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Medicaid and State Budgets: Clearing Storm, Foggy Forecast

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OVERVIEW — *This issue brief examines the recent history and trends in state budgets and considers how those trends have influenced the role of the Medicaid program. The paper offers several indicators for predicting the future of states' fiscal standing, cautioning that, although the "stormy" period from 2001 to 2003 is over, states face many challenges in the near future. This issue brief also poses several questions regarding the appropriate roles of state and federal governments in administering the Medicaid program. These questions become particularly important as the population ages and states increasingly take the lead in developing solutions for covering the uninsured.*

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In 2003, the interaction between Medicaid and states' budgets was described as a "perfect storm" because of growing program enrollment, high medical inflation, plummeting state revenues, and a national economic recession.[1] At that time, state revenues were decreasing at double-digit rates while one of states' biggest expenditure categories, Medicaid, was increasing at a similar pace. Some wondered whether Medicaid was sustainable, given the states' tenuous fiscal situation.

Most states reacted to this perfect storm as they have historically: they used reserves and one-time measures to close budget gaps. States were also provided with one-time fiscal relief from the federal government in the Jobs and Growth Tax Relief and Reconciliation Act of 2003, which helped mitigate the decline in states' revenues.

In late 2003, a long-awaited reversal of state fiscal fortunes began. State revenues grew for the first time since early 2001, and Medicaid spending slowed for the first time since 1996.[2] By the end of 2006, state revenues had nearly recovered to prerecession levels.

The state fiscal storm is now over, but the forecast does not quite call for blue skies: several factors suggest that the current fiscal stability of states may be short-lived. What makes the future of state finances and the implications for Medicaid unclear are recent changes in the financial obligations of federal and state governments and slowing state revenue collection. Medicaid relies on federal and state funds, making the fiscal health of both levels of government critical in determining the program's future. This paper attempts to see through the fog by examining various factors that may determine the fate of state budgets and the Medicaid program over the next several years.

BACKGROUND

In most states (all except Vermont and Wyoming), the budget must be balanced every fiscal year. Each state's fiscal health, the balance between its revenues and expenditures, therefore becomes critical to state policymakers when they evaluate when to expand or constrain funding for programs such as Medicaid.

Revenues

Programmatic decisions regarding Medicaid and other state spending are often driven by the strength of state revenues. State budgeters undoubtedly

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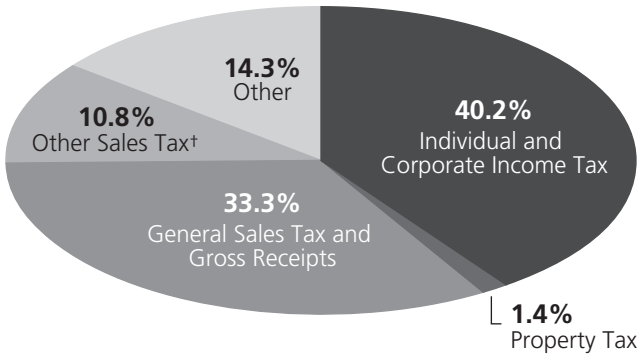
wish they could know exactly how much revenue their state will collect each year, but projecting revenues is complicated by the many factors that can affect revenue flow. The effectiveness of tax collections, employment rates, consumer spending, fluctuations in the real estate market, and changes in federal legislation are just some of the factors that state budgeters must consider when making revenue projections.

States revenues come from two major sources. The first is state-levied—personal income, corporate income, and sales taxes; fees and licenses; and other taxes, such as property, inheritance, or cigarette taxes (see Figure 1). The second and single largest source is intergovernmental revenue. Nearly 40 percent of intergovernmental revenue comes from federal matching payments for the Medicaid program.[3] Matching rates (called the federal medical assistance percentage, or FMAP) range from 50 percent to 83 percent and are calculated based on each state's per capita income.[4] Even states with the lowest matching rate still receive one federal dollar for every state dollar they spend on Medicaid, making the program a true partnership. In fact, the federal matching relationship in Medicaid is significant enough that many states have been reluctant to cut their programs because they do not want to forgo the opportunity to draw down federal funds.

FIGURE 1
Sources of State Revenue, First Quarter 2007*



**This figure excludes intergovernmental revenues.*
†Fuel, tobacco, and alcohol taxes and motor vehicle and operator's licence fees.

Source: U.S. Census Bureau, Quarterly Summary of State and Local Government Tax Revenue, table 2; available at http://ftp2.census.gov/govs/qtax/table2.pdf.

Despite the availability of federal support, however, many argue that Medicaid's financing structure is not sufficiently responsive to changing economic conditions, making it difficult for states to budget effectively. During economic slowdowns, unemployment rates tend to increase, causing individuals to lose access to employer-sponsored health coverage. The FMAP is calculated each year based on the average of the past three years of states' per capita income data. As a result, the federal matching rate often does not respond to current state economic circumstances, and states are therefore faced with making program cuts during times of greater need. Many experts have suggested that the financing formula be modified to be more "countercyclical," that is, more appropriately tied to immediate economic indicators, in order to provide more timely federal support to states.[5]

States vary significantly in revenue sources, and these variations often result in disparate effects when economic changes occur. Seven states do not collect any income tax, and two tax only dividend and interest income.[6] Even among states with similar sources of tax revenue there is variation. For instance, states with income taxes can have as many as ten brackets—or as few as one. States without income taxes tend to rely heavily on other revenue sources, such as sales taxes or fees. In general, southern states rely more on sales taxes,[7] while many states in the Northeast depend more on personal income taxes. There are exceptions; for example, New

Hampshire has no personal income tax, and North Carolina receives less than 15 percent of its revenue from the sales tax.[8] Using fees to pay for new programs or program expansions is one way states can raise revenues without increasing broad-based taxes. Many types of fees tend to be dedicated to one program area, such as motor vehicle fees that are dedicated to transportation projects and are therefore more transparent than general taxes that are used for various purposes. Fees may also be easier to institute because they encounter a lesser degree of public resistance to passage than broad-based tax increases.

