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Medicaid Expansion: Expensive, Ineffective, and Damaging to Existing Healthcare Infrastructure

Prudent public officials considering expanding their state's Medicaid program need to weigh the claimed gains from expansion against the certain losses expansion creates. Expanding the Medicaid entitlement can lay waste to a state's budget and damage its health infrastructure, reducing both the quality and quantity of medical care available to those who both pay for Medicaid and for their own medical care.

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Experience in the states that have expanded Medicaid under the Affordable Care Act (ACA) shows that those urging expansion generally underestimate the size of Medicaid expansion enrollments, underestimate Medicaid expansion's cost to the state, and overestimate its health benefits.

Spending on Medicaid has always been difficult to limit. As its enrollment expands, it reduces available funding for other pressing public needs like schools, infrastructure improvements, law enforcement, and higher education. Expansion fuels the development of interest groups that make money from Medicaid. They seek to fatten their bottom lines by pushing for more expansion and more spending. When Medicaid becomes both the largest health care coverage program and one of the largest budgetary items in a state, officials intent on protecting it may enact policies that do significant damage to a state's healthcare infrastructure, reducing access to necessary care, and reducing overall health care quality.

Estimates underestimate expansion enrollment and its costs.

Originally designed to provide medical care for the relatively small number of US citizens who were too sick and too poor to pay for their own care, Medicaid is now has a larger enrollment than any other government run health care program in the United States. Over time, the program has been expanded to cover even relatively healthy adults and children. Over 84.4 million people were enrolled in October 2022, roughly a quarter of the entire US population.[1] In some states, couples with incomes as high as $25,000 now qualify. The

1 Centers for Medicaid and Medicare Services. October 2022 Medicaid & CHIP Enrollment Data Highlights, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html, accessed February 18, 2023.

New York Medicaid program covers illegal aliens over 65.[2] California covers illegal aliens over 50.[3]

Medicaid's design encourages excess spending. The states administer the program, but the federal government pays for the largest fraction of it. The federal government matches state spending according to a state's Federal Medical Assistance Percentage (FMAP). The FMAP varies by state per capita income. States with lower per capita incomes generally have higher FMAPs. In 2021, state FMAPS ranged from 50 percent to 78 percent. Some programs have an increased match. The federal government pays 90 percent of the costs for adults added under the ACA expansion rules and 90 percent for family planning services. FMAP rates were raised by 6.2 percent from January 1, 2020, and the increase will continue until the quarter in which the federal government declares an end to the COVID public health emergency.

Enrollment in Medicaid today is 2 1/2 times what was originally predicted and costs are 50% higher.

In 2021, the states and the federal government spent $748 billion on Medicaid. Spending grew at an annual rate of 9.6 percent even though spending per enrollee was down by 4.4 percent, probably a result of expanding enrollments to include relatively healthy adults and children who need less medical treatment than the more costly severely disabled and seriously ill.[4] Medicare, the federal medical program that covers the disabled and those over age 65, covered an average of 64.5 million people in 2022. Its program spending in 2021 was $839 billion.

The Foundation for Government Accountability estimates that while states' estimates of expansion enrollment predicted, in total, an additional 6.5 million people, the actual number enrolled as of 2022 was 16.7 million. Per capita costs were also underestimated. In 2012, the U.S. Department of Health and Human Services predicted costs of $4,000 per person by 2018. Actual expansion costs in 2018 had grown to almost $6,100 per person.[5]

Higher than expected enrollment. Colorado's experience illustrates how wrong enrollment estimates can be. In 2011, Gruber and Associates were hired to estimate the costs of Colorado's proposed Affordable Care Act Medicaid expansion. They predicted that by 2016, Colorado's non-disabled under age 65 Medicaid enrollment would be 710,000. In fact, by 2014, Medicaid enrollment was over 1.1 million. It is now about 1.7 million out of a total population of about 6 million.[6]

2 Carl Campanile and Bernadette Hogan. April 11. 2022. "NYers buy Medicaid for illegal migrants in Gov. Hochul, Dems' $220B budget," New York Post, https://nypost.com/2022/04/11/nyers-buy-medicaid-for-illegal-migrants-in-hochul-dems-budget/ , accessed February 18, 2023/

3 Office of Governor, State of California. October 19, 2022. Medi-Cal Expansion Provided 286,000 Undocumented Californians with Comprehensive Health Care. https://www.gov.ca.gov/2022/10/19/medi-cal-expansion-provided-286000-undocumented-californians-with-comprehensive-health-care/, accessed February 18, 2023.

4 MACStats, Medicaid and CHIP Data Book. Exhibit 10: https://www.macpac.gov/wp-content/uploads/2022/12/EXHIBIT-10.-Medicaid-Enrollment-and-Total-Spending-Levels-and-Annual-Growth-FYs-1971%E2%80%932021.pdf

5 Hayden Dublois and Jonathan Ingram, "An Unsustainable Path: How ObamaCare's Medicaid Expansion Is Causing an Enrollment and Budget Crisis" (Foundation for Government Accountability, January 19, 2022), https://thefga.org/wp-content/uploads/2022/01/Medicaid-Enrollment-and-Cost-Hikes-2.0.pdf.

6 Linda Gorman, "How the Gruber Model Failed in Colorado," Issue Backgrounder (Denver, Colorado: Independence Institute, February 2015), https://i2i.org/wp-content/uploads/2015/03/IB_A_2015_web-

As a result of the expansion, Medicaid enrollment in Colorado has increased from about 1 in 12 people to more than 1 in 4 people. In FY 2021, Medicaid consumed 37.9 percent of the Colorado state government's expenditures.[7] Thanks to an additional expansion passed by the legislature in 2022, Colorado Medicaid will begin covering pregnant illegal women and their babies in 2025.[8]

The Medicaid program was designed to provide medical care for people with acute or chronic medical problems who were unable to provide for themselves due to sickness, inability to work, or extreme poverty. On paper, it provides the most extensive coverage plan in the US. Though benefits differ somewhat from state to state, they typically include transportation, extended nursing home care, prescription drugs, over the counter medications, home care, physical and occupational therapy, inpatient psychiatric care, home care, eyeglasses, hearing aids, and dental care.

In general, cost sharing for medical services encourages potential patients to use medical resources wisely. Medicaid was designed to help the people who could not afford cost sharing. Its legally allowed charges are so low that they are often not worth collecting. Cost sharing for most states is in the $2 to $8 range for everything from prescription drugs to emergency room visits to hearing aids.[9] Hospital admission copayments range from zero to $75 per admission. In 2018, charges for non-emergency use of the emergency department were generally zero to $4. Utah charged $8, and in Florida the copay could be as high as $15.[10]

Cost sharing for medical services encourages patients to use medical resources wisely. Medicaid eliminates that incentive.

No cost sharing made sense when Medicaid enrollment was limited to poor people who needed every dollar they had to deal with their personal and medical needs. As enrollment began to expand from those who were categorically eligible due to severe poverty, disease, or disability to healthy children and adults, the fact that most services were virtually

1. pdf. Colorado Medicaid Enrollment numbers are from the Colorado Department of Health Care Policy and Financing, Medical Premiums Expenditure and Caseload Report, various years.

7 "2022 State Expenditure Report, Fiscal Years 2020-2022" (Washington, DC: National Association of State Budget Officers), accessed February 6, 2023, https://www.nasbo.org/reports-data/state-expenditure-report.

8 Paolo Zialcita, June 7,2022. "Colorado expands Medicaid access to undocumented pregnant people and their babies," Colorado Public Radio, https://www.cpr.org/2022/06/07/colorado-expands-medicaid-access-undocumented-pregnant-people/, accessed February 18, 2023.

9 For example, see the Michigan beneficiary co-payment requirements for 2021 at https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder60/WebCo-PayTable_11-02-06.pdf?rev=39dfeae1839e4434b66f503f84d63e45&hash=0011A97D7B51605563D320E49EB224B9, For hospital admission charges see State Health Facts, Kaiser Family Foundation, "Medicaid Benefits: Inpatient Hospital Services other than an Institution for Mental Disease," https://www.kff.org/medicaid/state-indicator/inpatient-hospital-services-other-than-in-an-institution-for-mental-diseases/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, accessed February 18, 2023.

10 State Health Facts, Kaiser Family Foundation. Medicaid Benefits: Outpatient Hospital Services, https://www.kff.org/medicaid/state-indicator/outpatient-hospital-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D accessed February 18,, 2023.

free led to overuse of expensive emergency department care. Expanding the program to enroll hundreds of thousands of additional people whether they need medical care or not will lead to more overuse.

