1998-1999 State Health Care Expenditure Report

Co-Published by the Milbank Memorial Fund, the National Association of State Budget Officers, and the Reforming States Group

March 2001

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Dedication

This edition of the NASBO/RSG *State Health Care Expenditure Report* is dedicated to the memory of Gloria Timmer. Gloria helped to conceive and plan the report as the elected president of NASBO. Then, as

executive director of that organization, she directed data collection and collaborated in writing the first edition, which was published in 1999. Until she became ill in January 2000, she was central to work on the current edition. Her energy, dedication, and vision were essential to this series of groundbreaking reports documenting the role of the states in spending for health services. Her colleagues and friends in state government across the country will miss her dedication, warmth, intelligence, and wit.

Foreword

Spending by state governments is about one-fifth of total spending for health care in the United States. States spent $224 billion in fiscal year 1998 and $238 billion in 1999. In each of these years, state funds were 53 percent of the total; the remainder was federal matching funds and grants.

National health care expenditures are now 13 percent of the gross domestic product. Total spending for health care reached $1.1 trillion in 1998 and is projected to total $2.2 trillion by 2008, growing at an average annual rate of 7.2 percent.

Public spending for health care, by all levels of government, exceeds private-sector spending, according to a recent analysis by the Employee Benefits Research Institute (EBRI). According to this analysis, public spending in 1998 was 58 percent of the total; considerably more than the 45.5 percent calculated by the federal Health Care Financing Administration.*

This report places the state portion of public spending, and hence the influence of the states in health care markets, in perspective by cataloging the various forms of state health care purchasing—from Medicaid to state employees' health benefits to state facility–based expenditures. It provides an overview of the states' role in health care both as purchasers of services and as employers. Both as employers and as providers of services, states feel the changes in the world of health care, from the surge of prescription drug prices to turbulence in the managed care markets. In the past, these different activities often have been viewed as entirely separate enterprises; the influence that states, viewed collectively, can have on overall market behavior is now readily apparent, however.

State legislatures have seen considerable debate over the dramatic changes occurring in health care, but, for the most part, decision makers have not had access to the full spectrum of health care expenditure data for their respective states. To fill this void, leaders of the National Association of State Budget Officers (NASBO) and the Reforming States Group (RSG) decided to pursue a collaborative project to determine the total amount of state-funded health expenditures in each state. The first report, the *1997 State Health Care Expenditure Report*, which showed total health care spending by states for fiscal 1997, represented the first effort ever to detail state health care spending in such a thorough manner. Building on that foundation, the *1998–1999 State Health Care Expenditure Report* presents total state health care spending for the following two fiscal years.

While this edition closely follows the format of the previous report, it expands on the information provided in that report by giving data on employees' contributions to health insurance premiums and to flexible spending programs and by separately reporting expenditures for the State Children's Health Insurance Program (SCHIP). Readers should be aware that considerable differences exist from state to state regarding the types of services provided and the level of government providing the service. Spending by other units of government within states, such as counties and cities, is not included in the data.

This report is a collaboration between the RSG and NASBO, facilitated by the Milbank Memorial Fund. NASBO is a nonpartisan professional organization of governors' state finance officers that provides research and educational information on major public policy issues. The RSG, organized in 1992, is a voluntary association of leaders in health policy in the legislative and executive branches of more than 40 states. The Fund is an endowed national foundation, established in 1905, that works with decision makers in the public and private sectors to carry out nonpartisan analysis, study, research, and communication on significant issues in health policy.

Many individuals contributed to the preparation of this report. The following persons, who are listed in the positions they held at the time of their participation, provided advice and guidance: John Colmers, Executive Director, Maryland Health Care Commission; Lee Greenfield, Chair, Health and Human Services Finance

Division, Minnesota House of Representatives; Gerry Oligmueller, State Budget Administrator, Nebraska; Sheila Peterson, Director, Fiscal Management Division, North Dakota; Sandy Praeger, Chair, Public Health and Welfare Committee, Kansas Senate; and Mark Ward, Deputy Commissioner, Division of Budget and Planning, Missouri.

Individuals in state budget offices across the country provided this report's data. NASBO staff members Greg Von Behren, Stacey Mazer, and Jill Schamberger assembled the data and prepared the report's text.

Mark Gibson
Co-chair, Reforming States Group
Policy Advisor for Health Care, Human Services and Labor
Office of the Governor of Oregon

Robert L. Powell
President, National Association of State Budget Officers
Deputy State Budget Officer
North Carolina Office of State Budget and Management

Peggy Rosenzweig
Co-chair, Reforming States Group
Ranking Member, Audit Committee
Wisconsin Senate

Daniel M. Fox
President, Milbank Memorial Fund

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*There are two principal reasons for the different calculations. One is that EBRI counts public spending for health benefits for public employees as a public expense. The other is that EBRI includes as public spending tax expenditures, that is, taxes not collected as a result of public policy to exclude health care coverage from taxation. This report ignores tax expenditures but includes public employee health benefits.

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Deputy Budget Officer
North Carolina Office of State Budget,
Planning and Management

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Vice President and Chair, Insurance Committee
Kansas Senate
Chair Emeritus, RSG Steering Committee

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Nevada Senate

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Deputy Commissioner, Tenncare Bureau
Tennessee Department of Finance and
Administration

Elizabeth H. Roberts

Vice Chair, Finance Committee
Rhode Island Senate

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Ranking Member, Health, Utilities,
Veterans and Military Affairs Committee
Wisconsin Senate
Co-Chair, RSG Steering Committee

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Insurance Commissioners
Commissioner Kansas Department of Insurance

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Robert S. Zimmerman, Jr.
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Pennsylvania Department of Health

**ex-officio member*
 # to August 2000
† through December 31, 2000

Executive Summary

States' Fiscal Outlook

States continued to enjoy strong fiscal health in 2000 due to the economy's overall strength. In fact, the combination of strong revenue growth with the absence of cost drivers has made the period covered by this report—fiscal years 1998 and 1999—one of the strongest ever for state economies. Health care spending is once again surfacing in budget debates, however, as cost pressures confront state policymakers during fiscal 2001. Trends such as the growth in pharmaceutical prices and turbulence in the managed care market are affecting states both as providers of services and as employers.

The most recent NASBO *Fiscal Survey of States* shows that although balances held by states are still at healthy levels, they are projected to decline from the levels of a few years ago. Since fiscal 1998, balances as a percentage of expenditures have declined as states realize the effects of tax cuts, increases in state service obligations, and a slowing of the economy. Moreover, future revenue growth will be constrained by the states' inability to collect sales tax on remote purchases. Depending on the state and the rate of growth of remote sales, the erosion of sales-tax bases could have significant impact, particularly in states where the

economy weakens.

For the most part, the vibrant economy has meant increased revenue collections and decreased demand for some social services. But several state economies face long-term adjustments and are not likely to regain momentum for several more years because of continuing economic and demographic pressures.

State Expenditures

The current period of economic expansion has enabled states to stabilize their operations. Total state operating and capital expenditures in fiscal 1999, as reported in NASBO's *1999 State Expenditure Report*, were approximately $881.4 billion, an increase of 6.5 percent over fiscal 1998. Federal funds showed a 6.7 percent increase, while state funds showed a 6.1 percent increase over the previous fiscal year.

Total State Health Care Expenditures

Health care is the single most important cost driver for state and federal governments. At the state level, health care expenditures are often viewed narrowly as only Medicaid or as distributed into different programmatic areas, meaning that total expenditures are often obscured. The purpose of this report is to identify and summarize the amount of state-funded health care expenditures in each of the following broad categories: Medicaid, the State Children's Health Insurance Program (SCHIP), state employees' health benefits, corrections, higher education, insurance and access expansion, public health-related expenditures, state facility-based services, and community-based services.

