

Recent Changes in Health Policy for Low-Income People in New York

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Overview

New York has a tradition of funding a comprehensive health care system for its low-income population. By almost any measure—eligibility, provider payment, services covered—the state operates one of the most comprehensive Medicaid programs in the country, as well as a generous State Children’s Health Insurance Program (SCHIP). In addition, New York has in place some of the most far-reaching small group and individual insurance reforms. Further, it has a number of well-funded subsidy programs to help support safety net providers.

With a special focus on the low-income population, this report examines the major health issues New York has dealt with in the period between 1997 and 2001. During this period, states were given new opportunities in health policy for low-income people. Many developments increased state flexibility, including welfare reform, new funding for children’s health insurance coverage under SCHIP, and repeal of federal minimum standards for nursing home and hospital reimbursement that had constrained states’ control over Medicaid payments. Fiscal capacity also rose—from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

At the same time, states were put under new policy formulation and revenue pressures. These arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety

net support, which was believed to have been abused by some states; political pressures for state tax cuts; and, starting in 2001, an economic slowdown and fears of recession. Although New York’s fiscal picture was optimistic in early 2001, the outlook is now not so bright, especially in the wake of the September 11 terrorist attacks on the World Trade Center in New York City.

To examine how New York has responded to federal constraints and state flexibility during the last half decade, this case study examines state priority setting and program operations in health policy affecting the low-income population. The study reveals that during the late 1990s, New York’s policy attention on health care issues has been principally aimed at addressing the state’s large and growing uninsured population. The centerpiece of New York’s recent health policy is the Health Care Reform Act (HCRA) of 2000, a sweeping piece of legislation that addresses virtually all dimensions of the state’s health care system—from indigent care to graduate medical education to poison control. In addition to reauthorizing a number of established programs, HCRA 2000 contained funding for several new programs. Perhaps most important were the provisions to expand health insurance coverage to uninsured adults through two new initiatives—Family Health Plus and Healthy New York. Family Health Plus, when implemented, will expand coverage through Medicaid whereas Healthy New

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York provides state-subsidized health coverage for small employers and for individual workers. Together, these initiatives are designed to extend coverage to about one million New Yorkers at a cost to the state of nearly \$500 million over three and one-half years. Both Family Health Plus and Healthy New York were seen as building upon Child Health Plus—New York's Title XXI SCHIP initiative—one of the most politically popular health programs in the state. Another important HCRA 2000 provision was the expansion of state-sponsored prescription drug coverage for low-income seniors, the Elderly Pharmaceutical Insurance Coverage (EPIC) program. It is expected that the expansion will boost enrollment from roughly 120,000 to 200,000 seniors.

In addition to the force of political will, New York was able to undertake these progressive HCRA reforms because of its booming economy, which, as of early 2001, was in strong shape. Further, New York began receiving its tobacco settlement money in 2000, part of which went to fund HCRA 2000 initiatives. Monies from a cigarette tax increase also helped finance some of the HCRA programs.

In addition to HCRA 2000, this study found that the state's rollout of its Partnership Plan Section 1115 Medicaid waiver program is also high on the agenda of policymakers and advocates. New York's Partnership Plan, which calls for the enrollment of more than 2 million Medicaid recipients into managed care, has been implemented more slowly than initially anticipated. As of this writing, only about 700,000 of the expected 2 million individuals are enrolled in the waiver program.

Given the recent passage of the HCRA 2000, only a few health policy matters are on the table in 2001. However, health care is clearly on the minds of New York policymakers. Among other issues are how to deal with the labor shortage that is affecting hospitals, nursing homes, home health agencies, and other home care providers statewide. There is also concern about how to handle the enrollment "churn" in the Medicaid and Child Health Plus populations and improve retention. Another issue is the implementation of the HCRA 2000 health insurance programs—Healthy New York and Family Health Plus. After considerable back and forth between the state and federal officials, New York was granted a federal waiver on May 30, 2001, to implement Family Health Plus—nearly a year after submitting the waiver application. The program was expected to become operational in October 2001. Although Healthy New York was implemented in January 2001, program enrollment has been very limited.

Besides program implementation delays and relatively slow enrollment into Healthy New York and the Partnership Plan, New York, like many other states, is facing projected increases in Medicaid spending: In 2001, Medicaid expenditures are expected to increase 6 percent, about three times the annual growth rate over the period from 1995 to 2000. Owing to the strength of New York's fiscal situation, policymakers are not generally concerned about the spending jump. However, given the economic downturn and financial impact of the September 11 attacks, this sentiment may quickly change. A continued rise in Medicaid spending coupled with the economic downturn is likely to put considerable pressure on the state's budget, as Medicaid is by far the single largest budget item, accounting for 32 percent of New York's total spending in 2000.

This report suggests that New York has continued its longstanding practice of pushing the envelope of its health care system to improve care for its low-income residents. However, considerable work is needed to translate the many new initiatives into successful programs. In particular, the state will be faced with the important challenge of enrolling and retaining eligible populations in the new insurance coverage programs. If these programs do not meet their enrollment goals, New York and its providers will continue to confront the pressures of a sizeable uninsured population (estimated at more than 2 million nonelderly individuals in 1999). At the same time, given the September 11, 2001, terrorist attacks, which dealt a severe blow to state finances, and the general slowing of the nation's economy, budget pressures from rising Medicaid spending could raise some very tough issues for New York policymakers.

TABLE 1. Selected New York Characteristics

	New York	United States
Population Characteristics		
Population (1999) (in thousands) ^a	18,976	281,422
Percent under age 18 (1998) ^a	24.7%	25.7%
Percent Hispanic (1999) ^b	16.1%	12.5%
Percent black (1999) ^b	15.3%	12.8%
Percent nonmetropolitan (1996) ^c	5.6%	4.1%
	9.6%	20.3%
State Economic Characteristics		
Per capita income (1999) ^d	\$34,547	\$29,676
Percent change per capita income (1995–1999) ^d	11.8%	10.8%
Unemployment rate (1999) ^e	4.3%	4.5%
Family Profile		
Percent children in poverty (1998) ^f	21.6%	17.5%
Percent change children in poverty (1996–1998) ^f	–11.8%	–15.0%
Percent adults in poverty (1998) ^f	12.8%	11.2%
Percent change adults in poverty (1996–1998) ^f	–9.9%	–10.4%
Political		
Governor's affiliation (1999) ^g	Republican	NA
Party composition of senate (1999) ^h	25D-36R	NA
Party composition of house (1999) ^h	99D-51R	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC) ^j	70.1%	59.3%
1998 (TANF) ⁱ	64.1%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996 ^{j,k}	101%	124%
1998 ^{j,l}	185%	178%
2000 ^{j,m}	230%	205%

Table 1 notes begin on page 23.

Background

Demographic/Insurance Coverage

New York is a densely populated state, making up roughly 7 percent of the United States' population (see table 1). The state is racially and ethnically diverse, with a larger percentage of Hispanic and black populations than the national average. New York also has a larger share of the population in poverty than the national average. Moreover, compared with the nation, New York experienced a smaller drop in the percent of people in poverty between 1996 and 1998.

Among low-income families, the rate of employer-sponsored health insurance coverage in New York is lower than the national average (see table 2). In contrast, the rate of public insurance coverage in the form of Medicaid and SCHIP is notably higher—reflecting the state's comparatively generous program eligibility standards (see table 1). Overall, in 1999, New York had a lower rate of uninsured children and uninsured adults than the national average.

Political Developments

Since the mid-1990s there has been little change in the state's political environment: George Pataki, a Republican, started his second four-year term as governor in January 1999, and Democrats still maintain the majority of seats in the state assembly (99 D:51 R), while the Republicans maintain the majority of seats in the senate (36 R:25 D). With this political leadership, New York has continued to address challenging issues facing the

TABLE 2. Health Insurance Coverage, by Family Income and Type of Insurance, New York and the United States, 1999

	Children (Ages 0–18) ^a (%)		Adults (Ages 19–64) ^b (%)	
	New York	United States	New York	United States
Below 200% FPL				
Employer-sponsored	34.6	38.7	35.6	41.7
Medicaid/SCHIP/state	45.9	35.2	26.1	14.7
Other coverage	3.5	3.8	6.2	8.8
Uninsured	16.1	22.4	32.1	34.9
Above 200% FPL				
Employer-sponsored	86.5	85.3	84.6	83.7
Medicaid/SCHIP/state	5.4	3.8	1.5	1.1
Other coverage	3.3	4.9	4.8	5.8
Uninsured	4.8	6.0	9.1	9.4
All Incomes				
Employer-sponsored	64.0	66.7	70.9	72.3
Medicaid/SCHIP/state	23.0	16.4	8.4	4.8
Other coverage	3.4	4.5	5.2	6.6
Uninsured	9.7	12.5	15.5	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

Notes: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.

FPL = federal poverty level

SCHIP = State Children's Health Insurance Program

health care market through a variety of ambitious reforms, most recently and notably the Health Care Reform Act of 2000.

Interview respondents noted that on most issues the assembly is oriented toward the left, with the senate somewhat politically centered and the governor leaning politically toward the right. This arrangement usually leads to a balance between Democrat and Republican platforms, with the scale sometimes tipping left of center—particularly on health care reform issues. While the state has become more fiscally conservative, with tax cuts enacted in each year of Pataki's leadership and a slowdown in year-to-year budget growth, New York's reputation for generous health care spending (particularly Medicaid) and for implementing progressive health policy has not changed much in recent years.

