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An Economic and Policy Analysis of Medicaid Expansion in Ohio

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In June 2012, the U.S. Supreme Court ruled unconstitutional those provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) that deny federal matching funds for Medicaid to states that refuse to extend eligibility to individuals and families with incomes up to 138 percent of the federal poverty level (FPL). As a result, Ohio and other states now have the opportunity to compare the costs and benefits of expanding Medicaid eligibility.

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As the state legislature considers this issue — which could come before voters — Ohioans have an important choice to make.[2] A thorough discussion of the costs, obstacles, alternatives to and potential pitfalls of Medicaid expansion is critically important. Additional low- to middle-income individuals would qualify for a newly expanded Medicaid program. However, if Medicaid coverage were not available, many of them would qualify for generous federal subsidies for the purchase private health coverage in the ACA's new Health Insurance Exchange.

The ACA was initially expected to provide coverage for 32 million uninsured individuals and families when fully implemented.[3] About half of the newly covered were expected to obtain private coverage, while the other half would enroll in an expanded Medicaid program.[4] The ACA contains financial incentives designed to encourage states to expand Medicaid eligibility.[5]

The Obama administration and advocates for the poor have touted the benefits of expanding Medicaid. In addition to health coverage and improved access to care for low-income, uninsured individuals, the federal government promises to pay most of the cost.[6]

Effect of the ACA on Ohio Medicaid Enrollment and Costs. There are about 3 million individuals living in Ohio with incomes under 139 percent of the federal poverty level, about one-fourth of whom lack health coverage.[7] Ohio Medicaid does not currently cover poverty-level, nondisabled adults. Many of these individuals — at least theoretically — would become eligible for Medicaid under an expanded program.

Of the Ohio families and individuals with incomes under 139 percent of poverty, 1.2 million are already enrolled in Medicaid; 790,000 are nonelderly and lack health coverage; 426,500 have employer coverage; and about 125,500 are covered by some other type of health insurance.[8] Most of the newly eligible would be adults, whereas most children in families at this income level are already eligible.

Through 2016, the federal government will pay 100 percent of the cost of benefits for newly eligible enrollees.[9] The enhanced federal match will drop to 95 percent of costs in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.[10] The federal government will also pay 100 percent of the cost of boosting low Medicaid reimbursements for *primary care* providers (not specialists) to the same level as Medicare physician fees — but only for a two-year period (2013 and 2014). After 2014, the cost of

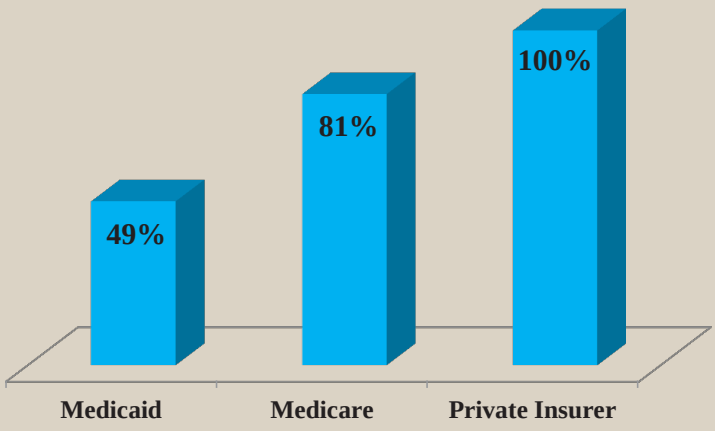
increasing primary care provider fees will fall to the states, as will the cost of boosting fees to specialists.

Effect of the ACA on Ohio's Physician Supply. As in other states, Ohio's physician supply is relatively "inelastic," which means that the number of physicians could not increase quickly to accommodate the rising demand for medical services that would be created by an influx of newly insured Medicaid enrollees. Ohio physicians have little if any capacity to expand the number of patients they treat. Currently, there are about 30,485 active physicians in Ohio, of whom only about 25,315 are involved in patient care.[11]

According to the Center for Workforce Studies, 80 percent of Ohio's active physicians are more than 39 years of age, while 23.5 percent are over the age of 60.[12] Thus, many of these physicians will retire in the next few years. Yet the demand for health care will continue to rise. A number of economic studies indicate the newly insured will nearly double their consumption of medical care.[13] Furthermore, an aging population will require more medical care. Nationwide, 78 million baby boomers are either retired or headed that way over the next decade.

