kaiser commission on medicaid and the uninsured

# State Responses to Budget Crisis in 2004: An Overview of Ten States

## Overview and Case Studies

*Prepared by*
*John Holahan, Randall R. Bovbjerg, Terri Coughlin, Ian Hill, Barbara A. Ormond and Stephen Zuckerman*
*The Urban Institute*

**January 2004**

THE HENRY J. KAISER FAMILY FOUNDATION

# kaiser commission medicaid and the uninsured

**The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.**


James R. Tallon
*Chairman*

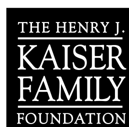
Diane Rowland, Sc.D.
*Executive Director*

kaiser
commission on
medicaid
and the uninsured

# State Responses to Budget Crisis in 2004: An Overview of Ten States

## Overview and Case Studies


*Prepared by*
*John Holahan, Randall R. Bovbjerg, Terri Coughlin, Ian Hill, Barbara A. Ormond and Stephen Zuckerman*
*The Urban Institute*


**January 2004**

**ABSTRACT**

In this report we examine how ten states from around the nation have responded to their budget crises in fiscal year 2004. While states vary in the depth of the budget pressures they faced, as state revenues remained depressed, all were required to make difficult choices among spending reductions, tax increases, or other revenue measures. In general, we found states with few exceptions relied on targeted revenue measures, such as cigarette and alcohol taxes, but were unwilling to engage in significant increases in personal or corporate income taxes or sales taxes. States did continue the pattern of recent years of drawing on reserves or rainy day funds, transferring monies from dedicated trust funds and shifting spending or taxes across time periods to address current shortfalls.

In contrast to fiscal year 2003, states relied much more heavily on reducing spending for many state programs in fiscal year 2004. Perhaps ost striking in the past year were policies that reduced support for higher education, aid to localities, and the size and compensation of the state workforce. States also found themselves with the need to make far more cuts in health care spending than in earlier years of the economic downturn. In addition to freezing or reducing provider reimbursement rates and cutting optional benefits in Medicaid, most of the states in this study made efforts to reduce enrollment in either Medicaid or SCHIP. The federal fiscal relief provided through the Jobs and Growth Tax Relief and Reconciliation Act helped most of the ten states reduce the extent of spending cuts or tax increases. A few states responded that decisions on spending or taxes were not affected and the new federal revenues were added to reserves as protection against future shortfalls.

**Introduction**

In 2000, the United States economy began to slow and the nation entered a recession early in 2001. The terrorist attacks of September 11, 2001 exacerbated the economic problems facing the nation. State revenues experienced a dramatic decline in the middle of 2001, and while beginning to increase again, have generally remained at depressed levels. At the same time, states were faced with strong public support for increasing spending on elementary and secondary education, rising enrollment in higher educational institutions because of the baby boom echo, and sharply growing Medicaid expenditures.

Because of all these factors, states were dealing with their most serious fiscal crises since World War II.[1] The pressures facing states were particularly acute as they enacted their fiscal 2003 budgets. Conditions were, in most states, just as severe if not worse as they prepared their fiscal 2004 budgets, in part because prior budget actions foreclosed some options for this year. In this report we examine the decisions states made to solve their budget problems in fiscal 2004. Among other things, we look at the extent to which states attempted to increase revenues through taxes or fees, cut spending, or used reserves or rainy day funds, trust fund surpluses, or tobacco settlement revenues.

This report updates one that was completed a year ago that examined state decisions from fiscal 2003 made by seven states (California, Colorado, Florida,

These case studies were written with the support of the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute's Assessing the New Federalism project.

[1] National Governors' Association/National Association of State Budget Officers,, *The Fiscal Survey of States*, Washington, D.C.: National Association of State Budget Offices, 2002).

Michigan, Mississippi, New Jersey and Washington).[2] In that report, we concluded that states solved their budget problems in fiscal 2003 largely by the use of one time budgetary mechanisms, such as drawing down rainy day funds or reserves, using trust fund surpluses, or securitizing tobacco settlement revenues, and various Medicaid special financing mechanisms. Of particular note, several states relied on upper payment limit programs and intergovernmental transfers as a way to leverage additional federal Medicaid funds. With the exception of the cigarette taxes, most states generally avoided tax increases. Beyond revenue measures, states cut a broad array of programs. Within Medicaid, states mostly avoided cutting eligibility or benefits and instead relied heavily on provider reimbursement rate freezes or reductions to achieve savings.

In fiscal 2004 we found more reliance on increases in taxes, primarily tobacco or alcohol taxes, or fees and user charges. With a few exceptions, the lack of support for increases in income or sales taxes persisted. Surprisingly, states continued use of so-called "one time" budgetary mechanisms, such as reserves or trust fund surpluses, that had seemed nearly fully exhausted after fiscal 2003 actions.

Spending cuts were much more severe in fiscal 2004 than in the previous year. While most of the ten states avoided cuts in K-12 education, higher education was slashed in many of our states, requiring state university systems to adopt significant tuition increases. States also cut both the level and compensation of the state workforce. In addition to layoffs or reductions through attrition, many states froze salaries and state employees were required to contribute more to health benefits. Many states reduced aid

[2] John Holahan et al., *The State Fiscal Crisis and Medicaid: Will Health Programs Be Major Budget Targets? Overview and Case Studies,* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2003.

to localities that could eventually affect at least lower income cities' and counties' ability to provide basic services, including education.

Particularly striking was the increased willingness of states to more aggressively cut health care programs. In addition to continuing to cut or freeze provider reimbursement, states eliminated some optional benefits, particularly for adults, and began to limit enrollment through reducing eligibility standards, imposing enrollment caps, reducing outreach, and making the enrollment process somewhat more cumbersome. Enrollment reductions took place in both progressive states that had recently enacted broad eligibility expansions as well as states with historically more narrow levels of coverage where cutbacks focused on curtailing outreach, requiring more frequent eligibility redetermination, and capping SCHIP enrollment.

This report is based on a review of policy changes in ten states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, New Jersey, New York, Texas, and Washington. These ten states are part of the focus of the Urban Institute's Assessing the New Federalism project, a large multi-state research effort that has followed state health, income support and social services policies in thirteen states since 1997. We collected information on state budgetary activity from state websites, newspapers, and public documents. We then conducted telephone interviews and site visits between October and December 2003 with key state government officials and representatives of provider and consumer organizations using an open ended structured protocol.

**Budget Pressures**

The ten states in this study varied greatly in the degree of budget pressure they faced in fiscal 2003-2004. As noted above, budget pressures were as great in FY 2003-

2004 as they had been in FY 2002-2003, if not worse. It is difficult to quantitatively compare the degree of pressure because states differ greatly in what they include in their general fund budgets. For example, many have several earmarked trust funds with dedicated revenue streams for education, transportation and other activities with the rest of state funded services financed with general fund revenues. But all of the states in this study, with the exception of Florida, unquestionably faced serious budget problems in fiscal 2004. A summary of the budget situations faced by our states, organized by region, is as follows.

*New York* experienced a $6.8 billion general fund budget gap (about 17 percent of the total general fund spending) in FY2002-03. The budget gap in FY2003-04 amounted to $11.5 billion or 25 percent of the general fund. New York's budget shortfalls were caused primarily by the national recession and the fiscal consequences of the September 11 attacks on the World Trade Center. The FY2003-04 gap was closed largely through borrowing onetime revenue measures, increases in cigarette and alcohol taxes, and of particular note, a temporary increase in income and sales taxes. Despite large service cuts proposed by the governor, only fairly modest cutbacks were enacted.

*New Jersey* faced an FY2004 shortfall of about $4.9 billion--about 18% of state appropriations. Spending was growing faster than expected because of higher Medicaid costs and employee benefits and the need to increase retiree pension contributions for the first time in several years. Revenues were down because of the economy. This pressure for FY2004 came on top of having had to fix a $5.3 billion shortfall for the FY2003 budget and implement a $2.8 billion mid-FY2002 supplemental appropriations, mainly because of unexpectedly low revenues. A big piece of FY2003 deficit reduction was a major increase in corporate income taxes. The FY2004 budget gap was solved through a range of spending cuts, tobacco securitization and fund transfers and some increase in taxes and fees, but not major taxes.

*Massachusetts* faced a projected budget deficit of $3 billion for FY2004 as of January 2003. This shortfall followed a $2 billion deficit that was filled in enacting the FY2003 budget and additional mid-year shortfalls met with supplemental appropriations of $650 million during FY2003. The main budget problem has been revenue shortfalls from the recession and to a lesser extent from a phase-out of a prior surcharge on income taxes implemented just as the recession hit. Spending pressures come heavily from health care and aid to localities, both projected to rise rapidly before cuts were made. The FY2004 budget gap was filled primarily with spending cuts or reductions in

projected growth. However, the state also closed some corporate tax loopholes and increased fees, and shifted revenues among funds.

*Michigan* had a budget gap of $1.6 billion in FY2004. The FY2004 budget gap followed shortfalls of $1 billion in FY2002, another $800 million that developed during the course of FY2002, and $1 billion in FY2003. The state has been seriously impacted by the effect of the recession on employment and state tax revenues. In October 2003, Michigan had the highest unemployment rate in the country. More than half of the budget gap in FY2004 was resolved through spending reductions with most of the rest through revenue increases.

*Alabama* faced a $123 million shortfall in FY2003 that it solved with a number of one time measures, including the use of rainy day funds and trust fund transfers. In FY2004 it faced a $675 million shortfall, amounting to 16.5 percent in the general fund and 11.4 percent in the education trust fund. Following the failure of a major tax reform initiative, the general fund budget gap was closed with a 5.3 percent reduction in spending that affected most state agencies.

*Texas* faced the largest revenue drop in state history -- $7.4 billion -- and an estimated shortfall of $9.9 billion, or 15 percent of projected general revenue spending for the FY2004-2005 biennium. Beyond this dramatic revenue drop, the deficit in Texas was attributed to increased state spending on Medicaid and SCHIP. The strong anti tax sentiment in the state meant that the solution to the budget crisis lay almost wholly in spending reductions.

*Florida*'s budget was in fairly good shape, particularly in comparison with other states. The state has aggressively reduced taxes each year since 1999, and despite a relatively strong economy, faced an FY2004 shortfall of about $1.0 billion (about 2 percent of the state budget). Some cuts in spending were used to address the gap but the primary response was the use of one time revenues and a bond issue to fund voter-directed capital expenditures for school construction.

*Colorado* faced an FY2003-2004 shortfall of nearly $900 million or about 7.0 percent of the state's $13.4 billion budget. This followed a FY 2002-2003 shortfall of $850 million. Colorado's deficits occurred because the state was especially hard hit with the recession because of the importance of high technology in its industrial base, and a decline in tourism following September 11. Because of the strong anti-tax sentiment in the state, budget shortfalls were made up largely through spending reductions.

*Washington* faced an FY2003-2005 biennium budget gap of $2.7 billion out a budget of $23.1 billion. The budget gap occurred because of slower than expected revenue growth related to the recession, increases in health care costs because of rising caseloads, higher education enrollment, rising prison populations, and ballot initiatives requiring the state to increase spending on K-12 education. The budget gap was closed almost entirely with spending cuts.

*California* faced a $38 billion budget shortfall in FY2003-2004, primarily because of reduction in income tax revenues (especially capital gains) that resulted from the economic downturn was never offset by spending reductions or other revenues. The $38 billion consisted of a $14 billion carryover from FY2002-2003, as well as $24 billion for FY2003-2004. The budget agreement reached prior to the recall of Governor Gray Davis was balanced mostly by borrowing and accounting devices, with about one-third of the gap billed by spending cuts or tax increases. Governor Arnold Schwarzenegger and the legislature have agreed to try to get voter approval for these bonds to finance past deficits but the governor is still proposing deep spending reductions.

**Revenue Increases**

There are three broad strategies available to states for closing budget gaps. The first is to increase revenues, the second is borrowing, and the third is spending cuts. Among study states, the first option appeared to be the least favorite, though the three northeastern states (Massachusetts, New Jersey and New York) and Michigan all relied on revenue strategies to close their FY2004 budget gaps.

New York in FY2003-2004 enacted a temporary three-year increase in the personal income tax as well as a .25 cent increase in the state's sales tax. The state also enacted several fee increases and closed some corporate tax loopholes. New Jersey enacted a large increase in corporate income taxes in FY2003. While in FY2004 it did not seek new revenue from any of the major tax sources (sales taxes, corporate income taxes, or personal income taxes), New Jersey did increase cigarette taxes and fees on hotels, motels and casinos. Massachusetts enacted a $1.2 billion increase in taxes and fees in FY2003 and raised $100 million through closing corporate loopholes and another $400 million through increases in fees in FY2004. Similarly, following a five-year phase

in of reductions in income and business taxes, Michigan increased its sales tax and closed various tax loopholes in FY2004.

Other than these four states, there was very little effort to increase taxes. Washington increased liquor taxes but no other tax increases were seriously considered. There were no new taxes in Colorado. The same was true in Florida, though there were some fee increases. Tax increases were proposed in Texas and Alabama but soundly defeated. California actually eliminated an increase in vehicle license fees, thus reducing revenues, after the election of Governor Arnold Schwarzenegger.

All states indicated that they benefited from the increased federal payments provided through the Jobs and Growth Tax Relief Reconciliation Act of 2003 which allocated $20 billion in federal funds to states between April 2003 and September 2004. How states used these funds varied. States such as Alabama, California, Colorado and Texas that addressed their budget pressures primarily by cutting spending responded that the federal revenues reduced the breadth and depth of the spending reduction measures that were taken. States like Michigan, New York, and New Jersey that included tax increases as part of their budget strategy stated that the federal revenues affected the scope of both spending reductions and tax increases; each of these states used federal revenues to add to reserves as well. Two states (Washington and Massachusetts) responded that the deep spending reductions that they made were not affected by the availability of federal revenues; nor was either state willing to increase taxes. Thus, the federal revenues added to state reserves to protect against revenue shortfalls in the future. Florida used the new federal revenues in part for a onetime investment in an economic

development project and added the rest to reserves to be used for anticipated budget difficulties in the 2004-2005 biennium.

**Other Revenue Measures**

As in FY2003, states continued to rely on onetime strategies to raise revenues, including using reserves and tobacco settlement funds, and borrowing from trust funds and from the public. Massachusetts, New York, California and New Jersey all shifted funds from trust funds to the general fund to relieve budget shortfalls. New York, for example, borrowed from its Environmental Protection Fund and TANF reserves whereas New Jersey borrowed from several funds, including transferring monies from the Unemployment Insurance Fund to the Hospital Charity Pool.

California is attempting to solve its budget problems with a substantial amount of borrowing. The Davis administration proposed a $10.7 billion bond issue at the end of FY2003 to resolve that year's budget problem. However, because of legal challenges, the bond issue requires voter approval which has not yet occurred. More recently, Governor Schwarzenegger has proposed a $15 billion bond initiative coupled with a constitutional amendment to limit spending as a way to solve California's budget woes.

New York, Colorado, New Jersey, and California are using funds obtained by securitizing tobacco settlement monies. Under these tobacco securitization arrangements, states issue bonds to raise revenues and use the flow of money from the tobacco settlement to pay principal and interest on the bonds. These arrangements provide states with an immediate influx of revenues but significantly reduce the amount of future

money they otherwise would have received from the tobacco settlement. For example, Colorado securitized 47 percent of its tobacco settlement funds by selling $530 million of the state's $1.2 billion total settlement award, and generated $313 million to help fill the state's FY2004 deficit.

States relied less on reserves in FY2004, primarily because these funds had already been used in previous years.[3] For example, Massachusetts, New York, Alabama and Michigan all used reserves or rainy day funds in FY2003, but they were not used much in FY2004. The one notable exception was Texas which used $1.3 billion from its rainy day fund to close its budget gap in FY2004-2005.

Two states took steps to sell state real estate to obtain immediate cash. Colorado enacted legislation allowing for the sale of $160 million of state buildings that it would then be leased back by the state (this authority has not yet been implemented). In FY2004, Massachusetts transferred title to state real estate in lieu of cash contributions to the state pension fund. Other creative measures included shifting spending or taxes across time periods. Texas, for example, deferred $1.3 billion in payments to local school districts until September 2005 (the first month of the next fiscal year), thus easing its FY2004-05 budget problem. Colorado delayed state employee pay checks for June of 2003 until July, thus moving $89.4 million in obligations to FY2004.

Three states--California, Colorado, and Texas--moved from accrual to cost based accounting for some Medicaid services. Rather than accounting for payments to

---

[3] According to the leading survey, the average state year-end balance was 10.4 percent of state expenditures for fiscal 2000, 3.1 percent for fiscal 2003. National Governors Association and National Association of State Budget Officers, The Fiscal Survey of States (December 2003). http://www.nasbo.org/Publications/fiscsurv/fsfall2003.pdf.

providers when liabilities are incurred, they began to account for them when they are paid, often in the next fiscal year. This results in shifting costs to the next fiscal year allowing the state to show savings in the current year, but increasing future obligations.

States also have increasingly relied on quality assessment fees as a revenue measure. These fees are essentially a tax on providers and are typically linked to a provider reimbursement rate increase. Generally, the state is able to increase provider rates, or avoid a reduction, without using state general funds. Among our study states, the design of the quality assessment fee is such that providers that serve large numbers of Medicaid patients end up being better off, i.e., the increased reimbursement rate more than offsets the fee. Providers that have smaller shares of Medicaid tend to be net losers with fees exceeding the revenues obtained from increased reimbursement rates. Quality assessment fees are used primarily for nursing homes; because it is largely a Medicaid industry, thus there are more winners than losers. For example, Massachusetts, Washington, and New Jersey have applied assessments to nursing home beds. Michigan is using quality assessment fees more aggressively, applying them to hospitals, nursing homes and HMOs. An attempt to apply them to pharmacies was strongly opposed and not implemented.

## Spending Reductions

### K-12 Education

Education is a major part of state budgets with K-12 schooling being the largest single item financed by states and higher education either second or third. K-12

education has been a high (if not highest) priority for states and not surprisingly most generally protected K-12 education in their FY2004 budgets. For example, a ballot initiative passed in Florida required the state to reduce class sizes with the result that capital expenditures for education (financed partly through a bond issue) needed to double. The state also increased operating expenditures for K-12 education in FY2004. Likewise, Colorado, through a constitutional amendment, is required to increase spending on K-12 education by inflation plus enrollment growth plus 1.0 percent. Michigan, despite its budget deficits, maintained state payments at $6,700 per pupil and increased payments for early childhood education in FY2004.

Not all states, however, protected K-12 funding with Washington being a notable exception. In FY2003-2005, the state chose not to fund increases in teacher pay and reductions in class size required by ballot initiatives. The ballot initiatives did not provide a revenue source and the state chose to delay implementation. The Texas Education Agency laid off 125 of its 860 full time positions, and school transfers, counselors and libraries had state contributions to their health insurance reduced from $1,000 to $500 per year. New Jersey, and to a lesser extent New York, also made cuts in K-12 education.

**Higher Education**

More prominently, many states reduced payments for higher education. California reduced higher education spending by 9.0 percent, leading to tuition increases of 30 percent or more. In Florida, the higher education budget was reduced by $11 million and $40 million for community colleges and universities respectively, with the

state allowing community colleges to increase tuition by 7.5 percent and universities by 8.5 percent. Colorado cut its higher education budget by $100 million or 30.0 percent, allowing tuition increases of 10.0 percent. Michigan made a 6.5 percent cut in higher education. Washington cut higher education budgets by $131 million, allowing undergraduate tuition increases of 7.0 percent for each year of the biennium. New Jersey cut higher education by $113.5 million, and Texas cut higher education research funds.

**Aid to Localities**

Several states made substantial cuts in aid to localities. Michigan and Massachusetts cut aid to localities in FY2004 by 3 percent, and 5 percent, respectively. California, by eliminating the vehicle license fee increase, which funded aid to cities and counties, in effect reduced state aid to localities. New Jersey reduced its payments from a program established to promote local property tax relief. New York was a prominent exception to the general trend in cutting aid to localities: Governor Pataki proposed substantial cuts to local aid but these were largely rejected by the legislature because of concerns over effects on local property taxes.

**State Workforce**

Virtually all of the states made reductions in spending on the state workforce. Most prominently, several states (for example, California and Washington) adopted actions to reduce the number of employees. States also froze salaries and increased employee contributions to health premiums. For example, Florida reduced the state workforce by 3.2 percent in FY2002-03 and by 1.0 percent in FY2003-04. Colorado cut 1,000 jobs in FY2003 whereas New Jersey and Alabama froze state employee

compensation in FY2004. Washington froze state employee salaries, required increased payments for health benefits and reduced the state workforce by 1,100. California cut state workforce expenditures primarily through layoffs and reduced compensation. Massachusetts increased the employee's share of health insurance premiums. Michigan reduced salaries and increased health insurance premiums. Moreover, the state threatened layoffs if the compensation changes were not accepted by the state employees' unions.

**Health Care**

In response to budget pressures faced in FY2003, states attempted to reduce Medicaid spending primarily through cuts or freezes in provider payment rates. In the past year, states had responded to rising health care expenditures much more aggressively than they had in the past. The FY2004 Medicaid budget actions adopted by the study states will likely affect Medicaid and SCHIP enrollment in many states as well as the scope of benefits. Further, for the second consecutive year, virtually all of the study states reduced or froze at least some provider payment rates.

*Enrollment.* Massachusetts, one of the leaders among states in its reliance on Medicaid to expand coverage, made major reductions in eligibility. It eliminated its program for long-term unemployed adults, replacing it with the new MassHealth Essential program that covers many of the same individuals but with capped enrollment and fewer benefits. The state also capped enrollment for its Family Assistance programs for near-poor children and working adults in small firms, its Common Health program for disabled individuals and its state funded Children's Medical Security program. Caps

have seemingly been set at levels that do not yet disenroll people or create waiting lists, but may be important in the future. Further, Massachusetts tightened eligibility determination and reduced outreach efforts.

Washington cut its state funded Basic Health Plan enrollment from 125,000 to 100,000. Further, it increased premiums and introduced a $150 deductible per person and 20 percent co-insurance up to $1,500 for the Plan. Washington also ended telephone applications, self declaration of incomes, and increased its frequency of eligibility redetermination for Medicaid. The state also terminated its medically indigent program, which helped hospitals pay for uncompensated care.

Texas reduced eligibility for pregnant women from 185 percent of poverty to 150 percent and eliminated its adult medically needy program. It further postponed implementation of an expansion of continuous eligibility in Medicaid from 6 to 12 months. In its SCHIP program, Texas effectively cut eligibility thresholds from 240 percent to 200 percent by switching to a net income rather than a gross income test. The state also reduced the length of continuous eligibility in SCHIP from 12 to 6 months, added an asset test for children in households with incomes above 150 percent of the federal poverty line, added a 90 day waiting period before coverage of newly enrolled children became effective, and increased premiums and co-payments.

Colorado attempted to cut legal immigrants (3,500) from the state Medicaid program (delayed at least temporarily by a court order) and capped enrollment in its SCHIP program in FY2004, limiting enrollment to about 53,000 children. It also ended

SCHIP coverage of pregnant women, allowing no new enrollees. Further, it terminated outreach efforts for the SCHIP program.

Enrollment actions in California included moving to more timely eligibility redetermination in Medicaid so that people no longer eligible did not linger on the program rolls. Governor Davis had proposed a rollback of the state's expansion to cover parents up to 100 percent of poverty, but this proposal was not passed by the state legislature. Governor Schwarzenegger is now proposing enrollment caps in the state's SCHIP program.

