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From Headache to Migraine?

Medicaid Cap Strengthens Need for Remedies in NY

By Tarren Bragdon

New York State has long stood alone in forcing local taxpayers to pay up to half of all Medicaid costs not reimbursed by the federal government. This divided financial responsibility is a key reason why New York easily leads the nation in Medicaid spending.

Effective in 2006, however, the state budget is beginning to absorb all local program growth above a statutory inflation rate that is less than half the current actual increase in Medicaid costs, as projected by the state Division of the Budget (DOB).

The cap on county and New York City Medicaid aims to relieve pressure on county property taxes and the city budget—and at the county level, at least, it may be working.[1] But, as Governor Pataki pointed out when he proposed the cap last year, shifting more local costs to the state level also increases pressure on state officials to enact the kind of fundamental Medicaid reform they have long resisted. Albany's chronic Medicaid headache could soon turn into a raging fiscal migraine—unless state lawmakers do much more to rein in the program's costs.

As shown in the chart below, state-funded Medicaid costs are projected to increase by $5.6 billion, or 47 percent, over the next four

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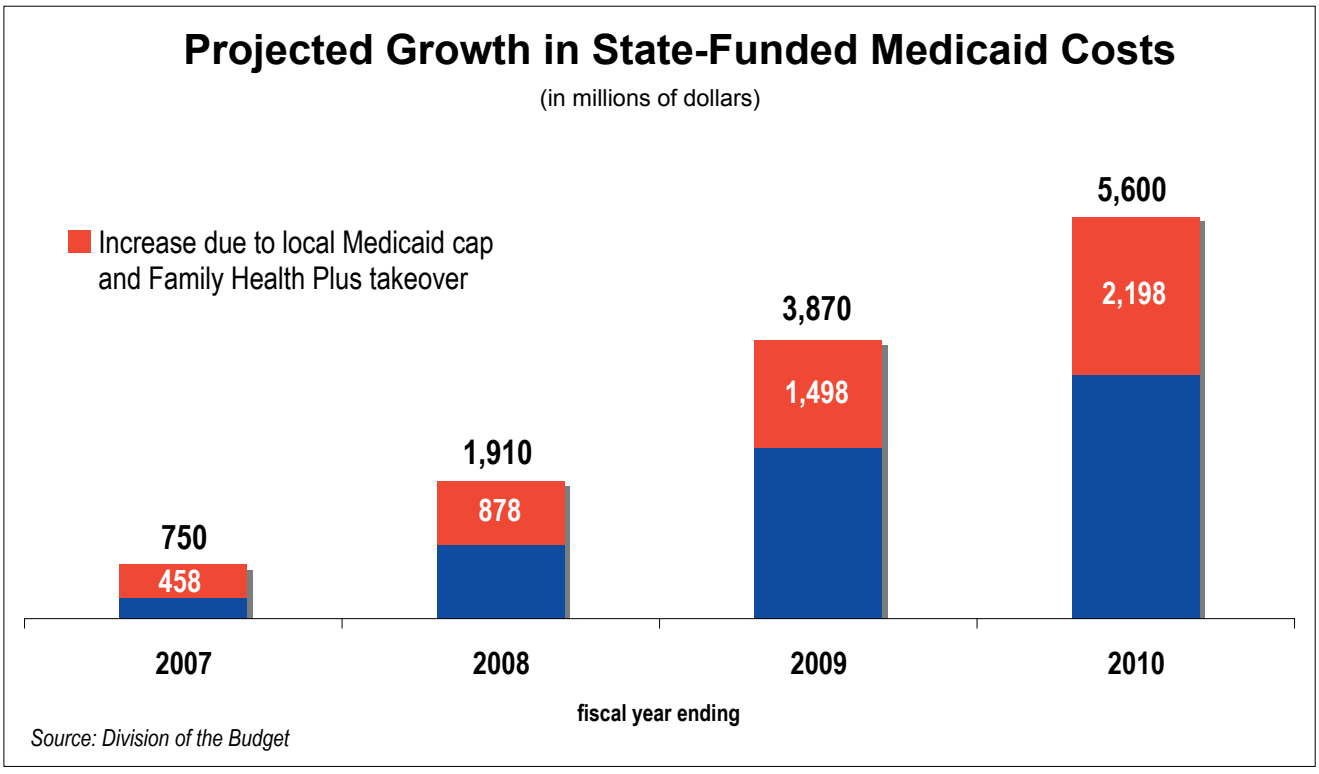
- **The annual increase in state-funded Medicaid spending will be about two-thirds larger than if there had been no takeover of local costs.**
- **New York's governor and Legislature will have a stronger financial incentive to hold annual Medicaid growth below 3 percent.**
- **State funds will be the fastest growing component of Medicaid in New York—a dynamic unmatched elsewhere in the country.**
- **Medicaid will pose an even greater budgetary challenge to the next governor than it has to Governor Pataki and his predecessors.**
- **In 2007, up to 25 counties may find it advantageous to swap their entire Medicaid burden to the state in exchange for a fixed portion of county sales tax receipts.**



