



UNDERSTANDING MEDICAID A Policymaker's Introduction

Office of Legislative Research and General Counsel

WHY THIS BRIEFING PAPER?

During the 2006 General Session and over the next several years, the Legislature may be called upon to modify the state's Medicaid program in response to actions by Congress to reduce federal spending and restructure Medicaid, and local efforts to reduce the number of persons without health care coverage.

This paper is designed to help policymakers effectively evaluate the existing Medicaid program and develop and respond to new policy proposals. Several important questions are answered:

1. Why is understanding Medicaid important?
2. What is the role of the Legislature and others in developing Medicaid policy?
3. What flexibility do Utah policymakers have in designing Medicaid?
4. What has been done, and could be done, to contain Medicaid spending growth?

HIGHLIGHTS

- **Impact of Federal Actions** Federal efforts to reduce Medicaid spending could shift a greater financial obligation for Medicaid to the state and present policymakers with difficult choices related to eligibility and services.
- **Impact on Budget** Except for Public Education, Medicaid is the largest program in state government. It is growing at an average annual rate of 11%. It is also doubling as a portion of total spending from the General Fund and school funds every 16 years.
- **Impact on People, Providers, and the Economy** Medicaid provides health care coverage to over 275,000 Utahns, is a significant source of funding for public hospitals and community health centers, and attracts federal funding that supports nearly 17,000 jobs in the state.
- **Optional Program Elements** Although Utah's Medicaid program incorporates many features required under federal law, nearly 60% of program spending is the result of optional elements adopted by state policymakers. Various methods are available to shape the program according to local priorities.
- **Cost Containment** Since 1997, ongoing Medicaid spending has been reduced by \$41 million as the result of various cost containment initiatives. Other strategies to reduce costs have been considered but not implemented.
- **Utilization Patterns** Although they make up only 25% of enrollees, the aged and persons with a disability account for 70% of Medicaid spending (U.S. figures).

WHY IS UNDERSTANDING MEDICAID IMPORTANT?

SUMMARY Understanding Medicaid is important because:

- as a result of growing federal budget deficits, Congress may increase states' financial responsibility for the program or take other action which could increase state spending
- it is a significant portion of the state budget
- it is growing rapidly
- it is growing faster than other state programs
- it has grown even while other program budgets have been reduced
- it is consuming an ever increasing share of the state budget
- it is a source of federal funds that have a large economic impact on the state
- it is the largest source of funding for public hospitals and community health centers
- it provides medical coverage to a significant portion of the state's population
- program costs may increase due to implementation of the Medicare Part D prescription drug benefit

POTENTIAL FEDERAL ACTION MAY AFFECT STATE SPENDING

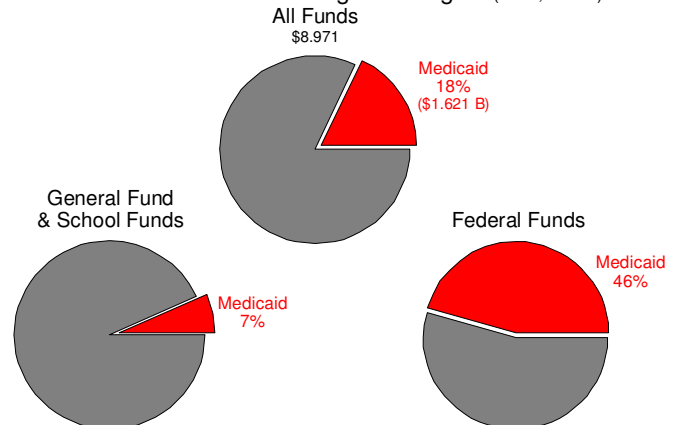
Short-term: Up to \$12 Billion Reduction As of the beginning of December, Congress was still working on a fiscal year 06 budget that would reduce Medicaid funding over five years by as much as \$12 billion.¹

Long-term: \$60 Billion Reduction President Bush has called for a \$60 billion reduction in Medicaid spending over 10 years.²

GAO Says Current Course is Unsustainable and Calls for Reform Earlier this year, the United States Government Accountability Office (GAO) informed Congress that "our nation is on an imprudent and unsustainable fiscal path driven by known demographic trends and rising health care costs, and relatively low revenues as a percentage of the economy."³ GAO projects that "balancing the budget in 2040 could require actions as large as cutting total federal spending as much as 60 percent or raising federal taxes up to 2.5 times today's level"⁴ but adds that increasing taxes by that amount "seems both inappropriate and implausible." GAO concludes that "substantive reform of...major mandatory programs [including Medicaid] remains critical to

Figure 1: Medicaid is a Significant Portion of the State Budget

Medicaid as a Percentage of Budgets (Utah, FY 06)



recapturing our future fiscal flexibility."⁵

Medicaid Commission Created to Recommend Reform Options

U.S. Health and Human Services Secretary Michael Leavitt has indicated that Medicaid, in its current form, is "not sustainable."⁶ Earlier this year, he created a Medicaid Commission to develop recommendations for ensuring the long-term sustainability of the program. The Commission was charged specifically to base its recommendations on three revenue scenarios, including one which assumes no spending increases other than for inflation, and one which assumes an even lower rate of growth. The Commission's report is due at the end of 2006.⁷