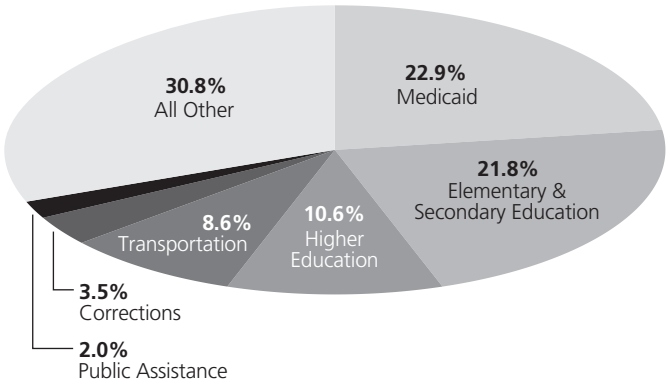
Correctly estimating revenues is important, not only because it helps states determine what is available to spend on their programs, but also because of the constitutional requirement in most states to have balanced budgets. Since matching estimated revenues with actual spending is difficult, states set aside extra revenues in reserves or fund balances, sometimes referred to as "rainy day funds," to use when spending exceeds collections. Rainy day funds are then saved for use when states experience fiscal downturns.

Expenditures

Sources of state expenditures include state funds (which come from broad-based taxes), bonds, and federal funds (which include the federal share of funding for programs like Medicaid).[9] There can be large differences in program spending between states, although most states spend the largest portion of state funds (not including federal funds) on kindergarten through grade 12 (K–12) education and Medicaid. These two areas comprise nearly half of all state spending.[10] In FY 2004, Medicaid's double-digit growth rates, combined with the slowing economy, caused Medicaid spending to surpass spending on K–12 education—making it the largest component of state budgets, if all funds are considered.[11] (Figure 2 shows the continuation of this situation in FY 2005.)

States' programmatic expenditures can also be difficult to predict because of market changes such as recessions, inflation, new legislative requirements, or unforeseen crises, such as natural disasters. For example, at the dawn of this century, state budgeters could not have predicted the terrorist attacks of September 11, 2001; Hurricane Katrina; or the recession that drove large enrollment increases in Medicaid.

FIGURE 2
Major State Expenditure Categories, 2005



Source: National Association of State Budget Officers, 2005 State Expenditure Report, figure 4, Fall 2006, p. 4; available at www.nasbo.org/Publications/PDFs/2005%20State%20Expenditure%20Report.pdf.

STATE BUDGET TRENDS

Beginning in 2001, stock market stagnation and terrorist events combined with other factors to slow the U.S. economy, and the recession had a

ripple effect on the states. A look at the trends in states' fiscal situations from 2001 to mid-2007 follows.

The Fiscal Storm: FY 2001 to FY 2003

Before the fiscal downturn of 2001, state expenditures had been growing substantially for a number of years.[12] Several decades of large per capita state expenditure increases, coupled with a sudden and dramatic drop in state revenues, caused the economic slowdown to last multiple years in many states. Initially, this slowdown was most severe in those states where revenue generation was most directly tied to stock market fluctuations. Market losses significantly affected the Northeast, including New York State, where the financial services industry is important to state revenues. Eventually, the economic slowdown spread to every region of the country, so that in fiscal year (FY) 2003, 36 states had mid-year budget gaps.[13] A significant contributing factor to states' budget difficulties was Medicaid's expenditure growth rate.[14] The combination of the revenue crisis and increases in Medicaid spending led the National Governors Association to characterize the state fiscal situation as the worst since World War II.

Recovery: FY 2003 to FY 2006

Many states initially reacted to the fiscal crisis by using one-time measures to fill budget gaps, for example, using rainy day funds, selling state assets, or drawing down all their tobacco settlement money at one time.[15] However, as the crisis persisted, some states made across-the-board cuts, enacted program cost controls, or raised taxes. These cutbacks caused negative percentage increases in annual state budgets from FY 2002 through FY 2004.[16] In the last quarter of 2003, lower growth, combined with an improving stock market and increased revenues, allowed states to experience their first positive adjusted real change in revenue collections. Since then, state revenue growth has remained positive, with the most notable gains occurring in FY 2004 and FY 2005, as shown in Figure 3 (next page).[17]

A significant slowdown in Medicaid expenditures in 2006 allowed the states to shore up their finances. The slower growth was due in part to changes in states' policies designed specifically to contain costs, such as freezing provider rates[18] or enacting prescription drug cost controls. Another factor that influenced the decrease in Medicaid expenditures was the implementation of Medicare Part D, the prescription drug benefit.[19] However, it should be noted that the shift in costs from the Medicaid to the Medicare program does not necessarily benefit the states because of the requirement, known as the "clawback," that states make payments back to the federal government in return for Medicare's takeover of prescription drugs for dually eligible beneficiaries. Hospital and nursing facility spending also slowed during this period. The slowdown in Medicaid spending was also encouraged by federal administrative actions, such as providing states greater flexibility

in structuring their program benefits to control costs and limiting states' use of techniques to maximize their federal match.[20]

