Resolved: The United States should replace means-tested welfare programs with a universal basic income.

Katherine and I negate.

Contention One: UBI replaces Medicaid with catastrophic effects

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Medicaid provides coverage to 75 million Americans.

The success of Medicaid is evident. Rudowitz 19 finds that the bidding system allows Medicaid to be 25% cheaper than private insurance. This is because Medicaid's market share makes it an appealing customer to healthcare providers, who compete in a bidding system to offer outstanding medical services at a low cost.[1]

Medicaid expansion extends coverage to all Americans earning below 138% of the poverty line. 36 states have already expanded Medicaid,[2] [3]which[4] has decreased mortality rate by 70%.

Not only would a UBI halt efforts to expand Medicaid's reach, but it would also take insurance away from 1 in 5 Americans.

The effects of disenrollment are two fold.

First, reducing care.

The Commonwealth Fund reports that uninsured individuals are twice as likely to forgo necessary care as individuals on Medicaid.[5]

Second, increasing uncompensated care.

Uncompensated care occurs when patients can't pay for services, so hospitals have to absorb the cost or transfer the bill to other patients. Song 18 quantifies that each newly uninsured person is associated with a $900 increase in uncompensated care.

Broaddus writes that uncompensated costs burden hospitals, making it harder for them to maintain needed capacity to serve patients, or even keep their doors open.

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[1] This is Medicaid Managed Care (MMC), as opposed to Fee for Service (FFS).
[2] https://www.advisory.com/daily-briefing/resources/primers/medicaidmap
[3] Other states like Arkansas and Kentucky are joining the expansion, a policy that three quarters of Americans support.#
[4] Golsan
[5] https://www.vox.com/policy-and-politics/2019/7/23/20703776/medicaid-expansion-obamacare-health-care-2020

Rural hospitals are some of the most vulnerable to uncompensated costs. Luthra 16[6] finds that they serve more low-income people and have narrower profit margins, thus any squeeze on the hospital budget "is going to be more influential." Indeed, 15/21 hospitals that closed in 2016 were in rural areas.

Luckily, Medicaid has helped rural hospitals. Broaddus finds that Medicaid expansion decreased the national uninsured rate by 35%, which decreased uncompensated care by 30%. For this reason, Medicaid directly increased rural hospital operating margins by 4%.

There are two impacts:

1. Mortality.

Rudowitz found in 2019 that Medicaid during childhood reduced teen mortality by 20%[7], and adult mortality by 9.8%.[89] Once Medicaid is fully expanded, it will prevent 35,000 deaths.

2. Losing rural hospitals

NBC 19 finds that 430 rural hospitals are at risk of closing, and each closure may increase mortality in the surrounding area by 5.9%. [10]

Contention Two: Programs, not cash

Mogstad 19 observes that throwing cash at a person and telling them to take it from there, like a UBI proposes, will not help. Instead, programs should invest in targeted spending.

Targeted spending has been effective.

First is through vocational training.

Vocational training usually costs $33,000, however, welfare programs provide the training for free. The US Department of Education[11]shows that these programs have provided 20 million people with jobs annually. Replacing the means tested system with a Universal Basic Income would put these programs out of reach of poor Americans who need them the most.

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[6] Lack Of Medicaid Expansion Hurts Rural Hospitals More Than Urban Facilities
[7] Katch finds that among African American children, Medicaid reduced mortality rates in their later teenage years by 20 percent.
[8] http://www-personal.umich.edu/~mille/ACAMortality.pdf
[9] and lowered rates of hospitalization and emergency department visits in later life, improved long-run educational attainment,
[10] https://www.nbcnews.com/news/us-news/rural-hospital-closings-cause-mortality-rates-rise-study-finds-n1048046
[11] http://scworksupstate.com/workforce-innovation-and-opportunity-act-fact-sheet/

Second is through SNAP.

The food assistance program provides benefits to over 40 million Americans, and also requires stores to carry healthy food items. Replacing the means tested system would push 23.5 million Americans deeper into the food desert where fresh groceries and healthy options are unavailable.

