The WIN Act is a Loser for Nebraska

March 19, 2014

The topic of Medicaid expansion is before the Nebraska Unicameral for its first round of debate in the 2014 legislative session. Last year's proposal, introduced by Senator Kathy Campbell, failed to advance from General File after three days of contentious floor debate.[1] In past weeks, Senator Campbell has geared up for another filibuster fight on her new Medicaid expansion proposal this year. She recently submitted four technical amendments in addition to the Health & Human Services Committee's amendment, each a guarantee of additional speaking opportunities during legislative debate on the bill.[2]

The new legislation, called the "Wellness In Nebraska Act" (LB 887), is represented as a more market-based approach to Medicaid expansion because it uses health insurance premium subsidies instead of directly compensating service providers. Proponents of Senator Campbell's bill argue that expanding Medicaid is the compassionate choice. They assert that the proposal will expand access to quality healthcare for Nebraska's most vulnerable citizens. Proponents claim that LB 887 will do this while promoting personal responsibility, avoiding waste, and reducing uncompensated care at hospitals. They assert that expanding Medicaid will ultimately make Nebraskans healthier.[3]

None of these things is true.

There is nothing compassionate about crowding out traditional Medicaid patients with the working age young adults—three quarters of whom are not supporting children—who will be eligible for premium subsidies under LB 887. The Qualified Health Plans (QHPs) that will be eligible for subsidy under the act will reimburse doctors and hospitals at a higher rate than traditional Medicaid. This would incentivize care for a more able-bodied segment of the population over care for traditional Medicaid patients who are truly vulnerable, including disabled adults and children in poverty.[4]

Provisions of the bill that are held out as promoting individual responsibility by requiring individual cost-sharing will not serve as a restraint on wasteful over-utilization. Traditional Medicaid allows for states to require a nominal co-payment, but the WIN Act will not even require that, except for unnecessary emergency room visits.[5] The new program will also not include other common forms of cost-sharing, like coinsurance or deductibles. Prices for qualifying plans can vary by as much as sixty percent, but new enrollees will have no financial

incentive to choose more affordable plans over the most expensive ones. It appears at first reading that under the bill certain benefit recipients above fifty percent of the federal poverty line will be required starting in the second year to contribute up to two percent of their income to pay for their healthcare. However, this requirement will be waived if participants get an annual physical or claim financial hardship. In other states, the federal government has permitted only nominal monthly required contributions far less than what the WIN Act requests.[6] New participants above the poverty line will be asked to pay between $345 and $476 less per year than what traditional Medicaid patients can be required to contribute.[7]

As for reducing waste and the cost-shifting that results from uncompensated care, there is no reason to believe that expanding Medicaid will achieve these reductions. When Maine expanded Medicaid eligibility in 2002, uncompensated charity care continued to rise unabated.[8] Arizona hospitals saw uncompensated care costs rise by approximately nine percent per year after Medicaid expansion.[9] Contrary to the claims of advocates for expansion, Oregon's expansion was correlated with a significant increase in emergency room visits for non-emergencies that should have been treated by primary care physicians.[10] Medicaid expansion is no panacea for reducing uncompensated care or waste or promoting personal responsibility. And indeed, states that have expanded Medicaid are now experiencing buyer's remorse. After enacting Medicaid expansion legislation similar to the bill being debated by the Nebraska Legislature, one Arkansas lawmaker stated his concerns that, "we just put another layer of complexity on top of a broken system…. It was sold as free money from D.C., but it's not free, and strings are attached."[11]

Regardless of all the objections above, some advocates will assert that expanding Medicaid is the right thing for policymakers to do. They claim that the expansion is worth the costs, because it will make people healthier and reduce healthcare costs in the long run. This does not seem to be the case. In a study of Medicaid expansion in Oregon, researchers found that the expansion did promote utilization of more healthcare services and increased hospital admissions by thirty percent.[12] However, those receiving the additional services did not see measurable improvement in blood pressure, cholesterol, or glycated hemoglobin (a key metric in managing diabetes) over the course of the study.[13]

Medicaid expansion in Nebraska will cost billions of dollars in the long-run. While Nebraska state taxes will not pay for the lion's share of those costs initially, costs to the state will gradually rise as the federal match tapers down in coming years. As one of two presidentially appointed trustees tasked with oversight of Medicare has remarked, it is a "near certainty" that federal support for Medicaid will have to be reduced in the future.[14] Expanding Medicaid is bad medicine for Nebraska, and it is bad medicine that we cannot afford.

---

[1] Legislative Bill 577: "Change provisions relating to the medical assistance program." 103rd Nebraska Legislature, 1st session. 2013. [URL: http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=18187]

[2] Legislative Bill 887: "Adopt the Wellness in Nebraska Act." Nebraska Legislature. 103rd Nebraska Legislature, 2nd session. 2014. [URL: http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=21586]

[3] *See, e.g.*, the prefatory language in sections 2 and 3 of LB 887.

[4] Ingram, Jonathan and Nic Horton. "Medicaid Expansion: A Bad Prescription For Nebraska." Platte Institute. February 2014. p. 4. [URL: http://www.platteinstitute.org/library/doclib/Platte-Medicaid-Policy-Study-Final-020914.pdf]

[5] *Ibid.*, p. 4.

[6] *Ibid.*, p. 5.

[7] *Ibid*.

[8] *Ibid.*, p. 6.

[9] *Ibid.*

[10] Finkelstein, Amy; Sarah Taubman; Bill Wright; Mira Bernstein; Jonathan Gruber; Joseph P. Newhouse; Heidi Allen; Katherine Baicker; and the Oregon Health Study Group, "The Oregon Health Insurance Experiment: Evidence from the First Year." *Quarterly Journal of Economics*. Vol. 127, no. 3. August 2012.[URL: http://qje.oxfordjournals.org/content/127/3/1057]. *See also* Taubman, Sarah; Heidi Allen; Bill Wright; Katherine Baicker; Amy Finkelstein; and the Oregon Health Study Group. "Medicaid Increases Emergency Department Use: Evidence from Oregon's Health Insurance Experiment." *Science*. January 17, 2014. [URL: http://www.sciencemag.org/content/343/6168/263.full.pdf?keytype=ref&siteid=sci&ijkey=GoMYHyTTSQ4.Q]

[11] Ward, Kenric. "Arkansas to Virginia: More Medicaid brings 'buyer's remorse.'" *Watchdog.org*. February 19, 2014. [URL: http://watchdog.org/129119/arkansas-virginia-medicaid/]

[12] Finkelstein, p. 1061.

[13] Baicker, Katerhine; Sarah Taubman; Heidi Allen; Mira Bernstein; Jonathan Gruber; Joseph P. Newhouse; Eric Schneider; Bill Wright; Alan Zaslavsky; Amy Finkelstein; and the Oregon Health Study Group. "The Oregon Experiment – Effects of Medicaid on Clinical Outcomes." *New England Journal of Medicine*. Vol. 388, no. 18. May 2013. [URL: http://www.nejm.org/doi/full/10.1056/NEJMsa1212321]

[14] Ingram and Horton, p. 8.