THE IMPACT OF THE AFFORDABLE CARE ACT ON MEDICAID FINANCING BETWEEN NATIONAL AND STATE GOVERNMENTS

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ABSTRACT

The passage of the Patient Protection and Affordable Care Act (ACA) will have significant impact on how Medicaid is financed between national and state governments. Medicaid is a national program aimed at providing insurance coverage for low-income individuals and administered by state governments. The financing of Medicaid is an open-ended categorical matching grant program based on a formula called the Federal Medical Assistance Percentage (FMAP) where the national government will provide at least 50% of funds for each state's Medicaid program. Demographic changes and list of optional services each state selects to include in their program are critical spending determinants. The ACA expands Medicaid to individuals below 138% of the poverty line with the national government funding the expansion in full from 2014-2016 until funding is reduced to 90% by 2020. 29 states and the District of Columbia have expanded Medicaid coverage. Despite Medicaid expansion providing more low-income individuals with health insurance, the intergovernmental transfers and Certified Public Expenditures (CPEs) utilized within each state attempts to reduce the individual state's funding responsibilities and increase national funding obligations. The ACA's increase in national funding appropriations of Medicaid expansion endorses states actions to continue to decrease their funding rates. Hence, the ACA could generate unsustainable national Medicaid funding responsibilities and produce an inefficient and ineffective program. A provision limiting state's utilization of intergovernmental transfers and CPEs and strict application of national funds on Medicaid alone is recommended.

INTRODUCTION

In 1965, Congress passed Title XIX of the Social Security Act, which created Medicaid and Medicare.[1] Medicaid was established to provide medical insurance coverage for individuals at or below the poverty line.[2] This paper will provide a background of Medicaid, examine the Medicaid financing structures between national and state governments, and discuss the impact of the Patient Protection and Affordable Care Act (ACA) on Medicaid with particular emphasis on a fiscal analysis. In addition, provisions to ACA to monitor states utilization of inter-governmental transfers and Certified Public Expenditures (CPEs) and strict application of national funds for Medicaid expenditures solely are recommended.

MEDICAID

Background

Medicaid provides insurance coverage to individuals who cannot afford private insurance through an employer or the non-group market and to Medicare recipients who need additional assistance with premium and co-payment or co-insurance payments; particularly, long-term care.[3] While private insurance and Medicare do not cover nursing home and similar services, Medicaid provides these services for three out of five nursing home residents and accounts for 40% of the total spent on long-term care in the United States.[4] Most importantly, Medicaid cannot have an enrollment cap or waiting list. Despite states administering the Medicaid program, the national government asserts that certain core groups must be covered to receive national funding.[5] The core groups include "pregnant women, children, parents, elderly individuals, and individuals with disabilities with income below specified minimum thresholds."[6] States do have the option to expand the core group for their respective Medicaid programs, but only citizens and some lawful immigrants are eligible for Medicaid.

Coverage Demographics

Medicaid provided coverage to over 62 million individuals in 2012, including 70% of children, 40% of parents under the poverty line, 41% of all births, 50% of all individuals with HIV, 45% of the non-elderly below the poverty line and 27% of the non-elderly between 100% and 199% above the poverty line.[7] However, there is variation among the states in the income eligibility for working parents among the states. For instance, the income eligibility level for working parents in Arkansas is 16%, but in Minnesota, it is 215%.[8]

1 The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer* (The Henry J. Kaiser Family Foundation, 2013), 3.
2 Kaiser, *A Primer*, 3.
3 Ibid., 3.
4 Ibid., 4.
5 Ibid., 7.
6 Ibid., 7.
7 Ibid., 8.
8 Ibid., 9.

