



The **UN**Affordable Care Act

Why Medicaid Expansion is Bad Medicine for South Carolina

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Table of Contents

Foreword from Our Founding Chair	iii
Setting the Stage: The Who, What and Why of Medicaid Expansion	1
Question 1: What is Medicaid’s purpose & current status in South Carolina?	3
Question 2: Is there a sufficient social safety net without expansion?	4
Question 3: How would expansion impact current Medicaid recipients?	5
Question 4: Medicaid or Emergency Room: the only two options?	5
Question 5: What is expansion’s long-term budgetary impact?	6
Question 6: Would expansion impact education, infrastructure and other spending?	7
Question 7: What is the true impact of expansion on jobs?	8
Question 8: Will South Carolina “lose money” if we don’t expand?	9
Question 9: Could South Carolina expand and then change its mind?	9
Question 10: What could we expect based on other state expansions?	10
Conclusion: What are we buying?	11
Founding Focus: Competitive Federalism in action	11
Policy Opportunity: Measuring results, not inputs	11
Endnotes	12

Foreword

Medicaid expansion wrong for South Carolina

by Jim DeMint

“For every problem,” H.L. Mencken wrote, “there is a solution which is simple, clean and wrong.” Enter Obamacare and one of the main ways that it purports to reduce the number of uninsured: putting more people on Medicaid.

S.C. legislators are being pressured to do just that. The House has rejected the idea, and Gov. Nikki Haley has vowed to veto it, but it’s not dead. And if they ultimately sign on to the idea, they’ll find they’ve made a costly mistake and created a long-term fiscal problem. Specifically, some in the Legislature want to expand Medicaid eligibility to more adults during the three years the federal government covers the expansion population.

But this allegedly good deal will only bring turmoil to the state’s budget in the future. For one thing, Medicaid expansion is not “catch and release” for the states. Once such an expansion has occurred, it is politically difficult if not impossible to roll back enrollment. It becomes a permanent entitlement — and one that is completely unaffordable. If South Carolina expands Medicaid, taxpayers would be on the hook for millions. According to our research at The Heritage Foundation, the expansion would begin costing the state just four years from now and would cost \$612 million over the next 10 years — outstripping any purported “savings.”

Already Medicaid is consuming a greater share of the state budget. Expanding Medicaid will make it even larger and harder to pay for other state priorities, including schools and roads, in the future. This also assumes that federal funding for the Medicaid expansion goes unchanged. Right now, Washington is struggling to get the country’s fiscal house in order. Any serious efforts to address this crisis would have to address real entitlement reform, including Medicaid.

Although administration officials say Medicaid is off the table, it was just last year that the president’s own budget proposed changing Medicaid financing. So these promises are good only until the president needs money to pay for his many other spending priorities. But affordability isn’t the only issue. Extending coverage via Medicaid doesn’t mean that individuals will, in fact, gain access to the health care they need. Already, it is becoming harder to find a doctor who will accept a new Medicaid patient, primarily due to lower payment rates.

Obamacare tries to temporarily raise Medicaid payment rates for some doctors. But here too it leaves the state holding the bag and ignores the reality that you can’t add millions of people on to a program where there are fewer doctors to see them. Not only will new and existing patients have a harder time finding a doctor, but the doctors will have less time to spend with each patient. The expansion of Medicaid also will displace private insurance and shift more of the cost of health care to the few who still have private insurance.

Who suffers the most if this happens? The needy, of course, including children. Medicaid doesn’t pay for many procedures, and physicians are only able to manage because of their non-Medicaid patients. If more people are dumped into the program, that lack of compensation will only worsen, and the doctors will be forced to do more for even less.

A massive expansion of Medicaid will not meet the needs of those it is intended to reach and will only further exacerbate the challenges of delivering quality care to those currently on it. Medicaid needs reform, not expansion. These reforms can start now with states, like South Carolina, working to develop their own solution for addressing the needs of the uninsured. Ideas that don’t depend on approval or more financing from the federal government.

But as the Hippocratic Oath says, “First do no harm.” S.C. legislators can honor that dictum by not expanding our Medicaid program.

Former United States Senator Jim DeMint is President of The Heritage Foundation in Washington, DC and Honorary Founding Chair of Palmetto Promise Institute in Columbia.





“If we don't get control over costs, then it is going to be very difficult for us to expand coverage. These two things have to go hand in hand. Another way of putting it is we can't simply put more people into a broken system that doesn't work.”

— President Barack Obama
The White House, June 2, 2009

SETTING THE STAGE: THE WHO, WHAT AND WHY OF MEDICAID EXPANSION

How did we get here?

President Obama and his allies inside and outside of Congress who led the fight for the Affordable Care Act (ACA) cited the reduction in the number of uninsured Americans as a major goal of the law. A key strategy in the ACA for reducing the uninsured population was to expand Medicaid, government sponsored insurance for the poor. In the form the law passed Congress on March 23, 2010, the ACA required that “individuals under 65 years of age with income below 133 percent of the federal poverty level (FPL) ... be eligible for Medicaid” beginning in January of 2014.¹

The law also included a new method for calculating each person or family's eligibility, disregarding the first 5% of income, so the effective percentage of federal poverty under the law actually became 138%. For a single person, 138% of the 2013 Federal Poverty Level is an income of \$15,856 per year. For a family of four, the income limit is \$32,499.²

In order to ensure compliance by the states, the ACA conditioned all federal Medicaid funding on a state's acceptance of this ACA Medicaid expansion.³ There is no denying that for the authors and promoters of the ACA, the link between ACA's ultimate goals and an expansion of Medicaid were inseparable.

