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# Medicaid:

*Good Medicine  
For State  
Economies  
2004 Update*

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A REPORT BY  
**Families USA**

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*May 2004*

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**Medicaid: Good Medicine for  
State Economies – 2004 Update**

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## INTRODUCTION

**M**edicaid provides essential health care services for an estimated 51 million people, reaching people of all ages and all economic classes. For low-income children and their parents, Medicaid pays for essential primary and preventive health care services that these families otherwise could not afford. For seniors and people with disabilities, Medicaid fills gaps in Medicare coverage by helping Medicare beneficiaries with their prescription drug costs, as well as other essential services such as hearing aids and dental care. Medicaid is also the nation's largest payer of nursing home care, and each year, Medicaid helps millions of families with the cost of home-based long-term care services.

While Medicaid's role in providing critical health care services is clear, what is less clear is the unique role that Medicaid plays in stimulating state business activity and state economies. Every dollar a state spends on Medicaid pulls new federal dollars into the state—dollars that would not otherwise flow into the state. These new dollars pass from one person to another in successive rounds of spending. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of auto dealerships, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. Economists call this the “multiplier effect.” The magnitude of the multiplier effect varies from state to state, depending on how the dollars are spent initially and on the economic structure of, and conditions in, the state. Because of the multiplier effect, the aggregate impact of Medicaid spending on a state's economy is much greater than the value of services purchased directly by the Medicaid program.

In 2003, Families USA analyzed the effects of Medicaid spending on states' economies. That earlier report, produced at a time when state governments were under considerable fiscal stress and were weighing steep cuts in Medicaid spending, demonstrated that each dollar cut from state Medicaid spending would result in significant losses in business activity,

jobs, and wages in the state. After the report was issued, Congress passed legislation that temporarily increased the amount the federal government contributes towards the costs of each state's Medicaid program. This federal aid helped states minimize the cuts in their Medicaid programs: Although nearly every state and the District of Columbia took steps to reduce Medicaid spending these steps were generally taken as a last resort, and were less severe than they would have been without the additional federal aid.

Now, more than a year later, state Medicaid budgets are still under pressure. However, the temporary fiscal relief provided by the federal government is scheduled to end on June 30, 2004. And, although state economies are beginning to show signs of recovery, the struggle to fund Medicaid has led to a national debate about the future of the program. Against this backdrop, Families USA has developed updated Medicaid multipliers (based on the March 2004 RIMS II input-output economic model created by the U.S. Department of Commerce, Bureau of Economic Analysis) to determine the aggregate impact of Medicaid spending on each state's economy for fiscal year 2005. The RIMS II model allowed us to capture the specific economic conditions in each state and then calculate the new economic activity that will be generated by Medicaid spending in the following three areas:

1. business activity (the increased output of goods and services),
2. employment (the number of new jobs created), and
3. employee earnings (wage and salary income associated with these new jobs).

We analyzed the economic impact of Medicaid spending based on states' estimated Medicaid expenditures in federal fiscal year 2005, which will begin October 1, 2004. States report their estimated expenditures on a quarterly basis, and we used the most recent estimates, which were reported to CMS in February 2004. This report provides updated economic impact multipliers that can be used to predict the economic impact of potential state Medicaid spending increases or cuts in fiscal year 2005, as well as the potential stimulus to state economies if Congress extends the fiscal relief formula past June 30, 2004.

## KEY FINDINGS

### Spending on Medicaid Has a Significant Impact on a State's Economy

- **Business Activity (output of goods and services)**
  - In fiscal year 2005, the 50 states will spend an estimated combined total of more than \$132 billion on Medicaid. This investment in Medicaid will generate an almost three-fold return in state economic benefit—\$367.5 billion in increased state-level output of goods and services from increased business activity (see Table 1).
  - In fiscal year 2005, the rate of return per state dollar invested in Medicaid will range from \$6.22 in Mississippi to \$1.92 in Delaware.
  - The five states with the highest rate of return for every state dollar spent on Medicaid in fiscal year 2005 will be Mississippi (\$6.22), New Mexico (\$5.57), Arkansas (\$5.48), Utah (\$5.45), and West Virginia (\$4.95).
  - Of the remaining 45 states, 22 will realize a return of at least \$3.00 in increased state business activity for every dollar the state invests in Medicaid.
  - In fiscal year 2005, every million dollars a state invests in Medicaid will generate, on average, \$3.35 million in new state business activity (see Table 3).
- **Jobs and Wages**

Estimated fiscal year 2005 state Medicaid spending will generate more than 3.3 million jobs with wages in excess of \$133 billion in the 50 states (see Table 2). These jobs will include Medicaid personnel, other employment in the health care sector, and jobs generated as the Medicaid dollars circulate through different sectors of the economy.
- **Jobs**
  - The number of new jobs created per million state dollars invested in Medicaid will range from 67 jobs in Mississippi to 15 jobs in Delaware (see Table 3).

- On average, investing \$1 million of state funds in Medicaid will generate 33.76 new jobs in fiscal year 2005.
- The five states with the largest number of new jobs created for each \$1 million of state funds invested in Medicaid will be: Mississippi (67.19), Arkansas (61.40), New Mexico (61.30), Utah (58.03), and Oklahoma (57.13).
- Wages
  - On average, investing \$1 million of state funds in Medicaid will generate nearly \$1.23 million in new wages.
  - The five states with the largest increase in wages per \$1 million of state funds invested in Medicaid will be Mississippi (\$2.31 million), New Mexico (\$2.10 million), Arkansas (\$2.03 million), Utah (\$2.02 million), and Oklahoma (1.81 million).

### States Would Receive Even More Economic Benefit with an Extension of Temporary Federal Fiscal Relief

Congress may extend the expiring temporary federal fiscal relief through the end of fiscal year 2005. If this happens, based on estimates of state-by-state Medicaid spending for fiscal year 2005:

- the 50 states, taken together, would realize an *additional \$48.4 billion* in new business activity—a 13.2 percent increase;
- an additional 447,553 jobs would be created; and
- additional wages of \$17.5 billion would be generated (see Table 1).

