



Managing Medicaid Take-Up

Is Medicaid Retrenching? State Budgets and Medicaid Enrollment in 2002

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Study Highlights

The gradual but sizeable expansion of state Medicaid programs has led to the existence of an extensive and varied constituency of individuals and organizations that depend upon the program financially. When combined with other budgetary resources that were one-time in nature, this allowed many states to avoid substantial Medicaid cuts in FY 2003 despite lagging revenues.

- ❖ A study of 17 states shows that many were reluctant to make sizeable cuts to Medicaid in an election year and that most states were able to avoid these cuts by using one-time measures such as rainy day funds and tobacco settlement money to plug budget gaps.

More states in the Rockefeller Institute's study expanded eligibility for public health insurance than cut eligibility but did so at the expense of some services.

- ❖ Four states extended eligibility for Medicaid or CHIP by applying for waivers to use unspent CHIP funds or money from co-pays and premiums. These expansions often came at the cost of cutting optional benefits for other individuals. Only two states in the study, Tennessee and New Jersey, cut a sizeable number of individuals from their public health insurance programs. Even after these cuts, both states continue to have some of the most generous eligibility levels for public health insurance in the country and Tennessee's cuts are currently facing a legal challenge.

Across the board cuts to agencies, early retirement, and hiring freezes were used by many states to balance their budgets, negatively impacting the capacity to administer Medicaid and CHIP at the local level.

- ❖ Nearly every state in the study noted that hiring freezes or other cuts to administration would force them to limit outreach efforts. Some states were more severely impacted and questioned the ability of workers to deal with rising caseloads at the local level.

The outlook for Medicaid in fiscal year 2004 is less positive given that states already cut other programs this year and Medicaid costs continue to rise.

- ❖ Field reports indicated that there was more likelihood that Medicaid would be cut in the upcoming year because there were less one-time measures available to balance budgets. More states indicated they would implement cost-sharing measures for certain categories of eligible recipients in the upcoming year and implement further cost controls for prescription drugs.

Introduction

The late 1990s were the setting for virtually unprecedented activity by federal agencies, advocates, foundations, and many state governments to expand eligibility for and enrollment in public health insurance programs. Following the passage of welfare reform in 1996, Medicaid enrollment fell in many states and quite substantially in some. This decline was broadly interpreted as an unanticipated consequence of welfare reform's emphasis in many states on reducing dependency and increasing participation in the labor force.

This decline led federal agencies and foundations to undertake significant legislative and administrative initiatives to encourage states to make public insurance programs available and accessible to more low-income residents, particularly children. The passage of the Children's Health Insurance Program (CHIP) in 1997 allowed states to expand eligibility for children well beyond the income limits of state Medicaid programs, and explicitly provided funds for outreach programs to make low-income residents aware of the availability of coverage and encourage them to apply. The Health Care Financing Administration (HCFA, now the Center for Medicare and Medicaid Services, or CMS) provided a steady stream of communications which variously instructed states to review closed welfare cases for continued Medicaid eligibility, provided advice and examples of how to maximize coverage, and promised lenient treatment in the quality control process for mistakes. Several health-related foundations also initiated research and service programs intended to publicize, analyze, and address the enrollment problem. The Robert Wood Johnson Foundation, for example, allocated approximately \$50 million to fund community coalitions in all fifty states to develop outreach initiatives and encourage states to simplify and improve eligibility processes and computer systems.

Most evidence suggests that almost all states have made at least perfunctory efforts to make

Medicaid more accessible, and significant numbers — perhaps even a majority — have invested considerable administrative energy and resources both to increase the proportion of their population that is eligible for public insurance programs and to increase enrollment among those who are eligible. Earlier publications in this series have examined a broad range of these responses in detail in a sample of 18 states.

More recent developments have raised questions about the sustainability of these efforts. State budgets, which had been in sound financial shape over the late 1990s, have deteriorated significantly as a result of recession and the sharp decline in the stock market which both began in 2001. In addition, Medicaid spending, which had grown only modestly over the mid-1990s, began to grow significantly over the late 1990s, largely in response to increases in the cost of prescription drugs. These developments have led to concern that states may begin to roll back eligibility expansions, eliminate outreach programs, reinstitute elaborate application procedures and requirements, and do other things intended to make Medicaid and CHIP less accessible.

This paper examines the sustainability of Medicaid and CHIP enrollment efforts in the large majority of the states where enrollment initiatives have been examined in earlier publications in this series.¹ This paper will review recent trends in state revenues and Medicaid spending in these states, then examine state actions to balance their FY 2003 budgets, with particular attention to changes in Medicaid spending and activities affecting Medicaid and CHIP enrollment initiatives. The states in this study are listed on page 3.

Our main findings are somewhat surprising. While states confronted significant budget problems in FY 2003, they did not rely on substantial Medicaid cuts, either in eligibility or services, as a means of addressing these problems. Most states relied on increasing revenue, frequently through one-shot efforts such as securitizing tobacco settlement proceeds or drawing down on rainy day

¹ Maryland and Missouri were not included in this analysis but were included in the analysis of enrollment trends. Mississippi was included in this analysis but not in the analysis of enrollment trends.

States Participating in the Study		
<i>Arizona</i>	<i>Colorado</i>	<i>Florida</i>
<i>Georgia</i>	<i>Kansas</i>	<i>Maryland</i>
<i>Michigan</i>	<i>Missouri</i>	<i>New Jersey</i>
<i>New York</i>	<i>Ohio</i>	<i>Oregon</i>
<i>Tennessee</i>	<i>Texas</i>	<i>Utah</i>
<i>Washington</i>	<i>West Virginia</i>	<i>Wisconsin</i>

funds, or cuts in other programs as the primary means of balancing budgets. While Medicaid expenditures were reduced at the margin in almost all states, these cuts were typically small compared to the overall size of the Medicaid program, the size of the budget “gap” states were attempting to address, or the size of the budget reductions imposed on other programs. Only a few states made any appreciable changes in Medicaid eligibility; more actually expanded eligibility than reduced it.

