Virginia Has Better Alternatives than Medicaid Expansion[1]

Statement of Devon M. Herrick, PhD, to the members of the Medicaid Innovation and Reform Commission, Commonwealth of Virginia, October 21, 2013.

Chairman Hanger, Vice-Chair Landes, Secretary Hazel, Secretary Brown and members of the Commission, I am Devon Herrick, health economist and senior fellow with the National Center for Policy Analysis. The NCPA is a public policy research institute with offices in Dallas and Washington DC. Thank you for allowing me to share my thoughts and I look forward to your questions.

The Medicaid Innovation and Reform Commission has an important choice to make. In June 2012, the U.S. Supreme Court ruled unconstitutional those provisions of the Patient Protection and Affordable Care Act (ACA) that would have forced Virginia to expand Medicaid. As a result of the Supreme Court decision, Virginia now has the opportunity to compare the costs, benefits and alternatives of extending Medicaid benefits to a less needy population.

The Obama Administration and Medicaid advocates have all touted the benefits of expanding state Medicaid programs. Indeed, the Affordable Care Act contains financial incentives designed to strongly encourage states like Virginia to expand Medicaid eligibility. However, a thorough discussion of the costs, obstacles, alternatives to and potential pitfalls of Medicaid expansion is critically important.

Virginia has better alternatives to a one-size-fits-all Medicaid expansion. Initially, about half of those newly covered under the ACA were expected to enroll in an expanded Medicaid program.[2] These were primarily childless adults with incomes up to 138 percent of the federal poverty level (FPL).[3] The uninsured with incomes above 138 percent of poverty were expected to sign up for coverage through their job or obtain coverage through the newly-created state and federal Health Insurance Exchanges.

However, if Medicaid coverage is not made available to them, many moderate-income Virginians — those with incomes between 100% and 138% — will also be eligible for generous federal subsidies to purchase private health coverage in the ACA's new Health Insurance Exchange.[4] For individuals who qualify, this is a much better option.

The Virginia Medicaid program. Virginia Medicaid currently covers roughly 1 million people — about 1-in-8 Virginians. About three-quarters of these are children and non-elderly, non-disabled adults and their children. Virginia Medicaid does not currently cover poverty-level, nondisabled adults; but the ACA seeks to change that.[5] Most of the newly eligible would be adults, whereas most children in families at this income level are already eligible.

Effect of the ACA on Virginia Medicaid Enrollment and Costs. There are about 1.7 million individuals living in Virginia with incomes under 139 percent of the federal poverty level, nearly three-quarters of them which have health coverage.[6]Most of these individuals — least theoretically — would become eligible for Medicaid under an expanded Medicaid program. Of the nonelderly Virginia families and individuals with incomes under 139 percent of poverty,

485,800 lack health coverage; 423,200 are already enrolled in Medicaid; 339,400 have employer coverage; and about 208,400 are covered by some other type of health insurance.[7]

Obstacles to Overcome. There are a number of problems with Medicaid expansion. Medicaid expansion is promoted as program that will cost states little.[8] However, the enhanced federal match decreases over time, and will fall to 90 percent in 2020 and thereafter — unless further cuts are made to accommodate federal budgetary constraints.[9]

How Medicaid Displaces Private Insurance. Most Americans incorrectly believe that none of the poor have private health insurance. However, many of the newly Medicaid insured will be those who previously had private coverage. Crowd-out (or substitution) occurs when people who are already covered by employer or individual insurance drop that coverage to take advantage of the public option. Crowd-out is likely to be a significant problem for states that expand Medicaid eligibility to adults who are not disabled. Estimates of crowd-out are controversial among analysts. Some researchers find a high rate of Medicaid substitution for private coverage, while others believe it is negligible. Estimates of crowd-out for diverse populations vary.

For instance, analysis of past Medicaid expansions to mothers and children in the early 1990s by economists and Obama administration advisers David Cutler and Jonathan Gruber found that when Medicaid eligibility is expanded, 50 percent to 75 percent of the newly enrolled have dropped private coverage.[10] A recent analysis by Gruber and Kosali Simon estimated crowd-out for the Children's Health Insurance Program averages about 60 percent.[11]

Working adults are the target of Medicaid expansion under the ACA. Academic researchers Steven Pizer, Austin Frakt and Lisa Iezzoni analyzed the likely effect of crowd-out on working adults, and estimated crowd-out could reach 82 percent.[12] A conservative estimate indicates that Medicaid rolls might have to rise by 1.4 people in order to reduce the uninsured by 1 person.[13]

Poor Access to Care Under Medicaid. Nationally, about one-third of physicians do not accept new Medicaid patients.[14] This is nearly double the proportion of doctors who have closed their practices to new Medicare patients (17 percent) and to new privately insured patients (18 percent).[15] Physicians are four times as likely to turn away new Medicaid patients as they are to refuse the uninsured who pay out-of-pocket (31 percent versus 8 percent).[16] Studies show it is easier for the uninsured to make doctors' appointments than it is for Medicaid enrollees.[17]

Medicaid enrollees' access to physicians is only slightly better in Virginia. Nearly one-quarter (24 percent) of Virginia physicians refuse to accept any new Medicaid patients.[18] Access to care for Virginia's Medicaid enrollees will only get worse if more people are added to the rolls.

