A SERVICE OF THE WISCONSIN TAXPAYERS ALLIANCE

The Wisconsin Taxpayer

A monthly review of Wisconsin government, taxes, and public finance

Wisconsin Medicaid Trends & Comparisons

IN BRIEF

Medicaid, or Medical Assistance (MA), provides health coverage to more than 60 million low-income individuals nationally. Through new programs and expanded eligibility, Wisconsin now has 1.2 million MA enrollees, 191% more than in 1998. State spending on the program, excluding the federal contribution, totalled $2.1 billion in state fiscal year 2009, up from $905 million in 1998.

- Most Wisconsin Medicaid recipients are covered under the state's family-related MA program, BadgerCare Plus.
- Medicaid enrollment here increased second fastest nationally during the period from 2001 to 2009.
- Total state MA spending ranked 20th highest nationally in 2009.

wis tax February 2011 Vol. 79 No. 2

Medical Assistance, also known as Medicaid or MA, presents Wisconsin state government with its most significant challenge as it struggles to close a projected 2011-13 budget deficit of $3.6 billion. No major state program has grown faster over the past decade; only K-12 school aid claims a larger share of the general fund budget; and few recipient populations are as needy as MA's.

Nevertheless, recent enrollment and spending trends leave many questioning the long-term sustainability of the program. From 2001 to 2009, Medicaid enrollment here increased faster than in all states except Arizona. State spending on the program also exceeded the national average.

OVERVIEW

Since Congressional enactment in 1960, MA has grown to be one of the nation's largest entitlement programs, along with Social Security and Medicare. However, unlike Medicare, which serves seniors and certain individuals with disabilities, MA funds health services for more than 60 million low-income Americans, including elderly and disabled individuals also enrolled in Medicare (dual eligibles). In Wisconsin, the program is largely administered by the Department of Health Services (DHS) and individual counties.

Medicaid is financed with a combination of state and federal dollars. The share of costs paid by federal funds varies with state per capita income. To relieve state budget pressures, the federal share of MA funding was increased from October 2008 through December 2010, as part of the American Recovery and Reinvestment Act (ARRA). The increase boosted federal MA spending by $87 billion nationally. Additional relief for states was passed by Congress in August 2010, and the period of higher federal cost-sharing for the program was extended through June 2011, providing states with an extra $16 billion.

ENROLLMENT

According to the DHS, Wisconsin had 1.2 million people, or about 20% of the state's population, enrolled in one of its MA programs at the end of November 2010. In

November 1998, less than eight percent of state residents were enrolled.

By Group

Although many programs serve the MA population here, there are two primary recipient groups.

BadgerCare Plus. Approximately 67% of MA participants are covered by the family-related care program, known as BadgerCare Plus. In November 2010, enrollment totalled 773,457.

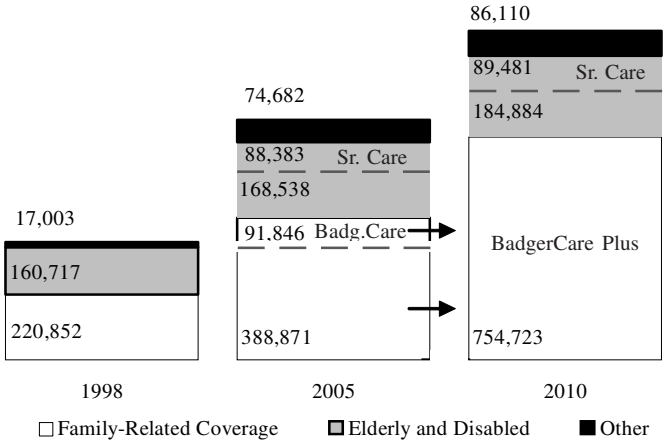
BadgerCare Plus, which replaced the Family Medicaid and BadgerCare programs in early 2008, provides health care services for low-income (defined as a percentage of the federal poverty level) children and families, including children under 19, parents and caretaker relatives under 19, pregnant women, young adults up to 21 who were in out-of-home care on their 18th birthday, and parents and caretaker relatives whose children have been removed from the home and placed in out-of-home care. The 2009-11 state budget also provided funding for a BadgerCare Plus Core Plan for childless adults.

