Your Money and Your Life:
The Case for Medicaid Expansion in the Time of Coronavirus

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Outline for Today

• Overview of research findings on the Affordable Care Act (ACA) and Medicaid
  – Coverage effects and disparities
  – Recent data on health impacts of coverage expansion

• Medicaid reform – proposed and actual

• Medicaid’s role in the COVID-19 epidemic
Medicaid Expansion: The Basics

• Expansion to adults with incomes under 138% of the poverty level ($16,800 for single person)
• ~16 million low-income adults enrolled, as of 2018

Pre-ACA Federal Eligibility Requirements

Medicaid Expansion: 2014

Red: No (23)

Yellow: Maybe (2)

Green: Yes (26)
Medicaid Expansion: 2020

Red: No (13)

Yellow: Maybe / Pending (2)

Green: Yes (36)
Medicaid Expansion: Coverage

Figure 3. Uninsured Rates for Low-Income Adults in Medicaid Expansion vs Nonexpansion States

Source: Sommers, Gunja et al., JAMA 2015
Gains in coverage under the ACA have been largest among Blacks and Hispanics

Asian-White disparity has been completely eliminated

Native Americans have had large coverage gains, especially in expansion states and among those living on/near reservations

Sources: Frean et al., JAMA IM 2016; Park et al., JAMA IM 2018
Access to Care

“We have a higher purpose than just handing out Medicaid cards… We will not just accept the hollow victory of numbers covered.”

–Seema Verma, CMS Administrator

“Medicaid is a program that has by and large decreased the ability for folks to gain access to care.”

–Tom Price, Former HHS Secretary
Medicaid Expansion:
Better Access & Affordability

Changes from 2013 to 2015 after Medicaid expansion in two states (KY and AR), compared to no expansion (TX)

- Has a personal physician: 12.1
- Cost-related delay in care: -18.2
- Skipped medication because of cost: -11.6
- Trouble paying medical bills: -14.0
- Checkup in past year: 16.1

Source: Commonwealth Fund, “In the Literature,” Adapted from Sommers et al., JAMA Int Med 2016
Types of Health Care Use

Table 2. Changes in Coverage, Access to Care, Utilization, and Health after the ACA Medicaid Expansion

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mean in Expansion States, 2013</th>
<th>2014 Net Change, vs 2013 % (95% CI)</th>
<th>P Value</th>
<th>2015 Net Change, vs 2013 % (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any office visits in past year</td>
<td>55.5</td>
<td>2.5 (-3.4 to 8.4)</td>
<td>.41</td>
<td>3.0 (-3.8 to 9.7)</td>
<td>.38</td>
</tr>
<tr>
<td>Any ED visits in past year</td>
<td>21.0</td>
<td>-1.9 (-7.6 to 3.8)</td>
<td>.51</td>
<td>-6.0 (-11.7 to 0.3)</td>
<td>.04</td>
</tr>
<tr>
<td>No. office visits in past year</td>
<td>2.80</td>
<td>0.54 (-0.33 to 1.40)</td>
<td>.22</td>
<td>0.69 (0.05 to 1.33)</td>
<td>.04</td>
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<tr>
<td>No. ED visits in past year</td>
<td>1.16</td>
<td>-0.12 (-0.45 to 0.21)</td>
<td>.48</td>
<td>-0.09 (-0.45 to 0.27)</td>
<td>.62</td>
</tr>
<tr>
<td>Any hospitalization in past year</td>
<td>16.9</td>
<td>-1.5 (-6.8 to 3.7)</td>
<td>.57</td>
<td>2.1 (-3.1 to 7.3)</td>
<td>.43</td>
</tr>
<tr>
<td>ED is usual location of care</td>
<td>9.6</td>
<td>-5.2 (-10.5 to 0.1)</td>
<td>.06</td>
<td>-6.1 (-10.1 to 2.2)</td>
<td>.003</td>
</tr>
<tr>
<td>Glucose check in past year</td>
<td>43.0</td>
<td>2.3 (-5.2 to 9.8)</td>
<td>.54</td>
<td>6.3 (0.0 to 12.6)</td>
<td>.05</td>
</tr>
</tbody>
</table>

- More office-based care and preventive care
- Less reliance on the Emergency Department

