Estimating the Effect of the Patient Protection and Affordable Care Act on Kansas Medicaid Expenditures

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by

Jagadeesh Gokhale

Senior Fellow, Cato Institute, Washington, D.C.

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1. Introduction

I am Jagadeesh Gokhale, senior fellow at the Cato Institute, a nonpartisan, nonprofit foundation in Washington, D.C. The Cato Institute's mission is to educate the public on the principles of individual liberty, limited government, free markets, and peace. I am pleased to submit this testimony to Chairperson Ruth Teichman, Vice Chairperson Clark Shultz, and members of the 2011 Special Committee on Financial Institutions and Insurance of the Kansas state legislature.

2. Policy Perspective

A crucial issue facing Kansas policymakers is how to deal with the likely escalation of the state's health care spending resulting from the Patient Protection and Affordable Care Act (PPACA). Meeting this policy challenge requires estimates of how the PPACA will affect Kansas' health care expenditures. This testimony provides such estimates based on a study of this issue that I conducted earlier this year. I conclude my testimony with some additional remarks about why those estimates are likely to be conservative.

The PPACA was enacted by the U.S. Congress and signed into law by President Barack Obama in March 2010. After its enactment, I began a project to study PPACA's implications for selected U.S. states, including Kansas, at the request of the Kansas Policy Institute [Refs. 1-5]. I compiled detailed information on the rules and operations of Medicaid programs to investigate PPACA's effect on state budgets through their Medicaid programs.

The PPACA imposes large unfunded mandates on states, principally to extend Medicaid coverage to large additional population groups. As described below, the additional cost of new Medicaid enrollees will not be fully covered by additional federal financial support. State general funds must pay for the remaining increase in Medicaid spending resulting from PPACA's implementation. Estimates based on my study of this issue for Kansas suggest that once the PPACA

becomes fully effective as scheduled in 2014, Kansas' general fund Medicaid spending is projected to increase significantly: Under baseline calculations, the cumulative 10-year spending on Medicaid (2014-23) is projected to be larger by $4.7 billion under PPACA than it would be without it.

Already, Kansas Medicaid's historical and rapid projected expenditure growth—even without PPACA—threatens to compromise the state government's provision of other important public services. Medicaid's further expansion under PPACA is likely either to force a reduction in key public services—education, infrastructure, research, community development, and so on—or to impose considerably larger burdens on the state's taxpayers.

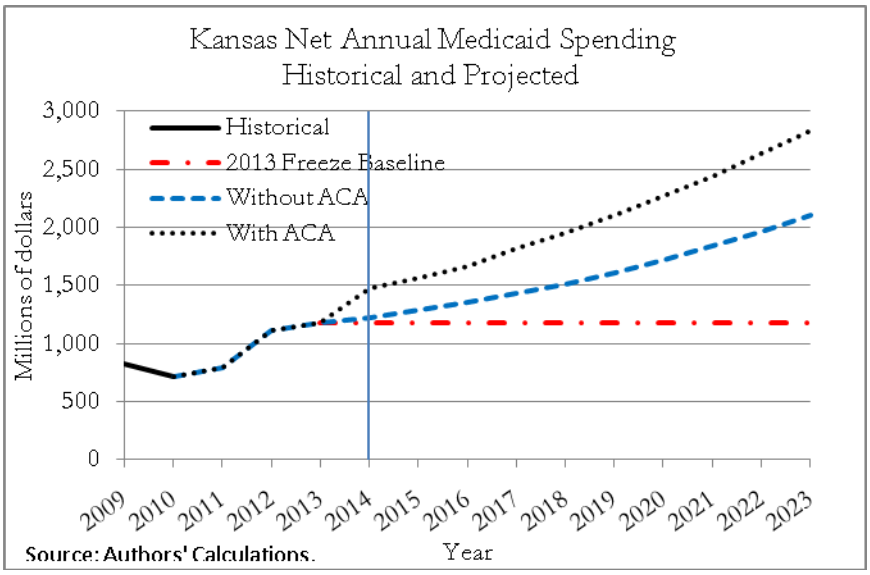
3. PPACA's Effect on Kansas Medicaid Expenditures

