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States' Commitment to Medicaid Before the Affordable Care Act: Trends and Implications

Medicaid insures more than 65 million low-income people, and the Affordable Care Act of 2010 gives states the option to enroll millions more. Historical trends in state Medicaid effort possess important implications for health policy going forward. Nearly all states steadily ratcheted up their Medicaid effort in the period from 1992 to 2009, holding out promise that most will sustain their programs and ultimately participate in the expansion authorized by the Affordable Care Act. But the growth in Medicaid over this period did not appreciably curtail vast geographic disparities in program benefits that threaten to undermine the goals of health reform.

Medicaid has become a key pillar of the American health insurance system covering more than 65 million low-income people. A federal grant program created in 1965, Medicaid has long afforded states considerable discretion to shape eligibility for the program and the services that enrollees receive. Hence, who gets what from Medicaid has varied greatly from one state to the next (Holahan and Pohl 2003; Grannemann and Pauly 2010). The Affordable Care Act (ACA) of 2010 promised to reduce this variation by mandating that state Medicaid programs cover nearly all Americans with incomes below 133% of poverty. Medicaid was thereby projected to insure about half those who would gain coverage under the ACA in 2014. In June 2012, however, the U.S. Supreme Court (2012) ruled that the federal government could not penalize a state's existing Medicaid program if it failed to implement the expansion. This development essentially has made the ACA's Medicaid expansion a state option and opened the door to the possibility of even greater variation among states in the generosity of their Medicaid programs.

How states will use their ample Medicaid discretion over the next several years therefore has important implications for insurance coverage. This article provides a platform for considering future developments by examining trends in Medicaid enrollment and expenditures from 1992 to 2009.[1] Through the growing use of waivers and changes in federal law, this period featured substantial devolution to the states. More than any time over the last four decades, states were able to innovate and tailor their Medicaid programs. Thus, the period provides an excellent opportunity

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to appraise Medicaid's fortunes under unprecedented conditions of high state empowerment.[2] In this regard, we address four overarching questions. First, to what degree and in what ways did the Medicaid program expand over this period? Second, did this expansion involve all states or did some Medicaid programs grow apace while others shrank? Third, did varying growth rates for different states result in greater convergence in their Medicaid effort so that geographic disparities among state programs declined? Fourth, what are the implications of our findings for Medicaid's future?

Medicaid Policy Context

The Medicaid policy context provides an important backdrop for assessing trends in state Medicaid efforts from 1992 through 2009. To a limited degree, the period featured the imposition of new federal mandates. Legislation enacted prior to 1992, for instance, required states to cover all uninsured children up to age 6 with incomes below 133% of poverty and to phase in coverage for all poor children ages 6 through 18 by 2002. The coverage mandate also extended to pregnant women up to 133% of poverty.[3]

By and large, however, a remarkable trend toward devolution characterized the period. The Clinton and G.W. Bush administrations proved much more willing to approve comprehensive demonstration waivers under Section 1115 of the Social Security Act than prior presidential administrations (Coughlin and Zuckerman 2008; Thompson 2012). Prior to 1993, the federal bureaucracy had used its Medicaid demonstration authority sparingly, approving just 50 waivers in nearly three decades. By the end of the G.W. Bush administration, the federal bureaucracy had signed off on more than 150 waiver requests. Many states used these waivers to reinvent their Medicaid programs in major ways. For instance, the enactment of the Massachusetts plan for near-universal coverage in that state rests on a Medicaid waiver renegotiated in 2005 and 2006. Federal administrators also made it easier for states to obtain Section 1915(c) waivers to extend Medicaid home and community-based services (HCBS) to more enrollees. By 2010, states had obtained nearly 300 HCBS waivers. About two-thirds of all Medicaid monies spent on HCBS occurred via these waivers (Howard, Ng, and Harrington 2011).

Changes in federal law also opened new Medicaid doors for the states. For instance, statutory modifications in 1997 increased states' discretion to extend Medicaid to children well above the poverty line and enhanced states' flexibility over payment rates to nursing homes.[4] In 2005, Congress afforded states new authority to extend HCBS up the income ladder, to limit services to specific geographic areas, and to cap enrollments.[5]

Our examination of trends in state Medicaid efforts occurs, therefore, during a time of greater state empowerment. To assess states' commitment to the program, we primarily focus on trends in Medicaid expenditures and enrollments derived from data provided by the Kaiser Commission on Medicaid and the Uninsured. The commission staff works with the administrative data sets of the Centers for Medicare and Medicaid Services (CMS) to assure their accuracy.[6] The spending data incorporate payments for the full range of services—hospital, outpatient, drugs, long-term care—as well as subsidies to institutions that serve disproportionate numbers of uninsured and Medicaid enrollees (disproportionate share hospital or DSH payments). Enrollments refer to an unduplicated count of all those in Medicaid for at least part of a year. Since Medicaid features considerable churning of the rolls, the number of enrollees at any point in time typically approximates a little more than two-thirds of all beneficiaries in a given year.

