Economic Perspectives on Utah Medicaid Reform under the ACA

Sven E. Wilson, PhD[1]

[1] The author is Professor of Public Policy at Brigham Young University in the Departments of Political Science and Economics, Research Economist at the National Bureau of Economic Research, and Senior Consultant in the Utah Department of Health. All opinions expressed in this document are solely those of the author.

Executive Summary

ESSENTIAL CONSIDERATIONS:

- The state budgetary impacts of Medicaid expansion are small in comparison with off-budget impacts. *Which categories of costs and benefits (for which people) should be considered?*
- The direct benefits of health insurance to the poor are very large—*much* larger than the cost to the state. *Are the people of the state willing to pay for these benefits?*
- The impact of the ACA is uncertain. *Should the state learn by observing other states or by implementing the expansion?*
- Both federal and state-level studies ignore a crucial question: *what is the capacity of the state's health care industry to absorb new demand in response to the ACA?*
- In the short run, the ACA will significantly disrupt health care and insurance markets, put upward pressure on prices, and likely lead to a reduction in the quality and availability of care. *Is there a feasible expansion option that reduces these disruptions?*
- When the individual insurance market fails to achieve efficient outcomes, the biggest losers are low and middle-income people. *Can Medicaid be expanded in a manner that does not undermine the individual market?*
- Evidence shows that low-income people are willing and able to pay more for health care than Medicaid asks of them. *Is there a way for the state to institute greater consumer responsibility within a Medicaid expansion?*

People on both sides of the political divide view the question of Medicaid expansion as a "no brainer." The economics of the issue, however, are not so simple. Public decision-makers are dealing with hard questions as they weigh large costs and benefits in the face of substantial uncertainty.

This brief articulates some basic principles of health economics as they relate to the issue of the ACA in general and Medicaid expansion in particular. Unfortunately, there is no single number that captures the net effects of Medicaid expansion. Instead, policy-makers must consider a variety of factors that are difficult or impossible to quantify.

Ultimately, the decision regarding Medicaid expansion comes down to one of values. What is the appropriate role of government, and what kind of society do the citizens of the state want to have? The motivation for this analysis is that those questions are best answered on a foundation of sound economic principles.

Broadening the Scope of Inquiry

A common misconception about economics is that it *narrows* the scope of inquiry to budgetary issues or to dollars spent on market transactions. But when conceived correctly, economic valuation actually *broadens* the question to include all the things that affect human welfare and happiness—things like health, suffering, life expectancy, family relations, leisure time and quality of life.

The role of economic analysis, therefore, is to point out to decision-makers this broader view of policy impacts. Policymakers may, for a number of reasons, choose not to consider certain categories of costs and benefits, but they should make those decisions knowingly with all the information that is possible to have.

The state of Utah, like other states, faces crucial decisions in the coming months. This brief provides an economic perspective for thinking about policy options under the ACA, particularly the decision of if and how the state of Utah should expand Medicaid.

The essentials of cost-benefit analysis

What counts?

A vitally important question that the state's policymakers must address is which costs and benefits are going to be considered. The academic terminology for this is determining which costs and benefits have *standing*.[2] Those benefits or costs without standing are ignored, and policymakers may decide—for philosophical, political or pragmatic reasons—not to consider certain categories of costs or benefits that result from Medicaid reform. That decision about standing will shape the appropriate state actions under the ACA.

KEY QUESTION:

To what extent should policymakers consider the large effects of Medicaid expansion that occur off-budget?

Probably the most important question concerns the government role in providing health care coverage for the poor. The

[2] This is different that than the legal use of the word standing, which has to do with whose case can be heard by a court.

analysis in this brief will not address questions about the proper role of government. Instead, the aim here is to identify and evaluate a broad set of policy impacts. These impacts occur both "on-budget" and "off-budget." The on-budget values (those that show up in state budgets that must be balanced) receive far more attention, ***but the off-budget values have far greater impacts on the citizens of the state.***

The net effect of Medicaid expansion on state budgets

Because state and local governments must balance their budgets, a first order of business is to assess the impact of different policy options on those budgets, including both benefits and costs. Federal dollars are used to pay for the costs of enrolling newly eligible people in Medicaid so there is no direct benefit to the state's budget from expansion. However, the state will received some additional revenues associated with the expanded economic activity that the expansion is likely to generate (see the section on "External Effects of Medicaid Expansion)."

The budgetary costs to the state include:

- The cost to the state of covering those who come into the Medicaid program under the expansion even though they are currently eligible but not enrolled (this is the so-called "woodwork" effect).
- The share of Medicaid costs that the state must cover after 2016 when the 100% federal match no longer exists.
- Increased administrative costs not covered by the ACA.

Each state faces a different cost scenario. These differences are driven by many factors, including differences in current Medicaid eligibility levels. State-by-state comparisons conducted by the Kaiser Foundation (Holahan, et al., 2012) show that 40 of the 50 states, including Utah, will face increased costs over the next 10 years. (Adding all 50 states together leads to net positive benefits for the country as a whole, since a few states, such as New York, gain benefits that are sufficiently large to offset the losses in the 40 states that do not benefit.)

The recent PCG (2013) analysis of Medicaid expansion for Utah estimated costs to the state of $158 million beyond the $220 million costs over which the state has no control under the ACA. In the first three years, there are savings, but those costs eventually kick in and grow over time. Over that same 10-year period, PCG estimates that full expansion would provide just over 1 million person-years of Medicaid coverage— ***an annual average cost of only $158 per person per year.***[3]

[3] These costs uses the Scenario 2 numbers from the PCG report. Counties actually have a $1.9 million gain over 10 years due to reductions in public assistance costs, according to PCG.

A partial expansion scenario is quite a bit more costly to the state budget, yet even this option (using similar math) comes out to an annual costs of $745 per person per year.[4]

Of course the federal government (through taxes imposed on Utahns and other Americans) is paying the balance of the costs not included in these numbers The total (federal plus state) costs of the full expansion total approximately $3,200 per person-year. However, Utahns will pay the federal taxes associated with the expansion whether or not the state expands Medicaid.

Another way to assess the magnitude of the budgetary costs is as a percentage of the state budget. When measured this way[5] (assuming a 3% annual increase over FY 2013 levels), full expansion represents an average annual budget increase of 0.26%, and partial expansion to 100% FPL represents a 0.60% increase.

These are not trivial numbers, but compare them to how much average Utahns spend on their health care. Using CMS (2013) data from 2009, state health care expenditures (for all payers) were $4,257 per person. In the same year, employer-provided insurance plans charge an average premium (including both the employer and employee portion) $4,257 for a single policy and $11,869 for a family policy (Schoen, 2010). ***Thus, looking at the state budgetary costs alone, Medicaid expansion seems like a very good bargain.***

These numbers do not tell the full budgetary story, however. Additional good news for the state is that the PCG report estimates that economic growth generated by influx of federal money will lead to $113 million in additional tax revenue for the state and $90 million for county governments. As will be discussed later, there are reasons to be skeptical of those economic development numbers. However, there will likely be some effects on economic development that bring in additional tax revenues. The revenues may not be as high as estimated by PCG, but new tax revenues significantly offset the budgetary outlays projected by the state.

