Congressional Plans Would Make Us Sicker and Health Care More Expensive

JUNE 2017 | CARRIE WELTON

The House and Senate health care bills would both weaken the health care premium tax credits created by the Affordable Care Act (ACA) and raise consumers' costs while reducing their benefits. Both the House American Health Care Act (AHCA) and the Senate Better Care Reconciliation Act of 2017 (BCRA) include deep and permanent cuts to the Medicaid program that would result in millions of people losing coverage and billions of dollars in tax cuts that will primarily benefit corporations and wealthy people. These bills would impose extreme costs on states and force them to ration care for low-income seniors, children, workers, and individuals with disabilities.

Both bills claim to support continuous coverage as a core goal. And yet, both the House and the Senate bills include provisions that do just the opposite and will result in people experiencing gaps in coverage. The proposals create barriers to continuous health care coverage under Medicaid by reducing retroactive coverage, shortening redetermination periods, and giving states the option to institute work requirements as a condition of getting health coverage. These administrative and procedural barriers have been demonstrated to reduce access to benefits in health care as well as the other programs.[1] In addition, the bills penalize people purchasing coverage on the nongroup market who have experienced gaps in health insurance. By reducing access, eviscerating Medicaid expansion efforts, adding administrative costs, and penalizing people for caps in coverage, these bills will make Americans sicker and health care more expensive.

Moreover, these bills would be a sharp departure from recent bipartisan efforts by states to reduce administrative costs, streamline eligibility, and improve efficiency in Medicaid and other work supports, such as efforts under the Work Support Strategies (WSS) initiative (see box on page 2).

Congressional proposals would increase churning, reduce access

Despite claims to the contrary, the Congressional health care bills would make it harder for low-income people to maintain continuous coverage. A key lesson from WSS was the need to focus on retention, and specifically on reducing the loss of benefits while still eligible (also called "churn"). Research shows that large numbers of recipients churn out of a program only to re-apply and re-enter after a short period of time, suggesting that the reason their benefits stopped was not due to improved or stabilized financial circumstances.[2] This often happens at redeterminations because the complexity of the process results in families missing recertification appointments or failing to meet other procedural requirements. Even when clients meet all requirements for participation, state and local offices may be unable to track documents or

may otherwise incorrectly terminate eligible individuals. Nevertheless, the House-passed AHCA would require redetermination for the expansion population every 6 months, as opposed to the current 12 months, while the Senate BCRA would allow states to do redeterminations even more frequently.

Both the House and Senate bills would reduce retroactive eligibility to the first day of the month that the application is filed, rather than the three-month lookback under current law, resulting in even more interruptions in coverage. Many beneficiaries who fail to complete the Medicaid renewal process do not realize that their coverage has lapsed until they attempt to use it when they seek care. With retroactive coverage, they are usually able to restore their benefits and not incur health care bills they cannot pay. The proposed policy presents a major burden to health care providers and emergency rooms that shoulder the burden of uncompensated care for beneficiaries who do not get retroactive coverage. For example, if a patient goes to the emergency room on the 30th of a month and is found eligible for Medicaid on the 2nd of the following month at discharge, the patient's Medicaid coverage will begin the 1st day of the month—and the entire burden of the emergency room visit will be uncompensated care for the hospital.

Both Congressional proposals would allow states to institute work requirements as a condition of eligibility for Medicaid. From other programs, we know that such requirements frequently result in loss of benefits. Largely due to implementation of the Supplemental Nutrition Assistance Program (SNAP) time limit for unemployed childless adults, an estimated 500,000 childless adults lost food assistance at some point in 2016.[3] A Maryland Temporary Assistance for Needy Families (TANF) study found that, among cases where the work requirement applied, an astonishing 60 percent of closed cases had lost benefits as the result of a "sanction" for not meeting the requirement in the course of a year.[4] Yet these same complications and requirements are used as the model in the Congressional bills.

