STATEMENT BY
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Hearing on "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program"
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Summary

Medicaid faces many challenges. ObamaCare's Medicaid expansion has exacerbated many of those problems and added some new ones, mostly at the cost of the vulnerable. Unlike traditional Medicaid, Medicaid expansion:

1) Transforms the program into an income-based entitlement.
2) Serves able-bodied, working-age adults, almost all of whom do not have children.
3) Provides a higher reimbursement rate for expansion enrollees, which results in heartbreaking unintended consequences for the truly vulnerable.

Medicaid spending growth at the state level is far outpacing revenue growth and is redirecting limited resources away from education, public safety, and infrastructure. As states balance their budgets, Medicaid is often the first place to look as it is the biggest line-item in almost every state. Unfortunately, for a state to save $1.00 in state funds this year, they would need to cut $20 from the expansion population. On the other hand, states would need to cut only $2.32 (on average) from the truly needy in traditional Medicaid. Several pre-ACA expansions are highlighted as examples where the truly vulnerable were directly harmed.

Medicaid expansion was implemented based on promises of modest enrollment and costs, assistance to hospitals, additional jobs, and lower uncompensated care. Yet in every state with available data, enrollment has skyrocketed beyond projections, by an average of 110 percent. Some states have signed up more than *four times* as many able-bodied adults as they said would ever enroll. Meanwhile, nearly 600,000 individuals sit on waiting lists for Medicaid services. These include those with developmental disabilities, traumatic brain injuries, and mental illnesses.

Finally, long running issues for the traditional Medicaid population such as high emergency room utilization, access concerns, and deep eligibility issues remain.

Chairman Murphy, Ranking Member DeGette, and Members of the Committee,

Thank you for this opportunity to bring a state perspective to the important issue of protecting our most vulnerable citizens on Medicaid. My name is Josh Archambault and I serve as a Senior Fellow at the Foundation for Government Accountability (FGA), a think tank that specializes in health and welfare issues and is active in thirty-seven states.

This morning I would like to highlight some of the challenges in Medicaid programs around the country and how Medicaid expansion has exacerbated these problems in many states. Sadly, many of the issues I highlighted as I testified in front of the Health Subcommittee in 2013 still remain and in fact have gotten worse under the Patient Protection and Affordable Care Act (ACA). I want to start by talking about the ACA's Medicaid expansion and its impact on the truly vulnerable in our country.[1]

1. Who Gains Under ACA Medicaid Expansion and How It Hurts The Truly Needy

Under the ACA, commonly known as ObamaCare, state policymakers may expand Medicaid eligibility to cover able-bodied, working-age adults earning up to 138 percent of the federal poverty level.

It is important to understand that this expansion differs greatly from traditional Medicaid in distinct ways:

1) The ACA expansion transformed the program from a historical safety net into an income-based entitlement.
2) New expansion enrollees are very different from those on traditional Medicaid as the new population consists of able-bodied, working-age adults, almost all without children.

3) The new expansion population is awarded a higher reimbursement rate. Unfortunately, this new funding formula leads to some pernicious unintended consequences that impact the truly vulnerable.

To be very clear, Medicaid expansion does not cover the elderly, individuals with disabilities on waiting lists, or even poor children — patients most frequently considered among the nation's most vulnerable and most in need of support. Instead, ObamaCare expands Medicaid eligibility to a new group of able-bodied, working-age adults who do not traditionally qualify for long-term welfare. Nationally, more than 82 percent of these able-bodied adults have no dependent children.[2]

In addition, nearly half of this ObamaCare Medicaid expansion population does not work at all, even during favorable economic times.[3] Only one-fifth are employed full-time, year-round. Unlike most social service entitlement programs, Medicaid currently does not have a work requirement, meaning states are expanding eligibility for taxpayer-funded Medicaid to an able-bodied, non-working adult population. There continue to be concerns in the economic research community about the negative labor market impact of expanding Medicaid to this new group of individuals as it can discourage work, depress earnings, and reduce labor-force participation.[4]

In part because of these negative incentives, many of these able-bodied adults have transitioned from employer-based insurance to taxpayer-funded public insurance. For example, in Massachusetts, Governor Charlie Baker recently highlighted in a letter to Congress that, since the implementation of the ACA, roughly 500,000 previously privately insured residents now receive public coverage.[5] Medicaid expansion and the resulting crowd out of private coverage have contributed to significant and sustained budget problems for states.

a. ObamaCare expansion funding threatens the truly vulnerable

ObamaCare's new Medicaid entitlement for working-age, able-bodied adults ultimately redirects limited state and federal resources away from some of the most needy individuals. These vulnerable individuals already struggle in a tattered Medicaid safety net. Care is frequently fragmented, access to quality care is often low, and health outcomes remain lackluster.

