
Medicaid:

Good Medicine For State Economies

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Medicaid: Good Medicine for State Economies

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INTRODUCTION

Nationally, Medicaid helped pay for essential health care services for an estimated 47 million people in 2002. However, as state policy makers struggle to balance strained budgets during the current economic downturn, Medicaid has become a prime target for spending cuts. In 2002, 45 states took actions to limit their Medicaid spending. In 2003, the budget crisis in the states will be more severe as state revenue growth continues to decline.

Medicaid is a target for spending cuts because it is the second largest item in most states' budgets, after elementary and secondary education. Indeed, the Medicaid program reaches people of all ages and from 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 elderly and disabled people, 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 also is 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. Clearly, any reduction in state Medicaid spending will jeopardize coverage for people who depend on these health care services.

Less understood 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 the auto dealership, 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 varies from state to state, depending on how the dollars will be 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.

To determine the aggregate impact of Medicaid spending on each state's economy, Families USA used the RIMS II input-output economic model created by the U. S. Department of Commerce, Bureau of Economic Analysis. 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 state Medicaid spending and its economic impact in each state for two different years. First, we looked at the economic impact of actual state Medicaid spending in fiscal year 2001,¹ the most recent year for which expenditure data are available. Second, we provide readers with updated economic impact multipliers that can be used to predict the economic impact of potential state Medicaid spending increases or cuts in fiscal year 2003.

KEY FINDINGS

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

- Business Activity (Output of Goods and Services)
 - In fiscal year 2001, the 50 states spent a combined total of nearly \$97.7 billion on Medicaid. This investment in Medicaid generated an almost three-fold return in state economic benefit—\$279.3 billion in increased state-level output of goods and services from increased business activity (see Table 1).
 - In fiscal year 2001, the rate of return per dollar invested in Medicaid ranged from \$6.34 in Mississippi to \$1.95 in Nevada.
 - The 10 states with the highest rate of return for every state dollar spent on Medicaid in fiscal year 2001 were Mississippi (\$6.34 in new state business activity per dollar of Medicaid spending), New Mexico (\$5.76), Oklahoma (\$5.46), Utah (\$5.35), West Virginia (\$5.25), Montana (\$5.14), Arkansas (\$5.11), South Carolina (\$4.97); Alabama (\$4.82), and Kentucky (\$4.71).

- In the remaining 40 states, a state dollar invested in Medicaid generated anywhere from \$1.95 to \$4.71 in increased state business activity.
 - Of these 40 states, 10 realized a return of at least \$3.50 in increased state business activity for every dollar the state invested in Medicaid.
 - Another 10 of these 40 states realized a return of at least \$3.00 in increased state business activity for every dollar the state invested in Medicaid.
- In fiscal year 2001, the average value of increased business activity generated from state Medicaid spending was nearly \$6 billion per state. The total value of increased business activity generated by state Medicaid spending ranged from \$33.9 billion in New York (from \$16.1 billion in state Medicaid spending) to \$298 million in Wyoming (from \$92 million in state Medicaid spending).
- The 10 states with the largest increase in business activity attributed to state Medicaid spending were New York (\$33.9 billion in increased state business activity), California (\$31.5 billion), Texas (\$17.8 billion), Pennsylvania (\$14.0 billion), Ohio (\$11.5 billion), Florida (\$11.1 billion), Illinois (\$10.2 billion), Michigan (\$8.9 billion), North Carolina (\$8.8 billion), and New Jersey (\$8.4 billion).
- Even in the two states with the smallest Medicaid budgets, North Dakota and Wyoming, the new business activity attributed to Medicaid spending was valued at \$555 million and \$298 million, respectively—4.3 times North Dakota’s Medicaid investment of \$130 million and 3.2 times Wyoming’s Medicaid investment of \$92 million.
- Jobs and Wages
 - Fiscal year 2001 state Medicaid spending generated almost 3 million jobs with wages in excess of \$100 billion in the 50 states (see Table 2). These jobs included Medicaid personnel, other employment in the health care sector, and jobs generated as the Medicaid dollars circulated through *different* sectors of the economy.

