

The Final Days of Federalism?

Ten Reasons Why Ohio and Other States Must Not Expand Medicaid or Create Exchanges — And a Fiscally Responsible Alternative —

March 30, 2013

*CL Gray, MD
Physicians for Reform*

Abstract

A political prisoner's dilemma now pressures state governments to do what Washington cannot do by itself—implement the Affordable Care Act (ACA). In order to secure federal funding, many governors and state legislatures believe they must expand Medicaid, but to do so ends in bankruptcy for all.

Driven by a quest to garner federal dollars, over the past 20 years Medicaid spending has expanded to consume state budgets. Yet, in spite of spending more than \$407 billion annually,ⁱ Medicaid currently yields worse patient outcomes than every other form of American healthcare coverage. Medicaid expansion generates dollars for states, not quality care for patients.

However, this growing dependency on federal funding fundamentally changes the balance of power between Washington and the states. Even more, it threatens the very foundations of federalism. When state budgets rely on federal funding, Washington wields control far beyond the Constitution's enumerated powers. This dynamic may even serve to usher in a federally run, single payer healthcare system.

To expand Medicaid states will rely on an “enhanced” FMAP (Federal Matching Assistance Percentage) making them vulnerable. Should Washington reduce the FMAP, states will not be able to support their expanded programs. To off-load this expense, states may be compelled to transfer Medicaid to the federal government. When cost shifting drives private insurers out of business, President Obama will achieve his stated goal—a single payer system.

Physicians for Reform, a patient / physician / business advocacy non-profit, strongly recommends rejecting both the creation of state exchanges and the expansion of Medicaid in favor of a more efficient, fiscally responsible model outlined in this paper.

To preserve their role envisioned by our Founding Fathers, states must work together to secure Medicaid block grants from Washington. This approach gives states long-term control of their budgets. Even more, it gives them the incentive and ability to craft leaner, more efficient Medicaid programs and let them achieve better patient outcomes at lower cost.

This paper details ten reasons why states should not expand Medicaid or create state based exchanges. It then offers an alternative solution.

1. Medicaid produces bad patient outcomes.
2. The ACA will leave many presently insured patients without insurance.
3. Medicaid expansion will include a significant number of previously insured patients.
4. Having Medicaid does not equal having access to a physician.
5. Medicaid expansion will cost Ohio taxpayers \$3.1 billion through 2022.
6. Medicaid expansion will crowd out spending on other state priorities such as education and transportation.
7. Medicaid expansion will produce economic burden, not recovery.
8. Medicaid and social welfare programs condemn Americans to a life of poverty.
9. Medicaid expansion and state exchanges pave the way for a federally run single payer system.
10. The forces pushing Medicaid expansion threaten America's federalist system of government.

1) Medicaid Produces Bad Patient Outcomes

Medicaid provides the worst healthcare outcomes compared to every other form of insurance in America. While *Physicians for Reform* seeks to extend healthcare coverage to those without insurance, adding patients to the program with by far the worst patient outcomes is the worst possible way to approach the problem.

A Government Accountability Office report revealed that children on Medicaid have worse access to physicians than children with no insurance at all.ⁱⁱ Scott Gottlieb of the American Enterprise Institute cites several other major studies in his *Wall Street Journal* article, "Medicaid Is Worse Than No Coverage at All":

- *Head and neck cancer*: A 2010 study of 1,231 patients with cancer of the throat, published in the medical journal *Cancer*, found that Medicaid patients and people lacking any health insurance were both 50% more likely to die when compared with privately insured patients—even after adjusting for factors that influence cancer outcomes. Medicaid patients were 80% more likely than those with private insurance to have tumors that spread to at least one lymph node. Recent studies show similar outcomes for breast and colon cancer.

- *Major surgical procedures*: A 2010 study of 893,658 major surgical operations performed between 2003 to 2007, published in the *Annals of Surgery*, found that being on Medicaid was associated with the longest length of stay, the most total hospital costs, and the highest risk of death. Medicaid patients were almost twice as likely to die in the hospital than those with private insurance. By comparison, uninsured patients were about 25% less likely than those with Medicaid to have an "in-hospital death." Another recent study found similar outcomes for Medicaid patients undergoing trauma surgery.

- *Poor outcomes after heart procedures:* A 2011 study of 13,573 patients, published in the American Journal of Cardiology, found that people with Medicaid who underwent coronary angioplasty (a procedure to open clogged heart arteries) were 59% more likely to have "major adverse cardiac events," such as strokes and heart attacks, compared with privately insured patients. Medicaid patients were also more than twice as likely to have a major, subsequent heart attack after angioplasty as were patients who didn't have any health insurance at all.

- *Lung transplants:* A 2011 study of 11,385 patients undergoing lung transplants for pulmonary diseases, published in the Journal of Heart and Lung Transplantation, found that Medicaid patients were 8.1% less likely to survive 10 years after the surgery than their privately insured and uninsured counterparts. Medicaid insurance status was a significant, independent predictor of death after three years—even after controlling for other clinical factors that could increase someone's risk of poor outcomes.ⁱⁱⁱ

2) The Affordable Care Act will Leave Many Presently Insured Americans Without Insurance

Current federal law sets up a cycle that is forcing businesses to drop healthcare coverage for presently insured patients:

- The penalties of the Affordable Care Act may force businesses such as Darden Restaurants^{iv, v}, Taco Bell, Kentucky Fried Chicken^{vi}, Applebee's,

Jimmy Johns,^{vii} the giant theme-park resort, Universal Orlando,^{viii} and others to shed full-time employees or drop healthcare coverage for part-time workers. Not only does this cause the inefficiency of increased employee turnover, many of these previously insured employees will fall into the expanded Medicaid system.

