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UHPP | Sustainable Health Care Solutions for Underserved Utahns

October 2019
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Why Fully Expand Medicaid?

Analyzing the Out-of-Pocket Cost Burden for Low-Income Utahns

Introduction

This report explores potential out-of-pocket costs facing low-income enrollees in the Affordable Care Act individual Marketplace and compares the cost burden between Medicaid and Marketplace plans. Including creating sample profiles on healthcare.gov, reviewing all plan options and calculating the median estimated yearly total cost by expected usage. After converting total costs into a percentage of annual income, results found that for the expansion population, there is a dramatic difference in cost between Marketplace and Medicaid, with individual market enrollees expected to pay up to fifteen-times more out-of-pocket per year.

Background

Utah has long resisted full Medicaid expansion with the arguments that the state cannot afford it, while low-income Utahns *can* afford the cost sharing required in the Marketplace.

This position relies on the insistence that there is highly-subsidized "platinum-level" coverage available on the Marketplace for people above the poverty line. However, that claim quickly loses steam once you dig deeper into the options available and examine the out-of-pocket costs facing the lowest-income enrollees.

The Affordable Care Act provides generous premium subsidies[1] on a sliding scale for families and individuals from 100%-400% of the Federal Poverty Level (FPL).[2] There are also cost-sharing reduction[3]

[1] Healthinsurance.org. "Premium Assistance Tax Credits Definition." *Healthinsurance.org*, Healthinsurance.org, 31 Jan. 2019, www.healthinsurance.org/glossary/premium-assistance-tax-credits/.
"How to Save Money on Monthly Health Insurance Premiums." *HealthCare.gov*, www.healthcare.gov/lower-costs/save-on-monthly-premiums/.
[2] "2018 Poverty Guidelines." *ASPE*, 11 Jan. 2019, aspe.hhs.gov/2018-poverty-guidelines. – Note: the 2018 Poverty Level is used to calculate ACA subsidies, while 2019 guidelines are used for Medicaid eligibility
[3] "Extra Savings on out-of-Pocket Health Care Costs." *HealthCare.gov*, www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/.

subsidies for people between 100% and 250% FPL, which subsidize out-of-pocket costs like copays and deductibles.

Even with this financial assistance, Medicaid is still far more affordable than the Marketplace for the expansion population. For people right above the poverty line (from 100-138% FPL), their annual income is so low that even with the generous assistance and subsidized coverage, their out-of-pocket expenses can exceed 50% of their before-tax income.

Methodology

UHPP created several sample profiles on healthcare.gov to "shop" for plans and compare prices. These profiles included rural and urban areas (Wayne County and Salt Lake County) to check for locational variations in price; Different ages (35, 55, and 63) to compare the impact of age-banding on price; and different income levels from 107 to 165 percent FPL to compare the cost burden by income.

UHPP used the healthcare.gov "plan finder"[4] option to shop for plans for these sample profiles. Each sample profile was a non-smoker, meaning that the findings of this report reflect lower costs than a smoker will face. Each sample profile was female, which does not impact the results for males since the Affordable Care Act did away with gender discrimination in health insurance pricing.

The data that will be featured in this report comes from the profile of a 35-year-old female, nonsmoker in Salt Lake County. This sample was chosen after rural and urban results were nearly-identical outside Wayne County having 18 plan options and Salt Lake County having 38. UHPP chose age 35 because the results across ages were similar in the low and high usage categories, with medium usage reflecting the only dramatic variation. By highlighting the 35-year-old, UHPP was opting to be more conservative.

Using the plan finder, there is an option to view the estimated total yearly cost. This includes premiums, deductibles, and copays and coinsurance. The average annual out-of-pocket expense numbers are divided into three categories: low, medium, and high usage. Low usage is defined as few doctor visits, occasional prescription drugs, and no hospital visits expected. Medium usage is defined as regular doctor visits, regular prescription drugs, and hospital visit unlikely. High usage is defined as frequent doctor visits, frequent prescription drugs, and at least one hospital visit likely. The total yearly cost is calculated as monthly premium, minus subsidy, for the year, plus expected payment toward deductible and anticipated copayments and coinsurance.

