

Three Years Of State Fiscal Struggles: How Did Medicaid And SCHIP Fare?

After the difficult fiscal period that states have just weathered, getting back on track will be a challenge.

by **Teresa A. Coughlin and Stephen Zuckerman**

ABSTRACT: During 2003–05, states faced some of the largest budget shortfalls since World War II. With a focus on Medicaid and SCHIP, we examine budget decisions in eight states during this period. Increasing Medicaid enrollment because of the economic downturn and rising health care costs compounded state budget shortfalls as state revenues dropped; problems peaked in 2004. States, however, were reluctant to confront their budget deficits as long-term problems and implemented a variety of one-time revenue strategies and spending reductions that push fiscal problems into the future. The arrival of federal fiscal relief in late 2003 helped states avoid deeper cuts but did not eliminate cutbacks.

THE RECESSION THAT STARTED IN 2001 resulted in a decline in tax revenues that forced states to confront some of the biggest budget shortfalls since World War II. After several years of unprecedented growth, state tax revenues declined for eight consecutive quarters from mid-2001 until mid-2003.¹ Adding to the drop in revenues, during the economic boom of the 1990s many states had enacted major tax cuts in response to both large budget surpluses and a strong antitax sentiment. Apart from a plunge in revenues, states faced strong spending pressures, particularly for education and Medicaid, the two largest spending items in state budgets.

States felt these budget pressures mounting in 2001 and began addressing the problem in early 2002 as they closed out their fiscal year 2002 budgets and prepared for FY 2003. Unlike the federal government, virtually every state is required to present a balanced budget each cycle. States typically accomplish this by cutting spending, drawing on reserves, or raising revenues. FY 2003 budgets were projected to be in balance, but revenues continued to lag, and many states projected even greater budget shortfalls for 2004. By the end of FY 2004, state budget pressure eased, and revenue growth picked up.² Even with the increase, though,

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per capita state tax revenue in 2004 was still well below the peak of 2001.³ As a result, most states projected sizable budget shortfalls in FY 2005, with growth in spending for education and Medicaid continuing to outpace revenues.

With a special focus on Medicaid and the State Children's Health Insurance Program (SCHIP), this paper reviews the experiences of eight states during 2003–05. We examine budget decisions made by state policymakers in Alabama, California, Colorado, Massachusetts, Michigan, New York, Texas, and Washington. Although no group of eight states can be representative of the entire country, the study states account for 37 percent of the U.S. population and 43 percent of the nation's Medicaid spending. However, the states tended to be wealthier (measured in terms of per capita income) than the average, with five (California, Colorado, Massachusetts, New York, and Washington) receiving the minimum 50 percent Medicaid match rate in 2003.⁴

The paper is based on a review of state documents, Web sites, media reports, and interviews with key state government officials and representatives of provider and consumer organizations that took place at various intervals during the three-year study period. It combines results from earlier research that focused on FY 2003 and FY 2004 separately.⁵

Revenue And Spending Strategies, 2003–2005

Exhibits 1–3 highlight states' major revenue and spending actions during the 2003–05 study period.⁶ Below we provide details on these actions.

■ **Tax and fee strategies.** Despite the problem of reduced revenues, there was little political support to increase taxes in FY 2003 (especially income and sales taxes). In most states, policymakers did not actively consider raising broad-based taxes, reflecting the country's persistent antitax sentiment. A notable exception was Massachusetts, the only state to enact an income tax increase in FY 2003.⁷

States were much more likely to increase taxes and fees or to close tax loopholes to balance their budgets in 2004 than in 2003. However, policymakers again largely avoided enacting increases in broad-based taxes. An important exception was New York, which enacted a temporary three-year increase in the personal income tax as well as an increase in its sales tax. Michigan also increased its sales tax. Massachusetts, Michigan, and New York passed measures designed to close corporate tax loopholes. States also raised user fees. California, Colorado, Massachusetts, Michigan, New York, and Washington increased fees on a broad range of goods and services, from college tuition to cellular phones.