Measuring state Medicaid "effort" necessitates that we examine spending and recipient data relative to need—that is, compared to the size of the disadvantaged population targeted for program benefits. In this vein, we scrutinize Medicaid spending and enrollees per poor person.[7] The two measures have limitations as proxies for Medicaid effort. But, as Grannemann and Pauly (2010) suggest, they provide a "reasonable and convenient" way to capture "the overall level of resources a state devotes annually to

meeting the needs of a typical low-income person."[8] We also frame our results by contrasting trends in Medicaid spending to state fiscal capacity using two measures, expenditures relative to state gross domestic product (GDP) and as a share of total state government outlays.[9,10] Although not necessarily reflecting the degree to which the poor's needs for medical coverage are met, these alternative metrics provide reasonable proxies of Medicaid effort relative to state fiscal capacity.

Findings

Aggregate National Growth

Overall, Medicaid grew substantially in the period from 1992 to 2009. Table 1 views the Medicaid expansion through four lenses. The first focuses on total state and federal outlays for the program (see "U.S. percent change" column). In constant 2009 dollars, Medicaid spending surged at an average annual rate of 4.6%, and in constant medical dollars by nearly 3%. A second lens zeroes in on trends in Medicaid expenditures per poor person. While increases here lagged the two aggregate measures by just under one percentage point, the story line also shows appreciable annual growth whether in dollars adjusted for general or medical inflation. A third lens peers at Medicaid spending relative to a state's economy and overall government budget. These figures show a nearly 3% annual increase in the share of a state's GDP claimed by Medicaid and about 1% growth in the proportion of state government outlays consumed by the program. Finally, Table 1 analyzes trends in Medicaid enrollments. Both total enrollment and beneficiaries per poor person grew by about 3% annually.

Overall enrollment and expenditure trends could obscure substantial gains for some Medicaid cohorts and erosion for others. To probe this possibility, we examined trends for the four main categories of beneficiaries – children 18 and under, nonelderly, nondisabled adults, the elderly, and people with disabilities under 65. With one exception, there appear to be no significant shifts in the share of Medicaid benefits garnered by the four cohorts. Children consistently comprised about 50% of enrollees,[11] nondisabled adults, 25%, the elderly, 10%, and people with disabilities, 15%. Substantial stability also characterized the share of Medicaid dollars directed to nondisabled adults and children. As of 2009, these two cohorts absorbed 14% and 20% of Medicaid spending, respectively, not much different from 1992 or any other year.[12] However, a trend occurred in the monies spent on the elderly compared to people with disabilities. From 1992 through 2009, Medicaid outlays on the elderly declined from 33% to 23%. In contrast, expenditures on people with disabilities crept from 37% to 42%. The exact dynamics leading to this shift are unclear.

In a related vein, it deserves noting that Medicaid spending per enrollee grew only modestly over this period (a 1% increase annually in dollars adjusted for inflation and a .5% decline for constant medical dollars). This squares with the view that rising enrollments tend to drive Medicaid expenditure increases rather than changes in case mix, service intensity, or provider payment (Garfield et al. 2012).

Variations in State Medicaid Growth

Surveying national trends with respect to Medicaid expenditures and enrollments can, of course, mask vast differences in the program's fortunes in particular states. Indeed, some of the pessimism about Medicaid's durability comes from the failure of widely publicized program expansions in states such as Oregon and Tennessee (Bonnyman 2006; Oberlander 2007). Have some states aggressively expanded Medicaid while others have allowed it to wither?

The five right-hand columns in Table 1 cast preliminary light on this issue. These columns capture the range of state growth rates, showing the maximum and minimum rates as well as the annual average rate for the states at the first, second (median), and third quartiles. Two core conclusions emerge from the table. First, state growth rates varied considerably on all eight measures. In the case of expenditures per poor person in 2009 dollars, the annual rate of increase among states ranged from just over 1% in constant

Table 1. Annualized percentage changes in Medicaid expenditures and enrollment, 1992 to 2009

	U.S. percent change	State percent change				
		Minimum	Bottom quartile	Median	Top quartile	Maximum
Total expenditures (2009 dollars)						
Adjusted for general inflation	4.6	1.3	4.0	5.1	5.8	10.8
Adjusted for medical prices	2.9	−.2	2.4	3.4	4.1	8.9
Expenditures per person in poverty (2009 dollars)						
Adjusted for general inflation	3.8	1.4	3.8	4.9	6.1	9.5
Adjusted for medical prices	2.2	−.2	2.3	3.3	4.4	7.7
Expenditures relative to state capacity (current dollars)						
Ratio of expenditures to state GDP[a]	2.9	−.6	2.3	3.1	4.5	9.9
Ratio of expenditures to total state spending[b]	1.1	−1.4	.9	1.4	2.2	6.3
Medicaid enrollment						
Total enrollment	3.5	−.2	2.6	3.6	4.6	7.7
Enrollment per person in poverty	2.7	1.0	2.6	3.3	4.3	8.4

Sources: Authors' analysis of Medicaid and state population, GDP and spending data, see text notes 6, 7, 9, and 10.
Notes: Based on average annualized growth for even federal fiscal years 2002 to 2008, plus 2007 and 2009. GDP= gross domestic product.
[a] A change in Department of Commerce methods of calculating state GDP precludes comparison trends before and after 1997, thus trend shown reflects 1998 to 2009 only.
[b] Total spending data are unavailable for Washington, D.C., which is excluded from the calculations shown.

dollars to nearly 10%. In constant medical dollars, annual growth ran from a little less than zero to nearly 9%. As for enrollments per poor person, the average annual increment ranged from 1% to more than 8%. Medicaid spending changes relative to state capacity also varied appreciably. Annual changes in Medicaid spending relative to GDP among states ran from a 10% increase to a half-percentage-point decline. The ratio of Medicaid spending to all other outlays ranged from an annual rate gain of over 6% compared to a decrease of 1.4%.

