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# Estimating ObamaCare's Effect on State Medicaid Expenditure Growth:

# A Study of Five Most Populous U.S. States

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by

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**Executive Summary**

Unless repeal attempts succeed, the Patient Protection and Affordable Care Act of 2010 (ObamaCare) promises to increase state government obligations on account of Medicaid by expanding Medicaid eligibility and introducing an individual health insurance mandate for all US citizens and legal permanent residents. Once ObamaCare becomes fully effective in 2014, the cost of newly eligible Medicaid enrollees will be almost fully covered by the federal government through 2019, with federal financial support expected to be extended thereafter. But ObamaCare provides states with zero additional federal financial support for *new enrollees among those eligible for Medicaid under the old laws*. That makes increased state Medicaid costs from higher enrollments by "old-eligibles" virtually certain as they enroll into Medicaid to comply with the mandate to purchase health insurance. This study estimates and compares potential increases in Medicaid costs from ObamaCare for the five most populous states: California, Florida, Illinois, New York, and Texas.

The results suggest that Medicaid costs would increase considerably even on a pre-ObamaCare basis in California, Florida, and Texas -- states with rising populations across many Medicaid eligibility and enrollment groups by age and gender. Cost increases on a pre-ObamaCare basis are projected to be smaller in Illinois and New York -- states whose populations are projected to remain generally stagnant or decline during the next two decades. On a post-ObamaCare basis,

the projected cost increase is small for California -- just 4.5 percentage points in cumulative costs during 2014-23 compared to the pre-ObamaCare ten-year total cost projection. That's because enrollment rates among "old-eligibles" are already high in California on a pre-ObamaCare basis, implying little scope for additional enrollment increases from the introduction of ObamaCare.  In Florida and Texas, projected post-ObamaCare increases in Medicaid costs are larger, because these states are projected to have larger populations of non-enrolled "old eligibles."  Illinois and New York exhibit historically stable or declining enrollment rates among "old eligibles," implying larger potentials for higher enrollments and increased costs when ObamaCare becomes effective after the year 2014.

Calculations of total additional costs during ten years (2014-23) from ObamaCare beyond cost projections in the absence of ObamaCare are shown in Figure 1.  Those costs range from just $11.7 billion for California to a high of $65.5 billion in New York.
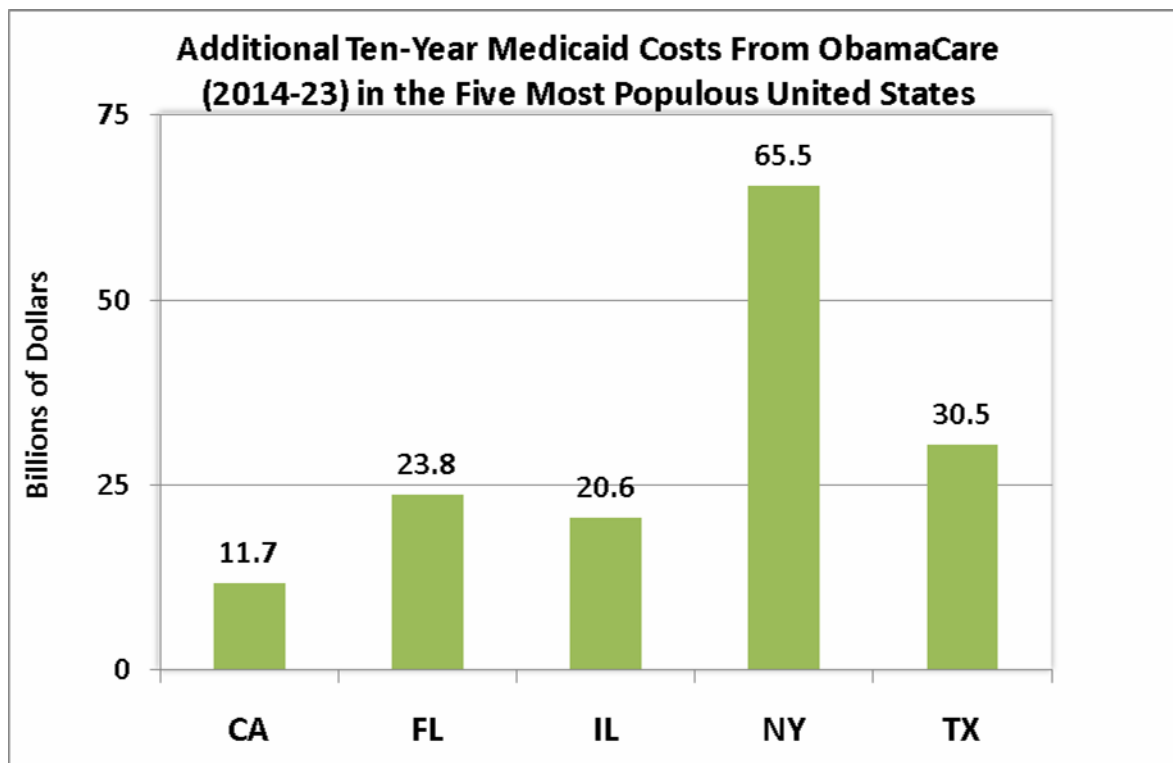
Such large cost increases would constitute significant budget pressures on other state priorities such as investments in infrastructure and education. For example, the 30.5 billion additional Medicaid cost in Texas represents a nearly 20 percent increase from the pre-ObamaCare ten-year cost. And the cumulative increase (including the projected cost increase on a pre-ObamaCare basis) would be 56 percent larger than the ten-year flat cost baseline beginning in 2014.

Finally, the significantly larger increase in New York's ten-year Medicaid costs from introducing ObamaCare can be traced to that state's the high cost per enrollee. Figure 2 shows that New York's Medicaid costs per enrollee are almost twice those of the other four states -- because of the generally high rates of doctor reimbursements and medical goods costs prevalent in that state.
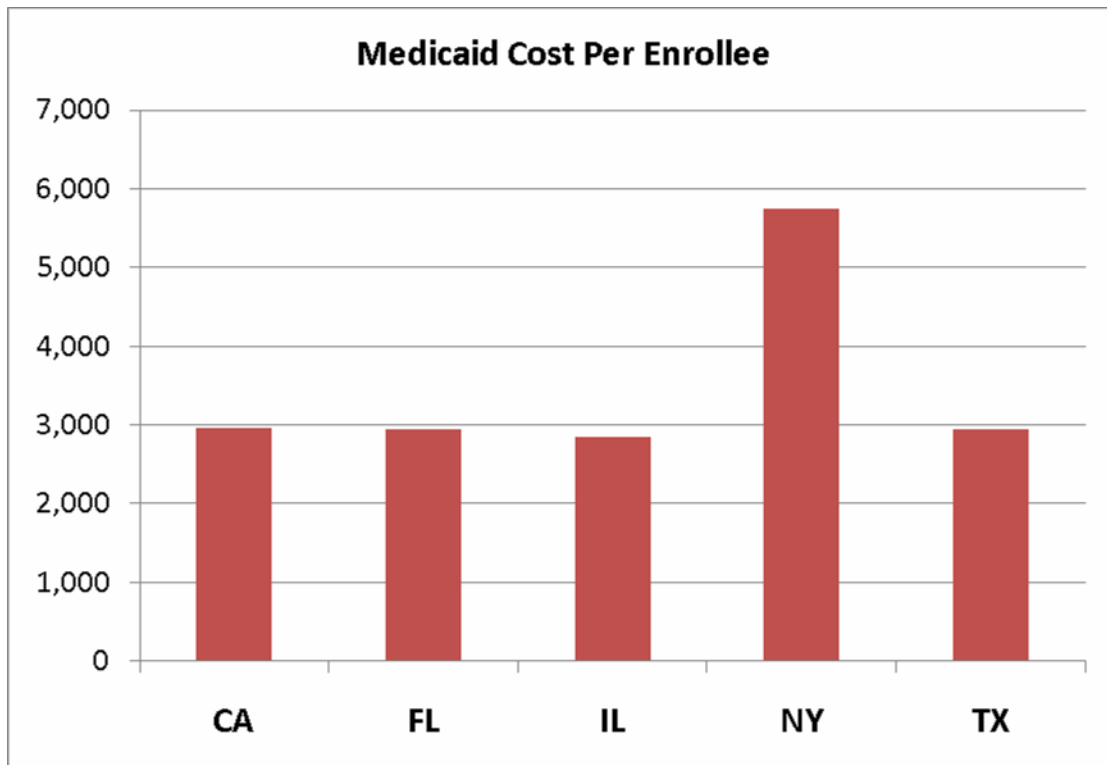


The results reported in this study about how large ObamaCare-induced increases in state Medicaid costs would be after 2014, are considerably larger compared to those reported elsewhere -- for example, estimates of the Kaiser Family Foundation. The latter, however, appear to exclude

potentially large cost increases from new Medicaid enrollments of "old eligibles" arising from

ObamaCare's individual mandate to purchase health insurance.

**Introduction**

This study focuses on the effect of ObamaCare on the future growth of states' General Revenue Medicaid spending obligations.[2]  Ever since Medicaid was introduced during the mid-1960s as a key element of Great Society programs, state expenditures on items such as infrastructure, education and other public services to maintain economic competitiveness have been constrained by rapid growth in state Medicaid obligations.  The Patient Protection and Affordable Care Act (ObamaCare) enacted in March 2010 expands states' Medicaid funding burdens yet again by mandating health insurance coverage among those already eligible for Medicaid but not enrolled in it.  It also expands eligibility for Medicaid benefits to additional categories of people and to those with incomes both above and below the federal poverty level (FPL).  Moreover, ObamaCare increases uncertainty about future escalations in state Medicaid costs -- through the possibility that surging federal deficits and debt will force a reduction of  federal financial support beyond 2019 for those made newly eligible for Medicaid.

The study estimates Medicaid costs for the five most populous states -- California, Florida, Illinois, New York, and Texas[3] -- by projecting future Medicaid costs on a pre- and post-ObamaCare basis.  In each case, the difference in the two cost trajectories reveal by how much the burden of financing Medicaid will increase because of the new health care law.

The results differ across the five states.  They suggest that Medicaid costs will soar in California, Florida, and Texas even on a pre-ObamaCare basis:  Even without ObamaCare, these three states would have experienced rapid growth in future Medicaid spending, primarily because their populations are projected to grow and age rapidly.  For these three states, ObamaCare is projected to compound the population growth and aging effect by spurring Medicaid enrollments,

thereby reinforcing upward pressure on health care costs and transmitting downward pressure through the state budget on other public services.

In the case of Illinois and New York, however, Medicaid cost growth is relatively much slower on a pre-ObamaCare basis. The reason, again, lies in their much slower projected population growth during the next two decades. However, the introduction of ObamaCare will provide a much stronger impulse for Medicaid expenditure growth in these two states. The main reasons for the latter outcome is their especially low and declining enrollment trends among key groups that are eligible for Medicaid. That implies, of course, that the introduction of ObamaCare's health insurance mandate will compel many more eligible individuals to sign up for Medicaid coverage.

As described in the Appendix, the estimation of Medicaid expenditure projections carries forward historical Medicaid eligibility, enrollment, recipiency, and per-recipient benefit rates into the future, separately for each state and for detailed demographic and special-eligibility population groups. The calculations are first implemented by excluding the effects of ObamaCare. If recent state-specific trends in population growth, Medicaid eligibility, enrollments, benefit receipt, and cost per beneficiary were to continue into the future:

- California's general revenue (GR) funded Medicaid expenditures would almost double from $19.4 billion in 2008 to $35.2 billion by 2020. Medicaid expenditures will continue to increase during the 2020s, amounting to almost $60 billion per year by the end of that decade. From 2010 forward, the average annual (nominal) Medicaid expenditure growth rate is projected to be almost 9 percent through 2020, slowing to 5.5 percent per year thereafter.[4] The 2010-30 projected Medicaid cost growth rate of 7.2 percent is considerably faster than the California's average annual (nominal) GDP growth rate of 5.2 percent per year.[5]

- Florida's GR funded Medicaid expenditures would double from $6.3 billion in 2008 to $12.6 billion by 2020 and would increase to 19.5 billion by 2030. Medicaid expenditures will grow rapidly through 2020 at 7.9 percent per year and the growth rate will slow to 4.5 percent per year during the 2020s. The two decade projected Medicaid cost growth rate of 6.2 percent per year is appreciably faster than Florida's historical average annual GDP growth rate of 5.8 percent per year.

- For Texas, general revenue (GR) funded annual Medicaid expenditures would grow from $8.5 billion in 2008 to $17.6 billion by 2020 and to $32.2 billion by 2030. Medicaid expenditures are projected to grow at 9.3 percent per year between 2010 and 2020. The two-decade projected annual Medicaid expenditure growth rate through 2030 equals 7.7 percent -- far exceeding historical annual (nominal) GDP growth in Texas of 5.9 percent.

- Of the five states considered here, Illinois has the smallest Medicaid expenditures. It also has the lowest Medicaid cost growth rates: Illinois' Medicaid costs are projected to increase from $5.8 billion in 2008 to 6.9 billion by 2020, and to 7.6 billion by 2030. The two decade cost growth rate is projected to be 3.0 percent per year, well within the historical rate of annual (nominal) GDP growth of 3.9 percent.

- New York's Medicaid costs are projected to grow from $23.8 billion in 2008 to $32.9 billion by 2020 and to $37.1 billion by 2030. The two decade projected cost growth rate beginning in 2010 is 3.7 percent per year, slower than New York's historical annual (nominal) GDP growth of 4.5 percent.

Thus, even if ObamaCare had not been enacted, projected growth in Medicaid spending in California, Florida and Texas would be on an unsustainable trajectory--if judgment is based on

projected Medicaid cost growth relative to historical experience in state GDP growth rates. On that basis, projected Medicaid expenditures under pre-ObamaCare law appears to be sustainable in Illinois and New York. These results suggest a positive association between economic growth and growth in Medicaid expenditures. States with slower population and economic growth rates -- Illinois and New York experience slower growth in Medicaid costs--attributable to slower-growth in Medicaid eligibility, enrollment, and benefit claiming rates and benefit amounts. States that experienced more rapid population and economic growth since the mid-1990s and who appear likely to continue growing relatively faster are likely to experience more rapid growth in Medicaid costs, attributable to high and rapid growth in Medicaid eligibility, enrollments, and benefits.

Adding ObamaCare's expansion of eligibility for Medicaid coverage will increase future Medicaid costs in all states. However, ObamaCare's health insurance mandate implies that Medicaid cost increases from the new law would be especially pronounced in Illinois and New York--states with the smallest capacity to fund the increases because these two states are likely to continue their slower historical growth experience in the future as their populations remain stagnant or decline.

- The projected number of new enrollees among "old eligibles" from ObamaCare in 2020 calculated as a percentage of total projected enrollments without ObamaCare in 2020 is at least as high or higher in Illinois (21.2 percent) and New York (16.8 percent) compared to California (1.9 percent), Florida (16.3 percent) and Texas (13.4 percent).