Florida capped enrollment in its SCHIP program with spending limited to the appropriation. Outreach was eliminated and a waiting list was established and reached 44,000 by November 2003. In FY2003 New Jersey made cuts in its broad expansions to low-income parents and childless adults by reducing its Family Care program by 60,000 enrollment through attrition. The state continued to reduce adult enrollment through attrition in FY2004 but no further enrollment cuts were enacted. Alabama made no Medicaid enrollment changes but it did reduce outreach for its SCHIP program. New York and Michigan were the only two states that made no reductions in enrollment.

*Reimbursement Rates.* Although the eligibility reductions were new in FY2004, following FY2003 budget actions, states continued to freeze or cut provider reimbursement rates. California cut rates for physicians, pharmacies, and managed care plans, but not hospitals or federally qualified health centers. The new governor, Arnold Schwarzenegger, is proposing additional cuts of 10 percent across a range of provider rates and eliminating a recent supplement in nursing home rates that allows workers to

receive higher wages. Massachusetts cut pre-existing rates for hospitals, nursing homes, physicians, community health centers, dentists, and managed care plans by 3.0 to 5.0 percent. In Alabama cuts of 2 to 3 percent in payment rates for physicians, hospitals and dentists are to be implemented this fiscal year and next. Texas reduced hospital and physician payment rates by 2.5 percent and nursing home rates by 1.7 percent. New Jersey froze physician fees but increased hospital and managed care rates. Florida cut nursing home rates, but postponed an increase in staffing requirements. Washington cut rates for hospitals and managed care plans.

*Benefits.* Benefit cuts were also widespread. Florida introduced 2.5 percent co-insurance on some prescription drugs and introduced co-payments for non emergency room use of emergency rooms. Michigan eliminated dental care, podiatry, and chiropractic services and expanded its estate recovery efforts from families of deceased nursing home patients.

Texas' Medicaid program eliminated several optional services (adult mental health counseling, podiatry, chiropractic, eyeglasses and hearing aids), introduced cost sharing to the maximum permitted by federal law and introduced additional limits on prescription drugs. The Texas SCHIP program also saw the elimination of numerous benefits, including dental, vision, hearing, chiropractor, home health, and hospital services, as well as the addition of several new layers of cost sharing.

Massachusetts maintained cuts in optional services (e.g., adult dental care, prosthetics, eyeglasses and drug co-payments) enacted in FY2003 and this year increased its generic substitution requirements and imposed prior authorization for 7 or more

prescriptions per month. Washington cut dental care and sought a HIFA waiver to introduce premiums for non-poor children. New Jersey cut payments to pharmacists and mandated generic substitution. Alabama was planning (again either this fiscal year or next) to implement cuts in optional services including hospice services, eye care and eye glasses for adults, limiting prescription drugs and physician visits, and limiting non emergency use of emergency rooms.

While the bulk of states enacted some benefit cuts, some rejected the call for such reductions. Washington and California both had considered elimination of dental care but agreed on a more carefully crafted reduction in the scope of dental benefits. Elimination of dental and chiropractic services for adults was proposed in New Jersey but was rejected. Michigan ended its cap on enrollment in its home and community based waiver program and expanded its drug program for seniors.

*Special Financing Arrangements*. States continued to rely on funding obtained through hospital disproportionate share payments (DSH) and upper payment limit (UPL) programs to finance Medicaid. Until the recent passage of the Medicare prescription drug bill, many states faced substantial cutbacks in federal DSH payments in fiscal 2004. With the passage of the bill, DSH cutbacks were restored for the current year and beyond. By contrast, federal legislation phasing out state use of UPL payments still holds, with cutbacks for many states beginning this fiscal year.

Recently, states have introduced a new version of special financing arrangements through the provider quality assessment fees discussed above. These fees have essentially the same effect as DSH and UPL programs. The key difference between most

DSH and UPL programs and quality assessment fees, is that rather than being financed by intergovernmental transfers, the fees are a true tax on providers. Among our study states, another difference is that under fee programs, providers -- rather than the state -- reap most of the financial gains.

**Conclusion**

In this report we have focused on decisions made by state executive and legislative branches in FY2004 as they faced the third consecutive year of severe budget pressures. In our previous report, we examined state budget decisions made in FY2003. One of our conclusions in last year's report was that choices would become more difficult in FY2004: The states had used up much of their reserves and rainy day fund surpluses in FY2003. Moreover, they were becoming increasingly limited in their ability to transfer funds from dedicated or earmarked funds to the general fund. Further, the anti-tax sentiment remained strong in most states, K-12 education was a high priority with most voters, and higher education spending was increasing because of rising enrollment.

Beyond these pressures, states in 2003 found that the Medicaid and SCHIP programs were difficult to cut because providing health and long term care coverage for low income children, disabled and elderly was politically popular. Further, reducing state general fund expenditures on Medicaid means losing federal matching funds. That is, a cut of a dollar in Medicaid does not translate into a dollar less in state spending. Indeed, depending upon a states match rate, it can be far less. Provider groups are also powerful politically, restricting (but not eliminating) the ability to cut payments. Finally, with the

exception of drugs, cutting optional benefits does not generate much in savings, and these services are often of great importance to certain beneficiaries and providers.

Given all of these constraints, we found that in FY2004 states did in fact make less use of reserves and rainy day funds (simply because they were less available), and the use of trust fund transfers also seemed less frequent. We find that several states continued to tap tobacco settlement funds through securitization arrangements. Some states also used fairly unorthodox measures of dealing with budget deficits, including postponing the payment of bills until the next fiscal year and the sale of state real estate to obtain cash. In the coming months, California will be appealing to the voters to get approval of deficit financing through a major bond issue as a way to close its ever-growing budget shortfall.

Beyond these measures, states relied heavily on increasing fees and, in some cases, taxes to increase revenues. Importantly, while there was a general reluctance to raise personal or corporate income taxes or sales taxes, particularly in the southern and western states, our three northeastern states and Michigan did enact tax increases in FY2004.

On the spending side, elementary and secondary education were generally protected although a few states cut spending for capital and/or operating expenditures. A major budget target was higher education, with significant cuts in budgets for colleges and universities enacted in most states. Institutions were expected to make up for some of the lost revenues through increases in tuition. Another budget cutting measure was to cut state workforce expenditures through a combination of layoffs, salary freezes and

increased employee contributions for health benefits. Many states also reduced aid to localities.

In FY2004, states also made cutbacks to Medicaid and SCHIP, sometimes substantial ones. Unlike in the previous year, state cuts in health care extended beyond lowering provider reimbursement. Among our study states, we saw more willingness to eliminate or cut optional benefits, particularly for adults. But more importantly, several states attempted to reduce the growth, if not the actual level, of enrollment.

The consequences of the FY2004 budget decisions are likely to be felt in states for many years. Even if revenues improve in the near future, states will need to replenish reserves and rainy day funds. And, some will need to replenish the trust funds that have helped bail out the general fund in the past few years. State tobacco settlement revenues that have been used in the current budget crisis will not be available in the future. The cuts in higher education are likely to affect both the number and the demographic characteristics of young adults who can seek higher education. Owing to widespread efforts to reduce spending on the state workforce, the quality of the state workforce may deteriorate, eventually requiring states to increase compensation if services are to be maintained. State cuts in aid to localities may affect basic services, particularly in lower income communities, if local areas are unable to make up the loss in state funds. Rising revenues with an economic turnaround will help, but the continued strong anti-tax sentiment likely means that states' ability to raise additional funds to address these problems will be limited.

The cuts in Medicaid and SCHIP could also have long term effects. The wide ranging cuts in provider reimbursement rates will likely affect beneficiaries' access to care. Rate cutbacks also raise questions about the financial viability of many institutions, especially safety net hospitals. Owing to the eligibility and outreach changes, states will likely see a rise in the uninsured. When the fiscal environment improves, there may be calls to expand eligibility, but states may be reluctant to restore Medicaid cutbacks. In 2004, state legislatures made very difficult decisions to reduce coverage and benefits because of budget shortfalls. Whether they will be willing to risk again the significant financial commitments -- especially over the long-term -- that come with eligibility expansions is unclear. Medicaid and SCHIP, both through law and waiver policy, now offer states a broad set of options for expanding coverage and having the federal government share in much of the costs. Given recent budget pressures, states may be unwilling to take advantage of these options for many years to come.

## ALABAMA

**Barbara A. Ormond**

### Background

Alabama is one of the poorest states in the nation, ranking 44th in median family income in 2000-2001.[1] Nonetheless, it has a smaller share of its under-65 population uninsured than the national average (10.0 percent versus 12.1 percent for children and 17.1 percent versus 19.1 for adults under age 65). Rates of employer-sponsored insurance are above the national average and rates of coverage by Medicaid are near national averages for both adults and children.[2]

Alabama's budget is characterized by a high degree of earmarking. About 87 percent of revenue is earmarked with specific taxes linked to specific purposes with limited ability to move funds between dedicated accounts.[3] The two largest budget funds are the General Fund and the Education Trust Fund (ETF), which are estimated at $1.2 billion and $4.2 billion, respectively, for FY 2003. Medicaid is partly funded out of the General Fund and, at 18.3 percent of appropriations, it is the largest single category of General Fund expenditures. When all state funds are considered together, Medicaid represents 11 percent of overall state appropriations; the largest single category for all state funds is education at 56 percent.

The Medicaid program enjoys a very favorable federal match, nearly 71 percent, and Alabama has been successful in structuring its program to take advantage of this

---

[1] Kaiser Family Foundation State Facts Online, http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Demographics+and+the+Economy&subcategory=People+in+Poverty&topic=Distribution+by+FPL.

[2] Urban Institute calculations using data from the Current Population Surveys, 2002 and 2003 Annual Social and Economic Supplements.

[3] State of Alabama, Legislative Fiscal Officer, Presentation to the Permanent Joint Legislative Committee on Finances and Budgets, February 11, 2003, http://www.lfo.state.al.us/pdfs/BudgetHearingPres2_03.pdf.

incentive. Mentioned above, the state share of the program is funded only partly from the state General Fund. A substantial proportion, about three quarters in FY 2002, of the state share comes from "other state funds," a category that includes intergovernmental transfers, provider taxes, tobacco settlement revenues, and drug rebates. So, while Alabama's budget problems are severe, the state's financing of Medicaid is threatened more by changes in non-General Fund revenue sources, particularly federal funding for the Medicaid disproportionate share hospital (DSH) and upper payment limit (UPL) programs.

Historically, one of the largest sources of revenue, about 11 percent, for the General Fund has been interest on state fund balances. Interest rates are at the lowest level in forty years; as a result, total income from this source to the General Fund was down by more than forty percent between FY 2001 and FY 2002.[4] Estate taxes are also paid into the general fund, constituting about 7 percent of revenues. The state estate tax is linked to the federal estate tax and the changes in the federal tax have reduced these receipts by one quarter each year since FY 2002. Total appropriations for the General Fund increased by less than one half percent between FY 2001 and FY 2004.[5] The General Fund has no formal reserve provision but some $13 million has been put aside in the past several years in an informal rainy day fund.

In fiscal years 1998 to 2000, Alabama saw exceptional growth in receipts in its General Fund.[6] The Alabama Medicaid Agency took advantage of the growth to improve

---

[4] State of Alabama, Legislative Fiscal Officer, Presentation to the Permanent Joint Legislative Committee on Finances and Budgets, February 11, 2003, www.lfo.state.al.us/pdfs/BudgetHearingPres2_03.pdf, accessed October 3, 2003.
[5] Urban Institute calculations using data on General Fund appropriations at the State of Alabama, Executive Budget Office website, http://www.budget.state.al.us/stgovfin.html.
[6] State of Alabama, Legislative Fiscal Officer, Presentation to the Permanent Joint Legislative Committee on Finances and Budgets, February 11, 2003, http://www.lfo.state.al.us/pdfs/BudgetHearingPres2_03.pdf.

access to care under Medicaid, most notably by raising reimbursement rates for physicians and dentists in order to improve provider participation, rather than expanding eligibility or benefits. In addition, it streamlined its Medicaid enrollment procedures to improve the take-up rate and enrollee retention. The number of Medicaid enrollees rose from 496 thousand in 1997 to 704 thousand in 2002.[7] Growth in enrollment is expected to drop back to the historical rate of under four percent this year after three years of growth of over seven percent a year. Also during the late 1990s, the Department of Public Health instituted an aggressive and effective outreach program for its SCHIP program, ALLKids.

**Alabama's Budget Problem**

Lean years followed this period of relative prosperity and, in FY 2003, Alabama again found itself in a tight budgetary position. The projected General Fund budget shortfall going into the fiscal year was $123 million. The state used several one-time revenue strategies to fill this gap, including shifting funds from a tax escrow account that had been built up over several years,[8] and using settlement funds from litigation over off-shore drilling royalties and monies from an abandoned property reserve account. The informal rainy day fund in the General Fund was also tapped to fill the FY 2003 budget gap.

When the new governor, Bob Riley, took office in January 2003, he found a budget gap of $675 million projected for FY 2004 for the combined General Fund and

---

[7] Alabama Medicaid Agency, FY 2002 Annual Report and FY1997 Annual Report, http://www.medicaid.state.al.us/ABOUT/MediciadAR2002.pdf, and http://www.medicaid.state.al.us/ABOUT/97anrep/97anrep.htm.

[8] Specifically, the tax escrow account is an administrative fund that was established to provide for potential refund requests associated with previous franchise and shares taxes.

ETF budgets, $198 million of which was attributable to the General Fund. The gap represented about 16.5 percent of the General Fund; in the ETF, the gap was about 11.4 percent. In his State of the State address in March 2003, Riley announced an ambitious plan to reduce unnecessary government expenditures and to reform state tax policy to address Alabama's budget problems.

In Alabama, certain changes in the tax system require a constitutional amendment passed by voter referendum. Riley put forward a comprehensive tax proposal designed not only to meet the projected budget shortfall but also to provide sufficient revenues to invest in a "world-class education" system for the state.[9] The tax reform plan proposed both raising some tax rates and redistributing the burden of taxes across groups. Although the plan would have added an estimated $1-1.2 billion in annual revenues, many Alabama residents, particularly the poor, would have seen reduced taxes. Property taxes would have been raised substantially but would still have remained the lowest in the country. Income taxes would have been reduced for the poorest state residents and raised for the highest income group. A variety of other tax increases were proposed including taxes on cigarettes, sales, businesses, and utilities.[10]

The tax reform referendum was put to the voters in September 2003 and failed by a large margin. Those who would have been hurt by the proposed increases, notably large landowners and timber companies who would have paid substantially more in property taxes, campaigned hard against the plan, invoking Alabamians' distrust of

[9] Governor Bob Riley, State of the State Address, March 04, 2003, http://www.governorpress.state.al.us/pr/sp-2003-03-04state-of-state-2k3.asp.
[10] Paul Prososki, The Alabama Tax and Budget Situation: History, Effects, and Alternatives (draft), Americans for Tax Reform, http://www.atr.org/alabamareport_files/frame.htm.

government by asserting that there was no guarantee that legislators would use the money as they had promised.[11]

A budget for FY 2004 reflecting the level of revenues projected without the reform had been proposed in March and, following the defeat of the referendum, passed the legislature in late September with little controversy. The FY 2004 General Fund budget represented a reduction of about 5.3 percent from the 2003 level. Most programs funded from the General Fund saw cuts of about 18 percent with some losing half or more of their funding.

Expenditures for government operations were cut by 26.3 percent in the legislative branch and 9.9 percent in the judicial branch. Expenditures for the executive branch, which, in addition to operational expenses, includes the Medicaid program as well as numerous small line items for local programs, were cut by 3.7 percent. Most of the small local programs had their funding cut completely. Merit raises have been eliminated in recent years for all state employees, and, in FY 2004, cost-of-living increases were skipped. By contrast, state employee benefits were protected. While many spending cuts were enacted, there were some increased allocations. Notably, the allocation for debt service was doubled, and the budget for the Board of Pardons and Paroles was increased by 74 percent in order to facilitate the planned reduction in the prison population.

Expenditures from the ETF were cut by about 2 percent. Higher education and K-12 education were cut by similar percentages. Teachers' jobs were maintained but health insurance copayment requirements were increased. Cuts were made in appropriations for

[11] Kim Chandler, "The Choice is Yours," Birmingham News, September 9, 2003, http://www.al.com/news/birminghamnews/index.ssf?/base/news/106309905165000.xml.

books, computers, training, and tutoring programs, and allocations to private schools were cut in half.

**Cuts in Medicaid and SCHIP**

In FY 2003, Medicaid faced a projected shortfall of $30-40 million in state funds. Officials were able to make it through the year without cuts in eligibility or services, however, by taking advantage of one-time funding sources. The temporary enhancement of the federal matching rate provided for under the Tax Relief and Reconciliation Act of 2003, in effect for the last two quarters of FY 2003 and the first three quarters of FY 2004, filled most of this gap.

The Medicaid FY 2004 General Fund appropriation was approved at $220 million, a decrease of about 0.8 percent with respect to the FY 2003 General Fund appropriation of $222 million. However, after accounting for earmarked Medicaid funds that are "off" the General Fund, the FY 2004 budget reflected an increase of 8.8 percent in total (federal and state) program expenditures over the previous year. As mentioned earlier, the bulk of Alabama's Medicaid expenditures are paid for out of earmarked funds, not the General Fund. Indeed, the General Fund appropriations for Medicaid have been decreasing since FY 2000 when the appropriation was $245 million but total Medicaid expenditures have risen over that same period from $2.9 billion in 2000 to $3.7 billion projected for 2004.

The declining share of General Funds in the Medicaid program is evidence of the state's growing reliance on both one-time revenue sources (such using tobacco settlement funds) and federal funds drawn in through significant DSH and UPL payments. By depending so heavily on one-time revenue sources and DSH and UPL--which have come

under considerable federal scrutiny in recent years—has put Alabama's financing of its Medicaid program in a precarious position. For example, federal DSH funding was expected to decline in 2003 and beyond (but was restored as part of Medicare Prescription Drug bill) and UPL payments are largely being phased out.

The state is keenly aware that its financing of Medicaid is not on solid financial ground, and sought to partly address the issue in this year's budget request. Specifically, in putting together the FY 2004 Medicaid General Fund budget request, the state moved some program expenditures that had been paid for with earmarked funds (where some of the revenue sources are being phased out) to the General Fund. By making this shift, General Fund costs were estimated at $330 million, the amount that was put into the budget request.[12] However, the state only appropriated $220 million in Medicaid General Funding spending, $110 million less than the requested amount. Put another way, Alabama's FY 2004 General Fund Medicaid budget is about one-third short of projected costs.

The state expects to meet about $74 million of this gap through the enhanced FMAP provided as part of the federal relief package. In addition, in FY 2003 Alabama adopted a preferred drug list that will be phased in beginning in November 2003 and is expected to save about $13 million in FY 2004. The remaining $26.5 million of the gap will have to be funded through cuts in program expenditures. The details of the cuts were left to be decided after the passage of the budget.

To date, no cuts in eligibility or benefits have been made, but officials are currently considering which of several proposed changes in benefits they will make to meet the $26.5 million shortfall. Further, whatever cutbacks are not used in FY 2004,

---

[12] The budget request sought FY2003 eligibility and benefit levels for FY 2004.

state officials expected that they will be implemented in FY 2005. Eligibility changes for Medicaid are not currently being considered but outreach for the ALLKids SCHIP program has been reduced. Alabama's Medicaid program has historically been close to federal minimums in most areas so there are few options available. Attention is being given to those optional services that can be cut without causing a compensatory increase in expenditures in other areas. Officials expect to choose from among the following benefit changes (with estimated savings) to meet the shortfall:

- Elimination of hospice services for adults in the community ($7 million);
- Decreased the annual limit on inpatient days and inpatient physician visits from 16 to 14 ($2 million);
- Elimination of routine eye care and eye glasses for adults ($5 million);
- Imposition of a monthly limit on prescription drugs of seven per month without prior approval and up to ten per month with prior approval[13] ($33 million);
- Limitation of non-emergency use of hospital emergency departments to three visits per year (savings not yet projected); and
- Reduction of the nursing home income eligibility from 300 to 100 percent of the SSI income limit, and tightening of the nursing home medical criteria by incorporating activities of daily living criteria ($85 million).

In addition, the state may have to reduce provider payments rates by two percent for physicians and dentists ($9 million) and three percent for hospitals ($9.3 million). The physician and dentist rate reductions are particularly painful for the state since they represent a rollback of the increases made three years ago that many credit with having improved provider participation in Medicaid. Nursing home rates are set statutorily and cannot be changed without action by the legislature.

[13] Long term care patients and children under EPSDT are exempted since these benefits are mandatory.

**The Future**

Mentioned above, Medicaid officials expect that the cuts not implemented this year will be implemented in FY 2005 when the cumulative effects of the end of the enhanced FMAP, the end of Alabama's five-year phase-out period for its UPL program, the exhaustion of various repositories of one-time funds combine with an aging population and the continuing rise in pharmaceutical and other costs to present a nearly insurmountable budget hurdle for the program. Eligibility and benefits are as close to federal minimums as is practical, and further cuts to provider rates risk deteriorating access for beneficiaries. While the restoration and expansion of federal DSH funding provided in the Medicare Prescription Drug bill provides some relief, it does not solve all of Alabama's Medicaid financing problems.

Overlaying these issues, the defeat of the tax reform proposal implies that the vast majority of Alabamians prefer lower taxes to improved government services or possibly even maintenance of the current level of services. With the cuts in state funding for programs this fiscal year across the board, not just in Medicaid, the effect of diminished state budgetary resources will be highly visible and voters may reconsider their positions. The large margin of the tax proposal's defeat, however, argues against its being revisited in the near future. For the Medicaid program, the consequences are stark. With very little room to cut the program further because of basic federal requirements and no new funding on the horizon, Alabama is certain to face many fiscal challenges and tough policy choices in maintaining its Medicaid program.

**CALIFORNIA**
**Stephen Zuckerman**

## Background

California is a large state in which about 6.3 million people – about 1 out of 5 non-elderly residents - lack health insurance coverage at some time during the year.[1] The state's basic strategy for addressing the health care needs of its low-income population has been to maintain fairly broad eligibility for Medi-Cal (the name for Medicaid in California) and Healthy Families (California's State Children's Health Insurance Program), while providing support for a county-based system of indigent care for the uninsured who are not eligible for these programs. To keep broad eligibility affordable, the state has a history of keeping payment rates low relative to national averages. After Governor Gray Davis took office in 1999, the state used increasing state revenues to broaden eligibility in both Medi-Cal and SCHIP, to make enrolling and staying enrolled in the programs easier, and to increase provider payment rates. However, the ability to afford what many viewed as "improvements" in these public programs came into question as state revenues declined.

The decline in income taxes was particularly serious, because they provide about half of the revenues needed to support general fund programs. California's dependence on the progressive income tax as a source of revenue grew because, as capital gains and stock option income surged in the late 1990s, other fees and taxes were cut (e.g., the vehicle license fee). Although tax revenues fell precipitously in state fiscal year (SFY) 2001-02, the state did not cut spending or increase other revenues sufficiently to address the operating shortfall that emerged.

---

[1] Brown, E. Richard, Ninez Ponce, Thomas Rice and Shana Alex Lavarreda, "The State of Health Insurance in California: Findings From The California Health Interview Survey," Los Angeles, CA: UCLA Center For Health Policy Research, June 2002.

By the time the SFY 2002-03 budget agreement was adopted - 67 days into the fiscal year - the state was forced to close a $24 billion gap between revenues and expenditures that included about $5 billion left from SFY 2001-02 and a projected $19 billion for SFY 2002-03.

