Gurtin Municipal Bond Management

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Executive Summary

As we look toward 2016 and beyond, we would contend that insufficient attention is being paid to the rising burden of Medicaid expenditures on state budgets and the potential consequences for obligors that rely on annual state support.

Medicaid's transformation and its growing share of state budgets poses potential credit risks for the municipal market.

Medicaid's 50th anniversary is an opportune time to consider the program's expansion from modest beginnings to a federal and state budget behemoth.

- Understanding Medicaid's funding structure and its primary role in state budgets is imperative to analyzing future state fiscal policy.
- Medicaid's accelerating consumption of state resources shows few signs of easing in the near future.

The dramatic growth in states' Medicaid spending is taking place against what we believe to be a potentially ominous backdrop of credit factors:

- State revenue growth is not keeping pace with Medicaid cost growth.

"Should the federal government become more ambitious and decide that Medicaid is in need of more than just minor tweaks, a push for a complete revamp is not unprecedented. In recent history there were two attempts (in 1995 and again in 2003) to transform Medicaid into a block grant program. Though both efforts ultimately failed, the basic concepts of block-granting Medicaid retain their luster for many budget hawks. At the core of each attempt was a desire to place the federal government, as opposed to states, in control of how much money would come out of the federal budget for Medicaid each year. Under this scenario, states would need to not only devise a way to contain growing Medicaid expenses, but do it in an environment with a fixed amount of help from the federal government."

- Anti-tax sentiment presents a significant hurdle for most states' willingness to look at revenue enhancements.
- Increased vocal advocacy for federal spending cuts and Medicaid's history as a prime target of deficit reduction measures suggests uncertainty over future federal support.
- Medicaid costs tend to run counter-cyclical to the economy; while state Medicaid spending is already growing, another economic downturn could leave state budgets extremely vulnerable.

While states have flexibility to reduce Medicaid spending, their ability is somewhat constrained and often politically contentious.

While obligors such as school districts and universities are potential targets of the Medicaid "crowding out" effect, we believe not-for-profit healthcare is an almost certain victim should Medicaid cuts or reform occur.

As we look toward 2016 and beyond, we would contend that insufficient attention is being paid to the rising burden of Medicaid expenditures on state budgets and the potential consequences for obligors that rely on annual state support.

In keeping with Gurtin Municipal Bond Management's credit philosophy of emphasizing a forward-looking approach to credit analysis, we decided that instead of writing a year-end piece that looked back upon the major events of 2015, of which there were many – Puerto Rico's default and continued spiral towards a full-blown debt crisis, the ongoing debate regarding public pensions, and the State of Illinois' budget impasse to name just three – we would instead look ahead to risks that may emerge in 2016 or beyond. One such risk that we do not believe many are adequately accounting for is the potential fiscal headaches that Medicaid's growth and transformation may pose for state budgets and the resultant consequences for underlying obligors that depend on annual state support.

Medicaid's transformation and its growing share of state budgets poses potential credit risks for the municipal market.

Medicaid's accelerating consumption of states' general fund expenditures is occurring against a backdrop of stark political realities that suggest difficult decisions may lie ahead for state policymakers. These realities include strong anti-tax sentiment in many states that make revenue enhancements unlikely, largely sluggish revenue growth that is not keeping pace in many cases with states' increasing Medicaid costs, and mounting calls for federal austerity that could result in reduced federal support for the program. While we do not anticipate that Medicaid costs will result in widespread distress at the state level given the generally strong credit quality of the sector, we do believe it is yet another obstacle for clear outliers such as Illinois and New Jersey to repairing their deeply damaged finances.

We do believe that Medicaid's growing burden on state budgets will have consequences for obligors that depend on annual state aid. The idea that Medicaid costs may start "crowding out" other areas of state spending is one that is already being taken seriously in academia and amongst state budget officials; however, we believe many in the municipal market are not yet cognizant of the potential looming threat.[1] Given the possibility that Medicaid costs may begin crowding out other state expenditures as the program's growth confronts hard fiscal realities, we remain committed to closely monitoring obligors that rely on annual state support and ensuring that our clients are not exposed to weak obligors that could be pushed toward distress by future state aid reductions.

