Texas Public Policy Foundation

The Big Squeeze

Analysis of Spending Cuts or Tax Increases Necessary to Maintain Current Medicaid

by The Honorable Arlene Wohlgemuth & Spencer Harris | January 2011

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Introduction

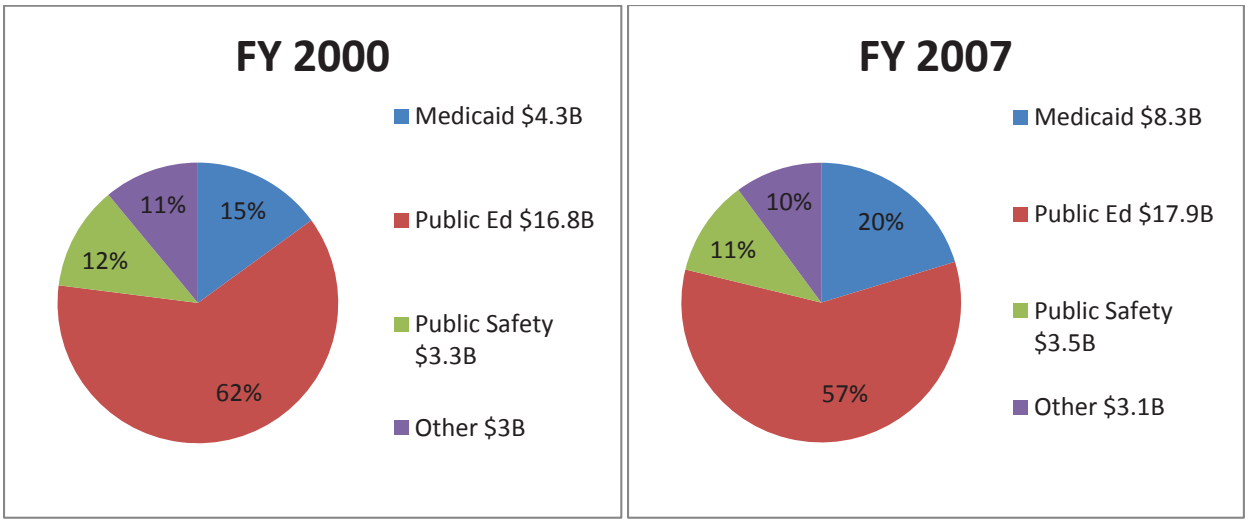
Medicaid, established under the Social Security Act of 1965, is the government-sponsored health care delivery program to the nation's indigent. It is a dually funded, state administered, federal entitlement welfare program for health care. Though participation in Medicaid is optional for a state, once in, benefits and eligibility are not. Therefore, the state's obligation to pay for Medicaid is set by the federal government.

Medicaid has grown consistently since its inception, both in size and scope. Numerous efforts to curtail its growth have failed. It is currently the second largest program in the state budget and serves 3.3 million Texans.[1] Legislative Budget Estimates (LBE) recommended that Health and Human Services should consume 26.8 percent of General Revenue Expenditures (GRE) for the 2010-11 biennium.[2]

Future prospects for Medicaid funding are bleak. The Patient Protection and Affordable Care Act (PPACA of 2010, known as ObamaCare) adds considerable stress to the program while removing the state's ability to adjust to the changes. Under the most conservative estimate of the impact of the PPACA, the next decade will see Medicaid costs triple. The first 10 years of full implementation, which begins in 2014, Medicaid is slated to cost the state an additional $31 billion to $38 billion of general revenue (GR).[3]

One might conclude from these numbers that Medicaid can be fixed by repealing the PPACA, but both history and the projected costs tell a different story. Medicaid's recent growth, in relation to the rest of the budget, is exhibited in **Figure 1**.

Figure1: Medicaid in Relation to Total General Revenue Spending, FY 2000-2001



Source: Texas Legislative Budget Board, "Legislative Budget Estimates" website (23 Nov. 2010)

To continue the program as currently structured, the state must immediately raise taxes or cut other programs to make room for Medicaid's growth.

