POLITICALLY TOXIC: WHY THE STEPHEN REPORT PROVIDES NO ANTIDOTE FOR THE PRIVATE OPTION

By Marc Kilmer *3/15/16*

As Governor Asa Hutchinson has noted, the idea of the private option – Arkansas's version of Medicaid expansion – has become "politically toxic." Hutchinson's response to this political toxin has been to ask the Obama Administration for minor changes to the private option and to rechristen it as "Arkansas Works."[1] No cosmetic change, however, will transform the underlying reality: the program under consideration is an expansion of Medicaid, extending its traditional coverage to able-bodied adults, without dependent children, who live in households making less than 138% of the federal poverty level. Regrettably, a rebranded toxin is no less dangerous. To bolster the case for Medicaid expansion, however, last year the Arkansas Health Reform Task Force commissioned the Stephen Group to complete an assessment (the "Stephen Report") of the traditional Medicaid program and the Arkansas version of Medicaid expansion. This report, delivered in October 2015, concluded that ending the private option would impose hundreds of millions of dollars in costs onto the state budget and deprive the state of billions of dollars in federal matching funds

There is no doubt that ending Medicaid expansion would create fiscal consequences for Arkansas's budget. But the Stephen Report provides an unrealistically optimistic view of the consequences of Medicaid expansion by:

Omitting any discussion of Medicaid expansion's long-term impact on public finances;

Assuming that increased public borrowing and public spending will spur economic expansion; and

Ignoring Medicaid expansion's actual economic history – namely, that it slams down the brakes on job creation and economic growth.

The bottom line is that expanding Medicaid will most likely force Arkansas policymakers into choosing between two unpleasant alternatives in the near future: a set of politically impossible government spending cuts, as compared to the marginally more tenable alternative of significant tax increases.

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Arkansas policymakers must understand the limits of the Stephen Report's analysis before making policies based on its analyses. Instead of pursuing Medicaid expansion, with all the drawbacks that it brings, Arkansas policymakers should focus on reforming the traditional Medicaid program to better serve both taxpayers and recipients of its services.

THE PRIVATE OPTION VS. "ARKANSAS WORKS"

Because the private option failed to live up to its promise as a pro-work, fiscally sustainable measure, there is great skepticism from legislators – especially those who are fiscal conservatives – about continuing provision of Medicaid benefits to the expansion population. Governor Hutchinson has asked the federal government for permission to make some minor changes to the program, and then to proceed with Medicaid expansion under the name of "Arkansas Works" (see this paper's Appendix for a lengthier explanation of this program). Ultimately, legislators will decide whether to go along with implementing Arkansas Works – or whether to return to Medicaid's traditionally austere scope.

Although the Stephen Report examined the private option, much of its conclusions about Medicaid expansion can be used to examine Arkansas Works. If legislators use the Stephen Report to inform their decision on Arkansas Works, they should familiarize themselves with its flaws.

THE FISCAL FLAWS OF "ARKANSAS WORKS"

The central message of the Stephen Report is that Arkansas loses lots of money by ending the state's Medicaid expansion. The report therefore paints expansion as a positive for the state's taxpayers. However, upon closer scrutiny, this conclusion appears overstated.

The Stephen Report's Defective Five-Year Window

The Stephen Report gives two fiscal benefits for Medicaid expansion: $9 billion in money from the federal share of the Medicaid match, and $757 million in potential state budget savings because of changes to state programs and new tax revenue.[2]

This fiscal picture is presented over a five-year period. While a five-year budget picture is a normal way to discuss government spending, in this case it

obscures the true cost of Medicaid expansion. That is because the federal government has a temporarily higher matching rate during this period than during the time period after the budget is described. After 2020, the federal government will require the state to pay for 10% of the cost of expansion enrollees. This rate is higher than the matching rate for enrollees in traditional Medicaid, but it will still require hundreds of millions of dollars from the state every year.

