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POLICY BRIEF #6 | JUNE 12, 2013

Medicaid in Ohio: The Choice is Clear

Buckeyes should resist Medicaid expansion and instead make Medicaid work for patients and taxpayers

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EXECUTIVE SUMMARY

In its decision to uphold the federal Patient Protection and Affordable Care Act, the U.S. Supreme Court also held that states were not required to implement an expansion of Medicaid, which the law initially mandated. This leaves Ohio policymakers with a choice; accept federal funding to expand Ohio Medicaid to cover able-bodied, working-age adults with no children or reject the optional Medicaid expansion called for in the Affordable Care Act (ACA).

Eight Reasons Medicaid Expansion is Wrong for Ohio Patients and Taxpayers

1. **Able-bodied childless adults have never been—and were never intended to be—eligible for taxpayer-funded Medicaid.** **(Page 5)**

   Medicaid was created to be a health care safety net for the most vulnerable: the elderly, individuals who are blind or disabled, and low-income families. A recent poll found that 77 percent of Americans oppose providing Medicaid for working-age adults without kids.

2. **Medicaid costs are growing and jeopardizing all other state priorities.** **(Page 7)**

   Between 2000 and 2011, Ohio's Medicaid welfare spending grew from $7.5 billion to nearly $16 billion. Governor Kasich's latest budget proposal increases Medicaid welfare spending even more, to $21.5 billion in fiscal year 2014 and $23.6 billion in fiscal year 2015. If Ohio expands Medicaid, total Medicaid welfare spending could rise to $321 billion during the next decade.

3. **Ohio policymakers have no reliable cost estimates on which to base their decision.** **(Page 8)**

   A series of groups have released cost projections were Ohio to expand Medicaid, but modest differences in enrollment assumptions and costs to provide care for the newly-eligible populations have resulted in a wide-range of estimates. Because of the lack of agreement among these projections, no reliable estimate of the true cost of Medicaid expansion exists.

4. **Expanding Medicaid is unlikely to reduce hospitals' uncompensated charity care.** **(Page 9)**

   Although supporters of the ACA's optional Medicaid expansion promise a reduction in uncompensated charity care, actual experiences of other states that previously expanded Medicaid confirm expansion has little impact, and those promises are unlikely to be kept.

5. **Medicaid is failing to meet its mission of protecting Ohio's most vulnerable patients.** **(Page 10)**

   Ohio Medicaid patients already face a declining number of doctors who are accepting new Medicaid patients, primary care doctor shortages in 55 of the state's 88 counties, poor access to specialists and worse health outcomes. Dumping hundreds of thousands more people into the program will make these problems worse for truly vulnerable Ohio Medicaid patients.

6. **Medicaid expansion crowds out private health coverage.** **(Page 11)**

   ACA proponents promise a reduction in the number of Ohioans without health coverage if policymakers expand Medicaid, but other states saw a huge number of individuals drop their private insurance to enroll in Medicaid after previous expansions, while the rate of uninsured residents was essentially unchanged.

7. **The federal government is unlikely to keep its funding promises to Ohio.** (Page 12)

   The ACA promises to fund 100 percent of Ohio's Medicaid expansion costs for three years, and 90 percent thereafter, indefinitely. With the federal debt already standing at $16.7 trillion, and expected to grow to more than $26 trillion in the next decade, and a poor record of keep past funding promises to the states, it is highly unlikely Washington will be able to keep its funding promises to Ohio, and probable that expansion costs will be passed down to the states.

8. **It is unlikely Ohio will ever be able to scale back the size of Medicaid once it expands.** (Page 14)

   Expanding Medicaid to able-bodied childless adults would turn this group of people into a "mandatory population" for Ohio, and make it difficult, if not impossible, to discontinue providing taxpayer-funded Medicaid to those childless adults unless policymakers exit the Medicaid program entirely.

ACA supporters want Ohio policymakers to overload the state's broken Medicaid system with hundreds of thousands more people, but doing so poses too great a risk to the most vulnerable patients Medicaid was created to protect. Rather than stretch the broken safety net even more by enrolling working-aged adults with no disabilities and no kids, policymakers should first do no harm, and focus on fixing the underlying Medicaid system so it works for the patients who rely on it and the taxpayers who fund it.

Eight Ways to Upgrade Ohio's Medicaid Program

1. **Launch program integrity initiatives to root out fraud, waste and abuse.** (Page 15)

2. **Include all services, benefits and populations in Ohio's Medicaid managed care program.** (Page 16)

3. **Permit provider-led plans—physician practices, hospitals, federally qualified health centers, patient-centered Medicaid homes, etc.—to compete for patients alongside traditional managed care organizations.** (Page 16)

4. **Allow specialty plans to be offered alongside other health plans.** (Page 17)

5. **Enable health plans to offer more customized and extra benefits.** (Page 17)

6. **Build enhanced benefits rewards into capitated rates that help patients take more control of their health.** (Page 17)

7. **Transform Medicaid into a personalized, patient-centered program.** (Page 17)

8. **Institute reasonable work requirements for government assistance.** (Page 18)

Ohio policymakers should first commit to opposing the ACA's short-sighted Medicaid expansion, then to upgrading the state's existing Medicaid program through proven reforms that save tax dollars and improve patients' health and happiness.

PART 1

Under the Affordable Care Act (ACA), Ohio policymakers may choose to expand Medicaid eligibility to cover individuals earning up to 138 percent of the federal poverty level.[1] Although Ohio is permitted to expand Medicaid eligibility, it is under no obligation to do so.[2]

In February, Governor John Kasich announced his support for expanding Medicaid eligibility under the ACA.[3,4] However, the House of Representatives took a more cautious approach after its Finance and Appropriations Committee heard testimony from a panel of national Medicaid experts on the potential risks to patients and taxpayers of expanding Medicaid eligibility.[5] After deliberating the issue, House members stripped Gov. Kasich's Medicaid expansion plan out of the state budget.[6] But in late May, Representative Barbara Sears introduced separate legislation to expand Medicaid eligibility.[7,8]

The wisest course for Ohio policymakers is to reject Medicaid expansion, or, at the very least, delay any decision until there is a clear understanding of how it will impact patients and taxpayers. There are at least eight reasons why lawmakers should take this course:

1. Able-bodied childless adults have never been—and were never intended to be—eligible for taxpayer-funded Medicaid.
2. Medicaid costs are growing and jeopardizing all other state priorities.
3. Ohio policymakers have no reliable cost estimates on which to base their decision.
4. Expanding Medicaid is unlikely to decrease hospitals' uncompensated charity care.
5. Medicaid is failing to meet its mission of protecting Ohio's most vulnerable patients.
6. Medicaid expansion crowds out private health coverage.
7. The federal government is unlikely to keep its funding promises to Ohio.
8. It is unlikely Ohio will ever be able to scale back the size of Medicaid once it expands.

In light of these obvious failures of the current Medicaid system and the daunting unknowns associated with expansion, Ohio policymakers should reject Medicaid expansion at least until they can assess the impact of Medicaid expansion in other states. Instead, lawmakers should refocus their efforts on fixing the current program so it works for patients and taxpayers. This should be the priority before even considering stretching the Medicaid safety net further with hundreds of thousands of able-bodied adults without children.

