

analysis

The Impact of ObamaCare on Nevada's Medicaid Spending

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Executive Summary

Medicaid is a state-operated program that originally was intended to provide critical medical services for highly vulnerable populations. Although the federal government assumes a large share of its financial cost, Medicaid still accounts for an increasingly significant proportion of Nevada's budget expenditures: More than 12 percent of general fund spending was allocated to Medicaid in fiscal year 2010.

As the number of people eligible for Medicaid has grown, so too has the range of services offered by Nevada's Medicaid program. It now offers benefits comparable to those of the most generous corporate health plans in America, providing comprehensive coverage to 10 percent of the state's population. Medicaid's growth is already crowding out state expenditures on other policy objectives.

The declining ability of taxpayers to support the growing costs of Medicaid is clearly evidenced by Nevada's current structural deficit. The state general fund began to experience negative revenue growth in fiscal year 2009, and projected revenues of \$5.34 billion for the 2011-13 budget period are \$1.1 billion less than budgeted expenditures of \$6.42 billion for the current 2009-11 budget period. Despite this gap, state agencies initially requested a \$2 billion increase in spending for the 2011-13 budget cycle, primarily

driven by projected growth in Medicaid expenditures.

The Silver State's mounting long-term obligations also present a bleak picture: Official estimates of unfunded pension obligations now top \$10.4 billion and even this figure significantly understates the true shortfall because it is based on unduly optimistic actuarial assumptions. In addition, the state's unemployment rate of 13.6 percent — highest in the nation — implies larger entitlement expenditures and slower growth in tax revenues compared to most other states. Serious as Nevada's budget problems already are, the Patient Protection and Affordable Care Act of 2010 — popularly known as Obamacare and hereafter referenced for brevity by the initials ACA — promises to compound them by further increasing the state's future Medicaid spending commitments.

This study estimates ACA's effect on Nevada's Medicaid expenditures. It does so by constructing and comparing state Medicaid spending projections with and without ACA mandates. The resulting detailed assessment shows that Nevada would spend \$17.4 billion on Medicaid during the first 10 years (2014 through 2023) of ACA's implementation, which is \$5.4 billion (45 percent) more than its projected spending without ACA during the same period. We also compare Nevada's Medicaid spending growth with Medicaid growth in other states — California, Illinois, Oklahoma and Texas.

Introduction

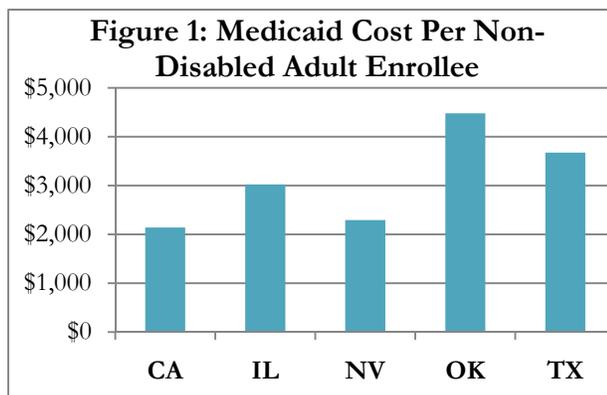
Medicaid, created in 1965 under the Social Security Act, is an optional state-operated health program for low-income families, children, the elderly and disabled. It is financed with state revenues and federal matching grants determined by a formula that is more generous toward poorer states. Nevada's regular federal Medicaid matching rate for 2011 is 51.7 percent — far below the average FMAP rate across all states.¹ The 2009 American Recovery and Reinvestment Act (ARRA) is providing temporary relief through higher federal matching of state Medicaid expenditures, increasing Nevada's matching rate to 65 percent. Without a reversal, pressure on the state's general fund will intensify when the federal match rate reverts to its normal level after June 2011.

Each state is free, under certain constraints, to determine who and which health costs will be covered by Medicaid. To receive federal funds, states must satisfy minimum federal coverage rules — such as covering those receiving Supplemental Security Income, deemed disabled, or over 65 and below 135 percent of the federal poverty level (FPL). Children under age 6 and pregnant women with family incomes below 133 percent of FPL, and children 6-18 below 100 percent of FPL, must be covered. States must also cover people eligible for their Temporary Assistance for Needy Families (TANF) program.² These rules ensure that those most medically and financially vulnerable can receive health care support.

