Can $200 Billion Offset Lost Medicaid Expansion Coverage under the Better Care Reconciliation Act?

Linda J. Blumberg, Matthew Buettgens, John Holahan, and Robin Wang
July 2017

Republicans could be adding $200 billion in federal funding to the Better Care Reconciliation Act (BCRA) to offset Medicaid expansion coverage losses that would result from provisions of the bill.[1] Building off our previous analysis of the cost and coverage effects of BCRA,[2] we estimate the 2022 costs of enrolling the Medicaid-expansion population in BCRA-compliant Marketplace coverage and providing "wrap" benefits that would cover the premiums and cost-sharing requirements associated with that coverage. These estimates are provided for each of the 31 Medicaid expansion states plus the District of Columbia and are summed to provide a benchmark for understanding how far $200 billion would go toward financially protecting this population. In addition to estimates for 2022, we estimate the number of years these benefits could be financed with the $200 billion being considered.

Our main findings are as follows:

- Without the additional wraparound funding being considered, very few (1.3 million out of 13.3 million) people who would be covered under the ACA's Medicaid expansion would enroll in BCRA Marketplace coverage because of the premium contribution requirements and the large cost-sharing requirements (deductibles, copayments, co-insurance, out-of-pocket maximums).[3]

- Enrolling people with incomes up to 138 percent of the federal poverty level (FPL) who would otherwise have been enrolled in Medicaid under ACA expansion rules into BCRA Marketplace plans would increase the cost of the bill's premium tax credits by $17.4 billion in 2022.

- Government financing of the premium contributions these additional enrollees would be required to pay (2 percent of income for those with incomes up to 100 percent of FPL; 2–2.5 percent of income, depending on the person's age, for those with incomes between 100 and 138 percent of FPL) would cost an additional $6.1 billion in 2022.

- Government financing of the cost-sharing requirements associated with BCRA Marketplace coverage would cost an additional $33.6 billion in 2022.

- We also estimate $19.0 billion in claims costs in the nongroup market associated with the higher use of health care services by this population (compared with other nongroup insurance enrollees) because there would be no cost-sharing requirements for this population. Given the goal of retaining coverage for the ACA's Medicaid-expansion population, we assume the government would pay these costs in some manner, through either direct subsidies to insurers or increased premium tax credits.

- Together, these additional costs would amount to $76.1 billion in 2022. If the states that had expanded Medicaid eligibility before the ACA chose not to maintain those early expansions under BCRA, the additional costs would be $24.6 billion higher, or $100.7 billion in 2022.

- Two hundred billion dollars in additional funding for these purposes, provided exclusively to expansion states and apportioned based on ACA Medicaid expansion enrollment, would cover little more than two full years of these additional aggregate costs. If the funds were not provided until later years, fewer years could be financed because of the increasing costs of health care over time.

- In contrast, the loss of federal dollars devoted to Medicaid would be permanent, and it would increase over time because of the compounding of BCRA's deeper cuts to Medicaid's per capita growth rates beginning in 2025.

- If, in addition to the specified $200 billion, funds from the State Stability and Innovation Fund were allocated to cover these costs instead of being used for reinsurance as is assumed here, premiums in the Marketplace would rise, increasing the federal cost of the premium tax credits for all people eligible for Marketplace tax credits. We have not assumed that alternative scenario here and thus have not estimated the additional federal costs associated with doing so.

Assumptions and Methods

Our simulation of BCRA, using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), is consistent with our methods in earlier related analyses.[4] Our analysis is consistent with the July 20, 2017, version of the bill that excludes Title III, the so-called Cruz amendment. We did not make any changes based on the findings of the Senate Parliamentarian, released July 21, 2017.[5] We assume, again consistent with our earlier work, that all states would end their ACA Medicaid eligibility expansions by 2022 as a result of the reduced federal matching rates under BCRA. Our main results assume that states that expanded Medicaid eligibility before the ACA for nonparent adults with incomes at least up to 100 percent of FPL would return to those pre-ACA eligibility levels; however, we do a sensitivity analysis to show the additional government costs if the states do not.

