

# Health Policy For Low-Income People: States' Responses To New Challenges

States may be facing increased pressure in the coming months as current systems reach their capacity and new fiscal challenges loom.

by John Holahan, Joshua M. Wiener, and Amy Westpfahl Lutzky

**ABSTRACT:** The past five years have given states new opportunities in health policy for low-income people, with many changes increasing states' flexibility. However, new pressures on state policy also have arisen from a variety of factors, most recently from the economic downturn that has reduced revenues and increased demand for spending. This paper analyzes recent changes in health policy in the thirteen states that are the core of the Urban Institute's Assessing the New Federalism project, focusing on state fiscal conditions, health care coverage, acute care, and long-term care. Implications for the future are discussed.

ALTHOUGH THE PAST FIVE YEARS have given states new opportunities in health policy for low-income people, they have also put new pressures on policy formulation. Many developments have increased states' flexibility, including welfare reform and the delinking of Medicaid from cash assistance, new funding for children's health insurance coverage under the State Children's Health Insurance Program (SCHIP), repeal of federal minimum standards for nursing home and hospital reimbursement that constrained states' control over Medicaid payments, and increased federal willingness to grant waivers under Medicaid (and now under SCHIP as well). Fiscal capacity also rose—from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

However, new pressures on revenues and state policy have resulted from recent federal economizing under Medicaid and Medicare, including cuts in safety-net support programs that some states were thought to be abusing; political pressures for state tax cuts; and, starting in 2000, an economic slowdown followed by recession. New pressures also arose from the Supreme Court's *Olmstead v. L.C.* decision, which established a limited right to home and community-based services under the Americans with Disabilities Act; rapid growth in pharmaceutical spending; and the difficulties faced by Medicaid managed care. Political demands for public

.....  
*John Holahan is director of the Health Policy Center at the Urban Institute. Joshua Wiener is a principal research associate there, and Amy Westpfahl Lutzky is a research associate.*

action resulted from developments such as the increase in the number of uninsured persons, growth in private and public managed care, rising drug costs, and hospitals' fiscal woes, as well as events specific to each state.

To examine how states have responded to both federal constraints and state flexibility over the past few years, the Assessing the New Federalism (ANF) project at the Urban Institute examined state priority setting and program operations in health policy affecting the low-income population in thirteen states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. These states represent a wide range of policy approaches, fiscal capacities, and attitudes toward government and support for services for low-income populations. A description of the overall project, including the rationale for the states selected, is available elsewhere.<sup>1</sup> Building on earlier baseline studies in the same states, the study team prepared reports on health policy for the low-income populations in each state.<sup>2</sup> In addition, short summaries of each state case study can be found in the report, *Health Policy for Low-Income People: Profiles of Thirteen States*.<sup>3</sup>

Information for the case studies was obtained from publicly available documents, newspapers, Web sites, and interviews with state officials, provider organizations, consumer advocates, and other stakeholders. In-person interviews were conducted in state capitals from February through June 2001. Questions were asked using an open-ended interview protocol, and state officials were given the opportunity to comment on the draft reports. Additional information was obtained to update the status of each state through roughly the end of 2001.

This paper uses the information in the thirteen case studies to address four major sets of state health policy issues. First, how have the fiscal circumstances of the states changed over the past several years, and how have those changes affected health programs? Second, have the states expanded public or private health insurance coverage through Medicaid, SCHIP, Medicaid research and demonstration waivers, or state-funded programs? Third, how have Medicaid managed care and other acute care issues changed? For example, has access been affected by managed care plans' withdrawals from Medicaid or backlash against health plans by providers or beneficiaries? Fourth, how are state systems of long-term care changing? For example, how are states responding to pressures to expand home and community-based services for disabled persons, their new freedom to set nursing home reimbursement rates, and the labor shortage?

## Overview Of The Major Findings

■ **State fiscal conditions and health policy.** From 1995 to 2000 state economies were expanding, inflation and unemployment were low, and state revenues increased rapidly. As a result, states were able to increase spending, cut taxes, and increase the size of their "rainy day funds." Medicaid spending from state general revenues increased at only about 5 percent a year as a result of low rates of medical

care inflation, falling enrollment because of welfare reform and a strong economy, cost savings from the expansion of managed care, and, arguably, repeal of federal minimum standards on Medicaid nursing home reimbursement. Many states used their good fiscal status to expand health programs, among other activities.

The national economy started to slow in 2000; by March 2001 the country was in a recession that reduced state revenues and caused state spending to climb. As states reexamine their already enacted fiscal year 2002 budgets and begin to plan their FY 2003 budgets, the ANF states generally did not appear to be planning major Medicaid cutbacks. While growth in Medicaid and SCHIP spending was regarded as a major contributor to their fiscal problems, states did not appear to view large cuts in these programs as a way to balance their budgets, although they are likely to trim optional benefits and cut (or freeze) provider reimbursement rates. The loss of federal matching funds was often cited as a constraint on Medicaid cuts. If the recession deepens or is prolonged, this stance could change. But so far, the primary effect of the economic slowdown is likely to be the failure to take advantage of new coverage expansion opportunities, such as parental coverage under Section 1931(b) of the Social Security Act or SCHIP waivers.

■ **Health care coverage.** Medicaid rolls fell between 1995 and 1998 because of the improved economy and welfare reform. Welfare reform allowed states to expand eligibility in new ways, but because of confusion on the part of beneficiaries and caseworkers, Medicaid enrollment fell, although not as much as enrollment in Temporary Assistance for Needy Families (TANF) fell. States responded to the declines in Medicaid enrollment by reforming state outreach and enrollment practices, and Medicaid rolls rebounded to some extent over the next few years. States are now anticipating further increases in enrollment as a result of the recession.

Welfare reform created a new category under Section 1931(b) of the Social Security Act that enabled states to expand Medicaid eligibility to families with much higher incomes than was previously allowed. Of our thirteen states, only New Jersey and California elected to use Section 1931(b) to expand coverage. Massachusetts, Minnesota, Wisconsin, and New York had substantial Medicaid coverage expansions under Section 1115 waivers during the same period.

SCHIP was enacted in 1997 and began to be implemented in 1998. There was a strong response on the part of states, even those with historically very restrictive Medicaid eligibility levels, to expand coverage for children in families at relatively high income levels. Most states adopted programs separate from Medicaid in an attempt to establish programs that were not open-ended entitlements and that did not have a welfare stigma. States embarked on ambitious outreach campaigns, and many developed innovative strategies to streamline the eligibility determination process. By December 2000 SCHIP had enrolled 2.7 million children; the number who were previously uninsured is not known.<sup>4</sup>

In 2000, three ANF states—New Jersey, Minnesota, and Wisconsin—received Section 1115 waivers under SCHIP to expand coverage to parents. California was

granted a waiver in early 2002. States argue that expanding coverage for parents increases participation by children. There has been less interest in premium assistance programs that use Medicaid or SCHIP funds to subsidize employer-sponsored insurance because of the administrative complexity and the limited benefits of many employer plans compared with Medicaid or SCHIP.

■ **Acute care.** Medicaid managed care remains strong in most states; the exceptions are Alabama and Mississippi, where it was tried but quickly abandoned. But expectations of Medicaid managed care's ability to control costs have diminished. Most states have experienced plan withdrawals, usually over issues of rate adequacy, administrative burdens, and the difficulty of maintaining provider networks. Capitation rates have often been increased in response. As a result, Medicaid programs are not finding the same levels of new savings from managed care that they had in previous years.

Disproportionate-share hospital (DSH) payments and upper payment limit (UPL) programs remain an important part of Medicaid financing. States have expended considerable energy and creativity in developing arrangements that bring in ample federal funds with few or no new state expenditures. Providers benefit from these initiatives to varying degrees. States are expanding these programs when they can but are deeply concerned about the fiscal consequences of federal cutbacks in DSH payments and new restrictions on the use of UPL programs.

With recent Medicaid spending for prescription drugs increasing 14–18 percent per year, prescription drug outlays are a major issue for all states. Federal rules limit states' ability to restrain drug prices and utilization. However, some states (Florida and Michigan) are developing innovative approaches that offer the potential to obtain greater discounts from manufacturers.

Several ANF states have adopted new programs to subsidize prescription drug coverage for the low-income elderly and disabled populations. These programs vary in the income groups that are covered and the structure of the subsidies.

■ **Long-term care.** The long-term care sector, including nursing homes and community-based services, faces severe workforce shortages. Several states have responded with rate increases that require that the increased funds be used to raise workers' wages. The labor shortage has serious short- and long-term implications for quality of care and program spending. Several states have responded to concerns about the quality of care in nursing homes by raising reimbursement rates, tightening regulatory oversight, increasing staffing requirements, and providing consumers with more information.

States continue to expand home and community-based services. These expansions include home care through the Medicaid personal care option, but they increasingly depend on extensive use of Medicaid and home and community-based services waivers. Efforts to expand home and community-based services are driven in part by the Supreme Court's 1999 *Olmstead v. L.C.* decision, which ruled that inappropriate institutionalization was discrimination against people with

*“Medicaid and SCHIP account for a large portion of total state spending, making them a potential target for budget cuts.”*

.....

disabilities. However, some states have not yet responded to *Olmstead* because they believe that their extensive range of home and community-based services makes further actions unnecessary.

### **State Fiscal Conditions And Health Policy**

From 1995 to 2000 all fifty states enjoyed very favorable fiscal conditions, which allowed them to cut taxes and increase spending at the same time. But in 2000 the economy began to slow, and by spring 2001 the country was in a recession. The terrorist attacks of 11 September 2001 added to the slowdown. Most states are now facing deficits for state FY 2002 and are considering how to cope with what are expected to be substantial shortfalls for FY 2003. Medicaid and SCHIP account for a large portion of total state spending, making them a potential target for budget cuts.

■ **A strong economy: 1995–2000.** From 1995 to 2000 the overall economy was expanding, inflation and unemployment were low, and state revenues increased rapidly. Fiscally, times were good for all fifty states. At the national level, total state spending (federal and state) increased at an average rate of 6 percent a year during this period, while states’ general fund spending increased by an average rate of 5 percent per year.<sup>5</sup> The average annual rate of increase in states’ general revenue spending for the ANF states was about 5 percent.