Second, and in spite of this variation, the overwhelming majority of states upped their Medicaid efforts. All 50 states boosted their total Medicaid expenditures (constant dollars) as well as their per-poor-person spending and enrollment. Forty-nine states increased their Medicaid expenditures and spending per poor person in constant medical dollars; 49 also boosted their ratios of Medicaid expenditures to state GDP and enlarged their Medicaid enrollments. Forty-six saw their ratios of Medicaid spending to overall budget outlays grow. In sum, the Medicaid expansion from 1992 through 2009 involved virtually all states, not just a cluster of pacesetters.

Fastest and Slowest Growing States

Table 2 peers behind the veil of these aggregate numbers to identify the fastest and slowest growing Medicaid programs between 1992 and 2009. (Appendix Table 1 provides data on all states.) Hawaii, Oklahoma and Vermont ranked in the top five on annual average growth in both spending and enrollment per poor person. Other states reached the top five via a big step forward on one indicator. Minnesota and New Mexico did so on the spending measure, while Louisiana and New Hampshire had pacesetting increases in enrollment per poor person.

Among the slowest growing states, Colorado ranked in the bottom five on both the expenditure and enrollment measures. Indiana, Nevada, New Jersey, and Rhode Island ranked last in expenditure growth rates, while Kansas, Ohio, Utah, and Virginia achieved this distinction in terms of enrollment per poor person.

In terms of their national impact on health insurance coverage, some state Medicaid

Table 2. Annualized percentage change in Medicaid expenditures and enrollment per 100 persons in poverty, selected states, 1992 to 2009

	Expenditures		Enrollment	
States	Percent change adjusted for general inflation	Percent change adjusted for medical prices	States	Percent change
Fastest growing				
New Mexico	9.5	7.7	New Hampshire	8.4
Oklahoma	8.3	6.5	Vermont	7.0
Vermont	8.1	6.3	Oklahoma	6.5
Hawaii	7.7	5.8	Louisiana	6.3
Minnesota	7.5	5.8	Hawaii	6.2
Ten most populous				
Illinois	5.9	4.2	Illinois	4.4
North Carolina	5.2	3.5	California	3.8
California	4.8	3.2	New York	3.2
Pennsylvania	4.7	3.1	Florida	2.8
Florida	4.3	2.7	Pennsylvania	2.7
Texas	4.1	2.5	North Carolina	2.6
Michigan	3.9	2.4	Texas	2.6
Ohio	3.8	2.2	Michigan	2.3
Georgia	3.4	1.7	Georgia	2.0
New York	3.3	1.8	Ohio	1.5
Slowest growing				
Nevada	3.2	1.6	Ohio	1.5
New Jersey	2.7	1.1	Utah	1.4
Rhode Island	2.5	.9	Colorado	1.3
Indiana	1.9	.4	Kansas	1.2
Colorado	1.4	−.2	Virginia	1.0

Sources: Authors' analysis of Medicaid and state poverty data, see text notes 6 and 7.
Notes: Based on average annualized growth for even federal fiscal years 2002 to 2008, plus 2007 and 2009. Dashed line (----) indicates all-state median.

programs matter much more than others. The 10 most populous states contain over half the U.S. population. Because of their importance, data on their growth rates also appear in Table 2. In general, the rates of increase in most of the larger states fell below the median (the dashed line on the table). But states varied considerably with Illinois setting the pace in spending and enrollment gains per poor person. New York ranked last in the rate of annual expenditure growth, while Ohio brought up the rear in the case of enrollees.

Climbers, Sustainers, and Backsliders

Tracing the complex interplay of factors that fueled pacesetting and lagging growth rates lies beyond this study's purview. But the implications of a state's rate of increase for its relative ranking in Medicaid effort in the 1992–1994 and 2007–2009 periods deserve attention. The 50 states and the District of Columbia fall into three general categories—climbers, sustainers, and backsliders. (See Appendix Table 2 for pertinent data on each state.) "Climbers" grew at a rate that improved their rankings relative to other states by at least 10 places (e.g., from 35th to 25th). "Backsliders" increased at a rate that caused their rank order to fall by at least 10 positions. "Sustainers" constituted the residual category, having relative gains or declines of less than 10 places. Given these definitions, 39 states plus the District of Columbia emerged as sustainers between the periods 1992–1994 and 2007–2009 in terms of their Medicaid real spending per poor person, while five states were climbers and six were backsliders. State rankings evinced more fluidity on the enrollment measure. Compar-

ing the 1992–1994 and 2007–2009 rankings on Medicaid enrollment per poor person, 26 states and the District of Columbia proved to be sustainers, while 12 states were climbers and 12 were backsliders.