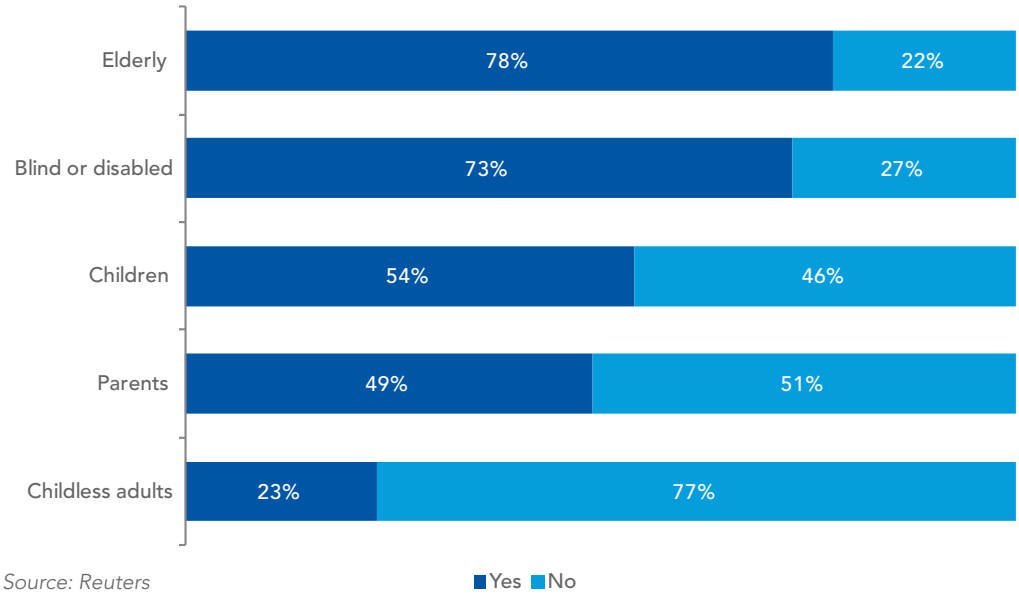
1. Able-bodied childless adults have never been—and were never intended to be—eligible for taxpayer-funded Medicaid.

Nearly every person who would be newly eligible for Ohio Medicaid under the ACA's optional expansion is a non-disabled working-age adult without children.[9] Ohio Medicaid already covers children in households earning up to 200 percent of the federal poverty level and parents earning up to 90 percent of the federal poverty level.[10]

Medicaid was created to be a health care safety net for the most vulnerable. It was never intended to include adults without children and without any disabilities keeping them from meaningful employment. The groups considered most vulnerable are the elderly, individuals who are blind or disabled, low-income children and, to a lesser extent, low-income parents. A recent poll conducted by Reuters found that most Americans want to preserve safety net programs for the truly needy, with 77 percent opposing non-cash assistance, such as food stamps and Medicaid, for working-age adults without children.[11]

An overwhelming majority of Americans oppose non-cash assistance from the government for childless adults

Question: Who deserves non-cash assistance from the government, such as food stamps and Medicaid?



Source: Reuters

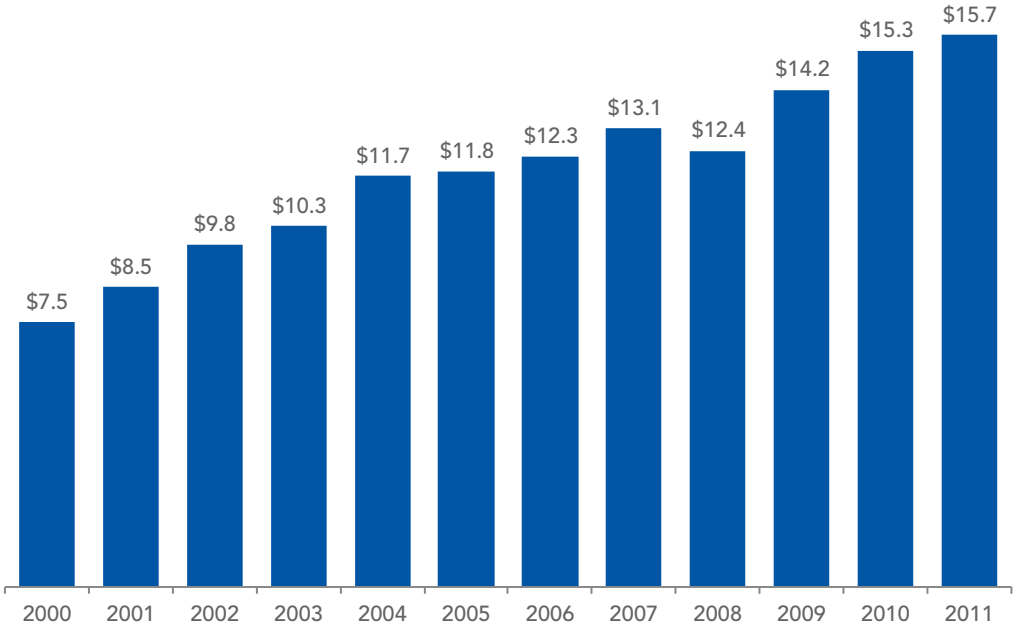
Because non-disabled adults without children have never been considered among the most vulnerable populations, they have generally been ineligible for other types of taxpayer-funded welfare. For example, childless adults are not eligible for cash assistance under the Temporary Assistance to Needy Families (TANF) program.[12] Only low-income pregnant women and families with minor children qualify for Ohio's TANF program.[13]

The ACA's optional Medicaid expansion would create an entirely new class of individuals eligible for Medicaid welfare benefits. This expansion would redirect limited state and federal resources away from the elderly, from children and from disabled individuals in order to fund Medicaid welfare coverage for working-age, able-bodied adults without children.

2. Medicaid costs are growing and jeopardizing all other state priorities.

Ohio's Medicaid welfare spending is spiraling out of control, consuming a larger and larger share of the state budget. In 2000, Ohio spent $7.5 billion on its Medicaid program.[14] But by 2011, Medicaid welfare spending spiked to nearly $16 billion.[15] Gov. Kasich's latest budget recommends spending an unprecedented $21.5 billion on Medicaid in fiscal year 2014 and $23.6 billion in fiscal year 2015.[16]

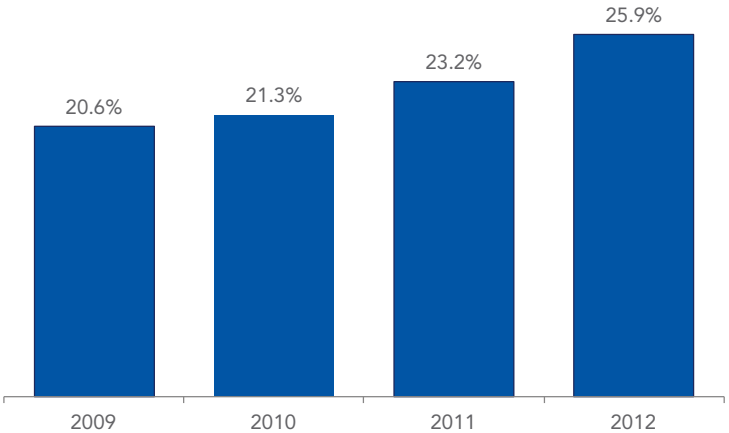
Ohio's Medicaid welfare spending has more than doubled since 2000 (in billions)



Source: Centers for Medicare and Medicaid Services

Because of this skyrocketing spending, Medicaid is devouring a larger and larger share of the state budget. In fiscal year 2009, for example, Medicaid made up only 21 percent of the budget.[17] But by fiscal year 2012, that share rose to 26 percent.[18] Under Gov. Kasich's proposed budget, Medicaid welfare spending would represent more than a third of the state's total budget.[19]

Medicaid continues to consume an ever-larger share of the state budget



Source: National Association of State Budget Officers

These costs will continue to grow. Ohio's Medicaid welfare spending is expected to reach $263 billion during the course of the next decade, even without expanding eligibility.[20] If Ohio opts to expand Medicaid, total Medicaid welfare spending would rise to $321 billion during the next decade.[21] For comparison, Ohio spent just $126 billion on Medicaid during the 2002-2011 period.[22]

Medicaid's skyrocketing spending leaves fewer resources for education, public safety, roads, bridges and other state priorities.