Several states also made changes that affected Medicaid eligibility indirectly. Some states reduced spending on outreach activities, while several others enacted hiring freezes. Frontline worker positions in most states are high turnover jobs, so that hiring freezes may reduce the number of workers responsible for eligibility determination, which may increase caseloads and make it difficult for workers to provide much assistance to clients in completing applications.

While this evidence suggests that the Medicaid eligibility and enrollment initiatives of the late 1990s have largely survived state budget difficulties to date, it is unclear that this political success can persist. State finances remain in extremely poor condition, and many states have exhausted the surplus funds and other revenue enhancing devices that have allowed them to avoid sizeable expenditure cuts to date. The year 2002 was an election year, which may have made governors and legislatures unwilling to take drastic measures on either the revenue or expenditure side that might prove politically unpopular. After election pressures have subsided, however, these officials may be more willing to take aggressive measures to bring budgets into balance. Several states have already announced the need for mid-year revisions to the FY 2003 budgets exam-

ined here, and initial projections for FY 2004 budgets are quite pessimistic.

An Overview of State Budgets and Medicaid

State Financial Deterioration

One of the major enabling conditions for state efforts to expand eligibility and enrollment over the late 1990s was the strong position of most states’ finances. Economic growth was strong, unemployment was low, and the stock market was rising steadily. As a result, state revenues grew steadily at higher than historically average rates, allowing many states both to cut taxes and increase spending. The rate of growth in Medicaid expenditures also declined substantially from the high rates of the early 1990s, further reducing pressure on state finances.

This favorable fiscal situation may have made states more willing to support expanded eligibility and enrollment enhancement efforts than they otherwise might have been. The low-income families and children who were the main target of these efforts are basically healthy and do not generate large medical bills compared to the elderly and disabled, who are the other major population groups enrolled in Medicaid. In addition, CHIP’s match rate was more favorable to states than Medicaid’s, which meant states could expand coverage at a relatively low cost.

This combination of strong finances, inexpensive clients, and favorable matching rates made expanding Medicaid and CHIP coverage and enrollment attractive for many states. In addition, the availability of both federal and foundation

funding to support outreach and administrative improvements lessened the need to seek funds from state sources, and the favorable publicity given to well-performing states allowed elected officials in these states to claim credit for these achievements. Children are a popular political constituency even in conservative states, and the availability of financial support and favorable publicity may have limited potential opposition to these efforts.

Current Revenue Situation

These favorable conditions have deteriorated significantly over the last two years.² The most substantial deterioration has been in state finances. This decline is the result of two factors. One is the national recession, which began in early 2001, which was relatively mild by historical standards. Consumer income growth and spending have remained relatively strong over this period, but unemployment has increased substantially and business spending on new equipment has been slow. These changes have slowed growth in state income and sales taxes appreciably. More important has been the near collapse in the stock market, which began over this same period. A major cause of strong state finances over the late 1990s, was significant growth in income tax revenue from capital gains, stock options, and bonuses from investment banking and other financial services firms. The sharp decline in the stock market from highs in 2000 has dramatically reduced state income from these sources, particularly for states, which have large numbers of wealthy people and rely heavily on income taxes as a revenue source. A disproportionate share of income tax revenue in these states is paid by a small number of high-income tax payers, whose incomes have been sharply affected by the market decline. These declines in income have produced equally sharp declines in state revenues.

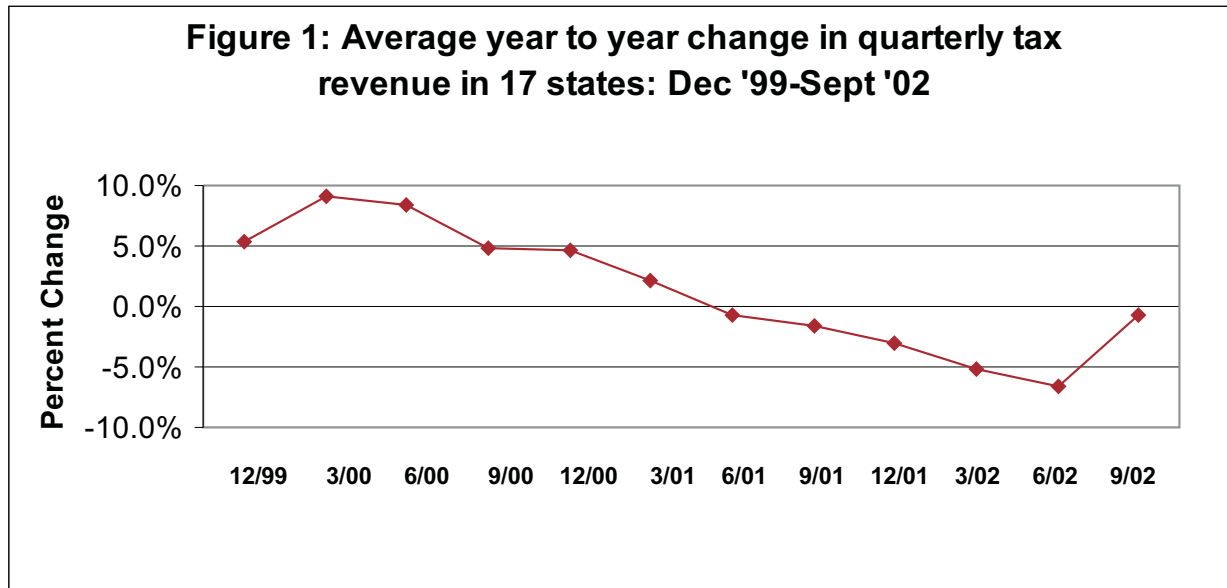
These declines have been exacerbated in many states by sizeable cuts in income and other taxes enacted during the “boom” period of the 1990’s. Beginning in the early 1990s, states cut taxes significantly for seven years in a row.³ While a complete accounting of the total revenue loss from these tax cuts is difficult, their cumulative impact has likely been quite substantial. Between 1998 and 2000, for example, states enacted significant tax cuts — those amounting to more than one percent of state general fund revenues — that amounted to more than \$20 billion annually in lost revenue, or in excess of four percent of state general fund revenue. This figure does not include revenue from tax cuts enacted earlier that were phased in over this period.