Federal Actions Could Lead to Greater State Fiscal Effort

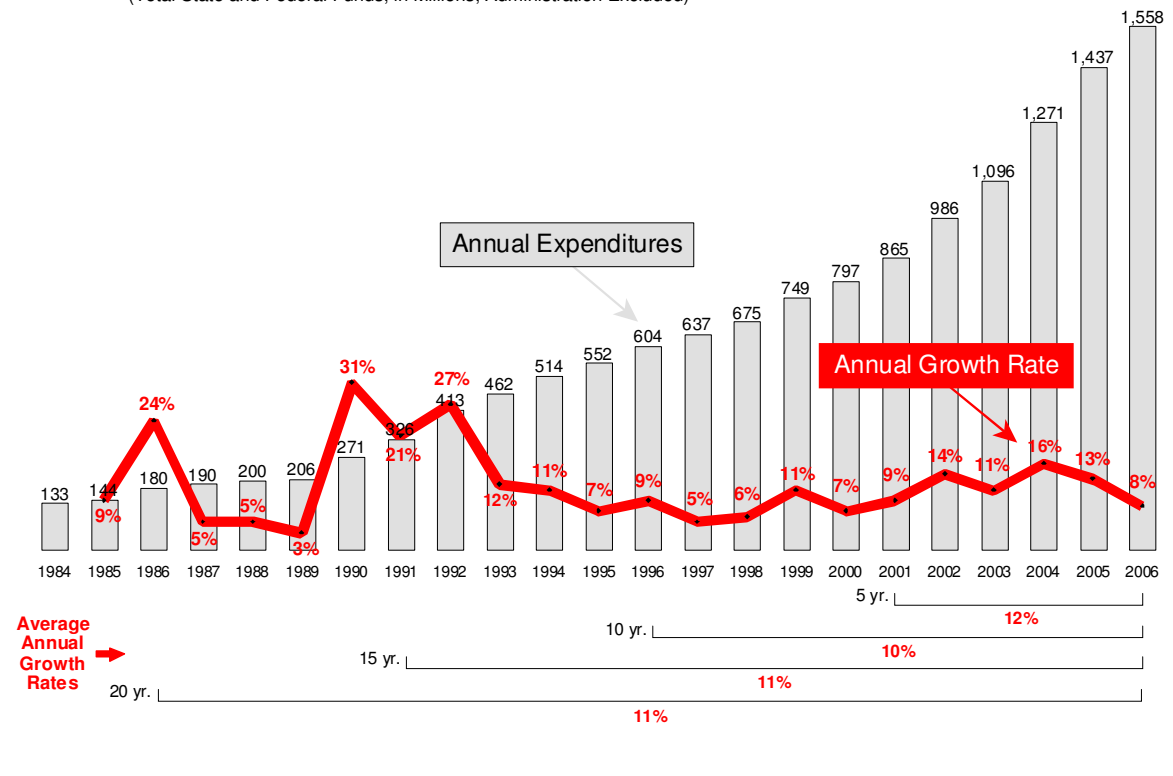
Cuts in federal funding or reform, particularly "substantive reform," could shift a greater financial obligation for Medicaid enrollees to the states and present state policymakers with difficult choices related to eligibility and services.

THE GOVERNOR'S INITIATIVE TO REDUCE THE NUMBER OF UNINSURED MAY LEAD TO MEDICAID PROPOSALS

Earlier this year, Governor Huntsman kicked off an effort to reduce the number of uninsured in Utah.⁸ Historically, expansion of Medicaid has been one of the key methods used by state policymakers to extend health care coverage to the uninsured or underinsured.

Figure 2: Medicaid is Growing Rapidly

Utah Medicaid Expenditures and Growth Rates, 1984–2006
(Total State and Federal Funds, in Millions; Administration Excluded)



MEDICAID HAS A LARGE IMPACT ON THE STATE BUDGET

Medicaid Is the Second Largest Budget Item In the current fiscal year, FY 06, the \$1.6 billion appropriated to Medicaid accounts for 18% of the state's nearly \$9 billion budget (See Figure 1).⁹ Only Public Education receives a greater portion of state appropriations.¹⁰

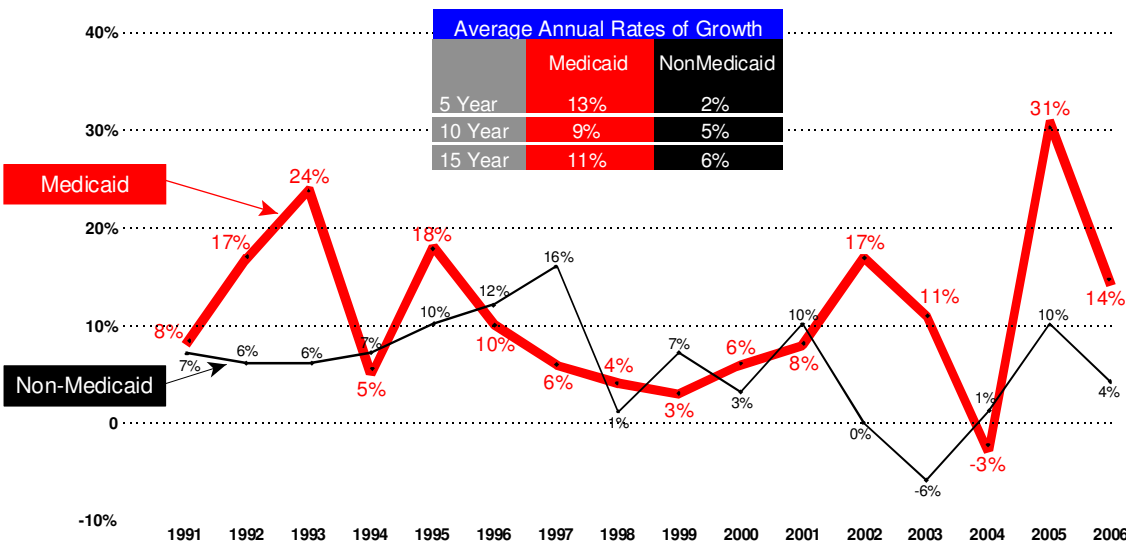
Medicaid Is Growing Rapidly Medicaid expenditures have grown from \$180 million in 1986 to \$1.6 billion in 2006 (Figure 2).¹¹ Over one-half the annual increases in the Medicaid budget during this period have exceeded 10%.

