

Partnered Evidence-Based Policy Resource Center

POLICY BRIEF

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Medicaid—Midterms, Waivers, and What It Means for the Veterans Health Administration

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Veterans have other choices beyond the Veterans Health Administration (VHA) for health care coverage, including Medicaid. Approximately one in ten (875,000) non-elderly Veterans are enrolled in Medicaid, 340,000 because of Affordable Care Act (ACA) expansion.^{1,2} Therefore, policy changes, such as inclusion of Medicaid work requirements or further expansion, could affect enrollment in the VHA and demand and use of its services, as documented in a previous PEPRc *Policy Brief*.³ This policy brief surveys the new Medicaid landscape in the wake of the 2018 midterm elections, taking into account recent expansion of and changes to the program in some states, as well as the implications for future expansion.

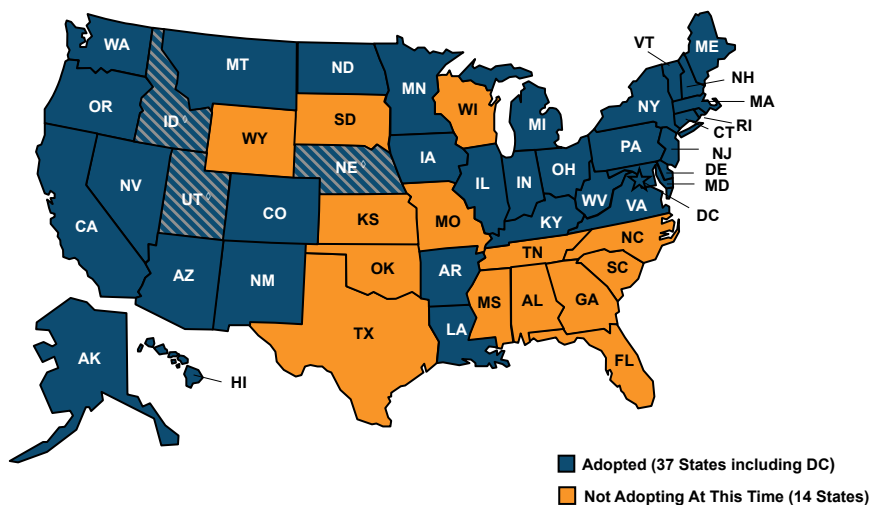
Medicaid, November 2018 and Beyond

With the Democratic party taking over the majority in the House of Representatives, ACA repeal, and consequently expansion repeal, is off the legislative agenda. Instead, we can expect to see historically resistant states slowly continue to expand Medicaid in the coming years, as Idaho, Utah, and Nebraska have recently voted to do. Currently, seventy-three million people are covered by the Medicaid program.⁴ The number of people and percentage of state residents in the program has increased yearly since its inception in 1966, sometimes as a result of shifting federal policy levers or legislation, but in recent years as a consequence of state-level policy.⁵

Expansion

Since 2014, 37 states have adopted Medicaid expansion under the ACA, 34 of which have fully implemented expansion. Idaho, Utah, and Nebraska adopted expansion in the November 2018 midterm election but have not yet implemented it.^{6,7} Figure 1 shows the current status of state Medicaid expansion decisions. Though Maine had voted in favor of expansion, implementation had been blocked by former Governor Paul LePage. Maine Governor Janet Mills has stated that she will follow through with implementation. Moreover, Governor Laura Kelly of Kansas is a strong supporter of expansion, notably in a state where former Governor Sam Brownback had blocked expansion efforts. In Montana, a ballot initiative that would have increased the state's tobacco tax to fund expansion into the future failed. The Montana legislature has signaled that it

Figure 1: Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *Expansion is adopted but not yet implemented in ID, NE, and UT. (See link below for additional state-specific notes).
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 23, 2019.
<https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



will take the issue up in its next session, but absent action expansion will sunset next year.⁸ Governor Tony Evers of Wisconsin supports Medicaid expansion, though it isn't clear that it would gain traction in the state legislature.