- Jobs
 - The average number of jobs generated by state Medicaid spending was 58,785 per state. The number of jobs generated by state Medicaid spending ranged from 300,352 in New York to 3,949 in Wyoming.
 - The 10 states with the largest number of jobs generated by state Medicaid spending were New York (300,352), California (291,439), Texas (187,901), Pennsylvania (143,110), Florida (132,215), Ohio (132,028), North Carolina (100,353), Michigan (98,754), Illinois (98,435), and Tennessee (81,675).
- Wages
 - The average increase in employee wages attributable to state Medicaid spending was \$2 billion per state. The increase in employee wages attributable to state Medicaid spending ranged from \$11.7 billion in New York to \$114 million in Wyoming.
 - The 10 states with the largest increase in wages attributable to state Medicaid spending were New York (\$11.7 billion), California (\$11.4 billion), Texas (\$6.5 billion), Pennsylvania (\$4.9 billion), Florida (\$4.3 billion), Ohio (\$4.1 billion), Illinois (\$3.6 billion), Michigan (\$3.3 billion), North Carolina (\$3.2 billion), and New Jersey (\$2.9 billion).
 - Even in the two states with the smallest Medicaid budgets, North Dakota and Wyoming, Medicaid spending generated significant numbers of jobs and corresponding wages: 7,248 jobs paying \$200 million in wages in North Dakota and 3,949 jobs paying \$114 million in wages in Wyoming.

The Economic Impact of a Change in State Medicaid Spending in Fiscal Year 2003 Will Be Significant and Predictable

In fiscal year 2003, the economic impact on business activity, jobs, and wages of state Medicaid spending will be comparable, but not identical, to the impact in fiscal year 2001 (see Table 3). The changes in impact from fiscal year 2001 to fiscal year 2003 are due to both changes in the federal-to-state Medicaid matching rates and changes in the economic factors and conditions in play in each state.

- In fiscal year 2003, every million dollars a state invests in Medicaid will generate, on average, \$3.4 million in new state business activity. The rate of return on the one million dollar investment will range from \$6.25 million in Mississippi to \$1.96 million in Delaware.
- The 10 states that will have the highest rate of return in new state business activity per million dollars of state Medicaid spending in fiscal year 2003 are Mississippi (\$6.25 million), New Mexico (\$5.72 million), Arkansas (\$5.41 million), Utah (\$5.27 million), West Virginia (\$5.16 million), Oklahoma (\$4.98 million), Alabama (\$4.93 million), Montana (\$4.90 million), Louisiana (\$4.87 million), and South Carolina (\$4.78 million).
 - Of the remaining 40 states, nine will realize a return of at least \$3.50 million in increased state business activity for every million state dollars invested in Medicaid.
 - Another nine of these 40 states will realize a return of at least \$3 million in increased state business activity for every million state dollars invested in Medicaid.
- The 10 states that will have the largest number of new jobs generated per one million dollars of state Medicaid spending are Mississippi (72), New Mexico (67), Arkansas (65), Montana (64), Oklahoma (62), Utah (60), West Virginia (57), Idaho (56), Louisiana (55), and Alabama (55).
- The 10 states that will have the largest amount of new wages per one million dollars of state Medicaid spending are Mississippi (\$2.28 million), New Mexico (\$2.14 million), Arkansas (\$1.98 million), Utah (\$1.92 million), Alabama (\$1.83 million), Montana (\$1.83 million), Oklahoma (\$1.81 million), Louisiana (\$1.77 million), West Virginia (\$1.77 million), and Idaho (\$1.74 million).

Table 1

Return on State Investment in Medicaid: Economic Benefits* to State Economy, FY2001

