Medicaid Expansion Under the Patient Protection and Affordable Care Act

Testimony submitted to

Public Health and Welfare Committee

Kansas State Legislature

Kansas, USA

by

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February 19, 2013

1. Introduction

I am Jagadeesh Gokhale, senior fellow at the Cato Institute, a nonpartisan, nonprofit foundation in Washington, D.C. The Cato Institute's mission is to educate the public on the principles of individual liberty, limited government, free markets, and peace. I am pleased to submit this testimony to The Kansas State Senate Public Health and Welfare Committee. I thank the Chairman, Sen. Vicki Schmidt, Vice Chair, Sen. Pete Brungardt, and Ranking Minority Member, Sen. Laura Kelly for the opportunity to testify before your committee. I request that my written testimony be submitted into the record.

2. Policy Perspective

A crucial issue facing Kansas' policymakers is how to deal with the likely escalation of the state's health care spending resulting from the Patient Protection and Affordable Care Act (ACA). Meeting this policy challenge requires estimates of how the ACA will affect Kansas' health care expenditures. This testimony provides such estimates based on a study of this question that I conducted earlier. I conclude my testimony with some additional remarks about why those estimates are likely to be conservative.

The ACA was enacted by the U.S. Congress and signed into law by President Barack Obama in March 2010. That law was challenged in court by more than one-half of the nation's states and, ultimately, the U.S. Supreme Court upheld most of its provisions in June 2012. There are two key features of the ACA that are important for today's discussion: The first is the law's individual mandate which requires all U.S. citizens and legal residents to either obtain private health insurance coverage -- if they are not already covered under an employer sponsored health plan, Medicare, or

Medicaid – or pay a penalty.[1] In particular, those who are eligible for Medicaid coverage under the "old law" (pre-ACA law) but are not yet enrolled into Medicaid will be impelled to enroll beginning next year. I label this group of "new enrollees among old eligibles" (or just "old eligibles" as a shorthand). The federal government's financial participation for this group of new Medicaid enrollees will remain at the pre-ACA (standard) Federal Medical Assistance Percentage (FMAP) rate. For Kansas, the standard FMAP rate will be 56.5 percent during this and future years.[2] To the extent that those already eligible for Medicaid are induced to newly enroll into the program beginning in 2014, the Kansas state general fund will have to cover the remaining 43.5 percent of their Medicaid costs.

The second key element is ACA's Medicaid expansion: Extending eligibility to Medicaid to all individuals and families with incomes up to 138% of the federal poverty level and simplifies the enrollment process under SCHIP. The U.S. Supreme Court's decision, however, granted to states the choice of opting out of Medicaid expansion. Several states such as Alabama, Maine, Texas, Florida, Georgia, South Carolina, Louisiana, Mississippi, Oklahoma, Pennsylvania, and Florida have already announced their intention to opt out of Medicaid expansion. States that choose to reject the Medicaid expansion can set their own Medicaid eligibility thresholds. Historically, those thresholds have varied across states but many were well below 138 percent of the federal poverty level and many states did not make Medicaid available to childless adults unless they were included in a

[1] Exempt from this individual health insurance coverage mandate are those whose health insurance premiums would exceed 8% of their income, those with incomes below the limit for filing a federal tax return, those with religious exemptions, undocumented immigrants, those in correctional facilities, and members of Indian tribes.

[2] FMAP rates are higher for special categories of patients and services such as breast and cervical cancer treatments, adult clinical preventive services, family planning services, home health services for those with chronic ailments, and so on. Beginning 2014, newly eligible Medicaid enrollees will receive much higher federal matching rates as described later in the text.

special-needs Medicaid coverage category. This Medicaid coverage choice – a revealed preference – that most states have made is relevant from a "value for money" perspective as described below.

As is well known, the additional cost of *newly eligible* Medicaid enrollees will not be fully covered by additional federal financial support beyond the first three years of ACA's implementation—2014-16. For years after 2016, the federal financial match rate for covering this group of Medicaid enrollees will be phased down gradually – to reach 90 percent by 2020, where it is expected to remain during later years. After 2016, the remaining 10 percent of these enrollees' health care costs must be paid for out of state general funds.

