

medicaid  
and the uninsured

October 2001

## The Role of Medicaid in State Budgets

Medicaid is the nation's major public financing program for providing health and long-term care coverage to low-income people. Financed jointly by the states and the federal government and administered by the states, the program provides a broad range of services with nominal cost sharing because of the limited financial resources of its beneficiaries. Last year, Medicaid covered some 44 million people, including 22.6 million children, 12 million elderly and disabled people, and 9.2 million adults in low-income families. More than one in four children in the United States now rely on the program for their health care coverage. Medicaid also plays a particularly vital role in the health care coverage of poor elderly and disabled individuals, as well as pregnant women—it is the single largest purchaser of nursing home services and other long-term care services, as well as of maternity care in the United States. From a fiscal perspective, Medicaid is a critical component of both the states' and the federal government's budget. In 1999, federal Medicaid funds represented roughly 40 percent of federal grant-in-aid dollars that flowed to the states.

Until recently, states experienced several years during which their Medicaid spending grew only modestly even as they expanded the purpose and scope of their Medicaid programs. While Medicaid spending grew at the relatively modest average annual rate of 5.5 percent between fiscal year 1996 and 1999, it grew by 9 percent in fiscal year 2000 and by an estimated 11 percent in fiscal year 2001. Soon after the resurgence in Medicaid spending, states began to experience fiscal difficulties due to a downturn in the economy. Since the terrorist attacks of September 11, 2001, the rate at which states' fiscal conditions are deteriorating has accelerated, and many states have either made budget cuts or announced plans to do so.

The downturn in the economy and the resurgence in Medicaid spending growth impose competing pressures on states. If, as expected, the unemployment rate continues to rise in the months ahead, the number of people eligible for and in need of Medicaid coverage will increase, making it important to maintain or even expand Medicaid coverage. States have an incentive to maintain Medicaid spending because each \$1 that a state spends on Medicaid brings an additional \$1 to \$3.31 in federal funds to the state, depending on the state's Medicaid matching rate. On the other hand, state policymakers may face significant pressure to limit Medicaid spending. With the exception of Vermont, all states and the District of Columbia are required to balance their budgets each year. Given the resurgence in Medicaid spending growth and Medicaid's relatively large share of state budgets (on average 15%), it seems likely that Medicaid will be a central focus as state policymakers seek to address budget shortfalls.

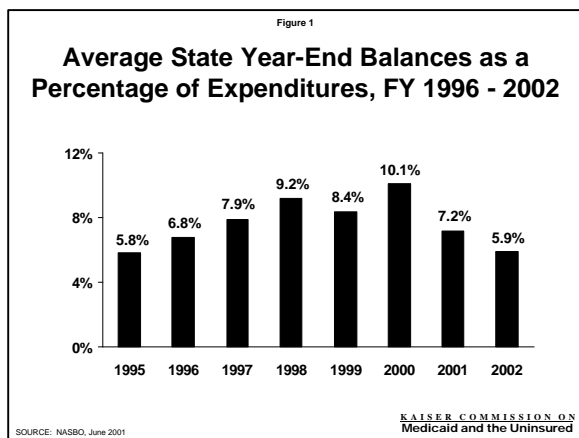
This issue brief provides updated information on the fiscal status of states; examines the role that Medicaid plays in state budgets and the reasons behind rising Medicaid growth rates; and explores the strategies available to states to cope with higher Medicaid spending during difficult economic times.

## I. States' Fiscal Conditions

Even prior to the September 11, 2001 terrorist attacks, a majority of states were experiencing difficult fiscal conditions for the first time in nearly a decade. Since the attacks, the rate of deterioration in states' fiscal conditions has accelerated.

### *After Nearly a Decade of Strong Economic Growth, States' Fiscal Conditions Began to Deteriorate at the End of 2000*

During the mid-to-late 1990s, most states reaped the benefits of the nation's sustained economic expansion. Despite cutting taxes for seven years in a row, states nevertheless enjoyed strong revenue growth and in many cases were able to shore up their budget reserves. As shown in Figure 1, states budget reserves grew from 5.8 percent of expenditures in fiscal year 1995 to 10.1 percent in fiscal year 2000.<sup>i</sup> In the second half of calendar year 2000, however, states began to see their tax collections fall as a result of a slowing economy.<sup>ii</sup> As a result, many states had to dip deeply into their year-end balances to cope with budget pressures, leaving them in fiscal year 2002 with balances at a level that is roughly only half of the level they enjoyed two years earlier, at the height of recent state balances (Figure 1).



The outlook for the current year is even bleaker, primarily because state revenue growth has slowed dramatically. According to new data gathered by the National Conference of State Legislatures in mid-October, 44 states are now reporting that revenues have come in below forecasted levels in the opening months of state fiscal year 2002 (which began in July of 2001 for most states). A smaller, but still significant number of states also are reporting that their expenditures are exceeding budgeted levels. In these states, Medicaid is often cited as one of the programs that is growing most rapidly. The growing fiscal pressure in states already has led Governors in seven states to convene special sessions aimed at addressing budget shortfalls, and has led 28 states to implement or to consider budget cuts.<sup>iii</sup>

