NATIONAL REVIEW

Say No to Medicaid Expansion - Governors should send this gift horse packing

August 27, 2012 | John Hood

Rick Perry of Texas, Scott Walker of Wisconsin, Bobby Jindal of Louisiana, and many other governors and state legislators across the country are proving to be rather obstreperous. In the aftermath of the Supreme Court's controversial decision on Obamacare, they've looked past the convoluted ruling on the individual mandate and zeroed in on the clearer 7-2 decision that Washington may not compel the states to go along with the law's massive expansion of Medicaid. These Republican state officials have already decided not to comply with the Medicaid provisions; other state leaders, both Republicans and Democrats, are considering doing the same.

The Obama administration and its supporters on the left are apoplectic about this. They are demanding, loudly and furiously, that state officials not be so rude as to look the gift horse of Obamacare in the mouth. Why in the world, they ask, would governors and legislators pass up a deal to insure millions of Americans at little or no cost to state governments? Why aren't governors and legislators salivating at the prospect of drawing billions of federal tax dollars into their local economies through new Medicaid spending? "They would be committing fiscal malpractice if they left all this money on the table," Ron Pollack, head of the nonprofit group Families USA and an Obamacare supporter, told the Washington Post a few days after the Supreme Court decision.

But liberals such as Pollack know exactly why many fiscal conservatives in state capitals are seizing on the high court's ruling to forgo the Medicaid expansion. They also know that the future of Obamacare itself may be at stake. They just won't spell out why. So I will.

For all the focus on federal mandates, free riders, and insurance exchanges over the past two years, Obamacare was never primarily about expanding private health-care coverage to the uninsured. More important were the bill's provisions to expand Medicaid, the joint federal-state health-insurance program for low-income, elderly, and disabled Americans.

According to early projections, Obamacare would add 17 million people to the Medicaid rolls from 2014 to 2019, more than half of the 30 million uninsured Americans projected to gain coverage under the bill. That would be significant

enough. But, intentionally or not, the proponents of Obamacare overestimated the private-insurance count and underestimated the Medicaid count. Their models did not account sufficiently for the number of non-poor uninsured who would rather pay the tax/fee associated with the individual mandate than buy private insurance, or for the number of businesses that would reorganize their benefits and work forces to escape the mandates that apply to them. Nor did the models account sufficiently for the number of Americans currently eligible for but not enrolled in Medicaid who would be swept into the program during the implementation of Obamacare. Crucially, this group of Medicaid recipients will not trigger the bill's generous federal matching payments. They'll cost state budgets plenty.

Medicare and Medicaid were created in the same 1965 legislation, and they both pose a serious threat to the nation's fiscal health, but they operate in very different ways. States have no role in financing, and almost no role in overseeing, the Medicare program. But with Medicaid, while the federal government pays part of the cost and sets overall parameters, the state governments pick up the rest of the tab and make key decisions about eligibility and benefits. The federal share of the Medicaid budget varies widely by state, from just over half in some to about three-quarters in others. On average, states are paying a bit over 40 percent of the tab right now. That creates a perverse incentive for governors and legislatures to increase enrollment or cover additional services, since they can claim political credit for all of the benefits while having to appropriate state funds for only some of the cost.

When you combine that perverse incentive with the broader problem of health-care inflation, you can see why Medicaid has been among the fastest-growing categories of state spending. In most states, lawmakers must balance their operating budgets with current revenues. So, faced with surging Medicaid projections, their only options have been to raise taxes, cut Medicaid, or lower the rate of spending growth for services that benefit a wider range of constituents, such as education. During tough budget years, you might think the path of least political resistance would be to cut Medicaid, but the argument that every state Medicaid dollar draws "free" federal money has proven persuasive to many state policymakers. Even more important, the passage of Obamacare made cutting Medicaid even less plausible by extending a maintenance-of-effort requirement originally imposed in the 2009 stimulus bill. This rule forbids states to make major changes in Medicaid eligibility. Therefore, Medicaid spending has continued to rise as lawmakers have chosen to cut other programs or raise taxes. According to a new report from the State Budget Crisis Task Force, which is co-chaired by former Fed chairman Paul Volcker, Medicaid is one of the chief causes of "persistent and growing structural deficits in many states which threaten their fiscal sustainability."

States with fiscally conservative governors and legislatures have tended not to maximize their participation in Medicaid, particularly when trying to cope with the demand from rapidly growing populations for public education and other

popular services. In most northeastern and midwestern states, enrollment of children in Medicaid or the closely related Children's Health Insurance Program (CHIP) approaches or exceeds 90 percent of the level allowed by federal law, but in the South and West, the enrollment rate is often lower: in Texas and Florida, for example, just 77 percent of those who are eligible according to federal standards. The variation is even greater for adults: States such as Pennsylvania and Massachusetts enroll more than 80 percent of current eligibles, while Georgia, Texas, Oklahoma, Oregon, Florida, and Nevada enroll less than 50 percent.