UHPP compiled the expected out-of-pocket cost for all three usage levels, for all of the plan options for each sample patients. From this data, UHPP calculated the median out-of-pocket costs for each of the sample patients and each usage level, then used the median out-of-pocket costs to calculate expected out-of-pocket costs as a percentage of annual income.

[4] "See Plans and Prices." *Healthcare.gov,* https://www.healthcare.gov/see-plans/

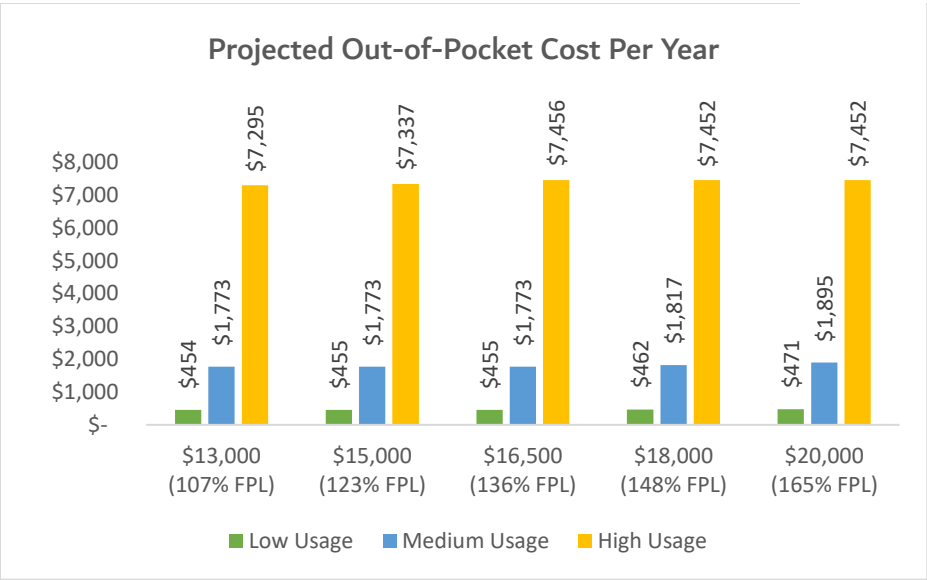
UHPP used the healthcare.gov definitions of low medium and high usage to create parallel categories for Utah Medicaid. For these categories, UHPP defined low usage as two prescriptions per month, every month and four doctor's appointments. Medium usage as five prescriptions per month, every month and ten doctor's appointments. And high usage as the maximum out-of-pocket cost for prescriptions (five per month) and doctor's appointments (twenty-five), as well as five hospitalizations and two non-emergency ER visits. UHPP then calculated the expected out-of-pocket cost as a percentage of income for Medicaid and compared out-of-pocket costs for Medicaid versus Marketplace.

RESULTS

High Usage, High Cost for Marketplace Enrollees

For Utahns with Marketplace plans, projected out-of-pocket costs vary widely depending on how much physical and mental health care someone needs. These expected costs include monthly premiums, but also cost-sharing that accumulates as they access their care through deductibles, copayments, and coinsurance. These expenses are where the out-of-pocket burden accelerates, particularly for patients with disabilities, chronic illness, mental illness, and substance use disorder.

CHART A



As seen in chart A, there is a dramatic difference in cost between low, medium and high usage-- with the enrollees with the highest need facing yearly expenses exceeding $7,000. This steep expense is even more damning when translated into a percentage of annual pre-tax income, as seen in chart B.