Table 1

### Return on State Investment in Medicaid: Economic Benefits\* to State Economies, FY 2005 (Under current law and if fiscal relief is extended)

State	State Medicaid Spending (in millions of dollars)	Business Activity Multiplier (per \$1 change in state Medicaid spending) <sup>1</sup>	New Business Activity (in millions of dollars) <sup>2</sup>	Business Activity Multiplier With Extended Fiscal Relief <sup>1</sup>	Total New Business Activity With Extended Fiscal Relief (in millions of dollars) <sup>2</sup>
Alabama	\$1,015	4.88	\$4,952	5.63	\$5,720
Alaska	\$358	2.44	\$873	2.82	\$1,009
Arizona	\$1,888	4.25	\$8,033	4.86	\$9,184
Arkansas	\$795	5.48	\$4,358	6.41	\$5,095
California	\$17,299	2.29	\$39,609	2.55	\$44,087
Colorado	\$1,335	2.24	\$2,989	2.51	\$3,347
Connecticut	\$1,902	2.09	\$3,975	2.34	\$4,453
Delaware	\$395	1.92	\$759	2.15	\$849
Florida	\$5,561	3.03	\$16,850	3.41	\$18,985
Georgia	\$2,777	3.44	\$9,540	3.88	\$10,763
Hawaii	\$385	2.77	\$1,069	3.17	\$1,223
Idaho	\$306	4.41	\$1,347	5.07	\$1,549
Illinois	\$5,406	2.39	\$12,902	2.67	\$14,407
Indiana	\$1,926	3.45	\$6,651	3.91	\$7,521
Iowa	\$881	3.43	\$3,019	3.95	\$3,483
Kansas	\$759	3.15	\$2,393	3.55	\$2,699
Kentucky	\$1,230	4.49	\$5,528	5.30	\$6,516
Louisiana	\$1,163	4.67	\$5,433	5.55	\$6,458
Maine	\$751	3.57	\$2,683	4.26	\$3,200
Maryland	\$2,501	2.23	\$5,575	2.49	\$6,225
Massachusetts	\$4,652	2.16	\$10,048	2.42	\$11,245
Michigan	\$3,906	2.60	\$10,171	2.92	\$11,416
Minnesota	\$2,848	2.19	\$6,224	2.44	\$6,960
Mississippi	\$794	6.22	\$4,937	7.39	\$5,862
Missouri	\$2,370	3.39	\$8,025	3.88	\$9,191
Montana	\$165	4.72	\$780	5.74	\$950
Nebraska	\$616	2.89	\$1,780	3.29	\$2,027
Nevada	\$556	2.41	\$1,338	2.69	\$1,494
New Hampshire	\$504	2.01	\$1,012	2.24	\$1,128
New Jersey	\$3,901	2.26	\$8,805	2.53	\$9,858
New Mexico	\$654	5.57	\$3,639	6.72	\$4,391
New York	\$25,074	2.05	\$51,355	2.28	\$57,216
North Carolina	\$3,154	3.75	\$11,815	4.25	\$13,394
North Dakota	\$175	3.77	\$660	4.48	\$786
Ohio	\$5,022	3.18	\$15,962	3.58	\$17,988
Oklahoma	\$890	4.94	\$4,395	5.71	\$5,085
Oregon	\$1,158	3.12	\$3,614	3.53	\$4,086
Pennsylvania	\$7,146	2.74	\$19,566	3.15	\$22,475
Rhode Island	\$724	2.41	\$1,748	2.75	\$1,992
South Carolina	\$1,090	4.69	\$5,111	5.40	\$5,888
South Dakota	\$200	3.59	\$718	4.09	\$817
Tennessee	\$2,807	3.92	\$11,006	4.44	\$12,473
Texas	\$6,476	3.64	\$23,585	4.11	\$26,606
Utah	\$412	5.45	\$2,248	6.31	\$2,603
Vermont	\$345	2.74	\$946	3.26	\$1,125
Virginia	\$2,306	2.18	\$5,029	2.42	\$5,589
Washington	\$2,836	2.09	\$5,918	2.33	\$6,608
West Virginia	\$527	4.95	\$2,605	5.96	\$3,142
Wisconsin	\$1,992	2.79	\$5,557	3.13	\$6,243
Wyoming	\$162	2.28	\$371	2.77	\$450
<b>Total Average</b>	<b>\$132,097</b>	<b>3.35</b>	<b>\$367,506</b> <b>\$7,350</b>	<b>3.85</b>	<b>\$415,859</b> <b>\$8,317</b>

\* Value of additional state business activity attributed to state Medicaid spending, measured in dollar value of goods and services produced.

<sup>1</sup> This economic impact multiplier incorporates both the federal matching multiplier and the RIMS II economic output multiplier. It predicts the total change in economic activity, measured in value of goods and services produced, per dollar change in state Medicaid spending.

<sup>2</sup> Total new business activity in this column may not equal the state Medicaid spending multiplied by the economic impact multiplier due to rounding. In addition, totals do not exactly sum due to rounding.

Table 2

**Return on State Investment in Medicaid: New Jobs and Wages Attributed to State Medicaid Spending, FY 2005 (Under current law and if fiscal relief is extended)**