WORK SUPPORT STRATEGIES

Recent evidence from the Work Support Strategies (WSS) initiative, a foundation-funded initiative led by the Center for Law and Social Policy (CLASP) and its national partners, the Center on Budget and Policy Priorities and the Urban Institute illustrate how several states achieved large-scale improvement in families' access to programs that help people meet basic needs, reduce poverty, support stability and success at work, and improve low-income children's long-term health and economic wellbeing. WSS provided funding, peer learning, and expert technical assistance from 2011 to 2016 to six diverse states (Colorado, Idaho, Illinois, North Carolina, Rhode Island, and South Carolina) to design, test, and implement more effective, streamlined, and integrated approaches to delivering key supports for low-income working families, with two goals: ensuring that all families get and keep the full package of benefits for which they are eligible and reducing the burden of bureaucratic processes.

The WSS states substantially improved eligible children's and parents' participation in safety net programs, as well as dramatically reduced the time it takes to deliver benefits. States accomplished these goals without spending more money on administrative costs or increasing errors; rather, they used existing flexibility within the programs, proving that block grants aren't needed to achieve these striking results.

The House AHCA would also cut off enhanced funding for Medicaid beneficiaries in the "expansion" population as soon as they leave Medicaid for more than a month – even if they remain eligible. This policy means that these administrative requirements would also undermine the expansion, cutting off the

higher match rate for most beneficiaries within a short period of time. The CBO estimates that with this provision, two-thirds of those enrolled in the expansion by the end of 2019 would fall off the program by 2021 and fewer than 5 percent would remain on by end of 2024.[5]

In addition to the administrative burdens imposed in the Medicaid program, both bills also propose punitive measures for people who need to buy insurance on the nongroup market. Their purported goal is to encourage healthy people to buy and maintain insurance even before it is needed. But the impact of the continuous coverage provisions in the House and Senate bills is to make coverage more expensive, encourage people to forgo needed care, and to lock people out from coverage when they need it. For those who have more than a 63-day lapse in coverage the Senate bill will deny access to health care through the Marketplace for six months, while the House bill will permit insurers to charge a 30 percent penalty above their original premium if someone has been uninsured for 63 days or more. This means that people who miss premium payments – whether because of competing urgent financial needs or simple oversight in a period of crisis – or fail to return recertification paperwork could be locked out or priced out of coverage for an extended period.

Access to benefits matters for everyone

Federal safety net programs have dramatically changed the lives of low-income families, both poor and near-poor, through large improvements in access to health care and nutrition—and bodies of research continue to grow that show these programs' effects on family stability, children's health, and future earnings.[6] This includes access to preventive care and the early treatment of illnesses for individual, societal, and economic wellbeing. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes, "Insurance coverage increases access to care and improves a wide range of health outcomes."[7]

People without insurance often forgo treatment until minor ailments have become major. Studies repeatedly show that the uninsured are less likely than those with insurance to get preventive care and services for major chronic conditions.[8] For example, children who go without regular well-child screenings may miss immunizations, increasing the spread of communicable diseases,[9] and they are twice as likely to be hospitalized with a chronic condition compared to children who make all or most well-child visits.[10]

Because children do better when their parents and other caregivers are healthy, both emotionally and physically, parents' access to health care also has significant positive effects on their children.[11] Untreated parental chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.[12] When adults have access to health care to address physical and mental health needs, it has a significant positive effect on their ability to be more effective parents. For example, a mother's untreated depression can place at risk her child's safety, development, and learning.[13]

Health insurance is also critical to the entire family's financial stability because coverage lifts the burdens of unexpected health problems and related costs. A report in Ohio found that Medicaid expansion

enrollees were more than twice as likely to realize improvements in their financial situation and therefore better able to meet basic needs. Over half of enrollees reported that health coverage made it easier to buy food and nearly half stated it was easier to pay their rent or mortgage and address other debts.[14]

Interruptions in care have health consequences

Continuous coverage is important and leads to improved health care outcomes. Even short-term gaps in health insurance coverage can have significant effects on health and wellbeing. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than six months are less likely than those continuously enrolled to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care, and more likely to have unmet medical or prescription drug needs.[15] A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have been to a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.[16] Even when people shift between health insurance programs without a gap in coverage, this transition often requires changes in health care providers, which can lead to interruptions in treatment. In one recent study, those who alternated between sources of health insurance with no gap in coverage still reported a 29 percent decrease in their overall quality of care due to the transition.[17] The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders.[18]

