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The Effect of Federal Health Care 'Reform' on Kansas General Fund Medicaid Expenditures

by Jagadeesh Gokhale, Ph.D., and Angela C. Erickson

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Executive Summary

Medicaid is the second largest expenditure in Kansas, exceeded only by education. Kansas Medicaid covered 355,000 people in 2008, just under 13 percent of the state's total population of 2.8 million. The Kansas Division of the Budget says Medicaid accounted for $871 million, or 14.3 percent of state general fund expenditures of $6.1 billion in that year. Anticipating increased budget pressure on states from recession-induced revenue declines and increased welfare expenditures, the federal government's American Recovery and Reconstruction Act (ARRA) gradually increased Kansas' federal match rate from 59.4 percent to 69.7 percent through June, 2011. As a result, although total (including federally funded) Kansas Medicaid outlays increased during 2009, Medicaid spending out of state general funds declined to $820 million, or 13.5 percent of general fund expenditures during that year. According to the Kansas governor's state budget for 2012, the state's general fund Medicaid expenditures were $713 million during 2010, or 13.5 percent of its general fund expenditures of $5.3 billion.[1]

Despite ARRA-enhanced federal funding of Medicaid for two years, the Kansas budget situation remains precarious, as the state has experienced nearly a billion dollars in deficit spending over the last three years. Over the long term, moreover, Kansas legislators must contend with at least $9.3 billion in unfunded pension obligations to state employees and retirees.[2] In view of large revenue shortfalls and the non-recurring measures consistently used to repair the Kansas budget, Moody's investor rating service recently lowered its outlook on Kansas, indicating an imminent ratings downgrade.[3] When ARRA-related higher federal funding of Medicaid is terminated in July, 2011, Kansas' general fund Medicaid expenditures will spike as health care costs have continued to increase since 2008. The Patient Protection and Affordable Care Act of 2010 (PPACA), commonly referred to as ObamaCare or "Health Care Reform," promises to intensify the pressure by accelerating Kansas' already-increasing Medicaid spending commitments.

This study estimates PPACA's effect on future Kansas' Medicaid expenditures by constructing and comparing state Medicaid expenditure projections with and without PPACA mandates. Our detailed assessment shows that Kansas would spend $20.8 billion on Medicaid during the first ten years (2014-23) of PPACA's implementation, which is $4.7 billion (29 percent) larger than projected spending without PPACA. If Kansas continues to operate its Medicaid program as in past years and implements PPACA, spending on Medicaid will quadruple, going from $713 million in 2010 to $2.8 billion in 2023. Kansas historical budget share trends suggest that large and growing budget pressure from Medicaid expansion under PPACA would compel reductions in education, infrastructure and other primary functions.

Background

Created in 1965 under the Social Security Act, Medicaid is an optional state-operated health program for low-income families, children, elderly and disabled. It is financed with state revenues and federal matching grants determined by a formula that is more generous toward poorer states. Kansas' regular Federal Medical Assistance Percentages (FMAP) match rate for 2011 is 59.1 percent—close to the average FMAP rate across all states.[4] The 2009 ARRA is providing temporary relief through higher

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1 Kansas Division of the Budget, "Governor's Budget Report for Fiscal 2012," table "Major Medicaid Programs" on page 120. See http://budget.ks.gov/publications/FY2012/FY2012_GBR_Volume1.pdf.

2 Kansas Public Employees Retirement System (KPERS), "2010 Comprehensive Annual Financial Report" using market value of plan assets.

3 Dow Jones Newswires. Moody's Cuts Kansas Outlook To Negative Over Ongoing Budget Trouble. April 6, 2011. http://online.wsj.com/article/BT-CO-20110406-709310.html.

