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Unwinding the Worst of Obamacare:

Why Congress Must Rescind ACA's Massive Medicaid Expansion

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Executive Summary

Given the focus on the disastrous launch of the Obamacare insurance Exchanges in 2013, many people don't know that most of Obamacare's coverage gains have come not through those Exchanges, but through a new expansion of Medicaid to able-bodied, working-age adults.

Medicaid was originally intended to provide important safety net coverage to vulnerable populations such as individuals with disabilities, low-income children and the elderly, among others. But Obamacare's massive expansion of this entitlement to able-bodied adults has placed added strain on an already stressed program in many states.

Even prior to Obamacare, Medicaid stood in desperate need of reform. In many states, low physician reimbursement rates resulted in poor access for beneficiaries. One supporter of the program called a Medicaid card a "hunting license"—the chance for beneficiaries to try to find a doctor who will treat them.

And the program has fared no better under the Obamacare expansion. For states that bought into expansion's false promise, it has proved to be bad medicine, both for patients in the system and for state budgets:

- **Undermining the Most Vulnerable**
  Because Obamacare provides a 90-100 percent federal match to states covering the able-bodied, but only a 50-75 percent match to cover individuals with disabilities, many states have chosen to prioritize coverage of the able-bodied. In some cases, they have gone so far as to cut coverage for the most vulnerable even while expanding it elsewhere. Nationwide, nearly 600,000 individuals with disabilities are sitting—and in some cases, dying—on waiting lists to access needed care through Medicaid.

- **Exploding Enrollment and Skyrocketing Spending**
  In 24 expansion states, Medicaid programs have far exceeded the highest enrollment projections. Costs for newly eligible beneficiaries have increased for 2 straight years, with new able-bodied enrollees costing on average over $1,000 more than existing populations. This has created a "double-whammy" for state budgets. Even Democrat state legislators have publicly mused that the unexpectedly high costs their states will face due to Medicaid expansion will crowd out other important priorities, like education for children or care for the disabled. And this has already become a reality in states like Kentucky and Ohio.

- **Failing to Save Hospitals**
  The non-partisan Congressional Budget Office concluded that Medicaid expansion would be insufficient to overcome Obamacare's Medicare cuts in terms of reversing the fortunes of struggling – especially rural – hospitals.

Thankfully, lawmakers in 19 states, including South Carolina & Alabama, have wisely avoided this expansion train wreck. But as the 115th Congress and incoming Trump Administration prepare to take on the thorny challenge of Obamacare repeal, what comes next? Will non-expansion states get the short end of the stick for pursuing prudential policy-making? This paper makes the case that unwinding the Medicaid expansion fairly and putting the program on a sustainable path for the future must start with three basic principles:

- **Freeze enrollment in this massive new entitlement.**
  Individuals currently enrolled in Medicaid expansion should be held harmless and not face coverage disruptions. But states and the federal government need to begin unwinding the massive, unsustainable spending associated with Obamacare.

- **Roll back the enhanced federal Medicaid match for able-bodied populations.**
  This match has distorted states' behavior, encouraging them to discriminate against the most vulnerable.

- **Reorient Medicaid toward the vulnerable populations for which it was originally designed.**

The need for reform is urgent. By unwinding Obamacare's Medicaid expansion the right way, Congress can slow the gusher of spending that has jeopardized federal and state budgets, treat fiscally prudent states fairly and focus on restoring the safety net for the most vulnerable.

Unwinding the Worst of Obamacare:

Why Congress Must Rescind ACA's Massive Medicaid Expansion

Introduction

As Congress prepares to consider legislation repealing and replacing Obamacare in 2017, unwinding that law's massive expansion of Medicaid should stand at the top of the Congressional agenda. The source of most of the law's spending, Medicaid expansion has resulted in exploding enrollment, creating state budget shortfalls that legislatures will need to remedy in 2017.

Moreover, Obamacare's expansion of Medicaid to the able-bodied has undermined Medicaid's original mission to provide services to the most vulnerable in society—including seniors and individuals with disabilities. The law effectively discriminates against vulnerable populations, providing states with more federal funding to cover the able-bodied than individuals with disabilities. Sadly, even as able-bodied beneficiaries have flooded into Medicaid, hundreds of thousands of individuals with disabilities continue to suffer long waits for needed care.

Congressional Republicans have put forward proposals seeking to reform Medicaid, transforming the program into a system of block grants or per capita allotments that will provide greater flexibility to states in exchange for a fixed federal spending commitment. However, such reforms are necessary—but not sufficient—in reforming the Medicaid program. First and foremost, Congress should take immediate action to unwind Obamacare's Medicaid expansion, re-orienting the program to serve the most vulnerable populations for which it was originally designed.