Projected Growth in State-Funded Medicaid Spending

(in millions of dollars)

	fiscal year ending				
	2006	2007	2008	2009	2010
Assuming adoption of 2006-07 Executive Budget:					
Total State Funds Medicaid	11,820	12,570	13,730	15,690	17,420
Cost of local cap and Family Health Plus takeover	402	860	1,280	1,900	2,600
Assuming continuation of current law:					
Total State Funds Medicaid	11,820	13,920	16,050	18,050	20,140
Cost of local cap and Family Health Plus takeover	402	1,160	1,760	2,420	3,200

Source: Division of the Budget

years. Of this amount, $2.2 billion—about 40 percent of the total increase—will consist of Medicaid and Family Health Plus expenses formerly borne by county and New York City taxpayers.

Under this scenario, which assumes adoption of Governor Pataki's 2006-07 budget proposals, state-funded Medicaid expenditures are expected to rise at an average annual rate 10.2 percent through fiscal 2010.

With no further change in current Medicaid law, the spending curve will be steeper. As shown in the table above, state-funded Medicaid expenditures would rise $8.3 billion by 2010, including $2.8 billion in formerly local costs.

Viewed solely from an Albany perspective, the pre-cap cost sharing arrangement created a relatively high effective reimbursement rate for Medicaid spending by the governor and Legislature.

New York = Tennessee?

Medicaid's costs are shared with the federal government; the more a state spends, the more money flows in from Washington. For the poorest states, such as Mississippi, the Federal Medicaid Assistance Percentage (FMAP) can reach 76 percent, translating into $3.20 of federal money for every dollar spent at the state level.[2] New York, among the 14 wealthiest states as measured by per-capita income, receives the minimum FMAP of 50 percent—$1 of federal funds for every dollar of state and local resources.[3]

New York and North Carolina are the only two states that require counties to pay a significant portion of state Medicaid program costs. In North Carolina, the federal government pays 63.5 percent of program costs[4], the state pays about 31 percent and counties finance the remaining 5.5 percent,[5] about one third of New York's local share. In New York, the share paid by counties and New York City has ranged from 10 to 25 percent of total Medicaid spending depending on the service and population involved. In the aggregate, the state financed about 34 percent of total Medicaid expenditures, leaving the counties and New York City to pick up the remaining 16 percent.

Viewed solely from an Albany perspective, this arrangement created a relatively high effective reimbursement rate for Medicaid spending. Every dollar spent on Medicaid out of the state budget alone yielded almost $2 from other sources (47 cents from the counties and New York City, and $1.47 from the federal government). Thus, in weighing the *state* cost of any Medicaid change, New York's governor and Legislature were effectively budgeting on the basis of a Medicaid match higher than that available to their counterparts in less wealthy states such as Tennessee (and dramatically higher than those of California, Texas and Florida).[6] This large effective match, combined with a rich tax base, super-sized New York's incentives to grow an enormous Medicaid program.

In times of fiscal austerity, the incentives were reversed. The governor and the Legislature had good reason to focus on cost-containment and revenue-raising measures that reduced the burden of the state share more than the local share.

In 2004, New York ranked number-one among all states in total Medicaid spending per capita (almost $2,200) and in non-federal Medicaid spending per capita (about $1,100). The next nine states in per-capita total Medicaid spending have an average FMAP of 64 percent, or a $2 match for every $1 of state spending,[7] roughly the same as New York's pre-2006 effective match rate from a state-only perspective.

The New Medicaid Spending Cliff

The 2005-06 New York State budget enacted a new cap on how much counties and New York City would send to Albany for Medicaid.[8] Counties and the city can limit their Medicaid payments to Albany to an annual inflation factor of 3.5 percent in 2006, 3.25 percent in 2007 and 3 percent in 2008 and thereafter. The state must assume any growth above those amounts.

The cap substantially alters Medicaid budget incentives and spending consequences at the state level. Whenever state spending exceeds 3 percent (or the effective compounded growth factor for that year[9]), the state-financed share will be the fastest growing portion of the New York Medicaid budget.

Reforms Needed

Incremental cost-containment won't be enough to ensure an affordable future for New York's Medicaid program. States such as Florida and South Carolina have adopted more sweeping reforms that encourage Medicaid recipients to take more responsibility for their own coverage in partnership with private insurers. Recent federal changes encourage such approaches.

Nearly one in five New Yorkers is now enrolled in Medicaid, not even counting the Family Health Plus program, and Governor Pataki's 2006-07 budget projects this total will continue increasing over the next three years. But rather than resign themselves to a steadily growing Medicaid caseload, the governor and Legislature should take steps to make private insurance more accessible to the working poor. Ways to accomplish this include:

- repealing costly regulations, reducing healthcare taxes and removing some of the 43 coverage mandates that drive up premiums, and
- using Medicaid to pay the employee's portion of employer-provided insurance for low-income workers when it proves cost-effective to do so, as is now done in 14 states, including neighboring Massachusetts, New Jersey and Pennsylvania.

