Medicaid

Health Economics

Bill Evans

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Basics of Medicaid

- Federally mandated but programs run by states
  - 51 different Medicaid programs
- Primarily for low income/high medical needs
- Federal government determines minimum eligibility requirements/benefits
- States can expand eligibility, scope of services, payments rates for services

2

3 main groups

- Low income women and children
- Low income elderly
  - Dual eligible (Medicare and Medicaid)
  - Those in long term care
- Disabled

3

Two paths to eligibility

- Categorical eligibility – if participate in TANF (welfare) or Supplemental Security Income (Disability insurance)
- Income/asset tests
  - Children with low income
  - Pregnant women with low income
  - Elderly w/ high expenses or low income
  - Poor in long term care

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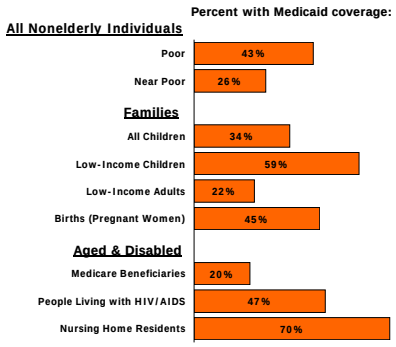
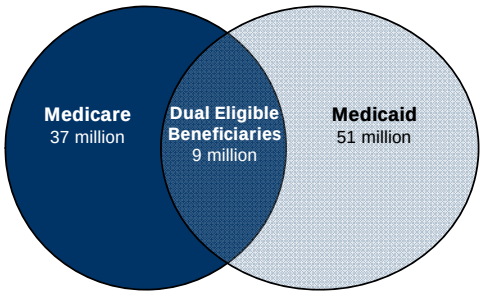
Medicaid plays a critical role for selected populations



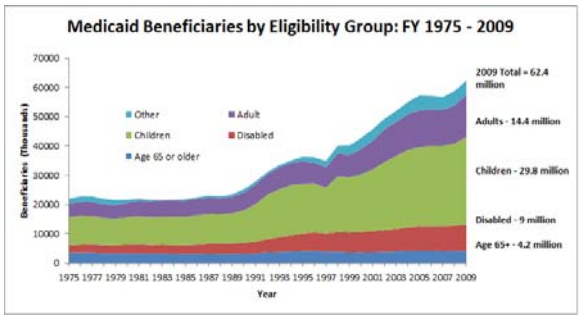
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of ASEC Supplement to the CPS; Birth data from *Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007*, National Governors Association, 2008; Medicare data from USDHHS.

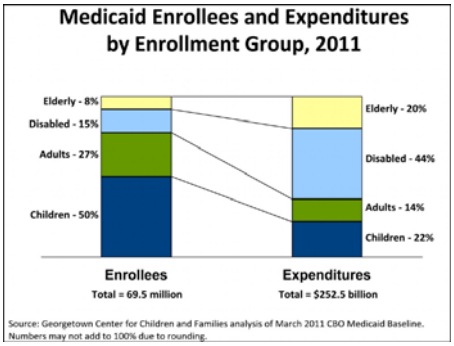
Dual eligible beneficiaries comprise 20% of the Medicare population and 15% of the Medicaid population in 2008



Total Medicare beneficiaries: 46 million **Total Medicaid beneficiaries: 60 million**

SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2008, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY2008 MSIS and CMS Form-64.





Source: Georgetown Center for Children and Families analysis of March 2011 CBO Medicaid Baseline. Numbers may not add to 100% due to rounding.

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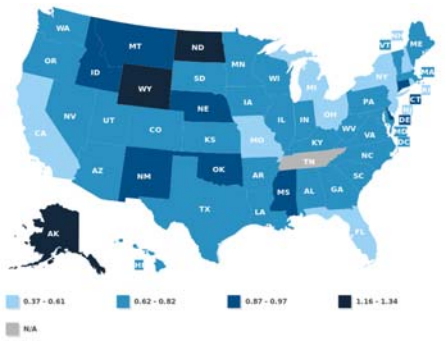
Medicaid/Medicare Fee Index



