kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

Financing Health Coverage: The Fiscal Relief Experience

By Victoria Wachino, Molly O'Malley, and Robin Rudowitz

In May 2003, the federal government provided $20 billion in temporary fiscal relief to help states handle serious budget pressures brought about by the weak economy. This fiscal relief was intended to help states address staggering budget pressures that left states facing budget shortfalls that reached about $80 billion at their height and caused states to cut spending on many state programs, raise taxes and fees, and generate many one-time revenue sources to balance state budgets. The fiscal relief, which expired June 30, 2004, was comprised of a temporary 2.95 percent increase in the federal share of Medicaid spending as well as some unrestricted grants that states could apply to any area of their budgets.

This marked the first time since the inception of the Medicaid program, which provides health and long-term care coverage to more than 52 million low-income Americans including children, families, elderly individuals and persons with disabilities, that the federal government used the federal matching percentage as a policy tool for fiscal relief. The increased federal Medicaid matching funds helped states meet Medicaid spending increases that were driven in part by the economic downturn, successfully forestalled many additional and potentially larger reductions in Medicaid spending growth, and preserved Medicaid eligibility. Based on these results, the temporary matching rate increase could serve as a potential model for funding Medicaid coverage during recessions.

The results of the fiscal relief experience are relevant to the current Medicaid policy and financing debate. Temporary fiscal relief expired on June 30, 2004 and state revenues are starting to rebound; however states continue to grapple with Medicaid spending growth driven largely by factors beyond state control such as overall health care costs, demographic trends and the erosion of private health insurance. Additionally, the federal government will consider a variety of Medicaid savings proposals to meet the FY 2006 federal budget requirements to cut up to $10 billion from the program over the next five years. Some of these proposed Medicaid reductions could shift costs to the states at a time when many states already face additional fiscal responsibility for the program as a result of formula-driven reductions in the federal match rates and the implementation of the new Medicare Part D program. These financing issues are fundamentally about the allocation of costs between the federal government and the states. The results from the experience with fiscal relief show that increases in federal Medicaid support could be a model for how to support state's capacity to meet future demands on the Medicaid program.

This paper provides an overview of the context which prompted the fiscal relief, the results of the fiscal relief and a discussion of the implications of this experiment in federal intervention for financing the Medicaid program. Because detailed tracking of how states spent funds provided through the temporary fiscal relief is not available, the survey data used in this paper are the best available information on how states used the fiscal relief funds.

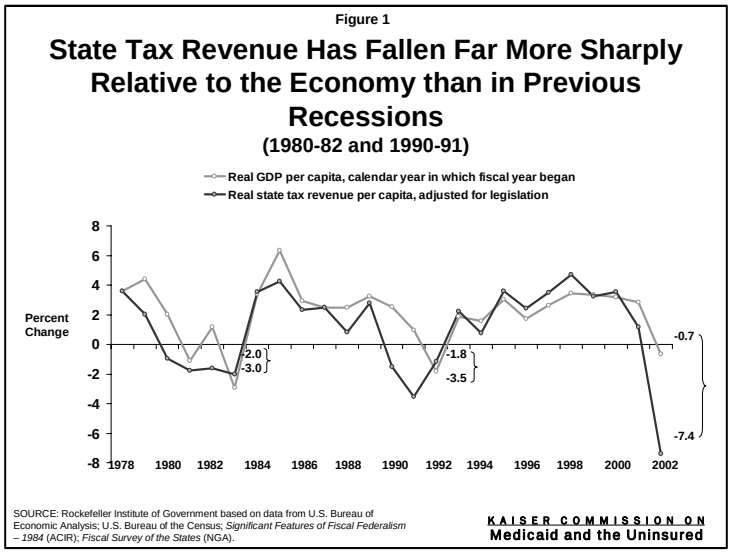
Overview and Context for Federal Fiscal Relief

Congress provided the federal fiscal relief in May 2003 as a means of delivering immediate assistance to cash-strapped states that were facing what some called the most difficult fiscal conditions since World War II. State tax revenues had fallen dramatically and left states struggling to fund basic government services. States faced aggregate budget shortfalls for fiscal year 2003 that were estimated at $80 billion. As a consequence of these conditions, states were reducing spending, increasing borrowing, relying on one-time revenue sources and increasing fees and taxes. States had begun to work aggressively to reduce spending growth in their Medicaid programs, implementing a wide array of cost containment strategies. Many of these actions resulted in negative consequences for beneficiaries and providers.

During economic downturns, upward pressure on Medicaid spending increases as unemployment increases, individual income falls and more people become eligible for the program. Over the past several years of weak economic conditions, the rates of growth in Medicaid spending and enrollment have increased.[1] In 2004, enrollment growth, primarily driven by the economic downturn, was most frequently cited by states as the primary driver of Medicaid spending in a survey released in October 2004 for the Kaiser Commission on Medicaid and the Uninsured conducted by Health Management Associates (KCMU/HMA annual budget survey). Since 2001, Medicaid enrollment grew by almost one-third.[2] Additionally, like private health insurance premiums, prescription drug costs and overall health care costs have been key drivers of Medicaid spending growth.