Several states (Alabama, Massachusetts, Michigan, and Washington) increased provider taxes or quality assessment fees to balance their FY 2004 budgets. These taxes are typically linked to a Medicaid reimbursement rate increase and allow the state to raise provider rates (or avoid a reduction) by drawing in federal payments without using state general funds. States have applied these taxes to nursing homes, hospitals, and health maintenance organizations (HMOs).⁸

EXHIBIT 1
Highlights Of Revenue And Spending Budget Actions In Eight Study States,
Fiscal Year 2003

Revenue actions	AL	CA	CO	MA	MI	NY	TX ^a	WA ^b
Taxes								
Income/sales		x ^c		x				
Cigarette/liquor					x	x		
Provider					x	x		
Corporate ^d		x						
User fees				x		x		
One-time measures								
Fund transfers	x	x		x	x	x		
Rainy-day reserves	x		x	x	x	x		x
Debt financing						x		
Securitizing tobacco funds		x				x		x
Accounting strategies		x	x		x	x		
Medicaid maximization		x	x		x	x		x
Spending actions								
Medicaid								
Eligibility standards				-				
Administrative eligibility changes		-		-	-			
Benefits				-	-			
Provider payment			-	-	-			+/-
Prescription drugs		-	-	-	+/-			-
SCHIP		+	+					
Other health coverage programs								-
K-12 education		+	+			+		-
Higher education			-	-	-			-
State employees			-	-	-			-
Local aid			-	-	-			-

SOURCE: Authors' summary of state budget actions.

NOTES: For revenue actions, X indicates that the state adopted measures designed to increase revenue from stated source. For spending actions, - indicates that reductions were made in the spending category, whereas + indicates that spending was increased. SCHIP is State Children's Health Insurance Program.

^a Texas uses a biennial budgetary process, and its fiscal year (FY) 2002/03 budget was passed in September 2001, before our study began.

^b These reflect actions taken in Washington's 2001-03 biennial budget.

^c California's increase in this category were targeted, time-limited changes in tax rules to raise revenue in one or two years.

^d Increased corporate revenue comes from closing corporate loopholes rather than a tax increase.

By FY 2005, state revenues had improved, and none of the states saw a need to increase broad-based taxes. They did, however, enact some targeted tax and fee increases as well as measures designed to close corporate tax loopholes.

■ **One-time revenue strategies.** With broad-based taxes largely off the table, states relied heavily on a number of temporary revenue measures to fill their 2003 budget gaps. One strategy was to borrow from a range of funds, including dedicated education funds (Alabama), Temporary Assistance for Needy Families (TANF) reserves (New York), and transportation projects (California).

Another strategy used by California, Colorado, and Michigan was to postpone paying bills, including state workers' paychecks and Medicaid payments. Some

EXHIBIT 2
Highlights Of Revenue And Spending Budget Actions In Eight Study States,
Fiscal Year 2004

Revenue actions	AL	CA	CO	MA ^a	MI ^a	NY	TX ^b	WA ^c
Taxes								
Income/sales		x ^d			x	x ^e		
Cigarette/liquor	x							x
Provider	x			x	x			x
Corporate ^f				x	x	x		
User fees		x	x	x	x	x		x
One-time measures								
Fund transfers	x	x	x	x	x	x	x	x
Rainy-day reserves					x		x	x
Debt financing		x						x
Securitizing tobacco funds		x	x			x		
Accounting strategies		x	x		x	x	x	
Medicaid maximization	x			x	x			x
Spending actions								
Medicaid								
Eligibility standards			-	-			+/-	
Administrative eligibility changes	-	-		-			-	-
Benefits	-	-	-	+/-	-		-	-
Provider payment		-	-	-	+/-	-	-	-
Prescription drugs	-		-				-	-
SCHIP	+/-	+	-				+/-	
Other health coverage programs								
K-12	-		+		+/-	-	-	-
Higher education	-	-	-	+/-	-	-	-	-
State employees	-	-	-	-	-	-	-	-
Local aid		-	-	-	-			

SOURCE: Authors' summary of state budget actions.

NOTES: For revenue actions, X indicates that the state adopted measures designed to increase revenue from stated source. For spending actions, - indicates that reductions were made in the spending category, whereas + indicates that spending was increased. SCHIP is State Children's Health Insurance Program.

^a Includes mid-cycle adjustments.

^b Actions reflect those enacted in Texas's 2004-05 biennial budget and mid-cycle adjustments.

^c Actions reflect those adopted as part of Washington's 2003-05 biennial budget and mid-cycle adjustments.

^d California's increase in this category were targeted, time-limited changes in tax rules to raise revenue in one or two years.

^e New York's income and sales measures were temporary tax increases.

