patient is the most important pa-
tient in the hospital. Clinicians
will do what it takes to meet
their patients’ needs.

That leaves radiologists as the
natural choice for managing uti-
лизation. Such a shift will require
two key changes. The more obvi-
ous barrier is the incentive sys-
tem: there are no rewards for de-
nying an imaging study — one
loses a reimbursable exam and
expends time in which other re-
imbursable studies can be read.
But the bigger obstacle is the ser-
vice-provision mindset. Radiolo-
gists don’t wish to displease re-
ferring physicians, lest they take
their business to someone who
won’t question their test-ordering
ability.

Referring physicians may be-
lieve that radiologists, who gen-
erally haven’t seen the patient,
shouldn’t question the appropri-
ateness of clinical suspicion. But
preauthorization — standard in-
urance-company practice for ap-
proving advanced imaging — in-
volves decisions by personnel
who aren’t directly involved in
the clinical consultation. Indeed,
insurers could save the money
that they pay third-party agents
to determine the appropriateness
of imaging if they trusted radiol-
ogists to manage utilization.

Radiologists may resist gate-
keeping because of the stigma at-
tached to “rationing” in the United
States. Even though the diagnos-
tic pursuit of PE in an intubated
patient with severe intracranial
injuries may be futile, the radiol-
ogist sitting at the outpost of de-
cision making may hesitate to
say so and risk being labeled a
“death panelist.” It will be harder
for U.S. radiologists to be gate-
keepers than it is for their NHS
counterparts, simply because im-
aging is so abundant here — one
can easily justify rationing of
something that’s truly scarce.

The emphasis on service provi-
don, operations, and efficiency has
pushed radiologists to the periph-
ery of clinical decision making. To
be effective gatekeepers, they will
have to move to the center. They’ll
have to develop clinical-imaging
conferences, act as imaging con-
sultants, and conduct imaging
rounds. Radiology leadership must
provide incentives for these activi-
ties without compromising effi-
ciency, by developing granular met-
rics for quality. Benchmarks will
have to be established for the ac-
ceptable proportion of negative
studies. Bundled payments for
accountable care organizations
will offer a sentinel opportunity
to face these challenges.

Some radiologists may hope
that clinical decision-support sys-
tems will do the gatekeeping for
them. It’s ironic: the profession
has great angst about its propen-
sity to be commodified and out-
sourced, yet it may relinquish its
last bastion of clinical involvement
to software. But gatekeepers don’t
simply advise on the best imaging
method; they question wheth-
er a given diagnosis should be
suspected in the first place.

Whoever plays gatekeeper, all
clinicians will have to exercise
greater restraint in the use of
imaging. Radiologists must de-
cide whether to greet the ebb of
imaging passively or by stepping
forward to captain and manage
a rational decline.

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Using Medicaid to Buy Private Health Insurance —
The Great New Experiment?

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The Medicaid expansion is a
cornerstone of the Affordable
Care Act (ACA), but since the Su-
preme Court ruled in 2012 that
states could opt out of expanding
their Medicaid programs, resis-
tance has been strong. With un-
certain-to-dim prospects of adop-
tion in roughly half of states, the
Obama administration has moved
to allow states to adopt a model
whereby Medicaid funds could be
used to buy private health plans
sold through the new health in-
surance exchanges. Arkansas has
enacted legislation to adopt such
an expansion; other states, in-
cluding Ohio, appear to be nego-
tiating with the federal govern-
ment over replacing the standard
Medicaid approach with premium
assistance.

It’s clear why the White House
is engaged in such a high-stakes
effort. Without the Medicaid ex-
ansion, the poorest Americans
will remain uninsured, since sub-
sidized coverage through the ex-
changes is available only for U.S.
citizens with incomes above 100% of
the federal poverty level (FPL). In
many states, including Arkan-
sas, existing Medicaid coverage
for adults falls far short of this
mark. For example, with the ex-
ception of a very limited demon-
Rates of Continuous Insurance Eligibility among Adults over Time, According to Various Approaches to Expanding Medicaid under the Affordable Care Act.

Rates are based on the authors’ analysis of the 2008 Survey of Income and Program Participation. The sample includes all adults 19 to 63 years of age with family incomes of less than 400% of the federal poverty level (FPL) who don’t have employer-sponsored insurance or Medicare (38,737 people). The graph shows the percentage of adults with uninterrupted eligibility for a given type of insurance over time. The three models considered are the baseline Affordable Care Act, in which individuals with family incomes below 138% of the FPL are in Medicaid and others are in exchange plans; the hypothetical premium-support model using Arkansas baseline Medicaid eligibility, in which individuals meeting the current eligibility criteria for Arkansas Medicaid remain in Medicaid (income below 17% of the FPL for parents and 75% and 83% for single and married disabled adults, respectively) and all others (including all childless adults) are in exchange plans; and the hypothetical premium-support model using Ohio baseline Medicaid eligibility, in which individuals meeting the current eligibility criteria for Ohio Medicaid remain in Medicaid (income below 90% of the FPL for parents and 65% and 83% for single and married disabled adults, respectively) and all others (including all childless adults) are in exchange plans. The differences between the curves are significant at each time point (P<0.001). See the Supplementary Appendix for more details.