4 Federal matching percentages are published in the Federal Register, Vol. 74, No. 227 available at http://aspe.hhs.gov/health/fmap11.htm.

federal matching of state Medicaid expenditures, increasing Kansas' match rate to 66.3 percent for 2009 and 69.7 percent for 2010. Although overall historical Medicaid enrollment increases have been small in Kansas, recent recession-induced enrollment increases, unless reversed, will add to the state-s general fund shortfall when the federal Medicaid match rate reverts to its normal level in July, 2011

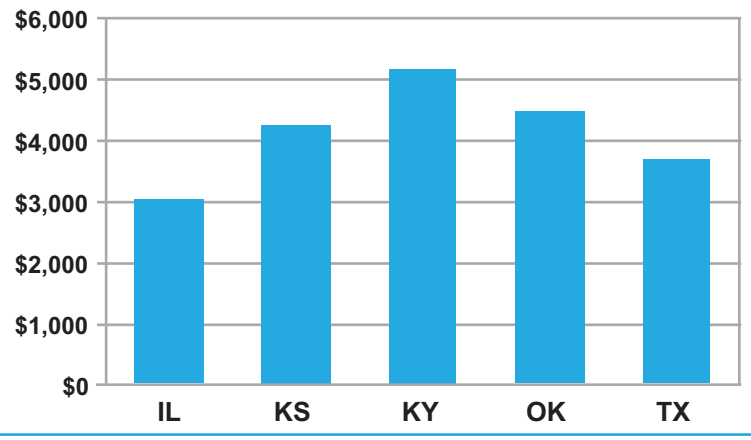
Before PPACA's enactment, each state was free to determine who and what types of health care services would be covered by Medicaid under certain federal guidelines.[5] To receive federal funds, states have to satisfy minimum federal coverage rules—such as covering those receiving Supplemental Security Income, deemed disabled, or over 65 and below 135 percent of the federal poverty income level (FPL).[6] Children under age 6 and pregnant women with family incomes below 133 percent of FPL, and children 6-18 below 100 percent of FPL must be covered. States must also cover people eligible for their Temporary Assistance for Needy Families (TANF) program.[7] These rules ensure that the most medically and financially vulnerable can receive health care support.

Before PPACA, non-disabled adults were only eligible for Medicaid if they had a child and were eligible for cash assistance or received a special waiver. Beginning in 2014, PPACA extends eligibility to all U.S citizens earning less than 133 percent of FPL whether or not they have children or are disabled. PPACA also creates an individual health insurance mandate, which will induce additional enrollments from those already eligible for Medicaid pre-PPACA. Under PPACA, the federal government is to pay almost the entire cost of expanded eligibility. But it will pay only a fraction of the cost of new enrollees among those eligible under pre-PPACA laws. These "old eligibles," induced to enroll because of the individual health insurance mandate, will increase stress on the Kansas budget.

How Things Stand Today

Including federal funds, Kansas spent $2.5 billion on Medicaid during fiscal year 2009. After subtracting spending from federal funds at the ARRA enhanced match rate of 66.3 percent and subtracting state dedicated funds, Kansas' general fund share of that spending was $820 million, or 13.5 percent of its general fund expenditures of $6.1 billion. This amounts to $605 per Kansas worker in 2009.[8]

Figure 1:
Medicaid Cost Per Non-Disabled Adult Enrollee



Source: Authors' calculations

According to the latest available information (micro data and budget aggregates for 2009), 13 percent of the Kansas population was enrolled in Medicaid (355,000 enrollees) at an average cost of $6,769 per enrollee. The annual average cost of a non-disabled adult on Medicaid in Kansas is $4,264, reflecting the potential cost of new eligibles under PPACA. Figure 1 compares Kansas' spending per non-disabled adult enrollee to that in other geographically-close states, most with demographic

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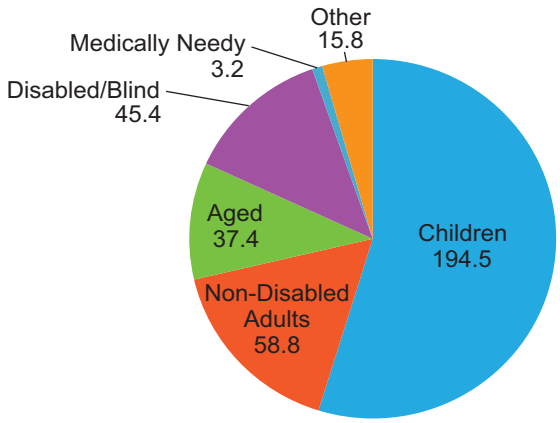
5 As discussed later in the text, PPACA prevents states from reducing Medicaid eligibility rules or making it more difficult for people to enroll until state health exchanges are established and certified by 2014.

