
Medicaid:

*Good Medicine
For California's
Economy*

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Medicaid: Good Medicine for California's Economy

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INTRODUCTION

Medi-Cal, California's Medicaid program, helped pay for essential health care services for an estimated 5.9 million people in January 2003.¹ However, Governor Gray Davis has proposed major cuts to Medi-Cal spending for the remaining months of the current budget year, which ends June 30, 2003, and for the following budget year. These cuts would eliminate Medi-Cal coverage for almost one half million (486,000) beneficiaries, primarily low-income working parents with incomes below the federal poverty level (\$15,020 for a family of three).² In addition to the proposed Medi-Cal cuts, Governor Davis also has postponed a long-planned expansion of health coverage for low-income parents, even though the legislature had already approved funding; this expansion would have covered an additional 300,000 low-income uninsured parents.

In California, as in all states, the Medicaid program pays for essential primary and preventive health care services for low-income children and their parents that these families could not otherwise afford. For seniors and people with disabilities, Medi-Cal fills gaps in Medicare coverage by helping Medicare beneficiaries with their prescription drug costs as well as other essential services, such as dental care and hearing services. Medi-Cal pays the largest share of nursing home costs in California and helps families with the cost of home-based long-term care services. Clearly, reductions in Medi-Cal spending will jeopardize coverage for people who depend on these health care services.

Less understood is the unique role that Medi-Cal plays in stimulating state business activity and the California economy. Every dollar California spends on Medi-Cal pulls new federal dollars into the state—dollars that would not otherwise flow into the state. These new dollars pass from one person to another in successive rounds of spending. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of auto dealerships, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. Economists call this

the “multiplier effect.” The magnitude of the multiplier 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 Medi-Cal spending on California’s economy is much greater than the value of services purchased directly by the Medi-Cal program.

To determine the aggregate impact of Medi-Cal spending on the California 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 California and then calculate the new economic activity that will be generated by Medi-Cal spending or economic activity that will be lost due to Medi-Cal cuts 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 California Medi-Cal spending and its economic impact for two different years. First, we looked at the economic impact of actual state Medi-Cal spending in federal fiscal year 2001 (which runs from October 1, 2000 through September 30, 2001), the most recent year for which official expenditure data are available from the federal government. We used the federal fiscal year to enable us to compare California to the other 49 states.³ Second, we provide readers with updated Medi-Cal economic impact multipliers that can be used to predict the economic impact of currently proposed Medi-Cal budget cuts and to predict the impact of other additional cuts that may be proposed by the governor or the state legislature.

KEY FINDINGS

Spending on Medi-Cal Has a Significant Impact on California’s Economy

■ Business Activity (Output of Goods and Services)

In federal fiscal year 2001, California’s investment in Medi-Cal generated more than a two and a half-fold (255 percent) return in state economic benefit—an increase in business activity of \$31.5 billion from a state investment of \$12.4

billion. The value of increased business activity from California's Medi-Cal program spending was the second largest in the country, surpassed only by that of New York (see Table 1).

■ **Jobs and Wages**

In federal fiscal year 2001, California Medi-Cal spending generated 291,439 jobs with wages in excess of \$11.4 billion (see Table 2). These jobs included Medi-Cal personnel, other employment in the health care sector, and jobs generated as the Medi-Cal dollars circulated through different sectors of the economy. Only New York saw a larger benefit from Medicaid program investment than California.

The Economic Impact of a Cut in California's Medi-Cal Spending in 2003 Will Be Significant and Predictable

In federal fiscal year 2003 and beyond, the economic impact on business activity, jobs, and wages of California's Medi-Cal spending will be comparable, but not identical, to the impact in federal fiscal year 2001 (see Table 3). The changes in impact from federal fiscal year 2001 to federal fiscal year 2003 are due to both changes in the federal-to-state Medi-Cal matching rate and in changes in the economic factors and conditions in California. The economic multipliers for federal fiscal year 2003 can be used to project the economic consequences of the governor's proposed Medi-Cal cuts.