State	Estimated State Medicaid Spending (in millions of dollars)	Total New Jobs Created <sup>1</sup>	Total Wages from New Jobs Created (in millions of dollars) <sup>1</sup>	Total New Jobs Created With Extended Fiscal Relief <sup>1</sup>	Total New Wages from New Jobs With Extended Fiscal Relief (in millions of dollars) <sup>1</sup>
Alabama	\$1,015	50,275	\$1,839	58,076	\$2,124
Alaska	\$358	7,748	\$324	8,955	\$375
Arizona	\$1,888	78,527	\$3,059	89,782	\$3,498
Arkansas	\$795	48,807	\$1,610	57,061	\$1,882
California	\$17,299	314,809	\$14,515	350,399	\$16,156
Colorado	\$1,335	28,356	\$1,127	31,757	\$1,262
Connecticut	\$1,902	31,695	\$1,484	35,507	\$1,663
Delaware	\$395	5,907	\$249	6,604	\$278
Florida	\$5,561	173,697	\$6,474	195,702	\$7,294
Georgia	\$2,777	86,023	\$3,470	97,059	\$3,915
Hawaii	\$385	9,888	\$407	11,308	\$466
Idaho	\$306	15,543	\$520	17,866	\$597
Illinois	\$5,406	109,254	\$4,534	122,001	\$5,063
Indiana	\$1,926	66,409	\$2,406	75,092	\$2,721
Iowa	\$881	34,450	\$1,121	39,749	\$1,293
Kansas	\$759	25,112	\$838	28,316	\$945
Kentucky	\$1,230	55,774	\$1,966	65,744	\$2,318
Louisiana	\$1,163	57,668	\$1,995	68,557	\$2,372
Maine	\$751	30,530	\$1,025	36,415	\$1,223
Maryland	\$2,501	49,382	\$1,977	55,142	\$2,207
Massachusetts	\$4,652	79,252	\$3,585	88,694	\$4,013
Michigan	\$3,906	98,773	\$3,824	110,861	\$4,292
Minnesota	\$2,848	60,915	\$2,359	68,116	\$2,638
Mississippi	\$794	53,328	\$1,829	63,324	\$2,172
Missouri	\$2,370	71,538	\$2,613	81,930	\$2,992
Montana	\$165	9,445	\$296	11,499	\$360
Nebraska	\$616	19,492	\$653	22,196	\$744
Nevada	\$556	11,918	\$523	13,308	\$584
New Hampshire	\$504	9,047	\$357	10,089	\$398
New Jersey	\$3,901	65,965	\$3,062	73,852	\$3,429
New Mexico	\$654	40,071	\$1,375	48,350	\$1,660
New York	\$25,074	396,621	\$17,926	441,883	\$19,971
North Carolina	\$3,154	116,055	\$4,320	131,567	\$4,898
North Dakota	\$175	7,585	\$240	9,035	\$286
Ohio	\$5,022	160,618	\$5,789	180,997	\$6,524
Oklahoma	\$890	50,842	\$1,612	58,828	\$1,865
Oregon	\$1,158	34,775	\$1,332	39,314	\$1,506
Pennsylvania	\$7,146	175,063	\$6,859	201,088	\$7,878
Rhode Island	\$724	16,596	\$617	18,916	\$703
South Carolina	\$1,090	51,390	\$1,870	59,202	\$2,154
South Dakota	\$200	8,484	\$274	9,662	\$312
Tennessee	\$2,807	97,615	\$3,924	110,627	\$4,447
Texas	\$6,476	214,597	\$8,571	242,084	\$9,668
Utah	\$412	23,928	\$833	27,697	\$964
Vermont	\$345	10,333	\$352	12,287	\$418
Virginia	\$2,306	46,252	\$1,784	51,398	\$1,983
Washington	\$2,836	52,895	\$2,201	59,058	\$2,458
West Virginia	\$527	27,009	\$909	32,575	\$1,096
Wisconsin	\$1,992	59,747	\$2,145	67,118	\$2,409
Wyoming	\$162	4,275	\$144	5,184	\$174
<b>Total</b>	<b>\$132,097</b>	<b>3,354,278</b>	<b>\$133,119</b>	<b>3,801,831</b>	<b>\$150,649</b>
<b>Average</b>		<b>67,086</b>	<b>\$2,662</b>	<b>76,037</b>	<b>\$3,013</b>

<sup>1</sup> Total economic impact on jobs and wages in these columns may not equal the state Medicaid spending multiplied by the relevant multiplier due to rounding. In addition, totals may not sum due to rounding.



Table 3

**Economic Gains\* for Each \$1 Million Invested in State Medicaid Spending, FY2005 (Under current law and if fiscal relief is extended)**

State	Business Activity Gained for Each \$1 Million	Jobs Gained per \$1 Million Investment	Employee Wages Gained per \$1 Million Investment	Business Activity Gained per \$1 Million Investment With Extended Fiscal Relief	Jobs Gained Per \$1 Million Investment With Extended Fiscal Relief	Wages Gained Per \$1 Million Investment <sup>1</sup> With Extended Fiscal Relief
Alabama	\$4,877,000	49.52	\$1,811,000	\$5,634,000	57.20	\$2,092,000
Alaska	\$2,440,000	21.65	\$907,000	\$2,820,000	25.03	\$1,048,000
Arizona	\$4,254,000	41.59	\$1,620,000	\$4,864,000	47.55	\$1,852,000
Arkansas	\$5,483,000	61.40	\$2,025,000	\$6,410,000	71.78	\$2,367,000
California	\$2,290,000	18.20	\$839,000	\$2,549,000	20.26	\$934,000
Colorado	\$2,239,000	21.25	\$844,000	\$2,508,000	23.79	\$945,000
Connecticut	\$2,090,000	16.67	\$781,000	\$2,342,000	18.67	\$874,000
Delaware	\$1,919,000	14.94	\$630,000	\$2,146,000	16.70	\$704,000
Florida	\$3,030,000	31.23	\$1,164,000	\$3,414,000	35.19	\$1,311,000
Georgia	\$3,436,000	30.98	\$1,250,000	\$3,877,000	34.96	\$1,410,000
Hawaii	\$2,774,000	25.66	\$1,057,000	\$3,172,000	29.34	\$1,209,000
Idaho	\$4,410,000	50.87	\$1,701,000	\$5,070,000	58.48	\$1,955,000
Illinois	\$2,387,000	20.21	\$839,000	\$2,665,000	22.57	\$936,000
Indiana	\$3,454,000	34.49	\$1,250,000	\$3,906,000	39.00	\$1,413,000
Iowa	\$3,425,000	39.08	\$1,272,000	\$3,952,000	45.10	\$1,467,000
Kansas	\$3,151,000	33.06	\$1,104,000	\$3,553,000	37.28	\$1,244,000
Kentucky	\$4,495,000	45.35	\$1,599,000	\$5,298,000	53.46	\$1,885,000
Louisiana	\$4,672,000	49.60	\$1,716,000	\$5,555,000	58.96	\$2,040,000
Maine	\$3,572,000	40.64	\$1,365,000	\$4,261,000	48.48	\$1,628,000
Maryland	\$2,229,000	19.75	\$790,000	\$2,489,000	22.05	\$883,000
Massachusetts	\$2,160,000	17.04	\$771,000	\$2,417,000	19.07	\$863,000
Michigan	\$2,604,000	25.28	\$979,000	\$2,922,000	28.38	\$1,099,000
Minnesota	\$2,185,000	21.39	\$828,000	\$2,443,000	23.91	\$926,000
Mississippi	\$6,220,000	67.19	\$2,305,000	\$7,386,000	79.78	\$2,737,000
Missouri	\$3,387,000	30.19	\$1,103,000	\$3,879,000	34.58	\$1,263,000
Montana	\$4,716,000	57.11	\$1,790,000	\$5,741,000	69.53	\$2,180,000
Nebraska	\$2,890,000	31.65	\$1,061,000	\$3,291,000	36.04	\$1,208,000
Nevada	\$2,406,000	21.43	\$941,000	\$2,687,000	23.93	\$1,051,000
New Hampshire	\$2,007,000	17.94	\$708,000	\$2,238,000	20.01	\$790,000
New Jersey	\$2,257,000	16.91	\$785,000	\$2,527,000	18.93	\$879,000
New Mexico	\$5,567,000	61.30	\$2,104,000	\$6,717,000	73.97	\$2,539,000
New York	\$2,048,000	15.82	\$715,000	\$2,282,000	17.62	\$796,000
North Carolina	\$3,746,000	36.80	\$1,370,000	\$4,247,000	41.71	\$1,553,000
North Dakota	\$3,765,000	43.28	\$1,371,000	\$4,485,000	51.55	\$1,633,000
Ohio	\$3,179,000	31.99	\$1,153,000	\$3,582,000	36.04	\$1,299,000
Oklahoma	\$4,938,000	57.13	\$1,811,000	\$5,714,000	66.10	\$2,096,000
Oregon	\$3,120,000	30.02	\$1,150,000	\$3,527,000	33.94	\$1,300,000
Pennsylvania	\$2,738,000	24.50	\$960,000	\$3,145,000	28.14	\$1,103,000
Rhode Island	\$2,414,000	22.92	\$852,000	\$2,752,000	26.12	\$971,000
South Carolina	\$4,688,000	47.13	\$1,715,000	\$5,401,000	54.30	\$1,976,000
South Dakota	\$3,593,000	42.47	\$1,371,000	\$4,092,000	48.37	\$1,562,000
Tennessee	\$3,920,000	34.77	\$1,398,000	\$4,443,000	39.41	\$1,584,000
Texas	\$3,642,000	33.13	\$1,323,000	\$4,108,000	37.38	\$1,493,000
Utah	\$5,453,000	58.03	\$2,019,000	\$6,313,000	67.18	\$2,338,000
Vermont	\$2,742,000	29.94	\$1,019,000	\$3,260,000	35.60	\$1,212,000
Virginia	\$2,181,000	20.05	\$774,000	\$2,423,000	22.29	\$860,000
Washington	\$2,087,000	18.65	\$776,000	\$2,330,000	20.83	\$867,000
West Virginia	\$4,945,000	51.28	\$1,726,000	\$5,964,000	61.84	\$2,081,000
Wisconsin	\$2,789,000	29.99	\$1,076,000	\$3,133,000	33.69	\$1,209,000
Wyoming	\$2,285,000	26.33	\$885,000	\$2,771,000	31.93	\$1,073,000
<b>Average of 50 States</b>	<b>\$3,345,980</b>	<b>33.76</b>	<b>\$1,228,060</b>	<b>\$3,854,100</b>	<b>38.96</b>	<b>\$1,414,760</b>