History of Medicaid and Obamacare

As originally enacted into law in 1965, the Medicaid program provided federal matching funds to states to cover certain discrete populations, including the blind, seniors, individuals with disabilities, and needy parents. Obamacare changed the program fundamentally by expanding the program to all low-income adults; under Section 2001 of the law, all those with incomes under 138 percent of the federal poverty level (FPL) qualified for Medicaid coverage.[1] The statute as written made expansion mandatory for all states participating in Medicaid. States could decline to expand Medicaid, but in so doing, they would have had to forfeit all federal Medicaid funds, including funds for their existing aged, blind, and disabled populations.

In June 2012, the Supreme Court struck down the mandatory nature of Medicaid expansion as unconstitutionally coercive. Speaking for a seven-member majority, Chief Justice John Roberts concluded that "the threatened loss of 10 percent of a state's overall budget [i.e., the federal share of Medicaid spending]…is economic dragooning that leaves states with no real option but to acquiesce in the Medicaid expansion."[2] The Court left the expansion, and the rest of the law, intact, but prohibited the federal government from withholding all Medicaid funds from any states that chose not to pursue the categorical expansion to all adults with incomes under 138 percent FPL.

Because the Supreme Court ruling gave them a free choice about whether or not to embrace Obamacare's Medicaid expansion, states—the "laboratories of democracy"—have taken different approaches. Some states, fearing that the federal government will renege on its promised high levels of funding, declined to expand. Some states passed a traditional Medicaid expansion, ratifying Obamacare's massive new entitlement as its authors intended. Other states have utilized a system of premium assistance—also called the "private option"—that uses Medicaid dollars to subsidize private Exchange insurance coverage for individuals qualified for Medicaid under the Obamacare expansion.

Whether through the "private option" or traditional Medicaid, outcomes for states embracing Obamacare's massive expansion of Medicaid to the able-bodied have been little different. States that have embraced Obamacare's expansion have faced spiking enrollment and skyrocketing costs, all while perpetuating a system that encourages discrimination against the most vulnerable. Policy-makers should closely examine these cautionary tales as they look to rescind and replace Obamacare.

Undermining the Most Vulnerable

Supporters' claims to the contrary, Medicaid expansion actually undermines principles of social justice and fairness—in which our society focuses the safety net first and foremost on those unable to provide for themselves. Expanding Medicaid under Obamacare serves only to endorse a horrifically unfair system created by the law, which effectively discriminates against individuals with disabilities—prioritizing coverage of able-bodied adults over protecting the most vulnerable in society.[3]

How does this happen in practice?

In 2013, the congressionally-appointed Commission on Long-Term Care heard testimony about the significant numbers of individuals with disabilities on waiting lists for home- and community-based services (HCBS).[4] Because coverage of HCBS—as opposed to institutional care in a nursing home—remains an optional service for state Medicaid programs, Americans in 42 states remain on lists waiting for access to home-based care.[5] More than 582,000 individuals—including nearly 350,000 with intellectual and developmental disabilities, over 155,000 aged and/or disabled individuals, over 58,000 children, more than 14,000 individuals with physical disabilities, and more than 4,000 Americans with traumatic brain injuries—remain on Medicaid waiting lists.[6] All these individuals could benefit from home-based care that would improve their quality of life, and could keep them from requiring more costly nursing home care in the future—yet they must wait in the Medicaid queue, in many cases for years on end.

Yet even as more than half a million Americans with disabilities wait for service, Obamacare prioritizes coverage of able-bodied adults over treating the most vulnerable—providing states as much as 45 cents on the dollar more to cover the able-bodied than individuals with disabilities. In 2017, the law provides a federal match for expansion populations—that is, individuals with incomes under 138 percent of the federal poverty level—of 95 percent, dipping slightly to 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and future years.[7] Conversely, states wishing to expand coverage to individuals with disabilities—to eliminate their Medicaid waiting lists—will receive only the normal Medicaid matching rate, which for the current fiscal year ranges from 50 percent to 75 percent, based on states' relative income.[8] In other words, in 2017, states will receive at least 20 cents, and as much as 45 cents, more on the dollar for covering able-bodied adults than they will ending waiting lists for individuals with disabilities seeking care.