- Medicaid reimburses hospitals approximately 86 percent of the actual cost of delivering care (this number varies from state to state).^{ix} Physicians are reimbursed even less. This under-reimbursement shifts costs to patients with traditional insurance. Avik Roy of the Manhattan Institute explained in "How Ohio's Medicaid Expansion Will Increase Health Insurance Premiums for Everyone Else":

"In 2008, Milliman, the leading insurance consulting firm, estimated that the average American family with private health insurance paid \$1,800 extra, because of Medicaid and Medicare's underpayments to providers. With the number of people on government-subsidized insurance set to double, cost-shifting is destined to go up."^x

- Insurance rates will necessarily rise forcing even more business owners to drop private insurance for their employees.

- As employers drop coverage, more young, healthy Americans will not purchase insurance. They know insurers are now forced to accept them even with a pre-existing condition should they develop one.

- When healthy Americans exit the insurance market, a higher percentage of at risk or chronically ill patients remain. This drives insurance costs even higher and the cycle begins anew.

We see the devastating impact of this cycle reflected in the Bureau of Labor Statistics February 2013 jobs report. Underneath the headlined .2 percent decline in unemployment, the data appeared far more worrisome.

During February 2013, the working age population grew by 165,000, yet 130,000 people dropped out of the labor force. Even more, the number of full-time workers fell by 212,000. We saw a “drop in unemployment” because the number of part-time employment rose by 382,000.^{xi}

The Bureau of Labor Statistics does not discriminate between full-time and part-time employment when calculating the unemployment rate. This hides the clear shift from full-time to part-time employment, exactly the shift we would anticipate given the business penalties of the ACA. Expanding Medicaid will only accelerate this process.

3) Medicaid Expansion will Include Previously Insured, Not Just the Uninsured

Even before passage of the ACA, economists estimated the crowd-out rate from previous expansions of Medicaid stood at approximately 60 percent. This means that out of every 10 new Medicaid patients, six previously had private insurance.^{xii}

Because new forces now threaten to push even more patients out of the traditional insurance market into Medicaid, the next expansion of Medicaid may well have even higher crowd-out rates. This means a significant portion of the massive funding spent on “healthcare reform” will only displace those who already have insurance and place them on Medicaid—a program with demonstrably poor outcomes.

4) Having Medicaid Does Not Mean Having Access to a Physician

Approximately half of the uninsured gaining coverage under the Affordable Care Act do so through the expansion of Medicaid. However, having Medicaid does not even guarantee access to a physician. This is, in part, secondary to significant Medicaid under-reimbursement.

In 2008, Ohio Medicaid paid primary care physicians 53% of private insurance. For states with larger programs such as California and New York reimbursement was even lower, 38% and 29% respectively.^{xiii} Because physicians often lose money caring for patients on Medicaid, studies reveal diagnosis and treatment are delayed.

A study published in the New England Journal of Medicine found mothers seeking specialty care for their children covered by Medicaid / S-CHIP were denied appointments 66% of the time. Mothers of children with private insurance were denied only 11% of the time. Even when children covered by Medicaid / S-CHIP were accepted, they experienced more than double the wait

time, 42 days, rather than 20 days for children covered by private insurance.

A similar study evaluating access to a dentist revealed that children covered by Medicaid / S-CHIP were denied appointments 63.5% of the time; children covered by private insurance were rejected 4.6% of the time.^{xiv}

Even more, the expansion of government control over healthcare will drive physicians out of medicine altogether. A February 2012, non-partisan survey of 5,105 physicians found that:

- 60% believed the Affordable Care Act would negatively affect patient care.
- 24% believed they would very likely retire within the next five years because of the ACA.

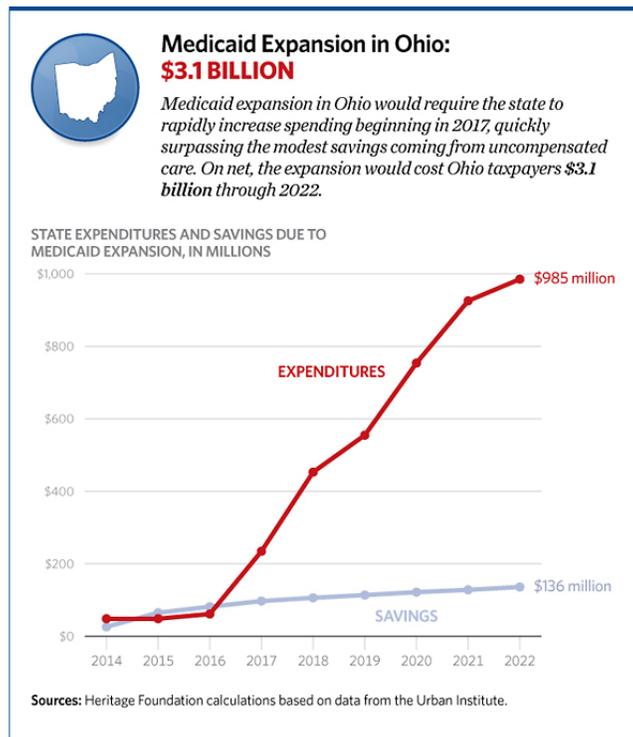
- 19% believed they would somewhat likely retire within the next five years because of the ACA.

