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## PROPOSED STATE MEDICAID CUTS WOULD JEOPARDIZE HEALTH INSURANCE COVERAGE FOR ONE MILLION PEOPLE

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### Executive Summary

After having taken action to close \$50 billion in budget deficits in state fiscal year 2003, deficits of at least \$17.5 billion have reemerged for the current fiscal year as state fiscal crises have deepened,<sup>1</sup> and burgeoning deficits of \$60 billion to \$85 billion are now projected for fiscal year 2004, which starts July 1 in most states.<sup>2</sup> These represent the largest state deficits in half a century; they are at least twice as deep as the deficits states faced in the recession of the early 1990s. Since all states but one are required to balance their budgets each year, these deficits mean states will be under intense pressure to institute steep budget cuts in the weeks and months ahead.

Because of these large budget shortfalls — which equal 13 percent to 18 percent of state expenditures — a number of states have adopted major reductions in their Medicaid programs or are considering new budget proposals from their governors that include deep Medicaid cuts. If all of these reductions are implemented — both those that have already been adopted and those that governors have proposed in the past few weeks — approximately one million low-income individuals will lose health insurance coverage.<sup>3</sup>

Furthermore, this estimate is certain to grow substantially. It includes only those Medicaid cuts already adopted and those cuts proposed in the past few weeks by the handful of governors who unveiled budget-cut plans in December. In most states, governors will not release their budgets until January or early February. Those budgets are likely to include

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<sup>1</sup> National Conference of State Legislatures, *2003 State Budget Update*, November 2002.

<sup>2</sup> Iris Lav and Nicholas Johnson, *State Budget Deficits for Fiscal Year 2004 are Huge and Growing*, Center on Budget and Policy Priorities, December, 2002.

<sup>3</sup> The estimate of about one million was derived by totaling the projected number of people who would be dropped from coverage in 11 states, based on a combination of Medicaid policy changes that have been implemented, policy changes that have been approved and are scheduled to be implemented, and changes that have been proposed by governors in recent weeks. These projections are based on a variety of sources, including published state estimates, interviews with state officials, and analyses by state-based policy organizations. It is possible that some of the reductions that have been proposed may not be enacted by state legislatures and that some of the scheduled cuts may be delayed or rescinded. It also is possible, however, that Medicaid cuts may become still deeper in some of these states, as the states struggle to close widening deficits for 2003 and 2004. About half of this approximately one-million-person estimate represents cuts that have been adopted, while the other half represents cuts that governors have recently proposed.

proposals for substantial health insurance cutbacks, and the total number of individuals who would lose coverage consequently is expected to climb much higher.

Most of the approximately one million individuals who would lose Medicaid or state-funded health insurance coverage (and, in most such cases, become uninsured) are parents and children in low-income *working* families. The cutbacks in Medicaid eligibility overwhelmingly affect poor and near-poor working families with incomes too high to qualify for welfare. (In most states, families must have incomes many thousands of dollars below the poverty line to qualify for welfare.) In some states, Medicaid coverage also is being eliminated for some elderly and disabled people living below the poverty line.

- In California, the Governor has submitted proposals to eliminate health care coverage for nearly 300,000 low-income parents with incomes between 61 percent and 100 percent of the poverty line (between \$9,160 and \$15,000 for a family of three) and close to 200,000 parents with even lower incomes. These cuts would predominantly affect working poor families.
- Changes already being implemented in Tennessee's Medicaid program, TennCare, will eliminate health care coverage for between 160,000 and 250,000 adults and children. Here, too, those affected overwhelmingly are people in working families.
- Deep cuts in Oklahoma's health care programs have been approved and are scheduled to take effect in coming months, including near-elimination of the state's SCHIP program (the State Children's Health Insurance Program). If fully implemented, these cuts will cause approximately 80,000 children, adults, seniors and people with disabilities to be dropped from coverage. Those affected include large numbers of low-income children, as well as elderly and disabled people with incomes between 74 percent and 100 percent of the poverty line (between \$6,560 and \$8,860 for an elderly or disabled individual).
- Nebraska has implemented a series of Medicaid cuts that will likely result in the loss of health care coverage for an estimated 26,000 children and adults, including a number of parents who have recently left welfare for low-paid jobs that offer no health insurance.
- New Jersey has begun to phase out enrollment of low-income parents in NJ Family Care coverage, the state's joint Medicaid and SCHIP program, which has served more than 100,000 working parents. New Jersey has reduced the maximum income for parents not already enrolled in the program from 200 percent of the poverty line to about 25 to 37 percent of the poverty line (from about \$30,040 for a family of three to about \$3,800 to \$5,600).
- Missouri recently ended coverage for 36,000 low-income working parents, including a reduction in the income limit for working parents from 100 percent of the poverty line to 77 percent (from \$15,020 to \$11,565 for a family of three).