Sadly, some states have responded to Obamacare's perverse incentives in predictable ways. In the few years since the law took effect, the most vulnerable in society have suffered, while able-bodied adults received a new, taxpayer-funded entitlement:

- A recent report from Illinois found that 752 individuals with disabilities died while awaiting access to home- and community-based services since Obamacare's expansion took effect. Ironically enough, on the very day that Illinois voted to expand Medicaid to the able-bodied early, it also cut funding for medication and services provided to special needs children.[9]

- In Arkansas, while Gov. Asa Hutchison pledged to cut his state's waiting list for individuals with disabilities in half, instead it has grown by 25 percent—even as Hutchison has embraced Medicaid expansion to the able-bodied. The individuals waiting for care include ten-year-old Skylar Overman, whose mother worries she will die before she ever receives access to the in-home care she needs.[10]

- In Ohio, Gov. John Kasich's administration cut Medicaid eligibility for 34,000 individuals with disabilities, even while expanding the program to the able-bodied.[11]

Any law that results in these types of inequities—the most vulnerable cast aside to hasten access to care for the able-bodied—cannot be considered compassionate or just.

The disparities and perverse incentives present in Obamacare apply to South Carolina just as much as they do in other states. The law provides massive incentives for South Carolina to expand Medicaid to these able-bodied adults—many of whom may be unemployed or under-employed—rather than ending waiting lists for individuals with

disabilities. In fiscal year 2017, South Carolina will receive a 71.3 percent match from the federal government for the traditional Medicaid program—including coverage for individuals with disabilities.[12] Yet Obamacare will provide a 95 percent match should the state choose to expand Medicaid to able-bodied adults. Effectively, the law provides South Carolina with nearly 25 cents more on the dollar should the state discriminate against the most vulnerable in our society.

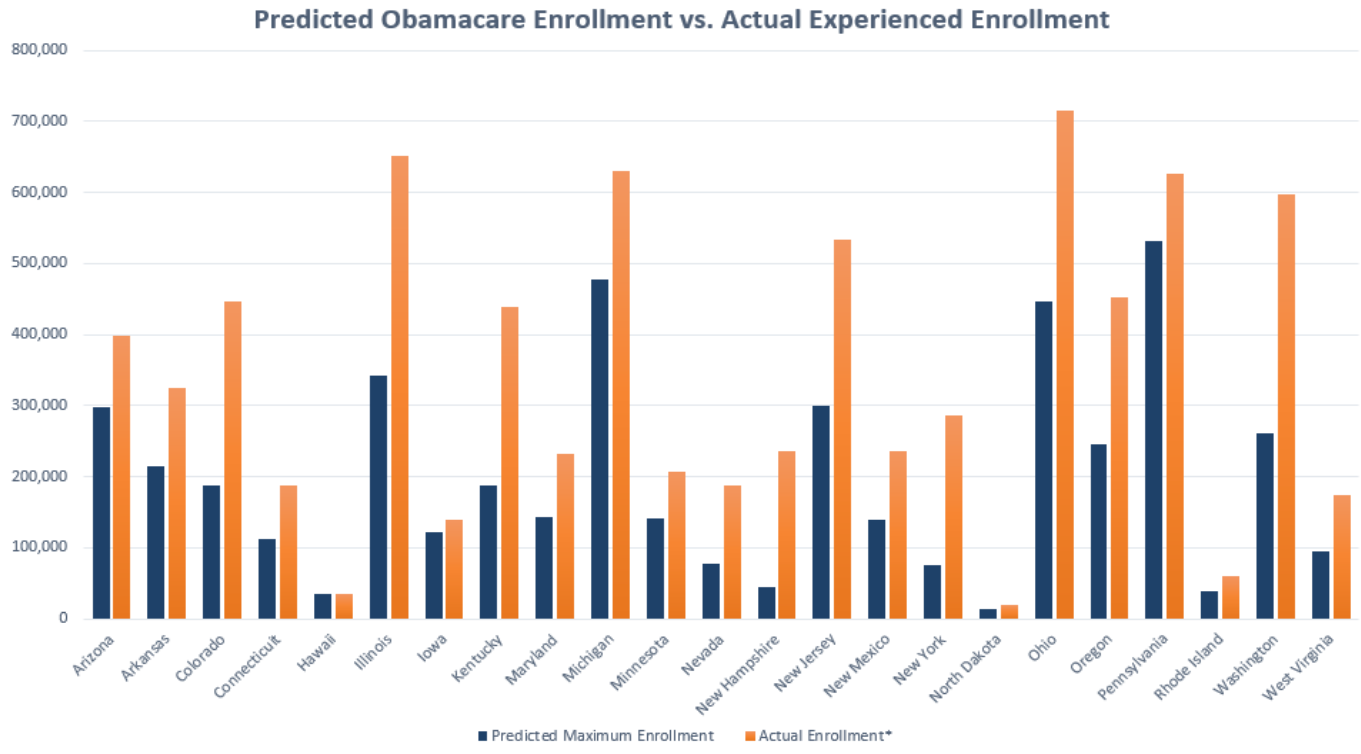
South Carolina has rightly rejected the effective discrimination perpetuated by Obamacare, for multiple reasons. The state has a list of 5,656 individuals with disabilities waiting to receive HCBS.[13] Providing enough funding to end the Medicaid waiting list should stand as the state's pressing health care priority—not expanding health coverage to able-bodied adults, many of whom would exceed the income limits to qualify for Medicaid if they pursued full-time employment. The fact that Washington does not agree with South Carolina's decision to prioritize the most vulnerable—because federal officials want the state to put the able-bodied, rather than individuals with disabilities, at the head of the Medicaid line—is a reason for Washington to change its priorities, not South Carolina.