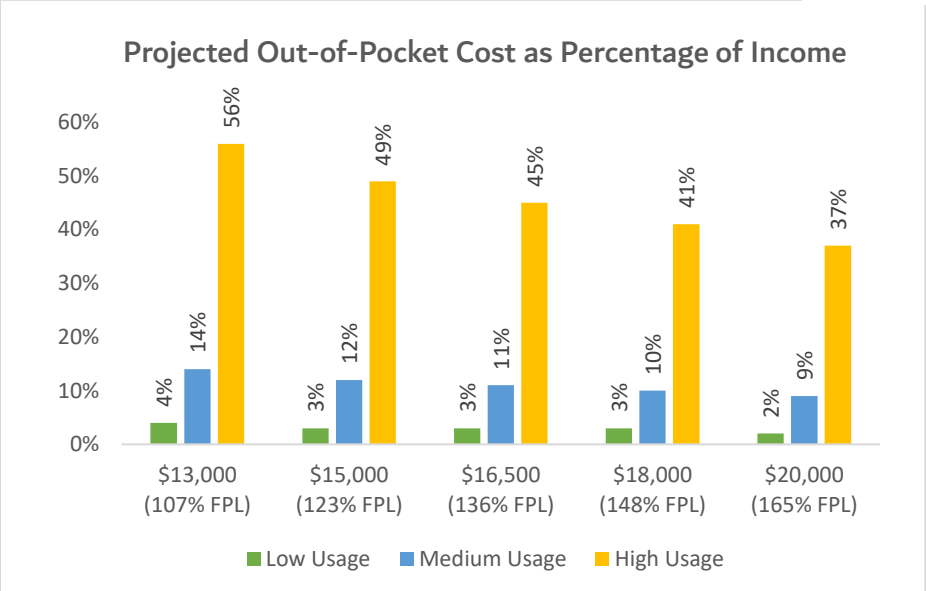
There are a wide range of chronic health issues that could lead to this kind of expensive high usage. An example noted below in Marcie's story, is Inflammatory Bowel Disease (IBD). Crohn's disease is the most

common IBD, which causes a range of painful gastrointestinal symptoms, as well as comorbidities like nutrient deficiencies, arthritis, cardiovascular disease, mental health complications, and more.[5] The Crohn's and Colitis Foundation recently released a study identifying the high cost of treating IBD, finding that IBD patients "incurred over three-times higher annual costs than non-IBD patients.[6]" The standard treatment of Crohn's disease includes biologic medications which can cost thousands of dollars per month, regular colonoscopies, and, for 70% of patients,[7] costly surgeries. Managing Crohn's disease is estimated to average $19,000 in direct medical costs annually per patient.[8]

Why Full Medicaid Expansion? Variations in Cost Burden by Income Level

While enrollees nearest the poverty level receive the most generous premium assistance and cost sharing reduction subsidies, they also face the steepest cost-sharing burden when viewed as a percentage of income.

CHART B



That $7,000 high usage estimate translates into 56% of an individual's income when they are at 107% FPL, earning $13,000 per year. However, once that individual crosses above the 138% FPL expansion eligibility threshold, the out-of-pocket cost burden becomes less extreme, dropping 19% by the time the individual is earning $20,000 (or 165% FPL). This illustrates why Medicaid is so essential for this select

[5] Román, Antonio López San, and Fernando Muñoz. "Comorbidity in inflammatory bowel disease." *World journal of gastroenterology* vol. 17,22 (2011): 2723-33. doi:10.3748/wjg.v17.i22.2723

[6] "New Research Reveals High Cost of Care for Inflammatory Bowel Disease Patients in the United States." *Crohn's & Colitis Foundation*, www.crohnscolitisfoundation.org/new-research-reveals-high-cost-care-inflammatory-bowel-disease-patients-united-states.

[7] "Crohn's Disease Treatment Options." *Crohn's & Colitis Foundation*, www.crohnscolitisfoundation.org/What-is-crohns-disease/treatment.

[8] "The New Economic Reality in the World of IBD." *Inflammatory Bowel Disease: Diagnosis and Therapeutics*, by Russell D. Cohen, Humana Press, 2017.

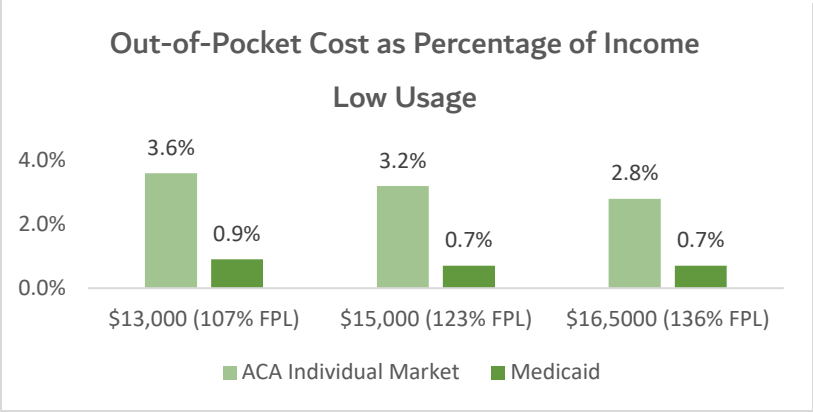
population. While an expected out-of-pocket expense of 37% is still very concerning, an out-of-pocket expense of 56% is insurmountable.

