

## SPECIAL COMMENT

# Healthcare Reform Expected to Create Longer Term Financial Pressure for States

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**Introduction**

On March 23, 2010, President Obama signed into law healthcare reform legislation that will overhaul payment mechanisms for the U.S. health care system over the next decade. The biggest potential credit impact for states will be the expansion of Medicaid eligibility, although it does not take effect until 2014. Federal subsidies to states will cover 100% of the additional costs of those who are newly eligible through 2016. As a result, the near-term budget implications related to Medicaid expansion appear minimal for most states. However, states will not receive additional support to cover those who are currently eligible for but not served by Medicaid and these expenses could hit state budgets as early as 2014. State and federal government officials are in the early stages of absorbing the details of the healthcare reform package, especially its cost implications. Since many states are still reeling from the fiscal challenges of the Great Recession, the federal government's near-term coverage of the newly eligible Medicaid population provides some breathing room. Over the longer term, we expect these costs to become financially burdensome to states, especially those that will experience proportionately larger increases in their eligible Medicaid population, including childless adults who are not currently covered in 39 states. States may also face higher administrative costs that come with increased coverage, the creation and regulation of state insurance exchanges, regulation of products and rules within exchanges, and enforcement of individual or employer mandates. A decline in state funding for charity care is expected to partially offset anticipated state costs.

## Highlights of the Healthcare Reform Act

The 2010 healthcare reform bill represents the first significant change in the country's health care payment system since Medicare was adopted in 1965. The bill includes the following major provisions:

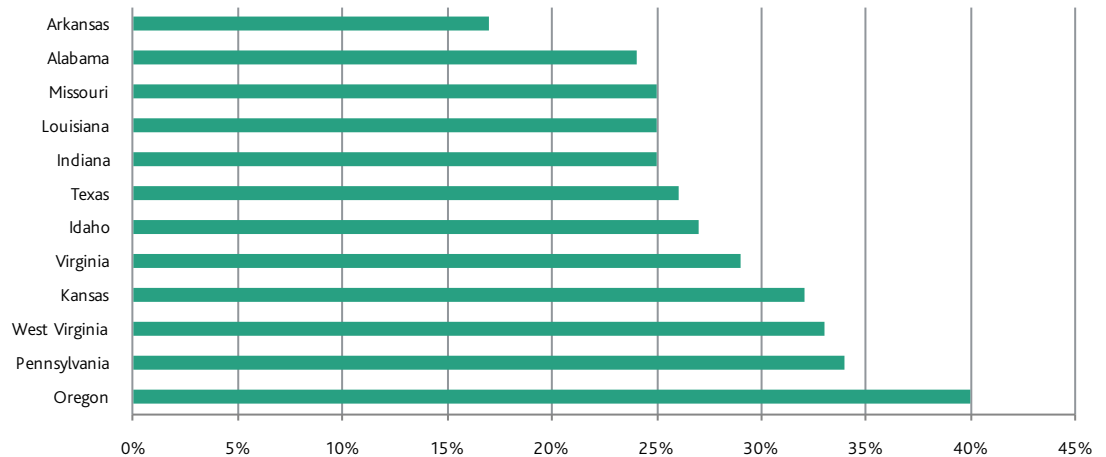
- » Expands Medicaid eligibility up to 133% of federal poverty level (FPL), beginning in 2014; childless adults, previously excluded from Medicaid, to be covered
- » Federal coverage of 100% of new Medicaid costs from 2014 through 2016, dropping gradually to 90% in 2020 and maintained at that level
- » Increases Medicaid provider rates for primary care services for 2013 and 2014 with 100% federal funding
- » Reduces Medicaid Disproportionate Share Hospital (DSH) allotments in 2014
- » Mandates that most Americans buy health insurance, beginning in 2014, through their employers or state specific exchanges; penalties for non-compliance
- » Insurance cost assistance through tax credits or federal subsidies for low income households (between 133% and 400% FPL)
- » Ban on policy cancellations, exclusion of individuals with pre-existing conditions, and lifetime coverage limitations
- » Employer (50 or more workers) responsibility to offer health insurance
- » Adult uninsured children can be covered under parent's insurance up to age 26

## Healthcare Reform Expected to Increase Costs for States in Long Run

The most significant effect of healthcare reform on states will be the mandatory level of Medicaid eligibility set at up to 133% of the FPL and the expansion to include childless adults, beginning in 2014. Federal subsidies will cover 100% of the incremental expenses of those who are newly eligible through 2016. Thus, state budgets will temporarily be spared these additional costs, although state administrative costs are likely to rise in the near term as the number of people served by Medicaid increases. Beginning in 2014, states will also be responsible for covering the costs of those who are currently eligible for but not served by Medicaid. Given the fiscal damage of the recession on state budgets, these additional costs may be difficult to absorb even a few years from now when implementation of the reform measures begin.