Also unchanged in recent years is the important role county governments play in the administration of health and welfare programs. New York counties contribute 25 percent of the cost of the Temporary Assistance for Needy Families (TANF) program and Medicaid services.¹ In contrast, most other states require little to no county share in the funding of their Medicaid programs. This financing arrangement sometimes leads to tension between the counties and state government when program expansions affect local budgets. For example, with Family Health Plus, the soon-to-be-implemented expansion of Medicaid coverage to low-income adults, passed as part of HCRA 2000, New York counties are concerned about the fiscal impact on their local budgets because the program will require the same local share as regular Medicaid expenditures.

There also continues to be long-standing political tensions between New York City and the rest of the state. In general its policymakers believe that the city contributes more to the state treasury than it receives in return through resource allocation, particularly for

education and public health. In contrast, policymakers in the rest of the state believe that New York City is a major beneficiary of the distribution of state resources because of the services received by its large low-income population.

A new dimension to New York's health care policy arena is the increasing power wielded by the health care unions. In particular, 1199 National Health and Human Service Employees Union (SEIU) was identified as being very active in health care matters. SEIU is the largest health care union in New York, representing over 200,000 workers in the hospital, nursing home, and home care industry. Most recently, SEIU was a key player in the development of HCRA 2000. Forming an alliance with the hospital industry, the union lobbied for specific issues that included health insurance expansions, preservation of charity care and medical education funding, and the use of tobacco settlement funds for health care programs. The union was also actively involved in the development of the \$1.25 billion federally-funded Community Health Care Conversion Demonstration Project, which is part of New York's Section 1115 Partnership Plan waiver (see below). Monies secured under this project are used to help hospitals restructure their delivery systems for the new, competitive managed care marketplace. Major initiatives funded under the project include hospital worker retraining.

Market Developments

As in many other states, an important development affecting New York's health care markets has been the steady increase in the number of the uninsured over the 1990s. According to the Current Population Survey, in 1998, nearly 20 percent of New Yorkers were without insurance, up from 18 percent in 1994.² In New York City the rate of uninsured was nearly 30 percent in 1998, the third highest rate among large urban areas in the United States.³ The lack of coverage is especially high among New York's low-income population. In 1998, nearly 32 percent of persons with incomes below the federal poverty level (FPL) had no health insurance, up from 26 percent in 1994.⁴

One explanation for the state's high proportion of uninsured is its low rate of employer-sponsored health insurance coverage. As mentioned above, the rate of employer-sponsored coverage among the low-income population is considerably lower in New York than in the rest of the nation. The impact of welfare reform is another explanation for the growing number of uninsured.

Overlaying the rise in uninsured, New York has continued to struggle with problems in its individual insurance market. The individual market has experienced dramatic rate increases making it unattractive to healthy uninsured individuals. Consequently, the individual market has a much higher incidence of persons with serious disease and those who need ongoing health treatments.⁵ In short, while access to insurance has long been guaranteed in New York, affordability has become a major issue.

On several occasions New York policymakers have sought to address the issue of the working uninsured and the individual market.⁶ For example, in 1998, in an effort to avoid major rate increases in the individual insurance market, the New York State Department of Insurance provided subsidies totaling \$110 million to insurers that serve individuals. Funding for the subsidies came from surpluses in two state reinsurance pools that were established as part of the state's landmark 1992 community rating law for both individual and small groups. All insurers that serve these markets contribute to the pools, and those that draw a disproportionate number of sick enrollees receive disbursements from the pools to make up for the adverse selection.

The state's most recent effort to address the individual markets was the enactment of the Healthy New York program (see section below for program details) as part of HCRA 2000. State officials view this initiative as a formal recognition of the significant number of working uninsured individuals in the state.

Beyond these measures, New York did not enact other major insurance reforms in the late 1990s. While many states needed to implement a number of reforms to comply with the federal 1997 Health Insurance Portability and Accountability Act (HIPAA), New York

was already largely compliant and needed to make only minor changes to its existing statute.⁷

Another important market change in the late 1990s has been in the hospital sector. In 1997, hospital payment in New York underwent a dramatic shift with the enactment of the New York Health Care Reform Act, which deregulated hospital reimbursement rates.⁸ Under deregulation, hospitals began in January 1997 to negotiate their own rates with all payers except Medicaid fee-for-service, automobile no-fault insurance, workers' compensation, and Medicare. Policymakers hoped that deregulation would reduce the cost of hospital care and hospital capacity, with financially strong hospitals reducing bed capacity and lengths of stay, and financially weaker hospitals downsizing or closing. Deregulation was generally supported by legislators, the governor, insurers, and providers, but not by the unions that believed deregulation would result in worker layoffs.

Thus far, it appears that hospital deregulation has not resulted in many hospital closures. Only two hospitals closed in New York between 1997 and 1999, a relatively small number compared with other states.⁹ For example, 22 hospitals in California and 15 hospitals in Texas closed from 1997 to 1999. During our site visit we learned of one additional closure in 2000 (Genesee Hospital, Rochester) and of another hospital that filed for bankruptcy in 2001 (Crouse-Irving Hospital, Syracuse). Although few closures have resulted, there have been a number of hospital mergers and acquisitions—8 mergers and acquisitions in 2000, 6 in 1999, and 20 in 1998.¹⁰ Concerns regarding worker layoffs have not materialized—conversely, hospitals have been trying to cope with workforce shortages (see below).

State health officials believe that hospital deregulation has had several positive effects. For instance, they believe that the high volume of merger and acquisitions has made the hospital market more efficient than it had been under rate setting. They believe that this will lower hospital costs in the long run. State officials did acknowledge that, in retrospect, they “put hospitals out there too fast” and deregulation should have been implemented more slowly. Hospital representatives agree with this sentiment. According to the industry, some hospitals moved too hastily after deregulation went into effect. For example, some hospitals' initial response to the new policy was to attempt to become competitive by making capital investments with money they did not really have. At the same time, in their first-ever negotiations with insurers, hospitals often signed contracts with low rates, causing them to lose more money. Meanwhile, Medicare and Medicaid managed care rates were being cut back. Together, according to one recent hospital report, these trends have caused substantial financial instability among New York hospitals.¹¹ According to the hospital industry, operating margins among New York hospitals have steadily declined since 1997. Further, operating and total margins of New York hospitals are reported to be the second worst in the nation. HCRA 2000 contained some provisions to address the financial condition of hospitals. Among these was the designation of \$82 million per year as a special fund for rural and urban safety net hospitals, for the three and one-half years of HCRA authority. This new fund is in addition to several long-standing hospital subsidy programs that New York funds.

State officials expressed some concern about the hospital closures. Although they do not believe that hospital closures are necessarily bad, they are concerned about maintaining access, especially for the low-income population. Although state officials believe that there is a definite role for the state in the hospital market, policymakers are also under pressure from insurers and the business community to make the New York health care system—at the heart of which are the hospitals—more efficient and less costly. Balancing these competing demands is often challenging, according to officials.

Although hospitals have had to adjust to deregulation, they have not experienced any substantial Medicaid rate cuts with the 1997 repeal of the Boren Amendment, as some feared. While there have been proposals to cut rates (which were not enacted), industry representatives felt it was difficult to directly attribute the proposals to the elimination of Boren. What representatives are concerned about is the future: If there is a downturn in the

economy, Medicaid costs will rise. Given the size of Medicaid in New York's budget, the potential for cutbacks would be likely to increase in the absence of Boren.

Another recent major market development is the labor shortage in the health care market, which New York, like many other states, is experiencing in several markets—hospital, nursing homes, and home health. Interview respondents attributed the labor shortage to low wages, poor working conditions, negative publicity regarding the nursing home industry, and a good economy able to absorb these workers into higher paying jobs. Several measures have been proposed to address the labor shortage problem. The state assembly's 2001–2002 budget, for example, proposed additional funding for providers to help enhance staffing levels. The senate proposed a nursing scholarship program and created a committee to study workforce issues. Moreover, in February 2001, providers organized to create the Workforce Investment Now (WIN) initiative. The WIN coalition has urged the state legislature to allocate \$500 million this year for hospitals, nursing homes, and home health care agencies to boost wages and to enhance recruitment and retention. The coalition has also pushed to increase the state's Medicaid reimbursement rates to hospitals, nursing homes, home health care agencies, and other providers to allocate more funds to raise staff wages and benefits. In addition, the health care industry could use funding to subsidize health care training and education and to establish tax credits and loan forgiveness programs for those entering the health care workforce.

Fiscal Circumstances of the State

General Fiscal Condition and Budget Priorities

Prior to the September 11, 2001, terrorist attacks, New York's financial situation was better than it had been for quite a while. Since 1995, when Governor Pataki began his first term, the state has enjoyed strong revenue collections and enacted tax cuts in each of the last five years. In 2001, a sixth scheduled tax cut totaling \$1.8 billion is to go into effect. While cutting taxes, New York has managed to build its "rainy day" reserve fund and produce budget surpluses. In 2001, the surplus is estimated by the governor at \$1.4 billion; by the assembly at \$2.2 billion.

Table 3 details New York spending by major budget item in 1995 and by what is estimated for 2000. The first panel shows general fund spending while the second shows total spending which includes federal funds. The budget provides some insight into overall state policy and program priorities. Education, a top policy and budget agenda item of the governor's, commands the highest spending priority in the state, accounting for 34 percent of the general fund budget for K–12 education and 7 percent for higher education. Among the major budget categories, education spending was the only item that increased between 1995 and 2000. Spending on all other major budget items declined, with general fund spending on AFDC/TANF dropping the most—an average of 10 percent each year over the five-year period.