The budget that was adopted for SFY 2002-03 relied on a variety of spending and revenue strategies to close the $24 billion gap. However, only about one-third of the gap ($7.5 billion) was closed through reductions in program spending. Borrowing against the state's future payments under the tobacco settlement closed about one-fifth of the gap ($4.5 billion). Nearly one-half of the budget gap was closed through a large number of spending deferrals, loans, funding shifts and time-limited tax increases ($10.5 billion). The budget also assumed that $1.1 billion in additional federal funds will be forthcoming, including a higher Medi-Cal matching rate, reduced child support penalties, and additional assistance to deal with the costs of incarcerating illegal immigrant felon and increasing homeland security. Although federal legislation did send some additional revenues to the states, this did not happen until California was into its next fiscal year.

Going into SFY 2003-04, California was faced with crafting a budget package that would have to close a cumulative two-year shortfall in the general fund budget estimated to be $38 billion.[2] This shortfall represented about one-third of the state's general fund budget from the preceding year. By the summer of 2003, the budget debate was complicated by the fact that a recall petition had put Governor Gray Davis' job on the line. Although the recall election did not move into full swing during the budget debate, California voters removed Gray Davis from office and replaced him with Arnold Schwarzenegger in a little over two months after the deal

[2] Elizabeth Hill, *California Spending Plan 2003-04: The Budget Act and Related Legislation,* Sacramento, CA: Legislative Analyst's Office, October 2003.

was signed. Some of the issues in the election were directly related to elements of the budget package.

Of the $38 billion shortfall, roughly $14 billion was left from SFY 2002-03 (due to late implementation of the previous year's plan and unmet revenue and cost projections) and $24 billion was projected for SFY 2003-04.[3] Rather than impose significant cuts on state programs near the end of SFY 2002-03 or increase taxes, the state decided to borrow $10.7 billion by selling bonds to generate most of the money needed to close out the 2002-03 shortfall. These deficit financing bonds (that are still awaiting voter approval and have not yet been sold) and other loans and borrowing from state funds filled about 41 percent ($16.3 billion) of the $38 billion dollar budget gap. Another $4.5 billion (about 11 percent) came from new or accelerated revenues, principally from further securitization of the tobacco settlement, increases in tribal gaming revenues and revision of prior revenue forecasts. Shifts from other state funds to the general fund and spending deferrals accounted for $6.1 billion (about 15 percent of the gap).

California also adopted a large number of program changes that led to $9.2 billion in savings, closing about 23 percent of the gap. One of the largest elements of these savings was simply an accounting change that shifted Medi-Cal costs from an accrual to a cost basis (discussed in greater detail below). Otherwise, spending cuts were spread across all areas of the budget. Perhaps the most noteworthy part of the budget package was the cut in higher education spending from the general fund (about 9 percent) that led to tuition increases of 30% or more

[3] The Legislative Analyst's Office (LAO) felt that the $38 billion estimate that Governor Davis used to shape the debate was overstated, and that a better estimate was $30 billion. The reasons given by LAO for this discrepancy were that (1) baseline expenditures had included some of Davis' spending priorities that exceeded current law; (2) baseline expenditures and revenues the budgetary benefits in SFY 2003-04 that accrued from the package of changes adopted for the previous year; and (3) improvements in baseline expenditures and revenues were not used to adjust the baseline but were counted as part of the budget solution package. To avoid confusion, LAO presented the budget package relative to the $38 billion estimate, because the legislature adopted that figure in its budget deliberations.

(varying across the different components of the higher education system). General fund spending on the judiciary and criminal justice was also reduced (by about 15 percent), but 70 percent of this reduction resulted from a decision to allocate federal fiscal relief funds to this area of state spending. Higher court fees offset some of the actual cut in program spending (that was about 4.4 percent). There was an also agreement to reduce state employee compensation costs across all departments by 10 percent through layoffs or unspecified reductions in compensation.

One area of the budget that did not change very much was K-12 education. After some mid-year reductions in K-12 education in SFY 2002-03 that lowered per-pupil spending by less than 1 percent, the budget agreement for SFY 2003-04 allowed for 4 percent growth in the budgeted level of per-pupil spending. However, because some of this budgeted amount was associated with covering spending that was deferred from SFY 2002-03, actual programmatic spending for K-12 education fell by 0.5 percent per-pupil in SFY 2003-04.

The remainder of the gap (9 percent) was filled with $3.4 billion in revenues from the restoration of previous reductions in the vehicle license fee (VLF). The VLF was allowed to increase under an automatic trigger mechanism that was included in the 1998 legislation that cut the fee by two-thirds. The new revenues were collected on all automobiles registered after October 1, 2003. The VLF increase emerged as a major issue in the recall campaign and Governor Schwarzenegger rolled it back after he took office.[4]

**Medi-Cal and Healthy Families**

The general fund budget for Medi-Cal in 2003-04 was set at $10.5 billion ($28.7 billion if all funds are included). This represented about a 3.3 percent ($363 million out of $10.5 billion)

---

[4] Peter Nicholas, Evan Halper and Joe Mathews, "Schwarzenegger Retreats on Key Campaign Vows: The Governor Backs Off Promises To Spare Education Funds And To Cover Local Governments' Loss Of Car-Tax Revenue," *Los Angeles Times,* December 10, 2003.

reduction in general fund spending for Medi-Cal. The net decrease in Medi-Cal spending was due primarily to a shift in the way the state accounts for Medi-Cal program costs. Instead of making appropriations that allow for services to be paid for according to the date they are delivered (on an accrual basis), the state decided to time appropriations to be in line with when a bill was actually paid (on a cost basis). This meant that the state shifted some spending that would have been budgeted for 2003-04 into the next year. This accounting shift was estimated to have created a one-time general fund savings of $930 million in 2003-04. If this accounting change had not been implemented, Medi-Cal spending from the general fund would have grown by 5.2 percent, or about $570 million.

Although the state made a number of changes in Medi-Cal rules and payment policies that led to actual cuts in spending, many of the Medi-Cal cuts that Governor Davis proposed were either reduced or simply not enacted. The extent of these cuts may have been limited because of an additional $890 million in federal payments that the state expected to receive for 2002-03 and 2003-04 as a result of the temporary increase in the federal matching rate. It is impossible to know if, in the absence of this additional federal payment, Medi-Cal cuts would have been $890 million greater or if an additional $890 million in cuts would have been distributed across other areas of the budget. However, what is clear is that the $890 million federal payment reduced the size of the spending gap facing the governor and the legislature.

The greatest actual projected savings within Medi-Cal were associated with policies aimed at reducing enrollment, but these were still small relative to the overall Medi-Cal budget. By requiring that county workers complete annual eligibility redetermination in less time than it has been taking, the state estimates that it will save $194 million in 2003-04 and that average monthly enrollment will be reduced by about 300,000 people, or 5 percent. However, some

analysts felt that this was an over-estimate. In addition, the state imposed semi-annual status reports to verify eligibility of adult beneficiaries and projects that this will save $21 million. The legislature opted for semi-annual status reports instead of the quarterly status reports that Governor Davis proposed, even though the savings were roughly one-quarter as large as those projected for the quarterly reports. It is hard to estimate the effect of the semi-annual status reports because of their interaction with the annual redetermination. Formal cutbacks in eligibility standards were not adopted. When Governor Davis submitted a revised budget in May 2003, he had already dropped a January proposal to rollback a 1931(b) eligibility expansion that provides coverage to parents in families with incomes up to 100 percent of the federal poverty level.

The budget also included targeted provider rate cuts that rolled back some increases that had been implemented in SFY 2000-01. Rates paid to physicians, pharmacies and managed care plans were to be cut by 5 percent as of January 1, 2004. This will produce $115 million in savings for 2003-04, less than half as large as the cut proposed by Governor Davis which would have cut rates by 15 percent and would have applied to nursing homes as well as those providers actually affected. As enacted, nursing home rates will actually increase slightly in 2003-04. In the deliberations over provider rate cuts, hospitals (inpatient and outpatient services), federally qualified health clinics or rural health clinics were exempted. A coalition of providers affected by the rate cuts--led by the California Medical Association--sued the state in an effort to stop them from going into effect.[5] The plaintiffs claim that the 5 percent cut "is illegal because it

---

[5] Karen Nicos, Ron Lopp and Peter Warren, "California Medical Assn. And Coalition of Health Care Providers File Lawsuit Against State to Stop Illegal Medi-Cal Cuts," Press Release. CMAnet: The Online Resource for California Physicians. November 7, 2003. http://www.cmanet.org/publicdoc.dfm/708/207/PRESS/280.

violates the Social Security Act by ignoring how those cuts would affect access to care … provided by Medi-Cal." A judge has temporarily blocked the rate cuts.

Another area in which the final budget produced smaller savings than Governor Davis had proposed related to the elimination of optional services. For adult beneficiaries living outside of long-term care facilities, there was a proposal to eliminate 18 optional services that would have saved $88 million for the general fund. The legislature refused to cut any optional services, however, they did reduce coverage of adult dental benefits by limiting the types of crowns beneficiaries could get and requiring X-rays to document the medical necessity for dental restorations. The total savings from these changes are estimated to be about $46 million.

Despite the need to close a large budget gap, budget negotiators chose to reinstate $46 million to fund a program that provides supplemental payments to nursing homes. These payments were initiated on the condition that nursing homes use them to increase wages paid to their workers. These supplemental payments had been eliminated during SFY 2002-03 as part of mid-year budgetary changes, but will be continued through SFY 2003-04. However, the SFY 2003-04 budget agreement also included plans to suspend these payments in SFY 2004-05 in order to save an estimated $64 million.

The Healthy Families program did not experience any cutbacks as part of the budget agreement. In fact, total spending for this program (federal and state) is expected to increase by about 37 percent in SFY 2003-04 to a level of $954 million. About $294 million would come out of the state general fund. This technically represents a $268 million increase in general fund spending, because California is no longer able to use tobacco settlement revenues to fund this program. The reason for this is that, during SFY 2003-04, the entire tobacco settlement will be securitized and applied to the general fund. The overall level of funding for Healthy Families

assumes continued growth in enrollment (from roughly 675,000 to 725,000) and payments to counties to support local insurance initiatives for children.

**The Future**

The assumptions required to be able to include the deficit financing bonds in the SFY 2003-04 agreement highlight the problems California faced. In order to try to sell the bonds, the state agreed to redirect one-half of one percent of local sales tax revenues to begin repaying the bonds in SFY 2003-04.[6] To replenish this loss in sales tax to cities and counties (approximately $2.5 billion), the state shifted property taxes that would have been used for K-14 education (including community colleges). The money lost to the schools was made up through increased state appropriations from the general fund. The success of this three-part approach - dubbed the "triple flip" – hinges on the general fund growing as the economy rebounds. The state believed that the bond houses were unlikely to accept the risk of these deficit financing bonds unless they were backed by a new state revenue source; in this case, local sales taxes. It is not clear how this mechanism will play out if economic growth is not sufficient enough to provide the additional general fund revenues. Although state finance experts believed this approach was legally sound, the fact that this bond issue has not yet received voter approval has led to some legal challenges. The new governor, Arnold Schwarzenegger, decided to go forward with the bond sale, but is first asking for voter approval.

These deficit financing bonds were only part of the set of one-time solutions used to close the budget gap that the state faced going into SFY 2003-04. Overall, this year's budget plan was quite dependent on borrowing, spending deferrals, funding shifts and revenue acceleration. In

[6] California Budget Project, *The 2003-04 Budget and Beyond,* Sacramento, CA: September 2003.

fact, the Legislative Analyst's Office concludes that "the disappearance of such solutions … would leave a large budget hole."[7] The LAO estimated that, if the VLF increase had remained in effect, the state would be facing a shortfall of about $10 billion entering SFY 2004-05. However, the VLF was rolled back in December 2003 shortly after the new Governor was sworn in. If the state fills in the VLF revenues that will be lost to cities and counties, the shortfall for SFY 2004-05 will be roughly $14 billion. However, at present, Governor Schwarzenegger is backing away from his plan to compensate cities and counties for lost revenues due to the VLF roll back.[8] Although economic improvements are leading to higher tax revenue projections, LAO indicates that these gains will be more than offset by higher spending on, for example, education, Medi-Cal, and corrections and lower revenues than had been assumed from tribal gaming. The bottom line, from LAO's perspective, is that the state needs to make further real spending cuts or decide to "enhance revenues" if the budget is to be brought into longer-term balance starting in SFY 2004-05.

The new governor and the legislature have agreed to ask voters to consider a $15 billion bond initiative that would remove potential legal challenges from the deficit financing bonds that were part of the SFY 2003-04 budget agreement.[9] A larger bond initiative that might have helped with projected deficits for SFY 2004-05 was considered by the new Governor's advisors but not announced because of concerns over adverse impacts on the state's credit rating.[10]

---

[7] Elizabeth G. Hill, "California's Fiscal Outlook: LAO Projections, 2003-04 Through 2008-09," Sacramento, CA: November 2003.
[8] Nicholas et al., Ibid.
[9] Dan Morain and Carl Ingram, "Revived Fiscal Plan Goes to Ballot: Compromise Clears Senate on Governor's Alliance With Democrats," *Los Angeles Times,* December 13, 2003; Nancy Vogel, Evan Halper and Peter Nicholas, "Assembly Passes Fiscal Plan: Senate OK Would Put Spending Limit, $15-Billion Bond on Ballot," *Los Angeles Times,* December 12, 2003.
[10] Evan Halper and Jeffrey L. Rabin, "Massive Loan For State Weighed: Aides For Gov.-Elect Schwarzenegger Float The Idea Of Borrowing $20 Billion To Balance The Budget As Key Players Reverse Fiscal Stances," *Los Angeles Times*, November 11, 2003.

Governor Schwarzenegger claimed that the $15 billion bond initiative – being called Economic Recovery Bonds - was necessary "to make good for the damage done in the last few years."[11] He and the legislature have coupled the bond initiative with another voter initiative that would impose a constitutional spending limit designed to end future shortfalls. The proposed spending limits require that the state have a balanced budget and that the state gradually build up a reserve fund that would equal $8 billion or 5 percent of the budget, whichever is greater. There would be a predetermined redirection of general funds into this reserve fund – 1 percent in 2006, 2 percent in 2007 and 3 percent in 2008 and subsequent years – until the reserve fund was fully funded.

Even before announcing his proposed budget for SFY 2004-05, Governor Schwarzenegger proposed spending cuts for the current fiscal year. He sent a package of $1.9 billion in cuts for the legislature to consider in a special legislative session. Included in these cuts are an additional 10 percent cut in Medi-Cal provider rates, elimination in SFY 2003-04 of the program that increases rates paid to long-term care facilities so that workers' compensation can be increased, and enrollment caps in a number of health and human services programs (at January 1, 2004 levels) – including Healthy Families and Medi-Cal Non-Emergency Services for Documented and Undocumented Immigrants. In addition, there is a proposal to eliminate the component of the In-Home Support Services (IHSS) Program funded only with state dollars. This program serves the aged, blind and disabled who do not qualify for Medi-Cal but require assistance to continue living in their homes. By far, the biggest component of the health-related cuts is the provider rate reduction, although the IHSS cutback would become large as these proposals carry into SFY 2004-05. Based on the fact that last year's interim budget cuts took

[11]Evan Halper and Peter Nicholas, "Gov. Proposes Bond Measure of $15 Billion: Under The Plan, The State Would Borrow The Money To Cover The Shortfall In This Year's Budget. He Also Seeks A Cap On Future Spending," *Los Angeles Times*, November 19, 2003.

over four months to be modified and enacted after they were proposed by then-Governor Davis, observers expect these new proposals by Governor Schwarzenegger will also move slowly through the legislature.

Governor Schwarzenegger's budget proposal for SFY 2004-05 attempts to close a projected $15 billion shortfall through a combination of spending reductions, additional borrowing and the retention of some local property taxes by the state. The LAO believes "the proposal has several positive attributes, including realistic revenue and caseload assumptions, as well as real and ongoing solutions."[12] However, it is not without problems. Many program areas would be affected and state services would be reduced. Moreover, LAO estimates that, despite "serious spending reductions," the state will still be facing a $6 billion shortfall in SFY 2005-06.

Prior to the election of Governor Schwarzenegger, California was already preparing for significant budget cuts for SFY 2004-05. The Department of Finance had requested all state departments to develop plans to reduce budgets by 20 percent. Included in that request were suggestions to consider scaling back required programs, eliminating optional programs and shifting responsibilities from the state to local governments. The recent proposals for supplemental cuts and for the SFY 2004-05 budget suggest that the new Republican Governor is willing to go beyond these actions and consider significant cuts in popular programs. His statements clearly indicate that he is set against new taxes as a way to avoid spending cuts. The legislature is still heavily Democratic and has not signaled a change in its fundamental priorities to protect programs that aid lower-income Californians. The recent agreement on the ballot initiative covering the Economic Recovery Bonds and state spending limits suggested that the debate between the legislature and the governor might be somewhat less intense than many had

---

[12] Elizabeth Hill, *2004-05: Overview of the Governor's Budget*, Sacramento, CA: Legislative Analyst's Office, January 2004.

expected. However, the size of the shortfall that still must be closed and the vocal public dissent from parties that may be adversely affected by the budget process make it difficult to envision how a broad consensus backing the Governor's proposal will be able to emerge.

## COLORADO
**Ian Hill**

### Background

At the outset of 2003, Colorado was looking at entering its third straight fiscal year in a serious deficit situation. Available estimates placed the Fiscal Year 2003-04 shortfall at nearly $900 million, or roughly 7 percent of the state's $13.4 billion General Fund budget. The previous year, the shortfall was only slightly less--$850 million. In the words of State Senator Andrew Romanoff (D), Senate Minority Leader, Colorado was mired in "the worst fiscal crisis since the Great Depression." Yet no relief was anticipated from the revenue side of the ledger; Republican Governor Bill Owens, a fiscal conservative, re-elected by an overwhelming majority in November 2002, pledged to not raise taxes "as long as I am Governor." The Republican-controlled Senate and House were of an identical mindset, and looked again to budget cutting as the primary solution to the state's deficit.

However, Colorado, a traditionally conservative state and currently ranked 43rd among states in total tax collections as a percentage of personal income, has less flexibility to trim spending than most states. Indeed, four laws passed over the prior decade combine to constrain the state's ability both to weather, and address, difficult budget times. First, the Taxpayer Bill of Rights (*TABOR*), passed by the voters as an amendment to the state constitution in 1992, made all tax increases subject to voter referendum and, therefore, unlikely. In addition, the law limits state government revenues and expenditures to the previous year's levels plus inflation and population growth. Thus, Colorado must refund excess revenue to the taxpayers and cannot retain

surpluses in good years to build reserves for future lean times. Furthermore, tying the coming year's expenditures to the previous year's revenue means that the state can not increase spending, even in good years, nor recover from budget cuts enacted during an economic downturn; in essence, once program cuts are made they become the new baseline for future budgeting purposes.

A second constraint began as a constitutional amendment that passed with all the best intentions. After years of cuts to K-12 education (cuts that were fueled by property tax decreases described below), Coloradans rallied behind the notion that the state needed to catch up. *Amendment 23* was passed in November 2000 requiring the state to annually increase spending on per pupil K-12 education by the rate of inflation plus enrollment plus one percent until 2010-11. Hailed as a boon for the state's children, *Amendment 23* allowed Colorado to increase spending on K-12 education by 11.4 percent in the two subsequent fiscal years, even while almost all other state departments were cutting their budgets. However, from another perspective, the law has effectively tied the hands of legislators by requiring them to devote ever-increasing proportions of the state's shrinking budget to K-12 education

Finally, two laws have dramatically limited the amount of revenues the state can collect from property taxes—1982's *Gallagher Amendment* and 2000's *Referendum A (the Senior Homestead Exemption*).[1]

Combined, these laws have made it virtually impossible for Colorado policy makers to raise taxes, build a surplus, or rebound from tough economic times.

[1] The senior property tax exemption (Referendum A) was reduced to zero in the last legislative session, as allowed under the legislation because of the budget crisis. A bill has been introduced in the current session to restore some portion of the exemption, but many legislators have predicted it won't pass because there are no other sources of revenue available to make up for the budget deficit.

*Amendment 23* (which this year locked in K-12 expenditures at a level accounting for over 43 percent of General Fund spending), coupled with mandatory spending for persons entitled to Medicaid coverage, mean that fully 62 percent of the state's budget is spoken for, leaving less than 40 percent available for discretionary cutting.

**The State Budget Situation and Policy Response**

The roots of Colorado's deficits are similar to those of many states. The recession led to a doubling of the unemployment rate during 2001/2002 (it currently stands at 5.7 percent, slightly below the national average of 6.2 percent); the state economy was especially hard hit because of its heavy reliance on tourism (which declined precipitously after September 11) and high technology. Colorado depends more on capital gains taxes than any other state, a revenue source that has dramatically declined as a result of the stock market downturn. In addition, the state continues to suffer its worst drought in recorded history, hitting farmers and ranchers the hardest.

For FY 2002-03, the $850 million shortfall was made up through a combination of accounting measures and across-the-board cuts to state agency budgets. For example, some of the deficit was addressed by delaying state employees' June paychecks until July, effectively shifting $89.4 million in obligations to FY 2004. In addition, in May 2003, Governor Owens imposed a four percent cut on all state agencies (with the exception of K-12 education), and an additional six percent cut was called for later in the year, bringing the total to 10 percent. These cuts, at least in part, drove a reduction of approximately 1,000 jobs from state government over the course of the year. State support for mental health services was cut by approximately $30 million. Capital

construction projects less than 25 percent complete were also frozen, saving $24.2 million.

Actions to address the $900 million FY 2003-04 shortfall were a continuation of many of the same general strategies, as well as some new efforts. The state's higher education budget was reduced by more than $100 million (or 30 percent), even after many institutions were allowed to raise their tuition by at least 10 percent. In April 2003, legislation was passed to securitize 47 percent of the state's tobacco settlement revenue; the state expects to sell $530 million of its $1.2 billion revenue stream and receive upfront payment of $313 million. Two additional bills were passed that would have allowed the state to raise millions in case of fiscal emergency: one allowed the sale of up to $160 million of state buildings that would then be leased back to the state; the other allowed up to 60 percent in future tobacco proceeds to be securitized. Neither of these two bills has been implemented, however.

**Medicaid and SCHIP**

Medicaid spending accounts for roughly 19 percent of state spending and is the second largest line item in Colorado's budget (behind K-12 education). While the program is one of the leanest, nationally, due to its tight income eligibility thresholds and limited coverage of optional services and populations, the program continued to grow rapidly during the economic downturn due to increasing adult and child enrollment. Spending increases have also been fueled by rising rates of utilization, as well as medical cost inflation.

For FY 2002-03, the Medicaid program's share of imposed reductions totaled approximately $133 million. Over one-third of this amount--$36.4 million—was

achieved from service reductions, including hospital rate reductions and cost recoveries ($10.8 million), pharmacy reimbursement and prescription drug controls ($4.5 million), and the suspension of provider rate increases ($3.8 million). The remaining $96.4 million in savings were garnered from financing changes, particularly a $70 million savings from a switch to cash accounting (from accrual accounting), $7.5 million from one-time cost recoveries from HMOs; and $17.4 million from adjustments to upper payment limit (UPL) arrangements. (Under UPL, payments to providers are increased so that additional federal matching funds can be drawn, with the state share paid by intergovernmental transfers; the state gains when extra reimbursement is returned to the state by providers.)

The SCHIP program, called *Child Health Plan Plus* in Colorado, was held harmless in FY 2002-03. In fact, the program was expanded during the course of the year as the state carried out program enhancements that were passed in previous years. Specifically, *Child Health Plan Plus* added dental coverage to its benefit package. In addition, the state added coverage of pregnant women to SCHIP under a new Health Insurance Flexibility and Accountability (HIFA) waiver.