- 90% of physicians were unwilling to recommend healthcare as a profession.^{xv}

The hospital industry's support for the ACA and for Medicaid expansion is shortsighted. Hospitals may soon find themselves without physician staff.

5) Medicaid Expansion will Cost States Billions of Dollars

Using data from the Urban Institute, the Heritage Foundation calculated Medicaid savings vs. expenditures through 2022 for all 50 states. Beginning in 2017, expenditures far outpace savings resulting in a net cost of billions of dollars for individual states. The analysis for Ohio is shown below.^{xvi}



6) Medicaid Expansion Compromises State Spending on Other Priorities

The prospect of federal funding tempts states to expand Medicaid far beyond their original intent. According to a 2011 Congressional report, Medicaid expansion will cost states at least \$118 billion over the next decade.^{xvii}

Washington promised to cover 100% of the initial cost of the expanded program; this falls to 90% by 2020. However, this only covers *newly eligible* patients and there is no guarantee these higher rates will continue. In fact, President Obama signaled his intent to cut these rates by proposing a \$100 billion cut to federal Medicaid spending over the next decade.^{xviii}

Once Medicaid is expanded, history teaches us that it never contracts. When Washington reduces its percentage of

matching funds, states will be exposed to the tremendous financial liability of an over-expanded program, a liability they have no margin to cover.

Physicians for Reform analyzed the budgets of fourteen states (California, Colorado, Florida, Georgia, Iowa, Nebraska, New York, North Carolina, Ohio, Pennsylvania, Texas, West Virginia, Virginia, and Wisconsin). The data from each state tells the same story. Medicaid consumes state budgets and crowds out spending on other priority items such as education and transportation.

While intended to “help” states, the federal matching system produced disproportionate Medicaid growth. By adjusting the data for inflation and population growth, the table below clearly demonstrates the real growth of state spending per Ohio resident.

Ohio State Per Capita Spending

	1989	2009	Growth	Growth Rate
Total State Expenditures	\$3,124	\$5,010	\$1,886	60%
Medicaid	\$358	\$1,217	\$860	240%
Elem & Secondary Edu	\$629	\$1,087	\$458	73%
Higher Education	\$247	\$261	\$14	6%
Transportation	\$204	\$366	\$162	80%
Corrections	\$93	\$170	\$78	84%
Cash Assistance	\$213	\$110	-\$103	-48%
Other	\$1,342	\$1,799	\$457	34%

Sources:
The National Association of State Budget Officers --- State Expenditure Reports between 1989 and 2009.
U.S. Census Bureau Data --- 1990 and 2010 Censuses.
All dollars are reported as per capita, inflation adjusted 2009 dollars.

For Ohio, inflation-adjusted, per capita Medicaid spending increased 240 percent over these two decades. This tripled the rate of increase in spending on elementary education and transportation; Medicaid spending rose an astonishing 40 times faster than the rate of increase in spending on higher education.

7) Expanding Medicaid Will Produce Economic Burden, Not Economic Recovery

Some argue expanding Medicaid will create tens of thousands of jobs in each state that adopts the expansion. However, writing for Forbes, Chris Conover comes to a quite different conclusion regarding this economic impact:

“Every additional dollar of new taxes shrinks the economy. Virtually anything we tax we get less of, whether that be labor, consumption, or savings. Based on dozens of studies of this so-called ‘deadweight loss’ or ‘excess burden’ that inevitably accompanies higher taxes, I have calculated that currently every added dollar of federal taxes essentially shrinks the economy by 44 cents. Thus, if we convert this to jobs, we will lose 144 jobs for every 100 health sector-related jobs that are induced by expansion.

“Technically, it’s worse than this. On average, health sector jobs pay more than other jobs in the rest of the economy. Thus, we will lose even more than 144 jobs for each 100 health-sector-related jobs.”^{xxix}

However, even if we accept expanding Medicaid will create new jobs (without considering its impact on the private sector or growing federal debt), this signals increased inefficiency and economic burden, not economic growth.

For example, according to a 2009 Medical Group Management Association report, the average physician office requires 4.43 support staff for every provider. That number rises to 5.24 staff per physician for “better performers.”^{xxx} The billing and administrative burdens of Medicare, Medicaid, and traditional insurance drive much of this need for excessive staffing.

By dropping all third party payers, a North Carolina physician (Brian Forrest, MD) reduced this ratio to 1.0 support staff per working physician. Running a direct pay / low overhead practice enables Dr. Forrest to spend more time with patients and achieve better outcomes at a fraction of the cost of a traditional practice. If a physician office can triple its efficiency by ridding itself of the billing, collections, and administrative overhead of third-party payers, this provides a target ripe for reform.^{xxxi}

