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Why states should not expand Medicaid

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12 reasons NOT to expand Medicaid

1. Medicaid expansion harms the truly needy
2. State spending will explode, crowding out other priorities
3. Waste, fraud, abuse and misspending will skyrocket
4. Expansion crowds out private coverage
5. Access to timely and proper care will worsen
6. Expansion causes emergency room use to surge, and hospital capacity to deteriorate
7. Expansion not associated with improved health outcomes overall
8. Expansion enriches health insurance companies
9. States' finances will be more vulnerable to federal law changes
10. Refusing to expand saves taxpayer dollars and reduces federal deficits
11. There are many good healthcare options available already
12. Targeted initiatives have better results than Medicaid expansion

Medicaid was created in 1965 as a joint federal/state program to finance healthcare services for low-income Americans. The program now covers about 73.5 million Americans.[1] The federal government establishes certain requirements, but states manage their own programs—setting payment rates, contracting with insurers to manage enrollee care, and often broadening eligibility beyond federal requirements. The federal government reimburses state expenditures, generally covering half of the cost in the wealthiest states and around three-quarters of costs in the poorest states. During Fiscal Year 2018, the federal government covered 63 percent of total Medicaid expenditures.[2]

[1] "Total Monthly Medicaid and CHIP Enrollment," Kaiser Family Foundation, May 2020, accessed September 20, 2020, https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2] "MACStats: Medicaid and CHIP Data Book," Medicaid and CHIP Payment and Access Commission, December 2019, Exhibit 16, p. 49-50, https://www.macpac.gov/wp-content/uploads/2020/01/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf

The reimbursement percentage was actually higher than this because states have developed accounting gimmicks that generate federal reimbursements for artificial state expenditures. Of note, Congress raised each state's federal reimbursement by 6.2 percentage points during the coronavirus public health emergency. For Medicaid to meet its core mission, its focus should remain on the truly vulnerable—low-income children, pregnant women, seniors and individuals with disabilities.

The Affordable Care Act (ACA) expanded eligibility to Medicaid beyond its core and historic populations to cover childless, non-disabled, working-age adults with income below 138 percent of the federal poverty level. States that have resisted expansion have witnessed the soaring costs in other states and the adverse impact on the vulnerable patients already on Medicaid who must compete for providers with expansion enrollees.[3]

The ACA did nothing to expand the supply of providers, and as a result, states that expanded the program have found that fewer health care resources are available for truly vulnerable recipients. This makes it more difficult for recipients for whom the program was designed to find a doctor, particularly specialists, and get the care they need. Many turn to emergency rooms for access to even routine care.

State taxpayers pay 10 percent of the costs of covering the expansion population, although Congress has considered numerous times shifting more of these costs onto states.[4] Expansion means state taxpayers would be picking up 10 percent of the costs of covering individuals who had been receiving heavily subsidized insurance in the ACA exchanges but who would instead be shifted to state Medicaid rolls. So, in addition to harming their truly needy citizens, states that have expanded Medicaid face skyrocketing state expenditures for their share of the expansion costs, drive people into Medicaid who had been receiving private coverage in the exchanges, and face costs that crowd out spending on other state priorities.

Moreover, the massive enrollment and cost overruns resulting from Medicaid expansion substantially worsen the federal deficits.

Here are twelve reasons states should not expand Medicaid and should instead demand from Washington flexibility that will allow them to develop programs that better meet their states' needs, resources and budgets.

1. Medicaid expansion harms the truly needy

Medicaid has traditionally provided medical assistance to people who are unable to work. For example, low-income people who are very young (children) or old (over 65), and low-income people with disabilities, pregnant women, and parents of dependent children are generally eligible for assistance. The federal government bears between 50 percent and 75 percent of the costs of providing assistance to these populations, with states that have lower per capita income receiving a higher federal matching rate.

