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THE EVER CHANGING MEDICAID

by Cagdas Agirdas, Ph.D.

Since its foundation in 1965, Medicaid has changed significantly. Today, Medicaid is the largest health insurance program in the U.S., covering over 62 million Americans, more than Medicare or any single private insurer. The Affordable Care Act (ACA) will further expand Medicaid to include 17 million new people by 2022, if all states implement the Medicaid expansion. This article outlines the changes in Medicaid since 1965, discusses the strengths and weaknesses of the program, and provides an overview of the debate on whether states should accept Medicaid expansions under the ACA.

President Franklin D. Roosevelt wanted to include health insurance in the draft of the Social Security proposal, but due to a concern that it would jeopardize the entire bill, the President's Committee on Economic Security opted against it. President Roosevelt signed the Social Security Act as part of his Second New Deal in 1935. Later, President Truman attempted unsuccessfully to integrate a health insurance amendment into his Fair Deal program.

When Lyndon B. Johnson won a landslide victory in 1964, controlling both chambers of Congress, health insurance reform was the first bill introduced. President Johnson signed two amendments to the Social Security Act on July 30, 1965: Titles XIII and XIX, founding Medicare and Medicaid respectively. Wilbur Cohen, who helped craft the bill, wrote: "Many people, since 1965, have called Medicaid the 'sleeper' in the legislation. Most people did not pay attention to that part of the bill…[It] was not a secret, but neither the press nor the health policy community paid any attention to it". Despite receiving less attention than Medicare in 1965, Medicaid has had more enrollees than Medicare since 2002.

A quick recap of the key changes to Medicaid since 1965 is relevant. Medicaid was initially a health insurance program for poor Americans who were also eligible for public cash assistance. It was optional for states to participate in Medicaid. Indeed, it took another 17 years, until 1982, for all states to join the program. Unlike Medicare, Medicaid provides considerable flexibility to states in setting their own standards of eligibility, determining the benefits and establishing the rate of payment for services. States administer their own Medicaid programs within broad national guidelines.

Since 1965, three major changes have transformed Medicaid. First, during the late 1980s and early 1990s, Congress passed a series of bills to expand Medicaid. Specifically, it relaxed income thresholds and/or age restrictions to extend coverage to more children and pregnant women. Between 1987 and 1992, the number of eligible pregnant women more than doubled, while at least 50 percent more children became eligible.

The second major change came in 1996, when reform of the welfare program severed the link between public cash assistance and Medicaid. States could provide Medicaid to groups who were not eligible for cash assistance, which also meant that losing cash assistance did no longer translate into losing Medicaid coverage.

Finally, in the early 2000s, several states opted to extend Medicaid to low-income childless adults. As of January 2013, eight states and the District of Columbia continued to provide full Medicaid benefits to low-income childless adults. These changes, along with many other minor changes, have transformed Medicaid into its current status today.

Where is Medicaid today? Although Medicaid is perceived as an insurance program for the poor, more than 50 percent of poor uninsured adults were not eligible before 2014. Besides low income, federal guidelines required that a person had to fit in one of the following categories: 1) children under age 18; 2) parents with dependent children; 3) pregnant; 4) elderly; 5) blind; or, 6) disabled. Figure 1.1 presents the share of each category.

Almost half of Medicaid beneficiaries are children. Low-income parents and their children constitute about two-thirds of Medicaid enrollees. Overall, Medicaid covers more than 1 in 3 children in the U.S. and over 40 percent of births. To be eligible, federal guidelines required that pregnant women and children under age six to have an income below 133 percent of the Federal Poverty Level (FPL). For children between ages six and 18, their parents had to have income below 100 percent of FPL—the FPL in 2014: $11,670 for a person, $23,850 for a family of 4.

