Hello, everyone. I’m Jonathan Bechtle, the COO and the general counsel of the Foundation for Government Accountability. I want to welcome all of you to today’s call. The FGA builds paths to better lives by equipping leaders with proven strategies to reform health and welfare programs in states all across America. Many of you are our partners in this. We certainly look forward to continuing to work with you to develop, promote and implement solution to these tough problems in the states.

I want to thank all of you for taking the time to join us today. We have people from twenty different states all across the country. I especially want to thank our co-sponsors of this call at the Galen Institute, Institute for Policy Innovation, the Mercatus Center and the State Policy Network. We appreciate very much their helping us spread the word about this important topic and the call today.

Now, we’re privileged to be joined as well by two distinguished guest that we’re going to hear from and that you’ll get the change to ask questions of. First of all, we’re going to start with the FGA Director of Research, Jonathan Ingram, who is going to spend a little bit of time discussing his new report called The Exaggerated Epidemic. This report we sent out this morning in our last reminder email and we’ll send it out as well again after the call.

Secondly, we’re going to hear from Dr. Robert Graboyes who is the Senior Research Fellow at the Mercatus Center at the George Mason University. Dr. Graboyes also served as the senior health care advisor for the National Federation of Independent Businesses during the passage of the Affordable Care Act and throughout the legal challenge by NFIB. Certainly close to many of these issues. Dr. Graboyes is going to be discussing some of the broader impacts of Medicaid expansion to businesses, particularly the small businesses that are really the lifeblood of our economy.

After both of our guest have presented, we will make sure that there’s plenty of time for you to ask questions. At that time, we’ll tell you how to do that. It’s a pretty simple process. Before we do that, we’re going to dive into our topic and give our guest an opportunity to present for a few minutes.
I’m sure most of you are probably very familiar with the Affordable Care Act’s employer mandate, which requires that all employers with at least fifty full-time-equivalent employees to offer affordable health insurance to any employee who works at least thirty hours per week.

Any such employers who fail to offer affordable insurance could be subject to substantial tax penalties. Some folks have suggested that Medicaid expansion is a way to shield businesses from these tax penalties. They argue that if a state does not expand Medicaid, many businesses will then be on the hook for up to $3,000 for each worker who has not been given affordable health insurance. This theory is supported by a widely-cited report from Jackson Hewitt, the nation’s second-largest tax preparation company.

One of the big questions we’re going to talk about today is whether that’s true, first of all, and then secondly, whether states should expand Medicaid just to save businesses from the employer mandate—whether that’s a good strategy.

We’re going to start off, as I mentioned, with Jonathan Ingram and ask him to explain first a little bit more about the ObamaCare penalties and how the employer mandate works. Then the theory put forward by Jackson Hewitt that says that Medicaid expansion could help prevent these penalties from being put in place. So, Jonathan, why don’t you talk to us about those two things for a little bit.

Jonathan Ingram: Well, I think it’s really important to understand sort of what Jackson Hewitt was trying to analyze to really understand why they got it so horribly wrong. As you’ve mentioned, ObamaCare has the two types of penalties for large employers. Both penalties are really triggered when an employee gets an ObamaCare subsidy on the exchange. One type of penalty occurs if they don’t provide any health insurance for full-time workers. In that case they pay $2,000 per full-time employee...not just on those getting the subsidies, but on their entire workforce, all of their full-time employees. That includes people who are on Medicaid and people who are receiving health insurance somewhere else, like through their spouse’s employer or something like that.

The second kind of penalty occurs if the coverage that the employer offers is unaffordable, and then they would pay $3,000 for every employee who actually receives the ObamaCare subsidy.

Because of the way that ObamaCare was written, people between 100 and 138 percent of the federal poverty level actually qualify for subsidies if they don’t expand Medicaid, but they lose those subsidies if states do expand Medicaid. It’s really only this second type of penalty for offering “unaffordable coverage” that could be even affected by the Medicaid expansion.

Jackson Hewitt hired a couple of people that use to work for Tennessee’s ObamaCare exchange to try to find out what kind of penalties would be paid for this really narrow sliver of people—these full-time workers who only earn between 100 and 138 percent of the federal poverty level. Of course, they said
there would be this huge doomsday scenario, several billions of dollars per year in ObamaCare penalties should states say no.

But their analysis is really based on several unsupported assumptions about how low income people are distributed across the states, about who can really even trigger the penalties and really the behavior of what large employers will ultimately do. Their conclusions also clearly entirely contradict the estimates put out by the non-partisan Congressional Budget Office. It’s pretty clear that lawmakers shouldn’t really rely on these couple of flaw-filled reports when they think of their Medicaid expansion decision.

Ultimately, one of the earliest flaws that I noted was that they were using some really strange assumptions. Instead of actually using the data that they said they’re citing, which is the Census, to find out how many people fall in to this narrow sliver of population, they actually decided to just make an unjustified assumption about how states’ populations were distributed. That has major impacts. In Utah, for example, they actually assumed that about twice as many people fall into this income group than the Census say actually belongs there. In Missouri, they overestimate it by about 65 percent, which amounts about 15,000 people. They don’t really come up with a good explanation for why they use this assumption, especially when the data is readily available from the very source of their citation.

