NATIONAL CENTER FOR POLICY ANALYSIS

Medicaid Expansion: Wisconsin Got It Right

Issue Brief No. 151 by Devon M. Herrick October 2014

A well-known provision of the 2010 Patient Protection and Affordable Care Act (ACA) required states to expand Medicaid eligibility to individuals with incomes up to 138 percent of the federal poverty level (FPL) or face the loss of federal matching funds for the joint federal-state health program for the poor.

Dallas Headquarters:
14180 Dallas Parkway, Suite 350
Dallas, TX 75254
972.386.6272

www.ncpa.org

Washington Office:
600 Pennsylvania Ave., SE
Suite 400
Washington, DC 20003
202.830.0177

However, the U.S. Supreme Court ruled that provision of Obamacare unconstitutional.[1] As a result, a number of states have opted not to expand Medicaid eligibility or, as Wisconsin has done, only partially expand eligibility, allowing many low-income residents to access private coverage rather than be forced into Medicaid.

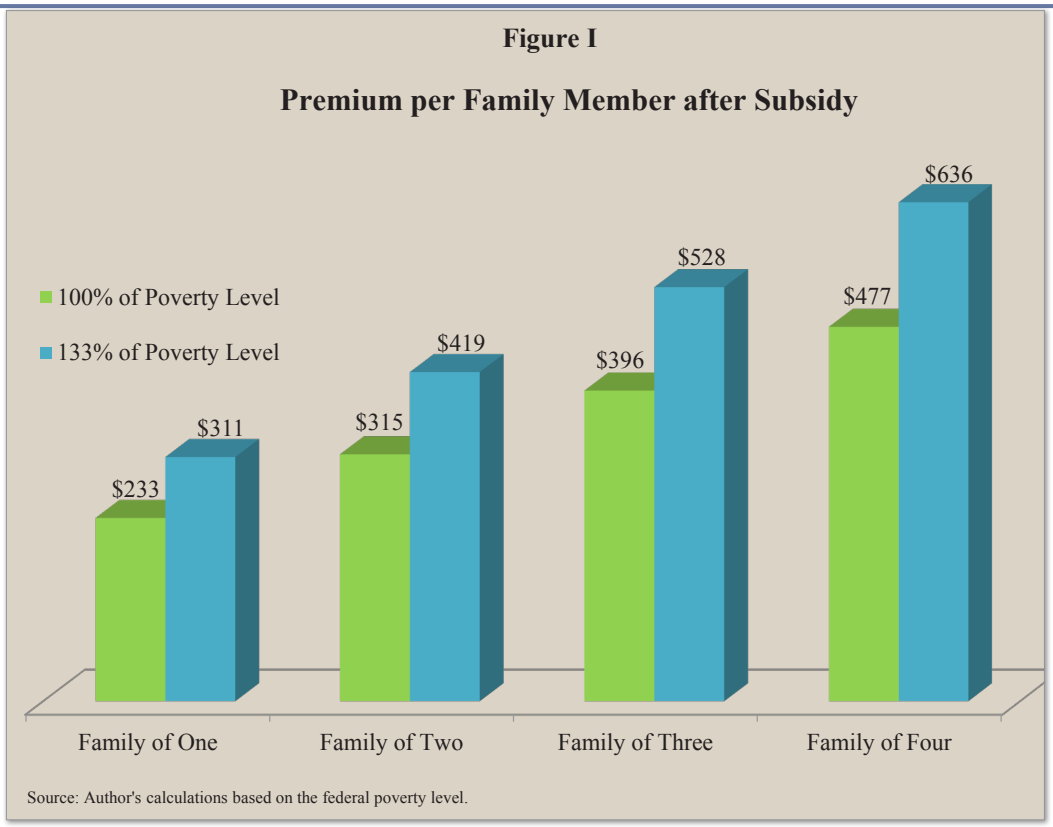
For states choosing to expand Medicaid eligibility to 138 percent of the FPL, the federal government will pay 100 percent of the cost of benefits for newly eligible enrollees through 2016.[2] The enhanced federal match will drop to 95 percent in 2017, and 90 percent in 2020 and thereafter.[3]

However, states that choose partial expansion will receive their historic matching rate for new enrollees.[4] (The Federal Medical Assistance Percentage for Wisconsin is 58 percent.)[5] In addition, other provisions of the ACA provide generous, sliding-scale subsidies for low- to middle-income individuals to purchase private health coverage in a health insurance exchange operated by the state or federal government.