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Average Inpatient Costs

Year	Claims	Medicaid	Medicare	Ratio
2009	1.88 mil	$5,872	$8,220	0.70
2010	2.55 mil	$5,592	$8,828	0.66

http://www.maac-actuary.org/Future_Meetings/Session_5B_Stone.pdf

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ACA and Fees

- Medicaid fees increased to Medicare levels
- In effect 2013/14
- Passed because of concerns about Doc's not wanting to treat Medicaid patients
- Prices were not kept at the Medicare level
- Will evaluate a little later when we talk about crowd out

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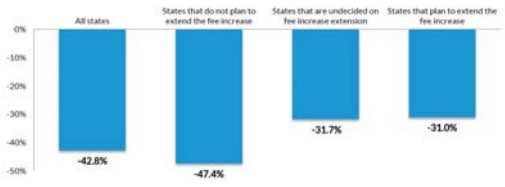
FIGURE 2

Reduction in Medicaid Primary Care Fees for Eligible Physicians in 2015 by State Intention to Continue the Fee Bump



Sources: Urban Institute 50-State Survey of Medicaid Physician Fees, 2014; state decisions from Snyder, Paradise, and Rudowitz (2014).

Note: For comparability, this figure presents average fee reductions in 2015 as if no state except Maryland was continuing the fee bump. For example, in the states that plan to extend the fee bump, fees would fall an average of 31.0 percent in 2015 if the fee bump were not extended. Since 2013, Maryland has used state funds to provide the primary care fee increase to all providers, not just the provider types specified by the Centers for Medicare and Medicaid Services. Given this unique situation, we assume Maryland will continue paying all providers at the increased rate in 2015 and beyond.

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SCHIP

- State Children's Health Insurance Plan
- Designed to provide health insurance to children not poor enough for Medicaid but too poor to purchase health insurance
- States given autonomy to run program. Can use funds to
  - Run independent program
  - Use funds to expand Medicaid to include more kids

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- 19 states expanded Medicaid, 15 had separate SCHIP programs, rest had combination
- 11 states enacted programs in 1997, 34 states in 1998, 6 states in 1999/2000
- Tremendous variation across states in eligibility

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Variation in coverage levels SCHIP

	FPL cutoff, ages 1-5		FPL cutoff, 15 y.o.	
State	1996	2000	1996	2000
CT	185	300	81	300
ID	133	150	29	150
NY	133	192	51	192
RI	250	250	51	250
TX	133	133	17	100
TN	400	400	100	400

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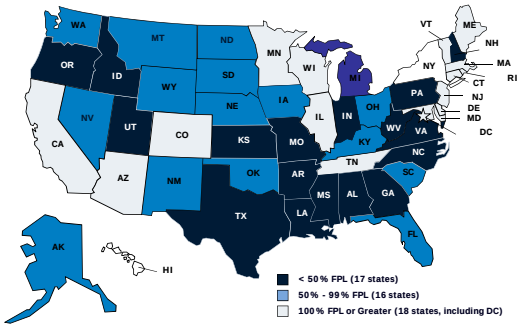
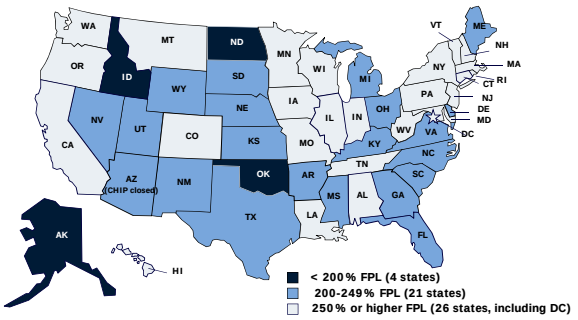
Medicaid Eligibility for Working Parents by Income, January 2012



NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

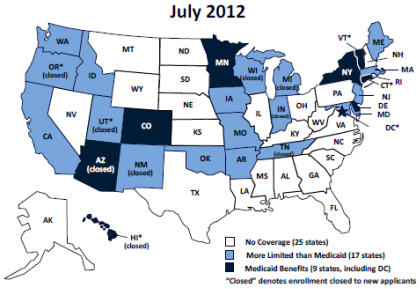
Children's Eligibility for Medicaid/CHIP by Income, January 2012



NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment. IL is waiting for approval for federal funding of its state-funded coverage between 200% and 300% FPL.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Figure 2

Coverage of Low-Income Adults by Scope of Coverage, July 2012



NOTE: Map identifies the broadest scope of coverage in the state. HI, MN, & VT also offer waiver coverage that is more limited than Medicaid. OR and UT also offer "premium assistance" with open enrollment. The coverage in MO is limited to adults residing in the St. Louis area.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012, with state updates.

