2000-2001 State Health Care Expenditure Report

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

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Foreword

The purpose of this collaboration between the National Association of State Budget Officers (NASBO) and the Reforming States Group (RSG) is to identify and summarize the amount of state health care expenditures in broad categories. This third edition of the report significantly expands upon the earlier two editions by broadening the definition of health care to include population health expenditures.

Health care spending by state governments totaled $260.6 billion in fiscal 2000 and $290.7 billion in fiscal 2001, representing about one-fifth of the nation's overall health care spending.1 Of the total amount of state spending, about 53 percent was from state funds, with the remainder from federal funds. The change of $30.0 billion between the two fiscal years represents an 11.5 percent increase.

The largest components of state health care expenditures were Medicaid, state employees' benefits, and population health services. Together these components accounted for more than four-fifths of total state health care spending.

State health care spending comprised approximately 30 percent of all state spending in fiscal 2001. While this report covers expenditures in fiscal 2000 and fiscal 2001, the continued acceleration of health care costs both absolutely and relative to other state expenditures would most likely increase this percentage over time. National health care expenditures by the Centers for Medicare and Medicaid Services, for example, project a rise from $1.4 trillion in 2001 to $2.8 trillion in 2011, an average annual increase of 7.3 percent. By 2011, national health care spending would comprise approximately 17 percent of the gross domestic product, up from the current 14 percent, outpacing economic growth during this period. Health care continues to be one of the most important cost drivers for state governments.

The expansion of spending on population health represents an initial attempt to catalog state spending in the areas of environmental health, surveillance, and promotion of healthy behavior, as well as the public health aspects of disaster preparation and disaster response. While this effort had been underway, the tragic events of September 11 underscored the significance of the nation's public health infrastructure. Federal expansion in this area of public health began in fiscal 2002 with bioterrorism grants, but this is not reflected in the fiscal 2000 and fiscal 2001 data. As such, this report can serve as a baseline against which to compare future spending affected by these grants and other funding sources.

This report also provides a perspective on the significance of state health care spending in the nation's provision of personal health care services. It provides an overview of the states' role in health care both as purchasers of services and as direct deliverers of care. Both as employers and as providers of services, states are feeling the changes in the world of health care—from the surge of prescription drug prices to new demands to protect the public's safety. The surge in health care costs, most notably in Medicaid and employees' health insurance, has added to the budget stress recently felt by states. While Medicaid dominates in both dollars and impact on state fiscal conditions, state spending in non-Medicaid programs accounted for $79.7 billion in fiscal 2000 and $89.5 billion in fiscal 2001—an increase rate of 12.4 percent.

States have seen considerable debate over the dramatic changes occurring in health care, but for the most part, decision makers did not have access to the full spectrum of health care expenditure data for their respective states. To fill this void, leaders of NASBO and the 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*, showed total health care spending by states for fiscal 1997, and 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* presented total state health care spending for the following two fiscal years.

While the 1998–1999 edition closely followed the format of the previous report, it differed by providing data on employees' contributions to health insurance premiums and flexible spending programs, and by

separately reporting expenditures for the State Children's Health Insurance Program (SCHIP).

This 2000–2001 edition significantly expands upon the previous two editions with the addition of the population health expenditures. Some elements of these expenditures had been previously collected in the earlier editions under direct public health expenditures. Comparisons among various editions need to take into account the changes in definitions from one report to another.

Readers also should be aware that considerable differences exist from state to state regarding the types of services provided and the level of government providing the services. Spending by other units of government within states, such as counties and cities, is not included in the data.

Finally, the individual state profiles included in both the print and electronic versions of the two previous editions are this time included in the electronic version only. In addition, NASBO will provide access to the electronic data files to qualified individuals upon request; such persons include officials of the legislative and executive branches of government and persons conducting sponsored research. Data availability is further contingent upon compliance with NASBO's data release policies regarding nonpublication, secondary release, and the like.

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, Milbank Memorial Fund; 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; Wayne Roberts, Budget Director, Texas; and Sandy Praeger, Chair, Public Health and Welfare Committee, Kansas Senate.

The expansion of this report to include population health required input from many individuals. Representatives gathered in September 2001 to develop the definitions used for population health expenditures. In addition to those individuals mentioned above, the following individuals, listed in the positions they held at the time of their participation, provided insight and guidance for the process. They are: Andres Alcantar, Texas Office of Budget Planning and Policy; Anne Barry, Deputy Commissioner, Minnesota Department of Finance; Georges Benjamin, Secretary, Maryland Department of Health and Mental Hygiene; Kevin Concannon, Commissioner, Maine Department of Human Services; Robert Fordham, Milbank Memorial Fund; David Kindig, Milbank Memorial Fund; Ann Kohler, New Jersey Office of Management and Budget; Joel Lunde, Iowa Department of Management; Kevin Madigan, Rhode Island Senate Fiscal Office; Joanne Mrazik, New Jersey Department of Treasury; Elizabeth Roberts, Vice-Chair, Health, Education, and Welfare Committee, Rhode Island Senate; Avry Smith, North Dakota Office of Management and Budget; and Linda Stahr, Chief of Staff, Public Health Services, Maryland Department of Health and Mental Hygiene.

Individuals in pilot states provided a review of the added questions for the population health expansion. These pilot states were Iowa, Maine, Maryland, Minnesota, Nevada, New Jersey, North Dakota, Oregon, and Texas. Individuals in state budget offices across the country provided data for this report.

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Executive Summary

States' Fiscal Outlook

During the period covered by this report—fiscal years 2000 and 2001—state fiscal conditions started to deteriorate. By fiscal 2002, state budgets were in a weakened condition, with states forced to reduce budgets enacted in fiscal 2002 by a variety of measures. Revenue growth continues to be anemic, spending pressures continue to rise, and states face massive budget shortfalls. During fiscal 2002, 37 states were forced to cut their enacted budgets by approximately $13 billion. In this fiscal climate, states enacted a 1.3 percent general-fund increase for fiscal 2003, after expanding by only 1.3 percent in fiscal 2002—the lowest levels since 1983, according to NASBO's *The Fiscal Survey of States* (November 2002).

Weak revenue collections continued to plague state budgets throughout fiscal 2002, making budget deliberations for fiscal 2003 a difficult task. In addition to weak revenues, states also have faced rising costs for health care, most notably in Medicaid.

The impact of the recession has had a dramatic impact on all aspects of state budgets, including state balances. The fiscal woes caused by the recent recession have forced states to draw heavily on budget stabilization funds. Total state balances for budgets enacted in fiscal 2003 are nearly three-quarters smaller than they were in fiscal 2000, the peak of state balances.

Because state revenue growth generally lags behind the end of a recession by as much as 12 to 18 months, state fiscal woes are expected to continue in fiscal 2003 and fiscal 2004. Already in the beginning of fiscal 2003, states are requiring additional actions to maintain balanced budgets for the current fiscal year, due to the continued steep decline in revenues.