The annual average growth rates presented in Table 2 often, but not invariably, predict significant changes in the relative rankings of the states shown. Two of the five states with the greatest annual growth rates in spending per poor person were climbers—New Mexico and Oklahoma. Among the five slowest growing states, Colorado and Indiana emerge as backsliders. Turning to Medicaid enrollment per poor person, two of the states with the highest rates of increase qualified as climbers—New Hampshire and Oklahoma. Among the slowest growing states on the enrollment measure, four of the five were backsliders—Colorado, New Jersey, Ohio, and Virginia. The most populous states listed in Table 2 tended to be closer to the median in their annual average growth rates. Not surprisingly, therefore, sustainers comprised about 80% of this cohort. On the expenditure measure of Medicaid effort, California was the sole climber and Georgia the only backslider. In terms of growth rates in enrollment per poor person, New York was a climber while Georgia and Ohio were backsliders.

Finally, the degree to which states that had historically been leaders in Medicaid effort (e.g., Connecticut, Massachusetts, New York, Rhode Island) sustained their positions deserves note. Seven of the 10 highest ranked states (excluding Washington, D.C.) in Medicaid spending per poor person in the years 1992–1994 had annual growth rates that allowed them to remain in the top group at the end of the period. The same pattern applied in the case of enrollment per poor person. Only three states that ranked in the top 10 on this indicator in the years 1992–1994 had fallen from the top cohort by 2007–2009.

Ratchet or Accordion?

Data reporting annual average growth could conceivably obscure great volatility from one year to the next. Does an analysis of shorter time frames suggest a steady ratcheting upward in expenditures and enrollment per poor person? Or do states behave more like accordions, increasing sharply in certain years and then shrinking in others? To address this issue, we examined trend lines for the states from 1992 to 2009. With a few exceptions, states edged upward and did not seesaw dramatically between growth and contraction.

Figure 1 illustrates selected patterns by focusing on five states based on their Medicaid spending per poor person in the years 1992–1994. The figure tracks growth in 2009 constant dollars for states with the highest (New Hampshire), lowest (New Mexico), and median (Tennessee) expenditure efforts in the baseline period.[13] It also follows the states whose baseline spending efforts were at the 25th (Alaska) and 75th (Virginia) percentiles. Four of the states in the figure suggest the greater relevance of the ratchet metaphor, rather than the accordion metaphor. With occasional modest downturns, they increased their Medicaid spending efforts at a fairly steady clip. New Hampshire evinced somewhat greater volatility: initially falling, then trending sharply upward, leveling off, and then slipping again. An examination of patterns in the remaining 45 states and the District of Columbia (not presented here) also suggests the pertinence of the ratchet metaphor. Eighty-four percent of the Medicaid programs evinced increases in at least three of the four intervals (31% in all four).

We replicated this analysis of trends focusing on enrollment per poor person. Using the 1992–1994 years as the baseline, Figure 2 tracks five states selected by the same criteria as the prior figure. In the baseline period of 1992–1994, Vermont ranked at the top in enrollment per poor person, Nevada at the bottom, and Virginia at the median. Wyoming placed at the 25th percentile of states, while Arkansas came in at the 75th percentile. Trends in all five states generally lend credence to the ratchet model. Three of the states (Vermont, Arkansas, and Nevada) showed modest declines in the 2007–2009 period on this metric, but ended the period with higher enrollment per poor person than they began. The Medicaid programs not presented in the figure tend to support the ratchet metaphor. Sixty-five percent of these programs manifested increases in at least three of the four intervals.

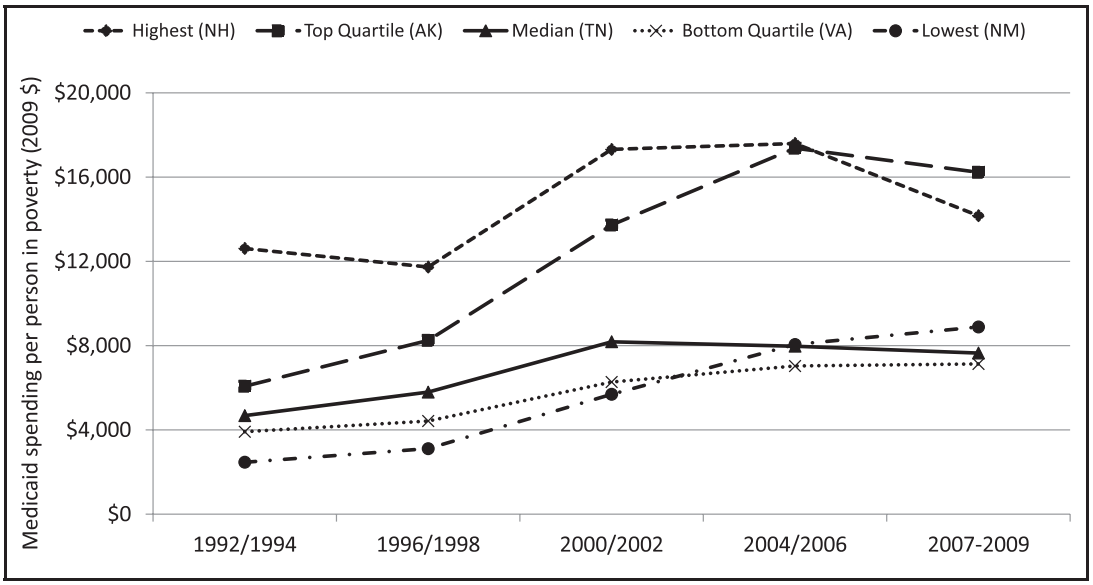

Figure 1. Medicaid expenditure per person in poverty, 2009 dollars (Source: Authors' analysis of state Medicaid expenditure and poverty population data, see text notes 6 and 7.) (States are ranked by average of 1992 and 1994 spending per person in poverty. Data shown are two-year averages for even years 1992 to 2006 and the three-year average for 2007 to 2009.)