Medicaid has several other roles in our health care system. First, it covers more than six out of 10 nursing home residents, each costing more than $60,000 per year, an expense not covered by Medicare. In addition, Medicaid serves as the largest payer of medical care for

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people with HIV. Almost half of people with HIV receive their care and costly prescription drugs through Medicaid. Another role that Medicaid plays is related to the uncompensated care for the uninsured. In 2012, 48 million people were uninsured in the U.S.—15.4 percent of the population. The cost of uncompensated care for the uninsured has long been a problem for hospitals and other health-care providers. Medicaid not only finances more than one third of the uncompensated care in safety-net hospitals, but also is the source of over one third of community health centers' revenues. Finally, Medicaid is the second largest provider of funding for graduate medical education, contributing to faculty salaries, resident stipends and administrative expenses.

One of the main concerns about Medicaid is its cost. Medicaid costs almost $450 billion in fiscal year 2013, jointly paid by federal and state governments. The federal government pays between 50 percent and 83 percent of the cost, varying inversely with state per capita income. For the average state, the federal government pays 57 percent of the cost of Medicaid. Therefore, Medicaid is the second largest item in state budgets, after education. Figure 1.1 displays the enrollment distribution. Figure 1.2 displays the breakdown of this cost by eligibility category. Blind, disabled and elderly citizens constitute 25 percent of Medicaid enrollees, but they account for 64 percent of the cost of Medicaid.

Medicaid's cost has significantly increased since 1965 (see Figure 1.3). Based on the data, this increase can be attributed to more people becoming eligible over the years, rather than an increase in Medicaid costs per participant. Figure 1.4 shows that it is about 20 percent cheaper to insure an adult through Medicaid than private insurance. This cost efficiency of Medicaid over private insurance stems from two facts:

- Administrative costs for Medicaid are significantly lower than private insurance.
- Medicaid limits payments to health care providers more than private insurance or Medicare does.

While reducing the cost of Medicaid per enrollee, these cost efficiencies lead to a weakness: 31 percent of physicians do not accept Medicaid patients due to low reimbursement rates, as reported by Sandra Decker of the National Center for Health Statistics, as opposed to a 19 percent and 18 percent physician denial rate of patients carrying private insurance and Medicare, respectively.

Medicaid might also affect labor market outcomes, as individuals would have an incentive to quit their jobs or reduce their hours in order to stay below Medicaid's income threshold. Gruber and Madrian (2002) survey over 50 studies on this topic. They concluded that health insurance is not a central determinant of the labor supply of low-income mothers. However, research on the labor supply behavior of childless adults led to mixed results. In 2008, Oregon used a lottery to expand Medicaid to 10,000 randomly selected childless adults. Baicker et al. (2013) find that labor supply behavior of these adults, or their earnings, did not significantly change after gaining health insurance through Medicaid. They also found that Medicaid increased receipt of food stamps. On the other hand, Tennessee dropped 170,000 adults from Medicaid in 2005. Garthwaite et al. (2013) found that Tennessee disenrollment resulted in an immediate increase in employment and job search behavior for the adults who lost Medicaid.

Similarly, the results on the effects of Medicaid on health outcomes are mixed. Arizona, Maine and New York were three of the states that expanded Medicaid in the early 2000s to cover low-income childless adults. Using these three states, researchers at the Harvard School of Public Health published a study in the Sept. 13, 2012 print issue of the New England Journal of Medicine. They found that Medicaid saved lives: mortality rate was down by 6.1 percent in those three states compared to the neighboring states that did not expand Medicaid.

Baicker et al. (2013) analyzed the Oregon's 2008 lottery to expand Medicaid. They found Medicaid coverage significantly increased the use of many preventative services, nearly eliminated catastrophic out-of-pocket medical expenditures, increased the probability of diagnosis of diabetes and decreased the probability of positive screening for depression. However, the same study found that Medicaid had no significant effect on the prevalence or diagnosis of hypertension, high cholesterol levels or average glycated hemoglobin levels within two years.

