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Expansion of Medicaid could bankrupt states: NCPA

By Palash R. Ghosh

Hidden costs related to the expansion of Medicaid will likely strain, and perhaps bankrupt, states, according to Devon Herrick a senior fellow with the National Center for Policy Analysis, a conservative think tank.

The Patient Protection and Affordable Care Act (PPACA), which was signed into law by President Obama in March of this year as part of his overall health care reform program, is expected to add up to 16 million more Medicaid enrollees and significantly expand eligibility for families with incomes up to 133 percent of the federal poverty level.

The new law, which has various provisions that will take effect over the next four years, requires states to streamline their enrollment process, thereby making it easier for eligible populations to enroll and retain Medicaid coverage.

Initially, Herrick said, the federal government will pay 100 percent of the cost of the newly eligible, newly enrolled populations and 95 percent of costs through 2019.

"However, there are hidden costs that will strain state budgets," he asserts.

Herrick cites four major problems with Medicaid expansion: the cost of enrolling the already eligible; low Medicare provider payments; and lower payment to safety net hospitals.

According to various estimates, there are about 10 million to 13 million uninsured people who are already eligible for Medicaid, but not yet enrolled.

"When the individual mandate to obtain health coverage takes effect in 2014, many of the uninsured are likely to be swept up in outreach efforts," Herrick states.

"Although the cost of enrolling newly eligible individuals will be paid by the federal government, the cost of covering those previously eligible for Medicaid must be paid for under the current federal matching formula. Many states will find the cost of their Medicaid programs higher as a result."

For example, Herrick cites that ten years after the PPACA's implementation, the Texas Department of Health and Human Services predicts that the state's Medicaid rolls will climb by 2.4 million people. Of those, only 1.5 million enrollees will be newly eligible. About 824,000 people will be those previously eligible but not enrolled.

“The federal government will contribute a much smaller share of the cost of these previously eligible enrollees compared to newly eligible enrollees,” Herrick writes.

Moreover, he adds, on average, reimbursements for Medicaid providers are only about 59 percent of what a private insurer would pay for the same service, although it varies from state-to-state.

For instance, the state of New York pays primary care physicians only about 29 percent of what private insurers pay for primary care. The comparable figure in New Jersey is 33 percent.

California pays primary care providers 38 percent of what private insurers pay. Texas reimburses primary care physicians for about 55 percent of what private insures pay.

“Low provider reimbursement rates make it more difficult for Medicaid enrollees to find physicians willing to treat them compared to privately insured individuals,” Herrick indicates.

“States will bear much of the cost of keeping Medicaid provider fees at a level necessary to ensure enough physicians are willing to participate in the program.”

Indeed, states with historically low reimbursement rates, such as New York state and New Jersey, will be hardest hit.

In Texas, which is near the national average, Herrick said, the cost of maintaining higher Medicaid reimbursements will start at $500 million in 2016 - rising to $1 billion annually by 2023.

Herrick explains that the PPACA provides funding that will temporarily raise primary care provider reimbursements to the same level as Medicare payments, which pays health care providers an average of 81 percent of what private insurers pay.

“But the federal government will only fund this provision for two years (2014 and 2015),” he adds.
“If states truly want their Medicaid enrollees to have access to quality medical care, they will have no choice but to increase provider reimbursements on par with Medicare.

Herrick explains that disproportionate share hospital (DSH) payments are used to compensate hospitals that treat a disproportionate share of indigent and uninsured patients.

“Some of these patients enter the hospital through the emergency room, while others are referred by physicians,” he said.

“In total, the federal government distributes about $12 billion annually to help hospitals that treat indigent patients offset part of the cost.”

The PPACA will reduce DSH payments by about one-quarter through 2020. Beginning in 2018, annual reductions are about $5 billion per year.

“The rationale is that as more patients have coverage, hospitals will have fewer uninsured patients,” Herrick notes.

“However, 23 million people will remain uninsured - some of whom may seek uncompensated care. Hospitals do not have the means to determine whether their future case mix will include the newly insured or those who have fallen through the cracks. States may have to bear some of the additional costs if their hospitals are to stay solvent.”

Finally, Herrick proposes, many of the newly insured under Medicaid will likely be those who previously had private coverage. Research going back two decades confirms that when Medicaid eligibility is expanded, 50 percent to 75 percent of the newly enrolled are those who have dropped private coverage.

“Thus, it is reasonable to conclude that much of the increase in Medicaid rolls will be individuals who were previously privately insured, meaning the number of uninsured will not fall as expected,” Herrick said.

Herrick concludes that while the federal government will pay much of the costs related to the expansion of Medicaid, the beleaguered states will find their share of costs unaffordable.