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Highlights

- Medicaid is the largest state-run health care program in Utah and is a vital health care safety net for low-income populations. In FY 2002, Utah spent \$985.9 million (about 13.4% of its total budget) to provide Medicaid services to 188,817 low-income individuals in Utah. Spending for CHIP totaled \$30.1 million and provided services to approximately 26,700 children in Utah.
- When ranked by absolute dollar spending for Medicaid, and spending as a share of total budget, Utah is among the lowest states in the country. In 2001, only nine states spent less on Medicaid than Utah. When ranked by share of spending as a percent of total state budget, only three states allocated a smaller portion to Medicaid than Utah. In 2001, Utah committed 12.5% of the total state budget to Medicaid compared to the national average of 19.6%.
- Utah's federal Medicaid match rate in 2002 was 70.0%—one of the highest in the nation (a higher federal match rate means a larger contribution). Utah's 2002 match rate for CHIP was 80%. With such high matching rates, Utah was able to leverage its commitment of \$328.4 million to attract \$687.7 million in federal funds.
- The dollars Utah spends on Medicaid and CHIP stimulate business activity in the local economy. In 2001, Utah spent \$269.4 million in general funds and other local funds on Medicaid and CHIP. This investment generated \$619.2 million in federal funds (\$600.4 million in Medicaid and \$18.8 million for CHIP).
- Federal dollars received for Medicaid supported 16,818 jobs and provided \$437.4 million in earnings for Utah workers in 2001. Federal dollars received for CHIP supported 560 jobs and provided \$16.1 million in earnings for Utah workers.
- Tax revenue generated by federal funding for Medicaid and CHIP is significant. In 2001, the earnings derived from expenditures for Medicaid and CHIP generated tax revenues of \$49.1 million. Of this, \$32.8 million flowed to the state's treasury. To put this in perspective, for every dollar Utah spent for Medicaid and CHIP from the General Fund, it received \$0.37 in tax revenue.

The Economic Impact and Importance of Medicaid and CHIP on Utah's Economy*

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Introduction

Medicaid and CHIP (Children's Health Insurance Program) are federally matched health insurance programs that provide funding to help cover the cost of providing health care for low-income individuals. While ample information is available about the services provided under Medicaid and CHIP, little is known about the economic impact that these programs have on the local economy. With their federal matches, both Medicaid (and to a lesser extent CHIP) become large and important health insurance funding programs for Utah's less advantaged citizens. Without such well-funded programs, many individuals would forgo health care, utilize health care services less frequently, or access more expensive forms of health care (trips to the emergency room rather than preventive trips to a physician). All of these alternatives impose "hidden" costs on the Utah economy.

In contrast, a well-funded health insurance program provides basic health services to low-income individuals who cannot afford them. In addition, the money spent for these services flows through the Utah economy, supporting jobs, providing income for Utah workers and generating tax revenue for state and local units of government.

In 2002, the state of Utah and other local agencies allocated approximately \$322.3 million for Medicaid services. This contribution was matched by \$663.7 million in federal funds. Together, these funds provided health care services to 188,817 low-income residents throughout the state. During the same year, the state allocated approximately \$6.1 million to CHIP. This contribution resulted in a federal match of \$24.0 million. More than 26,000 children were enrolled in CHIP in 2002. This study provides a descriptive, but brief, overview of both Medicaid and CHIP and estimates the economic impact these programs had on the state's economy during 2001.

** The information presented in this report is based on a economic impact study undertaken by the Bureau of Economic and Business Research, commissioned by Utah Issues, Center for Poverty Research and Action.*

Overview

The Medicaid Program

Authorized under Title XIX of the Social Security Act, Medicaid is a joint federal-state health insurance program that provides medical and long-term assistance for certain low-income populations. States that participate in Medicaid (as of 1982 all states have elected to do so) have significant flexibility in designing their programs. Although states must provide a certain core set of services and must cover specific groups and/or individuals, each state has broad discretion in defining a benefits package, setting limits on the amount of services provided to its beneficiaries, establishing eligibility requirements and setting provider reimbursement rates.¹

Medicaid is the largest health insurance program in the U.S., covering more people and spending more money than Medicare.² However, unlike Medicare, Medicaid is a means-tested program, limiting coverage to low income individuals who cannot afford private insurance. Medicaid is also an entitlement program for both individuals and states. The government is required to cover the cost of services to all individuals who meet the program's eligibility requirements. And, each participating state has the right to federal matching funds for all expenditures incurred for covered services provided to eligible individuals. For the states, this entitlement is open-ended as there is no cap on the amount a state may receive.