Individuals and families living in or near-poverty face endless barriers to good physical, mental, and social health. Full Medicaid expansion is a proven way[9] to enable these underserved people to improve their health, which in turn enables them to improve their employment situation, improve their financial situation, and improve their quality of life. This has the added benefit of improving population health, which benefits the entire state.

Comparing Medicaid and Individual Market Out-of-Pocket Cost Burden

When comparing the out-of-pocket cost burden for potential Medicaid enrollees from 100-138% FPL with these Marketplace projections, the anticipated expense is far lower on Medicaid across all usage levels. As seen in chart B above and chart C below, expected costs for low usage on Marketplace plans vary from 3.6% to 2.8%. Meanwhile, on Medicaid similar usage costs enrollees around $100 per year--totaling less than 1% of their pre-tax income.

CHART C



For medium usage, charts B, D and E show that expected costs for healthcare.gov plans vary from 11 to 27%, while similar usage on Medicaid costs just 1.7-2.2%, making Medicaid up to twelve-times less expensive. This is the one area where there was a noticeable difference between enrollees of different ages. For the medium usage category, a 35-year-old is projected to pay 11-14% of their annual pre-tax income toward health care costs, while a 55-year-old at the same income and usage level is projected to pay 21-27%, as seen below in chart E. This makes the difference between Marketplace and Medicaid even more extreme as enrollees with medium usage age.

[9] Antonisse, Larisa, et al. "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." *The Henry J. Kaiser Family Foundation*, 15 Aug. 2019, www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/.

CHART D

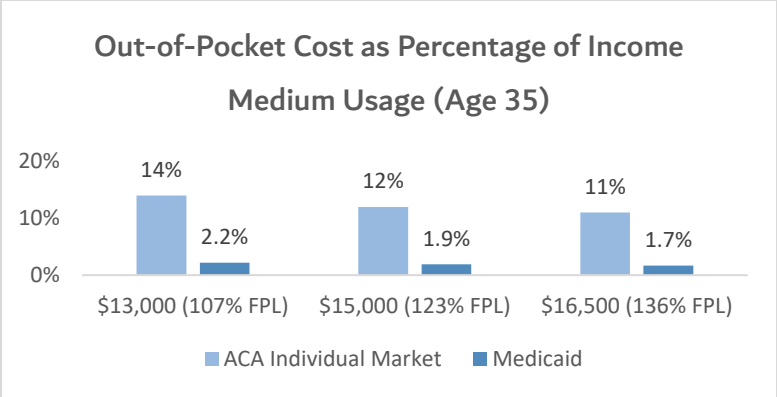
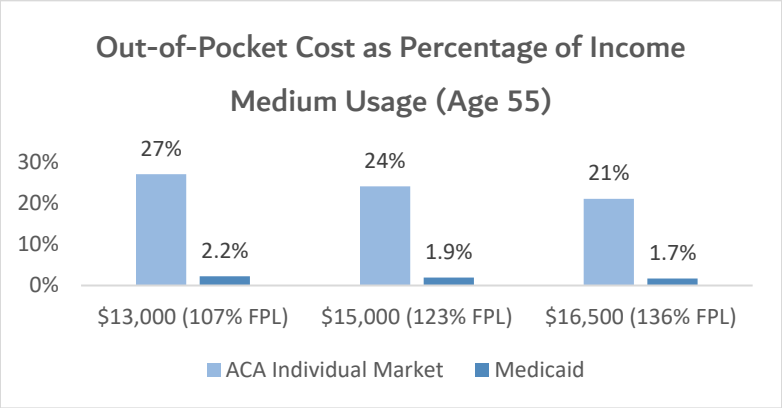
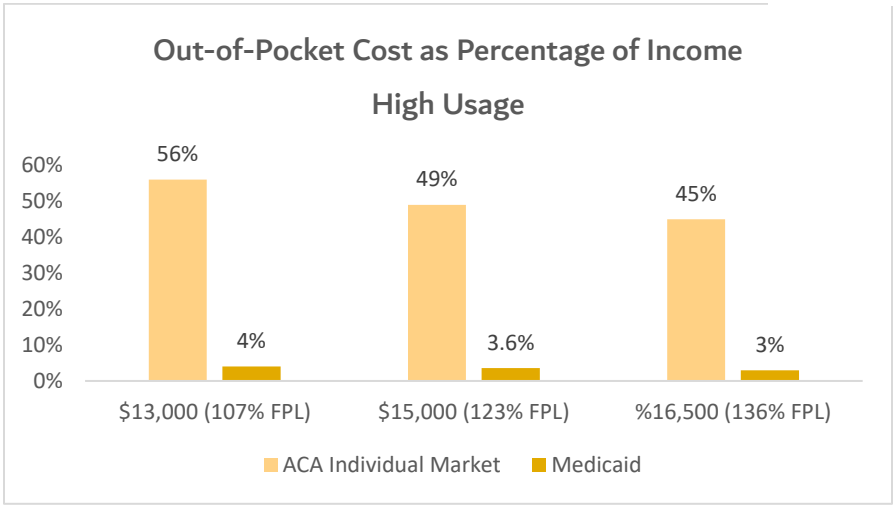


