



As Arizona Goes, So Goes the Nation: How Medicaid Ruins the States' Fiscal Health

By Michael S. Greve and Philip Wallach

The Government Accountability Office (GAO) has issued a bleak report on the long-term financial prospects of state and local governments.¹ Their fiscal balances, GAO's simulations show, will rapidly deteriorate in less than a decade. For 2007–2050, GAO estimates a fiscal gap on the order of \$10.6 trillion. GAO identifies Medicaid (along with health insurance expenditures for state and local employees and retirees) as the principal culprit. In some states, the crisis has already arrived. Arizona provides an early and stark illustration of Medicaid's ruinous effects.

All is not well in Senator John McCain's home state. Confronted with a general fund budget shortfall of more than \$1.3 billion, the Arizona legislature in June enacted modest cuts (primarily in community college and prison budgets), a stepped-up traffic enforcement system to produce some \$90 million in speeding tickets, and \$2 billion in new debt—half of it to close the hole in the \$10.9 billion budget. (The other half will fund university construction.) The budget is a stopgap measure that bodes ill both for next year's budget and for the state's fiscal future, and no Arizona politician pretends otherwise.

Measured as a percentage of the state's fiscal year 2008 general fund, Arizona's projected FY 2009 deficit was the most serious shortfall of any state, exceeding even California's. Cyclical factors contributed: Arizona is heavily exposed to the meltdown in the subprime mortgage market and its attendant economic and fiscal consequences. But then again, Arizonans have long

enjoyed a relatively modest, broad-based tax burden imposed on an economy that has for four decades been among the fastest-growing in the nation. How did the state get into such a pickle?

In a *Wall Street Journal* op-ed of uncommon chutzpah, Arizona governor Janet Napolitano attributes her state's travails to Washington's alleged failure to "pay its bills." Characterizing supposed cuts in federal transfer programs—including contemplated *and rejected* cuts—as federal "debts" to the states, she maintains that "Arizona would not be in deficit this year" if Washington paid up on only a few of its obligations.² The governor could not be more wrong. Arizona's fiscal crisis is due chiefly to the state's expansion of its Medicaid programs. That decision, in turn, is largely attributable to the perverse incentives created by Medicaid's inordinately generous transfers to the states. To oversimplify slightly, states get into fiscal trouble not because the feds shirk their obligations, but because they have made promises to pay in the first place. While Arizona's problems are exacerbated by a dysfunctional political system, the state's predicament illustrates a pervasive structural crisis.

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Taxes, Spending, and Federal Transfers

Despite a relatively conservative political climate, Arizona used to be a high-tax state. Over the decades, however, Arizona's tax burden has remained roughly constant, while that of many other states has risen. As a result, Arizona has improved its position relative to other states. By the most widely used measure (the Tax Foundation's index of state tax burdens), Arizona is now near the median in terms of combined state and local tax burden on citizens (see figure 1).

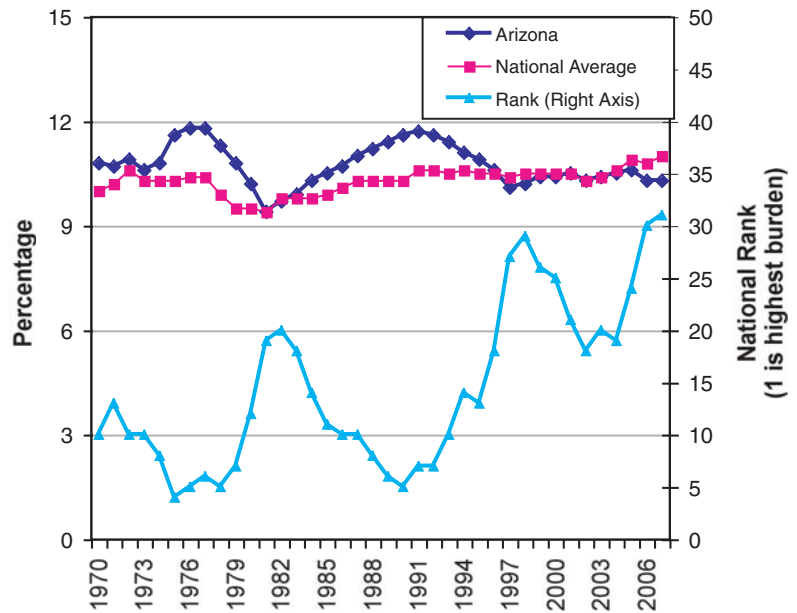
Over the past decade, however, restraint on the tax front has been accompanied by a lack of spending discipline. Between 1997 and 2006, inflation-adjusted per-capita state spending increased from a previously stable level of roughly \$3,300 to over \$4,200 (see figure 2).