Exploding Enrollment, Sky-rocketing Spending

The evidence among those states that have expended Medicaid demonstrates the massive effects on state budgets—due in large part to skyrocketing enrollment. A recent report by the Foundation for Government Accountability showed how the Medicaid rolls exploded in states that chose to expand the program under Obamacare. As seen in Figure 1 and 2, in 24 states that decided to expand (as well as nationwide), state Medicaid programs exceeded the highest enrollment projections.[14]

While Medicaid is considered a counter-cyclical program—one in which enrollment typically rises during recessions, as household incomes shrink and individuals lose access to employer-sponsored coverage — Obamacare's Medicaid expansion went into effect at a time of steady, albeit slight, economic growth. In other words, Medicaid enrollment under the Obamacare expansion could eventually exceed these figures—even as the actual enrollment numbers themselves exceeded projections prior to implementation, in some cases by several multiples.

By contrast, enrollment in health insurance Exchanges remains far below expectations set at the time of the law's passage. Just



before Obamacare passed in March 2010, the Congressional Budget Office (CBO) concluded that in 2016, the Exchanges would enroll a total of 21 million Americans.[15] For the first half of 2016, the Exchanges averaged enrollment of only 10.4 million—less than half the original CBO projection.[16]

Moreover, an analysis of Exchange enrollees shows enrollment concentrated largely among the individuals who qualify for the largest subsidies. According to an analysis conducted by the consulting firm Avalere Health, 81% of eligible individuals with income below 150 percent FPL—who are eligible for both subsidized premiums and reduced cost-sharing—have selected an Exchange plan.[17] On the other hand, only 16% of those with incomes between 300 and 400 percent FPL—who qualify for modest premium subsidies, but not reduced cost-sharing—have enrolled in Exchange coverage, while only 2% of individuals with incomes above 400 percent FPL—who do not qualify for subsidies at all—have signed up.[18] When it comes to both Medicaid expansion and Exchange coverage, the evidence suggests that only those individuals who receive free, or heavily subsidized, insurance have signed up in great numbers.

Just as enrollment for subsidized Medicaid under Obamacare dramatically exceeded expectations, so too have per-enrollee health costs for Medicaid participants. In the official 2014 report on the state of Medicaid's finances, government actuaries acknowledged for the first time that per-enrollee costs for Obamacare's newly eligible Medicaid enrollees ($5,488) exceeded those of previously eligible Medicaid participants ($4,914).[19] Actuaries had previously assumed that per-enrollee costs for the newly eligible population would be 30 percent lower than spending on existing populations—but the actual data suggested otherwise.[20] At the time, the actuaries believed some of the higher Medicaid spending arose because of pent-up demand—newly insured individuals requesting care for long-ignored medical conditions—a phenomenon they suggested might fade over time.[21]

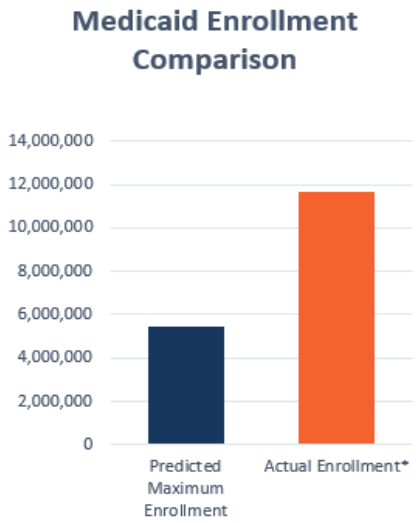


Figure 2

But contrary to the expectations of government actuaries, costs for newly eligible beneficiaries continued to increase for a second straight year in 2015. Whereas the gap between per-enrollee costs for newly eligible beneficiaries and existing beneficiaries stood at approximately $500 in 2014, in the following year the gap grew to over $1,000—an average cost of $6,366 for every newly enrolled adult, versus $5,159 for every adult previously eligible for Medicaid.[22] As a result, the Congressional Budget Office likewise increased their estimates of per-enrollee spending on Obamacare's Medicaid expansion—at least in the short term.[23] CBO still believes that per-enrollee spending on Obamacare's Medicaid expansion will stabilize at lower levels over time, despite the evidence that actual costs continue to exceed prior assumptions by sizable margins.

