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United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on "Building on the ACA: Legislation to Expand Health Coverage and Lower Costs"
Written Testimony Submitted by Cindy Mann, JD, Partner, Manatt, Phelps & Phillips, LLP
Tuesday, March 23, 2021

Good morning, Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the Committee. Thank you for the invitation to participate in this hearing on Tuesday, March 23, 2021.

I am Cindy Mann, a partner at Manatt, Phelps & Phillips, where I work with states, health care providers and provider associations, foundations, and consumer organizations on matters relating to health care coverage and access, delivery system and payment reform, and financing, focusing primarily on Medicaid and the Children's Health Insurance Program (CHIP). Prior to joining Manatt, from June 2009 through January 2015, I served as Deputy Administrator for the Centers for Medicare & Medicaid Services (CMS) and the Director of the Center for Medicaid and CHIP Services (CMCS). In that capacity, I was responsible for federal policy and oversight of Medicaid and CHIP and for supporting state implementation of those programs.

While at CMS, much of my attention centered on the implementation of the Patient Protection and Affordable Care Act (ACA), both with respect to federal policy development and helping states prepare for and implement the provisions of the law relating to Medicaid and CHIP, along with the changes needed to interface seamlessly with the newly created ACA Marketplaces. I welcome the opportunity to provide this testimony looking at the ways the ACA modernized and strengthened the Medicaid program. With more than ten years since enactment and seven years since most of the ACA coverage provisions became effective, there is much evidence to draw from to assess impact and help chart a path for making further improvements in coverage, delivery, and financing.

In 2010, when Congress enacted the ACA, more than 15 percent of the United States (U.S.) population was uninsured; that equated to about 47 million people.[1] The uninsured rate plummeted after implementation of the ACA coverage provisions, dropping to 8.5 percent in 2016, the lowest uninsured rate ever recorded in the U.S. Regrettably, uninsured rates have been creeping up since then to just over 9 percent in 2019.[2]

The ACA coverage changes were particularly consequential for low- and moderate-income people given that the lack of affordable insurance options has been the primary reason people were uninsured. Pre-ACA, while much of the public assumed that poor people had Medicaid coverage, that was far from reality. Medicaid is a means-tested program, meaning that it covers people based on their income, but before the ACA, federal Medicaid law excluded certain categories of people, despite their low incomes. Children, the elderly, people with disabilities, and pregnant women could be covered, but major coverage gaps existed for other adults. States were required to cover parents but at very low eligibility

[1] State Health Access Data Assistance Center (SHADAC), State Health Compare (data from the Census Bureau's American Community Survey).
[2] *Ibid.*

levels, and states had no authority—except through a waiver–to cover adults without children (including parents who had no minor children at home) no matter how low their incomes might be. These exclusions not only left these individuals without coverage, but also made little sense in terms of the investments the federal government and states were making through the program. Consider the following:

- States were required to cover children, but once they "aged" out of the children category, those young, childless adults could not retain Medicaid coverage (unless they were pregnant or disabled).
- States were required to cover women when they became pregnant, but they could not cover those women pre-pregnancy (unless disabled).
- Similarly, states were required to cover low-income adults when they turned 65, but those adults were likely to have been uninsured perhaps for decades before Medicaid eligibility attached.

In each of these pre-ACA scenarios, Medicaid was investing funds in coverage and care at different points in the person's life cycle but with significant gaps depending on circumstances that had nothing to do with their need for affordable coverage. This was hardly a cost-effective way to provide coverage or care.

The Impacts of Medicaid Expansion

The ACA sought to close these gaps. The categorical exclusions were dropped, and all adults with incomes below 138 percent of the federal poverty level (FPL) ($17,774 in annual income for a single individual in 2021) were eligible for Medicaid (subject to Medicaid's citizenship and immigration requirements). Those with incomes above that level could qualify for Marketplace subsidies. Employer-based coverage continued to be the mainstay of our nation's health coverage system under the ACA, but Medicaid and the Marketplace provided subsidized coverage for those without affordable job-based insurance.

