New Hampshire Center for PUBLIC POLICY Studies

New Hampshire Medicaid Expansion

August 13, 2013 Presentation to the Commission on Medicaid Expansion

"…to raise new ideas and improve policy debates through quality information and analysis on issues shaping New Hampshire's future."

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Putting ideology aside .... Do the potential benefits of a Medicaid expansion offset the costs to New Hampshire?

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What are the goals?

- There are simple (and separate) goals:
  - Maximize access to health care services
  - Maximize health outcomes for NH
  - Minimize the role of state government
  - Maximize federal dollars to the state
- There are complicated goals:
  - Maximize federal dollars, health coverage, community health, and private insurance coverage, while minimizing state dollars…

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What might this look like?

		2014	2015	2016	2017	2018	2019	2020
State General Fund Impact								
	Cost of New Program (Enrollees)							
	Administrative Costs							
	Corrections Savings							
	Other Savings							
	Net General Fund Impact							
Statewide Impact								
	Net General Fund Impact							
	New NH Tax Liability (NH Spend Spread Across US Pop)							
	Community Health Status (Costs)							
	Direct and Indirect Economic Impact of New Spending							
	Impact on Business Health Insurance Premiums, Relative to other States							
	Estimated Productivity and Tax Benefit of Deaths Averted (Reduction of Mortality)							
	Impact of Supply Constraints on Overall Health							
Net Statewide Impact								

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Goals

- The Center could provide hours of testimony in response to questions about physician impacts, hospital finances, personal responsibility and the welfare state, tax levels, and individual health improvement etc….
- Two problems for those trying to get to a bottom line assessment
  - Identifying all of the inputs into that model is difficult because the goals haven't collectively been established.
  - Are the costs outweighed by the difficult-to-monetize benefits of health and community outcomes, economic development impacts, and other factors?
- Is there agreement on the goals?

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Commissioners' Medicaid Expansion Questions

- **Who will potentially be eligible and affected?**
  - **Uninsured**
  - **Insured**
  - **Community Health Status**
  - **Current access to health care**
- **How might providers be affected?**
  - **Physician Supply**
  - **Hospitals and Financing**
  - **Other Provider Impacts**
- **What are the financial implications for state and local government?**
  - **Financing the expansion**
  - **Impact on Corrections**
  - **Impact on Local Government (Municipal and County)**
- **Short Term versus Long Term**

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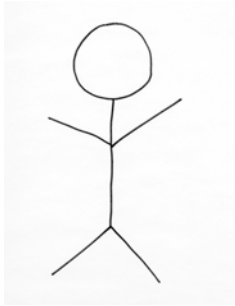
If your goal is coverage … the "who"

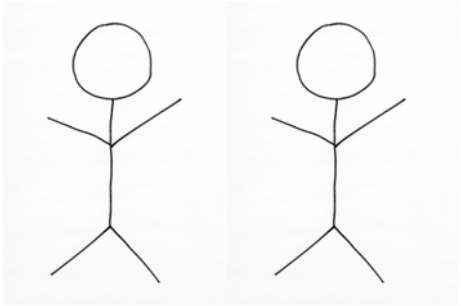
Who would be affected by a Medicaid expansion?

138% of the Federal Poverty Level

$15,856 in annual income

$21,404 in annual income





Non-Disabled Individuals

40% of the Poverty Level

$4,596 in annual income

$6,204 in annual income

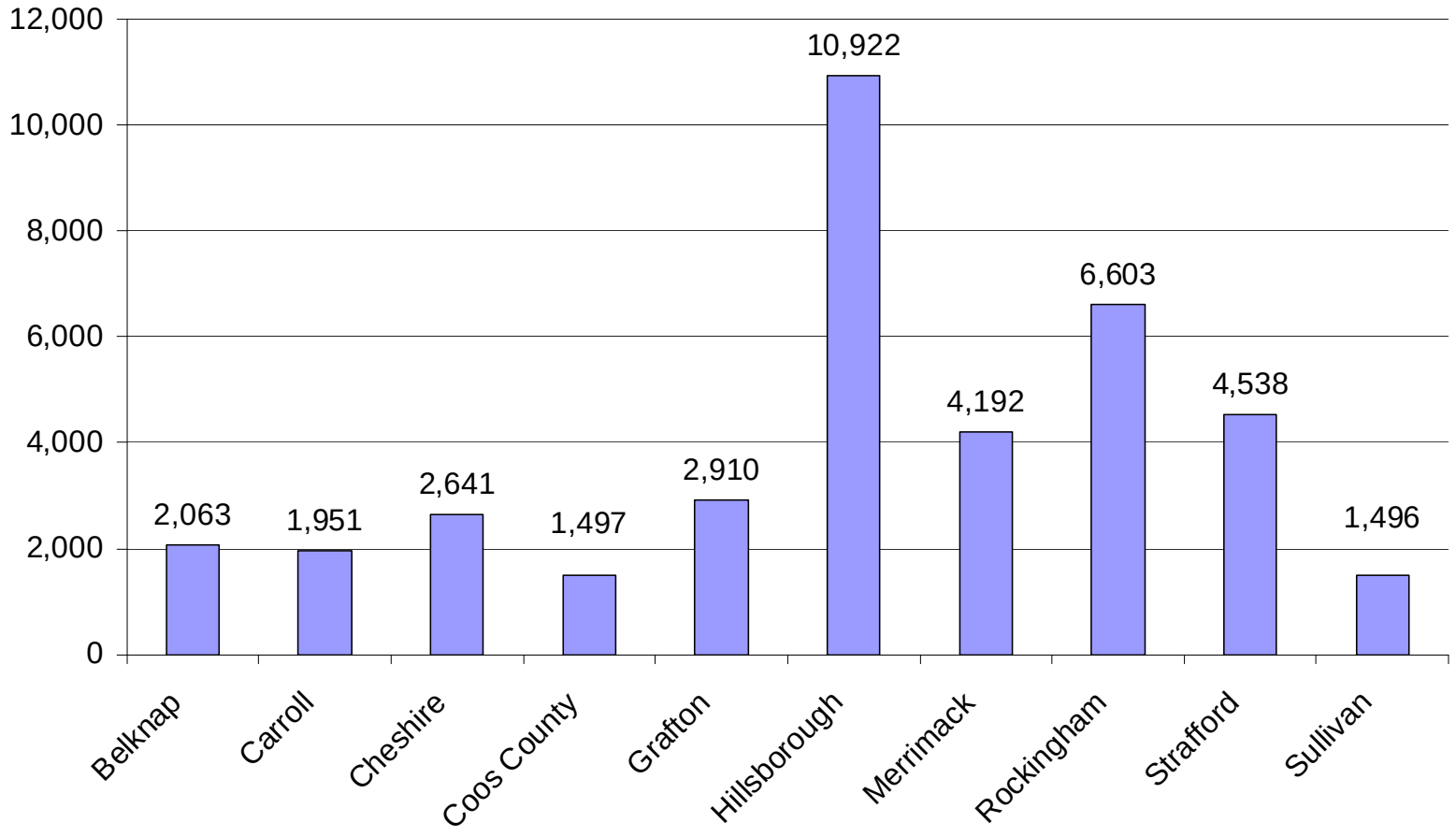
0% of FPL

Not otherwise covered via other Medicaid programs

~ 38,000 Uninsured Adults aged 18 - 64

Uninsured individuals, 19 to 64 with incomes below 138% of the FPL

Estimates of the Number of Uninsured with Incomes less than 138% of FPL by County 2010



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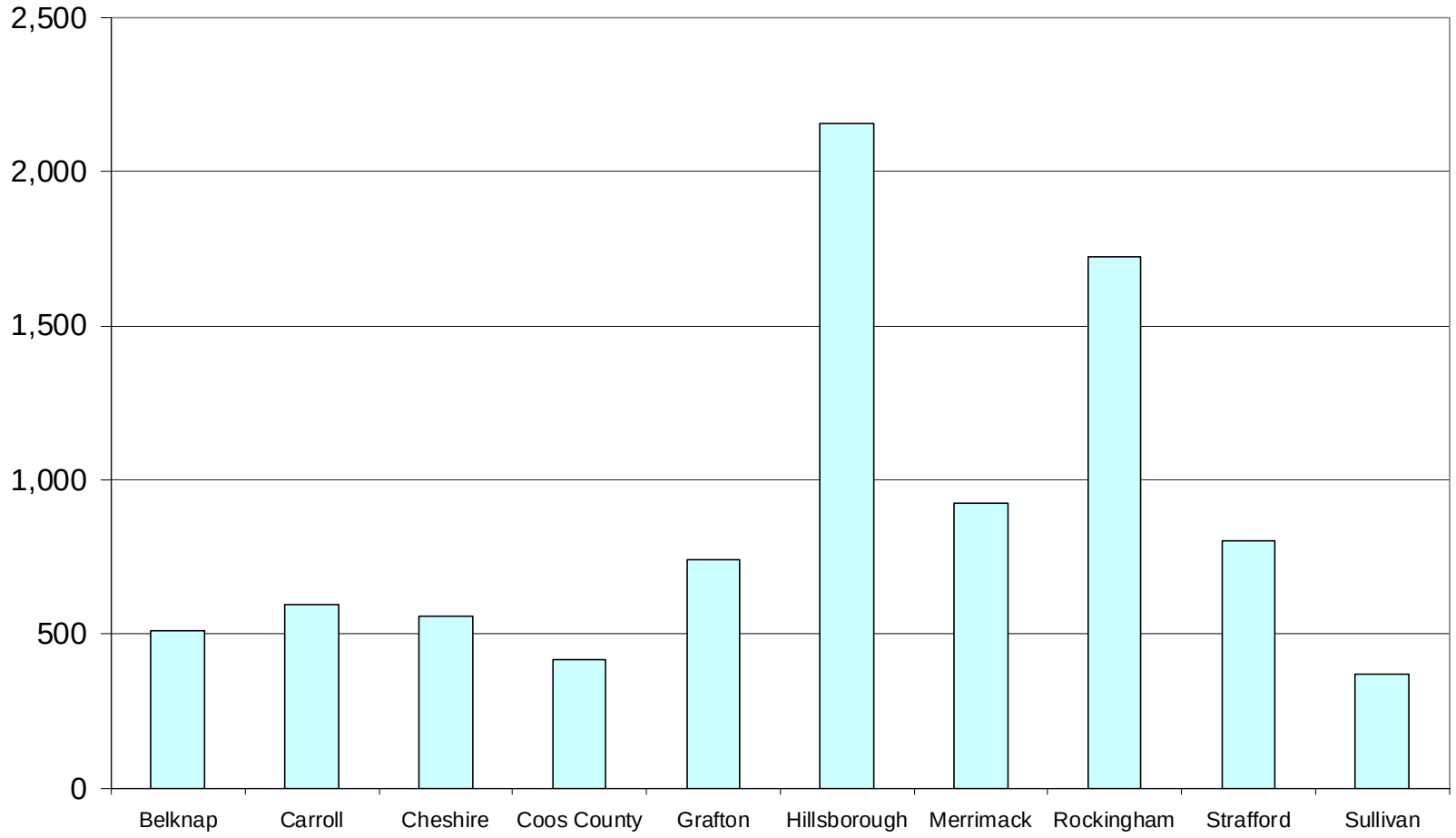
Who are the Uninsured?

