



**THE NELSON A.  
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# **State Budgets, Health Care, and Health Care Reform**

**National Academy of  
Public Administration**

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State “health” spending about 1/3 of total budget, 1/4 of own funds.  
 Medicaid 60% of own-funds health, state employees about 14%.

**State government health expenditures in 2002-03**

	<i>\$ billions</i>			<i>As % of total</i>		
	State funds	Federal & other funds	Total	State funds	Federal & other funds	Total
Total State Health Expenditures	\$175.4	\$182.4	\$357.8	100.0%	100.0%	100.0%
Medicaid	\$104.7	\$150.4	\$255.0	59.7%	82.4%	71.3%
State Employees & Retirees	\$24.0	\$5.4	\$29.4	13.7%	3.0%	8.2%
Community-Based Services	\$13.3	\$3.8	\$17.1	7.6%	2.1%	4.8%
Population Health Services	\$10.0	\$9.2	\$19.2	5.7%	5.1%	5.4%
State Facility–Based Services	\$8.4	\$1.0	\$9.4	4.8%	0.5%	2.6%
Public Health Services	\$5.0	\$5.6	\$10.7	2.9%	3.1%	3.0%
Corrections	\$4.3	\$0.0	\$4.3	2.5%	0.0%	1.2%
Higher Education	\$2.5	\$2.8	\$5.3	1.4%	1.6%	1.5%
SCHIP	\$1.9	\$4.0	\$5.9	1.1%	2.2%	1.7%
All other	\$1.2	\$0.2	\$1.3	0.7%	0.1%	0.4%
Total State Expenditures	\$775.5	\$361.2	\$1,136.7			
Health as % of total expenditures	22.6%	50.5%	31.5%			

Source: Millbank Memorial Fund, NASBO, Reforming States Group, 2002-2003 State Health Expenditure Report

# Medicaid and state budgets

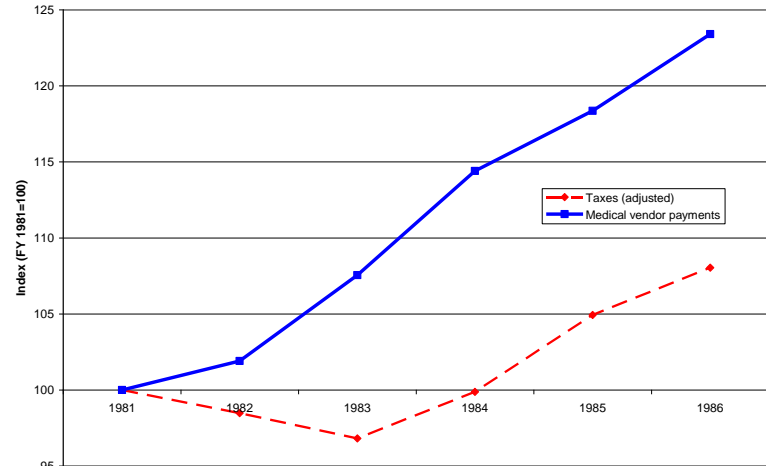
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- \$305b total in FY 2007, excluding admin costs
- 21.2% of total expenditures, tied with K-12 spending as largest budget area
- Considerable variation across states, whether measured as % of budget, or spending per capita, or services provided, etc. – highly devolved

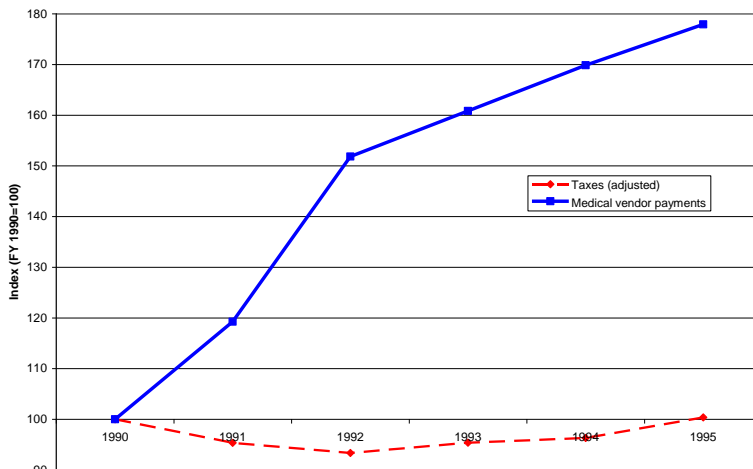
# Medicaid and the business cycle (1)

- Tax revenue falls in recessions (in current one, real per capita tax revenue down over 10%)
- But Medicaid spending pressures continue – and in fact rise, with a lag.

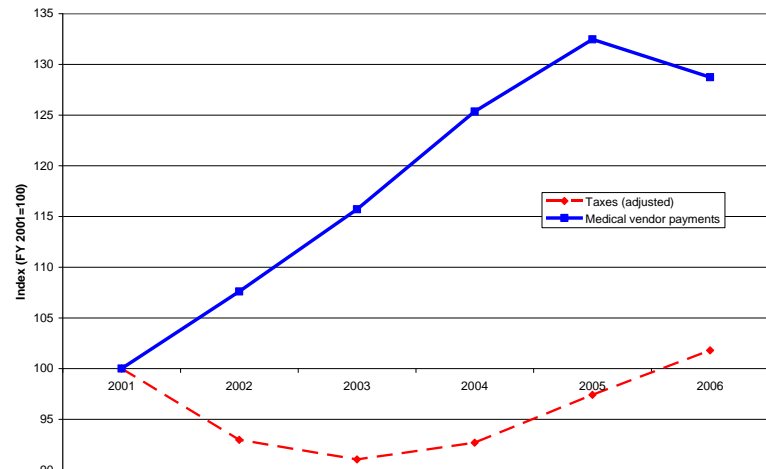
Real per-capita tax revenue (adjusted for legislative changes) and medical vendor payments  
Fiscal crisis of 1980s