### ***Since the Terrorist Attacks, The Rate At Which States' Fiscal Conditions Are Deteriorating Has Accelerated***

Most of the recent fifty-state data on states' fiscal conditions reflect how they were faring in the late summer and early fall of 2001, prior to economic effects of the September 11, 2001 attacks. Many states expect it may take several months to evaluate the full effect of the attacks on their fiscal situations. Nevertheless, the early anecdotal evidence strongly indicates that the attacks have accelerated the rate at which many states' fiscal conditions are deteriorating, particularly those that rely heavily on revenues from the tourism and airlines industries. In a survey of twenty states conducted for the KCMU in mid-October, Health Management Associates found that nearly two in three states reported that their fiscal conditions had taken a noticeable turn for the worse since September 11, 2001. A state official in Michigan, for example, reported that "The September 11 attacks appear to have sent an already weak economy into a tailspin," while a Florida official reported that things "went south" after the attacks.<sup>iv</sup>

### ***States' Reserve Funds Are Not Sufficient to Get Them Through Even a Relatively Modest Recession***

Although most states still have some reserve funds, it appears likely that these funds will not be sufficient to tide states over if the economic downturn lasts for more than a few months. During the relatively modest recession of the early 1990s, states would have needed reserves that equaled approximately 17 percent to 19 percent of their state general funds budgets to maintain expenditures through the recession without increasing taxes.<sup>v</sup> At the beginning of state fiscal year 2002, states had reserves that equaled 5.9 percent of general fund expenditures--only a little more than a third of what would have been needed to get through the last recession without spending cuts or tax increases. In light of the limited reserve funds in the states, states are likely to need to consider a broad array of strategies to cope with budget pressures during the months ahead.

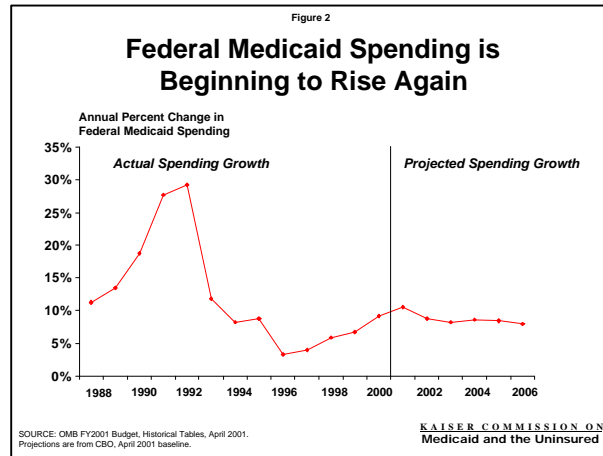
## **II. The Role of Medicaid in States' Fiscal Conditions**

Although the major factor behind many states' budget problems is the decline in revenue growth, a number of states also are finding that their spending, particularly their Medicaid spending, is exceeding budgeted levels. This section reviews the latest data on trends in Medicaid spending and explores the reasons for the recent growth in Medicaid spending growth. The resurgence in health care inflation; the role of rising prescription drug costs; Medicaid's unique role in serving elderly and disabled individuals; and states' use of creative financing arrangements; all contribute toward the rise in annual Medicaid expenditures.

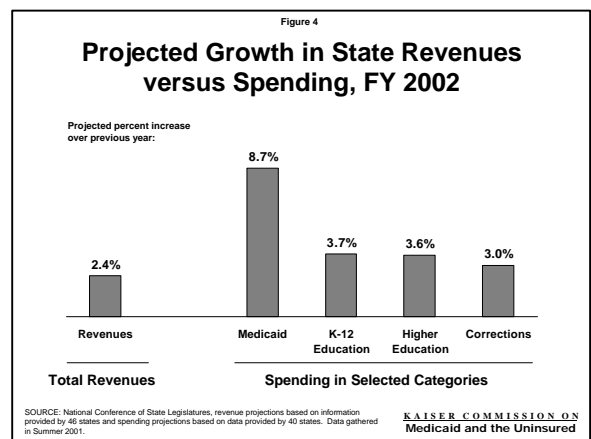
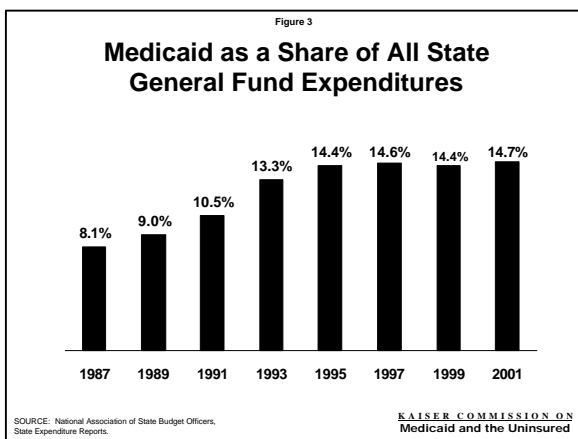
### ***Trends in Medicaid Spending***

Even prior to the attacks and the deterioration in states' fiscal conditions, many state policymakers were expressing concern about the rate of growth in Medicaid spending. After a four-year lull in the mid-to-late 1990s when Medicaid expenditures grew at a rate far below their historical average, Medicaid spending has begun again to

rise at a more rapid rate. In fiscal year 2000, Medicaid spending grew 9 percent and in fiscal year 2001 it grew an estimated 11 percent. Over the next several years, the Congressional Budget Office anticipates that Medicaid will grow at an annual rate of 8 percent to 9 percent (Figure 2).<sup>vi</sup> Such growth rates are in line with the average rate of growth in Medicaid since 1980 and certainly far below the astronomically high rates of growth in Medicaid spending – which reached as high as 30 percent -- that states experienced during the early 1990s, fueled by their use of creative financing mechanisms to generate additional federal funds.