For this analysis, we simulate a scenario where everyone who would enroll in Medicaid under the ACA's expansion eligibility pathway in 2022 would enroll in a BCRA Marketplace plan instead. This simulation allows us to estimate the additional government costs associated with making the ACA expansion population "whole" by providing standard BCRA Marketplace coverage, government financing to cover their premium contribution requirements, and government financing for their cost-sharing requirements. We also do a sensitivity analysis to estimate the savings to the government if the new benefit did not cover the premium contribution requirements for the Medicaid expansion population with incomes between 100 and 138 percent of FPL because, under current law, people in that income range who live in nonexpansion states and enroll in Marketplace coverage make premium contributions of 2 percent of income.

Providing a government-funded "wrap" to cover the cost-sharing associated with BCRA nongroup policies would lead to higher use of medical services than under a standard BCRA policy. At this point, it is unclear how these additional claims costs would be absorbed. Under BCRA, these costs would not be spread across insurers, and that could cause insurers to take financial losses or avoid enrolling people eligible for the additional cost-sharing assistance. If the risk-adjustment mechanism were changed to take these additional costs into account, average premiums would increase across the board, leading to higher federal premium tax credit costs. Because the people otherwise eligible for their state's Medicaid expansion would make up a large share of nongroup enrollees under this approach to BCRA, their additional costs would represent a significant increase in average market premiums. Or the federal government could directly subsidize insurers enrolling this population to compensate for the additional claims. We include these costs in the total government costs associated with this type of assistance. Without government funding for these additional claims, coverage for the ACA's Medicaid expansion enrollees could not be maintained.

If everyone eligible for the ACA Medicaid expansion was instead offered enhanced Marketplace nongroup coverage under BCRA, we assume only those who would have enrolled in Medicaid would take up this alternative. Depending on age and income, the expansion population would be eligible for tax credits for BCRA Marketplace premiums that would limit their premium for the benchmark plan to 2 to 2.5 percent of family income. According to the bill's language, some of these people would be ineligible for tax credits because they have an employer offer of insurance coverage; however, we assume that language would be added to the bill to permit this very low–income population to enroll regardless of the presence of an employer offer. If this were not the case, the policy could not make this population "whole" relative to having Medicaid coverage because BCRA would make any employer offer of coverage disqualifying, regardless of required premium and regardless of how limited the coverage offered might be.

Consistent with our previous simulations of BCRA, we assume that all State Stability and Innovation Fund dollars would be drawn down by all states, that all states would provide the full required state matching funds, and that all these combined government funds would be devoted to reinsurance of high claims in the private nongroup market. If some funds were instead directed to offsetting the increased costs facing Medicaid-expansion enrollees under BCRA, the cost of private nongroup premiums would

increase, and federal premium tax credit costs would therefore increase. The additional federal tax credit costs that would be associated with redirecting the Stability and Innovation funds are not calculated here. Any shift of those funds to cover the costs estimated here would increase other federal costs.

As with all projections of the effects of new policy proposals, actual state responses and factors affecting implementation could be different from those assumed here. Few details of this proposal have been made public; our analysis relies on our interpretation of the proposal provided through limited media reports. If, for example, states were required to provide matching funds in order to obtain their share of the $200 billion, some states might choose not to participate. We assume that funds would be allocated to states based on the size of their Medicaid expansion population and in proportion to their population's health care needs. If a different allocation method was used, the state-by-state effects could be different. If outreach and enrollment assistance under BCRA was not provided at the same level as under the ACA, enrollment of this population might be lower than it is now, leading to lower government costs but more people uninsured.

