

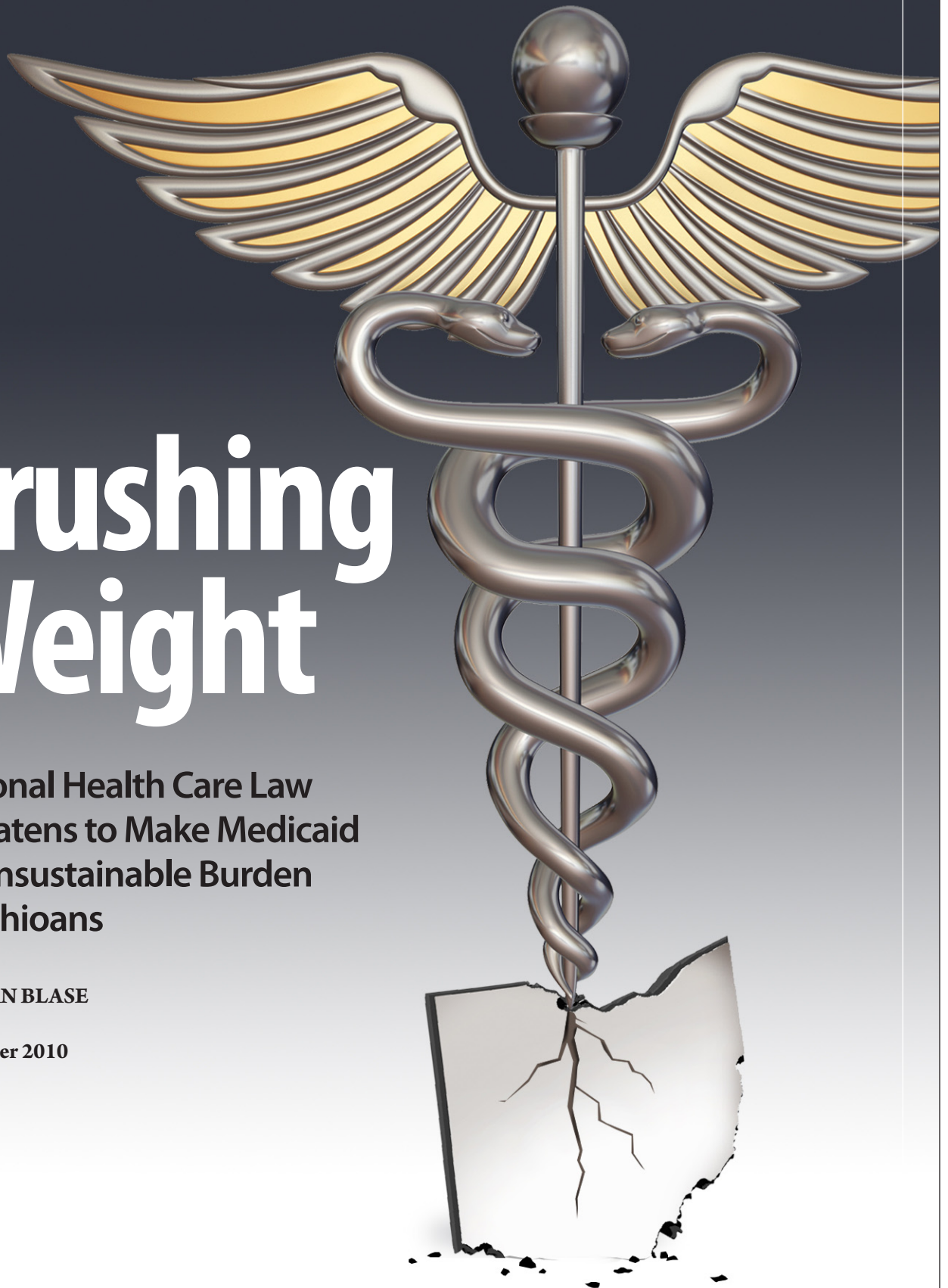
THE BUCKEYE INSTITUTE *for* PUBLIC POLICY SOLUTIONS

Crushing Weight

**National Health Care Law
Threatens to Make Medicaid
an Unsustainable Burden
for Ohioans**

By **BRIAN BLASE**

December 2010



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Why This Report Matters to You

Medicaid—an entitlement program which serves a very heterogeneous group, ranging from low-income children and their parents to middle-class elderly in nursing homes—is one of the most complicated and fastest growing government programs in the country. Medicaid is America’s largest health insurance program, but it is facing numerous problems. The key issues are unsustainable increases in spending, low payment rates that cause many providers to opt out of Medicaid, and an unacceptably low quality of care for many beneficiaries.

Ohio now spends about \$14 billion annually on Medicaid. Ohio’s Federal Medical Assistance Percentage is slated to be almost 64 percent beginning on July 1, 2011. This means that for every dollar Ohio spends on Medicaid, federal taxpayers will fund about 64 cents and state taxpayers will fund about 36 cents. Since Ohio’s Medicaid program is about \$14 billion, state taxpayers fund approximately \$5.1 billion of the cost.

Therefore, a typical household of four in Ohio pays approximately \$2,000 annually to finance the state Medicaid program, up from under \$600 in

1990. Each additional state dollar spent on Medicaid is one less dollar that could have been spent on another state priority or returned to Ohioans through tax cuts.

*A typical household of four in Ohio pays approximately **\$2,000** annually to finance the state Medicaid program.*

In Ohio, an extra dollar of Medicaid state spending brings in an extra \$1.75 in federal dollars. Furthermore, Medicaid is one of the last places states look to cut during economic recessions because each dollar a state cuts results in a loss of federal funds. For example, Ohio has to cut \$2.75 from Medicaid to save a \$1 of state revenue since it will lose \$1.75 in federal dollars from the cut.