Of particular concern to states is that future Medicaid spending growth is projected to outstrip relatively weak revenue growth, causing Medicaid to consume a larger share of their budgets over time. Medicaid rose rapidly as a share of state budgets between 1987 and 1995, but during the mid-to-late 1990s it remained relatively steady (Figure 3).<sup>vii</sup> But, as of the summer of 2001, states were projecting that their revenues would grow by only 2.4 percent during fiscal year 2002 even as their Medicaid spending was slated to grow by 8.7 percent.<sup>viii</sup> Given these revenue and spending projections, it seems almost certain that Medicaid is slated again to grow as a share of state spending (Figure 4).

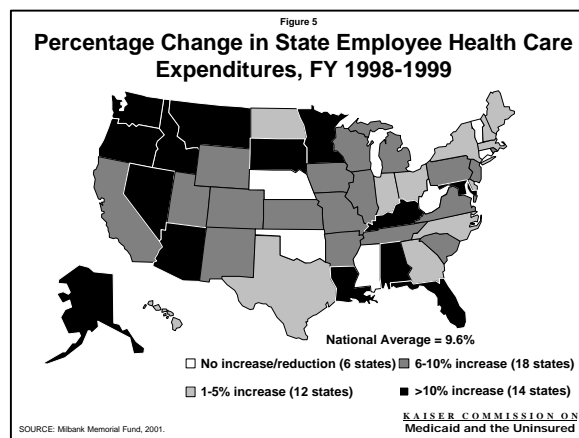


In light of the worsening fiscal situation of states the pressure to find effective strategies to control Medicaid spending is likely to be stronger than ever. In a survey of state Medicaid directors and budget officials conducted by Health Management Associates for KCMU in 20 states in October of 2001, more than half reported that in response to deteriorating fiscal conditions they had been directed by their Governors to prepare proposals to reduce *current* year (fiscal year 2002) Medicaid spending below the level authorized by the legislature.<sup>ix</sup>

The pressure to reduce Medicaid spending may be exacerbated by the decision made by a significant number of states to under fund their Medicaid programs as they prepared their fiscal year 2002 budgets. In an earlier KCMU survey of Medicaid officials conducted this summer, Health Management Associates found that officials in 20 of 47 states expected that their state's actual Medicaid expenditures in fiscal year 2002 would exceed the amount that was authorized or was being proposed for authorization. In these states, policymakers will likely need to adopt supplemental appropriations for Medicaid even if expenditures grow no faster than anticipated.<sup>x</sup>

***Much of the Recent Medicaid Spending Growth Tracks Trends in the Private Sector***

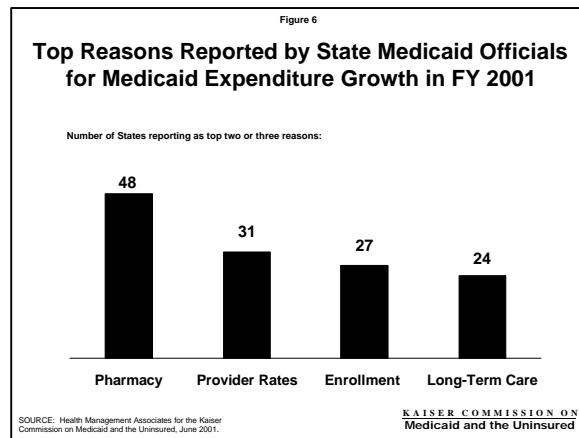
The trends in Medicaid expenditures in recent years have tracked to a large degree the trends in private sector health spending. Health care inflation explains much of growth in spending on publicly financed health programs, as well as employer-based coverage. For example, during the mid-1990s when Medicaid growth rates were in a four-year lull, employers enjoyed the lowest rate of increase on record in the cost of providing health insurance coverage. Now, however, both Medicaid expenditures and private sector health care premiums are experiencing significantly higher growth rates.<sup>xi</sup> Similarly, the growth in state spending on health insurance coverage for state employees has matched or exceeded the rate at which Medicaid expenditures have increased in recent years (Figure 5).



Like the private sector, states are finding that a significant portion of the growth in their Medicaid expenditures can be attributed to a rapid increase in the cost of providing prescription drugs. In recent years, the growth in Medicaid spending for prescription drugs has far outstripped the growth in Medicaid spending on nearly all other services. The Urban Institute estimates that Medicaid spending for outpatient prescribed

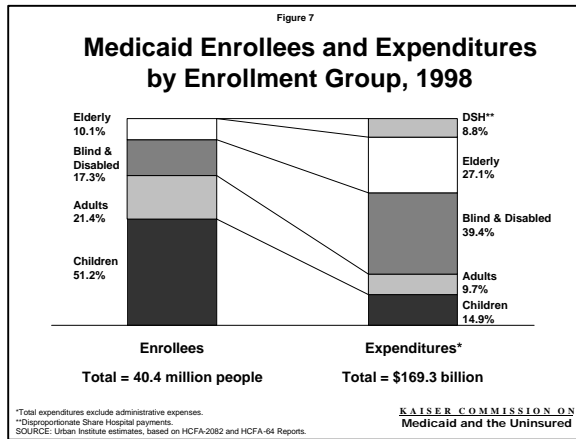
drugs increased by an average of 18.1 percent per year from 1997 to 2000, compared to 7.7 percent for all Medicaid expenditures.<sup>xii</sup>