Covered Items

As a condition for receiving the national matching rate, states are obligated to provide coverage for the following items: physician services, inpatient and outpatient hospital care, laboratory and x-ray services, early screenings, diagnostics, and treatment for people under 21 years old, rural and federally approved health center/clinic services, family planning services and supplies, pediatric and family nurse practitioner services, nurse midwife services, nursing facility services for those 21 and over, home health care for eligible population, and transportation services.[9] Additionally, states can and do choose to expand the basket of services covered to meet the demands and preferences of their populations. Most states have similar lists of additional items covered, including such services as dental care, rehabilitation and other therapies, case management, hospice services, personal care services, prosthetic devices, eyeglasses, and medical equipment.[10]

Medicaid operates similar to an insurance company that happens to cover lower income individuals – it is not a provider of health care services but a publicly backed financier. The program pays for services on a fee-for-service basis, as part of a managed care organization or a combination of both. The two predominant models are managed care organizations (MCOs), which pay providers monthly to provide a basket of defined services, and primary care case management (PCCMs), which pay primary care physicians monthly a per-enrollee fee for managing Medicaid patients.[11]

MEDICAD FINANCING STRUCTURE

Medicaid Costs

In 2013, Medicaid covered 68 million low-income individuals at a total cost of $413.7 billion, excluding administrative costs.[12] In 2010, Medicaid expenditures accounted for 15.5% of all health care spending in the U.S.[13] The national government covered 56.6% of total costs and states covered the other 43.4% (31.6% from general funds and 11.8 % from other state funds).[14]

Partnership of National and State Governments

Medicaid is funded as a partnership between the national and state governments. The national government provides matching grants based on a formula called the Federal Medical Assistance Percentage (FMAP).[15] Individual state per capita income levels relative to national income per capita determines the FMAP. States that have reduced fiscal capacity receive higher matching grants whereas states with higher income per capita levels have lower matching rate (with a floor of 50% and cap of 83%). For example, Mississippi has the lowest income per capita and received 73.43% of Medicaid funding from the national

9 Ibid., 13.
10 Ibid., 14.
11 Ibid., 16.
12 The National Association of State Budget Officers, *State Expenditure Report* (Washington, D.C.: The National Association of State Budget Officers, 2014), 46.
13 Alison Mitchell, *Medicaid Financing and Expenditures* (Congressional Research Service, 2012), 9
14 Budget Officers, *State Expenditure Report*, 46.
15 Mitchell, *Medicaid Financing*, 2.

government in Fiscal Year 2013, and in the same year, Illinois received the minimum 50% matching rate from the national government because its higher per capita income.[16]

Overall, the national government funds 57% of Medicaid expenditures and the states fund 43%.[17] In addition, Medicaid is an open-ended program with no specified end date. However, there are certain aspects of coverage that are capped. For example, Medicaid is bounded in funding disproportionate share hospital expenses to each respective state's limit and some states do receive exceptions and modifications to FMAP during economic depressions.[18] In terms of Congressional funding, Medicaid is considered mandatory spending but, unlike other entitlements, Congress must appropriate it every year.[19] As a consequence, Congress has the ability to cap certain items such as contraception coverage.[20]

The lack of federal provisions on how states generate and allocate funding for their respective share produces differences in how each state finances Medicaid.[21] Typically, states will allocate general funds generated from "personal income, sales, and corporate income taxes" and "'other state funds' (i.e., provider taxes, local government funds, tobacco settlement funds, etc.)" to finance Medicaid.[22] In fiscal year 2010, states financed Medicaid 76% from general funds and 24% from other state funds.[23] In fiscal year 2013, Medicaid accounted for 24.5% of total state spending and 18.9% of general fund spending.[24] States do utilize intergovernmental transfers from counties to the state and between state agencies to produce the state's share of Medicaid expenditures. An issue arises when states use intergovernmental transfers to extract additional funds from the national government. For instance, when a state required a county to pay additional funds for Medicaid services, the state is responsible less the county's share; thereby, reducing the state's Medicaid costs. In addition, individual state Medicaid agencies process Certified Public Expenditures (CPEs) where the agency certifies the expenditures of certain government-owned providers, pays providers from state or local taxes, and states draw additional funds from the national matching grant.[25]

Demographic characteristics and the list of optional services each state selects to cover are key determinants in the disparity in state level of Medicaid spending. States with low-income individuals and expanded coverage of numerous optional services will have higher spending levels. Moreover, the utilization rates among Medicaid participants have an enormous impact on overall spending levels. With just 5% of Medicaid recipients accounting for over 50% of total Medicaid expenditures, utilization rates among certain individuals is a critical aspect of Medicaid spending.

