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Quantifying Costs to States of Noncompliance with the PPACA's Medicaid Expansion

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Abstract: *In March 2012, two years after the enactment of the Patient Protection and Affordable Care Act (PPACA), the Supreme Court will hear challenges to the federal health care legislation. One issue the Court will take up is whether the PPACA's Medicaid expansion constitutes a coercive infringement on state sovereignty by the federal government. Relevant to that dispute is the economic burden to a state that—in the face of the impending PPACA-mandated Medicaid expansion—decides to end its participation in Medicaid, thus forfeiting its entire federal Medicaid funding. This Heritage Foundation analysis attempts to calculate that burden.*

Talking Points

- In March, the Supreme Court will hear arguments on issues arising from challenges to the Patient Protection and Affordable Care Act (PPACA).
- One of those issues is whether the PPACA's expansion of Medicaid infringes on state sovereignty by coercing state governments and commandeering state resources.
- Analyses to date have not measured the main point of contention in this instance: the economic burden to a state of ending, in the face of the impending Medicaid expansion, its participation in Medicaid.
- The steadily increasing fiscal burden imposed by Medicaid on state budgets is already a major problem for state lawmakers, and the PPACA's Medicaid expansion will make that problem worse in 2014.
- Regardless of how the Supreme Court rules on the constitutional issue, this case should serve as an object lesson for states on the dangers of becoming too dependent on federal funding.

In March, the Supreme Court will hear arguments on issues arising from challenges to the Patient Protection and Affordable Care Act (PPACA).[1] While public attention has focused principally on whether the PPACA's requirement that Americans buy health insurance (the "individual mandate") is constitutional, one other issue the court has agreed to review also has important constitutional implications. That issue is whether the PPACA's expansion of Medicaid infringes on state sovereignty by coercing state governments and commandeering state resources.

Since the PPACA's enactment in March 2010, a number of analyses have been conducted, including by state governments, estimating the cost to states of the Medicaid expansion,[2] but those analyses did not measure the main point of contention in this instance:

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the economic burden to a state of opting, in the face of the impending Medicaid expansion, to end its participation in Medicaid. This analysis attempts to calculate that missing element.

Background

Medicaid is administered by state governments, but at least 50 percent of the funding (depending on the state) comes from the federal government. As a condition of receiving federal funding, states must comply with federal Medicaid rules. The PPACA's Medicaid expansion provisions will add costly new requirements to those existing rules. However, Congress wrote the legislation to provide that if a state refuses to comply with the additional requirements, it will lose its entire federal Medicaid funding.[3]

The Supreme Court has asked the parties to brief the Court on the following question raised by the petitioners in their appeal of the district and circuit courts' decisions in *Florida v. Dept. of HHS* (11-400):

> Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress's spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?[4]

In its opinion in *South Dakota v. Dole*, the Supreme Court noted that "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" However, the Court held in that case that the disputed provision—a 5 percent reduction in federal highway funds for states that did not adopt a minimum age of 21 for the purchase or public possession of alcoholic beverages—was not coercive.[5]

In *Florida v. Dept. of HHS*, the lower courts ruled against Florida (and the other 25 state plaintiffs), reasoning that, since state participation in Medicaid is voluntary, a state could elect to terminate its participation in the program if it thought the PPACA's new Medicaid requirements were too onerous. In their appeal, the 26 states argue that the loss of all federal Medicaid funding would be so damaging to states that the states are effectively being coerced by Congress into complying with the PPACA's Medicaid provisions.

Thus, the magnitude of the impact on a state from the loss of federal Medicaid funding is relevant to the issue in contention.

The Cost to States: Projections

The methodology described in the appendix was used to project federal and state Medicaid spending for 2013 (the last fiscal year before the PPACA's Medicaid expansion takes effect) and state general-fund tax and fee revenues for the same year. A state's economic burden of opting out of Medicaid was expressed as the percentage increase in state general-fund tax and fee revenues needed to replace lost federal funding. Table 1 shows the results, by state.

