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Medicaid Expansion in Colorado: An Exercise in Futility

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With the ongoing debate in Oklahoma about whether to expand Medicaid under the federal Affordable Care Act (ACA or Obamacare), experiences of other states that have done so can be illuminating. A study conducted in one expansion state, Colorado, particularly explores how the finances of hospitals were impacted.[1] It specifically looks at the argument made by the health care industry that if more uninsured people who do not pay their hospital bills were covered by Medicaid, prices could moderate or fall since they are high due to the unpaid bills (cost shifting). From the point of view of the healthcare-consuming and tax-paying public, the results in Colorado are, to say the least, disappointing. It shows that rather than lowering insurance premiums, Medicaid expansion only encourages hospitals to improve their profitability all the more, both at public and private expense. Instead of being a solution to cost shifting and higher health care prices, Medicaid expansion encouraged even greater price increases.

The report is authored by the Colorado Healthcare Affordability and Sustainability Enterprise Board, a unit of Colorado government that makes policy recommendations regarding hospital reimbursements under Medicaid. The thorough report includes data tables and detailed explanations. However, its major conclusions are laid out simply as bullet points in a summary introduction. The full meaning of these findings are easily lost on those unfamiliar with the specialized vocabulary of the health care policy world. What's more, the findings need proper context for their full meaning to be understood. This paper is an attempt to do just that, by first providing some high-level context regarding the health care industry in the United States, and then by providing "translations," or detailed explanations of each individual bullet point from the Colorado report's summary.

Disclaimer: *The translations offered in this paper are purely the work of the 1889 Institute and were not submitted to the Colorado Healthcare Affordability and Sustainability Enterprise Board for approval.*

The crux of the Colorado report is simply this. The health industry argues that Medicaid expansion will reduce medical prices for the privately insured because they will not have to foot the bill for as many of the uninsured. This occurs because hospitals are supposedly forced to raise prices to make up for unpaid bills. This is the "cost shift" narrative that the health industry has used to help justify its enormous price increases for years. The evidence from Colorado makes clear that this narrative is false. Hospitals in Colorado did not stop raising prices with Medicaid expansion; in fact, they raised prices even faster. The same phenomenon has been documented in Arizona.[2] Were Medicaid expanded in Oklahoma, we could expect the same.

Health Care - the Richest Sector in the Economy

Health care spending represents nearly one-fifth of the U.S. economy (17.9 percent of GDP in 2017). That's $10,379 per person.[3] Health care is now the largest employment sector in the economy, and still growing.[4] Nonetheless, health care employment, at 9.1 percent,[5] is not even 10 percent of all U.S. employment. This fact, compared with health care's 18 percent of GDP, is a strong hint of the out-size incomes health care occupations command. Of the top ten highest-paying occupations in the United States, the first nine are in health care (with chief executives coming in at tenth). For that matter, of the top 15 highest-paying occupations, 13 are in health care.[6]

Hospitals, especially urban-based chains, certainly claim their share of the nearly 20 percent of GDP that goes into health care. As demonstrated in the 1889 Institute's publication, *The Profitability of Nonprofit Hospitals*, large nonprofit hospitals in Oklahoma are awash in cash and often provide rich salaries to top management.[7] Other health care researchers have described this nationwide phenomenon.[8] Nevertheless, hospital lobbyists show up at busy state legislatures all over the country to plead poverty on the part of hospitals and demand more Medicaid money. They usually get it, even though their claims are easily shown to be largely

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false[9] simply by looking at their publicly-disclosed Form 990 tax forms, required of all nonprofit entities.

Health Care's Unique Environment

The health industry operates in a unique environment. Overall, only a dime of every dollar that goes to pay for health care in the U.S. is directly paid by patients.[10] This proportion of "out-of-pocket" expenditure is actually down from 12 percent in 2006.[11] The rest is paid by "third-party payers" – government and private health insurance. These third parties are outside the doctor (seller)/patient (consumer) relationship. Medicare and Medicaid alone cover 37 percent of total health care costs. Another third is covered by private health insurance.[12] The rest is covered by various governmental entities like the military services and the Veterans' Administration.