Before ACA, non-disabled adults were eligible for Medicaid only under a special waiver unless they had a child and their households were eligible for cash assistance. Beginning in 2014, ACA extends eligibility to U.S citizens earning less than 133 percent of FPL³ whether or not they have children or are disabled. ACA also creates an individual health insurance mandate, which will induce additional enrollments from those eligible for Medicaid pre-ACA. The federal government intends to pay almost the entire cost of expanded eligibility, but new enrollees among those eligible under pre-ACA laws will place an additional strain on the Nevada budget.

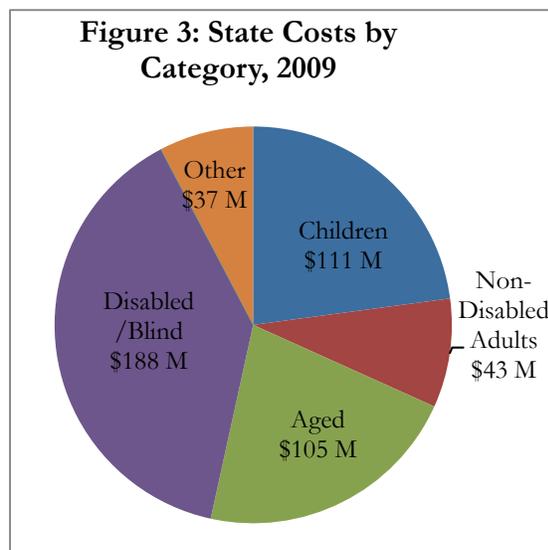
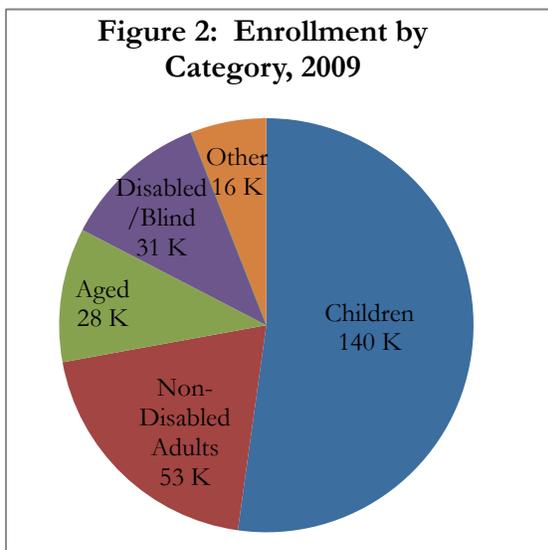
How Things Stand Today

Nevada spent \$1.4 billion on Medicaid in 2009. After subtracting federal funds at the ARRA matching rate of 65 percent, Nevada's share of that spending was \$480 million — 12 percent of general fund revenues or \$375 in state taxes per Nevada worker.⁴



Currently, 10 percent of the Nevada population is enrolled in Medicaid (268,000 enrollees) at an average cost of \$4,770 per person. A non-disabled adult on Medicaid in Nevada costs about \$2,300 annually. Figure 1 compares Nevada's spending per non-disabled adult enrollee to that in some other states: Nevada spends slightly more than \$2,000 per enrollee, similar to that of its neighbor, California; Illinois spends about \$3,000; Texas about \$3,750 and Oklahoma about \$4,500.⁵ Nevada's spending is also less than that of several other states not included here — such as Kentucky and New York.