Two factors explain the situation. First, Arizona has outperformed the U.S. economy for four consecutive decades. The 1990s were especially kind to Arizona, as the real size of its economy nearly doubled between 1990 and 2000. Sustained economic growth covered budgetary decisions that might otherwise have proven unsustainable.

Second, generous federal transfer payments have helped Arizona expand the size of government without commensurate tax increases. Federal spending in the state rose from \$6,823 per capita in 2000 to \$8,039 in 2005 (in 2007 dollars).³ In FY 2009, federal transfer payments to the state are expected to amount to \$8.31 billion, or 28.6 percent of the state's expenditures.

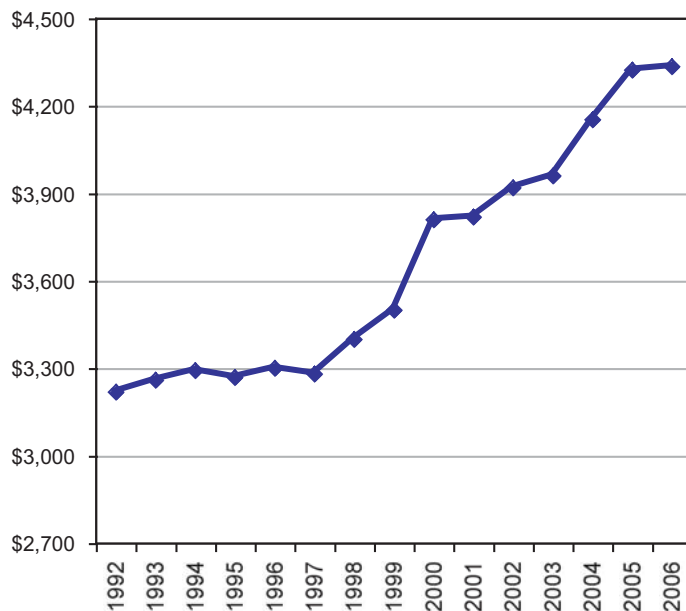
In Arizona, as elsewhere, federal funding principally sustains the service sector rather than the physical infrastructure. Three functions—health, welfare, and education—account for over 90 percent of federal transfers.⁴ The agency receiving the most funds is the hilariously misnamed Arizona Health Care Cost Containment System (AHCCCS), which administers the state's Medicaid program. AHCCCS has for several years accounted for well over half of all federal funds received.

FIGURE 1
AVERAGE STATE AND LOCAL TAX BURDENS



SOURCE: Tax Foundation, "Arizona State-Local Tax Burden Compared to U.S. Average," *Tax Data*, April 4, 2007, available at www.taxfoundation.org/taxdata/show/441.html (accessed July 3, 2008).

FIGURE 2
ARIZONA'S PER-CAPITA EXPENDITURES



SOURCE: Census Bureau, Governments Division, *State and Local Government Finances 1992–2006* (Washington, DC: Census Bureau, 2006).