States were challenged to meet these spending increases, because at the same time that Medicaid spending was increasing, state tax revenues fell dramatically.[3] This dynamic – of a recession simultaneously driving state revenues down and Medicaid spending up – is not unusual; it is inherent in Medicaid's role as a program that serves the low-income population and a financing structure that relies substantially on state tax revenue to fund the program. However, even by the standards of recent recessions, the falloff in state tax revenues that started in 2001 was dramatic (Figure 1).

[1] Between state fiscal years 2000 and 2003, growth in Medicaid spending averaged 10.2 percent per year, although that rate has fallen off more recently and is estimated in FY 2004 at a still significant 7.9 percent.
[2] Medicaid enrollment growth reached a high of 9.9 percent in 2002, more than two and a half times the rate of growth in 2000. While enrollment growth was slower, 4.1 percent in 2004, it was still a significant factor driving Medicaid spending growth.
[3] The falloff in state tax revenue, not the increase in Medicaid spending, was the primary contributor to state budget shortfalls. See D. Boyd, "The State Fiscal Crisis and its Aftermath," Kaiser Commission on Medicaid and the Uninsured, September 2003.



Despite a recession that was relatively mild, the falloff in state tax revenues was severe, and significantly outpaced the falloff that either of the two previous recessions caused.[4] The mismatch between growth in Medicaid spending and available tax revenues to finance Medicaid was therefore more significant than it had been in some time. Senator Collins, one of the lead sponsors of the fiscal relief provision observed at the time of its enactment that states were "facing a dramatic and unexpected decline in government revenues at precisely the time when the demand for government services has never been higher because of a lagging economy."[5]

States faced a range of difficult choices as they struggled to balance their budgets. States relied heavily on reductions in spending for state programs, and also raised taxes and fees as part of their budget balancing efforts.[6] Although reductions in state spending on Medicaid mean a significant loss of federal Medicaid matching funds, after the first year of the fiscal crisis states became increasingly aggressive at reigning in their Medicaid spending, with nearly every state in the nation implementing at least one new Medicaid cost containment action in each of fiscal years 2002, 2003, and 2004, and many states layering on several different actions simultaneously. States pursued restrictions and reductions in eligibility and benefits, reductions in provider payments and pharmacy spending, and increased beneficiary cost-sharing.[7] As a consequence, some low-income individuals lost Medicaid eligibility; others found needed

[4] Ibid.
[5] Congressional Record, Senate, May 14, 2003, page S6204.
[6] N. Johnson, et al., "State Revenues Have Fallen Dramatically," Center on Budget and Policy Priorities, November 25, 2003.
[7] V. Smith et. al, "Medicaid Spending Growth: Results from a 2002 Survey," Kaiser Commission on Medicaid and the Uninsured, September 2002, and V. Smith et., al. "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Commission on Medicaid and the Uninsured, September 2003, and V. Smith et., al. "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Commission on Medicaid and the Uninsured, October 2004.

benefits unavailable, had their ability to access care diminished, or had their coverage become financially out of reach.[8]

To help states resolve their overall budget shortfalls and to provide specific assistance to state Medicaid programs, Congress provided $20 billion in fiscal relief in the Jobs and Growth Tax Relief and Reconciliation Act of 2003, which was enacted in May 2003. The fiscal relief package contained two parts. The first part was $10 billion in grant payments to states to support states' general government activities.[9] These funds were allocated to states based on their overall population. The second part was a temporary increase in each state's federal Medicaid matching rate.

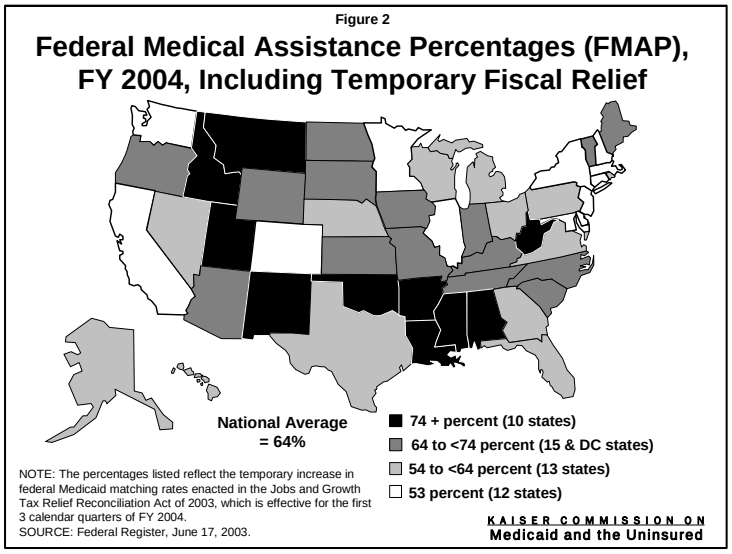
Temporary increase in the federal share of Medicaid spending. Under federal Medicaid law, the federal government matches a share of each state's total Medicaid spending. The federal matching rate (referred to as the Federal Medical Assistance Percentage, or FMAP) varies by state based on per capita income. The formula sets statutory floors at 50 percent and ceilings at 83 percent. On average across all states, the federal government typically pays for about 57 percent of Medicaid spending, with states responsible for the remaining 43 percent.

