

# THE ECONOMICS OF MEDICAID

Assessing the Costs and  
Consequences

EDITED BY JASON J. FICHTNER



**MERCATUS CENTER**  
George Mason University

An earlier version of chapter 3 was published by Jason J. Fichtner and John Pulito as “Medicaid Overview” (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, December 11, 2013), available online at <http://mercatus.org/publication/medicaid-overview>.

Copyright © 2014 by the Mercatus Center at George Mason University

Mercatus Center at George Mason University  
3434 Washington Boulevard, 4th Floor  
Arlington, VA 22201

Library of Congress Cataloging-in-Publication Data

The economics of Medicaid : assessing the costs and consequences / edited by Jason J. Fichtner.

p. ; cm.

Includes index.

ISBN 978-0-9892193-6-5 (paperback) -- ISBN 978-0-9892193-7-2 (kindle)

I. Fichtner, Jason J., editor of compilation. II. Mercatus Center, issuing body.

[DNLM: 1. United States. Patient Protection and Affordable Care Act. 2. Medicaid--economics. 3. Health Care Reform--economics--United States. 4. Health Policy--economics--United States. W 250 AA1]

RA412.4

368.4'200973--dc23

2014003886

Printed in USA

## CHAPTER 9: MEDICAID AND HEALTH

ROBERT F. GRABOYES

**T**he expansion of Medicaid is a central component of the Patient Protection and Affordable Care Act (ACA).<sup>1</sup> The law sought to increase the nation's health insurance rolls by approximately 30 million (out of roughly 50 million uninsured). About half of the newly enrolled would themselves be covered not by private insurance, but rather by Medicaid—the country's insurance program for the poor.<sup>2</sup>

The disastrous rollout of [healthcare.gov](http://healthcare.gov) has thrown the ACA's survival into doubt. The entire ACA depends on a vast array of data flows and, in early 2014, it is unclear when or whether the public website will become fully functional. Arguably, regardless of whether the website becomes fully functional, even worse problems await the law.<sup>3</sup> Before anyone imagined the problems with [healthcare.gov](http://healthcare.gov), there were warnings that the ACA's biggest obstacles would lie in the perpetual need to meld disparate data on every American from an enormous array of public and private databases that have great difficulty interfacing.<sup>4</sup> At the same time, the Supreme Court's 2012 ruling on the ACA<sup>5</sup> greatly weakened the incentives for states to agree to the law's Medicaid expansion, precipitating heated debate in many states over how to proceed.

Given these uncertainties, it is an appropriate time to evaluate the efficacy of Medicaid as an institution capable of improving or maintaining its recipients' health. This chapter examines a growing body of evidence that Medicaid badly fails the enrollees it is designed to help. The program provides poor coverage, poor care, and poor outcomes. Therefore, Medicaid falls into the same category as inner-city public schools and government-run housing projects—hugely expensive social engineering initiatives that often fail their recipients.

An eloquent criticism of the program came in 2009 from Senator Ron Wyden (D-OR), who referred to Medicaid as a “caste system” that limits the ability of the poor to access the providers and care they desire. “I want poor people in this country to have the kind of quality of care and dignity that members of Congress have,” he said.<sup>6</sup> On that note, it is worth reviewing some of the key points made by the other authors in this volume.

Joe Antos noted Medicaid's sheer size (\$465 billion per year) and rapid growth rate (7 percent per year during 2000–12, versus 4.2 percent gross domestic product growth). Antos also explored the conflicting incentives that allow states to draw funds from other states, but only if they are willing to simultaneously raise their own residents' taxes. Jason Fichtner notes that with 57 million enrollees, Medicaid is the nation's largest health insurer. He, too, describes the tension between the states' beggar-thy-neighbor and beggar-thyself incentives. Nina Owcharenko describes the massive fiscal impact that Medicaid has on the states. Charles Blahous notes the financial risk to state budgets posed by the so-called “woodwork” effect—previously eligible enrollees drawn in by publicity surrounding the expansion. June O'Neill noted that Medicaid has effectively become a long-term care program. James Capretta describes the waiver option that some states have used to improve on the general Medicaid model (e.g., Indiana, Rhode Island, Massachusetts). Darcy Nikol Bryan describes physician–patient interactions in the Medicaid environment.