In FY 2003-04, however, the SCHIP program experienced severe cuts and Medicaid found itself in a state of flux. With regard to Medicaid, Colorado made national headlines when it announced that it would eliminate coverage of legal immigrants, a move that would result in 3,500 individuals losing coverage, for a savings of $8 million. At the time, eight other states did not cover this optional group, but Colorado would have been the first of the remaining 42 to stop benefits for this group. The cut was scheduled to go into effect on April 1, 2003, but the American Civil Liberties Union (ACLU) of Colorado filed a suit that temporarily blocked the provision.

An initial court ruling was made in favor of the state, but that decision was appealed by the ACLU and the outcome of that appeal was still pending at the time of this writing. Other cuts made to meet the FY 2003-04 Medicaid target included reduced funding for county transportation ($3.8 million); a change in reimbursement to Federally Qualified Health Centers ($1.4 million); additional prescription drug controls ($1.3 million); increases in copayments ($.5 million); and a one-month delay in medical payments that will shift between $20 and $25 million in costs to the following year. On the financing side, expenditures increased by $93.4 million through implementation of changes made in FY 2002-03, including the change to cost accounting (cost of $70 million) and upper payment limit adjustments (cost of $12.5 million), among others.

An important development not directly growing from the state's budget crisis, but certainly fueling the problem, pertains to Medicaid managed care. In less than one year, the state lost four of its participating health plans, and has suspended enrollment (effective April 2003) in it sole remaining prepaid plan—Colorado Access. This swift and dramatic change began in 2002 when Rocky Mountain HMO won a lawsuit against the state in which it claimed that the Medicaid program had underpaid the plan because its formula for calculating 95 percent of equivalent fee-for-service fees was incorrect. The judge presiding over the suit issued a summary judgment in favor of Rocky Mountain HMO, which opened the door for every other participating health plan to file similar suits. In total, Colorado Medicaid has had to pay out over $30 million in decisions thus far[2] and will likely face further obligations from other lawsuits.[3] The now-

[2] Comprising $21.5 million to Rocky Mountain HMO and $9.8 million to Community Health Care Plan of the Rockies.
[3] Qual-Med and Colorado Access allege that Medicaid has underpaid them by more than $100 million since the mid-1990s.

strained relationship between the HMO industry and the state Medicaid program has led to the recent decision by the state's Department of Health Care Policy and Financing to not renew Colorado's Medicaid 1115 waiver and to shift all Medicaid recipients into fee-for-service and primary care case management arrangements. State officials are describing this development as a cost-savings initiative, claiming that the "new" approach will be more efficient.

Meanwhile, *Child Health Plan Plus* was forced to impose an enrollment cap, effective November 2003. The cap, which will halt enrollment at a peak of roughly 53,000 children, is expected to be in place indefinitely. In addition, the legislature directed the program to discontinue its coverage of pregnant women a mere five months after starting this new coverage. Pregnant women already enrolled in SCHIP will retain coverage through the completion of their pregnancies, but no new pregnant woman enrollees were permitted after November 2003. The SCHIP program also discontinued its funding for mass media outreach and advertising. Each of these cuts was described as "very painful" for state legislators, as the SCHIP program continues to enjoy very strong bi-partisan political support and was held harmless for "as long as humanly possible."

**The Future**

At the time this case study was prepared, new revenue estimates actually came in higher than expected, giving state officials hope that economic recovery was around the corner. Specifically, the September 2003 General Fund revenue forecast for FY 2003-04 was higher than the June '03 estimate by $74.7 million. Furthermore, Colorado is also in a better fiscal position entering 2004 as a result of recent federal assistance—the Jobs and Growth Tax Relief Reconciliation Act of 2003 will distribute $227.1 million to Colorado

during FY 2003-04, with $80.8 million coming from increased Medicaid assistance and $146.3 million in the form of federal grants for specific purposes.[4]

However, the previous three years have had a sobering effect and state officials are not presuming that the future won't hold further fiscal challenges. Efforts are underway to modify *TABOR* and *Amendment 23* so that they would not hamper the state from addressing future budget shortfalls. At the time of this writing, a bi-partisan effort was underway in the legislature to devise amendments that would permit the state to more easily build "rainy day" funds during good times, and provide increased flexibility to raise spending faster than currently permitted by *TABOR* in years following budget cuts. The proposal would also protect *Amendment 23* but also allow the state to suspend its mandatory one percent K-12 increase during an economic downturn. The likelihood of these amendments passing is anything but assured, however, as both the Governor and many state legislators believe that laws like *TABOR* are "good things." For example, in his State of the State Address for 2003, Governor Owens called *TABOR* "an economic bulletproof vest" which controlled state spending during the boom years, and thus put Colorado in a better position (spending wise) when revenues turned down.

Health care advocates are particularly concerned about the potential long-lasting effects of recent budget cuts on low-income persons' ability to access needed care. A recent survey of physicians along the Front Range found that just 21 percent of Denver-area primary care physicians, on average, accept new Medicaid patients, but in some metro areas the number is as low as 9 percent. Similarly, 2003 saw an increasing number of reports from hospitals that serve Medicaid recipients and the indigent (including the

---

[4] However, the 2003 federal tax act will also reduce Colorado's income tax receipts by $58.5 million and FY 2003/04 and by $31.2 million in FY 2004/05.

largest—Denver Health and Hospitals) that patients were being turned away from emergency rooms unless their conditions were, indeed, emergencies. Advocates presume that such situations have arisen in the aftermath of continued cuts to hospital reimbursement rates.

An initiative emerging from the agency that administers Medicaid and SCHIP may hold potential to improve access for low-income Coloradans, however. Specifically, state officials are in the process of designing a new Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver that would combine the resources of Medicaid, SCHIP, and state-funded Indigent Care Program (ICP), to maintain current coverage for all federally-mandated groups, and purchase a new SCHIP-like basic benefit package for optional groups and current ICP enrollees. Operating under the assumption that the SCHIP package will meet the needs of the vast majority of recipients, state officials are busy working on alternatives for providing "wrap around" benefits for persons needing additional care, such as children with special health care needs.

## FLORIDA

Barbara A. Ormond

### Background

While Florida ended state fiscal year (SFY 2002-2003) in better shape than most states, the outlook for the future is less sanguine. Voter-directed spending on several issues, including high cost initiatives on class size reduction in public K-12 education and the development of state-wide high-speed rail, cloud the picture for the out years. In addition, in recent years legislators have met much of the gap between revenues and expenditures by using non-recurring revenue to fund recurring expenditures, including Medicaid. Within the Medicaid budget, estimates of savings to be achieved by policy changes have sometimes been higher than actual savings, and caseload growth has exceeded projections in the more expensive eligibility categories, leaving the state with a carry-forward deficit at year-end reconciliation for the past three years that will need to be addressed eventually.

Insurance coverage is low in Florida for both children and adults relative to the national average. Forty-three percent of low income adults and 25.9 percent of low income children are uninsured as compared with 38.9 and 21.1, respectively, in the nation as a whole.[1] Employer-sponsored coverage is low with 61.8 percent of all adults and 56.8 percent of all children covered; the national averages for employer coverage are 67.0 and 63.3 percent, respectively. The state has fairly strict eligibility standards for Medicaid which are reflected in the program coverage rates—14.7 percent for low income adults and 42.2 percent for low income children—which are below the national

[1] All of the coverage figures in this paragraph are from Urban Institute calculations using data from the Current Population Surveys, 2002 and 2003 Annual Social and Economic Supplements.

averages of 18.1 and 45.6, respectively, for these groups. There is no state-sponsored general medical assistance program for people not eligible for Medicaid and the State Children's Health Insurance Program (SCHIP).

Florida's governor, Jeb Bush, is a Republican, and both chambers of the legislature are controlled by the Republican party. The Republican leadership has established a fiscal environment that has been characterized as "frugal," with substantial pressure to limit the growth of state government; the size of government and the role of taxes remain the central political debates. The governor's stated priorities are literacy, economic diversification, and families.[2] The state has a large elderly population and one of the fastest growing child populations in the nation.[3]

The lack of a state income tax makes sales, business, and intangibles taxes important. Tourism represents a substantial part of the economy, and Florida's tourism industry has rebounded since the aftermath of September 11$^{th}$, attracting a record number of tourists in 2002. Unemployment remains below the national average.[4] When Governor Bush was inaugurated in 1999, he inherited a $3 billion surplus.[5] Tax cuts between 1999 and 2002 reduced annual state revenues by $1.2 billion, with the cumulative reduction in tax payments since Governor Bush took office estimated at $8.2 billion. While there were no tax cuts or increases in SFY 2002-2003,[6] Florida was one

---

[2] Governor Jeb Bush, State of the State Address, January 8, 2003, http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech&year=2003&state=FL.
[3] Kenneth Finegold et al., Social Program Spending and State Fiscal Crises, Assessing the New Federalism Occasional Paper no. 70, November 2003.
[4] As of the first quarter of 2003. Adam Carasso and Roseana Bess, "The Disposition of Federal Dollars in Florida's Social Services: Informing a Federal Funding Maximization Strategy," Final Report to the Florida Philanthropic Network, The Urban Institute, June 2003.
[5] Finegold et al.
[6] National Governor's Association and the National Association of State Budget Officers (NGA/NASBO), Fiscal Survey of the States, November 2002, p. 11.

of only two states with a net decrease in estimated revenues based on actions affecting revenues for fiscal year 2004.[7] Tax changes in SFY 2003-2004 included decreases in corporate and other taxes and an increase in fees for a net decrease in revenues estimated at $27 million.[8]

Budgetary reserves in general revenues are held in the working capital fund, which can be appropriated for general revenue purposes, and the budget stabilization fund, which can only be used in the event of emergencies, such as hurricanes. All revenue is classified as recurring or non-recurring depending on whether the income stream is time-limited or not and, by practice not statute, only recurring revenues are to be used to fund recurring expenditures.[9] Some revenues are earmarked for certain purposes and held in trust funds, e.g., hospital tax revenues are deposited in the Public Medical Assistance Trust Fund (PMATF) and used to fund Medicaid expenditures. Trust funds make up 58 percent of the total state budget with the rest classified as general revenue.

Medicaid represents 23.5 percent of the total state budget of $53.9 billion (SFY 2003-2004 general revenue and trust funds), and so is an important consideration in any budget talks. Changes in Medicaid policy designed to slow the growth in this program have resulted in a reduction in expenditures of at least $100 million (relative to the rising baseline defined by expected growth in caseload and services given existing policies) in almost every year since 1993.[10] Growing caseload is one source of expenditure growth

---

[7] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 12.
[8] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 12.
[9] Finegold et al.
[10] Finegold et al.

but pharmaceuticals are the biggest factor, in spite of substantial policy initiatives over the past several years aimed at containing this area of expenditure growth.[11]

**Florida's Budget Problem**

Despite a 3 percent drop in the state's largest revenue source, sales taxes, total tax collections for SFY 2002-2003 were ahead of projections led by a 25 percent increase in collections from corporate taxes.[12] Combined sales and corporate tax collections are projected to be up by 4.6 percent for SFY 2003-2004.[13] Nonetheless, the shortfall going into current fiscal year (SFY 2003-2004) was estimated at about $1 billion,[14] representing nearly two percent of the total budget. As was the case in SFY 2002-2003, the state had sufficient funds to cover the shortfall but these funds were from non-recurring sources. Appropriations from general revenues were $21.6 billion, which represents a nominal increase of 2.7 percent over SFY 2002-2003 and is well over the national average increase of 0.2 percent.[15] This increase follows a 8.0 percent increase between SFY 2001-2002 and 2002-2003.[16]

Governor Bush's proposed SFY 2003-2004 budget (general revenue, trust funds, and other state funds) recommended an increase of 6.8 percent over the SFY 2002-2003 total state budget. The budget as passed represented an increase of 5.8 percent. Funding for K-12 education rose by 6.6 percent but more than half of the increase was slated to be

---

[11] John Holahan et al., The State Fiscal Crisis and Medicaid: Will Health Programs Be Major Budget Targets? Overview and Case Studies, The Henry J. Kaiser Family Foundation, January 2003.
[12] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 39.
[13] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 41.
[14] Bob Mahlburg, State budget woes mount," Orlando Sentinel, July 1, 2003, http://www.orlandosentinel.com/news/local/state/orl-asecbudget01070103jul01.story.
[15] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 28.
[16] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 28.

used to address the requirements of the class size initiative. Community colleges faced a cut of $4.3 million, and universities a cut of $40.7 million. More of the cost of higher education has been shifted to students with tuition at community colleges rising by 7.5 percent and at universities by 8.5 percent. State government employment continues to decline, with a 3.2 percent decline between 2002 and 2003 followed by a 1.4 percent decline (1700 jobs) for the current year (2003-2004);[17] government salaries were increased 2.0 percent across the board (subject to a $500 floor and $1400 ceiling), and cost-sharing for health insurance premiums for state employees remained fixed.[18]

The legislature was unable to reach agreement on the budget at the end of the regular session. The Senate proposed new revenues while the House proposed additional tax cuts or new economic stimuli. Meeting in special session, the legislature compromised by agreeing not to impose new taxes but allowing some fee increases. The bulk of the shortfall was met through the use of $1.0 billion in non-recurring revenues. The state issued bonds to cover the cost of the class-size reduction initiative, adding $600 million to the state's debt, raising the state's total indebtedness to over $20 billion.[19] Governor Bush intends to send the high speed rail initiative back to the voters.[20]

The crux of Florida's budget problem can be seen in the state's position at the end of SFY 2002-2003. The budget stabilization fund was intact, totaling $959 million at the end of the budget year.[21] The total year-end balance (including the budget stabilization fund) was $1.4 billion, or 7.0 percent of expenditures. While this balance is healthy, it has

---

[17] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 34.
[18] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 37.
[19] Randolph Pendleton, "State close to debt ceiling," Tallahassee Democrat, June 9, 2003, http://www.tallahassee.com/mld/tallahassee/news/local/6045437.htm.
[20] Finegold et al.
[21] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 22.

been declining over time as a percentage of expenditures. At the end of SFY 2001-2002 it was 10.0 percent of expenditures; at the end of SFY 2003-2004 it is projected to be 6.6 percent of expenditures.[22] Furthermore, most of the surplus is in non-recurring revenue and so its use for funding recurring expenditures is ill-advised.[23]

**Cuts in Medicaid and SCHIP**

The most contentious issue in the debates on the Medicaid budget in SFY 2002-2003 was funding for the medically needy program. This program was slated to be cut but funding was reinstated on a time-limited basis using non-recurring funds. Hospitals argued in favor of the program, saying that the costs of caring for those no longer covered under the program would show up in their uncompensated care bill. Continued funding for the program, with no time limitation specified, was approved at the end of SFY 2002-2003. Consideration was given both to raising the income limit and to strengthening the spend-down requirements for SFY 2003-2004. After costing out both of these changes, the legislature opted to continue the operation of the program unchanged, a decision that respondents reported was based chiefly on compassion rather than cost comparisons. Administrative changes in the program will not be felt by the beneficiaries. The necessary funding for the program was found in a $29.1 million increase in voluntary contributions from counties as part of their existing upper payment limit (UPL) program and, since hospitals have a stake in seeing the program continue, by delaying the annual

[22] NGA/NASBO, Fiscal Survey of the States, December 2003, p. 55.
[23] Wenner, Kurt, "New General Revenue Estimates Are Increased, But Use of Non-Recurring Revenues Still Has Florida in a Hole for Upcoming Budget Year," Budget Watch, vol. 9, issue 2, Florida TaxWatch, http://www.floridataxwatch.org/resources/pdfs/budgetWatchSeries/budgetwatch_non-recurring11-03.pdf.

price level increase for hospitals from July 1st to October 1st for an estimated general revenue savings of $5.6 million.

The Medicaid budget for SFY 2003-2004 is $12.5 billion, of which $3.5 billion comes from general revenue, $7.1 billion from federal financial participation, $404 million from trust funds, $452 million in other state funds, $95 million in tobacco settlement funds, and $1.0 billion in grants and donations, chiefly from contributions by localities. The initial estimates for Medicaid spending showed a $113 million (3.2 percent) general revenue shortfall. The legislature was not eager to revisit the sometimes acrimonious debate surrounding the medically needy program and so looked elsewhere for savings within Medicaid. The $314 million in cuts (federal and state funds) was achieved through small savings across many programs. The areas with the largest predicted savings were a cut in nursing home rates accompanied by postponement of a increase in the staffing requirement ($19.5 million), institution of 2.5 percent coinsurance for certain drugs ($26.8 million), expansion of the nursing home diversion program which promotes community based alternatives to institutional care ($35.7 million), and institution of a $15 co-payment for non-emergency use of hospital emergency departments ($24.3 million). Nursing homes had had a scheduled rate increase funded in SFY 2003-2003 with non-recurring funds; this year that increase was eliminated, effectively decreasing nursing home rates for an estimated savings of $27 million.

The state looked widely for savings as evidenced by the smaller but significant savings in areas such as eliminating circumcision ($2.4 million) and transferring non-emergency transportation services from a state commission to a competitive procurement with capitated rates ($11 million). Prior year cuts to adult hearing and vision were not

restored, and adult dental remains limited to emergency care only. The "value-added" program that the state has in place with four major pharmaceutical companies was renewed. Under this program, the pharmaceutical companies provide disease management services free-of-charge in exchange for having their products not subject to the Medicaid preferred drug list. Supporters of the value-added program estimate savings at $15.9 million in state funds last year, but detractors say that greater savings could be achieved by abandoning the deals and demanding larger rebates from the companies. Pharmaceuticals remain a target area for future cost savings. The one-third of the pharmaceutical budget that is unmanaged, chiefly in drugs for HIV/AIDS patients and for mental health, is seen as offering some potential for additional savings. Fraud and abuse in pharmaceuticals is an area of ongoing concern.[24]

The state also applied for a state plan amendment to raise an additional $33 million through an upper payment limit program for physicians. Managed care was expanded by further increasing the percentage of clients assigned to health maintenance organizations rather than the more lightly managed MediPass primary care case management program beyond the increase mandated last year. The state did not look to localities for additional help this year beyond the $29.1 million in increased UPL program participation; a mandatory realignment of state-county responsibilities is scheduled for SFY 2004-2005, and the legislature chose not to impose new burdens in anticipation of this change.

[24] Florida Officials Say They Will Increase Scrutiny of Medicaid Prescription Drug Fraud, Following Release of Grand Jury Report, Kaiser Daily Health Policy Report, December 19, 2003, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=21441.

One of the most difficult issues in this year's budget debates was funding the state's SCHIP program, Healthy Kids, which is not part of Medicaid. Enrollment in the program was capped with spending limited to the appropriation. State savings from this action were estimated at only $300,000 because of the high federal match for SCHIP. Current expenditures, however, exceed the state's allotment and include carry-forward amounts from prior years. Outreach was eliminated, and a waiting list was established, which, by November 2003, had over 44,000 names.[25] A cap of $750 was put on annual child dental benefits which allowed the state to decrease the capitation rate it paid to plans, saving an estimated $1.3 million in state funds. Monthly premiums for children's programs were raised to $15 per family per month for families with incomes under 150 percent of the federal poverty level and $20 per family per month for those between 150 and 200 percent of poverty, for an estimated $3.6 million savings in state funds.

**The Future**

As was the case in SFY 2002-2003, the state's decision to rely on non-recurring funds to meet recurring expenditures has postponed some hard choices that will eventually have to be made. The state will need to find a source of recurring revenue to replace the $1.0-3 billion in non-recurring funds in the SFY 2003-2004 budget. In addition, unfunded expenditures have been accruing in Medicaid in the form of carry-forward deficits that will need to be addressed in the near future. Total Medicaid expenditures are calculated at the end of the calendar year, six months after the end of the

[25] Donna Cohen Ross and Laura Cox, "Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children," Kaiser Commission on Medicaid and the Uninsured, December 2003, http://www.kff.org/medicaid/4159.cfm.

fiscal year. When expenditures exceed the appropriation, the difference is carried forward into the next year. These deficits are in part a function of billing cycles but are also driven by the failure to fully realize savings that had been projected from program and policy changes. In some cases, the policy changes represented initiatives that had not been tried before and for which savings could not be reliably estimated. In other cases, implementation delays have meant that a full year's savings could not be achieved.

While some of the carry-forward deficits in Medicaid have been repaid, significant amounts remain. The remaining $10.7 million general revenue carry-forward deficit in Medicaid from SFY 2001-2002 will be added to the projected carry-forward deficits of $58.0 million for SFY 2002-2003 and $113.6 million for the current budget year. The deficit for the current year is likely to be higher; Medicaid enrollment in the more costly categories began rising after the expenditure projections had been made for the current year, resulting in projected expenditure numbers that were recognized as overly optimistic very early in the fiscal year. Early estimates put the gap for Medicaid in SFY 2004-2005 at $526.1 million in state funds, continuing the upward trend. The state is not confident that it will be able to live within the current appropriation for Medicaid, and a mid-year adjustment to institutional provider rates is expected to be necessary to bring expenditures into line with the appropriation.

The fiscal relief provided to the Florida through revenue sharing by the federal government totaled $543 million, and the temporary increase in the federal matching rate for Medicaid will yield $413.4 million. The state has allocated $310 million of the fiscal relief funds for economic development in the form of a one-time investment incentive for the establishment of a Florida branch of the California-based Scripps biomedical research

center, to be matched by up to $200 million in funds from the county in which the institution will be located.[26] The balance was deposited in the working capital fund and transferred to the general revenue budget as non-recurring revenue for allocation in the SFY 2004-05 budget. Because these funds are non-recurring, they do not solve the underlying budget problem of the imbalance between recurring expenses and recurring revenues, a problem that the state again decided not to address in the current fiscal year. The sticking point remains the role of taxes, with some believing that tax cuts will spur the economic growth that will lower demands on the social services budget and others asserting that tax increases are needed to bring in the funds to meet the commitments of the state in its social services program. In the same context, arguments have arisen on the role of trust funds in limiting budgeting flexibility and the role of tax exemptions in limiting the revenues that the state could collect without fundamentally altering the tax structure.

[26] Scripps Florida Project, Biotechnology Research Institute & Campus, http://www.co.plam-beach.fl.us/PubInf?EDO/Scripps_Florida.htm.

**MASSACHUSETTS**
Randall R. Bovbjerg

## Background

Massachusetts is a high-income, moderately high-tax state that has faced severe fiscal pressure since SFY 2001. Voter registration is heavily Democratic, but since 1990, voters have elected fiscally conservative Republican governors balanced by nearly veto-proof, more liberal Democratic legislatures. New Republican Governor Mitt Romney won handily in November 2002, pledging not to increase taxes, but Democrats slightly increased their legislative dominance. Anti-tax sentiment is strong, yet co-exists with pro-expansionary attitudes on public services. Massachusetts ranks high on any measure of public generosity in health care,[1] reflecting its political philosophy, its large medical sector, and pride in its reputation for high-quality care.

In 1997, the state began a comprehensive expansion of public coverage, termed MassHealth, under a section 1115 Medicaid waiver whose fiscal assumptions proved very generous. The next year, SCHIP was integrated into MassHealth. MassHealth covered a very broad set of beneficiary categories and set income eligibility standards very high.[2] The state also ended asset tests for eligibility. Outreach has been strong, so a high proportion of eligibles actually enrolls. Beyond Medicaid, the state has also

---

1 Spillman, Brenda C. “Adults without Health Insurance: Do State Policies Matter?” Health Affairs 19(4):178-187 (Jul-Aug 2000). Note that this report does not cite to its interviews; for case study methods see overview chapter.

