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An Economic and Policy Analysis of Florida Medicaid Expansion

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In June 2012, the U.S. Supreme Court ruled as unconstitutional, those provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) denying federal matching funds to states that refuse to extend Medicaid eligibility to 138 percent of the federal poverty level (FPL). As a result, Florida and other states now have the opportunity to compare the costs and benefits of expanding Medicaid eligibility.

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Executive Summary

This legislation offers an important exercise for Florida, because many low- to middle-income individuals will qualify for a newly expanded Medicaid program, and might benefit from generous, sliding-scale subsidies in the health reform law, with the opportunity to purchase private health coverage in the ACA's new Health Insurance Exchange.

The ACA was initially expected to provide coverage for 32 million uninsured individuals and families when fully implemented. About half of the newly covered were expected to obtain private coverage, while the other half would enroll in an expanded Medicaid program. The ACA contains financial incentives designed to strongly encourage states to expand Medicaid eligibility.

The Obama administration, and advocates for the poor, and have touted the benefits of expanding Medicaid: The federal government promises to pay most costs for those newly eligible. However, a thorough discussion of the costs, obstacles, alternatives and potential pitfalls is critically important.

Effect of the ACA on Florida Medicaid Enrollment and Costs. The ACA encourages states to expand Medicaid eligibility to 138 percent of poverty ($32,500 for a family of four). The federal government would initially pay 100 percent of the cost of benefits for adults for three years — dropping to 90 percent in 2020 and thereafter.

If Florida expands its Medicaid program, up to 1.6 million additional individuals may enroll. Of these, 250,000 or more would not qualify for the enhanced federal match, because they were previously eligible but never enrolled. They would only qualify for the older — and much lower — federal matching rate of 59 percent. About 1.3 million would be newly eligible and subject to the enhanced federal match. This number will include some who drop private health insurance coverage. Despite

generous federal payments, the Cato Institute estimates the ACA's requirements would force Florida to increase general revenues allocated to Medicaid from just over $6 billion in 2008 (prior to the ACA), to nearly $24 billion in 2030 under an expanded program.

Effect of the ACA on Florida's Physician Shortage. Florida's physician supply is relatively inelastic and cannot increase quickly to accommodate rising demand for medical services. More than 85 percent of Florida physicians have already reached middle age, and many will retire in the coming years. Florida physicians have little if any excess capacity to treat additional Medicaid patients. Half of Florida's doctors already see more than 75 patients per week; nearly one-third (30.1 percent) see more than 100 patients each week.

Yet, demand for health care continues to rise. A number of economic studies indicate the newly insured will nearly double their consumption of medical care. In addition, over the next 17 years Florida's population will grow by one-fourth. During this period, Florida's senior population (age 65+) is expected to rise about three-fourths compared to the 2010 Census. An aging population will require more medical care.

Low Provider Fees Under Medicaid. The Florida Medical Association identified low reimbursement rates as one of several factors contributing to the shortage of physicians willing to treat Medicaid enrollees. On average, Florida fee-for-service Medicaid pays physicians only about 57 percent of what Medicare pays for the same service. For primary care, Medicaid only pays about half (49 percent) as much as Medicare. Compared to commercial insurers, Florida's Medicaid program pays less than half (46 percent) what a private insurer would pay. And the program pays even less for primary care — about $0.40 cents on the dollar compared to private insurers. Low provider reimbursement rates make it more difficult for Medicaid enrollees to find physicians willing to treat them, limiting their access to care.

Poor Access to Care Under Medicaid. Nationally, slightly less than one-third of physicians accept new patients enrolled in Medicaid. This is nearly double the rate of doctors who have closed their practices to new Medicare patients (17 percent) and to new privately insured patients (18 percent). Physicians are four times more likely to turn away new Medicaid patients than those with no insurance (31 percent versus 8 percent). Only about 41 percent of Florida physicians will accept new Medicaid patients. For instance, a survey found that in Miami:

- More than one-third (36 percent) of cardiologists will not accept Medicaid patients.
- About 60 percent of family practitioners will not accept new Medicaid patients.
- Nearly two-thirds (64 percent) of orthopedic surgeons will not accept new Medicaid patients.
- Nearly three-fourths (72 percent) of OB/GYN specialists will not accept new Medicaid patients.

How Medicaid Displaces Private Insurance. Many of the newly insured under Medicaid will be those who previously had private coverage. Thus, crowd-out is likely to be a significant problem for states that expand Medicaid eligibility to able-bodied adults. Crowd-out is a condition where people who are already covered by employer or individual insurance drop that coverage to take advantage of the public option. Analysis of past Medicaid expansions by the economists and Obama administration advisers David Cutler and Jonathan Gruber found that when Medicaid eligibility is expanded, 50 percent to 75 percent of the newly enrolled were those who had dropped private coverage. Estimates vary, but many economists reasonably believe that Medicaid rolls might rise by 1.4 people in order to reduce the uninsured by 1 person.

Health Outcomes and Medicaid. On paper, the Medicaid health plan appears far better than what most Americans enjoy — with lower cost-sharing and unlimited benefits. But by almost all measures, Medicaid enrollees fare worse than similar patients with private insurance. For instance, post-surgical individuals enrolled in Medicaid are almost twice as likely to die as privately insured patients and about 12 percent more likely to die than the uninsured, according to a University of Virginia study.

Alternatives to Medicaid under the Affordable Care Act. The ACA establishes health insurance

exchanges where, starting in 2014, qualifying individuals who have no access to an employer-provided health plan or Medicaid can purchase subsidized, individual health insurance. Those whose employers offer affordable health plans will not be eligible for exchange subsidies.

The share of premiums paid by enrollees in the exchange who earn between 100 percent and 133 percent of the poverty level cannot exceed 2 percent of their income. Thus, their annual cost will often average less than $200 per covered individual, for coverage potentially worth $15,000 for a family of four. If Florida wants to encourage this moderate-income population to enroll in private plans in lieu of Medicaid, the state could pay the non-subsidized portion of the premiums, but taxpayers would bear the cost, less than $1 billion over a decade.

How Would Private Coverage Affect Providers? Medicaid take-up varies from state to state. Certainly all those who qualify will not enroll. Private coverage that allows individuals and families to see most physicians and utilize large hospital networks may provide an added incentive. Florida hospitals would benefit from policies that maximize the number of people with commercial insurance, because private insurers reimburse at a higher level. Medicaid expansion would produce the opposite effect because an estimated 30 percent of adults in the 100 percent to 138 percent of federal poverty income range who have private insurance will drop it in favor of Medicaid. Thus:

If Florida does not expand Medicaid to those earning between 100 percent to 138 percent of poverty, the state will forgo about $12 billion in additional federal Medicaid money over the next 10 years.

- However, if Florida families take advantage of generous federal subsidies for private insurance, private insurers will spend approximately $28 billion in additional health care.
- After accounting for Florida's share of new spending, the $15 billion difference represents an additional infusion of nearly $1.5 billion per year — including extra money for the state's doctors and hospitals.

Does Medicaid Boost the Economy? Interest groups often tout the benefits of so-called "economic activity" that additional federal Medicaid funds might create within states. Yet, economists find it difficult to calculate the actual value of economic activity. Macroeconomic studies of the multipliers for increased government spending for the nation as a whole suggest that since 1950, "balanced-budget multipliers" show such increases negatively affect national economic output. If correct, these results suggest that the net effect of the new health law will be that GDP declines as the federal government pulls more revenues from citizens to fund its programs. Basically, consumers will cut back consumption elsewhere to pay for the increased tax burden. According to the RAND Corporation, most states can expect to see a net transfer of state resources to the federal government under the ACA. Only poor states will experience more benefits than costs.

Is Federal Spending Sustainable? Medicaid isn't the only commitment the federal government has to fund into the infinite future. At the federal level, health care is our most serious domestic policy problem, and Medicare is the most important component. Every year for decades, Medicare spending has increased an average of 2 percentage points more than the growth in gross domestic product (GDP). If this country continues consuming products whose cost is growing faster than national income, it will eventually crowd out every other thing we are consuming. For instance, the CBO found that if federal income tax rates are adjusted to allow the government to continue its current level of activity and balance its budget:

- The lowest marginal income tax rate of 10 percent would have to rise to 26 percent.
- The 25 percent marginal tax rate would increase to 66 percent.
- The current highest marginal tax rate (35 percent) would rise to 92 percent!

Tax rates this high are clearly unsustainable; thus federal spending is unsustainable.

Conclusion. Medicaid comprises more than one of every five dollars spent by Florida and is growing at an unsustainable rate. Florida would be better served

to free those earning above 100 percent of the federal poverty level to seek subsidized coverage in the health insurance exchange. For families earning less than 100 percent of poverty, Florida should tailor its Medicaid program in ways that makes sense and that are tailored to Florida residents' unique needs. These services might include selectively covering some optional populations but not others; the program might also involve providing limited benefits rather than open-ended entitlements. In any case, this spending would still qualify for federal matching funds — albeit at a rate of about 60 percent rather than 90 percent. The amount of benefits — and the populations covered — should depend on preferences and priorities held by Florida taxpayers.

Florida taxpayers, hospital budgets and patients will be better off if low-income families enroll in private coverage rather than Medicaid. Uninsured residents above 100 percent of poverty could obtain private coverage far more generous than Medicaid.

About the Authors

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Introduction

In June 2012, the U.S. Supreme Court ruled as unconstitutional, those provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) that deny federal matching funds to states that refuse to extend Medicaid eligibility to 138 percent of the federal poverty level (FPL). As a result, Florida and other states now have the opportunity to compare the costs and benefits of expanding Medicaid eligibility. This legislation offers an important exercise, because many low to middle income individuals who would qualify for a newly expanded Medicaid program could benefit from provisions of the new health reform law that provide generous, sliding-scale subsidies for the purchase of private health coverage in a Health Insurance Exchange set up by the federal government.

Table I

Federal Poverty Level (2013)

	Individual	Family of Two	Family of Four
100%	$11,490	$15,510	$23,550
138%	$15,856	$21,404	$32,499
200%	$22,980	$31,020	$47,100
300%	$34,470	$46,530	$70,650
400%	$45,960	$62,040	$94,200

Source: U.S. Department of Health and Human Services.

The ACA was initially expected to provide coverage for 32 million uninsured individuals and families when fully implemented. About half of the newly covered were expected to obtain private coverage, while the other half would enroll in an expanded Medicaid program.

The ACA contains financial incentives designed to strongly encourage states to expand Medicaid eligibility. Through 2016, the federal government will pay 100 percent of the cost of benefits for newly eligible enrollees in households with incomes between 100 percent and 138 percent of poverty.[1] Most of these enrollees are childless adults, whereas most children in families falling in this income range are already eligible. The enhanced federal match will drop to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.[2]

The federal government will also pay 100 percent of the cost of boosting low Medicaid reimbursement rates for primary care providers (not specialists) to the same level as Medicare physician fees — but only for a two-year period (2013 - 2014).[3] After 2014, the cost of increasing primary care provider rates will fall to the states, as will the cost of boosting fees to encourage more specialists to treat Medicaid enrollees.

