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With an update on the Arkansas “private option” deal

Why states should not expand Medicaid

By Grace-Marie Turner and Avik Roy

States are being strongly pressured to expand Medicaid to families earning up to \$30,000 a year, as the Affordable Care Act allows.

While several high-profile governors have agreed to expand this broken program, many others governors and state legislators are cautious. They are correct to be concerned.

They don’t want to deny people access to health care. But they do want to halt expansion of a program that provides limited access to quality care while devouring state budgets. Many political leaders are demanding that Washington allow states to improve Medicaid for their most vulnerable citizens.

Medicaid -- the joint federal and state program designed to finance health care for the poor -- has not been fundamentally changed since it was created in 1965. Legislators know Medicaid desperately needs to be modernized for the 21st century, and even President Obama argued the case during the debate over ObamaCare. “It is not sufficient for us simply to add more people to Medicare or Medicaid to increase the rolls, to increase coverage in the absence of cost controls and reform,” Mr. Obama said, adding that “another way of putting it is we can’t simply put more people into a broken system that doesn’t work.”¹

12 reasons NOT to expand Medicaid

1. Medicaid harms the poor
2. Medicaid spending will explode
3. Access to physicians will become even more difficult
4. Washington will likely alter the 100% match rate
5. Expansion will worsen the cycle of dependence
6. As many jobs could be lost as created by expansion
7. Medicaid crowds out private coverage
8. Expansion will increase premiums for private insurance
9. Medicaid’s low payment rates exacerbate uncompensated care
10. Expanding Medicaid will increase the prevalence of fraud and waste
11. Refusing to expand saves taxpayer dollars
12. States should demand more options and control

The health overhaul law did not improve Medicaid, but instead it offers a generous but temporary 100% federal match to encourage states to expand Medicaid to families earning up to 138% of poverty.

“Medicaid was designed as a safety net for our nation’s poorest and sickest people,” Rep. Joe Pitts, R-PA, chairman of the Energy and Commerce Health Subcommittee, [said](#) during a hearing on March 18, 2013.² “States are already struggling to serve this core population.

“Increasingly, doctors simply can’t afford to treat Medicaid patients. Is it fair that the president’s health care law will force millions of disabled and sick Americans to compete with able-bodied 25-year-olds for appointments with those doctors who will still see them?”

Chairman Pitts says that expanding Medicaid compromises states’ “ability to care for our country’s poorest and sickest citizens.”

If all states were to go along with the optional Medicaid expansion, nearly 90 million people would be enrolled in the program by the end of the decade, including those newly-eligible under the ObamaCare optional expansion. However, as many as [60% of these new enrollees](#)³ are likely to drop private coverage in order to sign up for Medicaid, moving from private to public insurance that will be funded by taxpayers. That will strain not only federal and state budgets, but would also shred the safety net for the poor as they are forced to compete with millions more people to get care from the limited number of providers who see Medicaid patients.

Hospitals are saying they desperately need the expansion money, especially in light of funding they are losing from other cuts in hospital payments built into ObamaCare. But Medicaid pays below their costs of providing care, and increasing the volume of patients on whom they lose money isn’t going to help.

We need every person currently employed in the health sector in our 21st century health economy. We must begin now to build a more

efficient delivery system rather than pour more money into a failing system.

Some governors are exploring ways to expand Medicaid in a different way. Gov. Mike Beebe, D-AR, has reached a tentative agreement with the department of Health and Human Services to allow federal money earmarked for Medicaid expansion to pay for private insurance. Other states have shown an interest in a similar arrangement.

But the Arkansas deal is a bait and switch, since federal regulations say Medicaid dollars can only be used to buy private insurance coverage if the costs are comparable with traditional Medicaid. The Congressional Budget Office estimated last year that private insurance plans cost about 50 percent more than the public program --\$9,000 vs. \$6,000. See page 9 for details.

It is up to state legislators and watchdog governors to protect taxpayers from expanding Medicaid and use their leverage to gain control over a program that poorly serves the people it is supposed to help.

Here are twelve reasons states should not expand Medicaid and should instead demand from Washington greater control over spending to better fit coverage expansion with their states’ needs, resources, and budgets.

