OFFICE OF THE MAJORITY LEADER

Majority Office Resource Guide:

Medicaid Expansion & LIP Funding

Republicans,

This packet is designed to provide you with important information regarding Medicaid expansion and funding for the Low Income Pool (LIP). Inside, you will find briefs on LIP and Medicaid, as well as articles and analyses on the perils of expanding Medicaid. You may tailor this information to communicate with your constituents on these important issues.

As you know, the Florida House has made the principled decision to take a very cautious and deliberate approach to implementing PPACA. While we support a safety net for our most vulnerable citizens, Medicaid expansion is the wrong approach to strengthening that net.

The rollout of President Obama's healthcare law has been fraught with problems, including delays and seemingly arbitrary enforcement. As our negotiations over LIP funding prove, how can we be certain that federal funding for any newly proposed programs would remain available? Unlike in Washington, Florida has a constitutional requirement to balance our budget. As Medicaid spending increases, we will have fewer resources to fund other critical needs, such as education and infrastructure.

More importantly, we know Medicaid does not serve patients well. The only scientific study of Medicaid in the country found that Medicaid patients' clinical outcomes are no better than the uninsured. Medicaid expansion is also expected to drastically increase demand for medical services without increasing the supply for those services, leading to an increase in wait times and fewer physicians accepting new patients.

There is also no flexibility in Medicaid expansion. Florida cannot choose the population, benefit design, price, or eligibility conditions. Medicaid is supposed to be a safety net, but the expansion population goes beyond traditional Medicaid populations of vulnerable people like low-income children, the disabled, and the elderly.

Furthermore, nothing should give our state more pause in this debate than the Obama Administration's attempt to force Florida to expand Medicaid under Obamacare in order to receive LIP funding.

I hope you will find the information included in this packet helpful as the debate over Medicaid expansion and LIP funding continues here in Florida. If you need additional information, please do not hesitate to contact the Majority Office at 850-488-1993.

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Talking Points

- Medicaid expansion and the Low Income Pool (LIP) are separate issues.
- Nothing should give our state more pause in this debate than the Obama Administration's attempt to force Florida to expand Medicaid under Obamacare in order to receive LIP funding.
- It is unthinkable that the federal government would leave our state on the hook for over a billion dollars simply because they want a specific policy outcome.
- I support a safety net for our most vulnerable citizens, but I believe that Medicaid expansion is the wrong approach to strengthening that net.
- Just because a person has Medicaid does not mean they will have better health. The only scientific study of Medicaid in the country found that Medicaid patients' clinical outcomes are no better than the uninsured.
- There is also no flexibility in Medicaid expansion. Florida cannot choose the population, benefit design, price, or eligibility conditions.
- Medicaid is supposed to be a safety net, but the expansion population goes beyond traditional Medicaid populations of vulnerable people like low-income children, the disabled, and the elderly.
- We must take a very cautious and deliberate approach to implementing PPACA. If Florida expands Medicaid, it may not be able to undo that decision.
- We will continue to listen to new ideas. I believe we should strengthen our safety net by continuing to find new and better market-based solutions that are sustainably funded and will provide Florida families and seniors with access to quality, affordable healthcare.

Low-Income Pool

The Low-Income Pool (LIP) is a supplemental payment program for hospitals and other providers. It is a pool of federal dollars matched primarily by voluntary contributions from counties, hospital taxing districts, and individual hospitals. These entities contribute local tax dollars to draw down federal matching funds, which the state distributes to hospitals and other health care providers.

The LIP is not a coverage program and has nothing to do with Medicaid expansion under the PPACA. Florida's LIP was approved by the federal government in 2006 to replace a prior supplemental payment program.

Medicaid expansion will not be enough to cover the loss of the LIP. Some LIP-funded programs will not be funded by expansion, and expansion increases the volume of patients for which hospitals will receive below-cost payments – not a good deal for the hospitals.

This year, the LIP totals $2.17 Billion ($1.3 Billion in federal funds).

Why do the local donors contribute to the LIP?

- The donors get every donated dollar back, to use for health care.
- The donors also get a guaranteed rate of return: 8.5% for one category of LIP, and 147% for another category of LIP.
- The donors may also receive LIP dollars indirectly through other kinds of distributions.

How is the LIP used?

- $963 Million is used by the donors to buy back state hospital rate cuts and raise Medicaid payment rates to Medicare levels.
- $764.5 Million is used to pay back the original donations plus an 8.5% return on investment to donor hospitals, for any health care use and to support rural hospitals.
- $115 Million supports special purpose hospitals, like trauma centers, rural hospitals, safety net hospitals and children's hospitals and to pay a quality-based payment for specific hospitals.
- LIP funds also support other health care programs:
    - Graduate medical education, through teaching hospital physician groups - $204 Million
    - State poison control centers - $3.2 Million
    - Some primary care programs in County Health Departments and Federally Qualified Health Centers - $114 Million
- The LIP program also finances $797 Million in enhanced hospital payment rates and managed care plan capitation rates statewide (paid outside of the LIP). These funds are paid to hospitals and other providers for Medicaid services.

Medicaid Clinical Outcomes

The Senate and the Obama Administration want Florida to make a tremendous new investment in government-provided health care. Medicaid expansion in Florida will cost taxpayers an estimated $55 Billion over ten years, including $3.5 Billion in state funds. Is this a good investment? What do taxpayers get for this commitment?

Not much. If the purpose of health care coverage is to improve health, Medicaid fails dismally.

- The only scientific study in the country found that **Medicaid had no effect on enrollees' clinical health**, compared to those without Medicaid.

