



THE NEW HEALTH CARE LAW'S EFFECT ON STATE MEDICAID SPENDING

A STUDY OF THE FIVE MOST POPULOUS STATES

JAGADEESH GOKHALE

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Executive Summary

Unless it is repealed, the Patient Protection and Affordable Care Act of 2010 promises to increase state government obligations for Medicaid by expanding Medicaid eligibility and introducing an individual health insurance mandate for all U.S. citizens and legal permanent residents. Once PPACA becomes fully effective in 2014, the Medicaid benefits of those who become newly eligible and enroll into Medicaid will be almost fully covered by the federal government through 2019, with federal financial support expected to be extended thereafter. But PPACA provides states with no additional federal financial support for *new enrollees among those eligible for Medicaid under the old laws*. That makes increased state Medicaid spending from higher enrollments by “old-eligibles” virtually certain as they enroll in Medicaid in response to the individual mandate to purchase health insurance.

This study estimates and compares potential increases in Medicaid expenditures from PPACA by the five most populous states: Cali-

fornia, Florida, Illinois, New York, and Texas. State Medicaid spending is projected to increase considerably even without PPACA in California, Florida, and Texas, with smaller increases in Illinois and New York. With PPACA, projected spending is actually reduced for California, while spending increases are positive and large for Florida and Texas. Both Illinois and New York have the potential for considerably higher enrollments and increased expenditures.

My estimates of the states’ PPACA Medicaid burdens are considerably larger than those reported elsewhere, such as in the Kaiser Family Foundation’s study, which appears to have used fixed enrollment rates for new- and old-eligibles based on 2007 data. In this study, the individual mandate’s impact depends on historical enrollment trends—stronger where enrollment rates were low or declining, weaker where they were high and increasing. Thus, methodological differences may underlie the sizable differences in estimates of states’ additional costs from PPACA.

Introduction

This study focuses on the effect of the Patient Protection and Affordable Care Act (PPACA) on the future growth of states' General Revenue Medicaid spending obligations.¹ Ever since Medicaid was introduced in the mid-1960s as a key element of President Lyndon Johnson's Great Society agenda, state expenditures on items such as infrastructure, education, and other public services to maintain economic competitiveness have been constrained by rapid growth in state Medicaid obligations. PPACA was enacted in March 2010 and expands states' Medicaid funding burdens yet again. It requires states to maintain current eligibility levels and also expands eligibility for Medicaid benefits to additional categories of people and to those with incomes both above and below the federal poverty level (FPL). The federal government will bear nearly all of the cost of providing Medicaid coverage to these newly eligible individuals. The effect of PPACA's "individual" mandate, however, will be to induce additional enrollments among those who are already eligible for but not enrolled in Medicaid, thereby increasing state Medicaid spending. Finally, PPACA increases uncertainty about future escalations in state Medicaid expenditures through the possibility that surging federal deficits and debt will force a reduction of federal financial support beyond 2019 for those made newly eligible for Medicaid.

This study projects future Medicaid expenditures for the five most populous states—California, Florida, Illinois, New York, and Texas²—both with and without PPACA, thereby revealing the burden that the law imposes on these state budgets.

The results differ across the five states. They suggest that even without PPACA, Medicaid expenditures will soar in California, Florida, and Texas, partly because their populations are projected to grow and age rapidly. For these three states, PPACA is projected to compound the population growth

and aging effect by spurring Medicaid enrollments, thereby reinforcing upward pressure on health care expenditures and transmitting downward pressure through the state budget on other public services.

In the absence of PPACA, Medicaid spending growth in Illinois and New York would be relatively slower than in the other three states. The reason, again, lies in their much slower projected population growth during the next two decades. However, the introduction of PPACA will provide a much stronger impulse for Medicaid expenditure growth in these two states. The main reason is Illinois's and New York's low and declining trends in enrollment rates among key groups that are eligible for Medicaid. The introduction of PPACA's individual mandate, combined with public awareness campaigns to drive home the importance of complying with the mandate and the availability of subsidized health coverage under Medicaid, is likely to cause many more individuals to sign up for Medicaid coverage rather than remain uninsured or else purchase costlier private health insurance. Indeed, some people may also terminate their existing private health coverage and enroll in Medicaid in response to such campaigns.

As described in the Appendix, the estimation of Medicaid expenditure projections carries forward historical Medicaid eligibility, enrollment, reciprocity, and per recipient benefit rates into the future, separately for each state and for detailed demographic and special-eligibility population groups. The calculations are first implemented by excluding the effects of PPACA. If recent state-specific trends in population growth, Medicaid eligibility, enrollments, benefit receipt, and Medicaid benefits per beneficiary were to continue into the future:

- California's general-revenue (GR) funded Medicaid expenditures would almost double from \$19.4 billion in 2008 to \$35.2 billion by 2020. Medicaid expenditures will continue to increase during the 2020s, amounting to almost \$60 bil-

State expenditures on items such as infrastructure and other public services have been constrained by rapid growth in state Medicaid obligations.

PPACA's health insurance mandate implies that Medicaid spending increases from the new law would be especially pronounced in Illinois and New York.

lion per year by the end of that decade. From 2010 forward, the average annual (nominal) Medicaid expenditure growth rate is projected to be almost 9 percent through 2020, slowing to 5.5 percent per year thereafter.³ The 2010–30 projected Medicaid spending growth rate of 7.2 percent is considerably faster than California's average annual (nominal) GDP growth rate of 5.2 percent per year.⁴

- Florida's GR-funded Medicaid expenditures would double from \$6.3 billion in 2008 to \$12.6 billion by 2020 and would increase to \$19.5 billion by 2030. Medicaid expenditures will grow rapidly through 2020 at 7.9 percent per year, and the growth rate will slow to 4.5 percent per year during the 2020s. The two-decade projected Medicaid spending growth rate of 6.2 percent per year is appreciably faster than Florida's historical average annual GDP growth rate of 5.8 percent per year.
- For Texas, GR-funded annual Medicaid expenditures would grow from \$8.5 billion in 2008 to \$18.0 billion by 2020 and to \$32.5 billion by 2030. Medicaid expenditures are projected to grow at 9.3 percent per year between 2010 and 2020. The two-decade projected annual Medicaid expenditure growth rate through 2030 equals 7.7 percent—far exceeding historical annual (nominal) GDP growth in Texas of 5.9 percent.
- Of the five states considered here, Illinois has the smallest Medicaid expenditures. It also has the lowest Medicaid spending growth rates: Illinois's Medicaid expenditures are projected to increase from \$5.8 billion in 2008 to \$6.9 billion by 2020, and to \$7.6 billion by 2030. The two decade expenditure growth rate is projected to be 3.0 percent per year, well within the historical rate of annual (nominal) GDP growth of 3.9 percent.
- New York's Medicaid expenditures are projected to grow from \$23.8 bil-

lion in 2008 to \$32.9 billion by 2020 and to \$37.1 billion by 2030. The two-decade projected spending growth rate beginning in 2010 is 3.7 percent per year, slower than New York's historical annual (nominal) GDP growth of 4.5 percent.

Thus, even if PPACA had not been enacted, projected growth in Medicaid spending in California, Florida, and Texas would be on an unsustainable trajectory—if judgment is based on projected Medicaid expenditure growth relative to historical experience in state GDP growth rates. On that basis, Medicaid expenditures projected without PPACA would be sustainable in Illinois and New York.

The results suggest a positive association between economic growth and growth in Medicaid expenditures. States such as Illinois and New York with slower population and economic growth rates experience slower growth in Medicaid expenditures, attributable to slower growth in Medicaid eligibility, enrollment, and benefit claiming rates and benefit amounts. States that experienced more rapid population and economic growth since the mid-1990s and that appear likely to continue growing relatively faster are likely to experience more rapid growth in Medicaid expenditures, attributable to high and rapid growth in Medicaid eligibility, enrollments, and benefits.

Adding PPACA's expansion of eligibility for Medicaid coverage will increase future Medicaid expenditures in all states. However, PPACA's health insurance mandate implies that Medicaid spending increases from the new law would be especially pronounced in Illinois and New York—states with the smallest capacity to fund the increases because these two states are likely to continue their slower historical growth experience in the future as their populations remain stagnant or decline:

- The projected number of new enrollees among old-eligibles from PPACA in 2020, calculated as a percentage

of total projected enrollments without PPACA in 2020, is 21.2 percent in Illinois and 16.8 percent in New York, as compared with 1.9 percent in California, 16.3 percent in Florida, and 13.4 percent in Texas.

- Estimates of enrollment increases among old-eligibles in 2030 are even more pronounced, with Illinois (23.3 percent) and New York (23.5 percent) projected to experience higher enrollment increases than California (2.7 percent), Florida (17.3 percent), and Texas (11.1 percent).

These enrollment increases will directly lead to higher GR Medicaid expenditures, if new enrollees claim benefits at the same rates as those projected to be enrolled in Medicaid irrespective of PPACA:

- Percentage increases in projected GR Medicaid expenditures in the year 2014 under PPACA compared with spending projected without PPACA in the same year are sizable in four states: 22.2 percent for Illinois, 6.4 percent for New York, 9.0 percent for Florida, and 13.5 percent for Texas. Only in California is the change negative—2.9 percent—because enrollment rates among old-eligibles are already very high whereas savings from uncompensated care are estimated to be sizable.⁵
- Projected GR Medicaid expenditures in the year 2020 (the seventh year of PPACA’s Medicaid mandate) in California, Florida, and Texas are 0.2 percent, 20.1 percent, and 13.3 percent larger, respectively, with PPACA than Medicaid expenditures in 2020 projected without PPACA.
- Percentage increases in projected GR Medicaid expenditures under PPACA in the year 2020 are 30.5 percent and 19.8 percent larger in Illinois and New York, respectively, compared with Medicaid spending projections for the same year without PPACA.

- Percentage increases in projected GR Medicaid expenditures under PPACA compared with projected spending levels without PPACA in the year 2030 are also striking: spending increases for Illinois (34.3 percent) and New York (31.5 percent) from introducing PPACA are much larger than for California (–1.4 percent), Florida (22.3 percent), and Texas (7.9 percent).

This result arises, in part, because the potential under PPACA for additional enrollments—relative to enrollments projected by excluding PPACA—are almost exhausted by the mid-2020s for California, Florida, and Texas. In Illinois and New York, however, enrollments in key age and eligibility groups were stable or declining during 2000–08, which means the potential for increases in enrollments driven by the health insurance mandate persists for much longer in these two states.

The potential for magnified state budget pressures can be appreciated by comparing differences in cumulative Medicaid expenditures over the first 10 years of the new law’s implementation beginning in 2014. The spending estimates, both with and without PPACA, are stated relative to a flat spending baseline: projected spending for 2014 multiplied by 10 to produce the 10-year flat spending total for each state. The results are consistent with those summarized above: the 10-year GR baseline flat expenditures are \$262.6 billion for California, \$98.4 billion for Florida, \$64.2 billion for Illinois, \$287.1 billion for New York, and \$126.8 billion for Texas.

Without PPACA, the 10-year Medicaid expenditures are projected to be larger than the flat-spending baseline after 2014 in all of the five states. This is because the projection carries forward historical trends of generally increasing eligibility, enrollments, benefit claim rates, and increases in Medicaid expenditures per beneficiary:

- Percentage increases in 10-year expen-

The 10-year Medicaid expenditures projection carries forward historical trends of generally increasing eligibility, enrollments, and benefit claim rates.

The federal budget is already under considerable strain without additional burdens imposed by PPACA.

ditures without PPACA relative to the flat-spending baseline in California, Florida, and Texas are 26.2 percent, 20.9 percent, and 31.7 percent, respectively.

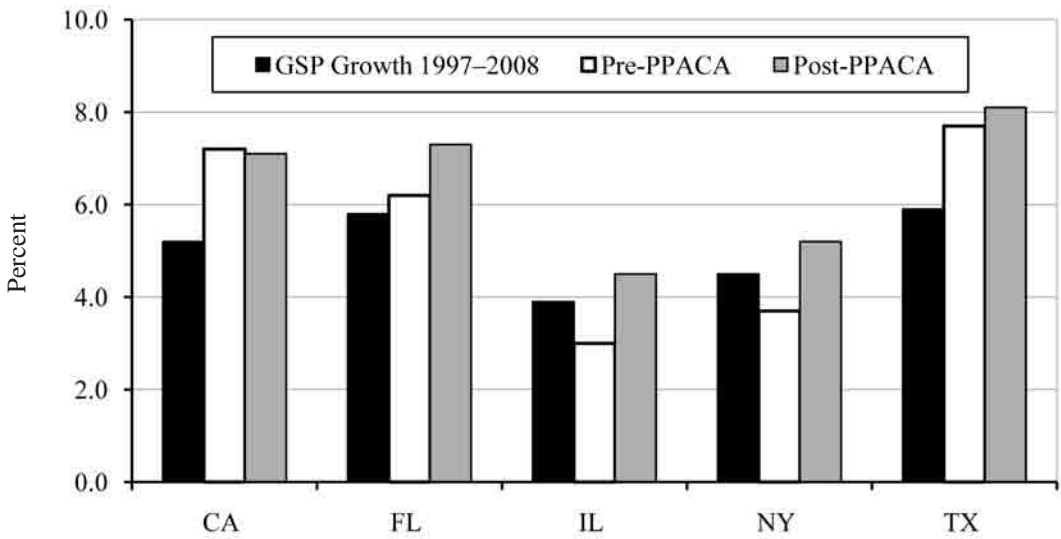
- Percentage increases in 10-year expenditures without PPACA relative to the flat-spending baseline are smaller for Illinois and New York, at 5.1 percent and 10.8 percent, respectively.
- With PPACA, the increase in 10-year expenditures relative to the flat-spending baseline is 25.4 percent for California—a small *decline* compared with the increase in spending of 26.2 percent without PPACA beyond the 10-year flat-spending level.
- GR Medicaid spending projected under PPACA is higher compared with flat spending by 41.6 percent for Florida and by 48.7 percent for Texas. These increases are sizable compared with those without PPACA.
- The with-PPACA increases, relative to flat spending, are 34.6 percent for Illinois and 29.1 percent for New York. These figures are not as large cumulatively as those for Florida and Texas, but nonetheless are considerably larger compared with spending increases without PPACA.
- In dollar terms, the 10-year spending increase from PPACA (compared with without it) is highest for New York, primarily because of its high health care costs and Medicaid benefits per enrollee. Additional enrollments of old-eligibles post-PPACA will cause a rapid increase in total additional Medicaid spending.
- Figure 1 shows that for both Illinois and New York, the growth of annual (nominal) Medicaid expenditures during 2010–30 increases well above sustainable rates as a result of PPACA. For Illinois, the two-decade expenditure growth rate increases from 3.0 percent to 4.5 percent—higher than its historical (1997–2008) gross state product

growth rate of 3.9 percent. New York’s annual Medicaid growth rate over the same period would increase from 3.7 percent to 5.2 percent, also above its historical gross state product growth rate of 4.5 percent per year.

