March 20, 2024

Members of the Health and Human Services Committee
Kansas House of Representatives

Chairman Landwehr, Ranking Member Ruiz, and distinguished Members of the Committee:

Thank you for this opportunity to testify on health care reform in Kansas and in particular on expanding Medicaid. We are grateful to have this opportunity to share our views.

On behalf of AFP's Kansas state director, Elizabeth Patton, and our thousands of activists, members, and supporters across this state, we respectfully oppose Medicaid expansion, for reasons I will explain.

In Kansas and across the country, Americans for Prosperity activists engage friends and neighbors on key issues and encourage them to take an active role in building a culture of mutual benefit, where people succeed by helping one another. Health care reform is a top priority for us because it is deeply personal and because no individual or community can thrive and flourish without good health care. Our members are committed to making health care truly affordable, transparent, and much less of a hassle for everyone.

I'm Dean Clancy, AFP's senior health policy fellow. I'm a former White House budget official and a long-time health policy analyst, with more than twenty years high-level experience in Congress, the executive branch, and the health care industry.

I'm familiar with this issue, in particular, because I had the honor of serving as the associate director for health care and entitlement issues at the White House Office of Management and Budget (OMB) from 2004 to 2006. I was part of the federal team that reviewed and negotiated a number of state Medicaid waivers, including important waivers for Vermont and Florida.

I had the honor and pleasure of testifying in the Kansas Legislature on this topic almost exactly nine years ago. I advised against expansion in March of 2015, and time has not altered my view. Kansas was, and is, wise to just say no.

Admittedly, health care today is far too expensive, complex, and frustrating. Prices are high and rarely transparent. It is getting harder to find a doctor in our insurance plan's network. Meanwhile, health insurance companies enjoy record profits and government health care programs are straining state and federal budgets. The way we subsidize health care is unsustainable in its current form.

The biggest problem we face, the root problem, is that In America the patient is not the customer, the patient is the product. This is because 90 percent of health care is paid for by strangers — third parties like health insurance companies, businesses, and government programs — rather than directly by patients. The good news is that, with incremental free-market reforms, we can put the patient in the driver's seat. We can make our system the best and most affordable in the world instead of merely the most expensive.

And yet, I want to be clear, it is still a good system overall. Despite all the problems I've just mentioned, we Americans enjoy superior quality and virtually universal access. Ninety-eight percent of us are either enrolled in or eligible for generous federal subsidies for their health insurance. And despite the excessive cost and hassle, most Americans are satisfied with their current coverage and are not looking for more government involvement. What they want and deserve instead is a Personal Option — more choice and control and more competition.

Medicaid Expansion goes in the wrong direction and would be wrong for Kansas. I count at least fifteen good reasons not to expand Medicaid. I will append to this written testimony a list of those fifteen reasons, including links to the relevant sources and studies.

For now, I just want to highlight a few key reasons to oppose it.

Perhaps the most pertinent one, from a taxpayer perspective, is that it will cost more than even the highest estimate you hear from experts. Back in 2015, I pointed out, and it is still true today, that

> *Kansas cannot count on the federal contribution remaining at 90 percent. It is going to go down, probably to a blended rate well south of 90 percent. Eventually, I would expect, it will go down to the regular Medicaid matching rate.*

During that hearing, I also warned that the cap on the federally permissible state provider-tax rate will almost certainly go down because, like the 90 percent match rate, it is a target for federal budget-cutters.

Indeed, House Republicans in Washington are now officially proposing to reduce the Medicaid expansion FMAP rate all the way down to the normal Medicaid matching rate. They have included this in their congressional budget plan. It's the low-hanging fruit of federal deficit reduction. The question is not whether, but when, federal support will go down. And therefore, we can expect state spending on this program to go up.

Over the past nine years, I've watched a number of states try to modify their Medicaid Expansion bills to make the idea more palatable for taxpayers and centrists. Indiana tried adding personal accounts to Medicaid, but they don't work. Arkansas tried using Medicaid expansion money to put enrollees on private insurance, and it has doubled the cost. Many states have tried to impose work requirements on the expansion population, only to be shot down by the federal Medicaid agency and federal courts.

Several states have even included dead-man switches in their expansion law — automatic triggers that say that, if the feds ever reduce their contribution, our expansion goes away and all the beneficiaries will be disenrolled. It is unlikely a state would go through with that threat.

Medicaid expansion is all-or-nothing. A state cannot tailor its program. And once it opts in, realistically, it cannot get back out. Even when the federal match rate falls, de-expansion will be hard to pull off without political and policy disruption.

With a decade of Medicaid expansion behind us, we can see what it means for a state. Nearly every state that has expanded has seen program costs exceed projections. Research from the Foundation for Government Accountability shows Medicaid expansion has cost the average state 157 percent more than initially estimated. In Colorado, Medicaid expansion has cost more than a billion dollars above original projections.

