PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

COVERAGE DENIED

ISSUE BRIEF PART EIGHT

Establishing an Efficient Healthcare Safety Net

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Executive Summary

- Enrollees in the joint federal-state Medicaid program face more access obstacles and lower quality healthcare compared to patients with private insurance. In addition, Medicaid under-compensates caregivers, creating significant financial distress for providers and hospitals.
- At the current expenditure and enrollee levels, Medicaid's per enrollee costs are approximately the same as the average costs to purchase private health insurance.
- Given these realities, a more effective healthcare social safety net would provide cash-based support to empower vulnerable populations to purchase private health insurance, which will create significant benefits for patients, providers, and insurers.

Overview

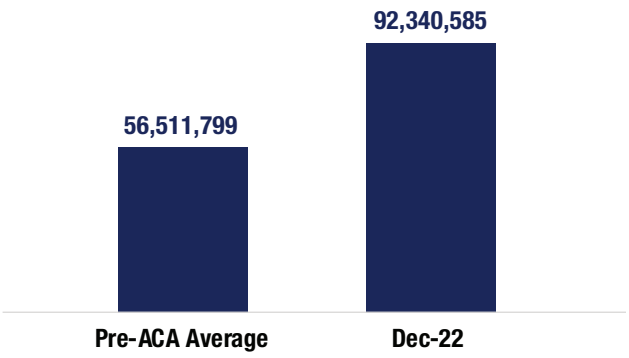
A well-functioning social safety ensures that people have access to quality healthcare regardless of their income. The joint federal-state Medicaid program is supposed to serve this purpose by directly covering the healthcare costs of low-income and vulnerable populations.

Unfortunately, Medicaid fails to fulfill this essential mission.

Compared with private insurance, Medicaid provides sub-par healthcare services to patients; underpays providers, directly causing significant revenue shortfalls; and is expensive for taxpayers.

Despite these deficiencies, enrollees in government subsidized healthcare assistance have exploded due to the passage of the Affordable Care Act (aka, Obamacare) in 2010 and the Medicaid expansions that were passed in response to the COVID-19 pandemic of 2020. The total number of enrollees in Medicaid and the Childhood Health Insurance Program (CHIP) – the program that covers children living in families that earn too much for Medicaid but deemed not enough to afford health insurance – as of December 2022 was 61 percent larger than the average number of enrollees in these programs prior to passage of the Affordable Care Act, see Figure 1.[1]

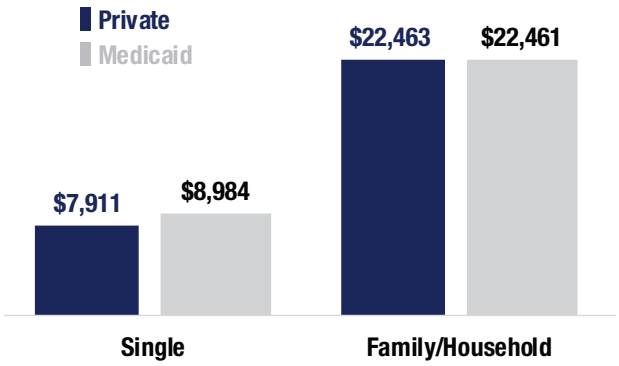
FIGURE 1
AVERAGE MONTHLY MEDICAID AND CHIP ENROLLMENT, PRE-ACA COMPARED TO DECEMBER 2022



Source: KFF

Thanks to these expansions, Medicaid and CHIP expenditures in 2021 (including both federal and state revenues) were more than $765 billion and were around $830 billion in 2022.[2] This equates to spending around $8,984 per enrollee in 2022 or, adjusting for the average size of a U.S. household (2.5 people), $22,461 per household. Noteworthy, these costs are nearly identical to the costs for the average private sector insurance premiums for an individual and family in 2022, see Figure 2. According to KFF, the "average annual premiums in 2022 are $7,911 for single coverage and $22,463 for family coverage."[3]

FIGURE 2
MEDICAID COSTS PER ENROLLEE AND AVERAGE HOUSEHOLD COMPARED TO AVERAGE HEALTH INSURANCE PREMIUM SINGLE AND FAMILY, 2022



Sources: KFF and CMS

These cost similarities indicate that unless Medicaid provides superior healthcare services compared to private insurance, or at a bare minimum comparable services, a more efficient social safety net would replace the entire Medicaid program with a cash-based system that enabled people to purchase private health insurance and healthcare services. The evidence demonstrates that Medicaid consistently provides inferior, not even comparable, healthcare services to enrollees.