Fraud opportunities expand as well. Profits for reselling drugs can be large. Organized networks have long encouraged patients, physicians, and pharmacists to resell virtually free Medicaid prescription drugs. The diverted drugs flow to street dealers and other middlemen who supply the gray market. In 1990, New York's social services department estimated that Medicaid drug diversion amounted to about 10 percent of the state's total Medicaid prescription drug expenditures.[11] In one set of high-profile prosecutions in 2012, Medicaid recipients in New York, New Jersey, Pennsylvania, Florida, Texas, Massachusetts, Utah, Nevada, Louisiana, and Alabama had allegedly resold $500 million in prescription drugs, including medications for treating HIV/AIDS, schizophrenia, and asthma.[12]

707,000 people with intellectual and developmental disabilities are on Medicaid waiting lists, while the expansion population is mainly healthy.

The size of the newly enrolled expansion population also tends to be far less predictable because membership is defined by income rather than by age or chronic health problems. Income can change rapidly as people enter and exit the labor force, and reported incomes are likely to be lower than expected as it is always difficult to verify unreported off-the-books employment.

The ability to administer an expanded program is also a problem. In 2016, the GAO reported that it submitted fictitious applications to states that had expanded Medicaid. Three of eight fictitious applications were approved "despite having identity information that did not match Social Security Administration records." In New Jersey in 2018, the state failed to disenroll deceased individuals, and made almost $750,000 in payments for services delivered after their deaths. In New York, during a 9-month period in 2014, at least 354 Medicaid enrollees were deceased. In 2017, the North Carolina state auditor found that error rates in the 10 sample county departments of social services responsible for verifying eligibility ranged from 1 percent to nearly 19 percent.[13]

11 Leslie G. Aronovitz, "Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities" (United State General Accounting Office Testimony, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, United States House of Representatives, Washington, D.C., August 2, 1993), https://www.gao.gov/assets/t-hrd-93-28.pdf. p. 3.

12 "Press Release: Manhattan U.S. Attorney Anounces Charges Against 48 Individuals in Massive Medicaid Fraud Scheme Involving the Diversion and Trafficking of Prescription Drugs" (U.S. Attorney's Office, Southern District of New York, July 17, 2012), https://archives.fbi.gov/archives/newyork/press-releases/2012/manhattan-u.s.-attorney-announces-charges-against-48-individuals-in-massive-medicaid-fraud-scheme-involving-the-diversion-and-trafficking-of-prescription-drugs.

13 Carolyn L. Yocom, "Medicaid Eligibility: Accurate Beneficiary Enrollment Requires Improvements in Oversight, Data, and Collaboration" (United States Government Accountability Office Testimony, Subcommittee on Health Care, Committee on Finance, U.S. Senate, Washington, D.C., October 30, 2019), https://www.gao.gov/assets/gao-20-147t.pdf.D.C.","event-title":"Subcommittee on Health Care, Committee on Finance, U.S. Senate","genre":"United States Government Accountability Office Testimony","publisher-place":"Washington, D.C.","title":"Medicaid Eligibility: Accurate Beneficiary Enrollment Requires

Of the 1.7 million Coloradans on Medicaid after the state's expansion, most are healthy adults and children added after the Affordable Care Act expansion. Just 150,000 of Colorado Medicaid enrollees are disabled. Of them, about 100,000 people are under 65. Another 50,000 enrollees are over 65 and eligible for both Medicaid and Medicare. With occasional exceptions, the people newly covered by the expansion need only routine, relatively inexpensive, medical care of the sort that that was covered by the commonly available, relatively inexpensive, insurance policies available before the Affordable Care Act went into effect.

About 16,000 of the disabled are part of the Colorado Medicaid buy-in program for working adults with disabilities. A state program. it allows people to purchase Medicaid coverage if they meet the Social Security Administration's definition of disability. Depending on income "disregards," people making as much as $10,000 a month can qualify. The program is free for people making up to $453 a month. Those in the highest eligible income range pay just $200 a month.

Colorado's Medicaid program expansion was not driven by growing poverty. In 2010, the state's median household income was $54,046, higher than the national median of $50,046. By 2019, the national median household income had risen to $65,712. Colorado's was even higher at $77,127.

Unanticipated budget impact. The fiscal consequences of expanding Medicaid to enroll basically healthy people have been significant. Colorado enrolls a large segment of its Medicaid clients in managed care programs. This means that it makes per-member-per-month payments to managed care operators even if a Medicaid enrollee never needs any medical care. Even with higher federal payments for people enrolled as a result of the Affordable Care Act's provisions, high enrollments use up state funds even if no additional medical care is provided. Though the continuing payment program rewards managed care groups for maximizing enrollment, it does not encourage keeping careful track of eligibility or providing oversight to ensure that patients get timely care.

Colorado's financial health, which the state comptroller measures as net position of assets minus liabilities, has generally declined since it embarked on its Medicaid expansion.[14] State revenue increases have been disproportionately allocated to the Medicaid program. Inflation-adjusted spending on social assistance, of which the largest portion is Medicaid, grew from about $3 billion in FY 1999-2000 to almost $8 billion in FY 2017-18. Spending on schools, which in FY 1999-2000 was slightly larger than social assistance spending, grew to just $5 billion.

Interest groups focused on expanding coverage to everyone who is uninsured have begun to focus on the fact that relatively large fractions of illegal immigrants are uninsured. They have been successful in their initial push to expand Medicaid eligibility to illegals in California. This turns California Medicaid into a residence based free health system like Britain's National Health Service. Because shortages are endemic in the National Health Service, and foreigners from across Europe migrated to England for

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Improvements in Oversight, Data, and Collaboration","URL":"https://www.gao.gov/assets/gao-20-147t.pdf","author":[{"family":"Yocom","given":"Carolyn L."}],"accessed":{"date-parts":[["2023",2,20]]},"issued":{"date-parts":[["2019",10,30]]}}],"schema":"https://github.com/citation-style-language/schema/raw/master/csl-citation.json"}

14 Linda Gorman. A Thumbnail Guide to Colorado State Government's Spending Problem. TaboRYes.com. 2018. https://taboryes.com/wp-content/uploads/Thumbnail_Guide_to_Spending_c.pdf, accessed February 6, 2023.

the free medical care, England has begun assessing surcharges for NHS on foreigners coming into the country and paying more attention to cost recovery.[15]

A woman in labor is classified as a medical emergency, and illegal aliens with medical emergencies have always been entitled to emergency care under the federal Emergency Medical Treatment & Labor Act (EMTALA). At present, 7 states have extended a year of postpartum Medicaid coverage to illegal mothers who deliver babies in the US. As illegal immigration grows, so will those payments.[16] Even if a state does not expand Medicaid, it will still need to keep reserves available to pay for increased future Medicaid expenditures resulting from the current surge in illegal immigration. In 2016, California, Illinois, and Texas spent over $150 million on care for illegal immigrants.[17]

If a state legislature fails to create budgetary reserves to pay for illegal immigrant health care before it expands Medicaid, it risks bankrupting hospitals. In Yuma, Arizona, illegal immigrants walk into the emergency department of Yuma Regional Medical Center needing dialysis, heart surgery, cardiac catheterization, and months of hospital care for premature babies. In December, 2022, the hospital estimated that it had delivered $20 million in uncompensated care in the last 6 months, much of it for untreated chronic conditions that afflicted people before they crossed the border.[18] In San Diego, where California's Medicaid program is now enrolling illegal aliens, U.S. Customs and Border Protection is releasing injured illegals from federal custody so that the agency can shift illegal health care costs from its budget to the California Medicaid budget.[19]

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Under federal law, U.S. hospitals may not discharge patients without finding someone to provide their post-acute care. Illegal immigrants may or may not have friends or family willing or able to care for them in the city where they receive emergency care. When that happens, a hospital may pay tens of thousands of dollars in costs to fly illegal immigrants back to their home countries. In one case, treating the patient cost $1.5 million. Transporting him home cost $30,000 more. The state's payment to the hospital under emergency Medicaid payment rules was $80,000.[20]

15 The King's Fund. 2015. "What do we know about the impact of immigration on the NHS? https://www.kingsfund.org.uk/projects/verdict/what-do-we-know-about-impact-immigration-nhs , accessed February 24, 2023.