State-operated Medicaid programs target multiple population groups, each with different characteristics and a unique history of enrollment, benefit take-up, and costs per patient. My study is designed to take account of these differences in considerable detail to estimate PPACA's effect on the state's projected trajectory of Medicaid expenditures as accurately as possible. The study isolates PPACA's likely effect on future Kansas general fund Medicaid expenditures by differentiating between (1) those who would become "newly eligible" through PPACA's expansion of income-eligibility thresholds and (2) those who are eligible for Medicaid under pre-PPACA rules but are likely to newly enroll into Medicaid as a result of PPACA's individual mandate to acquire health insurance. This distinction is crucial because, under PPACA, the costs of the latter group of new Medicaid enrollees will not be covered through expanded federal financial support. It must be borne by the state's general fund, and ultimately by its taxpayers.

In my study, I use micro-data survey information that is representative of Kansas's population to indentify the population of those eligible to Medicaid under PPACA and pre-PPACA rules. I use administrative information on Medicaid enrollments, benefit take-up, and benefits

awarded per patient to determine annual rates for those three items out of the eligible population. I note that PPACA's "maintenance of effort" clause prevents state governments from changing Medicaid eligibility standards to reduce caseloads until they have established health Exchanges. States could adopt policies—such as introducing managed care systems—to slow the growth of health care costs. But any changes in state costs from such initiatives would be attributable to state policy changes, not directly to PPACA. Hence, such policy effects on state Medicaid costs are excluded from the estimation procedure.

The study's results suggest that Kansas general fund expenditures would have cumulated to $16.0 billion without PPACA between 2014 and 2023. With PPACA, however, they will cumulate to $20.7 billion— larger by $4.7 billion. If federal financial support is gradually pared back after 2019 (in order to reduce high and rising U.S. federal debt) to gradually revert to standard Federal Medical Assistance Percentage (FMAP) rates, Kansas' 10-year Medicaid cost increase because of PPACA would be larger still—$5.5 billion over 2014-23. The accompanying chart adapted from my study provides details of how the PPACA would alter the path of Kansas Medicaid Expenditures. My study [Ref. 3] is included as an addendum to this testimony.



In this context, the history of Kansas' general fund expenditure shares of Medicaid, education, other public services (transportation, corrections, public assistance, housing,

environmental and natural resource programs, and parks and recreation) is quite revealing. An increase in Medicaid's general fund share during the 1990s—from 7.8 percent in 1990 to 10.8 percent in 1999—was more than fully absorbed by reducing the budget share of spending on other public services, which declined from 36.2 percent in 1990 to 24.5 percent in 1999. However, the expenditure share of education, which is obviously most important for nurturing future economic growth, was protected. Indeed, the budget share of education increased significantly from 56.0 percent in 1990 to 64.6 percent in 1999. The year 2000 was abnormal with an exceptionally low Medicaid budget share of 4.8 percent. During the rest of the 2000s decade, however, an increase in Medicaid's share from 9.8 percent in 2001 to 13.5 percent in 2009 forced reductions in *both* the shares of other public services, which declined from 23.8 percent in 2001 to 21.4 percent in 2009, and education, which also declined from 66.4 percent in 2001 to 65.1 percent in 2009. This suggests that the significantly steeper Medicaid expenditure trajectory that is likely to emerge after 2014 with the ACA in force—and which would increase Medicaid's general fund share well above 20 percent—is likely to compel large contractions in the future expenditure shares of both education and other public services, that is, unless additional financial burdens could be imposed on Kansas taxpayers without significant negative economic effects.

4. Additional Remarks

There are good grounds to believe that my study's estimates of PPACA's effect on the trajectory of Kansas health care expenditures are conservative. My estimates are based on historical enrollments rates among Medicaid-eligible groups. Those rates are likely to be lower than under the post-PPACA environment for several reasons. First, under pre-PPACA conditions, the availability of alternatives, including employer provided insurance that enjoys federal tax subsidies, are likely to

induce non-enrollment in Medicaid. The PPACA will alter employee and employer incentives to significantly increase Medicaid enrollment rates by both groups of new enrollees described above.