NH's Uninsured Adults with Incomes Less than 138% of FPL, 2101					
		Percent of Uninsured Adults			
Name	Uninsured Adults 19-64	Male	Age 18 to 40	Age 41 to 50	Age 51 to 64
Belknap	2,063	52.2%	51.1%	24.0%	24.9%
Carroll	1,951	55.5%	42.1%	27.4%	30.4%
Cheshire	2,641	55.0%	57.1%	21.8%	21.2%
Coos County	1,497	56.5%	46.8%	25.4%	27.8%
Grafton	2,910	56.2%	52.7%	21.7%	25.6%
Hillsborough	10,922	53.3%	59.5%	20.8%	19.7%
Merrimack	4,192	55.8%	53.1%	24.8%	22.1%
Rockingham	6,603	52.4%	48.9%	25.0%	26.1%
Strafford	4,538	54.5%	63.0%	19.4%	17.7%
Sullivan	1,496	53.5%	52.2%	23.2%	24.6%
Source:NHCPPS calculations using Small Area Health Insurace Estimates					

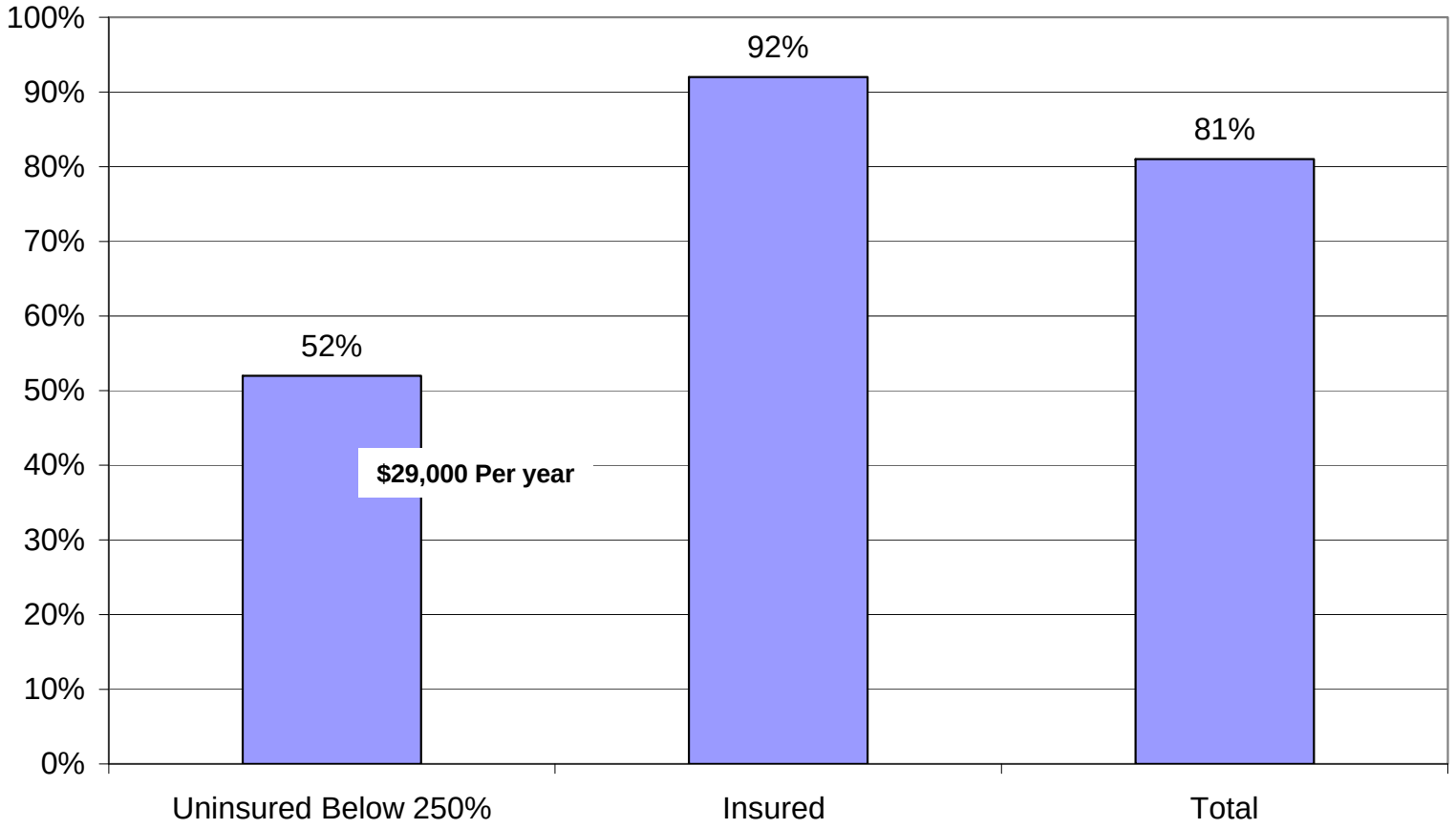
Those aged 50 to 64

Number of Uninsured Indivdiuals with incomes < 138% of the FPL Age 50 to 64, 2010



Insured are almost twice as likely to have a doctor visit as low-income uninsured.

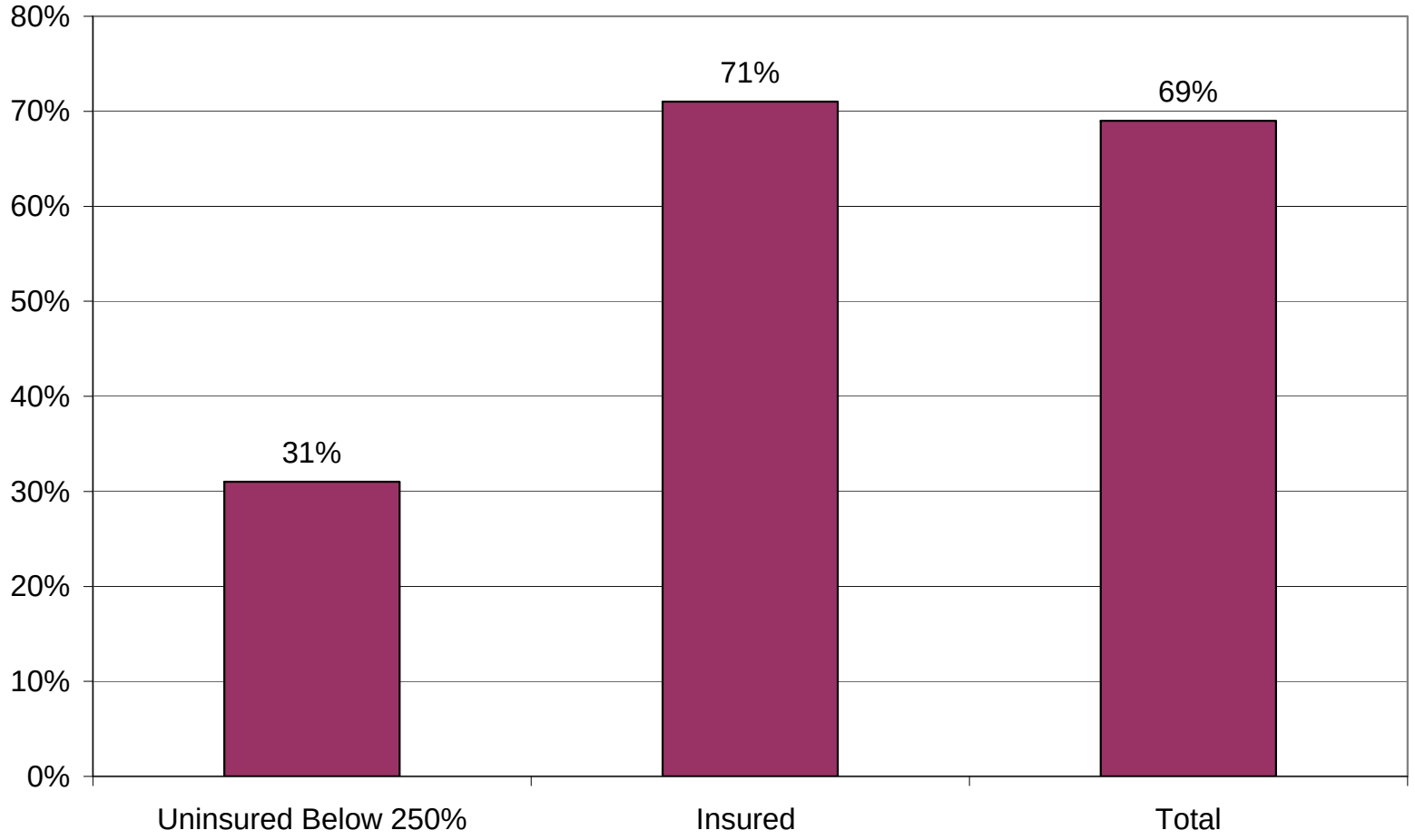
Adults 19-64 Who Have a Regular Doctor, Doctors Group, or Health Center Visit, 2011



Collins Et. Al, 2012 analysis of Commonwealth Fund Health Insurance Tracking Survey of US Adults, 2011

Insured are more than twice as likely to have a doctor's office as a regular source of care.