That all changed on June 28, 2012, when the Supreme Court of the United States found parts of ACA unconstitutional, holding that the federal government may not penalize “States that choose not to participate in [the Medicaid expansion] by taking away their existing Medicaid funding.”⁴

As a result, South Carolina now has the option to expand Medicaid under the ACA, but is not forced to do so.⁵ There is currently no deadline for expansion.

Who supports expansion?

Hospitals have been the most vocal advocates for Medicaid expansion. An understanding of their position is

important if policymakers are to make an informed decision about expansion. For that, some background is in order.

In November 2009, when the ACA first passed the U.S. House of Representatives, the American Hospital Association (AHA) thought the ACA could prove too expensive for states to be able to put up a match, saying:

*“We [also] are concerned about expanding eligibility for Medicaid to 150 percent of the federal poverty level at a time when states are struggling with severe budget shortfalls.”*⁶

But now, in 2013, the AHA says expansion is not only affordable, but essential for states. What changed?

The shift of the hospitals in favor of Medicaid expansion corresponds directly to what the AHA itself termed the “grand bargain” in its amicus brief to the U.S. Supreme Court,⁷ where it asked that mandatory Med-

icaid expansion not be separated from other ACA provisions. This “grand bargain” was the agreement by the hospital industry with Democratic Congressional leaders and the Obama Administration to absorb cuts in the Disproportionate Share Hospital (DSH) payments they receive for caring for the indigent in exchange for the increased revenue they would receive under the mandated state expansion of Medicaid as well as their public support for passing the ACA.

But the U.S. Supreme Court decision upset the applecart when it found the forced Medicaid expansion under the “grand bargain” unconstitutional. So as it turns out, the bargain was not so grand for hospitals, but it certainly was expensive, with national hospital interests spending \$18.67 million on federal lobbying in 2009, the year the bargain was reached.⁸ In fact, according to a special report in *Time* magazine’s March 4, 2013 edition, “Bitter Pill: Why Medical Bills are Killing Us,” “the healthcare industrial complex spends more than three times what the military industrial complex spends in Washington,” and “the bills they churn out dominate that nation’s economy and put demands on taxpayers to a degree unequalled anywhere else on earth.”⁹

But was this “grand bargain” even

necessary? Are hospitals going broke because of the Emergency Medical Treatment and Labor Act of 1986 that requires them to provide emergency care for all, regardless of health insurance status or ability to pay? National and state data are instructive.

For South Carolina hospitals specifically, FIGURE 1 shows a striking divide between the “haves” and the “have-nots.” For 2008-2011, twelve (12) large urban hospitals made nearly \$1.4 billion in combined profits while eighteen (18) small rural hospitals lost \$24.3 million.¹⁰ Much of this difference is due to the high level of Uncompensated Care (UCC) in rural hospitals.

Federal Disproportionate Share (DSH) payments cover part of this UCC loss. (It is DSH that the Obama administration planned to reduce in return for expanding Medicaid enrollment in the “grand bargain”). This year, DSH payments will amount to

\$461.5 million,¹¹ covering about half of the total cost of UCC in SC, and the 2014 budget passed by the SC House guarantees struggling rural hospitals a 100% reimbursement for UCC.¹²

As this article goes to press, the Obama Administration’s 2014 fiscal year budget was just released, showing a delay in reduced DSH payments until at least 2015.¹³ Because South Carolina does not spend its total allotment of DSH, depending on the formula set by the federal Secretary of HHS, proposed cuts may not actually hit in the Palmetto State until 2017.¹⁴ Some health analysts even suggest DSH cuts will never happen. Congress already annually delays cuts to Medicare reimbursement rates to doctors that are supposed to be tied to economic growth in an annual ritual known as “the doc fix.” Absent real health reform, delaying DSH cuts is likely to become another pro forma yearly exercise in stopping federal cuts in reimbursement rates.¹⁵



FIGURE 1: Profit/Loss Comparison of SC Hospitals, 2008-2011

(Source: SCDHHS/AP)

QUESTION 1: What is Medicaid's purpose and current status in South Carolina?

Begun in 1965, the Medicaid program was created as part of the Great Society social safety net, as a federal-state partnership to pay for medical and nursing home care for the poor.

