Backgrounder

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How Obamacare Burdens Already Strained State Budgets

Lanhee J. Chen, Ph.D.

Abstract: *A growing number of state budgets are in danger of collapsing under multibillion-dollar deficits—and are about to be burdened with billions more in costs imposed by the new Patient Protection and Affordable Care Act (PPACA). Huge numbers of additional Medicaid enrollees and associated administrative costs will force states to raise taxes, go into even deeper debt, or most likely, to cut spending in crucial areas like public safety or education. While PPACA's costliest provisions do not go into effect until 2014, state policymakers have no time to lose. They must use this three-year window to lay the groundwork for sound policies that will protect taxpayers, control health care costs, and expand choices for consumers. This Heritage Foundation* Backgrounder *details just what is at stake, and why state policymakers must act now.*

Talking Points

- The Patient Protection and Affordable Care Act (PPACA) will place unprecedented fiscal pressure on states, several of which are already suffering from multibillion-dollar budget deficits. Although the law's costly Medicaid expansion is three years away, states must begin to prepare for the added spending today.
- The added administrative and benefit costs of PPACA's Medicaid expansion will likely require cash-strapped states to make even deeper spending cuts, including in important policy areas, such as education or public safety.
- Florida and Mississippi have estimated PPACA's fiscal impact on their state budgets, and the news is not good. The added spending mandated by PPACA eclipses the amounts that both states currently budget for critical policy priorities.
- State policymakers should seize this opportunity to reduce discretionary spending, pass health care reforms that lower costs and expand consumer choice, and publicly hold the Obama Administration and Congress responsible for PPACA's unfunded mandates.

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214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

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The Patient Protection and Affordable Care Act (PPACA) will place unprecedented fiscal pressure on states, several of which are already suffering from multibillion-dollar budget deficits. Although many of the law's most costly requirements will not take effect until 2014, some states are bracing for billions in new spending, while others have already started to take costly steps toward implementing the new law.[1] This mandated spending makes an already bad fiscal situation in many states even worse, as their budget deficits are projected to exceed $350 billion between 2010 and 2011.[2] All but four states faced shortfalls in constructing their 2011 budgets, and these trends are expected to continue into 2012.[3]

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PPACA puts cash-strapped states in a tenuous position, forcing them into one or more unattractive policy choices: cut spending in crucial areas, such as public safety and education, to compensate for the additional health care costs, raise taxes to fund the new spending, or borrow money to pay the bill and sink further into debt. Given the political and economic challenges associated with higher taxes and more debt, it is likely that states will choose the least of three evils and make even deeper budget cuts.

A Zero-Sum Game

All but one state, Vermont, currently has some form of a balanced-budget requirement. The state budgeting process is, therefore, akin to a zero-sum game.[4] Absent higher revenues or greater borrowing, more spending in one area demands reduced spending in another. While applying some pressure to cut state spending is always good, PPACA threatens to place unreasonable burdens on state budgets that are already strained by the current economic slowdown.

Another complicating factor in many states is the severe underfunding of public-employee pension benefits. A recent study estimated that state pensions across America are underfunded by a total of $3.2 trillion.[5] These dramatic expenses, coupled with the additional spending mandated by PPACA, threaten to serve as a lethal one-two punch for state budgets in the years and decades to come.

Most fiscal burdens inherent in PPACA will begin to plague states in 2014, when the law mandates expansion of Medicaid to all non-elderly individuals with family incomes below 138 percent of the federal poverty level (FPL).[6] State policymakers cannot simply turn a blind eye toward the coming storm.[7] PPACA's Medicaid expansion will place an ever-increasing fiscal burden on state policymakers, both in added benefit and administrative costs.