For this report, states were asked to report *direct personal health expenditures*, including expenditures to cover treatment of physical health conditions as well as mental health and substance abuse services. These figures generally exclude expenditures for subsistence and personal care. Spending detailed in this report for public health-related expenditures, corrections, higher education, community-based services, and state facility–based services therefore does not represent the totality of spending in these areas but rather only the direct personal health expenditures in these categories.

In the demographic data collected for fiscal 1999, states reported a total population of 274.9 million, a total Medicaid caseload of 32 million, 3.2 million state employees, 1.1 million adult inmates, about 77,000 incarcerated juveniles, and 1.4 million SCHIP beneficiaries.

In fiscal 1999, states spent $238.5 billion on health care (see table 13). Health care spending represented approximately 27 percent of state budget totals, on average. Table 1 shows the proportion of total state health care expenditures from all funding sources.

Table 1: State Health vs. Non-Health Spending, Fiscal Years 1998 and 1999

	FISCAL 1998	FISCAL 1999
Medicaid	19.9%	19.8%
SCHIP	0.0	0.1
State Employees' Benefits	2.1	2.1
Corrections	0.3	0.3
Higher Education Health Care	0.6	0.6
Insurance and Access Expansion	0.1	0.1
Public Health–Related Expenditures	1.5	1.5
Community-Based Services	1.7	1.7
State Facility–Based Services	0.9	0.8
Total State Health Care Expenditures	27.1	27.1
Total Non–Health Care Expenditures	72.9	72.9

As table 2 shows, overall state spending shares for health care in fiscal 1999 were as follows: 73.0 percent for Medicaid, 0.4 percent for SCHIP, 7.9 percent for state employees' benefits, 1.3 percent for corrections, 2.2 percent for higher education, 0.3 percent for state insurance and access expansion, 5.5 percent for public health services, 6.3 percent for community-based services, and 3.1 percent for state facility–based services. These totals are broken down, state by state, in table 39, which highlights the share of each state's health care spending budget represented by various programs and shows the wide variation among states' spending patterns.

Table 2: Total State Health Care Expenditures, Fiscal Years 1998 and 1999

	FISCAL 1998	FISCAL 1999
SCHIP	0.1%	0.4%
State Employees' Benefits	7.7	7.9
Corrections	1.2	1.3
Higher Education Health Care	2.3	2.2
Public Health–Related Expenditures	5.5	5.5
Community-Based Services	6.3	6.3
State Facility–Based Services	3.2	3.1
Insurance and Access Expansion	0.2	0.3
Medicaid	73.6	73.0

Each state reported its health care spending by funding source (state general funds, federal funds, and other state funds) for each of the nine categories. In fiscal 1999, general-fund revenues are received from broad-based state taxes and account for 41 percent of funding for total state health care expenditures, as compared to approximately 48 percent of funding for all state spending. The general fund makes up varying amounts of the total funding, depending on the category: for example, the general fund accounts for

approximately 96 percent of total funds for corrections while making up only 14 percent of total funding for SCHIP. State general funds also supply the predominant share of the funding for state facility–based services and community-based health care.

States receive federal funds directly from the federal government to spend for specific purposes. Federal funds provide about 46 percent of total state health care expenditures and account for a much larger percentage of state health care spending than of total state spending. (Federal funds provide approximately 25 percent of total state spending for all functions.) The amount of federal funding in the various health care categories ranges from 0.7 percent for corrections to 68 percent for SCHIP expenditures. Other state fund expenditures, which provide about 12 percent of total state health care expenditures, are dedicated state funds. These are the primary source for insurance and access expansion, accounting for almost 66 percent of expenditures in that category, while providing only 2.8 percent of funding for corrections health care expenditures.

From fiscal 1998 to fiscal 1999, the percentage growth in non-health care expenditures totaled 6.5 percent while health care expenditures increased 6.3 percent during this period (see table 3). Excluding the outsize increases for SCHIP, which reflect implementation of a new program, insurance and access expansion showed the largest percentage increase (28.5 percent), followed by state employees' benefits (9.6 percent) and corrections (8.7 percent).

Table 3: Percentage Change in Health Care Expenditures by Category, Fiscal Years 1998 and 1999

	GENERAL FUND	OTHER STATE FUNDS	FEDERAL FUNDS	TOTAL FUNDS
Medicaid	4.7%	5.5%	6.0%	5.5%
SCHIP*	2,323.8	206.9	935.9	676.4
State Employees' Benefits	8.0	10.6	11.8	9.6
Corrections	8.8	-1.9	41.8	8.7
Higher Education Health Care	3.5	6.4	4.1	4.9
Insurance and Access Expansion	7.0	23.9	128.8	28.5
Public Health–Related Expenditures	11.9	2.8	5.3	6.6
Community-Based Services	5.5	30.1	-0.9	5.4
State Facility–Based Services	5.7	-0.3	17.4	5.6
Total State Health Care Expenditures	5.7	7.5	6.4	6.3
Total Non–Health Care Expenditures	7.1	4.4	6.9	6.5

*Reflects the implementation of a new program.

State Health Care Spending

Medicaid

Medicaid is a means-tested program with rules mandated by the federal government. It is administered by states and provides medical care for low-income individuals. State participation in the Medicaid program is voluntary, although all states have elected to do so because they receive matching federal funds for Medicaid programs. The jointly funded program requires state matching funds based on a federal rate that varies according to each state's per capita personal income.

States must provide Medicaid coverage to certain low-income population groups (members of families with children and pregnant women, and persons who are aged, blind, or disabled) and have the option to cover other populations as well. The state must provide certain basic medical services but may cover additional services if it chooses to do so. Services covered include inpatient hospital care, nursing home care, residence in state facilities for the mentally retarded, home health care, physician services, outpatient hospital care, and prescription drugs.

Annual increases in Medicaid expenditures have stabilized recently, primarily because federally enacted program expansions are fully phased in and because states, concluding that they could no longer afford the programs' sustained growth, have adopted a variety of cost-containment measures. These measures have included limiting eligibility, reducing the amount of services covered, and integrating acute and long-term care services. Other factors contributing to the stabilization have included congressional limits on the disproportionate share hospital program, the improving economy, and lower medical inflation.

After Medicaid growth rates of 3 and 4 percent a year in 1996 and 1997, the rate increased to 6 percent in 1998. Medicaid expenditures totaled $165.1 billion in fiscal 1998, representing 73.6 percent of total state health care spending and 19.9 percent of all state spending in that fiscal year. In fiscal 1999, these expenditures increased to $174.2 billion and represented 73.0 percent of total state health care spending and 19.8 percent of all state spending. The increase in Medicaid spending between fiscal 1998 and fiscal 1999 was 5.5 percent. But the rate of increase in Medicaid will probably grow. According to the most recent *Fiscal Survey of States*, Medicaid cost increases for fiscal 2000 were 7.7 percent. The Congressional Budget Office (CBO) estimates that Medicaid expenditures will increase by 7.8 percent in fiscal year 2001 and will average more than 8 percent a year thereafter. According to the CBO, this renewed growth may result from increased spending on pharmaceutical products and noninstitutional long-term care and from states' having completed the implementation of cost-containment measures. Also, outreach efforts for the State Children's Health Insurance Program have resulted in higher Medicaid utilization among children.

It is anticipated that the increased use of noninstitutional long-term care and the rise in pharmaceutical prices will continue to drive up costs in future years. Pharmaceutical cost increases reflect growth both in the cost of prescriptions and in the total number of prescriptions filled, which in the United States rose from 1.9 billion in 1993 to 2.5 billion in 1998. Among possible reasons for the rise in pharmaceutical usage are the aging of the population, direct consumer advertising, and the introduction of new, expensive pharmaceutical agents.

The total Medicaid caseload in fiscal 1999 was 32 million. Approximately 55 percent of Medicaid is financed by federal funds, with the remaining 45 percent split between the state general fund and other state funds. Table 4 shows fund shares for fiscal years 1998 and 1999.