^f Increased corporate revenue comes from closing corporate loopholes rather than a tax increase.

states also accelerated tax collections to meet short-term objectives with the hope that the budget picture would improve.

Three states (California, New York, and Washington) securitized their tobacco settlement funds to raise revenues.⁹ To maximize funds for FY 2003, these states sold tobacco-settlement bonds, which provided them with immediate cash in exchange for a share of future settlement payments from the tobacco companies.

In yet another temporary measure, California filled a sizable chunk of its \$38 billion 2004 shortfall by borrowing. After receiving voter approval for \$15 billion in deficit-financing bonds, the state elected to borrow \$8.6 billion by selling

EXHIBIT 3
Highlights Of Revenue And Spending Budget Actions In Eight Study States,
Fiscal Year 2005

Revenue actions	AL	CA	CO	MA	MI	NY	TX ^a	WA ^a
Revenue actions								
Taxes								
Income/sales		x ^b				x		
Cigarette/liquor	x							
Provider	x	x			x			
Corporate ^c				x		x		
User fees	x	x	x		x			
One-time measures								
Fund transfers	x	x	x	x	x	x		
Rainy-day reserves				x	x			
Debt financing		x					x	
Securitizing tobacco funds							x	
Accounting strategies	x	x			x		x	
Medicaid maximization		x		x	x			
Spending actions								
Medicaid	+ ^d		+	+				
Eligibility standards							-	
Administrative eligibility changes		-					-	
Benefits					+		-	
Provider payment		-	+/-	-	+/-			
Prescription drugs					-			
SCHIP	+	+/-	+		-		-	
K-12 education	+	-	+	+	+/-		+	
Higher education	+	-	+	+	+/-			
State employees	-			+			+	
Local aid	-	-	+				+	

SOURCE: Authors' summary of state budget actions.

NOTES: For revenue actions, X indicates that the state adopted measures designed to increase revenue from stated source. For spending actions, - indicates that reductions were made in the spending category, whereas + indicates that spending was increased. SCHIP is State Children's Health Insurance Program.

^aTexas's and Washington's 2005 budget decisions are provided in Exhibit 2, which shows these states' 2004-05 biennial actions as well as mid-cycle adjustments.

^bCalifornia's increase in this category were targeted, time-limited changes in tax rules to raise revenue in one or two years.

^cIncreased corporate revenue comes from closing corporate loopholes rather than a tax increase.

^dAlabama increased state general funding of Medicaid, which largely made up for the loss of federal relief funds and federal upper payment limit (UPL) funds.

bonds to fill its budget gap. By taking this approach, California has greatly increased its future financial obligations and will need an estimated \$2 billion each year for the next decade to pay off the bonds. California also financed a sizable part of its FY 2005 budget shortfall by going further into debt using this bond authority.

States relied much less on "rainy-day funds" in FY 2004, largely because these funds had been virtually depleted in 2003. States, however, relied again on various one-time revenue strategies. In a new one-time strategy, three states—California, Colorado, and Texas—moved from accrual to cost-based accounting for selected services, primarily Medicaid. Under this strategy, instead of accounting for pay-

ments to providers when liabilities are incurred, expenses are recorded when payment is made. This change shifted 2004 costs to 2005, allowing the state to lower spending in the current year but increasing future obligations. Despite improved revenue projections in FY 2005, the states again relied heavily on one-time revenue strategies to fill their ongoing budget gaps.

■ **Medicaid maximization.** Almost without exception, all states stepped up their use of Medicaid maximization strategies, including Medicaid disproportionate share hospital (DSH) and upper payment limit (UPL) payments, to balance their budget gaps during the 2003–05 period.¹⁰ The strategies took various forms. Michigan, for example, made heavy use of its Medicaid Benefits Trust Fund, which it had established with monies obtained through DSH and UPL mechanisms. California retained more of its DSH funds to pay for general program expenses instead of sending the funds to safety-net hospitals, whereas Alabama increased its use of intergovernmental transfers (IGTs) to help pay for the state's share of Medicaid spending.

