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Research Brief

TO: Senator Bill Wielechowski
FROM: Chuck Burnham, Legislative Analyst
DATE: January 8, 2014
RE: Selected Impacts of Rejecting Medicaid Expansion
LRS Report 14.117

You asked about selected impacts of Governor Parnell's recent decision to reject Medicaid expansion as proposed in the federal Affordable Care Act. Specifically, you wanted Alaska-specific information on the following topics associated with expanding Medicaid:

- ***Mortality attributable to lack of medical care that may be avoided through expansion;***
- ***Impacts on Alaska healthcare facilities that provide uncompensated care;***
- ***Effects on health insurance premiums;***
- ***The number of jobs expected to be created; and***
- ***An estimate of the federal funding rejected.***

Summary

Among the provisions of the federal Patient Protection and Affordable Care Act (P.L. 111-148), or ACA, when it was enacted is a requirement that states expand Medicaid programs to cover individuals with incomes of up to 138 percent of the federal poverty level.[1] Pursuant to the June 2012 U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*, Medicaid expansion under the ACA became optional for the states. As you know, on November 15, 2013, Governor Parnell announced his intention to reject Medicaid expansion. Although this decision will have far-reaching and, to some degree, unknown impacts, we confine this report to the specific questions you raised.

Mortality

Although we located no Alaska-specific research on the possible impact on mortality of rejecting Medicaid expansion, a significant body of research shows that health insurance improves access to medical care and outcomes related to a wide range of serious illnesses and disease. Recently published research specifically on Medicaid expansion in other states suggests that rates of mortality decrease among those who are enrolled in the program as compared to the uninsured. Due to differences among populations and Medicaid eligibility thresholds, we believe applying specific numerical finding to Alaska's uninsured population based on these results would be improper and problematic; however, it is reasonable to conclude that some of the specific benefits found elsewhere would generally accrue to newly enrolled Medicaid participants in Alaska.

Impacts on Healthcare Facilities

The ACA requires reductions in certain payments and reimbursement rates to hospitals. These reductions are more than offset, however, by the reductions in uncompensated care and increased revenues that are projected to occur through expansion of Medicaid. Nationwide, the net effect is estimated at $2.59 in revenues for every $1 in reductions. In Alaska, hospitals expect additional revenues of roughly $60 million per year and a reduction in uncompensated care of over 85

[1] Text of the ACA can be accessed at *http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html*. Portions of the federal healthcare overhaul are also contained in the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), *http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf*.

percent. However, because Alaska declined to expand Medicaid, hospitals will absorb the reductions implemented by the ACA without the offsetting benefits.

Effects on Health Insurance Premiums

Research suggests that in 2009 uncompensated care added roughly $257 to premiums per privately insured individual Alaskan, or about eight percent of total private insurance premiums. We are unable to isolate the impact of rejecting Medicaid expansion on insurance premiums; however, implementation of the ACA's health insurance exchanges *coupled with* Medicaid expansion in Alaska has been projected to result in savings that could reduce the premium increases associated with cost shifting from $301 in 2014 without the ACA / Medicaid expansion to $45 with the healthcare act fully implemented.

Job Creation

One study estimates that additional Medicaid spending under the ACA would result in the creation of over 1,500 jobs in 2014 with annual increases through 2020 when 4,000 new positions are expected. In that year, these jobs could provide approximately $220 million in wages.

Federal Funding

Three studies on Medicaid expansion projected resultant additional federal funding in "mid-case" enrollment scenarios at between roughly $1.1 billion and $2.9 billion in aggregate for the years 2014 to 2020. Increases in state spending in the same projections ranges from $79 million to $240 million. All three reports estimated federal to state spending ratios under expansion would be over $12 to $1.

Mortality Attributable to Lack of Medical Care

A far-reaching and deep body of research leaves little doubt that medical insurance generally improves health outcomes and increases longevity. The corpus of research on the impacts of expanding Medicaid coverage is not as large, but relevant studies show significantly improved outcomes for those receiving coverage as compared to the uninsured.

