A Complicated Subject: The Impact Of Medicaid Expansion On Hampton Roads

A COMPLICATED SUBJECT: THE IMPACT OF MEDICAID EXPANSION ON HAMPTON ROADS

This is about getting out there and helping to bend the cost of health care for every Virginian.
– Sen. Frank Wagner, R-Virginia Beach

(This) abandons Virginia's long-standing reputation for fiscal responsibility.
– Sen. Thomas K. Norment, R-Williamsburg[1]

On July 1, 2018, after years of heated debate, Virginia became the 33rd state (along with the District of Columbia) to sign an expansion of Medicaid coverage into law. Effective Jan. 1, 2019, the Commonwealth will extend Medicaid eligibility to approximately 400,000 more Virginians. Now is the time to take a look at the potential impact of Medicaid expansion on Hampton Roads.

Program Overview

Medicaid is a joint program between the federal government and the states to provide health coverage for low-income individuals. Medicaid operates in conjunction with another federal-state partnership, the Children's Health Insurance Program (CHIP), which aims to improve children's health insurance coverage and outcomes. According to the Centers for Medicare and Medicaid Services, more than 73 million Americans were enrolled in Medicaid and CHIP in May 2018; about 1 million of those enrollees reside in Virginia. Medicaid is one of the largest payers for health services in the U.S., with total spending topping $550 billion in 2016.

The impact of Medicaid expansion on Virginians is not merely an academic question. Chavelia Franklin, a 49-year-old certified nursing assistant, recently told The Virginian-Pilot she works only 12 hours a week, even though she is willing to work more. "Unfortunately, I fell into the gap where I didn't make enough money or hours for Obamacare," she said. Franklin made too much money to qualify for Medicaid, but not enough money to receive subsidized health insurance through the marketplace exchanges. What happens when she gets sick? "It forces me to go to the emergency room, which draws a humongous bill."[2]

State participation in the Medicaid program is voluntary, although every state participates. Why then has Medicaid expansion generated such heated debate? In 2012, the U.S. Supreme Court ruled that states could not be coerced by the federal government to expand Medicaid.[3] The choice of whether and when to expand would be left to individual states, with some choosing to expand immediately and others, such as Virginia, opting to debate

1 Both quotes come from Laura Vozzella and Gregory S. Schneider, "Virginia General Assembly Approves Medicaid Expansion to 400,000 Low-Income Residents," The Washington Post (May 30, 2018). Sen. Wagner voted in favor; Sen. Norment, the majority leader, voted nay.

2 https://pilotonline.com/news/local/columnist/roger-chesley/article_bc6ed2fa-900f-11e8-9a99-bf11176d81d5.html.

3 National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).

the merits of expansion before making a decision. To incentivize states to enroll new participants, the federal government initially covered 100 percent of the cost of new enrollees. In 2019, it will reimburse expansion states for 93 percent of the cost of new enrollees, a share that will decline and remain at 90 percent in 2020 and beyond. This is a much higher rate of reimbursement than the 50/50 split for existing Medicaid enrollees in Virginia.

In this chapter, we will look at how Medicaid expansion may affect health insurance coverage and health care in Hampton Roads. We'll consider opposing views, the history of health insurance, current eligibility, future eligibility under expansion and financial impact. It's complicated, but a topic worthy of discussion.

Two Sides Of The Debate

Detractors of expansion contend that the Medicaid program is poorly run, inefficient and an unwise use of the public purse. They also argue that the costs of Medicaid expansion have swelled beyond predictions. This claim is true, both because Medicaid has attracted more users than forecasted, and the average cost per user has exceeded expectations. New enrollments have outpaced Congressional Budget Office estimates by more than 50 percent. Costs per new Medicaid participant have been up to 50 percent higher than those projected by the Centers for Medicare and Medicaid. Even if the federal government continues to reimburse states for 90 percent of the costs associated with new enrollees, critics fear that costs will balloon at the federal and state level.[4]

Supporters, however, note that state expenditures per newly eligible Medicaid recipient fell by 6.9 percent in 2016 and are expected to decline further as states gain experience, and services for people with less urgent health problems increase. Further, multiple states have found that their health-related and criminal justice expenditures decline due to increased Medicaid coverage.[5] Proponents also cite numerous empirical studies showing Medicaid expansion

4 See Henry J. Kaiser Family Foundation, March 28, 2018, and the Mercatus Center, Charles Blahous, June 28, 2017, for more details.

5 See Henry J. Kaiser Family Foundation, March 28, 2018, and the Center on Budget and Policy Priorities, Judith Solomon, Jan. 24, 2017, for study details.

increases the scope of insurance coverage, produces demonstrably healthier individuals and has minimal or no adverse labor market participation effects.[6] (These effects appear to be more pronounced in poorer communities.)

Almost 135,000 residents, or 8 percent of the population of the Virginia portion of Hampton Roads, lacked health insurance in 2016.[7] More than 25 percent of our region's population received their health insurance through Tricare or the Department of Veterans Affairs (VA) in 2016. Only two of the nation's metropolitan areas, each with much smaller populations than Hampton Roads, had a higher percentage covered by Tricare and the VA in 2016: Fayetteville, North Carolina, and Clarksville, Tennessee.

6 Laura Antonisse, Rachel Garfield, Robin Rudowitz and Samantha Artiga, "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review," Henry J. Kaiser Family Foundation (March 28, 2018), www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018.

7 The Virginia portion of the Virginia Beach-Norfolk metropolitan statistical area includes the counties of Gloucester, Isle of Wight, James City, Mathews and York and the cities of Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach and Williamsburg.

Between 15,000 and 27,000 newly eligible adults in Hampton Roads are expected to enroll in Medicaid once expansion is fully implemented. Annual uncompensated care costs for health care providers are expected to decline between $18 million and $25 million. **Even with Medicaid expansion, the number of uninsured adults in Hampton Roads will still approach 100,000.** Along with the large number of residents who will remain without insurance, **we caution that if the federal government were to lower its reimbursement share for new Medicaid expansion enrollees to that of existing Medicaid enrollees, the costs of expansion could increase by a factor of five.**

Accidents Of History: Health Insurance In The United States

Constant change has been the trademark of health insurance in the United States over the past 150 years. Historian John Murray found that by the mid-1800s, employers, unions and fraternal organizations had established "sickness funds" as a form of insurance. Employees would typically contribute 1 percent of their weekly wages to the sickness funds, which would then pay sick or disabled employees up to 60 percent of their lost wages. By 1890, there were more than 1,300 such funds, and Murray estimates that 20 percent of industrial workers belonged to a sickness fund in the early 1900s.[8] While not health insurance per se, these funds provided workers with a semblance of indemnity coverage.