But the pressures ObamaCare presents to the truly vulnerable do not stop there. The ACA also created a perverse funding formula that results in states making cuts from the truly needy with disabilities or dependent children.

ObamaCare does not change the funding structure for patients covered by traditional Medicaid. States continue to receive their regular matching rate for providing coverage to low-income children, seniors, and individuals with disabilities. These rates range from a low of 50 percent to a high of 83 percent, depending on a state's per-capita income. On average, the federal government pays for roughly 57 percent of current Medicaid expenditures.

But the matching rates for Medicaid expansion are much different. States that expanded Medicaid for able-bodied adults under ObamaCare receive an enhanced matching rate for this new Medicaid population. The enhanced matching rate started at 100 percent in 2014. This year, it dropped to 95 percent and gradually declines to 90 percent by 2020, should Congress choose to keep the law in place or not significantly restructure its funding.

To reiterate, only the ACA's new group of able-bodied adults qualify for this enhanced funding. States do not receive an enhanced matching rate for the truly vulnerable patients already eligible for or enrolled in Medicaid. This means states receive more funding for able-bodied adults than they do for patients the Medicaid safety net was originally intended to protect – children, the elderly, and individuals who are blind or disabled.

Medicaid is now the single largest line-item in most state budgets and has been for years. For example, in Massachusetts, Medicaid accounts for 40-plus percent of the entire budget.

In most states, Medicaid spending is growing faster than state revenues. As an example, Kentucky's Medicaid commissioner recently stated that the agency now projects that every single new dollar of state revenue will be spent on Medicaid over the next ten years – and that the state will still be short the dollars needed to support the growing Medicaid spending. Put another way, not a single new revenue dollar would be left to invest in critical state services for educating children, providing public safety, or offering tax relief. Lawmakers in all states – blue, purple, and red – are starting to realize the Pac-Man effect that Medicaid is having on their budget.

Given the size of the Medicaid program, one of the only tools policymakers have to balance their budgets is to rein in Medicaid spending. But in order to save $1.00 in state Medicaid spending, states must make an average of just over $2 in total cuts to their traditional Medicaid programs.[6] This is because state funds typically cover only 43 percent of traditional Medicaid costs.

Amount of cuts to Medicaid spending on expansion individuals needed to save $1.00 in state spending

2017	2018	2019	2020
$20.00	$16.67	$14.29	$10.00

Source: Foundation for Government Accountability

On the other hand, states would need to cut services and benefits for the able-bodied, childless adult expansion population by a staggering $20 just to save a single state dollar in this

year.[7] This gives states a massive financial incentive to cut from traditional Medicaid first – a program for the truly needy – rather than cut funding for expansion.

b. States that previously expanded Medicaid made cuts that impacted truly needy

The most vulnerable patients in states that previously expanded Medicaid (pre-ACA) to childless adults were the targets of devastating cuts to services. Arizona, for example, expanded Medicaid eligibility to able-bodied, childless adults in 2000.[8] However, the state quickly discovered its Medicaid expansion would cost taxpayers four times what was initially expected. Instead of cutting expansion benefits, in 2010, Arizona eliminated Medicaid coverage for heart, liver, lung, pancreas and bone marrow transplants for traditional Medicaid enrollees in order to pay for the growing costs of its Medicaid expansion.[9] Truly vulnerable Medicaid patients in desperate need of life-saving organ transplants did not receive them so adults with no disabilities could keep receiving taxpayer-funded Medicaid coverage.[10]

Today, as the ACA expansion begins to make a direct impact on states, cuts to the truly vulnerable are being put on the table once again.