1. Medicaid harms the poor.

The Medicaid program actually harms the people it is intended to serve. Expanding Medicaid means that patients who are already enrolled in the program – many of whom have nowhere else to go for coverage – will be competing for medical services with up to 20 million more people being added to the program. And the most vulnerable patients who have the greatest needs are likely to have the hardest time getting care.

A father in Iowa writes⁴ that his handicapped daughter, who is on Medicaid, has to wait 2½ months for a doctor’s appointment to treat her bladder problems. “By adding 150,000 people

to the Medicaid rolls in Iowa, she will have to wait six months next time,” he says. “No one takes into consideration what will happen to those who are currently on Medicaid.”

Even before ObamaCare was enacted, Edward Miller, then-dean and CEO of Johns Hopkins Medicine, warned that putting millions more people on Medicaid would mean crushing demands for medical centers such as Hopkins, which treat a large number of low-income patients.

Dr. Miller wrote a commentary [article](#) in *The Wall Street Journal* in December of 2009 entitled “Health Reform Could Harm Medicaid Patients.”⁵ He warned that this large Medicaid expansion could have “catastrophic effects on those of us who provide society’s health-care safety-net.”

Hopkins serves tens of thousands of poor, disadvantaged people, including 150,000 in Maryland’s Medicaid program. Hopkins has worked very hard to create programs to provide quality care, ranging from routine care at clinics that are near people’s homes to sophisticated treatment for patients with serious and complex medical problems.

“The key fact is that for years the state did not cover all the costs [of] our Medicaid program,” Dr. Miller wrote. Hopkins lost more than \$57.2 million treating Medicaid patients between 1997 and 2005. The state had added thousands more people to Medicaid “whose costs were not completely covered by the state.” Then Maryland expanded Medicaid *again* to cover more people, and Hopkins lost another \$15 million in just the first nine months. There is just no way the system can handle the huge wave that is coming with ObamaCare’s Medicaid expansion, he said.

Given time, Dr. Miller says Hopkins could work with other medical facilities to create a system of care for thousands more patients. But if 26 million more people are added to the Medicaid rolls nationwide under ObamaCare, it could completely overwhelm the safety net system among his and other hospitals and clinics

around the country. And given Medicaid’s abysmally-low payment rates, it is unlikely that private doctors will be able to afford to take much more of the exploding caseload.

Mountains of clinical literature show that patients on Medicaid have, on average, poorer access to care and poorer health outcomes than those with no insurance at all. The largest national study, conducted by the University of Virginia, examined outcomes for 893,658 individuals undergoing major surgical operations from 2003 to 2007. It found that patients on Medicaid were 13 percent more likely to die in the hospital after surgery than those with no insurance, even when adjusting for age, gender, income, region, and health status. Medicaid patients were 97 percent more likely to die than those with private insurance.

The Heritage Foundation has compiled a [paper](#) citing more than 20 studies showing that “Medicaid patients have worse access and outcomes than the privately insured” with evidence from state studies in California, Florida, Michigan, Massachusetts, and Maryland as well as numerous national studies.⁶

2. Medicaid spending will explode.

The initial 100% federal match rate for the expansion population is very tempting, but the match rate starts to decline in three years and falls to 90% by 2020. In addition, the state must pay all added administrative costs as well as its higher share of coverage for other eligible citizens outside the expansion band who are not now enrolled but who would likely do so after the Affordable Care Act’s individual mandate triggers in 2014.

Medicaid spending will increase dramatically as the federal matching rate for the expansion population begins to drop. Adjusted for inflation, Medicaid spending has increased [more than 250%](#) since 1990.⁷ Expanding Medicaid would cost states an additional \$118 billion through 2023, according to a recent [congressional report](#).⁸ The additional spending surely would crowd out funds for

education, transportation, parks, public safety, and other vital state needs.

