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Just Say NO – and Keep Saying NO – to Federal Health Care Exchanges and Medicaid Expansion

POLICY STUDY

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by

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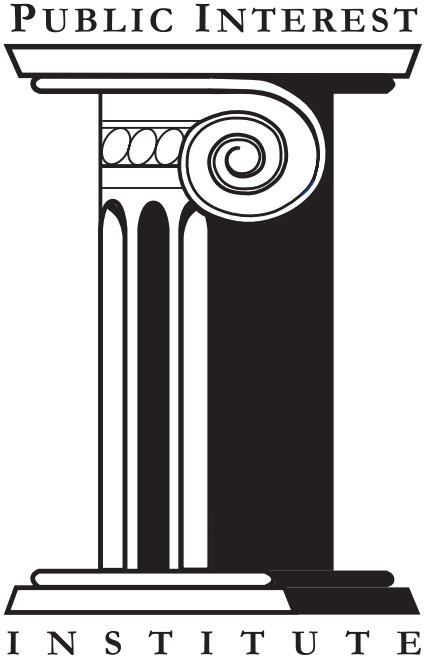

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Obamacare So Far…

Thomas Sowell said it best:

> "If we cannot afford to pay for doctors, hospitals, and pharmaceutical drugs now, how can we afford to pay for doctors, hospitals, and pharmaceutical drugs in addition to a new federal bureaucracy to administer a government-run medical system?"[1]

And we will pay for all this with federal and state government tax money, while not increasing taxes on anyone?

The promise of the Patient Protection and Affordable Care Act (PPACA) passed in March 2010, and better known as Obamacare, was that all Americans would have health insurance, that access would increase, and costs would go down. Most famously President Barack Obama promised American families, on multiple occasions, that PPACA would "cut the cost of a typical family's premium by up to $2,500 a year."[2]

At this time, none of these promises are true, and none appear to have any hope of becoming true. In the three years since the passage of the PPACA, health care news has all been bad – access is going down and costs, for both premiums and service, are going up. Additionally, taxes are going up significantly in order to pay for the administrative takeover of health care by the government.

Reports are already showing declining access to health insurance, as employers chose to drop coverage for their employees or alter their hiring so that they are not required to provide coverage. Based on a wide variety of estimates, from 11 to 35 million workers will lose employer-based coverage, basically equal to those gaining coverage.[3]

The Congressional Budget Office indicates that though the number of uninsured will drop from 56 million, approximately 26 million people will still not have health insurance even after PPACA is fully implemented.[4] This is even though all Americans will be required to purchase health insurance and fined if they do not.

Health insurance costs already rose by 7.5 to 9.5 percent or more from 2010 to 2011, with the cost for a family policy – whether paid by the employer or an individual – rising to over $15,000 a year, and individual policies going to almost $5,500.[5] Cost increases from 2011 to 2012 were comparable, and are continuing to rise. For 2013, Aon Hewitt's (a Chicago-based employee benefits company) employers are reporting an average 8 percent premium increase to their employees.[6]

Contrast this with the original claims of Senator Harry Reid, Congresswoman Nancy Pelosi, and the Obama administration of policy cost reductions.

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"In the three years since the passage of the PPACA, health care news has all been bad – access is going down and costs, for both premiums and service, are going up."

Just Say NO – and Keep Saying NO –

"Though the Supreme Court ruling in 2012 that state governments were not required to expand Medicaid in order to continue to receive federal funds for current coverage... the Obama administration continues to try to force both health care exchanges and expanded Medicaid on unwilling states."

On the tax side, a new 96-page report from the Joint Committee on Taxation on the tax implications of PPACA details 21 tax increases. They estimate the total taxes to be collected at just over $1 trillion ($1.058 trillion). Initially, the tax increases were estimated at a paltry $569 billion when Obamacare was passed in March 2010.[7] According to this report, the largest new taxes are the 0.9 percent payroll tax on wages and self-employment income, and the 3.8 percent tax on dividends, capital gains, and investment income for those workers earning over $200,000 (singles) / $250,000 (married).[8] The amount to be collected from these two new taxes alone is now estimated at over $315 billion. These are new taxes on virtually all workers.

Additionally, major new taxes are going to be collected both directly from employers ($106 billion) and from health-insurance providers ($102 billion).[9] The money employers pay in taxes cannot be used to increase wages or hire new workers, and the cost of the tax on health-insurance providers will naturally be passed on to the health-insurance purchasers – whether individual workers or their employers.

The medical device tax of 2.3 percent, which took effect as of January 1, 2013, and impacts a wide variety of businesses, has received the most attention. It is expected to total $30 billion over ten years, and will be passed onto the insurance companies and consumers. The medical device tax was actually overturned in a symbolic vote in the U.S. Senate on March 21, 2013. Thirty-three Democrat Senators joined all 45 Senate Republicans in voting to overturn it. This included four of seven who are in Democrat leadership positions.[10]

Though the Supreme Court ruling in 2012 that state governments were not required to expand Medicaid in order to continue to receive federal funds for current coverage provided some relief to the onerous regulatory burden of PPACA, the Obama administration continues to try to force both health care exchanges and expanded Medicaid on unwilling states.

