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Medicaid Expansion and State Health Exchanges: A Risky Proposition for the States

Nina Owcharenko and Edmund F. Haislmaier

Recent decisions by the Obama Administration concerning the health care exchanges and Medicaid expansion underscore what a risky proposition the Patient Protection and Affordable Care Act (PPACA) is for the states. Congress presumed in PPACA (Obamacare) that the states would agree to build and run exchanges and could be forced to expand Medicaid. The Supreme Court, however, ruled the Medicaid expansion voluntary, which has made states increasingly concerned over new burdens related to costs, control, and coverage—in both the exchanges and Medicaid.

State Health Care Exchanges

Cost. Proponents deflect attention from the true cost of the exchanges by focusing on the PPACA grants to fund states establishing them. However, unlike past federal-state policy ventures, like Medicaid or even the State Children's Health Insurance Program (SCHIP), there will be no steady flow of federal dollars to the states. The law specifies that starting in 2015, any state implementing a state exchange must develop its own revenue source to fund the exchange's annual operations. That puts the long-term costs squarely on the states.

Moreover, the recent announcement by the Department of Health and Human Services (HHS) that it will levy a 3.5 percent administrative fee on coverage sold through the federally run exchanges indicates there are significant costs if a state agrees to run its own exchange.[1]

Just this week a Maryland panel recommended to that state's governor and legislature new taxes and fees to fund its state exchange.[2] The Maryland report projects annual administrative costs for the state's exchange of $201 per enrollee in 2015, declining to $152 per enrollee in 2017.

In contrast, applying the 3.5 percent fee set by HHS to the $2,770 national average per-capita premium for all commercial group and individual major medical insurance sold in 2011 yields a projected annual administrative cost for exchanges of $97 per enrollee. The much higher Maryland figures are significant as they reflect thorough and detailed work by the state most committed to implementing a state Obamacare exchange.[3]

Control. Some argue that states should establish exchanges as a means to maintain control of their markets. However, in all matters not otherwise preempted by federal law, the states still regulate insurers (including those participating in the exchanges) regardless of who operates the exchange. States can also regulate exchange "navigators" through state professional licensure statutes to ensure a level playing field with existing insurance agents, regardless of who operates the exchange.

Furthermore, regulations promulgated by HHS allow states no meaningful flexibility or advantage by operating their own exchanges, relative to a federal exchange. Those states would simply be acting as vendors to HHS.

Coverage. Proponents point to the exchange as essential to expanding coverage. However, the law also created a federal default for states declining to establish exchanges. Therefore, the responsibility shifts to the federal government. With more Americans still opposed to the law than supporting it, the innumerable

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The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

technical challenges to implementation, and large and uncertain future costs, there is a significant risk that the whole law could unravel, or even collapse, before fully taking effect. Given those prospects, states that agree to run exchanges could face significant fallout from failures at the federal level over which they have no control. Instead, a state should focus on creating a viable market for their citizens in the event that the law breaks down.

Medicaid Expansion

Cost. As proponents attempt to convince states that the cost of the Medicaid expansion will be covered by the federal government, the facts remain the same. To start with, the enhanced match is only for the expansion population, not the existing Medicaid population. In addition, it does not apply to administrative costs, which add about 5 percent to benefit payments. Finally, the full 100 percent enhanced match is temporary, with states picking up 10 percent of the new costs in 2020 and thereafter. At a time when Medicaid is already overwhelming current state budgets, it would be counterproductive for states to voluntarily add to those liabilities.

In addition, there are numerous other cost pressures states need to consider when assessing the expansion.[4] First, states will see increased enrollment among the non-expansion population as the law also expands eligibility by changing how income is measured and corrals those eligible, but not enrolled, into the program.

Second, states will face pressure from their hospitals to backfill $18 billion in federal payment cuts for uncompensated care. Third, the PPACA lifts Medicaid reimbursement for primary care physicians to Medicare levels, with federal funding of the difference—but only for two years. Once the federal funding expires, states will face pressure to maintain those levels and to increase payments to other physicians accepting Medicaid.

Moreover, regardless of HHS's recent claim that it has backed away from previous proposals to shift Medicaid funding to a blended rate, the fiscal challenges facing Medicaid at the state and federal level make future financing adjustments to Medicaid unavoidable.

Control. While the HHS Secretary has touted offering flexibility to the states, the law and HHS regulations offer states no meaningful policy discretion. Specifically, the law extends the maintenance of effort (MOE) restriction from the stimulus law that prevents states from making key changes to their Medicaid programs. Moreover, the recent HHS decision to eliminate any possibility of a state expanding its Medicaid program short of the 138 percent federal poverty level (FPL) further underscores that flexibility was more talk than action.

Coverage. As with the exchanges, proponents stress the importance of Medicaid in expanding coverage. Unlike the federal default in the exchange, there is no federal default for the Medicaid expansion. However, rather than throwing more people into a broken program, states should focus on improving the current program and developing sustainable alternatives for meeting the needs of the proposed expansion population.

Fighting Back to Minimize the Damage of Bad Decisions

Sometimes opposing bad policy—such as by declining to run exchanges or expand Medicaid—while important, is not enough. In those instances, lawmakers need to work to minimize the impact of bad policies that they are unable to fully reverse. They also need to insist on transparency, accountability, and a level playing field, so as to create public awareness of the true consequences of bad policies and build support for future reforms.

Still a Risky Proposition for the States

Enormous uncertainty still surrounds the health care law. With less than one year remaining before the major provisions of Obamacare take effect, it is no surprise that barely more than one-fifth of states have publically agreed to both establish a state exchange and expand their Medicaid programs. The other states

1. *Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2014*, *Federal Register*, Vol. 77, No. 236 (December 7, 2012), pp. 73118-73218, http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf (accessed December 12, 2012).
2. Joint Committee on Maryland Health Benefit Exchange Financing, *Options for Financing the Maryland Health Benefit Exchange*, December 1, 2012, http://marylandhbe.com/wp-content/uploads/2012/12/Options-for-Financing-the-Maryland-Health-Benefit-Exchange.Joint-Committee-reportDec20121.pdf (accessed December 12, 2012).
3. Author's calculations using premium and enrollment data from Mark Farrah Associates, http://www.markfarrah.com. In 2011, U.S. commercial insurers wrote $198,334,667,140 in group and individual major medical premiums covering 71,597,719 individuals.
4. Edmund Haislmaier and Drew Gonshorowski, "State Lawmaker's Guide to Evaluating Medicaid Expansion Projections," Heritage Foundation *Issue Brief* No. 3720, September 7, 2012, http://www.heritage.org/research/reports/2012/09/state-lawmakers-guide-to-evaluating-medicaid-expansion-projections.

would be wise to decline those risky steps and instead prepare better alternatives for health care reform.

*—**Nina Owcharenko** is Director of the Center for Health Policy Studies and Preston A. Wells Jr. Fellow at The Heritage Foundation. **Edmund F. Haislmaier** is Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation.*