Medicaid's 50th anniversary is an opportune time to consider the program's expansion from modest beginnings to a federal and state budget behemoth.

Medicaid turned 50 in 2015, and is undergoing dramatic changes given its central role in the implementation of the Affordable Care Act (ACA). A program that was conceived as an afterthought (it was created at the same time as Medicare, which garnered considerably more attention from Congress and the Johnson administration in 1965) has over time morphed into the second largest entitlement program in the nation behind only Social Security.[2] Its role in the national economy and the healthcare delivery system is crucial; Medicaid is now the largest health program in America insuring nearly 70 million people, and represents one-sixth of the total healthcare

Medicare vs. Medicaid: Key Differences

Medicaid

- Funded through annual federal & state budget appropriations.
- Federal government monitors/ states implement and administer it.
- Program is voluntary for states, but all participate.
- States determine eligibility with federal guidelines
- Primarily covers low income families,but also primary vehicle for covering long term care (nursing homes).

Medicare

- Funded through federal FICA payroll tax. Revenues flow to the Medicare Trust Funds.
- A federal program – funded and administered by the U.S. Department of Health and Human Services.
- Covers those 65 and over that have paid into the program.
- Part A covers inpatient hospital care. Part B covers doctor's services. Part D covers prescription drugs.

[1] As an example of the academic research on the topic, see Marc Joffe, "Long-Term Trends in Medicaid Spending by the States," Mercatus Center at George Mason University, September 2015.

[2] Smith, David G. and Judith Moore, Medicaid Politics and Policy, 2nd Edition, 2015, pg. 36.

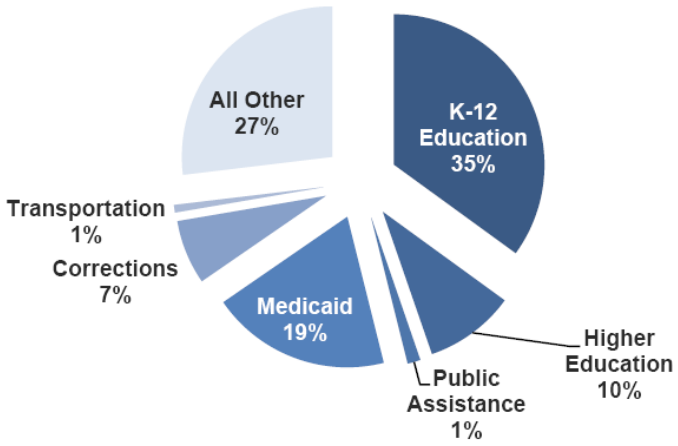
economy.[3] This was unthinkable when the program was created as a last minute legislative concoction to modestly add on to an existing poverty program that had suffered from scant interest from either states or potential beneficiaries.[4]

Understanding Medicaid's funding structure and its primary role in state budgets is imperative to analyzing future state fiscal policy.

Medicaid's funding structure is unique when compared to other federal entitlement programs given that it was created as a partnership between the federal government and states, with states ultimately responsible for a large share of the program's costs. Medicaid, unlike Medicare and Social Security, has no trust fund with dedicated revenue sources, but is instead financed almost entirely through annual appropriations from federal and state general revenues. Though the federal government provides grants to reimburse the states, state governments ultimately cover, on average, approximately 40% of the share of total Medicaid costs – though the state share of Medicaid spending differs widely from state to state.[5] Given this funding structure, Medicaid directly competes for resources with all other state spending priorities on an annual basis.

Medicaid has historically fared well in its competition for states' resources. When including federal support that flows through state budgets, total Medicaid expenditures accounted for, on average, over 27% of states' total spending in 2015 – the largest single component of total state spending by a fairly wide margin.[6] When netting out federal reimbursements, Medicaid spending constituted approximately 19% of state general fund expenditures in 2015, the second largest expense behind only K-12 education and more than double the next closest category (higher education).[7] As figure 1 illustrates, states' general fund Medicaid spending is greater than higher education, corrections and transportation spending combined.

Figure 1: States' General Fund Expenditures, Fiscal Year 2015[8]



[3] U.S. Department of Health and Human Services, 2014 Medicaid Actuarial Report, pg. 1.

