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Major Findings

This report assesses how Medicaid was treated in fiscal year 2004 in the budgets of ten states. Drawing on detailed analyses of state budgets, it examines state budget-balancing strategies, with particular attention to changes in Medicaid spending and eligibility compared to other government functions.¹ Major findings follow:

- 1. The states in the sample were in weak financial condition in FY 2004. The gaps between revenues and expenditures states had to address were large by historical standards. In seven of the ten states these gaps exceeded 10 percent.**
- 2. The major cause of state financial problems was revenue declines produced primarily by slowed economic growth and the decline in the stock market, rather than large increases in state spending. Political discussion of state financial problems did not focus on Medicaid as a major cause of the state's financial difficulties.**
- 3. Most states relied on a mix of revenue increases and expenditure cuts to bring their FY 2004 budgets into balance, with more reliance on expenditure cuts in FY 2004 than in FY 2003.**
- 4. Cutting Medicaid was not a major element of most states budget balancing strategies. While almost every state enacted some form of Medicaid expenditure reduction, most were modest compared to the size of the budget gap and total Medicaid expenditures. In three states, Medicaid spending cuts amounted to more than 10 percent of the state budget-balancing package.**
- 5. The availability of additional Medicaid funding enacted by Congress in 2003 had little effect on state decisions about Medicaid expenditure cuts. In two states, the availability of these funds appeared to restore or limit cuts in Medicaid. Most states used these funds to support the state budget generally rather than prevent reductions in Medicaid.**
- 6. Other state government functions were cut more than Medicaid, particularly public higher education, where official tuition rates were increased in many states.**
- 7. The attitudes and actions of elected officials, particularly governors, were the most important influence on the nature and extent of Medicaid spending cuts. In four states, governors made more or less explicit decisions to protect Medicaid from significant spending cuts and were largely successful. In one state, legislators opposed cuts proposed by the Governor.**
- 8. There are several reasons why Medicaid has proven so hard for states to cut. State governments derive considerable financial benefit from Medicaid by us-**

¹ An earlier paper in this series examined similar issues in state budgets for FY 2003. James W. Fossett and Courtney Burke, "Is Medicaid Retrenching? State Budgets and Medicaid Spending, FY 2003," *Managing Medicaid Take-Up*. Albany, NY: Rockefeller Institute, February 2003.

ing it to pay for social service programs previously supported by state funds and through various “creative financing” techniques that allow states to receive substantial Medicaid funding without increasing their own spending. In addition, providers such as hospitals and nursing homes that receive Medicaid payments are major employers and purchasers in legislative districts, adding to the constituencies opposed to reducing Medicaid spending.

Research Method

Adopted state budgets for fiscal year 2004 were examined in the ten states listed. Although this is not a random sample, the states selected represent a range of fiscal conditions, Medicaid program size and liberality, political circumstances, and other factors that might be expected to influence Medicaid spending. The sample states have experienced similar budget problems of declining revenue and increased Medicaid and education spending as the country as a whole.

Sample States

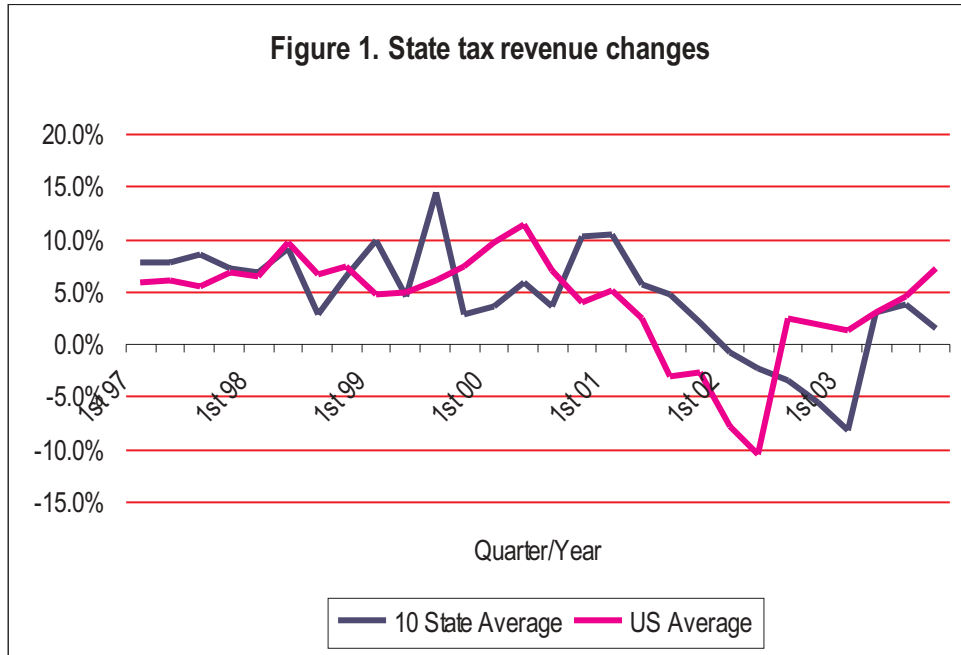
Arizona	Michigan	Oregon
Colorado	New Jersey	Texas
Kansas	Ohio	West Virginia
		Wisconsin

The analysis of individual state budgets was performed by a network of local academics familiar with state finances and in many cases extensively in studying Medicaid and other programs in their states. They were asked to assess the state’s financial situation and report on the mix of revenue and expenditure measures their state used to balance the FY 2004 budget, with particular attention to changes affecting Medicaid and Children’s Health Insurance Program (CHIP). The names and affiliations of the field researchers are listed in an appendix.