■ **Medicaid and SCHIP actions.** A number of factors, including increased enrollment because of the economic downturn and rising health care costs, put upward spending pressure on Medicaid during the 2003–2005 period. As the second-largest item in most state budgets (after education), Medicaid did not escape spending cutbacks. In 2003, however, the savings obtained from these spending cuts were a small share of budget gaps in that year. For example, California's Medicaid cuts amounted to \$800 million of the \$24 billion gap (3.3 percent), and Washington's Medicaid cuts totaled \$52 million of a \$1.6 billion gap (3.3 percent). Further, states maintained support for SCHIP, with California and Colorado increasing SCHIP funding in 2003.¹¹

For the majority of the states in the study, Medicaid savings initiatives in 2003 focused on reducing or freezing reimbursement rates, rather than on cutting eligibility and services. Another area where states sought to control Medicaid spending was prescription drugs. Some states adopted traditional approaches (such as beneficiary copayments in Colorado and Massachusetts) to curtail drug spending, whereas others (such as California and Michigan) implemented far more ambitious efforts. Michigan, for example, implemented one of the nation's first programs designed to secure additional rebates from drug manufacturers.

The one important exception to the limited Medicaid cutbacks in 2003 among our states was Massachusetts, which had greatly expanded coverage in recent years as part of its comprehensive MassHealth program.¹² To fill its 2003 budget gap, Massachusetts cut eligibility for the long-term unemployed and implemented administrative changes in enrollment and outreach, so that the MassHealth caseload declined by about 7 percent in 2003.¹³ Although California did not reduce eligibility standards, it did change enrollment and outreach policies, which some interviewees charged was a “back-door” eligibility cut.

Cuts to Medicaid and SCHIP were much more aggressive in 2004 than in 2003, but the depth of states' cuts varied considerably. New York and California enacted

few Medicaid cutbacks. Alabama, in a midyear supplemental budget, greatly increased general-fund Medicaid spending. In contrast, Texas, Colorado, Massachusetts, and Washington adopted fairly substantial Medicaid cuts.

Although Medicaid cuts were made in 2004, officials in all states noted that the reductions would have been greater still if not for the infusion of federal dollars provided in the 2003 Jobs and Growth Tax Relief and Reconciliation Act.¹⁴ A key condition of the act was that states had to maintain Medicaid eligibility standards to receive the funds. Specifically, states could not reduce Medicaid eligibility levels between 2 September 2003 and 30 June 2004.

This provision caused some states to restore earlier eligibility cuts. Texas, for instance, had reduced Medicaid income standards for pregnant women from 185 percent of the federal poverty level to 158 percent before the passage of the federal fiscal relief package. However, spurred by an improving revenue picture in 2004 and in response to the federal relief package, Texas policymakers reversed the cut.

At the same time, despite the condition that states could not lower eligibility levels if they accepted federal fiscal relief funds, virtually all states implemented policies aimed at reducing the number of Medicaid beneficiaries by changing administrative policies governing enrollment and outreach. California, for example, stepped up efforts to complete annual determinations more quickly so that people did not stay on the program when no longer eligible. This measure alone was projected to reduce Medicaid enrollment by 300,000 people, or 5 percent of California's program enrollment.

Several states also sought to reduce the number of people receiving long-term care services. Alabama, for example, tightened the penalty for nursing home asset transfer so that those who transferred away assets to qualify for Medicaid have a longer waiting period before receiving benefits. Likewise, Washington reduced the amount of assets that the spouse of a nursing home resident could retain. Washington also capped the number of home and community-based waiver slots and narrowed functional eligibility requirements for personal care services. Finally, Michigan expanded its efforts to recover Medicaid costs from the estates of recently deceased nursing home residents.

Several states exercised some of the flexibility afforded under SCHIP. Among our states, Texas enacted the boldest cuts. By reducing consideration of income disregards and reducing the length of continuous eligibility in SCHIP from twelve to six months, Texas effectively cut SCHIP eligibility thresholds from 240 percent of poverty to 200 percent. As a result, SCHIP enrollment fell by nearly 150,000 (30 percent) by mid-2004, and enrollment has not rebounded as of this writing.¹⁵ Using a different approach, in 2004 Colorado capped SCHIP enrollment for children, ended SCHIP coverage for pregnant women, and terminated outreach efforts for the program.¹⁶ Alabama also capped enrollment in SCHIP and suspended program outreach.

Beyond eligibility changes, several states cut benefits in 2004, eliminating or re-

ducing the scope of optional services, restricting access to services, and imposing beneficiary copayments. Michigan, for instance, eliminated adult dental care, podiatry, and chiropractic services. Texas terminated coverage of adult mental health counseling, podiatry and chiropractic services, eyeglasses, and hearing aids. Some benefits were also eliminated from Texas's SCHIP benefit package (including dental, vision, and home health), and mental health/substance abuse treatment services were reduced.

