**Testimony of Sofia Hamilton**

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**To the House Medicaid Committee, Ohio General Assembly**

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Chairwoman Gross, thank you for this opportunity to testify on Medicaid.

We applaud you for taking up this important issue, and we’re grateful to have this opportunity to share our views.

In Ohio 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. We believe in, and work to apply, the principles of human progress in our communities. We favor bottom-up solutions that respect human dignity and allow people to flourish and realize their full potential.

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 and transparent and much less of a hassle for everyone. We believe markets work in health care, when we let them. And we support strong but properly targeted government safety nets.

In this testimony, I will give an overview of Medicaid, its problems, and possible reforms.

***Overview***

AFP supports reforms that would reduce Medicaid costs and enrollment and restore it to its original mission as a safety net for the truly vulnerable.

The program has grown too big, too expensive, and too bloated with waste and improper payments. And it delivers too little in terms of access and quality for patients. Medicaid needs to change. Changing it should not mean spending more taxpayer money. It should mean spending less, and spending much more efficiently. It cries out for structural reforms that make it easier for states to focus resources on those who need them, to enable it to deliver better access, better quality, and better health outcomes for the people who rely on it, and to promote human dignity. Medicaid should not trap people in dependency. Rather, it should make it easier for those who have the potential to be self-reliant and to escape poverty and to flourish, to do so.

***What Is Medicaid?***

Medicaid is the nation’s largest public health insurance program for people with low income. By population, it is the largest single insurance program in the country. As you know, it is jointly funded by the states and the federal government. Combined state and federal Medicaid spending comprises nearly 20% of all personal health care spending in the United States. Medicaid is one of the largest expenditures in every state budget. It is the largest source of federal revenue to states. In State Fiscal Year 2022, Medicaid accounted for about 39% of Ohio’s budget expenditures, totaling approximately $35 billion.[[1]](#footnote-2)

***How Is Medicaid Financed?***

Subject to federal standards, states administer the program and have a certain degree of flexibility to determine what populations and services to cover, how to deliver care, and how much to pay providers for delivering that care.

States are guaranteed federal matching dollars for qualified services provided to eligible enrollees. This assistance is uncapped. The match rate, known as FMAP, or federal medical assistance percentage, is determined by a statutory formula that provides a match of at least 50% and provides a higher rate for states with lower per capita income. States may also receive a higher match rate for certain services and populations.

Federal rules generally limit enrollees’ out of pocket exposure. Medicaid is basically free to them, although, as we’ll see, they do pay for it in the form of time spent finding a doctor and waiting for an appointment and lower-quality items and customer service. Overall, Medicaid is low-quality compared to virtually every other major source of health insurance.

***Quality of Care***

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.[[2]](#footnote-3) 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.[[3]](#footnote-4)

A key reason for Medicaid’s low quality is its low payment rates. It reimburses providers below the cost of care, exacerbating financial pressures on hospitals, especially rural hospitals. On average, Medicaid pays only about 25% of what private commercial insurers pay for the same item or service. Unsurprisingly, Medicaid enrollees experience more difficulty obtaining health care than those with private insurance.

***Access Problems***

An ongoing challenge in Medicaid is the gap in access to certain providers, particularly psychiatrists and dentists. These gaps are exacerbated by Medicaid’s lower physician payment rates. In 2021, MACPAC found physicians were less likely to accept new Medicaid patients (74%) than those with Medicare (88%) or private insurance (96%), which reflects the relative generosity levels of these payers.

Medicaid patients are 1.6 times less likely than privately insured patients to successfully schedule a primary care appointment and 3.3 times less likely to successfully schedule a specialist appointment.[[4]](#footnote-5) And, [Medicaid patients wait longer for appointments than privately insured patients.](https://www.jabfm.org/content/jabfp/34/3/571.full.pdf) An HHS investigation found only half of doctors listed by the insurer as accepting new patients were accepting new Medicaid patients. And 25% of Medicaid patients with appointments had to wait over a month to be seen.[[5]](#footnote-6)

***Inefficiency***

Medicaid is wasteful. Increasingly, it is enriching Medicaid insurers, but only 20 [to](https://www.independent.org/news/article.asp?id=7469) 40 cents of each Medicaid dollar directly improves recipients’ welfare.[[6]](#footnote-7) Meanwhile, large profits for Medicaid Managed Care Organizations (MCOs) is a recurring news item. For example, from 2014 to 2016 Anthem made a profit of $549 million from California Medicaid plans.[[7]](#footnote-8) 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.