Exchanging Medicaid for Better Coverage. Prior to Obamacare, most legal residents of Wisconsin earning less than 200 percent of poverty were eligible for coverage under the state Medicaid program, BadgerCare.[6] But in 2009 — only four months after the program was launched — funds ran low and the state stopped accepting new enrollees.[7]

In 2014, rather than expand Medicaid to cover all legal residents earning up to 138 percent of poverty, Wisconsin opened enrollment to childless adults earning less than 100 percent of the poverty threshold.[8] Though these individuals were previously eligible, many were unable to enroll when the state stopped accepting applications in 2009. Wisconsin also removed from Medicaid an estimated 62,776 people earning more than 100 percent of poverty.[9] This allowed those earning above the poverty level to access subsidized private coverage in the health insurance exchange. As a result of the new reform, more poor Wisconsinites are now enrolled in Medicaid.

Wisconsin's innovative Medicaid changes could serve as a model for other states. In addition to increasing private coverage, partial expansion will give Wisconsin more flexibility when it applies for a federal waiver to continue its Medicaid reforms in 2017. Many experts believe the federal government will be more receptive to waiver applications from states that don't accept the enhanced match.



Exchange Subsidies Are More Generous than Medicaid. The ACA requires individuals with incomes below 133 percent ($15,556) of poverty to enroll in Medicaid if it is available in their state. Individuals and families who lack access to an employer-provided health plan — and are ineligible for Medicaid — may purchase coverage in the exchange.[10] Subsidies are available to individuals and families with incomes below 400 percent of the federal poverty level — just over $95,400 for a family of four in 2014. However, there are no exchange subsidies for people earning below 100 percent of poverty — because they are expected to enroll in Medicaid.

The subsidies in the exchange are very generous. The most a low-income individual or family will pay is 2 percent to 3 percent of income toward a private health plan that would otherwise cost a family of four $14,500 or more annually, according to the Congressional Budget Office. Consider [see Figure I]:[11]

- Two percent of annual income is $233 for an individual earning right at the poverty level.
- It is $311 for someone earning 133 percent.
- For a family of four, 2 percent of income at 100 percent of the poverty level is $477, while 2 percent of income for families earning 133 percent of poverty is $636.

Certainly this represents a significant amount of money for low-income families. For instance, a $477 premium payment by a family of four at 100 percent of the federal poverty level is $119 per year per family member, while a family of four at 133 percent of the federal poverty level would pay $159.

However, exchange enrollees are getting a subsidy that, on average, is roughly 50 percent greater ($9,000 versus $6,000) than the value of Medicaid.[12] Indeed, the Congressional Budget Office initially predicted that about half of states would follow a path similar to Wisconsin's and only partially expand Medicaid to 100 percent of poverty.[13]

Because of the greater subsidy in the exchange and the contributions toward their premiums by the individuals covered, there will be more funds available for the health care of individuals in the exchange than if they were covered by Medicaid. Thus, if the 62,776 Wisconsinites with incomes above 100 percent of poverty who were removed from Medicaid in 2014 instead enroll in private coverage in the exchange, health care providers will receive roughly $3 billion more over 10 years than Medicaid would have paid.[14]

What's Wrong with Medicaid? On paper, Medicaid coverage appears far better than the private health coverage most Americans enjoy — with lower cost-sharing and unlimited benefits.[15] However, Medicaid enrollees fare worse than similar patients with private insurance.[16] Medicaid enrollees tend to be in poorer health and face barriers to care.