[4] Medicaid was intended to build off of the Kerr-Mills program, which was only implemented by 28 states and at its height served approximately 1% of its targeted population: Cohen, Alan, et. al, Medicare and Medicaid at 50, 2015, pg.9.

[5] The federal government funds Medicaid through federal financial participation – essentially reimbursing states for a portion of Medicaid costs. The percentage of Medicaid expenditures covered by the federal government is called thefederal medical assistance percentage or FMAP. This varies from as low as 50% in wealthier states such as California and New York to as high as 74% in Mississippi. Data from U.S. Department of Health and Human Services. Retrieved from: http://aspe.hhs.gov/basic-report/fy2016-federal-medical-assistance-percentages

[6] National Association of State Budget Officers (NASBO), "State Expenditure Report – 2013-2015", pg. 2. K-12 spending was the next closest category of total state spending at 19%.

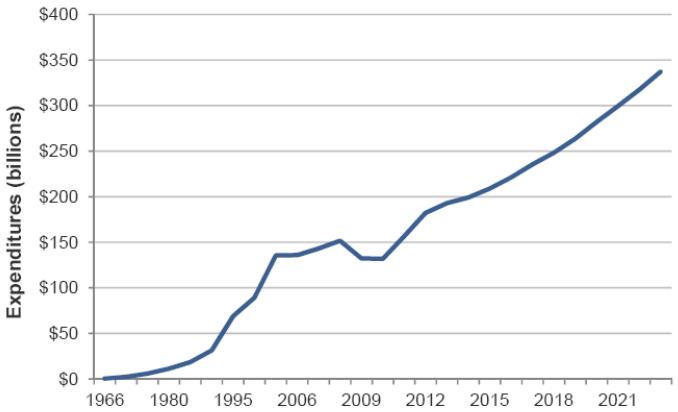
[7] Ibid, pg. 46

[8] Data taken from NASBO's "State Expenditure Report: 2013-15"

Medicaid's accelerating consumption of state resources shows few signs of easing in the near future.

Medicaid's growth and dominant role in state budgets is a trend that shows few signs of abating. Medicaid costs are often the fastest growing single line-item in state budgets. Using California as an example of a national trend, the California Legislative Analysts' Office (LAO) – a non-partisan and widely respected investigative arm of the California legislature – recently projected that California's general fund spending on Medicaid will increase by an average annual rate of 7.6% through 2020, nearly double the growth rate that is expected in higher education spending and almost four times the growth rate expected for K-12 spending.[9] By 2020, the LAO projects all Medicaid related costs will approach 25% of the state's general fund spending. This would continue a trend that has played out nationally as the share of state-generated revenues spent on Medicaid has increased sharply from only 12% in 2000 to nearly 20% in 2015.[10] Figure 2 illustrates the rapid growth in state spending on Medicaid since the program's creation and the significant increases that are projected for coming years.

Figure 2: Historical and Projected State Medicaid Expenditures (billions of dollars)[11]



[9] Pew Charitable Trusts & MacArthur Foundation, "State Health Care Spending on Medicaid," July 2014, pg. 13.

[11] Data taken from U.S. Department of Health and Human Services' Medicaid Actuarial Report (2014), pg. 24. Data from 2014 – 2023 is projected

The dramatic growth in states' Medicaid spending is taking place against what we believe to be a potentially ominous backdrop of credit factors.

State revenue growth is not keeping pace with Medicaid cost growth.

While a handful of states such as California and New York have benefited from robust revenue growth, the majority of states have experienced a tepid recovery from the recession. The most recent data from the U.S. Census Bureau shows that on aggregate overall state revenue grew by a mere 2.17% in fiscal year 2014 when compared to 2013.[12] A recent survey of state governments by the National Association of State Budget Officers found that states are projecting the sluggish revenue narrative to continue in 2016 with states estimating total revenue growth of just 3%.[13] This is problematic when the same survey shows that state budget officers estimate that Medicaid spending will increase 6% year over year on average until 2023.

Anti-tax sentiment presents a significant hurdle for most states' willingness to look at revenue enhancements.