The combination of higher-than-expected enrollment and higher-than-expected enrollee costs has created a "double whammy" for state budgets. While the federal government paid 100 percent of the cost to cover Obamacare's Medicaid expansion population for the law's first three years, states must contribute 5 percent of costs for the newly eligible beginning in 2017, rising to 10 percent by 2020—a share proving larger than expected, and one placing fiscal strains on states.

With the new entitlement costing much more than expected, states may have to cut other critically important spending priorities to continue funding Obamacare's expansion of Medicaid to able-bodied adults. In Kentucky, costs for fiscal years 2017 and 2018 are now estimated at $257 million—more than double the original estimate of $107 million.[24] As a result, education, transportation, corrections, and other priorities will receive $150 million less from the state budget. Ohio's budget for Medicaid expansion more than doubled from the $55.5 million originally projected, likewise robbing other important state spending programs.[25]

Even Democrats serving in state legislatures have expressed alarm at the rising tide of spending associated with

Obamacare's Medicaid expansion, and the other programs being cannibalized to pay for this new entitlement. In Oregon, facing a $500 million Medicaid-imposed budgetary shortfall over the next three years, Democratic state Senator Richard Devlin noted that "the only way to keep this [budget situation] manageable is to keep those costs under control, get people off Medicaid."[26] In New Mexico, also facing pressures due to higher-than-expected enrollment, Democratic state Senator Howie Morales expressed anguish over the fiscal choices:

> *"When you're looking at a state budget and there are only so many dollars to go around, obviously it's a concern. The most vulnerable of our citizens—the children, our senior citizens, our veterans, individuals with disabilities—I get concerned that those could be areas that get hit."*[27]

Sen. Morales' comments eloquently describe the plight that legislators face. States that expand Medicaid may have to cut important programs for individuals with disabilities, seniors, and the most vulnerable—to provide additional taxpayer funds for an expansion of Medicaid to able-bodied adults.

Not a Panacea for Hospitals

In many states debating the future of Medicaid under Obamacare, hospital associations have served as the biggest supporters of expansion. Hospitals claim that expanding Medicaid will result in substantial improvements to their bottom line, making the difference between facilities remaining open or shutting their doors. Unfortunately, however, Medicaid expansion will not make a meaningful impact on hospitals' bottom line.

In September 2016, staff at the non-partisan Congressional Budget Office (CBO) released a report illustrating the minimal impact of Medicaid expansion on hospitals' profitability.[28] The paper analyzed the effects of several changes associated with Obamacare on two variables: hospitals' aggregate profit margin nationwide, and the percentage of hospitals with negative margins. The analysis estimated these two factors in 2025, and compared hospital profitability with 2011, before most of Obamacare's major provisions took effect.

The CBO analysis found that, under the best possible scenario, hospitals will fare no better in 2025 than they did prior to Obamacare's major provisions taking effect—and they could fare much worse. A scenario that coupled the law's Medicare payment reductions with its coverage expansions yielded a best-case scenario similar to the status quo ante: about one quarter of hospitals with negative profit margins (26% in 2025, versus 27% in 2011), and an aggregate margin of 6.0% in both cases.[29] However, should hospitals fail to achieve the productivity gains contemplated under Obamacare, margins will fall significantly—with as many as half of all hospitals having a negative profit margin by 2025, and the industry as a whole barely profitable.[30] Thanks to Obamacare, hospitals will struggle mightily just to tread water—and many may end up sinking financially.

The CBO paper also specifically examined whether all states expanding Medicaid would make a material impact on its analysis. Would a broader expansion of insurance coverage overcome the damaging fiscal effects of Obamacare's Medicare payment reductions? CBO concluded that broader Medicaid expansion would have a minor impact:

> *Differing assumptions about the number of states that expand Medicaid coverage have a small effect on our projections of aggregate hospitals' margins. That is in part because the hospitals that would receive the greatest benefit from the expansion of Medicaid coverage in additional states are more likely to have negative margins, and because in most cases the additional revenue from the Medicaid expansion is not sufficient to change those hospitals' margins from negative to positive. Moreover, the total additional revenue that hospitals as a group would receive from the newly covered Medicaid beneficiaries… is not large enough relative to their revenues from other sources to substantially alter the projected aggregate margins.*[31]

Despite claims from some hospital

executives that Medicaid expansion represents a make-or-break financial decision for their industry, non-partisan experts disagree.

