

January 13, 2003

WHY ARE STATES' MEDICAID EXPENDITURES RISING?

by Leighton Ku and Matthew Broaddus

Summary

Rising Medicaid expenditures are of major concern to states during the current period of fiscal distress. The rapid recent growth in Medicaid costs, along with the weakness of the economic recovery and faltering state tax collections, is contributing to the continuing state fiscal crisis. Raymond Scheppach, executive director of the National Governors Association, has called the current situation "the worst budget crisis states have faced since World War II."¹ Recent analyses indicate that states still have to close budget gaps of \$17.5 billion in the current fiscal year (2003) and a projected \$60 billion to \$85 billion deficit in fiscal year 2004.²

In the next couple of months, almost all states will begin work on their 2004 budgets; a large number will also be forced to make mid-year cutbacks in their 2003 budgets. Most states are considering steps to cut Medicaid expenditures. Deep Medicaid reductions could have a number of adverse repercussions for the well-being of state residents and for the health of state economies.

Millions of children and adults lost *private* health insurance coverage during 2001 and the first quarter of 2002, according to data from the Census Bureau and the Centers for Disease Control and Prevention. The number of individuals who became uninsured during this period was much smaller, however, primarily because of offsetting increases in the number of children and adults served by Medicaid and the State Children's Health Insurance Program (SCHIP). If states scale back Medicaid eligibility to help balance their budgets, the program will become less effective in cushioning the loss of employer-sponsored health insurance during the current period of economic weakness, and the number of uninsured individuals will rise even faster than it is currently doing.

Deep cuts in state Medicaid spending also could create significant economic problems for states. For every dollar a state reduces its Medicaid expenditures, the state loses one to three dollars in federal matching funds. The loss of these funds, which help support public and private health care providers such as hospitals and clinics, could lead to the elimination of substantial numbers of jobs in each state. Studies conducted by the University of South Carolina, Oklahoma

¹ Ronald Brownstein, "States Facing Budget Cuts," *Los Angeles Times*, November 26, 2002.

² Iris Lav and Nicholas Johnson, "State Budget Gaps for 2004 Are Huge and Growing," Center on Budget and Policy Priorities, December 23, 2002.

State University, and the University of North Carolina show that federal Medicaid matching funds support thousands or tens of thousands of jobs. Deep Medicaid spending cuts could cost states thousands of jobs and tens or hundreds of millions of dollars in economic activity.

In addition to the above factors, state policy makers who are considering Medicaid cuts as a means of balancing their budgets should consider the reasons why Medicaid costs are rising (and are expected to continue doing so). Medicaid cost increases are *not* signs that Medicaid spending is “out of control.” Rather, they are symptomatic of demographic changes (such as increases in the number of Americans who are aged or disabled) and spiraling health costs that are affecting the private as well as the public sector. In fact, the average increase in private health insurance premiums in 2002 — 12.7 percent — is roughly twice the average increase in per capita Medicaid expenditures for children and non-elderly adults. Medicaid has often been more effective in controlling health care inflation than private insurance.

Congressional Budget Office (CBO) projections indicate that between fiscal years 2002 and 2004, Medicaid costs will continue to increase, largely because of two factors:

- *Increases in health care costs for the current caseload.* Almost two-thirds (65 percent) of the projected Medicaid expenditure growth between 2002 and 2004 reflects increases in the per capita cost of health services for current beneficiaries. Health care cost pressures are not unique to Medicaid; they are also affecting insurance premiums for private sector employees and state and federal government workers. The underlying causes include rising prescription drug expenses, advances in medical technology, and reductions in managed care savings.
- *Increases in the costs of caring for aged and disabled beneficiaries.* Four-fifths (82 percent) of the projected Medicaid expenditure growth reflects increases in the cost of caring for aged and disabled Medicaid beneficiaries. This includes an increase both in the number of individuals in these groups who are on Medicaid and in the per capita cost of covering individuals in these groups.

Less than one-fifth (18 percent) of the growth in Medicaid expenditures reflects increases in the costs of serving children and non-elderly adults. Indeed, CBO projected there will be *no* increase in costs between 2002 and 2004 from additional enrollment of children or adults since enrollment among these groups is expected to decline as the economy recovers (reversing the caseload growth that occurred in 2002). Even if the economy does not recover as quickly as CBO has anticipated and the enrollment of children or adults continues to rise, this still would add relatively little to overall Medicaid expenditure growth because the per capita cost of covering children and non-elderly, non-disabled adults is relatively low.