\* Gains were calculated by employing economic impact multipliers that incorporate both the federal matching multiplier and the RIMS II economic output multiplier.

<sup>1</sup> "Business Activity Gained" predicts the total change in economic activity, measured in value of goods and services produced, per one million dollar change in state Medicaid spending.

## DISCUSSION

Without question, the foremost concern for any policy maker who faces tough choices about Medicaid spending should be the potential harm to people who rely on Medicaid. However, the impact on a state's economy is another important consideration.

### Medicaid: A State and Federal Partnership

The Medicaid program is a unique federal and state partnership. It gives states great flexibility to design their programs and, thus, to control state spending commitments. Every state Medicaid program must cover certain very low-income children, pregnant women, and some seniors and people with disabilities, and it must provide them with a defined set of benefits. However, above these minimum requirements, states have broad authority to expand Medicaid to more people and/or to cover more services. To entice states to cover more people and services, the federal government "matches" every dollar that a state invests in Medicaid. The matching rate varies from state to state, ranging from a low of \$1.00 in federal funds per state dollar to a high of \$3.36 for each state dollar in 2005. In that same year, Medicaid spending will total an estimated \$306 billion.<sup>1</sup> Of this amount, about \$132 billion will be state funds, and \$174 billion will be federal funds. In fact, *Medicaid is the source of 43 percent of the total federal grant dollars given to the states.*<sup>2</sup>

In this context of flexibility and federal matching funds, each state's policy makers make their own unique political calculations about who will be covered, what kinds of health care services will be provided, how much will be spent, and where Medicaid should rank among competing demands for limited state dollars. This federal-state partnership, *with the guarantee of unlimited federal matching funds* for approved state Medicaid expenditures, is integral to the ability of states to provide health care to their most vulnerable residents.

### Medicaid: Good State Economic Policy

If *new* business activity, jobs, and wages are to be generated, money must flow into the state from outside. For example, visits by out-of-state tourists or the sale of manufacturing products to purchasers outside the state bring new spending into the state, contributing to economic growth.

The purchase of health care services through Medicaid brings new money into the state in the form of federal matching dollars. This injection of new dollars has a positive and measurable impact on state business activity, available jobs, and aggregate state income.

Medicaid spending adds to state economies in both direct and indirect ways. Medicaid payments to hospitals, nursing homes, and other health-related businesses have a direct impact, paying for goods and services and supporting jobs in the state. These dollars trigger successive rounds of earnings and purchases as they continue to circulate through the economy. They create income and jobs for individuals not directly, or even indirectly, associated with health care. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of auto dealerships, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. This ripple effect of spending is called the “economic multiplier effect.”

Medicaid spending also provides a uniquely positive, counter-cyclical stimulus to a state’s economy during a recession or downturn. State Medicaid spending has a greater economic impact than other state spending. Increases in state government spending on most programs do not have the same multiplier effect as Medicaid spending increases because most state government expenditures simply reallocate spending from one sector of the economy to another. When a state increases its spending on Medicaid, by contrast, new federal matching dollars are brought into the state’s economy.

The magnitude of Medicaid’s unique positive impact varies from state to state based on *both* the size of the state’s federal matching rate and the economic conditions in the state. The specific economic conditions in each state are captured by the RIMS II input-output economic model. The RIMS II model is built on Department of Commerce data that show the relationships among nearly 500 industries in the economy. These relationships are adjusted and updated to reflect a state economy’s current industrial structure, trading patterns, and wage, salary, and personal income data.

Tables 1 and 2 show the positive impact of estimated state Medicaid spending in fiscal year 2005 on each state’s economy. These tables show the

significant return—in increased business activity, new jobs, and additional wages—states will gain from their investment of dollars in the Medicaid program. They also show the increased economic gain states would receive if Congress were to extend the Medicaid fiscal relief provisions of Title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003 through September 30, 2005, which is the end of federal fiscal year 2005 (see next page for more detail). Table 3 presents the most recent Medicaid economic impact multipliers available (based on federal fiscal year 2005), which state policy makers can use to calculate the economic impact of state Medicaid spending decisions. These multipliers can be applied to changes in state Medicaid spending to calculate the economic impact in fiscal year 2005.