- Estimates of enrollment increases among "old eligibles" in 2030 is even more pronounced with Illinois (23.3 percent) and New York (23.5 percent) projected to experience higher enrollment increases compared to California (2.7 percent), Florida (17.3 percent) and Texas (11.1 percent).

These enrollment increases will directly lead to higher General Revenue Medicaid expenditures, if new enrollees claim benefits at the same rates as those projected to be enrolled in Medicaid irrespective of ObamaCare.

- Projected GR Medicaid costs in year 2020 in California, Florida, and Texas are 4.5 percent, 23.1 percent, and 20.9 percent larger, respectively, with ObamaCare than costs in 2020 projected without ObamaCare.

- Increases in projected Medicaid costs from ObamaCare are 32.9 percent and 23.8 percent larger, respectively, in Illinois and New York.

- The percentage increases in projected costs from ObamaCare for 2030 are even starker: Cost increases for Illinois (36.9 percent) and New York (35.6 percent) from introducing ObamaCare are much larger than for California (4.1 percent), Florida (27.1 percent) and Texas (15.2 percent).

This result arises because the potential under ObamaCare for additional enrollments -- relative to enrollments projected by excluding ObamaCare -- are exhausted by the mid-2020s for California, Florida, and Texas. In Illinois and New York, however, enrollments in key age and eligibility groups were stable or declining during the 2000s, which means the potential for increases in enrollments driven by the health insurance mandate persists for much longer in these two states.

The potential for magnifying state budget pressures through Medicaid cost increases from ObamaCare can be appreciated by comparing differences in cumulative Medicaid costs over the first ten years of the new law's implementation beginning in 2014. The results on a pre- and post-ObamaCare basis are stated relative to a flat cost baseline: Projected cost for 2014 multiplied by 10 to produce the ten-year flat cost total for each state. The results are consistent with those summarized above:

- The ten-year GR baseline flat costs are $262.6 billion for California, $98.4 billion for Florida, $64.2 billion for Illinois, $287.1 billion for New York, and $126.8 billion for Texas.

On a pre-ObamaCare basis, ten-year Medicaid costs are projected to be larger than the flat-cost baseline after 2014 in all of the five states -- because this projection carries forward historical trends of generally increasing eligibility, enrollments, and benefit claim rates, and increases in Medicaid costs per beneficiary.

- Percentage increases in ten-year costs on a pre-ObamaCare basis relative to the flat cost baseline in California, Florida, and Texas are 26.2 percent, 20.8 percent, and 31.6 percent, respectively.

- Percentage increases in ten-year costs on a pre-ObamaCare basis relative to the flat cost baseline are smaller for Illinois and New York -- at 5.0 percent and 10.8 percent, respectively.

- On a post-ObamaCare basis, increase in ten-year costs relative to the flat cost baseline is 30.7 percent for California -- an increase of just 4.5 percentage points relative to the increase on a pre-ObamaCare basis.

- The post-ObamaCare increases from flat cost are larger for Florida (45.0 percent) and Texas (55.7 percent). These increases are sizable compared to those on a pre-ObamaCare basis.

- The post-ObamaCare increases from flat cost are 37.1 percent for Illinois, and 33.7 percent for New York, not as large cumulatively as for Florida and Texas, but considerably larger compared to cost increases on a pre-ObamaCare basis.

- In dollar terms, the ten-year cost increase from ObamaCare (compared to without it) is highest for New York, primarily because of its high cost per enrollee. Additional enrollments of "old eligibles" post ObamaCare leads to rapid increase in total additional Medicaid cost.

- For both Illinois and New York, growth of annual (nominal) Medicaid expenditures during 2010-30 is increased well above sustainable rates as a result of ObamaCare: For Illinois, the two decade expenditure growth rate increases from 3.0 percent to 4.6 percent -- higher than its historical GDP growth rate of 3.9 percent. New York's annual Medicaid growth rate over the same period would increase from 3.7 percent to 5.3 percent, also above its historical GDP growth rate of 4.5 percent per year.

Finally, under ObamaCare, the Federal government is to pay the full cost for those newly made eligible for Medicaid during the first three years (2014-16). Under the new law, the *marginal federal cost sharing rate* (for newly eligible Medicaid enrollees) would be gradually reduced from 100 percent to 92.8 percent by 2019.[6] The standard expectation (or assumption) among budget experts is that the marginal cost sharing rate will remain at 92.8 percent after 2019. However, the federal budget is already under considerable strain with unprecedented budget deficits projected through 2019 and beyond. That puts all programs funded out of federal general revenues, including Medicaid support for states, at risk. To account for a possible further reduction in federal marginal cost sharing for newly eligible Medicaid beneficiaries, Medicaid's cost profile for each state is calculated under alternative assumptions regarding federal financial participation beyond 2019. For instance, assuming that federal financial support for newly eligible Medicaid beneficiaries is gradually reduced after 2019 at a rate consistent with making it equal to the standard Federal Medical Assistance Percentage (FMAP) rate after 10 years (after 2028), states' GR Medicaid costs will increase by even more.

- By 2030, for example, Illinois and New York will spend 47 and 49 percent more, respectively, compared to costs projected without ObamaCare -- much more than the 37 and 36 percent cost

increases, respectively, from introducing ObamaCare but maintaining marginal federal cost sharing at rates scheduled for 2019.

- For California, Florida and Texas, the cost increases from eliminating marginal federal cost sharing are 9.6 percent, 51 percent, and 26.8 percent, respectively -- again considerably larger than cost increases of 4.1 percent, 27.1 percent, and 15.2 percent, respectively, under ObamaCare with marginal federal cost sharing maintained at their 2019 rates through the end of the projection horizon -- 2030.

With the enactment of ObamaCare, concern about runaway Medicaid costs is motivating many state policymakers to find ways to restrain Medicaid expenditures. One way would be to reduce costs and eliminate waste, fraud and abuse while attempting to maintain benefits for the most vulnerable groups. Another method receiving serious consideration is to opt out of Medicaid altogether -- an option that has always existed under the original Social Security Act -- and to provide basic health coverage to low-income and medically needy groups financed exclusively out of GR funds. As of this writing, however, it is uncertain whether ObamaCare laws will be adopted or significantly modified because of court challenges being waged about the constitutionality of the individual health insurance mandate.

## 1. Medicaid: Programs, Coverage and Financing in the Texas Budget

Medicaid programs are a part of state welfare programs to provide subsidized health care to low-income and medically needy individuals. Federal rules determine basic coverage criteria that take account of household income and asset thresholds, medical conditions, and eligibility for special groups such as pregnant women, children, disabled individuals, the aged, and so on. However, state

governments, at their discretion may extend coverage to broader groups -- by specifying income thresholds higher and asset eligibility thresholds lower than federally mandated levels and by including additional groups based on medical conditions, family resources, and so on. Many states cover children and pregnant women even if their incomes are above the state's eligibility levels but are deemed insufficient to meet the medical costs they face. Other groups covered under optional programs in many states include non-disabled children and their related caretakers, pregnant women, the aged, blind, disabled and others with medical costs exceeding their incomes.[7]

State Medicaid programs pay for a wide range of health care services including physician, hospital (in-and out-patient), lab, nursing, home health care, pharmacy costs etc. Usually, the federal government provides matching funds to share state Medicaid costs. Federal cost sharing is implemented using the FMAP formula, which is based on each state's per-capita income relative to that of the nation overall.[8] The statutory minimum FMAP percentage for all states is 50 percent, the maximum being 83 percent. The average FMAP value across all states is about 59 percent. During 2009-10, FMAP rates were higher than normal because of the temporary FMAP enhancement enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

California, Illinois, and New York have pre-ARRA FMAP rates set to 50 percent -- they are among the nation's states with highest incomes per capita. Pre-ARRA FMAP rates for Florida and Texas are higher, 55.45 percent and 60.56 percent, respectively. The ARRA-inclusive (year-end) values are about 10-15 percentage points higher for all states during 2009 and 2010, implying a smaller Medicaid funding burden. Beginning in 2011, however, FMAP rates will revert close to their pre-recession values and require states to come up with additional financing as Medicaid caseloads have continued to increase during 2009 and 2010. Medicaid costs for all states are assumed to remain at their 2011 values when projecting future costs. Those values are also applied for

determining federal and state cost sharing for beneficiaries who are Medicaid eligible on a pre-ObamaCare basis and enroll into Medicaid to satisfy the individual health insurance mandate.[9]

ObamaCare mandates new spending commitments for state governments under Medicaid. All five states have constitutional balanced budget requirements -- either on the state legislature or on the governor's budget submission. Thus, increased spending commitments from entitlements such as Medicaid that are difficult to reverse and revenue losses during the recent recession are worsening pressures on other budget items. Many states, including the five being evaluated in this study, are projecting persistent budget gaps during 2011 and 2012 -- that must be addressed by increasing revenues and reducing state public services. Medicaid benefits are unlikely to be spared as federal financial assistance is reduced after 2010.

## 2. State population projections

For the five states under consideration, Table 1 shows population growth rates calculated based on projections of the US Census Bureau. Through 2020, California, Florida, and Texas are projected to experience significantly higher population growth rates than Illinois and New York. The growth rates in the former three states are larger in all age categories, and especially among their retiree populations. Illinois and New York are projected to have declining populations among the working aged -- ages 19 through 64. Beyond 2020, population growth is projected to increase in the three already rapidly growing states whereas it is expected to decline in the two slow-growing states. Indeed, New York's overall population growth is expected to be negative during this century's third decade.

Insert Table 1 About Here

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Examining each state's demographic profile and dynamics provides clues for understanding the results on state-specific Medicaid enrollment and expenditure changes, both pre- and post-ObamaCare, that are reported later in this study. That's because, as explained in the Appendix, each state's projected total Medicaid expenditures are anchored by its population projections by age and gender. State specific population projections are obtained directly from the Census Bureau.[10] These projections are based on the 2000 Census and use fertility, mortality and migration trends for each state to project their populations forward through 2030.

The Census projected population age-distributions (as shown in Figure 1.a) for the five states are shown in Figure 1. The Figure immediately clarifies that demographic changes are occurring more rapidly -- in terms of changes in the size and age composition -- in California, Florida, and Texas. Florida stands out for its rapid increase in the number and proportion of elderly residents -- as expected because the absence of income taxes makes it a popular destination for retirees. The California population profiles show a substantial increases in the number children, young adults, and the elderly. California's younger populations are expected to grow, partly because of continuing migration from the nation's eastern and mid-western regions. Similar to California, Texas' population profile is growing throughout the age distribution but the increase in the young-adults population is not as pronounced. The significant increases in these populations suggest growing Medicaid costs even on a pre-ObamaCare basis.

Population projections for Illinois and New York exhibit considerably greater constancy, both in population size and age composition. These projections suggest that Medicaid costs will not increase as rapidly in these two states compared to the other three with more robust population growth and faster population aging.

## 3. State Medicaid Cost Projections

*General Considerations*

ObamaCare broadens Medicaid eligibility by increasing income thresholds for children and adults. Children living in families with incomes less than 138 percent of the Federal Poverty Level (FPL) (gross with the new 5 percent income disregard added) will now qualify for Medicaid. In addition, adults with or without qualifying children are also made eligible under the new FPL threshold. Expanded eligibility levels under ObamaCare will increase state Medicaid expenditures. But it will not significantly increase state GR Medicaid costs, at least in the short-term, because of the high marginal cost sharing provided by the federal government for individuals made newly eligible for Medicaid. GR funded state Medicaid costs would not increase by much if enrollment rates among those eligible for Medicaid on a pre-ObamaCare basis remain low. That possibility is unlikely, however, because of the individual health mandate under ObamaCare -- which forces individuals to purchase health insurance or pay a fine.

Although it is uncertain whether the individual health care mandate will survive court challenges from many states, this study's Medicaid cost growth estimates are constructed under the assumption that it will. The mandate will force an increase in enrollment by those who were eligible under the old laws but were not enrolled in Medicaid or any other health insurance plan. Although ObamaCare provides full federal support for newly eligible Medicaid enrollees (through 2019), it provides zero additional support for new enrollees among "old eligibles."

ObamaCare will be implemented with special efforts to advertise the availability of Medicaid's health care coverage options to newly eligible populations--to increase enrollment rates among newly eligible children and adults. However, the enrollment facilitation will also induce some "old eligibles" to switch from non-Medicaid to Medicaid coverage because the latter is subsidized and imposes zero or much smaller costs on beneficiaries compared to their current employer-provided

or privately purchased health insurance coverage.  By how much future state Medicaid expenditures increase will depend on how successful those efforts turn out to be.[11]

In calculating enrollments on a post-ObamaCare basis, it is assumed that enrollments by those newly eligible will either follow the same enrollment rates as those presently eligible or they will enroll at the rate of those with no other health insurance, depending on which rate is larger. A similar method is followed for those who are eligible for Medicaid under the old laws but are not enrolled in Medicaid. Applying these rules yields a sizable increase in enrollments in 2014.

*Enrollment Projections*

Even before the enactment of ObamaCare in March, 2010, Medicaid enrollments are projected to increase substantially in California, Florida, and Texas.  The top panel of Table 2 shows projected increases in Medicaid enrollments in the five states being considered.  The 5 columns on the left show the number (in thousands) of new enrollees that would result under ObamaCare in selected future years (2014, 2020, and 2030). These are counts of enrollees estimated from among those made newly eligible for Medicaid benefits under ObamaCare's broader eligibility criteria.  The lower panel (again of the 5 columns on the left) shows the  increase that these new enrollees represent as a percent of projected enrollees in the same years *without* including the effects of ObamaCare.  The increases in Medicaid caseloads are sizable -- ranging from the mid-twenty percents for California to the mid-fifty percents for Florida and New York.  However, the costs of these increases in Medicaid caseloads will be paid for almost entirely out of marginal federal cost sharing.

Insert Table 2 About Here

The five columns on the right show the number (in thousands) of new enrollees among "old eligibles" that would result from ObamaCare's individual health insurance mandate. Effectively, applying for health insurance through state-operated health insurance exchanges would reveal if the applicant is Medicaid eligible under pre-ObamaCare laws. If so, the person would be directed/advised to sign up for Medicaid unless (s)he desires an alternative insurance source. The estimation procedure mentioned above -- taking the larger of the uninsured rate or the pre-ObamaCare enrollment rate -- produces the estimates reported in Table 2.[12]

The lower panel shows the increase that new enrollees among "old eligibles" represented as a percent of Medicaid enrollees in the same years projected on a pre-ObamaCare basis. The estimates are much smaller compared to those in the columns on the left. But the cost of these new enrollees, under the new law, would be paid for entirely out of state budgets: ObamaCare provides zero federal financial support on account of new enrollees among old eligibles.