As a result, state policies that seek to reduce or retard Medicaid enrollment of families and children will have little effect on the underlying causes of Medicaid expenditure growth.

Such policies also will harm low-income working families, which are the families most likely to have lost private insurance as a result of the economic downturn.

The federal government can take steps to help states avert deep Medicaid cuts during the current fiscal crisis. Last July, the Senate overwhelmingly passed a fiscal relief measure designed to relieve state budgetary problems and ease the pressures on states to tighten Medicaid eligibility or reduce benefits. The House of Representatives did not take comparable action so this measure was not enacted. The need for state fiscal relief has increased in recent months and new proposals offered in both the Senate and the House seek to address these needs as part of a broader federal economic stimulus package.

The federal government also can help states reduce their Medicaid expenditures over the longer term. One strategy, which the Administration proposed in its budget last year, is to require an increase in the size of rebates provided by pharmaceutical manufacturers for sales under Medicaid; this would reduce Medicaid costs for both states and the federal government. In the coming year, Congressional leaders plan to consider changes in Medicare (such as the creation of a Medicare prescription drug benefit) that could relax longer-term fiscal pressures on state Medicaid programs. Complementary federal approaches that combine temporary fiscal relief and longer-term policy changes could help states and Medicaid beneficiaries weather the current fiscal crisis and establish a firmer financial footing.

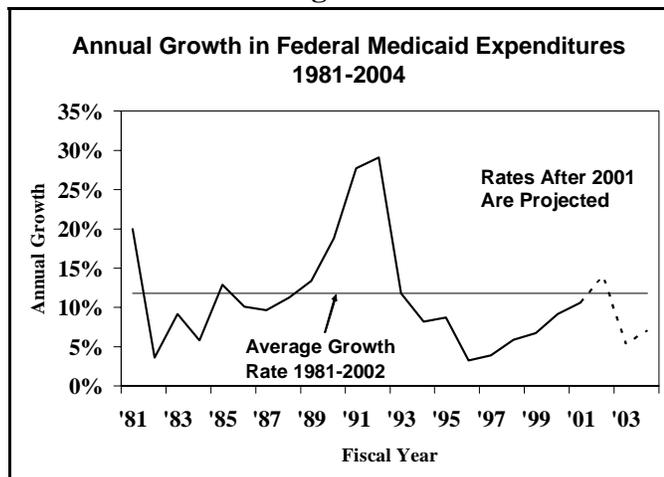
Projected Medicaid Spending Growth from 2002 to 2004

In August, CBO released new estimates of federal Medicaid expenditures. CBO estimates that federal spending on Medicaid rose 14 percent in federal fiscal year 2002. This is noteworthy since it follows a period of relatively low growth in the mid-1990s (Figure 1).

Part of the growth in 2002 reflects an increase in Medicaid enrollment, which was largely caused by the loss of employer-sponsored health coverage during the economic downturn. Data from the Centers for Disease Control and Prevention (CDC) show the number of individuals with private health insurance fell between 2001 and the first quarter of 2002. CDC data also

show that if Medicaid and SCHIP enrollment had not risen to compensate for part of the loss of private coverage, about one million more adults and two million more children would have

Figure 1



become uninsured.³ Rising Medicaid enrollment served a vital purpose by keeping millions of people from becoming uninsured during the economic downturn.⁴

In 2003, new federal policies will slow the growth in federal Medicaid expenditures but will not spare states in a parallel fashion. CBO projects that federal Medicaid spending will rise between 5 percent and 6 percent in 2003 and about 7 percent in 2004, less than half the rate of growth in 2002. Part of the projected slowdown in federal Medicaid spending reflects CBO's assumption that enrollment will stop growing in 2003, as discussed below. The main reason for the projected slowdown, however, is the tightening of federal policies for two components of Medicaid: disproportionate share hospital (DSH) payments and upper payment limit (UPL) arrangements.