Table 4: Medicaid

	FISCAL 1998	FISCAL 1999
Federal Funds	54.9%	55.2%
General Funds	36.8	36.5
Other State Funds	8.3	8.3

Medicaid commands the largest share of total state health care expenditures. Individual states' Medicaid spending ranged from 52.3 percent to 90.5 percent of total health care spending in fiscal 1999. Medicaid also represents the largest share of total state spending, accounting for 19.8 percent in fiscal 1999. Medicaid expenditures for fiscal 1998 and fiscal 1999 are broken down, state by state, in table 14.

State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP), enacted in 1997, provides coverage to uninsured

children in low-income families. The program was designed to reach children from working families with incomes too high to qualify for Medicaid but too low to afford private insurance. States may develop SCHIP programs in one of three ways to serve the needs of their specific populations: a state may (1) expand its Medicaid program, (2) develop an alternative, stand-alone state SCHIP program, or (3) create a program that is a combination of Medicaid and SCHIP. Within federal guidelines, each state determines its specific program design, eligibility categories, covered benefits, provider payments, and administrative and operating procedures. Tables 15–17 provide state-by-state breakdowns of total SCHIP expenditures, SCHIP Medicaid expansion expenditures, and SCHIP stand-alone expenditures, respectively.

Under SCHIP, states receive an enhanced federal matching rate that exceeds their federal Medicaid match by about 30 percent, with the federal share capped at 85 percent. States have up to three years to use their yearly federal allotment. Although states are eligible to receive additional SCHIP funds each year, they cannot use the new funds until the funds from the previous year are expended.

Nearly 2 million children were enrolled in SCHIP during federal fiscal year 1999 (October 1, 1998, to September 30, 1999). During this time more than 1.2 million children were served by stand-alone SCHIP programs, and almost 700,000 children were served by Medicaid expansion programs. SCHIP enrollment is expected to rise as states expand their programs, conduct effective outreach, streamline their application processes, and improve procedures to ensure that eligible children retain coverage. In addition, SCHIP programs help states identify and enroll children already eligible for Medicaid but not enrolled.

Of states tracking SCHIP-related Medicaid enrollment activities, most anticipate increased enrollment, averaging 14.8 percent, in fiscal 2001. On average, estimated SCHIP-related Medicaid enrollment growth in fiscal 2000 was 26.5 percent.

Expenditures for SCHIP programs totaled $127.4 million in fiscal 1998, representing 0.1 percent of total state health care spending and a negligible percentage of all state spending. In fiscal 1999, these expenditures increased to $989.1 million, representing 0.4 percent of total state health care spending and 0.1 percent of all state spending. These amounts represent the combined expenditures for Medicaid expansion programs, stand-alone programs, and combination programs. Table 5 shows fund shares for 1998 and 1999.

Table 5: SCHIP

	FISCAL 1998	FISCAL 1999
Federal Funds	51.2%	68.3%
General Funds	4.6	14.2
Other State Funds	44.3	17.5

State Employees' Health Benefits

Health care–related expenditures for state employees totaled $17.2 billion in fiscal 1998 and increased to $18.8 billion in fiscal 1999. State employee health care spending represented 7.7 percent of total state health care spending in fiscal 1998 and 7.9 percent in fiscal 1999; it accounted for 2.1 percent of total state spending for each of these fiscal years.

From fiscal 1998 to fiscal 1999, dollar expenditures increased by 9.6 percent. These expenditures included amounts employers paid for health insurance premiums for state employees, the medical portion of workers' compensation, and the Medicare payroll taxes paid on behalf of state employees. Also included in this category are amounts that employees contributed for their health insurance premiums and to flexible spending accounts. Of these amounts, state employee health premiums—$11.9 billion in fiscal 1998 and $13.1 billion in fiscal 1999—represented more than two-thirds of the total amount of state employee health care expenditures.

About one-half of the amounts spent were drawn from general funds, with the remainder comprising federal funds and other state funds. The range in the percentage of total state health care spending represented by state employees' benefits was fairly wide, accounting for anywhere from 2.1 to 23.7 percent of that spending in fiscal 1999. About one-third of the states spent between 2 and 7 percent of total health care spending on state employees' health benefits.

Services covered also vary and, depending on the state, may include prescription drugs, mental health, and vision programs. Amounts for self-insured plans include direct care plus administrative costs. Amounts for state employee health insurance premiums include benefits for dependents and for retirees and their dependents. The total number of state employees in fiscal 1999 was approximately 3.2 million. (Elementary and secondary school employees are excluded from the figures.)

Table 6 shows fund shares for fiscal years 1998 and 1999. Some states reported only total fund spending rather than categorizing spending by source; spending for these states appears in the "undesignated fund source" line in the table.

Table 6: State Employees' Benefits

	FISCAL 1998	FISCAL 1999
Federal Funds	8.7%	8.8%
General Funds	57.4	56.6
Other State Funds	27.1	27.3
Undesignated Fund Source	6.9	7.2

Corrections

Corrections health care expenditures consist of direct personal health expenditures for incarcerated adults and juveniles, including spending to cover treatment of somatic conditions as well as mental health and substance abuse treatment. Services reflected in corrections health care expenditures range from general health care costs to hospital and emergency room costs, infirmary medications, contractual medical services, and salaries of state-employed medical staff.

State officials expect corrections health care spending to increase during the next few years because of growth in adult and juvenile corrections populations. Elected officials have instituted longer sentences, mandatory sentences for repeat offenders, less generous parole, and higher sentencing rates for most serious crimes. And, just as for adults, the trend has been toward imposing tougher punishments on juvenile offenders. These factors, too, may potentially increase corrections health care costs in the future. Another significant factor behind rising costs is an increase among incarcerated populations in diseases such as AIDS and hepatitis that are expensive to treat—an increase that mirrors increases in the incidence of these diseases in the general population. Some states may also be seeing increases in corrections health care spending as a result of the aging of the inmate population.

In 1999, states reported a total of about 1.1 million adult and about 77,000 juvenile inmates. In 1998, states estimated they spent $2.8 billion on total corrections health care costs; of this amount, $2.6 billion was spent on adult corrections and $0.2 million on juvenile corrections. In 1999, states spent approximately $3.0 billion on total corrections health care costs, including $2.8 billion spent on adult corrections and $0.2 million on juvenile corrections.

Total corrections health care spending accounted for 0.3 percent of total state budgets in both fiscal 1998 and 1999. Relative to total state health care expenditures, total corrections health care spending accounted for 1.2 percent in both fiscal 1998 and 1999. As a percentage of total state health care spending, corrections ranged from 0 percent (as recorded because the number is so small) to 3.2 percent, with total dollar

expenditures ranging from $30,000 to $536 million. Tables 24, 25, and 26 give individual states' total corrections health care spending, adult corrections health care spending, and juvenile corrections health care spending, respectively. Fund shares for fiscal years 1998 and 1999 are provided in table 7, which reflects the fact that almost all funds for corrections health care are derived from state general funds.

Table 7: Corrections

	FISCAL 1998	FISCAL 1999
Federal Funds	0.5%	0.7%
General Funds	96.4	96.5
Other State Funds	3.1	2.8

Higher Education

Higher education health care spending covers state support for state university–based teaching hospitals, including any state funds for health insurance premiums or coverage of teaching hospital employees. Teaching hospitals are the sites of clinical education and training for students preparing for the health professions. Under supervision by faculty physicians, students have the opportunity to learn by observation and, if they are sufficiently advanced and appropriately licensed, by diagnosis and treatment of patients. Teaching hospitals are also a setting in which students participate in clinical research.

Higher education health care spending includes expenditures for postgraduate students who render reimbursable health care, costs of treating uninsured patients at the teaching hospitals, and salaries of other employees of the teaching hospitals that are not reimbursed by Medicare, private insurance, or direct payments by patients. Data on physician loan-repayment programs, other incentive programs, and student health clinics are not included in higher education health care spending totals.