Florida Medicaid Under the Affordable Care Act

Nationally, Medicaid currently covers about 48 million people.[4] In Florida, about 3.3 million people receive services from Medicaid — more than half of those are children, adolescents and young adults.[5] Florida will spend about $21 billion on this population in the 2013 fiscal year.[6] Figure I shows eligibility in Florida before and after the ACA for Medicaid and the Children's Health Insurance Program (which covers children in families that do not qualify for Medicaid). [For more on the Medicaid program, see the sidebar, "How Medicaid Works."] [See Figure I.]

Effect of the ACA on Florida Medicaid Rolls. About 5.5 million Florida residents live on less than 138 percent of the federal poverty level. Approximately 2 million of these individuals are uninsured, many of whom (at least theoretically) would be eligible to enroll in an expanded Medicaid program.[14] About 257,000 are thought to be eligible under prior regulations but remain unenrolled in Medicaid.

The Urban Institute estimates

How Medicaid Works

Medicaid is a complex, 50-state system of federal funds matched with state funds, with special pools of money limited to specific uses, all subject to a patchwork of both federal and state regulations. While Medicaid is a federal entitlement, each state runs its own program and establishes its own budget. Eligibility is based in part on family income compared to the federal poverty level. For a family of two, such as a mother and child, the federal poverty level in 2013 is $15,510; for a family of four the amount is $23,550.

Who Is Eligible for Medicaid? Nationally, about 65 million unique individuals will be covered in any given year.[7] Medicaid eligibility fluctuates with income; people may move in and out of Medicaid with some frequency. Of the 48.6 million uninsured individuals in the United States in 2011, many were eligible for Medicaid but not enrolled.[8] Estimates vary, but more than 10 million uninsured individuals are thought to have been Medicaid eligible under federal law prior to the ACA.[9] Additionally, 3 million to 6 million people identified as being uninsured may actually have Medicaid coverage, but mistakenly reported to the U.S. Census that they are uninsured.[10]

Prior to the ACA, Medicaid eligibility primarily covered expectant mothers, children, seniors and the disabled. For instance, mandatory Medicaid coverage includes:[11]

- Parents who qualify for Temporary Assistance for Needy Families.
- Pregnant women and children age 5 and under below 133 percent of poverty.
- Children age 6 and older below 100 percent of the poverty level.

State Medicaid programs cover far fewer single adults and childless couples.[12]

- About half of the states do not cover childless adults in the workforce.
- A similar proportion of states do not cover working parents of eligible children.
- Only four states (Connecticut, Maine, Massachusetts and Vermont) cover childless adults up to 300 percent of the poverty level.

States can elect to expand Medicaid eligibility to cover "optional" populations, including older children and adults above 100 percent of the poverty level, pregnant women and young children above 133 percent of the federal poverty level, and parents just above the Temporary Assistance for Needy Families income cut-off level. As an incentive to expand eligibility, states receive additional federal matching funds to cover optional populations. Coverage for certain types of medical services is required, while coverage for other services is optional. Federal matching funds are also available for approved optional services. Optional benefits and optional populations account for nearly two-thirds of Medicaid spending.[13]

The income thresholds for individuals and families are shown in Table I.

that Florida can expect as many as 357,000 more enrollees due to the ACA — even if the state does not expand Medicaid eligibility.[15] However, there are no reliable estimates of how many Florida residents currently eligible would enroll — with or without expansion.[16] Estimates of take-up rates vary, but some of these individuals will likely enroll when the individual mandate requiring all legal U.S. residents to have health coverage takes effect in 2014.[17]

If Florida does expand Medicaid, it eventually could have 1.6 million more enrollees, including about 1.3 million individuals who are newly eligible. Of those newly eligible under an expanded Medicaid program, it is estimated that slightly more than 1 million (83 percent) are adults without dependent children.[18]

Cost of the ACA for Florida. Currently, the federal government pays 58.62 percent of Florida's Medicaid costs.[19] [See Figure II.] Medicaid costs in Florida are likely to rise whether or not Florida expands Medicaid eligibility. Additional costs for the Medicaid expansion population could be higher than anticipated for many reasons, described below. Over the past two decades, as Florida's population grew about 50 percent, the Medicaid caseload tripled and expenditures increased about 450 percent.[20] [See Figure III.]

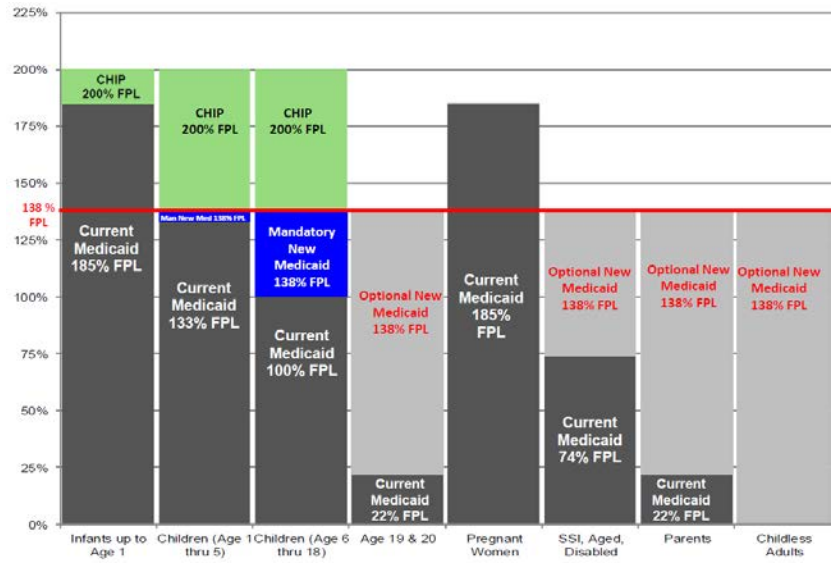
Florida would have to pay more than 40 percent of the cost of the additional enrollees because the enhanced federal matching rate does not apply to those eligible for Medicaid before the ACA was passed.

Regardless of whether states choose to expand Medicaid eligibility, Medicaid rolls will increase due to new regulations that require states to make it easier to enroll and maintain enrollment. A report for the state of Idaho found state Medicaid rolls are likely to increase 5 percent to 10 percent even if income eligibility is not expanded.[21] For instance, the ACA allows applicants to ignore up to 5 percent of income when qualifying for Medicaid. The ACA also modifies the definition of adjusted gross income, eliminates the asset test and loosens the definition of a household for purposes of determining Medicaid eligibility. The ACA also requires administrative changes to streamline the enrollment process and make it easier to determine eligibility.[22]

Despite generous federal payments, the ACA Medicaid expansion would raise the amount of Florida's general revenues required. According to Jagadeesh Gokhale, of the Cato Institute, Florida's general revenue expenditures would rise from just over

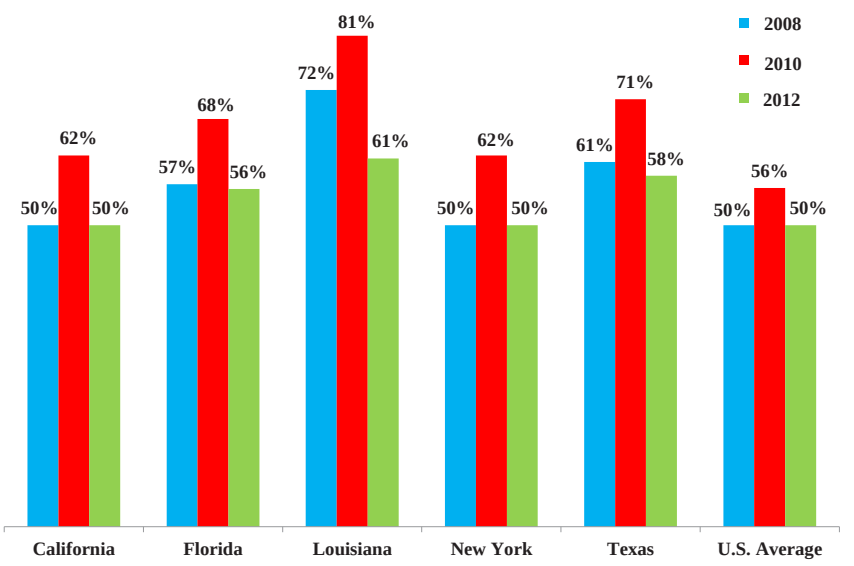
Figure I

Florida Populations Eligible for Coverage under the Medicaid and the Children's Health Insurance Program, with Income Ceilings as Percentages of the Federal Poverty Level



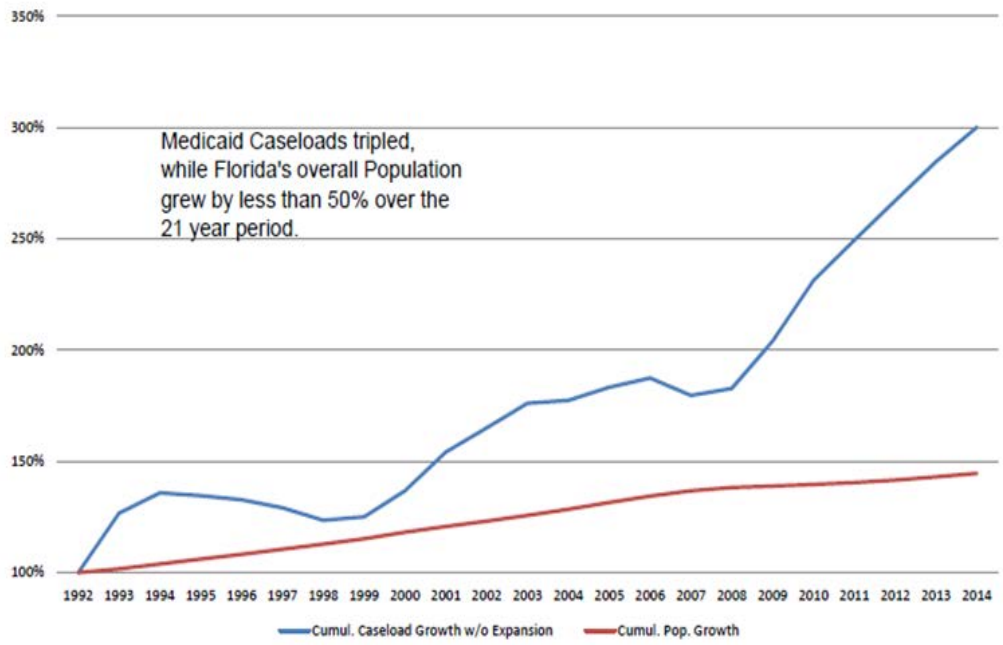
Source: "Welcome to Medicaid!" Florida Agency for Health Care Administration. Available at http://www.fdhc.state.fl.us/Medicaid/index.shtml.