The second major flaw that I saw was that they included a lot of employees who, by law, can’t even trigger the employer penalties. This includes people who are already eligible for Medicaid. You have some older children, some young adults and some low-income parents who are eligible for Medicaid before the ObamaCare expansion. We know that people who are already eligible for Medicaid can’t trigger the penalties under ObamaCare, because they can’t get the ObamaCare subsidies.

They also include, strangely, seasonal and part-year workers who also don’t trigger penalties. Nationally, about a third of the people of the Jackson Hewitt includes are these seasonal workers. In some states, that actually bumps up to about three-quarters of the people that they think could trigger these penalties are actually seasonal workers who can’t. It’s really unclear why they assume this, when the law is pretty clear on their point.

The last major assumption that they made is perhaps the strangest. They assumed that about 93% of these workers aren’t offered affordable coverage. They base that on a really, really gross misreading of a report by the Urban Institute. When you actually read that report, you find out that the 93 percent figure actually includes people who couldn’t trigger the penalty at all, because, either they work at small businesses who are not subject to the mandate or because they don’t work at all.

What the study actually found was that as few as 1 percent of uninsured full-time employees who are offered insurance are offered what’s considered under ObamaCare to be unaffordable coverage. That really is the group we’re talking about here.
It’s kind of interesting that Jackson Hewitt has put out these reports two years in a row, claiming these doomsday scenarios if states don’t expand Medicaid, when the very data that they’re saying they’re using to reach those conclusions paints a very, very different picture.

Of course, that doesn’t even get into the fact that, for two years in a row, the employer mandate has been completely or partially delayed and employers are going to do whatever they can to limit their exposure to ObamaCare penalties, regardless of what the states decide to do on Medicaid.

Jonathan Bechtle: Thanks, Jonathan, very much for that overview and for the research on that. That’s very enlightening. That’s kind of opened up a little bit of the facts behind the facts, if you will. What has been portrayed as doomsday, but maybe isn’t quite so much as of doomsday as it might look.

Let’s change gears now and hear from Dr. Graboyes, who has been researching the impacts of ObamaCare on employers for a long time. Dr. Graboyes, would you add your comments to Jonathan’s and talk about whether you think small businesses would be smart to push for Medicaid expansion or if that’s actually more harmful to them in these states.

Dr. Robert Graboyes: Absolutely. Thank you so much for having me. First of all, businesses all ought to think long and hard about buying into the Medicaid expansion. That’s whether they’re small, whether they’re large, medium size, it doesn’t matter. Furthermore, what I’m going to talk about what I just said holds true if Jonathan Ingram’s analysis is correct, it’s also true if Jackson Hewitt’s analysis is correct. Again, they need to think long and hard about this. You can read between the lines and say, “No. I don’t think they are to be advocating it.”

Back in 2009, Senator Ron Wyden, Democrat of Oregon, said before the whole law passed, “Medicaid is a caste system. It is unfair to poor people, and it is unfair to taxpayers.” His words are truer than ever. Now the businesses we’re talking about are in fact taxpayers and when the financial ramifications of this expansion take hold, businesses are going to be especially hard hit.

I’m going to also add and expand upon that. Business owners who believe in private markets and think private markets are desirable in health care and other fields, they ought to think twice about it for that reason, as well. And also, business owners who do care about the health of their employees and their neighbors and their families, once again, there’s another good reason not to be enthusiastic about this expansion.

Let me get into explaining why I say these things. First of all, the expansion is not good for business. The Jackson Hewitt is a very partial analysis as are most of the analyses floating around. To buy the expansion argument that’s made in this and other studies, you have to buy the following sequence: Take a whole bunch of your employees, shove them over to Medicaid, get the employees off of your plan, lose the employer mandate obligations and you’re off scot free. You saved that $3,000 or $2,000, or whatever.
To believe this, you have to believe that the federal government gets its money from a gigantic, magical ATM up in the sky. In truth, if we expand Medicaid in this way, the money’s going to come from one or three places. Either there are going to be a higher federal and state taxes—in which case businesses are going to be paying those—or, we’re going to borrow more money from overseas...pile up additional debt and the businesses are going to pay there. Or, we’re going to have to cut other federal programs there by ramping down some of the roots where businesses find the income elsewhere.

In any of these scenarios, the businesses are going to pay. They’re going to be paying the burden. The burden will be harder to see, but it’s still going to be there. I would contend that because of Medicaid’s inefficiencies, and it is a horribly inefficient program the burden may well end up larger than just that $3,000 penalty or the cost of insurance.

Businesses may sense some transitory savings as this happens, but the unintended consequences, the indirect consequences, will wipe out any transitory savings, I think, fairly quickly. In sum, it’s not a great thing to the business, the bottom line.