First, the law includes a deceptive funding mechanism for the added benefit costs associated with its expansion of Medicaid eligibility. PPACA promises three years of full federal funding to cover the benefit costs of expansion. Beginning in 2017, however, states are expected to shoulder a progressively larger

1. For example, in California, Governor Arnold Schwarzenegger recently signed legislation creating the first post-PPACA state health insurance exchange. An analysis of the law by Genest Consulting concluded that because PPACA allows the exchange to establish benefits beyond those mandated by federal law, it poses an "unknown General Fund risk" that has the potential to exceed $1 billion *annually*. Letter of analysis from Michael C. Genest, Genest Consulting, to Allan Zaremberg, president and CEO, California Chamber of Commerce, September 16, 2010, at *http://www.calchamber.com/Headlines/Documents/SB900AB1602analysis.pdf* (November 4, 2010).
2. Paul H. Keckley and Barbara Frink, "Medicaid Long-Term Care: The Ticking Time Bomb," Deloitte Center for Health Solutions *Issue Brief*, June 2010, at *http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_2010LTCinMedicaid_062910.pdf* (November 4, 2010).
3. Elizabeth McNichol, Phil Oliff, and Nicholas Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, October 7, 2010, at *http://www.cbpp.org/cms/index.cfm?fa=view&id=711* (November 4, 2010).
4. Ronald K. Snell, "State Balanced Budget Requirements: Provisions and Practice," National Conference of State Legislatures, 2004, at *http://www.ncsl.org/?TabId=12651* (November 4, 2010).
5. Robert Novy-Marx and Joshua D. Rauh, "The Liabilities and Risks of State-Funded Pension Programs," *Journal of Economic Perspectives*, Vol. 23, No. 4 (Fall 2009), pp. 191–210, at *http://www.kellogg.northwestern.edu/faculty/rauh/research/JEP_Fall2009.pdf* (November 4, 2010).
6. While PPACA specifies an income threshold of 133 percent of FPL for the Medicaid expansion, it also requires states to apply an "income disregard" of 5 percent of FPL in meeting the income test. Therefore, the effective income threshold is actually 138 percent of FPL. See Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services memorandum, April 22, 2010, at *https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf* (November 4, 2010).
7. In addition to the fiscal pressures created by PPACA's Medicaid expansion, states should also be prepared to deal with additional costs created by other aspects of the law. For a more detailed treatment of these additional pressures, see Edmund F. Haislmaier and Brian C. Blase, "Obamacare: Impact on States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010, at *http://www.heritage.org/Research/Reports/2010/07/Obamacare-Impact-on-States*.

burden of the benefit costs of new Medicaid beneficiaries. By 2020, and for every year after, state taxpayers will have to fund 10 percent of the benefits for new enrollees.[8] The impact of these added costs will be particularly pronounced in Nevada, Texas, and Oregon, three states whose Medicaid populations are expected to grow by approximately 50 percent or more because of PPACA.[9]

Second, PPACA sticks states with a significant amount of the administrative costs associated with its mandated expansion of Medicaid eligibility.[10] While the law promises three years of federal assistance to fully cover the *benefit* costs, it does not increase the federal match rates paid to states for associated *administrative* costs. Thus, states are on the hook to pay these added administrative costs beginning on day one of the Medicaid expansion and, even sooner, must shoulder much of the financial burden generated by any work they perform in preparation for the added caseload anticipated in 2014.

These administrative costs should not be understated. A July 2010 analysis of national Medicaid data by The Heritage Foundation's Ed Haislmaier and Brian Blase concluded that the administrative costs of PPACA's Medicaid expansion will run just under $12 billion total between fiscal years 2014 and 2020. When added to the $21 billion in additional benefit costs that PPACA's Medicaid expansion will impose on states during the same time period,[11] the outcome is nothing short of an impending fiscal disaster.[12] The additional state spending that PPACA's Medicaid expansion alone will mandate necessitates significant, if not debilitating, cuts of other spending priorities.

Several states have initiated their own estimates of PPACA's impact. Texas recently concluded that the Medicaid expansion may add more than two million people to the program and cost the state up to $27 billion in a single decade.[13] The Florida Agency for Health Care Administration estimated in April 2010 that PPACA's Medicaid expansion would require an additional $5.2 billion in spending between 2013 and 2019, and more than $1 billion a year beginning in 2017.[14] In California, the Legislative Analyst's Office concluded that PPACA's Medicaid expansion will likely add annual costs to the state budget in "the low billions of dollars."[15]

Mississippi, Indiana, and Nebraska each retained Milliman, Inc., a national health care econometrics firm, to perform a fiscal analysis of the Medicaid expansion on their states' budgets.[16] For Missis-

