

Should Kansas Expand Medicaid Under the Affordable Care Act? A Perspective On Weighing the Costs and Benefits

Executive Summary

In June of 2012, United States' Supreme Court upheld most of the provisions of the 2010 Affordable Care Act (ACA) including the individual mandate to purchase health insurance. However, the Court's decision permits U.S. states to choose whether to opt out of the law's Medicaid expansion provisions; extending coverage unconditionally to all adults with incomes less than 138 percent of the federal poverty limit. This brief utilizes projections from a June 2011 KPI analysis and is, in part, a disaggregation of the earlier study. The original study tracked historical trends in several factors underlying Medicaid costs such as eligibility, enrollment, benefit reciprocity, etc.

As a result of the "Mandate Effect" incumbent in the Supreme Court's ACA ruling, Kansas can expect a 10-year Medicaid State General Fund (SGF) spending increase of \$4.1 billion above expected non-ACA cost increases. Expanding Medicaid would result in an additional \$625 million in SGF expenditures and, when combined with the "Mandate Effect" would increase SGF spending on Medicaid to \$4.72 billion. This assumes that the federal government maintains its match of state Medicaid expenditures, hardly a guarantee given the federal government's extremely unsound financial condition.

KPI's original estimate for the number of potential new Medicaid enrollees (for both the "Mandate Effect" and a possible expansion) is well within the range of projections from other entities. Further, the KPI study takes into account that the same forces that have historically escalated (or reduced) costs per person in each of about 45 different enrollee categories per gender would continue to influence Medicaid cost changes in the future; these costs per person are appropriately weighted by the demographic type(s) of projected enrollees before aggregating – an important methodological step that is not present in other studies and that likely makes those estimates less reliable. These cost changes have a direct impact on SGF spending. For instance, between 2001 and 2009 Medicaid's share of SGF spending went from 9.8 to 13.5 percent and forced reductions in both the shares of education (from 66.4 to 65.1 percent) and other public services (23.8 to 21.4 percent), over the same time period.

Kansas' lawmakers face a crucial decision about whether to expand Medicaid according to the dictates of the ACA. Potential benefits must be weighed against the lost opportunities to spend on other priorities (e.g. K-12 education). It may be better to spend the \$625 million on other Kansas' budget items; especially considering that this is over and above the estimated \$4.1 billion Medicaid spending increase already committed under the "Mandate Effect."

Introduction

A crucial issue facing Kansas' policymakers today is whether to expand Medicaid according to the dictates of the Affordable Care Act (ACA) of 2010. In June of 2012, United States' Supreme Court upheld most of ACA's provisions including the individual mandate to purchase health insurance. However, that Court's decision permits U.S. states to choose whether to opt out of the law's Medicaid expansion provisions. Prior to the ACA, federal guidelines permitted Medicaid coverage for only those nonelderly adults who had dependent children covered under the program. The ACA, however, extends coverage unconditionally to all adults with incomes less than 138 percent of the federal poverty limit (FPL).¹ Medicaid expansion refers to the extension of health coverage under the ACA to all adults with incomes below that FPL limit and a simplified eligibility determination process under the state children's health insurance program (CHIP).

The primary information required for deciding whether to expand Medicaid under ACA's rules is a projection of how the ACA will affect Kansas' health care expenditures. This KPI Brief utilizes projections constructed by the author that were published in a June 2011 analysis also published by KPI [Ref. 3]; this brief is, in part, a disaggregation of the earlier study. Because those estimates are based on a detailed examination of the factors underlying Medicaid spending in Kansas, it is possible to parse out the state's expenditure commitment that Medicaid expansion would entail. This brief also provides an overview of the arguments that suggest that despite promises of generous federal matching in the short and medium term, a decision to expand Medicaid as prescribed by the ACA would risk an escalation of Kansas' general fund health expenditure commitments beyond affordable levels.

