

## Medicaid Expansion in Missouri

The Affordable Care Act (ACA) intended for all states to expand Medicaid eligibility for adults earning up to 138% of the federal poverty level (FPL) (\$17,236 individual annual income). In 2012, the United States Supreme Court ruled in the *National Federation of Independent Business v. Sebelius* that Medicaid expansion would be voluntary for states. Thirty-six states and Washington, D.C., have expanded Medicaid to date.<sup>1</sup> The majority of states passed expansion through legislative action while four adopted expansion through a ballot initiative. In Missouri, several initiative petitions have been submitted to the Missouri secretary of state for circulation and will be placed on the ballot in November 2020 if enough signatures are gathered in support of them.

This brief reviews and examines research and data from expansion and non-expansion states. This report first looks at the opportunities for Missouri concerning Medicaid expansion, including the impact on health insurance coverage, health outcomes, the state budget, and economic activity. The brief then reviews the challenges of Medicaid expansion, including enrollment, gaps in coverage, and possible budget shortfalls. Both sections cite to various studies on the issues. Both sections also consider Missouri's current Medicaid program, known as MO HealthNet. The goal of this report is to gain a better understanding of the advantages and disadvantages of Medicaid expansion in Missouri.

### Opportunities for Missouri

Studies have shown that Medicaid expansion has generated numerous positive effects in states across the country, most notably for improving health coverage. While the long-term impact may not be conclusive, there is substantial evidence that expansion is beneficial for both newly eligible individuals who have improved access to care and for states by enhancing economic growth and fiscal well-being.

#### **Health Insurance Coverage**

Missouri's current eligibility requirements are among the most restrictive in the nation. For example, adults with children qualify only if they earn less than 22 percent FPL (roughly \$3,720 annual income for household of two). Childless adults are not currently eligible. Approximately 970,000 people were enrolled in MO HealthNet during state fiscal year 2018.<sup>a</sup> Researchers estimate that 315,000 additional people would be eligible to receive coverage if Missouri expanded Medicaid, with about 73 percent (i.e., 230,000) of the eligible population likely to enroll. About two-thirds of anticipated expansion enrollees are currently uninsured. Others include people with incomes between 100 and 138 percent FPL who have coverage on the health insurance marketplaces. A limited number of Missourians with employer-sponsored insurance may also enroll. In addition to adults who gain coverage, more children who are currently eligible for Medicaid are expected to enroll as their parents sign up for coverage (estimated 40,500 children).<sup>2</sup>

Medicaid expansion states have seen significant declines in their uninsured population. In 2018, the average uninsured rate for expansion states was 6.6%. In contrast, the average rate for non-expansion

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<sup>a</sup> See [Missouri Medicaid Basics](#) for more information about current enrollment and eligibility requirements.

states was 12.4%. In Missouri, 9.4% of the population remained uninsured (564,000 people) in 2018.<sup>3</sup> Expansion states have experienced substantial increases in coverage among specific populations, including: young adults, women of reproductive age, children, prescription drug users, and veterans.<sup>4</sup> Rural areas of expansion states have also seen significant increases in health insurance coverage. In 2015, rural residents of non-expansion states were almost twice as likely to be uninsured than those living in rural areas of expansion states.<sup>5</sup>

Expansion has also alleviated financial strain for many individuals and families. The federal government imposes strict limitations on the amount that states can charge Medicaid consumers for premiums and cost-sharing. Accordingly, families earning 138% FPL in expansion states are 11% less likely to incur out-of-pocket (OOP) medical expenses than non-expansion households of the same income level. For those in expansion states that do have OOP expenses, spending is significantly lower, and they are less likely to incur catastrophic medical expenses than households in non-expansion states.<sup>6</sup> On average, people who gained Medicaid coverage through expansion filled 13.3 more prescriptions, but also paid 58% less per prescription drug.<sup>7</sup>