The ACA created a whole new category of recipient: childless, able-bodied, and working-age adults. Starting in 2020 and continuing until Congress changes the expansion matching rate,

[3] States that have not expanded Medicaid: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. Kaiser Family Foundation, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[4] Jonathan Ingram and Nicholas Horton, "Promises Made, Promises Broken: States cannot trust Washington's promise to fund Obamacare Medicaid expansion," Foundation for Government Accountability, April 9, 2015, https://thefga.org/wp-content/uploads/2015/04/UO-PromisesMadePromisesBroken-Final-1.pdf

the federal government pays 90 percent of the costs of medical assistance for the expansion population. By providing a higher reimbursement for this population, the federal government discriminates against the traditional Medicaid populations in favor of the able-bodied, working-age adult population.[5]

Since the 90 percent federal reimbursement rate for the expansion population is a much higher rate than the rate for the traditional population, states have an incentive to be aggressive in enrolling expansion-eligible individuals, which diverts government resources away from truly needy enrollees. At the extreme, some states set higher payment rates for the expansion population than for traditional enrollment groups because of the reimbursement differential.[6]

In 2000, only seven million able-bodied, working-age adults were enrolled in Medicaid.[7] By 2018, this number had increased to 28 million.[8] Although part of the increase occurred before the ACA, more than 60 percent of the increase resulted from the ACA expansion.[9]

According to statistics compiled by the Kaiser Family Foundation, 293,000 people in expansion states are on waiting lists to receive Medicaid home and community-based services.[10] Unfortunately, at least 22,000 of these individuals have died while waiting for the care they need.[11]

2. State spending will explode, crowding out other priorities

States that expanded Medicaid experienced large enrollment and spending increases—often greater than they thought possible. In expansion states, both enrollment and spending per enrollee averaged roughly 50 percent above federal government projections as enrollment surged almost immediately.[12] For example, according to the Associated Press, California expected

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[5] Jonathan Ingram, "Who is on the Obamacare Chopping Block?" Foundation for Government Accountability, July 17, 2014, https://thefga.org/wp-content/uploads/2014/07/Whos-On-The-ObamaCare-Chopping-Block.pdf

[6] According to briefings provided by CMS in 2017, in the initial years of the Medicaid expansion, several states set higher capitated payment rates and provider payment rates for the expansion population. While CMS has persuaded some of these states that basing higher payment rates on the different federal reimbursements is against the law, at least one state continues to pay differential rates.

[7] Nicholas Horton and Jonathan Ingram, "The Future of Medicaid Reform: Empowering individuals through work," Foundation for Government Accountability, November 14, 2017, https://thefga.org/wp-content/uploads/2017/11/The-Future-of-Medicaid-Reform-Empowering-Individuals-Through-Work.pdf

[8] Ibid.

[9] Ibid.

[10] Authors calculation based on: "Waiting List Enrollment for Medicaid Section 1915(c) Home and Community-Based Service Waivers," Kaiser Family Foundation, statistics for 2018, accessed August 25, 2020, https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[11] Nicholas Horton, "Waiting for Help: The Medicaid waiting list crisis," Foundation for Government Accountability, March 6, 2018, https://thefga.org/wp-content/uploads/2018/03/WAITING-FOR-HELP-The-Medicaid-Waiting-List-Crisis-07302018.pdf

[12] Brian Blase, "Evidence is Mounting: The Affordable Care Act has worsened Medicaid's structural problems," Mercatus Center, September 16, 2016, https://www.mercatus.org/publications/healthcare/evidence-mounting-affordable-care-act-has-worsened-medicaid%E2%80%99s-structural

800,000 enrollees and had 2.3 million enrollees the year following the expansion, and Illinois expected fewer than 300,000 enrollees in 2015 and more than 600,000 people enrolled that year.[13] Overall national enrollment was more than twice what expansion states had expected by 2016, largely driven by the surge in California.[14]

Nationwide, Medicaid spending increased from $99 billion to $585 billion—or nearly 500 percent—between 1988 and 2018 in inflation-adjusted 2018 dollars.[15] This additional spending on Medicaid crowds out funds for education, transportation, parks, public safety and other important state priorities and puts pressure on states to raise taxes. In 1988, states spent more than three times more on education than on Medicaid. Now the numbers are roughly equivalent. In fact, Medicaid now accounts for one out of every three state dollars spent.[16] Two-thirds of federal payments received by states flow through Medicaid.

When a state expands Medicaid, individuals in households with income between 100 and 138 percent of FPL eligible to receive heavily subsidized private coverage through the ACA exchanges would lose that coverage and shift to Medicaid. This would be a disruption and loss of private coverage for these individuals who are moved to Medicaid. And it has fiscal consequences for states: Instead of the federal government picking up all of the costs of coverage for those between 100 and 138 percent of FPL, as before expansion, states would now be responsible for paying 10 percent of the cost of covering these individuals under Medicaid.