■ **Business Activity**

If California reduces its spending on Medi-Cal by \$826 million in the state's budget year ending June 30, 2004, as the governor has proposed, the state will lose \$1,966 million in business activity.

■ **Jobs and Wages**

The proposed \$826 million in cuts in California Medi-Cal spending for the state's budget year ending June 30, 2004 will reduce the number of jobs in California by 17,140, and Californians will lose \$719 million in corresponding salary and wages.

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.

DISCUSSION

Without question, the potential harm to people who rely on Medi-Cal should be the foremost consideration for any California policy maker who faces tough choices about Medi-Cal 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 Medi-Cal spending result in a gain or a loss of federal dollars, which will have significant implications for the California economy.

Medi-Cal: A State and Federal Partnership

The Medi-Cal program, California's Medicaid program, is a unique federal and state partnership. The federal government gives California great flexibility to design its program and, thus, to control state spending commitments. Every state Medicaid program must cover certain very low-income children, pregnant women, and some seniors and people with disabilities and must provide them with a defined set of benefits. However, above these minimum requirements, California can decide to expand Medi-Cal to more people and/or to cover more services. At the same time, the federal government "matches" every dollar that California chooses to invest in Medi-Cal to encourage the state to help more people. In this context of flexibility and federal matching funds, state 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 Medi-Cal among competing demands for limited state dollars. And the demands are growing as the dollars become more limited.

Medi-Cal: A Target for Cuts in the Current California Budget Crisis

California, like most states, operates on a budget year that runs from July 1 to June 30. In December 2002, Governor Gray Davis reported that without spending cuts, California could expect a \$34.8 billion budget deficit through budget year 2003-2004. To cover this shortfall, the governor proposed a series of "mid-year spending reduction proposals," to be implemented in the remaining six months of the budget year and then continue into budget year 2003-2004.⁴ (The governor's proposal did not include any proposed increases in tax revenue.) While the state

legislature did not act on the governor's proposals in December, it is expected that these proposals will be included in the governor's 2003-2004 budget proposal, to be released in January. The budget deficit for 2003-2004 alone has been estimated to be between \$15 and \$25 billion—from 19.5 to 32.5 percent of the total state budget.⁵

In the budget balancing act facing California, Medi-Cal is a target for significant spending cuts because it is one of the largest items in the state's budget. The largest item is public education. However, in California, the state constitution guarantees public schools roughly 40 percent of state tax revenue. In fact, the state has been spending more than that share in recent years and cuts to education—though the largest item in the governor's December proposal—were not large enough to meet the state's budget shortfall. Thus, the second-biggest target for reductions in Governor Davis's proposal were in health and human services spending, including Medi-Cal.

Governor Davis's proposed cuts to Medi-Cal would reduce spending by at least \$826 million in 2003-2004 (see Table 3). These cuts would eliminate Medi-Cal coverage for almost half a million (486,000) beneficiaries, primarily low-income working parents with incomes below the federal poverty level (\$15,020 for a family of three).

First, Governor Davis proposed to eliminate Medi-Cal coverage for low-income parents with incomes between 61 and 100 percent of poverty (an eligibility reduction from \$15,020 to \$9,162 for a family of three). This dramatic lowering of the Medi-Cal income eligibility level would deny coverage to over 293,000 low-income parents in 2003-2004 and to hundreds of thousands more in future years. The corresponding reduction in state spending achieved by this eligibility change is estimated to be \$118 million in 2003-2004.

Second, Governor Davis proposed to increase the paperwork requirements for families with even lower incomes, a change that is projected to reduce the Medi-Cal rolls as low-income people lose coverage when they fail to complete the paperwork. The new paperwork requirements would push an estimated 193,000 people off Medi-Cal by June 2004. The corresponding reduction in state spending achieved by this change is estimated to be \$85 million in 2003-2004.

