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THE COSTS TO THE STATES OF NOT FUNDAMENTALLY REFORMING MEDICAID

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"We must, however, continue to express our concerns about mandated Medicaid expansions. States do not have the luxury of operating a budget deficit. Every mandated dollar that we spend is a real dollar that has to be taken from another program."

—Governor Bill Clinton of Arkansas, June 7, 1990

Much of the debate between Congress and the President on reforming Medicaid, the health care program serving the nation's poor, has transpired without adequate attention paid to the effect of the program on state finances. If significant reforms in Medicaid are not enacted, states will face a heavy increase in spending and a rise in the proportion of their projected revenues that must be dedicated to the program. And because the rate of growth in state Medicaid spending will exceed the rate for total state spending, the states will be forced either to increase taxes or to divert money from other programs, such as education and crime control.

Medicaid is a state-administered program that operates under federal guidelines. Federal and state governments jointly fund the program. Federal reimbursement to the states is based on a statutory formula designed to give a higher matching rate to states with lower per capita incomes. Matching rates for these services range from 50 percent to 83 percent and are adjusted annually.

The cost of Medicaid to the federal government has been growing at double-digit rates in recent years. The Congressional Budget Office (CBO) projects that annual federal Medicaid costs will almost double by 2002.

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1 Substantial portions of this were delivered in testimony before the Subcommittee on Human Resources and Intergovernmental Relations, U.S. House of Representatives, on January 18, 1996.

Annual Federal Medicaid Costs

(Millions of Dollars)

Fiscal Year	Annual Federal Medicaid Costs
1995	$89,216
1996	97,292
1997	107,021
1998	118,060
1999	129,631
2000	140,116
2001	156,600
2002	172,800
7-Year Total	1,010,736

Source: Congressional Budget Office (December 1995)

Although the financial impact on the federal government of generally unrestrained Medicaid growth is alarming enough, the future impact on states could be even more severe: a remorseless growth in the share of their own projected revenues going to Medicaid that forces them either to raise taxes in order to maintain spending for other programs or to reduce state expenditures for non-Medicaid programs. States can make some cost-saving reforms in the program, but only subject to federal rules requiring that certain levels of coverage (entitlements) be provided to certain populations.

To examine the probable future budget impact on states, The Heritage Foundation analyzed the likely trend of total Medicaid spending using certain assumptions to forecast the state share of Medicaid payments for the period 1995 through 2002.[2] This analysis resulted in two sets of findings: first, the additional costs to the states if no changes are made in the Medicaid program and, second, the additional costs stemming from President Clinton's proposed "per capita cap" reforms in Medicaid. Hence, the following charts and tables project the future state-level Medicaid burden if Congress either does nothing or adopts the President's proposal. These projections of state spending incorporate expected changes in state economic activity, in the size of the eligible population, and in the trend of federal Medicaid transfers to the states.

These forecasts of future state Medicaid spending were prepared jointly by Heritage and Wharton Econometric Forecasting Associates (WEFA), a nationally recognized economic consulting firm that maintains detailed models for each state. For 47 states, WEFA found a significant relationship between changes in historical Medicaid spending and fluctuations in the states' economic activity and Medicaid-eligible populations. In four cases, however, the relationship was sufficiently weak that WEFA simply projected the historical trend in spending; these states are North Dakota, South Carolina, Utah, and Wyoming. Table 1 shows the additional state revenues or program cuts needed if the states are to meet their projected Medicaid expenditures.

