



The Devil Is in the Details

How a sleeper provision in ObamaCare could bust Illinois's budget

Public option plans, health care rationing, and new surtaxes and fines – health care “reform” is receiving significant attention from a concerned public.

Yet one major aspect of health care plans being developed on Capitol Hill has received relatively scant attention – and it could end up busting Illinois's budget. House and Senate Democrats are planning on significantly expanding Medicaid to help decrease the rolls of the uninsured. In fact, about 30 percent of the people newly covered by the leading House bill – about 11 million individuals – would receive coverage via Medicaid.¹

Medicaid was originally conceived as a safety net for the poorest of the poor. Should this expansion take place, it would put an unprecedented 25 percent of the entire U.S. population – 85 million people – on Medicaid for at least some period of time in 2019.²

The cost for such an expansion is dependent on many moving factors, including eligibility guidelines, implementation timelines, and state vs. federal cost sharing. According to estimates, immediately expanding Medicaid to all Illinoisans earning less than 133 percent of the federal poverty level would boost the state's enrollment numbers by 25 percent, and it would increase Illinois's one-year share of Medicaid spending by \$1.391 billion under traditional reimbursement rates.

However it's fashioned, a large-scale expansion of Medicaid will come with a significant price tag, the cost of which will be difficult to reconcile with the looming deficits in the federal government's budget and Illinois's state budget.

The Medicaid expansion may not be getting as much media coverage as care rationing and end-of-life counseling provisions, but Illinoisans have every reason to pay close attention to this policy sleeper. It could mean the difference between a balanced – or busted – balance sheet.

Medicaid Today in Illinois

Medicaid is a public assistance program that is financed jointly by the state and federal governments to provide medical care for individuals who meet certain eligibility criteria. The poor, disabled, and elderly have been traditional recipients of Medicaid coverage. If an individual is disabled or has children, he or she may still qualify for Medicaid even if household income is above the federal poverty line.

Illinois's government medical plans include:³

- All Kids, which covers children in families with income up to 200 percent of poverty, regardless of other insurance coverage. Children in families above 200 percent of the federal poverty level must be uninsured to qualify.
- FamilyCare, which covers parents or caretaker relatives of children with income up to 185 percent of the federal poverty level regardless of assets.
- All Kids Moms and Babies, which covers

pregnant women and their infants up to 200 percent of the federal poverty level regardless of assets.

- Aid to Aged Blind and Disabled Medical, which covers individuals with income up to 100 percent of the federal poverty level and no more than \$2,000 of non-exempt assets (one person) who are seniors, blind persons and persons with disabilities.
- Health Benefits for Workers with Disabilities, which covers persons with disabilities who work and have earnings up to 200 percent of the federal poverty level who buy in to Medicaid by paying a small monthly premium. Eligible people may have up to \$10,000 in non-exempt assets.
- Illinois Cares RX Program, which provides comprehensive prescription coverage to seniors who are not eligible for Medicaid but who have income up to 200 percent of the federal poverty level, regardless of assets.

Between 2003 and 2008, the Medicaid population in Illinois grew at an average rate of 7.8 percent a year, while Illinois's population only grew 0.5 percent each year during that time period.⁴ This is in part because of eligibility being expanded to new populations. According to the Taxpayer Action Board:

Much of this growth has been driven by Medicaid eligibility changes over the last few years that have led to substantial increases in the number of enrollees. For example, in July 2000 the income eligibility threshold for the aged and disabled population was increased. This change alone has resulted in approximately 136,000 new enrollees in this category. In October 2002, the income standards for parents of low-income children, already eligible for coverage, were also increased, adding another 170,000 enrollees to the program. Then in June 2004, the State began a federal demonstration Waiver to provide family planning and related services to women of child-bearing age that were above the previous income standards. Finally, beginning with the enactment of

legislation covering all uninsured children of any income level in November 2005, Illinois began an aggressive public relations campaign to promote enrollment of children in the All Kids health insurance program. This campaign has resulted in 68,600 additional children being added to the Medicaid program.⁵

From 1993 to 1999, Illinois's Medicaid liabilities grew at a rate of 1.4 percent. Over the last 10 years, however, state Medicaid liabilities grew at a rate of 6.9 percent a year. The program's own administrators are projecting a 7 percent growth rate for 2010.⁶

Eligibility Expansions

In anticipation of a Congressional effort to expand Medicaid, the Federal Funds Information for States (a joint subscription service of the National Governors Association and the National Conference of State Legislatures) released a special analysis in April 2009 that looked at the impact of a general Medicaid eligibility expansion.⁷ Looking at the 2005-2007 time period, the Federal Funds Information for States (FFIS)

TABLE I- Three-Year Average of Uninsured by Federal Poverty Level (2005-2007)

	Below 100% Federal Poverty Level	Below 133% Federal Poverty Level	Below 150% Federal Poverty Level
Illinois	430,000	604,000	690,000

Source: FFIS Federal Funds Information for States

report found that 430,000 Illinoisans earning less than 100 percent of federal poverty level were uninsured. For those making less than 133 percent of federal poverty level, 604,000 were uninsured. At up to 150 percent of federal poverty level, 690,000 were uninsured.

