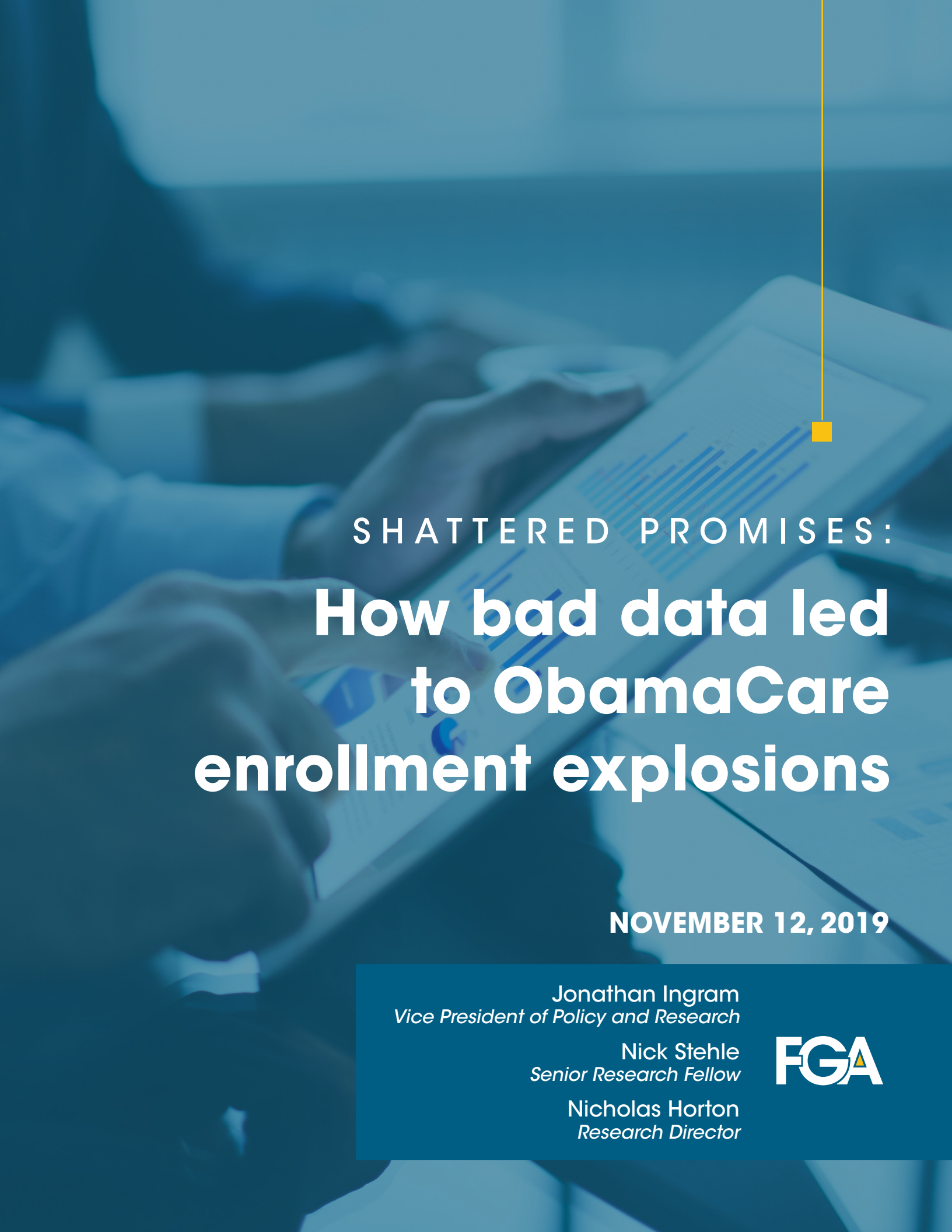

SHATTERED PROMISES:

How bad data led to ObamaCare enrollment explosions

NOVEMBER 12, 2019

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KEY FINDINGS

1

MEDICAID EXPANSION ENROLLMENT IS MORE THAN DOUBLE WHAT STATES PROJECTED.

2

MANY STATES ENROLLED MORE ABLE-BODIED ADULTS THAN THEY EXPECTED WOULD EVEN BE ELIGIBLE.

3

STATES RELIED ON BAD DATA TO DEVELOP ENROLLMENT PROJECTIONS.

4

THE NUMBER OF ADULTS MADE ELIGIBLE FOR MEDICAID EXPANSION COULD BE MORE THAN 72 PERCENT HIGHER THAN CENSUS DATA SUGGESTS.

BOTTOM LINE:

STATES SHOULD EXPECT FAR MORE ABLE-BODIED ADULTS TO SIGN UP FOR MEDICAID EXPANSION THAN INITIALLY ANTICIPATED.

Background

States have traditionally reserved Medicaid eligibility for the truly needy, such as seniors, individuals with disabilities, and low-income kids. But the Affordable Care Act, commonly known as ObamaCare, gives states the option to expand Medicaid to a new class of able-bodied, working-age adults.

States that have expanded their Medicaid programs under ObamaCare have witnessed skyrocketing enrollment and massive cost overruns.[1-2] States have signed up more than twice as many able-bodied adults as initially projected.[3] In many cases, more able-bodied adults signed up for the programs than state officials predicted would ever even be eligible.[4] Worse yet, the per-person price tag has been nearly twice as high as projected, compounding the cost overruns even further.[5]

“States that have expanded their Medicaid programs under ObamaCare have witnessed skyrocketing enrollment and massive cost overruns.”

States enrolled more able-bodied adults than they thought would ever be eligible

Few states that expanded Medicaid under ObamaCare provided details of all assumptions used to create their enrollment projections. Those with sufficient detail, however, show actual take-up rates of 100 percent or more of their projected universes.