Effective in January 2014, ACA eliminated the traditional eligibility categories and expanded Medicaid to all Americans whose family income is at or below 138 percent of the FPL. The federal government pays 100 percent of the cost of this expansion in 2014-2016, and at least 90 percent of the cost afterwards. On June 28, 2012, the U.S. Supreme Court issued its decision in the case challenging the

Figure 1.1: Enrollment in Medicaid
Source: Congressional Budget Office

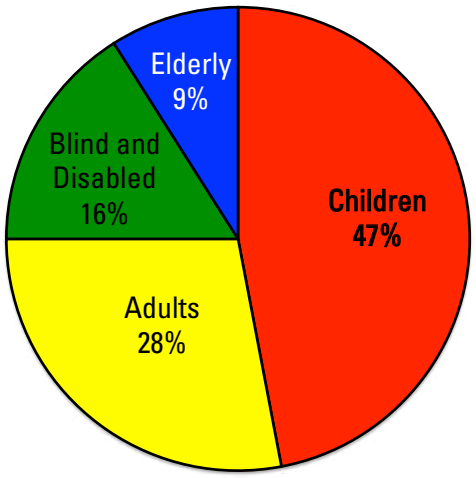


Figure 1.2: Spending in Medicaid
Source: Congressional Budget Office

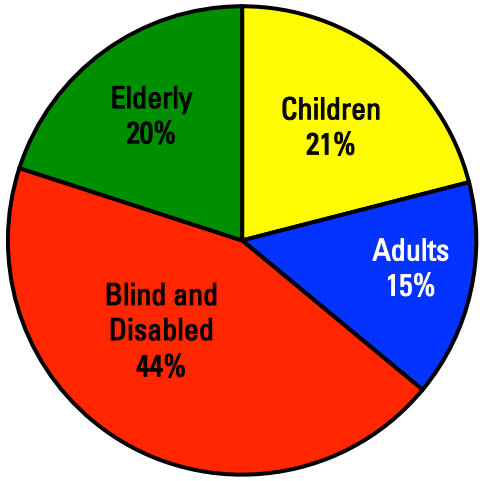


Figure 1.3: Medicaid Spending Over Time ($ Billions)
Source: Centers for Medicare and Medicaid Services

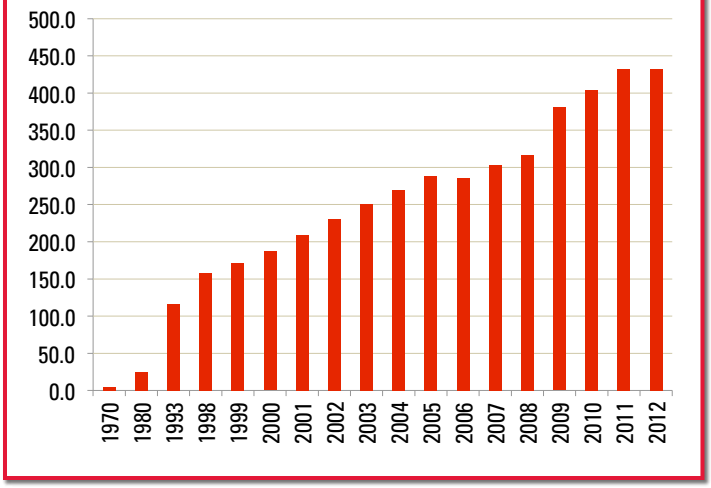
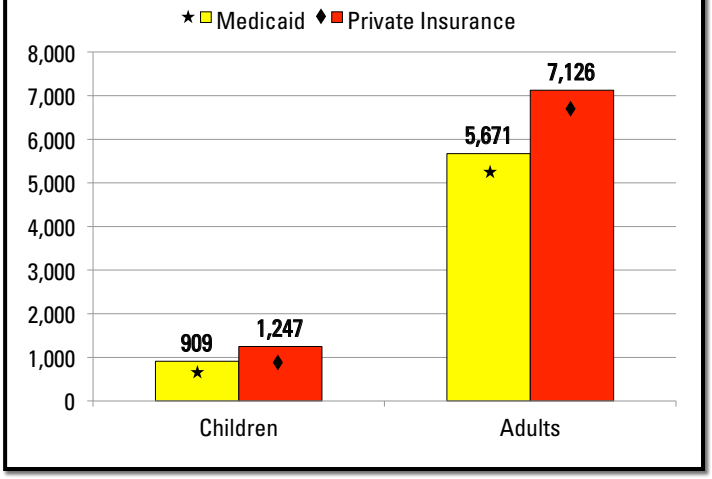