Like many smaller states (especially in the southwest and mountain west), Arizona has been a net beneficiary of a "cooperative federalism" that shuffles tax dollars

TABLE 1
PERVERSE INCENTIVES

Arizona's Incentive to Increase Spending	Arizona's Incentive <i>Not</i> to Reduce a Matched Program
With a Medicaid matching rate of 66.2 percent, for each dollar Arizona spends on Medicaid, the federal government sends the state \$1.96.	To reduce state Medicaid spending by \$1, Arizona would have to reduce total Medicaid spending by \$2.96.
With an SCHIP matching rate of 76.34 percent, for every dollar Arizona spends on SCHIP, the federal government sends the state \$3.23.	To reduce state SCHIP spending by \$1, Arizona would have to reduce total SCHIP spending by \$4.23.

through Washington, D.C., and returns them to the states. The state's balance of payments has been consistently positive, meaning that federal transfers have exceeded Arizona taxpayers' federal tax payments.⁵

However, the fiscal effects of federal-to-state transfers are not unambiguously positive, even for net recipient states like Arizona. While federal grant programs may have some fiscal substitution effect, on balance they increase state and local taxation and spending. By making program expansions look cheap and making cuts look outrageously expensive, federal matching grants ratchet up spending and taxes and tend to exacerbate the states' boom-and-bust budget cycles.⁶ All else equal, those effects increase in proportion to the matching program's size and generosity.

Far and away the biggest federal transfer program, accounting for \$190.6 billion—43 percent of all federal transfer payments to states and localities in FY 2007—is Medicaid. The program features a very high federal funding ratio coupled with highly decentralized spending authority and a lack of effective federal fiscal or program control. Arizona's experience illustrates the malign effects of that form of fiscal decentralization.

Medicaid: The Arizona Experience

Under Medicaid, the federal government reimburses between 50 and 77 percent of a state's qualifying expenditures, depending on the state's wealth. Put differently, a state can purchase a dollar's worth of Medicaid health services at a cost of less than fifty cents to itself. Less happily, it cannot cut a dollar from its domestic budget without "losing" federal transfers. Table 1 shows Arizona's basic fiscal calculus with respect to Medicaid and the

related, even more generous federal State Children's Health Insurance Program (SCHIP).

Medicaid is an *uncapped* entitlement program, meaning that total as well as federal costs are unconstrained by any federal fiscal limit. Federal programmatic controls are likewise weak. While Medicaid mandates the coverage of certain services and populations, the lion's share of expenses is incurred for "optional" services for beneficiaries (especially the elderly), which the states may, but need not, provide as a condition of federal funding. Throughout the Bill Clinton and George W. Bush administrations, the federal government has readily granted the states waivers from Medicaid mandates and limitations. Some states now cover families with incomes of up to 275 percent of the poverty level. Almost all provide long-term care for the poor and low-income elderly. In a few states, one-third of the population is now on Medicaid. In Arizona, about one-fifth of the population receives health care coverage through AHCCCS.

Due to its structure, Medicaid has been the primary cause of a huge increase in federal grants to the states. For example, the real per-capita size of Medicaid grants has grown almost exponentially (see figure 3 on the next page).

Unsurprisingly, Medicaid expenditures constitute an ever-growing share of state expenditures. In 1987, that share amounted to slightly more than 10 percent. In 1992, the number was 17.8 percent; in 2006, 22.2 percent.⁷

In Arizona, the crowding-out has been far more severe and rapid. The state's involvement with Medicaid did not begin until 1982, with the creation of AHCCCS. Previously, Arizona had been the only state to reject federal Medicaid funds. (Individual counties provided a piecemeal system of health care for the state's indigent.)