6 In 2011, the federal poverty limit (FPL) is $10,890 for an individual and $22,350 for a family of four. That makes 133 percent of FPL equal to $14,484 for an individual and $29,726 for a family of four http://aspe.hhs.gov/poverty/11fedreg.shtml.

7 Each state has its own TANF program with different eligibility standards, deductions and income levels. States also determine whether or not to have an asset test for Medicaid eligibility. Kansas does not have an asset limit.

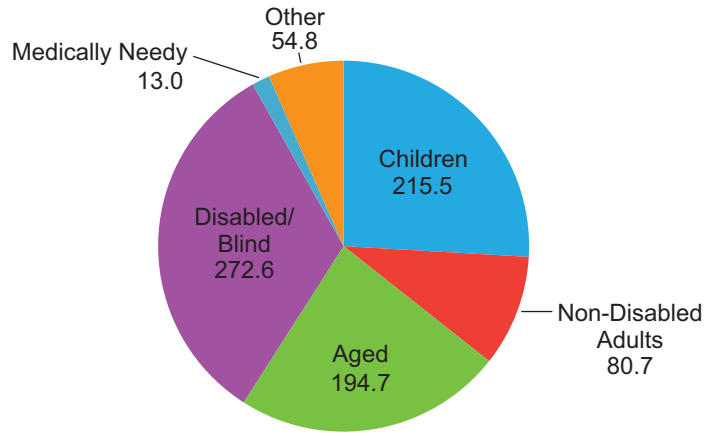
8 Based on authors' calculations using the Medicaid Statistical Information System (MSIS), NASBO general revenue numbers, federal FMAP levels and Bureau of Labor Statistics state employment numbers http://www.bls.gov/sae/.

Figure 2:
2009 Enrollment by Category *(in thousands)*



Source: Authors' calculations

Figure 3:
2009 State Costs by Category *(in millions of dollars)*



Source: Authors' calculations

and economic features similar to Kansas.[9] It shows that Kansas is near the middle of that pack: Illinois spends about $3,000; Texas about $3,750, Oklahoma about $4,500 and Kentucky more than $5,000.[10]

Figure 2 shows enrollment numbers by category, with children accounting for a majority of recipients.[11] Despite accounting for less than a quarter of Medicaid recipients the blind/disabled and elderly account for a majority of Kansas Medicaid spending, as shown in Figure 3.[12]

Peering Into the Future

Long term cost projections provide deeper insights into how a fully-implemented PPACA will change Kansas' Medicaid funding commitments. We construct Medicaid spending projections with and without PPACA to estimate the new law's effect on Kansas' Medicaid spending. Under both projections Medicaid eligibility, enrollments, the share among enrollees of those actually receiving benefits, and costs per benefit recipient are projected using historical trends from micro-data sources spanning the years 2000-08, with all but eligibility taken from state-wide administrative records.[13] The historical trends are projected separately for detailed population sub-groups—by gender, age and FPL categories and separately for special eligibility groups. Detailed eligibility rules specific to Kansas are applied (with and without PPACA) to determine eligibility counts from household surveys that provide data samples representative of the Kansas population. Projections are anchored on Kansas state population forecasts from the U.S. Census Bureau. Kansas Medicaid spending projections

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9 The comparison states differ in population size with Texas and Illinois being much larger than the others. But all have similar incomes per capita—ranging from $28,500 for Kentucky to $36,000 for Illinois, with Kansas in the middle of the pack at $32.700. All of the states in Figure 1 have similar rates of educational attainment (80 percent or more with high-school diplomas), poverty rates (10 percent or more below the federal poverty limit), median population age (about 35 years) and age-dependency ratios (close to 60 percent). These comparisons are based on data from Statemaster: http://www.statemaster.com/graph/peo_med_age-people-median-age.

10 Based on authors' calculations using the MSIS and Census Bureau data.

11 The 'other' category consists of family planning, breast and cervical cancer patients without insurance, and foster care children.

12 Under the Social Security Act states can elect whether or not to cover a state defined medically needy category. Thus when comparing this group to other states, costs and enrollments vary widely.