This combination of recession, stock market decline, and tax cuts has produced significant declines in revenues in almost all states between 2001 and 2002. Figure 1 displays average quarterly tax collection trends in our sample states for 1999 through the third quarter of calendar year 2002. The rate of growth in tax collections compared to the same quarter a year earlier declined steadily through 2000 and turned negative in 2001 through the middle of 2002 before turning up slightly in the third quarter of 2002. Declines in personal income tax revenue, particularly in New Jersey, New York, and Michigan, were especially steep over this period, falling as much as 25 percent compared to a year earlier in some quarters. Like other states, many of our sample states also enacted significant cuts in state taxes in earlier years. During the 2000 legislative session, for example, Colorado, Florida, Ohio, and Wisconsin enacted cuts in a variety of taxes that reduced general fund revenue by more than one percent; while New York, New Jersey, Texas, and Wisconsin, among others, had enacted sizeable tax cuts earlier.⁴

² This section draws heavily on the work of our colleagues Don Boyd and Nicholas Jenny of the Fiscal Studies Program of the Rockefeller Institute of Government. Please see the *State Revenue Reports* series on the Rockefeller Institute website (www.rockinst.org) for detailed descriptions of state revenue trends over this period.

³ Nicholas Jenny, “2000 Tax and Budget Summary” *State Fiscal Brief # 60* (Rockefeller Institute of Government, Albany, 2000).

⁴ *Ibid*, pp. 4-5



Medicaid's Recent Growth

Many analysts have pointed to recent increases in the rate of growth in Medicaid as one factor contributing to states' current budget woes. In March of 2002, the National Association of State Budget Officers (NASBO) released a report titled "Medicaid to Stress State Budgets" and much media attention has been given to rising health care costs since that time. Figure 2 uses NASBO's projections for the seventeen states in this study to show Medicaid's recent increase in expenditures. Medicaid growth has been antagonizing for states that saw the lowest growth rates ever for Medicaid in the mid 1990s. In 2002, and for the first time in more than a decade, Medicaid's spending growth reached the double digits, although the growth rate was still lower than the growth rate of 27.1 percent back in 1990-92, and came just after states had seen the lowest rates in the program's history (3.2 percent from 1995-1997).⁵ Some of the fluctuation in growth rates can be explained by overarching factors, such as the use of managed care by state Medicaid programs. Most states had enacted managed care by the mid 1990s, which helped control costs. There were also other factors such as a strong

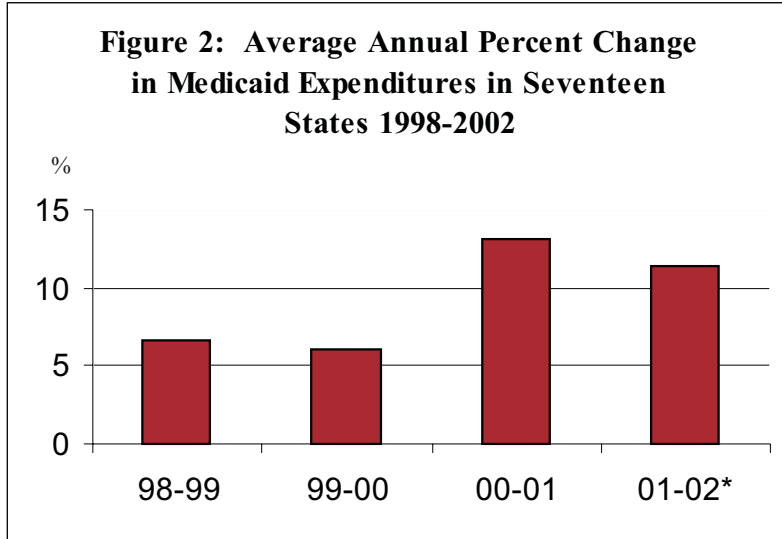
economy and enactment in 1996 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that contributed to a decline in enrollment.

By 2002, savings from managed care were long since maximized. Shortly thereafter, enactment of the CHIP program contributed to an increase in Medicaid enrollment. A number of states reported finding people who were previously eligible for Medicaid but not enrolled until publicity from CHIP helped to identify them. This became known as the "woodwork effect" whereby people who had not previously sought Medicaid applied for CHIP and were determined to be Medicaid eligible. When the economy slowed in 2000, enrollment in Medicaid and CHIP increased even more. Enrollment has grown to the point where the Congressional Budget Office estimates that Medicaid is expected to cover 47 million people in 2002.⁶ This is more than Medicare, the program for elderly and disabled individuals. If the economy continues at a weak pace, unemployment could rise, further increasing Medicaid enrollment. The Urban Institute estimates that for every 1 percent increase in unemployment, there are 1.6 million people who

⁵ Vernon Smith et al., "Medicaid Spending Growth: Results from a 2002 Survey" (Kaiser Family Foundation, September 2002).

⁶ Ibid.

Figure 2: Average Annual Percent Change in Medicaid Expenditures in Seventeen States 1998-2002



* Projected.

become eligible for Medicaid. In terms of cost, Medicaid is expected to reach \$247 billion or a quarter of a trillion dollars in state and federal spending. But enrollment is certainly not the biggest factor or the only factor driving cost. The rate of growth in the private health care market is comparable to Medicaid’s rate of growth. As private costs went up, so did Medicaid costs. Certain aspects of the program, such as prescription drugs have been growing at higher rates than during the mid 1990s. At the same time, other parts of the program, such as hospital costs, aren’t growing any more slowly.