In the late 1920s, to encourage patients to pay their bills, hospitals started offering plans where medical payments would be forgiven if one paid a monthly fee. This eventually evolved into the modern Blue Cross system.[9] Blue Shield, established in 1939, mirrored the expansion of the Blue Cross system, although the Blue Shield program paid consumers, who were then responsible for paying physicians.

During World War II, the federal government instituted wage and price controls, along with rationing, to control inflation and redirect resources to the war effort. Facing labor shortages as the conscription of men increased over the course of the war, businesses and industry increasingly turned to women, leading to a significant rise in female labor force participation. The rising strength of unions led to demands for additional forms of compensation, including the provision of health insurance. By 1944, the National War Labor Board exempted employer-sponsored health insurance from wage controls, and the Internal Revenue Service (IRS) ruled that employees did not have to pay income taxes on premiums paid by employers. These factors combined so that firms, constrained in their ability to offer workers higher wages, increased other forms of compensation, including employer-sponsored health insurance. One anonymous employer noted, "It was a case of paying the money for insurance for their employees or Uncle Sam in taxes."[10]

While precise historical data on private health insurance coverage are difficult to come by, Michael Morrisey notes in his book "Health Insurance" that coverage by any type of private health insurance rapidly increased during and after World War II. As we illustrate in Graph 1, 9.1 percent of Americans had some form of private health insurance in 1940, a percentage that vaulted to 50.6 percent by 1950.

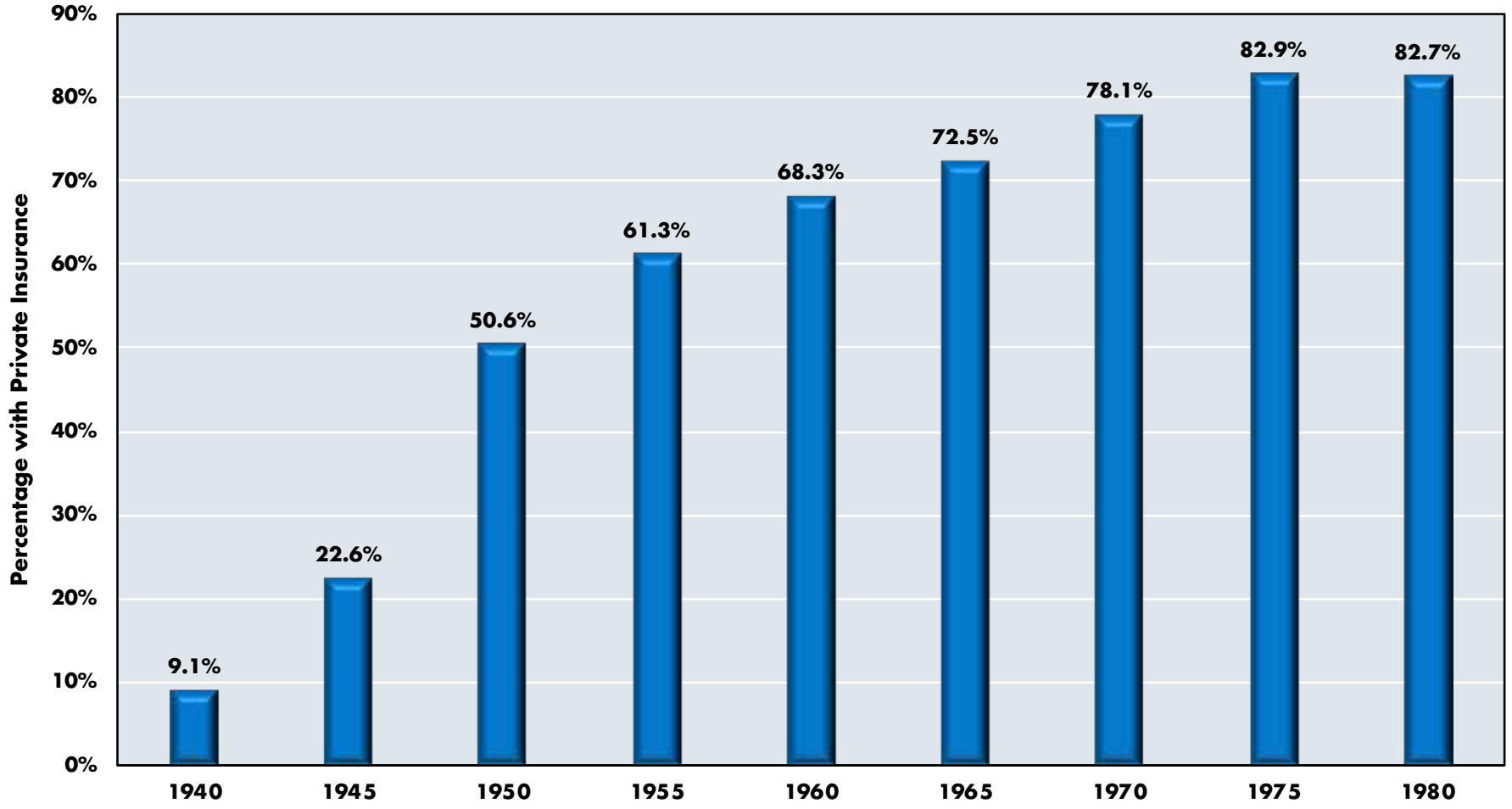
8 Murray, J.E., 2007, *Origins of American Health Insurance: A History of Industrial Sickness Funds*, New Haven, CT: Yale University Press.

9 Blumberg, Alex and Davidson, Adam, "Accidents of History Created U.S. Health System," NPR special series "Planet Money," Oct. 22, 2009, https://www.npr.org/templates/story/story.php?storyId=114045132.

10 Gordon, Colin, 2003, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*, Princeton: Princeton University Press.

GRAPH 1

PERCENTAGE OF POPULATION WITH SOME FORM OF PRIVATE HEALTH INSURANCE: UNITED STATES, 1940-1980



Source: Michael Morrisey, 2008, "Health Insurance, Second Edition," Chicago: Health Administration Press

Almost every president since World War II has called for reforms to the health insurance system in the United States. Most recently, the 2010 Patient Protection and Affordable Care Act (PPACA), otherwise known as Obamacare, attempted to strike a balance between private health insurance and public intervention in the marketplace. Obamacare allowed states to expand Medicaid coverage with higher federal rates of reimbursement, created health insurance marketplaces where individuals could compare plan costs and benefits across standardized plans, offered a federal tax credit for those earning between 100 and 400 percent of the Federal Poverty Level (FPL), prevented denial of coverage based on pre-existing conditions, and allowed young adults up to age 26 to remain on family policies. One of the most unpopular provisions of Obamacare was the mandate requiring individuals to purchase health insurance or face a financial penalty. The 2017 Tax Cuts and Jobs Act, however, reduced the penalty to zero, effectively eliminating the individual mandate as of Jan. 1, 2019.

