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Policy Analysis

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Obamacare Medicaid Expansion: Still a Bad Idea

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Under the federal Affordable Care Act (shortened to "Obamacare" in this publication – as explained in an endnote[1]), Medicaid coverage can be expanded by a state to most adults living in households at or below 138 percent of the federal poverty level (FPL) ($17,236 for one person; $35,535 for a family of four). Initially, 100 percent of the cost of the Obamacare Medicaid expansion would be covered by the federal government, with no less than 90 percent of the cost covered by the federal government after 2020.

Currently, Medicaid coverage in Oklahoma is limited to *children* in households at or below 205 percent of the FPL ($34,666 for a family of two; $52,788 for a family of four), pregnant women with incomes up to 133 percent of the FPL ($28,369 for a family of three), some adults with incomes up to 42 percent of the poverty line ($5,246 for one person), some who are blind or otherwise disabled, and poor senior citizens.[2]

Many with incomes up to 400 percent of the FPL ($49,960 for one person; $103,000 for a family of four) already qualify for subsidized insurance under federal health insurance exchanges. FPL incomes do not include employer benefits and are not adjusted for Oklahoma's low cost of living. In addition, Medicaid benefits are not currently predicated on work requirements. Although work requirements were passed into state law, the federal government must approve a pending waiver application for it to become effective.[3]

Though arguments in favor of Obamacare Medicaid expansion initially sound persuasive, there are good reasons not to expand. Given current Medicaid and assistance eligibility, the supposed need is greatly exaggerated, and the risks for Oklahoma's state fiscal health is understated. Obamacare Medicaid expansion will ultimately make the problem of spiraling health care prices worse, by expanding demand in health care while doing nothing to enhance supply. Finally, instead of Oklahomans directly helping their neighbors in real need, implementing the Oklahoma Standard by imagining and implementing Oklahoma-based solutions, Medicaid expansion is a top-down approach. It also mainly benefits the already-rich in a very rich health care industry.

Why the Push to Expand Medicaid Coverage?

Federal policy has, even before the enactment of Obamacare, provided that states could expand their Medicaid coverage above federal minimums. The federal matching funds were substantially less than 90 percent of the costs, but several states had expanded under the old law. Oklahoma had not, except to participate in CHIP (Children's Health Insurance Program), which passed into federal law in 1997.[4] Given this history, why the press for Oklahoma to expand Medicaid now?

Expansionists' Rationale #1: Federal Money (or, We're Already Paying the Taxes)

By one estimate, Oklahoma would see an infusion of $11.5 billion in federal funds over the next ten years, an average of $1.2 billion per year, were it to expand Medicaid under Obamacare.[5] To put this in perspective, were Oklahoma's GDP not to grow at all over the next ten years, this $11.5 billion represents a mere 0.6 percent, or a little more than one-half of one percent, of Oklahoma's GDP – even less, with economic growth.[6]

Some will argue this GDP comparison understates the impact of expanded Medicaid's potential economic impact. After all, this is new federal money, so there will surely be a multiplied impact. However, given that the health industry is arguably the richest industry in the nation (10 of the top 10 highest-paid professions are in health care), there is no guarantee a substantial portion of the money, once it is initially laundered through the health industry, will remain in the state. It is difficult to see how much more of their increased income the already-rich will keep in Oklahoma, as opposed to investing, saving, and spending on luxuries elsewhere.

The idea that Oklahomans are paying the taxes to fund Medicaid expansions in other states is belied by the fact that federal deficit spending has arguably funded Obamacare. Federal Medicaid funding is dispersed by formula independently of

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federal tax revenues. This unsustainable behavior is made all the worse as more states take advantage of the system. Oklahomans must consider, just because governments are subsidizing the lifestyles of the relatively wealthy due to some states' actions, whether Oklahoma should follow suit.

Expansionists' Rationale #2: Hospitals Need the Money

Some small and/or rural hospitals in the state are arguably in financial straits, but most of the state's hospitals, especially the urban-based hospital chains, are figuratively swimming in money. This can be seen by looking at non-profit hospitals' tax forms (Form 990), which are public records, as the 1889 Institute did for a September 2017 research publication.[7] 1889's sample of Oklahoma's nonprofit hospitals showed that they collectively held at least $1 billion in cash alone, fully a quarter of their total declared assets.[8] Their top-paid executive salaries averaged $347 per hour, based on their self-declared workloads.[9]