State health care expenditures for higher education totaled $5.1 billion in fiscal 1998, rising to $5.3 billion in fiscal 1999. These amounts represented 2.3 percent of state health care spending in 1998 and 2.2 percent in 1999, and accounted for 0.6 percent of total state spending in fiscal year 1998 and 0.6 percent in fiscal 1999. Overall, higher education expenditures accounted for 10.3 percent and 10.4 percent of state budgets in fiscal 1998 and fiscal 1999, respectively.

As a percentage of total health care spending, higher education ranged from 0 percent to 25 percent in fiscal 1999. As reflected in table 27, individual states reported higher education health care expenditures ranging from $0 to $599 million for fiscal 1999. Thirteen states reported no higher education health care spending, in most cases because those states do not have teaching hospitals.

Table 8 shows fund shares for higher education health care spending for fiscal years 1998 and 1999. Some states reported only total fund spending rather than categorizing expenditures by source; spending for these states appears in the "undesignated fund source" line in the table.

Table 8: Higher Education Health Care

	FISCAL 1998	FISCAL 1999
Federal Funds	22.9%	22.7%
General Funds	34.2	33.8
Other State Funds	42.6	43.3
Undesignated Fund Source	0.3	0.3

State Insurance and Access Expansion

States are using various approaches—including insurance programs funded by the state alone and public-private partnerships—to extend health care coverage. State insurance and access expansion includes state funding provided for high-risk pools and insurance subsidies. These pools help people who have difficulty buying health insurance in the private market (usually because they are in high-risk groups or have preexisting conditions). Participants are required to pay premiums under these programs.

State expenditures for insurance and access expansion totaled $470 million in fiscal 1998, rising to $603 million in fiscal 1999. These amounts represented 0.2 percent of total state health care spending in fiscal 1998, 0.3 percent of total state health care spending in fiscal 1999, and 0.1 percent of all state spending in both fiscal 1998 and fiscal 1999.

As table 28 shows, insurance and access expansion expenditures in the 50 states ranged from $0 to $159.5 million in fiscal 1999. Twenty-nine states reported spending nothing on state insurance and access expansion as defined in this report.

As shown in table 9, fund shares for 1998 and fiscal 1999 were predominantly other state funds, followed by the general fund and federal funds.

Table 9: State Insurance and Access Expansion

	FISCAL 1998	FISCAL 1999
Federal Funds	8.2%	14.6%
General Funds	23.9	19.9
Other State Funds	67.9	65.5

Public Health–Related Expenditures

As defined in this report, public health–related spending covers direct personal health expenditures for specific program areas but does not include subsistence, personal care, or general public health expenditures. The clients served by the public health care expenditures are specific to the programs offered and range from infants to the elderly and patients to medical professionals.

In addition to the overall public health total, states provided specific expenditure data for four public health areas:

- local health clinics
- Ryan White AIDS Grant
- non-federal Indian health care
- licensing boards and regulatory oversight

State-by-state data for these four areas are given in tables 30 through 33.

In addition, states provided totals for expenditures in other public health–related areas. Depending on the state, the amounts reported for other public health care expenditures may include money spent on the following kinds of services:

- pharmaceutical assistance for the elderly
- childhood immunization
- chronic disease hospitals and programs
- hearing aid assistance
- adult day care for persons with Alzheimer's disease
- health grants
- medically handicapped children
- Women, Infants, and Children (WIC) programs
- pregnancy outreach and counseling
- chronic renal disease treatment programs
- AIDS testing
- breast and cervical cancer screening
- tuberculosis (TB) programs
- emergency health services
- adult genetics programs
- Phenylketonuria (PKU) testing
- health promotion and education programs

The amounts reported under the "other public health–related programs" category, totaling $8.6 billion in fiscal 1998 and $9.2 billion in fiscal 1999, accounted for 70 percent of all state public health expenditures. State-by-state figures appear in table 34.

In fiscal 1999, total public health–related spending represented 1.5 percent of total state budgets. As a percentage of total state health care spending, total public health–related expenditures ranged from 1.0 percent to 10.8 percent in that year. Individual states' dollar expenditures ranged from $9.1 million to about $1.7 billion in fiscal 1999, as shown in table 29.

Table 10 gives public health–related fund shares for fiscal years 1998 and 1999.

Table 10: Public Health-Related Expenditures

	FISCAL 1998	FISCAL 1999
Federal Funds	47.3%	46.8%
General Funds	28.7	30.1
Other State Funds	23.9	23.1
Undesignated Fund Source	0.1	0.1

State Facility–Based Services

As shown in table 35, expenditures for state facility–based services totaled $7.1 billion in fiscal 1998, rising to $7.5 billion in fiscal 1999. These amounts represented 3.2 percent of total state health care spending in fiscal 1998 and 3.1 percent in fiscal 1999 and accounted for 0.9 percent and 0.8 percent of all state spending in fiscal years 1998 and 1999, respectively. State facility–based expenditures comprise monies spent on state-operated long-term care facilities and a variety of other facilities. Long-term care facility expenditures include all costs not covered by Medicaid for either medical treatment or room and board at veterans' homes and other nursing facilities that receive state support. Other state facilities covered under this category of expenditures might include any of the following:

- schools for the blind
- schools for the deaf
- mental health hospitals
- facilities for the developmentally disabled
- substance abuse facilities
- veterans' homes
- rehabilitation facilities

State spending on services provided in state facilities ranged from between 0.7 percent to 11.2 percent of total state health care spending in fiscal 1999. More than half of the states spent between 2 and 6 percent, eleven states spent less than 2 percent, and eight states spent more than 6 percent on what this report defines as state spending on services provided in state facilities. (For state-by-state breakdowns, see table 35.)

Table 11 provides state facility–based expenditure fund shares for 1998 and 1999.

Table 11: State Facility–Based Services

	FISCAL 1998	FISCAL 1999
Federal Funds	6.9%	7.7%
General Funds	75.7	75.8
Other State Funds	16.0	15.1
Undesignated Fund Source	1.4	1.5

Community-Based Services

Expenditures for community-based services totaled $14.2 billion in fiscal 1998, rising to $15 billion in fiscal 1999 (see table 38). In both fiscal years, community-based services accounted for 6.3 percent of total state health care spending and 1.7 percent of all state spending. Services in this category exclude those eligible for reimbursement under the Medicaid program, which are reported elsewhere. Examples of services covered under this category include the following:

- rehabilitation services
- alcohol and drug abuse treatment
- mental health community services
- developmental disabilities community services
- vocational rehabilitation services

States exhibited a wide range of expenditures for community-based services. As a percentage of total health care spending in fiscal 1999, 21 states spent less than 5 percent, 21 states spent more than 5 percent but less than 10 percent, and 8 states spent 10 percent or more on what this report defines as community-based

services.

Approximately two-thirds of the $15 billion states spent on community-based services in fiscal 1999 came from general funds, with the remainder divided between federal funds and other state funds. Table 12 shows community-based services fund shares for fiscal 1998 and fiscal 1999.

Table 12: Community-Based Services

	FISCAL 1998	FISCAL 1999
Federal Funds	26.8%	25.2%
General Funds	64.2	64.2
Other State Funds	6.7	8.2
Undesignated Fund Source	2.4	2.4

Guide to the Tables

Definitions

Fiscal Year 1998
State fiscal year beginning in calendar year 1997 and ending in calendar year 1998.

Fiscal Year 1999
State fiscal year beginning in calendar year 1998 and ending in calendar year 1999.

Actual vs. Appropriated
Data reflect actual expenditures for fiscal 1998 and fiscal 1999.

State General Fund Expenditures
The predominant fund for financing a state's operations. Revenues are received from broad-based state taxes.

Other State Fund Expenditures
Usually, state funds provided for health care expenditures through sources other than the general fund.

Federal Fund Expenditures
Funds received directly from the federal government and expended for health care. Can include block grants or federal funds obtained by state match.

Health Care Expenditures
Personal health expenditures, including spending to cover treatment of somatic conditions as well as mental health and substance abuse treatment. These do not include expenditures for subsistence, personal care, or general public health services (except direct health care services).