Results

Table 1 shows the findings for this analysis. In 2022, we estimate that 13.3 million people would lose Medicaid coverage because of BCRA's reduced federal matching rate for the ACA's expansion-eligible population (column 1). The estimated full effects of BCRA on insurance coverage and the uninsured in each state can be found in our earlier analysis;[6] these estimates are limited to those losing Medicaid from the elimination of the ACA's expansion. The number of people affected in each expansion state varies by population size, enrollment rates, and state income distribution. For example, California would have 3.6 million people losing coverage through 2022, and Delaware would have 20,000. We assume that Massachusetts, which had expanded Medicaid before the ACA, would return to its pre-ACA eligibility rules under BCRA; therefore, only 1,000 Massachusetts residents would lose expansion-related eligibility.

Adding these 13.3 million people to the Marketplaces would increase federal base premium tax credit costs by $17.4 billion in 2022 (column 2). This estimate nets the costs associated with the small share of this population that we project would enroll in Marketplace coverage absent the benefit enhancements assumed here. These additional premium tax credit costs would vary across states as a function of population size, enrollment rates, income distribution, age distribution of expansion-eligibles, nongroup premium levels, and average health costs of BCRA nongroup insurance enrollees. For example, the additional costs would be roughly $318 million in Nevada, $843 million in Washington, and $66 million in New Hampshire.

Providing government funding for the 2-to-2.5-percent-of-income premium contributions that would otherwise be required for Marketplace plans under BCRA would cost $6.1 billion in 2022 (column 3). Because the Medicaid-eligible population has income at or below 138 percent of FPL, and most have incomes below the federal poverty level, even a small share of income required for premiums

would mean that most would find enrollment unaffordable. Having the government pay those premium contributions parallels the zero (or, for a few states, nominal) premium contributions required by states for their Medicaid-expansion enrollees. As a sensitivity analysis, we also estimated the cost of this premium "wrap" benefit if it were provided only to those with incomes at or below the poverty level. We made this additional estimate because, under current law, people in that income range who live in nonexpansion states and enroll in Marketplace coverage make premium contributions of 2 percent of income. In that case, the government cost of the premium "wrap" would be $5.1 billion in 2022, $1 billion less than our main estimate (data not shown).

TABLE 1

Government Costs Associated with Providing Premium and Out-of-Pocket "Wraps" in Nongroup Marketplace to People Losing Medicaid under BCRA, by ACA Medicaid Expansion State, 2022

State	Number of ACA-expansion eligibles losing Medicaid under BCRA (thousands)	Additional base premium tax credits for the expansion population ($ millions)	"Wrap" to pay for expansion-population premium contributions ($ millions)	"Wrap" to pay for out-of-pocket costs (i.e., cost-sharing) for expansion population ($ millions)	Costs of additional health care use by "wrapped" enrollees compared with other nongroup insured under BCRA ($ millions)	Total additional costs ($ millions)
Alaska	42	225	13	106	54	399
Arizona	242	197	174	528	281	1,180
Arkansas	374	532	156	907	514	2,108
California	3,634	5,440	1,785	9,749	5,420	22,394
Colorado	468	630	209	1,066	622	2,527
Connecticut	224	485	166	720	375	1,746
Delaware	20	11	17	54	28	109
District of Columbia	52	66	21	147	83	318
Hawaii	28	29	23	72	39	164
Illinois	617	589	191	1,515	880	3,176
Indiana	488	457	141	1,190	707	2,496
Iowa	170	289	57	410	237	992
Kentucky	569	569	213	1,390	814	2,986
Louisiana	355	521	190	786	453	1,950
Maryland	356	296	156	918	517	1,887
Massachusetts	1	0	0	1	1	2
Michigan	658	577	195	1,573	934	3,280
Minnesota	217	406	117	565	313	1,400
Montana	71	84	38	141	82	345
Nevada	242	318	82	540	318	1,258
New Hampshire	76	66	27	211	123	427
New Jersey	583	860	273	1,439	810	3,381
New Mexico	297	385	118	688	387	1,578
New York	555	535	617	1,557	810	3,520
North Dakota	34	28	10	71	44	153
Ohio	832	658	265	2,028	1,201	4,153
Oregon	384	549	135	1,015	569	2,268
Pennsylvania	755	1,140	267	1,808	1,015	4,231
Rhode Island	79	70	39	241	134	483
Vermont	24	53	23	70	35	181
Washington	605	843	281	1,581	916	3,620
West Virginia	206	479	107	527	283	1,396
Total	*13,260*	*17,387*	*6,108*	*33,614*	*19,000*	*76,109*