For all fifty states Medicaid accounted for an average of about 15 percent of general revenue spending (19.5 percent of total state spending when federal funds are included), and these percentages remained stable between 1995 and 2001.<sup>6</sup> Between 1995 and 2000 states’ general revenue spending on Medicaid increased at a rate of only about 5 percent a year, much lower than Medicaid’s historical growth rate. Medicaid spending slowed during this period because of low rates of medical care inflation, falling enrollment as a result of welfare reform and a strong economy, cost savings from the expansion of managed care, and cuts in Medicaid reimbursement for nursing homes after the repeal of federal minimum standards on payment levels. States expanded coverage, enacted new programs to provide prescription drug coverage for older persons and persons with disabilities, and added home and community-based long-term care services. In contrast, state spending for Aid to Families with Dependent Children (AFDC) and its replacement, TANF, fell by 9 percent per year during this period.<sup>7</sup>

While overall expenditures were rising at a moderate rate, states were also cutting taxes and building up their reserves or “rainy day funds.” Almost all of the ANF states cut taxes or provided tax rebates repeatedly during this period. In-

deed, cutting taxes was a major priority for most governors between 1995 and 2000, not only in the states with relatively high taxes. Adding to the pressure for tax cuts were state constitutional limits on spending and revenues or state referendums reducing taxes in Colorado, Massachusetts, Michigan, and Washington. States also increased their reserves while cutting taxes, so that average state year-end balances as a percentage of total revenues increased from 5.8 percent in 1995 to a historic high of 10.1 percent in 2000.<sup>8</sup>

■ **The fiscal situation turns bleak: 2001–2002.** The national economy started to slow in 2000 and was in recession by March 2001.<sup>9</sup> During state FY 2001, spending grew fairly quickly, partly driven by a 14 percent increase in Medicaid spending—an increase of more than twice the level that was budgeted.<sup>10</sup> Taxes continued to be cut, although by smaller amounts than before. While some of the ANF states faced fiscal problems, most continued to expand their health programs. For example, several states, including Michigan, Wisconsin, New York, and Massachusetts, started or expanded pharmaceutical assistance programs for older people. Because of the slowing economy, however, to bring spending and revenues into balance, sixteen states nationwide enacted midyear cuts totaling \$1 billion during FY 2001 in a wide range of health and nonhealth programs.<sup>11</sup>

As states debated and passed their FY 2002 budgets in spring 2001 (almost all states have fiscal years starting July 1), the full fiscal consequences of the recession were not yet clear, and the terrorist attacks of September 11 had not yet occurred. While many states projected shortfalls for FY 2002 during their initial budgeting process, these fiscal problems seemed manageable through a combination of the use of financial reserves; tobacco settlement revenues; expanded Medicaid UPL programs, which increased federal revenues at little or no state cost (discussed in greater detail below); borrowing from other state accounts (such as pension funds); and selected tax increases. Many states enacted initiatives to curtail growth in Medicaid prescription drug costs. Enacted increases in states' general fund spending for FY 2002 were only 2.8 percent above FY 2001 levels, the smallest increase since 1983.<sup>12</sup> For the first time in seven years, enacted net tax and fee changes increased rather than decreased aggregate revenues, although by a very modest \$356 million.<sup>13</sup>

Many of the ANF states continued to expand their health programs, even though revenues were constrained. For example, in Texas the 2002–2003 biennium budget passed by the legislature in spring 2001 included Medicaid eligibility simplification for children as a way to increase enrollment, increased funding for SCHIP, higher reimbursement for nursing homes, the establishment of a new system of expanded health insurance coverage for public school teachers, and a pharmaceutical assistance program for older persons and persons with disabilities (although funding was not provided for the drug program).

In Wisconsin, despite financial pressures, Medicaid and other health programs were cut only very slightly, and funds were found to create a major new prescrip-

tion drug assistance program for senior citizens. To balance its books, Wisconsin greatly expanded its UPL program and raised cigarette taxes. It also maximized its current tobacco settlement revenues by selling off the stream of revenues as bonds, allowing the state to get most of the funds now rather than in the future.

Although Washington's governor initially proposed health care cuts to balance the budget, the state legislature rejected these cuts; funds to stave off budget cuts were ultimately found by revising the state's Medicaid UPL program. Although the final budget included some small cuts in the state-funded Basic Health Plan, which provides health care to the uninsured, the state expanded Medicaid coverage for the working disabled and for women with breast and cervical cancer.

Throughout FY 2002 the economy, especially after September 11, has deteriorated, with revenues falling short of projections and spending increasing faster than expected. By January 2002 a few states, including Florida and Massachusetts, had already had legislative sessions to deal with fiscal imbalances. All states except Vermont (and the District of Columbia) have constitutional requirements that prohibit them from running a deficit.

In November 2001 the National Conference of State Legislatures (NCSL) conducted a survey of FY 2002 conditions. Forty-three states and the District of Columbia reported that revenues were below forecasted levels; twenty-one states and the District of Columbia reported that spending was above budgeted levels.<sup>14</sup> Of the thirteen ANF states, five (Massachusetts, Michigan, Mississippi, New Jersey, and Washington) had spending overruns and lower-than-expected revenues; seven (Alabama, California, Colorado, Florida, Minnesota, New York, and Wisconsin) had spending that was on target but lower-than-expected revenues; and only Texas was on target for both spending and revenues. By December 2001 the National Association of State Budget Officers reported that thirty-nine states had an aggregate projected shortfall of \$38 billion for FY 2002.<sup>15</sup> After adjusting for tax law changes and inflation, real state tax revenues declined by 5 percent in July–September 2001 compared with July–September 2000.<sup>16</sup>

Medicaid was a major contributor to increased state spending. At the beginning of FY 2002, states were forecasting that Medicaid spending would increase by an average of 8.8 percent nationally, faster than overall state spending and revenue rates. As a result, Medicaid as a percentage of state spending seems likely to increase. In the November 2001 NCSL survey, four ANF states (Colorado, Massachusetts, Mississippi, and Washington) identified spending levels for Medicaid as an issue. Nationally, overspending by Medicaid is exacerbated by the program's projected initial underfinancing in the states' original FY 2002 budgets.<sup>17</sup>

Pressures for state Medicaid spending increases include medical inflation faced by the entire health system, increased costs for prescription drugs, demands for higher provider payment rates, expansion of community-based long-term care, and increased enrollment.<sup>18</sup> Of particular note is Medicaid spending for outpatient prescription drugs nationwide, which increased an average of 18.1 percent

per year from 1997 to 2000, compared with 7.7 percent for all Medicaid spending.<sup>19</sup> In a survey of state Medicaid programs, forty-eight states identified prescription drugs as a major cause of Medicaid spending growth in 2001.

Medicaid enrollment has grown for several reasons. Contributing factors include coverage expansions, deliberate efforts to reverse the enrollment slide caused by welfare reform, and the spillover from outreach for SCHIP. Enrollment is also increasing as a consequence of the recession. An increase in the unemployment rate from 4.5 percent to 6.5 percent could result in a growth in Medicaid enrollment of about three million persons.<sup>20</sup>

To balance their FY 2002 budgets, states are beginning to cut spending and consider some tax increases, although there is strong resistance to raising income and sales taxes.<sup>21</sup> While some health programs have been cut, Medicaid has been somewhat spared so far, except for some cutting or freezing of reimbursement levels (especially for prescription drugs) and cuts in optional benefits (such as adult dental services). Medicaid eligibility levels generally have not been reduced. Massachusetts, which did not finalize its budget until December 2001, cut several hundred million dollars in spending but left Medicaid relatively untouched, with the exception of reducing Medicaid reimbursement of Medicare cost-sharing requirements for the dually eligible (Medicare and Medicaid), increasing restrictions on the use of brand-name drugs, and temporarily postponing provider reimbursement rate increases. After September 11 Massachusetts expanded its Medicaid section 1115 waiver to increase the share of Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation payments that the state will contribute to help the unemployed retain insurance coverage. Mental health and public health programs, however, sustained larger cuts.

One ANF state that has reduced Medicaid eligibility in response to budget problems is Florida, which ended its medically needy program for adults, reduced eligibility standards for older persons and disabled beneficiaries from 90 percent to 88 percent of the federal poverty level, and eliminated planned coverage of certain persons with disabilities who are working. In addition, Florida ended Medicaid coverage of dental, vision, and hearing services for adults, as well as counseling to help beneficiaries choose managed care plans. It also limited enrollment in the state-funded pharmaceutical assistance program for older persons. These cuts, however, will not go into effect until FY 2003, which starts July 2002.

Not all state actions have been reductions in spending, however. In January 2002 New York enacted a major piece of health legislation designed to greatly increase wages for health care workers through Medicaid, expand Medicaid eligibility for disabled workers, and further streamline the Medicaid and SCHIP eligibility determination processes. The initiative will largely be funded through the one-time revenues obtained from the conversion of the state's nonprofit Blue Cross Blue Shield organization to for-profit status, an assumed increase in the state's Medicaid federal matching rate, and an increase in the tax on cigarettes.<sup>22</sup>

## Health Care Coverage

Over the past five years a number of developments led states to expand public coverage for the low-income population. There were new funding opportunities for children's health insurance coverage under SCHIP, additional possibilities created as part of welfare reform (Section 1931[b] of the Social Security Act), and demonstration waivers under Medicaid and SCHIP. At the same time, states had greater fiscal capacity from booming revenues and new tobacco settlement funds. Under SCHIP, the largest expansion in children's health coverage since Medicaid was enacted more than thirty years ago, all thirteen ANF states expanded children's coverage and were making major efforts to reach and enroll eligible persons. A number of states, such as New York and Massachusetts, continued their tradition of ambitious health care reform and implemented more comprehensive coverage expansions for low-income families and childless adults that use a combination of SCHIP, Medicaid, and state-only funding. Other states, such as New Jersey and Wisconsin, with less comprehensive records of reform, made large strides in expanding health coverage to low-income populations.