Charles Blahous, senior research fellow at the Mercatus Center at George Mason University, and Public Trustee for Social Security and Medicare, [writes](#): “The latest CMS Medicaid report projects state Medicaid costs to grow by 158% cumulatively over the next decade, assuming all states opt for expansion.”⁹

“Even relative to Medicaid’s troubled history of rapid cost growth, these projections point to a coming cost explosion. They embody substantially higher future growth rates than states faced during the last decade. Yet Medicaid already absorbs 24% of state budgets and is described by the bipartisan [State Budget Crisis Task Force](#) as ‘crowding out other needs.’”¹⁰

The Heritage Foundation has calculated the cost of expansion for every state, with [charts](#) for each one showing spending by 2022.¹¹

“Proponents predict that by expanding Medicaid, states will be able to reduce payments to health care providers, such as hospitals, for uncompensated care. As a matter of fact, nationally, the opposite is true,” Drew Gonshorowski of Heritage concludes.¹²

Stuart Butler of Heritage [writes](#) in a *JAMA* Forum¹³: “[T]he ACA assumes that states will be able to institute payment cuts to clinicians and health care facilities on top of the ACA’s federal payment cuts to Medicare and Medicaid funding for hospitals that treat indigent patients through the disproportionate share hospital program.

“That’s going to be a tall political order for most states, where health care lobbyists can be expected to push back strongly,” Butler concludes. “If those lobbyists are successful, the Medicaid expansion could be much more costly to states.”

Even under current spending projections, 40 states will see an increase in their costs if they expand Medicaid. After the first three years of the 100% federal match, state costs will continue to climb, dwarfing any projected savings. Only a few large states, such as New York, will see savings because they already have expanded Medicaid and can transfer additional costs to federal taxpayers.

Finally, not expanding Medicaid doesn’t mean other states get the money. The expansion is an entitlement; if one state doesn’t expand, the money stays in the federal coffers (or reduces the amount Washington must borrow).

3. Medicaid’s access problems will get worse as more doctors drop out.

Coverage is not the same thing as care. A [study](#) in *Health Affairs* found that in 2011, nearly one-third of physicians nationwide did not accept new Medicaid patients.¹⁴ This is largely because the Medicaid program generally pays doctors and hospitals far less than private insurers. Nationally, for every dollar primary care received from someone with employer-sponsored insurance in 2008, Medicaid only paid 52 cents.

As a result, few doctors can afford to take Medicaid, and patients, therefore, often lack a consistent source of outpatient care. When they can’t get predictable access to care, their cancers go undiagnosed and their heart conditions go unmanaged. Receiving care from a specialist or surgeon is particularly challenging. Doctors cite difficult Medicaid paperwork, administrative burdens and traps, and poor reimbursement rates as reasons they cannot accept more patients from the program.

The ACA provides for a temporary two-year increase in Medicaid payments for primary-care physicians, but few observers believe that this temporary increase will lead physicians to increase their participation.

4. States will be exposed to higher Medicaid costs when Washington recalculates its matching payments.

While the lure of the 100% match in federal funding tempts states to expand Medicaid, states will pay a high price for the expansion.

According to a 2011 [congressional report](#), Medicaid expansion would cost states at least \$118 billion over the next ten years.¹⁵ Once millions more people are enrolled in Medicaid, history teaches that it is nearly impossible for states to contract.

And there is no guarantee these high federal matching rates will continue. In outlying years, the federal government will attempt to reduce entitlement spending by reducing its matching payment for the expansion. Indeed, [President Obama proposed doing just that](#) in his fiscal-year 2013 budget, which would have reduced Medicaid spending by \$100 billion over ten years.¹⁶ HHS Secretary Sebelius' assurances that the match won't be reduced have no force of law and cannot influence future congressional policy.

"Every serious bipartisan budget discussion in recent years has envisioned reductions in future federal Medicaid outlays," Public Trustee Charles Blahous [writes](#). "The bare minimum of required savings appears to be \$100 billion over the next ten years, with much evidence suggesting that the savings required will be closer to \$200 billion."¹⁷

The new blended Medicaid match rate is likely to encompass Medicaid, the Children's Health Insurance Program, and the new ObamaCare Medicaid expansion population. States will find their costs overall for these entitlement programs will rise.