Health Impacts of Insurance Broadly

Among the numerous respected organizations and experts that have studied the impacts of health insurance, and the lack thereof, on human well-being is the Institute of Medicine (IOM) of the National Academy of Sciences.[2] In an extensive series of studies and literature reviews on "uninsurance," the IOM finds that a

> robust body of well-designed, high-quality research provides compelling findings about the harms of being uninsured and the benefits of gaining health insurance for both children and adults. Despite the availability of some safety net services, there is a chasm between the health care needs of people *without* health insurance and access to effective health care services. This gap results in needless illness, suffering, and even death.[3]

Specifically, among other findings, the IOM concludes that compelling evidence exists that uninsured adults are at higher risk than insured individuals for the following:

- Mortality in hospital and for at least two years after admission for serious acute conditions;

[2] The National Academy of Sciences, first chartered by President Lincoln in 1863, is an independent, nonprofit organization that provides "unbiased and authoritative advice to decision makers and the public." The work of the IOM often originates in requests from Congress, federal agencies, and independent organizations. More information on the Institute is available online at *http://www.iom.edu/*.

[3] "America's Uninsured Crisis: Consequences for Health and Health Care," IOM Report Brief, p. 2, February 2009. This brief and links to further reports on the topic are available at *http://www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx*.

- Extremely poor outcomes, including neurological impairment, intracerebral hemorrhage, and death due to ischemic stroke;
- Death from heart attack and congestive heart failure;
- Being diagnosed at advanced stages of cancer, particularly cancers for which effective early screenings or clinical assessments have been developed;
- Uncontrolled hypertension; and
- Poor recovery from serious injury or trauma and mortality from automobile accidents.

Children likewise benefit substantially from health insurance coverage. In summary, the IOM states that when children acquire health insurance, they "receive more timely diagnosis of serious health conditions, experience fewer avoidable hospitalizations, have improved asthma outcomes, and miss fewer days of school."[4]

In addition to the direct outcomes cited above, the IOM finds evidence that concentrated populations of the uninsured are strongly correlated to insured individuals in those areas having difficulty accessing quality healthcare. Although the reasons for this connection have not been made entirely clear, it stands to reason that for financial reasons many healthcare institutions locate facilities in areas where high levels of insurance exist.

In 2002, the IOM published a research review, which concluded that uninsured adults under age 65 have a 25 percent higher risk of dying than their peers with health insurance.[5] A 2008 report by the Urban Institute updated and expanded upon the IOM review.

Based on IOM methodology and data from the National Center for Health Statistics and the U.S. Census Bureau, the Urban Institute estimates that between 2000 and 2006, approximately 137,000 U.S. adults aged 25-64 died as a result of not having health insurance, including 22,000 people in 2006 alone. The Institute further explains that, in light of research findings subsequent to the 2002 IOM study, its methodology may actually under-estimate deaths attributable to a lack of health insurance.[6]

Impacts of Medicaid Coverage on Health and Mortality Specifically

Although the body of research on the detriments to health of uninsurance is compelling, such studies are notoriously difficult to design. In order for the comparison between insured and uninsured populations to be valid, numerous controls must be put in place to account for their many broad and significant differences.[7] Even greater differences in income, occupation, and lifestyle exist between the general population and participants in the Medicaid program. As a result, designing valid studies of the impacts of Medicaid on health status is very challenging, and the canon of research in this area is consequently smaller than studies comparing the broader insured and uninsured populations.

A primary challenge in studying the health impacts of Medicaid is devising a control group against which the study group can be legitimately compared. Two research reports, each published in the *New England Journal of Medicine* (*NEJM*), convincingly overcame this obstacle.

The first, published in 2011, studied 10,000 Medicaid recipients in Oregon for a year. The study group was comprised of new Medicaid enrollees selected by the State of Oregon by lottery from a waiting list of 90,000, thereby creating both study and

[4] IOM Report Brief, p. 3.

[5] This conclusion was based on a sub-set of the 130 studies reviewed that followed subjects aged 18 to 64 years for between 5 and 17 years. "Care Without Coverage: Too Little, Too Late," IOM, May 21, 2002, *http://www.iom.edu/Reports/2002/Care-Without-Coverage-Too-Little-Too-Late.aspx*.