Finally, under PPACA, the federal government is to pay the full cost for those newly made eligible for Medicaid during the first three years (2014–16). Under the new law, the *marginal federal cost-sharing rate* for newly eligible Medicaid enrollees would be gradually reduced from 100 percent to 92.8 percent by 2019.⁶ The standard expectation (or assumption) among budget experts is that the marginal cost-sharing rate will remain at 92.8 percent after 2019. However, the federal budget is already under considerable strain, with unprecedented and unsustainable budget deficits projected through 2019 and beyond. That puts all programs funded out of federal general revenues at risk, including Medicaid support for states. To account for a possible further reduction in federal marginal cost-sharing for newly eligible Medicaid beneficiaries, Medicaid’s spending-time profile for each state is projected under alternative assumptions regarding federal financial participation beyond 2019. For instance, assuming that federal financial support for newly eligible Medicaid beneficiaries is gradually reduced after 2019 at a rate consistent with making it equal to the standard Federal Medical Assistance Percentage, after 10 years (after 2028) states’ GR Medicaid expenditures will increase by even more:

- By 2030, Illinois and New York will both spend about 45 percent more, respectively, compared with expenditures projected without PPACA—much more than the 34 percent and 32 percent increases, respectively, from introducing PPACA but maintaining marginal federal cost-sharing at rates as scheduled for 2019.
- For California, Florida, and Texas, the

Figure 1
Medicaid Growth with and without PPACA and Historical Growth
in Gross State Products



Source: Author’s calculations based on data from the Bureau of Economic Analysis, Current Population Survey, and Medicaid Statistical Information System.

spending increases from eliminating marginal federal cost-sharing are 4.1 percent, 46.3 percent, and 20.9 percent, respectively. These numbers, again, are considerably larger than the spending increases of -1.4 percent, 22.3 percent, and 7.9 percent, respectively, under PPACA with marginal federal cost-sharing maintained at their 2019 rates through the end of the projection horizon of 2030.

With the enactment of PPACA, concern about runaway Medicaid spending is motivating many state policymakers to find ways to restrain Medicaid expenditures. One method receiving serious consideration is to opt out of Medicaid altogether—an option that has always existed under the Social Security Act—and to provide basic health coverage to low-income and medically needy groups financed exclusively out of GR funds. As of this writing, however, it is uncertain whether PPACA’s individual mandate to purchase health insurance will ultimately

be sustained or rejected in court cases filed by several states to challenge the mandate’s constitutionality. If it is rejected, large parts of PPACA could be struck down with it, or will become unworkable and require a radical overhaul. State lawmakers face considerable uncertainty about increased Medicaid spending commitments that they face because of PPACA—commitments that they must either accept and prepare for, or take steps to avoid, perhaps by opting out of Medicaid.

Medicaid: Programs, Coverage, and Financing

Medicaid programs are a part of state welfare programs that provide subsidized health care to low-income and medically needy individuals. Federal rules determine the basic coverage criteria that take account of household income and asset thresholds, medical conditions, and eligibility for special groups such as pregnant women, children, disabled individuals, the aged, and so on. However, state governments, at their discretion, may

With the enactment of PPACA, concern about runaway Medicaid spending is motivating many state policymakers to find ways to restrain Medicaid expenditures.

Beginning in 2011, FMAP rates will revert close to their pre-recession values, which will require states to come up with additional financing.

extend coverage to broader groups—by specifying higher income and asset eligibility thresholds than the federally mandated levels and by including additional groups based on medical conditions, family resources, and so on. Many states cover children and pregnant women even if their incomes are above the state’s eligibility levels but are deemed insufficient to meet the medical costs that they face. Other groups covered under optional programs in many states include non-disabled children and their related caretakers, pregnant women, the aged, blind, disabled, and others with medical expenditures exceeding their incomes.⁷

State Medicaid programs pay for a wide range of health care services including physician, hospital (in- and out-patient), lab, nursing, home health care, pharmacy costs, and more. Usually, the federal government provides matching funds to share state Medicaid costs. Federal cost-sharing is implemented using the FMAP formula, which is based on each state’s per capita income relative to that of the nation overall.⁸ The statutory minimum FMAP percentage for all states is 50 percent, the maximum being 83 percent. The average FMAP value across all states is about 59 percent. During 2009–10, FMAP rates were higher than normal because of the temporary FMAP enhancement enacted as part of the American Recovery and Reinvestment Act of 2009.

California, Illinois, and New York have pre-ARRA FMAP rates set to 50 percent; they are among the states with the highest incomes per capita. Pre-ARRA FMAP rates for Florida and Texas are higher, 55.45 percent and 60.56 percent, respectively. The ARRA-inclusive (year-end) values are about 10–15 percentage points higher for all states during 2009 and 2010, implying a smaller Medicaid funding burden. Beginning in 2011, however, FMAP rates will revert close to their pre-recession values, which will require states to come up with additional financing, as Medicaid caseloads have continued to increase during 2009 and 2010. For all states, federal Medicaid cost-sharing rates are assumed to

remain at their 2011 values when projecting future expenditures. Those values are also applied for determining federal and state cost-sharing for beneficiaries who are eligible for Medicaid under the old laws (without PPACA) and are projected to become new enrollees in Medicaid in response to the individual mandate to purchase health insurance.⁹

PPACA mandates new spending commitments for state governments under Medicaid. All five states examined here have constitutional balanced-budget requirements, either on the state legislature or on the governor’s budget submission. Thus, increased spending commitments from entitlements such as Medicaid that are difficult to reverse, and revenue losses during the recent recession, are worsening pressures on other budget items. Many states, including the five evaluated in this study, are projecting persistent budget gaps during 2011 and 2012 that must be addressed by increasing revenues and reducing state public services. Medicaid benefits are unlikely to be spared as federal financial assistance is reduced after 2010.

State Population Projections

For the five states under consideration, Table 1 shows population growth rates calculated based on projections of the U.S. Census Bureau. Through 2020, California, Florida, and Texas are projected to experience significantly higher population growth rates than Illinois and New York. The growth rates in the former three states are larger in all age categories, and especially among their retiree populations. Illinois and New York are projected to have declining populations among the working population—those aged 19 through 64. Beyond 2020, population growth is projected to increase in the three already rapidly growing states, whereas it is expected to decline in the two slow-growing states. Indeed, New York’s overall population growth is expected to be negative during this century’s third decade.

Examining each state’s demographic profile and dynamics provides clues for under-

Table 1
Projected Population Growth (annualized, percent)

| Age Category | 2010–20 | | | | | 2020–30 | | | | |
|--------------|---------|------|-------|-------|------|---------|------|-------|-------|------|
| | CA | FL | IL | NY | TX | CA | FL | IL | NY | TX |
| 0–18 | 0.69 | 1.47 | 0.12 | –0.15 | 1.33 | 0.64 | 1.70 | 0.02 | –0.11 | 1.24 |
| 19–64 | 0.51 | 1.12 | –0.13 | –0.27 | 0.85 | 0.56 | 1.21 | –0.30 | –0.63 | 1.24 |
| 65+ | 2.91 | 3.40 | 1.82 | 1.71 | 3.15 | 2.95 | 4.29 | 1.95 | 1.88 | 3.28 |
| All | 0.86 | 1.64 | 0.20 | 0.06 | 1.26 | 0.96 | 2.05 | 0.15 | –0.05 | 1.53 |

Source: Author’s calculations based on data on population projections from the Census Bureau. As the text explains, results for Illinois and New York (shaded) are qualitatively different from those for the other three states.

standing the results on state-specific Medicaid enrollment and expenditure changes, both with and without PPACA, that are reported later in this study. That is because each state’s projected total Medicaid expenditures are anchored by its population projections by age and gender (see Appendix). State-specific population projections are obtained directly from the Census Bureau.¹⁰ These projections are based on the 2000 Census and use fertility, mortality, and migration trends for each state to project their populations forward through 2030.

The Census-projected population age distributions for the five states are shown in Figure 2. The figure indicates that demographic changes in terms of changes in the size and age composition are occurring more rapidly in California, Florida, and Texas. Florida stands out for its rapid increase in the number and proportion of elderly residents—as expected, because the absence of income taxes makes it a popular destination for retirees. The California population profiles show substantial increases in the number of children, young adults, and the elderly. California’s younger populations are expected to grow, partly because of continuing migration from the nation’s eastern and mid-western regions. Similar to California, Texas’s population profile is growing throughout the age distribution, but the increase in the young-adult population is not as pronounced. The significant increases in these populations suggest growing Medicaid expenditures even without PPACA.

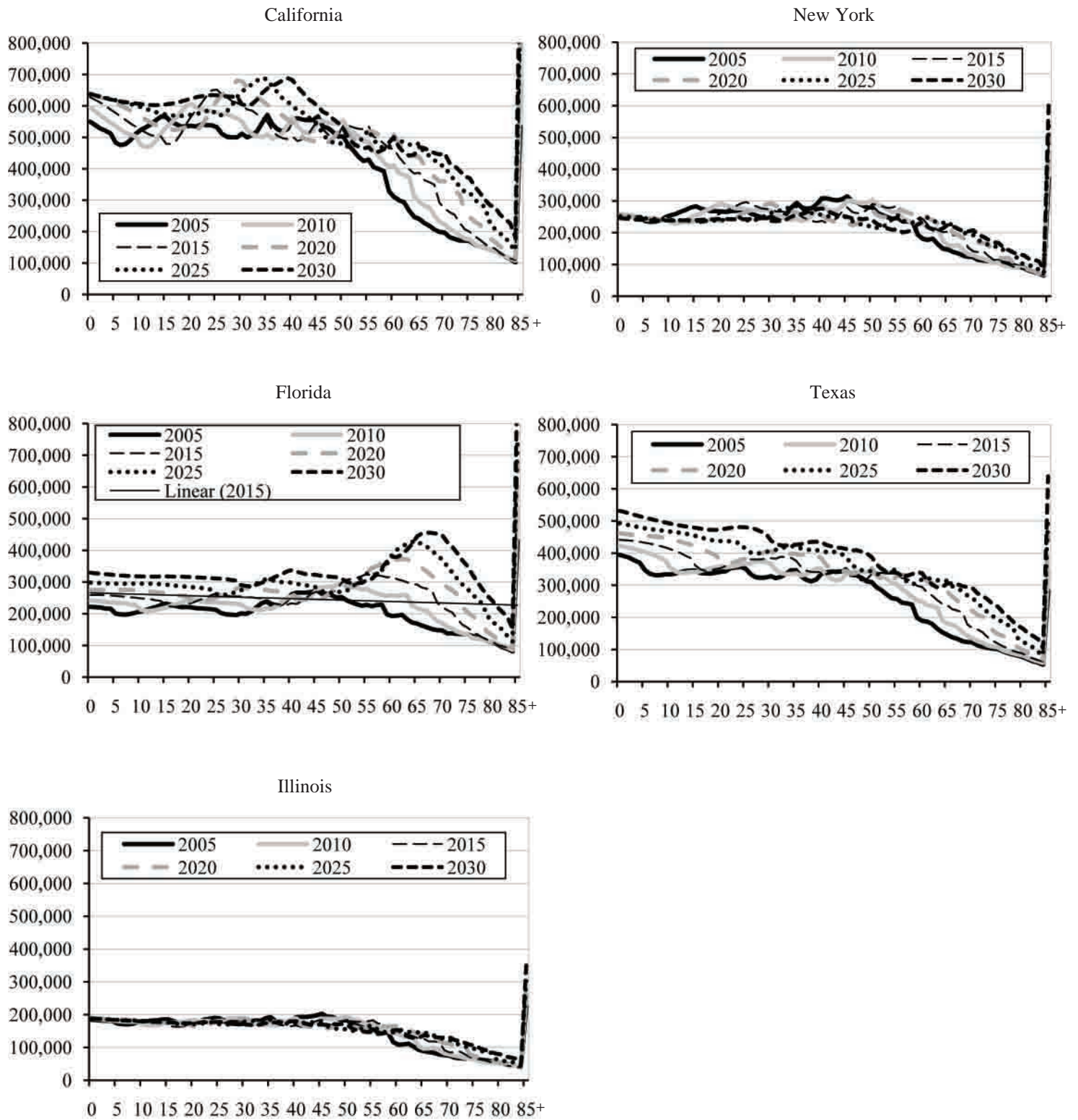
Population projections for Illinois and New York (shaded) exhibit considerably greater constancy, both in population size and age composition, and suggest that Medicaid expenditures will not increase as rapidly in these two states compared with the other three states with more robust population growth and faster aging population.

State Medicaid Spending Projections

PPACA broadens Medicaid eligibility by increasing income thresholds for children and adults. Children living in families with incomes less than 138 percent of the FPL (including PPACA’s new 5 percent income disregard) will now qualify for Medicaid. In addition, adults with or without qualifying children are also made eligible under the new FPL threshold. Expanded eligibility levels under PPACA will increase state Medicaid expenditures. But it will not significantly increase state GR Medicaid expenditures, at least in the short term, because of the high marginal cost-sharing provided by the federal government for individuals made newly eligible for Medicaid. GR-funded state Medicaid expenditures would not increase by much if enrollment rates among those eligible for Medicaid under the old laws remain low. That possibility appears unlikely, however, because the key goal of PPACA is to reduce rates of non-insurance extensively and intensively—that is, by expanding Medicaid eligibility *and* by facilitating enrollment and conducting widespread enrollment drives that induce non-enrolled old-eligibles to sign up

PPACA broadens Medicaid eligibility by increasing income thresholds for children and adults.

Figure 2
State Population Projections by Age, 2005–30



Source: United States' Census Bureau.

Table 2
Enrollment Increases Induced by PPACA (thousands of people)

| Year | New Enrollees (Newly Eligible) | | | | | New Enrollees (Old-Eligibles) | | | | |
|----------------|--------------------------------|-------|------|-------|-------|-------------------------------|------|------|-------|------|
| | CA | FL | IL | NY | TX | CA | FL | IL | NY | TX |
| 2014 | 2,985 | 2,315 | 979 | 2,059 | 2,118 | 204 | 624 | 518 | 467 | 858 |
| 2020 | 3,078 | 2,434 | 925 | 2,001 | 2,329 | 257 | 739 | 620 | 677 | 820 |
| 2030 | 3,479 | 3,125 | 886 | 1,917 | 2,729 | 412 | 937 | 767 | 1,014 | 864 |
| <i>Percent</i> | | | | | | | | | | |
| 2014 | 24.9 | 55.4 | 36.0 | 42.2 | 40.8 | 1.7 | 14.9 | 19.0 | 12.3 | 16.5 |
| 2020 | 23.3 | 53.6 | 31.7 | 41.3 | 38.0 | 1.9 | 16.3 | 21.2 | 16.8 | 13.4 |
| 2030 | 22.6 | 57.6 | 26.9 | 38.6 | 34.9 | 2.7 | 17.3 | 23.3 | 23.5 | 11.1 |

Source: Author’s calculations based on the Medicaid Statistical Information System and the Current Population Surveys. As the text explains, results for Illinois and New York (shaded) are qualitatively different from those for the other three states.

for Medicaid. Moreover, the individual mandate, even when it does not result in a penalty for non-insurance, will induce Americans to sign up for health insurance—Medicaid if they are eligible for it—simply out of a desire to comply with the nation’s laws.