16 Kaiser Family Foundation. Health Coverage and Care of Immigrants. December 20, 2022. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/

17 National Immigration Forum, September 21, 2022. Fact Sheet: Undocumented Immigrants and Federal Health Care Benefits. https://immigrationforum.org/article/fact-sheet-undocumented-immigrants-and-federal-health-care-benefits/

18 Bruce Golding. December 23, 2022. "Biden border crisis leaves Arizona hospital with $20 million in unpaid bills." https://nypost.com/2022/12/23/biden-border-crisis-leaves-arizona-hospital-with-20-million-in-unpaid-bills/

19 Gustavo Solis. October 7, 2022. KPBS.org. "Border Patrol avoiding medical costs by releasing injured migrants, records show. https://www.kpbs.org/news/border-immigration/2022/10/07/border-patrol-avoiding-medical-costs-by-releasing-injured-migrants-records-show

20 Lindita Bresa. November 8, 2010. "Uninsured, Illegal, and in Need of Long-Term Care: The Repa-

No entity can long sustain this kind of loss without having its operations affected. Before Medicaid expansion is considered, states should determine whether they have the budget to preserve their health care infrastructure from the losses created when federal law and policy combine to generate large losses for the people who supply a state's health care.

Unanticipated crowd out of other unmet health care needs. One of the crueler aspects of Medicaid expansion is that although state officials happily fund Medicaid coverage for adults and children with few medical needs, adults with intellectual disabilities so severe they cannot live on their own still wait for adequate residential care. In FY 2020-21, 3,501 Coloradans with intellectual and developmental disabilities were waiting for services and supports.[21]

Nationally, the Kaiser Family Foundation reported that more than 707,000 people with intellectual and developmental disabilities were on waiting lists for Medicaid home and community based services in 2017, a figure that was 8 percent higher than 2016. Despite enormous expansions in national Medicaid enrollment, the waiting lists were only reduced to 655,596 by 2021.[22]

Medicaid patients often have difficulty accessing the care they need. Normal supply and demand considerations operate in medicine just as they do in other markets for goods and services, and because Medicaid programs generally reimburse providers at the lowest possible rate, many suppliers choose not to participate. In 2013 and 2014, the Affordable Care Act raised Medicaid's primary reimbursement to Medicare levels in order to accommodate the expected number of new Medicaid enrollments. In some states, reimbursement for a primary care appointment more than doubled.

Polsky et al. (2015) found that increasing reimbursements increased appointments for Medicaid patients by 7.7 percentage points while appointments for private patients remained approximately the same. The states with the largest increase in appointments tended to be those with the largest reimbursement increase.[23]

As Charles Blahous and Liam Sigaud (2022) point out, the Medicaid expansions have shifted policy from coverage tailored to meeting the needs of poor people with chronic illness, acute medical needs, or life-altering disabilities to coverage tailored to the needs of able-bodied low-income adults.[24]

In states that embraced the ACA expansion by 2014, median per capita spending on non-disabled children increased 5.9 percent to $3,408 in FY2019. In states that did not expand Medicaid, median

triation of Undocumented Immigrants by U.S. Hospitals.," Seaton Hall Law Review, 40:1663. https://scholarship.shu.edu/cgi/viewcontent.cgi?article=1078&context=shlr

21 The Kaiser Family Foundation reports a waiting list of 3,037 for Colorado in 2021. The difference may be due to fiscal year reporting.

22 Kaiser Family Foundation. Medicaid HCBS Waiver Waiting List Enrollment, by Target Population and Whether States Screen for Eligibility, 2021. https://www.kff.org/medicaid/state-indicator/medicaid-hcbs-waiver-waiting-list-enrollment-by-target-population-and-whether-states-screen-for-eligibility/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Seniors%2FAdults%20with%20Physical%20Disabiltiies%22,%22sort%22:%22desc%22%7D , accessed February 6, 2023.

23 Daniel Polsky et al., "Appointment Availability after Increases in Medicaid Payments for Primary Care," New England Journal of Medicine 372, no. 6 (February 5, 2015): 537–45, https://doi.org/10.1056/NEJMsa1413299.

24 Charles Blahous and Liam Sigaud, "The Affordable Care Act's Medicaid Expansion Is Shifting Resources Away from Low-Income Children," Mercatus Policy Research (Arlington, Virginia: Mercatus Center at George Mason University, December 2022), https://www.mercatus.org/media/159596/download?attachment.

per capita spending on non-disabled children increased by 22.7 percent to $3,332 per child. California, New York, Massachusetts, and four other Medicaid-expansion states actually spent less per capita spending on children at a time when national personal health spending grew by 27 percent.[25]

After comparing enrollment changes in the expansion and non-expansion states, Blahous and Sigaud conclude that "Medicaid expansion states have simply slowed their spending growth on children since implementation of the ACA."[26] An analysis of spending on the disabled and the aged showed similar results.

Expansion states can lose control of their budgets

Medicaid was passed in 1965. It covered a generally predictable fraction of the population with predictable spending. In 1972 states were allowed to include elderly, blind, and disabled residents as defined by the newly enacted Federal SSI program. The next expansion, to pregnant women and infants up to 1 year old with incomes below the federal poverty level was enacted in 1988.

With the failure of the Clinton national health care bill in 1993, advocates for federal government control of health care began pushing to achieve it by expanding Medicaid and reducing the age for Medicare enrollment. In 1997, the State Children's health Insurance Program was passed and, in many states, integrated into Medicaid.

The Affordable Care Act Medicaid expansion of 2010 provided additional matching funds to states that enrolled all people with incomes under 133 percent of the federal poverty level. Developed in the mid-1960s, the federal poverty level was designed to measure money income needed to buy a minimum food diet. Non-monetary benefits like food assistance, housing assistance, Medicaid, childcare assistance and other benefits are not counted as income. As a result, more than a quarter of the US population had an income under 200 percent of the federal poverty level in 2021.[27]

The number of household members and their money income are used to calculate their federal poverty level. As one would expect, young people tend to have lower incomes. The longer they stay in the labor force, the less likely they are to be eligible for Medicaid. As the poor, the disabled, and pregnant women and children were already enrolled in Medicaid, states that participated in the ACA expansion enrolled large numbers of able-bodied, generally healthy, people. Healthy people, especially if they are young adults, tend to move in and out of the labor force creating significant swings in enrollment. Those enrollment fluctuations make it difficult to determine eligibility, and can generate significant year-to-year swings in state spending.

Unpredictable spending. In FY 2017-18, Colorado Medicaid enrolled about 10 percent fewer Medicaid expansion parents and children, 89,000 people, than in FY 2015-16. The enrollment decline was the "biggest contributor" to a total state spending reduction of $1.1 billion. When enrollment increases unexpectedly, balancing the budget requires unpredictable cuts in other state programs. Despite more than a decade of experience, Colorado once again appropriated too little to meet an

25 Blahous and Sigaud, 11.

26 Blahous and Sigaud, 17.

27 Kaiser Family Foundation. "Distribution of the Total Population by Federal Poverty Level (above and below 200% FPL." https://www.kff.org/other/state-indicator/population-up-to-200-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

adult expansion population growth rate of 19.85 percent in FY 2021-22.

Other expansion states have faced similar problems. In Montana, state Medicaid spending rose from 17.4 percent of the state budget before expansion to more than 25 percent of the state budget just three years after expansion.[28]

Unpredictable changes in federal policies. Expanding Medicaid gives the federal government significant control over a state's budget because the federal government controls the rules governing the federal matching funds that make the Medicaid program so attractive to state officials. When the federal government increased fiscal relief for state governments during the COVID pandemic, it attached conditions that prevented states from changing Medicaid "eligibility standards, methodologies or procedures."

Expanding Medicaid gives the federal government significant control over a state's budget, because the federal government controls the rules governing federal matching funds.

The federal freeze on eligibility standards effectively prevented state legislatures from changing their Medicaid programs.[29] They could not use new auditing methods to prune ineligible people from the program or reorient spending to better fit the needs of their states. In effect, the US government can freeze the structure of the Medicaid program at will, sticking states with the costs of a program that the federal Government Accountability Office has, since 2003, classified as exceptionally high risk for fraud, waste, and abuse.[30]

Under the Affordable Care Act expansions, the federal government initially paid for 100 percent of state Medicaid expenditures for clients who were newly enrolled in state Medicaid programs. When the federal government paid 100 percent of costs, states had little to lose by enrolling ineligible Medicaid recipients in their expended Medicaid programs. As of 2020 it was to pay 90 percent of claims. Sections of the American Rescue Plan Act of 2021 promise non-expansion states a two-year 95 percent matching rate if they expand.[31]

The problem is that with federal payments of 90 or 100 percent, states have little incentive to audit enrollment. Federal audits of Medicaid ebb and flow with the political tides. When the federal government finally got around to auditing Medicaid payment error rates in 2019 and 2020, it found that

28 Hayden Dublois.Medicaid expansion has been a disaster for Montana. October 8, 2020. Foundation for Government Accountability.