3. Ohio policymakers have no reliable cost estimates on which to base their decision.

A number of groups have produced cost estimates associated with Medicaid expansion. However, these projections lack consistency and use assumptions that vary widely from one analysis to the next. This should be a red flag to policymakers and taxpayers.

There is no agreement on the number of people who will actually sign up for the program if expansion occurs. At the lowest end, the Governor's Office of Health Transformation estimates that only 41 percent of newly-eligible individuals will actually enroll in the program once fully implemented.[23] This is even lower than the state's initial estimates, which predicted 58 percent of all newly-eligible individuals would sign up for Medicaid after expansion.[24]

The Governor's Office also estimates that just 57 percent of uninsured individuals who would be eligible after expansion will eventually enroll.[25] Again, this is lower than the state's earlier estimates, when it predicted that 70 percent would sign up for the program.[26]

For comparison, the Urban Institute estimates that 74 percent of the uninsured population that would be newly eligible after Medicaid expansion will enroll.[27] The RAND Corporation estimates 82 percent participation.[28] And actuaries for the federal Centers for Medicare and Medicaid Services predict participation rates of 95 percent.[29] The difference between the lower estimates and the higher estimates is nearly 220,000 uninsured Ohio residents who could enroll in the program.[30]

Study	Assumed participation rates
Ohio Governor's Office of Health Transformation (2013)	57%
Ohio Department of Job and Family Services (2011)	70%
Urban Institute (2012)	74%
RAND Corporation (2012)	82%
Centers for Medicare and Medicaid Services (2012)	95%

Another giant red flag to policymakers should be that Ohio's official cost estimates predict that providing Medicaid welfare coverage for the expansion population will cost less than coverage for low-income parents. These cost estimates assume that newly-eligible Medicaid enrollees will cost approximately 5 percent less than currently enrolled low-income parents.[31] But the states that have already expanded Medicaid eligibility to cover childless adults found that the childless adult population costs much more than low-income parents.[32]

In Arizona, which expanded Medicaid to childless adults in 2000, childless adults cost more than twice as much as low-income parents.[33] Similar cost differences exist in other states that have expanded Medicaid to cover childless adults, including Delaware, Maine and Oregon.[34] Indeed, research published by the Centers for Medicare and Medicaid Services found that costs were an average of 60 percent higher for childless adults than they were for low-income parents to provide the same benefits package.[35]

Flawed assumptions like the ones being used in Ohio have a huge impact on cost estimates. When Arizona expanded Medicaid eligibility, for example, it used many of the same assumptions that Ohio is using now.[36] These flawed assumptions have resulted in Arizona's Medicaid expansion costing four times what was originally projected.[37]

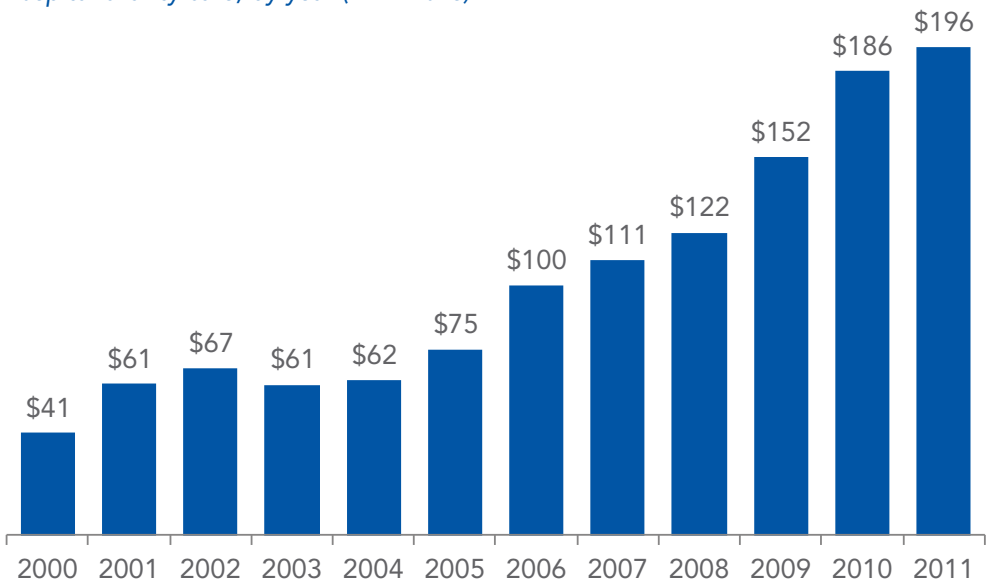
4. Expanding Medicaid is unlikely to reduce hospitals' uncompensated charity care.

Proponents of the ACA's Medicaid expansion argue that expanding Medicaid will reduce uncompensated charity care and cost-shifts to private insurance. But the experiences of states that have already expanded Medicaid tell a much different story, and are instructive for Ohio lawmakers. In those states, these same promises of reduced uncompensated charity care and cost-shifting were made by expansion supporters. Those expansion supporters were unable to keep their promises in those states and will likely fail to keep them in Ohio if lawmakers decide to expand.

In Maine, expanding Medicaid had little effect on reducing uncompensated charity care. In 2000, charity care provided by Maine hospitals amounted to roughly $40 million per year.[38] But by 2011, after Maine's Medicaid expansion in 2002, uncompensated charity care costs had risen to $196 million.[39]

Maine's Medicaid expansion did not reduce hospitals' uncompensated charity care

Hospital charity care, by year (in millions)



Source: Maine Department of Health and Human Services

Likewise, Medicaid expansions have not reduced the cost-shift to private insurance. In Arizona hospitals charged people with private insurance 125 percent of the actual cost to provide medical services in 2003.[40] But by 2007, hospitals were charging individuals with private insurance 140 percent of the actual cost of services.[41] This means that the cost-shift to private insurance increased following the expansion of Medicaid eligibility, rather than decrease as expansion supporters promised.

This is because Medicaid has created a cost-shift all of its own. Arizona hospitals were reimbursed approximately 104 percent of the cost of providing medical services in 2003, but were paid just 80 percent of the cost of medical services by 2007.[42] Ohio hospitals already report losing $1.3 billion from treating Medicaid patients, with those costs shifted to other payers.[43] Indeed, this is more than the entire amount of charity care Ohio hospitals provide to the uninsured, meaning that it costs hospitals more to treat Medicaid patients than it does to treat patients with no insurance at all.[44]

Proponents further claim that expanding Medicaid will reduce unnecessary use of emergency rooms, which in turn will reduce cost-shifting. This is yet another promise policymakers should not expect will be kept. In 2010, medical researchers at the University of California studied a decade of emergency room visit data provided by the National Center for Health Statistics.[45] They organized this data by type and seriousness of conditions, wait times, age, sex, race, ethnicity, insurance status, various hospital characteristics and other factors.[46] Their results were published in the Journal of the American Medical Association, and confirmed that Medicaid patients were three times as likely as the uninsured to use emergency rooms for preventable conditions such as hypertension, asthma and chronic obstructive pulmonary disease.[47] During the study period, the odds of using emergency rooms for preventable conditions went down by 13 percent for the uninsured, but increased by 26 percent for Medicaid patients.[48]

Massachusetts was one such state that experienced this first hand. In the four years following expansion, Massachusetts saw non-urgent visits to emergency rooms increase by 9 percent, and saw its total costs for providing emergency room services for non-urgent visits increase by 40 percent during the same time.[49]

5. Medicaid is failing to meet its mission of protecting Ohio's most vulnerable patients.

Ohio's Medicaid program is already failing to meet the needs of the state's most vulnerable citizens, calling into question the wisdom of expanding a broken program even further. Dumping hundreds of thousands of additional people into a failing system will only make its problems worse for truly needy Medicaid patients. Roughly 28 percent of Ohio doctors refuse to take a single new Medicaid patient.[50] Even among those doctors still willing to participate in the Medicaid program, many limit the number of Medicaid patients they will accept to a few.[51] Delayed or denied reimbursements to doctors for the care they provide Medicaid patients threatens their ability to keep their practice open to the rest of the community.

