Medicaid Expansion*

1. Introduction

In a February 2013 poll sponsored by Florida's James Madison Institute, one of the questions read: "To expand Medicaid coverage in Florida would require either additional taxes or less State spending on things like education, roads and law enforcement. Would you be more likely or less likely to support the Governor and Legislature expanding Medicaid coverage, if it meant higher taxes and less spending on other priorities?" This question appears at first glance to exemplify the tough nature of many public spending decisions. They involve trade-offs between compassion today and investment in better lives tomorrow. Often we have to make decisions between heart and head. Compassion tells us to assure the less fortunate among us that they will have medical care, but reason warns that there is no free lunch. Decisions can be hard to make.

A number of essays by opponents of Medicaid expansion leave the casual or hurried reader with the impression that the choice is not tough after all. Forbes columnist Avik Roy (2013), for example, writes that the PPACA's "cruelest feature is what it will do to low-income Americans who are already struggling. Study after study shows that patients on Medicaid do no better, and often worse, than those with no insurance at all." From this view, the decision is not between reason and compassion.

Governor Rick Scott also sees no clash between good judgment and empathy, but from the other direction. When he became the seventh Republican governor to favor expanding Medicaid, he appealed to both head and heart: "While the federal government is committed to paying 100 percent of the cost of new people in Medicaid, I cannot, in good conscience, deny the uninsured access to care Expanding access to Medicaid services for three years is a compassionate, common sense step forward." (Florida Governor's Office, 2013) "We have a choice—and it's not an easy choice—but my job is to worry about every Florida family," said the governor. (News Service of Florida) The Florida legislature, however, has prevented expansion. The legislature, or at least the Florida House Majority Office (FHMO), also sees no clash between judgment and empathy, but from the perspective of opponents of Medicaid expansion, emphasizing budget concerns and asserting that expanding Medicaid would not help low-income adults, but harm them. (FHMO, 2013)

Woody Allen (2007) once challenged college graduates: "Mankind is facing a crossroad – one road leads to despair and utter hopelessness and the other to total extinction—I sincerely hope you graduates choose the right road." Though less extreme than Allen's dilemma, state

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¹ Poll of 600 registered Florida voters conducted by Public Insight February 16-19, 2013. http://www.jamesmadison.org/wp-content/uploads/Florida-Statewide-Medicaid-Poll.pdf.

budget decisions all involve trade-offs: roads versus education, taxes versus going into debt, or state versus local responsibility. This is an obvious way in which budget decisions require tough choices. But there are other ways in which budgets can be tough. One is that policy choices are often complex and the future is unknown. Decisions must be made with limited information and in the face of uncertainty. A second is that people often have not just different information about a policy but also different preferences. The hard part is finding a creative compromise that makes everyone better off than does refusing to cooperate.

Policy makers, as most of us would from time to time, too often avoid the hard thought required to make good decisions in face of uncertainty and complexity by appealing to ideology instead. The devil is in the details and the temptation to avoid that devil is strong. Or difficult compromises among spending categories can be avoided by going into debt, putting the burden on our children. Or, at the state level, they can be avoided by mandating local governments to, for example, provide indigent health care but not funding that care. Whether Florida should expand Medicaid is a tough choice in all of these senses. Important parameters are fuzzy and the future uncertain, making it tempting to rely on ideology instead of careful analysis. Different parties have strong feelings that can be reconciled, if at all, only through creative approaches. The state legislature finds it easy to pass part of the burden onto hospitals and local governments, where the effects of what they do may not be transparent.

As discussed in a recent Collins Institute report, *Tough Choices Revisited*, available on their web site, Florida's spending per resident is low relative to the national average across states—only 72% of the national average in federal fiscal year 2012 excluding federal support, and only 67% of the national average after adjusting for differences in the age distribution. (Dewey et al 2014) The report argues that was mainly due to stringent requirements for eligibility, low fee schedules, and limited coverage of illnesses and procedures, though it may be due in part to somewhat higher efficiency related to Florida's active Medicaid reform environment. Thus, on its face, Florida would seem a prime candidate to gain from taking advantage of federal help in expanding access to healthcare for its poorer residents. Yet, Florida has currently elected to join 24 other states in rejecting the expansion provision of the PPACA that the Supreme Court made optional for the states. As a result, starting in 2014, the national average income limit for Medicaid eligibility for parents may average \$18,809 nationally but only \$6,809 in Florida. For other adults the income limit may average \$8,470 nationally, while such adults will not be eligible in Florida.²

Because of the high stakes involved, both for the state's budget and for many of its poorest citizens, in this essay I outline major arguments against expansion and why I find them unpersuasive, joining those encouraging the state to undertake fuller, sounder, and more dispassionate study of this debate. As further context, I look at conflicting polls to explore

² Calculations use data from the Kaufman Family Foundation website.

whether Florida's registered voters favor or oppose expanding Medicaid, concluding that the weight of the evidence is that they favor accepting federal funds for expansion. Why then has the legislature opposed expansion? Using data from across the states, I suggest (but do not prove) that partisanship played a large role. I then turn to four questions related to expansion. Would expansion:

- (1) benefit or harm those it is intended to help?
- (2) significantly increase the cost of medical care?
- (3) create a larger fiscal burden than it is worth?
- (4) benefit or harm the Florida economy?

2 Public Opinion about Expanding Medicaid

Could it be that registered voters in Florida oppose expansion and legislators are simply responding to their wishes? Knowing whether voters favor Medicaid expansion is complicated by the difficulty of phrasing survey questions to be unbiased. There is a tendency for surveys to find that voters favor the position taken by the group funding them. Of the surveys dedicated to Medicaid, the best I have come across is one of six states by the American Cancer Society's Cancer Action Network.³ The CAN hired two polling organizations, one liberal and one conservative, to work together. The pollsters are Lake Research Partners and GS Strategy Group. Their Florida December 13-22 2012 survey of 982 registered voters found 63% in favor of Medicaid expansion and 25% opposed. Then they asked respondents to listen to brief statements about the issue, one for each side. After listening, respondents changed their answers only slightly, to 62% in favor and 28% opposed. Adding to the weight of the Florida results, those for the other five states the Cancer Action Network surveyed were also positive. Kentucky, Michigan, and New Mexico were similar to Florida. New Jersey was higher with 70% in favor of expanding Medicaid, and Texas was lower with 58%. In all states, expansion was favored by larger shares of women, young voters, those with lower incomes, Democrats, and minorities. A majority of white registered voters were in favor in every state but Texas (47%). After hearing the arguments pro and con, respondents in all states still favored expansion by wide margins over those opposed.

