



## The Carrot and the Stick of Medicaid Expansion

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More than one-fifth of the population of the United States was receiving Medicaid benefits before the passage of The Affordable Care Act (ACA). The ACA expanded eligibility to adults under the age of 65 who have income up to 138 percent of the federal poverty level. As originally written, the ACA relied on two provisions intended to entice and prod states to expand their Medicaid programs. So far, about half of the states have expanded their programs.

The carrot enticing states to expand their programs is the generous federal participation. This year, the federal government will cover 100% of the spending by the newly eligible population. The federal contribution only declines to 90% of the cost for the newly eligible population by 2020 and later.

The ACA also originally included a prodding stick provision that withdrew federal Medicaid funding for states that chose not to expand. The Supreme Court struck down this provision, however, with

its ruling in the summer of 2012. These provisions were expected to increase the number of Medicaid recipients to more than one-fourth of the entire US population!

The states that have not accepted the carrot will continue to be enticed, and as time goes on, the variation in states' participation allows for study of important predictions related to state and individual behavior.

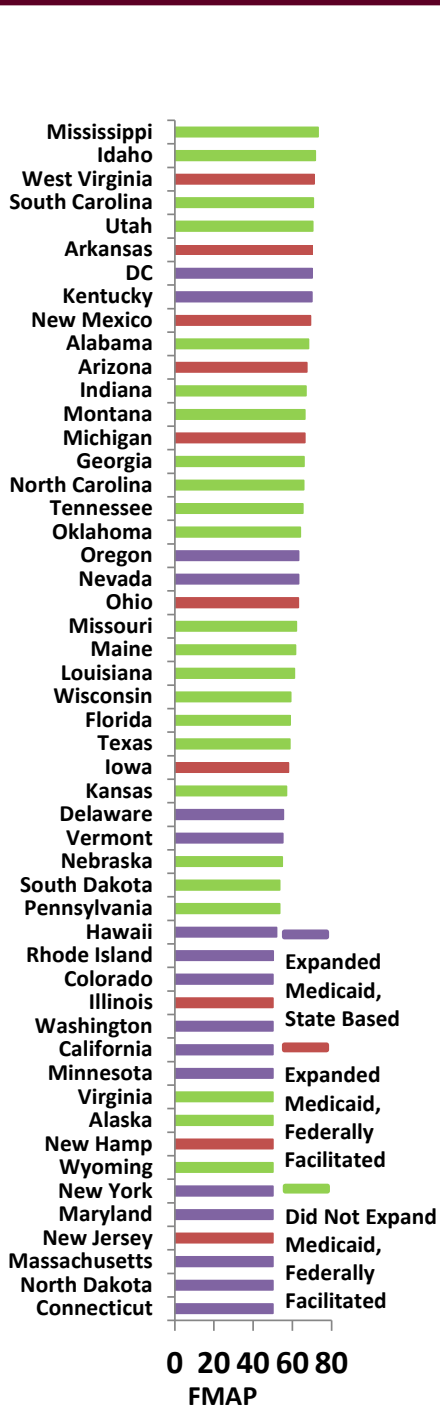
The federal contribution for the newly eligible is particularly attractive in higher income states. This is why. Medicaid is jointly funded through state and federal tax revenues. The minimum percentage of state Medicaid spending paid by the federal government is set at 50%. The federal share of Medicaid spending is referred to as the Federal Medical Assistance Percentage (FMAP) and is based on a formula relating a state's income to the national average. The FMAP is bounded by law to fall between 50% and 85% with the highest income states receiving the 50% federal share.

Figure 1 depicts the state FMAPs for fiscal year 2014 sorted in descending order. States are also identified by whether or not they expanded Medicaid and if they did, whether they set up their own state based market or relied on a federally facilitated market. There are currently 15 high income states, such as New York and Massachusetts that receive the minimum FMAP of 50%. Mississippi has the highest FMAP of 73%.

Of the 15 high income states receiving the minimum FMAP of 50%, 12 have chosen to expand Medicaid and only three, Virginia, Alaska, and Wyoming, have chosen not to expand. Also, of the 12 that have chosen to expand Medicaid, nine have set up their own exchange and three are federally facilitated.

From the vantage point of high income states the ACA has created a sizable discontinuity in the federal share of Medicare with respect to beneficiaries' incomes. For example, the federal government pays for 50% of Medicaid spending on

Figure 1. Federal Medical Assistance Percentage in 2014



behalf of New Yorkers who are under the age of 65 and have incomes that are just below the poverty line. But for New Yorkers whose incomes are just above the poverty line, the federal government will pay for 100 percent of their Medicaid spending. The discontinuity in the federal governments' share of spending is smaller in the lower income states, but still sizable. The average FMAP of the states that have opted to accept the ACA's expansion funding is 57 percent and the average in the states that have not is about 5 percentage points higher at 62 percent. These averages are significantly different.

Political leaders in states that have not accepted Medicaid expansion funding will continue to face pressure to accept funding, given the low cost to the states and the ability to have citizens of other states share in the cost. Empirically identifying the behavior of state Medicare programs in response to the new incentives will be difficult, but the prediction is that beneficiaries at the poverty level are more likely to move to just above the poverty threshold in the states that accept funding than in the states that do not accept the new funding.

Figure 2 depicts the percentage increase in states' Medicaid enrollments though February 2014 relative to pre-ACA monthly enrollment averages for July to September 2013. The data are from an April enrollment report from the Centers for Medicare and Medicaid Services (CMS). The states are limited to those for which enrollment data are available both periods, and they are sorted in descending order of the percentage increase in enrollment.