The success of the current means-tested system is evident. According to the CBPP 17, it has lifted 39 million Americans out of poverty. [12]

Unfortunately, a UBI would not only end these programs, but the monthly payments would not be enough to cover expenses. The government provides recipient families up to $49,000, and [13] Gunn 19 finds that a UBI causes the poorest to lose out by $28,000 a year.

The impact is poverty.

Overall, 4.5% of U.S. deaths were found to be attributable to poverty. 133,000 deaths can be attributed to individual-level poverty, and 119,000 to income inequality. Getting rid of means welfare programs not only exacerbates the wealth gap, it also further entrenches the poor into deep poverty. To mitigate these harms, negate.

[12] Alt card:
https://www.cbpp.org/poverty-and-opportunity/commentary-universal-basic-income-may-sound-attractive-but-if-it-occurred
44% out of pov.

[13] Greenstein 19 corroborates by using the proceeds from eliminating all means-tested programs outside health care, the result would be an annual UBI of $1,582 per person,

Resolved: The United States should replace means-tested welfare programs with a universal basic income.

Cards:

Rudowitz

Seniors and people with disabilities make up 1 in 4 beneficiaries but account for almost two-thirds of Medicaid spending, reflecting high per enrollee costs for both acute and long-term care (Figure 9). **Medicaid is the primary payer for institutional and community-based long-term services and support – as there is limited coverage under Medicare and few affordable options in the private insurance market.** Over half of Medicaid spending is attributable to the highest-cost five percent of enrollees. However, on a per-enrollee basis, **Medicaid is low-cost compared to private insurance, largely due to lower Medicaid payment rates for providers. Analysis shows that if adult Medicaid enrollees had job-based coverage instead, their average health care costs would be more than 25% higher.** Medicaid spending per enrollee has also been growing more slowly than private insurance premiums and other health spending benchmarks.

Modern Healthcare, 11 Feb 2019, "Medicare, Medicaid contain costs better than private insurers, study says,"
https://www.modernhealthcare.com/article/20190211/NEWS/190219996/medicare-medicaid-contain-costs-better-than-private-insurers-study-says

By breaking it down to a per-person basis, the study shows that average spending on private health insurance per enrollee grew 4.4% per year between 2006 and 2017—faster than the growth of spending per enrollee in Medicaid and Medicare, and faster than the growth of the gross domestic product per capita, which grew an average 2.4% each year.

Per-enrollee spending in Medicare grew an average 2.4% per year while per-enrollee spending in Medicaid grew 1.6% each year. Holahan said **Medicare and Medicaid experienced slower spending growth than private insurance because public programs have more leverage over provider payment rates, helping them to keep costs down**. Private payers end up paying higher hospital and physician prices. The study noted that CMS projects faster Medicare and Medicaid spending growth per enrollee from 2017 to 2026 than in the past decade, but the authors suggest that those projections may be overestimated. Medicare enrollment grew 2.8% to 57.2 million as the baby boomer generation began turning 65 and became eligible for the program. Medicaid enrollment grew 4.3% to 72.6 million in 2017 because income growth was slow over that period, and there was an increase in the number of disabled people as the population aged. Many states also opted to expand Medicaid under the ACA, which boosted enrollment. Enrollment in the private insurance market hovered at 197 million, however. As enrollment has increased in Medicaid and Medicare, so did total spending in those programs. Medicare spending grew an average 5.2% annually to $705.9 million and Medicaid grew 6% annually to $581.9 million in 2017. Spending on private health insurance grew 4.4% on average each year during the period, hitting $1.2 billion in 2017. The healthcare services that drove spending differed between the payers. Hospital expenditures drove spending in the private insurance market, while growth in hospital spending was slow for both Medicaid and Medicare. Private insurers also experienced rapid growth in spending on nursing and home health services over the study period. The study found that growth in administrative costs and spending on physician services drove Medicaid spending. Medicare spending growth, meanwhile, was driven largely by growth in spending on prescription drugs and administrative costs between 2006 and 2017.

Hannah Katch, 6-2-2017, "Medicaid Works: Millions Benefit from Medicaid's Effective, Efficient Coverage," Center on Budget and Policy Priorities,
https://www.cbpp.org/research/health/medicaid-works-millions-benefit-from-medicaids-effective-efficient-coverage

Resolved: The United States should replace means-tested welfare programs with a universal basic income.

