Expanding Medicaid: The *Wrong* Decision for Ohio

Executive Summary

Ohio must soon decide whether to participate in that portion of the Affordable Care Act (ACA), popularly known as ObamaCare, which would greatly expand the Medicaid program. There are at least six reasons why transforming Medicaid from a safety net into a broad-based welfare program that covers able-bodied adults with incomes up to 138% of the federal poverty level is the wrong policy decision for Ohio. Policymakers should not trade dubious short-term gains for long-term losses.

1. Future Federal Funding Reductions Would Shift Burden to Ohio
Under the ACA, the Federal Government is offering increased federal funding for states that participate in Medicaid expansion. These funding levels are unsustainable, and may be changed at any time. The Obama administration already recommended an adjustment that would cost Ohio an additional $2 billion. Even slight changes to federal spending rates will have devastating long-term effects for Ohio.

2. Increased Administrative Costs of Expansion
The enhanced federal matching funds provided under the ACA explicitly do NOT cover administration of the expanded program. The Obama Administration estimates that the states will need to pay an additional $12 billion in administrative costs for expansion.

3. Future Sales Tax Revenue Is Subject to Changing Regulatory Landscape
Proponents of expanding Medicaid have argued that Ohio could achieve a revenue windfall based upon a special sales tax Ohio levies on Medicaid Managed Care Organization plans. The federal government is already considering phasing out the loophole that allows these taxes. Relying on this revenue to pay for an expensive expansion therefore is reckless.

4. Flaws in Report Advocating Expansion
A recent report co-authored by the Urban Institute touting the short-term financial benefits of Medicaid expansion suffered from multiple flaws that make its windfall revenue projections unreliable, particularly for long-term planning purposes.

5. Relegates More Ohioans To a Failing Government Program
Numerous studies demonstrate that health outcomes for those in Medicaid are often worse than if the individual had no insurance at all. Many Ohioans who would be relegated to the failing Medicaid program could otherwise obtain subsidies for insurance through an exchange.

6. Expands Government Programs and Government Spending
States have a choice as to whether to expand Medicaid to ACA levels. The expansion fundamentally transforms Medicaid into a much larger government welfare program. This is contrary to conservative, limited government, and free-market principles.

Expanding Medicaid: The *Wrong* Decision for Ohio

POLICY REPORT

Ohio must soon decide whether to participate in that portion of the Affordable Care Act (ACA), popularly known as ObamaCare, which would greatly expand the Medicaid program. Ohio and Governor Kasich already confronted another issue concerning the ACA—whether to set up state-run exchanges—and made the correct decision for the state in rejecting a larger state role in implementing the ACA. The forthcoming decision on possible Medicaid expansion under the ACA will have massive long-term budgetary implications for Ohio extending far beyond the next biennium and into subsequent decades. Getting this decision right is therefore of critical importance for the long-term financial health of the state.

Currently, Ohio's Medicaid program covers certain low-income populations, including children, families with children, pregnant women, the elderly, and the disabled. The price tag already is significant: Medicaid accounts for nearly 30 percent of the state budget. Expansion would greatly increase expenditures for this already costly program.

The Supreme Court ruled in the legal challenge to the ACA that the federal government could not coerce states into expanding Medicaid by threatening to withhold the federal share of the *existing* Medicaid program. Thus, states have the choice of whether to opt into the Medicaid expansion, or to continue the program as it currently stands.

Under the terms of the ACA expansion, all Ohio citizens with income under 138 percent of the federal poverty level would become eligible for Medicaid. In return, Ohio would receive enhanced federal funding for these new enrollees. Such an eligibility change would transform Medicaid from a safety net into a much broader-based welfare program for able-bodied adults—something that it has never been—thereby fundamentally changing the size, scope, and role of government in providing health insurance. It would be ill-advised to expand government spending—federal and state—in the service of a program that has been demonstrated to deliver poor quality results to its enrollees.

A recent report entitled *"Expanding Medicaid in Ohio: Preliminary Analysis of Likely Effects"* (*"Expanding Medicaid"* report)[1] suggests that Ohio could gain a windfall from expanding Medicaid. Such conclusions are dubious at best, par-

1 The Health Policy Institute of Ohio, The Ohio State University, the Urban Institute, Regional Economic Models, Inc. (REMI), "Expanding Medicaid in Ohio: Preliminary Analysis of Likely Effects," January 15, 2013 at http://a5e8c023c8899218225edfa4b02e4d9734e01a28.gripelements.com/pdf/publications/oh_medicaid_expansion_study_1_15_2013_final_numbered.pdf, (January 15, 2013).

ticularly given the uncertainty of future federal decisions concerning spending. Even if the projections are true in the short-term, they are not supportable in the long-term. Ohio should not trade short-term gains for long-term losses.

