Medicaid Expansion: A BAD PRESCRIPTION FOR NEBRASKA

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Executive Summary

After lawmakers in Arkansas and Iowa adopted a new brand of Medicaid expansion in 2013, legislators in other states—even those opposed to traditional Medicaid expansion—began considering replicating these so-called “Private Option” Medicaid expansions.

The Nebraska Legislature is currently considering one of these “alternative” plans to expand Medicaid eligibility, which it calls the Wellness in Nebraska (WIN) plan. This program sets forth numerous goals, namely that it will protect the most vulnerable, promote personal responsibility, reduce uncompensated care and provide budget stability. Unfortunately, this new proposal is unlikely to meet any of these objectives.

Rather than protecting the most vulnerable, WIN is likely to create a two-tiered system of care, prioritizing able-bodied adults over the truly needy. Rather than encouraging cost-conscious behaviors, the WIN plan, as structured, will reduce personal responsibility and cost-sharing, incentivizing enrollees to pick the most expensive options and engage in inappropriate utilization of health care services. The experiences of other states that have expanded Medicaid also highlight why it is unlikely that the WIN plan will significantly reduce uncompensated charity care. Finally, the WIN plan is designed in a way that is likely to lead to uncontrollable and unpredictable costs, not the kind of budget stability hoped for by proponents.

Rather than creating a new entitlement for able-bodied adults, Nebraska lawmakers should instead refocus their efforts on fixing the current program so that it works for patients and taxpayers. Medicaid was intended to be an affordable health care safety net for the truly vulnerable. Nebraska policymakers should focus on meeting this critical goal instead of undermining long-term reform with a short-sighted Medicaid expansion scheme.

Medicaid Expansion Overview

Under the Patient Protection and Affordable Care Act (PPACA), state policymakers may expand Medicaid eligibility to cover all individuals earning up to 138 percent of the federal poverty level. However, the U.S. Supreme Court ruled in June 2012 that they are under no obligation to do so. The decision to expand rests solely with state lawmakers.

Half of the states have flatly rejected PPACA’s Medicaid expansion. Some states, fearing pushback from expanding a system already on the brink of collapse, have proposed “alternative” ways to expand Medicaid. But these “alternatives” are simply Medicaid expansion by another name.

Arkansas is perhaps the highest-profile case of Medicaid expansion through one of these so-called alternatives. Rather than expand Medicaid through the traditional fee-for-service system, Arkansas lawmakers approved an expansion of Medicaid eligibility through what they call the “Private Option.” Under this model, the expansion population receives Medicaid benefits through plans offered on a PPACA insurance exchange. While some Nebraska officials have proposed adopting a similar plan, lawmakers should be wary: many of the promises made by supporters of this new type of Medicaid expansion have failed to materialize in Arkansas and are unlikely to occur in Nebraska or elsewhere. There is little reason to believe that trend will change.

The Wellness in Nebraska Plan

Under the Wellness in Nebraska (WIN) plan, all individuals earning up to 138 percent of the federal poverty level will be made eligible for Medicaid benefits. Individuals below the federal poverty line will receive benefits through the state’s existing fee-for-service Medicaid program, while those above the federal poverty line will receive their benefits through Qualified Health Plans (QHPs) offered on the federal health insurance exchange.

Under this proposal, those above the federal poverty line would be able to select any Silver-level QHP offered on the exchange. The Medicaid program would pay the full cost of premiums for these plans, as well as any copayments, coinsurance and deductibles due at the point of service.

Unless explicitly waived by the terms of the agreement with the Obama administration, the WIN plan must comply with all requirements of the Medicaid program that are laid out by law, regulation or policy. WIN enroll-
ees will receive all Medicaid benefits, with traditional fee-for-service Medicaid coverage for all benefits not covered by the QHPs.\footnote{7}

**Will the WIN Plan Accomplish Its Stated Goals?**

The WIN plan sets forth a number of policy goals.\footnote{8} Unfortunately, WIN is unlikely to prove successful in meeting those goals, just as the promises made in Arkansas have fallen short.\footnote{9}

