

# Is Medicaid Expansion Worth It?

## A Review of the Evidence Suggests Targeted Programs Represent Better Policy

by Brian Blase, Ph.D., and David Balat

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## A Review of the Evidence Suggests Targeted Programs Represent Better Policy

Brian Blase, Ph.D., and David Balat<sup>1</sup>

### Introduction

Ten years after the Affordable Care Act (ACA) became law, its primary impact has been significantly expanding enrollment in Medicaid. This is largely because exchange enrollment is just 40 percent of what was expected.<sup>2</sup> As a result of the ACA, in 2019, the federal government spent about \$120 billion subsidizing coverage through both the Medicaid expansion and through subsidies for coverage purchased on the new exchanges.<sup>3</sup> All this new spending has been a boon to America's health care industry ([Council of Economic Advisors](#)). Still, two key questions remain: (1) how all these resources poured into insurance companies, hospitals, and health care providers has affected Americans' health and well-being and (2) whether these resources could have been directed in other ways to better improve Americans' health and well-being.

Two of the best designed health coverage studies—the RAND health insurance experiment and the Oregon Medicaid experiment—showed that health insurance expansions produce negligible average effects on health. At a macro level, there has been a significant coverage expansion since 2013, but on one key metric—mortality—population health has worsened since the implementation of the ACA. Life expectancy declined for three straight years from 2014 to 2017.

Three economic studies released since 2018 attempted to assess the effect of the ACA's Medicaid expansion on mortality. One paper found that near-elderly individuals who had low income in the five-year period before the expansion took effect had lower mortality rates after 2013 in expansion states ([Miller et al.](#)). A second paper found broader mortality reductions in Medicaid expansion states, but with the largest effect also concentrated among 55- to 64-year-olds ([Borgschulte and Vogler](#)). However, a third paper found no discernible effect of Medicaid expansion on mortality for the same age group and stresses the difficulty of drawing definitive conclusions from this type of research ([Black et al. 2019](#)).

This study contrasts the overall mortality trends for adults across four different categories of states—those that had already significantly expanded Medicaid to low-income, non-disabled, working-age adults before the ACA; states that adopted the ACA Medicaid expansion on January 1, 2014; states that adopted the expansion between January 1, 2014, and July 1, 2016; and states that had not adopted the expansion by the end of 2017. Perhaps surprisingly, mortality trends for non-elderly adults from 2013 to 2017 were worse in Medicaid expansion states, particularly states that expanded their Medicaid programs after January 1,

### Key Points

- The ACA significantly expanded insurance coverage between 2013 and 2017, but Americans' health worsened during this period as life expectancy declined for three consecutive years from 2014 to 2017.
- States that did not adopt Medicaid expansion had favorable mortality trends from 2013 to 2017 compared with states that adopted the expansion, in part because they had fewer people die from opioid overdoses.
- Medicaid expansion was associated with improvements in self-reported health and greater financial peace of mind, with mixed evidence on physical health benefits. It was associated with a decline in mortality for those near retirement age.
- The bulk of the evidence suggests that targeted health programs, including those geared toward children, prove to be far better public investments than does a massive Medicaid expansion.
- Large coverage expansions disappoint for several reasons: the uninsured receive nearly 80 percent as much care as similar insured people, the crowd-out of private coverage, and indirect effects on others such as longer wait times for care.

<sup>1</sup> This study was peer-reviewed.

<sup>2</sup> In 2013, the Congressional Budget Office (CBO) estimated there would be 25 million enrollees in the ACA exchanges in 2019. It turns out that there were fewer than 10 million ([Congressional Budget Office 2020](#)).

<sup>3</sup> According to the CBO, in fiscal year 2019, federal expenditures on adults made eligible for Medicaid by the ACA equaled \$66 billion, and the budgetary effect of premium tax credits equaled \$53 billion ([Congressional Budget Office 2019](#), Table 2-1).

2014, but before mid-2016, compared to non-expansion states. Part of the reason for the mortality differences could be that Medicaid expansion states experienced a far greater increase in drug overdose deaths from opioids after 2013 than states that did not adopt the expansion. This was potentially caused, at least in part, by the ACA's expansion of the program.

Large scale expansions of coverage, like the ACA's Medicaid expansion, produce a sizeable benefit to insurance companies as well as hospitals and providers. The former end up with a significant cut of the spending since most enrollees receive coverage through managed care ([Council of Economic Advisors](#)), and the latter gain additional payments for services they provided for free or low cost ([Finkelstein et al. 2015](#)). Other effects result from large coverage expansions, such as the crowd-out of often superior private coverage, the reallocation of medical services, including away from people who may have more pressing health care needs, and the potential risks that come from unnecessary treatments and testing. Moreover, the uninsured receive nearly 80 percent as much care as similarly insured people. Overall, while the Medicaid expansion benefited many enrollees, improving self-reported health and lowering financial stress, there is mixed evidence on physical health benefits after Medicaid expansion.

The conclusion drawn from several previous studies suggests that the most cost-effective way to use public resources to improve health is through targeted initiatives focused on individuals who are most likely to benefit from health care and medication and through investments in child health. Recent research from economists Nathaniel Hendren and Ben Sprung-Keyser showed that health programs geared toward lower-income children had a substantially positive rate of return but that the return was negative for health programs broadly targeted at lower-income adults ([Hendren and Sprung-Keyser](#)). Additionally, programs that focus aid on providers that care for lower-income populations are almost certainly a better public investment than programs aimed at boosting coverage. For example, federally qualified community health centers have been shown to have a much higher cost-effectiveness with respect to reducing mortality than Medicare ([Bailey and Goodman-Bacon](#)). Ultimately, the enormous outlays of economic resources plowed into Medicaid expansion likely could have been used in a variety of ways to better improve the economic well-being and health of Americans.

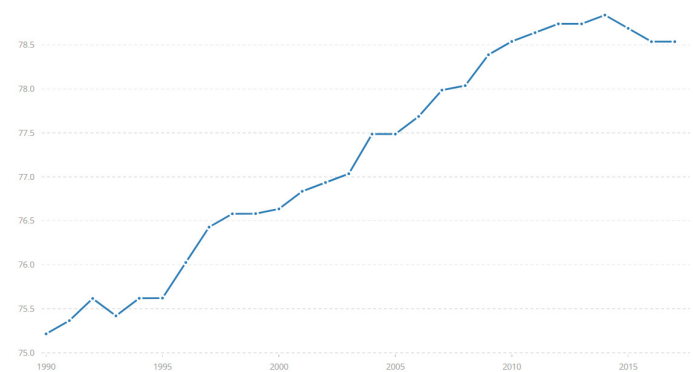
## Health Insurance Expanded and Health Worsened

Since the implementation of the ACA, Medicaid has substantially expanded while private coverage has remained

basically flat. The key provisions of the ACA—the Medicaid expansion and the insurance regulations and premium subsidies—largely took effect in 2014. Almost the entire net coverage gain attributable to the ACA is because of Medicaid's expansion, as roughly an equal number of people have individual market coverage who would otherwise have employer coverage without the ACA ([Blase et al. 2020](#)). This is due, in part, to relatively unattractive products being offered in the new health insurance exchanges as well as many states allowing people who do not meet Medicaid eligibility requirements to enroll. There are between 2.3 million and 3.3 million adults enrolled in Medicaid because of the expansion who report income above the eligibility thresholds and who would not be eligible through another eligibility category, like pregnancy or disability ([Blase and Yelowitz](#)).

Although coverage expanded, population health has worsened since the implementation of the ACA. This is best evidenced by the decline in average life expectancy. Average life expectancy began declining in 2014 in the United States—dropping each year from 2014 through 2017. Such a decline had not occurred in a century since between 1915 and 1918 during World War I and the Spanish Flu pandemic. Most experts largely attribute the recent decline to the opioid epidemic ([Saiidi](#)).

**Figure 1.** Life expectancy in the United States at birth, total years



Source: [World Bank](#)

## Connection Between Health Insurance and Health

Health insurance serves two main purposes—the protection of assets from a high medical expense and a way people obtain care. In essence, a large part of health insurance is essentially pre-payment of health care services with tax-preferred dollars. Health care refers to the services delivered by health care professionals as well as the medications used by people to maintain or improve health. Health generally

refers to peoples' physical, mental, and emotional states of being.