Secondly, it’s terribly unfair to employees. The Affordable Care Act, the ACA, already has given businesses enormous incentives to cut the number of employees to get them below that 50 number of full-timers and full-time equivalents.

It is already given businesses incentives to cut employees’ hours. Again, if you get them down below the 30 hours a week to 29, you again lose that obligation. Now, with this expansion, we are adding to some incentives, actually they are already in it, but now we’re augmenting the incentives to cut employees’ wages. Because, an employer’s going to have to look there and if their employee is somewhere just north of that Medicaid line, they know all they have to do is cut this guy’s wages or keep them below the line and I will not have that obligation. In this sense, it gives employers all sorts of incentives to treat similar employees in a very different fashion.

Another aspect that’s unfair to the employee is Medicaid is a hugely expensive program, and it provides really rotten-quality coverage, care and outcomes. Again, harking back to what the Senator said five years back. First off all, Medicaid has never been particularly good at enrolling people.

It’s interesting that about sixteen percent of the people who are eligible for Medicaid historically have not managed to get enrolled because of the inefficiencies of the program. Coincidentally, that’s just about identical to the sixteen percent of the Americans who don’t have any insurance. Medicaid’s no better at enrolling people than others. Once they do get enrolled, they find it difficult to get care. Many, many, many doctors and especially the better doctors and better hospitals and better institutions refuse to take Medicaid. And so, these people go off to the emergency room with very expensive care. It grossly underpays the doctors so they have no motive to accept Medicaid patients.
Beyond that, once people get their care through Medicaid, once they’re in the system, they’ve gotten care, their health improves relatively little over actually being uninsured. I’m not going to say...some people make the argument that you go to Medicaid from uninsured and your health gets worse. I’m not going to state that. It’s not true overall.

There is some benefit to having a Medicaid card in your wallet; however, it’s not a great benefit. Secondly, there areas of medical care where, in fact, Medicaid recipients don’t seem to fair as well health-wise as the uninsured. We can quibble over how powerful the data are, but there are an awful lot of academic studies that come out with that bottom line.

There’s another big one, and this is a philosophical one. If you want all of us to be rolled into a single-payer system, which plenty of people who supported the law would really love, well this is a great start. We’re going to take these people from 100 percent to 138 percent of the federal poverty level, move them on out of private insurance and move them on over to Medicaid. Let me put that in dollar terms. For a family of four, that’s roughly $24,000 to $32,000 annual income.

You move them out of private into Medicaid. First of all there is a fairness issue there. Those tens of millions of people in that category, they have access to private coverage. Coverage that works, private insurance with real networks of doctors and such. In order to expand Medicaid, you are required to snatch their coverage away, coverage they’re happy with, and move them on into something they are most certainly not going to be happy with.

Let me look a little bit at the logic here. The argument here is, well, if we take those 100 to 138s and move them on into Medicaid, you lose your obligations. It’s great for your bottom line. If that’s true, you can look at the businesses and quite similarly say, “Hey, why don’t we move the 138 to 200 or the 200 to 400? Why don’t we just move everyone in the Medicaid and then your bottom line will be great.”

Again, we all know that the tax burden that would accrue as a results of that would be horrendous. The health effects on the employees would be terrible. Again, to repeat, it’s a hugely expensive program, and businesses that would support this expansion or expansions beyond—and I guarantee you, if this expansion goes through there will be calls to expand further—the businesses are going to be paying huge taxes to support it.

Summing it up, it’s bad for business, it’s bad for employees, it’s bad for health, it’s bad for markets, it’s bad for the economy. We need to explore alternatives. It’s not a choice of this expansion or do nothing and walkaway. There are alternatives out there, and we need to look deeper at them. Some of them probably provide better care at lower cost. We need especially to look at some of those.

If you don’t mind my putting in the slight plug, a lot of these issues are covered in a book that the Mercatus Center is going to be issuing in April: The Economics
of Medicaid: Costs and Consequences. Maybe we can discuss it further in Q&A, but I’ll leave it at that.

Jonathan Bechtle: Thanks so much for covering all those different topics. That’s been very, very helpful. I’m sure that some of our folks have questions and we want to allow them plenty of time to ask questions. In just a moment, we’ll open it up for Q&A so get those questions ready. Before we do that though, I wanted to ask Jonathan Ingram to update us on something that many have seen as one of those alternatives to Medicaid expansion, but is another one that doesn’t quite to be what it seems.

That’s the “Private Option” that’s been tried in the state of Arkansas and has been looked at by some other states. We did a call on this a few weeks ago and talked about the ins and outs of it, and there’s been a couple of really important key developments in Arkansas since that time. So, while people are thinking of their questions for our guests, Jonathan, would you just give us a short update on what has changed and what we’ve seen happen in Arkansas in the past couple of weeks?

Jonathan Ingram: Absolutely. As you mentioned, a few weeks ago, we really discussed a lot of the empty promises that some of the lawmakers were making in Arkansas for the Medicaid expansion plan, which they call the Private Option. For those who don’t know, Arkansas received a waiver from the federal government so they could deliver basically regular Medicaid benefits, but deliver them through an ObamaCare exchange plan. As with all waivers, they had to prove that it was budget neutral.

