

Who is on the ObamaCare Chopping Block?

**THE IMMORAL FUNDING FORMULA OF
OBAMACARE'S MEDICAID EXPANSION PUTS
THE NEEDIEST PATIENTS AT RISK**

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EXECUTIVE SUMMARY

“But for us Democrats, ObamaCare is a badge of honor. Because no matter who you are, what stage of life you’re in, this law is a good thing.”

Kathleen Sebelius, U.S. Secretary of Health and Human Services
2012 Democratic National Convention, 9/4/2012

Then-Health and Human Services Secretary Kathleen Sebelius extolled the virtues of the Patient Protection and Affordable Care Act (ObamaCare) during her address at the 2012 Democratic National Convention in Charlotte, North Carolina. The quote above captures the essence of her remarks.

Too bad it’s false.

Medicaid expansion—one of the keystones of ObamaCare—is anything but “a good thing” for the patients already relying on the Medicaid safety net. These truly vulnerable patients face second-class care as a new Medicaid expansion population is rushed to the front of the line.

But what does this expansion population really look like? And what will be the impact of ObamaCare’s expansion on the needy patients who count on Medicaid to survive?

Able-bodied, working-age adults; almost all of whom (82 percent) have no children to support, nearly half of whom (45 percent) do not work, many of whom (35 percent) with a record of run-ins with the criminal justice system. ObamaCare has picked this population as the winner of its Medicaid expansion.

The losers? Low-income children, poor moms, the elderly, the blind, the disabled. The very people Medicaid was created to protect.

And what do these ObamaCare losers have in store for them? States that previously expanded Medicaid had to eliminate coverage for life-saving organ transplants, overload waitlists for services, cap enrollment and raise patient costs, all because promises were broken and costs exceeded projections.

ObamaCare’s Medicaid expansion is hardly “a good thing” for our most vulnerable patients. But the good news is states have a choice. They can protect their neediest patients who already rely on Medicaid by rejecting ObamaCare’s expansion. Or they can push those needy patients to the back of the line to make room for ObamaCare’s expansion population of able-bodied, childless adults.

The question state policymakers must ask themselves: who do you think needs help the most?

INTRODUCTION

Under the Patient Protection and Affordable Care Act, commonly known as ObamaCare, state policymakers may expand Medicaid eligibility to cover able-bodied, working-age adults earning up to 138 percent of the federal poverty level. The law initially mandated that all states expand their Medicaid programs in this way; however, the U.S. Supreme Court ruled in June 2012 that they are under no obligation to do so.¹ The decision to expand rests solely with state policymakers.

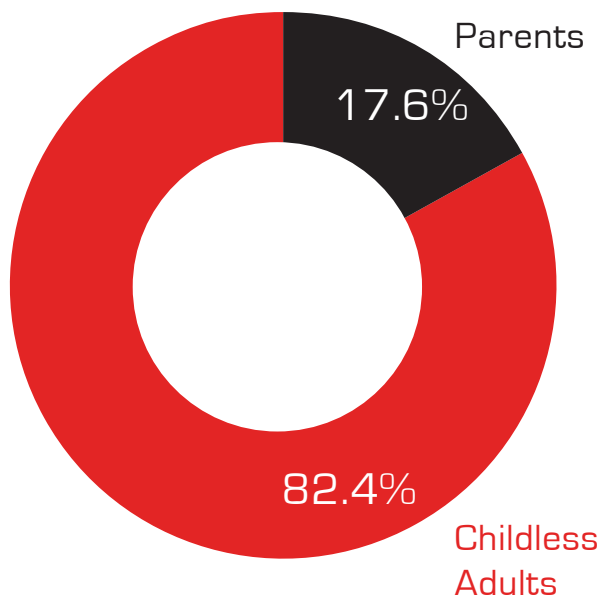
ObamaCare's unprecedented expansion of Medicaid eligibility fundamentally transforms the program from a safety net meant to protect the most vulnerable into an entitlement for a new population of able-bodied, working-age adults. ObamaCare's Medicaid expansion prioritizes this new entitlement class over the truly needy. Its perverse and immoral funding formula will likely result in states cutting benefits and services for existing Medicaid patients in favor of the new ObamaCare expansion population.