3. Waste, fraud, abuse, and misspending will skyrocket

As overall enrollment and spending have soared in expansion states, so have improper enrollment and spending. States have an incentive to enroll as many people as possible in Medicaid expansion because the federal government picks up so much of the costs. Insurance companies reap substantial profits from Medicaid managed care and have strong incentives to enroll as many people as possible in the program, regardless of whether they are eligible. The Obama administration stopped federal audits of Medicaid eligibility from 2014 to 2017, abdicating its responsibility to ensure that only those who actually qualified for Medicaid under the expansion rules were enrolled.[17]

There are between 2.3 and 3.3 million adults enrolled through the Medicaid expansion who have incomes above the eligibility thresholds and who do not meet other eligibility criteria, such as

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[13] Associated Press, "Projected, Actual Enrollment for Medicaid Expansion States," The Southern Illinoisan, July 20, 2015, https://thesouthern.com/ap/business/agate/projected-actual-enrollment-for-medicaid-expansion-states/article_86d25844-8e05-514a-ad4d-ac37c895d4ac.html

[14] Jonathan Ingram and Nicholas Horton, "Obamacare Expansion Enrollment is Shattering Projections," Foundation for Government Accountability, November 16, 2016, https://thefga.org/wp-content/uploads/2016/12/ObamaCare-Enrollment-is-Shattering-Projections-1.pdf

[15] Brian Blase, "Reform the Federal-State Medicaid Partnership to Better Help Those in Need and Save Money," The Daily Signal, February 12, 2020, https://www.dailysignal.com/2020/02/12/reform-the-federal-state-medicaid-partnership-to-better-help-those-in-need-and-save-money/

[16] Nicholas Horton, "The Medicaid Pac-Man: How Medicaid in consuming state budgets," Foundation for Government Accountability, October 29, 2019, https://thefga.org/wp-content/uploads/2019/10/Medicaid-Pac-Man-Paper-2.pdf

[17] Brian Blase and Aaron Yelowitz, "Why Obama Stopped Auditing Medicaid," Wall Street Journal, November 18, 2019, https://www.wsj.com/articles/why-obama-stopped-auditing-medicaid-11574121931

pregnancy or disability.[18] Many government audits have found sizeable errors.[19] For example, one audit found eligibility problems with more than half of sampled enrollees in California's Medicaid program.[20]

Largely as a result of eligibility problems, Medicaid's improper payments now almost certainly exceed $75 billion, or more than 20 percent of all federal Medicaid expenditures.[21] Before the ACA, the Medicaid improper-payment rate was 6 percent.[22] The improper payment rate will almost certainly increase given the provision in the Families First Coronavirus Response Act that prohibits states from disenrolling anyone from Medicaid for any reason for the remainder of the coronavirus public health emergency.

4. Expansion crowds out private coverage

When public coverage expands, there is a contraction, or "crowd-out," of private coverage. In a 2008 paper, economists Kosali Simon and Jonathan Gruber estimated that for every 100 people gaining coverage from expansions of Medicaid and CHIP, 60 replaced private coverage with Medicaid.[23]

Private coverage generally provides better access to care than government programs, which pay providers lower rates. Therefore, crowd-out can be harmful for the overall health of Medicaid expansion recipients since access to quality providers is more difficult.

A 2019 study by the Foundation for Government Accountability found that nearly 54 percent of potential Medicaid expansion enrollees had private coverage and that millions of able-bodied adults could be shifted out of private insurance and into Medicaid if remaining non-expansion states expanded.[24] This includes individuals between 100 to 138 percent of the federal poverty line who are enrolled in a subsidized plan in an ACA exchange.

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[18] Brian Blase and Aaron Yelowitz, "The ACA's Medicaid Expansion: A review of ineligible enrollees and improper payments," Mercatus Center, November 2019, https://www.mercatus.org/system/files/blase-medicaid-expansion-mercatus-research-v2_2.pdf

[19] Ibid. See pages 12-17 for a discussion of many of these audits.

[20] Daniel Levinson, "California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements," Department of Health and Human Services Office of the Inspector General, December 2018, https://oig.hhs.gov/oas/reports/region9/91702002.pdf?mod=article_inline

[21] Aaron Yelowitz and Brian Blase, "Medicaid Improper Payments are Much Worse than Reported," Cato Institute, November 20, 2019, https://www.cato.org/blog/medicaid-improper-payments-are-much-worse-reported

[22] Ibid.