Figure 2 shows enrollment numbers by category. Children account for most Medicaid recipients. The 'other' category consists of family planning, breast and cervical cancer patients without insurance, and foster care children. Blind/disabled eligibles and the elderly account for a vast amount of Nevada Medicaid spending:



Peering Into the Future

Long-term cost projections provide deeper insights into how ACA, assuming the provisions are fully implemented, will change Nevada's Medicaid funding commitments. We construct Medicaid spending projections with and without ACA to estimate the new law's effect on Nevada's Medicaid spending. Under both projections Medicaid eligibility, enrollments, benefit reciprocity and costs per recipient are projected using historical trends from micro-data sources spanning the years 2000-08. The historical trends are projected separately for detailed population sub-groups — by gender, age and FPL categories and separately for special eligibility groups. Detailed eligibility rules specific to Nevada are applied (with and without ACA) to determine eligibility counts from household surveys that provide data samples representative of the Nevada population. Enrollment, beneficiary and cost data are taken from state-wide administrative records.⁶ The projections are anchored on the Census Bureau's Nevada

state population projections. Nevada Medicaid spending projections are also constructed under alternative assumptions about federal matching rates going forward.⁷

Projections Without ACA

Freezing nominal Medicaid spending at the level projected for 2014 without ACA (the Freeze Baseline) generates a 10-year cost (over 2014-23) of \$9.3 billion. The cumulative 10-year cost during the same period without ACA is expected to grow to \$12 billion. This projected cost increase (without ACA over the Freeze Baseline) would arise partly from increased enrollments of 112,000 people — 12 percent of the state's population by 2023. As Table 2 shows, the projected composition of enrollees without ACA rises steadily over the years with the proportions being similar to today (as shown in Figure 2).

Projections Under ACA

The federal government promises to pay 100 percent of health care costs for newly eligible Medicaid enrollees during the first 3 years of ACA's Medicaid expansion (2014-16) and promises to cover around 85 percent of their costs thereafter. Despite this, Nevada's Medicaid spending will increase because the federal government will provide only the state's

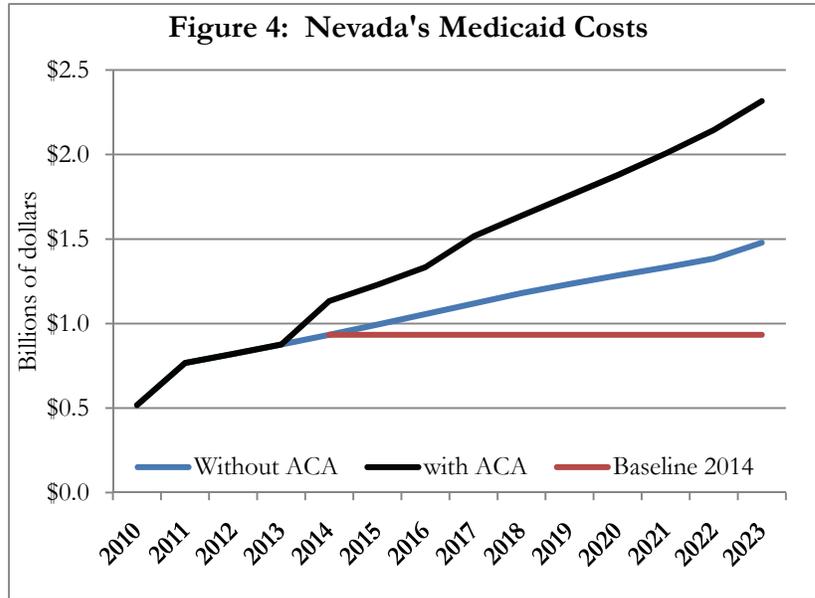
regular match rate (51.7 percent) for those who are Medicaid-eligible under pre-ACA laws but not enrolled. ACA's insurance mandate will induce most

Table 1: New Enrollees with ACA from Expansion and Mandate			
Year	2014	2020	2023
New Eligible	239,000	258,000	267,000
Old Eligible	65,000	90,000	104,000

of these individuals to enroll into Medicaid. Table 1 shows projected enrollments from ACA's Medicaid expansion (newly eligible) and from its individual mandate (old eligible).

ACA's “maintenance of effort” clause forbids states from changing Medicaid eligibility standards to reduce caseloads until they have established a federally approved state health exchange. Some states plan to adopt policies such as managed care systems to minimize the increase in state Medicaid costs from ACA. We exclude from consideration all such potential policies in order to isolate the cost increase from implementing ACA. Under these assumptions, ACA is projected to increase Nevada's Medicaid spending by an additional \$5.4 billion bringing the ten-year cost up to \$17.4 billion.