- A study by a major university found that **hospital surgical outcomes were far worse for Medicaid recipients** than for people with private insurance or Medicare, and even worse than for people with no insurance at all.

- Other studies of specific disease states (including cancer and vascular disease) found higher mortality rates, higher surgical complication rates, and higher rates of late-diagnosis for people with Medicaid compared to people with private insurance and even the uninsured.

- Two studies found that Medicaid expansion caused more emergency room use for non-emergency care.

Details on these studies are below.

At best, the value of Medicaid coverage is debatable. It is not worth adding billions of dollars a year to our current investment of $23 Billion annually.

Oregon clinical outcome study[1]: Researchers in Oregon conducted the only randomized controlled study of the clinical effects of Medicaid in the country. The two-year study measured several standard health indicators for chronic diseases states that, theoretically, should be better managed and improve with insurance coverage; specifically, blood pressure, cholesterol, blood sugar control (related to diabetes), and diagnoses for related diseases. **The study found no statistically significant effect on the recipient's clinical health, compared to those without Medicaid.** The only positive result documented was that people felt better, emotionally, because they were worrying less about health care costs. (This did not translate to fewer diagnoses of depression; it was only self-reporting.)

[1] Baicker, et al, The Oregon Experiment - Effects of Medicaid on Clinical Outcomes. N Engl J Med. 2013 May; 368:1713-1722.

Oregon emergency room use study[2]: The same Oregon research found that Medicaid expansion caused a big increase in inappropriate visits to the emergency room – visits for non-emergency reasons, or for things that should have been taken care of by a primary care doctor, which Medicaid would have paid for. While it is good that people received needed care, it indicates a massive increase in costs caused by people misusing their coverage (since the ER is the most expensive place to get care), and shows that expanding Medicaid doesn't necessarily reduce costs.

Colorado emergency room use analysis[3]: The Colorado Hospital Association performed an analysis of emergency room use in Colorado, Washington and Oregon (which expanded Medicaid) compared to Montana (which did not). Colorado experienced a 1.8% increase in ER visits after expansion, and Washington and Oregon had increases of 8.5% and 6.5%, respectively. Montana experienced a 0.8% increase.

University of Virginia study: This study analyzed 893,658 major surgeries over a 5-year period and compared the outcomes for people with Medicaid, Medicare, private insurance, and those with no insurance. The study took into account age, gender, race, income level, geographic region, and type of surgery, so the results control for the possibility that those differences caused the result, and the only factor that was relevant was type of insurance coverage.

- Medicare patients – 45% more likely to die before leaving the hospital than patients with private insurance.
- Uninsured patients – 73% more likely to die before leaving the hospital than patients with private insurance.
- Medicaid patients – 93% more likely to die before leaving the hospital than patients with private insurance.

In other words, Medicaid patients had worse outcomes than people with no insurance at all. The study also found that Medicaid patients stayed in the hospital longer than other patients, and had the highest costs, accounting for differences with other patients (besides source of insurance coverage). Other studies of more specific types of care made similar findings:

- In patients undergoing surgery for colon cancer, the mortality rate was 2.8% for Medicaid patients, 2.2% for uninsured patients, and 0.9% for those with private insurance. The rate of surgical complications was highest for Medicaid, at 26.7%, as compared with 24.5% for the uninsured and 21.2% for the privately insured[4].

[2] Taubman, et al, Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment. Science. 2014 Jan. 17; 343(6168): 263-8.
[3] Colorado Hospital Association, Center for Health Information and Data Analytics, "Impact of Medicaid Expansion on Hospitals: Updated for Second-Quarter 2014", Sept. 2014, available at http://www.cha.com/Documents/Press-Releases/FINAL-CHA-Medicaid-Expansion-Study-Q2-Sept-2014.aspx
[4] Kelz RR et al., Morbidity and mortality of colorectal carcinoma surgery differs by insurance status. Cancer. 2004 Nov; 101(10): 2187–94.

- Patients with clogged blood vessels in their legs or clogged carotid arteries (the arteries of the neck that feed the brain) fared worse on Medicaid than did the uninsured. Medicaid patients outperformed the uninsured if they had abdominal aortic aneurysms[5].

- Medicaid patients were 6% more likely to have late-stage prostate cancer at diagnosis (instead of earlier-stage, more treatable disease) than the uninsured, 31% more likely to have late-stage breast cancer, and 81% more likely to have late-stage melanoma. Medicaid patients did outperform the uninsured on late-stage colon cancer (11% less likely to have late-stage cancer).[6]

- Patients on Medicaid or without insurance were three times as likely to have advanced-stage throat cancer at the time of diagnosis, compared with those with private insurance. Those with Medicaid or without insurance lived for a significantly shorter period than those with private insurance.[7]

- For patients undergoing lung transplantation, Medicaid patients were 8.1% less likely to be alive ten years after their transplant operation, compared with those with private insurance and those without insurance. Medicaid was a statistically significant predictor of death three years after transplantation, even after controlling for other clinical factors. Overall, Medicaid patients faced a 29% greater risk of death.[8]

[5] Giacovelli JK et al., Insurance status predicts access to care and outcomes of vascular disease. Journal of Vascular Surgery. 2008 Oct; 48(4): 905–11.
[6] Roetzheim RG et al., Effects of health insurance and race on early detection of cancer. Journal of the National Cancer Institute. 1999 Aug; 91(16): 1409–15.
[7] Kwok J et al., The impact of health insurance status on the survival of patients with head and neck cancer. Cancer. 2010 Jan; 116(2): 476–85.
[8] Allen JG et al., Insurance status is an independent predictor of long-term survival after lung transplantation in the United States. Journal of Heart and Lung Transplantation. 2011 Jan; 30(1): 45–53.