State	State Medicaid Spending (in millions of dollars)	Business Activity Multiplier (Per \$1 change in state Medicaid spending) ¹	New Business Activity (in millions of dollars) ²
Alabama	\$ 907	4.82	\$ 4,373
Alaska	211	3.57	755
Arizona	938	4.30	4,035
Arkansas	536	5.11	2,738
California	12,366	2.55	31,477
Colorado	1,114	2.30	2,561
Connecticut	1,682	2.11	3,545
Delaware	310	1.97	612
Florida	3,925	2.82	11,084
Georgia	2,147	3.37	7,243
Hawaii	308	2.41	743
Idaho	223	4.51	1,008
Illinois	4,173	2.45	10,223
Indiana	1,606	3.36	5,399
Iowa	656	3.35	2,199
Kansas	714	3.10	2,214
Kentucky	1,014	4.71	4,777
Louisiana	1,286	4.71	6,052
Maine	478	3.73	1,782
Maryland	1,737	2.27	3,939
Massachusetts	3,430	2.21	7,595
Michigan	3,463	2.58	8,948
Minnesota	1,976	2.32	4,582
Mississippi	595	6.34	3,774
Missouri	1,925	3.46	6,655
Montana	142	5.14	730
Nebraska	495	3.08	1,525
Nevada	351	1.95	683
New Hampshire	456	2.03	929
New Jersey	3,653	2.29	8,355
New Mexico	403	5.76	2,320
New York	16,134	2.10	33,880
North Carolina	2,426	3.64	8,842
North Dakota	130	4.29	555
Ohio	3,645	3.15	11,493
Oklahoma	620	5.46	3,385
Oregon	1,148	3.08	3,540
Pennsylvania	5,233	2.67	13,988
Rhode Island	577	2.29	1,320
South Carolina	927	4.97	4,608
South Dakota	143	4.49	640
Tennessee	2,062	3.87	7,986
Texas	4,848	3.67	17,811
Utah	266	5.35	1,423
Vermont	244	3.11	757
Virginia	1,500	2.50	3,754
Washington	2,333	2.14	5,004
West Virginia	412	5.25	2,163
Wisconsin	1,704	2.93	4,986
Wyoming	92	3.25	298
Total	\$ 97,663		\$ 279,288

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

¹ 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.

² 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, FY2001

State	State Medicaid Spending (in millions of dollars)	Total New Jobs Created ¹	Total Wages from New Jobs Created (in millions of dollars) ¹
Alabama	\$ 907	51,558	\$ 1,621
Alaska	211	7,718	277
Arizona	938	45,611	1,528
Arkansas	536	34,807	1,000
California	12,366	291,439	11,419
Colorado	1,114	28,612	967
Connecticut	1,682	33,422	1,338
Delaware	310	5,491	201
Florida	3,925	132,215	4,268
Georgia	2,147	75,173	2,633
Hawaii	308	7,784	282
Idaho	223	13,332	387
Illinois	4,173	98,435	3,554
Indiana	1,606	62,181	1,944
Iowa	656	28,671	817
Kansas	714	26,392	767
Kentucky	1,014	54,451	1,676
Louisiana	1,286	72,937	2,199
Maine	478	23,193	682
Maryland	1,737	40,341	1,395
Massachusetts	3,430	70,697	2,713
Michigan	3,463	98,754	3,331
Minnesota	1,976	52,654	1,742
Mississippi	595	46,118	1,375
Missouri	1,925	69,144	2,162
Montana	142	10,126	273
Nebraska	495	18,900	556
Nevada	351	6,998	269
New Hampshire	456	9,861	330
New Jersey	3,653	71,226	2,899
New Mexico	403	28,913	866
New York	16,134	300,352	11,746
North Carolina	2,426	100,353	3,206
North Dakota	130	7,248	200
Ohio	3,645	132,028	4,145
Oklahoma	620	44,720	1,228
Oregon	1,148	39,549	1,302
Pennsylvania	5,233	143,110	4,874
Rhode Island	577	14,280	467
South Carolina	927	52,258	1,673
South Dakota	143	8,642	242
Tennessee	2,062	81,675	2,837
Texas	4,848	187,901	6,459
Utah	266	17,130	519
Vermont	244	9,607	283
Virginia	1,500	39,824	1,325
Washington	2,333	52,223	1,865
West Virginia	412	25,298	742
Wisconsin	1,704	61,934	1,928
Wyoming	92	3,949	114
Total	\$ 97,663	2,939,236	\$ 100,627

¹ 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 Losses* for Each \$1 Million Cut in State Medicaid Spending, FY2003