Medicaid expenditures made up 16 percent of estimated state spending in 2000, making Medicaid the second largest spending item in New York's general fund budget and the largest in its overall budget (second panel). While still a large budget item, general fund spending on Medicaid declined by 1 percent on average each year between 1995 and 2000. However, total (federal and state) Medicaid spending increased 2 percent each year. State officials attributed this increase to various Medicaid maximization strategies including the establishment of a nursing home upper payment limit program (see below for more details.) This increase also reflects the \$1.25 billion in federal dollars in hospital transition monies obtained as part of the Partnership Plan waiver mentioned earlier.¹²

Spending growth across all the major categories (i.e., Medicaid, education, public assistance, AFDC/TANF,¹³ corrections, and transportation) has been consistently less than the United States average. Controlling state spending growth has been a central policy goal of the Pataki administration.

Prior to the September 11, 2001, terrorist attack on New York City's World Trade Center, New York's fiscal outlook was strong based on a large surplus and a healthy rainy

day fund. According to a National Conference of State Legislatures survey, New York continued to experience strong revenue growth in early 2001, pushing up revenue estimates by \$450 million.¹⁴ At the time of our site visit, general fund expenditures were on target for 2001, making budget cuts unnecessary.

For 2002, revenue growth was projected to slow. In summer 2001, state budget office estimates placed 2002 revenue growth at 2.2 percent. However, when tax cuts were taken into account, the budget office estimated that 2002 will show no revenue growth. Legislature estimates are more optimistic and project a 5.3 percent increase in 2002. Governor Pataki has proposed \$500 million in tax cuts in his 2002 budget proposal. In keeping with prior years' patterns, the governor proposed an overall general fund spending growth of 3.6 percent. At the time of our visit, both the assembly and senate had put forth their budget resolutions but a final budget was still in development. In light of the September terrorist attacks, however, New York is likely to face a more dismal economic outlook, with budget officials estimating the state will lose about \$9 billion in revenue over the next 18 months in addition to billions of dollars in property damage because of the attacks.¹⁵

Tobacco Settlement Revenue and Priorities

Under the terms of the multi-state tobacco settlement agreement, New York received \$306 million in 1998. Beginning in 2000 and each year thereafter, New York is slated to receive payments ranging from about \$820 million to \$1.1 billion. New York's agreement also stipulates that 51.2 percent of the tobacco funds go to the state, 26.6 percent to New York City and 22.2 percent are for distribution to the state's other 57 counties.

For the 2000 payment to the state, no special fund for tobacco settlement dollars was established; instead the funds were added to general fund accounts. Thus it is difficult to precisely track how the money is being spent. However, it is widely acknowledged that some—estimated at about half—of the money is going to help fund initiatives included in HCRA 2000, such as Family Health Plus and Healthy New York as well as some tobacco prevention and control programs. The balance of the state's share is going to debt reduction and Medicaid general fund relief. As of early 2001, most of the counties had not decided what to do with their share of the settlement.

Medicaid Spending and Enrollment Trends

Enrollment

New York is one of 15 states nationwide in which Medicaid enrollment increased—though less than 1 percent—between 1995 and 1998 from approximately 2.7 to 2.8 million beneficiaries (see table 4). The primary reason for the increase was the implementation of the state's Medicaid Section 1115 waiver—the Partnership Plan—in 1997. Under the waiver, New York began receiving Medicaid matching dollars for roughly 300,000 adults enrolled in Home Relief, which is the state's general assistance program. This shift of the Home Relief population into Medicaid is noted by the 51 percent increase in the "Adults, Other Enrollees" category.

If the Home Relief enrollment is netted out, New York's Medicaid enrollment declined over the 1995–1998 period by about 200,000 individuals. This represents an average annual decrease in enrollment of approximately 0.7 percent, slightly less than the national 1.0 percent average decrease. In keeping with the national trends, New York's decline in enrollment was largely confined to the cash-assisted adults and children groups.

According to New York state administrative data, Medicaid enrollment continued to decline between 1998 and 1999 (from roughly 2.8 million beneficiaries in 1998 to 2.7 million beneficiaries in 1999), before leveling off between 1999 and 2000.¹⁶ Although Medicaid enrollment overall was fairly constant between 1999 and 2000, there was an approximately 12 percent decrease among cash-assisted adults and a 14 percent decrease among cash-assisted children. This decline in the cash-assisted populations, however, was offset by an increase in the TANF Medicaid-only groups (an 8.5 percent increase for adults and 19 per-

TABLE 3. New York Spending by Category, 1995 and 2000 (\$ in Millions)

Program	State General-Fund Expenditures ^a				Total Expenditures ^b			
	Actual	Estimated	Annual Growth (%)		Actual	Estimated	Annual Growth (%)	
	1995	2000	NY	U.S.	1995	2000	NY	U.S.
Total	\$30,579	\$35,771	3	5	\$66,678	\$78,369	3	6
Medicaid^{c,d}	\$5,969	\$5,617	-1	5	\$22,101	\$24,826	2	4
% of Total	20%	16%			33%	32%		
K-12 Education	\$8,926	\$11,985	6	7	\$12,059	\$15,299	5	7
% of Total	29%	34%			18%	20%		
Higher Education	\$2,898	\$2,505	-3	5	\$4,994	\$4,914	0	5
% of Total	9%	7%			7%	6%		
Public Assistance	\$2,077	\$1,330	-9	-6	\$3,857	\$2,863	-6	-5
% of Total	7%	4%			6%	4%		
<i>AFDC/TANF</i>	\$720	\$434	-10	-9	\$2,160	\$1,638	-5	-7
% of Total	2%	1%			3%	2%		
Corrections	\$2,411	\$2,362	0	6	\$2,841	\$2,842	0	6
% of Total	8%	7%			4%	4%		
Transportation	\$444	\$365	-4	5	\$3,950	\$2,773	-7	6
% of Total	1%	1%			6%	4%		
All Other^e	\$7,854	\$11,607	8	5	\$16,876	\$24,855	8	8
% of Total	26%	32%			25%	32%		

Source: National Association of State Budget Officers, *1996 State Expenditure Report* (April 1997) and *1999 State Expenditure Report* (June 2000).

a. State general-fund expenditures exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the CMS-64 for three reasons: first, NASBO reports on the state fiscal year and the CMS-64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the CMS-64.

e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

cent for children), suggesting that as the cash-assisted groups reached their TANF time limits many of them maintained their Medicaid coverage. The marked increase in the TANF Medicaid-only for children may also reflect New York's SCHIP Medicaid expansion for children ages 15 to 18 years old, up to 100 percent of FPL (see "Health Insurance section" below).

Expenditures

Between 1995 and 1998, New York's Medicaid expenditures grew by an average of 4.7 percent each year—a higher growth rate than the national average of 3.9 percent (see table 4). However, as shown in table 4, growth in Medicaid expenditures per beneficiary lagged slightly behind the national average with New York experiencing 5.9 percent growth between 1995 and 1998, in contrast with the national average of 6.1 percent. Although the state's Medicaid expenditure growth hovers around the national average, the amount New York spends per beneficiary is significantly higher compared with the nation as a whole. New York's \$8,825 average spending per enrollee in 1998 was roughly double that of the national average.¹⁷ Although New York spending is higher for all populations, spending is especially high for the elderly, blind, and disabled.

TABLE 4. Medicaid Enrollment and Expenditures in New York, 1998

	New York, 1998			Average Annual Growth (%), 1995–1998					
	Total Annual Expenditures (in billions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
				New York	United States	New York	United States	New York	United States
Total Expenditures	\$27.5	–	–	4.7	3.9	–	–	–	–
Medical Services									
By Eligible Group	\$25.1	2,848	\$8,825	6.8	5.1	0.9	–1.0	5.9	6.1
Elderly	\$8.1	327	\$24,644	4.9	4.3	–0.4	0.1	5.3	4.2
Blind and disabled	\$11.8	581	\$20,324	11.6	8.5	4.2	3.6	7.1	4.7
Adults	\$2.3	687	\$3,410	6.9	–1.4	9.6	–4.4	–2.5	3.1
Cash assistance	\$0.9	300	\$2,973	–12.5	–10.4	–9.8	–14.9	–3.0	5.3
Other enrollees	\$1.4	386	\$3,750	35.1	7.8	51.3	9.3	–10.7	–1.4
Children	\$2.9	1,253	\$2,325	–3.1	2.7	–3.8	–1.5	0.8	4.3
Cash assistance	\$1.3	716	\$1,759	–14.3	–8.8	–9.3	–12.2	–5.6	3.9
Other enrollees	\$1.7	536	\$3,080	11.4	12.4	6.2	9.8	4.9	2.4
By Type of Service	\$25.1	–	–	6.8	5.1	–	–	–	–
Acute care	\$12.8	–	–	6.9	4.0	–	–	–	–
Long-term care	\$12.3	–	–	6.7	6.5	–	–	–	–
DSH	\$1.9	–	–	–13.9	–7.3	–	–	–	–
Administration	\$0.5	–	–	2.8	8.5	–	–	–	–

Source: Urban Institute estimates based on data from CMS-2082 and CMS-64 reports.

Notes: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. “Cash assistance” refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. “Other enrollees” include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. “Acute care” services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners’ care, payments to managed care organizations (MCOs), and payments to Medicare. “Long-term care” services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. “DSH” stands for disproportionate share hospital payments.

Figures may not add to totals due to rounding.