Medicaid Expansion and Exchange Subsidy Eligibility

Obamacare makes every U.S. Citizen and lawfully present alien with an annual income between $11,770 and $47,080 eligible for federally subsidized private health insurance in the exchange.

Those subsidies are valuable.

People with incomes between $11,770 and $16,243 are subsidized for nearly the entire value of a silver-level plan on the exchange. They only pay up to 2% of their income in premiums, or no more than $235-$324 per year. That is $19-$27 a month.

Strangely, Obamacare also makes people with incomes up to $16,243 eligible for Medicaid – in states that expand Medicaid – and eliminates their eligibility for exchange subsidies.

So, Floridians making $11,770-$16,243 a year can get exchange subsidies ONLY if Florida does not expand Medicaid. If Florida expands, the federal government takes away their exchange subsidies.

- Today, over 609,000 Floridians are eligible for those federal subsidies. Over 257,000 of them have no coverage other than through the exchange.

- If Florida passes the Senate bill to expand Medicaid, those 609,000 people will lose access to subsidized private coverage in the exchange and at least 257,000 of them will have to move to Medicaid if they want coverage.

Our goal should be to keep people OUT of Medicaid if they have an affordable private market alternative. We should not do anything to make people LOSE private coverage, and move to a program with poor clinical outcomes.

This Hobson's choice is not right for Floridians. A federal government truly interested in increasing coverage would not give states an all-or-nothing offer, but would work with states to prioritize those most in need of a government safety net.

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Contact: Michael Williams
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Speaker Crisafulli Issues Statement In Response To A Question From Today's Media Availability

Tallahassee, FL – House Speaker Steve Crisafulli (R-Merritt Island) issued the following statement in response to a question from this afternoon's media availability.

"In a gathering of reporters this afternoon, I answered a question which I could have answered more precisely. I was asked what I would say to my constituents who are suffering because the federal government is threatening to withhold LIP funding."

"There are Floridians, including Floridians in my district, who are suffering. However, those individuals currently have access to hospitals and there is no denial of care to them. To that point, I do not believe constituents are suffering due to the threats from Washington, D.C. I do believe they could suffer greatly if the federal government fails to fund the Low Income Pool. The Florida House remains committed to job creation, low taxes, affordable healthcare, and quality education. Our efforts are aimed at creating a state where every Floridian can prosper."

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Medicaid Expansion: A Lesson in Unreliability

by Dr. Jason Fodeman

The Journal of The James Madison Institute

I've often heard the saying that "those who refuse to study history are destined to repeat it." Well, what about those who refuse to examine the present? In February of this year, the Director of the Children and Adults Health Programs in the Center for Medicaid and CHIP Services (CMCS) at CMS revealed what we should already know: that we should take the federal government's promise of the enhanced match for the newly eligible with a big grain of salt. Director Eliot Fishman informed those attending a health care conference in Orlando that funding for Florida's "Low Income Pool" program—amounting to roughly $1.3 billion—will not be extended. Low Income Pool (LIP) funds are reimbursement payments to hospitals for treatments delivered to poor and uninsured patients.

If the federal government can't be relied upon to extend a program that assists poor and uninsured Floridians for $1.3 billion, how then can anyone conclude that we should trust that the federal government will "cover" the costs of Medicaid expansion? Medicaid, a program that delivers substandard care with substandard outcomes, will eventually consume enough of Florida's budget to cripple all other priorities. To those in decision-making capacities in Tallahassee, consider this a lesson in what relying on federal government promises can ultimately lead to. Think about what the future will hold when it is no longer $1.3 billion in "federal" money being withheld, but $10 billion, or $50 billion or more.

Florida's leaders are uniquely situated in a state that has shown that free enterprise, innovation and sound economic policy can lead to prosperity, job growth, and dynamic success. They are also about to be courted by all manner of special interests, which will pepper them with every conceivable reason to "take the federal money." They'll be told it's free money—as if the federal government is not already $18 trillion in debt, or that there's a grand bargain at stake, as if that "bargain" will not cost us dearly down the road. They'll be told that there really is no other choice. Policymakers should reject these red herrings and remember this $1.3 billion lesson in reliance on the federal government.

As elected officials, constituents rely on decision makers to understand and weigh the short and long-term implications of the issues at hand. Do we need to examine reforms to Florida's Medicaid program? Absolutely. Those of us who believe in free-market solutions consistently point out that Medicaid is persistently insufficient. We should examine why that is and work together to implement sound free-market reforms to improve access to care for those in need, as opposed to jamming them into a program that results in far inferior care and worse health outcomes.

Expanding a Flawed Program is Bad Policy

As you consider the temptation to "take the money," it is important to keep in mind that Florida can barely afford to fund the current $21 billion-a-year Medicaid program. Over the last 12 years, Medicaid in Florida has grown five times as fast as general revenue and currently accounts for 30 percent of the state budget. As Medicaid's expenditures increase, it consumes funds that otherwise could be used for other important priorities such as education and public safety.