Medicaid Expenditures
Information reported on the HCFA-64 report, with the subcategories of the report incorporated and converted to state fiscal year. All Medicaid expenditures are reported under this category. To avoid double counting, Medicaid expenditures are not included in any other responses, with the exception of SCHIP expenditures.

State Children's Health Insurance Program (SCHIP) Expenditures
Information reported on the appropriate HCFA reports, with the subcategories of the report incorporated and converted to state fiscal year. Stand-alone SCHIP expenditures reported on the HCFA-21 report; Medicaid expansion SCHIP expenditures reported on the HCFA-6421 and HCFA-6421U reports; and combination SCHIP expenditures reported on the relevant Medicaid or stand-alone program report. SCHIP expenditures were not included in any of the Medicaid expenditures. No cost-share provisions are included.

State Employee Health Insurance Premium Expenditures
Expenditures for premiums for insurance products and direct care as well as administrative expenses for self-insured products. The covered population includes current state employees and dependents, state retirees and dependents, and college and university faculty and employees. "Carved-out" benefits for such services as prescription drugs, mental health treatment, and vision care are also included. Funds from employees in flexible spending ("cafeteria") accounts are excluded, as is the state employee match. K–12 employees are not included because health care premiums for such employees are usually budgeted through local school districts and therefore are not state costs.

State Employee Health Insurance Premium–Matching Expenditures
The amount state employees pay as a match for health insurance premiums.

State Employee Flexible Spending Account Expenditures
The amount that state employees place in flexible spending accounts to be used for medical/health expenses.

Medical Portion of Workers' Compensation Expenditures
The amount spent for state employees.

Medicare Payroll Tax Expenditures
The amount contributed by state employees to the Medicare fund. ("State employees" is defined in the same way as under State Employee Health Premium Expenditures, above.)

Corrections Health Care Expenditures
Personal health expenditures, including spending to cover treatment of somatic conditions as well as mental health and substance abuse treatment. These do not include expenditures for subsistence, personal care, or general public health services (except direct health care services). Expenditures for adults and juveniles are reported separately.

Higher Education Health Care Expenditures
State support to fund the operation of state university–based teaching hospitals, including any state funds for health care premiums or coverage of teaching hospital employees. Includes state funds for professional education (such as residency programs) conducted in combination with clinical practice. Excludes physician loan-repayment programs, other incentive programs, student health clinics, and state funds for degree-granting programs in any health professions.

State Insurance and Access Expansion Expenditures
State funding for high-risk pools and insurance subsidies. Also includes health care coverage extended through insurance programs funded by the state alone and through and public-private partnerships.

Public Health–Related Expenditures
Includes local health clinics, Ryan White AIDS Grant expenditures, Indian health, and regulatory and licensing expenditures, each of which is defined immediately below. Also includes items listed by states under "Other Direct Health Expenditures," also defined below.

Local Health Clinic Expenditures
State assistance to rural or other local health clinics.

Ryan White AIDS Grant Expenditures
Funds spent for the health care portion of Ryan White AIDS grants.

Non-Federal Indian Health Care Expenditures
State funds spent for Indian health care.

Licensing Boards and Regulatory Oversight Expenditures

State funds spent for licensing and regulating health care professionals and health care agencies.

Other Public Health Care Expenditures
Personal health expenditures not included in the four categories listed immediately above. Expenditures may include monies spent on pharmaceutical assistance for the elderly; childhood immunization; chronic disease hospitals and programs; hearing aid assistance; adult day care for persons with Alzheimer's disease; health grants; services for medically handicapped children; the Women, Infant, and Children (WIC) program; pregnancy outreach and counseling; chronic renal disease treatment programs; AIDS testing; breast and cervical cancer screening; tuberculosis programs; emergency health services; adult genetics programs; phenylketonuria (PKU) testing; and health promotion and education programs.

State Facility–Based Services
Includes state-operated long-term care facilities and veterans' homes, and "Other Direct Health" services provided in state facilities; both are defined immediately below.

State-Operated Long-Term Care Facilities Expenditures
All costs not covered by Medicaid for veterans' homes and other nursing facilities that receive state support. Includes medical treatment, room and board, and other costs.

Other State Facility Expenditures
State funds spent for health services provided in a state facility. Facilities may include schools for the blind, schools for the deaf, mental health hospitals, facilities for the developmentally disabled, substance abuse facilities, and rehabilitation facilities. These expenditures do not include funds spent on services eligible for Medicaid reimbursement, which are reported under Medicaid.

Community-Based Services Health Expenditures
State funds spent on health services provided in a community setting. Examples include rehabilitation services, alcohol and drug abuse treatment, mental health community services, developmental disabilities community services, and vocational rehabilitation services. These expenditures do not include funds spent on services eligible for Medicaid reimbursement, which are reported under Medicaid.

General Notes

The *1998-1999 State Health Care Expenditure Report* is a cooperative effort between the Milbank Memorial Fund, the Reforming States Group (RSG), and the National Association of State Budget Officers (NASBO). The survey was sent to governors' state budget officers in the 50 states and the territory of Puerto Rico.

The report presents aggregate and individual data on the states' direct personal health expenditures in the following categories: Medicaid, the State Children's Health Insurance Program (SCHIP), state employees' health benefits, corrections, higher education, insurance and access expansion, public health–related expenditures, state facility–based services, and community-based services. These include expenditures to cover treatment of physical health conditions as well as mental health and substance abuse services, but generally exclude expenditures for subsistence and personal care. Spending detailed in this report for public health–related expenditures, corrections, higher education, community-based services, and state facility–based services therefore does not represent the totality of spending in these areas but rather only direct personal health expenditures in these categories. Some states did not report direct health expenditures in all categories. Total state budget information detailed on the state profiles was obtained from NASBO's *1999 State Expenditure Report*.

Some methodological issues arose regarding the reporting of state expenditures in the various categories. These issues include the following:

Medicaid
The amounts reported are those reflected on the HCFA-64 form and converted to state fiscal year. These amounts differ from the figures contained in NASBO's *1999 State Expenditure Report* because the figures in the present report include administrative costs.

SCHIP
The amounts reported are those reflected on the various HCFA forms and converted to state fiscal year.

State Employees' Health Benefits
Some states were unable to break out state employee health-related expenditures by fund source and

included only total fund expenditures for state employees' health benefits.

Corrections
Because of variations among states, the data reported might include different items. For example, some juvenile corrections services are operated by counties, with state support via grants; some juvenile health care expenditures are funded through grants to county child welfare programs; and expenditure data may or may not include data on county correctional systems.

Higher Education Health Care
Because of variations in state operations, the data reported may reflect different types of higher education health care expenditures for different states. For example, not all states have teaching hospitals associated with their medical schools; the expenditures may include hospital employee benefits costs in some states but not others; and some states' higher education health care expenditures may include operating costs while others may not.

Public Health-Related Expenditures
The data do not include all expenditure information for state health departments, and most states reported a variety of different programs in the expenditure data.

Demographic Data
States were asked to include faculty and staff of state-owned and state-related colleges and universities.

State Health Care Spending by Region

Explanatory Notes Submitted by Particular States by Region

New England

Connecticut

Medicaid: The state utilizes gross budgets; thus, the appropriated amount under total funds includes the federal share. Federal financial participation is projected to be 50 percent.

SCHIP Medicaid Expansion: The state utilizes gross budgets; thus, the appropriated amount under total funds includes the federal share. Federal financial participation is projected to be 65 percent.

SCHIP Stand-Alone: The state utilizes gross budgets; thus, the appropriated amount under total funds includes the federal share. Federal financial participation is projected to be 65 percent. Higher Education Health Care: State funds do not directly support the hospital, they support the medical school program.

Massachusetts

State Employee Flexible Spending Account: Does not have a flexible spending account.

A*dult Corrections:* Does not include county prison spending.

Juvenile Corrections: Does not include county prison spending.