By FY 2006, most states' fiscal situations were very different than in FY 2003, with ending balances as a percentage of expenditures the highest since FY 2000, and with only two states requiring mid-year budget cuts.[21]

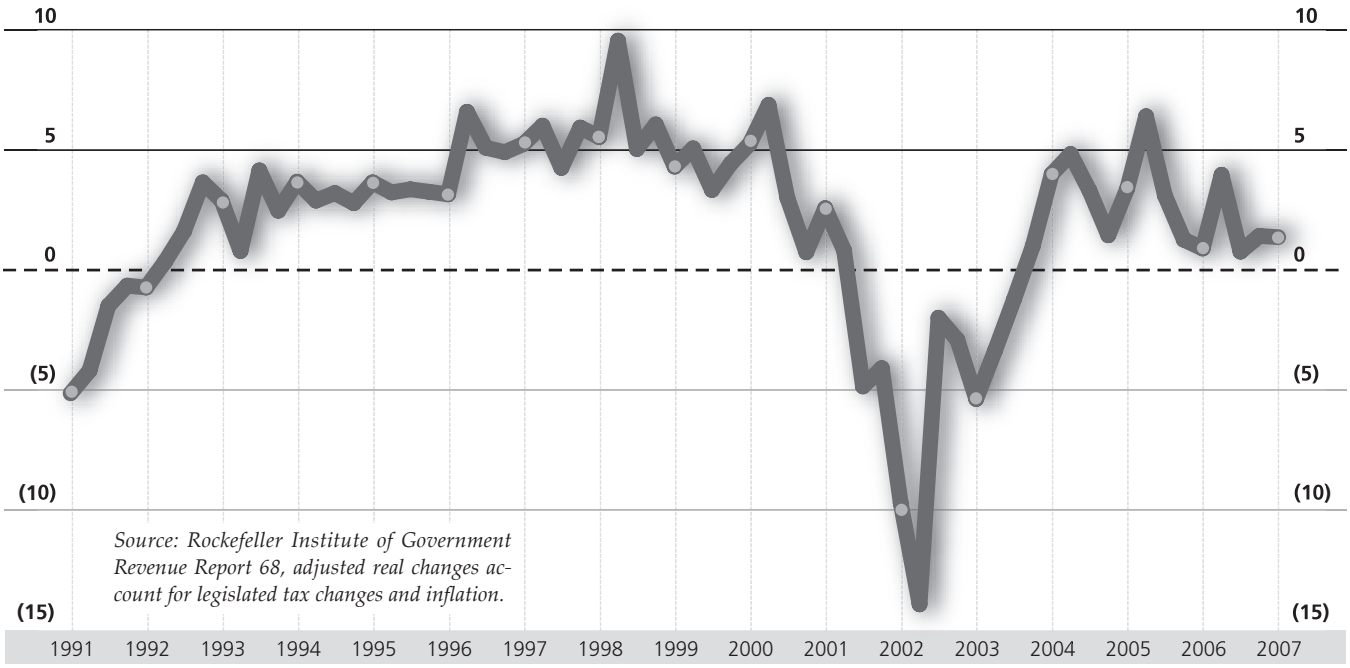
USING THE PRESENT TO PREDICT THE FUTURE

Very few states made mid-year budget cuts in FY 2007. One of the few was Michigan, which was considered to be experiencing a "one-state" recession.[22]

For the first time in six years, more states enacted net tax decreases in FY 2007.[23] The types of tax cuts varied: three states eliminated the tax on groceries in 2006, while at least five additional states are considering doing so in 2007. Property tax cuts are also being discussed in many states.

In addition to cutting taxes, many states are in the midst of debating or enacting bold new spending initiatives. The 2007 state of the state addresses and FY 2008 budgets reflect the confidence of states' governors and legislatures, with many of them using the current economic stability to support greater spending on everything from health care and education to infrastructure improvements.

FIGURE 3
Real Adjusted State Tax Revenue, Year-Over-Year Percent Change, 1991–2006



Source: Rockefeller Institute of Government Revenue Report 68, adjusted real changes account for legislated tax changes and inflation.

Future Indicators

How long will state budgets remain healthy? What do long-term trends mean for the future of the Medicaid program? Four indicators suggest that the current stability of state budgets may not last.

State revenues slowing—Revenue increases in 2006 were modest compared to 2004 and 2005. The first quarter of FY 2007 showed a nominal growth rate of 4.3 percent compared to the same quarter from a year earlier, which was slightly below the previous quarter's growth of 4.6 percent. This growth was characterized as "stable" but it was the weakest growth since the April–June quarter of 2003.[24] The second quarter of FY 2007 (January–March 2007) showed that state tax revenue increased 4.9 percent compared to the same quarter the year before. The nominal growth rate was stronger than the previous two quarters but not as strong as the first two quarters of FY 2006.[25] Of most concern is the fact that state sales tax collection slowed considerably. Looking ahead, many states believe that the modest slowdown in revenue growth will continue in the year ahead. A survey by the National Conference of State Legislatures (NCSL) in November 2006 indicated that many states were experiencing slower sales tax revenue and were not as optimistic as they had been in the previous year.[26]

