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# Medicaid Expansion

## The Economic Analysis Dilemma

by Sean Riley, Director  
Health and Human Services Task Force  
American Legislative Exchange Council

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## Executive Summary

In the multi-state lawsuit against several provisions of the Patient Protection and Affordable Care Act (PPACA), Nebraska joined the majority of states in asserting that Medicaid expansion would put states and the nation on a path towards government imposed universal coverage. Despite the U.S. Supreme Court striking down the law’s provisions as unconstitutional, it left policymakers the choice whether or not to fundamentally transform the state’s program for the most vulnerable.

Existing economic analyses of Nebraska expansion are necessarily based on a significant number of assumptions. Given the unprecedented nature of expansion, most differ on these assumptions. This variance lends a significant degree of uncertainty as to the true costs and benefits expansion might provide. Examples from states that undertook limited expansion pre-PPACA show that actual

costs significantly exceeded estimates, while neither the levels of uninsured, nor the levels of uncompensated care, were significantly reduced in the years following.<sup>1</sup> Given this limited data, and absent comparable data for full expansion, policymakers should recognize the inherent risks in relying on existing estimates as the basis for expanding Medicaid.

In the alternative, as select states move forward with expansion, invaluable data as to the costs and behaviors of the full expansion population will be revealed, benefitting those states that have maintained caution by providing more reliable data. Policymakers intent on making a decision absent such data through examining existing literature should carefully consider underlying assumptions and the basis for their expectations.

First, only incremental analysis should be considered when comparing Medicaid expansion. Such analysis provides the marginal impact of expansion, rather than comparison to the status quo. Estimates that ignore PPACA’s exchange subsidy provisions, e.g. a recent report from the UNMC Center for Health Policy, may lead policymakers to overestimate the marginal impact expansion will have.

Second, the expected participation rate of those who would be newly eligible under expansion, as well as the rate of churn between those already enrolled in private health insurance should be carefully examined. These two points will impact not only the Medicaid population, but significantly impact the overall cost of coverage for the potential expansion population, and thus the cost to both the federal government and the state.

Third, the likelihood of continued federal funding should be challenged as federal budget pressures will likely reduce Medicaid payments in the future. There have already been multiple proposals to reduce Medicaid spending since the PPACA was signed, and the most recent report from the Congressional Budget Office has health spending topping 50 percent of the federal mandatory budget in just 10 years. In response, policymakers in several states have considered language to roll back expansion in the event the federal government reneges on its promise. The risk with such an approach is that it ignores both the legal and political realities of an expansion.

On the other side of the coin—potential savings—policymakers should challenge assumptions as to the extent

savings would be realized via expansion. For a program that already comprises 16 percent of Nebraska’s budget, there are concerns as to how expanding Medicaid will alleviate those pressures, if at all. Key to many assumptions on savings is the issue of uncompensated care, and to what extent Medicaid expansion would reduce expenses for the state. Existing literature, however, suggests that Medicaid itself may be a contributor to uncompensated care. Meanwhile, elimination of state programs represents another significant share of potential savings in existing estimates. But these estimates should be more thoroughly examined through dialogue with relevant state agencies to get a clearer picture of the impact on Nebraska’s population.

Fundamentally, however, policymakers must recognize the non-economic impacts of expansion towards a government imposed universal health system. Treating expansion as a stimulus program ignores the purpose of Medicaid and the population it serves. Focusing on moving Nebraskans away from dependence towards independence should be paramount, as such a strategy similarly makes Nebraska less dependent on the same federal government it sued to protect itself and its constituents.

## Introduction

In Nebraska’s successful lawsuit against the Patient Protection and Affordable Care Act’s (PPACA) Medicaid expansion provisions, it joined 25 states in asserting that “[t]he Act converts Medicaid from a federal-State partnership to provide a safety net for the needy into a federally-imposed universal healthcare regime.”<sup>2</sup>

Accepting this argument, and the U.S. Supreme Court’s holding that expansion is optional, the state has been afforded a choice: forego expansion or convert Medicaid into a Nebraska-imposed universal healthcare system. While Nebraska has previously expanded Medicaid for children, voluntary expansion under the PPACA would represent a significant departure from the existing scope and purpose of the program.

Even if policymakers favor advancing such a regime, a thorough analysis of the benefits and costs is in order. As with any economically significant program, policymakers should challenge key assumptions within available economic analyses. For expansion specifically, these assumptions include: the basis of savings and cost

estimates, the impact of crowd-out and the woodwork effect, estimated participation rates, and the likelihood of continued funding.

In aggregate, these assumptions provide the basis of existing studies detailing the effects of Medicaid expansion. Even in isolation, however, changes in these assumptions can deliver widely varying results.

## Medicaid’s History and Mission

The legislative history of Medicaid is complex, and has been subject to numerous changes over its nearly 50 year history.<sup>3</sup> The Social Security Amendments of 1965 created both Medicare and Medicaid, establishing Title XVII and Title XIX of the Social Security Act, respectively. In Title XIX, Medicaid was established as “Grants to States for Medical Assistance Programs,”<sup>4</sup> creating a voluntary program for states to provide medical assistance to four specific groups: “families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.” Unlike Medicare, which is fully financed by the federal government and applies to Americans over age 65, Medicaid was designed as a state and federal partnership, administered at the state level with funding split between state and federal sources.

The financing mechanism in Medicaid generally operates through a federal match called the Federal Medical Assistance Percentage (FMAP). FMAP is calculated based on a state’s per capita income, with the federal government funding a larger portion of Medicaid costs in states with lower incomes relative to the national average.<sup>5</sup> At an FMAP of 50 percent, a state would receive half its Medicaid funding from the federal government, receiving \$1 from the federal government for every \$1 the state spent. When Title XIX was established, federal statute limited the FMAP to between 50 and 83 percent. The FMAP for states ranged from 50 to 65 percent in 1965. According to the Kaiser Family Foundation, the federal share of overall Medicaid spending was 57 percent in FY 2010.<sup>6</sup> Nebraska’s FMAP for FY 2013 is 55.76 percent.<sup>7</sup>

The Children Health Insurance Program (CHIP), a federal program created in 1997, extends health benefits to children in families whose incomes exceed Medicaid eligibility up to 200 percent of the federal poverty level (FPL). According to

the Nebraska Department of Health & Human Services (DHHS), CHIP in Nebraska is operated as a form “Medicaid expansion,’ meaning that CHIP, with a few exceptions ... us[es] the same delivery system, benefit package and regulations as Medicaid.”<sup>8</sup> The program receives a higher FMAP than traditional Medicaid, with a rate of 69.03 percent for FY 2013. Average enrollment in CHIP was approximately 30,000 in FY 2011.