Utilizing the national estimates released by the Office of the Actuary at the Center for Medicare and Medicaid Services, The Heritage Foundation estimated that nearly 565,000 additional Ohioans will be enrolled in Medicaid at a seven-year (2014–2020) additional cost to the state of nearly \$1 billion because of the Patient Protection and Affordable Care Act (“ObamaCare”).

The current trajectory of Medicaid is simply unsustainable and too big a burden for Ohio taxpayers to bear, especially with the new federal mandates.

Executive Summary

This report outlines Medicaid's current problems, explains how Medicaid is financed, describes and quantifies the impact of the Patient Protection and Affordable Care Act (PPACA) on state programs, and then offers some policy options moving forward.

Medicaid's Current Problems

- National spending on Medicaid has grown nearly 500 percent over the past two decades.
- Medicaid now represents one-quarter of Ohio state spending, more than doubling its share of the budget over the past two decades.
- Medicaid discourages individual success and leads to a crowd out of private insurance.
- Medicaid's long-term care entitlement component enables individual complacency about proper planning for long-term care and allows many non-poor seniors to exempt hundreds of thousands of dollars of assets and qualify for government assistance.
- In many states, including Ohio, Medicaid pays providers a much lower amount compared to commercial and Medicare rates. This causes many providers to refuse Medicaid patients and leads to an overuse of emergency rooms.
- A plethora of recent studies have concluded that Medicaid recipients likely receive a relatively low quality of care.

Impact of PPACA

- The maintenance of effort (MOE) requirement prevents states from reducing eligibility.
- The expansion to everyone below 138 percent of the federal poverty level will add about 20 million Americans and over half a million Ohioans into Medicaid.
- States will pick up a small portion of the cost of the expansion population, but they will have to pick up their usual portion of the cost for individuals who are eligible under the previous state eligibility guidelines.
- States are required to raise primary care physician reimbursement rates in 2013 and 2014 with federal funding, but states will no longer receive these federal funds beginning in 2015.

Policy Options

- Petition the federal government to remove the maintenance of effort requirements for eligibility, allow states to reduce exemptions for Medicaid long-term care eligibility, and remove the one-size-fits-all Medicaid expansion.
 - Increase state efforts to recover assets from the estate of individuals who have utilized long-term care services at taxpayer expense.
 - Consider applying for a waiver to trade money for flexibility.
 - Introduce free-market reforms to better align the incentives of patients, providers, and taxpayers.
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By BRIAN BLASE

National Health Care Overhaul Increases Ohio's Medicaid Burden

Medicaid—an entitlement program which serves a very heterogeneous group, ranging from low-income children and their parents to middle-class elderly in nursing homes—is one of the most complicated and fastest growing government programs in the country. Medicaid is America's largest health insurance program, but it is facing numerous problems. The key issues are unsustainable increases in spending, low payment rates that cause many providers to opt out of Medicaid, and an unacceptably low quality of care for many beneficiaries.

Instead of fundamentally reforming Medicaid and dealing with its problems, the 111th Congress doubled down on Medicaid. The Patient Protection and Affordable Care Act (PPACA) will increase national enrollment in Medicaid by approximately 20 million individuals at an annual estimated federal cost of \$80 billion.^{1,2} The Medicaid expansion will present Ohio with several additional challenges. The central ones will be raising revenue or cutting other spending in order to finance their share of the bill; balancing concerns of providers, beneficiaries, and taxpayers over payment rates; and dealing with the extra stress on the health care infrastructure the expansion will generate.

The most immediate concern for Ohio and most states next year is the combination of the maintenance

of effort (MOE) requirement in PPACA and the reduction of the federal Medicaid subsidy. The MOE requirement prevents states from reducing eligibility below the standards in effect on July 1, 2008, even as enhanced federal funding will disappear on July 1, 2011. The MOE requirement and the reduced federal funding mean that states are now between a rock and a hard place. Adding in the required Medicaid expansion has led several states to consider opting out of Medicaid altogether.³

Medicaid's Current Problems

Unsustainably Large Spending Increases.

While American spending on health care exploded over the past few decades, Medicaid spending grew twice as quickly. Between 1990 and 2010, national health care expenditures excluding Medicaid increased by nearly 240 percent from \$641 billion to \$2.173 trillion. During this same period, Medicaid spending increased 480 percent from \$74 billion to \$427 billion.⁴

Over the past two decades, Ohio's annual per capita state spending has increased 54 percent from under \$3,200 to just over \$4,900 in inflation-adjusted dollars. Nearly half of this growth is attributable to rising Medicaid expenditures, which have increased in real terms by 220 percent over the past two decades. In the

1 Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Passed by the Senate on December 24, 2009," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, January 8, 2010, at http://www.cms.hhs.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf (May 19, 2010).

2 The Congressional Budget Office estimates that revenue collected from the imposition of these employer mandates will offset the federal budget by \$104 billion over 2010 to 2019. See Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010," March 18, 2010, at <http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf> (April 22, 2010).

3 Janet Adamy and Neil King Jr., "Some states weigh unthinkable option: Ending Medicaid," *The Wall Street Journal*, November 22, 2010, at http://online.wsj.com/article/SB10001424052748704444304575628603406482936.html?mod=WSJ_hp_MIDDLENexttoWhatsNewForth#printMode (November 22, 2010).

4 U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, National Health Expenditures Data, at <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf> (November 22, 2010).

late 1980s, Ohio's annual per capita Medicaid expenditures averaged \$367 (using 2008 dollars); now Ohio's annual per capita Medicaid expenditures are approximately \$1,200. Medicaid represents about 23.2 percent of Ohio's state government spending, more than double the percentage it was twenty years ago.