Establishing the Federal Matching Rate

The federal government shares the cost of the Medicaid entitlement by providing states with "matching dollars." The rate at which state spending is matched by the federal government is known as the Federal Medical Assistance Percentage (FMAP) and is determined using a statutory formula based on state per capita income as a percentage of national per capita income. The formula is shown below:

$$1 - \left[\left(\frac{(\text{State Per Capita Income})^2}{(\text{National Per Capita Income})^2} \right) * .45 \right]$$

Under this formula, a state's FMAP rate is calculated using its ratio of per capita income squared to the U.S. per capita income squared. The percentages are calculated each federal fiscal year using state and national income data from the most recent three-year period. Poorer states (those with per capita income below the national average) have a larger FMAP rate, while a lower FMAP rate is given to more affluent states; however, no state's matching rate can be higher than 83.0%. Further, statutory provisions also provide that no state's matching rate is lower than 50%.³ Table 1 shows each state's FMAP for 2003. As a general rule, costs incurred by states in administering the Medicaid program are matched at a 50% rate by the federal government.

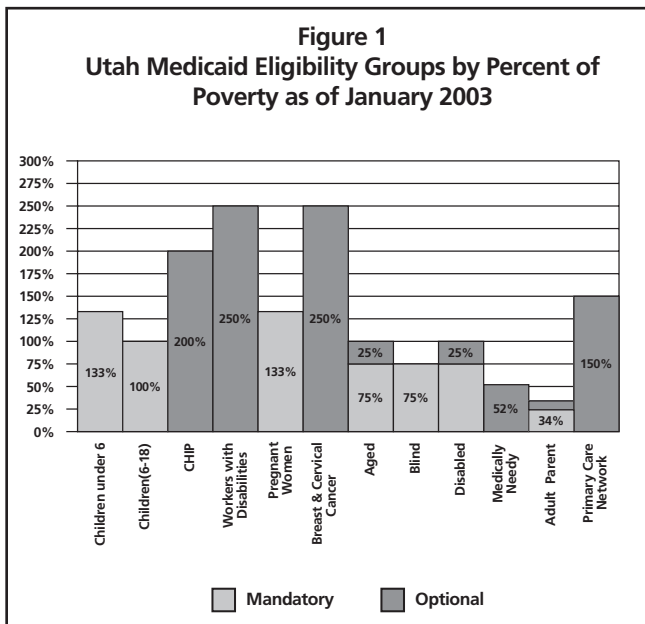
**Table 1
Federal Medicaid Assistance Percentages - 2003**

State	2003 FMAP	State	2003 FMAP	State	2003 FMAP
Alabama	70.60%	Kentucky	69.89%	North Dakota	68.36%
Alaska	58.27%	Louisiana	71.28%	Ohio	58.83%
Arizona	67.25%	Maine	66.22%	Oklahoma	70.56%
Arkansas	74.28%	Maryland	50.00%	Oregon	60.16%
California	50.00%	Massachusetts	50.00%	Pennsylvania	54.69%
Colorado	50.00%	Michigan	56.42%	Rhode Island	55.40%
Connecticut	50.00%	Minnesota	50.00%	South Carolina	69.81%
Delaware	50.00%	Mississippi	76.62%	South Dakota	65.29%
D.C.	70.00%	Missouri	61.23%	Tennessee	64.59%
Florida	58.83%	Montana	72.96%	Texas	59.99%
Georgia	59.60%	Nebraska	59.52%	Utah	71.24%
Hawaii	58.77%	Nevada	52.39%	Vermont	62.41%
Idaho	70.96%	New Hampshire	50.00%	Virginia	50.53%
Illinois	50.00%	New Jersey	50.00%	Washington	50.00%
Indiana	61.97%	New Mexico	74.56%	West Virginia	75.04%
Iowa	63.50%	New York	50.00%	Wisconsin	58.43%
Kansas	60.15%	North Carolina	62.56%	Wyoming	61.32%

Source: www.geocities.com/CapitolHill/5974

Utah's Medicaid Program

The Medicaid program in Utah is administered through the Utah Department of Health, Division of Health Care Financing. Each person applying for Medicaid must meet financial criteria and qualify as a member of a group that is categorically eligible for the program (low-income children, pregnant women, the elderly, persons with disabilities, and parents). Figure 1 shows the eligibility groups and the income standard guideline for each group.⁴ Table 2 shows the income standard guidelines for 2003.⁵