The fact that patients (consumers) directly pay for such a small proportion of health care, relying instead on government and private health insurance (mostly provided by employers), creates an incentive problem. Providers are very aware that the person receiving their services will directly pay only a small share of the bill for those services. They also know that the insurance companies and government will mostly know only what is billed; the third-party payers cannot know what the patient knows about their own treatment. Patients are not sensitive to price since they are not paying themselves, so providers, especially hospitals, provide almost no upfront pricing. In other words, *there is no such thing as a market in health care*, and we fail to gain the benefits and blessings in health care that market forces demonstrate in other areas of our economy.

As a consequence of our health care bills being paid mostly by third parties, the entire health care industry acts as if it is billing a spoiled brat's insanely rich uncle for the brat's living expenses. Health care pricing is not rational in that it is not driven by competition like most industries' prices in our economy.[13] Many services are over-prescribed. New facilities and equipment are often constantly and needlessly purchased. And, as demonstrated above, health care industry occupations are very well paid and hospitals are highly profitable.

None of this is to say that everything in health care is over-priced, over-provided, and bloated. Services such as Lasik and cosmetic surgery, which have not historically been readily paid for by either insurance or government, have shown that prices in health care can fall, in marked contrast to just about everything else. But for the most part, true markets in health care simply do not exist.[14]

In a true market, a consumer is not insulated from payment for the goods and services he consumes by employers and insurance companies where health care is paid for privately, or by government agencies and bureaucrats where it is paid for publicly. In markets, consumers directly pay providers of goods and services. Except for a dime on the dollar, this is nearly absent in health care. And the laws and institutions that have eliminated markets in health care are largely a result of the health care industry's lobbying and public relations efforts. It is a system designed for providers to take advantage, and take advantage they do.

The Colorado Study: Utterly Predictable Results

The Colorado Health Care Affordability Act (CHCAA) expanded Medicaid in that state in accordance with the federal Affordable Care Act. The ACA emphasized expanding health insurance, or third-party payer, coverage of health care expenses. That is, Obamacare expanded the third-party payer problem as explained above. Consequently, the ACA and any state law like the CHCAA implementing the ACA, cannot possibly result in a lower overall health care bill for the country. By expanding Medicaid and private health insurance, these laws doubled-down on the very system (third-party payer) that caused health care prices to rise faster than general inflation for decades in the first place. In this way, the ACA seems purposely misnamed since its failure to slow, and possibly accelerate, health care prices was predictable. It appears that the ACA was calculated to produce an outcome where there would seem no alternative but to go to a single-payer system (socialized medicine).

And why would measures like Obamacare and the CHCAA fail to curb health care prices? The simple answer is that providers would take advantage and continue to claim their costs are uncontrollable, using this as an excuse for raising their prices all the more. In other words, they would swallow every dime of new government spending on health care and call for more. The Colorado study's summary, as explained here, makes it plain that this is exactly what has happened in Colorado.

• The CHCAA and the ACA decreased the number of uninsured Coloradans by more than half. Because more people are insured, the amount of money hospitals are losing annually due to bad debt and charity care write offs has decreased by more than $400 million. (This and subsequent bolded bullet points are direct quotes from the Colorado study's summary.)

Translation: *CHCAA stands for "Colorado Health Care Affordability Act," that state's Medicaid expansion as financially incentivized by the ACA.*

The fact that hospitals claim less in write-offs for bad debt and charity care simply means that federal and state taxpayers are paying for more people's health care, so hospitals make more money. Given the fact that hospitals were constantly building new facilities all over the country even before Obamacare passed, this bullet does NOT mean that hospitals once on the brink of financial ruin have been saved. Most were never on the brink in the first place. Note that this bullet indicates nothing about an improvement in health outcomes in Colorado. It says nothing about increased health care availability. It simply says more money is flowing to hospitals.