State Expenditures

Total state spending in fiscal 2001 was approximately $1.0 trillion, an 8.3 percent increase from fiscal 2000, as reported in NASBO's 2001 *State Expenditure Report*. General funds reflect an increase of 7.6 percent, federal funds 9.4 percent, and other state funds 8 percent. State expenditures—namely money that flows through the state budgets—are used as a comparison of how the health care expenditures collected in this report compare to total state expenditures.

Based on the *State Expenditure Report*, general funds accounted for 47.7 percent of total state spending in fiscal 2001, followed by federal funds at 25.8 percent, other state funds at 24.3 percent, and bonds at 2.2

percent. The components of total state spending as tracked by the *State Expenditure Report* are as follows: elementary and secondary education, 22.2 percent; Medicaid, 19.6 percent; higher education, 11.3 percent; transportation, 8.9 percent; corrections, 3.7 percent; public assistance, 2.2 percent; and all other expenditures, 32.1 percent (numbers may not add up to 100 percent because of rounding).

Total State Health Care Expenditures

While the *State Expenditure Report* separately tracks Medicaid and State Children's Health Insurance Program (SCHIP) expenditures, the other components of state health care spending are not separately tracked. 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, SCHIP, state employees' health benefits, corrections, higher education, insurance and access expansion, direct public health care, state facility-based services, community-based services, and population health expenditures. The inclusion of population health expenditures in this edition of the report is the most significant change, serving to broaden the definition of health care provided by state governments.

With the exception of population health expenditures, 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.2 These figures generally exclude expenditures for subsistence and personal care. Spending detailed in this report for direct public health care services, 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 2001, states reported a total population of 266.7 million, a total Medicaid caseload of 31.2 million, 3.2 million state employees, 1.2 million adult inmates, about 89,000 incarcerated juveniles, and 3.0 million SCHIP beneficiaries (see table 49).

In fiscal 2001, states spent $290.7 billion on health care (see table 14). Health care spending represented an average of approximately 30 percent of state budget totals. 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 2000 and 2001

	Fiscal 2000	Fiscal 2001
Medicaid	20.1%	20.7%
SCHIP	0.2	0.4
State Employees	2.4	2.5
Corrections	0.4	0.4
Higher Education	0.6	0.6
Insurance and Access Expansion	0.1	0.1
Direct Public Health Care	0.9	0.8
Community-Based Services	1.7	1.7
State Facility–Based Services	0.9	0.9
Population Health Expenditures	1.7	1.9
Total State Health Care Expenditures	29.0	29.9
Total Non-Health Expenditures	71.0	70.1

As table 2 shows, state shares for health care spending in fiscal 2001 were as follows: 69.2 percent for Medicaid, 1.2 percent for SCHIP, 8.3 percent for state employees' benefits, 1.3 percent for corrections, 2.0 percent for higher education, 0.4 percent for state insurance and access expansion, 2.8 percent for direct public health services, 5.6 percent for community-based services, 3.0 percent for state facility-based services, and 6.3 percent for population health services. These totals are broken down, state by state, in table 43, 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 2000 and 2001

	Fiscal 2000	Fiscal 2001
SCHIP	0.8%	1.2%
State Employees	8.2	8.3
Corrections	1.3	1.3
Higher Education	2.0	2.0
Direct Public Health Care	2.9	2.8
Community-Based Services	5.9	5.6
State Facility–Based Services	3.3	3.0
Population Health Expenditures	5.8	6.3
Insurance and Access Expansion	0.3	0.4
Medicaid	69.4	69.2

Each state reported its health care spending by funding source (state general funds, federal funds, and other state funds) for each of the categories. General-fund revenues are received from broad-based state taxes, and account in fiscal 2001 for 40 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 98 percent of total funds for corrections while making up only 16 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 total state spending. (Federal funds provide approximately 26 percent of total state spending for all functions.) The amount of federal funding in the various health care categories ranges from 0.5 percent for corrections to 69 percent for SCHIP expenditures. Other state fund expenditures, which provide about 14 percent of total state health care expenditures, are dedicated state funds. These are the primary source for insurance and access expansion, accounting for almost 47 percent of expenditures in that category, while providing only 2 percent of funding for corrections health care expenditures.

From fiscal 2000 to fiscal 2001, the percentage growth in non-health care expenditures totaled 6.8 percent, while health care expenditures increased 11.5 percent (see table 3). SCHIP expenditures showed the largest percentage of increase (61.3), followed by insurance and access expansion (55.0 percent) and population health expenditures (20.4 percent).

Table 3. Percentage Change in Health Care Expenditures by Category vs. Non-Health Spending, Fiscal Years 2000 and 2001

	General Fund	Other State Funds	Federal Funds	Total Funds
Medicaid	9.8%	20.8%	10.8%	**11.2%**
SCHIP	44.0	83.8	61.3	**61.3**
State Employees	13.7	9.9	11.9	**12.0**
Corrections	8.5	12.5	1.7	**8.5**
Higher Education	8.8	–0.9	18.3	**7.6**
Insurance and Access Expansion	69.3	26.6	187.0	**55.0**
Direct Public Health Care	4.8	11.0	5.0	**6.0**
Community-Based Services	5.2	22.8	2.2	**6.8**
State Facility–Based Services	2.7	1.8	10.2	**3.1**
Population Health Expenditures	8.7	43.6	14.1	**20.4**
Total State Health Care Expenditures	9.4	19.0	11.3	**11.5**
Total Non-Health Expenditures	7.0	5.1	7.5	**6.8**

As a measure of each state's ability to finance health care or other government services, state health care expenditures as a share of state gross product for fiscal 2000 are shown in appendix table A. State health care expenditures, as a share of gross state product—a measure of production in each state—range from 1.3 percent to 4.8 percent.

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.

Medicaid spending in fiscal 2001 totaled approximately $201.2 billion, or 11.2 percent more than the 2000 level. According to NASBO's *State Expenditure Report*, Medicaid expenditures have increased as a percent of total state expenditures, rising from 10.8 percent in 1988 to close to 20 percent in 2001.

Medicaid spending grew 13.2 percent in fiscal 2002, the steepest rate of growth since 1992. This spending contrasts sharply with the lack of any growth in state revenues experienced in fiscal 2002. In fiscal 2003, Medicaid appropriations are 4.8 percent above the prior year's level and are predicated on extensive cost savings.

Medicaid cost increases stem primarily from increased costs for pharmaceuticals as well as enrollment increases, according to the recent report by the Kaiser Commission on Medicaid and the Uninsured, *Medicaid Spending Growth: Results from a 2002 Survey*. Spending on outpatient prescription drugs, which increased an average of 18 percent annually over the past three years, continues to be a significant component in rising Medicaid costs. According to a study by the National Institute for Health Care Management, overall spending on prescription drugs climbed by 17 percent in 2001. The study found that

the average cost of a prescription rose by 10 percent during this time period. Enrollment, estimated to rise by 6.2 percent in fiscal 2003 after increasing by 8.6 percent in fiscal 2002, is the second-most cited reason by states for increased Medicaid costs, according to the Kaiser Commission report.