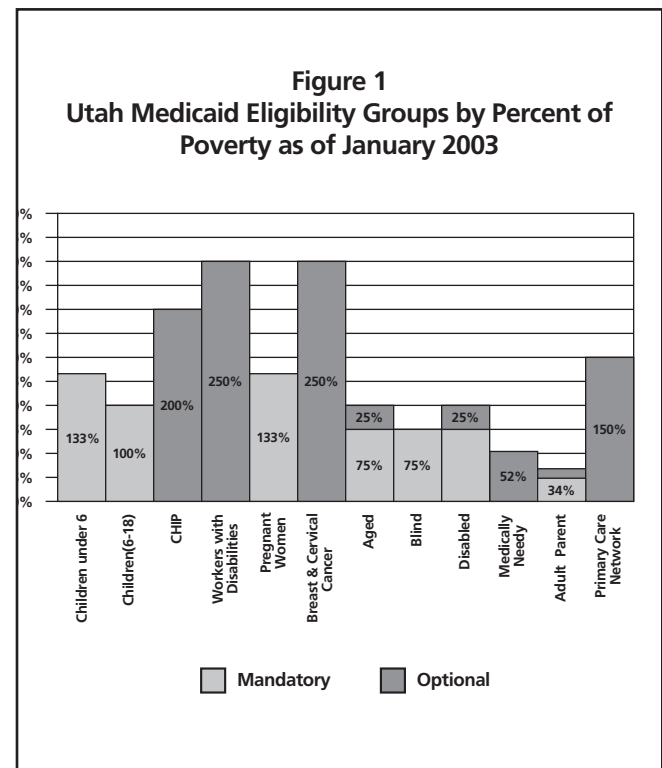


Medicaid is the largest state-administered public health insurance program for low-income Utahns. The populations served by Medicaid are often the poorest and most vulnerable. Medicaid is often the only source of health insurance for children and low-income families, and is the primary source of assistance for acute and long-term coverage for Utahns with disabilities. Based on Utah's eligibility requirements in 2002, 249,447 individuals (about 10% of the state's population) were eligible for the Medicaid program—an increase of 5.8% over the number of individuals eligible for services in 2001. The 2002 client count (people who were eligible and utilized the Medicaid program) was 188,817 compared to 173,284 in 2001—an increase of 9.0%.

Last year, expenditures incurred by clients through the Medicaid program totaled approximately \$986.0 million. Of this, the state provided \$183.9 million from its general fund and other organizations within the state contributed \$138.4 million. The remaining \$663.6 million came from federal sources. The capacity for the state to garner such a large share of matching dollars for Medicaid is its high FMAP.

In 2002, Utah's FMAP for the regular Medicaid program was 70.0%. This year, the FMAP increased to 71.24%—the seventh highest rate in the nation. Utah's high FMAP is the result of its demographic composition and the method used to calculate the FMAP. Per capita incomes in Utah tend to be low in comparison with the nation because the state's share of population in the working age group is comparatively small (59.3%). This works to Utah's advantage because the FMAP is based on a state's per capita income relative to the national average per capita income.

Since 1998, Medicaid costs in Utah have surged in large measure because of rapid growth in the cost of prescription drugs and providing care for disabled beneficiaries of Medicare who may be eligible for Medicaid. Under federal law, Medicaid is required to pay the cost of (1) providing drugs, (2) long-term care, (3) Medicare deductibles and (4) premiums for low-income Medicare recipients. Over half of Utah's Medicaid expenditures in 2002 were made on behalf of the disabled and the elderly. Although about 82% of Medicaid beneficiaries in Utah are children and adults, they account for only 42.7% of total Medicaid spending. At the same time, the elderly and people with disabilities comprise 17.5% of the beneficiaries but account for 57.3% of Medicaid spending for services, reflecting the high use of acute and long-term care. See Figure 2.



According to the Centers for Medicare and Medicaid Services, prescription drug spending, nursing home costs, and community-based long-term care have been significant contributors in expenditure growth and are expected to do

Table 2
Health and Human Services Poverty Guidelines
 All States Except Alaska and Hawaii

Size of Family Unit	Percent of Poverty Guideline								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	\$8,980	\$10,776	\$11,943	\$12,123	\$13,470	\$15,715	\$16,613	\$17,960	\$22,450
2	12,120	15,544	16,120	16,362	18,180	21,210	22,422	24,240	30,300
3	15,260	18,312	20,296	20,601	22,890	26,705	28,231	30,520	38,150
4	18,400	22,080	24,472	24,840	27,600	32,200	34,040	36,800	46,000
5	21,540	25,848	28,648	29,079	32,310	37,695	39,849	43,080	53,850
6	24,680	29,616	32,824	33,318	37,020	43,190	45,658	49,360	61,700
7	27,820	33,384	37,001	37,557	41,730	48,685	51,467	55,640	69,550
8	30,960	37,152	41,177	41,796	46,440	54,180	57,276	61,920	77,400

For family units of more than 8 members, add \$3,140 for each family member.

Source: Utah State Department of Health. Income guidelines as published in the Federal Register.

so in the future. (National Association of State Budget Officers).⁶ Expenditures for long-term care and pharmaceuticals accounted for 28% of all Medicaid spending in Utah in 2002.

Table 4 shows trends in Medicaid spending in Utah over the past five years.

Nationally, Medicaid has been one of the fastest growing components of the states' spending. As shown in Table 4, Medicaid expenditures as a percent of Utah's total budget have increased from 11.92% in 1998 to 13.48% in 2002. And, as shown in Table 5, Medicaid funding from non-federal sources has been increasing while the share of funding from federal sources has declined—in 1998, non-federal contributions to Medicaid represented 29.3% of total Medicaid spending in Utah but by 2002, the share of spending from non-federal sources increased to 32.7%.