[2] Children were covered to 150 percent of the federal poverty level, or FPL (and to 200 percent with payment of a premium), disabled children to 150 percent, parents to 133 percent, and childless adults if disabled or long-term unemployed (to 133 percent). Also, working families may be eligible for premium assistance (to 200 percent of FPL) for private coverage if the worker is in a small firm that pays at least 50 percent of premium. Even beyond these high coverage levels, disabled children or adults of any income are covered if they make sliding-scale premium contributions. Senior Medicare-Medicaid dual eligibles were covered up to 100 percent of FPL (one of 17 jurisdictions going so high). Also, all children through age 18 can participate in the separate Children’s Medical Security Plan--with no limit on income. Premiums are required but up to 400% of FPL are moderate; only outpatient care is covered, and there are controls on utilization and provider payment, as well as cost sharing. MassHealth also covered aliens, with lesser benefits depending on their status. For a full explanation of the very broad expansions of eligibility, see Center for Health Policy and Research, UMass Medical School, *Health Care Resources for the Uninsured in Massachusetts: A Road Map to Coverage for Vulnerable Citizens of the Commonwealth*. Shrewsbury, Massachusetts (last updated in April 2000) .http://www.umassmed.edu/healthpolicy/roadmap.

been one of the few to help pay for hospital charity, has run an unusually generous pharmacy program for the elderly, and is otherwise very generous in health care. Starting with a high rate of employer-sponsored insurance, the state by 2001 had added some 300,000 people to the MassHealth rolls. The state ranked among the nation's lowest in rate of uninsurance.[3] Since 2001, however, private coverage has declined, and more recently MassHealth enrollment has also dropped.

## General Budgetary Problems and Overall Responses

*Growing budgetary stringency since SFY 2001*

The main source of budget pressure has been shortfalls in revenue. Record state surpluses occurred through SFY 2001, despite over 40 tax cuts in the 1990s, culminating in a repeal of an income-tax surcharge in 2000. The repeal was worth $1 billion a year--about a 5 percent reduction in revenue. Problems began in SFY 2002. Tax revenues fell by 14 percent, mainly from the recession but also from the drop in surcharge. Medicaid also overspent its appropriation by almost $300 million. Since then, revenue trends have remained flat, while spending pressures have grown, especially for health care, debt service, and heavily formula-driven local aid. The SFY 2003 budget had to eliminate a projected deficit was some $2 billion (almost 10 percent of appropriations).

During calendar 2003, an additional mid-year deficit of some $650 million faced new Governor Romney in January. Revenue shortfalls were the primary problem; Medicaid did not overspend. The initial budget projections for SFY 2004 suggested a $3 billion deficit, but fiscal pressure eased somewhat during budget deliberations, and the year ended with a small surplus.[4] Short-term actions like a tax amnesty brought in more than expected and temporary federal fiscal relief was worth about $550

[3] Six percent of children are uninsured and 11 percent for adults aged 19-64, versus national averages of 12 percent and 19 percent. Data from 2000-2001 from Kaiser Family Foundation, *State Health Facts Online*. http://www.statehealthfacts.kff.org

million to the state, combining grant funds with enhanced medical assistance percentage (FMAP).[5]

*Overall Budgetary Responses, SFYs 2003 and 2004*

Through the SFY 2003 budget, Massachusetts maintained services by increasing revenues and drawing down reserves. About $2 billion of the stabilization or "rainy day" fund was spent during SFYs 2002 and 2003, in addition to other trust-fund shifts.[6] The state avoided securitizing future tobacco settlement funds, however. In SFY 2002, Medicaid, i.e., MassHealth, was cut, but very modestly. For SFY 2003, the $2 billion budget gap was mainly filled through a $1.2 billion increase in taxation and fees, including the nation's only income tax increases in that year.[7] Program cuts did occur, mainly in non-Medicaid programs. The administration proposed more cuts to MassHealth than the legislature accepted. Overall, the SFY 2003 budget grew by only 2.1 percent, half the 4.1 percent rise authorized the year before. Through calendar 2002, the state also shed some 7 percent of its workforce, largely through early retirement, which cut spending but raised pension obligations.

During the first half of SFY 2003, lame-duck Acting Governor Jane Swift made further cuts using her discretionary authority to maintain budget balance, including small ones in health care. In the second half of SFY 2003 new Governor Romney in January sought and received authority (although only for a year) to cut local aid and higher education, previously off limits to mid-year adjustments. The administration made additional cuts in Medicaid and elsewhere, including environmental programs and state operations.

---

[4] FY03 Year End Review: Current conditions, future expectations, Eric Kriss, Secretary of Administration & Finance, July 7, 2003. http://mass.gov/agency/documents/eoaf/FY03_Year_End_Review_FINAL.ppt.

[5] These funds come to states during FFYs 2003 and 2004, nationwide half as grant assistance and half as enhanced FMAP, under the Jobs and Growth Tax Relief Reconciliation Act of 2003, also called the stimulus bill, Public Law No. 108–27, 117 US Statutes at Large 752, May 28, 2003. Exactly how much FMAP a state gets depends of course upon how much it spends in state and local funds.

[6] E. Matthew Quigley, "Preparing for the Storm: Rainy Day Funds in New England," *New England Fiscal Facts*, Federal Reserve Bank of Boston, Summer 2003 No. 31. http://www.bos.frb.org/economic/neff/neff31/storm.pdf.

Faced with a larger gap for SFY 2004, some $3 billion, the state cut spending by larger amounts, stopped spending down reserves, and relied less on revenue increases. New Governor Romney's adamant opposition to taxes seems to have been influential and was largely accepted by the legislature, even though some leading Democrats had called for significant tax increases. Some revenue increases were passed: over $100 million in corporate tax "loophole closing," some $400 million in higher fees, and about $350 million in one-time shifts--plus new Medicaid maximizations. A smaller than usual amount of inter-fund transfers occurred; but there was no new borrowing, pension recapitalization, or securitizing of tobacco revenues--which the administration disdained as "fiscal gimmicks."

On the spending side, the budget sharply cut local aid and slowed Medicaid growth. Romney successfully argued that localities' finances were stronger than the state's and that Medicaid and other services had grown beyond "real need."[8] Local aid was cut by $230 million, almost 5 percent. Cuts to higher education were even greater, continuing its slide since 2001. Medicaid cutbacks totaled about $500 million below the preexisting trend, but spending was still budgeted to rise about $500 million (9 percent). Many cuts affected the much smaller public health programs, such as the tobacco control program. Other than Medicaid only K-12 education and debt service rose. Everything else was cut, so that the total SFY 2004 budget increase was only about 1 percent above adjusted SFY 2003 spending.

The SFY 2004 budget also accepted many of Governor Romney's proposals to reorganize health care administration to achieve administrative efficiencies. In the face of legislative resistance, a pension reform proposal was quickly withdrawn. In general, the legislature gave health care somewhat

---

[7] Nicholas W. Jenny, *2002 Tax and Budget Review and 2003 Budget Preview* (Nelson A. Rockefeller Institute of Government, Fiscal Studies Program, March 2003, State Fiscal Brief No. 66). http://stateandlocalgateway.rockinst.org/fiscal_pub/state_fb/FB_66.pdf.

8 Governor's Message & Executive Summary, February 26, 2003, http://www.mass.gov/budget/downloads/. The Message continues "for every three taxpayers, there is one person getting free health care. This is not fair, and it's not right." The

higher priority than the governor; being able to tap some of the federal fiscal relief helped, although the governor succeeded in saving most of the funds (grant and temporarily enhanced-FMAP alike) in trust for the future. The governor vetoed about $200 million of largely non-health-care spending, but three quarters of this was overridden. Since the budget was approved, there has been further sparring over supplemental revenue and spending bills, with mixed results.

## Specific Impacts on Health Care

*MassHealth*

MassHealth (including traditional Medicaid and SCHIP) was largely protected from cutbacks through the SFY 2003 budget, and Medicaid appropriations grew about 8 percent that year, well above the 2.1 percent overall rise. Significant cuts began in mid-year SFY 2003. The final SFY 2004 budget made many more and much larger cuts. The immediate cuts were less than initially proposed by the incoming governor and feared by advocates; the broad sweep of MassHealth remains; and Medicaid spending still grew by 9 percent. However, a shift toward contraction has begun, which the governor has clearly articulated. The governor won legislative acceptance for almost all the cutbacks sought in spring 2003, fully 61 separate changes affecting most parts of Medicaid, saving $553 million.[9] In general, cuts targeted adults much more than children.

Provider payment had the biggest cuts in mid-SFY 2003, affecting hospitals, nursing homes, physicians, CHCs, druggists, and MCOs. The cuts averaged 3-5 percent, varying by provider and by service. Because they took toward the end of SFY 2003, the full cuts were felt only for SFY 2004 and beyond. For nursing homes, the initial cuts were more than offset by a complex bundle of rate in-

---

Executive Summary notes that local property taxes grew by 6.4 percent in 2002, while state tax collections declined by 14.6 percent.

[9] MassHealth Overview, March 2003, Douglas Brown, Acting Commissioner, Division of Medical Assistance http://www.bcbsmafoundation.org/foundationroot/en_US/documents/massHealthoverview.pdf. (PowerPoint presentation).

creases funded through a new assessment on homes, plus the additional federal matching amounts drawn down by the higher payment rate for homes. The administration sought to economize in 2004 by phasing in increases, but the legislature barred any administrative reallocation of such savings and also required that the administration pay out the full appropriated amount during the year, thus barring any mid-year administrative reductions. Pharmaceutical rates were initially set to decline from "wholesale acquisition cost" (WAC) plus 10 percent to WAC minus 2 percent. But at a legislatively required hearing, participating pharmacies all threatened to quit, and compromised at WAC +6 percent, along with changes in dispensing fees that favored generics.

*Benefits* cutbacks started with the dropping of adult dental services in SFY 2002. Five more optional services were cut in the first half of SFY 2003, including prosthetics, orthotics, and eyeglasses, but some were reinstated for SFY 2004. The state later somewhat raised drug co-payments, required some ancillary therapies to get prior authorization, expanded the state drug list to promote generics, enrolled some high cost members in care management, and made other small reductions, some of which arguably maintained or improved overall quality of care. One change believed to be an improvement is a Senior Care Options plan that coordinates care for dual eligibles, now being phased in almost on a demonstration basis.

*Eligibility* cutbacks took many forms. Two eligibility categories were cut. Long-term unemployed adults--a special Massachusetts category, about 50,000 people--were dropped in April 2003, though some re-enrolled as disabled. For SFY 2004, most of these were re-enrolled in a similar new program that began operations in October 2003, MassHealth Essential. However, Essential has a lower income eligibility ceiling and fewer benefits, its funding is capped, and it is authorized only for SFY 2004. Also cut in SFY 2004 were special status immigrant adults--legal residents not eligible for federal match after welfare reform, except for emergency services, which continued to be covered for

most of the prior reform enrollees. Caps on enrollment and new waiting lists have changed some parts of Medicaid to a non-entitlement program more like SCHIP. Caps have been promulgated so far to Essential (above) and to two smaller MassHealth programs, but implementation awaits federal approval.[10] Cuts in eligibility standards of various magnitude were also passed for SFY 2004, including a reinstatement of eligibility asset tests for adults 19 to 65, changes to asset transfer rules; and a lower income eligibility level for HIV-waiver enrollees. Some of these changes are also pending federal waiver approval. Changes in processes of eligibility determination also occurred, premiums and cost sharing were sought to the extent allowed by federal law and outreach was reduced.

*New revenues* for MassHealth were sought from several sources other than traditional state taxes. One source was Medicaid maximization. The state sought to tap new sources of revenues to support MassHealth and thus draw down more federal support. Most notable was the new assessment on nursing home days for non-Medicare patients, noted above. The governor also proposed a new assessment on health insurers to help fund MassHealth in SFY 2004, but this was withdrawn during budget discussions. Starting in SFY 2003, a new "user fee" of $1.30 was legislated on all pharmaceutical prescriptions, but was ultimately abandoned after very strong industry resistance and an adverse judicial ruling. Lesser revenue increases came from some rises in premiums and co-payments, as well as from expanded recoveries against the estates of Medicaid beneficiaries.

*Prescription Advantage and the Uncompensated Care Pool*

These programs are two of the ways in which Massachusetts stands out as more generous than other states. Governor Romney initially sought to de-fund Prescription Advantage, a very generous drug program mainly for elderly and for disabled persons; but the final budget maintained it, with trims. De-funding seems to have been requested more to pressure federal officials to approve a Phar-

[10] Also affected are Family Assistance for HIV expansion members and working adults in small firms and CommonHealth for adults.

macy Plus waiver (unsuccessfully) than to pressure the legislature to stop spending. The program was maintained, but its enrollment period was limited to once a year. The final budget for SFY 2004 also boosted support for the Uncompensated Care Pool that provides free or reduced-fee charity care in hospitals and community clinics and also covers emergency bad debt. The Pool is not an entitlement program, and it has long been mainly funded by assessments on hospitals and health plans. The state's funds from traditional revenues are more than offset by the large annual federal DSH contribution drawn down by the Pool (payments for disproportionate share hospital programs). Because charity demand and costs rise over time while Pool budgets are fixed, financing had to be reformed in 1997 (with assistance from the MassHealth waiver), and another refinancing occurred for SFY 2004. The legislature was more generous than the initial administration proposal, partly because of the new availability of federal fiscal relief and new revenues from intergovernmental transfers from two localities where hospitals receive large amounts of Pool funding. The IGTs were used to raise hospital Medicaid rates and thus draw down open-ended federal match in addition to the capped DSH contribution. A new reform commission was also created and directed to find a more permanent solution. It is expected to control Pool payments to hospitals and to shift Community Health Centers' current payments from the Pool into higher MassHealth rates, so as to get open-ended federal match.

*Employee Benefits and Reorganization of Health Care Administration*

The SFY 2004 budget somewhat changed employee health benefits, but less than the governor's proposal to provide only level funding for employee health benefits and give group-benefit administrators new discretion over benefits. The final budget, however, merely increased the contribution that state employees make to their health care costs from the previous 15 percent to a sliding scale depending on the employee's salary. The legislature also largely accepted Governor Romney's reorganization of health agencies, which altered traditional stand-alone administration of what the Secretary terms "mission agencies" (like public health and mental health), merging provision of services

with the associated aspects of Medicaid. Four new offices were created involving 15 agencies, and the central Secretariat was strengthened. The reorganization plausibly will help streamline operations, assure that full FMAP support is sought for mission-agency services, and allow the administration to speak with one voice. In the 1990s a similar proposal would have brought the Department of Health within a Medicaid-oriented structure, and health advocates helped defeat it in part to maintain a separate voice for health.[11]

**The Future**

The long Massachusetts expansion in public coverage may well be ending, given ongoing budgetary stringency and a shift in the political climate. The budget crisis is arguably the precipitating event, as it helped elect Governor Romney and constrained legislative preferences. MassHealth caseload declined about 7 percent during SFY 2003, even before significant change occurred in eligibility standards--whereas rises are expected in a recession. Enrollment still exceeds 900,000, well above the pre-expansion level.

Budgetary pressure will continue for the immediate future. Revenue collections during SFY 2004 are running slightly ahead of budgetary assumptions, but still well below prior trends, while health spending continues to grow.[12] Such divergence seems unsustainable, as health care already constitutes about a third of the budget, counting MassHealth, Prescription Advantage, the Uncompensated Care Pool, and employee health benefits. Early projections forecast a SFY 2005 deficit of about $2 billion, driven by low revenue growth and high spending increases for health care,

---

[11] See John Holahan, Randall Bovbjerg, Allison Evans, Joshua Wiener, and Susan Flanagan, *Health Policy for Low-Income People in Massachusetts* (Washington, DC: Urban Institute/Assessing the New Federalism, November 1997). http://www.urban.org/UploadedPDF/Hp_mass.pdf.

[12] Massachusetts Department of Revenue, *Briefing Book*, FY2005 Consensus Revenue Estimate Hearing, December 8, 2003. http://www.mass.gov/eoaf/FY2005_ConsensusRevenueEstimateHearing.pdf.

pensions, and debt service (up some $1.6 billion). Accumulated debt is very high, and the bond rating remains middling.

Many continue to support expansion of coverage. But support for contraction has grown substantially, on grounds of ideology as well as immediate budgetary stringency. The administration has articulated the need to limit the share of population that can expect public help and has called for more sharing of responsibility by individuals. For health coverage, this has meant capping some enrollments, higher premiums and co-payments, and executive reorganization to support fiscal restraint and more centralized control. The legislature for SFY 2004 accepted budgetary constraint; it also approved the reorganization--very unlike the mid-1990s rejection of then-Governor William Weld's similar proposal.

For these reasons, SFY 2005 looks like a difficult year for Medicaid in Massachusetts.

**MICHIGAN**
**John Holahan**

## Background

Michigan is a large, industrial, heavily unionized state that has historically provided a generous array of health, education and social services. By national standards, the poverty rate is relatively low. The rate of employer-sponsored insurance is well above average, contributing to a low uninsurance rate. In 2002, only 7.7 percent of the state's children and 14.4 percent of adults were uninsured compared with roughly 12.1 percent and 19.1 percent of children and adults in the nation.[1] In November of 2002, Jennifer Granholm, a Democrat, was elected governor, replacing John Engler, a Republican, who had been in office for 12 years. During the Engler administration, Michigan benefited from the strong national economy and enacted several important policy initiatives including expanding the Medicaid program, implementing the State Children's Health Insurance Program (SCHIP), allocating substantial revenues to the state's budget stabilization fund and cutting personal and business taxes.[2]

There are several key fiscal and budgetary constraints that affect policymaking in Michigan. First, much of state revenue is earmarked for specific spending purposes. A separate trust fund is established for education. The state finances the vast majority of K-12 education, recently replacing much of local funding in an effort to equalize spending across geographic areas. Further, Michigan's constitution specifies percentages of the state sales, income and state property tax revenues to be allocated to education. There are

---

[1] Urban Institute tabulation from the 202002 and 202003 Current Population Surveys.
[2] Joshua Weiner 2003. "Michigan." In *The State Fiscal Crises and Medicaid: Will Health Programs Be Major Budget Targets?* Edited by John Holahan et al. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Washington, D.C.

also dedicated taxes and a separate trust fund for transportation. The general fund which finances the state share of Medicaid is actually relatively small: Of a total fund budget of $38.6 billion in fiscal year 2002-2003, the general fund was only $8.9 billion.[3]

Second, the state has long been reliant on the fortunes of the auto industry, although the state has made efforts to diversify its economy. As a result, the state felt the effects of the current recession relatively early. Efforts by the auto industry to offer zero percent interest rate financing softened the effects of the recession on employment and state tax revenues. However, unemployment in Michigan did increase sharply because of layoffs from auto manufacturers and Northwest Airlines. In October 2003, Michigan's unemployment rate was 7.6 percent, the highest in the nation.[4] The economic decline affected state budgets in fiscal 2002 and 2003 and continues to do so.

Third, the state's fiscal difficulties have been exacerbated by the reductions in personal income and business taxes that were cut by Governor Engler in 1999 and phased in over time. For example, in 1999, Michigan enacted tax changes that reduced the single business tax (SBT) by one-tenth percentage point per year over the next 23 years. Further, the personal income tax rate was to be reduced from 4.4 percent to 3.9 percent over five years (1999-2003).

**2002-2003 Budget Solutions**

Michigan faced a budget gap in the general fund of over $1 billion entering fiscal year 2002. This was followed by the need to pass two supplementary appropriations during the course of fiscal year 2002 of $462 million and $350 million respectively. The

---

[3] Michigan: Greatness Through Challenge, Fiscal Year 2004 Executive Budget, March 6, 2003.
[4] Bureau of Labor Statistics, "Local Area Unemployment Statistics," http://www.bls.gov/lau/home.

budget gap in fiscal year 2003 was also $1 billion. These budget gaps have been addressed through a broad variety of mechanisms. Some policies which helped solve problems in earlier years now affect the Granholm administration's ability to address the fiscal year 2004 budget gap (discussed below).

To address these problems (fiscal year 2002-2003) the state moved trust fund surpluses into the general fund, postponed capital outlays, and reduced local revenue sharing. It made substantial reductions in allocations to state agency budgets, including $112 million in the Department of Community Health which is responsible for Medicaid. Michigan also used much of its budget stabilization fund and some of its tobacco settlement funds. It enacted provisions for early retirement which reduced the state workforce by almost 10 percent. The state continued to phase in income and business tax cuts, though in fiscal year 2003 it delayed the cut in the business tax and increased the cigarette tax by 50 cents.

Within the Medicaid program, provider reimbursement rates were frozen or cut by small amounts. There were no cuts in Medicaid eligibility except for an attempt to eliminate coverage for about 40,000 caretaker relatives in fiscal year 2003 (subsequently rescinded by the courts). The fiscal year 2003 budget had a proposal to extend coverage through a Health Insurance Flexibility and Accountability Waiver (HIFA) to parents of Medicaid children and childless adults up to 100 percent of the federal poverty line. However, the waiver initiative was "withdrawn" by the state as state revenues deteriorated. The state enacted a preferred drug list, whereby only drug companies that agreed to provide supplemental rebates would be listed in the formulary. Other drugs would be available only through prior authorization. While establishing the preferred

drug list in 2002 to reduce spending, the state also implemented a new drug program for low-income elders (the Elder Prescription Insurance Coverage program). Finally, the state capped enrollment in home and community-based waiver programs, such that the number of enrollees was lower in fiscal 2003 than it had been in fiscal year 2001.

A potentially significant policy, in terms of its long term impact, was the use of funds from the Medicaid Trust Benefit Fund (MTBF) in both fiscal year 2002 and fiscal year 2003. For many years, Michigan has been reliant on disproportionate share payments and upper payment limit programs to bring in federal dollars to support payments to providers. Federal matching payments for these "special financing" programs increased throughout the 1990's, exceeding $1.7 billion in fiscal year 2002.[5] The state recognized that the federal government would phase out the ability to use these mechanisms, so special financing funds that exceeded state appropriations to these providers were placed in the MTBF. The original intent behind the MTBF was to allow the state to ease the transition into the period in which DSH and UPL payments would be substantially lower. The reduction in federal funds through these vehicles will present a serious challenge to the state. But with the severe budget pressures that the state faced in 2002 and 2003, the state drew down a considerable amount of money from the MTBF. The balance in the MTBF in fiscal year 01 was $421 million; after withdrawals in fiscal year 2002 and fiscal year 2003 it dropped to $44 million.[6]

In fiscal year 2003 the state imposed quality assessment fees on hospitals, nursing homes and HMOs. This allowed the state to increase reimbursement rates and collect federal matching payments. The rate increases were fairly substantial but how providers

---

[5] Paul Reinhart, "Michigan's Medicaid Fiscal Challenge," State Budget Office, November 21, 2002.
[6] Ibid.

fared depends both on the tax rate and the importance of Medicaid to their revenues. Those providers that have a high share of Medicaid enrollees would experience increased reimbursement rates that would more than offset the tax (fee) increase. Those with small shares of Medicaid patients would be net tax (fee) payers. The tax allowed the state to increase payment rates to Medicaid providers without using state funds. In fiscal year 2003 there were no provider rate increases other than those made possible by the quality assessment fee. In many other Medicaid services there have been no rate increases since the early 1990s.

The state also developed a second HIFA section 1115 waiver which was scheduled for implementation on October 1, 2003, subject to federal approval.[7] This has remained a high priority of the Granholm administration and figured prominently in its estimates of fiscal year 2004 budget savings (discussed below). The HIFA proposal called for expanding coverage for childless adults to 35 percent of the federal poverty line. The state share would be financed with local funds and with state mental health and substance abuse funds. The federal share would be from the state's unspent federal SCHIP allotment. Since the expansion population currently receives a limited set of benefits under an existing state program, the state would save by no longer paying for these services. State savings through the waiver were estimated to be $40 million. The state would, in essence, obtain federal matching funds at the higher SCHIP rate for a population that already had some state-funded coverage on an ad hoc basis. The waiver program would provide a larger set of benefits than the state program it replaced and create an entitlement to services, e.g., mental health and substance abuse services, drugs,

[7] Application for Health Insurance Flexibility and Accountability Section 1115 Demonstration Project. April 3, 2003.

ambulatory care and inpatient hospital care (which would be limited to $900 per admission).

