S. HRG. 104–846

MEDICAID DISTRIBUTION FORMULA

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JULY 27, 1995

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

38–848—CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-054989-2

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MEDICAID DISTRIBUTION FORMULA

THURSDAY, JULY 27, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, Nickles, Moynihan, Baucus, Bradley, Pryor, and Graham.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Committee will come to order please, if the witnesses could take their places.

I think we should surrender right now. We have been having enough difficulty, at least on the Republican side, with the formula issue for welfare, let alone what problems we may have when we get to the formula issue for Medicaid which, of course, is 10 times the amount of money involved in welfare or AFDC.

I am well aware that, when it comes to formulas, in Senators'—or Representatives'—home State and turf, it is often infinitely more important than substance. And matters get decided not on merits, but on whether you can figure out a formula that will get you 30 States in the Senate and, therefore, 60 votes? I can see Dr. Nathan smiling already.

But, unfortunately, if two or three of those States that you lose are New York and California, it gives you great problems in the House when the formula division comes up.

So we are here today to hear suggestions on the Medicaid formula, how it now works, does it work fairly? Should it be changed? How should it be changed?

And my mind is as open as the plains from the Appalachians to the Rockies on this, as to how to get a fair formula.

Senator Moynihan?

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. I do not want a fair formula. [Laughter.]

I think that is what I am trying to avoid.

All these years together, and we seem not to have an understanding on this.

I want the existing formula. But, I guess, more importantly, maybe some of our learned witnesses could speak to the question.

If we go from a shared Federal/State collaboration, and provision for matching grants, the Federal Government matching State efforts at some level—which has a national aspect to the whole enterprise—to a block grant, I think you change the structure of Federal funding and the trajectory in very important ways that you might not notice for 5 or 10 years.

But, 40 years hence, you will wonder what on earth you did. You changed everything that was put in place from 1930 to 1980, or so I would believe. And we learn.

Thank you.

The CHAIRMAN. Mr. Chairman, was it you or Bill Sapphire who had the longest word in the English language?

Senator MOYNIHAN. I had the longest word. The President Pro Tempore used it often. It is called floccinaucinihilipilification. It is a made-up word from the 18th Century Parliament, from the Eton grammar, Latin grammar. And it means, the futility of making estimates.

I wrote a review in The New Yorker of a book by John Kenneth Galbraith, which I titled "Floccinaucinihilipilification(ism)". They printed it; I promptly sent it to the "Oxford English Dictionary," and was told that, except for a few chemical terms, it is the longest word in the English language.

The CHAIRMAN. Well, I think Ms. Jaggar has the longest title of anybody we have had before the Committee this year.

The CHAIRMAN. Sarah Jaggar is the Director of Health Financing and Policy Issues, Health, Education and Human Services Division, U.S. General Accounting Office, Washington, D.C. And I think that takes the record this year. She is accompanied by Jerry Fastrup, who is the Assistant Director.

And we will take you in the order that you appear on the panel. So, Ms. Jaggar, we will take you first.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR OF HEALTH FINANCING AND POLICY ISSUES, ACCOMPANIED BY JERRY C. FASTRUP, ASSISTANT DIRECTOR, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. JAGGAR. Thank you, Mr. Chairman. Good morning. I am pleased to be here today to speak with you, to discuss the formula used to share the costs of the Medicaid program between Federal and State governments.

I would ask that our full statement be entered in the record, please, and we will summarize our points.

The CHAIRMAN. Without objection.

[The prepared statement of Ms. Jaggar appears in the appendix.]

Ms. JAGGAR. As Congress deliberates on whether to restructure the Medicaid program, the formula for determining the level of Federal funding for each State obviously becomes an important issue.

Today I will focus first on how well the current formula has achieved its objectives—namely, to promote across the States' various Medicaid programs, greater uniformity in coverage of people

and benefits, and greater fiscal fairness. Second, I would like to discuss what modifications might be appropriate to consider.

In 1965, when the Medicaid program was established, a matching formula was adopted to provide proportionately more Federal funds to States with high poverty rates and weak tax bases. The formula was designed to rely solely on per-capita income to measure a State's poverty level and tax base strength.

However, wide disparities seen in States' Medicaid programs demonstrate that the formula is not working as intended. For example, in fiscal year 1994, the number of people covered in Nevada's Medicaid program represented 61 percent of the State's poverty population, while Vermont's population covered by Medicaid equaled 139 percent of its poverty population.

In addition, the formula has not eliminated inequities in the tax burden States bear in financing their Medicaid programs. As illustrated by examples in my written statement, taxpayers and States with smaller tax bases are at a disadvantage, despite having a higher Federal matching rate.

Notably, Maine and Arkansas have devoted roughly the same shares of their tax bases to Medicaid as certain of their wealthier counterparts, but they can still only afford a significantly smaller program.

These findings lead me to discuss the potential modifications to the formula that might improve the prospect of achieving its original goals. For example, there are better and more direct measures than per-capita income, for both the incidence of poverty and States' ability to finance program benefits.

Using counts of a State's actual poverty population, rather than per-capita income, could significantly improve the measurement of people in need. Per-capita income is not always a good proxy for the incidence of poverty, because two States with the same per-capita income can have very different poverty rates.

For example, because West Virginia and Utah both have almost the same average per-capita income, the current formula treats them as if they had the same percentage of people in need. However, the percentage of West Virginians in poverty is nearly twice as large as Utah's. Data in our statement show that this is not an isolated example.

In addition, by using per-capita income to measure States' abilities to finance program benefits, the formula does not reflect all the income States can potentially tax, especially certain types of business income. The result is that the formula overstates the amount of taxable income for some States, and understates it for others.

While per-capita income may have been the best measure available in 1965, a more comprehensive measure called total taxable resources, or simply TTR, is now available. TTR for each State is published by the Treasury Department, and includes all of a State's personal and business income.

The Congress has approved the use of TTR as a substitute for per-capita income for distributing Federal funds under a drug and mental health block grant program. So it is in use.

Another modification to consider is the use of an adjuster in the formula, to reflect the cost differences that exist in delivering medical care in different parts of the country. The Medicare prospective

payment system's hospital wage index shows how important such adjustments can be, when so much of health care involves wages and salaries paid to those providing care.

Finally, a modification we have discussed in our prior work involves reducing the guaranteed minimum of a 50 percent Federal match provided in current law. This minimum allows high-income States, with low poverty rates, to finance generous Medicaid programs, with relatively low tax burdens. A lower Federal minimum would create a stronger incentive for such States to scale back their programs, making them more comparable with other States.

In conclusion, it is clear that the Medicaid formula can play, or will play, an important role in the restructuring of Medicaid. We believe that modifications to the formula, which we have reported on previously, could make the role of Federal funding to moderate program disparities more effective.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you may have.

The CHAIRMAN. Thank you very much.

Next we will take Dr. Jerry Cromwell, who is the president of Health Economics Research, from Waltham, Massachusetts.

Doctor?

STATEMENT OF JERRY CROMWELL, Ph.D., PRESIDENT, HEALTH ECONOMICS RESEARCH, WALTHAM, MA

Dr. CROMWELL. Thank you. I would to thank the Chairman, and Members of the Finance Committee, for inviting me to testify this morning on the ways Federal Medicaid funds are distributed to the States.

My remarks today focus on the Medicaid matching formula, its strengths and weaknesses, and how it might be made more equitable in the distribution of monies to the 50 States.

Let me preface my remarks with two important facts. First, over the last decade, the number of the poor—and especially poor children—given health care coverage through Medicaid has grown dramatically. Had the Congress not imposed certain mandates, beginning in the mid-1980's, the number of Americans without health insurance could be 25 percent higher.

Second, changing the way in which the Federal Government allocates its Medicaid dollars will produce potentially big winners and losers. There will be some pain involved in any kind of change.

This said, I still believe there are some changes in the allocation formula that are warranted, and their negative effects can be softened in several ways.

We should keep in mind, however, a few of the strengths of the matching formula. Because Medicaid is a matching grant program, the Federal Government has some assurances that States are extending coverage and paying for health services for their poverty populations.

Also, by using a sliding scale, based on per-capita income, the Federal Government helps poorer States like West Virginia, Oklahoma and South Dakota more.

Furthermore, a matching program allows States like Iowa, enrolling a more costly group of aged, blind and disabled recipients, to receive more Federal dollars automatically.

Fourth, a matching program, by itself delegates spending decisions to the States, which is an advantage in certain ways.

While the matching formula has these advantages, it can also have some technical and conceptual disadvantages. On the technical side, State per-capita income is generally regarded as a flawed measure of the States' abilities to raise revenues to support the Medicaid program.

The problem of counting welfare and other transfer payments as income has already been mentioned. In that way, it overstates the State's tax base because welfare subtracts, not adds, to taxpayers' wealth.

It also ignores the ability of some States to tax non-residents.

Third, per-capita income is not very sensitive to the business cycle, which is a very important point, especially when it includes Government transfer payments. Thus, downturns in local economies may not result in greater Federal assistance soon enough to weather the crisis.

Matching also permits the diversion or leakage of some State Medicaid funds to other activities, by reducing what the State itself spends on the poor.

Moreover, matching alone does not guarantee equal access to health care by the poor in all States. For example, as late as 1992, only 36 States had adopted a medically needy program.

Finally, matching may encourage overspending on health care in other States, because it significantly lowers the net price of health care.

Should the matching program be changed? The simple answer, of course, is yes. The more challenging question is how? Substituting another measure of State fiscal capacity for per-capita income would be a reasonable step. I certainly agree with the GAO on that.

Adjusting matching rates for differences in cost-of-living adjusted poverty rates, the demographic mix of the poor, and medical care prices across the States should certainly be explored.

Changing some of the mathematical parameters of the matching formula would be easy. This might involve reducing the matching rate factor, and broadening the range of matching rates, especially for the wealthier States.

However, I would point out that making across-the-board reductions will raise the real cost of the program in poorer States like Oklahoma.

Reducing the matching rate as State spending rises also has certain advantages over the present constant-match approach.

What about broader reforms? In my opinion, unrestricted block grants, or capping Federal expenditures, and doing nothing else, are a bad idea—at least, without specific enrollment or spending requirements. All the empirical evidence indicates that the coverage of health spending on the poor would fall by as much as 50 percent without Federal requirements.

However, combining Federal block grants with minimum State spending criteria would be an improvement, if wisely designed. The Federal Government could establish a minimum State spending contribution, based on each State's tax capacity, with wealthier States spending more.

A Federal block grant would them be established by Congress, based on a desired total spending per person in poverty, and adjusted for each State's minimum required contribution. States that wish to supplement their minimum contribution could do so, but would not receive any Federal match.

Thank you very much.

The CHAIRMAN. Thank you very much.

Next we have Dr. Richard Nathan, who is the director of the Nelson A. Rockefeller Institute of Government at the State University of New York in Albany. This is a man who has appeared here numerous times, and who we remember well and favorably from his recommendations as to what we should be doing in a related subject 20 years ago. Had we done this at the time, we would not be in the fix we are in now.

Senator MOYNIHAN. A quarter century ago, sir.

The CHAIRMAN. A quarter century ago. Senator Moynihan remembers it well.

[The prepared statement of Dr. Cromwell appears in the appendix.]

STATEMENT OF RICHARD P. NATHAN, Ph.D., DIRECTOR, NELSON A. ROCKEFELLER INSTITUTE OF GOVERNMENT, STATE UNIVERSITY OF NEW YORK, ALBANY, NY

Dr. NATHAN. Thank you, Senator. I am just going to paraphrase my testimony.

On the first page of the testimony, I have four laws of formula grant writing, which are based on a lot of experience I have had in this field.

As you said, Senator Packwood, in your exchange with Senator Moynihan, the first law is that formula writing is a political art form. No expert can tell you how to do it.

The second law is that an old formula—and this is what Senator Moynihan was saying—is a good formula. If you write a new formula, particularly if you do not have what Mr. Nixon called sweeteners, you open up a Pandora's box of political regional rivalries that, of course, you already know a lot about from the welfare field.

The third rule is that the formula has to be legislated. Do not just tell the bureaucrats to do it this way, and use these factors, because they will game you and not get the outcome you expect.

The fourth thing is that you have to test any formula you want to consider. And it has driven me nuts since Mr. Ranthum asked me to testify, because I have a secret formula chart, which he suggested I not give out until I finish my testimony because no one would listen to my testimony.

The CHAIRMAN. Now this is interesting. In addition to a secret plan to end the war, you have a secret chart?

Dr. NATHAN. I have a secret table on how to meet my four requirements in a way that deals with some of the issues that are the hot issues now for the high-growth States and on the poverty issue that has come up.

The next point I will make, just to use my introductory time, is the politics of printouts. When I began in this business, we did not have computers. And nobody knew what happened when you changed the formula. Nowadays, everybody knows.

So I have made two assumptions. These are not my ideas; these are just my assumptions.

One assumption is that people want to have a cap on the growth in Medicaid. So, on the basis of that assumption, I have done this illustrative run. And I personally cannot figure out how you can do a per-recipient or per-person cap. I have stayed up nights thinking about this, woke up in the middle of the morning thinking, how would that possibly work in a way that fits my four laws? I cannot think of an answer, even though the administration says they want to do it that way.

Page 3 of my testimony says that you should consider a "SuperBlock". Put Medicaid and AFDC together. When you look at how Mississippi does under Medicaid, compared to how they do under AFDC, a lot of the Hutchinson letter issues evaporate.

I also think that the employment and training Kassebaum work force development block grant ought to be included in SuperBlock, which may be what you do after the train wreck. Then States would have a real opportunity to integrate programs. We have been talking about it until we are blue in the face. This would really open up a lot of opportunities.

The approach I use is to create what I call "Dick's Dilemma". And I must have run about 20 different runs. And Mark McGrath, my assistant, has the secret plan. But, anyway, it is described on page 4.

First, you take all the States above the median, combine Medicaid and AFDC spending, and create a fund. Then you give that money back to the States that are very high-growth States. I also tried it for high-poverty States. Mr. Fastrup, who is the real expert on this, could do it faster than me. I could not get it done in time.

Page 5 shows the States that gain. There are 14 States that gain, and 23 States that lose. This is a 12 percent redistribution plan. No State loses more than 6.58 percent; that is Louisiana, and that is because of the high DSH.

The only thing that allows me to propose this plan, Senator Moynihan, and go back to New York tonight, is that it preserves the DSH on the table. I can explain all that, but I have only got a few minutes, so I will leave it out for now.

To go on in my testimony, I talk about a savings provision that would allow the States to keep the savings they make under their allocation. I know New Yorkers are interested in that, Senator.

I talk about maintenance of effort and say, if you are going to give a bonus to any State for anything under the Dick's Dilemma plan, there should be some consideration of some matching of the bonus. I can go into that.

I then talk about SuperBlock again, with the three parts—Medicaid, welfare and work force development. If you do anything like I think is headed our way, in terms of Federalism reforms, profound changes in Federalism grant policy and social policy, you have coming at us what I have been calling in previous testimony I have been giving lately, the devolution revolution of 1995. I believe it is a bigger deal than the Great Society, Senator.

On page 8, I say that you ought to put an automatic emergency add-on in this legislation. It does not cost you a penny because CBO will not project a recession. I think that you need to do that.

Then, Senator, I end with comments on your other questions—the quality of data and the per-capita cap. I just cannot figure out a way to do it. Now maybe somebody smarter than me can.

I end the testimony by saying that this is a very dull subject, and I hope my testimony is not as boring as it usually is when I talk about this.

This is for Senator Moynihan. I quote Joseph Schumpeter. He once said—and I am paraphrasing—"It is in fiscal issues like this that you can hear the thundering hoofbeats of history." This is not small potatoes.

The CHAIRMAN. Dr. Nathan, you are a lot of things, but you are never dull.

Next we have Dr. Paul Peterson, who is the Henry Lee Shattuck professor of Government at Harvard. And I am informed by Senator Moynihan that there is no department of political science at Harvard because it is not a science. Is that correct? Have I got it right?

Senator MOYNIHAN. Well, we do not think so. But, at Yale, they say that Aristotle did. So, who is smarter—us or Aristotle? So they have political science at Yale.

Dr. Peterson?

[The prepared statement of Dr. Nathan appears in the appendix.]

STATEMENT OF PAUL E. PETERSON, Ph.D., HENRY LEE SHATTUCK PROFESSOR OF GOVERNMENT, HARVARD UNIVERSITY, CAMBRIDGE, MA

Dr. PETERSON. Well, I agree with Senator Moynihan. I think there is no such thing as political science.

There is such a thing as Government—yet. [Laughter.]

Now it seems to me that any change in the Medicaid formula needs to achieve a balance among the following objectives: One, we need to encourage the introduction of cost-saving approaches by State governments; two, we need to assist the goal of deficit reduction; three, we need to discourage a race to the bottom among the States, so that the needy are deprived of this important program; four, we need to provide greater assistance to States with lower tax capacity and lower per-capita income, or some other measure of resources; and, five, we need to respond to shifts in the need for Medicaid services in particular States, caused by demographic and economic change.

In my prepared testimony, I discuss the current formula and the block grant formula. But what I would really like to talk about here in my oral testimony is the alternative I think is to be preferred. And that is one that I call a per-recipient matching formula, or what some people have called a per-capita cap.