State Financial Conditions — FY 2004

The ten states in the sample experienced budget problems similar to those of other states in FY 2004. Figure 1 compares average quarterly revenue growth in these states in the period 1997-2003 with the average for the country in this same period. Revenue conditions in these states were less severe than those in the country as a whole in 2001 and early 2002; however, their revenue continued to decline in late 2002 and reached their lowest level in early 2003 after other states were starting to experience revenue growth. As a whole, in the period covered in this report, the sample states were in slightly worse shape than the national average.

The rates of growth in Medicaid spending from 2000-2003 in the sample states as compared with the national average are displayed in Table 1. While these states demonstrate a wide range over this period, Medicaid spending in these states grew at a slightly faster rate than the U.S. average.



Source: Rockefeller Institute of Government, Fiscal Studies Program

Table 1. Percent Change in Medicaid Expenditures 2000-2003			
<i>State</i>	<i>Total Change</i>	<i>Fed Change</i>	<i>State Change</i>
Arizona	86.60%	92.41%	74.16%
Colorado	31.43%	35.08%	27.71%
Kansas	24.35%	27.86%	19.10%
Michigan	13.95%	18.18%	8.75%
New Jersey	33.73%	37.24%	30.18%
Ohio	37.81%	42.16%	31.66%
Oregon	26.56%	29.87%	21.56%
Texas	44.01%	44.67%	42.97%
West Virginia	35.13%	38.89%	24.46%
Wisconsin	43.49%	47.09%	38.37%
10 State Average	37.70%	41.35%	31.89%
U.S. Average	34.51%	38.45%	29.33%

Source: Centers for Medicare and Medicaid Services

Budget Gaps in FY 2004

The combination of declining revenues and increased Medicaid spending, along with other budget pressures, produced budget problems for the sample states in FY 2004. Table 2 reports on the size of the general fund budget gaps for FY 2004 in these states. The budget gaps are the holes states had to fill — what some places call a baseline budget that compares baseline revenues and expenditures — not what they wound up with. Gaps are measured in different ways in different states; generally they represent the difference between an extrapolation of expenditures for current services (as well as planned additional expenditures) and expected tax and other revenue. Different agencies and organizations involved in the budget process may begin with different estimates of this gap; the estimates reported here are those embodied in the final enacted state budget. Every state expected a general fund budget gap in FY 2004; in New Jersey and Arizona, this gap was over 20 percent. These are large estimated deficits by historical standards, and warrant the “fiscal crisis” label.

<i>State</i>	<i>Anticipated General Fund Expenditures</i>	<i>Estimated Gap Between Revenue and Expenditures</i>	<i>Gap as Percent of General Fund Expenditures</i>
AZ	7.000B	1.47B	21.0%
CO*	5.584B	253M	4.5%
KS	4.490B	760M	17.0%
MI	8.793B	1.34B	15.0%
NJ	23.700B	4.9b	21.0%
OH*	24.100B	694M	2.9%
OR	10.740B	1.2B	11.0%
TX	63.500B	8.8B	14.0%
WV	3.040B	250M	8.0%
WI	12.400B	1.5B	12.0%

** Estimated based on negotiations between Governors and legislatures. Texas budget is biennial.*

The fiscal crisis of the states, both in political perception and in fact, is primarily, although not exclusively, the result of sharp declines in state revenue rather than unusually large increases in state spending in general or Medicaid in particular. Declines in state revenue were the result of the mild recession and sharper declines in the stock market values that depressed state income tax revenue from capital gains, the exercise of stock options, and bonuses for the financial services industry. Nicholas Jenny explains the effects of these developments on state finances as follows:

...initially the market downturn affected relatively few wage earners, (but) it turned gains into losses for investors, thus sharply contracting a hitherto rich source of revenue almost overnight. Meanwhile, stock options became both less common and less lucrative. The recession only lasted eight months but it had significant after effects as the loss of investment capital manifested itself in weak employment numbers, which in turn depressed (tax revenue from) withholding.²

Medicaid spending growth over this period was higher than historical averages and the low growth rates of the late 1990s, but was well below the 20 percent plus annual growth rates of the early 1990s. Alan Weil has observed that Medicaid spending growth is high even in normal times:

...Medicaid operates from a high base of growth that is easily susceptible to shocks. Medicaid pays for health care services, which exhibit long-term growth rates in excess of general inflation and in excess of prevailing economic growth. The most expensive populations Medicaid serves — elders and people with disabilities — are growing steadily. These two characteristics assure that, on average, Medicaid will experience cost trends that outpace overall economic growth... In the longer view, it is the late 1990's, not the 2000's, that stand out as different.³

Budget discussions in most of the sample states followed a similar pattern. State financial problems were typically seen and publicly discussed as the result of declining revenues, rather than excessive spending growth. While Medicaid spending growth was discussed publicly and reported in the media, there were few attempts to cast Medicaid as the primary cause of state financial problems. In Ohio, for example,

Although there is general acknowledgment that Medicaid's growth has added to the difficulty of balancing Ohio's state budget, the Governor and the state legislature have continued to allow the largest portion of new spending to go to the Medicaid program. This is not to imply that certain aspects of the program have been immune to cuts and freezes, but budgets have allowed for increases in medical and prescription costs and caseloads. (The state's major newspapers) — the Cleveland Plain Dealer, the Toledo Blade, Canton Repository, Dayton Daily News, and Cincinnati Inquirer — have all covered the budget with specific mention of the Medicaid increases. The tone of the coverage has been less critical than matter of fact.⁴

Similarly, in West Virginia:

...Medicaid is not seen as the budget busting issue that it was in the early 1990's. Indeed, no one issue was seen as the budget buster in West Virginia during the development of the FY 2004 budget.... Explanations for the state's budget conditions are linked more to cyclical factors associated with a poor economy.... Some point to Medicaid as a source of continuing funding strains, but most attention is now focused on the costs of the Workers Compen-

2 Nicholas Jenny, "State Tax Revenue Grows Slightly," *State Revenue Report No. 54*. Available online at http://stateandlocalgateway.rockinst.org/fiscal_pub/state_rev/sr_reports/rr_54.pdf. Accessed March 11, 2004.