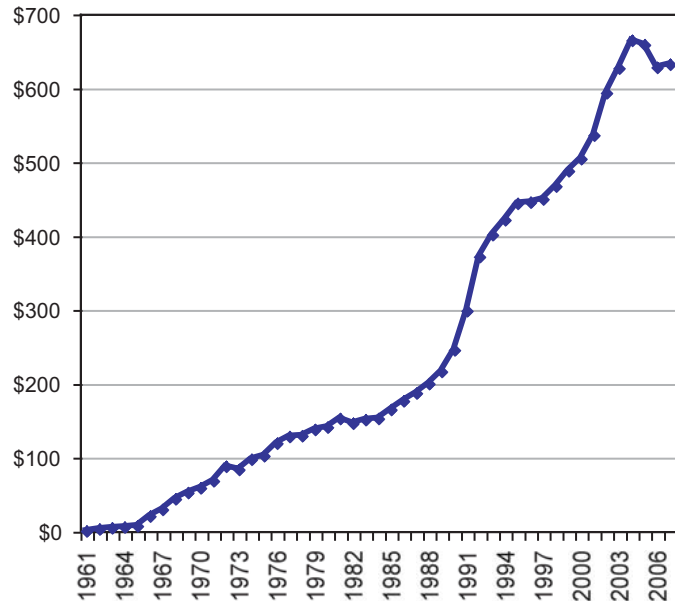
AHCCCS was the first statewide Medicaid program to use managed care, offering recipients a variety of private and public health plans that channeled them into private physicians' offices. As recently as 2002, AHCCCS was cited as a model Medicaid program.

But AHCCCS has since caused much fiscal and budgetary trouble. These difficulties can be traced to the enactment of Proposition 204 in 2000, which substantially expanded Medicaid-eligible populations and services. Proposition 204 significantly loosened eligibility requirements for several AHCCCS programs. (For example, it allowed persons with incomes above the poverty line to spend down their income on medical bills to qualify for coverage.) The background and origins of that fateful voter referendum merit a brief discussion.

In 1998, state attorneys general and the country's major tobacco companies signed the so-called Master Settlement Agreement (MSA), which established a nationwide regulatory regime for the sale and marketing of tobacco products and, moreover, entitled the states to a stream of payments, originally estimated at \$206 billion over the first twenty-five years of the MSA. (Arizona's share of those proceeds is 1.5 percent.) Nominally, the payments were supposed to make the states whole for past tobacco-related health care expenditures under Medicaid. On that interpretation and under then-extant law, the greater portion of the recovery should have reverted to the federal government, which had incurred those expenses in the first instance. The states, however, persuaded Congress to amend federal law so as to allow them to keep the entire recovery.

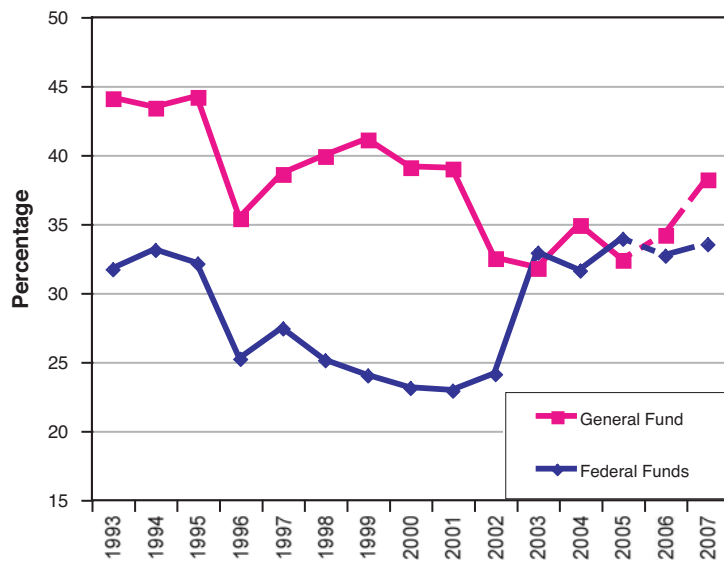
In a fine illustration of Medicaid's incentive effects, many states decided to leverage the "recovery" of expenditures they had not incurred into a second payment stream of federal dollars by devoting the tobacco payments to Medicaid programs. That, in substance, was the intent behind Arizona's Proposition 204. Each MSA windfall dollar