Expectations for the Future

As mentioned earlier, limitation of state spending growth has been a major priority for Governor Pataki. While committed to providing health care coverage for low- and middle-income New Yorkers and their families, the governor also supports control of Medicaid spending. Thus, the 2001–02 Executive Budget recommends several actions to restrain costs which will produce state savings of \$300 million. Of this amount, approximately \$140 million affects reimbursement to nursing home providers, while roughly \$160 million is attributable to maximizing other sources of revenue to lower state costs. However, both the assembly and senate budget resolutions rejected the proposed nursing home cutbacks because of concerns about quality of care as well as labor force shortage issues.

With pharmaceuticals accounting for one of the fastest growing costs in Medicaid, the governor has also proposed establishing an independent Pharmacy and Therapeutics Committee to make recommendations regarding drug formularies, utilization policies, and options to achieve price discounts on drugs. In another proposal, recipients in managed care plans will be expected to pay the same copayments for pharmaceuticals as other Medicaid recipients.

Medicaid state spending in 2001 is expected to increase by roughly 6.6 percent, up from nearly flat state spending in 2000. The projected state Medicaid spending increase is attributed to rising prescription drug costs (expected to increase by \$90 million or roughly 16 percent over 2000–01), dental spending (expected to increase by \$30 million or 90 percent over 2000–01), and nursing home and home care (expected to increase by \$180 million or 6 percent over 2000–01).

Health Insurance Coverage

New York policymakers have long been interested in expanding health coverage to low-income, uninsured state residents. Expansions in the late 1990s focused on extending coverage to children through the Child Health Plus program and Medicaid expansions, and more recently to adults with the passage of HCRA 2000.¹⁸

Child Health Plus

Since 1997, when Congress authorized SCHIP under Title XXI of the Social Security Act, all 50 states and the District of Columbia have implemented programs to expand access to low-income, uninsured children who do not qualify for Medicaid. While most of these programs were newly developed as a result of the SCHIP legislation, New York has been providing health coverage to children since 1991 through the state-sponsored Child Health Plus (CHPlus) program. When first implemented in the early 1990s, CHPlus provided only basic ambulatory care to children under the age of 13 in families earning up to 222 percent of FPL. In 1996, while still a state-only program, New York expanded the program's eligibility to children up to 19 years of age and expanded the benefit package to include inpatient care.

With the passage of Title XXI in 1997, New York applied for SCHIP funding for CHPlus and received approval from the Health Care Financing Administration—now Centers for Medicare and Medicaid Services (CMS)—in April 1998. Then in 1999, CMS approved an amendment to New York's SCHIP waiver as well as an expansion of Medicaid coverage for children. For the Medicaid expansion, the program now covers children between the ages of 15 and 18 with incomes up to 100 percent of FPL. Under CHPlus, SCHIP funding covers children up to age 19 living in households with incomes up to 250 percent of FPL. So between Medicaid and CHPlus, New York now covers all children up to 250 percent of FPL—a fairly generous eligibility threshold relative to other states' SCHIP programs. Unlike some other states, however, New York has not sought coverage of parents through SCHIP. The state has enacted the Family Health Plus and Healthy New York programs (mentioned earlier and discussed in more detail below), as ways to extend coverage to uninsured adults.

Under SCHIP, CHPlus now provides a comprehensive benefit package including inpatient, outpatient and preventive care as well as vision and dental services. These benefits

are delivered to children through a network of managed care plans under contract to the state. To ensure a link between CHPlus and the New York Medicaid managed care program, most CHPlus providers are also Medicaid managed care providers, and any new CHPlus provider must also be a Medicaid managed care provider. To participate, families with income levels between 160 and 222 percent of FPL contribute \$9 per child per month with a maximum of \$27 per month. Families with income levels between 222 and 250 percent of FPL contribute \$15 per child per month with a maximum of \$45 per month. These cost-sharing levels are fairly consistent with other states' SCHIP programs with premiums.

New York's pre-SCHIP Child Health Plus program provided a strong foundation for a rapid implementation and quick increase in enrollment after enactment of Title XXI. In June of 1998, Child Health Plus enrollment totaled 270,683, accounting for more than 30 percent of SCHIP enrollment nationwide. By June 2000, enrollment totaled 522,058, accounting for nearly a quarter of SCHIP enrollment nationwide.¹⁹ New York's relatively large enrollment is reflected in its program expenditures: Although on average states spent approximately 24 percent of the federal SCHIP dollars available to them between FY 1998–2000, New York spent 93 percent of its allotment.²⁰

While Child Health Plus has a relatively large enrollment, there remain many uninsured, potentially eligible children in New York. The state estimates that there are more than 500,000 uninsured children in the state that are eligible for the program.²¹ In addition to interest in reaching these children, there is growing concern about the retention of enrolled children in CHPlus and Medicaid. Although experiences vary, some health plans have estimated that as many as 25 to 50 percent of children are disenrolled because they fail to recertify.²² In New York City, as many as 50 percent of New York's Medicaid and CHPlus beneficiaries scheduled to recertify each month fail to complete the recertification process and are involuntarily disenrolled.²³ Another study found that 35 percent of CHPlus enrollees were denied coverage during the first quarter of 2000; of those denials, 68 percent were due to failure to comply with procedures and 30 percent were due to failure to recertify.²⁴

The state has undertaken efforts to improve the application, enrollment, and recertification processes. Efforts have included establishing a facilitated enrollment process (discussed further below), allowing SCHIP applicants to mail in their applications, eliminating the asset test, and making presumptive eligibility available to applicants. In addition, the 2001 legislature is currently working on more measures to correct problems in the SCHIP enrollment processes.

Another issue with which the state has had to contend in implementing its SCHIP program is getting enrollees into the right program. In a 1998 state audit of SCHIP, it was found that 41 percent of CHPlus kids were Medicaid-eligible.²⁵ CHPlus, since its inception, has allowed the health plans to conduct enrollment and eligibility determination as a means of fostering a public/private partnership.²⁶ Health plans presumptively enrolled potentially Medicaid eligible children in CHPlus, and while these children were then referred to Medicaid, few followed up and thus remained in CHPlus. In addition, local social services departments had no incentive to aggressively follow up and screen these potentially Medicaid-eligible children because adding to the Medicaid rolls increases a county's Medicaid spending whereas keeping the child on CHPlus does not: In New York, counties are required to contribute to the state Medicaid share but make no contribution toward CHPlus. In order to improve the "screen and enroll" process and ensure that eligible children were enrolled in the appropriate programs, New York established a facilitated enrollment initiative in spring 2000, whereby community-based organizations provide a "user-friendly" method of applying for Medicaid or CHPlus. Under facilitated enrollment, families are assisted with the joint application and enrollers determine which program the child appears eligible for and helps the family collect the required documentation. If the child appears Medicaid eligible, the enroller performs a face-to-face interview required for Medicaid so the family does not have to go to their local social services department. The

enroller also educates them about managed care and assists them in selecting a health plan.

Health Care Reform Act Insurance Coverage Provisions

With the passage of HCRA 2000, New York policymakers took major steps to expand health care coverage for low-income individuals. When fully implemented, the expansions, largely through the Family Health Plus and Healthy New York initiatives, will extend coverage to as many as one million uninsured New Yorkers. In an effort to complement its coverage of children under the CHPlus program, HCRA insurance provisions focus on providing coverage to low-income, uninsured adults. State funding for the expansions comes primarily from a 55-cent per pack cigarette tax increase and a share of New York's tobacco settlement.

Family Health Plus. When implemented, Family Health Plus (FHPlus)—by way of a Medicaid expansion—will provide health care coverage to uninsured adults, including a share of parents of children enrolled in CHPlus as well as childless couples and single adults. Specifically, at no cost to the individual, parents with incomes up to 150 percent of the FPL and single adults and childless couples with incomes up to 100 percent of the FPL are eligible.²⁷ Estimates suggest that about 600,000 individuals will qualify for the program at a cost of \$1.1 billion over three and one-half years.

The impetus for the FHPlus program came from a range of health stakeholders including the hospital industry and health care unions as well as community groups. In FHPlus, which is designed to build on Child Health Plus, participants will receive comprehensive acute care health benefits and care will be delivered through managed care plans, just like the state's CHPlus and Medicaid programs. The eventual goal is to create an integrated health care system across all three programs—CHPlus, FHPlus, and Medicaid—for low-income New Yorkers.

FHPlus has been the subject of some controversy. A major issue has been securing an amendment to New York's existing Medicaid Section 1115 waiver program, the Partnership Plan, from CMS. After considerable back and forth between the state and federal officials and nearly a year after submitting a waiver application, New York was granted a federal waiver on May 30, 2001, to implement FHPlus. Key issues to securing the amendment include budget neutrality terms, and discussions about FHPlus's benefit package, which is not as inclusive as that of New York's Medicaid program.²⁸

According to respondents and other observers, there was also a political dimension to the FHPlus waiver.²⁹ Some respondents suggested that the Pataki administration would not have been unhappy if the waiver had not been approved as the administration was not a strong proponent of FHPlus. Over time, the administration drew increasing criticism about not being active enough in pursuing the waiver. Indeed, one state legislator charged that the administration was stalling with the waiver because they were fearful of a recession and wanted to use the state funds that had been put aside for FHPlus for other purposes. Some critics called for the implementation of a state-operated FHPlus until federal approval was secured.³⁰

State officials blamed the delay on the Clinton administration, which was slow in responding to New York's request. However, when President Bush assumed office in January 2001, New York began to lobby the new administration for the FHPlus waiver. As of this writing, the state plans to begin accepting applications by September 1, 2001, and to have the program fully operational by October 1, 2001. A full set of services, similar to CHPlus, will be provided through managed care plans. Also similar to CHPlus, applicants will be able to enroll through local social service departments as well as through managed care plans and facilitated enrollers.

