WashACE
Washington Alliance for a Competitive Economy

COMPETITIVENESS BRIEF

CB 08-03 July 28, 2008

THE HEALTHCARE SPENDING SQUEEZE

THE BOTTOM LINE

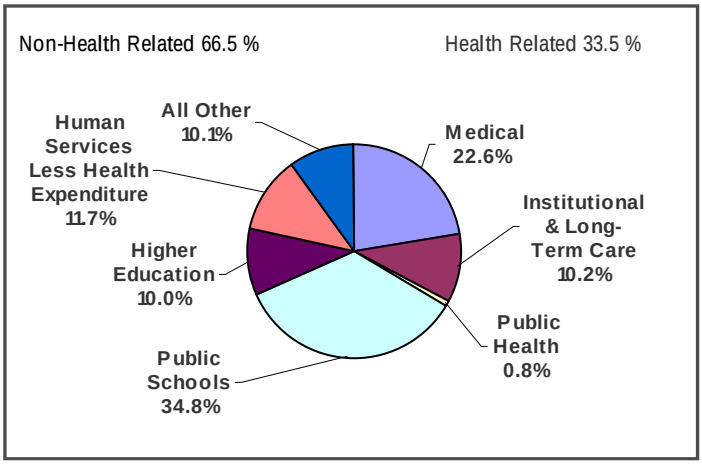
Health-related expenditures' share of state spending has increased 8 percentage points over the last decade. As healthcare costs continue to grow, other spending priorities are squeezed out.

The Washington Alliance for a Competitive Economy has a longstanding interest in the state's healthcare "squeeze" (WashACE 2005, 2006b, 2008). This brief examines data, newly compiled by the Legislative Evaluation and Accountability Program Committee (LEAP), that tracks the growth in state health-related spending between the 1997–99 and 2005–07 biennia. Health-related expenditures accounted for more than one-third of state general spending in the 2005–07 biennium, an increase of nearly 8 percentage points from their share of spending in 1997–99. Over the period, the growth in healthcare costs squeezed other spending priorities. Looking to the future, as health-related expenditures represent an ever-increasing share of overall spending, the squeeze their growth places on other priorities will become more severe.

Overview

In this brief, we will focus on Near General Fund State (NGFS) spending. The NGFS is a complex of eight separate accounts that includes the general fund itself (GFS) along with the health services account, the student achievement account, the education legacy trust account, the public safety and education account and its equal justice sub-account, the violence reduction and drug enforcement account, the water quality account, and the pension funding stabilization account. Traditionally, analyses of the state budget have focused on the general fund alone. In recent years, however, legislators have increasingly routed funding for general government purposes through dedicated accounts rather than the general fund. To ignore these accounts would give a misleading picture of spending trends (WashACE 2007). The spending trends we see in the NGFS accounts are very similar to what would be seen by looking at all budgeted funds.

Figure 1: NGFS Spending 2005–07



The new LEAP compilation breaks health-related costs from the budget to compare them with non-health-related spending. Figure 1 divides 2005–07 NGFS spending into three health-related categories (Medical Costs, Institutional and Long-term Care Costs, and Public Health) and four non-health-related categories (Public Education, Higher Education, Human Services and All Other). The expenditure shares shown for functional areas such as Public Schools and Higher Education are somewhat smaller than usually reported because contributions for employee health benefits have been captured in the medical category.

The Washington Alliance for a Competitive Economy is a coalition of business organizations working together to build economic opportunity for all Washingtonians.