Figure 4 shows the projected Medicaid costs for Nevada's budget from freezing Medicaid spending at its projected 2014 level (red line), without ACA (blue line), and with ACA (black line). In July 2011, the ARRA match rate enhancement disappears and Nevada's Medicaid costs will shoot up. Under ACA, spending spikes in 2014 when the law is first



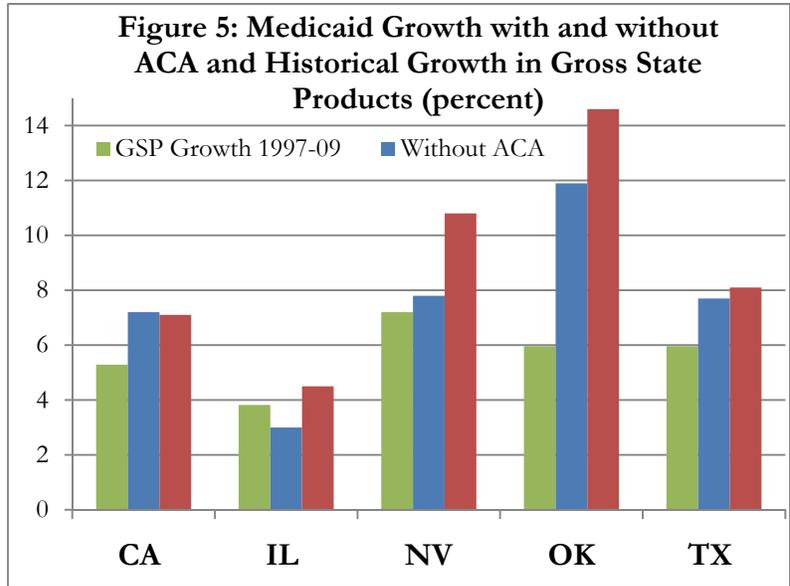
implemented and increases sharply again in 2017 when the federal government reduces its match rate for ACA's newly eligible enrollees.

Table 2 shows that under ACA, Nevada's Medicaid enrollment is projected to increase to 800 thousand by the year 2023 — or 22 percent of the Nevada population projected by the Census. This represents an addition of 371,000 in Nevada Medicaid caseloads by 2023 over and above the increase projected without ACA. Table 2 also shows that the composition of enrollees will change dramatically under ACA: Most of the enrollment increases under ACA will occur among non-disabled adults so that ten years after ACA's enactment, they will account for nearly 40 percent of Medicaid caseloads — much larger than today, as shown in Figure 2.

	2014		2020		2023	
	Without	With	Without	With	Without	With
Children	166	255	200	301	217	324
Non-Disabled Adult	61	259	73	289	80	306
Aged	41	45	66	73	78	88
Disabled/Blind	31	43	25	48	22	50
Other	21	22	29	30	34	35
Total	319	624	392	740	431	802
Enrollment Increase	304		348		371	

Another way to view the effect of ACA on the fiscal sustainability of state Medicaid programs is by comparing projected growth in Medicaid expenditures with the state's average historical economic growth — taken as a proxy for how rapidly state

incomes could grow in the future. Figure 5 shows the average historical growth in gross state product (GSP) for Nevada and four other states (1997-09). It also shows their projected Medicaid growth rates with and without ACA. Nevada, California, Oklahoma and Texas' historical economic growth was slower than growth in their general revenue Medicaid



expenditures, respectively, even without ACA. Although Nevada has experienced fairly rapid GSP growth, its Medicaid is scheduled to grow even faster. ACA worsens the situation by accelerating Medicaid expenditure growth in all of these states except for California.⁸ Oklahoma's double-digit Medicaid cost growth is by far the highest of all of the states shown in Figure 5. Overall, ACA is projected to increase fiscal stress on the budgets of all these states except for California.