These findings are borne out by states' own experiences as reported by their Medicaid directors. In the summer survey of the 50 state Medicaid directors conducted by Health Management Associates for KCMU, every state that responded identified prescription drugs as a source of growth in spending in state fiscal year 2001, and 48 states listed it among the top two or three reasons for growth (Figure 6). States noted that prescription drug costs grew 15 percent to 20 percent during state fiscal year 2001, and 13 states reported an annual increase of between 20 percent and 31 percent. As in the private sector, state officials are finding that the rise in prescription drug costs reflects both higher prices for drugs and an increase in the number of prescriptions used by beneficiaries.<sup>xiii</sup>

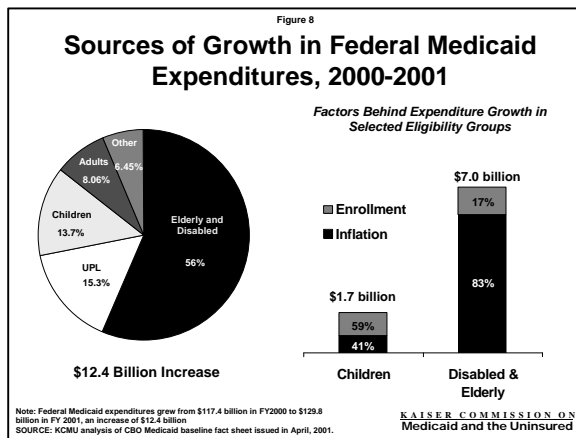


### ***Some of the Growth in Medicaid Spending Reflects the Program's Unique Role in Serving Vulnerable Populations***

Some of the key factors affecting Medicaid expenditures growth are unique to Medicaid, including the role the program plays in serving elderly and disabled people and providing long-term care services. Unlike private sector health plans and state employee health programs, Medicaid plays the special role of providing services to elderly and disabled beneficiaries who often have high medical costs and use a particularly large amount of prescription drugs. Although they represent a relatively small share of Medicaid beneficiaries, the elderly and disabled account for the vast majority of Medicaid spending. In fiscal year 1998, for example, elderly and disabled beneficiaries accounted for more than two-thirds of all Medicaid spending on benefits (Figure 7) and for four in five Medicaid dollars spent on prescription drugs.<sup>xiv</sup>



Not surprisingly, the elderly and disabled also account for a significant portion of the growth in Medicaid spending. According to a KCMU analysis of federal Medicaid spending projections prepared by the Congressional Budget Office, the increased cost of caring for elderly and disabled Medicaid beneficiaries was the single largest factor behind the \$12.4 billion increase in federal Medicaid spending between 2000 and 2001.<sup>xv</sup> About \$7 billion of the \$12.4 billion increase – or 56 percent – can be attributed to elderly and disabled beneficiaries (Figure 8). Only a small fraction of this amount (17 percent) represents costs associated with new enrollment among elderly and disabled beneficiaries; the vast majority of the spending growth attributable to the elderly and disabled reflects an increase in the per capita cost of serving this population. In comparison, even though states added close to a million children to Medicaid in fiscal year 2001, children accounted for less than 14 percent of the overall growth in federal Medicaid expenditures last year.



### ***States' Use of Creative Financing Arrangements Also Have Contributed to Medicaid Spending Growth***

Another “unique” factor behind Medicaid spending growth is the increasing use of “upper payment limit arrangements.” These arrangements allow states to draw down federal Medicaid matching funds without spending any state money, and then to use the federal Medicaid funds for Medicaid or other purposes unrelated to health care.<sup>xvi</sup> States can convert federal Medicaid funds into state general revenue funds where they can be used however a state likes. As shown in Figure 8, KCMU’s analysis of CBO data indicate that upper payment limit arrangements accounted for one-seventh of the \$12.4 billion increase in federal Medicaid spending that occurred last year. In comparison to the other sources of growth in Medicaid expenditures discussed in this policy brief, upper payment limit arrangements provide states with significant fiscal relief by bringing in additional federal dollars even as they appear on paper to cause state Medicaid spending to increase.

### ***Some States May See Their State Medicaid Spending Increase Due to Declines in the Federal Medicaid Matching Rate***

In some states, changes in their “Medicaid matching rate” or the share of Medicaid expenditures picked up by the federal government will contribute to a rise in state spending for Medicaid. Under the matching rate system used to finance Medicaid, the federal government picks up between 50 percent and 83 percent of the cost of a state’s Medicaid expenditures, but the exact matching rate in any given state is determined by a formula. The formula is designed to provide a higher matching rate to poorer states and a lower matching rate to more affluent states. It is based on a state’s average per capita income relative to national average per capita income during a three-year period that precedes the year for which the Medicaid matching rate is being determined.

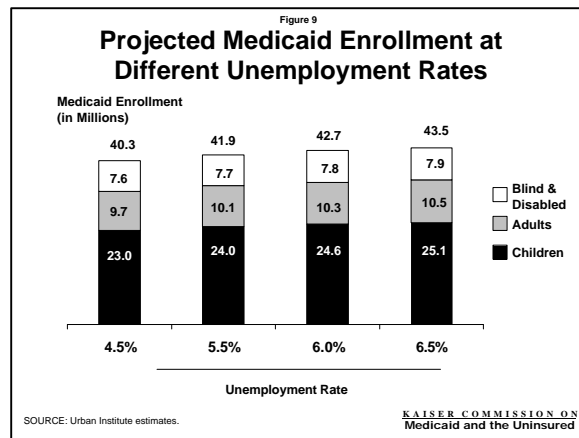
For example, a state’s fiscal year 2002 matching rate is based on its per capita income during 1997, 1998, and 1999. The considerable lag between the three-year period on which a state’s matching rate is based and the year for which the matching rate is being determined is due to the time it takes to process the survey data available on state and national income for any given year.