It is noteworthy that California is projected to experience very small increases in new enrollments among old eligibles into Medicaid. That's because California already has very high enrollment rates among Medicaid eligibles and there is not much scope for expanding enrollments among old eligibles under ObamaCare. Florida and Texas are projected to experience Medicaid enrollment increases in the 10 to 16 percent range in years beginning in 2014. However, Illinois and New York are projected to gain Medicaid enrollments among old eligibles much more rapidly -- clustered around 20 percent -- in the various years shown in Table 2. This occurs because these two states have smaller enrollment rates pre-ObamaCare, leaving more scope for enrollment increases as the new law's individual mandate becomes applicable after 2014. This means, that in each year in the future, Medicaid enrollments would be between 10 to 25 percent higher in all the states examined except in California.

Table 3 shows cost increases in the five states -- comparing post-ObamaCare against pre-ObamaCare costs in selected future years. Cost increases are generally larger than enrollment increases because the historical increases in costs per beneficiary are projected forward in time and augment cost growth from larger enrollments.

Insert Table 3 about here.

The top panel of Table 3 shows costs in selected future years on a Pre- and Post-ObamaCare basis in billions of dollars. The row in the middle of Table 3 shows the percentage increase in states' GR Medicaid costs on pre- and post-ObamaCare bases between 2014 and 2020, and between 2014 and 2030.

- In California, Florida, and Texas, cost growth is sizable between 2014 and 2020, including on a pre-ObamaCare basis. Cumulative changes range from about 28 percent to about 42 percent for these three states.

- In Illinois and New York, cumulative changes through the year 2020 are much smaller -- ranging between 6 percent to about 15 percent.

- Through 2030, cumulative cost increases on a pre-ObamaCare basis are, again, much larger for California, Florida, and Texas -- more than doubling even on an pre-ObamaCare basis. For Illinois and Florida, the cumulative cost increases are relatively modest -- ranging between about 18 and 29 percent.

Thus, GR cost projections exhibit very different trends on a pre-ObamaCare basis in the five states, increasing much more rapidly for California, Florida, and Texas, and more slowly for Illinois and New York. A salient reason is that the former states are projected to experience growing populations among age-gender groups that have high Medicaid eligibility and utilization rates

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historically, whereas the latter two states have stagnant or declining populations among those groups. On a post-ObamaCare basis, however, the cost increases are much larger compared to pre-ObamaCare costs in 2014, and the increases (relative to teh pre-ObamaCare cost increases) are especially sizable for Illinois and New York.

Another way to measure post-ObamaCare cost increases is shown in the last panel of Table 3. This panel of the Table shows the percent increase in projected Medicaid costs from ObamaCare in selected years. Here, the story is reversed compared to projected cost increases over time: States with high cost increases over time exhibit low projected cost increases from ObamaCare and states with low cost growth over time exhibit relatively more rapid cost increases from ObamaCare.

- ObamaCare's effects on Medicaid costs in California are very small--less than 5 percent in all of the years shown in Table 3.

- Medicaid costs in Florida and Texas increase more rapidly as a result of ObamaCare--ranging between 10 and mid-20 percents in the years shown.

- Illinois and New York are projected to have much higher cost increases as a result of ObamaCare -- ranging between 10 and the mid-30 percents in the years shown.

This result occurs because, consistent with historical data, Illinois and New York are projected to have lower eligibility and enrollment rates than California, Florida, and Texas, and those rates are projected to increase more slowly on an pre-ObamaCare basis in both states. With the introduction of the individual mandate, however, many among old eligibles who do not have health insurance will be required to do so under the new law. If applying for health insurance at state-operated Exchanges reveals eligibility for Medicaid under the old eligibility rules, enrollment in Medicaid will ensue, usually leading to benefit claims. In addition, the health insurance mandate may

cause some individuals to realize that obtaining health insurance through Medicaid is more cost effective than their existing private insurance and may cause them to shift to Medicaid. Alternatively, if employers choose to drop coverage, many old-eligibles who are currently insured in the private market may enroll into Medicaid.

The message from Tables 2 and 3 is that states with already high enrollments and rapid growth in Medicaid enrollments would face serious budget problems from rising Medicaid costs. ObamaCare adds to their fiscal burden, primarily by bringing forward in time enrollment increases that would likely have occurred later. Moreover, the additional Medicaid cost from ObamaCare is relatively small. However, states with heretofore low Medicaid enrollments and slower growth in enrollments are likely to experience a substantial increase in Medicaid costs because of ObamaCare's health insurance mandate.

Table 4 shows Medicaid cost growth rates by age group and special eligibility categories. The growth rates by age-categories are calculated on a pre-ObamaCare basis after excluding individuals that qualify for and claim Medicaid benefits under special eligibility rules. The Table shows that annual average Medicaid cost growth on account of children (not including costs of SCHIP), is projected to be quite high through the year 2020 in California, Florida, and Texas -- ranging between 9 and 12 percent per year. In Illinois and Florida, that growth rate is not as high. Between 2020 and 2030, the growth rate is lower in all states, but especially in Illinois and New York.

Insert Table 4 About Here

The same remarks are applicable to Medicaid cost growth for non-disabled adults aged 19-64. However, Illinois and New York will experience low or negative cost growth rates -- probably because of the projected decline in their populations of working-aged adults. Among retirees,

growth rates vary across states and over time: Highest in California, but negative over the long term in Florida and New York. Those negative growth rates are probably the result of increasing use of prescription drugs, payment for which was switched from Medicaid to Medicare during the early 2000s, and the consequent decline in the ratios of beneficiaries to enrollees in these two states.[13]

Among special eligibility categories, cost growth rates are highest among women with breast and cervical cancer, followed by foster-care children and blind/disabled adults. Across all categories, projected annual (nominal) Medicaid cost growth rates are 8.9 percent for California, 7.9 percent for Florida, and 9.3 percent in Texas -- much larger than the 5 percent for Illinois and 6.3 percent for New York. During the subsequent decade, annual (nominal) Medicaid cost growth rates are slower -- Between 5.5 and 6.1 percent for California, Florida, and Texas; and they are very small for Illinois (1.0 percent) and New York (1.2 percent). The slower cost growth after the year 2020 in most cases is explained by projected eligibility/enrollment/beneficiary rates eventually attaining maximum values of 100 percent with no scope for additional increases.

*Alternative Federal Cost Sharing Scenarios*

The Congressional Budget Office projects unprecedented federal deficits as a share of GDP -- indicating the precarious condition of federal finances -- through the next 10 years. It means that the promised high marginal federal cost sharing for new enrollees among those made newly eligible for Medicaid under ObamaCare could be reduced rather than maintained at the 2019 value of 92.8 percent. Two alternative projections are constructed for states' Medicaid expenditures assuming reduced marginal federal cost sharing. The first scenario implements a gradual reduction in marginal federal FMAP support after 2019 and the second a more rapid reduction of the same. The results are shown in Table 5.

Insert Table 5 About Here

The top panel of Table 5 shows Medicaid costs on a post-ObamaCare basis and the bottom panel shows the percentage increase in costs over the pre-ObamaCare projection for selected years. In each state's panel in Table 5, the first column repeats the results of Table 3 on a post-ObamaCare basis--the Base Case; the second column shows results under the assumption that marginal FMAP cost sharing rate under ObamaCare is gradually reduced by 1 percentage point per year until it reaches the standard FMAP rate applicable for each state -- Alternative 1; and the third column shows results under the assumption that federal marginal cost sharing is reduced rapidly so that it achieves the standard FMAP rate for each state by 2028 -- 10 years after 2019 -- Alternative 2. Note that the terminal year through which marginal federal cost sharing rates have been specified under ObamaCare is 2019.

Insert Table 5 here, or prior to this paragraph.

Focusing on the lower panel of the table, the results show that California's additional cost from ObamaCare in the year 2030 would increase from 4.1 percent under the Base Case to 5.9 percent under the first scenario and to 9.6 percent under the second scenario. very little under both alternative scenarios. For other states, however, cost increases under the two alternative scenarios are much larger. In Florida, for example, the additional Medicaid cost from ObamaCare would increase from 27.1 percent to 35.4 percent under the first scenario and to 51.1 percent under the second. Significant increases in additional Medicaid costs from ObamaCare also arise for Illinois, New York and Texas as Table 5 shows.

Table 6 provides the overall picture of Medicaid cost growth during the ten years after the reform is implemented in 2014. The first row of the table shows total ten-year cost under the assumption that Medicaid's dollar spending out of state general revenues is frozen at the 2014 level.

That cost is highest for New York, followed by California and with Texas being a distant third. The second row of the table shows flat-lined enrollments--that is, assuming that enrollments are maintained at the 2014 level for 10 years thereafter. Dividing the ten-year flat cost with the ten-year flat enrollment yields the average cost per enrollee -- as shown in the third row of the table. New York is by far the most expensive Medicaid state, spending almost $6000 per Medicaid enrollee. All of the other four states included in this study are projected to experience much smaller costs -- of a little more than $2000 per enrollee -- only about one-third of New York's average Medicaid cost per enrollee.[14]

Insert Table 6 About Here

The fourth row of Table 6 shows the percentage increase in projected costs if future enrollments and costs per beneficiary continue to evolve along historical trends in each of the age and special-eligibility categories as described in the Appendix. This pre-ObamaCare Medicaid cost projection shows that Medicaid costs would increase substantially for California (26.2 percent), Florida (20.8 percent) and Texas (31.6 percent) even without ObamaCare. Ten-year cost increases projected on a pre-ObamaCare basis are quite low for Illinois (5 percent) and New York (10.8 percent) because enrollment ratios and costs have been historically low and have increased less steeply in these two states.

The fifth row of Table 6 shows that ObamaCare increases California's ten-year Medicaid cost by very little -- from 26.2 percent to 30 percent. That's because the ratio of enrollees to old-eligibles is already quite high in California -- leaving little scope for ObamaCare to increase costs further on account of new enrollees among old-eligibles in California compared to Florida and Texas.[15] In the latter two states, pre-ObamaCare projections suggest much larger scope for cost as enrollment rates have stagnated, especially among the largest category of non-disabled adults aged

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19-64.  This is confirmed in Table 6, which shows that ten-year Medicaid costs would escalate not to

20.1 percent (as under the pre-ObamaCare projection) but by 45 percent because of ObamaCare. In

the case of Texas, the ten-year cost would increase, not to 31.6 percent (as under pre-ObamaCare

projections, but to 55.7 percent because of ObamaCare.  Thus, the cumulative impact of pre-

ObamaCare trends in eligibility, enrollments, and beneficiary ratios, and costs per beneficiary lead to

the largest escalation in Medicaid costs in Texas -- casting a bright spotlight on why Texas state

policymakers are so highly concerned with the implications of ObamaCare for that state's budget.

In Illinois and New York also, the ratio of enrollees to eligibles is low -- and, in some

instances, it has declined historically.  Again, this explains why ObamaCare would lead to sizable

cost increases -- the individual health insurance mandate forcing old-eligibles back into enrolling

under Medicaid.  Table 6 shows that compared to flat-lined costs, ObamaCare would escalate

Illinois' ten-year costs not by 5 percent (as under pre-ObamaCare projections) but by 37.1 percent.

And New York's cost increase would be by 33.7 percent, not by just 10.8 percent.

The results overall show that all of the five states are facing a ten-year Medicaid cost increase

larger than 30 percent -- resulting from a combination of already increasing trends in eligibility,

enrollments, and beneficiary ratios and costs per beneficiary.  Among the 5 states examined,

cumulative post-ObamaCare costs escalation is steepest for Texas and the least steep for California.

Even when the incremental Medicaid cost totals under this study are restricted to the 2014-19

period, cost increases among the four states excluding California (for which the increase is small)

range from 17 percent for Florida to 28 percent for Illinois.

These results are clearly at odds with standard understanding of how much state costs would

increase from ObamaCare.  Public understanding of incremental costs from ObamaCare appears to

be informed by estimates reported on the Kaiser Family Foundation's website which shows very

small increases in total state costs during 2014-19.[16]  Kaiser's estimates of state cost increases range

from 1.5 percent for Florida to 6 percent for New York – much smaller than the estimates reported

in this study.  From the description of Kaiser's methodology, it appears that only the small increase

in state costs from post-2017 reductions in marginal federal contributions for newly eligible

Medicaid enrollees have been taken into account. The potentially significant additions to Medicaid

costs from new enrollments by "old eligibles" appear to have been excluded.


**Conclusion**

Detailed estimates of the effect of ObamaCare on the budgets of the five most populous states

in the United States suggest unfunded mandates to expand caseloads and increase state Medicaid

outlays.  States' increased financial burden from Medicaid must come from cut-backs in other

needed public services or higher tax burdens -- both of which will exert negatives effects on states'

economies.

The results suggest that even on a pre-ObamaCare basis Medicaid costs would increase rapidly

in California, Florida, and Texas--which have growing populations across many Medicaid eligibility

and enrollment groups by age and gender. Cost increases on a pre-ObamaCare basis are projected to

be smaller in Illinois and New York -- states whose populations are projected to remain generally

stagnant or to decline during the next two decades.  When ObamaCare's effects on enrollment in

Medicaid are included--especially enrollment by "old eligibles" who would now be directed to enroll

as a consequence of the new law's health insurance mandate.

The projected, cumulative post-ObamaCare cost increase during 2014-23 is small only for

California: Costs are higher by 4.5 percentage points (30.7 percent instead of 26.2 percent) with

ObamaCare than without it. In Florida and Texas, however, projected post-ObamaCare increases in ten-year Medicaid costs are larger compared to ten-year costs pre-ObamaCare. because both of these states are projected to have larger populations of non-enrolled "old eligibles." Including the effects of ObamaCare, Florida's ten-year cost would be larger by 45.0 percent from the flat-cost baseline instead of by just 20.8 percent higher under the pre-ObamaCare basis. In Texas, projected Medicaid costs would be 55.7 percent larger under ObamaCare as compared to just 31.6 percent without the new law, where both are increases over the flat-cost ten-year baseline costs.

Illinois and New York exhibit historically stable or declining enrollment rates among "old eligibles," implying larger potentials for higher enrollments and increased costs when ObamaCare becomes effective after the year 2014. Costs in these two states are 37.1 percent and 33.7 percent, respectively, with ObamaCare compared to just 5.0 percent and 10.8 percent, respectively, without it.

It should be noted that the estimates presented here of projected Medicaid costs in five states, both pre- and post-ObamaCare, are based on standard assumptions and methods for extending eligibility, enrollment, benefit recipiency and benefit award rates into the future. The estimates may be conservative because the effect of future shifts from private coverage to Medicaid post ObamaCare are not fully incorporated. The results are also uncertain because future trajectories of all of these rates will be affected by many factors not considered here -- the economic environment, the implementation of ObamaCare laws, the availability non-Medicaid health insurance for low income individuals, and so on.