Source: Urban Institute analysis using HIPSM 2017.   **URBAN** INSTITUTE

Note: Simulation consistent with Urban Institute estimates of revised BCRA excluding Title III, the Cruz amendments.

Benchmark nongroup insurance plans under BCRA would have an actuarial value of 58 percent, and some would have an actuarial value as low as 54 percent because of permissible variation. Benchmark plans would have deductibles, copayments, co-insurance, and out-of-pocket maximums that would be unaffordable for this low-income population.[7] State Medicaid programs do not typically have deductibles, co-insurance, or copayments, and those that do have nominal copayments. Having the government fund the cost-sharing requirements associated with BCRA nongroup coverage for those otherwise covered by the ACA's Medicaid expansion would cost an additional $33.6 billion (column 4). These costs would total $527 million in West Virginia, $1.0 billion in Oregon, and $2.0 billion in Ohio in 2022.

Finally, there are additional health care claims costs associated with providing Marketplace coverage to the Medicaid-expansion population that result from covering the out-of-pocket costs associated with standard BCRA nongroup coverage. Providing a low-income population with health coverage that does not require deductibles, copayments, or co-insurance removes financial barriers to their accessing necessary medical care. As a result, they use more medical services than they would if they faced the unsubsidized out-of-pocket cost-sharing requirements associated with BCRA plans. We estimate the cost of these additional services to be $19 billion in 2022 (column 5). As described in the Assumptions and Methods section, we include these additional costs in the government total. If the government does not fund these costs in some manner, insurers would either incur unsustainable losses when enrolling this population or take steps to avoid enrolling them.

Taken together, we estimate that the additional premium tax credits, wraparound payments for enrollee premiums and cost-sharing requirements, and additional claims costs would total approximately $76.1 billion in 2022 (column 6, sum of columns 2 through 5). These totals would increase in each successive year, as health care costs and population increase. Thus, $200 billion devoted to a program like that described here could cover no more than two full years of benefits. The later the program began, the shorter the period such benefits could be covered with that amount.

As a sensitivity, we also estimated the total government cost of these benefits if the six states that had expanded Medicaid eligibility before the ACA (Arizona, Delaware, Hawaii, Massachusetts, New York, and Vermont) did not return to their pre-ACA eligibility rules and instead eliminated their expanded Medicaid eligibility categories, as the other expansion states are expected to do. Under that scenario, the government cost of the benefits described here would be $100.7 billion 2022, $24.6 billion higher than our main estimate (data not shown).

Discussion

Theoretically, additional government funding could be used to provide comprehensive insurance coverage through the BCRA Marketplaces for those who would otherwise have been enrolled in Medicaid through the ACA's eligibility expansion in 2022 and beyond. Several new costs, however, would be associated with doing so, including the following:

- additional base premium tax credits because of additional Marketplace enrollees: $17.4 billion in 2022

- subsidies to offset the premium payments required for this low-income population: $6.1 billion in 2022

- subsidies to offset the high cost-sharing requirements associated with BCRA Marketplace coverage: $33.6 billion in 2022

- the higher health care claims associated with providing this population with coverage without cost-sharing requirements, compared with their use under standard BCRA plans: $19 billion in 2022

Though additional, somewhat flexible, funds are available through BCRA's State Stability and Innovation Fund, we have assumed that all those funds would be devoted to reinsurance in the private nongroup insurance market. This assumption significantly reduces private nongroup insurance premiums and, consequently, reduces federal premium tax credits costs. If some of those funds were instead diverted to funding BCRA Marketplace wraparound costs for people who would have otherwise been enrolled in the Medicaid expansion under the ACA, private nongroup premiums would increase, as would federal premium tax credits costs.

