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THE MEDICAID MESS: HOW OBAMACARE MAKES IT WORSE

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The Patient Protection and Affordable Care Act (PPACA) is designed to extend health-insurance coverage to tens of millions of uninsured Americans. Rarely is it mentioned, however, that Medicaid, the government-run health-insurance program for the poor, will provide more than half of that new coverage under the law. The PPACA assigns Medicaid this central role, despite long-standing concerns about Medicaid's costs and the quality of its care.

Under the PPACA, individuals and families with incomes between 138 percent and 400 percent of the Federal Poverty Level (FPL) will be eligible for generous premium subsidies and cost-sharing credits, which they can use to offset the cost of purchasing private insurance on state or federal insurance exchanges created under the law. Uninsured individuals and families with incomes below that level, but who seek coverage on the exchanges, will be automatically enrolled in existing—but significantly expanded—insurance coverage programs for low-income Americans, namely, Medicaid and the Children's Health Insurance Program (CHIP).

The Congressional Budget Office estimates that the PPACA will reduce the nation's uninsured population by 30 million. Seventeen million Americans are expected to be added to the Medicaid rolls, at a ten-year cost of $795 billion.[1] This core feature of the PPACA is one of the law's most significant flaws.

Medicaid has been plagued by concerns about its quality, access, and financing virtually since its inception. The federal government matches state Medicaid funding at a rate adjusted by state income. Policy experts have

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long recognized that the program's dual state-federal structure creates perverse incentives for states to rapidly expand Medicaid coverage and services, while short-changing efforts to control waste, fraud, and abuse.[2]

Today, Medicaid poses a severe fiscal threat to many state budgets. Due to federal restrictions on Medicaid program management, state tools for managing Medicaid budgets are largely limited to adjusting payment rates for providers. Over time, this has resulted in severe underpayment of doctors and hospitals, preventing many Medicaid recipients from gaining access to basic and specialist health care. This access problem, in turn, leads to significantly worse health outcomes and higher mortality rates for Medicaid recipients when compared with private insurance and even Medicare.

This brief describes the inadequate health outcomes of Medicaid patients and how those outcomes are tied to the program's penurious payments to health-care providers. It calls into question the wisdom of expanding this flawed program before enacting sustainable reforms that improve access and quality while responsibly controlling costs for state and federal taxpayers.

Medicaid's Poor Health Outcomes

Studies consistently show that patients on Medicaid have the worst health outcomes of any group in America—far worse than those with private insurance and, in some cases, worse than those with no insurance at all.

A landmark study published in the *Annals of Surgery* examined outcomes for 893,658 individuals undergoing major surgical operations from 2003 to 2007.[3] The authors of the study, who hailed from the department of surgery at the University of Virginia, divided their patient population by the type of insurance they held—private, Medicare, Medicaid, and uninsured—and adjusted the database in order to control for age, gender, income, geographic region, operation, and comorbid conditions. That way, they could correct for the obvious differences in the patient populations (for example, older and poorer patients are more likely to have ill health).

They then examined three measurements of surgical outcome quality: the rate of in-hospital mortality; average length of stay in the hospital (longer stays in the hospital are a marker of poorer outcomes); and total costs.

The in-hospital death rate for surgical patients with private insurance was 1.3 percent. Medicare, uninsured, and Medicaid patients were 54 percent, 74 percent, and 97 percent, respectively, more likely to die than those with private insurance.

The average length of stay in the hospital was 7.38 days for those with private insurance; on an adjusted basis, those with Medicare stayed 19 percent longer; the uninsured stayed 5 percent shorter; and those with Medicaid stayed 42 percent longer.

Total costs per patient were $63,057 for private insurance; Medicare patients cost 10 percent more; uninsured patients 4 percent more; and Medicaid patients 26 percent more.