Problems with Obamacare

A recent report by the Heartland Institute analyzed and documented several significant problems with Obamacare:[11]

1. It is a complete government takeover of health care. There are at least 159 new government agencies created with a corresponding regulatory burden. Senator Chuck Grassley was recently photographed with a seven-foot-tall stack of new regulations, with still more to be issued.

2. It will result in "soaring" insurance and health care costs. Guaranteed issue

policies will be a key driver of this cost, along with higher mandated baseline coverage and "free" services.

3. It will result in government rationing of services and lower quality of care. Tight supply and high demand will cause rationing, for both the elderly and the young, especially with fewer new/continuing doctors and consolidated facilities. As more providers have higher numbers of patients to see and are paid less, care provided will go down. The approved (comparative effectiveness) treatment standards will add to this.

4. It imposes significant new and higher taxes. Both the individual and employer mandates, coupled with a near universal subsidy of policies by the federal government, must be paid for in one way or another. As a result, economic growth, new jobs, and wage increases are already being hindered. A wide variety of businesses are reducing the number of full-time employees and working to ensure they do not have 50 or more full-time employees.

5. It contributes to runaway government spending. When consumers of a product have no personal accountability for use or impact on the cost, inflation and overuse result. Government spending will correspondingly increase. From the very beginning in 1965, Medicare costs have been at least 9-10 times higher than projected. Medicaid fraud is rampant and famously hard to control and detect.

6. It will result in higher federal and state deficits. Though the federal government has promised to pay for 100 percent of Medicaid expansion for the first three years, that spending will add to the deficits. Enrollment and cost projections for expansion have been consistently underestimated.

7. It is in complete contradiction to the promises made by candidate, then President Barack Obama to the American people. The promise of "no higher taxes on families making less than $250,000 a year" pledge has long been broken. You will probably not be able to keep your current health insurance and doctor. If you can officially "keep" your doctor, you probably won't be able to actually get an appointment with him.

Employers, Governors, and State Legislators nationwide are now dealing with the reality of implementing this monstrosity of legislative and administrative confusion. Newspaper and internet articles about problems abound. No one is doing much of anything because they are concerned that doing the wrong thing will result in increased costs, taxes, and penalties to their business and their family.

In early March the Federal Reserve reported in the "beige book" that employers throughout the country, from

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"When consumers of a product have no personal accountability for use or impact on the cost, inflation and overuse result. Government spending will correspondingly increase. From the very beginning in 1965, Medicare costs have been at least 9-10 times higher than projected."

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"Seven states, including Iowa, have proposed doing a federal-state partnership."

Atlanta to Chicago were referencing the uncertainties associated with Obamacare as their reason for both layoffs and a "slowdown" in hiring.[12] And in the meantime, federally established deadlines for state implementation come and they go with little solid action.

Recently a health care analyst made the following statement concerning the implementation of Obamacare: "The pretense of increasing quality and lowering costs was abandoned months ago; now it's all about reducing the uninsured. If states refuse the Medicaid expansion, which the U.S. Supreme Court has ruled they can do, the whole idea of universal coverage goes out the window. And Obamacare will be judged a failure."[13]

Federal Health Care Exchanges

A key part of the PPACA is the establishment of statewide health care "exchanges" or government organizations set up to oversee the sale and purchase of health insurance. The exchanges were supposed to help individuals outside of the employer-sponsored insurance market purchase insurance by providing a clearinghouse of standard information. One of the main complaints about individual insurance has been that plans and costs are too complicated to understand and compare "apples to apples."

As determined by the U.S. Supreme Court last summer, states are not required to create these exchanges, but various "carrots" were included in PPACA to induce them to do so. They were supposed to decide by December 2012 what they were going to do – even without clear implementation plans and directions from the federal government. The deadline was pushed back to February 15 for several states, including Iowa.[14]

There have basically been three responses – set up a fully state-run exchange, refuse to set up an exchange and leave the responsibility with the federal government, or to do a partnership exchange with joint state and federal management. Each option has complicated additional decisions and financial commitments. The exchanges are supposed to be fully up and running by January 1, 2014.

As of March 2013, twenty-six states are refusing to create exchanges and are instead allowing the federal government to do so. Seventeen states and the District of Columbia have received conditional approval to set up their own exchange. Mississippi's application was turned down, and Utah's is still under review. Seven states, including Iowa, have proposed doing a federal-state partnership.[15] Arkansas, Delaware, and Illinois, in addition to Iowa, have been given conditional approval for their partnership exchanges.

According to Secretary of Health and Human Services (HHS) Kathleen Sebelius, "Conditional approval means HHS has found that the states are likely to be ready to open the online health insurance markets for enrollment by October 1 to sell individual and small group plans that take effect January 1, 2014."[16]

The main functions of these exchanges will be to monitor and rate the types of plans available, manage the tax credits and subsidies for people in different income levels, and issue non-compliance penalties to consumers and providers. Mainly, it appears, they will be top-heavy bureaucracies, controlling every aspect of health care and reducing competition, limiting individual choices, and stifling innovation.