State	Business Activity Lost Per \$1 Million Cut in Medicaid Spending ¹	Jobs Lost Per \$1 Million Cut in Medicaid Spending	Employee Wages Lost Per \$1 Million Cut in Medicaid Spending
Alabama	\$ 4,930,000	54.66	\$ 1,830,000
Alaska	2,570,000	24.70	940,000
Arizona	4,220,000	44.79	1,600,000
Arkansas	5,410,000	64.64	1,980,000
California	2,380,000	20.75	870,000
Colorado	2,290,000	24.02	860,000
Connecticut	2,110,000	18.66	790,000
Delaware	1,960,000	16.51	640,000
Florida	3,060,000	34.35	1,180,000
Georgia	3,350,000	32.66	1,220,000
Hawaii	2,900,000	28.55	1,100,000
Idaho	4,520,000	56.25	1,740,000
Illinois	2,440,000	22.05	850,000
Indiana	3,340,000	36.19	1,200,000
Iowa	3,460,000	42.35	1,280,000
Kansas	3,130,000	35.10	1,090,000
Kentucky	4,590,000	49.14	1,610,000
Louisiana	4,870,000	55.20	1,770,000
Maine	3,730,000	45.67	1,430,000
Maryland	2,270,000	21.86	800,000
Massachusetts	2,190,000	19.14	780,000
Michigan	2,510,000	25.99	930,000
Minnesota	2,200,000	23.75	840,000
Mississippi	6,250,000	71.78	2,280,000
Missouri	3,430,000	33.52	1,120,000
Montana	4,900,000	63.88	1,830,000
Nebraska	2,960,000	34.49	1,080,000
Nevada	2,070,000	19.96	810,000
New Hampshire	2,030,000	20.25	720,000
New Jersey	2,270,000	18.20	790,000
New Mexico	5,720,000	67.03	2,140,000
New York	2,090,000	17.41	720,000
North Carolina	3,640,000	38.80	1,320,000
North Dakota	3,880,000	47.58	1,400,000
Ohio	3,120,000	33.69	1,130,000
Oklahoma	4,980,000	61.78	1,810,000
Oregon	3,060,000	32.14	1,130,000
Pennsylvania	2,740,000	26.39	960,000
Rhode Island	2,420,000	24.65	860,000
South Carolina	4,780,000	50.95	1,740,000
South Dakota	3,570,000	45.28	1,350,000
Tennessee	3,990,000	38.35	1,420,000
Texas	3,570,000	35.37	1,290,000
Utah	5,270,000	59.67	1,920,000
Vermont	3,090,000	36.80	1,150,000
Virginia	2,280,000	22.73	800,000
Washington	2,080,000	20.36	770,000
West Virginia	5,160,000	56.70	1,770,000
Wisconsin	2,810,000	32.83	1,090,000
Wyoming	2,790,000	34.70	1,060,000
Average of 50 States	\$ 3,387,600	36.85	\$ 1,235,800

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

¹ "Business Activity Lost" 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 potential harm to people who rely on Medicaid should be the foremost consideration for any policy maker who faces tough choices about Medicaid spending. However, the impact on a state's economy is another important consideration. As policy makers consider their spending choices, they should be aware that increases or cuts in state Medicaid spending result in a gain or loss of federal dollars, which will have significant implications for the state's economy.

Medicaid: A State and Federal Partnership

The Medicaid program is a unique federal and state partnership. It gives states great flexibility to design their program and, thus, to control state spending commitments. Every state Medicaid program must cover certain very low-income children, pregnant women, and some elderly and disabled people and must provide them with a defined set of benefits. However, above these minimum requirements, states decide if they want to expand Medicaid to more people and/or to cover more services. At the same time, 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 \$1.00 to \$3.28 in federal funds for each state dollar. In 2003, Medicaid spending will total an estimated \$280 billion. Of this amount, about \$121 billion will be state funds and \$159 billion will be federal funds. In fact, Medicaid is the source of 43 percent of the total federal grant dollars given to the states.²

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 to spend, and where to ultimately place Medicaid among competing demands for limited state dollars. This balancing of spending priorities and state budget bottom lines became much more challenging for state policy makers when the national economic downturn began in 2001, and it continues to affect every state.