**Goal #1: Promote access and continuity of coverage for Nebraska’s most vulnerable citizens**

While protecting the most vulnerable is a worthy goal, the WIN plan actually puts the truly needy at great risk. It is important to remember who actually qualifies for Nebraska’s Medicaid expansion: Nebraska’s Medicaid expansion does not cover the elderly, individuals with disabilities or even poor children—groups most frequently considered among the most vulnerable.\footnote{10} Instead, the WIN plan simply expands Medicaid eligibility to a new class of able-bodied, working-age adults.\footnote{11}

More than three-quarters of these able-bodied adults who would be covered by WIN have no dependent children.\footnote{12} Able-bodied childless adults have never been considered among the most vulnerable citizens, which explains why they have historically been ineligible for other types of taxpayer-funded welfare, including cash assistance and long-term food stamps.\footnote{13} \footnote{14} It is no surprise then that the majority of Americans oppose giving non-cash assistance, such as food stamps and Medicaid benefits, to able-bodied, working-age adults, especially those without children.\footnote{15}

Nebraska’s plan to create a new entitlement for able-bodied adults will ultimately redirect limited state and federal resources away from the truly needy, including the elderly, individuals with disabilities and poor children. Nebraska’s most vulnerable citizens are already struggling in a Medicaid safety net that is broken. Care is frequently fragmented, access to quality care is often low, and health outcomes remain poor. Rather than protecting the most vulnerable, Nebraska’s plan to expand Medicaid actually prioritizes able-bodied adults over the truly needy patients relying on the Medicaid safety net.

Adding an additional 100,000 or more individuals to the Medicaid program will inevitably make access problems even worse as it greatly increases demand, but does nothing to increase the supply of providers. Compounding the problem, the WIN plan actually creates perverse incentives for physicians to prioritize able-bodied adults over the state’s neediest citizens: because QHPs reimburse doctors and hospitals at higher rates than Nebraska’s traditional Medicaid program, providers will have large financial incentives to treat the new working-age adults in the Medicaid expansion rather than the most vulnerable already enrolled in Medicaid. As a result, the WIN plan will likely create even larger access barriers for the elderly, individuals with disabilities, and low-income children.

**Goal #2: Promote incentives to encourage personal responsibility and cost-conscious utilization of health care**

While the goals of personal responsibility and cost-conscious decision-making are good, the WIN plan does nothing to promote these goals. In fact, the WIN plan will have fewer tools to promote personal responsibility and cost-conscious decision-making than even the traditional Medicaid program.

Under traditional Medicaid, Nebraska is allowed to charge patients nominal copayments when they receive care.\footnote{16} However, under the WIN plan, patients will not even pay these nominal amounts.\footnote{17} Instead, the state will cover all copayments, coinsurance, deductibles and other out-of-pocket costs this group would otherwise pay.\footnote{18} The only copayments that could be charged under the WIN plan are nominal payments for unnecessary emergency room usage.\footnote{19}

Enrollees will also have little-to-no responsibility for paying premiums and no incentive to choose less-costly plans. The WIN plan calls for patients to choose from any Silver QHPs available on the exchange at zero cost to the patient. But the cost difference between the least expensive plans and the most expensive plans range upwards of 63 percent in some regions.\footnote{20} Enrollees are likely to pick the most expensive plans, which typically have broader provider networks, because they have no financial incentive to do otherwise.
In the first year, the WIN plan calls for absolutely no cost-sharing or out-of-pocket costs for enrollees. In year two, the plan seeks to charge enrollees above 50 percent of the federal poverty level approximately two percent of their monthly income as a monthly contribution. However, the monthly contribution will be waived for those seeking preventive care, such as annual physicals or wellness exams, or for those experiencing a hardship. The federal government has required states imposing monthly contributions to grant hardship exemptions to anyone who signs a form stating that he or she is facing a financial hardship. The federal government has also limited monthly contributions to between $5 and $10 per month, far less than the two percent of income the WIN plan requests.

The federal government has also required states to give enrollees at least a 90-day grace period to pay monthly contributions. In many cases, federal rules have made it impossible to remove an enrollee from the program, even if the enrollee has refused to pay required contributions. As such, the WIN plan’s monthly contribution provisions operate largely as mere suggestions, rather than meaningful requirements.