It seems to me that the per-recipient formula meets these criteria more adequately than alternative approaches, provided that the specific amount is set separately for different kinds of Medicaid recipients—the elderly, the disabled, adults and children, who all have very different needs for Medicaid. And the amount should be set at some level, such as the existing level in 1994, with some kind of adjustment for changes in the cost of living.

The advantage of going with this per-recipient, or this per-capita cap, is that, one, it does help to encourage cost-saving among the

States because States do not get any additional grant from the Federal Government with a cap that is placed per recipient, simply because their costs are rising, unless you include an overall cost-of-living adjustment, which you may want to do.

Second, it encourages this cost-effective medical care delivery by focusing on containing medical costs, rather than restricting eligibility standards. State programs would be more apt to bloom than to wilt. One of the things that people are talking about is that we need to have more State experimentation. We want to have 50 flowers bloom.

One of the things that I am concerned about is that we are going to have 50 flowers wilting because a State that has got a very handsome Medicaid program, with very broad eligibility standards, is going to become very attractive to needy people if other States are forced by some kind of fixed block grant to cut their program to the bones. Then you could have a race to the bottom, as every State gets worried that it is going to become a Medicaid magnet. So we do not want to do that. And I am very much concerned that the block grant is going to do that.

But the per-recipient cap, which contains some of the same cost-saving objectives of the block grant, would be able to achieve that objective without leading to a race to the bottom.

Also, it would respond to State demographic and economic change. We know that some States grow faster than others. We know that some States are going to have a recession, and other States are not going to be going through a recession. And so we need to have a formula that is responsive to that situation.

Finally, it is quite feasible to do this. You can make some progress towards your deficit reduction objectives through this. And you can move even further if you try to achieve greater equity among the States by going to, say, a 40 percent match in your wealthiest States, however you choose to measure wealth. And you can adjust your cost-of-living adjustment from year to year in order to help achieve your deficit reduction targets.

So it seems to me that you do not need a block grant in order to get the deficit reduction objectives that are on the table. You can do it with the per-capita cap or per-recipient cap that I recommend to you.

The CHAIRMAN. Thank you very much.

We will conclude with Dr. Robert Strauss, who is the professor of economics and public policy at the Heinz School at Carnegie-Mellon University of Pittsburgh.

Doctor?

[The prepared statement of Dr. Peterson appears in the appendix.]

STATEMENT OF ROBERT P. STRAUSS, Ph.D., PROFESSOR OF ECONOMICS AND PUBLIC POLICY, THE HEINZ SCHOOL, CARNEGIE-MELLON UNIVERSITY, PITTSBURGH, PA

Dr. STRAUSS. Thank you, Chairman Packwood, for inviting me this morning.

I have a long prepared statement, which I ask be included in the record.

The CHAIRMAN. Without objection.

[The prepared statement of Dr. Strauss appears in the appendix.]

Dr. STRAUSS. What I will do is try to abstract from it. It has some historical notes about what transpired here 25 years ago, which may shed some new light on how revenue sharing got passed and inform today's formal discussions.

I have tried in my statement to look at the question of the formula in three or four ways. At the outset, I do not think that turning Medicaid into revenue sharing is a good idea, because I think there would be serious issues of fungibility and state maintenance of effort.

Given 33 million people are getting some kind of health services, I would be very nervous about the repercussions of serious leakage in a few years if it were "block granted" in any significant way. You may want to get back into that later in our discussions.

In the very short run, my suggestion to you is, for budgetary purposes, to pick an appropriation figure each year for the next few years, and proportionately reduce the reimbursement requests each year that come in under the current program.

Number one, this meets an annual budgetary objective and, number two, it effectively reduces the matching rate proportionately.

I think this sort of thing would be acceptable to both legislative bodies. One of the difficulties of formula wars, as you know very well, is what sells over here in the Senate does not in the House. And the disagreement can lead to perhaps nothing happening, which would then leave the Medicaid budget sort of out there, meandering upward.

So my suggestion, in the short run, would be to do a proportionate sort of deceleration, and try to look at some medium-term solutions that I will get into shortly.

With respect to the current formula, I do not think averages or per capitas are ethically compelling. I think median household income tells us a lot more about the ability to pay of representative consumers, who have to finance the poverty programs in each State. So I go through the analysis in my statement of the effects of moving to median household income by State. And you will see that it compacts the distribution for Federal matching rates thing a fair bit.

Second, I do not think that using the squared function in the formula is necessary. If you go to a linearization, as you will see in the graphs in the statement, it will make the system a little less disperse, and the matching rates will come down.

In my statement, where I talk about formula changes, I indicate the utility of looking at enrollment rates, and the idea of rewarding States that are getting the eligibles into the program. This is either encouraging or discouraging—depending on how you think about it—States that have not been very good at getting folks out there onto the program.

I show you mathematically how to get that into the formula in a way that may make the 50 percent floor not as painful to eliminate as otherwise might be the case.

Finally, at the end of my statement, I have some suggestions on how poverty and health outcomes are really relative concerns, rath-

er than absolute. We do not even have one speed limit any more; we have urban and rural speed limits.

I think, if you go back to some ideas that Mr. Ullman had some years ago in his welfare reform bill, where cash assistance was based on a proportion of median family income in each State, and think about a health assistance program that is based on the same relative notion, you could really control costs a lot better, and still have diversity out there, in terms of coverages of services.

Finally, I think I would like to make the observation, as Dick Nathan did, that Federalism is very much an issue in Washington, and in the Congress. I would urge that some other forums be developed or reinvigorated for talking about our Federal system.

We are about where we were after the Second World War. Then, there were some major commissions—the Groves Commission among others—that really thought very hard about what we should do when peace broke out. Well, it did not quite. But we really are at the same historical in our Federal system.

Beyond getting the budget reorganized in the next year or two, I would hope that the ACIR or some other forum could be a place where we work out who should do what, and how should we pay for these things.

Thank you.

The CHAIRMAN. Doctor, thank you.

Let me say to the Committee, we are going to have seven votes, starting in about 20 minutes, that could be 25 minutes.

Senator MOYNIHAN. Oh, no.

The CHAIRMAN. So I am going to ask that we hold ourselves to 3 minutes on the first round. We may not finish, and we may all have to come back in an hour and a half, and ask the witnesses to come back. But we will start with 3 minutes.

Dr. Peterson, I will start with you.

When you used the term "per-capita cap," I discovered this means different things to different people. Let us say we are going to spend $1,000 on Medicaid. We determine a formula, and the formula says that there are 100 eligible people around the nation. We satisfy the formula, and they are going to get $10 apiece.

Does that mean that, other than adjusting that for inflation or something like that, suddenly, instead of 100 people, there are 200 people eligible, so it is a $5 distribution, rather than a $10 distribution? It is still a per-capita cap. We have cut it in half in order to stay within the total money we spend. Is that what you mean by a per-capita cap?

Dr. PETERSON. No. I think you have to build your formula so that, if your eligible pool increases, the total is going to go up for that particular State.

The CHAIRMAN. Then it is not a spending limit, however.

Dr. PETERSON. Well, the way in which you would have to get your spending limit nationwide would be to say, all right, instead of doing a cost-of-living adjustment of 2 percent, we are going to have to have a cost-of-living adjustment of 1 percent. Or, instead of a cost-of-living adjustment of 4 percent, we will have to drop it to 3 percent. So there are ways of achieving your deficit reduction objectives.

The reason for going with a per-capita cap or a per-recipient cap is because some States could have a very rapidly growing elderly population, or a very rapidly growing disabled population. And other States may have a declining elderly or disabled population. So arranging a formula in this way responds to these kinds of demographic changes, as well as to economic changes that might lead to a greater demand for Medicaid services in one State or another.

The CHAIRMAN. Explain to me how we say we are only going to spend $1,000—maybe adjusted for inflation—but nothing more than that. How do we have a consistent formula? I realize that Florida's elderly population may rise, and South Dakota's may go down, or something like that. But how do we adjust the cap? I understand if inflation is 5 percent and we adjust it 1 percent. But can we keep it within the spending limits that we have agreed, and still do these variations from year to year, or State to State, as circumstances change, and still call it a per-capita cap?

Dr. PETERSON. Well, you know, I think there is always this pursuit of the will-o-the-wisp, the Gramm-Rudman formula, this automatic thing that we are going to somehow do today, which is going to forever solve the spending problem or the deficit problem. I do not really see how that is going to be possible.

And we say, all right, we are going to have a block grant that is fixed, because then we will know for sure that deficit reduction targets are going to be met, and that is the only goal we have in mind. The other goals that we also really all care about are going to have to be seriously sacrificed if that is the only goal we set.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, for the last 19 years I have put out an annual compilation of the flow of funds between the Federal Government and the States. Recently, the Kennedy School at Harvard has taken up the work.

Professors Leonard and Monica Friar have developed a State cost-of-living index, which will give you sometimes strikingly different perceptions of what the world is like, the North-South differential of our Medicaid formula, which is the Hill-Burton hospital formula of 1946. It is a very different world indeed.

I would ask if I could just have table 1, the State cost-of-living indexes put in the record.

The CHAIRMAN. Without objection.

Senator MOYNIHAN. And then a political question.

I think Dr. Nathan is exactly right. I will excuse our friends from GAO on this. The devolution revolution of 1995, which you say, Dr. Nathan, is more important than the Great Society, which in many respects just filled in from the 1935 work of the New Deal. What are the politics of it? It is not just an accident that this is being proposed. Something large in history is being proposed. What do you think?

Dr. NATHAN. I would like to respond, Senator. I think it is driven by the very conservative mood of the country, particularly on social issues as you are addressing. And deficit reduction is very closely related to the pressure to achieve block grants.

On page 9 of my testimony, I have a paragraph that I think answers Senator Packwood's question. I have tried as hard as I can

to think of a way to have a per-capita cap that achieves some fixed deficit reduction target. And I cannot think of a way to do it.

Now, if you want my personal opinion, in the beginning of my testimony, I say that I am not sure there should be a growth cap. But it seems to me there is, Senator, a very changed mood in the country.

When I testified last time, I had sort of a debate with Charles Murray before this Committee. I thought the Members of the Committee were wonderfully articulate about how fundamentally ideas have changed about social engineering and social policy in the country.

Senator MOYNIHAN. I will just leave it there, and pursue you individually. But I say that the pressure from the deficit is no accident, friend; it was a very important strategy called "starve the beast". If you deprived it of revenue, you would have to change the structure of the Federal Government. And this devolution will surely do that.

Dr. Peterson? Dr. Strauss?

Dr. PETERSON. Well, if I may just add to Dr. Nathan's comments, it seems to me that there is one aspect of the devolution that is to be applauded. And that is turning over to the State and local governments responsibility for their own economic growth and their basic governmental services. That has bipartisan support, and I think it is a good move in the right direction.

I think turning over responsibility for social services, which is essentially what you do with a block grant, because all incremental costs, 100 percent of marginal costs, are going to be borne by the States, is going to lead to the race to the bottom. Your having a good program only leads to a shift in responsibilities to another State.

Senator MOYNIHAN. That is all right, Dr. Strauss, I will get to you privately.

The CHAIRMAN. Senator Pryor, and then Senator Graham.

Senator PRYOR. Thank you, Mr. Chairman.

Dr. Nathan, with all due respect to you and your colleagues, if I invited you to a town meeting down in Arkansas, and we talked about the devolution revolution, we would probably both be locked up. [Laughter.]

Senator MOYNIHAN. That is because they would think it was the Scopes trial all over again.

Senator PRYOR. They might. They would not know what else it could be. They would not know what we would be talking about—the devolution revolution.

This sort of goes along Chairman Packwood's line of questioning, but I would like to go a little further.

I am worried that we are losing sight, to a degree. We are concentrating on formulas, statistics and studies. And we are kind of losing sight of the human aspect of this, and certainly the family aspect of this.

I received a letter from a lady in a nursing home, written in very scribbly hand. She is a Medicaid patient. My staff has deciphered it for me. It says, "I wish you would pass a bill to hire someone to stay with me so I could go home. How I want to go back home. You, the Government, are paying $1,600 a month to the nursing

home. I could pay $500 to a lady to stay with me in my home, and I could go back home."

In Arkansas, we work under a waiver. But this waiver does not entitle this person to have that option.

I just do not see the innovation at the Federal level that allows sufficiently flexible options for people like this. I hope that we will consider the family, and the human factor as we proceed and go forward with trying to find a solution.

Dr. NATHAN. If I could make a comment on that, in New York, where the State has been very liberal and innovative about using the home care option under Medicaid, the truth is that they have had a lot of problems with it.

The basic question is whether providing home care really does save that $1,100, or gets somebody cared for at home who would not necessarily be in a nursing home. So it is a very great dilemma, sir, that a lot of States have had trouble with. New York is using something like 70 percent of all the home care money under Medicaid. And that is why, if you look at my chart, New York is off the chart on Medicaid.

Senator PRYOR. Where today is the innovation? Is that at the local level, or is it at the Federal level?

Dr. NATHAN. I hope it is at the State level, sir. I think that is the one really hopeful thing about this movement. If you could unleash the States, some States could set up new systems that could be really creative. Now that may or may not happen. But, as Dr. Peterson said, there is a chance for that, so there is a little bit of good in everything. It seems to me that the little bit of good in the—pardon the expression—devolution revolution, may be that some States will really learn how to put services together.

I have a joke in my testimony about a caseworker who goes to a client's house, and cannot find parking because there are so many caseworkers serving the same client. We have program proliferation problems that are partly caused by Federal programs. By going to block grants in the way SuperBlock, or some of the things being discussed would do, it might create opportunities in States which are innovative, and I am sure Arkansas would be right there at the top of the list.

Senator PRYOR. Thank you, doctor.

The CHAIRMAN. We had a witness the other day, named Dick Ladd, who used to head Oregon's senior services division. Then Texas stole him away for an increase in salary, and he is now doing his own consulting. But we got a waiver to do home health care very early on. And we just about doubled our coverage for the same amount of money. And people were happier, being able to stay at home.

We had to get the waiver to do it. And, you are right, the innovation came at the State level. It did not come with the Federal Government forcing us to do it. It was like pulling teeth to get them to allow us to do it.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to make a couple of preliminary comments on my questions. My first comment is a repeat of what I said yesterday. This panel, as did yesterday's panel on Medicare, to me under-

scores the importance of getting beyond the generalities, into the details of what this Medicaid reform is going to be.

These are extremely important and complex issues. We need to move as quickly as possible with the American public to a consideration of specific proposals that can be the subject of debate, consideration, modification, so that there will at least be an informed public and an informed Congress when these major changes occur.

I am very much concerned that we are going to have an ignorant public, a frustrated public, and a less well-fashioned public policy if we defer the details of these proposals, as has been suggested, until mid-to-late September.

My second point is that I cannot accept the idea that my good friend, Dick Nathan, should stay up at night, as insomniac as he might be, trying to figure out a per-capita, capped program. To me, it is at least a first cousin, if not a sibling, of what every State has to do in allocating funds to its individual school districts.

If anything, the level of complexity of a State school allocation formula is significantly less than the complexity involved in the Federal Government allocating funds for children, adults, disabled and elderly poor, under a health formula. I would hold that discussion for another day.

But let me ask two questions. One, in this devolution revolution, we seem to be focusing on health care and welfare issues. I am struck at how different this debate was than in 1981, when those were the items President Reagan thought should be at the bottom of the list of devolution, because those were the ones that encouraged the kind of behavior that Dr. Peterson referred to.

If you had to array the Federal programs, in terms of devolution—everything from law enforcement to highways, to health care—which would you think would be the best candidates, and which would be the least desirable candidates for that devolution?

Dr. Peterson?

Dr. PETERSON. Well, thank you for asking that question. I just wrote a book on that topic, and it gives me a chance to advertise it.

Senator GRAHAM. Well, listen. Everybody is promoting their books these days, so go ahead. [Laughter.]

Dr. PETERSON. It seems to me that we should be turning over to the States responsibilities for transportation, crime control, education, and just a lot of Government services. I think a lot of things can be done better at the State and local level.

But I think Medicaid is just about at the bottom of the list of things to turn over. President Reagan was exactly right when he said that should not be done. So we are talking today about the last program.

One compromise on that, however, I think is the per-recipient cap. There you say, all right, we are going to ask you to make cost savings in this program, but we are going to ask you to do it without denying people eligibility.

Senator MOYNIHAN. That is the price of Federalism.

Dr. PETERSON. Thank you.

The CHAIRMAN. Our votes have started. We have seven votes. So, Max, will you go ahead. I will see if I can get these other two questions in.

Senator BAUCUS. Dr. Nathan, the Chairman asked questions of Dr. Peterson about per-capita caps, and what Dr. Peterson understood them to be.

And the Chairman questioned how we were going to make our budget allocation if there might be some growth.

I would just like to ask you, what is a better alternative? It seems to me that, when we set budgets anyway, we do our best to anticipate next year's expenditures and revenue. We do not know with precision what they are going to be, so we do the best we can, knowing what the budget expense will be, given the number of people who would be eligible, and set it at whatever inflation rate we think is appropriate.

So I do not see how it is a lot different than other budgets that we set around here. So, my question is, what is a better alternative? What is wrong, Dr. Peterson, knowing that we are going to give it our best shot, and try to do our best to determine what the expense is going to be in allocating?

