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LEGISLATIVE MEMO

SB 6272 - Increasing payments to primary care providers under Medicaid

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Key Findings

1. **Currently, 1.8 million people or nearly 25 percent of the Washington state population, are enrolled in the Medicaid federal entitlement for the poor.**

2. **Doctors and other providers have a difficult time paying their financial overhead with the low payment rates in the Medicaid program and consequently they frequently limit the number of Medicaid patients they will treat.**

3. **SB 6272 would increase provider payment rates in the Medicaid program to equal those of Medicare, the government health insurance entitlement plan for seniors.**

4. **State lawmakers unfortunately are caught in a vicious cycle in which the more they spend on Medicaid, the more money they receive from the federal government because of matching funds.**

5. **From a policy standpoint, the distinction between federal money and state money is misleading, because Washington state taxpayers are also federal taxpayers.**

6. **Simply increasing provider payments would not reform Medicaid in a meaningful and sustainable way.**

Introduction

Currently, 1.8 million people, or nearly 25 percent of the Washington state population, are enrolled in the Medicaid federal entitlement for the poor.[1] Depending on the medical specialty, the health insurance plan reimburses providers only 40 to 60 percent of what private insurance pays and 70 to 80 percent of what Medicare pays.[2] Doctors and other providers have a difficult time paying their financial overhead with these low payment rates and consequently they frequently limit the number of Medicaid patients they will treat.

In many cases doctors lose money on every Medicaid patient they see. For that reason, access to health care for Medicaid patients is a growing problem nationally and in Washington state.

A proposed bill, SB 6272, would increase provider payment rates in the Medicaid program to equal those of Medicare, the government health insurance entitlement plan for seniors.[3]

Background

The Medicaid entitlement program began in 1965 as a safety-net health insurance plan for poor families with children.[4] The traditional plan is paid for by both federal and state taxpayers on a 50/50 funding-match basis. In the past 50 years, Medicaid has enlarged dramatically and is now one of the top three budget items for every state. In Washington state it is the second

1 "Enrollment figures for the Medicaid program," Washington State Health Care Authority at http://www.hca.wa.gov/medicaid/reports/pages/enrollmentfigures.aspx

2 "Doctors face a huge Medicare and Medicaid pay cut in 2015," by M. Matthews, Forbes.com, January 5, 2015 at http://www.forbes.com/sites/merrillmatthews/2015/01/05/doctors-face-a-huge-medicare-and-medicaid-pay-cut-in-2015/#2715e4857a0b72cc4d5c6dc3

3 "Concerning the reimbursement rate primary care providers receive to participate in Medicaid," Washington State Legislature at http://apps.leg.wa.gov/billinfo/summary.aspx?bill=6272&year=2015

4 "Medicare and Medicaid at fifty," by R. Stark, Policy Note, Washington Policy Center, September 3, 2015 at http://apps.leg.wa.gov/billinfo/summary.aspx?bill=6272&year=2015

most expensive public program behind K-12 education.

The federal Affordable Care Act (ACA), or Obamacare, expanded Medicaid to include any low-income adult age 18 or older, with the federal government ultimately paying 90 percent of the new costs. The United States Supreme Court ruled that states could decide on their own whether or not to expand Medicaid under the ACA. In perhaps a first for federal entitlement programs, many states chose not to join in the expanded Medicaid.

In 2013, legislators and the governor in Washington state decided to accept the ACA's expanded Medicaid program. A formal vote was not taken, however. Instead, the entitlement expansion was placed as a line-item in both the 2013-2015 and the 2015-2017 state budgets and was approved by both Democrats and Republicans.

Physician participation in Medicaid is voluntary, and doctor reimbursement under the program has always been lower than that of any other payer, including Medicare. Consequently, an increasing number of physicians are withdrawing from the program, thus decreasing beneficiaries' access to health care by limiting their physician choices.

The cost of Medicaid was $1 billion in its first year, exploding to $476 billion nationally, and $10.4 billion in Washington state in 2014.[5] At the present rate of growth, the program's total cost is projected to be $900 billion by 2019.

Proposed bill SB 6272

SB 6272 is a simple bill. It would require that Medicaid reimbursement payments to primary care providers in Washington state would be the same as Medicare payments. Primary care providers are typically family doctors and internal medicine specialists. The goal of the legislation is to increase access to health care for Medicaid enrollees by financially encouraging more providers to access Medicaid patients.

The funding mechanism relies heavily on the federal government. For the 2015-2017 biennium, the total cost of SB 6272 is projected to be $133 million, with the state paying $38 million, or 28 percent. By the 2019-2020 biennium, the percent of state contribution stays the same, but the total cost increases to $309 million and the state's shares increases to $89 million. It is not clear that the federal government will pay this extra money.

Policy analysis

Since its inception in 1965, the Medicaid entitlement has resulted in a number of harmful consequences. First, it discourages work and job improvement for low-paid employees, since with increasing income workers lose their Medicaid benefits. It also encourages low-wage paying employers to not offer health benefits. They assume taxpayers will provide those benefits. Medicaid also discourages private insurance companies from offering nursing-home policies, and this market shrinks farther every year.