Figure 1.4: Per Capita Costs of Medicaid and Private Insurance
Source: Center on Budget and Policy Priorities
Note: Adjustment made for enrollees' health differences



constitutionality of the Affordable Care Act, National Federation of Independent Business (NFIB) v. Sebelius. This decision effectively made the Medicaid expansion optional for the states. As of Feb. 7, 2014, 25 states and the District of Columbia chose to expand Medicaid, while 25 others did not. The states that are not expanding Medicaid in 2014 still have the option to do so in the future, but 100 percent federal funding ends in 2016. In order to understand the debate in many states on whether to expand Medicaid, a discussion of states' incentives is relevant.

From the perspective of health care providers, Medicaid expansion reduces their cost for uncompensated care. The uninsured receive health care either at emergency rooms or safety net hospitals. Their uncompensated care creates externalities on the insured, as providers and insurance companies raise treatment costs and insurance premiums to recover some of the cost for uncompensated care. When more of the uninsured become eligible for Medicaid, providers are expected to have lower uncompensated costs.

A second incentive for expanding Medicaid is the federal government's high matching rate. Since the federal government will bear nearly 93 percent of the cost of Medicaid expansions between 2014 and 2022, the additional cost to state budgets is expected to be minimal. The Congressional Budget Office (CBO), Urban Institute and The Lewin Group have estimated the additional cost to the states of expanding Medicaid to be at 2.8 percent, 1.4 percent and 1.1 percent, respectively.

Proponents of the Medicaid expansions argue that insuring millions of poor and uninsured residents with such minimal additional costs is in the interest of the states. Even if a state rejects the Medicaid expansion, its taxpayers still have to contribute to Medicaid expansions in other states. Finally, ACA provides generous subsidies for people with incomes between 100 percent and 400 percent of the FPL to buy insurance from online insurance marketplaces. When a state does not expand Medicaid, many people with incomes below 100 percent of the FPL either remain uninsured or purchase insurance without subsidies, while people with incomes above 138 percent qualify for generous subsidies.

Opponents of the Medicaid expansions argue that the federal government will have to reduce its contribution to the cost of Medicaid expansions in the future, due to high national debt and entitlement spending. States that expanded Medicaid are likely to be left with a higher share of the cost than expected. Citing increased costs in her state budget, Gov. Nikki Haley (R-SC) said: "We will not expand Medicaid on President Obama's watch. We will not expand Medicaid ever." In addition, opponents argue that the national debt will only increase as more states expand Medicaid, since the federal government pays for most of its cost. Finally, opponents point out that the health outcomes of new Medicaid enrollees in Oregon did not improve compared to those who remained uninsured, after Oregon's lottery to expand Medicaid in 2008.

According to the U.S. Census Bureau, Florida has the fourth highest share of uninsured residents among 50 states, following Texas, Nevada and New Mexico. 21.5 percent of Floridians are uninsured, while Miami-Fort Lauderdale-Pompano Beach metropolitan area, with 25.7 percent, has the highest share of uninsured residents among all metropolitan areas across the nation. ACA's Medicaid expansion was expected to cover 1.3 million of the 3.7 million uninsured Floridians. Gov. Rick Scott (R) embraced the Medicaid expansion in February 2013: "While the federal government is committed to paying 100 percent of the costs, I cannot deny Floridians who need access to health care." However, the Florida Legislature did not include it in the state budget in May 2013. Therefore, Florida is one of the 25 states that will not expand Medicaid.

Medicaid, the nation's largest insurance program, is in transformation once again. Its success will depend on the market responses to the Medicaid expansions. As Medicaid is extended, uncompensated care costs are expected to go down, while the cost to the federal government of insuring more people is expected to increase. To make this transition easier, some cost sharing from Medicaid enrollees can be used to increase the reimbursement rates for physicians who accept them. As the ACA continues to be implemented in the following years, the heated debate surrounding it and its Medicaid expansions is likely to continue. The success of this transformation in the health care market is also likely to affect political outcomes in the 2014 midterm elections and beyond.