Medicaid's growth rate is simply unsustainable. The program threatens to bankrupt the state. Even without the PPACA, Medicaid costs will double every 10 years, growing to $38.3 billion in the 2020-21 biennium; $72.5 billion in 2030-31; and $144.5 billion in 2040-41. To continue the program as currently structured, the state must immediately raise taxes or cut other programs to make room for Medicaid's growth. Neither of these alternatives is acceptable.

An Historical Perspective (1987-2000)

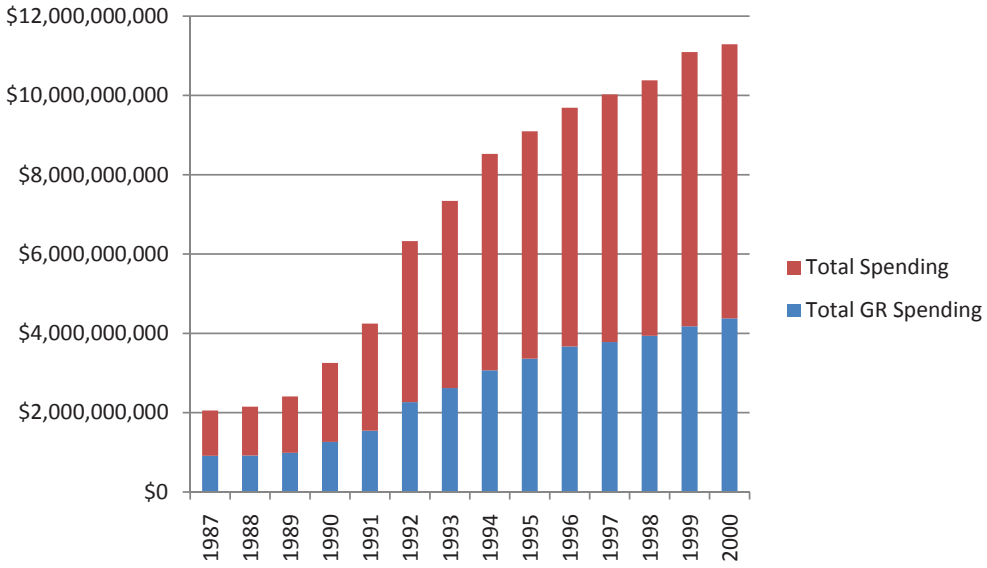
Ever since 1967, when Texas established its own Medicaid program, Medicaid spending has grown consistently year after year. **Figure 2** exhibits the total Medicaid spending in Texas on an annual basis from 1987 to 2000.

Medicaid increased from 7 percent of the GR budget in 1987 to 14.9 percent of the GR budget in 2000.[4] During this same period, while public education spending grew by 122 percent, Medicaid funding increased by over 600 percent.[5] Medicaid during the '90s grew faster than any other program—not once declining on an annual basis. Most government assistance programs, such as welfare, decline in cost and caseload during times of economic boom. But even during the economic upswing of the late 90s, Medicaid continued to grow, far outpacing population and inflation growth. Largely, this was due to the expansion of Medicaid in 1988 to income levels above that of the Temporary Assistance to Needy Families (TANF) population. This new clientele, along with the original population, increased both the caseload and the cost.

This vast growth invited two notable attempts to limit it. In 1989, the National Governor's Association (NGA) issued the "Resolution on Health Care." This accompanied a letter to Congress requesting a two-year freeze on all future expansions of Medicaid eligibility. The governors noted Medicaid's impact on their budgets. President Bill Clinton vetoed the bill containing the Medicaid reform measures. The governors' concerns were ignored as the 1990s experienced some of the largest expansions to Medicaid, including the Medicaid-lite Children's Health Insurance Program for middle class children.