Having health insurance, however, does not mean that one is immune from health care costs. A 2016 survey conducted by the Kaiser Family Foundation and the New York Times found that 20 percent of respondents had problems paying medical bills in the past year and, for those without health insurance, over 50 percent reported difficulty paying medical bills. One study from 2011 claimed that up to 26 percent of bankruptcies filed by low-income households were related to out-of-pocket medical costs.[11] These bills can be very problematic when combined with low savings amounts, leading to delayed procedures, which in turn can lead to poorer health outcomes.

Americans are generally unsatisfied with the state of the health care system but are happy with their doctors. **More than 70 percent of Americans responded in a February 2018 Gallup poll that the U.S. health care system is in a "state of crisis" or "has major problems."[12] Yet, when asked about their personal health care experience, three-quarters of employed Americans said their health care was "excellent" or "good."** These responses are like Americans' perceptions of Congress versus their individual representative or senator: unhappy with the institution but satisfied at the personal level.

11 "The Burden of Medical Debt: January 2016 Results from the Kaiser Family Foundation/New York Times Medical Bills Survey," and Gross, T. and Notowidigdo, M.J. (2011), "Health insurance and the consumer bankruptcy decision: Evidence from expansions of Medicaid," *Journal of Public Economics*, 95(7), 767-778.

12 http://news.gallup.com/poll/226607/news-americans-satisfaction-healthcare.aspx.

Critics of the U.S. health care system often argue that the Canadian system operates with lower costs and better outcomes. While 100 percent of Canadians have health insurance, not all services are covered, so individuals do have out-of-pocket expenses, and health needs may not always guarantee prompt access to care. The 2017 edition of "Waiting Your Turn," a report by the Canadian think tank Fraser Institute, found that wait times for medically necessary treatments reached the highest recorded levels in 2017. The median wait time from a general practitioner's initial referral to a specialist to final receipt of treatment was more than 21 weeks. Canadians could also expect to wait about four weeks for an ultrasound or a computed tomography (CT) scan and almost 11 weeks for a magnetic resonance imaging (MRI) scan. Every health care system has tradeoffs.

Who Has Health Insurance?

Today, the U.S. Census Bureau tracks not only how many Americans have health insurance, but also what types of organizations provide that insurance. Reflecting the fact that some people may have been covered by more than one type of health insurance during the year, Table 1 shows that in 2016, the majority of Americans had some form of health insurance through their employer. Another 16 percent directly purchased a plan through a private insurer or the Obamacare Marketplace exchanges. Over one-third of Americans received health insurance through Medicare (16.7 percent) or Medicaid (19.4 percent). About 5 percent of Americans received health insurance through either Tricare or the VA. Lastly, 8.8 percent of Americans were uninsured in 2016.

TABLE 1

HEALTH INSURANCE COVERAGE IN THE UNITED STATES: NUMBERS AND RATES, 2013 AND 2016 (IN THOUSANDS)

	2013 Number	2013 Rate	2016 Number	2016 Rate	Change from 2013 to 2016
Any Health Plan	**271,606**	**86.7%**	**292,320**	**91.2%**	**+4.6%**
Employer-based	**174,418**	**55.7%**	**178,455**	**55.7%**	**0.0%**
Direct-purchase	**35,755**	**11.4%**	**51,961**	**16.2%**	**+4.8%**
Medicare	**49,020**	**15.6%**	**53,372**	**16.7%**	**+1.1%**
Medicaid	**54,919**	**17.5%**	**62,303**	**19.4%**	**+1.9%**
Military Health Care	**14,016**	**4.5%**	**14,638**	**4.6%**	**+0.1%**
Uninsured	**41,795**	**13.3%**	**28,052**	**8.8%**	**-4.6%**
Total	**313,401**	**--**	**320,372**	**--**	**--**

Source: U.S. Census (2017), Health Insurance Coverage in the United States: 2016. Percentages may not sum to 100 percent, as people can be covered by more than one type of health insurance during the year. Individuals were considered uninsured if they were uninsured for the entire calendar year.

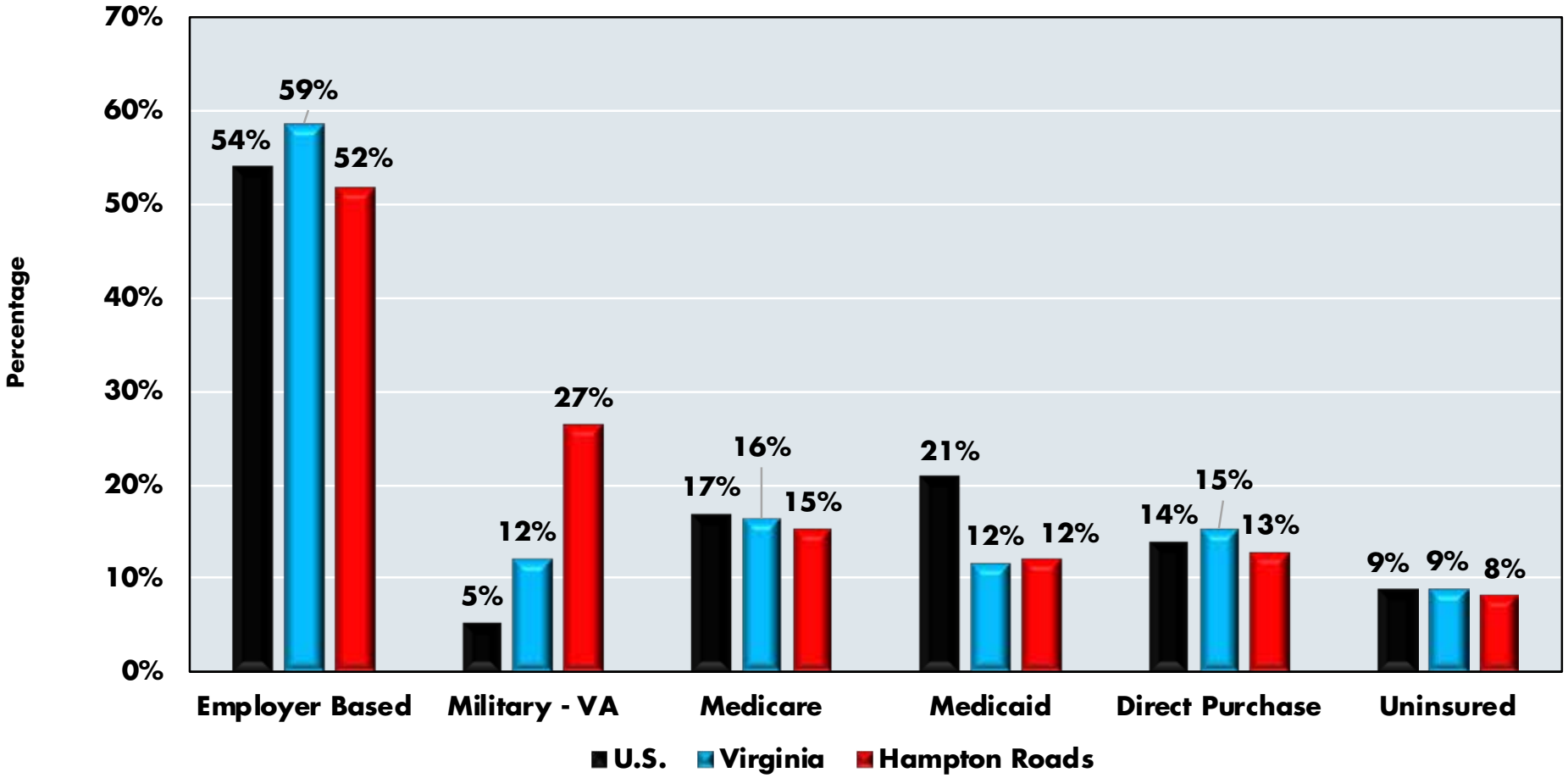
In 2016, Hampton Roads' uninsured rate of 8 percent was slightly below that of the United States and Virginia (Graph 2). **Over 25 percent of the population in Hampton Roads was insured through Tricare or the VA, the highest for any metropolitan area in the U.S. with a population over 1 million.** Given the large percentage of the population covered through Tricare and/or the VA, the percentage of individuals with employer-sponsored coverage and direct purchase insurance (where one directly buys private insurance, including via the marketplace exchanges) was lower in Hampton Roads than the U.S. or Virginia. Lastly, the percentage of individuals reporting coverage through Medicare or Medicaid was also lower in Hampton Roads than the U.S. or Virginia.

