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PPIC REPORT PROJECTING LONG-TERM MEDI-CAL SPENDING SHOULD BE USED WITH CAUTION

Health care costs have increased substantially in California and the US since 2000, following a period of modest growth in the 1990s. In addition, enrollment in California's Medi-Cal Program, which provides health coverage to children, seniors, and other individuals with low incomes, increased from 5.3 million in 2000-01 to 6.6 million in 2004-05 (25.3 percent).[1] Nonetheless, spending per Medi-Cal beneficiary has been relatively flat in recent years, as state policymakers have adopted a range of cost-containment measures, including limiting the growth of Medi-Cal provider payments.

A recent report by the Public Policy Institute of California (PPIC) attempts to construct a "baseline forecast" of Medi-Cal spending over the next decade. The PPIC projects that state Medi-Cal spending will increase substantially through 2014-15, absorbing "a growing share of the California budget."[2] The fundamental, though implicit, assumption underlying the PPIC's analysis is that California cannot sustain its Medi-Cal cost-containment policies. This paper questions that assumption, as well as other aspects of the PPIC's analysis. Specifically, this paper:

- Examines recent health care spending trends in California and the US;
- Reviews the most recent national health care spending projections developed by the federal government;
- Summarizes the PPIC's argument and the key assumptions underlying its Medi-Cal spending forecast; and
- Raises several concerns with the PPIC's analysis.

Taken together, the concerns outlined below suggest that the PPIC may have overstated California's long-term Medi-Cal spending growth rate. The PPIC's projections should therefore be used with caution in health policy debates in California and at the federal level.

California's Health Care Spending Growth Tends to Lag That of the US

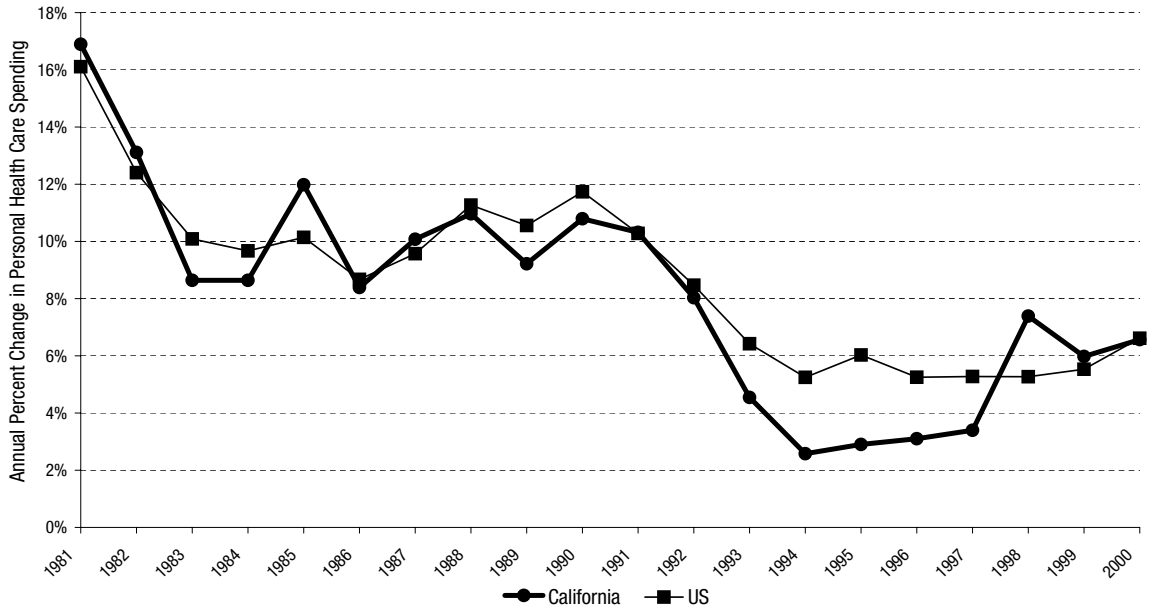
Annual growth in personal health care spending in California generally lags that of the US (Figure 1).[3] Between 1980 and 2000, personal health care spending in California increased at an average annual rate of 8.1 percent, compared to 8.7 percent for the US as a whole.[4] In other words, health spending in California increased at an average annual rate that was 7.4 percent lower than that of the US.