Source: Sommers et al., JAMA Internal Medicine, 2016
Overall Effect: 19% increase in Medicaid prescription drug utilization by mid-2015

Largest Gains - Diabetes Medications 24%, Birth Control 22%, Cardiovascular Medications 21%

Notes: “Rx per capita” is per non-elderly adult in the state (not just Medicaid beneficiaries).
Source: Ghosh et al. 2018 JHE
Health Outcomes

OPINION  |  MARCH 10, 2011

Medicaid Is Worse Than No Coverage at All

New research shows that patients on this government plan fare poorly. So why does the president want to shove one in four Americans into it?

By SCOTT GOTTLIEB

Does expanding coverage improve health care?

7:00 PM on May 5, 2014

Dan Diamond, Managing Editor

One of the trickiest questions in health policy seems like it should have an obvious answer:

Does giving people health insurance lead to better outcomes?

“We simply don’t know yet,” Kate Baicker told me last week.
Self-Reported Health

• Consistent finding in our studies of coverage expansions is improved self-reported health
  – State Medicaid expansions in early 2000s
  – Massachusetts health reform in 2006
  – ACA Dependent Coverage Provision in 2010
  – ACA 2014 Marketplace and Medicaid expansions

• Consistent with the Oregon Health Insurance Experiment (RCT of Medicaid coverage)

• Not just “subjective” – prior research shows this is a strong predictor of mortality

Sources: Sommers, Baicker, & Epstein *NEJM* 2012; Chua & Sommers, *JAMA* 2014; Sommers, Long, & Baicker, *Annals Internal Med* 2014; Sommers et al., *JAMA* 2015; Finkelstein et al. *QJE* 2012
Mental Health

• Among patients screening positive for depression, Medicaid expansion led to:
  – Increased coverage
  – Fewer cost-related delays in care
  – Better medication adherence

• These changes after expansion occurred even among those living in mental health profession shortage areas

• Other results from Oregon experiment showed large reductions in depressive symptoms after adults gained Medicaid coverage

Sources: Fry & Sommers, Psych Services 2018; Finkelstein et al. QJE 2012.
Surgery and Chronic Conditions

• Surgery patients get more timely care with better outcomes (e.g. fewer amputations, less invasive surgery) for conditions such as:
  – Acute appendicitis
  – Peripheral vascular disease
  – Aortic aneurysms

• More regular care for chronic conditions like diabetes, heart disease, and asthma

• Improved blood pressure control in community health center patients

Sources: Loehr et al. JAMA Surg 2018; Sommers et al. HA 2017; Cole et al. HA 2017
Chronic Illness: ESRD

- **Trend towards improved access to nephrology specialty care pre-dialysis**
- **Increased use of fistula / graft for dialysis, which reduces infection and clot risk**
- **1-year mortality dropped from 6.9 vs. 6.2% (Diff-in-diff= -0.6, p<0.05)**

*Source: Swaminathan et al., JAMA 2018*
Medicaid & Mortality

• Growing number of studies have linked Medicaid expansion to improved population-wide survival
  – Pre-ACA state expansions in New York, Arizona, & Maine showed to be a cost-effective way to reduce death rates
  – Cardiovascular mortality declined in ACA Medicaid expansion states compared to non-expansion
  – Census data linked to mortality shows Medicaid reduced deaths in adults ages 55-64
  – Most recently, a huge RCT by IRS used a postcard reminder to enroll showed increased insurance coverage reduced deaths

Sources: Sommers, Baicker, & Epstein NEJM 2012; Sommers AJHE 2017; Khatana et al. JAMA Cardiology 2019; Miller et al. NBER 2019; Goldin, Lurie, & McCubbin NBER 2019
Alternatives in Medicaid

State experimentation in Medicaid is not inherently good or bad—it depends on the policy.

But we need to ask:

"What problem is this policy trying to solve?"

"Does the policy actually work as intended to solve that problem?"

Seema Verma stated on February 11, 2020 in a speech to the American Medical Association:

"Yet, for all that spending, health outcomes today on Medicaid are mediocre and many patients have difficulty accessing care."