Though it is uncertain whether the individual mandate will survive court challenges from many states, this study’s Medicaid spending growth estimates are constructed under the assumption that it will. The mandate and health insurance enrollment drives will induce an increase in enrollment by those who were eligible under the old laws but who were not enrolled in Medicaid or any other health insurance plan. Although PPACA provides full federal support for newly eligible Medicaid enrollees through 2019, it provides zero additional support for new enrollees among old-eligibles. States will bear the cost of these old-eligibles according to their (post-ARRA) FMAP rates.

PPACA will be implemented with special efforts to advertise the availability of Medicaid’s health care coverage options to newly eligible populations to increase the enrollment rates among newly eligible children and adults. However, the enrollment facilitation will also induce some old-eligibles to switch from non-Medicaid to Medicaid coverage because the latter is subsidized and imposes zero (or a much smaller) financial

burden on beneficiaries compared with their current employer-provided or privately purchased health insurance coverage. The added burden states bear will depend on the success of those promotional efforts.¹¹

In calculating enrollments under PPACA, it is assumed that enrollments by those newly eligible will either follow the same enrollment rates as those presently eligible or they will enroll at the rate of those with no other health insurance, depending on which rate is larger. A similar method is followed for those who are eligible for Medicaid under the old laws but who are not enrolled in Medicaid. Applying these rules yields a sizable increase in enrollments in 2014.

Enrollment Projections. Even without PPACA, Medicaid enrollments are projected to increase substantially in California, Florida, and Texas. The top panel of Table 2 shows projected increases in Medicaid enrollments as a result of PPACA in the five states being considered. The five columns on the left show the number (in thousands) of new enrollees that would result under PPACA in selected future years (2014, 2020, and 2030). These are counts of enrollees estimated from among those made newly eligible for Medicaid benefits under PPACA’s broader eligibility criteria. The lower panel (again of the five columns on the left) shows the increase that these new enrollees repre-

The mandate and health insurance enrollment drives will induce an increase in enrollment by those who were eligible under the old laws but who were not enrolled in Medicaid or any other health insurance plan.

PPACA adds to states' fiscal burden, primarily by bringing forward in time enrollment increases that would likely have occurred later.

sent as a percent of projected enrollees in the same years in a world without PPACA. The increases in Medicaid caseloads are sizable—ranging from the mid-20 percents for California to the mid-50 percents for Florida and New York. However, the costs of these increases in Medicaid caseloads will be paid for almost entirely out of marginal federal cost-sharing.

The five columns on the right of Table 2 show the number (in thousands) of new enrollees among old-eligibles who are projected to enroll as a result of PPACA. Effectively, applying for health insurance through state-operated health insurance exchanges would reveal if the applicant is eligible for Medicaid under the old eligibility rules (without PPACA). If so, that person would be directed or advised to sign up for Medicaid unless he or she desired an alternative insurance source. The estimation procedure mentioned above—taking the larger of the uninsured rate or the existing enrollment rate observed for old-eligibles—produces the estimates reported in Table 2.¹²

The lower panel shows the increase that new enrollees among old-eligibles represents as a percent of Medicaid enrollees in the same years projected without PPACA. The estimates are much smaller compared with those in the columns on the left. But the Medicaid benefits of these new enrollees, under the new law, would be paid for entirely out of state budgets: PPACA provides zero federal financial support on account of new enrollees among old-eligibles.

It is noteworthy that California is projected to experience very small increases in new enrollments among old-eligibles into Medicaid. That's because California already has very high enrollment rates among Medicaid eligibles and there is not much scope for expanding enrollments among old-eligibles under PPACA. Florida and Texas are projected to experience Medicaid enrollment increases in the 10 to 16 percent range in years beginning in 2014. However, Illinois and New York (shaded) are projected to gain Medicaid enrollments among old-eligibles much more rapidly—clus-

tered around 20 percent—in the various years shown in Table 2. This occurs because these two states have smaller projected enrollment rates without PPACA, leaving more scope for enrollment increases as the PPACA laws take effect in 2014. This means that in each future year, Medicaid enrollments would be between 10 to 25 percent higher in all the states examined except in California.

Table 3 shows GR Medicaid spending increases in the five states, comparing projections with and without PPACA in selected future years. Spending increases are generally larger than enrollment increases because the historical increases in benefits per beneficiary are projected forward in time and augment expenditure growth from larger enrollments.

The top panel of Table 3 shows GR Medicaid expenditures (in billions of dollars) for selected future years constructed with and without PPACA. The two rows in the middle of Table 3 show the percentage increases in states' GR Medicaid expenditures, separately with and without PPACA, between 2014 and 2020 and between 2014 and 2030:

- In California, Florida, and Texas, spending growth is sizable between 2014 and 2020, even without PPACA. The increases range from about 28 percent to about 42 percent for these three states.
- In Illinois and New York, cumulative changes through the year 2020 are much smaller, ranging between 7 percent to about 15 percent.
- Through 2030, cumulative spending increases even without PPACA are, again, much larger for California, Florida, and Texas—doubling or more even without PPACA. For Illinois and Florida, the cumulative spending increases are relatively modest—ranging between about 18 and 29 percent.

Without PPACA, GR spending projections exhibit very different trends in the five states, increasing much more rapidly for California, Florida, and Texas, and more slowly

Table 3
Projected General Revenue Medicaid Expenditures with and without PPACA (billions of dollars)

| Year | CA | | FL | | IL | | NY | | TX | |
|--|---------------|------------|---------------|------------|---------------|------------|---------------|------------|---------------|------------|
| | Without PPACA | With PPACA | Without PPACA | With PPACA | Without PPACA | With PPACA | Without PPACA | With PPACA | Without PPACA | With PPACA |
| 2008 | 19.4 | - | 6.3 | - | 5.8 | - | 23.8 | - | 8.5 | - |
| 2014 | 26.3 | 26.5 | 9.8 | 10.7 | 6.4 | 7.8 | 28.7 | 30.5 | 12.7 | 14.4 |
| 2020 | 35.2 | 36.8 | 12.6 | 15.1 | 6.9 | 8.9 | 32.9 | 39.4 | 18.0 | 20.3 |
| 2030 | 59.9 | 62.3 | 19.5 | 23.8 | 7.6 | 10.2 | 37.1 | 48.9 | 32.5 | 35.1 |
| <i>Percent Increase from Spending Projections Without PPACA for 2014</i> | | | | | | | | | | |
| 2020/2014 | 34.1 | 34.4 | 27.8 | 53.6 | 6.8 | 39.3 | 14.5 | 37.2 | 41.7 | 60.5 |
| 2030/2014 | 128.0 | 124.8 | 97.9 | 141.9 | 17.8 | 58.2 | 29.4 | 70.2 | 156.6 | 177.0 |
| <i>Percent Change due to PPACA</i> | | | | | | | | | | |
| 2014 | -2.9 | | 9.0 | | 22.2 | | 6.4 | | 13.5 | |
| 2020 | 0.2 | | 20.1 | | 30.5 | | 19.8 | | 13.3 | |
| 2030 | -1.4 | | 22.3 | | 34.3 | | 31.5 | | 7.9 | |

Source: Author’s calculations based on the Medicaid Statistical Information System, Current Population Surveys, and CMS-64 reports. As the text explains, results for Illinois and New York (shaded) are qualitatively different from those for the other three states.

for Illinois and New York. A salient reason is that the former states are projected to experience growing populations among age-gender groups that have historically high Medicaid eligibility and utilization rates, whereas the latter two states have stagnant or declining populations among those groups. With PPACA, however, spending increases are much larger, and the increases are especially sizable for Illinois and New York.

Another way to measure PPACA’s effect on spending is shown in the bottom panel of Table 3. This panel shows the percent increase in projected Medicaid expenditures due to PPACA in selected years. Here, the story is reversed compared with projected spending increases over time: states with high spending increases over time without PPACA exhibit low projected spending increases from introducing PPACA and states with low spending growth over time without PPACA exhibit relatively more rapid spending increases from introducing PPACA:

- PPACA’s effects on Medicaid expen-

ditures in California are negative—the result of savings from uncompensated care (reductions in state Disproportionate Share Hospital expenditures) dominating those from increased Medicaid enrollments by old-eligibles.¹³

- Medicaid expenditures in Florida and Texas increase more rapidly as a result of PPACA, ranging between 8 percent and 22 percent in the years shown.
- Illinois and New York (shaded) are projected to have higher spending increases as a result of PPACA—increasing by up to the mid-30 percents by 2030.

This result emerges because, consistent with historical data, Illinois and New York are projected to have lower eligibility and enrollment rates than California, Florida, and Texas (without PPACA) and those rates are projected to increase more slowly in both of those states. With the introduction of PPACA’s individual mandate, however, many among the old-eligibles who do not have health insurance will be induced to acquire it. If applying for health

Table 4
Projected General Revenue Medicaid Spending Growth by Age and Special Eligibility Categories without PPACA
(annualized, percent)

| Age and Special Eligibility Category | 2010–20 | | | | | 2020–30 | | | | |
|--------------------------------------|---------|-------|------|------|------|---------|------|------|------|------|
| | CA | FL | IL | NY | TX | CA | FL | IL | NY | TX |
| 0–18* | 9.0 | 11.1 | 7.4 | 7.0 | 12.0 | 4.1 | 7.4 | 2.8 | 2.6 | 7.8 |
| 19–64* | 8.6 | 10.4 | -3.1 | 5.5 | 5.9 | 4.6 | 7.2 | -0.8 | -2.3 | 3.5 |
| 65+* | 12.5 | 4.6 | 6.3 | 4.0 | 5.5 | 8.4 | -2.8 | 1.9 | -3.3 | 2.3 |
| Medically Needy | 6.3 | 9.1 | 2.0 | 6.4 | -0.7 | 5.0 | 6.6 | -2.1 | 1.2 | -0.9 |
| Breast and Cervical Cancer Act | 16.3 | 20.7 | 22.7 | 15.6 | 16.8 | 9.8 | 11.7 | 14.2 | 8.4 | 10.1 |
| Foster Care | 10.3 | 9.4 | 2.4 | 1.5 | 13.6 | 7.2 | 5.5 | 2.1 | 5.2 | 8.5 |
| Family Planning | 13.4 | -30.0 | 9.4 | | | 10.0 | 7.6 | 7.5 | | |
| Disabled Adults | 7.0 | 6.9 | 5.8 | 7.8 | 7.6 | 2.4 | 2.5 | -0.1 | 2.4 | 3.8 |
| Waivers | 4.2 | 6.4 | 3.4 | 3.4 | 4.4 | 0.9 | 3.3 | 0.1 | -0.7 | 1.4 |
| All | 8.9 | 7.9 | 5.0 | 6.3 | 9.3 | 5.5 | 4.5 | 1.0 | 1.2 | 6.1 |

*Excludes people eligible under other special categories. Spending growth from PPACA is shown without netting out state saving from uncompensated care (DSH).

Source: Author’s calculations based on the Medicaid Statistical Information System, Current Population Surveys, and CMS-64 reports. As the text explains, results for Illinois and New York (shaded) are qualitatively different from those for the other three states.

insurance at state-operated exchanges reveals eligibility for Medicaid under the old eligibility rules, enrollment in Medicaid will rise, usually leading to benefit claims. In addition, the health insurance mandate may cause some individuals to realize that obtaining health insurance through Medicaid is more cost effective than their existing private insurance and may cause them to shift to Medicaid. Alternatively, if employers choose to drop coverage, many old-eligibles who are currently insured in the private market may enroll in Medicaid.

The message from Tables 2 and 3 is that states with already high enrollments and rapid growth in Medicaid enrollments would face serious budget problems from rising Medicaid expenditures. PPACA adds to their fiscal burden, primarily by bringing forward in time enrollment increases that would likely have occurred later. Moreover, the additional Medicaid spending from PPACA is relatively small. However, states with heretofore low Medicaid enrollments and slower growth in enrollments are likely to experience a substantial increase in Medicaid expenditures because of PPACA’s health insurance mandate.

Table 4 shows Medicaid spending growth rates by age group and special eligibility categories. The growth rates by age categories are calculated without PPACA after excluding individuals that qualify for and claim Medicaid benefits under special eligibility rules. The table shows that the annual average Medicaid spending growth on account of children (not including expenditures of the Children’s Health Insurance Program) is projected to be quite high through the year 2020 in California, Florida, and Texas—ranging between 9 and 12 percent per year. In Illinois and New York that growth rate is not as high. Between 2020 and 2030, the growth rate is lower in all states, but especially in Illinois and New York (shaded).

The same remarks are applicable to Medicaid spending growth on account of non-disabled adults aged 19–64. However, Illinois and New York (shaded) will experience low or negative spending growth rates, probably because of the projected decline in their populations of working-age adults. Among retirees, growth rates vary across states and over time: rates are highest in California but negative

over the long term in Florida and New York. Those negative growth rates are probably the result of increasing use of prescription drugs, payment for which was switched from Medicaid to Medicare during the early 2000s, and the consequent decline in the ratios of beneficiaries to enrollees in these two states.¹⁴

Among special-eligibility categories, spending growth rates are highest among women with breast and cervical cancer, followed by foster-care children and blind/disabled adults. Across all categories, projected annual (nominal) Medicaid spending growth rates are 8.9 percent for California, 7.9 percent for Florida, and 9.3 percent in Texas—much larger than the 5 percent for Illinois and 6.3 percent for New York. During the subsequent decade, annual (nominal) Medicaid spending growth rates are slower, between 4.5 and 6.1 percent for California, Florida, and Texas, and they are very small for Illinois (1.0 percent) and New York (1.2 percent) (shaded). The slower spending growth after the year 2020 in most cases is explained by projected eligibility/enrollment/beneficiary rates, eventually attaining maximum values of 100 percent with no scope for additional increases.

Alternative Federal Cost-Sharing Scenarios. The Congressional Budget Office projects unprecedented federal deficits as a share of

GDP—indicating the precarious condition of federal finances—through the next 10 years. It means that the promised high marginal federal cost sharing for new enrollees among those made newly eligible for Medicaid under PPACA could be reduced rather than maintained at the 2019 value of 92.8 percent. Two alternative projections are constructed for states’ Medicaid expenditures assuming reduced marginal federal cost sharing. The first scenario implements a gradual reduction in marginal federal FMAP support after 2019 and the second a more rapid reduction of the same. The results are shown in Table 5.