Elderly, Blind, and Disabled. Wisconsin's MA program also covers low-income elderly (those 65 years and above), blind, and disabled individuals. Various programs serve MA recipients under this classification, including the state's SeniorCare program. As of November 2010, nearly 280,000 people received MA benefits under the elderly and disabled classification, according to DHS.

Growth

From November 1998 to November 2010, total MA enrollment increased 191.3%, an average of 9.3% annually. Since 1998, there have been two periods of accelerated growth, one during the late 1990s and the other since 2008.

Figure 1:
Family-Related Care Fastest-Growing MA Category
Participants by MA Enrollment Category, 1998, 2005, 2010



1998-2003. From 1998 to 2003, total MA enrollment increased an average of 14.4% per year, primarily due to welfare reform and the creation of BadgerCare. Wisconsin created BadgerCare to maintain publicly funded health care coverage for low-income families who previously qualified for Medicaid under Aid to Families with Dependent Children (AFDC). BadgerCare also offered coverage to low-income individuals who were ineligible under the previous MA standards. Although welfare caseloads were lowered as a result of reform, the state's MA program was significantly expanded.

2008-Present. Since 2008, MA enrollment has increased nearly 25% (11.7% annually). Eligibility was extended to virtually all children during this time, though families with incomes greater than 300% of the federal poverty level must purchase coverage for children by paying monthly premiums equal to state costs.

In addition, beginning in 2009, childless adults in families with income less than 200% of the federal poverty level who had no access to other insurance coverage became eligible for coverage under the BadgerCare Plus Core Plan. However, because demand exceeded funding budgeted for the Core Plan, enrollment was suspended in October, 2009. In response, the legislature authorized DHS to offer a limited health care plan (the Basic Plan) for childless adults on the Core Plan waiting list. Premiums from individuals on the Basic Plan are currently covering program costs, according to DHS officials.

Economic factors also affected recent enrollment growth. During a downturn, many individuals qualify for MA after losing their jobs and private health benefits. For

The Wisconsin Taxpayer

February 2011 Vol. 79 No. 2

Publication Number USPS 688-800
Periodical postage paid at Madison, Wisconsin

Subscription Price:
One Year, $17.97; Three Years, $36.97
Published each month, except July, by the Wisconsin Taxpayers Alliance, 401 North Lawn Avenue, Madison, Wisconsin 53704-5033

Postmaster:
Send address changes to *The Wisconsin Taxpayer,*
401 North Lawn Avenue, Madison, Wisconsin 53704-5033
phone: 608.241.9789 fax: 608.241.5807
e-mail: wistax@wistax.org website: www.wistax.org

example, MA enrollment nationally increased 9.5% in 2002, following the early 2000s recession. According to state reports, MA enrollment nationally increased more in 2009 than it had in the prior five years.

Enrollment Growth by Group. As noted, MA enrollment here has grown over 9% per year since 1998, but enrollment for some MA groups has increased faster than for others—in particular, the state's BadgerCare Plus population. Although classification of recipients is somewhat problematic given program changes since 1998, the number of people receiving family-related care rose 241.7% (10.8% annually) during 1998-2010.

The number of elderly and disabled enrollees in MA increased comparatively less during the same period, rising 70.7% (4.6% annually). As a share of total MA enrollment, coverage for the elderly and disabled declined from 40.3% in 1998 to 24.6% in 2010.

Although enrollment growth was partly due to natural demographic and economic conditions, it has also been impacted by changes in program eligibility standards and the creation of new programs with limited benefits. The difference in enrollment changes between the elderly and the family-related care programs reflects the state's emphasis on covering children and families.

