The Affordable Care Act (ACA) is a national test of our political and technical ability to reshape health financing in the United States. The principal objective of the legislation is to expand health insurance to millions of people who previously did not have the resources or access necessary to obtain coverage.

The ACA established uniform national eligibility standards for Medicaid that were intended to guarantee health coverage to every low-income American. A subsidy program was established for individuals who did not already have access to private health insurance through their employer, and new rules were imposed requiring insurers to extend coverage to all who apply, regardless of their health status.

Despite its substantial detail, the 2010 legislation provided only a crude sketch of what was to come. Thousands of pages of regulations and other guidance associated with the law have more often than not obscured both the likely response of the health sector to the ACA and its impact on individuals. The Supreme Court upheld the constitutionality of the ACA but determined that Congress had overstepped its authority by threatening to withdraw funding from any state that did not fully expand Medicaid coverage to the federal standard.

Ongoing court cases could substantially alter the way the ACA operates. Health care providers, plans, and insurers are adapting their operations to meet the new requirements and changing business conditions. It will be years before the market stabilizes—assuming no substantial changes in legislation or regulation in the intervening period.

Even if the ACA’s provisions are not fully implemented, such sweeping legislation massively redistributes both resources and power in the health sector and the general economy. There will be winners and losers, but who wins and who loses—and by how much—was far from certain.
when the ACA was enacted and remains fluid. Research is needed to understand the complex interactions of federal, state, and private actions that the legislation has triggered. Such analysis can help identify the impact of the ACA on health care costs, the distributional consequences for individuals, and the changing financial incentives the ACA has created for health plans and providers. It could also provide insights into new policies that can promote efficiency, effectiveness, and value in the US health care system.

Supporters of the ACA are unmistakably unhappy that the states have been given the authority to decide whether to expand eligibility to their Medicaid programs. States that do not expand will leave a coverage gap for those who do not qualify for Medicaid under existing state eligibility rules but have too little income to qualify for subsidies through the health insurance exchanges. Some states quickly expanded program eligibility to all whose incomes are less than 138 percent of the federal poverty level. Others may expand eligibility in future years, at least part of the way to the federal standard, and some states may decide not to expand. That creates variation, if not a completely natural experiment. But unless states are also given more flexibility to shape their programs to meet the needs of their populations—and continue innovations that have proven valuable—opportunities to improve the health system in a manner that is cost effective for low-income families will be lost.

Why Expand Medicaid to 138 Percent of Poverty?

All too often, Congress passes legislation that includes provisions that do not seem to make sense. Sometimes those inexplicable provisions are simply mistakes. The complexity of the ACA and the chaotic legislative process that disgorged the bill undoubtedly account for many problems that are now beginning to emerge.

Other inconsistent aspects of the ACA reveal the thinking that motivated the policy. A case in point is the overlap between income eligibility for the subsidies for private insurance on the exchange, which begins at the federal poverty level, and the ACA Medicaid eligibility standard, which tops out at 138 percent of the poverty level. Keep in mind that these provisions were written more than two years before the Supreme Court gave states the authority to decide whether to expand their Medicaid programs.

Had the ACA's coercive tactics remained in place, the overlap in income eligibility would have been a minor issue because individuals who are eligible for subsidized insurance outside the exchange (whether from Medicaid or an employer) are not eligible for the exchange subsidy. Now that states can decide how much to expand Medicaid, individuals above the federal poverty level can be eligible for exchange subsidies, while those with lower incomes may not be eligible for any subsidy.

Medicaid is the single largest component of state expenditures, accounting for 23.5 percent of the $1.7 trillion spent by states in 2013.

Careful draftsmanship would have one subsidy program seamlessly ending where the other subsidy program begins. Corrections could have been made in a conference committee or through a technical corrections bill after the legislation was signed into law, if political conditions had permitted.

That leaves us with a version of the bill that reveals negotiations over the cost of expanding coverage. By increasing the upper income limit for Medicaid eligibility, fewer people would be eligible for exchange subsidies and CBO would reduce the estimated budget cost of the bill.

One can understand the lure for both the federal and state governments of what seems to be cheap insurance coverage. The federal government in 2014 will pay about 58 percent of the cost of benefits for individuals who are eligible for Medicaid under the pre-ACA rules. The match rate jumps to 100 percent for those who become eligible under expanded ACA rules. Eventually, the enhanced match drops to 90 percent of the cost of benefits, which is significantly higher than the current top rate (73.4 percent, which goes to Mississippi).