***Medicaid Expansion***

The Affordable Care Act of 2010 expanded Medicaid to cover adults without dependent children who earn more than the traditional Medicaid income cutoff, a population that had never been eligible for Medicaid coverage.

When a state expands Medicaid, able-bodied adults in the state with income between 100% and 138% of poverty are forced into Medicaid. They automatically lose access to the ACA’s private health insurance plans, even if they did not previously qualify for ACA premium subsidies.[[8]](#footnote-9)

Medicaid expansion is having numerous negative effects and costing taxpayers hundreds of billions annually. It has added millions to the Medicaid rolls — far more than originally projected — most of whom have other, better coverage options. And it has incentivized states to prioritize able-bodied, working age residents over needier populations like children, the elderly, and the disabled. Higher-than-expected enrollment has occurred in every state that has expanded.[[9]](#footnote-10) Expansion states predicted 6.5 million people would enroll, but 16.7 million did, 160% [more than projected.](https://thefga.org/paper/how-obamacares-medicaid-expansion-is-causing-crisis/)[[10]](#footnote-11)

The financial impact has been substantial. Cost per enrollee is now 64% higher than originally projected, contributing to budgetary strain.[[11]](#footnote-12) Nationally, Medicaid now accounts for one out of every three dollars states spend, up from one in five before expansion.[[12]](#footnote-13) Expansion’s growing costs are diverting resources from other priorities.[[13]](#footnote-14)

As with traditional Medicaid, fraud and error are a problem. Ten to 25% of expansion enrollees are ineligible or misclassified.[[14]](#footnote-15) [HHS audits continue to uncover states misclassifying enrollees as part of the expansion population rather than as part of the traditional population](https://americansforprosperity.org/afp-foundation-gets-cms-to-release-state-level-medicaid-improper-payment-data-after-years-of-stonewalling/), which saves the state money at federal taxpayers’ expense.[[15]](#footnote-16)

Medicaid expansion is negatively affecting health care access. Increased enrollment without a concomitant increase in the number of doctors and hospitals has created greater competition for those providers who take Medicaid patients, and this in turn has made it more difficult for traditional Medicaid recipients — the disabled and elderly — to access care.

***Reforming Medicaid Expansion***

A thoughtful approach to reforming Medicaid expansion would be to phase down the federal contribution rate for the expansion population. If the expansion FMAP were to be phased down to equal the FMAP for the traditional Medicaid population, states would be forced to reassess. Some would undoubtedly de-expand, as some vowed to do if the federal match ever falls below 90%. Others would accept the increased cost.

De-expansion, in the states that choose that course, is unlikely to increase the ranks of the uninsured, because most enrollees have other, and usually better, options. When the Biden administration disenrolled 25 million Medicaid enrollees after the pandemic, the national uninsured rate barely moved.

***Medicaid Reform Options***

Conventional reform approaches can save money. I mean reforms like reducing federal contribution rates (FMAP), cracking down on state financing gimmicks like provider taxes and intergovernmental transfers (IGTs), and beefing up efforts to combat fraud and improper payments. They can save a lot of money. They make a lot of sense, fiscally speaking. But such reforms do not address the program’s fundamental structural problem.

More promising are reforms that achieve greater cost control and better health outcomes through patient empowerment. And that requires structural changes in how we pay for the program.

**Consumer Empowerment**. Perhaps the best reform option is to convert Medicaid from a big, bureaucratic health insurance program into a relatively simple program that empowers patients to shop for value. This could take the form of a voucher program that includes a personal, government-funded spending account similar to a Health Savings Account (HSA). Enrollees could choose their own health plan, and whatever they didn’t spend on insurance, they could save in the account, which they could use for routine medical costs and items, services, and doctors that their insurance does not cover. And to encourage them to be good shoppers, they could keep the money in the account, or a portion of it, when they leave the rolls. With a consumer empowerment approach, patients would have more options, choice, and control. They would have strong incentives to comparison shop and take more personal responsibility. All of which would reduce costs because markets work in health care when we let them.

If that kind of restructuring cannot be achieved immediately, we could pave the way for it, with either of two commonly discussed approaches: block grants and per capita caps.