In addition, many states have made extra money from their Medicaid programs by taxing providers and insurers for participating in the program. These accounting gimmicks will almost assuredly be prohibited in future federal budget negotiations, leaving states on the hook for more Medicaid spending.

Florida Gov. Rick Scott has said he will cut the Medicaid expansion if Washington defaults on the deal. But he will not likely be able to do so. *The Wall Street Journal* [calls](#) this Medicaid's roach motel.¹⁸ "Chief Justice John Roberts and six of his colleagues did not stipulate a right to leave Medicaid at any time when they rewrote ObamaCare," the *Journal* wrote, adding "once states adopt new Medicaid, the program immediately becomes the old program for the purposes of the law and then states can't leave."

5. Medicaid expansion will worsen the cycle of dependence and harm the economy.

Medicaid imposes a huge disincentive on the poor to find work because they fall out of the program once they start earning better incomes. If states choose not to expand Medicaid, able-bodied adults who seek work and who successfully cross the poverty line should have the option of subsidized private insurance.

Private insurance is a morally superior approach, one that will increase the incentives for employment and stimulate the economy through privately generated income rather than the shell game of transfer payments.

Expanding Medicaid means that government programs will supplant private coverage. According to the Centers for Medicaid and Medicare Services, by 2021, 46% of Americans [will receive](#) health care through government programs, including nearly 87 million in Medicaid and the Children's Health Insurance Program.¹⁹

This should be the focus of negotiations with Washington — seeking a united front with other states to demand much more flexibility in expanding coverage and offering people the dignity of private insurance instead of trapping them in a failing public program.

6. Claims about job creation are exaggerated.

The claim that Medicaid will add millions of new jobs uses out-of-date Keynesian thinking that have been eminently disproven. Keynesian forecasts were used to predict that the American Recovery and Reinvestment Act of 2009 (ARRA) — commonly known as the “stimulus” — would bring the national unemployment rate [below 6% by 2012](#).²⁰ Instead, the unemployment rate has remained around 8%. Those who claim that the Medicaid expansion will create jobs should be required to explain, specifically, how their forecasting models differ from those used to project unemployment rates under the ARRA. And this is a misguided goal for a health care program: “Treating the health care system like a (wildly inefficient) jobs program conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price,” according to Kate Baicker in an article entitled “The health care jobs fallacy.”²¹

The RAND Corporation finds in a recent [study](#) that every new job added to the health care sector results in 0.85 fewer jobs in the rest of the economy.²² For every job created, the costs of running this health care system grow and eventually result in layoffs in other sectors unable to manage the growing burden of the cost of health insurance premiums for employees.

Chris Conover of Duke University calls economic analyses claiming Medicaid expansion will lead to huge job creation “a shell game.” He [explains](#) that “every dollar going into the U.S. Treasury to finance this expansion is a dollar taken out of the private economy.”²³ And he adds that “Every additional dollar of new taxes shrinks the economy...That dollar would have been spent (i.e., ‘created’ or supported jobs) anyway: the Medicaid expansion simply transfers the decision about how to spend that money to Washington, D.C.”

Conover adds, “Currently every added dollar of federal taxes essentially shrinks the economy by 44 cents. Thus, if we convert this to jobs, we will

lose 144 jobs for every 100 health sector-related jobs that are induced by expansion.”

State calculations are more complicated, Conover explains, but the bottom line is that expanding Medicaid means relegating up to 26 million more people to a program that can be worse than being uninsured.

7. Medicaid crowds out private coverage.

Advocates of expansion claim that up to 26 million people will be denied coverage if states don’t expand Medicaid. But these calculations do not account for the crowding out of private insurance that will occur. Medicaid expansion would end up displacing higher-quality, employer-sponsored health coverage for millions of Americans. While these individuals will still have “coverage,” and therefore will not increase the ranks of the uninsured, the *quality* of their coverage will meaningfully decrease.

MIT economics professor Jonathan Gruber [calculates](#) that the number of privately-insured falls by about 60% as much as the number of publicly-insured grows.²⁴ “From 1984 through 2004, the share of the non-elderly U.S. population that is uninsured rose from 13.7% to 17.8%. At the same time, the share of non-elderly U.S. population that is publicly insured rose from 13.3% to 17.5%. In other words, despite an enormous expansion in the public health insurance safety net in the U.S., the number of uninsured continues to grow,” Gruber writes. Over the same period, the share of the U.S. non-elderly population with private health insurance fell from 70.1% to 62.4%.