Third, Governor Davis called for the end of coverage of several important Medi-Cal benefits, including dental coverage; psychiatric, chiropractic, and podiatric services; rehabilitation services; and certain medical supplies such as syringes, testing strips for diabetes, catheters, and rubber sheets. There are no estimates of the number of seniors, people with disabilities, or chronically or seriously ill adults who will lose this needed care. The corresponding reduction in state spending achieved by these cuts is estimated to be \$263 million in 2003-2004.

Fourth, Governor Davis's proposal would lower reimbursement rates for physicians and other providers, including nursing homes, by 10 percent (hospitals and federally qualified health centers would not be subject to the reimbursement decreases). This cut, which will reduce the number of doctors and nursing homes willing to serve Medi-Cal beneficiaries, is estimated to reduce state spending by \$360 million in 2003-2004.

Table 3

Economic Consequences of Proposed 2003-2004 Medi-Cal Cuts

Proposed Medi-Cal Cut	Expected Reduction in California Spending (in millions of dollars)	Effect on California's Economy		Effect on California Jobs		Effect on California Wages	
		Economic Activity Multiplier	Economic Losses (in millions of dollars)	Jobs Multiplier	Jobs Lost	Wage and Salary Multiplier	Wages Lost (in millions of dollars)
Deny Medi-Cal eligibility to two-parent working families (incomes from 61-100% of federal poverty level)	\$118.0	2.38	\$280.8	20.75	2,449	0.87	\$102.7
Paperwork requirements (re-institution of quarterly status report)	85.0	2.38	202.3	20.75	1,764	0.87	74.0
Elimination of medically necessary benefits (including dental coverage, psychiatric, chiropractic, and podiatry services, rehabilitation therapy, and certain medical supplies)	263.0	2.38	625.9	20.75	5,457	0.87	228.8
10% rate reduction to health care providers (including doctors and nursing homes)	360.0	2.38	856.8	20.75	7,470	0.87	313.2
TOTAL	\$826.0		\$1,965.9		17,140		\$718.6

In addition to the above proposed Medi-Cal cuts, Governor Davis also has delayed a long-planned expansion of health coverage for low-income parents even though the legislature had approved funding. This expansion would have covered an additional 300,000 low-income uninsured parents.

Many of the Medi-Cal cuts proposed by Governor Davis were rejected by the state legislature last summer—California policy makers understand that tough economic times have a human face and Medi-Cal spending cuts will directly harm the 5.9 million people who rely on the program for critical health services.⁶

Unfortunately, the continued growth of the state's budget shortfalls has made it more difficult to balance spending priorities and state budget bottom lines. Unlike the federal government, California is prohibited by law from having budget deficits at the end of their budget year. Thus, California policy makers can either raise taxes or cut spending. Some policy makers argue that raising taxes on consumers or on business will further damage California's economy and make the budget situation worse. These policy makers should recognize that cutting Medi-Cal can also do serious harm to the state's economy.

Medi-Cal: Good State Economic Policy

To generate new business activity, jobs, and wages in the California economy, money must be received from outside the state. For example, visits by out-of-state tourists or the sale of manufacturing products to purchasers outside the state bring new spending into California, contributing to economic growth. Buying health care services through Medi-Cal brings new money into the state in the form of Medicaid federal matching dollars. This injection of new dollars has a positive and measurable impact on the level of business activity, available jobs, and aggregate income in California.

Medi-Cal spending adds to California's economy in both direct and indirect ways. Medi-Cal 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 em-

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.”

Medi-Cal spending also provides a uniquely positive, counter-cyclical stimulus to the state’s economy during a recession or downturn. California’s Medi-Cal 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 Medi-Cal spending increases because most state government expenditures simply reallocate spending from one sector of the economy to another. When California increases its spending on Medi-Cal, by contrast, new federal matching dollars are brought in to the state’s economy.

