To House Finance Committee: 5/5/15 p.1

I oppose adding medicade fonding.
These are appropriate considerations: April 13, 2015

I strongly oppose Resolution Serial No. 15-10! A resolution of the City of Wasilla to expand Medicaid Coverage.

Problems with this State expanding Medicaid coverage were presented this morning on Mr. Ridell's Radio Talk Show from a knowledgable caller. Essentially, physicians receive more reimbursement for medicaid patients than they do for Medicare service. If they choose to serve such programs it seems logical they will select ~~ones~~ patients whom will returns a higher payment. To date, fewer and fewer physicians are treating either of these "Federally Subsidized" medicare/medicaid individuals.

Should the State of Alaska opt to add medicaid qualified folks to its healthcare rolls, it may bump other folks to the back of the line & therefore increase the costs of emergency room use.

Furthermore, with the many documented failures of "Obama Care" health programs at the federal level Alaska would be foolish to

trust promises of the Feds to sustain either the amount or the duration of any federal health care subsidies. Dont be too eager to support this misguided resolution No 15-10 until you verify these points. Check with the Medical Community your city, State supported health care programs — your individual health care premiums will increase no doubt.

Sincerely,

Leonard Berberich
P.O. Box 870798
Wasilla, AK 99687

ANCHORAGE LEGISLATIVE INFORMATION OFFICE

Email: Anchorage.lio@akleg.gov 907-269-0111/ phone, 907-269-0229/fax

WRITTEN TESTIMONY

NAME: Ilona Farr MD

REPRESENTING: DFMC

BILL#/ SUBJECT: HB 148

COMMITTEE &

HEARING DATE: 4/11/15

1) American Surg Assoc
   → Medicaid poorer outcomes
2) Heartland - The True Cost of Medicaid
3) Dr. Milton Wolf - letter
4) Cato Institute - Should Virginia Expand Medicaid
5) ACA Impacts on Medical Care in Alaska Exchanges and Medicaid Expansion Power Point Presentation
   Ilona Farr
6) Darnell | Strevr - MESA study 2013 - already presented to House Finance 2015

American Surgical Association
The oldest surgical association in the United States
Established in 1880

130th Annual Meeting Abstracts

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Primary Payer Status Affects Mortality For Major Surgical Operations

***Damien J LaPar**, *Castigliano M. Bhamidipati, *Carlos M Mery, *George J Stukenborg, David R Jones, Bruce D Schirmer, Irving L Kron, MD, *Gorav Ailawadi, MD*
University of Virginia, Charlottesville, VA

Objectives: Medicaid and Uninsured populations are a significant focus of current healthcare reform. We hypothesized that outcomes following major surgical operations in the United States is dependent on primary payer status.
Methods: From 2003-2007, 893,658 major surgical operations were evaluated using the Nationwide Inpatient Sample (NIS) database: lung resection, esophagectomy, colectomy, pancreatectomy, gastrectomy, abdominal aortic aneurysm repair, hip replacement, and coronary artery bypass. Patients were stratified by primary payer status: Medicare (n=491,829), Medicaid (n=40,259), Private Insurance (n=337,535), and Uninsured (n=24,035). Multivariate regression models were applied to assess outcomes.
Results: Unadjusted mortality for Medicare (4.4%, OR= 3.51), Medicaid (3.7%, OR: 2.86) and Uninsured (3.2%, OR: 2.51) patient groups were higher compared to Private Insurance groups (1.3%, p<0.001). Moreover, mortality was lowest for Private Insurance patients independent of operation. Importantly, after controlling for age, gender, income, geographic region, operation, and 30 comorbid conditions, Medicaid payer status was associated with the longest length of stay and highest total costs (p<0.001). In addition, Medicaid (p<0.001) and Uninsured (p<0.001) payer status independently conferred the highest adjusted risks of mortality (Table 1).

Table 1: Multivariate regression analyses for adjusted outcomes.

Outcome	Medicaid	Uninsured	Medicare	Private Insurance
In-Hospital Mortality*	1.97 (1.84-2.10)	1.74 (1.60-1.90)	1.54 (1.48-1.61)	Ref
Length of Stay (days)*	10.49±0.04	7.01±0.03	8.77±0.01	7.38±0.01
Total Costs ($)*	$79,140±251.4	$65,667±231.0	$69,408±53.1	$63,057±53.0

* p<0.001. Reference group: Private Insurance. In-hospital mortality reflected as Odds Ratios (95% Confidence Interval), Length of Stay and Total Costs reflected as adjusted means.

Conclusions: Medicaid and Uninsured payer status confers increased risk of adjusted mortality. Medicaid was further associated with the greatest adjusted length of stay and total costs despite risk factors or operation. Possible explanations include delays in access to care or disparate differences in health maintenance.

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American Surgical Association
500 Cummings Center, Suite 4550, Beverly, MA 01915
(978) 927-8330 | FAX (978) 524-8890
Email ASA

12:42:25 AM
Saturday, April 11, 2015

The True Cost of Medicaid

Quick Facts

1. Medicaid's health care outcomes for the population it serves are terrible and unacceptable in any civilized society.
2. The costs of Medicaid for states are growing at an unsustainable rate, a problem accelerated as millions more Americans are added to the system under President Obama's health care law.
3. Medicaid's system is purposefully designed to be resistant to flexibility and positive, forward-thinking reform.

Studies and Reports

- Medicaid is already the largest budget expense for the states, accounting for nearly 22 percent of total spending in FY 2010.

- The University of Virginia finds it is better to be uninsured than to be on Medicaid: A large survey by UVA which compensated for several major factors found startling data last year. As Avik Roy writes: "surgical patients on Medicaid are 13% more likely to die than those with no insurance at all, and 97% more likely to die than those with private insurance. The Virginia group evaluated 893,658 major surgical operations from the Nationwide Inpatient Sample database from 2003 to 2007. They divided the patients up by the type of insurance—private insurance, Medicare, Medicaid, and uninsured—and adjusted the database in order to control for age, gender, income, geographic region, operation, and comorbid conditions (having 2 or more diseases simultaneously). That way, they could correct for the obvious differences in the patient populations (for example, older and poorer patients being more likely to have ill health)." The researchers found "Medicaid patients were almost twice as likely to die as those with private insurance; their hospital stays were 42% longer, and cost 26% more. Compared to those without health insurance, Medicaid patients were 13% more likely to die, stayed in the hospital for 50% longer, and cost 20% more. It is hard to see how this problem doesn't get significantly worse when Obamacare's expansion of Medicaid is fully phased in."

- Final Notice: Medicaid Crisis, A Forecast of Texas' Medicaid Expenditures Growth, is a paper by Jagadeesh Gokhale, Senior Fellow at the Cato Institute, conducted for the Texas Public Policy Foundation and released December 2010. It produces a far more significant expectation in terms of cost increases for states of the expansion of the Medicaid system. Cato Institute analyst Michael Cannon notes the cost increases Gokhale found are much greater than would be expected without Obama's health care regime: "Compared to a world without ObamaCare, state Medicaid spending will rise by 4.5 percent in California, 24.2 percent in Florida, 32.1 percent in Illinois, 22.9 percent in New York, and 24.1 percent in Texas over the first 10 years of full implementation."

- An Easy Path to Billions—Medicare and Medicaid Fraud: This 60 Minutes report provides examples of the sizeable fraud and ludicrous criminal operations that are robbing the nation's taxpayers: "The tiny medical supply company billed Medicare almost $2 million in July and a half-million dollars while 60 Minutes was there in August, but we never found anybody inside, and our phone calls were never returned."

- Jim Capretta and Tom Miller write: "Medicaid remains separate and not equal to the rest of the insurance system for working-age Americans. Its current structure provides no coordination or transition between Medicaid coverage and private health insurance. A move to replace both traditional Medicaid assistance and the tax preference for employer-paid health insurance with defined contribution payments would open up new possibilities for more beneficial coordination between both types of coverage. Integrating coverage options for the poorest Americans into the choices available to those with higher incomes will not be easy, in light of broader fiscal and political constraints, but it should proceed with all deliberate speed. Moving toward defined contributions across Medicare and Medicaid, as well as employer-based plans, involves a complex transition well beyond just hitting new budgetary targets. … Nevertheless, it's clear that taking the defined contribution route to health reform would create tremendous competitive pressure on the entire health sector to deliver more for less. Any player that did not step up would risk losing market share. That's the way to slow rising costs while also improving, not compromising, quality."