¹ The ACA's statutory income threshold below which individuals would be covered under Medicaid (if the state opts for Medicaid expansion) is 133 percent of the federal poverty limit, but the ACA specifies that the first 5 percent of individual incomes be disregarded. If the state does not opt for Medicaid expansion, the qualifying income limit remains.



Medicaid Expenditure Projections With and Without the ACA

The amount by which Kansas' general fund Medicaid expenditures would increase under the ACA depends on the number and health care costs associated with two types of new Medicaid enrollees that the law would impel. One of those types arises from the law's individual mandate that requires all U.S. citizens and legal residents to either obtain private health insurance coverage – if they are not already covered under an employer sponsored health plan, Medicare, or Medicaid – or pay a "tax."² In particular, those who are eligible for Medicaid coverage under pre-ACA eligibility rules (henceforth "old-law eligibles") but are not yet enrolled into Medicaid will be induced to enroll beginning in 2014, unless they are covered under an alternative health plan and choose to remain in it. The federal government's financial contribution for this type of new Medicaid enrollees will remain at the pre-ACA Federal Medical Assistance Percentage (FMAP) rate for regular Medicaid enrollees. For Kansas, the standard FMAP rate is currently set to 56.5 percent (for 2013) and is likely to remain at that level for the next several years.³ To the extent that those already eligible for Medicaid but not yet enrolled are induced to newly enroll into the program beginning in 2014, the Kansas state general fund will have to cover 43.5 percent of their Medicaid health service costs.

The second type of new Medicaid enrollees would emerge if Kansas chooses to expand Medicaid according to ACA's prescription: Extending Medicaid eligibility to all individuals and families with incomes up to 138% of the federal poverty level and introducing a simplified enrollment process for children under CHIP. The U.S. Supreme Court's allowance for states to opt out of the ACA's Medicaid expansion has already induced several states to do just that.⁴ States that reject Medicaid expansion can set their own Medicaid eligibility thresholds as was the case under pre-ACA laws.

Historically, those thresholds have varied across the states and many were set well below 138 percent of the federal poverty level. Most states do not make Medicaid available to childless adults unless they are included in a special-needs Medicaid coverage category.

The additional cost of *newly eligible* Medicaid enrollees will not be fully covered by additional federal financial support beyond the first three years of ACA's implementation—2014-16. For years after 2016, the federal financial match rate for covering this group of Medicaid enrollees will be phased down gradually – to reach 90 percent by 2020. It is unclear whether this matching rate schedule will be maintained beyond 2020 and even whether the schedule prescribed under the ACA through 2020 can be sustained. Under the current federal matching rate schedule for new enrollees among the newly Medicaid eligible, the federally unpaid portion of Medicaid costs must be paid for out of state general funds. The high currently promised match rate is intended to suggest that state general fund commitments for Medicaid expansion would be a relatively small portion of the total increase in state spending on Medicaid and that federal matching funds for Medicaid expansion would help spur economic growth in states' health care sectors and to state economies generally.

The latter claim, however, is rather weak because the supply health care goods and services is unlikely to keep pace with the growth in demand.

Incremental Cost Estimates: Old-Law Eligibles and the Newly Eligible

Soon after PPACA's enactment in 2010, the Kansas Policy Institute commissioned a study to examine the ACA's cost implications for the state's general fund.⁵ That study compiled detailed information on the rules and operations of Kansas' Medicaid program to investigate the ACA's effect on the state's budget arising from new enrollments by "old-law eligibles" and by those made newly eligible for Medicaid under PPACA. Because this