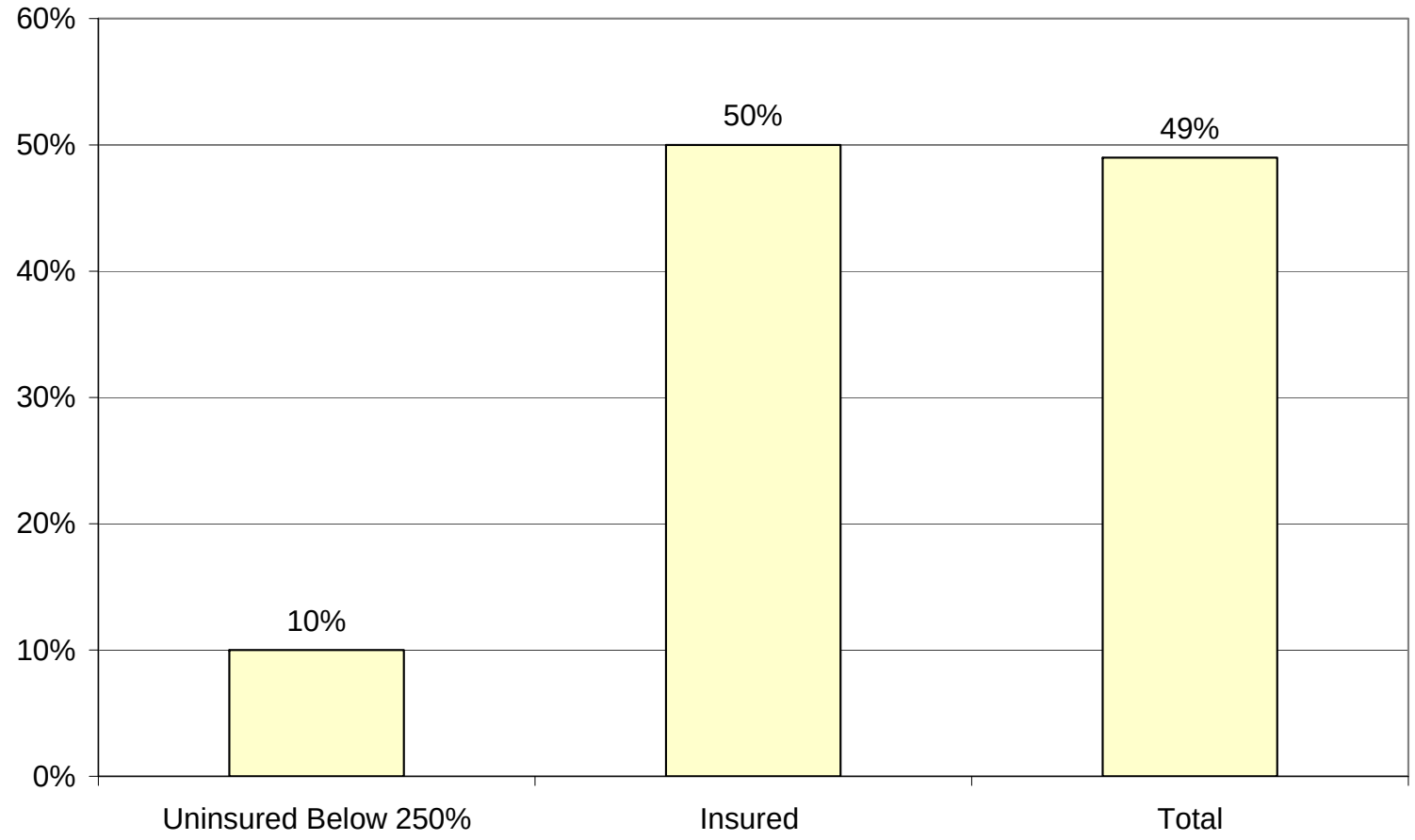
Adults 19-64 Who Have Doctors Office As Usual Source of Care, 2011



Collins Et. Al, 2012 analysis of Commonwealth Fund Health Insurance Tracking Survey of US Adults, 2011

Insured are 5 times more likely to have a colon screen than low-income uninsured.

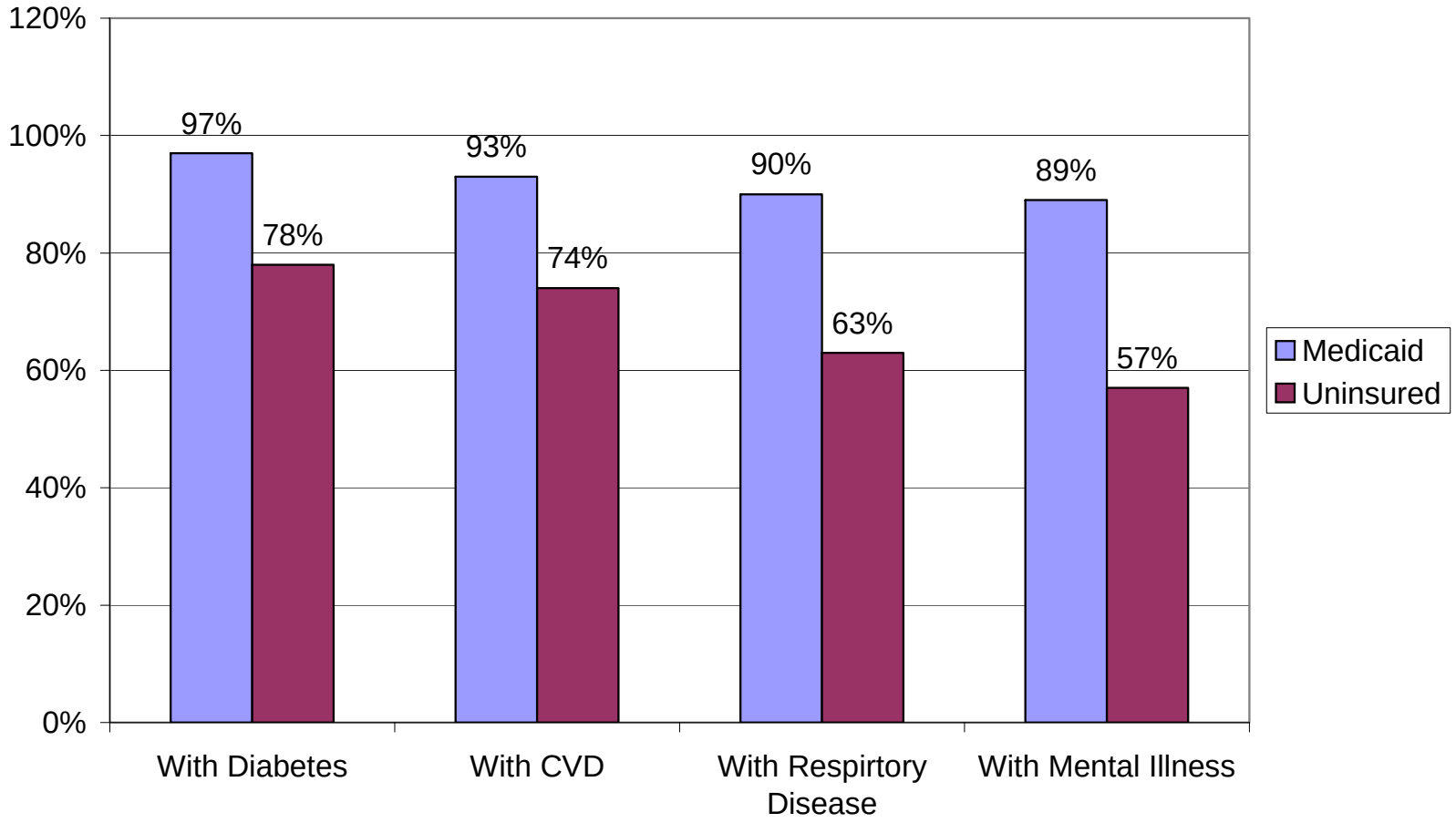
Adults 18-64 Who Received Colon Cancer Screen in past 5 Years, 2011



Collins Et. Al, 2012 analysis of Commonwealth Fund Health Insurance Tracking Survey of US Adults, 2011

Access to care for the chronically ill -- impact of Medicaid coverage

Usual Source of Care Among Medicaid and Uninsured Non-Elderly Adults < 138% FPL with Chronic Illness, 2009



Source: Data Derived from Medical Expenditure Panel Survey Data, 2009

Health Impacts of Insurance Coverage

- Institute of Medicine conducted an assessment of 130 studies, noting that health outcomes (not just service use) were worse for the uninsured than the insured.
  - Institute of Medicine. May 2002. "Care without Coverage: Too Little Too Late.' http://www.iom.edu/~/media/Files/Report%20Files/2003/Care-Without-Coverage-Too-Little-Too-Late/Uninsured2FINAL.pdf
- Two recent studies (both with methodological concerns) published in NEJM suggested Medicaid coverage has an impact ….
  - The first (Oregon) noted a statistically significant positive financial and mental health outcome, but noted no statistically significant short term impact on other health outcomes.
    - http://www.nejm.org/doi/full/10.1056/NEJMsa1212321
  - The second (Maine, New York, and Arizona) noted a decline in mortality, of approximately 6.2% in the relative risk of death among adults (similar to studies of reductions in infant and child mortality associated with expansions in the 80s).
    - http://www.nejm.org/doi/full/10.1056/NEJMc1212920

Summary: The Uninsured

- Varies both geographically and by age.
  - Hillsborough (large number), Coos (large percentage).
  - Half of adult uninsured potentially affected are age 40 to 64.
- Health impacts associated with lack of insurance coverage.
  - More than half of the uninsured currently have some access to care (by available measures).
  - The uninsured are less likely to have access to care (both general population and the chronically ill) than the insured.
  - The literature generally supports the notion that insurance coverage matters to health.
  - Coverage matters more for certain populations (e.g. the chronically ill, the older populations, and those with substance abuse issues).
  - Impact of insurance coverage -- especially for populations that are relatively more healthy – on health status likely takes time.