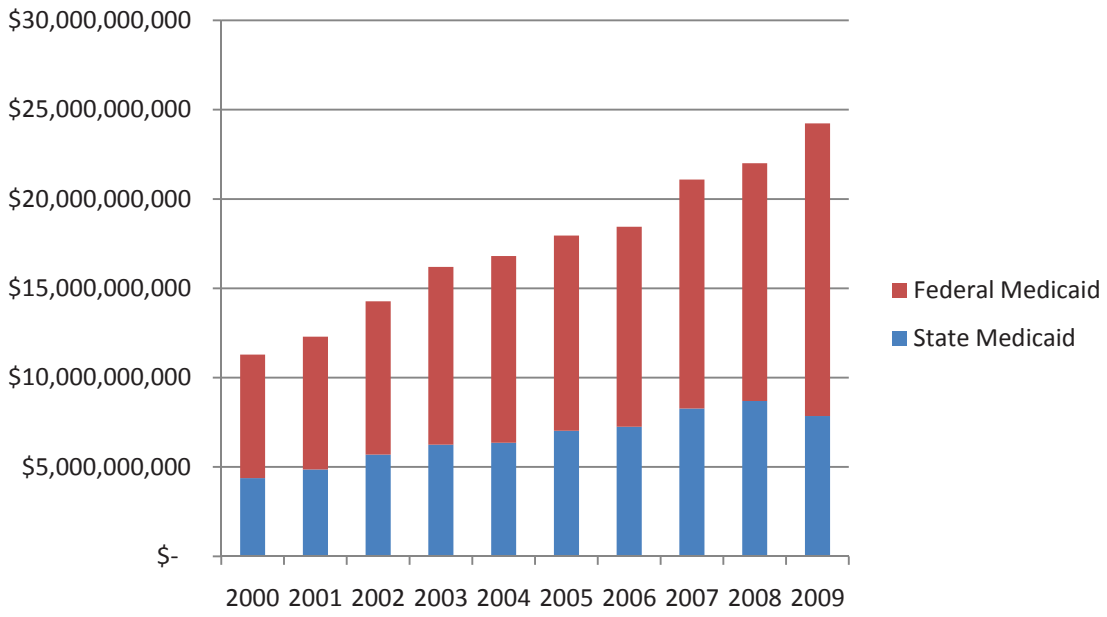
In 1995, Congressional Republicans pushed their reform package titled "Medigrants." It, too, was vetoed by President Clinton. "Medigrants" would have block-granted Medic-

Figure 2: Annual Medicaid Spending, 1987-2000



Source: Texas Legislative Budget Board, "Legislative Budget Estimates" website (23 Nov. 2010)

Figure 3: Total Medicaid Spending with DSH/UPL, 2000-2009



Source: Texas Legislative Budget Board, "Legislative Budget Estimates" website (23 Nov. 2010)

aid financing while removing many of the federal strings attached. This package would have been a step towards fiscal sustainability and state flexibility. In the end, the federal government left Medicaid out of its welfare reform measures. Medicaid costs increased an average of 22.4 percent per year during the 90s.

Current Situation (2000-2009)

Medicaid spending in the last decade has risen sharply. Figure 3 shows the total Medicaid spending in the state annually since 2000.

Between 2000 and 2009, Medicaid's total budget grew 114 percent[6] due to economic downturns and federal stimulus programs. Over the same period the state's general revenue budget experienced a growth of only 79.3 percent,[7] with the percentage going to Medicaid growing from 15 percent in 2000 to 21 percent in 2008.[8] This percentage would have been even higher if not for the American Recovery and Reinvestment Act (ARRA) which allowed the state to spend fewer of its own dollars by substituting federal dollars. However, state general revenue will again be required once ARRA funds run out. Whatever its funding sources, Medicaid over the last decade has grown enormously. The forecasted costs of this program must be addressed.

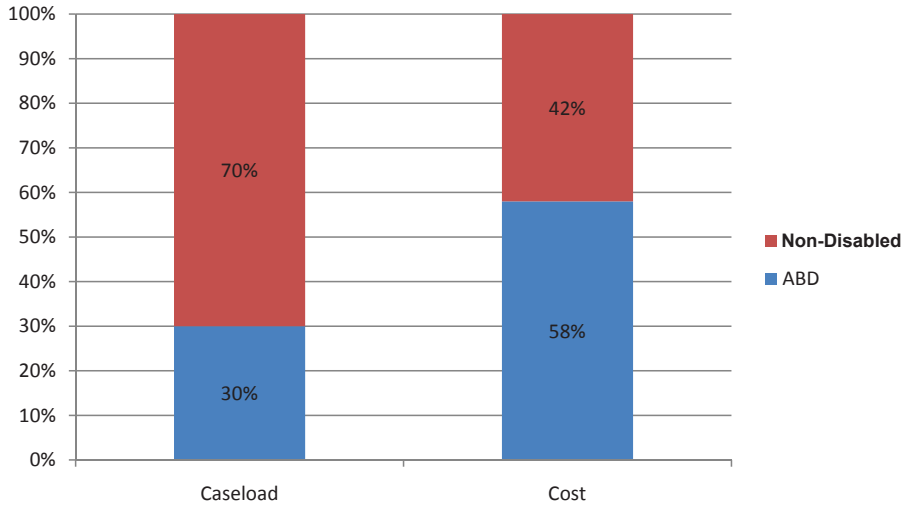
Where Are We Spending Our Money?