Many researchers have attempted to assess the connection between health insurance and health, trying to determine the causal link between the two. The most convincing evidence suggests that the link is weak ([Hanson](#)). Although somewhat dated, the RAND health experiment was the best designed randomized experiment relating health insurance to health. The participants were randomly divided into four categories based on the degree of patient cost-sharing. The researchers found that people with lower cost-sharing amounts received more care. The additional care, however, failed to produce beneficial health outcomes. The researchers found that while there were some positive impacts for individuals who were most sick, more care did not improve the health status of the average adult ([Newhouse](#)).

In 2008, Oregon utilized a lottery to expand Medicaid to some able-bodied uninsured adults with income below 100 percent of the federal poverty level (FPL). This gave researchers another important study opportunity to assess the causal impact of gaining Medicaid with about the best possible control group for a population health study ([Baicker et al. 2016](#)). New Medicaid recipients increased the amount of health care they received, as measured by hospital admissions, outpatient visits, emergency department utilization, and medication use. The use of several preventive services, such as blood cholesterol checks, diabetes tests, and mammograms, also increased.

Consistent with the RAND experiment, gaining Medicaid did not produce significant health improvements in the Oregon experiment. On the three physical health measures assessed—blood pressure, cholesterol, and blood sugar—people who gained Medicaid did not show a meaningful difference from people who lost out on the lottery ([Baicker et al. 2013](#)). Of note, if health would improve because of Medicaid, we should expect it would improve on these basic measures of health. Medicaid enrollment was associated with better self-reported physical and mental health, however ([Finkelstein et al. 2012](#)).

Importantly, as a testament to the low-perceived value of the program, 40 percent of people who won the lottery did not end up enrolling in Medicaid. One researcher analyzing the Oregon experiment found the potential negative effect that coverage may have increased tobacco use—a finding that suggests that some amount of moral hazard occurred,

i.e., people taking on more risky health behavior as a result of gaining coverage ([Roberts](#)).

Most studies that assess the impact of health insurance look at its effect on health care utilization or on self-reported health. One health outcome that is easy to measure is mortality, and some studies have assessed the impact of health insurance on mortality. Richard Kronick, who served as the deputy assistant secretary for health policy in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services during the Obama administration, conducted an extensive review of the association between health insurance and mortality, finding that lacking health insurance at baseline was not independently associated with an increased risk of mortality. According to Kronick, “there would not be much change in the number of deaths in the United States as a result of universal coverage” ([Kronick](#)).

In support of Kronick's findings, studies of the introduction of Medicare did not find that the program had a discernible effect on mortality for people upon turning 65 ([Finkelstein and McKnight](#); [Card et al.](#)). Moreover, according to Bernard Black et al.'s more recent review of the literature, “*There is no consistent evidence for statistically significant effects of insurance on mortality for the general adult population. There are some effects for specific vulnerable populations such as those with HIV, but not for others, such as those with a disability*” ([Black et al. 2018, 5](#); emphasis added).

More generally, in a 2004 paper, economists Helen Levy and David Meltzer performed an exhaustive search of the available literature to gather evidence of the causal impact of health insurance on health, finding that most studies claiming to show a causal effect of health insurance on health are not convincing, although there does appear to be a benefit for certain subgroups ([Levy and Meltzer 2001](#)). In a 2008 follow-up paper, Levy and Meltzer scrutinized 15 quasi-experiments<sup>4</sup> that examined the impact of changes in insurance coverage on health ([Levy and Meltzer 2008](#)). Generally, the studies analyzed policy changes that affected specific groups, such as low-income pregnant women, HIV-positive individuals, or seniors. Several studies find health and mortality gains from health insurance for children ([Currie and Gruber](#); [Wherry and Meyer](#); [Brown et al.](#)). Some studies show that insurance expansions can improve access to health care and health status ([Sommers et al. 2017](#); [Simon et al.](#)).

4 While quasi-experiments lead researchers to more reliable insights than observational studies, they are limited for understanding the broader impact of insurance expansions in two primary ways. First, since the insurance expansions generally only impact a small subgroup of the population, the results are not generalizable to broader populations. And second, quasi-experiments generally fail to measure the effects of the expansion on other subgroups in the population even though large expansions may have significant secondary effects.

## Medicaid Recipients Often Have Worse Health Outcomes

Many observational studies find that Medicaid patients typically have inferior health outcomes compared to people with either private coverage or the uninsured ([Dayaratna](#)). For example, a 2010 analysis from the University of Virginia that related insurance coverage and surgical outcomes for nearly 900,000 major operations in the United States and controlled for individual characteristics and co-morbidities, hospital characteristics, as well as factors such as whether the surgery was elective, found that Medicaid patients were 13 percent more likely to suffer in-hospital mortality than the uninsured and twice as likely to die in the hospital as individuals with private insurance ([LaPar et al.](#)). Since proper compliance with post-operative instructions is generally a key factor in recovery and compliance is likely correlated with the type of insurance coverage, looking at in-hospital mortality rates following surgery allows researchers to control for differences in compliance that would otherwise be impossible to control. The authors also found that Medicaid patients were also more likely to suffer complications as they stayed in the hospital an average of 10.5 days, compared to 7 days for the uninsured and 7.4 days for the privately insured.

Observational studies suffer from the design flaw that there may be important ways that individuals with Medicaid are different from individuals with private coverage and individuals without health insurance and that these differences are responsible for the relatively poor health outcomes of Medicaid patients. However, observational studies may be able to provide insights into why outcomes are worse for Medicaid recipients. There is evidence that Medicaid recipients are assigned to less-experienced surgeons, for example ([Calvin et al.](#)). Moreover, less access to providers is also an issue for Medicaid recipients. A 2012 study found that 31 percent of physicians in 2011 were unwilling to accept any new Medicaid patients—nearly twice the percentage of physicians who indicated they would not accept new privately insured or Medicare patients ([Decker](#)).

### *Benefits of Targeted Programs, Particularly Geared Toward the Young*

As discussed in the previous section, there is evidence that targeted health coverage expansions provide benefits to children and more vulnerable groups, such as pregnant women or HIV-positive individuals. Last year, Harvard economists Nathaniel Hendren and Ben Sprung-Keyser examined 133 policy changes over the past half-century to estimate the “marginal value of public funds,” essentially a measure of the return on investment for many government programs and policies ([Hendren and Sprung-Keyser](#)). They found that spending on the health and education of low-income children yielded the highest returns on investment, by bolstering both their future educational attainment as well as their future income. This was true of Medicaid expansions to children as they estimate that each \$1 of initial spending was fully repaid and that the policy returned an additional \$.78 to the government.

On the other hand, they found that additional health care spending on adult populations had among the worst returns, significantly negative, in fact, in part because such programs reduced incentives to work. It is also worth noting that large coverage expansions likely have a poor return on investment because there is already a myriad of government programs to help lower-income people obtain medical care, including requirements that hospitals render emergency services regardless of ability to pay, federal programs for uncompensated care, federally qualified health centers, and many block grants for low-income population needs.

### **Why Large Coverage Expansions Often Show Limited Health Benefit**

There are several plausible explanations for why targeted coverage expansions can be beneficial, but large increases in public programs may have more limited health effects. First, when public coverage expands, private coverage contracts to some degree. In the health policy literature, this is called “crowd-out.” In a 2008 paper, economists Kosali Simon and Jonathan Gruber estimated a 60 percent crowd-out rate with expansions of Medicaid and CHIP ([Gruber and Simon](#)). This means that for every 100 people gaining coverage from the public expansion, 60 of them replaced private coverage with the public coverage. Crowd-out may be harmful to overall health since private coverage generally provides better access to care than government programs, which pay providers lower rates.

Second, most of the uninsured are already receiving care. In fact, the average uninsured individual utilizes about 80 percent as much health care as similar people with insurance ([Black et al. 2017](#)). Moreover, there are other methods available for financing care, such as paying cash or participating

in other coverage models like a health sharing ministry or direct primary care.

Third, some individuals who are counted as uninsured have access to insurance; Gruber and economist David Cutler refer to these people as “conditionally covered” ([Cutler and Gruber](#)). For example, there are an estimated 6.8 million people who are eligible for Medicaid or CHIP but are not enrolled ([Badger and Hall](#)). Almost every state allows people who are eligible for Medicaid to enroll retroactively with providers able to receive payments for services that they delivered in the three-month period prior to enrollment. Moreover, hospitals can enroll people on site, when they require services, through a process known as “presumptive eligibility. Finally, some people have coverage, such as health sharing ministry plans, that provide them with value and protection against medical risk, but that may not fit the definition of having health insurance.