CHART E



The most dramatic difference, however, is apparent in the high usage category. As seen in chart B and F, Marketplace enrollees managing chronic conditions are faced with the challenge of health care costs estimated to total half of their pre-tax income.

CHART F



This forces Marketplace enrollees with chronic health conditions to make impossible choices, navigating which bills to put off, what care to do without, and whether to address their health needs or other

pressing budget concerns—like paying rent. If granted access to Medicaid, this high usage, low-income population would see their out-of-pocket cost burden drastically reduced, facing expenses up to fifteen-times lower than under Marketplace plans.

Human Impact: June

June is currently uninsured, because she cannot afford even a highly-subsidized Marketplace plan after being laid off unexpectedly. Without access to unemployment and with little savings, she is getting by with temporary, part-time jobs while finishing her master's degree and searching for a new full-time position. Her income is so unpredictable, that even applying for Marketplace insurance is challenging, because she can barely calculate her budget for this month, let alone her expected income for next year. Instead, she is playing a risky game. Two years ago, she had open abdominal surgery to remove a uterine tumor, and now she cannot afford to follow up to ensure that her health remains stable. She weighed her options, and the likelihood that she'll have a medical crisis is lower than the likelihood that she'll need to buy groceries next week, and so she must prioritize food over health insurance until she can secure a job that offers health care coverage.

Human Impact: Marcie

Marcie works part-time at Brigham Young University as a secretary. She was diagnosed with Crohn's disease in 2002, and she requires expensive biologic medication to manage her chronic illness, as well as regular colonoscopies. She is currently earning barely enough to push her over the poverty line, and so she does not qualify for Medicaid. She has a Marketplace plan, where she has struggled to afford the deductible. Thankfully, she lives with her parents and they can occasionally help her cover the medication which costs her thousands of dollars per infusion. Without access to Medicaid, Marcie must make difficult decisions with her budget and rely on assistance from family. Her out-of-pocket cost burden would be significantly less under full Medicaid expansion.

Human Impact: Brittany

Brittany is a woman who has had a long journey with homelessness, substance use disorder, and mental health issues. She was in the Medicaid coverage gap until she met one of UHPP's enrollment assisters at the VOA Center for Women and Children, where she was able to sign up for Medicaid under Utah's partial expansion "Bridge Plan".[10] With this new Medicaid, she was able to find a primary care physician, enroll in substance use disorder treatment, and receive necessary mental health medications. She recently spoke at a press conference celebrating Medicaid expansion,[11] where she credited the program for saving her life. Unfortunately, only a few hours later, while she was waiting to see a doctor, she

[10] "Medicaid Expansion." Medicaid Expansion | Utah Medicaid, 1 Apr. 2019, medicaid.utah.gov/expansion.

