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The Article IX Rider in SB 1 What's the Problem?

by The Honorable Arlene Wohlgemuth & John Davidson

The Medicaid rider in SB 1 was added in an effort to prevent Medicaid expansion under the Affordable Care Act. But in fact, the rider leaves the door to expansion open and should therefore be struck from SB 1.

The language of the rider refers to "newly eligible populations," and the federal Centers for Medicare and Medicaid Services (CMS) has made it clear that it will consider any new population to be Medicaid expansion.

In March, CMS issued a Medicaid expansion FAQ that clarified the issue: "As stated in the past, the Affordable Care Act does not provide for a phased-in or partial expansion. States that wish to take advantage of the enhanced federal matching funds for newly eligible individuals must extend eligibility to 133% of the federal poverty level (FPL) by adopting the new adult group."

The offending section of the rider is this: "…unless the commission develops a plan to create more efficient health care coverage options for all existing and newly eligible populations…."

"efficient" – In whose judgment? What are the criteria?

"newly eligible populations" – Unquestionably a reference to Medicaid expansion.

The "principles" listed are all achievable under the current Medicaid rules with waivers or state Medicaid plan amendments. Therefore, this rider does not serve as a "protection" against Medicaid expansion.

In addition, look at the results of some of the "principles" in the rider:

"the reduction of uncompensated costs" – This was the ***promise*** in the four states where Medicaid was expanded to a similar population last decade. Instead, in every state, the uncompensated care costs went up instead of down. And, in every state, the number of uninsured stayed the same within 1 percentage point up or down.[1]

"the promotion of the use of existing private coverage and employer sponsored coverage" – This was the Arkansas deal which turned out to be no deal at all. CMS has made it abundantly clear that Arkansas would have to provide, and pay for, ***all Medicaid benefits and cost protections*** not included in the private insurance plans adopted by the expansion population. The only difference between the Arkansas deal and the HIPPS program that has long been allowed under Medicaid is that the HIPPS program pays a premium for employer insurance while the Arkansas deal pays a premium for exchange insurance.[2]

"the reduction of non-emergency visits to emergency rooms for patients who can access services in other settings;" – Past Medicaid expansions all promised the same, but failed to deliver. A landmark study of Oregon's Medicaid expansion in 2008, released earlier this month, found that being on Medicaid had ***no effect*** on patients' health outcomes. The study also found that those on Medicaid used more health care dollars than those without insurance, and "***did not find significant changes in visits to the emergency department or hospital admissions***."[3]

THE RIDER

Sec. 17.12. Certain Medicaid Funds.

(a) Of the funds appropriated elsewhere in this Act to the Health and Human Services Commission in Goal B, Medicaid and notwithstanding any other provision of this Act, no amount may be expended to modify Medicaid eligibility unless the commission develops a plan to create more efficient health care coverage options for all existing and newly eligible populations, and the commission receives prior written approval from the Legislative Budget Board before implementing the plan.

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(b) Legislative Budget Board approval shall not be granted unless the plan satisfactorily addresses, as determined by the board, the following principles:

(1) the reduction of uncompensated costs;

(2) the promotion of the use of existing private coverage and employer sponsored coverage;

(3) the establishment of wellness initiatives;

(4) the development of cost-sharing initiatives that require a recipient to pay a copayment, deductible, premium payment or other cost-sharing payment;

(5) the creation of pay-for-performance initiatives;

(6) the creation of customized benefit plans for defined populations within Medicaid;

(7) the promotion of health savings accounts;

(8) the encouragement of individual responsibility;

(9) the achievement of efficiency, including containing cost growth and improving the coordination of care within Medic aid;

(10) the reduction of non-emergency visits to emergency rooms for patients who can access services in other settings; and

(11) the reduction of the need to gain federal approval for minor changes to the state Medicaid plan. ✯

[1] Jonathan Ingram, "Medicaid Expansion: We Already Know How the Story Ends," Foundation for Government Accountability (11 Mar. 2013).
[2] "Medicaid and the Affordable Care Act: Premium Assistance," Center for Medicare and Medicare Services (Mar. 2013).
[3] Katherine Baicker, et al., Oregon Health Study Group, "The Oregon Experiment—the Effects of Medicaid on Clinical Outcomes," *The New England Journal of Medicine* (2 May 2013).