What were the primary reasons for Dr. Forrest’s increased efficiency? His model eliminates unnecessary overhead and restores free-market forces. Patients know precisely how much a given visit or test will cost before seeking care; posting all prices on the web site and in the waiting room provides 100 percent transparency. The fact patients pay for his service incentivizes high quality care and gives patients some ownership of their healthcare decision-making. This

represents free-market forces working at their best.^{xxii}

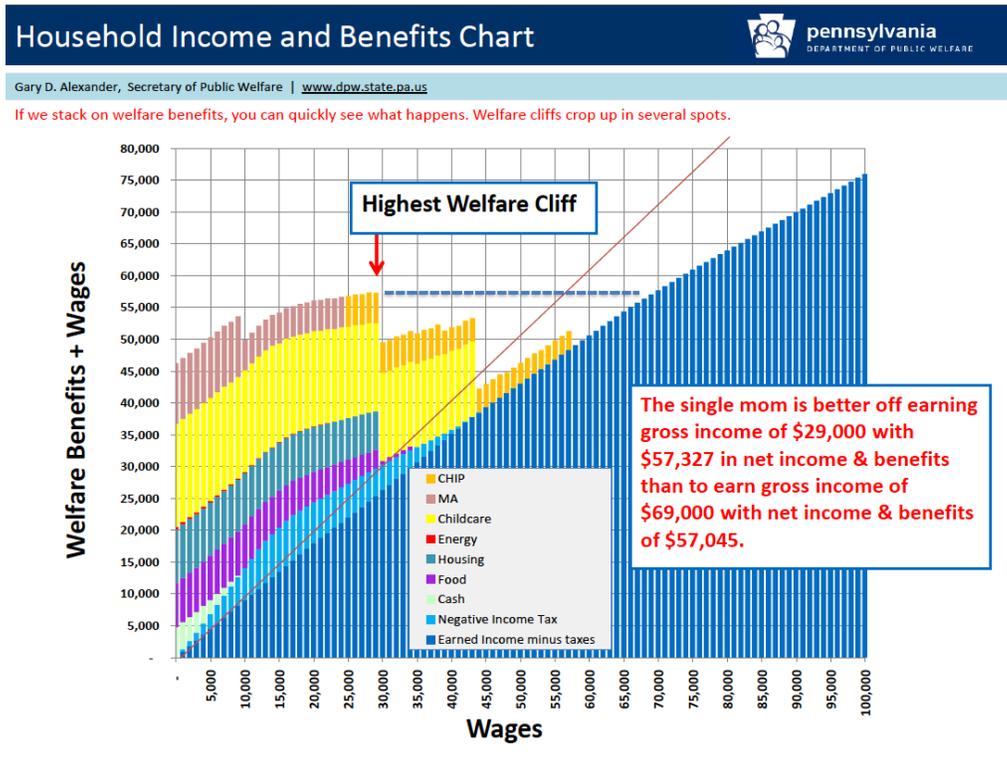
Based on Wake County data, Dr. Forrest carries three times more patients on Medicaid than his peers. Because Dr. Forrest does not bill Medicaid for his services, his Medicaid patients must pay the entire bill themselves. The fact these patients still choose to pay out-of-pocket to see Dr. Forrest, even though they could receive “free” healthcare at another clinic, speaks volumes regarding the degree of dysfunction in Medicaid.

True healthcare reform will produce increased efficiency, not expand inefficiency and call it job creation.

8) Medicaid Condemns Americans to a Life of Poverty

Rather than showing true compassion, our current entitlement state traps too many Americans in a life of poverty. Expanding Medicaid will only ensnare more people in this life of dependency.

A recent chart released by the Pennsylvania Department of Public Welfare (below) demonstrates why it is so difficult for lower income Americans to achieve the American dream. The two sharp “welfare cliffs” at annual incomes of \$30,000 and \$43,000 not only give little incentive to work harder, they create a marked disincentive to climb the economic ladder.

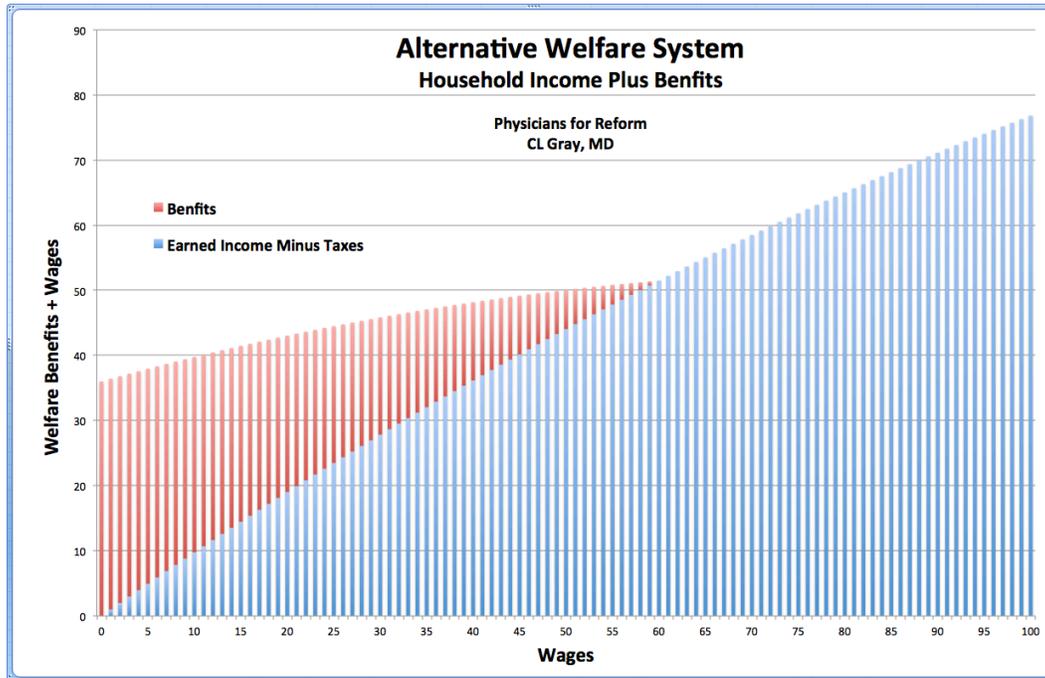


A single mom earning \$29,000 has a net income including social welfare benefits of \$57,327. If she goes back to school, gets a better job (or decides to work two

jobs), and earns \$69,000 her net income is \$57,045. Given this, there is no reason for her to work to change her situation.

