kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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STATE FISCAL CONDITIONS AND MEDICAID

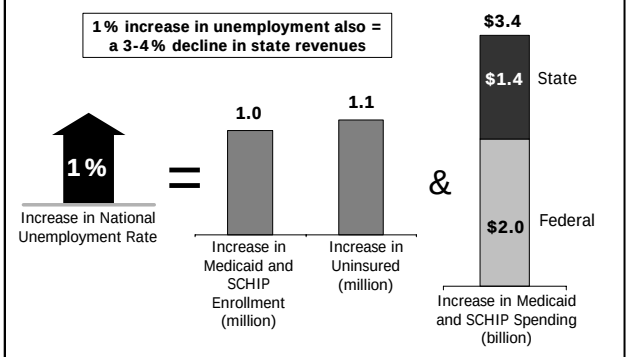
As the nation enters a recession, states are faced with slower than anticipated state revenue growth and significant budget shortfalls. Medicaid, the program that provides health coverage and long term care support services to 44.5 million people in low-income families and nearly 14 million elderly and disabled people, is financed by the federal government and the states, and is administered by states within broad federal guidelines. Demand for Medicaid increases when the economy is weak requiring states to manage the increase in enrollment and program spending just as state budget conditions are most constrained.

Medicaid and the Economy

During an economic downturn, unemployment rises and puts upward pressure on Medicaid. As individuals lose employer sponsored insurance and incomes decline, enrollment and therefore Medicaid spending increase. At the same time, increases in unemployment have a negative impact on state revenues making it even more difficult to pay the state share of Medicaid spending increases (Figure 1). The national unemployment rate in September 2008 was 6.1%, compared to 4.7% at the same time last year.

Figure 1

Impact of a 1% Growth in Unemployment



Source: *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses*, Kaiser Commission on Medicaid and the Uninsured, April 2008

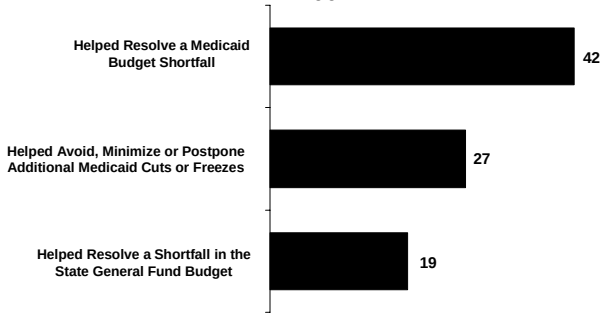
Unlike the federal government, states are legally required to balance their budgets. States can use reserves or rainy day funds, but often they must increase taxes to raise additional revenue or cut spending to achieve a balanced budget during periods of economic stress. Medicaid provides financing for a range of health care providers within communities across the country, supporting jobs, income and economic activity. Due to the program's matching structure, states must cut at least $2 in program spending to save $1 in state Medicaid spending. Given the negative effects on federal revenues and jobs, cutting Medicaid during a downturn can worsen the economy.

States were experiencing budget constraints heading into state fiscal year 2009 which began for most states on July 1, 2008. Twenty-eight states (including the District of Columbia) are projecting FY 2009 mid-year shortfalls of more than $12 billion. Estimates show state budget gaps of about $100 billion for FY 2010.

During the last economic downturn from 2001-2004, states cut spending for services and raised taxes or fees to balance their budgets. Every state enacted measures to control Medicaid costs during that time. In 2003 Congress passed the Jobs and Growth Tax Relief Reconciliation Act that provided a temporary increase in the matching rate for funding to the states from the federal government. States were required to maintain Medicaid eligibility levels as a condition for receiving the federal funds. States reported that this increase in the matching funds helped to resolve a Medicaid budget shortfall, avoid additional Medicaid cuts or freezes and resolve a shortfall in the state general fund budget (Figure 2).

Figure 2

How States Used Increased Federal Medicaid Matching Funds from Temporary Fiscal Relief in FY2004



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, January 2004.

Medicaid Spending and Enrollment Growth

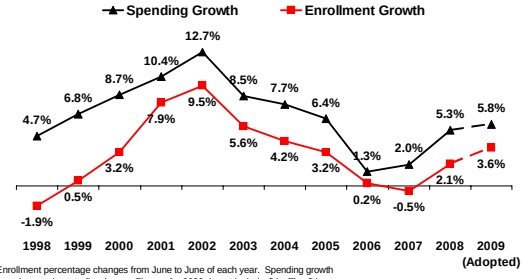
With the economy worsening, it was no surprise that states were reporting increases in Medicaid spending and enrollment starting in FY 2008 and going into FY 2009. Medicaid spending grew by an estimated 5.3% in FY 2008 and state legislatures appropriated Medicaid spending for FY 2009 at an average of 5.8% over FY 2008 levels (Figure 3). However, two-thirds of states predicted a likely chance of a Medicaid budget shortfall for that year, so Medicaid spending growth may ultimately exceed 5.8% growth.