Ohio taxpayers traditionally pay about 40 percent of the cost of state Medicaid spending with federal taxpayers paying the remaining 60 percent. Therefore, a typical household of four in Ohio pays approximately \$2,000 annually to finance the state Medicaid program, up from under \$600 in 1990. Each additional state dollar spent on Medicaid is one less dollar that could have been spent on another state priority or returned to Ohioans through tax cuts. For example, state support of higher education has undoubtedly been crowded out from increased spending on Medicaid. The percentage of the Ohio state budget spent on higher education has declined from 8 percent to 5 percent over the past 20 years.

Medicaid's Perverse Incentives. Medicaid was designed to provide health insurance for low-income individuals, mostly children and their parents. Because acute care services through Medicaid are conditional upon low-income, Medicaid penalizes those who succeed and earn higher incomes. Since Medicaid benefits for acute care services are also conditional on having few assets, the program discourages personal saving.

Furthermore, Medicaid is an alternative to private insurance and thus encourages eligible individuals to switch from private coverage to government coverage. Between 1987 and 1992, Medicaid eligibility for children increased by 50 percent and eligibility for pregnant women doubled. Researchers at Harvard and MIT estimated that between 50 percent and 75

percent of the increase in Medicaid coverage was associated with a reduction in private insurance coverage.⁵ The authors stated that "(t)his occurred largely because employees took up employer-based insurance less frequently, although employers may have encouraged them to do so by contributing less for insurance. There is some evidence that workers dropped coverage for their family and switched into individual policies." Parents with employer-sponsored insurance were incentivized to remove their children from their policies and enroll them in Medicaid, saving a portion of their premium payment in the process. This "crowd out" effect is more likely to occur as Medicaid eligibility becomes more generous.

Medicaid's Long-Term Care Entitlement. Medicaid reimburses half of all the dollars spent on long-term care (LTC) services in the United States.⁶ The reason is that there are generous exemptions that allow many non-poor individuals to qualify for Medicaid LTC services.⁷ With proper planning, nearly every American can qualify for Medicaid LTC support given the generous exemptions. Furthermore, there is a growing legal industry focused on assisting individuals in circumventing Medicaid's eligibility rules by transferring non-excluded assets prior to requesting LTC services.

There are several glaring problems with the generous exemptions for Medicaid services for LTC. The first is that taxpayers are spending money on many non-poor individuals during a period of fiscal crisis at the state and federal level. And under federal law, states possess little ability to remedy this situation because they are not allowed to tighten eligibility criteria for Medicaid LTC and still receive federal funding. The second is that current Medicaid policy actively enables individual complacency about proper planning for long-term care expenses. Moreover, Medicaid

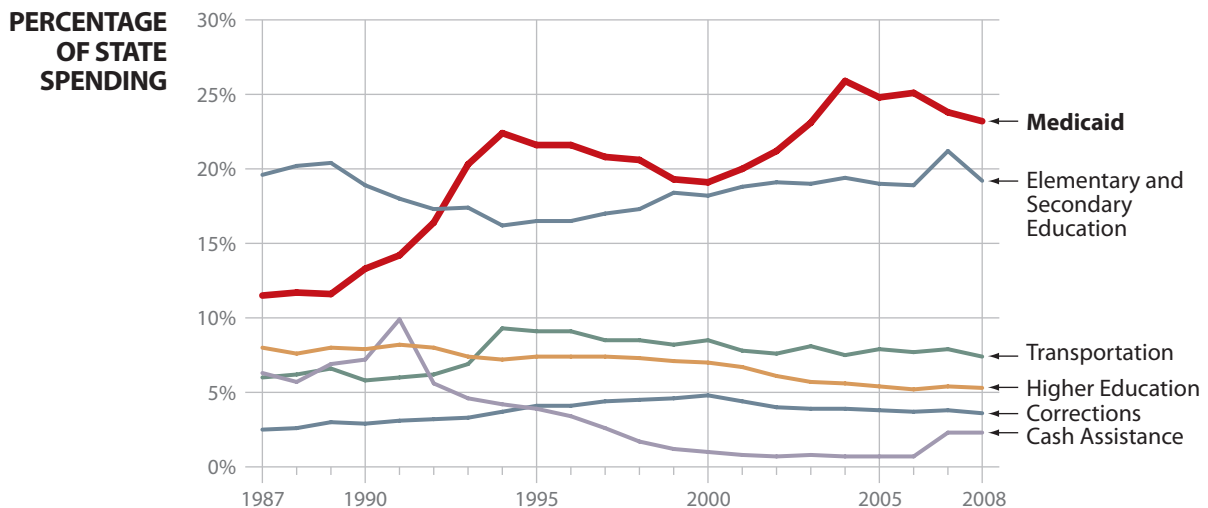
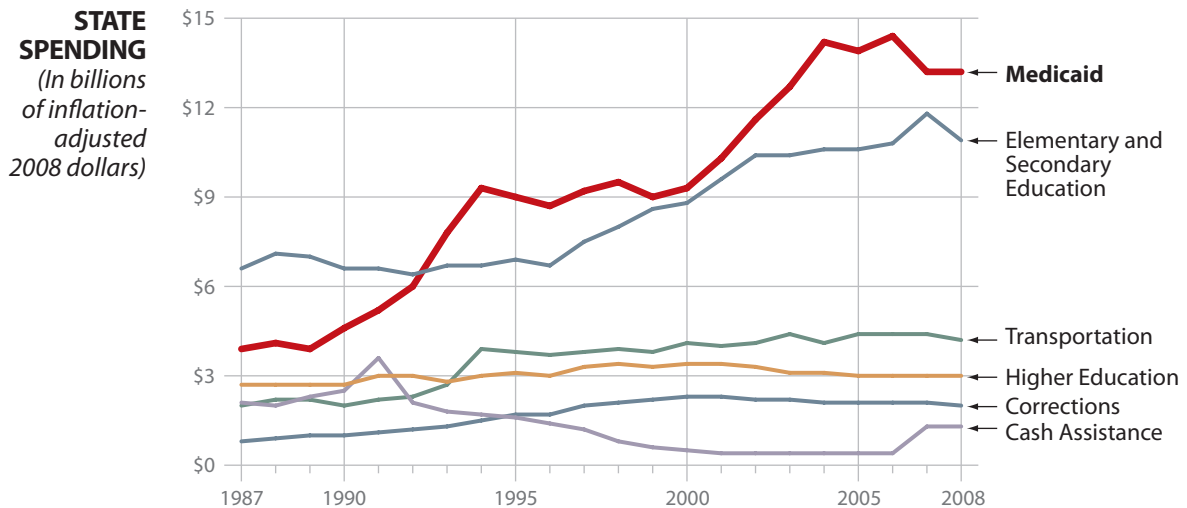
5 David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?"