[23] Jonathan Gruber and Kosali Ilayperuma Simon, "Crowd-out 10 Years Later: Have recent public insurance expansions crowded out private insurance?" *Journal of Health Economics* 27, no. 2 (2008): 201-17, https://www.researchgate.net/publication/5645883_Crowd-out_10_years_later_Have_recent_public_insurance_expansions_crowded_out_private_health_insurance

[24] In addition to potentially eligible Medicaid enrollees with private coverage, another 12 percent of individuals have income between 100 and 138 percent of the federal poverty level (would qualify for a nearly free or free exchange plan) but are not yet enrolled. See: Nicholas Horton and Jonathan Ingram, "The Obamacare Cost Shift: How Medicaid Expansion is Crowding Out Private Insurance," Foundation for Government Accountability, April 11, 2019, https://thefga.org/wp-content/uploads/2019/04/MedEx-Crowd-Out-Paper-DRAFT7.pdf

5. Access to timely and proper care will worsen

Coverage is not the same thing as care. A 2019 study by the Medicaid and CHIP Payment and Access Commission, a congressional advisory group, found that one-third of primary care physicians and nearly two-thirds of psychiatrists do not accept Medicaid patients.[25] Doctors cite difficult Medicaid paperwork, administrative burdens, and poor reimbursement rates as reasons they do not accept more patients on the program.

As a result, Medicaid patients often lack a consistent source of care. Receiving care from a specialist or surgeon is particularly challenging. When these patients cannot get predictable access to care, cancer more frequently goes undiagnosed and chronic conditions, such as heart disease and diabetes, can go unmanaged.

While Miller and Wherry found that people in Medicaid expansion states reported they were less worried about paying medical bills or affording follow-up care, they also found significant increases in respondents delaying medical care because no appointment was available or because waits were too long.[26] Courtemanche et al. found that people in expansion states experienced a significant slowdown in ambulance response time.[27] For some people with pressing medical conditions, a slowdown in ambulance response time may be life-threatening.

Many observational studies find that Medicaid patients typically have inferior health outcomes compared to people with either private coverage or the uninsured.[28] For example, a 2010 analysis from the University of Virginia related insurance coverage and surgical outcomes for nearly 900,000 major operations in the United States with a robust set of controls. Researchers found that Medicaid patients were 13 percent more likely than the uninsured to die in the hospital, and they were twice as likely to die in the hospital as individuals with private insurance.[29]

Medicaid patients also were more likely to suffer complications and their hospital stays were three days longer than the privately insured or uninsured.[30] One explanation for the worse outcomes may be that Medicaid recipients are assigned to less-experienced surgeons. According to Calvin et al., certain heart "patients with Medicaid (but not Medicare) as the primary payer were less likely to receive evidence-based therapies and had worse outcomes than patients

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[25] Kayla Holgash and Martha Heberlein, "Physician Acceptance of New Medicaid Patients," Medicaid and CHIP Payment and Access Commission, January 24, 2019, https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

[26] Sarah Miller and Laura Wherry, "Health and Access to Care during the First 2 Years of the ACA Medicaid Expansions," *New England Journal of Medicine* 376, (2017): 947-956, https://www.nejm.org/doi/full/10.1056/NEJMsa1612890

[27] Charles Courtemanche, Andrew Friedson, Andrew Koller, and Daniel Rees, "The Affordable Care Act and Ambulance Response Times," *Journal of Health Economics* 67, (2019), https://www.sciencedirect.com/science/article/abs/pii/S0167629618300523

[28] Kevin Dayaratna, "Studies Show: Medicaid patients have worse access and outcomes than the privately insured," Heritage Foundation, November 7, 2012, https://www.heritage.org/health-care-reform/report/studies-show-medicaid-patients-have-worse-access-and-outcomes-the

[29] LaPar, Damien, Castigliano Bhamidpati, Carlos Mery, George Stukenborg, David Jones, Bruce Schirmer, Irving Kron, and Gorav Ailawadi. 2010. "Primary Payer Status Affects Mortality for Major Surgical Operations." Annals of Surgery 252(3): 544-551, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071622/

[30] Ibid.

with HMO or private insurance as the primary payer."[31]

6. Expansion causes emergency room use to surge and hospital capacity to deteriorate

There is robust evidence that Medicaid expansion significantly increases emergency room utilization for non-emergent conditions.[32] Finkelstein et al. found that those who gained Medicaid through Oregon's Medicaid experiment (discussed more below) were 40 percent more likely to visit an emergency department.[33] Hospitals in expansion states have reported ER visit increases are twice the rate in non-expansion states.[34] For example, the non-expansion state of South Dakota saw just a 7 percent increase in emergency department visits from 2013-2017, while neighboring North Dakota, an expansion state, saw an increase in visits of 24 percent.[35] Medicaid expansion increases ER use because Medicaid increases health care demand without any increase in the supply of medical care. This is counter to the claim from ACA advocates that Medicaid expansion would result in *less* emergency room utilization under the theory that more people would have a usual place of care.[36]