The following report outlines six reasons why policymakers should resist entreaties to expand Medicaid in Ohio.

1. Future Federal Funding Reductions Would Shift Burden to Ohio

Under the ACA, the Federal Government is offering greatly increased federal funding for states that participate in Medicaid expansion through an enhanced "Federal Medical Assistance Percentage," or FMAP.[2] The enhanced FMAP for new Medicaid participants under the expansion is 100 percent federal share during the first three years, which is phased down in later years to 90 percent.

But these rates are not set in stone—indeed Congress could change the FMAP rates at any time in the future. In considering the states' successful legal challenge to coerced Medicaid expansion under the ACA, seven justices joined opinions acknowledging the real possibility that the federal rates could change, leaving a significant burden for the states. In responding to assertions of relative modest cost increases for the states, three justices cautioned that such a claim:

> ***"not only ignores increased administrative expenses, but also assumes that the Federal Government will continue to fund the expansion at the current statutorily specified levels. It is not unheard of, however, for the Federal Government to increase requirements in such a manner as to impose unfunded mandates on the States."***[3]

This concern was echoed in an opinion joined by four justices, which emphasized that "costs may increase in the future because of the *very real possibility* that the Federal Government will change funding terms and reduce the percentage of funds it will cover. This would leave the States to bear an increasingly large percentage of the bill."[4]

When pressed at oral arguments about the lack of any guarantee of current statutory funding levels in the future and the impact that a reduction could have on the states, the attorney for the United States did not dispute that possibility, responding that under those conditions a state would be left with the difficult choice of deciding whether to abandon Medicaid if it chose not to shoulder the additional burden.[5]

The Supreme Court is not alone in considering the possibility of future federal funding reductions—the Obama Administration itself has already suggested this as an option. In its Fiscal Year 2013 proposed budget, the Office of Management and Budget (OMB) suggested a potential "Blended FMAP."[6] The Heritage Foundation found that if this blended rate were implemented in 2013, Ohio's share of the Medicaid

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2 The FMAP is the federal portion of dollars that goes towards Medicaid spending and varies on a state-by-state basis depending on demographics.

3 National Federation of Independent Business v. Sebelius, 132 S.Ct. 2566, 2605 n.12 (2012) (plurality opinion).

4 Id. at 2666 (Scalia, J., dissenting) (emphasis added).

5 Florida v. Dept. of Health & Human Svcs., Tr. of Oral Arg. 76-77 (Mar. 28, 2012).

6 Alison Mitchell, "Medicaid Financing and Expenditures," Congressional Research Service, July 30, 2012 at http://www.fas.org/sgp/crs/misc/R42640.pdf (January 23, 2013). This rate would be a complex formulation comprised of an average of the state's current FMAP, the enhanced FMAP for the expansion population, and the federal rate paid for SCHIP, a children's healthcare program.

expansion would increase by $2 billion over the next five years alone.[7]

While current indications are that the Obama Administration has backtracked from this position, this also is not set in stone. At the very least, alternative scenarios should be simulated utilizing different FMAPs applied to the expansion population in order to assure that policymakers fully understand the significant downside risks of potential funding changes from Washington.

The federal debt currently exceeds $16 trillion. The Obama administration estimates that the federal Medicaid share for FY 2014-2022 will total a staggering $3.056 trillion.[8] Negotiations concerning debt reduction have included discussions of entitlement reductions by both parties. Prudence demands that states considering whether to accept the federal government's expansion offer should not rely on the current FMAP rates continuing in perpetuity.

2. Increased Administrative Costs of Expansion

In addition to the premium costs are administrative costs. The enhanced federal matching funds provided under the ACA explicitly do NOT cover administration of the expanded program. The *Expanding Medicaid* report makes no attempt to include this expense in its calculations. Indeed, no study to date has attempted to calculate the cost burden for the administration of the expansion.

The administrative costs are substantial. The Centers for Medicare and Medicaid Services estimates that Medicaid administrative costs will increase by $26 billion during fiscal years 2010 through 2019, with the states shouldering $12 billion of that cost.[9] According to a 2008 study from the Congressional Research Service, state-level Medicaid administrative costs in Fiscal Year 2006 amounted to 5.4 percent of total state Medicaid expenses, with the states responsible for approximately 45 percent of this total.[10] Using the additional enrollment cost estimates in the *Expanding Medicaid* report, Ohio will incur at least another $137 million in administrative costs between 2014 and 2022 if it chooses to expand Medicaid. Of course, the administrative costs could be significantly greater if the actual costs of expansion prove to be higher than projections at the point of implementation.