After two years of flat and declining growth, enrollment grew by 2.1% in FY 2008 and is expected to continue to increase by an average of 3.6% in FY 2009. For FY 2008, states attributed the increase in enrollment to policy changes to

address the uninsured such as eligibility expansions, simplified enrollment procedures, outreach campaigns as well as the worsening economy. However, the increase in enrollment in FY 2009 was primarily attributable to the economy. Enrollment growth is generally the primary driver of overall Medicaid spending; however, on a cost per enrollee basis Medicaid remains a cost effective program with growth in cost per enrollee in Medicaid consistently lower than health care costs and growth per person in the private sector.

Figure 3

Percent Change in Medicaid Spending and Enrollment, FY 1998- FY 2009



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentage changes in state fiscal year. Figures for 2009 do not include CA. The CA budget was adopted on 9/23/08 but caseload and spending projections for FY 2009 were not available.

SOURCE: Enrollment Data for 1998-2006: *Medicaid Enrollment in 50 States*, KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2007, FY 2008 and FY 2009 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008.

Enrollment increases were tempered by the continued implementation of the Deficit Reduction Act (DRA) which requires individuals applying for Medicaid to prove their citizenship and identity. This requirement did not affect eligibility requirements, but states have reported administrative delays in processing applications and renewals resulting in postponement and denial of coverage for individuals otherwise eligible for the program.

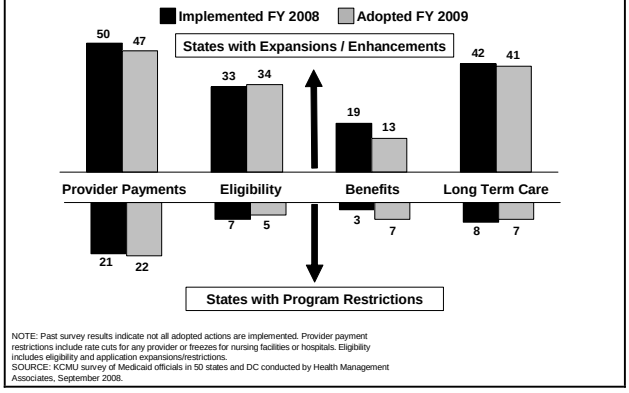
Policy Actions and Key Issues

For FY 2008 and FY 2009, states were still working to restore some cuts imposed during the last economic downturn and move forward with efforts to address the uninsured, improve access to care and implement cost effective service delivery models. Given the increased need for Medicaid as well as the negative financial implications for federal matching funds and jobs, states do not usually turn to Medicaid first to cut spending. Nevertheless, even at this early stage of the economic downturn, some states did adopt new budget-related Medicaid restrictions. Nearly half of all states were planning to freeze provider rates and a few states reduced eligibility, eliminated continuous eligibility, or imposed targeted benefit cuts (Figure 4).

States are continuing to expand managed care and disease management programs in an effort to both assure quality and manage costs over the longer term. Provider rate cuts or freezes tend to have a more immediate effect on slowing Medicaid spending, but can jeopardize provider participation in Medicaid and access for enrollees. Other cost containment measures enacted in early years have largely been kept in place, particularly strategies that control prescription drug spending. State interest in using the DRA options for more flexibility around benefits and cost sharing has remained low. Given the projections for mid-year budget shortfalls, it is likely that states will need to re-examine their adopted FY 2009 budgets and potentially implement mid-year Medicaid cuts to balance their budgets.

Figure 4

State Policy Actions Implemented in FY 2008 and Adopted for FY 2009



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. Eligibility includes eligibility and application expansions/restrictions.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008.

As of last summer, states remained committed to addressing the issues of the uninsured; however, with CMS imposed SCHIP eligibility limits and the absence of a full SCHIP reauthorization as well as the downturn in the economy, state efforts to maintain current Medicaid coverage and to cover more uninsured may be compromised. Most states also indicated that a series of proposed federal regulations could have significant fiscal and beneficiary implications.

Outlook

As the budget situation continues to worsen, states will fall under increasing pressure to control Medicaid spending at the same time growing demand and enrollment are putting upward pressure on program spending. The federal efforts to provide fiscal relief to states could help to balance state budgets, prevent Medicaid cuts and maintain Medicaid eligibility. Fiscal relief provided through an enhanced match rate, with the requirement that states maintain Medicaid eligibility levels proved to be a successful strategy during the last economic downturn.

A new Administration and Congress will immediately face the issues of SCHIP reauthorization, pending Medicaid regulations, state waiver requests, and the state-federal relationship around Medicaid. The resolution of these issues, the trajectory of the economy and renewed interest in a debate about broader health reform will inevitably impact Medicaid and the role it will play in the future within the nation's health care system.

For additional information see: Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn, Results of a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009, http://www.kff.org/medicaid/7815.cfm. Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses. http://www.kff.org/medicaid/7770.cfm. Financing Health Coverage: The Fiscal Relief Experience. http://www.kff.org/medicaid/7434.cfm

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