Overall, the program has grown at an 11% average annual rate of growth. During the most recent five years, the program has grown at a slightly higher annualized rate of 12%. In short, double-digit growth in Medicaid spending is the rule, not the exception.

Medicaid Is Growing Faster than Other State Programs Over the long term, Medicaid has been growing at nearly double the rate of other state programs (Figure 3).^{12,13} During the past 15 years, state funding of Medicaid has increased at an average annual rate of 11% while other programs have increased at only 6%. More recently, however, the difference in growth rates has been much greater. Since 2001,

Figure 3: Medicaid is Growing Faster Than Other State Programs

Annual Growth in General Fund & School Fund Expenditures, 1991-2006
(Utah; In Millions; Medicaid Administration Excluded)



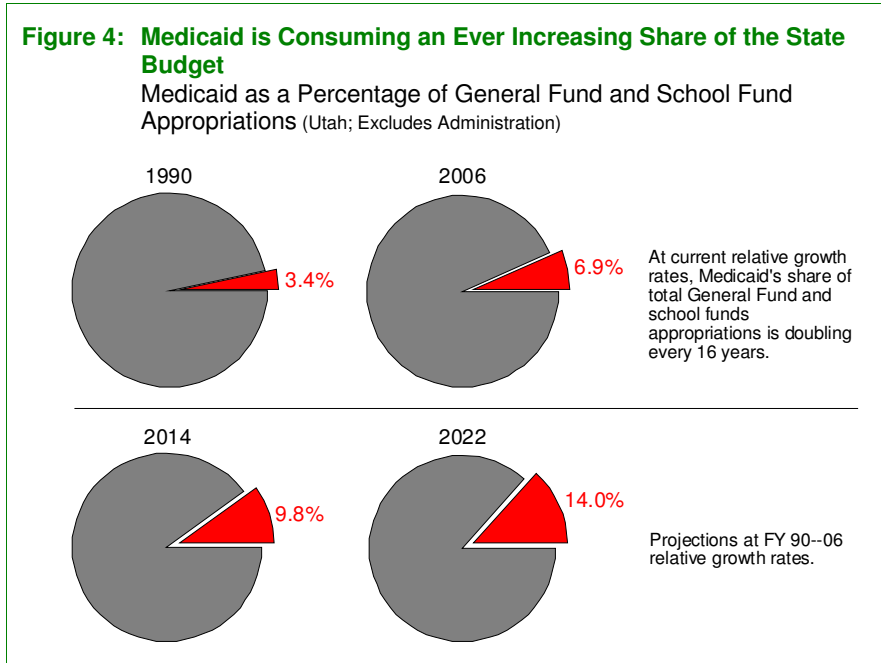
state funding of Medicaid has grown at an average annual rate of 13% while other programs have grown at about one-sixth that amount, 2%.

Medicaid Has Grown Even While Other Program Budgets Have Been Reduced

When the economy slows, state revenue growth drops but Medicaid enrollment, and thus expenditures, increase. During fiscal years 03 and 04, programs funded from the General Fund and school funds were reduced a total of \$137 million below FY 02 levels. However, during the same period, appropriations to health programs (Medicaid) increased \$45 million.¹⁴ In terms of funding growth, Medicaid was the state's top priority.

Medicaid Is Consuming an Ever Increasing Share of the State Budget

Because Medicaid, in the long-term, is growing at nearly double the rate of other state programs, it is claiming a growing portion of the state budget (Figure 4).¹⁵ During the period FY 90–FY 06, state Medicaid spending doubled as a percentage of total General Fund and school funds expenditures. At this rate, in another 16 years Medicaid spending will account for 14% of total General Fund and school funds expenditures.



MEDICAID IS A SIGNIFICANT SOURCE OF FEDERAL FUNDS THAT HAVE A LARGE ECONOMIC IMPACT ON THE STATE

Medicaid receives 46% of all federal funds appropriated by the Legislature (Figure 1).¹⁶ In FY 06, every dollar appropriated to Medicaid from state revenue sources will be matched by \$2.10 in federal revenue.¹⁷ Only four states receive a more favorable match than Utah.¹⁸

As it worked its way through the Utah economy, the \$600 million in federal funding received by the state for Medicaid in FY 01 generated \$32 million in state taxes and \$16 million in local taxes. The same amount also generated \$437 million in earnings and supported 16,818 jobs.¹⁹

MEDICAID IS THE LARGEST SOURCE OF "SAFETY NET" PROVIDER FUNDING

In the U.S., 35% or more of all revenue received by public hospitals and community health centers is attributable to Medicaid.²⁰ These two types of providers play a significant role in the delivery of health care services to the nation's low income and uninsured populations.

