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An Analysis of the Proposed Medicaid Expansion in Michigan

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Executive Summary*

Michigan policymakers must decide whether to expand the state's Medicaid program to cover people newly eligible for federal Medicaid subsidies under the federal Affordable Care Act of 2010. Federal Medicaid funding would now extend to people earning up to 138 percent of the federal poverty level, even if they are adults without children.

Under the proposed state Medicaid expansion, the number of potential new enrollees is high. In 2010-2011, approximately 1.2 million nonelderly people in Michigan had incomes of 138 percent or less of the federal poverty level and did not receive Medicaid. Of these 1.2 million, an estimated 647,700 were uninsured. Many of the low-income individuals in both groups would be eligible for Medicaid under an expansion.

The size of the scheduled federal Medicaid subsidies for the newly eligible is also large. Congress is slated to pay 100 percent of the cost of these enrollees' Medicaid coverage from 2014 through 2016, with the percentage slowly declining to 90 percent by 2020.

The potential magnitude of these payments does not mean accepting them is the best policy, however. For example, consider one target population of the expansion: people who are uninsured and have incomes between 100 percent and 138 percent of the federal poverty level. The authors estimate that in 2014, approximately 177,000 uninsured Michiganders will fall into this category. Assuming that about 70 percent — around 124,000 — of these newly eligible sign up for Medicaid, the authors estimate that the additional cost during the following decade would be $475 million to state taxpayers and nearly $7 billion to federal taxpayers.

These figures represent the costs for just one post-expansion population, but they are illustrative. The $475 million cost for state taxpayers over a decade is an estimated $144 million more expensive than it would be for the state to purchase 10 years of basic private insurance for these roughly 124,000 individuals on the federally subsidized state health exchange. Indeed, because the out-of-pocket cost of such basic exchange insurance is legally limited to just 3 percent of income or less for individuals in this income group, the insurance is a feasible alternative for these individuals without an added state subsidy.

Notably, the partial enrollment projections above do not include three other significant groups of possible post-expansion enrollees: uninsured people who are already eligible for Medicaid but have not yet enrolled; low-income, privately insured individuals who would switch to Medicaid; and childless adults and others who live below the poverty line and would now qualify for Medicaid under the broader definitions of the expansion.

Many of these individuals would apply for Medicaid, too. Supporters of the expansion have suggested it would produce 450,000 new Medicaid beneficiaries in Michigan. The Washington, D.C.-based Heritage Foundation projects that the net cost of the proposed expansion to Michigan taxpayers would be $1.3 billion through 2022.

The state's costs for post-expansion enrollees could rise quickly if Congress chooses to reduce the currently scheduled federal Medicaid subsidies of 90 percent and

* Citations provided in the main text.

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The authors have written about Medicaid expansion in Florida and elsewhere. Some of the language and organization from their prior work appears again in this Policy Brief.

more. Costs are also likely to exceed estimates due to the difficulties of determining someone's Medicaid eligibility under the Affordable Care Act.

A Medicaid expansion would likely shift many insurance costs being borne by the private sector to state taxpayers. Studies have found that as many as 50 percent or 60 percent of new enrollees following Medicaid expansions actually dropped their existing private insurance in order to enroll. A conservative estimate is that 29 percent of new enrollees under a state Medicaid expansion would be people relinquishing their private insurance.

A significant number of low-income Michiganders have private insurance. In 2010-2011, an estimated 512,000 Michigan residents with incomes of 138 percent or less of the federal poverty level were privately insured — about half of the 1.1 million Michiganders in this income group who were covered by Medicaid that year. When a portion of these privately insured individuals drop their insurance for Medicaid, they will be switching to a program that generally provides much smaller reimbursements to health care providers — one reason a Medicaid expansion is unlikely to have the positive economic impact that the expansion's supporters predict.

On paper, Medicaid appears to provide attractive coverage, but the program often delivers substandard health outcomes and access to medical services. Studies have found that Medicaid patients have worse surgical results and more late-stage breast cancer and melanoma diagnoses than the uninsured. A 2008-2009 survey of metropolitan Detroit medical specialists found Medicaid patients were not accepted by 33 percent of dermatologists, 41 percent of family practitioners, 50 percent of obstetrics-gynecology specialists and 67 percent of orthopedic surgeons.

Presented with federal Medicaid-expansion subsidies, state policymakers may find it easy to underestimate both Medicaid's drawbacks and the availability of viable alternatives. Medicaid's problems, its current burden on state taxpayers and the high and unpredictable costs of a Medicaid expansion under the Affordable Care Act suggest policymakers should be wary of widening the program's scope.

Introduction: The Medicaid Choice

In June 2012, the U.S. Supreme Court ruled unconstitutional key provisions of the federal Affordable Care Act of 2010.[1] These portions of the ACA would have denied federal matching Medicaid funds to states that chose not to extend Medicaid eligibility to people with incomes of up to 133 percent — practically speaking, 138 percent — of the federal poverty level.* Prior to passage of the ACA, most state Medicaid programs limited eligibility primarily to children and their parents, and only a few states enrolled childless adults earning above 100 percent of the federal poverty level.[2] As a result of the court's decision, Michigan and other states now have the opportunity to compare the costs and benefits of expanding Medicaid eligibility without the threat of losing substantial federal monies.

Graphic 1: 2013 Federal Poverty Levels

	Individual	Family of Two	Family of Four
100%	$11,490	$15,510	$23,550
138%	$15,856	$21,404	$32,499
200%	$22,980	$31,020	$47,100
300%	$34,470	$46,530	$70,650
400%	$45,960	$62,040	$94,200

Source: U.S. Department of Health and Human Services.