Other State Facility: The total shown is for mental retardation and mental health facility expenditures. Not included in the fund source breakdown is $100.7 million for fiscal 1998 and $110.1 million for fiscal 1999 used for mental health facility expenditures that includes some federal Medicaid reimbursements.

Community-Based Services: The totals include an additional $341.7 million for fiscal 1998 and $359.4 million for fiscal 1999 in community mental health services that could not be broken down into state, other, and federal fund sources.

Rhode Island

State Employee Health Premium: State employee match required only for full indemnity coverage.

State Employee Flexible Spending: No flexible insurance accounts.

Higher Education Health Care: No state-supported medical schools. Minor grant to Brown University.

Insurance and Access Expansion: The only state subsidy is for employees of child care providers with specified portion of public assistance clients.

State-Operated Long-Term Care Facilities: Primarily Veterans' Home. Most state hospital costs are Medicaid eligible.

Vermont

Juvenile Corrections: $30,000 was spent on juvenile corrections health care. Because all numbers are displayed in millions, the expenditure is not shown.

Total Corrections: $30,000 was spent on juvenile corrections health care. Because all numbers are displayed in millions, the expenditure is not shown.

Mid-Atlantic

Delaware

Total State Employee Health Expenditures: Unable to separate by fund source—all funds listed under totals.

State Employee Health Premiums: Unable to separate by fund source—all funds listed under totals.

State Employee Health Premium–Matching: Unable to separate by fund source—all funds listed under totals.

State Employee Flexible Spending Account: Unable to separate by fund source—all funds listed under totals.

Medical Portion of Workers' Compensation: Unable to separate by fund source—all funds listed under totals.

Medicare Payroll Tax: Unable to separate by fund source—all funds listed under totals.

Adult Corrections: Drop in costs partially reflects consolidation of substance abuse contracts.

New Jersey

State Employee Health Premium: Includes costs for higher education employees. Federal and other non-state funds reimburse a portion of these costs.

State Employee Health Premium–Matching: Includes higher education employees.

Higher Education Health Care: Money was spent on operational costs (Federal, State, Other); State Employees Health Benefits; State Employees Rx Program; State Employee Dental; and Public Employees Retirement System (PERS) PRM payments.

Local Health Clinic: Funds are from public health priority funding (state aid).

Licensing and Regulatory: General fund expenditures are for the following programs/categories: State Board of Dentistry; State Board of Medical Examiners; State Board of Nursing; State Board of Optometrists; State Board of Pharmacy; State Board of Ophthalmologists; State Board of Psychologists; State Board of Chiropractors; State Board of Physical Therapists; State Board of Audiology and Speech Pathology; State Board of Respiratory Care; State Board of Orthotics and Prosthetics; State Board of Occupational Therapy; Nursing home background check/Nursing aide certification program; Medicare-Medicaid inspections of nursing facilities; Health care quality monitoring fund; Medicare-Medicaid Facilities Inspection Program; and Health Care Facilities Licensing and Inspections.

Other Public Health: Expenditures are for the following programs: Alcohol and Drug Treatment; Family Planning Services; Childhood Immunization; maternal & Family Health; Tuberculosis Services; Special Health Services for Handicapped Children; Pharmaceutical Assistance to the Aged and Disabled (PAA/D): Home Care Expansion; Hearing Aid Assistance; Alzheimer's Disease Program; Respite Care; and Demonstration Adult Day Care Center Program-Alzheimer's.

Other State Facilities: This represents the costs of the state operated mental health hospitals.

Community-Based Services: Expenditures for 1998 and 1999 are for mental health and vocational rehabilitation.

New York

Adult Corrections: Data is not available.

Licensing and Regulatory: Reported state general fund expenditures for fiscal years 1998 and 1999 include expenditures for the direct regulatory oversight of the health care industry performed by state employees. The fiscal year 1997 state general fund expenditures, as reported in the *1997 State Health Care Expenditure Report*, did not include this category of expenditures.

Pennsylvania

Medicaid: Uses governor's budget reports of actual expenditures for relevant years rather than Health Care Financing Administration (HCFA) 64 report. Does not include SCHIP expenditures. There may be a slight overlap among Medicaid, state employee health premiums, and Medicare payroll taxes. Expenditures include Medicaid program administration that contains the cost of employee health care premiums.

SCHIP Medicaid Expansion: SCHIP is separate from Medicaid. Estimates are based on the amounts shown in the annual governor's budget rather than Health Care Financing Administration (HCFA) reports.

State Employee Health Premium: State employees' health care includes both the active employee program and retired employee program. Figures include contributions from independent agencies and only include collective bargaining unit employees for the State System of Higher Education. Not all university faculty and employees are included.

State Employee Health Premium–Matching: Matching rate was not completed. The commonwealth does have an employee share for certain part-time employees.

State Employee Flexible Spending Account: Flexible spending accounts do not exist.

Medical Portion of Workers' Compensation: Workers' compensation information is on a calendar basis.

Medicare Payroll Tax: Medicare payroll taxes for state employees include only those agencies on the commonwealth payroll system. It excludes the State System of Higher Education, Treasury, Auditor General, Legislature, Judiciary, and School Building Authority.

Juvenile Corrections: The state has a dual juvenile system with about half the youth being maintained in county or private facilities. The state shares health care costs through grants to county child welfare programs but that amount is unavailable.

Other Public Health: Other Public Health Care expenditures increase significantly in this report because they now include the cost of pharmaceutical assistance for qualified older Pennsylvanians and the vocation rehabilitation program, which previously were excluded.

Other State Facilities: May include some subsistence costs for clients in mental health and mental retardation facilities. Adjusted to exclude Medicaid portion. State school for the deaf is not included because health care portion of costs is unknown.

Great Lakes

Indiana

Medical Portion of Workers' Compensation: Data for state fiscal year 1999 not yet available.

State-Operated Long-Term Care Facilities: Figures include expenditures from the Indiana State Department of Health and the Indiana Family & Social Services Administration's Division of Disability, Aging, and Rehabilitative Services.

Other State Facilities: Figures include expenditures from the Indiana Family & Social Services Administration's Division of Mental Health and the Division of Disability, Aging, and Rehabilitative Services.

Community-Based Services: Figures include expenditures from the Indiana State Department of Health and the Indiana Family & Social Services Administration's Division of Mental Health and the Division of Disability, Aging, and Rehabilitative Services.

Michigan

SCHIP Stand-Alone: The SCHIP program was started mid-way through fiscal 1998 in five counties. By the end of fiscal 1998 the entire state was operational. Fiscal 1999 was the first full fiscal year in which this new program was operational.

State Employee Health Premium–Matching: The amount of employee contributions for each year is indicated under Other State Funds but are not state funds; rather, they are employee contributions for matching health care premiums.

State Employee Flexible Spending Account: The amount of employee contributions for each year is indicated under Other State Funds but are not state funds; rather, they are employee contributions for matching health care premiums.

Higher Education Health Care: The amounts in state general fund spending for both years include $0.9

million appropriated to Wayne State University for the Joseph F. Young, Sr. psychiatric research and training program. The remaining general fund and all of the federal funds are for masters in graduate medical education (MA GME) payments to teaching hospitals for the indirect and direct costs of residents, interns, nursing education and the supervising physicians.

State-Operated Long-Term Care Facilities: Figures are for long-term care veteran's facilities.

Community-Based Services: Fiscal year 1999 expenditures reflect implementation of a Medicaid mental health managed care waiver. Waiver costs are reported in table 14.

Wisconsin

SCHIP Medicaid Expansion: Figures represent omnibus budget reconciliation act (OBRA) teens in BadgerCare April 1–June 30, 1999. These teens are under age 19, date of birth before October 1983, and less than or equal to 100 percent federal poverty level.

State Employee Health Premium–Matching: Expenditures cannot be broken down by fund source.

State Employee Flexible Spending Account: Expenditures cannot be broken down by fund source.

Local Health Clinic: Funds from categorical grants may be awarded to local health clinics but it is not possible to identify these funds.