This is important because historically Medicaid spending has increased at a rapid pace. According to the Centers for Medicare and Medicaid Services, Medicaid grew from $900 million in its first year (1966) to $5.1 billion a mere four years later in 1970. That was an astonishing 54.4 percent average annual increase. Between 1971 and 2010, the annual growth rate in expenditures averaged 11.5 percent per year and the average expenditure per enrollee grew at 7.8 percent per year.[11] While growth rates have slowed

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7 Drew Gonshorowski, "Medicaid Expansion Will Become More Costly to States," The Heritage Foundation, August 30, 2012, at http://www.heritage.org/research/reports/2012/08/medicaid-expansion-will-become-more-costly-to-states (September 19, 2012).

8 Office of the Actuary, "2011 Actuarial Report on the Financial Outlook for Medicaid," Centers for Medicare and Medicaid Services, Dept. of Health and Human Services, March 16, 2012 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf (January 23, 2013).

9 Office of the Actuary, "2010 Actuarial Report on the Financial Outlook for Medicaid," Centers for Medicaid and Medicare Services, Dept. of Health and Human Services, Dec. 10, 2010 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2010.pdf (January 29, 2013).

10 April Grady, "State Medicaid Program Administration: A Brief Overview," The Congressional Research Service, May 14, 2008 at http://www.aging.senate.gov/crs/medicaid3.pdf (January 22, 2013).

11 Office of the Actuary, "2011 Actuarial Report on the Financial Outlook for Medicaid," Centers for Medicare and Medicaid Services, Dept. of Health and Human Services, March 16, 2012 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf (January 23, 2013).

in recent years, these historical references should give pause to those banking on long-term cost containment.

3. Future Sales Tax Revenue Is Subject to Changing Regulatory Landscape

Proponents of expanding Medicaid in Ohio have suggested that Ohio could actually generate a short-term revenue surplus from expansion. The *Expanding Medicaid* report, for example, analyzes potential revenue from Ohio's sales tax on Medicaid managed care organizations (MCOs). With recent state reforms to Medicaid placing most recipients in MCOs, that sales tax is projected to be a significant revenue source for Ohio. The *Expanding Medicaid* report found that Ohio would gain a total of $1.8 billion between 2014 and 2022 as a result of both the 5.5 percent sales tax on Medicaid MCOs as well as the 1 percent state health insurance tax. This fails to take into account possible regulatory changes that could greatly reduce or eliminate these revenues.

The sales tax is not a general sales tax on all managed care organizations, but is a provider tax solely levied on Medicaid MCOs. The tax generates revenue to increase payments to the same providers that are taxed in order to increase Federal Medicaid matching dollars.

The MCO sales tax is relatively new—it was implemented in 2010 to replace Ohio's prior franchise fee for Medicaid MCOs, which ended because of changes in federal law designed to restrict creative efforts of states like Ohio to use provider taxes to increase federal matching funds.[12]

And herein lies the problem with using the current sales tax as a source of revenue: the federal government is interested in restricting the sales tax mechanism as well. President Obama has already recommended phasing down the Medicaid provider tax threshold from its current cap of 6 percent to 3.5 percent.[13] This would greatly reduce the income projections relied upon in the *Expanding Medicaid* report.

A paper by Dr. Jon Honeck at the Center for Community Solutions raises additional long-term questions as to its viability as a mechanism to draw down additional federal dollars.[14] Honeck notes that the "application of the sales tax to Medicaid MCOs but not to other health maintenance organizations appears to violate federal rules that require Medicaid provider taxes to be broad-based and include all providers in a class."[15] He further notes that Michigan abandoned a similar sales tax because of "pressure from the federal government."[16]

The suggestion that Ohio should expand Medicaid in order to capitalize on short-term gains from this sales tax loophole, which could be closed by the federal government at any time and which is already under intense scrutiny, amounts to recklessness.

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12 Jon Honeck, "The Sales Tax and Medicaid Managed Care: Short-run Revenues vs. Long-run Challenges," The Center for Community Solutions, December 2011 at http://ccs.affiniscape.com/associations/13078/files/sbmV7N9MCOSalesTax-Honeck121511.pdf (January 22, 2013).