Michigan was given assurances that the waiver would be approved and proceeded to implement the program on October 1, 2003. The waiver may not be approved by Secretary Thompson of the Department of Health and Human Services in January 16, 2004, and thus the state will not receive federal matching funds prior to that date, i.e., the expansion was funded for 3.5 months with state funds[8]. A second phase of the waiver which would require an amendment to the initial waiver application would reduce benefits and charge new co-payments for all currently eligible parents (other than pregnant women), including medically needy, those on transitional medical assistance and non-disabled 19 and 20 year olds. The benefit reductions would include dental, vision, hearing, and physical and occupational therapies. This second phase of the waiver is on hold until the approval of the initial waiver request.

**The 2003-2004 Budget Debate**

When Governor Granholm took office in January of fiscal year 2003, she was faced with an unanticipated mid session shortfall in the fiscal year 2003 state general fund budget of $158.3 million. This was addressed in part by a $26.9 million cut in the Family Independence Agency (largely TANF and child support services), a $25.5 million cut in payments to state universities and a $16.9 million cut in the Department of Community Health.[9]

---

[8] "HHS Approved Michigan Request to Expand Coverage to Uninsured Adults," CMS Press Release, January 16, 2004.
[9] "Details of Budget Cutting Executive Order", Associated Press, February 19, 2003.

The larger problem facing the new governor was the $1.6 billion general fund gap projected for fiscal year 2004. This gap resulted from $966 million in spending increases and $601 million in lower than expected revenues. More than half of the added spending was attributed to increased Medicaid enrollment and rising health care costs, higher spending on prison populations, increases in state employee salaries and benefits and debt service.

Most of the $1.6 billion gap was eliminated with $423 million in revenue increases and $937 million of spending reductions, with the remainder made up by trust fund transfers. The former consisted of $19 million from closing tax loopholes and $110 million in assessments on bad drivers and eliminations of tax breaks for owners with second homes. There was also $152 million increase in sales tax revenues and the remainder of the revenue came from various fee increases.[10]

The $937 million in spending reductions came through an assumed $110 million in savings through the implementation of the second phase of the proposed Medicaid waiver (unlikely to materialize given that Phase I was not approved until January 16, 2004) and $64 million in other Medicaid savings; a 6.5 percent cut in payments to higher educational institutions ($154 million); and a 3 percent cut in payments to local governments ($43 million). In addition to reducing payments to higher education institutions, the state cut payments for adult education from $77 million to $20 million. Finally, the budget called for $217 million in administrative cost savings to be achieved primarily through reductions in state workers' salaries and increases in health insurance premiums. In the latter case, the governor has threatened layoffs if the state workforce

[10] Michigan: Greatness Through Challenge, Fiscal Year 202004 Executive Budget, March 6, 202003.

did not agree to reductions in compensation. Thus far, state employees are opposing reductions in compensation.

By contrast, Governor Granholm made funding of K-12 education a high priority. She maintained per pupil payments to schools at $6,700 and allocated another $73 million for early childhood programs.[11] The state also retained $2,500 in college scholarships, substantially more than initially proposed by the governor.

The Medicaid program actually received a 1.7 percent increase, despite the cuts mentioned above. There were no reductions in eligibility standards; caseloads are still expected to increase because of the poor economy. The 2004 budget called for elimination of dental, podiatry and chiropractic benefits for adults. The governor also continued the use of the quality assurance assessment program. It is anticipated that the tax will generate about $57 million in revenue thereby allowing the state to increase or maintain payment rates to HMOs, hospitals, nursing homes, and pharmacies. (The assessment on pharmacists and associated payment increase seems unlikely to be implemented because of opposition from pharmacists). All other provider reimbursement rates were increased slightly or frozen.

The state also expects to save $40 million through extending its preferred drug program to other states.[12] Thus far, three states, Vermont, Wisconsin and South Carolina, have agreed to join with Michigan in an effort to obtain reduced drug prices from pharmaceutical manufacturers. All approved pharmaceutical products will remain available to Medicaid enrollees, but only those companies who agree to reduce prices will

---

[11] Office of the State Budget, Executive Budget, March 6, 2003.

[12] "Michigan: Greatness Through Challenge, Fiscal 2004 Executive Budget," State of Michigan, Office of the State Budget, March 6, 2003.

be on the preferred list. Subsequent to the agreement, South Carolina was unable to obtain CMS approval.

The Governor's budget also would expand the state's estate recovery efforts, that is, collecting for nursing home costs from the estate after a nursing home resident's death. This measure is expected to yield $29 million in savings. Michigan is one of the few states that has not aggressively pursued estate recoveries; opposition is strong and the measure may not be implemented.

Several other provisions actually increase spending. For example, the state expanded the elder prescription insurance coverage (EPIC) program from $30 million to $68 million increasing the number of low income seniors that can obtain low cost prescription drugs from 15,000 to 42,000. The 2004 budget also allocated an additional $50 million to the Detroit Medical Center through a Medicaid DSH payment. The home and community based waiver program that had been capped was reopened, accepting new enrollees. The budget also included an increase of $18.3 million in new general fund resources for the Medicaid mental health program. This represented an increase of about 2 percent over the previous year to $2.2 billion.

The $665 million of federal fiscal relief from the Tax Relief and Reconciliation Act of 2004 contributed greatly to solving the state's fiscal 2004 budget problems.[13] It allowed the state to balance its budget without further cuts or any tax increases. It also allowed the governor to allocate $200 million to rainy day funds, including $50 million to the MBTF. In a separate action, the governor also restructured the way tobacco settlement funds are distributed, increasing the share allocated to health care from 25

---

[13]"Budget Boosts Granholm's Status," *Detroit Free Press*, July 17, 2003.

percent to 66 percent of the total annual allocation. This helped reduce the need to cut health care spending.

## The Future

These solutions to the fiscal year 2004 budget crisis seem to be unraveling. Recent projections indicate that state revenues will be lower than anticipated. The delay in receiving approval from the federal government for the state's HIFA waiver will reduce the savings that the state had anticipated from shifting its state funded programs into Medicaid and from reducing benefits and increasing cost sharing for current beneficiaries. There is also opposition to implementing the estate recovery proposal. The state has little room to proceed further with benefit reductions. Likewise, the ability to reduce provider rates is constrained by agreements entered into through the quality assurance assessment arrangements. Rates of payment to other providers have been cut or frozen for many years and there is little room to extract savings without further threats to access to care. Hospitals are under considerable stress as evidenced by the financial problems faced by the Detroit Medical Center.[14]

The picture will not improve in fiscal year 2005.[15] Health care costs are continuing to increase. Medicaid enrollment is also likely to continue to expand unless there is a dramatic turnaround in the state's economy. The state will also lose access to the revenues enhanced federal matching payments which phase out in July 2004. The Medicare drug benefit will allow some relief through its restoration of DSH funds. However, use of many of the other special financing arrangements is being phased out.

---

[14] "Burden from Uninsured People is Heaviest on DMC," *Detroit Free Press*, July 3, 2003.
[15] "State Medicaid Budget Outlook for '05 is Gloomy," *Detroit Free Press*, July 26, 2003.

In short, the options available for service cuts to the state are becoming increasingly limited.  At the same time there is strong opposition among Michigan residents to tax increases.

**NEW JERSEY**
Randall R. Bovbjerg

## Background

New Jersey is a high-income, high-tax state whose budgetary problems have become severe during the last three state fiscal years, 2002 through 2004. Politically, voter registration somewhat favors Democrats over Republicans, but independents constitute a majority. A grass-roots backlash against a Democratic governor's tax increase in 1990 gave Republicans control of both legislative and executive branches for the following decade, and numerous tax cuts ensued. Recessionary revenue shortfalls became apparent early in SFY 2002 and influenced the November 2001 elections (the state votes in "off" years). Democrats won the governorship, an Assembly majority, and a tie in the Senate. Fiscal prudence was a major campaign theme for new governor Jim McGreevey. In 2003's mid-term election, Democrats took full legislative control.

The state significantly expanded health programs in the late 1990s. This was affordable because state revenues rose rapidly despite repeated tax cuts, although borrowing also grew, notably to fill a gap in pension capital in 1997. Compared with other states, New Jersey traditionally covered only a moderate share of the state's uninsured,[1] but beginning in 1997 coverage was rapidly expanded to relatively high income levels for children, their parents, and uninsured adults, funded by a mix of Medicaid, SCHIP, and state-only funding.[2] Medicaid coverage as a percentage of population remained below the national average because of the state's high incomes, but above-average rates of employer-sponsored insurance kept the uninsurance rate below national norms.[3] Health programs have faced

---

1 Spillman, Brenda C. "Adults without Health Insurance: Do State Policies Matter?" Health Affairs 19(4):178-187 (Jul-Aug 2000). Note that this report does not cite to its interviews; for case study methods see overview chapter.

[2] By early 2001, New Jersey offered coverage to children with family incomes up to 350 percent of the poverty level, parents up to 200 percent, and childless adults up to 100 percent. Randall R. Bovbjerg and Frank C. Ullman, *Recent Changes in Health Policy for Low-Income People in New Jersey* (Washington, DC: Urban Institute/Assessing the New Federalism, State Update No. 21, March 2002). http://www.urban.org/UploadedPDF/310445.pdf.

[3] New Jersey state program covers 8 percent of its population of all ages, versus a national average of 11 percent (average of 2000 and 2001 for NJ). The uninsurance rate is 13 percent, below the national average of 15 percent because ESI is high, at 64 percent versus 58 percent nationally. Kaiser Family

budgetary pressure to cut back during SFYS 2002 through 2004, given historically high levels of projected deficits.

## The Budget Problem and Overall Responses

*Budget balancing prior to SFY 2004*

In January 2002, the new McGreevey administration projected large budget deficits both for SFY 2002 and for SFY 2003,[4] largely because revenues had declined from 2001 rather than increasing as expected. The mid-SFY 2002 gap of $2.8 billion was met largely from $1.7 billion in one-time shifts, along with cuts in administration and other programs. For SFY 2003, the governor's budget projected the deficit to grow to $5.3 billion, given pre-existing tax and spending projections, and projected shortfalls widened somewhat during the budget process. The SFY 2003 final budget filled this shortfall by raising revenues, inter-account shifts, and spending cuts. New revenues of about $2.9 billion included a boost in corporate taxes of about $1 billion, securitization of half of future tobacco settlement funds, a 70 cent per pack increase in cigarette taxes, and many increases in fees. Shifts among accounts and spending cuts or reductions in growth accounted for the remaining $2.4 billion: These included a shift of surplus unemployment insurance funds to the state's Hospital Charity Pool, zero increase in state aid to localities, a cut to higher education, and early retirements in the state workforce. Final state appropriations for SFY 2003 were $23.4 billion, barely 2 percent above the SFY 2002 initial appropriation.

Major health programs were largely spared from cuts in either budget--traditional Medicaid, state pharmaceutical coverage, and the Hospital Charity Pool (New Jersey is one of a handful of states

---

Foundation, *State Facts Online, New Jersey: Population Distribution by Insurance Status*, state data 2000-2001, U.S. 2001. http://www.statehealthfacts.kff.org.

[4] Randall R. Bovbjerg, "New Jersey," in *The State Fiscal Crisis and Medicaid: Will Health Programs Be Major Budget Targets? Overview and Case Studies*, prepared by John Holahan, Joshua M. Wiener, Randall R. Bovbjerg, Barbara A. Ormond and Stephen Zuckerman, 71-81 (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2003, pub. no. 4074). http://www.kff.org/medicaid/4074-index.cfm.

that help hospitals cope with charitable burdens). Indeed, among the SFY 2003 budget's "major increases and decreases" in appropriations, the largest single increase was $187.7 million for "Medicaid mandatory growth." Many marginal economies affected Medicaid, such as constrained increases in provider payment levels. But the only major cuts were focused on the late 1990s expansions in NJ FamilyCare for parents of uninsured children as well as other low-income adults (below). Despite the cuts, Medicaid appropriations were again slated to rise by over 5%--much more than the 2% rise for total state appropriations.

However, projections had worsened by mid-SFY 2003, suggesting a $1.3 billion deficit for the remainder of the fiscal year, about 5 percent of appropriations. Lagging revenues were the main cause, including a shortfall in state taxes of about $500 million, which worsened during the budget process to over $700 million. The state also failed to win federal approval for some $392 million in Medicaid maximization assumed in the year's budget. Higher than anticipated supplemental spending also occurred, including $60 million for court-mandated school aid, $50 million for post retirement medical costs, and $47 million for county solid waste debt service. Medicaid overspending was not a problem; indeed, it had a $35 million surplus for year's end.

Numerous stratagems helped fill the mid-year gap during SFY 2003, but Medicaid played little role. Many fixes were one-time measures. On the revenue side, the state accelerated some collections: Third-quarter estimated payments for large corporate taxpayers were shifted from September 2003 to June 2003, which put five payments into the FY 2003 budget. The state also tapped remaining funds of $413 million from its first tobacco securitization and $166 million from higher than expected revenues under a tax-amnesty initiative. On the spending side, payments totaling $361 million were postponed from late SFY 2003 into early SFY 2004 ($296 million for School Aid and $43 million for colleges and universities). After the changes, SFY 2003 ended in surplus. At least $100 million of surplus is

attributable to state funds, including higher than expected corporate taxes. Federal fiscal relief (below) was used for general budgetary purposes, for example, forestalling additional cuts to Medicaid or charity care.

*The SFY 2004 Budget Process*

Deficit Pressures and Overall Response In February 2003, the administration projected almost a $5 billion deficit for SFY 2004, beginning in July.[5] This amounted to 18 percent of projected state appropriations. Spending was estimated to rise some $3.6 billion to $27 billion because of Medicaid, debt payments, employee benefits for current and retired state and local workers, retiree pension-fund contributions, and need to increase state surplus. Revenues were projected to drop $1.4 billion from SFY 2003, partly because of the acceleration of 2004 collections into the year before. The new budget had to offset losses of $453 million in SFY 2003 one-time funding sources not available in 2004. Governor McGreevey blamed "national economic downturn, 10 years of [state Republicans'] fiscal irresponsibility, and a federal government that has turned its back on states."[6]

In response, for SFY 2004 the governor again proposed and the legislature enacted a slow-growth budget. Final state appropriations totaled $24.0 million, an increase of about 2.6 percent above SFY 2002 initial appropriations, about double the increase that had been proposed by the governor at the start of the process.[7] Deficit reduction was accomplished by a mix of revenue increases, spending cuts or reduced growth, and various shifts among accounts and other "temporizing measures," as at least one bond rating agency has called them, although the governor's budget termed them "special

[5] New Jersey Office of Management and Budget, Department of the Treasury, *NJ State Budget FY 2003 - 2004* (February 4, 2003), component documents. http://www.state.nj.us/treasury/omb/publications/04budget/index.shtml.

[6] *Governor's Message, State of New Jersey Budget, Fiscal Year 2003 -- 2004*, February 4, 2003, page i. http://www.state.nj.us/treasury/omb/publications/04budget/pdf/front.pdf.

[7] Office of Legislative Services, New Jersey Legislature, *Analysis of the New Jersey Fiscal Year 2003 - 2004 Budget; Final Budget Summary: Appropriation and Language Changes* (July 2003). http://www.njleg.state.nj.us/legislativepub/budget/finalchn04.pdf. Compare New Jersey Office of Management and Budget, *NJ State Budget FY 2003 - 2004*, above. The increase for SFY 2004 appropriations is 1.6 percent if compared with adjusted fiscal 2003 appropriations, because of mid-2003 supplemental appropriations. Budget Office, "Fiscal 2004 Appropriations" (Powerpoint file) http://www.state.nj.us/treasury/omb/publications/04veto/pdf/presentation.pdf.

revenue opportunities."[8] Overall, the legislature made modest changes to the governor's budget proposal, including some cuts in proposed taxes and fees sought by Republicans with an eye to November campaigning on tax issues and some restoration of proposed spending cuts championed by Democrats with a different electoral strategy. Many changes were negotiated in the final days and hours of the process.[9]

*Revenue increases* New Jersey taxes and fees were also increased for SFY 2004, but by less than for 2003, when corporate taxes alone were hiked by $1 billion. No increase was proposed or legislated in the "big three" taxes on incomes, sales, and corporations, despite opinion-poll support for a temporary surcharge on high earners and some Democratic support in the legislature. However, there were many smaller increases in taxes and fees, totaling nearly $600 million, notably on hotels and motels, realty transfers, cigarettes, and casino revenues. Anti-tax Senate Republicans won rejection or reduction of some $200 million in tax increases initially sought by the governor, including a new levy on telephones and part of the proposed realty-transfer fee. To reduce the governor's planned spending cuts, however, the legislature raised cigarette taxes by 55 cents a pack rather than the governor's 40 cents and imposed a new billboard tax. The cigarette increase came on top of last year's 70-cent rise and boosted the per-pack total to $2.05, highest in the nation.

For SFY 2004, as for the year before, the budget assumed successful new Medicaid maximization to increase receipt of federal funds. A small new nursing-home assessment (about $18 million) was designed to support a rise in Medicaid payment rates to enhance quality and also draw down additional federal matching dollars, starting at mid-year. Much larger were assumptions of federal authori-

---

[8] Business Editors, "Fitch Places State of New Jersey GOs & Appropriation Bonds on Rating Watch Negative," *Business Wire*, March 10, 2003 http://www.findarticles.com/cf_dls/m0EIN/2003_March_10/98575677/p1/article.jhtml; compare NJ Budget document Summaries of Revenues Expenditures and Fund Balances, February 4, 2003, p. C-4. http://www.state.nj.us/treasury/omb/publications/04budget/pdf/revexp.pdf.

[9] Information on legislative decisions comes heavily from press accounts, for example, Michael Symons, "Marathon Talks Produce a Deal on State Budget," *Cherry Hill Courier Post*, NJ, July 1, 2003; http://www.southjerseynews.com/issues/july/m070103f.htm. Michael Jennings, "Stalemate Ends as State Budget OK'd," *Trenton Times*, July 01, 2003; http://www.nj.com/search/index.ssf?/base/news-0/1057046795230491.xml?times?nxt. "The Budget Is Passed" [Editorial], *Trenton Times*, July 02, 2003; http://www.nj.com/search/index.ssf?/base/news-0/1057133101319530.xml?times?nex.

zation to continue intergovernmental transfers involving nursing homes, or other stimulus, along with a new Pharmacy Plus waiver to get federal matching revenues for two preexisting state-only pharmaceutical programs. The governor's budget in February assumed an increase in these federal funds totaling $630 million. Neither the IGT authority nor the pharmacy waiver was approved during SFY 2003 (which increased the mid-year deficit last year), and neither seems likely for 2004. Federal stimulus did arrive, enacted on May 28th and implemented on June 4th.[10] It supplied both grant funding and a one year's rise in the percentage rate of federal Medicaid match. New Jersey's estimated share is $561 million--$143 million in SFY 2003 and $418 million in fiscal 2004.[11]

*Spending cuts* Reductions in spending--or in anticipated growth--contributed at least as much to deficit reduction as did rises in revenues. The governor proposed numerous slowdowns or cuts in state programs, including some in health, totaling upwards of $2 billion in ongoing economies, but many were reduced or eliminated during the legislative budget process. Constituencies from arts groups to health advocates seemed pleased with the aftermath of their lobbying. Notable among final cuts or deficit reduction were essentially level funding in school and other local aid programs (perhaps $500 million in deficit reduction below previously projected growth)[12]; about $226 million from new limits on NJ SAVER (property taxpayer relief, cut even more than the governor had proposed); and about $50 million in reductions to higher education (about half the initial proposal). Employee health benefits were slightly trimmed for new hires. Moreover, the governor plans to cut direct state operations by about 4%, with some 1000 employees expected to depart via attrition. The governor also pro-

---

[10] The legislation was the Jobs and Growth Tax Relief Reconciliation Act of 2003, Public Law No. 108–27, 117 US Statutes at Large 752, May 28, 2003. Implementation occurred in early June. See letter of U.S. Secretary of the Treasury John W. Snow to state governors, June 4, 2003. http://www.ustreas.gov/press/releases/reports/stateletter.pdf. Exactly how much FMAP a state gets depends of course upon how much it spends in state and local funds.

[11] In New Jersey, increased federal revenues may be described as cut in state spending rather than a revenue increase, as federal funds are separately budgeted and may supplant other state appropriations.

12 Combining numerous categories of aid to help localities or their ratepayers shows that fiscal 2004 appropriations rose about 2 percent above adjusted 2003 appropriations, see "Funding for Property Tax Relief," slide no. 5 in Budget Office, "Fiscal 2004 Appropriations," above. The governor's budget projected $512 million in deficit reduction from reduced growth in school aid alone, NJ Budget Office, Summaries of Appropriations, above, page B-5.

posed cuts of $99 million in state pharmaceutical spending and $76 million for FamilyCare adult enrollees, both also moderated by the legislature (see below).

One significant economy in state spending did not reduce the deficit. In early calendar 2003, the McGreevey Administration had its first chance to negotiate contracts with unionized state employees, and won agreement that no cost-of-living wage increases would occur in SFY 2004. This slowdown from past trends was anticipated, so it was not counted as deficit reduction--but it did hold down spending growth. No dollar savings estimate is readily available.

*Temporizing measures* Again for fiscal 2004, a number of temporizing stratagems helped fill the budget gap. A second securitization of remaining future tobacco-settlement revenues generated about $1.6 billion of revenues for SFY 2004, which cannot be repeated next year.[13] A large pension contribution was due for SFY 2004 for the first time since former governor Whitman floated bonds to refinance pension obligations in 1997, but the governor and legislature agreed to stretch out the contribution over 5 years, thus postponing about $600 million from the current year. Fund balance transfers also continued, including $325 million from Unemployment Insurance to the Hospital Charity Pool, along with $220 million in shifts from a number of other funds.[14] Aid to public schools and higher education seems also to have "suffered a de facto cut of one-twelfth" by the postponement of a June payment into July.[15]

## Medicaid and SCHIP

For fiscal 2004, traditional Medicaid--as distinct from the recent expansions--was largely protected from the level of cuts felt elsewhere, both in the governor's budget and in final appropriations. As for

[13] The governor's budget proposed to appropriate only $250 million in SFY 2004; it is unclear from this report's research into which accounts all the money is allocated.

[14] Inter-fund shifts may be able to continue year after year if the fund being tapped for other purposes generates more ongoing revenues than needed for its basic purpose. This has occurred in New Jersey with the tapping of unemployment insurance funds to cover expenses of the hospital charity pool.

the year before, the largest of the 2004 budget's listing of "major increases and decreases" was $216 million for Medicaid and General Assistance health care growth.16 The governor and legislature agreed that growth needed to be slowed slightly, but large-scale changes were avoided. The final budget allowed more growth than the governor's budget had contemplated in February. Given the new availability of federal fiscal relief funds via grants and enhanced federal Medicaid match, the governor agreed during budget season to scale back some cuts, and the legislature rejected or reduced several others.