The real tragedy for people in Medicaid is that studies show the program provides no better medical outcomes than having no insurance. In 2008, Oregon lawmakers decided they had enough additional public money to put 10,000 more people on the state's Medicaid program. Oregon officials held a lottery that ultimately signed up 6,400 new Medicaid enrollees. A further 5,800 people were eligible for the program, but were not selected. People in the non-select group had the same health and economic profiles as the lottery winners, allowing researchers to make valid comparisons. This created the perfect test-case on the effectiveness of Medicaid in providing care. These 5,800 people became the control group in an objective, randomized health care study.[6]

It turns out that having Medicaid coverage does not improve health outcomes, nor does it decrease the number of emergency room visits. The Medicaid group had no improvement in the important objective measurements of blood sugar levels, blood pressure, and cholesterol levels. The study did find that vaguely-defined "mental health" was improved, however this was assessed through subjective telephone interviews, not by objective clinical data. For those few people requiring prolonged medical and hospital treatment, Medicaid did improve

5 "Total Medicaid spending," State Health Facts, The Henry J. Kaiser Family Foundation at http://kff.org/medicaid/state-indicator/total-medicaid-spending/

6 "The Oregon experiment-Effects of Medicaid on clinical outcomes," by K. Bailer, et.al., *New England Journal of Medicine*, May 2, 2013 at http://www.nejm.org/doi/full/10.1056/NEJMsa1212321

the financial status of those patients, because their medical bills were covered by federal and Oregon taxpayers. Medicaid is designed to distribute benefits for free, and by that standard it succeeded.

State lawmakers unfortunately are caught in a vicious cycle in which the more they spend on traditional Medicaid, the more money they receive from the federal government because of the 50/50 match. The ACA requires the federal government to pay for the entire Medicaid expansion for the first three years, 2014 through 2016. Then states will pay 10 percent of the expansion cost. Given these incentives, it is no surprise that Medicaid is the largest and fastest growing budget item for almost all states in the country. SB 6272 adds significantly to the overall cost of Medicaid and relies heavily on the federal government increasing its contribution to Washington state's entitlement.

From a policy standpoint, the distinction between federal money and state money is misleading, because Washington state taxpayers are also federal taxpayers. There is no safety-deposit box of federal money designated for Medicaid. The program is a pay-as-you-go entitlement funded by today's taxpayers.

At the same time, the federal government is running unsustainable budget deficits and has an enormous national debt. The increasing costs of Medicaid are unsustainable. It is hopeful, and perhaps naïve, to assume the federal government will continue to pay 90 percent of the Medicaid expansion costs. Medicaid has traditionally been a federal and state partnership. It is likely the federal government will eventually shift a greater share of the financial burden to the states to pay for the expanded Medicaid program.

The ACA temporarily increased primary care provider payments in the Medicaid program in 2014 and 2015. These increases were all paid for by federal taxpayers. There was no provision to continue the increases beyond 2015 and payment rates have dropped back to their pre-2014 level.

Although SB 6272 would tie Medicaid reimbursement rates to those of the federal Medicare program, the reality is that Medicare payments have been decreasing for at least the past 20 years. Senior citizens in the Medicare program are finding it increasingly difficult to access health care because doctors can't pay their overhead costs with the government's poor payments rates. It is also a distinct possibility that the federal government will reduce Medicare rates to the existing Medicaid rates. If passed, SB 6272 would have no substantial effect on improving health care access for Medicaid patients in Washington state.

It is also important to note that the legislature itself chose to expand Medicaid in Washington state, essentially ignoring the access to health care problem of the enrollees. The state portion of funding for SB 6272 is now scheduled to come from the state general fund, so Washington state taxpayers will bear the burden of this additional cost.

Ways to improve the Medicaid program

Simply increasing provider payments would not reform Medicaid in a meaningful and sustainable way. Plus, it can only be assumed that state taxpayers would be forced to pay for the increase in spending above what is already budgeted in SB 6272.

The most important first step to reforming the Medicaid program is to redesign it so it no longer functions as an unsustainable, open-ended entitlement. Welfare reform in the late 1990s succeeded because it placed limits on how many years people could expect to receive taxpayer support. Similarly, Medicaid recipients should have a co-pay requirement based on income and ability to pay.

Where applicable, Medicaid enrollees should have a work requirement. Like welfare, Medicaid should be viewed not as a permanent lifestyle, but as a transition program to help low-income families achieve self-confidence, economic independence and full self-sufficiency.

It is condescending to believe poor families cannot manage their own health care. Allowing them to control their own health care dollars through subsidized health savings accounts (HSAs) or premium support vouchers would financially reward enrollees for leading a healthy lifestyle and making smart personal choices. It would also show respect for low-income families, allowing them to be treated equally with others in the community, regardless of economic status. It would also help primary care providers establish reimbursement rates that would allow them to pay their financial overhead.

Local control of the management and financing of entitlement programs works best. States, rather than the federal government, should be placed in charge of administering Medicaid. Block grants and waivers from the federal government would allow states to experiment with program designs that work best for their residents and to budget for Medicaid spending more efficiently. Our state legislators should work to convince the federal government, as Governor Gregoire tried, to relinquish control of the Medicaid program so it could be better managed to the benefit of enrollees.

The income requirement for this entitlement should be returned to 133 percent of the federal poverty level. Medicaid should not distribute public subsidies to middle-income people and thereby make them dependent on a tax-subsidized government entitlement program for their health care.

Medicaid needs comprehensive reform, but unfortunately, SB 6272 would only compound the enormous problems currently facing the entitlement program.

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