Additional evidence comes from a poll by Quinnipiac University, with extensive experience in non-partisan political polling. Their June 11-16 2013 survey of 1,176 registered voters in Florida found that voters favored Medicaid expansion by 49% to 40%. A poll of 600 registered voters sponsored by the Florida Hospital Association and conducted by Public Opinion Strategies January 15-17, 2013, reported that 62% favored expanding Medicaid. Their primary question noted that Florida would be using mainly federal funds to "expand health care coverage." (Florida Hospital Association, 2013) A poll by Public Insight for the James Madison

³ http://www.acscan.org/content/wp-content/uploads/2013/01/ACS-CAN-Report National-Summary-Final.pdf

Institute, in contrast, reported that 63% of Florida voters *opposed* expansion. (James Madison Institute, 2013) A typical question: "Would you support expanding Medicaid coverage if the effect would be to pull many adults out of private coverage and into the Medicaid Program, where taxpayers would pay for their coverage and they might have decreased access to doctors?" A survey of Florida registered voters by the Foundation for Government Accountability (2013) found that 53% would be less likely "to support their state legislator in the next election if he or she voted in favor of adding 1 million more residents to Florida's Medicaid system." This question followed a series of queries with lead-ups such as:

"In 2002, 2 million people were enrolled in Florida's Medicaid system. Today, that number has grown to 3 million people. If Florida expands Medicaid, that number will increase to 4 million people at an estimated cost of six billion dollars a year total with 1 billion a year for Florida."

"Would you be more or less likely to support increasing the number of Florida residents on Medicaid if you knew it would mean cuts in funding for other areas like roads, schools, and public safety?"

In summary, professionally done polls found that most registered voters favor expanding Medicaid. The ones finding the reverse were push polls.

3. The Partisan Nature of State Decisions about Expanding Medicaid

By a common estimate, over the next ten years Florida will lose around \$50 billion in funds from the federal government by rejecting Medicaid expansion, while paying taxes to support expansion for the over 53% of the nation's people who live in the 26 states set to join. (Badger, 2013) Why would we let other states take advantage of us this way? At first glance, it seems implausible that any non-trivial share of legislators would oppose expanding Medicaid in their own states, when for the first three years the federal government will pay 100% of the cost, phasing down to an eventual 90%. Even counting Florida taxpayers' share of federal obligations, around six percent, at the 90% federal share the state would still be receiving six dollars for every dollar spent, a good return on investment. If on top of that voters favor expanding Medicaid, why would the legislature refuse? It would be naïve to ignore the role of partisan politics. Of the 22 states in which the governor and both houses of the legislature are all under Republican control, only two (Michigan and North Dakota) plan to expand Medicaid. Of the 12 states in which all three are Democratic, all plan to expand Medicaid.

Looking at the politics from a slightly different perspective, in the states refusing Medicaid expansion, the average Romney share of the total Romney plus Obama vote was 55%, compared to 42% in the states accepting expansion. Florida was in between, at 49% for

Romney.⁴ On that basis alone, the odds would be slightly better than 50% that Florida would accept rather than reject expansion. But there is another consideration: structural features of Florida politics—in particular gerrymandering, primary elections restricted by party, and single-member districts—favor the Republican party and, usually unintentionally, especially its Tea Party wing. That is also true in a number of other states. One proxy for structural features of a state's politics that favor the Tea Party is, controlling for the Romney vote, what share of its congressional representation voted to default on the national debt. That share, 38% in Florida versus 28% averaged across the states, is more strongly correlated with control of the state legislature than is the share voting for Romney.

My statistical analysis indicates that with Republican control of both houses of the legislature and the governor's office, the chance is only 6% that a state will expand Medicaid. Though Republican Governor Scott favors expanding Medicaid, he wants a three-year sunset and he proved unwilling to make expansion a major issue. According to very early opinion polls, there is a chance that the next governor of Florida will be a Democrat, which by my statistical analysis would be associated with Florida's probability of expanding Medicaid being 40%. I caution, however, that the analysis only shows correlation and does not prove causation. Finally, interest groups favoring expansion may be mobilizing more vigorously, lobbying legislators and helping keep a majority of Florida registered voters in favor of expanding Medicaid.

Politics, partisanship, and substantive debate intertwine. There are issues that reasonable voters and legislators would wish to see explored before approving expansion. As noted in the introduction, we consider four of them. (1) Would expansion in fact benefit those it is intended to help? In particular would their health improve? (2) Would expansion, by increasing the demand for medical services, significantly increase the cost of medical care? (3) Would expansion, even though financed largely by the federal government, create a larger fiscal burden on the state than it is worth? (4) How would expansion affect the Florida economy? I discuss the first two of these in the next two sub-sections and combine the discussion of the third and fourth in the following subsection.

4. Would Expanding Medicaid Help or Harm Low-Income Adults?

I begin with whether expanding Medicaid would help people newly eligible, a large share of whom are adults with incomes under 100% of the federal poverty line and, if they have children, above 20%. (Most adults from 100% to 138% of the FPL will benefit from other provisions of the Affordable Care Act.) In principle, this question should be easy to answer. How

⁴ Calculations and statistical analyses in this paragraph are by BEBR. Political data are from the *U.S. Statistical Abstract*, and news reports.

⁵ The point estimate resulting from the statistical analysis is 46%. However, of the five states in that condition Arizona and Minnesota are expanding Medicaid while Missouri, Montana, and New Hampshire are not.

could giving medical insurance to people who otherwise rely on hospital emergency departments either because they are poor over the long haul or because they are temporarily down on their luck not make them healthier and better off? Yet maybe the complexities of the medical care system or deficiencies in the behavior of recipients keep that from happening.

Whether Medicaid is in fact (empirically rather than a priori or ideologically) helpful or harmful should be, again in principle, easy to tell. Just compare those with it to those without, and see who has the better health. But finding out whether Medicaid improves health turns out to be difficult for several reasons. First, hospitals and physicians often sign up uninsured but eligible patients for Medicaid when they present with a serious condition. (Chen, 2013; Kaiser Commission on Medicaid and the Uninsured, 2013). Second, many people become poor because they have chronic and expensive-to-treat medical conditions. Third, sometimes people fare poorly in the labor market because of cognitive, emotional or family care limitations that also limit their ability to maintain their health or to take advantage of medical care. Fourth, those with no health insurance, public or private, often have chosen that status because they judge their overall health to be excellent. If they do experience an illness or accident, they have a better chance than average of recovering quickly and fully. Fifth, those with poor health habits and pre-existing conditions that make medical interventions expensive and cause poor outcomes are more likely to be unable to obtain private insurance. Worse yet, they may have had their private insurance rescinded because the insurer, realizing the policy holder was going to require expensive treatment, found an excuse to cancel the policy. Though simple comparisons of health outcomes for those with private insurance, no insurance, or Medicaid are often published, cited, and useful, interpreting them requires caution and attention to detail.6

Because of the serious difficulty of determining causation, I group studies of the effects of Medicaid into three standards: gold, silver, and bronze. An example of a gold study would be one that allocates people at random by lottery into one group eligible for Medicaid and a second group not eligible. That way there are no systematic unobserved or unmeasured characteristics causing people to select into Medicaid, aside from conditions that they all share. An example of a silver study would be one that uses regression discontinuity, looking at the experiences of people close to some arbitrary eligibility dividing line, such as being just above or just below a certain percentage, say 50%, of the federal poverty line. A problem with such studies is that they may not generalize beyond, say, 40% to 60% of the FPL. Another example of a silver study would be one using a good instrumental variable, a procedure too complicated to explain in this context. Bronze studies are those that do the best they can to control for

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⁶ Many such studies are cited by Jason D. Fodeman (2013) and the FHMO (2013).

