Thoughts on the Report "Expanding Medicaid in Ohio: Preliminary Analysis of Likely Effects" from Five National Health Care Experts

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From Michael Cannon, Director of Health Policy Studies at the Cato Institute:

The Urban Institute says expanding Medicaid will cost Ohio $6.6 billion over 10 years.[1] But my colleague Jagadeesh Gokhale, Senior Fellow at Cato, has run the numbers for around 10 states and found the costs are usually 2-3 times what the Urban Institute estimates.[2]

Either way, Congress doesn't have the money to keep up its end of the bargain, and President Barack Obama has advocated shifting more of the cost of Medicaid to the states, including the cost of this expansion. The Medicaid expansion is therefore an example of "predatory federalism," where Washington uses a low introductory rate to encourage states to adopt a program, and then changes the terms once states have taken the bait.

The Patient Protection and Affordable Care Act's (PPACA) Medicaid expansion will crowd out private health insurance and leave many Americans with less secure access to care. A recent study projected "high rates of crowd-out for Medicaid expansions aimed at working adults (82%), suggesting that the Medicaid expansion provisions of PPACA will shift workers and their families from private to public insurance without reducing the number of uninsured very much."[3]

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[1] John Holahan, Matthew Buettgens, Caitlin Carroll, and Stan Dorn, "The Cost and Coverage

[2] Jagadeesh Gokhale, Angela C. Erickson and Jason Sutton, "Projecting Oklahoma's Medicaid Expenditure Growth Under the Patient Protection and Affordable Care Act," Pklahoma Council of Public Affairs (May 2011), http://www.cato.org/articles/projecting-oklahomas-medicaid-expenditure-growth-under-ppaca; Jagadeesh Gokhale and Angela C. Erickson, "The Effect of Federal Health Care 'Reform' on Kansas General Fund Medicaid Expenditures," Kansas Policy Institute (June 2011), http://www.cato.org/articles/effect-federal-health-care-reform-kansas-general-fund-medicaid-expenditures; and Jagadeesh Gokhale, Angela C. Erickson and Geoffrey Lawrence, "The Impact of ObamaCare on Nevada's Medicaid Spending," Nevada Policy Research Institute Analysis (May 10, 2011), http://www.cato.org/articles/impact-obamacare-nevadas-medicaid-spending.

[3] Steven D. Pizer, Austin B. Frakt, and Lisa I. Iezzoni, "The Effect of Health Reform on Public and Private Insurance in the Long Run," March 9, 2011, http://ssrn.com/abstract=1782210. See also Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," *American Economic Review* 98, No. 3 (2008): 1083–1102; Geena Kim, "Medicaid Crowd-Out of Long-Term Care Insurance with Endogenous Medicaid Enrollment," 12th Annual Joint Conference of the Retirement Research Consortium, 2010.

Nationwide, nearly one third of physicians refuse to accept new Medicaid patients.[4]

If all states participate, the Medicaid expansion would add $931 billion to the national debt.[5]

According to Congressional Budget Office (CBO) estimates, the handful of states that have already refused to expand Medicaid are saving federal taxpayers $84 billion.[6]

"The goal of improving health and economic well-being does not go hand in hand with rising employment in health care. It is tempting to think that rising health care employment is a boon, but if the same outcomes can be achieved with lower employment and fewer resources, that leaves extra money to devote to other important public and private priorities such as education, infrastructure, food, shelter, and retirement savings."[7]

Medicaid is rife with waste and fraud.[8]

It increases the cost of private health care and insurance, crowds out private health insurance and long-term care insurance, and discourages enrollees from climbing the economic ladder.[9]

There is scant reliable evidence that Medicaid improves health outcomes, and absolutely no evidence that it is a cost-effective way of doing so.[10]

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[4] Sandra L. Decker, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs* 31, No. 8 (2012), http://content.healthaffairs.org/content/31/8/1673.full.

[5] Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012, p. 11, http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[6] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012, p. 2, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[7] Katherine Baicker and Amitabh Chandra, "The Health Care Jobs Fallacy," The New England Journal of Medicine 366: 2433-2435 (June 28, 2012), http://www.nejm.org/doi/full/10.1056/NEJMp1204891.

[8] Michael F. Cannon, "Entitlement Bandits," National Review, July 4, 2011, http://www.cato.org/publications/commentary/entitlement-bandits-how-ryan-plan-would-curb-medicare-medicaid-fraud.