Thomas Miller's chapter is perhaps the closest in spirit to the present chapter. He examines some of the evidence that Medicaid provides

poor coverage, care, and outcomes and warns that Medicaid critics who favor market approaches frequently slide toward complacency and all-too-easy dismissal of Medicaid altogether. He suggests that market advocates need to focus on the quality of care and not just on the fiscal aspects of Medicaid. And he stresses the need for Medicaid's critics to make the case that a more affordable system will more effectively address the health care needs of low-income Americans. He notes that some ideas popular among market advocates (e.g., defined-contribution plans, vouchers, Medicaid managed care) are not panaceas, especially given the particular qualities of Medicaid enrollees. This chapter will build on these authors' insights, and especially on Miller's.

## BACK TO BASICS

Medicaid is a means to an end, and the end is (or ought to be) health for lower-income Americans. Health, of course, is not the same as health care or health insurance or access to health insurance, though the distinctions are often forgotten in public policy debates. By and large, the subject of this book thus far has been the means—the institution of Medicaid and its impacts on America's finances. That is an important and appropriate topic, given that Medicaid is vast, deeply imbedded in our economy, a cornerstone of the social safety net, and unlikely to go away anytime in the near future. This final chapter focuses more on the end (health) than on the means (the particulars of Medicaid), and ultimately ponders whether the program ought to be replaced by some other form of low-income assistance.

A Mercatus publication I authored in 2013 stated the following: “An ideal health care system will provide better health to more people at lower cost on a continuous basis.”<sup>7</sup> By this standard, Medicaid is an abject failure. For lower-income Americans, Medicaid yields poor coverage, poor care, and poor medical outcomes. While promising coverage far beyond the program's original scope, it fails to enroll millions of people who are among its intended population and who are eligible for enrollment. The data suggest that Medicaid does

surprisingly little to improve its recipients' health and in some ways may even harm them indirectly. It is a pennywise-and-pound-foolish program that, paradoxically, sends costs soaring by underpaying providers. And the coverage, care, and cost elements show little or no improvement over time.<sup>8</sup>

Medicaid is problematic both for its recipients and for the taxpayers who underwrite the program. This chapter will explore some of the specific examples of how Medicaid fails with regard to coverage, care, and outcomes for its recipients. It will briefly discuss how the ACA amplifies Medicaid's already considerable negatives, but paradoxically affords an opportunity to steer Medicaid in directions that better serve the health of those in lower-income strata, as well as the rest of the health care system.

## MEDICAID PROVIDES POOR COVERAGE

With Medicaid, health care coverage is incomplete and in some cases, tenuous. Because eligibility is based on income and number of people in the household, some people drift in and out of coverage as their incomes and family sizes undulate. And expansion of eligibility can lead to mass cancellations of coverage when the financial costs prove infeasible.

Medicaid currently has approximately 57 million enrollees.<sup>9</sup> But about 11 million individuals are eligible for Medicaid but are not enrolled.<sup>10</sup> The eligible-but-not-enrolled comprise about 16 percent of the Medicaid-eligible population and 25 percent of America's uninsured.<sup>11</sup> Coincidentally the uninsured portion of those eligible for Medicaid is similar to the uninsured portion of the American public in general (about 16 percent).<sup>12</sup> In a certain sense, the eligible-but-not-enrolled are *de facto* covered in that they can enroll retroactively, thereby covering expenses incurred while the potential enrollees are technically uninsured. Of course, the eligible-but-not-enrolled may behave differently with respect to care. It is more difficult to say whether that altered behavior harms or helps the unenrolled.

The ACA aims to expand Medicaid enrollment by roughly 15 million individuals.<sup>13</sup> But eligibility is based on the federal poverty level (FPL) and therefore depends both on income and on the number of people in a household. Changes in either variable can shift individuals or families into or out of eligibility. Given the volatility of income among lower-income Americans, this can lead to “churn”—drifting in and out of coverage as family circumstances change over time. In 2011, Sommers and Rosenbaum, both supporters of the ACA, estimated the amount of churn that would be experienced in a fully realized ACA expansion of Medicaid (up to 138 percent of FPL). They estimated that over a given year, 50 percent of adults below 200 percent of FPL (28 million individuals) would experience a shift from the exchanges into Medicaid or vice versa.<sup>14</sup> They further predicted that some would see two, three, or even four or more shifts in a given year and suggested that such churn would likely lead to discontinuities in care.<sup>15</sup> Sommers and Rosenbaum expressed concern that individuals experiencing such churn might tire of the shifts and stop maintaining coverage or seeking care.<sup>16</sup>

Rapid expansion of Medicaid, as envisioned under the ACA, also has the potential to touch off a cycle of expansion, financial overload, and mass cancellations of coverage. The best example of such a process is the TennCare disaster that began in 1994 in Tennessee. The state sought to convert Medicaid to managed care, assuming this would lead to enough savings (from efficiency gains) to cover children and the uninsured. In less than a decade, however, enrollment swelled far beyond what had been predicted, and the savings proved elusive. The expansion threatened the state government with bankruptcy and, by 2006, the program was forced to cancel coverage for approximately 200,000 Tennesseans.<sup>17</sup> A high-profile study of Oregon’s Medicaid expansion provides powerful new evidence that expansion increases rather than decreases the use of emergency services; putting it another way, one of the principal arguments in favor of expansion now appears illusory.<sup>18</sup>

In sum, Medicaid has a longstanding problem enrolling those who are eligible. The eligibility requirements can lead to instability in a household's coverage, and there is some susceptibility to large-scale cancellations of coverage.