Fourth, although additional health care provides certain benefits, it can also cause harm. For example, health care researcher and surgeon Atul Gawande and others have written about the enormous amount of overtesting and overtreatment associated with certain conditions ([Gawande; Epstein and ProPublica](#)). This leads to harm from the treatments, such as radiation associated with imaging or unnecessary services, problems like hospital-acquired infections, as well as mental anguish and risk of unnecessary interventions that result from false positives ([Gawande](#)).

### Health Impact of ACA’s Medicaid Expansion

Most of the studies that have assessed the impact of the ACA’s Medicaid expansion have focused on the effect on increasing coverage or on utilization since these are easy to measure. These studies typically compare trends in expansion states with those in non-expansion states. These measures come largely from what individuals self-report, which has some value but is not as reliable as objective measures.

Medicaid expansion increased the number of Medicaid recipients and reduced the probability of being uninsured. Loehrer et al. find that expansion was associated with a 7.5 percentage point decreased probability of patients being uninsured and an 8.6 percentage point increase in patients having Medicaid ([Loehrer et al.](#))

The Medicaid expansion appears to have led to an increase in some forms of preventive health services ([Simon et al.](#); [Sommers et al. 2016](#); [Sommers et al. 2017](#)) as well as improved access to primary care services and fewer skipped medications due to cost ([Sommers et al. 2016](#)). One study found increased prescriptions for people gaining Medicaid, including for people with chronic conditions ([Ghosh et al.](#)).

Courtemanche et al. evaluated whether the ACA’s coverage expansion translated to changes in health care access, risky health behaviors, and short-run health outcomes. They find that gains in insurance coverage were 8.3 percentage points in Medicaid expansion states and 5.3 percent in non-expansion states, reductions in cost being a barrier to care were 5.1 percentage points in expansion states and 2.6 percentage points in non-expansion states. They found similar increases in the probabilities of having a primary care doctor and check-up between expansion states and non-expansion states. They found no statistically significant effect on risky behavior (smoking, alcohol consumption, and body mass index) or self-reported health measures (overall health, days in poor mental health, days in poor physical health, and days with health-related functional limitations) although like other studies they found a significant, albeit small, improvement in mental health among Medicaid expansion enrollees ([Courtemanche et al. 2018](#)).

Expansion states had a decline in people reporting worries about paying medical bills and inability to afford follow-up care ([Miller and Wherry](#)). Importantly, this study also reports a significant increase in people reporting delaying medical care in expansion states because of longer wait times for appointments. Similarly, one study found that expansion states experienced a significant slowdown in ambulance response time ([Courtemanche et al. 2019](#)).

It is generally more difficult to measure the impact on health outcomes, in part because health insurance is loosely related to health and in part because of confounding factors. Therefore, the experimental studies, like the RAND insurance experiment and the Oregon Medicaid experiment, are generally far superior. Many studies look at self-reported health even though it is not clear that self-reported health is well correlated with actual health. For example, the Oregon Medicaid experiment led to an improvement in self-reported health but not better health outcomes. Some studies found an increase in self-reported health associated with the expansion. Much of the benefit in self-reported health could be from greater peace of mind. McMorrow et al. suggest that improvements in mental health status may be driven by reduced stress associated with improved financial security from insurance coverage even though the study finds no significant effects of the expansion on general health status and on change in problems affording drugs or mental health services ([McMorrow et al.](#)). Winkelman and Chang found that Medicaid expansion was associated with a reduction in self-reported poor health days and days limited by poor health but only among adults with chronic conditions ([Winkelman and Chang](#)).

### ***Medicaid Expansion and Mortality***

Two National Bureau of Economic Research (NBER) working papers, as well as an IZA discussion paper released in 2019, assessed the impact of Medicaid expansion on mortality. The one that attracted the most attention was authored by Sarah Miller, Sean Altekruse, Norman Johnson, and Laura Wherry. Their study contrasted trends in mortality for 55- to 64-year-old adults with either low income or low formal education between states that adopted the ACA's Medicaid expansion and non-expansion states ([Miller et al.](#)). They focused on adults of this age because they “are at greater risk of mortality” ([Miller et al., 3](#)). In positing how Medicaid expansion might improve enrollee health, the authors discuss how lower-income populations are at higher risk of diabetes, cardiovascular disease, and respiratory disease and that these conditions can be better managed with medication. The authors also posit that “Medicaid coverage may also affect health if it leads to earlier detection and treatment of life-threatening health conditions. Existing research has documented increased screening of treatable cancers such as breast and cervical cancer with expanded Medicaid coverage ... as well as the detection of cancer both overall and at an early stage ... and improved access to cancer surgery” ([Miller et al., 2](#)). Adding to this finding, Khatana et al. find evidence of a decrease in rates of cardiovascular disease among adults ages 45-64 associated with states adopting Medicaid expansion ([Khatana et al.](#)).

Miller et al. used responses from the 2008 to 2013 American Community Survey (ACS)—an annual survey conducted by the U.S. Census Bureau—to identify individuals most likely to benefit from the Medicaid expansion. They focus on people aged 55-64 in 2014, who have income below 138 percent of the federal poverty line in 2008 through 2013 or who did not graduate from high school. The authors exclude non-citizens and those receiving Supplemental Security Income, i.e., people with a disability who are likely to be Medicaid-eligible in the absence of the expansion.

They track these individuals for whether they died, investigating the mortality trends between Medicaid expansion and non-expansion states.<sup>5</sup> According to their findings, starting in 2014—the year the Medicaid expansion took effect—the mortality trajectories diverged, with lower rates among the tracked individuals in expansion states. They found that in the first year, the probability of mortality declined by 6.4 percent with an increased impact in subsequent years. For this population, disease-related causes of death were reduced in expansion states, without evidence

that deaths from external causes, such as car accidents, declined. The paper suggests that crowd-out of other coverage was substantial—equal to about 48 percent in 2014 and 61 percent in 2017.<sup>6</sup>

A second paper, this one co-authored by Mark Borgschulte and Jacob Vogler, also estimates that the Medicaid expansion saved lives, equal to about a 3.6 percent reduction. They assessed aggregate mortality among all 20- to 64-year-olds, arguing that expansion may have benefited a broader population than the newly insured. Borgschulte and Vogler utilized propensity score matching to get a set of treatment counties (those in expansion states) and control counties (those in non-expansion states) for pre-2014 trends. They control for age, race, economic factors, political factors, and the uninsurance rate, and they separate mortality into amenable causes (deaths that are associated with access to care) and non-amenable causes. They find that declines in deaths from amenable causes account for slightly more than half of the reduction in mortality. Consistent with Miller et al., they find that the mortality decline is concentrated among 55- to 64-year-olds with much of the decline driven by cardiovascular and respiratory-related mortality ([Borgschulte and Vogler](#)). Borgschulte and Vogler claim that Medicaid expansion could have beneficial externalities, but this claim is odd since health care utilization overwhelmingly results in private benefits and costs, rather than social benefits and costs, and there is evidence that Medicaid expansion results in longer wait times and crowd-out of care for other populations.

A few months before the Miller et al. study appeared as an NBER working paper, another NBER paper published by Bernard Black, Alex Hollingsworth, Leticia Nunes, and Kosali Simon, linking mortality data compiled by the National Center for Health Statistics with county-level data from the Census Bureau, reached a very different conclusion ([Black et al. 2018](#)). They also focused on individuals aged 55-64 “both because they are more likely than younger persons to have health conditions for which healthcare is important for survival, and because focusing on this age band makes the above [those covered by Medicare] and below-65 groups more comparable” ([Black et al. 2019, 4](#)). The authors did not find a statistically significant pattern of results consistent with Medicaid expansion causing mortality changes, although they were unable to rule out large effects in either direction. They write that the “standard errors are far too large to allow detection of effects of plausible sizes” ([Black et al. 2019, 37](#)). They provide several

5 The authors use the Census Numident file, which contains administrative records on the date of death for all individuals with SSN who died in the United States. The administrative record does not include the cause of death.

6 Miller et al. find that “reported Medicaid coverage increases by 7.3 percentage points in the first year and by 9.9 percentage points four years after the expansion relative to the year prior to expansion, while uninsurance decreases by 3.8 percentage points in the first year and 3.9 percentage points four years after the expansion” ([10-11](#)).



explanations for the failure to find a discernible correlation between Medicaid expansion and mortality.