MEDICAID PROVIDES MEDICAL COVERAGE TO A SIGNIFICANT PORTION OF THE STATE'S POPULATION

In 2003, Medicaid covered 7% of the state's population.²¹ In fiscal year 04, the program provided health care coverage to

277,000 individuals: 14,000 aged, 34,000 persons with a disability, and 229,000 other children and adults.²² Medicaid covers 5% of Utah's aged population, 15% of Utah children, and 35% of Utah births.²³

MEDICAID COSTS MAY INCREASE DUE TO IMPLEMENTATION OF THE MEDICARE PART D PRESCRIPTION DRUG BENEFIT

Beginning January 1, 2006, Medicare will cover prescription drugs for all persons on Medicare, including those whose coverage was previously paid for by Medicaid (dual eligibles). This shift in coverage from Medicaid to Medicare will create large savings to the states, much of which will be recaptured by the federal government through payments by the states to Medicare beginning January 1, 2006.²⁴ Although Utah may realize savings from Part D, the final outcome is uncertain due to several factors:

- the Part D enrollment process creates new administrative duties for the state and may increase Medicaid enrollment
- the decrease in Medicaid pharmaceutical purchasing may reduce the program's ability to negotiate prescription drug price discounts
- Part D enrollees may not have access to all of the drugs currently available through Medicaid^{25,26}

WHAT IS THE ROLE OF THE LEGISLATURE AND OTHERS IN DEVELOPING MEDICAID POLICY?

STATE VS. FEDERAL ROLES

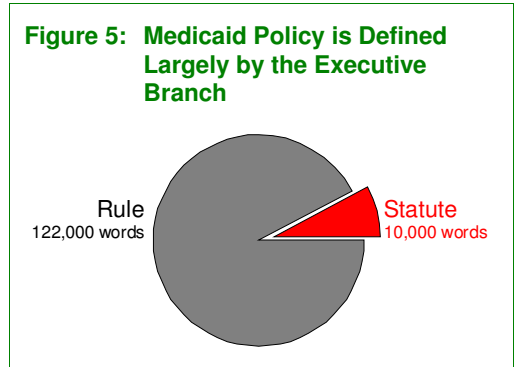
States Choose Whether to Participate in Medicaid Medicaid is a state and federal government partnership. The federal government establishes the general rules of the program and promises to match state fiscal effort. States choose whether to participate and agree to administer the program.

Medicaid Has Mandatory and Optional Features Each state that participates in Medicaid is required to provide a minimum set of services to particular groups of low income children, pregnant women, aged, and disabled persons. To these "mandatory" elements, states may add other "optional" categories of people and services. Because each state elects which elements to incorporate in its Medicaid program, no two state Medicaid programs are alike.

States May Seek Additional Flexibility Through Waivers In addition to the mandatory and optional components of Medicaid, states may cover additional groups and services or deliver services in nontraditional ways after obtaining federal approval to waive usual program requirements.

LEGISLATIVE VS. EXECUTIVE BRANCH ROLES

Medicaid Defined Largely by Executive Branch How the development of Medicaid policy is divided between the legislative and executive branches of government is a state by state decision. In Utah, the Legislature has given the Division of Health Care Financing within the Utah Department of Health broad leeway to define and administer the program. Although a few program specifics are spelled out in statute, these are the exception. The volume of Medicaid administrative rules outnumbers state



statutes twelve to one (Figure 5). Administrative rules address both optional and mandatory features of Medicaid.

Legislature Requires Reporting of Changes to Facilitate Oversight In 2003, concerned about its ability to provide oversight, the Legislature enacted a statute requiring the Department of Health to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee prior to adopting any Medicaid change affecting consumers or medical care providers. Reports must include the impact on consumers, other state programs, and future funding obligations.²⁷

WHAT FLEXIBILITY DO UTAH POLICYMAKERS HAVE IN DESIGNING MEDICAID?

POLICYMAKERS HAVE MUCH FLEXIBILITY, AS EVIDENCED BY SPENDING ON OPTIONAL POPULATIONS AND SERVICES

Optional Elements Account for 58% of Spending

Utah policymakers have significant leeway in crafting the state's Medicaid program as evidenced by current spending patterns. Only 42% of total Medicaid spending in Utah is the result of purely mandatory features of Medicaid. The remaining 58% (\$809 million) is the result of optional features adopted by the state (Figure 6).²⁸ These optional features include:

- optional services for mandatory populations (15% of total spending, or \$213 million)
- mandatory services for optional populations (17% of total spending, or \$243 million)
- optional services for optional populations (25% of total spending, or \$353 million)

Some Optional Spending Covers State-Mandated Services

Over one quarter of optional spending (\$215 million) pays for services provided by the Utah State Hospital, the Utah State Developmental Center, and the public mental health system. Given each entity's statutory responsibilities, these services would be paid for solely with state funds if they were not covered by Medicaid.²⁹

"Optional" Does Not Mean Medically Optional Although some services have been designated "optional" under federal Medicaid law (states may elect whether or not to provide them), many enrollees and health care providers probably believe that many of these services are not optional elements of high quality medical care.