Health Care Costs Have Increased Substantially in California and the US Since 2000

While comparable US and California personal health spending data are not available after 2000, other data can be used to examine changes in health care costs nationally and in California since 2000. For example:

- Premiums for employer-sponsored health coverage increased by 11.4 percent in California and by 11.2 percent in the US as a whole in 2004, the fourth consecutive year of double-digit increases at both the state and national levels.[5]
- The average premium for family health coverage in California has increased by 70.0 percent since 2000, rising from $5,904

Figure 1: Personal Health Care Spending Growth in California Generally Lags That of the US



Note: Personal health care spending includes hospital care, physician and dental services, prescription drugs, home health care, and nursing home care. 2000 is the most recent year for which state-level personal health care spending data are available.
Source: Centers for Medicare & Medicaid Services

in 2000 to $10,013 in 2004. In the US, the average premium for family health coverage increased by 56.7 percent over the same period, rising from $6,348 in 2000 to $9,950 in 2004.[6]

- National health spending increased from 13.3 percent of gross domestic product (GDP) in 2000 to 15.3 percent of GDP in 2003. National health spending as a share of GDP fluctuated very little between 1993 and 2000, a period of slower growth in health care costs.[7]

California Has Limited Medi-Cal Spending Growth, Despite Increased Enrollment and Rising Health Care Costs

State policymakers have limited the growth of Medi-Cal spending, despite increased enrollment and rising health care costs since 2000:

- In federal fiscal year 2001, California spent an average of $2,325 per Medi-Cal enrollee, compared to the national average of $4,011, spending the least per enrollee of the 51 Medicaid programs in the nation.[8]
- Spending per Medi-Cal enrollee has been relatively flat in recent years, even as per capita national health spending has continued to rise (Figure 2). Between 1994-95 and 2004-05, Medi-Cal spending per enrollee increased at an average annual rate of 4.2 percent, whereas national health spending per capita increased at an average annual rate of 5.5 percent.
- State Medi-Cal spending as a share of total California personal income has been constant since the early 1990s, averaging 1.0 percent per year between 1993-94 and 2004-05 (Figure 3).[9] In contrast, national health spending as a share of GDP increased from 13.3 percent in 2000 to 15.3 percent in 2003.

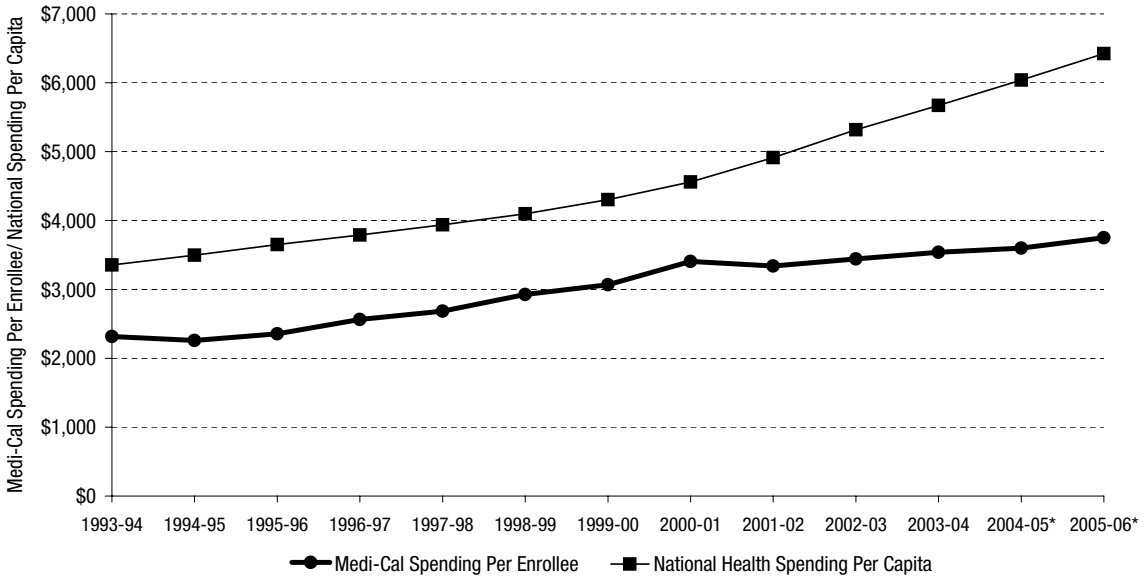
California has adopted several policies in recent years that limit Medi-Cal spending, including freezing and reducing provider reimbursement rates, reducing pharmacy rates, reducing dental benefits, tightening eligibility procedures, and freezing and reducing funding for county Medi-Cal administration.

National Health Care Spending Projections

Key Projections Through 2014

Each year, the federal Centers for Medicaid & Medicaid Services (CMS) produces 10-year projections of national, but not state-level, health care spending. The most recent projections, published in February 2005, cover the period 2004-2014.[10] The CMS projects that national health spending per capita will increase at an average annual rate of 6.3 percent during the forecast period and that health spending as a share of GDP will increase to 18.7 percent in 2014.[11] Total Medicaid spending is forecast to increase at an average annual rate of 7.9 percent through 2014.[12] Medicaid expenditure growth is projected to slow from a peak of 9.1 percent between 2006 and 2007 to 8.1 percent between 2013 and 2014, which is near the 8.3 percent average experienced between 1993 and 2003.[13]

Figure 2: Spending Per Medi-Cal Enrollee Flattened Between 2000-01 and 2004-05, While National Health Spending Continued to Rise