The fiscal relief provided that each state's matching rate would increase by 2.95 percentage points, and that states would be held harmless from any scheduled declines in their matching rates (Figure 2).[10] The temporary FMAP increase was available for the last two quarters of federal fiscal year 2003 and the first three quarters of federal fiscal year 2004, which means that the fiscal relief increased the federal share of Medicaid spending between April 1, 2003 and June 30, 2004. All states subsequently saw a decline in their fiscal year 2005 FMAP after the expiration of the fiscal relief.

[8] See, for example, L. Ku, "Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs," Center on Budget and Policy Priorities, December 2003, and C. Mann and S. Artiga, "The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program," Kaiser Commission on Medicaid and the Uninsured, June 2004.

[9] States were prohibited from using these general relief funds to fund their state share of Medicaid spending.

[10] Federal matching rates are based on a formula that calculates a state's average personal income relative to the national average over a three-year period. Each year, the formula is recalculated to incorporate new personal income data and states' FMAP rates change.



Eligibility maintenance of effort requirement. All states were eligible to receive the FMAP increase provided that they maintained their Medicaid eligibility levels. This "maintenance of effort" provision required states to maintain the Medicaid eligibility levels that were in effect in the state as of September 2, 2003. States that reduced their eligibility below the September 2nd levels would not receive the FMAP increase, although if a state that reduced its eligibility subsequently reinstated it, it would begin to receive the enhanced FMAP. This maintenance of effort requirement pertained only to reductions in Medicaid eligibility standards. States were not prohibited from making other eligibility changes such as changes to enrollment procedures. States could also scale back other parts of their Medicaid programs (by, for example, reducing the benefits offered, increasing beneficiary cost-sharing, or reducing provider payments) and still receive the increased FMAP.

Other aspects of the FMAP increase. The FMAP increase applied to all state Medicaid spending with the exception of Disproportionate Share Hospitals Payments (DSH), administrative costs, services for which the federal matching rate exceeds states' regular FMAPs (which includes family planning services, services incurred at Indian Health Service facilities, and breast and cervical cancer services), and spending on the State Children's Health Insurance Program (SCHIP). In addition, states that require local governments to finance a share of state Medicaid spending were prohibited from increasing that share.

Results from the Fiscal Relief Experience

The fiscal relief expired on June 30, 2004. What does states' experience with the increased federal matching rate tell us about how states used the $10 billion that became available, and whether it helped buoy state budgets and maintain Medicaid coverage? From the information that is available about states' use of the increased matching rate and its effect, several clear results emerge:

1. Funds from the increased matching rate were invested in Medicaid.

States used funds from the increased federal matching rates to meet spending increases in their Medicaid programs. While states have not systematically tracked the disposition of the funds that became available from the increased FMAP, two recent 50-state surveys have broadly documented how these funds were spent.[11] In the 2004 KCMU/HMA annual budget survey, state Medicaid directors were asked to report how the funds from the increased federal matching rate were used. Overwhelmingly, states reported that those funds were invested in the Medicaid program. Thirty-six states reported that they used the increased federal matching funds to resolve budget shortfalls in their Medicaid programs. In its semiannual state budget survey, the National Association of State Budget Officers' found similar results when they surveyed state budget officials about use of the increased matching rates.[12]

These responses indicate that as Medicaid spending increased, often at rates that exceeded the amounts states had appropriated for the program at the beginning of states' fiscal years, states were able to apply funds available as a result of the increased FMAP to meet these spending increases, and did not need to make supplemental appropriations, additional reductions in their Medicaid programs, reductions in other state programs or increases in taxes and fees as a result. States used the fiscal relief funds to meet unexpected spending increases in their budgets at a level that their state revenues alone may not have allowed.

> *"We were short of appropriations [for Medicaid] for FY 2003. Because of the new federal match, we know we are going to make it. It was a tight year."*
> *-- State Medicaid director commenting on the effect of the increased FMAP, December 2003*

States used the fiscal relief funds for purposes other than helping to fund Medicaid. Some states also used the fiscal relief funds to fill holes in their state general fund budgets and held funds in reserve. Michigan's experience in this regard is instructive. The state devoted some of the funds that became available as a result of the fiscal relief to fund a Medicaid Benefits Trust Fund, which serves as a cushion against a Medicaid budget shortfall, and devoted $200 million of the

[11] Once any federal funds arrive in a state, those funds are fungible, which makes their ultimate disposition difficult to track. As a recent General Accounting Office letter describing the use of the $10 billion in unrestricted grant funds provided in the fiscal relief package observed, "Once funds from different sources are commingled for budgeting purposes, it is difficult or impossible to identify the source of the dollars that fund specific expenditures." See General Accounting Office letter to Senator Don Nickles, *Federal Assitance: Temporary State Fiscal Relief*, May 7, 2004. The fiscal relief legislation did not require that the fiscal relief funds be spent in particular ways. Although the increased federal matching funds were by definition applied to state Medicaid spending, the increase in the federal share meant states spent less of their own funds on Medicaid, and the savings states realized in their own funds as a result was fungible in that states were free to apply it to other areas of their budget. Because detailed tracking of how states spent these funds is unavailable, the survey data used in this paper are the best available information on how states used the fiscal relief funds.