Another aspect of Obamacare was that applying for health care was supposed to be easier. Unfortunately, this doesn't seem to be the case. The draft application, released on March 14, is 21 pages long for a family of four, and will be reviewed by at least five federal agencies, including the IRS.[17]

The feel of the application is much like that for the Free Application for Federal Student Assistance (FAFSA), the form to apply for loans for college. In many cases the college reviewing your FAFSA and awarding the student loans also requires a complete, paper copy of your IRS Form 1040, with all schedules.

Full tax reporting is basically a requirement of Obamacare, as taxpayers at different income levels, up to 400 percent of the Federal Poverty Level (FPL), are to receive different subsidy amounts. Further, employers are limited in the employee contribution they can require based on an employee's federal taxable Modified Adjusted Gross Income (MAGI).

Thus employers must take into consideration income earned by an employee at a second job and by other family members, as well as changes in the number of family members. If even one employee purchases a policy through the exchanges which costs them more than the allowable amount, the company they work for will be fined – though the company had no input into the plan chosen and no control over the costs.[18]

Health Care Exchanges in Iowa

The decision made by Governor Terry Branstad, in conjunction with the Iowa Department of Public Health, the Insurance Division, the Department of Human Services, and the Department of Revenue, requested that the Iowa health care exchange be operated as a federal-state partnership. The state proposed implementing plan management functions and continuing to perform Medicaid and Children's Health Insurance Program (CHIP) eligibility processing and determinations.

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The proposal calls for moving to a completely state-based exchange in 2015.[19] The official blueprint was submitted on February 15, 2013, in "the format required by HHS."

This proposal received "conditional approval" from the U.S. Department of Health and Human Services on March 7, with final approval based on demonstrating readiness to perform all required functions on time.[20]

The Governor tried to establish a position of independence and state control in his December 14, 2012, letter to HHS Secretary Sebelius, stating that the PPACA has not "advanced…important principles" of improved care, lower costs, and a healthier population, and that a state-run health benefits exchange would not address these issues either.

He clearly expressed concerns about control, flexibility, and the regulatory framework of exchanges, as well as implementation costs and said that the "State of Iowa intends to minimize the Federal Government's intrusion into the regulation of insurance" and to "continue to regulate insurance plans" and "retain control of Medicaid and Children's Health Insurance Plan eligibility."

However, by March 2013, language and timelines used by Insurance Commissioner Nick Gerhart in the press release announcing the blueprint submission clearly show that any semblance of state control is quickly slipping away. For example, HHS determines if Iowa's plan is acceptable and approves the insurance companies offering plans and the benefits of the plans offered – the state has no final determination authority.

Instead of the strong language used in December, the words were keeps "some control" of the exchange in "the hands of the state."[21]

The alphabet soup of agencies and organizations involved in exchange approval and establishment constitutes a complex and, again, bureaucratically top-heavy implementation process. They include the Iowa Insurance Department (IID), which is responsible for the Qualified Health Plan (QHP) certification. Staff of the IID will use the System for Electronic Rate and Form Filing (SERFF) to do this.

The health insurance companies asking for plan certification (currently two major health insurance companies control most of the plans used in Iowa) will use the SERFF to submit the required information for every plan they offer.

Then the IID will make recommendations about each plan and send them to the national Center for Consumer Information and Insurance Oversight (CCIIO) for actual approval sometime in July. The original timeline was June. The CCIIO is to approve the plans by September 4, originally July. The insurers will then put

the plan information into the Federally Facilitated Exchange (FFE) by the end of September, originally August. Consumers are supposed to begin signing up for insurance on October 1, with the first open enrollment period to end next March (2014).[22]

IID will monitor the insurance companies and the care/services they are providing to consumers under the Qualified Health Plans (QHP). As now outlined, IID will work with the national CCIIO on how to best display this information to consumers. IID will also "perform reviews of form and rate filing, network adequacy, and accreditation, licensure, and solvency standards."[23]

"Navigators" licensed and hired by the State Insurance Commissioner or by the non-profit health benefit marketplace organization proposed by the Iowa Senate will help consumers understand the information provided, what level of subsidy they are eligible for, and help them choose a plan. However, the Navigators are not authorized to be insurance salespeople, only "consultants."[24]

A subcontractor has been hired to "examine design options" for the Navigator program and "develop a timeline" for implementation.

That is all for the individuals seeking private insurance. And all exchange expenses are to be paid by the exchange, which will be set up as a non-profit, through fees levied on the insurance plans offered. Presumably, these fees will be passed onto consumers.

For the small businesses that are required to provide insurance, there is a completely separate process.

Last November the state commissioned a report to review the Small Business Health Options Program (SHOP) Exchange "statutory, regulator, and administrative" requirements and to "discuss major design and procurement" decisions. According to the Kaiser Foundation Iowa status summary, that report recommended "engaging stakeholders in the small group market as a next step towards developing a specific SHOP exchange design."[25] So, the taxpayers paid for a report which recommended more research and another report.

Then we have the information technology requirements of Obamacare. The Iowa Department of Public Health does not think their system can be modified to meet the Obamacare requirements and will require significant upgrading and new funding.