Because of a pending lawsuit, 17,000 of these 36,000 parents are continuing to receive temporary transitional Medicaid coverage, but this coverage will terminate once these transitional benefits expire.

- Massachusetts will eliminate coverage for about 50,000 unemployed low-income adults in April 2003.

These losses will magnify the upward trend in the number of Americans who are uninsured. Between 2000 and 2001, the number of people lacking health insurance rose by 1.4 million, mainly because millions of individuals lost their private health insurance in the economic downturn. Growth in the number of people enrolled in Medicaid and SCHIP helped to offset some of the loss of private coverage, so far fewer people became uninsured than would have been the case if the public programs were not able to pick up many of the low-income unemployed.<sup>4</sup> If increasingly hard-pressed states significantly scale back Medicaid coverage in order to reduce their budget gaps, the number of Americans without insurance will climb substantially higher in the coming year.

In mid-December, the National Conference of State Legislatures released a survey of state legislators and legislative staff that found that in the coming year, 44 states expect to consider proposals to limit Medicaid eligibility, cut the health services that Medicaid covers, and/or freeze or cut back payments to health care providers. These findings are similar to those of a survey of state Medicaid directors conducted last summer, which found that most states have already adopted Medicaid reductions but are planning more. In that survey, 18 states said that they had planned to cut Medicaid eligibility in 2003.<sup>5</sup> State fiscal conditions have worsened since that survey of Medicaid directors was conducted, and the outlook is likely to be still bleaker today.

This report provides brief summaries of actions recently taken or proposals being discussed in 11 states across the country, which have diverse geographic, economic and political characteristics. The adopted or proposed eligibility cutbacks in these 11 states alone would lead to the elimination of insurance coverage for about one million low-income people, including children, parents, seniors and people with disabilities.

Most governors will unveil their budgets for fiscal year 2004 in January, along with proposals to close deficits that have reemerged for 2003. When this occurs, the one-million number will climb higher. The states covered here are limited to those in which action already has been taken to cut Medicaid eligibility or governors already have made their new budget-cut proposals public. The state actions and governors' proposals that are described below are examples of the types of proposals that many other states may make when their governors present budgets next month.

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<sup>4</sup> Leighton Ku, *The Number Of Americans Without Health Insurance Rose In 2001 And Appears To Be Continuing To Rise In 2002*, Center on Budget and Policy Priorities, Revised Oct. 7, 2002.

<sup>5</sup> Health Policy Tracking Service, *2003 Health Care Priorities Survey Report*, National Conference of State Legislatures, December 2002. Vernon Smith, et al., *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002.

In addition to the many individuals who are likely to lose coverage, a much larger number will receive fewer health services as states eliminate Medicaid coverage for services like dental, vision, or rehabilitative care. Medicaid providers also will face significant cuts in their reimbursement rates in many areas, which may affect the quality of care and cause some physicians who currently participate in the program to cease accepting Medicaid patients.

The federal government can take action to help states avoid these severe cutbacks by providing substantial fiscal relief, such as by temporarily increasing the federal matching rate for Medicaid and also providing aid that can be used to support other state-funded programs. This would not only help to meet the needs of low- and moderate-income families but also would be one of the most effective steps the federal government could take to stimulate the economy.

