Medicaid Expansion Background

SUMMARY: Medicaid expansion has added more money for education to the budget. Virginia's Medicaid expansion costs aren't a danger to the budget, because they're offset by reductions in existing state spending, and fully covered by a mix of federal funds and a tax on hospitals – which hospitals agreed to in hopes of saving money on unpaid emergency room visits. Ending Medicaid expansion won't address the real factors making Medicaid overall a bigger part of the state's budget – increasingly costly care for the relative minority of elderly and developmentally disabled people Medicaid already served. And Republicans' desire to impose work requirements could cost the state millions of dollars without actually getting more people back to work for good.

More than 555,000 Virginians had gained health care thanks to Medicaid expansion as of January 2021 -- a number that rose past 570,000 by August 2021, with 25% of those recipients serving as primary caretaker for children or disabled loved ones. More than 400,000 of Virginia's Medicaid expansion recipients are living below the federal poverty line. More than 142,000 Virginia parents now have health care thanks to Medicaid expansion. Expansion's helped 50,000 Virginians get treated for diabetes; 12,000 fight cancer; and more than 48,000 get treatment for addiction.

Does Medicaid expansion actually work?

YES. Research shows that Medicaid expansion saves lives. A July 22, 2019 study from the University of Michigan that analyzed death rates in expansion and non-expansion states showed that, just for low-income people aged 55-64, Medicaid expansion would have **saved 15,600 lives** by 2019 if every state had implemented it when it became available – a 9.3% reduction in deaths compared to the average. That's 15,600 friends, family members, and loved ones who didn't have to die, but did, because their states refused to implement expansion.

Medicaid expansion has helped more Virginians get and keep jobs, and work longer hours. DMAS reports that the percentage of eligible people who couldn't keep a job because of medical issues shrank from 40% to 35% after enrollment, and the percentage of people who had to cut back the hours they worked because of their physical or mental health dropped from 37% to 30%.

While Medicaid expansion isn't a cure-all for struggling hospitals, studies show that refusing Medicaid expansion can worsen their plight. States that refused Medicaid expansion represented 72% of rural hospital closures nationwide since 2010; these states have more money-losing hospitals and lower profit margins for hospitals overall.

Is Medicaid expansion a growing threat to the budget?

NO. Medicaid costs are rising in Virginia, but expansion's not to blame. The higher-than-expected costs owe to **people who were already on Medicaid before expansion** – specifically, **the 16.4% of the Medicaid-eligible population** who are either elderly, blind, or disabled, and who represented **43% of the program's costs** as of the fiscal third quarter of 2021. (You can see this trend in action by looking at CCC Plus expenditures, which include Medicaid spending on the aged, blind, and disabled, on DMAS's data site.)

On May 20, 2019, DMAS told me that Medicaid expansion is fully covered by federal funds -- 93% of the costs until January 2020, and 90% thereafter -- with the rest covered by "a provider assessment on most hospitals." That funding is permanent going forward, it's not going anywhere, and if expenses rise, the provider assessment and federal funds will increase to match them. In short: That $85 million is already paid for, and it won't come out of taxpayers' pockets or the state budget.

According to DMAS (and other sources mentioned below), hospitals still hope to come out ahead despite paying that extra expense, because when more of their poorer patients are covered by Medicaid, the hospitals don't have to eat the cost of expensive ER visits for which those patients can't pay.

As *The Washington Post* reported on Nov. 29, 2018:

The Virginia Hospital & Healthcare Association sees the higher expansion numbers as positive, spokesman Julian Walker said. Hospitals backed expansion — and swallowed a "bed tax" as part of the deal — partly on the notion that broader insurance coverage would allow more people to seek non-emergency care in doctor's offices, rather than in costly emergency rooms. Hospitals, which by law cannot turn anyone away from their ERs, have had to write off those visits as charity or "uncompensated" care.

"This will reduce uncompensated care, which is a strain on hospitals," Walker said. "The fact that people are signing up for coverage, we view that as an encouraging step."

*.... **Virginia's traditional Medicaid program has been one of the least generous in the nation.** To be eligible, a disabled individual can make no more than $9,700 a year. Able-bodied, childless adults have not been eligible, no matter how poor. About one million Virginians are currently receiving health coverage through Medicaid.*

*Under the Affordable Care Act, **Washington allowed states to open their Medicaid rolls to people with incomes up to 138 percent of the federal poverty level, which is $16,750 a year for a disabled person or able-bodied adult, and $28,700 for a family of three.** The*

federal government pledged to pay at least 90 percent of the cost, which in Virginia would amount to about $2 billion a year.

In 2017, Virginia hospitals spent $672 million on free or discounted care to low-income patients (up from $400 million in 2008), and lost an additional $359 million from the gap between the cost of providing care and what Medicaid reimbursed them. With expansion, hospitals will still be losing money, but less money, because partial Medicaid reimbursements are still better than getting nothing at all. Medicaid will likely also help more patients get preventative care from primary care providers, which would help keep them out of the hospital – a far more expensive place to receive care – in the first place.

Is Medicaid expansion costing Virginia money that it could be spending elsewhere?

NO. DMAS says that **Medicaid expansion is saving money in the state budget**, because it's picking up costs for charitable care and behavioral health services that Virginia used to cover out of its own funds. According to DMAS, **"Medicaid expansion is actually saving the state more than expected, and sooner than expected."**

Medicaid isn't endangering education funding or any other part of the budget. In fact, Medicaid expansion freed up money to let Virginia add $530 million to the K-12 general fund, and $131 million for the state's share of a 3% pay hike for teachers.