[11] Imlay, Ashley. "Advocates Say Underserved Utahns Don't Know They Can Sign up for Expanded Medicaid." *Deseret News*, Deseret News, 1 Oct. 2019, www.deseret.com/utah/2019/10/1/20893910/advocates-celebrate-6-months-of-medicaid-expansion.

found out that her Medicaid had been discontinued. She was told that her income had grown slightly, enough to put her about $20 above the eligibility limit. After paying out-of-pocket to finish the appointment and a week of back-and-forth, she successfully reversed the decision and is again enrolled in Medicaid. Thankfully, Brittany had the support to appeal—and the continued support needed to survive while keeping her income below the poverty line because Medicaid is especially vital for her due to the lack of out-of-pocket costs for mental health and substance use disorder treatment, which would quickly-accumulate copays under a Marketplace plan.

Adding More Cost Sharing to Medicaid

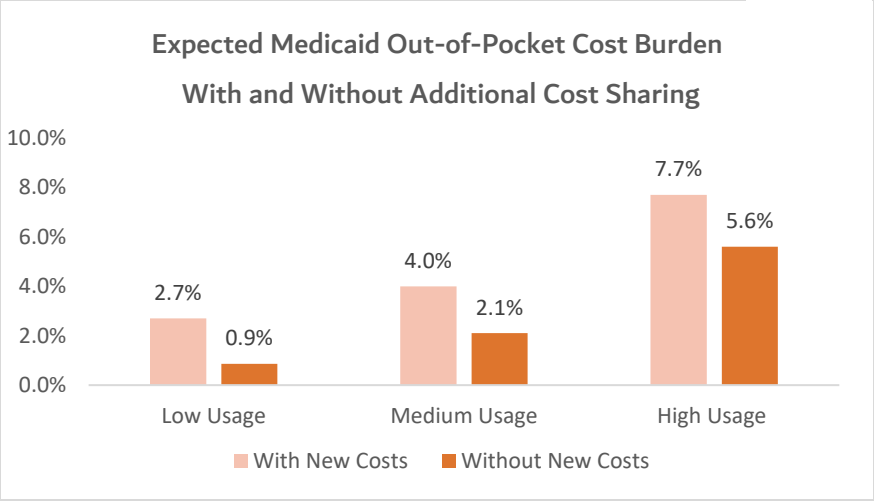
Utah's latest Medicaid expansion waiver, the "Fallback Plan"[12] would add new out -of-pocket costs to Medicaid enrollees in the 100-138% expansion population. The proposal includes monthly premiums ($20 per month for individuals and $30 for a couple), as well as an increase in the penalty for non-emergent emergency room usage from $8 to $25. While this increase in cost still leaves the out-of-pocket burden below individual market options, it is an unnecessarily harmful step back from the accessibility and affordability of Medicaid as it exists today.

Putting an additional cost sharing burden onto Medicaid enrollees will act as a barrier to care. For people in this income category- between $1,012 and $1,396 per month for an individual - even $20 per month can be prohibitive when faced with other expenses, like high housing, food, and transportation costs. Even the process of premium payment can be a red tape barrier, adding one more step to maintaining access to care. This hurdle can be seen in action on the CHIP program, where the number one reason[13] kids lose their health care is a missed premium.

The increased ER penalty is also concerning. This change is billed as a well-intentioned way to encourage people to prioritize more cost-effective alternatives like primary care and urgent care, instead of emergency rooms. However, there are better ways to address ER diversion upstream, rather than penalizing patients. Individuals seeking medical care are often not in a position to determine whether something is emergent, and deterring ER usage could backfire in dangerous ways for individuals with chronic health needs, mental illness, and others who may decide whether or not to seek care in a crisis based on whether they can afford the penalty they will face if the state does not agree that their situation was emergent.

[12] "Fallback Plan Public Hearings." *Fallback Plan Public Hearings | Utah Medicaid*, 27 Sept. 2019, medicaid.utah.gov/fallback-hearings.
[13] According to a report from the Children's Health Insurance Program Advisory Committee, which notes "premium not paid" as the number one reason for CHIP closures for the months of April, May, and June 2019.

CHART G



These changes in out-of-pocket costs will dramatically increase the financial burden on Medicaid enrollees. For an individual at 107% FPL, low usage out-of-pocket costs would triple with the addition of the premiums, while nearly doubling for medium usage. For high usage enrollees, the out-of-pocket cost burden could rise to almost 8% of their pre-tax income.