FIGURE 3
FEDERAL GRANTS TO STATES FOR MEDICAID



SOURCES: Office of Management and Budget (OMB), *Historical Tables: Budget of the United States Government, Fiscal Year 2009*, "Historical Table 16.1" (Washington, DC: OMB, 2008), available at www.whitehouse.gov/omb/budget/fy2009/pdf/hist.pdf (accessed July 3, 2008); Census Bureau, Population Division, "National Intercensal Estimates," available at www.census.gov/popest/archives/EST90INTERCENSAL/US-EST90INT-datasets.html (accessed July 3, 2008); and Federal Reserve Bank of St. Louis, *Economic Data—FRED*, "Series: GDPDEF, Gross Domestic Product: Implicit Price Deflator," July 1, 2007, available at <http://research.stlouisfed.org/fred2/series/GDPDEF?cid=21> (accessed July 3, 2008).

FIGURE 4
ARIZONA'S PER-CAPITA EXPENDITURES



SOURCE: National Association of State Budget Officers, *State Expenditure Reports, 1995–2007*, tables 3, 7, 12, 18, 28, and 43, available at www.nasbo.org/publicationsReport.php (accessed July 3, 2008).

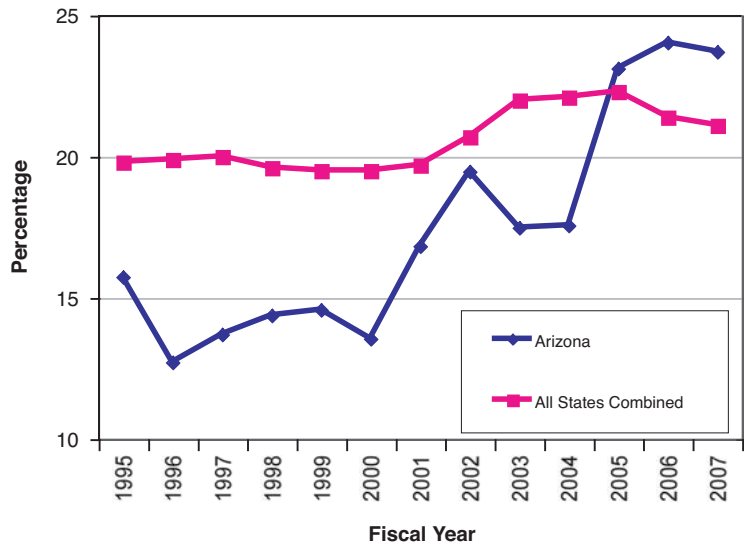
spent on Medicaid, the calculus went, would bring in another \$1.96 from the federal government.

In one sense, Proposition 204 paid off: after a prolonged downward drift, federal funds as a proportion of Arizona’s total spending rose as Proposition 204 kicked in (see figure 4 on the previous page).

The collateral effects, however, have been harrowing. Medicaid spending in Arizona was slightly over 10 percent of total spending in 1987. It hovered around 15 percent in the years prior to Proposition 204 and then rose sharply. One could argue that Proposition 204 simply brought Arizona—to that point a Medicaid “laggard”—up to the standard of other states. As figure 5 shows, however, Medicaid spending in Arizona now exceeds the average spending level. The trend is particularly striking because Arizona, as the second-youngest state in the nation, should have relatively low Medicaid expenses. (The elderly, not children, are the heaviest consumers of Medicaid expenditures.)

