WebMemo
Published by The Heritage Foundation

No. 3031
October 4, 2010

Obamacare's Medicaid Policy: Putting the Doctors in Another "Fix"

Brian Blase

Obamacare increases enrollment in the troubled Medicaid program by over 20 million persons. However, providers are already limiting the amount of Medicaid patients they accept because of low payment rates. To entice providers to accept more Medicaid recipients, Obamacare requires that states—with federal dollars—raise primary care physician (PCP) payment rates for Medicaid to parity with Medicare rates for 2013 and 2014.

Based on estimates from the Congressional Budget Office (CBO) and the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), the 10-year cost of raising PCP rates to Medicare levels would be between $37 billion and $68 billion. The Heritage Foundation estimates that the 10-year cost could rise to $350 billion if state reimbursement rates were to rise proportionally for all physician and clinical services.[1]

These Obamacare provisions raise potent issues for providers and policymakers: Will states raise provider rates across the board to match the PCP increase? What actions will states take when the federal funding expires and how will those actions impact doctors? Will Congress adopt a different model for Medicare payment rates than the current one, which requires temporary fixes about once a year?

Medicaid's Numerous Problems. Medicaid—the joint federal–state health insurance program for numerous categories of the poor—has significant problems. Medicaid spending growth is unsustainable, increasing over 6 percent annually (in inflation-adjusted dollars) during the past two decades.[2] Medicaid growth has resulted in three federal bailouts in the past decade, and its growth is crowding out other state priorities, such as education, transportation, and law enforcement.

At the same time, several states reimburse providers at extremely low rates. This causes many providers to refuse to treat Medicaid patients, effectively forcing Medicaid recipients to use emergency rooms for basic care. According to the Texas Health and Human Services Commission, less than a third of the state's practicing doctors are active in Medicaid.[3]

Furthermore, Medicaid recipients likely receive a lower quality of care than privately insured patients and perhaps even the uninsured. For example, a study of nearly 900,000 major surgeries in the U.S. found that patients on Medicaid were 13 percent more likely to suffer in-hospital mortality than uninsured individuals, controlling for a plethora of factors.[4]

Obamacare Substantially Increases Medicaid. Despite Medicaid's enormous problems, Obamacare expands it dramatically. Beginning in 2014, states are required to cover all individuals below 138 per-

This paper, in its entirety, can be found at:
http://report.heritage.org/wm3031

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

The Heritage Foundation
LEADERSHIP FOR AMERICA

cent of the federal poverty line with Medicaid.[5] The CMS estimates that this will increase enrollment in Medicaid by 23 million individuals in 2014 at an added annual cost of over $70 billion.[6]

Obamacare requires that states increase Medicaid reimbursement rates for PCPs to applicable Medicare payment rates for 2013 and 2014 to encourage PCPs to treat Medicaid patients. The estimated annual cost of raising the reimbursement rates by state is provided in Table 1. However, on January 1, 2015, both the mandate and the federal funding paying for it expire.

Many Medicaid providers, who are paid on average about half of commercial rates, are skeptical of this expansion. Medicaid requires an enormous amount of paperwork, the lag time between date of service and the date of reimbursement is more than twice as long as Medicare or commercial insurance reimbursement times, and the denial rate for Medicaid claims is three times larger than for both Medicare and commercial insurance.[7] Indeed, only 10 percent of PCPs believe that new Medicaid enrollees in their area will find a suitable PCP.[8]

The Problem with Tying Rates to Medicare. Medicare's payment rates to doctors are a central political issue nearly every year. To deal with skyrocketing Medicare costs, Congress enacted the Sustainable Growth Rate (SGR) in 1997. SGR links the increase in Medicare reimbursement rates to growth in GDP. Since medical costs historically increase at a rate more than twice GDP, the SGR reduces the real (inflation-adjusted) payments physicians receive. Congress has overruled this decrease (the so-called "doc fix") 10 times over the past decade, with short-term boosts in Medicare rates above SGR levels.

When prices are set by government, special interests have powerful incentives to devote valuable time and money lobbying to influence those prices. This intensifies conflict among providers, policymakers, patients, and taxpayers.