They had a lot of little crafty things built into that to try to up the cost of the budget neutrality agreement so that it looked like it was less expensive than it really is. But ultimately, they did have to agree to a cap with the federal government for how much the feds will reimburse the state for Medicaid expansion. It turns out that after just two months, the per-person costs, which are what the cap applies to, are about ten percent higher than their consultants originally estimated.

There’re already above the federal cap. Which means that if this trend continues, and there’re several reasons to believe it will, given the basic design of the program, which we talked about a few weeks ago, the state’s going to be on the hook for millions of dollars for a program that was promised to be 100 percent federally funded because it’s a Medicaid expansion. Taxpayers in Arkansas are really already starting to see that they’re going to be on the hook for this cost far earlier than they expected.

It’s not going to be that three years of free money. It turns out that they’re actually going to be on the hook for substantial amounts, even in the first couple of years. This really should serve as an example to leaders in other states who are really trying to think about this expansion plan and decide what’s best for their state. Not only is it a bad policy for the many reasons that we’re outlined in the past, but it really places your state at even more of a financial risk than a regular Medicaid expansion would.
Jonathan Bechtle: Great. Thank you, Jonathan. For anyone in the state that is looking at Arkansas as an example or talking to folks about that, certainly we would encourage you to take a look at Jonathan’s analysis of this cost overrun that’s already occurred. You can find it. We send it out in the email this morning, a link to it, but you can also find it on our website at UncoverObamaCare.com.

All right. Let’s move to Q&A session here. The way this works is that you can press *6 to ask a question. Then, we’ll just kind of go through the questions that are there and let you know when it’s your turn to ask. Certainly, I know that some of our co-sponsors are on the call as well. If they have any update they like to give, certainly press *6 as well and we’ll make sure we get to you.

Let’s start with a question that was submitted in advance. Dr. Graboyes, this is for you. You mentioned that Medicaid expansion is something that all businesses large or small or medium should think very, very carefully about before they support. Yet, we’ve seen in some of the states a real split in support from the business community for expansion.

For instance for many states, groups like NFIB were against it for many of the reasons that you suggested, but then we saw state chambers, similar groups that were in favor. Can you talk about why do we see that split and how should people respond to a difference there even in the business community over this issue?

Dr. Robert Graboyes: Sure. Part of it, I have no doubt, is simply the political differences in the states. Some states are more supportive of the law in its entirety. You have a lot of philosophical differences from one state to another. I think a lot of it comes down to what I noted that a lot of people have looked at it on a very partial basis. The “I will lose, I will lose any obligation to buy insurance, and I will lose that $3,000 penalty and that’s the end of the story.”

I would say in some places an inadequate job has been done of, let’s say, informing the businesses that you are going to be paying that. You may not be writing the $3,000 check in exactly that fashion, but it will come back to bite you through some indirect path. You’re not going to save money by doing this. I think there is a lack of understanding of that complete process. It’s kind of a tendency to think of federal money just kind of comes magically in to the states and doesn’t come from anywhere. I guess that’s the two things; Politics and incomplete analysis.

Jonathan Bechtle: Jonathan, would you add anything?

Jonathan Ingram: I think there’s also just a difference in sort of the make-up of the state chambers and NFIB members generally. A lot of the state chambers have been actively pursuing some of the special interest groups that are really pushing Medicaid expansion. In a lot of states you’ll see that hospital executives are on the boards for state chambers of commerce. You get a lot of the hospital groups, a lot of the insurance companies, some of the people who are really pushing for the Medicaid expansion being on the boards with the chambers and that might play a role on it, too.
Dr. Robert Graboyes: I would certainly agree with that.

Jonathan Bechtle: Excellent. Thank you both for answering that. We have a question that’s come in. Go ahead with your question. Yes. May I have your question?

Craig DiSesa: Hi. This is Craig DiSesa with Middle Resolution in Virginia. I recently read in Arkansas that they’ve just passed, after several attempts, to start funding the Arkansas plan again, and that one of the Representatives there, maybe, Jonathan, you can provide some more clarifications on this, switched his vote. The reason why is because if they didn’t pass this funding, a lot of people would be thrown off of Medicaid because initially they were placed on a Medicaid, because of the plan.

My point here is, to legislators is that, one of the arguments they used to, say if the federal government doesn’t keep up their commitment, then we would just disenroll all these people. My argument is, it’s politically impossible to do. I think Arkansas demonstrates that. Jonathan, could you comment on that?

Jonathan Ingram: Absolutely. That is one of the major arguments made by the last person who ended up flipping his vote. As you mentioned, the voted failed four times just a few weeks earlier. They voted every single day and it kept failing, kept failing, kept failing. One person in the Senate actually flipped their vote because they were getting a ... basically due to horse trading, they were getting a different deal out of it. Then, in the House, one person flipped their vote saying “obviously we’ve now put a 100,000 people on the Medicaid program, even if they’ve only been there two months, it’s impossible for us to take those people off now.”

