

Budgets in crisis

As lawmakers returned to state capitols in January, they faced the most difficult budget situation in at least a decade. Most states experienced revenue shortfalls this fiscal year, and, for some states, forecasts are not optimistic for the next fiscal year.

There is no shortfall in demand for state services, however. The needs are great, while the resources are limited. So are the choices.

“State budgets are in a crisis situation,” said Raymond C. Scheppach, executive director of the National Governors’ Association. “I expect economic development, health care, a continued focus on homeland security and education initiatives to be some of governors’ top priorities.”

Belt tightening is never easy. This year, two emerging issues make the process even more difficult — rising Medicaid costs and homeland-security initiatives.

Medicaid costs have become a tidal wave, threatening to capsize already shaky state budgets. Medicaid expenses — which account for 15 percent to 20 percent of state budgets — are expected to grow at 8.8 percent in 2002. The slowing economy and rising unemployment compound the problem since more people are eligible for Medicaid benefits.

The Sept. 11 terrorist attack added a new, expensive line item to state public-safety budgets — homeland security. NGA estimated that the cost of new homeland-security efforts would amount to \$4 billion in just the first year. At the same time, states must provide traditional public-safety services on tighter budgets.

— Magdalena Mook

Riding the Medicaid tidal wave

In 2001, Medicaid costs grew a startling 8.3 percent on average. Higher Medicaid spending is part of the upward

trend in health care inflation in the United States. Health care costs rose almost 7 percent last year, after nine years of growing at about the same rate as the economy, according to a recent report by the Centers for Medicare and Medicaid Services.

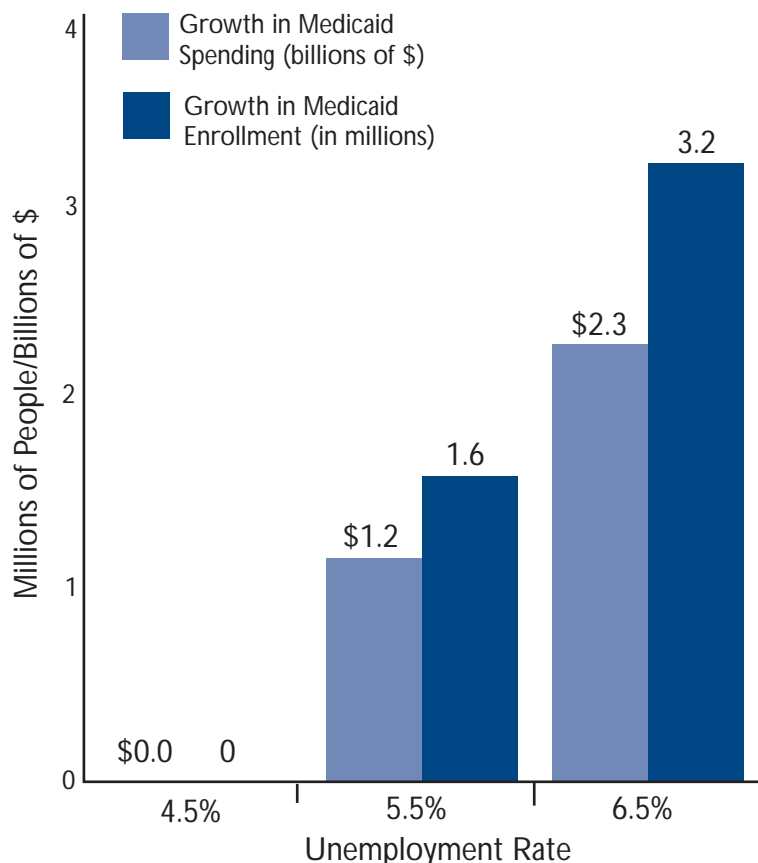
Just as the cost-per-person is rising, Medicaid enrollment is increasing due to the downturn in the economy. Nationwide, state Medicaid programs now provide health care coverage to some 44 million people. A study by the Urban

Institute estimates that for each 1 percent increase in the unemployment rate, another 1.6 million people will enroll in Medicaid.