Furthermore, linking Medicaid reimbursement rates to Medicare rates is unlikely to solve the Medicaid access problem. For one, Medicare rates are scheduled to be cut 23 percent in December 2010 when the latest doc fix expires. With near certainty, however, Congress will provide another temporary fix. But even if Medicare rates are not cut, they still pay only an estimated 78 percent of commercial rates.[9] Because of these facts, less than half of PCPs report they would be willing to see new Medicaid patients even if Medicaid rates reached Medicare levels.[10]

1. It is difficult to determine precisely how expensive raising Medicaid reimbursement rates to Medicare levels will be for taxpayers, because providers may respond to the changes in unforeseen ways. Contact the author for a description of how Heritage's estimates were calculated.
2. In 1990, the U.S. spent $121 billion (in current dollars) on Medicaid. Spending in 2009 on Medicaid and the Children's Health Insurance Program totaled $390 billion, more than a threefold increase in less than 20 years.
3. Associated Press, "Doctors Threaten to Pull Out of Medicaid," July 12, 2010, at *http://www.nbcdfw.com/news/health/Doctors-Threaten-to-Pull-Out-of-Texas-Medicaid-98202569.html* (September 28, 2010).
4. D. J. LaPar *et al.*, "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery*, Vol. 252, Issue 3 (2010), pp. 544–51.
5. Obamacare requires that states cover all individuals below 133 percent of the federal poverty line through Medicaid. However, a 5 percent income disregard boosts the actual rate to 138 percent.
6. Andrew M. Sisko *et al.,* "National Health Spending Projections: The Estimated Impact of Reform Through 2019," *Health Affairs*, Vol. 29, No. 10 (2010), at *http://content.healthaffairs.org/cgi/reprint/hlthaff.2010.0788v1.*
7. AthenaHealth, "PayerView 2010: Improving the Way Providers and Payers Work Together," May 2010, at *http://www.athenahealth.com/_doc/pdf/whitepapers/PayerView_Whitepaper_2010_Final.pdf* (September 29, 2010).
8. Doug Trapp, "New Medicaid Patients Will Lack Access, Most Doctors Say," Amednews.com, May 3, 2010, at *http://www.ama-assn.org/amednews/2010/05/03/gvsb0503.htm* (September 30, 2010).
9. Will Fox and John Pickering, "Hospital and Physician Cost Shift Payment Level Comparison of Medicare, Medicaid, and Commerical Payers," Milliman, December 2008, at *http://www.ahip.org/content/default.aspx?docid=25216* (September 28, 2010).
10. Trapp, "New Medicaid Patients."

What Happens to Doctors and States When the Federal Funding Disappears? The end of federal assistance will leave states and doctors in a precarious position. If states keep the elevated PCP reimbursement rates, they will have to make up the difference with their own funds, further adding to state Medicaid costs. But if states reduce Medicaid PCP payment rates to their previous levels when the federal funding disappears, Medicaid beneficiaries' access to providers would be further compromised.

Estimated Medicaid "Doc Fix" Costs

The federal cost of the mandated increase in primary care physician (PCP) rates in fiscal year 2014—when it is entirely paid for by the federal government—is estimated by CBO at $3 billion and by CMS at $5.5 billion. However those costs are estimated to increase by 25 percent (to $3.75 billion and $6.83 billion, respectively) because the CBO and CMS scored the health care bill as written and did not account for the near certainty that Congress would not allow the cuts in physician payment rates for Medicare to take effect.

The cost for each state is based on the state's aggregate Medicaid on PCP services and the ratio of the state's current Medicaid PCP payment rates relative to Medicare rates.

Estimated Annual Increase in Medicaid Costs by State, in Millions of Dollars

State	Based on Data from CBO	Based on Data from CMS	If All Physician Rates Increase Proportionally to the PCP Increase
Alabama	$29	$52	$387
Alaska	n/a	n/a	n/a
Arizona	$5	$10	$67
Arkansas	$23	$42	$338
California	$921	$1,677	$7,810
Colorado	$15	$27	$126
Connecticut	$13	$24	$113
DC	$37	$67	$522
Delaware	n/a	n/a	n/a
Florida	$266	$484	$2,531
Georgia	$32	$59	$397
Hawaii	$19	$35	$167
Idaho	n/a	n/a	n/a
Illinois	$113	$206	$965
Indiana	$46	$83	$576
Iowa	$5	$9	$55
Kansas	$2	$3	$16
Kentucky	$23	$42	$344
Louisiana	$11	$20	$127
Maine	$33	$60	$389
Maryland	$28	$52	$241
Massachusetts	$55	$100	$465
Michigan	$115	$209	$1,424
Minnesota	$64	$117	$545
Mississippi	$11	$20	$180
Missouri	$45	$82	$520
Montana	$0	$1	$6
Nebraska	$8	$14	$79
Nevada	$2	$4	$19
New Hampshire	$19	$35	$161
New Jersey	$152	$276	$1,285
New Mexico	$1	$1	$7
New York	$1,159	$2,110	$9,825
North Carolina	$13	$24	$160
North Dakota	n/a	n/a	n/a
Ohio	$83	$151	$967
Oklahoma	n/a	n/a	n/a
Oregon	$19	$35	$217
Pennsylvania	$116	$212	$1,110
Rhode Island	$17	$31	$155
South Carolina	$18	$32	$249
South Dakota	$3	$6	$34
Tennessee	n/a	n/a	n/a
Texas	$135	$246	$1,455
Utah	$13	$23	$188
Vermont	$2	$3	$19
Virginia	$13	$23	$106
Washington	$12	$23	$105
West Virginia	$10	$18	$153
Wisconsin	$44	$79	$464
Wyoming	n/a	n/a	n/a
Total U.S.	**$3,750**	**$6,825**	**$35,069**