The ACA was initially expected to provide coverage for 32 million uninsured individuals and families when fully implemented.† About half of the newly covered were expected to obtain private coverage, while the other half would enroll in an expanded Medicaid program.[3] The ACA contains financial incentives designed to strongly encourage states to expand Medicaid eligibility.[4] The Obama administration and advocates of the plan have touted the benefits of expanding Medicaid. In addition to providing health coverage and improved access to care for low-income

* Although eligibility for the proposed Medicaid expansion is technically cut off at 133 percent of the federal poverty level, applicants can ignore up to 5 percent of their income. "Compilation of Patient Protection and Affordable Care Act [As Amended Through May 1, 2010] including Patient Protection and Affordable Care Act Health-Related Portions of the Health Care and Education Reconciliation Act of 2010," (Office of the Legislative Counsel, 2010), Section 2002, p. 189-190, http://goo.gl/PxFe5 (accessed June 12, 2013).

† The ACA was estimated to cover 32 million uninsured by 2016 and 34 million by 2021. See Douglas W. Elmendorf, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," (Congressional Budget Office, 2011), Table 3, p. 18, http://goo.gl/87zua (accessed May 15, 2013). This estimate has been revised to 26 million by 2016. See Jessica Banthin, Holly Harvey, and Jean Hearne, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," (Congressional Budget Office, 2012), Table 3, Page 20, http://goo.gl/RnaNG (accessed May 28, 2013).

uninsured individuals, the federal government promises to pay most of the cost.[5]

Michigan has an important choice to make. A thorough discussion of the Medicaid expansion must involve costs, obstacles and potential pitfalls.

Effect of the ACA on Michigan Medicaid Enrollment and Cost Sharing

As suggested above, the Medicaid expansion envisioned under the ACA is designed to provide coverage to the uninsured. This uninsured population is composed predominantly of people up to age 64, since most people become eligible for Medicare at age 65.* Thus, while Medicaid does provide significant coverage to some financially stressed seniors, the primary population of interest in the ACA's proposed Medicaid expansion is the nonelderly uninsured.†

In 2010-2011, there were more than 2.3 million nonelderly individuals in Michigan with incomes at 138 percent or less of the federal poverty level, according to the most recent statistics from The Henry J. Kaiser Family Foundation.‡ Of these individuals, 1.1 million nonelderly were already enrolled in Medicaid.[6] Of the remaining 1.2 million, 361,900 had employer coverage;[7] about 221,600 were covered by individual coverage or some type of public health insurance other than Medicaid;[8] and an estimated 647,700 were uninsured.[9]

Depending on their circumstances, many of these 1.2 million low-income nonelderly — at least theoretically — would be newly eligible under an expanded Medicaid program. For example, a person with an income up to $15,856 or a family of four with an income of up to $32,499 would be eligible for benefits.§ However, most of the newly eligible would be adults, whereas most children in families at this income level are already eligible.

The ACA contains large financial incentives to encourage states to expand Medicaid eligibility. Under the Health Care and Education Reconciliation Act of 2010, the federal government is scheduled to pay 100 percent of the cost of benefits for newly eligible enrollees from 2014 through 2016.[10] The enhanced federal match will drop to 95 percent of costs in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.[11]

The federal government will also pay 100 percent of the cost of boosting low Medicaid reimbursements for primary care providers to the same level as Medicare physician fees, but it will do so only for the years 2013 and 2014.[12] The federal government did not include provisions to boost Medicaid reimbursements to medical specialists to improve access to specialty care for Medicaid enrollees. After 2014, the cost of any continued effort to elevate Medicaid primary care provider fees would presumably fall to the states, as would any cost of boosting Medicaid fees to specialists.¶

Despite these limits, the federal Medicaid-expansion subsidies, at least as currently scheduled, are significant. It does not automatically follow that accepting them is the best policy option, however.

Consider, for instance, a key population targeted by the expansion: people who are uninsured and have incomes between 100 percent and 138 percent of the federal poverty level. Extrapolating from Kaiser Family Foundation figures, we project that this population in Michigan will number 177,516 people in 2014, the first year of the proposed Medicaid expansion.[13] Assuming that

* The Social Security Administration states, "Most people age 65 or older who are citizens or permanent residents of the United States are eligible for free Medicare hospital insurance. …" See "Medicare," (Social Security Administration, 2013), 5, http://goo.gl/Y086r (accessed May 22, 2013). Eligibility for Medicare hospital insurance allows enrollment in Medicare's medical insurance, as well. Ibid., 7. Those ineligible for Medicare may include, for instance, recent immigrants.

† This focus on the nonelderly is not meant to detract from the problems faced by elderly seniors whose needs for long-term care exceed their financial means and Medicare coverage. These problems, however, are separate from the general public policy concerns raised by the uninsured population.

‡ "Health Insurance Coverage of the Nonelderly (0-64) with Incomes up to 139% Federal Poverty Level (FPL)(Number)," (The Henry J. Kaiser Family Foundation), http://goo.gl/RgRJc (accessed May 15, 2013). The table's title is somewhat ambiguous, but the table includes only those with incomes equal to 138 percent of the poverty level or below; it does not include those with incomes equal to 139 percent of the poverty level. Lindsay O'Brien, Kaiser Family Foundation, email correspondence with Thomas Shull, Mackinac Center for Public Policy, May 17, 2013.

§ Authors' calculations based on "2013 Poverty Guidelines," (U.S. Department of Health & Human Services, 2013), http://goo.gl/rMStC (accessed May 15, 2013); "The Patient Protection and Affordable Care Act (Public Law 111-148)," (Government Printing Office, 2010), 271, http://goo.gl/ipNH3 (accessed May 16, 2013). The federal poverty thresholds for the 48 contiguous states were used as the basis for the calculations.