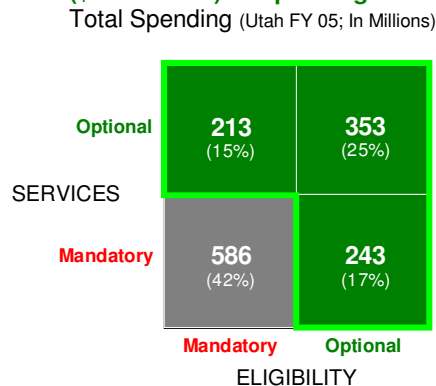
Elderly and Disabled Account for Bulk of Optional Spending Nationally, total spending for the elderly and persons with a disability represents 86% of all optional Medicaid spending.³⁰

FOUR BASIC APPROACHES TO CUSTOMIZING MEDICAID As discussed below, policymakers have four basic routes they may take to modify Medicaid:

- Expand or reduce eligibility

- Expand or reduce services
- Seek federal waivers to cover populations or provide services not normally funded under standard Medicaid regulations
- Modify outreach, eligibility determination, provider reimbursement, or other administrative aspects of the program that affect enrollment and access

Figure 6: Optional Elements Account for 58% (\$809 Million) of Spending

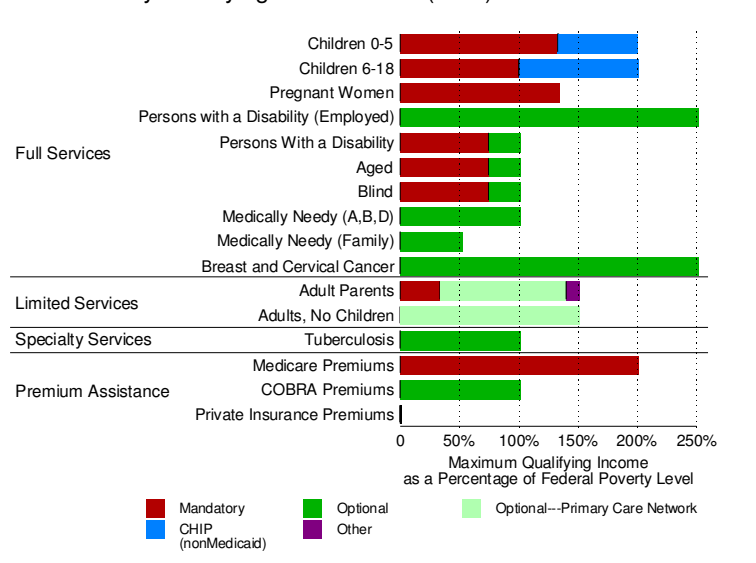


EXPAND OR REDUCE ELIGIBILITY

Five Tests Create 49 Categories Medicaid eligibility is determined by meeting five tests. Three are nonfinancial—residency, immigration status, and categorical qualification (e.g., aged, disabled, pregnant, under 18 years of age)—and two are financial—income and resource. By combining categorical, income, and resource tests in various ways, policymakers create numerous unique eligibility categories. Federal law currently defines at least 49 unique categories—28 mandatory and 21 optional.³¹

At Least 70 Pathways Sometimes a person is eligible for Medicaid through more than one category. As a result, there are at least 70 pathways to Medicaid eligibility.³²

Figure 7: Mandatory vs. Optional Coverage of Major Groups By Qualifying Income Level (Utah)



Utah Policy Utah has expanded Medicaid eligibility beyond mandatory populations to include children and adults at higher income levels, persons with a disability at higher income levels, persons with tuberculosis, certain persons with catastrophic medical costs (medically needy), adults who would not qualify under general Medicaid rules, and others (Figure 7).^{33,34,35}

Options for Expanding or Reducing Eligibility

State policymakers may expand or reduce eligibility by:

- adding or eliminating eligibility groups
- increasing or decreasing the income or resource standards for existing groups, within federally allowable limits

- modifying the methodologies used to calculate the income and resource standards (e.g., how income or the value of an asset is determined)³⁶

EXPAND OR REDUCE SERVICES

In Medicaid, some services are mandatory and others are optional. Each eligibility group has its own set of mandatory and optional services. More than one group may share the same set of services.

Mandatory vs. Optional and Acute vs. Long-term Services One commentator has broken Medicaid services down into 12 mandatory services and 20 optional services. This same analysis classifies 20 of the 32 total services as acute care and 12 as long-term care (Figure 8).³⁷ Mandatory services include care by a physician, certified nurse practitioner, or nurse midwife, laboratory diagnostics and x-rays, inpatient and outpatient hospital care, and other services. Optional services include care by various health care practitioners (including optometrists, dentists, and chiropractors), prescription drugs, and many other services.