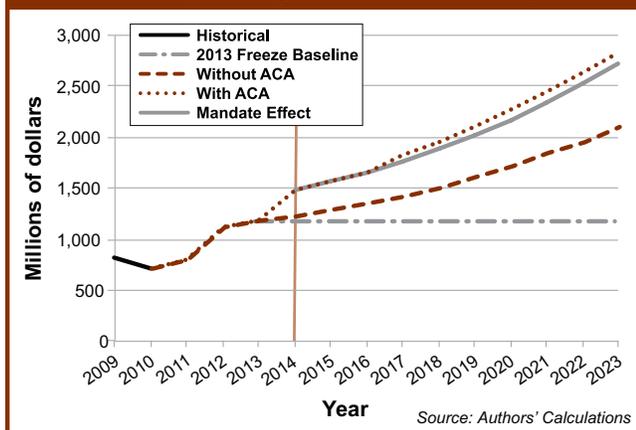
² Although not in the original legislation, use of the term "tax" is motivated by the U.S. Supreme Court's decision that upheld many of ACA's provisions, especially the individual health insurance mandate, by interpreting the payment for noncompliance as a tax and not as a penalty. Exempt from the individual health insurance coverage mandate are those whose health insurance premiums would exceed 8% of their income, those with incomes below the limit for filing a federal tax return, those with religious exemptions, undocumented immigrants, those in correctional facilities, and members of Indian tribes.

³ Note that FMAP rates are higher for children enrolled in the CHIP program. They are also higher for special categories of patients and services such as breast and cervical cancer treatments, adult clinical preventive services, family planning services, home health services for those with chronic ailments, and so on. Beginning 2014, newly eligible Medicaid enrollees will receive much higher federal matching rates as described later in the text.

⁴ Alabama, Maine, Texas, Georgia, South Carolina, Louisiana, Mississippi, Oklahoma, and Pennsylvania are among states that have already announced their intention to forego Medicaid expansion.

⁵ See Ref-3. This study was implemented prior to the introduction of KanCare, the new Medicaid program of coordinated care that went into effect on January 1, 2013.

Figure 1: Kansas General Fund Annual Medicaid Spending: Historical and Projected



study tracks historical trends in several factors underlying Medicaid costs such as eligibility, enrollment, benefit reciprocity, and cost per beneficiary, it is well suited to parse out the cost increments under the ACA from these two sources of new Medicaid enrollees.⁶ To do so, annual general fund Medicaid spending projections are first implemented without ACA's Medicaid eligibility rules. Next, the projections are implemented with just the individual mandate in place but with Medicaid eligibility determined under the state's pre-ACA rules. The final set of projections assume full ACA implementation, including Medicaid eligibility expanded to 138 percent of FPL as prescribed under the ACA. Differences between Kansas general fund expenditures under these alternative Medicaid eligibility scenarios reveal the incremental cost of just the individual mandate (the "Mandate Effect") and the Medicaid expansion (the "Expansion Effect").⁷

The results of the calculations for the state of Kansas are summarized in Figure 1. The lowest line (flat, with alternating dashes and dots) shows the "freeze baseline" or the result of holding Kansas general fund annual Medicaid expenditures at their 2013 (projected) level (\$1.18 billion). The cumulative 10 year (2014-23) Medicaid spending, if it were maintained at its projected annual level for 2013, would be \$11.8 billion.

The middle line (in dashes) shows Kansas Medicaid general fund expenditures that would result if the ACA had never been signed into law. Compared to the freeze baseline, the cumulative 10-year spending difference between the two cases ("2013 freeze baseline" and "without ACA") would be \$4.3 billion. It implies a 10-year cumulative Medicaid spending of \$16.1 billion under the "without ACA" Medicaid expenditure projection. The thin unbroken line shows the "Mandate Effect," – involving a 10-year Medicaid spending increase of \$4.1 billion over and above the "without ACA" spending trajectory.⁸ Finally, estimating the "Medicaid Expansion" effect under ACA's rules generates the top line in Figure 1 (in dots). The cumulative 10-year increment in Kansas general fund expenditures over and above the "Mandate Effect" trajectory turns out to be \$625 million. Thus, under full ACA implementation (including both the "Mandate Effect" and the "Expansion Effect") the projected expenditure increase adds up to \$4.72 billion. Note that the three expenditure projections begin to diverge in 2014 when the ACA is to become fully effective; and the "Mandate Effect" line and the "with ACA" line begin to diverge in 2017 when the federal match rate for newly eligible individuals is reduced to below 100 percent.⁹

