This commentary argues against Medicaid expansion in North Carolina for 5 reasons: Expansion will reduce access to care for highly vulnerable individuals who are already enrolled in Medicaid; it is unlikely to save lives; it is unaffordable in the long run; its current financing structure encourages fiscal irresponsibility; and it will eliminate more jobs than it creates.

There are at least a dozen good reasons for states not to expand Medicaid under the Patient Protection and Affordable Care Act (ACA) [1]. However, I will limit myself to a discussion of the 5 most compelling reasons why North Carolina should remain among the 19 states that have not adopted this expansion.

Medicaid Expansion Will Reduce Access for Existing Medicaid Recipients

Medicaid is among the worst forms of health insurance offered in our state. Despite the comprehensiveness of Medicaid coverage, many Medicaid beneficiaries have great difficulty in locating a provider.

Before the ACA was enacted, 31% of doctors nationally refused to accept new Medicaid patients, compared to only 17% refusing new Medicare patients and 18% refusing new patients with private insurance [2]. There are many reasons for this refusal to accept Medicaid patients, but a principal driver is low reimbursement rates [3].

While Medicaid reimbursement is lower than payments for other types of insurance, North Carolina actually pays physicians higher Medicaid fees than some other states. North Carolina’s physician fees under Medicaid are only 21% lower than Medicare fees, compared to 34% lower nationally [4]. This has resulted in a higher Medicaid provider participation rate in North Carolina than in other states, but access problems remain, with the average Medicaid caseload per physician in North Carolina being about 30% higher than the national average [5].

As this high caseload illustrates, the ACA is being implemented during a period when we are already facing a physician shortage. Further, a model developed by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill showed that, in the year 2020 alone, Medicaid expansion would increase the unmet demand for physician services by over 25% [6]. In the context of this physician shortage, it makes little sense on ethical or clinical grounds to divert care away from existing Medicaid beneficiaries, who are among our most vulnerable populations—elderly individuals, persons with disabilities, pregnant women, infants, and children. This is especially true given that the lion’s share of the expansion population consists of nonelderly able-bodied adults. It also seems unwise to make promises to newly eligible Medicaid beneficiaries on which we will be hard-put to deliver.

Medicaid Expansion Is Unlikely to Save Lives

One proponent of Medicaid expansion criticized the decision not to expand Medicaid by saying, “a thousand or more [North Carolinians] die each year as a result of one of the most cruel and indefensible decisions in N.C. history” [7]. However, there is no good evidence to support this hyperbole regarding the impact of health insurance on mortality risk. Indeed, it is worth taking the time to understand the origins of this misleading claim.

There is very mixed literature showing (possibly) that having private insurance lowers mortality risk relative to remaining uninsured [8]. These studies are inherently problematic in that they are observational studies rather than randomized controlled trials. Consequently, no matter how many sophisticated statistical adjustments we make, we can never entirely rule out the possibility that observed differences in the rate of death between insured people versus their uninsured “statistical twins” are due to unmeasured differences between the 2 groups rather than to their insurance status. Uninsured people, for example, may be more willing to make risky life choices that are not captured in the observed data (eg, driving without seatbelts or driving drunk), and it may be that these choices, rather than their lack of insurance, result in objectively higher death rates compared to the death rate of their insured counterparts.

Even if the studies were flawless, there are 2 reasons why it is inappropriate to use this literature to extrapolate...
the impact of Medicaid coverage on mortality risk. First, the same sort of observational studies that purport to show that private insurance reduces mortality risk actually show that having Medicaid increases mortality risk [9]. For example, even after controlling for a plethora of demographic and socioeconomic differences between uninsured individuals and those on Medicaid, one study found that the death rate for white males on Medicaid was more than twice that of statistically identical individuals with no insurance coverage [9]. The same study showed that uninsured white males had a 60% higher death rate than those with employer-based coverage. Thus, it is highly problematic to infer that Medicaid will save lives simply because private insurance appears to do so.

Second, the best available evidence regarding Medicaid’s actual impact on health and mortality risk comes from the Oregon Health Study, which is as close to a randomized controlled trial as we might ever get on this question. In that study, Medicaid “generated no significant improvement in measured physical health outcomes,” nor did it result in a statistically significant reduction in mortality risk. Avik Roy has done a thorough job of explaining these findings in more detail and debunking the counterclaims of ACA enthusiasts disappointed in the study’s results [10].