While the bulk of the states we studied enacted benefit cuts, a few rejected them. Washington and California both had considered eliminating adult dental care but agreed on a more scaled-back reduction of this benefit. Similarly, Alabama had considered reducing some of its optional services, but the state already had one of the least comprehensive programs in the nation, so there was not a lot to cut and still remain in compliance with federal Medicaid rules.

Increasing or imposing new copayments was another frequently used cost-saving strategy in 2004. Texas, for instance, introduced Medicaid beneficiary cost sharing at the maximum amount permitted by federal law and raised SCHIP premiums and copayments at all income levels. Massachusetts also increased Medicaid premiums and copayments to the fullest possible extent. Colorado and Washington also increased copayments, although at a more modest level.

In 2004, states again reduced or froze provider payment rates as they had in 2003. California, for instance, cut rates for physicians, pharmacies, and managed care plans. Massachusetts cut virtually all of the major types of providers. Texas also reduced provider payments for hospitals, physicians, nursing homes, and community care providers and lowered SCHIP reimbursement by 5 percent. Washington also implemented cost-saving measures, including expanding its preferred drug program and decreasing managed care rates.

About midway through FY 2004, Alabama faced a nearly 20 percent gap in its Medicaid budget. After delaying reimbursing Medicaid providers, Alabama enacted a supplemental Medicaid appropriation, which was financed with revenues from increased nursing home taxes, increased intergovernmental transfers from public hospitals, and the enhanced federal match provided as part of the federal relief package. Alabama's shortfall came about in part because of the phasing in of federal regulations that effectively lowered the amount of federal Medicaid funds states could obtain through UPL arrangements.¹⁷

In 2005, state budget actions were mixed for health programs. Some states continued to cut spending, while others began to reverse earlier actions. For example, New York (which made comparatively few Medicaid reductions in the previous two years) implemented program cuts in 2005, including reducing Medicaid eligibility for children ages 6–19 with family incomes of 100–133 percent of poverty, imposing an asset test and copays on selected Medicaid enrollees, and reducing funding for enrollment help.¹⁸ California also enacted some Medicaid reductions in 2005, including reducing rates for pharmacists and hospitals and adopting

more administrative policies aimed at reducing program enrollment.

Alabama policymakers, by contrast, made Medicaid the state's top budget priority and greatly increased program funding. In contrast with most other general-fund budget items, Alabama enacted no Medicaid cutbacks in 2005. However, no expansions or restorations were made, either. Instead, the new funds provided level funding for the program, as the state needed to backfill the loss of federal relief funds, among other things.

In their 2005 budgets, Colorado, Michigan, and Massachusetts reversed some earlier Medicaid cuts but also implemented new cost-saving measures. Colorado enacted several Medicaid increases, including funds to pay for caseload and inflation growth as well as payments for health centers and primary care physicians. At the same time, Colorado reduced payment rates for hospitals, private-duty nurses, and durable medical equipment and completely eliminated the incentive fee paid as part of its primary care case management (PCCM) program. Likewise, Michigan added back some of the optional services it cut 2004 but reduced pharmacy payments, increased beneficiaries' copayments, and froze reimbursement rates for most providers.

We also observed a mixed picture in how states handled their 2005 SCHIP budget actions. Colorado, for instance, restored the SCHIP cutbacks it made in 2004 by lifting the enrollment cap and allowing pregnant women to begin enrolling in the program again. Similarly, Alabama eliminated its enrollment cap, approved full-year funding for a media campaign, and implemented a new online application system. At the same time, though, Alabama increased beneficiaries' copayments. Despite a call from the governor to enact an enrollment cap, California increased SCHIP funding but also raised premiums for higher-income enrollees.

■ **Education and other state budget actions.** As with Medicaid, states managed to avoid making deep cuts in most other budget sectors in 2003; however, reductions were taken, and not all spending categories were spared. Respondents in several states acknowledged that the lack of program reductions was, in part, because 2002 was an election year (when states enacted their FY 2003 budgets), and lawmakers lacked the political will to implement major program cutbacks.

