ENGELBERG CENTER for Health Care Reform at BROOKINGS

The Future of U.S. Health Care Spending Conference, April 11, 2014

The Potential Impact of Alternative Health Care Spending Scenarios on Future State and Local Government Budgets

Author: Donald Boyd, Rockefeller Institute of Government

Abstract

Health care expenditures by state and local governments have approximately doubled over the last 25 years, and now total $475 billion. These expenditures are 18 percent of national health care consumption expenditures, 24 percent of state and local government spending from their own funds, and 35 percent of state and local government tax revenue. Continued rapid growth in these expenditures could pose significant fiscal issues and difficult choices for state and local governments.

This paper examines state and local government health care expenditure growth under three scenarios, and analyzes possible implications of those choices. It concludes that expenditures could increase over 20 years by 1.2 percentage points of GDP under the baseline scenario, 0.3 percentage points under a low cost-growth scenario, and 2.3 percentage points under a high cost-growth scenario. These cost increases are driven more by non-Medicaid costs than by Medicaid costs. The non-Medicaid increases are driven first by retiree health care costs (OPEB) and second by costs of health care for the existing workforce. The Medicaid cost increases are driven primarily by costs for the elderly and disabled. Children, adults, and Medicaid expansion enrollment play a much smaller role in the increases.

The low cost-growth scenario is unlikely to pose particularly difficult decisions for state and local governments, but the baseline and high cost-growth scenarios would. The baseline increase is more than twice as large as state tax increases enacted in either the 1980-82 recessions or the 1990 recession. It is equivalent to total state and local government spending on police and prisons. Adjusting budgets by that magnitude, even over 20 years, would undoubtedly raise very difficult policy and political choices.

This analysis is for state and local governments in the aggregate, but that is not how the real world works. The problems that state and local governments face are quite varied; in some places fiscal problems have been and will continue to be severe, particularly in older industrial cities and in many California cities. In those places, health care spending increases on top of other problems will make it very hard for elected officials to fund the spending. If health care spending does increase as much as in the baseline scenario then some governments undoubtedly will seek to make large cuts in health care spending. Health care premiums for workers and retirees, who do not appear to have strong political support and where cuts do not lead to a loss in federal aid, may be particularly susceptible. Governments may find it much harder and much less attractive to cut mandated Medicaid spending or to raise taxes relative to their current levels.

The high cost-growth scenario would present far more difficult choices. The growth in spending as a share of GDP would be the equivalent of more than a 20 percent cut in all non-health state and local government financed spending. A tax increase to fund this spending would raise state and local taxes as a percentage of GDP about 20 percent above the highest level that taxes have been in the last seven decades. While state and local governments increased taxes by even more between 1950 and 1970 to finance the education of baby boomers, they started from a level of taxation that was 37 percent lower than it is now. Support for similar tax increases now undoubtedly would be smaller. Health care spending increases of this magnitude seem likely to generate extraordinary political opposition and efforts to cut health care programs significantly. As with the baseline scenario, these numbers reflect national averages. Some governments – particularly where health care spending already is high or where fiscal pressures are particularly severe – would face much greater pressure.

I. State and local government spending on health care

State and local governments spent $475 billion on health care consumption in 2012, or $1,515 per capita.[1] This was 18 percent of all health care spending in the nation and amounted to 2.9 percent of gross domestic product. Health care spending accounted for one quarter of all state and local government spending from their own sources, and was more than one third of state and local government tax revenue (See Table 1).[2] The future course of state and local government health care spending will play an important role in state and local finances, and in the economy as a whole.

Table 1. State and Local Government Health Care Expenditures Relative to Economy and Budgets

State and local government expenditures on health care consumption, 2012:	
Expenditures, billions of dollars	$ 475.4
Expenditures per capita, dollars	$ 1,515
% of gross domestic product	2.9%
% of total national health care consumption expenditures	18.1%
% of state & local government spending from own funds	24.0%
% of state & local government tax revenue	34.5%

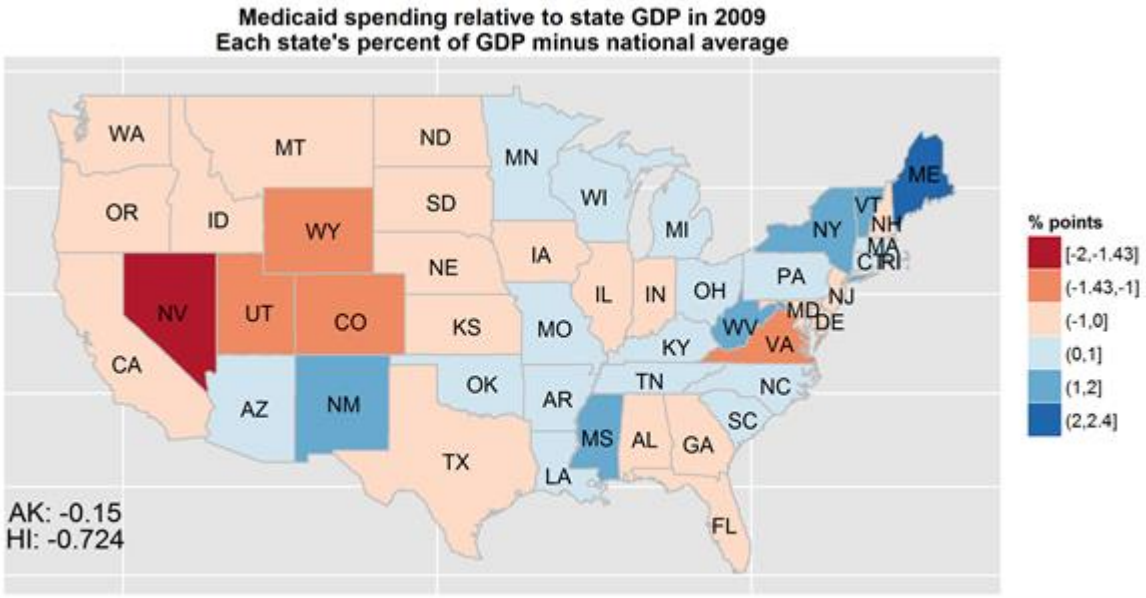
Source: Author's estimates based upon data from Centers for Medicare & Medicaid Services (National Health Expenditure Accounts), Census Bureau (population, and state & local finances), and Bureau of Economic Analysis (state & local finances, NIPA Table 3.3)