29 Bill Hammond. December 15, 2020. Beyond a Bailout, New York Needs Relief from Medicaid 'Maintenance of Effort' Rules. https://www.empirecenter.org/publications/beyond-a-bailout-new-york-needs/

30 U.S. Government Accountability Office. Strengthening Medicaid Program Integrity. https://www.gao.gov/highrisk/strengthening-medicaid-program-integrity, February 6, 2023.

31 Robin Fudowitz, Bradley COrallo, and Rachel Garfield. March 17, 2021. New Incentives for States to Adopt the ACA Medicaid Expansion: Implications for State Spending. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending/

more than 22 percent of payments were made on behalf of people who were enrolled in Medicaid but not eligible for it. Brian Blaise and Joe Albanese of Paragon Health Institute estimate that Medicaid payments for ineligible people, which "soared after the ACA's expansion of the program," reached a high of $98.7 billion in 2021.[32]

Now that the states with expanded Medicaid are responsible for 10 percent of the expenditures on newly eligible clients, ineligible enrollment has become more expensive, and states may have an interest in reducing it. Unfortunately, the federal freeze on eligibility standards prohibits them from taking steps to protect their citizens from enrollment fraud.

There is little evidence that expanding Medicaid creates measurable improvement in clinical health outcomes

It is hard to show that expanding a health coverage program improves health outcomes when the program expansion covers generally healthy people. There is a sizeable academic literature exploring whether having health coverage improves health. Its findings suggest that people use more health care services when they have coverage. Whether coverage itself improves health is unclear. If coverage does not necessarily improve health, it is difficult to advocate for Medicaid expansion simply because it increases coverage.

The effect of health coverage is difficult to identify because so many personal behaviors correlate with health outcomes. For example, married people with more education and higher incomes are more likely to have coverage. But income, education, and marital status are also associated with better health whether people have coverage or not.

Studies of the effect of Medicaid expansion generally do not correct for important demographic and social and economic status differences in states that have and have not expanded Medicaid. If, for example, the expansion states generally have higher income levels or higher marriage rates than the non-expansion states, health may improve in the expansion states, but the improvement result from higher incomes or marriage rates than Medicaid expansion.

Understanding how existing incentives may distort payments also deserves consideration when contemplating Medicaid expansion, especially in states with large groups in Medicaid managed care. Most government run managed care reimbursement programs calculate managed care reimbursements according to formulas that increase payments when a plan covers people who have diagnoses that increase the cost of treatment. As a result, all managed care organizations devote substantial resources to diagnosing conditions that increase measured patient risk, because increased risk means increased payments.

The problem, as Chorniy et al. (2018) point out, is that diagnoses to increase risk payments may inflate the proportion of the population diagnosed with chronic disease but not improve its treatment.[33]

32 Joe Albanese and Brian Blase, "America's Largest Health Care Programs Are Full of Improper Payments," Policy Brief (Paragon Institute, December 5, 2022), https://paragoninstitute.org/wp-content/uploads/2022/12/2022-Improper-Payment-brief-FINAL-V4.pdf. http://paragoninstitute.org/ wp-content/uploads/2022/12/2022-Improper-Payment-brief-FINAL-V4.pdf, accessed February 6, 2022.

33 Anna Chorniy, Janet Currie, and Lyudmyla Sonchak, "Exploding Asthma and ADHD Caseloads: The Role of Medicaid Managed Care," Journal of Health Economics 60 (July 2018): 1–15, https://doi.org/10.1016/j.jhealeco.2018.04.002.

Between 2007 and 2015 South Carolina expanded Medicaid and required Medicaid enrolled children to switch from fee-for-service Medicaid coverage to managed care Medicaid coverage.

No fully objective tests are used to diagnose either ADHD or asthma, and both can be diagnosed by general practitioners. During the period under study, asthma caseloads increased by 11.6 percent and ADHD caseloads increased by 8.2 percent. Visits to mental health specialists also increased. Visits to other specialists declined. Though there was no change in hospitalizations, emergency department visits increased by 7.7 percent. The authors concluded that about a third of the increase in asthma and ADHD diagnoses from 2004 to 2015 resulted from the switch from fee-for-service to managed care, and that in South Carolina at least, enrolling children in Medicaid managed care increased reliance on emergency rooms for non-urgent care.

Medical care without Medicaid. Though some people assert that medical care is unobtainable without health coverage, the United States has historically had large amounts of charitable care available. Its history of providing care to people whether they can pay or not blunts the health effects of being without coverage and makes it more difficult to determine whether Medicaid expansion to a relatively healthy group improves health.

The U.S. history of providing care to people whether they can pay or not blunts the health effects of being without coverage and makes it more difficult to determine whether Medicaid expansion to a relatively healthy group improves health.

Private organizations and US state and local governments have been providing free health care since the establishment of the Charity Hospital of New Orleans in 1737. Private fraternal organizations ran hospitals and health coverage in the 1800s. Public hospitals flourished with one or more in most major US cities or counties by the early 20th century, and the federal government has been funding free clinics throughout the country since 1964. Pharmaceutical and medical supply manufacturers, hospitals, and physicians have long had patient assistance programs to help financially needy patients. The federal Emergency Medicaid Treatment and Labor Act (EMTALA) requires that hospitals provide emergency care to anyone in danger of death or serious impairment of bodily functions regardless of his ability to pay. It also protects the health of pregnant women and their unborn babies.

Before the Affordable Care Act, a variety of large employers provided mini-med health coverage for low-wage employees. Mini-meds were affordable plans designed to cover run of the mill acute care problems and were specifically designed to make useful coverage available to people coping with restricted cash flows. The Affordable Care Act mandated that everyone buy the expensive coverage offered to employees of government and large corporations. It essentially outlawed mini-meds, denying an effective form of coverage to people who had previously relied upon it. (Goodman, 2015 and Puzder, 2015)[34]

34 John C. Goodman. January 8, 2015. How Obamacare Harms Low-Income Workers. The Wall Street Journal. https://www.wsj.com/articles/john-c-goodman-how-obamacare-harms-low-income-workers-1420760457, accessed February 5, 2023; Andy Puzder. January 13, 2015. Shunning ObamaCare. The Wall Street Journal. https://www.wsj.com/articles/andy-puzder-shunning-obamacare-1421192654, accessed February 6, 2023.

People traditionally counted as uninsured have also had coverage through health sharing plans. They allow people to voluntarily share large, unexpected, health care costs. Other sources of coverage for the technically uninsured include the Veterans Administration, the Social Security Disability Insurance program, state workers' compensation programs, auto coverage, and business and homeowners' liability policies.

Medicaid eligible but not yet enrolled. The uninsured in the US have historically been younger and healthier than the general population. Estimates in the 1990s suggested that about a third of uninsured Americans were eligible for Medicaid but had not signed up because they did not think they needed medical care. In states with "presumptive eligibility" in their Medicaid programs, these people were not formally enrolled but had coverage if they needed it. Under presumptive eligibility, providers treating an uninsured person who would qualify for Medicaid but had not enrolled assessed him for Medicaid eligibility, provided care, and received retroactive payment when the patient officially qualified for Medicaid.

Letting people be uninsured was probably an efficient way to run state Medicaid programs. It minimized the amount of money spent on administrative costs to cover people who did not really need medical care, avoiding the administrative overhead costs implicit in automatic payments to managed care organizations providing unnecessary coverage.

Medicaid managed care plans get paid whether their enrollees use medical care or not, and they push hard to enroll people, even if they don't think they need coverage.

Now that Medicaid managed care organizations routinely get paid whether members use medical care or not, they push hard to enroll people in Medicaid whether they need coverage or not. Federally qualified clinics also push for Medicaid expansion. They were chartered to provide free care for those without coverage, but they now get paid for their "free care" if a patient is enrolled in Medicaid.

Crowd out effects. Some people choose to forgo coverage because they believe that the premiums for coverage are so high that they will be better off paying cash for any medical care they need. Others calculate that they will be eligible for Medicaid should an illness make them unable to work. People in the upper half of the income distribution, those making more than about $54,000 a year if they are single, are ineligible for Affordable Care Act subsidies. With individual premiums averaging $450 a month, coverage consumes 10 percent of one's income even if one never sees the doctor.