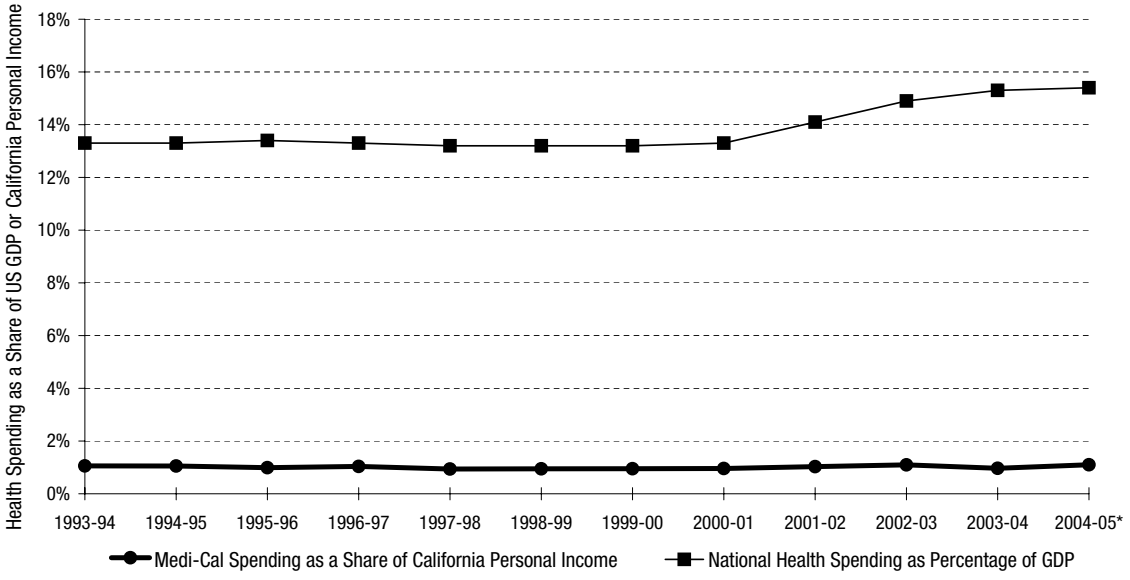


* 2004-05 estimated and 2005-06 proposed.
Note: Medi-Cal spending includes state and federal funds. National health spending includes public and private health expenditures.
Source: Centers for Medicare & Medicaid Services and Department of Health Services

New Medicare Prescription Drug Benefit Will Have a Significant Impact

The CMS indicates that "one of the most significant" changes affecting health spending projections is the new Medicare prescription drug benefit that will take effect on January 1, 2006 as part of the Medicare Modernization Act (MMA).[14] For the first time, the federal Medicare Program will offer an outpatient drug benefit designed to lower the cost of prescription drugs for seniors and people with disabilities.[15] The estimated impact of the MMA is included in the CMS's 2004-2014 projections.

Figure 3: National Health Care Spending as a Share of GDP Is Increasing, While State Medi-Cal Spending as a Share of California Personal Income Remains Flat



* 2004-05 California personal income is based on the first two quarters of state fiscal year 2004-05.
Note: Medi-Cal spending excludes federal funds. GDP = Gross Domestic Product.
Source: Centers for Medicare & Medicaid Services, Department of Finance, and Department of Health Services

While the new prescription drug benefit is expected to have a "minor effect" on total prescription drug spending, it will trigger a "substantial shift in funding from Medicaid and the private sector to Medicare in 2006."[16] More than six million low-income seniors and people with disabilities, including more than one million in California, are enrolled in both Medicare and Medicaid and receive prescription drug coverage through Medicaid, which is funded by states and the federal government. These so-called "dual eligibles" will receive drug coverage through Medicare starting in January 2006. As a result, Medicaid drug spending is projected to decrease by 42.1 percent nationally between 2005 and 2006. Since states provide funds to support their Medicaid programs, shifting dual eligibles' drug costs from Medicaid to Medicare will lower Medicaid benefits spending and thus result in state savings.[17] The Schwarzenegger Administration estimates that California's Medi-Cal prescription drug costs could be reduced by $1.8 billion in 2006-07.[18]

However, the MMA requires states to make monthly payments to the federal government beginning in 2006 to help finance the cost of the Medicare drug benefit – a requirement known as the "clawback."[19] States must pay 90 percent of their projected Medicaid drug savings in 2006 and declining shares of their projected savings in subsequent years until the clawback reaches 75 percent in 2014 and later.[20] The Administration estimates the clawback could cost California $1.3 billion in 2006-07.[21] State officials and analysts have expressed concern about the clawback, since the "calculations associated with determining the clawback payments are fraught with technical and political complications."[22] The Administration, for example, argues that the CMS regulation implementing the clawback "unduly disadvantages California by overstating the true net costs it had incurred in the past for providing prescription drugs to dual eligibles – a key component of the federal clawback formula."[23]