Even with full federal payment, the budget cost of an additional Medicaid enrollee is less than it would be if that person received an exchange subsidy. According to estimates from the Congressional Budget Office (CBO), the average federal cost of enrolling an adult in Medicaid under expanded ACA rules will be about $3,677 in 2014—higher than the $2,132 federal cost for enrollees under pre-ACA rules but significantly lower than the $6,348 average federal cost to subsidize individuals who enroll in the exchanges rather than in Medicaid.4

From that perspective, expanding Medicaid under the ACA looks like a bargain. Perhaps 25 percent of new Medicaid enrollees will be people who qualified for the
program under pre-ACA rules (the “woodwork effect”). That leaves about six million people enrolling in 2014 under the expanded rules. The federal government would save $16 billion in 2014 by shifting them to Medicaid rather than to the exchanges.

If the ACA Medicaid income level had been set equal to a more plausible figure, such as 100 percent of the poverty level, more than $100 billion would have been added to the estimated cost of an already expensive piece of legislation. By keeping one-third of newly insured individuals out of private insurance, bill sponsors could claim that the ACA was not a trillion-dollar spending bill.

Largely as a consequence of the ACA, state and local spending for Medicaid is projected to nearly double over the next decade.

The CBO score applies to only a 10-year budget window, but the commitment of taxpayer resources is permanent. The original estimate of the federal cost of insurance coverage provisions in the ACA was $788 billion for 2010 to 2019, which includes the four years prior to full implementation of the law. By now, the cost has ballooned to $1.4 trillion for 2014 to 2024, a period over which the exchange subsidies and Medicaid expansion are fully implemented. Without significant changes in the subsidy programs, those costs will continue to rise over time.

Is ACA Medicaid Expansion a Good Deal for States?

Medicaid is the single largest component of state expenditures, accounting for 23.5 percent of the $1.7 trillion spent by states in 2013. Given other demands on state budgets and their political ramifications, the decision to expand Medicaid eligibility cannot be taken lightly.

It is difficult for a state to determine whether it would face higher budget costs from expanding Medicaid eligibility. That depends on how many people enroll, how much their health care costs, savings that might accrue because of preventive health measures and earlier diagnosis and treatment, the shift of costs from other payers to Medicaid, and numerous other factors that are difficult to predict. During the years of full federal funding, states would not pay for the health services newly eligible beneficiaries use, although they would pay part of the cost of any enrollees who were eligible for Medicaid under the rules that preceded the ACA. Beginning in 2017, the federal match rate for the expansion population drops to 95 percent and continues to decline to 90 percent by 2020. States that expand Medicaid coverage to obtain “free” insurance in the near term face mounting costs over time.

States have a strong incentive to take advantage of the overlap in subsidies that the legislative drafters left in the ACA. By not expanding Medicaid eligibility, individuals with incomes between 100 and 138 percent of the federal poverty level gain comprehensive private insurance coverage at no cost to the state.

States have been discouraged from partially expanding Medicaid to those with incomes up to the poverty level. The administration’s position is that any partial expansion would receive only the regular match rather than the enhanced federal matching payment. That is intended to encourage states to fully expand their programs, but it also discourages states from any expansion at all. Particularly in states that have tightly limited access to Medicaid coverage, the additional cost of an expansion would ultimately be substantial.

The budgetary impacts vary across states depending on the generosity of their current programs. New York, which already provides support for people through state-only programs, could save as much as $33.8 billion over the next decade by shifting those costs into Medicaid. In contrast, Georgia could be faced with $1.8 billion in higher state costs by expanding Medicaid to 138 percent of the poverty level.

Largely as a consequence of the ACA, state and local spending for Medicaid is projected to nearly double over the next decade, from $188 billion in 2013 to $340 billion in 2022. Even after the initial cost increase as a result of expanded coverage, however, state and local Medicaid spending is projected to grow about 7 percent a year—substantially faster than the economy or state revenues.

As the baby boom generation ages, more people will become eligible for Medicaid and will need long-term care and other expensive services covered by the program. Those costs will add to budget challenges at all levels of government whether or not states expand their programs.

That adds an additional uncertainty to what is already a complex decision. The federal government could respond to its own fiscal pressures by cutting back on the enhanced matching rate for new Medicaid enrollees, leaving states with a larger bill. By the same token, there is no reason to think that the exchange subsidies would not be
reduced to help with a federal budget problem, although that might wait until after 2016.