Medicaid: A Target for Cuts in Current State Budget Crises

There is no doubt that states are experiencing severe budget crises. With slowing economies and state tax cuts enacted during the 1990s, state tax revenues are falling dramatically (by 10 percent in the second quarter of 2002).³ Compounding the problem, changes in the federal income tax code have also affected state revenues.⁴ Most states are facing their third consecutive year of budget shortfalls. In the current fiscal year, states expect budget deficits to reach a combined \$58 billion, with many states facing a budget gap greater than 10 percent of their total budget.⁵ Unlike the federal government, all states (except Vermont) are prohibited by law from having budget deficits at the end of their fiscal year. Thus, the choices facing states are to cut spending, raise taxes, or spend reserve funds (if they have not already done so).

The size and rapid growth of state Medicaid budgets makes the program a prime target for budget cuts. In most states, Medicaid is the second-largest item in the state budget after elementary and secondary education and, on average, represents 20 percent of state expenditures.⁶ In addition, Medicaid spending is growing faster than the spending on other state programs. Nationally, Medicaid spending grew 10.4 percent between fiscal years 2001 and 2002 and 10.0 percent between fiscal years 2000 and 2001. During this two-year period, state revenues grew about 5 percent.⁷

Forty-five states took action to reduce Medicaid spending growth in fiscal year 2002. At least 41 states report that they will act again this year to reduce their Medicaid spending. States report that they will continue to look for ways to reduce the use and cost of prescription drugs, limit payments to providers, eliminate covered benefits, and cut back eligibility.⁸ While some savings might be identified that will not harm beneficiaries (states obtaining discounts on prescription drugs, for example), most cuts will directly harm the people who rely on Medicaid coverage for health care. What is more, Medicaid spending decisions also affect the health of a state's economy.

Medicaid: Good State Economic Policy

To generate *new* business activity, jobs, and wages in a state economy, money must be received from outside the state. For example, visits by out-of-state tourists or the sale of manufacturing products to customers outside the state bring new spending into the state, contributing to economic growth.

Buying 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 in to the state’s economy.

Medicaid: A Health Care Safety Net for Millions of People

- ✓ Medicaid helped to pay for the health care of an estimated 44.6 million people in 2001 and an estimated 47 million in 2002—**one in six Americans**.
- ✓ Medicaid is the most widespread type of health insurance among the poor: More than 40 percent of all people living below the federal poverty level rely on the program.
- ✓ Medicaid provides health coverage to more than one-fifth of the nation's children (16.5 million in 2001) and is the source of health coverage for more than 40 percent of low-income children (in families with incomes below \$30,000 for a family of three).
- ✓ Medicaid is the nation's largest single purchaser of maternity care, paying for approximately 35 percent of all births in the nation.
- ✓ Medicaid is an important source of financial help for over seven 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 five 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, paying for about half of all nursing home care in this country.
- ✓ Although elderly and disabled people 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: 2001* (Washington: U. S. Census Bureau, September 2002); The Kaiser Commission on Medicaid and the Uninsured, fact sheets on Medicaid available online at www.kff.org (visited on November 27, 2002).

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, wage and salary data, and personal income data.

Tables 1 and 2 show the positive impact of actual state Medicaid spending in fiscal year 2001 on each state's economy. These tables show the significant return—in increased business activity, new jobs, and additional wages—gained by states from their investment of dollars in the Medicaid program.

Table 3 presents the most current Medicaid economic impact multipliers available (based on federal fiscal year 2003), 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 2003. The fiscal year 2003 multipliers in Table 3 also can be used to estimate the economic impact of changes in fiscal years 2004 and 2005 since the federal matching rate and economic conditions in states do not change dramatically over one or two years.

For example, Table 3 can be used to estimate the impact of a hypothetical reduction in Texas state Medicaid spending on the overall Texas economy. In fiscal year 2001, Texas invested a total of approximately \$4.85 billion in Medicaid. Taking into account even a very modest inflation factor, it is safe to say that Texas would need to spend *at least* \$5 billion in fiscal year 2003 to maintain the same basic Medicaid program. If Texas were to reduce its spending on Medicaid by only 5 percent—a \$250 million cut—the losses to the Texas economy can be calculated using Table 3: Texas would lose more than \$892.5 million worth of state business activity ($250 \times \$3,570,000$), 8,843 jobs (250×35.37), and \$322.5 million in wages paid to workers in Texas ($250 \times \$1,290,000$).