3 Alan Weil, "There's Something About Medicaid," *Health Affairs* 22 (January/February 2003): 19-20.

4 Miriam Wilson, Ohio Field Report.

sation program, the Public Employees Insurance Program, and the long term debt obligations found in the state teachers pension program.⁵

Our findings indicate little support for major cuts in Medicaid in most of the sample states. While growth in the cost of Medicaid was seen as a problem in almost every state, there was no substantial political sentiment that it was a or the major cause of state financial problems. Public discussion focused on revenue declines as a major cause of budget stress, and cuts to Medicaid were put forward as one, but far from the only, possible means of addressing this problem.

State Budget Balancing Strategies

Table 3 shows the budget balancing strategies used by these states, divided between revenue enhancements and expenditure cuts. Revenue enhancements include borrowing, shifting general fund expenditures to other revenue streams, raising tuition, securitizing tobacco settlement funds, and drawing down rainy day funds or other surpluses, in addition to raising taxes and fees. Expenditure cuts, particularly in Medicaid and similar programs, are typically reductions from an estimate of projected spending rather than reductions in the absolute amount of money to be spent. If state Medicaid spending, for example, was \$1.5 billion in FY 2003 and is estimated to grow to \$2 billion in FY 2004, then policy changes estimated to save \$250 million are counted as a “cut” because they reduced the expected rate of spending growth, even though Medicaid still costs more in FY 2004 than in FY 2003.

<i>State</i>	<i>Percent of Gap to be Filled With Revenue Enhancements</i>	<i>Percent of Gap to be Filled With Expenditure Cuts</i>
AZ	92%	8%
CO	10%	90%
KS	67%	33%
MI	30%	70%
NJ	25%	75%
OH	30%	70%
OR	0%	100%
TX*	30%	70%
WV	90%	10%
WI	77%	23%

* The Texas budget is biennial.

Compared with the actions taken by many of the sample states in FY 2003, Table 3 shows a shift towards expenditure cutting, rather than revenue enhancement, as a budget balancing strategy in FY 2004.⁶ States may have used available options for covering spending from other than general fund sources in FY 2003 and thus had fewer such alternatives available for the 2004 budget.

This research indicates that the choice of whether to reduce expenditures or raise revenue was not related to the magnitude of a state's budget problem. There is little relationship between Medicaid expenditure growth, the size of budget gaps, and decisions to cut programs or raise revenue. Arizona and New Jersey, which had the largest budget gaps of the sample states, enacted opposing strategies. Arizona, which had by far the largest Medicaid growth rate among the sample states in the early 2000s, filled most of its budget gap by raising revenue. New Jersey enacted a 2004 budget with greater emphasis on expenditure cuts.

How the sample states balanced their budgets had less to do with the severity of their budget problems and more to do with the positioning of governors and others in the budget process. In Arizona, Kansas, and West Virginia, governors made more or less explicit decisions to protect Medicaid and other human service programs from cuts and were able to sustain this position in the legislature, thus focusing their state's budget balancing actions around revenue enhancement. By contrast, there was little sentiment for raising taxes or other revenue among elected officials in Texas and New Jersey (the governor in New Jersey had run his campaign promising to balance the state's budget without raising taxes) thus increasing the amount of expenditure reduction that had to be done to bring their budgets into balance.

Other states were constrained externally. Colorado operates under a voter-mandated limit on expenditure growth, making it difficult for the state to cover large budget gaps by raising revenue. Oregon's outcome was shaped by requirements that tax increases be approved by voters; the legislature passed a budget relatively evenly balanced between expenditure cuts and revenue increases. However, the revenue measures that were enacted did not receive voter approval. The failure of the revenue measures at the polls triggered a pre-established set of expenditure cuts which were called "disappropriations."

Revenue Enhancements

Similar to FY 2003, states used a variety of revenue enhancements to balance their budgets in FY 2004, with one-shots the most widely used method. Colorado and New Jersey securitized tobacco money. Ohio transferred proceeds from the Tobacco Use Prevention and Control Foundation to the general fund; Michigan transferred \$10 million from an employee contingent fund. Some states used rainy day funds both in FY 2003 and in FY 2004. Most states used a variety of revenue enhancing strategies. For example, Arizona used \$75 million in lawsuit settlement funds and \$150 million in transfers from other dedicated funds, among other sources, to help balance its budget. Other methods that states used to increase revenues included deferring payments, transferring money from special funds to the general fund, tax amnesty programs, drawing on Temporary Assistance for Needy Families (TANF) funds, and increasing tuition at state universities. Table 4 provides an overview of state revenue enhancement strategies in FY 2004.