Over time, state Medicaid spending will grow as the federal coverage of newly eligible Medicaid recipients is phased down to 90% by 2020. States that are currently funding Medicaid at levels that are well below the FPL will experience proportionately larger increases in Medicaid costs. The average level of Medicaid eligibility for working parents across states is 64%, slightly less than half the 133% FPL level mandated by the healthcare reform act. In 12 states, Medicaid eligibility is below 44% FPL, one-third of the newly mandated level. (Figure 1) Childless adults are currently covered in only 11 states through Medicaid waivers or state funded health programs.

FIGURE 1

**State Medicaid Eligibility for Working Parents (% FPL)**

Source: Kaiser Family Foundation

It is important to note that the 10 states that already provide Medicaid at or above the eligibility requirement will not benefit from the incremental new federal funding for this segment of the population. However, their Medicaid costs will not increase dramatically as a result of this aspect of healthcare reform. These states and current eligibility levels for working parents are shown in Figure 2. Many of these states are known as “expansion states” because they already offer healthcare coverage to childless adults. These states will receive phased-in federal funds for this population so that they are receiving the same federal funding (93%) as other states by 2019. This may create savings in states that are not currently receiving a federal match for childless adults through a waiver program. The expansion states are: Arizona, Delaware, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington, and Wisconsin. The majority of states do not currently offer healthcare for childless adults, and the eligibility expansion to this population could add substantial costs in some cases, especially once the additional federal funding is phased down to 90% from 100%.

FIGURE 2

**Current State Medicaid Eligibility Levels [1]**

STATE	% FPL
Minnesota	215%
Maine	206%
New Jersey	200%
Wisconsin	200%
Connecticut	191%
Vermont	191%
Illinois	185%
Rhode Island	181%
New York	150%
Massachusetts	133%

Source: Kaiser Family Foundation

[1] For working parents

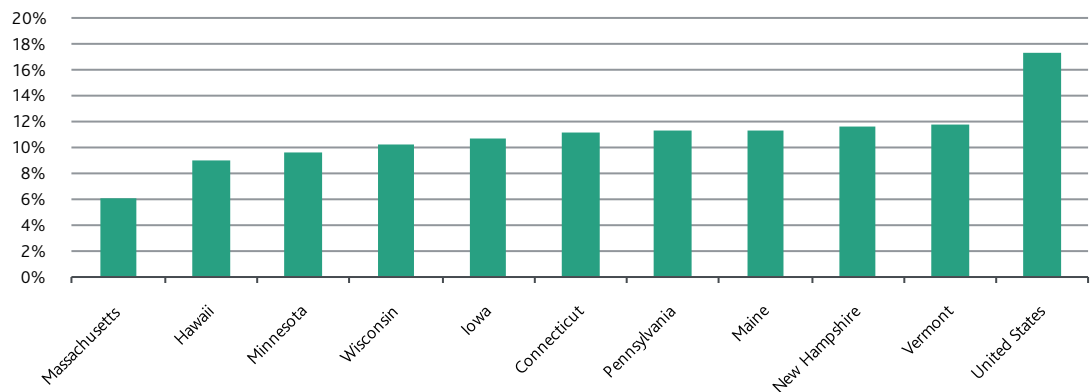
One positive for states on the spending side is the expected reduction in charity care costs. As more people are covered by health insurance through their jobs, new health insurance exchanges or Medicaid, the need for free care should diminish. However, the need for charity care is not expected to be completely eliminated as some people may still not qualify for insurance and illegal immigrants will not benefit from the legislation. A few states that piggy-back on the federal income tax calculation will also receive additional revenues from the increase in capital gains taxes for high income earners. These revenues along with higher Medicare tax rates for wealthier taxpayers will help pay for healthcare reform.