13 The Census Bureau's Current Population Surveys from various years and MSIS are used.

are also constructed under alternative assumptions about federal matching rates going forward.[14]

Projections Without PPACA

Table 1 shows that Kansas general fund Medicaid spending in fiscal-year (July through June) 2009 was $820 million—smaller than its spending of $889 million in 2008 because of ARRA federal matching rate increase from 59.4 percent to 66.3 percent. Kansas' General Fund Medicaid spending in 2010 was $713 million. Costs are projected to increase slightly in 2011 and then spike in 2012 when the FMAP rate returns to pre-ARRA level.

Table 1:
General Fund Medicaid Costs 2009-2023 ***($ millions)***

	Without ACA		With ACA	
Year	**Annual**	**Cumulative**	**Annual**	**Cumulative**
2009	$ 820.2		$ 820.2	
2010	$ 713.2		$ 713.2	
2011	$ 791.9		$ 791.9	
2012	$ 1,109.7		$ 1,109.7	
2013	$ 1,177.6		$ 1,177.6	
2014	$ 1,226.9	$ 1,226.9	$ 1,479.0	$ 1,479.0
2015	$ 1,283.7	$ 2,510.7	$ 1,561.7	$ 3,040.7
2016	$ 1,352.1	$ 3,862.7	$ 1,658.4	$ 4,699.1
2017	$ 1,429.2	$ 5,291.9	$ 1,818.3	$ 6,517.4
2018	$ 1,513.7	$ 6,805.6	$ 1,953.8	$ 8,471.2
2019	$ 1,610.1	$ 8,415.6	$ 2,107.0	$ 10,578.2
2020	$ 1,718.6	$ 10,134.3	$ 2,266.2	$ 12,844.4
2021	$ 1,836.1	$ 11,970.4	$ 2,440.1	$ 15,284.6
2022	$ 1,963.4	$ 13,933.8	$ 2,629.8	$ 17,914.4
2023	$ 2,101.5	$ 16,035.3	$ 2,837.0	$ 20,751.4

Source: Kansas Division of the Budget through 2012; authors' calculations thereafter. See Appendix for methodology.

It should be noted that according to micro-data information (see note 13), historical trends in eligibility and enrollment rates are only slightly positive or flat for several age and special Medicaid eligibility groups in Kansas. Indeed, the eligibility rate trend is negative for non-disabled adult females and the enrollment rate trend is negative for non-disabled adult males during 2000-08. Among the elderly, the share of those receiving benefits among enrollees (the recipiency rate) also exhibits a negative trend. When making future projections of Medicaid spending these negative trends in eligibility, enrollments and recipiency offset the generally rapid increases in Medicaid health care costs per patient. Those cost increases ranged from 6 percent and 11 percent per year for most age and eligibility groups during 2000-08. Taken together, these historical trends explain the relatively modest annual growth of Kansas' Medicaid spending projections without PPACA during the next few years.

During fiscal year 2012 Kansas' general fund Medicaid spending is expected to be $1.1 billion, much higher than that projected for fiscal year 2011 because of the end of ARRA-enhanced federal matching rates beginning in July 1, 2011. Medicaid spending in fiscal year 2013 is projected to increase to $1.2 billion. This reflects the projection based on historical trends of rising health costs per patient for children and non-disabled adults offset slightly by stable or declining eligibility, enrollment, and the rates of benefit receipt among enrollees for several population groups. The projected increases in Kansas' Medicaid costs would be even smaller if ARRA enhanced matching rates are extended beyond June, 2012.

Freezing nominal Medicaid spending at the level projected for 2013 without PPACA (Freeze Baseline) generates a cumulative 10-year cost (2014-23) of $11.8 billion (at the 2013 projected annual cost without PPACA of $1.177 billion per year). The cost during the same 10-year period under pre-PPACA policies is much larger—$16.0 billion. This projected cost increase (without PPACA over the Freeze Baseline) is the result of extending historical trends in eligibility, enrollments, the share benefit recipients among enrollees, and Medicaid health care costs per beneficiary into the future.

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[14] The methods are described briefly in the appendix. For a more detailed explanation, see "Estimating ObamaCare's Effect on State Medicaid Expenditure Growth: A Study of Five Most Populous U.S. States," by Jagadeesh Gokhale. Cato Institute Working Paper, January 2011. http://www.cato.org/pub_display.php?pub_id=12693. and in "Final Notice: Medicaid Crisis: A Forecast of Texas' Medicaid Expenditures Growth," by Jagadeesh Gokhale. December 2010. http://www.texaspolicy.com/pdf/2010-12-RR12-FinalNoticeMedicaidCrisis-ForecastofTexasMedicaidExpendituresGrowth-CHCP.pdf.