Another factor driving Medicaid costs was states’ use of Medicaid maximization strategies. By the late 1990s, more states learned to take advantage of the flexibility provided by the federal government to draw down federal dollars through the Upper Payment Limit System (UPL) and the Disproportionate Share Hospital payment system (DSH) as well as shifting populations and services

into Medicaid that were normally funded entirely by state money. An Urban Institute examination of states’ Medicaid maximization strategies estimated that most states were able to draw down several billions of dollars in additional federal revenues with no comparable state match through these strategies.⁷ The estimated percent of additional federal Medicaid dollars that were generated with no comparable state match shows that states in the Rockefeller study were able to effectively increase their federal match anywhere from 1 to 6.8 percent in 2000.⁸

Medicaid growth in the 1990s, especially the federal share of funding, is evidence that even those

states that once shunned expansion of social services saw the fiscal benefit of expanding Medicaid. Mississippi and Louisiana were among the states that had historically rejected Medicaid expansion but saw the advantages of expanding Medicaid, especially because of their own higher-than-average federal matching rate. These expansions have resulted in Medicaid being the largest source of federal funds to states.⁹ In states where Medicaid was already accepted politically, flush state budgets in the late 1990s only served to augment efforts to expand eligibility and services.

Not only has the Medicaid program grown in terms of costs but the constituency served by Medicaid now includes a population much different than that which the program originally served. The program started out as a safety net, only for the poor, but with incremental expansions, now serves more aged, blind, and disabled individuals, who account for roughly one-quarter of the beneficiaries but close to two-thirds of the cost.¹⁰ Many of

⁷ Teresa Coughlin and Stephen Zuckerman, “States Use of Medicaid Maximization Strategies to Tap Federal Revenues: Implications and Consequences 02-09,” The Urban Institute, June 2002.

⁸ Ibid, Table 3.

⁹ Smith, et al.

¹⁰ Lawrence D. Brown and Michael S. Sparer, “Poor Program’s Progress: The Unanticipated Politics of Medicaid Policy” *Health Affairs* 22, 1 (2003).

Table 1: Budget Balancing Methods in FY 2003**

<i>State</i>	<i>% of Gap Filled Through Increased Revenue</i>	<i>% of Gap Filled Through Cuts</i>	<i>Medicaid Cuts as % of Total Cuts</i>
Arizona	20%	80%	*
Colorado	18%	82%	
Kansas	50%	50%	<1%
New Jersey	40%	60%	1%
New York	67%	33%	*
Michigan	80%	20%	*
Ohio	33%	66%	*
Oregon	55%	45%	1.4%
Tennessee	75%	25%	100%
Utah	58%	42%	*
Washington	60%	0-40%	12.8%
Wisconsin	91%	9%	1%

** These estimates are based on information provided in August 2002 and could change over time based on mid-year adjustments and special legislative sessions.

* Interestingly, a handful of states enacted cuts to the Medicaid program but the program ultimately received an increase. In Utah, the state initially cut \$15.4 from the Medicaid program through reduced HMO payments, cuts to prescription drugs, and lag pay to providers. However, the program also received a \$26 million increase as part of a plan to restructure benefits under a federally approved waiver. This was also true in Arizona where the state made selected cuts in the Medicaid program but ultimately increased the program's budget by \$126.8 million. Certain items in the agency that housed the Medicaid program in Ohio were cut but the overall expenditure for the department increased by 8.2 percent. Michigan delayed rate increases for providers but increased spending in anticipation of increased program enrollment by \$25.3 million. New York also increased Medicaid spending in order to fund eligibility expansions.

Note: Florida, Georgia, Texas, and West Virginia did no unusual gap filling as of mid 2002.

these expansions occurred as a result of enterprising politicians who reasoned that they could gain politically by being able to offer the program to a larger constituency. The result of this incremental expansion has been the creation of a widespread and politically powerful constituency that has been active in advocating for the program's expansion to the point where many states view the Medicaid program as more generous in terms of benefits than private health insurance or Medicare. These expansions have created a public health insurance program that is the largest single purchaser of maternity care and pays for half of all nursing home

care.¹¹ Expanding eligibility under the program has therefore been beneficial for politicians who seek the support of these constituencies and has contributed the program's growth in recent years.

State Budget Gap Filling in FY 2003

Regardless of the financial and political benefits of Medicaid expansion, states were still faced with sizeable budget gaps in fiscal year 2003 that required actions impacting Medicaid. Table 1 shows a rough breakdown of the methods used by states in

¹¹ Smith, et al.

the study to balance their FY 2003 budgets. For the states in this study, budget gaps ranged from \$5.7 billion in New York to no gap in some states.¹² The states that are in **red** are those that increased their Medicaid expenditures in light of budget gaps. Despite these budget gaps, most states were able to use a combination of one-time measures to enhance revenue, combined with some administrative cuts to avoid substantial programmatic cuts to Medicaid as demonstrated by the last column in Table 1. This column shows that most states cut Medicaid by a small amount, usually less than 1 percent of the total cost cutting. Tennessee and Washington are the two exceptions in this column. Washington targeted 12.8 percent of its \$466 million in cuts at Medicaid because it was by far one of the largest costs in the state's budget. The second largest part of the state's budget, K-12 education, took a \$92 million cut. Tennessee targeted its Medicaid program called TennCare, because it was also one of the largest parts of the state's budget.