⁷ We place IV methods in the silver category, not the gold, because of the difficulty of finding instruments that are correlated with the variable (being insured through Medicaid) the effect of which we wish to determine, but have no other effect on outcomes, such as health.

covariates, such as income, education, and pre-existing conditions that, along with insurance status, also affect outcomes. They are seriously limited because of the impossibility of controlling for all relevant characteristics.

Fortunately a gold standard study is underway and preliminary results are available. In 2008, Oregon had funds to expand Medicaid to only ten thousand more adults, though many times that number with low incomes and meeting other criteria were eligible. The state awarded the new slots to winners of a lottery, entered by about ninety thousand applicants. Seeing a chance to gain insight into the likely results of the expansion of Medicaid under the Affordable Care Act, several foundations funded leading health economists and epidemiologists to conduct the Oregon Health Insurance Experiment. Their most recent findings appear in the May 2013 New England Journal of Medicine and are summarized on the web page of the National Bureau of Economic Research. (Baicker et al, 2013) The researchers report a number of positive outcomes. Relative to controls (losers of the lottery), Medicaid increased use of diabetes medication from 4% to 11.8%, reduced the incidence of depression from 30% to 21%, "virtually eliminated out-of-pocket catastrophic medical expenditures, and reduced the probability of having to borrow money or skip paying other bills because of medical expenses by more than 50%." Medicaid boosted cholesterol monitoring by 50% and mammograms by 100%.

Not all results were positive, however. The study reports a troubling negative finding: after two years, researchers found no effect on measurable physical outcomes. Quoting from the National Bureau of Economic Research web page: Compared to controls, "Medicaid has no statistically significant effect on measured blood pressure, cholesterol or glycated hemoglobin (a measure of diabetic blood sugar control), or on the diagnosis of or medication for blood pressure or cholesterol." Especially puzzling is the lack of change in glycated hemoglobin, which should have been reduced by the use of diabetes medication. Though sometimes more than two years are required for long-term physical benefits to appear, doing as the doctor tells you will lower blood pressure, cholesterol, or blood sugar—all indicators of long-term outcomes—in less than two years.

Thus it is likely that many if not most Medicaid recipients are not changing their lifestyles to follow doctors' orders. That perverse behavior, incidentally, goes far beyond Medicaid recipients. In Oregon, 24% of all children and 61% of all adults are overweight. Of all adults in Oregon, 27% are obese. (Kaiser Commission on Medicaid and the Uninsured 2012; Robert Wood Johnson Foundation, 2013) In Florida the overweight shares are 33% of children and 65% of adults, with 25% of adults also obese. So strong are the signals to overeat in our culture that the United States is rare among rich countries in that obesity rates for men do not decline with educational attainment. For women the relation is weakly inverse. The incidence of smoking, in contrast, is higher for those in poverty than for those with higher incomes, 29%

versus 18% according to the Centers for Disease Control and Prevention. Remarkably, 10% of college graduates smoke.

If studying Medicaid outcomes by choosing among potential recipients by lottery is the gold standard, a member of the silver standard is an article that uses a difference-in-difference approach to compare changes in outcomes between counties in states that expanded Medicaid eligibility and counties in states that did not. (Sommers, Baicker, and Epstein, 2012) In 2001 and 2002, Arizona, Maine, and New York expanded coverage to childless adults with incomes below the federal poverty line. New Hampshire, Pennsylvania, Nevada, and New Mexico did not expand coverage in those or close years. Sommers, Baiker, and Epstein compare the outcomes county-by-county across those states with controls for age, sex, race, income groups, as well as county fixed effects, for adults 35 through 64, and conducted thorough tests of specification and robustness. Comparing mortality in years one through six after expansion to the five years before, they found that expanding Medicaid reduced annual mortality by 25 per 100,000 people. Medicaid had its strongest impact in high-poverty counties. Importantly, in view of the Oregon results, the reduction in mortality increased year by year over years one through six. Perhaps the two years to date of the Oregon study are in fact not enough to detect changes in measurable physical outcomes.

Turning to the bronze studies, research that makes the best of limited data, I consider the question of access to care for adults 18 through 64, those most affected by whether Medicaid coverage is expanded. Access is of special concern since Florida appears to have the highest proportion in that age group who have postponed care due to cost. They estimated the effect of Medicaid coverage by analyzing the 289,333 adults 18 to 64 in the 2010 Behavioral Risk Factor Surveillance System survey. As with everything from air travel to zip codes, access and quality in medical care differ by income. Compared to those with incomes of \$75,000 and more, delays were four times more likely for those with incomes under between \$25,000 and \$50,000 and eight times more likely for those with incomes under \$25,000. Compared to people with jobs, those unemployed for over a year were twice as likely to experience delays. Delay differed little by race.

The question of interest is whether people in that age group, controlling for socio-economic and health variables, had better access to care in states where Medicaid coverage for those ages is more generous. The result is clear: the more generous the coverage, the better the access. For example, people ages 18 to 64 in states with an eligibility cutoff from 17% to 44% of the federal poverty level (that includes Florida) are 42% more likely to experience delays

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⁸ Based on a map in Clark et al (2013). Florida may be better than some states, such as Alaska, with too few respondents for reliable estimates. Also, though Florida is the darkest of the well-covered states, the shadings are for intervals. Even in the best case, however, Florida is far down the list in access. The detailed results we cite are in an online appendix to Clark et al.

than are those in states with a cutoff of 133% or higher. The strength of this study is that the better access is an average across the entire population controlling for income and other variables, and thus is less likely to be plagued by selectivity bias. It is, however, in the bronze category—not gold or silver—because there may be other features of states that the analysts cannot measure but affect access to care, a different social attitude toward the poor, for example. The evidence from this massive survey suggests that expanding Medicaid would enhance access to care for low-income adults but does not prove it.

Incidentally, Medicaid may now give the people it covers a greater choice of hospitals than most private insurance does. Medicaid limits payment rates but gives freedom of choice. Many private insurers now strengthen their bargaining power to reduce costs by offering preferred provider or point-of-service plans. (Moses et al, 2013) Whether Medicaid patients often choose hospitals based on sound information about quality of care is not known. If they do, studies of the quality of care they receive that control for hospital effects would be biased downward. That is, if Medicaid eligibles take advantage of being allowed to choose to select good hospitals, that should be considered an advantage of Medicaid over private insurance, unless private insurers restrict choice to better hospitals, not just cheaper ones.

