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Obamacare and Medicaid: Expanding a Broken Entitlement and Busting State Budgets

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Roughly half of the anticipated gains in insurance coverage from the Patient Protection and Affordable Care Act (PPACA)[1] are achieved through a massive expansion of Medicaid, the joint federal–state health insurance program for the poor. The Medicaid program, with its soaring price tag and dubious level of care for recipients, is in serious need of reform, not expansion. Increasing enrollment in this program by a third is a major flaw of the new health care law.[2]

Summary. Section 2001(a) of PPACA requires states to increase Medicaid eligibility to cover all Americans below 138 percent of the federal poverty level (FPL) beginning January 1, 2014.[3] At that time, the FPL will be about $33,000 for a family of four, *excluding* the value of any welfare benefits. Section 1201 of the reconciliation bill (H.R. 4872) specifies that the federal government will pick up 100 percent of the cost of providing coverage for the expansion population (those who qualify under the new requirements but were ineligible under the previous state eligibility criteria) between 2014 and 2016. The federal reimbursement for the newly eligible will gradually decline thereafter until 2020, when the federal share of the cost will stay at 90 percent.

States will not receive such a high reimbursement for individuals who apply for Medicaid and were eligible under the previous state eligibility criteria in place when PPACA was signed into law.[4] States will be reimbursed for these individuals at their traditional federal reimbursement, which ranges from 50 percent in the wealthiest states to nearly 75 percent in the poorest states. Nationally, about 12 million individuals are eligible for Medicaid but are not yet enrolled.[5] The state cost of the Medicaid expansion will largely be affected by how many of these individuals sign up for the program, which will probably be increased because of the publicity likely to surround the penalties in the law for not maintaining health insurance.

One provision of PPACA, the maintenance of effort (MOE) requirement in Section 2001(b), impacts states immediately. Under PPACA's MOE, a state would lose all federal Medicaid funding if it makes eligibility more restrictive than the standards in effect for the state's program at the time the law was enacted.[6] This essentially freezes the state's eligibility requirements regardless of the impact on its bottom line.

Not only are states forced to keep eligibility at that level, but they are being forced to raise payments to primary care physicians. Section 1202 of H.R. 4872 requires that states increase Medicaid reimbursement rates for primary care physicians (PCPs) to the same level as the applicable Medicare payment rates for 2013 and 2014. The legislation specifies that the federal government will pay this entire cost—temporarily. This requirement, along

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with the federal funding for it, expires on January 1, 2015. At that time, states will have to either maintain the physician payment rate themselves or make drastic cuts.

Impact. Instead of reforming Medicaid—by targeting taxpayer dollars to populations truly deserving of public assistance and pursuing fundamental reform of the basic structure—PPACA doubles down on the program's existing flaws. This will lead to a substantial increase in cost to taxpayers and a dramatic swelling in the number of individuals dependent on the government paying their health care bills.

Increases in Taxes and Pressure on Other Areas of Public Spending. The Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) project that PPACA will increase federal spending on Medicaid by between $75 billion and $100 billion *annually*.[7] This dramatic increase is irresponsible given current annual federal budget deficits well in excess of $1 trillion. Further spending on Medicaid will necessitate an increase in federal taxes or cuts to other public programs. Given the evidence of poor health outcomes for Medicaid recipients,[8] the expansion likely fails a cost–benefit analysis.

Massive Increase in Government Dependence and Crowding Out of Private Coverage. CBO projects that PPACA will increase national enrollment in Medicaid by 16 million individuals in 2019, while CMS projects 20 million individuals.[9] The Heritage Foundation estimates that the growth in Medicaid caseloads will range from 9 percent in Massachusetts to 66 percent in Nevada.[10] Recent research by economists Jonathan Gruber and Kosali Simon finds that "the number of privately insured falls by about 60 percent as the number of publicly insured rises."[11] This means several million individuals below the new income threshold who currently have private coverage will be swept into Medicaid when PPACA takes effect.

