WebMemo
Published by The Heritage Foundation
No. 2554
July 21, 2009

Medicaid Expansion: The Impact of the House and Senate Health Bills

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Congress is proposing a major expansion of Medicaid as a primary vehicle to reduce the number of people without health insurance.

But this idea would balkanize families based on arbitrary income levels, history, and geography. While it might theoretically be a cheaper alternative, it would not necessarily serve the best interests of families inside or outside of Medicaid. Further expansion of Medicaid would create new inequities among individuals, even within families.

Medicaid Eligibility. Not all poor people are eligible for Medicaid, and not all people on Medicaid are poor. Medicaid is based not only on income but also on other criteria, such as disability or whether the household includes a dependent child.

Federal law *requires* states to cover certain populations (including parents of children on Medicaid at old welfare eligibility levels), *allows* states to cover additional "optional" populations (including parents of children on Medicaid with higher family income levels), and *refuses* to pay for other populations (childless, non-disabled adults).

For children, there is no upper income eligibility limit. Thus, children in Maryland in families of four with income of $66,150 are eligible for Medicaid, while a childless adult in Virginia making $5,000 is not.

Health Status and Coverage. Being uninsured does not mean an individual is in poor health. According to a recent report by the Kaiser Commission on Medicaid and the Uninsured, 50 percent of uninsured adults below the poverty level report that they are in excellent or very good health, and another 33 percent report that they are in good health.[1] Only 17 percent of the "poor" (below 100 percent of the federal poverty level [FPL]) and 11 percent of those considered "near poor" (100–199 percent FPL) consider themselves to be in poor or fair health.

So why send healthy but uninsured adults to Medicaid? If these individuals were connected to the private sector pools, they would help lower costs by spreading risk among healthy populations. Putting these and other healthy Medicaid lives back into the private health insurance pool would help reverse the "crowd out" effect and lower costs for everyone.

Undermining Private Pooling. According the Congressional Budget Office (CBO), under the House bill, the number of uninsured individuals will be reduced by 37 million by 2019.[2] Of these, 11 million, or 30 percent, will be moved into Medicaid. Combining the CBO estimates of the Medicaid baseline under current law[3] with the new expansion reveals that more than 85 million people—approximately 25 percent of the entire U.S.

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/wm2554.cfm
Produced by the Center for Health Policy Studies
Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

population—will be on Medicaid for at least some period of time in 2019.

The Census Bureau projects total population will grow from 310.2 million individuals in 2010 to 338.2 million in 2019.[4] So adding 11 million people to Medicaid is approximately equal to half of the population growth in the next 10 years, or approximately the current population of Michigan.[5]

A Medicaid expansion undermines the logic for having an individual mandate. The individual mandate is necessary, according to its congressional advocates, to ensure that everyone is in the insurance pool so that risk can be spread across everyone and thereby lower costs. But keeping 64 million children and non-disabled adults (53 million "moms and kids" currently on Medicaid plus 11 million newly eligible) on Medicaid rather than in the rest of the insurance pool dilutes the effectiveness of the mandate.

High Costs. According to the CBO March 2009 Medicaid Baseline, the benefits payments for children and non-disabled adults under current law will total over $1 trillion in the period 2010–2019. With the state share, total spending will be approximately $1.8 trillion.

The House bill would increase federal Medicaid spending by $438 billion for a combined total of $2.2 trillion. Spending $2.2 trillion to keep generally healthy individuals outside the rest of the insurance pool is counterintuitive as well as counterproductive.

Growing Government. CBO estimates that it costs less to expand Medicaid than to provide subsidies that can be used to buy into private health plans. But why is Medicaid cheaper? Because of Medicaid's low provider reimbursement rates and limited access to health care providers, particularly medical specialists. People on Medicaid are served in medical and surgical specialty offices at about half the rate of those on private insurance.[6]

The policy of expanding Medicaid also ignores the reality that people move on and off Medicaid. For continuity of care, families would be better served by remaining in private coverage. Treating individuals differently based on income level will also result in the creation of new inequities among and even within families.