Clearly, “crowd-out remains a pervasive phenomenon for recent public insurance expansions,” Gruber writes.

There are many factors responsible, but greater access to publicly-funded insurance clearly replaces private insurance for well over half of those enrolling. And the more the coverage is

offered to families and the more people are deemed “presumptively eligible,” the greater the likelihood private insurance will be crowded out.

Therefore, expanding Medicaid will lead up to 16 million people losing private health insurance (60% of 26 million) — a fact that is not included in the standard assessments of how much Medicaid expansion would increase coverage.

8. Medicaid raises premiums for those with private insurance.

There is an additional hidden cost to people with private insurance of expanding Medicaid. Because both Medicaid and Medicare underpay doctors and hospitals for their costs of care, providers make up the difference by charging higher rates to private insurers.

In 2008, Milliman, the leading insurance consulting firm, [estimated](#) that the average American family with private health insurance paid \$1,800 more in premiums because of this cost-shifting phenomenon.²⁵ By dramatically expanding Medicaid, states will impose a hidden tax on tens of millions of people with private insurance.

Because expanding Medicaid leads hospitals and doctors to shift costs onto patients with private insurance, this makes private insurance less affordable and contributes to the vicious cycle of increasing the number of people without insurance.

9. Medicaid’s undercompensated care is a bigger problem than providing uncompensated care for the uninsured.

There is much concern about the problem of “uncompensated care,” in which hospitals are required to treat patients even if they cannot afford to pay the bills. (Under federal law, hospitals must serve all who come, and emergency rooms are often a source-of-last-resort for care.) But the problem of undercompensated care is a larger one.

Many hospitals believe that they will be able to improve their bottom lines if Medicaid is expanded and more patients have coverage. But because Medicaid generally pays below costs, it’s hard to see how they can make up the losses with more volume.

In Maine, a 2002 expansion of Medicaid was “[a calamitous failure](#)” for hospitals because uncompensated care did not meaningfully decrease at the same time Medicaid crowded out higher-paying commercial insurers.²⁶ [In Ohio in 2010](#), for example, hospitals lost \$1.3 billion on Medicaid patients while spending \$1.1 billion on charity care.²⁷ In Massachusetts, hospitals have [not seen](#) a drop in patients needing uncompensated and have successfully lobbied to continue receiving \$200 million a year in supplemental payments from state taxpayers.²⁸

10. Expanding Medicaid will expose states to increased risks of fraud and waste.

The vast majority of Medicaid providers are underpaid for their services -- and a few are bilking the system.

Official federal estimates show that [at least 10%](#) of Medicaid payments are fraudulent.²⁹ Many prosecutors believe that the figure is closer to 30%. Unfortunately, there is little incentive to police fraud and waste because excess Medicaid spending frequently accrues to the benefit of providers and politicians.

In North Carolina, state auditor Beth Wood, a Democrat, [recently](#) found that the state’s Medicaid program endured \$1.4 billion in cost overruns each year, including \$375 million in state dollars.³⁰ As a result, North Carolina has decided not to expand its Medicaid program. Before considering a Medicaid expansion, other states should conduct a similar audit of the program and demand flexibility to fix the problem.

11. By rejecting the Medicaid expansion, states encourage others to do the same, fueling the spending cycle.

As states decide whether or not to expand their Medicaid programs, a principal justification is that declining to expand Medicaid means that a state's taxpayer dollars go to fund Medicaid in other states.

But the large "blue states" mostly have gone along with the Medicaid expansion because they already have expanded their programs beyond the law's 138% limit. Indeed, only half of the funds dedicated to the Medicaid expansion are being spent outside the South. Large "red states," on the other hand, where the ACA's Medicaid dollars are directed, have mostly rejected the expansion.