■ **Medicaid coverage.** *Rebounds in Medicaid enrollment.* Although SCHIP has received a great deal of recent attention, Medicaid is still by far the dominant public financing program for acute and long-term care services for low-income populations. From the mid-1990s onward, Medicaid enrollment generally declined in response to an improved economy and welfare reform. The welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, allowed states to expand eligibility, but it also had an immediate chilling effect on Medicaid participation because it created administrative barriers to enrollment. By delinking eligibility for Medicaid from the receipt of cash assistance, PRWORA altered the way most low-income families gained access to Medicaid. The net result was a nationwide reduction in average monthly Medicaid enrollment of approximately 6.8 percent between 1995 and 1998, mostly resulting from a drop in the adult cash-assistance population. The ANF states generally reflected the national trend, with a few notable exceptions. In Wisconsin, Medicaid enrollment among non-elderly and nondisabled adults and children dropped by about 27.4 percent between 1995 and 1998, four times the national rate; enrollment for this population fell 15.4 percent in Texas, 17.7 percent in Florida, and 20 percent in Mississippi. Conversely, over this same time period, Medicaid enrollment in Massachusetts grew by 20.9 percent as a result of the implementation of the state's Section 1115 Medicaid demonstration project.

Medicaid enrollment rebounded in the late 1990s, partly in response to several Centers for Medicare and Medicaid Services (CMS) directives urging states to spread awareness that beneficiaries could retain Medicaid eligibility after their cash assistance terminated, and partly as a result of new state coverage expansions to low-income populations. In addition, some states simplified the Medicaid application and redetermination process. This simplification (discussed below)

*“The MassHealth expansions were a major factor in reducing the state’s uninsurance rate by almost ten percentage points.”*

.....

largely occurred for children’s Medicaid coverage and was a result of political pressure on SCHIP to increase enrollment and retention rates. However, some states reformed Medicaid enrollment processes more broadly, including implementing disregards for income under Section 1931, eliminating asset tests, shortening application and renewal forms, and simplifying verification requirements. These efforts contributed to increased enrollment; the total number of Medicaid participants rose by 3.6 percent between December 1998 and December 1999 and another 5 percent between December 1999 and December 2000.<sup>23</sup>

*Section 1931(b).* When Congress severed the link between cash benefits and Medicaid as part of welfare reform, it also created a new Medicaid eligibility category under the Social Security Act. Under Section 1931(b), families that would have qualified for Medicaid under a state’s AFDC program are generally eligible for Medicaid, whether or not they receive TANF cash assistance. States must maintain Medicaid eligibility at least at pre-welfare reform levels. Section 1931(b) also allows states to expand Medicaid to cover more low-income families.<sup>24</sup>

Only two ANF states (California and New Jersey) elected to expand Medicaid coverage under Section 1931(b). In 2000 California increased the income limit for parents up to 100 percent of the federal poverty level, and New Jersey expanded coverage for parents up to 133 percent of poverty. More recently, New Jersey received federal approval to cover all parents of Medicaid- and SCHIP-eligible children under an SCHIP Section 1115 demonstration waiver, which entitled the state to receive a higher federal match.

*Medicaid expansions for seniors and persons with disabilities.* In recent years several of the study states expanded eligibility for the aged, blind, and disabled populations. Mississippi used increased income disregards under Section 1902(r)(2) of the Social Security Act to raise the eligibility level for these populations to 135 percent of poverty—the highest in the nation. Minnesota expanded its income eligibility for this population to 100 percent of poverty under Medicaid and covered those earning up to 175 percent of poverty under the state-funded portion of MinnesotaCare. California and Massachusetts expanded Medicaid eligibility levels for these populations to 133 percent of poverty. Massachusetts, under its Medicaid 1115 demonstration program, also offered comprehensive Medicaid benefits to disabled persons who were ineligible for its traditional Medicaid program, with cost sharing for persons above 200 percent of poverty.<sup>25</sup> Several ANF states also moved to provide Medicaid coverage to working persons with disabilities under the federal Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. Under TWWIIA states may create a Medicaid buy-in program that allows working

persons with disabilities to pay premiums for access to Medicaid.

*Medicaid Section 1115 demonstration projects.* States have also used Section 1115 research and demonstration waivers to expand coverage to additional low-income populations. Several ANF states, including Massachusetts, Minnesota, Wisconsin, and New York, have expanded their traditional Medicaid programs or implemented new coverage programs under Medicaid 1115 authority.

Probably the most extensive Medicaid Section 1115 demonstration waiver is Massachusetts's MassHealth program, which offers very broad coverage to all low-income persons and increased Medicaid enrollment by approximately one-third between 1997 and 2000. The waiver expanded eligibility up to 133 percent of poverty for parents, disabled adults, and long-term unemployed adults and up to 200 percent of poverty for parents, some childless adults, children, pregnant women, and newborns. The MassHealth expansions have been credited as a major factor in reducing the state's uninsurance rate by almost ten percentage points.<sup>26</sup>

Wisconsin developed a new program under a Section 1115 waiver, BadgerCare, that uses Medicaid and SCHIP funds to cover parents and children up to 185 percent of poverty. Wisconsin believed that covering parents would make it easier to enroll children in the new program because parents could make insurance decisions for the whole family and would directly benefit from the program.

In March 2001 New York was granted a federal waiver to expand adult coverage as an amendment to the state's Medicaid Section 1115 waiver program, the Partnership Plan, which is phasing in mandatory Medicaid managed care. Family Health Plus (FHPlus), implemented in October 2001, provides coverage to parents with incomes up to 150 percent of poverty and to single adults and childless couples with incomes up to 100 percent of poverty.<sup>27</sup> Designed to build on Child Health Plus (CHPlus), New York's SCHIP program, FHPlus enables participants to receive comprehensive acute care benefits delivered through managed care plans, as in the state's CHPlus and Medicaid programs.

Eligibility for Medicaid in Minnesota has historically been extensive, and the state has continued to expand eligibility around the margins. Under its Section 1115 waiver, the state obtained Medicaid funding for parents and caretakers of children enrolled in MinnesotaCare with incomes up to 175 percent of poverty in 1999 and up to 275 percent in 2001. In addition, beginning in July 2002 the income limit for children under Medicaid will be raised to 170 percent of poverty, and the income limit for parents will be raised to 100 percent of poverty.

■ **The State Children's Health Insurance Program.** SCHIP, enacted in 1997, provided states with \$40 billion in federal funding over a ten-year period to expand health insurance coverage for children. States were given the option of expanding coverage through Medicaid, creating a new program or expanding an existing program, or a combination of the two. Only two ANF states (Minnesota and Wisconsin) elected to pursue a Medicaid expansion as their sole strategy, and only two (Colorado and Washington) chose a totally separate approach; the remaining states

chose a combined strategy to expand coverage.<sup>28</sup> For most of the states that chose the combined approach, the major emphasis was on creating separate programs, and the Medicaid expansion was a relatively small component.<sup>29</sup> States created separate programs for a variety of reasons, including political resistance to expanding a Medicaid entitlement program, the perception that access problems in Medicaid would spill over into SCHIP, and the desire to test an alternative to Medicaid that might be more innovative and efficient and “more like private insurance.”<sup>30</sup>

In response to SCHIP, states raised income eligibility thresholds for children; between June 1997 and June 2000 the average state raised its eligibility threshold from 121 percent to 206 percent of poverty.<sup>31</sup> Across the thirteen ANF states, the increased eligibility threshold under SCHIP ranged from 185 percent of poverty in Colorado and Wisconsin to 350 percent in New Jersey.<sup>32</sup> Whether measured by income eligibility threshold or increase in eligibility threshold after SCHIP, New Jersey’s expansion is the most generous in the nation.

States that created separate programs were given the flexibility to offer a more limited scope of benefits than Medicaid requires and to impose cost sharing. Although consumer advocates feared otherwise, all ANF states with separate programs provide optional benefits such as vision, hearing, and dental services. Most services are delivered through managed care organizations. States generally implemented modest cost-sharing levels, with monthly premiums (based on income level and family size) that typically ranged from \$5 to \$25 and copayments generally around \$5 for nonpreventive services.

Initial spending under SCHIP was much lower than the funds that were available; on average, states spent only 24 percent of the federal SCHIP dollars available to them between FY 1998 and FY 2000.<sup>33</sup> New York was an exception, spending 93 percent of its federal SCHIP 1998–2000 allotment.<sup>34</sup>

In an effort to increase enrollment in SCHIP, states embarked on extensive outreach campaigns and initiated a number of strategies to streamline the eligibility determination process, such as minimizing documentation requirements and allowing families to submit applications by mail. The requirement to screen and enroll children simultaneously for Medicaid and SCHIP led states to adopt joint application forms that simplified eligibility requirements for both programs. To improve the process, a number of states engaged community-based organizations to perform eligibility screening.

SCHIP enrollment has increased with the program’s maturation. As of December 2000 national SCHIP enrollment had reached 2.7 million.<sup>35</sup> Many states noted a Medicaid spillover effect that they believed was related to SCHIP outreach and enrollment efforts; that is, outreach aimed at increasing SCHIP enrollment brought in children who were eligible for Medicaid. In Washington, 70–75 percent of those applying for SCHIP were determined to be eligible for Medicaid. In New Jersey, spillover from SCHIP added about 22,000 children to the Medicaid rolls by September 1999.<sup>36</sup> Despite recent enrollment successes, though, many

children still remain uninsured—8.9 million nationally, three-quarters of whom are eligible for Medicaid or SCHIP.<sup>37</sup> Some states have looked beyond outreach and enrollment efforts to reach uninsured children by shifting their focus to covering parents as a means of covering all uninsured persons in the family.<sup>38</sup>

*Covering parents.* During the initial implementation of SCHIP, the CMS discouraged states from providing parental coverage under SCHIP because it believed that states should focus their early efforts on covering uninsured children and that covering parents would leave coverage for children underfunded. In January 2001, however, the CMS reversed this position and approved SCHIP Section 1115 waiver demonstration projects in Wisconsin, New Jersey, and Rhode Island that expanded SCHIP coverage to parents. By that time, the CMS had decided that covering parents was an effective strategy for increasing the enrollment of children. Wisconsin initially began providing coverage for parents of SCHIP- and Medicaid-eligible children in January 1999 under its BadgerCare Medicaid 1115 demonstration project. After gaining federal approval, Wisconsin received the enhanced SCHIP match to cover parents in BadgerCare who had incomes of 100–185 percent of poverty. New Jersey also received approval at this time to cover parents and pregnant women with incomes up to 200 percent of poverty through FamilyCare, the state’s Medicaid- and SCHIP-funded health insurance program for both children and adults.<sup>39</sup>

With the incentive of a higher matching rate under SCHIP, and states such as Wisconsin and New Jersey experiencing considerable enrollment increases after providing family coverage, other states followed suit. Minnesota received approval in June 2001 to cover parents with incomes at 100–200 percent of poverty. In January 2002 California received approval to expand its SCHIP program, Healthy Families, to parents with incomes up to 200 percent of poverty.<sup>40</sup> Washington is in the process of seeking a waiver to use SCHIP matching funds to cover parents in its Basic Health Plan.