In summary: Medicaid patients were almost twice as likely to die as those with private insurance; their hospital stays were 42 percent longer and cost 26 percent more. Compared with those without health insurance, Medicaid patients were 13 percent more likely to die, stayed in the hospital for 50 percent longer, and cost 20 percent more.

Other studies have found similar results:

- A University of Pennsylvania study published in *Cancer* found that, in patients undergoing surgery for colon cancer, the mortality rate was 2.8 percent

Figure I. Comparison of Outcomes for Surgical Patients

Outcome	Private	Medicare	Uninsured	Medicaid
*In-hospital mortality (vs. private insurance)**	1.00	1.45	1.74	1.97
Length of stay (days)	7.38	8.77	7.01	10.49
Total costs ($)	$63,057	$69,408	$65,667	$79,140

*Mortality rates are normalized to multiples of private insurance.

for Medicaid patients, 2.2 percent for uninsured patients, and 0.9 percent for those with private insurance. The rate of surgical complications was highest for Medicaid, at 26.7 percent, as compared with 24.5 percent for the uninsured and 21.2 percent for the privately insured.[4]

- A Columbia-Cornell study in the *Journal of Vascular Surgery* examined outcomes for vascular disease. Patients with clogged blood vessels in their legs or clogged carotid arteries (the arteries of the neck that feed the brain) fared worse on Medicaid than did the uninsured; Medicaid patients outperformed the uninsured if they had abdominal aortic aneurysms.[5]

- A study of Florida patients published in the *Journal of the National Cancer Institute* found that Medicaid patients were 6 percent more likely to have late-stage prostate cancer at diagnosis (instead of earlier-stage, more treatable disease) than the uninsured; 31 percent more likely to have late-stage breast cancer; and 81 percent more likely to have late-stage melanoma. Medicaid patients did outperform the uninsured on late-stage colon cancer (11 percent less likely to have late-stage cancer).[6]

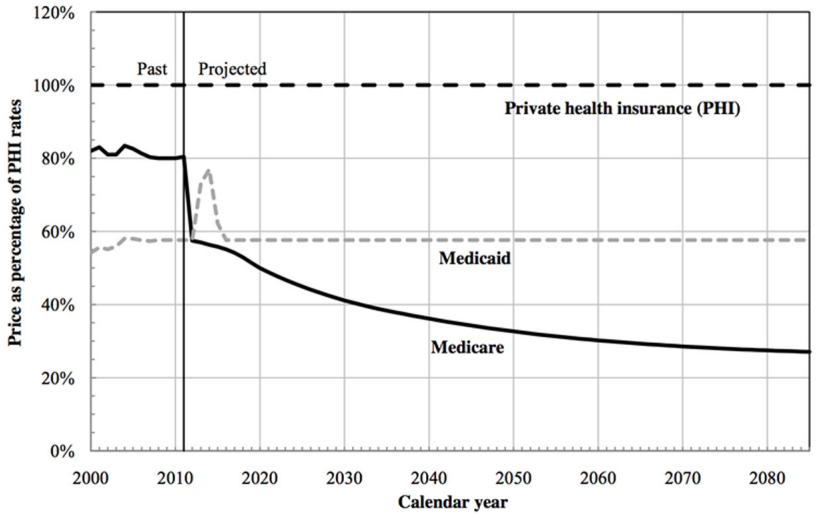
- A University of Pittsburgh study of patients with throat cancer, published in *Cancer*, found that patients on Medicaid or without insurance were three times as likely to have advanced-stage throat cancer at the time of diagnosis, compared with those with private insurance. Those with Medicaid or without insurance lived on for a significantly shorter period than those with private insurance.[7]

- A Johns Hopkins study of patients undergoing lung transplantation, published in the *Journal of Heart and Lung Transplantation*, found that Medicaid patients were 8.1 percent less likely to be alive ten years after their transplant operation, compared with those with private insurance and those without insurance. Medicaid was a statistically significant predictor of death three years after transplantation, even after controlling for other clinical factors. Overall, Medicaid patients faced a 29 percent greater risk of death.[8]