As the Stephen Report shows, the state's share of costs for Medicaid expansion increases every year during this five-year period. Even though the Stephen Report does not report costs past 2021, Medicaid cost escalation will continue after that year. The Stephen Report's projections concede this, if not in so many words. For four of the five years in this projection, the federal matching rate is temporarily higher. The increased federal matching rate ends in 2020. In that year, there is a projected $43 million increase in cost to the state compared to 2019. This increase is partially explained by the end of the temporarily high federal matching rate. But between 2020 and 2021, when the federal match remains the same, the Stephen Report projects that costs will increase by $36 million.[3] In other words, an observer cannot blame the increasing costs of Medicaid expansion solely on the end of the higher-than-normal federal matching rate.

A ten-year projection would almost certainly show that the state's share of funding for the private option would continue increasing in 2022 and beyond. Those who want a more accurate picture of Arkansas's long-term fiscal burden under expansion should demand this ten-year projection, not a five-year projection which – by unlikely coincidence – halts just as Arkansas's share of spending shifts into high gear. The costs of Medicaid expansion will not flatten after 2021. As is the case with the traditional Medicaid program, the expansion population will rise as more people enroll in the program (as a result of natural population growth), as medical expenses increase, and as economic downturns occur. This is how Medicaid works, whether in its traditional form or in the private option – its impact on the budget grows from year-to-year, with few exceptions. For instance, the total spending on the traditional Medicaid program in Arkansas increased from $3.2 billion in 2007 to $4.9 billion in 2015, an increase of 53% in eight years.[4]

Furthermore, during the final year of the Stephen Group's five-year projection, Medicaid expansion in and of itself (that is, putting aside new tax revenue) is a fiscal burden on the state. For four of those years (2017-2020), the Stephen Group projects that changes in the state's Medicaid program will save money by shifting certain Medicaid populations into the private option, as well as undertaking other changes to the Medicaid system. These theoretical savings

would be larger than the state match (which is temporarily low in these years due to a higher-than-normal federal matching rate) to cover the expansion population. However, in 2021, the state will be paying more for its Medicaid match to cover this new population than it would save from the population shift and other changes. This is an indication that the savings from population-shifting and related changes are temporary (and linked to the temporarily-higher federal Medicaid match), but beyond the five-year window the burden on the state budget will continue to grow.

All these factors mean that the state will be responsible for paying an ever-increasing amount of money to cover Arkansas's new enrollee population. The effects of this are obscured by a five-year budget projection, since this shorter time period focuses on the years in which the state government's share of the tab is temporarily low. It is a safe bet that a ten-year projection will demonstrate that the average yearly savings from Medicaid expansion are sharply overstated: a back-of-the-envelope calculation shows that the savings in the 2022-26 period would be roughly half of those claimed for 2017-2021.[5] Regrettably, even the five-year figures that the projection relies on are on shaky ground: for instance, the Stephen Group argues that the establishment of the private option saves $117 million in public expenditures over that period "from optional Medicaid waiver programs discontinued after the establishment of the PO."[6] In reality, these "savings" from *optional* waiver programs can accrue with or without Medicaid expansion. It is unfortunate that the Hutchinson Administration appears to be uncritically relying on the Stephen Group's calculations to justify its claim that ending Medicaid expansion would result in a $100 million budget deficit.[7]

Notably, there are no guarantees from the federal government that the 90% matching rate will continue. Given the long-term fiscal problems facing the federal government, it seems inevitable that federal policymakers will be forced at some point to cut spending, increase taxes, or both. At that point, reducing the high reimbursement rate for this expansion population will be a tempting target. If the federal government does reduce this matching rate, the state will be forced to make up the difference. Indeed, Speaker of the House Paul Ryan has warned the country to keep this eventuality in mind. In 2013, Ryan told the *Chicago Tribune*:

> The fastest thing that's going to go when we're cutting spending in Washington is a 100 or 90 percent match rate for Medicaid. There's no way. It doesn't matter if Republicans are running Congress or Democrats are running Congress. There's no way we're going to keep those match rates like that.[8]

The signals that the 90% match rate will eventually drop are hardly confined to Republicans. President Obama's budget for FY 2013 included a "blended" Medicaid match rate that would have cut Medicaid payments to states by $17.9 billion over 10 years; that budget also included a proposal to reduce and cap the applicable Medicaid provider taxes – which was estimated to lower federal spending $21.8 billion over 10 years.[9] In short, the blithe assumption that the 90% match rate will continue begins to look more and more like willful ignorance.