Limited Movement Toward Convergence

The different growth rates among states in their Medicaid expenditures and enrollment per poor person naturally prompt the question: Are states becoming more alike in their Medicaid efforts? If so, there may be less concern that Medicaid permits excessive geographic disparities, fueling inequality in health care access and health outcomes among the states (e.g., Holahan 2007). To address this issue, we examined coefficients of variation among states for Medicaid real spending and enrollment per poor person.[14] The coefficient of variation on the spending measure averaged .42 and declined slightly from .46 in 1992 to .41 in 2009. Variation among states in enrollments per poor person averaged .25. In contrast to expenditures, the enrollment indicator evinced no signs of convergence. Instead, the coefficient of variation rose from .20 in 1992 to .28 in 2009. While all states grew during the 1992–2009 period, the variation among them remained substantial. In 2009, Medicaid spending per poor person in the highest state (Connecticut) was five times greater than that in the lowest state (Nevada). Enrollment per poor person ranged from a high of three in Vermont to less than one (.85) in Nevada.

Implications of Economic Downturns

Medicaid faces special challenges when the economy sours. During hard times, unemployment typically rises, those covered by employer-sponsored insurance declines, and the number of people becoming eligible for Medicaid benefits grows. Simultaneously, however, the economic downturn precipitates declining tax revenues. Faced with mandates to balance their budgets, the pressures on states to retrench Medicaid heighten. How do states balance these conflicting pressures?

The 1992–2009 period does not permit a definitive answer to this question. But state responses to economic stress during the periods 2000–2002 and 2007–2009 provide some clues. In 2001 and 2002 national GDP grew at annual rates of .8% and 1.6%, respectively, and unemployment edged upward. Despite a sluggish economy, Medicaid real spending and enrollment per poor person moved upward at annual rates of 5% and 3%, respectively. Thirty-eight states grew on the spending metric and 34 on the enrollee measure.

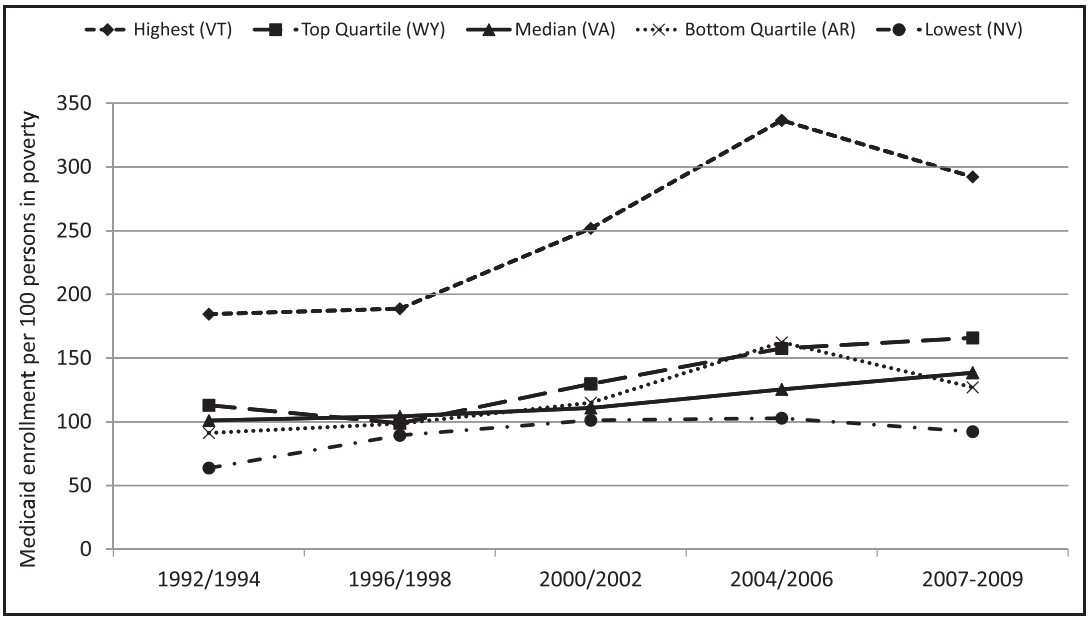

Figure 2. Medicaid enrollment per 100 persons in poverty (Source: Authors' analysis of state Medicaid expenditure and poverty population data, see text notes 6 and 7.) (States are ranked by average of 1992 and 1994 enrollment per 100 persons in poverty. Data shown are two-year averages for even years 1992 to 2006 and the three-year average for 2007 to 2009.)