Many states are confronted not only with sluggish revenue trends, but also with the reality that tax increases are unlikely given rampant anti-tax sentiment. The growing anti-tax sentiment in many

[12] U.S. Census Bureau, "Quarterly Summary of State & Local Taxes from 2001 to 2015", http://www.census.gov/govs/qtax/

[13] NASBO, pg. 3.

states has resulted in policymakers that are resistant to even discuss tax increases for fear of political backlash. Eleven incumbent governors have taken the Americans for Tax Reform Pledge to oppose any effort to increase taxes in his/her respective state, and we would suggest that many who have not signed have openly declared support for the platform or are confronted by legislatures that will not approve tax increases. [14] When coupled with sluggish revenue growth, an unwillingness to consider tax increases would suggest that many states will be forced to make difficult expenditure decisions in coming budget cycles.

Increasingly vocal advocacy for federal spending cuts and Medicaid's history as a prime target of deficit reduction measures suggests uncertainty over future federal support.

While states are wrestling with Medicaid's impact on their budgets, a deeply divided government in Washington is also debating how to reduce the federal budget deficit. Given its prominent role in the federal budget and its projected growth rates, Medicaid is far from immune to potential cuts.[15] We believe that federal Medicaid reductions could take a variety of shapes, but each alternative would pose unique problems for states.

One likely alternative is new restrictions on states' usage of provider taxes. Medicaid dollars are distributed to states in line with the Federal Medical Assistance Percentage (FMAP) formula that is calculated annually. Despite the FMAP formula remaining largely unchanged since 1965, the average level of federal support has trended downward.[16] In response, states have derived creative means such as "provider fees" to boost federal support. A provider fee is a tax levied on healthcare providers that operate within the state. States then use the tax revenues to pay for Medicaid expenses (essentially reimbursing the hospitals for the tax) but also collect the matching federal dollars. The provider tax snares federal money while being revenue neutral for states and healthcare providers. Variations of a provider fee are now levied in every state but Alaska.[17] The federal government has responded by placing certain limitations around the redistribution of the fee, with more changes likely to come. These changes have very real budget impacts and may ultimately result in state general funds assuming an even greater share of Medicaid costs. Again using California as an example, the State expects to lose approximately $1.1 billion in revenue in the near future as it does not believe that its current managed care provider tax will pass federal scrutiny.[18]

Should the federal government become more ambitious and decide that Medicaid is in need of more than just minor tweaks, a push for a complete revamp is not unprecedented. In recent history there were two attempts (in 1995 and again in 2003) to transform Medicaid into a block grant program. Though both efforts ultimately failed, the basic concepts of block-granting Medicaid retain their luster for many budget

[14] Americans for Tax Reform, "Taxpayer Protection Pledge Database", Retrieved on November 25, 2015 from http://www.atr.org/pledge-database

[15] The Congressional Budget Office's 2015 Long Term Budget Outlook estimates that federal spending on Medicaid in 2014 was approximately 300 billion and that Medicaid and Medicare growth rates continue to be catalysts for long-term federal deficit projections.

[16] Kaiser Family Foundation, "An Overview of Changes in the Federal Medical Assistance Percentages (FMAPs) for Medicaid", July 2011, p. 3

[17] Kaiser Family Foundation, "Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts", July 2013

[18] California Legislative Analyst's Office, "Analysis of the Health Budget", February 2015, p. 23

hawks. At the core of each attempt was a desire to place the federal government, as opposed to states, in control of how much money would come out of the federal budget for Medicaid each year. Under this scenario, states would need to not only devise a way to contain growing Medicaid expenses, but do it in an environment with a fixed amount of help from the federal government.

Medicaid costs tend to run counter-cyclical to the economy; while state Medicaid spending is already growing, another economic downturn could leave state budgets extremely vulnerable.