For the states that have relatively low Medicaid participation, Obamacare's expansion plan poses a major problem. The bill promises to pay all of the cost of enrolling those newly eligible for Medicaid from 2014 to 2016, but the federal-funding share will then decline to 90 percent by 2020. Even if that timetable sticks -- and governors can't be sure Congress won't try to cut funding sooner, as President Obama actually proposed during deficit-reduction talks in 2011 -- states start to incur significant budget expenses for newly eligible enrollees in just a few years.

But the states have a bigger problem, stemming from the fact that Obamacare will increase Medicaid enrollment regardless of current eligibility status. The bill streamlines the enrollment process. "It won't be an in-person visit, it won't be a 'Bring six forms of ID,'" said University of Virginia health-care analyst Jeff Goldsmith on a recent National Public Radio program. "There will be an expedited -- lubricated, if you will -- process to get people onto the rolls, and I think that's the part that's giving state budget officers serious indigestion at this point." In addition to changes in the application process, the legislation calls for a major promotional effort to enroll the uninsured, an effort that will benefit from all the media attention surrounding the individual mandate. The states will have to cover these new enrollees' care, with the federal government paying only the pre-Obamacare level of, on average, about 60 percent of the cost.

This "woodwork effect" could quickly increase the direct costs to some states by hundreds of millions, if not billions, of dollars a year. And the adverse effects won't just be fiscal. In many states, hospitals and doctors simply aren't able to accept new Medicaid enrollees, who are uneconomical to take on as patients because Medicaid reimburses health-care providers at extremely low rates.

The new federal Medicaid money will thus end up costing the states a lot. And there's yet another wrinkle that could make saying no attractive even to states with more liberal Medicaid policies. Remember that maintenance-of-effort requirement that Obamacare imposed on state Medicaid programs right off the bat? For states that choose not to participate in the Medicaid expansion, the requirement will vanish in 2014. (Some states, in fact, argue that the recent Supreme Court decision has already voided the requirement as an unconstitutional coercion.) Once states regain the ability to adjust their eligibility rules, it might even make sense for previously generous states to make the rules

more restrictive -- by refusing anyone with an income higher than 100 percent of the poverty line ($23,050 for a family of four). This is because, under Obamacare, those with incomes between 100 percent and 400 percent of the poverty line will be eligible for federal subsidies to buy plans within the insurance exchanges. Cutting off Medicaid eligibility at the poverty line would get previous enrollees out of the program, and thus off the state's books permanently, without leaving those individuals uninsured. The federal government would pick up the full tab rather than just part of it.

If all this sounds like a fiscal and political fiasco for the Obama administration, then you're getting the picture. As state governments say no to Medicaid expansion, the result will be either a reduction in the benefits of Obamacare, an increase in its negative impact on the federal budget, or some of both. If just the few states that have already announced opposition to the expansion follow through on their plans, the number of uninsured Americans gaining coverage under Obamacare's Medicaid increases will shrink by millions. In fact, a Congressional Budget Office analysis published in July pegged the reduction in Medicaid growth at 6 million people -- about half of whom would be eligible for federally subsidized private plans through the health-insurance exchanges. The CBO then estimated the federal fiscal impact of states' refusing Medicaid expansion as close to a wash, by assuming that the other 3 million would be left uninsured and thus unsubsidized by Washington.

Nevertheless, Obama-administration officials and liberal groups argue that Obamacare critics are giving states bad fiscal advice. They say that even after shouldering the cost of expanding Medicaid, states would come out ahead through savings in other programs that subsidize medical treatment for the uninsured. But **Cato Institute** analyst Jagadeesh Gokhale has checked the numbers carefully. "Even after taking into account potential savings from uncompensated care and the higher federal match rate for newly eligible Medicaid enrollees," Gokhale says, "the choice to expand Medicaid is likely to significantly boost state-general-fund spending on that program."

What's even more questionable than the liberals' math is their political judgment. State leaders won't be punished back home for eschewing a costly Medicaid expansion. What's more likely is that the resulting mess will lead even a reelected President Obama and a divided Congress to rewrite significant sections of the law. Under a President Romney and/or a Republican Senate, such a rewrite would likely become a repeal.

Mr. Hood is the president of the John Locke Foundation, a public-policy think tank in Raleigh, N.C., and the author, most recently, of Our Best Foot Forward.