On average, state Medicaid spending currently represents about 20 percent of state general-fund revenues. As the table shows, that average is projected to be 25.75 percent in 2013. That percentage reflects baseline trends in health care cost growth

1. Paul Larkin, "Supreme Court Takes Up Obamacare," Heritage Foundation *The Foundry*, November 14, 2011, at *http://blog.heritage.org/2011/11/14/supreme-court-takes-up-obamacare/*.
2. 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*. For a list of state-level studies, see Joint Congressional Report by Senate Finance Committee, Orrin Hatch (R–Utah), Ranking Member, and House Energy & Commerce Committee, Fred Upton (R–Michigan), Chairman, "Medicaid Expansion in the New Health Law: Costs to the States," March 1, 2011, p. 3, at *http://energycommerce.house.gov/media/file/PDFs/030111MedicaidReport.pdf* (January 9, 2012).
3. § 1901 and § 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396 and 1396a) as amended by § 2001 of P.L. 111-148.
4. Petition for Writ of Certiorari, *State of Florida, et al. v. Department of Health and Human Services* (11-400).

Projected Medicaid Spending and State Revenues

By State in Fiscal Year 2013, with Dollar Figures in Millions

State	Medicaid Spending		State General-Fund Revenues	State Medicaid Spending as Percentage of State General-Fund Revenues	Percentage Increase in State General-Fund Revenues Needed to Replace Federal Medicaid Funding
	Federal	*State*			
Alabama	$4,040.6	$1,823.8	$7,575.7	24.07%	53.34%
Alaska	782.4	576.4	7,916.0	7.28%	9.88%
Arizona	6,267.5	3,157.3	9,317.9	33.88%	67.26%
Arkansas	3,237.7	1,173.3	6,308.3	18.60%	51.32%
California	25,613.9	25,613.9	105,376.6	24.31%	24.31%
Colorado	2,085.1	2,085.1	8,349.5	24.97%	24.97%
Connecticut	3,098.5	3,098.5	20,104.5	15.41%	15.41%
Delaware	705.7	705.7	3,925.7	17.98%	17.98%
Florida	11,376.1	7,971.0	24,917.5	31.99%	45.66%
Georgia	6,189.1	3,793.3	18,353.4	20.67%	33.72%
Hawaii	900.7	663.0	5,694.6	11.64%	15.82%
Idaho	1,099.5	462.3	2,622.7	17.63%	41.92%
Illinois	9,017.2	9,017.2	27,907.1	32.31%	32.31%
Indiana	4,565.1	2,727.4	14,759.0	18.48%	30.93%
Iowa	2,240.0	1,374.1	6,510.6	21.11%	34.41%
Kansas	1,833.9	1,209.9	6,539.6	18.50%	28.04%
Kentucky	4,551.3	1,989.8	9,738.2	20.43%	46.74%
Louisiana	5,342.5	2,323.6	8,638.6	26.90%	61.84%
Maine	1,794.6	1,041.8	3,276.4	31.80%	54.77%
Maryland	3,870.9	3,870.9	14,700.1	26.33%	26.33%
Massachusetts	7,331.4	7,331.4	22,798.4	32.16%	32.16%
Michigan	7,443.1	5,758.6	8,365.1	68.84%	88.98%
Minnesota	4,409.2	4,409.2	17,019.3	25.91%	25.91%
Mississippi	3,552.2	1,128.5	5,004.2	22.55%	70.98%
Missouri	5,784.0	3,605.6	7,979.3	45.19%	72.49%
Montana	721.1	322.3	1,982.3	16.26%	36.38%
Nebraska	1,267.9	920.7	3,891.3	23.66%	32.58%
Nevada	955.5	816.2	3,487.7	23.40%	27.40%
New Hampshire	829.8	829.8	2,434.8	34.08%	34.08%
New Jersey	6,350.2	6,350.2	31,061.2	20.44%	20.44%
New Mexico	2,698.7	1,053.1	5,864.7	17.96%	46.02%
New York	31,575.4	31,575.4	60,922.8	51.83%	51.83%
North Carolina	9,029.9	4,969.9	20,434.7	24.32%	44.19%
North Dakota	468.3	255.3	1,897.8	13.45%	24.67%
Ohio	11,093.5	7,501.0	30,866.6	24.30%	35.94%
Oklahoma	3,273.9	1,530.8	5,712.4	26.80%	57.31%
Oregon	2,517.7	1,605.0	7,092.1	22.63%	35.50%
Pennsylvania	12,340.1	10,348.1	29,784.9	34.74%	41.43%
Rhode Island	1,288.0	1,172.4	3,436.5	34.12%	37.48%
South Carolina	4,124.1	1,806.5	6,625.2	27.27%	62.25%
South Dakota	555.4	327.3	1,276.3	25.64%	43.51%
Tennessee	6,463.2	3,691.1	11,136.8	33.14%	58.03%
Texas	17,824.5	11,501.7	41,152.9	27.95%	43.31%
Utah	1,389.2	591.4	5,072.0	11.66%	27.39%
Vermont	759.0	529.0	1,279.7	41.34%	59.31%
Virginia	3,534.2	3,534.2	16,364.4	21.60%	21.60%
Washington	4,133.7	4,113.9	17,010.4	24.18%	24.30%
West Virginia	2,253.8	842.1	4,160.3	20.24%	54.17%
Wisconsin	4,041.2	2,990.6	14,355.4	20.83%	28.15%
Wyoming	326.5	290.6	1,080.7	26.89%	30.21%
ALL STATES	**$256,946.8**	**$196,380.3**	**$702,082.5**	**25.75%**	**39.70%**