The "steadying" of revenue growth that states are experiencing differs from the recession that began in 2001, in which the drop in revenues was abrupt and severe. However, with the state fiscal crisis of 2001 to 2003 still a recent memory, some states are being cautious with their revenue estimates and spending proposals as they enter FY 2008. The NCSL's preliminary report on state budget and tax actions for 2007 shows that year-end balances of more than half of the states were lower in FY 2007 than they had been in FY 2006.[27]

Local governments are not as large as state governments, but their financial health is still a consideration for the states. If local governments are strapped for cash, they look to state government for assistance. Property taxes are the major source of income for local governments—an estimated 73 percent of total revenues. Property taxes have performed well in recent years, as they are linked to the real estate market and can be updated yearly, unlike other taxes, which are more statutorily rigid.[28] This year, however, many governments are considering property tax cuts,[29] and the real estate market has softened, which will further decrease revenues from this source.

Federal funding levels and national economic trends—Notable changes have taken place with federal revenues since the last fiscal crisis. The first of these is the end of extra federal revenue, $20 billion of which the federal government provided to states during the fiscal crisis through the Jobs and Growth Tax Relief Reconciliation Act of 2003. Half of this money was used to relieve states of the growing cost of Medicaid through a temporary increase in the amount of Medicaid matching dollars states received from

the federal government, and half was used for general fiscal relief. This one-time measure helped states but has now ended.

More significant to the future of state budgets are decreasing amounts of federal grants-in-aid. This trend began in 2006, and the president's proposed FY 2008 budget would further cut discretionary and mandatory grants to state and local governments (excluding Medicaid).[30] States will experience revenue losses because of other changes at the federal level, such as implementation of the federal "domestic production deduction." The domestic production deduction is a corporate tax break created by the federal government that allows corporations to claim a tax deduction for certain "qualified production activities." The tax break also affects corporate income tax collections at the state level.[31] Not all states will be affected by this deduction but, for those that are, losses are expected to double in 2007. With the wars in Iraq and Afghanistan still surging and the first members of the baby boom generation nearing age 65, federal entitlement spending is expected to continue to increase, so it is unlikely that federal grants-in-aid to state and local governments will increase any time soon.

Significant to the future of state budgets are decreasing amounts of federal grants-in-aid.

Projections based on the most current national economic data are mixed. According to the Bureau of Labor Statistics, unemployment trends vary considerably from state to state, but the overall U.S. unemployment rate has been steady since the fall of 2006.[32] The Bureau of Economic Analysis indicates that there was a small acceleration in the gross domestic product (GDP) in the fourth quarter of 2006.[33] The Congressional Budget Office's economic outlook for FY 2008 through FY 2017 indicates that revenues will be less than required outlays from FY 2007 until FY 2012.[34] The federal government has considerable financial liabilities of its own to address.

Increasing state spending rates—States' reliance on one-time measures such as rate freezes and temporary spending controls to close gaps during the last fiscal crisis meant that not all states enacted structural changes to control long-term spending trends. Within health care, several states attempted to control costs by implementing disease management programs, expanding managed care, or placing utilization limits on certain services. Many of these measures helped slow Medicaid spending. In FY 2007, state general fund spending as a percent of GDP was still lower than prerecession levels, but it is unclear how long this will continue.[35]

In 2007, many states have been proposing programmatic changes that would increase short- and long-term spending levels. These changes include universal prekindergarten, universal health care, and substantial increases in other education funding. For instance, at least nine states are proposing health care coverage expansions, while seven others have established commissions to examine reform and coverage expansion options. California has proposed universal health care estimated to cost $12 billion yearly, while New York took the first steps to increase K-12

education spending by $7 billion over four years, and, for FY 2008, 34 governors introduced plans to reduce the number of uninsured.[36] A recent NCSL paper indicates that projected spending increases may be higher than revenue growth.[37]

Trends also suggest that the slowdown in Medicaid spending will reverse and that significant eligibility expansions, such as those proposed by California and Pennsylvania and recently passed in New York,[38] may increase Medicaid enrollment and corresponding expenditures even more in future years. However, the exact amount that these projected program expansions will increase states' spending obligations is unclear.

The Centers for Medicare & Medicaid Services, which predicted less than a 1 percent growth rate in Medicaid in 2006, expects Medicaid to grow between 7.3 percent and 8.3 percent over the next several years.[39] This is above the rate of inflation and, in most years, greater than Medicare and private insurance growth. Adding to concern over the potential for Medicaid to grow faster than expected is the fact that these projections were made prior to the changes in eligibility for the Medicaid program mentioned previously. Also uncertain is the level of federal funding for the State Children's Health Insurance Program (SCHIP), which is due for reauthorization by September 30, 2007. If federal funds are insufficient, states may end up shifting a share of program costs to Medicaid. Finally, the proportion of people over age 65 will increase significantly as the "baby boom" generation retires. Medicaid is the largest public source of funding for long-term care in the United States, representing 49 percent of total national long-term care expenditures in 2004. About one-third of Medicaid spending is for long-term care.[40] The growth in spending by the federal government and states for long-term care services through Medicaid will likely continue to increase as the population ages.

If federal funds are insufficient, states may end up shifting a share of program costs to Medicaid.