### Ability to Handle Increased Costs Will Vary Among States

States come to healthcare reform offering varying levels of health care coverage. Some states, including several in the Northeast and Midwest, already have expanded eligibility for public health insurance programs for working parents at or above the 133% FPL required by healthcare reform. As a result, the working parent Medicaid eligible population in these states is not expected to expand directly as a result of the reform. Many of these states also have a higher proportion of their population with incomes above 400% FPL, thereby providing another limitation on Medicaid eligibility in those states. In addition, some Northeast and Midwest states have higher employer coverage and below average overall uninsured rates, resulting in a lower incremental number of people that will need to be served under the new healthcare mandates. (Figure 3)

FIGURE 3

#### States – Lowest % Uninsured Rates



Source: Kaiser Family Foundation

Medicaid already represents an average of 20% of total state spending. In the latest recession, Medicaid rolls grew as job losses mounted, enabling more people to qualify for healthcare assistance through the program. This added spending pressures to states that were already challenged to balance their budgets, although a temporary increase in the Federal Medical Assistance Program (FMAP) match provided significant solutions to operating deficits in many cases. If revenue recovery is slow, states will have a hard time replacing the one-time federal revenues to maintain their Medicaid programs. In fact, many states are counting on an extension of additional FMAP funds for their fiscal 2011 budgets. Based on current forecasts most states should be well into recovery by the time healthcare reform costs begin to affect budget decisions. However, given the uncertainty of the strength and timing of the economic recovery, especially in regions that were hard hit by the latest recession, many states will be challenged to accommodate the healthcare reform provisions.

## State Insurance Exchanges Add Budget Pressure

One key feature of the reform legislation is the availability of healthcare coverage to those who are currently uninsured and ineligible for Medicaid, even following the expanded eligibility levels. This population, excluding illegal immigrants who will not benefit from healthcare reform, will be covered by state-based insurance exchanges through which small business and individuals can purchase health insurance. States will also be permitted to form regional exchanges or allow one to operate in a state as long as each exchange serves a distinct geographic area.

Federal funds will be available until January 1, 2015 to help states establish these exchanges. However, state administrative costs will increase to cover a variety of new management expenses associated with the exchanges: enrollment mechanisms, eligibility determination, transparency regarding plan provisions, premium costs, and covered benefits, and coordination between the exchanges and state insurance departments.

## States Challenge Healthcare Reform

Attorneys General in 14 states have joined a lawsuit challenging that the healthcare legislation violates the 10th Amendment of the Constitution because it requires nearly all Americans to buy health insurance. The governors of the states that have filed are not all in agreement with these actions. The outcome is far from clear, and the challenge is not likely to be debated or resolved in the immediate future as the federal government and states are in the early process of clarifying the legislation that was passed.

## Federal Government to Cover Major Costs, Initially

The Congressional Budget Office (CBO) has estimated the healthcare reform costs for the federal government at about \$940 billion over the next decade. These expenses will be offset by a new excise tax on high-value employer sponsored health insurance plans as well as increased Medicare payroll taxes and taxes on capital gains for high income earners. In addition, beginning in 2012, new annual fees will be imposed on the pharmaceutical manufacturing industry, and in 2014 annual fees will be collected from the health insurance sector.

On the expense reduction side, Medicare benefits will be reduced by \$500 billion over 10 years, including approximately \$132 billion in cuts to Medicare Advantage plans that provide supplemental coverage. Effective in 2014, Medicare Disproportionate Share (DSH) payments will initially be reduced by 75% and subsequently increased, based on the percentage of the population that is uninsured and the amount of uncompensated care provided.

The CBO projects that the net result of healthcare reform will be a \$143 billion reduction in the federal deficit over the next decade.

## Conclusion

The healthcare reform legislation that was enacted in March 2010 represents the biggest change in the delivery and payment of health care in the United States in the last four decades. The federal government will initially shoulder the burden of increased costs due to increased Medicaid eligibility. However, the administration of expanded Medicaid programs may add near-term costs in some states. States may also have additional expenses for people who are now Medicaid-eligible but not enrolled in the program. As federal funding begins to decline in 2017, state costs will increase most where Medicaid eligibility is currently well below the now mandated 133% FPL and in states with large numbers of childless adults who are not currently covered. States can also expect expenditure increases to establish health insurance exchanges although charity care costs will be lower as more residents are covered by Medicaid or their own insurance. A delayed and/or modest economic recovery would pose additional budget challenges just when states begin to feel the impact of healthcare reform.

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