Insured rates also vary within Hampton Roads. As illustrated in Table 2, the percentage of insured varies from a low of 85.4 percent in Norfolk to a high of 96.1 percent in Poquoson. The impact of Medicaid expansion is likely to be greater in those cities and counties with higher rates of uninsured residents.

Ariel Phelps is a Virginia Beach resident, and once she turned 27, she could no longer stay on her father's health insurance plan. She is currently pursuing a master's degree and earns too little for coverage through Obamacare, but too much to qualify for Medicaid. As noted in a July 25, 2018, article in The Virginian-Pilot, when Phelps had a recent health scare, she received care through Planned Parenthood. "It worked out. ... But I had to pay out of pocket," Phelps said.

GRAPH 2

HEALTH CARE COVERAGE TYPES FOR ALL INDIVIDUALS: UNITED STATES, VIRGINIA AND HAMPTON ROADS, 2016



Source: Estimates based on the 2016 American Community Survey one-year microdata. Only 0.51, 0.06 and 0.08 percent of respondents for the U.S., Virginia and Hampton Roads, respectively, stated that they only had Indian Health Service insurance and are excluded from the graph. Percentages may not sum to 100 percent, as individuals may have more than one type of health insurance.

TABLE 2

HEALTH INSURANCE COVERAGE IN CITIES AND COUNTIES OF HAMPTON ROADS, 2012-2016

Locality	Total Population	Number of Insured	Percentage Insured	Number of Uninsured	Percentage Uninsured
Chesapeake	220,652	202,265	91.7	18,387	8.3
Gloucester County	36,385	32,480	89.3	3,905	10.7
Hampton	131,597	116,152	88.3	15,445	11.7
Isle of Wight County	35,549	32,919	92.6	2,630	7.4
James City County	70,246	64,930	92.4	5,316	7.6
Mathews County	8,757	8,024	91.6	733	8.4
Newport News	172,213	150,795	87.6	21,418	12.4
Norfolk	218,963	186,980	85.4	31,983	14.6
Poquoson	11,864	11,401	96.1	463	3.9
Portsmouth	92,130	80,623	87.5	11,507	12.5
Suffolk	84,759	77,062	90.9	7,697	9.1
Virginia Beach	424,254	384,568	90.6	39,686	9.4
Williamsburg	14,825	14,050	94.8	775	5.2
York County	63,499	59,714	94.0	3,785	6.0

Source: U.S. Census Bureau, 2012-2016 American Community Survey data obtained through American Fact Finder. Total population is the civilian noninstitutional population.

Who Is Currently Eligible For Medicaid In Virginia?

Until Jan. 1, 2019, the Virginia Medicaid program is limited to residents of the Commonwealth who are U.S. citizens, permanent residents or legal residents in need of health insurance. To qualify, individuals must be pregnant, a parent or relative caretaker of a dependent child or children under age 19, under age 21 and in foster care, in a nursing facility, blind, disabled, or 65 years of age or older.[13] Nondisabled adults without children are currently not eligible to enroll in Virginia's Medicaid program.

Who can enroll in Medicaid in the Commonwealth is determined, in part, by household income. Virginia sets income eligibility guidelines relative to the Federal Poverty Levels (FPL), which are determined by the U.S. Department of Health and Human Services.[14] The income eligibility thresholds for each category of Medicaid eligibility are based on these poverty limits (Table 3).

13 Individuals who receive Social Security disability benefits (https://www.ssa.gov/benefits/disability/) may be eligible to enroll in Medicaid, https://www.healthcare.gov/people-with-disabilities/ssi-and-medicaid/.
14 https://aspe.hhs.gov/poverty-guidelines.

TABLE 3

2018 FEDERAL POVERTY LIMITS AND MEDICAID INCOME ELIGIBILITY GUIDELINES

Number of Persons in Household	Annual Federal Poverty Limits	Pregnant Women and Children*	Aged, Blind and Disabled Adults	FAMIS and FAMIS Plus
	--	148% of FPL	80% of FPL	205% of FPL
1	$12,140	$17,968	$9,712	$24,887
2	$16,460	$24,361	$13,168	$33,743
3	$20,780	$30,755	$16,632	$42,599
4	$25,100	$37,148	$20,080	$51,455
5	$29,420	$43,542	$23,536	$60,311
6	$33,740	$49,936	$26,992	$69,167

Sources: Federal Poverty Guidelines, U.S. Department of Health and Human Services and Virginia DMAS. For households with more than six persons, add $4,320 per individual to the FPL. *For pregnant women who qualify for Medicaid only in households with more than six persons, add $6,394 per individual. For FAMIS and FAMIS Plus, Virginia's CHIP programs for households where income exceeds 148 percent of FPL, add $8,856 per additional household member. Table includes 5 percent income disregard for children, parents and pregnant women. The income disregard means that, for certain groups of individuals, the first 5 percent of income is not included in income eligibility calculations.

