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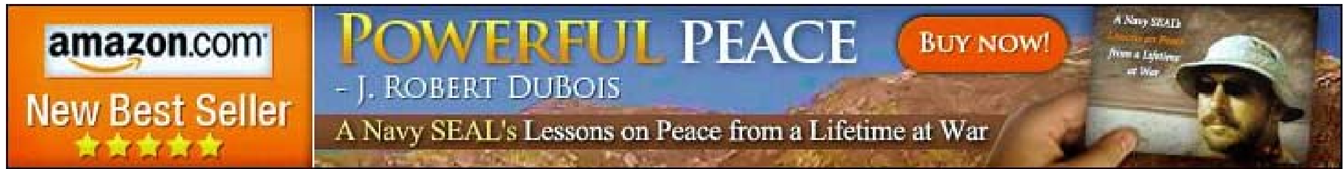

When States Opt Out of Expanding Medicaid, People Get Shafted

By Martin Gaynor

Whether for fiscal or ideological reasons, some states are pledging not to participate in Washington's Medicaid expansion plan. If they follow through, that would leave millions of Americans uninsured.

Dr. Russ Webb (standing, R), a volunteer oral and maxillofacial surgeon, helps a patient during a free medical clinic in Oakland, California, which attracted thousands of attendees, often without insurance. (Stephen Lam/Reuters)

If the Supreme Court had not upheld the individual mandate in its recent decision, it's unlikely that the insurance exchanges, in which 22 million people are expected to obtain coverage, would have worked well, if at all. Insurance works by having everyone, healthy and sick, in it together. Everyone pays in, and those who need care draw on the fund. Since everyone needs health care at some point,

everyone uses insurance eventually, but not all at once. This benefits everyone. You don't have to be a health-care economist to see this.

So the decision is hugely important for the United States. But even if we now have clarity on the individual mandate, the decision raises a major question about what happens with Medicaid expansions, which would cover about 17 million people.

The court's decision--that the Federal government can't penalize states for failing to comply with the ACA's Medicaid expansions by revoking their current levels of Medicaid funding--raises doubts about whether all states will choose to participate in the Medicaid expansions. Even though the Federal government will pay for 90 percent of the expense of Medicaid expansions--and 100 percent initially--some states may face such difficult fiscal problems that they might choose not to participate. Or for ideological reasons: so far the governor of Florida, Rick Scott, has said that his state will opt out. Politicians in a number of other states, too, have already declared their resistance to the ACA Medicaid expansions.

This raises two issues. If states do refuse the Medicaid expansion, what happens to the people who would have been covered under it? Second, what implications will opting out have for the Federal budget? In states that participate, everyone with incomes between the state's current Medicaid eligibility cutoff (for example, 26 percent of the Federal poverty line in Texas, which is less than $4,000 for an individual) and 133 percent of the poverty line (less than $15,000) will be covered by Medicaid. It's estimated that this would extend coverage to 1.4 million people in Texas.

If a state opts out, none of these people will be eligible for Medicaid. The rules of the ACA insurance exchanges say that only people with incomes between 100 and 400 percent of the Federal poverty line will be eligible for the substantial premium subsidies the Federal government will give people who enroll.

That leaves out the poorest people. Those who aren't currently eligible for Medicaid and whose incomes are below 100 percent of the poverty line are technically eligible to enroll in the exchanges--but, because they are ineligible for premium subsidies, they will effectively be excluded. If Texas refuses to participate, everyone in the state with incomes between 26 and 100 percent of the poverty line with be in this situation, and will almost certainly remain uninsured. This would be a substantial number of the 1.4 million people eligible for the Medicaid expansion in Texas--and certainly many more, if a number of states refuse to participate. These people will remain uninsured, and will continue to have to face the specter of choosing between their health or financial ruin, let alone basic necessities, in addition to ending up in high cost emergency rooms at taxpayer expense.