If we think it is going to be a certain number of billion dollars, we make an adjustment somewhere else. If it is going to more or less, we make changes. But we still do not know with exact precision what it is going to be. What is wrong with just going along the lines of a per-capita cap?

Dr. NATHAN. Senator, it is not my personal preference to say this, but I just cannot see how it can work. I do not know if you were here at the time, but I do have my secret plan, which is an alternative.

Senator BAUCUS. But, could you just outline, why would it not work?

Dr. NATHAN. All right.

Senator BAUCUS. Other than the budget.

Dr. NATHAN. Yes. All right, I will stick to the point. And that is, every experience we have had with an open-ended program, the States learn how to make very heavy use of it. They know how to play the game.

So, if it is a per-capita cap, that means that anybody who is eligible for Medicaid in your State can get whatever the per-capita cap amount is, I think Medicaid costs are likely to go through the roof, sir.

If you then want to do what Senator Packwood said, and put some kind of a total cap on Federal spending on Medicaid, you have to annually recalibrate to stay within the cap. And I do not know how you do that.

So I am trying to figure it out. If I could figure out what I think is a system that meets these four laws of formula writing, I would do it.

Martha Derthick wrote a book about what Wilbur Mills called the biggest loophole—social services spending. Senator Moynihan remembers it. When that was open-ended, it just took all the discretionary money out of HEW.

So I just do not see how you do it. As a technician, I do not see how you do it. It is not that I am against it, intellectually or philosophically.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Nickles?

Senator NICKLES. Mr. Chairman, thank you very much.

I would like to continue on that. You can take the amount of money that is appropriated to Medicaid, the amount of money that they received last year, increase that by whatever percent that the appropriators in the Budget Committee decide to do. That was what, 7 percent?

The CHAIRMAN. Four point four.

Senator NICKLES. Four point four. Say, for next year, the State of Oregon receives 7 percent more than you received last year. You make that determination.

Now the States may have to do that by a per-capita amount. The State would have some flexibility. The State may have to redefine eligible participants. They have to make some adjustments, what services will be covered. But that is doable, is it not?

Dr. NATHAN. Yes. That is what this secret plan is, sir. That is what it does. It takes the 1994 base, takes some money away from what I call the very high-user States, particularly the very high DSH States. Louisiana is the champion, by the way.

Senator NICKLES. Disproportionate share?

Dr. NATHAN. Disproportionate share States. And then it gives that money back to States that have had very high population growth, so they get a bonus.

And I think you can do that in a way that is politically workable. I know where Oklahoma is on the chart. I would be happy to go over the numbers later.

Senator NICKLES. I would like to learn more about that. I think that is doable, but my problem, Mr. Chairman, is that it perpetuates inequities. Some States have utilized the disproportionate system significantly; some States have, in my opinion, abused the provider tax, through schemes, scams, or whatever, to really milk the system.

So I like the idea of caps. I happen to think, from the budget standpoint, we need to do something to have a limit on how much we are going to spend. And a logical starting point is how much did you receive last year?

But there are gross inequities, partly because of geographic differences, cost-of-living differences, and so on. But a lot of it is abuse of the system through the DSH program and, I would say, even more of an abuse through the provider tax. And I hate to reward that kind of inequity forever. That is a problem.

I would be happy to learn more about your plan. I would be happy to hear from GAO with their recommendations, as well.

Dr. NATHAN. Just a quick comment. You could give half a DSH, or three-quarters of a DSH, but I think you have to play the game that way, sir.

Senator NICKLES. Ms. Jaggar, did you want to add something?

Mr. FASTRUP. If I could just interject for a second, I think capping the program can technically be done fairly easily. To address the equity issue, what it really comes down to is that the program is going to grow an average of 5 percent a year.

To correct those inequities, you are going to have to have some means of allowing the States who have been disadvantaged in the past to grow a little faster than that 5 percent. And States who have been advantaged under the system can grow a little slower

than 5 percent. Those are technical issues that can be worked out and dealt with quite easily.

We would be happy to work with you in searching through a few of those kinds of schemes to see how they could work.

Senator NICKLES. Well, we tightened up on the provider tax abuse a year or so ago, but we did not eliminate it. We basically froze it and stopped it. I do not know how you would remedy that, but we welcome your suggestions.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. I come from a State that has, relative to the other States, relatively minor, less costly delivery of medical care.

I guess my question would go to you, Dr. Cromwell. Your formula is based upon need and State fiscal capacity, adjusted for demographic mix and medical care prices. If you try to work out a formula around those variables, how should we adjust for the fact that some States have made greater efforts to contain their Medicaid costs than others?

I am getting at it from this standpoint. Somehow it seems unfair that we should not take that into consideration because, if you do not, those States are going to be hurt.

Dr. CROMWELL. I think the idea of making these adjustments that I was talking about would be to have some set of fairly independent measures of State need as a basis for starting out.

If there were going to be adjustments made for the number of poor in the State, which I think makes sense, one would want to make some adjustments for the cost of living, at the very least. The number of poor in New York, adjusted for cost of living, is greater than would currently appear. So I think you want to make these adjustments, just for equity reasons.

Yes, some States have been a bit better about their management of the program. That is very difficult to measure in any objective way that I can determine. I think you want to put incentives in the system, and bonuses or rewards for those programs that tend to be efficient.

And I think that a matching program, with a minimum State contribution and a block grant, based upon some sort of national average, would actually give some of the States who are relatively low cost to begin with, actually more Federal money than they currently have been getting, simply because they are currently well below a national average.

Senator GRASSLEY. So, even though you do not know exactly how it would be done, you ought to take into consideration States who have been modest in their increases?

Dr. CROMWELL. Yes, absolutely. I think you have got to be concerned. There has to be a compromise between those States who have currently not been as expansive on their programs as the Congress, as a body, might want to be, and those who probably have been too aggressive in terms of health care spending. And there has to be some kind of compromise arrived at.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. Thank you very much, Mr. Chairman.

I know we are rushing, and we only have a few minutes, so I would just like to ask one question. That pertains to the fact that

the cost of delivering health care varies from place to place in the country.

Some people say cost differences just measure differences in efficiency. But there actually are cost differences beyond the efficiency level. My question to you is, how would you suggest we deal with these different costs of delivering health care in different parts of the country, if we were actually trying to formulate a block grant?

Dr. PETERSON. Senator, what I would recommend is that we go with the existing base, since it is easier to go with that than anything else. And then you say, any increases that are due to the number of recipients you are serving, that will be covered, but we are going to put a very tight control on the increase in the cost of service delivery.

Maybe there would be some adjustment for inflation, but not very much. Maybe there should be less adjustment in the States that have very high costs already, so they are encouraged to go for more cost savings than States that do not have such high costs at the present time.

It seems to me that what you really want to do is focus your formula in such a way that it encourages cost savings by providers, without denying people eligibility.

Dr. STRAUSS. Senator, if I could add a consideration I have not heard this morning, which troubles me.

We have not talked about benefits. We have talked about money. We have talked about access. But we have not talked about well-offness, healthiness.

It seems to me, if you really want to get control of the system with the States, there has to be much more concern and focus on whether the recipients are healthier than they would otherwise be. You can never be healthy enough.

This Congress, or myself, can never spend too much on health care because we can always get a little better. The issue is, what are we getting in return for poor people who we want to be healthy? And how does that compare to the majority of us who have to finance it? I think that really ought to be the long-term question, especially with the changing demographics. Otherwise, we should all become MD's.

The CHAIRMAN. That is exactly what Oregon attempted to do in its Medicaid plan, but there is an unending supply of illnesses that you could correct with an unending supply of money. But we finally said we have not got enough money. We do not pay for the common cold. We do not know how to treat it; it does not do any good. We just cut it off. We will not do plastic surgery for purely cosmetic purposes. If you do not like your face, we are not going to pay for it publicly to fix it.

But you are right. We could spend all the money we have.

We are going to have to run. They are holding the vote for us now, Bill. I am not going to ask you to come back. We have three votes, then 10 minutes debate between three more votes. It just will not work.

So we will submit questions to you in writing. I apologize for the abbreviation.

Thank you very much.

[Whereupon, at 10:28 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF JERRY CROMWELL, PH.D.

OVERVIEW OF THE MEDICAID PROGRAM

The Medicaid program that provides health care coverage to the nation's poor is one of the fastest growing budget items. Since 1975, when total federal and state outlays on Medicaid roughly equaled cash welfare payments, to 1992, spending has grown from $12 to $91 billion dollars, not counting administrative costs (see Table 1). In just two years, 1990-92, total outlays grew 43%, a rate exceeding 20% annually.

But of more concern is the growing share of new tax revenues devoted to the program. Nearly 23% of new state tax revenues generated in 1991 went to support the $5.4 billion extra spending just by the states on Medicaid (Cromwell, et al., 1994, Table 10-4; Gold, 1992). As burdensome as this is, the spending impact on the federal government was even greater. In just two years, federal support of Medicaid rose by $12 billion to $52.5 billion (see Table 2).

Many factors have contributed in varying degrees to the secular increase in spending. Eligibility and service expansions have played a major role at times--especially in the last ten years, but the constant underlying force has been health care cost inflation more generally. The medical care component of the Consumer Price Index rose 2.5-fold alone between 1980 and 1992. State Medicaid payment rates grew more slowly, but still far exceeded the growth in tax revenues.

In addition to the accelerated increases in program spending, wide variations exist in state coverage and spending on the poor (see Figure 1). As of 1990, Nevada covered just 29% of its poor after adjusting for cost of living and partial-year eligibility status. By contrast, California covered 90%. While some states cover many of their poor, others spend far more, in real terms, on eligibles. Wisconsin and Massachusetts, for example, spent nearly $8,000 per enrollee after adjusting for local health care prices while West Virginia spent only $800 and California just $1,265. A clear trade-off exists between covering more of the poor, usually healthier, younger, women and children, and how much is spent per enrollee. States spending more in real terms per enrollee tend to cover disproportionately more elderly nursing home and medically needy patients. Nevertheless, what is striking in Figure 1 is the variation across states in both breadth and depth of Medicaid coverage as well as total outlays in real terms.

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DESIGN OF THE MEDICAID MATCHING FORMULA

The Congress in 1965 recognized that states varied in their financial capacity to extend health care coverage to the poor under their jurisdiction. Consequently, they extended federal matching of any state spending on health care services for welfare recipients plus other selected groups. Of these, the two most important were the elderly poor receiving federal SSI payments and the state-determined medically needy.

The Federal Medical Assistance Percentage (FMAP), or matching rate, is defined as

$$FMAP = 1 - .45 \times [\, PCI_s / PCI_{us} \,]^2$$

where PCI_s and PCI_{us} are the per capita incomes of any state, s, relative to the United States, us. Federal sharing percentages are further bounded at a minimum of 50% and a high of 83%. Several characteristics of the matching formula are noteworthy. First, federal sharing is greater percentagewise in states with below average incomes. Second, federal sharing rises if state per capita income falls relative to the national average income. If both the state and national values fall by the same percentage, then the federal government's share of state Medicaid spending does not increase. Third, federal sharing rises or falls exponentially with differences in relative incomes. For example, if a state's per capita income is 90% of the U.S. average, the federal government will pay for 63.6% of Medicaid outlays vs. 55% in another state whose income equaled the national average; a difference of 8.6 percentage points. From the state's perspective, if it spends up $1 of its own money on Medicaid, the federal government will pay $1.75 if its per capita income is 90% of the U.S. average. The federal matching dollar multiplier grows rapidly as per capita income falls. Thus, a state with a per capita income only 70% of the national average will enjoy an FMAP = 78% and a multiplier of $3.55-to-$1. The upper sharing limit is reached for states with incomes approximately 60% of the national average.

The sharing effects are very different for richer states. This is because the lower bound of federal sharing is set at 50%. Consequently, any state whose income exceeds the national average by more than 5.4% will not experience any more loss in matching dollars but continue to receive at least $1-for-$1 matching.

STRENGTHS OF THE FEDERAL MEDICAID MATCHING FORMULA

A matching formula keyed to state wealth has several advantages.

Helps Poorer States More. First, and most obvious, is that poorer states receive disproportionately more aid through higher matching dollar multipliers. To purchase $4 of health care, a poor state with a 75% matching percentage only has to spend $1. Taxpayers in a wealthy state can purchase only $2 of health care for the same $1. Progressivity in matching

rates is deemed a positive virtue in two senses. For one, it frees up lower income states from having to raise taxes and divert scarce private dollars into the public sector. For another, it allows taxpayers in poorer states to provide decent health care to the poor.

Encourages all States to Expand Health Care Coverage for the Poor. This is because it lowers the net price to the state of purchasing health care--in some states to as low as 20%. Both theoretical and empirical studies have shown that states respond to such incentives by spending more than they would have otherwise on the poor's health care (Grannemann and Pauly, 1983; Musgrave and Musgrave, 1989; Cromwell, et al., 1994).

Assures That States Must Extend Coverage and Purchase Health Care Services Before Receiving Aid. This is a critical point. A matching requirement goes beyond a promise (or a hope) that states will expand coverage: without verified spending on Medicaid-covered patients and services, there is no federal support. This is distinct from an unrestricted block grant approach where the federal government has no guarantee that states will use any of the monies for the intended purpose. An unrestricted grant approach to supporting either welfare or Medicaid services for the poor inevitably will shift the burden of responsibility to those states willing to care for the poor (Musgrave and Musgrave, 1989). This is because the poor, unlike roads, are mobile and will move to states offering higher benefits.

Automatically Pays More For a More Costly Mix of Enrollees. By matching state spending, federal outlays automatically rise when states enroll a disproportionately sicker population, including the aged, blind, and disabled. Thus, to the extent states enroll a demographically representative mix of its poor, federal payments will follow true health needs.

Delegates to the States Decisions on How to Spend the Money (so long as its spent on health care). Of course, the Congress has always required that certain groups (e.g., cash welfare) and key services (e.g., hospital and physician care) be covered. But states have considerable latitude in what to pay providers and what other groups and services to include. They also have latitude in deciding whether to pay providers more or less depending upon local market conditions. Recruiting physicians to West Virginia, for example, may require higher fees than in other states in order to assure access to obstetrical and specialist care. Massachusetts and D.C., on the other hand, can afford to pay less to physicians because they are so plentiful.

WEAKNESSES OF THE FEDERAL MEDICAID MATCHING FORMULA

While the matching formula has several advantages, it also has disadvantages that can be improved upon.

Per Capita Income is a Flawed Measure of the Ability of States to Support Medicaid. The Bureau of Economic Analysis uses a measure of resident personal income that includes all pretax income from wages, interest, rents, and dividends. It also includes transfer payments, as well as the imputed value of housing services of homeowners (ACIR, 1982). The emphasis on income received, while nearly equivalent to income generated for the country as a whole, is less of a measure of total economic strength at the state level. For example, it ignores income flowing to nonresidents. In the case of Washington, D.C., total income produced is more than twice total income received by residents of the District (ACIR, 1982, p. 7). But unlike the District, other states can tax out-of-state residents. Dividend outflows to nonresident stockholders also goes uncounted.

Another drawback with per capita income is the inclusion of transfer payments. Because taxes paid by residents to support these transfer payments are not deducted from income, real income is overstated--especially in states where such payments are a larger percentage.

BEA per capita income would be a better measure of state fiscal capacity if it relied more on individual income taxes. However, as of 1991, five states still did not impose such taxes while four others had very modest income tax programs (ACIR, 1993, p. 196). Overall, income tax revenues ranked only fourth as a revenue source behind property taxes, sales taxes, and user fees. Because of the "income received" focus, per capita income is imperfect on two important counts. For one, it doesn't adequately reflect the strength of many state tax bases relying either on income produced--such as corporate profits and minerals and resources--or on income spent--such as sales and special consumption taxes. Nevada, to take an extreme example, relies almost twice the national average on "tourist" taxes, with Hawaii, Vermont, and Florida similarly dependent (ACIR, 1993, p. 197). Alaska received $5,540 per resident in miscellaneous (mostly mineral and fuel) taxes in 1991 vs. $387 in the average state.

For another, by counting state and federal transfers as income, per capita income understates the true fiscal capacities of taxpayers. Transfers reflect a lack of income-earning capacity and impose severe financial obligations on the part of state governments. Indeed, it is its insensitivity to downturns in the business cycle that makes per capita income a less than ideal measure for allocating federal Medicaid dollars. A declining state economy places state legislators in double jeopardy of having fewer tax revenues to disperse while having to service more unemployed eligibles through unemployment insurance, welfare, public housing,

Medicaid, etc. By including transfers in income, the state's fiscal problem is understated just when federal help is needed most.

Two more points are worth making regarding the business cycle. First, the states are far more vulnerable to economic downturns than the federal government, which relies on taxes from all fifty states, some of which are enjoying economic upturns at any one time. Second, the federal government can run long-run, extensive deficits which are prohibited under most state laws. Thus, the Congress can, and does, smooth out short-run state fiscal crises, e.g., disaster relief.