The additional costs we estimate here to provide further assistance under BCRA for people who would have otherwise had Medicaid coverage under the ACA's eligibility expansion total $76.1 billion in 2022. Depending upon the response of states that had expanded Medicaid eligibility before the ACA, the costs could be as high as $100.7 billion in 2022. For later years, the aggregate costs would be higher because medical costs per person increase each year. Therefore, the $200 billion in federal funds reportedly being discussed to finance this strategy could cover the costs of the program for no more than two full years. In contrast, the loss of federal dollars devoted to the Medicaid program would be permanent, compounding the loss of federal funding to states from BCRA's deeper cuts in its per capita growth rates for Medicaid beginning in 2025.

Notes

1. See Alexander Bolton, "Source: Senate Leaders to Offer $200 Billion to Win Over Moderates," *The Hill*, July 19, 2017, http://thehill.com/policy/healthcare/342853-source-senate-leaders-to-offer-200b-to-win-over-moderates; and Russell Berman, "What the Republican Health-Care Holdouts Want," *Atlantic*, June 28, 2017, https://www.theatlantic.com/politics/archive/2017/06/what-the-republican-health-care-holdouts-want/532047/.

2. See Linda J. Blumberg, Matthew Buettgens, John Holahan, Bowen Garrett, and Robin Wang, "State-by-State Coverage and Government Spending Implications of the Better Care Reconciliation Act" (Washington, DC: Robert Wood Johnson Foundation and Urban Institute, 2017); and the Urban Institute's data tables on the effects of revised BCRA on the uninsured and on federal health care funding for the nonelderly, released July 18, 2017, available at http://www.urban.org/sites/default/files/2017.07.18_revisedbcratables2_finalized.pdf.

3. Under BCRA, premium tax credits would be tied to the price of the median 58 percent actuarial value plan. These plans, which would reimburse 58 percent of covered benefits for an average population, are permitted to vary to 54 percent actuarial value. This compares to virtually 100 percent actuarial value coverage provided under Medicaid, though some states, such as Indiana and Iowa, require Medicaid enrollees to pay nominal premium or cost-sharing requirements.

4. See Blumberg et al., "State-by-State Coverage and Government Spending Implications."

5. "Background on the Byrd Rule Decisions from the Senate Budget Committee Minority Staff," US Senate Budget Committee, published July 21, 2017, https://www.budget.senate.gov/imo/media/doc/Background%20on%20Byrd%20Rule%20decisions_7.21[1].pdf.

6. See the Urban Institute's data tables, available at http://www.urban.org/sites/default/files/2017.07.18_revisedbcratables2_finalized.pdf.

7. The Congressional Budget Office estimates that under BCRA, the combined medical and drug deductible for a single policyholder in a benchmark plan would be $13,000 in 2026. See Congressional Budget Office, letter to Mike Enzi, Chairman, Committee on the Budget, US Senate, "Re: H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN17500], as Posted on the Website of the Senate Committee on the Budget on July 20, 2017," https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.

About the Authors

Linda J. Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA)—in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of specific policies. She codirects a large multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, estimation of the implications of ACA repeal through the reconciliation process, strategies for improving the ACA, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation.

She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

Matthew Buettgens is a senior research analyst in the Health Policy Center, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.

John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

Robin Wang is a research associate in the Health Policy Center, where he helps develop Urban's Health Insurance Policy Simulation Model. Previously, Wang researched health policy, long-term care insurance schemes, and pay-for-success models, and had professional engagements with the UK House of Commons and the European Parliament.

Acknowledgments

URBAN INSTITUTE

2100 M Street NW
Washington, DC 20037

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.