[12] In NASBO's Fiscal Survey of States, conducted between January and April 2004, 35 states reported using the increased FMAP to resolve a Medicaid budget shortfall.

fiscal relief to state rainy day funds. More broadly, the fiscal relief funds enabled Michigan to balance its budget without increasing taxes or fees.[13]

While states in general used the increased FMAP to support their Medicaid programs, and some states used them for other programs as well, at least a few states chose not to invest these funds in Medicaid. Florida, for example, did not invest its fiscal relief funds in any ongoing state programs, but instead used them to promote an economic development project and to build up a state working capital fund.[14] This may reflect that the state faced budget pressures that were less severe than those of other states; Florida's revenue growth had been stronger than that of most other states. Florida's decision not to invest the fiscal relief funds in any existing state program may reflect the state's overall set of policy priorities. Health care advocates argued that the fiscal relief funds be used to reduce or eliminate eligibility restrictions and an enrollment freeze in the state's Children's Health Insurance Program; the state decided instead to maintain a robust working capital fund to cushion against potential future downturns.

2. Funds from the increased matching rate helped states maintain the Medicaid program, avoid making additional reductions in spending growth and in some cases helped fund modest program restorations.

The net result of the fiscal relief was that for about half of all states, the funding helped states avoid making additional and larger reductions in their Medicaid spending growth than they would have without the increased FMAP. Twenty-two states responding to the KCMU/HMA 50-state survey in the summer of 2004 reported that they used the fiscal relief to avoid, minimize, or postpone making additional Medicaid reductions or freezes. Seven states also reported using some of the increased FMAP funds to finance targeted program improvements, including provider rate increases and benefit restorations that would not have been made otherwise.[15] These results were consistent with results reported in the NASBO survey earlier in 2004.[16]

Since 2002, states have implemented a series of measures designed to slow the rate of growth in Medicaid spending including reductions in Medicaid eligibility, benefits and provider payments. These measures have helped to constrain costs, but have also placed an additional burden on Medicaid beneficiaries and the providers who serve them. States continued to implement Medicaid cost containment strategies, which reflects that they still faced budget shortfalls, even after the fiscal relief took effect. Every state and the District of Columbia implemented at least one new Medicaid cost containment action in FY 2003 and FY 2004 and plan to do the same in FY 2005.[17] However, states' emphasis on restricting Medicaid coverage seemed to start to diminish somewhat in FY 2004.

---

[13] J. Holahan, et al., "State Responses to Budget Crisis in 2004: An Overview of Ten States," Kaiser Commission on Medicaid and the Uninsured, January 2004.
[14] Ibid.
[15] V. Smith et. al. "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Commission on Medicaid and the Uninsured, October 2004.
[16] In NASBO's Fiscal Survey of States, 25 states reported using the increased FMAP funds to avoid additional Medicaid reductions and 5 states reported using the funds for program increases.
[17] V. Smith et. al. "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Commission on Medicaid and the Uninsured, October 2004.

"..With the availability of the enhanced FMAP, the legislature used some of those funds to restore parents' coverage so parents up to 100% [of the federal poverty level] continues to be Medicaid eligible in Ohio. I am convinced that without some of the federal revenue, the eligibility would have been rolled back."

-- Barbara Edwards, Ohio Medicaid director, September 2003

Having an infusion of additional federal support for the Medicaid program helped some states avoid making additional reductions in Medicaid spending growth in FY 2004 altogether, and helped other states make fewer reductions or scale back proposed reductions. A number of states reported specific reductions that their legislatures had been planning before the fiscal relief took effect that became unnecessary as a result of the increased FMAP. In Ohio, the legislature had been considering a significant rollback in Medicaid coverage for parents, which it decided not to pursue after the fiscal relief was passed.[18] Similarly, Missouri and New Jersey turned back planned reductions in parent coverage and Minnesota deferred a planned eligibility reduction for about 30,000 people, including pregnant women. Some states used the fiscal relief to restore eligibility that had already been cut. Massachusetts restored coverage for about 36,000 long-term unemployed adults; Montana was able to provide coverage to about 1,300 children who were on an SCHIP waiting list.[19] Other states, like Oregon and Louisiana, reported that they used the fiscal relief to avoid making additional reductions to their Medicaid spending growth.[20]

The increased FMAP helped states avoid some Medicaid reductions; however, as states began FY 2004, some states were able to avoid reductions because fiscal conditions began stabilizing, and for the first time in three years began improving modestly rather than getting significantly worse. Despite overall improvements in the state fiscal outlook starting in FY 2004, every state and the District of Columbia implemented at least one new cost containment measure and in many cases efforts to control costs intensified even with the improved revenues and the fiscal relief.

"We are focused on program expansions and we are committed to them. The FMAP will help us in the overall picture."

-- State Medicaid director, September 2003

"We have a budget but there is a significant hole in that budget. There is a big cloud hanging over it, even after accounting for the new FMAP relief."

-- State Medicaid director on state's FY 2004 budget, September 2003

[18] Barbara Edwards, Ohio Medicaid Director, in transcript of Kaiser Family Foundation press briefing "State Budgets and Medicaid," September 22, 2003, available at www.kaisernetwork.org, p. 33.
[19] L. Ku, "Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs," Center on Budget and Policy Priorities, December 2003.
[20] V. Smith et al., "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Commission on Medicaid and the Uninsured, September 2003.