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 2000 and 2001.

Table 4. Medicaid

	Fiscal 2000	Fiscal 2001
Federal Funds	56.7%	56.5%
General Funds	36.0	35.5
Other State Funds	7.3	8.0

Based on the continued fiscal pressures, virtually all states either have taken action in fiscal 2002 or plan to take action in fiscal 2003 to control Medicaid costs. The most prevalent type of cost containment in both fiscal 2002 and fiscal 2003 is controlling pharmaceutical costs, followed by reductions or limits to provider payments. According to the Kaiser Commission report, *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003*, in fiscal 2003, 45 states plan to implement pharmacy controls, 37 plan to implement reductions or freezes to provider payments, 25 plan reducing Medicaid benefits, and 27 plan to restrict eligibility.

State Children's Health Insurance Program (SCHIP)

The enactment of the State Children's Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997 has increased health coverage for previously uninsured children. SCHIP is targeted to children whose families have incomes too high to qualify for Medicaid but too low to afford private insurance. States receive a federal match for their SCHIP programs, ranging from 65 percent to 85 percent within a capped allotment. During fiscal 2001, approximately 4.6 million children enrolled in SCHIP, representing a 38 percent increase over fiscal 2000 levels.

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 16—18 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.

The major legislative proposal for SCHIP at the federal level is the extension of SCHIP funds that are due to expire from fiscal 1998 and fiscal 1999 allotments. Federal costs for SCHIP are estimated to be $4.4 billion in fiscal 2003, an 18 percent increase over the previous year. Faced with growing enrollment and limited resources, several states are proposing actions in fiscal 2003 to limit the increase in SCHIP expenditures, while other states are planning to expand SCHIP. Proposed cost containment activities include reducing payments for health care providers, capping enrollment, and increasing cost-sharing requirements.

Expenditures for SCHIP programs totaled $2.1 billion in fiscal 2000, representing 0.8 percent of total state health care spending and 0.2 percent of all state spending. In fiscal 2001, these expenditures increased to $3.4 billion, representing 1.2 percent of total state health care spending and 0.4 percent of all state spending. The significant increase reflects the ramping up of this program in the states during this time period. These amounts represent the combined expenditures for the three types of SCHIP programs: Medicaid expansion programs, stand-alone programs, and combination programs. Table 5 shows fund shares for 2000 and 2001.

Table 5. SCHIP		
	Fiscal 2000	Fiscal 2001
Federal Funds	69.0%	69.0%
General Funds	17.4	15.5
Other State Funds	13.6	15.5

State Employees' Health Benefits

Health care-related expenditures for state employees totaled $21.4 billion in fiscal 2000 and increased to $24.0 billion in fiscal 2001. State employee health care spending represented 8.2 percent of total state health care spending in fiscal 2000 and 8.3 percent in fiscal 2001; it accounted for 2.4 percent of total state spending in fiscal 2000 and 2.5 percent of total state spending in fiscal 2001. After Medicaid, spending for employees' health is the next major category of health care spending by state governments. The rate of growth between fiscal 2000 and fiscal 2001 for state employee health expenditures rose by 12.0 percent, relative to an overall state spending increase of 6.8 percent.

The acceleration in health care costs has greatly affected state governments, most especially in Medicaid and in employees' health benefits. According to an analysis by the Center for Studying Health System Change, insurance premiums increased by 11 percent in 2001 and are estimated to rise by 13 percent in 2002. State governments are experiencing similar cost pressures in providing health benefits to employees.

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—$15.7 billion in fiscal 2000 and $17.6 billion in fiscal 2001—represented more than 70 percent 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 ranged from 3.3 to 29.9 percent of that spending in fiscal 2001.

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 2001 was approximately 3.2 million. (Elementary and secondary school employees are excluded from the figures.)

Table 6 shows fund shares for fiscal years 2000 and 2001. 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 2000	Fiscal 2001
Federal Funds	6.0%	5.9%
General Funds	47.8	48.5
Other State Funds	40.9	40.2
Undesignated Fund Source	5.3	5.4

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.

A 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 2001, states reported a total of about 1.2 million adult and about 89,220 juvenile inmates. In 2000, states estimated they spent $3.4 billion on total corrections health care costs; of this amount, $3.2 billion was spent on adult corrections and $0.2 million on juvenile corrections. In 2001, states spent approximately $3.7 billion on total corrections health care costs, including $3.5 billion spent on adult corrections and $0.2 million on juvenile corrections. Overall, corrections spending accounted for 3.7 percent of state budgets in fiscal 2001 and increased by 4.9 percent from fiscal 2000 to fiscal 2001.

Total corrections health care spending accounted for 0.4 percent of total state budgets in both fiscal 2000 and 2001. Relative to total state health care expenditures, total corrections health care spending accounted for 1.3 percent in both fiscal 2000 and fiscal 2001. As a percentage of total state health care spending, corrections ranged from 0.1 percent to 2.7 percent, with total dollar expenditures ranging from $3.2 million to $722.8 million. Tables 25, 26, and 27 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 2000 and 2001 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 2000	Fiscal 2001
Federal Funds	0.5%	0.5%
General Funds	97.7	97.6
Other State Funds	1.8	1.9

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.

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, student health clinics, and state funds for degree-granting programs in any health professions are not included in higher education health care spending totals.

State health care expenditures for higher education totaled $5.3 billion in fiscal 2000, rising to $5.7 billion in fiscal 2001. These amounts represented 2.0 percent of state health care spending in both fiscal 2000 and fiscal 2001, and accounted for 0.6 percent of total state spending in both fiscal years. Overall, higher education expenditures accounted for 11.3 percent of state budgets in fiscal 2001 and rose by 8.1 percent from fiscal 2000 to fiscal 2001.

As a percentage of total health care spending, higher education ranged from 0 percent to 8.3 percent in fiscal 2001. As reflected in table 28, individual states reported higher education health care expenditures ranging from $0 to $1.2 billion for fiscal 2001. Twelve states reported no higher education health care spending, in most cases because those states do not have state university-based teaching hospitals.

Table 8 shows fund shares for higher education health care spending for fiscal years 2000 and 2001. 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 2000	Fiscal 2001
Federal Funds	20.9%	23.0%
General Funds	37.8	38.2
Other State Funds	27.0	24.9
Undesignated Fund Source	14.3	14.0

State Insurance and Access Expansion

States use 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 $771 million in fiscal 2000, rising to $1.2 billion in fiscal 2001. These amounts represented 0.3 percent of total state health care spending in fiscal 2000, 0.4 percent of total state health care spending in fiscal 2001, and 0.1 percent of all state spending in both fiscal 2000 and fiscal 2001.

As table 29 shows, insurance and access expansion expenditures in the 50 states ranged from $0 to $351.9 million in fiscal 2001. Twenty-nine states reported no spending on state insurance and access expansion as defined in this report.