By way of illustration, Table 3 can be used to estimate the impact of a hypothetical reduction in Georgia state Medicaid spending on the overall Georgia economy. In fiscal year 2005, Georgia will invest an estimated \$3 billion in Medicaid. If Georgia were to reduce its spending on Medicaid by only 5 percent—a \$150 million cut—the losses to the Georgia economy can be calculated using Table 3. Georgia would lose:

- more than \$515 million in state business activity ( $\$150 \times \$3,436,000$ ),
- 4,647 jobs ( $\$150 \times 30.98$ ), and
- \$188 million in wages paid to workers in Georgia ( $\$150 \times \$1,250,000$ ).

Some states are considering state Medicaid spending reductions that are greater than the 5 percent in the above hypothetical example. In addition, the impact of other state cuts may be greater per dollar than in Georgia. In fact, 20 states have Medicaid spending multiplier effects greater than that in Georgia. In other words, in 20 states, every dollar change in state Medicaid spending would have an even greater economic impact than that in Georgia.

With Table 3, state policy makers and other policy stakeholders can estimate the economic impact—on business activity, jobs, and wages—of proposed Medicaid spending decisions in any state. Less quantifiable, of course, is the impact on the lives of state residents who rely on Medicaid as their only source of health care.

### Medicaid: Federal Fiscal Relief Funds Spur Economic Recovery

In May 2003, Congress enacted a \$20 billion fiscal relief package as part of the Jobs and Growth Tax Relief Reconciliation Act of 2003. These funds were intended to help reduce the stress on state budgets during the fiscal crisis that has gripped them for the past three years. The package included an estimated \$10 billion specifically aimed at helping states prevent cuts to their Medicaid programs in 2003 and 2004. The 15-month plan increased the federal share of Medicaid expenditures by 2.95 percentage points in every state.<sup>3</sup> The fiscal relief package was retroactive to April 1, 2003 and is scheduled to end on June 30, 2004.

This fiscal relief was helpful to states, both by mitigating the cuts they made to the Medicaid program and by stimulating state economies. A Families USA survey of state Medicaid agencies found that the additional federal Medicaid matching funds provided in the fiscal relief package reduced budget shortfalls and helped prevent Medicaid reductions.<sup>4</sup> Without this federal fiscal relief, state Medicaid programs would have been under significantly more budgetary pressure and would likely have seen even more mid-year cuts than actually took place. Moreover, to be eligible for the temporary fiscal relief, states could not reduce eligibility for Medicaid after September 30, 2003. To date, no state has risked losing fiscal relief funds by reducing eligibility for Medicaid.<sup>5</sup>

Without Congressional action, the temporary federal fiscal relief will end on June 30, 2004, reducing the share of Medicaid program costs paid by the federal government and increasing the amount of state resources required to maintain the programs. The demand for public health insurance has only grown in the last year, but states will have fewer resources to devote to Medicaid. Moreover, early indications of economic recovery at the state level need to be reinforced—rather than undermined—by federal policy. Tables 1 and 2 show the increased value in economic activity, jobs, and wages that would be generated if Congress were to extend the temporary Medicaid fiscal relief through September 30, 2005.<sup>6</sup> As the expiration of last year's fiscal relief package approaches, Congress should understand that

the premature loss of Medicaid fiscal relief not only will affect the decisions state policy makers will have to make regarding Medicaid funding for fiscal year 2005, but also will hinder each state's economic recovery.

### **Medicaid: A Health Care Safety Net for Millions of People**

- ✓ Medicaid helped pay for the health care of an estimated 47 million in 2002 and an estimated 51 million in 2003—**one in six Americans**.
- ✓ Medicaid provides health coverage to more than one-fifth of the nation's children (25 million in 2002) and is the source of health coverage for more than 40 percent of low-income children (in families with incomes below \$31,340 for a family of three).
- ✓ Medicaid is an important source of financial help for over 6 million Medicare beneficiaries living in poverty—paying their Medicare Part B premiums and the costs of other essential services not provided by Medicare, including prescription drugs.
- ✓ Medicaid provides health insurance coverage to one in five noninstitutionalized, non-elderly people who have specific, chronic disabilities—approximately 8 million people. Medicaid assists seven out of 10 poor children with chronic disabilities and 41 percent of poor, working-age adults with disabilities.
- ✓ Medicaid is the nation's largest single purchaser of nursing home care. Medicaid pays for about half of all nursing home care in this country.
- ✓ Although seniors and people with disabilities comprise one-quarter of Medicaid beneficiaries, because they need more expensive care, they account for two-thirds of total Medicaid spending.

**Sources:** Robert J. Mills, *Health Insurance Coverage: 2002* (Washington: U. S. Census Bureau, September 2003); The Kaiser Commission on Medicaid and the Uninsured, fact sheets on Medicaid available online at [www.kff.org](http://www.kff.org) (visited on April 13, 2004); American Academy of Pediatrics Medicaid Fact Sheet, available online at [www.aap.org](http://www.aap.org) (visited on April 13, 2004).

## CONCLUSION

Medicaid provides a vital health care safety net in every state. It is a life-line to health care for children, people with disabilities or chronic illness, and low-income elderly people. Medicaid is the only source of financial help for millions of families struggling to pay for nursing home or other long-term care services for a parent or family member. Every Medicaid spending decision made by state policy makers affects people in very real, and often irrevocable, ways. At the same time, the economic downturn and state budget pressures have forced state policy makers to confront hard choices about state spending priorities.

As state budget options are weighed and balanced, the equation should include recognition of the economic benefit of using state spending on Medicaid to pull in new federal dollars. These new dollars are a powerful stimulus to state economies. The federal dollars that flow into a state to match state Medicaid spending generate new business activity, increase output of goods and services, create new jobs, and increase aggregate state income. In turn, these positive effects increase state revenues, which can then support further state spending.

These positive effects are even greater when the federal government provides additional federal funds for each dollar spent by states. If Congress extends the temporary federal fiscal relief past the June 30, 2004 expiration, the additional federal funds provided will help states struggling to cope with increasing health care costs as they emerge from the economic crisis that has gripped them for the past three years.

Thus, Medicaid spending is good medicine—both for the health of state residents and for ailing state economies.

## ENDNOTES

<sup>1</sup> U.S. Department of Health and Human Services, CMS 37 summary table of Medicaid and SCHIP budget estimates, February 2004 submission. These figures do not include estimated expenditures for DC, or the U.S. territories, and they do not include expenditures for the Medicaid Disproportionate Share Hospital (DSH) program.

<sup>2</sup> National Association of State Budget Officers, *2002 State Expenditure Report* (Washington: National Association of State Budget Officers, November 2003).