The MMA will have other fiscal impacts on California's state budget, including the loss of drug rebates paid by pharmaceutical companies under the Medi-Cal Program as drug purchases for dual eligibles are shifted from Medi-Cal to Medicare.[24] These lost rebates could cost California an estimated $539.7 million in 2006-07, according to the Administration.[25]

Some analysts have cited the clawback and other potential state costs to argue that states may see little or no savings from the new Medicare drug benefit.[26] Certainly, California and other states may derive a relatively small fiscal benefit in the short term from shifting dual eligibles' prescription drug costs from Medicaid to Medicare. However, over the long term, states are likely to experience larger net savings in their Medicaid programs as the clawback decreases to 75 percent in 2014 and remains set at that level in perpetuity under the MMA.[27]

Summary of the PPIC's Argument

The PPIC's report compares projected state Medi-Cal spending to projected General Fund revenues in order to assess whether Medi-Cal expenditures are likely to increase as a share of state revenues through 2014-15. For its revenue forecast, the PPIC relies on an LAO analysis that projects General Fund revenues will increase at an average annual rate of 6 percent through 2009-10.[28] For its Medi-Cal spending projection, the PPIC calculates 2002-03 Medi-Cal benefits expenditures for six enrollee groups (seniors with disabilities, for example) and six health care service categories (hospital care and prescription drugs, for example). The PPIC then applies assumptions about Medi-Cal "cost drivers" to the baseline benefits expenditures to "determine future expenditures in the program." The two key "cost drivers" identified by the PPIC are:

- **Enrollment growth rates.** The PPIC assumes that Medi-Cal enrollment rates will remain constant for each enrollee group in the model and that each group will increase at the same rate in Medi-Cal as in the California population as a whole.[29]
- **Growth rates of average spending per enrollee in each health care service category.** The PPIC assumes that average Medi-Cal spending per enrollee in each health care service category will increase at the same rate as that projected for Medicaid by the CMS.[30] In other words, the PPIC assumes Medi-Cal spending will increase at the same rate as national Medicaid spending, even though health care spending growth in California has historically lagged that of the US and the state has limited Medi-Cal spending through various cost-containment measures, as noted above.

Given these assumptions, the PPIC projects that General Fund expenditures on Medi-Cal benefits will increase at an average annual rate of 8.5 percent over a 10-year period ending in 2014-15. According to the PPIC:

> "Given that we project an 8.5 percent annual growth rate in Medi-Cal expenditures and LAO projects a 6 percent annual growth in revenues, the obvious conclusion is that Medi-Cal will absorb a growing share of the California budget over the next ten years."[31]

Specifically, the PPIC projects that General Fund spending on the Medi-Cal Program will increase from 15.3 percent of General Fund revenues in 2002-03 to 18.7 percent in 2009-10 and to 20.7 percent in 2014-15 – if its assumptions prove accurate.[32] The PPIC also examines projected costs for Medi-Cal under an alternative assumption that California's health care expenditures "grow 10 percent more slowly than the national rates – at 7.65 percent annually rather than 8.5 percent annually." This alternative suggests that General Fund spending on Medi-Cal as

a share of General Fund revenues would increase more slowly to 17.8 percent in 2009-10 and to 19.0 percent in 2014-15.[33]

The PPIC concludes that the "rising share of revenues that would be absorbed by Medi-Cal leads to difficult choices on the part of policymakers." The report suggests that the state could reduce Medi-Cal spending, redirect funds from other state programs to Medi-Cal, or generate "additional General Fund revenues presumably through tax increases."[34]

Concerns with the PPIC's Analysis

Forecasting is an inherently uncertain process built on multiple assumptions that may prove inaccurate. Projections beyond one or two years are highly likely to diverge from actual trends, and even short-term forecasts are subject to considerable error. As the CMS states with respect to its own 10-year projections of national health care expenditures:

> "These estimates must be regarded as an indication of possible trends, conditional on our assumptions regarding future macroeconomic conditions, as well as assumptions regarding the nature and impact of future institutional change in the health sector."[35]

The PPIC's long-range forecast of state Medi-Cal spending is equally subject to these caveats. This section raises several concerns with the PPIC's analysis. Taken together, these concerns suggest the PPIC may have overstated California's long-term Medi-Cal spending growth rate. The PPIC's projections should thus be used with caution in health policy debates in California and at the federal level.