The Stephen Report's Shaky Budgetary Assumptions

The Stephen Report's projected savings from Medicaid expansion come from spending that is no longer going to certain state programs, such as a fund to pay for uncompensated health care and behavioral health care spending. The state also moved certain populations of Medicaid recipients from traditional Medicaid to the private option to take advantage of the latter's higher reimbursement rate. Essentially, this strategy relies on saving public money by buying more goods at a more highly subsidized rate.

However, the Stephen Report acknowledges that shifting some people from traditional Medicaid to the Medicaid-expansion categories, as well as discontinuing some state health care programs, is not enough to make Medicaid expansion budget-neutral. From 2017 through 2021, the Stephen Report projects that the state match for the private option would be $598 million. Administrative costs would add another $14 million. The Stephen Report projects that the state would save $504 million from shifting current Medicaid recipients into the expansion group, thus receiving a higher reimbursement rate. It also projects $203 million in savings from reductions in uncompensated care, and $117 million from discontinuing certain Medicaid waiver programs. With all these projected savings, the state is projected to save $213 million through Medicaid expansion during this five-year period.[10]

Assuming new tax revenue also leads the Stephen Group to claim that Medicaid expansion will have a positive impact on the state budget. Part of the assumption underlying this increased tax revenue is that the state could tax the new insurance policies offered under the private option. That is, the state and federal government would pay for new policies, then the state would tax these policies. The other new tax revenue that the report's predictions rely upon would come from state taxes on the federal money coming into the state (which, itself, is a controversial assumption). The Stephen Report projects that, over five years, taxes on insurance policies would produce $208 million in new revenue. Tax revenue

from increased economic activity would produce $336 million during this period. That assumed tax revenue of $544 million would theoretically produce a $757 million surplus for the state.[11]

As mentioned above, outside the 2017-2020 time frame (when the federal matching rate is temporarily higher than normal), Medicaid expansion *as such* is a burden on the state budget. Only through theorizing new tax revenue that will theoretically be produced in response to this expansion can the state see a net positive effect in 2021 and the future. As discussed below, legislators should be cautious in assuming that tax money from this new federal revenue will appear. Furthermore, if the state terminates Medicaid expansion, legislators can look for ways to restructure uncompensated care spending as well as restructure the traditional Medicaid program to introduce cost savings (more on this below). With the right reforms, the cost of returning to the pre-expansion Medicaid system wouldn't be anywhere near as sizable as the Stephen Report assumes.

Contributing to the Federal Deficit

Notably, the $9 billion in federal funding that finances Medicaid expansion does not drop from the sky, like manna from heaven. This $9 billion necessarily comes from increased federal borrowing or increased federal taxation. Federal taxation creates current burdens, while federal spending and borrowing creates future burdens. These new costs of taxes and deficit spending will certainly not be confined to Arkansas; nonetheless, current and future residents of this state will bear a large share of them.