States' long-term fiscal obligations—A fourth important financial burden for states in the years to come is state employee pension and benefits obligations. Before 2004, states did not account publicly for all of these expenses, but that changed in 2004 when the Governmental Accounting and Standards Board (GASB) issued "Statement No. 45," (GASB 45), which required governments to report annual "other than pension employee benefits" (OPEB). States must report unfunded actuarial accrued liabilities (the difference between a government's total obligation for OPEB and any assets it has set aside for financing the benefits).[41] Financing these obligations will be a substantial challenge for many states. For example, Illinois estimates that its unfunded liability in the state pension system is over $40 billion.[42] In California, Governor Schwarzenegger established a commission to address public employee pensions and other obligations, which must recommend by January 2008 a plan to the legislature for dealing with these liabilities.[43] And New Jersey's pension fund, estimated to be the sixth largest in the country, is also estimated to be $56 billion in deficit.[44] Some states view

the GASB 45 requirement as the top issue for the 2007 legislative session.[45] The states' difficulty in meeting the requirements shows how the aging of the baby boom generation will have major implications for state budgets. As baby boomers retire from state jobs, pensions and retiree health care costs for states will be significant.

IMPLICATIONS FOR MEDICAID

Historical patterns indicate that a stronger economy and flush state coffers make Medicaid enrollment and spending rates more predictable.[46] The current state fiscal environment reflects that the economy has been doing well. If the economy continues to thrive and the federal government does not take the lead in covering the uninsured, states are likely to continue requesting that the federal government help finance coverage expansions through Medicaid and SCHIP.

One of the largest unknown variables in the current equation for determining what will happen with state Medicaid programs is what happens with the economy. Based on an analysis of the most recent economic indicators (tax revenues and employment), the economy is stable and perhaps slowing, albeit at a much slower and more predictable rate than in 2001. A slowing economy may not hinder current debates about coverage expansions, but it may make these same expansions less sustainable in the future.[47]

While states have contemplated coverage expansion, the Bush administration has been looking for ways to reduce Medicaid program growth. The federal Medicaid Commission released its final recommendations in December 2006, suggesting several ways for federal and state governments to reduce Medicaid spending.[48] Before the release of the commission's final report, the administration had been using administrative mechanisms to slow federal and state spending on Medicaid. In particular, it has been clamping down on states' use of "Medicaid maximization" techniques such as utilizing the upper payment limit, disproportionate share hospital payments, and intergovernmental transfers,[49] and limiting the use of provider taxes.[50]

State Variations Persist

The degree to which states' budgets and Medicaid programs thrive or lag may vary. Thirty states have made revenue forecasts for FY 2008, 23 for FY 2009, and 14 for FY 2010. The growth estimates range from 0.5 percent to 6.5 percent in FY 2008. For FY 2008 through FY 2010, the revenues of those states that make projections are expected to be lower than nominal GDP changes each year.[51] Contributing to differences in states' economic conditions are the varied changes in their tax laws and new policy directives.

Tax changes can vary considerably. Oregon is projecting $1.3 billion in refunds, while other states predict much less. Regionally, the Southwest and the Rocky Mountains states saw the biggest changes in tax revenues

in the first fiscal quarter of 2007—nearly 12 percent, while the far West experienced growth of less than 2 percent.[52]

There may also be widening differences in states' Medicaid programs. Already, states vary significantly in terms of the eligibility levels they use for Medicaid, the services they cover, and their mechanisms for care delivery. The Deficit Reduction Act of 2005 makes it even easier for states to tailor their Medicaid programs to meet both fiscal and political priorities.[53] Some states may choose to continue looking for ways to contain costs in their Medicaid programs, while others may choose to expand them. Whether states choose expansion or retraction may depend on their financial health.

In addition to variations in spending, revenue collection, and Medicaid program costs, demographics and long-term debts also are likely to create different situations for state budgets. States that have lower long-term pension obligations and fewer high-needs populations may have an easier time in the coming years. The structure of state economies will also create differences in states' financial health. States that can adapt their workforces more easily in ways that produce economic growth are likely to do better then those with less adaptable workforces and industries.

Addressing the FMAP

As noted previously, during times of economic slowdown and increased unemployment, more people turn to Medicaid for assistance with medical care needs. However, the nature of the financing structure makes the program inherently more vulnerable during these times of greater need. (And, perhaps a bit ironically, states may receive a higher proportion of federal Medicaid funds during strong economic times because of the lag in the data used for the FMAP calculation.)

Analysts representing a wide range of perspectives (state, federal, and beneficiary groups) have come up with several suggestions for making the federal matching formula more appropriately responsive to the economy:

- Increase the FMAP by one percentage point for states with higher unemployment rates (or during times of higher national unemployment rates).
- Shorten the time period for calculating the average per capita income for each state (for example, from three years to two years).
- Apply the new matching rates in the same year they are calculated, rather than delaying them for two years.[54]

While these modifications may seem highly technical, the slight changes that would result could mean the difference in states' ability to sustain program expansions and other experimentation, regardless of inevitable fluctuations in the economy. Of course, such changes would require a commitment by the federal government to provide a higher level of support to states through a program that has grown exponentially over the past several years.

Policy Questions

Now that states and Medicaid have weathered the storm, policymakers will need to consider a few fundamental questions about the program's future. The uncertainty of state finances and the dynamic between the federal and state governments raise important policy questions for the Medicaid program.