Today, Nebraska’s Medicaid program, including CHIP, covers approximately 237,000 people, or about 12 percent of Nebraska’s population.<sup>9</sup> Total enrollment numbers are higher, but because individuals move in and out of Medicaid, average monthly enrollment is generally cited. Expenditures for Medicaid and CHIP totaled \$1.6 billion in FY 2012, accounting for roughly 16.2 percent of the state budget. The majority, 64.1 percent, of the Medicaid/CHIP population is comprised of children. The blind and disabled make up 15 percent, adults with dependent children, 13.4 percent, and the aged, 7.5 percent.

Compared to Medicaid’s original implementation, Nebraska has already significantly expanded both its Medicaid population, and the services it offers. Optional services Nebraska provides include medical and dental services, as well as substance abuse and school-based administrative services.<sup>10</sup> Likewise, eligibility thresholds in Nebraska exceed FPL levels in major categories. Despite the ability to extend Medicaid to childless adults through the waiver process, Nebraska maintained traditionally covered Medicaid groups prior to the PPACA.

## PPACA’s Medicaid Expansion Provisions

Medicaid expansion under the PPACA represents a significant departure for the program and health policy. Rather than raising eligibility thresholds for existing covered groups, or expanding services, the PPACA creates an entirely new covered group—low-income childless adults. This group will for the first time be eligible for Medicaid absent a state waiver. With Medicaid expansion, the program will shift from aiding low-income children, the aged, blind, and disabled, to a public health insurance program for all individuals below 133 percent FPL.

As Chief Justice John Roberts pointed out in the U.S. Supreme Court decision striking down expansion as unconstitutional:

[Expansion] accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.<sup>11</sup>

The PPACA’s intended mechanism to enforce this policy was to tie Medicaid expansion to existing Medicaid provisions, requiring the U.S. Department of Health & Human Services (HHS) Secretary to “notify such State agenc[ies] that further payments will not be made to the State[s] (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply.”<sup>12</sup> That is, HHS was empowered to withhold *existing* Medicaid funding from states that did not accept Medicaid expansion.

In the 7-2 U.S. Supreme Court decision finding this mechanism unconstitutional,<sup>13</sup> Chief Justice Roberts wrote, “[t]he threatened loss of over 10 percent of a State’s overall budget ... is economic dragooning that leaves the States with no real option but to acquiesce.”<sup>14</sup> The solution for the majority of the Court was to eliminate the enforcement mechanism while allowing the remaining Medicaid expansion provisions to remain. Bifurcating these two components effectively made Medicaid expansion voluntary.

The remaining provisions of the PPACA call for medical assistance to all those whose income “does not exceed 133 percent of the poverty line” and are not currently eligible for existing Medicaid programs.<sup>15</sup> As further evidence that this expansion represents a departure from previous expansions, the package of benefits for the expansion population is distinct from traditional Medicaid, requiring that assistance covers services outlined as essential health benefits in Section 1302(b) of the PPACA. In still another departure from Medicaid and CHIP, the FMAP schedule for the new population exceeds the statutory limits previously set in the Social Security Amendments of 1965.

Unlike traditional Medicaid, which allows for an FMAP between 50 and 87 percent, Medicaid expansion provisions start at 100 percent for years 2014 through 2016. In these years, the rate is not technically a match, but complete coverage. The FMAP drops to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and each year thereafter. This phase down was likely included to alleviate the shock to state budgets, as again, the provisions were previously mandatory, not voluntary. These new rates, however, apply only to the newly eligible population, that is, those not currently eligible for Medicaid. Existing FMAP rates will apply to traditional Medicaid and CHIP enrollees, including those newly enrolled if states expand.

Because the PPACA as originally written required states to expand in 2014, and did not contemplate the U.S. Supreme Court striking down the enforcement mechanism, states do not currently face a deadline to expand. Centers for Medicare & Medicaid Services Deputy Director Cindy Mann acknowledged this shortly after the U.S. Supreme Court's decision; “[a] state may choose whether and when to expand, and if a state covers the expansion group, it may decide later to drop the coverage.”<sup>16</sup> Indeed, a few states have thus far expressed interest in Medicaid expansion with the caveat that expansion will be rolled back if the federal match stops. However, for reasons discussed later in this analysis, there is serious question as to both the legal and political viability of such a strategy. Instead, policymakers should thoroughly examine the costs and benefits of expansion under the assumption that eliminating coverage after expansion is unlikely.

## **Economic Impact on Nebraska**

Several studies and estimates have been released since the PPACA's passage attempting to outline the impact Medicaid expansion will have on Nebraska, including enrollment, costs, savings, and economic impact. A study from the Kaiser Family Foundation provides state-by-state estimates of the incremental cost of Medicaid expansion, including adjustments for the estimated reduction in the level of uncompensated care. The University of Nebraska Medical Center's (UNMC) Center for Health Policy study provides cost estimates, uncompensated care estimates, and an estimate of the economic activity Medicaid expansion

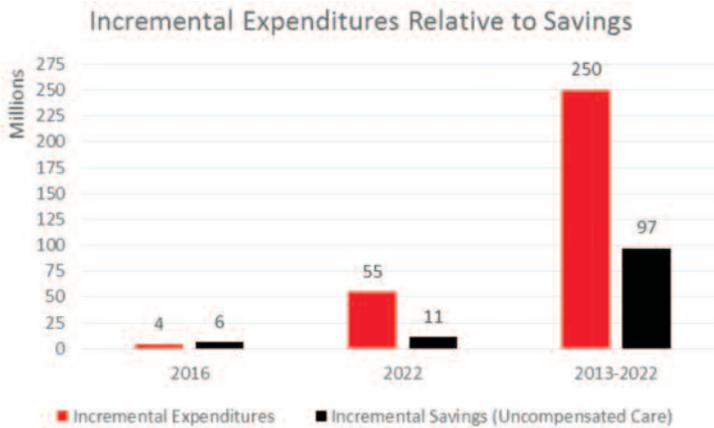
might provide. Milliman, Inc., retained by the Nebraska Department of Health and Human Services, provides enrollment and costs estimates, including savings from eliminating state programs. Nebraska's Legislative Fiscal Office (LFO) provides a fiscal estimate of the cost of expansion, including savings from elimination of state programs. Because the estimates have varying time horizons and assumptions, each will be discussed below in turn.

### **Kaiser Family Foundation/Urban Institute**

In November 2012, the Henry J. Kaiser Family Foundation and the Urban Institute released a report titled, “The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis.”<sup>17</sup> The report concludes that “by implementing the Medicaid expansion with other provisions of the ACA, states could significantly reduce the number of uninsured.” The report further concludes that “[o]verall state costs of implementing the Medicaid expansion would be modest compared to increases in federal funds, and many states are likely to see small net budget gains.” The report covers 2013 through 2022.

It is true that Medicaid expansion would reduce the number of uninsured, though other provisions of the law would reduce the number of the uninsured regardless of Medicaid expansion. As well, given the federal match, state costs of implementing Medicaid expansion are low relative to federal costs, though still significant. As to the finding that many states are likely to see small net budget gains, these results were driven primarily by 10 states. The remaining 40, including Nebraska, will instead realize net costs according to the report.