State policymakers who roll out the red carpet for this federal funding bear some complicity in worsening the long-term fiscal health of the United States. Medicaid is one of the entitlement programs that is responsible for most of the current deficit and projected future deficits. Michael Cannon of the Cato Institute explains how state legislators' action on this issue will affect overall federal spending (and borrowing):

> Supporters pretend Congress has collected a fixed pot of money from all states that it will divide among states that participate in the expansion. Yet Congress hasn't collected or set aside a dime. When states choose to participate, the Treasury will borrow money to cover its share of the cost, which taxes future taxpayers, not current ones. States can therefore reduce federal deficits by not participating.[12]

State legislators who believe their actions do not have a significant impact on the budget deficit could stand to be better acquainted with some basic budget facts. In 2014, the White House released a paper which projected that federal spending would be reduced by $88 billion over three years from the states that refused to expand Medicaid.[13] The recent budget sequester, which was arguably the most effective budget-cutting measure of the last decade, helped reduce federal spending over a three-year period by $97 billion.[14] With Congress and the president working to evade the sequester caps, it is unlikely that this type of budgetary savings will continue. However, if Arkansas joins the states that reject Medicaid expansion, it will be part of an effort which will have a far larger effect on reducing the deficit over the long run.

THE WORK DISINCENTIVES OF "ARKANSAS WORKS"

The Stephen Report concluded that "Between 2017 and 2021, it has been estimated that the PO will contribute an additional $3.2 billion to the state GDP and support over 6,000 jobs over that same period."[15]

The Stephen Report's analysis is difficult to defend. Speaking generally, pumping billions of dollars into the state will obviously "support" jobs. Regrettably – because, again, the billions of dollars at issue do not fall, like manna, from the sky – this analysis ignores the long-term cost of borrowing to support these jobs. It also ignores the historical experience of other states – states which expanded Medicaid, but (as described below) did not see the promised job increases. In other words, the historical evidence at hand suggests that expansion-fueled job creation is not economic analysis, but political mythology. Notably, the revenue estimates that the Stephen Report supplies assume a "multiplier" effect of zero[16] – which itself serves as a concession that Medicaid expansion will not create economic expansion. Instead, the zero multiplier suggests that what is being done is simply shifting resources around.

Furthermore, under Gov. Hutchinson's Arkansas Works proposal, the design of future Medicaid expansion will carry with it a disincentive for employers to create jobs and for some employees to increase earnings. As mentioned above, the federal funding for Medicaid expansion comes from either borrowing or taxes. If it comes from borrowing, it follows that future tax revenue will be needed to pay for it. Taxes have a large negative effect on economic growth and job creation. Health care scholar Chris Conover explains the net effect of the taxes that will finance Medicaid expansion:

> 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.[17]

The Stephen Report's estimate of Medicaid expansion's job effects is based on controversial economic modeling. Actual experience in other states calls that estimate into question. In Kentucky, for instance, then-Governor Steve Beshear claimed that expanding Medicaid would support tens of thousands of jobs. In reality, jobs in Kentucky's health care sector decreased post-expansion.[18]

Overall, health care jobs are growing nationally. However, there is no evidence that Medicaid expansion is boosting this trend. In fact, national data show that states that expanded Medicaid have slower rates of health care job growth than do states which did not expand Medicaid.[19]

An analysis from the Foundation for Government Accountability (FGA) explains that there is no positive impact for overall job growth:

> The Congressional Budget Office estimates that Medicaid expansion will reduce employment, earnings, and economic activity overall. But several Medicaid expansion supporters nevertheless promise that expansion will spur economic activity and drive employment growth. Despite those promises, an analysis of government data reveals that states that have expanded Medicaid have actually had slower job growth than states that have not.[20]

If Arkansas were an exception to this trend and Medicaid expansion could actually spur job creation, is that something that should sway lawmakers? According to Harvard University economist Katherine Baicker, health care policy should not focus on job creation:

> Salaries for health care jobs are not manufactured out of thin air – they are produced by someone paying higher taxes, a patient paying more for health care, or an employee taking home lower wages because higher health insurance premiums are deducted from his or

> her paycheck. Additional health care jobs leave Americans with less money to devote to groceries, college tuition, and mortgage payments, and the U.S. government with less money to perform all other governmental functions – including paying teachers, scientists, and social workers. That trade-off can be justified if it goes along with improved health outcomes, but not if those jobs do not generate benefits that exceed those of alternative uses.[21]