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

Tables 1 and 2 show the positive impact of actual state Medicaid spending in federal fiscal year 2001 on the economies of California and the other 49 states. These tables show the significant return—in increased business activity, new jobs, and additional wages—gained by California from the state’s investment of dollars in Medi-Cal, the California Medicaid program.

Table 3 presents the most current Medi-Cal economic impact multipliers available based on the most recent RIMS II input-output economic model. These multipliers are applied to proposed changes in California’s 2003-2004 Medi-Cal spending to calculate the economic impact of these proposed cuts.

Governor Davis's proposed \$826 million in Medi-Cal cuts will result in:

- \$1,966 million in business activity lost ($\$826 \text{ million} \times 2.38$),
- 17,140 jobs lost (826×20.75), and
- \$719 million in employee salaries and wages lost ($\$826 \text{ million} \times 0.87$).

Less quantifiable, of course, is the impact on the lives of state residents who rely on Medi-Cal as their only source of health care.

Medi-Cal: Health Care at a Discount Price for the States

As California reduces spending on Medi-Cal, 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 and the counties. Thus, as states reduce the number of people served by the Medi-Cal 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 California really cannot avoid paying for at least some health care needed by its uninsured residents. By paying for that care through Medi-Cal, California can, in essence, buy these services at a 50 percent "discount" provided by the federal government through the federal-state matching formula. In any calculation of savings to the California budget from a Medi-Cal cut, these off-setting demands on state- and locally-funded programs must be part of the equation.

CONCLUSION

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

As California's budget options are weighed and balanced, the equation should include recognition of the economic benefit of using state spending on Medi-Cal to pull in new federal dollars. These new dollars are a powerful stimulus to the state's economy. The federal dollars that flow into California to match state Medi-Cal 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 on programs for Californians.

Thus, Medi-Cal spending is good medicine—both for the health of California residents and for an ailing state economy.

¹ Data downloaded on January 6, 2003 from the California Department of Health Services, Medical Care Statistics Section Web site, electronic file (Elig0301_Benes_by_Month_2003_01). Available online at (http://www.dhs.ca.gov/mcss/RequestedData/Monthly_Elig/monthly_elig.htm). This count does not include those who are on Medi-Cal but who have not met their share of cost for the month.

² Governor Gray Davis, State of California, "Mid-Year Spending Reduction Proposals," December 2002, on file at Families USA. Anthony Wright, "Health Care Budget Cuts Scorecard" (Sacramento, CA: Health Access), on file at Families USA.

³ 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. We used the 2001 federal fiscal year to facilitate comparison of the states.

⁴ Governor Gray Davis, *op. cit.*

⁵ Iris J. Lav and Nicholas Johnson, *State Budget Deficits For Fiscal Year 2004 are Huge and Growing* (Washington: Center on Budget and Policy Priorities, December 23, 2002).

⁶ See Endnote 1. While some savings in the Medi-Cal program might be identified that will not harm beneficiaries (in the area of prescription drugs, for example), the vast majority of cuts will directly harm the people who rely on Medi-Cal coverage for health care. For additional information about the impact of Medicaid program cuts on beneficiaries, see Families USA, *Medicaid State Budget Cuts: Preserving Medicaid in Tough Times, An Action Kit for State Advocates* (Washington: Families, USA, January 2003).

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, and wage and salary and personal income data.

Events or programs have an economic impact by attracting new spending that would otherwise not exist in a state. A new source of spending from outside a state creates a larger impact on a state economy than the amount of new spending alone through what economists call "multiplier effects." An economic multiplier quantifies the total impact on a state economy of successive rounds of spending that occur as the new spending is earned by state businesses and residents who then spend these earnings on purchases from other state firms or residents, who in turn make other purchases, creating successive rounds of earnings and purchases. However, these successive rounds of spending do not continue endlessly because, in each round of spending, a portion of purchases are made from outside of 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 federal fiscal year 2003, the federal match for Medicaid assistance ranged from a low of 50 percent (in twelve states including California) 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 otherwise would not occur or would 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 to the state economy.