[6] Stan Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis of Uninsurance on Mortality," Urban Institute, January 2008,

[7] That is variables such as income, occupation, tobacco use and factors that tend to directly impact health typically vary significantly between the insured and uninsured. As a result, researchers must account for these variables to ensure that the impacts they measure are due to insurance status rather than some other factor.

control groups by random assignment—an ideal circumstance for scientific study—from a population with relatively consistent characteristics. This study design allowed a rare opportunity to compare the impact of having Medicaid versus being uninsured.[8]

Among the study's finding are the following:

- Medicaid coverage raises the probability of using outpatient care by 35 percent, of using prescription drugs by 15 percent, and of hospital admission by 30 percent;
- Overall, health care use from enrollment in Medicaid translates into about a 25 percent increase in total annual health care expenditures;
- People with Medicaid coverage were 70 percent more likely to report having a regular place of care and 55 percent more likely to report having a usual doctor;
- Coverage also increased the use of preventive care such as mammograms (by 60 percent) and cholesterol monitoring (by 20 percent);
- Medicaid reduces by 40 percent the probability that people report having to borrow money or skip payment on other bills because of medical expenses. Although it does not appear to reduce their risk of bankruptcy (at least in the first year), it decreases by 25 percent the probability that they will have unpaid medical bills that are sent to a collection agency;
- Medicaid enrollees are 25 percent more likely to indicate that they're in good, very good, or excellent health (vs. fair or poor health). They are 25 percent less likely to screen positive for depression. They are even 30 percent more likely to report that they are pretty happy or very happy (vs. not too happy).[9]

The authors of the Oregon research concede that, due to the relatively short period of study—one year—it is difficult to ascertain whether physical health had improved in the study group; however, the findings on increased access and uptake of medical services suggests that outcomes will improve over time. The researchers caution, however, that "system-level" impacts of insuring millions of people at once, including the strain placed on healthcare delivery systems, may differ from their results.

Another study, published in the *NEJM* in September 2012, is the only recent research of which we are aware to look specifically at whether expanding Medicaid programs changed rates of mortality.[10] The authors of the report, one of whom also worked on the Oregon study, compared Medicaid programs in Arizona, New York, and Maine, which expanded eligibility. The study group was comprised of 68,012 adults aged 20-64 years, who were observed for five years before and after the expansions in question (1997-2007). This cohort was then compared to populations of neighboring states that did not expand Medicaid.

The research found that mortality for all ages and causes was reduced in the study group by an average of 19.6 deaths per 100,000 individuals, or a relative reduction of 6.1 percent. Secondary observations generated by the research include a 14.7 percent reduction in uninsurance, decreases of 21.3 percent in delayed care due to costs, and increased rates of self-reported health status of "excellent" or "very good" of 3.4 percent.

This research, like most, has its critics. Even its authors point out a number of the study's limitation, which include the following:

- Only three states are studied, and results are driven by the largest—New York;

[8] Katherine Baicker, Ph.D., and Amy Finkelstein, Ph.D., "The Effects of Medicaid Coverage—Learning from the Oregon Experiment," *NEJM*, 2011; 265:638-685, *http://www.nejm.org/doi/full/10.1056/NEJMp1108222*.

[9] Baicker, et al., p. 684.

[10] Benjamin D. Sommers, M.D., Ph.D., Katherine Baicker, Ph.D., and Arnold M Epstein, M.D., "Mortality and Access to Care Among Adults after State Medicaid Expansions," NEJM, 2012;367:1025-34, *http://www.nejm.org/doi/full/10.1056/NEJMsa1202099*.

- Because Medicaid rules and population characteristics vary among states, results may not be generalizable to other states;
- Mortality data did not allow for controls of individual characteristics other than race, sex, and age;
- Most importantly, unlike the Oregon study, the structure of this study is non-randomized and cannot, therefore, definitively demonstrate causality.