Expanding Medicaid would have a significant cost to the state and federal government. Even so, proponents of expansion contend the enhanced match makes this a good deal for states such as Florida. However, there are several flaws with this viewpoint. First, the federal government's promise to fund 100 percent of the cost is temporary, and it's only applicable to the newly eligible. At the same time, there are no guarantees that a future Congress and administration will maintain this higher match. In fact, the 2013 Obama budget actually attempted to modify it. Most important, looking at the Medicaid expansion in terms of state versus federal costs is quite misleading. It will be the same taxpayers paying the bill. Does it really matter to the taxpayer whether it's state or federal money? The end result to Floridians will be the same: increased costs, more taxes, slower growth and another step for the nation toward becoming an entitlement state.

The economics of the Medicaid expansion are bad, but the health care involved for the underserved is even worse. Medicaid is beleaguered by bureaucracy, fraud, rising expenditures, restricted access and compromised patient care. As costs swell, policy makers have little choice but to try to constrain costs by paying providers less and less. Uncompetitive reimbursements jeopardize the access of beneficiaries to timely, high quality medical care. The Medicaid expansion will not rectify these problems. To the contrary, what Medicaid expansion would really expand is these problems, which will affect more patients. Moreover, by applying further strain to an already strained system, expansion could very well worsen the quality of the care that current Medicaid patients receive.

The James Madison Institute recommended practical reforms in a 2014 Policy Brief, and the concepts behind our recommendations are still valid. Florida has made some strides, but there is more to do. We need to address why we have such a shortage of physicians in this state, and why so many leave Florida after graduating medical school. Medical malpractice reform is a good first step. Florida's legal climate is consistently ranked as one of the worst in the U.S., and medical malpractice rates are astronomical because of frivolous lawsuits. Further, while we embrace groundbreaking technologies in the operating room, we need to be more open to addressing the same advancements in areas such as telemedicine, which can revolutionize care to underserved communities. We also must address the obscene complexities in the cost structure of care delivery and bring more transparency to the industry.

Inevitably, discussion of real reforms will run up against the power of entrenched interests whose financial ties are vested in the status quo, but make no mistake, real reform is what's needed. Doubling down on the flaws of the Medicaid program is a risky proposition for the state of Florida, but solutions do exist at both the state and federal level that can improve the health care of the underinsured and uninsured in Florida. As Florida debates ways to improve care for the uninsured and underinsured, it is very important to grasp the problems that currently plague the Medicaid program. These flaws are not mere peripheral trivialities. Rather, they are deeply rooted at the core of the Medicaid statute. They cannot be rectified without comprehensive Medicaid reform, and they are too grave a burden to impose on more people. As the Affordable Care Act rolls out, in many ways, not only our health care system but our country, stands at the precipice. The stakes could not be higher and these are definitely principles that are worth the effort.

Jason D. Fodeman, M.D. is an Assistant Professor of Medicine at the University of Arizona. He specializes in health care policy and is currently studying for his MBA.

House can't support Senate plan, or count on fed money

By: Jason Brodeur & Matt Caldwell

The Florida House of Representatives unequivocally believes in the noble goal of ensuring every Floridian has affordable and quality health care.

We are a compassionate state and nation that ensures lifesaving care is available to everyone. Thanks to the federal Emergency Medical Treatment and Labor Act (EMTALA) signed by Ronald Reagan, no one can be denied hospital emergency care. However, we all know that using emergency rooms for primary care wastes money.

Chief among the proposed solutions to this waste is the federal government's plan to expand Medicaid. Traditional Medicaid is a joint federal-state program for low-income people with federally imposed benefits and defined coverage groups. In Florida, Medicaid is 31 percent of the state budget, or $23.3 billion per year for 3.74 million people. That's roughly $6,500 per enrollee. Medicaid expansion would add more enrollees with the federal government picking up 90 percent of the cost.

However, there is no guarantee those funds will continue past this decade. With its continuing reckless budgets, spending initiatives and unsustainable entitlements will likely be the first in line for cuts when Congress finally makes the hard choices. This is just too risky for Florida. Today, even a 1 percent shift in the match would cost Floridians about $180 million every single year.

We know from experience that federal partnerships can be unreliable. They committed to pay 50 percent of Everglades Restoration and 40 percent of Special Education (Individuals with Disabilities Education Act), but in both cases have met less than half of that promise. The money we do receive comes with strings, making these funds far from "free."

More important, we know Medicaid doesn't serve patients well. Researchers in Oregon conducted the only scientific study of Medicaid in the country. The study found that Medicaid coverage had no statistically significant effect on clinical health, compared to those without Medicaid. In short, Medicaid patients were no better off than the uninsured.

The University of Virginia also studied 893,658 major surgeries over a 5-year period and compared the clinical outcomes, accounting for all factors except coverage type. They found that Medicaid patients were 93 percent more likely to die before leaving the hospital than patients with private insurance, while uninsured patients were 73 percent more likely to die than patients with private insurance. In short, Medicaid patients were worse off than the uninsured.

The Florida Senate has proposed a plan to expand coverage using (promised) federal dollars; one they call market-based. Sadly, it is pure, plain old Medicaid expansion. It's the same Medicaid expansion group mandated by Obamacare. It uses the same federal dollars. And it provides the same Medicaid services.

The Senate plan is unrealistic. While this proposal may contain a few creative, free-market elements, the federal government will not approve them. Other states have already asked for federal approval of these ideas, and they were denied. This gambles with people's lives. If the plan is not approved within six months, those people will see their coverage terminated, making the state as unreliable and unpredictable as the federal government.

The Florida Senate wants to expand a government program proven not to work, with money that taxpayers don't (or won't) have, to people that may not be eligible in six months, contingent upon a federal waiver that is unlikely to be approved. Yet, some people can't believe that the Florida House thinks this is a bad idea.