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 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 California Medi-Cal spending and its economic impact for two different years:

- The report first looks at the economic impact of actual California Medi-Cal spending in federal fiscal year 2001 and compares it to state Medicaid spending for all 50 states (federal fiscal year 2001 is the most recent year for which federal expenditure data are available).
- The report then provides policy makers with the relevant economic impact multipliers needed to predict the economic impact of potential California Medi-Cal spending changes in budget year 2003-2004.

The economic impact of actual state Medicaid spending in 2001 and the economic impact multipliers for 2003 are based on federal fiscal years 2001 and 2003. *State* fiscal years vary. Forty-six states, including California, 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 federal fiscal year 2003 economic impact multipliers presented in this report in Table 3 can be applied to changes in California Medi-Cal spending to calculate the economic impact of changes in state budget year 2003-2004 (July 1, 2003-June 30, 2004) since the federal matching rate will not change and the economic conditions of a state do not change dramatically over several months or even over a period of one or two years.

Analysis 1:

The Economic Impact of Fiscal Year 2001 State Medicaid Spending

The first analysis measures the economic impact of state Medicaid spending in federal fiscal year 2001 for the 50 states. Fiscal year 2001 data on actual state and federal Medicaid expenditures, the most recent year 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 multipliers for state Medicaid spending were derived in two steps.

Using CMS-64 report expenditure data, the first step was the development of a state-specific federal matching multiplier that reflects the total amount of actual federal matching funds received by the state for each dollar of state funds spent. Actual federal matching rates were calculated by dividing the level of federal Medicaid assistance and administrative payments by the level of state Medicaid assistance and administrative spending to derive the average number of federal matching dollars generated for each dollar spent by the state government. The state-specific federal matching multiplier is then derived using the following formula ($1 / [1 - \text{Federal Match Percentage}] - 1$). This multiplier measures the actual federal dollars that flowed into the state for every state dollar spent on Medicaid in federal fiscal year 2001.

In the second step, for each state a total economic impact multiplier for Medicaid spending is derived by combining the state-specific federal matching multiplier with the appropriate state-specific RIMS II economic multipliers. The RIMS II multipliers vary according to how the dollars will be spent (differentiating between administrative spending and health care services spending) and according to a variety of measures of state economic structure and conditions.

Table 1 shows the impact of state Medicaid spending on total state economic output. Table 2 shows the impact of state Medicaid spending on jobs and the wages associated with these jobs.

Analysis 2:

The Fiscal Year 2003 Economic Impact Multipliers for California Medi-Cal Spending

The first analysis was based on Medicaid spending in federal fiscal year 2001. In order to analyze the impact of proposed Medi-Cal budget cuts, economic impact multipliers for federal fiscal year 2003 were developed. These multipliers measure the change in economic activity per dollar cut in California Medi-Cal 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 California 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 2003 Federal Medical Assistance Percentage for California (50.00 percent). The federal match percentage used in the formula for California's administrative costs was the actual federal match rate from federal 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 the mix of activities will not change substantially from fiscal year 2001 to fiscal year 2003 in California. The final federal matching multiplier is a weighted average of the federal matching multiplier for medical assistance payments and the California-specific administrative matching multiplier. The weighting of medical assistance to administrative expenditures is based on the allocation to each category in federal fiscal year 2001 for California.

The second step was the derivation of the economic impact multiplier for California Medi-Cal expenditures by multiplying the California federal matching multiplier by the relevant economic impact (output, employment, and earnings) from the RIMS II model. The resulting multiplier yields the total impact per dollar change in California Medi-Cal spending.

The Medi-Cal economic impact multipliers for federal fiscal year 2003 are presented in Table 3 and are used to calculate the impact of changes to the Medi-Cal program that were proposed by California Governor Gray Davis in December 2002.

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