Increased affordability through Medicaid expansion has reduced the likelihood of individuals incurring medical debt and decreased the proportion of people who borrow money or skip payments on other bills to pay for health care. In Missouri, over 20% of the population has medical debt in collections.<sup>8</sup> One study shows that, from 2014 to 2016, expansion reduced newly accrued medical debt up to 40% and, on average, reduced annual medical debt by \$900 per person (totaling \$3.4 billion).<sup>9</sup> Residents of expansion states are also 2% less likely to become delinquent on an existing debt and to have an improved credit score.<sup>10</sup> As a result, fewer people in expansion states resort to pay day loans to cover the cost of health care.<sup>11</sup>

### ***Health Impact***

Health outcomes can be difficult to measure because they often take many years to produce and are affected by social, environmental, and behavioral factors. As such, research findings about the health impact of expansion have been less consistent than other areas of study and will require more time to draw conclusive results. Experts have reviewed differences in access to health care and utilization patterns in order to make initial assessments about the health impact of Medicaid expansion.

Multiple studies have illustrated an association between expansion and increased use of primary care, mental health, and preventive services.<sup>12</sup> Individuals in Medicaid expansion states are more likely to have a usual source of care and receive routine checkups.<sup>13</sup> The overall impact on emergency department utilization has been less consistent in the literature. Some findings suggest that people who gain Medicaid coverage visit the hospital more than the uninsured due to deferred medical care.<sup>14</sup> While states may have experienced increases in emergency department visits after expansion, evidence suggests that there has also been a 27% increase in paid visits and 31% decrease in uninsured visits.<sup>15</sup>

Perhaps due to more frequent use of routine care, expansion states have seen increases in diagnosis rates, treatment, and management of chronic conditions. For example, expansion states have increased early stage cancer diagnosis rates and utilization of surgery to treat cancer.<sup>16</sup> Several studies have found that expansion states also have higher prescription rates for opioid use disorder treatment

and opioid overdoses.<sup>17</sup> Prescriptions for buprenorphine, used in medication assisted treatment to relieve withdrawal symptoms, have increased at a slower rate on average in non-expansion states. Between 2011 and 2018, buprenorphine prescriptions increased from 40 to 138 per 1,000 people in expansion states compared to 16 to 41 in non-expansion states.<sup>18</sup>

Beneficiaries in expansion states have reported less psychological distress, fewer days of poor mental health, and improved overall health.<sup>19</sup> Recent studies suggest that Medicaid expansion can even lead to lower mortality rates. Between 2010 and 2016, the decline in infant mortality in Medicaid expansion states was more than 50% greater than in non-Medicaid expansion states.<sup>20</sup> The mean infant mortality rate in non-expansion states in 2016 was 6.5 per 1000 live births, while the mean rate for expansion states was 5.6 per 1000 live births. In that same year, Missouri's infant mortality rate was 6.3 per 1,000 live births.<sup>21</sup> Findings from a 2019 study also found a link between expansion and maternal mortality, with 1.6 fewer maternal deaths per 100,000 in expansion states.<sup>22</sup> The average maternal mortality rate in the U.S. is 29.6 per 100,000 live births, whereas Missouri's average is 40.7 per 100,000 live births.<sup>23</sup> Moreover, expansion states have experienced lower cardiovascular mortality for people ages 45 to 64.<sup>24</sup> Another study estimates that expansion states have had 15,600 fewer deaths for individuals ages 55 to 64 compared to non-expansion states between 2014 and 2017.<sup>25</sup>

### ***State Budget***

Evidence from other states suggests that Medicaid expansion could help alleviate some concerns about MO HealthNet's financial sustainability. The federal government finances the majority of costs related to Medicaid expansion. One hundred percent of costs were covered between 2014 and 2016. In 2017, the federal contribution began gradually phasing down and will reach 90 percent of expenditures in 2020 where it will remain moving forward.<sup>26</sup>

Spending for new Medicaid expansion enrollees is lower than traditional beneficiaries, and costs for the newly eligible have been declining over time.<sup>27</sup> While per person spending grew initially after the first states expanded in 2014, overall Medicaid spending declined by 5% in expansion states and grew by 5% in non-expansion states. Costs are typically less expensive for the healthier expansion population compared to traditional Medicaid enrollees.<sup>28</sup> Per person monthly costs for Missouri's expansion population is estimated to be \$425 compared to \$676 for current nonelderly adults enrolled in MO HealthNet.<sup>29</sup>