Medicaid spending is divided roughly in two categories of eligibility. The first is the traditional population, primarily low-income women and children. The second is the long term care (LTC) population, comprised of the aged, blind, and disabled (ABD). These populations have unique costs and concerns.

The non-disabled population, made up of families, women, and children is generally eligible under different classifications of income level. Many of these clients are healthy, needing more basic acute and preventative care than the ABD population.

The biggest difference between these two populations is the services provided. The ABD population consists of clients with often complex conditions that require long term care plus a multi-faceted treatment approach that includes everything from preventative screenings to institutional care to hospice care. **Figure 4** (next page) shows the two populations' current respective caseloads and costs.

Figure 4: Caseload and Costs of Low Income and ABD Populations



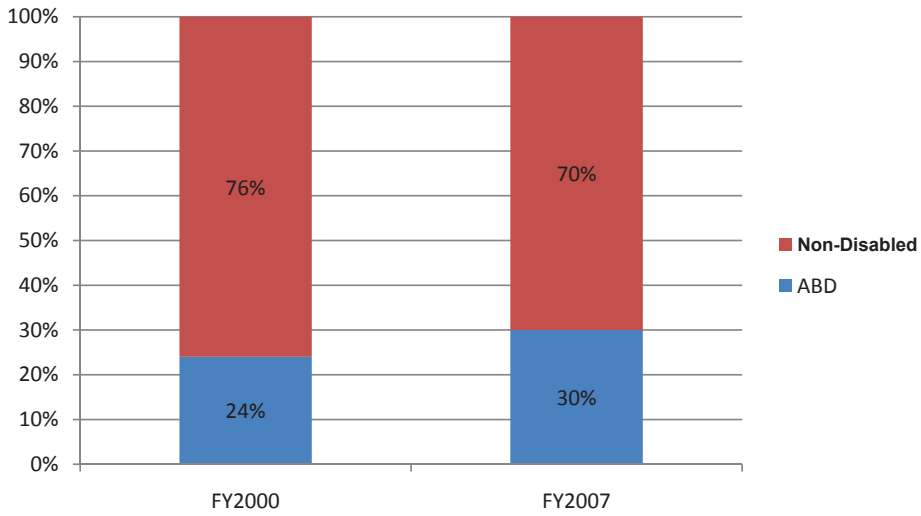
Source: Medicaid Caseload and Cost Dynamics Report

While the non-disabled population comprises two-thirds of the caseload, it accounts for less than half the costs. Conversely, the ABD population, at 30 percent of the caseload, consumes almost 60 percent of the Medicaid cost. The residential, institutional, or community based services required by this population are expensive, and the state's aging citizenry means these costs will be growing in proportion. **Figure 5** illustrates the effect is already being felt.

ABD is also the most expanded category of eligibility in all of Texas Medicaid. Federal law requires that the state cover up to 74 percent of the Federal Poverty Limit (FPL), but the state has increased the eligibility level to 220 percent of FPL, higher than for any other group.[9]

The expense will become more burdensome as the statewide population of nursing home residents triples from

Figure 5: Caseload Percentages, FY 2000-2007



Source: Texas Health and Human Services Commission, "Texas Medicaid and CHIP in Perspective: Fourth Edition" (April 2002)

Figure 6: Average Monthly Cost by Eligibility Category, 2000-2007

Source: Texas Health and Human Services Commission, "Texas Medicaid and CHIP in Perspective: Seventh Edition" (29 Jan. 2009)

101,000 in 2010 to a projected 309,000 in 2040.[10] In order to continue providing long term care, the state must find a way to slow the growth of the costs associated with the ABD population.

