

Why a State's Health Insurers Should Support Expanding Medicaid



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Since the Supreme Court's decision gave states the choice of whether or not to expand Medicaid under the Affordable Care Act, some governors have already come out against implementing the expansion. The resulting "coverage gap" in states that do not expand Medicaid would leave millions of poor uninsured individuals and families without coverage.

As advocates work to convince state policymakers to expand Medicaid, private insurers could be critical allies. This memo explains why a Medicaid coverage gap would adversely affect private health insurers and why insurers should support the Medicaid expansion in the states in which they operate. First, failing to expand Medicaid would likely destabilize the private insurance market and drive up premiums. Second, insurers would benefit financially from the expansion, whether they only offer Medicaid managed care plans, private individual and small-group market plans, or both.

Background: What Happens to People in States that Don't Expand Medicaid?

The Affordable Care Act (ACA) includes a mandatory Medicaid expansion that was intended to cover all non-elderly people with incomes of up to 133 percent of the federal poverty line starting in 2014. Individuals and families with higher incomes (up to 400 percent of the federal poverty line) will be eligible for federally financed subsidies through the exchange in their state. The Supreme Court decision upholding the constitutionality of the ACA, however, allows states to reject the Medicaid expansion. As a result, some governors have already stated that they do not plan to expand Medicaid.

In a state that does not expand Medicaid, an insurance exchange nevertheless will begin operating in 2014 and will provide a pathway for many low- and moderate-income people to access federal subsidies for premiums and cost-sharing for the purchase of private insurance plans offered in the exchange. (The federal government will establish the exchange in a state that does not do so.) If Medicaid is not expanded, federal exchange subsidies will still be available for near-poor people who would have otherwise received Medicaid coverage (those between 100 percent and 133 percent of the poverty line). However, anyone who falls between the current Medicaid eligibility level in a state and the poverty line will be left without access to subsidized health coverage. For example, in Texas, Medicaid eligibility for working parents stops at 26 percent of the federal poverty level, which translates to an annual income of less than \$5,000 for a family of three. If Texas does not expand Medicaid, as Governor Rick Perry has stated, then parents with incomes higher than this level, but lower than the poverty level, would *not* be eligible for Medicaid or federal subsidies to purchase coverage through an exchange. This would result in a highly inequitable scenario under which a significant number of poor, uninsured individuals and families would likely remain without coverage.

Medicaid Coverage Gap Would Increase Uncertainty for Insurers, Destabilize Private Markets, and Raise Premiums

In states that fail to expand Medicaid, many people who would otherwise have gained health coverage will remain uninsured. The Congressional Budget Office estimates that 3 million more people will lack health coverage in 2022 compared to what coverage would have been prior to the Supreme Court decision. Another 3 million people who would have gained Medicaid coverage will instead enroll in federally subsidized exchange coverage. This group is likely to have greater health spending, on average, than the rest of the exchange population.¹ In addition, in states that do not expand Medicaid, many more people will be “churning” back and forth between coverage (Medicaid and private insurance) and being uninsured (for those caught in the coverage gap between current Medicaid eligibility levels and 100 percent of the poverty line).

A coverage gap in states that do not expand Medicaid raises a number of serious concerns for insurers:

- **Higher-cost enrollees:** People who lack health insurance (particularly when they have low incomes) are more likely than people with coverage to forgo preventive services and delay or skip needed care.² When people who have been previously uninsured gain access to coverage, they tend to incur higher costs compared to when they lacked insurance, at least initially. For insurers, the claims they must pay on behalf of such individuals are likely to be higher than those who have had continuous coverage, as previously uninsured people tend to concentrate their health care use within periods when they have coverage. Moreover, people with unmet health needs are more likely to enroll in coverage when they first become eligible than those who do not expect to need health care.³

As a result, in states that do not expand Medicaid, the group of people enrolling in subsidized exchange coverage is likely to have higher costs than would have been the case prior to the Supreme Court decision. This would worsen the overall risk pool of people in the exchange and would therefore raise premiums. This adverse selection could then discourage more young and healthy people from enrolling in coverage, thus destabilizing the exchange.

- **Greater uncertainty:** Insurers are already uncertain about the characteristics of people (such as their health status, health care utilization, and health spending) who will newly enroll in coverage under the ACA. As a result, there is serious concern that insurers may build in a “risk premium” in the initial years of health reform implementation that would unduly raise premiums in the exchange and in the individual market outside the exchange. Once the major ACA market reforms have been in place for a period of time and insurers gain more experience with the newly covered population, the market should stabilize and insurers should no longer

¹ Congressional Budget Office, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” July 2012.

