chilling effect welfare reform had on enrollment in health coverage among immigrant families. Decreased participation in Medicaid would increase the uninsured rate among immigrant families, reducing access to care and contributing to worse health outcomes. Coverage losses also would result in lost revenues and increased uncompensated care for providers and have spillover effects within communities.