Although this is a nationwide problem, Ohio doctors are less likely to accept new Medicaid patients than doctors in neighboring states.[52] Ohio doctors are nearly 1.5 times as likely to stop seeing new Medicaid patients as doctors in Michigan and West Virginia.[53] This is even more troubling because Ohio has fewer primary care physicians per capita than its neighbors.[54] According to federal data, Ohio has a primary care doctor shortage in 55 of its 88 counties.[55] Facing a continuing decline in access to physicians, it is unsurprising Medicaid patients use emergency rooms for preventable conditions more often than any other group, including those with no insurance at all.[56]

Dumping hundreds of thousands of additional people into Ohio's Medicaid program will only make these access problems worse. After Massachusetts expanded Medicaid eligibility, for example, the number of family doctors accepting new patients abruptly declined. The number of family physicians accepting new patients dropped to 50 percent by 2012, down from 70 percent in 2007.[57] This has led to Medicaid patients experiencing longer wait times for care. The average wait time to see an internal medicine physician spiked to 52 days in the year following expansion, up from 33 days in 2006.[58] Wait times have remained high, averaging 49 days since 2007.[59] The current Medicaid program already has a massive problem with wait times, with Medicaid patients often waiting weeks or even months to see specialists.[60] Flooding the Medicaid program with so many more people will make this even worse. Even Ohio's own report on Medicaid expansion notes that Medicaid expansion "will put additional strain on the current provider network that already struggles to provide adequate access to care" for Ohio's most vulnerable.[61]

Huge access problems inevitably lead to poor health outcomes. Medicaid patients frequently suffer worse health outcomes than the privately insured and, in some cases, fare worse than patients with no health coverage at all.[62,63] Indeed, the only randomized controlled trial studying the effects of Medicaid expansion found that it produced "no significant improvements" in clinical health outcomes.[64]

In 2008, Oregon officials wanted to expand Medicaid eligibility, but only had enough funding to enroll 10,000 of the 90,000 eligible people wanting to sign up. To remain fair, Oregon officials held a public lottery. Health economists used this unique opportunity to create the first-ever randomized, controlled study of the effect of Medicaid on patients' health. The economists spent the next two years tracking those who won the lottery and those who did not. Despite the fact that those who won the lottery ended up using much more health care than those in the control group, the researchers could find no significant improvement in the Medicaid-lottery winners' health outcomes.[65] Although researchers also found an increased diagnosis and treatment of depression among Medicaid patients, they did not measure any clinical improvement in outcomes.[66]

This is even more troubling for Ohio, given that Oregon's Medicaid program is performing much better than Ohio's. Oregon pays physicians about 29 percent more to treat Medicaid patients than Ohio does.[67] It is no surprise, then, that Ohio doctors are 1.4 times as likely as Oregon doctors to stop taking new Medicaid patients.[68] If researchers found that Oregon's Medicaid program did not result in improved health, is it likely that Ohio's program, which fares worse, could produce significant improvements in health outcomes? Worse yet, by redirecting scarce Medicaid resources toward able-bodied adults without children, the most vulnerable will be disproportionally affected, leading to worse outcomes for the truly needy already in the Medicaid program.

6. Medicaid expansion crowds out private health coverage.

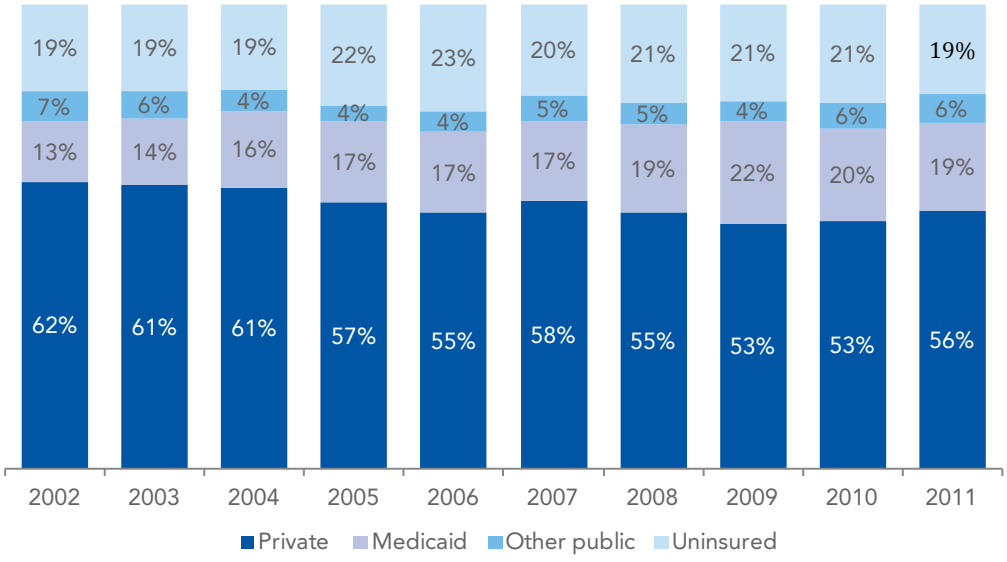
According to official estimates of potential enrollees under the optional Medicaid expansion, the majority of people made eligible by the expansion would not come from the ranks of the uninsured, but rather shifted out of the private health insurance market. This reality raises doubts about another promise of proponents that expansion will reduce the rate of uninsured.

Approximately 41 percent of all people made eligible by Medicaid expansion currently qualify for federal subsidies to purchase private insurance through the health insurance exchange.[69,70] If Ohio opts into Medicaid expansion, those individuals would lose access to federal subsidies and instead be forced into Medicaid.[71] Another 25 percent of all potentially newly-eligible individuals are currently ineligible for federal subsidies but already have health insurance.[72] This means that two thirds of those made eligible by Medicaid expansion would be shifted from the private insurance market.

Indeed, states that have already expanded Medicaid eligibility have seen a huge number of individuals drop their private insurance to enroll in Medicaid. In Arizona, for example, the share of non-elderly individuals with private insurance dropped to 56 percent in 2011, down from 62 percent in 2002.[73] During that same time, the share of non-elderly individuals enrolled in Medicaid grew to 19 percent in 2011, up from 13 percent in 2002.[74] At the same time, the expansion did not reduce the rate of uninsured.[75] Similar patterns played out in other states that expanded Medicaid eligibility.[76]

Arizona's Medicaid expansion has not reduced the rate of uninsured

Non-elderly population, by insurance status



Source: Census Bureau

Economists, including ACA architect Jonathan Gruber, estimate that the Medicaid expansions occurring in the late 1990s and early 2000s produced a crowd-out effect of 60 percent.[77] This means that for every ten new Medicaid enrollees, six were previously covered by their own private insurance. Research focusing specifically on the populations targeted by the ACA predicts a much higher crowd-out effect resulting from Medicaid expansion. Economists predict the ACA's Medicaid expansion will produce a crowd-out rate of 82 percent, suggesting that the optional expansion will merely "shift workers and their families from private to public insurance" rather than reduce the number of individuals without insurance.[78] This means that for every ten new Medicaid enrollees, eight will have come from the ranks of the privately insured.