The average increase in health insurance coverage attributable to Medicaid expansion over 2014-2016 is only around 1.1% for persons aged 50-64, and only around 4% even when we hone in on low-educated populations; precise income measures used to determine ACA eligibility are unavailable in mortality data. A second reason for failure to reject the null of no effect is a high level of “noise”—substantial background variation in mortality, and mortality trends, across states and demographic groups. A third reason is that mortality is a low-frequency outcome. We note too that effects of health insurance on mortality are more likely to emerge over a long time frame. ([Black et al. 2019, 4](#))

They also noted “non-parallel pre-treatment trends between treated and control states; mortality among those aged 55-64 drops fairly substantially in treated [Medicaid expansion] states over 2009-2013 relative to control [non-Medicaid expansion] states” ([Black et al. 2019, 7](#)). Ideally, the trend in the dependent variable—in this case mortality—between the treatment and control groups in the period before the treatment occurs would be similar, so that the treatment could be better isolated as the key factor in explaining differences between the two groups in the post-treatment period.

Black et al. also “provide a simulation-based power analysis, showing that even the nationwide natural experiment provided by the ACA is underpowered to detect plausibly sized mortality effects in available datasets” ([Black et al. 2019, 2](#); emphasis added). According to the authors, “[t]he power challenge is to find statistically significant evidence for a fall in mortality of 100 persons (or less), in a combined treated and control population of around 29 [million], with 170,000 annual deaths. ... that challenge cannot be met without individual level data on personal characteristics (income, family status, pre-ACA insurance and health status) ... linked to mortality data. Even with that data (not currently available), one would need a very large sample of newly insured persons and similar controls” ([Black et al. 2018, 31](#)).

Black et al. conclude that “While it is possible that the mortality effect of the ACA health insurance expansion variation we study may materialize with more time, other factors make it unlikely they too could be statistically detected; lengthening the study period would increase likelihood that other sources of variation, including cross-border moves, the instability of insurance status over time, and the underlying causes of the non-parallel pre-treatment trends we observe, will pose challenges for credible causal inference. Moreover, our power analysis implies that an extra few

years would still be insufficient to attain reasonable power, given plausible effect sizes” ([Black et al. 2018, 37](#)).

### **General Concerns and Bias with Many Health-Related Economic Studies**

It is increasingly recognized that many economics studies reach unreliable conclusions because of a lack of statistical power. John Ioannidis, T.D. Stanley, and Hristos Doucouliagos find that nearly 80 percent of reported effects in a review of nearly 7,000 empirical studies had reported effects that were exaggerated, typically by a factor or two with one-third inflated by a factor of four or more ([Ioannidis et al.](#)).

Black et al. also discuss “file-drawer bias,” or the tendency for insignificant results to remain unpublished ([Black et al. 2018, 4](#)). They reference work done by McCrary, Christensen, and Fanelli, who “propose a minimum t-statistic of around 3 to correct for file-drawer bias alone” ([Black et al. 2018, 4](#); [McCrary et al.](#)).

In addition to file-drawer bias, there is also ideological bias with what topics get researched and which results get published. For example, research that suggests that big social programs are not working as intended or not as successful as left-of-center politicians promote may cause professional damage to individuals who release such findings. For example, Kronick has said he hesitated and agonized over whether to publish his research showing that health insurance did not lead to mortality reductions. According to a PolitiFact piece on health insurance and mortality,

*Kronick even told PolitiFact that his finding was “not the answer I wanted,” and, as a result, he agonized over whether to publish it or not. He said he’s “grateful” that it has so far been unnoticed in the increasingly hostile debate over health care. “I don’t have a whole lot of friends, and will probably lose a few over this,” he told us. “And I might make some friends I didn’t want.”* ([Jacobson](#))

### **Mortality Trends Worsened in Expansion States Relative to Non-Expansion States After 2013**

While both the Miller et al. paper, Borgschulte and Vogler paper, and Black et al. papers engage in advanced statistical techniques to try to gauge the effect of Medicaid expansion on the mortality of lower-income adults, simple trends show that overall mortality worsened in Medicaid expansion states relative to non-expansion states after 2013. In other words, the percent increase in mortality rates in states that adopted the Medicaid expansion, particularly for states that adopted the expansion between January 1, 2014, and July 1, 2016, exceeded the increase in states that did not adopt the expansion after 2013.

**Figures 1-6** and **Tables 1-6** are for the entire population in the state, based on age category. Therefore, they do not show separate effects for people who are lower-income and thus more likely to be directly affected by the Medicaid expansion. That level of demographic breakdown is not possible with the Center for Disease Control mortality data. However, a large public insurance expansion creates important indirect effects on people who do not directly gain coverage as a result. For example, as referenced above, states that expanded Medicaid had a significant slowdown in ambulance response time ([Courtemanche et al. 2019](#)). For some people with pressing medical conditions, a slowdown in ambulance response time could be life-threatening. Thus, it is important to be aware of overall trends in population health after a big demand-side impact, such as moving a significant number of people into Medicaid coverage.

**Table 1** and **Figure 1** show the trends in age-adjusted mortality for the population between the ages of 15 and 64. The tables show the percent change in mortality in the pre-expansion period (2009 through 2013) and the post-expansion period (2013 through 2017). There are four categories of states—(1) those that expanded their Medicaid programs significantly into the non-disabled, working-age adult population before 2014 (early expansion states), (2) states that adopted the expansion on January 1, 2014, (3) states that adopted the expansion between January 1, 2014, and July 1, 2016 (later expansion states), and (4) states that had not adopted the expansion as of the end of 2017.

**Tables 2-6** and **Figures 2-6** are for ten-year age groups. The main contrast to determine the effect of the expansion on mortality over this period is states that adopted the expansion on January 1, 2014, with the non-expansion states. The last column in the tables shows the differences between the mortality change on January 1, 2014, in expansion states and the mortality change in non-expansion states. Positive

numbers indicate a worsening trend in expansion states. Here are some main observations:

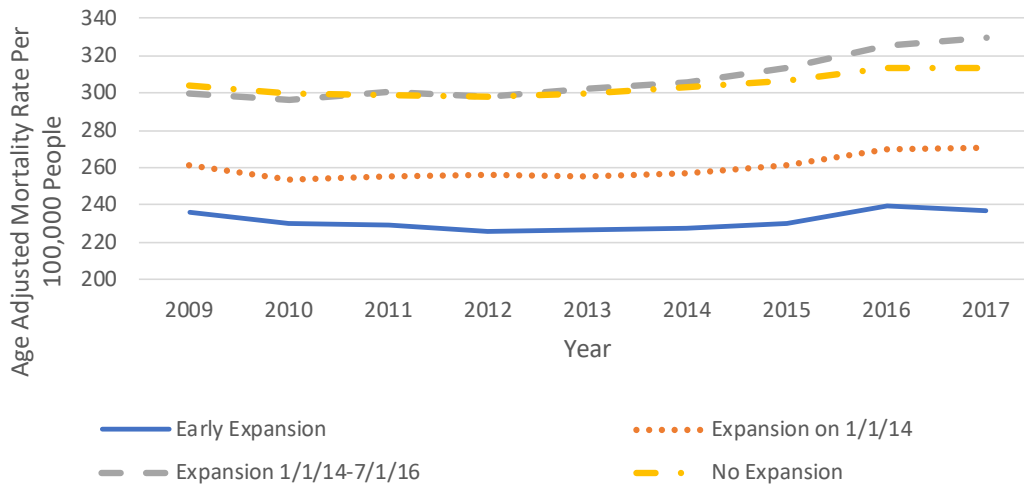
1. Mortality rates declined from 2009 to 2013 in all the categories of states, except in states that adopted Medicaid expansion between January 1, 2014, and July 1, 2016.
2. Mortality rates increased from 2013 to 2017 in all the categories of states, but the increase was the smallest in non-expansion states.
3. Between 2013 and 2017, the difference in the percent increase in mortality on January 1, 2014, in expansion states exceeds that in non-expansion states by about 1.5 percent.
4. For all but one age group, the mortality trend in non-expansion states outperformed the mortality trend in expansion states from 2013 to 2017. For 15- to 24-year-olds, it was better by 1.5 percent; for 25- to 34-year-olds, it was better by 1.9 percent; for 35- to 44-year-olds, it was better by 3.7 percent, and for 45- to 54-year-olds, it was better by 3.1 percent. The trend was worse for 55- to 64-year-olds by 0.8 percent.
5. As the figures, particularly **Figure 1**, make clear, the best comparison with non-expansion states in the pre-period was states that adopted the expansion between January 1, 2014, and July 1, 2016. The overall mortality rate between these two sets of states was nearly identical in the earlier years in the period but diverged in the middle of the period, with the mortality trends worsening in expansion states relative to non-expansion states. The differences are pronounced for all the age groups between 15 and 54.