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THE TAMPA BAY ECONOMY: APRIL UPDATE

by Brian T. Kench, Ph.D.

The Tampa Bay metropolitan statistical area's (Hernando, Hillsborough, Pasco and Pinellas counties) recovery from the Great Recession continues to move forward. Gross sales are growing, employment is expanding and unemployment is declining. Existing home price appreciation continues, but the pace of new home permits has slowed since May 2013.

Gross sales in Tampa Bay totaled $8.97 billion in January 2014, a 2.8 percent increase from January 2013 (see Figure 2.1). The year-on-year change in gross sales averaged 7.6 percent per month for 2013, which is faster than the 2012 average by 2.5 percentage points. Since March 2010, the year-on-year change in gross sales has averaged 6.6 percent per month.

Figure 2.2 illustrates Tampa Bay's job loss duration because of the Great Recession and the last two U.S. recessions. As of February 2014, six years and two months have passed since the recession began in December 2007 and the area remains net negative 37,200 jobs, which is three percent of the employment level observed in December 2007.

The year-on-year percent change in nonfarm payroll jobs for Florida, Tampa and the U.S. are shown in Figure 2.3. As of October 2010, Tampa's year-on-year job growth turned positive. Relative to a year earlier, February 2014 nonfarm payroll jobs increased 2.5 percent in Tampa Bay and 2.8 percent in Florida.

The unemployment rate measures the ratio of those unemployed and looking for work divided to the labor force. In Tampa Bay and Florida, the unemployment rate (NSA) was 6.5 percent in February 2014, which was lower than the national unemployment rate (SA) by 0.2 percent and higher than the unemployment rate (NSA) for the state of Florida by 0.3 percent. Despite its elevated level, the Tampa Bay unemployment rate fell in February 2014 relative to February 2013 by 1.4 percent. In February 2014, the unemployment rate (NSA) was 8.6 percent in Hernando County, 6.3 percent in Hillsborough County, 7.3 percent in Pasco County and 6.3 percent in Pinellas County.

Figure 2.4 reports Tampa Bay's 2013 employment shares by sector relative to the U.S. Higher ratios indicate the sectors in which Tampa Bay specializes. The analysis neutralizes common macroeconomic events in the dataset by comparing local sector shares relative to national sector shares. The analysis reveals that the top sectors in Tampa Bay are: insurance; wired telecom; banks; other telecom; real estate; amusements, gambling and recreation; professional and business services; and ambulatory care.

The S&P's Case-Shiller housing price index (HPI) for Tampa Bay is based on

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Figure 2.1: Gross Sales in Tampa Bay: January 2007 – January 2014
Source: Florida Department of Revenue

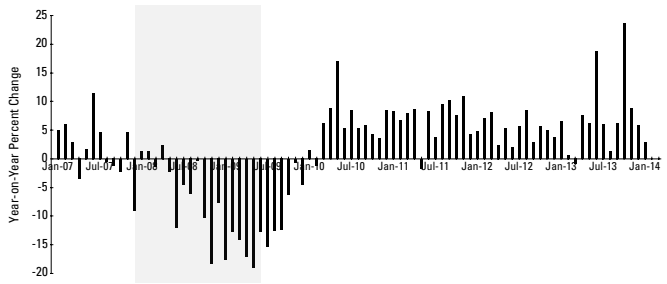


Figure 2.2: Duration of Job Loss in Tampa Bay
Source: Bureau of Labor Statistics

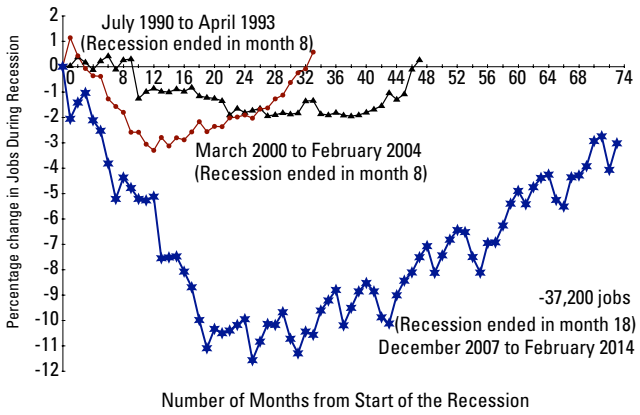


Figure 2.3: Nonfarm Payroll Jobs: January 2000 – March 2014
Source: Bureau of Labor Statistics