3. **Making the increased FMAP contingent on states' maintaining Medicaid eligibility helped to preserve coverage.**

Requiring states to maintain their Medicaid eligibility levels as a condition of receiving the increased federal matching rate proved to be a powerful incentive for states, and helped preserve health coverage for low-income people. Between September 2, 2003, the date on which the eligibility maintenance of effort (MOE) was established, and June 30, 2004, when the fiscal relief expired, no state made a reduction in Medicaid eligibility that would have disqualified it from receiving the FMAP increase. A few states considered reducing Medicaid eligibility, but decided not to out of fear of losing the fiscal relief funds. For example, in Alabama the governor proposed reducing Medicaid eligibility for some seniors and people with disabilities after a tax referendum there failed, but this proposal was not adopted because it would have violated the eligibility MOE.

As a result of the MOE requirement, the number of states implementing eligibility reductions or restrictions dropped from 25 states to 21 states from FY 2003 to FY 2004. The eligibility restrictions that were imposed in FY 2004 happened either before September 2 or were changes that did not qualify as an eligibility change under the CMS guidance for the federal fiscal relief. For example, Georgia did impose new premium requirements for some disabled children who receive Medicaid coverage, but this did not disqualify the state from receiving the enhanced FMAP. Other eligibility changes included more frequent re-verification periods for Medicaid enrollment, the elimination of 12-month continuous eligibility for certain groups and increased documentation requirements for Medicaid applications. All of these activities worked to slow enrollment growth, but were not direct changes to the eligibility standards.

States' made even more eligibility changes in the State Children's Health Insurance Program, which was not covered by the eligibility MOE. A number of states imposed higher premiums, procedural barriers and enrollment caps in their SCHIP programs that were more widespread and severe than the eligibility restrictions imposed on Medicaid enrollees. For example, from April 2003 to July 2004, a total of 23 states made it more difficult to secure and retain health coverage for children and families. Of those 23 states, 13 states made eligibility more difficult in the SCHIP program, 5 states in both programs and 5 for just Medicaid.[21] A total of 16 states increased premiums for children and families (13 states did so in SCHIP and only 3 states for Medicaid).[22] Despite limited eligibility restrictions due to the MOE, as noted above, states made other reductions to Medicaid including benefits cuts and provider payment reductions during the period fiscal relief was provided.

4. **Providing fiscal relief through an increase in the Medicaid matching rate targeted funds and helped provide support to states quickly.**

As a potential model for providing fiscal assistance to states, Medicaid proved to have some unanticipated advantages. This is the first time comprehensive state fiscal relief has been

[21] D. Cohen Ross and L. Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families". Kaiser Commission on Medicaid and the Uninsured, October 2004.
[22] Ibid.

provided through Medicaid. Many fiscal analysts have discussed potential methods for how the federal government can best support states during recessions, and although the dominant approach is general revenue sharing, some analysts also identify increasing the federal share of Medicaid as a method of fiscal support to states.[23]

One advantage of providing fiscal relief through Medicaid is that increasing the federal share of spending automatically targets increased federal support to states with the largest Medicaid programs and programs where spending is increasing the most rapidly. This targeting was critical, because one of the goals of the fiscal relief package was to help states maintain their health care programs. As a general targeting approach devoted exclusively to helping states plug their budget shortfalls, using Medicaid to target funds would be an imprecise tool, because states with large Medicaid programs do not necessarily have the largest budget shortfalls (Table 1). But because Medicaid is the second largest part of most states' general fund budgets, second usually to education, and its spending is growing quickly, increasing federal support for Medicaid relieves significant budget pressure for states.

The fiscal relief experience also demonstrates that increasing federal support for Medicaid can provide immediate financial assistance to states. The increase in the federal share of Medicaid spending was effective as of April 2003, predating the date on which the fiscal relief legislation was passed. Congress was able to do this because Medicaid was an existing program with an established structure by which states obtain federal payment on a quarterly basis. Contrast this with the experience of the $10 billion in unrestricted grants to states as part of the fiscal relief package, which were disbursed in two allotments to states, one in June and the other in September of 2003. States had to submit an application to the Treasury Department in order to receive the grants. While the payments to states were made at the same time, the FMAP increase took effect three to six months before the unrestricted grants.

5. **The fiscal relief came to states at the point when state tax revenues were lowest, but it came at the end of the recession, after significant Medicaid restrictions had occurred and in the middle of state fiscal years minimizing its impact in some states.**

The fiscal relief was received as state tax revenues were continuing to decline, and helped states balance their budgets, as it was intended to. While overall the fiscal relief achieved its primary objective, some could argue that if the fiscal relief had been implemented earlier, the impact could have been more significant as measured by different standards.