This session, the House proposed several bills that encourage transparency and consumer choice. They include ideas that encourage direct primary care models, assist state employees to be better informed about their health care options, and give more regulatory freedom to lower-cost health care providers like ambulatory surgical centers and recovery care centers. We passed healthcare workforce reforms in 2014, designed to increase access to needed care, which the Senate declined to pass. Before that, we passed an alternative coverage plan in 2013 that the Senate refused to even debate.

Expanding Medicaid is too risky for Florida and it doesn't provide better outcomes for those who are currently uninsured. We want everyone to have access to high quality health care, but expanding the federal Medicaid program is not the answer.

Rep. Matt Caldwell, R-North Fort Myers, represents District 79. Also contributing were Ray Rodrigues, R-Estero; Dane Eagle, R-Cape Coral; Rep. Heather Fitzenhagen, R-Fort Myers; Rep. Jason Broduer, R-Sanford, Chair of Health & Human Services Committee in the House.

Medicaid Expansion Numbers Don't Add Up

By Tom Jackson

Whenever talk turns to expanding Medicaid in Florida, one number that instantly surfaces is 800,000. That's about how many working-class adults would qualify for coverage.

Also prominent: 51 billion. That's the number of dollars, over 10 years, the feds would cough up to cover the aforementioned 800,000.

And, finally, there's zero. That's what the Legislature would have to appropriate in the first three years of the expansion era. After that — under current law — Washington's role would shrink incrementally each year until it reached 90 percent, with state taxpayers shouldering the other 10.

When you put it that way, what's not to like?

No wonder Gov. Rick Scott, who is otherwise preternaturally opposed to every aspect of Obamacare, has been on both sides of Medicaid expansion so often he could be skiing a slalom course.

But here's a number that's almost never mentioned: 536 million. According to an August 2014 report by the Robert Wood Johnson Foundation, that's how many dollars annually, averaged over the first 10 years, Florida will have to pony up for its portion of expansion.

Of course, given the federal government's early generosity, the pain doesn't kick in until later. Remember, the first three years are free, making Medicaid expansion pushers eerily similar to schoolyard drug dealers eager to hook new clients. Toss the gratis introductory period, however, and Florida's eventual 10 percent responsibility becomes more like $1 billion a year. Forever.

That's a minimum $1 billion less, annually, for education or transportation or hurricane shelters or reservoirs or flood control or services to the elderly. Or it's a permanent $1 billion tax increase. Or some combination of the two: spending cuts and a tax increase. It would be like Florida became Illinois.

And that's assuming Washington kept its bargain, which is no sure thing. President Obama likes boasting he's cut the annual budget deficit by more than two-thirds, which is commendable, even if the credit resides elsewhere (sequester cuts and Federal Reserve easy money policies). But where we are, with deficits running roughly $470 billion, is about as good as the Congressional Budget Office says it's going to get. Absent unanticipated economic growth and/or fundamental adjustments to Washington's financial plans, the CBO forecasts a 2018 deficit of $540 billion, with annual increases until it tops $1 trillion in 2025.

What this means, for openers, is a favorite argument of expansion proponents — Washington would simply be rerouting money sent north by Florida taxpayers — couldn't be more wrong. Every dime of Florida's $51 billion would be borrowed.

So, when some future Congress and some future president decide they have to mop up all that red ink, we shouldn't be astonished if the forecasts of opponents — ballooning costs for every Medicaid-expansion state — materialize.

Expanding Medicaid sets a ticking time bomb in the heart of every state's budget, which is reason enough to be wary. And that's not even getting into a CBO report from 2014 that found expansion "on balance, reduce[s] incentives to work," encouraging able-bodied (mostly) younger adults to drop out of the workforce, increasing their reliance on other forms of government support. Or the studies, in Virginia and Oregon, that suggest hospitalized Medicaid patients suffer worse outcomes than even those without insurance.

Nonetheless, Florida Senate Republicans are promoting furiously a hybrid plan they say embraces cost-curbing market forces and personal responsibility, encouraged by medical industry leaders whose waterfall of tax dollars depends on a collapse by no-we-won't state House GOP leaders. Because, you know, the first three years are free.

And after that, you're owned.

Lessons from Arkansas: Alabama Should Reject Medicaid Expansion

By Senator Bryan King and Katherine G. Robertson

In 2013, Arkansas's then-Governor Mike Beebe (D) pushed a non-traditional Medicaid expansion program that gives low-income individuals subsidies to use toward private coverage, rather than enrolling them into Medicaid. This initiative was marketed as a "state-based" plan for reform and one that inserts flexibility and innovation into expansion as outlined under the Affordable Care Act (ACA).

While nearly all Republican governors took a firm stand against traditional expansion, some now perceive Arkansas's model as a means to get their hands on federal money while distancing themselves from the ACA. Unfortunately, as Arkansas can now attest, Medicaid expansion remains a bad deal for states and cannot truthfully be sold as a fiscally prudent or free market idea.

When you get beyond the rhetoric, Arkansas's expansion has been a disaster. There are (at least) five lessons from Arkansas that Alabama's leaders should bear in mind as they consider expansion:

1. Describing expansion through waivers as state-based, flexible, or innovative is misleading. Arkansas's model is a far cry from a block grant and the few concessions offered from Washington are mere window dressing. No state has been granted the work requirements that were promised ad nauseam by governors. No state has been able to assign any meaningful cost-sharing requirements to beneficiaries. And no state has successfully negotiated any eligibility threshold that is more limited than that of the ACA. Additionally, any state-initiated waiver agreed to by the federal government is time-limited, whereas expansion itself goes on forever.