Expanding Medicaid to people between 100-138% FPL is a crucial way to expand real access to health care for some of the most underserved Utahns. Adding more cost-sharing is an unnecessary step backward, which is guaranteed to keep people away from the care they need.

Conclusions

This report provides data that support what Medicaid expansion advocates have argued for years—the ACA individual Marketplace provides cost-effective options for many people. However, for the lowest-income Utahns, Medicaid is a better option.

The results of this analysis are in line with findings of a 2018 study in Health Affairs examining the effect of Medicaid coverage for adults from 100-138% FPL. That research, "Medicaid Versus Marketplace Coverage for Near-Poor Adults: Effects on Out-Of-Pocket Spending and Coverage" concluded that "living in an expansion state was associated with a $344 decline in average total out-of-pocket spending".[14] That decline amounts to a 33.9% reduction in the out-of-pocket cost burden for Medicaid enrollees. The researchers also noted that there was a "4.5 percentage point reduction in the probability of being uninsured"[15], which they linked to the burden of premiums and out-of-pocket costs, as well as the challenges inherent in the Marketplace enrollment process. While Medicaid is open for enrollment year-

[14] Medicaid Versus Marketplace Coverage For Near-Poor Adults: Effects On Out-Of-Pocket Spending And Coverage
Fredric Blavin, Michael Karpman, Genevieve M. Kenney, and Benjamin D. Sommers
Health Affairs 2018 37:2, 299-307

[15] Ibid

round, the Marketplace has a limited 6-week open enrollment period, and unless someone applies during that time, or qualifies for a special enrollment period,[16] they are locked out of eligibility. It can also be challenging for people to estimate their expected yearly income in order to determine Marketplace eligibility, while Medicaid is determined based on monthly income. Finally, the availability of presumptive and retroactive eligibility streamlines the enrollment process, which can increase the take-up rate on Medicaid as compared to Marketplace.[17] The Health Affairs data provide a look at the improvement Utahns on the Marketplace could see after Utah fully expands Medicaid.

The correlation between poverty and health makes the disparity between the relatively-low expected yearly cost in Medicaid and the alarmingly-high out-of-pocket Marketplace costs for individuals with chronic illness, or high usage, even more concerning. Medicaid is uniquely suited to provide truly-accessible health care coverage for Utahns in the expansion population. Living in or near poverty is associated with chronic health conditions like diabetes,[18] heart disease,[19] and mental illness.[20] Treatment for these health issues can be prohibitively expensive when out-of-pocket costs pile up under Marketplace plans. Medicaid copays are significantly lower (zero for outpatient mental health and substance use disorder treatment), and there are currently no premiums or deductibles on Medicaid.

Expanding Medicaid to cover individuals up to 138% FPL is essential to ensure that they have more than just theoretical access to health care, but real, affordable, usable access. This is especially crucial when you consider rising rents and housing costs, rising transportation costs, and other essentials that individuals and families must cover near-poverty wages. The Marketplace is a great option for many Utahns, but for those nearest the poverty line access to Medicaid is crucial.

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[16] "Special Enrollment Period (SEP) - HealthCare.gov Glossary." *HealthCare.gov*, www.healthcare.gov/glossary/special-enrollment-period/.
[17] Medicaid Versus Marketplace Coverage For Near-Poor Adults: Effects On Out-Of-Pocket Spending And Coverage
Fredric Blavin, Michael Karpman, Genevieve M. Kenney, and Benjamin D. Sommers
Health Affairs 2018 37:2, 299-307
[18] Rabi, Doreen M et al. "Association of socio-economic status with diabetes prevalence and utilization of diabetes care services." *BMC health services research* vol. 6 124. 3 Oct. 2006, doi:10.1186/1472-6963-6-124
[19] Lemstra, Mark et al. "Income and heart disease: Neglected risk factor." *Canadian family physician Medecin de famille canadien* vol. 61,8 (2015): 698-704.
[20] Hudson, C. G. (2005), Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses. American Journal of Orthopsychiatry, 75: 3-18. doi:10.1037/0002-9432.75.1.3