MOSTLY FALSE

POLITIFACT
TRUTH-O-METER™
State Experimentation in Medicaid

- Via federal waivers, increased interest in alternative approaches in Medicaid – most recently, guidance on block grant option
- “Private Option” – use Medicaid dollars to buy private insurance (AR, IA, MA proposal)
- Health Savings Accounts (IN, AR), more cost-sharing (many)
- Healthy Behavior Incentives (MI, IA, IN)
- Work Requirements (AR, KY, MI, NH approved but then blocked by courts; others pending)
Health Savings Accounts: Lots of Confusion, Affordability Problems

Indiana Medicaid: POWER Health Savings Accounts

- Haven't heard of them: 39%
- Heard of them, but don't pay regularly: 25%
- Making regular payments: 36%

Source: Sommers, Fry, Blendon, & Epstein; Health Aff 2018

Note: Survey of 300 adults in Indiana Medicaid, ages 19-64, with incomes < 138% of the federal poverty level
Healthy Behavior Incentives: *Lots of Confusion*

Implementation Matters: Lessons From Iowa Medicaid’s Healthy Behaviors Program

Natoshia M. Askelson, Brad Wright, Patrick J. Brady, Youn Soo Jung, Elizabeth T. Momany, Brooke McInroy, and Peter Damiano

**AWARENESS AND KNOWLEDGE**

Fewer than half of the enrollees (47.9 percent) indicated that they had heard about the HBP. Enrollees who were aware of the program were more likely to have completed the HBP requirements (exhibit 1). Those who completed the
Arkansas Work Requirements

• 30-49 year olds, starting June 2018, required to report work or other “community engagement” for 80 hours a month to keep Medicaid
• 18,000 removed from program by early 2019 for non-compliance
• We surveyed ~6000 low-income adults in 2016 and 2018 in Arkansas and neighboring states
• Uninsured rates went up, employment unchanged, and 1/3 of the target group hadn’t even heard of the requirement – sound familiar?

Source: Sommers et al NEJM 2019
Work Requirements: Arkansas

Source: Sommers et al NEJM 2019
Medicaid Costs

- ACA expansion covered newly-eligible with 100% federal dollars until 2016, 90% for 2020 and beyond
- Traditional Federal Medical Assistance Percentage (FMAP) range of 50-83% per state continues for those eligible by pre-ACA criteria
- GOP leaders have proposed changing this to a per capita allotment or block grant going forward
Total Medicaid Spending

Medicaid Expenditures, 2014 Dollars, in Billions

Source: Iglehart & Sommers NEJM 2015
Enrollment vs. Per Capita Costs

Source: Iglehart & Sommers NEJM 2015
Expansion Budget Effects

Expansion Budget Effects

State per capita spending on major spending categories in fiscal years 2010–15, by Medicaid expansion status

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid</th>
<th>Education</th>
<th>Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,200</td>
<td>2,500</td>
<td>500</td>
</tr>
<tr>
<td>2011</td>
<td>1,250</td>
<td>2,550</td>
<td>550</td>
</tr>
<tr>
<td>2012</td>
<td>1,300</td>
<td>2,600</td>
<td>600</td>
</tr>
<tr>
<td>2013</td>
<td>1,350</td>
<td>2,650</td>
<td>650</td>
</tr>
<tr>
<td>2014</td>
<td>1,400</td>
<td>2,700</td>
<td>700</td>
</tr>
<tr>
<td>2015</td>
<td>1,450</td>
<td>2,750</td>
<td>750</td>
</tr>
</tbody>
</table>

Source: Sommers & Gruber, Health Affairs 2017
Expansion Budget Effects

State per capita spending on major spending categories in fiscal years 2010–15, by Medicaid expansion status

Paying for Medicaid — State Budgets and the Case for Expansion in the Time of Coronavirus

Jonathan Gruber, Ph.D., and Benjamin D. Sommers, M.D., Ph.D.