In practice, many expansion enrollees are already eligible for Medicaid but have not bothered to sign up. They come out of the woodwork when they hear about the expansion.

And a significant percentage of those who sign up are able-bodied adults who already have health insurance. Over the past several years, 57 percent of new enrollees in government-funded insurance, which is overwhelmingly dominated by Medicaid, already have private insurance. If Kansas expands Medicaid, it's likely that more than half of new able-bodied enrollees will already have employer-based coverage or individual coverage.

Newly enrolled individuals will end up with worse access to care. Data compiled by the U.S. Centers for Disease Control and Prevention show that only 64 percent of Kansas's primary care physicians accept new Medicaid patients. By contrast, 86 percent of Kansas physicians accept private insurance. Drawing Kansans off private coverage and onto the Medicaid rolls will only make it more difficult for families to access basic medical care.

Every Medicaid dollar that the state spends on able-bodied adults is one less dollar it can spend on individuals with disabilities, pregnant mothers, and children in poverty. States that expand Medicaid have fewer resources to treat truly needy patients. Medicaid expansion would harm several thousand of these disabled, pregnant, and otherwise vulnerable Kansans who currently rely on Medicaid.

Nationally, expansion states have forced more than 250,000 sick patients to languish on waiting lists because they lack the funding for their care. Tragically, tens of thousands of these individuals have died before they can receive their care.

Medicaid expansion's unsustainable costs will crowd-out funding for other public services. In recent years, the growing cost of Medicaid has left state legislatures with fewer taxpayer dollars to spend on public education, public safety, and transportation. In fact, a 2018 study from Harvard University found that every $1 increase in Medicaid spending reduces per-pupil higher-education funding by $2.44. The study's author concluded, "Medicaid has been the single biggest contributor to the decline in higher-education support at the state and local level."

Even worse, a gigantic portion of new Medicaid spending is wasted. Recent audits by the federal Office of Inspector General, and data from the Centers for Medicaid Services — data disclosed only after Americans for Prosperity Foundation filed suit to end CMS's stonewalling — found that as much as one out of every five dollars Medicaid spends is improperly spent on individuals who do not qualify for the program, that is, persons who are not entitled to be on the rolls due to citizenship status or household income above the eligibility threshold. As a result of these improper expenditures, families are paying higher taxes for individuals who aren't even eligible for the program. I hope you'll agree it makes more sense to reform Medicaid than to make it bigger in its current form.

Expansion would bring these negative consequences to Kansas. It would dramatically increase costs and crowd-out funding for public services Kansans rely on every day. Moreover, it would make it significantly more difficult for Kansas' existing Medicaid program to provide essential health care services to its most vulnerable patients.

For all these reasons, we urge the committee to reject this expensive and, in our view, misguided proposal.

Instead of Medicaid expansion, Kansans need and deserve a Personal Option: a set of sensible, targeted, nonpartisan reforms that expand choice, reduce costs, and guarantee universal access to the high-quality health care Kansas families — and all American families — need, when they need it.

We stand ready to help you make the Personal Option a reality. Let's work together to give Kansas families and small businesses the better health care system they deserve — not with more government, but with more freedom, transparency, and more personal choice and control.

There are a number of policy reforms we can work together on. Before I go into detail, though, I want to take a moment to congratulate you on a few things you've already done right. Kansas is one of the most enlightened states in the country when it comes to regulating health insurance and health

care delivery. This state has traditionally had some of the lowest individual market premiums in the country. Good job!

Kansas has no certificate of need barriers for new and expanded hospitals and health facilities. CON laws are the biggest con in health care — protectionist schemes that limit competition, protect local monopolies, and increase prices instead of protecting patients. AFP activists are working to repeal these CON laws in the more than three dozen states that are not as enlightened as Kansas. Kudos to the Sunflower State on saying no to CON.

We also congratulate Kansas on having a safe harbor law that protects direct primary care arrangements. Direct primary care, as you know, is a popular new model of care delivery that offers unparalleled access, quality, affordability, and convenience. A DPC membership brings virtually unlimited access to trusted doctors, referrals to discounted lab tests and imaging services, and often deep discounts on generic drugs — all for one low monthly fee, with no additional fees or hidden charges. Subscriptions are typically very affordable, and doctors make themselves available to patients at all hours, spending more time with them, on average, than traditional, insurance-based doctors do. We at AFP view subscription-based and direct-pay models as the future of health care. And it's exciting to think Kansas is leading the way.

And Kansas can be proud to have a good law on the books with respect to Farm Bureau style health plans. These plans, which are personally owned and portable, can be significantly more affordable than traditional group health plans because they are mutual aid rather than insurance. Only five other states have passed similar laws. We're working to persuade the remaining forty-four states to follow your good example.