**Block grants.** Under a block grant, the program would no longer be an individual entitlement, it would become a capped grant to states. Federal spending would be a fixed amount based on a statutory formula. The grant could be indexed to increase with medical inflation and population growth. Even with such escalators, a block grant would likely produce substantial savings for federal and state taxpayers. Federal taxpayers would no longer face open-ended financial exposure. State taxpayers would no longer have to directly underwrite the costs of the program. But they would have much greater flexibility to manage the money they receive, within broad federal guidelines. States would bear the risk of future rises in medical costs, but the maximal flexibility they enjoy would compensate for that risk. A likely result of such a restructuring would be a focusing of resources on the neediest state residents — the program’s original mission. Medicaid would no longer be an entitlement to individuals, nor countercyclical, but other need-based federal income support programs, like Food Stamps, would remain in place to fulfill those functions. And of course, states could supplement the Medicaid Block Grant with state-only dollars. In crafting the grant, Congress would need to deal with questions related to certain populations, such as nursing home residents and Medicare-Medicaid dual eligibles. It may prove necessary, as a practical matter, to create, say, three block grants tailored to different populations — mothers with young children, the elderly, and the blind and disabled — because of their different demographics and medical needs.

**Per capita caps.** This may be thought of as a per-person block grant. Federal payment would be capped on a per capita basis, but unlike a pure block grant, it would not have a fixed aggregate ceiling. Medicaid would remain an individual entitlement, and countercyclical, but costs would become more manageable and predictable, and benefits could be improved. States could be asked to continue contributing financially to the program. For example, a bill introduced by Congressman Pete Sessions of Texas, the Health Care Fairness for All Act, H.R. 3129 (2023), would split the burden 75/25. The federal government would pay 75% of the cost, and the states would pay 25%. Over time, Congress could change this division, perhaps moving toward a 50/50 split, which might be regarded as the fairest or “least bad” approach. Alternatively, it could move toward a 100/0 split in either direction, meaning either devolution of the program entirely to the states or assuming it fully into the federal portfolio. Federal assumption could make it easier to individualize the program on a national scale. But overall, devolution would be better because health care is essentially local, and states are better suited to providing safety nets for the poor and needy.

***Conclusion***

Medicaid is big, growing, popular, and deeply flawed. We need government safety nets that protect the poor and the vulnerable, but today’s Medicaid program is far from ideal.

As it’s currently structured and administered, Medicaid entails states’ having to sign away control of the state budget and puts most of its beneficiaries in low-quality HMOs with limited access and poor quality.

We think there’s a better way. In addition to reforming Medicaid through consumer empowerment, we should reform health care more generally along the same lines. Arm patients with control over their own health care choices. Remove barriers to supply and robust competition among providers of care. Let market forces work. Plenty of real-world evidence shows markets work in health care when we let them. Just think of things like Lasik eye surgery and direct primary care — services that cut out bureaucratic middlemen and leave health care to patients and their trusted doctors.

We strongly recommend that this and every state take action to liberate health care markets. Reduce hospital prices by removing certificate-of-need laws and other barriers to competition. Combat physician shortages by streamlining licensure for medical graduates who have not been able to find a residency slot. Make it easier for international physicians to practice in our rural and underserved communities. Remove barriers to telehealth. And so on.

Instead of giving people a government option, give them a Personal Option – hassle-free health care they can afford.

We appreciate the Committee opening this subject up for comment and are hopeful that Ohio’s health care market will see these needed changes for the good of all Ohioans and the state itself.

**With gratitude,**



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**Cut Content**

***What is Medicaid?***

Right now, about 90 million Americans are enrolled. Enrollment is currently falling as the pandemic surge wanes, and it may level at around 80 million, but that will still represent an all-time high, pre-pandemic. Despite being countercyclical, the average Medicaid enrollment level continues to grow.

Medicaid currently covers more than 1 in 5 Americans. It covers 62% of nursing home residents. And it pays for 41% of all births in the United States. Half of Medicaid spending is for persons who are over 65 or disabled. The other half goes to lower-income people, the majority of whom are mothers with young children.

This year, total Medicaid spending will exceed $900 billion, of which around 70% will be paid for by federal government, with states covering the rest. It has grown to become the fifth largest expenditure in the federal budget, exceeded only by Social Security, Net Interest, Defense, and Medicare. At around $650 billion this year, it is still well behind Medicare, which has surpassed $1 trillion, but it is catching up.

Medicaid is means-tested, based on income and assets. It is an individual entitlement: individuals who meet eligibility requirements are guaranteed coverage. And it is counter-cyclical: the number of people enrolled goes up and down with changes in the economy. But the average number of enrollees has increased steadily over time, and right now the Medicaid population, as we’ve seen, is at an all-time high.