16 Federal Register, *FMAP for FY 2013*, (Federal Register, Vol. 20, No. 230, November 30, 2011), 74061-63.
17 Kaiser, *A Primer*, 31.
18 Mitchell, *Medicaid Financing*, 3.
19 Ibid., 4.
20 Ibid., 4.
21 Ibid., 4.
22 Ibid., 4.
23 Ibid., 4.
24 Budget Officers, *State Expenditure Report*, 46.
25 Mitchell, *Medicaid Financing*, 7-8.

IMPACT OF AFFORABLE CARE ACT ON MEDICAID

With its many provisions, the ACA is the most important modification to the Medicaid program since its inception in 1965. The ACA expands the Medicaid program to all individuals below 138% of the poverty line in 2014.[26] The objective of the expansion is to provide adults under 65 who are 50% of the uninsured population access to affordable health care.[27] Originally, the ACA did not allow states to receive the national matching grants unless the states agreed to expand Medicaid to persons 138% above the poverty line.[28] However, on June 28, 2012, the Supreme Court ruled that the national government could not stop funding Medicaid until the states expanded coverage.[29] Further, states have the option to choose to expand coverage per the national governments guidelines to receive additional matching grants to finance the expansion.[30] As of January 2015, 29 states and the District of Columbia have expanded Medicaid coverage.[31]

A key aspect of the law states that the national government would pay in full the extension of Medicaid from 2014 to 2016 and national government funding would be reduced to 90% by 2020.[32] If all fifty states extended Medicaid coverage to individuals 138% above the poverty line, total Medicaid spending would increase by 16%, or roughly $1 trillion, between 2013 and 2022, the national government would fund 93% of the program or increase expenditures by 26%, and states would increase Medicaid spending by 3%.[33] Furthermore, only eight states will experience a cost-savings with Medicaid expansion[34] because the national government funds a larger portion of Medicaid, 50% of the states would see up to 5% increase in costs, and the other states could see costs escalate 5%-11%.[35] However, over the same ten year period, there could be a Medicaid enrollment increase of 21.3 million individuals.[36] Conversely, if no state adopts new measures to expand Medicaid, other provisions of the ACA would still increase enrollment and over the ten-year period 2013-2022, state expenditures would increase $68 billion and national government spending would rise by $152 billion.[37] Overall, expansion of Medicaid services would cost states significantly less than the national government. If all states expanded Medicaid, there would be an $8 billion increase in states' costs, or 0.03% above current state Medicaid spending levels.[38] In comparison, the national government would increase spending by $800 billion or 21% of above current levels.[39] Additionally, if no state expands Medicaid,

26 Holahan, et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2012), 3.
27 Kaiser, *A Primer*, 11.
28 Ibid., 11.
29 Ibid., 11.
30 Ibid., 11.
31 The Kaiser Commission on Medicaid and the Uninsured, *An Overview of the Actions Taken by State Lawmakers Regarding Medicaid Expansion – Fact Sheet* (The Henry J. Kaiser Family Foundation, 2015), 1.
32 Holahan, et al., *The Cost*, 3; Budget Officers, *State Expenditure Report*, 46.
33 Ibid., 3.
34 Connecticut, Delaware, Iowa, Massachusetts, Maryland, Maine, New York, and Vermont (Holahan, et al., *The Cost*, 3).
35 Holahan, et al., *The Cost*, 3.
36 Ibid., 19.
37 Ibid., 5.
38 Holahan, et al., *The Cost*, 5.
39 Ibid., 5.

uninsured enrollment would rise but at a smaller rate. Specifically, there would be a 28% reduction in the uninsured whereas a full expansion among all the states would decrease the uninsured number by an estimated 48%.[40] Therefore, with or without state expansion of Medicaid, there will be a slight increase in aggregate state expenditures and significant increase for national government spending on Medicaid.

