MEMO

HMA "Study" is Dead-Wrong on Medicaid Expansion

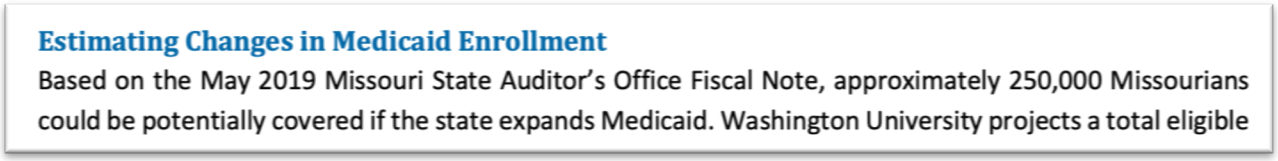
Five ways the hospitals' hired-gun consultants get it very wrong

#1 – Projected enrollment is wildly underestimated, based on other states' actual experience. As a result, cost is underestimated as well

Myth from Health Management Associates (HMA): Missouri will only enroll 231,000 able-bodied adults in Medicaid expansion

Reality: Based on actual experience in other states, Missouri can expect to enroll more than 593,000 able-bodied adults[1]

The HMA report does not use any new information, instead relying on previously **debunked numbers** from the state auditor and others.



Estimating Changes in Medicaid Enrollment

Based on the May 2019 Missouri State Auditor's Office Fiscal Note, approximately 250,000 Missourians could be potentially covered if the state expands Medicaid. Washington University projects a total eligible

Screenshot from HMA report 1

These regurgitated incorrect numbers are from other places including the previously debunked Washington University study. The estimates are built on an assumption of around 50% take-up rate of Medicaid eligibility, when in fact, most states see more than 100% take-up.

For example:

- Colorado: Assumed 75% overall take-up rate, projected to increase enrollment by 187,000. Actual enrollment: 458,000, implying a take-up rate of 184%.[2]
- Montana: Assumed take-up rates of 85% for uninsured and 70% for privately insured, projected to increase enrollment by 46,000. Actual enrollment: 84,000, implying a take-up rate of more than 128%.[3]
- North Dakota: Assumed take-up rate of 66%, projected to increase enrollment by 13,600. Actual enrollment: 21,000, implying a take-up rate of more than 100%.[4]
- Pennsylvania: Assumed take-up rate of 75%, projected to increase enrollment by 531,000. Actual enrollment: 706,000, implying a take-up rate of 100 percent.[5]
- Washington: Assumed take-up rate of 73%, projected to increase enrollment by 262,000. Actual enrollment: 607,000, implying a take-up rate of 168 percent.[6]

Operating based off this faulty enrollment projection, HMA estimates a state cost of $201 million. While this is not insignificant at all, it still understates the likely cost. Based on the more likely enrollment of 593,000 able-bodied adults, **expansion would cost Missouri approximately $349 million per year in state general funds.**[7]

#2 – "Savings" and "offsets" are imaginary and have not materialized in other states

Myth from HMA: Missouri will actually make money because of the many "savings" and "offsets" from expansion

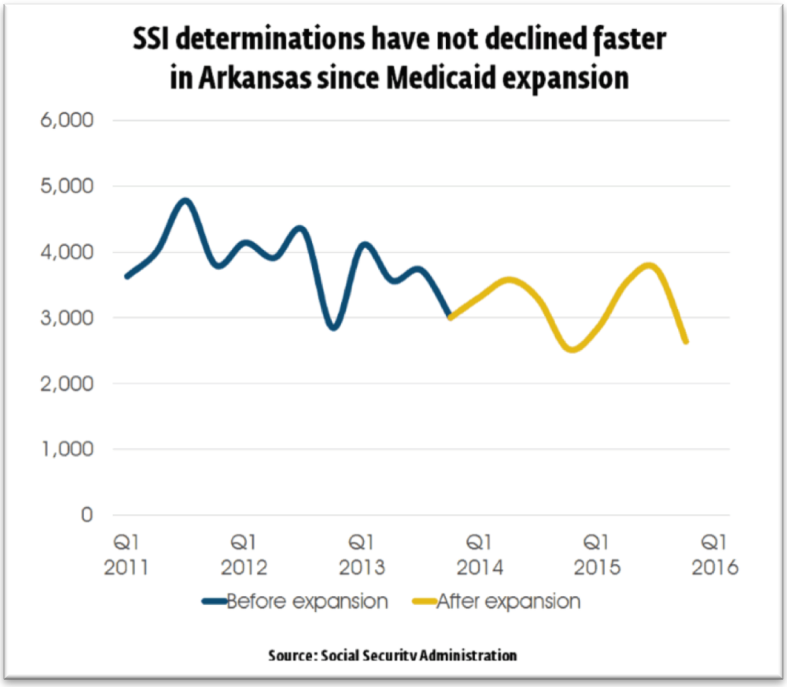
Reality: The claims of savings from other states have not materialized

Taxpayers still pay: HMA first suggests that the state will see "substantial" savings because of a shift from Missouri general fund dollars to federal dollars. First of all, this ignores the reality that Missourians pay federal taxes as well, and therefore are paying regardless. It's disingenuous to tell taxpayers they are saving money by doing a balance transfer from one credit card to the other.