The two largest components of state and local government spending on health care are Medicaid, which accounts for approximately 40 percent of all state and local government health spending, and employer contributions to cover health insurance premiums for state and local workers, which accounted for another quarter. Perhaps surprisingly, despite frequent stories in the press about unfunded liabilities for retiree health care that may approximate $1 trillion, often referred to as OPEB, spending on retiree health care accounted for only an estimated 8 percent of state and local government healthcare spending.[3] [4] [5] [6] other major expenditures on health care by state and local governments include public health activities, which consist primarily of state and local health departments, and a variety of smaller programs including programs for maternal and child health, vocational rehabilitation, general assistance, school health, S-CHIP, and other state and local programs (see Table 2).

Healthcare spending by state and local governments varies enormously around the country and by level of government. While there are no comprehensive 50-state data on state and local government spending on

healthcare, we do have data on some components.[7] In 2009, the latest year for which complete data are available, state Medicaid spending as a percentage of state gross domestic product ranged from 4.9 percent in Maine to 1.1 percent in Nevada.[8] Many Northeastern states tend to spend far more on Medicaid relative to their economies than do Southern and Western states, reflecting differences in generosity, health care costs, utilization, and other factors (see Figure 1).

Figure 1. Large Differences Across States in Medicaid Spending Relative to the Economy



Sources: Centers for Medicare and Medicaid Services (Medicaid) and Bureau of Economic Analysis (State GDP)

Health care spending also varies significantly depending upon the type of government. Local governments in aggregate have about three to four times as many workers as do state governments, and in most cases they appear to finance employee related health care expenses themselves rather than having those expenses paid by their state governments. (By contrast states often pay pension contributions on behalf of local governments. This appears to be much less common for retiree health benefits.) Thus, employee-related health care expenses are likely to be larger for local governments on average than for state governments, and local governments will face different challenges than state governments.

Table 2. State and local government health care expenditures are dominated by Medicaid and employee and retiree insurance costs

State and local government expenditures on health care consumption, 2012

	Billions of dollars	Percentage of state & local total	Notes
Medicaid	$ 188.8	39.7%	Excludes federal share; dominated by state governments
Employer contributions to health insurance premiums	152.5	32.1%	
Employee health insurance *	114.3	24.0%	likely dominated by local governments
Retiree health insurance (OPEB) **	38.2	8.0%	likely dominated by local governments
Public health activity	64.1	13.5%	primarily state & local health departments
Other programs	58.5	12.3%	includes maternal and child health, vocational rehabilitation, general assistance, school health, CHIP, and other state and local programs
Employer contribution to Medicare trust fund	11.4	2.4%	
Grand total	$ 475.4	100.0%	Excludes research, equipment, and structures ($21.8b)

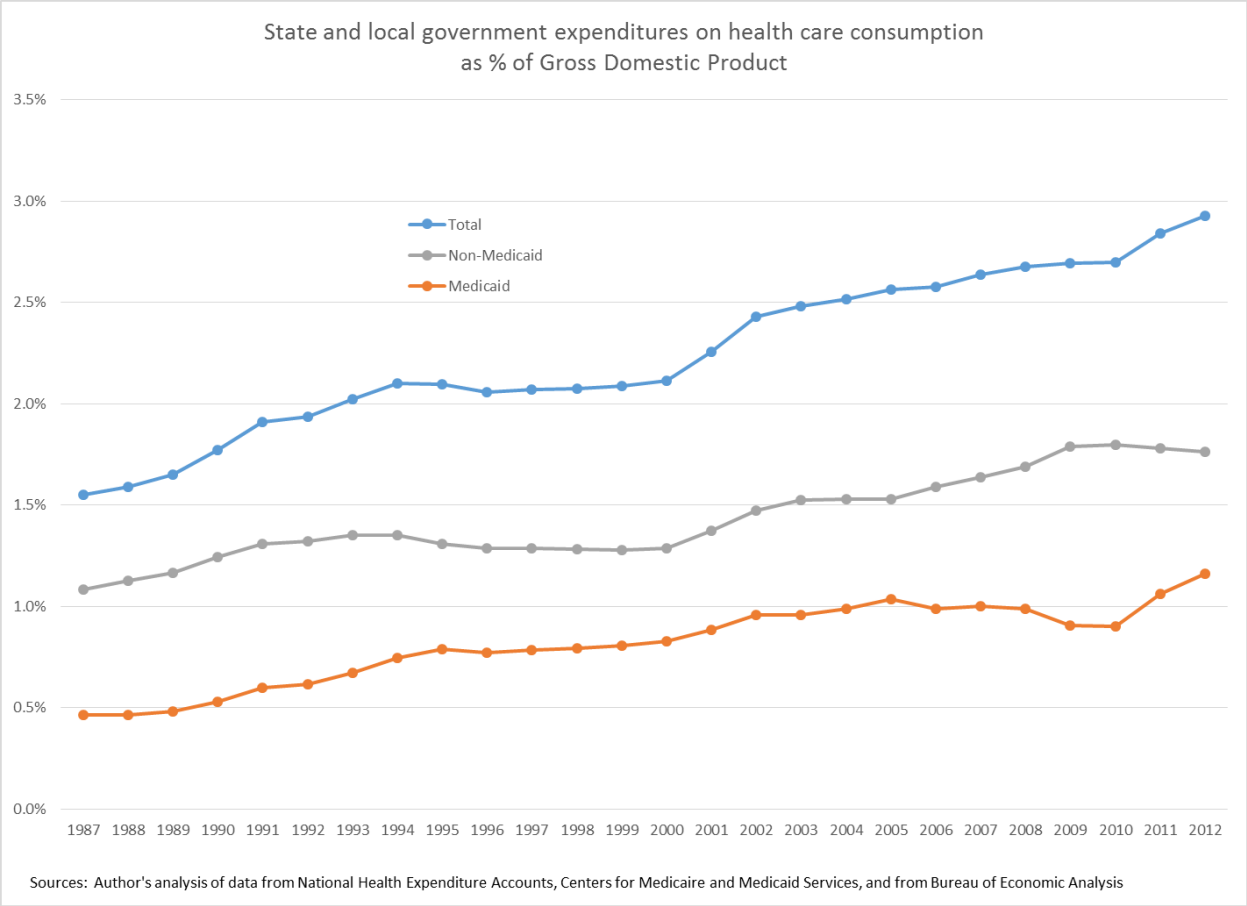
* Estimated by author from Medical Expenditure Panel Survey