¶ Boosting Medicaid reimbursements could help ameliorate medical care access problems faced by Medicaid enrollees (a point discussed further below). Attempting to project the size of these costs if the state chose to assume them would not be a trivial exercise, however. The federal government's Medicaid subsidies for Medicare-level reimbursements involve only a handful of specific primary care billing codes. To estimate the cost would require determining how much was spent in Michigan on these billing codes in the past and then estimating future utilization. Determining the cost for Medicare-level reimbursements to specialists would also involve projecting how many of the nonprimary care services and their associated billing codes would have to be increased to entice specialists to see Medicaid patients, and from this calculation, estimating the resulting utilization.

about 70 percent of this newly eligible population enrolled under an expanded state Medicaid program,* we estimate the number of people added to Medicaid would be 124,261 in 2014 at a cost of $4,686 per enrollee in federal and state spending.† Adjusting annually for population growth and increases in the program costs over the 10-year period, we estimate enrollment in this category to reach 125,137 in 2023 at a cost of $7,438 per enrollee in federal and state spending. Over the 10-year period, these costs would amount to nearly $7 billion in federal money and $475 million in state money (nominal dollars).

Several things should be noted about these figures. First, these numbers represent projected costs for only one of the target populations of the proposed Medicaid expansion. The figures do not include cost estimates for three significant populations of potential new Medicaid enrollees: uninsured people who are already eligible for Medicaid, but would apply only after the expansion; people who are currently insured under a private plan, but would switch to Medicaid;‡ and people who are below 100 percent of the federal poverty line, but would become eligible for Medicaid only under the ACA's provisions for a Medicaid expansion.§

Proponents of the Medicaid expansion have forecast the enrollment of an additional 450,000 people[14] — considerably more than the roughly 125,000 in the single Medicaid-expansion target group we described above. A full cost estimate would yield much higher figures. The Washington, D.C.-based Heritage Foundation, for instance, has projected that a Medicaid expansion would have a net cost to Michigan taxpayers of $1.3 billion through 2022.¶

Second, note that these estimates are based on the assumption that the federal government will provide the Medicaid subsidy levels currently stipulated in federal legislation. Future Congresses, however, have the right to renew, alter or cancel the initiatives of past Congresses. Thus, federal Medicaid matching rates could be substantially reduced if rising federal deficits prompt budget cuts in future years.** Such a retrenchment in federal Medicaid spending could force Michigan taxpayers to bear significantly higher costs to maintain the Medicaid expansion.

Third, state policymakers should also recognize that even with generous federal Medicaid subsidies, the cost to the state is substantial. Indeed, this cost even exceeds what the state would spend to ensure that these roughly 125,000 potential new Medicaid enrollees paid nothing to obtain private health insurance on the ACA's health insurance exchanges. Such private insurance could be valued at $12,500 per year.††

To see why, policymakers should recall that under the ACA, starting in 2014, qualifying individuals can purchase federally subsidized individual health insurance in a state-based health insurance exchange if they have no access to Medicaid, Medicare, an employer-provided health plan or other forms of "minimum essential coverage"

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* Congressional Budget Office assumptions appear to be in the 66 percent to 70 percent range. Ben Sommers et al., "Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act," (U.S. Department of Health & Human Services, 2012), 7-8, http://goo.gl/R8bNt (accessed May 20, 2013).

† The Michigan Medicaid program spent $3,625 per adult enrollee in fiscal 2009, according to the Kaiser Family Foundation. "Medicaid Payments per Enrollee," (Kaiser Family Foundation, 2013), http://goo.gl/axwch (accessed June 11, 2013). We estimate a per-enrollee Medicaid cost growth rate of a little less than 5.3 percent by adjusting a historical 7.9 percent annual increase in Michigan Medicaid spending by a historical 2.5 percent annual increase in Michigan Medicaid enrollment (see "Average Annual Growth in Medicaid Spending," (Kaiser Family Foundation, 2013), http://goo.gl/Gql6B (accessed June 11, 2013)); "Health expenditures by state of residence: Summary Tables, 1991-2009," (Centers for Medicare & Medicaid Services, 2011), 27, http://goo.gl/JvrvG (accessed June 11, 2013). This growth rate produces an estimated Medicaid cost per enrollee of $4,686 in 2014 and $7,438 in 2023.

‡ See the discussion below under "Medicaid and Displacement of Private Insurance." The Kaiser Family Foundation estimates 512,000 people in Michigan were at or below 138 percent of the federal poverty level and covered by employer-sponsored or individual private insurance in 2011. Authors' calculations based on "Health Insurance Coverage of the Nonelderly (0-64) with Incomes up to 139% Federal Poverty Level (FPL)(Number)," (The Henry J. Kaiser Family Foundation), http://goo.gl/RgRJc (accessed May 15, 2013).

§ This group would include low-income nonpregnant nonelderly adults; see "Compilation of Patient Protection and Affordable Care Act [As Amended Through May 1, 2010] including Patient Protection and Affordable Care Act Health-Related Portions of the Health Care and Education Reconciliation Act of 2010," (Office of the Legislative Counsel, 2010), 179 (Sec. 2001(a)(1)(C)), http://goo.gl/PxFe5 (accessed June 12, 2013).

¶ Drew Gonshorowski, "Medicaid Expansion in Michigan: Impact and Cost to Taxpayers," (The Heritage Foundation, March 5, 2013), http://goo.gl/p9CUY (accessed June 12, 2013). The estimate represents a *net* cost because a Medicaid expansion could lower some expenses by reducing payments that states might make to health care providers for uncompensated care. The Heritage study concludes, however, "Medicaid expansion in Michigan would result in a rapid increase in spending beginning in 2017, quickly surpassing any modest savings from reductions in state payments to providers for uncompensated care."