8. State taxpayers will foot 5 percent of the benefit costs for the newly eligible in 2017, 6 percent in 2018, 7 percent in 2019, and 10 percent in 2020 and beyond. See Health Care and Education Reconciliation Act of 2010, P.L. 111-152, § 1201.
9. Haislmaier and Blase, "Obamacare: Impact on States."
10. Nicole Johnson, "Healthcare Reform Expected to Create Longer Term Financial Pressure for States," Moody's Investors Service, April 2010, at *http://inside.ffis.org/ff/Healthcare_Reform_Expected_to_Create_LongerTerm_Finan_Pressure_for_States.pdf* (November 4, 2010).
11. Haislmaier and Blase, "Obamacare: Impact on States."
12. A recent study by the Deloitte Center for Health Solutions painted an even bleaker picture for the fiscal health of states in future years; it concluded that the increased costs generated by Medicaid expenditures, particularly spending on long-term care, would cause Medicaid spending as a percentage of state operating budgets to double. In fact, the Deloitte study concluded that Medicaid expenses in New York will consume nearly 40 percent of the state budget by 2030. For more information, see Keckley and Frink, "Medicaid Long-Term Care."
13. The Texas estimates run from 2014 to 2023. Thomas M. Suehs, "Federal Health Care Reform—Impact to Texas Health and Human Services," Presentation to Texas House Select Committee on Federal Legislation, April 22, 2010, at *http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf* (November 4, 2010).
14. Florida Agency for Health Care Administration, "Overview of National Health Reform Legislation: Estimated Fiscal Impact to Florida's Medicaid Program Under Public Law 111-148 and Public Law 111-152," April 1, 2010, at *http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/National_Health_Care_Reform_040110.pdf* (November 4, 2010).
15. California's estimates begin with the start of the Medicaid expansion in 2014. Mac Taylor, "The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs," *LAO Report*, May 13, 2010, at *http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.pdf* (November 4, 2010).

sippi, Milliman estimates that between 206,000 and 415,000 people will be added to Medicaid with a 10-year impact on the state budget of between $858 million and $1.66 billion.[17] The seven-year cost of the Medicaid expansion in Indiana is estimated to be between $2.59 billion and $3.11 billion, with 388,000 to 522,000 people joining the state's Medicaid rolls.[18] Finally, Milliman estimates that PPACA will result in nearly one of five Nebraskans being covered by Medicaid, at a cost of $526 million to $766 million over the next decade.[19]

This is not an exhaustive list of the states that have pursued their own estimates.[20] Nor is there agreement regarding the most precise way to estimate increases in Medicaid enrollment and higher spending as a result of PPACA. What is clear, however, is that states will be in the best position and possess the best data to assess the impact that PPACA will have on their own budgets.

PPACA in Florida and Mississippi

PPACA's mandated Medicaid expansion could have a major impact on Florida and Mississippi, two states that have already conducted assessments to determine how much new spending the law will inflict on their budgets.

As noted, Florida's Agency for Health Care Administration has estimated the substantial impact that PPACA will have on the state's Medicaid budget beginning in 2013. The state is bracing for just under $1.1 billion in added spending in 2017, the first year that federal funding for the benefits costs of the Medicaid expansion begins to decline. To provide some perspective on the potential impact of this added spending, compare it to spending in Florida's 2009–2010 budget.[21] The new spending created by PPACA's Medicaid expansion is roughly equivalent to the entire budget of the Florida Agency for Persons with Disabilities.[22] It is almost half of the state's entire corrections budget.[23] And it approximately equals the *combined* total of what Florida currently spends on its Departments of Highway Safety and Motor Vehicles, Law Enforcement, and Juvenile Justice.[24]

Similarly, PPACA's Medicaid expansion will have a substantial impact on Mississippi's state budget. The Milliman study commissioned by the state of Mississippi estimated the average yearly impact of