In short, the focus on job creation through new spending is misguided – because if jobs, on net, could be created by government spending, then government programs could spend us all into higher and higher levels of prosperity. It is a matter of some concern that allegedly conservative policymakers in Arkansas have ignored the crushing impact on job creation and employment that is created by Medicaid expansion generally. One reason for that downward pressure is the welfare cliff that must be faced by those who might consider increasing their income above the 138% poverty level: for instance, single adults (on average, nationally) face out-of-pocket expenses of nearly $2,000 the moment their income goes north of that line.[22] In Arkansas, out-of-pocket expenses under the 138% line are capped – which results in an even larger cliff for those whose income goes over the line. This is an incentive that encourages a lifetime of welfare-funded poverty – an incentive for which the architects of Medicaid expansion bear political responsibility.

The Real-World Effect of Arkansas Works

Furthermore, Arkansas policymakers should consider whether the specific features of Arkansas's Medicaid expansion discourage job growth. Under Arkansas Works, Governor Hutchinson has proposed that anyone eligible for the program must sign up for employer-sponsored insurance when available. The state will then pay for the employee's share of the premium. This will, arguably, save the state money. Instead of purchasing (and paying) for a health insurance policy, under this proposal the state will force the employer to pay for the policy, and Arkansas taxpayers will only pick up part of the cost.

Although this shift may provide some savings to the state, it imposes new burdens on employers. Under this mandate, employers' cost of providing insurance will rise. Employers could react to this in a number of ways; for instance, they might cancel the health insurance coverage they provide. For larger employers, cancellation would trigger a penalty under Obamacare; nonetheless, some employers might decide that it may make more economic sense to cancel employee

coverage than to pay for insurance. Smaller employers can end employee coverage without any penalty, but those businesses which expand their payroll to 50 employees will then face the Affordable Care Act's employer mandate and its resultant penalties. The Arkansas Works mandate, therefore, discourages job growth.

Another reaction by employers to this mandate might be to increase the share of health insurance costs that is paid by employees. This decision would not directly affect employees covered by Arkansas Works. Those employees' share will be paid for by taxpayer dollars. However, if businesses make this choice, it will increase the cost of this program to taxpayers. Such a choice would also affect any employees covered by the employer's insurance, but not enrolled in Arkansas Works – because they will be paying more for health insurance.

Obamacare already imposes a burdensome mandate on employers. Arkansas Works would make that employer mandate even more burdensome by requiring more workers to obtain insurance through their work. This will exacerbate the negative employment effects we already see under Obamacare.

Job loss can come on both the supply (business) and demand (worker) sides. On the supply side, Obamacare has had a terrible impact on job creation.[23] In Arkansas, the design of Arkansas Works would likely dampen job creation further by increasing the size of the employer mandate on businesses. Also, by increasing the number of people on employer-sponsored health insurance, it will hike the cost of providing this benefit to workers.

Ultimately, Arkansas Works will create a disincentive to raise salaries above 138% of FPL – which will encourage Arkansans to limit their hours or forgo opportunities for advancement in their jobs. This is because an Arkansas Works enrollee who increases his or her salary above this limit will lose the insurance subsidy – and then must pay for the employee share of the health insurance premium. This is even more pronounced because some other government programs in the state, such as WIC, make recipients automatically eligible if they are on Medicaid. The linking of such benefits to Medicaid exacerbates the disincentive for workers to increase their salaries above the Medicaid limits, since they stand to lose far more in benefits than they gain in salary. Relatedly, the poisonous mandates of Obamacare have already encouraged employers across the country to reduce their employee hours;[24] Arkansas Works threatens to have the same consequences.