Recent years have seen a surge in Medicaid spending. From 1980-2010, inflation-adjusted Medicaid spending in South Carolina has increased 646% to over \$5 billion annually. At the same time, the number of Medicaid recipients in the Palmetto State has increased more than 244%, from 277,000 in 1980 to 953,317 in 2010.¹⁶

Much of this growth in Medicaid has been in the last 10 years. FIGURE 2 shows that from 2001 to 2010 the number of Medicaid recipients increased 27% in South Carolina, and 41% nationwide. At the same time, inflation-adjusted spending on Medicaid increased 37% in South Carolina and 27% in the nation.¹⁷

In 2011, approximately 70 million Americans received some level of Medicaid assistance, the total nationwide cost of which was approximately \$412 billion.¹⁸

As for the current status of Medicaid in South Carolina, for FY 2013,

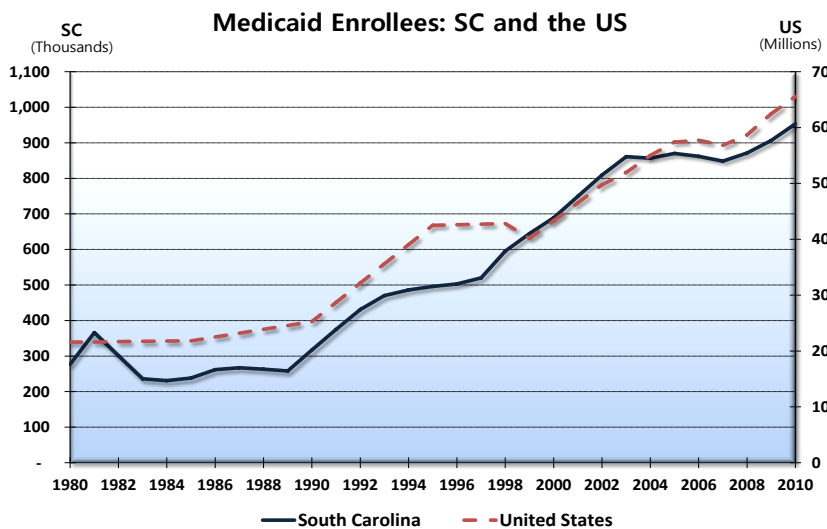


FIGURE 2

(Source: SC Cultural Indicators)

this one program already represents about 17% of state General funds and 26% of the total state budget.¹⁹ Even without expansion, FIGURE 3 shows that Medicaid is already projected to grow dramatically both in number of participants and required funding. On its current trajectory, SC Medicaid will grow by 8.9% next fiscal year, FY 2014. This will re-

quire an additional \$123 million in state funds. Almost 200,000 more people are projected to enroll in Medicaid next fiscal year, even without ACA's optional expansion. Through the year 2020, the state's current Medicaid program will need an additional \$2.4 billion in state funds.²⁰ Estimates show that from FY 2007 to

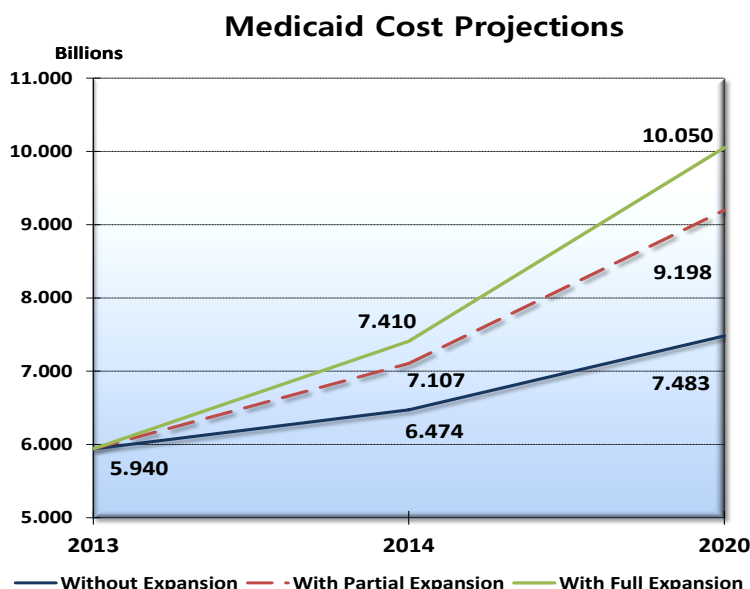


FIGURE 3 (Source: SCDHHS, Milliman)



FY 2014, without expanding eligibility, Medicaid expenditures will have grown 38% and be the largest single driver of growth in state spending.²¹

QUESTION 2: Is there a sufficient social safety net without expansion?

Medicaid was created to be a social welfare program for those who could not help themselves, not as a catch-all insurance program for able-bodied adults. So an important question in evaluating expansion is determining whether Medicaid is performing its intended core function. What is its growth trajectory given the current population it is serving? Is the medical safety net that Medicaid and affiliated programs provides sufficiently large in South Carolina, and is it expanding or contracting? According to the SC Department of Health & Human Services (SC-DHHS), approximately 22% of South Carolinians are enrolled in Medicaid. Medicaid pays for more than 50% of South Carolina births, covers 40% of the state's children, contracts with 82% of the state's nursing homes, and pays for 70% of the people in those facilities.²²

South Carolinians at triple the federal poverty level are covered for Longterm Care & Disability, Children at double the poverty rate are

covered, Pregnant Women and Infants at 185% of the poverty rate are covered, and the Aged, Blind, and Disabled right at the poverty line (100%) are covered. Low Income Parents are covered if the family income is half the poverty level.

By way of comparison, the lowest level of coverage for Children in America is North Dakota at only 160% with a number of states covering Pregnant Women at only 133%. South Carolina's current safety net put us in the middle to upper half of all states, with only eighteen states & D.C. covering more Low Income Families, and only twenty six states with D.C. covering more Able-Bodied Childless Adults.²³

This is a significant net.