If Medicaid were expanded among all 50 states, total states expenditures would receive a net savings of $10 billion between 2013 and 2022.[41] The $8 billion increase in expenditures would be offset by the $18 billion in savings associated with declining costs of uncompensated care for the uninsured.[42] The $8 billion increase in state spending is approximately 0.1% increase, and would represent only a nominal increase in expenditures. Also, the "ACA established a new state option to implement 'health homes' for Medicaid beneficiaries with chronic conditions, including severe mental illness" in an effort to improve quality of care and reduce costs to one of Medicaid's most expensive coverage items, long term care.[43] The ACA does increase primary care physician payments by 73% on average to incentivize primary care doctors to accept Medicaid patients. Other reforms were included in the ACA to experiment with "patient-centered, coordinate, and integrated care" models to decreases costs and increase quality of care over the long term.[44]

FISCAL ANALYSIS

Intergovernmental Transfers

There are three primary reasons for intergovernmental transfers to occur: 1) allocative efficiency, 2) equity through correction of vertical or horizontal fiscal imbalances, and 3) to achieve national or state merit good. Allocative efficiency is typically applied as subsidies to incentivize an increase in production or consumption of a positive externality and, usually comes in the form of matching grants. An attempt to achieve equity manifests in re-balancing vertical or horizontal fiscal imbalances. Vertical fiscal imbalance is when different levels of government (e.g., national versus state versus local governments) have varying resource capacities. The national government frequently has a comparative advantage in raising funds and, therefore, resource capacity, which can be redistributed among the diverse levels of government.[45] The primary objective of vertical re-balancing is fiscal equalization or "the process through which a central government makes funds available to lower level governments with the objective of reducing the degree of inequality in the revenues that such governments can raise using their own revenue instruments."[46] A lump-sum grant based on derivation basis, or each district that collects revenues receives a fixed percentage predicated on that district usage of the good. Under vertical

40 Ibid., 6.
41 Ibid., 6.
42 Ibid., 6.
43 Kaiser, *A Primer*, 18-19.
44 Ibid., 24.
45 Richard Bird, "Threading the Fiscal Labyrinth: Some Issues In Fiscal Decentralization" *National Tax Journal* (1993): 218.
46 William Oakland, "Fiscal Equalization: An Empty Box?" *National Tax Journal* (1994): 199.

fiscal re-balancing, there is no re-distribution of revenues but a distribution. Horizontal fiscal re-balancing is re-distributive and does not attempt to produce equal outcomes but equalization in capacity to choose a certain level of a particular good among similar levels of government (e.g., between counties in a given state, etc.).[47] Naturally, a matching grant based on a formula that accounts for differences in income is utilized to determine the rate. Fiscal capacity, need, or tax effort levels are used to determine the horizontal fiscal imbalance. National and state priorities are extreme cases of externalities and indicate serious allocative efficiency issues that need to be resolved. The appropriate type and grant funding characteristics depend on purpose of national merit good. The most appropriate grant program will depend on the objective of the policy and should incorporate, per Ladd and Yinger, public service costs in any formula to determine grant amounts.[48]

Medicaid is an open-ended uncapped matching categorical grant based on the FMAP formula with power equalization for income per capita levels. An open-ended matching grant results in an increase in government goods and reduction of private goods. Specifically, open-ended matching grants result in an income and substitutive effect. The local population's income elasticity of demand for the good (in this case, health insurance for low-income individuals), the price elasticity of demand for the same good, and the amount or proportion of the grant amount determines the substitutive effect. For Medicaid, the matching rate represented by the FMAP impacts the local population's price elasticity of demand and, consequently, the magnitude of the substitutive effect. By reducing the price of insuring individuals below certain income levels, the national government has decreased the costs of insuring low-income individuals and, therefore, increased the incentive to consume more of the good – in this case, the good being providing coverage to low-income individuals in the states. Under ACA, the national government fully funding the expansion of Medicaid for states that choose to do so intensify any multiplier effect associated with newly eligible or enrolled members utilizing medical services.[49] Furthermore, the level of positive externality, or positive effects of insuring low-income individuals, informs the appropriate matching rate to achieve fiscal equivalence.