[9] Michael F. Cannon, "Medicaid's Unseen Costs," Cato Institute Policy Analysis No. 548, August 18, 2005, http://www.cato.org/publications/policy-analysis/medicaids-unseen-costs. See also Michael F. Cannon, "Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs," Cato Institute Briefing Paper No. 99, September 27, 2007, http://www.cato.org/publications/briefing-paper/sinking-schip-first-step-toward-stopping-growth-government-health-programs-0.

[10] Michael F. Cannon, "Oregon's Verdict on Medicaid," National Review Online, July 7, 2011, http://www.nationalreview.com/articles/271252/oregon-s-verdict-medicaid-michael-f-cannon.

Even if states were facing deadlines and armed with all the regulatory guidance they need (neither of which is the case), states cannot afford to expand Medicaid.

Rejecting the Medicaid expansion would reduce federal deficits and would reduce total government spending even more.

From Grace-Marie Turner, President of the Galen Institute:

All of the numbers [in the report] are predicated on the federal government providing a 100 percent, then 90 percent match for the Medicaid expansion populations. The federal government is in deep financial trouble and one of the first things that is likely to be proposed is a leveling out of the federal contribution to Medicaid. President Obama already has proposed this idea twice.

So, this is nothing more than a lure to get states to buy in to the expansion. Once states do, they can expect that the federal match rate will fall. At that point, they will be stuck. That fact is the information that legislators in Ohio most need to hear.

From Nina Owcharenko, Director of the Center for Health Policy Studies, Edmund F. Haislmaier, Senior Research Fellow, and Drew Gonshorowski, Policy Analyst at The Heritage Foundation:[11]

Three Scenarios Don't Bode Well. In the first scenario, the federal match rates are set according to the PPACA. In the first three years of the PPACA, the federal match rate is 100 percent, gradually rolling back to 90 percent by 2020. Each following alternative scenario reduces the federal match rate in some other fashion.

In the second scenario, a flat 90 percent federal match is assumed. In the third scenario, the match rate is reduced by 10 percent but keeps the same schedule as described in the PPACA. In the fourth scenario, the match rate is reduced to a level that can be called the "blended rate"—an estimation of what the match rate could be under the Administration's suggestion.[12] This blended rate is an average of a state's current Medicaid match, its enhanced match rate for the Children's Health Insurance Program, and the expansion match rate. The result of this scheme is a drastic reduction in federal spending at the expense of the states.

While these scenarios do not capture potential (although uncertain) savings from

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[11] Excerpts taken with permission from Edmund F. Haislmaier and Drew Gonshorowski, "State Lawmaker's Guide to Evaluating Medicaid Exapnsion Projections," The Heritage Foundation Issue Brief #3720 (September 7, 2012), http://www.heritage.org/research/reports/2012/09/state-lawmakers-guide-to-evaluating-medicaid-expansion-projections.

12 Office of Management and Budget, Fiscal Year 2013: Cuts, Consolidations, and Savings.

less uncompensated care or increased tax revenues, what is certain is the cost of adding millions of individuals to Medicaid in the expansion.

Ohio would see increased spending in the first five years by $407 million and an increase on the budget by around $1 billion total by 2022 in the first scenario. Under a flat 90 percent match rate, costs increase from $407 million to nearly $1.3 billion in the first five years. Under the blended rate, costs increase to $2.5 billion in the first five years.[13]

Projected Savings from Reduced State Spending on the Uninsured. Hospitals and clinics have proven adept at blocking or reversing cuts to state "supplemental" funding for treating the uninsured. For example, the 2006 Massachusetts health reform legislation, which transformed supplemental payments going to "safety net hospitals" into premium support for the low-income uninsured, achieved near-universal coverage. However, Massachusetts's safety-net hospitals have successfully lobbied to continue receiving over $200 million a year in supplemental payments from state taxpayers.[14]

Under Obamacare, it is even more implausible to assume state savings from cutting uncompensated care payments, since any state payment cuts would have to be imposed in addition to Obamacare's federal payment cuts. Obamacare cuts federal Medicaid "Disproportionate Share Hospital" (DSH) funding by $18.1 billion and Medicare DSH funding by $22.1 billion over the years 2014–2020.[15] Furthermore, the President's Fiscal Year 2013 budget proposed an additional $8.25 billion in Medicaid DSH cuts for 2021 and 2022.[16] Consequently, governors and state legislators should expect their state's hospitals and clinics to lobby them for more—not less—state funding to replace reduced federal supplemental payments.