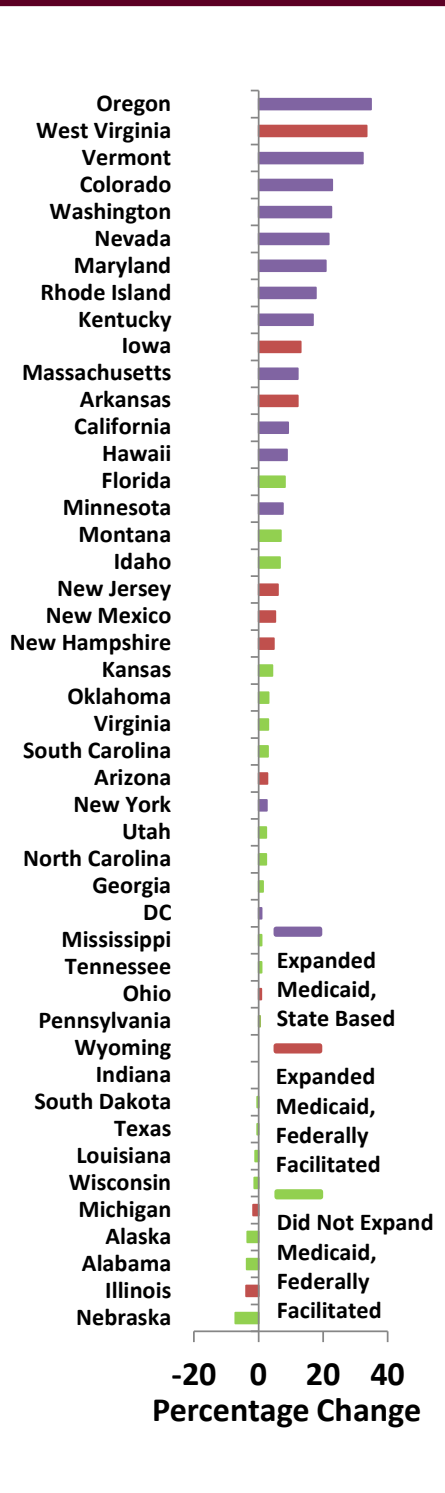
Again, the states are distinguished by how and whether they expanded Medicaid. Oregon had the biggest percentage increase of almost 35%. At the other end of the spectrum, Nebraska experienced a 7% drop in enrollment over the period considered.

Enrollment increased 7.8% across all of the states that expanded eligibility. But of the expansion states, those that set up their own exchanges have seen an increase of 10.5% thus far, compared to the significantly smaller 2.4% increase among the states with federally facilitated marketplaces.

The effects of the ACA's Medicaid expansion on individuals are multidimensional. In states that expand Medicaid there will not be a discontinuity in eligibility at the poverty level. However, there will be a discontinuity between Medicaid coverage at 138 percent of poverty and the insurance available on the exchanges. The discontinuity is either in the form of less complete insurance coverage at low additional expense to the consumer or in the form of higher premiums for comparable coverage. In all states the tax subsidies are phased-out as income rises, which acts as a tax on labor earnings.

But perhaps the more interesting effect of the differential Medicaid expansion will be revealed through state-to-state migration. Newly eligible individuals and families will have the incentive to move from states that do not expand coverage to the states that expand coverage. This effect will be greatest in bordering states that share metropolitan areas but chose differently in regards to expanding Medicaid.

Figure 2. Pre-ACA to Feb-2014  
% Change in Medicaid  
Enrollment



The differential uptake by states in the ACA’s Medicaid expansion promises researchers a range of interesting outcomes to track. The ACA’s cumbersome structure has led many to call for further reform. Some argue that all that is needed are a few targeted tweaks while others look to fully replace the law. The unequal incidence of the Medicaid expansion serves to open the door to exploring more fundamental, yet possibly simpler reform, than the ACA.

A more fundamental reform would begin by limiting the magnitude of the preferential tax treatment afforded employer provided health care insurance that has up to now distorted the health care market. Workers implicitly purchase more comprehensive health insurance than they would in the absence of the tax exclusion. With this insurance in hand, patients then face less than the full cost of the care they receive from a provider. The level of insurance enjoyed by those covered through an employment relationship becomes a benchmark of the coverage politicians are expected to deliver in the public programs.

Limiting the size of the tax preference can be coupled with a tax credit made available to individuals who do not have employer-based coverage. This could include those currently covered by Medicaid. Individuals would then essentially have the option to enter the private insurance market with their tax credit or remain in a recast Medicaid program.

The recast Medicaid program would replace the current funding formula with block grants to the states. The reform could be imple-

mented initially with the states receiving a block grant in the amount that they receive currently, but over the course of the first decade the amount would be gradually adjusted based on the coverage provided and eligibility criteria. States would be free to innovate in the ways they deliver and structure the insurance, but the federal portion of spending would be indexed so per capita Medicaid spending grows at a rate tied to per capita GDP growth. The innovations would likely include the coupling of catastrophic insurance with health savings accounts.

The expressed intent of the ACA was to extend health insurance coverage to the uninsured. But underlying the expressed intent was the desire by health care providers to shore up their financing of delivered care that is originally uncompensated. Tax reform can move us a long way toward achieving broad insurance coverage where the insurance is closer to true insurance that covers the expenses associated with unlikely events. Making the health care market more efficient ultimately requires that both sides of the market – patients and providers – are cost conscious.

Sources: Federal Register, Vol.77, No. 231, Nov. 30, 2012 and “Medicaid & CHIP: February 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report,” Centers for Medicare and Medicaid Services, April 4, 2014.





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