We must fundamentally transform our social support system to help lower income Americans escape a life of poverty and dependence.

Physicians for Reform recommends our social support network be fundamentally redesigned to encourage education, advanced skill, and hard work.



9) State Exchanges Pave the Way for a Federally Run Single Payer System

For multiple reasons, the healthcare system set up under the Affordable Care Act is at risk of imploding within the next 3 to 5 years. In review:

- Medicaid’s poor outcomes and limited access to physicians will fuel public unrest as the program expands.
- Medicaid’s expansion will include many patients who currently have private insurance.
- Medicaid’s under-reimbursement of hospitals and physicians will lead to poorer quality of service, longer wait times, and more difficulty finding a physician.

- Washington’s reduction of the FMAP will saddle states with a growing share of Medicaid expenses causing state budgets to fail.
- Because of the Affordable Care Act, physicians will leave the practice of medicine.
- Expanding Medicaid’s inefficiencies will burden economic growth.

When the healthcare system begins to visibly melt down, the states—not Washington—will receive the political blame for not administering Medicaid and the state exchanges effectively. This will set the stage for Washington to move in with a single payer, federally run healthcare system.

President Obama is on record stating this is his ultimate goal. In an address to the AFL-CIO he said, “I happen to be a proponent of a single payer, universal healthcare plan... but as all of you know we may not get there immediately.”^{xxiii}

He explained this transition in more detail at an SEIU Health Care Forum, “My commitment is to make sure that we’ve got universal healthcare for all Americans by the end of my first term as president.... But I don’t think we’re going to be able to eliminate employer coverage immediately. There is going to be potentially some transition process. I can envision a decade out, or fifteen years out, twenty years out...”^{xxiv}

Congressman Barney Frank stated this agenda even more explicitly, “I think if we get a good public option it could lead to single payer, and that is the best way to reach single payer.”^{xxv}

States should not set themselves up to serve as the fall guy. Even more, they should not shoulder the expense of laying the groundwork and infrastructure for a federally run, single payer system. Rather, they must act in concert to lead the nation back onto a path of fiscal sustainability.

10) Forces Behind the Expansion of Medicaid Threaten Our Nation’s Federalist System of Government

The Hospital Lobby

Hospitals around the country are aggressively lobbying state legislatures to expand Medicaid. However, Medicaid reimburses Ohio hospitals only 83 cents for every dollar they spend caring for

patients on Medicaid.^{xxvi} When hospitals routinely lose money caring for patients on Medicaid, the question is, why? Two forces are at work:

1) One answer is simple. Hospitals hope that an expanded program will force states to increase Medicaid reimbursement rates to near parity. However, given Washington is approaching \$17 trillion of debt and state budgets are strained to pay for their present Medicaid programs, this will almost certainly not happen.

2) A second reason is less obvious, but far more disturbing. It comes in the form of another federal program called Disproportionate Share Hospital (DSH) payments.

In 2011, Washington doled out \$11.3 billion in such payments to compensate hospitals caring for the uninsured. The Affordable Care Act cuts these payments by 75 percent on October 1, 2013, the beginning of the 2014 fiscal year.

Many hospitals will face significant financial shortfalls without these supplemental funds. To recover these losses, hospital associations now seek to expand Medicaid. If Medicaid is expanded, patients previously paid for with DSH money will then be covered with Medicaid funds.

Notice what happened:

- To administrate the ACA, Washington needed states to set up exchanges and expand Medicaid. Without state cooperation, the ACA lay dead in the water.

- A majority of states initially refused to take these steps.
- Washington withdrew billions of dollars of state funding (75 percent reduction of the DSH payments) offering to replace the money if states expanded Medicaid.
- To recapture the loss of DSH payments, hospitals aggressively lobbied state legislatures to take Washington’s deal.
- Facing budget shortfalls, many governors and state legislatures reversed course to recapture this money by implementing the very legislation they fought tooth and nail to defeat.

Essentially, Washington pulled money away with one hand while offering to

replace it with the other... only with more strings attached.