**Medicaid Expansion Is Unaffordable in the Long Run**

All previous Medicaid expansions simply promised states that expanded their Medicaid programs that they could draw down federal funds at the same matching rate being used to fund the existing Medicaid program, but the ACA was quite different. It offered states the opportunity to get 100% federal funding for the expansion in the first few years, with this federal matching rate gradually declining to 90%, purportedly in perpetuity.

This is a promise Uncle Sam almost certainly cannot keep. As of 2014, the federal government faced a fiscal gap of $210 trillion [11]. That amount represents 58% of the present value of projected future taxes, meaning that in order to close the gap, we would have to increase federal taxes by 58%. It should be patently clear to any impartial observer that securing a political consensus to raise taxes on Americans by such a gargantuan amount is unlikely. Given that health entitlements account for more than half of the fiscal gap, it is equally obvious that, at some point, Medicaid policy is going to have to adjust to these inconvenient facts, however much today’s politicians appear reluctant to touch this issue.

Even in the short term, fiscal realities forced President Obama to propose reductions in the federal matching rates for the Medicaid expansion as part of his fiscal year (FY) 2013 budget. These reductions were designed to reduce Medicaid spending by $100 billion over 10 years [12]. Indeed, Medicare public trustee Charles Blahous has written, “Every serious bipartisan budget discussion in recent years has envisioned reductions in future federal Medicaid outlays” [13]. These fiscal pressures can only be expected to grow. The most recent annual report on Medicaid’s finances issued by the US Department of Health and Human Services (HHS) showed that the average cost of the ACA’s Medicaid expansion enrollees was nearly 50% higher in FY 2015 than HHS had projected just 1 year previously [14]. Additionally, enrollment exceeded projections in states that elected to expand Medicaid by 110% nationally, and this problem has been much more severe in some states. Expansion enrollment exceeded projections by 322% in California, by 276% in New York, and by 134% in Kentucky [15].

**Medicaid Financing Encourages Fiscal Irresponsibility**

Part of the reason we face $210 trillion in unfunded liabilities relates to perverse incentives created by Medicaid’s formula for open-ended federal matching. For decades, this formula encouraged wasteful spending and discouraged states from economizing; this creates a one-way ratchet effect that fuels ever-rising Medicaid spending. The 90% federal matching rate under the expansion puts such incentives on steroids; now, states that save $1 of Medicaid funds get to pocket only 10 cents, while states that waste $1 pay only 1 dime more.

Equally troublesome are the perverse incentives this formula creates for states to take from one another and to transfer obligations to future generations. The formula encourages states to expand their programs as much as possible, knowing that a majority of the cost will be exported to neighbors. This gold rush mentality likewise minimizes whatever concerns state policy makers might otherwise have about the burden being placed on future generations by profligate entitlement spending.

If we can justify an expenditure only when someone else pays for it, then we ought to be thinking very hard before incurring that obligation. We can do better. State policy makers would be far better served by resisting the urge to take federal money now and instead waiting until Medicaid financing is reformed along the lines of a more sensible capped entitlement.

**Medicaid Expansion Will Eliminate More Jobs Than It Creates**

In other articles, I have examined in detail the flaw in logic underlying the numerous state-level studies purporting to show huge employment gains arising from Medicaid expansion [16]. Taken collectively, they imply that millions of jobs have been created across the 32 states (and the District of Columbia) that have opted for Medicaid expansion. But this conclusion is the result of one-sided bookkeeping that entirely ignores the reality that every tax dollar used to finance a new job in the health sector represents a dollar taken away from someone with an existing job in the private sector. Thus, every visible job gained results in
an unseen job lost elsewhere in the economy.

No one doubts that shoveling more money into the health care sector may increase health sector jobs. But the RAND Corporation has shown that every new job added to the health care sector results in 0.85 fewer jobs in the rest of the economy [17]. Even worse is that every $1 raised in taxes shrinks the economy by 44 cents. This implies we would lose 144 jobs for every 100 health sector-related jobs that might be induced by expansion. In the end, then, Medicaid expansion is not merely a break-even proposition that shifts jobs from the general economy into the health sector; it actually reduces total employment in the economy overall.

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