• The impact of the Colorado hospital trends on consumers suggests that rising hospital costs and margins have contributed to rising insurance premiums.

Translation: *Insurance premiums have been rising because hospitals' expenses AND their profit margins have been increasing. (See additional detail and explanation after the next bullet below.)*

• Actual hospital cost growth trends and actual hospital margins contribute to commercial cost shift and hospital overcompensation, more so than Medicaid or Medicare undercompensation.

Translation: ***"****Cost shift" is said to occur when the insured are*

charged more than they otherwise would be in order to compensate for bills left unpaid, presumably, by the uninsured. Cost shift is considered by many a partial explanation for why the cost of American health care has increased so markedly in the past. What this actually implies, however, is that in days of yore, when doctors did not charge indigent patients as an act of mercy, these doctors were apparently mistaken in the belief that they were being generous. This was not an act of charity on their part, but an act of cost shifting to all their other patients. Obviously, this is silly. Doctors were voluntarily sacrificing income as an act of charity, but apparently, in today's system, nonprofit hospitals, considered charitable institutions, and their well-paid employees, do not expect to ever have to sacrifice income and, instead, shift costs to others. At least, that is what the cost-shift explanation for rising health care costs would lead us to believe.

"Hospital overcompensation" occurs when hospitals charge more than it actually costs to render a service. While it is a fact that Americans lavish money on hospitals, individuals and businesses do not do so without at least first being billed. It seems the authors of this report were, for some reason, reticent to use the term hospital overcharging, but this appears to be a reasonable, albeit politically incorrect, translation of the term.

Since nonprofit hospitals do not technically turn a profit, what would be called profit in other businesses is distributed in the form of "costs" through generous compensation, excessive hiring, and facilities that are nicer, newer, and more expensive than truly necessary. Thus, cost growth is substantially under hospitals' control. This is subtext in this short bullet point.

Revenues that nonprofit hospitals do not immediately spend are characterized as "margins" and are spent later as bonuses, retirement packages, for art (so important for recovery of one's health), and the latest and greatest in facilities and technology (to justify high prices).

Given that both costs AND margins are rising, it is clear that hospitals are increasingly inefficient AND taking price advantage of the insured. They do this simply because they can.

• Colorado hospital costs grew 58.7% between 2009 and 2017 while adjusted discharges only grew 14.2%.

Translation: *"Adjusted discharges" is a statistic intended to measure inpatient and outpatient services to create an overall measure of patient services/charges and is a measure of service volume.*

This bullet point simply means that total hospital costs grew more than 4 times faster than the rate of growth in patient volume. Keep in mind that most of these costs are entirely within the control of hospitals, which clearly are becoming less efficient with no regard for how this is affecting their patients', government's, or employers' finances.

• In 2009, Colorado hospital operating expenses were 3.2% higher than the national average. By 2017, Colorado hospitals operating expenses per adjusted discharge were 14% higher than the national average.

Translation: *Given the increase in the proportion of insured between 2009 and 2017, the fact of Colorado's relative rise in expenses simply indicates that hospitals in Colorado got less efficient even than hospitals did nationally, overall – again, simply because they could.*

• This report identifies rapid cost growth as a major contributing factor to the cost shift. Hospitals could have passed on significant savings to commercial consumers had they matched national cost benchmarks using Medicare Cost Reports suggesting as much as 8.3% in cost savings or $7.9 billion from 2009-2017.

Translation: *In case it was not clear from the earlier bullets, once again, the authors of the report are saying that hospitals have it in their power to better control their costs. Hospitals choose not to better control costs because our third-party payer system allows them to choose not to. Thus, health insurance companies/customers did not see savings as more people were covered by Medicaid, even with hospitals writing off less in charity care and bad debt. Instead, hospitals became less efficient and more profitable at the same time, and continued to pass on the bill for their internal bloat and largesse to insurance rate payers. Most of these rate payers are employers, so most patients/employees never even see that cost, much less accurate itemized statements from caregivers.*

• Overall, payment-to-cost ratios across all payers increased from 1.05 to 1.08 between 2009 and 2017.