Very often, the chief reason hospital representatives claim their industry needs more funding is "uncompensated care." This occurs when services are rendered but patients do not pay their bills. Uncompensated care might result from a bill not being paid at all, or it might result from only a partial payment, with the balance counted as uncompensated. It stands apart from charity care, which is separately recorded on tax forms. Eventually, uncompensated care is written off as bad debt. *In any case, the dollar numbers reported by hospitals as bad debt and charity care are greatly exaggerated.*

It is now well-documented that hospital pricing bears little resemblance to actual cost, with hospitals' "chargemaster" (or list) prices for services generally far and away higher than could be justified in a truly competitive market. For example, patients using the Surgery Center of Oklahoma, which has historically taken only cash, pay one-eighth to one-sixth of what is charged by Mercy and OU Medical.[10] The list prices are also higher than what is generally charged according to insurance-negotiated pricing. Yet, it is these highly-exaggerated list prices that are used to value the services written off as bad debt and charity care.

In 2011, according Steven Brill of *Time*, Mercy in Oklahoma City claimed charity care worth 3.2 percent of its total revenue, but that was based on chargemaster prices, likely 10 times greater than actual costs, meaning the cost of charity actually amounted to about one-third of one percent of revenues.[11]

To the extent that rural hospitals need help to stay open, funds should be targeted for that purpose, not sprinkled over every hospital in the whole state, rich and poor alike.

Expansionists' Rationale #3: More People Will Have Health Coverage

Early evidence conflicts on whether Medicaid expansion in other states has had any measurable, positive impact on the health of targeted populations.[12] This alone calls into question the desirability of "health coverage" as a public policy goal, although more recent studies, touted by advocates, show greater promise. Regardless, "health coverage" is part of the third-party payer problem that has caused the decades-long upward spiral in health care prices relative to other prices in the first place.[13] Studies promoting the benefits of Medicaid expansion say essentially nothing about the costs beyond the dollars involved, and dollar costs alone are often dwarfed by so-called "secondary" effects, so studies that fail to take account of these extra costs are not valid.

"Health coverage" is not the same thing as actual "health care." As hospital lobbyists are quick to point out, some individuals receive care even when they have no insurance or government program coverage, and some do not pay at all for the care they receive. In other words, the indigent and others with low incomes tend to get care that they truly need.

This leads, however, to the argument that "lack of coverage" is a culprit in the health care cost spiral. The argument goes that when people do not pay their health care bills, hospitals have to make up the cost of uncompensated services to everyone else by charging higher prices which, in turn, drives up health insurance rates. But if these costs were covered by taxpayers in general instead of insurance companies and hapless cash payers, at least they would be more evenly distributed, goes the argument. Of course, collectively, taxpayers would not save one dime. One way or the other, through taxes or insurance premiums, we all pay for uncompensated care.

A common theme from the hospital lobby is that they are "obligated to treat everyone," as a result of the Reagan-era-enacted EMTALA (Emergency Medical Treatment and Active Labor Act). This law merely states that after an initial examination to determine if a true emergency exists, hospital emergency rooms are obligated to stabilize a patient, who can then be transported elsewhere, even if the reason is based on ability to pay.[14] There is no requirement that minor ailments like colds be treated in an emergency room. In other words, hospital lobbyists purposely grossly exaggerate EMTALA's requirements.

Medicaid Expansion's Actual Effects

Making Oklahomans Needlessly Dependent

It is not uncommon to hear anecdotes of pregnant women in Oklahoma cutting back on work hours or having employers drop them from insurance benefits in order to qualify for Medicaid coverage as a cheaper or otherwise better alternative. One situation in Oklahoma, known to be true, sees a family of five with one spouse intentionally choosing to stay home. Even when offered, they avoid extra income in order to keep the children eligible for CHIP (childrens' Medicaid), since they are near the five-person household CHIP income limit of $61,849.

Oklahoma has the second-lowest cost of living in the country.[15] This means that Oklahomans at a given income level are in better shape than most Americans at a similar income level. A family of four in New York with $25,000 in income is truly destitute. The same family in Oklahoma lives decently. This helps explain the state's lower-than-average median income and higher-than-average percentage of households in poverty according to the Federal Poverty Level of income (FPL). Federal statistics overstate how poor we are.

At 138 percent of the FPL, a family of four's income amounts to $34,638. For a family with this income in Oklahoma to have the same standard of living in New York, their New York income would have to be $53,353. Or, to put it another way, a family of four in New York with $34,638 in income would have a standard of living equivalent to only $22,488 in Oklahoma. A family of five with $60,000 in income in Oklahoma, whose children qualify for CHIP, would have to make over $92,000 in New York to achieve the same standard of living and would not qualify for CHIP.[16]

In other words, proportionately many more Oklahomans will

be eligible under the Obamacare Medicaid expansion than New Yorkers. Yet this is needlessly the case when cost of living is taken into account.