If Medicaid were to be expanded in South Carolina as essentially a new government-controlled insurance program, new potential enrollees would be: 1) Low Income Parents or caregivers with incomes up to 138% of the federal poverty level who have children who are already eligible for Medicaid,²⁴ and 2) non-elderly, Able-Bodied Childless Adults with incomes up to 138% of the federal poverty level.

Though expansion to these populations was part and parcel of the ACA, it represents a significant shift in

Medicaid's traditional focus. Before ACA, "Medicaid coverage could only be extended to able-bodied adults without dependent children as part of a demonstration waiver program."²⁵ Coverage of able-bodied adults was not allowed due to the assumption that the able-bodied could earn income to cover their healthcare costs. South Carolina Medicaid has not covered childless adults previously.

Under the proposed expansion, of those newly eligible for Medicaid, the Urban Institute estimates that in South Carolina 85% would be able-bodied, childless adults, and 85% would be residents between 19 and 54 years old.²⁶

Not expanding Medicaid would in no way leave *millions* of needy South Carolinians behind. There will be a growth of Medicaid enrollees under current eligibility standards through what has been termed a "woodwork effect," meaning that as Medicaid expands nationally, individuals and families who qualify already but have not yet signed up will come out of the woodwork to enroll.²⁷

Additionally, SCDHHS estimates that a full 71% (521,000) of SC's 731,000 uninsured will gain new access to subsidized insurance through the newly created federal exchanges, or through enrollment of those who



are currently Medicaid eligible but not enrolled. 95% of South Carolinians will have access to Medicaid or subsidized private health insurance coverage – *all without ACA's optional Medicaid expansion.*²⁸

QUESTION 3: How would expansion impact current Medicaid recipients?

Clearly those who are currently on Medicaid should be our priority as a state: children, the elderly, the poorest of the poor. But there is nothing in ACA Medicaid expansion for children, the disabled, or the elderly. Expanding Medicaid to the able-bodied adults would leave existing recipients competing with an influx of new Medicaid patients for scarce doctors' appointments and procedures. A growing number of physicians are refusing to see Medicaid patients or are limiting the number of patients they see already. Patients turned away from crowded doctors' offices would have no place to go but to even more over-extended hospital Emergency Rooms. Expanded Medicaid equals more ER visits.

This backlash was experienced in Massachusetts, where the percentage of insured increased only 5 percent (from 89% to 94%) from 2006 to 2010. According to Kaiser:

*"As more residents enroll in insurance coverage, the demand for health care---particularly in underserved communities---has increased. Safety net providers such as community health centers and safety net hospitals experienced a 12% increase in patient volume from 2009 to 2010---with almost 100,000 more visits to safety net hospitals during that time. Visits to community health centers rose by 50,000 between 2008 and 2010."*²⁹

Imagine the cost shift and provider shortage should rolls be expanded by as much as 18% in South Carolina.³⁰

The dominoes drop from there: because hospitals are paid less for Medicaid patients, they raise prices on those with private insurance, driving up private insurance rates, which in turn increases the cost to South Carolina businesses to hire and maintain employees. In fact, the average American family with private insurance is already paying \$1,512 extra to cover the cost shifting resulting from Medicaid underpayments.³¹

And quality of outcomes will continue to suffer. A number of medical studies are now showing that Medicaid patients fare worse than the uninsured for cancer, heart disease, and pulmonary issues.³² It can be reason-

ably expected that the crowding out effect of expansion will cause primary care to deteriorate even further.

QUESTION 4: Medicaid or Emergency Room: the only two options?

Absolutely not. In a recent interview with Stateline, North Carolina's new Medicaid director, Carol Steckel, succinctly addressed this point:

"...there are other alternatives besides the emergency room that low income people can go to without a Medicaid card. They're called federally qualified health centers. They're called rural health centers and they have billions of dollars that are put into their systems to do a sliding-scale fee schedule, and they are primary care focused."

*More outreach is needed. People need to be talking about it. Right now, all they're talking about is Medicaid or emergency rooms like there's nothing in between. Well there is this whole system in between. That doesn't even include free clinics that are out there and state health departments. That gets back to the frustration over the one-size-fits-all approach of (federal) health care reform. They (Congress) didn't seem to recognize or build on the systems that were there."*³³

Our neighbor to the north has it right. And in fact, South Carolina has more of these alternatives to the emergency rooms per capita than North Carolina.

South Carolina has 20 Federally Qualified Health Centers (FQHC), and 157 service delivery sites operated by federally-funded Federally Qualified Health Centers that served 312,135 patients in 2010 according to Kaiser.³⁴ The ACA is slated to spend \$11 billion over the next five years nationwide to expand these types of community health centers. And this does not include the many other safety net programs for the uninsured, like Rural Health Clinics, County Clinics and Free Clinics. South Carolina has 40 free clinics of varying age, from 3 which have been around for 25 years

to a new, full-service, faith-based clinic that opened in March, 2013.³⁵

QUESTION 5: What is expansion's long-term budgetary impact?