Off-budget impacts

Costs and benefits that are not reflected in the state's budget are highly relevant to the Medicaid expansion decision since cost-benefit analysis should reflect the societal impacts of policy that go beyond questions of financing public expenditures.

[4] Using estimates from Scenario 4. Under Scenario 4, there are an additional 485,552 person-years of coverage at a total cost of $362 million. Costs would be lower using the modeled benefits plan in scenario 5.

[5] This uses the FY 2013 state spending of $5,117,872,000. This number includes the Education Fund, which is not available for Medicaid, but does not include other dollars from the federal government and other sources that are part of state spending. The percentages in the text would be higher using only the General Fund as the denominator and lower using all state expenditures as the denominator.

There are four large categories of benefits that result from Medicaid expansion:

- Direct benefits to the newly insured
- Reduction in uncompensated care provided by the private health care industry
- Health care industry profits
- Economic development
- Positive social externalities

The first of these—direct benefits to the newly uninsured—is discussed in the next section. By any reasonable measure, these benefits are high and vastly exceed the state expenditures necessary to obtain them.

Second, a reduction in uncompensated care is a significant benefit to all of Utah citizens, not just health care providers. The cost of providing that care is reflected in higher health care costs for all Utahns. According to PCG, the gain from full expansion would be $815 million in savings. And because uncompensated care often is the result of uninsured people using expensive emergency rooms when they could more efficiently be treated in a primary care system, there are overall efficiency gains associated with this benefit—in other words, we spend less on health care and we spend it more intelligently.

Third, most of the $3.12 *billion* dollars spent over ten years under a full Medicaid expansion will be realized in the form of revenues to the health care industry in the state. Because that spending will, in part, displace other spending (including spending on health care that is compensated at higher private-market rates), the whole increase in government spending will not be reflected in new revenues. But, a large portion of it will be. Industry costs will increase as well as supply increases, but the new spending will undoubtedly lead to large increases in industry profits.[6]

Fourth, as just noted, the economic benefits that accrue beyond the direct expenditures on Medicaid expansion are hard to estimate. The model used by PCG estimates an economic impact of $2.91 *billion* dollars over the next 10 years. Even if development benefits might be overstated (as discussed later in this report), they are certainly going to occur to some extent. Even a very small multiplier effect of government spending would more than cover the $158 million in budgetary costs.

Fifth, when people have access to health care it affects not only their lives of extended family members and others who are connected to them. Just as health care organizations often provide

[6] Because some shareholders of Utah health care companies live outside of the state, not all of those profits can be counted as benefits to the state.

uncompensated care, friends and family of low-income people often contribute to the expenses of health care. They would, therefore, gain financially as their loved one gained access to insurance. These friends and family might also have caregiving burdens reduced. And just as there is significant "surplus value" (see the next section) that individuals have from health insurance, their loved ones derive similar benefits from that insurance as the stress and worry they feel are reduced. It would be very difficult to come up with a dollar value for these external social benefits, but they are very likely to be higher than the $158 per year budgetary costs.

In sum, the five categories of off-budget benefits coming from expansion are, individually, likely to be significantly higher than the budgetary costs. And when those benefits are added up across categories, they exceed the state's budgetary costs many times over.

However, just as there are non-budgetary *benefits*, there are also non-budgetary *costs* that should give policymakers pause. The non-budgetary costs are felt primarily by the consumers of health care and health insurance. These costs are much harder to forecast and have received almost no attention in the cost-benefit studies of Medicaid expansion, either at the state or federal level.

Important *non-budgetary* costs include:

- Disruption of insurance markets through changing and uncertain risk pools caused by both the mandatory and voluntary changes to Medicaid eligibility
- Denial or delay in medical services for both the Medicaid and non-Medicaid population due to lack of industry capacity
- Denial or delay in medical services for current Medicaid enrollees
- Increase in the price of medical services for the non-Medicaid population[7]
- The lack of state capacity to provide valuable services such as education or law enforcement as state dollars are diverted to Medicaid.

It is important to keep in mind that past experience tells us relatively little about the magnitude of these costs. This is because the large subsidies under the ACA will induce additional spending on health care without any Medicaid expansion. Thus any additional Medicaid expansion that the state undertakes will occur in a health care sector that is already expanding rapidly because of the ACA.

Further analysis of these supply-side issues will be taken up later in this brief.

[7] The decrease in uncompensated care lowers costs to the hospital and, therefore, puts some downward pressure on the price of hospitalization; thus the net effect of Medicaid expansion on hospital prices is ambiguous.

Long term effects

The PCG report covers the next 10 years of costs and benefits.[8] At the end of that period, the costs of Medicaid are rising and will continue to rise after the period is over. The state would not want to adopt a program for short-term benefits if future generations end up paying the costs.

One thing that we know about the future of health care in America is that we do not know very much. The ACA is a vast undertaking that will disrupt every aspect of medical care. Medicare, as well, is rapidly heading towards insolvency, and the federal government is showing no signs of addressing the financial train wreck that is being driven by rising medical costs and a steadily aging population.

The analysis by PCG uses data from the past to estimate linear models used to forecast costs and benefits into the future. The further we go into the future, the less likely those models are to be reliable (this is always the case with forecasting). This inherent uncertainty justifies a cautious approach going forward, especially with respect to decisions that are hard to reverse.

Summary

The focus of the public discussion will continue to be on the costs to the state budget of Medicaid expansion. While those costs are significant, the costs and benefits that occur off-budget (the benefits to enrollees, the reductions in uncompensated care, the economic development, and the disruptions in the markets for health care and health insurance) are potentially much larger in magnitude.

Indeed, from an economic perspective, the impact of Medicaid expansion on the state finances is the smallest part of the Medicaid expansion calculus.

Uncertainties

Thinking broadly about the economic valuation question is essential for good judgment, but a complex decision such as Medicaid expansion cannot appropriately swing on a single number or set of numbers. This is because the complexities and uncertainties are simply too numerous and too large. Some of these complexities include:

[8] Typically, cost-benefit analysis that takes place over several years uses discounting, which down-weights future costs and benefits at an increasing rate. PCG apparently apparently did not discount future values; if they had, the 10-year net costs to the state would be even lower, since most of the costs occur towards the end of the period.