6 Harriet Kosimar and Lee Shirley Thompson, "National Spending for Long-Term Care," Georgetown University, Long-Term Care Financing Project, February 2006, at <http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf> (July 21, 2010).

7 Current law allows individuals to exclude certain assets to qualify for Medicaid: a home and all contiguous property with up to \$500,000 in equity (or in some states \$750,000), household goods regardless of value, one business including the capital and cash flow of unlimited value, retirement funds such as Individual Retirement Accounts up to \$500,000, one automobile of unlimited value, unlimited prepaid burial plans for the Medicaid recipient and immediate family members, and an unlimited amount of term-life insurance.

Medicaid Spending in Ohio

In the late 1980s, Medicaid spending in Ohio began increasing rapidly, both in dollars and as a proportion of total state spending. In 1993, it became the most expensive category, surpassing Elementary and Secondary Education. In 2008, Medicaid spending in Ohio was \$13.2 billion, or 23.2 percent of the budget. Shown below are spending figures for Ohio's six largest categories.



Note: Figures include federal funds.

Source: State Expenditure Reports from the National Association of State Budget Officers.

crowd-out also occurs in the market for private LTC insurance. This problem was highlighted by a recent economics study that Medicaid crowds out the purchase of private insurance for about two-thirds of the wealth distribution as private insurance would pay for a benefit that Medicaid already provides.⁸

Low Provider Reimbursement Rates. Several states reimburse providers at extremely low rates, some lower than one-third of commercial rates. Ohio's Medicaid program pays primary care physicians (PCPs) slightly below the national average at 66 percent of applicable Medicare rates and around half of what commercial insurers reimburse.⁹ In addition to low reimbursement rates, Medicaid requires an enormous amount of paperwork and the lag time between date of service and the date of reimbursement is more than twice as long as Medicare or commercial insurance reimbursement times. Furthermore, the denial rate for Medicaid claims is three times larger than for both Medicare and commercial insurance.¹⁰

Low reimbursement rates, substantial amounts of paperwork, and significant lag times between service and payment contribute to a lack of enthusiasm among physicians to participate in Medicaid. For example, in Texas, less than a third of that state's practicing doctors are active in Medicaid.¹¹ Indeed, only 10 percent of PCPs believe that new Medicaid enrollees in their area will find a suitable PCP after the PPACA Medicaid ex-

pansion.¹² This will lead to many Medicaid recipients using emergency rooms for basic care.

Poor Results from Medicaid. The weight of the evidence suggests adults with Medicaid, the primary recipients gaining coverage through PPACA, have worse outcomes than privately insured individuals and oftentimes have worse outcomes than uninsured individuals, even after controlling for appropriate demographic and clinical factors. One study found that Medicaid patients who suffered a heart attack were significantly less likely than patients with other forms of insurance to receive important clinical interventions.¹³ Another found that Medicaid patients received fewer evidence-based therapies than patients with private insurance coverage.¹⁴ The conclusion of another study was that individuals with Medicaid were more likely to experience complications and in-hospital mortality after surgery for colorectal cancer than both privately insured and uninsured patients.¹⁵

Furthermore, a University of Virginia study of nearly 900,000 major operations in the United States found that surgical patients on Medicaid were 13 percent more likely to die in the hospital than uninsured individuals, controlling for demographic factors and health status.¹⁶ The apparent inferiority of Medicaid suggests that increasing national enrollment by one-third through PPACA will not lead to discernable health improvements.

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- 8 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 (3), pp. 1083–1102.
 - 9 The Henry J. Kaiser Family Foundation, "Medicaid-to-Medicare Fee Index 2008," at <http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4> (November 24, 2010).
 - 10 AthenaHealth, "PayerView 2010: Improving the Way Providers and Payers Work Together," May 2010, at http://www.athenahealth.com/_doc/pdf/whitepapers/PayerView_Whitepaper_2010_Final.pdf (September 29, 2010).
 - 11 Associated Press, "Doctors Threaten to Pull Out of Medicaid," July 12, 2010, at <http://www.nbcdfw.com/news/health/Doctors-Threaten-to-Pull-Out-of-Texas-Medicaid-98202569.html> (September 28, 2010).
 - 12 Doug Trapp, "New Medicaid Patients Will Lack Access, Most Doctors Say," *Amednews.com*, May 3, 2010, at <http://www.ama-assn.org/amednews/2010/05/03/gvsb0503.htm> (September 30, 2010).
 - 13 E. F. Philibin et al., "Underuse of Invasive Procedures Among Medicaid Patients With Acute Myocardial Infarction," *American Journal of Public Health*, Vol. 91, No. 7 (2001), pp. 1082–1088.
 - 14 J. E. Calvin et al., "Insurance Coverage and Care of Patients with Non-ST-Segment Elevation Acute Coronary Syndromes," *Annals of Internal Medicine*, Vol. 145, No. 10 (2006), pp. 739–748.
 - 15 R. R. Kelz et al., "Morbidity and mortality of colorectal carcinoma surgery differs by insurance status," *Cancer*, Vol. 101, Issue 10 (2004), pp. 2187–2194.
 - 16 D. J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery*, Vol. 252, Issue 3 (2010), pp. 544–551.