It should be noted that other private and public agencies have also estimated the financial impact of the Mandate Effect and Medicaid Expansion Effect on the Kansas General Budget. Examples are those by the Kansas Health Institute, the Lewin Group, Urban Institute, Center for Budget and Policy Priorities, and the Kansas Department of Health and Environment. Estimates for the number of currently eligible but not Medicaid-enrolled individuals range from 30,000 (Kansas Health Institute, December, 2012) to 162,000 (also KHI, December 2012, alternative study). The KPI estimate of this group of potential new enrollees into Medicaid is 102,000 individuals—well within the range of other estimates. In terms of new enrollments from Medicaid Expansion, most estimates fall within the range of 100,000 (Kansas Health Institute, December 2012) to 200,000 (Center for Budget and Policy Priorities, latest

⁶ These elements are influenced by specific legal, environmental, health, and market factors and they are projected separately based on their historical trends. Those factors include federal and state eligibility rules, the frequency, type, and duration of health conditions, and the frequency of adverse health episodes in the population; the availability of alternative insurance sources (employer-provided or private); and the supply of medical facilities, services, technology, and personnel in the area, and so on.

⁷ The data sources used for constructing the estimates included the Current Population Survey (to calculate Medicaid eligibility ratios for various Kansas population subgroups), the Medicaid Statistical Information System (administrative data on Medicaid enrollment, beneficiary, and cost per beneficiary data), and the U.S. Census Bureau (state population projections by age and gender).

⁸ Post ACA enrollment rates among currently uninsured old-law eligibles are calibrated based on the observed Medicaid enrollment rate within their age/gender/health status/income category. But this may understate the rate because, under the ACA, enrollment facilitation drives to sign up uninsured individuals and families through health exchanges may result in even higher enrollment rates.

⁹ The increase in Medicaid spending before the year 2014 arises because of the withdrawal of temporarily high federal matching rates under the American Reconstruction and Recovery Act of 2009.

available but undated). The KPI study's estimate of newly eligible enrollees is 130,000 by 2023, also well within the range of other estimates. However, the KPI study's total annual dollar cost projections from the two effects of ACA are larger than those of other studies. The key reason for this is that other studies' cost estimates are calibrated based on a per person cost from a given year in the past. This is then used as a global estimate—applied to all new enrollees regardless of their demographic (gender/age/income/health) attributes—and it is either kept constant or increased at a fixed, relatively low growth rate. The KPI study does not “flat-line” the cost per person to be used to calculate future expenditure increments from Mandate Effect or the Medicaid Expansion Effect. Rather, historical trends in Medicaid costs per person are (a) differentiated by demographic/age/income group and (b) future years' costs are based on extrapolating the historical trend for each separate category of enrollees. This is a methodologically sounder approach to making projections of future Medicaid expenditure increments from the two types of new enrollees that the ACA's individual mandate and Medicaid expansion (if adopted) would trigger. Its key advantages are, first, the implicit assumption that the same forces that escalated (or reduced) costs per person for particular categories of enrollees in the past would continue to influence cost growth in the future. Second, those cost rates per enrollee are appropriately weighted by the trend-determined shares of future enrollees by demographic (gender/age/income/health) type. A brief perusal of the historical data suggests that per person costs have been growing at a rapid rate in Kansas for most categories of enrollees. Non-incorporation of historical information on the rate of cost growth (assuming, instead, a lower cost rate per person) and not weighting the cost rate according to the size of the projected new-enrollee group by the other studies cited above is the most likely explanation of why those projections of future Kansas Medicaid expenditure increases from both types of new enrollees are considerably smaller than KPI's projections.