Table 2: New Enrollees With PPACA from Expansion and Mandate

Year	2014	2020	2023
Newly Eligible	132,000	126,000	123,000
Old Eligible	102,000	119,000	130,000

Source: Authors' calculations.

Historical trends show that without PPACA, total projected Medicaid enrollment in Kansas increases only slightly during 2014-23—with only about 3,000 (1 percent) additional enrollees by 2023. Thus, in the absence of PPACA, projected Kansas Medicaid cost growth arises predominantly from projected increases in costs per patient.[15]

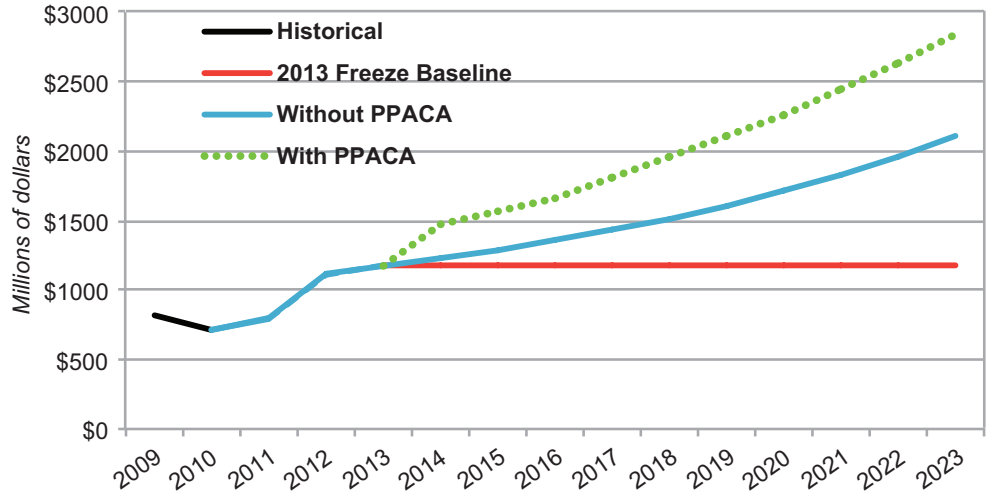
The federal government promises to pay 100 percent of health care costs for newly eligible Medicaid enrollees during the first 3 years of PPACA's Medicaid expansion (2014-16) and promises to cover around 92 percent of their costs thereafter.

Despite this, Kansas' Medicaid spending will increase because the federal government will only provide the state's *regular match rate* (59.1 percent) for those who are Medicaid-eligible under pre-PPACA laws but not yet enrolled.[16] PPACA's insurance mandate will induce most of these individuals to enroll into Medicaid. Table 2 shows projected enrollments from PPACA's Medicaid expansion (Newly Eligible) and from its individual mandate (Old Eligible).

PPACA's "maintenance of effort" clause forbids states from changing Medicaid eligibility standards to reduce caseloads until they have established a federally approved state health exchange. Some states plan to adopt policies such as managed care systems to minimize the increase in state Medicaid costs from PPACA. We exclude from consideration all such potential policies in order to isolate the cost increase from implementing PPACA. Under these assumptions, PPACA is projected to increase Kansas' Medicaid spending by an additional $4.7 billion, bringing the ten year cost up to $20.8 billion.

Figure 4 shows Kansas' historical general fund Medicaid expenditures (black solid line) and projected Medicaid expenditures from freezing Medicaid spending at its projected 2013 level (red line), spending without PPACA (blue line), and spending under PPACA (black dotted line). The figure shows the surge in Kansas' Medicaid costs in fiscal year 2012—as the ARRA match rate enhancement is eliminated in July, 2011. Medicaid spending spikes when PPACA is fully implemented in 2014 and increases slightly again in 2017 when the federal government reduces its match rate for PPACA's newly eligible enrollees.

Figure 4:
Kansas General Fund Medicaid Spending: Historical and Projected



Source: Kansas Division of the Budget and Authors' Calculations

15 This is unlike most of the other states shown in Figure 1 For example, enrollments grow by 11 percent in Illinois, 12 percent in Kentucky, 14 percent in Oklahoma, and 27 percent in Texas.