The Great Recession, which started in late 2007, presented a sterner test for Medicaid. In 2008, national GDP shrank by .3% and in 2009 by 3.5%. During these two years, overall Medicaid expenditures in constant dollars grew by a little over 5% annually. However, Medicaid real spending per poor person declined by 3% per year.[15] Less than half the states increased on this spending measure over this time—only 17 in 2007–2008 and 23 in 2008–2009. Data on enrollments point to a similar pattern with the number of beneficiaries growing, but not at a rate that kept up with increases in the poor.[16] In sum, the moderate economic downturn did little to reduce Medicaid growth rates. But the more acute economic stress later in the decade saw declines in the program's ability to meet the needs of the disadvantaged as the ranks of the poor swelled. This finding is consistent with other analyses that have estimated Medicaid growth in response to rising unemployment.[17]

Implications for Health Reform

The period examined in this study featured substantial federal willingness to approve state waiver requests as well as changes in federal law that did much to empower states in the Medicaid arena. All 50 states responded by increasing their Medicaid effort on most of our indicators. Overall program spending and enrollments grew apace (faster than Medicare) and helped compensate for the erosion of employer-sponsored insurance.[18] Even the most politically conservative states embraced the expansion of Medicaid. The trends identified in this study also contain a less sanguine message for those who believe that all Americans should enjoy access to health insurance. While states expanded their programs, their annual growth rates varied greatly and the period witnessed little convergence in state Medicaid efforts.

In the wake of the Supreme Court decision of 2012, the state in which a person lives will matter more than ever for Medicaid eligibility. Some states, such as California, are avidly pursuing the Medicaid expansion. Meanwhile, to date, other states have not moved forward. Of particular note, it remains unclear whether state policymakers in three of the 10 most populous states—Florida, Georgia, and Texas—will approve the Med-

icaid expansion. As of 2009, these three states ranked in the bottom quartile of states in Medicaid spending and enrollment per poor person. The decisions of these states loom particularly large because they are home to over 20% of those targeted for Medicaid coverage under the ACA (Holahan and Headen 2010).

Will the great majority of states eventually sign on to the ACA's Medicaid expansion and reduce state variation? The fact that all states during a time of greater devolution increased their Medicaid expenditures and enrollment per poor person provides some grounds for hope. The federal government's willingness to pay 90% (100% initially) of the costs of extending benefits to the expansion population also makes it harder for states to decline. Moreover, the history of the Medicaid program suggests that states will eventually participate. A year-and-a-half after the program's inception in 1965, only half the states had signed on to Medicaid. By mid-1968, however, this number had grown to 37. By the end of 1970, all but two states had opted to participate (Thompson 1981). Arizona, the last state to join, did so in 1982.

If all states ultimately participate, it deserves noting that variation among state Medicaid programs will diminish, but not disappear. The ACA does not appreciably constrain state discretion in serving its most expensive cohorts—the elderly and people with disabilities. Medicaid spending per beneficiary for these clusters is much greater than for those adults slated to gain coverage under the ACA. The elderly and people with disabilities currently account for two-thirds of Medicaid costs; most state spending on these groups is optional and states differ greatly in the long-term care they provide (Courtot, Lawton, and Artiga 2012). Variation will also spring from differences in the degree to which state enrollment and renewal practices promote high take-up rates among those entitled to Medicaid benefits. Historically, some states have proven to be much more committed and adroit in fostering higher take-up rates than others (e.g., Sommers, Swartz, and Epstein 2011; Thompson 2012).

Possible Countervailing Factors

The factors[19] that fueled strong Medicaid growth from 1992 through 2009 may not persist. State policymakers may be more reluctant than in the past to expand Medicaid. Fiscal stress in many states has in the wake of the Great Recession reached levels that surpass those present in the 1990s and much of the early 2000s. In addition, many states (including several with more generous Medicaid programs) are struggling with the costs of paying for the pension and health benefits of retired employees.[20] Concern has also grown that spending on Medicaid is crowding out much needed investments in education and other traditional areas of state investment (Kane, Orszag, and Apostolov 2005; Orszag 2010). Political changes also may matter. If the Republican Party persists in its ideological tilt to the right,[21] states dominated by policymakers from this party may be less inclined to join the Medicaid expansion than they were in the less polarized period of the late 1960s.

At the federal level, Medicaid has gotten caught up in the debate over debt reduction. During the recent presidential campaign the Romney-Ryan ticket proposed not only to repeal the ACA, but to massively retrench the remaining Medicaid program and convert it to block grants.[22] President Obama's re-election removed this option from the table for the next four years. But policymakers could reshape and trim Medicaid in ways that reduce its appeal to the states.[23] To the degree that federal policymakers cut Medicaid subsidies to the states, growth trajectories evident from 1992 to 2009, and further promised by ACA, will likely ebb.

Notes

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agement and advice, and to Bram Poquette of the Rutgers Center for State Health Policy for assistance in manuscript preparation.