The Medicaid program has been instituted to achieve national merit good, or the positive externalities associated with insuring low-income individuals. Under this theory, people who are uninsured utilize health care services with higher costs and lower quality than otherwise could be achieved. Medicaid enables low-income persons to not rely on emergency room visits and to regularly see primary care physicians to receive the care they need. Moreover, the comprehensive or pooling nature of health insurance prevents limiting the spillovers of negative externalities of one state on others throughout the nation. If uninsured individuals exist predominantly in one state, then it is difficult to stop these individuals from receiving emergency room and other medically necessary services from hospitals in other states. Uninsured individuals, who do not pay taxes that helps

47 Bird, "Threading," 218-19.
48 Helen Ladd and John Yinger, "The Case for Equalizing Aid." *National Tax Journal* (1994): 220.
49 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)*, (Washington, D.C.: The Henry J. Kaiser Family Foundation, 2012), 4.

fund the hospital, would increase the hospitals costs and produce a negative spill over. However, it is difficult to determine the extent of the spillover.[50] Additionally, insuring all individuals in the U.S. is perceived to be a national good that will generate a healthier populace more likely to increase economic output. Health insurance for all citizens and certain legal immigrants generates a more vibrant population capable of increasing productivity and GDP. As William Brandon argues, "a principal pillar of the ACA, is that government regulations would require that responsible individuals have community-rated insurance-subsidized, if necessary – continuously available to them without pre-existing conditions exclusions or waiting periods."[51] Furthermore, one study analyzing the Medical Expenditure Panel Survey found that Medicaid eligible individuals after the ACA were as healthy or healthier a population as the Medicaid population before ACA.[52] By providing coverage to low-income individuals who are as healthy as the current Medicaid population, the national priority of ensuring cost-effective health insurance is met. Therefore, reducing the negative spillover effects of uninsured populations and encouraging the positive externalities associated with healthier populations benefits the entire nation and merits investment.

Also, states have utilized intergovernmental transfers to reduce horizontal fiscal imbalance within their respective state to effectively increase national matching rates. Some states require counties to transfer a percentage of local tax revenues to the state to fund the state's Medicaid portion – up to 60% of state's financing responsibilities can be generated from local tax revenue collection.[53] In March 2004, Kathryn Allen, Director of Health care: Medicaid and Private Health Insurance Issues, testified before the subcommittee on Health for the Energy and Commerce committee for the House of Representatives, about how states developed financing mechanisms utilizing intergovernmental transfers to increase national matching rates. She testified that states were claiming Medicaid expenditures to state-owned medical providers, and once national funds were provided to providers, the states would require funds to be re-allocated to state funds; effectively increasing the national matching rate.[54] One state paid $277 million - $155 million from national matching grant and $122 million in state monies - in Medicaid payments to county health providers within the state and, then, on the same day, had $271 million transferred back to the state.[55] In this manner, the use of intergovernmental transfers manipulates attempts to provide horizontal fiscal balance with attempts to increase the national matching grant amount to states. Instead of states attempting to provide the same capacity to cover low-income individuals throughout the counties or municipalities, states alter the financing

50 Bird, "Threading," 219.
51 William Brandon, "Medicaid Transformed: Why ACA Opponents Should Keep Expanded Medicaid," *Journal of Health Care for the Poor and Underserved* (2012): 1371.
52 Steven Hill, et al., "Adults In The Income Range For The Affordable Care Act's Medicaid Expansion Are Healthier Than Pre-ACA Enrollees," *Health Affairs* (2014): 696.
53 Kathryn Linehan, *Medicaid Financing*, (Washington, D.C.: National Health Policy Forum, 2013), 6.
54 Kathryn Allen, "Intergovernmental Transfers Have Facilitated State Financing Schemes," GAO - Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives (Washington, D.C.: United States General Accounting Office, 2004), 3-4.
55 Allen, "Intergovernmental," 6.

system to increase their revenues without verification of how those funds will be spent.