Figure 1 (page 2) shows MA enrollment growth by major category. From 1998 to 2005, family-related coverage increased by 259,865 people. Although over half of the enrollment growth was largely due to more people qualifying for existing programs, over 90,000 people received family-related care due to the creation of BadgerCare. As mentioned, BadgerCare was established in 1997 to help low-income individuals that had not qualified for MA. Enrollment began in July 1999 and added over 10% to MA enrollment totals by the end of that year.

New programs also added elderly and disabled individuals to MA. Although 96,204 additional individuals received care under the elderly and disabled category from 1998-2005, 88,383 of them were enrolled in the state's new SeniorCare program. SeniorCare began providing prescription drug assistance to the elderly in September 2002.

In 2008, BadgerCare Plus replaced BadgerCare and Family Medicaid, again expanding eligibility. In its first month, total MA enrollment increased 6.1%. From February 2008 to November 2010, BadgerCare Plus enrollment rose 39.2%.

Table 1:
Wis. MA Enrollment Rises Second Fastest Nationally
MA Enrollment, Per 1,000 Residents (In Thousands)

	Enrollment Totals				Enrollment Per 1,000 Residents	
Rk.	State	2001	2009	Avg. Chg.	State	2009
1	Ariz.	606.9	1,204.3	8.9%	N.Y.	236.6
2	Wis.	520.0	975.0	8.2	N.M.	221.8
3	Colo.	290.8	494.7	6.9	Vt.	214.7
4	Utah	147.6	247.0	6.6	La.	206.7
5	Nev.	142.9	238.6	6.6	Maine	203.7
U.S. Avg.		35,796.8	48,569.6	3.9	***U.S. Avg.***	158.2
46	Miss.	561.8	596.2	0.7	N.H.	96.6
47	Mo.	770.9	810.3	0.6	N.J.	96.5
48	Nebr.	193.1	200.0	0.4	Va.	96.4
49	S.C.	642.1	651.7	0.2	Nev.	90.3
50	Tenn.	1,492.5	1,248.1	-2.2	Utah	88.7
					Wis. (17)	172.4

As Figure 1 also shows, BadgerCare Plus significantly impacted MA enrollment. From 2005 to 2010, family-related care enrollment increased by nearly 275,000 people. Although some individuals would likely have been eligible for MA under the earlier BadgerCare program, many qualified due to expanded eligibility under BadgerCare Plus.

Interstate Comparisons

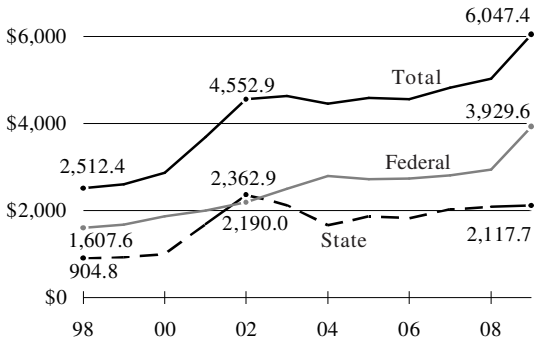
Wisconsin's MA enrollment can be compared to that of other states using the Kaiser Report on Medicaid and the Uninsured. Although Kaiser and DHS figures differ slightly, Kaiser's are the most recent available for comparing states.

From February 2008 to November 2010, BadgerCare Plus enrollment rose 39.2%.

MA enrollment growth here outpaced the national average over the past eight years. During 2001-09, the number of Wisconsin MA participants increased an average of 8.2% per year, compared to 3.9% nationally (see Table 1, above). Only in Arizona did MA enrollment grow faster than in Wisconsin. Colorado, Utah, and Nevada followed these two states. MA enrollment grew slowest in Nebraska and South Carolina, and declined in Tennessee.