How sustainable is Medicaid, given state fiscal volatility? As discussed in this paper, states are more likely to expand Medicaid eligibility when revenues are strong. But because Medicaid is countercyclical, the number of enrollees and resulting expenditures grow when state economies are weak. The fact that Medicaid tends to grow at precisely the time states are looking to cut spending makes the program vulnerable.[55]

Should the Medicaid financing relationship between the federal and state governments change? Questions about the state-federal fiscal partnership of Medicaid are often raised when Medicaid expenditures are at issue. Should the federal government change the way it finances Medicaid so that the allocation of funding to states is more responsive to the economy? Should the formula consider factors in addition to per capita personal income levels? Should the FMAP rates continue to be based on three-year averages or should they be updated more frequently? Should certain responsibilities be shifted from states to the federal government, and vice versa, for better cost management? For example, should states bear the fiscal responsibility for caring for low-income children and families, while the federal government bears the fiscal responsibility for the elderly and disabled and those dually eligible for Medicare and Medicaid? How much fiscal responsibility should the federal government assume for state-initiated Medicaid expansions? Given the commencement of the Medicare Part D drug benefit, should states be relieved of the fiscal responsibility of having to pay the federal government for estimated savings to the Medicaid program? Finally, should the funding formula for Medicaid be based, at least in part, on unemployment rates, which—given the country's overall reliance on the employer-based health insurance system—could provide a fairly reliable indication of anticipated need for assistance with medical costs?

How large a role will Medicaid play in covering the uninsured? Medicaid's utility as a means for covering the uninsured is being debated by Congress and the 2008 presidential candidates. Some of the candidates and members of Congress view Medicaid/SCHIP expansion, combined with other initiatives, as a means to universal health insurance coverage, while others seek alternate solutions. Regardless of whether politicians at the federal level view Medicaid/SCHIP expansion as part of a solution for covering the uninsured, state governments are already moving forward. In the absence of a federal initiative to expand the Medicaid program, the more pressing question for federal policymakers is the degree to which they will politically and financially support states' expansion efforts.

How vested is the federal government in sustaining Medicaid in future years? If the fiscal circumstances of states become as precarious as they were from 2001 to 2003, a second question is whether the federal government, given its fiscal obligations, could provide the same type of fiscal relief for states as it did under the Jobs Growth and Tax Relief Reconciliation Act of 2003, which allowed many states to avoid cuts to their Medicaid programs. That last fiscal crisis occurred at a time when federal government had fewer long-term financial obligations (that is, before the wars in Iraq and Afghanistan). How would states avoid significant cuts in Medicaid if the economy were the same as it was during the recent recession but states received no equivalent federal fiscal relief?

What is the appropriate role for Medicaid in financing long-term care? The looming growth in the U.S. elderly population raises questions about Medicaid's large role in funding long-term care services. Should the federal government assume greater responsibility for paying for care for the elderly? Was the addition of the Medicare Part D drug benefit in 2006 just the first step toward the federal government's fully covering the health care needs of Medicare beneficiaries? The answers to these questions could affect whether Medicaid will continue to be the major source of funding for a growing number of people in need of long-term care.

How federal and state governments respond to these policy questions may be partially dependent on the fiscal health of states. But these questions also depend on how states and the federal government view their intergovernmental relationship and how they think the responsibilities to Medicaid should be balanced between the two levels. Can the intergovernmental relationship that maintains Medicaid be expected to continue in the future? Only time will tell how the fiscal health of state budgets will affect policy discussions on the future role of Medicaid as a major provider of health insurance coverage.

READING THE FORECAST

The year 2006 was fiscally solid for states. The economic storm that began in FY 2001 had ceased, revenues had strengthened, and Medicaid spending growth had fallen. The most recent fiscal survey of states indicates that the large majority remain in good financial condition in 2007. Recent proposals by state governments to either cut taxes or increase spending reflect confidence in the economic stability of states. However, declining revenue sharing by the federal government, a return to escalating Medicaid costs, long-term fiscal obligations, and the aging of the baby boom generation suggest that states will experience more fiscal challenges in the coming years.

The direction of state budgets will be tied closely to state spending obligations, particularly Medicaid, education, and long-term obligations. Monitoring state-level differences will be important for gauging the general

direction of the Medicaid program. Analysis suggests that the Medicaid program will be sustainable over the long term.[56] But at what level—and with what variation by state—remains to be seen.

ENDNOTES

1. Alan Weil, "There's something about Medicaid," *Health Affairs,* 22, no. 1 (January/February 2003): pp. 18–19.

2. State revenues grew for the first time in real terms (that is, after adjusting for inflation and tax increases).

3. Donald Boyd, "Impact of Proposed 2007 Federal Budget Actions on States," Nelson A. Rockefeller Institute of Government, May 2006; available at www.rockinst.org/WorkArea/showcontent.aspx?id=11626.

4. 42 CFR, section 433.10(b).

5. The term "countercyclical" is referenced in a variety of ways when discussing Medicaid financing issues. Some people refer to the financing structure as countercyclical, indicating that it does not adequately respond to economic fluctuations, while others suggest that the financing should be made to be more countercyclical by more closely tying federal funding levels to the economy.

6. States with no income tax include Arkansas, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming; New Hampshire and Tennessee do not tax dividend and interest income.

7. Rockefeller Fiscal Studies, "Fast Facts," Rockefeller Institute of Government, March 3, 2005; available at www.rockinst.org/WorkArea/showcontent.aspx?id=12076.

8. Alison J. Grinnell and Robert B. Ward, "Personal Income Tax Revenue Rebounds As Sales Tax Falters," Nelson A. Rockefeller Institute of Government, *State Revenue Report,* no. 68, June 2007; available at www.rockinst.org/WorkArea/showcontent.aspx?id=11934.