Financed through dozens of programs and waivers, Medicaid spending has risen across the board. **Figure 6** shows the increase in monthly costs by eligibility category between 2000 and 2007.

Effect on the Rest of the Budget

As Medicaid has grown, the rest of the budget has suffered. In 2000, Medicaid accounted for 17 percent of the state's general revenue budget; in 2007 for 22 percent. At the same time, public education's share dropped from 62 percent to 57 percent. Public safety's portion dropped from 12 percent to 11 percent.[11]

From 2000 to 2008 state funding for Medicaid rose 98.5 percent[12]—more than three times the rate for population and inflation. In 2009, Medicaid costs averaged $370 per Texas resident, an increase from $253 in 2000.[13] When broken down by household the Medicaid burden is even heavier: $808 per household in 2009 vs. $537 in 2000.[14] This 2009 average is likely underweighted considering the addition of ARRA funds that increased the amount of the federal contribution. However, since these funds are set to run out in 2011, the burden on Texas households will be significantly greater in the next biennium.

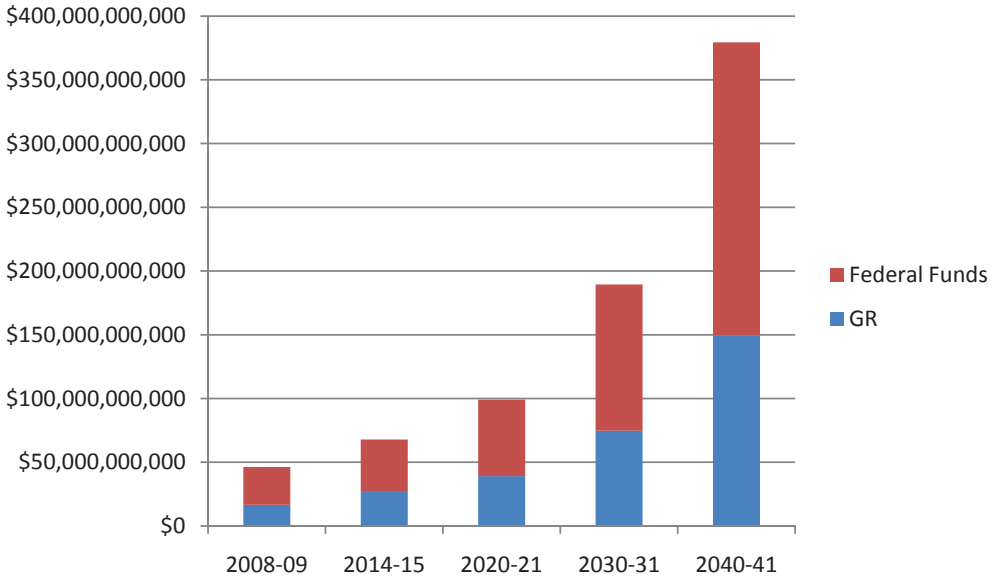
Medicaid's structure prevents any meaningful cost sharing. Those on Medicaid are covered 100 percent at all levels of eligibility; there is no sliding scale, no co-payments, and no premium payments. Because of this all or nothing structure, those who could share a portion of the burden are not allowed to do so.

Heavy as Texas has found Medicaid's past burdens, the weight could soon become crushing.

The Future of Medicaid

The implications of a perpetually growing Medicaid program are deeply disturbing. In *Final Notice: Medicaid Crisis*, Dr. Jagadeesh Gokhale forecasts that Medicaid, under the PPACA, will consume 46.6 percent of the all funds budget by the 2014-15 biennium. Even without the PPACA, Medicaid becomes 30.8 percent of the all funds budget and 23.3 percent of the general revenue budget. **Figure 7** (next page) shows the program's growth through 2040 without the PPACA.

Figure 7: Total Medicaid Spending, 2008-2040



Source: "Final Notice: Medicaid Crisis"

Medicaid's size along with its costs is also expected to grow.[15] Even before ObamaCare, Medicaid caseloads were forecast to increase to 5.3 million in 2014; projections now call for 8.4 million, an 88 percent increase. Again, due to the all or nothing structure of Medicaid eligibility, the more people on Medicaid the greater the burden to the rest of Texas.