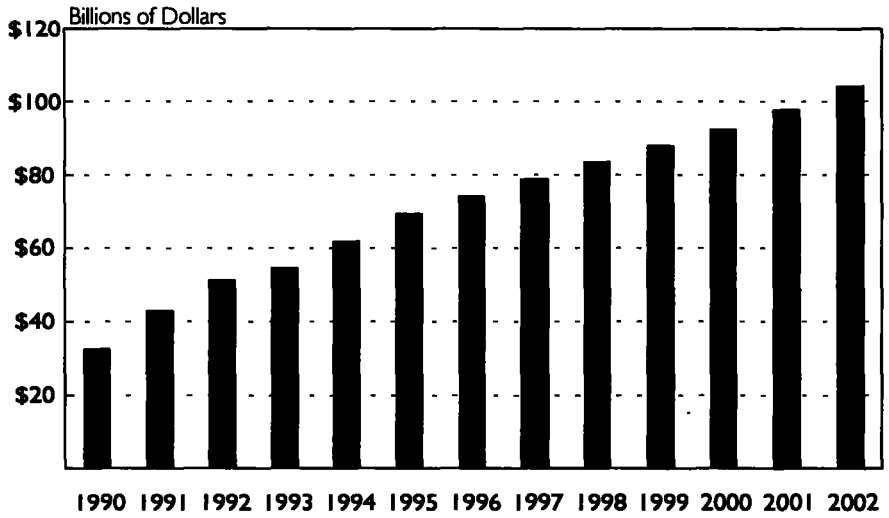
2 The original estimates of additional state Medicaid costs under current law and the technical assumptions behind these estimates are contained in William W. Beach, "The Cost to States of Not Reforming Medicaid," Heritage Foundation *F. Y. I.* No. 63, September 26, 1995. The cost estimates in this earlier paper were revised downward on December 18, 1995, after the Congressional Budget Office recalculated its seven-year projections of federal Medicaid outlays. The CBO made its revisions in order to reflect the influence of lower forecasted inflation on federal Medicaid outlays. See William W. Beach, "Updated Estimates of the Costs to the States of Not Reforming Medicaid and the Additional Costs of Adopting Per Capita Caps," Heritage Foundation *F. Y. I.* No. 81, December 18, 1995.

Estimated Additional Costs Without Reform

Between 1995 and 2002, if no reforms are enacted that address the costs of entitlements and the composition of covered groups, states will have to spend $688 billion of their own money on Medicaid. Total state spending over this period is projected to be $1,700 billion, of which $1,011 billion will be supplied by the federal government (if CBO's forecasts of federal spending prove correct). The difference between federal and state spending on Medicaid means that states will have to devote an average of 8 percent of their non-federal revenues to the program. Among the hardest hit states, Pennsylvania will have to devote 17 percent of its revenues to the health care program.

Chart 1

Medicaid Expenses Paid With State Revenues, 1990-2002

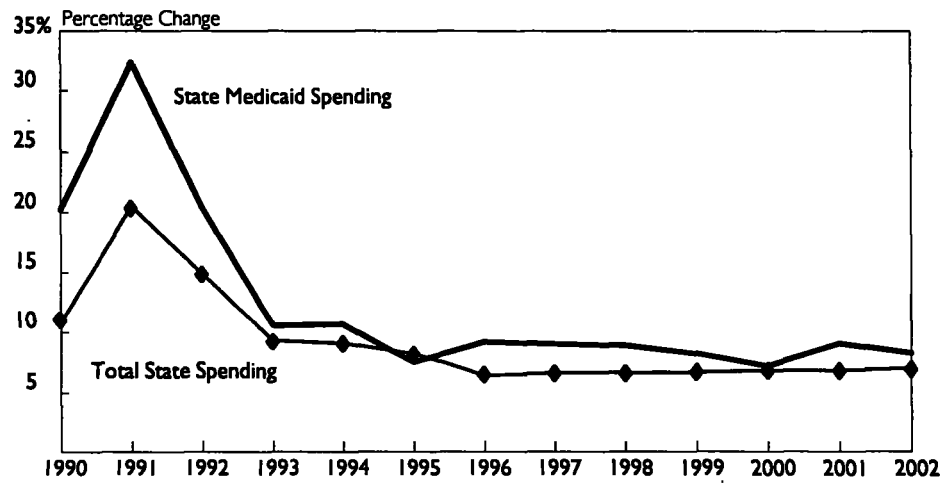


Source: 1990-1994 data from WEFA, forecasts for 1995-2002 from WEFA and Heritage calculations.

As Chart 1 shows, the amount of state Medicaid payments alone steadily increases between 1995 and 2002. In 1990, the states spent just $32 billion of their non-federal funds on Medicaid. These unfunded payments are projected by our analysis to grow to $69 billion by 1995 and $104 billion by 2002. In other words, the Medicaid amount paid by the states will have increased by 225 percent over the 12-year period between 1990 and 2002.