**Table 1.** Age-adjusted mortality percent change, ages 15-64, by Medicaid expansion status

Year	Early Expansion	Expansion on 1/1/14	Expansion 1/1/14 – 7/1/16	No Expansion	(2) - (4)
'09-'13	-3.86%	-2.41%	0.93%	-1.41%	-0.99%
'13-'17	4.54%	6.00%	8.96%	4.54%	1.46%
<b>Difference</b>	<b>8.40%</b>	<b>8.40%</b>	<b>8.03%</b>	<b>5.95%</b>	<b>2.45%</b>

Source: CDC Mortality Data

**Figure 1.** Age-adjusted mortality percent change, ages 15-64, by Medicaid expansion status



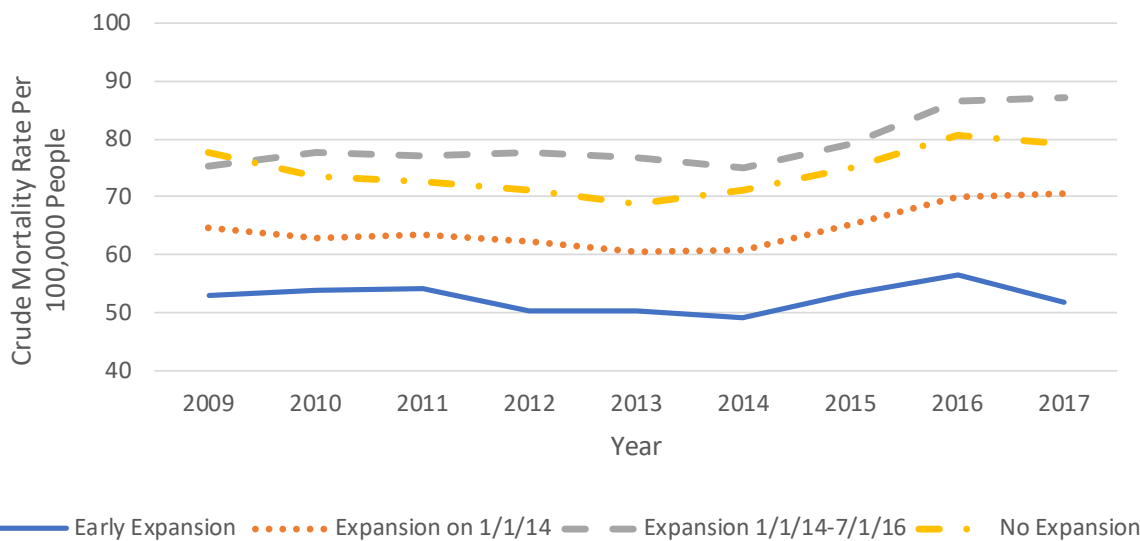
Source: CDC Mortality Data

**Table 2.** Crude mortality percent change, ages 15-24, by Medicaid expansion status

Year	Early Expansion	Expansion on 1/1/14	Expansion 1/1/14 – 7/1/16	No Expansion	(2) - (4)
'09-'13	-4.73%	-6.18%	1.99%	-11.33%	5.14%
'13-'17	2.78%	16.14%	13.28%	14.66%	1.49%
<b>Difference</b>	<b>7.50%</b>	<b>22.33%</b>	<b>11.29%</b>	<b>25.98%</b>	<b>-3.66%</b>

Source: CDC Mortality Data

**Figure 2.** Crude mortality percent change, ages 15-24, by Medicaid expansion status



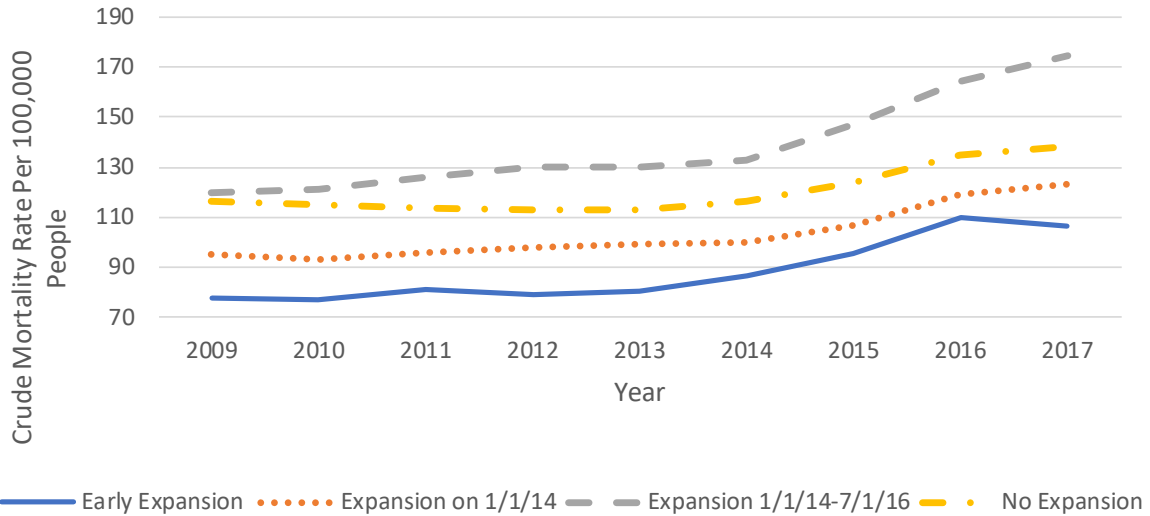
Source: CDC Mortality Data

**Table 3.** Crude mortality percent change, ages 25-34, by Medicaid expansion status

Year	Early Expansion	Expansion on 1/1/14	Expansion 1/1/14 – 7/1/16	No Expansion	(2) - (4)
'09-'13	3.72%	3.87%	8.17%	-2.50%	6.37%
'13-'17	31.89%	23.89%	34.44%	22.00%	1.89%
<b>Difference</b>	28.17%	20.02%	26.27%	24.49%	-4.48%

Source: CDC Mortality Data

**Figure 3.** Crude mortality percent change, ages 25-34, by Medicaid expansion status



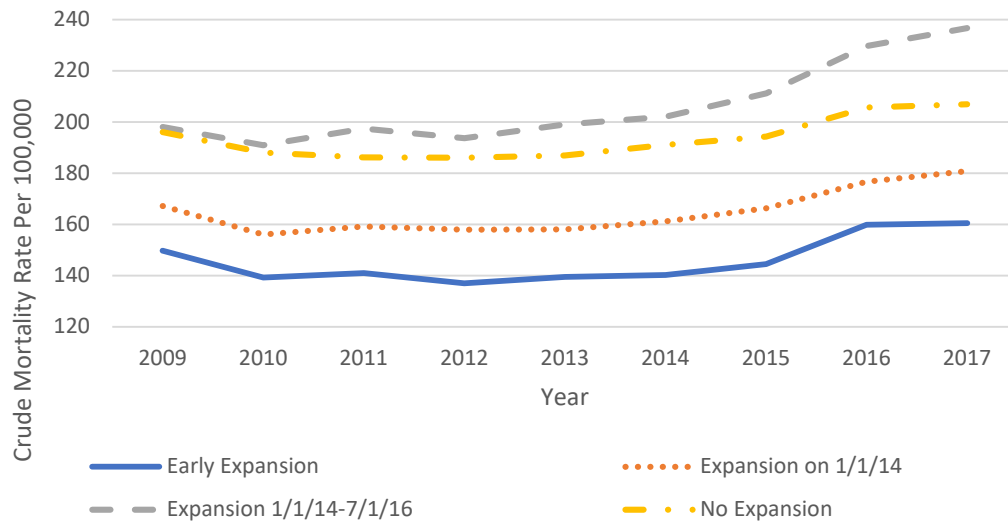
Source: CDC Mortality Data

**Table 4.** Crude mortality percent change, ages 35-44, by Medicaid expansion status

Year	Early Expansion	Expansion on 1/1/14	Expansion 1/1/14 – 7/1/16	No Expansion	(2) - (4)
'09-'13	-6.88%	-5.50%	0.51%	-4.64%	-0.86%
'13-'17	15.06%	14.43%	18.94%	10.70%	3.73%
<b>Difference</b>	21.96%	19.93%	18.44%	15.34%	4.59%