In fiscal year 2002, 29 states had their Medicaid matching rates decline because they experienced relatively strong economic growth during the late 1990s. Due to the data lag in the Medicaid matching rate formula, the decline occurred even though these states may have faced relatively difficult economic times in more recent years. As a result of the matching rate decline, these states must replace the lost federal support with state funds if they want to maintain the scope of their Medicaid programs, creating upward pressure on state Medicaid spending. In total, the loss of federal funds to these states has been estimated at more than half a billion dollars.<sup>xvii</sup>

### ***Future Trends in Medicaid Spending: An Expanding Role During an Economic Downturn***

In April 2001, the Congressional Budget Office projected that Medicaid spending would increase at an average annual rate of 8 percent to 9 percent for the next several years. At that time, the economy was significantly stronger and the terrorist attacks had not yet taken place. In light of the economic downturn, the Medicaid program will be called upon to play a role in providing coverage to many of the workers who lose their jobs and end up without health insurance coverage. Due to the nature of Medicaid eligibility rules, most newly unemployed workers without children are unlikely to meet their state's Medicaid eligibility criteria. However, many of the children and some of the parents in families where a worker loses a job are likely to meet the state's Medicaid eligibility criteria and enroll in coverage.

Using historical information on the relationship between the unemployment rate and Medicaid enrollment, the Urban Institute has estimated that if the unemployment rate rose from 4.5 percent to 6.5 percent next year, it would cause the number of children enrolled in Medicaid to increase by 2.1 million, the number of adults to increase by 800,000, and the number of disabled and blind enrollees to increase by 200,000 (Figure 9). If this new enrollment occurred, the Urban Institute projects that federal Medicaid spending would increase by \$3 billion and state Medicaid spending would increase by \$2.3 billion.<sup>xviii</sup> Although these spending increases would be modest compared to overall Medicaid spending, they would hit states at a time when they are already concerned about rising Medicaid costs.



### **III. State Options for Responding to Rising Medicaid Spending During an Economic Downturn**

The downturn in the economy and the resurgence in Medicaid spending growth impose competing pressures on states. In many ways, states now have particularly compelling reasons to maintain or even expand their Medicaid programs. In light of rising unemployment, the Medicaid program is an important vehicle to provide health care coverage to recently unemployed workers and their families. As North Carolina's Deputy Director of Health and Human Services recently explained, Medicaid will be protected in his state despite a difficult budget situation "because more people are likely

to need it in bad economic times.” Moreover, during economic downturns, states may be reluctant to take the anti-stimulatory step of reducing state Medicaid spending given that a reduction in state Medicaid spending also causes a significant loss of federal Medicaid matching funds and the state only saves half to three quarters of the dollars cut. At the same time, state policymakers face significant pressure to cut Medicaid spending. With the exception of Vermont, all states and the District of Columbia are required to balance their budgets each year. Given the resurgence in Medicaid spending growth and Medicaid’s large share (on average 15%) of state budgets, many state policymakers will be looking for options to cope with Medicaid expenditure growth during the downturn.

### ***Recent State Efforts to Slow the Rate of Growth in Medicaid Spending***

With some notable exceptions, states to date have largely addressed their recent Medicaid budget concerns without reducing eligibility for their programs or cutting benefits. In the spring 2001 KCMU survey of state Medicaid officials, Health Management Associates found that the vast majority of states were looking for ways to address Medicaid spending issues without cutting back on eligibility or benefits for beneficiaries. In fact, a number of states continued to improve their child health application and enrollment procedures, expanded eligibility for women diagnosed with breast or cervical cancer, or otherwise took steps to improve coverage for beneficiaries. Instead of cutting benefits, states often opted to draw on reserve funds or Medicaid trust funds to finance supplemental appropriations for their programs.<sup>xix</sup>

In addition, states also sought to control overall Medicaid expenditures growth by reducing the cost of prescription drugs. For example a number of states imposed new prior authorization requirements on the use of non-generic drugs while others limited the number of prescriptions that beneficiaries can use in any given month. Along with controlling prescription drug expenditures, states also took steps to limit increases in the rates at which providers are paid; increased their use of Medicaid managed care; and adopted new fraud and abuse initiatives. Finally, states also aggressively pursued upper payment limit arrangements in order to maximize federal Medicaid matching funds flowing into their states.