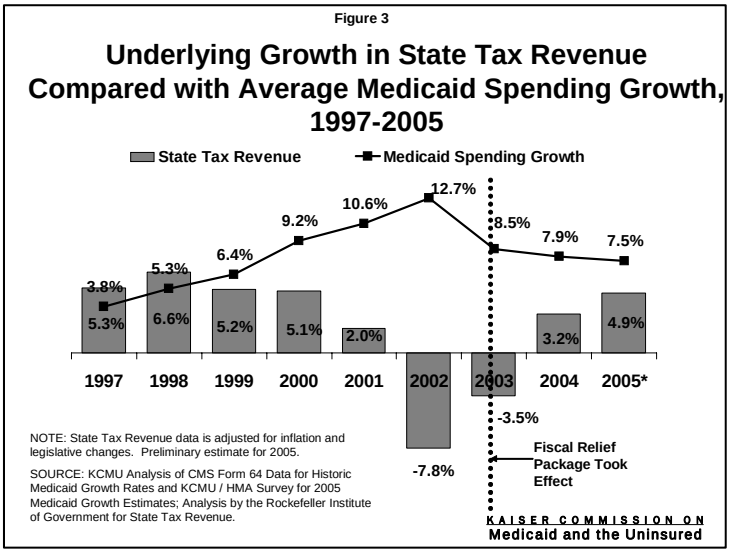
One clear Congressional goal for the fiscal relief was to help state budgets and to help states avoid the need for additional spending reductions or tax increases. To evaluate the success of the fiscal relief in achieving that goal, an appropriate comparison would be between the timing of the fiscal relief package and the beginning of the falloff in state tax revenues, which severely compromised states' ability to fund their programs without increasing taxes.[24] The fiscal relief package became law about a year and a half after the start of the state revenue crisis in late 2001.

[23] M. Sawicky, "An Idea Whose Time Has Returned: Anti-recession fiscal assistance for state and local governments," Economic Policy Institute, October 2001.

[24] In its report, GAO notes that national employment levels, which have a significant effect on state tax revenues, continued to decline after the technical end of the recession.

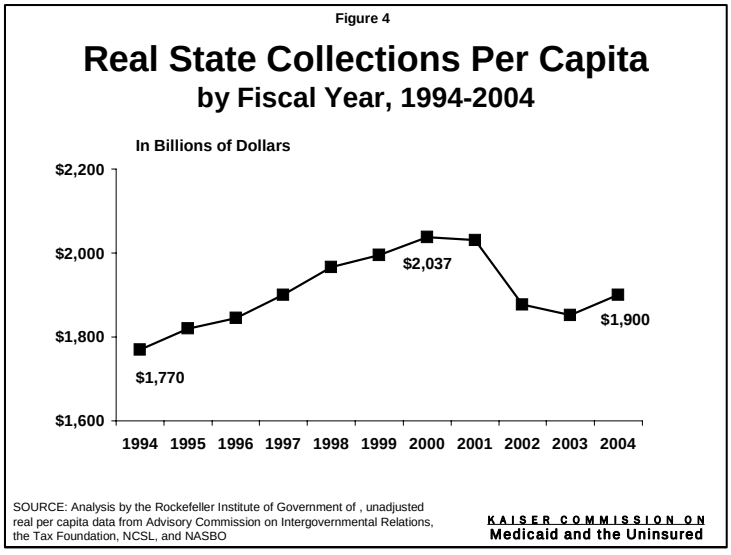
Growth in state tax revenues slowed significantly in 2001 to a rate of two percent, then fell at a fairly dramatic 7.8 percent rate in 2002, and the decline continued in 2003 (Figure 3). The fiscal relief did not take effect until well after the fiscal crisis began, but states still clearly needed the fiscal relief in 2003, as state tax revenues fell even further, and in 2004, as they began a recovery.

Figure 3



Even though state revenues started to recover in 2004, states' collective revenue levels are not yet approaching the levels they were prior to the start of the recession in 2001 (Figure 4). States have a large budgetary hole out of which to climb. As a Rockefeller Institute of Government report noted, "While the curve is now clearly headed upwards, it may still be years before the states have as much real revenue as they had before the recession."[25] Additionally, the economic recovery has been uneven across the states with revenue growth slowest in the Great Lakes region and fastest in the Far West. Revenue growth varies significantly by state and a few states are still experiencing revenue declines.

Figure 4



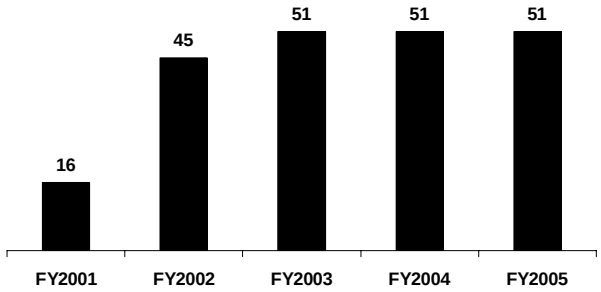
[25] NW. Jenny, "State Tax Revenue Growth Gains Momentum," The Rockefeller Institute of Government State Fiscal News: Vol. 4, No. 3, May 2004.