² Congressional Budget Office, “Key Issues in Analyzing Major Health Insurance Proposals,” December 2008.

³ See, for example, J. Michael McWilliams, Ellen Meara, Alan Zaslavsky, and John Z. Ayanian, “Use of Health Services by Previously Uninsured Medicare Beneficiaries,” *New England Journal of Medicine*, July 12, 2007, and Rob Damler, “Experience under the Healthy Indiana Plan: The Short-Term Cost Challenges of Expanding Coverage to the Uninsured,” Milliman Inc., August 2009.

build in risk premiums. In states that do not expand Medicaid, however, these risk premiums are more likely to persist beyond the initial years due to continued insurer uncertainty. As noted, in states with a coverage gap, many more people will continually churn between Medicaid, private coverage, and no coverage at all. Insurers would thus face greater uncertainty about their cost exposure and would be more likely to build a “risk premium” into their premium prices for a longer period of time, or even permanently. This would result in a substantially less stable private insurance market, more lasting uncertainty in pricing, and higher premiums than would otherwise have been the case.

- **Disruptions in care and coordination:** As people churn in and out of coverage in a state with a Medicaid coverage gap, they will face discontinuity in their care and interrupted access to their health care providers. Insurers that want to do a good job of managing care for people with chronic conditions will have a harder time doing so. They will lose contact with people as they drop out of coverage and then have to reestablish these relationships if and when coverage resumes. This will result in insurers incurring higher administrative costs that will likely be difficult to recover, in part because administrative costs are limited by the requirement that plans meet certain medical loss ratio or MLR thresholds. This could discourage insurers from managing care for individuals with chronic conditions. In states that expand Medicaid, consumers moving between programs will be more likely to have access to their health care providers and an insurer’s care management programs amid such churning because they will continue to have coverage. And states are already considering ways to minimize potential disruption for patients, by for example making some plans available both in Medicaid and the private insurance market.
- **Depressed overall enrollment:** A coverage gap would also undercut the effectiveness of public outreach efforts that are crucial to ensuring broad participation and a balanced risk pool in the newly reformed private insurance market. Community-wide marketing of annual open enrollment events, for example, would have less impact as large numbers of uninsured people in the state learn that they are not eligible for any coverage option that they can afford. To insurers, who support getting as many people as possible into some form of coverage, this would be highly problematic. They already fear that the youngest and healthiest individuals — those that cost less to cover and are therefore more profitable — are those most likely to remain without coverage.
- **Less effective risk adjustment:** Several elements of the ACA are designed to mitigate the risk of adverse selection, and thus limit insurer uncertainty and reduce premiums. Risk adjustment, in particular, is a permanent program that will begin in 2014 and is critical to compensating insurers in the individual and small-group markets for the risks of the individuals they enroll, so they have less incentive to cherry pick the healthy and avoid enrolling sicker, higher-cost individuals. Risk adjustment, however, is imperfect; it will not fully compensate insurers with sicker-than-average enrollment for the additional risk they take on. This is expected to be particularly true in the initial years after full implementation, when the risk adjustment system is new and insurers have no experience with pricing in the reformed market. But in states with a Medicaid coverage gap, this problem would be more acute and more persistent. It would be harder to institute an accurate risk adjustment system while significant portions of a state’s population remain uninsured. That would lead to greater insurer uncertainty and the likelihood that insurers will continue to build in risk premiums.

- **More costly reinsurance:** The ACA also establishes a temporary reinsurance program from 2014 through 2016 to compensate insurers in the individual market when they cover people whose health costs exceed certain thresholds. The program is funded with assessments on the entire insurance market in a state. In a state with a Medicaid coverage gap, the cost of the reinsurance program would be expected to be greater because of the higher costs associated with previously uninsured individuals, so assessments on insurers and third party administrators (on behalf of group health plans) would have to be higher, or the reinsurance payments provided to insurers would have to be made less generous. That would also have the effect of increasing premiums in the individual market inside and outside the exchange.

Medicaid Expansion Directly Benefits Health Insurers

Health insurers — whether they are only involved in Medicaid managed care, offer only health insurance plans in the private individual and small group markets, or have a presence in both markets — have a clear financial interest in ensuring that as many states as possible expand their Medicaid programs.