The size of general fund gap filling was not negligible. As a percent of the total budget, New Jersey's gap was the largest of the study states. Out of a \$23.7 billion budget, the gap was over 20 percent of the state's entire budget. Other states, such as Wisconsin and Ohio, had much smaller gaps percentage wise. Out of \$22.5 and a \$45 billion budget, the budget gaps in Wisconsin and Ohio were \$1.1 and \$1.2 billion, respectively. The Center on Budget and Policy Priorities estimated that all 50 states had to close an estimated total budget deficit of over \$50 billion.¹³

Not all states in the study were experiencing unusual budget gaps at the beginning of FY 2003. This was true in Georgia, Texas, and Florida. Despite their relatively better fiscal situation, each of these states still enacted measures to control spending. Florida cut costs by \$86.5 million through the elimination of the Department of Labor and Employment Security while at the same time it implemented a \$262 million tax break for corporations to

stimulate the economy. Although it had not done any unusual gap filling, Texas was anticipating a budget shortfall and instructed agencies to "hold the line" on spending. Georgia's lack of a budget gap was due to conservative forecasting and a budget surplus from previous years — although state officials were less optimistic about the future.

Revenue Generation Strategies

State revenue generation strategies tended to be one-time in nature with many state legislatures and governors relying on these one-time fixes because it was an election year and because there was usually less resistance to these measures. The types of revenue enhancements that states used varied. Transfers from other funds were one strategy. Utah transferred \$100 million in state building projects and highway projects and dipped into several funds in order to fill its budget gap. Ohio transferred money from its unclaimed funds as well as unclaimed lottery prizes. Arizona used a \$40 million one-time payment of federal Disproportionate Share Revenue as well as a transfer from its Budget Stabilization (rainy day) Fund. Michigan used \$33 million from its rainy day fund. Washington securitized its tobacco money, used its rainy day fund, and increased borrowing. Many states also delayed payments, such as in Texas where the legislature "deferred" one month's Medicaid payments for nursing facilities, managed care organizations, and acute care insurance premiums for nursing facilities for consecutive legislative sessions.

Not all states relied upon one-time measures. A few states actually increased taxes, reversing the impact of some of the tax breaks that were so common in the late 1990s. One of the most sizeable tax increases was in New Jersey where the state raised the corporate income tax. New York increased the cigarette tax as did Michigan and other states. Michigan's 50-cent-a-pack increase was expected to generate \$290 million annually. Oregon was relying upon a temporary tax surcharge that was ulti-

¹² This projection was from June 2002. Revised budget gaps estimates for New York and other states have since been determined.

¹³ Iris J. Lav and Nicholas Johnson, "State Budgets Deficits For Fiscal Year 2004 Are Huge and Growing" (Center on Budget and Policy Priorities, December 23, 2002).

mately rejected by the state's citizens in a public vote in January 2003.

States also took advantage of the Medicaid maximization strategies discussed earlier to balance budgets despite attempts by the federal government to limit these strategies. In its analysis of the Benefits Improvement and Protection Act (BIPA) of 2002, the Congressional Budget Office estimated that limiting the UPL as published in the Federal Register on January 12, 2001, would reduce federal Medicaid outlays by \$21.7 billion over the 2001-2005 period and by \$77.3 billion over the 2001-2010 period. Regardless, many states still chose to use the UPL and other maximization strategies for revenue. In fact, more than half the states in the Rockefeller Institute's study indicated that they would continue to pursue Medicaid maximization strategies this fiscal year in order to help balance their budgets. Arizona planned to use a conversion of the state's Medically Indigent/Medically Needy program — estimated to increase funding between \$2.43 billion and \$2.69 billion by 2005 while relieving counties of the responsibility to provide care for the indigent. Colorado was planning to attain a higher federal match for family planning services through HMOs for an estimated \$1.4 million. Georgia expects to obtain \$132.2 million in extra revenue through the UPL while Florida anticipates \$234 million. Wisconsin is using an Intergovernmental Transfer (IGT) from its Medicaid Assistance Trust Fund to generate an estimated \$850 million in additional revenue — although this amount was already factored into the budget when a shortfall was announced. Recent changes to the UPL loophole will impact the ability of some states to use it as a revenue source. For instance, Kansas will not be able to rely on this revenue source after 2002, and is instead estimating revenue generation of \$50 million from DSH payments.

Revenue enhancements that were one time in nature were particularly prevalent in 2002 because it was an election year and because there tended to be much less resistance to these measures. Using rainy day funds, since they were designed for this

purpose, were particularly popular. Securitization of tobacco money was slightly more difficult because some advocates argued the money should be dedicated to health programs and that cashing in this money means less revenues for future legislative sessions. Delaying payments was also a popular strategy but will tend to hurt states even more in the next fiscal year.

Expenditure Cuts

In most cases, states tended to target cuts to programs other than Medicaid partly because these programs do not have a federal match rate as generous as Medicaid's. Commonly targeted programs included public safety, economic development, transportation, the environment, and even education. For example, Utah cut the budget for transportation and the environment by 24.1 percent, capital facilities by 7.8 percent and economic development by 6.4 percent while its overall health budget was only cut by 3.3 percent. Florida's major expenditure cut was to its Department of Labor and Employment Security. New Jersey's largest cuts were to the Department of Corrections, Personnel, Community Affairs, Treasury and Environmental Protection. Many states exempted K-12 education from cuts, such as in Michigan, but with weakened revenues, some states are reconsidering cuts to elementary and secondary education.¹⁴ The largest part of Arizona's \$730 million in spending reductions was in the School Facilities Board, which allowed the state to push out the cost of new school construction to developers for a certain time period. The largest cut in Washington was to the agency that housed the Medicaid program — the Department of Social and Health Services (DSHS) — since it by far comprised the largest share of the state budget. K-12 education received the second largest cut with higher education taking the third largest cut.

Some states made across the board cuts or did not allow spending to increase above previous year's budgets. West Virginia used a 3 percent "hold-back" for state agencies in 2002 and Mississippi used a 2 percent holdback meaning that agen-

¹⁴ See "State Schools Feel Squeeze of Growing Budget Deficits" by June Kronholz, *The Wall Street Journal*, December 26, 2002.