This idea that three years down the road, you’re suddenly going to throw those people off of Medicaid is really suspect. Not only just for legal reasons of whether you could do it or not, but just for political reasons of what’s the political reality of throwing hundreds of thousands of people off of Medicaid. Even if they are able bodied, childless adults.

Dr. Robert Graboyes: Jonathan, if you don’t mind, I’ll chime in on that one as well.

Jonathan Bechtle: Please do.

Dr. Robert Graboyes: This has been an interesting part of the argument. If you don’t expand, you’re going to throw all of these people out on the cold. Again, the way they designed, the way the Congress designed the expansion was specifically ... in order to add all those people to 100 percent of the poverty level, you are going to have to throw that 100 to 138 bunch out of private insurance. They’re sort of holding their coverage hostage to the other group.

The question to me is not, “Should you throw these people out in the cold?” Rather it is, “why did Congress construct it in this way that forces the state to throw them in the cold if they don’t want to expand all the way up into 138?” I don’t know what the motives were. I don’t know whether it was bad drafting or sort of a cynical ploy to essentially coerce the state into doing this.
It certainly gave a powerful political motive, but my answer in that is go back to Congress and say, “You can fix this. You can allow the expansion up to 100 without bothering those people who are above 100.” Ask your Congressman why they don’t do that.

Jonathan Bechtle: Thank you gentlemen. Thank you for the good question. If anyone else has questions, again you can press *6 to get in the question queue. Let me, Jonathan, ask you a follow up question that was sent to us. This is essentially kind of a recap about your conversation about the Jackson Hewitt study. Could you just talk again for a moment about ... you’re saying that businesses are very likely to be on the hook for a whole lot less than Jackson Hewitt’s study implies. Is that right? There will be many less businesses that are potentially going to be in trouble with that than they’re saying?

Jonathan Ingram: Yeah. You really need to consider the very, very narrow sliver of people we’re talking about here. Full-time employers must have at least fifty full-time equivalents to be subject to the mandate. They have to have more than thirty actual full-time employees, not just the equivalents. And they actually have to either not offer health insurance to full-time workers at all or the coverage has to be “unaffordable,” which means that it cost more than 9.5 percent of their household income.

To trigger the penalties, at least one of their full-time workers has to get the ObamaCare subsidies, which means that they have to be between that 100 to 138 percent of the poverty level. Although if the individuals above 138% of the federal poverty level go and get an ObamaCare subsidy, the employer is still subject to the mandate for that.

The Medicaid expansion really affects that small group between 100 and 138. Those would be the only workers who would “be saved” under the Medicaid expansion for that employer. Even then, Medicaid workers count and determining whether you’re actually subject to a mandate. They count in the penalty for not offering insurance whatsoever. The only time it really affects the business is if it’s offering what the government determines is unaffordable insurance to people who are at 100% of the federal poverty level that is considered affordable for people who are at 138%.

When you look at it, employers would actually have to actively decide to pay the penalty rather than either restructure their compensation or restructure their workforce. The wisest action, which most employers are looking at right now, and a lot of them are already taking it, is to simply restructure their workforce so that the people who ObamaCare classifies as “full-time workers” – who would not qualify for full-time benefits under businesses’ usual model operating policies – reduce their hours so that they no longer qualify under ObamaCare.

What you’re seeing are a lot of people working 30 to 35 hours per week maybe, having their hours reduced to probably 25 to 29 hours per week. That’s really the best move that employers have to make sure that they’re not subject to the mandate. They can also do a few other things if ObamaCare calls your current
insurance “unaffordable,” which in many cases still cheaper than paying the penalty.

Employers are smart. They’re going to find the best way to keep their payroll costs down and they’re going to do that. Medicaid expansion isn’t some kind of silver bullet to save employers.

Jonathan Bechtle: Thank you for that clarification, Jonathan. Some of this is hard to keep your hands wrapped around because it seems like the landscape is changing so often. Dr. Graboyes, maybe you could talk for a moment about just … we’ve seen a couple of delays of the employer mandate by the Obama administration. Could you just quickly walk us through what delays have we seen, where we are right now, how does that impact this whole issue of Medicaid expansion for employers?

Dr. Robert Graboyes: Right, that’s a great question. I think it has an enormous impact on how businesses are thinking about this and probably ought to be thinking about it. The first of these sort of arbitrarily shoved the whole thing off for a year. Then, there was a second one, so that for businesses between 50 and 100, it would be pushed off an additional year. We’ve been on the phone for about half an hour, for all I know, something else has changed since we’ve been on the phone.

If I were a business, I would really be asking the question, “Are they ever going to activate, implement the employer mandate?” Personally, I’m kind of doubting that they ever will. It’s not being pushed off for economic or operations reasons. I think it’s an enormous burden and there’s an awareness that businesses are going to react in highly unpredictable ways if it ever is imposed.

I just have a big question mark as to whether they are ever actually going to say, “Okay. It’s actually going into effect.” If I were business, that would be part of my calculation.