- Pennsylvania Medicaid Waste Estimated at a Quarter of a Billion Per Year: States routinely underestimate the levels of fraud in their states, as Pennsylvania experienced earlier this year, this article from Health Care News notes: "A new state government report shows fraud in Pennsylvania's Medicaid program may have cost taxpayers more than $1 billion over the past four years—more than three times what the state had previously reported. An audit by Pennsylvania Auditor General Jack Wagner found improper Medicaid eligibility determinations on nearly 2,000 randomly selected Medicaid applications between 2005 and 2009. The audit found a 14.7 percent fraud rate, three times the rate anticipated by the Pennsylvania Department of Welfare."

- The True Costs of Medical Fraud: Wide-Ranging Effects: Two leading University of Miami health academics, both of whom support national health care reform, say fraud cuts off resources to people who need them.

- A University of Pennsylvania study published in *Cancer* found that for patients undergoing surgery for colon cancer, the mortality rate was higher for Medicaid patients than for the uninsured or those with private insurance, and the rate of surgical complications was highest for Medicaid patients as well.

- A Columbia-Cornell study in the *Journal of Vascular Surgery* examined outcomes for vascular disease found that patients with clogged blood vessels in their legs or clogged carotid arteries fared worse on Medicaid than did the uninsured.

- A study of Florida patients published in the *Journal of the National Cancer Institute* found that Medicaid patients were 31% more likely to have late-stage breast cancer and 81% more likely to have late-stage melanoma than the uninsured.

- Aging America's Achilles' Heel: a 2005 report from Stephen A. Moses, president of the Center for Long-Term Care Reform, a Medicaid state representative for the Health Care Financing Administration and senior analyst for the inspector general of the U.S. Department of Health and Human Services: "While Social Security and Medicare have spurious "trust funds," Medicaid draws its financing from general tax revenue without even the pretense of a trust fund. Medicaid is the principal payor for long-term care (LTC), especially nursing home care. LTC is an 800-pound gorilla of social problems that lurks just around the bend. If we wait to deal with Medicaid and LTC until after we handle Social Security and Medicare, it will be too late."

- **Reform + Medicaid**

The need to reform the broken Medicaid system has never been greater. Medicaid fails to serve people who need care the most and burdens states with unsustainable costs as more people are added to the system. The only way Medicaid can be saved from collapse is through responsible national reform. This site is dedicated to that mission.

- **Medicaid Reform in Your State**
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  - California
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  - Florida
  - Georgia
  - Hawaii
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- **Topics**

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- To search, type and hi
- *"Long before Social Security goes bankrupt, Medicaid is going to bankrupt all the states."* -Sen. Mark Warner (D-VA)
- **Medicaid News**
  - Viewpoints: Kansas And Abortion; Stop Missouri's Move To Medicaid Managed Care
  - After Procedural Play, Montana Medicaid Expansion Gets Initial House Approval
  - Medicaid Expansion One Step Closer To Reality In Montana
  - Research Roundup: Young Adult Coverage; Alternatives To Subsidies; Critical Care Hospitals
  - Montana Moderates Revive Medicaid Expansion
  - Viewpoints: 'Medicaid Shenanigans' In Florida; The Need For Better Food Safety
  - Gilead's Pricey Hep C Drug Drives State Medicaid Spending
  - Balanced Budget, Abortion Dominate Paul Campaign's First Day
  - Rep. Lois Capps To Retire After 10 Terms In House
  - In Montana, Bipartisan Effort Muscles Medicaid Expansion Bill To House Floor
- **Blogroll**
  - Avik Roy: The Apothecary
  - Cato Institute: Medicaid
  - Center for Long Term Care Reform
  - Don Berwick Online
  - e21: Medicaid
  - Greg Scandlen: Real Health Reform
  - Health Affairs: Medicaid
  - Health Care News
  - Heritage Foundation: Medicaid
  - John C. Goodman: Medicaid
  - John Graham: Free American Health Care
  - Medicaid Transformation Project
  - New England Journal of Medicine
  - Pacific Research Institute
  - SPN Medicaid Exchange
  - Thomas Sullivan: Policy and Medicine

A Project of The Heartland Institute.

OLF: Obamacare wrecks Medicare by design, but why?

The clue lies in the president's own words

By Dr. Milton R. Wolf
The Washington Times
6:43 p.m., Wednesday, June 8, 2011

"We don't want to take away people's health insurance," Health and Human Services Secretary Kathleen Sebelius so graciously declared earlier this year. But then she quickly qualified that with these ominous words: "before they have some realistic other choices."

Americans have overwhelmingly, consistently and wisely been opposed to a European-style, single-payer, government-run, socialized health care system. So how might the big- government types who are hell-bent on forcing their will upon us attempt to implement this oppressive system in America? Simple. By creating medical refugees desperate for any port in a storm. That storm is coming and, unlike global warming, it's actually man-made.

America somehow managed to survive for 189 years without Medicare or Medicaid and, in fact, became the greatest nation in the history of humankind. Established in 1965 - a mere 46 years ago - too many politicians today lack the perspective to understand this health care altar at which they worship. Instead of reforming the system to align it with American values, they abuse it as an eternal source of giveaways to buy votes. As for the politicians of the 1960s, except for the mop tops and go-go boots, they were very much like the politicians of today: They made a lot of empty promises.

President Lyndon B. Johnson promised that Medicare would cost about $500 million a year - yes, million. He even said that if costs went higher, then he was going to look like the "worst kind of damn fool." Just a year later, in 1966, the House Ways and Means Committee estimated that Medicare would cost about $12 billion a year by 1990. The actual 1990 cost was $107 billion - off by an order of magnitude but close enough for government work. And that's when costs really took off. By 2008, annual costs hit $599 billion and the program for the first time went into deficit-spending mode.

For all the Democrats' dishonesty and reckless spending, Republicans weren't exactly blameless either. In 2003, President George W. Bush and a Republican Congress doubled down and ushered in the largest expansion in Medicare history with their senior citizen prescription drug entitlement program. They claimed the price tag would be $400 billion for the first decade but quietly adjusted that estimate upward to $534 billion just one month after passage.

Parenthetically, just three years later, in 2006, the free market roared as a private company in Bentonville, Ark. - without a single dime of taxpayer money or the compulsion from know-it-all government bureaucrats - lowered prices of the top 331 prescription medications to just $4 per month (and later to $10 per three months), not just for seniors but for all Americans. And equally importantly, Wal-Mart did not send the bill to our children.

Today we know that LBJ and a lot of other politicians indeed are the worst kind of damn fools. Medicare - like Social Security - is collapsing under its own weight and threatens to take America with it. The Medicare Trustees declared last month that Medicare Part A (Hospital Insurance Trust Fund) will be insolvent by 2024, a mere 13 years from now. Others estimate it will be only nine years. The entitlement program has racked up almost $25 trillion in unfunded liabilities. Others say it's actually $38 trillion. It turns out free health care is pretty expensive.

Despite Democrats' breathless claims that private insurance companies are the enemy, it is our federal government that is the largest denier of medical claims in the world. And that's before the president unleashes his rationing board, the Independent Payment Advisory Board (IPAB) or so-called "death panel." And if that wasn't enough, the Democrats have plundered $1.9 trillion from Medicare over the next decade ($8.2 trillion over 20 years) to fund Obamacare and have all but destroyed the popular Medicare Advantage program. Make no mistake: Obamacare is killing Medicare.

We have selfishly forced our children into lifelong indentured servitude to pay our debts, and for what, exactly? World-class, government-run health care? Not quite. The average U.S. life expectancy in 1965, the first year of Medicare, was 70.2 years. Forty years later, in 2005, it rose to 77.4 years, an improvement of 10 percent. Compare that to the 40 years before Medicare, from 1925 to 1965, when life expectancy improved by nearly twice that - 19 percent.

Medicaid is even worse. A recent University of Virginia study shows Medicaid surgical patients, for example, are 97 percent more likely to die than private insurance patients. And get this: They are 13 percent more likely to die than uninsured patients. This shouldn't surprise you. Health care decisions that are based on political considerations are meant to benefit politicians, not patients. President Obama's solution is to force even more people into government health care. Obamacare will increase the Medicaid rolls by 16 million poor souls.

In the few remaining years Medicare has left, dispirited doctors are already fleeing the program in droves - and medicine altogether - leaving behind helpless patients. Democrats' only plan is to maintain the crumbling status quo: Plunder Medicare, chase more doctors away with an additional 30 percent cut in reimbursement next year, and then watch from the bleachers as Americans are turned into medical refugees desperate for any salvation.