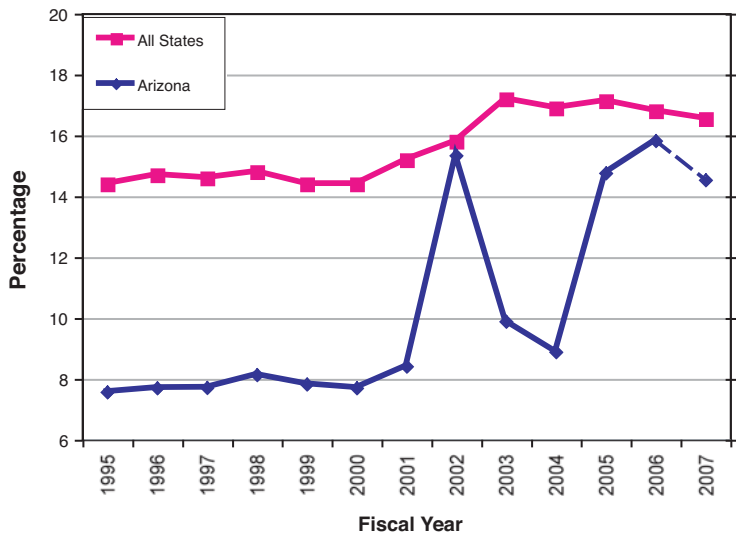
Contrary to the pro-204 campaign rhetoric at the time, it soon became clear that the MSA funds (and the federal dollars that they leverage) would not remotely cover Proposition 204’s expansion of the Medicaid population and services.⁸ As a result, general fund spending on Medicaid has also risen very sharply. The percentages in figure 6 are heavily affected by one-time budget maneuvers. Thus, the steep drop in 2003–2004 is partially attributable to the 2002 enactment of Proposition 303, which dedicated the proceeds of an increase in the tobacco excise tax to various programs within AHCCCS and effectively shifted some general fund spending into a “Tobacco Tax and Health Care Fund” administered by AHCCCS. Still, the fact remains that Medicaid spending has increased from a relatively stable pre-204 level of roughly 8 percent of general fund spending to a projected 14.4 percent in FY 2009. The raw numbers are more bracing. In 2000, Arizona general fund spending on Medicaid was just \$463 million. That figure is projected to grow to

FIGURE 5
PERCENTAGE OF TOTAL BUDGET SPENT ON MEDICAID, 1995–2007



SOURCE: National Association of State Budget Officers, *State Expenditure Reports*, 1995–2007, tables 3, 7, 12, 18, 28, and 43, available at www.nasbo.org/publicationsReport.php (accessed July 3, 2008).

FIGURE 6
PERCENTAGE OF GENERAL FUND SPENT ON MEDICAID, 1995–2007



SOURCE: National Association of State Budget Officers, *State Expenditure Reports*, 1995–2007, tables 3, 7, 12, 18, 28, and 43, available at www.nasbo.org/publicationsReport.php (accessed July 3, 2008).

\$1.5 billion in FY 2009, representing a threefold increase in less than a decade.

The extent to which one attributes Arizona’s budget travails to Proposition 204 depends on the baseline. Had the state shifted a chunk of preexisting general fund

Medicaid obligations to an MSA payment fund (as opposed to trying to leverage those funds into additional federal payments), it would have confronted no fiscal crisis at all. Had it held Medicaid general fund spending constant at 8 percent (that is, in line with other expenditures), the FY 2009 shortfall would still have been less than half the \$1.3 billion-plus amount—still not a pretty picture, but far more manageable. Slice the numbers as you will, though: Medicaid and Proposition 204 are the principal culprits. No other factor or set of factors comes close.

While certain features of Arizona politics have exacerbated the crisis in that state, the root cause is Medicaid's incentive structure.

Among the more demoralizing aspects of the Arizona legislature's budget debate is the fact that Medicaid and Proposition 204 have gone virtually unmentioned. While the legislature's research staff has consistently supplied sophisticated analyses of the basic facts and trends, no politician wants to tell the voters the truth. Putting aside the awkwardness of attacking a popular referendum, the political absurdity of proposing a three-dollar cut in services for a mere dollar in domestic savings has stopped even Goldwaterite legislators in their tracks. Those forces in Arizona politics resisted Medicaid participation until 1982—when the program was a shadow of its present self—because they knew that to play the game was to concede it. And so it has come to pass.

Is Arizona Special?