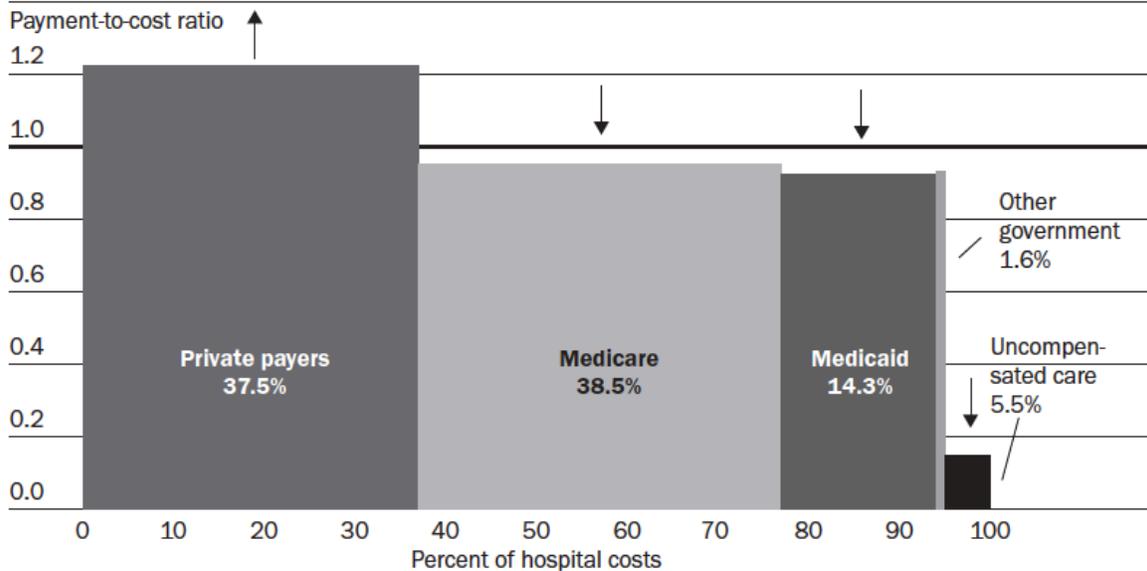
The Hydraulic Effect

A 2006 paper, “The Cost-Shift Payment Hydraulic”,^{xxvii} masterfully lays out how Medicare / Medicaid underpayment drives up the cost of private insurance. The chart below makes two points intuitively clear:

- 1) Decreasing Medicare or Medicaid reimbursement will drive up the cost of private insurance.
- 2) Expanding Medicaid while reducing patients with private insurance will drive up the cost of private insurance.

Both of these forces will be at work if states move forward with the expansion of Medicaid.

EXHIBIT 1
The Cost-Shift Payment Hydraulic, As Of 2002



SOURCE: Lewin Group analysis of data presented in Lewin Group, *Trendwatch Chartbook 2005: Trends Affecting Hospitals and Health Systems* (Washington: American Hospital Association, May 2005).

NOTE: The bold ruling line at 1.0 represents costs and payments in balance.

As you review the data below, bear in mind the primary source of profit keeping hospitals open comes from privately insured patients. Hospitals generally lose money caring for patients on Medicare and Medicaid. As the percentage of privately insured patients decreases, it becomes more and more difficult for hospitals to stay financially viable.

Comparing data from 2002 with data from 2011^{xxviii} we find that while Medicaid expanded, not only was there a rise in uncompensated care, the percentage of privately insured patients decreased:

	<u>2002</u>	<u>2011</u>
• Private Payer	37.5	34.6
• Medicare	38.5	39.3
• Medicaid	14.3	16.3
• Uncomp. Care	5.5	5.9

Under the ACA, Medicaid enrollment will expand by approximately 50 percent. In 2011, Medicaid accounted for 16.3 percent of hospital expenses. Under the expanded program, Medicaid will account for approximately 25 percent of total hospital expenses.

Using the afore mentioned crowd out estimate of 60 percent (see page four), the private payer percentage will drop below 30 percent.

	<u>2011</u>	<u>Post-Medicaid Expansion</u>
• Private Payer	34.6	29.4
• Medicare	39.3	39.3
• Medicaid	16.3	25
• Uncomp. Care	5.9	2.4

Many hospitals will not survive when the shrinking privately insured population is combined with Washington’s 75 percent cut to DSH payments. In pushing for Medicaid expansion, hospitals failed to account for the substantial crowd out effect of the Affordable Care Act.

In 2010, hospitals received 93 cents for every dollar they spent caring for patients on Medicaid; they received 92 cents for every dollar they spent caring for patients on Medicare.^{xxix} Soon there will simply not be enough privately insured patients to offset these losses. Small hospitals will close.

The States’ “Prisoner’s Dilemma”

Given our nation’s massive debt, the common sense solution is for every state to limit spending. However, Medicaid’s open-ended federal matching system encourages states to do precisely the opposite. States now seek to increase Medicaid spending in order to draw federal dollars. This creates the classic prisoner’s dilemma.¹

¹ The classic prisoner’s dilemma: Two men are in prison for committing a crime together. The police do not have enough evidence to convict either, but neither prisoner knows this. Each prisoner is then offered a reduced sentence for testifying against his partner, but threatened with a harsh sentence for remaining silent.

If neither man talks, both go free. However, when the uncertainty of not knowing if the other will talk is combined with the threat of a harsh sentence for remaining silent, each prisoner talks, so both men remain in prison.

The prospect of an enhanced FMAP for expanded Medicaid programs only accentuates this destructive force. Governor Kasich's February 4, 2013 letter to the Ohio General Assembly explicitly makes this point:

“Additionally, [expanding Medicaid] avoids leaving Ohioans' federal tax dollars on the table and keeps the federal government from simply giving them away to other states.”^{xxx}

Here we see Governor Kasich implementing a key portion of the Affordable Care Act (which he strongly opposed) in order to keep taxes paid by the residents of Ohio in Ohio. The importance of this cannot be overstated.

Washington used its power to distribute federal tax dollars (through Medicaid payments) to set up a prisoner's dilemma. In order to retain their state's portion of federal funding, governors adamantly opposed to the ACA agreed to create an essential portion of the infrastructure that Washington could not create on its own. In capitulating, these governors set the stage for a federally run, single payer system.

Once states expand Medicaid and set up exchanges, Washington can easily decrease the FMAP and gain control over the entire system. When states can no longer support the expanded program, they will have no choice but to turn Medicaid over to Washington.