*Premium assistance.* Under SCHIP, states can subsidize employer-sponsored insurance. Very few states have pursued this option because of the administrative difficulties of meeting stringent federal requirements and the complexity of coordinating with the employer coverage market. Wisconsin’s premium assistance program subsidizes coverage for families that have qualifying insurance coverage and earn up to 185 percent of poverty. The Massachusetts program provides assistance to children whose families earn up to 200 percent of poverty.<sup>41</sup> Although both programs have several years of experience, enrollment remains low—primarily because many employer health plans do not meet SCHIP’s benefit requirements and because employers must contribute a substantial portion of the premium to qualify. As of fall 2001 Wisconsin’s program included only forty-seven families, and Massachusetts’s SCHIP-funded program covered about 700 children.<sup>42</sup> Although Mississippi and New Jersey received approval to provide premium assistance under SCHIP, these programs have not yet been implemented.

## Acute Care Issues In The States

State policymakers face a number of acute care issues, including Medicaid managed care, DSH payments and UPL programs, provider payment policy, and prescription drugs.

■ **Medicaid managed care.** Medicaid managed care has struggled in all of the states but is surviving, and in some states it is expanding in terms of enrollment of TANF and TANF-related beneficiaries, disabled enrollees, and rural populations. In most states, health plans have left the Medicaid program, and capitation rates have been increased to maintain the participation of others. Quality issues and marketing abuses have led to increased pressure to regulate health plans more strictly. This additional regulation imposes administrative burdens on managed care plans, which has reportedly affected plans' willingness to participate in Medicaid. Some states prefer having fewer plans because it reduces their administrative burden, but they acknowledge that it reduces their bargaining power with plans in negotiations over payment rates and limits choice for beneficiaries. Plans have also faced increased provider resistance to reduced payment rates for providers. The provider pushback is causing financial problems for managed care plans, which have become more aggressive in pushing for rate increases. The bottom line is that states are not receiving the same savings from Medicaid managed care now that they did in earlier years.

Most of the ANF states have substantial capitated managed care programs. Alabama and Mississippi attempted to implement capitated managed care systems but were unsuccessful, largely because of the rural character of the states and the lack of commercial health maintenance organizations (HMOs) on which to build. The two states now operate primary care case management (PCCM) programs. All of the other ANF states have large numbers of Medicaid enrollees in capitated managed care programs. Some states, such as New Jersey, Wisconsin, Washington, and Michigan, rely mainly on HMOs. Others, such as Florida, Colorado, Texas, and Massachusetts, have a mix of HMOs and PCCM programs.

States have not enrolled the Supplemental Security Income (SSI) population in managed care in a broad-based manner. The SSI population is enrolled in HMOs in Michigan and in some counties in California; is enrolled in PCCM in Florida and Massachusetts; and may choose between PCCM and HMOs in Colorado. Enrollment of the SSI population is voluntary in New York, Texas, and Wisconsin. The SSI population is not in managed care at all in Minnesota and Washington. Because of administrative complexity, dually eligible beneficiaries, which includes almost all older enrollees and about a quarter of younger disabled beneficiaries, are usually excluded from Medicaid managed care.

PCCM programs, essentially fee-for-service plans with gatekeepers, remain important in several states. Florida relies heavily on MediPass, its PCCM program, as well as on HMOs. A proposal by the governor to greatly scale back MediPass and substitute less expensive capitated managed care was defeated, but the state is now assigning beneficiaries to capitated arrangements if they fail to choose a

*“In addition to being a state expenditure, Medicaid has become a revenue source through DSH payments and UPL programs.”*

.....

plan. To reduce reliance on PCCM, in 1997 Colorado began to require that the Medicaid beneficiaries in the Primary Care Physician program—the state’s PCCM program—enroll in an HMO if their physician was in an HMO. Massachusetts, on the other hand, has seen little change in HMO enrollment. The state operates what it calls an enhanced PCCM model in which it contracts for HMO-like administrative services, such as provider profiling and rate negotiations. The state is content to see no growth in HMOs, regarding them as more expensive than PCCM.

Rate adequacy and plan withdrawals remain the major barriers to Medicaid managed care stability. Payment rates were cited as a major issue in almost all of the ANF states that had sizable managed care programs. In New York most commercial plans left Medicaid between 1997 and 1999 because of a combination of dissatisfaction with payment rates, administrative burdens, and difficulty in establishing networks. The state is now left with Medicaid-dominated plans organized around safety-net providers. The dominance by Medicaid-oriented plans and their ties to safety-net providers dependent on public revenues means that the state has less freedom to maneuver in setting rates. Payment levels have increased considerably since the late 1990s.

In Florida, because of the combination of low rates (among the lowest in the nation) and tight regulations in response to marketing and quality problems, some plans have left the managed care market entirely, and others have ceased participating in Medicaid. The number of plans participating in Medicaid fell from twenty-six in 1995 to fourteen in 2001. The state does not see this as a problem, because it eases administrative tasks. Rates have been increased substantially since 1998, although a round of payment cuts is scheduled for 2001–2002 in response to budget pressures.

In Massachusetts only four capitated plans now serve MassHealth, down from thirteen in 1992, as a result of both plan consolidations and withdrawals from Medicaid. Plans cite reimbursement as an issue, despite the fact that Massachusetts has among the highest payment rates in the United States, as well as the favored treatment of safety-net plans. Washington also has had a history of relatively generous rates. However, a new round of competitive bidding in 2001 led to only a 3 percent Medicaid rate increase. Two major plans withdrew, forcing the state to increase rates by 8 percent in 2002 to retain the rest.

Plan withdrawal was not an issue in California. In response to complaints about payment levels, in 2000 California increased rates by 9.2 percent as part of a broader package of provider reimbursement increases. Despite rates that are low

compared with those in other states, plans in California do not report financial problems, seemingly because of a combination of low utilization; low hospital, physician, and other provider payment rates; deterrence of emergency room use; and carve-outs of high-cost services to mental health patients and children with special needs.<sup>43</sup>

■ **DSH payments and UPL programs.** Since the late 1980s states have developed an increasingly complex set of financing arrangements that have the effect of bringing in new federal funds with little or no new state financial effort. In addition to being a state expenditure, Medicaid has become a revenue source through DSH payments and UPL programs.

Federal law requires that Medicaid payment rates for inpatient hospital care take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. This requirement is known as the Medicaid DSH payment adjustment. DSH payments are lump-sum payments made to hospitals or higher reimbursement rates. States have used provider taxes and donations, intergovernmental transfers, and certified public expenditures to finance the state share and bring in federal dollars. In response to the growth in DSH payments, in 1991 and 1993 Congress passed legislation that limited states' ability to increase DSH spending or to make large payments to specific hospitals.

In the late 1990s states developed UPL programs that are similar in design to DSH but not subject to the federal legislative restrictions enacted in 1991 and 1993. Under Medicaid law, states cannot pay providers more than what Medicare would have paid—thus the term “upper payment limit.” In UPL programs, states pay Medicaid rates that are usually much higher than the regular payment levels to largely nonstate public facilities, which supply the state share through intergovernmental transfers. The facilities then return some (if not all) of the extra payments to the state. Participating providers include hospitals as well as nursing homes, school clinics, and mental health centers. States receive federal matching funds on the enhanced payments, thus obtaining additional federal money while contributing few or no state funds. These programs grew rapidly in the late 1990s.

Both DSH payments and UPL programs may add to providers' revenues, although the extent to which providers benefit varies among states and by individual program. In many cases, however, the DSH payments and UPL programs are clearly intended to add to state revenues. Under the typical arrangement, a locality or its hospitals or nursing homes transfer an amount to the state—say, \$100 million. The state makes a payment back to the hospital or nursing home—say, \$200 million—collecting \$100 million in federal funds in states with a 50 percent federal match. The facility keeps \$100 million or more depending on the arrangement and returns the rest to the state. The facility has not lost money and perhaps has gained (depending on how much of the federal funds it retains), while the federal government has spent more. The largest financial beneficiary is often the state. In this example, the state has \$100 million more (if it retains all of the federal

funds) in revenue but has not spent any state general revenues. DSH and UPL arrangements give the appearance of adding more to health spending than they actually do.

*Legislative changes.* In the Balanced Budget Act (BBA) of 1997, Congress reduced federal DSH allotments to states each year until 2002; afterward, allotments are permitted to grow with inflation as long as a state's DSH expenditures are less than 12 percent of its Medicaid expenditures. States whose actual DSH spending was less than their allotments were allowed to increase their spending. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 provided states some temporary relief from the BBA cutbacks by freezing DSH allotments in 2000 and 2001. However, in FY 2003 the DSH provisions of BBA will again prevail, and some states—New York, California, and Massachusetts among them—will face fairly substantial reductions in their federal DSH allotment. But states with relatively small DSH programs—less than 12 percent of Medicaid spending—will be able to increase DSH payments in FY 2003 by the percentage rise in the Consumer Price Index.

While easing limitations on DSH, BIPA placed limits on UPL payments to government facilities that are not owned or operated by the state, such as county hospitals and nursing homes. At the same time, however, it allowed states temporarily to increase Medicaid payment to public nonstate hospitals from 100 percent to 150 percent of the Medicare limit. Thus, while BIPA placed some restraints on the use of UPL programs, the exceptions allowed by the law mean that UPL programs are still alive and well. However, the Bush administration has raised concerns over the financing of these programs; in January 2002 the administration issued regulations that limit UPL payments to public hospitals to 100 percent of the Medicare payment level.

Thus, DSH payments in many states were reduced between FY 1998 and FY 2000 because of the BBA, relaxed in FY 2001 and 2002 because of BIPA, and will begin to decline again in FY 2003. Similarly, new restraints on the use of UPL programs are being phased in, but there is still plenty of room for additional state use of these mechanisms. Alabama, California, Colorado, Massachusetts, Michigan, Mississippi, New Jersey, New York, and Texas have large DSH programs, and they faced cuts in their allotments in the late 1990s. Because they were spending below their allotments, DSH expenditures actually increased in Michigan and New York in the late 1990s and were essentially unchanged in Mississippi, Colorado, New Jersey, and Washington. Certain BIPA provisions meant that DSH programs in these four states were not subject to further cuts in 2001 and 2002, but their allotments will decline again in 2003. Alabama, California, Michigan, New York, Washington, and Wisconsin have large UPL programs. While smaller and newer, the UPL programs in Florida, Mississippi, and Texas are growing rapidly. These states will be affected by recent legislative developments and by the new federal regulations.