Source: CDC Mortality Data

**Figure 4.** Crude mortality trends, ages 35-44, by Medicaid expansion status



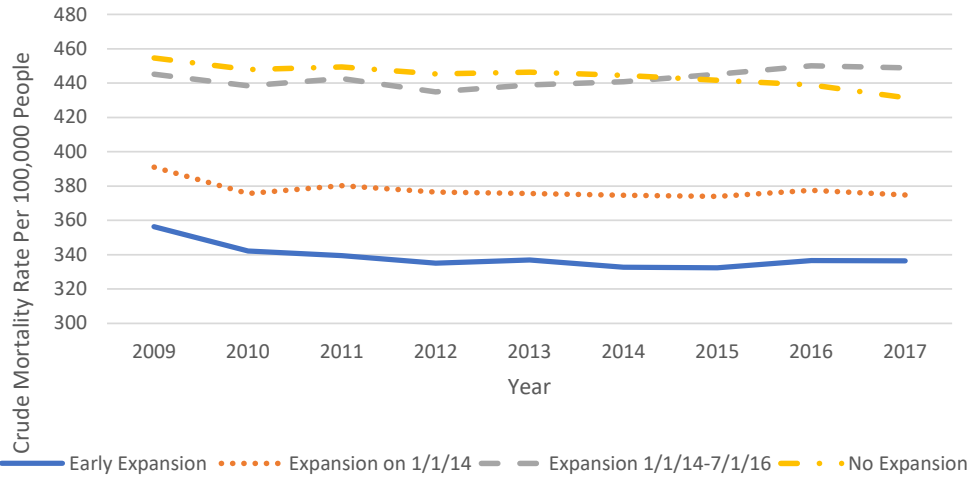
Source: CDC Mortality Data

**Table 5.** Crude mortality percent change, ages 45-54, by Medicaid expansion status

Year	Early Expansion	Expansion on 1/1/14	Expansion 1/1/14 – 7/1/16	No Expansion	(2) - (4)
'09-'13	-5.44%	-3.94%	-1.42%	-1.83%	-2.11%
'13-'17	-0.18%	-0.21%	2.28%	-3.32%	3.10%
<b>Difference</b>	5.27%	3.73%	3.69%	-1.49%	5.22%

Source: CDC Mortality Data

**Figure 5.** Crude mortality trends, ages 45-54, by Medicaid expansion status



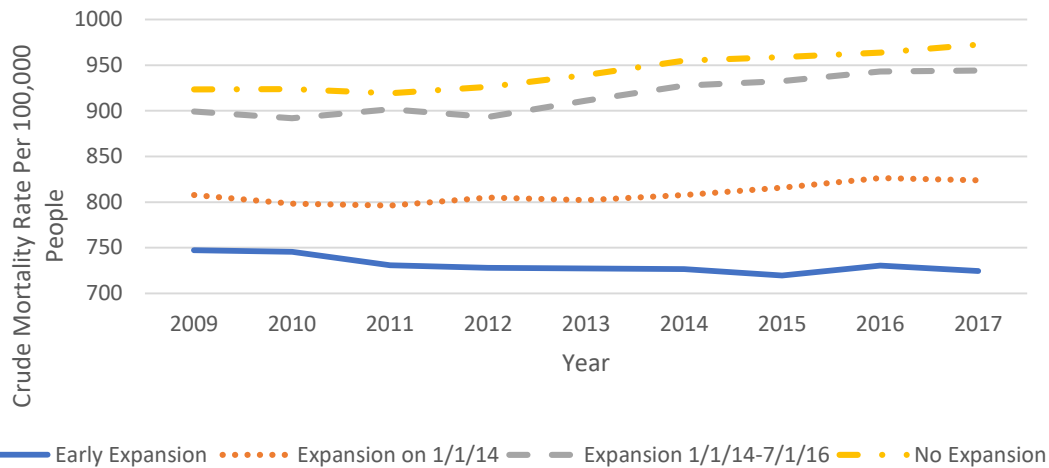
Source: CDC Mortality Data

**Table 6.** Crude mortality percent change, ages 55-64, by Medicaid expansion status

Year	Early Expansion	Expansion on 1/1/14	Expansion 1/1/14 – 7/1/16	No Expansion	(2) - (4)
'09-'13	-2.68%	-0.69%	1.32%	1.70%	-2.39%
'13-'17	-0.37%	2.72%	3.62%	3.56%	-0.84%
<b>Difference</b>	2.31%	3.41%	2.30%	1.86%	1.56%

Source: CDC Mortality Data

**Figure 6.** Crude mortality trends, ages 55-64, by Medicaid expansion status



Source: CDC Mortality Data

**Table 7.** Medicaid expansion categories

Early Expansion	Expansion Jan. 1, 2014	Expansion 1/2/14-7/1/16	Non-expansion
Delaware	Arizona	Alaska (9/1/15)	Alabama
DC	Arkansas	Indiana (2/1/15)	Florida
Massachusetts	California	Louisiana (7/1/16)	Georgia
NY	Colorado	Michigan (4/1/14)	Idaho*
Vermont	Connecticut	Montana (1/1/16)	Kansas
	Hawaii	New Hampshire (8/15/14)	Maine*
	Illinois	Pennsylvania (1/1/15)	Mississippi
	Iowa		Missouri
	Kentucky		Nebraska*
	Maryland		North Carolina
	Minnesota		Oklahoma
	Nevada		South Carolina
	New Jersey		South Dakota
	New Mexico		Tennessee
	North Dakota		Texas
	Ohio		Utah*
	Oregon		Virginia*
	Rhode Island		Wisconsin
	Washington		Wyoming
	West Virginia		

States have been categorized by their Medicaid expansion status. DW, DC, MX, NY, and VT implemented comprehensive Medicaid expansions for childless adults before the ACA. Expansion Jan. 1, 2014, are states that expanded on the date set forth by the ACA. Expansion Jan. 2, 2014, to Dec. 31, 2017, are states that expanded during those dates, with the data set used including mortality information through 2017. Non-expansion states did not expand prior to Dec. 31, 2017.

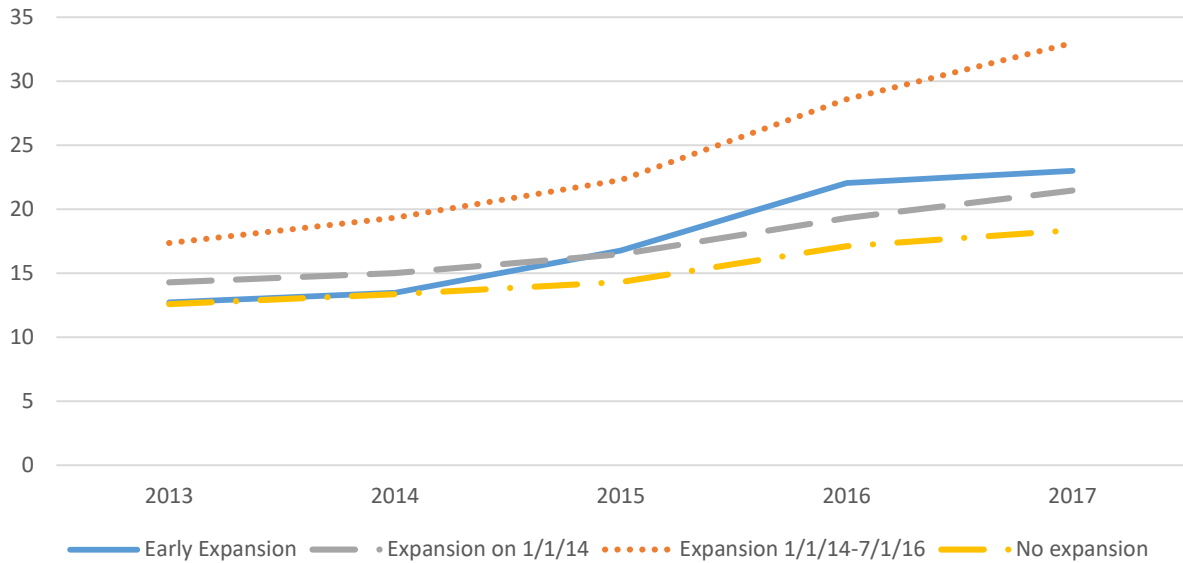
\* These states have since expanded their Medicaid: ID (1/1/20), ME (1/10/19), UT (1/1/20), and VA (1/1/19). NE submitted a section 1115 waiver to CMS on 12/12/19 and has a state plan amendment that delays expansion until 10/1/20 to allow the state time to have its 1115 waiver approved.