Eligibility cuts were a major gubernatorial proposal, with some 60,000 adults to be dropped from FamilyCare coverage by reducing the income limit to 133% of FPL and dropping immigrants, saving $76 million (a majority in unmatched state support for such enrollees). Eligibility standards for SCHIP-funded children in FamilyCare were not affected, remaining at a high 350% of FPL. Enrollment of adults in the program had far outpaced initial authorizations, was frozen in June 2002 and childless adults were moved back into less generous General Assistance coverage. The final SFY 2004 budget rejected outright cuts, but it maintained the freeze on adult enrollment and allowed attrition to continue to reduce enrollment. As of early November 2003, adult enrollment was about 146,000, dropping somewhat more slowly than expected toward the target of 125,000. The legislature made up for the $76 million in savings proposed by trimming benefits instead, also allowing higher spending than proposed, though still $45 million less than in 2003.

The main benefit-related proposal was to eliminate dental and chiropractic services for non-pregnant adults; this $15 million cut was rejected. Also rejected was a proposal to impose a co-payment on non-emergency outpatient hospital services, worth almost $2 million.

Provider payment changes were also proposed. A freeze on hospital outpatient rates was en-

---

[15] *Trenton Times* Editorial, July 2, 2003, above.

acted, saving $24 million in state appropriations. Physician fees were unchanged; a zero rate increase is the norm for New Jersey fee-for-service Medicaid. The regular fee-for-service inpatient hospital payment update was allowed to proceed unchanged, providing its standard annual increase by the "TEFRA" economic-index. MCO rates were also unaffected, increasing by 8.5%, although some FamilyCare coverage was removed from capitation into an ASO-like arrangement, with slight budgetary impact. The governor sought to reduce growth state spending on nursing homes by not "re-basing" the rate-making methodology and by starting mid-year to impose a new assessment on beds to pay for care, drawing down new federal funds to offset state appropriations, together achieving $34 million in savings. The legislature increased the state savings to $51 million, but relied entirely on new federal funds to do so (by imposing the new assessment earlier in the year). The state awaits federal approval, hoped to be retroactive.

Proposed and enacted changes in pharmaceutical spending were substantial for the first time in New Jersey. Both for Medicaid and for the state-only pharmaceutical programs for the elderly and disabled, the governor sought mandatory generic substitution, an increase in the discount below average wholesale price (from AWP minus 10 percent to minus 15), a preferred drug list (only for 6 months of fiscal 2004), prescription drug co-payments, and a voluntary mail order program--totaling $65 million in state savings, according to Medicaid staff. Mandatory generic substitution and AWP less 12.5% were enacted, but the other cuts were reduced or rejected.

The legislature also made small additional changes, adding $10 million in new spending for federally qualified community health centers in recognition of increased demand by the uninsured, and calling for about $13 million in new savings not proposed by the governor, through long term care drug recycling, disease management, and a generic rebate program. (Similar reforms achieved bigger

---

[16] NJ Budget Office, *Summaries of Appropriations, SFY 2004*, above, page B-41. http://www.state.nj.us/treasury/omb/publications/04budget/pdf/summaries.pdf.

savings in the state pharmaceutical programs.)

An unusual non-Medicaid increase helped Human Services' Division of Youth and Family Services. The governor requested increases to upgrade computer systems to track youth and parents as well as higher state staffing. Still larger increases were enacted, presumably influenced by news accounts of horrible abuse and starvation of children. The total increase, however, was only $30 million. The state is moving toward better integration of youth and Medicaid services, to improve quality and efficiency; children under medical care should be better monitored.

In part the modest legislative changes to the governor's proposals reflect differing philosophies and responsiveness to constituents. In part they also reflect new circumstances, notably the arrival of new federal stimulus after the budget was originally proposed.

**The Future**

Budget deficits began running at about 10% each year in New Jersey, starting in mid-SFY 2002. One year ago, despite hard times, the state had successfully continued its relatively generous support for health care, even beyond conventional Medicaid. But it seemed then that policymakers had exhausted one-time fixes and the state's unusual political willingness to raise taxes other than income and sales. Accordingly, serious cuts in Medicaid and other health programs were expected to begin in SFY 2004. However, this year's budget looks much the same: Again, New Jersey proved unusually willing to raise fees and taxes, although not the big three on incomes, sales, and corporations. Temporary federal stimulus support also boosted revenues. There were significant cuts in much spending, including in some public health programs. Changes in traditional Medicaid, the hospital charity care pool, and the state's elderly-and-disabled pharmaceutical benefits seem relatively small. Health care advocates appear to have been gratified that cutbacks were much smaller than expected, though one

outside observer commented that a number of changes were occurring “below the radar.” Overall, growth in health benefits spending continues to outpace growth in revenues.

The Democratic governor’s cutbacks and fiscal gymnastics have not made him popular, as shown by low ratings in opinion polls. At the election polls in November, however, counterattacking Republicans suffered unusual off-year setbacks. Republicans lost control of the Senate that they had shared since 2001, and fell further into minority in the Assembly. Bond raters ratified the SFY 2004 budget deals by holding the state’s rating steady in July, although some maintained a rating watch on the state.

SFY 2005 budget pressure also looks to be severe. Many gap-filling mechanisms to date have been temporary, the state’s reserves are only 1.5 percent of state appropriations, federal fiscal stimulus is scheduled to expire, and some SFY 2004 expectations may prove unrealistic. Most clearly, the anticipated ongoing federal support for intergovernmental transfers and new pharmaceutical-program matching has yet to be realized. However, four months into SFY 2004, most other revenue sources were growing slightly faster than expected, according to the state’s Office of Legislative Services, and support was growing for increasing the state’s gasoline tax after the election.[17] Continued growth in Medicaid may still be difficult to sustain. Interviewees were not at liberty to discuss specific potential cuts to Medicaid, but it is acknowledged that “everything is on the table” at this point.

[17] OLS Revenue Snapshot, FY 2004 - Through November 2003; http://www.njleg.state.nj.us/legislativepub/budget/novsnap04.pdf. Michael Symons, “N.J. Gasoline Tax Increase Called Likely; Governor quickly Rejects 15 Cent per Gallon Hike,” Courier-Post online (Cherry Hill), November 11, 2003; http://www.southjerseynews.com/issues/november/m111103e.htm.

## New York
## Terri Coughlin

### Background

Prior to the September 11, 2001 terrorist attacks, New York's financial situation was better than had been for quite a while. Since 1995, when Republican Governor George Pataki began his first term, the state had enjoyed strong revenue collections, especially in the late 1990s when personal income tax receipts grew by double digits.[1] During this same period, New York implemented a multi-year tax reduction plan. While cutting taxes, New York also managed to build its "rainy day" reserve fund and produce budget surpluses.

Also beginning in the mid-1990s New York undertook several major health program initiatives, building on the state's long-standing history of funding a comprehensive health care system for its low-income population. Some of the more important initiatives were the expansion of the Child Health Plus program as part of the federal State Children Health Insurance Program (SCHIP) and the establishment of the Family Health Plus Program that provides Medicaid coverage to nearly 700,000 low-income parents and childless adults.

Reflecting its large network of public health programs, in 2002 New York's Medicaid program covered about 30 percent of children and 10 percent of adults in the state; by comparison, national Medicaid coverage rates for children and adults were 23 and 6.7 percent, respectively.[2] Importantly, despite having comparatively high public insurance coverage rates, the share of adults lacking insurance in New York was higher than the national average in 2002

[1] Fiscal Policy Institute. 2003. "Balancing New York State's 2003-2004 Budget in an Economically Sensible Manner." Latham, New York, February.
[2] Urban Institute tabulations from the 2002 and 2003 Current Population Surveys.

(21 percent versus 19 percent), owing to lower rates of employer-sponsored insurance for adults in the state.[3]

Like many other states, beginning in late 2001 New York's economic picture began to dim owing to the emerging national recession and the World Trade Center attacks. Within a short period, state tax revenue declined dramatically. A particular issue for New York was the drop in the net amount of capital gains on personal income tax returns, which went from $62 billion to $28 billion between 2000 and 2001. At the start of the state fiscal year 2002-03, which began in May 2002, New York faced a budget deficit of $6.8 billion, accounting for about 17 percent of the state's $40 billion general fund budget.

**Fiscal Year 2002-03**

Despite facing a bleak financial situation, New York's 2002-03 budget debate was described by study interviewees as relatively painless with limited policy action. Governor Pataki and leading state legislators negotiated a budget that used a broad array of revenue measures--rather than service cuts--to close the state's $6.8 billion general fund. The overall strategy to fill the budget gap was to rely on the state's reserve funds, borrowing and one-time revenue actions. These additional revenues enabled New York policymakers to avoid making deep cuts to services.

While Governor Pataki and legislative leaders expressed satisfaction with the enacted budget, others were critical charging that it relied too heavily on one-shot revenues and borrowing, and did not squarely deal with the state's structural budget problems.[4] Many

---

[3] In contrast with adults, the number of uninsured children in New York was lower than the national average (10 percent versus 12 percent).

[4] McKinley JC. 2002. "Year of a Shrinking Budget and Tough Choices in Albany." Section B, Page 1, Column 2, *The New York Times*, January 7. McKinley JC. 2002. "Budget for New York: Overview: Pataki's Budget Would Close $5 Billion." Section B, Page 1, Column 2, *The New York Times*, January 23.

interviewees attributed the limited service cuts in the 2002-03 budget to the fact that 2002 was an election year for both Governor Pataki and the entire New York legislature.

Key revenue actions included allocating most of the state's reserve funds as well as balances from existing dedicated funds such as the Environmental Protection Fund and TANF reserves to cover general fund spending. Revenue measures also entailed increasing or imposing taxes and fees on a range of items--for example, cigarettes, cellular telephones, alcoholic beverages, and motor vehicle licenses and registration. In addition, New York's budget balancing involved accounting strategies, including moving some spending "off" the general fund to dedicated state fund accounts.

On the spending side, the budget provided for an overall increase in spending of about $600 million across the major budget sectors—school aid, higher education, state operations, and health programs. Spending levels for most budget sectors were kept at about the same level as 2001-02 or received modest increases. For example, local aid for schools received a 1.5 percent spending increase over 2001-02. State spending on Medicaid for 2002-03 was estimated at $5.85 billion, about a $360 million decline from the previous year. However, the reduction in state Medicaid spending was offset by an increase in taxes on nursing homes, increased use of intergovernmental transfers and upper payment limit payments to get extra federal Medicaid matching dollars, and shifting selected Medicaid spending categories from the general fund to dedicated funds.

**Fiscal Year 2003-04**

By the January 2003, New York's budget picture had worsened and the state faced an estimated budget gap totaling $11.5 billion--$9.3 billion for 2003-04 and $2.2 billion that was

carried over from 2002-03. Put another away, New York needed to find a way to fill a 25 percent shortfall in its general fund.

In distinct contrast with the previous year, the 2003-04 budget process was a major political struggle between Governor Pataki and the legislature. At the heart of the debate was whether to close the gap through service cuts or raising taxes. Governor Pataki's proposed budget strategy relied heavily on cutting services. Service cutbacks totaling more than $5.6 billion were proposed for virtually all the major budget categories, including state aid to local schools ($1.3 billion), state operations ($1 billion), Medicaid ($1 billion) and higher education ($580 million).

For Medicaid a laundry list of service cuts was put forth that affected all the key stakeholders (beneficiaries, providers and health plans). Some of the most important proposed cuts were reducing Family Health Plus[5] eligibility, establishing a prescription drug formulary and freezing hospital and nursing home reimbursement. In addition to Medicaid programmatic changes, the governor's budget proposal called for increasing taxes on hospitals and home care providers.

Governor Pataki's 2003-04 budget plan contemplated several other revenue actions. About $1.4 billion worth of fee increases, surcharges and other revenue enhancement strategies to be imposed on individuals and businesses (such as elimination of tax exemptions on clothing items less than $110 and closing corporate tax loopholes) were included. In addition, the budget called for using one-shot revenue strategies. Chief among these was Governor Pataki's proposal to securitize a share of New York's tobacco settlement money. Specifically, the plan proposed

---

[5] Family Health Plus provides health insurance to lower-income parents and other adults and is included as part of New York's Medicaid Section 1115 waiver program, the Partnership Plan. Coverage to parents is provided to adults with incomes up to 150 percent of the federal poverty line and for adults without children, coverage is offered to those with incomes up to 100 percent of FPL. The governor's 2003-04 budget proposal called for rolling back FHP eligibility for parents from 150 percent to 133 percent of FPL.

securitizing $3.8 billion ($1.5 billion to cover the 2002-03 shortfall and $2.3 billion for the 2003-04 shortfall) in tobacco funds. The budget proposal also included delaying Medicaid payments so they would not count against the 2003-04 budget. While the governor's budget contained some tax measures (such as doing away with tax exemptions), raising broad-based taxes (such as income taxes) were not included.

The popular press as well as many study interviewees acknowledged that Governor Pataki's budget proposal was not well received by the legislators in either political party.[6] Democrats did not like the heavy reliance on service cutbacks while some conservative Republicans complained that the proposal relied too much on accounting gimmicks and taxes in disguise. Beyond legislators, important players in the budget process—including labor unions, health care providers and citizens —were unhappy with the budget proposal. Labor unions and health care providers were unhappy with cutbacks in Medicaid reimbursement, whereas citizens feared that with the proposed cutbacks in local school aid and Medicaid, communities would have to raise local property taxes to make up the shortfall or experience declines in education and health programs.

The concern about the budget's potential impact on local property taxes was cited by interviewees as being a driving force behind the formation of an unusual political alliance between the Republican-led Senate and the Democrat-led Assembly. The budget crafted by the legislature—and what ultimately became the New York budget for 2003-04-- restored many of the service cuts proposed by Governor Pataki, and, in distinct contrast to most other states, raised income and sales taxes to pay for the restoration. Specifically, a temporary three-year increase in

---

[6] Baker A. 2003. "The Governor's Budget Plan: Overview, Pataki Seeks Cuts in Aid to School and Health Care." Section A, Page 1, Column 2, *The New York Times,* January 30. Odato JM. 2003. "Governor's Budget Proposal Avoids Use of Tax Increases; Pataki Plans to Trim Government, Use One-Time Revenue Funds to Reduce Deficit." Main Section, *The Time Union*, January 27, 2003.

the personal income tax on higher income residents was imposed and the state sales tax was increased by one-quarter of a percentage point. In addition to these tax measures, the legislature adopted all of Governor Pataki's proposed revenue actions, including fee increases, eliminating corporate tax loopholes, and securitizing tobacco settlement money.

Charging that the revenue sources identified by the legislature were not sufficient to fully finance the restoration of the service cuts, Governor Pataki cast 119 vetoes to the legislature's submitted budget. On the very next day, with the broad support of Democrats and Republicans, the Assembly and the Senate gathered enough votes and overrode all 119 vetoes, the first time the New York legislature has reversed a vetoed budget plan in more than 20 years.

While the legislature restored many of the Governor's proposed cuts, virtually all budget categories sustained some reductions. For example, on a school year basis general fund spending for school aid declined by about 1 percent compared to 2002 levels while spending for higher education was cut by an estimated 8 percent. About $1 billion was cut in the state operations general budget, representing a 13 percent reduction compared to fiscal year 2002-03. Included in this cutback was savings derived from a continuation of a strict hiring freeze for state employees and aggressive use of a retirement incentive program.[7]

For Medicaid, the legislature restored about two-thirds of the Governor's proposed $1 billion cuts to the program. Importantly, no eligibility or benefit changes were enacted; instead, Medicaid spending reductions were targeted primarily at providers. Cutbacks were spread across a range of providers and services, thereby making the scope of cuts to any one group relatively

[7] The contract with state employees expired in spring 2003 and negotiations for a new contract are currently underway. In the meantime, state employees are working under the rules of the expired contract. As a result, the full 2003-04 budget impact on state employees is unclear as of this writing. For example, cost-of-living adjustments have not been determined. Further, enacted 2003-04 budget calls for restricting pharmacy benefits and increasing employee copayments for doctor visits and prescription drugs for state employees. However, these changes are subject to the pending negotiations with state employees unions.

modest—for example, program reductions to prescription drugs totaled about $25 million, hospitals $10 million and home care providers $6 million.

The state fiscal relief provisions contained in the federal Jobs and Growth Tax Relief Reconciliation Act passed in May 2003, just after New York had enacted its 2003-04 budget.[8] The provisions provide New York with a total of $1.4 billion through the Medicaid match rate increase (of which $900 million goes to the state and $500 million to counties) and $645 million in revenue sharing. According to study respondents, the revenue sharing funds were deposited in the general fund to cover existing general state expenses. Similarly, the temporary increase in federal Medicaid match went to cover general program expenses. With the infusion of federal dollars, both from the revenue sharing and the increase in the match, the Pataki Administration felt that 2003-04 budget became balanced; previously, the administration claimed that the enacted budget had a $900 million shortfall.

**The Future**

While revenues are improving, New York's budget gap for fiscal year 2004-05 is estimated to be between $5 and $6 billion. Owing to the improving economy and the increased revenues obtained the temporary tax increases passed in 2003-04, the budget shortfall is projected to be about half the level of the previous fiscal year. Despite this sharp decline, however, several interviewees felt that they may have a bigger problem closing the gap because fewer strategies are available. Respondents, for example, noted that the state has all but exhausted several of the one-time budget strategies such as using TANF reserve funds or tobacco securitization.

[8] Unlike most other states, New York's fiscal year runs April 1 to March 31.

Interviewees also felt that imposing another increase in the personal income tax is not likely given that what was passed last year was a temporary tax making it very difficult to add to. Unless there is a significant improvement in the state's revenue picture, many believe that service cuts will likely be a central budget strategy in the upcoming fiscal year. However, several respondents also noted that that cutting services may be problematic because all 212 seats in the New York legislature are up for reelection in 2004. Other possible budget balancing strategies mentioned were closing more corporate loopholes and obtaining savings from more efficient purchasing (for example, prescription drugs for Medicaid beneficiaries).

Beyond revenue and spending matters, respondents identified other factors that will likely be important in the 2004-05 budget debate. A key one is the recent ruling by the New York State Court of Appeals finding that the state's financing of its educational system has deprived New York City students of their constitutional right to a decent education. In a case brought by the Campaign for Fiscal Equity, the ruling mandates that the state implement corrections by June 2004. Described as "the elephant in the room" and a "wild card," the budget implications of the ruling are at present unclear, but several interviewees believe it could have a major financial impact on the state's 2004-05 budget.[9]

Another uncertain factor that could have important consequences for the 2004-05 budget debate is if the state changes how it finances its Medicaid program. Unlike most states, New York counties contribute a significant share of the state financing for Medicaid, about 17 percent of total spending on Medicaid. Counties, however, are eager for the state to assume the full financial responsibility for Medicaid. While various realignment proposals have been put forth

---

[9] Of note, in December 2004 the Campaign for Fiscal Equity recently called on New York to include funding for a $2 billion "down payment" in the upcoming 2004-05 budget to comply with the court ruling (Campaign for Fiscal Equity. 2003. Campaign for Fiscal Equity. 2003. "CFE and AQE Call for $2 Billion Immediate 'Down Payment' and Prompt Phase In of Court-Mandated Funding Reforms." http://www.cfequity.org/PressRelease12.18.03.PDF).

in the past, some interviewees felt that the idea may have some political traction this year.[10] According to several respondents, counties have become increasingly vocal about the state assuming the full share of non-federal Medicaid costs. Counties maintain that local portion of the Medicaid bill has become particularly onerous in the last few years with the economic downturn and rapid growth in health care costs. Further, state aid to localities (including educational assistance) has not kept pace with rising costs and revenues from local sales taxes (one major source of income for localities that is independent of the state) are not up to projections. As a result of these pressures, some counties have had to raise local taxes (sales and property taxes, the other major independent income source for local areas) while cutting back on some services such as special education programs and libraries.[11]

Finally, state officials expressed concern about the potential budget implications of recent interactions with federal officials about obtaining matching funds for some Medicaid payments, including Medicaid disproportionate share hospital payments and school-supported health services.

As of this writing it is not known what strategies New York will adopt to close its projected budget gap but, without doubt, the issues and challenges the state faces in its 2004-05 budget will be difficult and certain to raise a number of tough policy issues and choices.

---

[10] Indeed Governor's Pataki's 2003-04 budget proposal included a Medicaid realignment plan. This provision, however, was not enacted. The governor's budget proposed realignment of state and local responsibilities for selected parts of the Medicaid. Specifically, the state would have assumed the full non-federal cost for prescription drugs. In return, counties would have paid 37 percent of non-federal costs for fee-for-service hospital, outpatient and clinic services, costs, up from the 25 percent share of non-federal Medicaid costs that New York counties are required to contribute for these services.

[11] Steinhauer, J. "Bloomberg and County Leaders Urge Albany to Reduce their Medicaid Burden." *New York Times*, March 12, 2003; Polgreen, L. "Hard Times Get Harder Upstate As Fiscal Crisis Spans New York." May 18, 2003.

## TEXAS
## Ian Hill

### Background

Governor Rick Perry, sworn in to replace George W. Bush in December 2000 and elected to a four-year term in November 2002, presented a budget to the state legislature in January 2003 that contained nothing but zeros. Facing the largest revenue drop in state history--$7.4 billion--the Governor presented this budget as a symbolic gesture to emphasize that this would be a year of "re-examining the core responsibilities of government and state spending." The official estimate of the shortfall facing Texas for the 2004/2005 biennium was $9.9 billion, or 15.5 percent of the Comptroller's projected $64 billion in General Revenue spending for the period, a figure that did not include any adjustment for growth in public school enrollment. (However, the Center for Public Policy Priorities, an Austin-based not-for-profit think tank, placed the shortfall at $15.6 billion, or 22.4 percent of a projected $69.7 billion in GR spending, which recognizes both current services cost increases in health and education budgets, and adjusts for population and inflation growth.) "In tough budgetary times, every dollar spent by government…must be scrutinized to determine whether it justifies consideration as a priority. That is why this budget contains no numbers," he said in his budget letter to the 78th legislature.[1]

In the same letter, the Governor reiterated his commitment to not raise taxes as a means of addressing the state budget crisis. This despite the fact that Texas is one of the nine remaining states that does not have a broad-based personal income tax, and has a business franchise tax that is "easily evaded by corporations by restructuring into limited partnerships."[2] Instead, the state imposes one of the highest sales taxes in the nation, thus making Texas' tax structure "extremely

---

[1] http://www.governor.state.tx.us/divisions/bpp/budget/letter.
[2] Study by Governing Magazine and Pew Center on the states, http://www.statesman.com/hp/content/coxnet/texas/legislature/0203/0204brfs.html..

regressive,"[3] as well as relatively high local property taxes. Cutting spending, therefore, was the primary strategy entertained by the Governor and the Republican-dominated state legislature.

Texas is a large state in terms of both geography and population, with many low-income people, high levels of uninsurance, a substantial number of foreign-born residents, and a traditionally minimalist approach to government that has resulted in low spending on health and social welfare programs relative to other states. Given that, Texas already ranked 43rd in the nation in per capita health, hospital, and public welfare spending in 2000 and 41st in state aid per K-12 pupil in 2001-2002, the prospect of further cuts did not bode well for these two largest components of the state's budget.

**The State Budget Situation and Policy Response**

During the late winter/early spring of 2003, policymakers worked to balance the biennial 2004/2005 budget. (The 2002/2003 biennial budget was set in 2001, with supplemental cuts and spending for 2003 authorized by the 78th legislature.) As was the case in states across the nation, decreased revenue collections played a large part in fueling the deficit in Texas. In 2002, sales tax revenue was down 1.0 percent from the prior year; in 2003, it dropped another 1.6 percent.