While DSH and UPL payments are designed to provide additional federal reimbursements to safety net hospitals and nursing homes, some states have exploited loopholes to increase federal matching payments without a commensurate contribution of state funds.⁵ Legislation enacted in 2000 temporarily increased DSH payments in 2001 and 2002, but those provisions expired at the end of fiscal year 2002, so federal DSH payments are scheduled to fall by \$1 billion in 2003. In addition, federal regulations issued in 2001 and 2002 sharply limit UPL payments, so CBO projects federal UPL payments will drop by \$2 billion in 2003.⁶

Because the DSH and UPL policy changes reduce federal payments to states in 2003, a large number of states will have to bear a greater share of total Medicaid expenses in 2003 than in 2002. The precise effect of these changes on each state will vary depending on the state's DSH and UPL arrangements, but the drop in federal payments will deepen states' budgetary troubles.⁷

³ Leighton Ku, "New CDC Data Show the Importance of Sustaining Medicaid and SCHIP Coverage as Private Health Insurance Erodes in 2002," Center on Budget and Policy Priorities, October 8, 2002.

⁴ In addition to the increased demand for public coverage caused by economic conditions, another factor that likely contributed to enrollment growth in Medicaid and SCHIP is the simplification of enrollment and renewal procedures that many states implemented in recent years, particularly for children.

⁵ Teresa Coughlin and Steve Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues," Urban Institute, June 2002.

⁶ More detailed information about Medicaid spending provided in the rest of this analysis, such as data on DSH, UPL, and enrollment levels, is based on CBO's March 2002 estimates. Although CBO updated overall Medicaid spending estimates in August, more detail about the underlying assumptions is contained in the March estimates. The levels of Medicaid spending estimated in March and August are similar, so the general trends should be similar. CBO plans to update its overall estimates again in late January 2003, but detailed revisions will not be available until March 2003.

⁷ States typically account for additional federal revenue gained from DSH or UPL in their Medicaid budgets, so
(continued...)

State Budget Troubles and Cuts in Medicaid

Most states are facing their most serious budget shortfalls in decades. Buffeted by the recession, the stock market plunge, and other factors, state revenues are much lower than projected, and state deficits for 2004 are expected to total \$60 billion to \$85 billion.⁸ To balance their budgets (unlike the federal government, virtually all states have balanced-budget requirements), a number of states have tapped their rainy day funds, borrowed against future revenue from the tobacco settlement, raised cigarette taxes, reduced state employment, and pared expenditures on Medicaid and other services. Yet with state revenue collections continuing to deteriorate in many areas, many states will need to take further budget-balancing actions.⁹

A survey conducted this summer for the Kaiser Commission on Medicaid and the Uninsured found that most states scaled back Medicaid expenditures in state fiscal year 2002 and plan further reductions in 2003.¹⁰ Reductions planned for 2003 include:

- 18 states said they would restrict Medicaid eligibility (including postponing planned expansions or instituting measures that can make it more difficult for beneficiaries to become or stay enrolled);
- 15 states will reduce Medicaid benefits;
- 15 states will increase beneficiary co-payments;
- 40 states will adopt cost containment strategies for prescription drugs; and
- 29 states will freeze or reduce payments to health care providers.

Of particular concern, 41 states reported a better-than-equal chance that their Medicaid

⁷ (...continued)

that DSH or UPL reductions would necessitate adjustments to their Medicaid budgets. But since money is fungible, the additional federal revenue also can affect other parts of states' budgets. In either case, the loss of federal funds means that states must replace the lost federal funds using other revenue or reduce spending in Medicaid or other areas.

⁸ Iris Lav and Nicholas Johnson, *op cit*.

⁹ National Governors Association and National Association of State Budget Officers, *The Fiscal Survey of States*, November 2002.

¹⁰ Vernon Smith, et al., *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, Sept. 2002. This is based on a survey conducted during the summer of 2002. Given the continuing deterioration of state budgets, the planned actions could be much worse today. The Kaiser Commission plans to release an update of this survey in mid-January.

programs would need more funding than the amount already appropriated for the current fiscal year and that additional cutbacks would be needed if this additional funding is not provided. It is reasonable to expect that a number of states will consider additional mid-year reductions in their Medicaid programs in the months ahead.

A new review of state actions taken to date for 2003 or proposed by governors for 2003 or 2004 finds that the cuts in just 11 states — where Medicaid reductions have been recently adopted or where governors have unveiled budget-cutting proposals in December — would terminate coverage for approximately *one million* Medicaid beneficiaries.¹¹ The number whose coverage is jeopardized will surely mount as more governors issue their budget proposals in January and February.

Reasons for Medicaid Expenditure Growth

As shown above, the principal reasons Medicaid expenditures are expected to rise between 2002 and 2004 are general increases in health care costs and increases in the cost of caring for aged and disabled beneficiaries. Some Medicaid spending growth results from the cost of care for children or non-elderly adults, but its effects on Medicaid costs are surprisingly small.