As shown in table 9, fund shares for fiscal 2000 and fiscal 2001 were predominantly other state funds.

Table 9. State Insurance and Access Expansion

	Fiscal 2000	Fiscal 2001
Federal Funds	8.6%	15.9%
General Funds	34.3	37.4
Other State Funds	57.1	46.6

Direct Public Health Care

As defined in this report, the category of public health care services covers direct personal health expenditures for specific program areas but does not include subsistence, personal care, or general public health expenditures. Included in this category are local health clinics and funds spent on Indian health care. The clients served by public health care expenditures are specific to the programs offered, and range from infants to the elderly and patients to medical professionals.

Expenditures for direct public health care services totaled $7.7 billion in fiscal 2000, rising to $8.1 billion in fiscal 2001. These amounts represented 2.9 percent of total state health care spending in fiscal 2000 and 2.8 percent in fiscal 2001, and accounted for 0.9 percent in fiscal 2000 and 0.8 percent in fiscal 2001 of all state spending. As a percentage of total state health care spending, total public health-related expenditures ranged from 0.4 percent to 6.1 percent in fiscal 2001. Individual states' dollar expenditures ranged from $2.8 million to about $1.0 billion in fiscal 2001, as shown in table 30.

Depending on the state, the amounts reported for direct public health care may include money spent on the

following kinds of services:

- pharmaceutical assistance for the elderly
- 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 treatment
- breast and cervical cancer treatment
- tuberculosis (TB) programs
- emergency health services
- adult genetics programs
- Phenylketonuria (PKU) testing

In the *2000—2001 State Health Care Expenditure Report*, expenditures for certain services that had been previously recorded under public health in the previous editions are now reported under the new categories for population health. This includes expenditures for licensing boards and regulatory oversight now included in the public health infrastructure.

Table 10 gives direct public health care fund shares for fiscal years 2000 and 2001.

Table 10. Direct Public Health Care Expenditures

	Fiscal 2000	Fiscal 2001
Federal Funds	51.2%	50.8%
General Funds	32.0	31.6
Other State Funds	16.8	17.6

State Facility–Based Services

As shown in table 31, expenditures for state facility-based services totaled $8.5 billion in fiscal 2000, rising to $8.8 billion in fiscal 2001. These amounts represented 3.3 percent of total state health care spending in fiscal 2000 and 3.0 percent in fiscal 2001, and accounted for 0.9 percent of all state spending in fiscal years 2000 and 2001. 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 20.5 percent of total state health care spending in fiscal 2001. Table 11 provides state facility-based expenditure fund shares for 2000 and 2001.

Table 11. State Facility–Based Services		
	Fiscal 2000	Fiscal 2001
Federal Funds	7.9%	8.4%
General Funds	68.2	68.0
Other State Funds	23.9	23.6

Community-Based Services

Expenditures for community-based services totaled $15.3 billion in fiscal 2000, rising to $16.4 billion in fiscal 2001 (see table 34). Community-based services accounted for 5.9 percent of total state health care spending and 5.6 percent of total state health care spending in fiscal 2000 and fiscal 2001, respectively, and 1.6 percent of all state spending in both fiscal years. 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, ranging from 1.7 percent to 13.3 percent of total health care expenditures in fiscal 2001. Approximately two-thirds of the $15 billion states spent on community-based services in fiscal 2001 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 2000 and fiscal 2001.

Table 12. Community-Based Services		
	Fiscal 2000	Fiscal 2001
Federal Funds	23.1%	22.1%
General Funds	64.0	63.1
Other State Funds	12.8	14.8

Population Health Expenditures

The major expansion of this study is the collection of state expenditures for population or public health services to protect citizens. Since the disastrous events of September 11, there has been much focus on the nation's investment in public health. The public health system in this country is made up of a network of federal, state, and local governments. Reflecting the awareness of the need for a greater investment in the nation's public health infrastructure, a new federal grant for bioterrorism beginning in fiscal 2002 was distributed to state and local governments. The collection of this data for population health is a major step in documenting state expenditures as an initial baseline. The reader should note that funds spent by local governments are not included in the overall amounts unless they pass through the state budget.

In total, population health expenditures accounted for 5.8 percent of health care expenditures in fiscal 2000 and 6.3 percent of health care expenditure in fiscal 2001. The level in fiscal 2001 made it the third-largest category of state health spending—trailing only Medicaid and State Employees' Benefits. These expenditures accounted for 1.7 percent of total expenditures in fiscal 2000 and 1.9 percent of total expenditures in fiscal 2001. State expenditures ranged from $21.3 million to $3.5 billion in fiscal 2001. As a percentage of total health care expenditures, the range was from 0.8 percent to 33.2 percent in fiscal 2001.

Within population health expenditures for fiscal 2001, most were in the promotion of chronic disease control and of healthy behavior, and environmental hazards protection. These two categories made up

approximately 66 percent of the total expenditures for population health. Population health expenditures are collected in the following categories for the purpose of this report (see tables 35-42).

Prevention of Epidemics and the Spread of Disease

Expenditures for the prevention of epidemics and the spread of disease reflect the activities to control, screen, and monitor infectious diseases such as AIDS and sexually transmitted diseases (STD). Other costs include immunization, microbiology lab services, licensing for food and lodging establishments, food safety and inspection programs, pest eradication, and control of veterinary disease that could affect the food chain, such as mad cow disease.

These expenditures totaled $1.5 billion in fiscal 2000 and $1.6 billion in fiscal 2001. Expenditures for states ranged from $1 million to $185.1 million in fiscal 2001 (see table 36).

Protection against Environmental Hazards

Protection against environmental hazards includes expenditures in programs such as non-point source pollution control, leaking underground storage tanks, air quality, water and wastewater disposal systems, environmental labs, solid and hazardous waste management, radon screening, water quality and pollution control, mining regulation, and nuclear power safety.

These programs span state governments and are not necessarily operated out of the health departments.

Expenditures for protection against environmental hazards totaled $3.9 billion in fiscal 2000, rising to $4.3 billion in fiscal 2001. Expenditures for protection against environmental hazards ranged from $0.7 million to $696.7 million in fiscal 2001 (see table 37).

Injury Prevention

Programs to prevent injuries include those such as product safety, fire injury prevention, highway safety, occupational health, mine and cave safety, and boating and recreational safety. Spending on these programs totaled $1.6 billion in fiscal 2000, rising to $1.7 billion in fiscal 2001 (see table 38). State spending ranged from $0.1 million to $761 million in fiscal 2001.

Promotion of Chronic Disease Control and Encouragement of Healthy Behavior

Promotion of chronic disease control and encouragement of healthy behavior includes programs for substance abuse prevention, domestic violence prevention, nutrition programs, preventive health and promotion, food stamp nutrition education programs, breast and cervical early detection screening, newborn and childhood screening, maternal and child health block grants, and data collection on disease and health behavior.