Turning from access to quality of care, I have already noted that Governor Scott's support for expanding Medicaid coverage was based in large part on his belief that doing so would help low-income adults, presumably by improving their health. But a number of influential essays contest that belief by citing papers that I place in the bronze category, those making the best of data with serious limitations. This view matters. Expanding Medicaid could affect the health and well-being of low-income people in one of three different ways: (1) cause significant improvement, (2) cause significant harm, and (3) not have much net effect. Evidence favoring the helpful case argues for expansion. The harmful case argues against. The little effect case leaves the matter up in the air. If as a result of expanding Medicaid, low-income people would receive about the same amount and quality of care, the question becomes financial and not humanitarian. Should Floridians pay for all of that care themselves or accept funds from taxpayers in other states in compensation for the funds Floridians will have to send them anyway.

The essays that cite bronze studies, sometimes without saying so directly, leave the reader with the impression that these studies demonstrate that extending Medicaid would harm low-income people, that it would be the opposite of compassionate. The executive summary of a position paper by the FHMO (2013) includes the statement that "Medicaid patients already suffer from worse outcomes compared to privately insured patients as a result of poorer access to specialists, longer wait times, and limited access to early screenings and treatments." Later it reports that after heart surgery "Medicaid patients even had higher risks than patients with no insurance." A report on Florida by the National Center for Policy Analysis

states that "Various academic papers have found that Medicaid enrollees sometimes fare worse than patients with private insurance and often worse than patients with no insurance." (Herrick and Gorman, 2013) Forbes columnist Avik Roy (2013), as noted earlier, writes that the PPACA's "cruelest feature is what it will do to low-income Americans who are already struggling. Study after study shows that patients on Medicaid do no better, and often worse, than those with no insurance at all." Grace-Marie Turner (2013), president of the Galen Institute, wrote "numerous ... studies show that in some cases Medicaid may even be harming the very people it is designed to assist." Physician Scott Gottlieb, a fellow of the American Enterprise Institute, summarized several studies as reporting that compared to the uninsured, Medicaid patients were more likely to die after several types of surgery and after lung transplants and were "more than twice as likely to have a major, subsequent heart attack after angioplasty" "In all of these studies," he said, "the researchers controlled for the socioeconomic and cultural factors that can negatively influence the health of poorer patients on Medicaid." (Gottlieb, 2011)

From among policy essays opposing Medicaid expansion, I emphasize one by Jason Fodeman, M.D., published by the James Madison Institute. (Fodeman, 2013) I select it because it is well-informed, thoughtful, and documented. I look at the studies he cites to support his statement that "As a result of poor Medicaid reimbursements and diminished access to care, Medicaid patients receive low quality care." He refers to several studies showing that patients on Medicaid or no insurance fare worse than patients with private insurance. "Some peer-reviewed literature," he writes, "even goes so far as to suggest that patients with Medicaid not only receive a lower quality of care than privately insured patients, but also the uninsured." I look at the studies he cites partly because the other essays I mention refer to some subset of those studies or at least have a large overlap.

Before considering the studies cited by Fodeman, I emphasize that our interest is in the *causal* effect of Medicaid on the quality of care received by low-income adults who would be newly eligible. To illustrate why I stress causation, consider Medicare beneficiaries in Florida. Among that group in 2010 a leg was amputated for 5 per 10,000 whites and 26 per 10,000 African Americans. Similarly, 20% of whites and 28% of African Americans did not visit a primary care physician during the year. There were also differences in the shares having mammograms and in the shares of diabetics having eye exams and blood lipids tests. The point is that the two groups had the same insurance, Medicare, but different outcomes probably partly related to differences in income and education. If income and education matter, then a problem for the bronze studies is how to control for them. Control is necessary because on average even those with no insurance at all have higher incomes than those on Medicaid. The

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⁹ Data from the Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth Atlas of Medicine, online version.

FHMO (2013) reports that about 72% of the uninsured have incomes above the poverty line and that their average household income exceeds \$51,000. Further, over "91 percent self-report that they are in good or excellent health."

Fodeman says that the first of these articles, published in the New England Journal of Medicine in 1993 by Ayanian et al, "explored the impact of insurance status on the stage of breast cancer at diagnosis and subsequent survival." Notice that "impact ... on" implies causation, whereas the authors are careful to use "Relation between" in their title. 10 Moreover the authors state explicitly that "Higher screening rates among privately insured women may lead to the detection of cancers that spread more slowly (i.e., take longer to become symptomatic) and are less likely to be lethal within a given stage. These potential biases can be evaluated in randomized trials, but we cannot evaluate their effects with our observational data." Ayanian and co-authors analyze observational data for 4,765 women in New Jersey "in whom invasive breast cancer was diagnosed from 1985 through 1987." Of these women, 4,283 were privately insured, 277 were uninsured, and 115 were covered by Medicaid. The authors "conclude that women without private health insurance who have breast cancer receive this diagnosis later and die sooner after the diagnosis than privately insured women with breast cancer." They remark that pinning down causation requires more research and note that "From 1985 through 1987, New Jersey did not cover screening mammography for Medicaid enrollees."

Fodeman cites a second breast cancer study, this one by USF and Moffitt researchers, who study 11,113 cases diagnosed in Florida in 1994 (Roetzheim et al, 2000). In this instance the authors do imply causation in their title. ¹¹ I do not think their data justify that. Fodeman states, correctly, that "the researchers attribute this increased mortality [of uninsured and Medicaid women] to delayed diagnosis." In the discussion section, Roetzheim and his coauthors say "The higher mortality rates observed among the uninsured and those with Medicaid appeared to be entirely the result of later stage at diagnosis." Which is the more humane conclusion to draw from these two studies of breast cancer: Florida should not expand Medicaid, or Florida should encourage low-income women at high risk to be screened and counseled? All states now cover screening. In 2010 Florida was one of only 11 that required a co-pay for screening and one of 19 that did not cover genetic counseling for breast cancer risk. In "Medicaid coverage of recommended adult preventive services" Florida is one of the four lowest states. ¹² (Kaiser Commission on Medicaid and the Uninsured, 2012)

Fodeman describes a paper by University of Virginia researchers on major surgical procedures and reports that "After adjustments, Medicaid increased the risk of inpatient death

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¹⁰ "The Relation Between Health Insurance Coverage and Clinical Outcomes Amongst Women with Breast Cancer."

^{11 &}quot;Effects of Health Insurance and Race on Breast Carcinoma Treatments and Outcomes"

¹² The others are Georgia, Louisiana, and Nebraska.

by 97 percent compared to patients with private insurance. This exceeded the 74 percent increase of in-hospital death conferred by being uninsured." (LaPar et al, 2010) The Virginia analysts imply both in their title and in their discussion that they do indeed believe that they have demonstrated that being either uninsured or covered by Medicaid *causes* worse outcomes from major surgery. Their view is that they have controlled sufficiently well for confounders to make that claim. They do not claim that they have demonstrated that Medicaid harms poor people relative to being uninsured. Except for longer length of stay in the hospital and higher total costs for Medicaid patients (compared to the uninsured), the differences in outcome between Medicaid patients and the uninsured are not statistically significant. They do, however, point in the direction that Medicaid outcomes are worse—by 13% for mortality, 16% for wound complications, and 21% for infectious complications, for example. Thus whether they successfully control for confounders matters to Florida policy makers.

