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TO: Honorable Members, Medicaid Innovation and Reform Commission (MIRC)

FROM: Jill Hanken, Staff Attorney

RE: Medicaid Expansion – Getting the Facts Straight

As you know, I strongly support the Medicaid expansion in Virginia. Not only will the expansion secure health insurance for up to 400,000 low-income, uninsured Virginians, but it will also bring about $2 billion each year in federal funding to Virginia. This funding will support the entire health care industry, jobs and Virginia's economy. This funding is available to Virginia, and it represents federal taxes that Virginians pay.

Without expansion, there will be an awful Coverage GAP in Virginia's health care system: Beginning January 1, 2014, adults (ages 19-64) with income from 100% - 400% of the federal poverty line will qualify for subsidized private coverage through the federal exchange (marketplace). But poorer adults will qualify for **nothing** (unless they can meet Virginia's abysmal eligibility levels for parents which are under 30% of the poverty line.) This terrible Coverage Gap denies coverage to the most vulnerable populations, and it will be extremely confusing and harmful to Virginia citizens.

Since the MIRC's last meeting in June, there have been several op-eds and other published comments from state legislators and others that contain misstatements and/or omissions that I want to bring to your attention.

1. Medicaid is a "broken" program that needs serious reform.

IN FACT, Medicaid is the cornerstone of health care for low-income Virginians. In many ways, Virginia's Medicaid program (although restrictive in terms of eligibility and provider payments) is a very successful program that has efficiently served millions of Virginians, especially children, pregnant women, the disabled and elderly. Of course, a large program like Medicaid should always be subject to scrutiny to ensure efficiencies and cost effectiveness. Many of the reforms identified by the 2013 legislature and being considered now by the MIRC could improve the program. Reform has been – and must continue to be - an ongoing process in Virginia. However, reform should not postpone adoption of the Medicaid expansion.

2. The costs of Medicaid are "spiraling out of control".

IN FACT, when you review increases in Virginia's Medicaid budget over the past 10 years, the biggest increases in costs are found in long-term care services and in behavioral health – areas where the legislature deliberately expanded the availability of services through waivers and other programs.

It is also important to keep in mind that overall medical costs have increased in the U.S. for everyone over the past ten years (2002-2012). While the cost of private health insurance increased 96.7% during that timeframe, Virginia's Medicaid costs for acute and medical care rose less – 83.8%. Again, the primary cost driver is the cost of long-term services in Virginia's Medicaid program which increased 108.3% over the ten year period. See, slide 44, [redacted]

3. Medicaid is inefficient, rigid and inflexible, providing patients with limited coverage options.

IN FACT, Medicaid provides comprehensive services that are very similar to services provided by private health insurance – and certain additional services which are typically not covered by private insurance (such as broad screenings and treatment for children and non-emergency - but medically necessary - transportation.) Most Virginians on Medicaid today receive their healthcare through private, managed-care companies, and DMAS continues to expand the use of managed care to more populations of Medicaid enrollees.

4. The federal government mandates inflexible coverage policies that leave consumers without options. "For example, podiatry services…must be offered to all enrollees or to no enrollees at all."

IN FACT, podiatry is an optional service under Medicaid law, but Virginia has specifically chosen to cover it because it is extremely cost-effective for people with serious chronic conditions, such as diabetes. It is also not accurate to suggest that podiatry is available to everyone on Medicaid who wants it. There are stringent "medical necessity" requirements that must be met before podiatry (and other Medicaid services) are covered. DMAS actually has a special "Podiatry Manual" for doctors. This manual provides specific, detailed requirements that govern reimbursement of podiatry services. The DMAS Podiatry Manual has at least 6 pages describing when podiatry services are covered – and "routine foot care" is NOT covered. See Chap. IV, pages 3-6 , 12 -13

[redacted]

5. A study of Oregon's expansion of Medicaid showed that while "people received more medical care — they just didn't get any added benefit from it".

