EXPANDING MEDICAID WOULD HAVE UNINTENDED NEGATIVE CONSEQUENCES

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OVERVIEW

Though advertised as a $3.5 trillion package, the fiscal year 2022 budget reconciliation bill may have a true cost more than 50% higher than that—$5.5 trillion—according to analysis from the Committee for a Responsible Federal Budget.[1] Among other proposals that together seek to significantly expand the federal government's role in healthcare, the bill proposes a new federal Medicaid program beginning in 2025 in states that have not expanded Medicaid.[2] The program would be fully federally funded and operated by the Department of Health and Human Services through contracts with third-party entities (such as Medicaid managed care organizations) to provide health benefits.[3]

Medicaid was created in 1965 as a state and federal partnership to provide health coverage for those most in need, primarily low-income children, families, and pregnant women, as well as those with disabilities.[4] The Affordable Care Act (ACA) extended nationwide Medicaid eligibility to low-income adults, but in 2012 the Supreme Court in *NFIB v. Sebelius* made this expansion optional for states.[5] Currently, 38 states have expanded Medicaid, and 12 states have not expanded Medicaid, in many cases citing a desire to avoid the budgetary pressures that can accompany expansion.[6] Research shows that states that expanded Medicaid enrolled twice as many able-bodied adults as estimated, with per-person costs exceeding original estimates by 76 percent, leading to a combined cost overrun of 157 percent.[7] Low-income individuals in non-expansion states who make too much to qualify for Medicaid, but too little to qualify for ACA subsidies, are considered to fall in the Medicaid coverage gap. This number is estimated to be about 2.2 million adults.[8] Despite the coverage gap, these individuals have access to care through 3,000 federally funded health centers in non-expansion states and to free or low-cost care at public and non-profit hospitals.[9]

A NEW FEDERAL PROGRAM

High-level Points:

- Budget reconciliation bills have time limits on debate, require only a simple majority to pass, and have limits around creating new government programs. Thus, this is not the right vehicle to create new entitlements, particularly in the form of Medicaid

[1] https://www.crfb.org/blogs/true-cost-budget-plan-could-exceed-5-trillion
[2] https://docs.house.gov/meetings/IF/IF00/20210913/114039/HMKP-117-IF00-20210913-SD002.pdf
[3] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Subtitle%20G_Medicaid.pdf
[4] https://www.cms.gov/About-CMS/Agency-Information/History
[5] https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf
[6] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
[7] https://thefga.org/paper/budget-crisis-three-parts-obamacare-bankrupting-taxpayers/
[8] https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/
[9] https://www.heritage.org/health-care-reform/commentary/what-you-should-know-about-the-uninsured

expansion. Research has shown that Medicaid expansion had higher enrollment and costs than projected, impacting state budgets without clear benefit on population health outcomes.

➢ Targeted solutions for vulnerable populations represent better policy than a broad Medicaid expansion that subjects states to increased federal government control. An inefficient one-size-fits-all program is not the right solution. Medicaid crowds out private coverage dollars, forces providers to shift costs to private patients, and often results in individuals waiting for treatments.

➢ This presents an opportunity for states, business leaders, and healthcare providers to find innovative solutions for access to care for those who fall in the coverage gap. This work should also drive improved affordability of care to improve health.

Supporting Research:

- An April 2020 review of the evidence found that, after 2013, when the ACA was implemented, mortality trends worsened in expansion states compared to non-expansion states for three consecutive years, indicating that expansion may have a negative population health effect. Other cited studies in the review found either mild positive health effects or minimal health effects. Overall, the analysis found that the health effects of Medicaid expansion are highly uncertain—from negative to mildly positive at best—and concluded that targeted programs are better public investments than massive Medicaid expansion.[10]

- Federal law already permits states to apply for waivers (Section 1115) that allow them to develop innovative policy proposals to address the unique needs of their state populations. There are currently 62 approved waivers across 45 states.[11] For example, non-expansion states such as Texas, Florida, Georgia, and Tennessee used these waivers to implement pilot programs through their existing Medicaid programs.

- The new Federal Medicaid program will pay 100% of the costs of the new expansion population—who are likely to be healthier on average than current Medicaid recipients—which creates the incentive for states to maximize enrollment. The unfair prioritization of new and likely relatively healthy Medicaid beneficiaries may actually make it more difficult for the disabled, pregnant women, and children from low-income families to access the already limited Medicaid services in states.

- Medicaid coverage does not automatically equal better care or better health.
    - In 2008, Oregon utilized a lottery to expand Medicaid to some able-bodied uninsured adults with income below 100 percent the federal poverty level (FPL), allowing researchers to assess the causal impact of gaining Medicaid with a control

[10] https://files.texaspolicy.com/uploads/2020/04/20142441/Blase-Balat-Medicaid-Expansion.pdf
[11] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

group for a population health study.[12] New Medicaid recipients increased the amount of health care they received, as measured by hospital admissions, outpatient visits, emergency department utilization, and medication use. Gaining Medicaid coverage did not produce significant health improvements in the Oregon experiment. On the three physical health measures assessed—blood pressure, cholesterol, and glycated hemoglobin levels (the measure of diabetes control)—people who gained Medicaid did not show a meaningful improvement. The results of this randomized, controlled study may indicate that more targeted programs, rather than coverage alone, are needed to improve health in low-income adults. Importantly, as a testament to the low-perceived value of Medicaid, 40 percent of people who won the lottery did not end up enrolling.