9. National Association of State Budget Officers (NASBO), Fiscal Year 2005 State Expenditure Report, Fall 2006; available at www.nasbo.org/Publications/PDFs/2005%20State%20Expenditure%20Report.pdf. General funds accounted for 43.7 percent of total FY 2005 state spending, federal funds were 28.9 percent, other state funds were 25.1 percent, and bonds reflected 2.3 percent of the total.

10. NASBO, *FY 2005 State Expenditure Report.* Medicaid and education comprised approximately 44.7 percent of all spending in FY 2005.

11. NASBO, FY 2005 State Expenditure Report. See also NASBO, 2004 State Expenditure Report; available at www.nasbo.org/Publications/PDFs/2004ExpendReport.pdf. In FY 2004, Medicaid constituted approximately 22.3 percent of state spending, while K–12 education spending was 21.4 percent. K–12 education was the largest component (35.7 percent) of general fund spending.

12. Donald J. Boyd, "The Bursting State Fiscal Bubble and State Medicaid Budgets," *Health Affairs*, 22, no. 1 (January/February 2003): pp. 46–61.

13. National Conference of State Legislatures (NCSL), "State Budget Update," February 19, 2004; available at www.ncsl.org/programs/fiscal/sfo20042.htm.

14. Boyd, "The Bursting State Fiscal Bubble."

15. James W. Fossett and Courtney Burke, "Medicaid and State Budgets in FY 2004: Why Medicaid Is So Hard to Cut," Nelson A. Rockefeller Institute of Government, July 2004; available at www.rockinst.org/assets/A660B716-175E-4343-BFBF-C38184F69C4E.pdf.

Endnotes / continued ➤

Endnotes / continued

16. National Governors Association (NGA) and NASBO, "The Fiscal Survey of States," table 2, June 2006; available at www.nasbo.org/Publications/PDFs/FiscalSurveyJune06.pdf.

17. The two states with mid-year FY 2007 budget gaps were Louisiana and Indiana, according to NGA and NASBO, "Fiscal Survey of States."

18. Vernon Smith *et al.*, "Low Medicaid Spending Growth Among Rebounding Revenues," Kaiser Commission on Medicaid and the Uninsured, October 2006; available at www.kff.org/medicaid/upload/7569.pdf.

19. Centers for Medicare & Medicaid Services, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program: CMS-64"; available at www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp. The CMS-64 expenditure reports show a decline in Medicaid prescription drug spending due to the shift in payment for drugs for dual eligibles to the Medicare program. However, these reports do not account for the "clawback" payments states are required to provide to the federal government to make up for the cost shift. These payments are not technically considered a Medicaid program expenditure and would therefore not be reported on the CMS-64.

20. Around 2003, the federal government began limiting states' use of "Medicaid maximization" strategies. States were using two main ways to draw down extra federal dollars without spending more state dollars: upper payment limit, or UPL, which enabled them to receive higher reimbursement for services like nursing care, and intergovernmental transfers, or IGTs, whereby they received matching dollars for transfers between levels of government but did not actually spend more money. For more information, see Theresa A. Coughlin and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," Urban Institute, Discussion Paper, June 1, 2002; available at www.urban.org/UploadedPDF/310525_DP0209.pdf.

21. NGA and NASBO, "Fiscal Survey of States," December 2006; available at www.nasbo.org/Publications/PDFs/Fall%202006%20Fiscal%20Survey%20of%20States.pdf. The two states that made mid-year budget cuts were Louisiana and Indiana.

22. Daniel Vock, "'One-state recession' hampers Michigan," Stateline.org, April 11, 2007; available at www.stateline.org/live/details/story?contentId=197521.

23. NGA and NASBO, "Fiscal Survey of States," December 2006, p. vii.

24. Alison J. Grinnell and Lucy Dadayan, "Fourth Quarter 2006 State Tax Revenue Report—A Cautionary Tale," State Revenue Report, no. 67, March 2007; available at www.rockinst.org/WorkArea/showcontent.aspx?id=9774.

25. Grinnell and Ward, "Personal Income Tax Revenue."

26. NCSL, "State Budget Update," November 2006.

27. NCSL, "State Budget and Tax Actions 2007: Preliminary Report," August 2007; and Associated Press, "Most States Facing Budget Declines," *New York Times,* August 9, 2007.

28. Gerald Prante, "Property Tax Collection Surged with Housing Boom," Tax Foundation, Special Report, no. 146, October 2006; available at www.taxfoundation.org/files/sr146.pdf.

29. Chris W. Courtwright, "Kansas Gubernatorial Candidates Debate Property Tax Relief for Seniors," *State Tax Notes,* 42, (November 6, 2006): p. 355; and Joe Follick, "With Election Near, Candidates for Governor Lay Out Property Tax Plans," *State Tax Notes,* 42, (November 6, 2006): p. 354.

30. For information on federal grants to states, see Iris J. Lav, "Federal Grants to States and Localities Cut Deeply in Fiscal Year 2008 Federal Budget," Center on Budget and Policy Priorities, February 6, 2007, available at www.cbpp.org/2-6-07sfp.pdf; also Christopher Cooper, "States Set Big Spending Plans As Washington Preaches Austerity" *Wall Street Journal*, February 24, 2007.

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31. Nicholas Johnson, "State Revenue Losses from the Federal 'Domestic Production Deduction' will Double in 2007," Center on Budget and Policy Priorities, January 2, 2007; available at www.cbpp.org/1-2-07sfp.pdf.