Other Public Health: This is significantly lower than the fiscal 1997 survey since $24 million in federal funds was included in that survey for the alcohol and other drug abuse (AODA) and mental health block grants. In the fiscal 1998 and 1999 survey, a major portion of the funds is included under Community-Based Services.

Community-Based Services: Excludes vocational rehabilitation services (approximately 10 percent total funding in each year). The social service system is county-based. Counties receive funding as a block grant and have the flexibility to use it for a wide range of social services, including alcohol and other drug abuse (AODA), mental health, and developmental disabilities community services.

Plains

Missouri

State Employee Health Premium–Matching: All departments are paid by the Office of Administration, Division of Accounting.

State Employee Flexible Spending Account: All departments are paid by the Office of Administration, Division of Accounting.

Medicare Payroll Tax: All departments are paid by the Office of Administration, Division of Accounting.

North Dakota

Higher Education Health Care: Totals represent the annual budget of the University of North Dakota Medical School. The definition refers to "teaching hospitals," which the medical school is not. Family practice centers and local hospitals where the students do their residencies are teaching hospitals. The state is unable to determine how much of the total medical school's budget supports this.

South Dakota

Medicare Payroll Tax: Does not have information by general, federal, and other funds.

Southeast

Alabama

State Employee Health Premuim: Does not include higher education employees and totals are actual figures. The breakout is by fund type and is estimated by across-the-board percentages.

State Employee Health Premium–Matching: Does not include higher education employees and totals are

actual figures. The breakout is by fund type and is estimated by across-the-board percentages. Items include dependent premiums paid by employees.

State Employee Flexible Spending Account: Has developed a plan that is effective in fiscal 2000.

Medical Portion of Workers' Compensation: Totals are actual figures. The breakout is by fund type and is estimated by across-the-board percentages.

Medicare Payroll Tax: Does not include higher education employees and totals are actual figures. The breakout is by fund type and is estimated by across-the-board percentages.

Higher Education Health Care: No direct funding of university hospitals or higher education employee insurance premiums. Amounts shown are reported expenditures of state university hospitals.

Insurance and Access Expansion: Paid for by insurance assessments; premiums are paid for by individuals.

Arkansas

SCHIP Medicaid Expansion: Spent an aggregate of $785,530 on Medicaid expansion programs.

Florida

State Employee Health Premium: The portion paid from federal funds is included in other state funds. Florida's accounting system does not track expenditures by federal and state funds.

State Employee Health Premium–Matching: Not able to provide data by funding source.

State Employee Flexible Spending Account: Not able to provide data by funding source.

Medicare Payroll Tax: Not able to provide data by funding source.

Higher Education Health Care: Not able to provide data by funding source.

Insurance and Access Expansion: Other state funds include county contributions of $5.6 million for fiscal 1997–1998 and $4.9 million for fiscal 1998–1999. It also includes parent participation of $9.5 million for both fiscal years.

Non-Federal Indian Health Care: There are state expenditures on Indian Health Care, but they are not tracked separately.

Kentucky

State Employee Health Premium–Matching: In 1999, a total of $121.2 million was spent on matching contributions for health care premiums that do not include state funds. Premiums are based on actual collections that in some cases include adjustments for deductible credits. Data was not available for 1998.

Mississippi

Medical Portion of Workers' Compensation: Figures are not available in the format that was requested. Breakout of medical portion of workers' compensation and private-firm payments for workers' compensation premiums is not available.

North Carolina

State-Operated Long-Term Care Facilities: Could not be separated from other facility expenditures. All expenditures were included in Other State Facility Expenditures. NA indicates not applicable.

Other State Facility: State-operated long-term care facilities could not be separated from other facility expenditures. All expenditures were included in this category.

Tennessee

SCHIP Medicaid Expansion: Has recently been approved to receive federal funding at the enhanced SCHIP rate. However, expenditures for prior years have not been determined at this time.

SCHIP Stand-Alone: The SCHIP program, as approved, is a Medicaid expansion program. It has recently been approved to receive federal funding at the enhanced SCHIP rate. However, expenditures for prior years have not been determined at this time.

State Employee Flexible Spending Account: Higher education information is not included.

Virginia

Medicaid: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other State Funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

SCHIP Medicaid Expansion: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other State Funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

SCHIP Stand-Alone: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other State Funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

State Employee Health Premium: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other State Funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

State Employee Health Premium–Matching: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other State funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

State Employee Flexible Spending Account: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other State Funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

Medical Portion of Workers' Compensation: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other State funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

Medicare Payroll Tax: Does not separately report federal expenditures in these categories. Federal funds expended are included in Other state funds figure. (Less than 3 percent of state employees are coded as being federally funded.)

Higher Education Health Care: Provides state funding to support two university-related teaching hospitals: the University of Virginia Medical Center (UVaMC) and the Medical College of Virginia Hospitals Authority at Virginia Commonwealth University (MCVHA/VCU). The two teaching hospitals receive no direct state funding to support the operation of state university-based teaching hospitals or related health care activities. In order to maximize federal Medicaid funding, the commonwealth appropriates all state funding for its two teaching hospitals to the Department of Medical Assistance Services (DMAS). The majority of this funding, if not all, is provided to support indigent care services and related health care activities at each hospital.

Typically, hospitals must meet certain criteria to receive federal disproportionate share funding (DSH). In order to qualify for DSH in Virginia, 15 percent of the total patient days must be Medicaid eligible. Once the hospitals meet this criterion, they are eligible for additional dollars under what Virginia calls "regular DSH." In addition, the two University Teaching Hospitals are eligible for "enhanced DSH" funding. This "enhanced" funding is provided only to MCVHA/VCU and UVaMC in recognition of the costs of training medical students in a teaching facility.

Southwest

Oklahoma

SCHIP Medicaid Expansion: SCHIP Medicaid Expansion Program began in December 1997.

Higher Education Health Care: Teaching hospitals were privatized under a lease agreement with Columbia

Hospital Corporation of America (Columbia HCA) during fiscal 1998. The joint operating agreement governs what were formerly the Children's Hospital and University Hospital along with Columbia-Presbytarian HCA. These three entities now form the University Health Partners. The transfer of the employees from state employment took place in February 1998. However, the hospitals still serve as the venue for the University of Oklahoma Medical School Residency programs. In addition, the state still makes an appropriation to the University Hospital Authority (UHA) for indigent care. The University Hospital Authority is a small state agency that has oversight responsibilities for the joint operating agreement. UHA contracts with University Health Partners for the provision of indigent care. It was this indigent care expenditure that has been counted in this category in the past, and since the state is still spending it for the same purpose, it is included.

Texas

State Employee Health Premium: Includes all general state employees and higher education institutions. Fund source detail is estimated. Federal funds and other state funds are reported for general state employees and higher education institutions that participate in the state's Uniform Group Insurance Program. The University of Texas system and the Texas A&M University system provide their own health insurance to their employees. The state makes only a general revenue appropriation to these systems. As a result, only the state's contribution to their health plans is reported here.

State Employee Health Premium-Matching: Includes all general state employees and higher education institutions that participate in the state's Uniform Group Insurance Program. The University of Texas system and the Texas A&M University system provide their own health insurance to their employees. The state makes only a general revenue appropriation to those systems, as the state does not track contributions made by employees of these university systems.

State Employee Flexible Spending Account: Includes all general state employees and higher education institutions that participate in the state's Uniform Group Insurance Program.

Total Public Health: Figures for 1999 do not include local health care expenditures. These are about $100 million in 1998 totals.

Non-Federal Indian Health Care: There are state expenditures on Indian health care, but they are not tracked separately.

Rocky Mountains

Colorado

SCHIP Stand-Alone: Other state funds are from the Children's Basic Health Plan Trust Fund. This Trust Fund consists of general fund and donations. As revenue from this Fund is appropriated to the Children's Basic Health Plan, it is no longer general fund.