Some states are hit harder than others, but states in every region are feeling the pain. “The peaks and valleys of the rest of the nation don’t hit West Virginia as hard as some states,” said Sen. Roman Prezioso, chair of the Health and Human Resources Committee. “But with the agency numbers still coming in, we proj-

Rising Unemployment Impacts Medicaid

Estimated Growth of 2002 Medicaid Spending and Enrollment at Unemployment Rates Greater than 4.5 Percent.



Source: Kaiser Commission on Medicaid and the Uninsured from Urban Institute estimates, December 2001

ect a \$1 (million) to \$2 million shortfall.”

“Even with supplemental funding, we will have a \$16 million deficit,” said Joyce McRoberts, deputy director of Idaho’s Department of Health and Welfare.

“In Rhode Island, we had a big Medicaid overrun last year, around \$50 million,” said Sen. Catherine Graziano, chair of the Health, Education and Welfare Committee.

Florida last year faced a \$1 billion shortfall in its Medicaid program.

Getting to the bottom of rising costs:

Medicaid is an entitlement program that was designed to counter downturns in the economy and was closely linked to welfare and unemployment. When unemployment rises, Medicaid enrollment expands; when the economy grows, Medicaid enrollment should contract as workers return to their jobs.

Yet, throughout the economic expansion of the 1990s, states expanded the number of people eligible for Medicaid,

so that rolls expanded instead of shrinking. With the decoupling of Medicaid and Temporary Assistance for Needy Families program under welfare reform and with the creation of the State Children’s Health Insurance Program, states expanded eligibility for health care programs to cover more low-income working families and children. From 1999 to 2000, there was a \$1 billion increase in spending in the CHIP program alone. Enrollment in Medicaid grew by nearly 2 million people

Selected state strategies for containing Medicaid costs

State	Eligibility or benefits	Benefit utilization	Payments	Cost-sharing	Private-insurance assistance
IDAHO	Plans to enhance primary-care case management	Plans to require prior authorization for medical equipment and five or more prescriptions per month; require use of 75 percent of prescriptions before refilling	Plans to decrease payments to specialists		
FLORIDA	Drug formulary	Enhanced disease-management programs	Drug manufacturers must provide additional rebate		
OHIO		Examining high drug use in nursing homes; targeting home services to those at-risk for institutionalization	Pricing changes for hospitals; studying nursing home costs		
RHODE ISLAND				Charge small premiums for Medicaid and co-payments for drugs	Rite Share – pay premiums, copayments for employer-sponsored insurance
TENNESSEE	Closing enrollment to uninsurable populations	Uninsurables receive HMO-style coverage		Greater cost sharing for enrollees between 100 and 200 percent of federal poverty level	TennAssist – assistance with paying for employer-sponsored insurance
WASHINGTON		State could impose waiting lists for services; New Therapeutic Consulting Service will help providers to select the most appropriate, cost-effective drugs		Plans to charge copayments and premiums	

Definitions: Drug formularies: Lists of drugs pre-approved for doctors to prescribe for patients; if patients want or need a drug NOT on the formulary, usually they or their doctors have to prove it is medically necessary.

Prior authorization: Enrollees or providers must get approval before a product or service is delivered to ensure they will be reimbursed.

Source: CSG staff and State of the States, Academy for Health Services Research and Health Policy, January 2002.

from 1999 through 2001.

Medicaid's unique federal-state funding and countercyclical nature present states with both advantages and problems during a recession. For every dollar a state spends for Medicaid, it receives from \$1 to \$3.31 in matching federal funds. To save state money, the state has to cut spending by more than a dollar. States cannot cut Medicaid benefits at will, because they have to meet federal requirements to qualify for matching funds.

Other factors are driving up costs for both public and private health care programs.

Hospital costs, the largest portion of health care spending in the United States, grew by 5.1 percent in 2000. In recent years, hospitals have been more resistant to rate cutting by health plans. Labor shortages, particularly among nurses, have driven wages, and therefore hospital spending, higher.

Prescription-drug spending, the other major driver of health care costs, rose by 17.3 percent in 2000. Analysts attribute rising drug costs to the increase in prescriptions and the preference for newer, more expensive drugs.