Table 1 also shows states with the highest and lowest MA enrollment relative to population. In 2009, New York was highest, with 236.6 MA recipients for every 1,000 state residents, while Utah (88.7) was lowest. Wisconsin

Figure 2:
Stimulus Drives Fed. & Tot. Spending Higher
MA Spending, FYs 1998-2009 ($ Millions)



Federal MA spending here increased 8.5% annually during 1998-2009.

(172.4) had the 17th-highest proportion of MA enrollees to population. Among neighboring states, Michigan (179.7) had the highest enrollment per 1,000 residents and Minnesota (130.4) the lowest.

Per capita MA figures are a reflection of state demography, as well as MA eligibility standards. Everything else being equal, states with a higher percentage of poor people will have a larger share of their population enrolled in MA.

SPENDING

Federal and state MA spending combined increased 140.7%, or an average of 8.3% annually, during 1998-2009. Spending was up from $2.51 billion in 1998 to $6.05 billion in 2009 (see Figure 2, above).

State spending per MA enrollee averaged $1,921 in 2009.

By Source

State. The state portion includes spending from the general fund, segregated funds, and program revenues. State MA spending rose 134.1% (8.0% annually) from $904.8 million in 1998 to $2.1 billion in 2009. However, MA spending from the general fund rose significantly less during that time, averaging just 2% per year.

Prior to 2000, state MA spending was funded with general purpose revenue (GPR), which is generated mostly through state income and sales taxes. However, recent state budget problems have resulted in Wisconsin funding MA with transfers from segregated funds, including the Injured Patients and Families Compensation Fund and tobacco settlement funds. Particularly in recent years, all-funds state spending—and not GPR—is a more accurate measure of the state's MA commitments. For example, Wisconsin's general fund support for MA declined more than 36% in fiscal 2009 from the prior year, while state support from all sources rose 1.2%.

Federal. Federal spending here increased 144.4% (8.5% annually) during 1998-2009, slightly faster than annual state spending (8.0%). Recent growth in federal spending was primarily due to enhanced federal cost-sharing the state received under ARRA, as well as to recent changes in state policy.

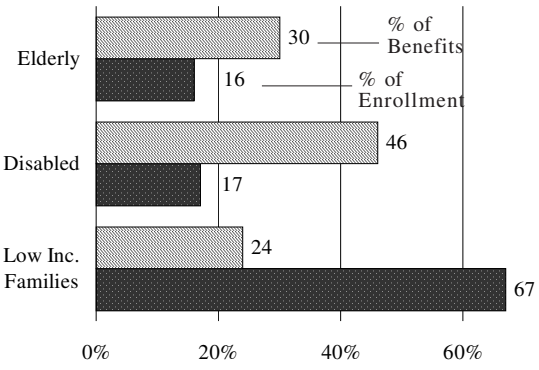
FMAP. All states receive federal funds to support their MA programs. The amount is partly determined by the Federal Medical Assistance Percentage (FMAP). The FMAP determines the share of state MA expenditures funded by the federal government and is calculated using a formula comparing a state's per capita income to the national average.

ARRA increased federal MA funding by temporarily raising the FMAP. In 2009, Wisconsin's FMAP was 69.9%, up from 57.6% in 2008 and 57.5% in 2007. According to state financial statements, Wisconsin received an additional $347 million from the federal government in fiscal 2009.

The temporary increase in federal MA funds during the past three years helped the state maintain programs during the recent recession. However, the expiration of this extra federal support will require increased state funding, contributing to the state's structural imbalance going into 2012. On the other hand, an economic rebound may result in at least a partial reduction in the number of people qualifying for MA, potentially reducing the number of total recipients and program costs.

Hospital Assessments. Although ARRA resulted in more federal spending here,

Figure 3:
People with Disabilities Highest % of Costs
% of Total MA Enrollees and % of Total MA Benefit Expenditures, By Category, 2005



Wisconsin's new hospital tax was also responsible for higher MA benefits spending beginning in 2008-09.

