Handout #2

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214 Massachusetts Ave. N.E Washington D.C. 20002 (202) 546-4400 www.heritage.org

TESTIMONY

Medicaid Expansion

Testimony before Joint Senate and House Committees on Public Health, Welfare and Labor of the Arkansas Legislature

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Edmund F. Haislmaier
Senior Research Fellow
Health Policy Studies
The Heritage Foundation

My name is Edmund Haislmaier. I am Senior Research Fellow at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Thank you Madam Chairman and Members of the Committees for inviting me to testify today on Arkansas' adoption of the Medicaid expansion included in the federal Patient Protection and Affordable Care Act (PPACA) through an approach termed the "private option."

Any assessment of the effects of the Medicaid expansion, including through the private option, should start with an understanding of how the expansion population differs from other populations already covered by Medicaid.

Since it's inception, Medicaid has been a program focused on providing health care to vulnerable low-income individuals—specifically, children, pregnant women, the disabled, and the elderly. In many instances, parents or caregivers of children on Medicaid also receive coverage.

States adopting the PPACA expansion will be extending Medicaid to a very different population, consisting of able-bodied adults, the vast majority of whom do not have dependent children.

Table 1 reproduces Arkansas data from an Urban Institute analysis of the composition of the uninsured population targeted by the Medicaid expansion.

Table 1

Arkansas Uninsured Adults Newly Eligible for Medicaid with Incomes Below 138% of FPL (Numbers in 1000's)

Age	**19 to 24**	**25 to 34**	**35 to 54**	**55 to 64**	**Total**
Number	56	53	79	29	217
Percent	25.8%	24.4%	36.4%	13.4%	100%

Age	**19 to 34**	**35 to 64**	**Total**
Number	109	108	217
Percent	50.2%	49.8%	100%

Parental Status	**Parents**	**Non-Parents**	**Total**
Number	63	155	218
Percent	28.9%	71.1%	100%

Source: Urban Institute tabulations of the Census Bureau 2010 American Community Survey (ACS), published in: Genevieve M. Kenney, et. al., "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?," Urban Institute, August 2012.

The data show that parents account for only 29% of the target population, while 71% are adults without dependent children. Furthermore, the target population is relatively young, with half between the ages of 19 and 34.

The Urban Institute estimates that there are 217,000 uninsured Arkansans that will qualify for the Medicaid expansion. Of those, an estimated 167,000 (77%) are below the federal poverty level, while the remaining 50,000 individuals (23%) have incomes between 100% and 138% of the FPL. If the state does not expand Medicaid, those 50,000 individuals will instead qualify for either employer-sponsored coverage or federally subsidized exchange coverage. Table 2 shows the same demographic data for the subgroup with incomes below 100% FPL. Comparing the data in Table 1 with that in Table 2 shows that this subgroup is slightly younger, with an even larger proportion of non-parents.

Table 2

Arkansas Uninsured Adults Newly Eligible for Medicaid with Incomes Below 100% of FPL (Numbers in 1000's)

Age	**19 to 24**	**25 to 34**	**35 to 54**	**55 to 64**	**Total**
Number	46	40	57	24	167
Percent	27.5%	24.0%	34.1%	14.4%	100%

Age	**19 to 34**	**35 to 64**	**Total**
Number	86	81	167
Percent	51.5%	48.5%	100%

Parental Status	**Parents**	**Non-Parents**	**Total**
Number	43	124	167
Percent	25.7%	74.3%	100%

Source: Urban Institute tabulations of the Census Bureau 2010 American Community Survey (ACS), published in: Genevieve M. Kenney, et. al., "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?," Urban Institute, August 2012.

Given that the target population consists of non-disabled adults, their lower incomes are a reflection of lower pay rates (particularly among young adults entering the workforce) and less time spent working, as many in this population work less than full-time, full-year. Depending on the individual, a lower level of workforce participation is often the result of one or more of the following factors: full- or part-time enrollment in school, a local economy with limited opportunities for full-time employment, inadequate skills, behavioral problems, or poor motivation. Like their more affluent peers, low-income young adults tend to be in relatively good health, while those older than age 30 with low incomes are more likely to also have chronic health conditions or behavior health issues, such as substance abuse that affect their ability to work consistently.

This leads to the first consideration in assessing the Medicaid expansion. Is it the best solution for this target population? I do not believe that it is.

Medicaid starts from a basic premise that the populations it serves are vulnerable and dependent, with little if any ability to improve their circumstances on their own. That is certainly true for the 54% of Arkansas' current Medicaid enrollees that are poor children. It is also largely true for most of the 30% of the state's current enrollees that are aged, blind or disabled.