The report found that the incremental impact of expansion would cost a combined total \$3.314 billion through 2022 in Nebraska. Because of the new FMAP for expansion, \$3.063 billion of this would come from the federal government, with the remaining \$250 million being covered by the state. The report also found that Nebraska's budget would realize \$97 million in savings due to a reduction in uncompensated care. Accepting the report's estimates, the net expenditures for Medicaid expansion after accounting for uncompensated care total \$153 for the state through 2022. The report contends that savings for all states are “likely to be even greater because of other state fiscal gains,” which the study did not estimate.



As to coverage, the report found that 107,000 Nebraskans would be newly enrolled by 2022, of which 88,000 would be newly eligible. The remaining 20,000 (rounding), represents existing eligibles that will enroll by 2022.

Significantly, the report found that the majority of the reduction in the number of uninsured Nebraskans results with or without Medicaid expansion. Approximately 65,000 uninsured Nebraskans will have coverage regardless of Medicaid expansion. With expansion, an additional 49,000 uninsured would have coverage. The discrepancy between the 88,000 newly eligible and the 49,000 reduction in the uninsured is the result of two factors. First, a significant portion of the population below 133 percent FPL will be eligible for tax credits in health exchanges if Medicaid is not expanded, allowing them to purchase private insurance. Second, many that would be covered under expansion would receive employer sponsored coverage without expansion.

While this discrepancy cannot technically be characterized as crowd-out (discussed later), it implicitly reveals the report’s estimate that Medicaid expansion would place 39,000<sup>18</sup> Nebraskans in Medicaid that could otherwise attain private health insurance.

For policymakers examining the impact of Medicaid expansion, the 49,000 reduction in the number of uninsured, and the 39,000 shift from private insurance should be taken into particular consideration. The report’s incremental analysis is crucial to understanding that the number of uninsured in Nebraska will be reduced regardless of Medicaid expansion, and that expansion comes at the cost of shifting Nebraskans out of private insurance.

As to costs, the report finds that by 2022, when the Medicaid expansion is fully implemented and the

temporary increased FMAP falls to 90 percent, Nebraska will have net costs to the state of roughly \$44 million per year. This estimate includes an offset for the reduction of uncompensated care paid for by the state. Because the reduction in uncompensated care is the key driver of Nebraska realizing net savings in the early years of expansion, policymakers should carefully consider the basis of the estimate. The report applies a uniform reduction rate for uncompensated care across all states, however, as discussed below, there are several issues raised when calculating savings from uncompensated care.

### UNMC Center for Health Policy

Unlike the Kaiser report, the August 2012 report from the UNMC Center for Health Policy does not provide an incremental analysis of Medicaid expansion. This distinction is important for policymakers because without an incremental analysis, the financial impact will be overstated. Similarly, the savings from uncompensated care in the UNMC report are significantly overstated due to an error in methodology. Nonetheless, the report provides an interesting argument for using Medicaid expansion as stimulus for the state.

The study finds that “[s]pending by the federal government on Medicaid expansion would generate at least \$700 million in new economic activity every year in Nebraska, which could finance over 10,000 jobs each year through 2020.”<sup>19</sup> These estimates are based on the UNMC’s analysis of direct federal spending on Medicaid expansion and its secondary effects, and assumes a participation rate for newly eligibles between 75 and 90 percent, or between 90,021 and 108,025 individuals. Setting aside the argument that states should be viewing expansion as stimulus in the first place, policymakers should consider that these figures do not reflect the incremental impact of expansion. Without expansion, Nebraska will still realize significant inflows from the federal government, including inflows through tax credits in exchanges, as discussed above.

Accordingly, the following analysis attempts to provide an estimate for what those inflows might be:

The Congressional Budget Office (CBO) estimates that states will receive roughly \$949 billion dollars through 2023 in exchange subsidies and related spending, available to Americans between 100 and 400 percent FPL.<sup>20</sup>

Accepting the UNMC’s view that government spending creates jobs (further discussed below), the population between 100 and 138 percent FPL that will be eligible for exchange subsidies absent Medicaid expansion is critical to drawing a true comparison.

Significantly, exchange subsidies carry federal costs that are roughly 50 percent higher than expansion, according to the CBO.<sup>21</sup> In the CBO’s August 2012 report following the U.S. Supreme Court decision, it estimated the average cost of Medicaid coverage in 2022 to be \$6,000 annually, while exchange subsidies for those that would otherwise be eligible for expansion would average \$9,000.<sup>22</sup> The CBO’s updated February 2013 estimates lowered its cost of Medicaid expansion per person by 6 percent, but the \$6,000 figure will be used for simplicity.<sup>23</sup> The 50 percent differential means that if measuring marginal economic benefit under the UNMC’s standards, a state would break even by foregoing Medicaid expansion if, for every person under 100 percent FPL that would be newly eligible, the state could shift two into exchanges.

The CBO estimates support this observation, but find that the ratio will be flipped—“roughly two-thirds of the people previously estimated to become eligible for Medicaid as a result of the ACA will have income too low to qualify for exchange subsidies, and roughly one-third will have income high enough to be eligible for exchange subsidies.”<sup>24</sup> Given this ratio, states will not break even, but will still recognize a significant economic benefit under the UNMC standards even when foregoing expansion.

States that refuse expansion, therefore, will not forego all new federal spending. While the UNMC’s report provides a thoughtful analysis of Medicaid expansion revenues compared to the status quo, the status quo is not the actual alternative to foregoing Medicaid expansion. The

alternative to Medicaid expansion, instead, is making a portion of the otherwise expansion population eligible for exchange subsidies. For the population between 100 and 138 percent FPL, Nebraska would potentially be eligible to receive 50 percent more federal funding by refusing to expand than it would under expansion. While the state would forego Medicaid funding for otherwise newly eligibles below 100 percent FPL, a significant portion of that would be offset.

If the CBO’s ratio—that one-third of those who would otherwise be eligible for Medicaid expansion would be eligible for exchange subsidies—is applied, and all eligibles enroll in a private plan, approximately 40,000 Nebraskans would receive insurance through exchanges. Using the average UNMC estimate for Medicaid costs per person, adjusted by 50 percent, the direct economic impact would total \$302 million. When adjusted to include indirect economic impact per the UNMC’s ratio, the estimated economic impact exceeds \$515 million. Using the UNMC’s \$65,000 salary plus benefits proxy for job creation, 7,923 jobs could be financed.

However, because those receiving exchange subsidies in this group would still be required to spend 2 percent of their income<sup>25</sup> to purchase a private plan, not all those eligible for subsidies will likely accept them. Borrowing the UNMC’s low and high range estimates for Medicaid expansion of 75 percent and 90 percent enrollment,<sup>26</sup> the economic impact would fall in a range between \$386 and \$464 million, with between 5,942 and 7,131 jobs created. Even if only half of the uninsured exchange population between 100 and 138 percent FPL received subsidies, the total economic impact would exceed \$257 million, with 3,961 jobs created. Under any of the above scenarios, if employers drop coverage and more Nebraskans move to exchanges, the impact would be higher.