States are not limited in the amount of matching funds they can receive from the federal government. Therefore, the more a state spends on MA, the more federal dollars it receives. To secure more federal money, Wisconsin recently enacted hospital assessments. The assessments tax hospital revenues and use the collections to support higher reimbursement rates to hospitals, and to provide non-GPR support for the state's share of general MA benefit costs.

Table 2:
Wis. Growth in MA Spending Above U.S. Avg.
Chg. in MA spending ($ Millions), Spending per MA Enrollee

	State MA Spending				Spending per MA enrollee	
Rk.	State	1998	2009	Avg. Chg.	State	2009
1	Mo.	839	4,079	15.5%	Conn.	$11,827
2	Wyo.	56	220	13.2	Mass.	7,700
3	Mass.	2,319	8,679	12.7	Ohio	5,969
4	Idaho	124	428	11.9	N.J.	5,186
5	Ariz.	640	2,001	10.9	Mo.	5,034
U.S. Avg.		71,534	132,540	5.8	***U.S. Avg.***	2,737
46	HI	310	447	3.4	Ariz.	1,662
47	R.I.	525	731	3.1	W.V.	1,661
48	Mich.	2,659	3,183	1.6	Ga.	1,546
49	N.Y.	10,479	11,118	0.5	La.	1,482
50	Tex.	3,680	2,356	-4.0	Tex.	760
	Wis.(20)	905	2,012	7.5	Wis. (34)	2,064

By Area

Some areas of MA cost more than others. Thus, the size of a particular enrollment group is not necessarily proportional to its cost. According to 2005 Legislative Fiscal Bureau (LFB) figures, low-income families accounted for 67% of MA enrollees, but less than 25% of MA benefit costs (see Figure 3). People with disabilities, on the other hand, were 17% of enrollees but claimed 46% of benefits. Elderly individuals were 16% of MA enrollees and 30% of costs.

It is important to note that these figures do not reflect growth in the number of low-income families on Medicaid due to new eligibility standards established under BadgerCare Plus. Although updated figures are unavailable, DHS estimates that low-income families today account for 40% of MA benefit costs, compared to 60% for elderly, blind, and disabled recipients.

Part of the reason the elderly and disabled account for a larger share of MA expenditures is because of the services they require. Unlike family-related care, which is most often used for hospital and other acute care services, the elderly and disabled often require long-term residential care services (e.g., nursing homes). According to LFB figures, the average cost of an elderly MA recipient can be more than 10 times higher than for an average BadgerCare Plus enrollee.

Per Enrollee

In 1998, MA costs funded by state taxpayers were $2,295 per enrollee. In 2009, that amount was $1,921, 16.3% below the 1998 level.

Many argue the decline in state MA costs per enrollee is a sign that the program is operating more efficiently. However, declining per enrollee costs were largely due to recent MA expansions, the federal government funding a larger share of the program, and cost containment measures implemented by DHS. Cost saving efforts included reducing provider reimbursement rates, increasing recipient cost-sharing, and reducing payments for some medications.

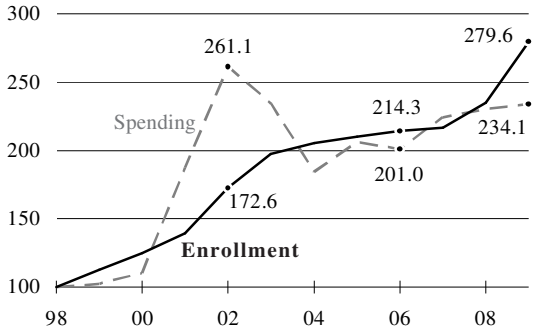
In fiscal 2010, Wisconsin was one of 39 states to adopt cost-containment initiatives relating to provider payments and was one of 36 states to make changes to pharmaceutical coverage. However, Wisconsin was not one of 20 states that reduced the scope of services offered under their MA programs, according to the Kaiser Foundation.