16 The projections assume that the match rate for general fund Medicaid expenditures is slightly higher at 60.7 percent during 2012 and later. This is justified because of the relatively smaller match rate applicable to Medicaid expenditures out of state dedicated funds, with the overall match rate equal to the 59.05 percent as specified for Kansas by the federal department of Health and Human Services. See http://aspe.hhs.gov/health/fmap11.htm.

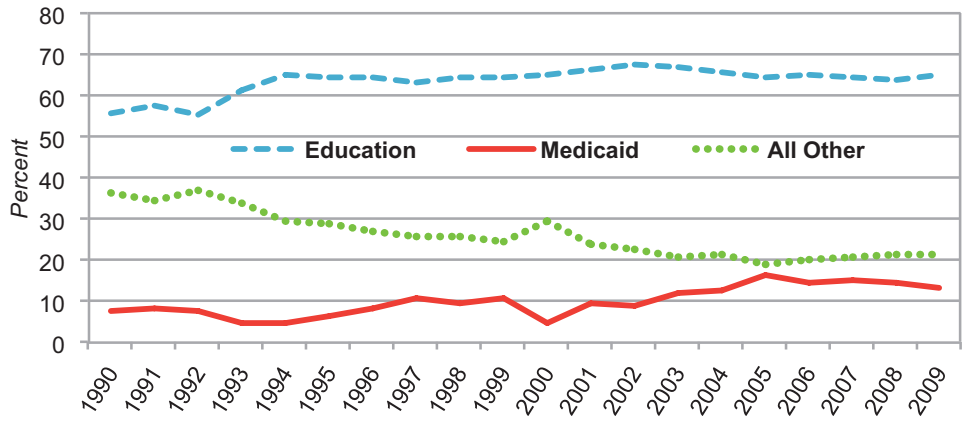
Table 3 shows that under PPACA Kansas' Medicaid caseloads are projected to increase to 610,000 by the year 2023—or to 21 percent of Census Bureau projections of Kansas' population. This represents an addition of 254,000 people to Kansas Medicaid caseloads by 2023 over and above the increase projected without PPACA. Table 3 also shows that the composition of enrollees will change dramatically under PPACA. Most of the enrollment increases under PPACA will occur among non-disabled adults so that ten years after PPACA's Medicaid expansion goes into effect, they will account for one third of Medicaid caseloads—much larger than today as shown in Figure 2.

Table 3: Medicaid Enrollments With and Without PPACA by Category *(thousands)*

	2014		2020		2023	
	Without	With	Without	With	Without	With
Children	192	266	183	266	176	265
Non-Disabled Adult	61	205	62	207	63	208
Aged	44	46	56	57	63	65
Disabled/Blind	35	45	29	39	29	40
Medically Needy	2	2	1	1	1	1
Other	19	23	23	29	25	32
Total	353	587	354	599	356	610
Enrollment Increase	234		245		254	

Source: Authors' calculations.

Figure 5:
Trends in Kansas General Fund Expenditure Shares: 1990-2009



Source: National Association of State Budget Officers.

Figure 5 shows trends in expenditure shares within the Kansas general fund budget. It's clear that Kansas has maintained the budget spending share of education (which includes elementary, secondary, and higher education) despite an increasing share of Medicaid expenditures. However the increase in Medicaid's share is mirrored by a decline in the budget share allocated to the "all other" item—which includes transportation, corrections, public assistance, housing, environmental and natural resource programs, parks and recreation, and so on. Note that when the Medicaid share increased consistently between 2000 and 2005, it eventually forced a decline in the share of education expenditures. Thus, accelerating the long-term trend of increasing Medicaid spending—as is projected to happen under PPACA—is likely to dramatically reduce funds available for other state priorities including education. Alternatively, tax increases that would be required to cover exploding Medicaid costs could significantly erode job growth and employment in the state and devastate its economy.