6 Compare these figures with those in Fossett and Burke, "Is Medicaid Retrenching?," Table 1.

Table 4. Summary of Revenue Enhancement Strategies, FY 2004

<i>State</i>	<i>Raise Tax</i>	<i>Fees, Sur-charge</i>	<i>Tap Earmark</i>	<i>One Shot</i>	<i>Draw Surplus</i>	<i>Rainy Day Fund</i>	<i>Special Finance</i>	<i>Tuition Increase</i>	<i>Other</i>
AZ	*	*		*		*	*		*
CO				*					*
KS	*		*	*		*		*	*
MI		*	*	*					*
NJ	*	*		*	*				
OH	*	*	*	*	*				*
OR*	*								
TX		*				*			*
WV	*		*	*		*	*	*	*
WI		*		*			*	*	*

* Oregon proposed tax increase did not receive the required voter approval.

One difference between the budget balancing strategies in 2003 and 2004 was that more states resorted to increasing taxes, although these increases were often limited in scope and impact. For instance, rather than implementing a new tax, Kansas eliminated the expiration of a 2002 state sales tax increase. Sin taxes on such items as tobacco, alcohol, and other luxuries were preferred over broad-based income and sales tax increases. Fees were increased on automobile registration, realty, nursing home beds, and utilities.

The Impact of One-Time Federal Medicaid Revenue

In FY 2004, a major Medicaid-related federal revenue enhancement came from one-time payments under the Jobs Growth Tax Relief Reconciliation Act (JGTRRA) that provided \$20 billion to the states. Ten billion was for Medicaid and \$10 billion for general fiscal relief. The Medicaid money was provided in the form of a temporary increase in the federal Medicaid assistance payments (FMAP).

At the time this law was passed, this temporary increase in the Medicaid FMAP was seen as a way to avoid cuts to Medicaid.⁷ *However, our study revealed that a small number of states actually used the federal money to restore enacted Medicaid cuts.* Texas was the only state in our sample that clearly used the federal money to restore Medicaid cuts. Texas received a total of \$1.3 billion, of which \$372.3 million was used for Medicaid to partially restore provider cuts, cuts in community care programs for the

7 Leighton Ku, "State Fiscal Relief Provides an Opportunity to Safeguard Medicaid Budgets," Center on Budget and Policy Priorities, June 4, 2003.

aged and disabled, and for the partial restoration of mental health benefits under the CHIP program. The remainder was used to support general fund expenditures. Even in this case, the first inclination was to put these funds toward general fiscal relief. However, public pressure from advocates eventually allowed this money to be used for partial restoration of Medicaid cuts. In Ohio, the legislature passed a budget without some of the Medicaid cuts that the governor had proposed. Observers of the budget process believed that the added federal fiscal relief avoided the need for a more intense debate between the Ohio governor and legislature about the proposed cuts.

The other states in the sample used the federal money for general fiscal relief rather than for restoration of Medicaid cuts. In Arizona, other programs were seen as receiving more relief from the extra federal money than Medicaid. Wisconsin used the money as a replacement for Upper Payment Limit (UPL)⁸ revenues that were projected to be lower than the state had previously anticipated. West Virginia viewed the federal fiscal relief as a one-time measure and was debating whether the money should be used to *expand* Medicaid eligibility. Kansas was already far enough into the budget decision process that the enhanced FMAP had little impact on spending decisions in FY 2004.

At the time this report went to print, a handful of states in the sample had yet to resolve how the added federal money would be used. This was true in Colorado where federal funds were placed in a special account while the Governor and Assembly debate over who had the authority for allocating these funds. The governor suggested that some of the funds be used to restore some of the cuts that were made to Child Health Plan Plus (CHP+).⁹

In sum, this research indicated that the initial round of extra federal money in FY 2004 arrived too late, was irrelevant to many of the state budget debates of 2003, and except in Texas, did little to help restore cuts to Medicaid.

Expenditure Cuts

Compared to our examination of state budgets in 2003¹⁰ states had to rely slightly more on expenditure cuts in FY 2004. This is probably because the use of one-time revenue enhancements in 2003 left fewer resources for states to use in this way in FY 2004. Two states in the sample relied almost exclusively on expenditure cuts — Colorado and Oregon. But these states differ because each was subject to voter-approved measures that limit spending. In the case of Colorado, a voter-approved measure limits the growth of state revenue and state spending.¹¹ In the case of Oregon, as mentioned before, cuts were the result of voters disapproving a tax increase after the budget had been agreed to by elected officials. The defeat of this tax increase subsequently resulted in what

8 “Upper Payment Limit” revenue comes from a provision that allows states to nominally pay certain types of nursing homes more than would otherwise be possible and keep the excess revenue. Regulations were recently enacted to curb this practice limiting the amount of money states could draw from this funding source. For more information see, *States Use of Maximization Strategies to Tap Federal Revenue* by Teresa Coughlin and Stephen Zuckerman. Urban Institute, June 1, 2002.

9 As this paper went to press, it was not clear if a final determination had been made as to the use of these funds.

10 James W. Fossett and Courtney Burke, “Is Medicaid Retrenching? State Budgets and Medicaid Spending, FY 2003,” *Managing Medicaid Take-Up*. Albany, NY: Rockefeller Institute, February 2003.

11 Colorado is subject to limits on local property tax collection, causing the amount of revenue share from property taxes to shrink substantially over the past decade.

was called a “disappropriation” assigned to Oregon state agencies. The original budget, by partially relying on revenue enhancements, would have avoided these cuts.

In the remaining states in the sample, a variety of measures were used to cut expenditures such as across the board cuts, staff cuts, hiring freezes, and discretionary program cuts. Most states directed agencies to look for ways to control spending, so the size of the cuts varied by program area. For instance, in New Jersey, health and senior services was cut by 12.8 percent and Treasury was cut by 6.1 percent. Other examples of cuts included eliminating the Medicaid outreach program in Michigan and positions in the Corrections Department in Colorado; cuts to information technology projects in schools in Wisconsin; and to the civil rights commission, adult corrections program, library and historical programs in Ohio.