To make matters worse, these suggested contributions are lower than what both the traditional Medicaid program and the PPACA exchanges allow. While the Medicaid program caps cost-sharing at five percent of income, the WIN plan suggests just two percent of income be contributed. This means that individuals above the poverty line will be asked to contribute between $345 and $476 less per year than allowed under Medicaid’s nominal cost-sharing rules.

Additionally, the Medicaid expansion population will have less skin in the game under the WIN plan than if the state does not expand Medicaid. For example, if Nebraska does not expand Medicaid, a 34-year-old non-smoking individual earning just under 138 percent of the federal poverty level would pay $522 per year in premiums for the second-cheapest Silver plan. If he or she chose a more expensive Silver plan, he or she could be responsible for as much as $1,983 per year in premiums, after accounting for federal subsidies.

But if the state expanded Medicaid under the WIN plan, that individual could pick that more expensive Silver plan.
at no additional cost. Except for nominal copayments for unnecessary emergency room use, WIN plan enrollees will also pay no copayments, deductibles or other out-of-pocket costs. But if the state does not expand Medicaid, those same individuals will be responsible for out-of-pocket costs can reach between $1,850 and $2,117 per year, on top of their monthly premiums. Expanding Medicaid through the WIN plan will provide less “skin in the game” than not expanding.

It is difficult, considering these facts, to see how the Wellness in Nebraska plan will encourage personal responsibility or cost-conscious utilization. In fact, the WIN plan promotes even less personal responsibility than traditional Medicaid.

**Goal #3: “Eliminate cost shifting and substantially reduce uncompensated care”**

Supporters of WIN hope that expanding Medicaid will eliminate or greatly reduce the amount of cost-shifting that results from uncompensated care. Unfortunately, states that have already expanded Medicaid to able-bodied, childless adults provide significant and meaningful insight into this promise.

When Maine expanded Medicaid eligibility in 2002, for example, it had little effect on reducing uncompensated charity care: in 2000, charity care provided by Maine hospitals amounted to roughly $40 million per year. By 2011, uncompensated charity care costs had risen to $196 million. While Maine did make a slight adjustment in classifying charity care in 2007, the growth trends before and after the adjustment remained relatively the same.

It should then come as no surprise that Medicaid expansions have not reduced the cost shift to private insurance. In fact, the cost shift to private insurance actually increased in Arizona after it expanded Medicaid to childless adults. Arizona hospitals saw their uncompensated care costs rise by an average of 9 percent per year following expansion. An unfortunate reality is that Medicaid has created a cost-shift all of its own.

This may be explained by the fact that states that have already expanded Medicaid eligibility to childless adults

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**Figure 2: Maine’s Medicaid expansion did not reduce uncompensated charity care**

*Hospitals’ uncompensated charity care, by year (in millions)*
have also seen little change in the number of uninsured residents, while a large number of individuals shifted from private insurance to Medicaid.\textsuperscript{40} In fact, economists predict that the Medicaid expansion will mostly shift individuals from private to public insurance rather than reduce the number of those without insurance.\textsuperscript{41} Because Medicaid reimburses doctors and hospitals less than private coverage, hospitals are likely to see their revenues actually decrease for those who previously had private insurance.

Even those who receive their benefits through QHPs instead of traditional Medicaid will have little effect on the total cost uncompensated care. This group, which comprises roughly one-quarter of potential Medicaid expansion enrollees, is already eligible to purchase the exact same QHPs in the federal exchange.\textsuperscript{42-43} It is difficult to see how the same health plans serving the same eligible individuals would have a meaningful effect on uncompensated care simply by paying for plans with Medicaid funding instead of federal subsidies.

\textbf{Goal \#4: Promote health care cost containment}

While Medicaid expansion proponents hope the WIN plan will make health care costs and the budget more predictable, lawmakers should be aware that this hope is largely misplaced. Nebraska’s Medicaid expansion plan is likely to prove more expensive and create budget instability in the coming years.

Unlike Medicaid managed-care reforms, the state does not set multi-year contracts with capitated rates through the competitive bidding process under the WIN plan.\textsuperscript{44} Instead, it pays both premiums for enrollees and additional subsidies to insurers to cover deductibles, coinsurance, copayments and other out-of-pocket costs, depending on actual utilization.\textsuperscript{45} The state has no negotiating leverage with the plans and no predictability of future premium increases. In fact, the state is trading away any leverage it may have and instead tying its annual budget to the ultimate success of PPACA regulations and its insurance exchange pool.