The Supreme Court, however, intervened, ruling in 2012 that states could decide whether or not to adopt the Medicaid expansion component of the law.[3] On January 1, 2014, the effective date for the ACA coverage, 24 states and the District of Columbia (D.C.) had expanded Medicaid.[4] Today, 36 states are covering the ACA expansion group and two of those states are poised, as a result of successful ballot initiatives, to begin coverage in July of this year, leaving 12 states with a coverage gap.[5]

Medicaid expansion covered millions of people across the states that adopted it. While the ACA drove down overall uninsurance rates in every state, in 2019 the uninsured rate in non-expansion states was significantly higher than that of expansion states (11.1 percent as compared to 6.9 percent, respectively).[6] Were the 12 remaining states to adopt expansion, some 4 million people could gain coverage.[7] A high percentage of those individuals are Black, Hispanic, or other people of color:

[3] *National Federation of Independent Business v. Sebelius,* 648 F. 3d 1235, affirmed in part and reversed in part.
[4] Congressional Research Service, The ACA Medicaid Expansion.
[5] Kaiser Family Foundation (KFF), Status of State Medicaid Expansion Decisions: Interactive Map.
[6] SHADAC, State Health Compare (data from the Census Bureau's American Community Survey). "Expansion states" excludes those that implemented expansion in 2020 (Idaho, Nebraska, and Utah) and those that have adopted but not yet implemented expansion (Missouri and Oklahoma).
[7] KFF, Who Could Get Covered Under Medicaid Expansion? State Fact Sheets.

accounting for over 50 percent of the people in the gap in Texas, Mississippi, Georgia, and Florida, and over 40 percent in North Carolina, South Carolina, South Dakota, and Alabama.[8]

Since 2014, the evidence has mounted showing the positive impact of Medicaid expansion.[9] Key findings include the following:

- **Medicaid coverage translates into needed care.** One study found that, following expansion, cancer patients were diagnosed at an earlier stage, the portion of patients who were uninsured decreased, and patients of low socioeconomic status experienced improved access to surgical care.[10]
- **Expansion reduces racial disparities in health coverage, access, and outcomes for people of color**.[11] Between 2013 and 2018, the difference in uninsured rates between white and Black adults dropped by about 50 percent in Medicaid expansion states as opposed to 33 percent in non-expansion states.[12] Another study showed that expansion was significantly associated with a reduction in maternal deaths, with the positive effects concentrated among non-Hispanic Black mothers.[13]
- **Medicaid expansion improves coverage among working Americans**. A 2017 analysis of data from the American Community Survey and the Current Population Survey found gains in health coverage among workers to be greater in Medicaid expansion states as compared to non-expansion states, with 63 percent of workers who gained coverage residing in states that expanded under the ACA.[14]
- **Coverage for expansion adults results in more coverage and greater preventive care for children**.[15] For example, children in poverty in Louisiana were more likely to have well-child visits after Medicaid expansion as compared to children in Texas and Mississippi.[16]
- **Rural hospitals are helped significantly by expansion**. Between 2013 and 2015, rural hospital uncompensated care costs fell 43 percent in expansion states as compared to 16 percent in non-expansion states. Rural hospitals located in Medicaid expansion states are 62 percent less likely to close than those located in non-expansion states.[17]

States have realized these and other strong, positive impacts of expansion with little or no new state spending, with the influx of federal funds also fueling economic growth.[18] While non-expansion states are today spending state general funds to underwrite program costs of health care services for

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[8] *Ibid*.

[9] State Health and Value Strategies (SHVS), Finishing the Job of Medicaid Expansion; KFF, Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care; and Medicaid and CHIP Payment and Access Commission (MACPAC), Changes in Coverage and Access.

[10] The American Journal of Surgery, Disparities in Access to Cancer Surgery After Medicaid Expansion.

[11] SHVS, Finishing the Job of Medicaid Expansion.

[12] Center on Budget and Policy Priorities (CBPP), Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care.

[13] Women's Health Issues, Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality.

[14] Urban Institute, Workers Gaining Health Insurance Coverage Under the ACA.

[15] Health Affairs, Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children.