	Medicaid Expansion		No Expansion			Incremental Impact	
	75%	90%	50%	75%	90%	75%	90%
<b>Economic</b>							
Direct	\$2,878	\$3,486	\$1,059	\$1,585	\$1,901	\$1,293	\$1,585
Indirect	\$2,028	\$2,457	\$747	\$1,117	\$1,340	\$911	\$1,117
Total	\$4,906	\$5,943	\$1,806	\$2,702	\$3,241	\$2,204	\$2,702
Average per Year	\$701	\$849	\$258	\$386	\$463	\$315	\$386
<b>Employment</b>							
Jobs Financed per Year	10,770	13,044	3,961	5,942	7,131	4,828	5,913

An alternative approach to the CBO's general enrollment estimate is to use more detailed Nebraska census data. According to the latest American Community Survey data, there were roughly 70,000 adults under 65 between 100 and 137 percent of FPL in 2011.<sup>27</sup> This roughly corresponds to the population that will be eligible for exchange subsidies to purchase private insurance if Nebraska refuses Medicaid expansion. Of this group, approximately 16,600 have Medicaid or Medicare coverage, and 22,000 have employer sponsored coverage. Assuming no employers or employees drop coverage, that leaves 31,400 Nebraskans who can receive sliding scale exchange subsidies to purchase insurance. Applying the same 50-75-90 percent enrollment range as in the above analysis, the economic impact ranges from \$202 to \$303 to \$364 million, and between 3,109, 4,663, and 5,596 jobs created even when foregoing Medicaid expansion.

While the estimates in the above analysis are subject to actual enrollment and the receipt of exchange subsidies, they indicate that foregoing expansion would still have a significant positive economic impact, and that the incremental impact of expansion is less than half of the UNMC report's estimates.

Additionally, unlike Medicaid expansion, the full cost of exchange subsidies comes at no cost to the state. Exchange subsidies are 100 percent covered by the federal government beyond 2016, even when the match for Medicaid expansion begins to drop. Moreover, because exchange subsidies reduce out of pocket expenses for premiums to 2 percent for the majority of this population, and because the PPACA's insurance market regulations will likely place upward pressure on premiums, subsidies will grow over the medium- and long-term. This could be outweighed by people dropping coverage who aren't willing to direct 2 percent of their income to rising premiums, but with the federal government covering 98 percent of the cost of premiums for this population, there will be a strong incentive to maintain coverage. In either scenario, however, reliance on federal funding should carefully examined (discussed below).

Turning to the report's findings on uncompensated care—it estimates that “[w]ithout the Medicaid expansion, more than \$1 billion in uncompensated care through 2019 would be incurred in Nebraska,” and that “[w]ith the Medicaid expansion, health care providers would save at least \$163

million and as much as \$325 million from costs associated with uncompensated care.”<sup>28</sup> This conclusion is flatly incorrect.

The figures the report cites to draw this conclusion come from a previous Urban Institute study that compared spending on uncompensated care between PPACA and no PPACA scenarios, not Medicaid expansion and no Medicaid expansion.<sup>29</sup> The result is that the UNMC report vastly overstates the savings in uncompensated care that Medicaid expansion would provide. Of note, three of the authors of the Urban Institute report cited by the UNMC contributed to the subsequent Kaiser report discussed above, which found only \$97 million in savings through 2022.

The above analysis highlight the shortcoming of comparing Medicaid expansion estimates to the status quo, demonstrating that the marginal impact of expansion will be significantly lower than if looking at expansion in isolation. Additionally, the report from the UNMC overstates the reduction in uncompensated care by citing a report that made no such claims. In determining the relative economic benefit of Medicaid expansion, it is critical to compare actual alternative scenarios so as not to overestimate the marginal impact.

### **Milliman, Inc.**

The original Milliman study prepared for Nebraska's DHHS was prepared before the U.S. Supreme Court decision rendering Medicaid expansion optional.<sup>30</sup> As such, the study did not undertake an analysis of the incremental impact of Medicaid expansion. Nonetheless, the study provides various costs estimates of PPACA implementation. Through 2020, the study found that Nebraska will have expenditures totaling \$4.503 billion, with the cost to the state of \$526 million.

The estimate also included two rarely discussed economic effects that will impact Medicaid spending.

First, estimates includes the *woodwork effect*. That is, the impact of those already eligible for Medicaid, but not enrolled, who will seek enrollment due to outreach efforts surrounding expansion. This population will not receive the 100 percent FMAP, and will instead receive the existing FMAP for their population. The cost of the woodwork population is estimated at \$538.7 million through 2022.

Second, the estimates included *crowd-out*, which the study refers to as “insured switchers.” In this case, the study estimated that nearly 40,000 Nebraskans currently with health insurance will drop coverage or be dropped by employers and enroll in Medicaid as a result of expansion. This is significant, as it again highlights that Medicaid expansion is shifting its focus away from providing for the most needy, instead providing an entitlement for individuals who can attain coverage without expansion. The participation rates for these estimates ranged from 50 to 75 percent, meaning up to 75 percent of those already with coverage will switch to Medicaid. The cost of this population according to the study totals \$1.56 billion through 2020.

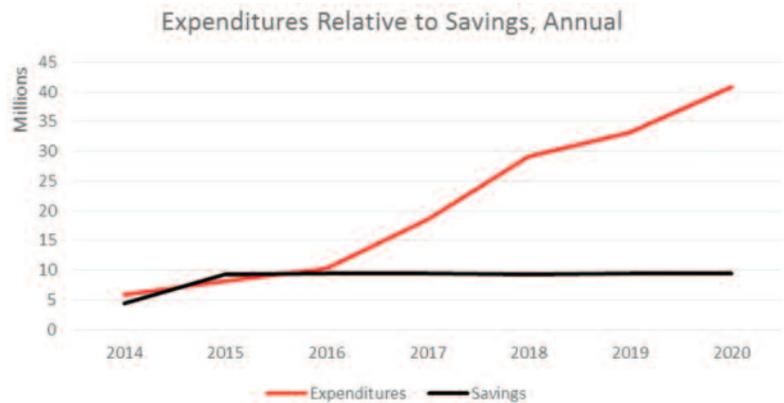
The cost of the woodwork and crowd out populations combined total \$2.09 billion through 2020. When combined with the newly eligible population, the total climbs to \$4.14 billion, with the state’s share totaling \$465.1 million through 2020.

Estimates for the crowd-out population, however, may be high. The Kaiser report estimated that only 4.2 percent of those with employer sponsored coverage would switch, while 69.2 percent with non-group coverage would switch. Applying Kaiser’s average rate—23.4 percent for all currently eligible but not enrolled—to Milliman estimates that approximately 14,970 Nebraskans with health insurance would switch to Medicaid under expansion. At this level of enrollment, about 37.4 percent of Milliman’s estimates for this group, the population would cost \$582 million compared to \$1.56 billion. This would drop the state’s share of costs down to approximately \$400.7 million through 2020, compared to \$465.1 million above.

