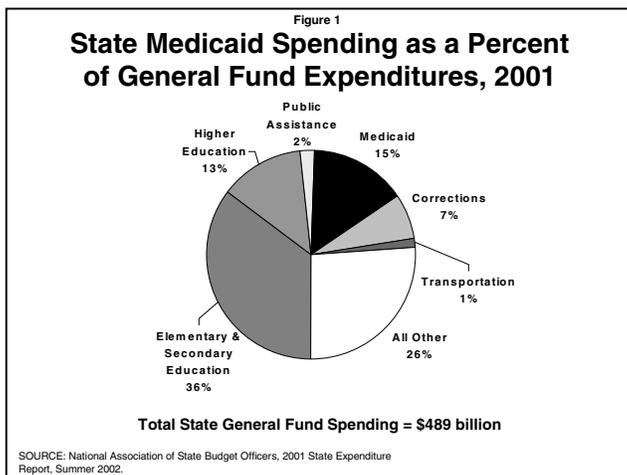


STATE BUDGET CONSTRAINTS: THE IMPACT ON MEDICAID

States are facing falling tax revenues and rising budget shortfalls that are estimated to total nearly \$50 billion this fiscal year and predicted to grow substantially in the next fiscal year. As states have tried to close their budget gaps, many are turning to reducing funding growth for Medicaid, a joint state and federal program which provides health and long-term care coverage for more than 42 million low-income families, the elderly and persons with disabilities.

STATES AND THE FEDERAL GOVERNMENT FINANCE MEDICAID

The states and the federal government share responsibility for financing Medicaid. The federal government matches state spending on Medicaid with the federal matching rate varying by state from 50 percent to 77 percent. Medicaid's size and matching payments mean that Medicaid is the primary source of federal grant support to states, representing almost 44 percent of all federal grants to states. On average, states spend about 15 percent of their own funds on Medicaid (Figure 1) making it the second-largest program in most states' general fund budgets. Medicaid plays a major role in the health care delivery system, paying for half of all nursing home care and 17 percent of prescription drugs. Therefore, hospitals, doctors, and clinics in every state rely on Medicaid as a source of revenue.



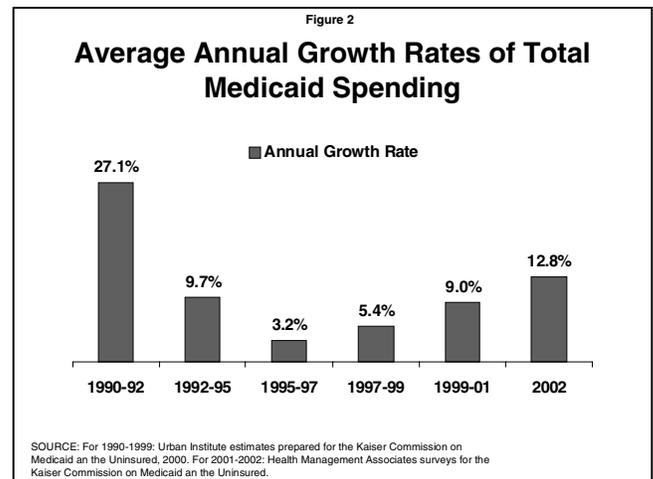
STATE REVENUE COLLECTIONS CONTINUE TO BE WEAK

Nationally, state tax revenues are falling more sharply than they have at any time in more than 10 years. States have experienced five consecutive quarters of declining tax revenues, in real terms. A majority of states faced significant budget shortfalls this year, where state revenue collections were not sufficient to meet state spending obligations. Many states used their reserve "rainy day" funds or tobacco

settlement money to fill their budget gaps but those funds are rapidly depleting.

TRACKING THE PRIVATE SECTOR, MEDICAID SPENDING IS INCREASING

After a period of slow growth in the 1990s, spending growth on Medicaid has started to increase. Between 1995 and 1997, a robust economy, falling welfare rolls and a decline in the number of people enrolled in Medicaid translated into an average annual rate of increase in Medicaid expenditures of 3.2 percent, the lowest in the program's history (Figure 2). Recently, Medicaid spending has started to increase more rapidly. Medicaid costs grew at a rate of almost 13 percent for fiscal year 2002.



This rate of increase is comparable with that occurring in the market for private health insurance, where premiums rose 12.7 percent in 2002. The sources of the growth in the private market and Medicaid are similar: in both sectors, increased spending on prescription drugs and increased payments to doctors, hospitals, and other providers account for a significant share of increasing health care costs.