** This concern is discussed in greater detail in "Is Federal Spending Sustainable?" below.

†† The Congressional Budget Office estimated that in 2016, the average unsubsidized premium for the health exchange's least expensive "bronze" health plans, with an actuarial value of 60 percent, "would probably average between $4,500 and $5,000 for single policies and between $12,000 and $12,500 for family policies." Health plans covering a higher proportion of medical costs would also be available, though at a higher cost. See Director of the Congressional Budget Office Douglas W. Elmendorf, "Letter to Senator Olympia Snowe," (Congressional Budget Office, 2010), 1-2, http://goo.gl/li7fo (accessed May 20, 2013).

as defined under the ACA.* Federal exchange subsidies ensure that exchange enrollees who earn 100 percent to 133 percent of the poverty level pay no more than 2 percent of their incomes for their insurance premiums, and these subsidies likewise ensure that exchange enrollees earning 138 percent of the federal poverty level pay no more than 3 percent of incomes for their insurance premiums.† We estimate the average cost of a state subsidy for these percentages of the premiums for each of the approximately 125,000 potential enrollees at about $265 per year, yielding a total cost to the state of approximately $33 million annually, or roughly $331 million over 10 years (in nominal dollars).‡ From 2014 through 2023, this considerable exchange subsidy would still be about $144 million less than the state Medicaid subsidy projected above.

This exercise points in turn to another important policy observation. The estimate in the previous paragraph is based on the cost of the exchange's so-called "silver plan," which has an actuarial value that pays on average 70 percent of all medical costs.[15] The premiums for this plan for individuals with incomes in the range of 100 percent to 138 percent of poverty level are, as noted above, on the order of 2 percent to 3 percent of income. While such premiums are not inconsequential for low-income families, they are not impossibly high, either. In addition, low-income individuals who opt for the less generous "bronze plans," which have an actuarial value of 60 percent, may have to pay almost nothing for their coverage.§ The health insurance exchange therefore provides a feasible financial alternative for many members of the population targeted by the proposed Medicaid expansion.

Effect of the ACA on Michigan's Physician Supply

As in other states, Michigan's physician supply is relatively "inelastic," meaning the number of physicians cannot increase quickly to accommodate a rising demand for medical services created by an influx of newly insured Medicaid enrollees. Michigan physicians have little if any capacity to expand the number of patients they treat. A survey by the Michigan Department of Community Health and Public Sector Consultants found that about 30,400 physicians were actively practicing in Michigan in 2011.[16] According to the Michigan Department of Community Health:

- Less than two-thirds (65 percent) of Michigan's licensed physicians are actively caring for patients.[17]
- Less than one in five active Michigan physicians (19 percent) are under 45 years of age, and more than half (60 percent) are either approaching or past retirement age.[18]
- More than half (54 percent) reported plans to retire no later than 2021.[19]
- Less than one in five (17 percent) plan to continue to work more than 20 years.[20]
- More than two-thirds (71 percent) of Michigan's active physicians reported planning to retire by 2026.¶

Yet the demand for health care continues to rise. A number of economic studies indicate the newly insured

* Chris L. Peterson and Thomas Gabe, "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA)," (Congressional Research Service (National Conference of State Legislatures), 2010), 2, http://goo.gl/mBiRw (accessed May 20, 2013). In general, these state-based health insurance exchanges are set up and administered either by the federal government or the state government. In Michigan, the exchange will be run by the federal government, though some efforts have been made to develop a "partnership" exchange that would give Michigan government some role.

† Ibid., i (Summary), 5-6, 7. Those earning above 133 percent would receive sliding-scale subsidies. Premiums would be no more than 3 percent of income at just over 133 percent of the federal poverty level and rise to no more than 9.5 percent of income at just under 400 percent of the federal poverty level. Ibid., i (Summary), 5-6, 8.

‡ Authors' estimates based on a take-up of 124,261 enrollees at an average subsidy cost of $265 per year, with 70 percent from individual households and with 30 percent from two-member households (many of the newly eligible are single childless adults, although some may be couples). The authors estimate the annual cost of state premium subsidy for a single person at $230, $306, $458 and $476 for income levels of 100 percent, 133 percent, just above 133 percent and 138 percent of the poverty level, respectively. The authors estimate equivalent costs for a person in a two-member household at $155, $206, $309 and $321 for 100 percent, 133 percent, just above 133 percent and 138 percent of the poverty level, respectively. Authors' calculations based on "2013 Poverty Guidelines," (U.S. Department of Health & Human Services, 2013), http://goo.gl/rMStC (accessed May 15, 2013). Amounts are based on a "silver plan," which has an actuarial value that pays 70 percent of all medical costs.

§ Peterson and Gabe, "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA)," (Congressional Research Service (National Conference of State Legislatures), 2010), http://goo.gl/mBiRw (accessed May 20, 2013). For examples of subsidies in the health insurance exchange, see the Kaiser Family Foundation Subsidy Calculator available at http://kff.org/interactive/subsidy-calculator/.

¶ "Michigan Department of Community Health Survey of Physicians," (Public Sector Consultants Inc. and Michigan Department of Community Health, 2011), 7, http://goo.gl/G2XeM (accessed May 16, 2013). The primary reasons given for retirement or reduced hours were age (69 percent), "increasing administrative/regulatory burden" (38 percent) and "inadequate reimbursement for services" (30 percent). Ibid., 6, 8.

will nearly double their consumption of medical care.* Furthermore, an aging population will require more medical care.