Real per-capita tax revenue (adjusted for legislative changes) and medical vendor payments  
Fiscal crisis of 1990s



Real per-capita tax revenue (adjusted for legislative changes) and medical vendor payments  
Fiscal crisis of 2000s



# Medicaid and the business cycle (2)

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- Sustained rise in unemployment leads to fewer workers covered by employer-sponsored insurance, increase in Medicaid/SCHIP enrollment, and increase in costs of uncompensated care for uninsured adults
- Holahan & Garrett estimate unemployment rise from 4.6% (2007) to 10% would lead to 3.4m more children enrolled in Medicaid/SCHIP and 2.0m more adults; 2009 annual costs of \$7.4b and \$11.2b respectively, \$18.6b total. State share of this is about \$8b.
- In addition, they estimate 5.8m more uninsured adults, and increase in uncompensated care costs of \$7.2b (federal/state/other split not clear).
- Total, all levels of gov't, about \$25.8b annual rate.

# Medicaid and the business cycle (3)

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- Lessons:
  - Hard to finance spending that has stable/rising demand/cost-pressures in recessions when you rely on revenue sources that are volatile and fall significantly in recessions
  - Harder still to finance this spending if new responsibilities are added to existing responsibilities
  - Even harder still (from budget-balancing perspective) if new responsibilities come with maintenance-of-effort requirements limiting flexibility to cut in hard times. Balanced budget requirement meets health care reform.

# Health care and longer-term pre-reform outlook (1)

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- Sisko et al.:
  - Project average-annual growth rate for national health expenditures of 6.2% over next decade, vs. GDP growth of 4.1%
  - And project AAGR for state-local gov't health expenditures of 6.9% (8.5% Medicaid, 4.9% other)
  - Growth accelerates toward end of decade as population ages
- GAO estimates that (absent policy changes) state & local gov'ts will face structural budget gaps that rise from 1+% of GDP in 2010 to around 2% by 2020, 2.5% by 2030, and 3.5% by 2040. (2009 state cyclical gaps were around 1.3%) Gaps driven by health care:

Rapidly rising health care costs are not simply a federal budget problem. Growth in health-related spending also drives the long-term fiscal challenges facing state and local governments. The magnitude of these pressures presents vexing long-term sustainability challenges for all levels of government. (GAO-09-210T)

## Health care and longer-term pre-reform outlook (2)

- Lesson:
  - “Bending the curve” is almost as important to state & local gov’ts as it is to the feds

# Health care reform and state budgets (1)

- Selected important features of HR 3962 affecting state & local finances:
  - Extends ARRA FMAP increase for 6 months (\$23.5b)
  - Requires Medicaid to cover to 150% FPL, including childless adults; 100% federal financing for 2 years, then 91% federal beginning 2015 (states pay rest)
  - Increases Medicaid payment rates to primary care providers
  - Reductions in DSH payments
  - Reduction in # uninsured provides potential savings for SLGs in uncompensated care and related programs

# Health care reform and state budgets (2)

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- Lewin estimates Senate Finance bill would have resulted in net savings to SLGs of \$63.7b over 2010-2019:
  - States would finance 10% of Medicaid expansion to 133% FPL beginning 2014 – about \$14.4b
  - Health benefit costs for SLG workers would increase \$45.4b over 2010-2019 due to excise taxes on “Cadillac plans,” and costs of covering uninsured workers or paying employer penalty
  - These costs would be more than offset by \$122.2b in savings for uncompensated care and other programs for uninsured, due to decline in number uninsured. Hence net projected savings.
  - No estimate for costs due to new Medicaid beneficiaries who were previously eligible but not enrolled. Some states believe this could be large and expensive.
- House-passed bill (HR 3962) appears generally more favorable to states

# Health care reform and state budgets (3)

- Council of Economic Advisors analysis of health care reform proposals that were under discussion in September argued that:
  - States will receive considerable relief from the cost of uncompensated care and cost of providing non-Medicaid programs for uninsured above 133% FPL (or, if House bill, 150%)
  - And relief from the “hidden tax” on state employee health premiums (higher premiums needed to help finance cost of uncompensated care)
  - CEA appears to estimate these savings to be in the range of \$11b to \$17.5b annually
  - CEA argues these savings are several times larger than the state share of cost for coverage expansions

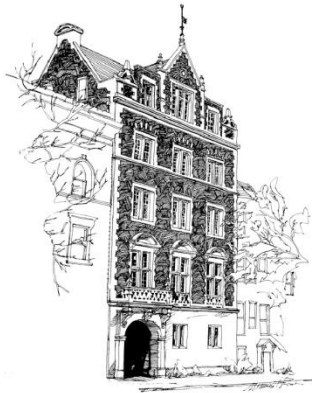
# Health care reform and state budgets (4)

- But states remain worried:
  - Health care reform could lead many people currently eligible for Medicaid but not enrolled to enroll – big numbers, potentially big costs
  - Maintenance of effort provisions could limit flexibility
  - Concern that states that previously had been most generous with Medicaid will benefit least (or be harmed most)
  - Concern about “cliff” when ARRA FMAP extension runs out
  - Hard to know what secondary and tertiary effects there will be – e.g., insurance tax impacts if there is a successful public option; possibility of “bending the curve”

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