## MEDICAID PROVIDES POOR CARE

Once one is enrolled in Medicaid, access to quality care becomes a serious challenge. Because of low reimbursement rates and other factors, many providers do not accept Medicaid patients; others may retain existing Medicaid patients but decline new ones. Excess demand by Medicaid enrollees requires rationing, which occurs in several ways, including discouragement by wait times and by political allocation of care. The end result is frequent and medically suboptimal use of emergency rooms outside of the desired Medicaid channels.

Medicaid represents a classic shortage market. Providers are compensated less by Medicaid than they would be in a free-market equilibrium. In fact, Medicaid generally pays among the lowest reimbursement rates of any health insurance program.<sup>19</sup> Providers are also discouraged from accepting Medicaid patients by long delays in receiving their reimbursement funds and by the fact that Medicaid patients require more provider time and resources on average than many other classes of patients.<sup>20</sup> As a result, providers often experience financial losses when treating a Medicaid patient. At the same time, Medicaid patients pay even less, or receive care at no out-of-pocket expense. As in any market, if consumer and producer prices are set below equilibrium levels, there will be excess demand and, hence, the need to ration allocation by nonmonetary methods. This problem will likely only become exacerbated with the expansion of Medicaid under the ACA.

During 2011–12, roughly one-third of physicians declined to accept new Medicaid patients.<sup>21</sup> The problem is not improving.<sup>22</sup> During 2003–08, Medicaid's reimbursement rates rose by less than the general rate of inflation—thus implying a real reduction in the already low compensation level (equal to 72 percent of that



of Medicare).<sup>23</sup> The ACA included temporary increases in Medicaid reimbursement rates, but the rollout of even those temporary increases has been problematic. The increase, planned for early 2013, has experienced delays.<sup>24</sup> The ACA's reimbursement increase, set to last two years, would increase reimbursement rates up to Medicare levels; but states have been slow to implement these rate increases, and the change remains in question.<sup>25</sup> The delays have resulted from slow rollout of federal regulations and slow responses by state authorities.<sup>26</sup> In California, where Medicaid enrollment is expected to rise from seven million to nine million, reimbursement rates are low and are being cut still further.<sup>27</sup> In 2012, the Texas Medical Association reported that only 31 percent of Texas physicians will accept new Medicaid patients, citing red-tape and administrative burdens as important causes.<sup>28</sup>

Medicaid recipients often face substantial wait times for care, and the nonmonetary cost of waiting discourages some from seeking care.<sup>29</sup> One result of these resource shortages is that Medicaid patients often seek routine and other care in emergency rooms rather than in far less expensive settings—such as doctors' offices. Emergency room visits increased in Massachusetts after the state's 2006 health care reform ("Romneycare"<sup>30</sup>) became law.<sup>31</sup> Many expect the situation to worsen nationally as the ACA expands the Medicaid rolls with no commensurate increase in provider resources.<sup>32,33</sup>

But rationing also occurs by political means. States limit the types of procedures and providers to be compensated. The Medicaid program in Oregon has perhaps the most sophisticated of these state allocation systems, and that state's experience with rationing provides some of the more vivid examples of the moral challenges of rationing of care via politics.

Up through 1985, reimbursement for transplants was determined on a case-by-case basis. Beginning in 1985, however, Congress required a more systematic process for approving and disapproving reimbursement. In a celebrated case in 1987, seven-year-old Coby Howard was diagnosed with a form of leukemia. The only available treatment was a \$100,000 bone marrow transplant, which was not

covered under the state's post-1985 plan. The child's plight became the subject of intense nationwide publicity and lobbying efforts to alter the plan's restrictions. While the child's death ultimately rendered the controversy moot, in the heat of the controversy there were legislative proposals to reverse the regulation. Ted Koppel, host of ABC's Nightline program, asked the following on-air: "Is the cost of modern medical technology forcing public officials to play God?"<sup>34</sup>