Sources: Author's calculations. For more information, see the methodology.

Table 1 • B2640 heritage.org

and illustrates why state lawmakers across the country are already concerned that state funding obligations for Medicaid, even as the program is currently configured, are steadily crowding out funding for other state budget items.

The last column in the table reports the key metric this analysis sought to calculate: the relative economic burden on a state that decides to end its participation in Medicaid. A state making that decision would then need to replace the lost federal funding with additional state funds if it wanted to maintain its program at the pre-PPACA level. Under that scenario, states would need to increase their general-fund revenues by an average of 39.7 percent in 2013 to replace federal Medicaid funding.

Table 1 shows how this economic burden would vary among the states. The first state in the table, Alabama, would need to increase its projected $7.5 billion in general-fund revenues for 2013 by another $4 billion, or 53 percent, to cover a loss of federal Medicaid funding. The variations among the states can be attributed to four main factors:

1. **Size of federal Medicaid contribution.** A wealthy state with the minimum federal Medicaid contribution of 50 percent—such as Connecticut—would have to double state Medicaid spending to replace the half previously paid for by the federal government. In contrast, a poor state with a federal Medicaid contribution of 75 percent—such as Mississippi—would have to quadruple state Medicaid spending to replace the three-quarters share previously paid by the federal government.
2. **Size of Medicaid enrollment.** The larger the share of a state's population enrolled in Medicaid, the greater the relative burden on the state's taxpayers. However, it is important to note that the share of a state's population enrolled in Medicaid does not simply correlate with relative poverty. It is also the product of a state's Medicaid eligibility standards. While Mississippi is the poorest state and New York is one of the wealthiest, for instance, both have the same high share (25 percent) of their respective populations covered by Medicaid. The reason is that New York has much more expansive Medicaid-eligibility standards than most other states have.
3. **Overall state fiscal policy.** The burden also varies somewhat due to differences among states in the size of their Medicaid programs relative to the size of their total spending and taxing for all state activities. This variation can be illustrated by assuming two states with identical populations and identical Medicaid programs. In such a hypothetical scenario, Medicaid would account for a larger share of the total in the state with the lower level of overall taxation and spending and a smaller share of the total in the state with the higher level of overall taxation and spending.
4. **Extent of "off-budget" state financing.** As noted in the methodology appendix, the data on general-fund revenues exclude "off-budget" financing arrangements. Those involve "Expenditures from revenue sources that are restricted by law for particular governmental functions or activities. For example, a gasoline tax dedicated to a highway trust fund."[6] In the case of Medicaid, the principal "off-budget" financing sources are provider taxes and payments by local governments. The more that a state relies on off-budget revenues to finance Medicaid (or other activities), the greater the percentage increase it would need in general-fund revenues to replace federal Medicaid payments. The most extreme example is Michigan. In 2007, Michigan funded only 58 percent of the state share of its Medicaid program out of general-fund revenues, and only 31 percent of state funding for all activities was from general-fund revenues. Thus, a state that already relies heavily on non-general-fund financing would need a greater increase in general-fund taxing and spending to replace lost federal Medicaid revenue.

5. *South Dakota v. Dole*, 483 U.S. 203 (1987).
6. National Association of State Budget Officers, "Fiscal Year 2010 State Expenditure Report," December 2011.