The president's intentions are chillingly clear: "I happen to be a proponent of a single payer universal health care program. ... That's what I'd like to see." Obamacare is a major step in that direction. "I don't think we're going to be able to eliminate employer coverage immediately," he says, but he can envision it "a decade out, or 15 years out, or 20 years out."

Rep. Paul Ryan, Wisconsin Republican, has put forward the only serious proposal to date that can save Medicare by reforming it into a system that is in line with America's values. It wrestles control away from

Washington and instead entrusts states and empowers American citizens. And this is precisely why Barack Obama and the Democrats oppose it.

Dr. Milton R. Wolf, a Washington Times columnist, is a board-certified diagnostic radiologist and President Obama's cousin. He blogs at miltonwolf.com.

Should Virginia Expand Medicaid?

Testimony of Michael F. Cannon
Director of Health Policy Studies, Cato Institute[1]

Before the Medicaid Innovation and Reform Commission
Senate Room B, General Assembly Building, Richmond, VA

April 7, 2014

Chairman Hanger, Vice Chairman Landes, and members of the Medicaid Innovation and Reform Commission, thank you for the opportunity to share my views on why Virginia should not participate in the Patient Protection and Affordable Care Act's Medicaid expansion in any way, shape, or form.

My name is Michael F. Cannon. I live in the City of Alexandria and have been a resident of the Commonwealth for more than three decades. I am a product of Virginia elementary and secondary education. I received a degree in American Government from the University of Virginia, and degrees in economics and law & economics at night from George Mason University. I am the director of health policy studies at the Cato Institute. Founded in 1977, the Cato Institute is a non-partisan, non-profit, 501(c)(3) educational foundation located in Washington, D.C., whose mission is to promote the principles of individual liberty, limited government, free markets, and peace. To maintain its independence, the Cato Institute accepts no government funding.

In June 2012, the Supreme Court made the Patient Protection and Affordable Care Act's expansion of Medicaid optional for states. It is not in the interest of Virginia taxpayers, present or future, to participate in that expansion. Key points from my testimony include:

- Expanding Medicaid will not "recapture Virginia dollars being sent across the Potomac." If Virginia expands its Medicaid program, every single penny it receives from the federal Treasury will be raised by issuing new federal debt. The Medicaid expansion will not recapture Virginia dollars. It would impose an unfair tax on future generations who are not represented here today.

- Expanding Medicaid would require Virginia to increase taxes and/or reduce spending on education and other services by far more than initial projections suggest.

- Refusing to expand Medicaid would reduce federal deficits and the federal debt, which are an implicit tax on future Virginia taxpayers. A recent study estimated the states that have most forcefully rejected the expansion will reduce federal deficits and debt by more than $8 billion per year.

- According to one estimate, the vast majority (82 percent) of those who would receive Medicaid coverage under the expansion already have private insurance today. Expansion could reduce their access to care, with potential negative health

consequences.

- Expansion would increase, not reduce, emergency-room use by an estimated 40 percent, leading to greater overcrowding. A back-of-the-envelope calculation suggests emergency-room spending could increase by $43 million per year.

- Expanding Medicaid may not improve enrollees' health at all. A study of the most vulnerable people targeted by the expansion found "Medicaid coverage generated no significant improvements in measured physical health outcomes."

- Expansion would reduce jobs, not increase them.

- Expanding Medicaid means forcing Virginia taxpayers to give even more of their income to Medicaid fraudsters.

- The federal government has announced a plan to rescind the Medicaid "DSH" cuts that were leading many hospitals to argue for the expansion.

- Expanding Medicaid would neither eliminate discrimination against U.S. citizens nor eliminate penalties against employers. Alternative strategies are available that would completely eliminate both.

- The Medicaid expansion is all but irrevocable. Any "sunset" provision would be easily overridden – particularly if, as some legal scholars warn, the federal government prevents Virginia from exiting the expansion.

- Covering the expansion populations through the state's health insurance "exchange," as Arkansas has proposed, would increase the expansion's cost to both to the state and the federal government by 50 percent, and is likely unlawful.

- Under *NFIB v. Sebelius*, Virginia can refuse to implement all mandatory Medicaid provisions in the PPACA—including eligibility for all children below 138 percent of poverty, "maintenance of effort," the "MAGI" income standard, and eligibility determinations for Exchanges—not just the newly eligible adult population.

- Virginia would have plenty of company if it chose not to participate. Twenty or more states are refusing to implement the Medicaid expansion.

- Expanding Medicaid exposes Virginia to the risk of becoming a "Medicaid magnet," where people move to the Commonwealth from non-expansion states such as North Carolina or Tennessee for the purpose of enrolling in Medicaid and taking advantage of other state services.

Finally, there are better alternatives. Rather than burden taxpayers with this new expense, Virginia should continue to refuse to implement the Medicaid expansion or a health insurance Exchange; join Maine in challenging HHS's attempt to force states to implement parts of the

expansion the Supreme Court rendered optional; join Oklahoma in challenging the IRS's attempt to issue subsidies and impose taxes that Congress did not authorize; launch an Oregon-like study to discern what impact if any Medicaid has on the health of existing populations; and enact a Tennessee-style "Good Samaritan" law and medical malpractice liability reforms that expand access to care for the poor without imposing new burdens on taxpayers.

Background

The "Patient Protection and Affordable Care Act" of 2010 carries costs that far outweigh its benefits. The PPACA makes access to care less secure for millions of Americans, depresses economic activity, eliminates jobs, increases health care costs, increases the burden of government, and traps people in poverty.[2] It imposes $1.2 trillion in new taxes through 2022.[3] According to one estimate, these taxes will reduce economic output by as much as $750 billion in just the first six years.[4]

The PPACA commits taxpayers to pay for an estimated $1.6 trillion in new federal spending through 2023.[5] Roughly half of this new spending consists of subsidies to private health insurance companies that will flow through new government agencies called health insurance "exchanges." The balance comes from a 50 percent increase in the number of nonelderly Medicaid enrollees.[6] This is money the federal government simply does not have.

The non-partisan Congressional Budget Office estimates the PPACA will eliminate roughly 2.5 million jobs by 2019.[7] The Federal Reserve has reported, "Employers in several Districts cited the unknown effects of the Affordable Care Act as reasons for planned layoffs and reluctance to hire more staff."[8] The law has caused employers to cut hours for everything from waiters to college professors. Former Obama economic advisor Austan Goolsbee predicts that even if overall hiring in the economy increases, the PPACA could cause overall hours worked to fall,[9] while former advisor Jared Bernstein admitted, "I'm a little nervous about that [Federal Reserve report]…I think there's something to it…I've got a news flash for you. The Affordable Care Act is not a jobs program."[10]

Congress and President Obama have already repealed one of the PPACA's three new entitlement programs—the Community Living Assistance Services and Supports Act, or CLASS Act[11]—as well as other provisions of the law.[12] Repealing the remaining provisions of the PPACA is essential to making health care better, more affordable, and more secure, as well as making the federal government live within its means. A union that formerly supported the PPACA, the United Union of Roofers, Waterproofers and Allied Workers, has reversed its position and is now calling for the law's repeal.[13]

The Role of States in the PPACA

The PPACA relies on states to implement the Exchanges and Medicaid expansion.[14] Each provision would impose significant costs on the state of Virginia. Virginia is under no obligation to implement either. Between the two, the Medicaid expansion would cost the state far more.[15] Whether to implement the expansion may be the most important decision facing Virginia officials.

Somewhat ironically, the PPACA gives Virginia officials considerable power to shape how the Act operates, but only if state officials refuse to implement these provisions. Implementing either an Exchange or the Medicaid expansion cedes more control over the state's health care sector and destiny to the federal government. If Virginia officials wish to reassert control over their health care sector, they must refuse to implement these provisions.

The Unknowable Cost of Medicaid Expansion

Under the PPACA, Virginia has the option of expanding its Medicaid program to cover all citizens and legal immigrants below 138 percent of the federal poverty level. The federal government will cover 100 percent of one category of spending (i.e., claims) for one category of enrollees (newly eligible adults), for the first three years. Virginia would be responsible for funding the administrative costs, plus the cost of covering newly eligible children, plus the cost of any already-eligible new enrollees at the state's current matching rate (roughly 50 percent).[16]

Beginning in 2017, Virginia would also begin to pick up a larger share of the cost of claims for newly eligible adults. That share would rise to 10 percent by 2019. According to one news report, "States will receive more than $9 in federal money for every $1 they spend to cover low-income residents under" the expansion.[17] This offer stands, as one observer puts it, in "theoretical perpetuity."[18]

The Kaiser Family Foundation and the Urban Institute project Virginia's share would total a considerable $2.6 billion over 10 years.[19] Economist Jagadeesh Gokhale is a leader in his field and a member of the Social Security Administration's advisory board; when the Social Security program wants to know how to make these sorts of projections, they come to him. Gokhale more realistically projects the expansion will cost up to 45 percent more than the Kaiser/Urban estimates,[20] which suggests the expansion, under current law, would cost the state of Virginia close to $4 billion.