The growth rate of Medicaid as a percentage of state spending is concerning, but we would suggest that there is another risk that looms large. Medicaid enrollment and costs tend to run counter-cyclical to the economy, therefore, Medicaid costs swell during economic downturns as laid off workers seek coverage. Medicaid costs tend to naturally spike at the exact time when states' revenues are falling – a dangerous predicament. During the most recent recession, crisis was averted in large part by the federal government's decision to include $87 billion in the stimulus plan to help states with Medicaid costs. In fact, the support for Medicaid costs was the second largest single program in the stimulus bill behind only new tax credits for workers.[19] However, this type of federal support during downturns is far from guaranteed. In fact, during past recessions including during the early 1980's, many state budgets were brought to the brink of distress by a confluence of events that Medicaid directors called the "triple squeeze": the federal government's reduction of Medicaid support which was done to reduce the federal budget deficit, declining state revenues and increasing numbers of unemployed and uninsured people seeking Medicaid coverage.[20]

While states have flexibility to reduce Medicaid spending, their ability is somewhat constrained and often politically contentious.

States have options to reduce Medicaid costs, but the alternatives carry both political and practical costs. The options to reduce spending include: reducing benefits or eligibility levels that are offered above federal guaranteed minimums, seeking federal waivers that allow experimentation with new models for care delivery which can save money, and reducing provider reimbursement rates or payments to managed care organizations.While states can cut Medicaid, we note that many reductions require approval from the federal government (a process that can be time consuming and arduous). Additionally, Medicaid cuts are often contentious given that every state dollar that is cut also reduces federal support by a like amount thus multiplying the effect of cuts.

While obligors such as school districts and universities are potential targets of the Medicaid "crowding out" effect, we believe not-for-profit healthcare is an almost certain victim should Medicaid cuts or reform occur.

Beyond the crowding out effect we have discussed, another concern for the municipal market is the potential impact any future changes to Medicaid funding could have on notfor-profit healthcare obligors – the sector most likely to be wounded should

[19] "The Stimulus Plan: How to Spend $787 Billion," New York Times, retrieved from: http://projects.nytimes.com/44th_president/stimulus on November 18, 2015.

[20] Smith, David, Medicaid Politics and Policy, pg. 128.

either the federal or state governments choose to implement Medicaid reductions. Reimbursement rates for Medicaid procedures are already below market rates and there is little room to decrease rates further as many hospitals in this sector are operating with relatively thin margins and precarious credit cushions. Almost all hospitals receive some payments from Medicaid but a subgroup receives a lopsided share of revenue from the program. These hospitals, referred to as Disproportionate Share Hospitals (DSH), serve a large number of Medicaid and low-income, uninsured patients. Under current federal law, states are allowed to provide these hospitals with additional revenue in the form of DSH payments in order to compensate for this disparity. Hospitals receiving large amounts of DSH payments are especially vulnerable to any changes with the Medicaid program. The ACA was passed with the goal of shrinking the uninsured population, and it calls for a gradual reduction of DSH payments by the federal government to coincide with the projected increase of insured Americans. Federal reductions are expected to total over $17 billion by 2020, nearly the entire amount sent to Disproportionate Share Hospitals in FY 2011. Although the passage of the ACA has greatly expanded insurance coverage, the expansion has thus far fallen short of initial projections.[21] Should this gap remain or grow, many hospitals will have to serve high volumes of uninsured patients with far less federal help given the loss of DSH support.

Conclusion

Medicaid has been a transformative program in its first 50 years of existence, extending well beyond its humble origins into a crucial bulwark of the American healthcare economy. However, this transformation continues to carry a significant price tag for both the federal and state governments. We believe that should the price tag continue to grow as currently projected, many states will be forced to choose between cutting Medicaid, which as we noted can be arduous for a host of reasons, or allowing its growth to crowd out other state priorities. This crowding out effect would likely impact underlying obligors that rely on annual state support and may push already weak obligors towards distress. Given our concerns, we continue to posit that our clients are best served by vigilant credit research that can protect them from both states that begin to weaken to unacceptable levels should Medicaid growth contribute to fiscal deterioration and underlying obligors that are ill-positioned to withstand state aid reductions.

Please feel free to contact us at research@gurtin.com for additional information.

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[21] Congressional Budget Office, "Updated Budget Projections: 2015 to 2025," March 2015, pg. 19. The report estimates that approximately 8 million fewer uninsured have enrolled under the ACA than initially projected.

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