Illinois's 2008 Medicaid enrollment totaled 2.4 million individuals.⁸ Generally speaking, adding 604,000 individuals to Illinois's Medicaid rolls would represent a 25 percent increase over current enrollment. Total enrollment of Illinoisans in Medicaid would go from roughly 1 in 5 to 1 in 4.

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Federal Legislation Would Balloon Medicaid Rolls

The primary House health care bill (H.R. 3200) would expand Medicaid to cover individuals making up to 133 percent of the poverty level – regardless of whether an individual has children or is disabled. Various income and expense disregards in the bill could put the actual eligibility for many at closer to 150 percent of poverty.⁹ A Senate version puts coverage at 150 percent of poverty.

According to the Congressional Budget Office, the House bill would gradually add 11 million people nationwide to Medicaid’s rolls by 2019 (benefits would not start until 2013). The CBO estimate did not include state-by-state population breakdowns. Assuming that Illinois’s state-to-nation population proportion stays constant at 4.2 percent¹⁰ and applying this to the new Medicaid enrollees in 2019, the increase to Illinois’s Medicaid enrollment baseline would be 466,741 people.

It is important to note that current federal law does not pay for states to expand Medicaid coverage to childless, non-disabled adults. H.R. 3200 would make this population newly eligible for Medicaid. Opponents of this change have likened it the “slacker expansion.” Able-bodied individuals with no dependents would now be eligible to receive government health insurance.

Costs of Expanding Medicaid Today

Traditionally, the federal government has reimbursed Illinois 50.32 cents for every Medicaid dollar spent. The federal stimulus legislation offered another dime to the going reimbursement rate, putting the federal reimbursement rate to Illinois at 60.48 cents retroactive to October 2008 (although this ends in December 2010).¹¹ An expansion of Illinois’s Medicaid rolls under traditional cost-sharing arrangements would necessarily increase spending demands on Illinois’s state budget.

The Federal Funds Information for States calculated the state-by-state FY 2009 cost of expanding eligibility to all uninsured under 100 percent, 133 percent, and 150 percent of federal poverty level.¹² Their calculations used the initial FY 2009 Federal Medical Assistance

Percentage reimbursement rates (not the temporary increases included in the federal stimulus legislation) and their numbers assume that all eligible uninsured individuals would enroll.

TABLE 2- FY 2009 Estimated Illinois Impact of Increase in Mandatory Medicaid Eligibility (at Mandatory Rates)

100% Federal Poverty Level	
Federal Share	State Share
\$1,002,734,000	\$989,981,000
133% Federal Poverty Level	
Federal Share	State Share
\$1,409,312,000	\$1,391,388,000
150% Federal Poverty Level	
Federal Share	State Share
\$1,609,038,000	\$1,588,573,000

Source: FFIS Federal Funds Information for States

For FY 2009, the additional state share cost to Illinois for expanding Medicaid to all individuals making up to 100 percent of poverty level at mandatory coverage rates would be \$989 million. At up to 133 percent of federal poverty level, the additional cost to Illinois would be \$1.391 billion. If eligibility went up to 150 percent of federal poverty level, the cost would be \$1.588 billion.

The Taxpayer Action Board estimated Illinois’s total 2009 Medicaid spending at \$11.2 billion,¹³ with state share costs making up roughly half of that amount. Adding a \$1.3 billion spending increase to state Medicaid costs of \$5.2 billion would represent a 25 percent increase.

The FFIS report noted that because a large expansion of Medicaid “could require states to increase their current reimbursement rates to ensure sufficient physician participation,” they also prepared estimates to include an increase in existing Medicaid rates to more generous Medicare reimbursement rates.