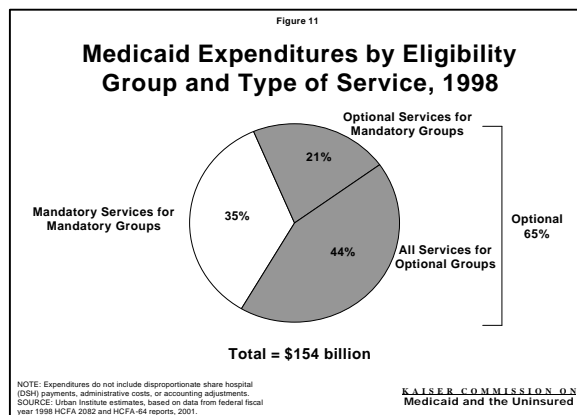
Even though the vast majority of states opted not to reduce eligibility or make major changes in their benefit packages and cost-sharing requirements, there were some notable exceptions. For example, the State of Idaho eliminated its outreach program for children’s health coverage. As a result, the state had to pull TV and radio public service announcements about children’s health coverage and cancel its contracts with community organizations such as Head Start and the Girl Scouts of America to promote enrollment. It also imposed a new cap on spending for children’s health coverage, creating a scenario under which the state is obligated to cut back on eligibility for children should it appear that state spending is likely to exceed the spending cap.<sup>xx</sup>

### ***Options for Increasing State Capacity to Finance Medicaid***

Given the new fiscal reality of many states, states are likely to look to a broader array of strategies in the months ahead to cope with the growth in Medicaid expenditures. Many states are likely to consider a range of options aimed at increasing their ability to

finance the cost of maintaining or even expanding their Medicaid programs during the difficult economic times ahead. The options include:

- **Tapping Reserves.** Many states still have relatively substantial reserve funds that could be used to help cope with the growth in Medicaid expenditures, at least for a limited period of time while states regain their fiscal strength. As noted above, many states tapped reserve funds last year to cover Medicaid expenditures that had exceeded budgeted levels. A number of states already have indicated that they plan to draw on reserve funds to balance their fiscal year 2002 budgets. In a survey of states conducted in October, the National Conference of State Legislatures found that four states already had plans to take such a step, while an additional 16 states indicated it was possible that they would use reserves to balance their fiscal year 2002 budgets. Similarly, states such as Hawaii, Massachusetts, Ohio, and Oregon have indicated that they will consider tapping their tobacco settlement funds to address budget problems.<sup>xxi</sup>
- **Increasing State Revenues.** For the past seven years, states have cut taxes (Figure 10). In the current environment, however, some states may need to consider raising taxes or at least holding off on implementing scheduled tax cuts to cope with the budget shortfalls they are experiencing, include the aspects of their shortfalls that are associated with the Medicaid program. During the last recession, a number of states chose to raise general taxes to cope with budget shortfalls.<sup>xxii</sup> These states increased taxes due to broader fiscal problems generated by economic conditions and their budget situations, but Medicaid was a contributing factor. Policymakers in a small number of states, including California and Florida, opted to increase cigarette taxes and earmark the revenue from these taxes to pay for health care programs, including Medicaid. There already are signs that states will need to revisit their tax policies as they seek to balance their budgets. Eight states raised taxes and fees by at least one percent when crafting their fiscal year 2002 budgets.<sup>xxiii</sup>



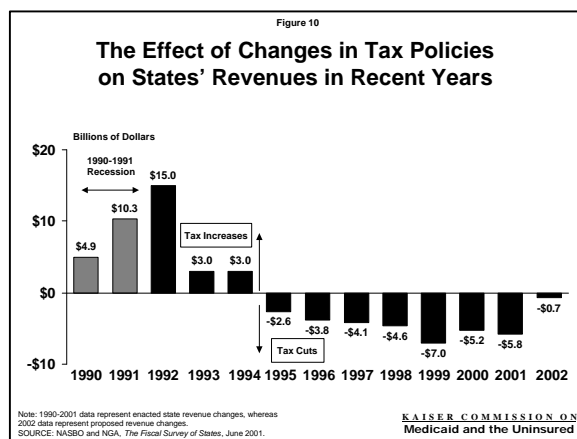
- **Looking to the Federal Government.** Along with shoring up their revenue streams, states may also look to the federal government for assistance in coping with rising Medicaid expenditures during the economic downturn. Unlike nearly all states, the federal government can engage in counter-cyclical fiscal policy by increasing expenditures during an economic downturn because it is not subject to a balanced budget requirement. Both the National Governors Association (NGA) and the National Conference of State Legislatures have put forth proposals to increase federal spending on Medicaid during the economic downturn. NGA has asked that Congress grant states a 10 percent increase in their Medicaid matching rates for acute care services for families with children in order to provide fiscal relief to states and help states shore up their Medicaid programs during the months ahead. Both NGA and NCSL has put forth proposals that Congress “hold harmless” those states that experienced a decline in their Medicaid matching rate in fiscal year 2002. Instead of seeing their matching rates decline in the midst of an economic downturn, these states would be allowed to keep the matching rate that they had in place during the preceding year.

### *Strategies for Reducing Medicaid Spending*

As noted above, states in recent years have generally sought to slow the rate of growth in their Medicaid expenditures without reducing eligibility for their programs and without directly cutting benefits. As the budget pressure on states’ continues, however, it is likely that a growing number of states may consider such options. Some states already have taken steps to reduce eligibility for Medicaid, to increase cost-sharing obligations, or to cut benefits. The State of Florida, for example, is considering a series of cuts in Medicaid, including a proposal to rollback Medicaid eligibility for pregnant women from 185 percent of poverty to 150 percent and eliminating the state’s medically needy program for adults. As with the state options for increasing their capacity to finance Medicaid, however, states may encounter a series of difficulties with pursuing any of these options.