Okay, so what would a Personal Option approach look like in Kansas?

For one thing, it would include broader access to association health plans, which can help small businesses band together to purchase more affordable benefits for their members' employees.

Doctor shortages, especially in rural areas, are a national challenge. Why not make Kansas the national leader in reducing them?

For example, we should remove government barriers to the practice of medicine, so more physicians can practice here. A number of states allow, or are considering allowing, foreign-trained physicians, and medical-school graduates who have not yet completed a residency to practice under a temporary license under a doctor's supervision, with a chance, after a few years, to become permanently licensed doctors. Why not Kansas too?

And another idea. Why not reduce barriers to doctors and nurses delivering care to Kansas residents from out-of-state, including by way of telehealth?

To be fair, most of today's health care woes stem from misguided federal policies. There's not much we can do about those here in Topeka. But we can work with our congressional delegation. We can promote sensible, nonpartisan federal reforms that reduce the cost of coverage while maintaining protections for patients with preexisting conditions.

For example, reforms like universal access to tax-free Health Savings Accounts (HSAs), which give people more choices and more money for care. Also, we can reform the federal tax code to allow greater access to direct primary care. And perhaps best of all, we can create a universal, optional personal health credit for everyone under sixty-five, which they could use in conjunction with an HSA to obtain the mix of health coverage and out-of-pocket freedom that is tailored to their unique needs. Such a credit would be usable in lieu of existing health subsidies, but it would not replace them, and it would be 100 percent voluntary. If you like your health plan, you can keep it.

Other needed federal reforms include ending Medicare's ban on physician-owned hospitals and the adoption of site-neutral hospital payment by insurance plans. Site-neutral payment would end today's needless and harmful discrimination against outpatient facilities and doctor's offices, discrimination that tilts the playing field against healthy competition, drives up prices, and reduces access for patients. Site-neutrality would also save American patients and taxpayers tens of billions of dollars annually.

At the same time, we need good reforms to reduce the cost of prescription drugs through more generic competition and not through more government price controls or mandates.

Happily, these and other good federal reforms are reflected in a number of excellent bills, including, for example, Congressman Pete Sessions's Health Care Fairness for All Act of 2023 (HR-3129) and Congressman Greg Steube's HSA ACCESS Act of 2024 (HR-5608).

To learn more about these and other Personal Option reforms, visit our website, personaloption.com.

Let's do it. Let's work together on both sides of the aisle to make Kansas the best place in the world to be sick, and the best place to get and stay healthy.

Again, respectfully, we oppose Medicaid expansion because it is wrong for Kansas patients and taxpayers — and because there is a better way.

Thank you for this opportunity to share our views.

Submitted respectfully,

Dean Clancy
Senior Health Policy Fellow

Americans for Prosperity

APPENDIX

15 Reasons Not to Expand Medicaid

1. **It will cost more than projected.**
    a. On average, costs per enrollee for Medicaid expansion are 64% higher than projected.
    b. Before Medicaid expansion, the program accounted for one of every five dollars states spent. After expansion, it accounts for one of every three dollars spent.
    c. Arkansas's "private option" is costing more than twice as much as traditional Medicaid expansion.
2. **More people will enroll than projected.**
    a. Expansion states predicted 6.5 million people would enroll — but 16.7 million did — 160% more than projected.
3. **It will cause hundreds of thousands of people to lose their current health insurance.**
    a. If you like your health plan — oops, sorry, you can't keep it. As the Foundation for Government Accountability explains, "when states choose to expand Medicaid, able-bodied adults with income between 100 and 138 percent of the federal poverty level become eligible for Medicaid and [thus] automatically lose access to the [ACA's] free, private health insurance plans."
4. **It will crowd out health care spending for children.**
    a. A 2022 Mercatus report found that from 2014 to 2019 expansion short-changed children in expansion states by about $500 per child on average over the period, compared to non-expansion states, because it shifted scarce resources to adults.
5. **It will crowd out higher education spending.**
    a. A 2018 Harvard study found that every $1 increase in Medicaid spending reduces per-pupil higher-education funding by $2.44 and that "Medicaid has been the single biggest contributor to the decline in higher education support at the state and local level."
6. **It will open the door to massive increases in fraudulent and improper payments.**
    a. In 2020, the federal Medicaid agency estimated that one in five dollars spent on Medicaid was an improper payment, a loss of $86 billion in that fiscal year alone.
    b. Much of those improper payments come from paying for people who aren't eligible for the program — as of today more than 10 million enrollees nationwide are not actually eligible for Medicaid.
7. **It won't prevent hospital closures.**
    a. Arkansas expanded Medicaid based on promises of higher revenue for struggling hospitals that would enable them to keep their doors open. Those promises proved false.
8. **It will crowd out private insurance coverage.**
    a. Most people eligible for expansion are already eligible for private insurance. Expansion merely crowds out private options, hurting doctors and hospitals financially and drawing people into a broken health plan that won't be there when they need it.
    b. After Kentucky expanded, its hospital association reported that one in five Medicaid patients seeking treatment at their hospitals actually had private insurance when they enrolled in Medicaid.
    c. In North Carolina 63% of potential expansion enrollees already have private insurance.
9. **It will increase enrollment in traditional Medicaid — costing states beyond what they budgeted for.**