Estimates on the liability to South Carolina differ, but analysts agree that the numbers are staggering.³⁶ The figures that have been widely accepted in South Carolina are those developed for SCDHHS by the healthcare actuarial firm Milliman (and illustrated in FIGURE 4). These estimates project a growth from 1 million recipients in 2013 to 1.7 million enrollees in 2020 with Medicaid expansion and anywhere from 1 million to nearly 1.3 million enrollees without Medicaid expansion. The natural growth in Med-

icaid will come from over 100,000 people dropping private insurance to enroll in Medicaid and an additional 62,000 currently eligible but not yet enrolled for a total of 162,000.³⁷

It has been widely touted that the federal government will pay the entire cost (of *services* not administrative costs) for those who are newly eligible from 2014 to 2016. After that, Washington has promised to pay 95% in 2017 and reduce its contribution to 90% by 2020.³⁸

Paying no more than 10% to expand health coverage for South Carolinians may sound like a good deal, and the offer of “free money” is always politically enticing. Unfortunately, the revenue necessary to pay for this 10% will be hard to find in South Carolina's current budget. If SC expands Medicaid under ACA, this could cost the state a total of anywhere from \$613 million to \$1.9 billion in state funds from 2014 to 2020, assuming the federal government continues to borrow or print the money to cover their full share. SCDHHS/Milliman estimates total costs to exceed \$11 billion for the entire South Carolina Medicaid program for FY 2020 (SC would require about \$3 billion in state funds to use as Medicaid match in 2020.)³⁹

Even more troubling is what could

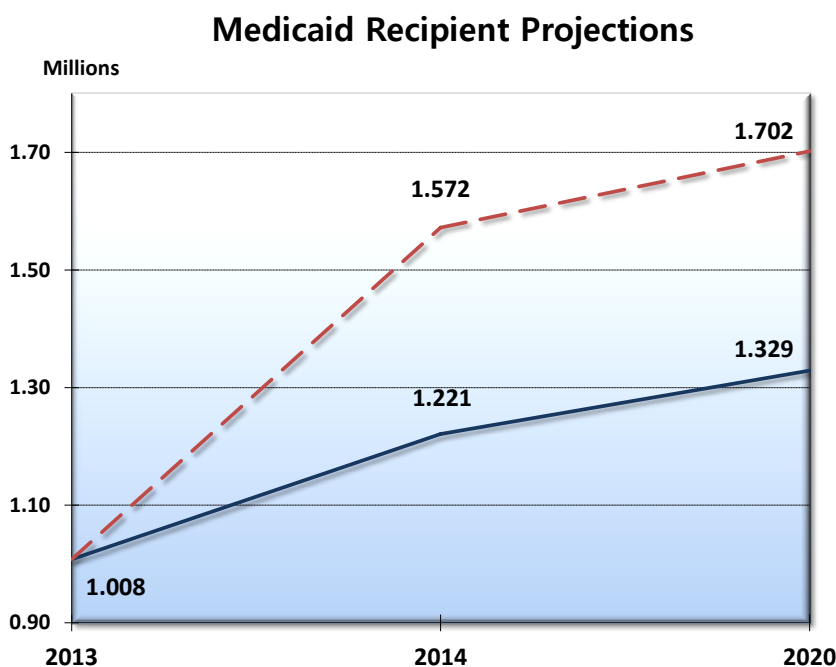


FIGURE 4

(Source: SCDHHS, Milliman)



happen after 2020. Under the current Medicaid program in South Carolina, the federal government pays about 70% of the bill.⁴⁰ If South Carolina expands its Medicaid rolls by hundreds of thousands, and a cash-strapped federal government does not indefinitely extend its 90% match for new populations under the ACA expansion, South Carolina would face massive and unprecedented budgetary repercussions.

Expansion of Medicaid in America has proved a dicey proposition even before the ACA tried to mandate it for the country. The experience of another neighboring state is enlightening:

*“In 1993, Tennessee rushed TennCare into law. The state was allowed to take Medicaid money and use it to cover the uninsured, and also some people not usually covered by Medicaid. Eventually, the TennCare costs ballooned, from about \$3 billion in the mid-1990s to about \$9 billion now. Yet as the funding grew, people had to be dropped and the state even considered a new income tax to fund TennCare.”*⁴¹

State experience over nearly fifty years has shown that expansion of a federally-based command and control “insurance” model simply does not work.

QUESTION 6: Would expansion impact education, infrastructure and other spending?

SCDHHS’s FY 2014 budget request, which did not include ACA Medicaid expansion, was for \$123 million new state dollars to cover increasing Medicaid costs (SCDHHS is essentially the “Department of Medicaid”). Given that the state Board of Economic Advisors expects “New Recurring Revenue” for the entire state budget to grow by only \$297 million, an increase of that level is highly unlikely.⁴²

It is not hard to see how the ballooning budget of SCDHHS – driven primarily by Medicaid expenditures – is already far outpacing spending in key state economic development priorities like education and infrastructure. For example, as FIGURE 4 illustrates, from the 2005-2006 fiscal year to 2012-2013, state budget expenditures for education (not including local

and federal funding) increased from \$2,781,510,746 to \$2,882,575,298, a growth of \$101,064,552 or 4%. But, for the same period, South Carolina’s HHS budget grew from \$1,315,411,844 to \$1,880,329,058, an increase of \$564,917,214 or 43%.⁴³ In FY 2009, Medicaid as a percentage of state government budgets overtook and passed K-12 spending and hasn’t looked back.