The high premiums, unreasonable amount of coverage for inexpensive services, and financially ruinous deductibles resulting from the Affordable Care Act have driven people in the upper half of the national income distribution to drop coverage. They now make up an estimated 16 percent of the uninsured population in the US. Ilegal aliens make up another 16 percent.[35] Medicaid expansion will help neither of these groups.

35 Benjamin D. Sommers, "Health Insurance Coverage: What Comes After The ACA?: An Examination of the Major Gaps in Health Insurance Coverage and Access to Care That Remain Ten Years after the Affordable Care Act.," Health Affairs 39, no. 3 (March 1, 2020): 502–8, https://doi.org/10.1377/hlthaff.2019.01416.

There are indications that Medicaid expansion also induces lower income working-age people to substitute expanded Medicaid for existing private coverage. This group includes college students,[36] women near retirement,[37] early retirees,[38] the near elderly,[39] and adults aged 50 to 64.[40] The substitution reduces incomes to the extent that people reduce their work hours to qualify for Medicaid, and shifts health care costs to taxpayers from newly covered individuals and the charities that formerly aided them.

Other evidence that some people use Medicaid as a substitute for private coverage for Medicaid comes from Tennessee's 2005 reduction in Medicaid eligibility. In a group that was 63 percent female, Tello-Trillo (2021)[41] estimates that 52-69 percent of those who lost Medicaid did not get other coverage--this means that 30 to 40 percent did. The expanded Medicaid eligibility offered by the Affordable Care Act will likely make it easier to substitute Medicaid for private coverage.

Academic studies of health outcomes. In Oregon, a Medicaid lottery allowed researchers to compare health outcomes and utilization for randomly selected people who applied for Medicaid coverage. Taubman et al. (2014)[42] found that while self-reported hospital use did not change, hospital administrative data suggested that Medicaid coverage increased emergency department use by 40 percent relative to a control group average of 1.02 visits per person over a two-year period. The Oregon study also showed no significant improvements in physical health outcomes in the first two years.

No other recent Medicaid study has been as carefully constructed as the Oregon study. While it is unlikely that spending such large amounts on Medicaid has not had some beneficial health effects, the evidence for large health benefits derived from Medicaid is surprisingly limited. The academic studies suggesting that Medicaid expansions did improve health generally fit into one of three categories.

The first category typically compares what might be thought of as macro variables—those studies

36 Priyanka Anand and Dora Gicheva, "The Impact of the Affordable Care Act Medicaid Expansions on the Sources of Health Insurance Coverage of Undergraduate Students in the United States," Medical Care Research and Review 79, no. 2 (April 2022): 299–307, https://doi.org/10.1177/10775587211015816.

37 Erkmen Giray Aslim, "The Relationship Between Health Insurance and Early Retirement: Evidence from the Affordable Care Act," Eastern Economic Journal 45, no. 1 (January 2019): 112–40, https://doi.org/10.1057/s41302-018-0115-8.

38 Padmaja Ayyagari, "Health Insurance and Early Retirement Plans: Evidence from the Affordable Care Act," American Journal of Health Economics 5, no. 4 (October 2019): 533–60, https://doi.org/10.1162/ajhe_a_00132.

39 Mark Duggan, Gopi Shah Goda, and Gina Li, "The Effects of the Affordable Care Act on the Near Elderly: Evidence for Health Insurance Coverage and Labor Market Outcomes," Tax Policy and the Economy 35 (June 1, 2021): 179–223, https://doi.org/10.1086/713496.

40 Ozcan Onal, Sezen, Does the ACA Medicaid Expansion Encourage Labor Market Exits of Older Workers? (July 31, 2022). Available at SSRN: https://ssrn.com/abstract=4193045 or http://dx.doi.org/10.2139/ssrn.4193045

41 Daniel Sebastian Tello-Trillo, "Effects of Losing Public Health Insurance on Preventative Care, Health, and Emergency Department Use: Evidence from the TennCare Disenrollment," Southern Economic Journal 88, no. 1 (July 2021): 322–66, https://doi.org/10.1002/soej.12504.

42 S. L. Taubman et al., "Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment," Science 343, no. 6168 (January 17, 2014): 263–68, https://doi.org/10.1126/science.1246183.

typically compare mortality of one sort or another in states that have expanded Medicaid to mortality in states that have not expanded Medicaid. The second category looks at outcomes of treatment for specific health conditions like lung cancer, access to specific types of specialty care like radiation treatment, or specific quality measures before and after Medicaid expansion. The third category uses activity measures as a proxy for health. Health is assumed to have improved if physician visits increase, more patients can cite a place of usual care, or people have more mental health appointments or fewer days in the hospital after Medicaid expansion.

Medicaid is a substitute for private coverage for one-third of enrollees, or more.

Expansion advocates often say that Medicaid expansion improves health because mortality is lower in expansion states. The mortality studies generally compare mortality in entire expansion states, or in counties in expansion states, to supposedly similar non-expansion states or counties. Sometimes, as in Miller et al. (2021),[43] they restrict the population studied to mortality in carefully specified groups, such as people aged 55 to 64, or to mortality for something specific, such as cardiovascular mortality in all adults.

It is difficult for statistical studies of mortality declines resulting from Medicaid expansion to distinguish between mortality differences caused by Medicaid expansion and mortality differences caused by other factors. States have wide variations in characteristics which are known to be associated with mortality, and these characteristics are typically not specifically controlled for in the Medicaid expansion mortality studies.

Differences between the expansion and non-expansion states differ in their incomes, proportion of the population that is overweight, the fraction of diabetics, the proportion of illegal residents, and the extent of illegal drug use. Each of these things is independently related to mortality. Other differences are real but less obvious. Mississippi, for example, has 25.4 auto crash fatalities per 100,000 population,[44] while Massachusetts has 4.9.

The health benefits that have been attributed to Medicaid expansion are less striking than one would hope given its enormous cost. Gotanda et al. (2021)[45] used data from the National Health and Nutrition Examination Survey (NHANES), and, after adjusting for age, sex, race/ethnicity, education, and neighborhood socioeconomic status, compared NHANES health results in expansion and non-expansion states three years after expansion. Limiting their examination to low-income individuals, they found that expansion states enjoyed "modest" improvement in systolic blood pressures, which were reduced by 3mm, and HbA1c levels, which were lowered 0.14 percentage points. Medicaid expansion had no apparent effect on cholesterol levels or diastolic blood pressure.

It is unclear what, if any, clinical significance an average drop of 3mm might have as mean systolic

43 Sarah Miller, Norman Johnson, and Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics 136, no. 3 (June 30, 2021): 1783–1829, https://academic.oup.com/qje/article-abstract/136/3/1783/6124639?redirectedFrom=fulltext

44 Fatality Facts 2020, State by State. Insurance Institute for Highway Safety/Highway Loss Data Institute. https://www.iihs.org/topics/fatality-statistics/detail/state-by-state, accessed February 6, 2023.

45 Hiroshi Gotanda et al., "Association Between the ACA Medicaid Expansions and Changes in Cardiovascular Risk Factors Among Low-Income Individuals," Journal of General Internal Medicine 36, no. 7 (July 2021): 2004–12, https://doi.org/10.1007/s11606-020-06417-6.

blood pressures had fluctuated around 120mm for both expansion and non-expansion states since 2005-2006. The clinical significance of the HbA1c difference is also unclear. It fluctuated around 5.6 percent in both sets of states, was equal in 2005-2006, generally lower in expansion states through 2010, was equal in 2013-14, and returned to a lower level in the expansion states in 2015-16. In any case, the differences were small, 5.6 to 5.4 percent A1c.

Did Medicaid expansion cause these differences? No one knows. Researchers disagree about exactly how blood pressure affects health, and the US has large geographic variation in things like the dietary intake variables[46] that some people believe affect blood pressure.

The geographic variations make it especially difficult to know whether Medicaid expansion caused better health, Medicaid expansion states were simply healthier to begin with, or whether Medicaid expansion states were getting healthier at a faster rate when the measurements were made.

Gillum et al. (2012) found that male non-Hispanic African Americans aged 35-84 years had coronary heart disease mortality rates in 2005-2007 that were 3.1 times higher in Michigan than in Minnesota. And while death rates declined in all Census Divisions from 1999 to 2007, the rate of decline was higher in some divisions than others. To complicate matters further, the decline varied by race, sex, and extent of urbanization.[47]

Evidence from a variety of studies on early-stage cancer detection suggests that Medicaid coverage is associated with earlier detection for cancers for which screening and early detection exist, cancers such as breast cancer, colorectal cancer, and lung cancer.[48] Expansion apparently made little or no difference, however, in the stage at which hepatocellular carcinoma was diagnosed.[49] Whether Medicaid expansion is necessary to improve cancer care remains an open question. Many of the studies showing that expansion states detected cancer at an earlier stage focused on patients older than 40. The groups that swell the Medicaid expansion rolls tend to be children and younger adults.