In general terms, Medicaid expenditure increases can be caused by: (1) cost increases for current enrollees resulting from changes in health care prices or health care utilization, (2) cost increases caused by enrollment growth, and (3) increases in “other” costs, such as those for DSH or UPL payments or administrative costs. The first two categories can be further subdivided by the type of beneficiary: aged, disabled, child, or non-elderly adult. (“Other” expenditures cannot be subdivided because they are aggregate payments not made on behalf of individual beneficiaries.) Table 1 summarizes the components of Medicaid expenditure growth from fiscal year 2002 to fiscal year 2004, based on CBO’s March 2002 baseline estimates. (CBO estimates projected federal Medicaid expenditures. State expenditures parallel federal Medicaid expenditures because of the federal-state matching structure, except for a few areas like disproportionate share hospital and upper payment limit spending which are discussed below.)

¹¹ Leighton Ku, Melanie Nathanson, Edwin Park, Laura Cox, and Matthew Broaddus, “Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for One Million People,” Center on Budget and Policy Priorities, revised January 6, 2003.

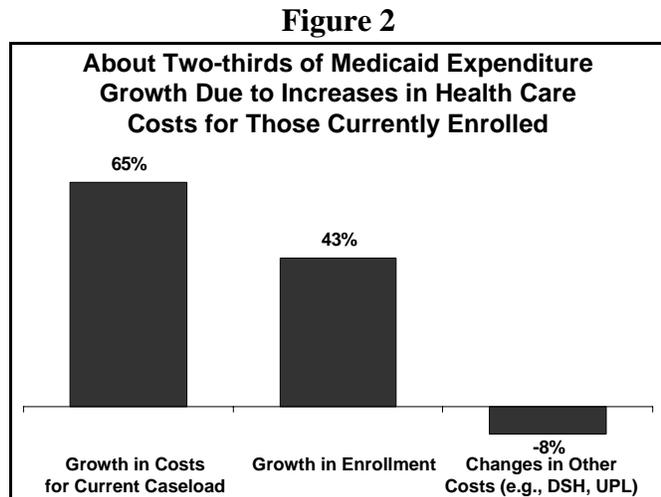
Table 1
Components of Average Annual Federal Medicaid Expenditure Growth, Fiscal Years 2002 to 2004

	Average Annual Increase in Costs for Serving the Current Caseload	Average Annual Increase in Costs Due to Additional Enrollees	Average Annual Change in Other Expenditures*	Total Average Annual Increase in Costs
Total	4.4%	2.9%	-0.5%	6.8%
Aged	-0.3%	2.3%	—	2.0%
Disabled	2.9%	1.0%	—	3.9%
Children	1.1%	-0.3%	—	0.7%
Adults	0.7%	-0.1%	—	0.6%
Other*	—	—	-0.5%	-0.5%

* Other expenditures include DSH and UPL payments, administrative expenditures, and the costs of Vaccines for Children (a small, unrelated program included in the Medicaid account).

Source: CBPP analyses of CBO Medicaid baseline estimates of March 2002. Sums do not total due to rounding.

According to the CBO estimates, federal Medicaid expenditures will rise at an average annual rate of 6.8 percent from 2002 to 2004. As shown in Figure 2, about two-thirds (65 percent) of the growth reflects general increases in health care costs for those currently enrolled — in other words, health care cost inflation. The main sources of the cost increases in Medicaid are similar to those in the private sector: higher costs for prescription drugs, greater use of medical technology, and fewer savings from managed care.

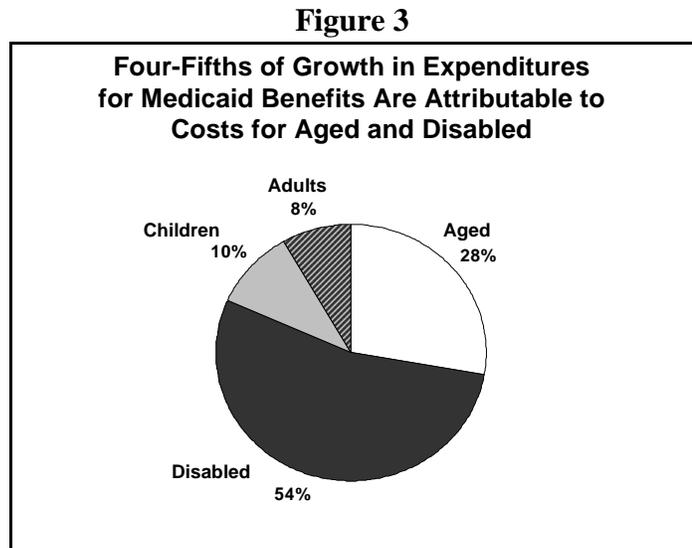


A smaller share of the projected Medicaid expenditure growth (43 percent) is attributable to increases in enrollment. The entire projected enrollment increase is among aged and disabled individuals, since CBO projects the number of children and non-elderly adults on Medicaid will fall.