32. The Bureau of Labor Statistics reports that unemployment has ranged from 4.4 percent to 4.6 percent since September 2006. See Bureau of Labor Statistics, "Employment Situation Summary," August 3, 2007; available at www.bls.gov/news.release/empsit.nr0.htm.

33. Bureau of Economic Analysis, U.S. Department of Commerce, "Growth Continues in Fourth Quarter," February 28, 2007; available at www.bea.gov/newsreleases/national/gdp/2007/pdf/gdp406p_fax.pdf.

34. Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2008 to 2017," January 2007; available at www.cbo.gov/ftpdoc.cfm?index=7731&type=0.

35. Elizabeth C. McNichol and Iris J. Lav, "State Budgets: On the Edge?" Center on Budget and Policy Priorities, November 8, 2006; available at www.cbpp.org/5-4-06sfp.pdf. This article shows how state general fund spending as a percent of GDP is still lower than prerecession levels.

36. NGA and NASBO, "Fiscal Survey of States," June 2007; available at www.nasbo.org/Publications/PDFs/Fiscal%20Survey%20of%20the%20States%20June%202007.pdf.

37. Outlays are expected to be 7.5 percent, while receipts are expected to be 3.1 percent. See NCSL, "State Budget Update," November 2006.

38. New York passed legislation in 2007 to increase eligibility for the state's children's health insurance program (known as Child Health Plus) to 400 percent of the federal poverty level.

39. Centers for Medicare & Medicaid Services, "National Health Expenditure Projections 2006-2016"; available at www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf.

40. Georgetown University Long-Term Care Financing Project, "National Spending for Long-Term Care," Fact Sheet, January 2007; available at http://ltc.georgetown.edu/pdfs/whopays2006.pdf.

41. Government Accounting and Standards Board (GASB), "GASB Statement 45 on OPEB Accounting by Governments: A Few Basic Questions and Answers"; available at www.gasb.org/project_pages/gasb_st45_basic_q&a.pdf.

42. Daniel W. Hynes, "Illinois State Pensions Continue to Put Pressure on the State Budget," *Fiscal Focus,* February 2007; available at www.comptroller.state.il.us/FiscalFocus/article.cfm?ID=222.

43. Office of the Governor of California, "Governor Schwarzenegger Establishes Commission Addressing Public Employee Pensions, Retiree Health Care Obligations," press release, December 28, 2006; available at http://gov.ca.gov/index.php?/press-release/5012/.

44. Mary Williams Walsh, "New Jersey Diverts Billions and Endangers Pension Fund," *New York Times*, April 4, 2007.

45. NCSL, "State Budget Update," November 2006, table 9.

46. The author's judgments are based on a rough analysis of Medicaid CMS-64 expenditure data.

47. During the economic slowdown that began in 2001, states were more likely to roll back recent eligibility expansions in public health insurance programs.

48. For more information about the Medicaid Commission, see U.S. Department of Health and Human Services, "Medicaid Commission"; available at http://www.aspe.hhs.gov/medicaid.

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49. The Medicare upper payment limit allowed nursing facilities to bill for a rate higher than their actual costs in 2003. The Bush administration set limits on what states could bill using this method. Disproportionate share hospital payments allow state hospitals to collect extra revenues for serving a disproportionate number of low-income persons; both Massachusetts and California (in 2005) renegotiated the amount, use, and conditions under which they could receive these funds. Limits are being placed on federal Medicaid match amounts for intergovernmental transfers.

50. Karen Matherlee, "The Federal-State Struggle over Medicaid Matching Funds: An Update," National Health Policy Forum, Background Paper, May 31, 2002; available at www.nhpf.org/pdfs_bp/BP_UPL_5-02.pdf. Also see Robert Mechanic, "Medicaid's Disproportionate Hospital Payment System: Complex Structure, Critical Payments," National Health Policy Forum, Background Paper, September 14, 2004, available at www.nhpf.org/pdfs_bp/BP_MedicaidDSH_09-14-04.pdf; and Shelly Gehshan *et al.*, "Moving Beyond the Tug of War—Improving State Fiscal Integrity," National Academy for State Health Policy, August 2006; available at www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf.

51. Vic Miller and Andy Schneider, "The Medicaid Matching Formula," AARP, September 2004, p. 5 and table 2, p. 39; available at http://assets.aarp.org/rgcenter/health/2004_09_formula.pdf. The projected changes are expected as a result of provisions in the Deficit Reduction Act of 2005.

52. Grinnell and Ward, "Personal Income Tax Revenue."

53. For a fuller description of the implications of the Deficit Reduction Act of 2005, see Jennifer Ryan, "Medicaid in 2006: A Trip Down the Yellow Brick Road?" National Health Policy Forum, Issue Brief No. 810, March 29, 2006; available at www.nhpf.org/pdfs_ib/IB810_Medicaid2006_03-29-06.pdf.

54. Miller and Schneider, "The Medicaid Matching Formula."

55. Recent analyses predict that Medicaid, and states' role in funding it, will be sustainable because growth is projected to slow over the next 20 years. See Richard Kronick and David Rousseau, "Is Medicaid Sustainable? Spending Projections for the Next Forty Years," *Health Affairs*, Web Exclusives, 26, no. 2 (February 23, 2007): pp. w271–w287.

56. Kronick and Rousseau, "Is Medicaid Sustainable?"