The Heritage Foundation
LEADERSHIP FOR AMERICA

ISSUE BRIEF

No. 3867 | MARCH 5, 2013

Why the Obamacare Medicaid Expansion Is Bad for Taxpayers and Patients

Nina Owcharenko

Medicaid needs reform, not expansion. This federal–state health care program provides health care to over 60 million Americans and consumes a growing portion of state and federal budgets. Research shows a long history of Medicaid enrollees having worse access and outcomes than privately insured individuals.[1] Due in part to low reimbursement, one in three doctors refuses to accept new Medicaid patients.[2] Despite access issues, Medicaid spending continues to grow. In 2010, total federal and state spending on Medicaid exceeded $400 billion.[3]

Instead of reforming Medicaid, the Patient Protection and Affordable Care Act (Obamacare) expands eligibility to *all* individuals earning less than 138 percent of the federal poverty level (FPL).[4] The Medicaid program is already struggling to provide care to its core obligations—a diverse group of low-income children, disabled, pregnant women, and seniors. Adding more people further exacerbates Medicaid's underlying problems.

The expansion of Medicaid fuels a larger trend under Obamacare: government coverage supplanting private coverage. By 2021, 46 percent of all Americans will be dependent on the government for their health care. Of this group, 86.9 million will be on Medicaid/Children's Health Insurance Program (CHIP), followed by 64.3 million on Medicare and 23.4 million enrolled in government exchanges.[5] This will push U.S. health care closer to a government model.

The Temptation of Medicaid Expansion. Obamacare provides additional federal funding to the states for this new expansion population. Starting in 2014, the federal government would pick up 100 percent of the benefit costs for the newly eligible population for three years. Thereafter, this enhanced federal funding would gradually decline to 90 percent in 2020.

Obamacare also directed states to expand eligibility or risk forgoing *all* of their federal Medicaid dollars. The Supreme Court, however, ruled on behalf of 26 state plaintiffs that this "all-or-nothing" proposition was coercive. To rectify this, the Court essentially made the expansion optional, meaning that a state could reject the expansion but not lose its existing Medicaid funding.

Today, governors and state legislators are weighing this option as they develop their budgets for the coming year. Proponents use a variety of unrealistic arguments in support of the Medicaid expansion:

- **It provides states with an influx of new, generous federal revenue.** This will cause states to spend money that they otherwise would not have spent. Moreover, due to the structure of Obamacare, states will likely have to absorb many currently eligible but not enrolled individuals as well as those who lose their existing employer coverage. These effects would add to the cost.[6]

- **It will result in savings as the cost of uncompensated care declines with expanded coverage.** Heritage data analysis shows that in the first few years, when federal funding is at its peak, states may see some savings. Over time, however, in the majority of

This paper, in its entirety, can be found at **http://report.heritage.org/ib3867**

Produced by the Center for Health Policy Studies

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

states, Medicaid spending will accelerate and dwarf any projected uncompensated care savings.[7] These savings are also contingent on states enacting legislation to further reduce uncompensated care funds (Disproportionate Share Hospital [DSH] payments) on top of the $18 billion of federal cuts enacted under Obamacare. Heritage analyst Ed Haislmaier predicts that "governors and state legislators should expect their state's hospitals and clinics to lobby them for more—not less—state funding to replace cuts in federal DSH payments."[8] Finally, contrary to the theory that expanding Medicaid would cause the number of uninsured to decline and reduce the need for uncompensated care, a similar expansion in Maine found the opposite effect. In Maine, uncompensated care increased, and the number of uninsured in the targeted population (those below 100 percent of FPL) saw limited change.[9]

- **Rejecting the expansion will mean that other states get more.** The federal share of Medicaid is based on a formula calculation and actual expenditures. Rejected funds do not go into a general fund for redistribution to other states. The fewer states that expand, the less the federal government spends. States that draw down on these new federal funds fuel the fiscal crisis in our country.

The Trade-Off Dilemma. Committing to an expansion creates a dilemma for the states. To control Medicaid spending, states typically fall back on predictable techniques to manage costs, such as limiting reimbursements to health care providers and limiting services, which ultimately limits access to care. These Medicaid cost controls, however, go only so far. Today, Medicaid consumes over 23 percent of state budgets, surpassing education as the largest state budget item.[10] As Medicaid spending continues to rise, other important state priorities such as education, emergency services, transportation, and criminal justice are squeezed.

Finally, if states resist balancing among spending programs, the alternative is generating more revenues with tax increases. But higher taxes come with a steep price: They reduce economic growth. With most states still experiencing anemic growth, tax increases on top of already higher taxes at the federal level are not an appealing option.[11]

Fueling the Country's Fiscal Crisis. Any positive assumptions about Medicaid expansion also assume that federal funding remains unchanged. With deficits running over $1 trillion a year, the country's fiscal future is in need of reform. Federal spending on health care