Interruptions in care drive up health care and administrative costs

In addition to the human cost of increased illness, missed preventive services and delayed treatment drive up health care costs because it becomes more expensive to treat illness or injuries at later stages. When people re-enroll in Medicaid after a gap in coverage—and after delaying or forgoing needed care— they will likely be sicker and have higher health care needs. Public programs will end up spending more to bring these people back to health. Chronic health conditions left untreated create significant economic burdens, costing employers, and reducing the ability of people to work and support their families.[19] Avoidable hospitalizations are also costly for states. A 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per-member per-month cost following reenrollment after a coverage gap rose by an average of $239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.[20]

The proposals in the Congressional health bills would also add to administrative costs. We learned from WSS that reducing unnecessary steps in the application and renewal process reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school. Every form a customer submits must be processed by a caseworker, so less frequent renewals and streamlined verification policies can both improve the customer experience and increase efficiency. Churn is expensive for states, since new applications are more time consuming and

costly for states to process than renewals.[21] Closing and reopening a case is inefficient and costly for states and burdensome for clients who are already contending with the challenges that led them to seek assistance. A 2014 study revealed that processing an initial application takes double or triple the time of processing a simpler redetermination. The study concluded that the average cost in six states ranged from of $82–133 in additional administrative costs for each household that cycled off of benefits.[22] WSS also learned from a client experience survey in Colorado that those who reported gaps in benefits called offices more often, and people with longer gaps called even more.[23]

Conclusion

The Congressional Republican bills seek to shrink Medicaid by breaking the relationship between federal funding and the actual cost of providing health care and by placing hurdles in the path of those who seek coverage. This is both cruel to people struggling to attain economic security and counter-productive to the Congressional Republicans' proclaimed goal of promoting work.

In a recent paper highlighting the lessons of WSS, Governor C.L. "Butch" Otter of Idaho explained to us why his state chose to participate in the initiative. "Idaho is committed to helping families find paths out of poverty and into the workforce. That means making smart investments in technology and integrating services not only to reduce the costs to taxpayers but more importantly to help people find the jobs they need to support themselves and their families. This effort [WSS] is aimed at increasing self-reliance and enabling success, not fostering entitlement and government dependence."[24] Governor Otter is right—health coverage allows people to take care of the issues that prevent them from working. The Ohio study of Medicaid expansion enrollees confirms that access to Medicaid reduces barriers to employment. Three-quarters (74.8 percent) of unemployed Medicaid expansion enrollees looking for work reported that their health coverage made it easier to seek employment.[25] Congress should reject these cruel and short-sighted proposals that will make people sicker, and drive up health care costs.

[1] Jessica Gehr, *Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers*, CLASP, 2017, http://www.clasp.org/resources-and-publications/publication-1/Doubling-Down-How-Work-Requirements-in-Public-Benefit-Programs-Hurt-Low-Wage-Workers.pdf. Julia Isaacs, Michael Katz, Ria Amin, *Improving the Efficiency of Benefit Delivery: Outcomes from the Work Support Strategies Evaluation*, Urban Institute, 2016, http://www.urban.org/research/publication/improving-efficiency-benefit-delivery.

[2] Gregory B. Mills, Jessica F. Compton, Olivia Golden, *Assessing the Evidence about Work Support Benefits and Low-Income Families*, Urban Institute, 2011, http://www.urban.org/research/publication/assessing-evidence-about-work-support-benefits-and-low-income-families.