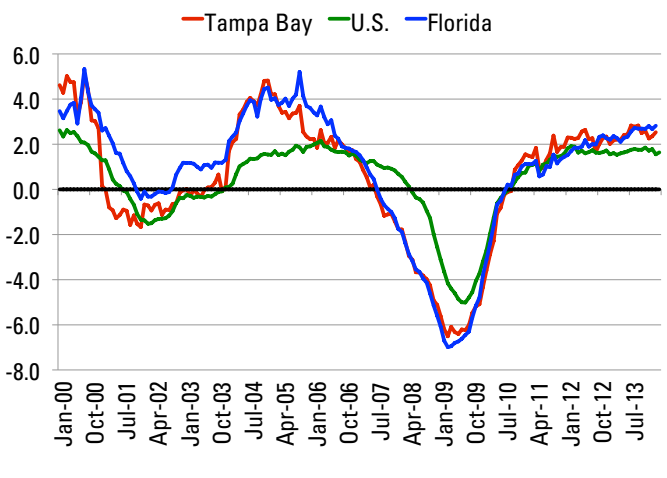
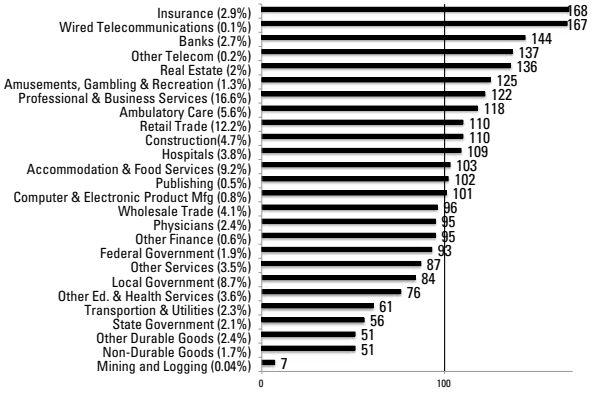


Figure 2.4: Tampa Bay Employment Share by Sector: 2013
Source: Bureau of Labor Statistics
Note: Sector share of Tampa Bay's labor market in parentheses.



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observed changes in home prices in the area. Figure 2.5 shows the high, middle and low tier HPI segments of the Tampa Bay housing market. The top third of Tampa Bay's housing market—the high tier segment—reached a maximum value of 225.96 in May 2006. The high tier declined 43.1 percent over more than five years to reach a low HPI value of 128.73 in September 2011. As of January 2014, this segment of the Tampa Bay housing market has increased nearly 25 percent from its low point. The middle third of Tampa Bay's housing market—the middle tier segment—reached a maximum value of 244.56 in June 2006. The middle tier declined 52.3 percent over more than five years to reach a low HPI value of 116.7 in November 2011. As of January 2014, this segment of the Tampa Bay housing market has increased 29 percent from its low point. The bottom third of Tampa Bay's housing market—the low tier segment—reached a maximum value of 279.07 in July 2006. The low tier declined 63.2 percent to reach a low HPI value of 102.93 in December 2011. As of January 2014, this segment of the Tampa Bay housing market has increased 40 percent from its low point.

Figure 2.6 shows the absolute number of privately owned one-unit residential permits for new homes in the Tampa Bay area. In May 2013, new permits totaled 882—a level not observed since November 2006. However, the rate of growth in new permits slowed in the subsequent months as the Federal Reserve announced and then began the tapering of its stimulative bond-buying program. As of February 2014, new permits totaled 457.