On the face, it appears that Utah is assuming a larger share of the Medicaid burden; however, the percentage of Medicaid funding provided from the state's general fund has actually declined over the past five years. Funds provided by Other Local Sources are becoming an ever larger component of the state's Medicaid funding strategy. This phenomena is a reflection of a nationwide trend to maximize Medicaid financing. Some of these creative financing mechanisms include Disproportionate Share Hospital (DSH) payments, Provider Taxes and Donations and Administrative Claiming for School Based Services.⁷ In most cases, the states file claims with the federal government for expenditures made on behalf of Medicaid beneficiaries for covered services. And, in most cases, the

state does not ultimately spend it own general funds to satisfy the state matching requirement. Instead, through various mechanisms, some or all of the state matching requirement is ultimately paid by the federal government.⁸ Some of the maximization strategies used by Utah include pharmacy rebates, DSH payments, school district participation and Graduate Medical School participation.

While Medicaid expenditures represent an important share of the state's budget, Utah is consistently among the lowest ranked states in spending on Medicaid as a percent of total state appropriations. Detailed information collected by the National Association of State Budget Officers (NASBO) on state spending shows that Utah ranked 45th in percent of total state spending that went to support the Medicaid program in 2000 and 46th in 2001. Table 6.

Table 5
Sources of Medicaid Spending
by Share Contribution
1998 to 2002

Year	State Share	Other Local Share	Federal Share
1998	19.79%	9.53%	70.68%
1999	19.21%	10.50%	70.29%
2000	19.03%	11.16%	69.81%
2001	18.78%	11.81%	69.40%
2002	18.66%	14.04%	67.30%

**Table 4
Medicaid Service Expenditures, 1998 - 2002**

Fiscal Year	State Funds	Other Local Funds	Federal Funds	Medicaid Total	Percent Increase	Medicaid as a State Budget
1998	133,676,296	64,345,984	477,320,442	675,342,722	--	11.92%
1999	143,806,669	78,556,445	526,119,018	748,482,132	10.8%	12.24%
2000	151,739,019	88,962,144	556,541,347	797,242,510	6.5%	12.47%
2001	162,463,380	102,189,046	600,364,379	865,016,805	8.5%	12.51%
2002	183,931,966	138,356,686	663,670,491	985,959,143	14.0%	13.48%

Note: The figures reported as "Other State Funds" include Disproportionate Share Hospital payments, provider taxes, pharmaceutical rebates, fees, donations, assessments, and local funds.
Source: Utah State Department of Health.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is another federally matched health insurance program that provides children of eligible families access to health care services. CHIP was established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. It permits states to expand children's health coverage to children whose family incomes exceed the requirements for Medicaid, but are insufficient to afford private insurance coverage. CHIP makes approximately \$4.0 billion a year available to states in the form of federal grants to provide health coverage to children less than 19 years of age with family incomes at or below 200% of the federal poverty level. Implemented in Utah in 1998, CHIP has provided health services to nearly 50,000 children.

CHIP is also administered by the Utah Department of Health. CHIP contracts with private health care networks to provide health services. While the federal legislation that established CHIP does have certain requirements, the state has a substantial amount of freedom in designing a program that best meets the needs of Utah's children.

In Utah, families that may qualify for CHIP are those with children 18 years or younger and that meet the federal poverty guidelines implemented by the state of Utah for the CHIP program, earn too much to qualify for Medicaid and cannot afford health insurance. Approximately 26,700 children were enrolled in CHIP during 2002.

Funding for CHIP is provided primarily by the federal government through a federal match program. Unlike Medicaid, CHIP is not an entitlement program and limits the amount of federal money that states may access. The federal match maximum formula changes yearly, but generally ranges between \$23 million and \$24 million for the state of Utah. In 2001, the federal matching rate for Utah's CHIP was 80.03%, or, for every CHIP dollar spent

**Table 6
Medicaid Expenditures as a Percent of Total Expenditures**

State	Fiscal 2001	2001 Ranking	Fiscal 2000	2001 Ranking
Tennessee	31.4	1	28.4	1
Pennsylvania	28.3	2	27.9	2
Missouri	27.8	3	24.6	7
New Hampshire	26.9	4	24.2	8
Connecticut	26.2	5	26.1	4
Rhode Island	25.4	6	25.8	5
Louisiana	25.3	7	23.1	10
New York	25.3	8	26.3	3
Maine	24.9	9	25.0	5
Mississippi	22.6	10	21.8	11
Illinois	22.5	11	21.5	14
New Jersey	22.3	12	19.9	17
North Carolina	22.1	13	19.4	19
Vermont	21.5	14	23.4	9
West Virginia	21.3	15	21.8	11
Washington	20.6	16	20.0	16
South Carolina	20.6	17	20.2	15
Texas	20.1	18	21.8	11
South Dakota	19.9	19	18.6	23
Kentucky	19.8	20	19.6	18
Ohio	19.8	21	19.1	21
Georgia	19.4	22	14.9	37
Alabama	19.4	23	18.9	22
Michigan	19.1	24	19.4	19
Indiana	18.7	25	17.9	26
Nebraska	18.3	26	17.7	27