Washington can then merge Medicaid with Medicare and federalize the entire system. When skyrocketing private insurance rates become uncompetitive, American healthcare will collapse into a single payer system.

In essence, Washington used tax revenue it collected from citizens of individual states to coerce those states into actions they strongly opposed. This violates the concept of enumerated federal powers and threatens the very foundations of divided government. Indeed, it may even mark the end of federalism.

When addressing the great 1788 federalist / anti-federalist debate at the New York Ratification Convention, Gilbert Livingston said:

“True it is, sir, there are some powers wanted, to make this glorious compact complete. But, sir, let us be cautious that we do not err more on the other hand, by giving power too profusely [to the federal government], when, perhaps, it will be too late to recall it.”

Finding a Better Way

Washington now borrows 42 cents for every dollar it spends. In 2011, interest on our debt was \$227 billion. This is expected to grow to \$1 trillion annually by 2020. Americans will soon pay more to serve interest on the national debt than they do for either Medicare or Medicaid.

At an HIS Global Insight forum, Erskine Bowles recently stated, “We'll be spending over \$1 trillion a year on interest by 2020. That's \$1 trillion we can't spend to educate our kids or replace our badly worn-out infrastructure.”^{xxxi}

Unless the current system of an unlimited federal match is fundamentally reformed, the explosive growth of Medicaid spending will continue

unabated. Yet, spending ever-more money is not enough. In spite of spending \$407 billion a year on Medicaid, these patients have worse outcomes than under any other form of insurance in America.

Because Washington refuses to control spending and remains unable to produce good patient outcomes, states must work together to begin solving our nation's challenges.

Fourteen states have rejected the expansion of Medicaid; another eleven are in the process of deciding. State governors and legislators of both parties must stand together, reject Medicaid expansion, refuse to set up exchanges, and demand Medicaid block grants.

Medicaid block grants will allow states to regain control over their budgets and improve patient outcomes through state level, patient-centered, fiscally responsible reforms. Block grants:

- Carry bipartisan support.
- Could save enough money at the federal level to substantially reduce the deficit.

- Give states the *ability and incentive* to create lean, efficient Medicaid programs.
- Enable states to restructure their spending patterns to reflect what they feel best meets the needs of their citizens.

Once block grants are secured, *Physicians for Reform* has laid out a detailed plan of state level solutions to restructure Medicaid. (See, *Cutting the Gordian Knot: A Patient-Centered, Fiscally Responsible Plan for Healthcare Reform*.^{xxxii})

In 2011 Standard & Poor's downgraded the United States' credit rating. The national debt now approaches \$17 trillion. President Obama's last budget predicted trillion dollar deficits as far as the eye can see.

America must rethink its entitlement programs and find politically achievable solutions. In an age of relentless partisan gridlock, the time to transform Medicaid from a system of unlimited federal matches into a system of limited block grants is long overdue.

CL Gray, MD
Founder and President
Physicians for Reform
www.PhysiciansForReform.org

-
- ⁱ National Health Expenditure Data, Centers for Medicare & Medicaid Services, Analysis 2011. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>
- ⁱⁱ U.S. Government Accountability Office, “Medicaid and CHIP: Most Physicians Serve Covered Children but have Difficulty Referring them for Specialty Care,” GAO-11-624 June 30, 2011. <http://www.gao.gov/products/GAO-11-624?source=ra>
- ⁱⁱⁱ Scott Gottlieb, “Medicaid Is Worse Than No Coverage at All,” *The Wall Street Journal*, March 10, 2011, <http://online.wsj.com/article/SB10001424052748704758904576188280858303612.html>.
- ^{iv} Galen Moore, “Obamacare Prompts Part-Time Labor Test at Olive Garden, Capital Grille and Other Restaurants,” *Boston Business Journal*, October 9, 2012, http://www.bizjournals.com/boston/blog/mass_roundup/2012/10/restaurant-health-care.html
- ^v Robert Samuelson, “Obamacare: Rhetoric Vs. Reality,” *Real Clear Politics*, October 22, 2012. www.realclearpolitics.com/articles/2012/10/22/obamacare_rhetoric_vs_reality_115851.html.
- ^{vi} Paul Bedard, “Franchisors Warn Obamacare will Halve Profits.” *Washington Secrets*, September 13, 2012. http://washingtonexaminer.com/franchisors-warn-obamacare-will-halve-profits/article/2507920#.UG-nqVia_3g.sodahead
- ^{vii} Paul Bedard, “Applebee’s, Jimmy John’s Warn Obamacare Will Cut Profits, Employees,” *Washington Secrets*, October 17, 2012. <http://washingtonexaminer.com/applebees-jimmy-johns-warn-obamacare-will-cut-profits-employees/article/2511002>
- ^{viii} Jason Garcia, “Universal to Drop Health Insurance for Part-Time Workers,” *Orlando Sentinel*, February 19, 2013. <http://www.orlandosentinel.com/business/tourism/os-universal-part-time-insurance-20130219,0,4887679.story>
- ^{ix} Allen, Dobson, Joan DaVanzo, Mamrata Sen, *Health Affairs*, “The Cost-Shift Payment ‘Hydraulic’: Foundation, History, and Implications,” January 2006, pp. 22-33.
- ^x Avik Roy, “How Ohio’s Medicaid Expansion Will Increase Health Insurance Premiums for Everyone Else,” *Forbes*, February 8, 2013. <http://www.forbes.com/sites/aroy/2013/02/08/how-ohios-medicaid-expansion-will-increase-health-insurance-premiums-for-everyone-else/>
- ^{xi} Louis Woodhill, “The Real Story Behind Friday’s Unimpressive Unemployment Rate Decline,” *Forbes*, March 10, 2013. <http://www.forbes.com/sites/louiswoodhill/2013/03/10/the-real-story-behind-fridays-unimpressive-unemployment-rate-decline/>
- ^{xii} Jonathan Gruber and Kosali Simon, “Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?,” *Journal of Health Economics*, Vol. 27 (2008), pp. 201–17.
- ^{xiii} Avik Roy, “How Do Blue States Expand Medicaid? By Paying Doctors Less,” *Forbes*, July 23, 2012. <http://www.forbes.com/sites/aroy/2012/07/23/how-do-blue-states-expand-medicaid-by-paying-doctors-less/>
- ^{xiv} Avik Roy, “New England Journal: Two-Thirds of Medicaid Children Denied a Doctor’s Appointment, vs. 11% for the Privately Insured,” *Forbes*, June 6, 2011.