Translation: *Overall (profit) margins (payment-to-cost ratios) increased from 5 percent to 8 percent from 2009 to 2017, on top of all the excess "costs" hospitals bear for their own benefit as a result of not having to be efficient.*

• Hospital margins for all payer types (commercial, Medicaid, Medicare, other) increased by more than 250% from $538 to $1,359 per adjusted discharge between 2009 and 2017.

Translation: *Gross profit ($ amounts) per individual patient nearly tripled from 2009 to 2017. Increased health care insurance coverage merely makes a rich sector of the economy richer.*

The report's bottom-line conclusion:

• Hospitals could have reduced their cost shift or fee increases to commercial carriers and their employer and consumer clients. This could have been achieved by managing costs at or close to the national average while maximizing the benefits of CHCAA, CHASE and the ACA: increased hospital Medicaid reimbursement, reduction in charity care and bad debt, and increased revenues from the reduction in the number of uninsured Coloradans.

Translation: *It bears repeating: Hospitals COULD have saved commercial health insurers and their clients (employers and patients) money when the government started covering more people with Medicaid expansion, but they didn't. Why not? Because the issue of rising health care costs in our economy has NEVER been about cost shifting – or expensive technology, for that matter, one other common "reason" cited by industry and advocates for higher costs. The issue of the high and rising cost of health care has always been that in our system, health providers (hospitals in this case) can demand more money, get it, and then demand more money, and get that, too, practically without end. Our system is set up to make this possible, and that system's primary author is the federal government.*

Conclusion

Some readers paying careful attention might realize that Medicare and Medicaid are obviously creatures of the federal government, but wonder about the claim that federal policies are the primary author of the third-party payer problem. After all, the federal government did not create health insurance.

Yes, the federal government *did* create health insurance as we know it today, along with the states. The key is to ask why health insurance is provided through employers rather than purchased by individuals. It is because the federal income tax law does not tax the value of non-cash benefits provided by employers. By providing health insurance, which involves expense and trouble, employers avoid paying payroll taxes such as social security, Medicare, and unemployment taxes. Employees also avoid income, Social Security, and Medicare taxes.

Our insurance benefits, which are a tax avoidance scheme,[15] have created a giant economic distortion where health care is financially eating us alive, divorced from competitive economic forces that encourage efficiency and maximum net benefits for consumers. Like an experiment with good intentions gone awry, tax policy created with the best of intentions has helped to create a monster that has backed us into a corner. So today, we neither fight nor flee, because we are afraid to pay for health care ourselves due to the high prices. But the prices are high because we do not pay for health care ourselves.

The lesson from Colorado, Arizona, and other states like them, is that the promises the health industry makes about the benefits of Medicaid expansion are often false, especially the false claim that Medicaid is a solution to cost shifting (cost shifting itself being subterfuge rather than a real explanation). While 90 federal cents on the dollar sounds tempting, policymakers must remember that this money first passes through a financially bloated sector of our economy, one that has no compunction to do whatever it takes to claim for itself more income and wealth. In fact, Medicaid expansion only encourages the health industry to raise prices all the more and claim even more of the nation's GDP. Therefore, despite all the propaganda about the economic benefit of Medicaid expansion, including jobs expansion, that benefit does not accrue generally to a state's populace. The fourteen states that have not yet expanded Medicaid, including Oklahoma, should continue their stand.

Dumping more money on the health care industry with Medicaid expansion might result in some additional hiring in that industry. More likely, it will cause all 15 of the highest-paid occupations in the U.S. to be in health care instead of "only" 13. People and talent hired away from other industries, would only distort our economy all the more, further enriching an already-rich sector, given its one-fifth share of our gross income. Hiring more people into health care will not result in new economic production, with the benefit that comes from it. Instead, that hiring would be a manifestation of a further redistribution of resources to an already grossly favored and bloated industry that is financially capable of providing health services to anyone who needs them, but would rather exploit them for the sake of grabbing more taxpayer dollars.