Healthy New York. In contrast with FHPlus, the Healthy New York initiative was spearheaded by Governor Pataki and is designed to address the significant and growing number of working uninsured individuals in New York. A subsidy program, Healthy New York became operational January 2001; as of April 2001, 150 individuals were enrolled.

Two populations are targeted under the Healthy New York initiative—small business owners and direct pay individuals. For the small business component, which receives the bulk of the subsidy (see below), participating firms must meet the following criteria:

- they must have 50 or fewer eligible employees;
- they must have offered no employer-based insurance for the past 12 months;
- one-third of employees make less than \$30,000 per year (for sole proprietor household income cannot exceed \$35,000 per year); and
- the employer must pay at least 50 percent of employee premiums.

Further, employees of participating firms must pay up to half of the premium as well as any service copayments.

For the direct pay component of Healthy New York, uninsured workers and their families who work for firms that do not provide coverage and whose incomes are below 250 percent of FPL are able to purchase direct coverage under Healthy New York. However, individual enrollees must pay the full premium as well as any copayments.

An important innovation to the Healthy New York initiative is that its subsidy feature is provided in the form of stop-loss protection to participating health plans. Other publicly subsidized programs, such as Washington's Basic Health Plan and Minnesota's MinnesotaCare program, generally subsidize the participant's premium. The intent behind the stop-loss protection was to lower premium costs, which in turn, would make the Healthy New York product more affordable and attractive to prospective enrollees. Health plans are reimbursed for 90 percent of claims paid for enrollees who incur between \$30,000 and \$100,000 in medical expenditures during a single year. Below \$30,000 and above \$100,000, health plans are fully responsible for medical costs. The program mandates the participation of all HMOs in the state; other insurers are given the option to participate. The HCRA authorized subsidies of \$163 million for small businesses and \$56 million for individual components over the three and one-half year lifespan of the HCRA legislation.

Healthy New York legislation also required that a new benefits package be designed, one that was more limited than generally available in the small group and direct pay market. The intent was to create a product that would cover basic health services at affordable premiums that small business owners and uninsured individuals would find attractive. According to state officials, developing such a product was a major challenge. Ultimately, they settled on a benefit package that provides core services but that eliminated some mandated benefits (e.g., coverage of inpatient mental health and substance abuse). The Healthy New York package also imposes higher copayments than typically required under small group policies.

Another challenge New York faced in implementing the program was developing a sound premium level. Among other things, the state needed to determine how much the subsidy was worth. Further, like the rest of New York's insurance products, the Healthy New York premium is community-rated with adjustments only for family size and location. Thus, for rating purposes, individual and group enrollees are pooled together. HMOs were very concerned about rate adequacy, especially with the blending of individuals and groups. In the end, HMOs were "conservative" in submitting rates, according to state officials. However, some interviewees maintained that certain plans set their rates so high that they effectively priced themselves out of the Healthy New York market.

As of mid-2001, the program had 900 enrollees. A number of interviewees expressed concern about the long-term viability of the program. However, state officials hope that with a planned advertising campaign, scheduled to begin in summer 2001, enrollment will pick up. Meanwhile, several changes to the program are being considered. There is discussion about changing the stop-loss corridors to make it more attractive to plans. There is also discussion of altering the risk pools so that there would be separate pools for individuals and groups. Another possible change is eliminating the so-called "crowd out" provi-

sion that prevents employers that offered insurance in the previous year from participating in the program.

Clearly, it is too early to judge the success of Healthy New York. State officials readily acknowledge that the initiative is a work in progress and that they are going through a learning process as they proceed.

Direct Pay Market Subsidies. Beyond establishing new health insurance programs, HCRA 2000 also funded subsidies for insurers in the general direct pay market. As mentioned earlier, the direct pay market has been highly unstable in recent years and enrollee premiums have increased greatly over the past several years (see the “Market Developments” section above). The new fund—financed in part with tobacco settlement dollars at a level of \$40 million per year for three years—was an effort to help stabilize premiums in the direct market. Specifically, the new program creates a stop-loss program for direct-market insurers so that plans are eligible to receive reimbursement for 90 percent of paid claims between \$20,000 and \$100,000 for a given individual in a year.

Acute Care Issues

Medicaid Managed Care

With the CMS approval of the Partnership Plan Section 1115 waiver program in July 1997, mandatory managed care was set to become a centerpiece of New York’s Medicaid program. Designed to both reduce Medicaid costs and improve access to care, the Partnership Plan—an effort led by Governor Pataki—calls for the phased-in enrollment of more than two million Medicaid recipients into managed care on a mandatory basis. When fully implemented, the waiver program will include the TANF, TANF-related, and Supplemental Security Income (SSI) populations, as well as special programs—called special needs plans or SNPs—for selected high need/high cost recipients. The waiver also includes an expansion of Medicaid to New York’s general assistance program—the Safety Net program—which allows the state to receive federal Medicaid matching dollars for program recipients.³¹

As of May 2001, about 700,000 adults and children statewide were enrolled in managed care, approximately 34 percent of all Medicaid recipients eligible for managed care under the waiver program.³² This level of managed care enrollment has been fairly constant since 1997, despite implementation of the Partnership Plan.

Mandatory enrollment had been implemented in 14 counties and in selected areas of New York City as of May 2001. Beginning July 2001, New York will initiate mandatory enrollment in two more counties as well as in additional areas in the city. All mandatory enrollment as of April 2001 has been limited to the TANF, TANF-related, and safety net populations.³³ No mandatory enrollment of SSI beneficiaries has taken place³⁴ and the SNPs have not been implemented.³⁵

Although New York has clearly made progress in implementing its waiver, the state had hoped to be much further along by this point. Implementation has moved more slowly than planned for several reasons.³⁶ An important reason has been the problems inherent in, and expected with, any public process that involves the significant changes called for under the Partnership Plan. Another important reason is the strong economy that New York has enjoyed for the past several years. This, along with a decline in Medicaid enrollment in the late 1990s, was cited as removing some of the fiscal imperative for managed care.

Another factor cited as delaying implementation, particularly in New York City, has centered around the relationship between the New York State Department of Health and CMS. CMS officials have reported that the past marketing abuses in the city, and the size and composition of the city’s Medicaid population being shifted into mandatory managed care, warrant CMS’s careful scrutiny of New York’s waiver. State officials attribute part of the delay to CMS’s high level of sensitivity toward New York’s advocacy community.

New York City hospitals have also been identified as a factor in slowing the waiver’s implementation. While the hospital industry—described as a key power center in the city’s

health care market—has not actively sought to stall the waiver, its support has waned largely because Medicaid capitation rates were viewed as being low.

The level of capitation rates has also played a role in several commercial health plans exiting New York's Medicaid managed care program. For example, in New York City, four commercial plans left the market between 1997 and 1999 and no new commercial plan entered within that period.³⁷ As of December 2000, health plans sponsored by hospitals and community health centers—which tend to be primarily Medicaid-dominated plans—enrolled nearly 70 percent of all Medicaid managed care recipients in New York City and more than half of all recipients statewide.³⁸

Commercial plan representatives cited several reasons for leaving the New York City Medicaid market.³⁹ In addition to capitation rates being perceived as low, health plan representatives also believed that program administrative burdens imposed by the state were high. Further, some plans had difficulty developing provider networks given the market power of the city's hospitals. Another factor contributing to commercial plan exits has been plans' need to concentrate resources on the keenly competitive private market. While some plans have left the upstate market area, this market has generally been more stable than in the city.

For the future, New York hopes to continue implementing mandatory managed care. The state has just received approval to expand the Partnership Plan—again for the TANF-related populations only—into several more areas, both upstate and in the city. So enrollment in the mandatory program will likely increase. Further, the state hopes to begin voluntarily enrollment in the HIV SNPs sometime in 2001. In June 2001, the state began the CMS's approval process to mandatorily enroll the SSI population in two upstate counties under the waiver.⁴⁰

Medicaid Disproportionate Share Hospital (DSH) and Related Payment Programs

Medicaid DSH. New York operates a comparatively large Medicaid DSH program with spending that totaled \$1.8 billion in 1998. Overall the program's structure has not altered in recent years: State funding comes from several sources, with the intergovernmental transfers the biggest.⁴¹ Provider taxes and state general funds are also used to support the program. Unlike many other states, New York does not "retain" federal DSH funds to be used for other purposes. Instead, the bulk of federal DSH dollars are paid to private or local hospitals.

New York's Medicaid DSH expenditures dropped substantially in the late 1990s, from \$2.9 billion in 1995 to \$1.8 billion in 1998. Some of this decline is tied to the "budget neutrality" provisions of New York's 1115 Partnership Plan waiver. In brief, under a Section 1115 waiver, a state must show CMS that the federal government will spend no more under the demonstration program than it would have spent otherwise. In other words, the waiver program has to be budget neutral for the federal government. As part of its Partnership Plan waiver negotiations, New York in essence traded some of its DSH spending to be allowed to do other things under the waiver, such as getting federal match for the Safety Net population. Another factor accounting for the drop in DSH spending was the DSH provisions included in the 1997 Balanced Budget Act which cut New York's federal DSH allotment nearly \$239 million over the 1998 to 2002 time period.