Medicaid expansion has not been associated with an increase in hospital-based jobs, counter to what proponents have argued.[37] In 40 percent of expansion states, hospital-based jobs declined in the first year of expansion. And hospitals in expansion states have actually lost hospital beds since 2013, compared to non-expansion states, which have increased bed capacity in the same timeframe.[38] Therefore, on average, expansion

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[31] James Calvin et al., "Insurance Coverage and Care of Patients with Non-ST-Segment Elevation Acute Coronary Syndromes," *Annals of Internal Medicine* 145, no. 10, (2016): 739-748, https://www.acpjournals.org/doi/10.7326/0003-4819-145-10-200611210-00006

[32] Craig Garthwaite, John Graves, Tal Gross, Zeynal Karaca, Victoria Marone, Matthew J. Notowidigdo, "All Medicaid Expansions are not Created Equal: The geography and targeting of the Affordable Care Act," Brookings Institution, September 2019, https://www.brookings.edu/wp-content/uploads/2019/09/Garthwaite-et-al_conference-draft.pdf

[33] Amy Finkelstein, Sarah L. Taubman, Heidi L. Allen, Bill J. Wright, Katherine Baicker, "Effect of Medicaid Coverage on ED Use—Further Evidence from Oregon's Experiment," *New England Journal of Medicine* 375, (2016):1505-1507, https://www.nejm.org/doi/full/10.1056/NEJMp1609533

[34] Hayden Dublois and Jonathan Ingram, "Short on Space: How Obamacare expansion is pushing hospitals to the brink," Foundation for Government Accountability, April 21, 2020, https://thefga.org/wp-content/uploads/2020/04/ObamaCare-expansion-pushing-hospitals-to-brink.pdf

[35] Ibid.

[36] On March 3, 2010, a few weeks before the ACA passed Congress, President Obama said, "taxpayers currently end up subsidizing the uninsured when they're forced to go to the emergency room for care…. You can't get … savings if those people are still going to the emergency room." A few months after passage of the law, Speaker of the House of Representatives Nancy Pelosi said, "the uninsured will get coverage, no longer left to the emergency room for medical care." See: "Will fewer people rely on emergency rooms for health care?" ProCon.org, last modified August 24, 2020, https://healthcarereform.procon.org/questions/will-fewer-people-rely-on-emergency-rooms-for-health-care/

[37] Jordan Roberts and Nicholas Horton, "Five Key Signs Obamacare Expansion is Not a Silver Bullet for Hospitals," Foundation for Government Accountability, February 25, 2020, https://thefga.org/wp-content/uploads/2020/02/ObamaCare-Expansion-Not-A-Silver-Bullet.pdf

[38] Hayden Dublois and Jonathan Ingram, "Short on Space: How Obamacare expansion is pushing hospitals to the brink," https://thefga.org/research/medicaid-expansion-hospitals-covid-19/

states appear to have lost capacity to deal with public health crises such as COVID-19.

7. Expansion is not associated with improved health outcomes overall

After the ACA's coverage expansion took effect in 2014, Americans' life expectancy declined for three straight years. Such a decline had not occurred in a century since between 1915 and 1918 during World War I and the Spanish Flu epidemic.[39] Although the decline reversed in 2018, American life expectancy is still lower than it was before the ACA's coverage expansion took effect.[40] This, of course, occurred before the coronavirus pandemic, which is likely going to cause a further decline in life expectancy starting in 2020.

Overall mortality worsened for lower-income individuals in expansion states compared to non-expansion states among non-elderly adults.[41] Among 15-64 year-olds, between 2013 and 2017, mortality increased by six percent in states that expanded on January 1, 2014, nine percent in states that expanded after that but before mid-2016, and only 4.5 percent in non-expansion states.