Poor Access to Care. Studies across the United States show it is easier for the uninsured to make doctors' appointments than it is for Medicaid enrollees.[17]

- Nationally, about one-third of physicians do not accept new Medicaid patients.[18] This is nearly double the portion of doctors who have closed their practices

to new Medicare patients (17 percent) and to new privately insured patients (18 percent).[19]

- Physicians are four times more likely to turn away new Medicaid patients as they are to refuse the uninsured who pay out-of-pocket (31 percent versus 8 percent).[20]

Although Medicaid enrollees' access to physicians is currently better in Wisconsin than in some other states, access to care for new BadgerCare enrollees would likely decrease if more people are added to the Medicaid rolls and new patients flood doctors with requests for appointments.

Low Medicaid Provider Fees. Low reimbursement rates are one of several factors contributing to the shortage of physicians willing to treat Medicaid enrollees.[21] On average, Wisconsin pays physicians participating in the fee-for-service Medicaid program only about three-fourths as much (77 percent) as Medicare pays for the same service. [See Figure II.] For primary care, BadgerCare only pays about half (49 percent) as much as private insurers for the same service.[22] Low provider reimbursement rates make it more difficult for Medicaid enrollees to find physicians willing to treat them, limiting their access to care.

As with low Medicare reimbursements, Medicaid fees often do not cover the cost to physicians of treating enrollees. Physicians must have more highly reimbursed, privately-insured patients to offset the lower fees paid by Medicaid. If more people are placed in Medicaid, many more physicians will balk at accepting them.

Displaces Private Insurance. In states which expand Medicaid eligibility to all legal residents earning from 100 percent to 138 percent of poverty, many of the new enrollees 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 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 predict a high rate of Medicaid substitution for private coverage, while others believe the effect will be negligible. Estimates of crowd-out for diverse populations vary:

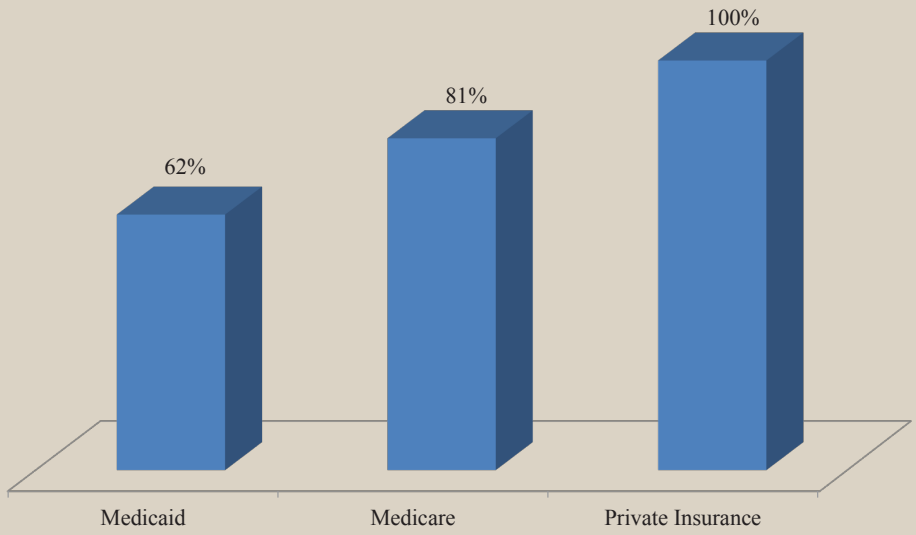
- An analysis of past Medicaid expansions to mothers and children in the early 1990s by economists and Obama administration advisers David Cutler and Jonathan Gruber found that when Medicaid eligibility was expanded, 50 percent to 75 percent of the newly enrolled dropped private coverage.[23]
- A recent analysis by Gruber and Kosali Simon estimated crowd-out for the Children's Health Insurance Program averages about 60 percent.[24]
- Academic researchers Steven Pizer, Austin Frakt and Lisa Iezzoni estimated the crowd-out of working adults (the target of Medicaid expansion under the ACA) could reach 82 percent.[25]