State workforces were noticeably impacted by staff cuts, merit award reductions, performance pay delays, and the elimination of salary increases. The cumulative impact of cuts to state agency staff, early retirements, and hiring freezes in FY 2003 and FY 2004 resulted in noticeable attrition and staffing shortages in many states. This was particularly true in Ohio where the workforce was reduced by 3,000 positions in FY 2003 and in Michigan where an early retirement incentive caused the state workforce to shrink dramatically.

Medicaid Spending Cuts

Even in this environment of severe budget difficulties and significant spending cuts, Medicaid was not a major budget target in most of the sample states. Table 5 shows estimated general fund spending cuts to Medicaid in the final enacted budgets in the sample states, together with the associated federal match. Cuts are largest in dollar terms in Texas and Oregon. In Kansas and West Virginia Medicaid spending cuts were not enacted.

Table 5. FY 2004 Medicaid Cut (in thousands)			
<i>State</i>	<i>Medicaid General Fund Cut</i>	<i>Total Fed Cut</i>	<i>Fed & State Medicaid Cut</i>
AZ	26,700	54,735	81,435
CO	36,000	36,000	72,000
KS	0	0	0
MI	64,000	79,360	143,360
NJ	4,900	4,900	9,800
OH	155,000	221,650	376,650
OR	167,000	252,170	419,170
TX	777,000	1,165,500	1,942,500
WV	0	0	0
WI	52,500	74,025	147,251

Note: Based on FY 2003 match rate and does not include enhanced FMAP from JGTRRA

Table 6 summarizes the types of Medicaid spending cuts enacted in the sample states. The most common action was prescription drug cost controls, with nearly every state implementing some sort of mechanism to control drug costs.¹² Other cost control measures included freezing or cutting provider rates, cutting optional services, or slowing enrollment. In the sample states, cuts were made to a variety of services, including: durable medical equipment, chiropractic benefits, prescription drugs, transportation services, mental health, and substance abuse (among others).

<i>State</i>	<i>Cut Eligibility</i>	<i>Eliminated/Slowed Expansion/Enrollment</i>	<i>Cut Services/Limited Utilization</i>	<i>Cut or Froze Provider Rates</i>
AZ		*	*	
CO		*	*	*
KS	*			“minimal”
NJ		*	*	
OH			*	*
TX	*	*	*	*
WV		*	*	
WI			*	*

* Data for Oregon and Michigan unavailable

Most states in the sample were reluctant to make major cuts to eligibility. The fact that states resisted outright eligibility cuts is indicative of the perceived political ramifications of eliminating populations from Medicaid. To get around outright eligibility cuts, a number of the sample states used other methods, such as capping enrollment, or limiting or eliminating planned program expansions.

Eligibility Changes

States that did cut or limit eligibility tended to target adults. For instance, Arizona planned to repeal eligibility for parents under KidsCare beginning June 30, 2004. Kansas planned to cut adults receiving general assistance benefits from Medicaid if they had received services for a total of 24 months — impacting approximately 400 adults. Texas reduced eligibility for pregnant women from 185 percent of the federal poverty level to 158 percent and eliminated the Medically Needy Spend Down, a temporary coverage program that averages 10,000 adults with dependent

12 For information on state prescription drug cost controls see Dawn Gencarelli, “Medicaid Prescription Coverage: State Efforts to Control Costs,” George Washington University, National Health Policy Forum, May 10, 2003.

children per month.¹³ Ohio eliminated a planned expansion of the CHIP program to parents.¹⁴ Parents/adults may have been targeted for two reasons: First, it may be seen as politically easier to cut adults than children from government programs; second, most states had well-established programs for children and had only recently begun to consider eligibility expansions for adults; therefore, the most recent expansions generally tended to be the first programs to be rolled back.

Enrollment Outreach

Our findings indicate that although legislative and budget actions in FY 2003 and FY 2004 impacted Medicaid enrollment and services, *administrative actions to increase enrollment remained largely unchanged*. For instance, in Arizona, aside from the legislatively enacted tightening of the redetermination time frame, there were no efforts to limit enrollment and the state was still using a simplified application form. Colorado was still pursuing enrollment efforts even with the implementation of a cap on enrollment of children. State officials in Kansas continued support for sustaining enrollment as did those in New Jersey Michigan, Ohio, Wisconsin, and West Virginia.

Simplified Enrollment Processes

The research indicated that efforts by front-line workers to streamline eligibility processes continued during the fiscal downturn. However, in some Texas counties, staff cuts made it difficult for front-line workers to provide the same level of enrollment assistance. This resulted in higher transaction costs for applicants to pursue Medicaid enrollment and in a lower enrollment. In general, most states expected Medicaid enrollment to continue to increase in 2004 and 2005, although not necessarily as fast as in prior years.

Access to Care

The effects of spending cuts on access to care for current and former Medicaid recipients are hard to assess. Eligibility reductions have a clear negative effect on access, as do such measures as the shortening of the enrollment period adopted in Arizona. The effects of other types of policy changes are less clear. For example, efforts to address the high cost of prescription drugs by adopting a preferred drug list, may have little adverse effect on Medicaid clients, depending on the details of co-pays and the availability of off-list drugs. In similar fashion, freezing or making decremental cuts in the rates paid to providers may not have a large short-term effect on the availability of care; physicians may be unwilling to eliminate connections with established patients, although they may limit the number of new Medicaid patients they accept. Hospitals, particularly so-called “safety net” facilities, typically have less choice about the patients they accept, especially for emergency care, so cuts and freezes in these rates may have a limited effect on access to care.