Medicaid is much more efficient and cost-effective than private insurance: adults on Medicaid cost about 22 percent less than if they were covered by private insurance, after adjusting for differences in health status, Urban Institute research shows.[19] Medicaid also provides more comprehensive benefits than private insurance with significantly lower out-of-pocket cost to beneficiaries. Over the past 30 years, Medicaid costs per beneficiary have essentially tracked costs in the health care system as a whole, public and private. **In fact, costs per beneficiary grew much more slowly for Medicaid than for private insurance between 1987 and 2015**[20] (see Figure 3) **and are expected to continue growing more slowly than for private insurance in coming years**, according to both the Urban Institute and the Medicaid and CHIP Payment and Access Commission.[21]

Modern Healthcare, 11 Feb 2019, "Medicare, Medicaid contain costs better than private insurers, study says,"
https://www.modernhealthcare.com/article/20190211/NEWS/190219996/medicare-medicaid-contain-costs-better-than-private-insurers-study-says

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Lisa Clemans-Cope, Urban Institute, John Holahan, Urban Institute, and Rachel Garfield, 4-13-2016, "Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence," Henry J. Kaiser Family Foundation,
https://www.kff.org/report-section/medicaid-spending-growth-compared-to-other-payers-issue-brief/

The research reviewed above, which shows that Medicaid spending per capita and Medicaid spending growth have historically been relatively low despite a disproportionately sick enrollee population with more health problems, raises questions about how the cost savings has been achieved. Cost-containment efforts, such as expanded enrollee copayments and pharmacy management tools (e.g. preferred drug lists [PDLs]), as well as constrained access, have almost certainly played a role in constraining costs in the Medicaid program. However, a critical factor driving savings appears to be low payment rates.44 A handful of studies have assessed how provider payments for particular services under Medicaid fee-for service (FFS) or Medicaid managed care compare with provider payments under Medicare or private insurance. In these studies, Medicaid is generally demonstrated to have lower payment rates. The studies are summarized in Table 3.

Between 1993 to 2014, researchers at the Urban Institute produced multiple studies that have shown that **part of the reason that Medicaid is successful in constraining costs is that the program has consistently had lower fees for physician services compared with the fees paid by private payers or Medicare**.45,46 Most recently, a 2014 Urban Institute study collected data on Medicaid physician fees for 27 procedure codes for three types of services: primary care, obstetric care, and other services.47 The researchers computed a state-specific Medicare-to-Medicaid fee index, or the ratio of the Medicaid fee for each service in each state to the Medicare fee for the same service. The study showed that, on average, Medicaid fees in the survey were 66 percent of the Medicare fees.

A recent study of payments per inpatient hospital stay between 1996 and 2012 compared inflation-adjusted payment rates that were also standardized across patient and stay characteristics; **it found that private insurance had the highest rates,** followed by Medicare **and then Medicaid**—with Medicaid payment rates averaging approximately 90 percent of Medicare rates across the period.48 However, the study did not include supplemental Medicaid payments to hospitals. A 2015 analysis by the Office of Inspector General (OIG) demonstrated that Medicaid's **per unit pharmacy costs** were less than half of Medicare's per unit pharmacy costs—**with much of the savings due to Medicaid's rebate policies.49** The study evaluated the costs of 200 selected brand-name drugs and found that pharmacy average unit costs were similar under Medicare Part D and Medicaid. For example, the average unit reimbursement amounts in Medicare Part D and Medicaid differed by less than 2 percent for 135 of the 200 selected drugs.
However, Medicaid's average net unit pharmacy costs (the average unit pharmacy reimbursement amounts minus the average unit rebate) were far lower than net unit costs under Medicare's Part D in 2012.

Resolved: The United States should replace means-tested welfare programs with a universal basic income.