** Estimated by subtracting employee health insurance estimate from total employer contributions

Source: Author's analysis of National Health Expenditure Accounts, Centers for Medicare & Medicaid Services; and Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

As has been true for the federal government and for private employers, health care expenditures have been a source of major fiscal stress for state and local governments. State and local government health care consumption costs have nearly doubled relative to the size of the economy over the last 25 years. This has been driven by increases in both Medicaid spending and non-Medicaid spending, depending upon the particular time period examined (see Figure 2). If health care costs continue to grow rapidly, state and local governments are likely to face continued fiscal stress.

Figure 2. State and local government health care expenditures have nearly doubled relative to the economy over the last 25 years, driven by increases in both Medicaid and non-Medicaid spending



II. Three scenarios for state and local government health care consumption

This paper examines state and local government health care cost projections under three different cost-growth scenarios: a baseline scenario, a low cost-growth scenario, and a high cost-growth scenario. It also considers the policy choices state and local governments might make in response. The analysis is based on a simple model that projects each major component of health care expenditures described in Table 2 above for 20 years, from 2014 through 2034. In general, the model forecasts population or workload that is relevant to health care expenditures in a particular category, and it forecasts the average cost of health care for that category. For example, the model forecasts the number of state and local government workers who are covered by health insurance and the average cost of the insurance.

Similarly it forecasts the number of state and local government retirees covered by retiree health insurance and the average cost of that insurance.

The forecast for Medicaid is a bit more complicated. The model forecasts Medicaid enrollment for each of the major eligibility groups: children, adults, the aged, and the disabled. It also forecasts average total Medicaid costs (federal plus state and local) for each such group based on the forecast of average cost for the group. It then calculates state and local government Medicaid expenditures based on the expected federal reimbursement rate, known as the Federal Medical Assistance Percentage (FMAP). Because Medicaid is subject to considerable policy changes during the forecast period, the model also forecasts enrollment of the Medicaid "expansion population" - people added to the Medicaid rolls as a result of the Affordable Care Act.[9]

Table 3 shows on the left-hand side the major categories that are forecasted and, on the right-hand side, the demographic or economic variables that drive the forecast. The top half of the table shows for each enrollment, population, or workload variable an associated economic or demographic variable. The bottom half shows that the average cost for each category is driven by the concept of "excess cost growth," which is commonly used in forecasting health care expenditures. Excess cost growth indicates the extent to which average cost of services, holding age and gender constant, is assumed to grow more quickly than growth in real GDP per capita plus price inflation. In essence it is a measure of the extent to which costs for a given population are presumed to grow more quickly than the economy.

Table 3. Key factors underlying expenditure projections

Key factors assumed to drive projected health care expenditures

Enrollment, population, and workload projections	**Enrollment, population, or workload grows at same rate as:**
Medicaid enrollment	
Child	Population, age 0-19
Adults	Population, age 20-64
Aged	Population, age 65+
Disabled	Population, total
State & local government workers covered by health insurance	Population, total
State & local government retirees covered by retiree health insurance	Population, age 65+
Public health activity - workload	Population, total
Other health programs - workload	Population, total
Health care costs	**Nominal costs per unit grow at following rate:**
Cost per member of relevant population (enrollee, worker, retiree, etc.) or per unit of workload	growth in real GDP per capita + general price inflation + excess cost growth for the scenario in question

Details of the scenarios were developed by other participants in this project. The three scenarios share a common set of demographic and economic assumptions, but have differing assumptions about excess cost growth for health care. Table 4 summarizes the key assumptions.

The table shows, for example, that the elderly population is expected to grow about 2.63 percent on average per year during the forecast horizon, reflecting the impending retirement of baby boomers, while younger populations are expected to grow much more slowly. Similarly it includes forecasts for real GDP per capita and price inflation, both of which are important inputs into estimating average cost for health care services. The population, real GDP per capita, and price inflation assumptions combined indicate that nominal GDP grows approximately 4.3 percent annually, on average, over the projection period.