The actual cost is likely to be much higher, for two reasons.

First, actual enrollment and spending in government health programs typically far surpasses initial projections. Congress' Joint Economic Committee notes, "In 1967, the House Ways and Means Committee predicted that the new Medicare program, launched the previous year, would cost about $12 billion in 1990." Instead, "Actual Medicare spending in 1990 was $110 billion—off by nearly a factor of 10."[21] Jonathan Ingram of the Foundation for Government Accountability reports that when Arizona expanded its Medicaid program in 2002, actual enrollment reached nearly three times the projected level, while spending quadrupled initial projections.[22] In just one year, the actual cost to the federal government of establishing state-run Exchanges more than doubled the projected cost, from $2 billion to $4.4 billion.[23] Over the long term, such programs expand, and are almost never eliminated or pared back in any significant way.

Second, the federal government is likely to renege on the initial 9-to-1 match—because it must. The federal debt stands at $12 trillion, or 74 percent of gross domestic product. In 2014,

the federal government will run a projected $514 billion deficit. Under current law, annual deficits could cause the federal debt will grow to $21 trillion by 2024.[24] According to the Congressional Budget Office (CBO):

> Under current law, federal debt held by the public as a percentage of GDP in 2024 is projected to reach its highest level in more than 75 years and roughly double the average of about 40 percent experienced over the 1974–2013 period…
>
> Continued rising debt would dampen economic growth and thus reduce people's income compared with what it would otherwise be. It would also increasingly restrict policymakers' ability to use tax and spending policies to respond to unexpected challenges and would boost the risk of a fiscal crisis, in which the government would lose its ability to borrow at affordable rates. To avoid those consequences, lawmakers will ultimately have to make significant changes to tax and spending policies—letting revenues rise more than they would under current law, reducing spending for large benefit programs below the projected amounts, cutting other federal spending to even lower levels by historical standards than currently projected, or adopting some combination of those approaches.[25]

Since Congress tends to reverse spending cuts or tax increases before they take effect, the CBO also makes the more realistic projection that if current *policies* continue, federal debt will grow to $28 trillion by 2023, or 83 percent of GDP,[26] and the adverse consequences "would be exacerbated if federal debt exceeded the amounts projected in CBO's baseline, as it would if certain deficit-reducing policies that are scheduled to take effect were instead reversed without being replaced by other policies with similar budgetary effects."[27]

It is unrealistic to assume the federal government will maintain the Medicaid expansion's 9-to-1 matching rate. House Budget Committee chairman Paul Ryan (R-WI) has told governors and state legislators, "The fastest thing that's going to go when we're cutting spending in Washington is a 100- or 90-percent match rate for Medicaid. There's no way. It doesn't matter if Republicans are running Congress or Democrats are running Congress. There's no way we're going to keep those match rates like that."[28] Indeed, President Obama proposed reneging on that commitment in two consecutive budget proposals.[29] Republicans in both the House and Senate have introduced legislation to eliminate the enhanced matching grant formula.[30] When Congress reneges on that commitment, the Medicaid expansion will cost Virginia even more than the direst projections.

Virginia currently spends about $3.5 billion per year to cover 1 million residents through Medicaid.[31] Under the Medicaid expansion, each of those numbers would rise dramatically and continue to climb.

South Carolina governor Nikki Haley summarized the situation: "The federal government likes to wave around a nine dollar match like it is some silver bullet, some extraordinary benefit that we cannot pass up. But what good do the nine dollars do us when we can't come up with the one? And what good are any dollars when they come through a program that doesn't allow us the flexibility to make the decisions that are in the best interest of the people?"[32]

Medicaid Expansion Cannot and Will Not "Recapture Virginia Dollars"

Expanding Medicaid will not "recapture Virginia dollars being sent across the Potomac."[33] That claim is innumerate, demonstrably false, and should have no part in this debate.

Every penny Virginia sends to the federal government has already been spent. If it hadn't, the federal government would be running surpluses instead of deficits. If Virginia expands its Medicaid program, therefore, every single penny it receives from the federal Treasury will be raised by issuing new federal debt.

If you choose to expand Virginia's Medicaid program, you will not be recapturing Virginia dollars from Washington." You will be taking dollars from future generations who are not represented here today. It is unfair – it is immoral – to tax future generations to expand Medicaid for current generations. And it is the height of either ignorance or hypocrisy to say Virginia must expand Medicaid out of fairness to taxpayers.

Supporters of expanding Medicaid must to explain how it is unfair when Virginia must send tax dollars to Washington for the benefit of other states, but not unfair when they tax people who are not represented here today (future generations) for the benefit of those who are. If supporters of the Medicaid expansion want to live by their own standard of fairness, they would propose a new tax by which Virginia would cover the entire cost of the Medicaid expansion. The fact that they have not suggests their support for expanding Medicaid is less about fairness than the opportunity to hand out benefits to favored constituencies without having to be the ones to impose the taxes that pay for those benefits. If you ever wanted to know how important Virginia's balanced-budget requirement is, look no further than how hungrily many Virginia elected officials eye an attempt to spend government funds that they themselves do not have to raise through taxation. Some are even willing to shut down the government to do it.

Virginia Officials Can Reduce Federal Deficits, Debt

Implementing the expansion would not only increase state spending. It would increase federal spending as well. But states can reduce federal spending, deficits, and debt by rejecting the expansion.

Shortly after the Supreme Court's ruling, the CBO estimated that the handful of states that would refuse to expand Medicaid had reduced federal deficits by $84 billion.[34] One study estimates that just 14 states will reduce federal deficit spending by $8 billion per year by refusing the expansion.[35]

More Medicaid, More Fraud

Expanding Medicaid means forcing Virginia taxpayers to give even more of their income to Medicaid fraudsters. The amount of fraud in Medicaid is stunning even by government standards.[36] In one example, a Brooklyn dentist billed taxpayers for nearly 1,000 procedures in a

single day.[37] Rampant fraud has led the Government Accountability Office to designate Medicaid as a "high-risk" program for the past decade.[38] Official estimates suggest Medicaid loses tens of billions of dollars to fraud annually—but experts deride those estimates as "comfortingly low and quite misleading."[39]

Crowding Out Private Coverage

Expansion is neither a wise or well-targeted use of Virginia taxpayers' dollars, because it would spend scarce state resources on people who already have private insurance. A recent study by PPACA supporters projected "high rates of crowd-out for Medicaid expansions aimed at working adults (82%), suggesting that the Medicaid expansion provisions of PPACA will shift workers and their families from private to public insurance without reducing the number of uninsured very much."[40] Medicaid expansions in Arizona, Delaware, Maine, and Oregon did not reduce those states' uninsured rates at all, though they were accompanied by declines in private coverage.[41]

Worse Access to Care

When Medicaid crowds out private health insurance, it often leaves patients with less-secure access to care. Nationwide, roughly one third of physicians refuse to accept new Medicaid patients.[42] According to the U.S. Department of Health and Human Services, "Only about 20 percent of the nation's 179,000 practicing dentists accept Medicaid."[43] In states like Maryland, the number is one in six.[44]

According to the *Annals of Emergency Medicine*, Medicaid patients are twice as likely to experience barriers to primary care as privately insured patients. The authors conclude, "Expansion of Medicaid eligibility alone may not be sufficient to improve health care access."[45]

Medicaid Expansion Will Increase Emergency-Room Use

Supporters of have repeatedly promised that the Medicaid expansion will reduce emergency-room overcrowding. Yet the evidence shows that implementing the expansion will *increase* emergency-room use, not reduce it.