Supporting such high Medicaid cost increases would require higher taxes or reductions in other public services, both of which are economically undesirable. Concerns about runaway Medicaid costs are motivating policymakers in many states to explore ways to restrain Medicaid

expenditures -- either by eliminating waste, fraud and abuse or through more drastic measures such as opting out of Medicaid altogether -- an option that has always existed under the original Social Security Act--and providing basic health coverage to low-income and medically needy groups instead.  Another possibility is to allow the quality of Medicaid-covered health care services to deteriorate in order to prevent the crowd-out of private health coverage that has historically occurred after every expansion of the Medicaid program.  Prospects of such steep increases in Medicaid costs probably explain growing support among citizens and many state policymakers to alter ObamaCare laws, if not to repeal them.

**F**igure 1: State Population Projections By Age, 2005-2030.
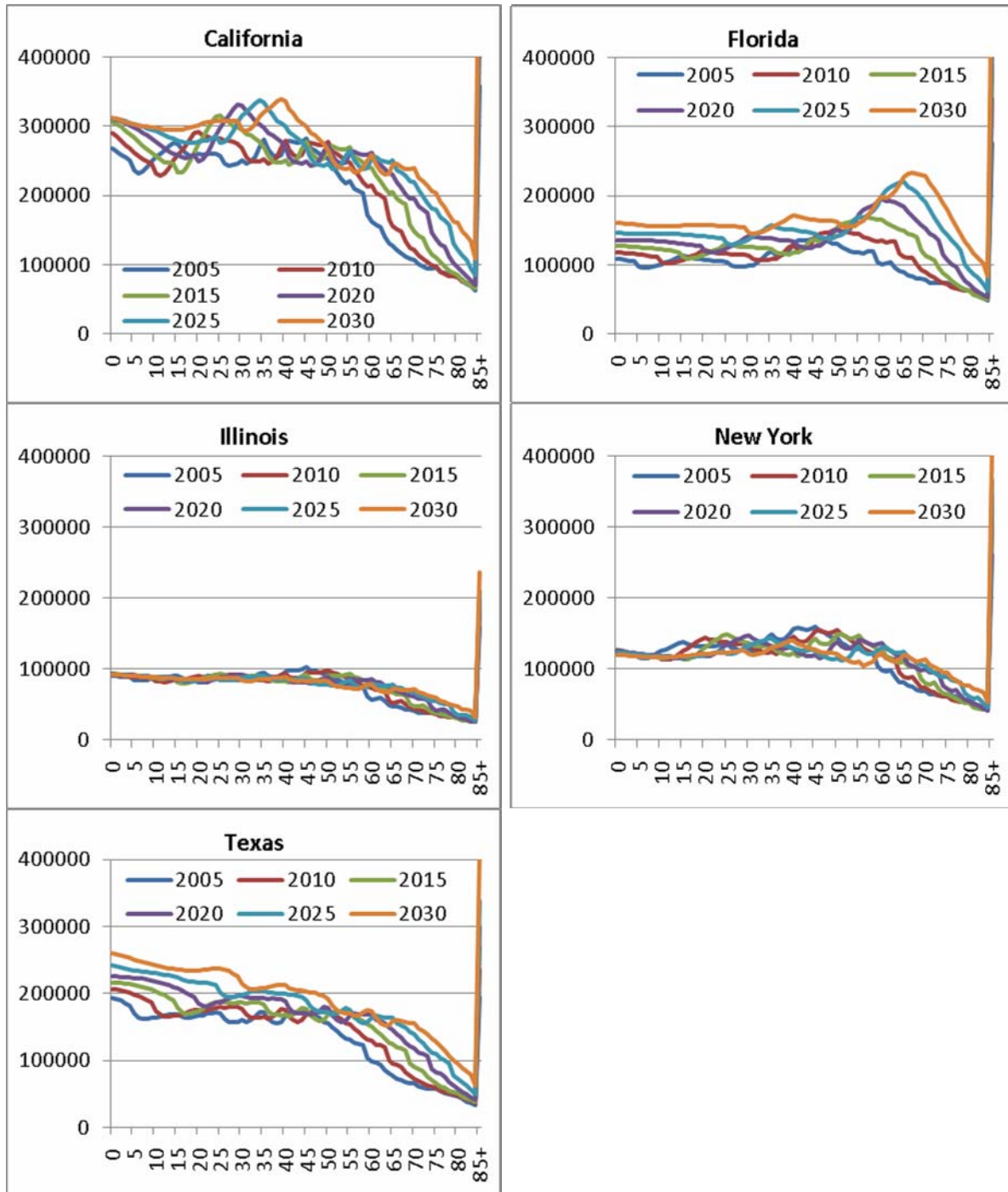


Source: United States' Census Bureau.

Table 1: Projected Population Growth (annualized, percent)

| Age Category | 2010-20 | | | | | 2020-30 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | CA | FL | IL | NY | TX | CA | FL | IL | NY | TX |
| 0-18 | 0.69 | 1.47 | 0.12 | -0.15 | 1.33 | 0.64 | 1.70 | 0.02 | -0.11 | 1.24 |
| 19-64 | 0.51 | 1.12 | -0.13 | -0.27 | 0.85 | 0.56 | 1.21 | -0.30 | -0.63 | 1.24 |
| 65+ | 2.91 | 3.40 | 1.82 | 1.71 | 3.15 | 2.95 | 4.29 | 1.95 | 1.88 | 3.28 |
| All | 0.86 | 1.64 | 0.20 | 0.06 | 1.26 | 0.96 | 2.05 | 0.15 | -0.05 | 1.53 |

Source: Author's calculations based on data on population projections from the Census Bureau.

Table 2: Enrollment Increases Induced by ObamaCare (thousands of people)

| Year | New Enrollees (Newly Eligible) | | | | | New Enrollees (Old Eligibles) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | CA | FL | IL | NY | TX | CA | FL | IL | NY | TX |
| 2014 | 2,985 | 2,315 | 979 | 2,059 | 2,118 | 204 | 624 | 518 | 467 | 858 |
| 2020 | 3,078 | 2,434 | 925 | 2,001 | 2,329 | 257 | 739 | 620 | 677 | 820 |
| 2030 | 3,479 | 3,125 | 886 | 1,917 | 2,729 | 412 | 937 | 767 | 1,014 | 864 |
| | Percent Increase from Pre-OC Enrollment Projection | | | | | | | | | |
| 2014 | 24.9 | 55.4 | 36.0 | 42.2 | 40.8 | 1.7 | 14.9 | 19.0 | 12.3 | 16.5 |
| 2020 | 23.3 | 53.6 | 31.7 | 41.3 | 38.0 | 1.9 | 16.3 | 21.2 | 16.8 | 13.4 |
| 2030 | 22.6 | 57.6 | 26.9 | 38.6 | 34.9 | 2.7 | 17.3 | 23.3 | 23.5 | 11.1 |

Source: Author's calculations based on the Medicaid Statistical Information System and the Current Population Surveys.

Table 3: Projected GR Medicaid Expenditures On A Pre- and Post-ObamaCare Basis (billions of dollars)

| Year | CA | | FL | | IL | | NY | | TX | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Pre OC | Post OC | Pre OC | Post OC | Pre OC | Post OC | Pre OC | Post OC | Pre OC | Post OC |
| 2008 | 19.4 | : | 6.3 | : | 5.8 | : | 23.8 | : | 8.5 | : |
| 2014 | 26.3 | 26.5 | 9.8 | 10.9 | 6.4 | 8.0 | 28.7 | 31.8 | 12.7 | 15.0 |
| 2020 | 35.2 | 36.8 | 12.6 | 15.5 | 6.9 | 9.1 | 32.9 | 40.7 | 18.0 | 21.3 |
| 2030 | 59.9 | 62.3 | 19.5 | 24.7 | 7.6 | 10.3 | 37.1 | 50.4 | 32.5 | 37.0 |
| | Percent Increase from Pre-ObamaCare Cost in 2014 | | | | | | | | | |
| 2020/2014 | 34.1 | 40.1 | 27.8 | 57.3 | 6.8 | 41.9 | 14.5 | 41.7 | 41.7 | 68.1 |
| 2030/2014 | 128.0 | 137.3 | 97.9 | 157.5 | 17.8 | 61.2 | 29.4 | 75.4 | 156.6 | 192.1 |
| | Percent Change Post-ObamaCare over Pre-ObamaCare | | | | | | | | | |
| 2014 | 0.9 | | 11.3 | | 24.6 | | 10.7 | | 21.8 | |
| 2020 | 4.5 | | 23.1 | | 32.9 | | 23.8 | | 20.9 | |
| 2030 | 4.1 | | 27.1 | | 36.9 | | 35.6 | | 15.2 | |

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys and CMS-64 reports.

Table 4: Projected General Revenue Medicaid Spending Growth by Age and Special Eligibility Categories On A Pre-ObamaCare Basis (annualized, percent)

| Age and Special Eligibility Category | 2010-20 | | | | | 2020-30 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | CA | FL | IL | NY | TX | CA | FL | IL | NY | TX |
| 0-18[*] | 9.0 | 11.1 | 7.4 | 7.0 | 12.0 | 4.1 | 7.4 | 2.8 | 2.6 | 7.8 |
| 19-64[*] | 8.6 | 10.4 | -3.1 | 5.5 | 5.9 | 4.6 | 7.2 | -0.8 | -2.3 | 3.5 |
| 65+[*] | 12.5 | 4.6 | 6.3 | 4.0 | 5.5 | 8.4 | -2.8 | 1.9 | -3.3 | 2.3 |
| Med. Needy | 6.3 | 9.1 | 2.0 | 6.4 | -0.7 | 5.0 | 6.6 | -2.1 | 1.2 | -0.9 |
| BCCA | 16.3 | 20.7 | 22.7 | 15.6 | 16.8 | 9.8 | 11.7 | 14.2 | 8.4 | 10.1 |
| Foster Care | 10.3 | 9.4 | 2.4 | 1.5 | 13.6 | 7.2 | 5.5 | 2.1 | 5.2 | 8.5 |
| Fmly Plng | 13.4 | -30.0 | 9.4 | | | 10.0 | 7.6 | 7.5 | | |
| Dsbld Adlts | 7.0 | 6.9 | 5.8 | 7.8 | 7.6 | 2.4 | 2.5 | -0.1 | 2.4 | 3.8 |
| Waivers | 4.2 | 6.4 | 3.4 | 3.4 | 4.4 | 0.9 | 3.3 | 0.1 | -0.7 | 1.4 |
| All | 8.9 | 7.9 | 5.0 | 6.3 | 9.3 | 5.5 | 4.5 | 1.0 | 1.2 | 6.1 |

[*] Excludes people eligible under other special categories.
Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys and CMS-64 reports.


Table 5: Medicaid Cost Increases Post-ObamaCare Under Alternative Federal Match Policies

| Year | CA | | | FL | | | IL | | | NY | | | TX | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 | Base Case | Alt 1 | Alt 2 |
| 2014 | 26.5 | 26.5 | 26.5 | 10.9 | 10.9 | 10.9 | 8.0 | 8.0 | 8.0 | 31.8 | 31.8 | 31.8 | 15.0 | 15.0 | 15.0 |
| 2020 | 36.8 | 36.9 | 37.3 | 15.5 | 15.6 | 16.1 | 9.1 | 9.1 | 9.3 | 40.7 | 40.8 | 41.7 | 21.3 | 21.4 | 21.9 |
| 2030 | 62.3 | 63.4 | 65.6 | 24.7 | 26.3 | 29.4 | 10.3 | 10.6 | 11.1 | 50.4 | 52.1 | 55.4 | 37.0 | 38.5 | 41.2 |
| | Percent Change Over Pre-ObamaCare | | | | | | | | | | | | | | |
| 2014 | 0.9 | 0.9 | 0.9 | 11.3 | 11.3 | 11.3 | 24.6 | 24.6 | 24.6 | 10.7 | 10.7 | 10.7 | 21.8 | 18.7 | 18.7 |
| 2020 | 4.5 | 4.7 | 5.8 | 23.1 | 23.9 | 28.1 | 32.9 | 33.2 | 35.3 | 23.8 | 24.3 | 26.9 | 20.9 | 19.2 | 22.1 |
| 2030 | 4.1 | 5.9 | 9.6 | 27.1 | 35.3 | 51.1 | 36.9 | 40.4 | 47.2 | 35.6 | 40.2 | 49.2 | 15.2 | 18.2 | 26.8 |

Alt 1 - Marginal federal match for new eligibles is reduced by one percentage point each year through 2030.
Alt 2 - Marginal federal match for new eligibles is eliminated by 2028.
Source: Author's calculations from the Medicaid Statistical Information System, Current Population Surveys and CMS-64 reports..


Table 6: Pre- and Post-ObamaCare Increases in Ten-Year Medicaid Costs -- From a Flat Cost Baseline

| | | CA | FL | IL | NY | TX |
|---|---|---|---|---|---|---|
| 1 | Ten-year Flat-Cost Baseline (2014 Pre-OC; billions of dollars) | 262.6 | 98.4 | 64.2 | 287.1 | 126.8 |
| 2 | Ten -year Pre-OC Change from Flat-Cost Baseline (percent) | 26.2 | 20.8 | 5.0 | 10.8 | 31.6 |
| 3 | Ten -year Post OC Change from Flat-Cost Baseline (percent) | 30.7 | 45.0 | 37.1 | 33.7 | 55.7 |
| 4 | Ten-year Post-OC Change from Flat-Cost Baseline Alt 1 (percent) | 31.0 | 46.0 | 37.5 | 34.2 | 56.5 |
| 5 | Ten-year Post-OC Change from Flat-Cost Baseline Alt 2 (percent) | 32.1 | 50.0 | 39.0 | 36.3 | 59.5 |
| 6 | Memo: Ten-year Flat enrollment (millions of people) | 119.7 | 41.8 | 27.2 | 48.8 | 51.9 |
| 7 | Memo: Average Cost Per Enrollee (dollars) | 2,195 | 2,355 | 2,358 | 5,879 | 2,441 |

Source: Author's calculations from the Medicaid Statistical Information System, Current Population Surveys and CMS-64 reports.

**Appendix**

**Methodology for Projecting Texas Medicaid Expenditures Under ObamaCare**

Medicaid cost projections for the five states considered in this study are based on various data sources, namely, the Medicaid Statistical Information System, the Current Population Surveys, and the U.S. Census Bureau. Section A1 explains the general methodology and Section A2 discusses the rules applied to determine Medicaid eligibility for various age and eligibility categories, including differences in rules across the five states evaluated here; and Section A3 describes historical trends of Medicaid eligibility, enrollment, recipiency, and average benefits per recipient separately for various demographic groups and eligibility categories -- children, adults, the elderly, blind/disabled and others qualifying for Medicaid under special rules.

*A1. Methodology for Projecting Medicaid Expenditures in Texas*

The Medicaid Statistical Information System (MSIS)--State Data Mart website provides administrative information on the number of Medicaid beneficiaries by gender ($g$), age-category ($a$), and eligibility group ($e$) for years 1999-2008. It also provides information on total Medicaid benefits awarded to state residents ($B\_STT$) in those years, where the suffix, *STT,* stands for the state in question.