Low Medicaid Provider Fees. Low reimbursement rates are one of several factors contributing to the shortage of physicians willing to treat Medicaid enrollees.[19]State Medicaid programs assume doctors are benevolent, and most are willing to treat Medicaid enrollees for fees far lower than reimbursed for their privately-insured patients — even below less lucrative but more plentiful Medicare patients. Most physicians *are* willingly to treat *some* Medicaid patients out of benevolence —in return for reimbursements that are close to marginal cost. This strategy may work when doctors have some slack in their schedules and only a few of their patients are on

Medicaid. However, as state governments put more and more people in Medicaid, this arrangement breaks down. When the number Medicaid patients calling physicians' offices for an appointment turns from a handful of low-income enrollees into a deluge of lower-middle-income Medicaid enrollees, doctors may balk.

On average, Virginia pays physicians participating in the fee-for-service state Medicaid program only 80 percent as much as Medicare pays for the same service — in other words, physicians treating Medicare patients get paid significantly more for the same services. For primary care, Virginia Medicaid only pays 74 percent as much as Medicare.[20] For all services, Virginia's Medicaid program pays less than two-thirds (65 percent) as much as a private insurer.[21] Low provider reimbursement rates make it more difficult for Medicaid enrollees to find physicians willing to treat them, limiting their access to care.

Alternatives to Medicaid Under the Affordable Care Act. Under the ACA, starting in 2014, qualifying individuals who have no access to an employer-provided health plan or Medicaid can purchase federally-subsidized individual health insurance in health insurance exchanges set up by the federal government or the states.[22] Those whose employers offer affordable health plans will not be eligible for federal exchange subsidies, but can still purchase coverage in the exchange if they choose.[23]

The share of premiums paid by enrollees in the exchange who earn 100 percent to 133 percent of the poverty level cannot exceed 2 percent of their incomes. Premiums are limited to 3 percent of income for those earning 134 percent to 138 percent of poverty.[24]

Thus, their annual cost will often average less than $240 per covered individual depending on income and number of family members covered.[25] The amount an individual will receive in federal exchange subsidies will be based on a "Silver Plan" covering 70 percent of medical needs. Additional cost-sharing subsidies boost the actuarial value to about 94 percent. Coverage this comprehensive for a family of four is potentially worth $15,000. Low-income families choosing less comprehensive "Bronze Plans" covering 60 percent of medical costs may have to pay nothing for their coverage.[26] If Virginia wants to encourage this moderate-income population to enroll in private plans in lieu of Medicaid, it could pay the non-subsidized portion of the premiums.

How Would Private Coverage Affect Providers? History shows that not all those who qualify for Medicaid will enroll. The rate at which they do enroll varies depending on a variety of conditions. Private coverage that allows individuals and families to see most physicians and utilize large hospital networks may further encourage the uninsured to obtain insurance, rather than to go without it. Virginia doctors and hospitals would benefit from policies that maximize the number of people with commercial insurance, because private insurance reimbursements are higher. Medicaid expansion would produce the opposite effect, because an estimated 30 percent of adults in the 100 percent to 138 percent poverty income range with private insurance will drop it in favor of Medicaid.

If Virginia does not expand Medicaid to those earning 100 percent to 138 percent of poverty, the state will forgo about $7.6 billion in additional federal Medicaid spending on that population over the next 10 years. However, if Virginia families use the generous federal subsidies for

private insurance in the health insurance exchange, private insurers will spend approximately $10.3 billion on medical care for these enrollees.43 After accounting for Virginia's share of new Medicaid spending, the $2.8 billion difference represents an additional infusion of nearly $300 million per year — including extra money for the state's doctors and hospitals.

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[1] Devon M. Herrick and Linda Gorman, "An Economic and Policy Analysis of Medicaid Expansion in Virginia," National Center For Policy Analysis, Issue Brief No. 129, September 2013. Available at: http://www.ncpa.org/pdfs/ib129.pdf.

[2] The ACA was estimated to cover 32 million uninsured by 2016 and 34 million by 2021. See Douglas W. Elmendorf, "CBO"s Analysis of the Major Health Care Legislation Enacted in March 2010," Congressional Budget Office, 2011, Table 3, p. 18, http://goo.gl/87zua (accessed May 15, 2013). This estimate has been revised to 26 million in 2016. See Jessica Banthin, Holly Harvey and Jean Hearne, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," Congressional Budget Office, July 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[3] Eligibility is technically cut off at 133 percent of FPL, but individuals with incomes up to 138 percent of poverty may be eligible, due to a 5 percent income disregard.