As a result, last September a contractor was hired to develop a new Medicaid and CHIP computer system. This is called the Eligibility Integrated Application Solution (ELIAS) project, and will determine the applicants' eligibility in real-time by "interfacing" with the federal IRS "hub" data to access every applicants

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MAGI, determine eligibility, and manage "consumer account information."[26]

ELIAS is part of the partnership aspect and will go away in 2015 when Iowa fully implements the "state-controlled" health exchange. It is still in the design phase and not operational, according to the Kaiser report.

Next there is the part of Obamacare which requires all insurance plans to provide Essential Health Benefits (EHB), unless the plan is grandfathered in. These EHB include the contraception and abortion coverage, which has garnered extensive media coverage.

In lieu of a specific determination, all plans in Iowa must meet the standards of the largest small-group plan currently operating. This is the Wellmark (Blue Cross Blue Shield) – Alliance Select, Preferred Provider Organization plan. Presumably, the IID and CCIIO reviews will ensure all QHP offered through the exchange meet this standard.

In the meantime, the state has received over $35 million in federal grants, which is being spent on the preceding activities.[27]

Insurance Premium Costs Under PPACA

Again, President Obama's promise that health insurance costs would decrease under PPACA are not holding true. A report by the House of Representatives Energy and Commerce Committee, working with its Senate counterparts, recently provided a table of expected premium cost increases by state. For Iowa the expected increase is from 56 to 100 percent of a family of four's current individual premium.[28]

Those who support Obamacare counter this by referencing the "generous" premium subsidies offered under the exchanges to families earning up to 400 percent of the FPL. However, the money for these subsidies comes from increased taxes, as noted earlier. It is estimated these subsidies will cost cost taxpayers over $1.2 trillion in the first 10 years of the PPACA. The government giveth with one hand, and taketh away with the other.

Comments From Health Care Providers

Irrespective of how the health care exchanges work, the Iowa medical-industrial complex bureaucracy is well into expansion mode. An October 2012 article in the *Corridor Business Journal (CBJ)* detailed the "proactive" cooperation by the University of Iowa Health Care, Mercy Health Network via Medical Center Cedar Rapids, and Genesis Health Systems to form the "University of Iowa Health Alliance," a statewide Accountable Care Organization (ACO) network "devoted to

achieving the triple goals" of high-quality and patient-focused care, improving the health of communities, and reducing costs by providing "seamless, personalized care for all" medical needs.[29]

According to the leaders of these organizations, key to this effort is "streamlined and coordinated" care, with "improved" clinical integration and "greater standardization of care based on best practices" to reduce costs. This will involve multiple locations and hundreds of individuals involved in every aspect of care authorization.

They did not detail the number of meetings and administrative, overhead staff involved in this alliance, nor their salaries. Every person working to implement this ACO is not providing direct patient care. In addition the article referenced the improvements and cost saving to be made by using the ubiquitous electronic medical record.

What happens if standardized care is not the right answer for your individual situation? Sorry for being skeptical, it all sounds like rationing to me.

In a January 2013 article from the same publication, the CEO of St. Luke's Hospital in Cedar Rapids added further commentary, saying that health-care providers will be moving from running brick and mortar hospitals, using technology for tests and diagnosis, and prescribing needed medicines to being "health coaches," your friend and partner.[30]

He encouraged business leaders reading the *CBJ* to lead by example – to lose weight and get in shape, to insist providers focus on health promotion, and work to transform the "high utilization," "entitlement" mentality health care culture we've come to expect.

Unfortunately, this does not sound as if medical care access is being expanded under Obamacare, but rather as if these health care executives are planning to reduce the actual medical care received and replace it with….a $15,000-a-year friend. Wonder if they'll buy dinner next time we go out together?

National Medicaid Expansion

The Medicaid program expansion and management is also an important part of the PPACA. Currently, enrollment is limited not only to those meeting financial requirements, but also "financially needy parents with children, children under 21, people with disabilities, elderly people (over 65), and pregnant women."[31]

If agreed to by state governments, Medicaid expansion will extend government health care to all those who earn less than 138 percent of the federal poverty level (approximately $32,500 per year modified adjusted gross income for a family of four, irrespective of other

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"What happens if standardized care is not the right answer for your individual situation?"

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"The current growth in state spending on Medicaid, of about 8 percent a year, is projected to increase rapidly – more than doubling by 2020."

qualifying criteria and asset or resource tests). As incentive to implement the program states will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years.[32]

The Supreme Court ruled in 2012 that it was unconstitutional for the federal government to require this expansion, because of the financial liability it would force on the states and because HHS was threatening to stop funding current state programs.

Nevertheless, the expansion is proceeding and several Governors who were originally opposed to the program have now changed their minds.