Source: Author's calculations for the first two columns are derived from CBO and CMS estimates of the federal cost of the mandated payment increase in 2014, when it is 100 percent federally funded. These estimates were increased 25 percent because CBO and CMS scored the bill as written and did not account for the near certainty that Congress will not allow the large Medicare cuts in physician payment rates to take effect. Since the Medicaid rates are benchmarked to the Medicare rates, a Medicare increase will have a proportionate impact on Medicaid rates in 2013 and 2014. Costs were distributed among the states based on a weighting that adjusted for each state's 2004 Medicaid spending on physician and clinical services and the PCP Medicaid fee rate as a ratio of the applicable Medicare rate. The estimates in the third column are based on the assumption that all state Medicaid spending on physician and clinical services is increased proportionally to the increase for PCPs.

Table 1 • WM 3031

Medicaid reimbursement rates are already quite low, particularly in states such as New York, New Jersey, and California that pay providers approximately one-third of commercial rates.

Moreover, reducing physician payment rates is typically one of the primary ways state officials control Medicaid spending. For example, 41 states and the District of Columbia cut provider reimbursements rates in 2009 or 2010, and 29 states and the District did so in both years.[11] The mandated Medicaid expansion would strip states of the ability to reduce enrollment as a cost-controlling mechanism, so reductions in Medicaid reimbursement rates seem likely to continue, especially during difficult economic periods.

In addition, setting provider rates even lower will not necessarily reduce the aggregate costs of state Medicaid programs. More Medicaid enrollees will likely seek care in hospital emergency rooms because they cannot find doctors willing to accept them, and there will be an increased incentive for providers to "up-code" their payment to maintain their incomes.

A doctor's time is better spent serving his or her patients than lobbying politicians for payment increases. And the heavy administrative burden of Medicaid is another cost inflicted on physicians and their practices, which considerably reduces their levels of job satisfaction and the likelihood they will accept new Medicaid patients.[12]

Fundamental Reform, Not More Money. When a federal program is hemorrhaging taxpayer dollars and delivering poor results, policymakers should reform it. Fundamental Medicaid reform is desperately needed. Market-based principles should be introduced to re-align incentives of doctors and patients so that quality can increase and cost can decrease. Instead of addressing the many problems of Medicaid, Obamacare doubles down on the broken program and greatly adds to its rolls.

Based on recent experience, many states will cut provider rates when they are faced with tough budgetary decisions and the federal money goes away. Doctors will be left to rely on "fixes" at the state-level similar to what Congress does continually with Medicare rates.

A better approach: Repeal the Medicaid expansion and stop these temporary fixes that produce uncertainty, division, and socially wasteful lobbying efforts and focus instead on how to best provide a social safety net within an affordable budget.

*—**Brian Blase** is Policy Analyst in the Center for Health Policy Studies at The Heritage Foundation and is a Doctoral Candidate in Economics at George Mason University.*

11. Kaiser Family Foundation, "Medicaid Cost Containment Actions Taken by States, FY 2010," StateHealthFacts.org, at *http://www.statehealthfacts.org/comparetable.jsp?ind=187&cat=4* (June 18, 2010).
12. According to a 2004–2005 survey, 84 percent of physicians cite inadequate reimbursements as an important reason for not accepting new Medicaid patients, with 65 percent citing delayed reimbursements and 70 percent citing billing requirements/paperwork reasons. See Peter J. Cunningham and Jessica H. May, "Medicaid Patients Increasingly Concentrated Among Physicians," Supplementary Table 2, Center for Studying Health System Change, August 2006, at *http://www.hschange.com/CONTENT/866/SP2.htm* (September 30, 2010).

The Heritage Foundation
LEADERSHIP FOR AMERICA