Table 2: Cost Cutting/Saving Methods Used by States

<i>Cost Cutting/Savings Method</i>	<i>State</i>
Generic drug use requirement, caps, pricing reductions	UT, GA, CO, MI, KS, TX, FL
Elimination, cuts to optional benefits	AZ, UT, KS, WA, FL, MI*
Cuts to provider rates (hospitals, transport, MCOs)	CO, MS, TX, MI*, UT, FL
Use of co-payments	UT, WV, WA, GA
Limits or caps to enrollment	UT, CO, KS, WA
Changes to enrollment or eligibility process	MS, TN, KS, TX

* Michigan did not cut rates to providers but instead only delayed rate increases and delayed an expansion of the dental program.

cies essentially gave back to the state a percent of what had been given to them. Arizona used a 2.25 percent across-the-board cut. Wisconsin used a 3 percent across the board cut to state operations while Colorado used a hiring freeze that cut spending in most agencies. Such actions demonstrate the efforts of states to “share the pain” among state agencies with a tendency to target a range of programs and not just Medicaid.

Medicaid Cuts

When Medicaid was cut, the target was often optional services, such as dental care, podiatry, speech therapy, audiology, and mental health. Michigan was considering delaying implementation of an expansion of the Healthy Kids dental program but put that expansion on hold to gauge the impact of the increase in the cigarette tax. There were exceptions to this generalization. For instance, Tennessee made more substantial cuts to Medicaid primarily because the program was so large relative to other social service programs. Interestingly, the measures implemented by the state to cut Medicaid are facing a legal challenge. Except for Tennessee and New Jersey, eligibility was usually left untouched and instead most states “trimmed around the edges” of their Medicaid programs. The extent of the cost cutting measures varied. For instance, Arizona eliminated required

circumcision for newborn males as well as coverage for Adult Emergency Dental Care. It was estimated that this action would save the state *only* \$300,000 over the course of the year. On the other hand, Michigan estimated a savings of \$800,000 a week from its modified prescription drug savings plan. Table 2 outlines some of the cost cutting methods used by states.

Cost savings measures for prescription drugs were common although states’ methods for controlling prescription costs differed. Mississippi planned to limit prescriptions to five per month. Kansas put in place higher rates for pharmacies to promote the use of generic drugs. Utah implemented a system to recycle drugs and was requiring generic drugs unless otherwise medically necessary. Prescription drugs have been targeted because they tend to be one the fastest growing costs within state Medicaid programs, although not necessarily the largest cost in many states.¹⁵ In the coming year, several states are planning or are in the process of applying for Pharmacy Plus Waivers, in an effort to maintain prescription drug coverage without substantially increasing state costs.

More states also began to look at the option of cost sharing. Cost sharing measures that states implemented were targeted at higher-income categories of eligible individuals. Texas, West Virginia, Oregon, and Utah were all exploring the use of co-payments

¹⁵ See Figure 4 in “Medicaid Spending Growth: Results from a 2002 Survey” by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, September 2000.

for certain services. Other cost-saving methods included rolling back enrollment simplification measures, or implementing measures that made it harder to stay enrolled. States are also turning to cuts in provider rates or delaying planned increases in provider rates. The types of providers impacted by these cuts range from hospital rates to HMOs.

Why Did States Avoid Medicaid Cuts?

The avoidance of Medicaid cuts was a welcome response for both state legislators and Medicaid advocates because program expansion benefited individuals being served by the program as well as a much larger constituency of health care providers, hospitals, and related industries. This constituency represents a significant number of individuals geographically and makes sizeable reductions to Medicaid politically difficult.¹⁶ Since 2002 was an election year in many states, cutting the Medicaid program would have been riskier politically than it would be in a nonelection year. Indeed, many analysts agree that there is now a sizeable Medicaid “constituency” that encompasses much more than just poor people and that any actions to the Medicaid program are watched closely by these interests.¹⁷

From the point of view of state budget analysts, Medicaid is also a last resort for cuts because it is seen as a revenue source as well as an economic development tool. Almost every community in every state has a hospital or other health care provider that stands to benefit or lose from the action of the state government in regard to Medicaid. As a result, many state governments have found ways to expand Medicaid in part because the federal match is generous and can be used to support a variety of health-related activities. This strategy has resulted in Medicaid becoming such a large

part of the nation’s health care system that in 1998 it accounted for nearly one out of five dollars spent on health care and in some states, as high as one out of three dollars.¹⁸ Indeed, Medicaid impacts a large segment of the population including working families, doctors and healthcare institutions that serve as vital economic development tools in communities all over the country, and in particular the East Coast.¹⁹ Medicaid is also by far the largest federal grant-in-aid to state governments. The fact that Medicaid’s receives partial funding from the federal government, and the fact that it impacts so many people *and* their surrounding economy, made it difficult for states to cut Medicaid especially in an election year.

Budget Actions Impacting Medicaid and CHIP Eligibility

The budget balancing actions and methods outlined in Table 1 and Table 2 allowed many states to maintain Medicaid and CHIP eligibility for individuals at higher income levels because they could turn to revenue sources to fill budget gaps. Table 3 shows the actions that states took in 2002 related to Medicaid eligibility. Four states in the study expanded eligibility while only three froze enrollment or cut eligibility. States that expanded eligibility often did so at the expense of cutting optional services or provider rates. States also used resources such as unspent CHIP funds to extend coverage to new categories of individuals.

Eligibility Expansions

Some of the states that expanded eligibility used the flexibility afforded under waivers to cost shift. Oregon’s eligibility expansion occurred via a waiver request to expand coverage, while requiring

¹⁶ See “A New Puzzle for Federalism: Different State Responses to Medicaid and Food Stamps” by James Fossett and Thomas Gais, Rockefeller Institute of Government, presented to the American Political Science Association, August 2002.

¹⁷ See Lawrence D. Brown and Michael Sparer “Poor Program’s Progress: The Unanticipated Politics of Medicaid Policy” *Health Affairs* 22, 1 (2003).

¹⁸ See “Healthcare Spending During 1991-1998: A 50 State Review” Martin Anne et al., *Health Affairs*, July/August 2002.