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Those Already Insured Who Will Participate in Medicaid → Crowd-out

Employment Status of Adults by Poverty Status (US)

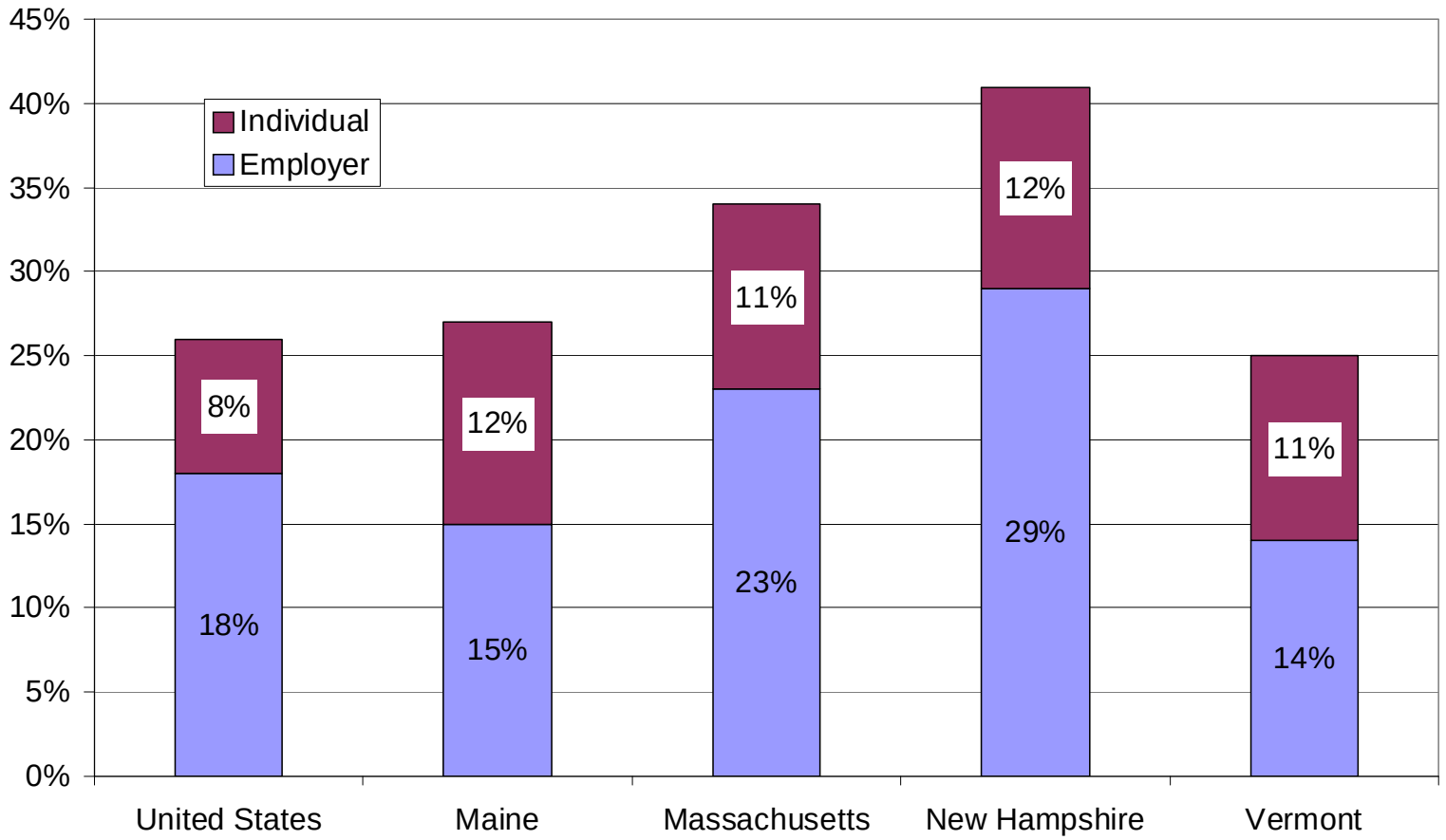
	Primarily Self-Employed (%)	Little or No Employment (%)	Irregular Employment (%)	All Other
? 50% FPL	3.1	78.9	8.1	9.9
050% < and ? 100% FPL	6.4	24.8	19.1	49.6
100% < and ? 138% FPL	6.2	22.3	10.4	61.1
All Incomes	4.2	26	6.3	63.4

Source: http://mathematica-mpr.com/publications/pdfs/health/income_eligibility_assistance_brief2.pdf

All Others: Worked 35 or more weeks and had no more than two employers during the year.

New Hampshire has a high share of low-income population enrolled in private coverage.

Share of Adults with Income < 138% of FPL with Employer and Individual Coverage, 2010-11



Summary: Crowd-out

- Expansions to pregnant women, children and adults (in other parts of the country) demonstrated that crowd-out exists.
  - Estimates of crowd-out generally suggest somewhere between 30% and 40% of those low income individuals with private insurance would seek public assistance if available. Sources available upon request.
  - Lewin estimated that half of the newly covered Medicaid individuals would be crowd-out.
  - DHHS model, including HIPP, would attempt to significantly reduce crowd-out (DHHS assumes 80% reduction in crowd-out).
- Costs and Benefits?
  - Shifting from private to public coverage financially benefits individuals, but comes at federal and state costs.
  - Potentially a benefit to the business that would otherwise be participating, but this impact is difficult to assess.
- HIPP program – described by DHHS at prior meeting – is designed to avoid crowd-out.
  - DHHS model assumes 80% avoidance
  - What administrative systems exist to implement such a program? Are there natural partners in this (such as the brokers?)

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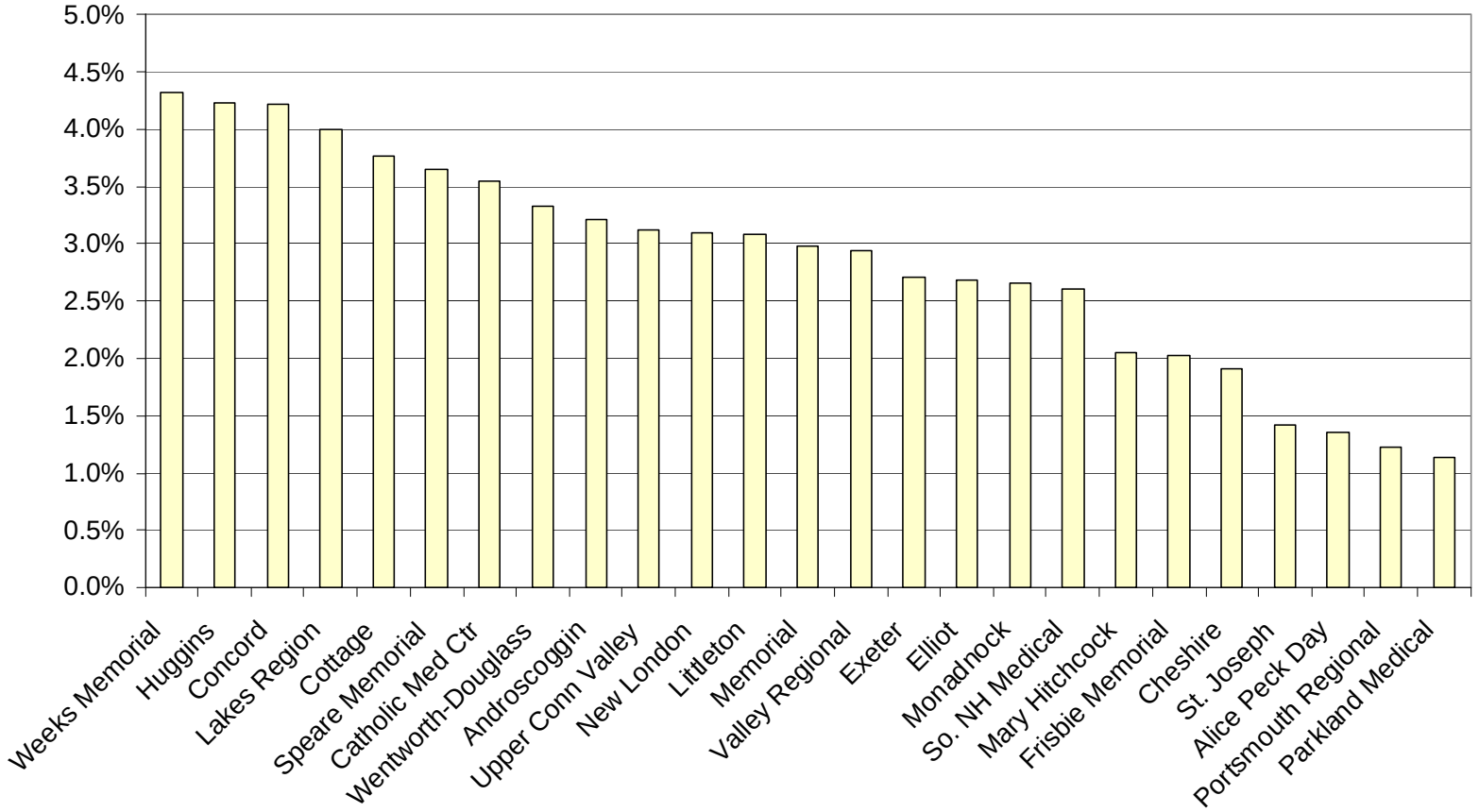
If your goal is to understand stresses and strengths associated with the health system (and providers) ....