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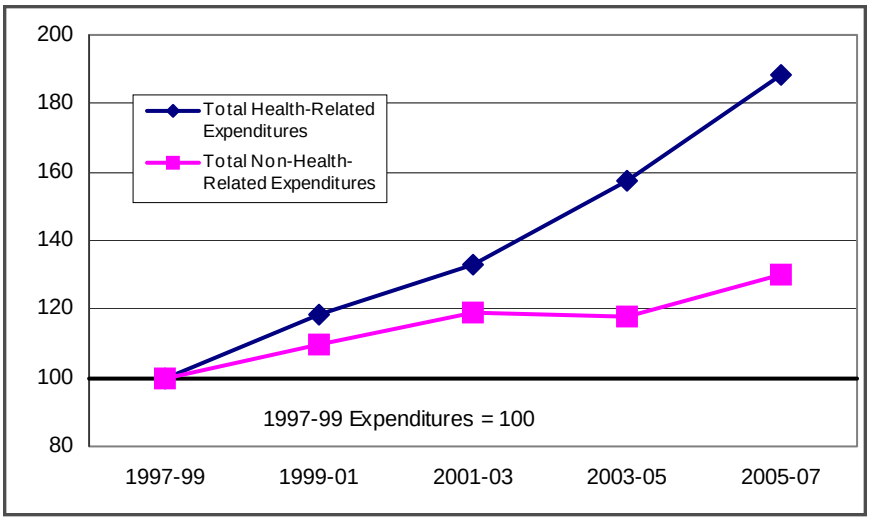


Figure 2: Health-Related and Non-Health-Related Spending Growth from 1997-99

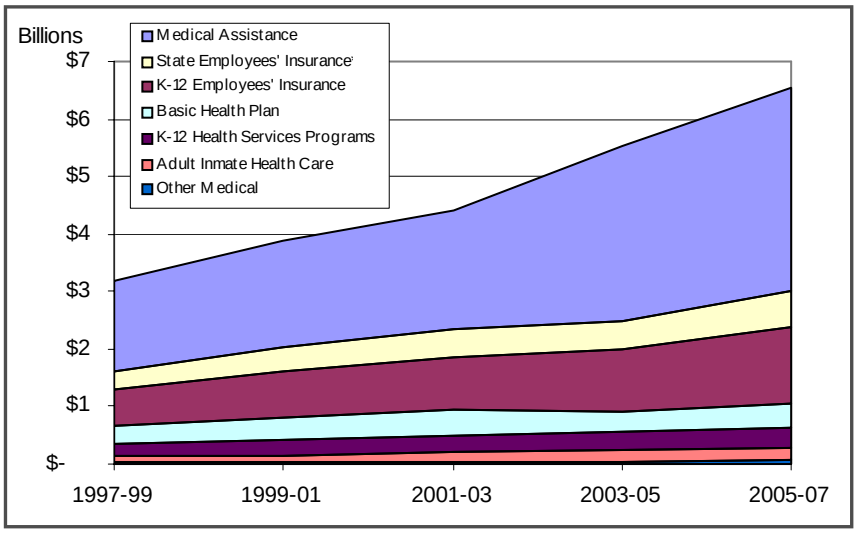
In the 2005–07 biennium, 33.5 percent of NGFS spending was health related. This is an increase of 7.6 percentage points over the 1997–99 biennium when health-related expenditures accounted for just over a quarter of total NGFS spending.

Figure 2 shows health-related expenditure growth compared with non-health-related spending. From 1997–99 to 2005–07, health-related expenditures grew by 85.5 percent. Over the same period, non-health-related expenditure grew by only 30.1 percent. When lawmakers wrote the 2003–05 budget, resources were severely constrained as a result of the dot-com recession. They were forced to make cuts to non-health-related programs to accommodate the continued relentless growth of health-related spending. From 2001–03 to 2003–05 health-related expenditure increased by 18.3 percent. Non-health-related expenditures actually fell by 0.9 percent between the two biennia.

Medical Costs

Of the three health-related categories, medical cost expenditures have increased the most over the last decade, from $3.18 billion in 1997–99 to $6.54 billion in 2005–07, an increase of 105.5 percent. In 2005-07, medical costs accounted for 22.6 percent of NGFS spending compared to 16 percent in 1997–99. Figure 3 depicts the dramatic increase in medical costs over the last decade. Medical Assistance accounts for the largest share of Medical Costs and Medical Cost growth.