Lower Medicaid Provider Fees

Low reimbursement rates are generally one of several factors contributing to the shortage of physicians willing to treat Medicaid enrollees.[21] On average, Michigan pays physicians participating in the fee-for-service state Medicaid program only about half (51 percent) as much as Medicare pays for the same service — in other words, physicians treating Medicare patients get paid twice as much for the same services.† For primary care, Michigan Medicaid fee-for-service pays less than half (46 percent) as much as Medicare.[22] Compared to commercial insurers, the authors estimate that Michigan's Medicaid fee-for-service program pays physicians about two-fifths (41 percent) as much as a private insurer does.‡

It should be noted, however, that in Michigan a majority of Medicaid enrollees participate in Medicaid managed care plans, rather than Medicaid's fee-for-service program.[23] Proponents of these plans say they provide better access to health care providers than standard fee-for-service Medicaid.[24] There is considerable disagreement, however, about whether Medicaid spending is lower under managed care than fee-for-service programs.[25] To the extent that managed care saves money, managed care payment rates are unlikely to greatly exceed fee-for-service rates.

Poor Access to Care Under Medicaid

Nationally, about one-third of physicians do not accept new Medicaid patients.[26] This is nearly double the proportion of doctors who have closed their practices to new Medicare patients (17 percent) and to new privately insured patients (18 percent).[27] Physicians are four times as likely to turn away new Medicaid patients as they are to refuse the uninsured who pay out-of-pocket (31 percent versus 8 percent).[28] Studies show it is harder for Medicaid enrollees to make doctors' appointments than it is for uninsured patients who say they'll pay out of pocket.[29]

In a 2011 survey of Michigan physicians, nearly one in six said they refused to treat any Medicaid patients.[30] This figure may not fully reflect the access problems for Michigan's Medicaid enrollees. Some physicians will accept some — but not all — new Medicaid-enrolled patients who enquire about an office visit. In addition, some physicians will treat their current Medicaid patients, but will not accept new Medicaid patients. For instance, in the same survey of Michigan physicians, more than one-quarter (28 percent) said they were not accepting new Medicaid patients into their practice.[31] Indeed, a 2008-2009 survey found that many specialists in metropolitan Detroit did not accept Medicaid patients (see Graphic 2).[32] These specialists included:

- 33 percent of dermatologists;[33]
- 41 percent of family practitioners;[34]
- 50 percent of obstetrics-gynecology specialists;[35] and
- 67 percent of orthopedic surgeons.[36]

The exception to this pattern was cardiology; all cardiologists surveyed in 2009 said they accepted Medicaid.[37]

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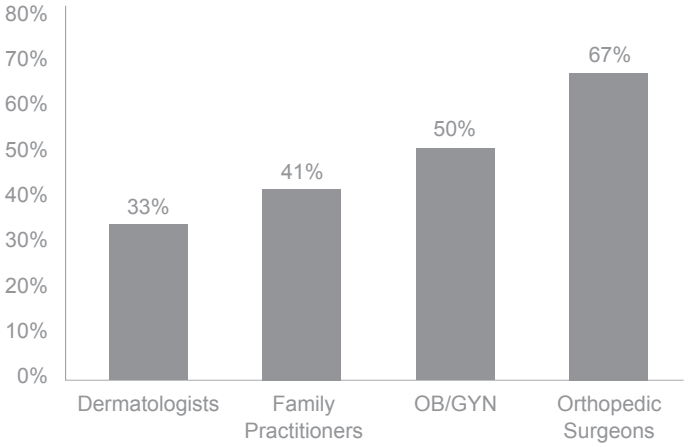
* Jack Hadley and John Holahan, "Covering The Uninsured: How Much Would It Cost?," Health Affairs (2003) http://goo.gl/cAqJ0 (accessed May 16, 2013). For an actuarial analysis of how insurance affects the medical consumption of diverse populations, see "Cost of the Future Newly Insured under the Affordable Care Act (ACA)," (Society of Actuaries, 2013), http://goo.gl/XfhWa (accessed May 16, 2013).

† "2012 Medicaid-to-Medicare Fee Index," (The Henry J. Kaiser Family Foundation), http://goo.gl/ZVuWb (accessed May 16, 2013). Physicians who treat Medicaid patients and who are not affiliated with managed care organizations are reimbursed based on a state fee-for-service fee schedule. By contrast, some physicians who participate in Medicaid managed care plans are paid rates negotiated with the sponsoring plan, rather than the fee-for-service fee schedule. Nationwide, Medicaid managed care physicians are also generally paid much less for treating Medicaid patients than they are for treating Medicare enrollees with the same condition.

‡ Authors' calculations in part using data from ibid. The ratio of Medicare to commercial insurance reimbursements is estimated at about 81 percent; see John Sheils, "The Cost and Coverage Impacts of a Public Plan, Testimony before the Ways and Means Committee," (The Lewin Group, 2009), 4, http://goo.gl/Udn1S (accessed May 16, 2013). Precise calculations of the ratio of Medicare physician fees to private insurers' fees are problematic at best. A study commissioned by the Medicare Payment Advisory Commission estimated that Medicare physicians' fees were 83 percent of private insurers' fees in 2001; see Christopher Hogan, "Medicare Physician Payment Rates Compared to Rates Paid by the Average Private Insurer, 1999-2001," (Medicare Payment Advisory Commission, 2003), 2, http://goo.gl/alYXC (accessed June 9, 2013). The actuarial consulting firm Milliman estimated that Medicare physician fees were 78 percent of private insurer fees in 2007; authors' calculations based on Will Fox and John Pickering, "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," (Milliman, 2008), 7, http://goo.gl/xgTqF (accessed June 9, 2013).