stratification program, Arkansas covers no poor adults without minor children, and eligibility for parents is set at 17% of the FPL (about $4,000 in annual income for a family of four). Thus, unless they are pregnant or elderly or have a severe disability, virtually no impoverished working-age Arkansans have Medicaid. The situation is similar in Texas, South Carolina, Louisiana, and other states that either have said no to the expansion or remain on the fence.²

Although the idea of using Medicaid to buy private health insurance rather than insuring people directly has been portrayed as radical (the Arkansas “game changer”2), it’s not a new idea. Since 1965, Medicaid has authorized the secretary of health and human services to use federal funds to pay insurance premiums in states that elect such an approach. But until the ACA created a viable individual insurance market, there was effectively no private insurance for states to buy other than employer-sponsored coverage, which is rarely available to poor workers. Instead, over the past two decades, most states have developed Medicaid managed-care systems that now cover 75% of beneficiaries. Many of the insurance companies likely to participate in the exchanges already offer Medicaid managed-care plans.

So is this proposal much ado about nothing? Definitely not: moving Medicaid beneficiaries into a new and untested marketplace raises large challenges even as it creates important opportunities. On the plus side, premium support would allow states such as Arkansas that lack a robust Medicaid managed-care market (some states, like Arkansas, currently use only a limited form of managed care known as “primary case management”) to enroll the large 2014 expansion population into larger, more organized plans.

In addition, such arrangements might improve enrollment stability and continuity of care, even in states with robust Medicaid managed-care markets. Our research suggests that low-income adults experience so much income fluctuation that 28 million annually could “churn” across the Medicaid–exchange divide,³ set by the ACA at 138% of the FPL. Without health plans spanning both markets, shifts in financing could disrupt coverage and care. Buying exchange plans with Medicaid funds might shield families from the effect of small income shifts, since they could keep their plans and providers regardless of whether Medicaid or federal premium subsidies were paying the bill at any given moment.

Using national survey data and methods similar to those we’ve used previously,³ we estimate that purchasing coverage in an exchange could reduce churning by nearly two thirds in states such as Arkansas that currently have highly restrictive Medicaid coverage for adults (see graph; for methods, see the Supplementary Appendix, available with the full text of this article at NEJM.org). However, in states such as Ohio, whose income limits under traditional Medicaid are higher, this policy could create churning between the traditional Medicaid-
eligible group and the expansion group (which will now be buying exchange plans). Although that effect would reduce potential gains in coverage stability, there would still be less churning than there would under a Medicaid expansion that doesn't use premium assistance. In both cases, this analysis assumes that people shifting from Medicaid-funded private coverage (when their income is below 138% of the FPL) to tax-credit–supported private coverage (when their income increases) would have a fairly seamless transition and could remain with the same plan and provider networks. But as discussed below, such seamlessness is hardly guaranteed.

A third potential advantage of using Medicaid to buy private insurance is the higher provider-payment rates offered by private insurers, which might improve beneficiaries' access to care. This advantage will materialize only if insurers' provider networks agree to care for a new patient population, but networks that don't already treat Medicaid beneficiaries may resist this expanded line of business. Indeed, similar provider resistance was an original contributing factor to the development of separate Medicaid managed-care products with distinct networks.

There are also major challenges involved in using Medicaid to buy private insurance. Medicaid provides more extensive coverage and lower cost sharing than private health insurance, and plans selling services to Medicaid agencies will need to abide by Medicaid's coverage rules, according to guidance on premium assistance issued by the Department of Health and Human Services (DHHS). The guidance appears to restrict the use of Medicaid for buying private insurance to either an additional coverage option for newly eligible adults or part of time-limited demonstrations testing compulsory premium assistance for newly eligible people while exempting medically frail beneficiaries. The DHHS has yet to address other important questions. Can states require newly eligible parents to enroll in plans separate from those that their children belong to? Will plans be required to assure continuous coverage even during transitions between Medicaid and exchanges as people's incomes fluctuate? Will insurers be required to contract with traditional safety-net providers such as community health centers? Medicaid networks tend to use many such providers, who have greater experience than traditional private medical practices in serving poor adults with complex clinical and social needs.

But cost may remain the largest obstacle to a premium-support model. Many policymakers oppose the Medicaid expansion because they believe it's financially unsustainable. Buying private insurance for beneficiaries would probably raise costs further, chiefly because private insurers pay providers much more than Medicaid does. The Congressional Budget Office estimates that tax credits for coverage purchased in exchanges will cost $9,000 annually per adult, 50% more than the $6,000 in projected costs per Medicaid beneficiary, although these differences could vary greatly by state. Some analysts argue that private insurers in a competitive marketplace will find ways to save thousands of dollars per beneficiary, but no evidence from either the private insurance or Medicaid managed-care markets supports such claims. The DHHS's recent guidance does not elaborate on existing federal regulations prohibiting states from purchasing private plans unless costs are “comparable” with those of traditional Medicaid. But unless private insurers reduce provider payments to Medicaid rates (or close to them), it's unclear how most states could meet that standard.

Given the politics surrounding the Medicaid expansion, using Medicaid to buy private insurance will continue to generate great interest. Ultimately, the most important aspect of premium assistance may be its appeal to conservative politicians who are skeptical of the ACA generally and the Medicaid expansion in particular — even if the policy differences between an expansion featuring robust Medicaid managed-care and private insurance coverage are less dramatic than they might first appear. If the challenges can be resolved and the approach encourages widespread state participation in expanding Medicaid, the U.S. health care system will be a far better place for our poorest citizens.

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