Expenditures of some of these programs, such as cancer screening and health promotion and education programs, have been collected in the previous *State Health Care Expenditure Reports* under direct public health related expenditures.

Expenditures in fiscal 2000 totaled $5.6 billion, rising to $7.8 billion in fiscal 2001 (see table 39). State expenditures in fiscal 2001 ranged from $2.9 million to $2.1 billion.

Disaster Preparation

Disaster preparation expenditures reflect the costs associated only with disaster preparation as they relate to population health, not all disaster preparation costs. The new investment in bioterrorism at the federal level will increase these expenditures in the future. Expenditures totaled $286 million in fiscal 2000, rising to $296 million in fiscal 2001 (see table 40).

Disaster Response

Expenditures for disaster response include the population health costs associated with disaster response. Fiscal 2001 expenditures totaled $214 million, rising to $371 million in fiscal 2001 (see table 41).

Health Infrastructure

Health infrastructure costs are those associated with maintaining public health services, and include health department administration, licensure and certification of health facilities, data analysis, health related boards and commissions, vital records, forensic services, and lab certification. Some of these costs, such as licensing and regulation of health boards, have been previously collected under public health-related expenditures.

Expenditures in fiscal 2001 totaled $2.0 billion, rising to $2.2 billion in fiscal 2001. Individual state expenditures ranged from $0.5 million to $213.3 million in fiscal 2001 (see table 42).

As shown in table 13, federal funds accounted for the largest share of total population health followed by other state funds and general funds.

Table 13. Total Population Health

	Fiscal 2000	Fiscal 2001
Federal Funds	42.7%	40.4%
General Funds	30.1	27.2
Other State Funds	27.1	32.3
Undesignated Fund Source	0.1	0.1

Guide to the Tables

Definitions

Fiscal Year 2000

State fiscal year beginning in calendar year 1999 and ending in calendar year 2000.

Fiscal Year 2001

State fiscal year beginning in calendar year 2000 and ending in calendar year 2001.

Actual vs. Appropriated

Data reflect actual expenditures for fiscal 2000 and fiscal 2001.

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 or personal care.

The addition of population health includes indirect health care in this report.

Medicaid Expenditures

Information reported on the CMS-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 CMS reports, with the subcategories of the report incorporated and converted to state fiscal year. Stand-alone SCHIP expenditures are reported on the CMS-21 report; Medicaid expansion SCHIP expenditures are reported on the CMS-6421 and CMS-6421U reports; and combination SCHIP expenditures are 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 public-private partnerships.

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.

Direct Public Health Care Services

Includes local health clinics, Ryan White AIDS Grant expenditures, and Indian health. Expenditures may include funds 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; and phenylketonuria (PKU) testing.

Population Health Expenditures

Prevention of epidemics and the spread of disease: Includes programs such as the following: AIDS and other STD control, screening, outreach, and monitoring, including data collection and registries; immunization, including the cost of vaccine and infrastructure only; infectious disease control, including analysis and monitoring; emerging infections program; microbiology lab services; food and lodging licensing and inspection; all food safety and inspection programs; fish consumption advisory; pest eradication (such as rats, roaches, and mosquitoes); and veterinary diseases, such as mad cow disease, that affect the food chain.

Protection against environmental hazards: Includes programs such as the following: lead poisoning programs (excludes treatment of individuals); non-point source pollution control; leaking underground storage tanks; air quality; environmental lab; solid and hazardous waste management (includes Brownfields and Superfund); hazardous material training; EPA indoor radon; water quality/pollution control (includes safe drinking water, safe fishing, swimming, etc.); chemistry lab services and analysis for state agencies; water and waste water disposal systems; mining regulation, effects, and reclamation; pesticide regulation and disposal; wood dust intervention; and nuclear power safety.

Injury Prevention: Includes programs such as: childhood agriculture safety and health; safety programs; consumer product safety; firearm safety; fire injury prevention; injury prevention or surveillance; defensive driving; highway safety (e.g., CFDA 20.600); highway design safety; crash outcome data evaluation; mine and cave safety; on-site safety and health consultation; workplace violence prevention; occupational health; safe schools; boating and recreational safety; and monitoring of childhood fatalities or accidents.

Promotion of Chronic Disease Control and Encouragement of Healthy Behavior: Includes programs such as: substance abuse prevention/intervention; domestic violence / family violence awareness; family planning education; abstinence programs; tobacco prevention; nutrition programs; fluoridation; preventive health and

promotion programs; child abuse prevention programs, including shaken baby syndrome; refugee preventive health programs; food stamp nutrition education programs; safe and drug-free schools; health education; nutrition education; student preventive health services; breast and cervical cancer early detection and screening (not treatment); newborn and childhood screening, detection and intervention; Title V Maternal and Child Health (MCH) Block Grants (excluding direct personal health care services); and data collection on disease and health behavior.

Disaster Preparation: Includes programs such as disaster preparedness and bioterrorism. This includes only the population health costs associated with disaster preparation, not all disaster preparation costs. Disaster Response: Includes such programs as water, food, and mental health response. Excludes such programs as housing and employment assistance. This includes only the population health costs associated with disaster response, not all disaster response costs, such as road repair.

Health Infrastructure: Includes programs such as: local ambulance services training; health department administration; infrastructure for public health services; equipment quality (x-ray, mammogram, etc.); licensure and certification of health facilities; emergency medical system; planning, licensing, training, data analysis, and standards; nursing home survey and inspections; CPR and first aid; all health-related boards, councils, or commissions; health practitioner continuing education; licensure functions for regulated health professionals; licensing boards and regulatory oversight; physician and other provider loan programs for underserved communities; health plan, provider, and facility quality reporting; vital records (births, deaths, marriages, divorces; forensic services); and lab certification programs.

General Notes

The *2000–2001 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, direct public health care, state facility-based services, community-based services, and population health. 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 direct public health, 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 2001 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 CMS-64 form and converted to state fiscal year. These amounts differ from the figures contained in NASBO's *2001 State Expenditure Report* because the figures in the present report include administrative costs.

SCHIP

The amounts reported are those reflected on the various CMS 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.

Direct Public Health

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

Maine

Demographics 2000 and 2001: • State Employees: Represents the number of vacant and filled positions (rather than authorized) at the end of these fiscal years, excluding faculty and staff of state-owned and state-related colleges and universities.

Rhode Island

State Employee Health Premium: Does not include $5.9 million in expenditures for retiree health premiums in FY 2000 and $6.9 million in expenditures for retiree health premiums in FY 2001.

Mid-Atlantic

Delaware

Direct Public Health: Includes injury prevention, linked with Child Health and WIC.

Prevention of Epidemics and Spread of Disease: These totals represent expenditures from all funding sources.

Protection against Environmental Hazards: These totals represent expenditures from all funding sources.

Promotion of Chronic Disease Control and Healthy Behavior: Health behavior promotion through the employee health plan. Many staffing expenditures in direct public health care services are related to this service delivery.