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Financing of Medicaid

- Financed jointly by Feds and states
  - Both paid for out of general revenues
- Reimbursement rates across states vary depending on per capita income of state
- Problem for states: as federal government expands program, they are forced to eat the additional costs –
  - Has changed under ACA

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Medicaid and the ACA

- Key element to ↑ insurance coverage
- All adults under 65 years of age and income <138 FPL eligible for Medicaid
  - $15,415 for individual (in 2012)
  - $26,344 for family of 3
- Starts January 1, 2014

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Financing

- Fed's will cover full costs of the expansions for 3 years, phasing down to 90% in 2020
- If a state is already insuring populations that are newly covered by the ACA, they will subsidized by the Feds for those already covered

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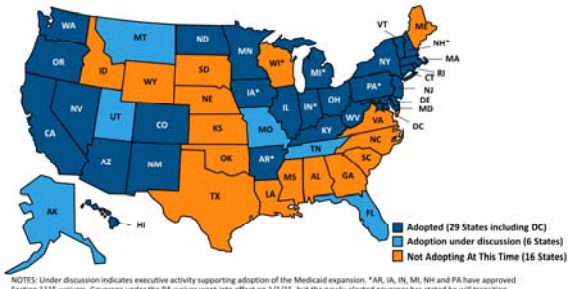
Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, IN, MI, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on 1/1/15, but the newly-elected governor has stated he will transition coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated March 6, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

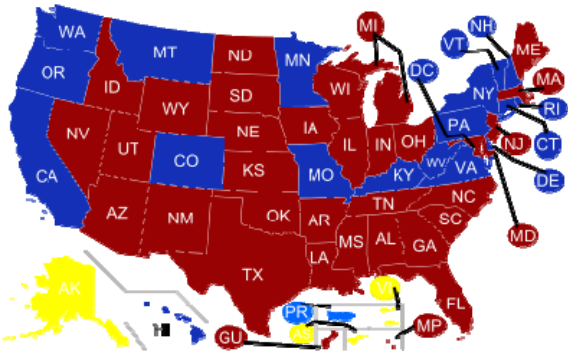


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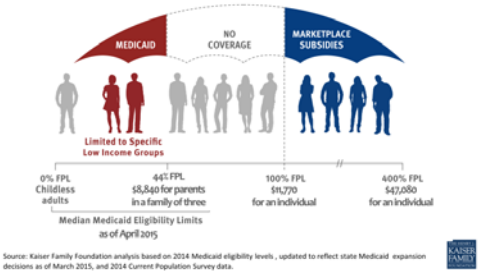
Figure 1

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.



Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels , updated to reflect state Medicaid expansion decisions as of March 2015, and 2014 Current Population Survey data.

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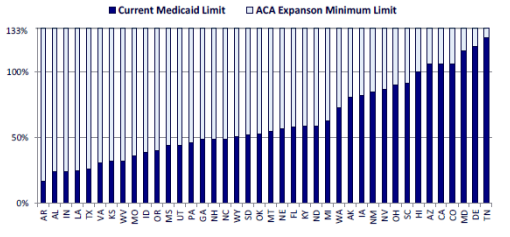
Figure 4

Changes in Parent Medicaid Eligibility Under the ACA Medicaid Expansion, as a Percent of the Federal Poverty Level



NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. Eligibility levels shown are for full Medicaid coverage for working parents. Several states also offer coverage with a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage. Ten states (CT, I, ME, MA, MN, NJ, NY, RI, VT, WI) and DC already offer coverage to parents at or above 133% FPL.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012, with state updates.