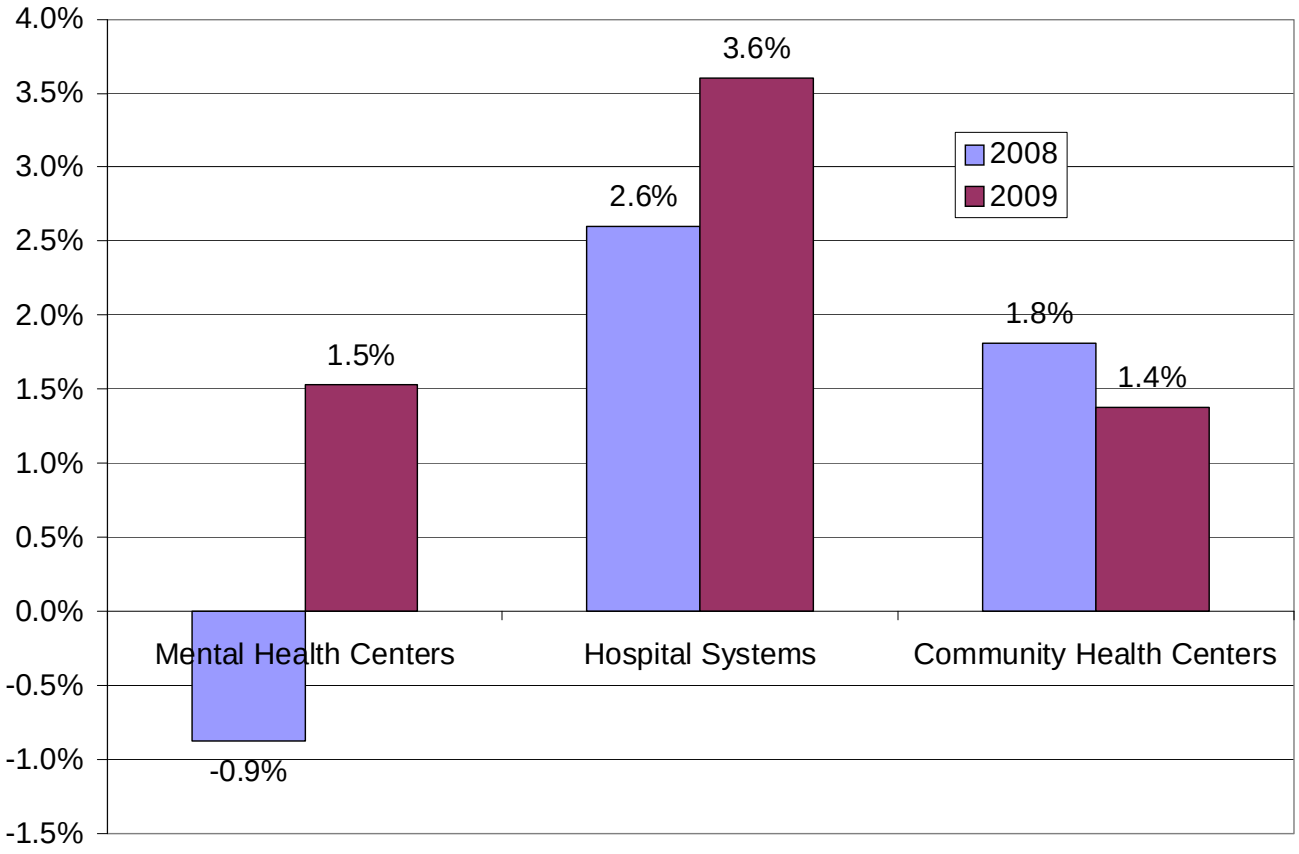
Between $20 and $40 million reduction in demand for Uncompensated Care: Impact Varies Geographically

Charity Care Expense As % of Net Patient Service Revenues, 2011
(Calculated as charges adjusted by cost to charge ratio divided by Net Patient Service Revenues)



Impact will vary by provider type

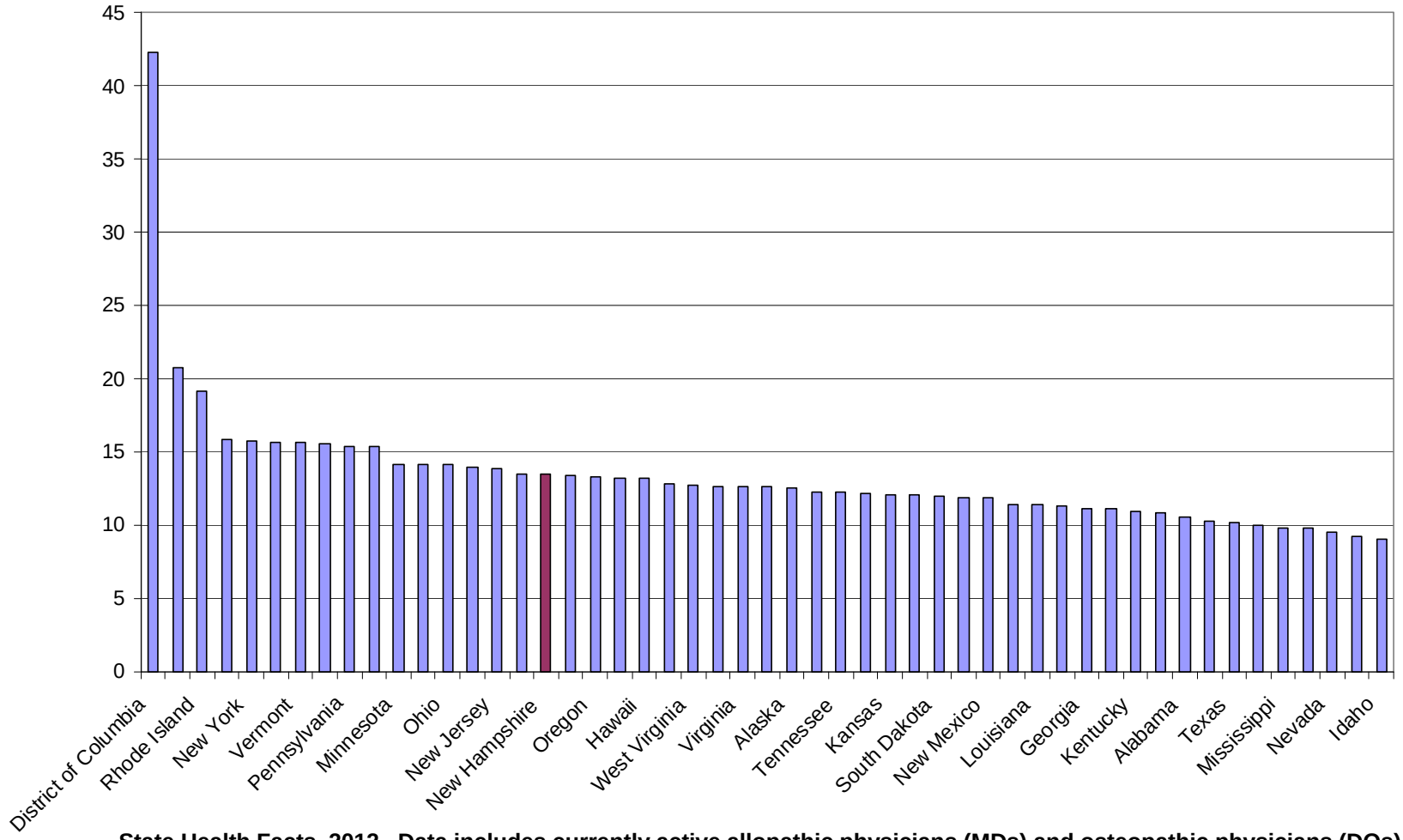
- Financial Status (included), Charitable Care Provision (not included), and revenue from private insurance (not included) all vary significantly by type of provider.
- Lewin report provides additional info on charity care.



Source: Various; available upon request.