One thing to note is that ObamaCare covers the full cost for newly eligible Medicaid recipients only for the first three years and then reduces that amount to 92.8 percent over the next three years. Due to the precarious nature of the federal budget it is unlikely that such a high FMAP will be maintained indefinitely. Far more likely is an FMAP readjustment back to current levels after the initial period provided for in the bill, which ends in 2029.

The Rest of the Budget

Already Medicaid's growth is starting to impinge upon vital programs such as education and public safety. By the 2040-41 biennium, as shown in **Figure 8 (next page)**, Medicaid will have become the State of Texas' principal service to voters and taxpayers; this reality will not be an anomaly unique to Texas.

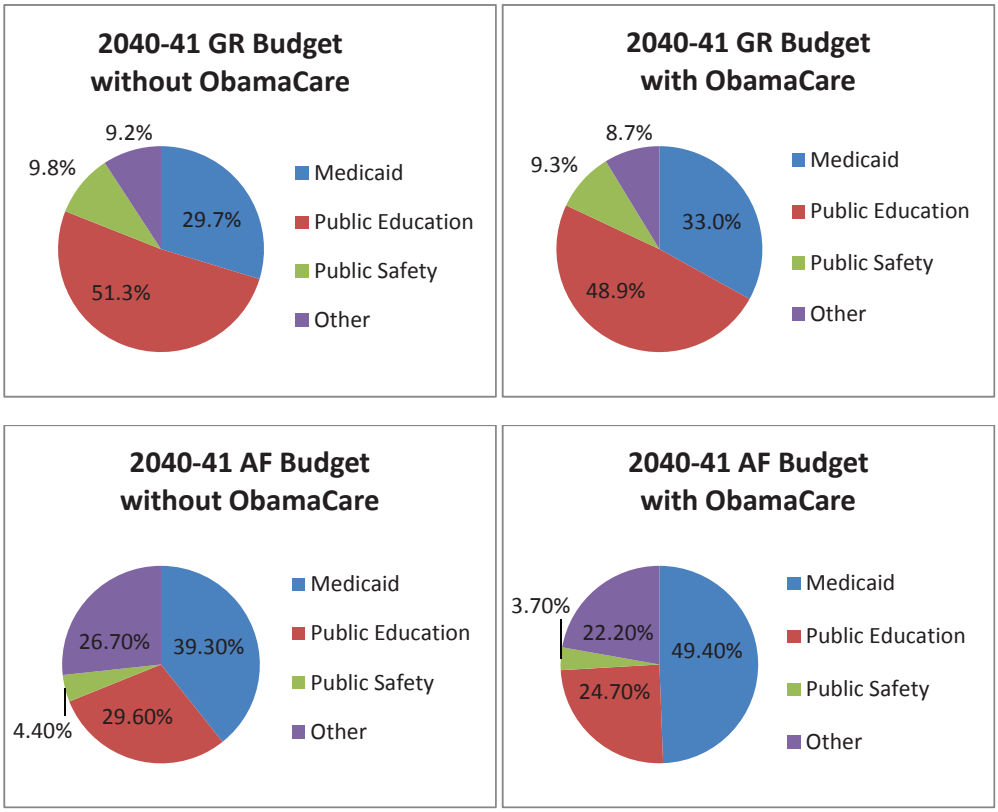
The projections in Figure 8 assume that the budget areas outside of Medicaid remain the same proportional size in relation to the rest of the budget.* Were the total dollars in the general revenue budget to remain the same, in just two decades Medicaid would consume it all—even without ObamaCare.[16] If ObamaCare remains in effect, the dread day, where Medicaid is the principal program of Texas, will come even sooner.

Burden on Texans

The scenario that Texas forsakes all of its constitutional duties for the sake of Medicaid is inconceivable. Likelier, the state would raise taxes to cope with rising Medicaid costs. Currently, Texas spends just over $1,600 per household per biennium on Medicaid.[17] By 2020-21, that cost—without ObamaCare—becomes $3,179, a figure that grows to $4,723 in 2030-31 and $7,457 in 2040-41.[18] This means that even if ObamaCare were repealed, Medicaid costs to Texans would double over the next 10 years and continue to double for each of the next two decades. The difference between Medicaid's tax burden with ObamaCare and without is slight compared with the overall cost of the program.