*Alabama.* Alabama has relied heavily on DSH and UPL programs, and among the ANF states it is perhaps the most threatened by recent federal efforts to curtail them. Alabama has folded DSH payments (\$356.5 million in 2000) into managed care capitation rates that are paid to hospitals, which allows the state to avoid hospital-specific payment caps. The state share is financed through intergovernmental transfers. Alabama also has developed a large UPL program, which is financed with intergovernmental revenues. Most of the federal funds from both programs are returned to the state. The Office of Inspector General of the U.S. Department of Health and Human Services (HHS) has raised concerns over the lack of a real state financial contribution to these programs and has further questioned whether Alabama's DSH payments should be exempt from the hospital-specific caps. Furthermore, Alabama may have to reimburse the federal government for much of the federal share of its UPL payments to hospitals, including retroactive payments.

*Wisconsin and Washington.* Although Wisconsin has a small DSH program, it has a large UPL program. Wisconsin funds the state share with intergovernmental transfers. Under its UPL program, Wisconsin makes payments to county nursing facilities and claims federal matching payments that will bring in \$604 million during the 2001–2003 biennium. Most of these funds are used to raise payments to nursing homes without increasing state spending. Some funds are retained by the state and used as the state share for other Medicaid expenditures. In a similar initiative, Washington expanded its UPL program by using intergovernmental transfers from public nursing homes to claim \$450 million in additional federal funds, temporarily solving its budget problems for FY 2002 and 2003.

■ **Provider payment policy.** Despite the growth of Medicaid managed care, substantial amounts of Medicaid services are still provided on a fee-for-service basis. Thus, states still face decisions over payment rates to hospitals, physicians, dentists, and other providers. Hospitals in general, and those that serve low-income populations, in particular, have been affected by the BBA (which cut Medicaid DSH payments and Medicare payments to teaching hospitals), as well as by the growth of commercial managed care. Both factors have put major pressures on hospital revenues. At the same time, rising labor costs and increased costs for prescription drugs add to hospitals' financial pressures.

States are under pressure from hospitals to increase rates, but they are also under budget pressures to hold down hospital payments. Some states, such as Florida, Texas, and California, appear to have used DSH and UPL programs in lieu of rate increases. Other states, including Minnesota, Massachusetts, Wisconsin, and Washington, have increased or are considering increasing rates in response to pressures from hospitals. Through the end of 2002 only Colorado reported a major rate cut, eliminating the facility fee when physicians provide outpatient services.

Many states have long held physician fees well below Medicare and private market rates. A number of the ANF states, including Alabama, California, Missis-

*“In virtually all states, drug costs are the leading cause of rising Medicaid spending.”*

.....

sippi, New Jersey, and Washington, raised rates in the past two years as a way to increase provider participation. Physicians also should benefit from the increases in managed care rates. Two states (Alabama and Mississippi) report raising dental fees in an effort to increase participation rates by dentists.

■ **Prescription drugs.** Expenditures on prescription drugs, while only 10 percent of Medicaid outlays, are a major issue for all states. In virtually all states, drug costs are the leading cause of rising Medicaid spending. States estimate that prescription drug spending is increasing by 14–18 percent per year, and these rates of growth are expected to continue, affecting both fee-for-service and managed care spending. This increased spending reflects greater utilization and increases in prices, combined with the fact that the aged and disabled populations, who are heavy users of prescription drugs, are growing as a share of Medicaid beneficiaries.

There have been two broad responses by states: (1) controls of prices and use of drugs within Medicaid, and (2) programs to help older persons and persons with disabilities with incomes above Medicaid levels purchase prescription drugs.

*Controlling Medicaid spending.* States’ ability to control Medicaid drug spending is limited. The federal Medicaid drug rebate program created by the Omnibus Budget Reconciliation Act (OBRA) of 1990 requires pharmaceutical manufacturers participating in Medicaid to provide rebates to the states for outpatient prescription drugs paid for by the program.<sup>44</sup> The key restriction is that the federal drug rebate program restricts states’ use of formularies. States may create formularies that limit the coverage of certain drugs that do not have important therapeutic advantages over alternatives that are included in the formulary, but any drug excluded from the formulary must be covered if the prescribing physician receives prior authorization from Medicaid.

States have more control over the amounts they pay for drugs. Medicaid regulations limit reimbursement for brand-name drugs, as well as other multiple-source drugs, to the drug’s estimated acquisition cost, which is generally based on the average wholesale price (AWP). Because pharmacists can generally buy drugs for less than the AWP, states pay some percentage of the AWP. A common cost containment strategy is to reduce this percentage.

To control utilization, states often require physicians to obtain prior authorization before prescribing specific drugs, and many mandate the use of generic or lower-cost substitutes. They can also limit the number of prescriptions a beneficiary can have, the amount of a drug dispensed per prescription, and the number of refills within a specified period. States must also employ drug utilization review programs.

In general, states use some variant of these approaches to control drug spending. For example, New Jersey and Wisconsin reduced the percentage of the AWP they will pay. In 2002 Colorado reduced pharmacists' dispensing fees and the amount it reimburses pharmacists for ingredient costs. Massachusetts requires Medicaid beneficiaries to receive generic medications except when physicians demonstrate that a brand-name drug is medically necessary. To substitute a brand-name drug, physicians must obtain prior approval from the state. (New Jersey has a similar policy.) Massachusetts is now proposing to lower the number of days' worth of drugs that can be dispensed and to limit the number of refills.

The most ambitious programs for controlling drug spending have been enacted in Florida and Michigan. Florida adopted a new drug formulary that gives preference to drugs from manufacturers that have negotiated rebates with the state beyond the federally mandated levels. Because states are required to provide access to drugs from manufacturers participating in the federal rebate program, Florida now requires prior authorization for drugs not on its preferred list. Florida has allowed drug manufacturers to provide services that offer savings to the program in lieu of further rebates. For example, Pfizer has developed a disease management program that is required to show a specified level of cost savings. Pharmaceutical Research and Manufacturers of America (PhRMA) sued Florida, claiming that the new formulary violates the federal rebate law, but a federal court ruled in favor of the state. In September 2001 the CMS approved the new formulary initiatives.

In November 2001 Michigan announced a new formulary program that extended its preferred drug list beyond Medicaid to all state-funded prescription drug programs. The state will select a set of approved drugs within each of forty therapeutic categories. Physicians must receive prior authorization for any drug not on the preferred list. To avoid prior authorization requirements, manufacturers whose drugs are not on the preferred list must offer additional rebates. PhRMA has also brought suit against Michigan, and several large drug makers have refused to participate in the program, despite risking a loss of market share.

Florida and Michigan have been particularly aggressive in attempting to control prescription drug costs; several other states have not gone quite as far. New Jersey reports frustration with the relatively minor provisions the state has enacted, but it feels constrained by the importance of the drug industry in the state. New York is exploring the use of more-extensive drug formularies but has not yet acted. In the past year Washington attempted to enact broad controls over drug spending, which were defeated in the legislature.

*New programs for the elderly and disabled.* Several of the ANF states have adopted programs to subsidize drug costs for the low-income elderly (and sometimes the disabled as well). The most extensive program is in Massachusetts. Beginning in April 2001 the state's Prescription Advantage program offered unlimited benefits for older persons (with no income ceilings) and for persons with disabilities who earn up to 188 percent of poverty. Enrollees are required to pay premiums up to

\$82 per month depending on income, and they are responsible for copayments up to an annual ceiling of \$2,000 or 10 percent of their income, whichever is less.

Other states subsidize the costs of prescription drugs up to different income levels and with varying amounts of cost sharing. In 2000 New York extended subsidies to single persons with incomes up to \$35,000 and to couples earning up to \$50,000. Enrollees are assessed a premium, and higher-income enrollees pay an annual deductible. As part of its 2001–2003 budget, Wisconsin extended subsidies to seniors with incomes below 240 percent of poverty; participants earning above 160 percent of poverty have a \$500 deductible, but there is no deductible for lower-income enrollees. In 2001 Michigan adopted a drug subsidy program for seniors below 200 percent of poverty, with premiums based on incomes. Florida, Minnesota, New Jersey, and Texas have also recently established subsidy programs for prescription drugs (although Texas has not funded its program).

### Long-Term Care

Long-term care for persons with disabilities is a large component of state health policy and states' funding for health care. In 1998 long-term care represented 42 percent of Medicaid expenditures (excluding administration and DSH payments) and 14 percent of all state and local health care spending.<sup>45</sup> About half of these Medicaid expenditures are for the elderly population. Because of the high cost of long-term care (a year in a nursing home cost an average of \$49,000 in 2000), Medicaid coverage for long-term care provides a safety net for the middle class as well as for the poor.<sup>46</sup> States are addressing issues that affect long-term care generally, as well as those specifically involving nursing homes and home and community-based services.

■ **Issues cutting across service providers.** Two issues that cut across nursing homes and home and community-based services were the problems of the long-term care workforce and the fragmentation of the financing and delivery system of services for people with disabilities.

*Long-term care workforce.* In almost all states the recruitment and retention of high-quality workers is a major problem. Long-term care providers report many vacancies and high turnover rates for both registered nurses and paraprofessional workers, such as certified nurse assistants, home health aides, and personal care attendants. Recruitment and retention problems are reported to be the consequence of low wages (usually around the minimum wage), few fringe benefits such as health insurance, lack of opportunities for career advancement, the demanding and unpleasant nature of much of the work, and the organizational culture of nursing homes and home care agencies. The tight labor markets of the late 1990s exacerbated these problems by giving low-wage workers other opportunities for employment. The economic downturn may lessen the recruitment and retention problems over the short run. However, the long-run demographic imbalance between the sharply increasing projected demand for long-term care due to the

aging of the population and the very slow expected increase in the size of the working-age population will exacerbate the problem. These staff shortages are likely to have a major impact on Medicaid spending and on quality of and access to care.