Alternative Federal Support Scenarios

The federal government is already feeling the strain of growing projected deficits and debt compounded by looming shortfalls in federal entitlement programs. This increases the likelihood of future cuts in federal spending, including reductions in federal financial support for state Medicaid programs. Here we look at the effect on the Kansas budget of two alternative ways to reduce the additional federal match for newly eligibles under PPACA to the regular matching rate.[17]

[17] PPACA specifies the additional match rate for new eligibles for '2019 and succeeding years.' See Social Security Act, 1905 [42 United States Code 1396d]. Here we explore alternatives wherein the matching rate applicable in 2019 will be gradually reduced beginning in 2020.

Table 4: Kansas' Medicaid Expenditures *($ billions)* Under Alternative Federal Support for New Eligibles (2014–23)				
Freeze Baseline	**Without PPACA**	**With PPACA**	**Alternative 1**	**Alternative 2**
$11.77	$16.04	$20.75	$20.91	$21.49
Source: Authors' calculations.				

Table 4 shows Kansas' Medicaid costs during 2014-23 under various scenarios: the Freeze Baseline, without PPACA, with PPACA (with continued additional federal financial support after 2019), and with PPACA under two alternative levels of federal support.[18] Under federal financial support Alternative 1, the federal support (beyond Kansas' regular match rate) is phased out for new eligibles at a rate of one-percentage point per year beginning in 2020. The resulting increase in Medicaid spending is quite small—just $160 million during 2014-23 compared to that with PPACA and maintained support. Under federal financial support Alternative 2, the federal government would fully eliminate extra support for new eligibles at a constant rate over ten years beginning in 2020. Medicaid spending would increase by an additional $580 million by 2023 under this alternative compared to that with PPACA and maintained support.

Policy Proposals in Kansas and Other Policy Options

Governor Sam Brownback has asked Health and Human Services Secretary and former Kansas Governor Kathleen Sebelius for an exemption from the new Medicaid requirements under PPACA, primarily the maintenance of effort requirement. Gov. Brownback has also asked to receive federal Medicaid spending as a block grant to be spent on providing health care according to the state's needs and voter preferences. In response to PPACA, Kansas Leutenient Governor, Jeff Coyler, asked to test ideas in health care provision in 2012 and received 120 recommendations in areas including managed care, eligibility, cost sharing and payment reform.[19] But Kansas needs more flexibility to run these pilot programs—the reason for Gov. Brownback's waiver requests.

The enactment of the PPACA is increasing concerns about runaway state Medicaid costs and motivating many state policymakers to find ways to contain Medicaid expenditures. Of course, there is the perennial requirement to "eliminate Medicaid waste, fraud and abuse." Under PPACA's maintenance of effort clause, states are generally unable to remove optional eligibility categories until after 2014, but Arizona's expiring waiver, which allows them to remove 250,000 childless adults, seems to be an exception.[20] The federal Department of Health and Human Services has suggested a long list of proposed changes,[21] but it remains unclear if they can collectively deliver the needed cost savings to make Medicaid affordable because those changes do not allow reductions in target enrollments or coverage based on those projected under PPACA. Several Republican governors have proposed turning Medicaid into a block grant program, thus reducing future growth and allowing the states to spend the money as they find appropriate.

Going beyond minor tinkering is the possibility of opting out of Medicaid altogether and providing basic health coverage to low-income and disabled groups funded exclusively out of state general revenue funds. However, most policymakers do not view this as a practical solution because it involves the loss of significant federal Medicaid dollars. Some state lawmakers are exploring the combination of an opt-out option with block grants from the reversion of states' federal income taxes

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18 Medicaid spending under alternatives with PPACA are net of uncompensated care savings of $640 million.

19 http://media.khi.org/news/documents/2011/03/18/Remaking_Kansas_Medicaid_Proposalslistsum.pdf

20 The state of Arizona's expanded eligibility waiver expires on September 30, 2011. According to officials of the Department of Health and Human Services, removing these enrollees does not conflict with PPACA.

21 Sebelius, Kathleen. "Sebelius outlines state flexibility and federal support available for Medicaid - Full Letter." February 3, 2011. http://www.hhs.gov/news/press/2011pres/01/20110203c.html.

used for funding federal matching grants. However, this would require multi-state agreements with the federal government—a very difficult proposition at best. Thus, policy options for state lawmakers remain limited, unless the constitutional court challenges joined by several states, including Kansas, succeed in effectively repealing PPACA.