Flowing from the premise that the populations it serves are both vulnerable and dependent, Medicaid is therefore structured to cover an extensive range of benefits with no obligation on enrollees to either pay premiums or cost sharing. Indeed, even in cases where federal law permits states to charge some Medicaid enrollees cost-sharing, only nominal copays are permitted. Not surprisingly, those copays are typically not collected since they have no effect on enrollee behavior anyway.

In contrast, the expansion population consists of able-bodied adults, who are neither vulnerable, nor dependent, nor incapable of bettering their current circumstances. Indeed, nearly three-quarters of them do not have dependent children, meaning that while their incomes may be low, no one else depends on their income and they do not have any child rearing responsibilities that might affect their ability to work full-time.

Thus, any health care assistance provided to this population should incorporate strong incentives for both work and appropriate health system utilization, neither of which are features of the Medicaid program. A more appropriate health care assistance program for this population would include the following specific design features:

1) Any coverage should be subsidized on an income-related sliding scale, so as to avoid creating economic disincentives for work.

2) Assistance should be conditioned on a strong work requirement. Recipients should be required to be working, actively seeking work, or engaged in job preparation activities (including education), on a full-time basis. A recipient could satisfy the requirement by engaging in more than one of those activities, as appropriate to the individual's circumstances, provided that the total effort was normally 40 hours per week.

3) The coverage should be structured to emphasize the provision of primary care services.

4) Like private insurance, the coverage should include strong disincentives (such as significant copays) for inappropriate use of hospital emergency department services.

5) For those with chronic conditions such as diabetes, or behavioral health issues such as substance abuse, the program should offer disease management and behavior modification programs, accompanied by compliance monitoring and tangible rewards for successful participation.

Any state that agrees to cover this population through a Medicaid expansion, will find that federal Medicaid rules prevent the state from implementing some of these features, such as work requirements, and significantly limit the state's ability to implement others, such as more appropriate copay structures or rewards for behavior modification. Furthermore, any variances for this population from the standard coverage provided to existing Medicaid populations will require federal approval. The private option approach that Arkansas has proposed is no different in this regard, as can be seen from reviewing the "terms and conditions" set forth by the Federal Centers for Medicare and Medicaid Services (CMS) in response to Arkansas' waiver application.

The second consideration is how the Medicaid expansion interacts with other provisions of the PPACA, particularly with respect to young adults.

For instance, it is commonly assumed that because the PPACA requires employers to extend dependent coverage to children of their workers up to age 26, that most young adults will be covered on a parent's policy. However, under the PPACA, eligibility for Medicaid or exchange coverage subsidies is calculated based on tax code standards and definitions. Under the tax code, a young adult may be claimed as a dependent up to age 24 if the parent(s) provide 50 percent or more of the child's support. A young adult that does not meet those conditions is treated as a separate taxpayer, and thus his eligibility for Medicaid or exchange subsidies is based on only his own income (plus any spousal income, if married). Furthermore, there is no requirement that a young adult enroll in the health plan of a parent's employer, if that option is available.

Similarly, colleges and universities typically provide health plans to students. However, because several of the PPACA's new insurance rules will make that coverage much more expensive, many higher education institutions are considering dropping their student plans. That is much more likely to happen in states that expand Medicaid, thus enabling students, particularly graduate students who do not have access to coverage under a parent's policy, to obtain Medicaid coverage.

A third consideration is the "crowd out" effect that the Medicaid expansion will produce. That term refers to the fact that individuals in the expansion income range who currently have private coverage can be expected to drop that coverage and instead enroll in Medicaid. The limited data available indicates that in Arkansas the crowd out effect will likely add to the Medicaid expansion enrollment a further two to three percent of the total adult population with incomes below 138% of the FPL.

A fourth consideration is how the Medicaid expansion will affect economic mobility.

One of the arguments being offered in support of the Medicaid expansion is that by adopting the expansion a state will enable its large employers to not only avoid the cost of insuring their low-wage workers, but to also avoid the PPACA's fines on employers that don't provide coverage. That is because, under the PPACA, a large employer is fined for not providing coverage if one or more employees qualify for the exchange coverage subsidies, but not if those employees qualify for Medicaid.

Certainly employers have no desire to increase their costs by providing (expensive) coverage for their least productive workers or paying a fine of $2,000 per worker. As Table 3 shows, the fine alone would add $1.00 per hour in labor costs for each uncovered full-time worker—a 13.8 percent increase for a job paying the federal minimum wage of $7.25 an hour. Even for jobs paying $12 an hour, the fine would still represent a significant (8.3 percent) increase in labor costs.