Wisconsin's total Medicaid spending was 20th highest nationally.

Recent program changes were the primary reason for declining MA costs per enrollee. Unlike states that cover only individuals and services required by federal law (often the most needy and expensive individuals to cover) Wisconsin has expanded coverage beyond federal requirements. Therefore, Wisconsin's per enrollee costs are driven lower by covering groups that cost less.

One example is the state's SeniorCare program, which provides prescription drug assistance to the elderly. Although the program has 88,000 recipients, the per enrollee costs are significantly less than for the elderly, blind, and disabled receiving comprehensive coverage.

Figure 4:
MA Enrollment & Spending Continue Rising
Total MA Enrollment and Total-State Spending
Indexed to 100, Dec. 1998 - Dec. 2009



Spending per MA enrollee was 34th highest in 2009.

By State

According to most-recent state expenditure reports, Wisconsin's total state spending on Medicaid was 20th highest nationally in fiscal 2009. Spending here was below that of neighbors Illinois (6), Michigan (13), and Minnesota (14), but was higher than in Iowa (28). Spending was highest in California, Ohio, and New York.

Table 2 shows states with the largest and smallest increases in MA spending during 1998-2009. Wisconsin's spending growth averaged 7.5% annually (20th fastest nationally), faster than that of neighbors Minnesota, Illinois, and Michigan. Expenditures grew fastest in Missouri and Wyoming.

Medical inflation rose 4.5% annually during 1998-2009.

Although Wisconsin's average annual spending growth exceeded the national average (5.8% annually), the Badger State's spending per MA enrollee was 24.6% below the U.S. and ranked 34th highest nationally. As previously mentioned, this is likely due to Wisconsin covering many low-cost individuals.

Spending Drivers

Many factors led to increases in state MA spending over the past decade. However, enrollment growth, rising health care costs, and increased use of provider assessments—including the hospital assessment—were some of the main contributors.

Caseloads. Figure 4 compares growth in the number of MA enrollees and total state MA spending from 1998 through 2009. As shown, state spending tends to accelerate during periods of high enrollment growth. It is worth noting, however, that other factors were in play during 2001-03. In addition to a number of new programs created during that time (e.g., SeniorCare and FamilyCare), the state was also transferring money to and from counties through a questionable process called intergovernmental transfers. These transfers were considered spending by the federal government, so the state received about $1 billion in additional federal money from 2001 through 2003.

Rising Costs. A second reason often cited for increased Medicaid spending is rising health care costs. From 1998-2009, total state MA spending here rose an average of 8.0% per year. Although MA spending increases outpaced growth in most other state programs during that time, growth has been comparable to increases in total health spending. According to the Census, health spending nationally increased an average of 7.0% annually during 1998-2009.

One factor contributing to rising health care costs was medical inflation. During 1998-2009, medical inflation rose nearly 4.5% annually (compared to 2.5% annually for consumer prices). According to some estimates, that accounted for over 35% of rising health costs over the past two decades.

Disagreement exists over the effect of rising medical costs on MA spending. Generally, MA providers are not reimbursed based on their costs of providing services; rather, DHS establishes reimbursement rates based on funding from the legislature. As costs of services increase, the higher costs are not funded unless reimbursement rates are increased. Others argue that, because providers receive payments based on volume, new and expensive drugs and procedures drive MA costs higher because even though reimbursement rates remain unchanged, the level and amount of service rises.

CONCERNS

Wisconsin has been a national leader in insuring its residents. However, rising MA costs and enrollment are putting pressure on both public budgets and private health sectors.

Crowd-Out

In the late 1990s, over 70% of Wisconsin residents received health insurance through an employer. In 2009, that percentage was down to 57%, though still above the national average (49%). Some argue the state's expanded MA program has led to a reduction in employer-sponsored health care. Others view public health programs as a response to fewer private sector options.