Chart 2

Relationship Between Total Expenditures and Medicaid Spending



Source: WEFA Trend Forecast, July 1995

Some individual states will be particularly hard hit. For example, California will need to raise $18 billion in new revenues or in budget cuts to pay its part of Medicaid growth between *1996 and 2002*. Similarly, New York will need to raise $17.3 billion; Flor-

ida, $12.9 billion; Pennsylvania, $11.6 billion; and Texas, $7.2 billion. If these states choose to raise taxes to meet their Medicaid obligations, then California will have to increase the average taxpayer's bill by $246 per year; New York, by $370; Florida, by $374; Pennsylvania, by $362; and Texas, by $177.

This rapid growth in the states' Medicaid share is reflected in the annual percentage change in state-level Medicaid spending as compared with total state spending, which includes support of such things as education, crime control, and transportation infrastructure (see Chart 2). The Heritage analysis anticipates 1995 state Medicaid spending to grow at a rate of 7.5 percent, while total state spending should grow at a 6.4 percent rate. This higher rate of change for Medicaid means that states either must raise taxes or must take funds away from other state programs. The forecast suggests that state spending on Medicaid will continue to keep pace with total spending. Over the forecast period (1995-2002), Medicaid spending is projected to grow at an 8.4 percent rate, while total state expenditures are expected to grow by an average of 5.8 percent.

Fiscal Effects of the "Blue Dog" Democrat Plan

The Democratic "Blue Dog" plan to reform the federal Medicaid program, the principal elements of which have been advanced by the Clinton Administration in its seven-year budget proposal, would increase the federal fiscal burden on the states by an estimated $47.4 billion over the next seven years. This new fiscal burden has been described as "one of the biggest and most expensive unfunded [federal] mandates ever"[3] and, over the seven-year period 1996-2002, would amount to $4.4 billion in California, $3.7 billion in Florida, $3.4 billion in New York, $3.2 billion in Pennsylvania, and over $2.9 billion in Texas. Overall, this unfunded federal mandate would exceed $1 billion in 16 states.

First proposed by a group of Democratic House members earlier this year,[4] this plan would further challenge the fiscal resources of the states by maintaining all the existing program mandates which the federal government imposes on the states[5] while simultaneously reducing the federal government's contribution through the mechanism of a "per capita cap" on the federal share of the program. Under the "Blue Dog" plan, the per capita cap limits the amount of federal medical assistance that states would receive for each Medicaid recipient. Any expenses that exceed this limit would be the sole responsibility of state and local taxpayers. Because the full array of federal Medicaid mandates would remain in effect, states would not be able to offer innovative, and less expensive, health care options to Medicaid recipients. Overall, the per capita cap would shift an estimated $47.4 billion of mandated Medicaid spending from the federal to state governments over the next seven years.

States would probably respond to this shift in one of three ways: 1) enact dramatic tax increases; 2) reduce state spending on education, infrastructure, law enforcement, and other important state functions; or 3) some combination of the above. Indeed, the proliferation of Medicaid mandates during the late 1980s and early 1990s has already forced the states to reallocate their resources to Medicaid. According to the National Association of State Budget Officers, Medicaid spending has doubled from approximately 10 percent to 20 percent as a share of overall state spending since 1987.[6]

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3 News release, "Clinton Medicaid Plan Places New Unfunded Mandate on States," House Committee on Government Reform and Oversight, December 15, 1995.

4 On October 26, 1995, Representative Bill Orton (D-UT) and a group of House Democrats offered a substitute for the Balanced Budget Act of 1995 (H.R. 2491). This proposal, which would reduce baseline federal Medicaid expenditures by $85.1 billion over seven years, was defeated by a vote of 72-356. Sixty-eight Democrats and four Republicans supported the plan.

5 Federal Medicaid law defines precisely who is eligible to receive benefits under the program, which medical services beneficiaries can receive, and the amount, scope, and duration of these benefits.

Technical Assumptions

The Heritage Foundation and Wharton Econometric Forecasting Associates used state models of economic activity to develop state-by-state estimates of Medicaid spending and the additional funds states would need to meet their future Medicaid obligations.

Our baseline estimates assume no change in current Medicaid eligibility rules and allowed federal Medicaid transfers to the states to grow at the rates implied by the history of this program. Total Medicaid program spending in each state is a function of the state's historical Medicaid expenditures and expected demographic and economic change. We used this as the basic structure for future Medicaid spending.