16. Each of the Milliman studies provides a range of impacts on state budgets to reflect uncertainty regarding the anticipated level of enrollment by the Medicaid-eligible population. These studies rely on assumptions that fundamentally differ from those underlying a May 2010 study by the Urban Institute and the Kaiser Family Foundation. Thus, enrollment and cost estimates in the Milliman reports vary from those found in the earlier Urban/Kaiser report.
17. Mississippi estimates run from state fiscal years 2011 to 2020. John D. Meerschaert, "Financial Impact Review of the Patient Protection and Affordable Care Act as Amended by H.R. 4782, The Reconciliation Act of 2010 on the Mississippi Medicaid Budget," Milliman *Client Report*, October 1, 2010, at *http://healthreform.kff.org/~/media/Files/KHS/Source%20general/DOM%20MILLIMAN%20REPORT.pdf* (November 4, 2010).
18. Indiana estimates run from state fiscal years 2014 to 2020. Robert M. Damler, "Affordable Care Act (ACA)—Financial Analysis Update," Milliman, October 18, 2010, at *http://www.in.gov/aca/files/AffordableCareActFinancialAnalysisUpdateOct2010.pdf* (November 4, 2010).
19. Nebraska estimates run from state fiscal years 2011 to 2020. Robert M. Damler, "Patient Protection and Affordable Care Act with House Reconciliation—Financial Analysis," Milliman, August 16, 2010, at *http://www.governor.nebraska.gov/news/2010/08/pdf/Nebraska%20Medicaid%20PPACA%20Fiscal%20Impact.pdf* (November 4, 2010).
20. As of the writing of this paper, several other states, including Kansas, Maryland, Michigan, and North Dakota, have made some effort to assess PPACA's fiscal impact on their state budgets.
21. All Florida budget figures are based on an analysis of the 2009–2010 budget. Budget figures include a combination of General Fund and state Trust Fund spending and exclude all federal funding. See "The People's Governor, the People's Budget: Agencies," Florida Governor Charlie Crist, at *http://ebudget.state.fl.us* (November 8, 2010).
22. Florida state spending on the Agency for Persons with Disabilities in 2009–2010 was $1.05 billion.
23. Florida state spending on corrections in 2009–2010 was $2.4 billion.
24. Florida state spending for the Department of Highway Safety and Motor Vehicles in FY 2009–2010 was $381 million; for the Department of Law Enforcement, $191 million; and for the Department of Juvenile Justice, $561 million.

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the expansion on its budget at $86 million to $166 million, depending on the actual number of individuals who eventually enroll in Medicaid.[25] Using the study's "moderate participation" scenario, which estimates the addition of about 310,000 new enrollees to Mississippi's Medicaid program, PPACA will add about $126 million in average yearly spending to the state's budget between 2011 and 2020.[26] A quick glance at Mississippi's budget reveals that the amount of spending mandated by PPACA's Medicaid expansion in one year far exceeds the amount the state will spend in FY 2011 on its public safety, military, and veterans affairs agencies combined.[27] That means the expansion will cost the state more in one year than it spends on its Highway Safety Patrol, Emergency Management Agency, Bureau of Narcotics, Crime Lab, and other similar government functions. The average yearly cost of PPACA's Medicaid expansion far exceeds what the state spends on vocational and technical education, is over four times the amount appropriated for student financial aid at the state's institutions of higher learning, and is over half of what it spends on its community and junior colleges.[28]

While there is no guarantee that policymakers in Tallahassee and Jackson will make spending tradeoffs in the policy areas mentioned here, these examples provide an illustration of the magnitude of changes that must be made to compensate for the fiscal pressures created by PPACA.

No Good Options

States that choose not to reduce spending in other areas to pay for PPACA's new mandates will be left with the unpalatable options to raise taxes or borrow money to compensate. The continuing economic slowdown and high levels of unemployment make tax increases both bad policy and bad politics. Additional borrowing and debt will only kick the proverbial can down the road while placing added fiscal pressure on states for years (and perhaps decades) to come. The new spending dumped onto states by PPACA is therefore likely to force policymakers in capitals across America to make tough spending cuts in other areas.

The Path Ahead

In every crisis there is opportunity—state policymakers should act quickly to seize it. What they cannot and should not do is ignore what is to come and hope that the budgetary pressures will disappear. By making smart decisions today, states can put themselves in a position not only to weather the coming storm, but to make lasting changes that will improve the lives of their citizens in the years and decades ahead.