Maryland

Insurance and Access Expansion: Totals represent Maryland's pharmacy assistance program, subsidized adoption, and kidney disease program.

Prevention of Epidemics and Spread of Disease: These totals represent expenditures from all funding sources.

New Jersey

Demographics 2000 and 2001: • State Employees: Full-time paid employees only. Excludes Higher Education employees and part-time employees.

New York

Medicaid: The data include Medicaid expenditures for community-based services that were excluded in previous surveys, but instead were included in community-based expenditures. These expenditures totaled approximately $531 million in fiscal 2000 and $563 million in fiscal 2001. For state-to-state comparison purposes, other state funds include the local share of Medicaid costs that total approximately $4 billion.

Total SCHIP: The State's Child Health Plus Program, which served as the model for federal SCHIP, is a separate, stand-alone program, not a Medicaid expansion program.

SCHIP Medicaid Expansion: The State's Child Health Plus Program, which served as the model for federal

SCHIP, is a separate, stand-alone program, not a Medicaid expansion program.

SCHIP Stand-alone: The State's Child Health Plus Program, which served as the model for federal SCHIP, is a separate, stand-alone program, not a Medicaid expansion program.

State Employee Health Premium-Matching: Employee payments come from payroll deductions and are not state funds.

State Employee Flexible Spending Account: Employee payments come from payroll deductions and are not state funds.

Higher Education Health Care: Unlike prior years, expenditures for fiscal 2000 and fiscal 2001 include transfers from the State University of New York (SUNY) hospitals to the state for reimbursement of fringe benefits and debt service paid in the first instance by the state on behalf of the SUNY hospitals. SUNY now budgets hospitals as paying their own fringe benefit and debt service bills rather than reimbursing the state.

Insurance and Access Expansion: This does not include the off-budget Healthy NY program ($45 million) created by the Health Care Reform Act of 2000. The Health NY program provides comprehensive health insurance to uninsured workers and their families.

Community-Based Services: Data exclude Medicaid expenditures that were included in previous surveys and account for a significant percentage of the funding provided for community-based services. Medicaid expenditures for these services are included in table 15. These expenditures totaled approximately $531 million in fiscal 2000 and $563 million in fiscal 2001.

Promotion of Chronic Disease Control and Healthy Behavior: General fund spending for AIDS Institute, under State Education Department, includes a suballocation from the Department of Health.

Demographics 2000 and 2001: • Juveniles Incarcerated: Defined as youth in residential care in state-operated facilities or placed in voluntary agencies, but in the custody of the Office of Children and Family Services. The Department of Correctional Services counts inmates under the age of 21. • State Employees: State employees are counted as full-time equivalent employees funded from all funds including part-time and temporary employees but excluding seasonal, legislative, and judicial employees.

Pennsylvania

Medicaid: Uses the governor's budget reports of actual expenditures for relevant years rather than the CMS-64 report. The expenditures shown here include Medicaid program administration that would include the cost of employee health care premiums.

Total SCHIP: SCHIP is totally separate in Pennsylvania from Medicaid. Figures are based on the governor's budget rather than on the CMS-64 report.

SCHIP Medicaid Expansion: SCHIP is totally separate in Pennsylvania from Medicaid. Based on the governor's budget rather than on the CMS-64 report.

SCHIP Stand-alone: SCHIP is totally separate in Pennsylvania from Medicaid. Based on the governor's budget rather than on the CMS-64 report.

State Employee Health Premium: State employees health care includes both active health plan and retired employee health program. The amount includes contributions from independent agencies. Includes university faculty and employees who are covered by collective bargaining agreements for the State System of Higher Education.

Medical Portion of Workers' Compensation: Information is on a calendar year basis.

Medicare Payroll Tax: Medicare payroll tax data only includes agencies on the Commonwealth payroll system. Does not include State System of Higher Education, Treasury, Auditor General, Legislature, Judiciary, or 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 in the health care cost through grants to county child welfare programs but the amount is unknown.

Insurance and Access Expansion: An adult basic health care program will be provided in 2002 using proceeds from the Tobacco Settlement. The funds shown represent initial planning.

State-Operated Long-Term Care Facilities: Reflects veterans homes. Geriatric mental health facilities are included in Medicaid or Other State Facility categories. Geriatric cost in prisons are not included.

Community-Based Services: Includes community alternatives to nursing home care for older Pennsylvanians. This is in addition to the Medicaid waiver included in Medicaid table.

Protection against Environmental Hazards: Includes all program and administrative costs for the Department of Environmental Protection.

Great Lakes

Illinois

Medicare Payroll Tax: Funding sources cannot be isolated; the total is represented as general funds.

Health Infrastructure: Figures include capital expenditures on hospitals and other health care facilities.

Michigan

SCHIP Medicaid Expansion: Does not separate Medicaid expansion programs and stand-alone programs in reporting SCHIP expenditures. See SCHIP stand-alone expenditures for totals.

State Employee Health Premium: Figures do not include college and university faculty and staff.

State Employee Health Premium-Matching: The amounts for employee contributions in each year are indicated under other state funds but are not state funds; rather these funds are employee contributions for matching health care premiums.

State Employee Flexible Spending Account: The amounts for employee contributions in each year are indicated under other state funds but are not state funds; rather these funds are employee contributions for matching health care premiums.

Higher Education Health Care: The amounts in state general fund spending for both years include $2.4 and $1.9 million appropriated for the Joseph Young, Sr. psychiatric research and training program. The remaining general fund is for masters medical education payments to teaching hospitals for the indirect and direct costs of residents, interns, nursing education, and supervising physicians.

State-Operated Long-Term Care Facilities: Figures are for long-term care services in veterans' facilities.

Community-Based Services: The Medicaid mental health managed care waiver costs are reported with Medicaid expenditures.

Demographics 2000 and 2001: • State Employees: Includes permanent positions per pay periods ending June 24, 2000, and June 23, 2001. Does not include university staff.

Wisconsin

Medicaid: CMS/HCFA-64 report was not used because it reports federal fiscal year expenditures. For consistency's sake, the state used state fiscal year data from its accounting system.

SCHIP Medicaid Expansion: CMS/HCFA-64 report was not used because it reports federal fiscal year expenditures. For consistency's sake, the state used state fiscal year data from its accounting system.

State Employee Health Premium: Federal funds are included in other state funds.

Medical Portion of Workers' Compensation: Federal funds are included in other state funds.

Medicare Payroll Tax: Federal funds are included in other state funds.

Plains

Iowa

State Employee Health Premium: Amount cannot be broken down between state general fund, other state funds, and federal funds. Does not include Regents Institutions or Community-Based Corrections.

State Employee Health Premium-Matching: Amount cannot be broken down between state general fund, other state funds, and federal funds. Does not include Regents Institutions or Community-Based Corrections.

State Employee Flexible Spending Account: Amount cannot be broken down between state general fund, other state funds, and federal funds.