After weighing the costs of expanding Medicaid, it remains unclear what will best serve the uninsured public. According to a recent survey, nearly one-third of physicians will not accept new Medicaid patients. Another survey finds that more than half of primary care physicians will not accept new Medicaid patients. Low payment rates and administrative hassles are commonly cited as the causes of reduced provider access in the program. By comparison, 18 percent of physicians will not accept new patients with private insurance.

Subsidized health plans on the exchanges are likely to be no better. The ACA requires exchange plans to offer generous benefits but limits the ability of plans to manage patient costs. Consequently, narrow networks are common among exchange plans, triggering complaints from consumers who are faced with costly premiums, high deductibles and other cost-sharing requirements, and restricted access to physicians and hospitals.

For persons with incomes between 100 and 138 percent of the poverty level, the cost of premiums, deductibles, and other cost-sharing requirements is largely covered by the exchange subsidies—but only for lower-cost “silver” plans that have limited provider networks. The plans cost less, but enrollees are likely to lose access to their neighborhood hospital and their physicians.

**Reform, With or Without Expansion**

Medicaid serves different populations with sharply different needs, and reforms must account for that diversity as well as varying conditions in each state. Regardless of individual state decisions on whether to expand eligibility, there are opportunities to make Medicaid more responsive to the populations it serves without driving costs to unsustainable levels.

Medicaid reform should seek to restore to beneficiaries a sense of ownership and responsibility that poverty, disease, and bureaucracy all too often take away. That means ensuring that our scarce resources serve those most in need of public help. It means removing the disincentives that discourage poor Americans from joining the middle class. And it means returning power and responsibility to states, localities, and families.

As America’s largest means-tested entitlement program, Medicaid operates with a similar philosophy to welfare programs of old. Individuals with sufficiently low incomes are entitled to benefits with no further obligation or responsibility to contribute in some way to the greater good, even if they are able. Moreover, Medicaid beneficiaries have little opportunity to be active consumers of health services, a long-standing problem in the health sector.

Welfare reform in the mid-1990s changed the way we think about cash assistance to the poor. As a condition of receiving support through Temporary Assistance for Needy Families, able-bodied adults are now required to meet a work requirement. The objective is to wean families from welfare dependency and, in so doing, reduce the chances that they will continue to need help years from now. By any reasonable measure, we are on our way to achieving that goal.

In contrast, Medicaid operates without work requirements. This is particularly relevant to the expansion population who will become Medicaid beneficiaries as a result of the ACA. If all states expanded their eligibility limits, 82 percent of the new eligibles would be adults not living with dependent children. Moreover, more than half would be below the age of 35. Many of them are working, but many who are not could seek employment.

There are two sides to every contract, even a social contract. Both sides should have responsibilities that they must meet.

We should also integrate medical assistance with mainstream health insurance. The vast majority of Americans participate in health plans sponsored by employers. Medicaid coverage should be converted into a premium assistance program to subsidize the cost of private insurance, including high-deductible plans with health savings accounts. Medicaid beneficiaries should not have to choose between a job and health care for their children.

By mainstreaming healthy children and adults and providing temporary assistance to purchase health insurance when it is needed, we can focus Medicaid on beneficiaries with chronic infirmities who depend on government assistance for their survival. The latter group has multiple needs that may include mental health and addiction services, housing, social services and other activities provided across a number of state and local agencies. Better coordination among those agencies, and between the agencies and charitable organizations and families, can yield more effective use of limited funds.

To make such reforms work, we need to shift decision-making authority back to the families and state and local governments who actually manage—or cope with—the Medicaid program on a day-to-day basis. Shifting from the current financing system, in which the federal
government pays at least half of the cost of the state’s program cost, to a block grant would reverse the incentives that drive up spending.

There is a built-in inflationary bias in Medicare financing. Because the states pay a percentage of the costs of Medicaid, with the federal government paying the rest, state policymakers can take credit for expanding Medicaid coverage without having to pay the full cost. Moreover, actions to reduce spending yield no more than 50 cents on the dollar in Medicaid savings to the state. Sensible cost-cutting policies are less likely to be adopted if the state keeps only part of the savings but incurs all of the political opposition.

When a state does decide to adopt a new policy or adjust an old one, it must seek permission from the Centers for Medicare and Medicaid Services (CMS). That additional layer of bureaucracy can be enough to stop a good idea before a state can try it.

To address both issues, Medicaid should be converted from an open-ended entitlement to federal dollars to a form of defined contribution. Federal subsidies to the states should be set at a fixed amount that does not increase as a result of state actions designed to increase federal matching payments. This is essentially a block grant, although the precise form of the grant could account for inflation, population growth, and other circumstances outside direct state political control that influence the cost of Medicaid.