In 1996 (the earliest year data were available), 45.6% of small (less than 50 employees) private firms here offered a health insurance plan. By 2009, that percentage dropped to 36.8%. Among large employers, the percentage offering health insurance declined from 96.8% to 95.5%.

The cost of providing health insurance for small firms is generally higher than for large ones. Thus, expanded government-sponsored health programs disproportionately impact small private firms whose employees may find a public health plan less expensive than the private one.

Cost-Shifting

Some say state MA programs also shift costs from the public to private sector, leaving businesses and individuals unable to afford rising health premiums. Because government often reimburses health providers less for services than private health insurers do, hospitals often provide MA services at a loss. Opponents of expanded MA argue this results in higher private sector costs as health providers shift the cost of covering MA recipients to those covered by private plans.

Trade-offs

Like private employers, state government has limited resources. This means that growth in one area of state spending often means less money for others. Even with an increasing share of MA funding coming from sources other than GPR spending, general fund budget trends do offer clues as to what program areas are most affected by growth in MA expenditures.

As a share of state GPR spending, Medicaid increased from 10.1% in 1990 to 12.8% in 2008 (see Table 3). Other major programs consuming a larger share of the state budget over that time include K-12 education—largely due to two-thirds funding passed in 1997—and corrections. Both higher education and shared revenue for local governments accounted for a considerably smaller share of the budget in 2008 than they did in 1990.

A trend similar to Wisconsin was seen when GPR expenditures are reviewed nationally. Between 1990 and 2008, Medicaid, corrections, and K-12 education all accounted for a larger share of GPR spending. Higher education declined from 14.9% to 11.3% of general fund expenditures.

Table 3:
K-12, Corrections, Medicaid Account for Larger Share of Budget
Major Programs as % of GPR Expenditures, Wis. and U.S. 1990, 2008

	U.S.			Wis.		
Program	1990	2008	Diff.	1990	2008	Diff.
K-12 Education	33.5%	34.5%	1.0%	27.9%	39.5%	11.6%
Medicaid	9.3	16.3	7.0	10.1	12.8	2.7
Higher Ed.	14.9	11.3	-3.6	13.5	8.6	-4.9
Corrections	5.5	7.0	1.5	3.1	8.0	4.9
Other	36.8	30.9	-5.9	45.4	31.1	-14.3
Transportation	1.2	0.8	-0.4	—	—	—
Public Assistance	4.8	1.8	-3.0	—	—	—
Prop. Tax Credits	—	—	—	5.5	4.4	-1.1
Shared Revenue	—	—	—	13.9	7.0	-6.9

Note: Wis. GPR Medicaid spending does not include SeniorCare expenditures.

Federal Dollars

State leaders will likely need to make major decisions regarding MA funding and other programs before the federal FMAP increase expires at the end of June 2011. As noted, the additional FMAP resulted in nearly $350 million dollars for the state in fiscal 2009. Although the money was used for the Medicaid program, it meant less GPR funding was needed for MA, and it could be spent elsewhere (e.g., school aids, corrections, etc.). Forthcoming state budgets will need to replace one-time federal funds with ongoing state support in 2012 and beyond.

FINAL REFLECTION

Facing a current year shortfall of $153 million and a combined fiscal 2012 and 2013 shortfall of $1.8 billion, Wisconsin's Medicaid program faces serious, and immediate, financial challenges. State leaders need to confront these challenges in the pending budget legislation. Facing a budget hole of more than $3 billion by mid-2013, any new money for Medicaid will likely come at the expense of other state programs, most notably education and property tax relief.

The state's Medicaid program faces more uncertainty in future months as implementation of the federal health care law takes affect. DHS estimates put the price tag of federal health care reform at more than $400 million for state taxpayers during 2014 to 2019. □

Medicaid spending rose from 10.1% of GPR spending in 1990 to 12.8% in 2008.