The explanation for the mortality differences is likely partially because Medicaid expansion states experienced a far greater increase in drug overdose deaths from opioids than non-expansion states. According to Sam Quinones' book, *Dreamland*, which investigated the history of the opioid crisis, Medicaid played a key role in fueling it. He writes, "The [Medicaid] card provides health insurance through Medicaid, and part of that insurance pays for medicine—whatever pills a doctor deems an insured patient needs."[42] The U.S. Department of Health and Human Services also produced an analysis showing that the percentage increase in overdose deaths surged in Medicaid expansion states relative to non-expansion states from 2013 to 2015.[43]

The most significant economic analysis of Medicaid on health also casts huge doubt on whether the program promotes health. In 2008, Oregon utilized a lottery to expand Medicaid to some able-bodied uninsured adults with incomes below 100 percent of the federal poverty level. The winners of the lottery received Medicaid, which allowed researchers a quasi-experiment to evaluate the impact of gaining Medicaid using the "losers" of the lottery as a control group.[44] The main takeaway from the study is that the new Medicaid recipients increased the amount of

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[39] Uptin Saiidi, "US life expectancy has been declining. Here's why," CNBC, July 9, 2019, https://www.cnbc.com/2019/07/09/us-life-expectancy-has-been-declining-heres-why.html

[40] American life expectancy was 78.9 years of age in 2014. It declined each year, reaching 78.6 years of age in 2017 before increasing to 78.7 in 2018.

,[41] Brian Blase and David Balat, "Is Medicaid Expansion Worth It? A review of the evidence suggests targeted programs represent better policy," Texas Public Policy Foundation, April 2020, https://files.texaspolicy.com/uploads/2020/04/20142441/Blase-Balat-Medicaid-Expansion.pdf

[42] Sam Quinones, *Dreamland: The True Tale of America's Opiate Epidemic* (Bloomsbury Press, 2015).

[43] Ron Johnson, Letter to the Honorable Daniel R. Levinson, Inspector General, Department of Health and Human Services, United State Senate Committee on Homeland Security and Governmental Affairs, July 27, 2017, https://www.hsgac.senate.gov/imo/media/doc/2017-07-27-RHJ%20to%20Levinson%20(HHS%20OIG)%20%20re%20Medicaid-Opioids.pdf

[44] "Overview," The Oregon Health Insurance Experiment, accessed September 27, 2020, http://www.nber.org/oregon/1.home.html

health care they received, including emergency services, but did not show improvement on the three physical-health measures assessed—blood pressure, cholesterol and blood sugar.[45] If Medicaid would cause health improvements, it would likely occur on these basic measures of health. The main benefit of Medicaid for the lottery winners was that they felt more secure knowing they had coverage.

A new argument for Medicaid expansion has emerged this year with advocates demanding expansion as part of the solution to address COVID-19. However, the data show that Medicaid expansion has not helped. In fact, the five states with the highest COVID-19-related deaths per capita are all Medicaid expansion states, as are nine of the top 10 states in that category. States that have expanded Medicaid have almost 31 percent more deaths per 100,000 population than non-expansion states.[46] While other factors surely are involved, including decisions by their mayor and governors, Medicaid expansion does not appear to be correlated with minimizing COVID-related damage.

8. Expansion provides limited benefit to enrollees, but enriches health insurance companies

As a testament to the low value many people place on Medicaid, 40 percent of people who won the Oregon lottery described above did not end up enrolling in the program. Separately, a study by economists Amy Finkelstein, Nathaniel Hendren and Ezro Luttmer found that Oregon's Medicaid expansion enrollees placed relatively low value on the program, estimating that they receive only 20 to 40 cents of benefit for each dollar that the program spent on their behalf.[47] That would mean if the government were to provide a choice of $5,000 in a Medicaid managed care benefit or $2,000 cash, most recipients would take the cash. In effect, a large amount of the Medicaid benefit goes to providers who can reduce their uncompensated care costs.[48]

Another main beneficiary of Medicaid expansion are insurers offering managed care plans to the new enrollees. The White House Council of Economic Advisers (CEA) found that health insurance companies have been enormously profitable as a result of the ACA, largely because of the law's Medicaid expansion. Between January 1, 2014, and March 2018—the date of the CEA report—health insurance stocks outperformed the S&P by 106 percent.

Insurers are benefitting from the incentives provided to states by the enhanced match rate, which have led to robust enrollment and much larger-than-expected payment rates to insurers.[49]

[45] Ibid.

[46] "United States COVID-19 Cases and Deaths by State," U.S. Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker/#cases_totaldeaths (accessed September 30, 2020). "2019 National and State Population Estimates," U.S. Census Bureau, December 30, 2019, Table 3. https://www.census.gov/newsroom/press-kits/2019/national-state-estimates.html (accessed September 30, 2020).

[47] Amy Finkelstein, Nathaniel Hendren, and Erzo Luttmer, "The Value of Medicaid: Interpreting results from the Oregon health insurance experiment," NBER Working Paper No. 21308, issued June 2015, https://www.nber.org/papers/w21308

[48] Ibid.