Clearly, studies of expansions in other states, preferably using randomized research methods, are required to confirm the above results. The U.S. Supreme Court decision leaving expansion of Medicaid under the Affordable Care Act to the discretion of the states will likely provide ample opportunities for such research, as large numbers of Americans become newly enrolled Medicaid recipients while those in states that decline expansion remain uninsured. For now, the available research on the impacts of obtaining medical insurance in general, and of expanding Medicaid specifically, indicate that healthcare access and outcomes, including reduced mortality, are likely to improve as a result.

Possible Change in Mortality in Alaska Attributable to Medicaid Expansion

With the data and resources available, we are unable to produce reliable estimates regarding the illnesses and deaths that may be avoided should Alaska expand its Medicaid program as contemplated in the ACA. Although applying the results of the research we mentioned above to Alaska is possible, doing so is inappropriate due to numerous differences between the populations studied and those in Alaska who would be impacted by Medicaid expansion. Such dissimilarities include current mortality rates, socioeconomic characteristics, median age, race/ethnicity, and other demographic factors, all of which tend to impact research on health. Further, the qualifying criteria for the Medicaid programs studied differ from those of the ACA. Specifically, in the study that compared states that expanded Medicaid to those that did not, the expansion states had the following income eligibility limits:

- 100 percent of federal poverty level (FPL) for childless adults—Arizona, Maine, and New York;
- 150 percent of FPL for adults with children—New York; and
- 200 percent of FPL for adults with children—Arizona.

By contrast, the expansion of Medicaid under the ACA provides eligibility for those with family incomes up to 138 percent of FPL. In light of the disparities in attributes and eligibility criteria between the groups studied and the cohort of Alaskans that would be covered by Medicaid expansion, applying the research findings discussed above to Alaska is problematic.

Having noted our reservations with applying *specific* findings elsewhere to Alaska regarding the impacts of Medicaid expansion, it does not follow that those results are not *generally* applicable. That is, the broad findings of the positive impacts of medical insurance on human health and longevity, and the narrower results of research on expanding Medicaid, show they significantly improve outcomes in a variety of measures. We find no reason to expect that the positive impacts found elsewhere would not occur, to some degree, in Alaska. With regard to your specific question on mortality, if even half of the reduction in mortality found by the study on Medicaid expansions in Arizona, Maine, and New York were to occur in Alaska under the ACA provisions, scores of deaths would ultimately be averted among the roughly 40,000 currently uninsured Alaskans that would be expected to enroll in Medicaid by 2020.[11]