Figure 8: Mandatory vs. Optional Services

	Mandatory	Optional
Acute Care	<ul style="list-style-type: none"> • Physician • Certified nurse practitioner • Nurse midwife • Lab & x-ray • Inpatient hospital • Outpatient hospital • Early & periodic screening, diagnostic, & treatment (EPSDT) for <21 yrs. • Family planning • Federally-qualified health centers • Rural health clinics <p style="text-align: right; color: white;">10 categories</p>	<ul style="list-style-type: none"> • Other licensed practitioner <ul style="list-style-type: none"> ✓ Chiropractor ✓ Podiatrist ✓ Optometrist ✓ Psychologist ✓ Nurse anesthetist • Prescribed drugs • Diagnostic, screening, preventive, and rehabilitative services • Clinic services • Primary care case management • Dental, dentures • Physical therapy & related services • Prosthetics, eyeglasses • Tuberculosis • Other specified medical and remedial services <p style="text-align: right; color: white;">10 categories</p>
Long-term Care	<ul style="list-style-type: none"> • Nursing facility for 21+ yrs. • Home health care (for those entitled to nursing facility care) <p style="text-align: right; color: white;">2 categories</p>	<ul style="list-style-type: none"> • Inpatient hospital and nursing facility services for 65+ yrs. in an institution for mental diseases (IMD) • Intermediate care facility services for persons with mental retardation (ICF/MR) • Inpatient psychiatric hospital services for <21 yrs. • Home health care services • Case management services • Respiratory and ventilator-dependent • Personal care • Hospice • PACE (all inclusive care for elderly) • Home and community based <p style="text-align: right; color: white;">10 categories</p>

Most Optional Services Are Provided by at Least One-half the States CMS (Centers for Medicare and Medicaid Services), has broken the 20 optional services mentioned above into 38 categories (Figure 9).³⁸ Only three of these 38 services are provided to one degree or another by all 50 states—services in intermediate care facilities for the mentally retarded, prescription drugs, and prosthetics. Most optional services (33 of 38) are each provided by at least one-half the states. Five services are each provided by fewer than one-half the states.

States Vary Widely in the Number of Optional Services Provided No state provides every one of the 38 services designated by CMS as optional. Some provide as few as 19. Utah provides 33. Eleven other states provide as many optional services as Utah. Each state determines whether each optional service is available to Medicaid enrollees generally or limited in some way by eligibility group.³⁹

SEEK FEDERAL WAIVERS State Medicaid programs, including those elements serving optional populations or providing optional services, are bound by numerous federal regulations, including several overarching requirements that ensure access and adequacy of care.⁴⁰ Specific regulations, however, may be waived upon request by a state and approval by CMS. For example, Utah's Primary Care Network required the waiving of 11 requirements⁴¹ and Florida's recently approved proposal to move certain populations to defined contribution (rather than defined benefit) plans required the waiving of nine requirements.⁴² Utah's Medicaid program currently operates under eight separate waivers, each one exempting the state from compliance with one or more federal regulations.⁴³

MODIFY ASPECTS OF THE PROGRAM THAT AFFECT ENROLLMENT AND ACCESS

About 30% of Eligibles Do Not Enroll A significant portion of those eligible for Medicaid do not enroll in the program. In 2000, 30-34% of eligible persons nationally did not enroll.⁴⁴ An earlier estimate put the nonparticipation rate for nonelderly Utahns at 27%.⁴⁵ The level of nonparticipation is important because it represents people who may not have health care coverage but would qualify for it if they simply enrolled in an existing program. It also represents the potential for increased program spending even without expanding eligibility or services.

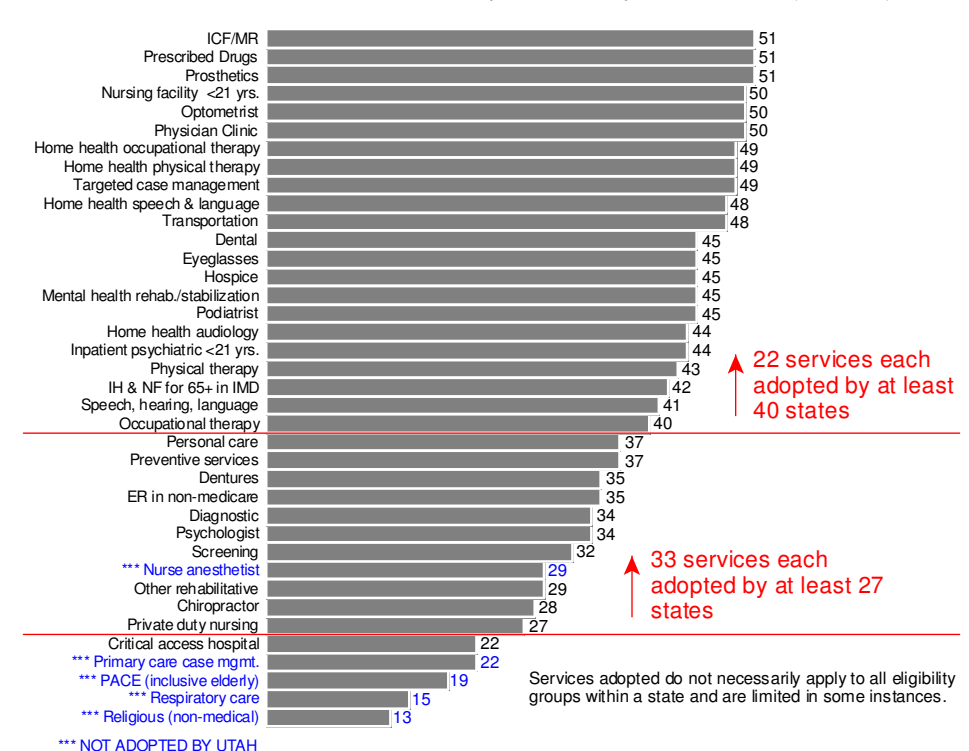
Various Policies Affect Enrollment Levels Public outreach, eligibility processes, and medical provider participation are several aspects of Medicaid within the control of state policymakers which may affect enrollment and eventual utilization of services.