Currently, Virginia's income guidelines are the same across all localities for pregnant women and children under the age of 19, in that countable income cannot exceed 148 percent of FPL. For the aged, blind and disabled, countable income cannot exceed 80 percent of FPL.

Parents and caretakers of children under the age of 18 who qualify in the category of Low Income Families with Children (LIFC), however, face income guidelines that depend on where they live.[15] **The LIFC income guidelines can cause confusion and may deter work effort. As illustrated in Table 4, a family of three with countable income of around $10,000 a year would be eligible for Medicaid in Hampton but would become ineligible if they moved to any other jurisdiction in Hampton Roads.**

TABLE 4

MEDICAID INCOME ELIGIBILITY GUIDELINES FOR LOW-INCOME FAMILIES WITH CHILDREN, EFFECTIVE JULY 1, 2017

	Maximum Annual Countable Income
Gloucester, Isle of Wight County, James City County, Mathews County, Suffolk, York County	$6,720
Chesapeake, Newport News, Norfolk, Poquoson, Portsmouth, Virginia Beach, Williamsburg	$7,968
Hampton	$10,536

Source: Virginia Department of Medical Assistance Services, "Medical Assistance Eligibility Policy & Guidance," Chapter 4 (May 2018), Appendix 5. Annual countable income is determined by the geographical income category monthly income guideline plus the 5 percent FPL Disregard. For a family of three, the 5 percent FPL Disregard is $87 per month.

15 Virginia Department of Medical Assistance Services, "Medical Assistance Eligibility Policy & Guidance," Chapter 4 (May 2018).

Who Will Be Eligible To Enroll Once Expansion Occurs In Virginia?

On Jan. 1, 2019, nondisabled adults with countable incomes up to 138 percent of the FPL will become eligible to enroll in the Virginia Medicaid program (Table 5). The income thresholds for disabled adults and low-income families will also adjust upward. These changes are not insignificant.

A single, childless, nondisabled adult who is ineligible for Medicaid in 2018 could earn up to $16,754 and be eligible for Medicaid in 2019. For a single, disabled adult, the income limit rises from $9,712 in 2018 to $16,754 in 2019. Families will also see a rise in income limits. **A family of three in Norfolk, for example, will see the income limit rise from $7,968 in 2018 to $28,677 in 2019.**

TABLE 5

2018 FEDERAL POVERTY LIMITS AND EXPANSION INCOME LIMITS BY HOUSEHOLD

Number of Persons in Household	Federal Poverty Limit	Medicaid Enrollees as of Jan. 1, 2019 (138 percent of FPL)
1	$12,140	$16,754
2	$16,460	$22,715
3	$20,780	$28,677
4	$25,100	$34,638
5	$29,420	$40,600
6	$33,740	$46,562

Sources: Federal Poverty Guidelines, U.S. Department of Health and Human Services and Coverva.org/expansion. For households with more than six persons, add $4,320 per individual to the FPL.

Who Among The Nonelderly Has Insurance In Hampton Roads?

People who are 65 and older are automatically eligible for Medicare, even if they continue to carry private health insurance. While some individuals 65 and older may qualify for Medicaid (as it offers benefits such as nursing home care and personal care services), these "dual eligibles" already have health insurance through Medicare. This is important since Medicaid only pays after Medicare, private-employer group health plans and Medicare supplements have paid.[16] An individual who has Medicare and qualifies for Medicaid would not be considered as transitioning from uninsured status to insured status.

Almost 135,000 residents of Hampton Roads under the age of 65 lacked health insurance coverage in 2016 (Table 6). Of this number, nearly 119,000 were adults and about 16,000 were under the age of 19.

Approximately 42,000 adults lacked health insurance and earned less than 138 percent of the Federal Poverty Level, the target group for Medicaid expansion in 2016. **Surprisingly, almost 7,000 residents of Hampton Roads under the age of 19 lacked health insurance even though their households earned less than 138 percent of the poverty limit. In many cases, these children should be eligible for Medicaid or Virginia's FAMIS or FAMIS Plus programs. It appears that some children may fall through the cracks in the system.**

16 https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html.

TABLE 6

NUMBER OF UNINSURED UNDER 65 BY FEDERAL POVERTY CATEGORY: HAMPTON ROADS, 2016

	Adults (19 to 64 Years)	Minors (0 to 18 Years)	Total
Less than 100% of FPL	30,254	5,310	35,564
100% to 138% of FPL	11,898	1,465	13,363
139% to 400% of FPL	56,273	6,945	63,218
Greater than 400% of FPL	20,513	1,943	22,456
Total	118,938	15,663	134,601

Source: Hampton Roads estimates based on the 2016 American Community Survey 1-year microdata.

Martha Harding's case was recently highlighted by the Virginia Poverty Law Center. She cares for four grandchildren who are on Medicaid, and works in a minimum-wage administrative job. "I don't have insurance, and I worry about what would happen to my grandchildren if I get sick or hurt and can't work. Hardworking people like me, age 55 to 64, have a difficult time because we are not yet able to get Medicare due to age and can't go on Medicaid because we try to earn money to take care of our families."

Focusing On The Working-Age Population In Hampton Roads

As many lower-income people who are disabled, pregnant, or children may already qualify for Medicaid, the impact of Medicaid expansion is likely to be greatest among working-age adults. Expansion, however, does not mean that these individuals will automatically be enrolled in Medicaid. They will need to actively seek to enroll in the program. Based upon the behavior of the uninsured in other states where Medicaid previously expanded, we know that not all eligible individuals will enroll. The additional requirement that nondisabled adults must work or volunteer may deter some from enrolling in Medicaid.

Table 7 illustrates that the uninsured rate for the working-age (19-64) population in Hampton Roads was 11.4 percent in 2016, compared to 12.6 percent for the entire U.S. population. As with the general population, over one-fourth of the working-age population receives health insurance through Tricare or the VA. As one might expect, a higher percentage was covered by employer-based group health insurance plans, and a lower percentage was covered by Medicare relative to the total population. Within the working-age population in Hampton Roads, 7.1 percent were covered by Medicaid, compared to 15.4 percent for the United States.