TABLE 3- FY 2009 Estimated Illinois Impact of Increase in Medicaid Eligibility (at Medicare Rates)

100% Federal Poverty Level		
Federal Share	State Share	% Increase over Medicaid Rates
\$3,463,748,000	\$3,419,694,000	61%
133% Federal Poverty Level		
Federal Share	State Share	% Increase over Medicaid Rates
\$4,020,761,000	\$3,969,622,000	71%
150% Federal Poverty Level		
Federal Share	State Share	% Increase over Medicaid Rates
\$4,294,385,000	\$4,239,767,000	76%

Source: FFIS Federal Funds Information for States

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For FY 2009, the additional cost to Illinois for expanding Medicaid at Medicare rates to all individuals making up to 100 percent of poverty level would be \$3.419 billion. At up to 133 percent of federal poverty level, the additional cost to Illinois would be \$3.969 billion. If eligibility went up to 150 percent of federal poverty level, the cost would be \$4.239 billion.

It's worth noting that the FFIS study only considered Medicaid maintenance payments, although the study noted "any expansion would also increase Medicaid administrative costs." Requiring state Medicaid programs to allow adults to apply for Medicaid coverage at Disproportionate Share Hospitals, Federally Qualified Health Centers, and locations other than welfare offices (as outlined by the H.R. 3200),¹⁴ would require staffing increases.

Congressional Legislation: Who Would Pay and By How Much?

According to the Congressional Budget Office, the ultimate cost of Medicaid expansion legislation moving through Congress is dependent on many aspects,¹⁵ including:

- How eligibility for the program was determined;
- Whether the expansion started immediately or later on;
- Whether the costs for newly eligible people was borne by the federal government vs. state governments; and
- Whether states faced a maintenance-of-effort requirement regarding current Medicaid programs.

According to the Congressional Budget Office, the Medicaid expansion in H.R. 3200 would cost the federal government \$438 billion over the next ten years. Because benefits won't take effect until 2013, it is more accurate to focus in on the seven-year cost estimate (2013-2019) of \$429 billion. One outside observer noted that if the Medicaid expansion went into place almost immediately (which is feasible), the costs could

go up another \$200 to \$300 billion.¹⁶

The House bill would have the federal government pick up the entire tab of the Medicaid expansion¹⁷ (although a compromise with Blue Dog Democrats would have states pay a portion of the costs, potentially 7 percent). Cost estimates of H.R. 3200 from the Congressional Budget Office did not include state-by-state breakdowns. A Senate version would have the federal government pay the entire cost for five years and then require states to pick up their normal cost share.

Precisely because Medicaid is a large burden on state budgets, a number of governors have spoken out against its expansion. Tennessee Governor Phil Bredesen (D) called Medicaid expansion proposals the "mother of all unfunded mandates."¹⁸ Added Pennsylvania Governor Ed Rendell (D), "These could essentially be unfunded mandates, and would be enormously destructive to state budgets."¹⁹

From the taxpayer perspective, the "hot potato" payment responsibility fight between the federal government and state governments is relatively moot. Federal taxpayers and state taxpayers are often one and the same. Both the federal government and the Illinois state government are running massive budget deficits. A higher spending requirement will require higher taxes somewhere, whether at the federal or state level.

According to the bill language, states wouldn't be allowed to cut Medicaid eligibility elsewhere to help pay for this expansion. In particular, the House bill would "prohibit states from adopting eligibility standards, methodologies, or procedures in their Medicaid programs more restrictive than those in effect as of June 16, 2009."²⁰ This removes opportunities for states to reduce eligibility for cost containment purposes. Illinois state legislators would have less prospective control over the design of the state's Medicaid system.

Reform, Don't Expand

In 2009, Governor Pat Quinn appointed a Taxpayer Action Board that would look into efficiencies in current state spending.

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The Medicaid subcommittee came up with a number of ideas,²¹ including:

- Rebalancing long-term care away from high-cost, state-operated institutions toward lower-cost community care for the elderly, disabled, and mentally ill.
- Implementing a mandatory managed care system where provider reimbursements are tied to performance and outcomes (e.g., reducing the reliance on expensive emergency room care).
- Promoting transparency and publishing anonymous Medicaid claims data to identify cost savings and health outcomes.
- Requesting a waiver from federal mandates in order to give Illinois a greater degree of flexibility in designing a reformed Medicaid system.

The Taxpayer Action Board report came out in June 2009, but little has been done with their recommendations. Before a massive expansion of Illinois's Medicaid program is even considered, policy makers need to implement vigorous reforms to control Medicaid's current costs. A federal mandate to vastly expand Medicaid without the opportunity to prospectively reform the system isn't the prescription for what ails Illinois's health care system.

Conclusion

Even though it's not the stuff of daily news headlines, a Medicaid expansion is likely to play a large role in health care "reform" plans favored by those holding power in the Congress. This becomes even more assured if public furor kills the public option proposal, which increasingly looks to be the case. Expanding Medicaid would be one of the administratively "easier" ways to insure more individuals, but that doesn't mean it's free of serious policy detractions. State legislators should be very concerned about a growing Medicaid burden – particularly when they can't pay their existing bills.

