

Testimony of Dean Clancy

Foundation for Government Accountability

Kansas Legislature

Topeka, Kansas

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Chairman Hawkins and distinguished Members of the Committee:

Thank you for inviting me to testify on Medicaid expansion. I'm here on behalf of the Foundation for Government Accountability. FGA is a 501(c)(3) educational organization that works to improve the lives of Americans by promoting fiscally sensible, sustainable government policies in the areas welfare and health care.

FGA opposes expanding the existing, broken Medicaid program. Medicaid should not be expanded in its current form. It should be reformed for the benefit of its enrollees and federal and state taxpayers. FGA advocates that Old Medicaid receive what we call the Medicaid Cure, which would ensure health care providers full payment rates in a fundamentally redesigned incentive structure that gives enrollees much more choice and control over their own health care.

FGA has been asked to testify on proposed Medicaid expansions in numerous states, and we are pleased to have this chance to speak to this Committee today on this important subject.

I want to make three basic points today.

First, Kansas cannot count on the federal contribution remaining at 90 percent. The 90-10 match is going to go down, probably to a blended rate well south of 90 percent. Eventually, I would expect, it will go down to the regular Medicaid matching rate.

Second, the provider tax subsidy that helps provide relief to some, though not all, Kansas hospitals is going to go down. Like the 90 percent match rate, it's a target for federal budget-cutters.

Third, the widely discussed Indiana Medicaid expansion is not a model for Kansas, but rather an expansion of Old Medicaid in all but name and therefore not an affordable model for state taxpayers and not good for patients or providers. Emulating the Indiana model in Kansas would likely put a real strain on the Kansas budget, should the 90 percent match rate and provide tax

U.S. House Budget Chairman Paul Ryan (R-WI) has called reducing the 90 percent rate “low-hanging fruit” for budget-cutters.

Meanwhile, President Obama has talked about saving money on the federal side by going to a “blended rate,” meaning a lower rate that reduces the amount states receive from Washington.

The 90 percent match rate is going away.

Provider Tax, Likewise

A higher provider tax would certainly provide relief to some, though not all, hospitals in Kansas, but in Washington provider taxes are viewed as abusive—as ways for states to maximize federal matching contribution beyond what their services really merit. There is continuing pressure in Congress to ratchet down on provider taxes.

I took part in a number of discussions about lowering permissible provider tax rates during my time in the White House, and I am sure such discussions continue.

Any reform in Kansas should not, in my opinion, count on changes in provider taxes being treated neutrally by Washington.

Medicaid: Flawed, but Curable

Medicaid is a deeply flawed program, one that limits poor people’s access to doctors, offers them inferior health outcomes, and encourages them to prefer dependence over work.

Medicaid’s problems are mostly a result of its joint federal-state structure, which is truly counterproductive, incentivizing politicians at all levels to expand welfare dependency while making sensible reforms well-nigh impossible. As a result, Medicaid is now among the biggest drivers of federal and state deficits, growing at a staggering 9 percent a year. Medicaid has become the default health plan for one in five Americans and pays for half of all U.S. births. Expanding the existing Medicaid program, which we call Old Medicaid, is fiscally and morally imprudent. True reform is urgently needed.

We think Kansans would be best-served by sticking with what we call Project Medicaid Cure, a comprehensive reform plan that is in part based on patient-centered reform strategies that originated here in Kansas as well as Florida and Louisiana. The Medicaid Cure infuses Old Medicaid with the winning strategies of choice, competition, innovation, and real accountability. Under this approach:

welfare entitlement for able-bodied, working-age adults. Many of the “concessions” were far less significant than advertised.

The original Healthy Indiana Plan, designed by Pence’s predecessor, Governor Mitch Daniels, required individuals to contribute up to 5 percent of their income in order to receive Medicaid benefits. The minimum contribution required was \$160 per year.

Gov. Pence’s Obamacare expansion seriously waters down these requirements. Under the “deal” negotiated with the Obama administration, Indiana may not charge able-bodied adults in its Medicaid expansion more than 2 percent of their income. For those choosing the “Basic” benefit package, the minimum contribution is zero. For those seeking the plan with extra generous benefits, such as vision and dental, the contribution starts as low as \$1 per month. In fact, Medicaid expansion enrollees might not have to pay at all; the Pence plan allows any third party to pay all of the required contribution.

One of the much-heralded aspects of Indiana’s deal is the so-called “lockout” for Medicaid expansion enrollees who refuse to make “required” contributions. The theory is that enrollees who don’t pay premiums lose coverage and are barred from re-enrolling in Medicaid for six months. The lockout is a paper tiger. The federal government is prohibiting Indiana from imposing lockout periods on any Medicaid expansion enrollee below the poverty line. That means 77 percent of Indiana’s Medicaid expansion population can pay nothing and still receive taxpayer-funded Medicaid welfare indefinitely.