It stands to reason, consequently, that enrollees, providers, and the broader healthcare system would benefit from replacing the ineffective Medicaid support program with a cash-based system that would serve as a more effective safety net than the current system.

Medicaid Poorly Serves Patients and Undercompensates Providers

Health outcomes for Medicaid patients are materially worse than patients with private health insurance, even after adjusting for key health disparity differences. To start, it is significantly more difficult for Medicaid patients to even schedule a healthcare appointment compared to patients with private health insurance. Hsiang et. al. (2019) performed a meta-analysis of "audit studies of healthcare appointments and schedules" finding "that Medicaid insurance is associated with a 1.6-fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private insurance."[4]

Beyond less access to primary care physicians, patients on Medicaid also have worse outcomes when more advanced care is required. LaPar et. al. (2010) evaluated the patient outcomes from nearly 900,000 surgical operations including lung resections, colectomies, and coronary artery bypasses.[5] The authors found that private insurance patients had the lowest mortality rates (compared to patients on Medicaid, Medicare, and the uninsured) while patients on Medicaid and the uninsured had the highest adjusted risks of mortality.[6] Additionally, after "controlling for age, gender, income, geographic region, operation, and 30 comorbid conditions, Medicaid payer status was associated with the longest length of stay and highest total costs."[7] **Put simply, Medicaid patients required longer hospital stays for the same operation, incurred higher costs, and had higher risks of death.**

Other studies confirmed these results. Xu et. al. (2017) examined the mortality risks following hip replacement surgery.[8] Their results concluded that Medicaid patients had a higher risk of postoperative mortality and other adverse health complications from the surgery compared to patients with private insurance.

Rozental et. al. (2020) examined the mortality rates after abdominal aortic aneurysm repair. Their results found that Medicaid insurance is associated with higher chances for in-hospital mortality after abdominal aortic aneurysm repair relative to patients with private insurance.[9]

Patients on Medicaid also have higher readmission rates following surgical procedures than patients with private health insurance. White et. al. (2018) found that following hip replacement surgery, Medicaid patients had higher 30-day and 90-day readmission rates than patients with private insurance.[10] With respect to readmission rates following coronary artery bypass surgery, the results from Feng et. al. (2018) estimated a 20.2 percent readmission rate for patients with Medicaid compared to an 11.7 percent readmission rate for patients with private insurance.[11]

The lack of access and worse outcomes following healthcare treatments raise serious concerns that the Medicaid program provides enrollees with lower quality healthcare services compared to patients with private insurance. These concerns are worsened by the uneconomical compensation Medicaid pays providers and hospitals.

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Amazingly, even though Medicaid spends so much money, the program still manages to undercompensate healthcare providers. According to the American Hospital Association, Medicaid reimbursed hospitals 88-cents for every dollar of costs in 2020.[12] A 2019 NBER Working Paper noted that Medicaid reimburses doctors less than two-thirds of the compensation paid by private insurers, which helps drive the access issues that Medicaid patients face.[13]

It is not just Medicaid's compensation that is inadequate. Dunn et. al. (2023) evaluated the administrative costs that Medicaid, Medicare, and

private insurance impose on providers.[14] The authors write that they analyze

> the complexity of healthcare billing and estimate its economic costs for doctors and consequences for patients. Observing the back-and-forth sequences of claim denials and resubmissions for past visits, we can estimate physicians' costs of haggling with insurers to collect payments. Combining these costs with the revenue never collected, we estimate that physicians lose 18% of Medicaid revenue to billing problems, compared with 4.7% for Medicare and 2.4% for commercial insurers. …(W)e find that physicians respond to billing problems by refusing to accept Medicaid patients in states with more severe billing hurdles.[15]

The combination of poorer outcomes for patients, less reimbursement and higher costs for providers, and the high cost of Medicaid argue that the program is in desperate need of reform.