7. The federal government is unlikely to keep its funding promises to Ohio.

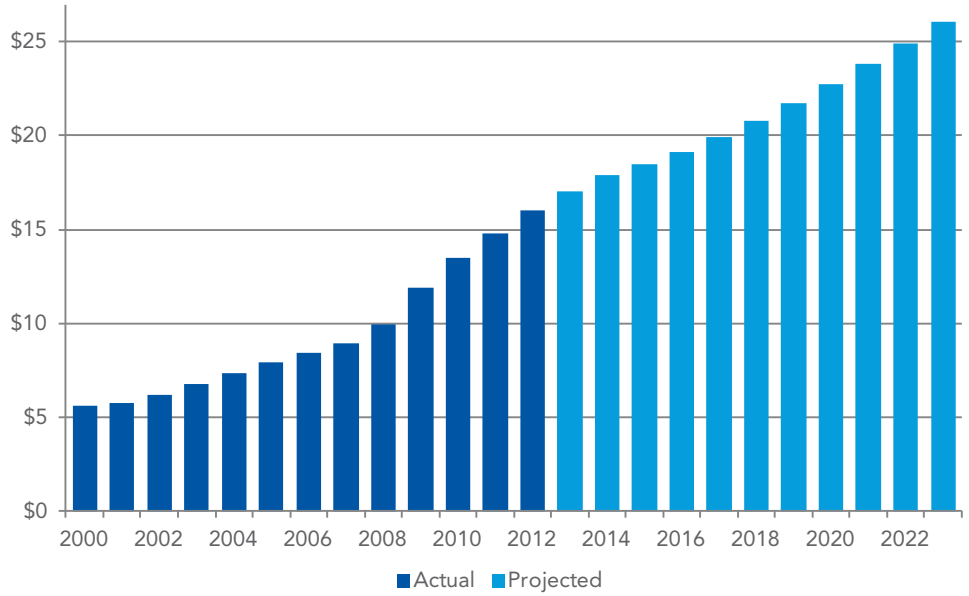
Congress has promised to provide enhanced federal support for Medicaid expansion. For the first three years, the federal government has promised to pay for the full cost of providing Medicaid coverage to the newly eligible patients, with federal support phasing down to 90 percent thereafter, indefinitely.[79] The federal government will not provide enhanced funding for individuals who were previously eligible for Medicaid who enrolled as a result of the ACA, or for the additional administrative costs of the Medicaid expansion.[80] But Congress can arbitrarily change these rates at any time in the future. The federal government's severe and widely-known fiscal problems make it highly likely that future federal support will be reduced for Ohio and other states that opt to expand Medicaid.

Federal Medicaid welfare spending already represents one-fourth of the federal deficit and is expected to more than double over the next decade.[81] This spending growth is nearly twice as fast as the expected growth in the economy.[82] Medicaid expansion is expected to cost more than $800 billion during the first ten years.[83-84] Should Ohio opt into Medicaid expansion, federal spending would increase by another $53 billion, further increasing the federal debt.[85]

Today, the federal debt already stands at $16.7 trillion and is expected to grow to more than $26 trillion within the next ten years.[86-87] The Government Accountability Office has called this debt trajectory an "unsustainable long-term fiscal path" that must be addressed immediately.[88] Ben Bernanke, chairman of the Federal Reserve, testified before Congress that this unsustainable debt trajectory "cannot actually happen," as creditors would stop lending to the federal government before such levels were ever reached.[89]

Federal debt is expected to grow to more than $26 trillion within a decade

(in trillions)



Source: Office of Management and Budget; Congressional Budget Office

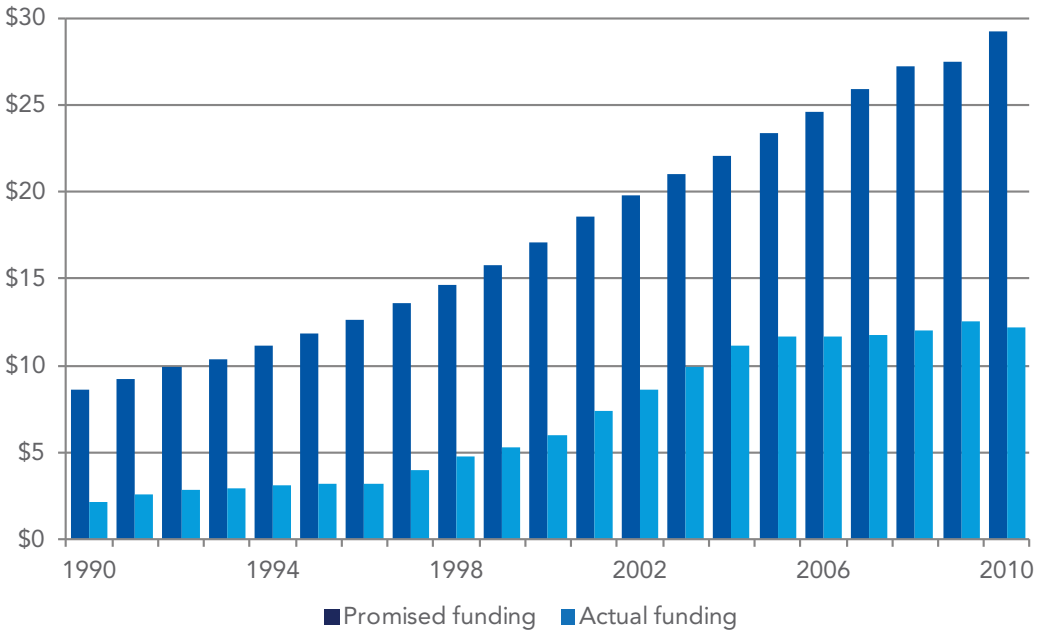
The Congressional Budget Office has previously estimated that balancing the budget long-term with tax hikes would require tax rates to more than double on all income tax brackets.[90] It is inevitable, then, the federal government will be forced to reduce budget deficits and substantial spending cuts will be required to balance the budget. Given that entitlement spending is the core driver of the deficit, states must prepare themselves for the likely event that federal support for Medicaid will be greatly reduced from promised levels.