Finally, because of the projected reductions in federal DSH and UPL payments, the “other” part of federal Medicaid expenditures contributes a *negative* share of growth (minus 8 percent). That is, changes in the other costs reduce federal expenditures (although, as explained

earlier, they raise state costs).¹² This has a significant effect on total Medicaid expenditure growth. If we exclude these other costs and look only at changes in Medicaid benefits, the projected growth would average 8.7 percent from 2002 to 2004.¹³

Another way to look at the projected increase in Medicaid expenditures is to examine how that increase is distributed among different groups of beneficiaries. As Figure 3 shows, about four-fifths (82 percent) of the growth in Medicaid benefit expenditures reflects the cost of caring for aged and disabled Medicaid beneficiaries. Roughly half of the increase in costs for seniors and the disabled is caused by increased enrollment, while the other half reflects increased health care costs per aged or disabled beneficiary.



One reason for the projected growth in the number of aged and disabled Medicaid beneficiaries is the general aging of the population: more Americans will turn 65 and many middle-aged people will become disabled as they grow older. Another reason is Pharmacy Plus waivers, which expand Medicaid coverage for low-income seniors for subsidized coverage of prescription drugs (although not for other Medicaid benefits). As of November 2002, five states have received federal approval for waivers to provide prescription drugs under Medicaid (Illinois, Wisconsin, Maryland, South Carolina, and Florida), and other states are seeking approval for similar waivers.

While projecting an increase in the number of elderly and disabled Medicaid beneficiaries, CBO projects a *decrease* in the number of children and non-elderly adults in the program. CBO estimates that enrollment among these latter groups grew by about 2.2 million in 2002, primarily because of the economic downturn and the drop-off in employer-sponsored insurance coverage. CBO projects that, beginning in 2003, however, Medicaid enrollment of children and adults will decline, falling by 1.2 million between 2002 and 2004. CBO based this

¹² More specifically, federal DSH and UPL payments fall substantially, but administrative costs rise slightly and Vaccines for Children does not change. When combined, “other” costs fall from 2002 to 2004.

¹³ The growth of 8.7 percent in Medicaid benefit expenditures is larger than might be expected given the data in Table 1, in which the sum of enrollment and health cost increases shows an increase of 6.3 percent. In both cases, the numerator – the growth in Medicaid benefit expenditures – is the same. But the 8.7 percent statistic uses Medicaid benefit expenditures as the denominator, while the 6.3 percent statistic uses the broader measure of total Medicaid expenditures, including benefits, administrative costs, DSH and so on, as the denominator.

projection on assumptions that the economy will recover relatively quickly and that the Transitional Medical Assistance (TMA) program will expire after September 30, 2002 (as was prescribed under current law at the time CBO made these estimates). Now, however, there is reason to doubt these assumptions. The economy has not rebounded as vigorously as had been hoped, and TMA has been temporarily extended under a continuing resolution and will almost certainly will be continued for a longer period.

Yet even if the assumptions about declining enrollment of children and adults were revised, the effect on overall Medicaid expenditure growth would be slight. For example, if we assume that the number of enrolled children and adults will remain constant between 2002 and 2004, annual Medicaid expenditure growth over this period would average 7.1 percent instead of the 6.8 percent growth estimated by CBO. If, instead of falling by 1.2 million, the number of enrolled children and adults grows by 1.2 million from 2002 to 2004, the annual growth rate in Medicaid expenditures would be 7.5 percent. In other words, completely reversing the assumptions about children’s and adults’ enrollment affects Medicaid expenditure growth rates by less than one percentage point.

Changes in the enrollment of children and adults have a relatively small effect on overall Medicaid expenditures because the average per capita cost of covering these groups is relatively low. The Medicaid cost per child is about one-eighth of the annual cost of a disabled or aged beneficiary, while the cost per adult is about one-fifth the cost of an aged or disabled person.