A January 2012 report from the Centers for Medicare and Medicaid Services, Office of the Actuary shows that by 2020 over 50 percent of Americans will be receiving government paid health care. Of these, 25 percent will be on Medicare, 18 percent Medicaid, and 7 percent exchange subsidies.[33]

As of March 5, 2013, according to data compiled by the Heritage Foundation, 25 states (including Washington, D.C.) have agreed to expand Medicaid under Obamacare, 20 states (including Iowa) are not expanding, and 6 are undecided.[34]

Merrill Mathews, past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, is a health care expert.[35] He provides a list of the seven reasons states should not expand their Medicaid programs.[36]

They are:

1. Medicaid Is Bad Coverage. The number of doctors who take new Medicaid patients is small and growing smaller. This results in users going to the emergency room rather than a personal, family doctor, and prescriptions authorized are very limited.

2. The Exploding Medicaid Population. The number of people being covered is estimated to grow significantly based purely on the eligibility limits, including those who are disabled. This was a goal of the law, but nevertheless this increase in users will also stress a system with no more, or even fewer, providers.

3. The Woodwork and Crowd-Out Effects. Many of those eligible for Medicaid, who are currently not enrolled, will "come out of the woodwork" and join the program. Additionally, as employers drop coverage for their lower-paid workers or move people to part-time work, more will become eligible – the crowd-out effect.

4. The Cost to State Budgets. The current growth in state spending on Medicaid, of about 8 percent a year, is projected to increase rapidly – more than doubling by 2020. At the same time, overall

economic growth remains at 1 to 2 percent. For many states, Medicaid is their largest budget item – even more than government education.

Though the federal government is supposed to fund 100 percent of this cost for three years, what happens afterwards? And whether from the state or the federal government – all this money comes from either workers' paychecks, or borrowed and printed money.

5. Federal Controls. Federal control of this, and all health care, is expanded significantly. State governments and health care users will have few, if any, options for deciding their own health care needs. Yet state officials will be held responsible by their citizens for problems and increased costs.

6. Rampant Fraud. Fraud in the Medicaid program is well-documented and has proven hard to stop. This will continue.

7. Loss of State Sovereignty. This will result in yet more micromanagement of state government actions by the federal government. State and individual autonomy will continue to be reduced. Additionally, business owners will see increased control of their operating decisions by the federal government.

The Arkansas Proposal

Interestingly, what is being called the "Arkansas" proposal may be the most beneficial for state governments. In this Medicaid expansion design, childless adults who make above 100 percent of the FPL are declined Medicaid coverage by the state. This forces them to go to the health exchanges, where they are eligible for the federal insurance subsidy for those making between 100 and 400 percent of the FPL. The amount of the federal subsidy for those at less than 100 percent of the FPL is estimated to be about $9,000 by 2022, while Medicaid is valued at only $7,000.[37] Though the money still comes from taxpayers and businesses, the federal government is responsible, not the state government.

With current and increasing restrictions by the providers on accepting Medicaid patients, and the limits of reimbursement for procedures under Medicaid, it is anticipated that these people will have better insurance, and hopefully better health care, in the long run by using insurance purchased through the exchanges.

Additionally, Arkansas Governor Mike Beebe is proposing an outcomes-based provider payment system, versus the current fee-for-service model. As Julie Munsel, Director of Communications for the Arkansas Department of Human Services said recently, the state analysis shows that as much as 30 percent of the Medicaid costs are for potentially unnecessary tests

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and treatments, providing little or no impact on patient outcomes.[38]

Experience in Arizona and Maine

Importantly, there is factual evidence of what might happen in Iowa and other states. A report by the Foundation for Government Accountability reviews the results of states that have already expanded Medicaid, particularly in Arizona (Proposition 204) and Maine.

These are real numbers, from real experiences – not hypothetical guesses. It shows that none of the expectations and promises concerning the reduction in the number of uninsured, gradual enrollment increases, low and predictable costs, and reductions in the amount required for charity care have held true.

Instead, in Arizona enrollment expansion was higher and faster (3 times higher) than predicted, yet the number of uninsured either remained the same or actually increased. Costs for the newly covered were higher than for those already enrolled, especially for the childless adults added to the rolls, which were twice as high as projected.

Total costs in Arizona have been four times as high as expected.[39] The jump in enrollments and costs were especially significant from 2008 on, as the recession impacted employment and health outcomes.

Maine, which started to cover childless adults in 2002 under a special waiver from the federal government, has seen similar results.

Enrollment projections were for about 11,000. The number immediately went to over 17,000 and has now been capped at 11,000 with a waiting list of over 24,000 more.

The costs for childless adults have been massive, averaging over $5,000 per year, per person – even with usage limits on prescription drugs, out-patient visits, and mental health and drug/alcohol abuse coverage.

Families with children, in comparison, cost from $1,200 to $2,500 per year, less than half.[40] The state is simply unable to afford the costs incurred.

This pattern has repeated itself in Delaware, Michigan, Oregon, Utah, Vermont, and Washington, D.C., following similar expansions of their programs.[41]

While many of the supporters of the PPACA express concerns about access to and costs of health care for children and families, the real users (and it might be said – abusers) of Medicaid are single, childless adults.

Though the Foundation for Government Accountability report does not delve into the reasons for such high utilization of health care, other reports indicate that much of the cost is driven by drug and alcohol

abuse and resulting emergency room visits.