2. Expansion provides a disincentive to work. The population of newly-eligible Medicaid recipients is largely made up of those who ought to be in the workforce and states can't do anything to change that. Estimates for Alabama show that over 75% of the newly-eligible would be able-bodied adults with no dependents. Furthermore, states that have expanded Medicaid inevitably create a welfare cliff for these individuals. For those on the cusp of the 138% poverty threshold, earning only a few more dollars a year in income kicks them out of Medicaid and into the ACA's exchange plans that subject them to potentially thousands of dollars more in out of pocket costs.

3. States that expand Medicaid allow thousands of non-disabled, childless adults into the program which puts at risk the Medicaid safety net for truly vulnerable patients and families. States like Arkansas and Alabama already struggle to serve their Medicaid populations. With expansion, the poor and disabled who truly need this healthcare--those who Medicaid was created to

serve--will be competing with those who are able-bodied and without dependent children for the time and attention of the state's limited number of providers.

4. Much like traditional expansion, the private option is driven neither by fiscal responsibility nor free markets. The Government Accountability Office reported that Arkansas's private option expansion will cost nearly $1 billion more than traditional expansion. Following implementation, Arkansas's spending was over budget every month for the whole first year until the federal reimbursement cap was raised. This affirms that the Obama administration will recklessly agree to spend whatever it takes to pressure states into expansion. Again, this is because the federal government-not the state-maintains the real control, and the strict parameters agreed to leave very little room for free market competition. Furthermore, there is zero cost-sharing required for enrollees below the poverty line. While the state is now implementing an optional cost-sharing program for some enrollees, the federal government will not allow non-payers to be disenrolled from the program.

5. Expansion imposes a substantial cost to the state, despite the federal government's guarantee. Medicaid spending already consumes 35% of Alabama's General Fund. Medicaid costs continue to increase year after year, inevitably siphoning resources away from other budget priorities (the same is true for federal budget priorities like defense spending). Expansion is not a solution to this problem. While the federal government agrees to pay 100% of the cost of expansion for the first few years, this reimbursement tapers off to 90% in 2020. The 10% price tag alone represents millions of dollars, but does not even include the added administrative costs that the state will immediately incur if Medicaid is expanded. To further complicate matters, Congress is already moving to cut the enhanced match for expansion so, in reality, the total cost to the state is immeasurable.

Medicaid expansion was bad for Arkansas and there is no reason to believe that Alabama's experience would be any different. Alabama's conservative legislators should learn from Arkansas's mistake and commit to saving their state from a similar disaster.

Bryan King is a member of the Arkansas Senate and represents the 5th District. Katherine Robertson serves as Vice President for the Alabama Policy Institute, an independent non-partisan, non-profit research and education organization dedicated to the preservation of free markets, limited government and strong families.

Obama Administration Tells Texas It Could Play Medicaid Hardball There, Too

The Centers for Medicare and Medicaid Services holds a call with Lone Star State officials, as the drama in Florida heats up.

By Dylan Scott

The Obama administration looks to be taking its Medicaid hardball tactics to Texas.

The Centers for Medicare and Medicaid Services indicated to Texas officials Thursday that whether the state expands Medicaid under the Affordable Care Act would factor into the renewal of a multibillion-dollar Medicaid funding stream next year, according to state officials.

Federal officials requested a call with the Texas Health and Human Services Commission, during which they outlined their position, Linda Edwards Gockel, a spokeswoman for the Texas health agency, said in an email to *National Journal*.

The call came the same day that Florida Gov. Rick Scott said he would sue the Obama administration, accusing CMS of pushing the state to expand Medicaid by leveraging $1 billion in federal Medicaid funding, which is up for renewal this summer and helps cover some uncompensated care.

CMS said in a letter to Florida this week that one of the three principles it would use to evaluate the program, known as the Low-Income Pool, was that "uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion."

In the phone call with Texas officials, "CMS said they recognize each state is different, but they intend to use the same three principles outlined in their letter to Florida as they evaluate uncompensated care funding pools in all states," Edwards Gockel said. "We don't have more details than that at this point."

A CMS spokesman confirmed that the agency would use the principles outlined in the Florida letter, which include a state's Medicaid expansion status, when reviewing uncompensated-care funding pools in other states like Texas.

"We will also use these principles in considering similar proposals in other states," CMS spokesman Aaron Albright said in an email, "but discussions with each state will also take into account state specific circumstances." Texas's uncompensated-care funding pool, part of a broader Medicaid waiver, is coming up for renewal in September 2016. According to the Texas Hospital Association, the program provides more than $3 billion to Texas hospitals for uncompensated care.

The Lone Star State is the biggest state not to expand Medicaid under Obamacare; about 950,000 low-income Texans would receive health coverage if the state did accept the expansion.

Congress of the United States
Washington, DC 20515

April 14, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
201 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Dear Acting Administrator Slavitt:

Over the past three months, Florida has been working with the Centers for Medicare and Medicaid Services (CMS) to determine the future of the Low Income Pool (LIP) in order to prevent disruption of access to quality health care for low income individuals in the State of Florida. Currently, the LIP includes approximately $2.1 billion in annual funding. These dollars, among other things, allow local governments to make investments in their own health care delivery systems, fund hospitals for providing services to the current Medicaid population, fund the faculties at Florida's medical schools for services provided to the current Medicaid population, and offset losses providers incur from rendering services to uninsured and underinsured Floridians. The LIP program, however, is in many ways separate and apart from any decision to expand Medicaid as envisioned under the Affordable Care Act.