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Medicaid expansions and crowd out

- Before late 1980s, Medicaid was available for non-elderly in cash assistance, e.g. AFDC
- AFDC eligibility was determined by income/asset/expenses test and lack of spouse
- Could also become eligible if 'medically needy' e.g., high medical bills 'spend down' income past income limit
- Income line was well below poverty level (average across states was 60% of PL)
- States have always had the option to expand Medicaid past federal mandates

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- Starting in 1985, Medicaid was expanded to include pregnant women and children not eligible for welfare, but still poor
- Severed the link with welfare
- Hoped to provide insurance without the disincentive associated with welfare participation
- Example, by 1990, Medicaid covered all kids < 9 born after 9/30/83 and <100% FPL
  - Some states expanded above this limit

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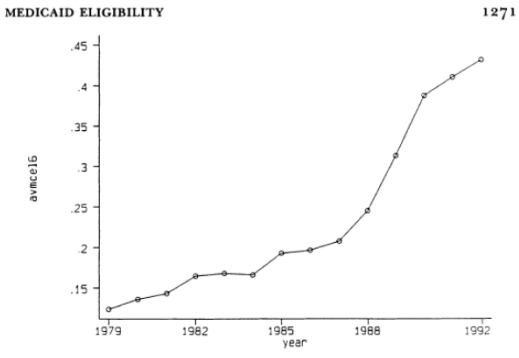

FIG. 2.—Medicaid eligibility trends

Fraction of women, 14-44, eligible for Medicaid if they became pregnant

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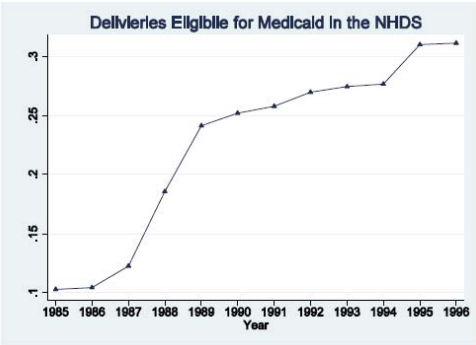

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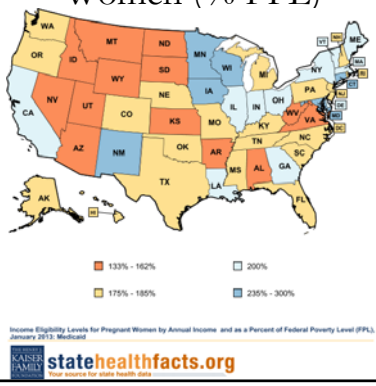
Coverage Levels for Pregnant Women (% FPL)



Income Eligibility Levels for Pregnant Women by Annual Income and as a Percent of Federal Poverty Level (FPL), January 2013: Medicaid

statehealthfacts.org

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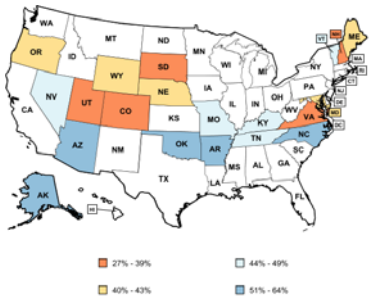
% Births Covered by Medicaid



Births Financed by Medicaid as a Percent of Total Births, 2009

statehealthfacts.org

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TABLE I
MEDICAID ELIGIBILITY AND COVERAGE

Year	% of children eligible	% of children eligible—fixed population	% of children covered
1984	16.1	16.1	13.2
1985	18.2	18.4	13.5
1986	19.0	18.9	13.8
1987	19.3	19.7	13.5
1988	18.8	20.3	12.8
1989	20.4	21.6	13.9
1990	25.7	26.2	16.5
1991	28.7	28.1	19.3
1992	31.2	30.3	20.6

Based on data from March 1985–March 1993 CPS. Column 1 shows the percent of children eligible for Medicaid in each year. Column 2 shows the percentage of the 1984 sample that would have been eligible for Medicaid in each subsequent year (holding their characteristics constant and inflating income appropriately). Column 3 gives the percentage of children actually covered in each year. Figures are from the authors' calculations as described in the text and in Appendix I.

Eligibility rates double (94%)but fraction insured increases by 56%
Big increase in eligibility after 1989

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Crowd out

- Some with employer provided health insurance (EPHI) may pay large chunk premiums OOP.
- They may also be eligible for Medicaid under the new expanded coverage
- Could respond to expansions by dropping EPHI coverage, pick up Medicaid
- Expansions could increase eligibility, increase Medicaid use, but not increase coverage

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TABLE II
SOURCES OF INSURANCE COVERAGE FOR THE NONELDERLY POPULATION, 1987