a. Many who sign up for the expansion are already eligible for regular Medicaid. They cost the state more than expansion enrollees do. States see a woodwork effect of about ten%, meaning a 10% rise in the traditional Medicaid enrollee population above the anticipated enrollment rate.
b. Woodwork enrollees cost the state more than expansion enrollees because they come with a lower federal contribution. Projections of expansion's costs often fail to account for this fact.
c. HHS audits continue to uncover states misclassifying enrollees as part of the expansion population rather than as part of the traditional population. This means many states are underpaying for Medicaid. If forced to comply with federal law, they will have to fill a budget hole.

10. **It will increase emergency room overcrowding.**
    a. Emergency department wait times increased 10% in states that expanded Medicaid coverage, compared to states that didn't.
    b. The hospital emergency room is the most expensive outpatient care setting, but for Medicaid patients, it's "free." They incur no out-of-pocket costs or debt when they waste ER resources on non-emergencies.
    c. To be fair to Medicaid enrollees, many have few good alternatives to the ER, because low payment rates cause physicians to shun them. On average, Medicaid pays only about 25% of what private commercial insurers pay for the same service.
    d. Medicaid patients are 1.6 times less likely than privately insured patents to successfully schedule a primary care appointment and 3.3 times less likely to successfully schedule a specialist appointment. And, Medicaid patients wait longer for appointments than privately insured patients. An HHS investigation found only half of doctors listed by the insurer as accepting new patients were actually accepting new Medicaid patients. And 25% of Medicaid patients with appointments had to wait over a month to be seen.
11. **Medicaid recipients receive lower quality care.**
    a. The strongest randomized control studies show health outcomes for Medicaid enrollees are consistently worse than health outcomes for the privately insured and even for the uninsured.
    b. Quality in state Medicaid programs is so abysmal that some Medicaid recipients have sued their state governments over it. A group of Medicaid recipients in California lodged a civil rights suit against the state over the substandard care they received. Despite this pressure, the state is still struggling with its Medicaid health plans. Just a few weeks ago the state leveled massive fines against an insurer "for failing to ensure adequate care and allowing treatment delays that threatened enrollees' health."
12. **It's fiscally risky — states can easily be forced to shoulder more of the costs.**
    a. Congress could alter its financial contribution to Medicaid, shifting more of the cost onto states.
    b. CMS could require states to correct erroneous enrollee classifications, increasing the state's costs.
    c. D.C. could crack down on states' use of provider fees to fund their share of Medicaid funding. While there are currently limits on this practice, the federal government could certainly go further if it chose — leaving states scrambling to find additional funding sources. This is not a hypothetical; legislation to do this is regularly considered by Congress.

13. **It's wasteful — expansion enriches Medicaid insurers, but little of that money directly benefits patients.**
    a. Only 20 to 40 cents of each Medicaid dollar directly improves recipients' welfare.
    b. Yet we consistently see reports on massive profits for Medicaid Managed Care Organizations (MCOs), private insurers that provide health plans to Medicaid enrollees. For example, from 2014 to 2016 Anthem made a profit of $549 million from California Medicaid plans. Yet during that time, eight of its twelve Medicaid health plans received low scores for patient care, and the company only spent 77% of the money it received from the state on medical care.
14. **It's all or nothing — once a state expands Medicaid, there's no going back.**
    a. No state has rescinded expansion to date for the simple reason that there is no politically realistic way to do so. A state that wanted to pull out would have to disenroll its entire expansion population, cold turkey. There is no provision for a "phase-out" or "off ramp."
    b. There's no way to trim or limit expansion enrollment if costs spiral out of control. Federal officials will not let states cap enrollment or reduce eligibility below statutory income thresholds. States like Ohio and Arkansas have sought relief but have been unsuccessful at reducing or reforming their expansion program.
    c. States have not been able to successfully implement a work requirement for enrollment in Medicaid expansion after numerous legal challenges.
15. **There's a better way — give patients a Personal Option.**
    a. There are many other things states can do to provide high-quality health care for their residents. We call such reforms a Personal Option. A personal option doesn't require signing away control of the state budget or pushing people into low-quality health plans.