<sup>3</sup> In addition to increasing the federal Medicaid match rate by 2.95 percentage points, the legislation also held states “harmless” for annual reductions in the regular federal Medicaid match rate during the life of the plan, so that if a state’s match rate for 2002 was higher than their 2003 match rate, it retained the higher 2002 match rate in 2003, plus 2.95 percentage points. The same principle applied for 2004: If a state’s match rate for 2003 was lower than its match rate for 2004, it retained the higher 2003 match rate in 2004, plus the 2.95 percentage points.

<sup>4</sup> On file at Families USA.

<sup>5</sup> *Financing the Medicaid Program: The Impact of Federal Fiscal Relief* (Washington: Kaiser Commission on Medicaid and the Uninsured, April 2004).

<sup>6</sup> This analysis assumes that states would spend the same amount of their own funds as they would without an extension of Medicaid fiscal relief.



**APPENDIX I:  
METHODOLOGY**



## METHODOLOGY

In order to measure and quantify the role of Medicaid in state economies, Families USA retained Richard Clinch, Director of Economic Research at the Jacob France Institute of the Merrick School of Business at the University of Baltimore, to conduct an economic input-output analysis of the impact of state-level cuts in the Medicaid program on the economies of all 50 states.

This economic input-output analysis is based on the most recently updated RIMS II economic input-output model created by the U.S. Department of Commerce, Bureau of Economic Analysis (March 2004). The RIMS II model is built on Department of Commerce data that show the relationships among nearly 500 industries in the economy. These relationships are adjusted and updated to reflect a state economy's current industrial structure; trading patterns; and wage, salary, and personal income data.

Events or programs have an economic impact by attracting new spending that would otherwise not exist in a state. A new source of spending from outside a state creates a larger impact on a state economy than the amount of new spending alone through what economists call "multiplier effects." An economic multiplier quantifies the total impact on a state economy of successive rounds of spending that occur as the new spending is earned by state businesses and residents who then spend these earnings on purchases from other state firms or residents who in turn make other purchases, creating successive rounds of earnings and purchases. However, these successive rounds of spending do not continue endlessly because, in each round of spending, a portion of purchases is made outside the state. These multiplier effects are measured by the RIMS II economic model. The RIMS II model allows economists to estimate three economic impacts:

- **Economic output**, or the value of goods and services produced in the state;
- **Employment**, or the number of jobs in the state; and
- **Employee earnings**, or the wage and salary income associated with the affected jobs.

In fiscal year 2005, the federal match for Medicaid assistance will range from a low of 50 percent (in 12 states) to a high of 77.1 percent (in Mississippi). This federal spending represents a new source of funding to a state economy because it supports health care expenditures that would otherwise not occur or that would need to be taken from other sources of spending. Each state determines the total level of federal Medicaid matching funds that will flow into the state: When a state increases its Medicaid spending, it gains federal matching dollars; when it decreases Medicaid spending, it loses matching dollars.

Because the level of state Medicaid spending determines the amount of this federal support, changes in state Medicaid budgets can have a significant impact on the overall level of health care spending and related health care sector employment and earnings. Furthermore, these changes in spending influence the broader economy through the multiplier effects discussed above.

Relative to other kinds of state spending, spending on Medicaid is especially beneficial to the state's economy. This economic advantage derives from the federal match. Medicaid has a *net* positive economic impact when compared to state spending on other programs because it pulls a large infusion of new dollars into the economy from outside the state. The magnitude of this unique net positive impact on a state's economy differs from state to state based on both the size of the state's federal matching rate and the state's economic multipliers (which reflect economic conditions in the state).

This report analyzes state Medicaid spending and its economic impact in each state for 2005. The analysis uses two different federal match rates:

- First, the report looks at the economic impact of estimated state Medicaid spending in fiscal year 2005, the fiscal year for which state policy makers are currently budgeting, as well as the relevant economic multipliers needed to predict the economic impact of potential state Medicaid spending changes in fiscal year 2005.
- Second, the report looks at the economic impact states could gain in fiscal year 2005 if Congress were to extend Medicaid fiscal relief (described below).

The economic impact of estimated state Medicaid spending in fiscal year 2005 and the economic impact multipliers for fiscal year 2005 are based on *federal* fiscal year 2005. All references in the report to fiscal year 2005 refer to the federal fiscal year that begins on October 1 of the preceding year—in this case, October 1, 2004. State fiscal years vary. Forty-six states begin their fiscal years in July and end them in June. Alabama and Michigan have October-to-September fiscal years; New York has an April-to-March fiscal year; and Texas has a September-to-August fiscal year. Additionally, 20 states operate on a biennial budget cycle.

The fiscal year 2005 economic impact multipliers present in this report can be applied to changes in state Medicaid spending to calculate the economic impact in any state's 2005 fiscal year. These multipliers can also be used to estimate the economic impact of changes in state fiscal years 2006 and 2007, since the federal matching rate and the economic conditions of the state do not usually change dramatically over several months or even over a period of one or two years.

Although an analysis of the District of Columbia was also performed, the data are not presented in the report. As an economic system or unit, the District of Columbia is more like a city than a state. When new dollars flow into the District of Columbia and generate successive rounds of spending, a relatively high portion of purchases are made from outside the city (in the Maryland and Virginia suburbs). Therefore, comparisons of the economic multipliers in the District of Columbia to state economic multipliers are inappropriate. Data from the analysis of the District of Columbia are available from Families USA upon request.

### **Analysis 1:**

#### **The Economic Impact of Estimated Fiscal Year 2005 State Medicaid Spending**

The first analysis measures the economic impact of state Medicaid spending in fiscal year 2005 for the 50 states. Fiscal year 2005 data on estimated state and federal Medicaid expenditures were obtained from the CMS-37 reports collected by the Centers for Medicare and Medicaid Services, U. S. Department of Health and Human Services in February 2004. The economic impact multipliers for state Medicaid spending were derived in two steps:

1. Using CMS-37 report expenditure data, the first step was the development of a state-specific federal matching multiplier that reflected the total amount of actual federal matching funds received by the state for each dollar of state funds spent. Actual federal matching rates were calculated by dividing the level of federal Medicaid assistance *and* administrative payments by the level of state Medicaid assistance *and* administrative spending to derive the average number of federal matching dollars generated for each dollar spent by the state government. The state-specific federal matching multiplier is then derived using the following formula  $(1 / (1 - \text{Federal Match Percentage}) - 1)$ . This multiplier measures the estimated federal dollars that will flow into the state for every state dollar spent on Medicaid in fiscal year 2005.
2. Then, for each state, a total economic impact multiplier for Medicaid spending is derived by combining the state-specific federal matching multiplier with the appropriate state-specific RIMS II economic multipliers. The RIMS II multipliers vary according to how the dollars will be spent (differentiating between administrative spending and health care services spending) and according to a variety of measures of state economic structure and conditions.