The real problem for hospitals lies elsewhere within Obamacare, in the Medicare productivity adjustments that will affect hospitals each and every year. The Medicare actuary, along with other non-partisan experts, has made annual warnings every year since the law's passage concluding the productivity reductions are unsustainable, and will make most hospitals, skilled nursing facilities, and home health agencies unprofitable in the coming decades.[32] The September CBO report confirms, and further validates, the Medicare actuary's work highlighting the unrealistic nature of the payment reductions used to fund Obamacare.

As has been explained elsewhere, hospitals made a terribly unwise bargain when negotiating behind closed doors with the Obama Administration: They agreed to annual reductions in their Medicare payments forever in exchange for a one-time increase in the number of insured Americans.[33] Hospital lobbyists themselves know full well that the agreement they negotiated will ultimately destroy the industry.

At a televised event in August 2010, months after the law passed, Chip Kahn—the CEO of the Federation of American Hospitals, which represents the for-profit hospital industry—admitted his knowledge of Obamacare's long-term effects on the hospital sector.[34] Then-Medicare actuary Richard Foster asked Kahn why hospitals agreed to what appears on its face to be a bad deal:

Perpetual Medicare payment reductions in exchange for a one-time increase in insured Americans. Mr. Kahn first claimed that "from the hospital industry standpoint, there never was any kind of illusion that this was some kind of standard that we could meet in terms of improving quality"—even though the law itself assumes that hospitals will become more productive year-over-year, and reduces their Medicare payments accordingly.[35] When pressed on this issue—what will happen to the hospital industry when these year-on-year reductions cascade over time—Mr. Kahn eventually threw up his hands: "Now, you could say, did you make a bad deal? And fortunately, I don't think I'll probably be working after 2020. [Laughter.]…I'm glad my contract only goes another six years. [Laughter.]"[36]

The candid comments by the head of the Federation of American Hospitals months after the law passed say it all. In endorsing Obamacare, hospital lobbyists knew they were agreeing to provisions that would decimate their industry in the long run—but didn't care, because those devastating provisions would only take effect well after they had retired. These incredibly cynical comments provide two additional reasons for legislators not to embrace Medicaid expansion. As both the CBO analysis and Mr. Kahn's comments indicate, expanding Medicaid will not solve hospitals' financial difficulties, which arise from a self-inflicted blow—namely, agreeing to massive Medicare payment reductions that overwhelm the comparatively small revenue gain associated with Medicaid expansion. But while expanding Medicaid will not save hospitals in the long term, it will serve to sink state budgets, leaving them with the worst of both worlds on the fiscal front.

Work Disincentives

Supporters of Medicaid expansion claim that the additional federal funds generated by expansion have created jobs and economic growth. In reality, expanding Medicaid has only created additional disincentives for work, according to non-partisan economic experts.

Many studies claiming Medicaid expansion will create jobs represent one-sided—and therefore highly biased—analysis, examining the federal revenue flowing into states as a result of expansion without studying the impact of the tax increases necessary to generate said revenue. However, many studies—including a seminal analysis undertaken by President Obama's former chief economic adviser, Christina Romer—find that the economic damage—in technical terms, the deadweight losses associated with Obamacare's tax increases—will vastly outweigh any job gains associated with Medicaid expansion.[37]

Ironically, one of the architects of Obamacare disputes the economic theories put forward by Medicaid expansion

proponents. In a New York Times op-ed, former Obama Administration advisor Zeke Emanuel stated that "Health care is about keeping people healthy or fixing them up when they get sick. It is not a jobs program."[38] Likewise, two Harvard economists note that viewing the health system as a jobs program will ultimately increase spending and raise health costs, limiting access for the poor: "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."[39]

Rather than creating jobs, the Congressional Budget Office (CBO) believes that Medicaid expansion will discourage work. In part of its 2014 update on Obamacare's effects on the labor supply—in which CBO asserted that the law as a whole will reduce the supply of labor provided by the equivalent of 2.5 million jobs by 2024—the budget office noted that "expanded Medicaid eligibility under [the law] will, on balance, reduce incentives to work."[40]For instance, individuals who exceed Medicaid eligibility limits by even one dollar could face hundreds, or thousands, of dollars in premiums and co-payments to obtain subsidized Exchange coverage; such workers will likely work fewer hours to keep their income below eligibility caps.