Respondents indicated that neither the decline in DSH funding nor the BBA cutbacks has been a major policy issue—for state policymakers or hospitals. One explanation offered was that with the 1997 approval of the Partnership Plan, the state's Section 1115 waiver program, New York hospitals received a substantial amount of federal funds through the Community Health Care Conversion Demonstration Project (CHCCDP). An adjunct to the state's waiver, CHCCDP provides \$1.25 billion in federal funds (no state match is required) over the five-year waiver demonstration period. CHCCDP funds are targeted to safety net hospitals and are intended to help these facilities restructure their delivery systems and retrain their workers to compete in the new managed care environment.

Upper Payment Limit Programs. While New York has a small hospital upper payment limit (UPL) program, its nursing home UPL program, which began in 1995, has been the state's primary activity in this area. Spending nearly \$1 billion in Medicaid funds (federal and state) in 2000, New York's UPL program is structured much like other states' programs: State funding is provided through intergovernmental transfers from nursing homes operated by counties or the Health and Hospital Corporation in New York City.⁴² Federal Medicaid matching funds, amounting to about \$500 million, are then secured. Through the program, the overall net gain to nursing homes is about \$100 million while the state gains about \$400 million.

According to respondents, as much as \$950 million of the \$1 billion program is potentially in jeopardy with the passage of the federal Beneficiary Information and Protection Act (BIPA) of 2000. Under BIPA, Medicaid provisions call for the phasing out of programs such as the New York nursing home UPL program. However, as of this writing, the final regulations on the BIPA UPL measures have been developed, but it is unclear what the fiscal implications might be for New York.

Also unclear at this point is how the state will respond if it loses the UPL funds. According to industry officials, the assembly budget resolution contained a provision to get additional Medicaid nursing funds as a way to help backfill the potential loss in UPL dollars. However, neither the senate resolution nor the governor's budget contained a similar provision. Indeed, as discussed below, the governor has proposed cutting Medicaid nursing home funding.

Pharmaceutical Assistance to the Aged: The EPIC Program

New York established the Elderly Pharmaceutical Insurance Coverage (EPIC) program in 1987 to subsidize the cost of prescription drugs for seniors, based on annual income. EPIC is a cost-sharing program for senior citizens over age 65 who are not enrolled in Medicaid. Initially program eligibility was limited to individuals with annual incomes up to \$18,500 or married couples with annual incomes under \$24,400. However, as part of HCRA 2000, EPIC was expanded to include singles with annual incomes up to \$35,000 and couples with combined incomes of up to \$50,000. It is expected that the expansion will boost enrollment from roughly 120,000 to 200,000 seniors.

EPIC provides subsidized prescription coverage through two different plans, based on the enrollees' income: (1) the Fee Plan, for individuals with incomes no higher than \$20,000 per year or for couples with incomes no higher than \$26,000 per year, provides financial assistance for an annual fee based on income; and (2) the Deductible Plan, for individuals earning between \$20,000 and \$35,000 or couples earning between \$26,000 and \$50,000 per year, subsidizes the cost of prescription drugs after seniors meet an annual deductible. Under the deductible plan, enrollees save approximately 50 percent of prescription drug costs over the course of a year.

Issues in Long-Term Care for Older People and Younger Persons with Disabilities

New York's commitment to a strong health care system extends to the provision of long-term care (LTC). In 1998, the state spent more than \$12 billion on Medicaid LTC—accounting for nearly 45 percent of New York's total Medicaid spending (table 4). On a per enrollee basis, New York's spending for elderly, blind, and disabled beneficiaries is double the national average.⁴³ New York's high LTC costs are related to the state's comprehensive benefits, to innovative programs, to the many Medicaid estate planning attorneys who guide the elderly in divesting their assets, and to a system that is fragmented and difficult to regulate.⁴⁴ The high spending level is also related to the high proportion of poor elderly living in New York. In 1998, the state had 14.5 percent of seniors aged 65 and older living in poverty, compared with 9.8 percent nationally. As will be discussed in this section, the state is actively trying multiple strategies to help control LTC spending to address these fiscal problems. Such strategies include reducing Medicaid reimbursement, maximizing

Medicare, limiting services, promoting managed care programs, and encouraging residents to purchase long-term care insurance.

Nursing Home Care

New York operates a sizeable nursing home industry, with 659 facilities and a total of about 120,000 beds.⁴⁵ The system has grown in recent years with a 10 percent increase in total beds between 1995 and 1999, a significant increase compared with the national average of 3.2 percent.⁴⁶ While the number of beds has increased, mirroring national trends, occupancy rates in New York have fallen in recent years: In the mid-1990s, occupancy was about 98 percent; in 2001, it has dropped to about 95 percent.⁴⁷ This decline was attributed to two main factors: more alternatives and a better economy.

As noted earlier, New York spends a considerable amount on long-term care, particularly nursing home care. In 1998, nearly 50 percent of the state's LTC Medicaid spending went to nursing facilities, totaling nearly \$6 billion.⁴⁸ Further, nursing home spending has increased on average 8 percent per year between 1995 and 1998, almost twice the national rate. As a result of these high and growing costs, Governor Pataki has sought to curtail Medicaid nursing home spending, on several occasions in recent years.

Among other possible solutions, the governor has proposed not reimbursing for capital expenditures for additional nursing homes being built—so-called “pipeline” nursing homes. According to state officials, the reason for targeting these facilities is that there are already enough nursing homes to meet demand. In his 2001 state of the state address, the governor proposed several provisions—totaling approximately \$330 million (federal, state, and local)—to cut state Medicaid funding for nursing homes. These included eliminating automatic “inflationary” payments to nursing homes and supplemental payments to homes with more than 300 beds. However, both the assembly and senate budget resolutions rejected these proposed cuts, because of concerns about the impact on quality of care as well as labor force shortage issues in the nursing home sector. The shortage of health care workers, especially in the nursing home market, is almost universally acknowledged among key stakeholders as being one of the biggest health care issues that New York currently faces.

According to respondents, another factor contributing to the governor's desire to cut nursing home spending stems from the belief that nursing homes are making too much profit from Medicaid. Soon after Governor Pataki released his 2001 budget, he was quoted as saying that “nursing homes have been ‘banking’ profits instead of using them for capital improvements and increasing staff sizes.”⁴⁹

The nursing home industry counters that the market is a “tale of two cities.” That is, a small number of predominantly down-state, for-profit homes are making substantial profits but the bulk of homes are just making ends meet. According to industry representatives, the nursing home market has had considerable financial difficulties in recent years. A number of factors were cited. A key factor has been rising labor costs because of the shortage of workers: To attract new employees, homes have had to increase salaries and benefits, driving up costs. The perceived inadequacy of Medicaid reimbursement was cited as another factor. Given that Medicaid accounts for the bulk of nursing homes' revenues, the program's professed low rates were viewed by the industry as a significant reason for the current financial state of nursing homes.

While nursing home representatives maintain that rates are insufficient, the state has not enacted—though the administration has proposed—any new rate cuts since the Boren Amendment was repealed in 1997. As mentioned earlier, the industry is particularly concerned about rates in the future: If the economy begins to slow, Medicaid spending generally begins to increase, often becoming a major budget target. Industry representatives worry that without the Boren Amendment on the books, the state may successfully impose rate cuts.

Quality of care in New York's nursing homes has become a key issue in recent years following reports of serious quality of care violations in 1998.⁵⁰ In response to these reports,

the state has stepped up efforts to monitor quality of care in LTC facilities. In 2000, additional funding was set aside to hire at least 80 additional nursing home inspectors, and lawmakers enacted legislation that requires an applicant for nursing home administrator licensure to pass an examination before receiving a license. In 2001, Governor Pataki proposed further nursing home quality improvement measures including criminal background checks for all nursing home employees and increased fines for providers found to be noncompliant. The governor also proposed establishing a centralized nursing home complaint hotline, which now exists in the Department of Health.

Home- and Community-Based Care

Historically, New York has been considered a model in its provision of home- and community-based services in light of its extensive provider network, generous benefits, and innovative programs.⁵¹ In 1999, New York led the states in Medicaid spending for home- and community-based services per person for older persons. It also led the nation in having the highest percentage of Medicaid beneficiaries receiving home care services.⁵²

Among other programs, New York operates the most extensive personal care program in the country, accounting for nearly half of the national Medicaid spending for personal care. In addition, New York operates a comprehensive home- and community-based waiver program, called the Long-Term Home Health Care Program, which provides nursing home level home care for chronically ill individuals regardless of age. In 1999, New York spent \$1.6 billion on its waiver programs, accounting for about 13 percent of the state's total LTC expenditures. Another important community-based program is New York's Medicaid home health care program. In addition to Medicaid, New York also sponsors some state-funded, community-based programs including Supplemental Nutrition Assistant Program and Expanded In-Home Services for Elderly Program.⁵³

Unlike some other states, New York, with its already strong community-based care (CBC) system, has not substantially expanded community-based services in recent years. Instead, policymakers have been working on strategies designed to control LTC spending. Managed LTC is one such cost-containment strategy, and it was a major component of the Long-Term Care Integration and Financing Act passed in 1997. Another cost-containment strategy is promoting the purchase of long-term care insurance. However, it should be noted that both these initiatives are still very much works in progress. For example, with roughly 2.4 million elderly individuals in the state, there were only 21,000 active long-term care insurance policies in 1998.⁵⁴ Yet another long-term care strategy is the home-care target initiative, which was designed to encourage better management of the local district's long-term care system by bringing certain districts' spending down to levels in keeping with their regional counterparts.