Uncompensated care will still exist in Florida with or without the expansion of Medicaid, and thus it is important to continue the LIP so that the federal government and Florida continue to support providers who serve this ongoing uninsured population.

Time is of the essence. Florida's House of Representatives and Senate must propose, negotiate, and finalize the state's budget by the second half of April 2015. CMS therefore must agree in principle on the LIP in the first half of April 2015. This agreement in principle need only express the total dollar value of the LIP going forward, along with any general parameters around the flow of the funds.

CMS has stated that it will not provide LIP funds to pay for costs associated with uninsured Floridians who would become insured if the state expanded the Medicaid program.

Florida has sought out independent studies that estimate the amount of uninsured costs that would remain in the state even if Florida were to expand its Medicaid program. In a report from 2012, the Urban Institute, in conjunction with the Robert Wood Johnson Foundation, estimated that **Florida would still have nearly $1.6 billion in costs related to uncompensated care even after it expanded its Medicaid program.** This $1.6 billion dollar figure is particularly reliable, in that it comes from an independent source and predates the current negotiations.

Additionally, the LIP currently includes incentives of over $400 million annually that are fully independent of any political decision around Medicaid expansion. These funds

support Florida's medical schools, county health departments, local health centers, and poison control initiatives.

CMS should not destabilize, eliminate, or hold these programs hostage to an expansion decision. Continuing LIP, at approximately the current level of funding, would treat Florida equally with other states, like California, that have both expanded Medicaid and continue to receive uncompensated care funds for their remaining uninsured populations. Florida strongly believes $1.6 billion in remaining uncompensated care, coupled with the over $400 million in support of the medical schools and other providers, should be the basis of a renewed LIP.

Florida is willing to address other concerns expressed by CMS during the current LIP discussions, such as streamlining and refining the rate of return local governments receive for participation and tweaking the funds' distribution to more closely follow the patient.

Florida is asking CMS to treat the state consistently with other states that have expanded, like California, and to support health care providers in the state that provide services to people who would remain uninsured even if Florida Medicaid expanded. Florida is also asking CMS to continue to support institutions and initiatives, like medical schools, that are critical to Florida's health care system and that have nothing to do with the expansion decision.

As members of the Florida Congressional delegation, we ask that you strongly support Florida's efforts in this regard, and urge CMS to agree in principle to continue LIP funding near the current level of funding prior to mid-April.