Alternative Scenarios

The federal government is already feeling the strain of growing deficits and debt compounded by looming shortfalls in federal entitlement programs. This increases the likelihood of future cuts in federal spending, including reductions in federal financial support for state Medicaid programs. Here we look at the effect on the Nevada budget of two alternative ways to reduce the additional federal match for newly eligibles under ACA to the regular match rate.⁹

Table 3 shows Nevada’s Medicaid costs during 2014-23 under various scenarios:

Table 3: Nevada's Medicaid Expenditures (billions of dollars) Under Alternative Federal Support for New Eligibles (2014 -23)	
Freeze Baseline	9.33
Without ACA	11.99
With ACA	17.42
Alternative 1	17.48
Alternative 2	17.70

the Freeze Baseline, without ACA, with ACA with continued additional federal financial support after 2019, and with ACA under two alternative levels of federal support.¹⁰ Under federal financial support Alternative 1, the federal support (beyond Nevada's regular match rate) is phased out for new eligibles at a rate of one-percentage point per year beginning in 2020. The resulting increase in Medicaid spending is quite small — just \$60 million during 2014-23 compared to that with

ACA. Under federal financial support Alternative 2, the federal government would fully eliminate extra support for new eligibles at a constant rate over ten years beginning in 2020. Medicaid spending would increase by an additional \$270 million by 2023 under this alternative compared to that with ACA.

Recent Proposals in Nevada and Other Policy Options

Nevada recently signed a five-year, \$176 million contract with Hewlett-Packard, under which HP would improve the state Medicaid program's information management system. Governor Brian Sandoval's 2011-2013 budget has proposed cutting Medicaid nursing home reimbursements — by \$20 per day per patient to save \$10.1 million. But health care analysts suggest that such deep cuts would be challenged in the courts and, based on previous court rulings, would probably be deemed illegal.¹¹ On the other hand, state Senate Majority Leader Steven Horsford has proposed a floor on health care provider reimbursements equal to those of Medicare in 2002. This proposal limits Medicaid spending reductions, while seeking to preserve the viability of health care facilities that serve Medicaid patients.¹²

The enactment of the Patient Protection and Affordable Care Act has increased policymaker concerns about runaway state Medicaid costs, motivating many state policymakers to seek ways to contain Medicaid expenditures. One approach is the perennial requirement to “eliminate Medicaid waste, fraud and abuse.” Under ACA's maintenance-of-effort clause, states are generally unable to remove optional eligibility categories until after 2014. Arizona's expiring waiver, which allows the state to remove 250,000 childless adults, appears to be an exception.¹³

Another policy option for states is to apply for a “global” Medicaid waiver similar to that granted to the state of Rhode Island in 2009.¹⁴ Rhode Island's waiver allows greater flexibility to design health care provision to poor and medically needy groups with block-granted support from the federal government. However, a similar waiver may not be granted to other states by federal officials unless the state agrees to broaden its Medicaid eligibility rules. Rhode Island, for example, has set Medicaid income eligibility thresholds for most groups at or above 200 percent of FPL — which qualifies people for full Medicaid coverage. In the long term, such a waiver could afford other states better opportunities to economize on Medicaid costs. But if states must broaden their Medicaid eligibility rules to be similar to those of Rhode Island, their short-term Medicaid expenditures are likely to increase, making this type of waiver less desirable, especially during the early stages of an economic recovery. The Medicaid reforms suggested by U.S. House of Representatives Budget Committee Chariman Paul Ryan, included in his 2012 federal budget proposal, would more effectively relieve pressure from surging Medicaid expenditures in state budgets.

The federal Department of Health and Human Services recently suggested a long list of proposed changes,¹⁵ but it remains unclear if they can collectively deliver the needed cost savings to make Medicaid affordable. The reason: those changes do not allow reductions in the target enrollments or coverage projected under ACA. Some states with GOP Governors have proposed to turn Medicaid into a block-grant program, thus reducing future growth and allowing the states to spend those funds as they find appropriate.

Going beyond minor tinkering is the possibility of opting out of Medicaid altogether — an option that was explored by former Nevada governor Jim Gibbons soon after ACA's passage by Congress in March 2010. This option would see states assume full responsibility for providing basic health coverage to low-income and disabled groups, funded exclusively out of state general fund revenues. Most state policymakers, however, do not view this as a practical solution because it involves the loss of significant federal Medicaid dollars. Some state lawmakers are exploring whether a Medicaid opt-out could be combined with a reversion to the states of federal income taxes used for funding federal matching grants — as block grants. However, this would require multi-state agreements with the federal government — a difficult proposition at best. Thus, policy options for state lawmakers remain limited, unless the constitutional court challenges joined by several states succeed in effectively repealing ACA.