Table 6
Medicaid Expenditures as a
Percent of Total Expenditures
continued

State	Fiscal 2001	2001 Ranking	Fiscal 2000	2001 Ranking
Minnesota	18.2	27	18.5	24
Idaho	17.8	28	16.0	34
North Dakota	17.8	29	17.3	28
Florida	17	30	16.1	33
Colorado	16.9	31	16.9	29
Oklahoma	16.7	32	15.1	36
Arkansas	16.6	33	16.2	32
Massachusetts	16.5	34	18.3	25
California	16.4	35	16.5	31
Wyoming	16.4	36	14.1	40
Maryland	16	37	16.8	30
Arizona	15.9	38	13.5	41
Nevada	15.4	39	14.3	39
Montana	15.4	40	15.9	35
Oregon	14.9	41	13.0	43
Iowa	14.9	42	13.1	42
Kansas	14.7	43	14.6	38
New Mexico	13.8	44	13.0	43
Virginia	12.5	45	12.2	46
Utah	12.5	46	12.3	45
Wisconsin	11.2	47	11.0	47
Delaware	10.5	48	10.1	48
Hawaii	8.4	49	8.3	49
ALL STATES	19.6			19.1

in Utah, roughly 80¢ came from the federal government. Total spending in Utah for CHIP during 2001 was \$23.6 million. Of this, approximately \$4.7 million was contributed by the state of Utah. The remaining \$18.9 million was provided by the federal government. In 2002, the state committed approximately \$6.1 million which was matched with \$24.0 from federal sources.

Estimating the Job and Income Impacts of Medicaid and CHIP Spending

Because state revenues invested in Medicaid and CHIP can be leveraged with federal dollars, the economic impact of these programs on the Utah economy is significant. Dollars spent for Medicaid and CHIP generated from outside Utah (in the form of the federal match) inject new spending into the state's health services sector when they are used to pay for services provided by physicians, hospitals, nursing homes and other health-related business. These expenditures ultimately generate income and sustain jobs

for individuals not directly associated with the health care industry. This is known as the multiplier effect.

The multiplier effect is the sum of economic activity associated with Medicaid and CHIP spending in Utah. For example, as health care providers supported by Medicaid and CHIP funding purchase goods and services from other local business, a portion of that money is spent in Utah. This spending leads to subsequent rounds of income and spending by other businesses and individuals. In addition, employees of health care businesses also spend a portion of their earnings in Utah which, in turn, sustains jobs and provides income for workers in other sectors of the economy. In each round of spending, the impact dissipates as money is taxed, saved, or used to purchase goods from outside the state. Therefore, the multiplier effect continues but grows smaller as spending turns into income in ever-decreasing shares. The impacts that result from purchases made by business and purchases made by employees with their incomes are the indirect and induced impacts of the Medicaid and CHIP programs.

The jobs and earnings supported by Medicaid and CHIP spending can be estimated using a standard tool of regional economic impact analysis known as the Regional Input-Output Modeling System (RIMS II). Developed by the Bureau of Economic Analysis, U.S. Department of Commerce, RIMS II provides a 480-sector input-output model of the U.S. economy. This model tracks the flow of money, or input requirements, throughout the Utah economy. The model then infers the amount of output required from each industrial sector to satisfy the purchase requirements. In this case, health care expenditures paid for with federal matching monies represent the initial inputs. The model then estimates the indirect and induced impacts (outputs) that are required to satisfy the initial purchase requirements.

Federal matching dollars are the only initial inputs considered in this analysis since it is this money that flows from outside the state and is the impetus for economic expansion. New jobs are created when money from outside a region enters the local economy. Activities such as export-oriented manufacturing plants and out-of-state visitors are prime examples of activities that foster economic expansion. These activities bring new dollars into Utah which translate to additional jobs and income for Utah residents. In comparison, most state government expenditures, and spending for education and health care services, generally represent a reallocation of jobs and income among different industries within the state. So, although specific agency functions may provide a framework for economic development, they do not create new jobs and income in the local economy.

Utah's Medicaid and CHIP programs are exceptions. Medicaid and CHIP expenditures represent an injection of new spending into the economy rather than a reallocation

of existing resources because they include a substantial federal match. This federal match provides health care funding that would otherwise be taken from other sources or lost all together.

The federal match enters the Utah economy when the state contributes to the Medicaid program and CHIP. Conversely, when the state cuts Medicaid funding, it loses a portion of the federal contribution and health care spending declines. Cuts in Medicaid and CHIP not only limit the availability of health care for less advantaged individuals, if severe enough, and long enough in duration, program cuts could, over a period of time result in a loss of job and income.

Caveats to Job and Income Estimates

The jobs and income estimates presented here represent the activities that are supported by federal matching money, not necessarily *created* by federal matching money. For several reasons, the net economic impacts of federal Medicaid and CHIP spending in Utah are likely to be lower than the job and earnings estimates generated using RIMS II.