Many 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 Texas. In fact, 18 states have Medicaid spending multiplier effects greater than that in Texas. In other words, in 18 states, every dollar change in state Medicaid spending would have an even greater economic impact per dollar than the impact in Texas.

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: Health Care at a Discount Price for the States

As a state reduces spending on Medicaid, more state residents will be left uninsured. A significant number of these people will go without needed care—with long-term consequences to their health and to their ability to contribute productively to the state's economy.

Research shows that, as low-income, uninsured individuals and families balance competing financial needs, they may delay seeking care until their condition grows more serious—even though it may then be more expensive to treat. For example, the average cost of hospitalization is \$25,000 for a heart attack and \$7,300 for a severe asthma attack.

When low-income, uninsured people must find health care, they go to local public hospitals, local health departments, state and county health clinics, school health clinics, and other programs and services financed by the state when they are available. Thus, as states reduce the number of people served by the Medicaid program, the funding demands for other public programs go up and must be met by the state and local communities—*usually without federal financial assistance*.

The bottom line is that states really cannot avoid paying for at least some health care needed by its uninsured residents. By paying for that care through Medicaid, states can, in essence, buy these services at a 50 to 76.6 percent “discount” provided by the federal government through the federal-state matching formula. In any calculation of savings to a state budget from a Medicaid cut, the resulting increase in demands on state- and locally-funded programs must be part of the equation.

CONCLUSION

Medicaid provides a vital health care safety net in every state. It is a lifeline 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 deficits are forcing 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 federal 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.

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

ENDNOTES

¹ Data in this report are based on federal fiscal years 2001 and 2003. All references to fiscal year 2001 and 2003 refer to the federal fiscal years that begin on October 1 of the preceding year (October 1, 2000 and October 1, 2002, respectively). State fiscal years vary. Forty-six states begin their fiscal years in July and end them in June. The exceptions are Alabama and Michigan, with October-to-September fiscal years; New York, with an April-to-March fiscal year; and Texas, with a September-to-August fiscal year. Additionally, 20 states operate on a biennial budget cycle.

² Vernon Smith, et al., *Medicaid Spending Growth: Results from a 2002 Survey* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2002).

³ Ibid. From 1995 to 2001, states cut taxes by \$36 billion, with the largest single annual cut—\$9.9 billion—occurring in 2000. Corina Eckl and Arturo Perez, *State Budget and Tax Actions 2002: Preliminary Report* (Washington: National Conference of State Legislatures, August 28, 2002).

⁴ For example, states may lose more than \$14 billion unless they act to de-link their tax code rules that govern business depreciation deductions for new equipment from new federal rules. Business interests who want the advantage of the new rules in both federal and state tax treatment make this a hard fix to make at the state level. Nicholas Johnson, *States Can Avoid Substantial Revenue Loss by Decoupling from New Federal Tax Provision* (Washington: Center on Budget and Policy Priorities, April 30, 2002).

⁵ National Association of State Budget Officers, *NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal Year 2003* (Washington: NASBO, March 15, 2002).

⁶ Ibid.

⁷ Ibid and National Association of State Budget Officers, *2001 State Expenditure Report* (Washington: NASBO, Summer, 2002). Both are available online at (www.nasbo.org/Publications/PDFs/nasbo2001exrep.pdf). Medicaid spending is growing rapidly for three main reasons. First and foremost, Medicaid costs are increasing because health care costs are increasing. In fact, private health insurance premiums grew faster than the cost of Medicaid: 12.7 percent in 2002. Like private insurance, Medicaid is affected by rising prescription drug prices, higher hospital and inpatient and outpatient costs, and increased demand for and cost of new medical technologies. Second, Medicaid enrollment is increasing in the current economic downturn as more people become income-eligible for Medicaid. In addition, enrollment is increasing because of some state eligibility expansions enacted in recent years. Third, the increasing cost of and demand for nursing home and other long-term care is an important factor driving up Medicaid spending.

⁸ Vernon Smith, et al., op. cit.

**APPENDIX:
METHODOLOGY**

METHODOLOGY

In order to measure and quantify the role of Medicaid in the states' 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 the 50 states.