Exploding deficits and debt may explain why President Barack Obama's last three budgets have proposed shifting more of these costs to state governments, and why he has included these cost-shift proposals in debt ceiling and fiscal cliff negotiations.[91-94] These proposals make clear the president's willingness to require states to pay more. As one of the two trustees President Obama appointed to oversee Medicare recently warned, it is a "near certainty" that federal support for Medicaid will be cut in future years.[95]

The federal government has a record of reneging on its funding promises to states. In 1975, Congress enacted what is now known as the Individuals with Disabilities Education Act (IDEA), requiring states to provide disabled children with appropriate educational services.[96] In return, Congress committed to authorizing federal funding for 40 percent of states' additional costs to educate disabled children.[97] But after almost forty years, Congress has never actually appropriated the full funding authorized under the law.[98] This has become a huge cost-shift—essentially an unfunded mandate—that has forced state and local governments to make up the difference. Between fiscal years 1981 and 2010, the federal government came more than $250 billion short of fully funding IDEA, despite its promises to the states.[99] In fiscal year 2010 alone, the federal government's underfunding totaled a whopping $17.1 billion.[100]

The federal government has never kept its promise to fund special education

(in billions)



Source: Department of Education

States are also beginning to face yet another broken federal promise. In 2009, the federal government asked state and local governments to borrow money through taxable bonds, rather than the tax-exempt bonds they typically used.[101] The federal government created these bonds through the American Recovery and Reinvestment Act in order to encourage more state and local governments to invest in capital projects through the stimulus package. Because taxable bonds have higher interest rates for borrowers, the federal government offered to help offset those higher interest charges through subsidies to the states.[102] These federal subsidies were meant to bring states' total interest costs down to slightly below where interest costs would have been had they borrowed with the typical tax-exempt bonds.[103]

Across America, state and local governments issued 2,275 Build America Bonds, worth more than $181 billion.[104] Ohio governmental bodies accounted for 123 of those issues, worth more than $8.3 billion.[105] But state policymakers are beginning to realize the federal government will not keep up its end of the bargain. The Treasury Department recently notified state and local governments it was cutting the federal subsidies it had promised by 8.7 percent, shifting more than $250 million of interest costs onto state and local governments.[106] States were lured into borrowing with more expensive taxable bonds on the promise that the federal government would offset those higher costs, but are now discovering that some of the promised federal money simply will not be there. This bait-and-switch is likely to occur with Medicaid expansion funding as well.

8. It is unlikely Ohio will ever be able to scale back the size of Medicaid once it expands.

Gov. Kasich and others have discussed including a "trigger" to back out of the expansion in the event the federal government reduces the enhanced matching rate. However, this trigger is unlikely to be effective. Federal law classifies the expansion population as a new "mandatory population" for states that opt into the expansion, which authorizes the federal government to take away all federal Medicaid funds if a state were to roll back eligibility for that group.[107]

In June 2012, the U.S. Supreme Court held that the federal government could not require states to opt into the Medicaid expansion. It did not hold that separate federal requirements on maintaining eligibility for mandatory populations would not apply after a state agrees to expand Medicaid.[108] Indeed, this question came up during Supreme Court oral arguments. Chief Justice John Roberts asked what would happen if the federal government decided to renege on the deal and reduce the enhanced matching rate.[109] As the government explained in its response to Chief Justice Roberts, states' only choice at that point would be to exit the Medicaid program altogether.[110] This means that accepting the federal government's enhanced matching rate would trap Ohio into Medicaid expansion permanently, even if Congress later shifted more costs to the states.

PART II

EIGHT WAYS TO UPGRADE OHIO'S MEDICAID PROGRAM

Rather than overload more people into a broken program, Ohio lawmakers should look to reform the underlying Medicaid system in a way that works for patients and taxpayers. A number of key reforms to Ohio's Medicaid managed care program are in the implementation process, but policymakers can still do more. Lawmakers should focus their efforts on making upgrades that have proven successful in other states, and lay the foundation for even more innovative solutions in the coming years.

Under Ohio's current Medicaid managed care program, the state operates eight regions with two or three plans offered per region.[111,112] The state offers only two plans in the majority of its regions.[113,114] Because federal rules require patients have a choice of at least two plans, managed care organizations have much greater leverage over the state than if more plans were offered.[115]

In the 2000s, Oklahoma experienced what can happen when managed care organizations have too much leverage. The state was forced to cancel its managed care program altogether when one of the contracted managed care organizations demanded an 18 percent rate increase.[116] The organization dropped out of Oklahoma's program when its demand was not met, leaving the state short of the federally-required two-plan minimum.[117,118]

Ohio is seeking to avoid this same dynamic by moving away from regional contracting toward selecting health plans that will be offered statewide.[119] State officials are also contracting with five different plans, after receiving bids from 11 plans.[120] This will help Ohio's Medicaid marketplace to be more competitive and ensure the state will have more leverage over the plans, not the other way around. These reforms are expected to launch statewide in July 2013.[121]

In addition to reforms already in the works, Ohio policymakers should consider these additional reforms to upgrade the state's Medicaid program:

1. Launch program integrity initiatives to root out fraud, waste and abuse in Medicaid.

The Medicaid welfare program is plagued with wasteful spending. The U.S. Government Accountability Office (GAO) designates Medicaid as a high risk program because it is "particularly vulnerable to fraud, waste, abuse and improper payments" and has inadequate oversight to prevent wasteful spending.[122] Indeed, the U.S. Department of Health and Human Services (HHS) reports an improper payment rate of nearly 10 percent.[123] This means that, across the country, up to $40 billion in Medicaid welfare spending is wasteful and/or fraudulent.[124]

Fraud prevention efforts traditionally focus on provider fraud. While provider fraud prevention efforts are noble, the increased administrative burden often leads to fewer doctors willing to see Medicaid patients. Fraud prevention efforts largely ignore program integrity for those receiving Medicaid benefits, despite the fact that HHS officials estimate that eligibility determination errors account for most of the improper payments made by the Medicaid welfare program.[125] Taxpayers are not the only ones hurt by this fraud. Every dollar spent on individuals who are ineligible for Medicaid is a dollar that is unavailable to the most needy and vulnerable.

The nearby states of Pennsylvania and Illinois, which have Medicaid programs similar in size to Ohio's, have launched program integrity Initiatives that ensure individuals receiving Medicaid welfare benefits are actually eligible. These measures include verification efforts for initial eligibility determinations and annual redeterminations, followed by case cancellation for ineligible enrollees.

The Pennsylvania Department of Public Welfare (DPW), which oversees the state's Medicaid program, began its Enterprise Program Integrity Initiative in June 2011.[126-127] In its first 10 months of operation, the DPW identified more than 160,000 ineligible individuals who were receiving Medicaid benefits, including individuals who were in prison and even millionaire lottery winners.[128] This led to nearly $300 million in savings in the first ten months.[129]

In January 2013, Illinois followed Pennsylvania's lead and began its own program integrity initiative.[130] An earlier Inspector General report found that 34 percent of randomly selected Medicaid files in Illinois contained eligibility errors.[131] The vast majority of these errors were discovered in the areas of income and other basic eligibility requirements, such as residency and household composition.[132]

This sparked a push to use an independent third-party vendor to verify eligibility for Medicaid enrollees. The vendor will use advanced data matching technology to verify income, residency and other criteria of Illinois' 2.7 million Medicaid enrollees each year. So far, the vendor has reviewed nearly 78,000 cases and has another 84,000 cases ready for review.[133]

The vendor has recommended that 66 percent of reviewed cases be cancelled, meaning that the enrollees appear to be no longer eligible for benefits.[134] Another 8 percent of enrollees were found to be eligible for benefits, but enrolled in the wrong program.[135] For example, some individuals enrolled in Medicaid may actually only qualify for programs with greater cost-sharing. Illinois expects the enhanced eligibility verification program to save approximately $350 million.[136]

Massachusetts is also moving toward implementing an enhanced eligibility verification program for Medicaid, TANF, food stamps and other public assistance programs.[137,138] The proposed Massachusetts plan would verify income, asset and identity eligibility for applications of public assistance prior to them receiving benefits and during all eligibility redeterminations and reviews.

Ohio's Medicaid program is similar in size and scope to the Medicaid programs in both Pennsylvania and Illinois.[139,140] Accordingly, it's likely Ohio has similar levels of waste, fraud and abuse in its own Medicaid program. A similar eligibility verification initiative in Ohio could save taxpayers $300 million or more.