The Price-Rent Index (PRI) for Tampa Bay measures the price of area homes relative to their implicit rental value. The price component of the PRI is the S&P's Case-Shiller HPI for Tampa Bay. The rent component of the PRI is the owner's equivalent rent index (OWRI) for Tampa Bay, published by the Bureau of Labor Statistics. Each series is adjusted to one in 1987 and the PRI computes the HPI/OWRI ratio. A PRI greater than one means home prices are high relative to rents in Tampa Bay, while a PRI less than one means that home prices are low relative to rents in the Tampa Bay. Figure 2.7 informs the reader that from 2003 to 2007 home prices were high relative to rents. During the Great Recession, the PRI declined dramatically. By the end of 2011, the price-rent ratio reached a level not seen over the period of study. The 2013 PRI reveals that in Tampa Bay an individual could purchase a home and maintain a monthly payment for 89 percent of the cost required to rent the same home.

In summary, recent data continue to point in a very positive direction. Gross sales in Tampa Bay continue to grow on a year-on-year basis. The area is adding nonfarm payroll jobs—the year-on-year change in nonfarm payroll jobs has been positive since October 2010. Area unemployment rates are falling. And on net, the housing market continues to strengthen, despite headwinds from the Federal Reserve.

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Figure 2.5: Case-Shiller HPI: 1987 – 2014
Source: St. Louis Federal Reserve

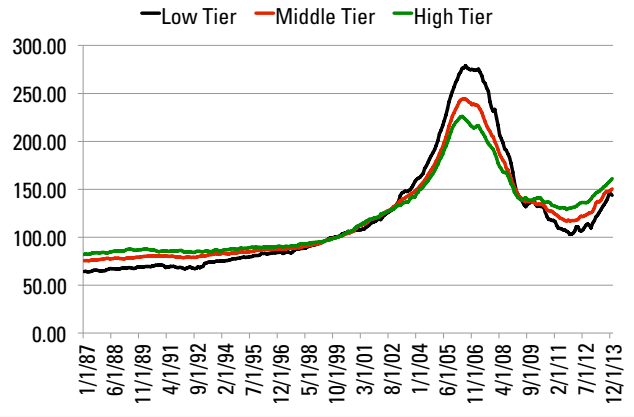


Figure 2.6: Number Residential Building Permits: January 1990 – February 2014
Source: U.S. Department of Housing and Urban Development

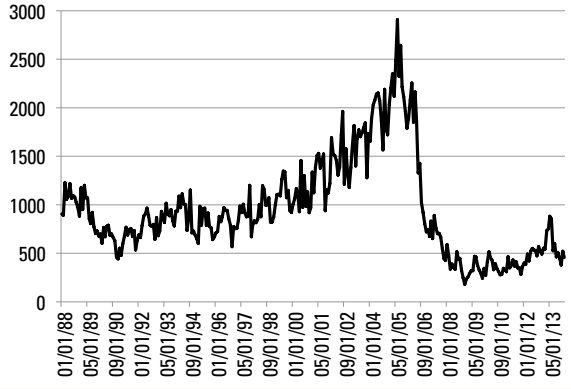
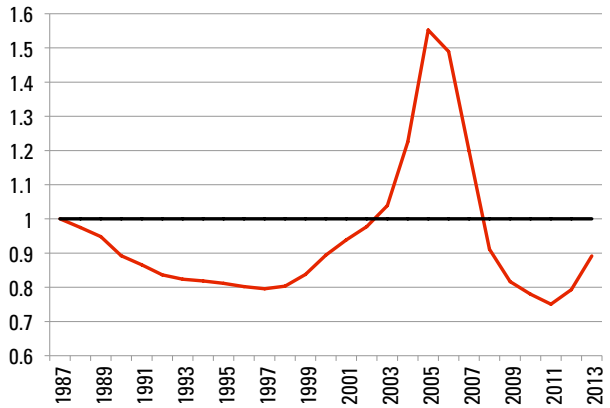


Figure 2.7: Tampa Bay's Price-Rent Ratio: 1987-2013
Sources: St. Louis Federal Reserve, Bureau of Labor and personal calculations



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