After the Coby Howard controversy, Oregon moved toward an overt rationing plan modeled somewhat on the procedures used by Britain's National Health Service. The state assembled panels of experts—doctors, consumer advocates, health care administrators, and medical ethics experts—to determine how the state's Medicaid program would limit its payouts.<sup>35</sup> The result was that 1,600 medical procedures were ranked by a measure of how much health would be provided by one dollar of expenditure; to put it in the vernacular, procedures were ranked by how much bang for the buck each provided.<sup>36</sup> Across this list, the state figuratively drew a line; the allegedly high-value procedures above the line would be covered, whereas those below would not. The line was drawn in such a way as to balance the cost of the above-the-line procedures with the state's global Medicaid budget.<sup>37</sup> The rationing system again made national headlines in 2008; Oregon Medicaid does not reimburse treatments such as chemotherapy if medical authorities determine that the procedure will have less than a 5 percent probability of success. In 2008, Oregon Medicaid declined to cover cancer treatments for 64-year-old Barbara Wagner but, instead, sent her a letter offering coverage of assisted suicide services.<sup>38</sup>

Aside from other moral questions, programs like Oregon's raise a serious question: Will ad hoc rationing (as during the Coby Howard episode) or algorithmic rationing (as in the later period) bias care and resources toward diseases that especially afflict the well connected and the telegenic?

In sum, as a market perpetually in a state of excess demand, Medicaid is forced to ration care. Whether intentionally or not, the

excess demand is reduced as wait times and other inconveniences increase. However, as the Oregon example shows, rationing can also be overt and political.

## MEDICAID PROVIDES POOR OUTCOMES

The beginning of this chapter stressed that Medicaid's goal ought to be health, rather than health insurance or health care. It is in this realm that the evidence against Medicaid is most powerful. Glenn Reynolds,<sup>39</sup> Avik Roy,<sup>40</sup> and Scott Gottlieb<sup>41</sup> provide excellent overviews of the program's dismal record in improving people's health. A Heritage Foundation study examined data related to the TennCare disaster described above. The study found that even after TennCare's explosive increase in costs, Tennessee's mortality rate did not improve vis-à-vis neighboring states.<sup>42</sup> A large and growing academic literature documents situations in which Medicaid recipients fare no better than or fare even worse than the uninsured. The following are some of the more prominent of these studies:

A 2008 Columbia–Cornell study showed that uninsured and Medicaid patients had a higher risk of certain serious cardiovascular conditions than people with other types of insurance; among those treated, the differences were mostly absent, suggesting that access to care was the key difference.<sup>43</sup> A 1999 University of Florida study indicated that, along with the uninsured, Medicaid recipients' cancers are diagnosed later than those of individuals with other forms of insurance.<sup>44</sup> A 2011 study in *Cancer* showed Medicaid patients' survival rates to be lower than those insured by other plans.<sup>45</sup> A 2010 University of Pittsburgh study found that "Patients with Medicaid/uninsured and Medicare disability were at increased risk of death after a diagnosis of [head and neck cancer] when compared with patients with private insurance, after adjustment for age, gender, race, smoking, alcohol use, site, socioeconomic status, treatment, and cancer stage."<sup>46</sup>

In 2010, the University of Virginia conducted a large-scale study that suggested that an individual without insurance has better health

outcomes than an individual on Medicaid.<sup>47</sup> Even after adjusting for risk factors, Medicaid patients had higher in-hospital mortality, longer hospital stays, and higher costs—compared with the uninsured, those on Medicare, and those on private insurance plans.<sup>48</sup> A University of Pennsylvania study examined data on patients receiving surgery for colorectal cancer; Medicaid patients had higher mortality and surgical complications than uninsured patients.<sup>49</sup> A 2011 Johns Hopkins study found that “Medicare and Medicaid patients have worse survival after [lung transplantation] compared with private insurance/self-paying patients.”<sup>50</sup>

Perhaps the most damning of all the recent studies is the Oregon Experiment.<sup>51</sup> This was a rare example of a large-scale, fully randomized experiment in health care. In 2008, Oregon expanded its Medicaid program. Approximately 90,000 people applied for 30,000 newly available slots, and the state used a lottery to choose who got in and who did not. Afterward, the state tracked the health of 6,387 adults who were chosen and 5,842 who were not. From a standpoint of physical health, the results were devastating: “This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.” Supporters of Medicaid point to positives that follow the word “but” in the preceding sentence.

None of this evidence suggests that Medicaid harms its enrollees’ overall health; in fact, there is a strong case to suggest that, other things being equal, it is better to be on Medicaid than to be uninsured. But the lack of improvement in physical health metrics strongly bolsters the case that whatever its merits, Medicaid is deeply substandard in providing its recipients with health.