A final way to look at the projected increase in Medicaid expenditures is to examine changes in expenditures among specific types of Medicaid services. The Office of the Actuary in the Centers on Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services projects Medicaid expenditures by type of service; CBO does not. The estimates for the period from 2002 to 2004 are summarized in Table 2. CMS’ estimate of changes in spending for Medicaid benefits is slightly less (8.3 percent per year) than CBO’s (8.7 percent). CMS expects prescription drug costs to be the fastest-rising component of Medicaid costs. Medicaid expenditures for physician and clinical services also will rise relatively quickly, according to CMS.¹⁴

Table 2
Average Increases in Aggregate Medicaid Expenditures, 2002 to 2004

Type of Service	Avg. Annual Growth
<i>Total, All Health Services</i>	8.3%
Prescription drugs	14.4%
Physician and clinical services	10.4%
Dental care	10.0%
Home health services	7.9%
Hospital care	5.3%
Nursing home care	4.9%

Source: Office of the Actuary, CMS 2002

Prescription drug costs are rising sharply because of increases in the number of

¹⁴ Office of the Actuary, Centers for Medicare and Medicaid Services, “National Health Care Expenditures Projections: 2001-2011,” March 2002.

prescriptions used, increases in the prices of prescription drugs, and the tendency for prescriptions to shift from older, less-expensive drugs to newer, more-expensive ones. In the past year, the great majority of states have adopted initiatives to limit the cost of, or access to, prescription drugs to slow Medicaid spending growth.¹⁵

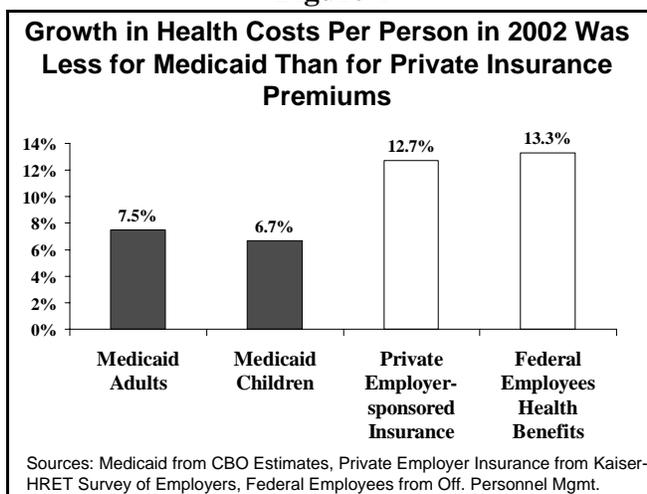
Health Cost Increases Are Widespread; Medicaid Has Been Containing Costs Better Than the Private Sector

The key factor driving up Medicaid expenditures is the general increase in medical costs, a problem that private insurers are facing as well and that reflects underlying changes in medical practices and costs, such as rising prescription drug costs, higher hospital costs, and greater use of technology. In both the public and private sectors, health care costs grew slowly in the mid- to late 1990s but have surged in recent years. The problem is not that Medicaid is “out of control” but that all sectors are experiencing spiraling health care costs.

In fact, state Medicaid programs have often been more effective in holding down health care costs than private insurance plans. As shown in Figure 4, CBO estimates that average per capita Medicaid costs for non-elderly adults were 7.5 percent higher in 2002 than the year before, while average per capita Medicaid costs for children were 6.7 percent higher. In contrast, a recent survey shows that, nationwide, per capita premiums for employer-sponsored insurance increased an average of 12.7 percent between 2001 and 2002.¹⁶ Similarly, average insurance premiums for federal employees rose 13.3 percent in 2002 and will rise 11 percent in 2003.¹⁷

States are understandably concerned that Medicaid is consuming a larger share of their budgets. Medicaid accounted for 16 percent of states’ general fund expenditures in 2002, up

Figure 4



¹⁵ Brian Bruen, “States Strive to Limit Medicaid Expenditures for Prescribed Drugs,” Kaiser Commission on Medicaid and the Uninsured, February 2002. Also see Vernon Smith, *op cit*.

¹⁶ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Summary of Findings*, September 2002.