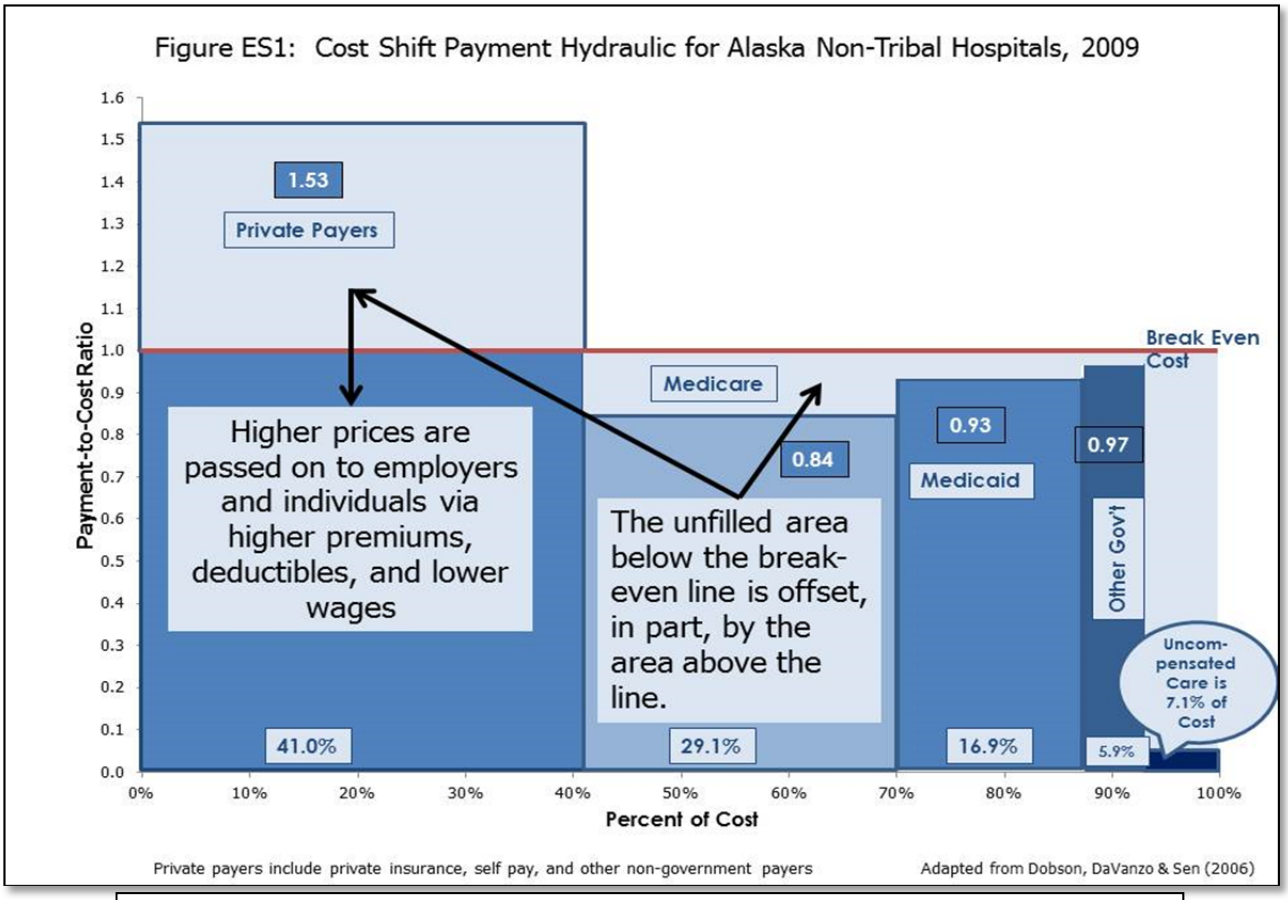
Impacts on Healthcare Facilities and Insurance Rates Related to Uncompensated Care

According to the Alaska State Hospital and Nursing Home Association (ASHNHA), in 2009, the state's hospitals reported non-payment losses of $410 million, or about 21 percent of total operating revenues, from underpayment of medical bills and the provision of uncompensated care to uninsured individuals. Uncompensated care alone totaled approximately $178 million.[12] A substantial portion of the remaining losses due to underpayment stems from the failure of reimbursement from public

[11] "Healthier Alaskans Create a Healthier State Economy," Alaska Native Tribal Health Consortium, February 2013, p. 5, *http://www.anthctoday.org/news/ANTHC%20Summary%20Report%202013-02-03v%20FINAL%20DRAFT%20dm.pdf*.

[12] "Hospitals and Nursing Homes in Alaska: The Economic and Community Impacts of Caring," ASHNHA, p. 5, *http://www.ashnha.com/wp-content/uploads/2012/11/ASHNHA_Econ-Comm-Benefit-Final-12-2-11.pdf*.

payers to fully cover the costs of care. For example, according to a recent study commissioned by ASHNHA, in 2009 Medicare and Medicaid respectively paid 84 percent and 93 percent of healthcare costs incurred by program participants in Alaska.[13] All told, enrollees in government health care programs incurred over half of all non-tribal hospital costs in that year. In order to compensate for these underpayments, and the roughly seven percent of total costs generated by the uninsured, hospitals shift the burden to private payers—specifically, private insurance, self-paying patients, and other non-government entities. As the figure below illustrates, this cost shifting results in expenditures for private payers that exceed actual costs by roughly 53 percent. This excess is used to offset payments below break-even costs from public programs and uncompensated care.



Source: Lanis L. Hick, Ph.D., et al., "Impact of Cost Shifting on Private Insurance," University of Missouri School of Medicine, Department of Health Informatics, April 15, 2013, p. iv.