The success of recent expansion efforts means that upwards of one million additional people are expected to enroll in the Medicaid program. Figure 2 shows the projected number of new Medicaid enrollees in pending* expansion states (ID, UT, NE, VA, ME, KS) stacked with current enrollees.⁹

Waivers, premiums, and other policies that may affect enrollment

There are a litany of Medicaid demonstrations pending or being implemented, as Figure 3 shows.

Work requirements, first implemented in Arkansas in March 2018, are among the most controversial. New evidence shows that 12,200 people have lost Medicaid coverage in that state, many because they were unable to properly record work hours because of lack of computer access or other technical issues. Another 6,000 may lose their coverage in December.¹⁰

Other states have proposed work requirements. In Wisconsin, Democrat Tony Evers defeated the Republican incumbent governor Scott Walker, so its work requirement proposal will most likely be rescinded.¹¹ Democrats Gretchen Whitmer and Janet Mills won their gubernatorial races in Michigan and Maine respectively, where term-limited Republican governors

had also submitted work requirement proposals. So, work requirements in these states are expected to be withdrawn as well. A federal judge stopped a plan in Kentucky. Indiana and New Hampshire will begin implementing work requirements in January. Alabama, Arizona, Mississippi, Ohio, South Dakota, and Utah also have pending waivers.

Other states have new requirements that reduce Medicaid enrollment. New Mexico, Michigan, and Maine have disenrollment mechanisms for non-payment of premiums.¹² New governors in Maine and Michigan will probably strike any disenrollment language from future Medicaid waivers. Several other states have proposals that raise copays above statutory limits, waive retroactive eligibility, place time limits on coverage, and institute fees for missed appointments. Some state waivers apply only to the expansion population while others apply to all Medicaid enrollees.¹³

Medicaid, Veterans, and the Demand for VHA Care

There are 9.4 million non-elderly Veterans in the country, but many have alternative health coverage (non-VHA coverage). Almost two in five non-elderly Veterans who have Medicaid have it as their only source of coverage, and three in five non-elderly Veterans with Medicaid use Medicaid-financed care as a supplement to other coverage.¹⁴ One study found that low-income (below 138% of the federal poverty limit) Veterans in expansion states are enrolled in Medicaid at twice the rate of those in non-expansion states (41.1% vs. 20.1%).¹⁵

Figure 2: Medicaid Enrollment Growth in Pending Expansion States

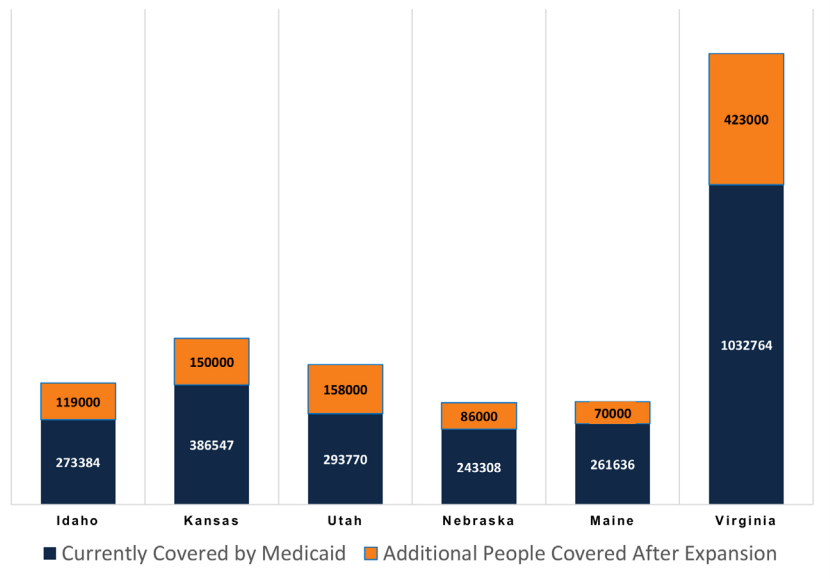
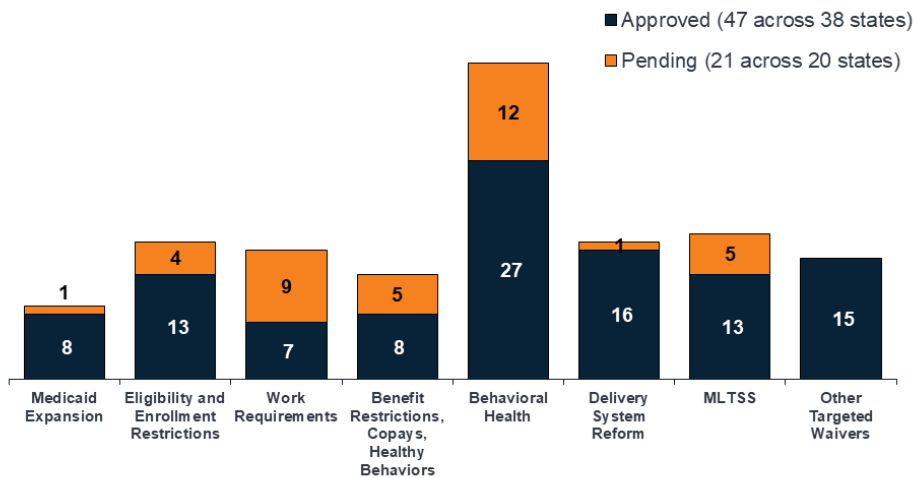