The top panel of Table 5 shows projected Medicaid expenditures with PPACA and the bottom panel shows the percentage increase in expenditures caused by PPACA for selected years. In each state’s panel in Table 5, the first column shows the “Base Case,” taken from the first panel of Table 3; the second column, “Alternative 1,” projects the percent increase in each state’s Medicaid spending under the assumption that the marginal FMAP cost-sharing rate under PPACA is gradually reduced by 1 percentage point per year until it reaches the standard FMAP rate applicable for each state; and the third column, “Alternative 2,” projects the percent

Table 5
Medicaid Spending Increases Post-PPACA under Alternative Federal Match Policies

| Year | CA | | | FL | | | IL | | | NY | | | TX | | |
|--|-----------|-------|-------|-----------|-------|-------|-----------|-------|-------|-----------|-------|-------|-----------|-------|-------|
| | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 |
| 2014 | 25.5 | 25.5 | 25.5 | 10.7 | 10.7 | 10.7 | 7.8 | 7.8 | 7.8 | 30.5 | 30.5 | 30.5 | 14.4 | 14.4 | 14.4 |
| 2020 | 35.3 | 35.4 | 35.7 | 15.1 | 15.2 | 15.7 | 8.9 | 9.0 | 9.1 | 39.4 | 39.5 | 40.5 | 20.3 | 20.4 | 21.0 |
| 2030 | 59.0 | 60.2 | 62.3 | 23.8 | 25.4 | 28.5 | 10.2 | 10.4 | 10.9 | 48.9 | 50.6 | 53.9 | 35.1 | 36.6 | 39.3 |
| <i>Percent change over Medicaid spending projections without PPACA</i> | | | | | | | | | | | | | | | |
| 2014 | -2.9 | -2.9 | -2.9 | 9.0 | 9.0 | 9.0 | 22.2 | 22.2 | 22.2 | 6.4 | 6.4 | 6.4 | 13.5 | 13.5 | 13.5 |
| 2020 | 0.2 | 0.4 | 1.5 | 20.1 | 20.9 | 25.1 | 30.5 | 30.8 | 32.9 | 19.8 | 20.3 | 22.9 | 13.3 | 13.8 | 16.7 |
| 2030 | -1.4 | 0.5 | 4.1 | 22.3 | 30.4 | 46.3 | 34.3 | 37.8 | 44.6 | 31.5 | 36.2 | 45.2 | 7.9 | 12.3 | 20.9 |

Notes: Alt 1: Marginal federal match for new-eligibles is reduced by one percentage point each year through 2030. Alt 2: Marginal federal match for new-eligibles is eliminated by 2028.

Source: Author’s calculations from the Medicaid Statistical Information System, Current Population Surveys, and CMS-64 reports. As the text explains, results for Illinois and New York (shaded) are qualitatively different from those for the other three states.

Table 6
Increases in 10-Year (2014–23) Medicaid Spending with and without PPACA, Relative to a Flat Spending Baseline

| | CA | FL | IL | NY | TX |
|---|-------|-------|-------|-------|-------|
| 1. 10-Year Flat-Spending Baseline (Based on 2014 Spending Without PPACA; billions of dollars) | 262.6 | 98.4 | 64.2 | 287.1 | 126.8 |
| 2. 10-Year Change from Flat-Spending Baseline to without PPACA (%) | 26.2 | 20.9 | 5.1 | 10.8 | 31.7 |
| 3. 10-Year Change from Flat-Spending Baseline to with PPACA (%) | 25.4 | 41.6 | 34.6 | 29.1 | 48.7 |
| 4. 10-Year Change from Flat-Spending Baseline to Alternate Scenario 1 (%) | 25.7 | 42.7 | 35.0 | 29.7 | 49.5 |
| 5. 10-Year Change from Flat-Spending Baseline to Alternate Scenario 2 (%) | 26.8 | 46.7 | 36.6 | 31.8 | 52.5 |
| 6. Memo: 10-Year Flat Enrollment (millions of people) | 119.7 | 41.8 | 27.2 | 48.8 | 51.9 |
| 7. Memo: Average State GR Medicaid Spending per Enrollee (dollars) | 2,195 | 2,355 | 2,358 | 5,878 | 2,441 |

Source: Author’s calculations from the Medicaid Statistical Information System, Current Population Surveys, and CMS-64 reports. As the text explains, results for Illinois and New York (shaded) are qualitatively different from those for the other three states.

increase under the assumption that federal marginal cost-sharing is reduced rapidly so that it achieves the standard FMAP rate for each state by 2028. Note that the terminal year through which marginal federal cost-sharing rates have been specified under PPACA is 2019.

The lower panel of Table 5 shows that PPACA would reduce California’s GR Medicaid spending in the year 2030 by 1.4 percent under the Base Case, but increase it marginally under both alternative scenarios—by 4.1 percent under Alternative 2, where the reduction of federal cost sharing is more rapid. For other states, however, spending increases under the two alternative scenarios are much larger. In Florida, for example, the additional Medicaid spending from PPACA would increase from 22.3 percent to 30.4 percent under the first alternative scenario and to 46.3 percent under the second. Significant increases in additional Medicaid expenditures from PPACA also arise for Illinois, New York, and Texas, as Table 5 shows.

Table 6 provides the overall picture of Medicaid spending growth during the 10 years after the law is implemented in 2014. The first row of the table shows total 10-year spending under the assumption that Medicaid’s dollar spending out of state general revenues is frozen at the 2014 level. That spending is highest for New York, followed by California, with Texas a distant third.

The sixth row of the table shows flat-lined enrollments—that is, assuming that enrollments are maintained at the 2014 level for 10 years thereafter. Dividing the 10-year flat spending with the 10-year flat enrollment yields the average spending per enrollee, as shown in the last row of the table. New York is by far the most expensive Medicaid state, spending almost \$6,000 per Medicaid enrollee. All of the other four states included in this study are projected to experience much smaller expenditures of a little more than \$2,000 per enrollee—only about one-third of New York’s average Medicaid spending per enrollee.¹⁵

The second row of Table 6 shows the percentage increase in projected Medicaid expenditures if future enrollments and benefits per beneficiary continue to evolve along historical trends in each of the age and special-eligibility categories as described in the Appendix. This projection shows that Medicaid expenditures would increase substantially for California (26.2 percent), Florida (20.9 percent), and Texas (31.7 percent) even without PPACA. Ten-year spending increases are projected to be quite low for Illinois (5.1 percent) and New York (10.8 percent) (shaded) because enrollment ratios in these two states have been historically low and increased less steeply than in others.

The third row of Table 6 shows that PPACA reduces California’s 10-year Medi-

caid spending by a small amount; the increase from the flat-spending with PPACA is just 25.4 percent compared with the 26.2 percent increase without PPACA. Because the ratio of enrollees to old-eligibles is already quite high in California, there is little scope for PPACA to increase Medicaid expenditures further on account of new enrollees among old-eligibles in California compared with Florida and Texas.¹⁶ Projections for the latter two states suggest a much larger scope for spending increases under PPACA, as enrollment rates have stagnated, especially among the largest category of non-disabled adults aged 19–64. This is confirmed in Table 6, which shows that compared with the flat-spending level, Florida’s 10-year Medicaid costs would escalate by 41.6 percent because of PPACA rather than by just 20.9 percent without it. In the case of Texas, the 10-year total spending would increase by 48.7 percent under PPACA rather than by just 31.7 percent without it. Thus, the cumulative impact of carrying forward historical trends in eligibility, enrollments, beneficiary ratios, and benefits per beneficiary lead to the largest escalation in Medicaid expenditures in Texas—both without and with PPACA—casting a bright spotlight on why Texas state policymakers are so highly concerned with the implications of PPACA for that state’s budget.

In Illinois and New York, the ratio of enrollees to eligibles is low and, in some instances, it has historically declined. Again, this explains why PPACA would lead to sizable spending increases—the individual mandate will spur old-eligibles into enrolling under Medicaid. Table 6 shows that compared with the flat spending baseline, PPACA would escalate Illinois’s 10-year expenditures by 34.6 percent, rather than by just 5.1 percent without PPACA. And New York’s spending increase would be by 29.1 percent, not by just 10.8 percent.

The overall results show that all of the five states are facing a 10-year Medicaid spending increase larger than 30 percent, resulting from a combination of already increasing

trends in eligibility, enrollments, beneficiary ratios, and expenditures per beneficiary, as well as PPACA’s Medicaid expansion. Among the five states examined, PPACA causes the steepest rise in spending in Illinois—by almost 30 percentage points—whereas the steepest cumulative increase (48.7 percent) is projected for Texas. California’s cost increase is already sizable, but much of its uninsured population would either be ineligible to enroll in Medicaid or be in categories that would impose higher costs on that state.

These results are at odds with previous portrayals of how much state expenditures would increase under PPACA. The debate appears to be informed largely by estimates reported by the Kaiser Family Foundation, which projects very small increases in total state expenditures during 2014–19. Kaiser’s estimates of state spending increases range from 0.0 percent for New York to 3.0 percent for Texas—much smaller than the estimates reported here.¹⁷ Kaiser’s methodology appears to have used future enrollment rates for new-eligibles and old-eligibles that are not calibrated from historical trends, but instead are based on calibrations from a given year (2007) and Congressional Budget Office assumptions about future enrollment rates that are assumed to remain fixed. These assumptions would tend to produce smaller estimates of enrollment and spending on old-eligibles compared with the assumptions made here. For example, in those cases where historical trends show consistently low or declining enrollments among old-eligibles, the enrollment-increasing effect of the individual health insurance mandate on non-enrolled old-eligibles may be understated under Kaiser’s methodology. This study does not assume that enrollment rates among old-eligibles would remain fixed at the levels observed in 2007, a year with no federal mandate to purchase health insurance or widespread public education campaigns about the need to comply with the law by obtaining health insurance. This study makes the alternative assumption that the individual mandate would raise

The overall results show that California, Florida, Illinois, New York, and Texas are facing a 10-year Medicaid spending increase larger than 30 percent.

The estimates of projected Medicaid expenditures may be conservative because the effect of future shifts from private coverage to Medicaid, post-PPACA, is not fully incorporated.

enrollment rates among old-eligibles and, therefore, tracks changes to historical trends in eligibility, enrollment, benefit reciprocity, and average benefits per beneficiary that would arise from introducing PPACA. All of these estimates are anchored to nationally representative historical micro-data surveys and Medicaid's state-wise administrative information. Thus, methodological differences between Kaiser's and this study's calculations may underlie the sizable differences in estimates of states' additional costs from PPACA, especially the potential additions to state Medicaid expenditures from new enrollments by old-eligibles.

Conclusion

Detailed estimates of the effect of PPACA on the budgets of the five most populous states suggest the law will impose large unfunded mandates to expand Medicaid case-loads and increase state Medicaid outlays. States will have to meet this increased financial burden either through cutbacks in other public services or higher tax burdens—both of which will exert negative effects on states' economies.

The results suggest that even without PPACA, Medicaid expenditures would increase rapidly in California, Florida, and Texas, each of which has growing populations across many Medicaid eligibility and enrollment groups. Medicaid spending increases projected without PPACA are relatively small in Illinois and New York, states whose populations are projected to remain generally stagnant or to decline during the next two decades. When PPACA's effects on enrollment in Medicaid are included—especially enrollment by old-eligibles who would now be directed to enroll as a consequence of the new law's health insurance mandate—Medicaid will impose large financial burdens on all five states.

The projected cumulative post-PPACA Medicaid spending increase during 2014–23 is negative only for California: spending is projected to decline by a smaller amount

under PPACA than without it. Florida and Texas, however, are projected to have larger populations of non-enrolled old-eligibles: spending without PPACA is projected to be 20.9 percent higher in Florida compared with holding it at the 2014 level for 10 years. With PPACA, it would be 41.6 percent higher compared with the flat baseline. The corresponding increases for Texas are 31.7 percent without PPACA and 48.7 percent with PPACA. Illinois and New York exhibit historically stable or declining enrollment rates among old-eligibles, implying higher potential spending on these individuals in 2014 and thereafter. Without PPACA, Medicaid expenditures are projected to increase from the flat-spending baseline by just 5.1 percent in Illinois and 10.8 percent in New York. With it, however, the increases in the two states are 34.6 percent and 29.1 percent, respectively.

It should be noted that the estimates presented here of projected Medicaid expenditures in five states, both with and without PPACA, are based on standard assumptions and methods for extending eligibility, enrollment, benefit reciprocity status, and benefit award rates into the future. The estimates may be conservative because the effect of future shifts from private coverage to Medicaid, post-PPACA, is not fully incorporated. The results are also uncertain because future trajectories of all of these rates will be affected by many factors not considered here: the economic environment, the specific implementation of PPACA, the availability and cost of non-Medicaid health insurance for low-income individuals, and so on.

Supporting such high Medicaid spending increases under PPACA, but also irrespective of PPACA, would require higher taxes or reductions in other public services, both of which appear to state policymakers as economically undesirable. Concerns about runaway Medicaid expenditures are motivating policymakers in many states to explore ways to restrain Medicaid expenditures, including opting out of Medicaid altogether—an option that has always existed under the

Social Security Act—using alternative state programs to provide basic health coverage to low-income and medically needy groups. Another possibility is to allow the quality of Medicaid-covered health care services to deteriorate in order to prevent the crowd-out of private health coverage that has historically occurred after every expansion of the Medicaid program. Prospects of such steep increases in Medicaid expenditures probably explain growing support among citizens and many state policymakers to alter PPACA, if not to repeal it.

Appendix

Methodology for Projecting Texas Medicaid Expenditures under PPACA

Medicaid spending projections for the five states considered in this study are based on various data sources, namely, the Medicaid Statistical Information System, the Current Population Surveys, and the U.S. Census Bureau. Section A1 of this Appendix explains the general methodology and Section A2 discusses the rules applied to determine Medicaid eligibility for various age and eligibility categories, including differences in rules across the five states evaluated here. Section A3 describes historical trends of Medicaid eligibility, enrollment, reciprocity, and average benefits per recipient separately for various demographic groups and eligibility categories.

A1. Methodology for Projecting Medicaid Expenditures in Texas. The Medicaid Statistical Information System State Data Mart website provides administrative information on the number of Medicaid beneficiaries by gender (g), age-category (a), and eligibility group (e) for the years 1999–2008. It also provides information on total Medicaid benefits awarded to state residents (B_{STT}) in those years, where the suffix, STT , stands for the state in question.

In all states, residents qualify for Medicaid benefits based on a range of income- and asset-related criteria. In addition, special

categories of individuals such as children, pregnant women, aged, blind, disabled, and medically needy individuals qualify for “categorical coverage,” even though their incomes and resources exceed federally mandated income and asset qualification thresholds.

First, the total population for the state in question is calculated by gender, age category, income range (f) relative to the federal poverty level (FPL), and year (t), based on data from the Current Population Survey, $CPS_STTPOP_{g,a,f,t}$.¹⁸ Because the CPS undercounts state populations relative to Census Bureau counts for all states, the Census population $CEN_STTPOP_{g,a,t}$ is also categorized according to gender, age category, and year cells, and the latter population is used to rescale CPS population counts: for each demographic cell, the ratio of the two populations

$$U_{g,a,t} = \frac{CEN_STTPOP_{g,a,t}}{\sum_f CPS_STTPOP_{g,a,f,t}}$$

provides a measure of the cell-specific population over- or under-counts in the CPS relative to the Census population.

Next, populations of Texas Medicaid benefit-eligible individuals by demographic cells are calculated from the CPS: $CPS_E_STT_{g,a,f,t}$. These cells are calculated separately for specific income ranges (f) relative to FPL values.¹⁹

For example, take a male aged a in 2008. Adults qualify for Medicaid coverage if they have a covered child. In turn, the child is Medicaid-eligible if the income of the child’s family falls within the income threshold or the child qualifies based on non-income-related criteria such as disability and foster care (for which income-eligibility limits are different). Thus, the eligibility rate, e , for adults aged a , of gender g , with FPL-relative income f , and in year t , can be calculated conditional on their children’s eligibility as

$$e_{g,a,f,t} = \frac{U_{g,a,t} \times E_CPS_{g,a,f,t}}{U_{g,a,t} \times CPS_STTPOP_{g,a,f,t}}$$

Here, the numerator refers to the total num-

Prospects of steep increases in Medicaid expenditures probably explain growing support among citizens and many state policymakers to alter PPACA, if not to repeal it.