This is one reason the many anecdotes of Oklahomans purposely keeping their incomes from rising enough to make them Medicaid-ineligible ring true. The FPL in Oklahoma is not so bad for a pregnant woman, who gets full coverage, and for those whose children are eligible for CHIP when family income can be up to 205 percent of poverty.

Adding to the Medical Price Spiral

Oklahoma's overall cost of living ranks second lowest in the nation, but its relative cost of health care ranks only 11th lowest.[17] In other words, while our cost of medical care is still relatively low, it is not nearly as low as it could be, or perhaps even ought to be.

There are several reasons for Oklahoma's relatively high cost of medical care. Oklahoma's occupational licenses tend to be relatively restrictive, something the legislature has only begun to try to remedy by considering proposals to allow nurse practitioners to practice more freely.[18] Zoning policies have pushed medical facilities to concentrate locationally, which has likely increased the cost of patient access as well as the price of real estate on which hospitals sit. A lack of proper policing for Medicaid eligibility has also had an impact.[19]

Put plainly, public policies have either restricted supply, which increases price, or they have expanded demand, which also increases price. A further expansion of Medicaid will expand demand all the more, increasing prices in medical care. And while those with incomes up to 138 percent of poverty will find the higher prices relatively easy to contend with, those with incomes above 138 percent of poverty will find themselves squeezed. If they pay cash for medical care or directly pay their own insurance, the squeeze will be direct. If their employer pays for insurance, the squeeze will be indirect.

State Spending

Because the federal government covers so much of the cost of Obamacare Medicaid expansion, the impact on Oklahoma's state budget per federal dollar will be relatively low, much lower than original Medicaid, where the federal match is closer to 60 percent of total costs. Many see this as a bargain; in order to get over $1 billion per year, the state need merely put up $120 million or so per year.[20] Compared to recent increases in public education spending, this seems not to be a terribly great burden.

But then, issues arise. One reason public education took the fiscal hit that it did during and following the last recession is that there is little wiggle room when it comes to states' share of federal entitlement spending. In fact, demand for federal entitlements increases during economic downturns, thereby increasing state and federal fiscal burdens. But states do not print money, and debt for such purposes is not an option. Policy makers should consider if an additional $120 million future hole in the funding of education, transportation, and other priorities is worthwhile during future recessions and fiscal shortfalls. It does not matter if Medicaid expansion is administratively and fiscally implemented through Insure Oklahoma or Sooner Care, the same question occurs.

In addition, one must wonder just how much longer the federal government can sustain current spending and debt accumulation without raising taxes. Total federal debt now exceeds U.S. GDP by $2 trillion, a state of affairs without precedent in peacetime. At some point, something will have to give, and it could well be federal spending on Medicaid. That means states could be on the hook for covering a higher percentage of Medicaid expenses in the future. The bottom line, though, is that in the here-and-now, Medicaid expansion represents an expanded burden for Oklahoma's taxpayers, whether one considers it modest or not.

Failure to Solve Our Own Problems

Federal policy has increasingly directed health care into a third-party payer model that sacrifices market discipline toward efficiency. Oklahoma could establish its own system, without a federal waiver, having clinics and hospitals bid for the privilege to treat low-income individuals in legitimate need by Oklahoma's cost of living standards and not otherwise eligible for health care benefits under the current system. However, our chasing of federal dollars, and state government's tendency to bow to the health industry, has prevented imaginative home-grown solutions from being devised.

Some Additional Tough Questions for Medicaid Expansionists

Given that Oklahoma's legislature would never spend just our own money to do the Obamacare Medicaid expansion, how does spending federal money make the benefits outweigh the costs? Aren't we just acting as enablers for bad federal policy?

We know that the third-party payment system (health insurance, Medicare, and Medicaid) is the primary cause of medical inflation being higher than general inflation. How is expanding Medicaid, whether directly or through Insure Oklahoma, NOT going to contribute to this even more?

Overall, health care constitutes about 1/7th of the U.S. economy now. How much more of the economy do we need to devote to health care?

What assurance do we have that an increasingly bankrupt federal government will keep up its side of a Medicaid-expansion financial "bargain?"

If hospitals statewide need Medicaid expansion for their financial survival, why are so many of them expanding and building new facilities right now?

Even if Medicaid expansion is implemented through Insure Oklahoma and partly administered by private insurance companies, how does this make Medicaid expansion market-oriented when real markets see consumers paying for goods and services themselves?