Medicaid — and how to pay for it — has become a recurring theme in several current critical policy debates. Fourteen U.S. states have not yet expanded the program under the deal for state Medicaid expansion, with newly eligible federal funding phased in starting in 2016, and the state share increasing from 0% in 2014 to 50% in 2017.
Expansion Costs: Year by Year

% Change in Medicaid Spending

Source: Gruber & Sommers NBER 2020
Spending Increases: Fully Federal

Panel A: Federal Funds

Panel B: State Funds

Expansion States vs. Non-Expansion, 2013 Base Year

Source: Gruber & Sommers NBER 2020
Other Budget Findings

- Expansion did not lead to cutbacks in education, transportation, or other spending
- State predictions in the aggregate were reasonably accurate

Source: Gruber & Sommers NBER 2020
Medicaid Financing & COVID

• **Medicaid** is both a health care safety net program and form of government economics stimulus

• **Block grants** – CMS recently proposed “Healthy Adult Opportunity” – capped federal contribution in exchange for state flexibility
  
  – Very hard to predict recessions and pandemics, so a pre-specified funding cap hampers Medicaid’s response to crises
  
  – Growth rates over time in these proposals nearly always produce state funding shortfalls

• **COVID boosting funding** – CARES Act boosted match rate by 6.2 percentage points though Sept. 2021 – but longer and more generous changes may be needed
Medicaid as Financial Stimulus

• Finally, with Congress passing trillion-dollar economic relief bills, Medicaid can be a critical tool
• Enhanced funding to Medicaid is an immediate form of stimulus, no new infrastructure or oversight needed
• Studies show Medicaid expansion can reduce food insecurity, payday borrowing, and evictions
• Can put money where it’s needed immediately
  – People who have lost jobs (and insurance)
  – Hospitals treating COVID patients and struggling with loss of normal revenues
  – Poorer communities hit hardest by pandemic and recession

Sources: Himmelstein AJPH 2019; Allen et al Heath Affairs 2017 & 2019
Medicaid as Financial Stimulus

Table 6. Annual Medicaid Spending Foregone In Non-Expansion States (2019 dollars), Due to Non-Expansion

<table>
<thead>
<tr>
<th>State</th>
<th>Pre-ACA (2013) Uninsured Population, Ages 19-64</th>
<th>Medicaid Spending Foregone (Millions of $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>582,200</td>
<td>$1,560</td>
</tr>
<tr>
<td>Florida</td>
<td>3,291,300</td>
<td>$8,821</td>
</tr>
<tr>
<td>Georgia</td>
<td>1,551,700</td>
<td>$4,159</td>
</tr>
<tr>
<td>Idaho</td>
<td>214,700</td>
<td>$575</td>
</tr>
<tr>
<td>Kansas</td>
<td>293,100</td>
<td>$786</td>
</tr>
<tr>
<td>Maine</td>
<td>129,900</td>
<td>$348</td>
</tr>
<tr>
<td>Mississippi</td>
<td>431,000</td>
<td>$1,155</td>
</tr>
<tr>
<td>Missouri</td>
<td>656,500</td>
<td>$1,759</td>
</tr>
<tr>
<td>Nebraska</td>
<td>164,300</td>
<td>$440</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1,329,600</td>
<td>$3,563</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>548,900</td>
<td>$1,471</td>
</tr>
<tr>
<td>South Carolina</td>
<td>643,400</td>
<td>$1,724</td>
</tr>
<tr>
<td>South Dakota</td>
<td>85,900</td>
<td>$230</td>
</tr>
<tr>
<td>Tennessee</td>
<td>786,000</td>
<td>$2,106</td>
</tr>
<tr>
<td>Texas</td>
<td>4,661,100</td>
<td>$12,492</td>
</tr>
<tr>
<td>Utah</td>
<td>293,100</td>
<td>$786</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>437,400</td>
<td>$1,172</td>
</tr>
<tr>
<td>Wyoming</td>
<td>63,200</td>
<td>$169</td>
</tr>
</tbody>
</table>

- But 14 states haven’t expanded, limiting Congress’s reach
- We estimate $43 billion in federal funds foregone by non-expansion states in 2018

Source: Gruber & Sommers NBER 2020
Concluding Thoughts

• ACA’s Medicaid expansion improved access to care, financial security, & many (though not all) health outcomes - including survival

• Several states’ alternative approaches to traditional Medicaid expansion have struggled with red tape and low awareness

• Expansion states have not experienced the negative budget impacts that some predicted

• Medicaid is likely to play key role in response to COVID and recession
Questions & Comments?

Thank you!

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