Low Medicaid Provider Fees. Low reimbursement rates are one of several factors contributing to the shortage of physicians willing to treat Medicaid enrollees.[14] On average, Ohio pays physicians participating in the fee-for-service state Medicaid program only 61 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.[15] For primary care, Ohio Medicaid only pays 59 percent as much as Medicare.[16]

Figure I
Physician Fees for Ohio Medicaid and Medicare, as a Percentage of Private Insurance Fees



Source: Authors' calculations based on data from Kaiser Family Foundation and the Lewin Group.

For all services, Ohio's Medicaid program pays less than one-half (49 percent) as much as a private insurer.[17] [See Figure I.] Low provider reimbursement rates make it more difficult for Medicaid enrollees to find physicians willing to treat them, limiting their access to care.

Poor Access to Care Under Medicaid. Studies show it is easier for the uninsured to make doctors' appointments than it is for Medicaid enrollees.[18] This is not surprising:

- Nationally, about one-third of physicians do not accept new Medicaid patients.[19]
- The proportion of doctors who won't accept new Medicaid patients is nearly double the number who have closed their practices to new Medicare patients (17 percent) and to new privately insured patients (18 percent).[20]
- Physicians are four times as likely to turn away new Medicaid patients as they are to refuse the uninsured (31 percent versus 8 percent).[21]

Medicaid enrollees' access to physicians is only slightly better in Ohio. About 28 percent of Ohio physicians refuse to accept any new Medicaid patients.[22] Access to care for Ohio's Medicaid enrollees will only get worse if more people are added to the rolls.

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 individuals 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 will likely 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.[23] A recent analysis by Gruber and Kosali Simon estimated crowd-out for the Children's Health Insurance Program averages about 60 percent.[24]

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.[25] A conservative estimate indicates that Medicaid rolls might have to rise by 1.4 people in order to reduce the uninsured by 1 person.[26]

Health Outcomes and Medicaid. On paper, Medicaid coverage appears far better than what most Americans enjoy — with lower cost-sharing and unlimited benefits.[27] But by almost all measures, Medicaid enrollees fare worse than similar patients with private insurance.[28] Various academic researchers have found that Medicaid enrollees often fare worse than patients with private insurance and often worse than patients with no insurance.[29] For example:

- Post-surgical patients enrolled in Medicaid are almost twice as likely to die as privately insured patients and about 12 percent more likely to die than the uninsured, according to a University of Virginia study.[30]
- Medicaid patients are 6 percent more likely to be diagnosed with prostate cancer at a less treatable, later stage than the uninsured.[31]
- Further, Medicaid enrollees are nearly one-third (31 percent) more likely to be diagnosed with late-stage breast cancer and 81 percent more likely to be diagnosed with melanoma at a late stage.[32]

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 coverage in health insurance exchanges set up by the federal government or the states.[33] Though they will not be eligible for federal exchange subsidies (regardless of income), individuals whose employers offer affordable health plans could still purchase coverage in the exchange if they choose.[34]

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 [see the table].[35] Premiums are limited to 3 percent of income for those earning 134 percent to 138 percent of poverty.

Thus, their annual cost will often average less than $240 per covered individual, for coverage of a family of four potentially worth $15,000 [see Figure II].[36] The amount an individual will receive in federal exchange subsidies will be based on a "Silver Plan" covering 70 percent of medical needs. Low-income families choosing less comprehensive "Bronze Plans" covering 60 percent of medical costs may have to pay nothing for their coverage.[37] If Ohio encouraged this moderate-income population to enroll in private plans in lieu of Medicaid, it could pay the nonsubsidized portion of the premiums. State taxpayers would bear the cost — around $30 million a year.[38]

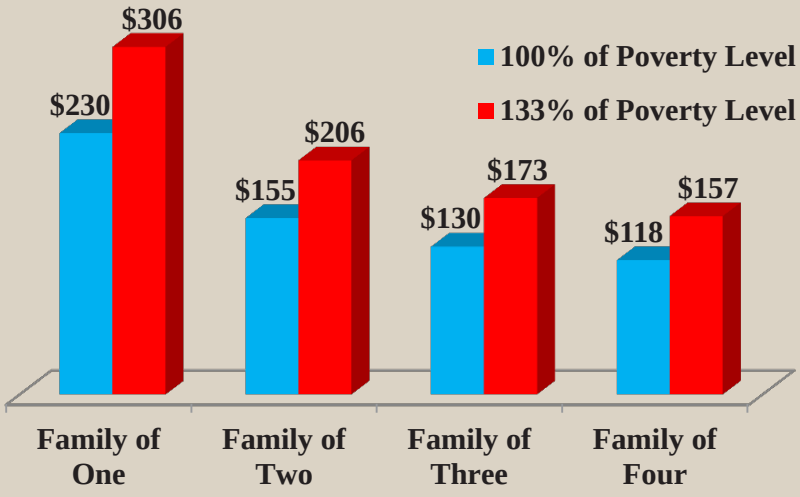
Premium Cost per Family Member

Annual Income	Percent of Poverty	Maximum Cost Share (Family of Four)
$23,550	100%	$471 per family or $118 per person
$31,322	133%	$626 per family or $157 per person
$32,499	138%	$975 per family or $244 per person