Figure II
Medicaid Federal Matching Rate
(select states)



Source: Federal Register and StateHealthFacts.org, Kaiser Family Foundation.

Figure III
Medicaid Caseload without Expansion versus Population Growth



Source: "Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) Program," Florida Agency for Health Care Administration, December 17, 2012, page 6 and 7.

$6 billion in 2008 (prior to the ACA), to nearly $24 billion in 2030.[23]

When the individual mandate to obtain health coverage takes effect in 2014, at least some of the Medicaid-eligible uninsured are likely to be signed up through outreach efforts. Covering them will be expensive. Texas is a good illustration of the costs Florida can expect. The Texas Health and Human Services Commission predicted that 10 years after ACA expansion, Texas Medicaid rolls would rise by 2.4 million people.[24] Of these, only 1.5 million enrollees will be newly eligible. About 824,000 individuals will be those previously eligible but unenrolled.[25] Covering those already eligible and boosting provider rate was a significant portion of Texas' projected costs. [See Figure IV.]

The Challenge of Medicaid Expansion

Many aspects of the ACA affect the physician workforce.[26] Arguably, the primary challenge is that 27 million uninsured Americans are expected to gain health coverage — nearly half of them through Medicaid.[27] In an expanding market, more physicians will be needed to provide services to this growing population.

Effect of the ACA on Florida's Physician Shortage. If economic studies are correct, the newly insured will nearly double their consumption of medical care.[28] In addition, over the next decade, 78 million Baby Boomers will need more medical care as they reach late middle-age and many retire. During this period, nearly one-third of physicians are expected to retire and the supply of new medical graduates is not expected to keep pace with demand.[29] Thus, millions of Americans will increasingly experience problems finding physicians willing to treat them.

Despite these dire predictions, the ACA offers only a few modest provisions to increase financial aid to medical students.[30] And these provisions will not materially impact the supply of physicians willing to participate in Medicaid. Indeed, the National Health Care Workforce Commission, a 15-member created by the ACA to investigate the shortage of health care professionals, has never met. The commissioners were appointed in September 2010; but in the 30 months that the group has existed, no money has been allocated to fund its work. The commission has no agenda, no staff and no budget.[31]

The United States graduates about 16,000 medical students annually, and they compete with foreign medical graduates to fill the 23,000 available first-year residency slots.[32] This number is not, however, sufficient to match the growing demand. The Association of American Medical Colleges (AAMC) estimates the current shortage of 20,000 doctors will swell to 91,500 physicians in

2020 — increasing to 130,600 by 2025.[33] Indeed, the projected shortfall increased 43 percent due to the ACA.[34] As a result, the United States will need 8,000 additional doctors each and every year beyond the expected supply at the current rate of growth. [See Figure V.]

The impending physician shortage in Florida is arguably more severe than in other states.[35] By 2030, Florida's population is projected to grow to 23.6 million — nearly five times the number of Florida residents in 1960. During this period, the number of seniors will grow to nearly one-fourth of Florida's population.[36] Indeed, by 2030, Florida's senior population (age 65+) is expected to rise about 74 percent compared to the 2010 Census.[37]

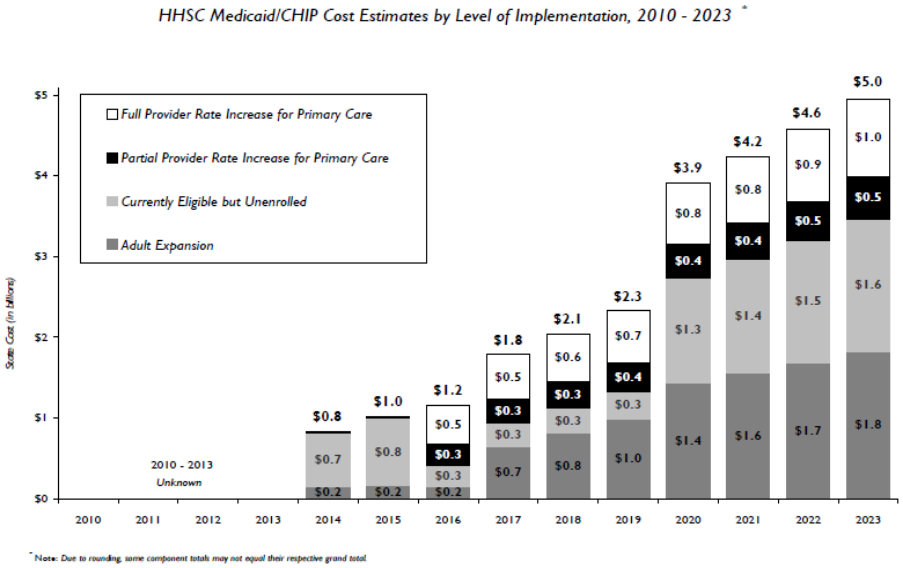
Health status is inversely related to age — older people need more medical care as they age. Thus, Florida retirees will compete with the young and Medicaid enrollees for medical care. Currently, about 45,000 physicians actively practice in Florida. But many of them will retire in the next few years. According to the Board of Governors of the State University System, less than 14 percent of Florida's physicians are under 40 years of age — 86 percent are older. More than one-fourth (27 percent) are either approaching or past retirement age — about half of them report they plan to retire in the next five years.[38]

Florida physicians have little if any capacity to expand the number of patients they treat. For example:

- Two-thirds of Florida physicians work full-time — only 22 percent of doctors spend less than 30 hours per week on patient care.
- Half of Florida's doctors already see more than 75 patients per week.

Figure IV

Estimated Costs of the Affordable Care Act to Texas



Source: Thomas M. Suehs, "Federal Health Care Reform — Impact on Texas Health and Human Services," House Select Committee on Federal Legislation, April 22, 2010.

Figure V

Projected Supply and Demand, Physicians, 2008-2020

Source: Association of American Medical Colleges.

- Nearly one-third (30.1 percent) see more than 100 patients each week.

Other health care workers are also in short supply, including nurses, physical therapists, occupational therapists and speech pathologists.[39] The Florida Center for Nursing predicts a shortage of more than 50,000 nurses by 2025 — partly due to the higher demand created by the ACA.[40]

The Florida Medical Association identified low Medicare and Medicaid reimbursement rates (discussed below) as one of several factors that contribute to the physician shortage.[41] The ACA will reduce Medicare fees 25 percent on January 1, 2014, unless Congress delays the cuts.[42] These cuts will exacerbate an already bad situation for Florida doctors struggling to keep their office doors open to Medicaid patients.

Low Provider Fees Under Medicaid. The federal government will pay to increase state Medicaid primary care physician fees to the same level as Medicare fees, but only for two years — from 2013 and 2014. After that, states will bear much of the cost of keeping Medicaid provider fees at a level necessary to ensure enough physicians are willing to participate in the program. Low provider reimbursement rates will make it more difficult for Medicaid enrollees to find physicians willing to treat them.

The Lewin Group, a consulting firm that analyzes public policy proposals, reported physician fees for doctors who treat Medicare patients are only about 81 percent as much as private insurer's fees for the same services. For hospitals, Medicare pays only about 71 percent of what private insurers pay.[43] And fees for doctors who treat Medicaid patients are even lower. For example, Florida fee-for-service Medicaid pays physicians only about 57 percent of what Medicare pays for the same services, on average. For primary care, Medicaid only pays about half as much.[44]

States with historically low reimbursement rates, such as New York and New Jersey, will be hardest hit. In Texas, which is near the national average, the cost of maintaining higher Medicaid reimbursements will start at $500 million in 2016 — rising to $1 billion annually by 2023. Nationally, Medicaid provider reimbursements average only about 53 percent of what a private insurer would pay, but the actual amount varies from state to state.[45] Compared to commercial insurers, Florida's Medicaid program pays less than half (46 percent) as much as a private insurer would pay.[46] Reimbursements are even lower for primary care; the program pays about 40 cents on the dollar compared to private insurers.[47]

Poor Access to Care Under Medicaid. Nationally, slightly less than one-third of physicians will not accept new Medicaid patients. This is nearly double the number of doctors whose practices are closed to new Medicare patients (17 percent), or to new privately insured patients (18 percent). Physicians are four times more likely to turn away new Medicaid patients than those with no insurance (31 percent versus 8 percent). This practice is especially true of doctors in larger cities or in small practices.[48] More than one-third (34 percent) of primary care physicians do not accept new Medicaid patients. This percentage is much higher than for those physicians who reject new Medicare patients (29 percent), privately insured patients (20 percent) or uninsured patients (12 percent).[49]

In Florida, the percentage of physicians whose practices are closed to new Medicaid patients is even higher than the national average. About 41 percent of Florida physicians will not accept new Medicaid patients.[50] Studies show that the uninsured have an easier time making doctors' appointments than Medicaid enrollees.[51] For instance, a survey found that in Miami:[52]

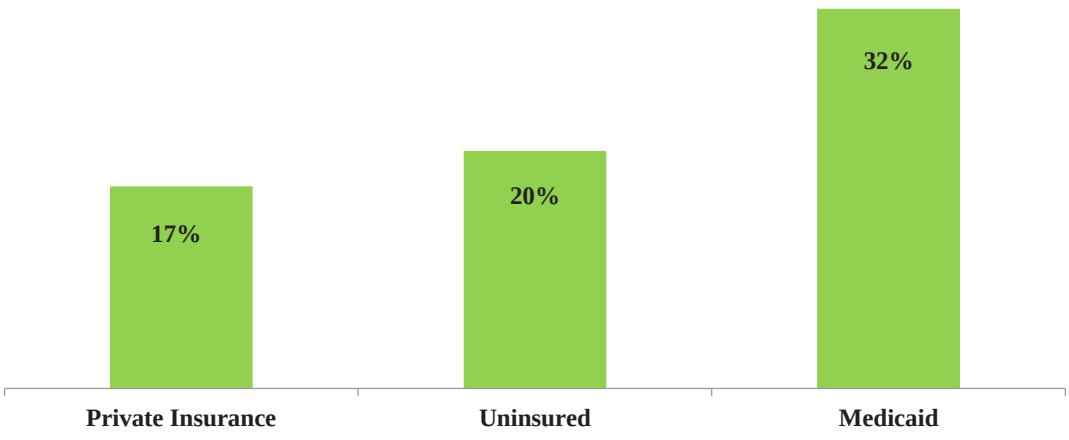
- More than one-third (36 percent) of cardiologists will not accept Medicaid patients.
- About 60 percent of family practitioners will not accept new Medicaid patients.
- Nearly two-thirds (64 percent) of orthopedic surgeons will not accept new Medicaid patients.
- Nearly three-fourths (72 percent) of OB/GYN specialists will not accept new Medicaid patients.

To improve enrollees' access to care, many states are moving more of their Medicaid enrollees into privately-run, managed care plans, but finding an adequate supply of physicians to treat them often remains problematic.