There is no indication that government – taxpayer-funded – access to medical services is actually solving the health problems. Further, by removing personal accountability and cost impacts from the use of these services, there is no incentive for the individuals to control or reduce their use.

Iowa Medicaid Facts

Currently Medicaid serves over 680,000 Iowans or 22.4 percent of the state population. Medicaid is the second largest payor of health-care costs, after Wellmark Blue Cross/Blue Shield, and processes almost 33 million claims a year.[42] Included in the population served are people with incomes over 133 percent of the FPL through a waiver program (IowaCare and Family Planning) and some Medicare-eligible people. "Regular" Medicaid has just over 420,000 participants.[43]

On average, Medicaid currently spends about $3,300 per person on recipients in Iowa.[44] Most recent growth in enrollees has been in the child category, which is also the least expensive care to provide – typically well-child check-ups, vaccinations, dental checkups, and occasional illness visits. The number of children enrolled is expected to increase from just under 65,000 to almost 69,500 in FY2015 alone.[45]

The highest expense category is for the elderly, typically a 72-year-old female in long-term care who needs assistance with at least one activity of daily living.[46] This care costs approximately $45,700 per year.

The typical enrollee with a physical and/or intellectual disability is a 28-year-old male with an intellectual disability who lacks life skills. The cost for this individual to live in an intermediate care facility is approximately $141,000 per year.

If both the elderly and the disabled can remain in their family homes and receive care there, the costs drop dramatically, to less than $10,000 for the elderly and $35,000 for the intellectually disabled.[47]

The highest cost patients have an average of 4.2 chronic conditions and five different doctors, with prescriptions from all five. They account for three-fourths of all in-patient hospital costs and 50 percent of drug costs.[48]

The Iowa Medicaid program recently ranked 6th best nationally for long-term care system performance. Additionally, an innovative "joint individual conference" program, where the patient and their family members/ caregivers work together to determine the best treatment plan, has been credited with reducing in-patient hospitalizations.

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"The Iowa Medicaid program recently ranked 6th best nationally for long-term care system performance."

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"The vast majority of the cost increases are driven by new federal requirements, irrespective of PPACA expanded Medicaid."

The total FY2015 Medicaid budget is almost $4 billion ($3.98 billion), currently 34.4 percent state funded and 53 percent federal funded, with the remainder coming from a variety of sources. The state budget amount has been growing at a rate of 15.6 percent per year recently, but the proposed FY2015 budget has a 7.5 percent increase ($95 million) from FY2014.

The vast majority of the cost increases are driven by new federal requirements, irrespective of PPACA expanded Medicaid.[49]

Additionally, the taxpayers of Iowa support a demonstration waiver program called IowaCare. This serves low-income adults who do not qualify for Medicaid. These are the core group which would convert to a straight Medicaid enrollment under the PPACA. The population is adults 19-64 who have incomes below 200 percent of the FPL, no other insurance, and who pay an income-based premium if their income is over 150 percent of the FPL. This requirement may be waived.[50] Approximately 69,000 adults are enrolled in this program.

The typical enrollee is a single adult or couple with a chronic condition who is in generally poor health, aged 41, with an income of less than 150 percent of the FPL. Chronic medical conditions include oral health, orthopedic needs, and hypertension. Enrollment has grown from just over 30,000 in FY2010 to an estimated 85,000 in FY2015. Most people who leave the program do so by going on Medicaid disability, not improving either their health or income.[51]

One criticism of this program is that services are provided only at limited facilities – primarily the University of Iowa Hospitals and Clinics (UIHC) in Iowa City and Broadmore Health Care in Des Moines. A new "Medical Home Model" with expanded UIHC locations is working to improve this access and reduce costs. The total cost is $162 million, with $8.6 million coming from the state General Fund.[52]

When reviewing the February 2011 UIHC report on services utilized by the IowaCare patients (predominantly single adults), the largest category of medical services provided was that of Emergency or Specialty Care, consistently about 83 percent. This is not expected to decrease under the Medical Home Model as primary providers will continue to refer patients to UIHC for specialty care.

The highest category was DRG Code 897 – people admitted for "Alcohol/drug abuse or other dependence issues, without rehabilitation services." Next highest was "circulatory disorders." Number five was code 918 – "poisoning and toxic effects of drugs." Other admissions were for major joint replacements, esophageal and

digestive disorders, cellulitis, and diabetes.

Prescriptions filled most often included drugs for acid reflux, pain, asthma, hypertension, and diabetes.[53]

Under Medicaid Expansion some individuals would be moved into the insurance exchange pool, primarily pregnant women, breast and cervical cancer patients, IowaCare, and Family Planning Waiver users who make more than 138 percent of the FPL.