[16] American Public Health Association, Medical Care, The Impact of Medicaid Expansion for Adults Under the Affordable Care Act on Preventive Care for Children: Evidence from the Southern United States.

[17] The Chartis Group, Chartis Center for Rural Health, The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability.

[18] National Bureau of Economic Research, Fiscal Federalism and the Budget Impacts of the Affordable Care Act's Medicaid Expansion.

uninsured residents, the other 36 states are able to underwrite all but ten percent of the cost of these services using federal dollars.[19]

Other Key Medicaid Changes in the ACA

Medicaid expansion is the most prominent feature of the ACA Medicaid changes, but the law changed Medicaid in other important ways, some of which are foundational. Most significantly, the ACA retrofitted Medicaid and CHIP so that they could operate seamlessly with Marketplace coverage. The law required one application and a "no wrong door" approach to coverage. Regardless of the origin (whether it be the Medicaid or CHIP online portal or through a state or the federal Marketplace), there is one integrated application and one eligibility evaluation; applicants are enrolled in whichever coverage program that they are eligible for. To the extent possible, verification of eligibility is done electronically rather than through paper-based documentation. Accomplishing these reforms required a revamping of Medicaid and CHIP eligibility rules and operations–a major lift for CMS as well as states. The integrated pathway to gaining and retaining coverage is the culmination of a decades long process of delinking Medicaid from the rules and processes that govern cash assistance.

Other Medicaid specific ACA changes were more discrete but important nonetheless. They include a new emphasis on and funding for care coordination for people with multiple chronic conditions; new authorities and resources to make long term services and supports (LTSS) more available to people in their homes and communities; and new flexibilities and incentives for states to cover prevention services.

Further Improvements Since the ACA

While much has been accomplished, the job is not done. First and foremost, the Medicaid gap must be closed. By providing additional federal Medicaid matching funds to newly expanding states for eight quarters, the American Rescue Plan Act of 2021 ("the American Rescue Plan") has made a significant new investment in expansion. It offers a welcome and timely boost aimed at encouraging the remaining non-expansion states to extend coverage to their low-income residents in these challenging times. The COVID-19 pandemic has disrupted jobs and coverage and also put some people at particular risk for infection. Many of those people—individuals providing home care or working at grocery and other retail stores in communities throughout the country–are uninsured, but could gain coverage through expansion. As of July 2020, an estimated 650,000 uninsured workers in front-line, "essential" jobs could qualify for coverage in the remaining non-expansion states.[20]

In addition to closing the coverage gap, there is work to be done in Medicaid and in the Marketplace, to reach and enroll those who are eligible but not enrolled. Concerted efforts to boost participation rates in Medicaid and CHIP for children–through community-based outreach and simplified enrollment systems—succeeded in reaching close to 94 percent of all eligible children in 2016 (with higher participation rates in Medicaid than in CHIP).[21] Given that Medicaid expansion for adults is more recent and that outreach/navigation resources were cut back in recent years, participation rates among low-income parents lag behind.[22] The Biden Administration has already directed more funds to navigation

[19] SHVS, Finishing the Job of Medicaid Expansion.
[20] CBPP, States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession.
[21] Health Affairs, Medicaid/CHIP Participation Reached 93.7 Percent Among Eligible Children In 2016.
[22] *Ibid*. Nationwide, the average was 79.9 percent, but with wide variations across states.

efforts.[23] A sustained investment in outreach by trusted community organizations is essential to reach people who may not know they are eligible or how to apply.

Enrollment has also been depressed as a result of the public charge rule, which made Medicaid enrollment *among those eligible under the law* a negative factor that would affect people's ability to adjust their immigration status. Here again, the Biden Administration has acted first by no longer defending the Trump era rule in court and then formally withdrawing the rule; more will be needed to once again make people who are eligible for coverage comfortable applying.[24] The Administration also has moved forward to reverse some of the Section 1115 Medicaid waiver policies that added new hoops and barriers to eligibility; the Arkansas work requirement waiver led to more than 18,164 individuals losing coverage over the five months it was in operation before the court revoked the waiver approval.[25]