13 U.S. Office of Management and Budget, "Living within our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction," p. 40. available at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf (January 30, 2013); see also Alison Mitchell, "Medicaid Financing and Expenditures," Congressional Research Service, July 30, 2012 at http://www.fas.org/sgp/crs/misc/R42640.pdf (January 23, 2013).

14 Jon Honeck, "The Sales Tax and Medicaid Managed Care: Short-run Revenues vs. Long-run Challenges," The Center for Community Solutions, December 2011 at http://ccs.affiniscape.com/associations/13078/files/sbmV7N9MCOSalesTax-Honeck121511.pdf (January 22, 2013).

15 Ibid.

16 Ibid.

4. Flaws in Report Advocating Expansion

As discussed above, the *Expanding Medicaid* report projects a net gain of $1.4 billion between 2014 and 2022 should Ohio opt into the ACA Medicaid expansion. It also concluded that Ohio would incur a net loss of $38 million over the same time period if it did not expand Medicaid.

While this report is the most serious effort to date to quantify the impact of Medicaid expansion on Ohio, our discussion above demonstrates that the report's projections are based upon unsustainable current federal spending levels that may be changed at any time, and on taxes, which are the subject of federal scrutiny, and may be phased out as well. These presumptions are dubious at best for the long-term program, and therefore cast serious doubt as to whether the report's conclusions should be relied upon by policymakers seeking to make a decision for Ohio.

Additional problems with the report include an understatement of non-expansion revenue. In the event that Ohio does not expand Medicaid, individuals who fall within 100 and 138 percent of the Federal Poverty Level would become eligible for generous subsidies from the federal government should they enter the health care exchange. Given those financial incentives and the ACA's requirement that individuals obtain coverage, policymakers should anticipate that a reasonable percentage of those in this category would elect to obtain coverage.

Accordingly, when comparing the revenues generated from expansion to those of non-expansion, it is necessary to calculate an increase in state revenues due to the health insurance taxes that will be imposed on plans sold through the exchange—something which the *Expanding Medicaid* report failed to do. Correcting this error both improves the budgetary outcome of the non-expansion scenario and establishes the less positive budgetary outcome of the expansion.

Even using optimistic presumptions, the report shows that the overall costs of the expansion come close to outstripping the savings and new revenues by Fiscal Year 2021. The annual net gain to the state shrinks from a high of $328 million in 2016 to a mere $1 million by 2022. This alone should give policymakers pause. But when the presumptions regarding federal spending and regulation of sales tax are challenged, and when the errors concerning the omission of administrative costs and failure to adequately account for non-expansion income are rectified, the economic projections for expansion are less favorable even in the short term.

5. Relegates More Ohioans To a Failing Government Program

In addition to the economic considerations, there is the more fundamental policy question of whether, as a matter of good public policy, Ohio should expand Medicaid. The answer is a resounding no.

Our 2010 report *Crushing Weight* cited numerous studies demonstrating that health outcomes for those in Medicaid are often worse than if the individual had no insurance at all.[17] For example, "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

17 Brian Blase, "Crushing Weight: National Healthcare Law Threatens to Make Medicaid an Unsustainable Burden for Ohioans," The Buckeye Institute for Public Policy Solutions, December 2010, at http://www.buckeyeinstitute.org/uploads/files/BUCKEYE-crushing-weight.pdf (September 18, 2012).

demographic factors and health status."[18]

Numerous other scholars such as Paul Howard[19] and Avik Roy[20] of the Manhattan Institute raise similar concerns, citing studies demonstrating worse outcomes for Medicaid patients than even the uninsured in areas including surgical complications, colon cancer mortality, and long-term survival following transplant surgery. [21]

Additionally, low Medicaid reimbursement rates leave many primary care physicians unwilling to accept Medicaid patients, meaning that there will continue to be an access problem for many entering the program.[22]

By expanding Medicaid, Ohio would be putting more residents into a program with subpar performance. This is particularly unwarranted because there are better options, even under ObamaCare. Individuals between 100 and 400 percent of the Federal Poverty Level will be eligible for subsidies in the federally-run exchanges. While the exchange does not offer the array of choices that a true, free-market exchange would offer, Ohioans would be better served by these options than by Medicaid.

6. Expands Government Programs and Government Spending

Medicaid already accounts for around 30 percent of the state budget. Prudence dictates that intense scrutiny be given to any claims suggesting that the expansion of an already gargantuan welfare program will not increase the long-term burden on Ohio taxpayers.