Jonathan Ingram: That’s a really great point. I think it’s also interesting to note that one of the other delays that they’ve made with this is that even the employers with over 100 workers are subject to a much smaller mandate than what the law originally required. Now they only have to offer coverage to, I think it’s 70 percent of their full-time employees. Beyond all the problems with sort of the Jackson Hewitt analysis and Medicaid expansion in general, it’s really unclear why states should buy this argument that they should dump nearly a trillion dollars into ObamaCare’s Medicaid expansion over the next decade just to save employers a few billion that may never actually even be fully implemented.

Jonathan Bechtle: That’s a great point. As I mentioned before, if anyone has any additional question they’d like to ask, certainly press *6. Let me throw out another one that was sent in ahead of the call. There are, kind of…speaking of things that may change the landscape, there are several lawsuits that are under way that are also attempting to block portions of the employer mandates. Dr. Graboyes, is there are anything that we should be watching with those lawsuits that could change the landscape here for businesses and the mandate?
Dr. Robert Graboyes: Oh, yeah. Absolutely. That’s probably the most interesting; I’d say certainly the most interesting judicial issue out there. Of course, the Supreme Court upheld the individual mandate, so to speak, by redefining it from a penalty to a tax. There is another set of suits that really came out of Michael Cannon over at Cato and Jonathan Adler, a law professor who’s working with him. They are arguing. I think they have some pretty solid arguments. I’m not an attorney so I have no idea how the courts will rule on it, but their argument was that the language of law makes very clear that the subsidies are only available in exchanges that are set up by the states. Not those large numbers that have been set up by the federal government. All the healthcare.gov states.

I’m not a lawyer, but I have read those parts and indeed it certainly looks as if the subsidies were only to be given in those state exchanges. They interpreted it to say now we’re going to extend it further.

I’ve read the arguments that suggest that it’s a weak legal argument. Again, I’ll defer to the attorneys and I’ll defer to the courts on that one. If the courts were to buy the Cannon and Adler logic, you would have a huge part of the United States where people could not get subsidies through the exchanges. I think the law would be thrown into utter pandemonium. All of the discussions we’re having here would be trivialities next to what ensued. Again, it will be very interesting to see how the courts view it.

Jonathan Ingram: I think the plaintiffs have a very good case in the idea that the employer mandate doesn’t apply in the states that don’t set up their own exchange. Because, the employer mandate is only triggered if an employee received an ObamaCare subsidy. It’s interesting to see sort of the broad ray of challenges that this kind of thing is getting.

The Attorney General of Oklahoma filed a lawsuit. Several employers in multiple states have filed lawsuits. The state of Indiana filed its own. A bunch of local school districts filed lawsuits. A lot of people are challenging this, and it’s going to be very interesting to see how it all plays out.

Dr. Robert Graboyes: Yeah, thanks for reminding me. I had meant to say that point, too. The only way that the employer mandate is triggered is if at least one of your employers gets a subsidy. If the court says, “None of your employees are entitled to subsidies,” from this non-lawyer’s opinion, there would be no employer mandate applicable in that state and that’s kind of the heart of the argument.

Jonathan Bechtle: Clearly it would make a pretty huge difference. Certainly something to keep a close eye on. Again, if you would like to ask a question, press *6 and we will go to our next question. Please go ahead with your question.

Grace-Marie Turner: Hello this is Grace-Marie Turner of the Galen Institute. Thank you so much for allowing us to co-sponsor this call with you. I think you’re very close to the concerns the states have and I think this issue about whether or not states will be harmed if a state does not expand Medicaid is really important to answer. I think you’ve done a terrific job, with your paper in particular, in answering that very flawed Jackson Hewitt study. Thank you very much for that.
This issue about the mandate, just so you know, there will be oral arguments just a week from Tuesday in the DC Circuit court in a major case involving the challenge—whether or not federal subsidies can flow through the federal exchange to people, in complete contradiction of the wording of the statute. The Galen Institute filed an amicus brief in this in which we made a very strong argument. Our whole amicus was organized around states’ rights and that this is yet another of the same kind of directive from the federal government that we saw with the Medicaid expansion, which the Supreme Court said was optional for the state. I would be happy to send you the link to our amicus so that you can circulate that to the group as well. I think there’s some really important states’ rights argument that we need to be including in our work.

Just to clarify, the employer mandate is in effect whether or not the state would expand Medicaid. It’s the penalties that could not be applied. There are a lot of other things to the employer mandate including a whole battery of reporting requirements, etc. that employers have to comply with but the penalty in particular could be stopped if these lawsuits are successful and it’s not possible for federal subsidies to flow through to the 35 states that have opted for a federal exchange and not set up state exchanges.

Jonathan Bechtle: Thank you so much for clarifying that. Absolutely. Please do send us the amicus brief and we’ll make sure that it gets around everyone on the call. Thank you so much for everything that you do and for co-sponsoring the call. We’re so glad to have you as an ally in these conversations. We have another question. We will go ahead with that. Please go ahead with your question.