The economic input-output analysis is based on the RIMS II economic input-output model created by the U.S. Department of Commerce, Bureau of Economic Analysis. 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, wage and salary data, 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 from 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 2003, the federal match for Medicaid assistance ranged from a low of 50 percent (in twelve states) to a high of 76.6 percent (in Mississippi). This federal spending represents a new source of spending to a state economy because it supports health care expenditures that would otherwise not occur or need to be taken from other sources of spending. The total level of federal Medicaid matching funds flowing into a state is determined by the level of state Medicaid spending. When a state increases or decreases state spending on Medicaid, federal matching dollars are gained or lost.

Because the level of state Medicaid spending determines the level 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.

The comparative economic advantage of state Medicaid spending over other state spending options is the substantial size of the federal matching rate for state Medicaid spending. Medicaid has a *net* positive economic impact when compared to state spending on other programs because it pulls a large (or larger) infusion of new federal 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 two different years:

- The report first looks at the economic impact of actual state Medicaid spending in fiscal year 2001, the most recent year for which expenditure data are available.
- The report then provides policy makers with the relevant economic impact multipliers needed to predict the economic impact of potential state Medicaid spending changes in fiscal year 2003.

The economic impact of actual state Medicaid spending in fiscal year 2001 and the economic impact multipliers for fiscal year 2003 are based on *federal* fiscal years 2001 and 2003. All references in the report to fiscal year 2001 and 2003 refer to the federal fiscal years that begin on October 1 of the preceding year (October 1, 2000 and October 1, 2002, respectively). State fiscal years vary among states. Forty-six states begin their fiscal years in July and end them in June. The exceptions are Alabama and Michigan, with October-to-September fiscal years; New York, with an April-to-March fiscal year; and Texas, with a September-to-August fiscal year. Additionally, 20 states operate on a biennial budget cycle. The fiscal year 2003 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 2003 fiscal year, and these multipliers can be used to estimate the economic impact of changes in state fiscal years 2004 and 2005, since the federal matching rate and the economic conditions of the state do not change dramatically over several months or even over a period of one or two years.

Although we also did an analysis of the District of Columbia, 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 of the city limits (in the Maryland and Virginia suburbs). Therefore, comparisons of the economic multipliers in the District of Columbia to state economic multipliers are misleading. Data from the analysis of the District of Columbia are available from Families USA upon request.

Analysis 1:

The Economic Impact of Fiscal Year 2001 State Medicaid Spending

The first analysis measures the economic impact of state Medicaid spending in fiscal year 2001 for the 50 states. Fiscal year 2001 data on actual state and federal Medicaid expenditures, the most recent data available, were obtained from the CMS-64 reports published by the Centers for Medicare and Medicaid

Services, U.S. Department of Health and Human Services. The economic impact of federal Medicaid expenditures was calculated by multiplying the total federal assistance and administrative expenditures by the appropriate RIMS II multiplier to yield the economic output, employment, and employee compensation impacts. The fiscal year 2001 state spending and economic impact multiplier was derived by dividing the total economic impact—which included both federal matching and economic multiplier effects—by the level of state spending.

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.

Analysis 2:

The Fiscal Year 2003 Economic Impact Multipliers for State Medicaid Spending

The first analysis was based on Medicaid spending in fiscal year 2001. In order to analyze the impact of future cuts, when the level of state and federal spending is not yet known, economic impact multipliers for each dollar of state Medicaid spending were developed. These multipliers measure the change in economic activity per dollar cut in state Medicaid spending. The economic impact multiplier was derived in a similar two-step process.

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 is the published fiscal year 2003 Federal Medical Assistance Percentage.* The federal match percentage used in the formula for each state's administrative costs was the actual federal match rate from fiscal year 2001 expenditures. This administrative match percentage was used because administrative match rates do not change from year to year, but certain administrative activities have different matching rates. Each state has a unique mix of these different administrative activities. We assumed that

* Source: (<http://aspe.hhs.gov/health/fmap.htm>).

the mix of activities will not change substantially from fiscal year 2001 to fiscal year 2003. 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 2001 for the relevant state.

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 million 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 2003 are presented in Table 3.

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