Before even considering adding additional people to the Medicaid program, policymakers should ensure every person already enrolled is actually eligible for coverage. This will help eliminate waste, fraud and abuse, ensuring that scarce Medicaid resources go only to the truly needy. Ohio should consider enhancing its use of federal, state and commercial databases in order to properly and accountably screen applicants and enrollees for eligibility.

2. Include all services, benefits and populations in the reformed managed care program.

Currently, Ohio excludes from its managed care reforms individuals eligible for Medicaid through a waiver, individuals who are institutionalized, dual eligibles and others. But carving specific services or populations out of the reform reduces its effectiveness. Moving all services, benefits and populations into the reform would improve integration of care and improve health outcomes through enhanced quality requirements in the plan contracts. The state could measure plan performance for specific populations, including the patients currently excluded from managed care in Ohio, and tie part of the fixed per-person funding to improved outcomes.

In Kansas, for example, long-term care benefits are included in the KanCare reform, which is expected to save the state approximately 8 percent of long-term care spending per year.[141] That amounts to savings of more than $3,500 per person.[142] Given the fact that Ohio has historically run one of the most expensive long-term care programs in the nation, including those patients in the reforms has the potential to generate substantial taxpayer savings.[143] If it matched KanCare's 8 percent long-term care savings, for example, Ohio could save upwards of $500 million.[144] Additional savings opportunities would also be created by carving other services, benefits and populations back into the reform.

3. Permit provider-led plans—physician practices, hospitals, federally qualified health centers, patient-centered medical homes, etc.—to compete for patients alongside traditional managed care organizations.

All five of the health plans contracted to provide Medicaid services in Ohio are operated by traditional managed care organizations. Provider-led plans are plans that are owned or run by networks of physicians, hospitals, clinics and other medical providers. These plans coordinate care for patients alongside traditional managed care organizations and, like their competitors, operate under at-risk contracts with the state.

Allowing provider-led plans to compete with managed care organizations, provided they are capitated (fixed, per person-price contract with the state) within two years, would give patients even more choices and further improve customer service and quality of care through more robust competition. In Florida, nearly half of the patients in the state's Medicaid Reform Pilot have chosen provider-led plans.[145] Likewise, slightly more than half of patients are enrolled in provider-led plans in Louisiana's Bayou Health reform.[146]

4. Allow specialty plans to be offered alongside other health plans.

Some patients have very specific health challenges that aren't served well under a traditional managed care plan. These patients require different benefits to manage specific diseases successfully. Ohio should allow patients with unique health challenges, such as those with acute mental health needs, children in foster care and patients with HIV/AIDS, to choose plans that are tailored to their needs.

Similar specialty plans are offered in Florida's Medicaid Reform Pilot. Permitting specialty plans to be offered alongside other health plans ensures patients are able to enroll in uniquely specialized plans customized to best address their special health needs. Likewise, KanCare offers programs that are specifically designed to help manage complicated conditions such as HIV/AIDS and schizophrenia. Ohio should offer specialty plans in addition to the slots available for statewide contracts with managed care organizations so patients can receive the unique care they deserve.

5. Enable health plans to offer more customized and extra benefit packages.

By allowing health plans to offer customized and extra benefit packages, patients could receive benefits not typically covered by the traditional Medicaid program, including over-the-counter drugs, vision, preventive dental coverage, nutrition therapy and respite care.[147] By allowing plans to offer multiple customized benefit packages, the state can create a more competitive Medicaid marketplace wherein patients have greater choices and more opportunity to select plans based on value.

In 2012, plan providers in Florida's Medicaid Reform Pilot offered 31 customized benefit packages from which patients could choose.[148] In KanCare, patients can choose plans with non-traditional benefits such as fitness memberships, coverage for sports physicals, more vision care benefits and more podiatry visits, among other additional benefits. Customized and enhanced benefit packages ensure plans are able to compete on value by tailoring their benefits to best meet the needs and desires of their patients.

6. Build enhanced benefits rewards into capitated rates that help patients take more control of their health.

In the private sector, wellness programs are becoming increasingly popular as a way to encourage individuals to take control over their own health. These wellness programs give patients financial rewards for engaging in healthy behaviors, such as receiving preventive care, complying with disease management programs, participating in weight loss programs and completing smoking cessation programs.

Florida's Medicaid Reform Pilot allows Medicaid patients to earn up to $125 per year for receiving certain preventive services, complying with maintenance and disease management programs and keeping appointments.[149] Individuals may then use these rewards to purchase over-the-counter items at participating pharmacies.[150] This wellness program encourages Medicaid patients to take control of their own health, and promotes healthy behavior. In Kansas, patients can choose plans that offer cash incentives for healthy behaviors, such as getting vaccinations, regular checkups and the like. Ohio should offer a similar, robust wellness program to its Medicaid patients, with the enhanced benefits rewards built into the health plans' capitated rates.

7. Transform Medicaid into a personalized, patient-centered program.

The reforms above will help Ohio begin its transition toward innovative reforms that make Medicaid a personalized and patient-centered program. With the expiring maintenance of effort requirements in 2014 and new State Innovator waivers becoming available in 2017, policymakers should lay the groundwork for a new approach to Medicaid that builds upon the successes seen in other states. Ohio can utilize one or more Section 1115 waivers and State Innovator waivers to fundamentally transform how the program operates.

One possible avenue would be to shift to much more customizable benefit packages. In Florida's Medicaid Reform Pilot, for example, patients can choose from 31 customized benefit packages.[151] By permitting plan providers to offer customized benefit packages, the Medicaid Reform Pilot has given patients more choices and has provided greater competition. Costs for the customized benefit packages in the Reform Pilot have been substantially below costs for similar populations statewide.[152] This example highlights how you deliver more choices to Medicaid patients and still save precious taxpayer dollars.

These customized benefit packages are not only delivering greater choice, they are delivering better results as well. Reform Pilot plans in Florida outperformed the traditional Old Medicaid program on 22 of 33 tracked health outcomes.[153] Better yet, 94 percent of the Reform Pilot's regularly-tracked health performance measures have improved since 2008.[154] Customized benefit packages have led to lower costs for taxpayers, and improved health outcomes and greater satisfaction among patients. Ohio should build on this success by transitioning to personalized Florida-style benefit packages.

The Medicaid program has certain federal minimum requirements for participation. These minimum requirements include inpatient hospital services, outpatient hospital services, early and periodic screening, diagnostic and treatment services, nursing facility services, home health services, physician services, rural health clinic services, federally qualified health center services, laboratory and x-ray services, family planning services, nurse midwife services, certified pediatric and family nurse practitioner services, freestanding birth center services, transportation to medical care and tobacco cessation services.[155] Beyond these minimum requirements, states can choose which services to offer and can set the scope and range of those services. There are wide variations among states, even for mandatory benefits, leaving Ohio with plenty of room to transform the program into a more personalized, patient-centered benefit package.[156]

Ohio could restructure its covered benefits to federal minimum requirements and set the monthly capitated rates somewhere between the actuarial value of the minimum federal requirements and its current capitated rates. This essentially creates two capitated rates: one for all benefits covered under federal requirements and one for a customized benefit package.

Today, Ohio's annual capitated rate for the elderly, blind and disabled populations is approximately $17,000 per person.[157] The annual capitated rate for low-income families is more than $3,000 per person.[158] Even with built-in savings, this would leave sufficient room between the value of federal minimum requirements and the state's current capitated rates, guaranteeing plans have the room to personalize and provide better value.