TABLE 7 HAMPTON ROADS AND UNITED STATES HEALTH INSURANCE PROVIDER DISTRIBUTION: INDIVIDUALS AGES 19-64, 2016		
Type of Insurance	**United States**	**Hampton Roads**
Employer-based	**60.6%**	**56.2%**
Tricare	**2.5%**	**21.7%**
Medicaid	**15.4%**	**7.1%**
Direct Purchase	**12.0%**	**11.3%**
Veterans Affairs	**1.7%**	**3.9%**
Medicare	**4.0%**	**3.2%**
Indian Health Service	**0.5%**	**0.1%**
Uninsured	**12.6%**	**11.4%**

Source: Hampton Roads estimates based on the 2016 American Community Survey 1-year microdata. Sample only includes individuals ages 19-64. Percentages may not sum to 100 percent, as individuals may have more than one type of health insurance

Estimating The Take-Up Rate Of Medicaid

What percentage of the eligible population can we reasonably expect to take up, or enroll in, Medicaid on or after Jan. 1, 2019? To answer this question, we draw upon the experience of Maryland and West Virginia, states that expanded Medicaid in 2014.

In both states, the insured rate increased following Medicaid expansion. By comparing the insured rate in 2013 with the insured rate in 2016, we can estimate the "take-up" rate. The take-up rate is an estimate of the percentage of individuals who added health insurance from 2013 to 2016. To make matters slightly more complicated, take-up rates vary by state and income category.

Maryland and West Virginia started out at different points. In 2013, a higher percentage of the population of Maryland reported having health insurance than West Virginia.[17] Because where you start often determines where you finish, the estimated take-up rates for the two states are quite different.

As shown in Table 8, Maryland's take-up rate was almost 30 percent for people earning less than 100 percent of the poverty limit. For those earning between 100 and 138 percent of the poverty limit, the take-up rate was about 46 percent. What does this mean? If you earned less than 100 percent of the poverty limit in Maryland, you were 30 percent more likely to have health insurance in 2016 when compared to 2013.

A similar but more significant story emerges from West Virginia. For those earning less than 100 percent of the poverty limit, the take-up rate was almost 63 percent. The take-up rate was even higher for people with incomes between 100 and 138 percent of the poverty limit, about 68 percent. Why the higher take-up rates? A contributing factor was the starting point, in which a lower percentage of West Virginia's population was uninsured prior to Medicaid expansion.

TABLE 8 ESTIMATED TAKE-UP RATES FOR MARYLAND AND WEST VIRGINIA, 2016				
	Maryland		**West Virginia**	
	Less than 100% of FPL	**100% to 138% of FPL**	**Less than 100% of FPL**	**100% to 138% of FPL**
2016	**29.9%**	**45.5%**	**62.5%**	**67.6%**

Source: 2016 American Community Survey one-year microdata. Sample only includes adults ages 19-64. The take-up rate is determined by the rise in the percentage of individuals reporting any health insurance coverage in each year relative to the percentage of individuals reporting health insurance coverage in 2013.

Drawing upon the experience of Maryland and West Virginia, we estimate the take-up rate for Medicaid expansion in Hampton Roads will be 44 percent for people with incomes

17 For Maryland, in 2013, 73.4 percent of those earning less than 100 percent of FPL and 69.6 percent of those between 100 and 138 percent of FPL reported having health insurance. For West Virginia, 64.1 percent of those earning less than 100 percent of FPL and 62.6 percent of those between 100 and 138 percent of FPL reported having health insurance

less than 100 percent of FPL and 55 percent for those with incomes between 100 and 138 percent of FPL.

Some might argue that these take-up rates are too low. In 2016, the Urban Institute estimated a take-up rate of 56.8 percent for a potential Medicaid expansion in Virginia.[18] In 2017, the Virginia Department of Medical Assistance Services (DMAS) projected take-up rates and enrollment for Medicaid expansion in Virginia. DMAS estimated that 85 percent of eligible (and interested) adults with incomes between 0 and 138 percent of FPL would enroll due to Medicaid expansion.[19] Of the 370,000 adults without insurance and sufficiently low incomes, 238,544 would enroll in Medicaid and 60,000 would transfer from other health insurance plans. From this, we obtain a take-up rate of 64.5 percent.

Of course, each of these estimates is, at best, a projection. We don't know exactly how many people will enroll in Virginia because the Commonwealth is different from other states. Hampton Roads is also different from other metropolitan areas in Virginia. Every estimate is fraught with uncertainty, and the best course of action is to present a range of outcomes for the interested reader.

How Many Will Enroll After Medicaid Expansion In Hampton Roads?

Table 9 presents low, medium, and high estimates of Medicaid enrollment in Hampton Roads after expansion.

Low estimates: If newly eligible individuals in Hampton Roads take up Medicaid insurance at the low take-up rates, about 20,000 newly eligible adults in Hampton Roads will enroll in Medicaid. Of these, we estimate that 13,276 will have incomes less than 100 percent of FPL and about 6,509 will have incomes between 100 and 138 percent of FPL.

Medium estimates: If newly eligible individuals in Hampton Roads take up Medicaid insurance at the medium take-up rates, about 24,000 newly eligible adults in Hampton Roads will enroll in Medicaid. Of this number, 17,184 will have incomes less than 100 percent of FPL and 6,758 will have incomes between 100 and 138 percent of FPL.

High estimates: Lastly, if newly eligible individuals enroll at the high take-up rates, about 27,000 Hampton Roads adults will enroll in Medicaid – 19,505 with incomes less than 100 percent of FPL and 7,671 with incomes between 100 and 138 percent of FPL.

Regardless of one's assumptions about take-up rates, Medicaid expansion will not result in every eligible individual enrolling in Medicaid. **Between 15,000 and 22,000 adults in Hampton Roads who might be eligible for Medicaid may not enroll. Some of these individuals may never enroll, others may lack information about Medicaid and some may be deterred by potential work requirements.** Contrary to some public perceptions, however, many adult Medicaid enrollees already work. In fact, the increased income eligibility limits may result in increased work effort by Medicaid recipients, who will be able to earn more without endangering their enrollment.[20]

Finally, Medicaid expansion does not address those who make more than 138 percent of the poverty limit. **Including all income groups, almost 100,000 adults will remain uninsured in Hampton Roads after Medicaid expansion.**

18 Buettgens, M. and Kenney, G.M. "What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured," (2016) Urban Institute.

19 DMAS estimated that 370,00 adults with incomes between 0 and 138 percent of FPL did not have insurance and 22.8 percent would remain ineligible for Medicaid; 5,000 of the remaining individuals would never enroll. Given an 85 percent take-up rate for these remaining individuals, 238,544 of 370,000 would enroll and 60,000 other individuals would transition from other insurance plans.

20 "Kaiser Family Foundation: Distribution of the Nonelderly with Medicaid by Family Work Status," https://www.kff.org/medicaid/state-indicator/distribution-by-employment-status-4. For further discussion regarding Medicaid work requirements, who is affected and impacts on enrollment, see "Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues," Musumeci, M.B., Garfield, R. and Rudowitz, R. (Jan. 16, 2018). Retrieved online May 31, 2018, from https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues.