Impacts on Healthcare Facilities

Hospitals in Alaska and elsewhere generally supported the ACA despite provisions in the law that reduced certain revenues. Specifically, payments to "disproportionate share hospitals" (DSH)—those that meet thresholds for providing care to the indigent—and cuts to Medicare fee for service payments are reduced under the ACA. In addition, expanded Medicaid eligibility means that certain individuals who had been covered by private insurance would shift to public programs and their associated lower reimbursement rates. Despite these potential reductions, research has shown the ACA would increase nationwide hospital revenues by nearly 23 percent over ten years due to significant increases in the number of people

[13] Lanis L. Hicks, Ph.D., et al., "Impact of Cost Shifting on Private Insurance," University of Missouri School of Medicine, Department of Health Informatics, April 15, 2013, *http://d2vx0b949pmiku.cloudfront.net/wp-content/uploads/2012/11/Impact-of-Medicaid-Expansion-on-Private-Health-Insurance-04-15-2013-Final.pdf*.

covered by some type of insurance. According to the Robert Wood Johnson Foundation (RWJF), for each dollar lost from private insurers, $2.59 of Medicaid payments would be collected by U.S. hospitals.[14]

In Alaska, under the healthcare law, ASHNHA expected the number of uninsured individuals to be cut by more than half, largely due to Medicaid expansion. These newly covered individuals would, in turn, result in increased revenues to hospitals of up to $60 million per year—a finding that is supported by research from the RWJF.[15, 16] With all impacts of the ACA (health insurance exchange plus Medicaid expansion) in Alaska considered, the cost of uncompensated care in 2014 would be expected to fall over 85 percent to just under $20 million.[17]

Of course, the lion's share of the benefits outlined above accrues to hospitals in Alaska only if the State expands Medicaid as contemplated in the ACA. The cuts in payments and reimbursements to hospitals in the healthcare law will be implemented regardless of whether states expand their Medicaid programs. Therefore, hospitals in Alaska and other states that reject expansion will face reduced revenues while providing services to similar numbers of indigent patients.

Effects of Uncompensated Care on Private Health Insurance Premiums

As we indicate above, the costs of uncompensated care and underpayments to hospitals is largely born by private payers. Although the "payers" distributing the funds to hospitals are often insurers, the actual costs are collected in the form of higher premiums to policyholders. Recent research in Alaska follows an extensive body of evidence that illustrates this cost-shifting mechanism. Specifically, research by the University of Missouri Department of Health Informatics (UoM) indicates that uncompensated care in 2009 added roughly $257 to premiums per privately insured Alaskan, or about eight percent of private insurance premiums. The study further found that, overall, cost-shifting increased premiums by approximately $628 per privately insured individual, or over 19 percent of private insurance premiums.[18]

We are unable to isolate the impact of rejecting Medicaid expansion on insurance premiums; however, the UoM study shows that implementation of the ACA's health insurance exchanges *coupled with* Medicaid expansion in Alaska could result in savings of approximately $111 million in insurance premiums in 2014 and $717 million, in aggregate, from 2014 to 2019. These savings could reduce the premium increase per privately insured individual due to cost shifting from $301 in 2014 without the ACA / Medicaid expansion to $45 with the healthcare act fully implemented.[19]

Projected Federal Funds and Job Creation

At least three studies were published in 2013 that specifically estimated additional federal funding that would come to Alaska through Medicaid expansion under the ACA. One of these also projected the number of jobs that would be created as a result of that funding. The Alaska Native Tribal Health Consortium commissioned two studies—one from Northern Economics and another by the Urban Institute—which were both released in February; the other was prepared by the Lewin Group for the Alaska Department of Health and Social Services (DHSS). Although the latter report was provided to DHSS in April, it was not released publicly until Governor Parnell announced in mid-November his decision to reject Medicaid expansion. Below we review the relevant findings of each study.

Northern Economics

The report "Fiscal and Economic Impacts of Medicaid Expansion in Alaska," projects in its "mid-participation scenario" that cumulative state spending on Medicaid for the period 2014-2020 would increase roughly $90.7 million under a fully-

[14] Stan Dorn, et al., "The Financial Benefit to Hospitals from State Expansion of Medicaid," *Timely Analysis of Immediate Health Policy Issues*, Robert Wood Johnson Foundation and the Urban Institute, March 2013, *http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf405040*.