Supply of Primary Care Doctors

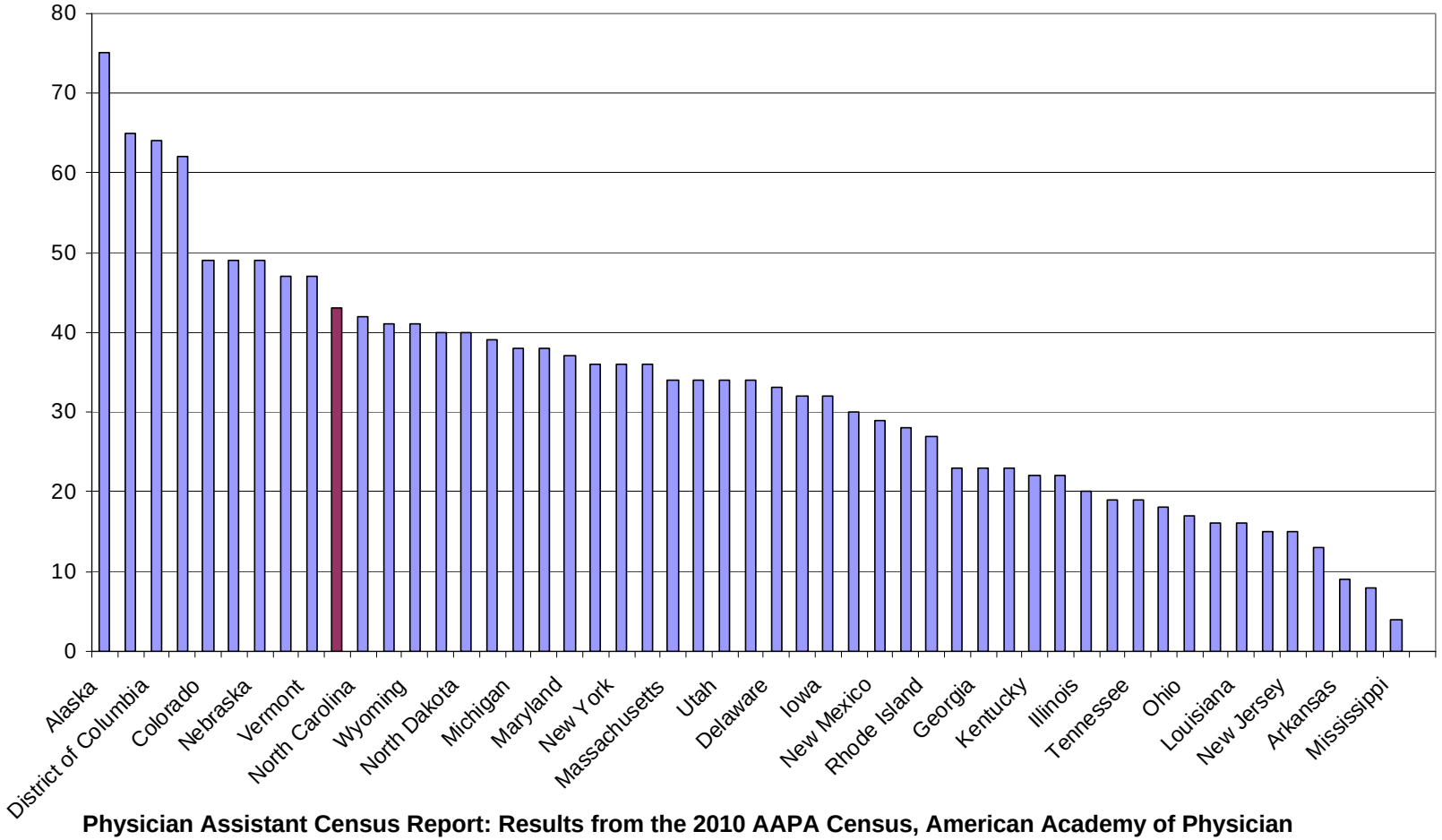
Primary Care Per 10,000 Residents



State Health Facts, 2012. Data includes currently active allopathic physicians (MDs) and osteopathic physicians (DOs).

Supply of Non-Physician Providers

Physician Assistants per 100,000 Residents
2010



Physician Assistant Census Report: Results from the 2010 AAPA Census, American Academy of Physician Assistants, 2010 and 2010 U.S. Census.

Impact on Providers: Varies by geography and by type of provider

- Lewin report indicated, on average, financial impact of Medicaid expansion on hospitals was zero.
  - This hides significant geographic variation.
  - North country hospitals and those with a higher share of uncompensated care, less private insurance may fare better.
- Community health centers and community mental health centers (with lower margins and lower share of private pay patients) will see larger positive impacts.
- With respect to supply of physicians for Medicaid expansions: Critical question?
  - What will the response be of safety net providers including hospitals and community health centers and behavioral health centers.
  - What about the growth in retail clinics?

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If your goal is to minimize state and local financial exposure ....

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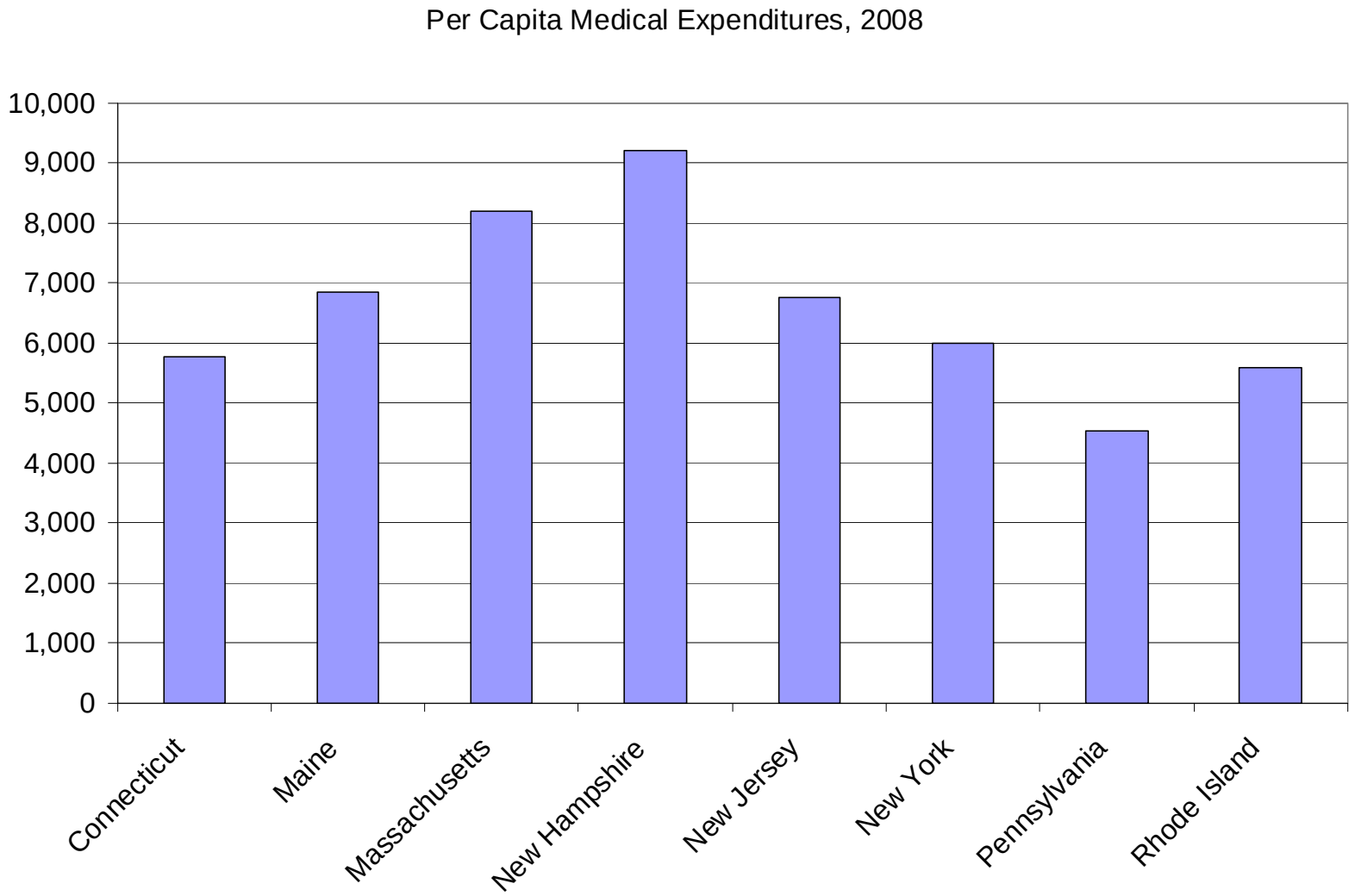
General fund offsets? The case of corrections

Potential State Spending Offsets	
State Employee Health Benefits	$27,429
State Corrections Department	$21,782
State Funding for Cypress Center	$4,725
Increased State Revenue	$13,200
Figure 2: Lewin Report Phase 2	

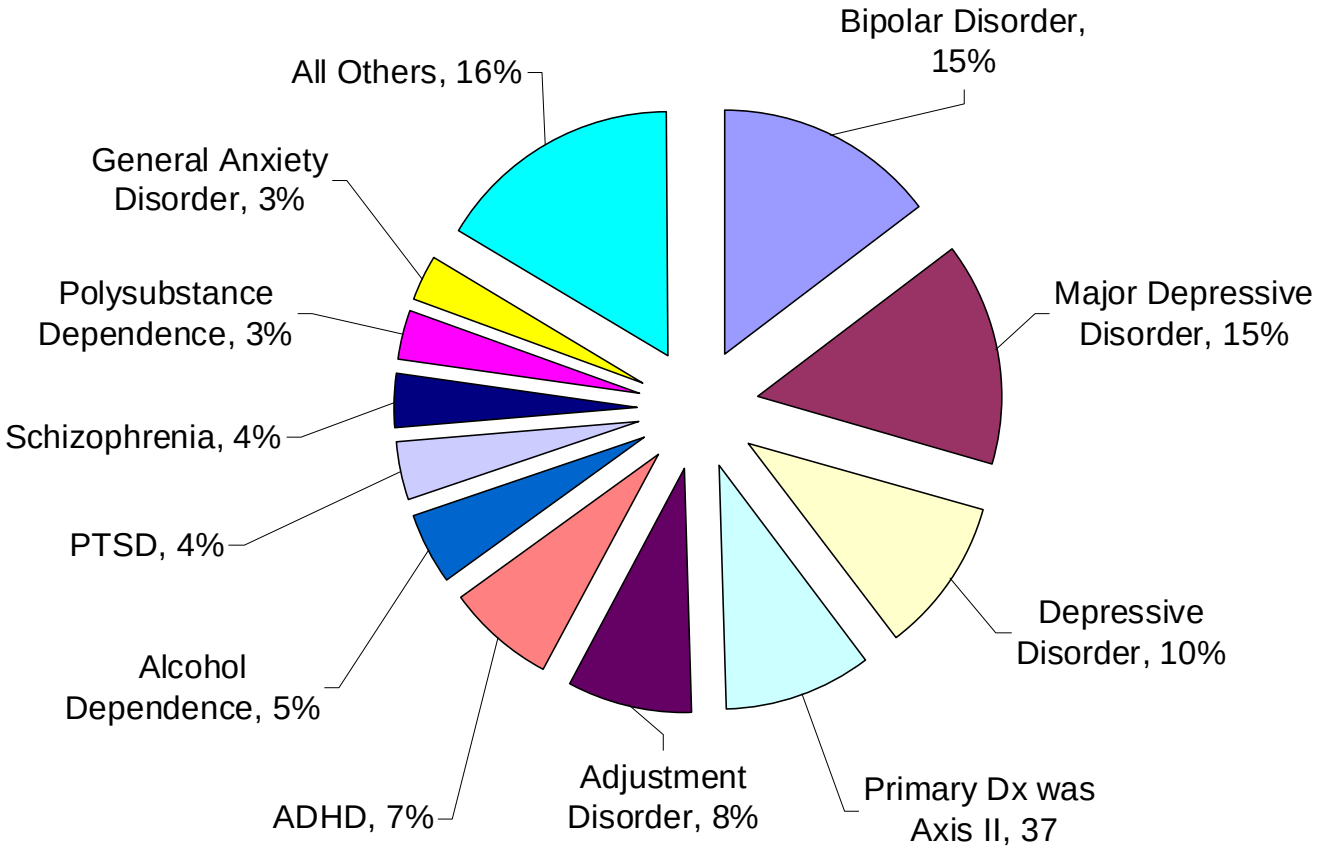
Medical Expenditures for Prisoners, 2008