End Notes

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1 The name, "Affordable Care Act" ("ACA") is an example of deliberate disinformation and deflection of truth, an art of propaganda called "Newspeak" in the novel *1984*. The "ACA" (Obamacare) was sold as a way to bring down the overall cost of health care in the United States by expanding the very payment mechanism (so-called health insurance – better described as prepaid or 3rd-party-paid health care) that has caused medical inflation to outpace general inflation for most of the last 60 years. Obamacare is actually making health care more expensive and more scarce (see following references). NOTE: A couple of the articles reference the costs of Electronic Medical Records, but fail to mention that they are an Obamacare mandate.

Byron Schlomach, "Removing the Middleman: What States Can Do to Make Health Care More Responsive to Patients," Goldwater Institute Policy Report No. 230, January 13, 2009, pp. 14-22, https://goldwaterinstitute.org/wp-content/uploads/cms_page_media/2015/2/10/Removing%20the%20Middleman.pdf.

Kevin D. Williamson, "Health Care, from the Top," *National Review*, May 5, 2017, https://www.nationalreview.com/2017/05/heath-care-reform-no-cure-scarcity/

Nicole Spector, The doctor is out? Why physicians are leaving their practices to pursue other careers," *NBC News*, August 18, 2018, https://www.nbcnews.com/business/business-news/doctor-out-why-physicians-are-leaving-their-practices-pursue-other-n900921

Rena Xu, "The Burnout Crisis in American Medicine, *The Atlantic*, May 11,2008, https://www.theatlantic.com/health/archive/2018/05/the-burnout-crisis-in-health-care/559880/

2 "Medicaid, Children's Health Insurance Program & Basic Health Program Eligibility Levels," Medicaid, gov, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

"Applying for Help with Long Term Care Expenses," Oklahoma Health Care Authority, https://www.okhca.org/individuals.aspx?id=532&menu=42.

3 Nathaniel Weixel, "Oklahoma Seeks Trump Approval on Medicaid Work Requirements," *The Hill*, December 10, 2018, https://thehill.com/policy/healthcare/420570-oklahoma-seeks-trump-approval-of-medicaid-work-requirements.

4 Dee Mahan, "The Children's Health Insurance Program," FamiliesUSA.org Fact Sheet, September 2017, https://familiesusa.org/product/children-health-insurance-program-chip.

5 Louise Norris, "Oklahoma and the ACA's Medicaid Expansion," healthinsurance.org, November 13, 2018, https://www.healthinsurance.org/oklahoma-medicaid/.

6 Based on U.S. Bureau of Economic Analysis data, https://www.bea.gov/data/gdp/gdp-state.

7 Baylee Butler and Byron Schlomach, "The Profitability of Nonprofit Hospitals: Do They Really Need More Money?" 1889 Institute, September 2017, https://img1.wsimg.com/blobby/go/8a89c4f1-3714-49e5-866b-3f6930172647/downloads/1d0kk5n58_914532.pdf.

8 Ibid, pp. 5-6.

9 Ibid, p. 8.

10 Haley Sweetland Edwards, "What Happens When Doctors Only Take Cash," *Time*, January 26, 2017, http://time.com/4649914/why-the-doctor-takes-only-cash/.

11 Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us," Time, April 4, 2013, http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/.

12 Byron Schlomach, "Rising Above Mere Politics: General Principles for Spending Taxpayers' Money," 1889 Institute Policy Guidance, p. 14, https://img1.wsimg.com/blobby/go/8a89c4f1-3714-49e5-866b-3f6930172647/downloads/1d0kljktb_630802.pdf.

13 Byron Schlomach, "Removing the Middleman."

14 Joseph Zibulewsky, "The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians," *Baylor University Medical Center Proceedings*, pp. 339-346, October 2001, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/.

15 "Cost of Living Data Series: Annual Average 2018," Missouri Economic Research and Information Center, Missouri Department of Economic Development, https://www.missourieconomy.org/indicators/cost_of_living/.

16 Author's calculations using FPL and Missouri's cost of living index.

17 See note 14.

18 See the 1889 Institute's webpage on licensing, particularly the Occupational Licensing Directory: https://1889institute.org/licensing.

19 Byron Schlomach, "Medicaid Expansion: Bad Policy by Any Name," 1889 Institute Policy Analysis, May 2016, https://img1.wsimg.com/blobby/go/8a89c4f1-3714-49e5-866b-3f6930172647/downloads/1d0kk5n57_73399.pdf.

20 Leavitt Partners, "Uninsured in Oklahoma: Recommendations for a Medicaid Demonstration Proposal," study prepared for the Oklahoma Health Care Authority, June 27, 2013, pp. 56-68, https://www.insureoklahoma.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=15182&libID=14165.