Medicaid Patients Have Very Poor Access to Care

Why do patients fare so poorly on Medicaid? The key reason is that Medicaid pays physicians far below market rates to care for Medicaid beneficiaries. In 2008, according to the Centers for Medicare and Medicaid Services, Medicaid paid physicians approximately 58 percent of what private insurers paid them for comparable services.[9]

Figure 2. Illustrative Comparison of Relative Medicare, Medicaid, and Private Health Insurance Prices for Physician Services under Current Law



Surprisingly, doctors even fare better treating the uninsured than they do caring for those on Medicaid. A 2007 study by MIT economists Jonathan Gruber and David Rodriguez found that, for nearly 60 percent of physicians, Medicaid fees were less than two-thirds of those paid by the uninsured, and that three-quarters of physicians receive lower fees for treating Medicaid patients than they do for treating the uninsured.[10]

The difference in reimbursement rates does not capture the additional hassles involved in treating Medicaid patients—such as late payments from the government and excessive paperwork—relative to the uninsured, who pay in cash.

Surveys consistently show that patients with private insurance have far superior access to care than those on Medicaid. The 2008 Health Tracking Physician Survey found that internists were 8.5 times as likely to refuse to accept any Medicaid patients, relative to those with private insurance.[11]

A study published in the *New England Journal of Medicine* found that individuals posing as mothers of children with serious medical conditions were denied an appointment 66 percent of the time if they said that their child was on Medicaid (or the related CHIP), compared with 11 percent for private insurance—a ratio of 6 to 1.[12]

Among clinics that did accept both Medicaid/CHIP and privately insured children, the average wait time for an appointment was 42 days for Medicaid and 20 days for the privately insured. A related study, published by the same group in *Pediatrics*, found that 63.5 percent of Medicaid/CHIP beneficiaries were unable to get an appointment, compared with 4.6 percent of those with private insurance—a ratio of 14 to 1.[13]

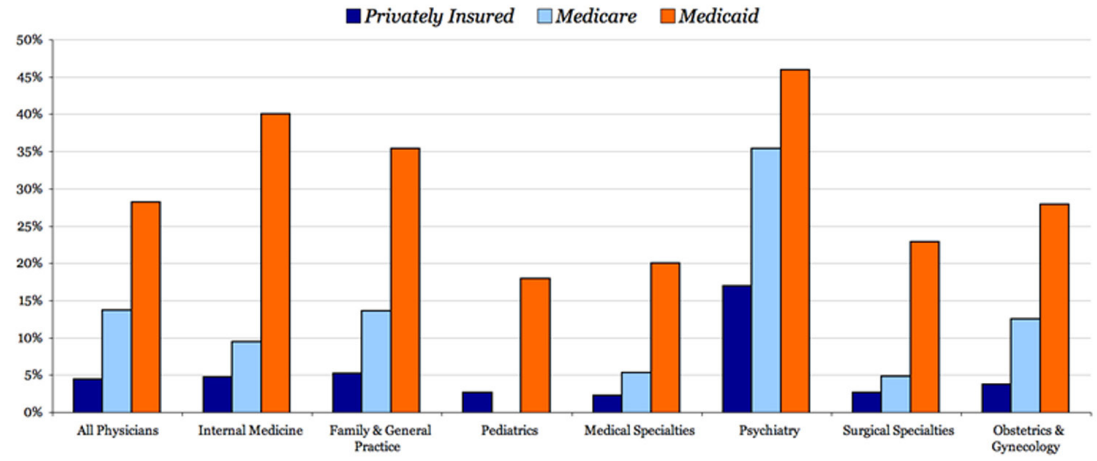
These differences in access to physician care go very far in explaining why Medicaid patients suffer from poorer health outcomes than their counterparts with private insurance. It is likely that the poor outcomes of cancer patients on Medicaid are caused by the fact that those patients' cancers are not diagnosed early enough to receive effective treatment.