Medical Portion of Workers' Compensation: Amount spent cannot be broken down between state general fund, other state funds, and federal funds.

Medicare Payroll Tax: Amount cannot be broken down between state general fund, other state funds, and federal funds. Does not include Regents Institutions or Community-Based Corrections.

Juvenile Corrections: Includes costs associated with Children in Need of Assistance Program.

Direct Public Health: Does not include Regents Institutions or Community-Based Corrections.

Prevention of Epidemics and Spread of Disease: Does not include Regents Institutions or Community-Based Corrections.

Protection against Environmental Hazards: Does not include Regents Institutions or Community-Based Corrections.

Injury Prevention: Does not include Regents Institutions or Community-Based Corrections.

Promotion of Chronic Disease Control and Healthy Behavior: Does not include Regents Institutions or Community-Based Corrections.

Disaster Preparedness: Does not include Regents Institutions or Community-Based Corrections.

Disaster Response: Does not include Regents Institutions or Community-Based Corrections.

Health Infrastructure: Does not include Regents Institutions or Community-Based Corrections.

Demographics 2000 and 2001:
- Adult Inmates: Does not include Community-Based Corrections population.
- State Employees: Does not include Regents Institutions or Community-Based Corrections facilities.

Missouri

Medicaid: It was not possible to separate general fund revenues from other state revenues.

SCHIP Medicaid Expansion: It was not possible to separate general fund revenues from other state revenues.

Adult Corrections: Fiscal 2000 information not available. Assumed that fiscal 2000 was equal to the average reported for fiscal 1998, fiscal 1999, and fiscal 2001.

Juvenile Corrections: Unlike previous years, medical expenditures for Heartland Hospital are not included in these numbers due to a coding error. This problem will be corrected in the future.

Community-Based Services: Does not duplicate Medicaid and SCHIP spending. Previous survey responses had duplication.

Southeast

Alabama

Total Health Expenditures: Does not include colleges and universities. Their portion does not flow through

the state system.

State Employee Health Premium: Totals are actual figures; break-out by fund type is estimated by across-the-board percentages.

State Employee Health Premium-Matching: Totals are actual figures; break-out by fund type is estimated by across-the-board percentages.

State Employee Flexible Spending Account: Totals are actual figures; break-out by fund type is estimated by across-the-board percentages.

Medical Portion of Workers' Compensation: Totals are actual figures; break-out by fund type is estimated by across-the-board percentages. Totals do not include colleges and universities. Their portion does not flow through the state system.

Medicare Payroll Tax: Totals are actual figures; break-out by fund type is estimated by across-the-board percentages.

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

Insurance and Access Expansion: This is paid for by insurance assessments and premiums paid by individuals.

Demographics 2000 and 2001: • State Employees: Figures do not include colleges and universities.

Florida

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

Georgia

Medicaid: Fiscal 2001 reflects the beginning of the use of intergovernmental transfers from non-state, public hospitals and nursing homes participating in the state's upper payment limit initiative.

State Employee Health Premium: For the State Health Benefit Plan, other state funds are received from the state appropriations of other state agencies. The agencies pay the State Health Benefit Plan based on a percent of payroll or, for some types of employees, a fixed amount.

Insurance and Access Expansion: Other funds represent tobacco settlement funds used to expand Medicaid eligibility for pregnant women and infants under 1 in families with incomes from 200 percent to 235 percent of the federal poverty level (FPL); expand SCHIP eligibility to 235 percent of the FPL; and expand the Independent Care Waiver and Traumatic Brain Injury programs. These expenditures are included in the Medicaid and SCHIP expenditures.

Health Infrastructure: Reflects expenditures of the following offices: Men's Health, Rural Health, Minority Health, and Women's Health; and the Composite Board of Medical Examiners, the Georgia Board for Physician Workforce, and the Medical Education Board.

Kentucky

State Employee Health Premium: Expenditures are based on calendar year. Fund source splits are not available.

State Employee Health Premium-Matching: Expenditures based on calendar year. Colleges and universities are not included.

State Employee Flexible Spending Account: Expenditures are based on calendar year. Colleges and universities are not included.

Medical Portion of Workers' Compensation: University of Kentucky and University of Louisville are self-insured and are not included. Fund source splits are not available.

Medicare Payroll Tax: Colleges and universities are not included.

Demographics 2000 and 2001: • State Employees: Totals include all three branches of government including colleges and universities.

Mississippi

State Employee Flexible Spending Account: Flexible spending accounts for state employees cannot be broken out of total expenditures at this time.

Medicare Payroll Tax: Medicare payroll taxes for state employees cannot be broken out of total expenditures at this time.

Total Corrections: Health care expenditures for juveniles are included in the health care expenditures for adults.

Adult Corrections: Health care expenditures for juveniles are included in the health care expenditures for adults.

Juvenile Corrections: Health care expenditures for juveniles are included in the health care expenditures for adults.

Tennessee

Medicaid: The state operates a managed care Medicaid waiver program with an expansion population. This program includes uninsured and uninsurable individuals with the traditional Medicaid population. This has become such a huge caption for health care expenditures that it is almost all-inclusive.

Demographics 2000 and 2001: • Medicaid: The state operates a managed care Medicaid waiver program with an expansion population. This program includes uninsured and uninsurable individuals with the traditional Medicaid population. This has become such a huge caption for health care expenditures that it is almost all-inclusive.

Virginia

Higher Education Health Care: The Commonwealth of Virginia provides state funding to the University of Virginia and Virginia Commonwealth University to support the operation of Family Practice Residency Programs and Family Practice medical student programs. For fiscal year 2000, the total was $8,463,263. For fiscal year 2001, the total was $8,966,178. In addition, the Commonwealth of Virginia provides state funding to support two university-related teaching hospitals: the University of Virginia Medical Center (UVAMC) and the Virginia Commonwealth University Health System Authority (VCUHSA). The two teaching hospitals, or academic health centers, 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, 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 refers to as "regular DSH." In addition, the two University Teaching Hospitals are eligible for "enhanced DSH." The Medicaid State Plan defines both formulas, which determine the amount of funding provided to each of the two state academic health centers. The "enhanced" funding is provided only to UVAMC and VCUHSA in recognition of the costs of training medical students in a teaching facility. See Medicaid table for dollar amounts.

West Virginia

Higher Education Health Care: The state does not have state university-based teaching hospitals.

Southwest

Oklahoma

Medicaid: Title XIX expenditures were reported on the CMS-64.9 report—gross expenditures. The revenue breakout for Title XIX is assumed to be the same breakout as reported on the Oklahoma Health Care Authority's financial statements.

SCHIP Medicaid Expansion: Title XXI expenditures were reported on the CMS-64.9 report—gross expenditures. For the revenue breakout for Title XXI, the blended federal share rate was used for both years, assumed the remaining revenue was general funds. The 2001 SCHIP expenditures do not include prior year reclassification of $33 million; only current quarter expenditures were used. The increase in SCHIP expenditures from state fiscal year 2000 to state fiscal year 2001 is due to rate increases after SB639 (provided by the Oklahoma Health Care Authority).