Too Narrow a Matching Range. As presently implemented, the Federal Medical Assistance Percentage has too narrow a range for targeting needed federal dollars and avoiding "overspending" by wealthier states. Consequently, it may not help poorer states or those undergoing short-run economic hardship enough while helping well-off states too much. State-only spending on Medicaid has nearly doubled per $100 of state tax capacity since 1975 (see Table 3). Figure 2 relates state-only spending on Medicaid to a measure of per capita tax capacity developed by the Advisory Commission on Intergovernmental Relations. Tax capacity is derived by multiplying 20 or more state tax bases by a national average tax rate, summing the total, and dividing by state population. States without income taxes, for example, are assumed to tax their populations at the state average rate. From the graph, it is clear that federal sharing of Medicaid costs achieves some vertical equity in the sense that states with greater tax bases per capita spend more of their own money on Medicaid. Nevertheless, even with progressive federal sharing, inequalities in state taxpayer burden for Medicaid are still significant. Nevada, Hawaii, and Alaska all have relatively high tax capacities or tax bases per capita but spend far less of their own money on Medicaid services in part because the federal government matches any spending 50-50. By contrast, Virginia and Illinois are far less well off in terms of potential tax bases but still only receive a 50% match and are more financially burdened by Medicaid. Inequalities is burden among states with the same tax capacity are also dramatic. New York taxpayers, for example, bear almost four times the financial burden for their poor's health care than Florida or Virginia. Similar inequalities are observed between Tennessee and Utah. The 68% matching rate in Tennessee still leaves the state bearing twice the Medicaid burden as Utah in part because the latter has a higher federal matching rate.

Another explanation for the inequalities in state Medicaid burdens may be the disparate mix of eligibles across the states. Aged, Blind, and Disabled eligibles naturally cost more than AFDC mothers and children. And, in fact, some highly burdened states such as Massachusetts, Rhode Island, and Connecticut do have disproportionate numbers of older, sicker, recipients (Cromwell, et al., 1994, p. H-2). Wyoming, Utah, and New Mexico, by

contrast, spend less than average in part because they enroll relatively few costly cases--presumably because of their younger populations. But New York's elderly and disabled mix, if anything, is less than Florida's and Virginia's. In this case, the difference is due more to differences in coverage rates of the poor and medical care costs. In 1990, New York covered 59% of its cost-of-living poor vs. 41% in Florida and 47% in Virginia. In addition, it spent $5,464 in price-adjusted terms per enrollee, eighth highest in the nation, versus $3,395 in Virginia and $3,332 in Florida (see Figure 1); both on a somewhat older demographic mix. New York, in effect, pays for a lot more services than most other states--more hospital days, more nursing home days, etc.

An interesting experiment is to simulate what the changes in federal matching rates would have to be in order to equalize both taxpayer burden and real health service coverage to the poor across the states. The results, shown in Table 4 are based on a few key adjustments. First, FMAPs are based on state tax capacity instead of per capita income. Second, each state's poverty figures are adjusted for cost-of-living. This has the effect of raising the number of poor in New York and lowering the number in, say, Mississippi. Third, matching rates are increased for states facing higher-than-average medical care prices. And fourth, rates are similarly raised for states with a more expensive recipient mix. One other caveat. The simulations do not reflect any changes state legislatures might make in response to changes in federal matching rates, which would almost certainly occur. In this sense, the simulations are illustrative of how far the matching system would have to go to equalize both health spending per poor person and individual state taxpayer burdens.

Clearly, state matching rates would have to change radically. Nearly all states would see their matching rates fall while California, Washington, D.C., and New York, three jurisdictions accounting for roughly one-quarter of all Medicaid spending, would see their matching rates rise. Overburdened states like Massachusetts and Minnesota would still see their matching rates fall because they are currently spending so much more per poor person than the national average relative to their taxpayer burden. New York also spends a lot on its poor, but it's current Medicaid tax burden is roughly double Massachusetts' or Minnesota's. Even Mississippi's matching rate would rise slightly even though it is spending well below the national average because its taxpayer burden is relatively low. No one is advocating such dramatic changes, but the results highlight the limitations of the current formula in achieving anything like equality in taxpayer burdens and generosity to the poor across states.

Permits Diversion of Medicaid Funds to Other Uses. Just because states must spend money on Medicaid patients in order to receive matching funds does not mean that federal funds cannot effectively be diverted to other means. When the federal government introduces a matching program, the net cost to states is lowered. This produces two kinds of responses.

One results in a standard substitution of more spending on the program whose costs have been lowered at the expense of other public programs. With federal matching, states are also inclined to lower (or at least not increase) tax rates. Except under unusual circumstances, the increase in total Medicaid spending from matching will not be as great percentagewise as the decline in net prices to the state. If a state were spending $100 million before a 50-50 matching, it might only spend $80 million after the match, putting in $160 million to the Medicaid program and returning $20 million to taxpayers in the form of lower tax rates. This is referred to as the leakage effect of federal matching programs. From a federal standpoint, any leakage is undesirable as it implies an implicit diversion of matching dollars into nontargetted public services or back to taxpayers. True, the state's poor are better off, but only by $60 million and not by the full $80 million the federal government put in.

How states respond to Medicaid matching programs depends upon taxpayer (and state legislator) viewpoints regarding spending on Medicaid (and on welfare more generally in that the majority of Medicaid eligibles receive cash payments as well). States that believe the poor need only a modicum of health services will be inclined to return more of the federal dollars to taxpayers or spend them on more popular programs. This explains a fair part of the difference in state coverage rates and Medicaid spending on the poor. The lesson is that the Congress, through matching, can encourage states to expand health care access to their poor, but financial incentives alone have not resulted in anything like equal access or taxpayer burdens.

It is the diversion of state dollars to other activities, freed up by federal matching, that lies behind the increasing number of mandates on the program. Even with high matching rates, many states choose not to enroll all of their poor or extend service coverage to levels desired by Congress. When mandated to do so under the OBRA legislation or risk losing all matching funds, states increased coverage rates and health spending on the poor as expected (Holahan, 1995; Cromwell, et al., 1994).

Enables States to Creatively Finance Their Programs. Federally-imposed eligibility and reimbursement mandates beginning in the mid-1980s, reinforced by economic downturns and Boren Amendment challenges to low Medicaid hospital payment rates, encouraged states to adopt creative methods to finance their burgeoning programs. Referred to as tax-and-donation schemes, these approaches all relied on the federal matching algorithm to generate extra federal funds. Providers would be taxed or asked to donate money to the state which would then flow back to them in a hold-harmless manner and become eligible for federal matching. The favorite vehicle for returning funds to providers was hospital disproportionate share payments which were outside the normal payment rules. Net payments to taxed providers usually rose as some of the new federal monies were used to finance expanded eligibility beyond a "hold harmless" proviso. But the important point is that net payments to

providers, which is the ultimate concern of the federal government, were not rising nearly as fast as federal outlays as states would use some of the tax collections to fund their portion of the new mandates or simply keep tax rates low.

Table 5 shows the impact of these programs on the stated Federal Medical Assistance Percentages for two of the most active years, 1991-92, before the Congress reined in some of the more expansive forms of creative funding. In 1992, on average, these programs may have been responsible for raising the federal matching rate from 57% to 69%, adding materially to Congress' budget difficulties. While the matching algorithm, itself, was not the motivating factor behind adoption of such schemes, its matching provisions via disproportionate share payments allowed states--especially those with high matching percentages (Cromwell and Bartosch, 1995)--to maximize federal reimbursement.

Fails to Assure Equal Access of the Poor to Health Care. A matching grant system varying within narrow bounds based only on per capita income has not achieved the desired result of equalizing enrollment of the poor. Beginning in the mid-1980s the Congress began imposing several new enrollment and spending mandates on the states. By 1990, many low-coverage states dramatically increased their coverage rates with little change in their federal matching percentages, e.g., Tennessee (+95%), Texas (+65%), West Virginia (+56%), (see Table 6).

Fails to Guarantee Coverage of the Health Needs of the Near Poor. While the link between Medicaid and welfare eligibility has been stretched in the last decade, still two-thirds of eligibles currently enjoy health insurance because they are also cash recipients (Cromwell, et al., 1994, Table 5-6). Until recently, states had considerable latitude in defining which of their poor were eligible for both welfare and Medicaid. Yet, only 36 states (including the District) in 1992 had extended health coverage to the medically needy population impoverished due to poor health. Some states are still reluctant to include this group because of the cost. Again, passive federal matching without requiring coverage of the most needy populations is not enough to guarantee similar treatment of the poor in Medicaid.

Encourages Overspending in Some States. By effectively lowering the net price of health services to Medicaid eligibles, federal matching by at least dollar-for-dollar encourages some states to spend more on their poor than might be the case if the program were administered by the federal government. Although hard to quantify, and certainly a relative term, overspending may manifest itself through lax utilization controls, overly generous provider reimbursement, or loose eligibility qualifications, just to name a few possibilities. The dictum that "states know best how to care for their own poor" may be flawed in both directions with some states providing too little care from a societal perspective and others too much.

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SHOULD THE MEDICAID MATCHING FORMULA BE CHANGED?

The simple answer to this question is: Yes. The more challenging question is: How? The Medicaid program is now almost thirty years old. It has grown so rapidly that it currently dwarfs cash outlays to the poor. In hindsight, the program has been plagued by technical problems and inconsistent goals on the part of both the Congress and state legislatures. More direct control of the program from Washington is a logical outcome of these problems and conflicts. With the escalating costs of health care generally, federal matching alone is not sufficient to support and encourage states to pay even a portion of the health care for all of their poor.

What are the alternatives to matching grants? **Block grants, either unrestricted or restricted,** are a popular answer. Their strengths are in minimizing creative financing and allowing states to better tailor their programs to their own poor and to voter preferences. On the negative side, they risk exacerbating the large inequalities that remain in the poor's access to health care and in taxpayer Medicaid burdens. When Medicaid block grants were first discussed in 1981, Grannemann and Pauly (1983) conducted numerous simulations of state responses to block grant and other funding approaches. Based in their research, they predicted that no state would supplement the federal grant with state taxpayer dollars. In other words, spending on the poor would fall back to levels defined solely by federal funding. This conclusion was based on the fact that simple block grants would raise the net price of Medicaid-covered services by 100-400%. Currently with matching, wealthy states effectively pay $50 for every $100 of health services purchased under Medicaid; the federal government's match reducing the total price by 50%. In Mississippi, $100 of services costs the state only $20 due to its 80% matching rate. With block grants, every $100 of services costs the state $100 at the margin; a 100% increase in rich states and a 400% increase in poor states. Thus, benefits per poor person in Mississippi, for example, which are already quite low, are predicted to fall over 20% as the state chooses to spend its own funds on other services (or private goods). In New York, simulations implied that block grants would halve the spending per poor person because the federal government would pick up a much smaller fraction of original spending.

Capping Federal Expenditures and linking their growth to the Consumer Price Index, also proposed by the Reagan Administration in 1981, would almost guarantee no growth in Medicaid programs. Again, states would face a net price of 100% for any expansion in Medicaid benefits, for whatever reason, that exceeded general inflation. Moreover, caps that locked in federal assistance would put low-income, but growing states in double jeopardy. The increase in effective net price would be greater than in richer states while the need would be growing faster.

In the first OBRA-1981, the Congress did enact **4.5% reductions in federal matching percentages.** This approach, again, hurts poorer, high-match states more. For states with a 50% match, net prices of health care would rise 4.5% as expected, but for states like West Virginia, a fixed percentage adjustment meant a 13.6% increase in net prices. To see this, let net price = (1-FMAP) x gross price, so that the ratio of net to total price is (1-FMAP). A 4.5% reduction in FMAP results in a new net price of (1-.955 FMAP). For a state with an FMAP = .75, net price before the reduction is 25% versus 28.4% after the reduction, or 13.6% higher. Overall, any reduction in FMAPs could reduce real benefits per person in poverty by twice as much due to the rise in effective net Medicaid prices; more so in poorer states.

Another option considered, then rejected, by the 1981 Congress, was simply to **reduce the minimum matching rate from 50% to 40%.** This would reduce spending in some very high-benefit states such as New York and Connecticut. But it would also affect several states with below-average spending per poor person and fail to concentrate Medicaid cuts where they would do the least harm (Grannemann and Pauly, 1983, p. 51).

A problem with all of these proposals is that they do not explicitly focus on improving recipient equity or state taxpayer burdens. They are designed primarily to reduce the federal burden. Cutbacks in the early 1980s produced the expected negative responses at a time when the private sector was retrenching on health coverage as well. Instead of overhauling the program, the Congress chose to mandate expansion and allow many states to fund the growth through state tax-and-donation schemes. Had the Congress set national Medicaid spending levels per person in poverty and adjusted matching rates to encourage greater spending in some states and less in others, taxpayer burdens would be more equal today and any absolute cutbacks in federal assistance less painful.

A key step in instilling greater equity and efficiency in Medicaid spending would be to properly adjust spending levels for differences in four factors:

1. number of adjusted poor in the state
2. demographic mix of the poor
3. medical care prices
4. state fiscal capacity.

Operating under the assumption that the poor ought to be treated equally in the 50 states, at least with regard to health care, federal assistance ought to be based on the number of poor in each state and not what states choose to spend as it is under current matching formulas. But, crucially, the federal poverty level that is used to determine the number in poverty in each state also ought to be adjusted for cost of living. This would have the effect of raising the estimated

number of poor in New York by roughly 37% while lowering the figures in Mississippi (-12%), West Virginia (-13%), and other low-cost states (see Table 7).

Moreover, because the demographic mix of poor varies in each state, consideration should be given to adjusting potential eligibles by age distribution of the poor, the fraction of female-headed households in poverty, and similar variables.

Third, the cost of hospital, physician, home health, nursing home, and other health services varies greatly across the states due to factors other than the size of the Medicaid program. As real benefits to the poor should be the focus of concern, states facing higher provider prices should have higher spending levels upon which to base federal sharing, holding other factors constant.

And fourth, a measure more directly related to state fiscal capacity than per capita income should be used in trying to equalize interstate taxpayer burden. ACIR's tax capacity index seems well suited to the purpose. It captures all potential sources of state revenue, not just those the state chooses to tax, as well as differences in states' abilities to export taxes via corporate profits taxes, mineral severance taxes, tourist hotel taxes, etc.

In implementing a more targeted, but equitable, approach to allocating federal Medicaid dollars, a few options are available. While a simple block grant approach cannot address concerns about reductions in benefits in certain states, **block grants combined with a mandatory state spending level** might. The minimum spending levels to qualify for federal block grants could be set to equalize state taxpayer burdens--possibly at current average levels. The Congress would set the national average Medicaid spending level per person in poverty. It would then adjust the levels in each state for the four factors mentioned above. Finally, the federal block grant to any state would be the difference between the state-specific spending level and the required minimum state contribution. Thus, for poorer states, the minimum state contribution would be lower than elsewhere, but the spending level would likely be much higher than currently, even after adjusting for medical care prices and the other three factors. Wealthier states would have higher minimums and possibly lower spending targets than current outlays. Without constructing the spending levels and making the appropriate adjustments, it is impossible to say a priori whether a particular state's own spending would increase or not. We do know, however, that state spending burdens would be more equal as would overall spending levels on the poor. Furthermore, states could spend more than the required minimum, without lowering the federal contribution, but they would do so without federal assistance.

A final option requiring the least tinkering with the program would set **declining matching rates within a spending corridor.** Currently, the federal government matches any additional state spending, which some believe leads to unnecessarily high enrollments,

payments and services. The federal government could set a very high matching rate (even 100%) up to some minimum spending rate per poor person. Beyond that point, the percentage would fall until a high threshold level is reached (possibly 150% of the established norm) at which point the state would pay entirely for extra benefits. Matching rates would be adjusted for the factors mentioned before. Thus, poorer states would receive higher matching rates and possibly higher minimum federal contributions before having to contribute.

AVAILABILITY AND QUALITY OF DATA

Altering federal matching rates or moving to block grants ought to take into consideration the four factors described above. First, **state tax capacity could be substituted for per capita income** as a superior measure of each state's ability to generate revenues to support Medicaid spending. The Advisory Commission on Intergovernmental Relations has produced such an index for the 1976-91 period in periodic publications. It is well documented and conceptually sound. Over the years, the Commission has made several refinements that have improved its accuracy and made it more user friendly to public agencies. A problem with ACIR's tax capacity index is that it is not produced annually but only every 2-3 years. Currently, only the 1991 index is currently available. Were the index substituted for per capita income, the data for analysis would have to be made available annually and resources devoted to processing it quickly. Because tax capacity depends on numerous tax bases in each of the states, a natural lag of some unknown period exists--possibly as much as two years. More current data may be available if the need existed, however.

The same geographic limitations apply to developing **a state index of medical care prices**. Under several reforms, it would be preferable to adjust block grant and matching amounts by an index of average medical care prices across states. Legislatures facing higher than average hospital, physician, and other prices would receive greater federal assistance, holding all other factors constant. Researchers have developed their own state indices of medical care prices, often based on program spending and utilization figures. These are not ideal. Original sources such as the American Hospital Association, publish statistics by state on total hospital inpatient costs and discharges from which a cost per discharge can be derived. Several of these sources by sector could be put together to construct a geographic price adjustor that could be updated periodically. Annual adjustments probably would not be necessary as relative prices across states change slowly.