DATA SOURCES:

Census Bureau; Centers for Medicare and Medicaid Services; Kaiser Foundation, State Health Facts; National Association of State Budget Officers, State Expenditure Reports; Wisconsin Department of Health and Family Services; Wisconsin Legislative Fiscal Bureau; WISTAX calculations.

PERIODICALS
USPS 688-800

Wisconsin Taxpayers Alliance
401 North Lawn Avenue • Madison, WI 53704-5033
608.241.9789 • www.wistax.org

WISTAX NOTES

■ **Reciprocity Dollars Owed.** Individuals living in Wisconsin or Minnesota but working in the other state will have to file income tax returns in both states starting this year (tax year 2010, 2011 filing). This is the first time in more than four decades that income tax reciprocity between the two states has not existed, affecting about 57,000 Wisconsinites and 22,000 Minnesotans. Minnesota, under former Governor Tim Pawlenty (R), ended the reciprocity agreement with Wisconsin in September 2009, pointing to Wisconsin's long delay in reimbursing its western neighbor for tax receipts owed to it.

Current Minnesota Governor Mark Dayton (D) is now demanding that Wisconsin pay its final payment of nearly $60 million to his state. According to Minnesota officials, the final payment was due December 1, 2010.

■ **Revenue Collections.** Wisconsin revenue collections from December were recently released. Compared to fiscal year 2010, adjusted general fund revenues were up 4.5% to date. Corporate income tax collections showed the largest gain relative to the prior year, up 10.7%. Sales tax revenues were 5.1% higher than the prior year, while excise tax collections were down slightly (-0.3%). Other tax collections, which includes the estate, utility, and real estate taxes, were down 3.5%.

■ **Tax Filing Delay.** Because the 2010 Tax Relief Act was passed by Congress in mid-December, some taxpayers may not be able to file their 2010 returns as early as in prior years. Changes will mainly affect itemized deductions, the tuition and fees deduction, and the educator expense deduction. The IRS is expected to be able to process these returns in mid- to late-February. Good news for tax filers does exist, however, as this year's filing deadline is April 18, 2011, not April 15. The extension is a result of the District of Columbia's Emancipation Day falling on what has historically been "tax day."

WISTAX FOCUS

■ **Gauging Fiscal Progress.** The change in state political leaders raises the question of how to evaluate state progress in improving its fiscal condition. Looking to general fund budgets is of little help because, in recent years, they have been balanced in name only. "How to gauge state fiscal progress, I" (*Focus* #26-10) offers a few suggestions for taxpayers when looking to evaluate if progress is being made.

One of the best tools for measuring the state's fiscal performance is not state budget documents, but instead the Comprehensive Annual Fiscal Report (CAFR). Submitted annually by the state controller and reviewed by the Legislative Audit Bureau, the CAFR is prepared in accordance with generally accepted accounting principles (GAAP). That means the CAFR reverses the various timing and fund-transfer techniques that state legislators have used to satisfy Wisconsin's requirement for a "balanced" budget. To illustrate differences between budget documents and the CAFR, that state ended 2010 with a fund balance of $89.6 million according to budgetary accounting, while it had a $2.94 billion deficit in the CAFR.

■ **Gauging Fiscal Progress II.** In addition to looking at general fund balances to assess the state's fiscal condition, there are other important measures often overlooked. "How to gauge state fiscal progress, II" (*Focus* #27-10) reviews the importance of looking at state debt and bond ratings when evaluating fiscal condition.

The state's 2010 financial statements show debt for governmental activities equalled $9.94 billion, a 6.8% increase over $9.30 billion in 2009. If debt from component units is included, the state's total debt is $15.21 billion. Another place to turn for an independent assessment of state finances is ratings of state general obligation bonds. According to Moody's, Wisconsin receives an Aa2 rating. Of 47 states rated, 33 are higher, 12 are rated the same, and two are rated lower. □