1. Kevin Dayaratna, "Studies Show Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation *Backgrounder* No. 2740, November 7, 2012, http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured.
2. Sandra L. Decker, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," Health Affairs, Vol. 31, No. 8 (August 2012), pp.1673–1679, http://content.healthaffairs.org/content/31/8/1673.abstract (accessed March 4, 2013).
3. Centers for Medicare and Medicaid Services, *2011 Actuarial Report on the Financial Outlook for Medicaid*,March 16, 2012, p. 19, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2011.pdf (accessed March 4, 2013).
4. An estimated 66 million people are below 138 percent of the federal poverty level.
5. Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2011–2021*, Table 17, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf (accessed March 4, 2013).
6. Edmund F. Haislmaier and Brian Blase, "Obamacare: Impact on the States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010, http://www.heritage.org/research/reports/2010/07/obamacare-impact-on-states.
7. Drew Gonshowroski, "Obamacare and the Medicaid Expansion: How Does Your State Fare?" The Heritage Foundation, *The Foundry*, March 5, 2013, http://blog.heritage.org/2013/03/05/obamacare-medicaid-expansion-state-by-state-charts.
8. Edmund F. Haislmaier, "Deconstructing State 'Savings' from Expanding Medicaid," Heritage Foundation *Commentary*, September 25, 2012, http://www.heritage.org/research/commentary/2012/09/deconstructing-state-savings-from-expanding-medicaid.
9. Mary Mayhew, testimony before Florida Senate Select Committee on Patient Protection and Affordable Care Act, February 11, 2013, http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2026.pdf (accessed March 4, 2013).
10. National Governors Association and National Association of State Budget Officers, "The Fiscal Survey of the States," Fall 2012, p. 26, http://www.nasbo.org/sites/default/files/Fall%202012%20Fiscal%20Survey_Final%20Version.pdf (accessed March 4, 2013).
11. J. D. Foster, "Tax Policy: Obama Is Still Wrong on Tax Rates," Heritage Foundation *Issue Brief* No. 3781, November 26, 2012, http://www.heritage.org/research/reports/2012/11/tax-policy-obama-is-still-wrong-on-tax-rates.

entitlements, including Medicare and Medicaid, is the largest driver.[12]

Even this Administration recognizes that such entitlement spending, including Medicaid, is unsustainable. The President's fiscal year (FY) 2011 budget outlined several Medicaid reform policies, including setting an across-the-board blend rate for federal reimbursement and limiting the states' ability to leverage provider taxes for the state share of matching funds. Although the Administration attempts to distance itself from its own proposal, any serious efforts toward entitlement reform must include Medicaid.

In spite of this fact, several Democrat and Republican governors that support Medicaid expansion condition their support on federal funding remaining untouched. In essence, pro-expansion governors are telling Washington, "don't touch entitlement spending." This reliance on federal revenues exacerbates the country's fiscal challenges and could also affect states' own fiscal health. Recently, Moody's cited Missouri's reliance on the federal government, including Medicaid funding, as adversely affecting its credit rating outlook.[13]

Setting Good Policy. There are several recommendations that the states and Congress could adopt to help mitigate the crisis that Obamacare has exacerbated:

- **Reject the Medicaid expansion.** Greater dependence on federal dollars tangles the states in bad fiscal policy and bad health care policy. States that reject the expansion avoid relying on unsound federal revenues, stretching an already thin program beyond its means and adding millions to a failing program.

- **Scale back existing eligibility where possible.** Some states have allowed Medicaid to grow beyond its original intent by moving middle-class families into a welfare program. To restore Medicaid as a safety-net program, states should review eligibility levels, scale back eligibility where possible, and restore the program's focus on its core Medicaid functions.

- **Advance a separate, state alternative.** Instead of using a flawed Obamacare model, states should put in place an alternative. States should develop a state solution tailored to the specific needs of this new population rather than placing them in a one-size-fits-all Medicaid option.[14] A non-Medicaid, state-based approach, especially for this targeted population, would give states the control to design policies best suited to addressing the needs of their citizens without onerous Medicaid constraints.

- **Congress should eliminate the federal enhanced Medicaid match.** To avoid the argument that states rejecting Medicaid are leaving federal dollars on the table, Congress should level the playing field by removing the new, enhanced federal dollars. This would remove/minimize the temptation of excessive and unsustainable federal funding and restore fiscal constraint at the federal level. States would still be able to expand eligibility but would have to do so with the traditional (non-enhanced) federal matching rate. If Congress ignores this opportunity to restrain federal spending, it could "block grant" the enhanced federal dollars to the states to develop their own state-specific approaches, including alternatives outside of Medicaid.

Alternate Solution Needed. Medicaid is already spread too thin. Adding a new and complex population to this program does not solve its challenges; it only makes them worse. States should resist, and Congress should remove, this temptation. Both should begin to lay out a better and more sustainable alternative than a failing government health program to care for the less fortunate.

*—**Nina Owcharenko** is Director of the Center for Health Policy Studies and Preston A. Wells, Jr., Fellow at The Heritage Foundation.*

12. "Tax Revenue Devoured by Medicare, Medicaid, and Social Security in 2045," Heritage Foundation *Federal Budget in Pictures*, http://www.heritage.org/federalbudget/entitlements-historical-tax-levels.
13. David Lieb, "Missouri Senators Cite Credit Concerns About Medicaid," *The Kansas City Star*, February 11, 2013, http://www.kansascity.com/2013/02/11/4061211/missouri-senators-cite-credit.html (accessed March 4, 2013).
14. States could adapt and modify existing frameworks, such as Healthy Indiana, as a stand-alone option. Merrill Mathews and Mark E. Litow, "Bad Medicaid Program Gets Worse Under Obamacare," *Investor's Business Daily*, February 26, 2013, http://news.investors.com/ibd-editorials-viewpoint/022613-645817-medicaid-still-out-of-control-despite-obamacare.htm (accessed March 4, 2013).