Nursing-home care spending for the elderly and disabled, largely paid for by state Medicaid programs, rose 3.3 percent in 2000. The elderly, blind and disabled, although they make up only 27 percent of enrollees, are responsible for about two-thirds of Medicaid spending. As baby boomers age, Medicaid spending on care for the elderly and disabled is likely to continue to climb dramatically.

Retreat from managed care has lifted the cap on health care costs. The health care industry has heeded consumers' insistence on greater choice and moved toward less-restrictive managed care. Because patients want choices, moving Medicaid enrollees to managed care to control costs will remain politically difficult.

State solutions: So far, state leaders have been reluctant to control spending by scaling back benefits or eligibility across the board in Medicaid and CHIP programs. Cutbacks during a recession hurt the people who need help the most.

"Enrollments are up, so tough times make us come up with innovative solutions," said Ohio Rep. Greg Jolivet, chair of the Health and Family Services Committee.

Some of the solutions states are trying include scaling back optional benefits, restricting access to certain services, changing payment rates, instituting cost-sharing and enhancing fraud and abuse detection.

On the prescription-drug front, Jolivet said Ohio will encourage use of generic equivalents for name brands and better management of medications in nursing homes, especially among residents who take more than eight pills a day. Other states such as New York, have instituted prior-authorization requirements for certain high-cost or high-usage drugs.

Many states have implemented or are examining disease-management programs for chronic illness to ensure that patients follow recommendations to control their conditions, use medications appropriately and avoid costly emer-

gency-room visits. Florida instituted a drug formulary and supplemental rebates for prescription drugs, as well as an expanded disease-management program.

Providers also are getting hit. Mississippi is looking to cut payments to providers by 3 percent to 5 percent. Idaho is cutting its rates to specialists and requiring prior authorization for durable medical equipment, McRoberts said.

Other states, including Rhode Island and Washington, are introducing small premiums and copayments for Medicaid recipients. California is projected to save nearly \$500 million dollars through its efforts to catch Medi-Cal fraud and abuse.

Many states are looking outside the Medicaid budget for solutions. Nevada and Virginia plan to use rainy-day funds to cover spending increases. Mississippi plans to use tobacco-settlement money to cover the \$125-million shortfall in the state's Medicaid budget. Iowa has diverted funds from other accounts to help pay for its \$18.6-million Medicaid shortfall.

—Trudi Matthews

Public safety under the gun

States expect to spend \$3 billion for initiatives this year aimed at preventing bioterrorism and boosting emergency communications, according to a recent NGA survey. States will spend another \$1 billion to guard critical infrastructures, such as bridges, tunnels, power plants and dams.

Homeland security also has an indirect impact on state public-safety budgets. As

Federal changes affect state Medicaid funding

Faster waivers and expanded coverage. Shortly after taking office, the Bush administration promised to make the Medicaid-waiver process easier and faster for states. The U.S. Department of Health and Human Services under the leadership of Secretary Tommy Thompson, formerly governor of Wisconsin and a past president of CSG, cleared a backlog of changes to state Medicaid plans.

Thompson also announced a new initiative called the Health Insurance Flexibility and Accountability initiative

that streamlines the application process for states that want to expand health care coverage. Arizona submitted its HIFA plan on Sept. 20, 2001, and on Dec. 12 became the first state to have its plan approved.

Medicaid loophole. DHHS announced changes in Upper Payment Limit regulations that would close the so-called "Medicaid loophole." Under the old regulations, Medicaid could pay up to 150 percent of the Medicare amount for certain services to local government-owned hospitals. Some states would draw down fed-

eral funds under the Upper Payment Limit rules and use a rebate of overpayments to fund other programs and community-based services. As many as 31 states could be affected by the change.

SCHIP dip. In the legislation that created the State Children's Health Insurance Program, Congress decreased federal funding by a billion dollars beginning in fiscal year 2002. This substantial drop in funding could result in even more budget problems for states and a reduction in the number of children offered coverage through state CHIP programs.