Medicaid Expansion Pros and Cons

The U.S. Supreme Court's has deemed the ACA's individual health insurance mandate constitutional and, therefore, state governments will not be able to avoid increases in Medicaid expenditures resulting from the

“Mandate Effect.” Choosing to expand Medicaid under the ACA's prescription – to cover non-elderly adults up to 138 percent of the FPL – would add \$625 million to Kansas' general fund Medicaid expenditures during 2014-23.¹⁰ What are the pros and cons of this policy choice?

A. Health Effects

The obvious pro for Medicaid expansion is that it would cover more individuals and presumably improve their sense of health and well-being and reduce their out-of-pocket health care expenses. But policymakers should not base their decision on the simple fact that more spending and larger subsidies for particular population groups under Medicaid would improve their (self-reported) health and well-being.¹¹ Rather, the decision should be based on a comparison of such benefits from committing scarce budget dollars at the margin to additional health care provision versus other budget items (e.g. transportation, K-12 education).

B. Opportunity Cost

The ACA's Medicaid expansion rules, especially the FPL cut-off, are designed as a one-size-fits-all policy by the federal government. Its intent is to expand coverage to those currently uninsured under an arbitrary FPL threshold. However, an FPL threshold that may be suitable for California or Virginia may not be appropriate for Kansas. Prior to the ACA's enactment, most U.S. states set their Medicaid qualifying income thresholds independently based on their own unique budget, social environment, norms, income distribution, and so on. In Kansas, that threshold was set to 32 percent (25 percent) of FPL for working (jobless) adults with dependent children. Pre-ACA, Kansas provided no Medicaid coverage to other (nondisabled) adults. That was a choice Kansas policymakers made, not in a vacuum, but with full knowledge of the marginal value of increasing health-care spending and subsidies for low-income individuals as compared to spending on other programs such as education, infrastructure, and community development.

C. Work Incentives

This pre-ACA choice by Kansans may also have been motivated by the huge hurdle a low-income health care subsidy would place before individuals attempting to better their economic circumstances by working harder or acquiring more skills and human capital. That hurdle

¹⁰ Opting for Medicaid expansion would imply that the state would cover almost everyone below age 65 who is not pregnant, not entitled to Medicare, not a member of an existing mandatory coverage group, and whose annual income is less than 138% of the federal poverty level (138% equaled \$15,415 per year for an individual in 2012).

¹¹ Studies about the effects of providing Medicaid coverage to previously uninsured households suggest that self-reported physical and mental health is improved, health care service utilization is increased, and out-of-pocket health care spending is reduced. However, whether this results in improved measures of objective health remains unconfirmed. See Ref-11.

would be increased to a much higher level and its scope broadened under the ACA, ultimately to trap low-income individuals and families in low wage jobs and poverty: Their natural incentive to climb the economic ladder would be dulled by the associated loss of Medicaid eligibility and ACA subsidies.

D. Budget Risks

The Federal offer of free coverage to state residents (under a 100 percent match rate) together with the promise of almost free coverage (at least a 90 percent match rate) through 2020 and possibly beyond that year, is motivated by recognition that it would be very difficult for state lawmakers to divert funds from other budget items toward expanding eligibility to Medicaid for low-income groups.¹² But federal lawmakers are fully aware that such generous matching of new state Medicaid spending on account of Medicaid expansion is, in reality, infeasible. This is now crystal clear from the Obama Administration's own proposal to scale down federal matching funds for state Medicaid programs by blending different match rates for Medicaid, CHIP, and Medicaid expansion in a way that would result in smaller overall Medicaid grants to states.¹³ This proposal should open state lawmakers' eyes to the potential for Medicaid deception by their federal counterparts. The federal government's fiscal condition is so poor – with rising debt and deficits projected “as far as the eye can see,” and debt projected to climb close to 100 percent of annual GDP – that sustaining a 90 percent match rate for state Medicaid expansion (or even the 100 percent match rates specified for the first three years of the ACA's implementation) is simply not credible.¹⁴ That means states will, over time, bear an ever-increasing burden of funding the costs associated with new enrollees induced by Medicaid expansion; which, once adopted, will become politically difficult to pare back.