Ongoing Medicaid expansion negotiations in

Congress will determine at what level benefits are set, when they take effect, and whether the federal government or the states will shoulder the cost. In the meantime, it is possible to get a sense of what it could cost and by how much Illinois's Medicaid enrollment could grow. The numbers are not comforting.

According to a report from the Federal Funds Information for States, the additional "state share" cost to Illinois for immediately expanding Medicaid to uninsured individuals who earn up to 133 percent of poverty level would cost \$1.391 billion (FY 2009 numbers, at regular Medicaid reimbursement rates). It would take Illinois's Medicaid enrollment from 2.4 million enrollees to 3 million enrollees, a 25 percent increase.

The last thing Illinois needs is a mandate to increase its Medicaid rolls. Illinois is already having a hard time paying for its current Medicaid obligations – the state's significant payment backlog is clear proof of this. An expansion – even one partially or temporarily funded by the federal government – would make the outlook for balancing Illinois's budget and honoring current commitments much more gloomy than it already is. This doesn't bode well for taxpayers or current Medicaid recipients and providers.

Health care reform is needed – but a forced Medicaid expansion isn't the answer that Illinoisans deserve.

Notes

1 Dennis Smith, "Undercutting State Authority: The Impact of the House and Senate Health Bills," *The Heritage Foundation*, July 23, 2009, <http://www.heritage.org/research/healthcare/nm2559.cfm>.

2 Dennis Smith, "Medicaid Expansion: The Impact of the House and Senate Health Bills," *The Heritage Foundation*, July 21, 2009, <http://www.heritage.org/Research/HealthCare/nm2554.cfm>.

3 Illinois Department of Healthcare and Human Services, "Annual Report: Overview," <http://www.hfs.illinois.gov/annualreport/>.

4 Taxpayer Action Board, "Report of the Taxpayer

The last thing Illinois needs is a mandate to increase its Medicaid rolls. Illinois is already having a hard time paying for its current Medicaid obligations.

Action Board,” June 2009, <http://budget.illinois.gov/documents/TABreport.pdf>.

5 *Taxpayer Action Board,* “*Report of the Taxpayer Action Board,*” June 2009, <http://budget.illinois.gov/documents/TABreport.pdf>.

6 *Taxpayer Action Board,* “*Report of the Taxpayer Action Board,*” June 2009, <http://budget.illinois.gov/documents/TABreport.pdf>.

7 *Federal Funds Information for States,* “*Special Analysis: State Impact of Medicaid Eligibility Expansion,*” April 23, 2009, <http://www.ffis.org/>.

8 *Illinois State Budget, Fiscal Year 2010,* <http://budget.illinois.gov/documents/FY2010OperatingBudget.pdf>.

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13 *Taxpayer Action Board,* “*Report of the Taxpayer Action Board,*” June 2009, <http://budget.illinois.gov/documents/TABreport.pdf>.

14 *House Ways and Means Committee,* “*America’s Affordable Health Choices Act, Section-by-Section Analysis,*” July 14, 2009, <http://waysandmeans.house.gov/media/pdf/111/sbys3200.pdf>.

15 *Congressional Budget Office,* July 7, 2009, <http://www.cbo.gov/ftpdocs/104xx/doc10445/07-07-2009-ExpandingMedicaid.pdf>.

16 *Dennis Smith,* “*Medicaid Expansion: The Impact of the House and Senate Health Bills,*” *The Heritage Foundation,* July 21, 2009, <http://www.heritage.org/Research/HealthCare/wm2554.cfm>.

17 *House Ways and Means Committee,* “*America’s Affordable Health Choices Act, Section-by-Section Analysis,*” July 14, 2009, <http://waysandmeans.house.gov/media/pdf/111/sbys3200.pdf>.

18 *Kevin Sack and Robert Pear,* “*Governors Fear Medicaid Costs in Health Plan,*” *New York Times,* July 20, 2009, http://www.nytimes.com/2009/07/20/health/policy/20health.html?_r=1&th&emc=th.

19 *Karen Tumulty,* “*Medicaid and the States: Health-Care Reform’s Next Hurdle,*” *TIME,* July 21, 2009, <http://www.time.com/time/politics/article/0,8599,1911856,00.html>.

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21 *Taxpayer Action Board,* “*Report of the Taxpayer Action Board,*” June 2009, <http://budget.illinois.gov/documents/TABreport.pdf>.