If federal Medicaid funds were to be distributed to states based in part on the number of poor, **poverty rates should first be adjusted by cost-of-living**. The U.S. Census Bureau provides annual estimates of the number of poor in each state using its Current Population

Survey. These figures are based only on the money income necessary to purchase a market-basket of goods and services. The levels are adjusted for family size and updated annually by the Consumer Price Index using the market basket proportions as weights. The drawback to applying a national poverty threshold (= $11,186 for a 3-person family in 1992) to individual states is that the cost-of-living varies considerably. Hence, the actual number of families in poverty in high-cost states is higher than in low cost states.

A significant drawback of the Consumer Price Index is that the Bureau of Labor Statistics does not produce one at the state level, although one is available for selected metropolitan areas and broad census regions. Other groups have developed more geographically detailed cost of living indices, but to our knowledge they have not been aggregated to the fifty states. Researchers, however, have developed statistical techniques for imputing state and county cost-of-living indices which could be used to correct the state poverty estimates produced by the federal government. Without such adjustments, the poverty estimates could be seriously flawed.

Adjusting for the demographic mix of the poor, if necessary, can be done using data from the Census Bureau. The decennial census is very accurate regarding the age and sex composition of household heads as well as their income, which can be used to simulate potential Medicaid eligibles in each state. Good estimates of the blind and disabled are also available from federal social insurance statistics. Again, the demographic structure of the poor does not change rapidly in any state and other than annual updating would suffice. Ideally, federal spending would also be adjusted for the number of medically needy in each state. Age and disability status, while reasonable proxies for the medically needy, are not perfect. Whether anything more can be done to adjust for the differential likelihood of being impoverished due to medical problems across states is doubtful, although the National Center for Health Statistics does have a wealth of epidemiological information that could be used.

REFERENCES

Advisory Commission on Intergovernmental Relations, 1979 Tax Capacity of the Fifty States, March 1982.

Advisory Commission on Intergovernmental Relations, Measuring State Fiscal Capacity: Alternative Methods and Their Uses, September 1986.

Advisory Commission on Intergovernmental Relations, RTS 1991 State Revenue Capacity and Effort, September 1993.

Cromwell J., Boulis A, Adamache KW, Ammering CJ, and Bartosch W, Examining the Medicaid Fiscal Crisis, HCFA Cooperative Agreement No. 18-C-90028/1-02, October 20, 1994.

Cromwell J, Adamache K, Ammering C, Bartosch W, and Boulis A, "The Equity of the Medicaid Program to the Poor versus Taxpayers." Health Care Financing Review Spring 1995; 16(3): 75-104.

Cromwell J and Bartosch W, "The Federal-State Medicaid Partnership: A Casualty of High Health Costs." Unpublished paper, 1995.

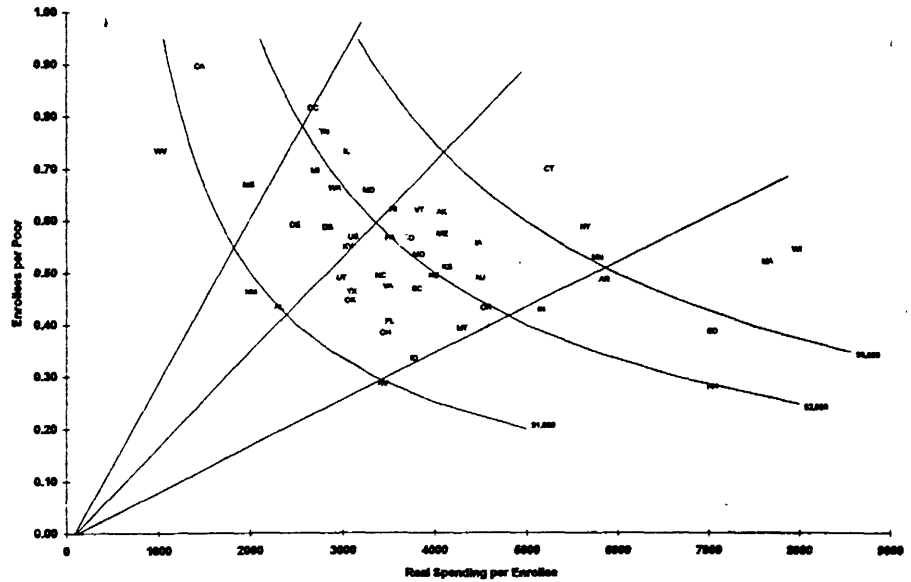
Gold S, The State Budget Context: How Medicaid Fits In. Revised version of a paper prepared for the Kaiser Medicaid Commission on the Future of Medicaid, September 1992.

Granneman, Thomas W. and Mark V. Pauly, Controlling Medicaid Costs: Federalism, Competition, and Choice, Washington, D.C. and London: American Institute for Public Policy Research, 1983.

Holahan J, The Implications of Past Medicaid Spending Growth for Future Debates. Washington, D.C.: The Urban Institute. Prepared for Commission on the Future of Medicaid of the Henry J. Kaiser Family Foundation under Grant #93-2290-C. January 1995.

Musgrave, Richard A. and Peggy B. Musgrave, Public Finance in Theory and Practice, Fifth Edition, McGraw-Hill, Inc. 1989.

FIGURE 1
BREADTH VS. DEPTH OF COVERAGE IN 1990



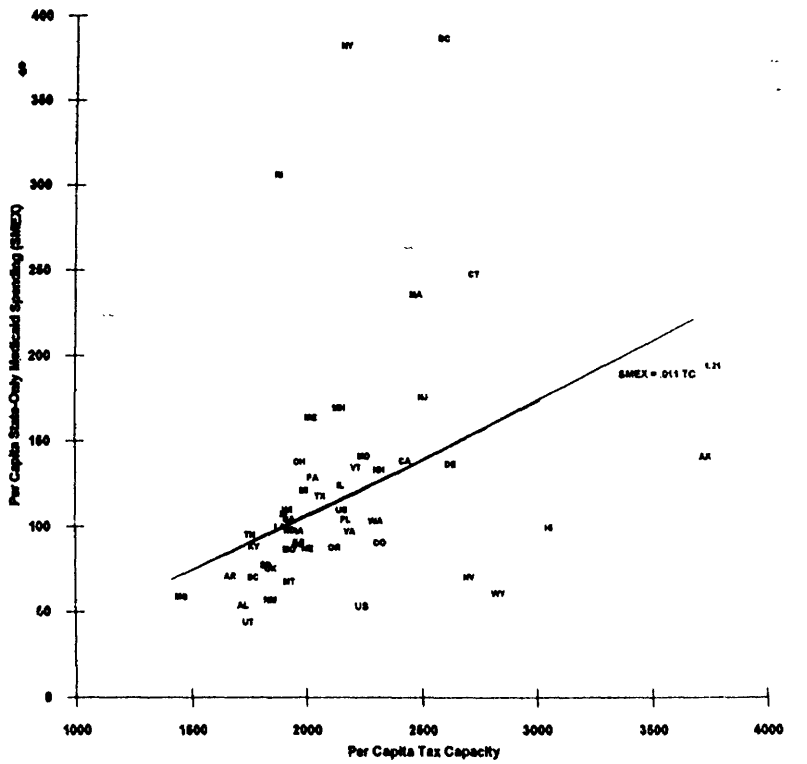
NOTES: Poverty estimates have been adjusted to reflect cost of living differences.
Medicaid payment estimates have been adjusted to reflect regional differences in the cost of Medicaid.
Rhode Island and North Dakota are not included in the analysis because of poor data quality.

SOURCE: HCFA 2082.

Taken From: Cromwell et al., 1995.

jerry/presents/FIG1.XLS/md

FIGURE 2
PER CAPITA STATE-ONLY MEDICAID SPENDING VS. TAX CAPACITY, 1991



SOURCE: State Medicaid Spending: HCFA-2082.
Tax Capacity: Advisory Commission on Intergovernmental Relations (ACIR), "Measuring State Fiscal Capacity, 1966 Edition."

TAKEN FROM: Cromwell, et al , 1995.

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TABLE 1

STATE VARIATION IN TOTAL NOMINAL MEDICAID EXPENDITURES, SELECTED YEARS (in millions of dollars)

		1975	1980	1985	1990	1992	Total Growth 1975-92	percent change 1975-92	percent change 1985-92
United States		12,127	23,213	37,277	63,818	91,106	651.3%	12.59%	13.62%
Wyoming	WY	4.9	14.4	28.2	58.9	113.9	2229.7	20.3	22.0
Alaska	AK	8.5	27.7	66.5	139.1	186.9	2094.6	19.9	15.9
Montana	MT	29.1	62.3	95.5	170.6	216.6	644.5	12.5	12.4
Delaware	DE	14.6	45.3	70.5	123.2	219.2	1398.3	17.3	17.6
Vermont	VT	31.3	59.3	89.4	152.9	221.9	609.3	12.2	13.9
South Dakota	SD	21.8	54.9	94.4	166.1	231.0	961.7	14.9	13.6
North Dakota	ND	23.5	46.7	116.7	193.8	252.8	977.8	15.0	11.7
Hawaii	HI	37.0	106.7	140.4	191.3	269.7	629.9	12.4	9.6
Idaho	ID	24.5	52.0	76.3	182.2	274.6	1022.5	15.3	20.1
Nevada	NV	16.1	44.9	66.7	148.6	281.8	1644.8	18.3	23.1
New Hampshire	NH	28.2	71.9	118.0	243.0	340.2	1106.9	15.8	16.3
Utah	UT	30.5	79.6	109.7	246.7	365.4	1097.6	15.7	18.8
Nebraska	NE	54.3	106.8	167.1	309.3	467.9	762.2	13.5	15.9
New Mexico	NM	29.0	70.3	148.3	275.2	478.5	1552.1	17.9	18.2
District of Columbi	DC	94.1	166.5	210.7	245.7	498.6	429.8	10.3	13.1
Kansas	KS	101.9	196.6	256.3	490.6	619.6	507.9	11.2	13.4
Maine	ME	60.4	131.3	232.4	432.0	641.7	962.3	14.9	15.6
Oregon	OR	74.1	178.9	238.7	518.8	747.6	908.4	14.6	17.7
Rhode Island	RI	72.1	160.4	250.0	442.2	774.1	973.9	15.0	17.5
West Virginia	WV	28.9	103.6	173.2	361.1	794.7	2648.0	21.5	24.3
Colorado	CO	96.0	181.7	315.8	515.7	813.7	730.0	13.3	14.5
Iowa	IA	81.7	230.2	369.9	620.3	854.7	946.2	14.8	13.2
Mississippi	MS	94.6	211.0	274.4	566.1	881.0	831.1	14.0	18.1
Arkansas	AR	93.0	234.7	358.3	599.2	884.6	851.4	14.2	13.8
Oklahoma	OK	140.6	265.4	460.4	687.5	1003.8	613.7	12.3	11.8
Alabama	AL	131.3	263.5	375.4	609.3	1056.0	704.1	13.0	15.9
South Carolina	SC	75.7	258.2	309.4	743.1	1150.9	1421.1	17.4	20.6
Washington	WA	176.1	326.9	564.1	952.4	1346.8	665.0	12.7	12.7
Missouri	MO	99.3	295.1	524.9	897.3	1350.3	1260.0	16.6	14.5
Virginia	VA	159.6	360.5	546.9	965.1	1511.3	846.6	14.1	15.6
Kentucky	KY	100.3	295.6	539.8	976.9	1543.5	1439.2	17.4	16.2
Maryland	MD	156.8	321.9	583.9	1090.3	1612.4	915.4	14.8	15.8
Connecticut	CT	181.1	349.7	594.9	1205.2	1663.1	832.5	14.7	15.8
Wisconsin	WI	361.2	687.1	942.2	1248.4	1677.3	364.3	9.5	8.6
Tennessee	TN	122.7	379.5	577.8	1162.8	1735.0	1314.0	16.9	17.0
Minnesota	MN	251.1	590.4	1001.1	1410.4	1750.3	597.0	12.1	8.3
North Carolina	NC	163.2	401.1	646.7	1426.0	2063.2	1176.2	16.2	18.2
Georgia	GA	256.3	462.4	759.6	1185.1	2149.1	738.6	13.3	16.0
Indiana	IN	172.4	354.2	746.7	1342.5	2224.8	1190.2	16.2	16.9
Louisiana	LA	143.3	415.2	725.3	1314.8	2478.9	1629.7	18.3	19.2
New Jersey	NJ	366.4	755.9	1144.7	2298.0	2601.6	664.6	12.7	13.6
Michigan	MI	620.7	1071.7	1516.6	2194.8	2802.0	351.4	9.3	9.2
Massachusetts	MA	493.7	1009.3	1432.8	2730.3	3247.7	557.8	11.7	12.4
Florida	FL	172.7	392.0	943.1	2360.7	3518.4	1937.6	19.4	20.7
Illinois	IL	682.4	1191.9	1652.9	2424.0	4070.0	496.4	11.1	13.7
Pennsylvannia	PA	709.1	1068.2	1797.4	2883.1	4213.0	494.1	11.1	12.9
Ohio	OH	350.5	809.4	1767.4	3132.0	4307.7	1129.1	15.9	13.6
Texas	TX	460.6	960.9	1413.9	2781.0	4406.6	856.6	14.2	17.6
California	CA	1491.1	2728.2	4045.3	6506.9	8691.7	482.9	10.9	11.5
New York	NY	2954.6	4542.6	7566.0	11877.4	15261.0	417.2	10.1	10.5
State Average		242.5	464.3	745.5	1276.4	1822.2	651.3		

NOTE: States ranked from least to greatest expenditures in 1992

SOURCE: HCFA 2082

Taken From: Cromwell et al., 1994

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TABLE 2

THE PUBLIC HEALTH CARE BILL BY PAYER (in billions of 1992 dollars)

	Medicaid	Total Public Health	Medicaid/Public Health	Federal Health Expenditures	Federal Medicaid	Fed Medicaid/Fed Health	State Health Expenditures	State Medicaid	State Medicaid/ State Health	State Share of Total Medicaid
1975	$46.51	$257.17	0.19	$137.40	$26.56	0.19	$119.77	$21.95	0.18	45.24 %
1976	51.13	272.47	0.19	148.93	28.13	0.19	123.54	23.00	0.19	44.98
1977	53.81	282.93	0.19	151.44	29.99	0.20	131.49	23.81	0.18	44.28
1978	55.01	295.96	0.19	159.06	30.32	0.19	136.90	24.89	0.18	44.88
1979	57.38	311.75	0.18	165.58	32.24	0.19	146.18	25.14	0.17	43.81
1980	58.66	327.76	0.18	175.02	32.61	0.19	152.74	26.27	0.17	44.81
1981	62.12	347.71	0.18	186.05	34.39	0.18	161.67	27.73	0.17	44.65
1982	60.14	347.82	0.17	186.33	33.19	0.18	161.49	26.96	0.17	44.82
1983	60.67	354.58	0.17	190.77	33.45	0.18	163.81	27.42	0.17	45.05
1984	60.07	362.63	0.17	196.09	33.05	0.17	166.54	27.02	0.16	44.98
1985	62.40	372.20	0.17	201.91	33.81	0.17	170.29	28.60	0.17	45.83
1986	63.61	373.44	0.17	200.62	34.71	0.17	172.82	28.90	0.17	45.44
1987	65.55	382.10	0.17	204.88	35.85	0.17	177.21	29.70	0.17	45.31
1988	66.59	393.37	0.17	210.91	36.57	0.17	182.45	30.03	0.16	45.09
1989	69.17	410.46	0.17	220.56	38.24	0.17	189.90	30.93	0.16	44.71
1990	74.48	426.02	0.17	225.49	40.56	0.18	200.52	33.92	0.17	45.54
1991	82.55	458.14	0.18	238.08	45.54	0.19	220.06	37.01	0.17	44.83
1992	91.32	470.74	0.19	243.06	52.51	0.22	227.67	38.81	0.17	42.50
Average Annual Growth										
1975-92	3.8%	3.6%	0.2%	3.4%	4.1%	0.7%	3.9%	3.4%	-0.4%	-0.4%
1975-80	4.0%	5.0%	-1.0%	5.0%	4.2%	-0.7%	5.0%	3.7%	-1.3%	-0.3%
1980-85	1.2%	2.6%	-1.4%	2.9%	0.7%	4.5%	2.2%	1.7%	-0.5%	0.5%
1985-92	5.6%	3.4%	2.1%	2.7%	6.5%	3.7%	4.2%	4.5%	0.2%	-1.4%
1988-92	8.2%	4.6%	3.5%	3.6%	9.5%	5.7%	5.7%	6.6%	0.9%	-1.5%

NOTES: MC-CPI = Medical Care Component of the Consumer Price Index used to deflate trends with 1992 as base

SOURCES: HCFA 2082 Reports
1993 Statistical Abstracts

Taken From: Cromwell et al., 1994.