Recent research estimates that expansion in Missouri would be revenue neutral and could even create costs savings. A 2019 study estimated savings of nearly \$39 million in fiscal year 2020 if Missouri were to adopt Medicaid expansion. That same study also estimated MO HealthNet annual savings could reach to more than \$930 million by fiscal year 2024.<sup>30</sup> The projections expect the state to collect the enhanced federal match rate for enrollees who were previously enrolled in other categories of eligibility with a lower match rate, including the following populations: spend-down, people with disabilities, and pregnant women. Other expansion states also reported saving money by spending less on programs for the uninsured such as behavioral health services, substance use treatment, and inpatient care for people in the criminal justice system.<sup>31</sup>

### ***Economic Activity***

Medicaid expansion can also help boost state economies. As more Medicaid dollars are infused into the system to deliver health care services, demand for supplies and other necessary inputs to provide

those services should also increase. Subsequently, health care providers and other health-related workers will further stimulate economic growth by increasing expenditures on local goods and services.<sup>32</sup> In addition, individuals who gain Medicaid coverage are expected to redirect spending from health care to other household needs. The increased spending derived from Medicaid expansion should enhance sales and income tax revenue for states and local governments alike.<sup>33</sup>

In Iowa, every \$100 million in federal funding is estimated to create 1,500 jobs and \$74 million in employee compensation. Furthermore, expansion is estimated to generate \$33.8 million in state tax revenue and \$20.8 million in local government taxes.<sup>34</sup> By 2035, Colorado estimates 43,018 new jobs will be created and average household income will increase by \$1,033 as a result of expansion.<sup>35</sup> States that have expanded have also seen increases in their gross domestic product (GDP). For example, in 2019, Ohio projects an additional \$3 billion GDP and increased earnings for employees beyond the health care sector.<sup>36</sup>

Medicaid expansion may also improve individuals' ability to work. Expansion enrollees surveyed in Ohio and Michigan indicated that Medicaid coverage has made it easier for them to work (69% and 84%, respectively).<sup>37</sup> In Montana, labor force participation among low-income residents increased 6 percentage points following Montana's expansion.<sup>38</sup> In Michigan, expansion enrollees who experienced improved physical or mental health since enrollment believed Medicaid helped them improve their job performance. Similarly, unemployed expansion enrollees reported that Medicaid allowed them to look for and secure a job.<sup>39</sup>

Health insurance coverage is financially beneficial to health care providers in addition to consumers. For clinics and offices that provide primary care and care for chronic conditions, expansion reduces barriers to routine care and allows nurses, doctors, and pharmacists to more effectively manage their patients' health problems. Medicaid expansion decreased uncompensated care by \$3.2 million as hospitals had fewer uninsured visits and more visits covered by Medicaid.<sup>40</sup> Expansion has helped bolster hospitals' financial performance and decreased the likelihood of closure, particularly in rural areas and in counties with higher uninsured rates prior to expansion.<sup>41</sup>

## Challenges for Missouri

Evaluations from expansion states make a compelling case for expanding Medicaid eligibility; although, the benefits may vary in Missouri. Varied conditions, such as eligibility requirements and population health, may impact applicability of research findings. Therefore, the current MO HealthNet program and its existing challenges should also be taken into account.

### ***Enrollment and Technology***

Other states have experienced challenges addressing consumer confusion about Medicaid eligibility requirements after expansion. The misunderstanding likely stems from inconsistent education, inadequate outreach, and limited availability of resources in multiple languages.<sup>42</sup> Enrollment challenges may contribute to expansion benefiting populations at varying degrees. Health insurance coverage generally increases with expansion, but some analyses have found limited impact on reducing disparities. Nationally, insurance coverage gaps widened between non-Hispanic whites and Hispanics after expansion.<sup>43</sup> Comparing 2011 to 2016 data, expansion led to a 7% decline in the

uninsured rate for Hispanics, while the uninsured rate dropped by 11 percentage points for whites and 14 percentage points for black consumers.