Thus, a conservative estimate is that Medicaid rolls might have to rise by 1.4 people in order to reduce the uninsured by 1 person.[26]

Benefits to Health Care Providers. Medicaid payments to doctors and hospitals vary from state to state, but, with only two exceptions (Alaska and Wyoming), private insurers pay much higher physician fees than

Figure II

Physician Fees for Wisconsin Medicaid and Medicare as a Percentage of Private Insurance Fees



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

state Medicaid programs. If Wisconsin residents were privately insured, they would have easier access to doctors willing to treat them. The Wisconsin health care economy — local doctors and hospitals — could expect far more generous reimbursements than under Medicaid. How much more? Although it varies by state (and insurer), a rule of thumb is that private insurers generally pay fees at least 50 percent higher — and often double — what Medicaid pays.[27]

Conclusion. On paper, Medicaid coverage appears far better than what most Americans enjoy — with lower cost-sharing and unlimited benefits. But by almost all measures, Medicaid enrollees fare worse than similar patients with private insurance and often experience worse health issues than patients with no insurance. Wisconsin made a wise choice when it decided to forgo a full Medicaid expansion in favor of a smaller program that would maximize the availability of private coverage for Wisconsin's low-income residents.

Devon M. Herrick is a senior fellow with the National Center for Policy Analysis.

Endnotes

[1.] MaryBeth Musumeci, "A Guide to the Supreme Court's Affordable Care Act Decision," Kaiser Family Foundation, July 2012. Available at http://www.kff.org/healthreform/upload/8332.pdf. Also see I. Glenn Cohen and James F. Blumstein, "The Constitutionality of the ACA's Medicaid-Expansion Mandate," *New England Journal of Medicine*, Vol. 366, No. 2, January 12, 2012, pages 103-104.

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

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

[4.] Robin Rudowitz, Samantha Artiga and MaryBeth Musumeci, "The ACA and Recent Section 1115 Medicaid Demonstration Waivers," Kaiser Family Foundation, February 5, 2014. Available at http://kff.org/report-section/the-aca-and-recent-section-1115-medicaid-demonstration-waivers-issue-brief/.

[5.] "Federal Medical Assistance Percentages (FMAP) by Quarter," Wisconsin Department of Health Services, 2014. Available at http://www.dhs.wisconsin.gov/ltcare/programops/fiscal/fmap.pdf.

[6.] Grace Wyler, "In Wisconsin, Scott Walker Looks for His Own Way to Insure the Poor," *Time*, November 4, 2013. Available at http://nation.time.com/2013/11/04/in-wisconsin-scott-walker-looks-for-his-own-way-to-insure-the-poor/.

[7.] Patrick Marley and Guy Boulton, "State suspends BadgerCare Plus Core Enrollments," *Milwaukee Journal Sentinel,* October 5, 2009. Available at http://www.jsonline.com/news/wisconsin/63529162.html.

[8.] "Department Provides Update Regarding Operationalization Of Governor Walker's Entitlement Reforms," Wisconsin Department of Health Services, July 16, 2014. Available at http://www.dhs.wisconsin.gov/News/PressReleases/2014/071614.htm.

[9.] Ibid.

[10.] MaryBeth Musumeci, "A Guide to the Supreme Court's Affordable Care Act Decision," Kaiser Family Foundation, July 2012. Available at http://www.kff.org/healthreform/upload/8332.pdf.

[11.] "Annual Update of the HHS Poverty Guidelines," *Federal Register,* January 22, 2014. Available at https://www.federalregister.gov/articles/2014/01/22/2014-01303/annual-update-of-the-hhs-poverty-guidelines.

[12.] Charles Blahous, "Medicaid Under the Affordable Care Act," in Jason J. Fichtner, ed., *The Economics of Medicaid: Assessing the Cost and* Consequences (Arlington, Va.: Mercatus Center at George Mason University, 2014), pages 83-97.