Other Variations

Of course, each state has its own unique fiscal picture, resulting from different combinations of these factors. For instance, the interaction of these factors makes Alaska another outlier in the table with the lowest projected burden. Alaska's share of residents covered by Medicaid is lower than that of 30 other states, and its federal Medicaid contribution rate of 57 percent is less than that of 29 other states. Thus, the proportionate size of the federal contribution to Alaska's Medicaid program is lower than that of most other states. Also, relative to most other states, Alaska devotes a larger share of its total budget to non-Medicaid activities—notably, the portion of its budget devoted to transportation is roughly double the average share for all states—making Medicaid a smaller component of Alaska's total fiscal picture.

Comparing Kentucky with South Carolina offers another illustration of how these factors interact to produce different results. Both are poorer states with nearly identical federal Medicaid contribution rates of 69.5 percent, and Medicaid covers about 20 percent of each state's population. However, Medicaid is a larger share of South Carolina's budget than of Kentucky's (22.4 percent versus 20.3 percent), and off-budget financing accounts for 50 percent of total state spending in South Carolina but only 42 percent in Kentucky. Thus, South Carolina would need to increase its general-fund revenues by a larger percentage than Kentucky in order to cover the loss of federal Medicaid funding.

Conclusion

The steadily increasing fiscal burden that Medicaid imposes on state budgets is already a major problem for state lawmakers, and the PPACA's Medicaid expansion will only make that problem worse in 2014. States argue that they cannot afford their current Medicaid programs, much less the scheduled expansion.

Indeed, earlier versions of the PPACA raised the possibility that states might be able (after January 1, 2014) to dump their Medicaid programs and redirect most beneficiaries into new, federally subsidized exchange coverage—a rational response by states.[7] However, the final legislation largely foreclosed that possibility by stipulating that the new federal subsidies would not be available to individuals with incomes below 100 percent of the federal poverty level.[8]

Thus, it is not surprising that states feel that the federal government is coercing them into accepting an unaffordable Medicaid expansion under the PPACA. Rather than enacting structural reforms in Medicaid, Congress expanded Medicaid in the PPACA.[9] Congress also wrote the legislation to provide that a state refusing to comply would need to replace federal funding with additional state funds or disrupt the existing health care coverage of its poorest residents. Regardless of how the Supreme Court eventually rules on the constitutional issue, this case should serve as an object lesson for states on the dangers of becoming too dependent on federal funding.

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7. Dennis G. Smith and Edmund F. Haislmaier, "Medicaid Meltdown: Dropping Medicaid Could Save States $1 Trillion," Heritage Foundation *WebMemo* No. 2712, December 1, 2009, at *http://www.heritage.org/research/reports/2009/11/medicaid-meltdown-dropping-medicaid-could-save-states-1-trillion*.
8. § 36B(c)(1)(A) of the Internal Revenue Code as amended by P.L. 111-148, § 1401(a).
9. For a further discussion of Medicaid structural reform, see Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, eds., *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity* (Washington: The Heritage Foundation, 2011), at *http://savingthedream.org/*.

Appendix

Methodology

The economic burden to states of forgoing federal Medicaid funding was calculated using the following methodology.

Fiscal year (FY) 2013 was chosen as the target year for the projections because it will be the last fiscal year before the PPACA's Medicaid expansion, which is scheduled to take effect in the second quarter of FY 2014.

Fiscal year 2007 was selected as the base year because it is the most recent normal year of historical Medicaid data. In this case, "normal year" means a year in which Medicaid spending data were not distorted either by the effects of a recession (which produce temporary enrollment growth in public-assistance programs) or by so-called counter-cyclical policy changes (such as Congress responding to a recession by enacting a temporary increase in federal Medicaid matching funding, as it did in 2009). Thus, for FY 2007, neither of the two biggest factors that could introduce distortions into projections of future federal and state Medicaid spending—a temporary increase in enrollment and/or a temporary increase in federal funding—is present in the base year data.

The selection of 2007 as the base year is also consistent with expectations that the target year of 2013 will be a "normal year," or at least reasonably close to one. Public and private economists forecast that by 2013, the U.S. economy will be in a post-recessionary phase, despite uncertainty as to the exact timing and size of the recovery. Thus, it is reasonable to project that in 2013, U.S. economic performance will be closer to normal than to abnormal.