- Goods and services in health care often do not have transparent prices, which makes economic valuation very difficult.
- The effectiveness of health care is inherently highly variable and uncertain across different populations within the state.
- The costs to industry of meeting increased demand are uncertain, and those costs are likely to have vary geographically within the state.
- The capacity of the different state health care systems to respond to the ACA (whether or not Medicaid expansion occurs) is a vital but unknown variable.
- The impact of the ACA on the health insurance market is very difficult to predict. The new health insurance exchanges and the new regulations regarding insurance coverage may significantly influence the price and availability of different insurance options for all the state residents (including, but not limited to, those eligible for Medicaid).
- Rules and guidelines for state policies under the ACA are still to be determined in many cases, as is the willingness of the federal government to allow state-designed alternatives to Medicaid expansion.
- Estimated behavioral models are based largely on behavior of people in the past, but people will be making decisions in a new and rapidly changing environment.
- The economic development gains through spending "multipliers" are highly ambiguous and difficult to quantify.

Wise decision-making requires identifying as many of the costs and benefits associated with each policy alternative and then identifying the policy option with the greatest net benefit to the state and its citizens. Because of the complexities and uncertainties involved, this remains a very challenging decision for the state.

Unintended consequences

Some of the unintended consequences of the PPACA, including a potential Medicaid expansion, will undoubtedly be positive and some negative. ***Information on the consequences of ACA is a very valuable commodity****.*

An important question that policymakers must ask is what can we do to learn more? Learning can come from additional study and by observing what is happening in other states. Learning can also come from implementation (either in full or in part).

Any honest evaluation of the ACA will conclude that it will have enormous consequences on the health care and health insurance industries in America and in Utah. Some of those consequences are intended, since the purpose of the ACA is to significantly expand health care coverage, which will necessitate a significant expansion of the health care industry. And since we all are consumers in those industries at some point in our lives, it will have very large effects on all of us. Any far-reaching, complicated set of policies such as the ACA will have significant consequences that no one yet appreciates. Over time, we will surely look back on these decisions with amazement at what we did not know but thought we did.

Decision-makers at both the state and the federal level are, therefore, wise to be very cautious and even humble about the effects of this monumental Act. When making decisions in a high stakes environment with multiple uncertainties, the ability to learn, to re-evaluate, and to change course is very desirable. This risky environment does not mean we should fail to make choices, but the citizens of the state will be best served by their leaders maintaining a very watchful eye—both at what is happening in the state and what is happening elsewhere—as implementation of the ACA presses forward.

KEY QUESTION:

Do the benefits of waiting and observing outweigh the benefits of immediate action?

Moral, legal, and political considerations

Fundamentally, the decision on if and how to expand Medicaid in the state has to do with important moral and political questions related to the proper role and scope of government. The arguments in this brief are focused on broad perspectives that go beyond narrow budgetary matters, but the economic arguments here do not address the important moral dimensions of this debate.

Furthermore, many Utahns would like to persuade the federal government—either through legislation or administrative action—to grant unto Utah the power to craft new solutions that are not explicitly authorized by the ACA. The analysis in this brief discusses aspects of these policy options, and it is possibly in the state's interest to pursue an alternative approach to using expansion dollars. However, this brief does not address the likelihood that particular proposals will be approved by the federal government or the legal questions of what type of authority the

federal government may or may not have to grant Utah authorization to pursue its preferred course of action.

This brief does also not address the political considerations that policymakers in the state may have, including the electoral consequences of Medicaid expansion for policymakers. Such considerations are certainly paramount for elected officials, but they have little to do with applying economic principles to this decision.

Health Economics and the ACA

The demand for health care services springs from the underlying value people place on good health, and people across the world consistently rank health and their family as the most important things in life (Spogard & James, 1999). The portion of GDP spent on health care has risen considerably over recent decades. The burden that the high costs of health care places on low income people is particularly relevant to the Medicaid expansion issue.

Income and the demand for health insurance & medical care

Though supply side factors get more attention, a fundamental reason that health care expenditures have risen is because real per capita income has risen. We spend so much on health care largely because we are such a prosperous country.[9] An increase in the demand for health care raises not only the total expenditures, but the price of health care services as well.

The income of the poor in America has not, however, increased significantly in recent decades; it has stagnated, as have incomes in the middle of the distribution. Most of the increase in income in recent decades has accrued to people with high education in the top part of the distribution. Yet the poor have had to face the same price increase in medical care as higher income people. When the price of health care goes up but income does not, people consume less health care.

To say that the poverty reduces the demand for health care does not mean that the poor do not have the need for health care. In fact, the health of the poor is worse, holding other factors

[9] It should be remembered of course that several other prosperous countries provide universal health care to its citizens at a much lower cost.

constant, than the health of higher income individuals.[10] Poor health (along with income), also raises the demand for care, which pushes up prices and expenditures.

The group with the greatest demand for health care is the elderly. And even though the elderly have access to Medicare in addition to Medicaid, the aging of the population puts more stress on our health care system, and the increase in health care demand due to population aging will also put upward pressure on prices as well.

In short, even as the nation has grown more prosperous and new medical technologies have improved the lives of many Americans**, *the poor have been put in an increasingly precarious position when it comes to health care*.** The combination of low income, poor health, population aging, the rising price of medical care, and a frequent lack of employer-provided insurance implies an increasingly important role for public health insurance programs, such as Medicaid and CHIP.

The ACA will make health care more affordable for many low-income people, with or without expansion of Medicaid. Those with incomes over 100% of the federal poverty level will have access to subsidies to buy insurance in the new health exchanges. Other mandated expansions to Medicaid will increase insurance coverage to many people with or without the optional Medical expansion now being considered. But without Medicaid expansion to at least 100% of FPL, some of the poorest Utahns will go without health insurance coverage for the foreseeable future.

The surplus value of health insurance

We often use expenditures as short-hand for the economic value of goods and services in the economy. However, expenditures on health insurance (or any other good), tell us only part of the story about the value of health care. The total economic benefit to the consumer is the *expenditure plus the consumer surplus.*

What is consumer surplus? It is the amount of money that consumers would be willing to spend on a good or service beyond what the market requires them to pay. Imagine if you needed health care and you didn't have insurance, how much would you be willing to pay? Probably far beyond what you are actually expected to pay. That difference between the willingness to pay for a good and the actual market prices is consumer surplus.

Even though our nation spends a lot on health care, the total economic benefit of health care spending dwarfs the amount we actually spend because the consumer surplus associated with health care is very high. This is seen by the fact that even as prices rise, people are not willing to

[10] Many, many studies document the different the relationship between socioeconomic status and health. For a recent review, see Williams, et al. (2010).

spend much less on health care.[11] The same is true for health insurance. Insurance is worth far more to consumers than they have to pay for it.