In all states, residents qualify for Medicaid benefits based on a range of income and asset related criteria. In addition, special categories of individuals such as children, pregnant women, aged, blind, disabled, and medically needy individuals qualify for "categorical coverage" even though their incomes and resources exceed federally mandated income and asset qualification thresholds.

First, the total population for the state in question is calculated by gender, age-category, income range (*f*) relative to the federal poverty level (FPL), and year (*t*), based on data from the Current Population Survey, $CPS_{STTPOP_{g,a,f,t}}$.[17] Because the CPS undercounts state populations relative to Census Bureau counts for all states, the Census population $CBN_{STTPOP_{g,a,t}}$ is also categorized according to gender, age-category, and year cells and the latter population is used to rescale CPS population counts: For each demographic cell, the ratio of the two populations

$$U_{g,a,t} = \frac{CBN_{STTPOP_{g,a,t}}}{\sum_f CPS_{STTPOP_{g,a,f,t}}}$$ provides a measure of the cell specific population over- or under-counts in the CPS relative to the Census population.

Next, populations of Texas Medicaid benefit-*eligible* individuals by demographic cells are calculated from the CPS: $CPS_{E_{STT_{g,a,f,t}}}$. These cells are calculated separately for specific income ranges (*f*) relative to FPL values.[18]

Take a male aged *a* in 2008. Adults qualify for Medicaid coverage if they have a covered child. In turn, the child is Medicaid eligible if the income of the child's family falls within the income threshold or the child qualifies based on non-income related criteria such as disability and foster care (for which income-eligibility limits are different). Thus, the *eligibility rate, e,* for adults aged *a* of gender *g* with FPL-relative income *f* and in year *t* can be calculated conditional on their children's eligibility as

$$e_{g,a,f,t} = \frac{U_{g,a,t} \times E_{CPS_{g,a,f,t}}}{U_{g,a,t} \times CPS_{STTPOP_{g,a,f,t}}}.$$

Here, the numerator refers to the total number of state residents found to be Medicaid eligible in the CPS after applying the eligibility rules and the population adjustment ratio, $U_{g,a,t}$ (described above).

Next, the *enrollment rate*, *n*, is calculated as the number of Medicaid enrollees divided by the number of Medicaid eligibles:

$$n_{g,a,t} = \frac{N_{MSIS_{g,a,t}}}{U_{g,a,t} \times \sum_f E_{CPS_{g,a,f,t}}}.$$

Here, the numerator is the total number of male state residents aged *a* of gender *g* in year *t* that are enrolled in Medicaid based on data obtained from MSIS. One limitation of the data from MSIS is that they are not decomposed by FPL-relative income categories. Therefore, the average age-gender enrollment rate is applied to all three FPL categories. Next, the *recipiency rate*, *r*, is calculated as the number of Medicaid recipients (or beneficiaries) among Medicaid enrollees.

$$r_{g,a,t} = \frac{R_{MSIS_{g,a,t}}}{N_{MSIS_{g,a,t}}}.$$

Again, data for the number of state residents who received Medicaid benefits are obtained from MSIS. Finally, *average Medicaid benefits per recipient, b*, in the state in question are calculated from the MSIS as

$$b_{g,a,t} = \frac{B_{MSIS_{g,a,t}}}{R_{MSIS_{g,a,t}}}.$$

where the numerator refers to total Medicaid benefits for this group. The average age-gender ratios $r_{g,a,t}$ and $b_{g,a,t}$ are applied to those who are Medicaid eligible in each FPL-relative income categories. Thus, total state Medicaid expenditures in 2008 on males aged *a*, gender *g*, FPL category *f*, and year *t*, can be represented as:

$$M_{g,a,f,t} = U_{g,a,t} \times CPS_{STTPOP_{g,a,f,t}} \times e_{g,a,f,t} \times n_{g,a,t} \times r_{g,a,t} \times b_{g,a,t}.$$

This method of calculating the four rates can be applied to all age groups and both genders and aggregated to yield total (MSIS based) Medicaid expenditures for the year in question.

Total Medicaid expenditures derived in this manner for the base year (2008) are benchmarked to total (expended) Medicaid expenditures in 2008 as reported in the state budget. This step takes account of DSH, UPL, and Medicaid administrative expenditures that are not included in MSIS data. Thus, these additional expenditures are implicitly distributed across age, gender, and eligibility categories in the same proportion as Texas Medicaid expenditures included in MSIS data.

The simplest way to project states' Medicaid expenditures for future years is to represent total expenditures in earlier years by age and gender, $M_{g,a,f,t}$     $t =$ 2001-2008, as above, and extrapolate each of the component elements over future years. The product of those terms in future years provides estimates of future Medicaid expenditures in the state for each particular gender, age, and FPL category. Summing over all categories provides the future year's total Medicaid expenditures.

The reason for calculating and independently projecting each of these component rates when constructing Medicaid's expenditure projections is that those rates capture different policy or environmental factors, each with the potential to exhibit its own future trend. For example, while the Medicaid eligibility rate for a particular population sub-group is determined by federal and state policies about which types of individuals should qualify for Medicaid benefits, enrollment rates for different population sub-groups may be determined by the availability and cost of alternative health insurance coverage, individual perceptions about their health care needs, the quality and out-of-pocket costs of Medicaid's health care provision, and public awareness about the availability of Medicaid coverage for people with similar demographic, economic, and health characteristics.

Furthermore, Medicaid recipiency rates could be different among different population sub-groups by age, gender, and other characteristics, depending on their frequencies of adverse health episodes and health service needs. Finally, average benefit rates would differ depending on the

incidence of chronic conditions, whether recipients are elderly or disabled, the type, quality, and cost of health care treatments that are locally available, and so on. Basing projections on detailed historical information on the group-specific trends of all four components separately -- by age, gender, whether disabled, income level (relative to the federal poverty level), whether medically needy, unemployed, single-or-dual headed family, child status, etc. provides greater confidence that the rich variety of independent influences of policies, environmental conditions, and behavioral propensities on Medicaid expenditures have been adequately accounted for.

ObamaCare changes eligibility rules for low-income individuals, and mandates health insurance coverage for all. In addition it envisions a vigorous public-awareness and enrollment facilitation drives that would increase enrollment rates among both, those eligible under the old laws and those newly eligible for Medicaid. So state Medicaid costs under ObamaCare are likely to be quite different (and considerably larger) compared to under the old health-care laws.

*A2. Medicaid Eligibility Criteria*

There are three key ways to be eligible for Medicaid in any state including pregnant women and children below a certain federal poverty level, families eligible for TANF/AFDC, and the blind/disabled and the aged. This section will briefly discuss each of these rules and how they vary by state. The section will then cover a handful of other reasons someone may be eligible for Medicaid. All of the rules described here for the three key eligibility criteria are coded to determine eligibility to Medicaid among the CPS sample populations by age, gender, FPL-relative income category, and those eligible under special rules for the years spanning 2000 and 2008--the latest year for which CPS data are available.

*a. Federal Poverty Level*

Having a family income below a specific federal poverty level (FPL) is one of the key eligibility criteria. Prior to the new health care law, Medicaid's federal income eligibility threshold was 100 percent of the FPL for children aged 6 through 18, with a state option up to 133 percent and to extend the age to 20 for those in school. For 1 to 5 year olds the federal income eligibility threshold was 133%. For newborns and pregnant women, the income limit was at 133 percent of FPL, with options for states to increase it up to 185 percent of FPL. The new law establishes an income eligibility threshold for everyone (including childless adults) at 133 percent of FPL. It also introduces an income disregard at 5 percent of family income.

Other special deductions were applied before the new health care laws were enacted and varied by state. These generally included items such as work-related ($90 a month) and dependent care expenses ($175-$200 a month), child support payments, earnings of children under age 19 and in school, all income from SSI, other public assistance, and educational assistance.

Of the five most populace states, California, Illinois and New York have elected to cover children aged 6 through 18 at the 133 percent level. All of the states cover newborns and pregnant women up to 185% of FPL. Not only that, but all five states except for Texas have chosen to pay for pregnant women up to 200% from outside their federal Medicaid budgets.

### b. TANF/AFDC

The older Aid to Families with Dependent Children (AFDC) program no longer exists, but rules using AFDC and TANF (Temporary Assistance for Needy Families) qualifying thresholds and conditions still apply to determine Medicaid eligibility. A family is eligible for AFDC/TANF and therefore Medicaid if they are citizens with dependent children and have incomes less than qualifying thresholds. In addition, for two parent households, the primary earner must either be unemployed (or disabled) or be earning less than the AFDC income threshold, or be under-employed (as defined by each state).

Run separately by each state, the TANF eligibility rules vary widely between these 5 states. In California the income limits vary each year, with the 2008 income limit of $12,960 for a 3 person household or around 70 percent of FPL. California also uses an income disregard which is 100 percent of FPL minus the 1996 AFDC Maximum Aid Payment. For a 3 person household this brings the effective 2008 FPL level to 125 percent. Unlike California, Florida's income limits are fixed at the 1996 AFDC standard of $3,636 for a 3 person household or around 20 percent of FPL and declining overtime. Furthermore, Florida only has an income disregard for those who are already receiving Medicaid. For these people it is the $200 and 1/2 earned income disregard, which pushes up the effective 2008 FPL level to 166 percent.

Illinois's income limits vary periodically and by whether or not there is an adult in the household. The 2008 limit was $4,752 for a 3 person household with a parent or 26 percent of FPL. If a family is already receiving Medicaid they are eligible for the $30 and 1/3 earned income disregard or 55 percent FPL level in 2008. New York income limits also vary overtime but not necessarily every year. In 2008 the income limit for a 3 person household was $12,276 or around 67 percent of FPL. New York also has the $30 and 1/3 earned income disregard for those already receiving Medicaid, bring the effective 2008 FPL level to 137 percent. Texas' AFDC income limit is also stagnant at the 1996 level which varies by number of adults in the household. The income level for a single parent, 3 person household is $16,668, which in 2008 was at 91 percent of FPL and declining. Texas also maintains separate TANF rules with a 1996 level income limit for a household of 3 with 1 parent at $9,012, approximately 50 percent of FPL and declining. If the family is currently receiving Medicaid they get a 1/3 earned income disregard, bringing the effective FPL to 74 percent.

*c. Blind/Disabled and Elderly*

SSI recipients are also eligible for Medicaid benefits under the Medicaid for Employed Persons with Disabilities program.  SSI qualifying rules consider unearned income (net of a monthly $20 exclusion) and earned income (net of a monthly $65 exclusion and an annually determined student earned income exclusion), the sum of which must be below a specific annually indexed dollar threshold ($11,472 for a couple in 2009). additionally, retirees and disabled individuals qualify for subsidies to pay for Medicare costs (premiums, co-pays etc) funded out of Medicaid, through the Medicare Savings Program.  These rules require individuals to be receiving Social Security or Railroad Retirement benefits and have family income less than 200 percent of FPL for the retired and 135 percent of FPL for blind/disabled individuals.  Further, disabled workers with earned income less than 250 percent of FPL qualify for the Medicaid buy-in program. The blind/disabled and elderly eligibility rules are the same across all states as dictated by the Social Security Act.

*d.  Other Reasons*

The federal government requires the above groups be covered by Medicaid, whereas the following groups are voluntary except for Foster-care children.  Meaning that states will not lose federal funding if they decide not to cover any of the following groups.  All five states discussed here cover each of these groups to some extent.

Foster-care children are covered under Medicaid given the household they came from qualified for AFDC or their income was below the FPL level.  When a foster-care child ages out of the system at age 18 the child continues to be fully covered through age 21 given an income below a certain FPL level.  Under the new healthcare reform, the age limit to receive Medicaid for aged-out foster-care children has risen to 25.  Medically Needy individuals can also be fully covered by Medicaid if the state elects to.  Medically Needy individuals are determined by a combination of income thresholds and medical expenses.

Women aged 18-44 with incomes below a state specific FPL level qualify for Medicaid family-planning services (of which pregnant women receive full Medicaid benefits). States may also receive waivers to expand family planning to more of their populations. Women between 18 and 64 may also be eligible for breast or cervical cancer care under Medicaid if they are found with either of these cancers and their income is below a certain threshold as determined by the states.

Last but not least, certain groups of people may become eligible under the waiver system. Specifically, the 1115 waiver allows states to write-off certain rules for a demonstration or pilot project. New York has taken this opportunity to allow childless individuals below 100 percent of FPL to be eligible for Medicaid. In most cases the 1115 waiver and the other waivers (1915(b) & 1915(c)) are used to expand services or change the way services are conducted.

*A3. Medicaid Eligibility, Enrollment, Recipiency, and Average Benefits Per Enrollee*

This section describes information obtained from calculating each of the four components for those with FPL less than 100 percent as noted in Section *A1* above--namely, eligibility rates, enrollment rates, recipiency rates, and average benefits per recipient. Because eligibility conditions and health needs differ substantially by age and gender, the four items are calculated separately for various age groups (see note 17), gender and FPL-relative income levels. In addition, special eligibility groups such as medically needy, foster-care children, family planning, and others are treated separately. The calculations span the years 2000-2008 corresponding to the latest available data from the CPS (on eligibility rates) and MSIS (enrollment and recipiency rates; average benefits per recipient).

   a. *Eligibility, Enrollments, Recipiency, and Benefits Among Children*

In all states, Medicaid eligibility rates increased during the last decade among children of all ages and both genders.[19] The data indicate that more than 80 percent of almost all child age-gender groups (except for newborns) were Medicaid-eligible by 2008. During the early 2000s, enrollment rates were much smaller for older children compared to younger ones. However, enrollment rates for older children have increased steadily so that by 2008, more than 60 percent of all eligible children are enrolled in the program. Medicaid recipiency rates were quite high during the early 2000s and have increased consistently during the last decade: At least 85 percent of all child groups received Medicaid benefits during 2008, again, except for newborns who have the smallest recipiency rates.

On the other hand, the data indicate that newborns incur the highest Medicaid expenditures. Excluding newborns and those aged 1-5, Average Medicaid expenditures per recipient are smaller for younger children and they increase with age. However, average expenditures for the oldest children are only about one-half of those for newborns. Average expenditures have trended upward during the last decade -- reflecting the general rapid increase in health care costs.

b. *Working-aged Adults*

Working aged adults are split between disabled adults, non-disabled adults and others, where the last category includes medically needy individuals and women eligible for benefits from the Breast and Cervical Cancer Act under Medicaid. For non-disabled adults, eligibility rates under Medicaid are distinctly different for males versus females. As Figure *A1* shows, female eligibility rates among the 0-100 percent FPL category were at 40 percent or smaller and barely increased during the last decade.[20] That is not surprising because women are more likely to be part of a low-income family. Figure *A2* shows that Medicaid eligibility rates are much smaller for men (as they are less likely to be in low-earning families and are also less likely to have a Medicaid eligible child as a dependent, on average), and the pattern of eligibility by age-group is reversed compared to females: Older males

have a higher likelihood of qualifying for Medicaid, probably because a higher proportion of men work in strenuous jobs and become disabled or unemployed at older working ages.