U.S. Census Bureau, Annual Survey of State Government Finances, 2008

15% of prisoners identified with significant mental health diagnosis (2005)

Distribution of Mental Health Diagnoses Among NH State Prison Inmates, 2005



Impact on State and County Corrections: Recidivism

- Individuals leaving the corrections system are likely to be eligible for Medicaid coverage, and behavioral health and substance abuse treatment, which may minimize demand for additional correctional supports. An estimated 1/3 will be eligible for Medicaid post release (http://content.healthaffairs.org/content/31/5/931.full.pdf+html)
  - Mancuso, D, Felver, B. *Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment*, Washington State DSHS Research and Data Analysis Division, RDA Report 4.81 (Sept 2010).
  - Mancuso, D, Felver, B. *Providing chemical dependency treatment to low-income adults results in significant public safety benefits*, Washington State DSHS Research and Data Analysis Division, Report 11.130 (Feb 2009).
  - Mancuso, D, Felver, B. *Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention*, DSHS, RDA Report 4.84 (Oct 2004).

Impact on State and County Corrections

- Hospitalizations – Assuming individuals can be determined eligible, any 24 hour inpatient visit for a prisoner is likely eligible for Medicaid reimbursement (in both jails and hospitals).
  - https://www.bja.gov/Publications/ACA-CJ_WhitePaper.pdf
  - http://www.cochs.org/files/CHCS%20Draft%20Final.pdf
- DHHS estimates, discounted the estimates from Lewin based on additional data on 24 hour inpatient stays from the Department of Corrections.
- In our modeling of the finances, we lowered DHHS estimates to reflect the additional expenditures from the general fund which would offset savings as federal participation falls in out years.

Summary: Local

- Savings potential to corrections system comes primarily from two sources:
  - Additional coverage for mental health and substance abuse for an estimated 1/3 or released prisoners.
  - Reduction in 24 inpatient stay costs associated with Medicaid eligibility for patients.
- Savings potential offset by administrative expenses associated with the programming and enrollment process, which were not included in DHHS financial estimates.
- Potential offset for local welfare expenditures, but were unable to assess.

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Economic Development

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Should the State Expand Medicaid? Economic Development

- Economic Development - Most of the economic value of the ACA comes from the private expansions
  - Cumulative impact of ACA without a Medicaid expansion (2.9%)
  - Cumulative impact of ACA with a Medicaid expansion (.5%) – This is smaller than the Lewin estimate, as ½ of the additional Medicaid coverage may be associated with care already being provided or as a result of crowd out.
- These dollars flow to managed care companies (perhaps) and to providers. The economic development implications of these will depend on what providers do with the additional resources
  - Premium reductions?
  - Build new facilities?
  - Hire new nurses and doctors?

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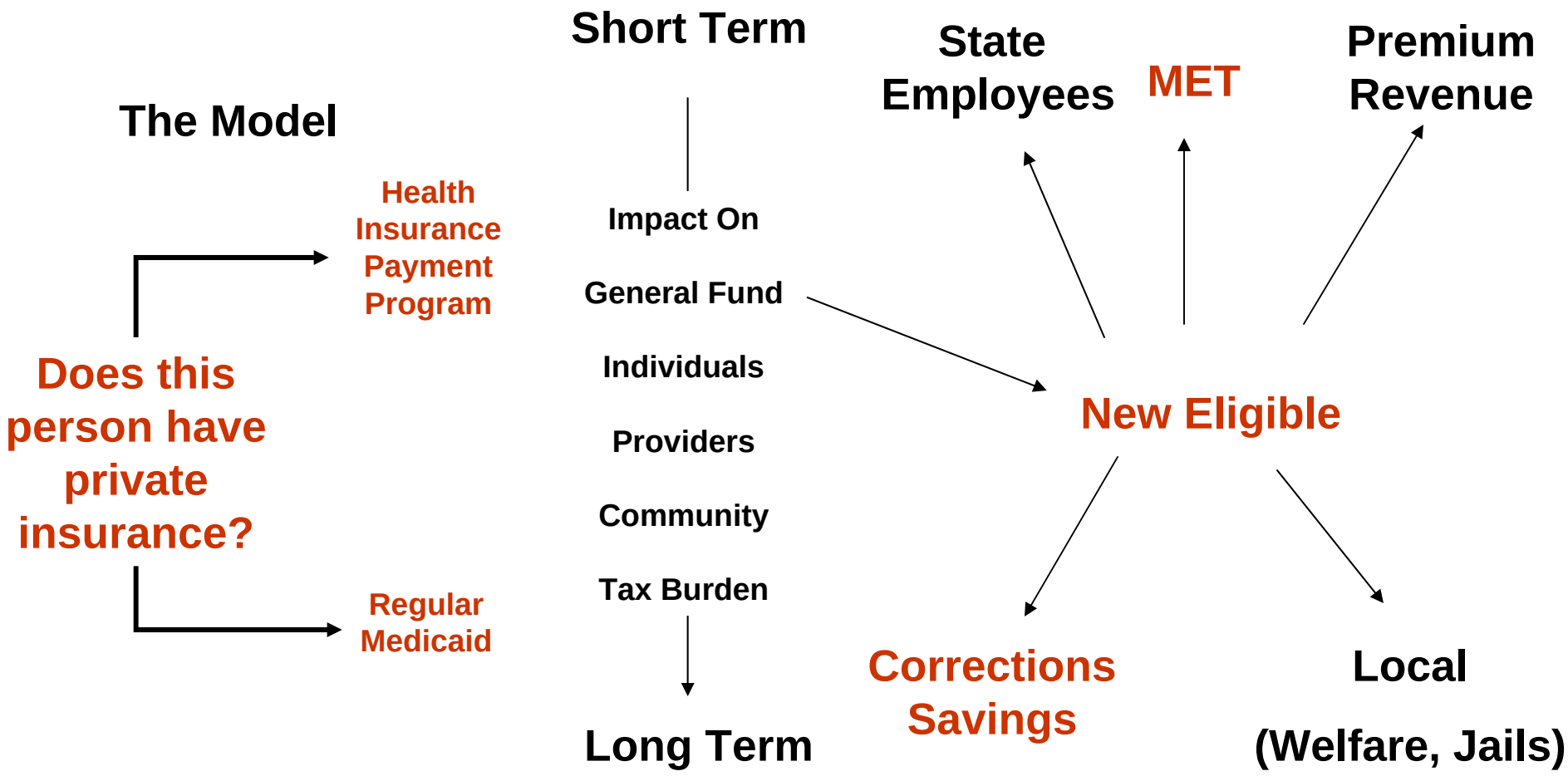
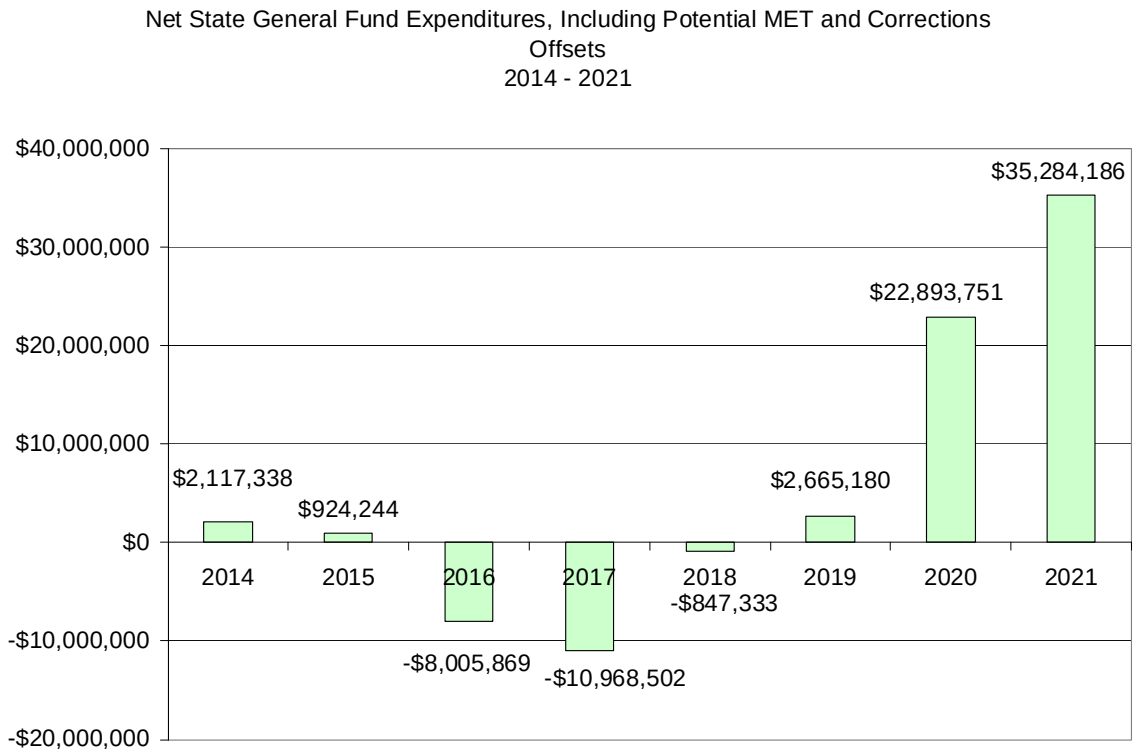
Modeling and Financing