Recently published research by economists Krueger and Kuziemko (2013) evaluates the consumer surplus associated with the demand for health insurance among uninsured Americans. They find that among low-income individuals, the consumer surplus associated with being covered by Medicaid is, on average, $1,900 a year (this is a US average; Utah's will be different). If we take this number and multiply it by the 1 million person-years of insurance, full Medicaid expansion will generate an estimated $1.9 billion in consumer surplus (assuming the Utah average reasonably approximates the US average).

But this amount, high as it is, is a lower-bound estimate of the value because it measures what the poor would be willing to pay *given their low income.* Consumer demand (another term for which is "willingness-to-pay") generally rises with income. What we need to think about is this: How much would health insurance be worth to Utah's low-income population *if they were not poor?*

KEY QUESTION:

Are the large non-budgetary benefits of health insurance adequately considered in the decision-making process?

To illustrate how high these numbers would be, consider that annual, per-capita spending on health insurance in the state of Utah is around $5,000. That amount includes only how much Utahns *have* to pay, not how much they are *willing* to pay. How much *more* would average Utahns be willing to pay to keep their insurance than they currently pay? $2,000? $5,000? $10,000?

We don't know the answer to that question so can only make educated guesses, but the sum of expenditures and surplus value for insurance could easily be over $10,000 per person, on average. Applying values of that magnitude to the person-years served by a Utah Medicaid expansion and the annual direct benefits of insurance is several billion dollars at least, perhaps tens of billions.[12]

In sum, the strongest economic argument for Medicaid expansion is that the total benefit of health insurance to the poor is very high. Indeed, it is many, many times the budgetary expense to the state.

[11] This is what economists call *price-inelastic demand.* When demand is inelastic, the consumer surplus will usually be much higher than the amount actually spent.

[12] It is only possible here to speak in these very rough terms given lack of data, but the point is that any reasonable "ball-park" estimate is going to be in the billions of dollars.

A very important question, however, is that if low-income people who would have Medicaid or other insurance plan under a full expansion would be willing to pay an average of $1,900 (or a similar amount) per year, why are they not being asked to pay for more for those benefits? Increases in cost-sharing or small annual premiums for Medicaid could easily generate sufficient funds to completely cover the costs to the state, as well as reducing Medicaid expenditures, but these changes are not allowed under current Medicaid rules.

A cautionary note is in order here, however. To say that low-income people could pay more under than they are asked to under the ACA does not mean that they have pots of unspent money lying around that they could use for health care. Spending more on health care means spending less on something else. Policies need to be designed that keep in mind what that "something else" is. Too much cost-sharing would clearly price people out of the market and defeat the purpose of extending them coverage in the first place.

The structure of Medicaid, in which cost-sharing rules are seen as a "protection" (to use the term favored by advocates for the poor) actually work against the long-term interests of the low-income population. Were the federal government to allow Medicaid programs with more significant consumer incentives (through either premiums or greater cost sharing), the costs to states of expansion could be reduced or even eliminated.

In short, well-intentioned efforts to shield the poor from responsibility for their health care decisions ends up hurting their interests as states opt out of coverage whose benefits are far greater than the costs would be.

How do we best assist the poor?

Insurance is not necessarily the asset most needed by the poor. Recent results on the Medicaid experiment in Oregon show that Medicaid participation lowers economic hardship by reducing out- of-pocket medical expenses while at the same time increasing the amount of medical care services received. However, the estimated *health* benefits from Medicaid participation are small and generally statistically insignificant.[13]

Do the Oregon findings contract the claim made earlier that the total economic benefits of Medicaid participation are high? No. Consumer surplus captures all the benefits that people perceive (and would be willing to pay for), not just the realized health benefits. Participation in insurance brings peace of mind, financial assistance with expenses that would otherwise be

[13] Meaning it is not possible to be confident that the differences are real and not just do to random errors within the sample.

covered out of pocket, and possibly many other benefits that have value to people beyond objective health benefits. The question becomes, then, whether the government (state or federal) should pay for the non-health benefits that come from program coverage.

Economists have long argued that the most efficient way (meaning the way with the highest total economic value) to help the poor is to provide them with more income and ways to build wealth, not to purchase goods and services that they may not need or that may do them little good. Policies such as the Earned Income Tax Credit, for instance, are highly favored by economists because they incentivize work, are designed to put money in the hands of the working poor, and they let individuals use those assets in the way that individuals—not government—deem to be most valuable.

Nonetheless, even though one can make plausible arguments that the entire thrust of federal social insurance programs are misguided, Utahns do not have the power any time soon to change those programs. Policymakers may decide, for a variety of reasons, to leave those federal dollars lying on the table unused, but they should not do so based on a rationale that the expected benefits of expansion do not justify the expected costs. ***If we put all the relevant costs and benefits on the table—meaning everyone's benefits and everyone's costs are given standing—the benefits to Utahns of using the federal dollars over the next decade vastly outweigh the costs.***

Incentives in health care and insurance markets

The economic approach to public policy problems is founded in a very basic notion: people respond to incentives. Patients, providers, insurers, legislators, and bureaucrats all face constraints that shape the choices they make. Successful policy reformers will consider how a new policy regime alters incentives and, therefore, behavior.

Incentives in the American health care system are profoundly shaped by both government regulations and health care markets. Governments issue rules and regulations which shape the health care system, but health care markets are a powerful disciplining force as well. Reformers differ in the extent they seek to effect change through government regulations and government expenditures on health care services. The ACA has a variety of "market-based" solutions, but it is primarily a collection of government mandates, taxes, subsidies and expenditures.

Crowding out and the capacity of Utah's health care markets

The economic efficiency mentioned above, however, is not the only goal of government. Governments often engage in the direct purchase of goods and services to assist low income people because they want to insure that particular items are purchased, such as food or health care.

When governments purchase items in a market, the increase in demand will tend to cause upward pressure on prices, which *crowds out* spending in the private market, making those people and those who sell to them worse off. Some markets can easily accommodate spending by government without causing much crowding out. But some markets are characterized by short term capacity constraints, and in that case the government spending can crowd out spending by private individuals.[14]

A large missing piece of the detailed studies on Medicaid expansion to date is that they have virtually nothing to say about the supply side of the health care industry. But the question of the capacity of the industry to absorb new Medicaid enrollees is just as important as the demand for services. Will there be the doctors and nurses to provide care, especially given existing shortages of providers in some locations? And, more important, what will happen to the situation in Utah as the demand for providers (as well as hospital care) increases due to the ACA. Where will this capacity come from? What tools are at the disposable of government to create the capacity needed to meet the increasing demand?

Because the health care industry contains so many players, it is hard to understand the overall capacity constraints in the industry. A recent workforce study (Koduri, 2012) of the Utah physician market showed that our current capacity is adequate, but there are warning signs for the future. There are only 178 patient care physicians per 100,000 people, which is below the 290 recommended by the Council on Graduate Medical Education and less than the 319 average in the US (Heisler, 2013). Because it has a younger population than the rest of the country, Utah needs fewer physicians per capita, but currently 50% or more of all primary care specialists report full or nearly full practices.