Mike Thompson: Hi. This is Mike Thompson with the Thomas Jefferson institute. We are told here in our budget battle over Medicaid that 400,000 people are not covered. The question I have is those 400,000 that are not covered by Medicaid, a whole lot of them could very likely be covered with health insurance which is an issue which has not been discussed of whether those 400,000 are truly sitting out there with no insurance. The way they word it, they’re not covered by Medicaid. They may very well be covered otherwise.

I’m just wondering where we might be able to find that out. We did a survey last summer that showed that 59% of those who are on Medicaid today had insurance before they went on Medicaid. Which is why this whole issue of the 400,000 I’m asking.

Dr. Robert Graboyes: This is Bob. I would just say either intentionally or unintentionally, I don’t know that the data exist to actually answer that. Obviously, we’re not getting very good information on how many people have actually enrolled as we now hurdle toward the end of March. Or, how many of the people who have enrolled actually already had insurance or how many people who had insurance are no longer enrolled. We’re certainly not getting flows of data enough to understand what’s going on and the question you just name is one that has been a big question mark for a long time. I don’t know that anyone could answer it.

Jonathan Ingram: I’ll just follow up on that a little bit. You now see this in a lot of states. The interesting thing, the pro-expansion people consistently use data that includes
people who are currently eligible for Medicaid, pre-ObamaCare, and Virginia does this as well. About 17 percent to 18 percent of the people that they say are eligible under the expansion are actually already eligible for Medicaid and they just haven’t signed up yet. About 17 percent of that 400,000 figure.

They also include people who as Bob has pointed before, are currently eligible for subsidies, but those subsidies go away at the state’s expanse in Medicaid. All in all, it ends up being about 40 percent of the uninsured adults who are under this 138 percent FPL level who either currently are eligible for private insurance through the exchanges or are already eligible for Medicaid and it wouldn’t be affected by the expansion at all.

But I think it’s really important to keep in mind who this population is to begin with. These are able-bodied adults, most of them have no dependent children. It’s a group of people that have never qualified for other types of welfare. They can’t qualify for cash assistance, they don’t qualify for long-term food stamps. They’ve never really been considered part of the core social safety net. This idea that suddenly we should create a new entitlement to these able-bodied adult with no disabilities keeping them from working is a little strange.

Dr. Robert Graboyes: One of the ironies of this whole thing is that if you go back to March 2010, before the whole law passed, there were probably somewhere between 10 and 12 million people eligible for Medicaid who were not signed up and were in the circumstance where if you became ill, you can retroactively sign up.

If they decided in March 2010 instead of passing this act, why don’t we just send a bunch of people out with clipboards and sign up the people who are already eligible, they would have done far more to expand insurance coverage in America than anything possible when this bill washes out. But, of course, that’s not what was done.

Jonathan Bechtle: Great point and great question. Thanks for asking that. We’ve got time for a couple more questions. Again, you can press *6 if you want to jump in to the conversation. We will go now to a question from South Dakota. Please go ahead with your question.

Speaker: Yes. Please don’t ignore South Dakota. We have Tom Daschle still active in pushing ObamaCare. What South Dakota has done, this is a question for your sponsor from the Galen institute. We have set up a very different kind of an exchange. It’s not a state exchange, they say, and they say it’s not a federal exchange. We’re the only one that has one that’s like a federal partnership, but not really.

I’m wondering how did our kind of exchange fit in with either the federal, where you can’t have the subsidies, or the state? Or you cannot have the subsidies with our quasi partnership?

Jonathan Ingram: That’s a really great question. The interesting thing is that these partnerships, which are starting to pop up in a couple of different states, aren’t actually defined in the law. You have to look in for the regulations where they came up
with this idea of a partnership. Ultimately, what it means is that these are federal exchanges, not state exchanges. They’re set up under the section of ObamaCare that creates federal exchanges. In those states with quasi-partnership exchanges, if these lawsuits pan out, those employers in those states would still be free from the penalties of the employer mandate.

Jonathan Bechtle: Dr. Graboyes, do you have anything to add on that?

Dr. Robert Graboyes: Nope. That was a great answer.

Jonathan Bechtle: All right. Thanks, gentlemen. Again, we’ve got time for probably one more question. Feel free to hit *6 to jump in the queue. I do have another follow-up question; it would be a final one, for Dr. Graboyes. Could you talk just a little bit about, now that we’ve seen a few months of the expansions being in place, we have a little bit of history to look to as to how those are going, could you talk for a moment, and certainly, Jonathan Ingram, you can jump on this as well, about what we’re seeing so far, and then also tell us just a little bit more about your book that’s coming out and how people can get a hold of that when it’s published?

Dr. Robert Graboyes: Sure, absolutely. The fact is, as I said a minute ago, we really don’t have a very clear picture. It’s a very smoky lens that we’re looking through. Again, I don’t know whether it’s because data are being withheld. If you look at the disaster with the website, then perhaps the data is simply not attainable. I think the best guess is we’re either going to see when March is finished passing, if we ever see the data, the number of people in America who are covered will have either conceivably drop somewhat. Drop slightly. More likely, it will have increased slightly. Not a great deal. Maybe by a couple of million.