## Opioids as a Potential Explanation for Rising Mortality in Medicaid Expansion States

Much of the blame for the decline in overall life expectancy between 2014 and 2017 has been placed on the opioid crisis. Some have speculated that the Medicaid expansion, at least initially, worsened the crisis. According to Sam Quinones' book *Dreamland*, which investigated the history of the opioid crisis, Medicaid played a key role in fueling it. He writes, "The [Medicaid] card provides health insurance through Medicaid, and part of that insurance pays for medicine—whatever pills a doctor deems an insured patient needs" (Quinones). The ACA led to a surge of additional people with Medicaid cards, generally starting in 2014, although

earlier in the early expansion states. According to data from the Centers for Disease Control and as **Figure 7** and **Figure 8** show, drug overdose death rates increased more in the states that expanded Medicaid, whether early expansion states, states that expanded on January 1, 2014, or states that adopted the expansion between January 1, 2014, and July 1, 2016, relative to non-expansion states. The figures show the CDC mortality data weighted by state population. According to the unweighted mortality data, from 2013 to 2017, the mean overdose death rate increased by 80.5 percent in early expansion states, 57.7 percent in states that expanded on January 1, 2014, 69.1 percent in late expansion states, and just 38.3 percent in non-expansion states.

**Figure 7.** Overdose rate per 100,000, per year



Source: [Centers for Disease Control and Prevention](#)

**Figure 8.** Growth in overdose rate, 2013-2017



Source: [Centers for Disease Control and Prevention](#)

In 2017, the Department of Health and Human Services also produced an analysis showing that the percentage increase in overdose deaths surged in Medicaid expansion states relative to non-expansion states from 2013 to 2015 ([Johnson](#)). HHS also contrasted the increase in overdose

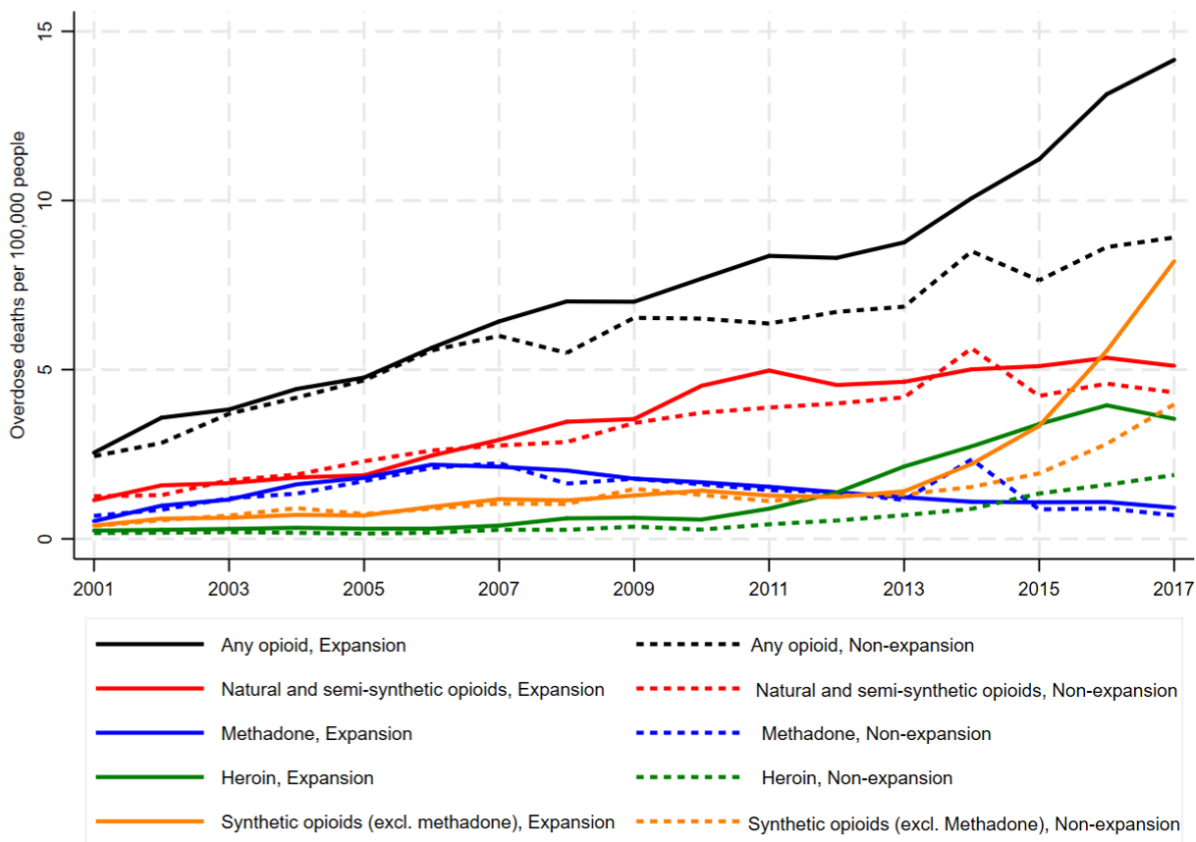
death rates in comparatively similar non-expansion and expansion states. Their findings are produced in **Table 8** ([Johnson](#)) and show that the expansion states all had much greater percent increases in opioid overdose deaths than did non-expansion states.

**Table 8.** Percentage increase in overdose deaths from 2013-2015, selective comparisons of similar states

Expansion State	Overdose Death Change	Non-Expansion State	Overdose Death Change
New Hampshire	108%	Maine	55%
North Dakota	205%	South Dakota	18%
Arkansas	23%	Louisiana	6%
Maryland	44%	Virginia	22%
Ohio	41%	Wisconsin	3%
West Virginia	27%	Mississippi	11%

Source: HHS analysis produced by Senator Johnson.

**Figure 9.** Opioid overdose deaths in U.S. counties, by state Medicaid expansion status



Source: [Kravitz-Wirtz et al. 2020b](#).

It is also possible to extend HHS’s analysis for late expansion states. One of the states worst hit by the opioid crisis was Pennsylvania, which began its expansion on January 1, 2015. Between 2014 and 2016, opioid overdose deaths soared in Pennsylvania, from a rate of 21.9 per 100,000 people to a rate of 37.9, an increase of 73 percent. (Of note, Pennsylvania represents more than a third of the population of late expansion states, so the surge in opioid overdose deaths in Pennsylvania is a key reason for the large increase in overdose rates shown in late Medicaid expansion states shown in **Figure 7** and **Figure 8**.) As a comparison, between 2014 and 2016, the rate in Wisconsin increased

from 15.1 to 19.3 (a 28 percent increase), and the rate in Virginia increased from 11.7 to 16.7 (a 43 percent increase) during this period. As another example, Indiana adopted its expansion on February 1, 2015, and its opioid overdose rate between 2014 and 2016 climbed from 18.2 per 100,000 people to 24 (a 32 percent increase). The rate in the neighboring state of Tennessee increased from 19.5 to 24.5 (a 26 percent increase) during this period.

The causal effect of Medicaid expansion on opioid death rates is controversial. Some critics of the link between Medicaid expansion and opioid overdose deaths, such as



economist Andrew Goodman-Bacon and former CMS spokesperson during the Obama administration Emma Sandoe, believe that it is inappropriate to compare Medicaid expansion and non-expansion states because the death rate from opioids started climbing in Medicaid expansion states relative to non-expansion states prior to 2014. According to their study, counties with more uninsured in 2013 experienced smaller increases in drug-related mortality than counties with fewer uninsured, which they assert casts doubt on the theory that Medicaid expansion worsened the opioid crisis ([Goodman-Bacon and Sandoe](#)).

A recent piece in the *Journal of the American Medical Association* (JAMA) contains a figure (reproduced below as **Figure 9**) in its supplementary online commentary that shows a large increase in opioid death rates in expansion states relative to non-expansion states driven by an increase in synthetic opioids, which are a class of drugs, including tramadol and fentanyl, that mimic naturally occurring opioids ([Kravitz-Wirtz et al. 2020a](#); [Kravitz-Wirtz et al. 2020b](#)).<sup>7</sup> As is clear from the graph, the difference between overdose deaths per 100,000 people in expansion states and non-expansion states was nearly three times greater in

2017 than it was in 2013 and 2014. However, after employing numerous controls and a one-year lag, the regression analysis shows that death rates from opioids, particularly from heroin, fell in expansion states. This result is heavily influenced by the control variables selected because, as **Figure 9** shows, the change from 2013 to 2017 in overdose deaths from heroin in expansion and non-expansion states has been roughly the same. The authors did not publish their results without the one-year time lag, so it is unknown how their decision to include a one-year time lag influenced the results.