The Oregon Health Insurance Experiment – the largest and most reliable study ever conducted of Medicaid or any health-insurance expansion – found that when the State of Oregon opened its Medicaid program to the same target population, emergency-room use increased by 40 percent.[46] A back-of-the-envelope calculation suggests emergency-room spending in Virginia could increase by $43 million per year.[47]

Medicaid's poor access to primary care leads enrollees often turn to emergency departments. As one emergency-room physician recently explained in *The Washington Post*:

> In our hospital, about one in 10 patients with Medicaid is a frequent visitor to the emergency department because many physicians don't accept that insurance. Trying to understand the inability of patients with insurance to see primary-care providers, I called

> three local clinics, pretending to be a patient with Medicaid, and tried to make an appointment. The soonest I could see a primary-care doctor was two months. Primary-care physicians who accept Medicaid insurance are overwhelmed with patients…[48]

It is little surprise, then, that the above-mentioned *Annals* study found Medicaid patients are twice as likely as those with private insurance to use the emergency room as a source of primary care.[49]

The *Journal of the American Medical Association* reports that emergency rooms "are increasingly serving as the safety net for medically underserved patients, particularly adults with Medicaid." The authors of that study found, "Adults with Medicaid accounted for most of the increase in ED visits" between 1997 and 2007, which was "almost double of what would be expected from population growth." Indeed, adult Medicaid patients are three times more likely than the uninsured, and seven times more than patients with private insurance (which the expansion would crowd out), to use an emergency room for conditions that could have been addressed with primary care.[50]

Medicaid Expansion May Increase Uncompensated Care

When Maine expanded its Medicaid program to cover childless adults, as the PPACA's Medicaid expansion would do, uncompensated charity care by hospitals did not fall. It grew at an accelerated rate, increasing five fold.[51]

Tragic Consequences

One Medicaid enrollee who turned to an emergency room when he couldn't find primary care was a 12-year-old Maryland boy named Deamonte Driver

. In 2007, Deamonte was suffering from a toothache, caused by an abscess. His mother struggled in vain to find a dentist who would accept the family's Medicaid coverage. According to one account, "the Public Justice Center in Baltimore…made dozens of calls" on the family's behalf to find a dentist who would accept the family's Medicaid coverage.[52]

Since only one in six Maryland dentists accepts Medicaid, the *Washington Post* reported, "By the time Deamonte's own aching tooth got any attention, the bacteria from the abscess had spread to his brain . . . After two operations and more than six weeks of hospital care, the Prince George's County boy died."[53]

"A routine, $80 tooth extraction might have saved him," the *Post* concluded. "If Medicaid dentists weren't so hard to find."[54]

Would Expanding Medicaid Improve Health?

The Medicaid expansion may not even improve the new enrollees' health at all. Oregon Health Insurance Experiment investigators published an article in the *New England Journal of Medicine* that found Medicaid had no discernible effect on measured physical health outcomes of

enrollees. Supporters thus have no reliable evidence to show the Medicaid expansion would improve enrollees' physical health at all, much less that it would deliver the largest gains in health per dollar spent.

Let's unpack that. Medicaid's effect on the health of enrollees is theoretically ambiguous. On the one hand, Medicaid will spend around half a trillion this year purchasing medical and long-term care services for around 60 million people.[55] It would be difficult to spend nearly half a trillion dollars on medical care without providing some benefits.

Yet Medicaid also has many effects that might negatively impact enrollees' health. The taxes that fund Medicaid—including both sales and income taxes—directly inhibit low-income families' ability to afford food, clothing, housing, and higher-quality educational options, all of which contribute to health. That tax burden also reduces incomes indirectly by decreasing economic activity and opportunity, making it more difficult for low-income workers to become self-sufficient. Medicaid further provides powerful disincentives to climb the economic ladder. If enrollees increase their earnings, they might lose a benefit worth thousands of dollars.[56] Medicaid also increases the cost of private insurance at the same time it lures people out of private insurance.[57]

One would hope that before state and federal governments would spend half a trillion dollars per year on a program like Medicaid, they would establish whether the program will improve health *and* achieve the greatest health improvements per dollar spent. Yet no one bothered to measure Medicaid's effect on the health of enrollees in a reliable way until Oregon began a monumental new study in 2008—42 years and $9 trillion after the program's inception. Indeed, Congress debated the PPACA's Medicaid expansion in 2009 and enacted it 2010 without even waiting until the first set of results from the Oregon study became available in 2011.[58]

The Oregon Health Insurance Experiment is essentially a PPACA field test. The State of Oregon held a lottery that randomly assigned thousands of able-bodied Oregon adults earning below 100 percent of the federal poverty level—in other words, the most vulnerable group targeted by the PPACA's Medicaid expansion—either to receive Medicaid coverage or nothing. Economists then collected data on the lottery winners and losers. The use of random assignment makes the Oregon Health Insurance Experiment's results the most reliable information ever collected on the effects of Medicaid.

Congress should have waited for the results.

In 2013, Oregon Health Insurance Experiment researchers reported, "Medicaid coverage generated no significant improvements in measured physical health outcomes" for poor adults.[59] Medicaid did increase per-person medical spending from $3,300 to $4,400. But even after two years, Medicaid produced no discernible improvement in enrollees' blood pressure, cholesterol levels, blood sugar levels, or risk of heart attacks. All that additional spending should have had an immediate impact on these important and treatable health measures, especially among the poor. Medicaid's failure to do so casts doubt whether the additional $1,100 of medical care it makes available to enrollees improves their health in other areas, or over the long term. Since government subsidies are less likely to improve health for people with higher baseline access to

care, the Oregon Health Insurance Experiment casts even greater doubt on whether the PPACA's subsidies for higher-income individuals will improve their health.

The results stunned and embarrassed supporters of the PPACA, who had portrayed the law's passage as a matter of life and death, particularly for the poor.[60] Some complained the sample size was too small, yet that's just another way of saying the disease burden among the expansion group is not as great as supporters have portrayed it. Others stressed the findings that Medicaid reduced depression and financial strain. While the effect on depression is unambiguously beneficial, it is unclear whether reducing the financial strain imposed by medical bills should be an indicator of success for a program like Medicaid. If Medicaid has no impact on health, one might prefer that the uninsured experience financial strain when they need expensive medical care. That risk might prod people to purchase insurance and thus reduce the number of people who experience financial strain.

Supporters of the Medicaid expansion have an obligation to show the $1 trillion the PPACA would spend on new health care entitlements will actually improve the health of enrollees. They cannot meet that burden of proof. There is no reliable evidence that Medicaid saves lives, scant reliable evidence it improves health outcomes at all, and absolutely no evidence that it is a cost-effective way of improving health. In the absence of such evidence, there can be no urgent need to expand Medicaid.

Expanding Medicaid Would Destroy Jobs

The most vocal advocates of the Medicaid expansion are the Virgina hospitals and other health care providers who would receive its subsidies.[61] As George Bernard Shaw noted, "A government which robs Peter to pay Paul can always depend on the support of Paul."[62]

These providers claim the Medicaid expansion would create or save jobs. In reality, it would destroy jobs. Government spending does not appear out of thin air. The money spent is diverted from other job-creating uses, and the taxes that raise those funds reduce overall economic activity.[63] University of Chicago economics professor Casey Mulligan explains:

> Medicaid is a transfer, so it creates jobs in the sectors where it is spent, but it destroys jobs at the source of financing (for example, someone fails to buy a new car because he or she is lending money to the government to finance the expansion)…
>
> States therefore have a choice of depressing their employment rates by accepting the Medicaid expansion and the significant additional financing that goes with it, or forgoing the expansion and its employment-depressing effects…
>
> If enough states [refuse to expand Medicaid], both state and federal taxpayers could save a lot, and the nation might avoid another depressing force on its labor market.[64]

Indeed, treating Medicaid like a jobs program is dangerously counterproductive. A thought experiment can illustrate. Consider the following medical innovations:

- Artificial respirators that pump oxygen into patients' lungs.

- Oximeters, the small devices that attach to a patient's forefinger, that automatically measure the oxygen in her blood and display the results on a monitor.

- Blood pressure machines that automatically track the patient's blood pressure, and display that information on the same monitor.

- Dosage machines automatically that dispense the right amount of medication to the patient at the right time.

- Mechanical hospital beds that automatically and gently adjust to prevent bed-ridden patients from developing painful pressure sores.

- Electronic medical records that make patient information more secure and accessible, and can reduce administrative costs and duplicative testing.

If supporters believe the purpose of Medicaid is to create jobs, they should endorse legislation denying Medicaid reimbursement for these devices. Even better, they should endorse legislation banning these innovations outright. Think of all the jobs such a ban would create for the nurses, lab technicians, orderlies, and clerks who would then have to perform those tasks by hand! Of course, that would be foolish, because it would make health care more expensive.

"Treating the health care system like a (wildly inefficient) jobs program," two Harvard economists recently explained in the *New England Journal of Medicine*, "conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price."[65] Expanding Medicaid for the sake of creating or saving jobs would reduce incentives to find ways of delivering better health care at a lower cost, and soak up resources that could be put to better use. The day Medicaid becomes a jobs program, we should abolish it—not expand it.