For the selected brand-name drugs in the study, median Medicaid unit rebate amounts were three times higher than median Medicare Part D unit rebate amounts, and for 37 of the selected drugs, median Medicaid unit rebate amounts were over 10 times higher than those for Medicare Part D. Medicare Part D unit rebate amounts exceeded Medicaid for just two of the selected drugs in the study. (Median unit rebate amounts in dollars were not published in the study.)
After accounting for rebates in both programs for the selected brand-name drugs in the study, Medicaid net unit costs were less than half of Medicare Part D net unit costs for 110 of the selected brand-name drugs. Medicaid net unit costs were lower than Medicare Part D net unit costs for all but five of the brand-name drugs. Overall, while Medicaid drug expenditures in 2012 were lower than Medicare Part D expenditures at $35.7 billion compared to of $66.5 billion, Medicaid drug rebates were higher than Medicare, at $16.7 billion compared to $10.3 billion. Thus, rebates totaled 46.8 percent of Medicaid drug spending, compared to just 15.5 percent of Medicare Part D spending. **A 2014 GAO study demonstrated that provider payments for selected services under Medicaid FFS and Medicaid managed care were generally substantially lower—about 30 to 65 percent lower—than private insurance.50** The report examined how payments for 26 evaluation and management (E/M) services (including E/M for office visits, hospital care, and emergency care) in selected states compare under Medicaid FFS and Medicaid managed care and private health insurance.
The study found that Medicaid rates were generally lower than private insurance in 2009 and 2010, prior to the temporary payment increases mandated by the Health Care and Education Reconciliation Act of 2010 (HCERA). **In the 40 states where data were available, Medicaid FFS payments were 27 to 65 percent lower than private insurance in 31 of the 40 states.** In the 23 states where data was available to compare Medicaid managed care payments to private insurance, GAO found that Medicaid managed care payments to providers were 31 to 65 percent lower than private insurance in 18 of the 23 states. The GAO found that **Medicaid payments generally were lower than private insurance for all three types of E/M assessed,** and that the magnitude of the payment differences was generally largest for emergency care and smallest for office visits.

A 2015 chartpack published by the American Hospital Association (AHA) examined reimbursements for hospital-based services for community hospitals, finding that **Medicaid reimbursements are far lower than those for private payers.51,52** This analysis of aggregate hospital payment-to-cost ratios for hospital-based services financed by Medicaid, Medicare, and private payers from 1993 through 2013 shows that Medicaid rates have historically been far lower than private payers, and similar to Medicare levels. This study included Medicaid and Medicare Disproportionate Share Hospital (DSH) payments. In 2013, while aggregate private payment-to-cost ratios were near 145 percent, Medicaid ratios were about 89 percent and Medicare ratios were about 88 percent. The gap between Medicaid and private payer ratios is larger than a decade earlier, when private payment-to-cost ratios were about 122 percent and Medicaid ratios were about 92 percent.

There are two impacts:
1. Mortality

Robin Rudowitz, 3-21-2019, "Medicaid Financing: The Basics – Issue Brief – 8953-02," Henry J. Kaiser Family Foundation, https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/#endnote_link_397008-6

A large body of research shows that Medicaid beneficiaries have far better access to care than the uninsured and are less likely to postpone or go without needed care due to cost. Moreover, rates of access to care and satisfaction with care among Medicaid enrollees are comparable to rates for people with private insurance (Figure 7). **Medicaid coverage of low-income pregnant women and children has contributed to dramatic declines in infant and child mortality in the U.S. A growing body of research indicates that Medicaid eligibility during childhood is associated with reduced teen mortality, improved long-run educational attainment, reduced disability, and lower rates of hospitalization and emergency department visits in later life.** Benefits also include second-order fiscal effects such as increased tax collections due to higher earnings in adulthood. Research findings show that state Medicaid expansions to adults are associated with increased access to care, improved self-reported health, **and reduced mortality among adults.**

Hannah Katch, senior policy analyst, June 2, 2017, "Medicaid Works: Millions Benefit from Medicaid's Effective, Efficient Coverage," Center on Budget and Policy Priorities, https://www.cbpp.org/research/health/medicaid-works-millions-benefit-from-medicaids-effective-efficient-coverag

Medicaid also produces long-term improvements in health and well-being. For example, **among African American children, Medicaid eligibility during early childhood reduced mortality rates in their later teenage years by 13 to 20 percent.**[6] In addition, research published in the New England Journal of Medicine reported that expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York reduced mortality by 6.1 percent.[7] Likewise, the expansion of Medicaid and other health coverage in Massachusetts in 2006 significantly reduced mortality, especially deaths from causes affected by health care.[8] Other studies show that children eligible for Medicaid for more of their childhood earn more as adults and are likelier to attend and complete college.[9] (For a discussion of the findings and limitations of the Oregon Health Insurance Experiment, see box.)