E. Cost Escalation

Even with the federal matching promised under the ACA, post-2016 growth in Kansas' outlay for Medicaid expansion will be quite rapid. For Kansas, the 2017 cost

of Medicaid expansion is estimated to be \$51 million under the KPI study's estimates cited earlier. The growth in this portion of Medicaid spending during years 2018 and 2019 is estimated to exceed 25 percent per year because of the combined effect of the decline in federal matching after 2016 and projected growth in enrollments and rapid increases in health care costs per beneficiary. Once the federal matching rate stabilizes after the year 2019, the annual cost growth is estimated to be about 8 percent per year.¹⁵ Thus, if Kansas lawmakers respond to the federal inducement of a generous federal match rate by expanding Medicaid according to the ACA's rules, they will almost surely regret that decision as program costs escalate during later years.

F. “Value for Money” Issues

Another reason for caution before opting to expand Medicaid under the ACA is that cost of this decision is “on the margin” of Kansas' general fund expenditures. Consider the simple example of an individual homeowner planning to build an extension to his home under a contract for \$40,000 worth of materials and labor expenses: Suppose that as the construction is progressing, the contractor recommends the inclusion of a new feature for a small additional cost – just \$5,000. Now, \$5,000 may seem to be a small amount in absolute terms, but it may be unaffordable because it's over and above the already committed outlay of \$40,000. In other words, the “value for money” calculus is different for the first \$5,000 of expenditure than for the marginal \$5,000 over and above of an already committed outlay of \$40,000. Spending at the margin on Medicaid competes more intensely with alternative spending possibilities. For a state government, spending on education, infrastructure, police, fire, community development, commerce, research and development, etc. may be more fruitful than spending more on health care, given that a large increase in Medicaid expenditures that is already committed via the ACA's Mandate Effect. This calculus may remain valid, despite the federal government's promise of sizable matching funds, especially if Kansas' policymakers properly discount future federal dollars, recognizing the large uncertainties attaching to those

¹² Under the methodology described earlier, Medicaid expansion would result in an additional 102,000 enrollees into the program in 2014 compared to enrollment projections without the ACA. By 2020, the difference in enrollments would be 119,000 and by 2023, it would be 130,000. Applying the demographic, health, and income related average Medicaid cost per enrollee yields the cumulative \$625 million spending increment from Medicaid expansion noted earlier.

¹³ President Obama made this proposal during the “super-committee” deliberations in 2011 on a grand bargain to reduce annual deficits and the national debt. For a description of the blended FMAP rate, see Ref-10.

¹⁴ The Congressional Budget Office projects that federal deficits will increase rapidly toward the end of this decade as baby-boomer retirements accelerate and the oldest baby-boomers enter their years of needing long-term care and begin to incur the highest medical expenses typical at the end of the human lifetime. See Ref-9.

¹⁵ This cost growth estimate may turn out to be low because as the baby-boomers retire, demand pressure on health care services nationwide is likely to intensify and boost health care inflation.

promises.