At the same time, the home care industry has felt the impact of the 1997 Balanced Budget Act Medicare home health provisions, which include the introduction of an interim prospective payment system and new reporting requirements. As a result of these trends, there have been a number of consolidations in the New York home health market in the late 1990s.

Overlaying programmatic changes, industry representatives and other observers believe that there has been a gradual erosion of support for home care among New York officials.⁵⁵ One important change cited was the dismantling of the Office of Continuing Care, within the Department of Health, which had been the lead group for home care policy within the state. Programmatic responsibility for home care within the department now resides in the Office of Medicaid Management, the Office of Health Systems Management, and the Office of Managed Care, making home care much less visible, according to several observers. However, state officials believe that spreading home- and community-based program responsibilities across these offices will give greater visibility and attention to long-term care issues.

In 1999, the U.S. Supreme court ruled in *Olmstead vs. L.C.* that inappropriate institutionalization as a result of state-run public long-term care programs is discrimination against people with disabilities. New York has not made any major changes to its

community-based care system in response to the Olmstead decision. Although New York officials were “aware of the decision” and are looking at their system to see what needs to be done to comply with it, they are not actively undertaking new initiatives.⁵⁶ State officials view New York as being a national leader in offering a wide range of home- and community-based services to their residents.

However, some observers cautioned that there are some “Olmstead-like” cases working their way through the New York courts. At issue is the geographic variation in several of New York’s community-based programs including the personal care and the long-term home health care waiver programs. For example, an institutionalized, chronically disabled person living in a rural upstate county could claim that if he or she had access to 24-hour personal care as some New York Medicaid beneficiaries have, they could live in the community. At this point it is not known how these cases will be decided, but they could have important financial implications for New York and other states.

Conclusion

New York has a tradition of funding an extensive health care system for its low-income population. By almost any measure—eligibility, provider payment, services covered—the state operates one of the most comprehensive Medicaid programs in the country. New York also has one of the most generous SCHIP programs. Between Medicaid and CHPlus, the state now covers all children up to age 19 with incomes up to 250 percent of FPL, among the highest levels in the nation. In addition, New York has in place some of the most far-reaching small group and individual insurance reforms. Further, it has a number of well-funded subsidy programs to help support safety net providers.

Despite a conservative shift in the governorship in the mid-1990s, New York has maintained its reputation as being a national leader in health policy. In 1997, in an effort to control cost and improve quality, New York began a statewide initiative to shift more than two million of its Medicaid recipients into managed care, one of the largest such shifts in the country.

Then in 1999, New York policymakers focused their attention on addressing the state’s growing number of uninsured, which totaled more than 2 million nonelderly individuals in 1999.⁵⁷ With the Health Care Reform Act of 2000, the state took major steps to expand health insurance to the uninsured. With pressure from several stakeholder groups (most prominently hospitals and labor unions) as well as community groups, New York enacted Family Health Plus, a Medicaid expansion, which is directed at low-income uninsured individuals. In an effort to shore up the small business and individual health insurance markets, the state also adopted the Healthy New York program as part of HCRA. Together, these initiatives are designed to extend coverage to about one million New Yorkers at a cost to the state of nearly \$500 million over three and one-half years. Beyond these coverage expansions, the HCRA legislation also contained funding for a range of other new health programs including funding for rural hospitals, an expansion of a state-funded drug program for seniors, and medical education.

New York was able to undertake these efforts in large part because of its booming economy that, as of early 2001, continues to be in strong shape. In addition, New York began receiving its tobacco settlement money in 2000, part of which went to fund HCRA 2000 initiatives. Monies from a cigarette tax increase also helped finance some of the HCRA programs.

Although the state adopted many major changes to its health care systems in the later part of the 1990s, implementation has been limited. Its Medicaid managed care initiative has not moved as quickly as expected: Only about one-third of the planned managed care population had been mandatorily enrolled in the waiver program as of mid-2001. Further, the Healthy New York program had only 900 enrollees at that time. In addition, the Family Health Plus initiative had not been implemented due to delays in obtaining a waiver from the federal government. Since our visit, New York has been granted a waiver and Family Health Plus is currently scheduled to become operational in October 2001.

Besides program implementation delays, New York, like many other states, is facing projected increases in Medicaid spending: In 2001, state Medicaid expenditures are expected to increase 6.6 percent—a sharp increase from relatively flat Medicaid growth in 2000. Owing to the strength of New York’s fiscal situation, policymakers were not much concerned about the spending jump at the time of our site visit. However, given the current economic downturn and the September 11 attack on the World Trade Center, this sentiment could quickly change. A continued rise in Medicaid spending coupled with the economic downturn may put considerable pressure on the state’s budget as Medicaid is by far the single largest budget item, accounting for 32 percent of New York’s total spending in 2000.

Such a situation could also raise important and difficult questions for the state policymakers: Medicaid would be in direct competition with other budget items, including education, which has been a policy priority of Governor Pataki’s. A rise in Medicaid spending could also limit the ability to enact tax cuts, another top agenda item for the Pataki administration.

In sum, during the late 1990s, New York continued its long-standing practice of pushing the envelope of its health care system to improve care for its low-income residents. However, considerable work is needed to translate the many new initiatives into successful programs. An important challenge is getting people to enroll in the new programs and then keeping them enrolled. If the new programs do not meet their goals, New York and its health care providers will continue to confront the pressures of a growing uninsured population. At the same time, given the economic downturn, the state may also face very real budget pressures from rising Medicaid spending, which could raise some very tough issues for New York policymakers.

Endnotes

1. It is important to note that counties are responsible for only 10 percent of the Medicaid long-term care costs.
2. The discrepancy between numbers cited in this paragraph and numbers listed in table 2 are attributed to the use of different data sources. Numbers in the paragraph come from the Current Population Survey (CPS) whereas numbers in table 2 come from the National Survey of America’s Families. Authors’ tabulations of 1994 and 1998 CPS data.
3. Wynn, Roberta, Stephanie Teleki, and E. Richard Brown. 2000. “Differences in Access to Health Care Among the Moderate- and Low-Income Population Across Urban Areas.” UCLA Center for Health Policy Research, Los Angeles. July.
4. Authors’ tabulation of 1994 and 1998 CPS data.
5. Scherzer, Mark. 2000. “Expanding Insurance Coverage for Individuals.” Robert Wood Johnson Foundation, State Coverage Initiatives Program Regional Workshops 2000, June 14–15, Washington, D.C.
6. Scherzer 2000.
7. Specifically, policymakers changed the definition of small group size (e.g., expanding the definition of small group from 3–50 to 2–50 workers), created antidiscrimination provisions, and added certification of creditable coverage. The state also conformed to the state law on tax deductibility of premiums paid for long-term care and brought the guaranteed renewal, guaranteed issue, and preexisting condition exclusion period provisions into compliance with HIPAA.
8. Previously, the New York Prospective Hospital Reimbursement Method (NYPHRM) determined hospital payment rates for all payers, including Medicaid, private insurance, and self-insured plans, but not HMOs or Medicare. As increased competition among managed care plans reduced hospital costs in many states, New York’s system was seen as being too costly and having considerable excess capacity and thus the movement to deregulate the market.
9. Healthcare Association of New York State. 2001. *Health Care under Stress: A Financial Profile of Hospitals and Health Systems in New York State*. Albany.
10. Modern Health. <http://www.modernhealthcare.com>.
11. Healthcare Association of New York State. 2001. *Health Care under Stress: A Financial Profile of Hospitals and Health Systems in New York State*. Albany.
12. The \$1.25 billion obtained as part of the Community Health Care Conversion Demonstration Project is only federal money; no state matching dollars are required.