Table 1 shows the impact of state Medicaid spending on total state economic output. Table 2 shows the impact of state Medicaid spending on jobs and the wages associated with these jobs. Table 3 shows the potential impact of a \$1 million change in state Medicaid spending on state economic output, jobs, and the wages associated with these jobs.

### **Analysis 2:**

#### **The Fiscal Year 2005 Economic Impact Multipliers for State Medicaid Spending with an Extension of the Medicaid Federal Match Rate Provisions of the Jobs and Growth Tax Relief Reconciliation Act of 2003**

The second analysis measures the economic impact on states of the loss of Medicaid fiscal relief provisions—or the benefit of extending the fiscal relief provisions—of the Jobs and Growth Tax Relief Reconciliation Act of 2003. In order to analyze the economic impact that Medicaid fiscal relief

could have in 2005, economic impact multipliers for each dollar of state Medicaid spending were developed based on the provisions of Title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003.<sup>1</sup> These multipliers measure the change in economic activity based on February 2004 estimates of fiscal year 2005 spending reported to CMS and per-dollar cut in state Medicaid spending. The economic impact multiplier for this analysis was derived in a two-step process similar to that used for the first analysis.

1. The first step was the development of a federal matching multiplier for the total amount of federal matching funds for each dollar of state funds. Again, this was derived using the basic formula  $(1 / (1 - \text{Federal Match Percentage}) - 1)$ . The federal match percentage used in this formula for medical assistance payments was generated using the formula in Title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003. This formula first gives states the higher of their fiscal year 2004 or 2005 federal Medicaid match rates for medical assistance payments as determined by the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services.<sup>2</sup> Then, that figure is increased by 2.95 percentage points. The federal match percentage used in the formula for each state's administrative costs was the federal match rate reported by the state on its Form CMS-37 report in February 2004. The final federal matching multiplier is a weighted average of the federal matching multiplier for medical assistance payments and the state-specific administrative matching multiplier. The weighting of medical assistance to administrative expenditures is based on the allocation to each category in fiscal year 2005 for the relevant state.
2. The second step was the derivation of the economic impact multiplier for state Medicaid expenditures by multiplying the state federal matching multiplier by the relevant economic impact (output, employment, and earnings) from the RIMS II model. The resulting multiplier yields the total economic impact per dollar change in state Medicaid spending. For economic output and earnings impact, the multiplier

measures the change in state economic output and earnings per \$1 change in state spending. The state employment multiplier is expressed in terms of jobs per \$1 million change in state Medicaid spending.

The Medicaid economic impact multipliers for fiscal year 2005 if the Medicaid fiscal relief provisions of the Jobs and Growth Tax Relief Reconciliation Act of 2003 were extended are presented in Tables 1 through 3.

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<sup>1</sup> *Jobs and Growth Tax Relief Reconciliation Act of 2003*, Public Law 108-27, Title IV, May 28, 2003.

<sup>2</sup> Federal Medical Assistance Percentages can be found on the Web site of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, available online at ([www.aspe.hhs.gov/health/fmap.htm](http://www.aspe.hhs.gov/health/fmap.htm)).



**APPENDIX II:  
FMAP TABLES**

## What is the Federal Share of Medicaid and the State Children's Health Insurance Program (SCHIP) in My State?

State	2004			2005	
	Original Medicaid	Enhanced Medicaid*	SCHIP	Medicaid	SCHIP
Alabama	70.8%	73.7%	79.5%	70.8%	79.6%
Alaska	58.4%	61.3%	70.9%	57.6%	70.3%
Arizona	67.3%	70.2%	77.1%	67.5%	77.2%
Arkansas	74.7%	77.6%	82.3%	74.8%	82.3%
California	50.0%	53.0%	65.0%	50.0%	65.0%
Colorado	50.0%	53.0%	65.0%	50.0%	65.0%
Connecticut	50.0%	53.0%	65.0%	50.0%	65.0%
Delaware	50.0%	53.0%	65.0%	50.4%	65.3%
District of Columbia	70.0%	73.0%	79.0%	70.0%	79.0%
Florida	58.9%	61.9%	71.3%	58.9%	71.2%
Georgia	59.6%	62.6%	71.7%	60.4%	72.3%
Hawaii	58.9%	61.9%	71.2%	58.5%	70.9%
Idaho	70.5%	73.9%	79.3%	70.6%	79.4%
Illinois	50.0%	53.0%	65.0%	50.0%	65.0%
Indiana	62.3%	65.3%	73.6%	62.8%	74.0%
Iowa	63.9%	66.9%	74.8%	63.6%	74.5%
Kansas	60.8%	63.8%	72.6%	61.0%	72.7%
Kentucky	70.1%	73.0%	79.1%	69.6%	78.7%
Louisiana	71.6%	74.6%	80.1%	71.0%	79.7%
Maine	66.0%	69.2%	76.2%	64.9%	75.4%
Maryland	50.0%	53.0%	65.0%	50.0%	65.0%
Massachusetts	50.0%	53.0%	65.0%	50.0%	65.0%
Michigan	55.9%	58.8%	69.1%	56.7%	69.7%
Minnesota	50.0%	53.0%	65.0%	50.0%	65.0%
Mississippi	77.1%	80.0%	84.0%	77.1%	84.0%
Missouri	61.5%	64.4%	73.0%	61.2%	72.8%
Montana	72.9%	75.9%	81.0%	71.9%	80.3%
Nebraska	59.9%	62.8%	71.9%	59.6%	71.8%
Nevada	54.9%	57.9%	68.5%	55.9%	69.1%
New Hampshire	50.0%	53.0%	65.0%	50.0%	65.0%
New Jersey	50.0%	53.0%	65.0%	50.0%	65.0%
New Mexico	74.9%	77.8%	82.4%	74.3%	82.0%
New York	50.0%	53.0%	65.0%	50.0%	65.0%
North Carolina	62.9%	65.8%	74.0%	63.6%	74.5%
North Dakota	68.3%	71.3%	77.8%	67.5%	77.2%
Ohio	59.2%	62.2%	71.5%	59.7%	71.8%
Oklahoma	70.2%	73.5%	79.2%	70.2%	79.1%
Oregon	60.8%	63.8%	72.6%	61.1%	72.8%
Pennsylvania	54.8%	57.7%	68.3%	53.8%	67.7%
Rhode Island	56.0%	59.0%	69.2%	55.4%	68.8%
South Carolina	69.9%	72.8%	78.9%	69.9%	78.9%
South Dakota	65.7%	68.6%	76.0%	66.0%	76.2%
Tennessee	64.4%	67.5%	75.1%	64.8%	75.4%
Texas	60.2%	63.2%	72.2%	60.9%	72.6%
Utah	71.7%	74.7%	80.2%	72.1%	80.5%
Vermont	61.3%	65.4%	72.9%	60.1%	72.1%
Virginia	50.0%	53.5%	65.0%	50.0%	65.0%
Washington	50.0%	53.0%	65.0%	50.0%	65.0%
West Virginia	75.2%	78.1%	82.6%	74.7%	82.3%
Wisconsin	58.4%	61.4%	70.9%	58.3%	70.8%
Wyoming	59.8%	64.3%	71.8%	57.9%	70.5%