### **States' Continuing Budget Problems**

Although the New Year is almost upon us, most states are not looking forward with optimism. State budget outlook are grim. About two-thirds (33) of the states report that, as of October, actual revenue collections were running below projected levels. Almost half (24) of the states report that their health care expenditures, including Medicaid, are exceeding budgeted levels for fiscal year 2003.<sup>6</sup> Even though most states struggled this past spring and summer to balance their budgets for the current state fiscal year (which runs from July 2002 to June 2003 in most states), the continuing fiscal problems will require many states to institute additional, mid-year budget reductions in the months ahead. The outlook for the state fiscal year 2004, which generally begins in July 2003, also is bleak. Raymond Scheppach, executive director of the National Governors Association, has described this as “the worst budget crisis states have faced since World War II.”<sup>7</sup>

Since all but one state is required to balance its budget each year, states face tough decisions on taxes and programs. Last year, many states eased their budget problems through one-time measures such as drawing down rainy day funds or tapping tobacco settlements, thereby avoiding structural tax changes or particularly harsh budget cuts. The coming year will be much tougher, since most states have depleted these one-time options and now must take more drastic steps to close their budget gaps.

### **Examples of Recent Policies and Proposals to Scale Back Medicaid**

The following are some of the actions that have been implemented in states in the past six months, have been adopted and are scheduled to be implemented in the months ahead, or have been proposed by governors in the past month or so. The last of these categories represents proposed actions rather than enacted policies: governors' proposals are not always accepted by state legislatures, but legislatures also often approve budget reductions that their governors did not submit.

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<sup>6</sup> National Conference of State Legislatures, *State Budget Update: November 2002*.

<sup>7</sup> Ronald Brownstein, “States Facing Budget Cuts,” *Los Angeles Times*, Nov. 26, 2002.

- **California.** In early December, Governor Davis proposed budget reductions beginning in the current state fiscal year that would eliminate Medicaid coverage for almost one half million (486,000) beneficiaries, primarily low-income working parents with incomes below the poverty line (\$15,020 for a family of three). Specifically, the governor has proposed to eliminate Medicaid coverage for approximately 293,000 low-income parents with incomes between 61 percent and 100 percent of the poverty line (an eligibility reduction from \$15,020 for a family of three to \$9,162). He also has proposed placing greater paperwork requirements on families with even lower incomes, a change that is projected to result in an additional 193,000 persons losing coverage because they fail to complete the paperwork required to remain enrolled. (These estimates are from the state Medicaid agency.) In addition, the proposal would lower reimbursement rates to health care providers by 10 percent and end coverage of certain dental, mental health, and rehabilitation services for adult beneficiaries.

The state legislature considered some of these proposals last summer and rejected them for current fiscal year, but the hemorrhaging of California's budget has brought the proposals back. In addition, in the fall, the state's budget problems led the governor to delay a long-planned expansion of health coverage for low-income parents even though the legislature had approved funding. It remains unclear when or whether the expansion, which was set to cover about 300,000 low-income uninsured parents, ever will be implemented. (These 300,000 individuals are in addition to the 486,000 described above, who are already enrolled in Medicaid and would be cut off). In January 2003, the governor may propose additional Medicaid budget reductions when he issues his budget for state fiscal year 2004.

- **Connecticut.** Governor Rowland released a proposed deficit reduction plan for the coming fiscal year on December 6, 2002. A large portion of his plan consists of changes that would eliminate health care coverage for thousands of parents and children in low-income working families. The plan also would freeze current enrollment in the state's SCHIP program and eliminate enrollment simplification tools such as presumptive eligibility and continuous eligibility, which have enabled uninsured children and families to gain and maintain health care coverage. Specific details regarding these proposals and the number of individuals whom they would affect are not yet available, but it is clear that the plan would reduce the Medicaid income limit for parents and other eligible adults from the current 150 percent of the poverty line to no more than 100 percent of the poverty line, and possibly to a lower level than that.
- **Massachusetts.** Under the budget passed this fall, the Massachusetts legislature voted to eliminate Medicaid coverage for about 50,000 unemployed adults with very low incomes, effective April 1, 2003. In October, the governor also took administrative actions to eliminate coverage for health services such as dentures and prosthetic devices for about 600,000 low-income beneficiaries, effective January 1, 2003.

