The Great Medicaid Swindle

By: Nick Gillespie – October 24, 2013

On Monday, Ohio became the 25th state to expand Medicaid thanks to new provisions in Obamacare. Nick Gillespie on why this is an unfortunate and expensive mistake.

On Monday, the same day President Obama gave a poorly received speech defending the glitchy Obamacare rollout, there was another unfortunate development in health-care reform: Ohio expanded Medicaid.

In a controversial (and possibly illegal) move, Ohio's Controlling Board voted to expand Medicaid coverage in the state to adults that were not previously eligible by way of accepting billions in federal funds. That means 25 states, plus the District of Columbia, have now signed on to take part in an aspect of the Affordable Care Act that is both optional and ill-considered. More states are expected to follow suit, even some that, like Ohio, have Republican governors and conservative legislatures.

This is bad news. Medicaid, the nation's health care program for low-income citizens and those with certain disabilities, is expensive. States are not required to participate in the program, but all do, though eligibility requirements differ from state to state. In 2011, states devoted nearly 24 percent (PDF) of total spending to Medicaid—the single largest state expense—despite the fact that there's little evidence that it actually improves the health outcomes of its beneficiaries.

In 2011, Washington covered about 64 percent of the $413 billion in costs associated with Medicaid, with the states kicking in the rest. As it stands, Medicaid provides health care to low-income children, pregnant women, parents with young children, seniors, and disabled adults but does not cover all low-income adults. The Medicaid expansion option in Obamacare extends health-care coverage to many people in households that earn up to 138 percent of the federal poverty line. The feds will cover all of the costs of those covered by the expansion for three years, then 90 percent of the costs started in 2020 (for those who qualify for Medicaid under pre-expansion rules, the feds will pay about 60 percent of costs and states will pick up the rest). In the case of Ohio, about 275,000 people will be newly eligible for Medicaid coverage and the state will receive about $2.5 billion in extra federal funds the first year.

Medicaid expansion is central to Obamacare's effort to reduce the number of uninsured. The Kaiser Family Foundation (PDF) says that 40 percent of the 25 million people who could gain insurance by 2016

would do so via Medicaid coverage. A 2012 Kaiser study (PDF) indicated that given the level of federal support, only eight states would ultimately save money until 2022 by signing on for Medicaid expansion—more than half would see cost increases of under 5 percent, and the rest would see totals costs rise by between 5 percent and 11 percent.

To supporters of Medicaid expansion, the prospect of boatloads of "free" federal money renders any objection not simply idiotic but morally depraved. "Red states seem more willing to let low-income people die than get healthcare," seethed political columnist Michael Cohen recently in the *Guardian*, writing that Republicans won't be able to "rehabilitate their image" from that of heartless bastards as long as "they operate as though saving money…is more important than reducing suffering and saving lives."

But there's a problem with that argument: there's little evidence that Medicaid coverage improves the health and longevity of beneficiaries. For instance, a major 2010 University of Virginia study found that for patients undergoing major surgical procedures, those on Medicaid were 93 percent more likely to die than patients with private insurance, while the uninsured were just 74 percent more likely to die. Such awful outcomes for Medicaid patients are found in a variety of studies looking at cancer, heart problems, and other maladies.

Evidence from the widely respected Oregon Health Insurance Experiment, which compared the health of Medicaid recipients to a control group, found "that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years." Such results are broadly consistent with findings that insurance status has little or no impact on longevity. In 2009, for instance, Columbia economist Frank Lichtenburg published a study looking at longevity in states between 1991 and 2004 and concluded that "growth in life expectancy was uncorrelated across states with health insurance coverage and education."

Even the lead author of a 2012 study that found decreases in mortality rates after some states voluntarily expanded Medicaid acknowledged that the data he worked with was too crude to make definitive statements: "I can't tell you for sure that this is a cause-and-effect relationship," he said.

The Oregon study did find that Medicaid recipients self-reported less depression and "nearly eliminated catastrophic out-of-pocket medical expenditures." Those are good things, but the Oregon study also found that people with Medicaid consumed *more* health care, which may be a reason why the program is so costly.

Like Medicare, Medicaid has for a long time posted year-over-year spending increases. Between 2000 and 2011 (PDF), the average increase was 6.8 percent and total expenditures on the program came to $432 billion in 2011 (PDF). The Department of Health and Human Services estimates that annual increases will average about 6.4 percent until 2021, when the federal government and states will spend $795 billion on the program.

By that time, too, the states will be on the hook for 10 percent of costs for the Medicaid expansion on top of other increases in the program; if past projections of the cost for federal health care programs are

any indication, expect the estimates for the cost of the Medicaid expansion—and Obamacare more generally—to be way short. Indeed, in 2012 the CBO doubled its cost estimate for the first full decade of Obamacare, from $938 billion to $1.76 trillion.

To be sure, the prospect of a $9 federal match for every $1 of state spending seems like a win-win proposition for states. But the Cato Institute's Michael Cannon notes that the match is only "theoretically" perpetual. Given increasing amounts of federal debt and other entitlement spending, argues Cannon, "It is wildly unrealistic to assume the federal government will maintain the Medicaid expansion's nine-to-one matching rate." As Mercatus Center economist Veronique de Rugy reminds us, increases in federal spending to the states don't reduce state-level spending. More begets more, and spending tends to stick at higher levels, which is why the phenomenon is known as "the flypaper effect." Research indicates that for every dollar of federal aid that disappears from state coffers, states raise their future taxes by between 33 cents and 42 cents.

Far from being cretins who hate the poor and the uninsured, the states that have thus far refused to expand Medicaid are declining to increase the number of people trapped in a health care program that (at best) does no harm to its patients. And they're actually thinking more clearly about where taxpayers will be a decade from now.