A particular priority for states was K-12 education, the largest single spending item in virtually every state. Study informants consistently identified K-12 education as being governors' top budget concern, and spending for it was either maintained or increased in FY 2003.¹⁹ Despite a move by states to cut spending for many programs in 2004, K-12 education was largely protected or modestly increased in most states. The one major exception to this was Texas, which made sizable reductions in K-12 appropriations. Although Washington did not cut K-12 appropriations, it delayed implementing education reforms that were mandated as part of a voter ballot initiative.²⁰ Michigan also cut appropriations for K-12 education as part of midyear 2004 cuts.

“Despite the severity of the recent budget shortfalls, the states in our study were reluctant to address them as long-term problems.”

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For higher education, states were mixed on how spending was handled in 2003: In Alabama, California, and New York, spending was largely maintained, but Colorado, Massachusetts, and Washington enacted cuts and raised tuition fees. However, higher education was a major budget target in 2004 and was cut sharply. Both California and Colorado reduced higher education spending by 30 percent, causing large college tuition increases. Washington, Michigan, New York, and Massachusetts also made sizable cuts to their higher education appropriations. Some of the cuts to higher education in Massachusetts and Washington were restored by 2004 supplemental appropriations as revenue projections improved.

The state workforce sustained large cutbacks in 2003. Colorado, Massachusetts, Michigan, and Washington all enacted measures to decrease spending for the state workforce. Michigan introduced incentives for early retirement, Massachusetts increased employee contributions for health insurance, and Colorado lost about 1,000 jobs from across-the-board cuts. Washington reduced contributions to health benefits for state employees and eliminated a cost-of-living adjustment. In 2004, all study states reduced spending for state employees. States achieved these reductions by layoffs, salary reductions, or freezes and increasing employees' contributions to health insurance. However, Washington reversed some of these workforce cuts as part of a mid-2004 supplemental budget.

Another budget sector that was cut sharply in FY 2003 was aid to localities, which had the effect of shifting some of the state's budget gap to local areas. Colorado, Massachusetts, Michigan, and Washington reduced local aid. Aid to localities also sustained major cuts in 2004. California also reduced aid to localities indirectly when it eliminated an increase in the vehicle license fee (which was a major issue in the recall campaign that replaced Gov. Gray Davis with Gov. Arnold Schwarzenegger), as the new revenues were to go to cities and counties.

The degree to which states restored programs in FY 2005 as revenues improved varied greatly. Massachusetts increased spending for virtually all major budget categories but did not restore eligibility cuts to Medicaid. New York also increased spending for several major items but made cuts in higher education and Medicaid in 2005. Colorado and Michigan ramped up education appropriations.

At the same time, some states cut program spending. Continuing to face a sizable deficit, California suspended the minimum guaranteed spending on K-12 education (saving \$2.3 billion) and decreased higher education funding by increasing tuition. Alabama greatly increased education spending but enacted a 7 percent across-the-board cut for most state agencies (excluding Medicaid) and completely eliminated funding for many nonstate programs such as privately sponsored or owned museums or parks.

Discussion

Despite the severity of the recent budget shortfalls, the states in our study were reluctant to address them as long-term problems. States did not fundamentally reassess the basic structure or rules related to their major budget items, and few questioned their tax structures and policies. Instead, this review of eight states shows that states relied on a range of short-term solutions that, in some cases, pushed fiscal problems into the future. By taking this approach, however, some states have created structural deficits that will profoundly influence state policy making for many years to come.

Several very clear strategies emerged from our review of how eight states handled their recent budget problems. First, in contrast with the fiscal crises in the early 1990s, states were generally reluctant to increase income or sales taxes as a way of closing budget shortfalls. States did eliminate some tax loopholes or deductions as a way of generating extra revenues. They also relied on increased provider taxes, cigarette taxes, and user fees where possible. Only Massachusetts and New York enacted higher income taxes, and only Michigan and New York increased sales taxes.

Another consistent theme was that by approaching budget gaps as short-term problems, states leaned on a large number of one-time measures to allow them to avoid taxes and limit program cutbacks. As expected, states first largely depleted their rainy-day reserves. Many states also moved spending from one fiscal year to the next, with the hopes that revenue projections would improve.

In addition, states developed many creative approaches to balance their budgets. With the promise of future payback, most states shifted dollars from dedicated funds with surpluses into their general-fund budgets. Several sold bonds backed by expected future stream of payments under the tobacco settlement, eliminating any potential future uses of those payments. Others moved from accrual to cost-based accounting in their Medicaid programs as another means of shifting obligations forward.