13. AFDC stands for Aid to Families with Dependent Children, which was replaced by TANF as part of welfare reform in 1996.
14. National Conference of State Legislatures. 2001. *State Fiscal Outlook for 2001: February Update*. <http://www.ncls.org/programs/fiscal/upsfo2001.htm>. [date accessed: March 1, 2001].
15. McKinley, James, and Richard Pérez-Peña. 2001. "Pataki Pledges 'Bold Steps' and Job Cuts." *New York Times*. 17 October.
16. These data are from the New York State Department of Health and are based on average monthly enrollment during a calendar year. In contrast, the other data presented in this section are from the Health Care Financing Administration 2082 reports, which are only available up to 1998.
17. Based on Urban Institute estimates on data from CMS-2082 and CMS-64 reports.
18. In addition to a Medicaid expansion to children, New York, as part of its 1997 1115 waiver, now gets Medicaid match for its Home Relief population. (See "Medicaid Trend" section for more details.)
19. Smith, Vernon. 2000. *CHIP Enrollment: June 2000*. Prepared for The Kaiser Commission on Medicaid and the Uninsured. Lansing, Michigan: Health Management Associates. June
20. Kenney, Genevieve, Frank Ullman, and Alan Weil. 2000. "Three Years into SCHIP: What States Are and Are Not Spending." Washington D.C.: The Urban Institute. *Assessing the New Federalism Policy Brief A-44*.
21. New York State Evaluation: April 15, 1998–September 30, 1999. State Evaluation of Children's Health Insurance Plans under Title XXI of the Social Security Act. Submitted to CMS March 31, 2000, in compliance with Title XXI of the Social Security Act.
22. Dutton, Melinda, Kimberly Chin, and Cheryl Hunter-Grant. 2001. *Creating a Seamless Health Insurance System for New York's Children*. New York: The Commonwealth Fund.
23. Bahrach, Deborah, Robert Belfort, and Karen Lipson. 2000. *Closing Coverage Gaps: Improving Retention Rates in New York's Medicaid and Child Health Plus Programs*. New York: Kalkines, Arky, Zall, & Bernstein.
24. Hill, Ian, and Amy W. Lutzky. Forthcoming. *Understanding SCHIP Enrollment and Retention: An Analysis of Processes and Outcomes*. Prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, D.C.
25. *American Health Line*. 2000. "Statelines—New York: State's CHIP Plagued by Enrollment Errors." 10 October. <http://nationaljournal.com>.
26. In addition, some believed that conducting enrollment through health plans, rather than local social services departments, would eliminate the stigma some applicants associated with applying for Medicaid.
27. Initially, parents with income up to 133 percent of FPL will qualify. Beginning in October 2002, eligibility limits will be expanded to 150 percent of FPL.
28. The principal difference between FHPlus and Medicaid is that FHPlus does not cover long-term care services.
29. Pérez-Peña, Richard. 2000. "Wrangling U.S. and Albany Delays Health Plan for Working Poor." *New York Times*. 22 April. Bureau of National Affairs. 2001. *Governor Pataki Comes under Criticism over Delay in Program for Uninsured*. BNA Health Care Policy Report. May.
30. Bureau of National Affairs. 2001. *Governor Pataki Comes under Criticism over Delay in Program for Uninsured*. BNA Health Care Policy Report. May.
31. In addition, as adjunct to the waiver, federal funds are provided under the Community Health Care Conversion Demonstration Project to help safety net hospitals restructure their delivery systems for the new, more competitive managed care environment. This component is discussed elsewhere.
32. The 680,000 figure represents total managed care enrollment—both voluntary and mandatory. Considering mandatory enrollment alone, the number of enrollees totaled 363,000 individuals as of December 2000 (New York state coalition of prepaid health service plans, December 2000). Mahan, Roberta. 2000. *Medicaid Managed Care Enrollment Report for December, 2000*. Albany, New York: Bureau of Managed Care Financing Office of Managed Care, New York State Department of Health.
33. The safety net population consists primarily of New York's general assistance population.
34. SSI recipients can voluntarily enroll in managed care.
35. Initially, the state had planned to implement two types of SNPs, one for persons with HIV and one for persons with mental illness. The state is moving forward with developing the HIV SNPs but has abandoned its efforts to develop mental health SNPs because the legislation that authorized mental health SNPs expired. As of this writing, the state hopes to have contracts in place for voluntary HIV SNP enrollment by the end of 2001.
36. Coughlin, Teresa, Sharon Long, Jessica Kasten, and Susan Goldenson. 2000. "New York's Partnership Plan: An Early Look at Program Implementation." Urban Institute Working Paper 06613-008-04. Washington, D.C.: The Urban Institute.
37. Commercial plan was defined by the authors as Medicaid enrollment accounts for 50 percent or less of overall plan enrollment. Coughlin, Teresa, Sharon Long, and John Holahan. 2001. "Commercial Health Plan Participation in Medicaid Managed Care: An Examination of Six Markets." *Inquiry* 38: 22–34.

38. New York State Coalition of Prepaid Health Services Plans. 2001. *Managed Care Enrollment Trends 2000 Year End Report*. New York.
39. Coughlin, Teresa, Sharon Long, and John Holahan. 2001. "Commercial Health Plan Participation in Medicaid Managed Care: An Examination of Six Markets." *Inquiry* 38: 22–34.
40. While New York has approval for mandatory enrollment of its SSI population under the Partnership Plan, it must go through a readiness review on a county-by-county basis.
41. Coughlin, Teresa, Leighton Ku, and Johnny Kim. 2000. "Reforming the Medicaid Disproportionate Share Hospital Program." *Health Care Financing Review* 22(2): 137–57.
42. The Health and Hospital Corporation is the entity that operates publicly owned hospitals and clinics in New York City.
43. An Urban Institute estimate based on data from HCFA-2082 and HCFA-64 reports.
44. Raetzman, Susan, and Susan Joseph. 1999. *Long-Term Care in New York: Innovation in Care for Elderly and Disabled People*. New York: The Commonwealth Fund. September. <http://www.cmwf.org>.
45. Nawrocki, Heather, and Steven Gregory. 2000. *Across the States 2000. Profiles of Long-Term Care Systems*. Washington, D.C.: AARP Public Policy Institute.
46. Nawrocki and Gregory 2000.
47. Ibid.
48. An Urban Institute estimate based on HCFA-64 data.
49. Pérez-Peña, Richard. 2000. "Wrangling U.S. and Albany Delays Health Plan for Working Poor." *New York Times*. 22 April.
50. *American Health Line*. 16 March 1998 and 24 August 1998. <http://nationaljournal.com>.
51. Wiener, Joshua M., and David G. Stevenson. 1998. *Long-Term Care for the Elderly: Profiles of Thirteen States*. Washington, D.C.: The Urban Institute. *Assessing the New Federalism Occasional Paper No. 12*; and Raetzman, Susan, and Susan Joseph. 1999. *Long-Term Care in New York: Innovation in Care for Elderly and Disabled People*. New York: The Commonwealth Fund. September. <http://www.cmwf.org>.
52. Nawrocki and Gregory 2000.
53. Other home and community-based programs in New York include New York's Consumer Directed Personal Assistance Program, Assisted Living Program, Care at Home Program, The OMRDD Home and Community-Based Waiver, the OMH Waiver, and the Traumatic Brain Injury Waiver.
54. Raetzman and Joseph 1999.
55. Ibid.
56. New York is developing proposals to submit for Olmstead grant funding.
57. National Survey of America's Families, 1999.

Table 1 Notes

- a. U.S. Census Bureau, Population Estimates Program, Population Division. "State Population Estimates: Annual Time Series, July 1, 1990, to July 1, 1999." <http://www.census.gov/population/estimates/state/st-99-3.txt>. And <http://www.census.gov/statab/www/states/ny.txt>.
- b. U.S. Census Bureau, Population Estimates Program, Population Division. "States Ranked by Hispanic Population, July 1, 1999." <http://www.census.gov/population/estimates/state/rank/hisp.txt>. And "States Ranked by Black Population, July 1, 1999." <http://www.census.gov/population/estimates/state/rank/black.txt>. Note: National population percentages are as of July 1, 1999, from "Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin." <http://www.census.gov/population/estimates/nation/intfile3-1.txt>.
- c. U.S. Census Bureau. 1999. *Statistical Abstract of the United States: 1999* (119th edition). Table 42. Washington, D.C.
- d. U.S. Department of Commerce, Bureau of Economic Analysis, News Release September 12, 2000: *1999 State Per Capita Personal Income Revised*. Table 1: Per Capita Personal Income, by State and Region, 1995–1999 (Dollars). <http://www.bea.doc.gov/bea/newrel/spi0900.htm>. Note: Percent change calculated in inflation-adjusted dollars by the Urban Institute based on the CPI-U as published in the *Economic Report of the President*. 2000. Table B-60. Washington, D.C.: U.S. Government Printing Office, February.
- e. U.S. Department of Labor, Bureau of Labor Statistics. 2000. "State and Regional Unemployment, 1999 Averages." Released February 2000. <http://www.bls.gov/bls/newsrels.htm>.
- f. Zedlewski, Sheila. 2000. "Family Economic Well-Being." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute. Notes: Percent change in poverty rates (1996–1998) calculated by the Labor and Social Policy Center, The Urban Institute. 1998 national and state adult and child poverty estimates show statistically significant decreases from the 1996 estimates at the 0.10 confidence level, calculated by the *Assessing the New Federalism* project, The Urban Institute.

- g. The National Governors' Association. 2000. "The Governors, Political Affiliations, and Terms of Office 2000." <http://www.nga.org/Governor/GovMasterList.htm>.
- h. National Conference of State Legislatures. 1999. "Directory of State Legislatures, Online. Partisan Composition of State Legislatures House and Senate." D indicates Democrat, R indicates Republican, I indicates Independent, other indicates Other, and V indicates Vacant. <http://www.ncsl.org>.
- i. Two Urban Institute calculations: (1) Average monthly number of AFDC 1996 recipient children divided by number of children in poverty 1996: U.S. Department of Health and Human Services. Administration for Children and Families. 1997. *Characteristics and Financial Circumstances of AFDC Recipients FY 1996*. Table 18. "Percent Distribution of AFDC Recipient Children by Age (October 1995–September 1996)"; (2) Average monthly number of TANF 1998 recipient children divided by number of children in poverty 1998: U.S. Department of Health and Human Services. Administration for Children and Families. 1999. *Second Annual Report to Congress August 1999*. Table 9:22. "Percent Distribution of TANF Recipient Children by Age Group (October 1997–September 1998)." The numbers of children in poverty in 1996 and 1998 are Urban Institute calculations from the *National Survey of America's Families II*.
- j. Based on three sources: (1) Urban Institute's TRIM [Transfer Income Model]; (2) Smith, Vernon K. 1999. "Enrollment Increases in State CHIP Programs: December 1998 to June 1999": Health Management Associates, July; (3) Urban Institute analysis of 1999 SCHIP [State Children's Health Insurance Program] Annual Report. Rules for 1996 and 1998 are policies in place the majority of the year. Rules for 2000 represent plans approved as of January 1, 2000.
- k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.
- l. In 1998, some states' thresholds represent Medicaid eligibility, and others are either Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.
- m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are eligible only through Medicaid.

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