¹⁷ Office of Personnel Management, press releases about the Federal Employees Health Benefits Plan, September 21, 2001 and September 17, 2002.

from 15.1 percent in 2001 and 10.5 percent in 1991.¹⁸ This percentage is expected to continue to rise in future years. However, rising public and private health care costs are consuming a larger share of the overall U.S. economy, not just a larger share of state budgets. The increase in state Medicaid spending parallels the growth of national health care expenditures as a share of the gross domestic product, estimated at 14.1 percent in 2001.¹⁹

It also is worth noting that increased Medicaid expenditures sometimes help *reduce* state expenditures in other areas. Many states have modified certain state-funded programs — such as services for the disabled or mentally retarded, case management services in the child welfare system, or pharmaceutical assistance programs for seniors — so they can be covered under Medicaid and thereby earn federal matching funds.²⁰ While these modifications make state Medicaid spending appear larger, they actually reduce overall state outlays because the federal government now covers a portion of the costs. In other words, some of the Medicaid growth experienced by states actually represents a reduction in state fiscal burdens, rather than an increase.

Medicaid's Contribution to State Economies

Medicaid is a key contributor to state economies and employment, in large part because of the program's federal matching structure. Medicaid is states' largest source of federal funds. Medicaid matching funds constituted 43.4 percent of all federal funds that states received in 2002, up from 31.8 percent in 1990, according to data from the National Association of State Budget Officers.

Every \$1 a state spends on Medicaid attracts \$1 to \$3.27 in federal matching funds, most of which goes to support local hospitals, clinics, physicians, nursing homes, pharmacies, and the like. Medicaid helps support employment by a wide range of health care personnel, ranging from physicians to nurses to less-skilled, low-wage employees like nurses' aides and home health workers. The income these workers receive enables them to pay mortgages and rents, buy food and other goods, and pay taxes, thereby contributing more broadly to state and local economies.

The impact of Medicaid on state economies, particularly the impact of federal matching funds, has been confirmed in three separate studies conducted by university-based researchers in

¹⁸ Vernon Smith, *op cit*.

¹⁹ Katherine Levit, et al. "Trends in U.S. Health Care Spending, 2001," *Health Affairs*, 22(1):154-64, Jan./Feb. 2003.

²⁰ Coughlin and Zuckerman, *op cit*. For example, the Medicaid Pharmacy Plus waivers that have been approved by CMS to date all involve states that had state-funded prescription drug programs and permit federal Medicaid funds to substitute for some of the state funding.

the last year.²¹ The studies consistently found that deep cuts in state Medicaid programs can trigger the loss of thousands of jobs and reduce state economic activity by as much as hundreds of millions of dollars. Moreover, since the health care providers that Medicaid supports are spread across the state — in urban and rural areas alike — the repercussions of these cuts would be felt statewide. These economic effects, of course, are in addition to the reduction in health coverage and services that Medicaid cuts would inflict on low-income households.

One study, conducted by the University of South Carolina's Moore School of Business, found that federal Medicaid matching funds were responsible for about 61,000 jobs in South Carolina — primarily health care workers in private and public facilities — and that a 10 percent reduction in state Medicaid expenditures could result in the loss of about 6,000 jobs.²² In a second study, economists at Oklahoma State University examined the economic impact of Alaska's Medicaid program and found that the state's \$150 million contribution toward Medicaid funding triggers federal matching funds and the state and federal funds together are responsible for the creation of 9,000 jobs and \$346 million in increased state economic activity.²³ Finally, researchers at the Institute for Public Health and the Kenan Institute of Private Enterprise at the University of North Carolina examined the potential impact of proposed Medicaid cuts in North Carolina and found that the loss of federal funds alone could cost the state approximately 6,500 jobs and about \$470 million in state economic activity.²⁴

Conclusions

The rapid growth of Medicaid expenditures, combined with states' severe budget shortfalls, has led most states to seek Medicaid reductions in their most recent legislative sessions. Pressures to cut Medicaid are likely to be as strong or stronger now, since a number of states used up their one-time funding sources to balance their budgets in the last legislative session and have fewer such options available for the coming year. A number of states also may consider making mid-year Medicaid cuts in early 2003.

In the state budget deliberations that lie ahead, state policy officials should be cautious in considering large reductions in Medicaid spending. Medicaid cutbacks can further weaken a slow state economy, especially by costing the state needed federal matching funds. Equally

²¹ In addition, Families USA plans to release a report on this topic with data for all states in January 2003.

²² University of South Carolina Moore School of Business, "The Economic Impact of Medicaid," January 2002.

²³ Gerald Doeksen and Cheryl St. Clair, "The Economic Impact of the Medicaid Program on Alaska's Economy," Oklahoma State University, March 2002.