Washington Plans to Rescind Medicaid "DSH" Cuts Anyway

State officials don't need to expand Medicaid to save hospitals from cuts in the federal government's Medicaid "disproportionate share hospital" payments. The federal government is already planning to rescind those cuts, a development that further weakens the case for the expansion.

Hospitals have lobbied for the expansion on the grounds that they need it to compensate for the PPACA's cuts to Medicaid DSH payments, which the hospitals receive from the federal government to cover the cost of treating patients who don't pay their medical bills. As a preliminary matter, if hospitals dislike those cuts, they should not have endorsed the PPACA in the first place. The hospital industry was nearly unanimous in its support for that law. Various hospital lobbies "strongly urge[d]" Congress to pass the PPACA "with or without bipartisan support" as a matter of "national security, equity and fairness." They hailed the law as "historic," "a giant and essential step forward," and a "major first step" full of "great improvements." If the Medicaid DSH cuts take effect, therefore, the hospital industry has no one to blame but itself.

As it happens, it appears those cuts will not take effect. The Obama administration and members of Congress from both parties have proposed eliminating them. In his budget proposal for fiscal year 2014, President Obama proposed to rescind the Medicaid DSH cuts the PPACA would impose in all states in 2015.[66] The Obama administration's Centers for Medicare & Medicaid Services has proposed to eliminate two years' worth of Medicaid DSH cuts.[67] Sens. Debbie Stabenow (D-MI) and Roy Blunt (R-MO) have introduced legislation to rescind those cuts.[68] The bipartisan support for rescinding these cuts means Virginia has even less reason to expand Medicaid.[69]

Expansion Doesn't Solve the PPACA's Discrimination against Citizens

Arizona Gov. Jan Brewer (R) has claimed that not expanding Medicaid would result in discrimination against U.S. citizens. In some cases the PPACA would provide larger subsidies to legal immigrants (who would receive subsidized private insurance through an Exchange) than to similarly situated citizens (who would receive Medicaid or no subsidies). The source of this discrimination is the PPACA's Exchange subsidies, and expanding Medicaid would not eliminate it. States *can* eliminate this discrimination by refusing to establish an Exchange, as 34 states including Virginia have done.[70]

Here's how the PPACA discriminates against U.S. citizens. Many states decline to cover certain legal immigrants through their Medicaid programs. The PPACA's authors therefore let those immigrants purchase subsidized health insurance through an Exchange. The practical effect is that if a legal immigrant and a U.S. citizen are both below the poverty level, the immigrant may receive government-subsidized private health insurance, while the citizen gets less – *regardless of whether her state expands Medicaid*. If her state expands Medicaid, she receives a subsidy in the form of Medicaid coverage, which is generally considered inferior to "private" Exchange coverage. If her state does not expand Medicaid, she receives no subsidy at all.

Note that expanding Medicaid does not end the discrimination against citizens, which occurs whether the state implements the expansion or not. The only way to prevent such discrimination is to block the Exchange subsidies, which the PPACA gives states the power to do.

The PPACA authorizes Exchange subsidies only in states that establish their own Exchanges. Virginia, along with 33 other states, has refused to establish an Exchange, which blocks those discriminatory subsidies.

Unfortunately, the IRS is trying to issue those subsidies in those 34 states anyway. The agency is attempting to tax, borrow, and spend more than $500 billion without legal authorization, and indeed contrary to the plain language of the PPACA and congressional intent.[71]

State officials who want to stop discrimination against U.S. citizens must challenge these illegal subsidies in court, as Oklahoma attorney general Scott Pruitt has done.[72] Stopping the IRS's $800 billion power grab is the *only* way to stop such discrimination. Expanding Medicaid

would not end it, because many citizens would still receive Medicaid coverage while immigrants receive private insurance.

Expansion Would Not Eliminate Penalties against Employers

Some employers have endorsed the expansion because it would reduce the penalties they face under the PPACA's employer mandate. Yet the expansion would not eliminate penalties against employers. Refusing to establish an Exchange and stopping the IRS's illegal power grab, on the other hand, would eliminate *all* penalties against all employers under the PPACA's employer mandate.

Expanding Medicaid would protect some employers from some penalties. The PPACA's employer mandate penalizes certain employers up to $2,000 per worker if (1) the employer fails to offer sufficient coverage to all full-time workers, and (2) one of those workers receives a subsidy through an Exchange. Workers who are eligible for Medicaid are not eligible for Exchange subsidies. If a state implements the expansion, therefore, workers with household incomes below 138 percent of the federal poverty level would not be eligible to receive Exchange subsidies, and their employers could not be penalized for failing to offer them coverage. Employers would still be penalized for failing to provide coverage to other workers, however, thus many employers would receive no relief at all.

If a state refuses to establish an Exchange, however, then by law all Virginia employers would be exempt from the employer mandate. The PPACA allows no Exchange subsidies through a federal "fallback" Exchange, and therefore authorizes no penalties against employers in Virginia and the 33 other states that have refused to establish Exchanges.[73] Virginia should join Oklahoma and Indiana in challenging the IRS's illegal Exchange subsidies in court.

No Exit

Supporters argue that if the cost proves too great, Virginia can simply back out of the expansion. Some have even proposed an automatic "sunset" provision that would automatically end the program on a specified date, thereby forcing the legislature to reauthorize it. A sunset provision, they argue, would guarantee that the program would become permanent only if it proves successful. In reality, even with a sunset provision, the expansion is a no-exit proposition. Once implemented, it will become permanent despite the inevitable cost overruns, the damage to the private insurance markets, and even if it fails to benefit enrollees. As Milton Friedman once quipped, "Nothing is so permanent as a temporary government program."[74]

Automatic sunset provisions have next to zero chance of sunsetting the expansion. State officials are loath to cut Medicaid even under the "old" matching grant system, where Virginia gets to keep 50 percent of the savings. Even if all else were equal, future Virginia officials will be much less likely to sunset the expansion if the state can only keep 10 percent or less of the savings.

Moreover, all else will not be equal. By the time a sunset provision would take effect, the health care providers who are lobbying for the Medicaid expansion today will have grown

dependent on the "their" new subsidies. If you think providers are lobbying heavily for the Medicaid expansion today, just wait until you see their efforts to reauthorize it. That lobbying campaign will be augmented by years of new expansion revenues, plus a new constituency that does not exist today—i.e., new enrollees.

The fact that some states have proposed automatically shutting down the expansion on December 31, 2016, illustrates how unserious and cynical sunset proposals are. Who can imagine a state legislature dropping thousands of people from the Medicaid rolls just one week after Christmas?

Even if Virginia tries to sunset the expansion, the federal government could nevertheless block the exit. HHS Secretary Kathleen Sebelius could simply decree that states that implement the expansion may not opt out, but must continue to comply with its requirements or lose all federal Medicaid funds – even if the federal government reneges on its promise to shoulder 90 percent of the spending. The Congressional Research Service writes:

> the [Supreme] Court did not address such matters as whether a state that chooses to expand its Medicaid coverage may later decide to "opt out" of that choice and of the expansion requirements…[T]hese practical ramifications of the Court's ruling…will need to be addressed by the Secretary of HHS, who has overall authority to implement the provisions of the Affordable Care Act, taking into consideration the Supreme Court's decision.[75]

This would not be a stretch for Secretary Sebelius, who has taken much greater liberties than this in implementing the ruling in *NFIB* (see below). Some legal scholars argue the Court could uphold such a decree:

> While the Supreme Court stated that the federal government cannot condition the first dollar of existing Medicaid coverage upon a state's decision of whether to opt into the expansion, it did not say that those requirements of federal law would not apply *after* a state has opted into the expansion. As such…it is entirely likely that a court would find that the Secretary of Health and Human Services has the legal authority to condition first-dollar federal Medicaid spending on…continuation in the expanded program. In other words: the federal government may shift a greater portion of the financial burden to states, but if [a state] has agreed to the expansion, it is likely that it will be locked into the program with no meaningful way to exit without risking ALL federal Medicaid funds.[76]

Is there a soul in Virginia willing to bet their own money that Sebelius would just let the Commonwealth walk away from the Medicaid expansion? Even if the Court ultimately rules against HHS, litigating the issue would be costly, not least because Virginia could have to keep funding the expansion while the litigation is pending.

Does the "Arkansas Plan" Make Sense?