  - Further, follow-up studies from the Oregon experiment found that individuals who gained coverage valued it at a level significantly less than it was worth: $0.20 to $0.40 of welfare benefit to recipients per dollar of government spending.[13]
  - This specific finding of low enrollment is consistent with the approximately 5.1 million Americans eligible for Medicaid or the Children's Health Insurance Program (CHIP) who remained uninsured in 2019.[14]
  - An economic analysis of the impact of the ACA on California's hospital sector found the expansion of health insurance (predominantly through Medicaid expansion) increased utilization of hospital and emergency room services but did not significantly improve patient health status when considering the primary metric of in-hospital mortality.[15]

- Medicaid coverage also does not equate to better access to care. Two helpful indicators of access to care are wait times and primary care needs met.[16] In January 2017, Merritt Hawkins performed a national survey of these measures.[17] New York and Texas figured prominently. At the time, Texas had an uninsured rate of 17 percent and New York had the lowest uninsured rate in the country at 5.4 percent. New York also had the highest enrollment in Medicaid or CHIP at 32 percent. Texas had the lowest Medicaid/CHIP enrollment of just 16 percent, half of New York's rate. New York City, representing the state with the lowest uninsured rate, had wait times of 22 days to 28 days, while Dallas, Texas, had the shortest wait time in the entire nation, 16.5 days. New York, with its low uninsured rate and high Medicaid enrollment, satisfied the primary care needs of its population 45 percent of the time. The state with the highest uninsured rate and the lowest Medicaid enrollment, Texas, did the best: Texas doctors met the primary care needs of Texans 71 percent of the time. These indicators suggest that Medicaid coverage alone does not mean access to care.

[12] https://www.nejm.org/doi/full/10.1056/NEJMsa1212321
[13] https://www.nber.org/system/files/working_papers/w21308/w21308.pdf
[14] https://www.cbo.gov/system/files/2020-09/56504-Health-Insurance.pdf
[15] https://www.nber.org/system/files/working_papers/w25488/w25488.pdf
[16] https://www.texaspolicy.com/waldman-texas-gets-bad-rap-on-uninsured/
[17] https://www.merritthawkins.com/news-and-insights/thought-leadership/survey/survey-of-physician-appointment-wait-times/

- Prior research demonstrated a work disincentive from public health insurance eligibility.[18] Due to significant budget deficits, Tennessee had to disenroll 170,000 individuals in 2005 after a 1994 Medicaid expansion which had included able-bodied adults in the newly eligible population. Of those disenrolled, 91% were childless adults. When studying the effects of disenrollment, a 2013 NBER analysis found "an immediate increase in job search behavior and a steady rise in both employment and health insurance coverage," indicating a relationship between expanded Medicaid eligibility and the labor market. This evidence suggests that federal Medicaid expansion would likely further impede economic recovery job growth.

- Prior research found that nearly 54 percent of potential Medicaid expansion enrollees already had private insurance, indicating that a new federal program could shift millions of Americans from private coverage into taxpayer-funded health coverage.[19]

- The current Medicaid program has been consuming a larger share of state budgets and thus competes with funding for education, infrastructure, workforce development, and tax cuts. In fiscal year 2017, states spent 17.1 cents of every state-generated dollar on providing Medicaid coverage, which is a 4.9 percentage point increase from 2000.[20] In fiscal year 2016, the Medicaid and CHIP Payment and Access Commission found that states spent 15.9% of their budget (absent federal dollars) on Medicaid, compared to 24.5% on elementary and secondary education and 13.7% on higher education.[21] When federal spending is included, Medicaid is the largest budget item for states. Because statutory requirements on Medicaid coverage limit the flexibility of state policymakers, the increase in Medicaid as a share of the state budget means less funds are available for other priority areas like public education, workforce development, public safety, housing, transportation, tax cuts, and more. The state experience with increased Medicaid spending and its crowd-out effect on other budget priorities should inform the considerations for a new federal program.

[18] https://www.nber.org/system/files/working_papers/w19220/w19220.pdf
[19] https://thefga.org/wp-content/uploads/2019/04/MedEx-Crowd-Out-Paper-DRAFT7.pdf
[20] https://www.pewtrusts.org/en/research-and-analysis/articles/2020/01/09/states-collectively-spend-17-percent-of-their-revenue-on-medicaid
[21] https://www.macpac.gov/subtopic/medicaids-share-of-state budgets/#:~:text=Medicaid%20accounted%20for%2019.6%20percent,state%20taxes%20(Figure%202)