* For example, if education is 70% of the non-Medicaid budget in 2008-09, it remains 70% of the non-Medicaid budget after ObamaCare in 2040-41 for this calculation.

Figure 8: General Revenue and All Funds Budget Projections, 2040-2041 Biennium



Source: Author's Calculations based on: "Final Notice: Medicaid Crisis," Dr. Jagadeesh Gokhale. Texas Public Policy Foundation (2010) and Texas Legislative Budget Board, "Legislative Budget Estimate (2000-2007)

With ObamaCare, the burden per household would grow to $8,277 in the 2040-41 biennium.[19] **Figure 9** (page 10) shows this growth over time.

This added tax burden would likely come from an increase in state sales tax. In order to cover the added $10 billion needed for Medicaid by 2014-15, without ObamaCare and without offsetting budget cuts, the Legislature would have to add over 3 cents to the sales tax. If ObamaCare stands as is, the state would need to enact a 4.5 cent increase to the state sales tax. This sales tax increase would need to be implemented during the 82nd legislative session in order to generate the necessary revenue in time. This would leave Texas with the highest average sales tax burden in the nation.*

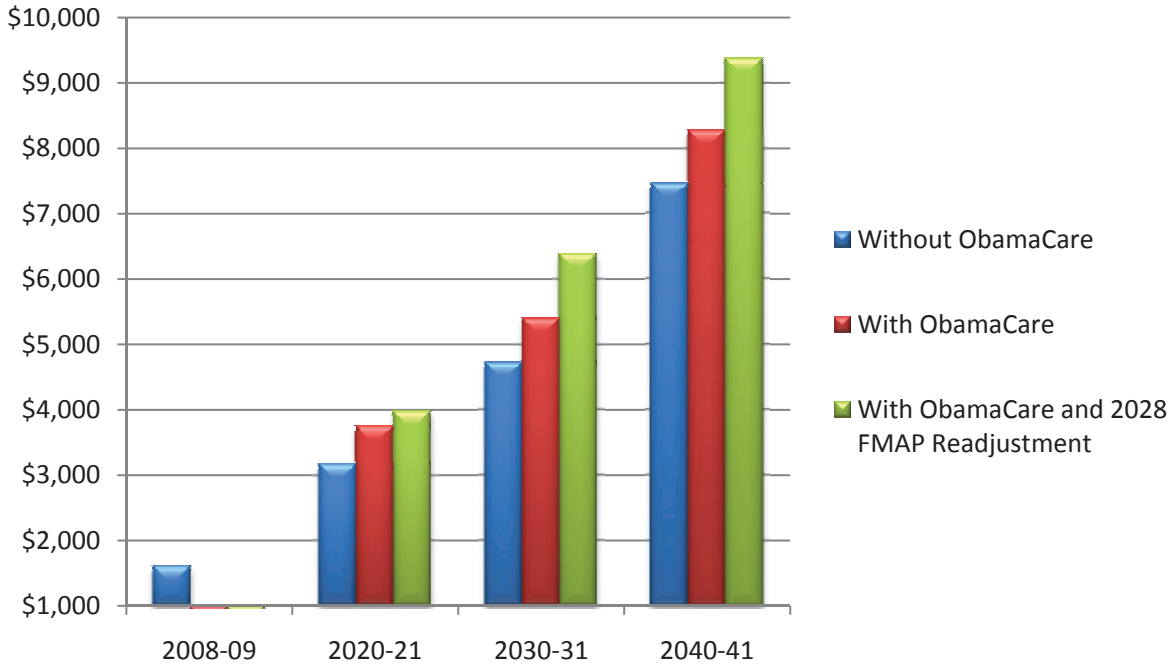
Currently, Medicaid constitutes 28.2 percent of our total budget. If it could be kept at the same percentage of the budget, there would be significantly more money for other services. Instead, by 2040-41 there will be $155.9 billion less for education, $21 billion less for public safety, and $26 billion less for business and economic development.†

Texas' education funding has also grown faster than population and inflation. Over the past 20 years, the number of workers in public education has increased 71.5 percent. Were this trend to continue over the next two decades Texas would add 462,472 new teachers, principals, and support staff, requiring $29.7 billion of additional funding for education. This assumes no across the board pay raises for

* For every 1 penny in sales taxes levied against consumers, the state collects $3.1 billion in net revenue. In theory, were the state's sales tax rate to increase by the amounts listed above, and assuming no changes in aggregate demand or consumer spending habits, then billions in additional revenue could be generated in this manner.