Incremental Cost Estimates: "Old-Eligibles" and the Newly Eligible

Soon after PPACA's enactment in 2010, I conducted a research project to study PPACA's cost implications for selected U.S. states. Kansas was included at the request of the Kansas Policy Institute [Refs. 1-5]. I compiled detailed information on the rules and operations of Medicaid programs in the selected states to investigate PPACA's effect on state budgets arising from new enrollments by "old eligibles" and by those made newly eligible for Medicaid under the PPACA.

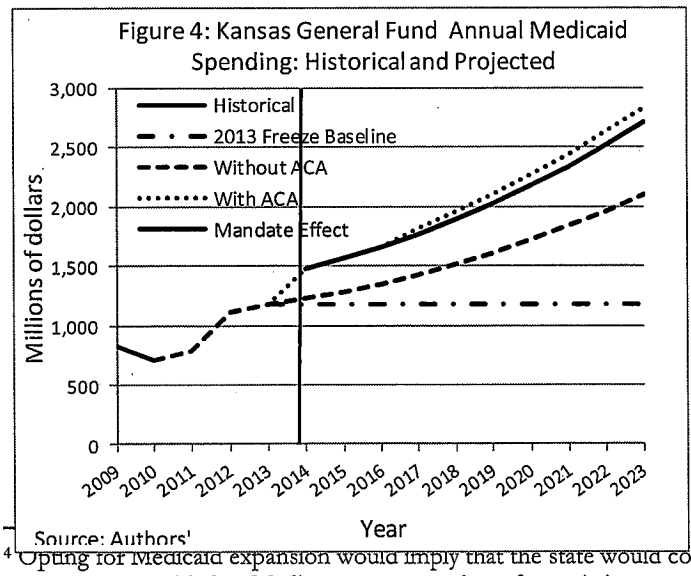
Several constituent elements must be considered when projecting how future Medicaid cost trends are likely to evolve. These include population growth, income distribution, the shares of those eligible in the population by age, gender, income level, and special health needs categories, enrollment rates among those eligible, the share of enrollees that experience health episodes and who receive health treatments under Medicaid, and the cost of those treatments per capita, and so on, each differentiated by the particular demographic groups mentioned earlier. These elements are influenced by specific legal, environmental, health, and market factors and they are projected separately based on their historical trends. Those factors include federal and state eligibility rules, the frequency, type, and duration of health conditions or episodes the population, the availability of

alternative insurance sources (employer-provided or private) and the supply of medical facilities, services, technology, and personnel in the area, and so on. The product of projections of the independent elements mentioned earlier, summed over the different demographic groups, yields future Medicaid cost estimates. The methodology, then, involves making state Medicaid cost projections with and without the law changes introduced by the ACA and comparing the two estimates. The data sources used for constructing the estimates included the Current Population Survey (to calculate Medicaid eligibility ratios for various Kansas population subgroups), the Medicaid Statistical Information System (administrative data on Medicaid enrollment, beneficiary, and cost per beneficiary data), and the U.S. Census Bureau (state population projections by age and gender).

The results of my calculations are summarized in Figure 1 for the state of Kansas. The lowest line (flat, with alternating dashes and dots) shows the "freeze baseline" or the result of holding Kansas general fund Medicaid expenditures at their 2013 (projected) level ($1.18 billion. The middle line (with dashes) shows Kansas Medicaid general fund expenditures that would have resulted under the absence of ACA. The uppermost line (in dots) shows Kansas general fund expenditures under the ACA. The three lines begin to diverge in 2014 when the ACA is to become fully effective.[3] The difference between Medicaid expenditure projections with and without the ACA taken cumulatively over 10 years (2014-23) is $4.72 billion. For more detailed information on Kansas cost and enrollment growth estimates under the ACA, please see the study attached herewith [Ref. 3].

[3] The increase in Medicaid spending during years before 2014 results from the withdrawal of temporarily higher federal matching rates under the American Reconstruction and Recovery Act of 2009.