Figure 3: Medical Cost Expenditures



Medical Assistance: Medical assistance provides medical care to low income and disabled individuals. Over the last decade, medical assistance caseloads have risen 21.2 percent while the population has increased 14.6 percent. (Since the beginning of 2005, children have accounted for most of the caseload growth.) Cost growth has dramatically outpaced caseload growth. Medical assistance costs increased 123.4 percent between the 1997–99 biennium and the 2005–07 biennium and have increased from 7.9 percent of the NGFS in 1997–99 to 12.2 percent in 2005–07.

The Caseload Forecast Council expects the medical assistance caseload to increase around 5.7 percent between 2005–07 and 2007–09. Under the adopted 2007–09 budget, Medical Assistance spending is projected to increase 8.1 percent (or $300 million) between 2005–07 and 2007–09 (these numbers include health insurance contributions for state employees in the Medical Assistance program).

Agency Contributions for State Employees Insurance: NGFS appropriations for state employee health insurance premiums totaled $660.6 million in 2005–07, representing 2.3 percent of NGFS spending compared to 1.5 percent in 1997–99. It is a 27.1 percent spending increase compared to

2003–05 and a 116 percent increase from 1997–99.

Funds for employee health insurance are appropriated from the NGFS to the Public Employee Benefit Board (PEBB), which administers the state employee benefits system. PEBB currently offers active state employees a choice among six different health care plans, although not every plan is available in every county of the state. In June 2008, 229,704 active state employees and their dependents were enrolled in a plan. The most popular plan, with 125,136 enrollees, was the Uniform Medical Plan (UMP). UMP is a self-funded Preferred Provider Organization, designed by PEBB and administered by the state Health Care Authority. Additionally, 35,271 retired state employees and their dependents were enrolled in a PEBB plan. Again, the UMP was the most popular plan, with 20,856 enrolled retirees.

State employee health care benefits are generous, and the 12 percent share of premiums paid by employees is low. A recent Towers Perrin survey of 200 large employers found that the average employee's share of health care premiums was 22.6 percent in 2008, up from 20.1 percent in 2003 (Towers Perrin 2008). In 2001 and 2002, state employees paid about 8 percent of their health insurance cost. The employee share jumped to 16 percent in 2003 and 2004, as budget writers reacted to rising insurance costs and revenue shortfalls due to the dot-com recession. In 2005, collective bargaining reduced the state employee share to 12 percent. News reports indicate that the state and public employee unions have agreed to maintain the employee share at 12 percent in the next labor contract (Wilson 2008).

We should emphasize that the health insurance expenditures we have cited are appropriations from the NGFS to PEBB for employee health benefits and not PEBB's actual expenditures. The amount appropriated to PEBB is based on projections of health insurance costs, and it is not necessarily the case that all funds appropriated to PEBB are spent in the year they are received.

Figure 4: Per Employee, Per Month State Contributions for Employee Health Benefits