These baseline forecasts of state Medicaid spending were adjusted upwards by Heritage to reflect the higher federal expenditures on Medicaid projected by the Congressional Budget Office. The difference between our initial baseline for total (federal and state) spending and the CBO adjusted estimates is $58 billion over the period 1996 to 2002. We distributed the state portion of this additional amount by each state's annual percentage of total national Medicaid spending for each of the seven forecast years following 1995. Estimates of additional taxes that would be raised to meet each state's additional funding requirement were calculated by dividing the additional funding requirement by the estimated number of taxable individual federal income tax returns in 1995.

6 Information obtained from House Commerce Committee handout, September 20, 1995.

Table 1

Additional State Medicaid Obligations Under Current Law and Per Capita Cap: 1996-2002

	Additional Spending Under Current Law	Addition to Current Law from Per Capita Cap	Total Additional State Medicaid Obligations
Alaska	$108,258,000	$24,883,000	$133,141,000
Alabama	1,699,383,000	1,024,889,000	2,724,272,000
Arkansas	832,824,000	567,691,000	1,400,515,000
Arizona	2,779,037,000	1,020,447,000	3,799,484,000
California	18,027,116,000	4,461,013,000	22,488,130,000
Colorado	1,629,869,000	419,704,000	2,049,574,000
Connecticut	2,155,812,000	547,555,000	2,703,367,000
DC	1,531,731,000	331,399,000	1,863,130,000
Delaware	663,156,000	115,971,000	779,128,000
Florida	12,870,910,000	3,710,823,000	16,581,734,000
Georgia	5,270,028,000	1,500,974,000	6,771,002,000
Hawaii	1,193,243,000	186,034,000	1,379,277,000
Iowa	448,548,000	449,939,000	898,487,000
Idaho	359,798,000	93,388,000	453,186,000
Illinois	2,321,244,000	1,718,303,000	4,039,547,000
Indiana	2,054,049,000	942,267,000	2,996,316,000
Kansas	1,023,210,000	426,814,000	1,450,024,000
Kentucky	1,647,154,000	855,243,000	2,502,397,000
Louisiana	2,352,886,000	1,319,094,000	3,671,981,000
Massachusetts	4,347,438,000	1,137,495,000	5,484,933,000
Maryland	3,143,417,000	704,388,000	3,847,804,000
Maine	377,690,000	180,319,000	558,010,000
Michigan	4,371,374,000	1,616,829,000	5,988,203,000
Minnesota	2,365,431,000	602,981,000	2,968,412,000
Missouri	2,079,914,000	943,278,000	3,023,192,000
Mississippi	719,280,000	632,456,000	1,351,737,000
Montana	229,234,000	144,534,000	373,768,000
North Carolina	4,224,599,000	1,454,869,000	5,679,468,000
North Dakota	73,614,000	103,467,000	177,081,000
Nebraska	586,179,000	227,303,000	813,483,000
New Hampshire	490,432,000	125,549,000	615,981,000
New Jersey	4,510,780,000	1,192,846,000	5,703,626,000
New Mexico	331,042,000	228,683,000	559,724,000
Nevada	1,026,297,000	196,689,000	1,222,986,000
New York	17,325,783,000	3,425,603,000	20,751,386,000
Ohio	5,141,895,000	2,068,439,000	7,210,334,000
Oklahoma	708,006,000	569,564,000	1,277,570,000
Oregon	864,518,000	439,316,000	1,303,834,000
Pennsylvania	11,556,950,000	3,188,606,000	14,745,556,000
Rhode Island	-31,354,000	105,709,000	74,355,000
South Carolina	1,037,409,000	601,712,000	1,639,121,000
South Dakota	102,365,000	94,091,000	196,456,000
Tennessee	5,438,037,000	1,874,606,000	7,312,643,000
Texas	7,228,538,000	2,941,115,000	10,169,653,000
Utah	-21,110,000	136,352,000	115,242,000
Virnigia	4,604,946,000	916,841,000	5,521,787,000
Vermont	175,053,000	71,058,000	246,111,000
Washington	2,243,972,000	607,348,000	2,851,320,000
Wisconsin	2,054,465,000	790,899,000	2,845,364,000
West Virginia	225,364,000	349,159,000	574,524,000
Wyoming	-88,126,000	11,673,000	-76,453,000
Total	**$146,411,691,000**	**$47,400,214,000**	**$193,811,905,000**

Note: Estimates include new CBO economic assumptions from December 12, 1995.