Delivering Medicaid benefits through QHPs is also certain to prove more expensive than a traditional Medicaid expansion. First of all, QHPs pay higher reimbursement rates than Medicaid, but under the WIN plan, they will not impose the types of cost-sharing that private insurers have historically used to encourage more appropriate utilization.\textsuperscript{46} Nebraska will also provide all regular Medicaid benefits to the expansion group, so it will not be able to reduce costs by providing a more limited benefit package.\textsuperscript{47} Indeed, actuaries providing information to the Nebraska Department of Health and Human Services predict that the WIN plan will cost $1 billion more than traditional Medicaid expansion and $3.5 billion more than not expanding Medicaid at all between 2015 and 2020.\textsuperscript{48}

The Congressional Budget Office has previously estimated that QHPs will cost roughly 50 percent more than traditional Medicaid.\textsuperscript{49} Even in Arkansas, which has led the charge to expand Medicaid in this way, policymakers admit that it is a more expensive way to expand Medicaid and were only achieve budget neutrality through faulty assumptions and budget gimmicks.\textsuperscript{50} Actuaries producing estimates for the Nebraska Department of Health and Human Services predict that delivering Medicaid benefits through QHPs will cost an average of $6,192 per person in 2015, with that cost rising to $9,096 by 2020.\textsuperscript{51} But those actuaries predict a traditional Medicaid expansion would cost an average of just $3,829 per person in 2015.\textsuperscript{52}

The cost difference under this plan is likely to be even higher than expected for at least two major reasons. First, cost-sharing is lower in the WIN plan than what is allowed on the exchange. But perhaps more importantly, the WIN plan enrollees can pick the most expensive plans at no additional cost, which is not allowed on the federal exchange. In the exchange, federal subsidies are capped at the second-cheapest plan. Unlike the WIN plan, if an individual wants a more expensive option, he or she must pay the difference. But this incentive to pick lower-cost options simply don’t exist in the WIN plan.

Expanding Medicaid to able-bodied adults without children has created budget uncertainty in other states, even when using tools like capitation that are typically used in order to create more predictability. When Arizona expanded Medicaid eligibility to childless adults through capitated managed care, for example, it quickly discovered that the expansion cost four times what it had initially projected.\textsuperscript{53}

State officials expect the WIN plan’s Medicaid expansion to cost more than $3.5 billion between 2015 and 2020, with state funds quickly approaching $60 million per year and growing rapidly thereafter.\textsuperscript{54} But this assumes that the
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federal government will approve a waiver that the state’s own consultants say is not budget neutral. When granting approval for waivers, the federal government generally requires that the waiver does not cost federal taxpayers more than what they would otherwise pay, meaning Nebraska would need to prove that the WIN plan would be less expensive than a traditional Medicaid expansion. Absent that proof, the state would be responsible for any costs over and above what the traditional expansion would otherwise cost.

Even setting aside the other methodological problems which may understate the total cost of the Medicaid expansion, it appears unlikely that the federal government will be able to keep its long-term funding promises. The federal government is already facing more than $17 trillion in debt, with Medicaid and other entitlement costs expected to drive skyrocketing federal spending over the coming years.56–57

But even if the federal government manages to keep its funding promises, at least in the short-term, Nebraska lawmakers should expect the current Medicaid expansion proposal to create even more budget uncertainty.

**What happens if the federal government shifts more costs to the state?**

Medicaid expansion supporters hope that the WIN plan will expand Medicaid in a manner that “safeguards the interests of Nebraska taxpayers,” which could explain why it has included a “trigger” in case the federal government reduces Medicaid funding. Unfortunately, the trigger does very little to safeguard the interest of Nebraska taxpayers: if the federal government reneges on its funding promises, the expansion proposal merely requires that the state review the WIN plan in order to determine how to “mitigate” the cost increases.59

Lawmakers are wise to prepare for the federal government to break its Medicaid funding promises. After all, Congress has the power to arbitrarily change its enhanced funding rates at any time. The federal government’s severe and widely-known fiscal problems make it highly likely that future federal support will be reduced for Nebraska and any other state that expands Medicaid. In fact, President Obama’s last three budgets have all proposed shifting more Medicaid costs to state governments.60,61,62 These proposals have also been featured prominently in debt-ceiling and fiscal cliff negotiations. As one of the two trustees President Obama appointed to oversee Medicare recently warned, it is a “near certainty” that federal support for Medicaid will be cut in future years.63

While Nebraska lawmakers are rightly concerned about the large financial risk posed by potential cuts to future federal funding, the WIN plan’s trigger provides no protection against that risk. In fact, even if the trigger required the state to back out of the Medicaid expansion in the event that the enhanced funding is reduced, it would likely be ineffective.