It is also highly unlikely that in 2013 state Medicaid programs will have been significantly altered (relative to their 2007 parameters) by either federal or state policy changes. The most recent period of enhanced federal matching payments for Medicaid expired at the end of June 2011, and it is unlikely that Congress will significantly alter payment arrangements between now and 2014. In addition, the "maintenance of effort" (MOE) requirement included in the PPACA prevents states from reducing Medicaid eligibility standards before 2014, and that MOE effectively extends the earlier MOE attached to the enhanced federal funding of 2009–2011. The combined effect of the two MOEs is to lock states into maintaining their Medicaid eligibility standards at July 2008 levels until January 2014.

There is also no reason to expect that states will, on their own, expand eligibility for their Medicaid programs between now and 2013, as states will still be faced with revenue collections rebounding from their recessionary trough, health care costs continuing to grow faster than revenues, and the PPACA's impending 2014 Medicaid expansion.

Thus, it is reasonable to expect that state Medicaid eligibility standards will have neither contracted nor expanded before 2014 relative to what they were in 2007.

The 2007 state and federal Medicaid spending data, disaggregated by state, were "aged" to 2013 by applying the cumulative growth in federal Medicaid spending implicit in the most recent (March 2011) Congressional Budget Office (CBO) Medicaid Baseline.[10] In both years, the analysis used data only for benefit spending that is funded jointly by federal and state governments. Thus, three minor items were

10. Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid," March 18, 2011.
11. National Association of State Budget Officers, *Fiscal Year 2010 State Expenditure Report*, Table 54, "Revenue Sources in the General Fund," p. 91.

excluded as not relevant to the analysis: (1) federal and state spending for Medicaid administrative costs (which historically add a further 5.5 percent to benefit costs—about 3 percent federal and, on average, 2.5 percent state); (2) the Vaccines for Children program, which is entirely federally funded but administered through state Medicaid programs (projected by the CBO to reach $4.4 billion in 2013); and (3) federal Medicaid payments to the District of Columbia and U.S. territories (just over seven-tenths of 1 percent of total federal Medicaid spending).

Federal Medicaid spending (not counting the above items) in FY 2007 was $180.4 billion, and the comparable CBO projection for federal Medicaid spending in FY 2013 is $256.9 billion. The difference is a cumulative growth rate for the six-year period of 42.43 percent, which translates into an annual average growth rate of about 7 percent. That growth rate is consistent with recent historical as well as projected spending growth for the entire health care sector (reflecting the combined effects of changes in price, volume, intensity, and population).

Using this growth rate to age the 2007 Medicaid spending data produced estimates of federal and state Medicaid spending for each of the 50 states in 2013, reflecting the implicit assumptions that the share of total federal Medicaid funding received by each state, and each state's federal medical assistance percentage (FMAP), will be essentially the same in 2013 as they were in 2007.

Next, a metric was needed to express the relative burden associated with a state forgoing federal matching funding for its Medicaid program and replacing it with additional state funding. Data on state general-fund tax and fee revenue published by the National Association of State Budget Officers (NASBO) were chosen as offering the best comparison measure because of both what it includes and what it excludes.[11]

The NASBO general-fund revenue data capture the diverse mix of revenue sources on which different states rely for general revenue funding. For example, 42 states have personal income taxes, but Florida and Wyoming are two of the eight that do not. Florida receives 74 percent of its general-fund revenues from sales taxes, while Wyoming's general-fund revenues stem 45 percent from sales taxes and 55 percent from "other taxes and fees," the bulk of which are severance taxes on oil, gas, and coal extraction.

At the same time, the NASBO general-fund revenue data exclude federal transfer payments to states; state borrowing (primarily through bond issuance); and activities funded through "off-budget" arrangements. The first two items (federal payments and state borrowing) are extraneous to this analysis, while the exclusion of "off-budget" taxing and spending explains some of the variations among states in the resulting projections.

State general-fund tax and fee revenues have begun to rebound from their recessionary decline. They peaked at $670.5 billion in FY 2008, bottomed out at $592.3 billion in FY 2010, and rebounded to $631.5 billion in FY 2011.

Given that state revenues appear to have exited their recessionary trough and that 2012 and 2013 are likely to see some level of continued economic recovery, the most recent (FY 2011) NASBO data for state general-fund tax and fee revenues for each state were projected to 2013 by applying the same 5.44 percent annual growth rate that the states, on average, experienced just before the onset of the recession (FY 2006 to FY 2007).

The relative burden associated with a state's forgoing federal matching funding for its Medicaid program in 2013 was then calculated as the percentage increase in a state's total general-fund tax and fee revenue that would be needed for the state to replace lost federal matching funding.