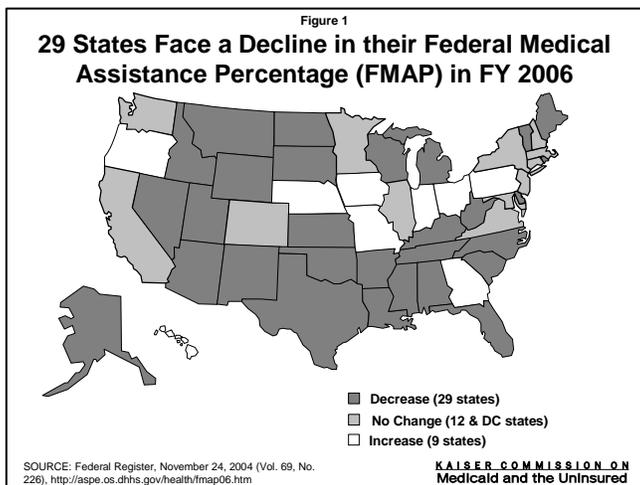


STATE FISCAL CONDITIONS AND MEDICAID

Medicaid serves many roles in the health care system, providing health coverage and long-term care assistance to over 39 million people in low-income families and 13 million elderly and disabled people, filling in gaps in Medicare coverage, and supporting safety net providers. After several years of fiscal stress, the state fiscal crisis is subsiding but Medicaid still faces long-term budgetary challenges.

STATES AND THE FEDERAL GOVERNMENT FINANCE MEDICAID

The states and the federal government share responsibility for financing Medicaid. The federal government matches state spending for the services Medicaid covers, with the federal matching rate varying by state from 50 to 77 percent of benefit costs. For FY 2006, 12 states have matching rates at the statutory floor of 50 percent and 11 states and DC have FMAPs of 69-76 percent. For FY 2006, 29 states were faced with a decline in their FMAPs due to data re-benchmarking, placing pressure on states to increase state dollars for Medicaid in order to maintain existing levels of funding (Figure 1).



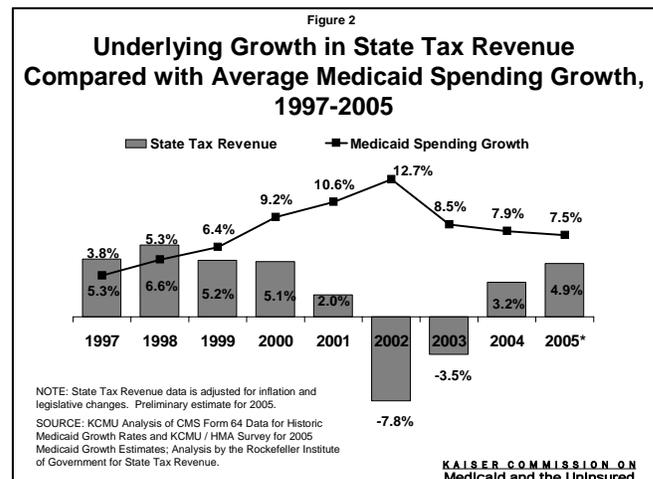
States design and administer their programs within federal rules that define the terms and conditions under which a state can earn federal matching funds. Medicaid's size and matching payments make Medicaid the single largest source of federal grant support to states, representing 43 percent of all federal grants to states. On average, states spend about 17 percent of their own funds on Medicaid, while education comprises the largest share (46%) of state budgets.

ECONOMIC RECOVERY SLOW AND UNEVEN

Beginning in 2001, the national economy worsened, state tax revenue plummeted, health care costs continued to rise, and more people became eligible for Medicaid as employers dropped coverage and poverty rates increased. Many states are now emerging from an extended period of extreme fiscal stress, although the economic recovery is uneven across the country. Revenue growth from 2004-2005 averaged 4.9 percent but was slowest in the Great Lakes region (1.5 percent) and fastest in the Far West (8 percent). Still, 26 states are expecting budget shortfalls totaling about \$26.9 billion in 2006. Additionally, the impact of the 2005 hurricane season has caused new stress on the economies of the Gulf States and the nation.

As the economy began to recover, state revenue growth started to climb while Medicaid spending growth slowed for the third straight year to an estimated 7.5 percent in 2005 after peaking in 2002 at 12.7 percent (Figure 2). One factor affecting the slowdown in spending is the decline in enrollment growth – dropping from a high of 9.9 percent in 2002 to 4 percent in 2005. While Medicaid growth still outpaces state revenue growth, Medicaid spending continues to grow at a slower pace than private health insurance premiums.

Although the gap between state revenue growth and Medicaid spending is narrowing, states are still under pressure to control Medicaid costs, although the primary drivers of the cost increases are generally beyond state control. States reported health care costs were the most significant factor driving spending. Pressures such as enrollment growth that are a function of the economy, poverty rates and changing demographics are likely to continue to impact Medicaid spending in the future.