¹⁹ David Leonhardt “Northeast Quietly Becomes a Healthcare Corridor” (*New York Times*, December 30, 2002)

Table 3: Action Impacting Medicaid Eligibility in 2002

<i>Eligibility</i>	<i>State</i>	<i>Total</i>
Expanded eligibility	UT, AZ, NY, OR	4
Delayed eligibility expansion	GA	1
Primarily Status quo	MI, OH, WV, WI, FL, KS, TX, CO*, MI, MS, WA**	11
Notable cuts to eligibility or caps on enrollment	TN, NJ, (UT)	3
<p>* Colorado's HIFA waiver was still pending at the time of publication and emulates Oregon's waiver, which expands coverage to some populations while limiting benefits to other populations. Utah expanded eligibility but made substantial cuts in other program areas.</p> <p>** Washington will allow the governor and legislature to freeze new enrollees in some optional programs if caseloads exceed budget forecasts. The state also enacted a measure to reallocate payments for Supplemental Security Income, causing approximately 3000 elderly and disabled beneficiaries to lose Medicaid coverage.</p>		

co-pays and premiums from other individuals. The eligibility expansion will cover childless adults between 100 percent of the FPL and 185 percent of the FPL.²⁰ Other individuals will receive this insurance through a program that provides federal dollars in the form of subsidies to employers who help employees purchase private insurance. These efforts are expected to allow 60,000 more uninsured residents to receive basic health care services. The end result is that more people will have health insurance with fewer benefits. Arizona also received permission to implement a waiver in 2001 to use unspent CHIP funds to expand coverage to new populations.

Ironically, many states expanded eligibility while cutting other services. This was true in Colorado, Oregon, Utah, and Washington. Colorado and Washington's pending waivers may expand eligibility for some populations while cutting services or charging co-pays for other populations. Utah's eligibility expansion will provide health coverage to 25,000 people through the "Primary Care Network" while at the same time, the state has closed enrollment in CHIP. Enrollment in CHIP was closed from March 2002, reopened in June 2002 and closed once again because of a flood of applications.

The governor and legislature in New York extended coverage to women diagnosed with cervical or breast cancer in the Fall of 2002 and will extend coverage to working individuals with disabilities beginning in April 2003. The state also went ahead with a planned expansion of its Family Health Plus program on October 1, 2002. This expansion allowed families and individuals without children under 150 percent of the Federal Poverty level to be eligible for Family Health Plus. As a result of these actions, several counties in the state have claimed that they must make cuts in other areas in order to implement the Medicaid expansions. For instance, the Monroe County legislature was considering a proposal by the county executive to cut 700 county positions, including a reduction of social service staff.

Delayed Decisions or Delayed Eligibility Expansions

Georgia did not expand or cut eligibility, but rather delayed a planned eligibility expansion. The delay was pushed by a legislature that is known for being fairly conservative relative to other states in its budgeting techniques. The delay was implemented in order to determine if an expansion would be prudent given the economic downturn. The original proposal would have expanded eligibility for children in families with incomes between

²⁰ See <http://www.cms.hhs.gov/hifa/orapp.pdf> for details about the state waiver requests.

100-150% poverty. The picture in Mississippi is still tenuous. The legislature had three special sessions to deal with its budget shortfall. Medicaid was a hotly contested issue with both the legislature and the governor. At one point, the governor vetoed the legislature's proposal for cutting Medicaid. The state eventually agreed to set up a task force to monitor the Medicaid program to help determine where money could be saved.

Substantial Cuts to Eligibility

Of all the states in the study, New Jersey experienced some of the steepest declines in revenue relative to other states and chose to implement cuts in eligibility to the NJ Family Care Program. These cuts were targeted at the CHIP program known as NJ Family Care, resulting in the retrenchment of a recent coverage expansion for adults. Children in the Family Care program will continue to be covered even if their parents are not. From these cuts, the state expected to achieve \$43 million in savings. Similar to New Jersey, Tennessee targeted its public health insurance program (TennCare) for cost savings. The state conducted a review of program eligibility of TennCare enrollees starting in July 2002. Program modifications to income standards were expected to disqualify up to 100,000 people, including 3,000 children by January 1, 2003. As a result, advocacy organizations are currently challenging the eligibility review in court. Eligibility for regular Medicaid under the TennCare program remained unchanged and some services were actually expanded for certain populations.

Budget Actions Impacting Medicaid and CHIP Administration

Staff Reductions

The majority of states in the study experienced some loss in Medicaid-related staffing, whether through attrition or outright cuts. Table 4 lists the actions taken by states with regard to staffing as well the expected impact on program implementation. In terms of access to health care, changes to the administration of the Medicaid pro-

gram resulted in less time for processing applications and unmanageable caseloads. Anecdotally, excessive workloads caused lower morale and less time for outreach to potentially eligible individuals. The cuts in staffing appeared to have most significantly impacted enrollment in Washington, New Jersey, New York, Texas, Ohio, and Mississippi. Five states in the study, Florida, Georgia, Kansas, Michigan, and Wisconsin, appeared as though they would be able to maintain service levels for the upcoming year.

Limits on Outreach

After the advent of the Children's Health Insurance Program, many states undertook aggressive and unprecedented outreach and enrollment campaigns. As a result, many states saw sudden increases in Medicaid enrollment beginning in 1998 and thereafter. Although many states relished increased enrollment, other states perceived the increase as a fiscal burden and subsequently curtailed outreach. For instance, Ohio reported that it has reduced some outreach activities especially as frontline worker caseloads have increased and there is less time for them to engage in outreach efforts. The state also eliminated contracts with other departments to do outreach. Oregon reported similar cutbacks to outreach due to increased caseloads and reduced staffing at the local level. Mississippi stopped aggressive outreach and New Jersey stopped outreach efforts for the New Jersey Family Care program. In Washington, staff funding for outreach has been reduced significantly from what it was two years ago. The message is subtler in Kansas where outreach efforts were not curtailed but less emphasis has been put on outreach.