[49] Brian Blase, "Evidence is Mounting: The Affordable Care Act has worsened Medicaid's structural problems," https://www.mercatus.org/publications/healthcare/evidence-mounting-affordable-care-act-has-worsened-medicaid%E2%80%99s-structural

9. States' finances will be more vulnerable to federal law changes

States' decisions about whether to expand Medicaid should take into account legal and political factors, as well as the possibility of other short- and long-term policy changes. States have long known that a relatively new government program with such complexity is vulnerable to legal challenges, potential disruption and changes to federal funding. This warning has been sounded consistently as states considered Medicaid expansion.

Now, a court case brought by 18 states and led by Texas is challenging the constitutionality of the entire ACA. The case now is before the U.S. Supreme Court which will be reviewing a federal district court ruling that invalidates the ACA in its entirety. The states argue that since Congress eliminated the tax penalty that enforced the law's individual mandate, that the mandate is unconstitutional. Moreover, the states cite findings in the ACA statute that the mandate is inextricably linked to the rest of the law, potentially impacting the Medicaid expansion provisions. The Supreme Court will hear arguments in November, with a decision likely in June 2021. Given the changing dynamics of the U.S. Supreme Court, the court could invalidate the statute in whole or in part.

The presidential candidates also have key differences on Medicaid expansion. A key part of former Vice President Joe Biden's health platform involves creating a "public option"—a plan where the federal government can collect premiums from enrollees, determine what the "plan" reimburses, and set payment rates for providers. His platform would enroll lower-income people in non-Medicaid expansions into the public option. The federal government would pay 100 percent of the premium, with no state matching funds required. This is likely far more attractive to states than expanding Medicaid since that would require a state to bear 10 percent of the cost of providing services for expansion enrollees.

In the longer term, at some point, the federal government will likely attempt to reduce entitlement spending. One recommendation that has been proposed in the past is to lower the 90 percent federal matching payment for the expansion population. Former President Obama proposed doing just that in his Fiscal Year 2013 budget. His proposal to create a "blended Medicaid match rate"– a uniform federal matching rate for both the traditional Medicaid population and the expansion population – would have reduced federal Medicaid spending by $100 billion over ten years.[50] Such a change would, of course, have huge fiscal consequences for states that decide to expand. In most cases, it would significantly increase the state's share of the Medicaid payment for millions of new Medicaid expansion enrollees.

In addition, many states have used financial gimmicks that minimize the state's share of Medicaid expenses. In essence, states create artificial expenditures and obtain federal matching funds for these "fake" expenditures, leveraging federal matching payments without states making actual expenditures.[51] Mr. Biden has referred to some of these gimmicks as

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[50] Avik Roy, "Governors' Worst Nightmare: Obama proposed shifting costs of Obamacare's Medicaid expansion to the states," Forbes, July 19, 2012, https://www.forbes.com/sites/theapothecary/2012/07/19/governors-worst-nightmare-obama-proposed-shifting-costs-of-obamacares-medicaid-expansion-to-the-states/#6f3f5a482572

[51] Brian Blase, "The Importance of the Medicaid Fiscal Accountability Rule," Health Affairs, April 7, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200331.308494/full/

"scams" that should be eliminated.[52] Federal action to provide greater transparency and limit these gimmicks and scams also would leave states on the hook for more Medicaid spending, particularly if they expand their Medicaid programs.

10. Refusing to expand saves taxpayer dollars and reduces federal deficits

Some state proponents of Medicaid expansion promote it as a way of getting the state's fair share from the federal Medicaid coffers. However, there is no pot of federal money where states access their Medicaid money. In reality, the costs of Medicaid expansion are added to the gigantic federal deficit and are thus borne by future generations of federal taxpayers. In fact, every non-expansion state already receives more from the federal government than they send back to the federal government. So, arguments about "getting our money back" from Washington, D.C. are invalid. In total, non-expansion states receive back $1.29 in federal money for every dollar they "send" to the federal government.[53] And the money spent on expansion is borrowed from future generations.