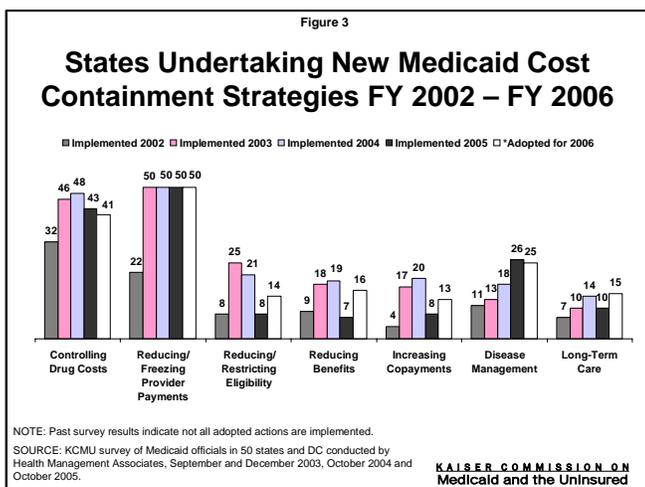
STATES CONTINUE COST CONTAINMENT EFFORTS

Responding to competing state budget demands and fiscal pressures, all 50 states and the District of Columbia implemented actions designed to control Medicaid spending growth in FY 2005 and adopted at least one new cost containment strategy for FY 2006.

In FY 2005 (Figure 3):

- 43 states implemented new pharmacy cost controls;
- 50 states froze or reduced payment rates for at least one group of providers, i.e. hospitals, physicians, or nursing homes;
- 8 states imposed new or higher beneficiary co-payments;
- 8 states imposed eligibility restrictions; and
- 7 states restricted or reduced benefits.

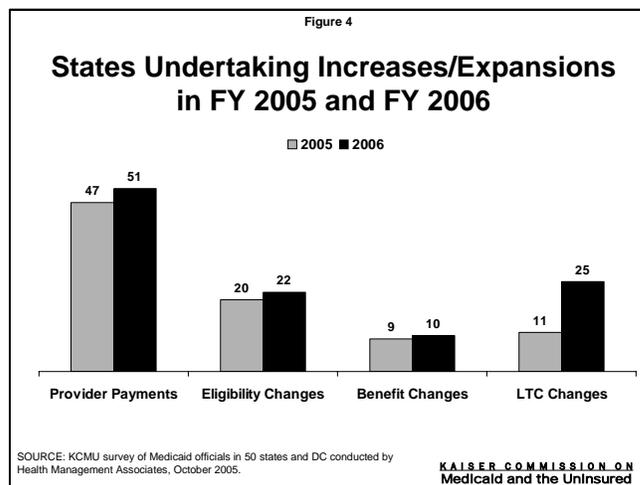
The number of states implementing eligibility and benefit cuts and increases to co-payments all declined in FY 2005, while efforts to implement disease management programs were expanded. In FY 2006, more states adopted measures to restrict eligibility and benefits, or increase co-payments; however, past surveys show not all adopted measures are implemented due to delays or positive changes in state revenues. In FY 2006, 25 states plan to implement new Section 1115 waivers that vary by size and scope. Of those states, 13 reported the primary goal of the waiver was to reduce cost while 14 states reported a goal to reduce the number of uninsured.



FY 2006 marks the fifth consecutive year of Medicaid cost containment action for most states. Between FY 2002 and FY 2006, all states reduced provider payment rates and implemented prescription drug cost controls; 43 states reduced eligibility by changing eligibility standards or income thresholds; and 39 states reduced benefits. These measures have helped constrain spending, but also place additional burden on Medicaid beneficiaries and providers.

STATES IMPLEMENT POSITIVE POLICY CHANGES

In FY 2005 and FY 2006, states implemented more positive policy initiatives such as expanding HCBS for long-term care. Forty-seven states in FY 2005 and all states in FY 2006 implemented or will implement at least one provider rate increase (Figure 4). More states implemented eligibility expansions or application simplifications (20 in FY 2005 and 22 in FY 2006) as states continue to use Medicaid as a vehicle to expand coverage.



FUTURE OUTLOOK

State Medicaid officials have expressed more optimism about the outlook for the future of Medicaid than in past years, but remain concerned about the long-term fiscal sustainability of the program. The overall state budget picture is beginning to improve in many states, as state revenue collections are improving and fewer states are reporting Medicaid budget shortfalls for FY 2006. However, the implementation of the new Medicaid Part D drug benefit will generate new fiscal responsibilities and administrative issues for states as well as challenges for beneficiaries. Major concerns also remain over the scheduled FMAP reductions in 29 states in FY 2006 and the potential impact of federal initiatives to reduce federal Medicaid spending being debated as part of the 2006 federal budget process.

In the future, continuing health care cost growth, demographic trends, and the erosion of private health insurance are all factors that will challenge Medicaid's role as a critical safety net that provides health and long-term care coverage to low-income people.

For additional information on Medicaid and state budgets please see the Kaiser Commission on Medicaid and the Uninsured report entitled, *Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006: Results from a 50-State Survey*, October 2005, available at www.kff.org. Additional copies of this publication (#4087-04 are also available online at www.kff.org.