Further, one study found that black and Hispanic enrollees did not report that expansion had the same level of benefits on health and access as white enrollees. For example, white beneficiaries reported improvements in all measures of health status, whereas black and Hispanic enrollees saw improvements in limited measures, such as the number of reported mental health days and fair health status overall.<sup>44</sup> Stigma, government distrust, and citizenship status are potential barriers that may limit enrollment and access to care.

Missouri has identified existing enrollment challenges for the current MO HealthNet program. Medicaid Transformation's "Rapid Response Review" suggests that Missourians are confused by notices and letters sent from the Department of Social Services.<sup>45</sup> Communication could be redesigned to optimize the consumers' experience, as well as reduce the department's call volume and overall administrative complexity. Confusion escalates when participants receive separate communication from Medicaid managed care companies, who oversee the delivery of health care services for more than 70% of the Missouri's Medicaid population. Since most of the expansion population would be enrolled in managed care, measures to streamline outreach and enrollment would be necessary.

Technology has also been identified as an area of improvement for Medicaid Transformation. Missouri's eligibility determination and enrollment system for children and families in Medicaid requires reformation to better promote consumer understanding and reduce administrative complexity. The system is not interactive for consumers, nor is it interoperable with enrollment systems for other safety net programs. System integration and updates would help reduce the administrative burden in the currently overwhelmed system, though such updates would require additional investment. For instance, a web portal that allows managed care participants to make health plan selections would streamline enrollment and reduce call volumes and staff time.<sup>46</sup>

Missouri's MO HealthNet Division has a systems strategy to update technologies beyond those used for enrollment. The Medicaid Management and Information System (MMIS) for claims processing and payment is approximately 40 years old. The MMIS has limited flexibility for new payment and delivery models with configuration changes consuming significant resources. Managed care was built in the current system but has limited processing and data capabilities. MO HealthNet is planning to modernize its MMIS and employ an enterprise data warehouse to enhance reporting and analytics capabilities.<sup>47</sup> These updates will be necessary to effectively manage benefits and payment for the expansion population.

### ***Coverage Adequacy***

As in the broader health care system, Medicaid beneficiaries experience gaps in coverage caused by provider shortages and geographic maldistribution of providers.<sup>48</sup> Access can also be impacted by provider willingness to accept Medicaid patients. Nationally, family practice physicians accept Medicaid patients at lower rates than patients with Medicare and private insurance (68% compared to 90% and 91% respectively). Physician participation in Medicaid varies by state, geographic area, and



medical specialty. Pediatricians, general surgeons, and obstetrics and gynecology providers are the most likely to accept Medicaid patients while psychiatrists are least likely to participate.<sup>49</sup> Low reimbursement compared to other payers is the primary driver of provider shortages in Medicaid. In 2016, Missouri's fee-for-service Medicaid program paid providers at approximately 72% of Medicare's payment rates.<sup>50</sup> Missouri ranks 46<sup>th</sup> nationally for its Medicaid fee-for-service reimbursement, paying just 79 percent of the national average.<sup>51</sup> Researchers have not found that provider participation varies significantly by Medicaid expansion status, but Missouri's already low reimbursement may warrant consideration to adequately meet the demand of additional Medicaid enrollees.

Existing health care shortages, particularly in rural areas, may impact the expansion population's access to health care. There have been mixed findings about whether the growth in Medicaid leads to longer appointment wait times.<sup>52</sup> Some providers have reported a surge in new enrollees who have previously deferred medical care, occasionally referred to as "pent-up" demand. Other research suggests that low-income individuals in expansion states delayed getting medical care because of long wait times and difficulty securing an appointment.<sup>53</sup> In 2014, community health centers in expansion states were more likely to report their patients experienced more difficulties securing an appointment compared to health centers in non-expansion states. Health centers in expansion states also expanded their capacity for dental and mental health services, likely supported by the increased revenue from the new expansion population.<sup>54</sup> One study in Michigan found that privately insured patients had a small decrease in appointment availability after expansion, which was caused in part by a requirement for new Medicaid enrollees to visit a primary care provider within 60 to 90 days.<sup>55</sup>