IN FACT, the Oregon study found a statistically significant relationship between Medicaid coverage and improvements in depression, access to care, financial security, and self-reported health status. Because the study was only for two years and the sample size was too small and the study population was too healthy, it could not show anything about health outcomes and the impact of Medicaid coverage on diabetes, blood pressure, or cholesterol. For a more information on this study, see [redacted]

IN FACT, there are other studies which show the benefits of Medicaid and other programs that offer low-income uninsured individuals access to regular coordinated care. For example, one five-year study found a Medicaid expansions in Arizona, Maine and New York were associated with a 6% decrease in all-cause mortality among adults ages 20-64. Benjamin D. Sommers, Katherine Baicker & Arnold Epstein, *Mortality and Access to Care Among Adults after State Medicaid Expansions*, 367 N. ENGLAND. J. MED. 1025, 1028 (2012).

And, closer to home, in 2012 the VCU Health System studied its "Coordinated Care" program which provides primary/preventive care for the uninsured. For people continuously enrolled in the program, emergency department visits and inpatient admissions declined, while primary care visits increased during the study period. Inpatient costs fell each year for this group. Over three years of enrollment, average total costs per year per enrollee fell from $8,899 to $4,569—a savings of almost 50 percent. See, Bradley, C, Gandhi, S, Neumark, D, Garland, S, Retchin, S, Lessons For Coverage Expansion: A Virginia Primary Care Program For the Uninsured Reduced Utilization And Cut Costs, *Health Affairs* 31, No. 2 (2012): 355

6. The Federal government cannot afford the Medicaid expansion and will not be able to meet its promise to fund 100% of the costs of expansion from 2014-2016.

IN FACT, twenty-four states are currently moving forward with Medicaid expansion, including nearby states - West Virginia, Maryland, Delaware, Kentucky, and D.C. They **WILL** receive 100% funding for the expansion, beginning in January 2014, and tens of thousands of their uninsured residents **WILL** gain health insurance.

No one is saying the federal money is "free", but it does represent federal taxes paid by families and businesses. The states that expand Medicaid will effectively receive a return of those tax payments to cover the insurance costs of their citizens who are newly eligible and enrolled in Medicaid.

In addition, concerns about the impact of the law on the federal deficit are incorrect. The Congressional Budget Office and the Joint Committee on Taxation have estimated several times

that, on balance, the direct spending and revenue effects of repealing the ACA would cause a net increase in federal budget deficits of $109 billion over the 2013–2022 period. The projected deficit increase would stem from the elimination of the law's taxes, fees and spending cuts. [redacted]

7. Virginia cannot afford the cost of expansion.

IN FACT, the cost to Virginia of expanding Medicaid was very carefully evaluated during the 2013 session. This analysis took into account all the potential offsets in state spending that would occur in areas such as behavioral health, prisoner health services, and indigent care. The Administration concluded that the ten-year cost to Virginia would be just $137 million. See pp. 11-16 - http://sfc.virginia.gov/pdf/committee_meeting_presentations/2013/020613_Hazel_Medicaid_Reform_Briefing.pdf Taking advantage of the 100% federal funding available in the first three years is an important part of the analysis, and the adopted budget language very wisely requires accumulation of early savings to pay for costs down the road. Item 307 RRRR.7.

As another important protection, the adopted budget language also directs the Commonwealth to withdraw from the expansion if the federal government reduces the percentage of matching dollars promised. Item 307 RRRR.8

Finally, it is critical to understand that, over the next ten years, Virginians are expected to pay $26 billion in federal taxes related to the ACA. See p. 17 of HHR briefing at [redacted]

If Virginia expands Medicaid, the Commonwealth would get $20 billion of those federal taxes back. Id. at p. 16. Virginians who buy private insurance through the exchange will also get back about $6 billion in tax credit subsidies. Id. at p. 17.

IN FACT, Virginia cannot afford NOT to expand Medicaid!

As a member of MIRC, you are required to review and evaluate the list of Medicaid reforms outlined in the budget. If those reform conditions are met, you are authorized to approve the Medicaid expansion. As you move forward with this process and you see that DMAS has made adequate progress on the reforms, I urge you to approve expansion without delay.

Thank you for your service and hard work on this issue.