13 Spend down is defined as the process in which an individual spends assets to pay for health care until the assets have been depleted to the required level for eligibility under the Medicaid program.

14 A summary of cost controls for all 50 states can be found in Vernon Smith, Rekha Ramesh, Kathleen Gifford and Eileen Ellis, “States Respond to Fiscal Pressure: A 50 State Update of State Medicaid Spending Growth and Cost-Containment,” Kaiser Commission on Medicaid and the Uninsured, January 2004.

Summary of Findings

While the 2004 reductions to Medicaid were larger than in prior years, our findings indicate that most states did not rely heavily on Medicaid cuts as a budget balancing strategy. The first two columns of Table 7 compare enacted Medicaid general fund expenditure cuts with the size of the state’s budget gap and total enacted general fund expenditure cuts. On average, Medicaid cuts accounted for less than 7 percent of the “gap filling” strategies these states adapted to balance their budgets and only about 12 percent of the expenditure cuts. In only three states — Colorado, Ohio, and Oregon — did cuts to Medicaid account for more than 10 percent of the state’s total budget balancing package. Medicaid cuts were a larger percentage of enacted general fund expenditure cuts, but it should be remembered that expenditure cuts were not very large in several states.

More significantly, the total reductions in Medicaid spending resulting from these expenditure cuts did not constitute a large share of Medicaid spending in most states. The third column of Table 7 compares the total estimated reduction in Medicaid spending (including both state and federal funds) with total Medicaid spending in FY 2003. Most Medicaid reductions were relatively small — in only two states did enacted cuts exceed 10 percent of Medicaid spending. In one of these states (Texas), most of these cuts were “backloaded” into the second year of a biennial budget, so that most of these cuts had not happened at the time of the preparation of this report and indeed may not actually happen, as the legislature can still meet in special session to rescind the cuts before implementation.

Table 7. Medicaid Cuts in Context, FY 2004

	<i>General Fund Medicaid cut as Percentage of 2004 GF Gap</i>	<i>Medicaid General Fund Cut as Percentage of Total Gen- eral Fund Expenditure Cuts</i>	<i>Total 2004 Medicaid Cut (State and Federal) as a Percentage of Total 2003 Medicaid Spending (State and Federal)</i>
AZ	1.82%	25.67%	1.95%
CO	14.20%	15.78%	2.83%
KS	0.00%	0.00%	0.00%
MI	4.78%	6.83%	1.85%
NJ	0.10%	0.13%	0.13%
OH	22.33%	31.89%	3.37%
OR	13.92%	13.92%	13.39%
TX	8.83%	12.61%	14.44%
WV	0.00%	0.00%	0.00%
WI	3.50%	13.22%	3.28%

* Medicaid; ** General Fund.

This analysis indicates that the impact of enacted Medicaid spending cuts on total Medicaid spending will be relatively small in most of the sample states. In two states — Oregon and Texas — spending cuts amounted to more than 10 percent of Medicaid spending in FY 2003, suggesting a slowdown in the rate of growth in Medicaid spending in FY 2004. In the other eight sample states, Medicaid spending cuts amounted to less than 4 percent of FY 2003 Medicaid spending.

How Did Other Programs Fare Compared to Medicaid?

If Medicaid was not substantially cut, did other programs fare better or worse? Elementary and secondary education was also relatively unaffected. The only state in our sample that substantially reduce K-12 education funding was Oregon because of the “disappropriation” of funds that resulted from the voters not approving a tax increase. Strong constituencies against cuts, lawsuits, and legislative requirements were factors that caused states to avoid cuts in K-12 education.

Cuts in human service programs were also modest relative to cuts in other program areas. Cuts occurred in Colorado (1.6%), and Michigan (1.2%). In New Jersey, although cuts to the Department of Health and Senior Services were by far the largest, Medicaid, which is in this Department, experienced only a \$4.9 million cut — less than 1 percent of the overall cut experienced by the department.

The program area that was most affected by state budget difficulties in 2004 was public higher education. It was cut in eight of the ten sample states, and by a much higher percentage than cuts in other program areas. If FY 2003 is taken into account, all ten of the sample states cut state spending on higher education, mostly by raising tuition, in some cases substantially. The cumulative impact of these cuts in Colorado, for example, was estimated to be 20.9 percent over two budget cycles, more than any other program area cuts. These cuts are reflected in Table 8, which lists changes in FY 2003 and FY 2004 in state appropriations for higher education operations and undergraduate tuition and fee increases for FY 2004 and over the last four years.¹⁵ On average, the sample states projected spending 4.5 percent less on higher education in FY 2004 than in FY 2003, and raised tuition and fees by almost 14 percent on average.

Other state departments and agencies also suffered relatively large cuts. Transportation agencies were cut significantly in Ohio, Kansas and Texas. Corrections spending was reduced in Oregon, Arizona, Ohio, and Texas. Michigan, Texas, and New Jersey relied on cuts to a variety of other programs, particularly environmental programs.

15 Data are from the State Higher Education Executive Officers (SHEEO), “Appropriations of state funds for higher education,” and differ only slightly from our research.