Source: Authors' calculations based on the Federal Poverty Level, U.S. Department of Health and Human Services.

How Would Private Coverage Affect Providers? History shows that not all of those who qualify for Medicaid will enroll.[39] The rate at which they enroll depends on a variety of conditions. Private coverage that allows individuals and families to see most physicians and utilize large hospital networks would encourage more of the uninsured to obtain insurance. Ohio doctors and hospitals would benefit from public policies designed to maximize the number of people with commercial insurance, because private insurance reimbursements are higher.[40] On the other hand, Medicaid expansion would produce the opposite effect, because an estimated 30 percent of adults in the 100

Figure II
State Subsidy per Family Member



Source: Authors' calculations based on federal poverty level.

percent to 138 percent poverty income range with private insurance will drop it in favor of Medicaid.

If Ohio does not expand Medicaid to those earning 100 percent to 138 percent of poverty, the state would forgo about $5.5 billion in additional federal Medicaid spending on that population over the next 10 years.[41] However, if Ohio families use the generous federal subsidies for private insurance in the health insurance exchange, private insurers will spend approximately $9.2 billion on medical care for these enrollees.[42] Thus, after accounting for Ohio's share of new Medicaid spending, private coverage would represent an additional infusion of nearly $4.1 billion, or$400 million per year — including extra money for the state's doctors and hospitals.

Does Medicaid Boost the Economy? Interest groups often tout the benefits of so-called "economic activity" that additional federal Medicaid funds might create within states.[43] Yet, economists find it difficult to calculate the actual value of economic activity. Macroeconomic studies of the multipliers for increased government spending for the nation as a whole suggest that, since 1950, such "balanced-budget multipliers" have reduced national economic output below what it would be otherwise.[44] If correct, these results suggest that the net effect of the new health law will be a *decline* in gross domestic product (GDP),as the federal government consumes a larger share of national income to fund its programs. Basically, people will cut their other consumption to pay the increased tax burden. According to the RAND Corporation, most states can expect a net transfer of state resources to the federal government under the ACA.[45] Only poor states will benefit.[46]

Is Federal Spending Sustainable? Medicaid isn't the only commitment the federal government must fund into the future. At the federal level, the growth in health care expenditures is our most serious domestic policy problem, and Medicare is the most challenging component.[47] For decades, annual Medicare spending has increased slightly more than 2 percentage points faster than GDP.[48] If this country continues consuming products whose cost is growing faster than national income, that consumption will eventually crowd out every other thing we are consuming. For instance, the Congressional Budget Office found that if federal income tax rates are raised to allow the government to continue its current level of activity and balance its budget:[49]

- The lowest marginal income tax rate of 10 percent would have to rise to 26 percent.
- The 25 percent marginal tax rate — the tax bracket of many two-income families — would increase to 66 percent.
- The 35 percent marginal tax rate would rise to 92 percent.

If the CBO's projected marginal tax hikes occur, the federal government's ability to raise sufficient tax revenue for its spending commitments is doubtful.

Conclusion. Medicaid comprises nearly one of every four dollars spent by the state of Ohio, with about one-third of general revenue dollars going towards Medicaid, and is growing at an unsustainable rate.[50] Ohio would be better served to free those earning above 100 percent of the federal poverty level to seek subsidized coverage in the health insurance exchange. For families earning less than 100 percent of poverty, Ohio could tailor its Medicaid program in ways that make sense and meet Ohio residents' specific needs. These services might include selectively covering some optional populations but not others. The program might also involve providing limited benefits rather than an open-ended entitlement to whatever health care is available. In any case, some of this spending would still qualify for federal matching funds — albeit at a rate of about 64 percent, rather than 90 percent.[51] The amount of benefits — and the populations covered — should reflect the preferences and priorities of Ohio taxpayers.

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References and sources can be found in the online version at www.ncpa.org/pub/ib128.

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