A General Accounting Office report observed that the fiscal relief was implemented more than a year and a half after the recession technically ended.[26] The economy began growing slightly in the fourth quarter of 2001, which for many economists marked the end of the recession, and the fiscal relief was not provided until May 2003.[27] GAO states that because the fiscal relief did not take effect until after the economy had begun to grow, it was not a powerful economic stimulus. However, it is not clear that the fiscal relief was intended to serve primarily as an economic stimulus.[28]

The increased FMAP also took effect after the major spike in Medicaid enrollment and well after states' focus on Medicaid cost containment increased. Reflecting the deepening of the state fiscal crisis, states' emphasis on Medicaid cost containment increased dramatically in 2002, and all 50 states and the District of Columbia implemented at least one new Medicaid cost containment plan in 2003 and 2004 (Figure 5). So although, as described in the previous sections of this paper, the increased federal matching rate helped states fund and maintain their Medicaid programs, had it been provided earlier, closer to the onset and early rapid acceleration of the fiscal crisis, it could have provided assistance to states at a time of significant state fiscal stress, and some substantial changes states made to the Medicaid program that had a negative effect on beneficiaries might have been avoided.

Figure 5

Number of States Undertaking At Least One Medicaid Cost Containment Plan FY 2001 – FY 2005



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, January 2003 and October 2004.

KAISER COMMISSION ON Medicaid and the Uninsured

[26] General Accounting Office letter to Senator Don Nickles, "Federal Assistance: Temporary State Fiscal Relief," May 7, 2004. See also Johnson and Park, A Response to GAO's Criticisms of State Fiscal Grants, Center on Budget and Policy Priorities, June 15, 2004.

[27] D. Boyd and V. Wachino, "Is the State Fiscal Crisis Over?" Kaiser Commission on Medicaid and the Uninsured, January 2004.

[28] Moreover, because the enhanced FMAP took effect for Medicaid spending that states incurred starting April 1, 2003, whereas the $10 billion in unrestricted revenue sharing grants to states were not disbursed until June 2003 and October 2003, the FMAP increase took place closer to the height of states' budget woes than the unrestricted grants did.

Finally, the fiscal relief also was provided after most states had completed their 2003 legislative sessions and had largely completed work on their FY 2004 budgets. This means that many states' budget plans for FY 2004 were not able to take the increased federal matching funds into account.[29] Many states therefore put the funds from the increased matching rate into reserve until their next legislative sessions, which in some states will not occur until 2005. Had the fiscal relief been available earlier in 2003, states would have been able to factor it into their FY 2004 budget plans and could potentially have avoided making some additional changes to their Medicaid programs. These timing criticisms do not reflect any inherent flaws in the design of the fiscal relief; they instead reflect the fact that the legislative process is often slow. Proposals to provide state fiscal relief were discussed in 2002 but not enacted by Congress until a year later.

Conclusion and Implications

As states faced the dilemma of funding Medicaid in light of daunting state budget conditions, the availability of increased federal support for the Medicaid program provided in the federal fiscal relief package helped states to both balance their budgets and maintain Medicaid eligibility. States used the increased federal matching funds to address spending increases in their Medicaid programs, without taking additional or larger actions to reduce spending. As a result of the fiscal relief, additional reductions to Medicaid programs were avoided helping to sustain accessibility and affordability of coverage for beneficiaries.

The fiscal relief experience demonstrates that increasing the federal share of Medicaid costs during recessions can help states preserve health and long-term care coverage despite sharply diminished state tax revenues. In this respect, the temporary increase in the federal matching rate provides a model for how to fund Medicaid during future recessions to help states balance their budgets without deep spending reductions or tax increases.

Tying the carrot of the $10 billion in increased federal Medicaid funding to a requirement that eligibility levels be maintained, discouraged states from pursuing eligibility restrictions during the time that the fiscal relief was in effect. States did not take the risk of losing increased federal matching funds if they reduced Medicaid eligibility levels. However, states were able to implement policies that limited enrollment without changing the eligibility standards, such as making enrollment more onerous. Overall, the fiscal relief helped preserve Medicaid coverage for people who might otherwise have lost it. This demonstrates the importance of providing additional federal support for the program at a time when state fiscal resources are low and the power of tying increased support to maintaining coverage as an incentive to states.

Timing also proved important. The increased FMAP was available quickly and targeted federal assistance to states based on the size of and rate of spending growth in their Medicaid programs. The directness of the fiscal relief to states through increasing Medicaid payments to states is more efficient than using unrestricted grant funds that require states to set up administrative

[29] V. Smith, et al., "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions." Kaiser Commission on Medicaid and the Uninsured, January 2004 and L. Ku, "Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs," Center on Budget and Policy Priorities, December 2003.

structures to disperse the funds. This was the first time the federal government employed Medicaid as a comprehensive fiscal relief tool to all 50 states in time of recession, and its speed and targeting show its potential as a fiscal relief tool again in the future.

Although the fiscal relief package helped states balance their budgets and maintain programs, some argue that had Congress enacted a fiscal relief package for states closer to the beginning of the state fiscal crisis in 2001, rather than in mid-2003, the temporary FMAP increase would likely have had a bigger impact in maintaining Medicaid coverage and helping states balance their budgets. The fiscal relief has now expired but states are only beginning to see some recovery in state revenues, and some have not yet experienced any revenue growth. The impact of the expiration on states is likely to be mixed. Relief could be better targeted if it were automatic when a recession drives up unemployment and diminishes state tax revenues. Different methods of designing such an automatic increase warrant consideration.