Table 8. Changes in State Higher Education Appropriations, and Changes in Tuition

<i>State</i>	<i>Changes in State Appropriations</i>	<i>Tuition and Fee Change, Undergraduate, Flagship Universities</i>		
		<i>FY 2002 to 2003</i>	<i>Projected FY 2004</i>	<i>2003-2004 % Change</i>
AZ	-2.80	0.09	39.1	59.1
CO	-11.00	-13.70	12.7	28.9
KS	-4.60	0.85	17.7	62.9
MI	0.30	Na	6.5	25.9
NJ	2.30	-1.30	8.5	2.1
OH	-1.00	0.80	17.6	56.0
OR	-11.10	-5.00	2.7	33.3
TX	1.50	-6.70	7.4	67.6
WV	-2.90	-5.90	9.5	29.1
WI	2.20	-10.48	16.1	37.5
10 State Average	-2.71	-4.59	13.8	43.2
U.S. Average	-0.80	-1.54	11.6	38.2

Sources: 2003-04 Tuition Fee Rates: A National Comparison” Washington Higher Education Coordinating Board, December 2003, and SHEEO data www.sheeo.com. “Appropriations of state funds for higher education.”

These findings suggest that although Medicaid was cut in most states, and substantially in a few, it was not the primary target of spending cuts. Other programs took bigger hits. This pattern appears to be largely the result of politics. In West Virginia, Kansas, Michigan, and Arizona, governors made more or less explicit decisions to protect Medicaid from budget cuts and were largely able to sustain this position even under challenge. In Arizona, for example, proposals from some legislators to cut Medicaid more substantially were blocked by the program’s legislative allies and others were vetoed by the governor. In West Virginia and Kansas, there appeared to be little political sentiment for cutting Medicaid, and the governor’s position against doing so went largely unchallenged. While there was a greater challenge to the governor’s position in Michigan, she was willing to accept only limited cuts in Medicaid. In Ohio, by contrast, the state legislature turned down a number of Medicaid cuts proposed by the governor. In the other sample states it was largely agreed that Medicaid should not be a primary budgetary target.

Why Is Medicaid So Hard to Cut?

These findings suggest that Medicaid — popularly thought to be a program which provides health care to poor people through medically and politically marginal safety net institutions — in fact has considerable political resilience. Despite expectations and predictions to the contrary, Medicaid has been able to survive these two bad budget years without major retrenchments in most states. While cuts have been significant in some of the sample states (Oregon and Texas) in most they have been modest, particularly in comparison to those experienced by other programs. Elected officials have found it in their political interest either to protect the program budgetarily or to resist cuts urged by others. Medicaid has not been expanded, and in some states, its growth has been appreciably slowed, but there has been no large-scale retrenchment.

Several factors appear to account for this resilience. One is the financial incentive problems that Medicaid presents to budget cutters. Since state spending for Medicaid carries a federal match. Cutting a state dollar from Medicaid causes total Medicaid spending to decline by at least two dollars and as many as four dollars. This makes cutting Medicaid less attractive than cutting programs funded solely by state funds where cutting a state dollar causes spending to decline by a dollar. In addition, cutting the Medicaid rolls rarely reduces the cost of treating former Medicaid clients, but rather transfers the financial burden for serving them to hospitals, county health programs, or other institutions.

State governments benefit from Medicaid in two major ways. One is achieved by having Medicaid support programs that traditionally had been supported with state general funds. While precise numbers are difficult to come by, many states have realized considerable general fund savings by “*Medicaiding*” programs in mental health, mental retardation, education, and other human service programs. Cutting Medicaid would jeopardize these savings and would require large cuts in state programs because of the loss of federal matching funds. States have also benefitted considerably from “creative financing” schemes under which states have been able to claim considerable federal reimbursement without spending their own money in more than an accounting sense.¹⁶ While the Clinton and Bush administrations have taken steps to limit excessive state claims under such schemes, many states can still claim significant amounts of federal funds this way. Cutting Medicaid services or enrollment appreciably could limit the ability of states to make claims under these schemes. Public-sector unions, too, have a big stake in Medicaid-funded jobs both in public and nonprofit health care institutions.

A second factor that limits the appeal of large-scale Medicaid cutting is the program’s substantial political constituencies.¹⁷ As shown in Table 9, Medicaid accounts for an average of one dollar in every eight spent on health care in these ten states, a figure which is below the national average. Its financial importance for health care industries is very large. Nationally, for example, Medicaid

16 For detailed descriptions and discussions of these mechanisms, see Teresa Coughlin, Brian Bruen, and Jennifer King, “States Use of Medicaid UPL and DSH Financing Mechanisms,” *Health Affairs* 23 (March/April 2004) and U.S. General Accounting Office, “Medicaid: Improved Federal Oversight of State Financing Schemes is Needed” (GAO 04-228), February 2004.

17 Lawrence D. Brown and Michael Sparer, “Poor Program’s Progress: The Unanticipated Politics of Medicaid Policy,” *Health Affairs* 22 (January/February 2003): 31-44.

accounts for almost half of all nursing home spending, approximately, 15 percent of spending on hospitals, and also large (though difficult to quantify) fractions of spending in such program areas as mental health and services for the mentally retarded and developmentally disabled.¹⁸ Medicaid is the largest maternal and child health program in the country, covering approximately 25 percent of children and as many as half the births in some states. This extensive coverage has created a large, geographically dispersed network of providers (including hospitals, nursing homes and other long-term-care facilities and programs, residential and treatment facilities for the mentally ill and mentally retarded, pediatricians and obstetricians/gynecologists) who receive considerable income from Medicaid and might be expected to object to loss of this income. The geographic dispersion of these providers means that large numbers of state legislators have influential constituents with an economic interest in Medicaid to answer to.

