HealthBlawg :: David Harlow's Health Care Law Blog

Interview of

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David Harlow: This is David Harlow at HealthBlawg. Today I'm speaking with Timothy Waidmann at the Urban Institute and with Kyle Caswell as well. Tim is a senior fellow in the Health Policy Center at the Urban Institute, where Kyle is a Research Associate. They are co-authors of a report on Medicaid released yesterday funded by the Robert Wood Johnson Foundation as part of the Affordable Care Act Implementation, Monitoring and Tracking Initiative. The report is titled, Financial Burden of Medical Spending by State and the Implications of the 2014 Medicaid Expansions. Welcome Tim and Kyle and thank you for speaking with us.

Tim Waidmann: Thank you. It's a pleasure.

Kyle Caswell: Thanks.

David Harlow: So, the title of the report you've just released is a bit dense and I wonder if you could unpack it a bit for us before diving in.

Tim Waidmann: Let me look at the title again.

David Harlow: The Financial Burden of Medical Spending by State and the Implications of the 2014 Medicaid Expansions.

Tim Waidmann: Right. So, the basic idea of this report is that we study how much income the non-elderly population devotes to medical spending and we look at that state-by-state. And the idea is by looking at this variation and then focusing in on a low income population in particular, we hope to learn what state's decisions about whether or not to expand their Medicaid programs as part of the Affordable Care Act. What implications those decisions might have for their own populations. So, this is, if a state has a particularly high level of burden of medical care spending, it's likely that expanding Medicaid will have a larger beneficial impact than a state that has relatively low level of financial burden, so that's kind of the – what we are trying to tease out of the data was a comparison along those lines.

David Harlow: Are there other takeaways from the report?

Tim Waidmann: Well, the first cut of this was just to look, I mean, this is relatively new data source with which we can do this kind of study. The Current Population Study is a nationwide large survey that has samples in every state and it allows us to look down at even small states and say, to get some idea of population characteristics and a couple of years ago they added to the survey a question or a couple of questions on how much people spend out of pocket on premiums and other expenditures for their healthcare, so whether co-pays or co-insurance, payments, deductibles, those kinds of things. And so, the first cut at this was just to look overall, the whole population -- and we focused on non-elderly because Medicare is just sort of different word for medical spending. But, excluding that population, we're able to see of quite a bit of variation from state-to-state in how burdensome medical care is to the typical family and to the typical person. So, for example, a typical person in New York say, in the State of New York spends about 2% of their total family income on medical care. But in Idaho, the typical person spends more than twice as much as a share of their income and they spend about 5% of their annual income on healthcare. So, that's just, you know, the typical person in the middle of the distribution.

David Harlow: So, that's in the general non-elderly population?

Tim Waidmann: Yeah.

David Harlow: And is the spread the differential as pronounced for the Medicaid population?

Tim Waidmann: So, in fact, it's even greater for the low-income population, which we focus in on later, but when you look, you know, if staying with the general population, if you look at, if you say well, the typical person doesn't really use a lot of medical care, what about the sort of higher-spending group and these differences that we see at the median persist and even grow, if you look at the top half of the spending – of the burden distribution. And again, you just compare typical -- the 75th percentile -- think about the typical person in the top half of the burden distribution. In Idaho that person spends 11% of income, while in New York they spend around 6, 6.5%. So, these differences that appear in one part of the distribution seem to carry through the rest of the distribution as well, that indicates…

David Harlow: And by the higher percentile of the burden distribution you're referring to someone who is making greater use of the healthcare system?

Tim Waidmann: Well, it's sort of relative to income.

David Harlow: Yes.

Tim Waidmann: So that if you think of, what someone can expect to spend out of their take home pay or out of their total income, this suggests that someone in Idaho should expect to spend about twice as much of their income as someone in New York would spend.

David Harlow: So, would you characterize these data as surprising? When we think of New York, California, a couple of other locations, Massachusetts where I am, as being high cost centers for healthcare. Are you saying that they may be high cost, but they're not necessarily high cost relative to income?

Tim Waidmann: So that's right, you pick up on a very important point that this measure of financial burden has both the spending component and an income component. And a state could appear to be a very high burden state just because it's a low income state. And, if people have the same medical care needs, but lower income, their burden would appear to be higher. And so, that – those same differences that would be apparent between individuals who show up across the states, so low income states are more likely to show high burden than high income states. But then, the other factor that matters and varies from state-to-state as you mentioned is that health care costs more in some states than it does in others. And so, two states that have similar levels of income, but different levels of medical care costs will also show up as having different levels of financial burden.

David Harlow: So, let's look at perhaps some of the states that we think of as having particular problems in this area -- and whose Governors had at least initially said that they would not buy into the Medicaid expansion. I'm thinking off the top of my head of places like Louisiana, Mississippi, where also traditional state level Medicaid coverage is rather slim.

Tim Waidmann: Right.

David Harlow: So that there is probably a higher burden now for lower income folk in those states.