Milliman released a revised report in January 2013 to reflect the state’s new freedom to accept or reject expansion.<sup>31</sup> It maintained its existing estimates for crowd-out, but also provided estimates as to what it called the “optional ACA provisions,” including Medicaid expansion and the associated administration costs.

In its mid-range participation scenario, with participation rates between 80 and 85 percent for newly eligibles, the report found state costs for Nebraska totaling \$148.2 million through 2020, including \$49.8 million in administrative costs. However, the state would realize significant savings by eliminating its State Disability

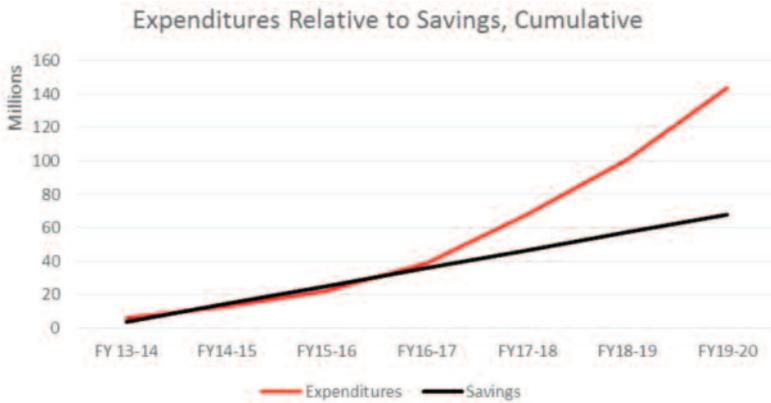
Program (SDP) and shifting that population to Medicaid. When accounting for these savings, the total incremental cost drops to roughly \$87.7 million through 2020. As discussed below, a more thorough analysis of these savings should be undertaken by policymakers.



### Legislative Fiscal Office

In February, Nebraska’s Legislative Fiscal Office (LFO) released a fiscal note accompanying legislation proposing to expand Medicaid consistent with the PPACA.<sup>32</sup> The estimates are largely based on the Milliman study, including administrative costs, IT costs, elimination of the SDP and new taxes on Medicaid. Where the LFO estimates differ, however, is in apportioning all tax increases according to the enhanced FMAP. The LFO estimate also includes savings from existing state programs providing prescription drug coverage for low-income individuals with HIV or AIDS, as they would be covered by expansion. Additionally, the estimate includes savings from extending Medicaid to inmates of correctional facilities in event they are hospitalized outside of their facility. Incorporating these savings yields an estimated cost through 2020 of \$75 million.





The vast majority of savings in both the Milliman and LFO estimates are based on eliminating the State Disability Program. The State Disability Program was established to provide financial aid and medical assistance to persons who are blind or disabled and who meet the program definition of blindness or disability but do not meet the durational requirements. It is currently 100 percent funded by the state, and available to Nebraskans under 100 percent FPL. The assumption under both estimates is that Medicaid expansion will cover this population. A previous report from Milliman<sup>33</sup> estimated that the State Disability Program will otherwise cost the state between \$830.5 million and \$10.6 million annually to temporarily cover disabled Nebraskans (the program requires Nebraskans to have been disabled for 6 months, and covers them for up to 6 months, after which they are eligible for Social Security and Medicare).

These savings represent approximately 85 percent of the savings found in the LFO analysis, and an even higher portion of savings in the Milliman revision. Nonetheless, the revised Milliman report contains a single line item for the state funding requirement for SDP. That is, the state savings from eliminating the SDP is combined with the state share of the Medicaid expansion costs for this group. As the most critical cost savings component of the LFO and Milliman estimates, policymakers should undertake a more thorough analysis of the estimated savings to the state by eliminating the State Disability Program.

**Takeaways**

The Kaiser report is valuable in that it includes an incremental analysis of Medicaid expansion rather than comparing expansion to the status quo. The report shows that 65,000 Nebraskans will receive coverage even absent

Medicaid expansion, either through exchanges or employer sponsored insurance. With Medicaid expansion, an additional 49,000 Nebraskans will receive coverage. However, expansion would also shift approximately 39,000 individuals onto Medicaid who could otherwise obtain health coverage. Kaiser estimates that expansion will have net cost of \$250 million through 2022, with potential savings of \$97 million from a reduction in uncompensated care, for a net cost of \$153 million.

The UNMC report is of more limited value compared to the Kaiser report because it lacks incremental impact analysis. Instead, the report presents estimates without accounting for spending and coverage that would exist even without expansion. The report does, however, raise the issue of Medicaid expansion as stimulus. However, because the study lacks incremental analysis, the impact is overstated. For example, the report might lead policymakers to conclude that foregoing expansion would mean foregoing the \$700 million in economic activity that the report estimates. This would be incorrect, however, because absent expansion, a significant portion of that population would be eligible for exchange subsidies at no cost to the state. Based on the calculations above, the marginal impact is less than half of the initial estimates, even assuming UNMC’s methodology is sound. Additionally, UNMC overstates savings from uncompensated care by incorrectly citing a previous Urban Institute study that compared PPACA and non-PPACA scenarios, rather than expansion and non-expansion scenarios.

The updated report from Milliman, Inc. includes incremental analysis through what it refers to as “optional ACA provisions.” Under this analysis, approximately 50,000 newly eligibles would receive Medicaid, while an additional 67,000 individuals already with coverage will switch to Medicaid. State costs through 2020, after including savings from eliminating the State Disability Program, net approximately \$87.7 million. The LFO report is substantially similar to the Milliman report, but includes additional savings from elimination of state programs for a net cost to the state of \$75 million through 2020.

The above reports highlight the degree of uncertainty inherent in estimating the fiscal costs and benefits of Medicaid expansion for a new population. Cost drivers will depend largely on enrollment, and there is little consensus between the estimates. Savings, on the other hand, rely on

estimates as to reductions in uncompensated care through the reduction in the number of uninsured, and the ability to eliminate existing state programs that might overlap with the new expansion population.

As policymakers look to these reports for guidance, understanding the rationale behind various estimates, such as uncompensated care and enrollment, and even funding, is essential to thoughtful consideration of the issue.

## Uncompensated Care

The Kaiser and UNMC reports both incorporate uncompensated care while the Milliman and LFO reports do not. The cost of uncompensated care is often used as economic justification for expansion under the argument that expansion will significantly reduce the cost of care. But the assumptions are tenuous. The Kaiser report, discussed above, states that the share is calculated as “the cost of care used by the uninsured but not paid for by the uninsured.” The estimate for uncompensated care is based on the state realizing 33 percent of savings of their 30 percent share of total uncompensated care. Backing out the total, the report’s implicit assumption is that Nebraska will provide \$979 million in total uncompensated care through 2022 compared to no expansion. It is unclear, however, as to the basis for the 33 percent savings assumption.