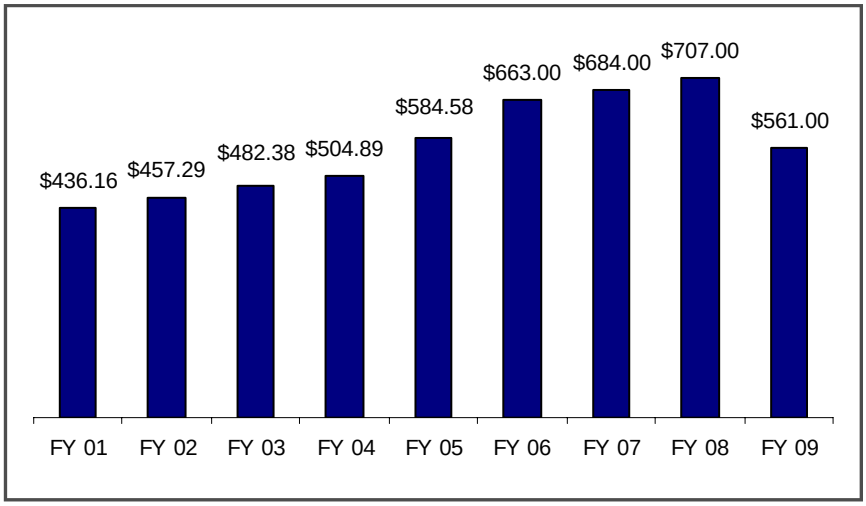


Figure 4 shows per employee-per month NGFS appropriations for employee health insurance for fiscal years 2001 through 2009. The 2007–09 budget originally enacted in April 2007 set the NGFS health insurance appropriation at $707 per employee per month for FY 2008 and $732 per employee per month for FY 2009. However, the growth rate in PEBB's average medical premium slowed dramatically in calendar years 2007 and 2008 (3.1 percent and 2.0 percent, respectively). Health Care Authority Administrator Steve Hill ascribed the reduction in growth rates to "changing the plans offered to state employees and an improved negotiation process with contracting plans—not by reducing benefits to employees" (Governor 2007). The 2008 supplemental budget reduced the FY 2009 appropriation to $561 per employee per month, effectively adding $115.7 million to NGFS reserves by spending down PEBB's unrestricted fund balance. The contribution rate will climb back in the next biennium.

The Health Care Authority recently announced that PEBB's average health insurance premium will rise by 7.9 percent in 2009.

K–12 Employees Insurance: The state allocates money for public school employee health insurance in the same amount allocated to state employees. As the cost of providing medical coverage for state workers increases, the amount allocated to school districts for health insurance also increases. School districts are allowed to purchase health insurance through PEBB, but most choose not to. In June 2008, 5,003 public school employees were enrolled in health plans through PEBB.

Payments by the state for K–12 employee insurance totaled $1.3 billion in 2005–07 and amounted to 4.5 percent of NGFS spending, an increase of 1.3 percentage points from 1997–99. The 2005–07 spending level is an increase of 24.9 percent from 2003–05 and a 106.7 percent increase from 1997–99.

Basic Health Plan: Washington State's Basic Health Plan provides subsidized healthcare to low-income individuals and families who are not eligible for Medicare. Monthly premiums are based on age, income, family size, and health plan chosen. The NGFS spending on the state's basic health plan has increased from $320.3 million in 1997–99 to $421.8 million in 2005–07—an increase of 31.7 percent since 1997–99. However, the basic health plan's share of the NGFS has actually decreased from 1.6 percent in 1997–99 to 1.4 percent in 2005–07.

K–12 Health Services Program: The K–12 health services program provides consultation to school nurses, staff, administrators, students and families to better provide a healthy learning environment. Services provided include school nurse services, physical and emotional well–being, student health screening, infectious diseases and medication administration.

The K–12 Health Services Program has seen NGFS spending increase from $221.7 in 1997–99 to $345.6 million in 2005–07, an increase of 55.9 percent. Its share of the NGFS has increased from 1.11 percent to 1.19 percent.

Adult Corrections: Growth in the state's prison population has closely mirrored that of the most susceptible demographic group: age 18–39. Growth in the cost of providing health care to the inmate population has increased far more rapidly than the incarcerated population. The inmate population growth coupled with the increased cost of providing medical care is responsible for budget growth in this sector.

NGFS adult inmate healthcare spending has increased from $106.1 million in 1997–99 to $224.2 million in 2005–07. This is an increase of 111.4 percent. Its share of NGFS spending has increased from 0.53 percent to 0.77 percent.

Juvenile Corrections: The juvenile incarceration rate has been steadily declining for the last several years due to a decrease in violent crime as well as legislation requiring older youth charged with violent crimes to be charged as adults. As a result, healthcare costs for juvenile corrections have not grown as rapidly as other sectors.

The NGFS spending for juvenile inmate healthcare has increased from $7.8 million to $12 million between 1997–99 and 2005–07. This is an increase of 54.5 percent.

Home Care Workers Health Insurance Benefits: In 2001 voters passed Initiative 775, which authorized state-funded home care workers to form a union in order to bargain more effectively with the state. In March of 2004

ABOUT THE DATA.