Just as with enrollment and outreach, Medicaid managed care plans play a crucial role in ensuring adequate provider access. Managed care organizations in expansion states have employed several solutions to improve network adequacy for consumers. Some have utilized community health workers, advance practice nurses, and other mid-level providers to help link beneficiaries to timely care. Plans also implement bonus payments to incentivize providers to accept more Medicaid enrollees. While these strategies may improve network coverage, most plans focus heavily on improving access to primary care, limiting the potential effectiveness for those Medicaid consumers who require specialty services.<sup>56</sup>

### ***Future Uncertainty***

States have not reported budgetary shortfalls caused by expansion; although, research has primarily focused on the first two years of expansion when the federal government financed 100% of the costs.<sup>57</sup> States will be responsible for 10% of the costs starting in 2020. Despite this transition, the arrangement is still beneficial for states who will continue to pay less for the expansion population compared to traditional enrollees (about 35% of expenditures in Missouri). State policymakers may still face fiscal constraints that make it challenging to finance the state share of expansion. In fiscal year 2020, 26 states are using general revenue funds to finance their share of expansion. Nine of the states using general revenue are also using other state funding sources such as premium taxes, cigarette taxes, or provider assessments. Four states are using only these alternative revenue streams.<sup>58</sup>

Missouri has data and research from other states to help assess the budgetary impact of expansion; although, estimates range depending on the assumptions used (i.e. enrollment, average per enrollee cost, spending growth rate, etc.). A fiscal analysis of expansion in Missouri projects a range of scenarios that span from costing \$42 million to saving \$95 million.<sup>59</sup> Several factors could influence expansion's impact. Since Missouri's current eligibility requirements are among the most restrictive, enrollment and costs for the expansion population could be higher than other states experienced. The cost estimates are also dependent on the state's payment to managed care companies. Managed care companies are paid a per member per month rate based on risk assessments, which are currently limited in large part due to the state's outdated technology. Further, there are challenges for managed care companies to accurately set rates for expansion enrollees because of "pent-up" demand for services and unique differences to the traditional Medicaid population.<sup>60</sup>

Cost estimates assume that the federal government will continue paying 90% of costs for the expansion population in perpetuity. Some state policymakers have raised concerns that the federal environment is uncertain, and policy may change. Following the 2016 elections, federal lawmakers proposed bills to repeal and replace the ACA. Congress proposed several pieces of legislation that would have changed Medicaid's structure and financing and put Medicaid expansion at risk.<sup>61</sup> Although these bills failed to pass Congress, uncertainty persists among some at the state level. Meanwhile, expansion advocates point out that the federal government has never lowered its state payment rates since Medicaid was created in 1965. Congress would presumably be less likely to make changes as more states continue to adopt expansion.

## Conclusion

Over two-thirds of states have passed Medicaid expansion since 2014, providing non-expansion states with an extensive body of research on the opportunities and challenges. There are significant data to illustrate the positive impact of Medicaid expansion on insurance coverage, health status, and economic activity, even if measuring other benefits such as long-term health impact and access requires a more nuanced understanding of the program. The weight of the evidence clearly calls for Missouri to expand its Medicaid program as intended under the ACA. Medicaid expansion presents a multitude of benefits for consumers, health care institutions, and providers, and is fiscally prudent for the state. While studies also highlight complications with Medicaid expansion relating to enrollment gaps, network adequacy, health equity, and potential costs, Missouri can use lessons from other states to overcome these hurdles. Based on the above, it is the view of Missouri Foundation for Health that expanding Medicaid eligibility is a sensible and effective policy solution to improve the health and well-being of Missourians.

## Missouri Foundation for Health Medicaid Portfolio

[Medicaid Value-Based Purchasing \(2019\)](#)

[Missouri Medicaid Basics \(2019\)](#)

[Analysis of the Fiscal Impact of Medicaid Expansion in Missouri \(2019\)](#)

[Medicaid Work Requirements \(2018\)](#)

[Health Care Reform – Capped Medicaid Funding \(May 2017\)](#)

[Strategies to Enhance Dentists' Participation in Medicaid \(2017\)](#)

[Medicaid Managed Care Final Rule: Implications for Missouri \(2016\)](#)

[Missouri Medicaid “Show-Me Healthy Babies” Program \(2016\)](#)

## Endnotes

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