According to the workforce study, Utah has a need of 332 physicians each year, but Utah trains only 95 physicians in the state. Will Utah continue to attract physicians from out of state as demand for physicians increases nationwide because of the ACA? Evidence suggests that America will experience a growing shortage of physicians in the coming decade (AAMC, 2013). The

[14] In economic lingo, when the short run supply curve for a good or service is relatively steep (or inelastic), then government spending will lead to significant crowding out.

American Association of Family Physicians claim that there could be a shortage of 40,000 primary care phycisians by 2020. A study by the Lewin Group estimates that under the ACA there will be a shortage of 91,500 physicians nationwide by 2020.[15]

KEY QUESTION:

Is there capacity in the state health care sector to accommodate Medicaid expansion, especially considering other market disruptions due to the ACA?

Shortages of providers lead to reductions in the quality of care. Nationwide the workload for primary care practitioners (including nurse practitioners and physician's assistants) will increase 29% from 2005 to 2025, but the number of practitioners will increase by only 2%--and that is without considering the impact of the ACA! (Kaisi, 2012). Newly insured Medicaid enrollees are more likely than uninsured Medicaid enrollees to seek care, and gaining Medicaid coverage is associated with a 35% increase in the likelihood of having an outpatient visit (Kaisi, 2012). Reductions in access to quality of care lead, for instance, to more hospitalizations, including increased use of emergency rooms.[16] Certainly the shortages of providers will also be felt as shortages are felt in any market: more difficulty finding assistance, longer waiting times, shorter times being seen by the provider, and higher prices as the market adjusts to these supply pressures.[17]

Furthermore, Utah is not one big health care market. The markets in rural communities, for instance, are very different than in urban areas. Because poverty tends to be geographically concentrated, the effects of Medicaid expansion will hinge on the availability of markets to provide services across the state. There are regions of poverty in both urban and rural areas. And because the profit-making opportunities are lower in those regions, the ability of low-income people to find providers will be shaped by the geographic constraints involved with health care provision. The poor often have difficulties travelling and seeking health care outside of their communities; this is especially true of the disabled population.

[15] Some (Green LV, et al., 2013) argue that physician shortages could be eliminated by structural reform to the industry, including using more nonphysicians and through electronic communications. These types of reforms will likely be the result of responses to shortages, but they will take considerable time to implement, whereas the increase in demand happens rapidly.

[16] See, for example, the studies by Bindman. et al. (1995) and Hurley, et al. (1988).

[17] The supply of other health care workers and other inputs are important concerns as well. See Ruttinger (2012) for a recent evaluation of the market for nurses.

When demand expands—for whatever reason, be it population growth, population aging, income growth, or increased government expenditures—that additional demand meets a supply response. When demand increases gradually and predictably, supply can keep up so the market is not disrupted. But when demand increases rapidly, five things happen, more or less in sequence:

- First: excess capacity is used up—this is the *win-win* part, but it does not last forever, and it is limited and localized.
- Second: shortages, delays and lack of availability develop
- Third: Providers and patients respond to those signals; the most important effect is an increase in health care prices
- Fourth: The capacity of the industry begins to expand in response to the above changes; this occurs relatively slowly.
- Fifth: Policies change in response to the industry effects; these changes induce additional market effects.

Although the expansion of markets can have positive effects (namely, more health care for more people), the expansion is not painless. The worst part of this story is that the poor are usually the least able to compete in this expanding market. For instance, those with greater resources are able to travel, comparison shop, and find better options. The economically advantaged also have health care plans that are far more advantageous for providers; ***thus, expanding demand may lead to more providers unwilling to participate in Medicaid, CHIP and other programs where profits are lower than in treating those with private plans purchased on the exchanges.***

The expansion of demand associated with Medicaid expansion would, however, lead to greater certainty among consumers and providers about the ability of low-income persons to pay for health care. This may induce some providers to feel more confident about expanding.

Any optional expansion of Medicaid will come on top of other increases in demand spurred by the mandatory parts of Medicaid expansion and, especially, by increased commercial insurance coverage through the health insurance exchanges. Expanding Medicaid has the advantage of moving people into health care networks that will improve efficiency by limiting the hospitalizations and adverse health outcomes associated with lack of access to primary care. But expansion will also put over 100,000 people per year into a primary care system that is facing large and increasing shortages of providers. The net effect of those two offsetting effects is not known. However, the costs of these market disruptions will be felt by everyone participating in the market, most notably by the low and middle income population.

Insurance

Expansion of Medicaid will have effects felt in the private insurance market. Full expansion of Medicaid will have the largest repercussions since those between 100 and 138% of poverty would be eligible for Medicaid even though they could also obtain subsidies to participate in the health insurance exchanges. A partial expansion to 100% FPL will have only small effects, since those people cannot receive subsidies to participate in the insurance exchanges.

KEY QUESTION:

Will Utah's recent implementation of the ACO framework for Medicaid be successful in reducing the growth of Medicaid costs?

Insurance companies naturally want to keep healthy people enrolled as much as possible, allowing them to expand coverage and limit the growth from premiums. The impact of Medicaid expansion, therefore, depends critically on how healthy, low-risk people will behave. Keeping those people in private coverage rather than in Medicaid benefits insurers and those who buy insurance on the private market.

What is often lost in the discussion of insurance markets is that lower and middle income people have the most to lose from rising insurance premiums. Higher income people are more likely to have employer-provided plans and can better afford insurance in the private market. Thus, expansion of Medicaid, to the extent that it draws lower-risk people out of the private market, ends up hurting those people who are low income but do not qualify for Medicaid.

Incentivizing Efficiency

An important innovation in the Utah Medicaid program involves the movement towards a model of provision referred to as the Accountable Care Organization (ACO). An ACO pays for care on a per-capita basis, rather than on a fee-for-service basis. This gives providers an incentive to better manage care as they treat the whole patient, rather than responding to episodes of poor health.

This reform effort is part of a drive to create greater efficiency (getting the best care for the buck) from the health care system. Berwick and Hackbarth (2012) estimate that 34% of all health expenditures in the US are wasted, and some of that wasted care actually harms patients. The ACO movement is an example of how reform can better align incentives with policy.

Even before the advent of Medicaid and Medicare, health economists pointed to the third-party compensation of care as a significant obstacle to economic efficiency. When a third party pays for

care—be it government or private insurance—neither the provider or the patient has the incentives to limit care to an amount that is cost-effective. Similarly, when providers own a stake in for-profit hospitals and other medical facilities, they face incentives to over-treat, which raises costs.

The other side of the over-treatment equation is consumer behavior. High deductible plans in combination with health savings accounts (HSAs) lower spending on health care for two reasons:

- First, consumers have the incentive to lower their spending either by shopping around for the best price and by consuming less
- Second, this consumer-driven effort spurs competition between providers, thereby lowering health care prices.