States have broad flexibility under federal law to establish the parameters of their Medicaid programs. States are required to extend eligibility to some “mandatory” groups, and they face some minimum federal requirements with respect to benefits and cost sharing. At the same time, states have broad flexibility to determine the extent to which they will cover a number of optional populations and a significant amount of discretion to determine the amount, duration, and scope of benefits that they will provide to enrollees (particularly with respect to groups other than children.) In a recent KCMU analysis of state Medicaid expenditure data from fiscal year 1998 (the latest year for which data are available), the Urban Institute found that more than two-thirds of Medicaid expenditures were for either “optional” groups and/or “optional” benefits that states are not obligated to cover (Figure 11).<sup>xxiv</sup> These data highlight that federal Medicaid law leaves states with significant flexibility to scale back the scope of their

Medicaid programs, but reducing coverage is politically challenging, especially when reductions affect the elderly and disabled.



The Department of Health and Human Services has the authority to approve waivers that give states additional flexibility -- beyond the discretion they already have under current law -- to change the benefits provided to enrollees, increase cost-sharing, or to otherwise revise spending on Medicaid beneficiaries. In August of 2001, HHS invited States to participate in the “Health Insurance Flexibility and Accountability” or “HIFA” demonstration initiative, a newly developed Medicaid and State Children's Health Insurance Program (SCHIP) section 1115 waiver approach. The purpose of the HIFA initiative is to encourage states to expand coverage to new populations, but does not offer states any new federal funds with which to help finance such expansions. Instead, states must finance any expansions that they adopt under the new HIFA waiver policy with “savings” that they generate by reducing spending on current Medicaid beneficiaries or by drawing on unspent SCHIP funds, if available. In describing the mechanisms by which states could generate Medicaid savings, HHS indicated states could cut the benefits of or impose cost-sharing on optional Medicaid beneficiaries beyond the levels that otherwise would be allowed under federal law. Although the HIFA waivers initially were designed to encourage states to expand coverage, it is likely in light of their deteriorating fiscal condition that some states will want to use waivers primarily to reduce benefits or impose cost sharing rather than to expand coverage.

### *Implications of Cutting Medicaid*

Although states may be under considerable pressure to identify ways to limit Medicaid spending, it is likely that many will find it relatively difficult to do. As shown in Figure 7 above, more than two-thirds of Medicaid dollars are spent on elderly and disabled Medicaid beneficiaries, a group on whom it may be hard to impose cost sharing or benefit reductions. Since the elderly and disabled typically have extensive medical needs, the effect of imposing cuts on these populations are likely to impose substantial hardship, making it particularly likely that these groups will use their often significant political clout to fight cuts.

At the same time, state policymakers may be reluctant to cut state Medicaid spending during a recession because doing so will result in the loss of an equal or even

greater amount of federal Medicaid funds. Due to the nature of the Medicaid matching rate system, a state's decision to reduce Medicaid by \$1 causes the state to lose between \$1 and \$3.31 in federal Medicaid funds. Since many policymakers would prefer to increase spending during an economic downturn as a means of easing its intensity and duration, it may be particularly difficult to impose state spending cuts that also cause the loss of an even greater amount of federal funds.

States' reactions to rapidly rising Medicaid expenditures during the recession of the early 1990s suggest that states indeed are wary about the political and economic consequences of cutting Medicaid (Figure 12). With some notable exceptions, most states did not reduce or eliminate many services or stiffen eligibility requirements in Medicaid. In contrast, many states did impose steep cuts on state-funded cash and medical assistance programs.<sup>xxv</sup> These programs serve primarily adults without children and cannot be used to draw down federal matching funds.

## **Conclusion**

States are clearly entering a period of enormous fiscal stress in which there will be pressure to cut state spending across the board. Medicaid expenditures have been growing more rapidly in recent years and already have attracted the attention and concern of state policymakers. In light of this trend, it appears likely that Medicaid may be a target for significant cuts at the same time as more people lose their jobs and need Medicaid coverage. The challenge for states will be to identify effective strategies for curbing Medicaid expenditures without compromising the care of Medicaid beneficiaries. States are likely to need to consider a broad array of strategies, including drawing on their reserve funds; making new efforts to control prescription drug costs; using tobacco settlement funds to shore up state spending on Medicaid; working with the federal government to increase its investment in Medicaid; taking steps to strengthen the state's revenue stream; and identifying strategies to contain costs.

<p>This policy brief was prepared by Jocelyn Guyer, Senior Policy Analyst of the Kaiser Commission on Medicaid and the Uninsured.</p>
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Figure 12  
*States' Responses to the Recession of the Early 1990s*

States' responses to the recession of the early 1990s offer some clues as to how states may respond to the current situation in which Medicaid expenditures are growing even as state revenues fall. States' responses fell into three general categories:

- **Maximized federal funds.** It was in the midst of the recession of the early 1990s that states use of creative financing arrangements based on payments to disproportionate share hospital truly took off. The increased use of these arrangements enabled states to transform federal Medicaid matching funds into state general revenue dollars that were then used to shore up state spending on Medicaid or, in some cases, to prop up a state's entire budget. The extent to which states relied on DSH schemes to cope with the Medicaid and budget pressures they faced in the early 1990s can be seen in the sharp increase in DSH spending that occurred in 1991 and 1992.
- **Limited cutbacks on eligibility and services.** During the last recession, some states took steps to reduce eligibility for Medicaid, cut benefits, and/or increased cost sharing. For example, states such as Kansas, Maine, Montana, Oregon, and Florida reduced eligibility for their medically needy programs. Since these programs most often serve elderly and disabled people, as well as families, with high medical cost, it is likely that the effect of these changes were quite profound on those beneficiaries who lost coverage.
- **Expanded coverage.** At the same time, a number of states opted to expand Medicaid eligibility during the last recession. For example, in 1991 eight states increased Medicaid income eligibility limits for pregnant women and infants above the federally mandated level of 133 percent of the poverty line; two states established or expanded existing medically needy programs; and one accelerated the phase-in of coverage for children up to age 19 ahead of the federally mandated schedule.