The table also includes a set of assumptions related to expansion of Medicaid eligibility under the Affordable Care Act. It assumes that enrollment will increase by approximately 10 million people in calendar year 2014, rising to 18 million in 2022 after which it grows slowly. Approximately 78 percent of the expansion population is assumed to be adults, and their average costs are assumed to be about 70 percent of the average costs of the counterparts in the existing Medicaid population. The lower cost reflects, among other things, assumptions that some will have other payors for healthcare. These assumptions have been calibrated to be consistent with assumptions in the most recent report from the Office of the Actuary at the Centers for Medicare & Medicaid Services, and with national health expenditure projections from CMS.[10]

Table 4. Key Assumptions

Summary of key assumptions underlying projections

	Value	Source note
Average annual growth rate (AAGR), 2014 to 2034		
Population, total	0.78%	a
Population, age 0-19	0.60%	a
Population, age 20-64	0.31%	a
Population, age 65+	2.63%	a
Real GDP per capita	1.39%	a
Price inflation	2.09%	a
Excess cost growth:		
Baseline	1.25%	a
High cost-growth scenario	2.50%	a
Low cost-growth	0.00%	a
Medicaid assumptions		
Average cost in dollars per enrollee in 2014, overall	$ 7,570	b,c
Child	3,353	b,c
Adult	5,357	b,c
Aged	18,492	b,c
Disabled	21,051	b,c
Affordable Care Act expansion population enrollment	10 million in 2014, rising to 18 million in 2022	b, d
Adults as % of expansion population (remainder are children)	78%	d
Expansion population average cost as % of non-expansion average cost	70%	d
Federal share of Medicaid costs (Federal Medical Assistance Percentage):		
FMAP - Base population	54 to 55%	b
FMAP - Expansion population	100% in 2014, falling to 90% in 2020 and thereafter	e

Sources

a. Provided to the author as part of this project.

b. Estimated and calibrated by author to be generally consistent with initial year of National Health Expenditure Projections, September 2013.

c. Implicitly includes a pro-rata share of non-enrollee costs such as Disproportionate Share Hospital payments

d. Estimated and calibrated by author to be generally consistent with Christopher J. Truffer, John D. Klemm, Christian J. Wolfe, Kathryn E. Rennie, and Jessica F. Shuff. 2012 Actuarial Report on the Financial Outlook for Medicaid. Office of the Actuary, Centers for Medicare & Medicaid Services, March 2013.

e. Affordable Care Act

Note that assumptions for individual years generally vary from overall averages.

The scenarios differ in their assumptions about excess cost growth. The baseline assumptions result in average excess cost growth of 1.25 percent and are largely consistent with assumptions used by the Congressional Budget Office. (The model actually uses different growth rates for each year in the projection period but result in average growth of 1.25 percent.) The high cost-growth scenario assumes that excess cost growth will instead average 2.5 percent, and the low cost-growth scenario assumes excess cost growth is zero. These assumptions are consistent with ranges experienced over history.

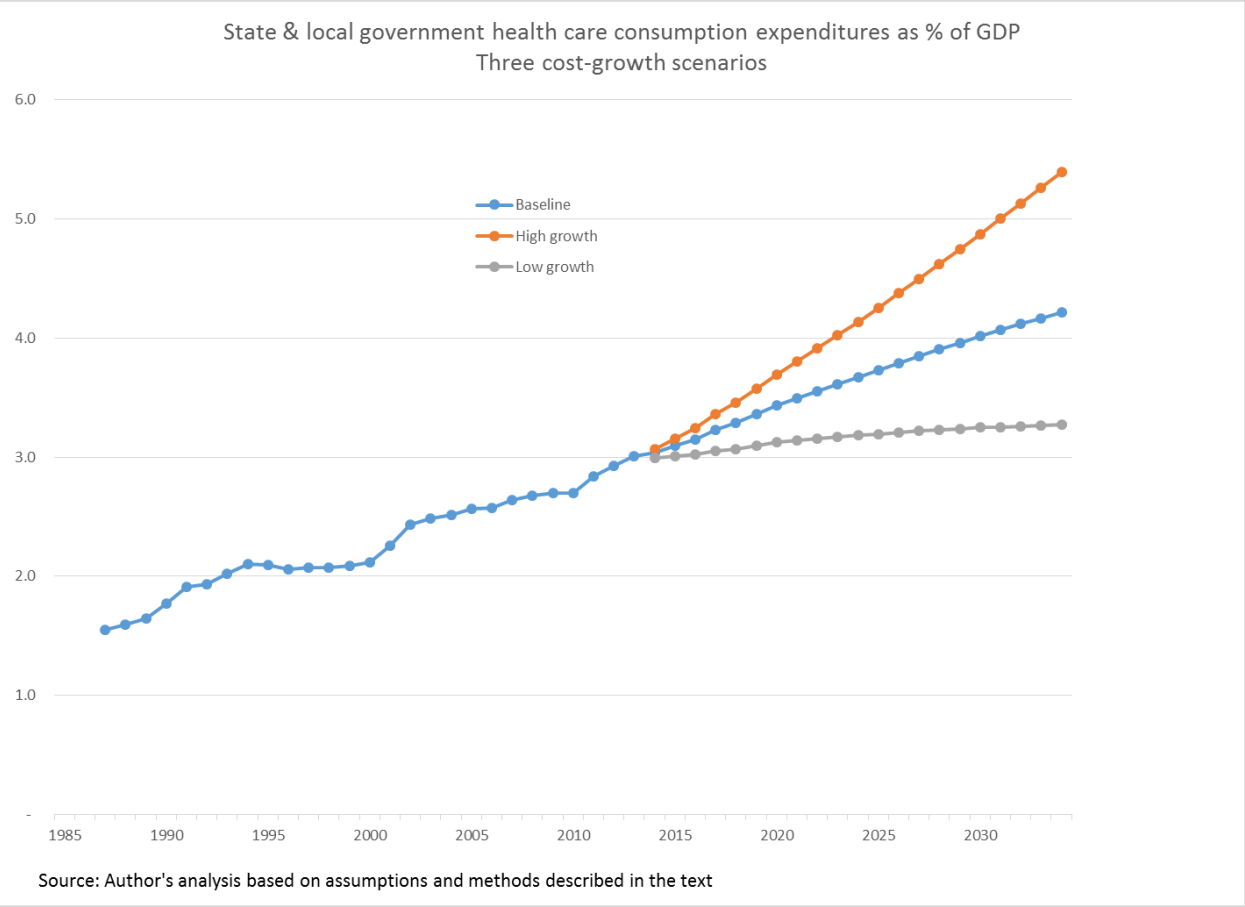
These scenarios cannot possibly take into account the richness of state policymaking over recent decades. Many state governments have been making dramatic changes to their Medicaid programs to expand use of managed care. In addition and more recently states have been trying to extend and increase managed long-term care, in an effort to reduce costs and improve access to and quality of care. These efforts are likely to continue and are not reflected in the model in any formal sense. Continued managed care expansion or other changes to the delivery and financing of Medicaid services might reduce or slow the rates of growth in average costs. Other than allowing for alternative scenarios, the model does not take these possibilities into account.