WHAT CAN BE DONE TO CONTAIN MEDICAID SPENDING GROWTH?

INCREASED SPENDING IS ATTRIBUTABLE TO VARIOUS FACTORS

Increased Enrollment During the recent period 2000–2003, national Medicaid spending increases were largely attributable to escalating enrollments resulting from a downturn in the economy and a decrease in employer-sponsored health insurance. Notably, the aged and disabled, who made up only 11% of the enrollment increase, accounted for 56% of the total increase in spending.⁴⁶

Figure 9: Most Optional Services Are Provided by at Least Half the States
Number of States That Have Adopted Each Optional Service (38 Total)



Other Factors Over both the long and short terms, state spending for Utah's Medicaid program has clearly outpaced enrollment growth (Figure 10).⁴⁷

During the most recent five-year period (2001–05), spending grew at 1½ times the rate of enrollment (12% vs. 8%). Over longer periods, spending has grown at two to three times the rate of enrollment. Various factors other than enrollment have contributed to this growth, including:

- medical inflation⁴⁸
- increased payments per case due to changes in technology (drugs, devices, and procedures)⁴⁹
- an increase in the number of cases treated per 100,000 persons (prevalence) for various conditions⁵⁰
- expansion of eligibility and services
- maximization of Medicaid funding for various services provided by state government

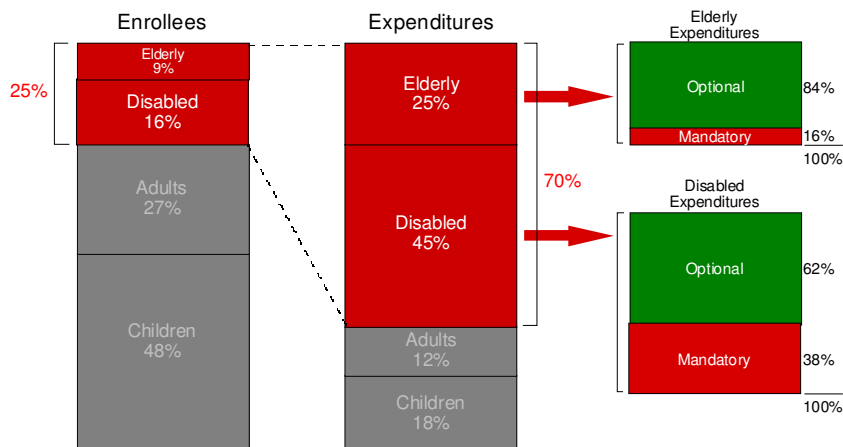
Figure 10: Spending Outpaces Enrollment
Utah Medicaid, 1991-2005
(State Funds Only)

Average Annual Rates of Growth		
	Spending	Enrollment
5 Year	12%	8%
10 Year	9%	3%
15 Year	11%	5%

A SMALL PORTION OF ENROLLEES ACCOUNT FOR A LARGE PORTION OF COSTS

Nationally, the elderly and persons with a disability make up only 25% of Medicaid enrollees but account for 70% of total Medicaid spending (Figure 11).⁵¹ Well over half of this spending is for optional populations and services (84% of spending for the elderly is for optional program elements adopted by states; 62% of spending for the disabled is for optional elements).⁵²

Figure 11: 25% of Medicaid Enrollees Consume 70% of Medicaid Resources (U.S. 2005)



UTAH HAS USED 32 STRATEGIES TO REDUCE SPENDING BY \$44 MILLION

Since 1997, the Division of Health Care Financing has implemented 32 initiatives generating an estimated annual savings of \$41million (\$13 million state funds; \$28 million federal funds). A sample of these initiatives includes:

- generic substitution of pharmaceuticals (\$11 M)
- a pharmacy copayment program (\$5.6 M)
- use of a pharmacy point-of-sale computer system (\$4.1 M)
- University of Utah drug utilization review and provider consultation (\$3.8 M)
- copayments for selected services (\$2.5 M)
- Drug Utilization Review Board recommendations (\$2.3 M)
- fraud and abuse detection and investigation (\$2 M)
- competitive bidding for oxygen concentrators (\$2 M)

- post-payment review of claims (\$1.6 M)
 - increased use of volunteers (\$1.5M)
 - pre-payment review of claims (\$1 M)
 - funding from other organizations for eligibility workers (\$1 M)⁵³
- (All savings shown are total state and federal funds.)

During the recent economic slowdown, the state also reduced, on a limited basis, Medicaid funding for several medical services, including restorative dental work for adults.