Furthermore, states do not pay their corresponding share in the increase of Medicaid expenditures. In fiscal year 2012, states funding share were comprised of health care providers payments (10.5% or $18.8 billion), local governments (15.5% or $27.9 billion - $18.1billlion from intergovernmental transfers and $9.7 billion from certified public expenditures), state funds (69.5% or $125.1 billion), and other sources of funds (4.6% or $8.3 billion).[56] These numbers are aggregates for all fifty states and substantial differences occur between states.[57] From 2008 to 2012, the percentages of funds collected from health care provider taxes and local governments (via intergovernmental transfers) increased by 21% or $15.6 billion.[58] Of this share, $6.6 billion came from intergovernmental transfers and certified expenditure funds that increased from $21.3 billion in spending in 2008 to $27.9 billion in 2012.[59] The ACA provision that fully funds the expansion of Medicaid for states that choose to do so from 2014 to 2016 exacerbates this problem. Since Medicaid's inception, the national government has paid 50% to 83% of the costs and states have paid 17% to 50%.[60] If Medicaid were altered to a block grant program, as Republican legislators have tried to enact since the 1980s, states would pay an equal share on a dollar-for-dollar basis.[61] States do not have an incentive to pay a larger share of the increasing costs of Medicaid and will continue to utilize intergovernmental transfers and health care provider payments to supplement their current spending levels to meet their Medicaid portion. Even after 2016, the national government will continue to pay for 90% of the expanded coverage. The price for expanding coverage to low-income individuals is cheaper and states have an incentive to increase coverage. Despite the national government's objective to view Medicaid expansion as a national merit good, the financing feasibility of the current structure portends unsustainable rising health care costs.

CONCLUSION

The ACA has significant implications for how health care is administered in the U.S. and among its most important consequences will be its effect on the Medicaid program. Medicaid was instituted into law to enable low-income individuals who could not receive health insurance through their employer or afford insurance through the non-group market. The ACA substantially changes the Medicaid program to provide coverage to all citizens and certain legal immigrants with access to affordable health care. In essence, the ACA uses Medicaid to achieve the perceived national merit good of universal health care for all Americans. In so doing, the national government is encouraging and

56 Government Accountability Office, *Report to Congressional Requesters. Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* (Washington, D.C.: Government Accountability Office, 2014), 15.

57 GAO, *Report to Congressional Requesters*, 15.

58 Ibid., 18.

59 GAO, *Report to Congressional Requesters*, 18-19.

60 Steven Gold, "Issues Raised by the New Federalism," *National Tax Journal* (1996): 275.

61 Gold, "Issues Raised," 275.

creating incentives for states to expand Medicaid coverage to all individuals up to 138% of the poverty line. The national government will pay in full the costs of expansion from 2014-2016; thereafter, the national government will reduce its share to no smaller portion than 90% of costs. The open-ended matching grant formulated with FMAP has led states to attempt to alter financing mechanisms to further increase national matching funds. With the ACA enacted, it is difficult to imagine how states would not continue to extract additional federal funding for Medicaid. Moreover, there is no precedent that states must use the additional funds received from the national government for Medicaid expenditures alone. Therefore, ACA potentially could distort incentives to produce inefficient and inequitable outcomes. In an effort to prevent such distortion of national funds, it is recommended that provisions be instituted to restrict states from utilizing national funds for Medicaid on other programs and to verify intergovernmental transfers and Certified Public Expenditures are not being manipulated to increase national matching rates.

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