State Employee Health Premium: Data provided by Accounting Division of the Office of State Finance.

State Employee Health Premium-Matching: Data provided by Accounting Division of the Office of State Finance.

State Employee Flexible Spending Account: Data provided by Accounting Division of the Office of State Finance.

Medical Portion of Workers' Compensation: The information is not available at this time.

Medicare Payroll Tax: Data provided by Accounting Division of the Office of State Finance.

Adult Corrections: Expenditures for inmate medical care (including substance abuse treatment) provided by the Department of Corrections, University Hospital Authority, and the Department of Mental Health and Substance Abuse Services.

Juvenile Corrections: Expenditures for the Office of Juvenile Affairs. In February 2001, juveniles in OJA-operated and certain other facilities were determined to no longer be eligible for Medicaid benefits. This resulted in an increase in fiscal 2001 costs. Expenditures include salaries and benefits for nursing positions.

Higher Education Health Care: In fiscal 1998, the University Hospitals were privatized through a long-term lease of the operations to Columbia HCA. The expenditures shown represent state appropriations provided to the private vendor for indigent health care.

Insurance and Access Expansion: Total spent for the state's high-risk pool.

State-Operated Long-Term Care Facilities: Includes expenditures for the Department of Veterans Affairs. All other state-operated long-term care facilities are funded with Medicaid.

Other State Facilities: Includes expenditures for the Department of Mental Health and Substance Abuse Services (state mental hospitals), the J.D. McCarty Center, and the George Nigh Rehabilitation Center (the other state fund expenditures for this center include Medicare funds).

Community-Based Services: Includes expenditures for the Department of Rehabilitation Services, the J.D. McCarty Center, and community-based mental health and substance abuse services for the Department of Mental Health and Substance Abuse Services.

Protection against Environmental Hazards: Includes expenditures for the Department of Health, the Department of Environmental Quality, the Conservation Commission, the Department of Mines, the Corporation Commission, and the Water Resources Board.

Injury Prevention: Includes expenditures for the Department of Health, Oklahoma Liquified Petroleum Gas Board, Conservation Commission, Department of Mines, Department of Public Safety, Department of Wildlife Conservation, Department of Labor, Water Resources Board, and the Oklahoma Commission on Children and Youth.

Promotion of Chronic Disease Control and Healthy Behavior: Includes expenditures for the Department of Health, Department of Mental Health and Substance Abuse Services, and the Department of Public Safety.

Disaster Preparedness: Includes expenditures for the Department of Health, Civil Emergency Management, and the Water Resources Board (floodplain management).

Disaster Response: Includes expenditures for the Department of Mental Health and Substance Abuse Services and Civil Emergency Management.

Health Infrastructure: Includes expenditures for the Department of Health, the Department of Mental Health and Substance Abuse Services, the Board of Medicolegal Investigations, the Physician Manpower Training Commission, the Board of Examiners for Nursing Home Administrators, the Chiropractic Examiners Board, the Cosmetology Board, the Board of Dentistry, the Embalmers and Funeral Directors Board, the Board of Medical Licensure and Supervision, the Board of Nursing, the Optometry Board, the Osteopathic Examiners Board, the Perfusionists Board, the Board of Pharmacy, the Board of Podiatric Medical Examiners, the Psychologists Board, the Licensed Social Workers Board, and the Speech-Language Pathology and Audiology Board.

Demographics 2000: • Medicaid Caseload: Title XIX recipients for an unduplicated count from the County Summary report ending June 30, 2000 (excluding SCHIP); figure provided by Oklahoma Health Care Authority. • SCHIP Enrollment: 2000 SCHIP recipients are an average for state fiscal year 2000 from Eligible report (M3040R01). • State Employees: Includes 27,221.7 FTE for fiscal 2000 from the Higher Education System.

Demographics 2001: • Medicaid Caseload: Title XIX recipients for an unduplicated count from the County Summary report ending June 30, 2001 (excluding SCHIP); figure provided by Oklahoma Health Care Authority. • SCHIP Enrollment: 2001 SCHIP recipients are actual July 2001 monthly recipients. This number was used because it reflected system change; figure provided by the Oklahoma Health Care Authority. • State Employees: Includes 27,889.9 FTE for fiscal 2001 from the Higher Education System.

Texas

Higher Education Health Care: Total funds include federal funds, other state funds, and appropriated receipts. Appropriated receipts represent a significant amount in total funds.

Rocky Mountains

Montana

Medical Portion of Workers' Compensation: Cannot be broken out into fund type. Expenditures for 2000 include the university system; expenditures for 2001 do not include the university system.

Protection against Environmental Hazards: All funds for the Performance Partnership Grant are included.

Injury Prevention: Dollars spent on safe schools are included in table 39 in the money for Safe & Drug Free Schools.

Promotion of Chronic Disease Control and Healthy Behavior: University unable to break out Student Health Expenditures from other costs.

Disaster Response: A total of $126,000 was spent in fiscal 2002 for crisis counseling done in 2001.

Utah

State Employee Health Premium: Amounts may include general fund on retired state employees that can be reimbursed by the federal government.

Demographics 2000: • Medicaid Caseload: This figure is the unduplicated count of total Medicaid clients for the year. The average monthly caseload was 132,000. • State Employees: This figure does not include 24,911 employees at 10 higher education institutions (12,357 paid from state appropriated funds and 12,554 paid from funds other than state appropriated funds).

Demographics 2001: • Medicaid Caseload: This figure is the unduplicated count of total Medicaid clients for the year. The average monthly caseload was 139,000. • State Employees: This figure does not include 25,967 employees at 10 higher education institutions (12,725 paid from state appropriated funds and 13,242 paid from funds other than state appropriated funds).

Far West

Alaska

Demographics 2000 and 2001: • Incarcerated Juveniles: Includes those in juvenile facilities as well as those 18 years old and under in adult facilities. • State Employees: Budgeted, permanent full-time positions. Does not include part-time or non-permanent positions.

Oregon

Higher Education Health Care: Includes state funds allocated schools of nursing, dentistry, and medicine. Includes overhead in financial reporting department. Excludes Child Development and Research Center, Allied Health and AHEC areas.

Insurance and Access Expansion: Includes program and administrative costs.

Individual State Profiles by Region

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:*

- Centers for Medicare and Medicaid Services
  www.cms.hhs.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

Selected Web Resources for *State Employees:*

- Bureau of Labor Statistics (Employee Benefits)
  www.bls.gov/ncs/ebs
- 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 *Resources for Direct Public Health Care:*

- 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

Selected Web Resources for *Population Health*

- Centers for Disease Control and Prevention
  www.cdc.gov
- Association of State and Territorial Health Officials
  www.astho.org
- American Public Health Association
  www.apha.org/index.cfm

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