The PPIC's Assumption That California Must Abandon Its Medi-Cal Cost-Containment Policies Is Questionable

The fundamental, though implicit, assumption underlying the PPIC's analysis is that California cannot maintain cost-containment policies – particularly controls on rates paid to doctors and other medical care providers – that have limited the rate of growth of Medi-Cal spending.[36] The PPIC acknowledges that:

- California's health care spending growth has tended to lag that of the US; and
- "Medi-Cal expenditure growth in the past has been slowed by the state's limits on managed care capitation rates, physician-reimbursement rates, and similar cost-containment efforts."[37]

However, the PPIC asserts that California's slower growth rate is "not maintainable" and that "it is hard to justify how future long-term growth rates in [Medi-Cal] expenditures by specific service categories would be dramatically different in California than in the rest of the nation."[38] In addition, the authors argue that, "over the long run, it is unlikely that containment efforts can be sustained without affecting [Medi-Cal beneficiaries'] access to care."[39] The PPIC assumes that California must abandon its "politically negotiated" cost-containment policies and increase payments to Medi-Cal providers, thereby significantly increasing spending on the Medi-Cal Program.[40]

In short, the PPIC implicitly assumes that California's policymakers must, over the next several years, depart from a set of cost-containment policies that have limited the growth of Medi-Cal spending during a period of rising program enrollment and persistent state budget shortfalls.

Ample evidence indicates that this assumption is questionable:

Federal Appellate Court Ruling Restricts Legal Challenges to California's Medi-Cal Policies

On August 2, the 9th US Circuit Court of Appeals ruled that Medicaid providers and beneficiaries do not have an individual right to legally challenge a state's compliance with the equal access and quality-of-care provisions of the federal Medicaid statute, which governs California's Medi-Cal Program. The ruling, which applies to California and other states in the 9th Circuit's jurisdiction, came in response to a lawsuit brought by advocates, service providers, and developmentally disabled persons who sought to require California to increase Medi-Cal funding for community-based services for developmentally disabled individuals. The plaintiffs could seek a hearing before a larger 9th Circuit appeals panel or could appeal to the US Supreme Court.

This ruling also allows California to implement a 5.0 percent provider rate reduction that was partly blocked by a federal district court in 2003 in a lawsuit brought by a dozen plaintiffs, including the California Medical Association. The 5.0 percent rate reduction was included in the 2003-04 budget agreement and would have affected a range of Medi-Cal providers, including doctors who serve fee-for-service patients. However, the 2003 district court ruling did not apply to managed care plans, which were subject to the 5.0 percent cut.

Unless overturned, the 9th Circuit ruling will make it harder for Medi-Cal providers and beneficiaries to use the federal courts to challenge state policies that could affect access to and quality of care, including policies that reduce or freeze Medi-Cal provider payments and other cost-containment measures. Consequently, this ruling increases the likelihood that California's Medi-Cal cost-containment policies will be maintained, rather than changed, as suggested by the PPIC.

- **Limiting the growth of Medi-Cal provider rates reduces state spending while averting policies that directly limit access to health services.** The Legislature has not increased taxes to help close the state's budget shortfall. Instead, the state has made efforts to close the gap with funding reductions and other savings measures affecting numerous programs, including Medi-Cal. However, the Legislature has been reluctant to enact cuts that would directly affect low-income individuals' access to health services, such as limiting Medi-Cal eligibility or substantially reducing benefits provided to enrollees. Rather, the Legislature has achieved savings by freezing, reducing, or otherwise limiting the growth of Medi-Cal provider rates, partly reversing the rate increases included in the 2000-01 Budget.[41] Controls have been maintained despite the fact that "Medi-Cal payment rates continue to significantly lag behind those of other purchasers of health care coverage in California."[42] In short, the Legislature has sought to control Medi-Cal spending growth, in part, by limiting provider payments. It is unclear why the Legislature would abandon this deliberate policy and enact substantial rate increases, as the PPIC suggests, given competing state budget priorities, persistent budget shortfalls, and the lack of additional revenues to pay for new or expanded program commitments.

- **Other programs have been stretched thin by policies that the state shows no sign of abandoning.** In response to the persistent budget gap, the state has frozen and reduced funding for a range of health and human services programs operated by counties.[43] State policymakers have not, by and large, eliminated services or changed eligibility requirements for these programs, including the Adult Protective Services and Foster Care programs. Instead, the state has withheld funding increases that would allow counties to pay for rising operating expenses, while maintaining core services for program participants. In some cases, the state has also reduced funding, adding to the cost pressures faced by counties. These budget cuts have resulted in a slow funding squeeze on programs that is largely hidden from view, particularly in the context of the state budget debate. Yet, the state has maintained these policies, despite the concerns of counties and advocates that services provided to vulnerable children, seniors, and people with disabilities have been negatively affected.