In Arkansas, Governor Asa Hutchinson has proposed nearly $1 billion in cuts to the traditional Medicaid program.[11] The governor said he "expects the cuts to come primarily from payments for services to patients with expensive medical needs, such as nursing-home residents, the developmentally disabled and the mentally ill." Meanwhile, nearly 3,000 Arkansans with disabilities are on the state's Medicaid waiver waiting list.

In Alaska, Governor Bill Walker's administration has proposed cuts to services for those with developmental disabilities.[12] They have also moved to cut general fund spending on Medicaid by $90 million.[13]

States also often reduce and delay payments to doctors, hospitals and other health care providers which worsens access for those on Medicaid. Maine, which expanded Medicaid eligibility to able-bodied, childless adults in 2002, saw expansion costs greatly exceed initial projections, forcing the state to cap enrollment at various times, draw up waiting lists of patients in need of services and lengthen payment cycles.[14] By 2013, Maine's accumulated unpaid hospital bills for Medicaid patients reached a staggering $500 million.[15]

Unfortunately, these types of traditional Medicaid cuts are only a preview of what's to come if Medicaid expansion is left in place. With expansion running billions of dollars over budget nationally, it is only a matter of time before more services for the most vulnerable are impacted.

2. Medicaid Expansion Has Failed to Deliver on Its Promises

Policymakers in a number of states that expanded Medicaid often did so citing promises of saving taxpayer money, creating jobs, and preventing hospitals from closing. Unfortunately, many of those promises have not come true as hoped for.

a. Medicaid expansion enrollment and costs have skyrocketed

Newly-obtained data from twenty-four expansion states shows that at least 11.5 million able-bodied adults have now enrolled in ObamaCare expansion – an overrun of 110 percent, or more than double initial projections.[16] Some states have signed up more than *four times* as many able-bodied adults as they said would ever enroll.

STATE	MAX ENROLLMENT	ACTUAL ENROLLMENT	AS OF DATE	OVER PROJECTIONS
Arizona	297,000	397,879	9/2016	34%
Arkansas	215,000	324,318	10/2016	51%
California	910,000	3,842,200	5/2016	322%
Colorado	187,000	446,135	10/2016	139%
Connecticut	113,000	186,967	12/2015	65%
Hawaii	35,000	35,622	6/2015	2%
Illinois	342,000	650,653	4/2016	90%
Iowa	122,900	139,119	2/2016	13%
Kentucky	188,000	439,044	12/2015	134%
Maryland	143,000	231,484	12/2015	62%
Michigan	477,000	630,609	10/2016	32%
Minnesota	141,000	207,683	12/2015	47%
Nevada	78,000	187,110	9/2015	140%
New Hampshire	45,500	50,150	8/2016	10%
New Jersey	300,000	532,917	1/2015	78%
New Mexico	149,095	235,425	12/2015	58%
New York	76,000	285,564	12/2015	276%
North Dakota	13,591	19,389	3/2016	43%
Ohio	447,000	714,595	8/2016	60%
Oregon	245,000	452,269	12/2015	85%
Pennsylvania	531,000	625,970	4/2016	18%
Rhode Island	39,756	59,280	12/2015	49%
Washington	262,000	596,873	7/2016	128%
West Virginia	95,000	174,999	12/2015	84%
Combined	**5,452,842**	**11,466,254**		**110%**

This enrollment explosion has led to significant cost overruns. Here are just a few examples:

- Alaska: $61 million (42%) over-budget in the first year
- California: $14.7 billion (222%) over-budget in the first 1.5 years
- Colorado: $550 million (45%) over-budget in the first 1.5 years
- Illinois: $2 billion (70%) over-budget in the first 2 years
- Iowa: $338 million (56%) over-budget in the first 1.5 years
- Kentucky: $3 billion (107%) over-budget in the first 2.5 years
- New Mexico: $600 million (45%) over-budget in the first 1.5 years
- North Dakota: $67 million (114%) over-budget in the first year
- Ohio: $4.7 billion (87%) over-budget in the first 2.75 years
- Oregon: $2 billion (128%) over-budget in the first 1.5 years
- West Virginia: $198 million (46%) over-budget in the first full fiscal year

These enrollment and budget trends mean even fewer resources will be available for services to seniors, poor children, and individuals with disabilities.