- Missouri.** This past summer, the Missouri legislature passed, and Governor Holden signed into law, a large package of Medicaid cuts. These changes reduced coverage for low-income parents from 100 percent of the poverty line (\$15,020 for a family of three) to 77 percent of the poverty line (\$11,565 for a family of three), curtailed coverage for about 160,000 new mothers, and eliminated dental coverage for about 300,000 people. Because of temporary injunctions, the elimination of dental coverage has been delayed and the number of people losing coverage has been reduced, at least temporarily. The state originally planned to terminate insurance coverage for about 36,000 low-income adults at once, but 17,000 have remained eligible for temporary, transitional Medicaid coverage because of a court ruling. Once their transitional coverage ends, these 17,000 people will lose Medicaid coverage.
- Montana.** Governor Martz has just issued a number of proposals to scale back Medicaid expenditures. Although her final budget proposal does not include some severe budget cuts discussed a few months ago that would have eliminated the state's SCHIP program, it does contain significant cuts. For example, poor elderly and disabled adults who receive assistance from TANF or SSI would be able to see a physician only ten times a year, unless they get special permission from the state. While ten visits a year may be sufficient for many people, that number may prove insufficient for senior citizens or disabled people with chronic health conditions. The governor also has proposed to limit Medicaid eligibility for elderly people, particularly those who need nursing home care. These changes are in addition to administrative action the state took earlier this year to raise the amount of medical costs that Medicaid beneficiaries must pay out of their own pockets to the highest level in the nation.
- Nebraska.** On November 1, 2002, Nebraska implemented reductions in its Medicaid program that will result in an estimated 26,000 Nebraska children and adults losing health care coverage. These cuts include significant reductions in health care coverage for families transitioning from welfare to work. The state also changed the way that income is calculated in determining Medicaid eligibility in a manner that eliminates coverage for some low-income working families.
- Nevada.** Nevada has deferred implementation of a number of Medicaid expansion and simplification policies authorized by the state legislature. These include eliminating the Medicaid asset test for children and pregnant women, creating a joint Medicaid/SCHIP online application, and increasing provider reimbursement rates. The state also has implemented a number of Medicaid reductions, including reductions in managed care payments and pharmacy reimbursements and the imposition of tighter controls on the use of some prescription drugs. In addition, in September 2002, the state eliminated its temporary exemption of unemployment income when determining Medicaid eligibility; that exemption had helped families affected by the economic downturn

to qualify for Medicaid. The change eliminated Medicaid coverage for some unemployed families.

- **New Jersey.** This summer, New Jersey began implementing a series of changes in its joint Medicaid-SCHIP program, NJ Family Care. The state will no longer accept new applications from low-income working parents unless their incomes are at or below the state's income limit for welfare benefits. This effectively reduces the income limit for health care coverage from 200 percent of the poverty line (\$30,040 for a family of three) to about 25 to 37 percent of the poverty line (a range of about \$3,800 to \$5,600). More than 100,000 low-income New Jersey parents with incomes above the welfare income limits had received benefits from NJ Family Care; that number will now fall over time through attrition.<sup>8</sup> In addition, the state is reducing and restructuring benefits, including certain mental health services and occupational and physical therapy for non-elderly adult beneficiaries. Some of those affected by these changes have severe physical or mental health conditions.
- **Oklahoma.** Oklahoma adopted a series of cuts in September 2002. When fully implemented, these changes will eliminate coverage for approximately 80,000 individuals and reduce benefits for nearly 13,000 others. The state also has begun implementing cuts enacted earlier in the year.

On February 1, 2003, the state will eliminate its "Medically Needy" program, which provides coverage for low-income individuals whose incomes are modestly above the state's Medicaid income limits but who have extremely high medical costs that reduce their disposable incomes to levels below the Medicaid limits.