Medicaid enrollment in Oregon produced no significant differences in physical health outcomes.

If the goal is to effectively screen for and treat people found to have early-stage cancers both taxpayers and patients might profit from consideration of more flexible, less expensive, alternatives. Why, for example, are able-bodied working age adults not taking advantage of the low or

46 Ihab Hajjar, Theodore Kotchen, Regional Variations of Blood Pressure in the United States Are Associated with Regional Variations in Dietary Intakes: The NHANES-III Data, The Journal of Nutrition, Volume 133, Issue 1, January 2003, Pages 211–214, https://doi.org/10.1093/jn/133.1.211

47 Richard F Gillum et al., "Racial and Geographic Variation in Coronary Heart Disease Mortality Trends," BMC Public Health 12, no. 1 (December 2012): 410, https://doi.org/10.1186/1471-2458-12-410.

48 For a representative example see Kristin M. Primm et al., "Impacts of Medicaid Expansion on Stage at Cancer Diagnosis by Patient Insurance Type," American Journal of Preventive Medicine 63, no. 6 (December 2022): 915–25, https://doi.org/10.1016/j.amepre.2022.06.001.The problem is that the effect on mortality is unknown. Han et al. found that 2 year survival increased more in Medicaid expansion states, but the difference as small when compared to the size of the increase in both expansion and non-expansion states.

49 Marianna V. Papageorge et al., "Beyond Insurance Status: The Impact of Medicaid Expansion on the Diagnosis of Hepatocellular Carcinoma," HPB 24, no. 8 (August 2022): 1271–79, https://doi.org/10.1016/j.hpb.2021.12.020.

zero premium health insurance plans available to them through the ACA marketplace plans?

The bottom line is that if Medicaid expansion does have a large effect on health, the studies trying to assess its effects should show consistent, similarly sized, effects on important clinical indicators of health. Existing studies of health outcomes from Medicaid expansion do not yet fulfill this requirement.

How potential enrollees value Medicaid. There are some indicators that expanded Medicaid spending may be a waste even from the recipients' point of view. Finkelstein et al. (2019) estimated the willingness of uninsured adults to pay for Medicaid. They found that the welfare value of each dollar of Medicaid spending to recipients ranged from $0.20 to $0.40.[50] In other words, if you offered to trade a person's Medicaid enrollment for money, he would be willing to sell his right to be covered by Medicaid for as little as 20 cents on the dollar.

The value enrollees place on being in Medicaid is as little as 20 cents on the dollar.

Finkelstein et al. also estimated that "the resource cost of providing Medicaid to an additional recipient was only 40 percent of Medicaid's total cost; 60 percent of Medicaid spending is a transfer to providers of uncompensated care for the low income uninsured." This means that taxpayers paid $1.00 to provide 40 cents in Medicaid services that recipients valued at 20 to 40 cents.

In short, Medicaid expansion to able-bodied adults is an undisputed windfall for people who get paid to provide Medicaid services. The problem is that many of those services likely have marginal value for recipients and is a sure loss for taxpayers.

How Medicaid expansion can harm healthcare infrastructure

Expansion advocates have long claimed that Medicaid expansion will reduce health care costs because it provides better access to primary care. They claim that better access to primary care reduces the need to use the more expensive health care available in the emergency department. Advocates also assert that better access to primary care will lower costs by detecting and treating disease while it is in its less expensive early stages.

Emergency room visits. While there is little evidence that increased primary care has done anything to reduce overall health care spending, two decades of academic work provides strong evidence that Medicaid expansion increases hospital emergency department crowding. The reason for this is clear. While private coverage typically requires substantial payments if a covered person visits the emergency department but is not admitted, the federal government either prohibits or limits requiring similar payments from Medicaid patients. When payments are allowed, federal requirements limit them to such small amounts that they are often not worth bothering to collect.

For practical purposes, those covered under Medicaid enjoy free visits to the emergency department and incur no cost when they call an ambulance to take them there. Medicaid clients are rational people. Why go to the expense of scheduling a primary care visit, waiting for it, and traveling to it when emergency departments are always open and offer doctors, imaging, and lab tests all in one place?

50 Amy Finkelstein, Nathaniel Hendren, and Erzo F.P. Luttmer, "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," Journal of Political Economy, December 17, 2018, 702238, https://doi.org/10.1086/702238.

Rational health policy experts should not be surprised when expanding Medicaid increases emergency department visits.

The estimated increase in emergency department use created by Medicaid expansion is substantial. Ellis and Esson (2019)[51] estimate that as of 2016, Affordable Care Act Medicaid expansions had increased California's healthcare expenditures by $429.3 million a year "by those who crowded-out from their private insurance."

Another result from the Oregon experiment detailed by Baicker et al. (2018) suggests that while Medicaid reduces the unmet need for dental care, it does so by doubling the share of people visiting the emergency department for dental care.[52] The share doubled even though Medi-Cal, California's Medicaid program, covers dental care.

Medicaid has led to a significant increase in emergency room traffic.

Medicaid vs. uncompensated care. In most respects, the supply side response to the changing private/payer mix created by Medicaid expansion is as misunderstood as the beneficiary response to essentially free emergency department care. Under adequately competitive circumstances, improved hospital and provider profitability is generally associated with improved patient care. Medicaid expansion undoubtedly decreases the amount of hospital-provided uncompensated care (the care hospitals provide to people who do not pay), and increases the use of hospital services. These changes might improve hospital profitability. But state Medicaid programs reimburse at low rates, and If Medicaid crowds out private payers who reimburse more generously, expansion could reduce hospital profitability.

If operating margins fall, hospitals and physicians adjust by decreasing the quality and quantity of the services they provide by making people wait, reducing staffing, letting facilities degrade, and hiring less qualified people.

Young et al. (2019) used hospital IRS filings to compare uncompensated care costs and Medicaid payment shortfalls in expansion and non-expansion states. They found that the savings from the decline in hospital uncompensated care costs was somewhat offset by a rise in the size of reported losses due to "Medicaid payment shortfall."[53] This means that discussions that focus only on changes in uncompensated care costs overstate how much Medicaid expansion improves hospital finances. They ignore the losses generated when people switch from private payers to Medicaid.

Stoecker, et al. (2020) also used IRS filings to look at the charitable activities of 2,253 nonprofit hospitals from 2012 to 2016. They found that across their sample, the mean uncompensated care cost was $4.2 million, and the mean unreimbursed Medicaid expense was $7.6 million. In states that

51 Ellis, Cameron and Esson, Meghan, Crowd-Out and Emergency Department Utilization (July 16, 2018). Fox School of Business Research Paper No. 18-038, Available at SSRN: https://ssrn.com/abstract=3214825 or http://dx.doi.org/10.2139/ssrn.3214825

52 Katherine Baicker et al., "The Effect of Medicaid on Dental Care of Poor Adults: Evidence from the Oregon Health Insurance Experiment," Health Services Research 53, no. 4 (August 2018): 2147–64, https://doi.org/10.1111/1475-6773.12757.

53 Gary J. Young et al., "Impact of ACA Medicaid Expansion on Hospitals' Financial Status:," Journal of Healthcare Management 64, no. 2 (March 2019): 91–102, https://doi.org/10.1097/JHM-D-17-00177.

expanded Medicaid, hospitals enjoyed a mean reduction of $1.11 million in their uncompensated care costs (about 2%), but those gains were offset by a mean increase of unreimbursed Medicaid expenses of $1.62 million, (also about 2%).[54] Chatterjee et al. (2022) concluded that Medicaid expansion did not improve critical access hospital postexpansion operating margins relative to hospitals in nonexpansion states. It also failed to improve quality, staffing, or mortality measures.[55]

The quality of the data may be a major problem in evaluating the effect of Medicaid expansion on hospital finances. Most U.S. hospitals are non-profits. Non-profit hospitals tend to have lower output efficiency than for profit hospitals. Unlike for-profit hospitals their administrators may aim to operate at a break-even level while maximizing community relations, prestigious services, favorable treatment from state government, or charitable activities. This means that studies that look only at changes in revenues or uncompensated care costs cannot show whether Medicaid expansion improved hospital finances. Rosko et al. (2018) reported that from 2000 to 2015, hospital profit margins in Medicaid expansion states were already lower than those in non-expansion states.[56] Santos (2021) et al. note that the net effect of expansion on the costs of Medicaid payment shortfalls and uncompensated care for not-for-profit hospitals in expansion states varied by 10-fold when based on IRS data and by 2-fold when based on Centers for Medicare and Medicaid Services data.