Medicaid expansion will discourage work precisely because most of the participants in the expansion are able-bodied adults of working age. According to analysis conducted by the liberal-leaning Urban Institute, nearly nine in ten individuals (88.1%) who would benefit from Medicaid expansion in South Carolina represent adults without dependent children.[41] Moreover, the vast majority of South Carolinians to be covered under expansion would come within the ages of 19-55—prime working ages for most Americans. More than one-quarter (27.6%) of would-be beneficiaries of expansion are aged 19-24, with a further 21.9% aged 25-34, and more than one-third (35.5%) aged 35-54.[42]

The Urban Institute data strongly suggest that the vast majority of the potential beneficiaries from Medicaid expansion in South Carolina constitute individuals who could be in work, or preparing for work. Indeed, many South Carolinians working full-time would generate enough income not to qualify for benefits under Medicaid expansion. In 2016, 138 percent of the federal poverty level represents an income of just under $16,400 for an individual.[43] A South Carolinian working a full-time job (40 hours per week, 50 weeks per year) at a wage of $8.25 per hour would earn $16,500 annually, thereby exceeding the limit to qualify for Medicaid benefits.

However, CBO believes the Medicaid "benefit cliff" will discourage individuals from working, precisely because they wish to remain eligible for benefits. A December 2015 CBO paper quantified this impact: Analysts concluded that Obamacare's Medicaid expansion will reduce beneficiaries' labor force participation by about 4 percent, by "creat[ing] a tax on additional earnings for those considering job changes" that would raise their income above the threshold for eligibility.[44]

While Obamacare's massive expansion of Medicaid to the able-bodied discourages work and will reduce the labor supply, unwinding the expansion will produce salutary economic effects. Tennessee's decision to roll back a Medicaid coverage expansion in 2005 encouraged more individuals to join the labor force, in order to obtain employer-sponsored health coverage.[45] If states wish to grow their economies and encourage work, unwinding Obamacare provides a better approach to achieving those objectives.

"Private Option" Results in Greater Public Spending

While some supporters of Medicaid expansion believe that the so-called "private option"—using Medicaid dollars to purchase Exchange coverage for beneficiaries—represents an efficient use of taxpayer dollars, evidence suggests otherwise. In 2012, immediately following the Supreme Court ruling that made Medicaid expansion optional for states, the Congressional Budget Office (CBO) considered expansion through health insurance Exchanges significantly more costly than expansion through traditional Medicaid:

> *For the average person who does not enroll in Medicaid as a result of the [Supreme] Court's decision and enrolls in an Exchange instead, estimated federal spending will rise by roughly $3,000 in 2022—the difference between estimated additional Exchange [premium and cost-sharing] subsidies of about $9,000 and estimated Medicaid savings of roughly $6,000.*[46]

Providing Medicaid beneficiaries private coverage through the insurance Exchanges could cost approximately 50% more, according to CBO's 2012 estimate—a concern other non-partisan experts have flagged.

Government auditors have raised significant concerns that the "private option" waiver method of providing coverage improperly wastes taxpayer funds. In an August 2014 report, the Government Accountability Office (GAO) noted that, when approving the first instance of this "private option" model in Arkansas, the federal Department of Health and Human Services (HHS) "did not ensure budget neutrality," which is required under federal law, in three key areas:

- "HHS approved a spending limit for the demonstration that was based, in part, on hypothetical costs—significantly higher payment amounts the state assumed it would have to make to providers if it expanded coverage under the traditional Medicaid program—without requesting any data to support the state's assumptions." GAO concluded that these higher payment assumptions increased the program's budget caps by $778 million—or nearly 20% of the approximately $4.0 billion, three-year budget for the program.

- "HHS gave Arkansas the flexibility to adjust the spending limit if actual costs under the demonstration proved higher than expected…one which HHS has not provided in the past."

- "HHS in effect waived its cost-effectiveness requirement that providing premium assistance to purchase individual coverage on the private market prove comparable to the cost of providing direct coverage under the state's Medicaid plan—further increasing the risk that the demonstration will not be budget-neutral."[47]

The GAO report illustrates how, in order to ensure that Arkansas endorsed Obamacare's massive new entitlement, federal officials raised the budgetary caps required under law so high that they became nearly meaningless—and then gave Arkansas officials discretion to raise them even higher. Such actions represent a disservice to taxpayers in all states, including South Carolina. The GAO report demonstrates why unwinding the law's Medicaid expansion—in all its forms, including the "private option"—represents the wisest way to protect taxpayer funds.

