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

Case Study - Michigan

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MICHIGAN
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Background

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

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

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

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

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

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

2002-2003 Budget Solutions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The 2003-2004 Budget Debate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Future

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

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

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

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

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