OTHER STRATEGIES EXIST TO REDUCE SPENDING OR INCREASE REVENUE

Strategies Considered in Utah The Division of Health Care Financing has considered, but not implemented, at least 13 other measures which would either reduce costs or increase revenue to Medicaid by tens of millions of dollars annually.⁵⁴

Cost Containment Strategies Generally Numerous strategies for containing Medicaid costs and enhancing revenues have been considered by states during the recent economic downturn. In summary, these strategies include:

- modifying eligibility or services
- modifying provider payments
- requiring enrollee cost sharing
- containing pharmaceutical costs
- implementing disease management programs
- imposing provider taxes
- reducing the growth of long-term care spending
- maximizing federal funding
- using managed care
- emphasizing prevention
- enhancing fraud and abuse detection
- adopting electronic records management
- taking advantage of federal flexibility
- conducting audits or other program evaluations^{55,56}

Pharmaceutical Costs Specifically One study has identified 45 ways used by public and private health care payers to contain prescription drug spending.⁵⁷ Many of these have been adopted by Utah's Medicaid program, but some have not.⁵⁸ The study notes that only a limited body of research is available on the effectiveness of various cost containment strategies.

SUMMARY

- Medicaid is a very significant program in terms of its impact on individuals, medical providers, the economy, and the state budget.
- Although it is subject to many federal requirements, 58% of total program spending is the result of optional elements adopted by state policymakers.
- Various mechanisms are available to either expand or reduce Medicaid eligibility and services.
- Over the past decade, Utah has implemented numerous strategies to contain Medicaid spending growth.

NOTES

1. National Conference of State Legislatures, "Capitol to Capitol" (Washington, D.C.), Vol. 12, Nos. 46-48.
2. National Conference of State Legislatures, "Federal Budget and Revenue Update," February 8, 2005, accessed 11/29/05 at <http://www.ncsl.org/statefed/PresBudg06.htm>.
3. Walker, David M., Comptroller General of the United States, "21st Century Health Care Challenges: Transforming Government to Meet Current and Emerging Challenges" (Washington, D.C.: United States Government Accountability Office, July 13, 2005), Highlights, accessed 11/1/05 at <http://www.gao.gov/new.items/d05830t.pdf>.
4. Walker, David M., Comptroller General of the United States, "21st Century Health Care Challenges: Unsustainable Trends Necessitate Reforms to Control Spending and Improve Value" (Washington, D.C.: United States Government Accountability Office, July 22, 2005), 8, accessed 9/9/05 at <http://www.gao.gov/cghome/chcw07222005/chcw07222005.pdf>.
5. Walker, David M., Transforming Government, 4-5.
6. Lemov, Penelope, Interview with Health and Human Services Secretary Mike Leavitt, at [Governing.Com](http://www.governing.com), accessed 8/11/05 at <http://www.governing.com/articles/6leavitt.htm>.
7. Medicaid Commission, "Report to the Honorable Secretary Michael O. Leavitt, Department of Health and Human Services and the United States Congress" (Washington, D.C., September 2005), 7, accessed 11/1/05 at <http://www.cms.hhs.gov/faca/mc/090105rpt.pdf>.
8. See <http://search.utah.gov/retina/public/suggest.do?title=Utah+Summit+on+Health+Insurance+Coverage+for+the+...&id=&links=%5BSUMMIT%2CUNINSUR%5D&reference=http%3A%2F%2Fhealth.utah.gov%2Funinsuredsummit%2F>.
9. Office of the Legislative Fiscal Analyst, "2005-2006 Appropriations Report" (Salt Lake City, Utah, April 2005), 13, 103, accessed 9/13/05 at <http://www.le.state.ut.us/interim/2005/pdf/00000519.pdf>. Figures include \$63.4 M from the "Health Care Financing" line item for administration, some of which is also used for activities related to the Children's Health Insurance Program. If this amount is excluded from the total and only the "Medical Assistance" line item is included, the percentage of total budget is reduced from 18.1% to 17.4%.
10. Ibid., 13.
11. Utah Department of Health, Division of Health Care Financing, October 2004 and September 13, 2005. Data on file at the Office of Legislative Research and General Counsel. In addition to the figures shown here, the FY 06 appropriation includes an additional \$63.4 M for administration, some of which is also used for activities related to the Children's Health Insurance Program. Rate changes calculated by OLRGC.
12. Ibid.
13. Utah Department of Health, Division of Health Care Financing, September 19, 2005. Data on file at the Office of Legislative Research and General Counsel. Rate changes calculated by OLRGC.
14. Governor's Office of Planning and Budget, "State of Utah Budget Summary: Fiscal Year 2004, Fiscal Year 2003 Supplementals" (Salt Lake City: April 2003), 22, accessed 9/14/05 at <http://governor.utah.gov/gopb/2004summary.pdf>.
15. Utah Department of Health, October 2004, September 13, 2005. Rates calculated by Office of Legislative Research and General Counsel.
16. Office of the Legislative Fiscal Analyst, "2005-2006 Appropriations Report" (Salt Lake City, Utah, April 2005), 13, 103, accessed 9/13/05 at <http://www.le.state.ut.us/interim/2005/pdf/00000519.pdf>. Figures include \$63.4 M from the "Health Care Financing" line item for administration, some of which is also used for activities related to the Children's Health Insurance Program.
17. Office of the Legislative Fiscal Analyst, "Compendium of Budget Information for the 2006 General Session: Joint Appropriations Subcommittee for Health and Human Services, Utah Department of Health" (Salt Lake City: November 18, 2005), 85, 98. Ratio calculated by Office of Legislative Research and General Counsel.
18. Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer" (Washington, D.C.: July 2005), 15, accessed 9/9/05 at <http://www.kff.org/medicaid/7334.cfm>. Rate comparison is for federal fiscal year 06.
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