Modeling an Expansion



Medicaid Costs and Coverage, as Modeled by DHHS

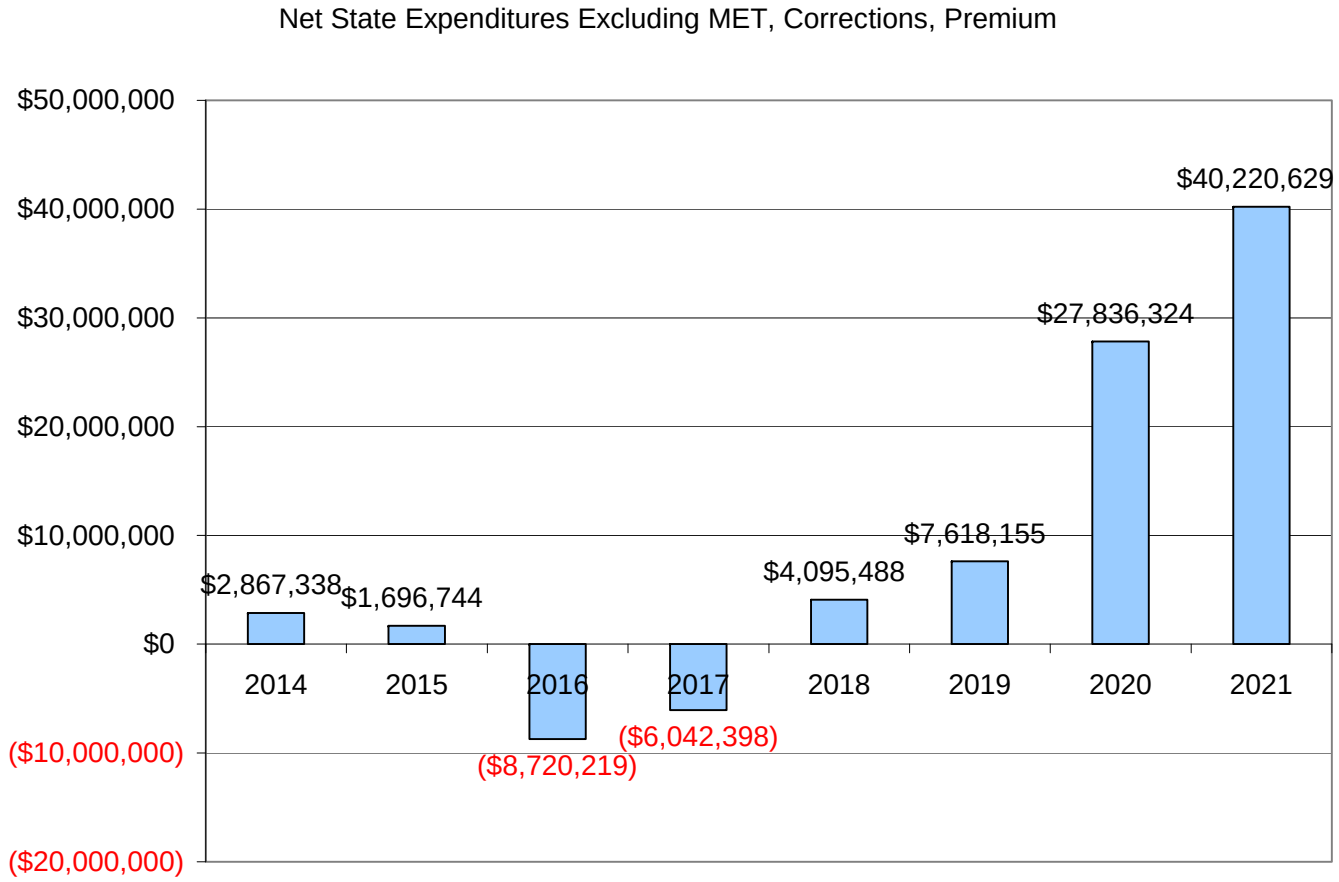
- Fully implemented (50,000) newly enrolled.
- Reduction in the number of uninsured would be smaller.
- What would that expansion cost over the 2014-2020 period?
  - *$8 million for the state*
  - *$2.0 billion for the federal government.*
- Increase in financial exposure begins in 2019 and accelerates through 2021.



Assumes small offsets for Corrections, MET revenues, and includes enhanced SCHIP revenues

Additional tax burden, not included, though this would be small as it is spread across the country

The Cost to the State, Excluding Any Offsets



- Excluding offsets: $29m from 2014 – 2020
- Increase in financial exposure from 2020-onward

Source: Based on DHHS model of participation and take-up

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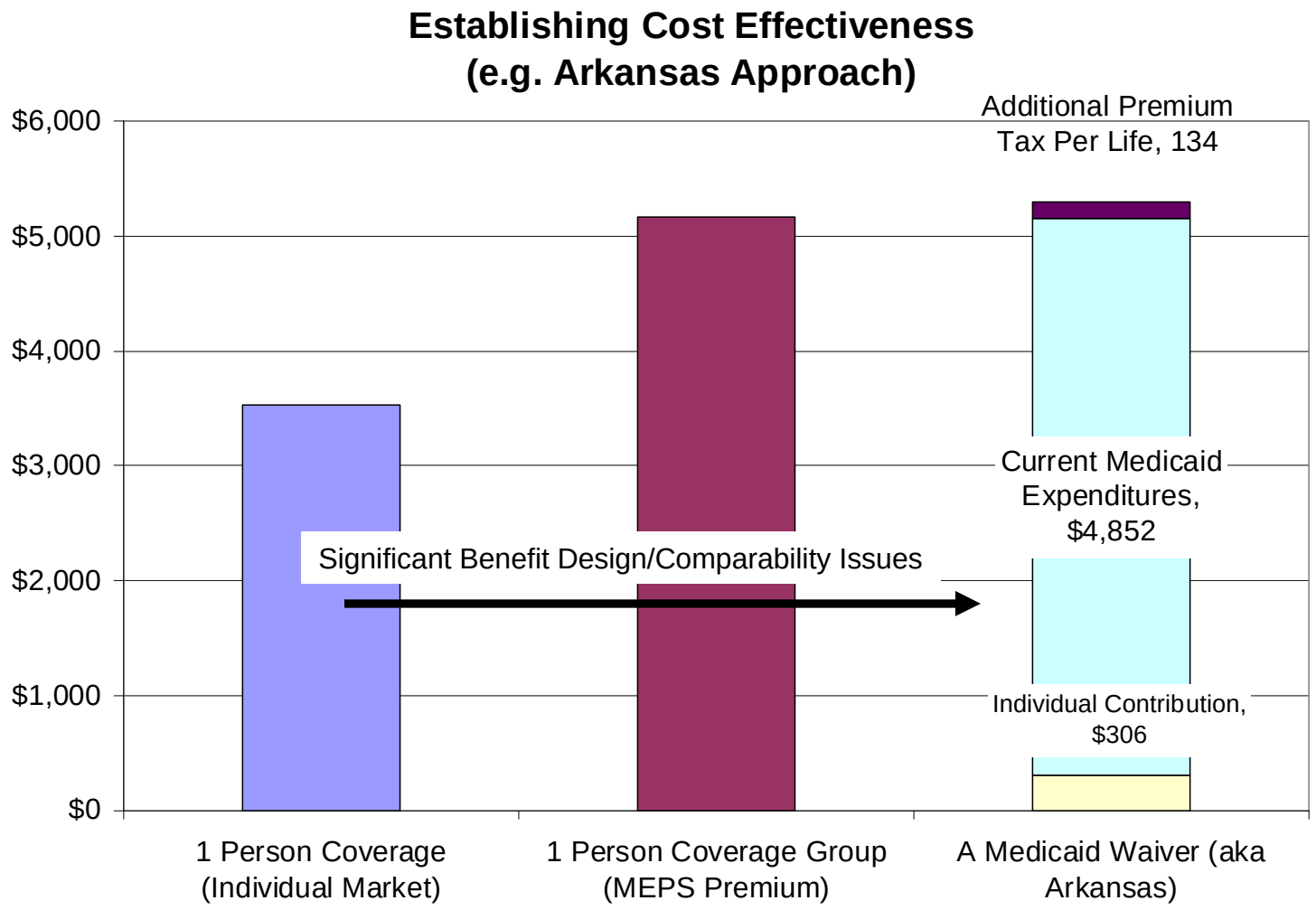
Models

Other Options On the Table

- An expansion including a HIPP approach is likely unique but ….
- Arkansas, Iowa, and New Hampshire would all be attempting to purchase health insurance on the private market assuming cost-effectiveness argument.
- Lewin provided financial modeling of other approaches, including shifting populations currently enrolled in Medicaid into new eligibility category (funded at 100% federal dollars), which would further reduce state expenditures.

A private model: Can we demonstrate cost effectiveness?



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