Such an expansion of government is inconsistent with conservative or free-market principles. The ACA transforms a limited safety net program into a vast welfare program—one which is likely to become entrenched, to cost huge sums, and to serve enrollees less well than the alternatives. The expansion also appears to be inconsistent with the wishes of Ohio voters, who expressed their strong disapproval of the ACA in 2011 when they passed the Ohio Health Care Freedom Amendment by a nearly 2-1 margin.

While there are myriad reasons for serious doubt about the long-term financial benefits to Ohio for availing itself of federal largesse in the short run, policymakers should also be concerned about the shift of greater control regarding the terms and conditions of Medicaid from Ohio to the federal government. In granting the states greater flexibility to choose whether to expand Medicaid, the Supreme Court highlighted the fundamental change the expansion causes to Medicaid—something that should not be lost on the states. State policymakers likely will be tempted to accept the substantial funds the federal government is currently offering to adhere to the terms of its expansive government healthcare program.

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18 Ibid.

19 Paul Howard, "How Block Grants Can Make Medicaid Work," The Manhattan Institute, September 2012 at http://www.manhattan-institute.org/html/ir_24.htm#.UQB0-46Fq4k (January 23, 2013).

20 Avik Roy, "The Medicaid Mess: How Obamacare Makes it Worse," The Manhattan Institute, March 2012 at http://www.manhattan-institute.org/html/ir_8.htm (September 19, 2012).

21 Ibid.

22 Brian Blase, "Crushing Weight: National Healthcare Law Threatens to Make Medicaid an Unsustainable Burden for Ohioans," The Buckeye Institute for Public Policy Solutions, December 2010, at http://www.buckeyeinstitute.org/uploads/files/BUCKEYE-crushing-weight.pdf (September 18, 2012).

> ***"The States are separate and independent sovereigns. Sometimes they have to act like it."***
>
> U.S. Supreme Court Chief Justice John Roberts

But the states are no longer coerced to participate in the Medicaid expansion; they are merely induced. As the Supreme Court noted in affirming the ability of the states to resist some measure of financial incentives offered by the federal government in support of state adoption of federal policy: "The States are separate and independent sovereigns. Sometimes they have to act like it."[23]

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23 National Federation of Independent Business, 132 S.Ct. at 2603 (plurality opinion).

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Alt's commentary has appeared in major publications including The Wall Street Journal, The Washington Times, New York Post, and The San Diego Union-Tribune. Alt is a regular contributor to National Review Online, where he has published more than a hundred articles and blogs. He has provided commentary on CNN, Fox News Channel, PBS, and numerous syndicated radio programs. In 2004, Alt spent five months in Iraq as a war correspondent.

Alt has testified on multiple occasions before Congress, including before the U.S. Senate during confirmation hearings for Supreme Court Justice Elena Kagan. He has also testified before the Federal Election Commission and Ohio's Eminent Domain Task Force.

Prior to joining Buckeye, he served as the Director of Rule of Law Programs and Senior Legal Fellow at The Heritage Foundation in Washington, D.C. Alt continues to serve as a Visiting Senior Legal Fellow at The Heritage Foundation, and a Fellow in Legal and International Affairs at the Ashbrook Center at Ashland University in Ohio, where he has taught constitutional law and political parties and interest groups. He also previously taught national security law, criminal law, and legislation at Case Western Reserve University School of Law in Cleveland. He is a regular speaker at universities and law schools across the country.

Alt is a graduate of the University of Chicago Law School, following which he clerked in Medina, Ohio for Judge Alice Batchelder on the U.S. Court of Appeals for the Sixth Circuit.

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Lawson graduated summa cum laude from Ohio State University in 2000 with a Major in Communications and a Minor in Economics.

His interest in the intersection of public policy and politics began while in college and fully took off when he became a Legislative Service Commission Intern in 2001 working with a state representative. Lawson took that legislative experience with him to the Ohio Council for Home Care where he focused on Medicaid issues, PAC fundraising and grassroots organizing. Lawson has also served as a Legislative Liaison with the Ohio Department of Commerce.

Other positions Lawson has served in include as a public relations strategist, Director of Communications for the U.S. Sportsmen's Alliance and as a Contributing Analyst with the global online geostrategic consultancy, Wikistrat.

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The Buckeye Institute for Public Policy Solutions is an Ohio based free market think tank that has provided the research and solutions to Ohio's toughest public policy challenges in economic freedom, competitiveness, job creation and entrepreneurship, and government transparency and accountability for nearly two decades.

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