G. Budget Priorities, Especially Education

Another consideration relevant to this decision is the history of Kansas' general fund expenditure shares of Medicaid, education, and other public services (transportation, corrections, public assistance, housing, environmental and natural resource programs, and parks and recreation). An increase in Medicaid's general fund share during the 1990s—from 7.8 percent in 1990 to 10.8 percent in 1999—was more than fully absorbed by reducing the budget share of spending on other public services, which declined from 36.2 percent in 1990 to 24.5 percent in 1999. However, the expenditure share of education (there is also a strong correlation between higher educational attainment and better health outcomes), was protected during those years. Indeed, the budget share of education increased significantly from 56.0 percent in 1990 to 64.6 percent in 1999. The year 2000 was abnormal with an exceptionally low Medicaid budget share of 4.8 percent. During the rest of the 2000s decade, however, an increase in Medicaid's share from 9.8 percent in 2001 to 13.5 percent in 2009 forced reductions in both the shares of other public services, which declined from 23.8 percent in 2001 to 21.4 percent in 2009, and education, which also declined from 66.4 percent in 2001 to 65.1 percent in 2009. This suggests that the significantly steeper Medicaid expenditure trajectory that is likely to emerge after 2014 with the ACA in force—and which would increase Medicaid's general fund share well above 20 percent—may compel large contractions in the future expenditure shares of both education and other public services. This budget pressure on education would be even greater with a decision to expand Medicaid coverage under the ACA.¹⁶

H. Medicaid Expansion Won't Expand the State's Economy

Not only will Medicaid expansion crowd out other uses of scarce dollars in the Kansas general fund, it would do little to spur economic growth – contrary to the claims made by the proponents of Medicaid expansion. Those claims are clearly motivated by the attractive opportunity that Medicaid expansion creates for the providers of health care goods and services – to expand market demand for their professions and businesses. From a macro-economic perspective, however, the additional federal dollars from the generous matching

rate promised for Medicaid expansion is unlikely to result in any significant expansion of economic activity in the state. Those dollars would only add demand pressure to a sector where supply responses are highly inelastic in the short and medium terms. Medical personnel take years to train and better medical technology and drugs require even longer gestation periods – of trials and federal approvals – before they can be brought to market. That means, additional demand will only cause the prices of health care goods and services to escalate further, sucking resources from the private-pay health care sector and causing unnecessary further crowding out of enrollees from employer-sponsored and private insurance markets. Medicaid expansion is likely to prove a sure-fire way of maximizing this effect, not of expanding economic activity in the state.

I. Market Response to the ACA and the Future Health Insurance Environment

There are good grounds to believe that the earlier KPI study's estimates of ACA's effect on the trajectory of Kansas' health care expenditures are conservative. Those estimates are based on historical enrollments rates among Medicaid-eligible groups, which are likely to be smaller than under the post-ACA environment: Under pre-ACA conditions, the availability of alternatives, including employer provided health insurance that enjoys federal tax subsidies, are likely to induce non-enrollment into Medicaid. In the post-ACA environment, although employers are subject to penalties for non-provision of health insurance to employees, those penalties are relatively small. Indeed, noncompliance penalties are also small on individuals who choose to remain uninsured.¹⁷ As a result, employers may find it more profitable to withdraw health coverage and pay the penalties rather than continue to provide health insurance to their employees. And individuals may find it worthwhile to remain uninsured and pay the “tax” until such time as they need health care services. The “guaranteed issue” of standard level of health insurance to all without regard to pre-existing conditions makes this possible, and may make it worthwhile if insurance premiums are sufficiently high. However, those individuals with sufficiently low incomes to qualify for Medicaid are likely to enroll—in larger numbers under an environment of high premiums for private and employer-sponsored insurance. Thus, the ACA is likely to alter employee and employer incentives to significantly

¹⁶ The statistics cited here are based on reporting by National Association of State Budget Officers.

¹⁷ Indeed, the low level of the charges for non-compliance with the individual health insurance mandate may have been the motivation for U.S. Supreme Court's Chief Justice, John Roberts to interpret them as “taxes” rather than as penalties, paving the way for his decision to uphold the individual mandate. But that means, those penalties cannot be increased sufficiently to make them significantly economically punitive for those who may choose to remain uninsured. See (Ref-8).

increase Medicaid enrollment rates – by both groups of new enrollees described above – at rates faster than historically observed. This fillip to Medicaid enrollment incentives will be enhanced by enrollment facilitation drives as envisioned under the ACA.¹⁸

It is noteworthy that ACA's regulatory system on health insurance coverage and pricing is likely to increase health insurance premiums for almost all individuals—and therefore increase Medicaid enrollment rates beyond those assumed on the basis of historical trends in the earlier KPI study. The law will, therefore, forcibly expand the demand for Medicaid coverage.