First, state lawmakers should focus on cutting or holding constant all discretionary spending. While policymakers will surely have differing opinions of what defines "discretionary," the fact is that states must begin to tighten their fiscal belts today and

25. This calculation is based on Milliman's conclusion that between FY 2011 and FY 2020, PPACA's mandated Medicaid expansion *alone* would add $858 million to $1.66 billion in spending to the state budget. The expansion's actual yearly impact on the budget will be substantially less pronounced during the front end of the 10-year window (particularly before the mandated expansion in 2014) and significantly higher toward the end of the period (after the expansion has occurred and federal matching funds decline).
26. The Milliman study furnishes three scenarios of estimated enrollment (low, moderate, and full) based on expansions in the Medicaid-eligible population due to PPACA and new enrollments of individuals already eligible for Medicaid but currently unenrolled. The "moderate participation" scenario lies between the "low participation" scenario, which estimates the addition of 206,000 individuals to Mississippi's Medicaid program, and the "full participation" scenario, which estimates the addition of 415,000 individuals. Milliman concludes that the low and moderate participation scenarios are most likely to occur.
27. All Mississippi budget figures come from Mississippi's FY 2011 budget. Figures cited refer to appropriations of state support funds, which include both General Fund and, where applicable, Special Fund appropriations. Federal funds are not included. Total state spending on agencies with public safety, military, and veterans affairs functions in FY 2011 is $88.9 million. See State of Mississippi, "Budget: Fiscal Year 2011," June 15, 2010, at *http://www.dfa.state.ms.us/Offices/OBFM/Forms/FY2011Budget.pdf* (November 4, 2010).
28. Mississippi state spending in FY 2011 on vocational and technical education is $77.6 million, on community and junior colleges is $223.6 million, and on student financial aid is $26.9 million.

make tough choices about the money they are already spending. The budgetary pressures that will be imposed on states by PPACA serve as the perfect argument for spending restraint and, more important, efforts to modernize, streamline, and create new efficiencies in state government.

Second, states should proactively enact their own health care reforms that focus on controlling costs, improving quality, and expanding consumer choice and market-based competition. States can do this by repealing burdensome state-mandated health benefits so that insurers can offer a wider array of coverage options at lower prices. Or, they can furnish consumers with more and better information about the cost and quality of health care services to encourage smarter decision making. States can also expand coverage choices and enhance portability by enabling citizens to purchase insurance with aggregated contributions from multiple employers[29] or, in the case of low-income families, a mix of public-sector and private-sector payers.[30]

Finally, state lawmakers should demand that federal officials be held accountable for dumping billions in unfunded liabilities onto states. They should apply maximum pressure on the Obama Administration and Congress to explain how states are expected to implement PPACA without appropriate funding or administrative guidance. This public pressure will inform taxpayers of the incredible burdens that PPACA places on the states and, ultimately, on them. Moreover, it allows citizens to hold the right people accountable for the poor policy outcomes created by PPACA.

The difficult budgetary choices that states face in the years ahead are yet more unintended consequences of President Obama's health care "overhaul." Had the Administration instead pursued a federalist model of health care reform, allowing states to be the laboratories of democracy that the Founders intended, states could then focus their energies on the innovative health care reforms that work best for their own citizens. Instead, PPACA has left policymakers in capitals across the country worrying about how to deal with billions in new spending during already-harsh times.

*—**Lanhee J. Chen, Ph.D.**, is a Visiting Scholar at the University of California at Berkeley's Institute of Governmental Studies, and was formerly Winnie Neubauer Visiting Fellow in Health Policy Studies at The Heritage Foundation.*

29. Gregg Girvan, "Utah's Defined-Contribution Option: Patient-Centered Health Care," Heritage Foundation *Backgrounder* No. 2445, July 30, 2010, at *http://www.heritage.org/Research/Reports/2010/07/Utahs-Defined-Contribution-Option-Patient-Centered-Health-Care*.
30. Dennis G. Smith, "State Health Reform: Converting Medicaid Dollars into Premium Assistance," Heritage Foundation *Backgrounder* No. 2169, September 16, 2008, at *http://www.heritage.org/Research/Reports/2008/09/State-Health-Reform-Converting-Medicaid-Dollars-into-Premium-Assistance*.

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