Patients become more informed and more involved in their health care when they face a significant incentive to do so. An important reason why health care costs have been slowing in recent years is that high deductible plans are causing more care to be paid out of pocket (Rae, Panchal & Claxtonm, 2012). The private market is bending the cost curve because consumers with those plans have strong incentives to push for cost-effective care (Douthat, 2013).

Over-treatment in America not only costs billions of dollars annually but actually lowers health outcomes, especially in the case of ineffective and harmful end of life care.[18] That is especially an issue for Medicare reform, but overtreatment occurs in the Medicaid population as well.

Managed care (of which ACOs are one example) creates incentives for providers to keep costs down. Consumer-driven health care, such as an HSA combined with a high-deductible plan, promotes economic efficiency in the following ways:

- It lowers insurance premiums, making insurance more affordable for employers and consumers
- It incentivizes consumers to be proactive and cost-conscious about their medical care, which creates downward pressure on health care prices
- It promotes transparency in health care prices and billing
- It provides a means of accumulating financial assets

Managed care and consumer incentives are two approaches to the overtreatment problem, though it still remains a largely unexplored puzzle of how to incentivize both providers and

[18] See Brownlee (2008) and Welch (2012) for excellent book-length treatments of the over-treatment problem.

patients *at the same time.* The Medicaid ACO approach adopted by Utah significant realigns provider incentives, but Medicaid has much less power to alter consumer decisions.

Advocates for the poor seek to minimize the cost-sharing required from Medicaid participants, and the ACA does little, in general, to incentivize consumers, especially in the Medicaid population. Furthermore, the federal government gives states little flexibility to alter benefits or create incentives among the Medicaid population to seek cost-effective care, though states generally have more flexibility with respect to provider compensation strategies and in the organization of health care systems (such as ACOs).

What can be done to incentivize patients in Medicaid? At the outset, it should be noted that the "catastrophic coverage" that high-deductible plans provide are less relevant for the very poor. ***This is because they are already in a catastrophic situation, namely poverty.***

However, there is room to build in greater cost-sharing into Medicaid. The Krueger and Kuziemko (2012) study mentioned earlier suggest that under the ACA, low income people have a willingness-to-pay of $1,900 per year for health insurance. Of course that amount varies within the low-income group and very little could be expected from the poorest citizens. Furthermore, one thing that the Oregon study (Backer, et al., 2013) of Medicaid showed is that those without Medicaid paid $215 dollars more in out-of-pocket spending, and the percentages borrowing money to pay bills increased as well. These numbers are interpreted by advocates as increased financial hardship, which is surely the case. But they also reflect capacity to pay.

Utah already operates the Medicaid Work Incentive program, which has small premiums that are paid on a sliding scale. This program is for those people with disability who do not qualify for free Medicaid services because their income and/or assets are too high. But insurance premiums (while helping to make the program lest costly to the state) do not create incentives for efficiency because they do not alter the link between health care choices and cost to the consumer. In a premium-based program, fee-for-service program, neither providers nor consumers have the incentive to hold down health care spending.

HSA-style plans in Medicaid have been tried in one state: Indiana. Enrollees have a "power account" that is used for health care, much like a health savings account. The state makes contributions to this plan, and the enrollee contributes to the account as well, on a sliding-scale. Enrollees who follow program rules can rollover their power account from year-to-year, so it will be available for expenses in future years.

In summary, consumer incentives to increase the efficiency of health care are largely absent from Medicaid. The Medicaid population is not in the economic position to pay high amounts of money for out-of-pocket medical expenses, but small incentives may generate efficiency gains in a system that is great need of more efficiency.

The probability of Utah getting federal approval for an Indiana-style plan for Medicaid is uncertain, especially given the Obama Administration's general hostility to increasing efficiency through consumer incentives. However, this period where many states are pushing for federal cooperation may be a policy window for consumer-based reforms to gain some traction. ***Just as Utah has been innovative in designing free-market insurance exchanges, the state could continue to show innovation in consumer-based reforms within Medicaid.***

KEY QUESTION:

What can be done to further incentivize cost-effective behavior by Medicaid enrollees, and what ideas will the federal government endorse under an alternative Medicaid expansion plan?

Transparency

The above discussion refers repeatedly to health care markets and the forces that operate in those markets, namely the parties involved responding to incentives. When markets function well, they provide a method of disciplining behavior that does not require government regulation. If, for instance, providers charge too much, patients go to lower-cost providers.

But health care markets are failing in America in very basic ways. The most basic market failure is the lack of transparent prices. A consumer pays for services often without knowing (or being able to find out) what the price for the services are. The providers themselves often do not know. Additionally, the amount billed for services will be one amount for the patient, another amount for insurance company, and yet another amount for government payers.

In addition to obstructing market efficiency, the current system of payer-dependent pricing constitutes one of the grossest inequities in the health care system. People with health insurance, including government insurance, have negotiating power when it comes to price. People with no insurance have very little power. Those without insurance who pay the "list price" for various medical services end up subsidizing those with insurance who pay a discounted price**.** There are, to be sure, large inefficiencies in Medicaid, but at least it is not a system in which the poor

subsidize the rich in the acquisition of health care. Medicaid expansion is a step towards reversing this severe inequity as the poor gain the protection of the government's negotiating power.[19]

The market for health insurance is similarly opaque. People are aware of their premiums, but coverage details are often very murky. It can be hard for individuals to compare prices because the differences between plans can be very hard to determine, even with considerable effort.

In short, when prices are not transparent, price competition does not have the disciplinary effect that it can have in a competitive market. Whether the competitive price pressures hoped for in the exchanges largely remains to be seen. The lack of price transparency makes it very difficult to predict or evaluate the effects of policy changes such as expanding Medicaid. We can talk in general terms about the market effects, but transparency failures make it difficult to assign any magnitudes to those changes.

Why do health care markets struggle with price transparency? There is an inherent complexity in health care (everyone person is different, for starters) that is partially to blame, though many industries with complex services have transparent prices. Historically, posting prices on health care seemed unseemly and unprofessional to some (though those norms are changing). But the lack of competitive pressure is certainly a large part of the problem. When insurers and providers face little competition, they see little need to make pricing transparent. When consumers have the bulk of their costs financed by a third-party, they have little desire to know the true prices of the services they receive.

But the most important explanation of our current system is the following: **in general, when prices are not transparent in any industry, it is because those earning profits in the industry are benefitting from the lack of transparency.**

Distributional Consequences of Medicaid Expansion

An important aspect of the valuation question is asking how the benefits are distributed across different groups of people in the state. Will the benefits go to those who need them most?