Component rates, independently calculated and projected, capture different policy or environmental factors, each with the potential to exhibit its own future trend.

ber of state residents found to be Medicaid eligible in the CPS after applying the eligibility rules and the population adjustment ratio $U_{g,a,t}$ (described above).

Next, the enrollment rate, n , is calculated as the number of Medicaid enrollees divided by the number of Medicaid eligibles:

$$n_{g,a,t} = \frac{N_MSIS_{g,a,t}}{U_{g,a,t} \times \sum_f E_CPS_{g,a,f,t}}$$

Here, the numerator is the total number of male state residents aged a , of gender g , in year t , who are enrolled in Medicaid based on data obtained from MSIS. One limitation of the data from MSIS is that they are not decomposed by FPL-relative income categories. Therefore, the average age-gender enrollment rate is applied to all three FPL categories. Next, the reciprocity rate, r , is calculated as the number of Medicaid recipients (or beneficiaries) among Medicaid enrollees:

$$r_{g,a,t} = \frac{R_MSIS_{g,a,t}}{N_MSIS_{g,a,t}}$$

Again, data for the number of state residents who received Medicaid benefits are obtained from MSIS. Finally, average Medicaid benefits per recipient, b , in the state in question are calculated from the MSIS as

$$b_{g,a,t} = \frac{B_MSIS_{g,a,t}}{R_MSIS_{g,a,t}}$$

where the numerator refers to total Medicaid benefits for this group. The average age-gender ratios $r_{g,a,t}$ and $b_{g,a,t}$ are applied to those who are Medicaid eligible in each FPL-relative income category. Thus, total state Medicaid expenditures in 2008 on males aged a , gender g , FPL category f , and year t , can be represented as

$$M_{g,a,f,t} = U_{g,a,t} \times CPS_STTPOP_{g,a,f,t} \times e_{g,a,f,t} \times n_{g,a,t} \times r_{g,a,t} \times b_{g,a,t}$$

This method of calculating the four rates can be applied to all age groups and both

genders and aggregated to yield total (MSIS-based) Medicaid expenditures for the year in question.

Total Medicaid expenditures derived in this manner for the base year, 2008, are benchmarked to total (expended) Medicaid expenditures in 2008 as reported in the state budget. This step takes account of Disproportionate Share Hospital, Upper Payment Limit, and Medicaid administrative expenditures that are not included in MSIS data. Thus, these additional expenditures are implicitly distributed across age, gender, and eligibility categories in the same proportion as Texas Medicaid expenditures included in MSIS data.

The simplest way to project states' Medicaid expenditures for future years is to represent total expenditures in earlier years by age, gender, and income, $M_{g,a,f,t}$, $t=2001-2008$, as above, and extrapolate each of the component elements over future years. The product of those terms in future years provides estimates of future Medicaid expenditures in the state for each particular gender, age, and FPL category. Summing over all categories provides the future year's total Medicaid expenditures.

The reason for calculating and independently projecting each of these component rates when constructing Medicaid's expenditure projections is that those rates capture different policy or environmental factors, each with the potential to exhibit its own future trend. For example, while the Medicaid eligibility rate for a particular population sub-group is determined by federal and state policies about which types of individuals should qualify for Medicaid benefits, enrollment rates for different population sub-groups may be determined by the availability and cost of alternative health insurance coverage, individual perceptions about their health care needs, the quality and out-of-pocket expenditures of Medicaid's health care provision, and public awareness about the availability of Medicaid coverage for people with similar demographic, economic, and health characteristics.

Furthermore, Medicaid reciprocity rates could be different among different population sub-groups by age, gender, and other characteristics, depending on their frequencies of adverse health episodes and health service needs. Finally, average benefit rates would differ depending on the incidence of chronic conditions: whether recipients are elderly or disabled; the type, quality, and cost of health care treatments that are locally available, and so on. Basing projections on detailed historical information on the group-specific trends of all four components separately: by age; gender; whether disabled; and income level (relative to the federal poverty level), whether medically needy, unemployed, single- or dual-income family, number of children, etc.—provides greater confidence that the rich variety of independent influences of policies, environmental conditions, and behavioral propensities on Medicaid expenditures has been adequately accounted for.

PPACA changes eligibility rules for low-income individuals and mandates health insurance coverage for all. In addition, it envisions a vigorous public-awareness and enrollment facilitation drive that would increase enrollment rates among both those people eligible under the old Medicaid laws and those newly eligible under PPACA. So state Medicaid expenditures under PPACA are likely to be quite different (and considerably larger) compared with expenditures under the old health care laws.

A2. Medicaid Eligibility Criteria. There are three key requirements to be eligible for Medicaid in any state. This section will briefly discuss each of these rules and how they vary by state. The section will then cover a handful of other reasons someone may be eligible for Medicaid. All of the rules described here for the three key eligibility criteria are coded to determine eligibility to Medicaid among the CPS sample populations by age, gender, FPL-relative income category, and those eligible under special rules for the years spanning 2000 to 2008—the latest year for which CPS data are available.

a. Federal Poverty Level. Having a family income below a specific FPL is one of the key eligibility criteria. Prior to the new health care law, Medicaid's federal income eligibility threshold was 100 percent of the FPL for children aged 6 through 18, with a state option up to 133 percent and an option to extend the eligible age to 20 for those in school. For 1- to 5-year-olds the federal income eligibility threshold was 133 percent. For newborns and pregnant women, the income limit was at 133 percent of FPL, with options for states to increase it up to 185 percent of FPL.

The new law establishes an income eligibility threshold for everyone (including childless adults) at 133 percent of FPL. It also introduces an income disregard at 5 percent of family income.

Other special deductions were applied before the new health care laws were enacted, and varied by state. These generally included items such as work-related (\$90 a month) and dependent-care expenses (\$175–\$200 a month), child-support payments, earnings of children under age 19 and in school, all income from Social Security's Supplemental Security Income program, other public assistance, and educational assistance.

Of the five most populous states, California, Illinois, and New York have elected to cover children aged 6 through 18 at the 133 percent level. All of the states cover newborns and pregnant women up to 185 percent of FPL. Not only that, but each of this study's states, except for Texas, has chosen to pay for pregnant women up to 200 percent from outside its federal Medicaid budgets.

b. TANF/AFDC. The original federal welfare program, Aid to Families with Dependent Children, was reformed in 1996, becoming the Temporary Assistance for Needy Families program. Originally, AFDC qualifying thresholds and conditions were used to determine Medicaid eligibility, but today, TANF thresholds and conditions are used. A family is eligible for AFDC/TANF, and therefore Medicaid, if they are citizens with dependent children and have incomes less than

The new law establishes an income eligibility threshold for everyone at 133 percent of the federal poverty level.

Run separately by each state, the TANF eligibility rules vary widely between the five states examined in this report.

the qualifying thresholds. In addition, for two-parent households, the primary earner must either be unemployed (or disabled) or earn less than the AFDC income threshold, or else be underemployed (as defined by each state).

Run separately by each state, the TANF eligibility rules vary widely between the five states examined in this report. In California the income limits vary each year, with the 2008 income limit at \$12,960 for a three-person household, or around 70 percent of FPL. California also uses an income disregard (income not included when calculating Medicaid's income eligibility threshold) that equals 100 percent of FPL minus the 1996 AFDC Maximum Aid Payment. For a three-person household this brings the effective 2008 FPL to 125 percent. Unlike California, Florida's income limits are fixed at the 1996 AFDC standard of \$3,636 for a three-person household, or around 20 percent of FPL, and are declining over time. Also, Florida only has an income disregard for those who are already receiving Medicaid. For these people it is the \$200 and a one-half earned income disregard, which pushes up the effective 2008 FPL to 166 percent.

Illinois's income limits vary periodically and by whether or not there is an adult in the household. The 2008 limit was \$4,752 for a three-person household with a parent, or 26 percent of FPL. If a family is already receiving Medicaid, they are eligible for the \$30 and one-third earned income disregard, or 55 percent of the FPL in 2008. New York income limits also vary over time but not necessarily every year. In 2008 the income limit for a three-person household was \$12,276, or around 67 percent of FPL. New York also has the \$30 and one-third earned income disregard for those already receiving Medicaid, bringing the effective 2008 FPL to 137 percent. Texas's AFDC income limit is also stagnant at the 1996 level, which varies by the number of adults in the household. The income level for a single-parent, three-person household is \$16,668, which in 2008 was at 91 percent of FPL, and declining. Tex-

as also maintains separate TANF rules with a 1996-level income limit for a household of three with one parent at \$9,012, approximately 50 percent of FPL, and declining. If the family is currently receiving Medicaid, they get a one-third earned income disregard, bringing the effective FPL to 74 percent.

c. Blind/Disabled and Elderly. Social Security Supplemental Security Income recipients are also eligible for Medicaid benefits under the Medicaid for Employed Persons with Disabilities program. The qualifying rules consider unearned income (net of a monthly \$20 exclusion) and earned income (net of a monthly \$65 exclusion and an annually determined student earned-income exclusion), the sum of which must be below a specific annually indexed dollar threshold (\$11,472 for a couple in 2009). Additionally, retirees and disabled individuals qualify for subsidies to pay for their Medicare costs (premiums, co-pays, etc.) funded out of Medicaid through the Medicare Savings Program. These rules require individuals to be receiving Social Security or Railroad Retirement benefits and have family income less than 200 percent of FPL for retired persons and 135 percent of FPL for blind/disabled individuals. Further, disabled workers with earned income less than 250 percent of FPL qualify for the Medicaid buy-in program. The blind/disabled and elderly eligibility rules are the same across all states as dictated by the Social Security Act.

d. Other Reasons. The federal government requires that states' Medicaid programs cover the above groups of people in order to receive federal matching funds for Medicaid. States are not compelled to cover the following groups of people, although many states—including all five states examined in this report—do extend at least some benefits to these groups.

Foster-care children are covered under Medicaid if the household they came from qualifies for AFDC/TANF or has an income below the federal poverty level. When a foster-care child ages out of the system at age

18, the child continues to be fully covered through age 21 if that child has an income below a certain FPL. Under the new health care law, the age limit to receive Medicaid for aged-out foster-care children has risen to 25. Medically needy individuals can also be fully covered by Medicaid if the state elects to. Medically needy individuals are determined by a combination of income thresholds and medical expenses.

Women aged 18–44 with incomes below a state-specific FPL qualify for Medicaid family-planning services (of which pregnant women receive full Medicaid benefits). States may also receive waivers to expand family planning to more of their populations. Women between the ages of 18 and 64 may also be eligible for breast or cervical cancer care under Medicaid if they are found with either of those cancers and their income is below a certain threshold as determined by the states.

Last but not least, certain groups of people may become eligible under the waiver system. Specifically, the 1115 waiver allows states to write-off certain rules for a demonstration or pilot project. New York has taken this opportunity to allow childless individuals below 100 percent of FPL to be eligible for Medicaid. In most cases the 1115 waiver and the other waivers (1915(b) and 1915(c)) are used to expand services or change the way services are conducted.

A3. Medicaid Eligibility, Enrollment, Reciprocity, and Average Benefits per Enrollee.

This section describes information obtained from calculating each of the four components for those with FPL less than 100 percent as noted in Section A1 above—namely, eligibility rates, enrollment rates, reciprocity rates, and average benefits per recipient. Because eligibility conditions and health needs differ substantially by age and gender, the four items are calculated separately for various age groups (see note 17), gender, and FPL-relative income levels. In addition, special eligibility groups such as the medically needy, foster-care children, family planning, and others are treated separately. The calcu-

lations span the years 2000–08, corresponding to the latest available data from the CPS (on eligibility rates) and MSIS (enrollment and reciprocity rates, average benefits per recipient).

It should be noted that the methodology for projecting eligibility, enrollments, and other ratios as described above is different from those adopted in other studies, particularly the Kaiser study referenced earlier (see note 16). As in my study, Medicaid eligibility rates are determined from the Current Population Survey’s Annual Social and Economic Supplement in the Kaiser study. The latter study fixes baseline eligibility rates according to those observed in the 2007 data. In my study, however, eligibility trends are established between 2000 and 2008 and those trends are projected forward using linear regressions—one for each eligibility group. This method is likely to more robustly establish and extrapolate the direction of change of group-specific population eligibility rates projected, with and without PPACA’s eligibility rules. The same remark applies to the determination of enrollment and beneficiary ratios and average benefits per beneficiary. Thus, my study tracks the change in the trend in state GR Medicaid spending that PPACA would induce over and above spending without PPACA, whereas the Kaiser study measures changes from fixed eligibility rates benchmarked to 2007. Also, the Kaiser study uses fixed, assumed rates of new enrollments post-PPACA for old-eligibles and for those newly eligible under PPACA. Those rates are taken from average enrollments over all groups reported by the Congressional Budget Office. My study, in contrast, allows the CPS and MSIS data to inform the calibration of group-specific new enrollment rates for those newly eligible and those who are not enrolled (without PPACA) among old-eligibles. For both types of new enrollees, group-specific enrollment rates are taken to be the larger of the enrollment rate without PPACA (for the entire group) or the non-insurance rate among those (old-eligibles or the newly eligible) not

Women aged 18–44 with incomes below a state-specific federal poverty level qualify for Medicaid family-planning services.

**In all states,
Medicaid
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both genders.**

enrolled in Medicaid, again assuming the absence of PPACA.

a. Eligibility, Enrollments, Reciprocity, and Benefits among Children. In all states, Medicaid eligibility rates increased during the last decade among children of all ages and both genders.²⁰ The data indicate that more than 80 percent of almost all child age and gender groups (except for newborns) were Medicaid-eligible by 2008. During the early 2000s, enrollment rates were much smaller for older children compared with younger ones. However, enrollment rates for older children have increased steadily so that, by 2008, more than 60 percent of all eligible children are enrolled in the program. Medicaid reciprocity rates were quite high during the early 2000s and have increased consistently during the last decade: at least 85 percent of all child groups received Medicaid benefits during 2008—again, except for newborns, who have the smallest reciprocity rates.

On the other hand, the data indicate that newborns incur the highest Medicaid expenditures. Excluding newborns and those aged 1–5, Average Medicaid expenditures per recipient are smaller for younger children and they increase with age. However, average expenditures for the oldest children are only about one-half of those for newborns. Average expenditures have trended upward during the last decade, reflecting the general rapid increase in health care costs.

b. Working-age Adults. Working-age adults are split between disabled adults, non-disabled adults, and others, where the last category includes medically needy individuals and women eligible for benefits from the Breast and Cervical Cancer Act under Medicaid. For non-disabled adults, eligibility rates under Medicaid are distinctly different for males versus females. As Figure A1 shows, female eligibility rates among the 0–100 percent FPL category were at 40 percent or less and barely increased during the last decade.²¹ That is not surprising, because women are more likely to be part of a low-income family. Figure A2 shows that Medicaid eligibility rates are much smaller

for men (as they are less likely to be in low-earning families and are also less likely to have a Medicaid-eligible child as a dependent, on average), and the pattern of eligibility by age-group is reversed compared with females: older males have a higher likelihood of qualifying for Medicaid, probably because a higher proportion of men work in strenuous jobs and become disabled or unemployed at older working ages.