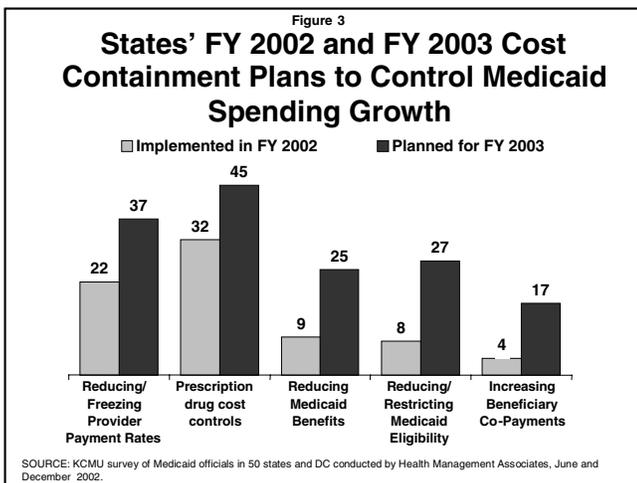
At the same time, Medicaid confronts cost pressures private sector insurers do not. One-quarter of Medicaid beneficiaries are elderly or disabled, two groups that most private insurers do not cover. Because they use many expensive healthcare services such as nursing home care and prescription drugs, the elderly and the disabled are particularly expensive to cover. The downturn in the economy has also placed additional pressure on Medicaid with more people qualifying for coverage. This creates a fiscal problem for states: Medicaid enrollment and spending generally rise during

difficult economic times, which is the same time that state revenues usually fall.

STATE RESPONSES TO BUDGET PRESSURES

The Kaiser Commission on Medicaid and the Uninsured surveyed state officials in all 50 states and the District of Columbia twice in the past year and found that 49 states planned to implement measures to reduce the rate of growth in their Medicaid spending in fiscal year 2003. Some of the cost containment measures states have implemented or are planning include:

- **Reducing or freezing provider payments (37 states)**, including freezing provider rates or reducing scheduled rate increases;
- **Prescription drug cost controls (45 states)**, including prior authorization, preferred drug lists, limits on the number of prescriptions beneficiaries may fill, new or higher beneficiary co-payments, and requiring use of generic drugs;
- **Reducing benefits (25 states)**, including restricting or eliminating dental coverage, occupational or physical therapy, and inpatient hospital days;
- **Reducing eligibility (27 states)**, including eligibility restrictions that would eliminate eligibility for significant numbers of people who had previously been eligible for Medicaid. Nebraska, for example, passed eligibility restrictions that would make approximately 16,000 children and 12,000 adults ineligible. And Massachusetts plans to eliminate coverage for 50,000 unemployed individuals, effective April 1st.
- **Increasing co-payments (17 states)**, including emergency room visits, non-emergency transportation, and physician visits.



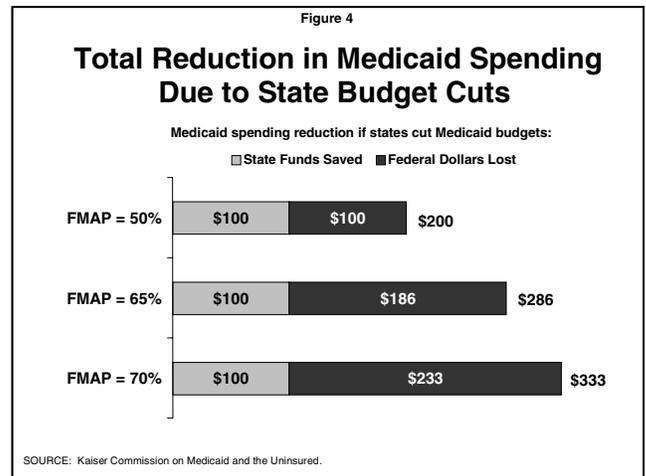
In addition, 17 states have planned to or have taken action to reduce spending on long-term care, both in nursing homes and community-based settings. More states planned to undertake each major type of Medicaid spending reduction in fiscal year 2003 than they did in fiscal year 2002 (Figure 3). For example, in 2002 only eight states reported plans to limit

Medicaid eligibility; in 2003, 27 states did. Moreover, as state fiscal stress has grown, states have increased their emphasis on Medicaid cost containment – 32 states that began FY 2003 with Medicaid cost containment plans also found it necessary to make additional cost containment plans midway through the fiscal year.

POLICY IMPLICATIONS

Medicaid is caught in a crossfire between the rapid deterioration of state revenues, on the one hand, and increased health care spending, on the other. Because Medicaid's enrollment has grown as the economy has declined, its importance has grown even as pressure has mounted to contain its spending. As the state fiscal crisis has deepened, increasing numbers of states have put plans in place to reduce their Medicaid spending growth, and most of the states that had already made such efforts are expanding them.

Medicaid's federal matching payments multiply the impact of state budget reductions. Depending on a state's matching rate, a state cutting its own Medicaid funding will generally lose more in federal matching funds than it saves in state funds (Figure 4). This means that the economic impact of reducing Medicaid funding, as well as the impact on states' health care systems, far exceeds the amount of state funds saved – A one-dollar reduction in state funds could mean a total reduction in health spending of at least two dollars.



The fiscal outlook for states does not yet appear to be improving. State budget shortfalls are significantly larger than the shortfalls states faced during the early 1990s. Prospects for economic growth are uncertain. Most states have exhausted temporary revenue measures like rainy day funds that they have used to forestall deeper spending cuts and tax increases. Unless Medicaid spending growth abates, or unless state revenue collections rebound, Medicaid will remain in a precarious position.

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