Another New Wrinkle

In 2007, counties and New York City have the one-time option of swapping their Medicaid payments (growing at a fixed, non-compounded rate) to the state for a sales tax "intercept"—effectively a form of reverse revenue sharing. Here's how it works:

The state now collects and processes all sales tax receipts and then remits the applicable county and local portion. The New York State sales tax rate is 4 percent with counties and New York City imposing additional sales taxes of 3 to 4.25 percent.

With the sales tax intercept, the State will keep a fixed portion of all future county sales tax receipts and remit only the remainder. The county, in turn, will no longer make *any* Medicaid payments to the State.

If a county believes its sales tax revenues will grow at a rate equal to or less than the effective growth rate of the capped Medicaid payments (which, on a compound annual basis, will be 2.7 percent from 2006 through 2016), it should strongly consider the sales tax intercept option. In low sales tax growth counties, the future 'cost' to the county of the sales tax intercept is less than the future increase of capped Medicaid payments.

Take, for example, financially troubled Erie County. The county is projected to collect $355 million as its share of sales tax for fiscal year 2006. Overall adjusted sales tax receipts in the county have grown less than 2.7 percent annually over the last decade. Erie County's FY2006 local share of Medicaid is $193 million, or 54 percent of the county's share of sales tax revenue. Rather than continuing to send the state its county Medicaid payment, Erie County could opt in 2007 to have the state keep 54 percent of Erie County's sales tax receipts for 2008 and beyond.[10]

As shown in the table above, up to 25 counties may reasonably consider this intercept option. Counties and New York City will have from April 13, 2007 to September 30, 2007 to decide whether to pursue this option. But if "reverse revenue-sharing" becomes popular, the state-level Medicaid migraine—and the pressure to reduce costs—could grow even stronger.

Which Counties Should Consider "Reverse Revenue-Sharing"?

Counties With Historical Sales Tax Growth* Below 2.7%

Allegany	Madison
Broome	Monroe
Cayuga	Niagara
Chautauqua	Onondaga
Chemung	Oswego
Clinton	Schenectady
Erie	Tioga
Jefferson	Wayne
Lewis	

Counties With Sales Tax Growth of 2.7% - 3.2%

Albany	Oneida
Delaware	Orleans
Essex	St. Lawrence
Livingston	Steuben

* 1993-2003 annual average, based on data from state Department of Taxation and Finance

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Endnotes

1 County property taxes increased by half as much in 2006 as they had in the prior five years, because Medicaid costs were $190 million less than without the Medicaid cap, the state comptroller's office recently reported. See research brief posted at www.osc.state.ny.us/press/releases/jan06/013106.htm.

2 Many argue that per-capita income is not an appropriate measure to determine state Medicaid matching funds. However, any change in the formula would produce dramatic winners and losers among the states. Unless Congress finds itself with substantial budget surpluses and a new federal match formula can "raise all boats," do not look for any change soon. To learn more, read a 2003 GAO study on the issue available at: www.gao.gov/new.items/d03620.pdf.

3 Kaiser Family Foundation. California, Colorado, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Washington with Delaware and Alaska just slightly above $1.00.

4 Federal Fiscal Year 2006 match rate. Kaiser Family Foundation. www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=FMAP+and+Multiplier

5 NC counties pay a fixed 15 percent of all non-federal program costs and 50 percent of all Medicaid administrative costs. "Medicaid Frequently Asked Questions." North Carolina Association of County Commissioners. www.ncacc.org/medicaid-faq.html. For this calculation, the 15% figure was used.

6 Only 15 states and the District of Columbia have match rates of $1.90 or higher in Federal Fiscal Year 2006, according to the Kaiser Family Foundation. These include Tennessee ($1.80), California ($1.00), Florida ($1.40) and Texas ($1.50).

7 All figures from the Kaiser Family Foundation. FY2004 Medicaid spending, FY2005 federal match rates (FY04 match rates were enhanced by the Federal Government as one-time state aid and were, therefore, not historically accurate) and 2004 state population data. The average federal match rate for the other 40 lower spending states (per capita) was 60.5 percent or a $1.53 federal match for every $1 of state money. Massachusetts is the only other top 10 spending state with a 50 percent federal match.

8 Chapter 58 – Part C. Laws of 2005. Available at: public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=LAWS

9 Interestingly, when the total Medicaid budget grows less than 3 percent (or the equivalent growth factor), the state's share of the budget drops as federal funding grows at a constant rate and the county payment to the state grows at a fixed 3 percent rate. However, a provision of the law also ensures that counties will not pay more under the cap than under previous law.

10 "2006 Erie County Executive's Budget Message and Summary." pp. 7-8.

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