There are a number of different cost impacts if states choose not to participate. The Federal government will pay premium subsidies for those people eligible to get them in the exchanges--adding to the costs of the ACA. On the other hand, the Federal government will save money it would have spent funding the Medicaid expansions in states that decline to participate. States that choose not to participate will have to continue to bear the costs of their uninsured populations through uncompensated care, including expensive visits to the emergency room. Economists are at this very moment generating new estimates of the cost of the ACA, taking these factors into account.

This ties in to what, in my view, is the key outstanding question about the ACA: cost. The ACA is

estimated to provide over 30 million people with the benefits of health insurance, and that's a good thing. However, this is going to be expensive, no matter how many states opt out of Medicaid expansion--and, unless Republicans do have the power to overturn the law in the future, all signs point to the great majority of states' accepting it. Unfortunately, Federal spending on health care is already a problem. Total US government spending on health care has risen 2.5 times as fast as national income over the past 30 years. In other words, the government's health care spending is rising much faster than our ability to pay for it. That means that additional spending on health care is limiting our ability to pursue other important goals, such as repairing and replacing our infrastructure, investing in our children, and enhancing national security. It's imperative that we rein this in.

The ACA recognizes that providing coverage to over 30 million new people is very costly, and so contains many different provisions aimed at health care costs. The honest truth, though, is that cost control is really hard and we don't really know how to do it.

Some of the provisions seem likely to have salubrious effects, while many others are more speculative. One is called the "Cadillac tax," which imposes a 40 percent tax on health insurance premiums over $27,500 for families and $10,200 for individuals. These premiums are paid by employers, which put money they might otherwise pay in wages, which are taxed, into expensive health plans, which are now tax-exempt. Because the new Cadillac tax is indexed to general inflation (as opposed to health care cost inflation), as health care costs grow over time, more and more of employer-paid premiums will be taxed, generating billions of dollars in tax revenue. That should do good things for cost control by reducing the excessive generosity of health insurance plans subsidized via the tax system. Less costly premiums will lead to higher take-home pay for workers. In addition, the new tax revenues will make it possible to lower income tax rates and to invest in our roads, airports, military, and schools. Separately, the introduction of health insurance exchanges will hopefully enhance competition among health insurers and thereby drive down costs.

It's harder to tell how effective most of the other features intended to address costs will be. The single largest part of the estimated cost savings come from reducing Medicare provider payments by $219 billion. Whether these cost savings will be realized is a political question. Medicare is an important payer, so doctors, hospitals, and other providers will undoubtedly engage in intense lobbying to undo these cuts. Congress hasn't shown itself terribly resolute in the past in the face of such pressure, so some pessimism may be warranted.

Others components, such as bundled payments, information technology, and accountable care organizations (ACOs), have some evidence base, but that evidence isn't terribly supportive of the idea that they will save significant amounts. Bundled payments give providers a single payment for an episode of care; they are supposed to improve coordination and reduce costs. The evidence on their success is lukewarm at best. While the use of information technology has a great deal of promise, research has not as of yet revealed evidence of a systematic impact on costs or quality of care.

ACOs are consolidated provider organizations. They are intended to better coordinate patient care, and thereby improve quality and reduce costs. However, evidence on the impacts of integrated provider organizations from the 1990s (physician-hospital organizations) shows no gains in quality or reduction in costs. In fact, ACOs could make things *worse*, by leading to consolidation that reduces competition. Reduced competition has been shown to harm quality for both Medicare and private

patients and increase prices for privately insured patients.

So the cost control features of the ACA are unlikely to make the coverage expansions costless. But they do represent a start. This is the next key health policy challenge, and it's going not going to be easy. Some of the ACA measures will work and some won't. The key thing is setting up a system that allows for innovation and gives all participants--individuals, providers, payers, employers--the right incentives. All of us are going to have to face hard choices. This may be unpleasant and painful. The alternative is even worse.

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