Under a proposal put forward by Gov. Mike Beebe (D), Arkansas has requested and received approval to enroll the Medicaid-expansion population through the state's Exchange.

That approach would increase the cost of the expansion; would strip even more Americans of their existing coverage by encouraging more employers to drop their health benefits; would violate congressional intent; is of dubious legality;[77] would make the PPACA even more of a giveaway to private insurance companies; and would add a new form of discrimination to the law—i.e., discrimination against low-income parents.

The Beebe plan would dramatically increase the cost of the expansion. MIT health economist Jonathan Gruber, one of the PPACA's architects, explains, "Medicaid coverage is less expensive than coverage in the exchange for this population."[78] The Congressional Budget Office estimates covering expansion enrollees through an Exchange would cost an additional $3,000 per person, increasing the overall cost of the expansion by 50 percent.[79] Implemented nationwide, such a plan would increase the cost of the PPACA and federal deficits by more than $50 billion over 10 years.[80]

Opening the Exchanges to Medicaid-expansion enrollees would encourage even more employers to drop coverage. Gruber explains, "if the entitlement for low-income individuals is to an exchange, disruption of existing employer insurance arrangements will be higher than if it is to a Medicaid."[81] Exchange plans will presumably offer better access to care than traditional Medicaid. If so, workers will be more willing to drop their employer's coverage to enroll in the expansion, and firms with low-wage workers will be more likely to stop offering coverage entirely. Under the Beebe plan, the share of expansion enrollees who would have had private insurance anyway would therefore likely be even higher than the 82 percent projected under the expansion.

The PPACA's authors forcefully and repeatedly rejected this proposal in two separate committees due to its cost. Shortly before the Senate's Committee on Health, Education, Labor, and Pensions voted down the idea, Sen. Jeff Bingaman (D-NM) said, "[F]or our committee to say…that anyone covered by Medicaid could opt to go into the [Exchange] and obtain subsidies I think would just add to the cost and I would have to oppose the amendment."[82] Before the Senate Committee on Finance likewise voted down the proposal, chairman Max Baucus (D-MT), the lead author of the PPACA, was strident:

> I must say that this is a very bad amendment…If you are concerned about affordability, you will reject this amendment outright immediately…this one just blows affordability out the window. We cannot accept this amendment…I cannot understand how anybody would vote for this amendment.[83]

Given such a clear statement of congressional intent, it would be wrong, and likely unlawful, for HHS to spend up to $50 billion or more on a proposal that Congress expressly rejected.

The main beneficiaries of those additional subsidies would be insurance companies. Since its introduction in 2009, left-wing critics have called the PPACA a giveaway to private health insurance companies because it forces nearly all Americans to purchase those companies' products. The Beebe plan would increase government spending by paying private insurers more to cover Medicaid enrollees *outside of Medicaid* than those insurers receive for covering them *through Medicaid*. It would therefore make the PPACA an even greater giveaway to private

insurers. Paul Krugman rightly calls Beebe's proposal "welfare for the medical-industrial complex."[84]

Finally, the Beebe plan creates a new "marriage penalty" or "family penalty" because it would offer better coverage to low-income bachelors than low-income families. The Medicaid-expansion population consists primarily of childless adults below 138 percent of the federal poverty level. Meanwhile, families in that income range are often already covered through the traditional Medicaid program. Under the Beebe plan, those childless adults would receive private coverage through an Exchange, while low-income children and their parents would receive Medicaid, which is widely regarded as inferior.[85]

States Can Decline All of the PPACA's Medicaid Provisions

States can further reduce their Medicaid outlays, and federal deficits, by refusing to implement any portion of the PPACA's Medicaid expansion. The Supreme Court's ruling in *NFIB v. Sebelius* gave states the power to reject not just the expansion's coverage for newly eligible adults, but all mandatory Medicaid provisions of the PPACA.

As originally conceived, the expansion mandated that states expand their Medicaid programs in numerous ways. States that failed to comply would lose all federal Medicaid funds, which amount to roughly 12 percent of revenues for the average state.[86] The Court found that mandate unconstitutionally coercive.

The Court then freed states to refuse all mandatory Medicaid provisions of the law, including mandatory eligibility for all adults and children below 138 percent of poverty, "maintenance-of-effort," the new "MAGI" income standard, eligibility determinations for Exchanges, and so forth.[87]

Shortly after the Court issued its ruling, however, Secretary Sebelius arbitrarily narrowed the Court's remedy. In a letter to governors, Sebelius invented the interpretation that states may only opt out of providing coverage for newly eligible adults.[88] Failure to implement any of the provisions of the expansion would result in the same penalty as before *NFIB*: the federal government would revoke all federal Medicaid grants. In other words, Sebelius is continuing to threaten states with the loss of all federal funds—a penalty the Supreme Court held to be unconstitutional coercion—unless they implement provisions of the law the Court made optional. Maine ran afoul of Sebelius' rewriting of *NFIB* and has challenged HHS in federal court.[89] States can further reduce the cost of their Medicaid programs, and federal spending and debt, by following Maine's example.

Better Options

Americans' access to medical care is less secure than it should be, thanks to decades of government interventions like the PPACA. Blocking and repealing this Act are positive steps that will make health care more affordable and secure. For example, the CBO reports that repealing the PPACA would reduce premiums for many consumers by freeing them to purchase more affordable health plans.[90]

Virginia and federal officials should not stop there. After rejecting both an Exchange and the Medicaid expansion, and stopping the Obama administration's attempts to ignore and rewrite the law, state officials should adopt reforms that make health care better and bring it within the reach of more patients.

A "Good Samaritan" Law

For example, Virginia should enact a "Good Samaritan" law like those enacted in Tennessee, Illinois, Connecticut, and Missouri.[91] Such a law would increase access to care for the poor without costing taxpayers a dime or threatening other priorities like education.

Volunteer groups like Remote Area Medical engage doctors and other clinicians from around the country to treat indigent patients in rural and inner-city areas of various states. These volunteers are often turned away from providing free medical care to the poor, because—even though they have a valid license from their own state—they do not have a license to practice issued by the state they are visiting. Remote Area Medical has had to turn away patients or cancel clinics in California, Florida, Georgia, and other states due to these licensing restrictions. "Before Georgia told us to stop," says founder Stan Brock, "we used to go down to southern Georgia and work with the Lions Club there treating patients." After a tornado devastated Joplin, Missouri, Remote Area Medical arrived with a mobile eyeglass lab. Missouri officials prohibited the visiting optometrists from giving away free glasses.[92]

Tennessee, Illinois, Connecticut, and Missouri have now enacted laws that allow out-of-state-licensed clinicians to deliver free charitable care in their states without incurring the considerable and unnecessary costs of obtaining a new license. To protect patients, visiting clinicians are still subject to the malpractice laws of whatever state in which they are practicing.

Let Patients and Doctors Reform Malpractice Liability

Virginia can also expand access to care for the poor, again without costing taxpayers a dime, by allowing patients and providers to enact their own "med mal" reforms via contract.

The cost of medical malpractice liability insurance increases the price of health care for patients, pricing many low-income patients out of the market. Some "med mal" reforms would reduce medical prices, potentially making medical care more affordable. On the other hand, to the extent that these reforms limit physicians' exposure to liability, they may reduce incentives to improve the quality of care, or prevent some injured patients from recovering the full cost of their injuries.[93] When these types of complicated tradeoffs exist, the best approach is to let patients choose the tradeoff that works best for them.

Virginia should allow patients and providers to adopt their own med-mal reforms via contract.[94] Patients who want caps on non-economic damages, mandatory binding arbitration, medical courts, or a "loser pays" rule could choose those reforms, and enjoy any concomitant reduction in their medical bills. Patients who prefer to have an unlimited right to sue could write one into contracts with their medical providers, and pay whatever markup comes with that added

protection. Where states have already imposed caps on noneconomic damages or other limitations on patients' right to recover, this freedom would allow patients to demand *greater* protection than those states currently allow. The resulting experimentation would inform all patients and providers about which med-mal reforms do the best job of protecting patients from the dual harms of negligent care and unnecessarily high prices.

The obstacle to such contracts is that courts will not enforce them. That unfortunate judicial trend denies care to low-income patients by denying them the opportunity to decide for themselves whether accessing medical care now is more important than an unlimited right to sue in the unlikely event they suffer an injury due to a provider's negligence. The General Assembly should direct courts to enforce such contracts. Such a law would expand access to care for the poor, again without imposing any costs on taxpayers.