OBAMACARE'S MEDICAID EXPANSION PICKS NEW WINNERS AND LOSERS

ObamaCare's Medicaid expansion strategy was never intended to benefit individuals typically considered truly needy. The Medicaid expansion does not cover the elderly, individuals with disabilities on waiting lists or even poor children—patients most frequently considered among the nation's most vulnerable and most in need of support.² Instead, ObamaCare expands Medicaid eligibility to a new class of able-bodied, working-age adults.³ More than 82 percent of these able-bodied adults have no dependent children to support.⁴

Most ObamaCare Medicaid expansion enrollees are working-age, able-bodied adults without children

Adults newly eligible for Medicaid, by parental status

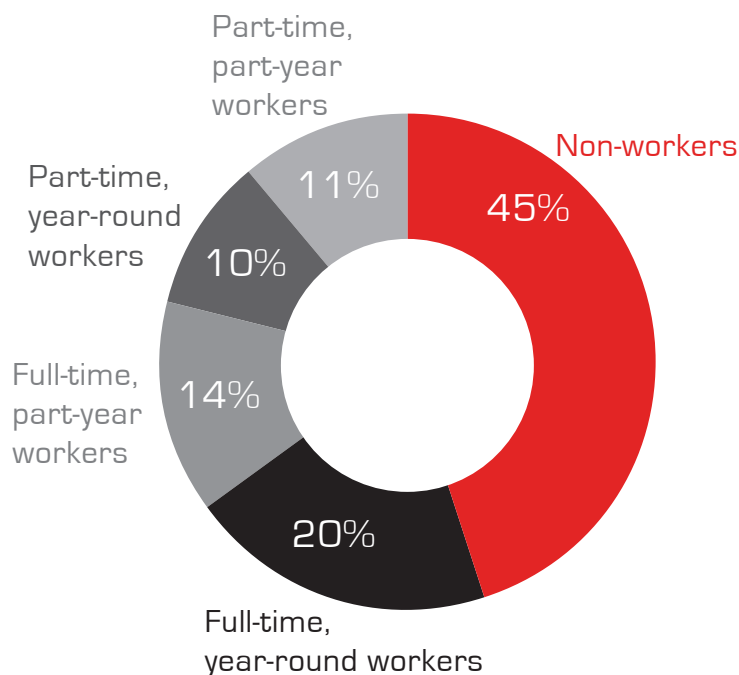


Source: Urban Institute

Despite not having any disabilities or parental obligations preventing them from doing so, few of these expansion adults actually work full-time jobs, even during favorable economic times. Nearly half of this ObamaCare Medicaid expansion population does not work at all, while just one-fifth are full-time, year-round workers.⁵ This is largely unprecedented for an entitlement program. Unlike other forms of welfare, Medicaid has no work requirement, meaning states are being asked to expand eligibility for taxpayer-funded Medicaid to able-bodied, non-working adults. Research shows that expanding Medicaid to this new class of individuals discourages work, depresses earnings, reduces labor-force participation and hurts the economy.⁶⁻⁸

Few potential Medicaid expansion enrollees are full-time, year-round workers

Uninsured adults below 138 percent FPL, by work status



Source: Census Bureau

Worse yet, the U.S. Department of Justice estimates that more than 35 percent of these potential new Medicaid enrollees have previous involvement in the criminal justice system, with many having been incarcerated.⁹ Put another way, ObamaCare’s Medicaid expansion does nothing to protect or support kids, seniors, individuals with disabilities on waiting lists or pregnant women. Instead, it gives taxpayer-funded Medicaid to able-bodied adults, largely without dependent children, largely unwilling to work, with many having a record of serving time in jail or prison.

Because non-disabled adults without children have never been considered among the most vulnerable, they have generally been ineligible for other types of taxpayer-funded welfare. For example, childless adults are not eligible for cash assistance under the Temporary Assistance for Needy Families (TANF) program.¹⁰ Only low-income pregnant women and families with children generally qualify for TANF cash assistance.¹¹ Able-bodied adults without children are also generally ineligible for long-term food stamp benefits under the Supplemental Nutrition Assistance Program (SNAP).¹²

ObamaCare’s new Medicaid entitlement for working-age, able-bodied adults ultimately redirects limited state and federal resources away from truly needy patients. These vulnerable individuals already struggle in a tattered Medicaid safety net. Care is frequently fragmented, access to quality care is often low and health outcomes remain poor. Rather than fixing Medicaid for the truly needy, ObamaCare’s Medicaid expansion overloads the safety net with able-bodied adults and prioritizes them over the nation’s most vulnerable patients.

MEDICAID EXPANSION PRIORITIZES ABLE-BODIED ADULTS OVER THE MOST VULNERABLE

ObamaCare’s goal of adding millions of able-bodied adults to Medicaid will inevitably make access problems even worse. Expansion greatly increases demand for services, but does nothing to increase the supply of health care providers accepting Medicaid patients. Compounding this problem is a perverse and immoral funding formula that prods states to attack the truly needy with cuts in services and gives preferential treatment to adults without any disabilities or dependent children.