States and localities also have been making significant changes to both employee health insurance and retiree health insurance (OPEB). These benefits do not ordinarily have strong legal protections, although they often have contractual protections. However the term of those contractual protections may be short, at least relative to the time horizon of these projections. Plus states and localities have been restructuring employee and retiree health benefits and are likely to continue to do so, in ways that may slow the growth of these costs.

III. Results of the three scenarios

The model forecasts each major component of state and local government health care expenditures under the three excess cost growth scenarios. Figure 3 shows state and local government health care consumption expenditures as a percentage of gross domestic product for history and for the forecast horizon under each scenario. Under the baseline assumption spending as a percentage of gross domestic product increases by 1.2 percentage points at the end of 20 years. Under the low cost-growth scenario it increases by only 0.3 percentage points, while under the high cost-growth scenario it increases by 2.3 percentage points of GDP.

Figure 3. Cost-Growth Scenarios



Source: Author's analysis based on assumptions and methods described in the text

Table 5 provides summary results for each scenario showing spending as a percentage of GDP on Medicaid and non-Medicaid categories in 2014, 2024, and 2034. The magnitude of impact is very different from scenario to scenario, but in each case non-Medicaid spending actually contributes more to increases in state and local government health care spending then does Medicaid spending.

Table 6 provides details of the baseline scenario, and Table 7 provides details of the high cost-growth scenario. These tables both show that the increase in Medicaid costs is driven primarily by increasing cost for the elderly and disabled, and that the Medicaid expansion enrollment plays a very minor role in cost increases. The tables also show that employee health insurance and retiree health insurance play roles that are as significant, or more significant, than the roles played by the aged and disabled in Medicaid. For example, in the baseline case employee health insurance plus retiree health insurance increase by 0.42 percentage points of GDP, while Medicaid spending on the aged and disabled increase by 0.38 percentage points.

Table 5. Comparison of Results

State & local government health care consumption spending as % of GDP

Comparison of three cost-growth scenarios

	Spending as % of GDP			Change in spending as % of GDP			2014 to 2034	
	2014	2024	2034	2014 to 2024	2024 to 2034	2014 to 2034	% change	Share of change
Baseline scenario								
State & local government health care total	3.04	3.67	4.22	0.64	0.54	1.18	38.9%	100.0%
Medicaid state & local total	1.18	1.48	1.71	0.30	0.22	0.52	44.0%	44.1%
Non-Medicaid total	1.85	2.19	2.51	0.34	0.32	0.66	35.6%	55.9%
High cost-growth scenario								
State & local government health care total	3.07	4.14	5.40	1.07	1.26	2.33	76.0%	100.0%
Medicaid state & local total	1.20	1.67	2.18	0.47	0.51	0.99	82.5%	42.3%
Non-Medicaid total	1.87	2.47	3.21	0.60	0.75	1.34	71.9%	57.7%
Low cost-growth scenario								
State & local government health care total	2.99	3.18	3.27	0.19	0.09	0.28	9.2%	100.0%
Medicaid state & local total	1.17	1.29	1.32	0.12	0.04	0.15	13.2%	56.0%
Non-Medicaid total	1.83	1.90	1.95	0.07	0.05	0.12	6.6%	44.0%

Source: Author's analysis based on assumptions and methods described in text.