In the past, public insurance programs have targeted populations thought to be particularly vulnerable and deserving of health, such as children and pregnant women. Over time eligibility

[19] This is not to say that Medicaid prices are appropriately determined. Providers complain compensation is too low, but without a functioning market to determine what the price should be in a competitive system, it is hard to say whether a government-mandated prices is too low or too high.

has expanded to other groups, though not to the same extent in Utah as in other states. The ACA makes some changes to Medicaid that are not optional for the state to follow, and the new insurance exchanges will provide subsidies for some low income people.

The benefits of Medicaid expansion are real, but they may go to categories of people that citizens in the state would choose not to assist. These might include:

- People who have access to employer-provided plans but choose not to purchase it because Medicaid is cheaper
- People who would qualify to buy insurance on the new federal insurance exchange
- People with high financial assets but temporarily low income
- College students who have access to insurance through parents or other relatives
- The able-bodied who are not actively seeking employment

No eligibility framework is going to perfectly identify those who are most in need of assistance. The additional features of the ACA (such as elimination of the asset test) provide coverage for new groups of people who the Utah Legislature in the past has chosen *not* to cover with Medicaid. Newly eligible enrollees will have costs covered by the federal government, but the coverage rate for that group will decline over time, shifting the costs back to the state.

Given the US Supreme Court ruling that states have the option to expand Medicaid but not to forego participation in an insurance exchanges, the resulting package of benefits leaves a strange and unanticipated hole in coverage. Those families who have earnings above the 100% of FPL level in poverty will qualify for subsidies to participate in the exchanges. But those currently ineligible individuals just below 100% cannot get subsidies and, unless the state expands Medicaid, will remain without insurance.

KEY QUESTION:

The Supreme Court ruling on the ACA allows significant benefits to be extended to many while leaving some of the poorest citizens uncovered. Should the state try to remedy this inequity?

In other words, those who are able to climb above the poverty line can get significant federal assistance to purchase health insurance, while ***those who fall just below the poverty line (or lower) get no assistance unless they are in one of the covered groups.*** This perverse outcome was a result of the 2012 Supreme Court rule on the ACA. Although Utah lawmakers are not

responsible for this feature, this result in which the worst-off adults are denied coverage while better off individuals have access to subsidies is a severe inequity that the state should consider in deciding how much to expand Medicaid.

This unanticipated hole in coverage presents an option for states that the ACA did not anticipate: covering individuals up to 100% of the FPL but no further. This would effectively generate coverage options for all of the poor. However, this option would come at significant cost to the state since the 100% match rate would not be available for any of the newly eligible people. Some states are considering the option of expanding Medicaid only up to the poverty line, but most states who are expanding at all are choosing full expansion to 138%, since a failure to do so forgoes significant dollars from the federal government. These alternative scenarios are analyzed in the PCG report.

External Effects of Medicaid Expansion

The idea of an economic multiplier is that spending by government spurs additional spending in the economy. In general, Person A uses government dollars to buy something from Person B, who buys something from Person C, and so on. According to this view, one dollar of government spending can be multiplied into several dollars of economic value, since persons A, B, and C all receive additional monies that they wouldn't receive otherwise.

The estimation of multipliers is complicated and controversial. The meaning of multipliers depends on their estimated value as follows:

- **A multiplier greater than 1** means a dollar of government spending generates economic output beyond the dollar spent.
- **A multiplier equal to 1** means that there is no net increases in economic output beyond the dollar spent by government.
- **A multiplier less than 1** means that government spending actually causes private economic activity to contract.

In the case of Medicaid expansion, it is also important to know the source of the government expenditures. When federal dollars are spent in the state, it is possible that a multiplier of less than 1 will still have positive effects *in the state of Utah*. This is because the federal expenditures are not linked to the federal taxes levied on state residents. Dollars spent from state funds will have a lower multiplier, since those expenditures come at the expense of other uses (either by taxpayers or by other state government programs). It is possible that state-financed expenditures

can actually cause economic activity to contract, since government spending always distorts markets. State spending on Medicaid may also crowd out state spending on other government programs, though that is an effect not typically associated with multipliers.

Is this multiplier real, or is it an economic myth? The better question is under what economic conditions could we see economic multipliers that would generate economic benefits.

Multipliers under "perfect competition"

Economic textbooks typically describe a situation characterized by *perfect competition*. This is the world where markets work perfectly to determine prices at which shortages and surpluses do not exist and productive resources do not lie idle. The No Free Lunch Principle applies with a vengeance. There are no multipliers greater than 1 in this world.

Spending by government under perfect competition also causes crowding out, as discussed earlier. When demand is subsidized in a competitive health care market, prices will rise. This crowds out private spending, which includes both care paid for by insurers and care paid for out-of-pocket by individuals. Private dollars crowded out by government spending may be spent on other goods and services, but those will have (at least slightly) lower values, since consumer dollars are being pushed from their most preferred use to less valued uses with no compensatory increases in income.

Consider what happens in this perfect competition world when new federal dollars are spent on Medicaid. The increased funds will cause additional people to seek medical care. What happens then? The provider who sees a new beneficiary either sees one less patient, spends less time with other patients (thereby reducing their quality of care) or spends more time than she would like to working in total. In each case, there is a negative feedback associated with the new spending. When markets are functioning, Medicaid expenditures go towards resources that have other productive uses. The same is true when those paid for their services use the dollars to purchase additional goods and services.

Multipliers in imperfect markets

The real world, of course, has many market imperfections. People are unemployed or are working fewer hours than they want to at prevailing wages; equipment lies idle; supplies are purchased which end up not being used; people realize that they underestimated or overestimated how much they value something once they experience it. When markets are not functioning well, prices and quantities do not adjust as the simple perfect competition model predicts. The more that resources are idle or poorly used, the greater is the potential for government spending to

have multiplier effects. The more that spending pushes resources into more productive uses, the greater the multiplier will be.

In a recession, the size of the multiplier is difficult to determine. On one hand, economically distressed locations are especially prone to large multipliers because there are many idle resources that could potentially be utilized. On the other hand, during a recession people and business are often reticent to spend, particularly out of income that is seen as temporary. After the recent financial crisis and resulting recession, individuals increased their savings rate and business stockpiled cash rather than increasing investing or hiring.

As an example, if increased health care spending leads to greater need for medical facilities, then construction resources need to be employed to expand the capacity of facilities. If there are a underutilized resources in the construction industry, then the new demand spurs new economic activity. If the construction industry is already robust, on the other hand, the new demand will mostly displace other uses, often by pushing up prices, and the multiplier will be small.

In robust markets, new government spending will mostly crowd out private spending and the multipliers will be small. If the spending is financed by state tax dollars, the net effect of the government spending can even be less than zero—the benefits minus the crowding are not even high enough to cover the taxes used to finance the spending.