Arkansas Should Learn from Tennessee's Disenrollment Experience

Some conservative pessimists have concluded that any expansion of the welfare state must be unstoppable and eternal. Those pessimists have been diverted into worrying about the following question: if Arkansas cancels coverage, how should Arkansas replace it? But – if the experience of neighboring Tennessee is any guide – when Arkansas decides to end Medicaid expansion, that decision will *encourage the people of Arkansas to move into productive work*. That is work which generates real income to them, real tax revenue to the state, real economic growth for the people of Arkansas, and real health-care coverage that is not directly subsidized by taxpayers.

In 2005, Tennessee disenrolled approximately 200,000 residents from Medicaid.[25] This failed to result in the kind of economic turmoil that had been predicted by doomsayers: rather, it created economic growth and higher employment. Tennessee's economy benefited from a sudden employment increase not seen anywhere else in the South, largely because able-bodied adults re-entered the labor force.[26] An astounding 63% of disenrolled adults increased their employment (for instance, part-time employees became full-time), leading to other significant changes – for instance, applications for Social Security disability benefits declined by 10%, and job-search behavior increased by 100%. The increase in private insurance coverage triggered by Medicaid disenrollment was perhaps even more notable: 90% of those who increased their employment gained employer-sponsored health insurance.[27] As explained in a *Quarterly Journal of Economics* paper, the disenrollment that led to Tennessee's employment spike was also accompanied by a jump in private health insurance coverage:

> The increased employment is concentrated among individuals working at least 20 hours per week and receiving private, employer-provided health insurance. We explore the dynamic effects of the disenrollment and find an immediate increase in job search behavior and a steady rise in both employment and health insurance coverage following the disenrollment.[28]

The Tennessee experience suggests that ending expansion will be unlikely to have a major catastrophic effect on the able-bodied, childless adults who are now enrolled in the private option. In Tennessee, many of those who previously had coverage adjusted to the change and found work, which created beneficial effects for them as well as all other Tennessee citizens – who benefit from a growing, productive economy.

The bottom line is that, contrary to the rosy scenario presented by the Stephen Report, continuing with Medicaid expansion will have a variety of negative effects. It will burden state taxpayers by mandating significant new spending in the future, bloating the federal budget deficit, and hurting efforts to create jobs and grow businesses in Arkansas.

OPPORTUNITIES FOR REAL REFORM

The Stephen Report didn't just look at the private option; it also examined the state's traditional Medicaid program. What did the Stephen Report conclude?

> TSG's review shows a traditional Medicaid program that is poorly positioned to meet the state's needs going forward. Future growth in the non-expansion program, even at a level below the growth projection of the federal government, shows an unsustainable, and unaffordable, path forward. To continue down the current path would result in substantial tax increases, reductions to other important State programs, cuts to Medicaid services or all three of the above.[29]

At its current level of growth, traditional Medicaid will require the state's taxpayers to pay an additional $520 million by 2021 to fund the program. There is good news, however; the state has numerous opportunities to find savings and provide better care. That's because, as the Stephen Report says, "There are several areas where the Arkansas Medicaid program has not yet taken approaches that are considered best practices across the country…"[30]

Expanding Medicaid to comply with Obamacare may interfere with attempts to reform traditional Medicaid. Such expansion can hurt those who receive traditional Medicaid, as the FGA report explains:

> Medicaid has historically been reserved for particularly vulnerable populations, including poor children, pregnant women, seniors, and individuals with disabilities. But Medicaid expansion would change that, extending Medicaid benefits to an entirely new class of able-bodied adults who have no dependent children. Worse yet, Arkansas' expansion model would prioritize these able-bodied adults over the truly needy.

> Under the Arkansas model, expansion enrollees would receive their benefits through QHPs–private insurance plans with higher reimbursement rates–while the most vulnerable continue to receive benefits through traditional Medicaid. This would create perverse incentives for medical providers to accept more able-bodied adults in the expansion population, while the truly needy trapped in Medicaid continue to struggle for access to care.[31]

Instead of trying to rebrand the Private Option as Arkansas Works, legislators would do well to turn their attention to restructuring the existing Medicaid program to serve the most vulnerable Arkansans and provide a better value for taxpayer dollars.