California went so far as to get voter approval to issue \$15 billion in deficit-financing bonds to be used to close budget shortfalls over several years. Given that all of the states we studied are required to present a balanced budget, these deficit-financing bonds appear, at the very least, to violate the spirit of this requirement. This increased borrowing mirrors recent strategies followed by the federal government that have allowed spending to expand, taxes to be cut, and deficits to balloon.

A third policy choice was that most states initially resisted balancing their budgets by making extensive cuts in program spending. However, as the fiscal crisis dragged into 2004, states made some substantial cuts. Because of strong political and constituent support, states generally did not cut spending for K-12 education. States were also initially reluctant to cut higher education, but by 2004 most states reduced general-fund contributions for higher education with the expecta-

tion that they would be replaced by higher tuition. By contrast, several states made deep cuts in aid to localities in FY 2003 and FY 2004. As revenues began to improve moving into FY 2005, some states that had made cuts or limited increases in education and aid to localities began to restore funding.

The state workforce sustained substantial cutbacks over the study period. In both 2003 and 2004, states, to varying degrees, reduced the size of their workforce, eliminated cost-of-living and other salary increases, and required greater employee contributions for health insurance. As of this writing, most states had not reversed these budget actions.

Medicaid and SCHIP were not immune from cuts. Although states had an incentive to preserve Medicaid to avoid losing federal matching funds, the severity of the state fiscal crisis led each of these eight states to adopt measures to control the growth of Medicaid spending. These actions ranged from repeated cuts to provider payments, controls on prescription drug spending, eligibility and enrollment restrictions, and reduced benefits and increased cost-sharing for beneficiaries. Given the prominence of Medicaid in state budgets and the depth of the financial crises, major Medicaid cuts seemed unavoidable. By and large, however, that was not observed in the eight study states.

The availability of temporary federal fiscal relief helped mitigate the level of cuts. States were quickly able to tap the funds, and many were able to defer planned cuts or restore cuts that had been made. A condition for getting the full benefit of the federal fiscal relief was for Medicaid eligibility to be maintained at September 2003 levels. As a result of this provision, no state made an eligibility cutback that would have precluded receiving the fiscal relief. Importantly, though, several states adopted “back door” eligibility reductions by limiting outreach or imposing new requirements on the enrollment process that made it more difficult for people to enroll and stay enrolled. A number of states also made other cuts that were outside of conditions for receiving the fiscal relief, including eliminating or reducing optional benefits.

When the fiscal relief expired in 2004, some states had started to see their tax revenues begin to recover, but many were still fiscally strapped. Some states restored selected areas of Medicaid; others implemented additional cost-saving measures. If states remain tentative about using new revenues to restore Medicaid eligibility, make enrollment easier, and increase provider rates, the damage that the recent recession did to Medicaid may take years to repair. Not only will fewer people be getting Medicaid coverage than would have previously, but providers who have had their rates frozen or reduced in recent years could turn away from Medicaid, creating access problems.

After the difficult fiscal period that states have just weathered, getting back on track will undoubtedly be a challenge. Because of the tax cuts many states adopted in the late 1990s, states have a much lower tax base to pay their bills. To compound the problem, many states borrowed or pushed current obligations into

the future. Although these obligations could be dealt with through new revenue sources, the reluctance to raise taxes makes that quite unlikely. However, if these structural deficits cannot persist indefinitely, states will be forced to confront the choice between cutting spending drastically and bucking the antitax sentiment.

Apart from fiscal difficulties at the state level, the federal government is looking to control its spending on Medicaid. Recently passed congressional resolutions guiding the federal FY 2006 budget, for instance, indicate that \$10 billion in federal Medicaid cuts could occur during the next five years.²¹ Furthermore, the federal government has stepped up its efforts to curtail the use of intergovernmental transfers in financing the state share of Medicaid; this has important and widespread fiscal implications for states.²² The federal government is also discussing putting limits on states' use of provider taxes in Medicaid, a particular problem given the increasing reliance on these taxes by states over the past couple years. Without doubt, states are going to continue to face tough policy decisions in the coming years, and Medicaid will certainly be at the heart of the debate.