Group	Insurance status		
	Private	Public	Uninsured
All	76%	14%	14%
Children	74%	19%	13%
Women of child-bearing age	76%	13%	15%
Men with no children or women of child-bearing age in family	84%	8%	11%
Other adults	75%	12%	18%
Children and women of child-bearing age			
Eligible in 1987	31%	50%	25%
Made eligible between 1987 and 1992	65	15	25
Not eligible by 1992	89	6	8

65% of those who were made eligible for Medicaid had Private insurance in 1987

Ability to crowd out is therefore very high

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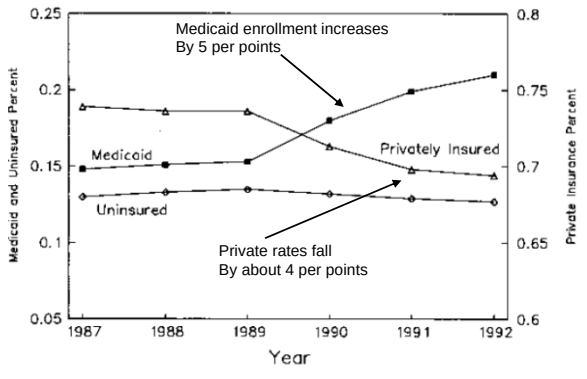

FIGURE IIa
Percent of Children with Different Types of Insurance

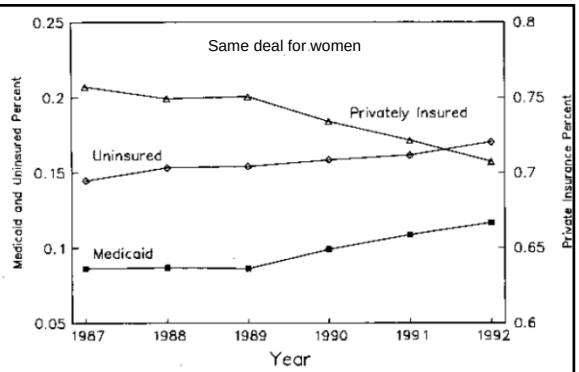

FIGURE IIb
Percent of Women 15–44 with Different Types of Insurance

Basic regression

- $Covered_{ist} = X_{ist}\beta + Eligible_{ist}\alpha + \mu_s + \lambda_t + \varepsilon_{ist}$
- Person i, state s, year t
- *Covered* is a dummy variable that equals 1 if you are covered by source (Medicaid, private, any insurance, etc)
- *Eligible* is a dummy that equals 1 if you are eligible for Medicaid

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- Question: why would OLS estimates generate a biased estimate for the parameter on α?
- Solution: 2SLS
  - Construct synthetic population with data
  - Generate fraction eligible in state s, year t
  - Use this as an instrument for *Eligible*
- Under what conditions does this instrument produced unbiased estimates?

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TABLE IV

REGRESSIONS EXPLAINING COVERAGE FOR WOMEN AND CHILDREN

	Children		
Independent variable	Medicaid	Private	Uninsured
Eligible for Medicaid	**0.235**	**−0.074**	**−0.119**
	(0.017)	**(0.021)**	**(0.018)**

Kids: Medicaid increases by 23 per points,
but 1/3 of that is wiped out
by a reduction in private insurance rates

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Table 1
Literature on crowd-out