The data presented in this brief were compiled by the staff of the Legislative Evaluation and Accountability Program Committee (LEAP) from various sources including: the Office of Financial Management's Agency Financial Reporting System and Monitor databases; the Recast History (historical expenditure and staffing data, reconstructed by agencies for comparability over time, which LEAP maintains); and Office of the Superintendent of Public Instruction detail for K-12 expenditures.

We have made one adjustment to the data provided to us by LEAP. To avoid double counting, we exclude from NGFS expenditures for 2005-07 appropriations totaling $1.214 billion from the general fund–state to other NGFS accounts.

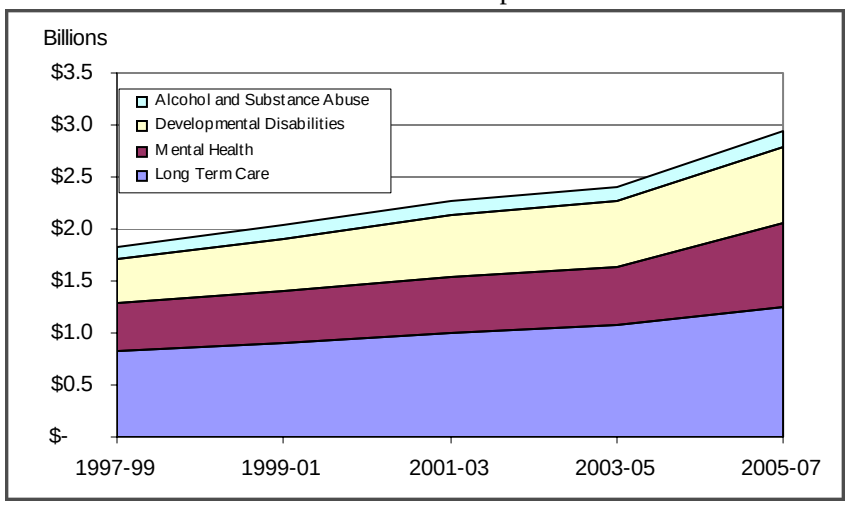
the legislature ratified a new contract with the union that, among other things, granted home care workers access to state health insurance benefits. In the 1999–01 biennium the state spent $5.2 million from the NGSF for homecare workers health insurance. With the contract this spending reached $24.4 million in 2005–07. Between 2003–05 and 2005–07 NGFS spending for home care worker health insurance increased by 41.3 percent.

Community Health Clinics: Community health clinics provide medical and dental care for the state's uninsured, under–insured and migrant populations. The state NGFS spending for community health clinics increased from $12.4 million in 1997–99 to $21.5 million 2005–07, an increase of 73.6 percent.

Institutional & Long–Term Care Costs

NGFS spending on institutional and long-term care increased from $1.8 billion in 1997–99 to $2.9 billion in 2005–07 and now accounts for 10.2 percent of the NGFS. This is an increase of 1.1 percentage points from 1997–99. Long-term care accounts for the largest share of spending in this category followed by mental health. Figure 5 shows the growth in these categories over the last decade. Institutional and long-term care costs have increased 61.3 percent from 1997–99.

Figure 5: Institutional & Long-Term Care Expenditure Growth



Long Term Care: State funding for long–term care increased from $825.9 million in 1997–99 to $1.25 billion in 2005–07. This accounts for 4.31 percent of the NGFS spending in 2005–07. The state's long–term care NGFS spending has increased 51 percent since 1997–99.

The Caseload Forecast Council predicts that nursing home caseloads will decrease by nearly 6.5 percent between June 2007 and June 2009, with home and community service care increasing 6.6 percent over the same period.

Mental Health: In 2005, 126,009 people received mental health services from Washington's Department of Social and Health Services. DSHS administers the public Mental Health Services department. It provides crisis support, in- and out-patient treatment programs and involuntary treatment programs, maintains residential treatment facilities, and licenses mental health professionals.