There is nearly universal agreement that infrastructure maintenance and expansion is vital to the future growth of our state economy. In fact, the South Carolina Department of Transportation estimates that over the next 20 years it will cost \$27.3 billion more than we currently budget just to maintain our current road system at a level of “good.” And this is before we even begin to talk about financing new projects to support the growth and development of new industry

2005-2006 to 2012-2013 Expenditure Increases

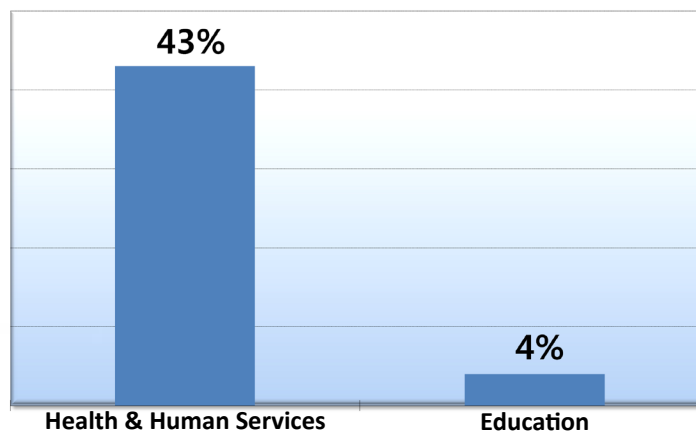


FIGURE 5

(Source: PPF Calculations; Office of SC Budget)

and jobs. The Transportation Infrastructure Task Force estimates that \$7,534,000,000 in new funds above existing obligations will be needed for roads in the same period (2014-2020) of the initial Medicaid expansion.⁴⁴

Unlike the federal government which can print money or run deficits, South Carolina must balance its budget. Skyrocketing Medicaid spending is clearly on a collision course with other state priorities. The General Assembly is especially sensitized to this issue after the discovery of a \$228 million shortfall at SCDHHS just two years ago. There is no question that funding for state programs like education, prisons, public safety and roads & bridges will of necessity be “crowded out” or else taxes will have to be raised, to plug the SCDHHS gap. And again, this is simply if we remain on the current growth trajectory, not even considering the question of further expansion of eligibility.

QUESTION 7: What is the true impact of expansion on jobs?

In nearly every state, the local hospital association has hired a researcher to produce a report showing that Medicaid expansion will be an economic panacea. The South Carolina Hospital Association’s own “Medicaid Expansion in South Carolina: The Economic Impact of the Af-

fordable Care Act” produced by a research office in the Moore School of Business in the University of South Carolina is no exception.⁴⁵

Given the desire of hospitals to offset the reduction in their federal healthcare payments over the next seven years that is intrinsic to ACA, this public relations effort is understandable. But the job creation expectations created by these state level reports rely on a number of assumptions that are debatable within the academic economic community and the healthcare profession itself.

Scholars and economists have long been wary of these types of “economic impact” studies, skepticism which is encapsulated by the research of Dr. John Crompton of Texas A&M University, who has identified ten common “mischievous procedures” in such research including inappropriate aggregation, abuse of multipliers, ignoring costs borne by the local community, ignoring opportunity costs, ignoring displacement costs and expanding the project scope.⁴⁶

The SCHA sponsored report suffered some of this mischief, but also consigned questions about its methodology to being “out of scope” of the research design. These “out of scope” questions include double counting, sensitivi-

ty analysis, and labor constraints.

In fact, “a similar economic impact study, done by USC for Health and Human Services in March 2011, said a planned reduction in state Medicaid spending would result in 5,452 lost jobs. Health and Human Services went ahead with the reduction in spending, and the number of health-care jobs in the state actually increased to 160,600 in October 2012 from 153,400 in April 2012, according to state employment statistics.”⁴⁷

According to one veteran South Carolina policy scholar, “These types of studies have run their course, nobody believes them now.”

One of the strongest advocates for the ACA is Professor Katherine Baicker of the Harvard School of Public Health. But in a telling report, “The Health Care Jobs Fallacy,” even she and her co-author Amitabh Chandra argue that a job creation approach to selling ACA provisions is misguided. “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,” they write. Putting a finer point on it, “Salaries for health care jobs are not manufactured out of thin air – they are produced by someone

paying higher taxes, a patient paying more for health care, or an employee taking home lower wages...”⁴⁸

Two other widely-cited reports further reinforce this claim:

- The Georgetown University Public Policy Institute concluded that the net impact of ACA on jobs is “insignificant.”⁴⁹
- Another report, “Healthcare Costs Slow Job Growth” stated, “In the private sector, healthcare costs have contributed to slowing the growth in wages and jobs.”⁵⁰

The truth of the jobs argument is a matter of simple economics: when more money is pulled from the private sector to pay for increased government spending (and inefficient spending at that), less will be available for use in the private sector, actually dampening economic activity (also known as job creation) in South Carolina.⁵¹

We already see similar effects of ACA provisions on a smaller scale for college students and small businesses. To cover the costs of ACA, at least one state university in South Carolina has been forced to levy a fee of \$40 on every student per semester.⁵² That is \$40 that won’t be spent on books, food and entertainment in the community that is home to that University.