State Employee Health Premium: The $87.1 million for fiscal 1997–1998 and $95.5 million for fiscal 1998–1999 represent the total amounts the state spent for State Employee Health Premiums and the total amounts state employees paid for matching contributions for health care premiums combined. These numbers represent total funds and are not broken out by fund source.

State Employee Health Premium–Matching: The $87.1 million for fiscal 1997–1998 and $95.5 million for fiscal 1998–1999 represent the total amounts the state spent for State Employee Health Premiums and the total amounts state employees paid for matching contributions for health care premiums combined. These numbers represent total funds and are not broken out by fund source.

State Employee Flexible Spending Account: The $3.0 million for fiscal 1997–1998 and $3.1 million for fiscal 1998–1999 represent the total amounts state employees paid into flexible spending accounts. These figures represent total funds and are not broken out by fund source.

Medical Portion of Workers' Compensation: The $5.7 million for fiscal 1997–1998 and $5.2 million for fiscal 1998–1999 represent the total amounts the state spent on the Medical Portion of Workers' Compensation. These figures represent total funds and are not broken out by fund source.

Medicare Payroll Tax: The $10.3 million and $11.7 million the state spent on Medicare payroll taxes for state

employees are calculated based on a calendar year, not a fiscal year. These numbers represent total funds and are not broken out by fund source.

Montana

Medicaid: State fiscal year 1998 equals Department of Public Health & Human Services (DPHHS) BSR for April 1999. State fiscal year 1999 equals Department of Public Health & Human Services (DPHHS) BSR for January 2000.

SCHIP Medicaid Expansion: Not doing Medicaid expansion under SCHIP.

SCHIP Stand-Alone: Began a pilot SCHIP program in state fiscal year 1999 with a full CHIP program authorized for state fiscal year 2000–2001.

Other Public Health: Personal health expenditures are not included in the above four categories of public health related expenditures. Examples include pharmaceutical assistance for the elderly; childhood immunization; chronic disease hospitals and programs; hearing aid assistance; Alzheimer's disease—adult day care; health grants; medically handicapped children; Women, Infants, and Children (WIC); pregnancy outreach and counseling; chronic renal disease; AIDS testing; breast and cervical cancer screening; tuberculosis (TB) programs; emergency health services; adult genetics; Phenylketonuria (PKU); and health promotion and education programs.

Other State Facility: Includes Montana State Hospital (MSH), Montana Chemical Dependency Center (MCDC), Montana Mental Health Nursing Care Center (MMHNCC), EHSC, Montana Developmental Center (MDC), and Montana School for the Deaf and the Blind. No Medicaid included. Note that there was a one-time financing expenditure in fiscal 1998 of $8.8 million.

Health services provided in a state facility. Examples include schools for the blind, schools for the deaf, mental health hospitals, facilities for the developmentally disabled, substance abuse facilities, and rehabilitation facilities. Does not include services eligible for Medicaid reimbursement; these should be reported under Medicaid.

Community-Based Services: Health services provided in a community setting. Examples include rehabilitation services, alcohol and drug abuse treatment, mental health community services, developmental disabilities community services, and vocational rehabilitation services. Does not include services eligible for Medicaid reimbursement; these should be reported under Medicaid.

Far West

Alaska

Medicaid: Includes administrative costs.

Local Health Clinic: Includes grants to local communities.

Other Public Health: Includes emergency medical service (EMS); breast/cervical; women, infants, children (WIC); grants; food; tuberculosis (TB); and nursing.

Hawaii

State Employee Health Premium: Other state funds include federal funds.

State Employee Health Premium–Matching: Does not include payments for union plans. Medical Portion of Workers' Compensation: Other state funds include federal funds.

Washington

Medical Portion of Workers' Compensation: Amounts refer to the Medical Aid Fund for State Fund employers. Does not maintain data for the self-insured employers who insure approximately one-third of Washington's workforce.

Individual State Profiles by Region

NEW ENGLAND:
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

MID-ATLANTIC:
Delaware
Maryland
New Jersey
New York
Pennsylvania

GREAT LAKES:
Illinois
Indiana
Michigan
Ohio
Wisconsin

PLAINS:
Iowa
Kansas
Minnesota
Missouri
Nebraska
North Dakota
South Dakota

SOUTHEAST:
Alabama
Arkansas
Florida
Georgia
Kentucky
Louisiana
Mississippi
North Carolina
South Carolina
Tennessee
Virginia
West Virginia

SOUTHWEST:
Arizona
New Mexico
Oklahoma
Texas

ROCKY MOUNTAIN:
Colorado
Idaho
Montana
Utah
Wyoming

FAR WEST:
Alaska
California
Hawaii
Nevada
Oregon
Washington

Additional Resources

Web sites provide a good starting point for finding further information. Web site addresses for the Milbank Memorial Fund and NASBO are listed below along with other resources that readers may find useful:

- Milbank Memorial Fund
  www.milbank.org
- National Association of State Budget Officers
  www.nasbo.org
- National Governors' Association
  www.nga.org
- National Conference of State Legislatures
  www.ncsl.org
- The U.S. Census Bureau
  www.census.gov
- RAND
  www.rand.org
- The Urban Institute
  www.urban.org

Selected Web Resources for *Medicaid and SCHIP:*

- Health Care Financing Administration
  www.hcfa.gov
- Center for Health Care Strategies
  www.chcs.org
- The Medicaid Clearinghouse

www.handsnet.org/medicaid

- Kaiser Commission on Medicaid and the Uninsured
  www.kff.org/section.cgi?.section=kcmu
- Administration for Children and Families
  www.acf.dhhs.gov

Selected Web Resources for *State Employees:*

- Bureau of Labor Statistics (Employee Benefits)
  www.bls.gov/ebshome.htm
- Employee Benefit Research Institute
  www.ebri.org

Selected Web Resources for *Corrections:*

- Bureau of Justice Statistics
  www.ojp.usdoj.gov/bjs
- Justice Information Center
  www.ncjrs.org
- National Institute of Justice
  www.ojp.usdoj.gov/nij
- Office of Juvenile Justice and Delinquency Prevention
  www.ojjdp.ncjrs.org
- National Archive of Criminal Justice Data
  www.icpsr.umich.edu/nacjd

Selected Web Resources for *Higher Education:*

- American Association of State Colleges and Universities
  www.aascu.org
- National Association of State Universities and Land Grant Colleges
  www.nasulgc.org
- American Council on Education
  www.acenet.edu
- Education Commission of the States
  www.ecs.org
- Washington Higher Education Secretariat
  www.whes.org
- Association of American Medical Colleges

www.aamc.org

Selected Web Resources for *State Insurance and Access Expansions*:

See NGA Publications on Health insurance Trends: www.nga.org

Selected Web Resources for *Public Health–Related Expenditures:*

- Indian Health Service
  www.ihs.gov
- National Immunization Program
  www.cdc.gov/nip

Selected Web Resources for *Community-Based Services:*

- National Association of State Mental Health Program Directors (NASMHPD)
  www.nasmhpd.org
- NASMHPD Research Institute
  www.nasmhpd.org/nri/
- NASMHPD National Technical Assistance Center for State Mental Health Planning
  www.nasmhpd.org/ntac/
- National Mental Health Association
  www.nmha.org
- National Association of State Directors of Developmental Disabilities Services
  www.nasddds.org
- American Association on Mental Retardation
  www.aamr.org

Selected Web Resources for *State Facility–Based Services:*

- Department of Veterans Affairs
  www.va.gov
- National Association of State Directors of Veterans Affairs
  www.nasdva.com
- National Association of State Mental Health Program Directors (NASMHPD)
  www.nasmhpd.org
- NASMHPD Research Institute
  www.rdmc.org/nri

- NASMHPD National Technical Assistance Center for State Mental Health Planning
  www.nasmhpd.org/ntac/
- National Mental Health Association
  www.nmha.org
- National Association of State Directors of Developmental Disabilities Services
  www.nasddds.org

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Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022

Printed in the United States of America.

ISBN 1-887748-25-3