TABLE 9

ESTIMATED IMPACT OF MEDICAID EXPANSION ON ADULTS IN HAMPTON ROADS

Income Group	Total Adults	Low Take-Up		Medium Take-Up		High Take-Up	
		Newly Insured	Remaining Uninsured	Newly Insured	Remaining Uninsured	Newly Insured	Remaining Uninsured
Less than 100% of FPL	30,254	13,276	16,978	17,184	13,070	19,505	10,749
100% to 138% of FPL	11,898	6,509	5,389	6,758	5,140	7,671	4,227
139% to 400% of FPL	56,273	0	56,273	0	56,273	0	56,273
Greater than 400% of FPL	20,513	0	20,513	0	20,513	0	20,513
Totals	118,938	19,785	99,153	23,942	94,996	27,176	91,762

Source: 2016 American Community Survey 1-year microdata files. Low estimate based on take-up in Maryland/West Virginia post-ACA expansion, medium estimate based on take-up in Buettgens and Kenney (2016) and high estimate based on DMAS 2017 estimate.

There Is No Such Thing As A Free Lunch

As part of Obamacare, the federal government match rate for expansion population costs (otherwise known as the Federal Medical Assistance Percentage, or FMAP) was 100 percent for 2014 to 2016. In other words, the federal government reimbursed states for 100 percent of the direct costs of newly eligible enrollees during this period.

Since then, the federal government reimbursement rate has declined and will be 93 percent in 2019. The FMAP ratchets down to 90 percent for 2020 and subsequent years.[21] For $1,000 in newly eligible enrollee costs in 2019, Virginia will bear $70 of the cost and the federal government will bear $930. In 2020 and beyond, for the same amount of cost, Virginia will bear $100 and the federal government will bear $900. To many, this seems too good a deal to pass up, but there are worries about the future.

Part of the hesitance to adopt the Medicaid expansion has been the lower FMAP rates states receive on previously eligible Medicaid enrollees and fears that future law changes might result in the newly eligible Medicaid enrollees receiving the same FMAP rates as current enrollees. With the current historically high federal budget deficits and debt, it is quite likely (if not guaranteed) that future federal spending will have to change, and likely in ways that shift more fiduciary burdens to the states. Current enrollee FMAP rates are adjusted each year based on state per capita income relative to the national rate, whereby states with comparatively higher per capita incomes receive lower FMAP percentages. For fiscal years 2010 to 2018, Virginia is subject to an FMAP rate of 50 percent for its current Medicaid-enrolled citizens.[22] The federal government matches Virginia's expenditure dollar-for-dollar.

While Virginia has been criticized in the past for being one of the more restrictive states with respect to Medicaid eligibility, this policy choice works in the Commonwealth's favor with regard to Medicaid expansion. With Medicaid expansion, more generous states which had previously allowed low-income, nondisabled, nonelderly adults to enroll in Medicaid received reduced reimbursements compared to states which chose to expand Medicaid in 2014 and beyond. By 2020, however, the matching rate will be equal for enrollees in the expansion income category across states.[23] Virginia, on the other hand, having previously been excluded from this group, will now be able to count all newly eligible enrollees with incomes 138 percent or less of FPL as being eligible for higher FMAP reimbursement. Obviously, receiving 90 percent reimbursement for newly eligible enrollees versus 50 percent is to Virginia's benefit.

Table 10 includes estimates for the possible cost per enrollee and cost overall for Virginia from 2019 to 2021 if the Medicaid expansion incurs costs comparable to those of current enrollees. We continue to use our previous take-up rate estimates of 44 percent for people with incomes less than 100 percent of FPL and 55 percent for those with incomes between 100 and 138 percent of FPL. We also assume that costs per enrollee will continue at the 2 percent rate observed from 2007 to 2013.[24] In the first scenario, we front-load the number of newly eligible individuals estimated to enroll in Medicaid into 2019. One can think of this scenario in terms of estimating the upper limit of costs and imposing the full costs of Medicaid expansion in Hampton Roads in 2019. In the second scenario, we mirror the take-up of Medicaid in Maryland and West Virginia and the costs are fully realized by 2021.

For the newly eligible enrollees in Hampton Roads, we estimate that costs to the Commonwealth will range from about $10 million to $15 million in 2019, depending on one's assumptions about the take-up rate. By 2021, the Commonwealth will incur costs between $16 million and $22 million for new Medicaid enrollees in Hampton Roads.

We caution that if federal reimbursement rates for newly eligible enrollees dropped to the 50 percent rate for currently enrolled participants, the estimated costs in Table 10 could multiply by a factor of five. Medicaid expansion costs in Hampton Roads would increase to between $78 million to $108 million in 2021, depending on the take-up rate of Medicaid expansion.

21 Medicaid's Federal Medical Assistance Percentage (FMAP) Congressional Research Service report 7-5700 by Mitchell, A., Feb. 9, 2016.
22 State Health Facts: Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, retrieved March 6, 2018, from https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier.
23 Congressional Research Service, 2018, Medicaid's Federal Medical Assistance Percentage (FMAP).
24 "Medicaid at a Glance" by the Virginia Department of Medical Assistance Services, http://www.dmas.virginia.gov/files/links/221/MAG%202018%20FINAL.021518.pdf

TABLE 10

ESTIMATES OF STATE COSTS FOR MEDICAID ENROLLEES IN HAMPTON ROADS

		Virginia's Cost per Enrollee		All Medicaid Expansion Occurs in 2019			Gradual Expansion of Medicaid*		
Year	Total Cost per Enrollee	Current Enrollee Cost	Newly Eligible Cost	Low Take-up Estimate	Medium Take-up Estimate	High Take-up Estimate	Low Take-up Estimate	Medium Take-up Estimate	High Take-up Estimate
2018	$7,479	$3,739							
2019	$7,628	$3,814	$534	$10,564,586	$12,784,408	$14,511,057	$4,757,255	$5,756,845	$6,534,359
2020	$7,781	$3,890	$778	$15,394,111	$18,628,708	$21,144,683	$13,705,569	$16,585,371	$18,825,374
2021	$7,936	$3,968	$794	$15,701,994	$19,001,283	$21,567,577	$15,701,994	$19,001,283	$21,567,577

Source: Kaiser Medicaid Spending Per Enrollee (full or partial benefit) for FY 2014. 2015 and after are per-enrollee cost estimates based on the 2007-2013 yearly average change of 2 percent from DMAS "Medicaid at a Glance." FMAP rates are 50 percent per current enrollee and are 93 percent in 2019 and 90 percent in 2020 and beyond. *Cost estimates assume take-up rates that mirror the three-year time profile of Maryland and West Virginia expansion enrollees; not all who eventually signed up for Medicaid in these states did so directly after initial eligibility in January 2014.