States and the federal government continue to struggle with Medicaid cost growth. Pressure to control costs remains high just as the program faces increased demands from rising enrollment, growing long-term care needs, overall health care costs and demographic changes. The ability of the Medicaid program to meet growing demands depends on adequate funding. However, even as the economy recovers, Medicaid spending growth is expected to continue to grow faster than state revenues. Congress is also considering a number of Medicaid savings proposals, some of these could shift additional costs to the states at a time when many states already face additional fiscal responsibility for the program as a result of formula-driven reductions in the federal match rates and the implementation of the new Medicare Part D program. To preserve Medicaid coverage and meet growing demands, the experience with fiscal relief shows that increasing the federal share of costs may be needed to offset states' more limited ability to raise revenue and the requirement that they balance their budgets.

Table 1: Fiscal Relief Amounts Compared to State Budget Shortfalls

Dollars in thousands

State	FY 2003 Medicaid Fiscal Relief	FY 2004 Medicaid Fiscal Relief	Total Medicaid Fiscal Relief	FY 2004 State Budget Deficit	FY 2004 Fiscal Relief as a % of 2004 Budget Deficit
Alabama	$47,481	$70,927	$118,408	NA	
Alaska	$11,570	$15,837	$27,407	$896,000	1.8%
Arizona	$56,903	$98,264	$155,167	$1,500,000	6.6%
Arkansas	$35,295	$57,447	$92,742	$0	
California	$563,860	$715,143	$1,279,003	$26,100,000	2.7%
Colorado	$35,028	$55,257	$90,285	$398,000	13.9%
Connecticut	$50,069	$80,706	$130,775	$1,942,000	4.2%
Delaware	$10,362	$17,581	$27,943	$196,000	9.0%
District of Columbia	$16,723	$25,697	$42,420	$143,000	18.0%
Florida	$162,970	$274,946	$437,916	$0	
Georgia	$115,648	$210,051	$325,700	$735,000	28.6%
Hawaii	$11,830	$19,697	$31,527	$110,000	17.9%
Idaho	$12,681	$23,935	$36,616	$160,000	15.0%
Illinois	$173,426	$224,817	$398,244	$3,600,000	6.2%
Indiana	$59,913	$108,504	$168,416	$750,000	14.5%
Iowa	$34,984	$48,529	$83,513	$414,000	11.7%
Kansas	$25,178	$37,308	$62,486	$980,000	3.8%
Kentucky	$52,995	$88,204	$141,199	$198,000	44.5%
Louisiana	$55,413	$89,001	$144,414	$600,000	14.8%
Maine	$32,156	$45,751	$77,908	$487,000	9.4%
Maryland	$69,254	$100,812	$170,066	$853,000	11.8%
Massachusetts	$115,669	$197,208	$312,878	$3,000,000	6.6%
Michigan	$139,241	$176,303	$315,545	$1,250,000	14.1%
Minnesota	$73,089	$124,489	$197,578	$2,376,000	5.2%
Mississippi	$40,172	$71,469	$111,641	$90,000	79.4%
Missouri	$74,609	$117,324	$191,933	$1,000,000	11.7%
Montana	$8,183	$14,948	$23,131	$116,000	12.9%
Nebraska	$19,445	$32,216	$51,662	$380,000	8.5%
Nevada	$13,289	$20,146	$33,435	NA	
New Hampshire	$11,489	$19,910	$31,399	$148,000	13.5%
New Jersey	$98,502	$148,340	$246,842	$4,600,000	3.2%
New Mexico	$30,456	$44,525	$74,981	$0	
New York	$559,357	$836,963	$1,396,320	$9,300,000	9.0%
North Carolina	$100,882	$175,999	$276,881	$2,000,000	8.8%
North Dakota	$10,643	$10,469	$21,113	$0	
Ohio	$151,268	$237,245	$388,513	$1,700,000	14.0%
Oklahoma	$34,098	$62,009	$96,107	$300,000	20.7%
Oregon	$36,982	$54,486	$91,468	$850,000	6.4%
Pennsylvania	$176,199	$285,421	$461,620	$2,403,000	11.9%
Rhode Island	$19,759	$35,644	$55,403	$174,000	20.5%
South Carolina	$46,213	$77,337	$123,550	$400,000	19.3%
South Dakota	$9,025	$11,779	$20,804	$54,000	21.8%
Tennessee	$83,431	$143,280	$226,711	NA	
Texas	$220,902	$330,481	$551,383	$3,700,000	8.9%
Utah	$16,639	$27,973	$44,612	$80,000	35.0%
Vermont	$12,241	$22,415	$34,656	$30,000	74.7%
Virginia	$68,201	$98,516	$166,717	$1,100,000	9.0%
Washington	$115,414	$63,162	$178,575	$1,000,000	6.3%
West Virginia	$30,396	$42,600	$72,995	$250,000	17.0%
Wisconsin	$72,483	$100,488	$172,971	$1,999,000	5.0%
Wyoming	$6,093	$12,193	$18,286	$0	
Total	***$4,028,109***	***$6,003,752***	***$10,031,865***	***$78,362,000***	**7.7%**

Source: FFIS, Issue Brief 05-09 Update on Medicaid Fiscal Relief Spending and Baseline Projections, March 9, 2005 and NCSL, State Budget Update: April 2003. NA = data not available

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/KCMU

Additional copies of this report (#7434) are available
on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.