Given the coverage was the major stated objective of this, it will not have done a very good job of that. We will have, assuming that a couple of million extra people are added, we will have done that at an enormous cost and complete disruption of the health care system.

I know people personally who are tearing their hair out, trying to find out whether their covered, they found that their network has shrunk, that they can’t go to the specialist they’ve been going to. It is enormous turmoil in individual human lives. Again, I suspect we will end up with a slight expansion in coverage and a worsening in the coverage that people actually have.

The second point, the book that we’ve got out is called The Economics of Medicaid: Assessing the Costs and Consequences. It will be available through Mercatus, I think sometime in early to mid-April. It’s a nice book. It will cover the structure of Medicaid, what drives the cost of it, the federal side, the states’ side, the budget equations, Medicaid under the Affordable Care Act.

We’ll have a physicians’ perspective on it. Some potentials on how to reform it. Hard truth on trying to achieve sustainable reform. In the last chapter, I had the pleasure of writing what’s called Medicaid and Health. When I actually looked at, does this program actually make these people healthier, as I said, the answer
is maybe they make them a little healthier, but certainly not nearly as healthy as real health insurance, real programs do.

I think it’s going to be great and it’s written by nine or ten of the most outstanding names here in DC and elsewhere. You can get it through Mercatus.org. Just keep your eyes out. You’re welcome to email me if you want to find out. Otherwise, it will certainly be on the Mercatus site sometime probably about a month or less.

Jonathan Bechtle: Excellent. We appreciate the effort that you put into that. We certainly look forward to that. I want to go ahead and wrap up and honor folks’ time. Maybe we can have just a little bit of a closing comments. Kind of parting thoughts, if you will, from our guests. Jonathan, let me start with you. Would you give us kind of your closing thoughts on this issue and where people can go and address this in their own states?

Jonathan Ingram: Absolutely. Lawmakers in several states are really taking the right approach and trying to fully understand this ObamaCare Medicaid expansion before really diving headfirst into it. I think that’s why a lot of states are really opting out of the Medicaid expansion. Because, once they fully understand the true facts surrounding it, they realize it’s not as good as advertised.

The flawed assumptions and the inconsistent data and all the other miscalculations made by these Jackson Hewitt studies urging the state to expand Medicaid, I think that really sets Jackson Hewitt up as a dangerous source for our lawmakers to rely upon. There are meaning policy questions about whether states should create a new entitlement for able bodied adults, especially when the track record, as Bob just said, has been really, really poor. But this idea that Medicaid expansion is going to really save the business community from the effects of the ObamaCare is just not true. It would behoove lawmakers to really look at these issues carefully, instead of relying on these flaw-filled reports that come out.

Dr. Robert Graboyes: Yeah, and I would-


Dr. Robert Graboyes: Sure. I would add to that, the calls are “let’s rush into this thing. Let’s do it fast. Get into it.” Which is kind of ironic, they’re telling the state, “Rush into Medicaid.” Meanwhile, we’re going to delay, delay, delay, delay, delay everything else in the law. I think one should take some good advice from those delays. Clearly the administration understands that there’s some very unpalatable, unworkable parts that they’re delaying. As I said, I think, some of them which may never come into effect.

The state legislators might want to take a similar tact and say, “Well, you know, the administration’s going to be delaying on everything, maybe we should delay this and think it through completely.” Thinking it through requires that you not simply look at the first round of effects. That $3,000 that Jackson Hewitt looks at, but all the other tendrils. All the other secondary and tertiary effects that this
thing is going to have on state tax levels, on a federal tax levels, on the quality of care, etc.

I’ll just add one thing. I think Jonathan was talking a little bit earlier about how unpalatable it is to put people on the Medicaid and then throw them off. We’ve actually seen that happen in a couple of failed expansions. Most notably the TennCare disaster in Tennessee where the state decided quite some years ago, close to 20 years ago, “Let’s go ahead and expand Medicaid, bring a lot more people into it.”

They did so. They took them and the state treasury nearly went bankrupt in the process. At the height of the crisis, they essentially mailed out something like 200,000 letters saying, “You know that insurance coverage that you had? You don’t have it anymore.” When push comes to shove, when you break the budget, terrible things like that can happen. The politically unthinkable becomes thinkable.

Jonathan Bechtle: Well. Thank you both very, very much for taking the time to talk with us about this important issue and for the research that you both have done. Thank you also certainly to everyone who joined us and to our co-sponsors for helping us to get the word out, and to all the work that they do. We are going to have a recording of this call posted on our website. UncoverObamaCare.com as well as a transcript, so if you’d like to get a copy of this and pass it on to others who’d be interested in it, please do that. We’ll send that out by email of those links after the call.

Again, thank you to Director of Research, Jonathan Ingram, and to Dr. Robert Graboyes. We will talk to you all again soon. Have a great day.