CFM Grand Rounds Continuing Education

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Evaluation

A short evaluation will be emailed to you within 48 hours. Please take a moment to give us your feedback.

Our next Grand Rounds will be
July 11, 2017 in Hanes 131.
The Case Against Medicaid Expansion in North Carolina

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If you don’t know where you’re going any road will get you there.
Roadmap

- 3 biggest flaws in ACA Medicaid expansion
- 5 major reasons NC should not expand Medicaid unless flaws corrected
- A market-oriented vision for Medicaid reform

Details will be posted at:
https://www.forbes.com/sites/theapothecary/people/chrisconover
Outline

3 biggest flaws in ACA Medicaid expansion
Flaw #1: Enhanced Federal Matching Rate

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States Vary Greatly in Altruistic Willingness-to-Pay

2012 State Medicaid Spending per $1,000 in Taxable Resources

Top 5 States
- Ohio (30)
- Vermont (21)
- Rhode Island (15)
- Pennsylvania (17)
- U.S. (9.05)

Bottom 5 States
- Wyoming (8)
- North Dakota (4)
- South Dakota (4)
- Utah (45)
- Washington (13)

Figures in parentheses show state’s ranking on per capita income: 1=highest
ACA Privileges Able-Bodied Adults Over Vulnerable Populations

Median Medicaid/CHIP Eligibility Thresholds, January 2013

Income as a percent of FPL:
- 235%
- 185%

Minimum Medicaid Eligibility under ACA Expansion = 138% FPL
($26,951 for a family of 3 in 2013)

Source: Based on the results of a national survey conducted by KCMU and the Georgetown University Center for Children and Families, 2013.

Source: Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer 2013*
Flaw #2: Matching Rate Remains Open-Ended

- Creates perverse incentives to waste money
- Crowds out spending on education and other state priorities
- Is a boondoggle to wealthy states
Medicaid’s Perverse Incentives to Waste Money

- Under Medicaid expansion:
  - Each dollar of spending costs states 1 dime
  - Each dollar of savings yields states 1 dime

- Real-world evidence:
  - 10 to 30% of Medicaid payments fraudulent
  - ACA Medicaid expansion enrollees each cost ~50% more than projected in 2015
  - NC Medicaid cost overruns=$1.4 billion annually from 2009-2012
Medicaid Crowding Out Spending on Other Priorities

Shares of Total State Spending by Category, 2000 and 2014

- Medicaid: 25.8% (2000), 32.4% (2014)
- K-12 education: 22.3% (2000), 19.5% (2014)
- Transportation: 8.9% (2000), 7.7% (2014)
- Corrections: 3.8% (2000), 3.1% (2014)
- Public assistance: 2.4% (2000), 1.4% (2014)
- Other: 32.0% (2000), 32.4% (2014)

Medicaid Is a Boondoggle for Wealthy States

2012 Federal Medicaid Spending per Person Below Poverty

Top 6 States
- Alaska (9)
- Vermont (21)
- Massachusetts (3)
- New York (6)
- U.S.
- District of Columbia (1)

Bottom 6 States
- North Carolina (40)
- Georgia (41)
- Illinois (18)
- Washington (13)

Figures in parentheses show state’s ranking on per capita income: 1=highest
Flaw #3: Lack of Integration with Private Insurance

- Medicaid crowd-out of private coverage
- Medicaid churn
- Perverse work incentives
Medicaid Crowd-Out

Estimated Coverage Status of Newly-Covered Medicaid Expansion Recipients in NC

Uninsured, 390,000

ACA Exchange, 198,000

Other Coverage, 496,000

Source: Derived from figures reported in Table 1, Matthew Buettgens and Genevieve M. Kenney What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured. Urban Institute, July 2016.
Medicaid Churn

Gap in Coverage for Adults in States that Do Not Expand Medicaid under the ACA

Limited to Specific Low Income Groups

- 0% FPL Childless adults
- 44% FPL $8,870 for parents in a family of three
- 100% FPL $11,880 for an individual
- 400% FPL $47,520 for an individual

Median Medicaid Eligibility Limits as of January 2016
Medicaid’s Perverse Work Incentives

Job Losses per 1,000 Covered Under Medicaid Expansion

Lower bound: 24
Upper bound: 103

Source: Laura Dague Thomas DeLeire Lindsey Leininger
Outline

- 3 biggest flaws in ACA Medicaid expansion
- 5 major reasons NC should not expand Medicaid unless flaws corrected
Reason #1: Medicaid Expansion Will Not Save Lives

Estimates of excess mortality risk facing uninsured adults are highly uncertain

Uninsured relative mortality risk (1.00 = privately insured)

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<th>Study</th>
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<td>Franks 1993</td>
<td>25-74</td>
<td>4,694</td>
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<tr>
<td>Wilper 2009</td>
<td>17-64</td>
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<td>Kronick 2009</td>
<td>18-64</td>
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<tr>
<td>Kim &amp; Milyo 2011</td>
<td>17-64</td>
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Figures show the risk of death relative to those with private health insurance coverage (employer-based health coverage in most studies shown), i.e., 1.25=25% higher risk of death for uninsured adults compared to statistically equivalent adults having private coverage. Lower and upper bounds represent a 95% confidence interval.
Oregon Health Insurance Experiment