Actual vs. Projected "Savings": HMA falsely claims that Virginia "saved" $421 million, but that in fact was merely a projection from 2018. It was disingenuous of HMA to say it was "savings."

Other examples like Arkansas and Nebraska are also "projections," not real savings figures.

Disability "savings": The HMA study is referencing imaginary savings that haven't taken place. One key example is that HMA claims the state will save $55 million by moving people from SSI disability to expansion. This ignores the reality that SSI disability qualifies people for cash and Medicare as well, and those individuals seeking those benefits will likely continue to apply for Medicaid through SSI, instead of simply being enrolled into Medicaid expansion. States like Arkansas, which HMA references, were already trending down on their SSI applications prior to expansion, making this "savings" number pure fiction.[8]



Mental health: HMA repeatedly cites "savings" that will be generated through "reductions in spending for existing state programs." While there are no specifics, it begs the question, which state contracts for mental health will Missouri be cutting under expansion? Those programs currently serve anyone in need and operate more as grants. Are Missouri mental health agencies ready to start billing Medicaid and checking enrollment? Will they stop serving the general population when their state funding is cut? Which providers will lose their contracts to achieve state "savings?"

#3 - Supposed increase in "revenues" are built around a scheme that is, at best, tenuous, and may soon be illegal

Myth from HMA: Missouri will see a huge influx of revenues from taxing hospitals

Reality: The Trump administration is taking action to stop provider tax schemes that states are using to draw down additional federal money

HMA projects that the state will see increased "revenue" of $30 million from a "well established provider tax" on hospitals. However, the practice of taxing hospitals or other providers, like Managed Care Organizations (MCO's), and using that revenue to draw down more Medicaid match dollars from the federal government is highly questionable and has come under intense legal and regulatory scrutiny by watchdog groups, Congress, and past and current administrations alike.[9] A panel commissioned by the Obama administration recommended eliminating the provider tax altogether.

The Centers for Medicare and Medicaid Services (CMS) has recently published a rule that could prevent states from using these schemes going forward.[10] Instead of banking on an expansion of this scheme to further tax MCO's or hospitals, Missouri should be thinking about unwinding this legally questionable practice.

#4 - The crowd-out of private insurance is completely dismissed despite real evidence showing that tens of thousands will lose private coverage and be forced onto welfare

Myth from HMA: Crowd-out will have only a small impact

Reality: At least 70,000 people in Missouri would be forced off their private coverage onto welfare

HMA boldly declares that expansion will not cause anyone to lose their private health coverage and move into Medicaid. This ignores reality entirely, both from a legal standpoint and from a common-sense standpoint. In Missouri, more than 83,000 were enrolled on the exchange in 2019 and had incomes between 100% and 150% of the federal poverty level (FPL).[11] 84% of these individuals have incomes below the Medicaid expansion threshold of 138% FPL.[12] If Missouri expands, that means roughly 70,000 people will be legally ineligible for the federal subsidies they currently receive to purchase private insurance, and they will be forced onto Medicaid.

This is not hypothetical or just a projection.

Louisiana saw their exchange enrollment among people with incomes between 100% and 150% FPL drop by 80 percent after expansion.[13] That crowd-out effect helped lead to expansion enrollment exceeding projections by more than 150,000 people.

Missouri can expect similar results if Medicaid is expanded to able-bodied adults.[14]

#5 - Medicaid expansion is not a silver bullet to save hospitals

Myth: Medicaid expansion will prevent hospitals from closing, especially in rural areas

Reality: Expansion has not saved hospitals in expansion-states and it could make things worse in Missouri

Despite all the promises made across the country, Medicaid expansion has not materially improved hospitals' financial health or prevented closures.[15] Several expansion states have seen thousands of hospital-related job losses.[16] This makes sense—more people enrolled on Medicaid means more payments at Medicaid's lower reimbursement rate. As a result, **non-expansion states have actually seen faster job-growth in their hospitals.[17]**

For example, Arkansas expanded Medicaid, in large part, to stop hospitals from closing. Yet, seven years later, Arkansas' hospitals are in "condition critical."[18] Hospitals across Arkansas of all sizes are struggling with unbalanced books, layoffs, and closures.[19] Today, despite expansion, Arkansas has more rural hospitals in financial distress than Missouri or Kansas.[20]

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