Existing evidence suggests that underpayment reduces the adoption of new curative technologies

Possible spillovers from low public payments and the treatment protocols that often accompany state Medicaid programs should concern legislators because current research often focuses on the direct impact of Medicaid expansion while ignoring the fact that as a single dominant insurer, the Medicaid bureaucracy can use its power to act in its own interest. It may, for example, have an incentive to force suboptimal reimbursement and clinical care policies on suppliers in order to maximize program enrollment, harming both Medicaid patients, those who self-pay, and the privately insured.

Existing evidence suggests that underpayment reduces the adoption of new curative technologies. Freedman et al. (2015) found that in "geographic areas where more of the new Medicaid-insured have come from the privately insured population, Medicaid expansion slows NICU [neonatal intensive care

54 Charles Stoecker et al., "Association of Nonprofit Hospitals' Charitable Activities With Unreimbursed Medicaid Care After Medicaid Expansion," JAMA Network Open 3, no. 2 (February 26, 2020): e200012, https://doi.org/10.1001/jamanetworkopen.2020.0012.

55 Paula Chatterjee, Rachel M. Werner, and Karen E. Joynt Maddox, "Medicaid Expansion Alone Not Associated With Improved Finances, Staffing, Or Quality At Critical Access Hospitals: Study Examines Medicaid Expansion Impact on Finances, Staffing, and Quality at Critical Access Hospitals.," Health Affairs 40, no. 12 (December 1, 2021): 1846–55, https://doi.org/10.1377/hlthaff.2021.00643.

56 Michael Rosko, Mona Al-Amin, and Manouchehr Tavakoli, "Efficiency and Profitability in US Not-for-Profit Hospitals," International Journal of Health Economics and Management 20, no. 4 (December 2020): 359–79, https://doi.org/10.1007/s10754-020-09284-0.

unit] adoption."[57] Ho and Pakes (2014) found that health plans with capitated payments would send obstetric patients further to utilize similar quality but lower priced hospitals.[58] While increasing travel time may lower spending on hospitals by insurers, longer travel can inflict substantial additional costs on patients. In general, health care cost control studies generally overestimate savings by ignoring costs that may be shifted to patients.

Cost shifting to other patients. In Colorado, state officials desperate for revenues to fund higher than expected Medicaid costs imposed new fees on private patients, insurers and hospitals, thus raising costs for people who paid for their own medical care in order to cover Medicaid's ballooning costs. To reduce Medicaid payments, Colorado officials also promoted quality measures that pressured hospitals and physicians to change patient care in ways that benefited Medicaid but not patients.

A more subtle example of cost shifting occurred after FY 2011-12 budget documents identified expenditures for cesarean births as a major Medicaid "cost driver." Colorado's Medicaid bureaucracy was determined to reduce those payments. In 2015, the state's Quality Incentive Payment Program notified hospitals that they would have to reduce cesarean births to 15 percent of all births in order to garner payments associated with its quality targets.

At the time, the medical literature clearly showed that cesarean rates of up to 20 percent were correlated with lower maternal mortality. Cesarean rates of up to 24 percent were correlated with lower neonatal mortality.[59] When queried, state officials were unable to explain how the 15 percent rate had been chosen. In effect, Colorado Medicaid was seeking to moderate a "cost driver" by simply spending less on the Medicaid clients who were having babies despite the fact that their actions would likely result in poorer health outcomes for some pregnant women and their children.

As the Affordable Care Act increased private health insurance premiums in some Colorado mountain towns to the highest in the country, Affordable Care Act premiums became a hot political topic. In 2020, state officials passed legislation to fund a state backed reinsurance program designed to lower ACA premiums. The legislation required Colorado hospitals as a group to pay up to $40 million a year into a fund to do this.[60]

As Medicaid and Medicare reimbursements are fixed and hospitals do not print money in their basements, that $40 million would have to have come either from higher payments by the privately insured or from lower hospital spending on patient care. Because hospitals rely on state licenses for their existence, they are vulnerable to political pressure. Colorado hospitals paid up and Colorado,

57 Seth Freedman, Haizhen Lin, and Kosali Simon, "Public Health Insurance Expansions and Hospital Technology Adoption," Journal of Public Economics 121 (January 2015): 117–31, https://doi.org/10.1016/j.jpubeco.2014.10.005.

58 Kate Ho and Ariel Pakes, "Hospital Choices, Hospital Prices, and Financial Incentives to Physicians," American Economic Review 104, no. 12 (December 1, 2014): 3841–84, https://doi.org/10.1257/aer.104.12.3841.the distance traveled, and plan- and severity-specific hospital fixed effects (capturing hospital quality

59 Linda Gorman. April 2016. The Hospital Provider Fee Fund. Independence Institute. https://i2i.org/wp-content/uploads/2015/01/IP-2-2016_c.pdf, p. 21

60 Linda Gorman. April 2020. Evaluating Health Care Reform Proposals: A Primer. Independence Institute. https://i2i.org/evaluating-health-care-reform-proposals-a-primer/ p. 8.

which had one of the most competitive hospital markets in the country in the mid-2000s, now has problems with staffing shortages and insufficient hospital capacity.

Rationing. When hospital capacity was insufficient to cope with Medicaid expansions, Colorado Medicaid officials chose to turn a blind eye to the hidden, and illegal, Medicaid waiting lists used by Denver's primary Medicaid provider to ration care.[61]

For some years, Denver Health, a hospital based health plan that was the main Medicaid provider in Denver, Colorado, maintained hidden appointment waiting lists that illegal discriminated between patients. Though the state knew that this was happening, Colorado Medicaid continued to automatically enroll Medicaid eligible people in the Denver Health program.

The problem was that Denver Health was an HMO in which people could not get care unless they could get an appointment. Without an appointment, they had plenty of coverage but no care. During this time, Denver Health scored 84 percent on Colorado Medicaid's "Compliance Monitoring Tool." The Tool rated Medicaid contractors in 54 categories. Roughly 10 percent of those categories measured access to timely, effective, curative care. The other 90 percent focused on mastery of cultural sensitivity training, having documents available in the proper variety of languages, and level of adherence to procedural paper shuffling.

The illegal denial of care to Medicaid clients who needed it stopped only after Dr. P. J. Parmar, a private clinician in Aurora, a city adjacent to Denver, began investigating. He had Medicaid patients who could no longer get medical care because they were automatically transferred to Denver Health Medicaid when they moved from Aurora, Colorado, to Denver, Colorado.

Though many of them still came to him and paid his reasonable fees in order to see him, he could not help them obtain the drugs or specialist care they needed. The Denver Health Medicaid plan would only honor prescriptions from a Denver Health physician, and no appointments were available for Denver Health physicians. The waiting list for appointments was also a waiting list for lifesaving drugs and advanced medical therapies. After Dr. Parmar created a public uproar, Colorado Medicaid officials quietly eased the program rules that forced people into the Denver Health Medicaid program.

There is strong evidence that rationing occurs when reimbursements are below cost.

In general, there is strong evidence that rationing occurs when reimbursements are below cost. To stay in business, providers adjust the supply of medical care to reimbursements, the prices dictated by generally dictated by fiat in government plans in the US and other countries. When reimbursements are below market clearing prices, providers ration care by scheduling shorter appointments, requiring

61 For some years Denver Health, the main Medicaid provider in Denver, Colorado, maintained illegal Medicaid appointment waiting lists. Colorado Medicaid continued passively enrolling people in the Denver Health program. The problem was that Denver Health was an HMO in which people could not get care unless they could get an appointment. Despite this, Denver Health scored 84 percent on Colorado Medicaid's "Compliance Monitoring Tool." Linda Gorman. October 20, 2014. "Waiting lists at Denver Health deny Medicaid patients health care access," Greeley Tribune, https://www.greeleytribune.com/2014/10/20/gorman-waiting-lists-at-denver-health-deny-medicaid-patients-health-care-access/, accessed February 6, 2023.

more appointments for the same care, requiring care pathways of dubious value, reducing access to sophisticated treatments, substituting less skilled labor, and maintaining waiting lists.