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
3. While Section 2001(a) of PPACA mandated this expansion for individuals up to 133 percent of the FPL, the reconciliation bill (H.R. 4872) included a standard 5 percent income disregard. This effectively increases the eligibility level to 138 percent of the FPL.
4. In reality, states cannot restrict eligibility below what it was on July 1, 2008, because the 2009 stimulus bill raised each state's federal reimbursement retroactive to July 1, 2008, on the condition that states not restrict eligibility below what was in place on that date.
5. Julie Schoenman, Nancy Chockley, and Brigid Murphy, "Understanding the Uninsured: Tailoring Policy Solutions for Different Subpopulations," National Institute for Health Care Management, April 2008, at *http://www.nihcm.org/pdf/NIHCM-Uninsured-Final.pdf* (November 17, 2010).
6. In fact, states are already subject to a similar MOE requirement imposed as a condition of receiving the increase in federal Medicaid funds as part of the 2009 stimulus legislation, which is set to expire on June 30, 2011. This means that states cannot reduce eligibility below what it was on July 1, 2008, when the first MOE took effect.
7. Cost estimates for the Medicaid expansion according to CBO are $56 billion in FY 2015, $81 billion in FY 2016, $87 billion in FY 2017, $91 billion in FY 2018, and $97 billion in FY 2019. The CMS estimates are $63 billion in FY 2015, $79 billion in FY 2016, $72 billion in FY 2017, $76 billion in FY 2018, and $81 billion in FY 2019. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, at *http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf* (June 22, 2010); Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, at *https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf* (July 21, 2010).

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Worsening State Budget Problems and Limits on State Options. States are already required to cover children and pregnant women below 133 percent of the FPL, but they have had flexibility to cover or not cover additional populations. That flexibility vanished with the passage of PPACA. In the short term, states cannot reduce eligibility criteria at all in order to deal with budget crises, and after 2014 state Medicaid programs must cover everyone below 138 percent of the FPL.[12] Most states will be forced to either cut benefits or cut provider payment rates. This is a significant problem in many states that already have low payment rates, particularly for PCPs. Setting payment rates lower will further reduce Medicaid patients' access to providers and will increase use of emergency rooms for basic care needs.[13]

Creation of a Medicaid "Doc Fix." The federal requirement that states boost Medicaid PCP rates to Medicare levels in 2013 and 2014 seems like a win for states, since federal taxpayers will finance it. However, this requirement will actually create problems for states. The increase in Medicaid payment rates for PCPs may cause other providers to lobby government to increase their rates as well. This would increase the cost to the state. When the federal funds go away, states could reduce payment rates again, but both physicians and their patients are likely to lobby against such a move. The state also has to be concerned with too many doctors leaving the Medicaid program.

Bureaucratic Nightmare and Intergovernmental Tension. The interaction of the Medicaid expansion and the creation of federal subsidies to purchase health insurance on the new state exchanges will create headaches and tensions for policymakers at the federal and state levels. Individuals below 138 percent of the FPL will be enrolled in state Medicaid programs, while many individuals between 138 percent and 400 percent of the FPL will be eligible for subsidies. There will be a lag between income on a household's W-2 (for the prior year) and current income for eligibility purposes. It also invites a conflict of interest between state policymakers—who are incentivized for individuals to receive subsidies (so the federal government pays the full cost)—and federal policymakers, who will prefer states to share the costs through Medicaid.

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8. Medicaid patients who suffered a heart attack were significantly less likely than patients with other forms of insurance to receive important clinical interventions. 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. 1082–88.

   Medicaid patients received fewer evidence-based therapies than patients with private insurance coverage. 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. 739–48.

   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. R. R. Kelz *et al.*, "Morbidity and Mortality of Colorectal Carcinoma Surgery Differs by Insurance Status," *Cancer*, Vol. 101, Issue 10 (2004), pp. 2187–94.

   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. D. J. LaPar *et al.*, "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery*, Vol. 252, Issue 3 (2010), pp. 544–51.
9. Elmendorf, letter to Pelosi; CMS, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended."
10. Ed Haislmaier and Brian Blase, "Obamacare: Impact on States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010, at *http://www.heritage.org/Research/Reports/2010/07/Obamacare-Impact-on-States.*
11. Jonathan Gruber and Kosali Simon, "Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" *Journal of Health Economics*, Vol. 27 (2008), pp. 201–17.
12. According to Section 2001(B)(3) of PPACA, the MOE requirement does not apply to non-pregnant and nondisabled adults above 133 percent of the FPL if the state has a budget deficit.
13. For further discussion of Medicaid's impact on the health care system, see John O'Shea, M.D., "More Medicaid Means Less Quality Care," Heritage Foundation *WebMemo* No. 1402, March 21, 2007, at *http://www.heritage.org/research/reports/2007/03/more-medicaid-means-less-quality-health-care.*

A New Direction. Instead of expanding the nation's fastest-growing entitlement, policies should move toward a fundamental restructuring of the Medicaid program to ensure fiscal sustainability, promote a patient-centered financing model, mainstream families into private coverage, and maintain a limited safety net for those individuals truly in need.

The federal financing structure, which encourages states to overspend, needs to be replaced with a structure that is more fiscally sustainable. In the short term, federal policymakers should, at the very least, allow states greater flexibility with eligibility and benefits so states can better manage their programs, control their costs, and balance their priorities.

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