\* The Enhanced Medicaid match rate is based on a temporary increase per the "Jobs and Growth Tax Reconciliation Act of 2003." States will receive the Enhanced Medicaid match rate through June 30, 2004. The federal share of Medicaid will revert to the original FY 2004 match rate on July 1, 2004. The FY 2005 match rate will be available October 1, 2004 through September 30, 2005.

Source: *Federal Register*, November 15, 2002, Volume 67, Number 221, pp. 69223-69225. Available online at ([aspe.hhs.gov/health/fmap04.htm](http://aspe.hhs.gov/health/fmap04.htm)). *Federal Register*, Vol. 68, No. 232 pp. 67676-67678. Available online at ([aspe.hhs.gov/health/fmap05.htm](http://aspe.hhs.gov/health/fmap05.htm)).

## How Much Does My State Get from the Federal Government When It Spends A Dollar on Medicaid and the State Children's Health Insurance Program (SCHIP)?

State	2004				2005	
	Original Medicaid	Enhanced Medicaid*	Difference	SCHIP	Medicaid	SCHIP
Alabama	\$2.42	\$2.80	\$0.38	\$3.89	\$2.43	\$3.90
Alaska	\$1.40	\$1.59	\$0.18	\$2.43	\$1.36	\$2.37
Arizona	\$2.05	\$2.36	\$0.30	\$3.36	\$2.07	\$3.39
Arkansas	\$2.95	\$3.47	\$0.52	\$4.64	\$2.96	\$4.66
California	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
Colorado	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
Connecticut	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
Delaware	\$1.00	\$1.13	\$0.13	\$1.86	\$1.02	\$1.88
District of Columbia	\$2.33	\$2.70	\$0.36	\$3.76	\$2.33	\$3.76
Florida	\$1.43	\$1.62	\$0.19	\$2.48	\$1.43	\$2.48
Georgia	\$1.47	\$1.67	\$0.20	\$2.53	\$1.53	\$2.61
Hawaii	\$1.43	\$1.62	\$0.19	\$2.48	\$1.41	\$2.44
Idaho	\$2.39	\$2.83	\$0.45	\$3.84	\$2.40	\$3.86
Illinois	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
Indiana	\$1.65	\$1.88	\$0.23	\$2.79	\$1.69	\$2.84
Iowa	\$1.77	\$2.02	\$0.25	\$2.96	\$1.74	\$2.92
Kansas	\$1.55	\$1.76	\$0.21	\$2.65	\$1.56	\$2.66
Kentucky	\$2.34	\$2.71	\$0.37	\$3.78	\$2.29	\$3.70
Louisiana	\$2.52	\$2.93	\$0.41	\$4.04	\$2.45	\$3.93
Maine	\$1.94	\$2.24	\$0.30	\$3.20	\$1.85	\$3.07
Maryland	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
Massachusetts	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
Michigan	\$1.27	\$1.43	\$0.16	\$2.24	\$1.31	\$2.30
Minnesota	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
Mississippi	\$3.36	\$4.01	\$0.64	\$5.23	\$3.36	\$5.23
Missouri	\$1.60	\$1.81	\$0.22	\$2.71	\$1.57	\$2.68
Montana	\$2.68	\$3.15	\$0.47	\$4.26	\$2.56	\$4.08
Nebraska	\$1.49	\$1.69	\$0.20	\$2.56	\$1.48	\$2.54
Nevada	\$1.22	\$1.37	\$0.16	\$2.17	\$1.27	\$2.24
New Hampshire	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
New Jersey	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
New Mexico	\$2.98	\$3.50	\$0.53	\$4.68	\$2.89	\$4.56
New York	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
North Carolina	\$1.69	\$1.92	\$0.23	\$2.85	\$1.75	\$2.93
North Dakota	\$2.16	\$2.49	\$0.33	\$3.51	\$2.08	\$3.39
Ohio	\$1.45	\$1.64	\$0.19	\$2.50	\$1.48	\$2.54
Oklahoma	\$2.36	\$2.78	\$0.41	\$3.80	\$2.35	\$3.79
Oregon	\$1.55	\$1.76	\$0.21	\$2.65	\$1.57	\$2.67
Pennsylvania	\$1.21	\$1.36	\$0.15	\$2.16	\$1.17	\$2.10
Rhode Island	\$1.27	\$1.44	\$0.16	\$2.25	\$1.24	\$2.20
South Carolina	\$2.32	\$2.68	\$0.36	\$3.74	\$2.32	\$3.74
South Dakota	\$1.91	\$2.19	\$0.27	\$3.16	\$1.94	\$3.21
Tennessee	\$1.81	\$2.08	\$0.27	\$3.01	\$1.84	\$3.06
Texas	\$1.51	\$1.72	\$0.20	\$2.59	\$1.56	\$2.65
Utah	\$2.54	\$2.95	\$0.41	\$4.05	\$2.59	\$4.13
Vermont	\$1.59	\$1.89	\$0.30	\$2.70	\$1.51	\$2.58
Virginia	\$1.00	\$1.15	\$0.15	\$1.86	\$1.00	\$1.86
Washington	\$1.00	\$1.13	\$0.13	\$1.86	\$1.00	\$1.86
West Virginia	\$3.03	\$3.57	\$0.54	\$4.76	\$2.94	\$4.64
Wisconsin	\$1.40	\$1.59	\$0.18	\$2.44	\$1.40	\$2.43
Wyoming	\$1.49	\$1.80	\$0.31	\$2.55	\$1.38	\$2.39

\* The Enhanced Medicaid match rate is based on a temporary increase per the "Jobs and Growth Tax Reconciliation Act of 2003." States will receive the Enhanced Medicaid match rate through June 30, 2004. The federal share of Medicaid will revert to the original FY 2004 match rate on July 1, 2004. The FY 2005 will be available October 1, 2004 through September 2005.

Source: Calculations by Families USA.



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