2. Protecting the elderly

Resolved: The United States should replace means-tested welfare programs with a universal basic income.

Robin **Rudowitz**, 3-21-2019, "Medicaid Financing: The Basics – Issue Brief – 8953-02," Henry J. Kaiser Family Foundation, https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/#endnote_link_397008-6 **Seniors and people with disabilities make up 1 in 4 beneficiaries but account for almost two-thirds of Medicaid spending, reflecting high per enrollee costs for both acute and long-term care** (Figure 9). **Medicaid is the primary payer for institutional and community-based long-term services and support – as there is limited coverage under Medicare and few affordable options in the private insurance market.** Over half of Medicaid spending is attributable to the highest-cost five percent of enrollees. However, on a per-enrollee basis, **Medicaid is low-cost compared to private insurance, largely due to lower Medicaid payment rates for providers. Analysis shows that if adult Medicaid enrollees had job-based coverage instead, their average health care costs would be more than 25% higher.** Medicaid spending per enrollee has also been growing more slowly than private insurance premiums and other health spending benchmarks.

Subpoint B) the uninsured
Decreased uninsured rate:

Lots of people get insurance through medicaid:
Marc S. Ryan,, "Why Medicaid is Good – Part 1," MHK, Why Medicaid is Good – Part 1
While Medicaid has many warts, at least it is a proven delivery mechanism that is relatively financially stable. With reform, it is capable of delivering the type of care Americans need in the future. It, too, is the place where all of our challenges, now and in the future, come together. **Almost 75 million people rely on Medicaid today, most of the them include the working poor. Medicaid covers the deliveries of about half of all babies in the nation. It can do the most to lower infant mortality and morbidity and ensure a solid start for our children.** Medicaid already serves as a safety net for many who face financially catastrophic health events. Medicaid picks up the costs of these events for a temporary period of time. Medicaid provides critical programs and coverage for the most vulnerable in our society. No one can question the moral imperative to serve them. In the next decade, Medicaid long-term care costs will double. Already, Medicaid covers 40 percent of all long-term care costs in the nation. Acute and long-term care services are fragmented and uncoordinated. Medicaid is the program that can best build a true continuum of care and manage both types of services effectively. Dual eligibles are individuals that qualify for both Medicare and Medicaid. They are about 20 percent of each program but account for more than 40 percent of total spending. This will only rise in the future. Medicaid will help coordinate Medicaid and Medicare funding streams, too. About 17 million people have obtained Medicaid coverage since late 2013, about 14 million of them due to the Obamacare expansion. They are relatively happy consumers. Contrast this with just over 12 million in 2017 on the Exchanges, with many of them at risk of losing coverage next year.

All of society pays the cost for uncompensated care.

Health Affairs, Safety-Net Health Systems At Risk: Who Bears The Burden Of Uncompensated Care?, Dhruv Khullar, Zirui **Song**, Dave A. Chokshi, https://www.healthaffairs.org/do/10.1377/hblog20180503.138516/full/
Recent years have brought a wave of hospital closures, especially in rural and suburban areas where hospitals are struggling financially. What happens when a safety-net health system closes? Evidence suggests that the total demand for uncompensated care in a health care market does not change and that there is nearly complete spillover of uncompensated care to remaining hospitals. **Each newly uninsured individual is associated with a $900 increase in uncompensated care annually, and some recent Medicaid disenrollment has likely resulted in even larger per capita uncompensated cost growth.** While it is widely believed that commercial insurers subsidize care for Medicaid and uninsured patients, research suggests that hospitals cannot fully shift increased costs onto commercially insured patients. **Medicaid expansion appears to have helped hospitals; reductions in uncompensated care through state Medicaid expansions were associated with substantially lower likelihood of hospital closures, especially in rural areas and in those with large numbers of uninsured patients.**

Resolved: The United States should replace means-tested welfare programs with a universal basic income.

Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains, May 23, 2018, **Broaddus**,

Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect

Hospitals' and other providers' uncompensated care costs have fallen significantly since the implementation of the Affordable Care Act's (ACA) major coverage provisions. But approved and proposed Medicaid waivers that would take Medicaid away from people not working or engaged in work activities for a set number of hours each month; lock people out of coverage for not paying premiums or meeting other requirements; and/or delay access to coverage jeopardize the financial gains beneficiaries, hospitals and other providers, and states have made. **By making it harder for beneficiaries to obtain and maintain coverage, these proposals will not only impede access to care, they will also increase uncompensated care (services for which neither an insurer nor the patient reimburses providers), especially for hospitals.**

Between 2013 and 2015, as the nationwide uninsured rate fell from 14.5 percent to 9.4 percent (a 35 percent decline), uncompensated care costs as a share of hospital operating expenses fell by 30 percent.[1] While such costs fell in all but two states, declines were larger in states where uninsured rates fell more, with a **roughly one-to-one relationship between percent declines in uninsured rates and percent declines in uncompensated care costs as a share of hospital operating expenses**. States that expanded Medicaid to low-income adults under the ACA saw both larger coverage gains and larger drops in uncompensated care: a 47 percent decrease in uncompensated care costs on average compared to an 11 percent decrease in states that did not expand Medicaid.

Less uncompensated care benefits patients, hospitals, and state budgets. While uncompensated care costs are bills patients don't pay up front, they still give rise to medical debt, which hospitals may seek to collect; become part of patients' credit history, reducing their access to loans; and can sometimes lead people to declare bankruptcy. Meanwhile, uncompensated care costs burden hospitals, making it harder for them to invest in new technologies or equipment, maintain needed capacity to serve patients, or even keep their doors open. Finally, uncompensated care costs burden state budgets, because many states cover a portion of these costs, at least for public hospitals and other safety net providers.

Hospitals saw significant reductions in uncompensated care costs as the ACA's Medicaid expansion to low-income adults, marketplace subsidies, and major insurance market reforms took effect in 2014. From 2013 to 2015, the nationwide uninsured rate fell 35 percent, and nationwide hospital uncompensated care costs fell by about 30 percent as a share of hospital budgets — a $12 billion drop in 2015 dollars. But such costs fell even more precipitously in expansion states, where hospitals' uncompensated care costs fell by roughly half.[2] And in the ten expansion states (Kentucky, West Virginia, Washington, Oregon, Rhode Island, California, Vermont, Minnesota, Michigan, Illinois) where uninsured rates dropped most, uncompensated care costs fell by 57 percent on average.

These large drops in uncompensated care costs were almost certainly the result of the large coverage gains made under the ACA. Nationally, the decline in 2014 was striking compared to the previous couple years.[3] Moreover, as Figure 1 shows, **there is a tight, roughly one-to-one relationship between the magnitude of a state's uninsured rate reductions and its drop in uncompensated care: the larger a state's uninsured rate drop, the larger the decline in uncompensated care**. (See Appendix Table 1 for state-by-state data.)[4] Declines in uninsured rates and uncompensated care costs were greater in Medicaid expansion states, and the relationship between uninsured rate declines and uncompensated care drops was also stronger in these states, likely because **Medicaid serves the most financially vulnerable who are least likely able to pay medical bills when uninsured, thus leading to hospital uncompensated care costs.**

The ACA's coverage expansions, and Medicaid expansion in particular, have significantly improved access to care. Nationally, the share of people failing to get needed medical care due to cost fell by about a quarter between 2013 and 2015, with larger declines in states where coverage gains have been larger.[5] Meanwhile, **Medicaid expansion resulted in increases in the shares of people with a personal physician, getting check-ups, and getting recommended preventive care such as cholesterol and cancer screenings, and decreases in the shares of people delaying care due to costs, skipping medications due to costs, or relying on the emergency room for care, studies have found.[6]**