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NOTES

1. N.W. Jenny, "State Tax Revenue Recovery Gathering Steam," State Revenue Report no. 56 (Albany: Nelson A. Rockefeller Institute of Government, Fiscal Studies Program, June 2004).
2. Ibid.
3. N.W. Jenny, "Strong Finish for Many States' Fiscal Years: Preliminary April-June Quarterly State Tax Revenue Data," *State Fiscal News* 4, no. 7 (August 2004).
4. This was the base 2003 Federal Medical Assistance Percentage for these states before the federal fiscal relief package was enacted. All totaled, ten states had the minimum 50 percent base match rate in 2003.
5. J. Holahan et al., *The State Fiscal Crisis and Medicaid: Will Health Programs Be Major Budget Targets?* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2003); and J. Holahan et al., *State Responses to Budget Crisis in 2004: An Overview of Ten States* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2004).
6. The exhibits highlight major budget actions taken by the states during the FY 2003-05 period. They are not meant to be an exhaustive accounting of the multitude of state budget measures adopted during the study period.
7. N.W. Jenny, "2002 Tax and Budget Review and 2003 Budget Preview," State Fiscal Brief no. 66 (Albany: Nelson A. Rockefeller Institute of Government, Fiscal Studies Program, March 2003).
8. A. Schneider et al., *The Medicaid Resource Book* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2002).
9. All eight states participate in the state attorneys general Master Settlement Agreement of 1998 and receive regular payments from the tobacco companies.

10. Under these special financing strategies, a state obtains money from providers, primarily through taxes, or from government agencies, through intergovernmental transfers. The state then uses these funds to make DSH or UPL payments to providers under Medicaid and in the process secure federal matching funds. State- or locally generated funds are typically returned, along with some or all of the federal Medicaid payment. Providers benefit to the extent that they retain some of the federal funds. These payments have been widely used and have generated a considerable amount of money for states and providers. For further details about such strategies, see T.A. Coughlin and S. Zuckerman, "States' Strategies for Tapping Federal Revenues: Implications and Consequences of Medicaid Maximization," in *Federalism and Health Policy*, ed. J. Holahan, A. Weil, and J.M. Wiener (Washington: Urban Institute Press, 2003), 145–178.
11. Although California increased SCHIP funding, it delayed a planned expansion to parents.
12. Before the budget crises, Medicaid eligibility in Massachusetts was extended to people with incomes up to 200 percent of poverty, higher for disabled beneficiaries. The state also provided partial coverage to other groups up to 400 percent of poverty. As a result of these efforts, Massachusetts insured 51 percent of its poor population through Medicaid in 2001.
13. As discussed below, Massachusetts reinstated the program for the long-term unemployed in mid-2004, albeit with scaled-back coverage.
14. The Jobs and Growth Tax Relief and Reconciliation Act of 2003 provided, among other things, \$20 billion in federal dollars to states between April 2003 and September 2004. Under the act, about half of the funds were made available to states through an increase in the federal Medicaid match rate. The balance of the funds was provided through a general revenue sharing program.
15. A. Dunkelberg and M. O'Malley, *Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2004).
16. Although Colorado terminated SCHIP coverage for pregnant women, current enrollees were allowed to remain in the program, but no new beneficiaries were enrolled.
17. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 included provisions that specified a transition period for states to bring their provider upper payment limits (UPLs) into compliance with the new limits established in BIPA. Before BIPA, many states had used the UPL payment structure as a way to draw down extra federal matching dollars, often without using any real state dollars. For more details on UPL, see T.A. Coughlin et al., "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23, no. 2 (2004): 245–257.
18. Children cut from Medicaid are now served under SCHIP in New York, which has a less comprehensive benefit package.
19. In California, Colorado, Michigan, and Washington, spending on K–12 education is protected by constitutional amendments or ballot initiatives; in Alabama, education is financed by a dedicated account. These special protections for education reduce the amount of funds available for other needs and increase the fiscal pressure on remaining programs.
20. Among other things, Washington's education initiatives called for increasing teacher salaries and reducing class size. The ballot initiatives, however, did not have dedicated funding sources. Instead, the state was to allocate general revenues to fund the initiatives, which was a problem given the state's fiscal situation in 2004. In the end, the legislature amended the initiative (allowable with a two-thirds majority vote) and delayed implementation. Moreover, as revenue projections improved, Washington committed to restoring some K–12 funding.
21. S.G. Stolberg, "Congress Passes Budget Cuts in Medicaid Growth and in Taxes," *New York Times*, 29 April 2005.
22. R. Pear, "Governors Resist Bush's Appeal for Quick Deal on Medicaid," *New York Times*, 1 March 2005.