State policymakers are just beginning to acknowledge the labor-shortage crisis and to craft responses to it. Several states have raised Medicaid and other public program reimbursement rates, earmarking the money for wage increases for workers. In 2001 Massachusetts enacted a comprehensive initiative, including a wage passthrough for certified nurse assistants in nursing homes, a supervisory training program, scholarships for entry-level aide certification training, the establishment of career ladders for certified nurse assistants in nursing homes, and the establishment of two advisory commissions. Minnesota has enacted a similar set of initiatives, although the state also has sought to relax training requirements as a way of increasing the number of long-term care workers available. California and Washington have established public authorities that will recruit and train independent providers and will establish and maintain a referral registry to help consumers find workers. These public authorities facilitate unionization and collective bargaining over wages and benefits.

*Managed care and capitation.* To address the fragmented financing and delivery system of services to persons with disabilities, several states are exploring the use of managed care and capitation in long-term care. To date, the number of beneficiaries involved is usually small. States hope that managed care will create a less fragmented and more flexible delivery system, provide incentives to reduce institutionalization, make state spending more predictable, and save money in the long run. The longest-running initiatives in this area have been the social health maintenance organizations (SHMOs) and the Program of All-Inclusive Care for the Elderly (PACE), which integrate acute and long-term care services in a capitated managed care system. In New York and Michigan more recent initiatives in applying managed care principles are limited to integrating long-term care services; in Florida, Minnesota, Texas, and Massachusetts new initiatives seek to integrate both acute and long-term care services. Wisconsin has initiatives that both integrate acute and long-term care services (PACE and the Wisconsin Partnership Plan) and integrate long-term care only (Family Care). The latter is notable because it integrates all Medicaid and state-funded long-term care on a capitated basis on a relatively large scale.

■ **Nursing homes.** In 2000 and 2001 nursing homes were under stress in most states and in some (including Wisconsin, Texas, and Florida) were in a state of crisis because of the interrelated problems of Medicaid reimbursement, poor quality of care, workforce shortages, reduced occupancy rates, and sharply increased premiums for liability insurance. Changes in the Medicare reimbursement system for skilled nursing facilities (SNFs) also adversely affected many nursing homes. Many facilities were in bankruptcy proceedings, and some nursing homes actually closed,

something previously unheard of in long-term care.

*Reduced utilization.* Although overall demand for long-term care has been increasing, use of nursing homes has slackened; waiting lists have been eliminated and occupancy rates are down in most ANF states. In some states, such as California, Washington, Minnesota, and Wisconsin, there has been an actual decline in the number of nursing home beds and residents in spite of an aging population. Occupancy rates have fallen despite limits on supply by certificate-of-need (CON) programs or moratoriums on new construction or participation in Medicaid in all the ANF states except California. In part, the lessening demand may reflect the growth in noninstitutional services, such as home care and assisted-living facilities, and possibly reduced disability rates among the elderly population. Aside from expanding home and community-based services, some states (such as Washington and Minnesota) have sought to reduce nursing home use by providing incentives for nursing homes to convert beds to the assisted living facility-level to take them out of service and by actively trying to move residents out of nursing homes (in Washington and New Jersey and, for younger persons with disabilities, in Minnesota).

*Medicaid reimbursement.* Because nursing homes account for a substantial portion of Medicaid expenditures, cutting payment rates has been a common cost containment mechanism when states have needed to balance their budgets. The industry has consistently complained that Medicaid rates are too low. From 1980 to 1997 federal law—the Boren amendment—limited states' ability to cut nursing home reimbursement rates. The Boren amendment required that states pay enough to cover the costs of an “economically and efficiently” operated facility that met quality and safety standards. These minimum standards led to a number of lawsuits that forced states to pay higher rates, which many states thought were unjustified. In response to calls by the states for greater flexibility to manage their Medicaid programs, the BBA repealed these federal rules, leaving only minor procedural requirements. Without federal standards, the nursing home industry and some consumer advocates feared that rates would be cut so deeply that they would erode quality of care and access by Medicaid beneficiaries.

In the period immediately following the repeal of the Boren amendment, some states, including Wisconsin, Texas, New Jersey, and Washington, took advantage of their new flexibility to trim Medicaid nursing home reimbursement rates, most commonly by reducing inflation updates and lowering cost-center ceilings. Some states, such as New Jersey, strongly contended that they could have done this even if the Boren amendment had not been repealed. In New York and other states, governors proposed major cuts in nursing reimbursement, but legislatures rejected the cuts. The lack of large across-the-board cuts in nursing home rates was attributable in part to the excellent financial condition of the states in the late 1990s, which lessened the need to cut Medicaid reimbursement as a way to achieve savings. Additionally, the nursing home industry is powerful at the state level and

usually does better than home and community-based services providers do in obtaining reimbursement increases.

In 2000 and 2001, however, several states, including California, Florida, Texas, Wisconsin, Minnesota, and Massachusetts, increased Medicaid reimbursement rates in response to a perceived deterioration in nursing homes' financial status and to concerns about inadequate quality of care and the difficulty of attracting workers. Rather than being across-the-board increases, these rate increases were often targeted to raising wages of nursing home workers or increasing staffing. As a practical matter, however, tracking the funds to make sure they result in wage increases has proved difficult in some states, such as California. Moreover, some of the wage pass-through requirements have been complicated, as in Minnesota, and providers have argued that they have not been fully reimbursed for their increased costs. Although workers have received some wage increases, few increases were large enough to greatly change the pay scale in the industry.

Beyond the level of payment, several states, including Minnesota, Colorado, Michigan, and Florida, made major changes to their nursing home reimbursement methodology by moving away from facility-specific prospective payment rates to case-mix-adjusted, often flat-rate systems. These case-mix systems are designed to improve access to services by heavy-care nursing home residents and to give states more control over the payment level by separating the reimbursement from individual facility costs. In theory, these systems should also address the higher average disability of nursing home residents that has occurred as lighter-care residents are diverted to assisted-living facilities and other home-based alternatives. Of the thirteen ANF states, only Alabama and California did not use any case-mix adjustments for their nursing home reimbursement system, a dramatic change from the early 1990s, when only a few states used case-mix adjustments. In a novel initiative, Minnesota is attempting to develop a "performance-based contracting system" for nursing homes that would include incentives for quality.

*Quality of care.* Almost all of the ANF states are engaged in efforts to improve the quality of care in nursing homes. Following the CMS's lead, these initiatives largely involve increased regulatory oversight—hiring more surveyors, conducting more frequent surveys, increasing fines, establishing complaint hotlines, tightening standards for nursing home administrators, and requiring criminal background checks for employees. In addition, Florida and California have raised staffing requirements for nursing homes, even though filling existing positions is difficult, and more staff will mean higher Medicaid costs. Colorado established the Quality Care Incentives Program to give financial rewards to facilities that provide high-quality care, but the program has been criticized for the inadequacy of its quality measures and the small size of the financial incentives. Other strategies include increasing consumer information by posting facility survey results on Web sites, providing consulting services to problem facilities, establishing total quality management systems in facilities, increasing training requirements, and

promoting best practices.

*Liability insurance.* Liability insurance for nursing homes was a major issue in Florida and Texas. In both states a substantial number of civil lawsuits alleging poor quality of care resulted in large financial judgments against nursing homes. As a result, liability insurance premiums rose dramatically, and insurers left the market. Reportedly, large numbers of facilities decided to forgo liability insurance coverage. Consumer advocates and trial lawyers blamed chronically poor quality of care in nursing homes for these problems, while the nursing home industry blamed “greedy” trial lawyers. After a major political battle in 2001, Florida passed major tort reform, limiting awards on punitive and compensatory damages as well as initiating a number of mechanisms to improve quality of care. Texas has made far less sweeping changes, addressing only insurance availability by allowing nursing homes into a special state-sponsored high-risk pool for medical malpractice coverage.

■ **Home and community-based services.** In all states a major policy goal is to expand home and community-based services, to create a more balanced delivery system. Nationally, however, in 1998 only about 13 percent of Medicaid long-term care expenditures for the older population were for noninstitutional services. Although New York, California, and Michigan provide a great deal of home care through the Medicaid personal care option, almost all states are relying on Medicaid home and community-based services waivers for their expansion initiatives. Unlike the personal care option, which must operate as an open-ended entitlement with no fiscal limit, waiver programs give states much greater control over spending by allowing them to limit the number of beneficiaries, target eligibility to severely disabled persons who need nursing home-level care, and require that the average cost per person be below the average Medicaid cost of nursing home care. In some states, including California, Minnesota, Massachusetts, Michigan, and Wisconsin, state-funded programs play an important role in providing services that are not covered under Medicaid or in covering persons who are not eligible for Medicaid.

*The Olmstead decision.* A factor that may push states toward expanding home and community-based services is the 1999 U.S. Supreme Court’s *Olmstead v. L.C.* decision, which ruled that inappropriate institutionalization was a violation of the Americans with Disabilities Act (ADA) and that there was a limited right to noninstitutional services. A few states, such as Texas, have engaged in extensive planning in response to the decision. But most states do not appear to have focused on it, at least for the elderly population, in part because they believe that their existing programs for home and community-based services already meet the Court’s standards. However, “*Olmstead*-like” cases now working their way through New York state courts allege that the geographic variation in the coverage of home and community-based services is illegal. Massachusetts, too, has had a number of lawsuits alleging inadequate supply of home and community-based services.

*Innovative services: consumer-directed care and nonmedical residential settings.* Within

*“As a state’s fiscal condition deteriorates, incentives to maintain Medicaid spending are overcome by the need to reduce spending.”*

.....

home and community-based services, two major innovations are the use of consumer-directed home care and nonmedical residential settings, such as assisted-living facilities. In some states, including California, Michigan, Washington, and Wisconsin, individual consumers rather than agencies are responsible for hiring, directing, scheduling, monitoring, and firing home care workers. The goal is to give consumers greater control over the services they receive. A major issue is the quality of care provided by these workers, who receive little training or outside supervision. As mentioned above, Washington and California have established public authorities to try to improve the working conditions of these workers. State officials report that the majority of people chosen to be independent workers are family members or people previously known by the client, rather than strangers found in the marketplace.