Examples abound. In Germany, physicians provide more timely access to people with higher paying private coverage. The publicly insured wait twice as long.[62] In the US, Medicaid eligibility expansions have been shown to slow hospital technology adoption.[63] When expensive but undoubtedly effective hepatitis C treatments were introduced, state Medicaid programs were slower than private insurers to allow reasonable access to treatment.[64] In Canada, where it is illegal for physicians to provide many services outside of the reimbursement systems run by the provincial health plans, the Fraser Institute estimates that patient wait times from referral by a general practitioner to consultation with a specialist average 20 to 65 weeks.[65] In England, where the government controls all aspects of medical provision in the public sector, 7 million people are waiting for hospital treatment,[66] and waiting times can be more than 12 hours in emergency departments. Working conditions for health care providers are so poor that

62 Anna Werbeck, Ansgar Wübker, and Nicolas Ziebarth, "Cream Skimming by Health Care Providers and Inequality in Health Care Access: Evidence from a Randomized Field Experiment" (Cambridge, MA: National Bureau of Economic Research, May 2021), https://doi.org/10.3386/w28809.MA","language":"en","note":"DOI: 10.3386/w28809","number":"w28809","page":"w28809","publisher":"National Bureau of Economic Research","publisher-place":"Cambridge, MA","source":"DOI.org (Crossref https://www.nber.org/system/files/working_papers/w28809/w28809.pdf

63 Seth Freedman, Haizhen Lin, and Kosali Simon, "Public Health Insurance Expansions and Hospital Technology Adoption," Journal of Public Economics 121 (January 2015): 117–31, https://doi.org/10.1016/j.jpubeco.2014.10.005.

64 Joshua M. Liao and Michael A. Fischer, "Restrictions of Hepatitis C Treatment for Substance-Using Medicaid Patients: Cost Versus Ethics," American Journal of Public Health 107, no. 6 (June 2017): 893–99, https://doi.org/10.2105/AJPH.2017.303748a public health problem for which effective but very expensive treatments are now available. Facing constrained budgets, most states adopted prior authorization criteria for sofosbuvir, the first of these agents. Using fee-for-service utilization data from 42 Medicaid programs in 2014, we found that strict behavioral criteria-those that limited coverage on the basis of drug or alcohol use and included specific abstinence or treatment requirements-were associated with significantly less spending on sofosbuvir. Despite the potential cost savings, such criteria raise troubling questions in terms of public health as well as medical ethics, clinical evidence, and potentially federal law. Decision-makers should reject these requirements in Medicaid coverage policy and pursue national and state policy strategies to balance short-term budgetary realities with long-term public health benefits.","container-title":"American Journal of Public Health","DOI":"10.2105/AJPH.2017.303748","ISSN":"1541-0048","issue":"6","journalAbbreviation":"Am J Public Health","language":"eng","note":"PMID: 28426313\nPMCID: PMC5425868","page":"893-899","source":"PubMed","title":"Restrictions of Hepatitis C Treatment for Substance-Using Medicaid Patients: Cost Versus Ethics","title-short":"Restrictions of Hepatitis C Treatment for Substance-Using Medicaid Patients","volume":"107","author":[{"family":"Liao","given":"Joshua M."},{"family":"Fischer","given":"Michael A."}],"issued":{"date-parts":[["2017",6]]}}],"schema":"https://github.com/citation-style-language/schema/raw/master/csl-citation.json"} ;

65 Mackenzie Moir and Bacchus Barua, 2022. Waiting Your Turn: Wait Times for Health Care in Canada, 2022 Report.Fraser Institute, Vancouver, British Columbia. https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2022?utm_source=Media-Releases&utm_campaign=Waiting-Your-Turn-2022&utm_medium=Media&utm_content=Learn_More&utm_term=700

66 Nick Triggle, October 13, 2022. "Fewer ops being done as NHS waiting list hits seven million." BBC News, https://www.bbc.com/news/health-63219147.

ambulance workers, nurses, and doctors have all voted to strike.[67]

International comparisons show that sustained rationing often accompanies expanded government control of health care. Before the ACA, rationing primarily affected US patients reliant on the Veterans Administration Health System, some groups in the much more limited state Medicaid systems, and certain HMO plans. By extending the reach of Medicaid, and its below market reimbursement, the ACA Medicaid expansions may extend medical rationing to a much larger part of the US population.[68]

International comparisons show that sustained rationing often accompanies expanded government control of health care.

The reason is that governments typically reimburse at less than market clearing prices and add rules that increase provider and patient costs. As government begins to control a majority of payments for medical treatments, reimbursements below market clearing prices will systematically reduce care quality, increasing both morbidity and mortality.

Claims that more Medicaid funding increases jobs or income are poorly supported

When government takes additional resources from the private sector, overall welfare improves only in exceptional cases. Medical care is not one of them. Private sector production rewards oversight with increased profits. Competition prevents excessive profit and keeps producers honest. Penalties for waste, fraud, abuse, and producing something no customer wants are absent in government run systems. And no penalty is assessed for deforming government run production systems to meet political goals.

At present, expanded Medicaid is a uniquely wasteful and ineffective program. The limited academic literature on the subject provides exceptionally weak evidence for overall employment gains from better health, or for gains from federal Medicaid inflows. One estimate of the combined economic effects of Medicaid and Medicare expansion by Dupor and Guerrero (2018) suggests that any additional jobs created by expanding Medicare could require taking as much as $448,000 from the private sector to create one job for one year.[69]

In response to the attempts to reopen the debate on Colorado's Medicaid expansion, the Colorado Health Foundation, which spends income from its over $2 billion endowment funding efforts to expand government control of Colorado health care, produced a 2016 modeling study claiming that Medicaid expansion had created 31,074 new jobs and raised annual household earnings by $643 a year.[70]

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67 Jasmine Cameron-Chileshe and William Wallis, February 20, 2023. "Junior doctors in England vote to strike as NHS pay dispute escalates." Financial Times, https://www.ft.com/content/832544eb-5318-4ed9-9229-8cd871b613e8.

68 For a more extensive discussion of international health rationing see Linda Gorman, Evaluating Health Care Reform Proposals: A Primer (2020), Independence Institute, Denver, Colorado. IP-1-2020_f.pdf (i2i.org)

69 Dupor, Bill, and Rodrigo Guerrero. "The Aggregate and Relative Economic Effects of Medicaid and Medicare Expansions." In Proceedings. Annual Conference on Taxation and Minutes of the Annual Meeting of the National Tax Association, vol. 111, pp. 1-51. National Tax Association, 2018.

70 Colorado Health Foundation. June 2, 2016. Analysis Reveals Medicaid Expansion Sparks Economic Activity in Colorado. Press release. https://coloradohealth.org/news/analysis-reveals-medicaid-expansion-sparks-economic-activity-colorado, accessed February 6, 2023..

In 2016, the Bureau of Labor Statistics estimated that almost 2.8 million people were employed in Colorado. In any month, 75,000 to 100,000 people were estimated to have been unemployed. An estimate of an additional 31,000 new jobs is close to a rounding error, and in fact, the Bureau of Labor Statistics would have treated any Colorado job increase of less than 25,000 as a statistically insignificant change. And while no one would turn down an extra $643 a year, it probably didn't materialize. The error associated with Census Bureau estimates of Colorado's $58,823 average household income during that year was ±$808.

Conclusion

State officials considering Medicaid expansion need to consider whether spending public money on basically healthy people who simply report lower incomes is a reasonable use of state funds. The evidence that Medicaid expansion improves health is lacking. Those who make coverage for all a major policy goal are remiss if they fail to consider that coverage make little difference if the entity offering coverage does a poor job of providing the medical care that people need.

States that have expanded Medicaid face much higher than predicted enrollment and costs. Recent actions of the federal government have made it clear that it may interfere with states' ability to monitor Medicaid expansion for fraud and remove ineligible people from the Medicaid rolls. Medical standards come under attack as state bureaucracies seek to reduce access to advanced care to reduce spending, medical care shortages develop as private payment is replaced with below cost Medicaid reimbursement, and wasteful spending on health care increases because Medicaid provides few incentives to use medical care wisely.

Because Medicaid expansion is so expensive, it crowds out state spending for roads, education, and policing. It may also use up the reserves that state will need as the illegal immigrants flowing into the US begin arriving at US hospitals. Federal law requires that they receive care regardless of the cost, and the cost threatens to bankrupt the doctors and hospitals that must provide their care. Some of those costs will be paid by state under the emergency Medicaid category. That category is not eligible for the enhanced federal match that is being used to bribe states into Affordable Care Act Medicaid expansions today without thinking about the problems it will create tomorrow.

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