TABLE 3

TRENDS IN STATE-ONLY MEDICAID EXPENDITURES PER $100 OF TAX CAPACITY, 1976-1991

State	1976	1977	1978	1981	1982	1984	1986	1991	1981-91 Aggregate Percent Change	1976-91 Aggregate Percent Change
Wyoming	0.7	0.9	0.8	0.8	0.9	1.2	1.4	2.2	171%	210%
Utah	1.4	1.7	2.4	2.3	2.2	2.0	2.1	2.6	11	83
Nevada	1.4	1.3	1.6	2.4	1.9	2.6	2.1	2.6	10	86
New Mexico	1.3	1.6	1.9	1.8	2.9	2.3	2.7	3.1	76	142
Alabama	2.1	2.3	2.7	2.7	3.1	2.8	2.8	3.2	17	51
Hawaii	3.0	4.4	5.1	5.3	3.4	4.8	4.1	3.3	-38	9
Idaho	1.8	1.9	2.1	2.3	3.5	2.4	2.4	3.4	47	87
Montana	2.1	2.5	2.4	2.8	3.9	3.6	3.7	3.6	28	71
Alaska	1.2	1.8	1.8	1.6	1.7	2.2	2.8	3.8	137	216
Colorado	2.6	2.3	2.6	2.9	3.1	3.1	2.9	4.0	36	52
South Carolina	1.8	2.3	2.7	3.2	3.4	2.4	3.1	4.9	26	170
Mississippi	2.0	2.1	2.2	2.6	5.4	3.1	2.9	4.1	48	107
Oklahoma	3.0	3.1	3.3	3.2	3.7	3.6	3.8	4.2	30	39
Oregon	2.2	3.0	3.0	3.2	3.0	3.1	2.9	4.2	31	91
West Virginia	0.9	1.5	2.0	2.3	2.1	2.1	2.8	4.2	84	368
South Dakota	1.7	2.0	2.7	3.5	3.8	4.1	4.5	4.3	24	156
Arkansas	2.4	2.9	3.4	3.8	6.9	4.0	4.8	4.3	14	81
Nebraska	2.2	2.4	3.0	3.4	4.1	3.6	4.0	4.4	30	100
Virginia	2.3	2.7	3.1	3.5	3.8	3.3	3.6	4.5	29	96
Washington	3.9	3.7	4.0	4.9	4.6	4.8	5.0	4.6	-7	17
Missouri	1.3	1.9	2.3	3.2	2.9	3.8	3.5	4.6	43	252
North Carolina	1.6	2.3	2.7	3.2	3.5	2.9	3.1	4.5	44	157
Kansas	3.0	4.0	3.4	3.5	2.7	4.1	3.6	4.7	23	56
Florida	1.3	1.3	1.7	1.9	2.0	2.2	2.7	4.9	156	274
Iowa	1.8	2.9	3.3	3.9	4.5	4.7	4.6	5.0	28	178
Kentucky	1.7	2.5	3.0	3.7	3.3	4.1	4.1	5.1	37	198
North Dakota	2.2	2.6	2.6	2.9	3.6	4.3	6.1	5.2	76	134
Delaware	1.8	2.2	3.4	3.8	3.6	3.7	3.8	5.3	39	229
Louisiana	1.9	2.2	2.9	2.6	3.3	4.5	4.9	5.4	107	183
Georgia	3.1	3.1	3.3	3.5	5.6	3.2	3.7	5.5	45	78
Tennessee	1.7	2.3	3.2	3.5	5.0	3.4	3.9	5.5	58	224
Indiana	2.2	2.4	2.8	3.5	4.1	4.6	4.7	5.7	64	160
California	5.0	5.5	5.5	5.8	5.4	4.7	5.1	5.8	-2	16
Texas	2.2	2.3	2.6	2.4	1.7	2.8	4.3	5.8	142	164
Wisconsin	5.3	5.6	5.8	7.9	8.0	7.6	7.2	5.8	-26	10
New Hampshire	2.0	2.5	3.1	3.4	4.3	3.4	3.8	5.8	71	191
Illinois	4.2	4.2	4.5	5.4	4.8	5.9	5.8	5.8	8	39
Vermont	3.4	3.7	4.4	5.0	5.1	4.6	4.3	6.2	23	81
Michigan	5.3	5.5	6.2	6.9	8.3	7.6	8.4	6.2	-11	16
Maryland	3.5	3.8	3.8	4.1	4.4	4.5	5.3	6.4	55	82
Pennsylvania	4.3	5.0	5.8	5.1	6.2	5.9	5.9	6.4	26	50
New Jersey	3.6	3.8	5.0	5.0	3.2	5.2	5.1	7.1	42	97
Ohio	2.2	2.7	3.2	4.3	5.2	6.3	6.7	7.1	65	223
Minnesota	4.7	5.4	5.7	7.1	6.1	5.8	8.4	8.0	13	71
Maine	3.2	3.7	4.4	4.9	5.7	5.0	6.0	6.2	26	157
Connecticut	3.7	4.0	5.1	5.4	4.8	5.7	5.8	9.2	70	148
Massachusetts	5.8	6.1	9.4	9.5	9.8	7.1	8.5	8.7	2	46
Dist. of Col.	8.9	9.4	11.2	11.1	9.5	8.9	9.7	19.1	36	89
Rhode Island	5.6	7.1	8.8	10.0	7.0	10.0	9.8	16.5	65	185
New York	13.2	12.8	14.2	16.3	10.8	16.2	15.9	17.9	10	35
US AVERAGE	3.0	3.4	3.9	4.4	4.4	4.5	4.7	5.8	31	93

NOTES: State Medicaid expenditures = Total Medicaid Spending * (1-FMAP), unadjusted for tax/donation schemes.
States ranked by 1991 values.
Spending excludes adjustments for tax and donation schemes.

SOURCE: HCFA 2082; ACIR Reports

Taken From: Cromwell et al., 1994

TABLE 4

SIMULATED FMAPs WITH HORIZONTAL EQUITY TO TAXPAYERS AND MEDICAID EQUITY TO THE POOR

State	1990 FMAP	Simulated FMAP	Difference	State Medicaid Tax Burden	Real Spending Per Poor
Alabama	72.9	72.5	-0.4	0.032	708
Alaska	50.0	-39.9	-89.9	0.038	3,327
Arkansas	75.8	48.5	-27.1	0.043	2,283
California	50.0	55.7	5.7	0.058	1,184
Colorado	54.7	15.5	-39.2	0.040	1,788
Connecticut	50.0	-52.9	-102.9	0.092	2,836
Delaware	50.1	N/A	N/A	0.053	1,439
Dist. of Col.	50.0	67.0	17.0	0.151	2,078
Florida	54.8	43.7	-10.9	0.049	1,278
Georgia	61.7	50.3	-11.4	0.055	1,442
Hawaii	52.5	-40.1	-92.6	0.033	2,330
Idaho	73.2	60.7	-12.5	0.034	1,194
Illinois	50.0	16.8	-33.2	0.058	2,373
Indiana	63.8	46.2	-17.6	0.057	2,105
Iowa	65.0	9.6	-55.4	0.050	2,343
Kansas	59.2	1.5	-57.7	0.047	2,274
Kentucky	72.8	60.8	-12.0	0.051	1,475
Louisiana	75.4	69.7	-5.7	0.054	1,533
Maine	62.4	48.3	-14.1	0.062	2,028
Maryland	50.0	27.4	-22.6	0.064	2,053
Massachusetts	50.0	-5.3	-55.3	0.097	3,395
Michigan	55.4	36.4	-19.0	0.062	2,101
Minnesota	54.4	17.6	-36.8	0.080	3,416
Mississippi	79.9	77.9	-2.0	0.041	1,139
Missouri	60.8	25.4	-35.4	0.046	1,720
Montana	71.7	50.7	-21.0	0.036	1,565
Nebraska	64.5	16.6	-47.9	0.044	1,901
Nevada	50.0	14.7	-35.3	0.026	853
New Hampshire	50.0	-15.3	-65.3	0.058	1,865
New Jersey	50.0	8.5	-41.5	0.071	2,140
New Mexico	74.3	70.9	-3.4	0.031	965
New York	50.0	51.1	1.1	0.179	3,115
North Carolina	66.5	46.3	-20.2	0.046	1,530
North Dakota	72.7	N/A	N/A	N/A	N/A
Ohio	60.6	54.4	-6.2	0.071	1,536
Oklahoma	70.7	61.2	-9.5	0.042	1,212
Oregon	63.5	-34.2	-97.7	0.042	2,187
Pennsylvania	56.8	16.2	-40.6	0.064	1,950
Rhode Island	53.2	N/A	N/A	N/A	N/A
South Carolina	72.6	59.7	-12.9	0.040	1,447
South Dakota	72.5	23.4	-49.1	0.043	2,419
Tennessee	68.4	53.9	-14.5	0.055	1,792
Texas	64.1	36.5	-27.6	0.058	1,446
Utah	75.1	6.8	-68.3	0.026	1,746
Vermont	61.3	13.5	-47.8	0.062	2,207
Virginia	50.0	27.0	-23.0	0.045	1,457
Washington	54.9	-13.0	-67.9	0.046	2,005
West Virginia	77.6	67.0	-10.6	0.042	845
Wisconsin	60.3	19.1	-41.2	0.058	3,688
Wyoming	69.1	-9.9	-79.0	0.022	1,203

NOTE. Simulated FMAPs based on national average real spending per poor person = $1,884 and taxpayer burden of 0.0662

SOURCES 1990 FMAP HCFA Medicare-Medicaid Data Books
Tax capacity ACIR (1991)
Medicaid Spending HCFA 2082 files

Taken From Cromwell et al., 1995

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TABLE 5

FEDERAL MEDICAID MATCHING ASSISTANCE PERCENTAGES ADJUSTED FOR TAX AND DONATION SCHEMES

	1991			1992		
State	Stated FMAP	Adjusted FMAP	Difference	Stated FMAP	Adjusted FMAP	Difference
New Hampshire	0.50	0.67	0.17	0.50	1.59	1.09
Alabama	0.73	1.15	0.42	0.73	1.46	0.73
Tennessee	0.68	N/A	N/A	0.68	1.14	0.46
South Carolina	0.73	1.00	0.27	0.73	1.10	0.37
West Virginia	0.78	0.78	0.00	0.78	1.12	0.35
Mississippi	0.80	1.19	0.39	0.80	1.14	0.34
Kentucky	0.73	0.92	0.19	0.73	1.01	0.28
Louisiana	0.75	0.90	0.15	0.75	1.03	0.28
Missouri	0.61	0.67	0.06	0.61	0.88	0.27
Nevada	0.50	0.50	0.00	0.50	0.74	0.24
Colorado	0.55	0.55	0.00	0.56	0.77	0.23
Pennsylvania	0.57	0.63	0.06	0.57	0.72	0.16
Illinois	0.50	0.50	0.00	0.50	0.66	0.16
Texas	0.64	0.65	0.01	0.64	0.79	0.15
California	0.50	0.51	0.01	0.50	0.64	0.14
Ohio	0.61	0.62	0.02	0.61	0.74	0.13
Maine	0.62	0.68	0.06	0.62	0.74	0.12
North Carolina	0.67	0.76	0.09	0.67	0.77	0.11
Michigan	0.55	0.65	0.09	0.56	0.66	0.10
Arkansas	0.76	0.76	0.00	0.76	0.85	0.10
Florida	0.55	0.61	0.06	0.55	0.64	0.09
Georgia	0.62	0.65	0.03	0.62	0.70	0.08
Massachusetts	0.50	0.68	0.18	0.50	0.57	0.07
Hawaii	0.53	0.54	0.01	0.53	0.60	0.07
Vermont	0.61	0.62	0.01	0.61	0.68	0.07
Washington	0.55	0.55	0.00	0.55	0.61	0.06
Indiana	0.64	0.64	0.00	0.64	0.70	0.06
Utah	0.75	0.79	0.04	0.75	0.80	0.05
Maryland	0.50	0.50	0.00	0.50	0.55	0.05
New Mexico	0.74	0.74	0.00	0.74	0.79	0.05
Rhode Island	0.53	0.53	0.00	0.53	0.56	0.02
Wisconsin	0.60	0.60	0.00	0.60	0.63	0.02
New York	0.50	0.51	0.01	0.50	0.52	0.02
Montana	0.72	0.72	0.00	0.72	0.73	0.01
Minnesota	0.54	0.54	0.00	0.54	0.56	0.01
Kansas	0.59	0.59	0.00	0.59	0.60	0.01
Oklahoma	0.71	0.71	0.00	0.71	0.71	0.00
Alaska	0.50	0.50	0.00	0.50	0.50	0.00
Connecticut	0.50	0.50	0.00	0.50	0.50	0.00
Delaware	0.50	0.50	0.00	0.50	0.50	0.00
Dist. of Columbia	0.50	0.50	0.00	0.50	0.50	0.00
Idaho	0.73	0.73	0.00	0.73	0.73	0.00
Iowa	0.65	0.65	0.00	0.65	0.65	0.00
Nebraska	0.65	0.65	0.00	0.65	0.65	0.00
New Jersey	0.50	0.50	0.00	0.50	0.50	0.00
North Dakota	0.73	0.73	0.00	0.73	0.73	0.00
Oregon	0.64	0.64	0.00	0.64	0.64	0.00
South Dakota	0.73	0.73	0.00	0.73	0.73	0.00
Virginia	0.50	0.50	0.00	0.50	0.50	0.00
Wyoming	0.69	0.69	0.00	0.69	0.69	0.00
US AVERAGE	0.57	0.61	0.04	0.57	0.69	0.12

NOTE. 1991 provider tax data for the State of Tennessee was unavailable. States ranked by the difference between stated vs. adjusted FMAPs in 1992.

SOURCES. HCFA Pub. No. 02155-91-92 and HPA (1992), Table 9 (unaudited State Submission of HCFA-Form 25.)

Taken From. Cromwell et al., 1995.

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TABLE 6

MEDICAID PERSON-YEAR-EQUIVALENT ENROLLEES PER PERSON IN POVERTY, 1982 AND 1990

	PYE ENROLLEES PER POOR		Percentage Change
	1982	1990	1982-90
U.S.	0.86	0.87	3.6 %
Quartile I			
Alaska	0.30	0.62	105.9 %
Tennessee	0.38	0.74	95.1
South Dakota	0.23	0.39	69.1
Utah	0.29	0.49	69.0
Wyoming	0.24	0.40	67.0
Texas	0.28	0.46	65.2
West Virginia	0.47	0.73	56.0
North Carolina	0.32	0.50	54.7
Mississippi	0.46	0.67	45.5
Colorado	0.37	0.53	42.0
Idaho	0.24	0.33	39.2
Washington	0.48	0.66	38.3
Quartile II			
Nebraska	0.36	0.50	37.5
Arkansas	0.36	0.49	35.9
Montana	0.29	0.39	35.5
Iowa	0.43	0.56	29.9
Oregon	0.34	0.43	27.2
New Mexico	0.34	0.43	26.9
Virginia	0.37	0.47	26.9
Delaware	0.47	0.59	25.9
Louisiana	0.44	0.55	25.5
Georgia	0.47	0.58	25.1
Kansas	0.41	0.51	24.7
District of Columbia	0.69	0.82	18.2
Quartile III			
Kentucky	0.47	0.55	17.1
Alabama	0.37	0.43	17.1
Florida	0.35	0.41	16.0
Oklahoma	0.39	0.45	14.4
Maryland	0.60	0.66	9.9
Indiana	0.40	0.43	7.1
Connecticut	0.67	0.70	4.7
South Carolina	0.45	0.47	4.1
Illinois	0.71	0.73	3.2
California	0.87	0.90	3.0
Nevada	0.28	0.29	2.2
Minnesota	0.52	0.53	2.1
Quartile IV			
Missouri	0.52	0.52	-0.7
Maine	0.63	0.56	-8.6
New York	0.66	0.59	-10.6
Vermont	0.73	0.62	-14.9
Michigan	0.89	0.67	-24.5
Pennsylvania	0.73	0.53	-27.9
Massachusetts	0.74	0.53	-29.0
New Hampshire	0.40	0.28	-29.7
New Jersey	0.72	0.49	-31.8
Wisconsin	0.87	0.55	-36.8
Ohio	0.63	0.36	-39.0
Hawaii	1.03	0.62	-39.6

NOTE: Rhode Island and North Dakota are not included because of poor data quality

SOURCE: HCFA 2082 data and Statistical Abstract of the United States

Taken From: Crosswell et al., 1995.

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TABLE 7

NUMBER OF PEOPLE BELOW THE FEDERAL POVERTY LEVEL BEFORE AND AFTER COST-OF-LIVING ADJUSTMENTS: 1990

	1990 Number of Poor	1990 Adjusted Number of Poor
Alabama	775,776	755,026
Alaska	62,700	49,368
Arkansas	460,776	454,801
California	4,136,640	4,006,621
Colorado	451,347	408,075
Connecticut	197,226	409,700
Delaware	45,961	89,820
Dist. of Col.	128,056	106,894
Florida	1,863,101	1,944,089
Georgia	1,023,477	950,539
Hawaii	121,902	115,717
Idaho	149,963	128,290
Illinois	1,565,979	1,543,897
Indiana	720,720	668,111
Iowa	268,756	361,447
Kansas	255,183	319,522
Kentucky	637,522	730,262
Louisiana	995,944	933,606
Maine	160,855	205,549
Maryland	473,329	482,315
Massachusetts	643,766	1,058,543
Michigan	1,329,285	1,364,538
Minnesota	525,000	544,386
Mississippi	661,390	583,741
Missouri	685,598	779,214
Montana	130,237	130,229
Nebraska	162,555	199,503
Nevada	117,767	144,974
New Hampshire	69,873	132,670
New Jersey	711,188	1,033,230
New Mexico	316,656	267,888
New York	2,572,670	3,528,002
North Carolina	861,757	943,761
Ohio	2,124,165	2,650,248
Oklahoma	490,729	535,091
Oregon	261,501	392,676
Pennsylvania	1,306,987	1,930,150
South Carolina	564,894	539,439
South Dakota	92,595	110,126
Tennessee	824,196	823,419
Texas	2,700,808	2,687,485
Utah	141,270	174,711
Vermont	61,334	84,421
Virginia	686,735	712,687
Washington	433,136	583,706
West Virginia	324,587	284,296
Wisconsin	454,984	790,457
Wyoming	49,885	59,390
North Dakota	87,475	
Rhode Island	75,263	

SOURCES: U.S. Census for column 1
Column 1 adjusted by CHER's state-level cost-of-living index for Column 2

Taken From: Cromwell et al., 1994

United States General Accounting Office

GAO

Testimony

Before the Committee on Finance
United States Senate

For Release on Delivery
Expected at 9:30 a.m.
Thursday, July 27, 1995

MEDICAID

Matching Formula's Performance and Potential Modifications

Statement of Sarah F. Jaggar, Director
Health Financing and Policy Issues
Health, Education, and Human Services Division

GAO/T-HEHS-95-226

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the formula used to share the cost of the Medicaid program between the federal and state governments. As the Congress deliberates on whether to restructure the Medicaid program, the formula for determining the federal match, or the level of federal funding each state is eligible to receive, becomes an important consideration.