On July 1, 2003, Oklahoma is scheduled to slice the Medicaid eligibility limit for children between the ages of one and five from 185 percent of the poverty line (\$27,787 for a family of three) to 133 percent of the poverty line (\$20,020 for a family of three). It also will reduce the income limit for children aged six through 18 from 185 percent of the poverty line to 115 percent of the poverty line (\$17,273 for a family of three). For elderly and disabled individuals, the Medicaid income limit will be cut from 100 percent of the poverty line (\$8,860 for an individual) to 74 percent of the poverty line (\$6,556 for an individual). The state has just identified a source of revenues that may help it avert or postpone these July cutbacks. If these plans do not work out, then the abovementioned reductions will take place.

Oklahoma also has instituted cuts in the health services that Medicaid covers. On January 1, 2003, Oklahoma will reduce the health services that Medicaid covers

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<sup>8</sup> While the eligibility restrictions in NJ Family Care are severe, declines in program enrollment will be gradual. This is because parents who were already enrolled or who had applied by June 15, 2002 will be "grandfathered" into the program under the old eligibility rules. Declines in enrollment will occur as currently enrolled individuals gradually leave the program and are not replaced by new, low-income parents. Parents with incomes at or below the income limits for welfare in the state remain eligible for Medicaid.

for disabled adults, people with AIDS, and others who receive coverage through the SoonerCare plus program (one of the state's Medicaid managed care plans). The new policies will limit prescription drug coverage to three prescriptions per month and limit hospital coverage, physician services, and various other services. For example, inpatient hospital stays will be covered for no more than 15 days, as compared to 24 days currently covered.

- **Tennessee.** In July, Tennessee began implementing changes to its Medicaid waiver program, TennCare. A complex series of program changes were instituted that reduced eligibility and scaled back services.<sup>9</sup> Initially, the state estimated that these new policies would eliminate coverage for at least 160,000 beneficiaries. Since that time, preliminary data from the first several months of implementation suggest that the number of individuals losing coverage could exceed 250,000 by January.<sup>10</sup> These data indicate that between three and five percent of the state's population could lose insurance coverage under the new policies.
- **Washington.** Washington state has reallocated payments it makes for its Supplemental Security Income program, which has caused approximately 3,000 elderly and disabled beneficiaries to lose state SSI benefits — and to lose Medicaid coverage as well. The state also has imposed new cost-sharing and premium requirements on certain Medicaid beneficiaries, including co-payments for emergency room services and premiums for the second six months of transitional Medicaid coverage for those who have left welfare for work.

Governor Locke released a proposed budget for the upcoming fiscal year on December 17, 2002. The governor's budget includes a number of additional cuts in health care coverage, including elimination of state-funded health coverage for 60,000 low-income childless adults under the state's Basic Health Plan. The budget also proposes eliminating adult dental, vision, and hearing services covered under Medicaid and changing Medicaid application and renewal policies that have made it easier for eligible low-income families to obtain and retain coverage. Under the proposal, Medicaid recipients would need to have their eligibility reviewed every six months instead of annually, a change that usually results in some eligible families falling through the cracks and losing coverage.

The state has proposed still other changes under a pending federal waiver. If the waiver is approved, the state would cap Medicaid enrollment levels and limit benefits for certain Medicaid beneficiaries, while increasing the amount that some low-income families must pay to enroll in Medicaid and to receive various health care services. For example, approximately 160,000 Medicaid recipients would be

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<sup>9</sup> A federal court recently ruled that these terminations were improper and required the state to re-enroll those terminated, on at least a temporary basis. However, as of January 2, 2003, a federal appeals court has issued an emergency stay of action and will hear a request from the state for a permanent stay which, if granted, would prevent the re-enrollment of those whose eligibility was terminated.

<sup>10</sup> The Tennessee Health Care Campaign, a non-profit organization that monitors TennCare, has estimated that more than 250,000 beneficiaries will be terminated, based on data released by the state agency.



required to pay monthly premiums ranging from \$10 to \$60. The waiver also proposes to increase enrollment in the Basic Health Plan by 20,000 people, but given the 60,000 enrollment reduction in the Basic Health Plan proposed in the 2004 budget, the net change would be a scaled-back program that covered 40,000 fewer individuals.