This would reduce spending, as the fixed monthly rates would be somewhat lower than current spending levels, and provide greater budget predictability year after year. But it would also allow Medicaid patients to have health plans that are more personalized to their unique health needs and personal circumstances. Patients would be able to select the additional benefits that mattered most to them and pick the plan that best meets their needs.

8. Institute reasonable work requirements for government assistance.

Unlike other public assistance programs, such as TANF, there are no work requirements for working-age adults to maintain eligibility for Medicaid welfare benefits. But eligibility for Medicaid may have a profound impact on both participation in the labor force and on full-time employment.

By looking at previous Medicaid expansions to enroll working-age adults, a group of researchers at Emory University and the University of Colorado were able to estimate the impact Medicaid eligibility has on employment.[159] Those researchers found that full-time employment among the group of people newly eligible for Medicaid declined by more than 8 percent after becoming eligible.[160] They also found that the share of this group who didn't work at all increased by nearly 11 percent.[161]

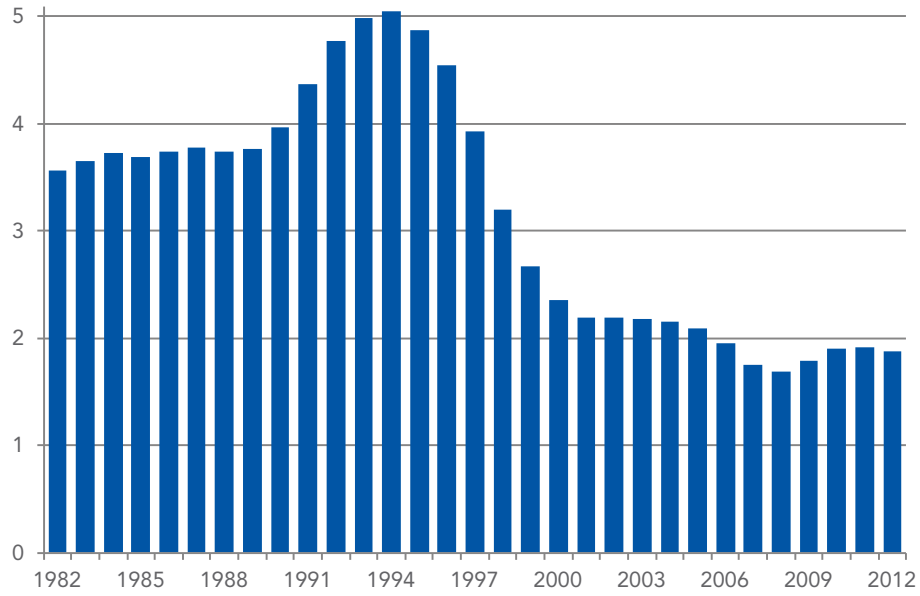
This is particularly troubling, given the fact that full-time employment moves people off of government dependence and into self-sufficiency. A single parent with one child, for example, would earn enough to move out of Medicaid and into the ACA's health insurance exchanges by working a full-time, minimum wage job.[162-164]

A recent poll found that 83 percent of Americans support a work requirement as a condition for receiving government aid, while just 7 percent opposed such a requirement.[165] Indeed, Americans have already seen work requirements succeed in other welfare programs, including TANF.

In 1996, there were more than 4.5 million families on Aid to Families with Dependent Children (AFDC), the predecessor of TANF.[166] Unlike TANF, the AFDC program was an open-ended entitlement and had no work requirements for eligible adults. Instituting reasonable work requirements was a cornerstone of President Clinton's bipartisan welfare reform policy. Today, there are fewer than 1.9 million families on TANF.[167]

The number of U.S. families on welfare has plummeted since implementing work requirements

(in millions)

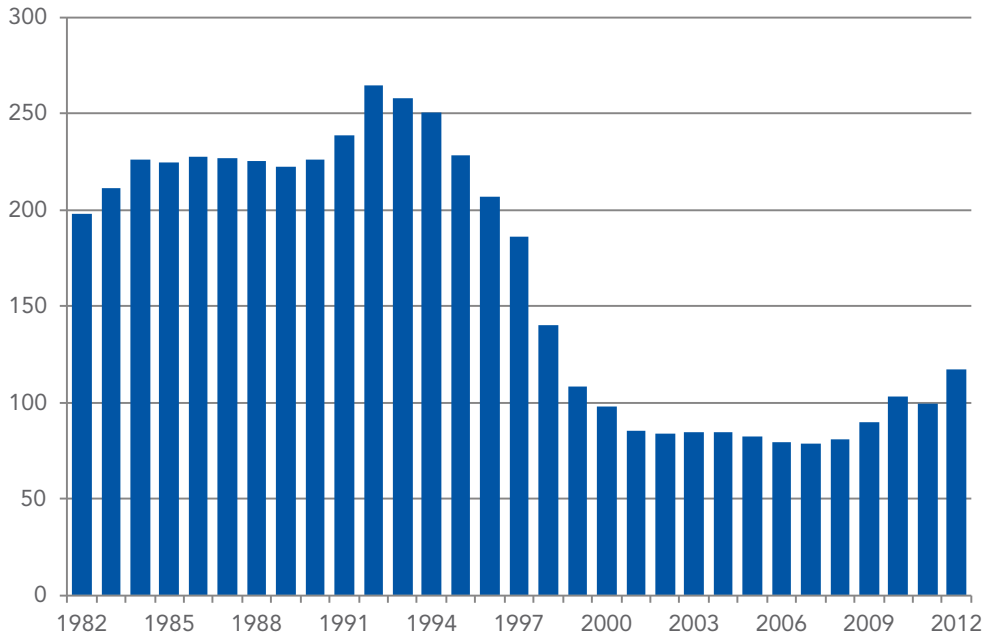


Source: U.S. Department of Health and Human Services

A similar trend occurred in Ohio. After years of growing welfare cases, the number of Ohio families on welfare began to drop following the work-requirement reform. The number of families on welfare dropped to 117,000 in 2012, down from approximately 207,000 in 1996.[168,169] Ohio should learn the lesson of welfare reform and implement reasonable work requirements for non-disabled adults receiving medical assistance.

The number of Ohio families on welfare has plummeted since implementing work requirements

(in thousands)



Source: U.S. Department of Health and Human Services

Under Ohio's current TANF program, families must be engaged in work activities for a minimum of 30 to 55 hours per week, depending on family makeup and specific circumstances.[170] These work activities include full- or part-time employment in the private or public sector, subsidized employment, job search and job readiness activities, vocational education, education directly related to employment or employability and other activities.[171]

Implementing similar requirements for working-age, non-disabled adults would encourage work among low-income families, rather than punish it as the current open-ended Medicaid entitlement does. This would build on the successful state-led welfare reform of the 1990s and move people out of government dependency and into self-sufficiency.

CONCLUSION

When it comes to Medicaid expansion, the choice is clear for Ohio policymakers. Medicaid is already failing patients and taxpayers. Promises of fewer uninsured residents and a reduction in hospitals' uncompensated charity care are unlikely to be kept. And the combination of a poor track record meeting its commitments to states and a $16+ trillion debt make it highly unlikely the federal government will keep its promise to Ohio to cover the cost of expansion.

Ohio policymakers should first do no harm by rejecting Medicaid expansion, or, at the very least, delaying their decision until the impact of the ACA's Medicaid expansion in other states is clear. Instead, policymakers should reform the state's current Medicaid program through proven strategies designed to improve patient health outcomes, reduce fraud and waste, and save taxpayer dollars.

Medicaid was intended to be an affordable health care safety net for the truly vulnerable. Ohio policymakers should focus on reforming the program so it can finally accomplish these critical goals.

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