The U.S. Supreme Court's has deemed the ACA's individual health insurance mandate constitutional and, therefore, state governments will not be able to avoid increases in Medicaid expenditures resulting from new Medicaid enrollments by "old eligibles." Those enrollments would increase as state residents seek to comply with the ACA's individual mandate and purchase health insurance through health exchanges. Under the Supreme Court's decision, however, state governments retain discretion over whether to expand Medicaid as the ACA prescribes – to non-elderly adults up to 138 percent of the federal poverty level regardless of having qualified dependent children.[4] The state's initial cost (for three years 2014-16) of opting for Medicaid expansion would be zero since federal funds would cover 100 percent of the incremental cost. For Kansas, the 2017 cost of Medicaid expansion is estimated to be $51 billion. The increase in this portion of Medicaid spending during years 2018 and 2019 is estimated to exceed 25 percent per year because of the combined effect of the decline in federal matching after 2016 and projected growth in enrollments and health care inflation (increase in costs per beneficiary).



Once the federal matching rate stabilizes after the year 2019, the annual cost growth is estimated to be about 8 percent per year.[5] Thus, in the short-term, the federal inducement to opt-in for Medicaid expansion -- in terms of full federal funding for just three years –

[4] Opting for Medicaid expansion would imply that the state would cover almost everyone below age 65 who is not pregnant, not entitled to Medicare, not a member of an existing mandatory coverage group, and whose annual income is less than 138% of the federal poverty level ($15,415 per year for an individual in 2012).

[5] This cost growth estimate may turn out to be low because as the baby-boomers retire, demand pressure on health care services nationwide is likely to intensify and boost health care inflation.

will prove to be an expensive bargain as cost increments pile up during later years. My estimate of the total 10-year cost to the Kansas general fund from opting for ACA's Medicaid expansion is $625 billion assuming that the federal government adheres to its commitment to contribute 90 percent of the incremental costs during the out years. Knowing how dire the federal government's finances are on account of soaring expenditures on entitlement programs, that commitment appears to be shaky at best.[6]

It's not surprising that the 10-year incremental cost estimate of Medicaid expansion ($625 million) is a relatively small portion of the state's full incremental Medicaid spending estimate arising from the ACA ($4.72 billion) during 2014-23. In Figure 1, the incremental cost of Medicaid expansion in Kansas is shown as the difference between the total cost projection under the ACA (the line with dots) and the "Mandate Effect" – which includes only the cost of new enrollees among "old eligibles" (unbroken line). Note that the gap in Figure 1 representing the cost of Medicaid expansion is zero until 2016 and grows wider thereafter.

Another reason for caution before opting to expand Medicaid under the ACA is that cost of this decision is "on the margin" of Kansas' general fund expenditures. Consider the simple example of an individual homeowner planning to build an extension to his home under a contract for $40,000 worth of materials and labor expenses: Suppose that as the construction is progressing, the contractor may recommend the inclusion of an new feature for a small additional cost – just $5,000. Now, $5,000 may seem to be a small amount in absolute terms, but it may be unaffordable because it's over and above the already committed outlay of $40,000. It may not be a good "value for money" deal because alternative spending opportunities may yield a better value. In Kansas, for example, spending $625 million on education or infrastructure development may yield better value

[6] The Congressional Budget office projects that federal deficits will increase rapidly toward the end of this decade as baby-boomer retirements accelerate and the oldest baby-boomers enter their years of needing long-term care and begin to incur the highest medical expenses typical at the end of the human lifetime.

given that the "Mandate Effect" is already projected to increase Kansas' Medicaid spending by approximately $4.0 billion. I note that the "value for money" economic calculus may remain unfavorable to Medicaid expansion despite the availability of large federal funding: That funding would have to be dedicated to Medicaid and it is highly uncertain whether it will be sustained as currently promised.

Another consideration relevant to this decision is the history of Kansas' general fund expenditure shares of Medicaid, education, and other public services (transportation, corrections, public assistance, housing, environmental and natural resource programs, and parks and recreation). An increase in Medicaid's general fund share during the 1990s—from 7.8 percent in 1990 to 10.8 percent in 1999—was more than fully absorbed by reducing the budget share of spending on other public services, which declined from 36.2 percent in 1990 to 24.5 percent in 1999. However, the expenditure share of education, which is obviously most important for nurturing future economic growth, was protected during those years. Indeed, the budget share of education increased significantly from 56.0 percent in 1990 to 64.6 percent in 1999. The year 2000 was abnormal with an exceptionally low Medicaid budget share of 4.8 percent. During the rest of the 2000s decade, however, an increase in Medicaid's share from 9.8 percent in 2001 to 13.5 percent in 2009 forced reductions in *both* the shares of other public services, which declined from 23.8 percent in 2001 to 21.4 percent in 2009, and education, which also declined from 66.4 percent in 2001 to 65.1 percent in 2009. This suggests that the significantly steeper Medicaid expenditure trajectory that is likely to emerge after 2014 with the ACA in force—and which would increase Medicaid's general fund share well above 20 percent—may compel large contractions in the future expenditure shares of both education and other public services. This budget pressure on education would be even greater with a decision to expand Medicaid coverage under the ACA. [7]

[7] The statistics cited here are based on reporting by National Association of State Budget Officers.