A block grant approach gives states incentives to reduce unnecessary spending and focus their resources on those most needing help. States should be given wider authority to make program changes without having to seek approval from the federal government. Since states would be fully responsible for any spending in excess of the grant, regulatory restrictions can be loosened without exposing the federal budget to unexpected costs. This also requires a clear set of rules establishing general expectations for an effective medical assistance program that can operate within reasonable budgetary limits.

**Waivers and State Experimentation**

Despite substantial barriers to innovation, many states have pioneered Medicaid reforms through waivers granted by the CMS. The lesson of these experiments is that one size does not fit all. The different populations Medicaid serves have varying needs for services and capabilities to navigate the health system. Some states are eager to try new approaches, and others face political and technical challenges that make innovation difficult. Limited fiscal capacity is a problem for all states.

An important theme of state initiatives is promoting more active consumer decision making and aligning incentives to reduce waste and inefficiency. For example, the Healthy Indiana Plan provides a benefit package modeled after a high-deductible health plan and health savings account. The combination of significant cost-sharing requirements and a subsidized personal account is intended to make enrollees more cost-conscious than beneficiaries of traditional Medicare.

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**Responsible reforms can improve the value of Medicaid coverage while placing program spending on a path that is sustainable both for the federal government and the states.**

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The plan, which began in 2008, expanded Medicaid eligibility to adults with incomes up to 200 percent of the federal poverty level. The deductible is $1,100, which is substantial for a low-income population. A Personal Wellness and Responsibility (POWER) account is used to cover the cost of the deductible. An individual contributes a modest income-related amount to the account, with the remaining cost of the deductible covered by a government subsidy. Enrollees with no income do not pay into their POWER accounts, and the program covers the full contribution. This gives everyone in the plan personal responsibility for how that money is spent.

The ACA mandated states to expand their traditional Medicaid programs to everyone with income up to 138 percent of the poverty level, but it did not create new opportunities for state innovation. The Supreme Court put the decision to expand Medicaid back in the hands of the states, but it, too, failed to give states more authority to run their own programs.

Several states have proposed to expand eligibility by incorporating premium assistance in their Medicaid programs. Premium assistance allows public funds from Medicaid or the Children’s Health Insurance Program to be used to purchase private coverage, which could include plans offered by employers or by insurance exchanges.

Arkansas received approval to shift its entire Medicaid population into the exchange, starting with all newly eligible beneficiaries but eventually including currently eligible beneficiaries as well. This step was taken in part...
because of concerns that the exchange market would otherwise not attract enough enrollees to be viable. Persons likely to have high medical costs—including those who are medically frail, pregnant women, and dual-eligible beneficiaries (who are typically elderly and in need of long-term care services)—are excluded.

The Arkansas project, which was approved for three years, transfers Medicaid’s requirements and inefficiencies into the insurance exchange. The Department of Health and Human Services (HHS) has stated that all Medicaid beneficiaries who are transferred into the exchanges “remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections.”

At least for beneficiaries under the poverty level, the only change is the name of their health plan: they will have full Medicaid coverage with no responsibility for premiums or cost-sharing. For beneficiaries between 100 and 138 percent of the federal poverty level, cost sharing will be minimal, reflecting existing Medicaid rules.

Under the terms of the waiver, the cost of this project is supposed to be no greater than current program costs. Although organized health plans might reduce the cost of care and improve the care that is delivered, it is more likely that the exchange plans will operate like Medicaid with little change in access to or quality of care.

Other states have adopted a more ambitious approach to expanding Medicaid using premium assistance. Iowa and Pennsylvania require beneficiaries to pay modest income-related premiums but reduce the cost for beneficiaries who participate in activities that promote healthy behavior. Pennsylvania also reduces the premium for beneficiaries who actively look for employment. Unlike Arkansas, both of these states also provide premium assistance for employer-sponsored insurance when available.

States could do more to develop better ways to provide Medicaid coverage if the federal waiver process were simplified and improved. For example, the US Government Accountability Office found that HHS does not have a consistent process for determining whether a state demonstration waiver would be budget neutral—that is, the proposed change in the program’s operation would not add to federal budget costs. Lack of a clear and detailed process for establishing budget neutrality and for evaluating state waiver applications results in delays, increases demands for additional information that can be difficult to obtain, and can discourage states from developing innovations that could reduce cost and improve Medicaid’s performance.