²⁴ Kerry Kilpatrick, et al., "The Economic Impact of Proposed Reductions in Medicaid Spending in North Carolina," Institute of Public Health and Kenan Institute of Private Enterprise at the University of North Carolina, April 11, 2002.

important, large reductions in Medicaid eligibility, when coupled with the loss of private health coverage during the economic downturn, will lead to substantial increases in the ranks of the uninsured population and reductions in access to health services.

The federal government can take a number of steps to ease the pressure on states to make Medicaid cuts. To help address states' immediate budgetary problems, the federal government can provide temporary fiscal relief. In July, the Senate approved by a 75-24 vote a bipartisan amendment, offered by Senators Jay Rockefeller (D-WV), Susan Collins (R-ME), Ben Nelson (D-NE), and Gordon Smith (R-OR), to provide \$9 billion in fiscal relief. The House of Representatives did not pass a comparable measure, however, and this measure was not enacted into law.

The 108th Congress will again have the opportunity to provide state fiscal relief. Since the size of projected state budget deficits and the magnitude of expected Medicaid cuts are much larger now than expected in July, the amount of fiscal relief ought to be substantially above the levels discussed last summer.

Measures to provide substantial and rapid state fiscal relief have already been proposed in the new session of Congress. On January 9, Senators Rockefeller, Collins, Nelson and Smith introduced a bipartisan bill (S.138) to provide \$20 billion in temporary aid to states, of which \$10 billion will be provided by temporarily increasing Medicaid matching rates and \$10 billion will be offered through temporary grants to states. Senators Kay Bailey Hutchison (R-TX), Hillary Rodham Clinton (D-NY) and Bob Graham (D-FL) are co-sponsors of this bill. Senator Max Baucus, ranking minority member of the Senate Finance Committee, recently proposed providing \$75 billion in state aid as part of his economic stimulus plan for the nation. House Democrats, led by Minority Leader Nancy Pelosi, have included state fiscal relief as a major element of their economic stimulus proposal, unveiled on January 6. They propose \$31 billion in state fiscal relief, including a temporary \$10 billion increase in Medicaid matching rates, \$10 billion in funds to help states address homeland security needs, \$5 billion to aid highways and transportation and \$6 billion to help states provide support to people harmed by unemployment and the weak economy. By contrast, the President's \$674 billion economic stimulus proposal does not include any relief for states and would, in fact, deepen their budget deficits because the federal tax changes proposed, such as eliminating taxes on dividends, would make state revenues drop further.²⁵

Temporary state fiscal relief should be a component of an economic stimulus package. A number of prominent economists, including Nobel Prize laureates Joseph Stiglitz and Robert Solow, have stated that state fiscal relief would be one of the most efficient and effective strategies to stimulate the nation's sluggish economy. In addition, state fiscal relief would have short-term payoffs for state employment and economic activity, as shown above, and would provide longer-term investments in the health and well-being of states' residents.

²⁵ Iris Lav, *Bush "Growth Plan" Would Worsen State Budget Crises*, Center on Budget and Policy Priorities, January 8, 2003.

Longer-term strategies to help states also need to be considered. The Administration's budget last year proposed increasing the level of rebates provided by pharmaceutical manufacturers for drugs purchased under Medicaid. This option would lower costs for both states and the federal government.

In addition, in the coming year, Congress will consider policy changes for Medicare (the federal health insurance program for senior citizens and the disabled) that could significantly affect *Medicaid* expenditures on a longer-term basis. Most of the expected growth in Medicaid expenditures reflects the rising cost of caring for elderly and disabled beneficiaries. Almost all elderly Medicaid beneficiaries are also on Medicare, as are about two-fifths of disabled Medicaid beneficiaries. Medicaid and Medicare thus share the cost of covering seniors and the disabled. However, since Medicare does not cover an outpatient prescription drug benefit or long-term care services, all those costs are borne by Medicaid.

While an exploration of these issues is beyond the scope of this paper, it is critical to understand the potential effect of Medicare policies on Medicaid's long-term financing. A Medicare prescription drug benefit could, depending on how it is designed, reduce Medicaid expenditure pressures in the states. However, since most proposals for Medicare drug benefits or other Medicare reforms would be phased in over a number of years, such changes would not help address states' immediate budget difficulties. Congress ought to consider both short-term, temporary fiscal relief and a longer-term restructuring of the relative federal and state roles in financing health care costs for the low-income elderly and disabled population.