Highlights of the Homeland Security Supplemental FY2002 (Public Law 107-117)

\$2.5 billion*	Bioterrorism (Several agencies)
\$745 million**	Federal Bureau of Investigation for counter-terrorism
\$549.4 million	Immigration and Naturalization Service for border presence
\$500 million	U.S. Postal Service for facility repair and improvements
\$399.7 million	Customs Service for counter-terrorism
\$226 million	Nuclear Nonproliferation
\$210 million	Federal Emergency Management Agency for firefighter grants
\$209 million	Coast Guard for counter-terrorism
\$200 million	Federal Aviation Administration for aviation security
\$93 million	U.S. seaports for security enhancements

* \$865 million earmarked for states

** \$400 million earmarked for states

Source: "Conferees approve \$20 billion supplemental," *U.S. House Committee on Appropriations*, Dec. 19, 2001

federal agencies focus on terrorism, they are leaving some of their traditional public-safety responsibilities to the states. For decades, federal agencies assisted states and communities with criminal investigations, prosecutions and law-enforcement needs. Since Sept. 11, the federal government has devoted many of its resources to investigating the attack and preventing future acts of terrorism — not chasing bank robbers or investigating interstate drug smugglers. As the states take up the federal slack, they, in turn, can provide less assistance, physically and financially, to local governments.

Congress appropriated \$8.3 billion for homeland security, but only about \$1.2 billion is earmarked for state and local governments — \$865 million to upgrade bioterrorism capacity and \$400 million for counter-terrorism assistance. The bulk of the funding package will augment national homeland-security efforts by federal agencies such as the Federal Emergency Management Agency, the FBI and the Immigration and Naturalization Service.

Until federal dollars are available, state governors and legislatures are forced to find alternative-funding mechanisms to finance their new homeland security and public-safety roles.

For example, Minnesota Senate leaders as of January planned to introduce a \$29 million homeland-security package, partly funded by increasing monthly tele-

phone surcharges from \$0.27 to \$0.49 to raise \$5 million a year. Sen. Jane Ranum, a co-sponsor of the bill said, "At a time when long-distance calls for a buck are considered a good deal, paying half as much for a call that saves a life is a real bargain." Ranum called homeland security "a top priority" for more funding.

Similarly, Pennsylvania Rep. John J. Taylor introduced HB 2219 to create a homeland security and anti-terrorism funding program. The program would be funded by imposing duties on the State Horse Racing Commission and taxing slot machines.

As homeland-security costs mount, states also are facing massive cuts in budgets for traditional public-safety and corrections duties. The boom in prison construction — which began in the days of revenue windfalls, get-tough-on-crime candidates and federal Violent Offender Incarceration/Truth in Sentencing grants — has fizzled. The trend now is toward cutting existing programs, bed space and health care costs.

Some states, such as Ohio and Illinois, have been forced to close prisons. Facing a \$55 million budget shortfall, the Michigan Department of Corrections is moving state prisoners from county/regional facilities into centralized state prisons to save money.

For most states, probation and parole can help meet the demand for bed space with fewer prison facilities. However, pro-

bation and parole caseloads are reaching unmanageable levels. And 16 states abolished discretionary parole as part of get-tough-on-crime efforts in the 1980s and 1990s.

States also face tough choices regarding rehabilitative programming and education. Though state officials know that programming is critical in inmates' successful re-entry into society, they also recognize the hard reality of operating programs with no money. Illinois, facing a \$500-million gap in the state budget, is cutting effective rehabilitative programs. State corrections officials are quick to point out, however, that budget cuts will not include general education courses.

The Florida Department of Corrections is targeting prison drug-treatment programs for cuts, fully expecting to reduce the statewide program by one-third. The cuts affect some 30 programs and will reduce bed space in the programs by some 32 percent.

Not all states, however, are cutting programs or closing prisons. Nebraska Gov. Mike Johanns said his state will increase spending on juvenile-justice programming, recognizing that it is better to respond to youths' unique needs now than to pay for incarceration later. Nebraska Sen. Nancy Thompson praised the move, despite the state's revenue shortfall. "By adding programs, we are getting kids treated quicker and back to their community with more hope," Thompson said in a January article in the *Lincoln Journal Star*.

Despite revenue shortfalls, North Carolina is proceeding with construction of three prisons through an innovative pseudo-private prison construction plan. The state finances the prison construction through tax-exempt bonds issued by a nonprofit entity, which the state treasurer's office established. The plan saves money in construction costs by taking lessons from private prisons and does so without a legislative budget line.

—John J. Mountjoy & Chad S. Foster

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