PPACA's requirements to expand health insurance coverage and administer premium supports for low-income individuals are to be implemented through health insurance "Exchanges," which are to be made fully operational by 2014. Private insurance companies would offer health insurance plans that adhere to strict government regulations on coverage and pricing. The exchanges will mediate individual health insurance purchases and distribute federal taxpayer dollars to private health insurance companies by way of premium supports for qualified individuals. However, if the exchange process identifies a person to be Medicaid eligible (under PPACA or pre-PPACA laws), that person would be more likely to enroll in the state's Medicaid program given the generous subsidies available for doing so rather than purchase a private insurance policy through the Exchange. This enrollment process under an individual mandate, including enrollment facilitation drives that PPACA envisions, implies that my estimates based on enrollment rates under pre-PPACA environment are likely to understate the number of new enrollees among those who are Medicaid eligible under pre-PPACA rules.

Furthermore, although employers are subject to penalties for nonprovision of health insurance under PPACA, those penalties are relatively small. As a result, employers may find it more profitable to withdraw health coverage and pay the penalties rather than continue to provide health insurance to their employees. As a result, more low-income workers would be forced to seek coverage through the Exchange and end up enrolling in Medicaid than is assumed in my study.

It is noteworthy that PPACA's regulatory system on health insurance coverage and pricing is likely to increase health insurance premiums for almost all individuals—beyond those assumed on the basis of historical trends in my study. PPACA's individual mandate would compel nearly all Americans to purchase health insurance policies. The law will, therefore, forcibly expand the

demand for health insurance coverage under an environment of limited, short-term capacity to boost the provision of health care products and services. Indeed, the PPACA implies large "hidden taxes" for most insurance purchasers— higher-than-actuarially-warranted premiums for those enjoying relatively good health; higher premiums compared to a competitive health insurance market with the freedom to choose coverage or to opt out depending on one's health status and expectations; higher state and federal income taxes to support the expansion of premium supports for qualified individuals under the PPACA; the loss for many of employer provided health insurance (that is tax-deductible to employers) either because employers prefer to pay PPACA's penalties or their plans are disqualified under PPACA's regulations. Under the last item, note that any increase in employee wages (net of the penalty on employers) to compensate for lost employer health coverage would be subject to income and payroll taxes. All of these effects argue for low-income individuals to enroll into Medicaid at greater rates than those underlying my study's estimates.

The claim I make here that the PPACA is likely to significantly increase health insurance premiums facing most of the population is also supported by other studies: One study [Ref. 6], which concerns PPACA's likely effects in Wisconsin, is by MIT economist Jonathan Gruber. His study finds that under PPACA's individual mandate and regulations, "87 percent of the individual market will experience an average premium increase of 41 percent." And if employers are able to game the system by retaining coverage for high-wage workers but jettisoning low-wage ones who are eligible for premium subsidies, the new Medicaid enrollment effect is likely to be stronger. Indeed, the Gruber study finds that even after accounting for PPACA's premium assistance for qualified individuals, "59 percent of the individual market will experience an average premium increase of 31 percent." Further toward addressing this point, a recent study [Ref. 7] by Richard Burkhauser of Cornell University concludes that "family based affordability" considerations during contracting between employers and employees could push between 1.6 and 6.0 million additional households

(depending on co-insurance rates for employer provided insurance) onto the health Exchanges, implying higher taxpayer costs. The estimates are even larger under "individual based affordability" rules. This, again, argues for larger enrollment rates in the post-PPACA environment compared to those used in my study.

I thank the committee for the opportunity to submit this testimony and my earlier study as aids toward its policy deliberations. I am available to answer questions related to this testimony. I can be contacted via e-mail at jgokhale@cato.org or by phone at (202) 789-5247 during workdays.

Jagadeesh Gokhale
Senior Fellow, Cato Institute, Washington, D.C.
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