Administrative Cost Estimates. Obamacare's "enhanced" federal match rates for the Medicaid expansion population (100 percent in the first three years; 90 percent in 2020 and thereafter) apply only to benefit spending. Medicaid's existing, separate administrative cost match rates will still apply to any additional administrative spending. Nationally, on average, administrative expenses add 5.5 percent on top of total (federal and state) benefit costs, with states paying about 45 percent of those

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13 Drew Gonshorowski, "Medicaid Expansion Will Become More Costly to State," The Heritage Foundation Issue Brief #3709 (August 30, 2012), http://www.heritage.org/research/reports/2012/08/medicaid-expansion-will-become-more-costly-to-states.

14 For more information, including state-level data tables, see U.S. Government Accountability Office, Medicaid: States Reported Billions More in Supplemental Payments in Recent Years, GAO-12-694, July 2012.

15 Congressional Budget Office, "Selected CBO Publications Related to Health Care Legislation, 2009–2010," December 2010.

16 U.S. Office of Management and Budget, Fiscal Year 2013: Cuts, Consolidations, and Savings, Budget of the U.S. Government (Washington, DC: U.S. Government Printing Office, 2012), p. 169, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/ccs.pdf (accessed August 30, 2012).

costs.[17] Thus, every $100 of new Medicaid benefit spending generates about $5.50 in additional administrative costs, of which states pay around $2.48.

States will still have to pay their share of the added administrative costs even during the initial three years of the expansion, when the federal government funds all benefit costs. State lawmakers should ensure the additional administrative costs their state would incur from expanding Medicaid are included in any analysis of state fiscal effects.

Cost to States for Covering Individuals Who Would Otherwise Be Eligible for Exchange Subsidies. The Obamacare Medicaid expansion will enroll all individuals with incomes below 138 percent of the Federal Poverty Level (FPL). If a state does not adopt the expansion, then individuals with incomes at or above 100 percent of FPL will instead qualify for the new federal exchange subsidies. This applies to not only new enrollees that would otherwise be added to the Medicaid rolls by the expansion, but also to existing enrollees with incomes at or above 100 percent of FPL.

Thus, a state adopting the expansion will not only incur Medicaid costs for a portion of the expansion population that would otherwise receive subsidized exchange coverage (at no cost to the state), it will also be unable to reduce state Medicaid costs by shifting current enrollees with incomes between 100 and 138 percent of FPL into the exchanges. State lawmakers should check that any fiscal projections accurately account for these alternative coverage scenarios.

Projected Increases in State Tax Revenue. In theory, new federal spending from the Obamacare Medicaid expansion will be income to someone (e.g., various health care providers) who will then pay state taxes on that income. Economists calculate such effects by applying what is called an "economic multiplier" to the new spending.

If an analysis uses a multiplier of 1, then the study's author is assuming that every dollar of new spending will generate a dollar of new taxable income. Some believe new government spending produces a multiplier greater than 1, as the recipients in turn spend some of that additional income, generating more economic activity. Others point out that the taxes to pay for the new government spending reduce economic activity, meaning the multiplier should be reduced to reflect that offsetting economic "drag."

Government spending multipliers are highly uncertain. A recent survey of the economic literature found multipliers ranging from 0.5 to 2.0, but concluded that

17 April Grady, "State Medicaid Program Administration: A Brief Overview," Congressional Research Service, Report for Congress, updated May 14, 2008.

justification was strongest for multipliers of between 0.8 and 1.2.[18]

State lawmakers should question the appropriateness of any economic multiplier assumed in a fiscal analysis. It is highly unlikely that all of the additional federal Medicaid spending will translate into new taxable income or spending within the state. For example, federal Medicaid funds paid to out-of-state providers will not be subject to the state's income tax. Similarly, if some of the additional income is spent outside the state, it will not generate in-state sales or excise tax revenue. Furthermore, any additional state spending associated with the expansion will come from increased taxation, creating an economic "drag."

Uncertainty of Future Federal Medicaid Match Rates. Although Obamacare stipulates the federal government will pay at least 90 percent of the benefit costs of the Medicaid expansion, state lawmakers have no guarantee future Congresses will keep that promise. Indeed, the Obama Administration has already foreshadowed that possibility in the President's FY2013 budget by proposing to combine the various existing and new Medicaid and Children's Health Insurance Program (CHIP) match rates (including those in Obamacare, which have not taken effect), into a single "blended" match rate for each state.[19] Depending on how a "blended" rate is calculated, the change could result in significant shifts in program costs from the federal government to states.[20]

18 Valerie Ramey, "Government Spending and Private Activity," National Bureau of Economic Research, January 2012, http://www.nber.org/papers/w17787 (accessed August 29, 2012).
19 U.S. Office of Management and Budget, "Fiscal Year 2013: Cuts, Consolidations, and Savings," p. 169.
20 Gonshorowski, "Medicaid Expansion Will Become More Costly to States."