† Numbers were calculated by assuming program levels would stay in their respective proportion of the current budget, and those levels were divided against Dr. Gokhale's total projected budget in *Final Notice: Medicaid Crisis*.

Figure 9: Household Tax Burden per Biennium, 2020-2040



Source: Author's Calculations based on Texas State Demographer's Projections and "Final Notice: Medicaid Crisis" and Steve Murdock, "The Texas Challenge in the 21st Century: Implications of Population Change for the Future of Texas" (Dec. 2002)

If Texans wish to maintain Medicaid as currently structured, they must be prepared for a sales tax increase of 3 to 4.5 cents or significant budget cuts to other government programs.

school professionals. A $1,000 raise over this period would increase that amount by an extra $1.1 billion in current dollars, bringing the total to $30.8 billion needed. Not only will such growth money not be available, but existing funding will be cut because of the Medicaid entitlement obligation.

Conclusions

Medicaid is growing at an unsustainable rate. If Texans wish to maintain the program as currently structured, they must be prepared for a sales tax increase of 3 to 4.5 cents or significant budget cuts to other government programs. However, Texas can and should look at alternatives. The Medicaid program is too large and comprehensive to tweak here and there to create meaningful reductions. Though doing so will present tremendous challenges, the state must totally restructure the program to bend the growth curve down. The Foundation will soon release our next paper examining alternatives to the present structure of Medicaid in Texas. ✯

Endnotes

[1] Texas Health and Human Services Commission. "Medicaid Enrollment by Month Completed Count," 19 Nov. 2010.
[2] The State of Texas, Legislative Budget Board, "Legislative Budget Estimate 2000-2007," 23 Nov. 2010.
[3] Dr. Jagadeesh Gokhale, "Final Notice: Medicaid Crisis," Texas Public Policy Foundation, Dec. 2010.
[4] Texas Legislative Budget Board, "Legislative Budget Estimate" website, 23 Nov. 2010.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Texas Health and Human Services Commission, "Texas Medicaid and CHIP in Perspective: Seventh Edition," 29 Jan. 2009.
[9] Ibid.
[10] Texas State Data Center, Office of the State Demographer, "Number of Nursing Home Resident and Total Monthly Costs," 23 Nov. 2010.
[11] Texas Legislative Budget Board, "Legislative Budget Estimate," 23 Nov. 2010.
[12] The State of Texas, "General Appropriations Act of 2000-2010," 81st Legislature, 2009.
[13] U.S. Census Bureau, "Texas Population Estimate" 2009.
[14] Ibid.
[15] Gokhale, "Final Notice: Medicaid Crisis."
[16] Ibid.
[17] Ibid.
[18] Author's calculation based on U.S. Census Bureau, "Texas Population Estimate" 2009; and Gokhale, "Final Notice: Medicaid Crisis," Texas Public Policy Foundation, Dec. 2010.
[19] Ibid.

About the Authors

Arlene Wohlgemuth is Executive Director and director of the Foundation's Center for Health Care Policy. She served 10 years as a state representative for district 58. During the 77th legislative session, she served as chairman of Appropriations Article II Subcommittee (Health and Human Services), vice-chairman of Calendars, CBO for Human Services, and member of the Select Committee for Health Care Expenditures. Wohlgemuth authored HB 2292, the sweeping reform of Health and Human Services which improved service delivery for the recipients, saving taxpayers more than $3.7B during its first five years. The reforms consolidated 12 agencies into five and was the largest government reform bill ever passed in the state.

Spencer Harris joined Texas Public Policy Foundation in 2010 as a Health Care Policy Analyst. His research focuses on identifying patient-centered, free market solutions for our state's health care challenges. No stranger to Texas public policy, Harris worked in the House of Representatives for Rep. Warren Chisum where he covered health care issues, immigration issues, and the Licensing and Administrative Committee. Harris is a native Texan, born and raised in Houston. He graduated from Texas A&M University with a degree in History and Anthropology.

Texas Public Policy Foundation

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