[15] *http://d2vx0b949pmiku.cloudfront.net/wp-content/uploads/2012/11/Medicaid-Expansion-Briefing-8-14-13.pdf*

[16] Dorn, et al., Table 4, p. 5.

[17] Hicks, et al., p. v.

[18] Hicks, et al., p. 7-8

[19] Hicks, et al., p. 12.

implemented ACA.[20] Aggregate federal spending in the same scenario and period would increase by approximately $1.1 billion, resulting in a ratio of federal to state costs under expansion of over $12 to $1.[21]

The report estimates that this additional spending would result in the creation of over 1,500 jobs in 2014 with annual increases in job creation through 2020 when 4,000 new positions are expected. By 2020, these jobs are expected to provide approximately $220 million in wages annually. The mid-participation scenario projects cumulative economic impacts of expanding Medicaid to be roughly $2.49 billion over the period studied.

Urban Institute

"Medicaid in Alaska Under the ACA" estimates that state spending would increase by $79 million in aggregate under the Medicaid expansion called for in the ACA for the period 2014-2020. Federal spending would, in turn, increase by $1.15 billion over these years. These increases represent funding above that projected with no Medicaid expansion of 18.5 percent and 1.9 percent for the federal and state governments, respectively.[22] The report does not consider job creation or other economic impacts.

The Lewin Group

The Lewin Group report estimates Medicaid enrollment and associated costs at rates substantially higher than that found in the studies discussed above. Consequently, government spending is projected to be much greater over the period 2014-2020. The Lewin report foresees cumulative spending over those years of approximately $240 million and $2.9 billion in its baseline scenarios for the Alaska and federal governments, respectively, under ACA expansion of Medicaid. Although the report does not provide specific values of broader economic impacts to the state, its authors do comment on secondary impacts of expansion as follows:

> Medicaid expansion will also have some more certain positive economic benefits for the state. State spending is expected to bring in significant federal matching dollars, much of which will pay for care that otherwise would have been provided at the state's expense. The influx of federal funds could also generate job growth within the state. In the health sector in particular, increased compensation resulting from an increased volume of insured patients may benefit hospitals and their providers. Finally, an increase in state revenue is likely given the impact of the rise in insurance coverage on insurance premiums taxes, medical provider taxes, and modest increases in [tax receipts].[23]

The following table summarizes the findings of the three studies we reviewed with regard to increases in state and federal spending projected under ACA Medicaid expansion.

	Northern Economics	Urban Institute	Lewin Group
		Millions of $	
State	$91	$79	$240
Federal	$1,105	$1,093	$2,897
Ratio - Federal to State	12.12 : 1	13.84 : 1	12.07 : 1

We hope this is helpful. If you have questions or need additional information, please let us know.

[20] All of the studies we reviewed acknowledge the uncertainty in projecting Medicaid enrollment increases, and therefore the increased spending, expected under the ACA. To account for this, each study crafted low, medium, and high scenarios of participation for Alaskans made Medicaid-eligible by the Act. For the sake of brevity and simplicity, we report only the mid-range projections in this report.

[21] "Fiscal and Economic Impacts of Medicaid Expansion in Alaska," Northern Economics, Executive Summary, February 1, 2013, pp. ES 1-4, *http://www.anthctoday.org/news/Final%20Report-Fiscal%20and%20Economic%20Impacts%20of%20Medicaid%20ExpansioninAlaska.pdf*.

[22] Matthew Buettgens, Ph.D., and Christopher Hildebrand, MPP, "Medicaid in Alaska Under the ACA," Urban Institute Health Policy Center, February 1, 2013, p. 1, *http://www.anthctoday.org/news/Medicaid%20in%20Alaska%20Under%20the%20ACA%20Final.pdf*.

[23] Megan Cole, MPH, et al., "Any Analysis of the Impact of Medicaid Expansion in Alaska," The Lewin Group, April 12, 2013, pp. 1-3 and 27, *http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf*.