## WHERE TO GO

The growing body of ambiguous evidence ought to raise questions about how America provides the poor with health care. One can strongly support the idea of a social safety net without assuming that the present-day incarnation of Medicaid is the only option. This final section offers some thoughts.

Several dozen states have rushed pell-mell into the ACA's Medicaid expansion, and many or most others at least feel some pressure to do likewise. The ACA leaves states in a difficult situation. The ACA offers the states two choices: Fully expand coverage to households with incomes up to 138 percent of FPL, or leave things as they are. Special pressure comes from one provision of the ACA. Subsidized insurance exchange policies are available only for those households with incomes above 100 percent of FPL. But in some states, Medicaid eligibility ends well below that 100 percent figure. In Virginia, for example, a couple with children is eligible for Medicaid as long as their income is at or below 31 percent of FPL. The ACA essentially offers Virginia two choices. Expand Medicaid all the way to 138 percent. Or leave those parents whose income lies between 31 percent and 100 percent of FPL without Medicaid and without private insurance subsidies. In other words, in order to cover the 31–100 percent group, the state effectively ends up denying the 100–138 percent group access to federal subsidies with which to purchase private insurance on the exchanges; practically speaking, that means denying them private insurance and moving them into Medicaid.<sup>52</sup>

Expansion advocates offer a moral argument for expansion—failure to do so would leave those in the 31–100 percent range without access to either Medicaid or to private insurance.<sup>53</sup> But there is an equally strong moral argument in the opposite direction. As we have seen, it is difficult to argue that distributing Medicaid cards among the 31–100 percent group will actually improve their health. On the other hand, expansion would mean that the 100–138 percent group would be shifted out of private insurance and shifted into Medicaid.

And the evidence is strong that doing so would be detrimental to their coverage, care, and health.

An added complication is the so-called “woodwork effect.” Under the ACA, the federal government is supposed to finance 100 percent of the expansion for three years. The federal share is then to taper off to 90 percent by 2020. However, this funding formula covers only those newly eligible for Medicaid. No doubt, the expansion will bring in some of the previously eligible-but-unenrolled, and they will not attract the federal funds allocated for the expansion; the states will have to pick up the tab for that portion of the expansion.<sup>54</sup>

In “The American Health Care System: Principles for Successful Reform,” I described an appropriate strategic goal for health care as follows:

An ideal health care system will provide better health to more people at lower cost on a continuous basis. This should be the ultimate goal of health care reform. Yet decades of legislative attempts have failed to achieve this aim. Why?

**First**, proposed and enacted reforms have tended to focus on the provision of services rather than on the outcomes of those services.

**Second**, reforms have tended to reinforce the weaknesses of the current system. Existing laws, regulations, institutions, and politics obstruct and discourage cost-cutting innovation. They unnecessarily constrain the supply of care, the means to improve it, and the capacity to lower costs. These problems predate the Affordable Care Act (ACA), but the ACA compounds them. Unfortunately, proponents of market-based solutions have mostly offered piecemeal fixes that have failed to convince broader constituencies.

**Third**, Washington has aimed far too low. We should not seek to “bend the cost curve,” but rather to break it to bits. Enabling more people to receive better care at lower cost on a continuous basis requires replicating the plunging costs and soaring quality in computing, transportation, agriculture, manufacturing, distribution, and communication. In the mid-1990s, simple cell phones were toys of the rich; 15 years later, smartphones dotted the world’s poorest villages. When American health care boasts the cost-cutting innovation we associate with a Steve Jobs or Henry Ford, we’ll be on the right track.<sup>55</sup>

A common suggestion among market advocates is to move Medicaid to block grants. A more radical suggestion is to restructure the program to meld today’s Medicaid recipients into the private insurance market. This is not uniquely an idea of the political right. The Wyden-Bennett bill in 2007 would have phased out Medicaid, and shifted the enrollees into private insurance.<sup>56</sup> Sommers and Rosenbaum<sup>57</sup> suggested relieving the churn problem by creating dual plans for both Medicaid and the insurance exchanges. Arkansas agreed to the ACA’s Medicaid expansion by this method, and it has been described favorably by Rosenbaum and Sommers.<sup>58</sup> The *New York Times* noted proposals to expand Medicaid via private insurance.<sup>59</sup> Thomas Miller’s chapter in this volume suggests that these ideas are not panaceas. But panaceas are not likely in the offing.