A clear road map for states seeking federal approval for Medicaid waivers would make the application process more efficient for everyone. That does not argue for a cookie-cutter approach to state experimentation. States are in a better position than the federal government to understand the specific challenges facing their Medicaid programs and the people they serve.

An innovation that could work in one state might fail in another state with superficially similar problems. Successful experiments are not easy to replicate because even a seemingly simple change depends on a set of social, economic, and programmatic systems that interact in unimaginably complex ways. That calls for a policy that promotes experimentation and adaptability to changing circumstances.

The ACA established the Center for Medicare and Medicaid Innovation, which is charged with testing innovative payment and service delivery models intended to reduce cost or increase the quality of care. However, this center remains tied to the idea that a successful demonstration project can become a template that should be replicated nationwide. A better approach would decentralize the process, giving states more flexibility to make program changes designed to meet the objectives of better care at lower cost.

Responsible reforms can improve the value of Medicaid coverage while placing program spending on a path that is sustainable both for the federal government and the states. A reasonable first step is to remove the bureaucratic barriers to state experimentation and allow greater flexibility in the way states work to solve the problems in their Medicaid programs.

Conclusion

Medicaid spending will increase dramatically as a result of the Affordable Care Act. Millions of people will become newly eligible in states that choose to expand their programs. Millions more who were eligible under previous rules have been encouraged to enroll as well. That will bump up total Medicaid spending by over 12 percent in 2014—almost double the average annual rate of increase in spending over the past decade.

Beyond the immediate surge in enrollment and cost, Medicaid spending will continue to grow very rapidly in coming years, averaging about a 6.7 percent annual increase from 2015 to 2022. Even if the recent slowdown in the growth of overall health spending continues, Medicaid will have a rising proportion of elderly and disabled beneficiaries who use expensive services, driving up program cost.
Those spending trends make Medicaid a growing problem for policymakers at all government levels. They face many competing demands for resources and have only limited capacity to expand revenue. They must find new ways to reduce the cost of Medicaid while improving the value that the program provides to those most in need.

The Affordable Care Act represents a lost opportunity to take on the daunting challenge of reforming Medicaid. Given the complexity of the program and the sensitivity of the politics, it may be asking too much for the federal government to take on that task. States are in a better position to understand the specific challenges their Medicaid programs face and to assess their fiscal and political capacity to make changes.

The federal government should adopt incremental policies that open the program to greater state innovation. States are on the front lines of Medicaid and the battle to control spending. They need relief from the straitjacket of excessive federal regulation and more flexibility to try local solutions for local problems.

Changes at the federal level are needed to give a stronger impetus to state-led reforms. The number-one problem is the system of matching payments, which promotes inefficient and unnecessary spending. A shift to a defined contribution–style federal subsidy would reverse five decades of perverse incentives. If it is implemented carefully, vulnerable populations would be protected and their care would be improved. Without fundamental financing reform, states and the federal government will continue to have conflicting policy objectives for Medicaid.

An earlier version of this paper was prepared for a conference on “Medicaid on the Eve of the Affordable Care Act: What are the Research Priorities?” held by Indiana University and the Urban Institute on November 6, 2013.

Notes

1. What is commonly referred to as the Affordable Care Act consists of the Patient Protection and Affordable Care Act, enacted March 23, 2010, and the Health Care and Education Reconciliation Act, enacted March 30, 2010. This discussion refers to the combined impact of those two acts.


5. CBO assumes that one-quarter of the six million people who will not have Medicaid coverage in 2022 as a result of the Supreme Court’s decision would have qualified under pre-ACA rules. See CBO, “Estimates for the Insurance Coverage Provisions.” We assume that a similar percentage applies to those who do enroll in Medicaid.

6. Assuming that 25 percent of new Medicaid enrollees were qualified under pre-ACA rules, 9 million of the 12 million people who have Medicaid coverage due to the ACA in 2016 would be eligible for 100 percent federal funding. Those 9 million constitute somewhat more than one-third of the 25 million people CBO estimates gained insurance coverage from all sources in that year. See CBO, “Effects on Health Insurance and the Federal Budget.”


8. CBO, “Effects on Health Insurance and the Federal Budget.”


11. The federal match is not raised for anyone who is eligible for Medicaid under pre-ACA rules. Even states that did not


24. Arkansas has said that it plans to impose some cost sharing on beneficiaries with incomes between 50 and 100 percent of the federal poverty level, subject to approval by CMS.

25. Musumeci, “Medicaid Expansion through Premium Assistance.”


30. Ibid.