Colorado officials, for example, assumed 75 percent of eligible individuals would enroll in the state's Medicaid expansion, boosting enrollment by 187,000 able-bodied adults.[6] By September 2017, 458,000 able-bodied adults had enrolled—an implied take-up rate of 184 percent.[7]

Montana officials assumed take-up rates of 85 percent for eligible uninsured adults and 70 percent for eligible privately insured adults—leading 46,000 adults to enroll in the program.[8] By September 2017, nearly 84,000 able-bodied adults had enrolled in the program, implying a take-up rate of more than 128 percent.[9]

North Dakota estimated that 20,500 individuals would be eligible for the expansion, with an estimated 13,600 eventually enrolling—an assumed take-up rate of 66 percent.[10] Actual enrollment hit more than 21,000 by July 2017, implying a take-up rate of more than 104 percent.[11]

Pennsylvania officials assumed 75 percent of eligible individuals would ultimately enroll in the state's Medicaid expansion, with 531,000 able-bodied adults projected to sign up.[12] By November 2017, nearly 706,000 able-bodied adults had enrolled in the program—an implied take-up rate of 100 percent.[13]

Washington estimated that 262,000 individuals would enroll in the program—an assumed take-up rate of 73 percent.[14] Actual enrollment hit more than 607,000 by May 2017, implying a take-up rate of 168 percent.[15]

Likewise, the Kaiser Family Foundation predicted a take-up rate of more than 60 percent nationally.[16] But actual enrollment exceeded its projections by an average of 55 percent, indicating an implied take-up rate of nearly 100 percent.[17]

While take-up rates of more than 100 percent may seem implausible, their existence is the result of bad data used to build the projected universe of eligible individuals.

States relied on bad data to develop projections

One of the biggest reasons states and independent organizations underestimated potential enrollment was their reliance on data from the Census Bureau to determine how many people would become eligible for the expansion. This reliance was problematic for at least four major reasons.

1. DIFFERENCES IN DEFINING HOUSEHOLDS

The Census Bureau generally organizes individuals into households.[18-19] But Medicaid eligibility rules are based on tax units, not households.[20] Consider an able-bodied adult male who does not work but lives at home with his parents. Census data would use his parents' income to determine his poverty status, as they are part of the same household. Medicaid eligibility, on the other hand, would be determined based on his personal income alone.

2. DIFFERENCES IN DEFINING INCOME

The Census Bureau also uses a different definition of income than the definition required by Medicaid eligibility rules.[21] For example, the Census Bureau includes workers' compensation benefits, cash welfare, veteran payments, educational assistance, child support, and financial support from outside the home in its definition of income—none of which is countable under federal Medicaid rules.[22] Medicaid rules also exclude non-taxable pensions or retirement income, net operating loss carryforwards, capital gains carryforwards, and other adjustments to gross income for tax purposes.[23]

3. DIFFERENCES IN DEFINING POVERTY THRESHOLDS

The poverty thresholds used by the Census Bureau are also different from the poverty guidelines used to determine Medicaid eligibility.[24] The Census Bureau's poverty thresholds vary based on age, household size, and the number of children in the household.[25] The poverty guidelines, on the other hand, vary by family size alone.[26]

4. DIFFERENCES IN DATA COLLECTION

Finally, the Census Bureau data is based on income information self-reported by a sample of survey respondents.[27] Medicaid eligibility, on the other hand, is determined by actual tax filing data for each applicant.[28]

RELIANCE ON CENSUS BUREAU DATA WAS PROBLEMATIC.

The result: Census data undercounts how many able-bodied adults could become eligible

As a result of these varying definitions of income, poverty, household compositions, and more, the Office of Tax Analysis (OTA) at the U.S. Department of the Treasury indicates that Census data significantly undercounts the number of people with income below 138 percent of the federal poverty level (FPL) for purposes of determining Medicaid eligibility.[29] As early as 2012, OTA researchers warned that the number of individuals eligible for Medicaid expansion would be nearly 50 percent higher than Census data suggests.[30]

OBAMACARE'S MEDICAID EXPANSION IS SHATTERING PROJECTIONS AND LEAVING TAXPAYERS TO PAY THE BILL.

More recent data released by OTA suggests the difference is even larger than anticipated. According to the Census Bureau, roughly 50 million individuals under the age of 65 live in households with income under the Medicaid expansion thresholds.[31-32] However, according to OTA, that number rises to nearly 87 million Americans when using actual tax filing data and Medicaid eligibility rules.[33] This means that the actual number of able-bodied adults made eligible for Medicaid expansion could be more than 72 percent higher than Census data suggests.[34]

This may even be an underestimate, as Medicaid eligibility is determined primarily by monthly income, while tax filing data is based on annual income. Individuals are more likely to fall below the eligibility thresholds based on monthly income. For example, a single, able-bodied adult who worked full-time at $17 per hour for six months and not at all for the subsequent six months would have annual income above 138 percent FPL.[35] However, based on monthly income, this adult would qualify for Medicaid, and his eligibility would generally not be redetermined for at least 12 months.[36] As a result, states should expect far more able-bodied adults to become eligible for Medicaid than these data sources suggest.

Conclusion

States' faulty assumptions and reliance on problematic data, coupled with actual results—states enrolled more than twice as many able-bodied adults as promised—should provide caution for policymakers weighing the impacts of expanding Medicaid. ObamaCare's Medicaid expansion is shattering projections and leaving taxpayers to pay the bill. Non-expansion states should learn from these inaccurate predictions and reject Medicaid expansion to able-bodied adults to preserve limited resources for the truly needy and protect state budgets.

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