Ultimately, the closest we can come to a panacea is likely to come from disruptive innovation. In a previous article, I noted that for the past 50 years, we may well have been closing off our pathways to medical innovation.<sup>60</sup> In another article, I said the following:

American health care has no Steve Jobs or Bill Gates. No Jeff Bezos, Elon Musk, Burt Rutan, or Henry Ford. No innovator whose genius and sweat deliver the twin lightning bolts of cost-reduction and quality improvement

across the broad landscape of health care. Why not? Either we answer that question soon and uncork the genie, or we consign our health care to a prolonged, unaffordable stagnation.<sup>61</sup>

Cost-cutting innovation is probably the best path available for bringing better health to America's poor—and America's not-poor as well. The Medicaid program as currently constituted likely discourages any such innovation. And Medicaid is not unique in that respect.

Medicaid was created in 1965 to provide medical coverage for the poor. As is now clear, coverage does not necessarily translate into care, and Medicaid's care does not necessarily translate into better health. For the federal and state governments, the program is pricey. For enrollees who navigate Medicaid's labyrinth on the way to care, it is perplexing. And in terms of improving health, it is poor. From a moral standpoint, lower-income Americans deserve a better system than the current one, which is pricey, perplexing, and poor. To improve their lot, we will have to harness private market incentives—either within Medicaid or within a more appropriate replacement structure. For the moment, the ACA is pushing in the opposite direction—expanding a broken program, exacerbating the existing problems, and delaying the onset of more effective, more humane reforms.

## NOTES

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended sections of 42 U.S.C.).
2. It is somewhat incorrect to use the term "newly enrolled," since some of those added to the Medicaid rolls would be people who previously had private insurance.
3. Robert Graboyes, "If They Ever Fix the Obamacare Website, the Worst May Be Yet to Come," *Forbes*, October 31, 2013, <http://www.forbes.com/sites/realspin/2013/10/31/if-they-ever-fix-the-obamacare-website-the-worst-may-be-yet-to-come/>.
4. C. Eugene Steuerle, "Can the New Health Subsidies Be Administered? The Government We Deserve," November 23, 2009, <http://www.urban.org/publications/901303.html>; Paul Howard and Stephen T. Parente, "Built to Fail: Health Insurance Exchanges Under the Affordable Care Act (Guest Opinion)," June 15, 2011,



- <http://www.kaiserhealthnews.org/Columns/2011/June/061511howardparente.aspx>.
5. National Federation of Independent Business v. Sebelius 132 S. Ct. 2566.
  6. Mary Agnes Casey, "Hot-Button Health Issue: Is Medicaid or Private Insurance Better for the Poor Uninsured?," *Kaiser Health News*, July 1, 2009, <http://www.kaiserhealthnews.org/Stories/2009/July/01/Medicaid.aspx?p=1>.
  7. Robert Graboyes, "The American Health Care System: Principles for Successful Reform" (Arlington, VA: Mercatus Center at George Mason University, October 14, 2013), <http://mercatus.org/publication/american-health-care-system-principles-successful-reform>.
  8. See, for example, Fichtner chapter in this book.
  9. Fichtner chapter in this book.
  10. Holahan, Cook, and Dubay, Kaiser Commission on Medicaid and the Uninsured, "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage?," February 2007, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7613.pdf>.
  11. Ibid.
  12. Ibid. 57 million have enrolled in Medicaid, and roughly 11 million have not.  $11/(11+57)=16.2\%$ . Roughly 50 million people in touch are uninsured, out of a US population of 310 million;  $50/310=16.1\%$ .
  13. "Status of the ACA Medicaid Expansion after Supreme Court Ruling," Washington, DC: Center on Budget and Policy Priorities, October 22, 2013, <http://www.cbpp.org/files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling.pdf>.
  14. Benjamin Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs* 30 (2011), [http://op.bna.com/hl.nsf/id/nwel-8dqu2l/\\$File/Sommerstudy.pdf](http://op.bna.com/hl.nsf/id/nwel-8dqu2l/$File/Sommerstudy.pdf).
  15. Ibid.
  16. Ibid.
  17. Blackburn and Roe, Real Clear Politics, "Lessons For Health Care Reform," July 22, 2009, [http://www.realclearpolitics.com/articles/2009/07/22/tenncare\\_lessons\\_for\\_modern\\_health\\_care\\_reform\\_97570.html](http://www.realclearpolitics.com/articles/2009/07/22/tenncare_lessons_for_modern_health_care_reform_97570.html); Blasé, The Heritage Foundation, "Obama's Proposed Medicaid Expansion: Lessons from TennCare," March 3, 2010, <http://www.heritage.org/research/reports/2010/03/obamas-proposed-medicaid-expansion-lessons-from-tenncare>.
  18. Finkelstein, Baicker, et al., "Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment," *Science* 17, no. 343 (6168) (January 2014): 263–68. Published online January 2, 2014. doi:10.1126/science.1246183.
  19. Sharon Long, "Physicians May Need More Than Higher Reimbursements to Expand Medicaid Participation: Findings from Washington State," *Health Affairs* no. 9 (2013): 1560–67.
  20. Ibid.
  21. Sandra Decker, "Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients in 2011–12: A Baseline to Measure Future Acceptance Rates," *Health Affairs* 32 (2013): 71183–87.