Conclusion

With 22 percent of Nevada's population projected to be on Medicaid by 2023 under ACA, Silver State Medicaid expenditures are projected to grow by an additional \$5.4 billion beyond the increase projected without ACA. To avoid making deep cuts in other necessary public services and to maintain the state's economic competitiveness by avoiding tax increases, Nevada lawmakers have a strong incentive to control the huge potential growth of Medicaid expenditures under ACA. However, few avenues appear to be available to restrain Medicaid spending, given ACA's prohibitions against reducing program eligibility and altering health care coverages. With ongoing court challenges, the final chapter of the ACA law and state Medicaid spending is yet to be written.

The authors

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End notes

¹ Federal matching percentages are published in the Federal Register, Vol. 74, No. 227 available at <http://aspe.hhs.gov/health/fmap11.htm>.

² Each state has its own TANF program with different eligibility standards, deductions and income levels. Each state determines whether or not to have an asset test to determine Medicaid eligibility. Under the Social Security Act states can elect whether or not to cover medically needy individuals. Thus when comparing this group to other states, costs and enrollments vary widely. Nevada does not define a special "medically needy" category for coverage under Medicaid.

³ 133 percent of the poverty level is \$14,404 for an individual and \$29,327 for a family of four.

⁴ Based on authors' calculations using MSIS, NASBO general revenue numbers, federal FMAP levels and Bureau of Labor Statistics state employment numbers (<http://www.bls.gov/sae/>).

⁵ Based on authors' calculations using the MSIS and the Census

⁶ The Census Bureau's Current Population Survey and MSIS are used.

⁷ The methods are described in "The New Health Care Law's Effect on State Medicaid Spending: A Study of the Five Most Populous States," by Jagadeesh Gokhale. Cato Institute White Paper no. 31, April 6, 2011. http://www.cato.org/pub_display.php?pub_id=12967. and in "Final Notice: Medicaid Crisis: A Forecast of Texas' Medicaid Expenditures Growth," by Jagadeesh Gokhale. December 2010. <http://www.texaspolicy.com/pdf/2010-12-RR12-FinalNoticeMedicaidCrisis-ForecastofTexasMedicaidExpendituresGrowth-CHCP.pdf>.

⁸ The case of Illinois is unique: Without ACA, Illinois' Medicaid expenditures would grow less rapidly than its overall economy, implying that the program would be sustainable in the future. However, as Figure 5 shows, the introduction of ACA makes Illinois' Medicaid cost growth faster than its historical GSP growth, implying that an increasing share of Illinois' income would have to be diverted toward Medicaid. California is projected to save money under ACA because there are few new enrollees among old-eligibles and the state's saving from uncompensated care for the uninsured and those ineligible for Medicaid exceeds the cost increase from ACA.

⁹ ACA specifies the additional matching rate for new eligibles for '2019 and succeeding years.' See Social Security Act, 1905 [42 United States Code 1396d]. Here we explore alternatives wherein the matching rate applicable in 2019 will be gradually reduced beginning in 2020.

¹⁰ Medicaid spending under ACA and alternatives with ACA are net of uncompensated care savings of \$550 million.

¹¹ "Memorandum" by Charles Perry, Nevada Health Care Association, <https://nelis.leg.state.nv.us/App#/Meeting/578/Exhibit/2617/SB54>.

¹² See Nevada Senate Bill No. 278 introduced by senators Horsford and Hardy, March 18, 2011.

¹³ The state of Arizona's expanded eligibility waiver expires at the end of September. According to officials of the Department of Health and Human Services, removing these enrollees does not conflict with ACA.

¹⁴ A description of the final version of Rhode Island's Medicaid waiver is available at http://www.povertyinstitute.org/matriarch/DocumentViewDirect.asp_Q_PageName_E_Legislation+-+Final+Global+Waiver+1.09

¹⁵ Sebelius, Kathleen. "Sebelius outlines state flexibility and federal support available for Medicaid - Full Letter." February 3, 2011. <http://www.hhs.gov/news/press/2011pres/01/20110203c.html>.

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