Table 6. Baseline Results

Baseline results: State & local government health care consumption spending as % of GDP

	Spending as % of GDP			Change in spending as % of GDP			2014 to 2034	
	2014	2024	2034	2014 to 2024	2024 to 2034	2014 to 2034	% change	Share of change
State & local government health care total	3.04	3.67	4.22	0.64	0.54	1.18	38.9%	100.0%
Medicaid state & local total	1.18	1.48	1.71	0.30	0.22	0.52	44.0%	44.1%
Child	0.24	0.27	0.30	0.03	0.03	0.06	26.6%	5.3%
Adult	0.18	0.21	0.22	0.02	0.01	0.04	19.4%	3.0%
Aged	0.25	0.37	0.47	0.12	0.10	0.22	88.8%	18.7%
Disabled	0.52	0.60	0.68	0.09	0.07	0.16	31.3%	13.7%
Expansion enrollment	-	0.04	0.04	0.04	0.00	0.04	.	3.4%
Non-Medicaid total	1.85	2.19	2.51	0.34	0.32	0.66	35.6%	55.9%
Employee health insurance	0.73	0.84	0.94	0.10	0.10	0.20	27.9%	17.3%
Retiree health insurance (OPEB)	0.26	0.37	0.47	0.11	0.10	0.22	83.8%	18.3%
Public health activity	0.41	0.47	0.53	0.06	0.06	0.11	27.9%	9.7%
All other	0.45	0.51	0.57	0.06	0.06	0.13	27.9%	10.6%

Source: Author's analysis based on assumptions and methods described in text.

Table 7. High cost-growth results

High cost-growth scenario: State & local government health care consumption spending as % of GDP

	Spending as % of GDP			Change in spending as % of GDP			2014 to 2034	
	2014	2024	2034	2014 to 2024	2024 to 2034	2014 to 2034	% change	Share of change
State & local government health care total	3.07	4.14	5.40	1.07	1.26	2.33	76.0%	100.0%
Medicaid state & local total	1.20	1.67	2.18	0.47	0.51	0.99	82.5%	42.3%
Child	0.24	0.30	0.38	0.06	0.08	0.14	60.5%	6.2%
Adult	0.19	0.23	0.28	0.04	0.05	0.10	51.4%	4.1%
Aged	0.25	0.41	0.60	0.16	0.19	0.35	139.3%	15.0%
Disabled	0.52	0.68	0.87	0.16	0.19	0.35	66.4%	14.8%
Expansion enrollment	-	0.04	0.05	0.04	0.01	0.05	.	2.2%
Non-Medicaid total	1.87	2.47	3.21	0.60	0.75	1.34	71.9%	57.7%
Employee health insurance	0.74	0.94	1.20	0.20	0.26	0.46	62.0%	19.7%
Retiree health insurance (OPEB)	0.26	0.42	0.61	0.16	0.19	0.35	133.0%	14.8%
Public health activity	0.42	0.53	0.67	0.11	0.14	0.26	62.0%	11.1%
All other	0.45	0.58	0.73	0.12	0.16	0.28	62.0%	12.1%

Source: Author's analysis based on assumptions and methods described in text.

IV. Implications of the cost-growth scenarios for other state and local government policies

How large are the increases in health care expenditures under the three scenarios, and what do they imply for other policies of state and local governments? Table 8 shows (1) the increase in health care expenditures by state and local governments between 2014 and 2034 as a percentage of GDP under each scenario (shaded), (2) the size of other actual policies that have been adopted over the years by states or states and localities, (3) other possible policies that might be considered, and (4) several policies that are unlikely ever to be considered. The purpose of the table is to give a sense of the budgetary and political difficulty that states and localities might encounter under different cost-increase scenarios, and in turn prove insight into how aggressively governments might try to cut health care expenditures.

As the table shows, the low health care cost-growth scenario which results in an increase in spending of 0.28 percentage points of GDP over a 20 year horizon is unlikely to create choices that are extremely difficult. It is approximately the same size as the tax increases adopted in the span of three years in response to the 2007 recession and it is slightly larger than the increases adopted in response to the 2001 recession. It is much smaller than tax increases adopted near the 1980-82 recessions and the 1990 recession.

By contrast the cost increase under the baseline scenario looks like it would cause much greater difficulty. The increase is more than the entire amount that states and localities spend on police and prisons annually. And it is almost as large as spending by states and localities on highways and the judicial system combined. States and localities seem unlikely to make cuts like these to pay for higher health care spending. But would they be willing to raise taxes enough to make room for this additional health care spending? The baseline health care spending increases are more than twice as large as the tax increases enacted in response to the 1980-82 recessions and the 1990 recession. Those tax increases appeared to have been quite difficult politically. This suggests states and localities are likely to look also to cuts in health care spending under this scenario.

Table 8. Size of potential health care spending increases relative to past policies, potential policies, and unlikely policies

How big are potential increases in health care spending?

Comparison	Percent of GDP	Comment
State tax increases enacted in and near 2001 recession	0.15	
Eliminate all cash assistance spending	0.16	
State tax increases enacted in and near 2007 recession	0.24	somewhat understated
Low health care cost-growth scenario	**0.28**	
Eliminate all state & local government-financed fire protection in the United States	0.28	volunteers would still operate
State tax increases enacted in and near 1980-82 recessions	0.48	
State tax increases enacted in and near 1990 recession	0.56	
Eliminate all state & local government police and prison spending	1.13	
Baseline health care cost-growth scenario	**1.18**	
Eliminate all state & local spending on highways and judicial systems	1.31	
Increase state & local sales taxes by 75%	1.75	
50% cut in ALL K-12 spending	1.89	
20% cut in all non-health state & local spending financed from own sources	2.00	
High health care cost-growth scenario	**2.33**	
Increase in K-12 spending between 1950 and 1970 to educate baby boomers	2.97	
Increase in state & local taxes between 1950 and 1970 to finance education of baby boomers	2.99	Taxes were 37% lower in 1950, relative to the economy, than they are now

Mitigating factors:
1) Under the projection assumptions, real per-capita GDP would be much higher in 2034 than in 2014 - people would be able to pay higher taxes and still have much more income left over than in 2014.
2) Governments would be able to gradually adjust policies, leaving opportunity to develop productivity improvements

Figure 4 provides further insight into the potential difficulty of tax increases. It shows state and local government taxes as a percentage of gross domestic product from 1945 through 2013 and the increase that would be required over the two decades to 2034 under each scenario. With the luxury of two decades to inch toward higher tax revenue the baseline scenario looks less out of line with history. However it would result in taxes that are about 10 percent higher relative to the economy than they were at any point in the seven decades from the end of World War II until the present.