Another regression analysis found that the best predictor for the change in overdose rates by states from 2010 to 2015 is the percent of white uninsured in the state in 2015, with states with lower percentages of uninsured having much larger increases in overdose rates ([Spotted Toad 2017b](#)). According to this analysis, in Medicaid expansion states, counties where the percentage of the uninsured declined the most were the ones that had the largest increase in overdose rates ([Spotted Toad 2017c](#)). (The Goodman-Bacon and Sandoe analysis referenced above assessed the uninsured rate in 2013, not the change in the percentage of uninsured.)

## The Failure of TennCare to Improve Health

Through an initiative dubbed TennCare, Tennessee significantly expanded Medicaid in the mid-1990s.\* According to CMS data, the number of Tennesseans receiving Medicaid services increased from 909,000 (17.5 percent of the state population) in fiscal year 1993 to 1,466,000 (28.2 percent of the state population) in fiscal year 1995. The number of individuals in Tennessee's Medicaid program remained near the 1995 level for the remainder of the decade. Of the more than half a million people added to Medicaid, approximately 55 percent were previously uninsured ([Kronick and Gilmer](#)). Consequently, between 1993 and 1995, TennCare increased the number of Tennesseans with health insurance by approximately 307,000 people (5.8 percent of the state population). An estimated 557,000 individuals (10.7 percent of the state population) gained Medicaid coverage, with about 250,000 (4.8 percent of the state population) of these individuals replacing private insurance with Medicaid.

Using Behavioral Risk Factor Surveillance System data, Blase examined trends in insurance coverage, regular doctor check-ups, prohibitively high medical costs, blood pressure and cholesterol checks, flu shots, self-reported health, and mortality rates between Tennessee and its neighboring states before and after TennCare ([Blase 2013](#)). Surprisingly, fewer individuals in Tennessee, particularly women, received regular check-ups with physicians after TennCare. However, the number of Tennesseans having their blood pressure checked and the number of women having their cholesterol checked did show a relative increase after TennCare. While TennCare's enactment was correlated with an increase in some aspects of preventive care, self-reported health among Tennesseans worsened after TennCare. On likely the most important indicator of health—the decline of mortality rates—Tennessee's decline was smaller than the decline in each of its eight neighboring states after the enactment of TennCare. Overall, the first few years after TennCare's enactment suggest that increasing health insurance coverage through a large public insurance expansion did not result in significant population health improvements.

\* The discussion on TennCare is largely excerpted from my dissertation: Brian C. Blase, "Three Papers Toward a Better Understanding of State Medicaid Programs and Program Efficiency," George Mason University. May 2013.

<sup>7</sup> The states were coded as Medicaid expansion states in the years that they expanded Medicaid.

Moreover, some of the pre-2013 effect could be attributed to Medicaid expansion states prioritizing coverage and taking steps to enroll people in Medicaid prior to 2014, and nationally as a result of the extension of employer coverage to young adults under the age of 26 ([Spotted Toad 2017c](#)).

Although the causal effect of state decisions to expand Medicaid on opioid overdoses remains controversial, it is undeniable that states that adopted Medicaid expansion—including the early expansion states, states that adopted the expansion on January 1, 2014, and states that adopted the expansion after January 1, 2014—had more people die from opioids than non-expansion states. It is not controversial that the biggest victims of the opioid crisis are young adults with the typical person who overdoses in their late teens to early 30s. Thus, it seems plausible that the massive expansion of Medicaid—much of which enrolled younger adults who tend to have lower income than older adults—was harmful to overall health for younger adults given that it occurred a few years prior to the peak of the opioid crisis.

### **Making the Best Use of Public Resources and Preserving Medicaid for Those Who Need It**

Since the government is expending enormous resources on the ACA's Medicaid expansion, some benefits to some people will occur. Between 2014 and 2018, more than \$300 billion—almost all federal resources—was expended on the expansion. Given this tremendous outlay, some people will receive treatments and services that will improve their health, and these treatments and services may extend their lives. On the other hand, other people may use this coverage to receive services that are harmful to their well-being. Moreover, there are other key impacts from major Medicaid expansion. For one, the crowd-out of private coverage is an important factor, particularly if private coverage produces better access and care than Medicaid ([Roy](#)). Many doctors, and often the best doctors, refuse to accept Medicaid patients because of low payment rates. For another, large coverage expansions can lead to people with more pressing medical needs being crowded out because of the surge of demand.

The key societal question, however, is how can resources of this magnitude best be used to improve population well-being. Economists refer to this as the “opportunity cost.” In other words, what could have been achieved with these enormous outlays if we pursued optimal policy? For example, economists Martha Bailey and Andrew Goodman-Bacon have estimated that community health centers are at least 3 to 8 times more cost-effective than Medicare in reducing mortality ([Bailey and Goodman-Bacon](#)).

In a recent Health Affairs blog post discussing how states can find the proper balance between social services and medical services, Shannon Brownlee, Vikas Saini, and Benjamin Miller, write:

*Rarely is the topic of excessive health care spending framed as an opportunity cost, which limits states' ability to provide other services that can have an even larger impact on population health.*

*If we want lawmakers to make different decisions about how to allocate tax dollars, voters will need to understand that medical care is responsible for only a fraction of the health and well-being of their communities. They need to see that allowing health care costs to continue to rise faster than the rest of the economy not only affects their pocketbooks but also their overall health.* ([Brownlee et al.](#))

While Medicaid coverage increases the demand for medical services, including emergency room utilization, the ACA did not contain measures to increase the supply of health care. Therefore, economic theory predicts wait times will increase. Medicaid enrollees often wait significantly longer in the waiting room to see a provider ([Ostrom et al.](#)). Unfortunately, the ACA may have restricted supply by leading to greater amounts of consolidation ([Singer](#)). A new paper shows that hospital mergers were “associated with modestly worse patient experiences and no significant changes in readmission or mortality rates” ([Beaulieu et al.](#)).

Given a relatively inelastic—at least in the short-term—supply of health care, an increase in health care demand will produce some reallocation of health care services, which may be harmful overall if people with more pressing health care needs are crowded out by people with less pressing needs. As referenced earlier, economists estimated that the ACA's Medicaid expansion slowed ambulance response times by about 24 percent ([Courtemanche 2019](#)). Moreover, there is robust evidence that Medicaid expansion significantly increases emergency room utilization ([Garthwaite et al.](#); [Finklestein et al.](#)). (This is counter to the claim from ACA advocates that Medicaid expansion would result in less emergency room utilization under the theory that more people would have a usual place of care.)<sup>8</sup>

The totality of the evidence suggests it is plausible that the Medicaid expansion harmed the health of younger adults by exacerbating the opioid crisis while improving the health of adults closer to Medicare age. Of course, there are non-physical health benefits from public coverage

<sup>8</sup> On March 3, 2010, a few weeks before the ACA passed Congress, President Obama said, “taxpayers currently end up subsidizing the uninsured when they're forced to go to the emergency room for care.... You can't get ... savings if those people are still going to the emergency room.” A few months after passage of the law, then-Speaker of the House of Representatives Nancy Pelosi said, “The uninsured will get coverage, no longer left to the emergency room for medical care.”

expansions to consider as well. For example, Medicaid enrollees do face a lower risk of out-of-pocket medical expenditures and medical debt. Several studies referenced earlier found improvements on non-physical and self-reported health outcomes, such as mental health stress levels and greater peace of mind, from coverage expansions.

Ultimately, we have insight from the Oregon Medicaid experiment that Medicaid expansion is a relatively low-value way to expend these resources. A study by Amy Finkelstein, Nathaniel Hendren, and Erzo Luttmer found that program recipients place relatively low value on the program—estimating that expansion recipients valued Medicaid spending by between 20 to 40 cents on the dollar. The authors found that most of the benefit of expansion

accrued to providers who were able to reduce the amount of uncompensated care they provided ([Finkelstein et al.](#)). There were already a plethora of programs geared to help lower-income people obtain medical services, and estimates suggest that the uninsured received about 80 percent as much health care as the insured, all else equal. While Medicaid expansions for children have shown benefit, the return on investment for adults has largely been disappointing. Overall, there is reason to believe that the large expansion of comprehensive Medicaid coverage is an unwise use of public resources and that targeted programs, geared toward individuals most likely to be aided by coverage, is a far better investment. ★

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Balat often volunteers to help families navigate their bills and how to understand their benefits. He serves as a board member for a nonprofit focused on educating legislators and the community about important matters pertaining to healthcare freedom.

Balat is a first generation American and the first in his family to graduate from college. He received his B.S. from the University of Houston and joint master's degrees in business administration and hospital administration from the University of Houston – Clear Lake.

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