Medicaid and Emergency Room Use. Americans see their doctors more than a billion times each year. They make another 136 million visits to hospital emergency rooms. Some of that care would be better performed in a non-emergency setting.[53] Estimates vary, but the rule of thumb is that as many as half of ER visits could be treated in physicians' offices. Medicaid patients seek care in the ER more frequently than both the uninsured and those covered by private insurance. [See Figure VI.]

The National Center for Health

Figure VI
Percentage of Individuals Who Visit an Emergency Room at Least Once a Year
(by insurance status)



Source: Tamyra Carroll Garcia, Amy B. Bernstein and Mary Ann Bush, "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?" National Center for Health Statistics, NCHS Data Brief No. 38, May 2010.

Statistics (NCHS), the nation's chief health statistics agency, found Emergency Room (ER) use is closely associated with Medicaid enrollment. For instance, the agency found that:

- Nearly one-third (32 percent) of Medicaid enrollees used the ER at least once during a 12-month period.
- Individuals with private health coverage were only about half as likely (17 percent) as Medicaid enrollees to visit an ER.
- One in five of individuals without health coverage visit an ER each year — similar to the privately insured.

Furthermore, Medicaid enrollees are three times as likely (15 percent vs. 5 percent) as the privately insured, and twice as likely as the uninsured (15 percent vs. 7 percent), to have visited an ER twice in the previous year.[54]

ER visits represent approximately 12 percent of all U.S. ambulatory care visits. So-called frequent fliers — as emergency department personnel sometimes describe costly and frequent ER visitors— are far more likely to be enrolled in Medicaid than any other type of coverage. One in twenty (5.1 percent) Medicaid enrollees visits the ER four or more times per year, whereas only 1 percent of people with private health coverage visit an ER that often. Indeed, Medicaid enrollees are 2.5 times as likely as the uninsured to be frequent users of ERs.[55]

A study in *The Annals of Emergency Medicine* found that only 15 percent of frequent ER users are uninsured. Nearly two-thirds (60 percent) are covered by Medicaid or Medicare. Patients who frequent the ER are only about 5 percent to 8 percent of ER patients, but they account for approximately one-fourth of all ER visits.[56]

Why do Medicaid enrollees visit emergency rooms significantly more often than either the insured or the uninsured? The main reason appears to be that Medicaid fees are so low that patients have difficulty finding private practitioners who will see them. Often, the emergency room is the only place they can access care. Studies show that even the uninsured have an easier time making doctors' appointments than Medicaid enrollees.[57]

Predicted Increase in Emergency Room Use. Expanding Medicaid coverage will result in more patients turning to the ER. How many? Assume that: 1) half the uninsured obtain insurance; 2) the newly insured enroll 50/50 in Medicaid and private plans; 3) the newly insured are similar to the current uninsured population; and 4) the newly insured behave similarly to other enrollees in the plans they join. A rough estimate is [see Figure VII]:[58]

- Among the newly insured under age 18, the number of emergency room visits each year will climb from 18 percent to 22 percent.
- Among 18-to-44 years old, annual emergency room traffic by the newly insured will increase from 21 percent to 28 percent.
- Among those ages 45 to 64, the increase will be from 19 percent to 28 percent.

How Medicaid Displaces Private Insurance. Most Americans incorrectly believe that the poor do not have private health insurance.

Indeed, many of the newly insured under Medicaid are likely to have had private coverage in the past. Thus, crowd-out is likely to be a significant problem for states that expand Medicaid eligibility to able-bodied adults. Crowd-out is a condition where people who are already covered by employer or individual coverage drop coverage to take advantage of the public option.[59] Crowd-out sometimes happens when firms that employ a disproportionate number of low-wage workers drop their employee health plan, knowing that workers have lower-cost options.[60] In other instances, workers seek jobs with higher wages and no health plan.

Analysis of past Medicaid expansions by economists and Obama administration advisers David Cutler and Jonathan Gruber found that when Medicaid eligibility is expanded, 50 percent to 75 percent of the newly enrolled dropped private coverage.[61] A 2007 analysis by Gruber found that, on average, about 60 percent of newly enrolled children in the State Children's Health Insurance Program (SCHIP) were previously covered privately.[62] Thus, a reasonable conclusion is that some of the increase in Medicaid rolls will be individuals who were previously privately insured, suggesting the number of uninsured will not fall as expected. Another reasonable assumption is that Medicaid rolls may have to rise by 1.4 people in order to reduce the uninsured by 1 person.[63] Some of these undoubtedly will come from those with private coverage. Privately-insured individuals who are newly eligible for an expanded Medicaid program are likely to drop their private plan in favor of Medicaid because it costs them less and, on paper at least, provides much better coverage.

Estimates from the 2012 Current Population Survey Annual Social and Economic Supplement suggest that there were 2.9 million people ages 18 to 64 with incomes below 138 percent of the poverty level in Florida, and that, in 2011, about 856,000 of them (almost 30 percent) were covered by private insurance.[64] Roughly 234,000 of Florida residents in poverty are undergraduates or enrolled in graduate or professional school. College students will be eligible for Medicaid under expansion rules, though many of them are likely eligible for coverage under their parents' insurance plans.

A decade ago, nearly 29 percent of adults ages 25 to 64 with incomes below the poverty line purchased private health insurance. Among individuals with family incomes of 1.5 times the federal poverty level, more than one-third (36 percent) of individuals purchased private insurance.[65] These numbers were likely underestimates. The definition of poverty in the ACA differs substantially from the official one; as a result, Current Population Survey data could significantly underestimate the number that will be newly eligible for Medicaid.[66] Furthermore, the percentage of the population without health coverage has not increased significantly over the past decade.

> *"Half to three-fourths of new enrollees in past Medicaid expansions dropped private coverage."*

Difficulty of Determining Medicaid Eligibility under the ACA. Determining income for the expansion population is likely to be difficult. Federal law relies heavily on tax and wage data. However, an estimated 15 percent of the U.S. population does not file federal income tax forms, and past filings do not necessarily reflect current income. Nonfilers are likely to be concentrated in the low-income population who are in turn eligible for expanded Medicaid. States are not allowed to request additional information from applicants unless electronic information from the IRS is either not available or not "reasonably compatible" with what an applicant reports. Medicaid does not define "reasonably compatible," and some experts believe that forms requesting additional information could require federal approval.

The only other form of income verification readily available to states — quarterly wage data from state unemployment insurance programs — does not include income earned out of state and does not include self-employment income. Oregon studied a sample of its Medicaid and CHIP applicants, and found that current income in the Medicaid database failed to match state employment data for 38 percent of Medicaid recipients due to "out-of-date employment data, self-employment income, off-the-books income, or out-of-state income."[67] States are also expected to verify that other affordable government or employer insurance is not available. It is not clear how they will do this, and with the emphasis on streamlining the eligibility process it is likely that fraud will be a problem.

Caseloads may increase more than expected under an expanded Medicaid program, because activist groups and advocates for the poor will engage in outreach programs to educate those eligible on how to enroll. The ACA requires a "simplification" of the

process used to determine eligibility and enrollment, which will lead to a longer period of enrollment between eligibility checks. Because their incomes tend to fluctuate, up to half of adults earning less than 200 percent of the federal poverty line typically migrate in and out of Medicaid eligibility in any given year.[68] A longer eligibility period has already been applied to children. If Florida extends eligibility to the newly enrolled, state Medicaid costs will increase.

Health Outcomes and Medicaid. Various academic papers have found that Medicaid enrollees sometimes fare worse than patients with private insurance and often worse than patients with no insurance.[69] For example:

- Post-surgical patients enrolled in Medicaid are almost twice as likely to die as privately-insured individuals and about 12 percent more likely to die than the uninsured, according to a University of Virginia study.[70]
- Florida Medicaid patients were 6 percent more likely to be diagnosed with prostate cancer at a less treatable, later stage than the uninsured, according to a study in the *Journal of the National Cancer Institute*.[71]
- Further, Florida Medicaid enrollees were nearly one-third (31 percent) more likely to be diagnosed with late-stage breast cancer and 81 percent more likely to be diagnosed with melanoma at a late stage. Medicaid patients did outperform the uninsured on late-stage colon cancer.
- The mortality rate for Medicaid patients undergoing surgery for colon cancer was more than three times higher than the privately insured, and more than one-fourth higher than the uninsured, according to a study in the journal *Cancer*.[72]
- Medicaid patients treated for vascular problems fared worse than did the uninsured, according to a study in the *Journal of Vascular Surgery* (though the uninsured with abdominal aneurysms fared worse than Medicaid patients).[73]
- Patients in children's hospitals that rely heavily on Medicaid payments have more adverse events than those in hospitals caring for predominately privately insured patients.[74]

Historically, Medicaid enrollees have been less healthy than people of similar age and socioeconomic status. Although some new enrollees may have health problems or chronic conditions, many of those newly eligible for Medicaid are thought to be relatively healthy adults.[75]

A recent study of Medicaid in Oregon did find newly insured Medicaid enrollees reported feeling they had better access to care — though this change in perceived access started within a month of coverage and included those who had not actually sought care.[76] That sense of well-being may have been partly because enrollees were awarded coverage through a lottery system.

An Alternative to Medicaid Expansion under the Affordable Care Act

Beginning in 2014, the ACA will establish health insurance exchanges where qualifying individuals and small businesses can purchase subsidized individual health insurance. Those with access to affordable health plans through their employer will not be eligible for exchange subsidies. However, qualifying individuals who do not have access to an employer-provided health plan or Medicaid will be eligible.[77] In states that do not expand their Medicaid programs under the ACA, the exchange will provide subsidized coverage for those individuals whose incomes are 100 percent to 133 percent of the federal poverty level, at very little cost.[78]

Tailoring Medicaid to Meet Florida's Needs. For individuals earning more than 100 percent of poverty level, subsidized private coverage in the health insurance exchange is a much better deal for Florida, doctors, hospitals and enrollees. (This option is not available for those earning less than 100 percent of the poverty level.)

The U.S. Department of Health and Human Services recently indicated that government will not consider approval of so-called partial expansion before 2017.[79] States attempting to selectively expand Medicaid eligibility cannot expect to receive 100 percent reimbursement from the federal government. Yet, for such targeted expansions, the standard federal match would be available — about 42 cents of every dollar Florida spends is matched by nearly 58 cents of federal money.