Interestingly, the Virginians find that uninsured Floridians were significantly *less* likely to experience urinary, pulmonary, gastrointestinal, or systemic complications from surgery than were those with private insurance. How could that be? A possible clue is that their control for income is based on the median income quartile in the patient's zip code of residence. Only 15% of patients with private insurance lived in zip codes in the top quartile, with median incomes higher than \$45,000. Over twice as large a share of the uninsured, 31%, lived in such zip codes. There were also twice as many of the uninsured in the lowest quartile (below \$25,000) of zip codes, 34% versus 17%. That suggests, though it does not prove, that we can usefully think of two types of uninsured people: (1) those so affluent or healthy they prefer to self-insure, and (2) those who cannot afford private insurance and lack coverage through their jobs. This interpretation is confirmed by where those on Medicaid lived. Of those on Medicaid, 41% lived in the bottom quartile of zip codes and only 11% in the top quartile. Some 31% of those covered by Medicaid lived in the top half of zip codes, far less than the 59% of the uninsured.

Another important difference is this: The 31% on Medicaid living in the top half of zip codes were almost by definition poor, in spite of their neighborhoods. Among the 59% uninsured, some were personally affluent. Though we do not know what that share was, it was surely higher than for patients covered by Medicaid. One reason for believing that is, as the Virginians state, "... the proportion of Medicaid patients may be artificially inflated due to the fact that normally Uninsured patients may garner Medicaid coverage during a given hospital admission." In other words, if you are uninsured and poor, you are likely to be classified as Medicaid upon admission. That cannot happen if you are uninsured and affluent. It is hard to believe a zip-code control for income adequately distinguishes patients with Medicaid from the uninsured.

¹³ "Primary Payer Status Affects Mortality for Major Surgical Operations."

In sum, we cannot conclude from this study that shifting the poor from no insurance to Medicaid would harm them. Better is the Virginians' more modest conclusion that Medicaid "serves as an important proxy for larger socioeconomic and health system-related issues that could be targeted to improve surgical outcomes for US patients." In a comment on this article, Max Langham, M.D., of Memphis asked whether their findings "reflect the medical system" proper or the "success of the for-profit insurance companies in selecting the most profitable segment of our population to insure." Author Gorav Ailawadi responded "Regarding the point that the best outcomes are seen in the private insured group, it is likely due to smart selection by private insurance companies that are generally for-profit. I think they do a very good job of picking the right patients." If Ailawada is correct, that obviously reduces the relevance of the results to the issue of whether Florida should expand Medicaid coverage for its low-income residents whatever their health status.

Another paper Fodeman cites is by analysts at the University of Pennsylvania who study outcomes of colorectal carcinoma surgery. (Kelz et al, 2004) The Pennsylvanians looked at data released in 1997 and 1998 from a national sample of colon cancer patients admitted for surgery. In-hospital deaths were recorded for 103 of 11,474 patients with private insurance (0.9%), 17 of 758 uninsured patients (2.2%), and 33 of 1182 Medicaid patients (2.8%). Controlling as best they good for co-morbidity, age, income, race, region, and hospital characteristics, they found that compared to those with private insurance, mortality odds ratios were about equally higher for Medicaid patients (1.57) and for the uninsured (1.56). With respect to surgical complications, Medicaid patients fared worse (odds ratio 1.22) than did the uninsured (odds ratio 1.12). The Pennsylvanians, however, controlled for income by using median household income in the zip code of residence, which entails the problems discussed earlier. The authors noted in addition that their controls for comorbid conditions "could not account for severity or stage of disease." I think that this study does not provide evidence that extending Medicaid coverage to poor Floridians would harm them.

Another Fodeman-cited study relating cancer outcomes to Medicaid was reported by researchers at Michigan State University. (Bradley, Given, and Roberts, 2001) Their purpose is to use Medicaid as a proxy for low income: "An improvement over previous research was our use of Medicaid enrollment to define low income rather than the use of ecologic proxies for low income." Notice that they are aware of the problem of using zip code income as a proxy for individual income. They also emphasize another difference between Medicaid patients and others. They find that those covered by Medicaid are much more likely to be diagnosed at a later cancer stage and are also much more likely to suffer mortality or complications, whether or not they control for stage. They conclude that their "finding underscores the need for

¹⁴ Langham majored in economics and then completed medical school at UF, where his father taught econometrics for many years.

effective cancer screening programs in the low-income population." Again, I am unable to see this report as evidence that Florida would harm its low-income residents by expanding Medicaid.

Finally, Fodeman mentions a 2007 study by Jay Shen and Elmer Washington. Based on data from the 2002 National Inpatient Sample they conclude "Disparities in neurologic impairment status and mortality between patients with Medicaid and privately insured patients existed in some cases but to a lesser degree than disparities between uninsured patients and privately insured patients. Our findings demonstrate that the uninsured group was the most vulnerable of the 3." Again, this report does not present evidence supporting the conclusion that extending Medicaid to low-income Floridians would harm them. Summarizing the six bronze studies cited by Fodeman, I fail to find in them persuasive evidence that, as he claims, "to contemplate expanding [Medicaid] to more people would be a flawed policy that flies in the face of a substantial body of credible, peer-reviewed evidence that expanding the eligibility for Medicaid could actually worsen their care."

Where does the research—gold, silver, and bronze--leave us? Even from results of the Oregon study it is possible to emphasize positive results: In the treatment groups, larger shares were seeing physicians, were diagnosed with diabetes and taking pills, and were using preventive care. Like the rest of us, though likely in even greater proportions, they were not as quick as they should have been to reduce their blood pressure or lower their blood sugar. But they were initiating behaviors that would pay off in the long run. With respect to the gold and silver studies, would the better response to these mixed findings, especially the delayed but favorable impact on reducing mortality, be to decline federal funds for health care for the poor or to use Medicaid eligibility as a lever to persuade this set of patients to pursue measurable health goals set by their physicians for weight, blood pressure, blood sugar, and smoking cessation? The goal would not be a physician-patient relation resembling a sergeant and a private in boot camp but rather the use of nurses and other medical professionals to track and encourage health-promoting behaviors, nudging patients toward exercise, better diets, and smoking cessation programs or medications. Making continued Medicaid insurance conditional on the patient's cooperation in achieving modest goals would require a federal waiver, but that may not be impossible to obtain. The state has experience with a similar policy, the Enhanced Benefits Rewards program that is part of the Medicaid reform pilot and "reward[s] patients for engaging in healthy behaviors..." (Fodeman, 2013, p. 9) It seems more reasonable to ask health providers to monitor the health of their patients than to link being insured to job seeking or other labor market activities. With luck, forming habits leading to better health would, along with improved health itself, spill over into the labor market. Additionally, experience gained in encouraging low-income Medicaid recipients to become involved in their health may spill over into groups with higher income.