22. <http://www.mcclatchydc.com/2013/05/13/191105/most-doctors-still-reject-medicaid.html>.
23. Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends In Medicaid Physician Fees, 2003–2008," *Health Affairs* 28, no. 3 (May/June 2009): 510–19.
24. Bruce Japsen, "Obamacare's 73% Medicaid Pay Raise for Doctors Is Delayed," *Forbes*, March 15, 2013, <http://www.forbes.com/sites/brucejapsen/2013/03/15/obamacares-73-medicaid-pay-raise-for-doctors-is-delayed/>.
25. Abby Goodnough, "Medicaid Growth Could Advocate Doctor Shortage," *New York Times*, November 28, 2013, [http://www.nytimes.com/2013/11/29/us/lack-of-doctors-may-worsen-as-millions-join-medicaid-rolls.html?\\_r=0&pagewanted=print](http://www.nytimes.com/2013/11/29/us/lack-of-doctors-may-worsen-as-millions-join-medicaid-rolls.html?_r=0&pagewanted=print).
26. Rebecca Adams, "Washington Health Policy Week in Review Medicaid Pay Increase Still Missing in Action in Most Places," *The Commonwealth Fund*, June 3, 2013, <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2013/Jun/Jun-3-2013/Medicaid-Pay-Increase-Still-Missing-in-Action-in-Most-Places.aspx>.
27. Ibid.
28. <http://www.texmed.org/template.aspx?id=24764>.
29. Denise Grady, "Children on Medicaid Shown to Wait Longer for Care," *New York Times*, June 15, 2011, <http://www.nytimes.com/2011/06/16/health/policy/16care.html>.
30. "Chapter 58 of the Acts of 2006, an Act Providing Access to Affordable, Quality, Accountable Health Care," Mass. Const., ch. 58, April 12, 2006.
31. Avik Roy, "Emergency Room Visits Increase in Massachusetts," *National Review Online*, July 7, 2010, <http://www.nationalreview.com/critical-condition/230795/emergency-room-visits-increase-massachusetts/avik-roy>.
32. [http://www.nytimes.com/2013/11/29/us/lack-of-doctors-may-worsen-as-millions-join-medicaid-rolls.html?\\_r=0](http://www.nytimes.com/2013/11/29/us/lack-of-doctors-may-worsen-as-millions-join-medicaid-rolls.html?_r=0).
33. Avik Roy, "Emergency Rooms Will Get More Crowded," *National Review*, July 13, 2010, <http://www.nationalreview.com/agenda/230979/emergency-rooms-will-get-more-crowded/avik-roy>.
34. The examples in this paragraph come from D. M. Fox and H. M. Leichter, "Rationing Care in Oregon: The New Accountability," *Health Affairs* 10, no. 2 (1991): 7–27.
35. Timothy Egan, "Oregon Lists Illnesses by Priority to See Who Gets Medicaid Care," *New York Times*, May 3, 1990, <http://www.nytimes.com/1990/05/03/us/oregon-lists-illnesses-by-priority-to-see-who-gets-medicaid-care.html>.
36. Ibid.
37. Daniel Calkthan catalogues the ethical challenges posed by such rationing. <http://content.healthaffairs.org/cgi/reprint/10/2/78.pdf>.
38. Letter noting assisted suicide raises questions; <http://abcnews.go.com/Health/story?id=5517492&page=1>.
39. Glenn Harlan Reynolds, "Medicaid's Awful Results: Column," *USA Today*, November 11, 2013, <http://www.usatoday.com/story/opinion/2013/11/11/obamacare-health-care-obama-medicaid-avik-roy-column/3489067/>.
40. <http://www.nationalreview.com/articles/313120/medicaid-america-s-worst-health-care-program-avik-roy>; <http://www.encounterbooks.com/books/how-medicaid-fails-the-poor/>.