In regional impact models, impacts are defined as either an expansion or a contraction in the local economy; that is, how does the activity under analysis impact final demand in the region. In this case, the infusion of Medicaid and CHIP dollars contributes to an expansion of local activity because money is flowing into Utah from an outside source; however, the full extent of the impact depends on how the economy would react to the loss of this outside money. From this vantage point, the actual loss of jobs and income would initially be lower than the estimate of jobs and income supported by Medicaid and CHIP spending because some of the current Medicaid and CHIP beneficiaries would still utilize some level of health care by paying for these services with their own funds, or with funds from other sources. In order for the loss of jobs and income to equal the full economic impact estimate provided here, two conditions need to be met: (1) the state loses all federal matching dollars, and (2) the individuals who qualify for Medicaid and CHIP would not seek any medical services in Utah.

In reality, the uninsured do seek health care services, albeit at a lower rate than those who are insured. Based on research conducted by the Institute of Medicine Committee on the Consequences of Uninsurance, while the uninsured are much more likely to forgo needed care, many do seek some level of health care. In a study cited by the Institute of Medicine, after adjusting for differences in age, sex, income, and health status, uninsured people were less than half as likely as insured persons to receive care for a condition that physicians deemed highly serious and requiring medical attention.^{9,10}

Although people who lack insurance will generally forgo

the care they need until their condition becomes intolerable, others obtain the health care they need even without insurance, by paying for it out-of-pocket or seeking it from providers who offer care free of charge or at highly subsidized rates.¹¹ Others may utilize emergency room services when their medical conditions become severe regardless of their ability to pay.

Further, without the safety net of Medicaid, a large share of the health care services provided by hospitals to the uninsured would be provided as uncompensated care (the sum of bad debt and charity care)--a burden that is not distributed evenly across providers. Historically, a disproportionate share of uncompensated care has been provided by hospitals. One study conducted by Health Affairs, a health policy journal, reports that in 1999, hospitals incurred \$20.8 billion, or 6.2% of their total expenditures, in costs for patients who did not pay their bills. Public teaching hospitals also tend to bear an even greater share of the burden than non teaching hospitals. Given the disproportionate burden of providing uncompensated care that is carried by public hospitals and the important role they play in providing access to care for the uninsured, cuts in Medicaid could have significant and profound effects on these institutions by damaging their revenue stream.

Finally, hospitals in the state of Utah are required to provide services to individuals who access care through hospital emergency rooms, regardless of that individual's ability to pay. Individuals who access emergency room services, but cannot afford to pay for such services drive up the cost of health for those who can afford to pay. At some point, uncompensated care will erode the financial viability of the providing institutions.

Therefore, the extent to which people continue to utilize health care services will ultimately determine the impact on the economy if Medicaid (or CHIP) funding is reduced. If funding cuts result in fewer individuals seeking services or accessing services less often, an overcapacity will develop in the system over time. The market will eventually compensate for this overcapacity and fewer health care professionals will be needed. The timing of the adjustment and the net job loss have not been estimated in this analysis.

Estimating Fiscal Impacts

In addition to the impact on jobs and earnings, federal dollars spent for health care in Utah generate fiscal impacts. The fiscal impacts presented here represent the tax revenue generated by earnings that can be attributed to Medicaid and CHIP spending in Utah during the study year.

To estimate the fiscal revenue, an effective state and local tax rate was derived by dividing total state and local tax receipts (less corporate income tax) by total state personal income. The base year used was 1999-2000 (the most recent year for which data are available). This ratio

(10.83%) was applied to the earnings attributed to Medicaid and CHIP spending to determine the portion of state tax revenue that may result from these expenditures.¹²

Caveats to Fiscal Estimates

The fiscal impact estimates generated in this report assume that all state and local taxes are tied directly to personal income. This assumption is certainly the case with respect to state income tax, and to a lesser extent sales tax; however, the relationship between personal income and property tax is less obvious. Receipts from property tax (and possibly other types of taxes) may not be in direct proportion to an increase in earnings. Increases in property tax in particular are tied to other factors - primarily increases in property values. Therefore, the fiscal estimates presented here should be viewed as an "upper bound" estimate of the impact on state and local tax revenues.

For clarification, the fiscal impacts that accrue to the state and those that accrue to local units of government are separately identified.

The Economic Impact of the Utah Medicaid Program

In 2001, Utah spent \$865.0 million for Medicaid services. Of this, \$600.4 million was provided by the federal government. These federal dollars supported 16,818 jobs and provided \$437.4 million in earnings for Utah workers.

From a fiscal perspective, the federal portion of Medicaid generated \$47.3 million in revenue for state and local governments. Of this, \$31.6 million flowed to the state's treasury. To put this in perspective, for every \$1.00 Utah spent for Medicaid, 12¢ was returned to the state treasury through the generation of net new tax revenue. Local units of government realized a tax benefit of \$15.7 million.

Based on Utah's matching rate in 2001, an allocation of \$1.0 million in state funds was matched with \$2.27 million in federal funds. This federal match supported 64 jobs, and provided \$1.6 million in earnings for Utah workers.