Why does Medicaid grow continuously despite being countercyclical? Partly because of persistent medical inflation in excess of general inflation, but also and more importantly because of structural incentives built into the program, incentives that have been reinforced by a steady stream of benefit and eligibility expansions since the 1980s, including and especially those enacted as part of the Affordable Care Act of 2010.

***Public Opinion***

Public opinion polling suggests that Medicaid has broad support. Majorities across political parties hold positive views of the program. Seven in ten say the program is working well for low-income people. Democrats tend to hold overwhelmingly favorable views of it, while Republicans are more skeptical but still lean favorable. Independents fall somewhere in between.

Despite its popularity, Medicaid suffers from serious defects and challenges.

***How Medicaid Is Financed***

Medicaid requires states to provide comprehensive benefits for children, known as Early Periodic Screening Diagnosis and Treatment (EPSDT) services, a broader set of benefits than what is traditionally covered by private insurance.

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In addition to covering the services required by federal Medicaid law, all states elect to cover at least some services that are not mandatory. All states cover prescription drugs, for example, and most states cover physical therapy, eyeglasses, and dental care.

Unlike commercial health insurance and Medicare, Medicaid covers non-emergency medical transportation, which helps enrollees get to their appointments, and long-term care including nursing home care and many home and community-based services. In recent years, states have been expanding coverage of behavioral health services and benefits to help enrollees address social determinants of health (SDOH), such as nutrition or housing.

Across the states, average Medicaid spending ranges from around $6,000 to $12,000 a year per full-benefit enrollee.

Within each state, there is substantial variation in the average costs for each eligibility group. Within each eligibility group, per-enrollee costs vary significantly, particularly for the disabled.

***Dual Eligibles***

Medicaid provides coverage for low-income Medicare beneficiaries, known as dual eligibles, to help pay for premiums, cost sharing, and services not covered by Medicare. Medicaid provides wrap around coverage for services not covered by Medicare (like most long-term care and other long-term services and supports), for nearly one in five Medicare beneficiaries.

Medicaid spending is concentrated among dual eligibles, who comprise 1 in 5 Medicaid enrollees but account for more than 50% of Medicaid spending.

***Managed Care***

States have flexibility in how to deliver services to enrollees, but most states have moved to a comprehensive managed care model, meaning HMOs, which the program calls Managed Care Organizations (MCOs). Seven in ten enrollees in 2020 were assigned to an MCO. These health plans are required to ensure adequate provider networks, but as we’ve seen, access is a problem.

***Quality of Care***

The quality of care under Medicaid is a major concern. The Oregon Health Insurance Experiment found that while Medicaid improves financial security and mental health, its impact on physical health outcomes, such as controlling blood pressure and diabetes, was minimal.[[16]](#footnote-17) Alarmingly, some research indicates Medicaid recipients fare no better, and sometimes worse, than uninsured individuals regarding certain health outcomes.[[17]](#footnote-18) In California, Medicaid recipients sued the state over substandard care, highlighting systemic quality issues.[[18]](#footnote-19)

***Improper Payments***

Medicaid is one of the most troubled programs in the entire federal portfolio when it comes to improper payments. 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.[[19]](#footnote-20) The bulk of those improper payments come from paying for people who aren’t eligible for the program [—](https://thefga.org/paper/bidens-plan-would-tighten-the-medicaid-handcuffs/) as of today more than 10 million enrollees nationwide are not actually eligible for Medicaid.[[20]](#footnote-21)

***Section 1115 Waivers***

Medicaid is designed in a fragmented and rigid way. But there is some flexibility. Nearly all states have received at least one section 1115 demonstration waiver to test approaches to coverage and payment not otherwise allowed under federal Medicaid rules. Under section 1115 of the Medicaid statute, a state may obtain a waiver to test and implement alternative approaches if the Secretary of HHS determines the waivers would advance program objectives without increasing overall federal expenditures. Despite that budget-neutrality rule, some waivers have the effect of increasing federal expenditures because predicting future costs is more art than science.

Each presidential administration uses its section 1115 flexibility to promote its own reform ideas and philosophy. At any given time, many states have a waiver application pending with CMS. The first Trump Administration’s Section 1115 waiver policy emphasized work requirements and other eligibility restrictions, payment for institutional behavioral health services, and capped financing.

The Biden Administration generally went in the opposite direction. It withdrew waiver approvals with work requirements and encouraged states to propose waivers that expand coverage, reduce health disparities, and advance “whole-person care” (social determinants of health). Recent areas of focus have included leveraging Medicaid to address health-related social needs and to provide health care to prisoners after and just prior to their scheduled release. A few states have sought waivers to provide continuous Medicaid coverage for newborns and their mothers for periods of longer than a year.