Tim Waidmann: So, if you look specifically at the low income population, which is where we wanted to get to, the differences across states just seem to grow quite a bit. But, in every state the average amount that a low income household spends on healthcare is going to be higher as a percentage of income than high income households. But, the sort of range that we see between low income folks in some states and other states is quite dramatic. And then, if you then further focus in on, you know, the population who doesn't have Medicaid, the low income population that doesn't have Medicaid -- that's kind of where I think the policy implication is strongest and you mentioned Louisiana, Mississippi as two examples and they happen to be, you know, if you look at the top five states nationwide in terms of the share of their population who is low income and doesn't have Medicaid and has high medical care burden, those two are among those top five.

Nevada is actually the state with the highest fraction of its population, who is not covered by Medicaid, has high burden and low income. But Nevada has decided that it's going to go ahead with the Medicaid expansion. So, what we would expect is that, you know, among these states that currently have – appear to have – a large portion of population who would be affected by the expansion, some of these states who go ahead with the

expansion, we expect them to reduce their place on this ranking. So, Nevada, we expect to fall -- once it expands its Medicaid program -- out of this top five, while Louisiana and Mississippi we expect will likely stay as high burden states for their low income population.

David Harlow: Right, unless they do accede to some pressures from the hospital industry and others, who would like to see some of their free care get reimbursed, which they would do if they had the Medicaid expansion in place.

Tim Waidmann: And so, I mean, it's interesting among these top five states that we have found. There were two, Nevada and Montana, who have agreed to expansion, two have said no to expansion so far, and one -- in Arkansas -- that has said yes to an expansion sort of, that would like to use a private, use the exchange system to expand coverage to this low income population. And so, you could sort of think of this as an intermediate case, you know, it would be interesting to see what happens to a measure like this. If the private version of the Medicaid expansion looks like Medicaid in that it has very low or zero cost-sharing requirements of its beneficiaries, I would expect that it will – what will happen in Arkansas will look very much like what happens in states that have full public expansion in Medicaid.

David Harlow: And so that would be private pay, in the Arkansas model?

Tim Waidmann: If what happens is that beneficiaries are fully subsidized to join private plans, you could imagine that they'll see very little difference between that and in public sector Medicaid expansion. But if they're required to – if what happens is that they get some subsidies for enrolling in a private plan that doesn't fully cover their expenses then it may well be that they don't reduce this burden.

David Harlow: Right. I had understood that there were not a whole lot of waivers available in order to reconfigure the way in which the Medicaid expansion would work, so that federal dollars would not necessarily be available for private premiums versus reimbursement of additional Medicaid expenses.

Tim Waidmann: Yeah, I mean, I think that, I was a little surprised that how quickly they seemed to – the federal government quickly seemed to agree to a private version of covering this population in some form. So, it will be interesting to see what happens there.

David Harlow: Sure … 50 laboratories, as they say.

Tim Waidmann: Yeah, that's true. One of the key takeaways for us, I think was that, you know, we see where the world or where the states line up now before the ACA is fully implemented and this is kind of an ideal from a social science perspective experiment that we have 50 different approaches and we've got the state of the world before implementation and it'll be a good sort of natural experiment to see what happens.

David Harlow: Sure. And, you have a good level of confidence in the data source that you are using in terms of the sort of self-reported statements that you described?

Tim Waidmann: Well, you know, Kyle actually is one of the people who did a study comparing this data source to other established sources and I think the Census Bureau folks, which is where Kyle was before he joined us, are fairly satisfied with the quality of this data. And it was a boon to us in the health services research world that CPS added this question. And I think we're beginning to see the usefulness of it in some of these research projects we have undertaken.

David Harlow: Sure. I imagine you have a cache of some other questions that you'd love to see added to that questionnaire as well.

Tim Waidmann: We have endless sets of questions that we would like to see added, but the Census Bureau is very careful with expanding that survey. I think they are worried about burdening their respondents too much and I think rightly so. This has been a great source of information even before this, even before these questions were added, especially on estimating coverage differences across states. But, we're just happy that they were able to add this most recently.

David Harlow: Great. So, how does this piece of work fit in with the other work that you have been doing about the roll-out of the Affordable Care Act?

Tim Waidmann: Well, you know, I think that we've also, using other data sources, looked at differences in access to care across states and differences in coverage across states, and kind of also trying to get a sense of where the world is before the ACA gets into full swing. And, you know, I think that we find similar amounts of variation in the use of – in access to basic healthcare and in the use of preventive services, I think that these findings here -- I think, from what I remember other members of our staff here have worked on that, but preventive care differences have been a little less dramatic, but certainly access to basic care does appear to have a bit of variation from state-to-state. And we expect as coverage is expanded through both Medicaid and the exchanges and other methods, we expect some of those differences and access to care to shrink, but we'll see what happens.

David Harlow: Right. Well again, Tim and Kyle, thank you very much for joining me today. It's been a very interesting conversation for me and I hope for our listeners and readers. And again, this is David Harlow at HealthBlawg. Thank you very much.

Tim Waidmann: Thank you, it's been pleasure.