The data in this paragraph on states' reserves are taken from the National Association of State Budget Offices, *The Fiscal Survey of States*, June 2001, Table 7. Figures for fiscal year 2001 are estimates; figures for fiscal year 2002 are based on recommendations. "Reserves" or "year-end" balances reflect the funds states may use to respond to unforeseen circumstances after budget obligations have been met. They include both ending balances and the amounts in budget stabilization funds.

<sup>ii</sup> Nicholas W. Jenny and Donald J. Boyd, *State Tax Revenue Growth Weakens Significantly*, State Revenue Report, No. 45, Fiscal Studies Program, The Nelson A. Rockefeller Institute of Government, September 2001.

<sup>iii</sup> National Conference of State Legislatures, *State Fiscal Outlook for FY2002: October Update*, Fiscal Affairs Program, October 31, 2001.

<sup>iv</sup> Vern Smith, Ph.D., and Mary Lanoye, *Medicaid and State Budgets: An October 2001 Update*, Health Management Associates, October 16, 2001, prepared for the Kaiser Commission on Medicaid and the Uninsured.

<sup>v</sup> Iris J. Lav and Alan Berube, *When It Rains It Pours: A Look at the Adequacy of State Rainy Day Funds and Budget Reserves*, Center on Budget and Policy Priorities, March 1999.

<sup>vi</sup> Congressional Budget Office, *Medicaid Baseline*, April 2001. Note that CBO subsequently issued a modified, but less detailed version of its baseline in August of 2001. Based on a recommendation made in a personal communication with CBO, KCMU has opted to present the Medicaid growth rates suggested by the April 2001 baseline rather than the more recent August 2001 baseline.

<sup>vii</sup> National Association of State Budget Officers, *State Expenditure Report*, various years. Data were compiled by Vern Smith of Health Management Associates.

<sup>viii</sup> National Conference of State Legislatures, *State Budget and Tax Actions, 2001*, August 1, 2001. Note that revenue projections are based on information provided by 46 states and spending projections are based on data provided by 40 states. Data were gathered by NCSL in the summer of 2001.

<sup>ix</sup> Vern Smith, Ph.D., and Mary Lanoye, *Medicaid and State Budgets: An October 2001 Update*, Health Management Associates, October 16, 2001, prepared for the Kaiser Commission on Medicaid and the Uninsured

<sup>x</sup> Vernon Smith and Eileen Ellis, *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002*, Health Management Associates, October 2001.

<sup>xi</sup> Leighton Ku and Jocelyn Guyer, *Medicaid Spending: Rising Again, But Not to Crisis Levels*, Center on Budget and Policy Priorities, April 2001.

<sup>xii</sup> Brian Bruen, *Prescription Drugs Push Medicaid Spending Upward, Inducing States to Take Action to Limit Growth of Pharmacy Costs*, The Urban Institute, forthcoming.

<sup>xiii</sup> Smith and Ellis, October 2001.

<sup>xiv</sup> Urban Institute data as reported in the Kaiser Commission on Medicaid and the Uninsured, *Medicaid "Mandatory" and "Optional" Eligibility and Benefits*, July 2001 and Brian Bruen, *Medicaid and Prescription Drugs: An Overview*, Urban Institute, October 2000 prepared for the Kaiser Commission on Medicaid and the Uninsured.

<sup>xv</sup> KCMU analyzed the expenditure data and projections issued in a Fact Sheet that accompanied CBO's April 2001 Medicaid baseline.

<sup>xvi</sup> For a detailed discussion of how these arrangements work, see the forthcoming paper by Andy Schneider and David Rousseau, *Upper Payment Limits: Reality and Illusion in Medicaid Financing*, Kaiser Commission on Medicaid and the Uninsured, forthcoming

<sup>xvii</sup> Leighton Ku and Edwin Park, *Federal Aid to State Medicaid Programs is Falling While the Economy Weakens*, Center on Budget and Policy Priorities, October 26, 2001.

<sup>xviii</sup> John Holahan and Bowen Garrett, *Rising Unemployment and Medicaid*, Urban Institute, October 16, 2001.

<sup>xix</sup> Smith and Ellis, October 2001.

<sup>xx</sup> Carson Strege-Flore, *The Role of Medicaid in Idaho's Budget*, prepared for the Kaiser Commission on Medicaid and the Uninsured, forthcoming.

<sup>xxi</sup> NCSL, October 2001.

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<sup>xxii</sup> Teresa A. Coughlin, Leighton Ku, John Holahan, David Heslam, Colin Winterbottom, *State Responses to the Medicaid Spending Crisis: 1988 to 1999*, *Journal of Health Politics, Policy and Law*, Vol. 19, No. 4, Winter 1994, Duke University Press.

<sup>xxiii</sup> Iris Lav, *State Fiscal Problems Could Weaken Federal Stimulus Efforts, Low-Income Households Likely to Be Hardest Hit by Cuts*, Center on Budget and Policy Priorities, October 4, 2001.

<sup>xxiv</sup> Urban Institute data as reported in the Kaiser Commission on Medicaid and the Uninsured, *Medicaid "Mandatory" and "Optional" Eligibility and Benefits*, July 2001

<sup>xxv</sup> Coughlin et al, 1994.

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