Exchanging Medicaid for Private Coverage

Currently, the Medicaid program in Florida covers children (and some parents) in families up to the poverty level. More than a quarter-million eligible individuals have not enrolled. Estimates vary about the number of eligible people who might enroll in an expanded Medicaid program or in commercial insurance plans offered through exchanges. Historically, about 79 percent of eligible Florida residents have enrolled in Medicaid.[80]

Those who are currently eligible but unenrolled may not feel compelled to enroll even after the individual mandate takes effect.[81] Estimates show that by 2014, nearly 500,000 uninsured Florida residents will have incomes between 100 percent and 138 percent of the federal poverty level. If Medicaid is unavailable, federal law will give them another option: subsidized private insurance in a health insurance exchange. Thus, the federal money Florida would forgo in Medicaid spending on those earning 100 percent to 138 percent could be replaced by private spending.[82]

Subsidies for Private Health Insurance in the Exchange. Though people of any income level may purchase coverage in the exchange, subsidies will be available only to individuals and families with incomes below 400 percent of the federal poverty level — just over $94,200 for a family of four.[83] The ACA requires families with incomes below 100 percent, and from 100 percent to 133 percent, of poverty level, to enroll in Medicaid if it is available.[84] The share of premiums paid by enrollees in the exchange who earn between 100 percent and 133 percent of the poverty level cannot exceed 2 percent of their income.[85] Thus, their annual cost will often average less than $200 per covered individual. [See Table II.] The federal government will subsidize the remaining cost of premiums — potentially worth $15,000 for a family of four. Certainly, 2 percent of income represents a significant amount of money for low-income families. Table II reveals the maximum cost to a family of four in two different income categories.

Economists generally agree that employee health benefits are a form of noncash compensation. Workers receive a portion of their wages as health benefits in lieu of take home pay. As such, employee health benefits substitutes dollar-for-dollar for wages.[86] If low-wage workers have access to private coverage through a health insurance exchange, employers would not have to offer health insurance in competition for labor. Instead, they could pay higher wages, resulting in increased take-home pay. After implementation of the ACA, firms employing less than 51 workers will not suffer a penalty for not providing coverage. Firms with more than 50 workers that fail to offer coverage will only be fined $2,000 per worker (minus the first 30 workers). Many employers — especially small- and medium-size employers

> *"Federally subsidized coverage in a health insurance exchange is an alternative to Medicaid expansion."*

— may consider a $2,000 fine per worker preferable to providing health coverage costing $5,000 per worker to the cost.[87]

Qualifying individuals who do not have access to an employer-provided health plan or Medicaid will be eligible for exchange subsidies.[88] As a result:[89]

- In every state, individuals earning 133 percent to 400 percent of poverty may purchase subsidized coverage in the exchange.
- In states that do not expand their Medicaid programs, individuals with incomes 100 percent to 133 percent of the federal poverty level can buy subsidized coverage in the exchange. Individuals with incomes below 100 percent of poverty will be ineligible for federal subsidies — rather, the ACA requires they enroll in Medicaid.
- Individuals with incomes above 400 percent of poverty will not be eligible for federal subsidies.[90]

How Generous Are the Subsidies in the Exchange? The subsidies in the exchange are generous. The sliding scale subsidies are a function of income. A low-income family earning just above 100 percent of the federal poverty level will pay only 2 percent of its income. A family earning 400 percent of the poverty level will pay no more than 9.5 percent. Because premiums are higher for older workers, the exchange grants larger subsidies for older workers than younger workers.

Moreover, private plans in the exchange will pay providers about double the fees they would have received from Medicaid. Safety net facilities scraping by on inadequate resources will experience great financial relief from the more patients enrolled in private coverage. The Congressional Budget Office (CBO) estimates that, perhaps, half of states will find this option very attractive.[91]

How Will Private Coverage Affect Florida Providers? Medicaid uptake varies from state to state. Certainly all those who qualify will not enroll. Private coverage that allows individuals and families to see most physicians and utilize large hospital networks may provide an added incentive.

Florida hospitals would benefit from policies that increase the number of people who have commercial insurance, because private insurance reimbursements are higher. For instance, privately insured patients make up only about one-fourth

of Florida hospitals' patients, but account for half of Florida hospitals' patient revenue by payor.[92] [See Appendix.] Medicaid expansion would produce the opposite effect, because an estimated 30 percent of adults in the 100 to 138 percent of federal poverty income range who have private insurance will drop it in favor of Medicaid.[93] Thus:

- If Florida does not expand Medicaid to those earning between 100 percent to 138 percent of poverty, the state will forgo about $12 billion in federal Medicaid money over the next 10 years.
- However, if Florida families take advantage of generous federal subsidies for private insurance, private insurers will spend approximately $28 billion in health care spending on this population.[94]
- After accounting for Florida's share of new spending, the $15 billion difference represents an additional infusion of nearly $1.5 billion per year — including extra money for the state's doctors and hospitals.

Enticing this low-income population to sign up for coverage would cost the state less than $1 billion over a decade. As mentioned previously, Florida Medicaid pays provider fees that are less than half what private insurers pay for the same services.[95] Thus, the federal money Florida would forgo by not expanding Medicaid could be replaced by private spending.[96] Hospitals may need the increased revenue in order to contend with coming cuts in Medicare reimbursements and federal disproportionate share payments.

Table II

Premium Cost per Family Member

Annual Income	Percent of Poverty	Maximum Cost Share (Family of Four)
$23,550	100%	$471 per family or $118 per person
$31,322	133%	$626 per family or $157 per person
$32,499	138%	$975 per family or $244 per person

Source: Authors' calculations based on the Federal Poverty Level, U.S. Department of Health & Human Services.

How Florida Can Encourage Individuals to Purchase Coverage in the Exchange. There are numerous factors that affect take-up — the rate at which eligible individuals enroll in a public program. How many individuals will enroll if states choose to utilize private coverage in place of expanded Medicaid? A few months prior to the Supreme Court ruling, the CBO estimated that by 2022, when the ACA is fully implemented, Medicaid will cover about 17 million people. After the high court ruling, however, the CBO lowered its estimate to 11 million people.[97] This lower estimate assumes that some states will opt out of Medicaid expansion or limit new Medicaid eligibility to the poorest subset of the low-income population.

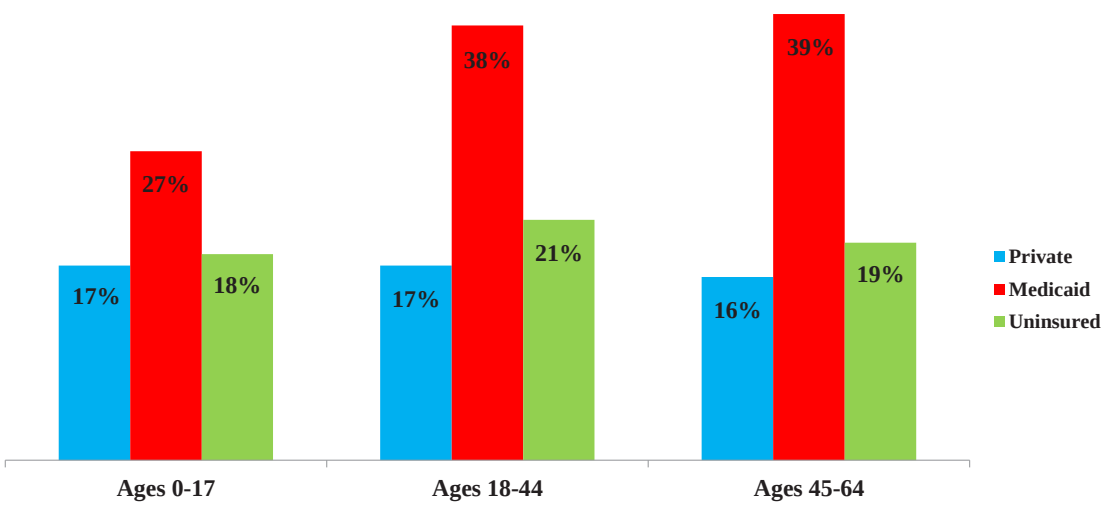
Assuming that about 70 percent of those who qualify will enroll in the program, approximately 350,000 Floridians will purchase private health coverage who would otherwise be uninsured or enrolled in Medicaid.

Florida could subsidize enrollment costs to low-income families of enrollment. Consider [see Figure VIII]:[98]

- Two percent of income is $230 for an individual earning right at the poverty level.
- Two percent of income is $306 for someone earning 133 percent.
- For a family of four, 2 percent of income at 100 percent of the poverty level is $471, while 2 percent of income for families earning 133 percent of poverty is $626.

Certainly, the share of exchange policy premium costs paid by families with modest incomes would be a significant amount of money to them. For instance, $471 (100 percent of the federal poverty level for a family of four) is $118 per family

Figure VII
Percentage of Individuals with Emergency Room Visits
(by age and insurance status)



Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?" National

member, while 133 percent of the federal poverty level for a family of four is $153. The state cost to pay this portion of the premiums would depend on take-up rates, income and family size. State subsidies to encourage individuals and families to enroll in subsidized health plans from the health insurance exchange would be about $200 to $300 per individual covered, depending on income and family size. [See Figure VIII.]

Does Medicaid Boost the Economy?

Many tout the benefits of state-level "economic activity" that additional federal Medicaid funds might create.[99] For instance, the welfare advocacy group Families USA purportedly found that Medicaid expansion could create 71,300 jobs in Florida alone, and generate nearly $9 billion in "economic activity." Implausibly, it even identified productivity gains from Floridians taking "fewer sick days" as a benefit.[100] Yet some of the benefits identified would be available to Florida without Medicaid expansion, such as more money flowing into the health care system from private "exchange" policies. And some of the spending included funds already subsidized by Florida taxpayers. The report identified "potential revenue" from increased health care-specific taxes as a benefit. But only about half of the economic activity involved new federal spending. Buried in the report was the following caveat:

> The relationship between new dollars and increased economic activity is not purely linear: Every new dollar does not create the same amount of economic activity. As more dollars flow into the state, the ability of the state's economy to create and meet demand declines. This creates "dampers" that slow the rate that the new dollars flow throughout the state economy. There are also potential "leakages," i.e., money that leaves the state through trading patterns that can reduce the multiplier effect.

Proponents of the 2008 federal stimulus package have cited it as an example of how federal spending on Medicaid can have a stimulus effect. For three years, from 2008 to 2010, the federal government paid a larger share of Medicaid spending — pumping $88 billion of additional funding into the economy.[101] Various studies have attempted to quantify the economic impact of Medicaid spending during this time.[102] For instance, one study of the Medicaid stimulus funds claimed each new dollar of Medicaid spending resulting in $2 dollars of economic activity — including gains in sectors of the economy other than health care.[103]

Yet, it is difficult to calculate the actual benefit of any change in economic activity. The lead author of the study cautioned that his research does not mean Medicaid expansion would have the same effect. The economy nationwide is in far better shape than it was in 2008, thus, as the country approaches full employment, stimulus spending tends to reallocate resources from one sector to another.