Empower Medicaid Patients to Purchase Private Health Insurance

Privatizing Medicaid often refers to the practice of contracting the administration of the public health insurance benefits to private firms. While there is evidence that this type of privatization can improve services received,[16] ultimately patients are still part of the public insurance program. Empowering Medicaid patients to purchase insurance through the market immediately would offer them the higher quality services being provided by private insurers. Patients would then have access to both higher quality health insurance services with an expected increase in their resulting healthcare outcomes.

Achieving this goal is politically complex, but administratively straightforward. Currently, based on the average household size in the U.S. as of 2022, the federal government is paying $16,478 per household to provide Medicaid patients lousy health insurance. The states, on average, are contributing an additional $5,983, although the exact amount varies significantly by state.

Instead of spending this money to create a less effective government health insurance program, the federal government could fund individual health savings accounts (HSAs) for all Medicaid patients. The size of the federal contribution would vary depending on household income and should contain work and education requirements, as well as reasonable time constraints, to ensure that the support provides a hand up that transitions people off Medicaid and other social safety net support programs.

Benefit levels should then be reduced at a constant rate as the individual/family earns additional income to ensure that the program serves its function as a safety net service. Reducing benefits at a consistent rate when certain income benchmarks are met serves as a type of flat tax on income earned that will avoid any disincentives that currently plague many government support programs. The emergence of a sudden and substantial reduction in benefits imposes an effective tax rate that often exceeds 100 percent – families lose more than one dollar of services by earning an additional dollar of income. Such confiscatory tax rates create a strong disincentive against work and can trap families in poverty.

Without federal support, it becomes challenging for most states to continue supporting patients through their current Medicaid programs. States will have to adjust, consequently, with the more effective approach being that the states piggyback on the federal established cash-based support program. Following this reform approach, enrollees will be capable of obtaining/remaining on the private health insurance options that have proven themselves to provide better healthcare outcomes than the current Medicaid program.

With respect to costs, as Figure 2 illustrates, the average Medicaid spending per household is essentially the same as the cost for the average health insurance

plan for a family. The federal and state governments, consequently, are spending more than enough money to ensure that all current Medicaid enrollees have access to private health insurance.

In addition to providing better health insurance, empowering Medicaid enrollees to participate in the private health insurance market creates other systemic benefits that include:

- **Eliminating Medicaid's uneconomical cost shift**: Medicaid undercompensates hospitals and providers, which inflates costs for patients with private insurance. Bringing Medicaid patients into the private market eliminates this cost shift.
- **Creating a more stable health insurance market**: The current Medicaid system pulls 92 million people out of the private system. Allowing them to remain in the private market not only removes the government-created distortions, but it also improves the vibrancy of the health insurance industry by broadening the insurance base.
- **Enabling individuals and families to maintain constant coverage during financially trying times**: Providing direct financial support allows families to maintain their current health insurance even should they hit difficult economic times. Ensuring consistency of coverage provides important benefits that will improve health outcomes and provide significant security benefits.

Ideally these reforms would be implemented along with the reforms outlined in Parts 5 through 7 of the *Coverage Denied* series. If implemented in tandem, then the reforms that turn Medicaid into a cash support program will further strengthen the benefits from improving the broader health insurance and healthcare delivery systems. As such, reforming Medicaid is an essential component of the broader comprehensive healthcare reform effort. The result will be a more efficient healthcare system where the many disincentives that are driving up healthcare costs and reducing healthcare quality have been removed.

Conclusion

This paper has focused on improving the healthcare portion of the social safety net. These concerns are the final component of the healthcare system reforms that have been developed in the second half of the *Coverage Denied* series. Taken as a comprehensive program, these proposals directly address the healthcare system's flaws that were outlined in the first half of the series.