Figure 4. Financing higher health care costs with taxes

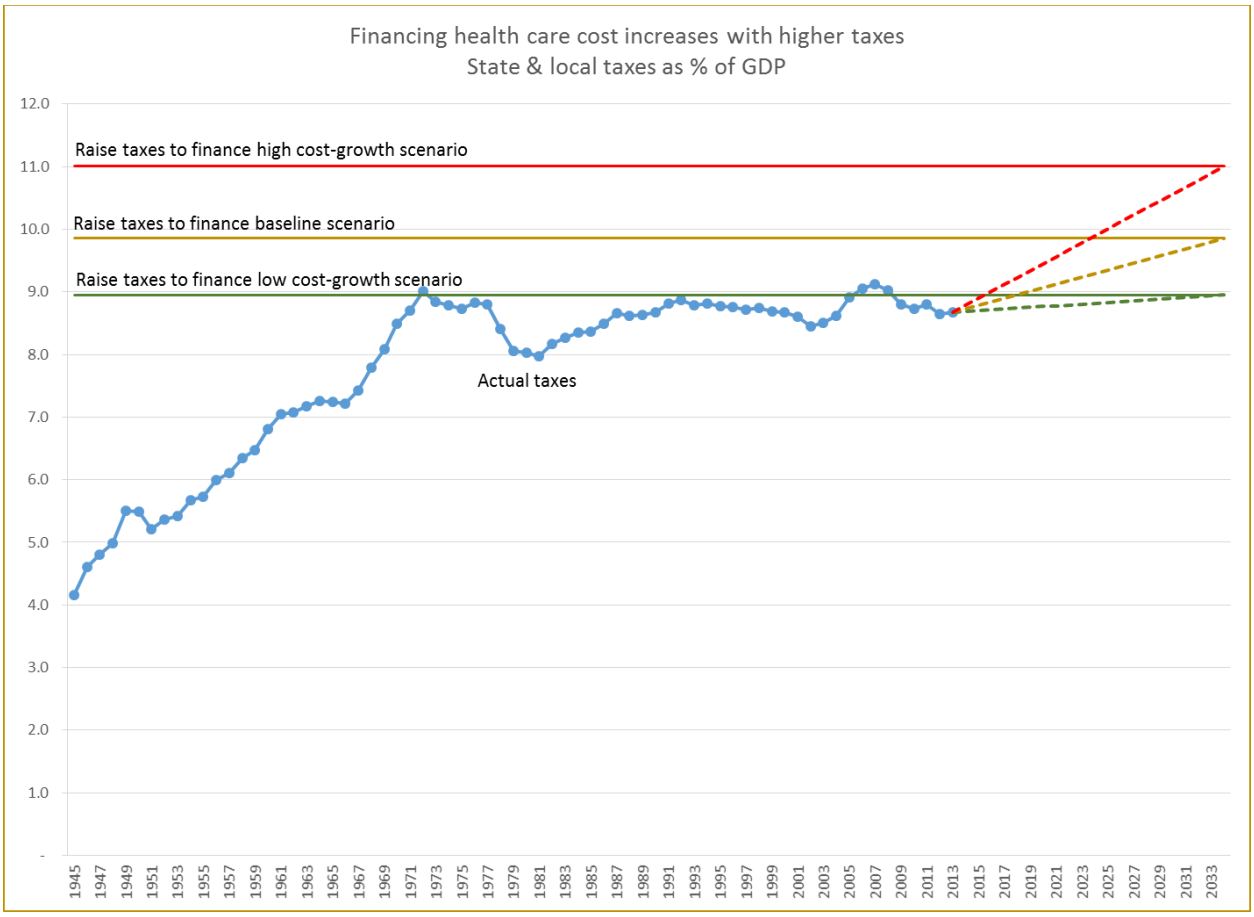


Figure 4 also shows the extent of tax increases that would be required to finance the high cost-growth scenario. It would require raising taxes by more than 20 percent above the highest point they were at in the last seven decades. That does not mean politicians are incapable or unwilling to raise taxes by that much, but it seems extremely difficult politically, particularly given how little appetite there was for tax increases in either of the last two recessions. This suggests that there will be a lot of pressure to cut other spending and to cut health care spending.

There is one episode in history in which states and localities increased taxes by far more than what would be required by the high cost-growth scenario: between 1950 and 1970, as states and localities needed to pay for the education of baby boomers, they increased K-12 education spending by 2.97 percentage points of GDP and they increased total state and local taxes by 2.99 percent of GDP (see

Table 8) – considerably larger than the 2.33 percent that would be required by the high-growth scenario. It is tempting to think that there might be a parallel here: society was willing to pay higher taxes to finance the education of baby boomers, and now perhaps society is willing to pay higher taxes to help finance the health care of aging baby boomers.

