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The Medicaid Mess

Now isn't the time for Republican governors to go wobbly on these fraudulent arguments.

By Michael Tanner
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Even as those parts of Obamacare that have not yet been postponed stagger toward the finish line on March 31, one part of the president's health-care law continues to build momentum. As of this writing, 25 states and the District of Columbia have chosen to expand their Medicaid programs in accordance with Obamacare. This includes several states governed by Republicans, including Arizona, New Jersey, New Mexico, and Ohio (Governor John Kasich has described the expansion as part of his duty as a Christian).

The Obama administration claims that nearly 7 million Americans have been added to the Medicaid rolls as a result of the Affordable Care Act, but those numbers are wildly inflated.

The *Washington Post*'s fact checker has given the claim "four Pinocchios," and firms that track the data, such as Avalere, suggest that the real number is somewhere between 1.1 and 1.8 million at last count. The rest of the enrollments are simply the normal turnover and reenrollments that occur in the program.

Yet the expansion could get a lot bigger over the next few months if several additional states decide to expand their programs. Among those expected to make a decision in the next few weeks: New Hampshire, where the Republican-controlled senate voted to pass a version of expansion earlier this month; Pennsylvania, where Republican governor Tom Corbett has proposed expanding the program in exchange for some overall Medicaid reforms, including a work requirement; staff for Utah governor Gary Herbert traveled to D.C. last week to discuss proposals for Medicaid expansion, with their boss expected to make the trip himself in April; and Virginia, where new governor Terry McAuliffe is pushing for expansion, though the Republican-controlled house has blocked him. Other states looking at the idea include Florida, Missouri, and Montana; expansion is also expected to be a key issue in gubernatorial campaigns this fall.

Supporters of expanding the program, along with much of the media, portray opposition to the idea as essentially political. It's about governors and state legislators who simply oppose Obamacare and refuse to do anything that would help implement it, they contend. No doubt there's a certain amount of truth to this claim.

But expanding Medicaid also raises serious policy concerns: It would increase government dependency, cost state taxpayers millions if not billions of dollars in new taxes, squeeze other state services, and do little to improve health care for the poor.

A close examination of the claims made by proponents of Medicaid expansion shows that they carry very little weight. For example:

Medicaid expansion will save lives. In Florida, Republican-cum-independent-cum-Democratic gubernatorial candidate Charlie Crist has been running ads claiming that six Floridians die every day because Republican governor Rick Scott has not succeeded in expanding Medicaid. (Scott actually tried to expand the program, but the legislature rejected his plan, and he has since backed away from it.) But Crist's numbers are based on studies with deeply flawed and discredited methodologies.

A gold-standard study in Oregon, with similar individuals randomly assigned to Medicaid or uninsured populations, concluded that "Medicaid coverage generated no significant improvements in measured physical-health outcomes." Other studies show that, in some cases, Medicaid patients actually wait longer and receive worse care than the uninsured.

Medicaid expansion saves money by reducing uncompensated care and emergency-room visits. Among the special-interest groups pushing hardest for Medicaid expansion are hospitals. They made a devil's bargain with the Obama administration to support Obamacare despite its cuts in hospital payments, in the hopes that new Medicaid enrollees (as well as subsidized exchange customers) would reduce the number of patients showing up without insurance and using emergency rooms for primary care.

Unfortunately, it doesn't. The Oregon study cited above found that Medicaid enrollment actually increased ER use by as much as 40 percent, meaning annual emergency-room spending increased by roughly $120 per covered individual. For a state like Virginia, for instance, that would mean almost $100 million in additional ER costs per year.

Medicaid expansion doesn't cost states anything. Under Obamacare, the federal government would pay the entire cost of Medicaid-expansion enrollees through 2016. After that, the federal share would gradually decline, but it is still supposed to pick up at least 90 percent of the cost for those made newly eligible in perpetuity. This is a much higher share of costs than states receive under traditional Medicaid. Many governors thus see this as virtually free money.

There are at least three big problems with that. First, even though the feds will cover 90 percent of the new costs, 10 percent of this really big number is still a really big number. Medicaid expansion would cost Pennsylvania taxpayers roughly $2.84 billion over ten years, for instance. In Virginia, taxpayers would be on the hook for as much as $1.3 billion by 2022. Other states would see similar costs. Medicaid is already the largest single line item in most state budgets, so the expansion will further crowd out other priorities such as education, roads, and prisons.

Second, the increased federal funding applies only to those added to Medicaid as a result of expanding eligibility to everyone earning less than 138 percent of the poverty level. This ignores a second category of recipients more likely to be added to the Medicaid rolls if this expansion moves forward, thanks to what the Robert Wood Johnson Foundation has dubbed "the woodwork effect." When states market the expansion, thousands of state residents will end up enrolling who would have been eligible under traditional Medicaid. Some will be uninsured, but

others will either be paying for insurance themselves or receiving it from their employer. This group is not eligible for the more generous federal matching funds, meaning state taxpayers must pay as much as half of their costs.

Finally, any estimate assumes the federal government will keep its side of the bargain when it comes to future funding. But with Washington facing a debt crisis, Medicaid cuts will almost certainly be on the table in the coming years. Indeed, in budget negotiations during the 2012 fiscal-cliff talks, the Obama administration reportedly offered to cut the 90 percent funding promise for Medicaid expansion to a lower "blended rate formula." While the administration has backed off that offer, it shows how tenuous federal funding promises really are.

The Medicaid expansion just gets states back the federal taxes that their citizens paid. There is a little something to this claim . . . but only a little. As the argument goes, citizens of all states pay federal income taxes. Some of those taxes fund the Medicaid program. Therefore, if a state does not expand Medicaid, its taxpayers will effectively be subsidizing programs in other states. But taking this argument to its logical extreme would suggest that states should massively expand every program that has partial federal funding. It's the same logic that has long underlain earmarks and other pork-barrel spending, but it ignores the fact that if a state expands Medicaid, it will increase total Medicaid costs nationwide, and therefore increase the amount of federal taxes that state taxpayers will ultimately have to pay. It also assumes that all states are net beneficiaries from federal largess, when in fact plenty of states are perennial losers.

Moreover, even if one buys into the "let's get our share of the plunder" argument, the Medicaid expansion is not as obvious a choice as proponents suggest. If a state doesn't expand Medicaid, individuals with incomes between 100 and 138 percent of the poverty level would be eligible for subsidies through the exchanges — with federal funds paying 100 percent of those subsidies. For at least that group of potential beneficiaries, not expanding Medicaid actually harvests more federal money.

The "private option" is a conservative way to expand Medicaid. Some states have tried to find a compromise on Medicaid expansion by using the dedicated Medicaid funds to allow recipients to buy into private health plans. Pioneered by Arkansas, where defections by Republican legislators recently allowed the experiment to move forward, this so-called private option attempts to address some of the worst aspects of Medicaid's centralized "command and control" structure. Because it incorporates private insurers and the rhetoric of "markets" and "choice," some conservatives might be fooled into believing that the private option represents a real step toward Medicaid reform.

In reality, however, the federal government continues to dictate many aspects of the insurance plans, including cost-sharing and benefits. The "private option" still lacks the price competition and innovation that characterize real markets. Nor is the private option likely to save states money. Indeed, evidence suggests it may end up being more expensive than traditional Medicaid. It's really little more than camouflage for an expansion of the flawed federal program.

It will be ironic indeed if the only aspect of Obamacare to ultimately survive is a bigger, unreformed version of a failed entitlement program. It will be even more ironic if it was Republican governors and legislators who brought it about.

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