Nationwide, there are nearly 600,000 individuals currently sitting on waiting lists for Medicaid services.[17] These are people with developmental disabilities, traumatic brain injuries, and mental illnesses who are less likely to receive needed care now that Medicaid has been expanded.

Since Illinois expanded Medicaid under ObamaCare, more than 750 individuals with developmental disabilities have died while on waiting lists for needed Medicaid services.[18] In

Arkansas, 79 members of the state's waiting list have died since the legislature voted to expand Medicaid through ObamaCare.[19] That experience has repeated itself across the country.

In order to stop the bleeding, Congress should immediately freeze enrollment in expansion states, and not allow new states to expand. This would provide states with an opportunity to unwind their expansions and refocus existing resources on the most vulnerable.

b. Expansion has not cured hospital ills

Supporters of expansion argued that adding more enrollees would accomplish some important outcomes in our health system. Unfortunately, many of those have not come to fruition. For example, expansion has not stopped hospitals from closing. Hospitals have closed in expansion states across the country including Arizona, Arkansas, California, Illinois, Kentucky, Massachusetts, Minnesota, Nevada, and Ohio.

According to Moody's Investors Services, the leading provider of credit ratings for hospitals, there is no significant difference in financial health of hospitals in states that expanded Medicaid and states that have not.[20]

Medicaid expansion jobs have not materialized either. In Iowa, consultants promised 2,400 new hospital jobs as the result of Medicaid expansion. Instead, the state has lost roughly 980 hospital jobs. In Arkansas, consultants promised over 1,000 new hospital jobs; the state instead lost 819 hospital jobs in the first 18 months of expansion. And in Kentucky, experts promised to create over 5,000 new hospital jobs, but instead lost over 1,200 in the first year of expansion.[21]

And although there is limited data available, experts remain critical about the promised drop in uncompensated care. In New Hampshire, state actuaries estimated that uncompensated care would go down by roughly $10 million after expansion. But after calculating in new costs and

lost revenue from shifting people out of private insurance and into Medicaid, New Hampshire hospitals are projected to lose more than $47 million as a result of Medicaid expansion.[22]

3. Traditional Medicaid Has Numerous Problems

Medicaid has been afflicted by concerns over its quality, access, and financing for decades. Even then-President Obama famously said, "…We can't simply put more people into a broken system that doesn't work."[23]

a. ER utilization is high

Medicaid enrollees continue to utilize emergency rooms at high levels. Low reimbursement rates may account for the elevated ER visits by Medicaid patients. They are roughly twice as likely to visit an ER compared to both the uninsured and Medicare patients and four times more likely than the privately insured. To make matters worse, a majority of these visits have been found to be avoidable. For example, in Massachusetts, more than 55 percent of visits to the ER were deemed "avoidable/preventable" for Medicaid beneficiaries.[24] Despite promises that Medicaid expansion would lower emergency room use, the best evidence available suggests that it is doing the opposite.[25]

b. Access remains a major concern

My 2013 testimony also highlighted some deeply concerning access issues from around the country including only 14 percent of offices in Barnstable County on Cape Cod accepting Medicaid.[26]

A New England Journal of Medicine article highlighted that very sick children in Cook County, Illinois on the Children's Health Insurance Program struggle to get an appointment and

for the few offices that did accept Medicaid, the wait times for an appointment were twice as long as for kids on private insurance.[27]

Children on Medi-Cal (Medicaid in California) seeking a urologist found that roughly 60 percent of providers did not accept Medicaid and 75 percent of the offices that did not accept Medicaid patients were unable to suggest another office that would.[28]

c. Eligibility checks are not conducted frequently enough or in enough detail

The problems with eligibility checks for Medicaid and exchange subsidies have been well documented by the Government Accountability Office (GAO), and at the state level for those that have bothered to check the federal government's work.[29] States need to be checking far more data sources to determine and redetermine eligibility. Yet the problems around eligibility run even deeper as most states fail to check eligibility frequently enough to identify major life changes, meaning resources for the truly needy are instead spent on individuals who no longer qualify.