One of the options being discussed as part of Medicaid reform is the Basic Health Program (BHP) option. The November 2012 subcontractor report – presumably the same report which recommended engaging stakeholders for more input and then doing another report – determined that the BHP would cost the state taxpayers more money unless fees paid to providers were reduced to the same amount paid by current Medicaid reimbursement levels, instead of being increased to the Medicare levels.[54]

Historically Iowa Medicaid reimbursement levels, as determined by the federal government, have been below the fees paid by other insurance companies, resulting in many doctors refusing to accept Medicaid patients. This is even though Medicaid is the second largest payor of health insurance claims in the state, after Wellmark.[55]

Nevertheless, if Medicaid is expanded the benchmark services offered must be the same as those in the exchange pool and must include "mental health parity" and both rehabilitative and habilitative services, irrespective of actual cost or of payment received. And fees paid to providers will still be controlled by the federal government.

In considering the overall Department of Human Services budget, it is important to note that the people being served by Medicaid are also utilizing a wide variety of other government entitlements and subsidies. This includes child support, child care and child welfare programs, food assistance, and the family investment program, to name a few.

The total number of Iowans receiving government assistance through these programs is almost 950,000 or a third of our total population.[56] This costs a total of $5.3 billion in both state and federal taxpayer funds.

Iowa Medicaid Expansion Impact

In evaluating Medicaid expansion, the state authorized reports by the Milliman group, which specializes in Medicaid actuarial projections. These reports, submitted December of 2011 and 2012, provide both insight and warning to those encouraging expansion.

Milliman predicts a three-year enrollment increase from 110,000 to 181,000 people,

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"Historically Iowa Medicaid reimbursement levels, as determined by the federal government, have been below the fees paid by other insurance companies, resulting in many doctors refusing to accept Medicaid patients."

Just Say NO – and Keep Saying NO –

"In rejecting the Medicaid expansion Governor Branstad cited a variety of other reasons, including loss of state control, uncertain costs, and regulatory burden....Branstad characterized the Medicaid expansion program as being 'a '60s federal program that's unaffordable and unsustainable.'"

caused by the coverage expansion itself, as well as woodwork and crowd-out enrollees. The prediction is that by June of 2015 over 710,000 Iowans would be on government provided health care.[57] This would be a 4.4 percent increase.

Milliman drops any discussion of the potential number of new enrollees after the first three years and estimates costs based on the initial numbers.

The December 2011 report projects that the expansion cost through FY2020 would be between a negative $72 million (or decrease) and an increase of $237 million.[58] This does not sound too bad, if you are a supporter of government health care.

However, by December 2012 the Milliman report increased those projections to a "low scenario" increase of $171.2 million and a "moderate" increase of $536.6 million. This is an increase in state funding costs, even with "100 percent federal payment" of providers!

The estimate of projected costs to Iowa taxpayers, done by a reputable actuarial firm, more than doubled from the 2011 report to the 2012 report. Even if the "low" increases for each year were the real numbers, the cost projections went up by almost $250 million. And if, as in states such as Arizona and Maine, these estimates are low, the state and taxpayers could see budget increases of almost $1 billion for Medicaid alone. This projection is not a political statement by the Governor, or Republican House or Senate members – this is a qualified academic projection of reality. What will the 2013 report cost estimate be?

Governor Branstad's Proposal

Iowa Governor Terry Branstad has said that he will not accept the federal expansion of Medicaid because of concerns that it "will either collapse, or the burden will be pushed onto the states in a very significant way."[59] He apparently has read the 2012 Milliman report.

In rejecting the Medicaid expansion Governor Branstad cited a variety of other reasons, including loss of state control, uncertain costs, and regulatory burden.[60]

He has instead proposed a federal waiver, along with a significant re-work of the IowaCare program, and a focus on the Healthiest State Initiative.

Branstad characterized the Medicaid expansion program as being "a '60s federal program that's unaffordable and unsustainable." He anticipates that the whole Obamacare program will either "collapse" or be financially pushed completely onto state governments.[61]

There is no deadline for agreeing to the Medicaid

expansion, and the deadlines established by HHS for various aspects of PPACA are mainly arbitrary and subject to continual pushback and change.

The IowaCare program authorization, as currently configured, expires on December 31, 2013, and the Governor has asked for an extension of that program. It has not yet been granted by HHS.

As part of the Governor's state reform efforts, the Iowa Medicaid Enterprise (IME) submitted a $1.3 million grant application to the Center for Medicare and Medicaid Services (CMS) to develop an ACO model for Iowa.

This model is supposed to:

1. Implement a multi-payer, value-based purchasing methodology across Iowa's primary care payers, including both Medicare and Medicaid. This is based on the current system used by Wellmark.
2. Expand on multi-payer ACO methodology to address integration of long-term care services, supports, and behavioral health services. Long-term care comprises half of the current Medicaid costs.
3. Engage Medicaid members in improving their own health.[62]

This effort will attempt to expand the "Blue Zone" and "Healthiest Iowa" approaches to Medicaid recipients, including the 50 percent in long-term care, and to children receiving CHIP services. Currently, irrespective of Medicaid expansion, the ACO model is being proposed by IME for all full-benefit Medicaid and CHIP recipients. Under the CMS grant, the model is to be tested this June.

Healthiest State Initiative

In response to reports of rampant obesity and increases in a variety of chronic health conditions, primarily diabetes, throughout Iowa, Governor Branstad has implemented the "Healthiest State" initiative. This program is based loosely on the "Blue Zone Project."