Some states, including Mississippi, Texas, Washington, and Wisconsin, are relying more on nonmedical residential settings as a service option under Medicaid waivers. Other states, including California, Minnesota, and New Jersey, are exploring the idea. Ideally, group residential facilities, such as assisted-living facilities and adult family homes, provide the economies of scale in service provision available in a nursing home without its institutional, medicalized setting. Services, but not room and board, in group residential settings may be covered through Medicaid home and community-based waivers and the personal care option. In some states (such as Alabama), however, state regulations specifically prohibit these facilities from providing services to persons who need nursing home-level care, thus precluding waiver beneficiaries from being served there. In New Jersey there has been a dramatic increase in the number of assisted-living facilities over the past five years, but few facilities participate in Medicaid.

### **Challenges For The Future**

From the latter part of the 1990s through 2000, state health policy benefited from extremely good economic times. States had strong revenue growth, were aggressively bringing in federal revenues through DSH and UPL arrangements, and had new tobacco settlement money to help finance health programs. Medicaid rolls rebounded from the lows experienced after the implementation of welfare reform. States responded positively to the new SCHIP and extended coverage for children of families with much higher income levels than before. Some states used new statutory authorities to extend coverage available through Section 1931(b) of the Social Security Act to cover parents under Medicaid; other states applied for Section 1115 Medicaid and SCHIP demonstration waivers. States benefited from

the fact that health care inflation was relatively low (except for prescription drugs), and they reaped savings from Medicaid managed care. In addition to expanding coverage, states enacted new programs to provide prescription drug programs for older people and persons with disabilities, and they extended home and community-based long-term care services.

The picture was not all positive in terms of expanding services to the low-income population, however. Not all states expanded coverage for children of families earning even 200 percent of the federal poverty level, and relatively few expanded coverage to include parents. An even smaller number of states developed or expanded initiatives to provide health care for nondisabled childless adults. Managed care initiatives in some states faced difficulty in obtaining sufficient providers. Funding for long-term care services remained very heavily tilted toward institutional care.

Recently the fiscal situation has changed. The national economy began to slow in 2000, and the country was in a recession by March 2001. The tax cuts that states enacted in the late 1990s have resulted in lower state revenues, which exacerbated the negative effect of the slower economy. States are now projecting Medicaid enrollment increases because of rising unemployment. Drug spending is rising at double-digit rates; providers are pressing for increased payment rates; and Medicaid managed care is no longer providing the cost savings that it once did. On top of this, the Bush administration is restricting states' use of UPL programs.

■ **Incentives to protect Medicaid and SCHIP funding.** While Medicaid expenditures are increasing faster than state revenues, states face powerful incentives to protect Medicaid and SCHIP funding and services, incentives that do not exist for other health programs or other parts of state budgets. These incentives include the fact that Medicaid is jointly funded with the federal government, which reduces net state costs; that the federal government establishes certain minimum standards for the program; that substantial amounts of tobacco settlement revenue have been earmarked for health programs, including Medicaid; that providers are organized to lobby in support of the program; and that health care coverage seems to be a favored area in the government decision-making process. Obviously, these incentives do not provide total protection for Medicaid. At some point, if a state's fiscal condition deteriorates far enough, incentives to maintain Medicaid spending will be overcome by the need to reduce state spending, and cuts will be made. The questions for this recession are, How will these incentives play out, and how will they vary by state?

Medicaid and SCHIP are jointly funded by the federal and state governments. States have an incentive to maintain Medicaid spending because each \$1 a state spends on Medicaid is matched by \$1–\$3.18 in federal funds, depending on the state's matching rate.<sup>47</sup> The federal matching rate is even higher for SCHIP; each \$1 that a state spends brings in \$1.86–\$4.88 in federal funds. This means that state spending on these two programs has a multiplier effect in terms of expenditures, whether they are increased or decreased. Thus, for Alabama, which has a 70.45

percent federal Medicaid match rate in 2002, a \$1 cut in state expenditures means a \$2.38 cut in federal revenues.

Medicaid and SCHIP have also benefited from tobacco settlement payments, which have reduced the requirements for general revenue financing. All of the ANF states either participate in the Attorneys General Master Settlement Agreement (MSA) of November 1998 or have made separate arrangements with the tobacco companies for payments. Virtually all of the ANF states devote at least a portion of their tobacco money to Medicaid, SCHIP, or other health programs.<sup>48</sup> At one extreme, all of Mississippi's tobacco settlement funds are targeted for health; two-thirds of the funds have been allocated to Medicaid.

Some states are limited in their ability to cut their Medicaid programs because all states must meet federal minimum standards, especially in regard to eligibility and benefits. Thus, for example, even if they wanted to cut Medicaid (which they do not), states such as Alabama, Colorado, and Mississippi are constrained in their ability to do so because they are already close to these minimum requirements. A substantial portion of total Medicaid expenditures nationwide are for optional benefits and coverage groups and, in theory, could be cut. However, while coverage of prescription drugs, intermediate care facilities for the mentally retarded (ICF-MR), and most nursing home residents is not mandatory, all states cover these services and groups and essentially treat them as integral to the program.<sup>49</sup>

Finally, the state politics of Medicaid, SCHIP, and health care are different from those for other services. First, although one should not overstate the distinction, health care is widely thought of as a "special" service. Even in states where cash welfare is held in low regard, there have been efforts to expand health insurance coverage to the uninsured. Thus, funding for health care often receives special protection. Second, funding of Medicaid and SCHIP is of considerable concern to health care providers, especially public hospitals and nursing homes. These providers lobby to protect the programs from budget cuts, a powerful political advocacy that is lacking for cash welfare.

Thus, states have strong incentives and pressures to avoid major reductions in their Medicaid and SCHIP spending. Nonetheless, smaller cuts, including trimming optional benefits and cutting (or at least freezing) reimbursement rates, are clearly likely in many states. States seem less inclined to reduce eligibility levels, although Florida has done so. They are more likely to slow outreach efforts to enlist new enrollees. While there are strong incentives to maintain Medicaid and SCHIP, these programs present serious funding problems for states during economic slowdowns. Although Medicaid and SCHIP are difficult to cut, states are extremely reluctant to increase taxes, and they do have to live within balanced budgets. States have rainy day funds that help ease the burden of recession or less vigorous economies, but the size of these reserves varies by state, and most are limited. Moreover, the pressure that Medicaid spending can place on state budgets can result in retrenchment in other program areas that affect the same low-

*“States have found that Medicaid managed care no longer greatly reduces the rate of growth in acute care spending.”*

.....

income populations.

■ **Longer-term structural problems for Medicaid and SCHIP.** Although Medicaid and SCHIP are likely to survive the recession largely intact, they face serious problems that will extend well into the future. The number of uninsured persons has not increased much since the mid-1990s, primarily because of substantial growth in employer coverage. The recession is likely to cause this source of insurance coverage to decline, as unemployment rises. At the same time, there is growing evidence of increases in health care costs and in the insurance premiums that employers pay. These increases could affect employers' decisions to continue to pay the same share of the premiums or even to offer coverage at all. Employees, particularly those with lower incomes, could find that coverage is no longer offered or that they can no longer afford it. Reductions in employer coverage would increase the demand for public coverage.

In addition, states have found that Medicaid managed care no longer greatly reduces the rate of growth in acute care spending. Hospital costs are rising, and states are limited in their ability to negotiate lower rates because Medicaid beneficiaries often rely on safety-net hospitals, which in turn are highly dependent on Medicaid revenues to help finance care for the uninsured. States also face rising prescription drug costs under Medicaid and have a limited array of tools with which to address the problem.

With the aging of the population, long-term care costs are projected to increase as well. The labor-force shortages that affect nursing homes and community-based care are almost certain to continue. These shortages may affect not only access but also long-term care spending, by forcing increases in wages and benefits for workers. Pressures to increase nursing home quality by increasing staffing will also raise Medicaid costs. Finally, although the Supreme Court's *Olmstead* decision has yet to fully affect policy making in most states, it may force increased spending for home and community-based services.

At the same time that Medicaid spending is likely to increase, DSH payments and UPL programs seem destined to decline as a source of revenue. Federally determined DSH allotments are scheduled to decline in FY 2003, and the Bush administration has issued regulations limiting the use of UPL arrangements. The administration has made it clear that it opposes states' use of these mechanisms to bring in additional federal revenues with few or no state matching contributions.

In the face of these pressures, states could have a hard time maintaining current eligibility levels under Medicaid and SCHIP. States will have very limited ability to respond to the new opportunities that are now present through Section 1931(b)

or through SCHIP waivers because they require additional spending. The Bush administration's Health Insurance Flexibility and Accountability demonstration initiative, which permits states to expand coverage by using the savings from reductions in spending on existing beneficiaries or by using their SCHIP allotments, may be of limited benefit. Cuts in optional acute care benefits are unlikely to yield enough savings to allow any appreciable coverage expansions. Reductions in spending on services to aged and disabled populations would yield more savings, but these cuts would fall on a sicker and more vulnerable population. Use of SCHIP allocations to provide health insurance coverage for parents may have to be limited if SCHIP participation rates continue to increase, because states will need to use more of the available funds for children. In addition, federal SCHIP funds are scheduled to decline in 2002.

**S**TATES WILL HAVE TO WORK HARD just to maintain current coverage commitments, and it seems unlikely that they will go much further in extending coverage. Additional initiatives, perhaps at the federal level, may be required to reduce the number of uninsured persons. These initiatives could include allowing states to cover all adults below an established income threshold, increasing the matching rate on current Medicaid beneficiaries, and permitting more flexibility in benefit packages. Higher matching rates would give states some fiscal relief and greater incentives to expand coverage. More flexibility could include providing broad benefit packages to the most vulnerable populations but allowing more flexibility in benefits and the use of cost sharing for higher income groups. The current system may be reaching its limits, and there are good reasons to believe that states will struggle greatly in the foreseeable future.