Table 9. Medicaid Spending as a Share of a State's Personal Health Care Spending in 1998	
<i>State</i>	<i>Medicaid Share of Personal Health Care Spending</i>
AZ	12.6
CO	11.9
KS	10.8
MI	14.9
NJ	14.0
OH	15.6
OR	15.3
TX	12.5
WV	17.3
WI	13.4
10 State Average	13.8
U.S. Average	15.7
Source: Anne Martin, Lekha Whittle, Katharine Levit, Greg Won, and Lindy Minman, "Health Care Spending During 1991-1998: A Fifty-State Review" Exhibit 4, <i>Health Affairs</i> , July/August 2002.	

18 Don Boyd, "Medicaid Spending — New York Versus Other States" Presentation to the New York State Health Care Task Force, Albany, New York, September 5, 2003.

Medicaid provides economic development benefits that are broadly dispersed geographically. Nursing homes and hospitals are major employers and purchasers in many states, particularly in rural areas, and Medicaid's support of these facilities supports jobs and business activities. Table 11 presents estimates by Families USA, a Medicaid advocacy group, of the total employment and business activity supported by Medicaid in the ten sample states. While it is difficult to judge the accuracy of these estimates, they suggest that Medicaid supports, directly or indirectly, tens of thousands of jobs and billions of dollars of business activity. Advocates in some states have begun to argue against cutting Medicaid not only on public health but also on economic development grounds. Elected officials who might otherwise be indifferent to Medicaid as a health care program are likely to be sensitive to these economic benefits and hence to be hesitant to reduce support for these employers in their districts.

Table 10. Medicaid's Role in the Economy, FY 2005*

<i>State</i>	<i>State Medicaid Spending (millions of dollars)</i>	<i>Total New Jobs Created</i>	<i>New Business Activity (millions of dollars)</i>
AZ	1,888	78,527	8,033
CO	1,335	28,356	2,989
KS	759	25,112	2,393
MI	3,906	98,773	10,171
NJ	3,901	65,965	8,805
OH	5,022	160,618	15,962
OR	1,158	34,775	3,614
TX	6,476	214,597	23,585
WV	527	27,009	2,605
WI	1,992	59,747	5,557

* Source: Families USA, "Medicaid: Good Medicine for State Economies," May 2004 update, select information from Table 1 & 2. Figures are based on an enhanced FMAP rate that is set to expire in June 2004.

The Future of Medicaid

Although the constituency behind Medicaid enhances the program's robustness, there are three factors that in the future could damp down Medicaid spending pressures: (1) enrollment growth rates; (2) implementation of cost controls; and (3) revenue collections. Each could impact budget decisions for Medicaid. Enrollment in the near term is not likely to be as big a cost pressure as in recent years. Enrollment growth projections for 2005 are one-third slower than for prior

year.¹⁹ Some states have been successful at controlling Medicaid costs — especially compared to the private market. This is particularly true of prescription drug costs, where states have implemented many cost-containment actions.²⁰ If states continue to be successful in doing this and Medicaid costs grow more slowly than the private market, there will be less reason to target Medicaid for cuts. Finally, there are signs that state revenue collection are recovering,²¹ although the full impact of the revenue recovery is slow and may not be fully felt by all states.

Still, predicting the future of Medicaid enrollment and services is difficult. Given the flexibility of the Medicaid program, the degree to which states will cut the program will likely depend on the following factors — the speed a state recovers from revenue losses, how much a state used one-time revenue enhancements during the past two years, how strongly budget makers view Medicaid as a revenue generating/economic development program, the diversity and strength of the constituency of institutions and individuals opposing cuts to other programs, how much other state-funded programs have already been cut, and other possible mitigating factors such as federal fiscal relief.

All of this suggests a need for close and continuing attention to Medicaid spending. Medicaid is one of the largest programs in state budgets, with total spending amounting to \$260 billion in FY 2003, roughly one dollar in every six spent on health care nationally. The program enrolls over 45 million people, ranging from low-income women and children to the elderly and disabled, and covers an enormous range of health care and other services. Medicaid covers one-third of all the births in the country and provides health insurance for one in every five children. It accounts for almost one-half of total spending on long-term care and significant portions of state spending on programs for the mentally ill, mentally retarded and developmentally disabled. Medicaid is a big deal in state budgets and health care systems. It is the most volatile program in state budgets, and Medicaid spending has proven extremely difficult to forecast even in the short run. Changes in prices, enrollment, and utilization of health care are especially hard to predict.

In spite of its size, importance and volatility, there is little on-going systematic analysis of state Medicaid spending and its consequences. Compared to other social programs, reporting systems for Medicaid are relatively underdeveloped and data are released only after lengthy lags. More systematic attention to Medicaid spending is needed on a continuing basis. A new Rockefeller Institute information initiative, now being established, will provide regular reports on Medicaid finances and enrollment.

19 Vernon Smith, Rekha Ramesh, Kathleen Gifford and Eileen Ellis, “States Respond to Fiscal Pressure: A 50 State Update of State Medicaid Spending Growth and Cost-Containment,” Kaiser Commission on Medicaid and the Uninsured, January 2004.

20 Ibid.

21 Nicholas Jenny, “The State Personal Income Tax Recovers,” *State Fiscal News* Vol. 4, No. 4. Albany, NY: Rockefeller Institute of Government, May 2004.

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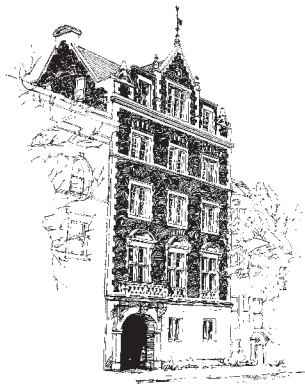
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