The PPIC Does Not Use the Most Recent CMS National Health Spending Projections, Which Include the Impact of the New Medicare Drug Benefit

The CMS, as noted above, published health care spending projections for 2004-2014 in February 2005. Those projections include the estimated impact on national health spending of the new Medicare prescription drug benefit, which was part of the Medicare Modernization Act (MMA) of 2003. However, the PPIC based its June 2005 report on outdated CMS projections for 2003-2013 that were published in February 2004 and that did not include the impact of the new Medicare drug benefit.[44] The PPIC's failure to use the most recent projections is troubling for at least two reasons:

- **National health spending projections can vary substantially from year to year depending on the magnitude of short-term changes in health sector spending.** For example, the CMS's 10-year outlook for prescription drug spending "changed substantively" between 2004 and 2005, and much of the change is not related to the implementation of the new Medicare drug benefit. As the CMS notes in an analysis of the 2004-14 projections:

  > "A major deceleration in prescription drug spending growth in 2003 changed our outlook for 2004 and 2005, years in which the MMA [Medicare drug benefit] is projected to have a minimal impact on prescription drug spending levels….Over the 2007-2014 period, we expect aggregate prescription drug spending growth to decelerate despite the new Medicare drug spending."[45]

Due to these and other health sector changes, the CMS projects that Medicaid spending will increase at an average annual rate of 7.9 percent between 2004 and 2014, substantially lower than its prior projection of 8.7 percent for the 2003-13 period. In short, the PPIC's forecast for Medi-Cal spending is built on outdated federal assumptions and health spending data. It is not clear how substituting the CMS's most recent projections (2004-2014) would affect the PPIC's Medi-Cal spending estimates.

- **The PPIC's forecast does not reflect the implications of the new Medicare drug benefit for state Medi-Cal spending.** The PPIC claims its analysis projects Medi-Cal spending trends based on current law. However, the MMA was signed into law in December 2003. Therefore, the impact of the new Medicare drug benefit should have been included in the PPIC's analysis. The new Medicare drug benefit will reduce California's Medi-Cal benefit expenditures by shifting drug costs for dually eligible Medicare/Medi-Cal enrollees to Medicare.[46] Nationally, Medicaid drug spending is projected to decrease by 42.1 percent between 2005 and 2006 after the Medicare drug benefit takes effect. While California and other states will incur offsetting costs in their Medicaid programs related to the new drug benefit (for example, the "clawback" discussed above), the magnitude of those costs through 2014 is not clear. States are likely to see savings in their Medicaid programs over the longer term as the clawback decreases to 75 percent of states' projected savings in 2014 and remains set at that level. The fact that the PPIC's analysis does not account for the impact of the new Medicare drug benefit on

California's Medi-Cal expenditures calls into question the reliability of the PPIC's Medi-Cal spending forecast.

The PPIC Does Not Explain Why Its Model Projects Substantially Higher Spending Growth for Medi-Cal Benefits Than the LAO's Model

The LAO projects that General Fund spending on the Medi-Cal Program – including benefits, county administration, and claims processing – will increase at an average annual rate of 4.2 percent per year between 2005-06 and 2009-10, which is substantially below the LAO's revenue projection of 6 percent.[47] General Fund spending on Medi-Cal benefits alone will increase at an average rate of 6.1 percent annually between 2004-05 and 2009-10, according to the LAO. These estimates reflect the savings and the costs to the state associated with the new Medicare drug benefit. This LAO forecast raises at least two issues relative to the PPIC's Medi-Cal spending projection:

- **The PPIC's projection that General Fund spending on Medi-Cal benefits will increase by 8.5 percent per year is substantially higher than the LAO's 6.1 percent projection.** The PPIC projects that General Fund spending on Medi-Cal will increase to $19.7 billion in 2009-10 – $3.7 billion higher than the LAO's estimate of $16 billion. The PPIC acknowledges, but does not attempt to explain, the substantial gap between its growth rate estimate and that of the LAO.

- **The PPIC may overstate the growth rate of the non-benefits components of Medi-Cal, thereby inflating its overall growth rate projection.** Most state Medi-Cal funding pays for medical services, or benefits, provided to beneficiaries. Two "non-benefits" components of Medi-Cal are claims processing and county administration of eligibility for the program. The PPIC implicitly assumes that spending on the non-benefits components of Medi-Cal will increase at an average annual rate that is equal to that projected for Medi-Cal benefits – 8.5 percent. However, the growth rate for county administration and claims processing is likely to be smaller than the growth rate for benefits. Consequently, the PPIC may overstate the growth rate of the non-benefits components of Medi-Cal, which would inflate its projected growth rate for the Medi-Cal Program as a whole.

The PPIC Does Not Explain Why It Accepts the LAO's General Fund Revenue Projection, But Not the LAO's Medi-Cal Spending Projection

The PPIC implicitly rejects the LAO's forecast of General Fund spending on Medi-Cal. However, the PPIC accepts the LAO's projection that General Fund revenues will increase at an average annual rate of 6 percent. The PPIC does not explain why it accepts the LAO's General Fund revenue forecast, but not the LAO's Medi-Cal spending projection.

Conclusion

Medi-Cal provides vital health care services to California's children, seniors, and other individuals with low incomes. While Medi-Cal enrollment has increased substantially since 2000-01, spending per Medi-Cal beneficiary has been relatively flat in recent years even as national health care spending per capita has continued to rise. Moreover, state Medi-Cal spending as a share of total California personal income has been constant since the early 1990s, averaging 1.0 percent per year between 1993-94 and 2004-05. California's policymakers have limited Medi-Cal spending growth, despite increased enrollment and rising health care costs, by adopting a range of cost-containment measures, including limiting the growth of Medi-Cal provider payments.