ObamaCare does not change the funding structure for patients currently eligible for Medicaid. States continue to receive their regular matching rate for providing coverage to poor children, seniors and individuals with disabilities. These rates can range from a low of 50 percent to a high of 83 percent, depending on a state’s per-capita income.¹³ On average, the federal government pays for roughly 57 percent of a state’s current Medicaid expenditures.¹⁴⁻¹⁶

But these matching rates fluctuate over time. In the last decade, 22 states have seen their federal Medicaid matching rates decline, 19 states have seen rates increase and 9 states have seen rates remain relatively stable.¹⁷⁻²⁷ The impact of these fluctuations can be massive, totaling hundreds of millions of dollars. North Dakota’s matching rate, for example, has dropped nearly 16 percentage points since 2006, equaling \$130 million less in annual federal funding for Medicaid.²⁸

A drop of just a few percentage points can wreak havoc on state budgets. A reduction in Texas’ federal matching rate of a single percentage point equals more than \$300 million.²⁹ Texas has watched its matching rate decline in six of the last 10 years.³⁰ Its matching rate is now nearly 3 percentage points lower than it was a decade ago, adding nearly \$1 billion to Texas’ state share of Medicaid spending.³¹

The matching rates for the Medicaid expansion population covered under ObamaCare are much different. States that expand Medicaid for able-bodied adults under ObamaCare receive an enhanced matching rate for this new Medicaid population.³² The enhanced matching rate starts at 100 percent in 2014 and gradually reduces to 90 percent by 2020.³³

Matching rate for population covered by ObamaCare Medicaid expansion

Year	Federal Share	State Share
2014-2016	100%	0%
2017	95%	5%
2018	94%	6%
2019	93%	7%
2020	90%	10%

But this enhanced funding only applies to the new class of able-bodied adults made eligible for Medicaid by ObamaCare. States do not receive an enhanced matching rate for the truly vulnerable patients already eligible for or enrolled in Medicaid. This means states receive less federal support to provide care for patients the Medicaid safety net was originally intended to protect, including children, the elderly and individuals who are blind or disabled.

THE NEW MEDICAID MATH

Medicaid is already the single-largest line item in state budgets.³⁴ Because Medicaid spending is growing faster than state revenues, the program devours resources for other critical state services, including education, public safety and infrastructure. State spending on Medicaid has more than doubled since 2000, growing more than twice as fast as state revenues.³⁵⁻³⁹ The only way for policymakers to take back control of their state budget is to rein in Medicaid’s out-of-control spending.

This is a critical task, but not an easy one. In order to save \$1.00 in state Medicaid spending, states must make an average \$2.32 in total cuts to the Medicaid budget.⁴⁰ This is because state funds typically cover only 43 percent of the costs of currently-eligible individuals.

The Critical Challenge to Save State Budgets

Amount of cuts to Medicaid spending for current Medicaid patients needed to save \$1.00 in state spending in fiscal year 2015, by state

State	Total cuts needed to save \$1.00	State	Total cuts needed to save \$1.00	State	Total cuts needed to save \$1.00
National average	\$2.32	Kentucky	\$3.33	North Dakota	\$2.00
Alabama	\$3.22	Louisiana	\$2.64	Ohio	\$2.68
Alaska	\$2.00	Maine	\$2.62	Oklahoma	\$2.65
Arizona	\$3.17	Maryland	\$2.00	Oregon	\$2.78
Arkansas	\$3.43	Massachusetts	\$2.00	Pennsylvania	\$2.08
California	\$2.00	Michigan	\$2.90	Rhode Island	\$2.00
Colorado	\$2.04	Minnesota	\$2.00	South Carolina	\$3.41
Connecticut	\$2.00	Mississippi	\$3.79	South Dakota	\$2.07
Delaware	\$2.16	Missouri	\$2.74	Tennessee	\$2.86
District of Columbia	\$3.33	Montana	\$2.93	Texas	\$2.38
Florida	\$2.48	Nebraska	\$2.14	Utah	\$3.40
Georgia	\$3.02	Nevada	\$2.81	Vermont	\$2.17
Hawaii	\$2.09	New Hampshire	\$2.00	Virginia	\$2.00
Idaho	\$3.54	New Jersey	\$2.00	Washington	\$2.00
Illinois	\$2.03	New Mexico	\$3.29	West Virginia	\$3.49
Indiana	\$2.99	New York	\$2.00	Wisconsin	\$2.40
Iowa	\$2.25	North Carolina	\$2.93	Wyoming	\$2.00
Kansas	\$2.31				

Source: Foundation for Government Accountability

In the states that hope to get Medicaid spending under control, an ObamaCare Medicaid expansion puts truly vulnerable patients at even greater risk. While states would have to cut an average \$2.32 in spending for currently-enrolled Medicaid patients in order to save \$1.00, they would need to cut services and benefits for the able-bodied, childless adult expansion population by a whopping \$10.00 just to save a single state dollar in 2020.⁴¹ This is because state funds will cover only 10 percent of the costs of newly-eligible individuals.