Under a Medicaid expansion, the disparity between Medicaid reimbursements and commercial insurance reimbursements would be decreased in 2014 by the federal government's subsidy to boost the Medicaid fees that primary care providers receive to Medicare levels. The gap would open again when the federal subsidy ceased in the following year, however, unless the state took over the cost of boosting Medicaid fees to Medicare levels.

Graphic 2: Percentage of Physicians Not Accepting Medicaid in Metro Detroit, 2009



Source: "2009 Survey of Physician Appointment Wait Times," (Merritt Hawkins & Associates, 2009), 4-8, http://goo.gl/Zytko (accessed May 16, 2013).

Medicaid and Displacement of Private Insurance

Many Americans incorrectly believe that none of the poor has private health insurance. However, at least some of the new Medicaid enrollees would be those who previously had private coverage.

"Crowd-out" (or substitution) occurs when people who are already covered by employer-paid or individual insurance drop that coverage to take advantage of a public insurance option. Estimates of crowd-out are controversial among analysts. Some researchers find a high rate of Medicaid substitution for private coverage, while others believe it is negligible. Estimates of crowd-out for diverse populations vary.

Nevertheless, crowd-out is likely to be a significant problem for states that expand Medicaid eligibility to adults who are not disabled. For instance, analysis of past Medicaid expansions to mothers and children in the early 1990s by David Cutler and Jonathan Gruber, economists who have since served as Obama administration advisers, found that when Medicaid eligibility was expanded to children and pregnant women, about 50 percent of the newly enrolled had dropped private coverage.[38] A recent analysis by Gruber and Kosali Simon estimated that crowd-out for the Children's Health Insurance Program averaged about 60 percent.*

Working adults are the target of Medicaid expansion under the ACA. The likely effect of crowd-out on working adults was analyzed for the Veterans Health Administration by academic researchers Steven Pizer, Austin Frakt and Lisa Iezzoni. They found crowd-out could reach 82 percent.[39]

A conservative estimate is that Medicaid rolls might have to rise by 1.4 people in order to reduce the uninsured by 1 person — a crowd-out rate of about 29 percent.† Medicaid, after all, will cost less money for many low-income people who are privately insured and provide, on paper at least, much better coverage.

According to the Kaiser Family Foundation, more than one in five nonelderly people with incomes of 138 percent or less of the poverty level in Michigan in 2011 were covered by private insurance.[40] This is about 512,000 people[41] — nearly half the 1.1 million nonelderly people in Michigan who are already enrolled in Medicaid and earning 138 percent or less of the poverty level.[42]

Approximately 685,526 Michigan residents were enrolled in Michigan degree-granting colleges and universities in the fall of 2010, according to the National Center for Education Statistics.[43] Many college students would be eligible for Medicaid under expansion rules, though many of them are likely eligible for coverage under their parents' private insurance plans.

A decade ago, an estimated 29 percent of adults ages 25 to 64 with incomes below the poverty line purchased private health insurance.[44] Among individuals with family incomes less than 1.5 times the federal poverty level, an estimated 36 percent of individuals — more than one-third — had private insurance.[45] These are probably conservative projections of the percentage of people who would qualify under an expanded Medicaid program and who currently have private insurance. The definition of poverty in the ACA differs substantially from the official one. As a result, a preliminary analysis by staff from the U.S. Treasury Department found the Current Population Survey data could significantly underestimate the number that will be newly eligible for Medicaid, potentially driving

* The actual rate varied depending on the conditions governing expansion and the populations covered. The authors conclude, however, "Our results clearly show that crowd-out is significant; the central tendency in our results is a crowd-out rate of about 60%." Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?," (National Bureau of Economic Research, 2007), ii, http://goo.gl/Xloa9 (accessed June 2, 2013).

† A ratio of 1.4 new Medicaid enrollees to reduce the uninsured by 1 assumes a crowd-out rate of 29 percent (1-(1/1.4)). One analysis found about one-quarter of the newly insured children in families earning less than 200 percent of poverty had substituted public coverage for private coverage. Peter J. Cunningham, James D. Reschovsky and Jack Hadley, "SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage," (Center for Studying Health System Change, 2002), 4, http://goo.gl/dVEPy (accessed May 17, 2013).

up the financial burden on the public and increasing the crowd-out of the private insurance market.[46]

Crowd-out is an important concern. Substituting public coverage for private insurance shifts costs being borne by the private sector to taxpayers without boosting health coverage.

Difficulty of Determining Medicaid Eligibility Under the ACA

Determining who qualifies for Medicaid if it is expanded is likely to be difficult. Federal law relies heavily on tax and wage data. However, an estimated 13 million people in the U.S. do not file federal income tax forms.[47] Nonfilers are likely to be concentrated in the low-income population who are in turn eligible for expanded Medicaid.* Moreover, past filings do not necessarily reflect current income.