The PPIC attempts to construct a "baseline forecast" of Medi-Cal spending over the next decade. The cornerstone of the PPIC's analysis is an implicit assumption that California's policymakers must, over the next several years, depart from a set of cost-containment policies that have limited the growth of Medi-Cal spending during a period of rising program enrollment and persistent state budget shortfalls. This paper questioned that assumption and raised concerns with other aspects of the PPIC's analysis.

Taken together, the concerns outlined in this Brief suggest that the PPIC may have overstated California's long-term Medi-Cal spending growth rate. The PPIC's projections should therefore be used with caution in health policy debates in California and at the federal level.

Scott Graves prepared this Brief. The California Budget Project (CBP) was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. General operating support for the CBP is provided by foundation grants, individual donations, and subscriptions. Please visit the CBP's website at www.cbp.org.

ENDNOTES

[1] Medi-Cal is California's version of the federal-state Medicaid Program. The enrollment increase between 2000-01 and 2004-05 was mainly due to the 2001 economic downturn and state policy changes that increased the number of low-income Californians eligible for the program. See California Budget Project, *Medi-Cal Program* (March 2005), for a program overview.

[2] Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. 43. The preface states that this report was prepared in response to a request by California Health and Human Services Agency Secretary Kimberly Belshé.

[3] Personal health care spending includes hospital care, physician and dental services, prescription drugs, home health care, nursing home care, and other health care services.

[4] Centers for Medicare & Medicaid Services, *2000 State Estimates – All Payers – Total Personal Health Care*, downloaded from http://www.cms.hhs.gov/statistics/nhe/state-estimates-provider/2000/us.pdf on July 7, 2005. The most recent year for which state-level personal health care spending data are available is 2000.

[5] California HealthCare Foundation and Health Research & Educational Trust, *California Employer Health Benefits Survey 2004* (December 2004) and The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2004 Summary of Findings* (September 2004).

[6] California HealthCare Foundation and Health Research & Educational Trust, *California Employer Health Benefits Survey 2004* (December 2004) and The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *2000 California Employer Health Benefits Survey* (May 4, 2001).

[7] Centers for Medicare & Medicaid Services, *National Health Expenditures Tables* (Table 1), downloaded from www.cms.hhs.gov/statistics/nhe/historical/ on July 1, 2005. National health expenditures measure private and public spending for health care in the US.

[8] The Henry J. Kaiser Family Foundation, *Medicaid Payments per Enrollee, FY 2001*, downloaded from www.statehealthfacts.org on July 6, 2005.

[9] Total California personal income provides an approximate measure of the size of the California economy and takes into account population growth, as well as taxpayers' ability to pay.

[10] Centers for Medicare & Medicaid Services, *National Health Care Expenditures Projections: 2004-2014* (February 2005), downloaded from http://www.cms.hhs.gov/statistics/nhe/ on July 1, 2005.

[11] CMS projects that total, not per capita, annual national health care spending will increase at an average annual rate of 7.1 percent during the forecast period.

[12] CMS does not provide per enrollee estimates of annual Medicaid expenditures.

[13] Stephen Heffler, et al., "U.S. Health Spending Projections for 2004-2014," *Health Affairs Web Exclusive* (February 23, 2005), p. W5-81.

[14] The Medicare Prescription Drug, Improvement, and Modernization Act (Public Law 108-173) became law on December 8, 2003. The federal Medicare Program provides health insurance coverage to about 35 million seniors age 65 and older and about 6 million non-elderly people with permanent disabilities. Medicare is financed mainly through payroll taxes paid by workers and employers, beneficiary premiums, and general tax revenues. See The Henry J. Kaiser Family Foundation, *Medicare Chartbook* (Third Edition, Summer 2005), for a Medicare overview.

[15] California HealthCare Foundation, *The Medicare Drug Benefit: Implications for California* (April 2005), p. 1.

[16] Stephen Heffler, et al., "U.S. Health Spending Projections for 2004-2014," *Health Affairs Web Exclusive* (February 23, 2005), p. W5-74.

[17] The cost of Medi-Cal is shared approximately equally between the state and federal governments.

[18] Senate Budget and Fiscal Review Subcommittee #3 on Health and Human Services, *Agenda* (May 20, 2005), p. 36.

[19] Andy Schneider, *The "Clawback": State Financing of Medicare Drug Coverage* (Kaiser Commission on Medicaid and the Uninsured: June 2004), pp. 4-5. The clawback is officially called the "phased-down state contribution" in federal statute.

[20] Earl Dirk Hoffman, Jr., et al., "Overview of the Medicare and Medicaid Programs," *Health Care Financing Review* (2003 Statistical Supplement).