<http://www.forbes.com/sites/aroy/2011/06/16/new-england-journal-two-thirds-of-medicaid-children-denied-a-doctors-appointment-vs-11-for-the-privately-insured/>

^{xv} “The Future of Health Care: A National Survey of Physicians,” The Doctors Company Market Research, February 29, 2012.

http://www.thedoctors.com/ecm/groups/public/@tdc/@web/documents/web_content/con_id_004676.pdf

^{xvi} Heritage Foundation, “Medicaid Expansion in Ohio, Impact and Cost to Taxpayers,” March 5, 2013. <http://www.heritage.org/multimedia/infographic/2013/03/medicaid-expansion/ohio>

^{xvii} Senator Orrin Hatch and Representative Fred Upton, “Medicaid Expansion in the New Health Law: Costs to the States,” Joint Congressional Report, March 2011, <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20110301medicaid.pdf>.

^{xviii} The White House, Office of the Press Secretary, “FACT SHEET: The President’s Framework for Shared Prosperity and Shared Fiscal Responsibility,” April 13, 2011.

<http://www.whitehouse.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp>

^{xix} Chris Conover, “Will Medicaid Expansion Create Jobs,” Forbes, February 25, 2013.

<http://www.forbes.com/sites/chrisconover/2013/02/25/will-medicaid-expansion-create-jobs/>

^{xx} MGMA 2009 Performance and Practices of Successful Medical Groups Report, referenced by MGMA blog, Caren Baginski, September 9, 2010.

<http://blog.mgma.com/blog/bid/42766/Staffing-your-medical-practice-for-productivity>

^{xxi} C. L. Gay, MD, Brian Forrest, MD, FOXNews.com Opinion, “A Call to Arms for Doctors... And Patients,” April 6, 2010,. <http://www.foxnews.com/opinion/2010/04/06/dr-cl-gray-medicare-medicine-doctors-health-care-law-physician-fee-service/>

^{xxii} Brian R. Forrest, MD, Family Practice Management, “Breaking Even on Four Visits Per Day,” June 2007, 14(6):19-24. <http://www.aafp.org/fpm/2007/0600/p19.html>

^{xxiii} Senator Barak Obama, Speech to the AFL-CIO, June 29, 2008.

<http://www.youtube.com/watch?v=fpAyan1fXCE>

^{xxiv} Senator Barak Obama, SEIU Health Care Forum, March 24, 2007.

http://www.youtube.com/watch?v=8_xwnVLC-YQ

^{xxv} Congressman Barney Frank, Interview, July 27, 2009.

http://www.youtube.com/watch?v=8_xwnVLC-YQ

^{xxvi} Avik Roy, “How Ohio’s Medicaid Expansion Will Increase Health Insurance Premiums for Everyone Else,” Forbes, February 8, 2013. <http://www.forbes.com/sites/aroy/2013/02/08/how-ohios-medicaid-expansion-will-increase-health-insurance-premiums-for-everyone-else/>

^{xxvii} Allen, Dobson, Joan DaVanzo, Mamrata Sen, Health Affairs, “The Cost-Shift Payment ‘Hydraulic’: Foundation, History, and Implications,” January 2006, pp. 22-33.

^{xxviii} American Hospital Association Resource Center Blog, “How Hospital Costs are Distributed by Payer Type,” American Hospital Association, March 5, 2013.
<http://aharesourcecenter.wordpress.com/2013/03/05/how-hospital-costs-are-distributed-by-payer-type/>

^{xxix} American Hospital Association, “Underpayment by Medicare and Medicaid Fact Sheet,” 2012.
<http://www.aha.org/research/policy/finfactsheets.shtml>

^{xxx} Governor John Kasich, Ohio’s Jobs Budget 2.0: The Ohio Executive Budget Fiscal Years 2014 - 2015,” Letter to the General Assembly, February 4, 2013.
<http://jobsbudget.ohio.gov/Budget.pdf>

^{xxxi} Danielle Kurtzleben, “National Debt Interest Payments Dwarf Other Government Spending,” U.S. News and World Report, November 19, 2012.
<http://www.usnews.com/news/articles/2012/11/19/how-the-nations-interest-spending-stacks-up>

^{xxxii} CL Gray, MD, “Cutting the Gordian Knot: A Patient-Centered, Fiscally Responsible Plan for Healthcare Reform,” Physicians for Reform, December 6, 2011.