From the *Newport News Daily Press,* May 31, 2018: "We either did Medicaid expansion or we wouldn't have pay increases for teachers, for deputies, for state employees," said Del. Gordon Helsel, R-Poquoson, one of the House Republicans who changed his longstanding opposition to Medicaid expansion to vote for the budget.

Virginia would *lose* money, increasingly, if it rolled back Medicaid expansion. For states, the Affordable Care Act came with a stick – cuts to previous supplemental federal funding for Medicare reimbursements, extra money for hospitals serving areas with a high concentration of lower-income people less able to pay medical bills, and other funds for states' medical care – and a carrot – new funding for Medicaid expansion to offset the effects of those lost funds and cover the people affected. Ideally, the carrot and the stick would balance each other out, if not give states and citizens a net benefit. When the Supreme Court made Medicaid expansion optional under the ACA, **states like Virginia refused the carrot – but still got the stick**. Even if Virginia rolls back Medicaid expansion, the cuts from the "stick" portion of the ACA will keep growing, forcing Virginia's state budget to pick up the slack.

Ironically, the work requirements Republicans advocate *would* cost the state an estimated $13 million, a figure not covered by the hospital tax revenue. (As of 2019, DMAS said it was still negotiating with the Center for Medicare and Medicaid Services about what form work

requirements will take and how much they'd cost. I'm not sure whether the state still intends to pursue work requirements under Democratic governance.)

Do work requirements get people back to work?

NO. They may even increase unemployment. But they do kick a lot of people off health care. Work requirements have been found to severely curtail access to care without increasing employment in significant or lasting ways. Most Medicaid recipients already work, and the rest are either severely disabled or caring full-time for a family member who is.

Even Virginia's own application to implement Medicaid work requirements estimates that **45% of the 120,000 people** who might otherwise be subject to work requirements are **already working 20 hours a week or more**.

Arkansas provides a particularly bleak example of work requirements. Between June 2018 and March 2019, until a federal judge stopped them, Arkansas tested work requirements for Medicaid recipients below the poverty line and ages 30-49. More than **18,000 people lost coverage** – about **25% of all the people in that group**. The uninsured rate among this group spiked four percentage points from 2016 to 2018, so **these folks weren't getting private insurance instead**; they were losing health care, period. While estimates suggested that **only 3%-4% of that group of people actually weren't working**, between 8% and 29% of them didn't report enough work hours in a given month, and 75% missed at least one month.

That seems to be at least partly because **Arkansas did a terrible job of setting up its system**. Lots of people didn't know they were losing coverage. The only site where they could report their hours went down every night between 9 p.m. and 7 a.m. The state refused to fund county offices where people could more easily report. And confusing rules left people unsure whether they were subject to work requirements, or whether or how often to report their hours worked. Arkansas also made no accommodation for people with disabilities. (To its credit, Virginia's proposed system seems like it will attempt to avoid many of these pitfalls.)

So did these requirements get lazy moochers off the couch and back to work? **18,164 people lost health care. Arkansas's own figures show that only 1,981 found any kind of new job.** And that data doesn't record whether the job was full time or part time, whether it was for hours or days or for the long haul.

A parallel Harvard study of affected Arkansans found **no growth in employment, hours worked, or community engagement** among folks kicked off their health care. Indeed, **reported employment went down; disability went up**. Other media reports suggested that at least some people *lost* their jobs when they were erroneously kicked off coverage, couldn't get health care, got sick, and either got fired or had to quit.

When the Kaiser Family Foundation talked to groups of affected Arkansans, it found that **losing Medicaid didn't motivate them to work**; they already had that motivation, and **losing health care only added to their stress and anxiety**. Some of them needed Medicaid care to keep them healthy enough to work; others were too sick to work even with Medicaid's assistance. Homeless or disabled people, unsurprisingly, had the hardest time complying with requirements.

Brain science shows that **we make worse decisions when we're faced with scarcity** or under pressure. **Living in poverty puts people in "scarcity mode" all the time**, and those added stresses lead to worse outcomes. **Everyone's brain is wired this way**; any of us would act similarly under similar circumstances. At least one analysis argues that to lift people out from poverty, you need to give them fewer obstacles and more breathing room, and treat them like people instead of despised cogs in an uncaring system.

Another analysis shows that the people most likely to fall under Medicaid work requirements already face some of the steepest challenges to getting a job, including poor education, health problems, transportation troubles, and neighborhoods with high unemployment. **Virginia's work requirement admirably builds in efforts to address these issues**, with funding for job training, gas or public transit subsidies, housing support services, and other educational programs. But enrollees will **still have to navigate red tape** to get this help. And by themselves, neither work requirements nor the included **20 to 80 hours a month of mandatory "get a job" seminars** – escalating in length the longer participants go without finding work – will solve any of those problems.

Though the folks in Arkansas who lost coverage in 2018 were eligible to reenroll in 2019, **only 4,300 of the more than 18,000 did**. Either they don't know they can get their care back, or they're too afraid of getting it taken away again.

On July 8, 2019, New Hampshire delayed implementing Medicaid work requirements because imposing them was proving costlier and more challenging than expected. The state had trouble reaching the 50,000 people who would have fallen under the program's umbrella; it spent $130,000 on outreach with a private contractor, but despite a state web site, information tables at numerous department and grocery stores, and help from health care providers, it managed to notify less than 20,000 people. If Virginia had the same cost per person to reach its estimated 120,000 requirements-eligible citizens, it would have to spend $780,000 *on outreach alone*.