[21] Senate Budget and Fiscal Review Subcommittee #3 on Health and Human Services, *Agenda* (May 20, 2005), p. 36.

[22] Judith D. Moore and Jennifer Ryan, *Implementing the New Medicare Drug Benefit: Challenges and Opportunities for States* (National Health Policy Forum, The George Washington University: NHPF Meeting Report, August 31, 2004), p. 9. See also Rutgers Center for State Health Policy, *States' Issues and Concerns with Implementation of Medicare Part D Prescription Drug Coverag*e (July 2004).

[23] Legislative Analyst's Office, *Analysis of the 2005-06 Budget Bill* (February 2005), p. C-114. CMS has not yet announced state clawback payments.

[24] Legislative Analyst's Office, *Analysis of the 2005-06 Budget Bill* (February 2005), p. C-112.

[25] Senate Budget and Fiscal Review Subcommittee #3 on Health and Human Services, *Agenda* (May 20, 2005), p. 36.

[26] Legislative Analyst's Office, *Analysis of the 2005-06 Budget Bill* (February 2005), p. C-112.

[27] In 2003, the Congressional Budget Office projected aggregate net state Medicaid savings of $17.2 billion between 2004 and 2013 due to the new Medicare prescription drug benefit. This projection included the clawback and other associated state costs, but did not include states' loss of Medicaid prescription drug rebates paid by drug companies.

[28] Legislative Analyst's Office, *California's Fiscal Outlook: LAO Projections, 2004-05 Through 2009-10* (November 2004), p. 21. The LAO revenue forecast period ends in 2009-10. However, the PPIC states, "we follow LAO and assume a 6 percent growth in revenues from 2010 to 2015" (p. 43).

[29] California population projections are based on the Department of Finance 2004 series.

[30] Growth rates incorporate both price increases (inflation) and increased service utilization per enrollee.

[31] Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. 43.

[32] The PPIC adjusts its projected Medi-Cal *benefits* spending forecast using historical Medi-Cal expenditure data in order to derive both *total* projected Medi-Cal expenditures and the percentage of total Medi-Cal expenditures that would be paid for out of the General Fund.

[33] Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. v.

[34] Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), pp. 44-45.

[35] Center for Medicare & Medicaid Services, *National Health Care Expenditures Projections: 2003-2013* (February 2004), downloaded from http://www.cms.hhs.gov/statistics/nhe/projections-2003/highlights.asp on July 14, 2005.

[36] This implicit assumption conflicts with the PPIC's explicit assumption of "no change in current state or federal policies" during the forecast period. Modifying the state's Medi-Cal cost-containment policies and substantially increasing Medi-Cal spending would constitute a change of significant magnitude. Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. 31.

[37] Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. v.

[38] Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), pp. v and 33.

[39] Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. v.

[40] Specifically, the PPIC argues: "In the short-run, capitation rates and other politically negotiated elements could drive [Medi-Cal] expenditure forecasts; in the long-run, however, California is not likely to experience substantially different growth rates in costs than those in the rest of the nation." Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. 31.

[41] The 2000-01 Budget "included provider rate increases for a variety of medical services totaling approximately $800 million ($403 million General Fund)." These were "the first across-the-board rate increases in the Medi-Cal Program since 1985-86." Legislative Analyst's Office, *Analysis of the 2002-03 Budget Bill* (February 2002), pp. C-76 - C-77.

[42] "Even after implementation of the 2000-01 rate increases, Medi-Cal's fee-for-service physician payment rates ranked 42 out of 51 of the Medicaid programs in the country when adjusted for differences in the cost of living." Legislative Analyst's Office, *Analysis of the 2002-03 Budget Bill* (February 2002), p. C-78, citing a study completed by PricewaterhouseCoopers in 2001, which took into account the rate increase provided in 2000-01.

[43] The information in this paragraph is based on California Budget Project, *Stretched Thin: State Budget Cuts Threaten California's Health and Human Services Programs* (May 2004). The report analyzed findings from a survey of 11 counties regarding the impact of state funding reductions on nine county-run health and human services programs.

[44] The PPIC forecast "does not account for the known policy change imposed by the implementation of the Medicare prescription drug benefit." Thomas MaCurdy, et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts* (Public Policy Institute of California: June 2005), p. 31.

[45] Stephen Heffler, et al., "U.S. Health Spending Projections for 2004-2014," *Health Affairs Web Exclusive* (February 23, 2005), pp. W5-77 to WS-78.

[46] As noted above, a "dual eligible" is an individual who is enrolled in both the Medicaid and Medicare programs. The cost of Medi-Cal is shared about equally the California and the federal government; Medicare is financed mainly through payroll taxes paid by workers and employers, beneficiary premiums, and general tax revenues.

[47] Legislative Analyst's Office, *California's Fiscal Outlook: LAO Projections, 2004-05 Through 2009-10* (November 2004), p. 37.