In 1989 the legislature created the Regional Support Network system as part of its effort to control healthcare costs. As part of the "managed care" approach the RSNs manage Washington's mental health program. There are 13 RSNs around the state. DSHS purchases services from the RSNs for Medicaid eligible clients. The RSNs then contract with mental health agencies around the state for treatment services. People eligible for Medicaid qualify for medically necessary treatment through the RSN program.

State funding for mental health has increased 77.1 percent since 1997–99 and now accounts for 2.8 percent of NGFS spending. This is an increase of 0.5 percent over the last decade. Funding increased from $459.4 million in 1997–99 to $813.6 million in 2005–07. From 2005–07 to 2007–09 expenditure is expected to increase by 6.6 percent.

Developmental Disabilities: The Division of Developmental Disabilities (DDD) is administered by DSHS. DDD provides, among other things, employment programs, dental programs, group homes, supported living services, early intervention programs, and medically-intensive care services to developmentally disabled individuals and their families.

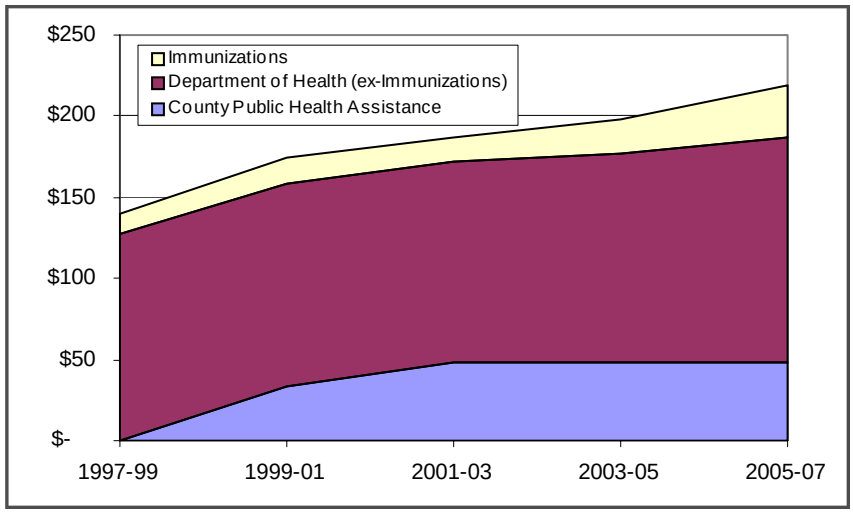
NGFS expenditures assisting individuals who are developmentally disabled have increased from $429.4 million in 1997–99 to $724 million in 2005–07. This is an increase of 68.6 percent. For 2007–09 biennial spending is expected to increase by 16 percent from 2005–07 levels.

Alcohol and Substance Abuse: The Division of Alcohol and Substance Abuse (DASA) is a state agency responsible for providing treatment and support for low–income drug and alcohol users and their families and also administering education and prevention programs.

Substance abuse treatment programs funded by the state have seen spending increase from $108 million in 1997–99 to $155.7 million in 2005–07, an increase of 44.1 percent. This represents 0.54 percent of NGFS spending. The Caseload Forecast Council projects a 4.4 percent increase in eligible patients between June 2007 and June 2009. Spending for the 2007–09 period is expected to increase by 24.6 percent from 2005–07.

Public Health Expenditures

Figure 6: Public Health Expenditure Growth



Public health spending accounts for less than one percent of NGFS spending. Its share has increased from 0.70 percent in 1997–09 to 0.76 percent in 2005–07. As shown in Figure 6, spending in this category has increased from $140.4 million in 1997–99 to $219.1 million in 2005–07, an increase of 56.1 percent.

County Public Health Assistance: There are 35 local health departments in Washington State. Local health departments are funded at the county level and are not satellite branches of the state Department of Health. Their mission is to promote health and disease prevention. NGFS contributions to county public health programs began after the motor vehicle excise tax was eliminated following the approval by voters of Initiative 695 in November 1999. During 1999–01 the state provided counties with $33.2 million in "backfill." By 2005–07 this had grown to $48 million, an increase of 44.6 percent.