Federal law classifies the expansion population as a new “mandatory population” for states that opt into the expansion.65 This authorizes the federal government to take away all federal Medicaid funds if a state were to roll back eligibility for that group. While the Supreme Court granted states the ability to forego Medicaid expansion without placing their existing Medicaid funding at risk, it did not hold that separate federal requirements on maintaining eligibility for mandatory populations would not apply after a state agrees to expand Medicaid.66–67

The federal government has said in non-binding letters that states may enter or exit Medicaid expansion as they please, but states should be wary that this non-binding promise has never been codified into law or regulation.68 This means that accepting the federal government’s enhanced matching rate could tether Nebraska to Medicaid expansion permanently, even if Congress later shifted more costs to the states.

Additionally, just as Congress lacks the power to bind the legislative authority of its successors, trigger provisions would still be subject to endorsement by a future Nebraska legislature.69 Even if they could, it is unlikely state politicians would later roll back eligibility for an entitlement, kicking hundreds of thousands of expansion enrollees off of the Medicaid program. States that have previously expanded Medicaid have had little success doing so, even when facing severe budget crises.

Even politically unpopular expansions have proven difficult to roll back. In 2007, Illinois’ disgraced former governor Rod Blagojevich expanded Medicaid eligibility to
families earning up to 400 percent of the federal poverty level without legislative approval. Even though the legislature invalidated the expansion and Blagojevich received a court-ordered injunction to halt the expansion, lawmakers were not able to successfully roll back the expansion until 2013, when the program faced a $2.7 billion budget deficit.

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Conclusion

Medicaid is already failing patients and taxpayers. Expanding Medicaid through the Wellness in Nebraska plan will only exacerbate the existing dysfunction. WIN is unlikely to meet its state goals and may in fact have the opposite effect. Rather than protecting the most vulnerable, the plan is likely to create a two-tiered system of care, prioritizing able-bodied adults over the truly needy. Rather than encouraging cost-conscious behaviors, the WIN plan is structured to reduce personal responsibility and cost-sharing, incentivizing enrollees to pick the most expensive options and engage in inappropriate utilization of health care services. The experiences of other states that have expanded Medicaid also highlight why it is unlikely that the WIN plan will significantly reduce uncompensated charity care. Finally, the WIN plan is designed in a way that is likely to lead to uncontrolable and unpredictable costs, not the kind of budget stability hoped for by proponents.

Rather than creating a new entitlement for able-bodied adults, Nebraska lawmakers should instead refocus their efforts on fixing the current program so that it works for patients and taxpayers. Medicaid was intended to be an affordable health care safety net for the truly vulnerable. Nebraska policymakers should focus on meeting this critical goal of long-term solutions instead of undermining it with a short-sighted Medicaid expansion scheme.

Endnotes

4 Ibid.
5 Ibid.
6 Ibid.
7 Ibid.
8 Ibid.
11 Ibid.
18 Ibid.
19 Ibid.
Authors’ calculations based upon the least and most expensive Silver QHPs in each region for non-smoking adults.


Ibid.

Ibid.

Iowa received approval to charge monthly contributions in a similar manner, but the special terms and conditions of the waiver require the state to grant hardship exemptions to “any member who self-at test to a financial hardship” and requires the state to provide an opportunity to attest to this hardship with each invoice. See, e.g., Centers for Medicare and Medicaid Services, Centers for Medicare and Medicaid Services, “Special terms and conditions: 11-W-00288/5,” U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf.


For individuals above 100 percent of the federal poverty level in Iowa’s approved waiver, enrollees must be given a 90-day grace period before being disenrolled from the program for failure to pay monthly contributions. See, e.g., Centers for Medicare and Medicaid Services, “Special terms and conditions: 11-W-00288/5,” U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf.