Expanding Medicaid would benefit both low-income adults and the state if it results in reduced incarceration. A report authored by Seminole County Sheriff Don Eslinger and others for the National Sheriff's Association and the Treatment Advocacy Center reports that in 2005 over 23,000 of the almost 150,000 prisoners in Florida's jails and state prisons were "seriously mentally ill." (Torrey et al, 2010) The odds that a person with a serious mental illness would be incarcerated rather than in a hospital were five to one. In 2002 Florida ranked 45th in per capita spending by the state mental health authority. Nationally, over half of prisoners are mentally ill, and less than half of those receive treatment. (Rich, Wakeman, and Dickman, 2011) After the harsh conditions of imprisonment, their illness is likely to be worse and, since when released they are usually ineligible for Medicaid, they are likely to impose costs on either a local hospital or on the criminal justice system. Steve Pittman, the COO at Meridian Behavioral Healthcare in Gainesville worries that "many Floridians will fall through the cracks because the state government didn't opt to expand Medicaid ... leaving a number of people with mental health conditions in the coverage gap." (Crane, 2013)

Related to the belief that Medicaid does not benefit recipients is the fact that many physicians refuse to treat Medicaid patients, which often makes patients wait longer for appointments. Access to certain specialties can be especially difficult. (Fodeman, 2013; FHMO, 2013) Part of the reason for that is that Medicaid payments are usually low, relative both to Medicare and to private insurance. The ACA will alleviate that problem, though not cure it, by setting Medicaid payments at parity with Medicare. (The ACA will not cure the problem because Medicare payment-to-cost ratios are likely to fall. Even more importantly, by current law the parity with Medicare is only temporary.) Many practitioners avoid the paper work and hassle that Medicaid often entails. Often the red tape is well intended, attempting to avoid encouraging procedures that though standard practice in some parts of the country are found empirically to have no benefit that can be measured. But surely in many cases the process could be streamlined.

One sound framing of the debate over whether expanding Medicaid would help newly eligible low-income people would be to combine the approaches of opponent Michael Cannon of the Cato Institute and a focus group report by a booster, the Kaiser Commission on Medicaid and the Uninsured. Cannon says that people who do not specialize in health policy often do not realize "how little reliable evidence there is that Medicaid has a positive impact on health, and how there is absolutely no evidence it is a cost effective way to improve health." To sort out causation from correlation, he calls for more random assignment studies of the Oregon type. (Cannon, 2013)

The Kaiser Commission (2013), in contrast, presents personal stories obtained from 64 individuals in eight focus groups spread through California, Connecticut, Minnesota, and the District of Columbia, all of which have extended Medicaid to low-income childless adults. From

the 64, the report chooses ten for one page stories. Though surely not chosen at random, the stories are compelling. Stephanie, 29, had suffered chronic pain from my fibromyalgia for eight months, unable to pay \$200 a month for medication before signing up for Medicaid. With Medicaid, she can afford the pills and is being treated for her migraines and depression. Cindy, 32, for two years received no treatment for her bipolar disorder, lupus, and panniculitis (her feet would swell to the size of footballs). With Medicaid, her ailments are under control and she is working again. Thomas, 50, uninsured for five years, had untreated headaches, fatigue, and depression. With Medicaid, he sought medical care and learned that he had multiple sclerosis, for which he is now being treated. Further, he had a colonoscopy and had polyps removed. Joy, 55, when uninsured could not find affordable care for her bipolar disorder. With Medicaid, she is being appropriately treated and looking for a better job with hopes of not being fired because of a manic episode. Bobby, 46, lost his job and his insurance during the recession and was no longer able to pay \$200 a month for his anti-depressants. With Medicaid, he is able to manage his depression and anxiety.

The Kaiser Commission report seeks to arouse unease in readers about the lack of compassion in a country that would allow low-income citizens to suffer for little reason. There is also a certain irony in the stories, especially in the instances of depressed, anxious patients who could not afford \$200 a month for medicine. The report does not say what the molecule was. It could well have been escitalopram, branded as Lexapro, for which a standard 20mg/day dose at that time would have cost around \$200 a month. The irony is that other countries free ride on the United States, setting low prices for pharmaceuticals while we do not. In Italy, for example, the price of escitalopram at the standard dose was around \$32 a month. (Memcacci et al, 2013) As a result of their monopoly power in the U.S., drug companies around the world invest in expensive research to develop and test new molecules. For people in Europe not only is the price low but also the cost for rich and poor alike is highly likely to be paid largely by insurance. The United States subsidizes research to produce drugs that our own poor, facing high prices and lacking insurance, cannot obtain. To add to the irony, Forest Laboratories manufactures Lexapro in Dublin, where there is no corporate profits tax, and uses transfer pricing to avoid paying U.S. taxes. (Drucker, 2010) One wonders whether the taxes avoided could have financed the drug, at least at European prices, for all poor adults not covered by Medicaid at the time. 15

The largest irony of all is this: We allow pharmaceutical companies to enjoy the pricing power of monopoly patents, benefiting us and the rest of the world by encouraging the development of new drugs. The biggest financial rewards come from new drugs to treat chronic diseases. But then, in contrast to every other rich country, after investing heavily in the

¹⁵ I became aware of the power of Big Pharma while working with a group lobbying the legislature to allow easier substitution of generics for branded molecules.

education of our young people, we make it difficult for many of them to take the drugs to control a chronic disease, which would boost their productivity and make us more competitive internationally. As an economic policy, letting a portion of our potential work force remain in poor health unnecessarily is perverse, whether for the United States relative to other countries or for Florida relative to other states.

Returning to combining the Cannon and Kaiser approaches, the need is for the best possible information that can be obtained quickly. One possibility among many would be to expand the Kaiser-type focus groups to, say, a thousand total participants, with 500 from states that expanded and 500 matched by propensity scoring in states that did not. They would be asked about changes in their medical care, health, insurance coverage, and employment while being videotaped. After editing to remove references to insurance coverage, their access to care, health, and employment would be scored by trained evaluators. The scores would be analyzed by people with appropriate statistical skill. This expense though high would be a tiny fraction of the funds at stake. Moreover, creative researchers could come up with yet better ways to combine Cannon and Kaiser.