***Medicaid Expansion***

The ACA made Medicaid expansion coverage mandatory for states, but a 2012 Supreme Court ruling (NFIB v. Sebelius) made it optional for them.

As of today, 41 states and the District of Columbia have expanded Medicaid, lured by generous federal subsidies and heavily pressured by hospitals, insurers, and progressive advocacy groups.

The American Rescue Plan Act of 2021 included an additional temporary fiscal incentive to encourage the small number of states that have not yet opted in to the Medicaid expansion, to do so. So far, it has not persuaded any of the holdout states to come in, except North Carolina.

Medicaid expansion is popular. Of the 40 states that have expanded, seven (Iowa, Maine, Missouri, Nebraska, Oklahoma, South Dakota, and Utah) have done so through ballot measures. Polling shows that two-thirds of people living in non-expansion states want their state to expand Medicaid.

Medicaid expansion crowds out private coverage because it incentivizes employers to stop offering health benefits and thus shift employees from private insurance to Medicaid, or it incentivizes them to shift employees from full to part-time status, rendering them ineligible for the workplace health plan. This leaves taxpayers to shoulder the increased cost while hospitals and providers contend with lower reimbursements.

Most people eligible for expansion are eligible for private insurance. [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.](https://www.usatoday.com/story/news/nation/2015/05/08/kentucky-hospitals-say-aca-has-hurt-them/26998939/) In North Carolina 63% of potential expansion enrollees already had private insurance.[[21]](#footnote-22)

By crowding out private options, expansion hurts doctors and hospitals financially and draws people into a broken health plan that is often not there for them when they need it.

Medicaid expansion increases enrollment in traditional Medicaid — costing states beyond what they budgeted for. Many who sign up for the expansion are already eligible for regular Medicaid. When they sign up due to hearing about expansion, it’s called the “woodwork effect.” Expansion states see a woodwork effect of about 10%, meaning a 10% rise in the traditional Medicaid enrollee population above the anticipated enrollment rate.[[22]](#footnote-23) Woodwork enrollees cost the state more than expansion enrollees because they come with a lower federal contribution. Projections of the costs of expanding often fail to account for this fact.

The last thing to keep in mind about Medicaid expansion is that it’s an all or nothing proposition. It’s not really possible to reform it, cap it, or dial it down. It works more like a light switch: it’s either fully on or fully off. There is no provision for a “phase-out” or “off ramp.” The Medicaid statute does not allow states cap enrollment or reduce eligibility below statutory income thresholds. Ohio has sought relief and been rebuffed.[[23]](#footnote-24) So has Arkansas.[[24]](#footnote-25)

Expansion states are required to cover everyone up to 138% of poverty. Non-expansion states may set their own eligibility cutoff, which may be above or below 100% of poverty. If the state does not cover the traditional population up to 100%, a gap will exist between that level and wherever ACA tax credit eligibility kicks in. In expansion states, eligibility for ACA tax credits begins at 138% of poverty. In non-expansion states, it begins at 100% of poverty.

Medicaid expansion increases emergency room overcrowding. Emergency department wait times increased 10% in states that expanded Medicaid coverage, compared to states that didn’t.[[25]](#footnote-26) 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 use ER resources on non-emergencies.

Expansion crowds out health care spending for children. A 2022 Mercatus study 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.[[26]](#footnote-27)

Expansion crowds out higher education spending. 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.”[[27]](#footnote-28)

Importantly, expansion does not prevent hospital closures. This is probably the most influential argument deployed in state expansion debates, that expansion keeps hospitals in business. The evidence doesn’t support that contention. Hospitals in expansion states fare worse financially than those in non-expansion states.[[28]](#footnote-29) 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.[[29]](#footnote-30)

***Medicaid’s Fundamental Flaw***

The fundamental flaw of today’s Medicaid program lies in its joint state-federal structure. Both parties — states and Congress — have incentives to shift costs to the other. Neither has a strong incentive to control costs because neither benefits fully from cost control. Roughly speaking, when a state spends an extra dollar, it must shell out only 22 to 42 cents. And when it reduces spending by a dollar, it only gets to keep 22 to 42 cents. And as we’ve seen, Medicaid expansion only costs 10 cents, virtually eliminating any incentive to seek reforms.

The joint state-federal structure of Medicaid is the main reason why it tends to grow over time, despite its countercyclical design.

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