End Notes

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1 State of Colorado, Colorado Healthcare Affordability & Sustainability Enterprise, *Cost Shift Analysis Report*, January 2019, https://www.colorado.gov/pacific/sites/default/files/2019%20January%20HCPF%20Cost%20Shift%20Analysis%20Report%20Draft.pdf.

2 Naomi Lopez Bauman, Angela C. Erickson, and Christina Sandefur, *The Arizona Medicaid Expansion Experience: Beware the Peddlers of Cost-Shifting Claims*, Goldwater Institute, August 7, 2018, https://goldwaterinstitute.org/wp-content/uploads/2018/08/ArizonaMedicaidExperience_FINAL.pdf.

3 Centers for Medicare & Medicaid Services, Health Expenditure Data, "Historical," https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

4 Derek Thompson, "Health Care Just Became the U.S.'s Largest Employer," *The Atlantic*, January 9, 2018, https://www.theatlantic.com/business/archive/2018/01/health-care-america-jobs/550079/

5 Henry J. Kaiser Family Foundation, "Health Care Employment as a Percent of Total Employment," May 2017, https://www.kff.org/other/state-indicator/health-care-employment-as-total/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

6 Bureau Of Labor Statistics, Occupational Outlook Handbook, "Highest Paying Occupations," https://www.bls.gov/ooh/highest-paying.htm.

7 Baylee Butler and Byron Schlomach, *The Profitability of Nonprofit Hospitals: Do They Really Need More Money?*", 1889 Institute, September 2017, https://img1.wsimg.com/blobby/go/8a89c4f1-3714-49e5-866b-3f6930172647/downloads/1d0kk5n58_914532.pdf.

8 Steven Brill, *America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System* (Random House, 2015).

David Goldhill, *Catastrophic Care: Why Everything We Think We Know about Health Care is Wrong*, (Vintage Books, 2013).

9 An exception is rural hospitals, which are highly disadvantaged in that they do not have sufficient volume to fund all the expensive diagnostic equipment the urban chains have at their disposal, or the many mandates put on hospitals under federal and state authorities. Since hospitals are not competing on the basis of price, they compete on the basis of "bells & whistles." Economists call this "non-price competition." See the books listed below.

Shannon Brownlee, *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer* (Bloomsbury USA, 2007).

Arnold Kling, *Crisis of Abundance: Rethinking How We Pay for Health Care* (Cato Institute, 2006).

10 Centers for Medicare and Medicaid Services, "National Health Expenditures 2017 Highlights," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf.

11 Byron Schlomach, *Removing the Middleman: What States Can Do to Make Health Care More Responsive to Patients*, Goldwater Institute Policy Report No. 230, January 13, 2019, p. 17, https://goldwaterinstitute.org/wp-content/uploads/cms_page_media/2015/2/10/Removing%20the%20Middleman.pdf.

12 See Note 10.

13 Steven Brill *America's Bitter Pill*.

Charles Silver and David A. Hyman, *Overcharged: Why Americans Pay Too Much for Health Care* (Cato Institute, 2018).

14 Mark J. Perry, "If Cosmetic Surgery Has a Working Market, Why Can't Medical Care? Here's a Clue: It's about Third-Party Payers," Foundation for Economic Education, March 22,2017, https://fee.org/articles/if-cosmetic-surgery-has-a-working-market-why-can-t-medical-care/.

15 During World War II, wage and price controls put many employers at a competitive disadvantage in attempting to hire labor. Their solution was to provide in-kind benefits, like health insurance, in order to get around the wage controls and compete better for labor. The IRS at first did not tax these benefits, but after the war, considered doing so. Congress made benefits non-taxable in 1954.