Medicaid and Proposition 204 have only just begun to wreak their havoc in Arizona. MSA tobacco payments have fallen well below predicted levels and will continue to fall, due mainly to declining smoking rates. Revenues from the aforementioned tobacco tax fund are affected by the same trend, which is further exacerbated by the fact that Arizona law forbids smoking in just about any public place except in Indian casinos. In short, Medicaid expenses will increasingly be paid out of the general fund.

The Arizona legislature is arguably the nation's most constrained legislature. It can do little to avert a fiscal train wreck, thanks largely to the conjunction of Proposition 204 with two other referendums. Proposition

108, adopted in 1992, requires a two-thirds majority in both houses to make a net increase in the state's revenue collection, thus effectively taking tax increases off the table. More fatefully, the 1998 Arizona Voter Protection Act requires a three-fourths majority of legislators to alter spending on programs created by referendum. Proposition 204—required spending is locked in unless three-fourths of both houses of the legislature vote to overrule.

The option of finding offsets for increased Medicaid spending elsewhere in the budget is illusory. Only the general fund and "other appropriated funds"—less than half of all state expenditures combined—are actually subject to the legislature's appropriation authority. "Other" appropriated funds are earmarked, and even within the general fund, about 60 percent of spending is essentially nondiscretionary, as it is automatically set to increase or decrease each year.⁹ Thus, short of closing down community colleges and state prisons (or, perhaps, launching an aggressive *pro*-smoking campaign to raise short-term revenues and long-term mortality rates among Medicaid consumers), the Arizona legislature can do only what it has, in fact, done: enact phony cuts, use traffic enforcement as a revenue device (not a tax and therefore not subject to the Proposition 108 two-thirds requirement), and issue a pile of new debt.

No doubt, the constraints on the Arizona legislature's budgetary authority have reached troublesome dimensions. And, no doubt, the unintended consequences of a profusion of referendums—enacted one at a time, without any serious consideration of their aggregate effects on institutional practices—ought to give pause to conservatives who believe that populism and government restraint usually go together. But while those features of Arizona politics have exacerbated the crisis in that state, the root cause is Medicaid's incentive structure. As the "all states" curves in our graphs suggest, *no* state has been able to resist the lure of providing "free" services for pennies on the dollar. *Every* state has to wrestle with the attendant fiscal displacement effects. Arizona is special (if at all) only in that most other state legislatures can resort more easily to tax increases. Arizona instead resorted to aping the Bush administration's major domestic policy innovation: the tax-free, debt-only finance of a major public health program.

No state can avoid the choice between more debt or rip-roaring tax hikes, combined in some way. The only plausible solutions to the states' Medicaid-induced fiscal troubles are to be found in Washington. Those solutions,

however, have foundered and will continue to founder—paradoxically, due to the opposition of the states.

No Way Out

It is tempting but wrong to view Medicaid's stupendous, irresistible growth trends and its effects on state budgets as accidents. Medicaid is *designed* to be fiscally unsustainable—but politically self-sustaining.¹⁰

Health insurance and health care are the subjects of an intense debate between proponents of government-provided health care and advocates of more consumer choice and competition. In that fight over inches of political territory, Medicaid hands a decisive advantage to the government health care camp. First, the program expands inexorably when Congress does what it does best, which is nothing. Second, Medicaid effectively enlists the intergovernmental lobby—the National Governors Association, the National Conference of State Legislatures, and their sister organizations—in a campaign for government-provided health care. In principle, everyone knows how to make Medicaid fiscally sustainable, both for the federal government and the states: cap the program at some level and perhaps recategorize the populations and services that qualify under the program. All states, however, regardless of party and fiscal condition, unanimously denounce even rhetorical gestures in that direction. Opposition to the state lobby's "give us more money" demands—the very root of the states' financial troubles—looks like an ideological crusade rather than a rational policy response to a real problem. Hence, it fails.