In 1965 when the Medicaid program was established, the matching formula was adopted with the objective of narrowing the differences likely to result among the Medicaid programs of wealthier and poorer states. By giving poorer states (as measured by per capita income) a higher federal match, the formula was designed to reduce disparities across states in (1) population groups and services covered in each state program and (2) the tax burden imposed by the financing of Medicaid relative to the size of the state's financial resources.

You have asked that we comment today on the status of the matching formula in reducing the disparity across Medicaid programs and on our work regarding potential modifications. My remarks are based on numerous GAO analyses conducted and reports issued on this subject over the past few years. (See app. V for a list of related products.)

In brief, we have found that the Medicaid matching formula, with its reliance on per capita income as a measure of state wealth, has not significantly reduced wide differences in states' Medicaid programs or the tax burdens to support them. Large disparities persist in coverage of population groups and types of services as well as in the burdens state taxpayers bear in financing state programs. Certain modifications to the formula could enhance the ability of federal payments to narrow program disparities.

BACKGROUND

Medicaid is not 1, but 56 separate programs (including the 50 states, the District of Columbia, and 5 U.S. territories). Federal mandates impose a core of eligibility and benefit requirements, but states have discretion to use Medicaid funds to cover additional low-income individuals and provide additional medical services. As a result, differences in populations served and benefits provided can vary dramatically across states.

To illustrate, Nevada serves 284 Medicaid beneficiaries for every 1,000 poor or near-poor individuals in the state, whereas Rhode Island serves 913 per 1,000. Similarly, Mississippi spends, on average, less than $2,400 per person on Medicaid services, while New York spends an average of almost $7,300 per person. These

differences reflect the states' respective spending priorities and their abilities to pay.

State programs also vary in the percentage of program expenditures that are covered by the federal government. The federal percentage is predominantly determined by a formula based on a state's per capita income. The federal government must match what the state spends on Medicaid by this percentage, which by statute must fall within the range of a 50-percent minimum for high-income states to an 83-percent maximum for low-income states.

By federally financing a larger share of total program costs in states with high poverty rates and weak tax bases, the formula was designed to encourage these states to provide levels of medical care services comparable to those provided by states with fewer persons-in-need and stronger tax bases. Per capita income was selected as the formula's proxy measure to reflect the greater burden associated with high poverty rates and limited resources. It was assumed that low-income states experienced a greater incidence of poverty. Policymakers also thought that per capita income could be used in the formula as a good measure of differences in the abilities of states to finance program benefits. Because per capita income was to serve two functions, it was entered into the formula with its value squared.

The use of per capita income squared magnifies income differences among the states and results in wider differences in federal funding percentages. Mississippi, with the lowest per capita income, receives 79 cents from the federal government for each dollar it spends for medicaid benefits. Higher-income states receive lower federal shares. However, current law guarantees that no state will have to pay more than one-half of the total cost of its Medicaid program. Under this provision, 13 higher-income states receive a higher federal share than they otherwise would.[1]

WIDE DISPARITIES IN STATES' MEDICAID PROGRAMS SHOW FORMULA NOT WORKING AS INTENDED

In fiscal year 1994 the number of people in Nevada's Medicaid program represented 61 percent of the state's population whose income was below the federal poverty level (FPL). Vermont's Medicaid population that year equaled 139 percent of the state's population "below FPL." (See app. I for a complete list of coverage rates and spending per recipient.) Such coverage disparities signal the limitation of the current Medicaid matching formula in making the provision of health benefits to the poor more

[1]Alaska, California, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, New Hampshire, New Jersey, New York, and Virginia.

uniform across the 50 states.

The formula has reduced, but not eliminated, inequities in the tax burdens states bear in financing their Medicaid programs. States making the same effort--devoting the same portion of their tax base to funding Medicaid services--are not able to provide the same spending per person in need.

A comparison of four states illustrates these inequities.[2] (See fig. 1.[3]) Massachusetts and Maine, which have relatively extensive Medicaid programs, incur roughly equal tax burdens (the percentage of their tax base spent on Medicaid). Yet Massachusetts, because of its richer tax base, is able to spend 20 percent more per person in need than Maine, even though Maine receives a higher federal match. Nebraska and Arkansas have smaller programs and also equal tax burdens, but Nebraska's richer tax base enables the state to spend (adjusted for cost of services) 37 percent more per person in poverty than Arkansas. Despite the higher match rate, Medicaid's federal matching formula does not compensate for the smaller tax bases of Maine and Arkansas. Taxpayers in these states are at a disadvantage, because they have expended comparatively the same effort or borne the same burden as their wealthier counterparts but can only afford a smaller program.

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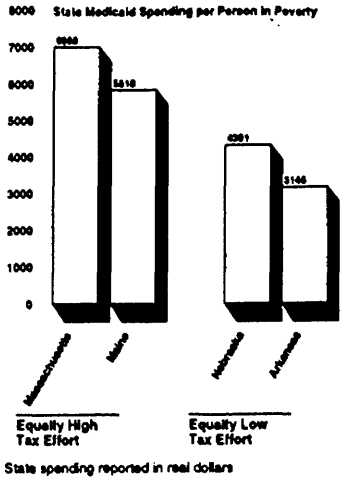
[2]For purposes of this illustration we have used the number of people below the official poverty line to reflect the number of people in need and we have adjusted state Medicaid spending by a health care cost index derived from the Medicare hospital reimbursement program in order to compare dollars of comparable purchasing power across states.

[3]Appendix II contains comparable data for all states.

Figure 1: Equal State Tax Effort Does Not Yield Equal Medicaid Spending on the Poor



FORMULA CHANGES WOULD MODERATE DIFFERENCES IN STATES' MEDICAID COVERAGE AND TAXPAYERS' MEDICAID CONTRIBUTIONS

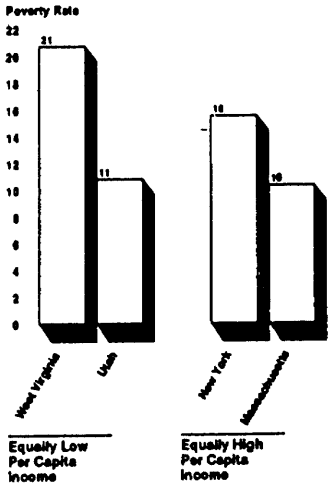
Our work indicates that modification of the formula could improve the prospect of achieving its original goals. Specific changes might include better and more direct measures than per capita income for both the incidence of poverty and states' ability to finance program benefits, adjustors for geographic differences in the cost of health care, and a reduced guaranteed federal minimum match.

Number of People in Poverty More Precise Measure of Poverty than Per Capita Income

Using a state's actual incidence of poverty (the number of people at or below FPL) would significantly improve the measurement of people in need. Per capita income is not always a good proxy for the incidence of poverty because two states with the same per capita income can have very different poverty rates. For example, because West Virginia and Utah both have almost the same average per capita income, the formula treats them as if they had the same

percentages of people in need. However, West Virginia's and Utah's poverty rates--the percentage of the state's population that is poor--are dramatically different. West Virginia's poverty rate is nearly twice as high as Utah's, as shown in figure 2.[4] This dramatic difference is not an isolated example. Despite similar per capita incomes, New York's poverty rate is nearly 50 percent greater than Massachusetts', and Florida's rate is over 35 percent higher than Minnesota's.

Figure 2: Income Is Not A Good Proxy for Poverty



Total Taxable Resources Better Indicator of State's Funding Capacity

Per capita income as an indicator of a state's ability to finance program benefits does not reflect all the income states can potentially tax. In particular, per capita income includes only a portion of business income generated in a state. Neither corporate profits retained for investment purposes nor dividends paid to out-of-state shareholders are included. Yet states can tax both through various business taxes.

[4]Appendix III contains comparable data for all states.

When income-based formulas were first adopted for federal grant-in-aid programs in the 1950s, per capita income was probably the best available indicator of a state's wealth. The Department of the Treasury now estimates each states' total taxable resources, called TTR. TTR is a more comprehensive measure of states' ability to finance program benefits because it reflects both income produced within the state and income received by state residents. Because TTR is a better measure of states' financing capacity than per capita income, the Congress approved its use as a substitute for per capita income for distributing federal funds under the Alcohol, Drug Abuse and Mental Health Services block grant program.[5]

Differences in a state's TTR and per capita income can be substantial. In such states as New Mexico, Louisiana, Delaware, Wyoming, and Alaska, per capita income understates taxable resources by 5 to 40 percent. At the other extreme, per capita income overstates taxable resources from 4 percent to 7 percent in New Hampshire, Pennsylvania, Rhode Island, Florida, and Maryland. (Data comparing per capita income and TTR for all 50 states are in app. IV.)

Accounting for Differences in Health Care Costs Would Enhance Equity

States' ability to purchase comparable services with similar tax efforts also depends on the cost of health care services in each locale. In states in which the costs of doctors, hospitals, and other health care professionals are relatively high, a dollar of state spending buys less medical care than where these costs are lower. Consequently, inclusion of adjustors to reflect geographic cost differences could enhance the Medicaid formula's ability to moderate disparities.[6]

Although an index based on Medicaid service prices does not exist, other available indices that suggest the geographic differences in the cost of health care are substantial. For example, the index used to adjust Medicare hospital payments for employee wage differences shows that hospital workers in New York and California are paid about 25 percent above the national

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[5]In fiscal year 1994, about $1.3 billion was distributed under this formula.

[6]Adjustments may also be appropriate to account for the cost differences in types of persons served. Medicaid provides services to poor and near-poor elderly, disabled, working-age adults and children. Because serving the elderly and disabled is much more expensive on average than serving other adults and children, adjusting federal payments to reflect these cost differences may be appropriate.

average. In contrast, wages paid to similar workers in Alabama and Wyoming are about 20 percent below the national average.

Reducing Guaranteed Minimum Match Would Likely Make Benefits More Comparable Among States

The considerable differences among states in the breadth and depth of their Medicaid programs is attributable in part to the formula's guarantee of at least 50 percent in federal matching dollars and the absence of a threshold limiting federal liability. Currently, the guaranteed minimum of 50 percent federal funds allows high-income states with low poverty rates to finance Medicaid programs with relatively low tax burdens. The low tax burden encourages these states to provide more generous programs than most other states may choose to provide. A lower federal minimum would create a stronger incentive for the wealthier states with more generous programs to scale back their programs, making them more comparable with other states.

CONCLUSIONS

In conclusion, the Medicaid formula for calculating a state's entitlement to federal matching funds could play an important role in the restructuring of Medicaid. The current formula has not moderated disparities across states with respect to the populations and benefits Medicaid covers and the relative financial burden states bear in funding their programs. Our work over the years shows that the use of per capita income to reflect a state's wealth sometimes overstates or understates the size of a state's poverty population and its financial resources. Our work also suggests that the inclusion in the formula of such measures as poverty rates, TTR, geographic adjustors of health care cost differences, and a reduction in the guaranteed federal match would help moderate program disparities.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Committee members may have.

For more information on this testimony, please call Jerry Fastrup, Assistant Director, at (202) 512-7123. Other major contributors included Richard Horte, Senior Evaluator, and Robert Dinklemeyer, Economist.

[118123]

APPENDIX I APPENDIX I

MEDICAID GRANT, EXPENDITURES, RECIPIENTS, AND POVERTY (FISCAL YEAR 1994)

Census regions and states	Federal grant per person in poverty		Recipients as a percent of persons in poverty		Federal plus state real expenditure per recipient	
	Amount	Index (U.S. = 100)	Percent	Index (U.S. = 100)	Amount	Index (U.S. = 100)
New England	$3,951	181.7	113.1	123.6	$5,985	144.3
Connecticut	4,341	199.6	122.7	134.1	5,815	140.2
Maine	3,325	152.9	98.9	108.1	5,970	143.9
Massachusetts	3,974	182.8	114.7	125.4	5,969	143.9
New Hampshire	4,380	201.4	90.3	98.8	9,440	227.6
Rhode Island	4,112	189.1	106.7	116.6	6,570	158.4
Vermont	2,814	129.4	139.0	152.0	3,648	87.9
Middle Atlantic	3,355	154.3	97.9	107.1	5,862	141.3
New Jersey	3,044	140.0	99.1	108.3	5,478	132.0
New York	3,887	178.8	103.7	113.3	6,004	144.7
Pennsylvania	2,499	114.9	86.3	94.3	5,220	125.8
East North Central	2,141	98.5	90.6	99.1	4,257	102.6
Illinois	1,674	77.0	85.9	93.9	3,937	94.9
Indiana	2,444	112.4	81.4	88.9	5,177	124.8
Michigan	2,166	99.6	88.2	96.4	4,144	99.9
Ohio	2,363	108.7	105.5	115.4	3,933	94.8
Wisconsin	2,505	115.2	84.6	92.5	5,459	131.6
West North Central	2,262	104.0	85.5	93.5	4,953	119.4
Iowa	2,425	111.5	102.2	111.7	4,555	109.8
Kansas	1,984	91.2	82.0	89.6	4,633	111.7
Minnesota	2,635	121.2	78.7	86.0	6,099	147.0
Missouri	2,010	92.4	84.7	92.6	4,432	106.8
Nebraska	2,411	110.9	99.7	108.9	4,397	106.0
North Dakota	2,640	121.4	80.1	87.6	5,546	133.7
South Dakota	2,072	95.3	71.4	78.1	5,339	128.7
South Atlantic	1,882	86.6	90.0	98.3	3,811	91.9
Delaware	2,516	115.7	124.0	135.5	3,864	93.1
District of Columbia	3,382	155.6	104.8	114.6	5,294	127.6
Florida	1,357	62.4	77.6	84.9	3,365	81.1
Georgia	2,019	92.9	103.4	113.1	3,446	83.1
Maryland	2,412	110.9	84.2	92.0	5,708	137.6
North Carolina	2,150	98.9	99.3	108.5	3,781	91.1
South Carolina	2,147	98.7	74.9	81.9	4,740	114.2
Virginia	1,626	74.8	106.0	115.9	3,415	82.3
West Virginia	2,586	118.9	97.9	107.1	4,234	102.1
East South Central	1,868	85.9	89.4	97.7	3,604	86.9
Alabama	1,732	79.7	73.3	80.1	4,134	99.7
Kentucky	1,877	86.3	88.2	96.4	3,578	86.2
Mississippi	1,659	76.3	83.3	91.0	3,635	87.6
Tennessee	2,132	98.1	108.7	118.8	3,387	81.7
West South Central	1,975	90.8	78.9	86.3	4,236	102.1
Arkansas	1,853	85.2	76.5	83.6	4,306	103.8
Louisiana	3,098	142.5	79.6	87.0	6,095	146.9
Oklahoma	1,304	60.0	65.0	71.0	3,612	87.1
Texas	1,766	81.2	81.8	89.4	3,728	89.9
Mountain	1,818	83.6	82.2	89.9	3,588	86.5
Arizona	1,953	89.8	89.9	98.3	3,372	81.3
Colorado	1,802	82.9	82.4	90.1	4,125	99.4
Idaho	1,557	71.6	72.7	79.5	3,570	86.1
Montana	2,103	96.7	78.6	86.0	4,476	107.9
Nevada	1,416	65.1	60.9	66.6	4,111	99.1
New Mexico	1,504	73.8	84.0	91.8	2,821	68.0
Utah	2,080	95.7	80.3	87.8	3,739	90.1
Wyoming	2,086	95.9	94.8	103.6	4,160	100.3
Pacific	1,558	71.7	100.2	109.5	2,482	59.8
Alaska	3,007	138.3	123.7	135.2	3,473	83.7
California	1,376	63.3	96.6	105.6	2,256	54.4
Hawaii	2,314	106.4	116.9	127.8	3,471	83.7
Oregon	2,032	93.4	111.8	122.2	2,811	67.8
Washington	2,664	122.5	120.6	131.8	3,851	92.8
U. S. average	$2,174	100.0	91.5	100.0	$4,148	100.0

APPENDIX II

STATE TAX EFFORT COMPARED WITH MEDICAID SPENDING PER PERSON IN POVERTY (FISCAL YEAR 1994)

State	Tax effort as percent of U.S. average	Real Medicaid benefits per person in poverty	Federal medical assistance percentage
New York	211.8	$6,411	50.00
Rhode Island	164.7	7,095	53.87
New Hampshire	154.6	8,554	50.00
Massachusetts	146.2	6,988	50.00
Maine	143.6	5,818	61.96
District of Columbia	135.2	5,699	50.00
Louisiana	122.5	4,746	73.49
Connecticut	119.9	7,323	50.00
Minnesota	108.6	4,800	54.65
Michigan	107.3	3,681	56.37
Pennsylvania	107.1	4,514	54.61
New Jersey	103.5	5,514	50.00
Vermont	100.9	5,016	59.55
West Virginia	99.4	4,021	75.72
Washington	96.5	4,677	54.24
Illinois	93.3	3,373	50.00
Maryland	92.2	4,803	50.00
Ohio	90.3	4,110	60.83
Missouri	90.1	3,680	60.64
California	88.4	2,248	50.00
Indiana	86.4	4,155	63.49
Tennessee	86.0	3,597	67.15
Georgia	85.0	3,511	62.47
Florida	84.4	2,590	54.78
Wisconsin	83.0	4,543	60.47
South Carolina	83.0	3,462	71.08
Kentucky	77.0	3,068	70.91
North Carolina	77.0	3,681	65.14
Texas	76.1	3,002	64.18
Arizona	74.5	3,020	65.90
Hawaii	74.4	4,130	50.00
Delaware	73.8	4,814	50.00
Kansas	72.8	3,720	59.52
Oregon	72.3	3,163	62.12
Iowa	70.7	4,512	63.33
North Dakota	68.0	4,321	71.13
Arkansas	67.3	3,146	74.46
Mississippi	67.3	2,844	78.85
Montana	67.2	3,424	71.05
Nebraska	66.7	4,301	61.98
Alabama	65.9	2,922	71.22
Alaska	65.5	4,447	50.00
Colorado	63.3	3,382	54.30
Virginia	62.2	3,556	50.00
South Dakota	61.7	3,655	69.50
Nevada	61.3	2,542	50.31
New Mexico	58.5	2,336	74.17
Oklahoma	55.5	2,262	70.39
Idaho	48.5	2,532	70.92
Wyoming	47.9	3,803	65.63
Utah	43.8	2,977	74.35
U.S. average	100.0	$3,795	...