Conclusion

By 2023, 21 percent of the Kansas population is projected to be on Medicaid under the PPACA—up from 13 percent currently. Kansas Medicaid expenditures are projected to grow by an additional $4.7 billion (29 percent) beyond the increase projected without PPACA. To avoid making deep cuts in other necessary public services and to maintain the state's economic competitiveness by avoiding tax increases, Kansas lawmakers will have to enact strong policies that effectively reduce the growth of Medicaid spending, including the huge anticipated increase under PPACA. Of course, allowing PPACA to be implemented in Kansas would limit avenues for state policymakers to constrain Medicaid spending given the prohibitions under PPACA against reducing program eligibility and operating rules.

With ongoing court and congressional challenges, the final chapter of the PPACA law and state Medicaid spending has yet to be written. However, since a federal court judgment has declared PPACA unconstitutional,[22] Kansas lawmakers should vigorously oppose the implementation of PPACA's health exchanges and other administrative and operational infrastructure. Given that Kansas' Medicaid costs are projected to increase significantly even without PPACA, success in preventing PPACA's implementation would not mean the end of efforts to control state-funded Medicaid expenditures.

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22 See the judgment of senior judge Roger Vinson of the United States Northern District Court of Florida available at: http://www.flnd.uscourts.gov/announcements/documents/10cv91doc150.pdf.

Appendix: Methodology for Projecting Medicaid Expenditures

The Medicaid Statistical Information System (MSIS) State Datamart website provides administrative information on the number of Medicaid enrollees (N_MSIS) and beneficiaries (R_MSIS) by gender (*g*), age category (*a*),[23] and eligibility group (*e*) for years 1999–08. It also provides information on total Medicaid benefits (B_MSIS) awarded to state residents.

First, the total population for the state in question is calculated by gender, age category, income range (*f*)[24] relative to the federal poverty level (FPL), and year (*t*), based on data from the Current Population Survey, $\text{CPS_STTPOP}_{g,a,f,t}$, where the suffix, *STT,* stands for the state in question. Because the CPS undercounts state populations relative to Census Bureau counts for all states, the census population, $\text{CEN_STTPOP}_{g,a,t}$, 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,

$$\text{U}_{g,a,t} = \frac{\text{CEN_STTPOP}_{g,a,t}}{\sum_f \text{CPS_STTPOP}_{g,a,f,t}},$$

provides a measure of the cell-specific population over- and under-counts in the CPS relative to the census population. Next, populations of the state's Medicaid benefit-*eligible* individuals (E_CPS) by demographic cells are calculated from the CPS. These cells are calculated separately for specific income ranges (*f*) relative to FPL values.

Take a male aged *a* in 2008. Non-disabled adults qualify for Medicaid coverage if they have a child and are eligible for cash assistance. Thus, the *eligibility rate, e,* for adults aged *a* of gender *g* with FPL-relative income *f* and in year *t* can be calculated as

$$\text{e}_{g,a,f,t} = \frac{\text{U}_{g,a,t} \times \text{E_CPS}_{g,a,f,t}}{\text{U}_{g,a,t} \times \text{CPS_STTPOP}_{g,a,f,t}}.$$

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, $\text{U}_{g,a,t}$ (described above).

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

$$\text{n}_{g,a,t} = \frac{\text{N_MSIS}_{g,a,t}}{\text{U}_{g,a,t} \times \sum_f \text{E_CPS}_{g,a,f,t}}.$$

Here, the numerator is the total number of male state residents aged *a* of gender *g* in year *t* who are enrolled in Medicaid based on data obtained from the MSIS. One limitation of the data from the 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:

$$\text{r}_{g,a,t} = \frac{\text{R_MSIS}_{g,a,t}}{\text{N_MSIS}_{g,a,t}}.$$

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23 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+.

24 The income ranges are defined according to the applicable cutoffs before and under the new health care law. Those cutoffs are generally different for population groups served by various Medicaid programs.

Again, data for the number of state residents who received Medicaid benefits are obtained from the 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 category. Thus, total state Medicaid expenditures (M) 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 Disproportionate Share Hospital and Upper Payment Limit 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 the state's 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, , where t=2001–08, as above, and to 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.

Calculating and independently projecting each of these component rates captures 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, individuals' perceptions about their health care needs, the quality and out-of-pocket expenditures 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 vary 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 has been adequately accounted for.

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