1 Calculations in this article are based on Medicaid enrollment and spending data for even years between 1992 and 2008 as well as 2007 and 2009. Trends shown reflect the annualized average changes over this period.
2 Only the initial 1965-1967 period provided states with relatively comparable latitude over their Medicaid programs. Congress restricted state discretion through legislation in 1967.
3 Legislation in the late 1980s also required states to pay the premium and cost sharing of certain low-income Medicare beneficiaries.
4 The Omnibus Budget Reconciliation Act of 1997 established the State Children's Health Insurance Program, which gave states the option of covering more children through a Medicaid expansion or a separate program.
5 These and other provisions enhancing state discretion are in the Deficit Reduction Act of 2005.
6 The expenditure data are from CMS-64 filings, which states use to claim reimbursement for Medicaid expenses, including disproportionate share hospital (DSH) payments. Enrollment data and expenditures for different enrollment groups are from the states' Medicaid Statistical Information System (MSIS) data filings (formerly known as form HCFA-2082), which allocates spending across different enrollment cohorts (e.g., the elderly). Both types of data are cleaned by the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured to remove errors and discrepancies.
7 Poverty data come from the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. See http://www.census.gov/hhes/www/poverty/data/historical/people.html (accessed January 2, 2013).
8 Grannemann and Pauly (2010, pp. 54-55) note that Medicaid spending per poor person "depends on the extent and mix of services covered and the prices paid for these services. Not all benefits go to persons actually below the poverty level, and not all persons below the poverty level receive benefits." Still, they conclude that the metric "provides a reasonable and convenient indicator of the overall level of resources a state devotes annually to meeting the needs of a typical low-income person."
9 Gross domestic product data come from the U.S. Department of Commerce, Bureau of Economic Analysis. See http://www.bea.gov/regional/index.htm (accessed January 2, 2013).
10 Governmental outlay data are from the U.S. Census Bureau, Annual Survey of State Government Finances. See http://www.census.gov/govs/state/historical_data.html (accessed January 2, 2013).
11 The data on children exclude those states that have chosen to cover them under a separate Children's Health Insurance Program rather than a Medicaid expansion.
12 This figure excludes DSH payments.
13 Figures 1 and 2 plot two-year averages of enrollment and spending data, respectively (2007-2009 spending and enrollment data averages three years). We pool years because of instability in the poverty data (especially in less populous states), based on annual sample surveys, that we used in the denominator of the rates shown.
14 The coefficient of variation is a commonly used metric to compare the variability of measures expressed in different units (in this case, dollars or enrollment per poor person). It is the ratio of the standard deviation to the mean of the respective distribution.
15 The stimulus package approved by Congress in early 2009 significantly increased the federal share of Medicaid costs over the short term. Without this intervention, state Medicaid efforts would in all likelihood have been much less in 2009.
16 Overall enrollment grew by a little more than 2% from 2007 to 2008 and by 5.5% from 2008 to 2009. But enrollment per poor person declined by 4.2% and 3.2% in those intervals, respectively, with only 19 states showing gains.
17 Holahan and Garrett (2009) found that rising unemployment yields declines in individuals covered by employer-sponsored insurance. In response, Medicaid enrollments increase (especially for children), but not by enough to prevent the uninsurance rate from rising.
18 To a degree, the Medicaid expansion may well have crowded out, or caused declines in, employer-sponsored insurance. Employees with access to other coverage may have opted for Medicaid instead because it cost less or offered more attractive benefit packages. Estimates of crowd-out vary considerably – from zero to as high as 92%. Whatever the exact rate, crowd-out substantially reflects the thinning of employer-sponsored insurance via greater cost sharing and limitations on benefits. For an overview of recent studies, see Jones (2012).
19 For an analysis of the factors spurring Medicaid growth, see Brown and Sparer (2003) as well as Thompson (2012).
20 See Lav and McNichol (2011: 2-3) and State Budget Crisis Task Force (2012). States facing more acute pressures on this front include California, Illinois, New Jersey and Pennsylvania.
21 For systematic documentation of this ideological shift to the right, see Abramowitz (2010).
22 The budget resolution sponsored by Rep. Paul Ryan (R-Wisconsin) and approved by the House of Representatives in 2012 cut Medicaid

spending by $810 billion over 10 years (U.S. House Budget Committee 2012).

23 For instance, the Debt Reduction Task Force (2010) of the Bipartisan Policy Center promulgated the Domenici-Rivlin plan, which, among other things, called for eliminating the current Medicaid matching formula. This formula did much to galvanize the Medicaid expansion with the federal and state governments each leveraging funds from the other. The Domenici-Rivlin plan sought to achieve Medicaid savings of more than $200 billion over 10 years.

Appendix Table 1. Average annual rates of change in Medicaid effort indicators, 1992–2009