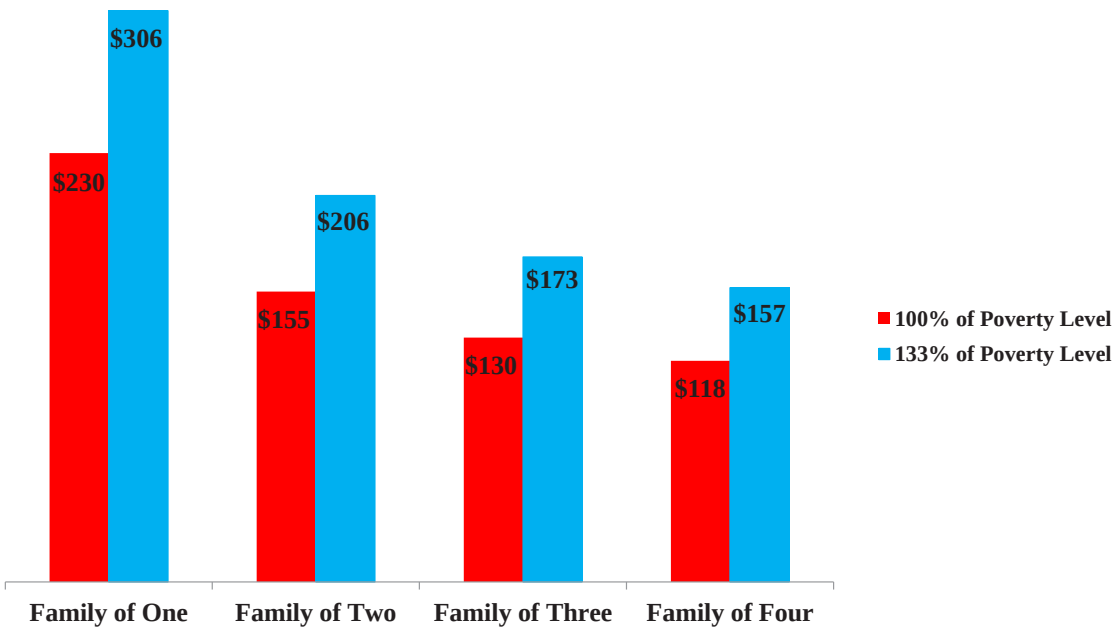
Economic impact studies tend to overlook the fact that additional federal spending crowds out private activity and depends on additional government revenues extracted from the private sector. For instance, proponents try to assess the impact as if an additional $1.00 of federal spending to Florida is

financed by equal tax liabilities on all states. Academic estimates of multipliers from the stimulative effect of an additional $1.00 of federal spending in this highly artificial case vary, but generally find increases of $0.50 to $2.00.[104]

However, economist Lauren Cohen and her colleagues found that the multiplier might be negative. In part, the negative effects arise from the fact that increases in federal spending cause individuals to think that they are wealthier, and wealthier people choose to work less and enjoy more leisure time. Increased government spending also crowds out the private sector by competing with it for labor and reducing private spending on investment and research and development.[105] Yaa Akosa Antwi provides some additional support for this conclusion with the finding that the requirement to allow "children" up to age 26 to be covered by parental health insurance policies reduced hours worked by 5 percent.[106]

Given that Medicaid expansion crowds out additional federal subsidies for private health insurance purchased through the exchange and would likely cause 30 percent of the targeted expansion group to substitute Medicaid for private policies, Florida should model the relative gains and losses from the two possible paths — Medicaid expansion versus exchange subsidies.

Figure VIII
State Subsidy per Family Member



Source: Authors' calculations based on federal poverty level.

State officials should also keep in mind that the models that predict large economic increases from reallocated federal spending generally ignore the fact that the money must come from somewhere. Federal health law includes substantial tax increases that potentially will reduce the revenues needed to finance both existing Medicaid and any Medicaid expansion. Florida pays more in federal taxes than it receives in federal spending, suggesting that Florida might end up paying more for any national program than it receives in benefits. According to the RAND Corporation, most states can expect to see a net transfer of state resources to the federal government under the PPACA. Only poor states will experience more benefits than costs.[107]

Macroeconomic studies using "balanced-budget multipliers," which offset estimated expenditure multipliers with the negative multipliers associated with increasing marginal tax rates, suggest that increases in the average marginal income tax rate negatively affect national economic output with a multiplier of about -1.1.[108] If correct, these results suggest that the net effect of the health law is to reduce gross domestic product (GDP) as the federal government pulls more revenues from the citizens in each state to fund its programs.

Hospitals and the unions representing hospital employees often claim that health care spending is good for the economy. Purportedly, health care spending creates jobs, and efforts to slow spending would harm job creation. This notion was rebutted by none other than Ezekiel Emanuel,

former White House adviser on health care issues. He states that "It's clear that, far from creating unemployment and hurting the economy, the more we can control health care costs, the more Americans will prosper. Health care is about keeping people healthy or fixing them up when they get sick. It is not a jobs program."[109]

Estimated stimulus effects from government spending multipliers defy easy measurement.[110] At best the estimated results are uncertain and at worst unreliable. An analysis of the academic literature on government spending finds deficit-financed, temporary increases in public spending increase GDP a multiple of 0.5 to 1.5 times for each dollar spent. According to one reviewer… "For the most part, it appears that a rise in government spending does not stimulate private spending; most estimates suggest that it significantly lowers private spending."[111]

Florida taxpayers will bear some of the additional costs of an expanded program. Nobel laureate economist James Tobin often described two different types of goods that we buy as a part of GDP — goods that we plan to enjoy, versus goods that are nonenjoyable.[112] For those Florida residents not likely to benefit directly from Medicaid expansion, additional spending on Medicaid will increase their non-enjoyable parts of the state GDP. By contrast, stakeholders likely to benefit from an expanded Medicaid program perceive only benefits of increased federal Medicaid spending,

French economist Frédéric Bastiat introduced the concept of the "fallacy of the broken window." Economics instructors use this classic parable to explain opportunity costs and alternative uses for resources. In the parable, a shopkeeper's son accidently breaks a shop window pane. As a result, the store owner will have to pay someone to haul the broken glass away; then order a new glass pane, hire a craftsman to install it and possibly someone else to clean up afterward. This is an example of "economic activity" created by a simple broken window. The broken window pane will create work and wages for the glassmaker, carpenter and anyone involved in the repair; but the shop owner will suffer a loss of disposable income. Moreover, society is worse off by one pane of glass that was needlessly broken. The resources employed to remove the broken glass and install a new pane could have been employed to produce something else that would please the shopkeeper more and possibly make society richer.

Indiana governor Mike Pence probably expressed the fears of many other governors when he compared Medicaid expansion to a gift of a baby elephant. The federal government promises to pay for the hay — for the first few years.[113]

Is Federal Spending Sustainable?[114]

Over the long term, Florida (and other states) may not be able to rely on the federal government to provide the same level of funding as promised in the ACA. In addition to promises made to the states, the federal government has unfunded obligations for other entitlement programs.

Medicaid Spending. Federal and state governments spent $389 billion on Medicaid in 2010.[115] Medicaid is the largest expense in most state budgets — and it is growing at unsustainable rates. For instance:

- State Medicaid spending was only $84 billion in 2000.
- State Medicaid spending is projected to quadruple to $357 billion by 2020 — less than a decade from now.
- Federal spending on Medicaid was about one-quarter of a trillion dollars in 2009.
- Federal spending is projected to more than double by 2020 to $574 billion.

The primary reason behind the rapid growth in Medicaid expenditure is that the federal government encourages states to spend by providing a federal matching rate for all state spending on approved Medicaid services. In economic terms, this is referred to as subsidizing at the margin — each marginal dollar spent costs states such as New York $0.50 cents, Florida $0.42 cents, but only about $0.27 cents for each dollar spent in Mississippi. The federal government's match of nearly 58 cents to Florida's spending of about 42 cents encourages more and unnecessary Medicaid spending. This situation will only grow worse as the federal match rates for newly-eligible Medicaid enrollees levels off at 90 percent in 2020. As a result, states are tempted to apply for the matching funds even when they know the spending is wasteful.[116]

The question remains: Can this perverse incentive go on forever? The country as a whole spends more on Medicaid than it spends on primary and secondary education. Medicaid is already the largest single expenditure state governments face today. If state Medicaid spending growth outpaces states revenue growth, over time state Medicaid programs will crowd out other beneficial activities state governments perform.[117]

It is reasonable to question whether the federal share of Medicaid spending will continue indefinitely. Is the federal commitment to fund Medicaid spending sustainable over the long

term? There is cause for concern. Although significant, projected federal Medicaid spending alone would not be an insurmountable problem, were it the only obligation the federal government faced. Unfortunately, Medicaid is not the only indefinite commitment of the federal government. In addition to Medicaid, the federal government is responsible for making up any shortfall in Social Security and Medicare's finances.

Federal Spending on Medicare and Social Security. At the federal level, health care is our most serious domestic policy problem. Medicare is the most important component. Every year for decades, Medicare spending has increased an average of 2 percentage points more than gross domestic product (GDP).[118] If this country continues consuming products whose cost is growing faster than national income, it will eventually crowd out every other thing we are consuming. Indeed, if the United States maintains this spending path, Medicare deficits will claim 1 in every 2 general revenue dollars by 2050. This means that in less than 40 years the federal government will have to stop doing one of every two things it does today, if taxes remain at their current level and promises to the elderly are kept.

Social Security is another federal entitlement that threatens to crowd out other types of federal spending. The Social Security and Medicare Trustees reports showed the combined unfunded liability of these two programs had reached $107 trillion in 2009 prior to the passage of the ACA. That is more than seven times the size of the U.S. economy and nearly 10 times the size of the outstanding national debt. The unfunded liability refers to the difference between the benefits that have been promised to current and future retirees and what will be collected in dedicated taxes and Medicare premiums.

Conclusion

Medicaid comprises more than one of every five dollars spent by states — and is growing at unsustainable rates. Any decision to expand Florida's Medicaid program should consider economic and fiscal impacts as well as the potential costs and benefits for both patients and providers.

The following points from this analysis should be considered:

- Medicaid is an inefficient way to reduce the number of uninsured.
- As much as 30 percent of new Medicaid enrollees will be individuals who previously had private insurance.
- Although seemingly a broader benefit package, Medicaid coverage does not guarantee access to needed services.
- Limited provider participation in Medicaid due to low payments and labor shortages create the most significant barrier to health care access.
- As a result of limited access to providers, Medicaid patients are more likely to rely on hospital emergency departments to obtain the care they need.
- Without access to appropriate primary and specialty care, Medicaid patients often experience worse health outcomes compared to people with private insurance.
- Providers shift costs to private payers when public programs such as Medicare and Medicaid limit payment rates; such cost shifts increase the price of insurance.
- Expanding Medicaid may exacerbate the cost shift by limiting payment levels for a larger share of patients and limiting the number of private payers due to crowd out.

Florida can better serve those earning above 100 percent of the federal poverty level by encouraging them to seek subsidized coverage in the health insurance exchanges. To increase coverage among families earning less than 100 percent of poverty, Florida should target certain optional populations and consider providing limited benefits to other groups. The amount of benefits and the populations covered should depend on preferences and priorities held by Florida taxpayers. To the extent possible Florida could structure this spending to still qualify for federal matching funds — albeit at a rate of about 60 percent rather than 90 percent. Helping more people obtain or retain private coverage will make Florida taxpayers, providers, and patients much better off.