Individuals below 50 percent of the federal poverty level in Iowa’s approved waiver may pay no monthly and individuals between 50 percent and 100 percent of the federal poverty level cannot be disenrolled from Medicaid for failure to pay monthly contributions. See, e.g., Iowa Medicaid Enterprise, “Iowa Health and Wellness Plan waiver approval: Frequently asked questions,” Iowa Department of Human Services (2014), http://www.dhs.state.ia.us/uploads/IHAWP_WaiverApproval_FAQ_01022014.pdf.

Ibid.

Authors’ calculations based upon the difference between an annual contribution equal to two percent of income and a cost-sharing maximum of five percent of income for individuals between 100 percent and 138 percent of the federal poverty level.

Authors’ calculations based upon an individual earning just below 138 percent of the federal poverty level. The applicable taxpayer percentage is capped at roughly 3.3 percent of household income for the second-cheapest Silver plan.

Authors’ calculations based upon an individual earning just below 138 percent of the federal poverty level. The applicable taxpayer percentage is capped at roughly 3.3 percent of household income for the second-cheapest Silver plan, but the subsidy only equals the difference between the applicable taxpayer percentage and the cost of the second-cheapest Silver plan. Individuals selecting more expensive plans must make up the difference.


Individuals between 100 percent and 150 percent of the federal poverty level qualify for cost-sharing reductions to bring Silver plans up to an actuarial value of 94 percent, which lower their deductible and total overall out-of-pocket costs. This means that, on average, the plan will pay 94 percent of qualified medical expenses, although individuals may pay more or less than the average in a given year. Out-of-pocket maximums for Silver plans with cost-sharing reductions for this group in Nebraska range up to $1,850 in 2014. The statute caps total out-of-pocket spending for this group at $2,117 per year. See, e.g., Bernadette Fernandez and Thomas Gabe, “Health insurance premium credits in the Patient Protection and Affordable Care Act,” Congressional Research Service (2013), http://dl.dropboxusercontent.com/s/bxchpmv4gience9/R41137.pdf.


Ibid.

Between 2000 and 2006, charity care grew by an average of 16 percent per year. Between 2007 and 2011, charity care grew by an average of 15 percent per year.


Ibid.


Ibid.

Ibid.

Ibid.

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51 Authors’ calculations based upon the cost of individuals between 100 percent and 138 percent of the federal poverty level receiving benefits through the WIN plan’s “marketplace coverage” option. See, e.g., Milliman, “Nebraska ACA fiscal impact estimate: Updated to reflect Legislative Bill 887,” Nebraska Department of Health and Human Services (2014), http://dhhs.ne.gov/medicaid/Documents/AffordableCareActFiscal%20Analysis%20DRAFTJan2014.pdf.

52 Authors’ calculations based upon the cost of uninsured individuals between 100 percent and 138 percent of the federal poverty level receiving benefits under the Medicaid state plan. See, e.g., ibid.


55 One of the biggest methodological flaws in the state’s estimates is the assumption that childless adults will be significantly less expensive to cover than low-income parents. This is particularly worrisome, given the fact that the childless adults have been much more expensive to cover than parents in states that have already implemented the Medicaid expansion. See, e.g., Jonathan Ingram, “Medicaid expansion: We already know how the story ends,” Foundation for Government Accountability (2013), http://uncoverobamacare.com/wp-content/uploads/2013/10/Medicaid-Expansion-UncoverObamaCare.pdf.


59 Ibid.


63 In the proposal offered during debt ceiling negotiations, President Obama proposed limiting federal reimbursement for durable medical equipment spending to reimbursement rates in the Medicare program, limiting states’ use of provider taxes to pay for their share of Medicaid spending and reducing the FMAP rate through a “blended” matching rate. See, e.g., Jacob J. Lew et al., “Living within our means and investing in the future: The President’s plan for economic growth and deficit reduction,” Office of Management and Budget (2011), http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.


67 The Supreme Court’s decision rested in large part on the fact that states could not foresee PPACA’s changes to federal rules when agreeing to participate in Medicaid. States will have a difficult time arguing that it could not foresee the federal government reducing future funding for the Medicaid expansion, especially when the Supreme Court itself explicitly recognized this possibility.


71 Ibid.


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