In addition to improving access to care and health outcomes for Medicaid beneficiaries, **expanding coverage also has increased financial security by lowering medical debt and reducing the risk of medical bankruptcy. Expanding Medicaid coverage results in fewer and smaller unpaid medical bills** as well as having fewer debts sent to third-party collection agencies, studies have found.[7] Another study showed that the share of low-income adults in Arkansas and Kentucky having trouble paying their medical bills dropped substantially, compared to low-income adults in Texas (which did not expand Medicaid).[8] Moreover, with fewer and lower unpaid medical bills, adults who gained coverage through the Medicaid expansion have been found to have better credit, qualifying them for lower-interest mortgage, auto, and credit card loans — leading to estimated savings that average $280 per adult gaining coverage per year on interest payments, and an estimated $520 million across the expansion population.[9]

Resolved: The United States should replace means-tested welfare programs with a universal basic income.

Meanwhile, **Medicaid expansion has substantially improved hospitals' finances, especially for rural hospitals. While Medicaid expansion has improved all hospitals' operating margins (i.e., the difference between their revenue from providing services to patients and their total operating expenses) and total margins (the difference between revenue from all sources, including donations, parking fees, vending machines, etc., and total operating expenses), the effect was particularly pronounced in rural areas.[10] From 2013 to 2015, rural hospitals in expansion states increased their operating margins by 4 percentage points more, and their total margins by 2.3 percentage points more, than rural hospitals in non-expansion states.**[11] Reducing uncompensated care costs helps hospitals by reducing strain on their budgets, enabling them to make investments such as in technology or equipment and increase or maintain capacity and making hospital closures less likely.[12]
State budgets also benefit from more people having coverage and lower uncompensated care costs. Medicaid expansion has produced savings in Arkansas, Louisiana, Kentucky, Michigan, and elsewhere, partly because of reduced uncompensated care, research has found.[13] As more low-income people have gained Medicaid coverage, demand for state-funded health programs that serve this population, including payments to hospitals to cover uncompensated care, has dropped, providing net savings. For example, Louisiana saved $199 million in the first fiscal year of its expansion and is projected to save an additional $350 million in the current fiscal year, in large part because of lower payments to hospitals for uncompensated care.[14] Colorado's Medicaid expansion is expected to produce $134 million in net savings through 2026.[15]

Medicaid decreased hospital closure.
Lindrooth, R. C., Perraillon, M. C., Hardy, R. Y., & Tung, G. J. (2018). Understanding The Relationship Between Medicaid Expansions And Hospital Closures. Health Affairs, 37(1), 111–120. doi:10.1377/hlthaff.2017.0976 file:///Users/kcassese/Downloads/lindrooth2018%20(1).pdf
States that did not expand Medicaid experienced a large increase (0.429 closures per 100 hospitals) from 2008–12 to 2015–16 in the unadjusted rate of closures (exhibit 1). In contrast, the closure rate decreased by 0.33 per 100 hospitals in expansion states. Total margins improved by 0.011, or about 33 percent, in expansion states; although the increase was more than the 0.005 increase in nonexpansion states, the differencein-differences was not significant. However, the difference between the unadjusted change in the Medicaid and uncompensated care margins was quantitatively larger in expansion states than nonexpansion states and statistically significant. The annual unadjusted hospital closure rate, measured as the number of closures per 100 hospitals, declined in both expansion and nonexpansion states as the United States emerged from the 2008–09 Great Recession (exhibit 2). Between 2010 and 2012, closure rates were nearly identical in the two groups of states. They began to diverge after 2012. This may be related to the June 2012 Supreme Court decision that made the Medicaid expansion optional for states. Beginning in July 2012, over the twelve to eighteen months following the Supreme Court decision, states announced whether or not they would participate in the 2014 expansion. The large increase in closures in nonexpansion states in 2013 occurred at a time when DSH payments were expected to be phased out. From 2012 to 2013 the closure rate increased from about 0.45 to just over 0.90 closures per 100 hospitals in nonexpansion states, whereas the rate remained at about 0.45 in expansion states. After 2014, the closure rate in expansion states declined but remained relatively high in nonexpansion states

According to Soper, these programs increased employment by 75%[14].

[14] https://www.brookings.edu/research/from-welfare-to-work-what-the-evidence-shows/