Figures *A3* (females) and *A4* (males) shows that Medicaid enrollment rates among eligibles is widely divergent across the five states examined here. Enrollment rates are highest in California for both genders. Enrollment rates are low and/or declining in Illinois and New York -- a fact that plays a key role in generating high cost increases in those two states when ObamaCare's individual health insurance mandate is included when making cost projections. Florida and Texas have mixed enrollment rates across age groups-- high for those aged 19-20 but low among many older age-gender groups.

Figure *A5* and *A6* show Medicaid recipiency rates are above 80 percent for females in all states. For males, recipiency rates in all states except California were low during the early 2000s, but increased rapidly to reach the same levels as those for females by the late 2000s. California's recipiency rates, however, appear to be declining rapidly -- a factor that explains the low impact of introducing ObamaCare when making cost projections. Figures *A7* and *A8* show that older non-disabled adult beneficiaries receive larger Medicaid benefits, on average, compared to younger ones-- except in California. Benefit awards per beneficiary are stable or gradually increasing in California, Florida, Illinois, and Texas. They increase more rapidly in New York for both genders. Differences in benefit awards per beneficiary by age-group are much larger for men compared to women.

*c.  Retirees*

Among those aged 65 and older in the 0-100 percent FPL range, eligibility rates are highest in Texas--well above 80 percent among younger retirees and close to 100 percent among older ones.[21] That means, given Texas' moderate historical enrollment rates, makes for a strong cost-increasing effect from introducing ObamaCare. Eligibility rates are lowest for Illinois and average about 50 percent for the other three states. Enrollment rates are highest for California and Florida,

with those in the three other states varying between 30 percent in Texas to 80 percent in Illinois and New York. Enrollment rates have generally increased, more so among the oldest retirees. Medicaid recipiency rates were quite high in all of the five states considered here—about 80 percent during the early 2000s—but have declined since for both genders, especially in Florida, New York and Texas. The reason may be the expansion of Medicare Part B coverage and the shift of many retirees' Medicaid coverage for prescription drugs to the Medicare program. Finally, average Medicaid expenditures per recipient increased across all retiree age groups -- Illinois being the exception -- and the increase was especially rapidly for the oldest retirees.

*d.   Other Groups*

Calculations of eligibility, enrollment, recipiency and average benefits per recipient are implemented separately for foster-care children, medically needy individuals, women qualifying under the Breast and Cervical Cancer Act (BCCA), family planning program and blind-disabled adults. Except for blind/disabled adults, CPS data does not allow identification of the eligible populations for these groups.[22] Hence, calculations are based on directly calculating the share of enrollees in the population based on MSIS data for foster-care children, BCCA women, family planning, and medically needy individuals. For blind/disabled adults, however, eligibility co-criteria based on income (including spousal income where applicable) are incorporated, again counting all eligible sources and net of applicable exemptions, deductions and income disregards. Medicaid eligibility rates were higher for older blind/disabled adults compared to younger ones in most states, and they have mostly increased during the 2000s across all age groups. Data show stable enrollment rates for most blind/disabled women--higher in California and Florida than in the other three states; and enrollment rates have been higher, but stable overall, for disabled/blind men compared to women during the last decade--also highest for California and Florida. Medicaid recipiency rates have been stable or declining in Florida and Texas for most disabled adults--and stable or increasing

in the other three states.  However, Medicaid expenditures per blind/disabled recipient are among

the highest among all population groups and have increased consistently for both genders in all
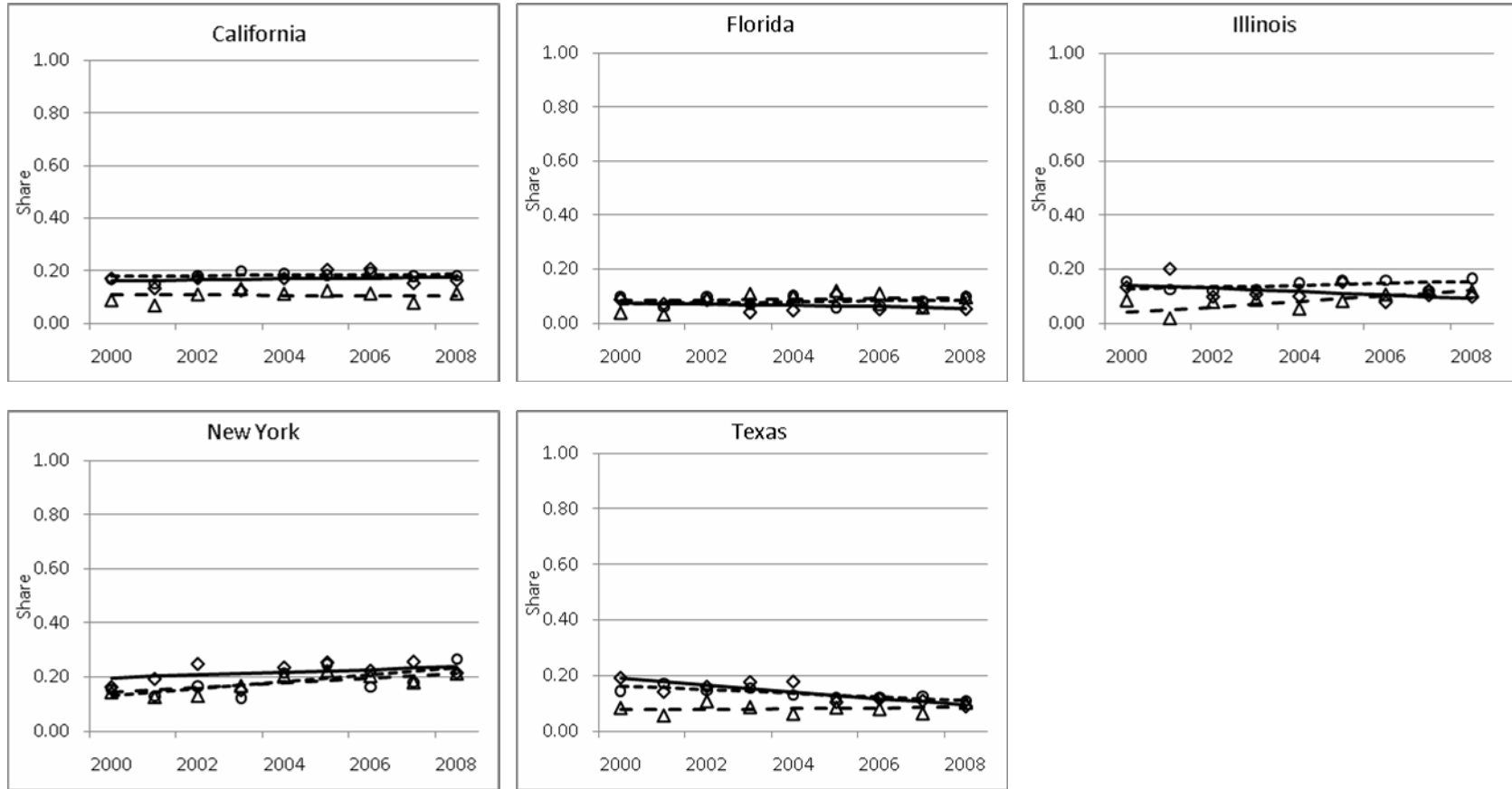
states except Illinois during the last decade.

Figure A1: *Shares of Medicaid Eligibles in State Populations* and Linear Trends For *Female Non-Disabled Adults aged 19-64*; 0-100 percent FPL; 2000-08.
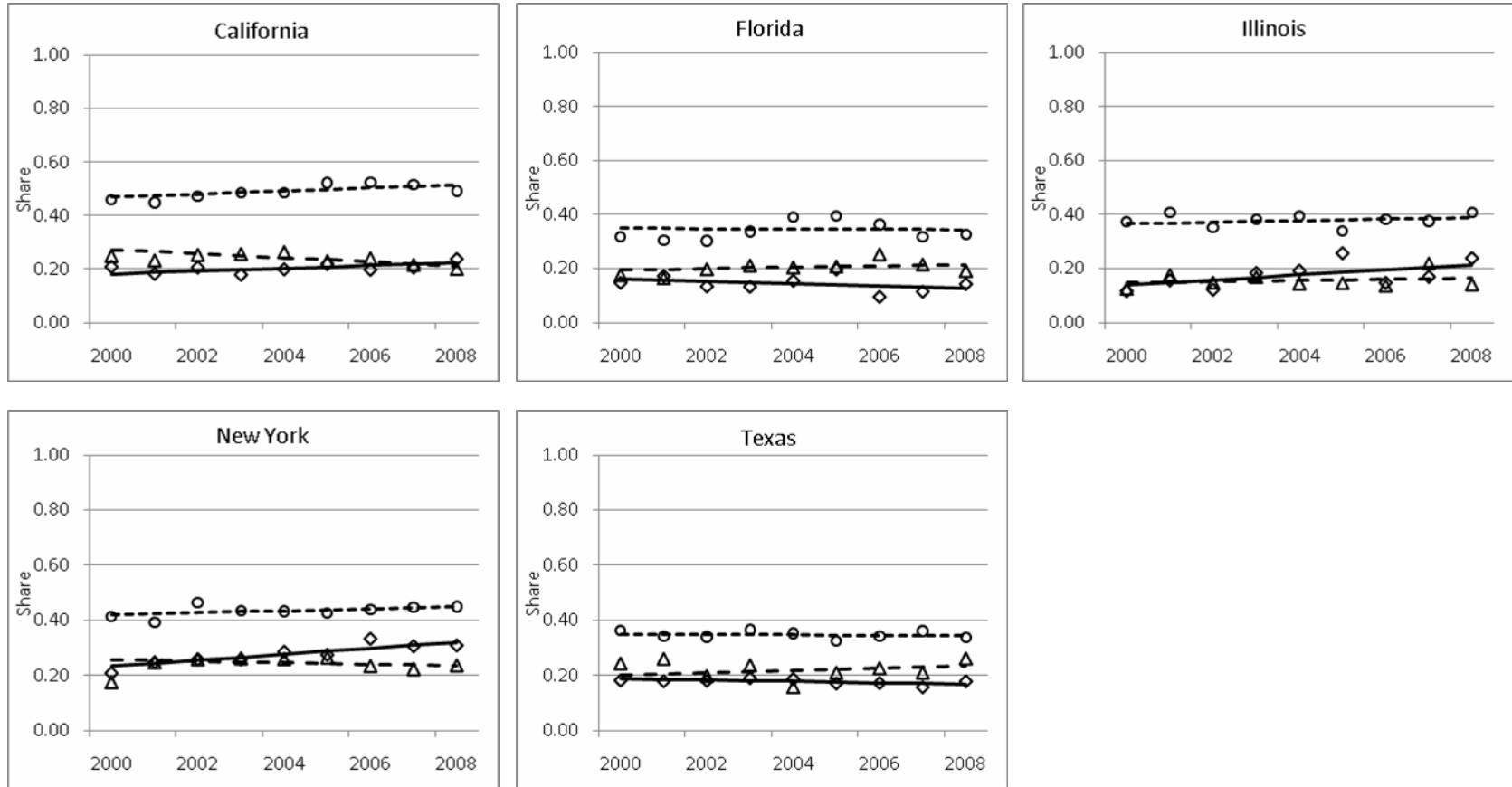


△       Age 19-20 (data);      o      Age 21-44 (data);      ◇      Age 45-64 (data);
- - - - - - Age 19-20 (regression);  ---------- Age 21-44 (regression); ———— Age 45-64 (regression).

Figure A2: *Shares of Medicaid Eligibles in State Populations* and Linear Trends For *Male Non-Disabled Adults aged 19-64*; 0-100 percent FPL; 2000-08.



△  Age 19-20 (data);  o  Age 21-44 (data);  ◇  Age 45-64 (data);
- - - - - - Age 19-20 (regression);  ---------- Age 21-44 (regression); ———— Age 45-64 (regression).