4. Additional Remarks

There are good grounds to believe that my study's estimates of ACA's effect on the trajectory of Kansas' health care expenditures are conservative. My estimates are based on historical enrollments rates among Medicaid-eligible groups. Those rates are likely to be smaller than under the post-ACA environment: Under pre-ACA conditions, the availability of alternatives, including employer provided health insurance that enjoys federal tax subsidies, are likely to induce non-enrollment into Medicaid. In the post-ACA environment, although employers are subject to penalties for non-provision of health insurance to employees, those penalties are relatively small. As a result, employers may find it more profitable to withdraw health coverage and pay the penalties rather than continue to provide health insurance to their employees. That would force more low-income workers to seek coverage through the state's health exchange and they would end up enrolling in Medicaid. Thus, the ACA is likely to alter employee and employer incentives to significantly *increase* Medicaid enrollment rates -- by both groups of new enrollees described above – at rates faster than historically observed. This fillip to Medicaid enrollment incentives will be enhanced by enrollment facilitation drives as envisioned under the ACA.[8]

It is noteworthy that ACA's regulatory system on health insurance coverage and pricing is likely to increase health insurance premiums for almost all individuals—beyond those assumed on the basis of historical trends in my study. ACA's individual mandate would compel many more Americans to purchase health insurance policies. The law will, therefore, forcibly expand the demand for health insurance coverage under an environment of limited capacity to boost the provision of health care products and services, especially in the short-term. Indeed, the ACA implies

[8] My colleague, Mr. Michael Cannon, may have suggested during this hearing, that there may be an unquantifiable but most likely positive synergistic interaction between Medicaid expansion and the Mandate Effect in terms of increasing Medicaid enrollments -- which would tend to increase state Medicaid expenditures.

large "hidden taxes" for most insurance purchasers— higher-than-actuarially-warranted premiums for those enjoying relatively good health; higher premiums compared to a competitive health insurance market with the freedom to choose coverage or to opt out depending on one's health status and expectations; higher state and federal income taxes to support the expansion of premium supports for qualified individuals under the ACA; the loss of considerable employer provided health insurance coverage (that is tax-deductible to employers) either because employers prefer to pay ACA's penalties or their plans are disqualified under ACA's regulations. Under the last item, note that any increase in employee wages (net of the penalty on employers) to compensate for lost employer health coverage would be subject to income and payroll taxes. All of these effects argue for low-income individuals to enroll into Medicaid at greater rates than those underlying my study's estimates.

The claim I make here that the ACA is likely to significantly increase health insurance premiums facing most of the population is also supported by other studies: One study [Ref. 6], which concerns ACA's likely effects in Wisconsin, is by MIT economist Jonathan Gruber. His study finds that under ACA's individual mandate and regulations, "87 percent of the individual market will experience an average premium increase of 41 percent." Indeed, the Gruber study finds that even after accounting for ACA's premium assistance for qualified individuals, "59 percent of the individual market will experience an average premium increase of 31 percent." Further toward addressing this point, a recent study [Ref. 7] by Richard Burkhauser of Cornell University concludes that "family based affordability" considerations during contracting between employers and employees could push between 1.6 and 6.0 million additional households (depending on co-insurance rates for employer provided insurance) onto the health Exchanges, implying higher taxpayer costs. The estimates are even larger under "individual based affordability" rules. This, again,

argues for larger enrollment rates in the post-ACA environment compared to those used in my study.

I thank the committee for the opportunity to testify as it considers the very important issue Medicaid expansion. I would be glad to answer questions related to my testimony. I can be contacted via e-mail at jgokhale@cato.org or by phone at (202) 789-5247 during normal work hours.

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