Under the Affordable Care Act, states are not allowed to request additional information from applicants unless electronic information from the Internal Revenue Service is either not available or not "reasonably compatible" with what an applicant reports.[48] Medicaid does not define "reasonably compatible," and some experts believe that forms requesting additional information could require federal approval.[49]

The only other form of income verification readily available to states — quarterly wage data from state unemployment insurance programs — does not include income earned out of state and does not include self-employment income. A review of a recent sample of Oregon's Medicaid and Children's Health Insurance Program applicants revealed that current income in the Medicaid database failed to match state employment data for 38 percent of Medicaid recipients "usually due to out-of-date employment data, self-employment income, off-the-books income, or out-of-state income."[50]

States are also expected to determine whether affordable employer coverage or another public health care assistance program is available to potential Medicaid enrollees using a streamlined application process to determine eligibility.[51] It is not clear how state governments will do this. With the federal law's emphasis on streamlining the eligibility process, it seems likely that fraud will be a problem, especially since states may face greater caseloads than expected under an expanded Medicaid program.[52] Activists will engage in outreach programs to educate potential Medicaid candidates on how to enroll. The ACA requires a "simplification" of the process used to determine eligibility and enrollment,[53] and this mandate will likely lead to a longer period of enrollment between eligibility checks. More people will remain on Medicaid even if their rising income means they no longer technically qualify. Indeed, up to half of adults earning less than 200 percent of the federal poverty level are projected to migrate between potential Medicaid eligibility and health exchange eligibility in any given year because their incomes will fluctuate.[54]

Health Outcomes and Medicaid

Medicaid coverage, with its lower cost-sharing and unlimited benefits, appears on paper to be far better than what most Americans enjoy.[55] But by almost all measures, Medicaid enrollees fare worse than privately insured patients with similar medical conditions.[56] Indeed, various academic researchers have found that Medicaid enrollees often fare worse than not only patients with private insurance, but also patients with no insurance, even when controlling for a variety of factors, including income, education and health status.[57] For example:

- Medicaid patients are almost twice as likely to die after surgery as privately insured patients and about 13 percent more likely to die than the uninsured, according to a University of Virginia study.†
- Medicaid patients are more likely to be diagnosed with cancers at a less treatable, late stage than both the uninsured and privately insured: They were nearly one-quarter (23 percent) more likely to be diagnosed with late-stage breast cancer and 45 percent more likely to be diagnosed with late-stage melanoma than the uninsured, according to a study of Florida in the Journal of the National Cancer Institute.‡

* William L. E. Freeland and Scott Hodge, "Tax Equity and the Growth in Nonpayers," (Tax Foundation, 2012), 3, http://goo.gl/60o7p (accessed June 7, 2013). As Freeland and Hodge note: "There are … millions of … Americans who earn some income but not enough to be required to file an income tax return. Currently, the threshold for filing a tax return is $9,500 for a single person and $19,000 for a married couple."

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‡ Authors' calculations based on Richard G. Roetzheim et al., "Effects of Health Insurance and Race on Early Detection of Cancer," Journal of the National Cancer Institute vol. 91, no. 16 (1999): Table 2 http://goo.gl/qSLGn (accessed May 20, 2013). The study's findings were controlled for age, income, education, health status and other variables.

- Medicaid patients undergoing surgery for colon cancer were three times as likely to die as the privately insured and more than one-fourth more likely to die than the uninsured, according to a study in the journal Cancer[58] (though survival rates for Medicaid patients with late-stage colon cancer were higher than for the uninsured).

Does Medicaid Boost the Economy?

Interest groups often tout the "economic benefits" that additional federal Medicaid funds might create within states.* Yet economists find it difficult to calculate the actual value of economic activities that are generally assumed to have beneficial spillover effects in industries far removed from the initial spending. For instance, a macroeconomic study published by the National Bureau of Economic Research indicates that since 1950, government defense spending has actually reduced national economic output below what it would have been otherwise.[59] Such results suggest that the net effect of the new health law will be that the national gross domestic product declines as the federal government consumes a larger share of national income to fund its programs. Basically, people will cut their other consumption to pay the increased tax burden.

State officials should keep in mind that models that predict large economic increases from reallocated federal spending generally ignore the fact that the money must come from somewhere. The ACA includes substantial tax increases that potentially reduce federal and state revenues needed to finance both existing Medicaid and any Medicaid expansion. For many years, Michigan has paid more in federal taxes than it has received in federal spending, suggesting that Michigan might end up paying more for any national program than it receives in benefits.† According to the RAND Corporation, most states can expect a net transfer of state resources to the federal government under the ACA.[60] RAND noted that only lower-income states will benefit.[61]

Nor would Medicaid expansion bring only new dollars to Michigan's health care sector. As discussed earlier under "Medicaid and Displacement of Private Insurance," an estimated 29 percent of those enrolling in a Medicaid expansion would be dropping their current private insurance. Private insurance reimbursements are generally higher, however, and they typically provide more income per patient to the state's health care sector.‡ Medicaid expansion would produce less of this higher rate of spending, reducing the benefits that the expansion might have otherwise been expected to generate for the health care sector.

The costs in taxes and redirected health care spending suggest why a Medicaid expansion, like many other forms of targeted spending, could easily fail to generate a net benefit for the state's economy, even if it did provide new cash for some segments of the state's health care sector.

Is Federal Spending Sustainable?

Michigan may not be able to rely on the federal government to provide indefinitely the same level of Medicaid funding promised in the ACA. In addition to promises made to the states, the federal government has unfunded obligations for other entitlement programs.

Medicaid Spending

Federal and state governments spent $389 billion on Medicaid in 2010, according to the Kaiser Family Foundation.§ Medicaid is the largest expense in most state

* For instance, the argument follows that federal money is a multiplier of state spending. The effect ripples throughout the economy from health care providers to their vendors and employees. See "The Role of Medicaid in State Economies: A Look at the Research," (The Henry J. Kaiser Family Foundation, 2009), http://goo.gl/6Wm9F (accessed May 20, 2013). For an example of an advocacy report touting Medicaid expansion in Michigan, see "The ACA's Medicaid Expansion: Michigan Impact," (Center for Healthcare Research & Transformation, 2012), http://goo.gl/HSfqF (accessed May 20, 2013).

† "Federal Taxes Paid vs. Federal Spending Received by State, 1981-2005," (Tax Foundation, Oct. 19, 2007), http://goo.gl/2pVdA (accessed May 24, 2013). While the ratio may have shifted since this data was collected, it seems unlikely that Michigan has become the kind of low-income state that would benefit from the ACA.