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys, CMS-64 Reports, and the US Census Bureau.
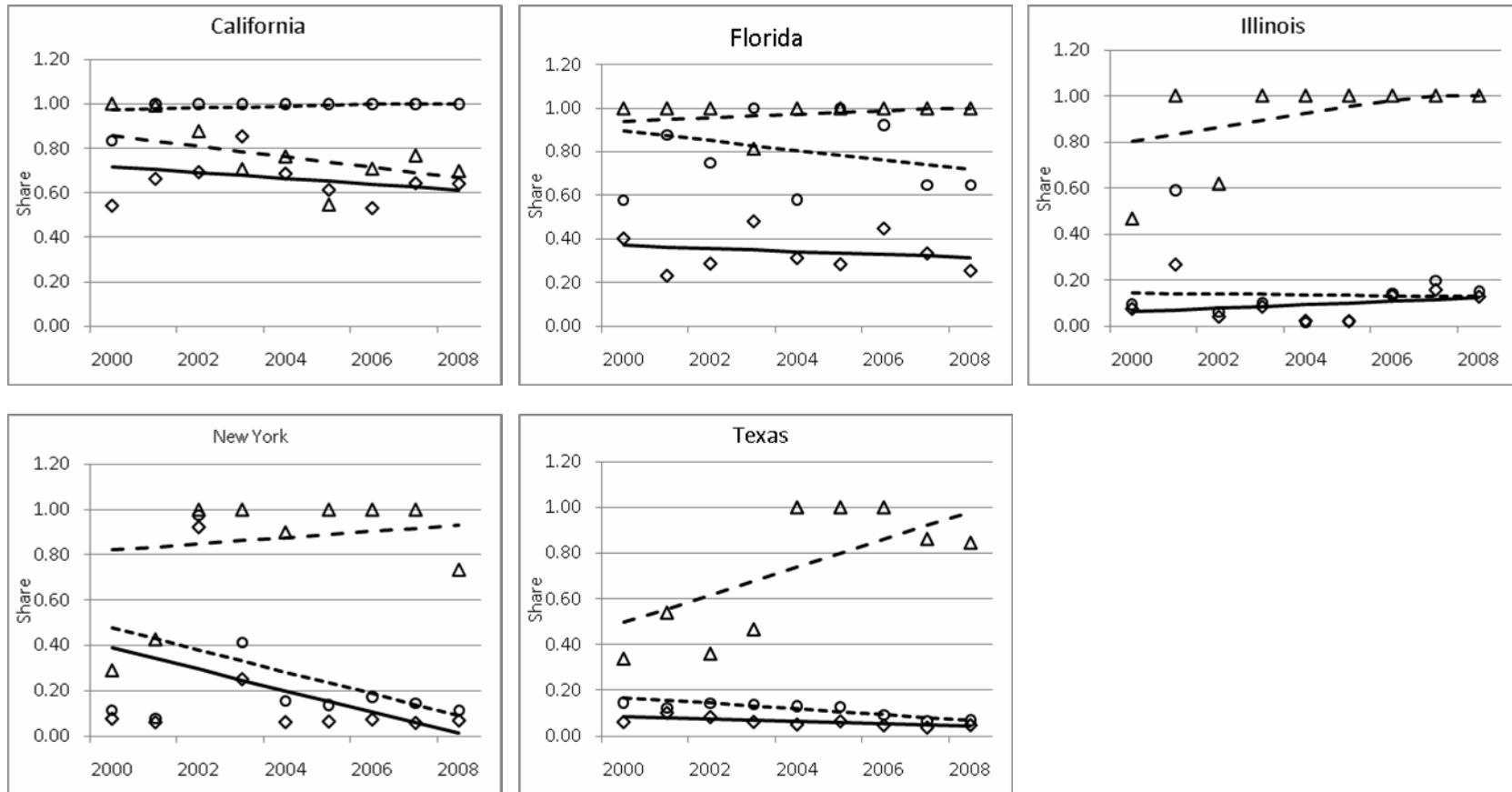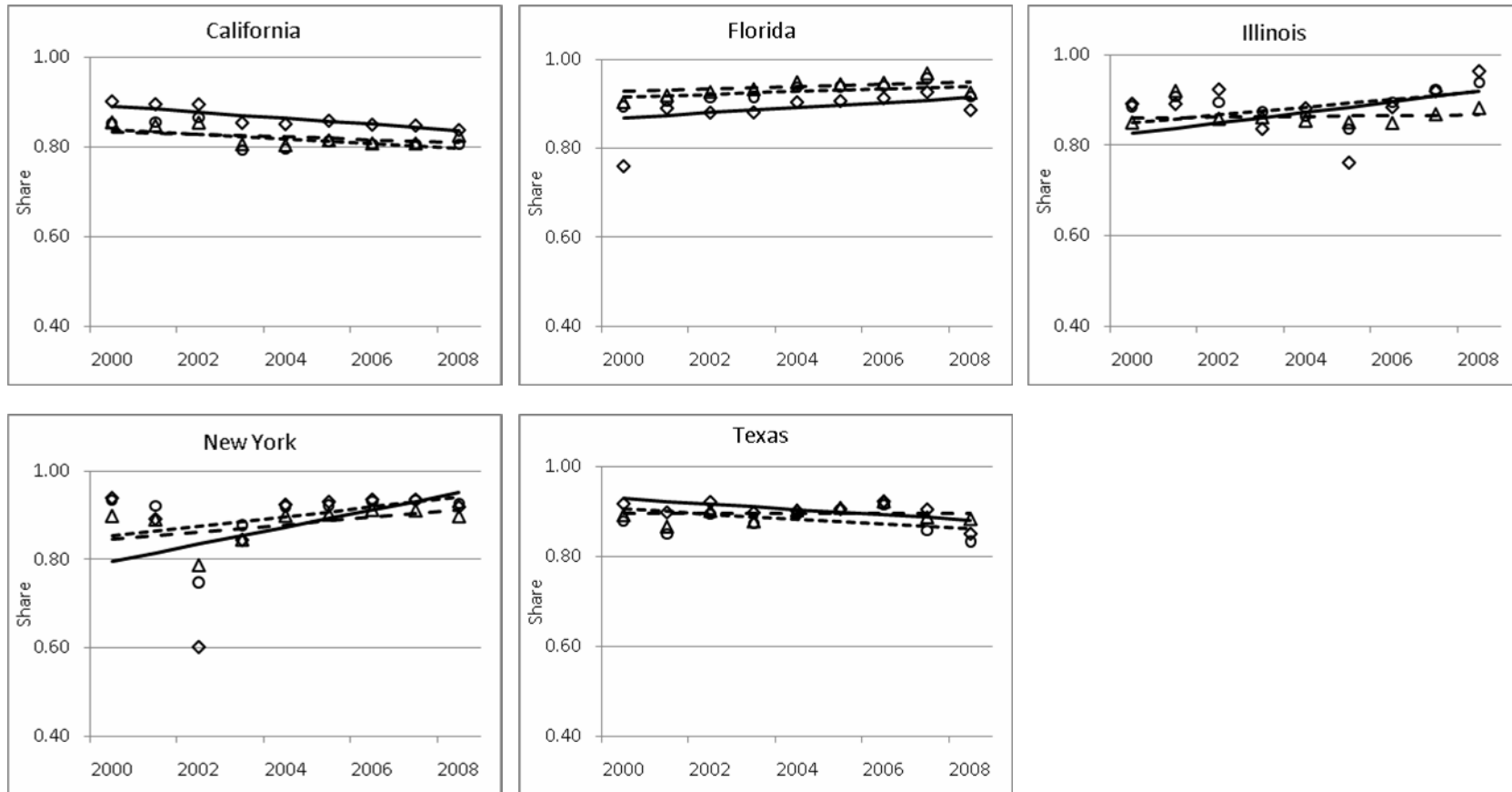
Figure A3: *Shares of Medicaid Enrollees Among Eligibles* and Linear Trends For *Female Non-Disabled Adults aged 19-64*; 0-100 percent FPL; 2000-08.
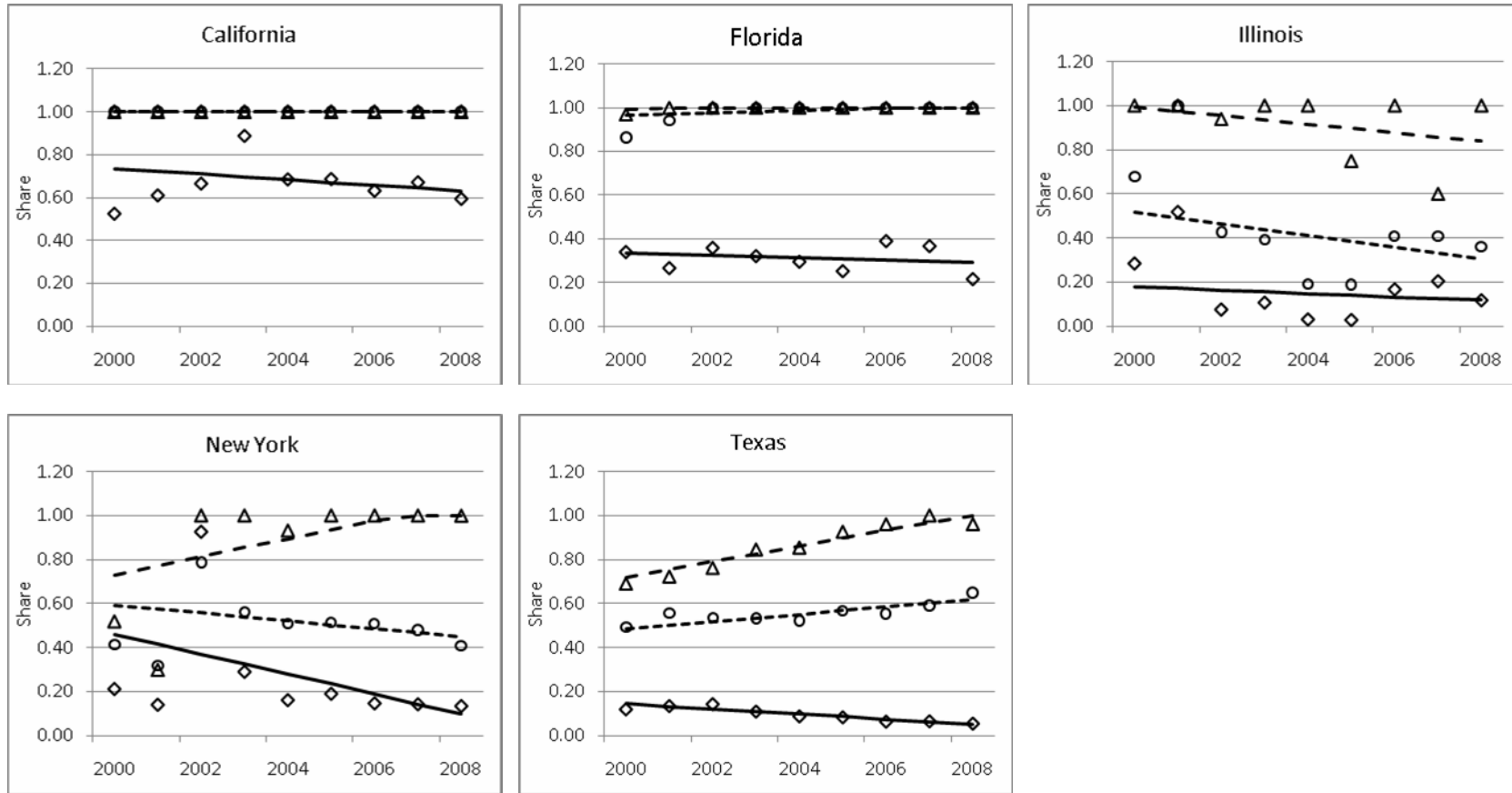


△      Age 19-20 (data);      o      Age 21-44 (data);      ◇      Age 45-64 (data);
- - - - - - Age 19-20 (regression); ---------- Age 21-44 (regression); ——— Age 45-64 (regression).

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys, CMS-64 Reports, and the US Census Bureau.

Figure A4: *Shares of Medicaid Enrollees Among Eligibles* and Linear Trends For *Male Non-Disabled Adults aged 19-64*; 0-100 percent FPL;  2000-08



△      Age 19-20 (data);      o      Age 21-44 (data);      ◇      Age 45-64 (data);
- - - - - - Age 19-20 (regression);  ---------- Age 21-44 (regression); ——— Age 45-64 (regression).

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys, CMS-64 Reports, and the US Census Bureau.
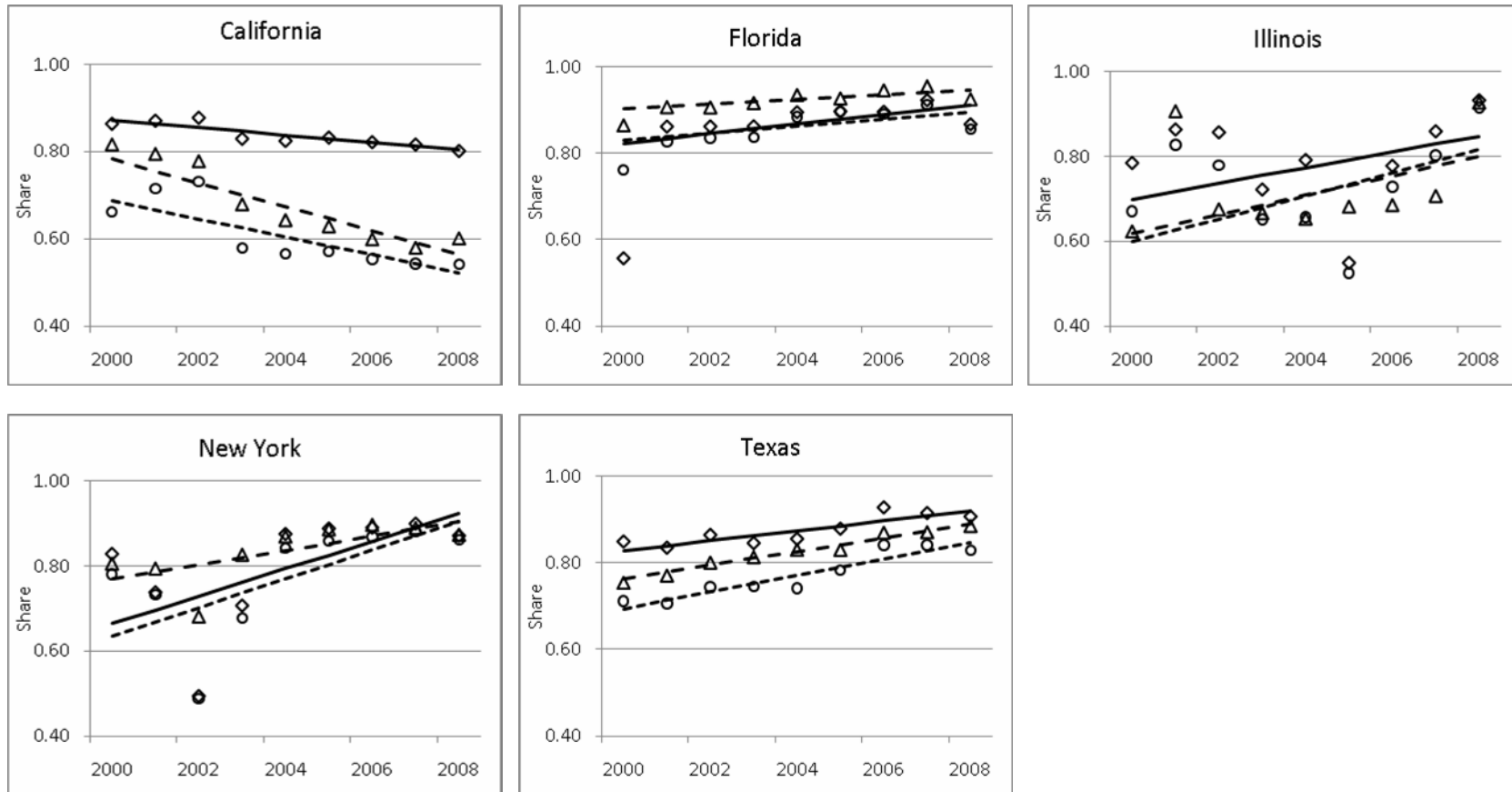
Figure A5: *Shares of Medicaid Beneficiaries Among Enrollees* and Linear Trends For *Female Non-Disabled Adults aged 19-64*; 0-100 percent FPL; 2000-08.



△        Age 19-20 (data);        ○        Age 21-44 (data);        ◇        Age 45-64 (data);
- - - - - Age 19-20 (regression);  ---------- Age 21-44 (regression); ——— Age 45-64 (regression).