- No statistically significant improvements in physical health:
  - Elevated blood pressure
  - High cholesterol
  - Elevated HbA1c levels
  - Long-term cardiovascular risk (Framingham risk score)
  - Mortality risk

- Statistically significant increase in the diagnosis and treatment of depression

- Study biased in favor of Medicaid
  - Oregon Medicaid pays doctors better than most states
  - Medicaid enrollees were sicker (more likely to benefit from care)

- This is as close to RCT as we’re likely to get regarding impact of Medicaid coverage on health
Sommers Study of Medicaid Expansions (AZ, ME, NY)

- Sommers et al. examined effects of pre-ACA Medicaid expansions to non-elderly adults
- Statistically significant decline in adjusted all cause mortality (by 19.6 deaths per 100,000 adults, for a relative reduction of 6.1%)

Study Limitations
- Study measures aggregate county-level mortality risk, not actual mortality risk among Medicaid recipients
- Study actually produced mixed results
  - Mortality declined in NY (significant)
  - Mortality declined in AZ (not significant)
  - Mortality \textit{increased} in ME (not significant)
- NY mortality reduction may be a statistical artifact
- NY experience not broadly generalizable
Sommers Study of Massachusetts Health Reform

- Sommers et al. (2014) examined effects of the Massachusetts health reform
- Statistically significant decline in mortality: 1 death averted for every 839 newly covered
- Study Limitations
  - Study measures aggregate county-level mortality risk, not actual mortality risk among formerly uninsured recipients
  - Only 12% of the expansion of coverage in Massachusetts between 2006-2010 came through Medicaid
  - MA experience not broadly generalizable
    - Massachusetts age-adjusted mortality rate 10% lower than US
    - Massachusetts ranks #3 in per capita income
    - Massachusetts ranks #5 in Medicaid spending per recipient
  - Even if all mortality gains due to uninsured, cost/QALY=$170K to $245K—i.e., not very cost-effective
Reason #2: Medicaid Expansion Won’t Create Additional Jobs

- Studies showing state-level job gains use one-sided bookkeeping
  - Fail to account for jobs lost in other states due to federal taxes used to bankroll expansion
  - Equivalent to a polluter ignoring all downstream costs since discharge pipe located right at the state border
- RAND study: each 100 health sector jobs results in 85 fewer jobs elsewhere in economy
- Conover study: every $1 raised in taxes shrinks economy by 44 cents
- Bottom line: 129 jobs lost per 100 new health jobs
Reason #3: Medicaid Expansion Will Aggravate Access Problems

Percentage Of US Office-Based Physicians Accepting New Medicaid Patients, 2011

Figures in parentheses show state’s ranking on per capita income: 1=highest.
Reason #4: Medicaid Financing Encourages Fiscal Irresponsibility

- Medicaid’s financing structure has always encouraged wasteful spending.
- ACA Medicaid expansion put these perverse incentives on steroids, creating a “gold rush” mentality.
- States encouraged to pick each others’ pockets.
- Current generation encouraged to shift debt burden to future generations.
Reason #5: Medicaid is Unaffordable in the Long Run

Federal Spending on the Major Health Care Programs, by Category

Percentage of Gross Domestic Product

Actual | Extended Baseline Projection

Medicaid, CHIP, and Marketplace Subsidies

Medicare

Source: Congressional Budget Office.
Americans Get Less Value for Health Spending Each Decade

Cost per Year Gained in Life Expectancy


$0 $50,000 $100,000 $150,000 $200,000 $250,000 $300,000

Outline

- 3 biggest flaws in ACA Medicaid expansion
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- A market-oriented vision for Medicaid reform
Per Capita Federal Medicaid Spending Cap

- Caps vary by state and eligibility category
- Increase with medical inflation
- Adjusted over time to compress geographic variation

Average Annual Spending per Medicaid Enrollee, FY2011

Source: Kaiser Family Foundation, State Health Facts
Far Greater Freedom of Choice for States

- Abandon one-size-fits-all eligibility standards
- Allow much greater flexibility over covered benefits
- Allow use of Medicaid to create Health Savings Accounts
- Federal role:
  - Ensure state accountability for safety-net insurance protection
  - Ensure state accountability for quality of care
  - Fund evaluation research & disseminate information about what works
Far Greater Freedom of Choice for Patients

- Allow states to use Medicaid as a premium support program for purchasing private health insurance coverage
- Allow use of Medicaid for HSAs or other mechanisms to incentivize patients to use health resources prudently
- Federal role:
  - Data collection to facilitate robust comparisons across states regarding health outcomes
  - Fund evaluation research to better understand the impact of various types of financial incentives on low income patient behavior and outcomes
Conclusions

- 3 major flaws in ACA Medicaid expansion:
  - Enhanced matching rate
  - Matching rate remains open-ended
  - Lack of integration with private insurance

- 5 major reasons NC should not expand Medicaid:
  - Will not save lives
  - Won’t create additional jobs
  - Will aggravate access problems
  - Medicaid financing encourages fiscal irresponsibility
  - Medicaid is unaffordable in the long run
Conclusions (2)

- Market-oriented vision for Medicaid reform
  - Per capita federal Medicaid spending cap
  - Far greater freedom of choice for states
  - Far greater freedom of choice for patients

- Prescription: more research!