41. Scott Gottlieb, "Medicaid Is Worse Than No Coverage at All," *Wall Street Journal*, March 10, 2011, <http://online.wsj.com/news/articles/SB10001424052748704758904576188280858303612>.
42. "Obama's Proposed Medicaid Expansion: Lessons from TennCare," Heritage Foundation, <http://www.heritage.org/research/reports/2010/03/obamas-proposed-medicaid-expansion-lessons-from-tenncare>.
43. J. K. Giacovelli et al., "Insurance Status Predicts Access to Care and Outcomes of Vascular Disease," *Journal of Vascular Surgery* 48, no. 4 (October 2008): 905–11.
44. R. G. Roetzheim et al., "Effects of Health Insurance and Race on Early Detection of Cancer," *Journal of the National Cancer Institute* 91, no. 16 (August 1999): 1409–15.
45. Siran M. Koroukian, Paul M. Bakaki, and Derek Raghavan, "Survival Disparities by Medicaid Status," *Cancer* 118, no. 17 (December 27, 2011), <http://onlinelibrary.wiley.com/doi/10.1002/cncr.27380/full>.
46. J. Kwok et al., "The Impact of Health Insurance Status on the Survival of Patients with Head and Neck Cancer," *Cancer* 116, no. 2 (January 2010): 476–85.
47. Damien J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," *Ann Surg* 252, no. 3 (September 2010): 544–51; <http://www.nationalreview.com/critical-condition/231147/uva-study-surgical-patients-medicaid-are-13-more-likely-die-those-without->.
48. Ibid.
49. Rachel Rapoport Kelz et al., "Morbidity and Mortality Of Colorectal Carcinoma Surgery Differs by Insurance Status," *Cancer* 101, no. 10 (November 2004): 2187–94.
50. J. G. Allen et al., "Insurance Status Is an Independent Predictor of Long-Term Survival after Lung Transplantation in the United States," *Journal of Heart and Lung Transplantation* 30, no. 1 (January 2011): 45–53.
51. Katherine Baicker et al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine* 368 (May 2, 2013): 1713–22, <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>.
52. Robert Graboyes, "Medicaid Expansion: States under Duress," *Richmond Times-Dispatch*, November 17, 2013, [http://mercatus.org/expert\\_commentary/medicaid-expansion-states-under-duress](http://mercatus.org/expert_commentary/medicaid-expansion-states-under-duress).
53. See "Medicaid Expansion: A Morality Issue?," <https://www.medicare.com/medicaid/medicaid-expansion-a-morality-issue.html>.
54. <http://capsules.kaiserhealthnews.org/index.php/2013/11/about-91000-enroll-in-medicaid-as-result-of-aca-woodwork-effect/>; <http://watchdog.org/65676/mt-bullock-seeks-medicaid-expansion-but-woodwork-effect-could-hurt-state-budget/>.
55. <http://mercatus.org/publication/american-healthcare-system-principles-successful-reform>.
56. Healthy Americans Act, [http://en.wikipedia.org/wiki/Healthy\\_Americans\\_Act](http://en.wikipedia.org/wiki/Healthy_Americans_Act).
57. Op cit.
58. Sara Rosenbaum and Benjamin D. Sommers, "Using Medicaid to Buy Private Health Insurance—The Great New Experiment?," *New England Journal of Medicine* 369 (July 4, 2013): 7–9, <http://www.nejm.org/doi/full/10.1056/NEJMp1304170>.

59. R. Pear, "States Urged to Expand Medicaid with Private Insurance," *New York Times*, March 22, 2013: A14.
60. Robert Graboyes, "American Medicine: Closing of the Frontier?," *USA Today*, November 7, 2013, [http://mercatus.org/expert\\_commentary/american-medicine-closing-frontier](http://mercatus.org/expert_commentary/american-medicine-closing-frontier).
61. Robert Graboyes, "Paging Dr. Jobs," *McClatchy Tribune*, October 2, 2013, [http://mercatus.org/expert\\_commentary/paging-dr-jobs](http://mercatus.org/expert_commentary/paging-dr-jobs).

# ABOUT THE MERCATUS CENTER AT GEORGE MASON UNIVERSITY

The Mercatus Center at George Mason University is the world's premier university source for market-oriented ideas—bridging the gap between academic ideas and real-world problems.

A university-based research center, Mercatus advances knowledge about how markets work to improve people's lives by training graduate students, conducting research, and applying economics to offer solutions to society's most pressing problems.

Our mission is to generate knowledge and understanding of the institutions that affect the freedom to prosper and to find sustainable solutions that overcome the barriers preventing individuals from living free, prosperous, and peaceful lives.

Founded in 1980, the Mercatus Center is located on George Mason University's Arlington campus.

[www.mercatus.org](http://www.mercatus.org)