Because such estimates offset a significant portion of spending, and can be the basis for whether expansion is a net benefit or cost to states, it should be especially scrutinized. Indeed, a recent article in *Forbes* by Avik Roy of the Manhattan Institute points out that because reimbursements for Medicaid are generally lower than costs, Medicaid expansion can actually compound the problem of uncompensated, or as he calls it, undercompensated care.<sup>34</sup> He contends that many of those who seek undercompensated care are in fact Medicaid patients over utilizing emergency rooms.<sup>35</sup>

Roy continues that after the Massachusetts’ health care law was implemented, emergency room visits and costs rose by 7 and 17 percent, respectively. On the other hand, he points out, a report from the Kaiser Family Foundation that found that the uninsured population makes up less of a proportion of emergency room care than its proportion to the total population.<sup>36</sup>

Additionally, a 2007 working paper from Jonathan Gruber, the MIT economist who has been called the architect of the PPACA and the Massachusetts health care law,<sup>37</sup> and a co-author found preliminary results indicating that physicians, on average, earn more from the uninsured than they do from Medicaid patients.<sup>38</sup> If a portion of uncompensated care includes that provided to Medicaid patients in the form of undercompensation, expansion may increase uncompensated care in certain cases.

Given these examples, the basis for reduction estimates in uncompensated care should be further explored to better approximate the impact on Medicaid expansion.

## Crowd-Out

The discrepancy between crowd-out estimates in the Milliman and Kaiser reports raises the question of the extent to which it will actually occur. As seen in the above analysis, variations in crowd-out rates can lead to significant changes in cost estimates. Again, the term generally relates to the extent public insurance expansions reduce private insurance coverage.

In a 2008 article in the *Journal of Health Economics*, Gruber and his co-author examined CHIP as a form of public insurance expansion. The article concludes that “crowd-out” is significant, finding that “private insurance coverage is reduced by 60 percent as much public insurance rises when there are public eligibility expansions.”<sup>39</sup> The article also concludes, however, that crowd-out was only half as large when looking at individuals. That is, the CHIP program likely accelerated crowd-out because parents were more willing to drop coverage if their children were eligible for public insurance.

A 2007 report from the CBO supports Gruber’s findings:

The crowd-out of private coverage can occur through various mechanisms. For example, some parents who would have otherwise had family coverage through their employer might decline it for their children—or might decline coverage altogether—if their children are eligible for SCHIP. In addition, previously unemployed parents might be more likely to decline coverage at a new job if their children are enrolled in SCHIP.<sup>40</sup>

A more recent paper from Gruber, however, reverses his

earlier claims when looking at Massachusetts' health care law.<sup>41</sup> In that paper, Gruber found that employers in Massachusetts' offered more coverage to employees, despite the law's "incentives for employers to drop insurance." His explanation for this disparity was that employees demanded coverage to meet law's mandates, leading employers to increase coverage to meet demand.

Ultimately, the law's numerous provisions make crowd-out a difficult phenomenon to predict. Increasing premiums will also reduce the number of insured, taxes on employers will also reduce the number of uninsured, even if only slightly. To what extent those in the expansion population will forego coverage to enter Medicaid is unknown, but what we do have are conflicting examples, and conflicting estimates of the impact.

As such, because the rate of crowd-out is a key driver to enrollment, and thus federal and state costs, policymakers should critically examine the basis of these estimates.

## Entitlement Stimulus

While much of the above analysis attempts to point out considerations for policymakers when looking to estimates of the fiscal impact, it fundamentally assumes that the Medicaid expansion question should be answered by whichever scenario generates the most federal spending—this is shortsighted for several reasons.

First, maximizing federal spending should not be a state policy goal. This narrative, unfortunately, has been supported by repeated assertions from HHS Secretary Kathleen Sebelius that Medicaid expansion is a good deal for the states. While maximizing the amount of Nebraska tax dollars returned to the state may be a goal, using the expansion of an entitlement to do so is not the proper vehicle. Again, Nebraska, in fact successfully sued the federal government along with the majority of states challenging the PPACA's Medicaid expansion provisions as coercive.

Besides, even if the premise of maximizing federal spending as a means of job creation and economic stimulus is accepted Medicaid expansion does not necessarily achieve that goal. An alternative for maximizing spending would be to follow the blueprint recently laid out by the state of Arkansas,<sup>42</sup> requesting that the federal government allow the state to shift all those in the Medicaid expansion

population into exchanges, where spending is higher. Under the spending rationale, Nebraska should also then reduce income thresholds for those already enrolled down to the federal minimums, shifting as many people as possible into exchanges. While this would increase the state's share of spending when the federal match drops below 100 percent, it would maximize total spending, creating the maximum amount of jobs. But again, that is only if the goal is to expend as much money as possible, and if the UNMC's premise is accepted.

Second, treating Medicaid expansion as government stimulus is a misguided approach to health reform. As Drs. Katherine Becker and Amitabh Chandra wrote in the *New England Journal of Medicine* in June, "[o]ur ability to ensure access to expensive but beneficial treatment is hampered whenever health care policy is evaluated on the basis of jobs. Treating the health care system like a (wildly inefficient) jobs program conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price."<sup>43</sup>

Third, stimulus for government dependence begets further government dependence. Ironically, the relationship between individuals and the state with respect to entitlements is beginning to mirror the states' relationship with the federal government. Expanding entitlements funded predominantly by the federal government not only leads to dependency by individuals on the state, but by states on the federal government. This phenomenon is precisely why the majority of states sued to block Medicaid expansion—states rely on the federal government too much for Medicaid funding as it is, and the U.S. Supreme Court agreed.

Finally, federal spending through tax revenues has been found to reduce, rather than increase, the size of the economy. Chris Conover, an adjunct scholar with the Cato Institute and the American Enterprise Institute, calculates that every added dollar of federal taxes shrinks the economy by 44 cents.<sup>44</sup> He cites Christina Romer, former economic advisor to the President, and her research that tax increases used to support increased spending reduce the size of the economy by \$2 to \$3 for every new dollar raised.<sup>45</sup> He also notes that the U.S. Office of Management and Budget has historically directed federal agencies to reduce the economic benefits of federal programs by 25 percent when performing analysis.

Unfortunately, in attempting to answer the Medicaid expansion question in terms of economic impact, many states are ignoring basic economic principles and the existing leverage the federal government holds over states. Maximizing spending is not a serious attempt to reform overburdened Medicaid programs. Moreover, expanding Medicaid as a jobs program weakens the states' position, and supports the broader trend of conditional federal money, sustaining the cycle of dependence on the federal government.

## Guaranteed Funding

The unsustainable nature of health spending and federal spending generally in the U.S. is well known. In its most recent public message, the Trustees of the Social Security and Medicaid trust funds stated, “both Medicare and Social Security cannot sustain projected long-run program costs under currently scheduled financing, and legislative modifications are necessary to avoid disruptive consequences for beneficiaries and taxpayers.”<sup>46</sup>

Nonetheless, a fundamental assumption in the economic analysis of Medicaid expansion is that federal funding will be sustained. The fiscal outlook for the United States and the long term sustainability of Medicare and Medicaid challenge that assumption. HHS, however, has assured states that the funding will be there. These assurances are suspect, and because the federal government has proposed cutting funding for Medicaid, even after the PPACA was signed, should be carefully scrutinized.