‡ Authors' calculations using an index of a ratio of Medicaid fees to private insurance fees as a proxy for spending by private insurers. Michigan Medicaid fee-for-service physician fees are only about 51 cents on the dollar of what Medicare reimburses a physician for the same service. See "2012 Medicaid-to-Medicare Fee Index," (The Henry J. Kaiser Family Foundation), http://goo.gl/ZVuWb (accessed May 16, 2013). Medicare reimburses physicians about 81 percent of what a private insurer reimburses physicians for the same service. Sheils, "The Cost and Coverage Impacts of a Public Plan, Testimony before the Ways and Means Committee," (The Lewin Group, 2009), http://goo.gl/Udn1S (accessed May 16, 2013). Physician reimbursements from private insurers may thus average about 2.42 times what Michigan fee-for-service Medicaid would pay for the same service.

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budgets — and it is growing at unsustainable rates. For instance:

- According to the federal Centers for Medicare and Medicaid Services, state and local governments' Medicaid spending was only $84 billion in 2000,[62] but as of January 2011, was projected to reach $357 billion by 2020* — a quadrupling (in nominal terms) in just two decades, in part as a result of the anticipated Medicaid expansion.
- Similarly, federal spending on Medicaid was about one-quarter of a trillion dollars in 2009, but was projected to reach $574 billion in 2020[63] — more than doubling (in nominal terms) in just a little over a decade.

The primary reason behind the rapid growth in Medicaid expenditure is that the federal government encourages states to spend by providing a federal matching rate for all state spending on approved Medicaid services. In economic terms, this is referred to as subsidizing at the margin — for instance, each marginal dollar of pre-ACA Medicaid spending costs New York state just 50 cents, Florida just 42 cents and Mississippi just 27 cents, according to 2011 federal government calculations for fiscal 2013.[64] The federal medical assistance percentage contribution of nearly 66 cents coupled with Michigan's share of spending (about 34 cents) encourages unnecessary Medicaid spending.[65] If the federal government is paying 66 cents of each dollar Michigan spends on its Medicaid program, program administrators have only a fraction of the incentive to root out waste, fraud and abuse that they would have if the state had to pay for the entire Medicaid dollar itself.

This situation will only grow worse as the federal government pays 90 cents or more of each new Medicaid dollar from 2014 to 2020. States will be tempted to apply for the matching funds even when they doubt the value of the spending.

Non-Medicaid Spending

Medicaid isn't the only commitment the federal government has to fund into the future. At the federal level, the growth in health care expenditures is our most serious domestic policy problem, and Medicare is the most challenging component.[66] For decades, annual Medicare spending has increased slightly more than 2 percentage points faster than gross domestic product.[67] If we continue to consume products whose costs are growing faster than national income, that consumption will eventually crowd out every other thing we are consuming. For instance, the Congressional Budget Office found that if federal income tax rates were raised to allow the government to continue its current level of activity and balance its budget:[68]

- The lowest marginal income tax rate — 10 percent — would have to rise to 26 percent.[69]
- The 25 percent marginal tax rate — the tax bracket for many two-income families — would have to rise to 66 percent.[70]
- The highest marginal income tax rate — 35 percent — would have to rise to 92 percent.[71]

If such marginal tax hikes were realized, the federal government's ability to raise sufficient tax revenue for its spending commitments would diminish as the rates rose and people lost the incentive to work.

Conclusion

As Mackinac Center analysts have noted elsewhere, Medicaid comprises nearly one of every three dollars spent by the state of Michigan — 30 percent of the state budget — and is growing at an unsustainable rate.[72] If Medicaid eligibility is expanded, an estimated 29 percent of new Medicaid enrollees will be individuals who previously had private insurance and dropped it to enroll in public coverage. Thus, Medicaid is an inefficient way to reduce the number of uninsured.

Limited provider participation in Medicaid creates a significant barrier to health care access for Medicaid enrollees. As a result, although Medicaid seemingly offers a generous benefit package, coverage does not guarantee access to needed services. A substantial body of research shows that Medicaid patients are more likely to rely on hospital emergency departments to obtain the care they need.[73] Without access to appropriate primary and specialty care, Medicaid patients often experience worse health outcomes compared to people with private insurance.

Many potential Medicaid enrollees targeted by the proposed Medicaid expansion will have access to federally

* "National Health Expenditure Projections 2010-2020," (Centers for Medicare & Medicaid Services, 2011), 21, Table 16, http://goo.gl/fvsTs (accessed June 7, 2012). A later edition of this report has been published, but appears to be based on the same general assumptions and makes only minor changes to the numbers in the previous report. "National Health Expenditure Projections 2011-2021," (Centers for Medicare & Medicaid Services, 2012), 22, Table 16, http://goo.gl/AWjuN (accessed June 7, 2012).

subsidized health insurance options on the ACA's health insurance exchange. The cost of insurance premiums to the participants would be a small fraction of their income, and in some cases (as with the bronze plan), the premiums might even be fully subsidized, limiting participants' costs to the health care spending not paid for by the plan they selected. In either case, the participants would be in a situation similar to that of many Michigan residents already covered under private insurance.

For at least some of the low-income uninsured, Medicaid is not the only insurance option. But faced with large potential federal subsidies for Medicaid expansion, state policymakers may easily underestimate Medicaid's downsides on the one hand and the availability of practicable alternatives on the other. Indeed, given Medicaid's current share of the state budget, its shortcomings in serving its present population, and its significant, unpredictable costs under the proposed expansion, policymakers have sound reasons to be wary of enlarging the program.

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