	Medicaid spending per person in poverty (constant 2009$) (%)	Medicaid enrollment per person in poverty (%)	Ratio of Medicaid expenditures to state GDP[a] (%)	Ratio of Medicaid expenditures to total state spending[b] (%)
Alabama	3.98	3.46	1.84	.48
Alaska	6.76	2.40	4.48	6.25
Arizona	6.21	3.01	9.87	5.27
Arkansas	5.11	3.82	4.26	1.44
California	4.84	3.83	3.09	1.81
Colorado	1.40	1.31	2.32	−.44
Connecticut	5.12	4.72	2.96	1.76
Delaware	4.70	3.24	5.10	4.03
District of Columbia	4.72	3.28	1.32	n/a
Florida	4.31	2.77	2.82	1.99
Georgia	3.37	2.00	4.47	1.05
Hawaii	7.65	6.17	2.33	4.67
Idaho	6.48	5.19	4.50	2.57
Illinois	5.90	4.40	3.05	1.25
Indiana	1.88	3.71	4.76	−.19
Iowa	5.73	3.68	3.41	2.04
Kansas	3.33	1.23	3.79	.53
Kentucky	4.74	2.33	3.53	.72
Louisiana	5.03	6.31	2.50	−1.32
Maine	7.34	5.51	3.86	2.38
Maryland	6.09	4.13	3.17	1.44
Massachusetts	3.27	4.05	3.66	1.24
Michigan	3.93	2.26	4.07	1.25
Minnesota	7.49	5.21	4.62	2.31
Mississippi	6.81	3.12	4.46	.91
Missouri	5.02	3.48	4.81	1.19
Montana	5.14	1.71	2.21	1.54
Nebraska	6.02	3.59	1.52	1.91
Nevada	3.18	5.47	3.01	1.07
New Hampshire	3.90	8.36	1.43	−1.39
New Jersey	2.69	1.65	1.60	.65
New Mexico	9.46	5.49	6.69	4.36
New York	3.34	3.23	1.40	1.27
North Carolina	5.15	2.63	3.70	2.70
North Dakota	4.91	2.83	−.60	.30
Ohio	3.81	1.53	4.53	1.35
Oklahoma	8.25	6.51	5.18	2.30
Oregon	5.69	1.82	2.67	2.53
Pennsylvania	4.68	2.73	2.85	1.62
Rhode Island	2.52	2.93	1.77	2.23
South Carolina	6.72	6.02	3.53	.73
South Dakota	4.74	3.67	1.00	.90
Tennessee	3.45	2.80	2.96	.96
Texas	4.06	2.57	2.97	.97
Utah	3.80	1.38	2.69	.79
Vermont	8.10	7.04	4.45	2.05
Virginia	3.89	1.03	3.19	1.37
Washington	3.66	2.58	1.92	1.69
West Virginia	6.03	3.33	1.90	1.11
Wisconsin	5.24	3.43	5.18	1.56
Wyoming	7.11	4.07	.69	2.74

Sources: Authors' analysis of Medicaid expenditure, enrollment, population, GDP, and state spending data, see text notes 6, 7, 9 and 10.

[a] A change in Department of Commerce methods of calculating state GDP precludes comparison trends before and after 1997, thus trend shown reflects 1998 to 2009 only.

[b] Total spending data are unavailable for Washington, D.C., which is excluded from the calculations shown.

Appendix Table 2. State rankings by Medicaid effort indicators

	Medicaid spending per person in poverty			Medicaid enrollment per person in poverty		
	Average, 1992 & 1994	Average, 2007–2009	Change in rank	Average, 1992 & 1994	Average, 2007–2009	Change in rank
Alabama	43	46	−3	43	33	10
Alaska	13	4	9	4	6	−2
Arizona	46	40	6	34	30	4
Arkansas	40	34	6	38	23	15
California	42	31	11	10	5	5
Colorado	23	48	−25	29	48	−19
Connecticut	4	1	3	23	7	16
Delaware	10	12	−2	3	3	0
District of Columbia	8	8	0	17	17	0
Florida	44	47	−3	36	34	2
Georgia	36	50	−14	28	44	−16
Hawaii	19	15	4	16	8	8
Idaho	49	39	10	45	40	5
Illinois	31	26	5	19	13	6
Indiana	18	42	−24	44	37	7
Iowa	25	16	9	25	11	14
Kansas	35	41	−6	42	49	−7
Kentucky	39	37	2	37	39	−2
Louisiana	22	24	−2	50	18	32
Maine	6	7	−1	2	2	0
Maryland	17	14	3	27	21	6
Massachusetts	2	5	−3	5	4	1
Michigan	24	28	−4	21	22	−1
Minnesota	14	10	4	30	20	10
Mississippi	47	45	2	32	38	−6
Missouri	27	23	4	40	35	5
Montana	32	43	−11	39	51	−12
Nebraska	20	21	−1	22	31	−9
Nevada	45	51	−6	51	50	1
New Hampshire	1	9	−8	33	12	21
New Jersey	7	13	−6	20	36	−16
New Mexico	51	22	29	46	25	21
New York	5	2	3	24	9	15
North Carolina	34	32	2	35	42	−7
North Dakota	16	27	−11	31	46	−15
Ohio	21	19	2	15	29	−14
Oklahoma	50	29	21	47	19	28
Oregon	37	35	2	18	45	−27
Pennsylvania	12	11	1	14	16	−2
Rhode Island	3	6	−3	9	15	−6
South Carolina	29	33	−4	41	28	13
South Dakota	41	38	3	49	32	17
Tennessee	26	30	−4	6	24	−18
Texas	48	49	−1	48	47	1
Utah	33	44	−11	11	41	−30
Vermont	9	3	6	1	1	0
Virginia	38	36	2	26	43	−17
Washington	15	20	−5	8	14	−6
West Virginia	28	25	3	12	26	−14
Wisconsin	11	17	−6	7	10	−3
Wyoming	30	18	12	13	27	−14

Sources: Authors' analysis of Medicaid expenditure, enrollment, and population data, see text notes 6 and 7.
Notes: For spending, rankings were calculated on the average expenditures per person in poverty for the years 1992 and 1994 and the years 2007 through 2009. For enrollment, rankings were calculated on the average enrollment per person in poverty for the years 1992 and 1994 and the years 2007 through 2009.

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