The system's current failings are usefully understood as three separate problems: a defective health insurance model, an inefficient healthcare delivery model, and an ineffective social safety net. The problems with health insurance arise because, too often, it fails to mitigate the financial risks associated with expensive medical care. Instead, health insurance's primary focus has become providing, rather inefficiently, pre-paid healthcare services.

Since health insurers and other payers have become the primary direct payer in the system, they now dictate the demand side of the healthcare market at the expense of patients. The significant decline in patient control causes distortions that are the prime cause of the problems of rising costs and declining quality.

Specifically, since insurers (and employer self-sponsored plans) are covering the costs, providers must respond to the needs of third-party payers. Patients' individual needs too often become secondary considerations to the financial concerns of the third-party payers. The inevitable consequences are overly restrictive access to care, inappropriate cost transfers to patients, excessive medical debt problems, and declining health outcomes. These distortions created by the private (mostly employer-sponsored) plans are worsened by the ever-expanding role of government-financed health care spending.

Arguably, these problems are most visible when patients require expensive drugs. Drug affordability problems arise because the perverse incentives created by the third-party payer system disempower patients in favor of insurers and other supply-chain intermediaries (e.g., pharmacy benefit managers, PBMs). The pricing system, consequently, reflects

the needs and desires of payers and PBMs rather than patients, which inequitably inflates the costs of expensive drugs for patients.

From the perspective of health care providers, the current system forces them to account for the needs of insurers and other payers as well as their patients. When coupled with overly restrictive regulations and the pall created by frivolous litigation, the ability of healthcare providers to provide higher quality care at lower costs is severely constrained.

Addressing the flaws in the health insurance market requires reforms that would empower patients over payers. Payers are currently empowered because, due to the tax system, patients are at a large disadvantage relative to their employers when they try to purchase health care and health insurance services. Making healthcare and health insurance expenditures tax deductible for all individuals would remove this disadvantage. When coupled with broader availability and usability of tax-free health saving accounts, patients would be better positioned to control how and where their healthcare dollars are spent. To help patients become more effective consumers of healthcare, it is essential to promote both greater price transparency and robust insurance competition.

While these reforms will also help improve drug affordability, drug specific reforms that eliminate unique drug supply chain inefficiencies are necessary to promote greater drug affordability. These reforms include fostering a patient-controlled generics market, fixing the drug formularies' systemic biases against low-cost medicines, improving price transparency for innovative medicine that includes ensuring patients directly benefit from all discounts when purchasing their medicines, and encouraging contracting innovations that could create more innovative ways for pricing medicines.

To improve the quality of healthcare services, the barriers disincentivizing productivity enhancing innovations should be removed. These include implementing regulatory reforms (e.g., eliminating certificate of need laws, scope of practice laws, and interstate licensing obstacles) and addressing the problems created by frivolous and excessively costly litigation that drives-up overall healthcare costs and decreases the quality of care. Additionally, by empowering patients to reward providers that better meet their healthcare needs, the health insurance reforms would also encourage innovative payment models that better align the incentives of providers and patients.

The same benefits generated by empowering patients are also applicable to creating a more effective social safety net. Unfortunately, the current system is based on the same flawed third-party payer model. In this case, the joint federal-state Medicaid program provides enrollees with health insurance services. As a result, Medicaid is burdened with all the flaws of the private third-party payer system, plus it provides sub-par care to enrollees, financially burdens providers, and creates additional distortions that harm the broader healthcare system. An income-based support program centered on enabling patients to participate in the private health insurance market would address these deficiencies.

Importantly, incorporating the Medicaid population into a more competitive health insurance market amplifies the benefits from the reforms to the broader healthcare system. Instead of relegating tens of millions of Americans to a flawed system, an income-based support program would enable them to participate in the broader health insurance and healthcare markets. The incentives to provide efficient care and develop delivery innovations would be strengthened subsequently.

As this series has emphasized, addressing the current healthcare system's flaws without jeopardizing the strengths of our current system requires reforms that establish a patient-centered health care system.

Patient-centered healthcare empowers patients and doctors to manage health care decisions, not third-party payers, drug middlemen, or the government. Such a transition would meaningfully help control rising costs, increase health outcomes, and improve the overall efficiency of the health care system.

Endnotes

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