[3] Dottie Rosenbaum and Ed Bolen, "SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit," Center on Budget and Policy Priorities, December 2016, http://www.cbpp.org/research/food-assistance/snap-reports-present-misleading-findings-on-impact-of-three-month-time.
[4] Lisa Nicoli, *An Overview of Work Sanctions in Maryland*, University of Maryland School of Social Work, 2016, http://www.familywelfare.umaryland.edu/reports1/worksanctionsbrief2016.pdf.
[5] Congressional Budget Office, "H.R. 1628, American Health Care Act of 2017, Cost Estimate," May 24, 2017. https://www.cbo.gov/publication/52752
[6] "Income, Poverty, and Health Insurance Coverage: 2015," presentation, US Census webinar, September, 2016.
[7] Benjamin Sommers, M.D., Ph.D., Atul Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, New England Journal of Medicine, 2017, http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.
[8] Ibid.
[9] "If You Choose Not to Vaccinate Your Child, Understand the Risks and Responsibilities," *CDC*, 2012, https://www.cdc.gov/vaccines/hcp/patient-ed/conversations/downloads/not-vacc-risks-color-office.pdf.
[10] "Young Children Who Miss Well-Child Visits are More Likely to be Hospitalized," *Kaiser Permanente Center for Health Research*, May 23, 2013, https://share.kaiserpermanente.org/article/young-children-who-miss-well-child-visits-are-more-likely-to-be-hospitalized/.
[11] Jack Shonkoff, Andrew Garner, *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, American Academy of Pediatrics, 2011, http://pediatrics.aappublications.org/content/early/2011/12/21/peds.2011-2663.
[12] *Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8.*,Center on the Developing Child at Harvard University, 2009, www.developingchild.harvard.edu.
[13] Stephanie Schmit and Christina Walker, *Seizing New Policy Opportunities to Help Low-Income Mothers with Depression*, CLASP, 2016, http://www.clasp.org/resources-and-publications/publication-1/Opportunities-to-Help-Low-Income-Mothers-with-Depression-2.pdf.
[14] The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*, January 2017, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.
15 Jennifer Haley and Stephen Zuckerman, *Is Lack of Coverage A Short or Long-Term Condition?*, Kaiser Family Foundation, 2003, http://kff.org/uninsured/issue-brief/is-lack-of-coverage-a-short-or/.
[16] Matthew Carlson, Jennifer DeVoe, and Bill J. Wright, *Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan*, Annals of Family Medicine, 2006, http://www.annfammed.org/content/4/5/391.short.
[17] Sommers BD, Gourevitch R, Maylone B, et al., *Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many*, Health Affairs, 2016, https://www.ncbi.nlm.nih.gov/pubmed/27702954.
[18] Andrew Bindman, Amitabha Chattopadhyay, and G. M. Auerback. *Interruptions in Medicaid coverage and risk for hospitalization for ambulatory care-sensitive conditions*, Annals of Internal Medicine, 2008, https://www.ncbi.nlm.nih.gov/pubmed/19075204?dopt=Abstract.
[19] Ronald Loeppke, MD, MPH Michael Taitel, PhD Vince Haufle, MPH, *Health and Productivity as a Business Strategy: A Multiemployer Study*, JOEM, 2009 http://www.acoem.org/uploadedFiles/Healthy_Workplaces_Now/HPM%20As%20a%20Business%20Strategy.pdf.
[20] A.G. Hall, J.S. Harman, and J. Zhang, *Lapses in Medicaid coverage: impact on cost and utilization among individuals with diabetes enrolled in Medicaid*, 2008, https://www.ncbi.nlm.nih.gov/pubmed/19300311?dopt=Abstract.
[21] Isaacs, Katz and Amin.
[22] Gregory B. Mills, Tracy Vericker, Kye Lippold, Laura Wheaton and Sam Elkin, *Understanding the Rates, Causes, and Costs of Churning in the Supplemental Nutrition Assistance Program (SNAP)*, Urban Institute, 2014. http://www.urban.org/research/publication/understanding-rates-causes-and-costs-churning-supplemental-nutrition-assistance-program-snap. Although this study is specific to SNAP, the relative costs of renewal vs. a new application are expected to be similar for Medicaid.
[23] Isaacs, Katz and Amin.
[24]Elizabeth Lower-Basch, *Improving Access, Cutting Red Tape: State Lessons from Work Support Strategies*, CLASP, 2017, http://www.clasp.org/resources-and-publications/publication-1/Improving-Access-Cutting-Red-Tape.pdf.
[25] *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*.