As the pandemic laid bare, racial and ethnic disparities are present in almost every aspect of our health care system. The public charge rule is an example of a policy directed primarily at people of color, but the drivers of disparities run much deeper, entwined in payment and delivery systems across the health care spectrum. Of particular note is the alarming rise in maternal mortality and morbidity, which is disproportionality impacting Black women. The American Rescue Plan addresses this problem by extending the period of time after birth during which Medicaid will provide continuous coverage. The option to extend postpartum coverage is a critical step forward; many states are expected to pick up the new option. Over time, Congress will need to evaluate whether the take up is broad enough to accomplish the goal, or whether 12-month postpartum coverage ought to be required, replacing the current 60-day postpartum period consistent with the science.

Social determinants of health, linked closely to racial inequities, must also be addressed in more fulsome ways. In this area, Medicaid is a leader. Many states are implementing or planning important new initiatives, some with broad implications across the health care system. All payers — Medicaid, Medicare, and commercial insurance–need to be part of the solution, but they cannot be the only part of the solution. No one can be expected regain health when they are released from a hospital only to live on the streets due to lack of affordable housing or when their families do not have enough to eat.[26] Children have been particularly impacted by food insecurity, a shocking failure for a country as wealthy as ours. The American Rescue Plan injects new resources to states, localities, and, importantly, directly to families. Many of these temporary measures should lead to significant permanent solutions.

Much has been done to reduce insurance churn– the phenomenon where people are in and out of coverage often despite ongoing eligibility– in order to provide a stable platform for coverage and care, but additional policies and renewed attention to how well the system is working are needed. In the few years leading up to the pandemic, coverage rates in Medicaid–particularly for children–have dropped, while uninsured rates have grown.[27] Several factors are likely responsible, but ensuring that the

[23] CMS, CMS Announces Additional Navigator Funding to Support Marketplace Special Enrollment Period.
[24] The Department of Homeland Security (DHS), DHS Secretary Statement on the 2019 Public Charge Rule; Federal Register Vol. 86, No. 48; and Urban Institute, One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019.
[25] CMS, Arkansas Works CMS Letter to State.
[26] The Association of American Medical Colleges (AAMC), 54 million people in America face food insecurity during the pandemic. It could have dire consequences for their health.
[27] The Georgetown University Center for Children and Families (CCF), Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade.

simplified eligibility and renewal systems are working as intended is key. Additionally, while states have the option to keep children continuously covered for 12 months, no such option exists for parents and other adults. And some states are exploring bolder policies to maintain coverage for young children for their first five years of life.

Finally, it is important to recognize the role that Medicaid plays financing LTSS; it is the single largest source of financing for these services and accounts for about one third of all Medicaid expenditures.[28] The pandemic has caused illness and deaths among far too many nursing home residents and staff. And it has tested our home care system, as children with special health care needs and adults with disabilities or chronic illnesses struggle to get the care they need during this time of crisis. Home care workers are too often paid poverty-level wages, without sick leave or health insurance. To bring better quality and equity to the system, investments are needed with particular attention to strengthening the workforce. The American Rescue Plan injects new funding into LTSS to help address COVID-19 related challenges, assisting states as they address some of the most critical gaps. Those resources along with more structural reforms are needed, whether reform is accomplished through Medicaid, Medicare, or, as at least one state is exploring, a social insurance type system.

Conclusion

Medicaid is highly valued by those it serves and by the public at large, even more so since the enactment of the ACA. Serving more than 75 million people—nearly half of whom are children–Medicaid plays a central role in our health care system and in our communities.[29] The ACA strengthened the program significantly, and the recently enacted American Rescue Plan provides new and vital–albeit mostly temporary–improvements. Thank you for your support for the program and all that it does.

[28] Office of the Assistant Secretary for Planning and Evaluation (ASPE), An Overview of Long-Term Services and Supports and Medicaid: Final Report.

[29] CMS, September 2020 Medicaid & CHIP Enrollment Data Highlights. As of September 2020, 49.5 percent of children were in enrolled in Medicaid or CHIP with the vast majority covered through Medicaid.

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About Manatt Health

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