States will set an example to others that are deciding what to do about the Medicaid expansion by saying No. Fifteen states have already rejected the expansion, with many others undecided. If others join them, it will do much to limit spending of both federal and state taxpayer dollars.

12. States should demand more control and flexibility to expand coverage their own way.

Instead of buying in to the expansion, states should demand much greater control over the program. Paul Howard, a senior fellow at the Manhattan Institute, [writes](#),³¹ "Congress should set some cap on federal Medicaid spending. In exchange, states would receive much greater flexibility to manage their programs as they saw fit – designing eligibility requirements, co-payment levels, and patient benefits to best meet the needs of the particular Medicaid populations within their own borders."

Howard cites the success of three states that show how states can use flexibility to save money and improve their Medicaid programs: Rhode Island, Indiana, and New York. Rhode Island's approach involved a capped allotment in exchange for greater flexibility. The state was

able to save money and improve access to care, without cutting access to care for any of its residents.

New York also was able to gain more control over how Medicaid subsidy money is spent in exchange for a global cap on a substantial fraction of its Medicaid expenditures.

The [Healthy Indiana Plan](#) also provides an attractive option.³² This popular program, initiated by former Indiana Gov. Mitch Daniels, provided a routine health spending account jointly funded by modest contributions from recipients and from the state, with a back-up insurance plan to cover larger medical expenses, including hospitalizations. The popular program provides a better path to private coverage, while saving taxpayers and recipients money.

Chris Jacobs, a visiting fellow at the Galen Institute, provides in a [new paper](#)³³ a number of additional examples of state initiatives that are far preferable to expanding the broken, abuse-ridden Medicaid program. Florida, Texas, North Carolina, West Virginia, and Utah are among those taking a pro-active role in solutions that work for their states and citizens.

Given greater flexibility, states could provide access to better health services, and in turn produce better health outcomes. Jim Capretta of the Ethics and Public Policy Center [argues](#) that states should collectively push for Washington to allow them to improve the Medicaid program rather than allowing the Obama administration to pick them off one by one with special deals.³⁴

If states join together, they have more leverage to demand flexibility in Medicaid spending and the ability to protect the state when Washington attempts to increase costs later on.

States can lead the way to show that Medicaid can have a more efficient and effective service delivery system that enhances quality of care and outcomes. Expanding Medicaid without a guarantee of flexibility would be a major missed opportunity for the states.

States need to demand more control and flexibility for Medicaid to build innovative models that give recipients a stake in their care. Together, they can insist that Washington provide more flexibility over Medicaid spending so they can expand access to care without burdening taxpayers with significant new costs or burdening their citizens with being relegated to a program that can be worse than being uninsured.

****UPDATE on the Arkansas deal****

Avik writes in his *Forbes* blog that the special deal Arkansas is trying to negotiate is a bad deal. In a presentation to Arkansas legislators in April, he said the state's so-called "private option" for Medicaid expansion is "Obama's Bait & Switch."³⁵

Arkansas has tentative agreement from HHS for a plan to expand Medicaid using private insurers. Avik lists a number of reasons why arguments in favor of this private option are flawed:

- **Strict rules:** The private option will still be controlled by federal 1965 Medicaid law. Due to Medicaid's cost-sharing restrictions, this will prevent Arkansas from giving patients market-based coverage. Any minor change that Arkansas seeks will still require HHS approval.
- **Provider costs:** The private option will have to pay providers more, costing the state more than traditional Medicaid. Arkansas' 2.5% premium tax will also artificially inflate costs.
- **Budget costs:** Expanding Medicaid through the private option or traditional Medicaid expansion will commit the state to massive, irreversible spending increases. Future Congresses are likely to reduce the federal matching rate a limit state options for provider taxes, etc., increasing the cost of any expansion.
- **Uncompensated care:** While expanding coverage would reduce this burden to some extent, uncompensated care is a highly overrated problem. Uncompensated care for those with incomes below the federal poverty level represents a tiny fraction (0.6%) of health expenditures.

— *Grace-Marie Turner is president of the Galen Institute (gracemarie@galen.org), and Avik S. Roy is a senior fellow at the Manhattan Institute (aroy@manhattan-institute.org).*

NOTES

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