Figures A3 (females) and A4 (males) show that Medicaid enrollment rates among eligibles is widely divergent across the five states examined here. Enrollment rates are highest in California for both genders. Enrollment rates are low and/or declining in Illinois and New York, a fact that plays a key role in generating high spending increases in those two states when PPACA's individual health insurance mandate is included when making spending projections. Florida and Texas have mixed enrollment rates across age groups—high for those aged 19–20, but low among many older age-gender groups.

Figures A5 and A6 show Medicaid reciprocity rates above 80 percent for females in all states. For males, reciprocity rates in all states except California were low at the turn of the century, but increased rapidly to reach the same levels as those for females by 2008. California's reciprocity rates, however, appear to be declining rapidly—a factor that explains the low impact of introducing PPACA when making spending projections. Figures A7 and A8 show that older non-disabled adult beneficiaries receive larger Medicaid benefits, on average, compared with younger ones—except in California. Benefit awards per beneficiary are stable or gradually increasing in California, Florida, Illinois, and Texas. They increase more rapidly in New York for both genders. Differences in benefit awards per beneficiary by age-group are much larger for men compared with women.

c. Retirees. Among those aged 65 and older in the 0–100 percent FPL range, eligibility rates are highest in Texas—well above 80 percent among younger retirees and close to 100 percent among older ones.²² Given Tex-

as's moderate historical enrollment rates, these conditions imply a strong spending-increasing effect from introducing PPA-CA. Eligibility rates are lowest for Illinois and average about 50 percent for the other three states. Enrollment rates are highest for California and Florida, with rates in the three other states varying from 30 percent in Texas to 80 percent in Illinois and New York. Enrollment rates have generally increased, more so among the oldest retirees. Medicaid reciprocity rates were quite high in all of the five states considered here—about 80 percent during the early years of the 21st century—but have declined since for both genders, especially in Florida, New York, and Texas. The reason for this may be the expansion of Medicare Part B coverage and the shift of many retirees' Medicaid coverage for prescription drugs to the Medicare program. Finally, average Medicaid expenditures per recipient increased across all retiree age groups—Illinois being the exception—and the increase was especially rapid for the oldest retirees.

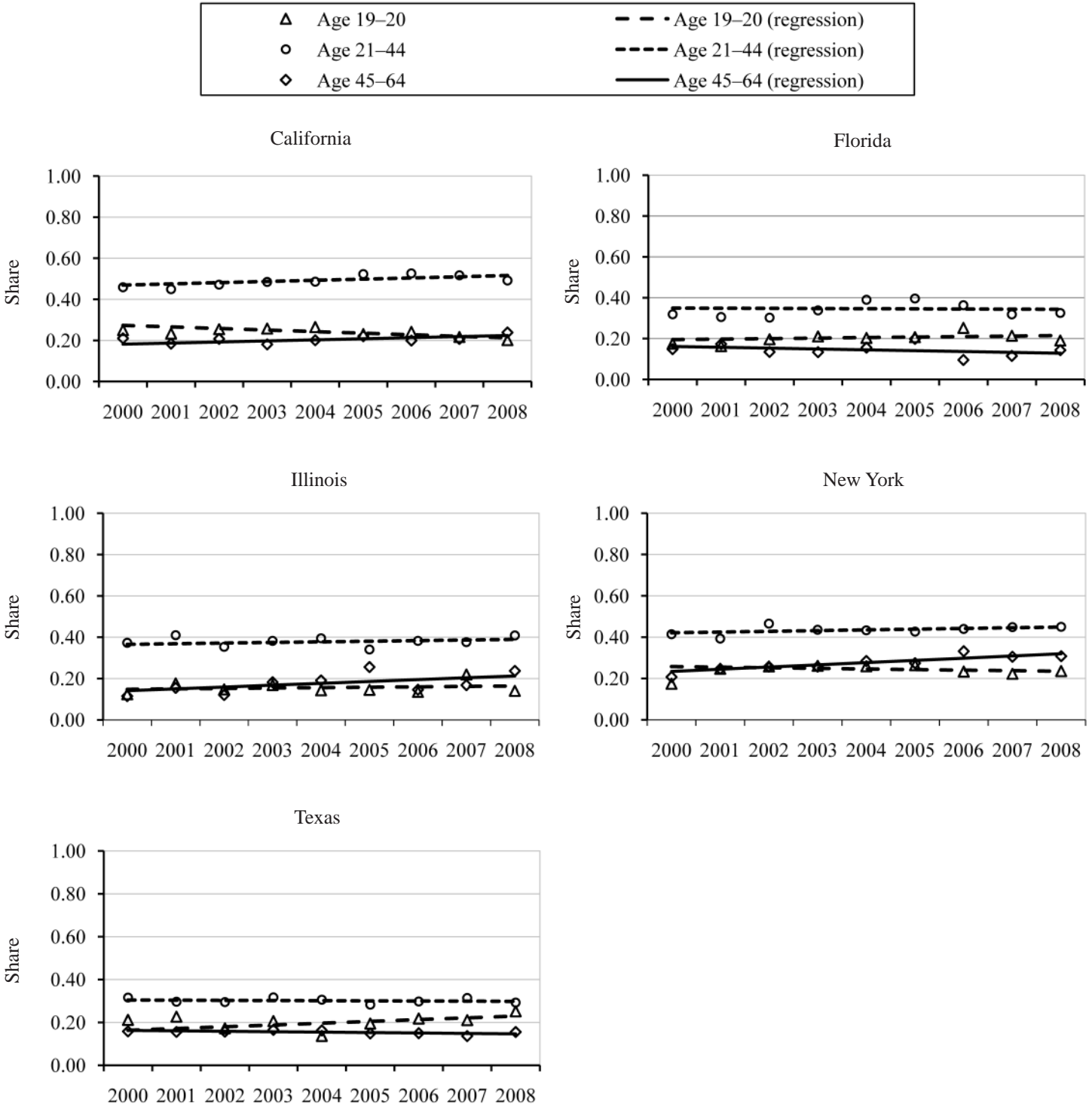
d. Other Groups. Calculations of eligibility, enrollment, reciprocity, and average benefits per recipient are implemented separately for foster-care children, medically needy individuals, women qualifying under the Breast and Cervical Cancer Act, the family-planning program, and blind/disabled adults. Except for blind/disabled adults, CPS data do not allow

identification of the eligible populations for these groups.²³ Hence, calculations are based on directly calculating the share of enrollees in the population based on MSIS data for foster-care children, BCCA women, family-planning recipients, and medically needy individuals.

For blind/disabled adults, however, eligibility co-criteria based on income (including spousal income where applicable) are incorporated, again counting all eligible sources and net of applicable exemptions, deductions, and income disregards. Medicaid eligibility rates were higher for older blind/disabled adults compared with younger ones in most states, and they have generally increased during the early years of the 21st century across all age groups. Data show stable enrollment rates for most blind/disabled women—higher in California and Florida than in the other three states. Enrollment rates have been higher, but stable overall, for disabled/blind men compared with women during the last decade—also highest in California and Florida. Medicaid reciprocity rates have been stable or declining in Florida and Texas for most disabled adults, and stable or increasing in the other three states. However, Medicaid expenditures per blind/disabled recipient are among the highest among all population groups and have increased consistently for both genders in all states except Illinois during the last decade.

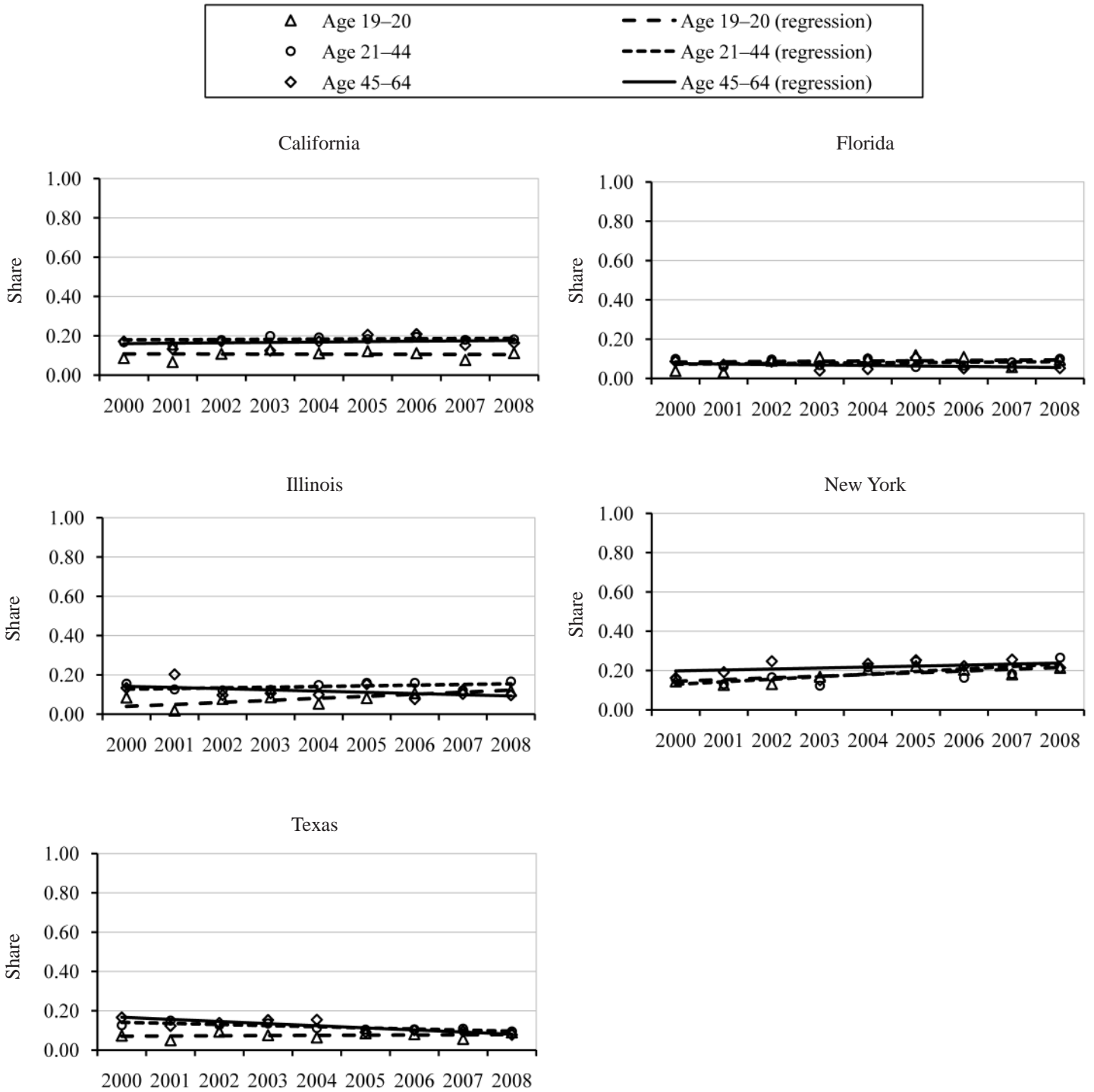
Medicaid reciprocity rates were quite high in all of the five states considered here—about 80 percent during the early years of the 21st century.

Figure A1
Shares of Medicaid Eligibles in State Populations and Linear Trends for Female Non-Disabled Adults Aged 19–64;
0–100 Percent of FPL; 2000–08



Source: Author’s calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

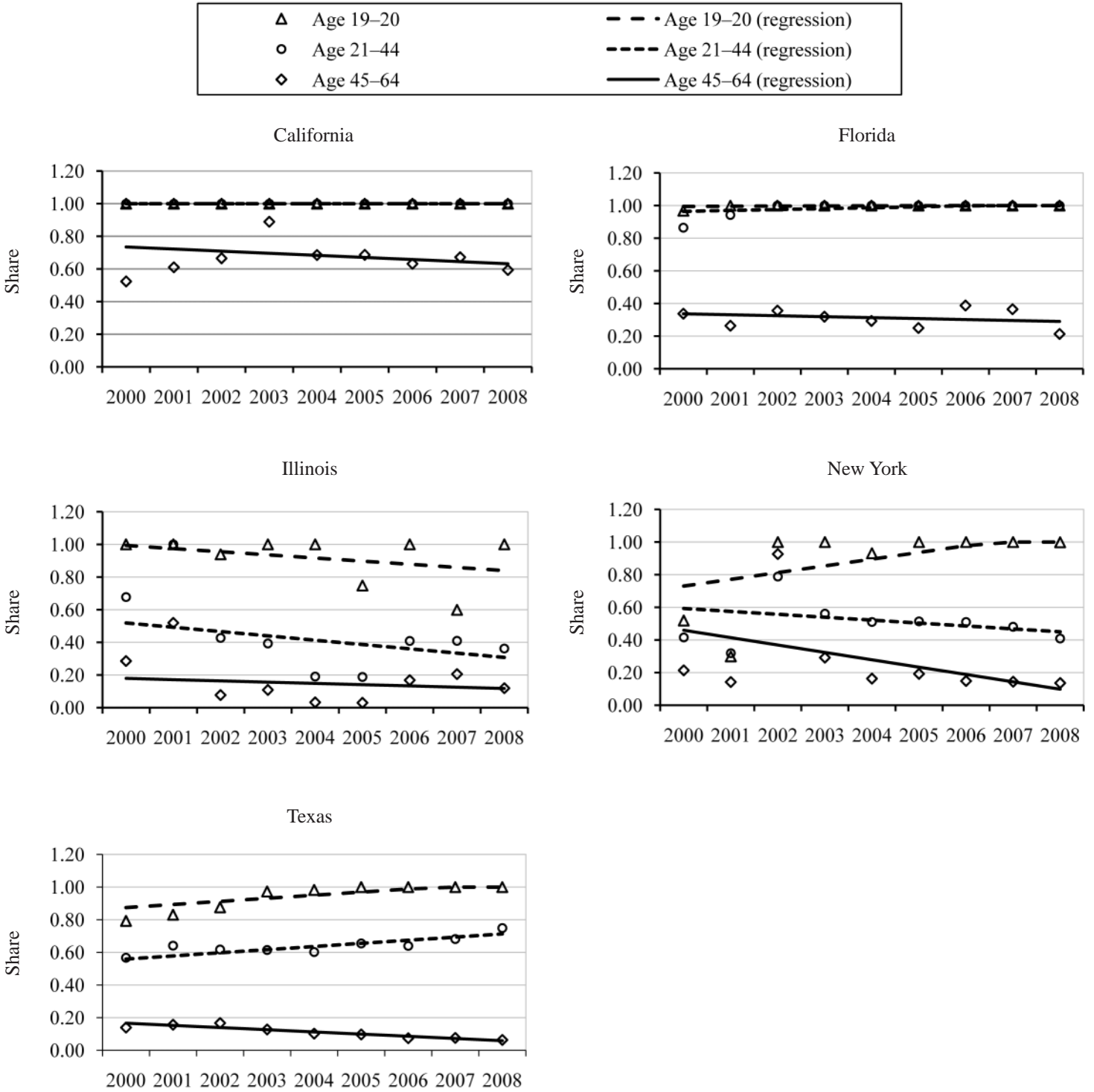
Figure A2
Shares of Medicaid Eligibles in State Populations and Linear Trends for Male Non-Disabled Adults aged 19–64;
0–100 percent of FPL; 2000–08