Paying for Medicaid

A significant portion of state Medicaid spending is reimbursed by federal taxpayers. The exact percentage is a function of the state's per capita income. Poorer states receive a greater reimbursement than do wealthier states, and the minimum state reimbursement is 50 percent. Over the past two decades, Ohio's reimbursement has been around 60 percent. As part of the stimulus bill passed in February 2009, states received an increase in their reimbursement, retroactive to July 1, 2008. This raised Ohio's reimbursement, officially called the federal medical assistance percentage (FMAP),¹⁷ in excess of 70 percent.

Ohio now spends about \$14 billion annually on Medicaid. Ohio's FMAP is slated to be almost 64 percent beginning on July 1, 2011.¹⁸ This means that for every dollar Ohio spends on Medicaid, federal taxpayers will fund about 64 cents and state taxpayers will fund about 36 cents. Since Ohio's Medicaid program is about \$14 billion, state taxpayers fund approximately \$5.1 billion of the cost.

Medicaid is purportedly a countercyclical safety net program that should grow during periods of economic recession and decline during periods of economic growth. However, during times of economic growth, states have tended to increase eligibility and benefit levels. The federal Medicaid reimbursement encourages this because an extra state dollar spent on Medicaid brings in at least as much money from federal coffers.

In Ohio, an extra dollar of state spending brings in an extra \$1.75 in federal dollars. Furthermore, Medicaid is one of the last places states look to cut during economic recessions because each dollar a state cuts results in a loss of federal funds. For example, Ohio

has to cut \$2.75 from Medicaid to save a \$1 of state revenue since it will lose \$1.75 in federal dollars from the cut.

Maintenance of Effort

According to the maintenance of effort (MOE) in PPACA, a state that makes eligibility more restrictive than the standards in effect for the state's program at the time the new federal overhaul was enacted will lose all federal Medicaid support. In fact, states are already subject to a similar MOE requirement imposed as a condition of receiving the temporary increase in federal Medicaid funding as part of the 2009 stimulus legislation, but the enhanced FMAP will expire on June 30, 2011. The Office of the Actuary at the Center for Medicare and Medicaid Services (CMS) projects that state and local spending on Medicaid will increase over 40 percent between 2010 and 2011 due to the loss of the enhanced match.¹⁹

The MOE requirements and the loss of the additional federal funds highlight the most important problem states must tackle next year: coming to grips with Medicaid's enormity and overall state spending which generally rose double or triple the rate of inflation for the better part of the last several decades. The reality is that money is fungible and states used the additional money coming through the enhanced FMAP to plug budgetary holes. If Medicaid cannot be significantly downsized, states will have to reduce spending in other areas, such as education or transportation, or significantly raise state taxes. A continuation of the state bailout through an enhanced FMAP is a virtual impossibility given the makeup of the new Congress.

Traditionally, states have utilized three main tools

17 The Federal Medical Assistance Percentage (FMAP) is the percentage of state Medicaid spending that is reimbursed by the federal government. The National Association of State Budget Officers, *State Expenditure Report: Archives, 2008 State Expenditure Report, Fall 2009*, at <http://www.nasbo.org/Publications/StateExpenditureReport/StateExpenditureReportArchives/tabid/107/Default.aspx> (November 16, 2010).

18 U.S. Department Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures FMAP*, 2011, November 27, 2009, at <http://aspe.hhs.gov/health/fmap11.htm> (November 16, 2010).

19 Andrea M. Sisko et al., "National Health Spending Projections: The Estimated Impact of Reform Through 2019," *Health Affairs*, Vol. 29, No. 10 (2010), pp. 1933–1941.

for reducing Medicaid expenditures: restrict eligibility, cut provider reimbursements, or reduce benefits. The MOE requirements effectively mean that states no longer have the first option of limiting eligibility. However, they can still cut provider payments or scale back program benefits. Forty-one states and the District of Columbia cut provider reimbursements rates in 2009 or 2010, and 29 states and the District did so in both years. Additionally, 39 states and the District cut Medicaid pharmacy benefits, and 22 states cut Medicaid medical benefits over the past two years.²⁰ All of these cuts are likely to continue if state budget projections do not significantly improve.

Although it raised certain provider payment rates in 2010, Ohio also cut others. It also reduced benefit packages in 2010, including scaling back pharmacy benefits. This past year, Ohio restricted dental visits and certain services provided by dentists.²¹

The problem is that in many states Medicaid reimbursement rates are already quite low, which limits Medicaid beneficiaries' access to health care providers. In addition, setting physician payment rates even lower may not substantially reduce overall Medicaid costs if more enrollees are forced to seek care in hospital emergency rooms because they cannot find doctors willing to accept Medicaid patients. Furthermore, cutting reimbursement rates will lead to a greater number of physicians up-coding, the practice of billing Medicaid for a service that pays more than the service that was actually provided.