When added together, the estimated number of people who would lose their Medicaid or state health coverage in these 11 states falls between 982,000 and 1,091,000, if all of the adopted, scheduled and proposed cuts are implemented.<sup>11</sup> About half that amount (546,000 individuals) represents reductions that have recently been proposed, while the other half (436,000 to 545,000 individuals) represents reductions already approved. These estimates are conservative since they do *not* include the effects of eligibility reductions in Nevada, Montana and Connecticut that have been adopted or proposed but for which estimates of the number of people affected are not available.

These examples reflect only a portion of the cuts that states will implement or consider in the months ahead. As governors issue their budget proposals and state legislatures take action to reduce expenditures in state fiscal years 2003 and 2004, additional proposals to cut Medicaid or SCHIP enrollment or benefits are certain to emerge in a much larger number of states.

## **The Role of Medicaid During An Economic Downturn**

In the past two years, almost all states have instituted some Medicaid budget reductions. A Kaiser Commission survey found that in fiscal year 2002, some 40 states imposed cost controls on prescription drugs, 22 states froze or reduced provider payment rates, and nine states reduced the scope of Medicaid benefits for fiscal year 2003. The Kaiser survey, conducted last summer when fiscal conditions in many states were not as dire as they are today, found states planned much more extensive Medicaid cuts in fiscal year 2003. Some 40 states reported they would impose drug benefit cost controls in 2003, while 29 states said they would reduce provider reimbursements, and 15 states said they would require Medicaid beneficiaries to pay more out of pocket.<sup>12</sup> Until now, many states have been able to avoid the most severe cuts, such as scaling back eligibility for low-income beneficiaries, although eight states cut Medicaid eligibility in 2002, and 18 states reported last summer that they planned to do so in fiscal year 2003. But the reemergence of substantial deficits in 2003 and the bleak forecast for fiscal year 2004 makes it almost certain that, absent an infusion of new revenues, many states will feel compelled to make still deeper program cuts. A number of states are likely to look to Medicaid to help close their burgeoning budget gaps.

Direct eligibility cuts would be especially harmful in view of the continued weakness in the economy and the important countercyclical role that Medicaid and SCHIP have been playing.

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<sup>11</sup> The range exists because there are differing estimates for Tennessee and Missouri. We consequently include a range for the estimates for these states.

<sup>12</sup> Vernon Smith, *op cit*.

Medicaid and SCHIP enrollment has risen in response to the economic downturn and prevented many families with children from becoming uninsured when they lose their jobs and health insurance. Survey data that the Centers for Disease Control and Prevention issued in 2002 show that if Medicaid and SCHIP had not been able to expand to meet the increased need that developed during 2001 and early 2002, the number of uninsured children would have been two million higher in the first quarter of 2002, and the number of uninsured working-age adults without health insurance would have been about one million higher.<sup>13</sup>

Medicaid eligibility cuts, as well as other Medicaid cuts such as reductions in covered benefits and in payment rates for providers, also would have the effect of further weakening state economies. Nobel Prize-winning economist Joseph Stiglitz, Brookings Senior Fellow Peter Orszag, and other economists have warned that balancing the budget during an economic slump by reducing government spending on goods and services is likely to be damaging to the economy and hence to be counterproductive.<sup>14</sup> This applies to Medicaid cuts. In fact, several recent studies have analyzed the potential adverse economic effects of substantial Medicaid cuts, including the loss of jobs and economic activity.<sup>15</sup>

## **The Federal Government Should Provide State Fiscal Relief**

The federal government could help avert or lessen the depth of damaging cuts in Medicaid and other state programs targeted to lower-income individuals. One effective means to do so would be to institute a temporary increase in the “Federal Medical Assistance Percentage” or FMAP, the matching rate that determines the federal government’s share of Medicaid costs. Such temporary fiscal relief could appreciably lessen the magnitude of Medicaid cuts that states otherwise would have to implement to balance their budgets in these times of fiscal stress. In July, the Senate passed by voice vote a strongly bipartisan amendment offered by Senators Jay Rockefeller (D-WV), Susan Collins (R-ME), Ben Nelson (D-NE), and Gordon Smith (R-OR) that would have provided \$9 billion in fiscal relief to states, in part by temporarily increasing Medicaid matching rates.<sup>16</sup> While this measure was never enacted into law (it was appended to

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<sup>13</sup> Leighton Ku, *op cit*.