Study Whether Medicaid Works

Most non-health care experts are surprised to learn, as discussed above, how little reliable evidence there is on whether Medicaid improves health, and how there is no evidence it is a cost-effective way to improve health.[95] Though the Oregon Health Insurance Experiment is a promising start, some observers complain it was too small[96] and Oregon officials have unfortunately halted that experiment.

Rather than expand Medicaid, Virginia should apply for a waiver to conduct an Oregon-like experiment with existing populations, to determine exactly what taxpayers are getting for the billions of dollars they are forced to contribute to the program. Such a study would reduce state and federal Medicaid spending while improving the state of knowledge about Medicaid's effects.

No doubt some will object to randomly assigning Medicaid slots among existing populations. Yet the Oregon Health Insurance Experiment showed that losing the lottery reduced average medical spending among study subjects by just 25 percent, with no indications of harm to their physical health. The truly unethical course would be to preserve or expand Medicaid without knowing whether that additional spending helps enrollees, or just harms taxpayers.

Conclusion

Twenty-six states argued before the Supreme Court that the PPACA coerced states into implementing an unaffordable Medicaid expansion. The Medicaid expansion remains unaffordable today given current projections, and its actual cost is likely to exceed those projections. Perhaps more important, expanding Medicaid conflicts with the goal of delivering affordable, high-quality health care. Virginia should wisely and politely decline to participate.

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[1] Portions of this testimony are adapted from Michael F. Cannon, "50 Vetoes: How States Can Block the Obama Health Law," Cato Institute White Paper, March 21, 2013, http://www.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper.pdf.

[2] See Michael F. Cannon, "50 Vetoes: How States Can Block the Obama Health Law," Cato Institute White Paper, March 21, 2013, http://www.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper.pdf.

[3] This $1.2 trillion figure represents the total projected burden of the revenue-increasing provisions of the law. Douglas W. Elmendorf, "Letter to Rep. John Boehner on Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012," July 24, 2012, p. 6, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf. As the CBO has not published updated projections for all such provisions, this estimate may not be directly comparable to subsequent projections.

[4] Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," Cato Institute Policy Analysis No. 669, October 13, 2010, p. 8, http://www.cato.org/pubs/pas/PA669.pdf.

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ACA Impacts on Medical Care in Alaska, Exchanges and Medicaid Expansion

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Access to care

- ACA has added over 20,000 new pages of regulations to over 130,000 pages of pre-existing medical regulations before ACA. Makes care more expensive and more confusing to provide.
- 40% Providers opted out of Medicaid nationally creates more limited access (low reimbursement so less time with patient results in poorer outcomes, more rules, more restrictions, more audits)
- Estimates of up to 60% providers will retire or opt out of Medicare/Medicaid in next 3 years. Alaska has 80% participation in Medicaid now because of high reimbursement will fall if reimbursement cut and as more rules and regulations are released from committees set up under ACA.
- Many states really limit services/medications which causes poorer Medicaid outcomes. Medicare now won't pay for services ordered by un-enrolled providers. Exchanges-15- 60 page applications, limits on eligibility $62,000/family of 2, expensive, limits on which insurance companies can participate, repayment if income higher than estimated
- More employers cutting back on employee hours<30/week or days <120/year of employment to avoid paying for rapidly increasing cost of health insurance premiums up over $2000/year/family, or eliminating spousal coverage--Children covered up to 26 years. Severe penalties if do not supply insurance.
- HSAs modeled after Healthy Indiana Program much better option as lower costs, less fraud, better outcomes consider linking this to permanent fund could cover many more people less expensively putting patients back in charge of health care

Increasing Costs

- No state opt out once expand Medicaid. (see ACA)
- No federal funding guaranteed beyond first 3 years of Medicaid expansion Federal government trillions in debt with ($220?) trillion unfunded liabilities Medicare, etc.(Baby Elephant model)
- Cost estimates range from $68 to $278 million/year just for cost to state for Medicaid expansion.
- CBO says 2014-2019 cost $570 million to state of Alaska with cost increasing from 2014-2022 to $987 million as federal reimbursement falls for Medicaid.
- Increasing premiums in private sector (Medicaid pays below cost- so costs shifted to private payers increasing the premiums especially for small businesses and individuals) as insurance premiums est. to increase by 30-70% and up to 200% for younger people. By 2018 est. 100% of private insurance plans in Alaska will be taxed at 40% level (More services mandated to be covered under ACA so premiums will go up)
- Expansion of Medicaid increases costs both to state and federal government paid for by increased taxes/fees/penalties on taxpayers and companies. (Block grants-RI which puts states in charge a better choice)

Problems with Medicaid

- Many who need help fall through cracks.
- Medicaid patients poorer outcomes (University of Virginia study 800,000 patients) than uninsured.
- Many not getting married or deliberately underemployed/unemployed to obtain Medicaid or coming from other states.
- 60% Alaskans now dependent on Fed government for services what about independence/freedom/personal responsibility? Small number actually paying the bill via taxes: federal government borrowing from foreign governments to pay bill is unsustainable!
- ACA transfers $700 billion from elderly (Medicare) to fund younger healthier people (Medicaid/Exchanges) and requires everyone to pay for abortions and other elective procedures (sex change operations)
- Confusing rules/regulations fed/state takes decisions away from patients/providers and limits medications/services-- disallows charity care/ boutique practices! (providers are told they are committing fraud if discount services below Medicare rate)
- Low reimbursements/audits in many states forcing practices to close/sell to large corporations.

Exchanges

- Mandated under ACA --many from Medicaid may be forced into these exchanges- confusing requirements/60 page application!
- Expensive to run $60 to 70 million to set up, $6 million/year to run in Alaska alone before any care given --duplicate administrative costs Medicaid/exchange-- restrictive on who can participate people limited by income to 400% poverty level and insurance companies government controls which ones participate.
- No clear guidelines as Governor Herbert of Utah said unsure if their exchange will qualify!
- Federal exchange no penalties to private companies if do not meet insurance requirements as there are in state exchanges as ACA is currently written
- Many states giving money back!
- Unsure number of people who will benefit or of cost to run- if employers drop coverage and pay less expensive penalties may be tremendous demand from new uninsured or may be very little demand as people may find it less expensive to buy as they do now privately- unsure how new premium taxes will impact these exchanges.

Providers

- Shortage of primary care providers now 50% MDs over 50; need 32 new/year, average 8 new MDs. 60% MDs considering retiring/opting out nationwide 2014/2015 (67% in an Anchorage survey I did of 400 providers)
- EHR increased time and expenses and security concerns (25%less efficient)$1.5 million in fines if security breach
- Coding changes in 2014 (10,000 to over 80,000 codes)
- Audits by 18 organizations now with increasing fines regular includes new RAC Medicaid/Medicare audits (commission based/extrapolate) mandated under ACA
- Bundling of payments(have to bill hospital if within 30 days of hospital admission)/ quality reporting/IPAB (Independent Physician Advisory Board sets rates and services allowed)
- Underpayment by Medicare, Medicaid ,Insurance, Large corporations(United ,etc. now buying up practices) US average 40% MDs not taking Medicaid; dramatic reduction in private practices since ACA passed selling to large corporations
- Federal mandates/limits on services or required unnecessary services (breast cancer screening/PSA testing/Pap smears, etc.) 50% of my breast cancer patients diagnosed before age 50 yet limit Mammograms to>50!

  Abortion coverage; Formula restrictions; pre-authorizations; increasing regulations

Summary

- ACA is a very expensive tax and regulatory bill that is going to drive providers out of business, increase insurance premiums and have a very detrimental impact on the economy of Alaska.
- We need to limit Medicaid, encourage the use of HSAs, not fund state exchanges, limit rules and regulations that increase costs for all, limit punitive audits and make them educational, support programs for the training of medical providers, continue efforts toward liability reform, pass legislation to allow boutique practices, and support health care freedom acts that put the patient, not the government, back in charge of their health care.

Better Solutions than ACA

- Block grants for states for Medicaid (Rhode Island)
- Educational not punitive audits
- Preventive care and prevention of accidents, Internet and school educational programs on diabetes, blood pressure, lipids, diet. etc.
- HSAs to model after Healthy Indiana Program(67% reduction in expenditures)
- Allow tax right offs or waivers for charity care without accusations of fraud for providers; pass legislation to allow boutique practices
- Increase vocational education programs for home care for disabled/ elderly, support WWAMI, PA, NP, Residency, Nursing, Dental programs
- Payment like VISA/debit cards
- Allow patients/providers to make decisions not government/insurance/ committees/UN/court(tort reform!)
- Pass a Health Care Freedom Act