Source: Author’s calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

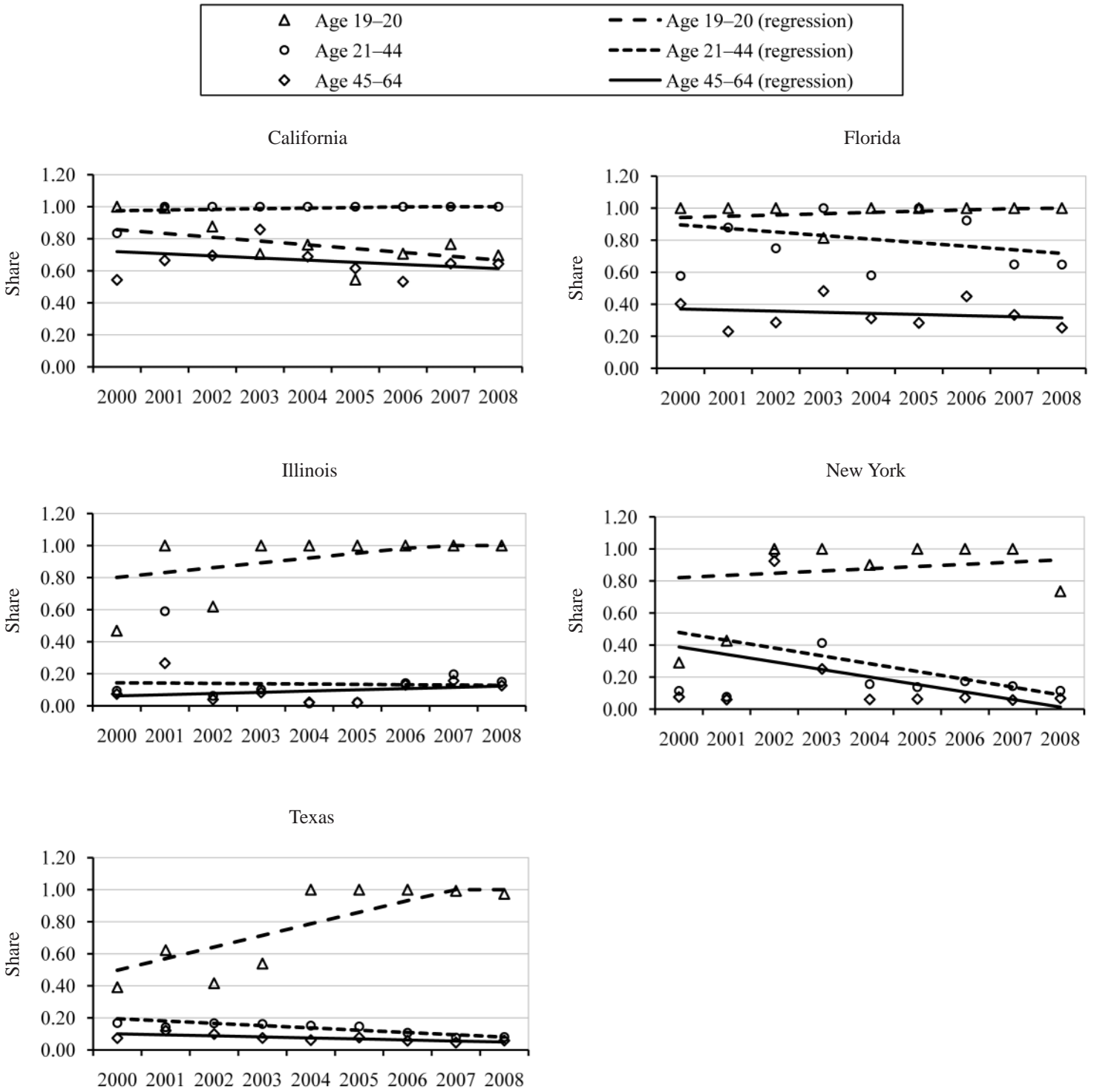
Figure A3

Shares of Medicaid Enrollees among Eligibles and Linear Trends for Female Non-Disabled Adults Aged 19–64; 0–100 Percent of FPL; 2000–08



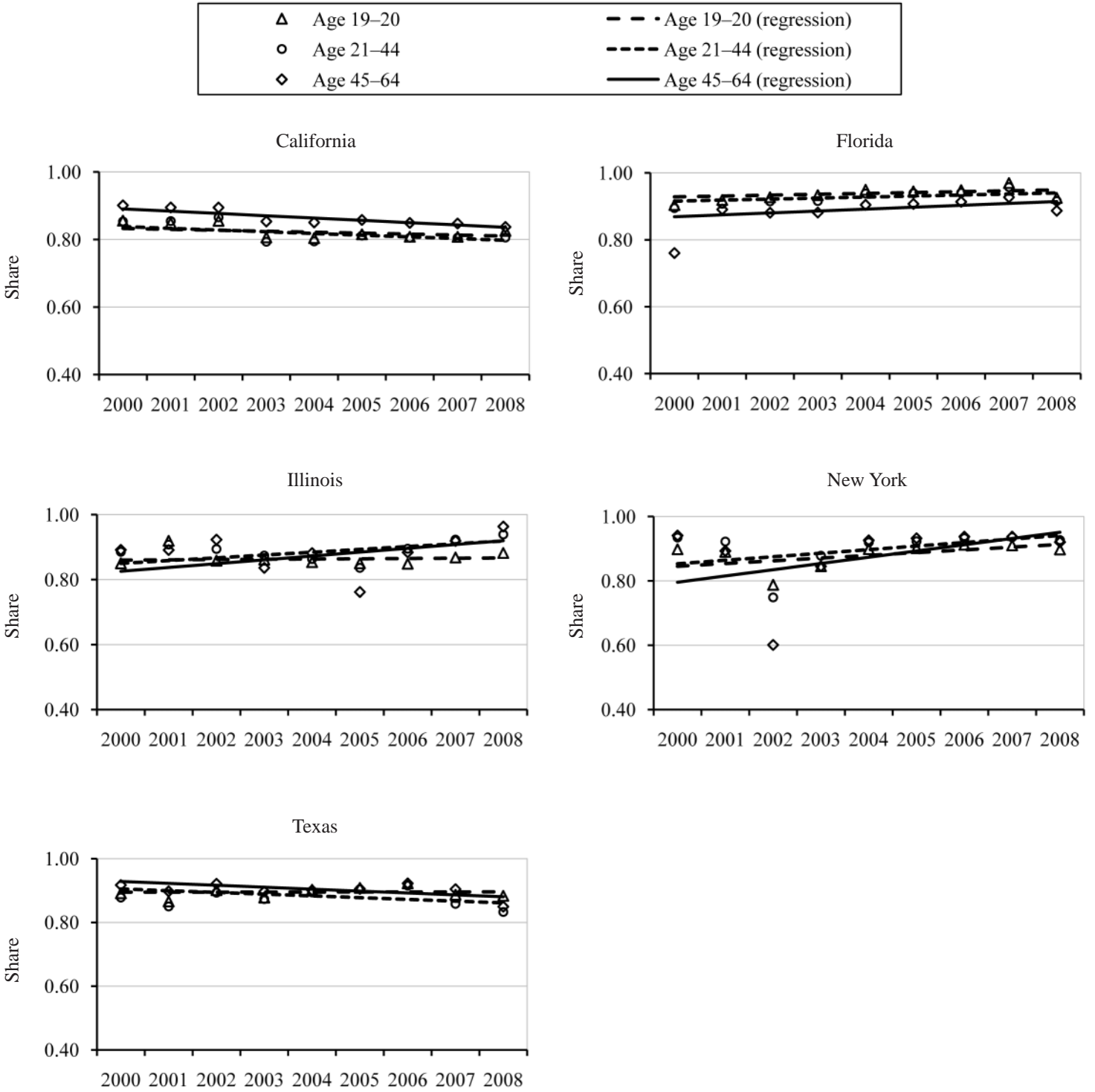
Source: Author's calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

Figure A4
Shares of Medicaid Enrollees among Eligibles and Linear Trends for Male Non-Disabled Adults Aged 19–64;
0–100 Percent of FPL; 2000–08



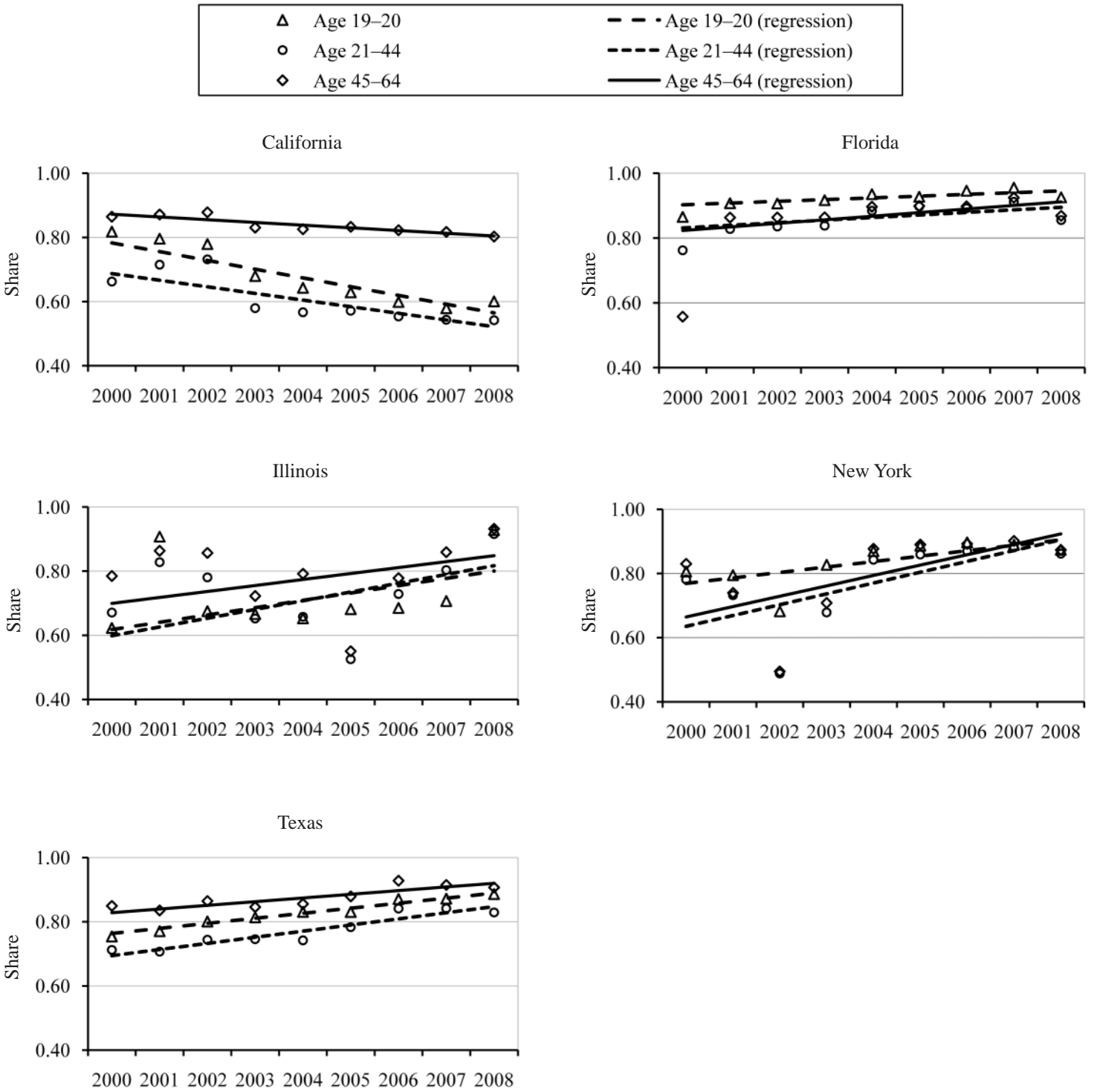
Source: Author’s calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

Figure A5
Shares of Medicaid Beneficiaries among Enrollees and Linear Trends for Female Non-Disabled Adults Aged 19–64;
0–100 percent of FPL; 2000–08



Source: Author's calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

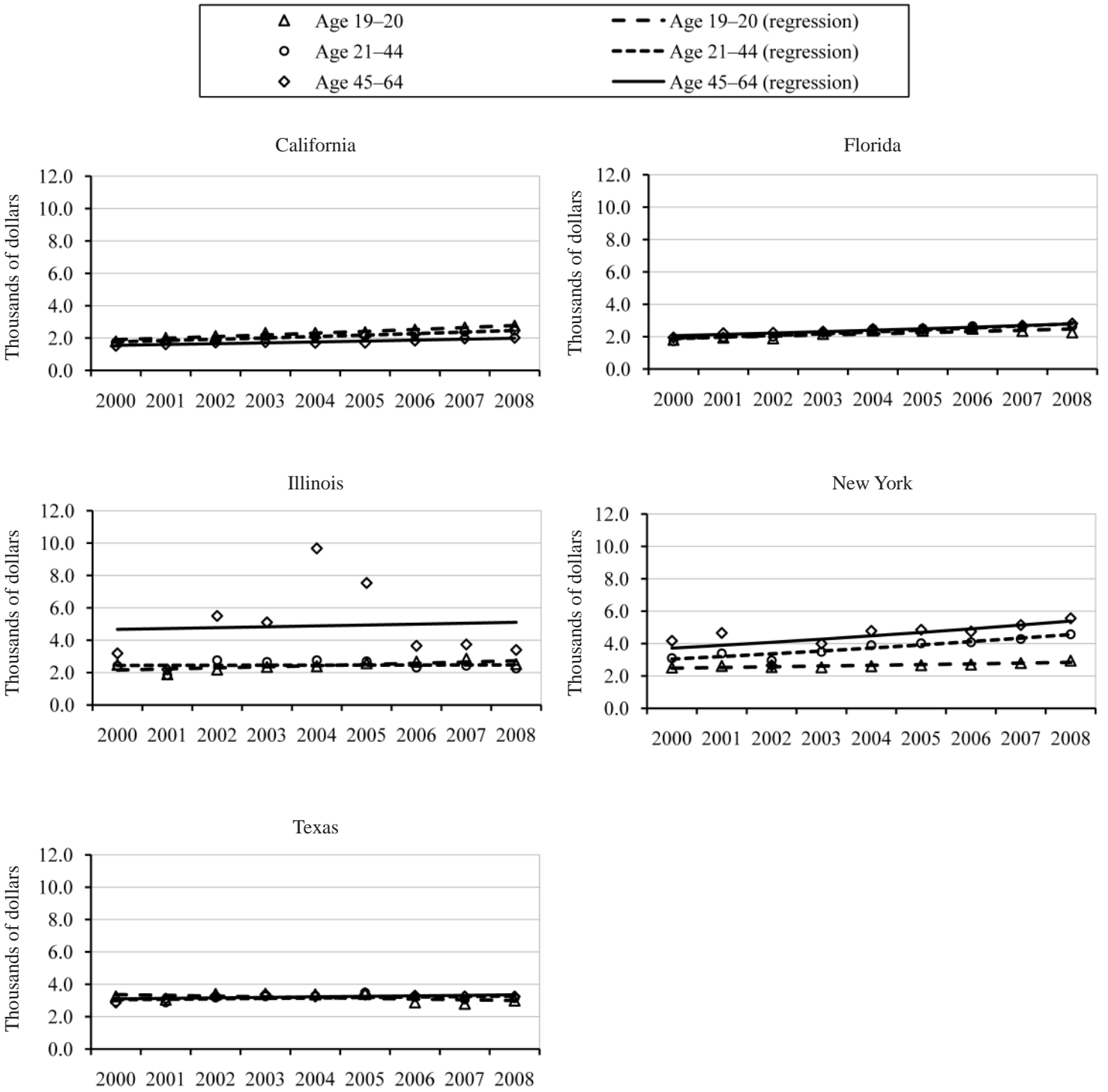
Figure A6
Shares of Medicaid Beneficiaries among Enrollees and Linear Trends for Male Non-Disabled Adults Aged 19–64;
0–100 percent of FPL; 2000–08