Improving the integrity of eligibility checks, especially for Medicaid enrollees, is critical to protecting resources for the truly needy. This kind of reform has a proven track record and wide bipartisan support.[30]

These close-to-real-time data checks provide monitoring during the whole year – they flag when someone gets a new job or increases work hours, moves out of state, gets married, deposits a large asset, or even passes away. By cross-matching existing state data and new commercial data sources more frequently, states can protect limited resources for those who truly need them.

Recent audits have highlighted why these checks are so crucial. Over the course of two years, Illinois identified more than 14,000 individuals who had died – some as earlier as the 1980s – but were still enrolled in Medicaid.[31-32] A similar audit in Arkansas revealed more than 43,000

individuals on Medicaid who did not live in the state, with nearly 7,000 having no record of ever living there.[33] More than 20,000 Medicaid enrollees were also linked to high-risk identities – including individuals using stolen identities or even fake Social Security numbers.[34] Michigan has recently identified more than 7,000 lottery winners receiving some kind of public assistance, including individuals winning up to $4 million jackpots in the state lottery.

A 2014 legislative audit of Minnesota's Medicaid agency found nearly 17 percent of enrollees were ineligible for benefits, with more than half of the cases needing additional verification to determine eligibility. Auditors were able to identify several applications who had under-reported income – in many cases by up to $70,000 per year – had failed to report changes in income, or even had moved out of state.[35]

An audit in 2013 of the Nebraska Health Insurance Premium Payment program—a component of the state's Medicaid program—found that the state lacked appropriate documentation in every single reviewed case file, calling into question the entirety of expenditures made under the program.[36] More than three-quarters of the audited cases had received incorrect payments, with auditors identifying several cases of apparent fraud.

A 2006 federal audit found that eight percent of New York's Medicaid payments were made on behalf of individuals who were ineligible, but nevertheless enrolled in the program.[37] A follow-up audit in 2013 found a significant number of cases for which case files had missing or invalid Social Security numbers, individuals were enrolled in the same program multiple times, or the files lacked any documentation to support the eligibility determination at all.[38]

A state and federal review of Ohio's Medicaid spending in 2008 found that nearly 10 percent of Medicaid payments were improper.[39] Nearly all of these improper payments were caused by errors and insufficient documentation in eligibility determinations.

States should use enhanced data-matching technology to verify and crosscheck income, residency, identity, employment, citizenship status, and other eligibility criteria for all welfare enrollees and applicants.

Federal law only requires states to perform these checks once a year and does not require any kind of active monitoring of income or other categorical requirements. But life changes happen much more frequently. Federal data shows that individuals in poverty typically remain there for only a short time. By reducing the amount of time between these periodic checkups, states can catch costly eligibility errors sooner and preserve limited resources for the truly needy.

Better verification already has a proven track record in the states. In the first 10 months of operation, Pennsylvania's award-winning Enterprise Program Integrity initiative identified more than 160,000 ineligible individuals who were receiving benefits, including individuals who were in prison and even millionaire lottery winners, resulting in nearly $300 million in taxpayer savings.[40]

In Illinois, an independent vendor identified eligibility errors in half of the cases it reviewed during the first year of operation.[41] By the end of that first year, the state had removed roughly 300,000 individuals from the program as a result of the initiative. In the second year, the state removed an additional 400,000 individuals. State officials projected that the enhanced program integrity initiative would save taxpayers $350 million per year. Based on the results of the second year, taxpayers can now expect to save between $390 million and $430 million per year.

Conclusion

While every state and Medicaid program is different, there are some universal troubling trends that Congress must address immediately. Solving these problems requires creative thinking and a true partnership with states to eradicate the billions of dollars of waste, fraud, and abuse that is preventing the level of care to be targeted at those that need it the most. It requires a departure from the current mindset that having access to a Medicaid card is the same as having access to a medical professional. It requires us all to ask the tough question — are the billions we are spending as a country serving the best interest of the beneficiaries and of the taxpayers?

I appreciate the opportunity to share some of my thoughts with you all today and look forward to answering any questions you may have.

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[1] Sections of my testimony are pulled from FGA research and publications and permission of the authors has been given.
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