Article	Data source	Methodology	Crowd-out definition	Results
Cutler and Gruber (1996)	1987–1992 CPS	Instrument eligibility with simulated eligibility based on entire nation; control for state, year, age; consider family level spillovers	(Private insurance/public insurance) or (1 – (uninsured/public insurance))	Children 31%, or children: 40%, family level: 50%
Dubay and Kenney (1996)	1988 and 1993 CPS	Change in insurance coverage of children relative to change for adult men	(Private insurance/public insurance)	Below poverty: 15%, 100–133%: 22%
Dubay and Kenney (1997)	1988 and 1992 CPS	Change in insurance coverage of pregnant women relative to change for men	(Private insurance/public insurance)	Below poverty: 0%, 100–133%: 27%, 133–185%: 59%
Thorpe and Florence (1998)	1989–1994 NLSY	Measure movement from private insurance onto Medicaid among children with privately insured parents	% of those entering Medicaid with privately insured parents	16%
Blumberg et al. (2000)	1990 SIPP Panel	Compare change in insurance coverage of children made eligible by expansions to those not made eligible	% of children made eligible losing private relative to gaining public	4%
Yazici and Kaestner (2000)	1988 and 1992 NLSY	Compare change in insurance coverage of children becoming eligible to those not becoming eligible	(1 – (uninsured/public insurance)) or (private insurance/public insurance)	55–59%, 5–24%
Aizer and Grogger (2003)	1995–2002 CPS	Compare change in insurance, for those above AFDC eligibility vs. below, in states with adult expansion, before vs. after expansion	Coefficient on private coverage equation (no crowd-out calculations)	Statistically insignificant effect on private coverage for mothers and for children
Card and Shore-Sheppard (2004)	1990–1993 SIPP panels	Compare changes in insurance coverage of children around income and age limits for eligibility	(Private insurance/public insurance)	Below poverty, eligible for <100: 0; below poverty, eligible for 100–133: 50%; 100–133: 0
LoSasso and Buchmueller (2004)	1996–2000 CPS	Instrument eligibility with simulated eligibility based on entire nation; control for state, year, age, state × year; interact with state waiting periods	(Private insurance/public insurance)	Average: 50% varies with state waiting periods
Shore-Sheppard (2005)	1987–1995 CPS	Same as Cutler–Gruber, but add additional controls - children only	(1 – (uninsured/public insurance)) or (private insurance/public insurance)	33% (age/year controls) to 59% (all controls), 0
Ham and Shore-Sheppard (2005)	1985–1995 SIPP	Instrument eligibility with simulated eligibility based on all other states; control for state, year, age	(Private insurance/public insurance)	No crowd-out
Hudson et al. (2005)	1996–2002 MEPS	Compare changes in children made eligible and remaining ineligible; instrument with simulated eligibility	(Private insurance/public insurance)	Comparison: 25–55%, IV: 39–70%

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Table 3
Tabulations by income group over time

Income group	Change in eligibility	Change in Medicaid	Change in private	Change in overlap
<100% FPL	0.103	0.023	−0.007	0.002
100–200% FPL	0.722	0.126	−0.123	0.021
200–300% FPL	0.291	0.052	−0.08	0.014
300–400% FPL	0.076	0.019	−0.047	-0.001

Note: Calculations are based on authors' tabulations of 1996 and 2002 SIPP data. Sample sizes are as follows: 5711 for the <100% FPL category; 5776 for the 100–200% FPL category; 5672 for the 200–300% FPL category; and 5389 for the 300–400% FPL category.

Table 4
Crowd-out calculations from tabulations in Table 3

Income group	Crowd1	Crowd2
DD1: 100–200% relative to <100%	1.11	1.13
DD2: 100–200% relative to 200–300%	0.62	0.58
DD3: 100–200% relative to 300–400%	0.76	0.71

Note: Crowd1 assumes that the overlap is a move from private to public coverage; Crowd2 ignores the overlap.

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Table 5
Effect of eligibility for any public insurance on insurance status

	Public only	Private only	Both public and private	Crowd1
Own eligibility				
Baseline	0.072*** (0.02)	−0.017 (0.02)	0.015** (0.01)	0.37
All interactions	0.055*** (0.02)	−0.011 (0.02)	0.008 (0.01)	0.30
Family eligibility				
Baseline	0.109*** (0.03)	−0.066** (0.03)	0.027** (0.01)	0.68
All interactions	0.156*** (0.05)	−0.122*** (0.04)	0.027* (0.01)	0.81

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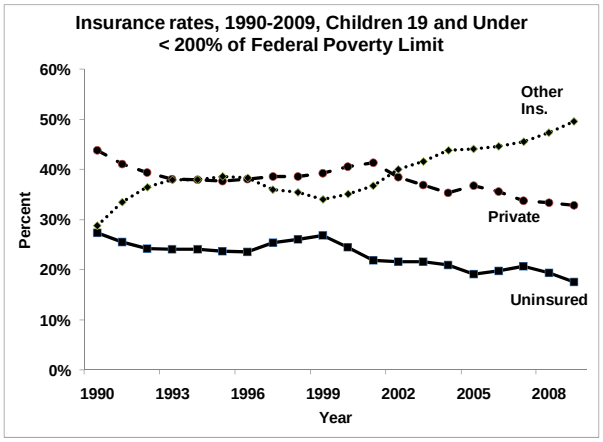