*States have utilized three tools for reducing Medicaid expenditures: **restrict eligibility, cut reimbursements, or reduce benefits.***

PPACA's Medicaid Expansion

PPACA mandates that states raise Medicaid eligibility for all Americans below 138 percent of the federal poverty level (\$30,429 for a family of four excluding the value of any welfare benefits) beginning January 1, 2014. The vast majority of individuals brought into the Medicaid program will be adults without dependents who are ineligible for current programs because they are under the age of 65 and not severely disabled.

States have expressed several concerns about the expansion. Among them, states are uncertain about how large the enrollment will be and what it will cost. States are also interested in whether and how providers are going to ration care as the demand for their services increase. Another concern for the states is the administrative costs of the expansion, beginning with eligibility determinations.

In order to encourage states to comply with the Medicaid expansion mandate, the federal government agreed to pick up 100 percent of the cost of the expansion population between 2014 and 2016. The federal reimbursement for the newly eligible will gradually decline thereafter until 2020 when the federal share of the cost of the expansion population will stay at 90 percent.

Individuals who apply for Medicaid and who are eligible under the previous state eligibility criteria in place on July 1, 2008 will not be reimbursed at the enhanced percentage.²² Rather, states will be reimbursed at their traditional FMAP for these individuals. Therefore, a key variable determining state costs is how

20 Kaiser Family Foundation, "Medicaid Cost Containment Actions Taken by States, FY 2010," StateHealthFacts.org, at <http://www.statehealthfacts.org/comparetable.jsp?ind=187&cat=4> (June 18, 2010).

21 Vernon K. Smith, et al. "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Family Foundation *Commission on Medicaid and the Uninsured*, September 2010, at <http://www.kff.org/medicaid/upload/8105.pdf> (November 17, 2010).

22 John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL," Kaiser Family Foundation *Commission on Medicaid and the Uninsured*, May 2010, p. 6, at <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf> (November 17, 2010).

many currently eligible individuals will come out of the woodwork to sign up for Medicaid and how much additional health care they will utilize when they enroll. Nationally, about 12 million individuals are eligible for Medicaid but are not yet enrolled.²³

PPACA requires that states make Medicaid reimbursement rates for services performed by PCPs on par with Medicare rates for 2013 and 2014. The federal government will pay the entire cost of the increase during this two-year period. The Congressional rationale is that many states reimburse PCPs for services delivered through Medicaid well below corresponding Medicare rates and an increase in reimbursements will encourage providers to see patients with Medicaid.

Raising PCP rates will present states that currently have low reimbursement rates, of which Ohio is one, with several looming problems. The first is that specialists and hospitals will likely also lobby strongly for an increase in their rates. The second is that states will probably face a difficult time cutting rates after they hike them in 2013 and 2014. And if states leave reimbursement rates at the higher levels, they will have to pay the share of this increase at an amount determined by the state's FMAP.

Assessing the Impact of Medicaid Expansion

Utilizing the national estimates released by the Office of the Actuary at CMS, The Heritage Foundation

estimated that nearly 565,000 additional Ohioans will be enrolled in Medicaid at a seven-year (2014–2020) cost to the state of nearly \$1 billion.²⁴ John Holahan at the Urban Institute also projected the state impact of the Medicaid expansion, and he estimated that the number of additional Ohioans enrolling in Medicaid at 667,000 under the standard participation scenario and 901,000 under the enhanced participation scenario.²⁵

The corresponding state costs for the six-year period between 2014 and 2019 are \$830 million and \$1.34 billion, respectively.

The estimates produced from CMS and Urban are both subject to great uncertainty about how many people will enroll and whether they will qualify under the old eligibility criteria or the new criteria. Furthermore, both sets of estimates anticipate that

provider reimbursement return to their lower levels when the federal funding disappears. The Heritage Foundation estimated that Ohio will need to increase annual Medicaid spending by \$151 million to keep the higher PCP rates. Based on its state FMAP, Ohio would be responsible for approximately 36 percent of this increase. Furthermore, if Ohio elects to raise the rates of all providers, the annual increase in spending would be around \$967 million with about \$350 million due from Ohio state taxpayers.²⁶

Milliman Incorporated, an actuarial and econometric consulting firm, was contracted by three states—Indiana, Mississippi, and Nebraska—to per-

Raising rates on primary care physicians will present low-reimbursement states like Ohio with several new problems.

23 Julie Schoenman, Nancy Chockley, and Brigid Murphy, "Understanding the Uninsured: Tailoring Policy Solutions for Different Subpopulations," National Institute for Health Care Management *Foundation Issue Brief*, April 2008, at <http://www.nihcm.org/pdf/NIHCM-Uninsured-Final.pdf> (November 17, 2010).

24 Ed Haislmaier and Brian Blase, "PPACA: Impact on States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010, at <http://www.heritage.org/Research/Reports/2010/07/PPACA-Impact-on-States> (November 18, 2010).

25 The standard scenario is one where 3 percent of those currently uninsured who qualify for Medicaid will enroll and 57 percent of the current uninsured who are new eligible enroll. The comparative figures for the enhanced scenario are 40 percent and 75 percent. There are also varying assumptions based on individuals with ESI or non-group coverage and whether they replace coverage with Medicaid. Holahan and Headen, "Medicaid Coverage and Spending in Health Reform," pp. 10–11.

26 Brian Blase, "Obamacare's Medicaid Policy: Putting the Doctors in Another 'Fix,'" Heritage Foundation *WebMemo* No. 3031, October 4, 2010, p. 3, at <http://www.heritage.org/Research/Reports/2010/10/Obamacares-Medicaid-Policy-Putting-the-Doctors-in-Another-Fix> (November 22, 2010).

form a state-specific analysis of the Medicaid expansion. Using their presumed participation scenario, Milliman estimated an annual increase in Indiana's state budget of \$370 million from the expansion.²⁷ This is two-and-a-half times Urban's enhanced scenario estimate and five times Heritage's estimate based on CMS national projections.