How to Unwind Obamacare's Medicaid Expansion: Congress

As Congress considers legislation to repeal Obamacare in January 2017, it should embark on a three-step approach to unwind the law's massive Medicaid expansion:

- First, Congress should take action to freeze enrollment in the Medicaid expansion immediately after enactment of the repeal bill. Freezing enrollment will hold those currently on Medicaid harmless, while beginning a process to roll back the higher levels of spending associated with Medicaid expansion.

- Second, Congress should roll back the enhanced federal match for expansion populations, consistent with budget reconciliation legislation that Congress passed, and President Obama vetoed, during the 114th Congress.[48] Ending the enhanced federal match by 2019 will eliminate the discrimination inherent in Obamacare—whereby states receive a higher match to cover able-bodied adults than individuals with disabilities.

- Third, Congress and states should reorient Medicaid towards the vulnerable populations for which the program was originally designed. Added flexibility from Congress, and the incoming Trump Administration, will allow states to achieve additional savings in their Medicaid programs—savings that will permit states to achieve other important priorities, like reducing waiting lists for individuals with disabilities seeking access to home-based care.

While proposals to transform Medicaid into a block grant or per capita allotment would give states welcome flexibility from Washington's dictates, lawmakers must focus first on unwinding Obamacare's Medicaid expansion—and eliminating distortions to the program caused by same. Any block grant or Medicaid funding formula that uses the years 2014 through 2017 as a "base year" will perpetuate the inequities caused by the Obamacare expansion—the massive enrollment of able-bodied adults, and the increased spending by states that used the prospect of a 100% federal match to increase Medicaid reimbursements. States that made the policy choice to keep Medicaid focused on the most vulnerable in society should not be penalized by a block grant formula that rewards those states who embraced Obamacare's expansion of Medicaid to the able-bodied.

How to Unwind Obamacare's Medicaid Expansion: The States

The states also have a role, albeit a limited one, in the undoing of Obamacare's massive Medicaid expansion. As state legislatures reconvene, they can:

- Continue to resist calls for expanding Medicaid to able-bodied adults. No state is expected to expand or choose a "private option" scheme in their new legislative terms, but fiscally responsible legislators should nevertheless arm themselves with the facts of this paper and prepare for misguided calls for subjecting more states to the excessive costs of Medicaid expansion.

- Pass resolutions memorializing Congress to resist attempts to retain any of the core principles of Obamacare, including Medicaid expansion, as having a negative impact on state budgets and state policies. Both with respect to the costs of Medicaid expansion, and with respect to skyrocketing premiums in health insurance Exchanges, states and consumers alike are begging for relief from Obamacare. If enough states call for a top to bottom repeal and replace of Obamacare, including Medicaid expansion, consumers will win.

- Prepare for possible common sense solutions, formerly known as "Obamacare off-ramps," that will insure freedom for the insured without bullying businesses or individuals into plans they don't like and doctors they don't want. Members of both the United States House and Senate previously introduced such plans in the last Congress.[49] The new Trump Department of Health & Human Services, and specifically the Centers for Medicare and Medicaid Services (CMS), should provide guidance on blanket waivers designed to maximize flexibility for state Medicaid programs immediately upon taking office.[50]

Need for Reform

Even prior to Obamacare, Medicaid stood as a program in need of significant reform. The program has nearly tripled as a share of state budgets since 1987, yet provides beneficiaries with care of questionable quality.[51] Results from Oregon suggest that newly enrolled individuals in Medicaid used the emergency room at rates 40 percent higher than the uninsured—a disparity that persisted over time—yet did not achieve measureable improvement in their physical health outcomes.[52] With high (and growing) levels of spending coupled with subpar outcomes, states should use the flexibility promised from the Trump Administration to rethink their approach to Medicaid.

However, such efforts should come only after Congress has first backed down Obamacare's massive expansion of Medicaid to the able-bodied. Restoring Medicaid as a safety net program for the most vulnerable in society would unwind more than $1 trillion in projected spending over the coming decade providing coverage to the able-bodied.[53] Just as important, it would remove the inequities created by Obamacare, and put all states on a level playing field for the reformed Medicaid program that should follow.

Palmetto Promise Visiting Fellow, Chris Jacobs, is the Founder and CEO of Juniper Research Group. Chris has over a decade of health care policy expertise, including time as Senior Policy Analyst for the U.S. Senate Joint Economic Committee and The Heritage Foundation. Chris is a regular contributor to national news outlets and teaches health policy at The American University.

ENDNOTES

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