.....  
*The authors thank the many state officials and representatives of consumer and provider organizations who participated in interviews and provided information for the case studies. The authors also thank their colleagues at the Urban Institute who researched the individual state case studies. Funding for this research was provided by the Robert Wood Johnson Foundation as part of the Urban Institute's Assessing the New Federalism project. The project received additional financial support from the Annie E. Casey, W.K. Kellogg, Henry J. Kaiser Family, Ford, Charles Stewart Mott, McKnight, Stuart, Weingart, Lynde and Harry Bradley, Joyce, and Rockefeller Foundations; the Commonwealth Fund; and the Fund for New Jersey. The views expressed are those of the authors and do not necessarily reflect those of the Urban Institute, its board, or its sponsors, or those of the Robert Wood Johnson Foundation or other funders.*

#### NOTES

1. A. Kondratas, A. Weil, and N. Goldstein, "Assessing the New Federalism: An Introduction," *Health Affairs* (May/June 1998): 17-24.
2. B. Ormond and A. Wigton, *Recent Changes in Health Policy for Low-Income People in Alabama* (Washington: Urban Institute, 2002); A. Lutzky and S. Zuckerman, *Recent Changes in Health Policy for Low-Income People in California* (Washington: Urban Institute, 2002); J. Tilly and J. Chesky, *Recent Changes in Health Policy for Low-Income People in Colorado* (Washington: Urban Institute, 2002); A. Yemane and I. Hill, *Recent Changes in Health Policy for Low-Income People in Florida* (Washington: Urban Institute, 2002); R.R. Bovbjerg and F.C. Ullman, *Recent Changes in Health Policy for Low-Income People in Massachusetts* (Washington: Urban Institute, 2002); J. Tilly, F. Ullman, and J. Chesky, *Recent Changes in Health Policy for Low-Income People in Michigan* (Washington:

- Urban Institute, 2002); S. Long and S. Kendall, *Recent Changes in Health Policy for Low-Income People in Minnesota* (Washington: Urban Institute, 2002); B. Ormond and F. Ullman, *Recent Changes in Health Policy for Low-Income People in Mississippi* (Washington: Urban Institute, 2002); R. Bovbjerg and F. Ullman, *Recent Changes in Health Policy for Low-Income People in New Jersey* (Washington: Urban Institute, 2002); T. Coughlin and A. Lutzky, *Recent Changes in Health Policy for Low-Income People in New York* (Washington: Urban Institute, 2002); J. Wiener and N. Brennan, *Recent Changes in Health Policy for Low-Income People in Texas* (Washington: Urban Institute, 2002); J. Holahan and M. Pohl, *Recent Changes in Health Policy for Low-Income People in Washington* (Washington: Urban Institute, 2002); and B. Bruen and J. Wiener, *Recent Changes in Health Policy for Low-Income People in Wisconsin* (Washington: Urban Institute, 2002).
3. Both the individual case-study reports and the short summaries are available on the Urban Institute's Web site, [www.urban.org](http://www.urban.org).
  4. V. Smith and D. Rousseau, *CHIP Program Enrollment: December 2000* (Washington: Kaiser Family Foundation, 2001).
  5. National Association of State Budget Officers, *State Expenditure Report, 1999* (Washington: NASBO, 2000); and NASBO, *State Expenditure Report, 1995* (Washington: NASBO, 1996).
  6. NASBO, *State Expenditure Reports* (Washington: NASBO, various years).
  7. NASBO, *State Expenditure Report, 2000* (Washington: NASBO, 2000).
  8. NASBO, *The Fiscal Survey of States: June 2001* (Washington: NASBO, 2001).
  9. Business Cycle Dating Committee, *The Business-Cycle Peak of March 2001* (Cambridge, Mass.: National Bureau of Economic Research, 26 November 2001).
  10. National Conference of State Legislatures, *State Budget and Tax Actions, 2001: Preliminary Report*, Executive Summary (Washington: NCSL, 2001).
  11. NASBO, "Fiscal Survey of States," Preliminary Release, December 2001, [www.nasbo.org/Publications/PDFs/fiscalsurveypreliminary.pdf](http://www.nasbo.org/Publications/PDFs/fiscalsurveypreliminary.pdf) (3 January 2002).
  12. Ibid.
  13. Ibid.
  14. NCSL, *Fiscal Affairs: State Fiscal Outlook for FY 2002, November Update*, 3 December 2001, [www.ncsl.org/programs/fiscal/sfo2002b.pdf](http://www.ncsl.org/programs/fiscal/sfo2002b.pdf) (3 January 2002).
  15. NASBO, "State Budgets—Update: Total Shortfalls Expected for Fiscal Year 2002," 25 January 2002, [www.nasbo.org/Publications/State%20Budgets%20-%20January%2025,%202002.htm](http://www.nasbo.org/Publications/State%20Budgets%20-%20January%2025,%202002.htm) (13 May 2002).
  16. N.W. Jenny, "Severe Decline in State Tax Revenue," State Revenue Reports no. 46, Fiscal Studies Program, Nelson A. Rockefeller Institute of Government (Albany: State University of New York-Albany, 2001).
  17. V. Smith and E. Ellis, *Medicaid Budgets under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002* (Washington: Henry J. Kaiser Family Foundation, October 2001).
  18. Ibid.
  19. B. Bruen, *States Strive to Limit Medicaid Expenditures for Prescribed Drugs* (Washington: Kaiser Family Foundation, 2002).
  20. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage during a Time of Rising Unemployment* (Washington: Kaiser Family Foundation, 2001).
  21. D. Gross, "Among the Governors, a Deficit of Foresight," *Washington Post*, 10 February 2002.
  22. J.C. McKinley Jr., "Albany Deal Would Raise Hospital Pay," *New York Times*, 16 January 2002.
  23. E. Ellis, V. Smith, and D. Rousseau, *Medicaid Enrollment in Fifty States, June 1997 to December 1999* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2000).
  24. For example, states can apply more generous earned income disregards, raise income and resource standards by as much as the rise in the Consumer Price Index since July 1996, or expand coverage to more two-parent working families by eliminating the "100-hour" rule (which prohibited states from providing Medicaid eligibility to two-parent families if the principal wage earner worked more than 100 hours per month).
  25. MassHealth Standard is essentially the traditional Medicaid program plus SCHIP. Coverage is available up to 200 percent of poverty for infants and pregnant women, to 150 percent for children, to 133 percent for parents of covered children and for adults below age sixty-five, and to 100 percent for seniors and refugees, as well as to all Supplemental Security Income recipients and some others.
  26. S. Zuckerman et al., "Shifting Health Insurance Coverage, 1997-1999," *Health Affairs* (Jan/Feb 2001):

- 167–177.
27. Initially, parents with income up to 133 percent of poverty will qualify. In October 2002 eligibility rules will be expanded to 150 percent of poverty.
  28. Nationally, twenty-one states adopted Medicaid expansions, sixteen states implemented separate programs, and nineteen states chose a combination approach. [www.hcfa.gov/init/chip-map.htm](http://www.hcfa.gov/init/chip-map.htm) (May 2002).
  29. I. Hill, “Charting New Courses for Children’s Health Insurance,” *Policy and Practice* 58, no. 1 (2000): 30–38.
  30. *Ibid.*
  31. F. Ullman and I. Hill, “Eligibility under State Children’s Health Insurance Programs,” *American Journal of Public Health* 91, no. 9 (2001): 1449–1551.
  32. In Wisconsin’s SCHIP program, once a family is enrolled, eligibility is retained in the program until the family income reaches above 200 percent of poverty.
  33. G. Kenney, F. Ullman, and A. Weil, *Three Years into SCHIP: What States Are and Are Not Spending* (Washington: Urban Institute, 2000).
  34. *Ibid.*
  35. Smith and Rousseau, *CHIP Program Enrollment: December 2000*.
  36. M. Rosenbach et al., *Implementation of the State Children’s Health Insurance Program: Momentum Is Increasing after a Modest Start*, First Annual Report, submitted by Mathematica Policy Research to the Health Care Financing Administration, 2001, [www.hcfa.gov/stats/schip1.pdf](http://www.hcfa.gov/stats/schip1.pdf) (15 March 2001).
  37. L. Dubay, J. Haley, and G. Kenney, *Children’s Eligibility for Medicaid and SCHIP: A View from 2000*, ANF Policy Brief B-41 (Washington: The Urban Institute, 2001).
  38. L. Dubay and G. Kenney, *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children* (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2001); and A. Davidoff et al., *Patterns of Child-Parent Insurance Coverage: Implications for Coverage Expansions*, ANF Series B (Washington: Urban Institute, October 2001).
  39. E. Howell et al., *Early Experiences with Covering Uninsured Parents under SCHIP*, ANF Series B (Washington: Urban Institute, forthcoming).
  40. In summer 2001 the legislature raised the income eligibility to 250 percent of poverty—mirroring the eligibility threshold for children. The state plans to submit an amendment to expand eligibility to 250 percent of poverty.
  41. Once enrolled, families may remain in the program until their income exceeds 200 percent of poverty, provided there is no cap on enrollment.
  42. A.W. Lutzky and I. Hill, *Premium Assistance Programs under SCHIP—Not for the Faint of Heart?* Prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington: Urban Institute, forthcoming).
  43. J. Holahan, S. Rangarajan, and M. Schirmer, “Medicaid Managed Care Capitation Rates in 1998,” *Health Affairs* (May/June 1999): 217–227.
  44. B. Bruen, *States Strive to Limit Medicaid Expenditures for Prescription Drugs* (Washington: Kaiser Family Foundation, 2002).
  45. B. Bruen and J. Holahan, *Medicaid Spending Growth Remained Modest in 1998, but Likely Headed Upward* (Washington: Kaiser Family Foundation, 2001); and Centers for Medicare and Medicaid Services, “National Health Expenditures, by Source of Funds and Type of Expenditures, 1994–1999,” [www.hcfa.gov/stats/nhe-oact/tables/t3.htm](http://www.hcfa.gov/stats/nhe-oact/tables/t3.htm) (3 January 2002).
  46. CMS Office of National Health Statistics, “Estimated Spending for Freestanding Nursing Home Care, Calendar Years 1960–2000” (Unpublished data, 2000); and J. Wiener, C.M. Sullivan, and J. Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington: AARP, 1996).
  47. Office of the Secretary, U.S. Department of Health and Human Services, “Federal Financial Participation in State Assistance Expenditures for October 1, 2001, through September 30, 2002,” *Federal Register* 65, no. 223 (2001): 69560–69561.
  48. Campaign for Tobacco-Free Kids, American Cancer Society, American Heart Association, and American Lung Association, *Show Us the Money: An Update on the States’ Allocation of the Tobacco Settlement Dollars*, [tobaccofreekids.org/reports/settlements/2002/fullreport.pdf](http://tobaccofreekids.org/reports/settlements/2002/fullreport.pdf) (15 January 2002).
  49. Kaiser Commission on Medicaid and the Uninsured, *Medicaid “Mandatory” and “Optional” Eligibility and Benefits* (Washington: Kaiser Commission, July 2001); and J. Holahan, *Restructuring Medicaid Financing: Implications of the NGA Proposal* (Washington: Kaiser Commission, 2001).