The remaining 23 percent of Indiana Medicaid expansion enrollees—those earning between 100 percent and 138 percent of the Federal Poverty Line (FPL)—have a number of broad exemptions to choose from to dodge the lockout requirement. According to the fine print of Pence’s deal, expansion enrollees can refuse to pay required premiums if they meeting any of the following conditions:

- are medically frail;
- have dependent children;
- are a victim of domestic violence;
- live in a county with natural disasters;
- “obtained” private coverage and then “lost” it (“obtained” and “lost” are not defined);
- claim residency outside of Indiana, then reclaim Indiana residency; or
- artificially boost their income above 138 percent FPL, then lower it to get back on Medicaid.

In addition, Gov. Pence’s deal allows Indiana to “add additional circumstances for granting exceptions, as it deems necessary,” which means the lockout exemptions may never end. And for

Claim: Indiana's proposed Medicaid expansion is not part of ObamaCare. Fact: Indiana's plan is authorized by Title II of the Affordable Care Act, otherwise known as Obamacare.

Claim: Indiana's proposed Medicaid expansion is a block grant that conservatives have long-championed. Fact: Medicaid block grants, by definition, give states a fixed, lump sum of federal dollars in exchange for broad autonomy. But under Indiana's plan, the state collects increasing amounts of deficit-financed ObamaCare dollars to add more people to the Medicaid rolls. And so much for federal flexibility: Indiana's plan delivers Obamacare Medicaid benefits, with Obamacare Medicaid cost-sharing, to the Obamacare Medicaid expansion population.

Claim: Indiana's proposed Medicaid expansion leverages Health Savings Accounts (HSAs) to increase personal responsibility and control costs. Fact: The so-called "POWER Accounts" under Indiana's plan look nothing like true Health Savings Accounts, where enrollees are expected to contribute toward the cost of their health care. Under Indiana's plan, the required contribution is \$0.

Claim: Indiana's proposed Medicaid expansion is designed to help the working poor. Fact: The Indiana plan creates a new entitlement for able-bodied adults in their prime working years, the vast majority of whom have no dependent children to support. Data from the U.S. Census Bureau suggests nearly half of the Hoosiers expected to sign up for the Indiana plan do not work at all. According to the U.S. Census Bureau, just 24 percent of potential enrollees work full-time, year-round jobs, while 42 percent do not work at all.

Claim: The federal government has approved Indiana's Medicaid expansion plan. Fact: Governor Pence submitted Indiana's Medicaid expansion plan to CMS on July 1, 2014, and recent reports have suggested that negotiations have stalled. The plan solicited unprecedented public opposition, as nearly 400 Indianans wrote Gov. Pence, telling him to oppose the plan.

Three Indiana Plans Compared

Now let's take a moment to compare Indiana's two existing health plan models with its Medicaid Expansion program, across a variety of features. The three options, to be specific, are: the existing Healthy Indiana Plan, Indiana's State Employee HSAs, and Gov. Pence's Medicaid Expansion.

Eligibility. The existing Healthy Indiana Plan is available to individuals in poverty, with enrollment capped based on available funding. Indiana's State Employee HSAs are available to full-time state employees. Gov. Pence's Medicaid Expansion is available to all able-bodied, working-age adults made eligible under the ObamaCare Medicaid expansion.

“Expanding enrollment, no matter the motivations, is fiscal suicide. We hope Mr. Pence thinks again before [his] rising star begins to fade.”—*Washington Times* Editorial Board

“There is little evidence that the additional costs imposed by Indiana’s proposed Medicaid expansion will be defrayed by measurable health benefits, the small monthly fees it will try to collect, or its copay window dressing.”—National Center for Policy Analysis

“[Mike Pence] affirms there’s no principle limiting who should be eligible for government-funded welfare.”—Heartland Institute

“Two camps are emerging among GOP governors: those who oppose the Obamacare expansion, and those who pretend to. Pence has now officially joined the pretender camp.”—Dean Clancy, *The Federalist*

“Mike Pence’s Medicaid plan—neither conservative nor federalist.”—Mercatus Center, at National Review Online.

Morally Indefensible

There is something morally indefensible about a system that features a 90 percent federal match for able-bodied, mostly childless adults who don’t put in much work effort, relatively speaking, while only providing a 66 percent federal match for people with severe disabilities. To expand Medicaid for the able-bodied in this way is, in effect, to allow them to cut in line, ahead of people who are more in need and who have been consigned to waiting lists, sometimes for quite a long time.

Time for the Medicaid Cure

Instead of allowing the able-bodied to cut in line ahead of disabled persons, Kansas should look for ways to reduce waiting lines and improve efficiency. Instead of expanding a broken and unaffordable Medicaid welfare program, Kansas and other states should seek greater flexibility from Washington, on a permanent basis. States have called in recent months for “devolution” of federal entitlements and income-support programs to the States. Medicaid is of course at the top of the list of programs that should ultimately be turned over to the states, who are closest to the people it serves.

But while Washington debates the future of Old Medicaid, we at FGA think Kansas should build on a model that works, on the Medicaid Cure that combines patient choice with sensible incentives and full payment rates for providers. Thank you.