Current or looming budget gaps did not cause Wisconsin, Tennessee, Texas, New York, Florida or Georgia to explicitly cut back outreach *yet*. A mixed picture regarding outreach efforts emerged from Michigan where the message was not to curtail outreach, although reductions were made in funding for outreach. Colorado was also an interesting case. As a result of a recent court decision, the state is in the process of directly contacting former Medicaid enrollees about their potential eligibility, which may have been lost as a result of problems with the state's computerized eligibility system.

Table 4: Staffing in Medicaid Agencies and Offices		
<i>State</i>	<i>Administrative Action</i>	<i>Estimated Impact on Service Delivery</i>
Arizona	35 FTE positions will be left vacant at the state level	Remains to be seen
Colorado	Temporary hiring freeze	A slight increase in caseload per frontline worker might be expected
Florida	No cuts in staffing	
Georgia	Medicaid and PeachCare staff were largely protected from spending cuts	
Kansas	No hiring freeze	
Michigan	Early retirement offered, hiring freezes — with exceptions if needed	The ability to lift the ban on hiring allows adequate number of caseworkers
Mississippi	High staff vacancy rate	Additional cuts possible – these could negatively impact application processing
New Jersey	Hiring freeze, 600 non union employees terminated, early retirement	There may be some loss in state Medicaid staffing at the counties where eligibility is determined
New York	Hiring freezes and staff cuts at the county level	Less ability to implement planned enrollment expansions under the Family Health Plus Program
Ohio	Hiring freezes	Locals feel stressed since they are under hiring freezes
Oregon	Hiring freeze	A decrease in the ability of workers to handle welfare caseloads is expected
Texas	The Department of Human Services case-worker staff reductions included 679 in '00-'01, 450 in '02, and 3000 for '03	There was an expectation that the simplified application process would reduce work loads but understaffing is reported in some regions
Utah	None noted	
Washington	Cuts in local office staff where applications are processed	Unmanageable caseloads and dysfunctional morale — cuts are expected to severely impair applications, enrollment, eligibility
West Virginia	The 2003 budget does not impose significant cuts on state government.	Efforts to freeze or cut back new hires in DHHS in the future will no doubt hinder the capacity serve eligibles
Wisconsin	3% reduction in state operations	This action is not likely to affect county staff that determine eligibility

Retrenchment of outreach activities was not surprising since many states devoted so much time and effort to this endeavor just prior to the economic slowdown. The benefits of outreach were twofold. Not only did outreach benefit potentially eligible individuals but it also benefited politicians who could heighten their visibility by appearing in advertisements that promoted enrollment. Enrollment began to accelerate and in 2000 many states saw enrollment increases that exceeded expectations. With increased caseloads and less money, it is likely that even more states will curtail outreach activities in the upcoming fiscal year.

Looking to the Future

Although some states are optimistic that revenues will improve, early predictions indicate a more pessimistic picture. The problem results both from the fact that revenues may again be lower than expected and in the fact that many states delayed program cuts this year. Early signs indicate that more expansive cuts in Medicaid, including more cuts to eligibility than would have been necessary had states chosen to curtail expenditures earlier are likely in Fiscal Year 2004. The prediction of more substantial cuts to Medicaid programs in FY 2004 is based on two arguments. First is that some states will not have access to the same one-time revenue sources, such as rainy day funds and tobacco settlement money. Second, if other programs were already targeted this year, Medicaid will be next in line for cuts. For budget planners, there are reasons to cut Medicaid. One reason is that Medicaid is a large target. In fact, it is often the largest part of many state budgets, accounting for upwards of 20 percent of general fund spending. Second, other programs were already cut this year so Medicaid is the next resort. Even if the economy bounces back, the fact that states have delayed measures to ade-

quately address their fiscal losses make the next half-decade look rather precarious.²¹ Our prediction is that states will take advantage of the flexibility provided under waivers and funding loopholes such as UPL and DSH to continue maximizing federal revenue. We also predict that states will resort to “rationing” care for certain populations or charging co-pays before turning to high profile and politically perilous eligibility cuts.

Conclusion

Despite the fact that states are experiencing “the worst budget crisis since World War II,” many have taken advantage of the flexibility afforded under the Medicaid and CHIP programs to maintain and even expand Medicaid eligibility. States have done this by using unspent State Children’s Health Insurance Program (SCHIP) funds or by developing savings in other aspects of their Medicaid program. These cost-saving measures have ranged from cutting optional services and provider rates to charging co-pays for certain services. The current federal administration is likely to reinforce its position that encourages state innovation in Medicaid especially as the number of uninsured increases and employer-based coverage becomes more expensive. This will mean more states are likely to apply for waivers that allow them to cut costs in order to maintain eligibility. However, given the grim predictions for revenue collection and the fact that many states have already used one-time measures to balance their budgets in FY 2003, more states may have to resort to Medicaid cuts in FY 2004. These cuts are likely to add to the current strain on administrative capacity in local offices and result in even less outreach, which could ultimately reverse the Medicaid and CHIP enrollment gains made in the late 1990s.

²¹ See “The Bursting State Fiscal Bubble and Medicaid Budgets” by Donald Boyd, *Health Affairs*, January/February 2003.

The Nelson A. Rockefeller Institute of Government

The Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

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The mission of the American Federalism group is to help fill this gap. The Group conducts research on trends affecting states and serves as a national resource on issues such as welfare reform, and Medicaid Managed Care for public officials, the media, public affairs experts, researchers, and others. The Group is directed by Tom Gais, who has spent the last decade analyzing state and local issues with federalism. Jim Fossett oversees research in the area of public health programs.

This Report

Courtney E. Burke and Jim Fossett of the Institute's American Federalism Group, wrote this report. Michael Cooper, the Rockefeller Institute's Director of Publications, did the layout, with assistance from Michele Charbonneau.

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