Uncompensated Care And The Financial Impact Of Medicaid Expansion

Prior to Obamacare, most states did not extend Medicaid insurance to low-income, nondisabled, childless adults under the age of 65. As the 1986 Emergency Medical Treatment and Labor Act forbade hospitals to turn away patients from emergency departments based on their ability to pay, one intent of Obamacare was to reduce the amount of uncompensated care provided by hospitals.[25] The numbers of uninsured are associated with lower hospital margins,[26] so one can reasonably argue that uncompensated care costs are not fully passed on by hospitals to other parties. Two recent studies found that when comparing Medicaid expansion states to nonexpansion states, uncompensated care costs drop by 1.0 to 1.7 percent.[27, 28]

Examples abound of how uncompensated care and bad-debt costs reduce the bottom line for hospitals in Hampton Roads. The Virginia Health Information System contains valuable information on the financial performance of hospitals throughout Virginia.[29] In 2016, Bon Secours Mary Immaculate Hospital in Newport News reported $25.7 million in charity care costs and $10.2 million in bad debts. Sentara Norfolk General Hospital reported delivering $165.9 million in charity care and $61.6 million in bad debts. Chesapeake Regional Medical Center had $12.3 million in charity costs and $44.3 million in bad-debt costs for the same period. In 2016, reported uncompensated-care costs likely exceeded $500 million and bad debts were over $850 million for hospitals in Hampton Roads. While some may argue that the costs of charity care and bad debts are overstated, as these costs are based on the full price of hospital services, we should be able to agree that uncompensated care and

25 "Emergency Medical Treatment and Labor Act (EMTALA)," Centers for Medicare & Medicaid Services, retrieved online March 13, 2013, from https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html.

26 Garthwaite, C., Gross, T. and Notowidigdo, M.J. (2018), "Hospitals as insurers of last resort," *American Economic Journal: Applied Economics*, 10(1), 1-39.

27 Dranove, D., Garthwaite, C. and Ody, C. (2016), "Uncompensated care decreased at hospitals in Medicaid expansion states but not at hospitals in nonexpansion states," *Health Affairs*, 35(8), 1471-1479.

28 "How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data," Blauvin, F. (April 2017), Urban Institute.

29 http://www.vhi.org/hospital_region.asp.

bad-debt costs negatively affected the bottom line of hospitals in Hampton Roads.

It stands to reason that if these costs are being incurred for specific patients without payment, additional revenues must be generated from those who are able or willing to pay to cover these uncompensated costs. Whether these costs are paid eventually by other patients, insurance companies, hospitals or governments, it should be clear that uncompensated care is a burden on the health care system.

Reductions in uncompensated-care costs can be substantial as people move from uninsured to insured status, with one estimate suggesting savings may reach $800 per newly insured individual.[30] Using this estimate, Medicaid expansion in Virginia could reduce direct annual uncompensated-care costs by $16 million to $22 million in Hampton Roads. Another recent study found that uncompensated-care costs drop by as much as 40 percent in Medicaid expansion states.[31] Such a drop would result in annual savings in the tens of millions of dollars to providers in Hampton Roads. Regardless of which estimate one uses, a reduction in uncompensated costs and, indirectly, bad debts, will improve financial outcomes for health care providers.

30 Garthwaite, C., Gross, T. and Notowidigdo, M.J. (2018), "Hospitals as insurers of last resort," *American Economic Journal: Applied Economics*, 10(1), 1-39.
31 http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf.

Final Thoughts

Virginia's decision to expand Medicaid will undoubtedly impact the overall picture of health care insurance and services in Hampton Roads. We estimate that of the 119,000 adults under the age of 65 without health insurance in Hampton Roads, between 20,000 and 27,000 will become eligible and enroll in Medicaid expansion. Uncompensated-care costs will decrease but the demand for health care services will increase, creating a higher demand for emergency department services and primary care physicians.

Expanding Medicaid in Virginia will not increase insurance coverage rates in Hampton Roads to 100 percent. We expect uninsured rates to drop to around 6 percent over time and almost 100,000 adults in our region will remain without health insurance. About 56,000 of these adults earn between 139 and 400 percent of FPL and 20,500 earn more than 400 percent of FPL. Increasing health insurance subsidies for these individuals may be one policy option, but it would involve substantial costs.

For newly covered residents, out-of-pocket expenses for health care will decline, leading to increased consumption. The increased demand for health care services will lead to gains in employment. The demand for city health care services will also decline, and an additional benefit is likely to be a reduction in the number of calls for emergency personnel to respond to routine medical conditions. Many current recipients of Medicaid will also be able to work more hours without endangering their eligibility, a positive factor in today's tight labor market.

The more successful the Commonwealth is in enrolling newly eligible individuals, the larger the potential decline in uncompensated-care costs. This, in part, explains why S&P Global Ratings recently stated that Medicaid expansion would be "credit positive" for Virginia's hospitals.[32]

We should not blithely assume that the federal government will continue to reimburse Virginia in perpetuity for new enrollees at a higher rate than existing enrollees. A reduction in the FMAP or an economic downturn that places significant pressure on the federal budget could result in a retrenchment of

32 https://www.richmond.com/news/virginia/government-politics/general-assembly/s-p-finds-medicaid-expansion-positive-for-va-hospitals-credit/article_27c9eb6d-d076-5759-8bd2-b546d3011194.html.

Medicaid eligibility and an increase in the uninsured rate. While history may be a guide, it is also not a promise.

Simply put, if the federal government were to reduce its reimbursement rate for new enrollees to 50 percent, Virginia's costs could increase by hundreds of millions of dollars. The Hampton Roads portion of these costs would approach $100 million, depending on how many newly eligible residents sign up for Medicaid.

In the end, if the intent of Medicaid expansion is to lower the number of uninsured among the most vulnerable in Hampton Roads, it will likely succeed in that goal. Medicaid expansion will also improve the financial health of hospitals and, over time, the health outcomes for new enrollees. Current and prospective enrollees may also be able to earn more income without threatening their eligibility, a boon to the economy of the region. Lastly, the federal government will bear most of the cost of new enrollees, which may be a net benefit to the state budget.

Medicaid expansion costs, however, will not be zero and there is a risk that costs could increase substantially in the future. The Commonwealth could mitigate some of the financial risks by setting aside some or all the current tax windfall resulting from the Tax Cuts and Jobs Act of 2017. Avoiding the temptation to return all this windfall to taxpayers is also important, as we are likely closer to the next recession than farther away from it. Investing in enrollment efforts and administrative capability at the state and local level will be necessary to cope with the influx of new enrollees.

Medicaid expansion will neither be free nor easy, but will likely have a net positive economic benefit for Hampton Roads. Now that the debate is over, the work begins in earnest.