Consider what the Stephen Report has to say about Long Term Support and Services (LTSS), which serves people with severe disabilities:

> Arkansas is in the third quartile of overall spending for traditional Medicaid (rank 19) and in the top quartile (rank 12) for LTSS spending. This reflects the lack of focus on managing care for the LTSS populations.
>
> This suggests a legislative strategy of focusing the Agency's attention on improving healthcare value (cost and outcomes) for those receiving LTSS care–introducing more aspects of care management to traditional Medicaid.[32]

In other words, the state could provide better service to this population – in ways that could have a positive fiscal impact.

In addition, the Stephen Report notes that the state "does not have full use of data analytic capabilities focused primarily on identifying patterns of fraud, waste and abuse"[33] in the current Medicaid program. If the state cannot adequately police the current program to ensure that taxpayers are not being bilked, then expanding the program means expanding the capability for further abuse of the system. This inability to detect waste, fraud, and abuse not only harms taxpayers, but it also harms the ability to provide health care services to those who most need them. Continuing with Medicaid expansion is irresponsible without beefing up the state's capability to ensure the program's integrity.

The Stephen Report outlines a variety of reforms being tried in other states that could restructure the Arkansas Medicaid program to provide a better value for both recipients and taxpayers. For instance, the Stephen Report noted deficiencies in addressing hospital payment and care management, reforming long-term care, and reducing costly institutional care. Legislators should also consider Florida's Medicaid reform model, which uses a risk-adjusted premium model that has worked well to contain costs as well as provide more choices to Medicaid recipients.[34]

Fixing the numerous problems with the state's traditional Medicaid program would save taxpayers money and provide better service to people with disabilities, pregnant women, children, and the truly vulnerable in the state as opposed to continuing the expansion of Medicaid services to able-bodied adults without children.

CONCLUSION

While supporters of Medicaid expansion – whether under the guise of the Private Option or Arkansas Works – claim that the state will benefit fiscally and economically by this expansion, there are ample reasons for skepticism. A close look at the budget numbers reveals that the long-term fiscal picture is far less positive for Arkansas with Medicaid expansion. In particular, policymakers who rest their decision on the meager five-year fiscal projection provided by the Stephen Report are making decisions in something like an informational vacuum, given the unique circumstances of Medicaid expansion under the Affordable Care Act; at a minimum, policymakers should demand a ten-year fiscal projection for expansion, as that time horizon would provide a more realistic account of the long-term costs of the program. Furthermore, the experience of other states and the structure of Arkansas Works will likely have a negative impact on job growth. Instead of continuing to try to make Medicaid expansion work, Arkansas policymakers would have better results if they focused on reforming the state's traditional Medicaid program. Fixing the numerous flaws in the Medicaid system would have real results for both the taxpayers and the vulnerable Arkansans that depend on this program.

APPENDIX: WHAT IS ARKANSAS WORKS?

Under Governor Beebe, Arkansas opted to expand Medicaid under the terms of the Affordable Care Act under the name of the "private option." For a variety of reasons, the private option failed to live up to the promises of its supporters. After

Governor Hutchinson came into office, he decided to continue Medicaid expansion while seeking permission from the federal government to make changes to that program (a federal program like Medicaid cannot be changed unilaterally by the state). His latest proposed revision of Medicaid expansion is called "Arkansas Works."

The major areas of change sought by Governor Hutchinson are:

Encourage employer-sponsored insurance. As discussed above, Arkansas Works would require recipients to use employer-sponsored insurance when available, with the state picking up the recipient's portion of the premium. As mentioned above, this will increase the burden of Obamacare on Arkansas business owners and, ultimately, hurt recipients by giving them a disincentive to increase their salaries. Its net effect will harm the Arkansas economy.

Incentivize work. Recipients would be mandated to job-training and job-referral systems, and the state would develop a work incentive program. While this may sound good, in reality there is unlikely to be much effect in moving people to work. Merely attending job training or requiring people to go to job interviews is not the same as requiring them to find work. A true work requirement for Medicaid is prohibited under federal law.