The Economic Impact of CHIP

In 2001, Utah spent \$23.6 million for CHIP. Of this, about \$18.9 million was provided by the federal government. These federal dollars supported 560 jobs and provided \$16.1 million in earnings for Utah workers.

The fiscal impact of CHIP totaled \$1.7 million. Of this, \$1.1 million flowed to the state's treasury. Or, for every \$1.00 Utah spent on CHIP, 25¢ was generated in tax revenue. Local units of government realized a tax benefit of \$581,262.

Based on Utah's matching rate for CHIP in 2001, an allocation of \$1.0 million in state funds was matched with

\$4.0 million in federal funds. This federal match supported 120 jobs and generated \$3.4 million in earnings for Utah workers.

Tables 7 and 8 summarize the economic impact estimates.

Summary

Table 7 Economic Impact Summary of Medicaid and CHIP - 2001		
	Medicaid	CHIP
Federal Contribution	\$600,364,379	\$18,880,000
Jobs	16,818	560
Earnings	\$437,413,719	\$16,146,176
Fiscal Impacts		
State Governments	\$31,625,012	\$1,167,369
Local Governments	\$15,746,894	\$581,262
Total	\$47,371,906	\$1,748,631

Source: Federal Medicaid and CHIP contributions: Bruce Wood, Utah State Department of Health.
Estimates of Jobs, Earnings and Fiscal Revenue: Bureau of Economic and Business Research, University of Utah, David Eccles School of Business.

Table 8 Summary Impact of State and Local Source Contribution		
Every \$1,000,000 of state and local source contribution resulted in ...		
	Medicaid	CHIP
Federal Contribution	\$2,270,000	\$4,000,000
Jobs	64	120
Earnings	\$1,664,576	\$3,459,900
State Tax Revenue	\$120,349	\$250,151

- Medicaid is a large entitlement program that provides health insurance for low income populations. A defining characteristic is the open-ended federal matching arrangement that enables states to draw federal funds, without limit, to help pay the costs they incur in providing basic medical and long-term care to low-income populations. CHIP is also a federally matched program that provides health insurance for children in low-income families with incomes too high to qualify for Medicaid. In contrast to Medicaid, CHIP is a federally capped block grant program with limits on the amount a state can access. Together, Medicaid and CHIP provide a vital health care safety net for low-income individuals in the state of Utah.

- Medicaid is the largest health insurance program in the United States covering more people and spending more money than Medicare. It is a means-tested program that limits eligibility to low-income individuals who cannot afford private insurance including the aged, disabled, and working poor. CHIP is also a means-tested program but is not an entitlement program. States are not federally mandated to provide services to children if their families do not qualify for Medicaid.

- While the amount Utah contributes to the Medicaid program is significant, the state also receives a substantial federal match. In 2002, Utah's FMAP was 70.0%; one of the largest matching rates of all states. Therefore, an allocation of \$322.3 million in state and other local funds for Medicaid services was matched with \$663.7 million in federal funding. The state's matching rate for CHIP was 80%, so an allocation of \$6.1 million in state monies for CHIP was matched with \$24.0 million in federal funding.

- Last year, Utah committed 13.4% of its budget to the Medicaid program compared to 11.9% in 1998. Rising costs for pharmaceuticals, long-term care and providing care for the elderly and disabled are major factors in explaining the increase. Costs for these services are expected to continue to escalate.

- Utah's contribution to the Medicaid program, while substantial in absolute terms, is low in terms of budget share allocation. In 2001, Utah committed 12.4% of its total budget to Medicaid. The average for all states was 19.1%. Only three states (Wisconsin, Delaware and Hawaii) contributed a smaller share their total state budgets to Medicaid than Utah.

- The dollars that flow into Utah in the form of the federal match for both Medicaid and CHIP represent new resources for the state. As state budget options are evaluated, the analysis should include the economic benefits of using state money to attract federal dollars. These federal dollars generate new business activity, create and sustain jobs and generate income for Utah's residents.

- In 2001, federally financed expenditures for Medicaid and CHIP sustained 17,378 jobs in the Utah economy and generated \$435.6 million in earnings. The fiscal impacts totaled \$49.1 million-\$32.8 million for the state's treasury and \$16.3 for local units of government.

- Based on these impact numbers, \$1.0 million in spending by the state was matched with \$2.27 million in federal money, supported 64 jobs and generated \$1.66 million in earnings for Utah residents. Likewise, a \$1.0 million allocation to CHIP was matched with \$4.0 million in federal money, sustained 120 jobs and generated \$3.45 million in earnings.

End notes

¹ Kaiser Commission on Medicaid and the Uninsured, "Medicaid at a Glance"; available at www.kff.org.

² Centers for Medicare and Medicaid Services, Office of the Actuary, "Health Spending Projections for 2002-2012." Based on these projections, Medicaid spending will exceed \$276.9 billion in 2003 compared to Medicare spending of \$254.4. Medicaid projections include both state and federal spending for Medicaid.