The estimated state costs of the Medicaid expansion produced by Milliman for the states of Nebraska and Mississippi are also substantially greater than the corresponding figures produced by Urban and Heritage's estimates based on CMS projections. Under the moderate participation scenario, Milliman's estimated annual cost of the expansion is \$85 million greater in Mississippi and \$40 million greater in Nebraska than Urban's estimate.^{28, 29, 30} Furthermore, the Texas Health and Human Services Commission estimated that the annual cost of the Medicaid expansion to Texas taxpayers, including a permanent increase in PCP rates, would be \$2.7 billion per year, which is about \$2 billion greater than the estimate produced by Urban.

The discrepancies in part arise from differing assumptions about how many people enroll in Medicaid and whether states extend the higher reimbursement rates, but also from state-specific reports having access to state data and also a better knowledge of the program specifics in that state. For example, it is unclear how large the crowd-out effect of the expansion will be because only a very few states have extended Medicaid eligibility to childless adults and those states have done so only recently. It is also important to note that the Milliman reports include many state-specific factors that were not considered by either Urban or CMS.

The Milliman reports should increase the skepticism of Ohio policymakers of the estimates from the Urban Institute and CMS regarding only minimal state costs for the Medicaid expansion. There is a great deal of uncertainty surrounding the assumptions that underlie all the projections. Policymakers should be concerned about the fiscal impact of the expansion, and this concern has fueled conversations in several states about opting out of Medicaid.

Only worrying about the fiscal impact to the states diverts attention from the true national costs of the expansion since the state costs are likely a small fraction of the federal costs. The vast majority of the expansion will be financed by federal taxpayers, and millions of them reside in Ohio. State policymakers, considering whether or not to embrace PPACA, should consider these costs as well when contemplating Medicaid reform. The massive cost of the Medicaid expansion will increase taxes for federal taxpayers, which will have a depressing effect on every state's economy. Nearly \$100 billion in new spending annually combined with the disappointing care that many Medicaid recipients receive and the perverse incentives created by the program should cause state legislators and policymakers in Ohio to fight, if not question the expansion.

The Fiscal Commission Impact on Medicaid

The Co-Chairs of the Fiscal Commission appointed by President Barack Obama recently released their recommendations of budget cuts. The proposal contained Medicaid cuts resulting in estimated savings to the federal government of \$181 billion over the nine-year period from 2012 to 2020.³¹ It is not certain how federal

27 Robert Damler, "Affordable Care Act (ACA) – Financial Analysis Update," Milliman Inc., October 18, 2010, p. 2, at <http://www.in.gov/aca/files/AffordableCareActFinancialAnalysisUpdateOct2010.pdf> (November 19, 2010).

28 Holahan and Headen, "Medicaid Coverage and Spending in Health Reform," p. 11.

29 Robert Damler, "Patient Protection and Affordable Care Act with House Reconciliation – Financial Analysis," Milliman Inc., August 16, 2010, p. 2, at <http://www.governor.nebraska.gov/news/2010/08/pdf/Nebraska%20Medicaid%20PPACA%20Fiscal%20Impact.pdf> (November 19, 2010).

30 John D. Meerschaert, "Financial Impact Review of the Patient Protection and Affordable Care Act as Amended by H.R. 4782," Milliman Client Report, October 1, 2010, p. 2, at <http://www.medicaid.ms.gov/Documents/Milliman%20Report.pdf> (November 19, 2010).

31 The following Medicaid cuts were in the recommendations: place dual-eligible individuals in Medicaid managed care (\$11 billion of savings between 2012 and 2020); reduce federal spending on Medicaid administrative costs (\$17 billion); increase nominal Medicaid copays (\$15 billion); reduce taxes that states may levy on Medicaid providers (\$49 billion); and convert the federal share of Medicaid payment for long-term care into a capped allotment (\$89 billion).

policymakers will tackle the gargantuan federal budget deficit, but Medicaid cuts are almost certain to come at the federal level over the next few years. State policymakers with a longer-term focus need to begin thinking now about how those cuts will impact their states.

Roughly half of the overall Medicaid savings come from a conversion of the federal share of Medicaid for long-term care into a capped allotment. At the federal level, this means that a budget would exist for what federal taxpayers would contribute to state Medicaid programs for long-term care services. A capped allotment would mean that states would be spending their own funds and thus would have a greater incentive to show restraint and target Medicaid toward the truly deserving of public assistance.

State Options

Petition the Federal Government for Increased State Flexibility. PPACA imposes uniform guidelines across all states without considering states' underlying Medicaid issues. States should petition the federal government to increase state flexibility in three key ways: removal of the MOE requirements, removal of the restrictions that prohibit states from properly managing public-sector long-term care (LTC) expenses, and repeal or delay of the Medicaid expansion.

If the MOE requirement stays in place, states cannot tighten Medicaid eligibility as a way to deal with their budget crises. And most states cannot reduce provider reimbursement rates further because many Medicaid patients will not be able to find doctors who are willing to treat them. Plus, further cuts to provider payments will likely face legal challenges. Providers in the state of California successfully sued for an injunction of a proposal to cut Medicaid reimbursement rates 10 percent. The providers presented evidence that the cuts would lead to an exodus of providers serving Medicaid patients. States can further cut Medicaid benefits, but they are unlikely to save nearly enough money—without touching eligibility—to avoid major

cuts in other state spending, or worse, tax increases.