Source: Author’s calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

Figure A7

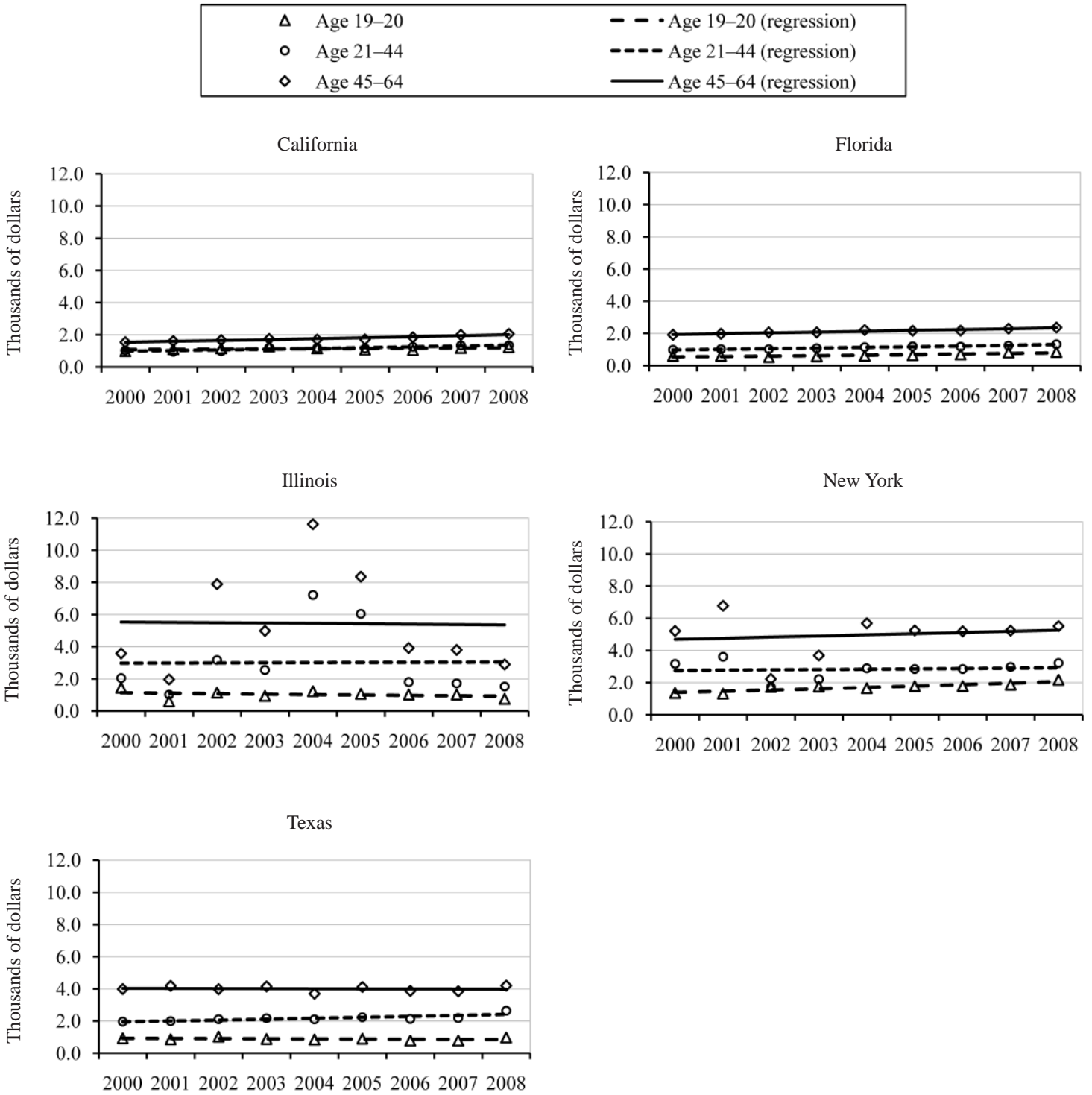
Average Medicaid Expenditures per Beneficiary and Exponential Trends for Female Non-Disabled Adults Aged 19–64; 0–100 percent of FPL; 2000–08



Source: Author’s calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

Figure A8

Average Medicaid Expenditures per Beneficiary and Linear Trends for Male Non-Disabled Adults Aged 19–64; 0–100 percent of FPL; 2000–08



Source: Author’s calculations based on the Medicaid Statistical Information System, current population surveys, CMS-64 reports, and the U.S. Census Bureau.

Notes

This paper draws heavily from “The Effects of ObamaCare on Texas’s Medicaid Expenditures’ Growth,” by Jagadeesh Gokhale, published in the 2010 *Policy Perspective* series of the Texas Public Policy Foundation. Angela Erickson provided excellent research assistance.

1. State budget reports include expenditures on a General Revenue basis and the All Funds basis, the former referring to expenditures out of state revenue sources and the latter being inclusive of expenditures funded out of federal grants. This study focuses only on states’ General Revenue-funded Medicaid expenditures, projected with and without PPACA.

2. Constructing these estimates is a laborious and time-intensive process, and doing so for all 50 states and the District of Columbia was not feasible.

3. The growth rate of state GR Medicaid expenditures is calculated beginning in the year 2010 and includes the effect of reduced federal support from the American Recovery and Reinvestment Act. However, see the note attached to Table 4.

4. The slowdown in economic growth all five states experienced during 2007–09 makes it very difficult to project GDP for future years. Projected Medicaid expenditure growth is, therefore, compared with historical GDP growth calculated using data from the United States Bureau of Economic Analysis. The earliest year of data available for historical calculations of annual (nominal) GDP growth is 1997.

5. States partially cover “disproportionate share hospital” (DSH) hospital costs of treating uninsured patients. Those include illegal immigrants, old-eligibles who are not yet enrolled into Medicaid, those who will become newly eligible to Medicaid under PPACA, and those who are not eligible to Medicaid currently and will not become eligible under PPACA. As everyone except illegal immigrants acquires health insurance under PPACA’s individual mandate, state payments to DSH hospitals for uncompensated care will decline. But some of the cost savings will be offset because some of the previously uninsured (among both old-eligibles and those made newly eligible under PPACA) will enroll into Medicaid. However, other newly insured individuals may enroll into private health insurance—generating sizable state savings of uncompensated care. State uncompensated care costs will remain positive on account of illegal immigrants. Because California has very few potential new Medicaid enrollees (especially among old-eligibles) but has a large number of uninsured,

much of California’s uncompensated cost saving under PPACA is likely to arise from newly privately insured individuals. These costs savings appear to dominate the state’s increased Medicaid spending from the few new Medicaid enrollees among old eligibles and those made newly eligible under PPACA.

6. There is an exception for states with waivers already covering these populations, such as New York. These states will continue to pay Medicaid benefits to these individuals for the first three years and then will have an increased Federal Medical Assistance Percentage for the newly eligible that will match those for other states by 2019. For New York and other non-expansion states this represents a cost savings per childless adult enrollee.

7. Qualification for Medically Needy Program benefits varies by state. In Texas, for example, an applicant must be: (1) a pregnant woman with no child eligible for the Temporary Assistance for Needy Families Program; (2) a child under 19 years of age; or (3) an adult caretaker whom the state’s Health and Human Services Commission includes in the certified group, and who ordinarily receives and manages the benefits for the certified group, except that the caretaker’s countable income exceeds TANF limits, the caretaker’s 60-month time-limited TANF benefits are exhausted, the caretaker chooses Medicaid-only benefits, or the caretaker is disqualified from TANF for a reason that is not applicable to Medicaid; and (4) have countable income that meets the applicable income limit. The income limit is defined based on family size; for a family of two people, it is \$216 per month. Applicants whose income exceeds the limit may spend down excess income to pay medical bills and qualify.

8. The formula equals 100 percent minus the state’s share where the state’s share equals $0.45 \times (\text{SPCI}/\text{USPCI})^2$, where SPCI is state’s per capita income and USPCI is the United States’ per capita income. A higher SPCI translates into a lower FMAP value.

9. The 2012 FMAP value for Texas is expected to be published by the federal department of Health and Human Services in November 2010.

10. Census Bureau state-wise population projections are available online at: http://www.census.gov/population/www/projections/projections_agesex.html.

11. Increases in future Medicaid expenditures in each state will also depend on how successful efforts are to repeal PPACA. Twenty-six states have filed court cases to challenge the new health care law on two grounds: (1) that mandating purchase

of health insurance by individuals (with failure punishable by a fine) is unconstitutional under the Tenth Amendment and Article I of the U.S. Constitution (the commerce clause); and (2) that the new health care law increases states' Medicaid expenditures without recompense from the federal government—that is, it constitutes an unfunded mandate.

12. Despite determining enrollment rates for heretofore non-enrolled old-eligibles (as described in the text), a valid question is whether it is appropriate to apply the same beneficiary/enrollment and benefits/beneficiary rates applicable to pre-PPACA Medicaid enrollees when making projections on a post-PPACA basis. There are several reasons that justify doing so: first, the uninsured do not have zero health care costs; their emergency room visits are costly and the costs are shifted to other patients who either pay out-of-pocket or through their insurers. Second, the uninsured have low measured health care costs *because* they are uninsured. Once they are insured under Medicaid via PPACA and the individual health insurance mandate, their utilization of health care goods and services is likely to increase and match that of other Medicaid enrollees. Third, some of the uninsured may be without insurance because they have pre-existing conditions that are expensive to treat. Indeed, after they enroll into Medicaid under PPACA, those costs may surpass the average costs of those already insured. Fourth, historical trends in the ratio of beneficiaries among enrollees are increasing, suggesting that future expenditures may be larger as more people need and claim health insurance benefits. Finally, the old-eligibles newly enrolled under PPACA may be uninsured and young, but their health care needs and costs will grow over time.

13. Uncompensated care savings are calculated by distributing total state DSH spending among the state's uninsured population, and allocating the cost to those who are legally obligated to acquire health insurance under PPACA—all uninsured except for illegal immigrants. Uncompensated care savings in future years are anchored on the state's population projections.

14. All five states exhibit stable or declining ratios of beneficiaries-to-enrollees among non-disabled retirees. The declines are steepest in Florida and New York.

15. These results depend on projections of average benefits per recipient and enrollments on a pre-PPACA basis between 2008 (the latest year with full information available at the time of writing this study) and 2014. However, the results obtained for 2014 and beyond are consistent with those obtained by simply dividing total expenditures by

enrollments in the base (historical) year, 2008.

16. See Note 6. A further reason for the low spending increase in California from PPACA is that the ratio of beneficiaries among enrollees has historically declined, especially among the largest group of non-disabled adults—a feature that would dampen future expenditures under the methodology of this study.

17. Even when the incremental Medicaid spending totals under this study are restricted to the 2014–19 period, spending increases among the four states, excluding California (for which the increase is small), range from 17 percent for Florida to 28 percent for Illinois. Kaiser's estimates are available online at: <http://www.statehealthfacts.org/comparereport.jsp?rep=68&cat=4>.

18. The age categories correspond to those of the Medicaid State Information System's age ranges: 0, 1–5, 6–12, 13–14, 15–18, 19–20, 21–44, 45–64, 65–74, 75–84, and 85+.

19. The income ranges are defined according to the applicable cutoffs before and under the new health care law. Those cutoffs are generally different for population groups served by various Medicaid programs in Texas.

20. Charts for selected child age/gender/FPL groups are available from the author upon request.

21. Although post-PPACA Medicaid eligibility is based only on an income test, pre-PPACA eligibility requires an asset test as well. The pre-PPACA asset test is incorporated based on information from the 2007 Survey of Consumer Finances. Calculations show that the population share of adult non-disabled household heads who fail the Medicaid asset test and who do not receive Medicaid is 13.2 percent for the nation as a whole. Unfortunately, the survey does not allow separate identification of Texas residents, nor of blind/disabled individuals. Therefore, an approximate asset-based constraint is applied to pre-PPACA eligibility rates, to restrict Medicaid eligibility to 86.8 percent (100 percent minus 13.2 percent) of the income-based eligibility rate as calculated from the Current Population Survey.

22. Charts for selected age/gender/FPL groups are available from the author upon request.

23. Medicaid eligibility criteria for children in foster care and younger than age 18 are the same as those for non-foster-care children aged less than 18. Eligibility under AFDC/TANF rules are based on the incomes of the household a child comes from before foster care placement. For children older than age 18 there is the Medicaid for Transitioning Foster Care Youth program,

whereby the person must have aged out of foster care, must be between the ages of 18 and 20, must not be covered under another health plan offering adequate benefits, and must have income at or below 400 percent of the Federal Poverty Level. Medicaid eligibility criteria for

persons with breast and cervical cancer include the provision that the person must be diagnosed with breast cancer (men and women) or cervical cancer (women only), must not have income more than 200 percent of the FPL, and must not have alternative medical insurance coverage.

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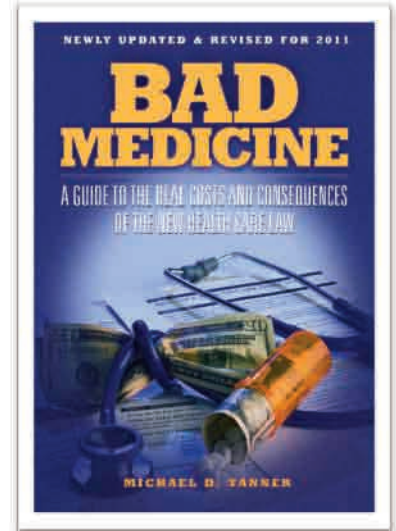
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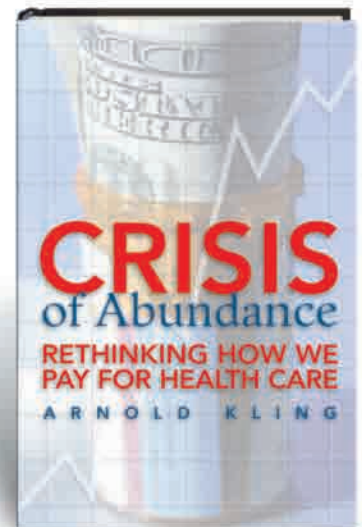
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