If the state wished to reduce Medicaid spending before 2020, when ObamaCare promises higher matching rates, it would need to cut even more services and benefits for this group. For example, if the state wished to save \$1.00 in state spending by cutting services for able-bodied, childless adults in 2017, it would need to cut roughly \$20.00 from the program.⁴²

Put simply, ObamaCare’s immoral funding formula makes the current population of truly vulnerable Medicaid patients a much easier target for slashed services and spending cuts than the ObamaCare expansion population.

ObamaCare’s immoral funding scheme prioritizes able-bodied, working-age adults over the most vulnerable

Amount of cuts to Medicaid spending on expansion individuals needed to save \$1.00 in state spending

2017	2018	2019	2020
\$20.00	\$16.67	\$14.29	\$10.00

Source: Foundation for Government Accountability

Lawmakers in states that expand Medicaid will be faced with a choice. They can make cuts that impact their neediest citizens, or make cuts five to ten times as large in order to target only able-bodied adults without children.

STATES THAT PREVIOUSLY EXPANDED MEDICAID TARGET TRULY NEEDY PATIENTS WITH CUTS

The most vulnerable patients in states that previously expanded Medicaid to childless adults are already the targets of devastating cuts to services. Arizona, for example, expanded Medicaid eligibility to able-bodied, childless adults in 2000.⁴³ However, the state quickly discovered its Medicaid expansion would cost taxpayers four times what was initially expected, forcing policymakers to cut other areas in order to maintain the expansion.⁴⁴

In 2010, Arizona eliminated Medicaid coverage for heart, liver, lung, pancreas and bone marrow transplants in order to pay for the growing costs of its Medicaid expansion.⁴⁵ As a result, truly vulnerable Medicaid patients in desperate need of life-saving organ transplants died so able-bodied adults with no disabilities keeping them from employment could keep receiving free, taxpayer-funded Medicaid coverage.⁴⁶

In Oregon, another state that previously expanded Medicaid coverage to able-bodied adults, the Health Evidence Review Commission serves as a cost-control panel that prioritizes certain health care procedures over others.⁴⁷ As the state’s Medicaid costs have grown over time, the list of covered services has been reduced, often with more critical, but costly, care relegated toward the bottom of the priority list of services to cover.⁴⁸ The commission has eliminated life-saving treatment for many patients with advanced-stage cancer and made it much more difficult for patients with diabetes to regularly monitor their blood glucose levels, among other things.⁴⁹⁻⁵¹

When broken Medicaid programs become too expensive, states often reduce and delay payments to doctors, hospitals and other health care providers to make ends meet. Maine, which expanded Medicaid eligibility to able-bodied, childless adults in 2002, saw expansion costs greatly exceed initial projections, forcing the state to cap enrollment at various times, draw up waiting lists of patients in need of services and lengthen payment cycles.⁵² By 2013, Maine’s accumulated unpaid hospital bills for Medicaid patients reached a staggering \$500 million.⁵³

Similar patterns have played out in other states that expanded Medicaid eligibility to able-bodied adults. Illinois, for example, owed doctors, hospitals and other medical providers more than \$2 billion for unpaid Medicaid services at the end of fiscal year 2012.⁵⁴ The average medical provider waited more than five months to receive reimbursement from the state for the care they provided, with some delays lasting eight months or more.⁵⁵⁻⁵⁶

Rhode Island, which recently adopted the ObamaCare Medicaid expansion, has already announced it would begin cutting payment rates for hospitals, nursing homes and health plans, while also instituting new premiums for disabled children amounting to roughly \$3,000 per year.⁵⁷

As Medicaid costs continue to rise, states will be forced to make difficult decisions. ObamaCare’s perverse and immoral funding formula ensures states will have a huge financial incentive to prioritize coverage services for able-bodied adults who were never intended to be served by the Medicaid safety net over the most vulnerable patients with nowhere else to turn.



CONCLUSION

Too many policymakers get lost in the weeds when it comes to ObamaCare's Medicaid expansion. While there are no shortage of details one should consider when facing the decision of whether to expand a state's Medicaid program, the issue is far more black and white than expansion supporters would have us believe.

ObamaCare's Medicaid expansion has drawn a line in the sand. On one side, the states that reject Medicaid expansion in order to protect their most vulnerable patients; on the other are the states that embrace ObamaCare's Medicaid expansion and put their neediest patients at risk.

The stakes are high. But the right choice has never been more clear.

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