However, that seems unlikely. First, state and local taxes were 37 percent lower relative to GDP in 1950 than they are now, so it might be much more challenging politically to increase taxes by as much as in that episode. Second, taxpayers have shown much less willingness to support higher taxes in the last two recessions than in the two prior recessions. Anti-tax sentiment appears strong by historical standards, perhaps reflecting stagnant incomes that make the effects of tax increases on living standards readily apparent. Third, much of the increase in state and local government healthcare spending would be for insurance premiums for workers and retirees (see Table 6 and Table 7). Judging by recent changes to pension benefits and retiree health benefits, political support for state and local government workers may have waned, at least when it comes to funding benefits attributable to service rendered previously and for which no new services are obtained.

V. Conclusion

Health care expenditures by state and local governments have approximately doubled over the last 25 years, and now total $475 billion. These expenditures are 18 percent of national health care consumption expenditures, 24 percent of state and local government spending from their own funds, and 35 percent of state and local government tax revenue. Continued rapid growth in these expenditures could pose significant fiscal issues and difficult choices for state and local governments.

This paper examines state and local government health care expenditure growth under three scenarios, and analyzes possible implications of those choices. It concludes that expenditures could increase over 20 years by 1.2 percentage points of GDP under the baseline scenario, 0.3 percentage points under a low cost-growth scenario, and 2.3 percentage points under a high cost-growth scenario. These cost increases are driven more by non-Medicaid costs than by Medicaid costs. The non-Medicaid increases are driven first by retiree health care costs (OPEB) and second by costs of health care for the existing workforce. The Medicaid cost increases are driven primarily by costs for the elderly and disabled. Children, adults, and Medicaid expansion enrollment play a much smaller role in the increases.

The low cost-growth scenario is unlikely to pose particularly difficult decisions for state and local governments, but the baseline and high cost-growth scenarios would. The baseline increase is more than twice as large as state tax increases enacted in either the 1980-82 recessions or the 1990 recession. It is equivalent to total state and local government spending on police and prisons. Adjusting budgets by that magnitude, even over 20 years, would undoubtedly raise very difficult policy and political choices.

This analysis is for state and local governments in the aggregate, but that is not how the real world works. The problems that state and local governments face are quite varied; in some places fiscal problems have been and will continue to be severe, particularly in older industrial cities and in many California cities. In those places, health care spending increases on top of other problems will make it very hard for elected officials to fund the spending. If health care spending does increase as much as in the baseline scenario then some governments undoubtedly will seek to make large cuts in health care spending. Health care premiums for workers and retirees, who do not appear to have strong political

support and where cuts do not lead to a loss in federal aid, may be particularly susceptible. Governments may find it much harder and much less attractive to cut mandated Medicaid spending or to raise taxes relative to their current levels.

The high cost-growth scenario would present far more difficult choices. The growth in spending as a share of GDP would be the equivalent of more than a 20 percent cut in all non-health state and local government financed spending. A tax increase to fund this spending would raise state and local taxes as a percentage of GDP about 20 percent above the highest level that taxes have been in the last seven decades. While state and local governments increased taxes by even more between 1950 and 1970 to finance the education of baby boomers, they started from a level of taxation that was 37 percent lower than it is now. Support for similar tax increases now undoubtedly would be smaller. Health care spending increases of this magnitude seem likely to generate extraordinary political opposition and efforts to cut health care programs significantly. As with the baseline scenario, these numbers reflect national averages. Some governments – particularly where health care spending already is high or where fiscal pressures are particularly severe – would face much greater pressure.

Endnotes

[1] In this paper I analyze health care consumption expenditures, in an effort to get at costs that are closely linked to the concept of excess cost growth. Health care consumption expenditures are all health care expenditures as defined in the National Health Expenditure Accounts prepared by the Centers for Medicare & Medicaid Services (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html) except for investment spending, which consists of research and development, and spending on equipment and structures. These excluded items accounted for 5.7 percent of total health expenditures in 2012. One gray area included in consumption expenditures that would be affected, in part, by excess cost growth is public health activities by state and local governments, which are dominated by expenditures of state and local health departments. Some of these expenditures, such as providing flu shots, undoubtedly are linked to the concept of excess cost, while other expenditures may be more administrative in nature. Public health activities accounted for 2.7 percent of all health expenditures in 2012.

[2] By "own source" spending I mean spending financed by state and local revenue sources, not including spending financed with federal aid.

[3] OPEB is the accounting acronym for Other Post-Employment Benefits. Pensions are one kind of post-employment benefit, and retiree health care is another. OPEB costs appear to consist primarily of health care costs, but there are some other kinds as well.

[4] Expenditures for retiree health care are not reported separately in the National Health Expenditure Accounts. They are embedded in expenditures by state and local governments for employer-sponsored health insurance. I estimated expenditures for current employees using data from the Medical Expenditure Panel Survey. I subtracted this estimate from total employer sponsored insurance to estimate the portion of insurance attributable to retirees.

[5] This does not mean that OPEB isn't a significant fiscal issue for state and local governments. However, it does indicate that these governments, on average, are not currently spending very much money to finance these promised benefits.

[6] Byron Lutz and Louise Sheiner, *The Fiscal Stress Arising from State and Local Retiree Health Obligations* (National Bureau of Economic Research, 2014), http://www.nber.org/papers/w19779.

[7] The National Health Expenditure Accounts have a set of "sponsor" tables that estimate spending by different payors. The State Health Expenditure Accounts do not have similar tables.

[8] Author's analysis of State Health Expenditure Accounts.

[9] This is not the only important change to Medicaid as a result of the ACA. Other impacts may include increased enrollment among currently eligible people as a result of improved outreach and reduced stigma associated with Medicaid.

[10] Christopher J. Truffer et al., *2012 Actuarial Report on the Financial Outlook for Medicaid* (Office of the Actuary, Centers for Medicare & Medicaid Services, March 2013).