For example, in a family with an income of 175 percent FPL, the child may be eligible for Medicaid while the parent will receive a subsidy to be in private coverage. Under the Senate HELP Committee proposal, a child on SCHIP can access private health plans through the Gateway while someone on Medicaid cannot. Because SCHIP starts at 100 percent FPL in many states, a child in a lower-income family may be in the private sector while an adult with higher income can only be served by Medicaid. Such a scenario is likely to occur across states and could occur even within the same family.

Playing Games to Hide the Costs. While the Administration and Congress insist that "[t]here are too many lives and livelihoods at stake"[7] to delay

1. Kaiser Commission on Medicaid and the Uninsured, "Expanding Health Coverage for Low-Income Adults: Filling the Gaps in Medicaid Eligibility," May 2009, at *http://www.kff.org/medicaid/upload/7900.pdf* (July 21, 2009).
2. Douglas W. Elmendorf, director of the Congressional Budget Office, letter to Chairman Charles Rangel, July 17, 2009, Table: Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group.
3. See Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Medicaid," at *http://www.cbo.gov/budget/factsheets/2009b/medicaid.pdf* (July 21, 2009).
4. See U.S. Census Bureau, "U.S. Population Projections," at *http://www.census.gov/population/www/projections/summarytables.html* (July 21, 2009).
5. See U.S. Census Bureau, "Estimates of the Resident Population by Selected Age Groups for the United States, States, and Puerto Rico: July 1, 2008," at *http://www.census.gov/popest/states/asrh/SC-EST2008-01.html* (July 21, 2009).
6. See Susan M. Schappert, and Elizabeth A. Rechtsteiner, "Ambulatory Medical Care Utilization: Estimates for 2006," U.S. Department of Health and Human Services, Centers for Disease Control, at *http://www.cdc.gov/nchs/data/nhsr/nhsr008.pdf* (July 21, 2009).
7. Associated Press, "Obama Challenges GOP Critics on Health Care," July 20, 2009, at *http://www.msnbc.msn.com/id/32008302/ns/politics-white_house* (July 21, 2009).

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consideration of legislation, it will take four years for benefits to begin. Under the House bill, the Medicaid expansion will cost $438 billion, even though it will not take effect until 2013.

While it will take some time for the creation of the new federal bureaucracy called for under other parts of the legislation, expanding Medicaid could be easily accomplished in a matter of months. It is therefore unclear why the 11 million uninsured Americans are required to wait four years for coverage. Presumably the delay is to avoid another $200–$300 billion in cost. The delay would appear to weaken proponents' argument as to the urgency of immediate passage of legislation.

Concentrating Power. The Senate HELP Committee has included in its bill a new voluntary program to provide benefits to individuals with limitations in their activities of daily living. The "Community Living Assistance Services and Supports" (CLASS) program will provide a cash benefit of at least $50 per day to qualifying individuals who paid into the program for at least 60 months.

In the period 2010–2019, CBO estimates that CLASS will generate savings of $58 billion, due principally to the fact that no benefits will be paid out in the first five years.[8] Over time, however, CBO determined that benefits would exceed premiums. To make the program solvent, CLASS gives the secretary of health and human services the power to raise premiums and lower benefits at will. CBO not only acknowledges this authority but expects a future secretary to use it.

Giving a federal official such awesome power to increase contributions and lower benefits would be unthinkable in Social Security, Medicare, Food Stamps, the Earned Income Tax Credit, or any other benefit program. While some may argue that contributions are voluntary, it is not hard to imagine the protests against a private insurance company that changed premiums and benefits at will.

A Bad Deal All Around. Congress's proposal to expand Medicaid as part of its health care reform effort is misguided and wrongheaded. It would subsidize coverage for people who do not need it while diluting the effects of other reform measures.

Congress could achieve more coverage and save money by transitioning those on Medicaid into private insurance. But such ideas are unlikely to emerge in this political climate.

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8. See Douglas W. Elmendorf, director of the Congressional Budget Office, letter to Senator Kay Hagan, July 6, 2009, at *http://www.cbo.gov/ftpdocs/104xx/doc10436/07-06-CLASSAct.pdf* (July 21, 2009).