³ The FMAP produced by this formula applies to a state's spending for almost all covered services provided to Medicaid beneficiaries. However, some services carry a higher matching rate. For example, family planning services and supplies are matched at 90%. The federal matching rate for services provided to Native Americans and Alaska Natives at a facility run by the Indian Health Service (or a tribal contractor) is 100%.

⁴ Utah State Department of Health, Bureau of Financial Services, Division of Health Care Financing. Data provided by Bruce Wood.

⁵ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Available at <http://aspe.hhs.gov/poverty/03poverty>. The income standard guideline is based on federal poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

⁶ "NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal 2003," National Association of State Budget Officers, March 15, 2002.

⁷ The DSH program was established in 1981 and requires state Medicaid programs to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when

determining payment rates for inpatient hospital care. This requirement is known as the Medicaid disproportionate share hospital adjustment. Essentially, it allows certain hospitals to access federal Medicaid funds using their own revenues as “seed money.” Pharmacy rebates have also been growing at a rate of about 20% per year. In this program, pharmaceutical manufacturers give the Health Department a rebate on all Medicaid prescriptions.

An simple example of how a Medicaid DSH program can work is shown here. There are other variations on this theme:

- (1) Revenue: A state receives revenue from a provider. In this example, the state receives \$10.0 million.
- (2) Spending: The state then makes a DSH payment back to the provider as a lump sum or an increase in the Medicaid inpatient reimbursement rate. Here, the state makes a \$12.0 million DSH payment to the same provider that made the donation.
- (3) Federal Match: Since DSH charges are matchable Medicaid expenses, the federal government reimburses the state at the state's FMAP rate. Assuming that the matching rate is 50%, the federal government would reimburse the state half of the \$12 million, or \$6.0 million.

At the end of the transaction, the provider has received \$2.0 million in DSH payments and the state has received \$4.0 million in federal money without spending any of its own funds. Urban Institute, “The Medicaid Disproportionate Share Hospital Payment Program” available at www.urban.org.

⁸ A detailed discussion of these maximization strategies is

provided in the “Medicaid Resource Book” Available from the Kaiser Commission on Medicaid and the Uninsured at www.kff.org.

⁹ According to the Institute of Medicine report “Coverage Matters: Insurance and Health Care” (2001) People without insurance are also less likely than people with insurance to receive preventive services and appropriate routine care for chronic conditions. Finally, those who lack health insurance are more likely to be hospitalized for conditions that might have been avoided with timely ambulatory care.

¹⁰ Baker, David W., Martin F. Shapiro, and Claudia L. Schur. 2000. “Health Insurance and Access to Care for Symptomatic Conditions,” *Archives of Internal Medicine* 160(9):1269-1274.

¹¹ Institute of Medicine, “Coverage Matters: Insurance and Health Care” (2001) National Academy Press (Washington, D.C.) Accessible at <http://www.nap.edu>

¹² Total tax revenue (less corporate income tax) in fiscal year 1999 in Utah was \$5,699,327,000. Total personal income in calendar year 1999 in Utah was \$52,622,000,000. Source: U.S. Bureau of the Census, “Utah State and Local Government Finances by Level of Government and State”; and “State Government Finances: 1999-2000.” Accessible at <http://www.census.gov>.

New at BEBR

Census 2000 City and County Profiles

The Bureau of Economic and Business Research at the University of Utah has produced Census 2000 data profiles for the state, all Utah counties, and all 289 Utah cities, towns, and Census Designated Places. These 58-page profiles contain all Summary File 3 (SF3) data for a given area, including population, income, education, housing, employment, poverty, disability, language, ancestry, migration, and transportation profiles. These profiles can be produced down to the block group level. Available online at <http://www.business.utah.edu/bebr/CensusData/webpage1.htm>

Utah Minorities: The Story Told by 150 Years of Census Data

The Bureau of Economic and Business Research at the University of Utah has released a study of Utah minorities based on census data going back to 1850. Immigration to the U.S. in the 1990s has been of historic proportions. Utahórelatively unaffected by major migrations of minorities in the pastóbecame the destination for many of these recent migrants (particularly Latinos), resulting in a significant increase in its diversity. While not present in large numbers, minorities have been counted in Utah from the Territorial Census of 1850. A county-level database has been constructed to account for the changing racial and ethnic composition of Utah. The story is further complicated by the changing racial/ethnic categories used by the Federal government to enumerate the population. The monograph is available in hard copy and online at http://www.business.utah.edu/bebr/onlinepublications/Utah_Minorities.pdf

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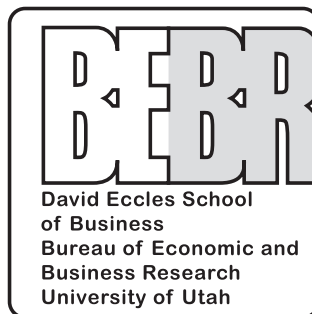
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