The long-term care (LTC) component of Medicaid is potentially a place where states can rein in spending. In order to better manage their state program and control its costs, states should petition the federal government to remove all restrictions on Medicaid LTC eligibility. Then states can tailor their programs to their own specifications and can experiment with policy improvements that lower spending.

While removing the MOE requirements and increasing state flexibility to better manage LTC eligibility would help states immediately, the massive Medicaid expansion is only three years away. State voters have different preferences regarding who are truly deserving of taxpayer assistance, but PPACA removes state discretion in this regard. States legislators and policymakers should petition Congress to repeal the one-size-fits-all Medicaid expansion so states can experiment with policy reforms that are better suited to their individual states.

Expanding the Medicaid program to cover 20 million additional individuals at an estimated annual cost of between \$80 billion and \$90 billion when the federal government is running trillion dollar budget deficits is fundamentally irresponsible. Moreover, expanding the fiscal obligations of states at a time when state policymakers are attempting to rein in spending is absurd. Further skepticism of the Medicaid expansion is warranted from the available evidence that Medicaid appears to deliver low-quality health care.

Increase Estate Recovery Efforts. While states are able to look back up to five years and impose penalties on those individuals who have transferred assets below fair market value for the purpose of qualifying for Medicaid, less than one percent of national Medicaid spending on nursing facilities is recovered by the government.³² In Ohio, even less is recovered. In fiscal year 2004, Ohio's Medicaid program spent in excess of \$2.7 billion in nursing facility expenditures and only recovered \$14 million, or one-half of 1 per-

32 Julie Stone-Axelrad, "Medicaid Asset Transfers and Estate Planning Testimony Before the Senate Committee on Finance," Congressional Research Service, June 29, 2005.

cent of payments.³³ Increasing estate recovery would remove a portion of the burden on taxpayers for funding LTC expenses.

Trade Money for Flexibility. Ohio should consider using a state plan amendment or a waiver to gain the ability to better control their Medicaid program. For example, Rhode Island was granted a Medicaid waiver, the Global Consumer Choice Compact Waiver, in 2009. In exchange for flexibility, Rhode Island is operating its Medicaid program under traditional FMAP reimbursement with an added budget cap. The waiver provides the state with greater freedom to design and redesign programs with a new process to seek federal approval that minimizes red tape. With federal budget deficits at record levels, CMS would be wise to approve waivers that limit federal liability to reimburse state spending. An unlimited federal reimbursement has encouraged states to expand their Medicaid programs to an unsustainable level. Capping the allotment will enable states to concentrate on improving the fundamentals of their Medicaid program instead of on how to leverage additional federal dollars.

Medicaid Opt-Out? Coupling current Medicaid problems with the mandated expansion has caused several states, including Texas, Nevada, Washington, Utah, and South Carolina, to float the idea of opting out of Medicaid. The reason: these states are worried about Medicaid spending consuming a greater share of their state budgets as well as reduced flexibility to manage their program. State policymakers' skepticism of the expansion is also due to the enormous uncertainty of Medicaid in the budgetary process as there is not a firm budget constraint with the fee-for-service component of the program. Through Medicaid the amount and type of services that will be provided are unknown when the state budget is set. As Medicaid grows, so does the uncertainty of major cost overruns.

The main concern state policymakers have about opting out is the lost federal Medicaid contribution, which in Ohio is over 60 percent of the total cost of

the state program. Ohioans would therefore lose the tax dollars they send to the federal government that come back as Medicaid funds plus some additional federal funds. Additionally, individuals below 100 percent of the FPL are likely ineligible for the subsidies created through PPACA to purchase health insurance. This means that individuals below 100 percent of the FPL receiving acute care services and individuals receiving Medicaid support for long-term care needs would have to be covered with state-only dollars or many would lack insurance coverage. And if individuals below 100 percent of the FPL were in fact deemed to qualify for subsidies for the exchange, the result of a state opting out of Medicaid is simply a cost-shift from state taxpayers to federal taxpayers, who must pay for the subsidy. Thus while opting out of Medicaid would allow a state to more appropriately target taxpayer assistance and experiment with care delivery, Ohioans would lose a substantial amount of their federal tax money as well as potentially increasing the amount of cost-shifting subsidies.

Real Structural Reforms to Improve Care

The central policy goal for Medicaid reform is to restrict the program to the truly deserving of public assistance and to deliver care to them that is cost-effective. A reform that would empower patients and limit state liability to a fixed amount would be to transition certain populations into premium assistance programs. The state could provide certain low-income populations with a voucher that could be used to purchase a private insurance policy. Individuals would be empowered to select an insurance plan that meets their individual needs and risk preferences. Another possible reform would be for the state to set up specialty clinics that focus on prenatal and postpartum care for eligible mothers and their infants in a cost-effective manner.

In fact, these few possible reforms represent just a small set of ideas on how to incorporate innovative thinking and limited government fundamentals into

33 Julie Stone, "Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery," Congressional Research Service, January 31, 2008.

health policy.³⁴ Allowing states to have the freedom to experiment is consistent with notions of federalism but it also enables states to be laboratories where they can adopt a variety of policies and learn from each other about what works and what does not work.

With the significant expansion of Medicaid, PPACA doubles down on a program with abundant flaws. While state policymakers can and should make improvements in the way Medicaid is designed and managed, one of the most important tasks for states is to make the case to Congress that the Medicaid expansion will bust both state and federal budgets. At every turn in the debate, policymakers should be ready to cite the overwhelming evidence that Medicaid already does not deliver significant health improvements to the intended recipients.

34 The Buckeye Institute published “Reforming Medicaid in Ohio: A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes” and would be of interest for readers who are interested in a comprehensive list of ideas for reforming Medicaid. The report is available in PDF format at <http://www.buckeyeinstitute.org/reports>.

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Crushing Weight

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