11. There are many good health care options already available

Coverage is not care. As described earlier, Medicaid recipients are often challenged to find physicians, especially specialists, who can afford to accept the program's low payment rates and tolerate the program's massive bureaucracy. Many of those who are uninsured have options for free care through Federally Qualified Health Centers or free clinics, or other low-cost coverage models such as direct primary care or health-sharing ministries. In addition, there already are a myriad of government programs to help low-income individuals obtain medical care, including requirements that hospitals render emergency services regardless of ability to pay, federal programs for uncompensated care, and many block grants for programs that serve those in need.[54] Black et al. found that the average uninsured individual utilizes about 80 percent as much health care as similar people with health insurance.[55]

Also, many individuals who are counted as uninsured have access to other coverage programs but are not enrolled. Economists Jonathan Gruber and David Cutler refer to this population as "conditionally covered."[56] For example, an estimated 6.8 million people are eligible for Medicaid or the Children's Health

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[52] Brian Blase, "Biden was Right: Medicaid provider taxes a 'scam' that should be scrapped," Forbes, February 16, 2016, https://www.forbes.com/sites/theapothecary/2016/02/16/biden-was-right-medicaid-provider-taxes-a-scam-that-should-be-scrapped/#305ec9131c6c

[53] Nicholas Horton and Jonathan Ingram, "Dispelling Four Myths About Obamacare Expansion Funding," Foundation for Government Accountability, March 5, 2020, https://thefga.org/wp-content/uploads/2020/03/Dispelling-four-myths-about-ObamaCare-expansion-funding.pdf

[54] "Volunteer Care," Foundation for Government Accountability, accessed September 27, 2020, https://thefga.org/solution/health-care/volunteer-care/

[55] Bernard Black, Jose-Antonio Espin-Sanchez, Eric French, and Kate Litvak, "The Long-Term Effect of Health Insurance on Near-Elderly Health and Mortality," *The University of Chicago Press Journals* 3, no. 3, (2017) https://www.journals.uchicago.edu/doi/abs/10.1162/ajhe_a_00076

[56] David Cutler and Jonathan Gruber, "Does Public Insurance Crowd out Private Insurance?" *The Quarterly Journal of Economics* 111, no. 2, (1996): 391-430, https://academic.oup.com/qje/article-abstract/111/2/391/1938373?redirectedFrom=fulltext

Insurance Program but are not enrolled.[57] Almost every state allows people who are eligible for Medicaid to enroll retroactively, with providers able to receive payments for services that they delivered in the three-month period prior to enrollment. This allowance means that people do not need to be enrolled in order to have their medical expenses covered.

12. Targeted initiatives have better results than Medicaid expansion

The most cost-effective way to use public resources to improve health is through targeted initiatives focused on individuals who are most likely to benefit from health care and medication, and through investments in child health. Research from economists Nathanial Hendren and Ben Sprung-Keyser demonstrates that health programs geared toward lower-income children had a substantially positive rate of return.[58] They found additional healthcare spending on adult populations had among the worst returns in part because such programs reduced incentives to work. This negative side effect of Medicaid expansion to able-bodied adults has been proven true, as research shows that 52 percent of all expansion enrollees do not report any income, an evidence of a lack of work.[59]

Conclusion

Although the allure of federal money has led too many states to adopt ACA's Medicaid expansion, doing so will worsen the safety net program for the truly needy, lead many people to replace private coverage with public coverage, will significantly increase state expenditures, will crowd out other vital priorities, and will worsen federal budget deficits. States should continue to press Washington for greater flexibility to best manage their programs and resist the ACA's failed Medicaid expansion.

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Our original paper[60] listing 12 reasons not to expand Medicaid was published in 2013 and written by Grace-Marie Turner and Avik Roy, then of the Manhattan Institute and now president and founder of the Foundation for Research on Equal Opportunity. That first paper was released after the Supreme Court decision giving states the option to expand Medicaid. Our warnings then have proven predictive today, as this new paper explains.

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[57] Doug Badger and Jamie Bryan Hall, "What You Should Know About the Uninsured," Galen Institute, October 25, 2019, https://galen.org/2019/what-you-should-know-about-the-uninsured/

[58] Nathaniel Hendren and Ben Sprung-Keyser, "A Unified Welfare Analysis of Government Policies," *Quarterly Journal of Economics* 135, no. 3, (2020): 1209-1318 2020, https://scholar.harvard.edu/hendren/publications/unified-welfare-analysis-government-policies

[59] Nicholas Horton and Jonathan Ingram, "The Future of Medicaid Reform: Empowering individuals through work," https://thefga.org/research/future-medicaid-reform-empowering-individuals-work/

[60] Grace-Marie Turner and Avik Roy, "Why States Should Not Expand Medicaid," Galen Institute/Manhattan Institute, May 1, 2013, https://galen.org/2013/why-states-should-not-expand-medicaid/