Increase personal responsibility. For some recipients, the state would charge co-payments and premiums. This proposal is actually a repeat of what supporters of the private option attempted to enact. The federal government declined to approve any significant attempts to mandate that recipients have "skin in the game." As experience with the private option demonstrated, when recipients failed to pay their copayments or premiums, they were still provided with services. This simply left providers with small debts that were generally uncollectible. While it may sound good to say that Arkansas Works will increase personal responsibility, this type of reform is unlikely to accomplish this goal.

Strengthen the program's integrity. There will be no retroactive eligibility for the program. This is a positive reform of the program, but is unlikely to result in significant fiscal savings because it will not affect a large number of recipients.

There is nothing wrong with these goals, but there is nothing especially right with them either. Implementing actual work requirements or real medical savings accounts – the supposed payoffs in the long string of broken promises that

supported the passage of the private option – would require federal approval, and that is highly unlikely to happen.

When the private option was being discussed, similar bells and whistles were discussed by Arkansas legislators and then-governor Mike Beebe. However, the federal government did not approve work requirements; it severely limited even the tiny co-payment aspects of the program. There is no indication that the Obama Administration will be more generous to Governor Hutchinson than it was to Governor Beebe. Even if the governor succeeded in implementing praiseworthy versions of these reforms, the basic structure of Medicaid expansion will be the same: as described in this paper, it will hamper job creation and economic growth in Arkansas while ultimately creating huge fiscal liabilities for state government.

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[1] Roby Brock, "Hutchinson Supports Private Option to 2016, Forms Task Force to Review Options," January 22, 2015, talkbusiness.net. *http://talkbusiness.net/2015/01/hutchinson-supports-private-option-to-2016-forms-task-force-to-review-options*

[2] Ramsey, David, "Updated numbers: private option will save state budget $757 million, consultant says," *Arkansas Times*, March 7. http://www.arktimes.com/ArkansasBlog/archives/2016/03/07/updated-numbers-private-option-will-save-state-budget-757-million-consultant-says

[3] *Ibid.*

[4] The Stephen Group (TSG), Volume 1, Findings Report, October 1, 2015, pp. 68

[5] If we assume a $10 million yearly spending increase on the state match for the private option and use least-square linear extrapolation for the chart's other factors, this demonstrates a sharply lower yearly impact on state funds for the extrapolated post-2021 period.

[6] *Ibid*.

[7] Email from Hutchinson spokesman J.R. Davis to AAI reporter Caleb Taylor of February 24, 2016. When asked for the basis of Hutchinson's estimate of a $100 million yearly deficit in a previous speech, Davis summarized the Stephen Group's savings categories and then added "I would also refer you to slide 10 in the Stephen Group's report if you have any other questions."

[8] Rick Pearson, "Rep. Paul Ryan Warns Governors on Obama Health Care Plan," *Chicago Tribune*, April 22, 2013.

[9] See, e.g., Drew Gonshorowski, "Medicaid Expansion Will Become More Costly to States," Heritage Foundation, August 30, 2012.

http://www.heritage.org/research/reports/2012/08/medicaid-expansion-will-become-more-costly-to-states

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[15] TSG, p. 48.

[16] TSG, p. 57.

[17] Chris Conover, "Will Medicaid Expansion Create Jobs?" *Forbes*, February 25, 2013.

[18] Jason Hart, "Kentucky's Medicaid expansion promises clash with reality," Watchdog.org, December 11, 2015.
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[19] Melanie Evans, "Economists Find No Evidence that Medicaid Expansion Adds Healthcare Jobs," *Modern Healthcare*, November 26, 2014.

[20] Jonathan Ingram, et al., "Arkansas's Failed Medicaid Experiment: Not a Model for Nebraska," The Platte Institute for Economic Research, January 16, 2016.

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