The Medicaid expansion would add an estimated 13 million people to the program in 2014 (rising to 17 million by 2016) if it is implemented in all states, according to CBO. This translates into \$40 billion to \$45 billion in annual new revenue for managed-care companies, according to projections by Carl McDonald of Citigroup Investment Research.⁴ For insurers already covering Medicaid enrollees, the case for Medicaid expansion is clear; these firms are well positioned to increase the number of people they cover in states that fully implement the ACA expansion and thus increase their revenues. The key private Medicaid insurers vary by state, but the biggest players in the country include WellPoint (which became the largest private provider of Medicaid managed care by membership when it purchased Amerigroup Corp. earlier this month), UnitedHealthcare, Centene Corp., and Molina Healthcare. Already, some of these Medicaid managed care insurers have begun to publicly weigh in on the need for states to expand Medicaid. For example, Jim Carlson, the CEO of Amerigroup stated that if a state fails to expand Medicaid, “you create, in effect, sort of a new donut hole between the people who have Medicaid coverage and people at 133% of federal poverty, who are now eligible for a fully subsidized benefit in an exchange. What do people say to the people who are the vast majority of folks who fall in between there, who are supposed to be covered by this law?”

Many of the private insurers providing Medicaid managed care today also offer coverage in various states’ individual and small group insurance markets. For example, Centene Corp. is known for providing Medicaid managed care, but it also operates Celtic Insurance Co., which is licensed in nearly all states to sell commercial insurance. UnitedHealthcare, part of UnitedHealth Group, also participates in Medicaid and commercial insurance markets, and Aetna Inc. recently announced it will acquire Coventry Health Care Inc., expanding its presence both in Medicaid and individual-market insurance.⁵ When WellPoint purchased Amerigroup, WellPoint’s then-CEO Angela Braly

⁴ Anna Wilde Mathews and Jon Kamp, “WellPoint’s Medicaid Bet,” *The Wall Street Journal*, July 9, 2012.

⁵ “Aetna Inc. Conference Call to Discuss its Definitive Agreement to Acquire Coventry Health Care Inc.,” Thompson Reuters Street Events, edited transcript, August 20, 2012.

noted this “powerful combination.” Carlson, the Amerigroup CEO (who is slated to remain with WellPoint post-acquisition) also said being in both markets “allows people to move fluidly back and forth as they gain and lose eligibility to either a Blue-branded product or Amerigroup.”⁶ Put another way, insurers recognize that churning will occur between Medicaid and private coverage and therefore see being present in both markets as an opportunity to limit the negative effects of churning and retain enrollees.

Insurers planning to expand their existing Medicaid managed care presence (or enter that market) also have much to lose in states that fail to expand Medicaid. For example, Bloomberg Government attempted to estimate the potential Medicaid revenues at stake in the 27 states participating in the Supreme Court lawsuit on the Medicaid expansion. Bloomberg’s analysis found that the largest share of new federal and state Medicaid spending among the lawsuit states due to the expansion — \$46.3 billion — would go to managed-care plans for the period 2014 to 2018, more than other sectors such as inpatient hospitals and home health care. Moreover, almost two-thirds of that \$46.3 billion, or \$29.8 billion, would be concentrated in just five states: Texas, Pennsylvania, Michigan, Ohio, and Georgia. “Managed-care companies doing business, or planning to do business, in these jurisdictions are at greatest risk for forfeiting new Medicaid revenues if the Supreme Court nullifies the Medicaid expansion,” the Bloomberg report found. The leading managed-care firms in those states include Amerigroup (since purchased by WellPoint), Molina, and UnitedHealthcare.⁷

Finally, as noted above, private insurers that do not currently contract with states to provide Medicaid managed care and do not plan to expand into that business would still be adversely affected by the churning, higher prices, and greater uncertainty that would result from a coverage gap in a state. A less stable private market would be less profitable for many of these insurers. In sharp contrast, the Medicaid expansion would stabilize a state’s insurance market, increase the certainty around the cost of covering people in the state, and decrease the risk of adverse selection for private insurers. It is also worth noting that major insurance industry trade associations including America’s Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA) have long supported expanding Medicaid to millions more low-income people for many of these reasons.⁸

⁶ “WellPoint Announces Definitive Agreement to Acquire Amerigroup – Conference Call,” edited transcript, Thomson Reuters StreetEvents, July 9, 2012.

⁷ Matt Barry, “Supreme Court Ruling May Undermine Increase in Medicaid Spending,” Bloomberg Government Study, March 9, 2012.

⁸ Specifically, AHIP and BCBSA have long endorsed expanding Medicaid to the poverty line. See, for example, <http://www.healthleadersmedia.com/HOM-235759-4625/Report-States-could-save-money-by-expanding-Medicaid-managed-care> and <http://www.blueadvocacy.org/site/page/medicaid>.