Early on in the process, there were some efforts to address the revenue side of the budget problem. The House Ways and Means Committee reviewed a proposal to eliminate virtually all tax exemptions from the tax code (including sales tax exemptions for consumers on such things as groceries, prescriptions, and electricity, and business exemptions on products used in manufacturing), as well as proposals to raise the state's sales tax rate. The State Comptroller proposed to increase the state's tax on cigarettes from $0.41 to $1.41 to raise $1.5 billion over two years. And in perhaps the most serious effort, lawmakers worked hard on bills that would have

[3] Ibid

closed the loophole in the state's franchise tax that permits corporations to escape paying the tax by reorganizing as partnerships and creating subsidiaries in other states. Some 4,000 companies, including such major firms as Cox Texas Newspapers, LP, Dell Computer Corporation, and SBC Communications, Inc., have used this loophole in the last four years, leading to drops in revenues to the state of approximately $200 million per year. Ultimately, each of these proposals failed, as lawmakers held fast to the principle of addressing the deficit through spending cuts, not tax increases.

The firmness of this stance can be attributed, as least in part, to the effect of term limits and a large crop of new Republican state legislators taking control in the House and Senate. Many of the incoming lawmakers looked to the previous biennium, a period that witnessed dramatic growth in enrollment and state spending on such programs as Medicaid and the State Children's Health Insurance Program (SCHIP), and expressed the belief that Texas had gone too far with its social services and needed to restore programs to a more appropriate, conservative level of generosity.[4] In response, the legislature returned to its traditional, more conservative stance, embracing reduced spending, "a philosophy more protective of taxpayers who pay for services than of Texans who receive them." [5]

To address the deficit, Texas adopted an array of cost-cutting and cost-avoidance measures. For example, a seven percent across-the-board cut in state agency spending was called for by the Governor to make up the $1.8 billion 2003 deficit by August 31, 2003. For 2004-2005, the largest part of the state budget, K-12 education, saw an all-funds increase of $893 million (three percent more than in 2002-03), but a General Revenue *reduction* of $1.1 billion (four percent less than in 2002-03), mostly because of postponed payments to school districts. K-12 cuts include the Texas

---

[4] Telephone conversation with Jason Cooke, Texas Medicaid/SCHIP Director, September 2003.
[5] Susswein, Gary. Austin American-Statesman. April 18, 2003.

Education Agency having to lay off 125 of its 860 full-time employees; and school teachers, counselors, and librarians having their health insurance stipends reduced from $1,000 to $500 per year (saving $700 million over the biennium). In other parts of the budget, the Texas Department of Criminal Justice saw its budget cut by $300 million, including the elimination of about 1,000 full-time positions; approximately $55 million was trimmed from three higher education research fund budgets; five agencies were eliminated-the Aircraft Pooling Board, the Wildlife Damage Management Service, the Council on Environmental Technology, the Criminal Justice Policy Council, and the Telecommunications Infrastructure Fund Board-for a combined savings of $21.5 million; twelve-and-one-half percent of the $82 million budget for Tuition Equalization Grants was cut, reducing funds that would be available to help students attend private colleges; and the Healthy Families child abuse protection program lost its funding (saving $2.8 million), along with several other child abuse/neglect prevention programs. The only areas of the budget that got more General Revenue were regulatory agencies (up three percent from 2002-03) and business and economic development (up 46 percent).

Lawmakers also reduced state spending through reorganization of state agencies. Of particular note was the sweeping reorganization of health and human services agencies designed to trim $110 million from the state budget. Under the new law, a dozen agencies will be dismantled and streamlined into five: The Health and Human Services Commission, the Department of State Health Services; the Department of Aging and Disability Services; the Department of Family and Protective Services; and the Department of Assistive and Rehabilitative Services. Part of the reorganization would also entail the state contracting with a private firm to serve as a “single point of entry” call and application center for all health and human services programs.

Other strategies for addressing the deficit included dipping into reserves and putting off certain payments to future fiscal years. For example, Texas took $1.3 billion from its surplus "rainy day" fund to cover a large portion of the shortfall. The state also got out from under $1.3 billion in spending by deferring payments to school districts and other program from August 2005 (the last month of the current biennium) to September 2005 (the first month of the next biennium), and by lowering Medicaid caseload projections to help balance the budget.

However, some of the most striking cuts to state programs were made in Medicaid and SCHIP, as described below.

**Medicaid and SCHIP**

With an uninsurance rate approaching one-quarter of the nonelderly population, Texas has traditionally relied on public hospitals and county health systems to meet the needs of the medically indigent, rather than on expansion of public coverage. The state departed from this practice in the late 1990s and early '00s by aggressively implementing SCHIP and, subsequently, passing rules to make it easier for eligible children to enroll in Medicaid. Even in the face of the economic downturn and tightening state budgets, the 2002/2003 biennium saw Texas hold the Medicaid and SCHIP programs virtually harmless. In mid-2002, the Medicaid program changed from an accrual- to a cost-based accounting system, permitting a one-time deferral of roughly $225 million. And a proposal to begin imposing copayments for prescription drugs on some adult Medicaid recipients was stopped by a court order late that year. For SCHIP, child and family health advocates successfully lobbied the state legislature throughout the summer of 2002 to persuade lawmakers to spare the program from cuts.

As mentioned above, the biggest policy change during the period, in fact, supported a significant expansion of the Medicaid program. In June 2001, SB 43 was signed into law calling for a dramatic simplification of Medicaid enrollment procedures for children bringing them in line with the already simplified rules for SCHIP. Specifically, the law directed Medicaid to adopt a simpler application form; drop the requirement for a face-to-face interview with local social services staff when filing a Medicaid application; reduce asset documentation requirements; adopt six-month continuous eligibility for children (with a provisions to extend to 12 months in the future); and drop the requirement for face-to-face interview at eligibility redetermination (on the condition that the child is up to date with his/her immunizations and well-child visits).[6] In all, these simplifications were expected to cost the program $123 million during the 02/03 biennium in the form of increased child enrollment.

Addressing the growing deficit for the 04/05 biennium followed a dramatically different course, however. Both Medicaid and SCHIP experienced significant cutbacks. Still, the cuts would have been worse, had the state not received $1.3 billion in federal relief resulting from the Jobs and Growth Tax Relief Reconciliation Act of 2003, $574 million of which was targeted at the Medicaid program through an increase in the federal matching rate. Many "worst case" scenarios and proposed budgets were floated in the legislature in the early months of 2003. These included such proposals as reducing Medicaid provider reimbursement by 33 percent and entirely eliminating the SCHIP program. Later versions of the proposed bills scaled back these cuts to a degree; for example, the House Appropriations committee put forth that the SCHIP program's upper income threshold be reduced from 200 percent to 150 percent of poverty. In April 2003, the Perryman Group (a Texas-based economic forecasting firm) released a study (co-sponsored by the Texas

---

[6] The original bill also called for elimination of the assets test for children; this was not passed, but families were permitted to self-declare their assets information.

Medical, and Hospital, Associations) declaring that Texas would lose more money than it would save if the proposed cuts were made (in the form of lost federal revenue, increased uncompensated care, increased private insurance premiums, and lost state and local tax revenue). Perhaps influenced by this, lawmakers (and the Governor) finally settled on a budget that contained the following cuts in Medicaid:

- Reducing upper income eligibility limits for pregnant women from 185 percent to 158 percent of poverty (for a savings of $43.9 million);
- Eliminating the Medically Needy "spend-down" program for adults with dependent children (for a savings of $45.8 million);
- Eliminating coverage of many optional services for adults, including mental health counseling, podiatric, chiropractic, eyeglasses, and hearing aids (saving $43.4 million);

Other Medicaid cuts to which individual cost savings estimates were not attached included postponing until FY 2006 the extension of continuous coverage for children from the current six months to 12 months); adopting more stringent verification of declared assets for children; imposing cost sharing at the maximum amount permitted by federal law; and implementing a preferred drug list and prior authorization requirements. Legislative budget decisions also reduced provider reimbursement for hospitals and physicians by 2.5 percent, nursing homes by 1.7 percent, and community care providers by 1.1 percent. Provider reimbursement reductions for both Medicaid and SCHIP (discussed below) will reduce state budget spending approximately $294.2 million in the 2004/2005 biennium.

SCHIP cuts included the following:

- Changing the income test from a "net" to a "gross" basis, effectively eliminating deductions from income and reducing the program's upper income limit from 240 percent to 200 percent of poverty;
- Adding an assets test to the eligibility determination process for children in families with incomes over 150 percent of poverty;

- Adding a 90-day waiting period before coverage becomes effective for new enrollees;
- Reducing continuous eligibility from 12 months to six months;
- Eliminating coverage of several benefits, including dental, vision, eyeglasses, hearing aids, chiropractic, home health, and hospice; and reducing coverage of mental health and substance abuse treatment services;
- Reducing provider reimbursement by five percent; and
- Raising premiums and copayments for enrollees of all income levels.

In total, Medicaid and SCHIP cuts are expected to reduce state General Revenue spending by $835.2 million ($206.7 million of which result from SCHIP eligibility and benefit cuts), and result in approximately 18,000 adults losing Medicaid coverage and 167,000 children losing SCHIP coverage. Furthermore, state officials estimate that eligibility changes made to children's coverage under Medicaid will reduce future growth in that program by 332,000 children from 2003 to 2005. Before these cuts were instituted, Medicaid enrollment stood at 2.5 million persons (1.6 million of whom were children under age 19), while SCHIP enrollment was 507,000 children.[7]

**The Future**

Like many states, Texas is expecting its budget picture to improve modestly in the coming year, as the economy recovers and revenues increase. However, strategies that deferred payment obligations from the current, to the next, biennium will exert pressure on spending flexibility in the next cycle, and state and local health care costs are likely to increase as a result of cuts to both Medicaid and SCHIP. Still, remarkably, most legislators are on the record that they believe the 2004/2005 budget process was a "success," pointing out that cuts could have been much worse, and

[7] Many of the specific budget numbers cited throughout this report, and in particular those pertaining to Medicaid and SCHIP, were provided by the Center for Public Policy Priorities in Austin, Texas. The author is indebted to both Anne Dunkelberg and Eva De Luna for their comments, feedback, and input on this paper.

philosophically believing that they have restored reason to a health and human service system that "got out of hand" during a time of economic strength.

## WASHINGTON
**John Holahan**

### Background

Since the early 1990s, Washington has been a leader among the states in efforts to expand health insurance coverage. The state extended Medicaid coverage to children to 200 percent of the federal poverty line and enacted the Basic Health Plan, a state funded program to cover low income working families up to 200 percent of the federal poverty line. In recent years the state has grown increasingly conservative with a strong anti-tax movement. A ballot initiative, I-601, enacted in November 1993 constrained annual spending increases to no more than inflation plus population growth. In most years this has been less than the rate of growth in per capita income. But more recently, slower revenue growth because of the recent recession has constrained state spending. At the same time, ballot initiatives have been approved requiring that the state increase teacher salaries and reduce class sizes. Because there was no dedicated revenue source for these initiatives they reduce the availability of general revenues for other purposes. This year for the first time the combination of the state's poor economic performance and opposition to tax increases has significantly affected health care programs.

This brief focuses on the debate over the budget enacted for the 2003-2005 biennium. In June 2003, the Washington state legislature enacted a $23.1 billion biennium budget which closed a projected gap of $2.7 billion.[1] The budget gap occurred because of slower than expected revenue growth related to the recession, increases in health care costs because of rising caseloads, and the ballot initiatives that required states

to increase spending on K-12 education. Other factors that contributed to the gap included higher education enrollments and rising prison populations.

**The 2003-2005 Budget Debate**

The 2003-2005 budget followed on the heels of a budget crisis that developed in 2002 when it became clear that the 2002-2003 general fund budget of $22.8 billion faced a shortfall of $1.6 billion. The state enacted a supplemental 2002-2003 budget in March 2002 to close the gap. [2] The supplemental budget included a tobacco securitization arrangement which meant that $450 million in tobacco settlement payments were received immediately in lieu of $1 billion in future payments. The state also used $325 million of the emergency reserve fund. Other revenue measures including joining a multi-state lottery and closing some tax loopholes, were adopted. There were $654 million in budget cuts including reductions in state government, reductions in assistance to cities and counties, reductions in contributions to health benefits for state employees, elimination of a 2.6 percent cost of living adjustment for state and higher education employees, reductions in public school funding, and some reductions in health care programs largely other than Medicaid.

The 2003-2005 biennium presented new problems, in part because decisions made in 2002 took some options off the table. Entering the 2003-2005 debate, legislators were faced with the difficulty of further limiting compensation of state employees. Ballot initiatives seemingly required increased spending on K-12 education. There was no

---

[1] Washington State 2003-2005 Omnibus Budget Overview, http://leap.leg.wa.gov/leap/budget/bns/2003partii.pdf.

[2] John Holahan, "Washington." 2003. In John Holahan et al, "The State Fiscal Crisis and Medicaid: Will Health Programs Be Larger Budget Targets?" Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.

political will, even among Democrats, to increases taxes substantially. Opposition to tax increases was further enhanced when the legislature sent a referendum to the voters to approve an increase in the gas tax by nine cents per gallon. This would have raised $750 million for the Department of Transportation, allowing them to address serious transportation infrastructure problems throughout the state. The initiative was defeated in November 2002 by a wide margin.

Higher education in principle could be a target, but demographic changes (the baby boom echo) were increasing the demand for higher education. Many of the accounting tricks and gimmicks that had been used in the past biennium had been used up. Medicaid enrollment and costs per enrollee continued to grow as did costs of the Basic Health Plan. But there was little support for cutting health programs in a major way. Most spending on health care was for children or for persons with disabilities, the medically needy, and the elderly in nursing homes. The state's Basic Health Plan, a program that covers low income working families up to 200 percent of poverty was highly popular and thought to be difficult to seriously cut. Provider payment rates were well below private and Medicare rates and could only be cut if the state was willing to risk serious reductions in access to care. With this background the state faced a set of very difficult choices in considering how to solve the $2.7 billion budget deficit.[3]

As expected, the 2003-2005 budget had little increase in new revenues, the most significant being an increase in liquor taxes.[4] Another revenue raising measure was a nursing home quality maintenance fee which was essentially tax on nursing homes that

---

[3] State of Washington Proposed 2003-2005 Budget and Policy Highlights, December 2002, http::/leap.leg.wa.gov/leap/budget/bns/2003partii.pdf.
[4]Ibid.

allowed the state to increase nursing home reimbursement rates and bring in additional federal matching dollars (described below). The additional revenue received from the temporary increase in the federal matching rate did not affect Medicaid spending decisions but rather was placed in the state's reserve account. The state by definition had to use the FMAP increase for Medicaid but in effect took the savings in the state share and put it in its reserve account. The argument was made that Medicaid forecasts often understated actual expenditures and that the funds would be needed in the event of a shortfall. Offsetting these revenue raising measures in a small way is $25 million in tax credits for the aerospace industry. Essentially the budget gap was closed through reductions in spending on education, reductions in state employee compensation, and in health care spending greater than those that had been contemplated in earlier years. The state also reduced spending by a comparatively small amount ($40 million) by the early release of non violent prisoners and by limiting community supervision of low risk non violent offenders following release from prison.

*Education*. Despite the high priority given to education, K-12 and higher education spending was cut by over $800 million.[5] The ballot initiatives did not call for new revenues, rather they required that the state allocate general revenues to fund these initiatives, reducing the amount of general revenue available for other purposes. The state legislature chose to slow down or suspend the implementation of these initiatives.[6] (A two-thirds majority allows the state to amend a ballot initiative). They gave no cost of living increase for teachers with more than seven years of experience, while those with less than seven years of experience were given a cost of living increase. Salaries for new

---

[5]Ibid.

teachers were increased. The legislature also delayed their commitment to reducing class sizes. College and university budgets were reduced by $131 million. Higher education institutions were allowed to increase tuition for resident undergraduate students by up to 7.0 percent for each year of the biennium. At the same time teachers, like other state employees, were required to pay more for health benefits.

*State Employees*. State employees were also a major target, with cuts amounting for over $400 million relative to baseline projections.[7] The legislature felt that with the Washington economy in dire straits state employees should not be treated better than the typical Washington worker. The number of state workers was reduced by 1,100 and state employee salaries were frozen for the biennium. At the same time, state workers were required to pay more for health insurance benefits (state payments for employee health benefits nonetheless increased by $200 million; $70 million was shifted to workers by increasing the employee share of cost). Finally, the state reduced the contribution to state employee pensions for a savings of $87 million.

*Health*. Despite the state's commitment to health care, substantial cuts were made in both the Basic Health Plan and in Medicaid. In all, cuts in health programs were over $600 million.[8] The Basic Health Plan had been budgeted to cover 125,000 enrollees and in the middle of 2003 over 118,000 were enrolled. The governor proposed to eliminate 60,000 slots or about half the people enrolled in the program. The House (under Democratic control) objected; the negotiated agreement was a reduction of slots (by

---

[6] "Divergent Views on School Funding: Administrators Breathe Sigh of Relief, Teachers Are Angry," *The Seattle Post-Intelligencer*, June 18, 2003.
[7] Governor Gary Locke's 2003-2005 Budget Overview, http://www.governor.wa.gov.
[8] "What's Being Cut," *The Olympian*, July 6, 2003.

attrition) to allow 100,000 enrollees.[9] A ballot initiative (I-773) approved in 2002 increased the tobacco tax by 60 cents per pack to expand the number of enrollees in BHP. It required that the state maintain BHP enrollment at 125,000 enrollees using general funds, with the tobacco revenues funding an additional 50,000 slots. Because of state budget pressures the legislature voted to use the tobacco tax revenues allocated for expanded BHP enrollment to fund current enrollees.

There was also an increase in BHP premiums and an introduction of deductibles and 20 percent coinsurance on such covered services as professional services, MRIs, and CT scans; these additional provisions also increase the likelihood of enrollment reductions. Co-payments remained for other services. Each member of the family enrolled in the Basic Health Plan was subject to the $150 deductible. After the deductible was met, the health plan would pay 80 percent of costs for covered services. There was an out of pocket maximum of $1,500 per person per calendar year. The deductible did not count toward the out of pocket maximum. The savings from the cut in Basic Health Plan enrollment as well as deductibles and co insurance were expected to be $350 million.

The Medicaid program also was affected. Eligibility standards were not changed but the state did end the use of telephone applications and self declaration of incomes. Further, it increased the frequency of eligibility redeterminations for children and adults from 12 months to 6 months. The former is given credit for a significant reduction in caseload growth; the latter has yet to take effect. Reductions in enrollment were expected to save at least $123 million. Dental care for adults, disabled, and elderly beneficiaries

[9] "Cuts to Basic Health Plan Leave Many Without Insurance," *The Olympian*, July 7, 2003.

was also reduced.[10] The governor had proposed that it be eliminated. The compromise was that adult dental care spending was reduced by 25 percent ($12 million) by eliminating a limited set of procedures, e.g., root canals on back teeth. Co-payments on adult vision services and durable medical equipment were introduced.

Washington benefited from federal legislation that allowed states to retain their SCHIP allotment for 1999 through 2001. In effect the state was allowed to draw down these funds by claiming federal matching funds at the higher SCHIP rate (66 percent) for children in families with incomes above 150 percent FPL ($26 million).

The state also sought a Health Insurance Finance Flexibility and Accountability Act (HIFA) waiver to allow it to increase premiums on children above 100 percent of poverty.[11] The original waiver application had also requested CMS approval to impose co-pays on higher priced drugs with generic equivalents and on the use of emergency room services, to eliminate adult hearing, vision, and non emergency dental care for adults, to use unspent SCHIP dollars to add enrollees to the Basic Health Plan, and to implement a temporary enrollment freeze on new enrollees when budget problems developed. The latter provisions were dropped from the waiver request. The state expects approval of authority to increase premiums on non-poor children with incomes above 100% of the federal poverty level.

The state commissioned an outside review of its managed care and hospital payment rates. The review suggested that managed care and hospital rates were more than adequate and could be cut. The state reduced the planned increases in managed care rates, increasing rates by only 1.5 percent in 2004 and 5.0 percent in 2005. Since these

[10] "Washington State Medicaid Program Cuts Some Adult Dental Procedures," *Seattle Times*, July 11, 2003.

increases were lower than planned increases they accounted for $25 million in savings. The review suggested that hospital rates could be cut in the short run. But rather than cut hospital rates the state eliminated its state funded medically indigent program. This program provided $100 million to hospitals for emergency room and trauma care for uninsured low income people. This program was replaced with a smaller $40 million grant program which was targeted to hospitals that provided a disproportionate share of care to low income people. Hospitals remain legally obligated to serve indigent cases and it is expected that hospitals would make up the balance through other revenues. The state also tightened eligibility for its general assistance program which had the effect of reducing people receiving medical benefits through general assistance.

Washington has also developed a drug formulary for Medicaid fee for service beneficiaries and other state fee for service programs. The formulary included clinically effective drugs for which the state is able to obtain a larger discount than the federal rebate. This is expected to achieve $46 million in savings over the biennium.

Finally, the state reduced the amount of assets that the spouse of a nursing home resident could obtain from $96,000 to $40,000.[12] The view was that Medicaid benefits should go to the poor and a $96,000 exemption was a benefit to the middle class. In other words, there was not much support for increasing taxes on the middle class to support a benefit for the non poor. Washington also capped the number of home and community-based case waiver slots, and narrowed functional eligibility for personal care services. Homecare workers negotiated a contract with the state's home care quality authority for a

---

[11] "State Sends Feds New Request for Medicaid System," *Seattle Tim*es, August 10, 2003.
[12] "Washington State Governor Considering Bill that would Decrease Amount of Assets People can Keep to Qualify for Medicaid," *Seattle Times,* June 23, 2003.

$2 hourly wage increase that was to be incorporated in payment rates for home healthcare workers. The governor rejected the agreement and approved a 75 cents per hour increase. This smaller hourly rate increase resulted in $67 million in savings to the state.[13]

The nursing home quality maintenance fee described above works as follows. Nursing homes were assessed a tax of $6.50 per bed day on all patients, thus meeting federal requirements that provider taxes be broad based. Medicaid nursing home rates were increased by 3.0 percent and the $6.50 was added to the Medicaid rate. The ultimate effect was that the nursing homes with largely Medicaid patients would receive more than enough revenue to offset the tax; nursing homes with few Medicaid patients would pay the tax but get little benefit from the increased reimbursement rates. Another effect was that all of the increase in the reimbursement rate was paid through federal matching funds or through the provider tax. No new state revenues were required. Thus the state received additional federal revenue and was able to increase nursing home rates for those who served Medicaid patients.

**The Future**

There is an expectation that there will be a small supplemental budget to keep the 2004 budget in balance. It is not expected to be a large because Medicaid spending is in line with projections primarily because caseloads for children are lower than projected, apparently because of the new enrollment tightening provisions. Spending growth in BHP is also expected to slow because of premiums and reduced benefits. Revenues are growing slowly but are in line with projections.

[13] "$23 Billion Budget Approved, No New Taxes; Prescription Drug Bill Also on Way to Governor Locke's Desk," *The Seattle Post Intelligencer*, June 6, 2003.

It will be of interest to see the public reaction to the enacted cuts such as the release of prisoners accused of drug and property crimes, the tuition increases in state universities and the suspension of the class size and teacher pay initiatives. The Basic Health Plan has been highly popular and the substantial reduction in scope may also be problematic. The premiums on non-poor children could be controversial particularly in light of the higher federal matching rate on children with incomes above 150 percent FPL. The elimination of the medically indigent program, along with reductions in Medicaid and Basic Health Plan enrollment could seriously increase burdens on hospitals that serve the uninsured. At the same time, it is clear that the opposition to revenue increases is also very strong within the state of Washington.

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

1330 G Street NW, Washington, DC 20005
*Phone:* (202) 347-5270, *Fax:* (202) 347-5274
*Website:* www.kff.org/KCMU

Additional copies of this report (#7002) are available
on the Kaiser Family Foundation's website at www.kff.org.