And businesses are making similar cutbacks and reducing full-time workers to part-time to avoid ACA impact.

QUESTION 8: Will South Carolina “lose money” if we don’t expand?

If this were true, the states should have most certainly expanded the program years ago just to get more of the current “free” match, which while lower than the promised ACA expansion rate, is still generous. Current federal Medicaid dollars are limited only in so far as a state is willing to cover its matching portion (beside the fact that the federal government is borrowing copious amounts of money to meet its obligations). Let’s be clear: the funds South Carolina doesn’t claim won’t be stranded or sent to another state. The more states that participate in expansion, the greater the expense to *all American taxpayers*. This is the logic of “saving money” by buying at a sale on credit. The truth is, if you don’t have the funds to spend, you’re still spending money you don’t have, just not at full price.⁵³

It is also important to note that the ACA’s new taxes will be distributed back to all states whether they expand Medicaid or not. The 0.9% tax on incomes and 3.8% investment tax on those earning over \$200,000 per year (\$250,000 per couple) will be returned

to South Carolina through Medicare and routine spending for education, infrastructure and the military.

QUESTION 9: Could South Carolina expand and then change its mind?

Under statute as it currently stands, states could choose to expand and then reverse or shrink the expansion.

But Ronald Reagan said it best when he suggested that “The nearest thing to eternal life we will ever see on this earth is a government program.” The political and practical considerations of revoking the benefits of a newly entitled class of Medicaid recipients is nothing much short of inconceivable.

Indiana Governor Mike Pence had it right when he called expansion “the classic gift of a baby elephant.” The federal government would pay for the hay for the first few years, but then, South Carolina would be stuck not only feeding a much larger elephant, but conceivably feeding more and more of him on our own.⁵⁴

The *Wall Street Journal* recently reminded its readers that in the future the federal HHS could “simply impose a blanket ‘maintenance of effort’ rule that prohibits opting out—or any other change.” And the states have learned from hard exam-

ple that this is too often business as usual from the federal government.

Take the Education for All Handicapped Children Act (EAHCA). This federal program, passed in 1975 to assist physically, mentally, and emotionally handicapped children in the United States required the feds to pay 40% of Special Education student costs, with the rest being paid by local and state sources. The current figure for federal support of EAHCA is not quite 20%, less than half of the original federal commitment. President Ford's comments on signing the bill acknowledge the dangers of such massive federal commitments: "Unfortunately, this bill promises more than the Federal Government can deliver, and its good intentions could be thwarted by the many unwise provisions it contains."⁵⁷ The thirty-eighth President could have been speaking of ACA.

It is difficult to predict where the Federal Medical Assistance Percentages (FMAP) will land, but according to analysis by Charles Blahous of the Mercatus Center at George Mason University, "If states participate in the ACA's full Medicaid expansion, the long-term share of federal support is projected to be 61%, with states picking up the other 39%, assuming that the federal

government does not retreat from the ACA's generous FMAP rates."⁵⁸

QUESTION 10: What could we expect based on other state expansions?

Some have characterized the possible expansion of Medicaid to able-bodied adults as uncharted waters. In a sense this is true due to the fact that expansion on such a massive, nationwide scale hasn't been tried. But we have a clear picture of what Medicaid expansion to the able bodied looks like in the real world examples of Arizona and Maine. These states expanded in 2000 and 2002 respectively.

In each state:

- Enrollment of the expanded population was higher and quicker than projected. Arizona expected to enroll 48,000 childless adults by 2010 but enrolled 139,000 instead.
- The per-capita costs were higher than projected and specifically costs for childless adults were much higher. Parents cost between \$1,168 and \$2,460 in Maine, but able-bodied adults cost an average of \$5,072 per year (2012).
- Expansion also had little impact on reducing the uninsured population and caused a drop in private insurance coverage. In two more states, Michigan and Utah, the number of uninsured actually increased in the period following Medicaid expansion. A mass exodus from private enterprise to gov-

ernment also occurred, leaving for-profit businesses with fewer customers.⁵⁹

Waste, fraud and abuse is also a significant problem in the Medicaid program. Just last month (April, 2013), a Charlotte woman admitted to defrauding Medicaid to the tune of \$5 million for mental health services she did not provide.⁶⁰ Also last month, an audit found that The Scooter Store overbilled Medicare and Medicaid between \$47 and \$88 million.⁶¹ It was only two years ago (May 2011) that a Bishopville children's dentist billed Medicaid \$800,000 for dental procedures he did not actually perform.⁶² According to the South Carolina Attorney General's office, Medicaid fraud can result from "Billing for Services Not Rendered, Billing for Medically Unnecessary Services, Upcoding (billing Medicaid for more expensive procedures than those that are actually performed), Double-Billing (billing both Medicaid and a private insurance company or the recipient directly, or multiple providers billing Medicaid for the same recipient for the same procedure on the same date) or Kickbacks (hidden financial arrangements between providers involving some material benefit in return for another provider prescribing or using their product or services, which frequently results in unnecessary treatment)."⁶³



Predicting the results of an unnecessary expansion of Medicaid in South Carolina isn't art, it is science. Based on our own Medicaid experience and the experience of a representative sample of expansion states, we know what we will get, and it won't be good for patients or the taxpayers who will foot the bill.