The CBO's February budget outlook estimates 12 million additional people will be enrolled in Medicaid by 2022 due to the PPACA. While the CBO does not predict the number of states that will expand Medicaid, this estimate represents about 70 percent of those eligible if all states expand.<sup>47</sup> Under this assumption, federal Medicaid spending will grow from 12.36 percent of all mandatory outlays in 2012 to 15.64 percent in 2023.<sup>48</sup> At that point, coupled with exchange subsidies, health spending will represent 50.44 percent of all federal mandatory outlays in the U.S. budget. By contrast, this number stood at just 9 percent in 1967 when Medicare and Medicaid began. That continued funding for a new entitlement like Medicaid expansion will take precedent over existing programs like Medicare and Social Security is doubtful.

Perhaps not fully appreciating her role as the merchant in the “bait and switch” analogy, HHS Secretary Sebelius thought to allay concerns of reduced Medicaid funding by assuring states that, “[t]his isn't a bait and switch.”<sup>49</sup> There is no reason to question the sincerity of her claims, only her authority to make one as such. HHS has no binding authority over Congress or the Administration. Not even Congress can bind itself. Meanwhile, the current Administration won't be in office when the 100 percent federal match ends in 2017.

More importantly, the Administration's FY 2013 budget proposal included Medicaid cuts to the states, including a *blended rate* that would result in \$3.4 billion in cuts to Medicaid starting in 2017. Cuts resulting from the blended rate total \$17.9 billion by 2022.<sup>50</sup> The blended rate, according to the proposed budget would replace existing FMAP rates—including the “increased match for newly-eligible individuals and certain childless adults beginning in 2014” in the PPACA—with a single uniform rate that would effectively be lower.<sup>51</sup>

The benefits of a blended rate from the Administration's standpoint are two-fold. First, it obscures the distinction between the expansion population, including childless adults, and the existing Medicaid population focused on low-income mothers and the disabled. Second, it streamlines potential changes to the rate. That the blended rate results in \$17.9 billion in cuts implies the overall effect will be a reduction in rates. In that case, the proposed blended rate would increase the costs to states in administering Medicaid.

An analysis from the Heritage Foundation has examined how a blended rate might affect the states' share of Medicaid expansion.<sup>52</sup> Heritage's estimates for Nebraska's share of state spending under Medicaid expansion are considerably lower than those discussed above, coming in at \$156.6 million through 2022. This total, however, jumps 389 percent to \$607 million over the same period after applying the blended rate. Again, the proposal for a blended rate came after the PPACA was signed into law, even though funding was presumably guaranteed then.

The Administration has since shied away from its blended rate proposal, but concerns remain. Plans from 2011 proposed finding \$100 billion in Medicaid savings as a means to reduce the deficit.

Several policymakers have attempted to quell uneasiness about future rate changes. Governor Jan Brewer of Arizona has proposed a so-called “circuit breaker,” rolling back Medicaid expansion if the federal government drops its match below 80 percent (implicitly acknowledging that the federal government will break its promise, since the current guarantee is a match of no less than 90 percent). The usefulness of such a tactic is largely based on two key assumptions, however. First, that the political climate would allow the state to roll back expansion once it becomes an entitlement. Second, and more importantly, that the federal government would permit states to opt-out at a later time. Assurances from HHS promise both that rates won’t be cut, and that states will be able to opt-out. However, once again, HHS has no binding authority over future administrations or members of Congress. Governors and legislatures at the state level cannot bind future governors or legislatures either for that matter.

Such assurances may provide comfort, however. But for an example of the federal government blocking states from rolling back Medicaid, policymakers need look no further than the PPACA itself. Its *maintenance of effort* provisions explicitly required states to maintain Medicaid “eligibility standards, methodologies, and procedures” no more restrictive than those in effect the day the PPACA was enacted as a condition of receiving continued Medicaid funding. The provisions apply up to and until a triggering event from HHS occurs, specifically, until the Secretary of HHS deems exchanges fully operational.<sup>53</sup>

As a key assumption in economic impact analysis, policymakers should evaluate the legal, fiscal, and political sincerity of any guarantee.

## Effective Marginal Tax Rates

Beyond the financial implications to the states are the financial implications for individuals. As Paul Howard of the Manhattan Institute has pointed out, Medicaid expansion increases the *reservation wage*, that is, the wage an individual requires to make employment worthwhile. Medicaid expansion increases wage dependent benefits to 133 percent of the FPL. If a married couple without children makes \$20,879 (138 percent FPL for a person household), and the benefit of Medicaid is \$6,000 per person, as discussed above, there is an immediate incentive

to forego even a dollar in additional wages. As the couple moves above the 138 percent threshold and receives subsidies in a health exchange, they face the uncertainty of rising premiums in the individual market.

There is an argument that raising the reservation wage is beneficial to those well below 138 percent, as it allows them to earn more without triggering the loss of benefits. But nonetheless, the reservation wage is being raised.

To illustrate the real-world effects of this phenomenon, Secretary Gary Alexander of the Pennsylvania Department of Public Welfare provides the example of a single mother.<sup>54</sup> In Pennsylvania, a single mother with two children would be better off earning a gross income of \$29,000 than earning an income of \$69,000. The reason is simple. As income increases, income taxes increase while government benefits decrease. With a gross income of \$29,000, she will receive \$28,327 annually in government benefits for a total of \$57,327. With a gross income of \$69,000, her combined net income and benefits will be just \$57,045. That is, due to the combination of government benefits and marginal tax rates, her income must more than double for her to realize an economic benefit. Alexander has referred to this phenomenon as the *welfare cliff*. Unless she can jump to earning \$69,000, or is willing to risk the loss of benefits in hope of achieving a higher salary at a later date, she will see her income and benefits fall by earning any more than \$29,000 and any less than \$69,000.

Another way to look at this phenomenon is the notion of *effective marginal tax rates*. The CBO defines these rates as the portion of an additional dollar of earnings that is paid in taxes or is offset by a reduction of benefits. In Alexander’s example, the mother is effectively being taxed at over 100 percent of her income until she earns more than \$69,000. Again, while it is true that those well below 138 percent FPL may benefit from this, it is also true that increasing the reservation wage increases the number of people with high effective marginal tax rates.

The practical consequence of this, in the CBO’s view, is that “increases in marginal tax rates on earnings tend to decrease the supply of labor by inducing people already in the workforce to put in fewer hours or to be less productive.”<sup>55</sup> This is intuitive—there is a disincentive to earn more if doing so triggers a net reduction in benefits, trapping more individuals in poverty.