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys, CMS-64 Reports, and the US Census Bureau.
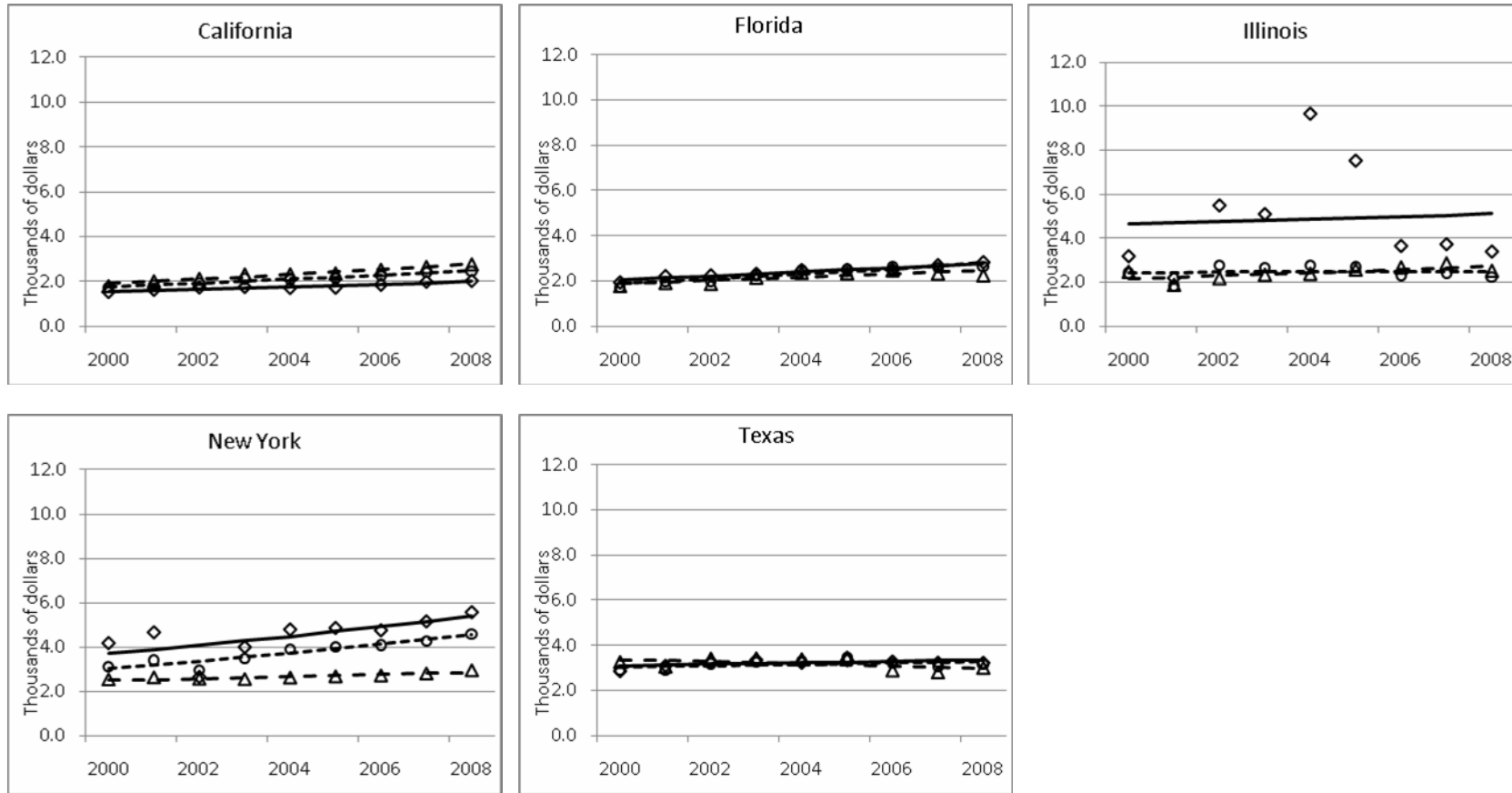
Figure A6: *Shares of Medicaid Beneficiaries Among Enrollees* and Linear Trends For *Male Non-Disabled Adults aged 19-64*; 0-100 percent FPL; 2000-08.



△      Age 19-20 (data);     o     Age 21-44 (data);     ◇     Age 45-64 (data);
- - - - - Age 19-20 (regression); ---------- Age 21-44 (regression); ———— Age 45-64 (regression).

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys, CMS-64 Reports, and the US Census Bureau.

Figure A7: *Average Medicaid Expenditures Per Beneficiary* and Exponential Trends For *Female Non-Disabled Adults aged 19-64*; 0-100 percent FPL; 2000-08.



△      Age 19-20 (data);      ○      Age 21-44 (data);      ◇      Age 45-64 (data);
- - - - - - Age 19-20 (regression);  ---------- Age 21-44 (regression); ————— Age 45-64 (regression).

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys, CMS-64 Reports, and the US Census Bureau.

Figure A8: *Average Medicaid Expenditures Per Beneficiary* and Linear Trends For *Male Non-Disabled Adults aged 19-64*; 0-100 percent FPL; 2000-08.
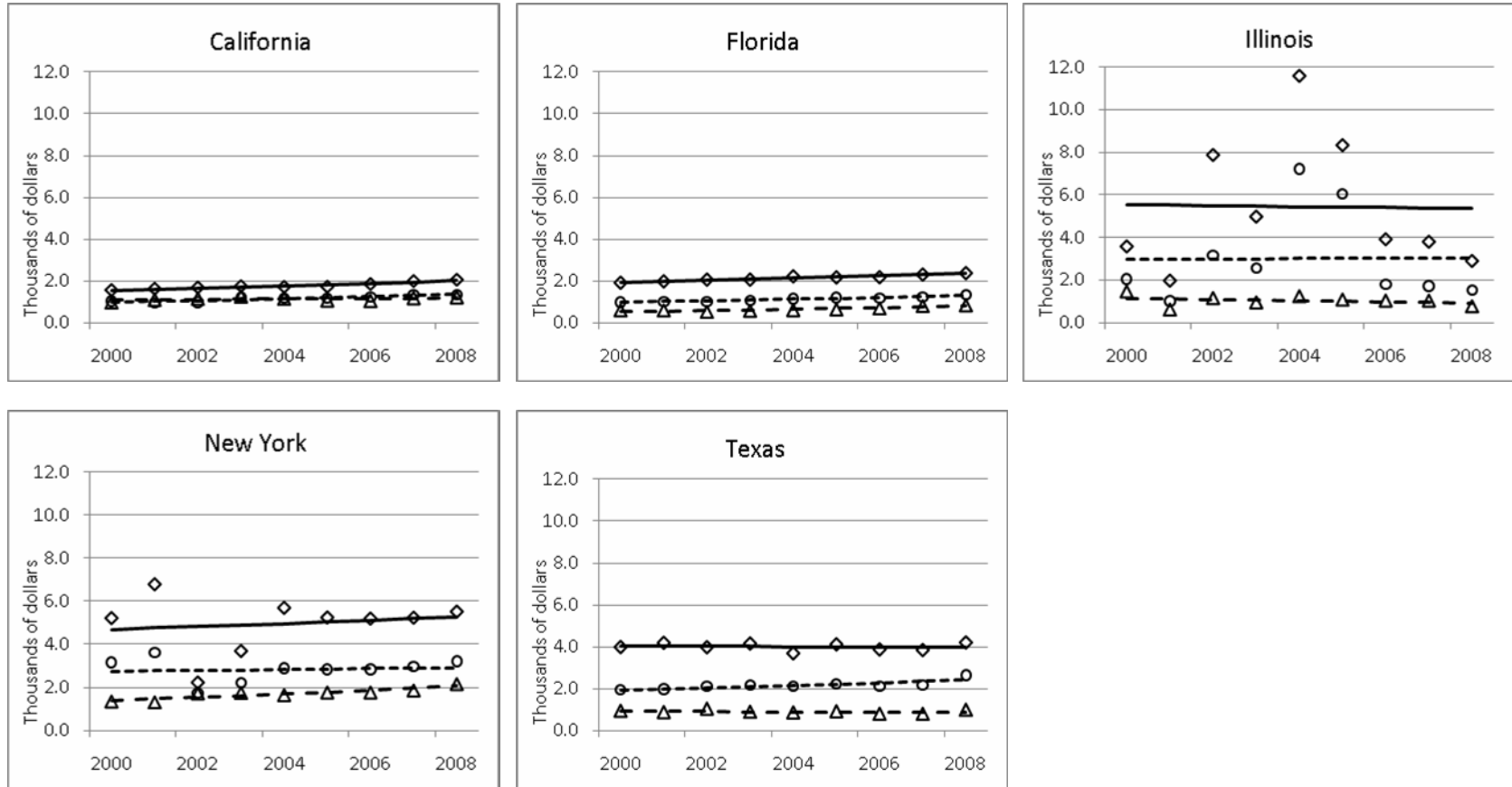


△      Age 19-20 (data);      o      Age 21-44 (data);      ◇      Age 45-64 (data);
- - - - - - Age 19-20 (regression);  ---------- Age 21-44 (regression); ————— Age 45-64 (regression).

Source: Author's calculations based on the Medicaid Statistical Information System, Current Population Surveys, CMS-64 Reports, and the US Census Bureau.

Notes

[1] This paper draws heavily from "The Effects of ObamaCare on Texas' Medicaid Expenditures' Growth" by the author that is published in the 2010 *PolicyPerspective* series of the Texas Public Policy Foundation. Angela Erickson provided excellent research assistance.

[2] State budget reports include expenditures on a General Revenue basis and the All Funds basis, the former referring to expenditures out of state revenue sources and the latter being inclusive of expenditures funded out of federal grants. This study focuses only of states' General Revenue funded Medicaid costs projected with and without ObamaCare.

[3] Constructing these estimates is a laborious and time-intensive process and doing so for all 50 states and the District of Columbia was not feasible.

[4] The growth rate of state GR Medicaid expenditures is calculated beginning in the year 2010 and includes the effect of reduced federal support from American Recovery and Reinvestment Act (ARRA).

[5] The slowdown in economic growth all 5 states during 2007-09 makes very difficult to project GDP during future years. Projected Medicaid expenditure growth is, therefore, compared with historical GDP growth calculated based on data from the United States Bureau of Economic Analysis. The earliest year of data available for historical calculations of annual (nominal) GDP growth is 1997.

[6] There is an exception for states with waivers already covering these populations, such as New York. These states will continue to pay the costs of these individuals for the first three years and then will have an increased FMAP for the 'newly eligibles' that will match the other states by 2019.

[7] Qualification for Medically Needy Program benefits varies by state. In Texas, for example, an applicant must be (1) a pregnant woman with no child eligible for the Temporary Assistance for Needy Families (TANF) Program; a child under 19 years of age; or an adult caretaker, whom HHSC includes in the certified group, and who ordinarily receives and manages the benefits for the certified group, except that the caretaker's countable income exceeds TANF limits, the caretaker's 60-month time-limited TANF benefits are exhausted, the caretaker chooses Medicaid-only benefits, or the caretaker is disqualified from TANF for a reason that is not applicable to Medicaid; and have countable income that meets the applicable income limit. The income limit is defined based on family size; for a family of two people, it is $216 per month. Applicants whose income exceeds the limit may spend down excess income to pay medical bills and qualify.

[8] The formula equals 100 percent minus state's share where state's share equals $0.45\times(SPCI/USPCI)^2$, where SPCI is state's per capita income and USPCI is United States' per capita income. A higher SPCI translates into a lower FMAP value.

[9] The 2012 FMAP value for Texas is expected to be published by the federal department of Health and Human Services in November, 2010.

[10] The Census Bureau website containing state-wise population projections is available here: http://www.census.gov/population/www/projections/projectionsagesex.html

[11] Increases in future Medicaid expenditures in each state will also depend on how successful are efforts to repeal ObamaCare: Thirteen US states have filed court cases to challenge the new health care law on two grounds: (1) that mandating purchase of health insurance by individuals (with failure punishable by a fine) is unconstitutional under the 10th Amendment and Article I of the U.S. Constitution (the commerce clause) and, (2) that the new health care law increases states' Medicaid costs without recompense from the federal government—that is, it constitutes an unfunded mandate.

[12] Despite determining enrollment rates for heretofore non-enrolled "old-eligibles" (as described in the text) a valid question is whether it is appropriate to apply the same beneficiary/enrollment and costs/beneficiary rates applicable to pre-ObamaCare Medicaid enrollees when making projections on a post-ObamaCare basis. There are several reasons that justify doing so: First, the uninsured don't have zero costs; their emergency room visits are costly and the costs are shifted to other patients who either pay out-of-pocket or through their insurers. Second, the uninsured have low measured health care costs *because* they are uninsured. Once they are insured under Medicaid via ObamaCare and the individual health insurance mandate, their utilization of health care goods and services is likely to increase and match that of other Medicaid enrollees. Third, some of the uninsured may be without insurance because they have pre-existing conditions that are expensive to treat. Indeed, after they enroll into Medicaid under ObamaCare, those costs may surpass the average costs of those already insured. Fourth, historical trends in the ratio of beneficiaries among enrollees are increasing -- suggesting that future costs may be larger as more people need and claim health insurance benefits. Finally, the old-eligibles newly enrolled individuals under ObamaCare may be uninsured and young, but their health care needs and costs will grow over time.

[13] All five states exhibit stable or declining ratios of beneficiaries-to-enrollees among non-disabled retirees. The declines are steepest in Florida and New York states.

[14] These results depend on projections of costs and enrollments on a pre-ObamaCare basis between 2008 (the latest year with full information available at the time of writing this study) and 2014. However, these results are consistent with those obtained by simply dividing costs and enrollments in the base year -- 2008.

[15] A further reason for the low cost increase in California from ObamaCare is that the ratio of beneficiaries among enrollees has historically declined -- especially among the largest group of non-disabled adults -- a feature that would dampen future costs under the methodology of this study.

[16] Kaiser's estimates are available at: http://www.statehealthfacts.org/comparereport.jsp?rep=68&cat=4.

[17] The age categories correspond to those of the Medicaid State Information System's age ranges: 0, 1-5, 6-12, 13-14, 15-18, 19-20, 21-44, 45-64, 65-74, 75-84, and 85+.

[18] The income ranges are defined according to the applicable cut-offs before and under the new health care law. Those cut-offs are generally different for population groups served by various Medicaid programs in Texas.

[19] Charts for selected child age-gender-FPL groups are available from the author upon request.

[20] Although post-ObamaCare Medicaid eligibility is based only on an income test, pre-ObamaCare eligibility requires an asset test as well. The pre-ObamaCare asset test is incorporated based on information from the 2007 Survey of Consumer Finances (SCF). Calculations show that the population share of adult non-disabled household heads who fail the Medicaid asset test and who do not receive Medicaid is 13.2 percent for the nation as a whole. Unfortunately, the SCF does not allow separate identification of Texas residents, nor of blind/disabled individuals. Therefore, an approximate asset-based constraint is applied to pre-ObamaCare eligibility rates, to restrict Medicaid eligibility to 86.8 percent (100 percent minus 13.2 percent) of the income-based eligibility rate as calculated from the Current Population Survey.

[21] Charts for selected age-gender-FPL groups are available from the author upon request.

[22] Medicaid eligibility criteria for children in foster-care and younger than age 18 are the same as those for non-foster-care children aged less than 18. Eligibility under AFDC/TANF rules are based on incomes of household that they were in before foster care placement. For children older than age 18 there is the "Medicaid for Transitioning Foster Care Youth" program whereby the person must have aged out of foster care, must be aged between 18 and 20 years, must not be covered under another health plan offering adequate benefits, and must have income at or below 400 percent of the Federal Poverty Level. Medicaid eligibility criteria for persons with breast and cervical cancer: Must be diagnosed with

breast cancer (men and women) or cervical cancer (women only), must not have income more than 200 percent of the Federal Poverty Level, and must not have alternative medical insurance coverage.