[13.] "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," Congressional Budget Office, July 2012. Available at http://www.cbo.gov/sites/default/files/43472-07-24-2012-CoverageEstimates.pdf.

[14.] Author's calculations based on 62,776 new exchange enrollees earning above 100 percent of poverty and removed from BadgerCare Plus. Private insurers tend to pay fees that are 50 percent higher than fee-for-service Medicaid. Thus, all else equal, the amount of funds spent on care should be higher under private coverage, even after subtracting the enhanced federal Medicaid match the state will forgo.

[15.] Evelyne P. Baumrucker and Bernadette Fernandez, "Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families," Congressional Research Service, February 28, 2013. Available at http://www.fas.org/sgp/crs/misc/R42978.pdf.

[16.] Kevin Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation, November 7, 2012. Available at http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured.

[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.

[19.] Ibid.

[20.] Ibid.

[21.] 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.

[22.] Author's 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.

[23.] 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.

[24.] 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.

[25.] 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*, Working Paper No. 2011-03, February 17, 2011. Available at http://www.hcfe.research.va.gov/docs/wp_2011_03.pdf.

[26.] 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.

[27.] Wisconsin Medicaid fee-for-service physician fees are only about 77 cents on the dollar of what Medicare reimburses a physician for the same service. Medicare reimburses physicians about 81 percent of what a private insurer reimburses physicians for the same service. See "Medicaid-to-Medicare Fee Index, 2012," StateHealthFacts.org, Kaiser Family Foundation. Available at http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/.

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

The NCPA developed the concepts of Health Savings Accounts and Roth IRAs.

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA's proposal for an across-the- board tax cut became the centerpiece of President Bush's tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax.

A major NCPA study, "Wealth, Inheritance and the Estate Tax," completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Senate Majority Leader Bill Frist (R-Tenn.) and Senator Jon Kyl (R-Ariz.) distributed a letter to their colleagues about the study. The NCPA recently won the Templeton Freedom Award for its study and project on free market solutions to the problems of the poor. The report outlines an approach called Enterprise Programs that creates job opportunities for those who face the greatest challenges to employment.

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, "Ten Steps to Baby Boomer Retirement," shows that as 77 million baby boomers begin to retire, the nation's institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are inadequately funded. State and local institutions are not doing better — millions of government workers are discovering that their pensions are under-funded and local governments are retrenching on post-retirement health care promises.

Pension Reform.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of

employees into companies' 401(k) plans, automatic contribution rate increases so that workers' contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

Environment & Energy.

The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

Educating the Next Generation.

The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

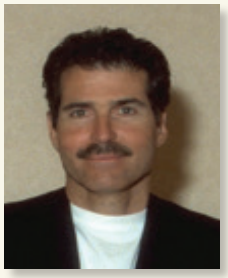
Promoting Ideas.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the Wall Street Journal, the Washington Times, USA Today and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from BurrellesLuce, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

What Others Say About the NCPA

"The NCPA generates more analysis per dollar than any think tank in the country. It does an amazingly good job of going out and finding the right things and talking about them in intelligent ways."

Newt Gingrich, former Speaker of the U.S. House of Representatives



"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like Health Savings Accounts. These things work, allowing people choices. We've seen how this created America."

John Stossel,
host of "Stossel," Fox Business Network

"I don't know of any organization in America that produces better ideas with less money than the NCPA."

Phil Gramm,
former U.S. Senator

"Thank you . . . for advocating such radical causes as balanced budgets, limited government and tax reform, and to be able to try and bring power back to the people."

Tommy Thompson,
former Secretary of Health and Human Services

The NCPA is a 501(c)(3) nonprofit public policy organization. We depend entirely on the financial support of individuals, corporations and foundations that believe in private sector solutions to public policy problems. You can contribute to our effort by mailing your donation to our Dallas headquarters at 12770 Coit Road, Suite 800, Dallas, TX 75251, or visiting our Web site at www.ncpa.org and clicking "Support Us."