## The Fixed Pie Fallacy

Still, there is concern that refusing Medicaid expansion will allow the state's tax dollars to be sent to other states. The argument goes like this: if Nebraska doesn't accept Medicaid expansion, the money that would have been spent will be sent to other states. There are two key flaws with this reasoning.

First, funding for Medicaid expansion isn't a fixed amount to be distributed evenly among states that expand. Prospective funding is based on the population served, contingent on enrollment. Refusing expansion in no way increases funding other states receive.

Second, if the PPACA overall reduces federal deficits through various taxes and penalties, there would be no cause for forwarding the state's share to other states. Instead, many states can directly reduce the federal deficit by foregoing expansion. The federal government is currently operating under a \$1 trillion deficit with a national debt exceeding \$16.5 trillion.<sup>56</sup> Accepting Medicaid expansion increases the deficit and supports the current fiscal situation.

Still, states may feel that they are leaving something on the table by refusing to expand. This is true in the same way it is true for economic actors in the *tragedy of the commons*. Garrett Hardin summarized the tragedy of the commons phenomenon in the journal *Science* in 1968—acting in their own self-interest, farmers will overuse public land, the commons, for grazing. Overuse results because individual farmers realize an immediate benefit while the negative impact of overcrowding is dispersed among the entire group.<sup>57</sup>

This rationale lends to the line of reasoning that, “if we don't, they will,” and is being employed to make the economic case for Medicaid expansion. Hardin's example ends with the land, or the commons, left in ruin even though each actor was rational in their short-term decision making. This observation isn't new. Aristotle in 350 BC noted, “[f]or that which is common to the greatest number has the least care bestowed upon it.”<sup>58</sup> By analogy, states are acting like the farmers in Hardin's example. Each state expanding Medicaid in isolation may have little effect on the federal deficit. In aggregate, however, states place themselves on an unsustainable path.

## Medicaid as Efficient Health Care

In addition to the foregoing analysis, policymakers should seriously consider the health benefits of Medicaid for the uninsured. It is not enough, however, to say that because there is a benefit that therefore Medicaid should be expanded. If this was a meaningful rationale, Nebraska would have covered childless adults before passage of the PPACA. Instead, evaluating the benefits relative to costs is the task of policymakers.

Unfortunately, the evidence of Medicaid as a cost-efficient means to providing health care is unsettled. It may come as a surprise that there have been few opportunities to compare Medicaid enrollees to the uninsured while controlling for variables. The only such study that the author is aware of is an Oregon study from 2011 that analyzes one year of data from an Oregon lottery providing Medicaid.<sup>59</sup> While the study found that those on Medicaid use more health services than the uninsured, and have lower out-of-pocket expenses, discerning the health benefits based on one year of data is difficult. Though the study found self-reported claims of improved health, many of these reports came before any increase in health care utilization, that is, before the test group was even receiving health care. The study could not conclude that Medicaid led to improvements in objective health.<sup>60</sup> This is understandable due to the limited nature of the data, and future study of this population may help provide insight as to the objective health effects of Medicaid.

Yet, even if the study found objective improvements in health, which may very well be the case, it will serve only as evidence that spending large sums can improve health. That has never been a question, however. Instead, the question in this context is whether Medicaid is the best way to spend that sum to aid low-income Americans.

## Conclusion

Policymakers find themselves faced with momentous decision: whether or not to expand Medicaid under the PPACA. Expansion would create a new covered class entitled to Medicaid and would push public health policy closer towards universal coverage. In consideration of such a move, policymakers should carefully examine the relative benefits and costs.

Current cost estimates in several major studies relating to Medicaid expansion in Nebraska range from \$250 million through 2022, to \$140 through 2020. Various estimates as to savings, either through eliminating state programs or reducing uncompensated care bring these estimates down to between \$153 and \$75 million, respectively. Nonetheless, these studies leave critical questions yet to be answered, and require a thorough analysis of their underlying assumptions. Uncompensated care, crowd-out, participation rates, and savings from eliminating existing state programs can dramatically shift the analysis when taken in isolation. In aggregate, these assumptions can be the difference between net savings and net costs for the state.

While no current data exists for states that have expanded Medicaid under PPACA, existing data from states that have undertaken limited expansions pre-PPACA can provide insight. A report from the Foundation for Government Accountability examining Arizona and Maine found that actual costs significantly exceeded initial estimates, and that expansion did little to reduce the level of uninsured and uncompensated care.<sup>61</sup> Because these results run contrary to existing estimates that rely on uncompensated care as a significant contributor to savings under expansion, policymakers would be wise to look to these states as historical examples, and states that are currently expanding as future data points for undertaking a more robust analysis of the impact of expansion on the state.

Still, the framework for making the decision to proceed with, or forego, Medicaid expansion necessitates a discussion as to whether such a decision will rely solely on the fiscal consequences. The incentives that expansion towards universal coverage creates may not be in the best interest of taxpayers, the private insurance market, or even those that would be covered by expansion. In assessing the benefits, policymakers would be wise to consider not only expansion compared to no expansion, but expansion at the expense of meaningful reform.

The broader financial landscape in the U.S. makes clear that regardless of the decision, the health sector and public health in general will face tremendous challenges in the years ahead. For a program that began as a safety-net for the most vulnerable, comprising a single-digit share of federal spending, Medicaid, along with Medicare are poised to envelope an ever increasing portion of America's budget, precisely at a time when much remains in doubt.

There is no doubt, however, that it is the responsibility of policymakers to help meet these challenges. For those committed to free-enterprise, limited government, and personal responsibility, promoting competition and consumer choice provide the cornerstones of real reform. Choice requires that consumers are equipped with the information necessary to make informed decisions. Competition requires a robust market with the ability to deliver the options consumers want without being undercut by taxpayer funded alternatives. Adding regulations under the guise of consumer protections has ultimately hurt consumers by limiting choice, pricing many of them out of health care and into the safety-net. That safety-net should always be there for the most vulnerable, but it is best preserved when policymakers focus on helping people out of it, not into it.

## Author Biography

Sean Riley is Director of the Health and Human Services Task Force at the American Legislative Exchange Council. He has previously served as a Ronald Reagan Fellow with the Phoenix-based Goldwater Institute, legal extern with the U.S. Senate Committee on the Judiciary, and judicial extern with the U.S. District Court for the District of Arizona. He holds a bachelor's degree in finance and received his J.D. from the James E. Rogers College of Law at the University of Arizona. All views expressed are his own, and do not necessarily reflect the views of the American Legislative Exchange Council.

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900 South 74th Plaza  
Suite 400  
Omaha, NE 68114  
402.452.3737  
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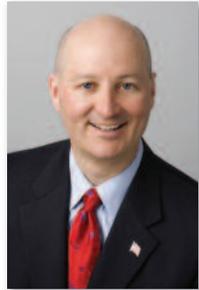
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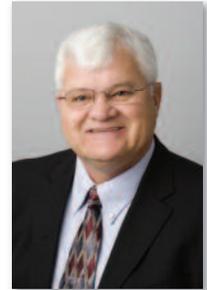
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