Sincerely,

Ted S. Yoho, D.V.M.
Member of Congress

Marco Rubio
United States Senate

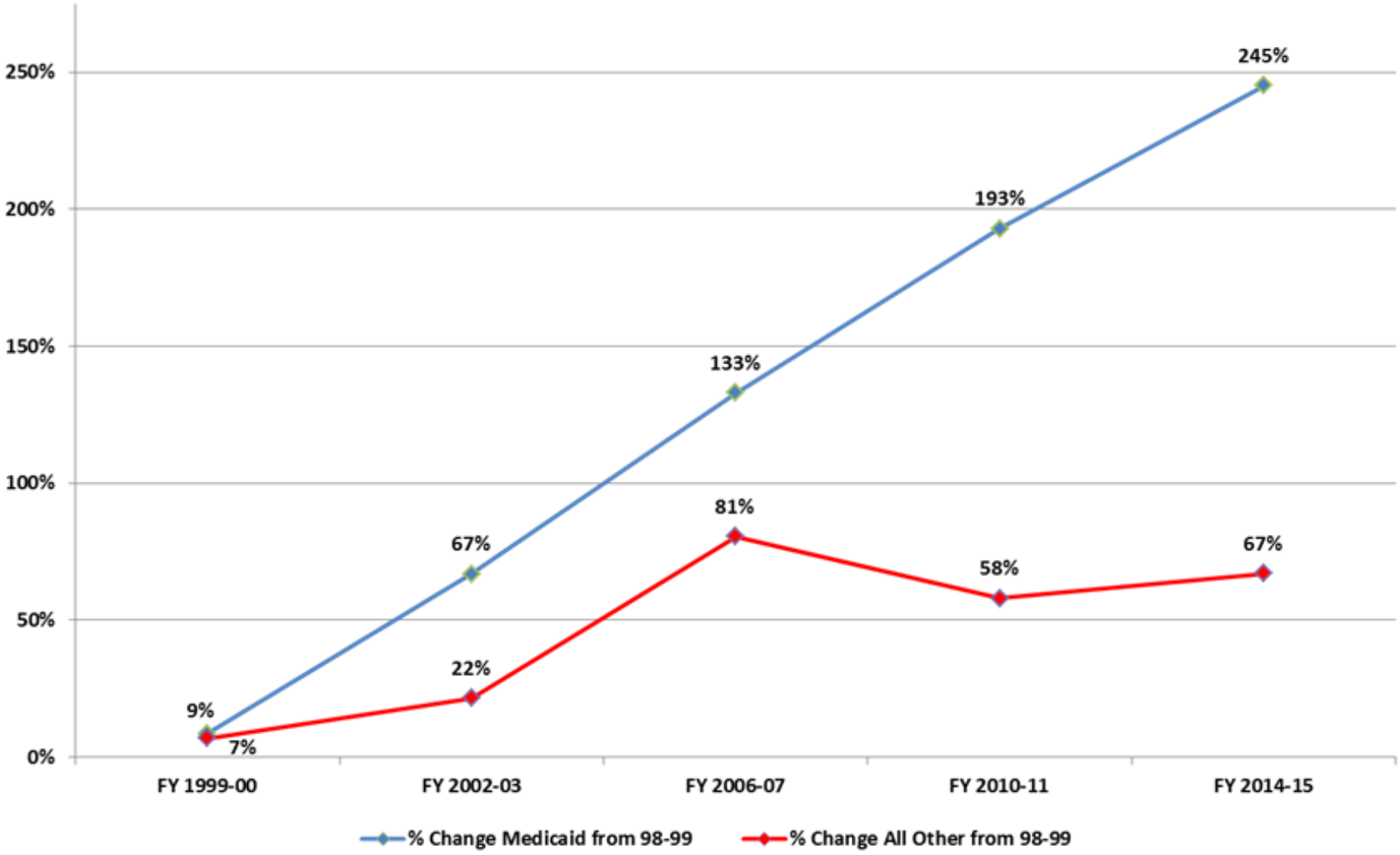
Gus Bilirakis
Member of Congress

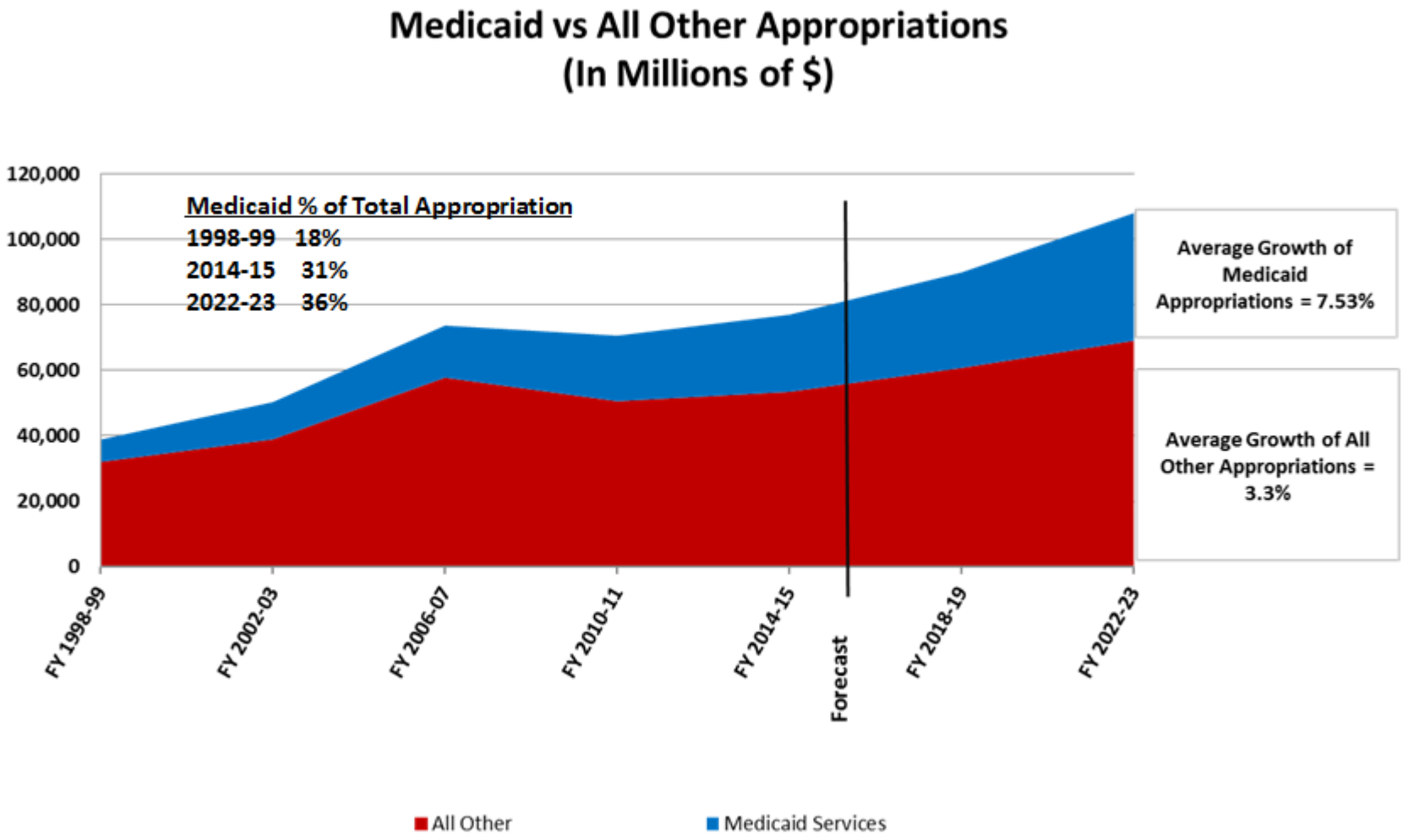
Ileana Ros-Lehtinen
Member of Congress

Richard Nugent
Member of Congress

Curt Clawson
Member of Congress

Percent Change in Medicaid Services and All Other Appropriations Since FY 1998-99




Medicaid vs All Other Appropriations
(In Millions of $)
120,000
100,000
80,000
60,000
40,000
20,000
0
Medicaid % of Total Appropriation
1998-99 18%
2014-15 31%
2022-23 36%
FY 1998-99
FY 2002-03
FY 2006-07
FY 2010-11
FY 2014-15
Forecast
FY 2018-19
FY 2022-23
Average Growth of Medicaid Appropriations = 7.53%
Average Growth of All Other Appropriations = 3.3%
All Other
Medicaid Services

Total FY 2014-15 Budget Compared to FY 2006-07 Budget
(Millions of Dollars)