Appendix Table

Florida Hospital Patient Revenue by Payer

Comparative Impact on Hospital Revenue: Two Methods for Reducing Uncompensated Care

Model 1: Expand Medicaid				
	Patient Mix	**% Revenue**	**New Mix**	**% Revenue**
Medicare	50%	41.8%	50%	41.8%
Medicaid	17%	13.2%	22%	17.8%
Private	25%	51.5%	24%	48.1%
Uninsured	8%	-6.5%	4%	-3.3 %
Additional Revenue				+5%
Model 2: Expand Private Insurance				
	Patient Mix	**% Revenue**	**New Mix**	**% Revenue**
Medicare	50%	41.8%	50%	41.8%
Medicaid	17%	13.2%	17%	13.2%
Private	25%	51.5%	29%	60.0%
Uninsured	8%	-6.5%	4%	-3.3%
Additional Revenue				+12%

Endnotes

[1.] Eligibility is actually limited to those earning 133 percent of FPL, but applicants can ignore up to 5 percent of income.

[2.] Future Congresses have the right to renew, alter or cancel the initiatives of past Congresses.

[3.] This impacts slightly more than one-third of primary care provider billing codes. See "Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs," Social Services Estimating Conference, State of Florida, August 14, 2012. Available at http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf.

[4.] "Health Insurance Coverage of the Total Population, States (2009-2010), U.S. (2010)," StateHealthFacts.org. Available at http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=125&cat=3&sub=39.

[5.] "Welcome to Medicaid!" Florida Agency for Health Care Administration, webpage: http://www.fdhc.state.fl.us/Medicaid/index.shtml.

[6.] This includes the federal share. See "Welcome to Medicaid!" Florida Agency for Health Care Administration, webpage: http://www.fdhc.state.fl.us/Medicaid/index.shtml.

[7.] "Medicaid Enrollment by State," Medicaid.gov. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html.

[8.] Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2011," Current Population Reports, pages 60-243, Census Bureau, U.S. Department of Commerce, September 2012. Available at http://www.census.gov/prod/2012pubs/p60-243.pdf.

[9.] For instance, one publication estimates that one-third (nearly 15 million people) may qualify for public coverage but are unenrolled. See "The Uninsured in America," BlueCross BlueShield Association, Publication W20-04-035, January 2005. Available at http://coverageforall.org/pdf/BC-BS_Uninsured-America.pdf.

[10.] Michael Davern et al., "An Examination of the Medicaid Undercount in the Current Population Survey: Preliminary Results from Record Linking," *Health Services Research*, Vol. 44, No. 3, June 2009, pages 965-987.

[11.] Pamela Villarreal and Michael Barba, "Update on Federal Medicaid Funding," National Center for Policy Analysis, Brief Analysis No. 744, May 10, 2011. Available at http://www.ncpa.org/pub/ba744. Also see: Linda Gorman, "Medicaid Block Grants and Consumer-Directed Health Care," National Center for Policy Analysis, Issue Brief No. 102, September 2011. Available at http://www.ncpa.org/pdfs/ib102.pdf.

[12.] Ibid.

[13.] Optional populations and optional services include people and services that states cannot easily ignore. These include services for low-income seniors needing long term care, and care for the disabled. Prescription drugs are also optional but are a highly efficient way to treat most ailments. See "Medicaid: An Overview of Spending on 'Mandatory' vs. 'Optional' Populations and Services," Kaiser Family Foundation, June 2005. Available at http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf.

[14.] Data available from StateHealthFacts.org. In 2012, 1,522,138 uninsured individuals earned less than 100 percent of FPL; while 494,434 had income between 100 percent and 138 percent. However, foreign-born individuals who lack legal status would not qualify for Medicaid.

[15.] Genevieve M. Kenney, Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley and Nathaniel Anderson. "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Urban Institute, August 2012. Available at http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[16.] The Florida Social Services Estimating Conference finds the precise number "indeterminate", but is certainly greater than 0. See Social Services Estimating Conference, "Impact Cost Components: Existing, Optional and Mandatory Expansion," Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid), FINAL per email from House received on December 20, 2012, page 18. Available at http://www.fdhc.state.fl.us/medicaid/pdffiles/Estimates_as_requested_by_House_Staff.pdf.

[17.] Some Medicaid eligible individuals may not enroll even when required to have health coverage simply because they have not done so in the past and see little reason to change their behavior. Fines for not having health coverage are waived for those with low income. Also, the people most apt to enroll are those with health problems; those in good health often do not place the same value on Medicaid coverage.

[18.] Genevieve M. Kenney, Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley and Nathaniel Anderson. "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Urban Institute, August 2012, Appendix 2. http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[19.] Official FMAP Estimate, State of Florida, November, 2012. Available at http://edr.state.fl.us/content/conferences/medicaid/fmap.pdf.

[20.] "Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) Program," page 7. Available at http://www.fdhc.state.fl.us/medicaid/pdffiles/SSEC_ACA_12-17-12_Medicaid_Estimates.pdf.

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[26.] For example, see Paul H. Keckley, "The Physician Workforce: Opportunities and challenges post-health care reform," Deloitte Center for Health Solutions, September 7, 2010. Available at http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_PhysicianWorkforce_101810.pdf.

[27.] The CBO originally estimated the number of newly insured by 2019 at 32 million. This was revised in wake of the Supreme Court ruling. "CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," Congressional Budget Office, February 5, 2013. Available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf.

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[29.] "Physician Shortages to Worsen Without Increases in Residency Training," Association of American Medical Colleges. Available at https://www.aamc.org/download/150584/dta/physician_shortages_factsheets.pdf.

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[35.] "AAMC Physician Workforce Policy Recommendations," Association of American Medical Colleges, September 2012. Available at https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendations.pdf.

[36.] Florida Demographic Estimating Conference, November 2011. Available at http://www.edr.state.fl.us/Content/population-demographics/data/Pop_Census_Day.pdf.

[37.] Ibid. This represents a tenfold increase in seniors from the 1960 Census.

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[47] Obstetric care is the exception. See "Medicaid-to-Medicare Fee Index, 2008," StateHealthFacts.org, Kaiser Family Foundation. Available at http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4. Also see Stephen Zuckerman, Aimee Williams and Karen Stockley, "Medicaid Physician Fees Grew by More Than 15 Percent From 2003 to 2008, Narrowing Gap With Medicare Physician Payment Rates," *Health Affairs*, April 2009. Available at http://www.kff.org/medicaid/kcmu042809oth.cfm.

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[49] Ibid.

[50] Ibid.

[51] Brent R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments," *Journal of the American Medical Association*, Vol. 294, No. 10, September 14, 2005. Available at http://jama.ama-assn.org/cgi/content/abstract/294/10/1248.

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[59] The estimated number of people dropping private coverage to take advantage of Florida Medicaid is 66,000 in 2014, rising to 166,000 in 2023. See "Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs," Social Services Estimating Conference, State of Florida, August 14, 2012.

[60] Economists generally agree employee benefits substitute for cash wages nearly dollar-for-dollar. Thus, workers receiving health coverage must

forgo an equivalent amount of cash wages. Firms that provide health coverage to Medicaid-eligible workers could boost cash wages and encourage workers to sign up for Medicaid.

[61.] David Cutler and Jonathan Gruber "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, Vol. 111, No. 2, May 1996, pages 391-430.

[62.] The rate of substitution varied and was worse in some cases depending on eligibility factors. See Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research, Working Paper No. 12858, January 2007. Available at http://www.nber.org/papers/w12858.

[63.] This assumes a crowd out rate of just under 30 percent; for every 100 new Medicaid enrollees, 29 will have previously been privately insured while 71 will have been uninsured.

[64.] 138 percent of the poverty level equals the income that would be eligible for Medicaid with an expansion to 133 percent of the federal poverty level and 5 percent of income set aside.

[65.] M. Kate Bundorf and Mark V. Pauly, *Is Health Insurance Affordable for the Uninsured?* National Bureau of Economic Research, Working Paper No. 9281, October 2002.

[66.] Ithai Z. Lurie and James Pearce, "The Effects of ACA on Income Eligibility for Medicaid and Subsidized Private Insurance Coverage: Income Definitions and Thresholds across CPS and Administrative Data," Office of Tax Analysis, U.S. Department of Treasury, September 10, 2012.

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[71.] Richard G. Roetzheim et al., "Effects of Health Insurance and Race on Early Detection of Cancer," *Journal of the National Cancer Institute*, August 18, 1999. Available at http://jnci.oxfordjournals.org/cgi/content/full/91/16/1409?ijkey=3894238ad956b166ab570c56f9648d625979f6d.

[72.] Rachel Rapaport Kelz et al., "Morbidity and Mortality of Colorectal Carcinoma Surgery Differs by Insurance Status," *Cancer*, Vol. 101, No. 10, November 15, 2004, pages 2187-2194. Available at http://www.ncbi.nlm.nih.gov/pubmed/15382089.

[73.] Problems included plaque in their carotid (neck) arteries which pump blood to the brain, and obstructions of the blood vessels in their legs. See Jeannine K. Giacovelli et al., "Insurance Status Predicts Access to Care and Outcomes of Vascular Disease," *Journal of Vascular Surgery*, Vol. 48, No. 4, October 2008, pages 905-911. Available at http://www.ncbi.nlm.nih.gov/pmc/ articles/PMC2582051/?tool=pubmed.

[74.] Richard B. Smith et al., "Medicaid, Hospital Financial Stress, and the Incidence of Adverse Medical Events for Children," *Health Services Research*, Vol. 47, No 4, August 2012. Available at http://www.hsr.org/hsr/abstract.jsp?aid=47903270811.

[75.] John Holahan, Genevieve Kenney, and Jennifer Pelletier, "The Health Status of New Medicaid Enrollees Under Health Reform: Timely Analysis of Immediate Health Policy Issues," Urban Institute, August 2010. Also see Richard S. Foster, "The Financial Outlook for Medicare, Medicaid, and Total National Health Expenditures," testimony before the House Committee on the Budget, Office of the Actuary, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, February 28, 2012, page 13. Available at http://budget.house.gov/uploadedfiles/fostertestimony_2-28-22012.pdf. See also Stephen A. Somers et al., "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States," Center for Health Care Strategies, Inc., Policy Brief, August 2010. Available at http://www.chcs.org/usr_doc/Medicaid_Expansion_Brief.pdf.

[76.] Amy Finkelstein et al. (the Oregon Health Study Group), "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research, Working Paper No. 17190, 2011. Available at http://www.nber.org/papers/w17190.pdf. Also see Katherine Baicker and Amy Finkelstein, "The Effects of Medicaid Coverage — Learning from the Oregon Experiment," *New England Journal of Medicine*, Vol. 365, No. 8, August 25, 2011, pages 683-685.

[77.] Health plans are deemed "affordable" if an employee's contributions do not cost more than 9.5 percent of wages.

[78.] Devon Herrick, "Health Exchange Subsidies Will Reduce Employer Health Plans," National Center for Policy Analysis, Brief Analysis No. 758, November 16, 2011.