Economic differences across the state are also important. For instance, new spending in communities that have high unemployment will have greater effects than new spending in communities with low unemployment. The same applies to non-labor resources. Thus, an issue for decision-makers to consider is how the Medicaid expenditures will affect different parts of the state. Some local economies may be helped much less than others.

Does Utah have a lot of excess capacity in health care? We considered this question earlier when considering the direct effects of increased Medicaid spending. But the capacity question also affects the value of the multiplier. Many of the dollars spent on health care providers and in health care facilities will then affect related industries, such as medical equipment, supplies, technical support and pharmaceuticals. If those related industries have significant excess capacity, then the multiplier will be significant.

Estimation of multipliers

Under the best of circumstances, the estimation of multipliers is extremely challenging. The theory of the multiplier is that spending ripples out from the original source. All those potential ripples are very hard to estimate for at least three important reasons:

- It is very hard to control for everything else that happens within an economy in addition to the new government spending. (The missing variables problem)
- It is very hard to know what would have happened had the spending not occurred. (The unknown counterfactual problem)
- It is very hard to know that a model whose parameters were estimated in the past will apply to a different economy in the future. (The external validity problem)

Multiplier models tend to track the increases in expenditures that follow after an increase in government expenditures, but they tend to miss the opportunity costs associated with those expenditures. Thus, the increase in measured expenditures will overstate the net effects. For instance, if a health-care worker increases his hours from 20-30 per week, those additional hours are now being used more productively, but the previous value of those 10 hours was not zero. People place value on their non-working time for a number of reasons. To accurately assess the value of the multiplier, it is important to count both the wage paid for those additional 10 hours of work but also to subtract out the second best use of that time. Because those alternative uses are often not traded in markets, they can be left out of multiplier estimation.

Models used to calculate the effects of government spending are not un-sophisticated. However, many economists put little stock in estimates of multipliers for the reasons mentioned above. Just as many economists reject Keynesian fiscal multipliers for the national economy, they reject state or regional multipliers are suspect for many of the same reasons. In the end, high multipliers are trying to convince people that a basic message of economics is not true, namely that there is no free lunch—that every resource used for one purpose is a resource taken from another. Higher multiplier estimates suggest lots of free lunches lying around just ready to be picked up if government would only start the spending cycle.

Families USA and the Utah Health Policy Project (2013) estimate that if Utah takes up Medicaid expansion in 2014 there will be $365 million spent on health care and an additional $670 million in additional economic activity spent on additional spending, suggesting a multiplier of close to 3. The PCG analysis concludes that, when combing the mandatory and optional aspects of Medicaid expansion will turn $3.89 billion in Medicaid service costs into an additional $3.42 billion in additional economic benefits. This corresponds to a multiplier of a little less than 2. Both these estimates are high and indicate significant benefits to the state in terms of jobs and economic activity. As in any economy, the resources of the state are not being fully utilized, and additional spending on Medicaid would likely generate economic activity that would not be there otherwise.

The discussion here is highly skeptical of multipliers of this magnitude. But in a full cost-benefit framework where the *direct* benefits of spending on health insurance is so high, these *indirect*

benefits are hardly needed to tip the balance in favor of Medicaid expansion. Only in the world where health insurance for the poor is not given standing in the cost-benefit calculus would these economic benefits be an important part of the story.

Concluding Comments

The goal of this brief is to encourage policymakers to think broadly about the entire range of costs and benefits associated with potential Medicaid expansion rather than limiting the question to one of making the state's budget balance. Since lawmakers control both the revenue and expenditure sides of the state budget, how to make the budget balance is fundamentally a political question, not an economic one.

There are *very* large benefits to the state's citizens from Medicaid expansion. According to the PCG report, the reduction in the cost of uncompensated care alone is much greater than the budgetary costs to the state. And when we add in economic benefits (including greater tax revenues) generated by billions of dollars of additional federal dollars coming into the state and—most important—the billions of dollars (perhaps tens of billions) in direct benefits to the uninsured over the next 10 years, the budgetary costs of expansion ($158 million, according to the PCG analysis) seem very small.

Still, there is no such thing as a free lunch. Every dollar granted to one person comes from someone, somewhere, and each of those dollars spent for one purpose are dollars not spent on something else. Similarly, every hour of time from providers or program administrators is an hour not used for other purposes, and every depletable capital resource (such as medications or other medical treatments) devoted to one use is a resource not available for another use.

Even as the ACA significant expands options for the poor to gain health insurance and health care, our low-income citizens will be the ones who pay the costs of the market disruptions sure to come as the ACA expands health care demand—shortages of providers, higher insurance premiums, higher health care costs, etc. Medicaid expansion will likely make all of these supply-side problems worse. There is no evidence that the economic impact of those effects are greater than (or even close to) the benefits, but they are still worthy of consideration.

Many Utahns are concerned, with good reason, that the promises of the ACA are not sustainable. There are some cost-control efforts in the ACA on the provider side which may bear fruit, but the ACA is mostly about pumping massive quantities of money into the demand side of health care and health insurance markets with almost no effort to get consumers to take greater responsibility

for their utilization of health care resources. Just as most federally-funded programs which have subsidized spending have experienced explosive growth over time, the ACA also faces the threats of increasing costs.

To put it another way, the ACA may or may not be a very bad idea for the nation as a whole, but standing up valiantly against the excesses of the federal government does little to protect the state's economically disadvantaged citizens, especially in an economic downturn (which will eventually come, for one reason or another). State policymakers may not want to buy into federal safety net programs, but it is important to remember who bears the greatest costs of the state leaving Medicaid expansion dollars lying on the table, especially since Utahns are paying taxes to support those programs.

Utah can do at least two things with respect to concerns about the sustainability of the ACA. First, the state can enact explicit provisions regarding an exit strategy. Exit strategies might include only agreeing to expand the program for a limited time or committing to withdraw from the expansion if certain cost targets are not met. The ability to quickly reverse course is a very valuable commodity.

Second, the state can be aggressive about seeking alternatives to using the expansion dollars rather than in traditional Medicaid. Alternatives that build in greater consumer incentives and that protect the private insurance market from competition with Medicaid for healthy customers are attractive options. These alternatives require approval from the federal government, but pursuing an alternative model (or series of them) sends the signal to the federal government that Utah is committed to forging its own path, and it avoids granting benefits that have to be later withdrawn. Meanwhile, as Utah seeks its own path, there is much to be learned from observing how implementation of the ACA plays out in other states. Indeed, delaying expansion for a little while to observe the actual details of implementation that we can only guess about now may be a prudent approach.

Finally, to say a policy action has high benefits is different from saying government should take that action. There are all sorts of ways the state *could* spend money that would benefit the lives of *some* people. But that does not mean such expenditures are within the appropriate role of government. Ultimately the Medicaid expansion decision comes down to those fundamental questions about the role of government in our society—questions that go beyond the calculations of costs and benefits.

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