<sup>14</sup> See, for example, Peter Orszag and Joseph Stiglitz, *Budget Cuts vs. Tax Increases at the State Level: Is One More Counter-Productive than the Other During a Recession?*, Center on Budget and Policy Priorities, Revised November 6, 2001. This paper finds that while any spending cuts or tax increases are counterproductive during a recession, tax increases — especially those targeted to higher-income individuals, who tend to save (rather than spend) a larger share of their income than people of lesser means — tend to have a less adverse effect than spending cuts, especially cuts targeted on low-income people.

<sup>15</sup> Division of Research, Moore School of Business, University of South Carolina, *Economic Impact of Medicaid on South Carolina*, January 2002; Gerald A. Doeksen and Cheryl St. Clair, *Economic Impact of the Medicaid Program on Alaska’s Economy*, March 2002; and Kerry E. Kilpatrick, Joshua Olnick, Michael I. Luger and Jun Koo, *The Economic Impact of Proposed Reductions in Medicaid Spending in North Carolina*, April 11, 2002.

<sup>16</sup> \$6 billion would have been provided through an increase in the FMAP. Some \$3 billion in fiscal relief would have been provided through temporary state fiscal relief grants under Title XX of the Social Security Act. Prior to being approved by voice vote, there was a procedural vote on a budget point of order that would have blocked consideration of the amendment. The point of order was defeated by a vote of 75-24, thereby allowing the amendment to be approved.

generic drug legislation that was opposed by the pharmaceutical industry and was never taken up in the House), Congress could consider proposals to raise federal Medicaid matching rates temporarily — and to supplement such a step with measures to provide fiscal relief to states in other ways as well — when Congress considers new stimulus or “growth” legislation in 2003.

Both the Administration and Congressional leaders are expected to call for large “stimulus” or “growth” packages to spur economic recovery. The Administration appears to be headed toward new tax cuts that are of dubious economic value as economic stimulus, would entail permanent rather than temporary costs, and would disproportionately benefit those with high incomes (a problematic approach for a stimulus package since affluent individuals tend to save rather than spend a greater share of their after-tax income than individuals with lower incomes do). A more appropriate and effective approach would involve providing substantial temporary fiscal relief to states with at least a significant portion being provided through a temporary increase in the federal Medicaid matching rate (or FMAP). Considering the deteriorating fiscal situation that states now face, the amount of fiscal relief provided needs to be considerably larger than that contained in the measure the Senate passed last July.

Relief of adequate size could avert or lessen the magnitude of devastating Medicaid eligibility cuts, as well as cuts in other programs such as education and child care. It also would ensure that state budget cuts do not undercut federal efforts to stimulate a stronger economic recovery. As economist William Gale, a Senior Fellow at the Brookings Institution, recently wrote: “the best way to boost the economy right now would be to increase federal aid to the states, which are facing their worst financial crisis in decades.”<sup>17</sup>

## **Conclusion**

States are facing budget gaps of historic proportions. Given that 49 states are required by law to balance their budgets, many will look to institute reductions in programs such as Medicaid. The impact of such cuts is likely to be severe for many poor and near-poor working families insured through Medicaid and SCHIP.

By providing states with fiscal relief through an increase in the federal matching rate for Medicaid and other means, the federal government can do its part to ensure that children, working families, seniors, and people with disabilities continue to receive health care coverage. Such assistance also would enable doctors, nurses, home health workers, hospitals, nursing homes and other health care providers to continue to provide the services needed to keep millions of Americans in good health.

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<sup>17</sup> William G. Gale, “Now Is the Time for All Good Feds to Come to the Aid of States,” *Los Angeles Times*, December 20, 2002.