Figure 3: Approved, Pending, and Invalidated Medicaid Waivers



NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. MLTSS = Managed long-term services and supports.



Medicaid eligibility is inversely linked to demand for VHA care, as covered in a prior PEPRc Policy Brief.¹⁶ More recent research has found that VAMCs in non-expansion states experience higher demand for care compared to expansion states.¹⁷ Hundreds of thousands of Veterans live in pending expansion states. In four out of six of those states (ID, KS, ME, NE), VHA care utilization is higher than the national average.

Despite a decrease in number of Veterans uninsured in recent years, 7.2% of Veterans aged 18-64 nationwide still lack health insurance.¹⁸ However, the uninsured rate of Veterans in states that will presumably expand is lower than the nationwide

average. For example, Maine's uninsured rate is 4%; Nebraska's is 1%. Yet, the Medicaid program is an important safety net for Veterans, some of whom would be uninsured otherwise.¹⁹ A recent study showed the uninsurance rate in two expansion states (Kentucky, Arkansas) dropped by more than 20 percentage points after expansion relative to a non-expansion state (Texas). Moreover, for uninsured people that gained Medicaid coverage, there was a 41 percentage point increase in having a usual source of care, \$337 reduction in yearly out-of-pocket spending, increases in preventive health service utilization and a 23 percentage point increase in "excellent" health status.²⁰

Conclusion

Medicaid enrollment has grown steadily since the program's inception, with a major boost occurring just after the ACA's Medicaid expansion. Eligibility for certain populations has fluctuated over time and continues to evolve in response to federal and state policy changes, including work requirements and other policies that expand or contract eligibility or encourage or discourage enrollment. The policy environment will continue to change post-midterms with the Democrats reclaiming majority status in the House and many state legislatures experiencing changes in their composition.

Medicaid coverage has substantial effects on access to care and service utilization, including for VHA care. Evidence shows VAMCs in non-expansion states experience higher demand for care compared to expansion states. Hundreds of thousands of Veterans live in pending expansion states. In four out of six of those states (ID, KS, ME, NE), VHA care utilization is higher than the national average.

Further research is needed to understand effects of changes to state Medicaid programs on VHA waiting times and reliance on VHA care or VA-financed community care. It may be worthwhile to explore how expansions in VHA community care availability and Medicaid interact to influence access to care. One open question, for example, is whether Medicaid expansion reduces the number of Veterans who use VA community care.

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About PEPRC Policy Briefs

This evidence-based policy brief is written by the Partnered Evidence-based Policy Resource Center (PEPRC) staff to inform policymakers and VHA managers about the evidence regarding important developments in the broader health care system or economy that could impact VHA. In addition to publishing evidence-based policy briefs, PEPRC is a QUERI-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, performs other, rigorous, quantitative analysis of high priority issues, and refines performance metrics.