The Blue Zone Project offers guidelines for healthier living based on the behaviors of the "world's longest-living communities." These include things such as more daily exercise, having a purpose for your life, reducing stress, being a healthful weight, eating a wide variety of foods including more vegetables, drinking a glass of wine each day, having positive people around you, belonging to a support community, and putting your family first.[63]

The five key, practical, implemental priorities of the Healthiest State initiative are:

1. decreasing the number of Iowans who smoke,
2. increasing visits to the dentist,
3. increasing consumption of fruits and vegetables,
4. increasing individual lifetime learning habits,

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"The Blue Zone Project offers guidelines for healthier living... such as more daily exercise, having a purpose for your life, reducing stress, being a healthful weight, eating a wide variety of foods including more vegetables, drinking a glass of wine each day, having positive people around you, belonging to a support community, and putting your family first."

Just Say NO – and Keep Saying NO –

"On a long-term basis these goals should help Iowans to be healthier, and potentially reduce medical costs. We can all do these things without Obamacare and without a government bureaucracy overseeing our every action."

and

5. improving job satisfaction through positive workplace management.[64]

Smoking has been shown to result in increased poor health, as has a lack of dental care. More fruits and vegetables and less sugar will help us all to lose weight. And lifetime learning coupled with positive work environments will help productivity and the economy.

On a long-term basis these goals should help Iowans to be healthier, and potentially reduce medical costs. We can all do these things without Obamacare and without a government bureaucracy overseeing our every action.

Summary

Any legislation passed by the Congress, which must be voted on before it is ever analyzed or read, and which results in over 7 feet of regulations – as demonstrated by Iowa Senator Chuck Grassley – with yet more to come, is not going to be successful. It is certainly not going to result in the "desired" outcomes of healthier citizens – whether families, senior citizens, or individuals, or provide them with greater access and lower costs.

The experiences so far with Obamacare and expanded government control of almost one-fifth of our economy show that it only creates more dependency. Having almost half of Iowans receiving government health care benefits is not a goal we should work toward. Obamacare will increase the regulatory burden and complexity, drive up costs, and reduce access for those who truly need help funding their medical care. It will result in higher taxes for virtually every citizen. It does not, and will not, work!

The core expectations of medical care, for any individual – whether insured or un-insured – should be the ability to be seen in a timely manner by a qualified provider, to have the necessary tools and equipment available to make an accurate diagnosis, to have the provider make an appropriate recommendation for treatment, to have the needed treatment – whether drugs, therapy, or surgery – quickly available at an appropriate cost, and finally to be assured that they are not being offered substandard care and options because of their age or income level.

The decision on type of care to receive and options used must be made jointly with the patient and their doctor. And yes, in some cases the cost may well be a driving factor. For example, does a broken little toe really need an x-ray? Will the treatment be any different? If not, and if the individual receiving the x-ray really cannot afford it, why insist it be done?

And even if they have "insurance" to cover the cost, is it an appropriate use of the

insurance plan money?

The rest, from "coaching" to electronic medical records, is basically make-work. People have received excellent medical care, as well as poor care, for many years without either coaching or electronic medical records. That care has been provided at all cost levels and by not only medically licensed MDs, but by nurses and physicians assistants.

The public commentary from leaders of major health care organizations in the eastern Iowa area, as documented earlier, does not address these issues in a solid, focused manner. We do not need our medical professionals to be our "friends," we need them to provide medical care.

Governor Branstad and the Iowa Legislature should say "NO" and keep on saying "NO" until Obamacare is repealed or defunded. It does not, and will not, work and is a massive drag on our workforce and economy.

We, the citizens, must not be lured by the "promise" of "free money" and "someone else" paying for our health care, and instead insist on free-market driven reforms to address the real issues of cost transparency, inter-state portability, malpractice reform, and increased providers.

Possibly even more importantly, we must act personally to ensure our health is as good as we can make it and to not expect the government to take care of us. We must ask questions, not settle for secret rationing, and be educated enough to insist that we, our children, and our elderly, receive needed medical care.

The Governor's Healthiest State approach, though mocked by those supporting the government industrial complex, is a good idea. As is Michelle Obama's childhood obesity initiative – though presented and handled in a ham-handed manner.

Most of us should lose weight, eat healthier foods, exercise more, drink less alcohol, and get enough sleep. We should step up and make sure our children do the same thing. We should help our elders stay active and take care of themselves.

Importantly, we should pay attention to our mental health and build good relationships with our families, our friends, and our churches. But the government cannot make us do these things.

When using medical care we must ask questions and understand the problem and potential solution. Then we must insist that the care we and our child need is provided, not accept delays in access or reduced access to necessary specialists and treatments, decided by either the federal or state governments, not by ourselves and our medical providers.

The squeaky wheel does get the grease, and the assertive patient will be more likely to get the care he or she needs.

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"Governor Branstad and the Iowa Legislature should say 'NO' and keep on saying 'NO' until Obamacare is repealed or defunded. It does not, and will not, work and is a massive drag on our workforce and economy."

Finally, we must say "NO" and keep saying "NO" to government control of our lives and decisions.

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