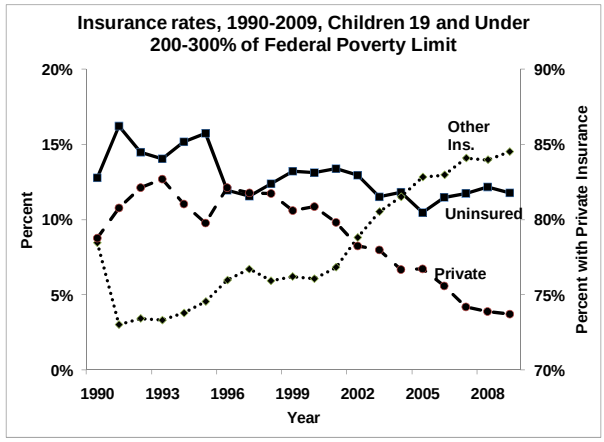

	Children, 0-19 < 200% of FPL			Children, 0-19 200-300% of FPL		
	Un-ins.	Other Ins.	Pvt. Ins.	Un-ins.	Other Ins.	Pvt Ins.
1997	25.4	36.0	38.6	11.5	6.2	81.8
2009	17.5	49.6	32.8	10.7	14.2	75.0
Diff.	-7.9	13.6	-5.8	-0.8	8.0	-6.0

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Is crowd out a concern? Data from 2011

- Adults 18-64 Income< 138% of FPL
  - 41.3 million adults
  - 58.2% are insured (24.1 million)
  - 26.3% have private insurance (10.9 million)
- Adults 18-64 with income 100-138% FPL
  - 12.7 million adults
  - 59.4% have insurance (7.6 million)
  - 33.1% have private insurance (4.2 million)

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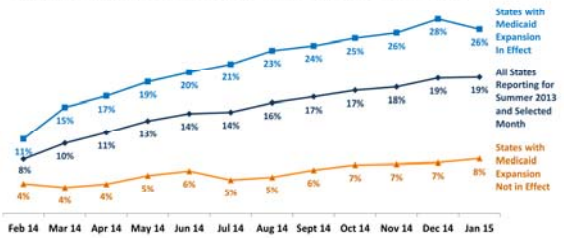
Figure 3

Change in Total Medicaid and CHIP Enrollment Compared to Summer 2013

Cumulative Change in Enrollment for each Month compared to Summer 2013:



NOTE: Summer 2013 enrollment data based on monthly average for July-Sept. 2013. Data not available for CT and ME for the entire reporting period. Data are not available for ND for Feb-Jun 14 and for VT for Nov 14. "States with Medicaid expansion in effect" changes over time to reflect adoption of the expansion in MI (Apr 14), NH (Jul 14) and PA (Jan 15). IN , which expanded Feb 1, 2015, is in the "States with Medicaid Expansion Not in Effect" calculation for in all periods.
SOURCE: CMS, Medicaid & CHIP: Monthly Application and Eligibility Reports, October 2013 – January 2015.

With Crowd-out, will physicians stop seeing Medicaid patients?

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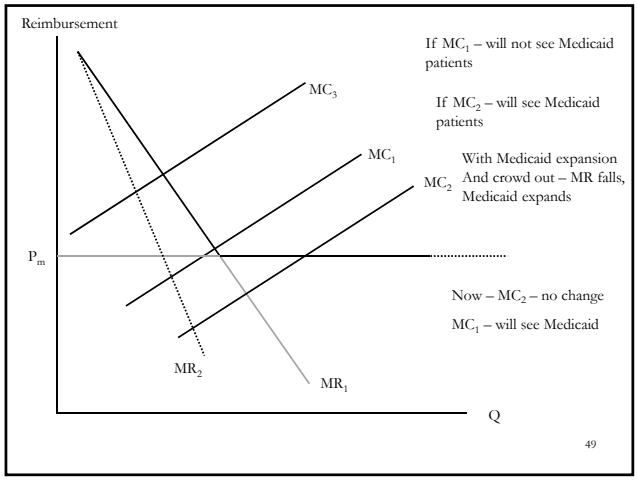
Reimbursement
If MC_1 – will not see Medicaid patients
MC_3
If MC_2 – will see Medicaid patients
MC_1
With Medicaid expansion And crowd out – MR falls, Medicaid expands
MC_2
P_m
Now – MC_2 – no change
MC_1 – will see Medicaid
MR_2
MR_1
Q
49