CONCLUSION: What are we buying?

When the Supreme Court ruled that the federal government may not take away existing Medicaid dollars as retribution for not complying with new standards mandated by the ACA, South Carolina's policymakers were presented with a choice.⁶⁴ Given the existing fiscal challenges facing South Carolina and the nation, Medicaid expansion – even for the laudable desire to expand health coverage – is simply not a financially feasible decision.

Heritage, Kaiser, Milliman, USDHHS, the US Social Security Administration, and SCDHSS have their conflicting cost projections, but all agree that Medicaid enrollees and spending would rise dramatically in the wake of expansion. As such, South Carolina's politicians must resist the short-term "gain" of an influx of federal dollars, and its attendant increase in "pain" of permanent, unfunded future fiscal liabilities.

One prominent South Carolina Senator said of the issue of Medicaid expansion: "Our job is to think about *today*." Really? What about *tomorrow*? Spending astronomical sums on expanding a dysfunctional program actually short circuits the much larger discussion that we must have about lowering costs and improving outcomes and consequently, value for taxpayer money that is spent. The key question is not who pays but what are we paying for? As the Heritage Foundation recently wrote: "The Medicaid expansion will bring long-term costs to the states, offer no new flexibility to the existing Medicaid program, and create greater dependence on government-run health care rather than less. Health care reform is important, but recognizing a failing solution is even more important."⁶⁵

FOUNDING FOCUS: Competitive Federalism in action

As Palmetto Promise institute has noted in our publication *Competitive Federalism*,⁶⁶ the division of powers the founding fathers built into the Constitution is in danger. The ACA may very well represent the most serious current threat to the authority of the states, the entities that created the national government. Medicaid, begun as a federal-state partnership, has now become a "dangling carrot" for exponentially greater federal control

of health care dollars and decisions. Once a state chooses to expand Medicaid in partnership with the Federal government, the Rubicon has been crossed. Medicaid expansion reduces even the minimal discretion states have long enjoyed to run their own programs, including management of physician reimbursement rates, eligibility standards, and definitions of care.⁶⁷ Our founding fathers understood that by reserving non-enumerated powers to the states, they were creating the flexibility for states to be innovators to find the best solutions to their unique needs and in so doing provide either a good example – or cautionary tale – to their neighbors. The proposed Medicaid expansion flies in the face of these founding principles. To expand the program will only encourage more waste, higher taxes, and lower quality services for our citizens, all while trampling basic principles of federalism.

POLICY OPPORTUNITY: Measuring results, not inputs

Every state is different, but ACA's one-size-fits-all Medicaid expansion ignores these differences. For example, according to Kaiser, the states of Hawaii, Massachusetts, Maine, and Vermont will actually spend less on Medicaid in the critical period 2014-2019. That is a very different fiscal situation from

Mississippi, Arkansas, Oklahoma, Montana, Utah, South Carolina, Oregon and Alabama, which are slated to see the largest increases in state Medicaid spending in America, even prior to any proposed expansion.⁶³

With these stark differences, why did the ACA attempt to mandate an all-or-nothing approach? Why does the ACA encourage *more* spending rather than *smarter* spending? And does spending on insurance necessarily equal spending on health?

By block granting Medicaid dollars back to states, the Obama Administration could actually leverage the power of competitive federalism to help states improve the health of their citizens rather than simply increasing their budgets. For example, on the last day of the Bush Administration, the state of Rhode Island received a “Global Consumer Choice Compact Waiver” that essentially converted its Medicaid program into a block grant. In return, the state agreed to cap its spending and create individu-

al health plans for each of its Medicaid recipients. This created incentives for providers to deliver quality services and rewarded enrollees for keeping down expenditures on costly services, like emergency room use. The result? For the first 18 months of the program, the state budgeted \$3.8 billion but spent only \$2.7 billion.⁶⁹ Opportunities like this abound. Wisconsin Governor Scott Walker wants to concentrate Medicaid resources on the truly poor (100% of poverty line and below) and let the rest move to ACA “exchanges.” Other plans proposed would provide assistance to low income families so that they could purchase the same private healthcare policies enjoyed by other citizens.⁷⁰

In rejecting these types of ideas in favor of a federally-controlled “solution,” the Obama Administration continues to illustrate that the goal was always a move towards more centralized control of health care, not state-based innovation to contain costs and increase health. It is undeniable that we must improve

health in South Carolina, but laundering funds through a broken federal program is not the way to achieve that goal...and in fact, achieves the opposite. One-size-fits-all federal health care spending has contributed greatly to our current situation of rising costs and diminishing returns. More of this same medicine won’t cure what’s wrong with our system.

We counsel *patience*. With so many unknowns related to the cost and implementation of the ACA, South Carolina would be wise to consider history, monitor the efforts of other states and then make a fully informed decision. In the meantime, finding new ways to unleash South Carolina health officials to provide the flexibility needed to meet specific benchmarks of care would make South Carolina a physically and fiscally healthier state. Our goal should be nothing less than South Carolina as a beacon of health freedom, both in terms of cost and outcomes for every citizen.



ENDNOTES

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