Table 3

Effect on Labor Costs of the PPACA Fine on Large Employers That do Not Provide Coverage

Hourly Rate	Fine as percentage of base pay	Hourly Rate	Fine as percentage of base pay
$7.25	13.8%	$9.75	10.3%
$7.50	13.3%	$10.00	10.0%
$7.75	12.9%	$10.25	9.8%
$8.00	12.5%	$10.50	9.5%
$8.25	12.1%	$10.75	9.3%
$8.50	11.8%	$11.00	9.1%
$8.75	11.4%	$11.25	8.9%
$9.00	11.1%	$11.50	8.7%
$9.25	10.8%	$11.75	8.5%
$9.50	10.5%	$12.00	8.3%

Note: Economists define full-time full-year employment as 2,000 hours per year (40 hours per week times 50 weeks per year). Thus, a $2,000 per worker fine for not providing coverage is equivalent to a $1.00 per hour increase in labor costs.

Yet the problem with this argument is that it cuts both ways. While expanding Medicaid would relieve employers of the burden of providing coverage or paying fines, it would also give them a tremendous incentive to keep their lower-wage workers eligible for Medicaid by limiting their wage rates and hours worked. That would act as a powerful brake on economic mobility for lower-wage workers, particularly in the case to younger adults without dependent children. The trade off is that they would get "free" health coverage, but at the price of accepting limited, stagnant incomes.

The implications of this effect can be seen it Table 4, which shows, for various pay rates, the maximum number of hours individuals can work and still avoid losing Medicaid

eligibility, and thus, also avoid triggering fines on their employers for not providing coverage.

Table 4

Single Individual With Medicaid Expansion
Maximum Hours to Stay Below 138% FPL

Hourly Rate	Annual	Weekly (50 wks/yr)
$7.25	2,221	44
$7.50	2,147	43
$7.75	2,078	42
$8.00	2,013	40
$8.25	1,952	39
$8.50	1,895	38
$8.75	1,841	37
$9.00	1,789	36
$9.25	1,741	35
$9.50	1,695	34
$9.75	1,652	33
$10.00	1,610	32
$10.25	1,571	31
$10.50	1,534	31
$10.75	1,498	30
$11.00	1,464	29

Thus, the effect of the Medicaid expansion will be to function as a large, in-kind welfare benefit for able-bodied, childless, young adults. They will be able to get and keep that free health care as long as they don't earn too much—a situation that their employers will also have a strong incentive to arrange for them.

Of course, a higher income is always better than a lower one. Yet, a childless, twenty-something with a low-wage job, doesn't have to spend anything he earns on anyone other than himself. If keeping free Medicaid coverage means working a few less hours—and having a bit more time off—he may not view that as a particularly bad trade-off.

Not only will these perverse incentives produce higher than projected Medicaid enrollment over time, they will also serve to increase the number of underemployed young adults. Indeed, higher rates of unemployment and underemployment among young adults have become permanent economic features of countries that provide able-bodied adults with taxpayer financed social-welfare benefits.

Of course, another result of this income suppression dynamic is that lower earnings produce a reduction in economic activity and an associated reduction in government revenues from income and sales taxes.

However, it is important for state policymakers to note that viewing this dynamic in reverse suggests solutions that will have the opposite effect. As mentioned, if Arkansas does not expand Medicaid, almost one-quarter of the expansion population will instead qualify for either employer-sponsored coverage or federally subsidized exchange coverage. The other three-quarters of this population have incomes below 100% of the FPL, and thus will not qualify for subsidized exchange coverage. However, if individuals in this second group increase the hours they work such that their incomes exceed100% of the FPL, then they too will qualify for either employer-sponsored coverage or federally subsidized exchange coverage.

Table 5 illustrates this effect by showing, for various pay rates, the minimum number of hours individuals must work in order to have incomes above 100% of the FPL.

Table 5

Single Individual Without Medicaid Expansion
Minimum Hours to Stay Above 100% FPL

Hourly Rate	Annual	Weekly (50 wks/yr)
$7.25	1,610	32
$7.50	1,556	31
$7.75	1,506	30
$8.00	1,459	29
$8.25	1,415	28
$8.50	1,373	27
$8.75	1,334	27
$9.00	1,297	26
$9.25	1,262	25
$9.50	1,228	25
$9.75	1,197	24
$10.00	1,167	23
$10.25	1,139	23
$10.50	1,111	22
$10.75	1,086	22
$11.00	1,061	21

The implication of this analysis is that, because of the design of the PPACA, any changes to public policies that increase employment and hours worked among the target

population will have the effect of reducing the number of able-bodied adults who would still lack health care coverage if a state does not expand Medicaid.

In sum, the lack of health coverage among this population is principally an effect of their lower earnings, which, in turn, is mainly the result of their lower rates of workforce participation.

Madam Chairman, this concludes my prepared testimony. Thank you for this opportunity and I will be happy to answer any questions you or the other members may have.

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