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Why State Decisions about Expanding Medicaid Matter for the Success of Their Insurance Marketplaces

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By 2016, the Affordable Care Act aims to expand health insurance coverage to an estimated 25 million Americans in two interrelated ways. About half of the 25 million stand to gain coverage through federally subsidized expansions of state-run Medicaid and Children's Health Insurance programs. The others are projected to gain coverage by purchasing regulated private health insurance plans, often through state-level "exchanges" or marketplaces. Roughly half of these enrollment gains have happened in 2014, and the rest can happen through expansions of Medicaid and private insurance coverage over the next two years.

Crucially, health reform's major elements must work together if each U.S. state is to be fully successful in reaching the uninsured. Many states have, at least for the time being, decided against expanding their Medicaid programs – leaving only the exchanges as a route to expanded coverage. Unfortunately, many observers have yet to recognize that Medicaid and the exchanges are closely linked; when states opt out of Medicaid expansion their exchanges will function less effectively.

Since 1990, various states have experimented with part or all of the set of reforms that now make up the Affordable Care Act. To better understand how these reforms work together, I conducted a study of this historical experience. Medicaid expansions, I find, complement insurance regulations and exchange marketplaces in their effort to offer affordable private plans to consumers.

What Shapes the Health of a Health Insurance Exchange?

A major, widely popular goal of the national health reform is to make insurance affordable for people who are sick or have longstanding health problems. Rules called "community rating regulations" prohibit insurance companies from charging higher prices to such people with preexisting conditions. However, these rules raise prices for generally healthy consumers and run the risk of driving them out of the marketplace. Policymakers worry a great deal about this "adverse selection" problem, and the health law takes multiple steps to prevent it. It uses the individual mandate to penalize those who forego coverage and it offers generous tax credits to help make private health insurance affordable to low- and middle-income households.

The new subsidies, along with the mandate, make it more attractive for both healthy and sick consumers to get health insurance coverage. But these measures will work better if a state has also expanded its Medicaid program to cover more of its poor and disabled citizens. If Medicaid is not expanded, the only route for these individuals to obtain insurance will be by claiming subsidies to make purchases through their state's exchange. But if more low-income and medically needy people must buy insurance on the exchange, premiums will be higher.

The key insight is that Medicaid expansions improve the health mix of those seeking exchange-based coverage. Low-income people who could be included in expanded Medicaid coverage tend, on average, to have much higher health expenses than exchange-based purchasers. By keeping such higher-cost individuals outside of the exchanges, Medicaid expansions can thus reduce the adverse selection problem.

Evidence from Prior State Experiences

In the early 1990s, several New England and Mid-Atlantic states enacted new rules for insurance – community rating regulations similar to those included in the Affordable Care Act. Unfortunately, they initially adopted these rules without also adopting mandates, subsidies, and Medicaid expansions to combat adverse selection. In a recent research study, I explored what happened to insurance coverage over this time period. The results provide some sense for what may happen now, as states makes important decisions about the Affordable Care Act's implementation.

- Not surprisingly, states that imposed new insurance rules without taking steps to keep insurance affordable for younger and healthier adults experienced immediate problems. In the early- and mid-1990s, coverage rates declined and comprehensive insurance policies became more difficult for people to obtain at affordable prices.

- But by the late 1990s and early 2000s, several of these states' markets had significantly recovered. Tellingly, private coverage rates rebounded most fully in states that expanded Medicaid to include more of the disabled, the medically needy, and other high cost populations.

Medicaid Expansion Helps Affordable Care Exchanges Work Better

A simple cost comparison using data from the Medical Expenditure Panel Survey illustrates why Medicaid expansions can substantially affect premium prices for private insurance plans. Under national health reform, community rating regulations apply to purchases made on state exchanges by both individual consumers and small employers. In 2011, the health care costs of individuals getting insurance in these ways averaged $4,300 (with lower costs for the healthiest among them). By contrast, health care costs for nonelderly adults on Medicaid averaged $8,300 (even though Medicaid pays low rates to hospitals and physicians). If all Medicaid beneficiaries were shifted to the exchanges, prices for each purchaser would go up by more than $1000.

These facts highlight the crucial role of Medicaid expansions in helping private health insurance markets work well under the Affordable Care Act. As of September 2014, 27 states plus Washington, DC are expanding Medicaid, and two others are in active negotiations to do so. But 21 states are so far declining to move ahead. Commentators tend to highlight the high stakes for the many who could have benefited directly from Medicaid. My work highlights that Medicaid expansions can further benefit young and healthy consumers by easing upward pressures on premiums on the exchanges. Medicaid expansions can relieve those pressures and help health reform deliver more affordable private insurance.

Read more in Jeffrey Clemens, "Regulatory Redistribution in the Market for Health Insurance," National Bureau of Economic Research, February 2014.