The ACA will require much higher direct and indirect costs per person for funding the ACA's health coverage expansion: large “hidden taxes” for most insurance purchasers—higher-than-actuarially-warranted premiums for those enjoying relatively good health; higher premiums compared to a competitive health insurance market with the freedom to choose coverage or to opt out depending on one's health status and expectations; higher state and federal income taxes to support the expansion of premium supports for qualified individuals under the ACA; the loss of considerable tax-deductible employer provided health insurance coverage either because employers prefer to pay ACA's penalties or their plans are disqualified under ACA's regulations. Under the last item, note that any increase in employee wages (net of the penalty on employers) to compensate for lost employer health coverage would be subject to income and payroll taxes. All of these effects argue for low-income individuals to enroll into Medicaid at greater rates than those underlying the KPI study's estimates.

The claim made here, that the ACA is likely to significantly increase health insurance premiums facing most of the population, is also supported by other studies: One study [Ref. 6], which concerns ACA's likely effects in Wisconsin, is by MIT economist Jonathan Gruber. His study finds that under ACA's individual mandate and regulations, “87 percent of the individual market will experience an average premium increase of 41 percent.” Indeed, the Gruber study finds that even after accounting for ACA's premium assistance for qualified individuals, “59 percent of the individual market will experience an average premium increase of 31 percent.” Further toward addressing this point, a recent study [Ref. 7] by Richard Burkhauser of Cornell University concludes that “family based affordability” considerations during contracting between employers and employees could

push between 1.3 and 6.0 million additional households (depending on co-insurance rates for employer provided insurance) onto the health Exchanges, implying higher taxpayer costs. The estimates are even larger under “individual based affordability” rules. This, again, argues for larger enrollment rates in the post-ACA environment compared to those used in KPI's original study.

Conclusion

Kansas' lawmakers face a crucial decision about whether to expand Medicaid according to the dictates of the ACA. That decision would expand the program and possibly improve health outcomes for low income households. However, that benefit must be weighted against the lost opportunities to spend on other budget programs that are also valuable – such as education, infrastructure, community development, and so on. The incremental 10-year cost to the Kansas general fund from expanding Medicaid of \$625 million would arise “at the margin” – that is over and above the Medicaid spending increases already committed under the Mandate Effect that was upheld by the U.S. Supreme Court, estimated to be \$4.1 billion. Because higher opportunity costs attach to marginal than inframarginal dollars, it may be better to spend the \$625 million on other Kansas budget items. The generous federal offer of matching funds for Medicaid expansion may tempt some lawmakers into opting for Medicaid expansion. However, the federal government's financial condition is extremely unsound and recent Medicaid funding policy proposals by the Obama administration – of blending matching formulae for different state health care programs to reduce overall matching grants to states – reveal the unsustainable and time-inconsistent nature of the generous federal promise of matching funds for Medicaid expansion under the ACA. Finally, the estimates of state cost increases on account of new enrollments into Medicaid are likely to understate future cost increases because of the likely effect of the ACA on future health care costs and premiums. Escalations in both may cause massive adverse selection in terms of waiting to obtain insurance until one encounters adverse health conditions. Under this environment, the crowd-out of private or employer-based insurees into Medicaid will be substantial, implying higher state costs of adopting Medicaid expansion. Kansas lawmakers owe their constituents a long-hard look at the Medicaid expansion option before they make a decision.

¹⁸ My Cato Institute colleague, Mr. Michael Cannon, suggests that there may be an unquantifiable but most likely positive synergistic interaction between Medicaid expansion and the Mandate Effect in terms of increasing Medicaid enrollments – which would tend to increase state Medicaid expenditures.

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