[79.] Sam Baker, "States Cannot Do Partial Medicaid Expansion, Says Obama Administration, *The Hill* (Healthwatch), December 10, 2012. Available at http://thehill.com/blogs/healthwatch/health-reform-implementation/272023-states-cant-do-partial-medicaid-expansion-hhs-says.

[80.] It is unclear whether or not all eligible individuals will enroll in both Medicaid and the exchanges. Some experts worry they will not enroll – rather, just show up at ERs when needing care. Other policy analysts argue for a so-called *woodwork effect*, where most will be swept up and enrolled.

[81.] Although the individual mandate will assess fines for not enrolling, Medicaid-eligible individuals will be exempt due to low income.

[82.] The estimate is based on 70 percent enrollment with a reasonably healthy population of adults. Uninsured individuals without access to employer coverage or Medicaid will be eligible for generous federal subsidies in the state health insurance exchange. Individuals at this income will be required to pay no more than 2 percent of income (about $200 per individual coverage) for private coverage costing thousands.

[83.] The law allows individuals to exclude up to 5 percent of income, making the 133 percent of poverty cutoff effectively 138 percent of poverty.

[84.] If Medicaid is available, families may exclude up to 5 percent of income in determining income eligibility—allowing individuals with incomes up to 138 percent of poverty to enroll.

[85.] Individuals earning between 133 percent of poverty to 138 percent of poverty would have to pay no more than 3 percent of income.

[86.] Many workers prefer health benefits to the equivalent wages because of the tax advantage for benefits received from an employer.

[87.] For more information, see Devon Herrick, "Health Exchange Subsidies Will Reduce Employer Health Plans," National Center for Policy Analysis, Brief Analysis No. 758, November 16, 2011. Available at http://www.ncpa.org/pdfs/ba758.pdf.

[88.] The ACA deems health plans "affordable" if an employee's contributions do not cost more than 9.5 percent of wages.

[89.] Devon Herrick, "Health Exchange Subsidies Will Reduce Employer Health Plans."

[90.] Mary Beth Musumeci, "A Guide to the Supreme Court's Affordable Care Act Decision," Kaiser Family Foundation, July 2012. Available at http://www.kff.org/healthreform/upload/8332.pdf.

[91.] "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," Congressional Budget Office, July 2012. Available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf

[92.] By contrast, Medicaid represents 17 percent of Florida hospital patients, but only 13 percent of revenue. Analysis of data from the Florida Hospital Uniform Reporting System for 180 Florida hospitals.

[93.] Estimates from the 2012 Current Population Survey Annual Social and Economic Supplement suggested that there were 2.9 million people aged 18 to 64 with incomes below 138 percent of the poverty level in Florida, and that in 2011 about 856,000 of them, almost 30 percent, were covered by private insurance.

[94.] Because private insurers pay higher fees than Medicaid, $2.17 of private spending would replace every $1 of potential Medicaid spending. Thus, $11,722 in potential federal and state Medicaid expenditure would result in $25.4 billion in private spending.

[95.] Estimates vary, but Medicaid rolls may rise by 1.4 people for every one uninsured person who gains coverage. When crowd-out rates are considered, Medicaid expansion that results in coverage of half of uninsured Florida hospital patients would boost hospital revenue by only 4.5 percent. If these same people instead had private coverage, hospital revenue would rise by nearly 12 percent.

[96.] Uninsured individuals without access to employer coverage or Medicaid will be eligible for generous federal subsidies in the state health insurance exchange. Individuals at this income level will pay no more than 2 percent of income (about $200 per individual coverage) for private coverage that costs thousands.

[97.] "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," Congressional Budget Office, July 2012. Available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[98.] The small segment of enrollees earning between 133 percent of FPL and 138 percent of FPL would likely be required to pay no more than 3 percent of income rather than 2 percent for those earning between 100 percent and 133 percent.

[99.] For instance, the argument follows that federal money is a multiplier of state spending. The effect ripples throughout the economy from

health care providers to their vendors and employees. See "The Role of Medicaid in State Economies: A Look at the Research," Kaiser Family Foundation, January 2009.

[100.] "Florida's Economy Will Benefit From Expanding Medicaid," Families USA, February 2013. Available at http://familiesusa2.org/assets/pdfs/medicaid-expansion/Florida.pdf. Also see Jodie Tillman, "Report: Florida Medicaid Expansion could create 71,300 Jobs," *Tampa Bay Times*, February 2013. Available at http://www.tampabay.com/news/politics/legislature/report-florida-medicaid-expansion-could-create-71300-jobs/1275894.

[101.] For a discussion, see Sarah Kliff, "Medicaid's Stimulative Effect," Wonkblog, *Washington Post,* July 10, 2012. Available at http://www.washingtonpost.com/blogs/wonkblog/wp/2012/07/10/medicaids-stimulative-effect/.

[102.] "The Role of Medicaid in State Economies: A Look at the Research," Kaiser Family Foundation, Policy Brief, January 2009. Available at http://www.kff.org/medicaid/upload/7075_02.pdf.

[103.] Gabriel Chodorow-Reich, Laura Feiveson, Zachary Liscow and William Gui Woolston, "Does State Fiscal Relief During Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act," *American Economic Journal: Economic Policy*, forthcoming. Available at http://www.stanford.edu/~waw/papers/Chodorow-Reich_Feiveson_Liscow_Woolston_state_fiscal_relief__aug_2011.pdf.

[104.] The estimated multiplier generally lie in the range of 0.50 to 2.00, meaning that the total effect of the new spending would range from $1.50 to $3.00 if the new $1.00 is included in the overall effect. See Valerie A. Ramey, "Can Government Purchases Stimulate the Economy?" *Journal of Economic Literature*, 2011, Vol. 49, No. 3, pages 673-685.

[105.] Lauren Cohen, Joshua Coval and Christopher Malloy, "Do Powerful Politicians Cause Corporate Downsizing?" National Bureau of Economic Research, Working Paper No. 15839, March 2010. Available at http://www.nber.org/papers/w15839.

[106.] Yaa Akosa Antwi, Asako S. Moriya, and Kosali Simon, "Effects of Federal Policy to Insure Young Adults: Evidence from the 2010 Affordable Care Act Dependent Coverage Mandate," National Bureau of Economic Research, Working Paper No. 18200, June 2012. Available at http://www.nber.org/papers/w18200.

[107.] Carter C. Price and Evan Saltzman, "The Economic Impact of the Affordable Care Act on Arkansas," RAND Corporation, Research Report, 2013. Available at http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR157/RAND_RR157.pdf.

[108.] Robert J. Barro and Charles J. Redlick, "Macroeconomic Effects from Government Purchases and Taxes," National Bureau of Economic Research, Working Paper No. 15369, September 2009.

[109.] Ezekiel J. Emanuel, "We Can Be Healthy and Rich," *New York Times,* February 3, 2013, page 11.

[110.] Edmund F. Haislmaier and Drew Gonshorowski, "State Lawmaker's Guide to Evaluating Medicaid Expansion Projections," The Heritage Foundation, September 7, 2012. Available at http://www.heritage.org/research/reports/2012/09/state-lawmakers-guide-to-evaluating-medicaid-expansion-projections.

[111.] Valerie A. Ramey, "Government Spending and Private Activity," National Bureau of Economic Research, NBER Working Paper 17787, January 2012. Available at http://www.nber.org/papers/w17787.

[112.] The story is told by one of Professor Tobin's former students, renowned Princeton University Economist, Uwe E. Reinhardt. See Uwe E. Reinhardt, "Make-Work and the G.D.P.," Economix, *New York Times*, October 14, 2011. Available at http://economix.blogs.nytimes.com/2011/10/14/make-work-and-the-g-d-p/?ref=business.

[113.] Quoted in Benjamin D. Sommers and Arnold M. Epstein, "U.S. Governors and the Medicaid Expansion – No Quick Resolution in Sight," New England Journal of Medicine, Vol. 368, No. 6, February 7, 2013, pages 496-499.

[114.] Selected calculations in this section are based on Pamela Villarreal, "Social Security and Medicare Projections: 2009," National Center for Policy Analysis, Brief Analyses No. 662, June 11, 2009. Available at http://www.ncpa.org/pub/ba662.

[115.] "Total Medicaid Spending FY2010," StateHealthFacts.org. Available at http://www.statehealthfacts.org/comparemaptable.jsp?ind=177.

[116.] John C. Goodman and Devon M. Herrick, "Reforming Medicaid: More Flexibility for the States," National Center for Policy Analysis, Brief Analysis No. 515, May 13, 2005. Available at http://www.ncpa.org/pub/ba515.

[117.] John C. Goodman and Devon M. Herrick, "Reforming Medicaid: More Flexibility for the States."

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The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, WebMD and the *National Journal*) as the "Father of HSAs." NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

NCPA President John C. Goodman is called the "Father of HSAs" by *The Wall Street Journal*, WebMD and the *National Journal*.

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA's proposal for an across-the-board tax cut became the centerpiece of President Bush's tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for *Forbes* ("A Kinder, Gentler Flat Tax") advocating a version of the flat tax that is both progressive and fair.

A major NCPA study, "Wealth, Inheritance and the Estate Tax," completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Senate Majority Leader Bill Frist (R-TN) and Senator Jon Kyl (R-AZ) distributed a letter to their colleagues about the study. The NCPA recently won the Templeton Freedom Award for its study and report on Free Market Solutions. The report outlines an approach called Enterprise Programs that creates job opportunities for those who face the greatest challenges to employment.

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, "Ten Steps to Baby Boomer Retirement," shows that as 77 million baby boomers begin to retire, the nation's institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are inadequately funded. State and local institutions are not doing better — millions of government workers are discovering that their pensions are under-funded and local governments are retrenching on post-retirement health care promises.

Pension Reform.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of employees into companies' 401(k) plans, automatic contribution rate increases so that workers' contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

The NCPA's online Social Security calculator allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

Environment & Energy.

The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

Educating the next generation.

The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

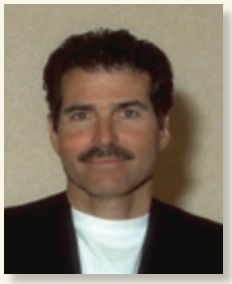
Promoting Ideas.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from Burrelles*Luce*, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

What Others Say About the NCPA

"The NCPA generates more analysis per dollar than any think tank in the country. It does an amazingly good job of going out and finding the right things and talking about them in intelligent ways."

Newt Gingrich, former Speaker of the U.S. House of Representatives



"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like Health Savings Accounts. These things work, allowing people choices. We've seen how this created America."

John Stossel,
host of "Stossel," Fox Business Network

"I don't know of any organization in America that produces better ideas with less money than the NCPA."

Phil Gramm,
former U.S. Senator

"Thank you . . . for advocating such radical causes as balanced budgets, limited government and tax reform, and to be able to try and bring power back to the people."

Tommy Thompson,
former Secretary of Health and Human Services

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