In addition, even when Medicaid patients gain access to care, the quality of that care is below average. A UCLA study published in the *Journal of the American Medical Association* found that those on Medicaid were far more likely to be treated in low-volume surgical centers than high-volume ones; high-volume surgical centers have consistently demonstrated superior outcomes.[14]

Consequences of the ACA's Dramatic Expansion of Medicaid

There is, therefore, plenty of reason for concern that dramatically expanding Medicaid, as the Affordable

Figure 3. Physicians Who Accept No New Patients, By Form of Insurance



Care Act does, will worsen the problems that drive the program's poor health outcomes.

A 2011 study by Peter Cunningham of the Center for Studying Health System Change found that the ACA's mandated Medicaid expansion will create special problems for states in the South and the Mountain West.[15] In these states, the supply of primary-care physicians per capita is low. In addition, these states have historically had relatively limited Medicaid programs. "Growth in Medicaid enrollment in these states will greatly outpace growth in the number of primary care physicians willing to treat new Medicaid patients," concluded Cunningham.

A 2012 study by Chapin White, published in *Health Services Research*, examined the 1997 creation of CHIP as a way of studying the impact of Medicaid expansions on access to care.[16] White found that expansion of Medicaid/CHIP had no significant impact on aggregate access to physician care; indeed, those who previously had insurance of any kind endured *worse* access to care as a result of the expansion.

White found that lower physician reimbursements were associated with poorer access to care. "Public health insurance plans … [can] reduce utilization (if coverage is expanded without making reimbursement more generous)," White concluded. "Coverage expansions by themselves do not necessarily spur increases or decreases in overall [physician] utilization—what does appear to matter is the nature of the coverage and the generosity of provider reimbursements in the public program."

White's study highlighted another serious problem with expansions of Medicaid: they crowd out higher-quality private insurance. Among the fourth-poorest quartile by socioeconomic status, a 23.3 percent increase in the penetration of Medicaid/CHIP was associated with a 13.2 percent decrease in the penetration of private insurance—a ratio of nearly 2 to 1. Among the three other quartiles, increases in the penetration of Medicaid/CHIP were associated with a decrease in private insurance in a 1-to-1 ratio.

In other words, the Affordable Care Act's dramatic expansion of Medicaid is likely to reduce the quality of care for millions of Americans who will gain access to Medicaid under the law but lose access to other forms of insurance. In addition, the law will trap millions more into Medicaid's fundamentally flawed system.

Policy Remedies for the ACA's Expansion of Medicaid

It appears clear, then, that the nation has a responsibility to repair the existing Medicaid program before foisting its flaws upon others. There are several ways to do so.

One approach would be to substantially expand Medicaid's federal funding but apply the extra funds to increasing Medicaid's reimbursement rates, rather than expanding the program to others. This approach, however, would fail to correct many of the program's structural inefficiencies that drive wasteful and fraudulent spending on things other than patient care.

Another approach would be to apply the ACA's subsidized, private-insurance exchanges to the existing Medicaid population. This would allow Medicaid beneficiaries to gain access to care that is comparable with that of the privately insured population, improving health outcomes. However, this approach would have a prohibitive fiscal cost, unless it were paired with a reduction in the law's subsidy of higher-income individuals.

The most attractive approach would be to apply to Medicaid our remarkably successful experience with reform of the classic welfare program, Aid to Families with Dependent Children (AFDC). In 1996, Congress restructured AFDC as a series of block grants to the states. Using this approach with Medicaid could trigger a revolution in American health policy, by allowing the 50 states to experiment with innovative new approaches to efficiently deliver health care to the needy.

Americans strongly believe that the nation should marshal its resources to provide health care to the needy. If we give states the independence to pursue these goals for themselves, we are likely to see substantial improvements to this enduring problem. The ACA's dramatic expansion of the deeply flawed status quo risks making that problem permanent.

ENDNOTES

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