Department of Health (DOH): Washington's DOH is responsible for promoting health through disease prevention, immunization, injury prevention and newborn screening. They provide education and training programs to promote healthy choices as well as license healthcare professionals and investigate disease outbreaks.

DOH funding has increased from $140.4 million in 1997–99 to $171.1 million in 2005–07. While this represents a 21.9 percent increase since 1997–99, the DOH share of NGFS spending has decreased from 0.7 percent in 1997–99 to 0.6 percent in 2005–07. For the 2007–09 biennium, funding is expected to increase by 47.5 percent from 2005–07.

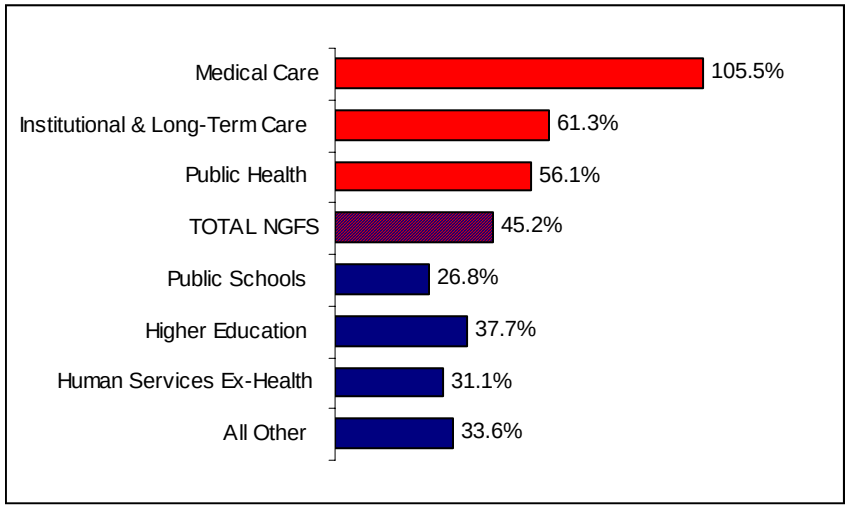
Washington State's DOH administers an immunization program that pro-

vides vaccinations to all children under age 19 regardless of income. State funding to promote and provide immunizations has increased from $13.5 million in 1997–99 to $32.3 million in 2005–07 (nearly two-thirds of the net growth for DOH). This represents an increase of 139.7 percent. Immunization's share of NGFS spending has increased from 0.07 percent to 0.10 percent.

Discussion

From 1997–99 to 2005–07 overall NGFS spending increased by 45.2 percent. Health-related spending increased by 85.5 percent, while non-health-related spending grew by 30.1 percent. As Figure 7 shows, each of the three major categories of health-related spending grew by more than overall spending grew, while each of the four major categories of non-health related spending grew less. Over the period, health-related share of NGFS spending has increased from 25.8 percent to 33.5 percent. In 1997–99 public school funding (excluding the state allocation for K–12 employee health insurance) accounted for 39.8 percent of NGFS spending; in 2005–07, it accounted for 34.8 percent.

Figure 7: NGSF Budget Growth 1997–99 to 2005–07



The most rapidly growing category of health-related spending is medical costs, including the medical assistance program, and allocations for state and public school employees' health insurance. Medical cost expenditures grew by 105.5 percent from 1997–99 to 2005–07. They were 16 percent of NGFS spending in 1997–99 and 22.6 percent in 2005–07.

The nation has been passing through a period of relatively slow growth in medical costs, but health care economists project that medical cost inflation will soon reaccelerate (WashACE 2008). Certainly Washington has seen an upturn in the rate of growth in employee health insurance costs after several quiet years.

Looking to the future, as health-related expenditures represent an ever-increasing share of overall spending, the squeeze their growth places on other priorities will become more severe. The ability of the state to provide ample funding for priorities such as higher education and public schools will depend on controlling health-related-spending growth.

UPCOMING

In December WashACE will publish a review of the health care reform proposals to be considered by the Citizens' Work Group on Health Care (ESSB 6333).

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