5. Would Expanding Medicaid Raise the Cost of Medical Care?

A limitation of the Oregon study is that the lottery increased Medicaid eligibility by only 10,000, too few to learn anything about whether expanding eligibility by a million patients would drive up the price of medical care in Florida, our second major issue. After expansion of Medicaid in Maine, the "payment-to-cost ratio for private payers ... rose to 140 percent in 2007, up from 125 percent in 2003." (FHMO, 2013, p.18) The payment-to-cost ratio for private insurers also rose in Arizona after Medicaid expansion. (FHMO, 2013, p.19) In Massachusetts, the introduction of universal health insurance introduced in 2006 added 400,000 people to the insured population by 2008. As a result employment of medical personnel rose above trend compared to the nation. The increase was not in physicians and nurses but in "people who provide patient care support, such as therapists, technicians, and aides, whose combined employment level increased by 18%." Health-related administrative employment also rose above trend. (Staiger, Auerbach, and Buerhaus, 2011) Adding to the concern about the supply of medical care, "According to the Florida Department of Health, just two of Florida's 67 counties have no primary care shortage areas. This is even more troubling considering the large number of physicians nearing retirement." Over 28% of Florida doctors are 60 or older, only 14% under 40. (FHMO, 2013, pp.10-11) The concern is that at a time when physician morale is already low, expanding Medicaid in Florida will "drastically increase demand for medical services, but will not substantially increase the supply for those services." Fewer doctors will take new patients and wait times will become longer, especially for low-fee Medicare and Medicaid patients.

Important for a state seeking to project how its decision whether to expand Medicaid will affect the cost and accessibility of medical services is the degree to which the market for medical professionals is national or even international. The more national or international the market, the smaller will be the impact of an increase in within-state demand, as service providers migrate in from elsewhere. With respect to physicians, Florida resembles the nation with one exception, a high share with foreign degrees. ¹⁶ In Florida, 35% of all physicians hold international medical degrees, above the U.S. average of 24% and exceeding all states but New Jersey (39%) and New York (38%). A good source of supply to match increased demand from expanding Medicaid could be international medical graduates, many of whom might welcome Medicaid patients, who in some cases would be good matches because of a shared primary language. What we do not know is how responsive physicians and other medical professionals elsewhere would be to increased demand in Florida. On average, 47% of physicians in the United States practice in the state in which they received their graduate medical education. Florida ranks fourth in retention, at 59%, behind only Alaska, California, and Montana. With more demand, that percentage could increase. And it could fall if Florida does not join the states expanding Medicaid.

As important as attracting new physicians to Florida is the response of existing doctors to a combination of (a) a large increase in rates, about 70%, brought about by the PPACA and (b) expanding Medicaid coverage, if the state should do that. A recent study by University of Chicago economist Alice Chen (2014) provides estimates of physician response parameters which she then uses to project the national effects of the PPACA plus Medicaid expansion by half the states. Nationally, the number of physicians newly accepting Medicaid patients would increase by about 8,000 and the number accepting all Medicaid patients (instead of a limited number) would increase by 44,000. Her estimates imply corresponding increases for Florida of approximately 500 and 2,600. She concludes that the increased rates imposed by the PPACA "should mitigate concerns over a worsening physician shortage" from expanding Medicaid. As noted earlier, however, the increase in Medicaid rates for primary care physicians may be temporary, which would reduce the Chen effect.

In contrast to the case with physicians, the historical shortage of nurses has been alleviated by an upsurge of young people entering the profession. In the five years to 2011, enrollment in nursing programs at all levels rose from 190,000 to 273,000, with the largest percentage gains in advanced degree programs. Moreover, some 75,000 qualified applicants

¹⁶ Data, for 2012, are from Association of American Medical Colleges (2013). Another possible exception is that Florida lags the U.S. average in primary care physicians per capita by seven percent. Florida's 29.4% of doctors 60 or over is, perhaps unexpectedly, only slightly higher than the U.S. (27.6%). One might expect Florida to have relatively more senior physicians coming to practice part time before fully retiring, but the senior share is larger in nine other states (CA, HI, ME, MT, NJ, NM, NY, OK, and WV).

¹⁷ To establish causation she uses panel data across states and instrumental variables.

were denied admission to nursing programs because of capacity constraints. (Inglehart, 2013) Projections are that supply growth will continue to match demand growth through the coming decade. (Auerbach, Buerhaus, and Staiger, 2012)

As a regulatory reform that would increase the supply of medical care, Florida could join pioneering states in giving nurse practitioners and physician assistants more authority in primary care. By joining the 17 states in which Advanced-Practice Registered Nurses need no physician supervision to diagnose, treat, and prescribe, Florida could both use its existing APRN's, many of whom are nurse practitioners, more effectively and attract more from the other 32 states at reasonable cost. In nine states, NPs have the authority to prescribe, but not to diagnose or treat. In 24, including Florida, they cannot prescribe, diagnose, or treat without physician involvement. 18 Even though median total compensation for general nurse practitioners (and for primary care physician assistants) is less than half that of M.D. general internists and family practitioners, a review of the literature, sponsored by the National Governors Association (Schiff, 2012), said that "the prescribing quality" of NPs matches that of physicians. 19 Patients of NPs were more likely to lose weight and to reduce blood pressure. Medical teams with nurse practitioners proved better at getting patients to control weight. NPs met longer with patients and gained higher patient satisfaction. The report concludes that "None of the studies in NGA's literature review raise concerns about the quality of care offered by NPs." The non-partisan National Institute for Health Care Reform (NIHCR, founders include the UAW and Ford Motor Company) recommends that legislatures "consider ... granting NPs authority as primary care providers.(NIHCR, 2013) In 2010 the Institute of Medicine, with the aid of the Robert Wood Johnson Foundation, formed a task force including physicians and nurses and chaired by Donna Shalala, eight years Secretary of Health and Human Services and since 2001 president of the University of Miami, to study the education and role of nurses. One conclusion from its 671-page report was that "nurses should practice to the full extent of their education and training through the elimination of historical, regulatory, and policy barriers." (Inglehart, 2013)

In sum, the relevant concerns with respect to expanding Medicaid in Florida appear to be (1) Can we avoid creating excessive red tape that increases the demand for administrative personnel? (2) How elastic is the supply of physicians to Florida—how flexible in response to changes in demand? (3) Can steps be taken, such as further regulatory and tort reform, to boost the supply of medical care?

6. Economic and Fiscal Impact of Expansion

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¹⁸ We base our count on the map (Figure 1) in Inglehart (2013), not on his count, which omits one state. ¹⁹ The median compensation numbers, from Inglehart, in 2011 were general internists, \$215,689; family

practitioners, \$200,114; nurse practitioners (general category), \$93,977; and physician assistants, \$92,635.

Regarding the effect of expanding Medicaid on the Florida economy (beyond the efficiency of the medical sector), I defer to a study by my University of Florida colleagues Alan Hodges and Mohammad Rahmani (2013). They apply an IMPLAN model for the state to enrollment, funding, and cost projections from the state's Office of Economic and Demographic Research March 2013 Social Service Estimating Conference." They project that on average over the next ten years expanding Medicaid would increase Florida's employment by 120,000 and annual gross state product by about \$9 billion. Not surprisingly, the largest increases in jobs (49,000) and annual value added (\$3 billion) are in health and social services, with professional, scientific, and technical services second (6,400 jobs, \$0.5 billion value added). Expanding Medicaid, they project, would aid Florida's goals of creating jobs and encouraging high tech. I note, however, that in normal times increasing jobs would not be a goal of expanding Medicaid. If productivity—output per worker—improves in the medical care industry, employment would decline but in the long run we would be better off. (Baiker and Chandra, 2012) Difficult to measure but potentially just as important is the improved competitiveness, noted earlier, that could come from having a healthier labor force. However, with recovery from the Great Recession continuing only slowly, the times are not normal, so the IMPLAN impact would matter in the near to medium term.