[4] Chris L. Peterson and Thomas Gabe, "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA), Congressional Research Service, April 28, 2010. Available at http://www.ncsl.org/documents/health/hlthinspremcredits.pdf.

[5] Dustin A. Cable, "Virginia Medicaid Now and Under Health Reform: Estimating Medicaid Eligible and Enrolled Populations, Demographics & Workforce Group, Weldon Cooper Center, University of Virginia, September 2010.

[6] Kaiser Family Foundation. http://kff.org/other/state-indicator/distribution-by-fpl/; see also http://kff.org/medicaid/state-indicator/distribution-by-fpl-4/ and http://kff.org/other/state-indicator/nonelderly-up-to-139-fpl/?state=VA

[7] Kaiser Family Foundation. Available at http://kff.org/other/state-indicator/nonelderly-up-to-139-fpl/?state=VA.

[8]"Affordable Care Act," Medicaid.gov. Available at http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html.

[9] Future Congresses have the right to renew, alter or cancel the federal match.

[10] David Cutler and Jonathan Gruber "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, Vol. 111, No. 2, May 1996, pages 391-430.

[11] The actual rate varied depending on the conditions governing expansion and the populations covered. Jonathan Gruber and Kosali Simon, "Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" *Journal of Health Economics*, Vol. 27, 2008, pages 201-217.

[12] Steven D. Pizer, Austin B. Frakt and Lisa I. Iezzoni, "The Effect of Health Reform on Public and Private Insurance in the Long Run," *Health Care Financing & Economics*, HCFEWP#2011-03, February17, 2011. Available at http://www.hcfe.research.va.gov/docs/wp_2011_03.pdf.

[13] A ratio of 1.4 new Medicaid enrollees to reduce the uninsured by 1 assumes a crowd out rate of 29 percent [1-(1/1.4)]. One analysis found about one-quarter of the newly insured children in families earning less than 200 percent of poverty had substituted public coverage for private coverage. See Peter J. Cunningham, James D. Reschovsky and Jack Hadley, "SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage," Center for Studying Health System Change, Issue Brief 59, December 2002, page 4.Available at http://www.hschange.com/CONTENT/508/508.pdf.

[14] Sandra L. Decker, "In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs*, Vol. 31, No. 8, August 2012, pages 1,673-1,679.

[15] Ibid.

[16] Ibid.

[17] Brent R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments," *Journal of the American Medical Association*, Vol. 294, No. 10, September 14, 2005. Available at http://jama.ama-assn.org/cgi/content/abstract/294/10/1248.

[18] Sandra L. Decker, "In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs*, Vol. 31, No. 8, August 2012, pages 1,673-1,679. Some physicians will accept some, but not all, new Medicaid-enrolled patients who enquire about an office visit.

[19] Peter J. Cunningham and Len M. Nichols, "The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective," *Medical Care Research and Review*, Vol. 62, No. 6, December 2005.

[20]"Medicaid-to-Medicare Fee Index, 2012," StateHealthFacts.org, Kaiser Family Foundation. Available at http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4.

[21]Authors' calculations using data from the Kaiser Family Foundation and the Lewin Group. See "Medicaid-to-Medicare Fee Index, 2008," StateHealthFacts.org, Kaiser Family Foundation. Available at http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4.

[22] Chris L. Peterson and Thomas Gabe, "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA), Congressional Research Service, April 28, 2010. Available at http://www.ncsl.org/documents/health/hlthinspremcredits.pdf.

[23]Ibid. If the employee cost exceeds 9.5 percent if wages, the worker will qualify for federal subsidies if wages are less than 400 percent of poverty.

[24]Ibid. Those earning 133 percent and above would receive sliding-scale subsidies limiting premiums to no more than 3 percent of income (133 percent of the federal poverty level) to no more than 9.5 percent of income for those earning up to 400 percent of poverty.

[25] Two percent of income for an individual earning 100 percent FPL is about $230; for an individual earning 133 percent of poverty, 2 percent of income is $306. Two percent of income for a family of four earning 100 percent FPL is $118 per family member (.02 x $23,550 / 4). The same family earning 133 percent of poverty would pay premiums no higher than $157 per family member.

[26] Chris L. Peterson and Thomas Gabe, "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA)," Congressional Research Service, April 28, 2010, page 7.Available at http://www.ncsl.org/documents/health/hlthinspremcredits.pdf. For examples of subsidies in the health insurance exchange, see the Kaiser Family Foundation Subsidy Calculator, available at http://kff.org/interactive/subsidy-calculator/.