Medicaid has created a political wonderland: to a man and woman, public officials who know the program to be ruinous to their states nonetheless clamor for more of the same. There is no will or incentive in Washington for a call to reality—not among Democrats, who rightly view Medicaid (and SCHIP) as HillaryCare on a bicycle, and not among Republicans, who are receptive to the intergovernmental lobby's call for "states' rights" and its clamor against "unfunded mandates" (and never mind that Medicaid is neither).

Eventually, Medicaid will fall victim to the late Herbert Stein's law: something that cannot go on will eventually stop. No one knows on what terms it will stop. We do know this, though: before it stops, there will be a lot more Arizonas.

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Notes

1. Government Accountability Office (GAO), *State and Local Governments: Growing Fiscal Challenges Will Emerge during the Next 10 Years* (Washington, DC: GAO, January 2008), available at www.gao.gov/new.items/d08317.pdf (accessed July 3, 2008).

2. Janet Napolitano, "'Stimulus' and the States," *Wall Street Journal*, April 24, 2008.

3. Tax Foundation, "Federal Taxes Paid vs. Federal Spending Received by State, 1981–2005," *Tax Data*, October 19, 2007, available at www.taxfoundation.org/taxdata/show/22685.html (accessed July 3, 2008).

4. Arizona law requires the Governor's Office of Strategic Planning and Budgeting (OSPB) to prepare a biennial report detailing the use of federal funds in Arizona. The most recent report contains data for forty-seven state agencies receiving federal revenue. See OSPB, *Statement of Federal Funds, Fiscal Years 2006–2008* (Phoenix: OSPB, August 2007), available at www.ospb.state.az.us/documents/FedFunds2006-2008.pdf (accessed July 3, 2008).

5. Tax Foundation, "Federal Spending Received per Dollar of Taxes Paid by State, 1981–2004," *Tax Data*, March 16, 2006, available at www.taxfoundation.org/research/show/347.html (accessed July 3, 2008).

6. See, for example, Aaron Wildavsky, "Fruitcake Federalism or Birthday Cake Federalism," in *Federalism and Political Culture*, ed. David Schleicher and Brendon Swedlow (New Brunswick, NJ: Transaction, 1998), 55; and Edward M. Gramlich, "Intergovernmental Grants: A Review of the Empirical Literature," in *The Political Economy of Fiscal Federalism*, ed. Wallace Oates (Lexington, MA: Heath, 1977), 219. Copious empirical evidence shows that state and local demand for services will rise in response to federal grants but fail to decrease proportionately to a grant decrease. See, for example, Edward M. Gramlich, "Federalism and Federal Deficit Reduction," *National Tax Journal* 40, no. 3 (September 1987): 299. A sophisticated discussion and review of the literature is found in Shama Gamkhar, *Federal Intergovernmental Grants and the States* (Northampton, MA: Edward Elgar, 2002).

7. National Association of State Budget Officers, *State Expenditure Reports*, 1995 and 2005, table 3, available at www.nasbo.org/Publications/PDFs/1995exrpt.PDF and www.nasbo.org/Publications/PDFs/2005%20State%20Expenditure%20Report.pdf (accessed July 3, 2008).

8. For an earlier, similar discussion of these issues, see Arizona Center for Public Policy, "Limitations and Constraints on Arizona's State Budgeting Process," October 2003, available at www.thinkaz.net/pdfs/TownHallCh3.pdf (accessed July 3, 2008).

9. David R. Berman, "Restrictions, Mandates, and the Arizona Budget" (Morrison Institute for Public Policy, Arizona State University, Tempe, AZ, April 2004), 9, available at www.asu.edu/copp/morrison/restrictmandates.pdf (accessed July 3, 2008).

10. See Robert B. Helms, "The Medicaid Commission

Report: A Dissent," *Health Policy Outlook* no. 2 (January 2007), available at www.aei.org/publication25434/; and Robert B. Helms, "The SCHIP Open: Hidden Incentives for States to Spend Federal Funds," *Health Policy Outlook* no. 10 (August 2007), available at www.aei.org/publication26708/.