Turning to the fiscal impact, if the state maintains the expanded eligibility into the out years when the federal match drops to 90%, state expenditures from general revenue will rise. A concern is that those expenditures must come from a budget that will be more and more squeezed by rising Medicaid expenditures. The question is by how much. Unfortunately forecasting health care spending is very difficult, and a high degree of uncertainty is involved with any answer. The burden of expansion in Florida will depend on what happens to medical costs nationally, growth of income per capita, and changes in poverty rates. (Dewey 2014, Section 5.) Concern about the impact of the uncertainty regarding the cost of expanding Medicaid was expressed by the FHMO (2013, p.16): "The annual cost of the Medicaid expansion could run anywhere from "\$3.7 billion to \$19.5 billion" The range cited is from a thoughtful comparison by Jonathan Ingram (2013) of assumptions used in four leading national projections.²⁰

For informing the decision whether or not to participate in expansion, the major task as I understand it is not a precise calculation of the impact under current law, which could be positive or negative in theory, but in either case would be small relative to the amount of federal money that would flow into the state and relative to trend expenditures with current coverage. That would be especially true if the state limited the expansion to the three years 2014 to 2016 during which the federal government bears nearly 100% of the cost (the

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²⁰ The projections compared are by The Urban Institute, the Congressional Budget Office, Georgetown University's Health Policy Institute, and Florida's Social Services Estimating Conference.

exception being added administrative costs). Even after the phase-in period following which the state would pay slightly over 10% of the cost (again, with added administrative expenses), the return to the medical sector and to overall job creation would be well worth it.²¹ Any extra cost would easily be covered by a modest hike in the sales tax, with the regressive feature of the sales tax being offset by the progressive nature of the expansion of medical insurance to low-income adults.

The true concern is rather that the federal government, with its unsustainable budget and dysfunctional partisanship, may both reduce federal funding and, at the same time, force states to maintain the expansion. (FHMO, 2013; Fodeman, 2013) That would indeed strain the state budget. One would think that the political cost of doing that would be so high that it would not happen. A report by the Health Policy Institute at Georgetown University states, "The Federal government has made clear that states can opt in and out of covering this newly eligible population at any time." (Alker, Hoadley, and Prater, 2012) But that interpretation warrants further study, since other statements at the federal level have had to be modified later. One proposal is for Florida to adopt the expansion for three years during which the budgetary cost to the state would be trivial and then rescind it. That, however, also seems politically unrealistic, though if Medicaid does in fact harm low-income people as badly as opponents say, that harm should become obvious over two or three years, making repeal easier. The most likely scenario that the state should analyze is permanent expansion with the federal government maintaining the law essentially as is. Consideration of possible alternatives, though they are unlikely, would be a good precaution.

Related to the effect on the Florida economy, with the removal of the extra federal Medicaid subsidies associated with the anti-recession stimulus package, even without the expansion of Medicaid under the PPACA, in federal fiscal year 2016 Florida would subsidize the Medicaid programs of other states, to the tune of around \$4.7 billion annually. IRS data suggest that in 2012, in 2005 Florida's share of federal taxes was 4.9%. Florida's 2012 FMAP (Federal Medical Assistance Percentage) was 0.5604, compared to a spending-weighted state average of 0.5702. Florida was 1.7% lower than the spending-weighted state FMAP average. Using admittedly rough-and-ready projections by Holahan et al (2013, Table 5) for federal spending on Medicaid by state, I estimate that without Medicaid expansion, Florida will subsidize other states by \$4.7 billion. If, however, Florida were to expand Medicaid, we would be a net recipient of subsidies *from* other states of \$1.7 billion. I emphasize that those are very approximate figures. But I do think they make an important point.

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²¹ See also Dorn et al (2013), Angeles (2012), Price and Eibner (2013), and State of Florida Social Service Estimating Conference (2013). Numerous reports for other states come to similar conclusions.

²² Calculated from data on the Kaiser Family Foundation's Medicaid web site. Florida was 2.7% below the population-weighted FMAP, but that is less relevant.

7 Conclusion

In *Tough Choices* (2005), published by the LeRoy Collins Institute in 2005, co-author Carol Weissert wrote a chapter titled "Medicaid: The 800-Pound Gorilla." Her title has turned out to be right on the mark. "Medicaid," she wrote, "is inexorably complicated and time-consuming." In this essay I have only touched on those complications. Moreover, to continue with large animal metaphors, I have somewhat ignored the elephant in the room, the strong partisan feelings about the PPACA or Obamacare. I suspect that many legislators, Republican and Democrat, base their opinion on whether Florida should expand Medicaid more on their opinions on the national issue of medical care reform than on their views about what is best for Florida alone. In voting on this particular state policy, their primary concern is for the nation and its citizens.

I do not disparage that concern. In fact, I applaud it. In **Tough Choices** I observed that when the legislature required that every classroom contain a flag, it was the stars and stripes not the red saltire on white. I also wrote that if Florida is a haven for retirees escaping their fair share of the cost of educating the new generation of Americans, the "effect on the nation is not disastrous, but also not helpful and not Florida's highest calling." (p. 414) While praising our legislators' national allegiance, however, Florida's citizens should ask whether rejecting or supporting Medicaid expansion is the best way to oppose or support the PPACA. The Commonwealth Fund estimates that Florida's net loss of federal funds in 2022 from rejecting Medicaid would be \$5 billion, making the state the second largest loser (after Texas). (Glied and Ma, 2013.) All such projections are crude, but nonetheless is rejecting expansion cost effective compared to alternatives ways of opposing or supporting Obamacare? Answers to questions such as whether expanding Medicaid would harm or help the state's low-income residents should be based on the best evidence that exists. Once I felt a twinge of failure as a teacher when a former student, now one of Florida's city commissioners, told me at lunch that he had quit seeking impartial sources. Now, he said, he made decisions based on his gut instincts and sought evidence merely to support his instinctive positions.

Medicaid, to repeat Carol Weissert's statement, is "inexorably complicated." As I read the evidence, I conclude that expanding Medicaid would slowly improve the health of low-income households (though by how much is hard to say), would probably not raise the average cost of medical care to other Floridians, would quite probably not endanger the state budget, would boost the economy in the intermediate term, and is favored by a majority of registered voters. But I cannot claim that I know enough about all of the ramifications of expanding Medicaid to assert with high confidence that the conclusions I reach in this essay are correct. I do think, however, that the details I present show that choosing whether to expand Medicaid is tough. Florida should not reject that much federal funding without at least convening its best-informed minds representing a variety of perspectives to guide the choice.

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