STATE PER CAPITA INCOME COMPARED WITH
STATE POVERTY RATES (CALENDAR YEARS 1991-93)

State	Per capita income as percent of U.S. average	Average poverty rate
District of Columbia	140.1	20.7
Connecticut	134.6	8.8
New Jersey	129.0	10.2
New York	119.5	15.5
Massachusetts	117.9	10.3
Maryland	115.8	10.0
Hawaii	112.1	9.0
Alaska	111.2	9.5
Nevada	108.9	11.7
Illinois	108.0	14.5
New Hampshire	107.9	8.7
California	107.1	16.8
Washington	105.2	10.8
Delaware	105.1	8.7
Virginia	104.0	9.5
Colorado	102.8	10.1
Pennsylvania	102.3	12.1
Rhode Island	101.2	10.7
Minnesota	101.2	12.1
Florida	99.2	16.5
Michigan	98.0	14.3
Kansas	95.4	12.2
Nebraska	94.9	10.3
Wisconsin	94.7	11.2
Wyoming	94.6	11.5
Missouri	94.2	15.2
Ohio	94.1	13.1
Vermont	93.2	11.4
Oregon	93.1	12.4
Georgia	92.0	15.5
Texas	91.6	17.4
Indiana	91.2	13.1
Maine	90.3	14.5
Iowa	89.2	10.6
North Carolina	88.7	14.5
Tennessee	87.4	17.2
Arizona	87.1	14.8
South Dakota	86.1	14.3
Idaho	83.3	14.2
North Dakota	82.9	12.4
Montana	82.6	14.9
Alabama	81.9	17.9
Oklahoma	81.8	18.8
Kentucky	81.2	19.3
South Carolina	80.6	16.0
Louisiana	79.0	22.9
New Mexico	77.7	20.2
Utah	77.2	10.8
West Virginia	77.1	20.7
Arkansas	76.6	18.5
Mississippi	69.8	24.6
U. S. Average	100.0	14.6

DIFFERENCES IN STATE PER CAPITA INCOME AND STATE PER CAPITA TOTAL TAXABLE RESOURCES (TTR) (CALENDAR YEARS 1991-93)

State	Per capita income		Per capita TTR		Differences in percent of U.S. average
	Amount	Percent of U.S. average	Amount	Percent of U.S. average	
Alaska	$22,289	111.2	$36,868	155.9	40.23
Wyoming	18,968	94.6	25,940	109.7	15.94
Delaware	21,057	105.1	28,736	121.6	15.70
Louisiana	15,839	79.0	21,167	89.5	13.30
New Mexico	15,570	77.7	19,315	81.7	5.17
Texas	18,352	91.6	22,673	95.9	4.74
North Carolina	17,784	88.7	21,908	92.7	4.44
Hawaii	22,477	112.1	27,392	115.9	3.32
Utah	15,470	77.2	18,791	79.5	2.98
Nebraska	19,014	94.9	22,899	96.9	2.11
California	21,459	107.1	25,772	109.0	1.92
Georgia	18,449	92.0	22,116	93.5	1.63
Tennessee	17,518	87.4	20,958	88.6	1.43
North Dakota	16,618	82.9	19,864	84.0	1.34
Kentucky	16,282	81.2	19,461	82.3	1.34
Nevada	21,819	108.9	26,064	110.2	1.28
South Carolina	16,154	80.6	19,293	81.6	1.25
Minnesota	20,279	101.2	24,201	102.4	1.18
Mississippi	13,994	69.8	16,651	70.4	0.88
South Dakota	17,255	86.1	20,431	86.4	0.39
Iowa	17,870	89.2	21,130	89.4	0.25
Illinois	21,650	108.0	25,510	107.9	(0.11)
Kansas	19,121	95.4	22,511	95.2	(0.19)
Indiana	18,279	91.2	21,471	90.8	(0.41)
Oklahoma	16,394	81.8	19,252	81.4	(0.44)
Arkansas	15,352	76.6	18,020	76.2	(0.48)
Massachusetts	23,633	117.9	27,719	117.3	(0.56)
Ohio	18,855	94.1	22,088	93.4	(0.68)
Washington	21,093	105.2	24,709	104.5	(0.69)
New York	23,947	119.5	28,040	118.6	(0.73)
Virginia	20,837	104.0	24,324	102.9	(1.03)
Alabama	16,406	81.9	19,143	81.0	(1.08)
Connecticut	26,966	134.6	31,472	133.1	(1.12)
Wisconsin	18,973	94.7	22,090	93.4	(1.29)
Missouri	18,880	94.2	21,968	92.9	(1.35)
Colorado	20,614	102.8	23,911	101.1	(1.66)
Idaho	16,705	83.3	19,303	81.6	(2.03)
Oregon	18,659	93.1	21,477	90.8	(2.42)
Montana	16,548	82.6	19,044	80.6	(2.43)
New Jersey	25,863	129.0	29,662	125.5	(2.76)
Vermont	18,686	93.2	21,397	90.5	(2.92)
Arizona	17,465	87.1	19,930	84.3	(3.25)
Maine	18,095	90.3	20,625	87.2	(3.37)
West Virginia	15,450	77.1	17,607	74.5	(3.39)
Pennsylvania	20,496	102.3	23,326	98.7	(3.51)
Michigan	19,641	98.0	22,227	94.0	(4.06)
Rhode Island	20,294	101.2	22,893	96.8	(4.36)
New Hampshire	21,623	107.9	24,337	102.9	(4.58)
Maryland	23,207	115.8	25,744	108.9	(5.95)
Florida	19,874	99.2	21,749	92.0	(7.22)
U. S. average	$20,043	---	$23,641	---	---

RELATED GAO PRODUCTS

Medicaid: Spending Pressures Drive State Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

Medicaid: Alternatives for Improving the Distribution of Funds to States (GAO/HRD-93-112FS, Aug. 20, 1993).

Medicaid Formula: Fairness Could Be Improved (GAO/T-HRD-91-5, Dec. 7, 1990).

Changing Medicaid Formula Can Improve Distribution of Funds to States (GAO/GGD-83-27, Mar. 9, 1983).

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FEDERAL AID FORMULAS ARE INHERENTLY POLITICAL!

Testimony for the U.S. Senate Committee on Finance

Richard P. Nathan

July 27, 1995

I am pleased to testify today at this hearing to consider issues and options for the allocation formula for Medicaid. To begin, I want to set forth what experience has taught me are four laws of grant-in-aid formula writing.

1. **Formula writing is a political artform.**

   No one who has been around in domestic politics would ever think you can call on an expert to tell you the right way to distribute grant-in-aid money. Formula writing is an inherently political act reflecting values, interests, and different ideas about public problems and public policies.

2. **An old formula is a good formula.**

   Writing a new grant-in-aid distribution formula is an act of political courage because it opens a political Pandora's box of regional rivalry. It is better to modify an existing formula wherever you can do so. In the case of the Medicaid program, I want to suggest ways this can be done based on computer runs we have done that I hope will be of interest to members of this Committee.

3. **The formula has to be legislated.**

   An important additional lesson for formula writing is that the formula has to be in the law. I can cite experience which shows that clever formula writers can achieve almost any result they want to with what is a good-sounding approach if you give them discretion. Never give formula discretion to the bureaucracy if you want to make policy.

4. **You have to test all formula revisions.**

   You can't just decide what is a good approach and then advocate it. You have to give it two tests - a "workability" test and a "political" test. There are bound to be surprises and glitches that can only be dealt with by repeated formula-test iterations.

The Politics of Printouts

In the old days when I first got into this business, it was much easier to write grant-in-aid allocation formulas. Before computers, when you changed a federal grant-in-aid formula, only a few gnarled hands (usually people who worked for this Committee) knew what was really going to happen, and they didn't say. Today, when even a small formula change is being considered, every Member, every staffer, every stakeholder has a computer printout on his desk and knows precisely and instantly who wins and who loses.

Basis for Illustrative Medicaid Formula Changes

I have made some assumptions in working on sample computer runs for this hearing:

1. There is a strong commitment at the present time to federal deficit reduction, which includes putting a growth cap on the states for entitlement-type (now open-ended) grant-in-aid programs;

2. The alternative to a state-by-state growth cap is a per-recipient cap. This idea has good properties in theory, but doesn't pass the "Old-formula" test.

Expanding on the second point, I don't see how you can establish a per capita cap and at the same time avoid major disruption of current inter-state Medicaid funding relationships.

I want to add several caveats here about the way I have prepared for this hearing. I am not passing judgment. I am not saying there should be a growth cap for Medicaid on a state-by-state basis. I have done computer runs that are illustrative. They suggest ways to avoid a new war between the states. They keep the existing allocation system as the base and adjust at the edges in ways that take into account points we hear often.

One, growth states don't get a fair shake if you just use the existing distribution as a base to allocate Medicaid funds under a capped program. Two, very poor states don't get a fair shake either.

"SuperBlock"

The computer runs I have done combine AFDC and Medicaid reflecting what I call "SuperBlock." Ultimately, I would also urge including the Workforce Development Block Grant as part of "SuperBlock."

There are good reasons for combining both the Medicaid and AFDC programs in a new growth-capped program if it is decided that such a growth cap (say 8%/7%/6%/5%/4%/4%/4%) is desirable for the Medicaid program. I will be happy to discuss my reasoning showing numbers that buttress my argument. Suffice it to say as a quick explanation that some low-income states, (Mississippi for example) have by their own choice opted for a significantly below-average AFDC draw-down, but are well above the national average in per capita terms in their utilization of Medicaid funds.

"SuperBlock" would work in a way similar to the House Commerce Committee's plan for a Medicaid block grant. It would have earmarks for particular purposes and groups with authority for the states to transfer funds up to some percentage among these social purposes and groups.

Such an approach would be a giant step forward to help states set up "1-stop" service systems for federally-aided social program management that are greatly needed. The GAO recently pointed out that often social programs serve the same people. Jokes are often made about how case workers for different social service agencies can't find parking places to meet with clients because so many other agencies are serving the same families. If states linked up their data systems for health, welfare, employment and training programs, and social services, by requiring state agencies to share data for these

programs, the world of social program management would never be the same again. Instead of top down coordination that agencies and interest groups fight and defeat, put the data together to create "1-stop" systems for social services. There is a little bit of good in everything: The little bit of good in the new world of domestic program devolution and federal deficit reduction is that some states could be really innovative.

'Dick's Dilemma'

At the Rockefeller Institute, the program name for this formula-testing project is "Dick's Dilemma." Some people here at this hearing are probably already way ahead of me in bringing to bear ideas for solving the current dilemma. There are unlimited ways to do this. The options I will present today are somewhat complicated, but I think they work as possible compromises for the problems being debated currently. You have to follow closely; however, basically the system is straight forward.

We begin with the existing 1994 state allocations as the base for distributing Medicaid and AFDC funds to the states.

> Step 1 is to create a one-time High-User Redistribution Fund (HURF) by taking 12% of the combined Medicaid and AFDC spending of each state above the national median in per capita spending for the two programs. Note: The 12% allocation applies only to spending above the national median. (We have also made a computer run for 10% above the national median.)
>
> Step 2 is to redistribute this money to states that have been fast population growers over the past five years on a moving-average basis adjusted by size of population increase.
>
> * * * * *
>
> **This way you get maximum adjustment for relatively minimal disruption.**

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Under this system, the following states receive first-year bonus payments as follows:

Illustrative Formula Highlights

State	Bonus Payment (millions of dollars)	% increase over 1994 base
Nevada	94.39	40.00
Alaska	41.09	25.05
Arizona	150.87	12.30
Washington	210.65	12.16
Florida	224.22	6.61
Oregon	51.49	6.22
Idaho	14.73	5.96
California	566.25	5.63
Utah	24.76	5.56
Virginia	30.41	2.83
Colorado	18.76	2.62
Georgia	18.61	.80
Texas	27.87	.50
Hawaii	.88	.28

No state is hit all that hard. The "dish" is on the table, which makes it possible for me to return to New York - *I hope*. ("Dish" refers to the disproportionate share Medicaid money for hospitals with especially high numbers of poor patients. It is in the original 1994 base under my formula approach, but under the growth-capped grant envisioned here this provision would not apply in the future to the way state Medicaid or successor programs work unless states decide they want to preserve this arrangement. It's up to them.)

The reductions for the states that are Medicaid high users that contribute to the High-Use Redistribution Fund range from .14% of their 1994 base to 6.58%. With a 10% contribution rate, the range is lowered from .12% to 5.48%. (Our hand

out tables use two levels of contribution rate - 10% and 12%.) The adjustment payments made from this special fund change over time so that high growth states at any point in time are assisted in a way that recognizes their condition on a current basis. In my estimation, this high-user redistribution fund should increase at the same rate as the overall "SuperBlock" growth cap; however, each state's base allocation, after the year-one adjustments are made, should not change except for the addition each year of the amount of money provided to each state under the growth cap.

In some of our computer runs, we also included a high poverty bonus. This bonus was given to states with a poverty rate more than 10% above the national average that were also low users (less than 10% below the national average) under the combined Medicaid and AFDC programs. We divided the total higher-user fund 80% for high growth states and 20% for high poverty states and set as a decision rule that no state could receive bonuses for both high growth and high poverty. Actually, very few states qualified for the high poverty bonus. Unfortunately, this seemingly-simple idea added a layer of complexity that we could not cope with in our computer runs in time for this hearing. Moreover, I am not sure this additional bonus is necessary when one looks at the numbers. Nonetheless, if it is seen as desirable to include a high poverty bonus, data crunchers could do this. We would be glad to work on this some more if it would be helpful to the Committee, although there are many experts inside the Beltway (for example at GAO) who could do this very well, probably better than we could.

My first instinct in working on the formula runs we did for this hearing was to tell our technical team that their goal is 26 winners and 24 losers. But as I thought about "Dick's Dilemma" I realized it is more efficient to adjust the tails of the distribution, not the whole universe of states. The approach just described has 23

states as one-time "contributors," none of which contribute more than 6.58% of their combined Medicaid and AFDC base amount. In year one, there are 14 states, as shown above, that receive a high growth bonus payment.

Specifically as a feature of "SuperBlock", I also suggest giving back savings to the states. What I mean by this is that if there are cases where states choose to draw down less than their allocation for the purposes of "SuperBlock," they would keep 75% or half of the savings. Also, I want to mention again that these plans leave the "dish" (disproportionate share provision) on the table. For a half dozen states (including my own), this is an important point that I believe may make this illustrative approach politically palatable as a possible compromise position.

Another important design issue involves state maintenance of effort. If it is retained in full or in part, the new system could require that high growth states have added to their maintenance of effort payment some portion (say 25%) of what they receive as their high growth bonus payment.

Let me stress again that the computer runs we have done are preliminary and illustrative. We would need more time to get all the wrinkles out and triple check all the numbers and procedures, but I am satisfied that the work we have done based on these runs can be useful now as you consider Medicaid formula revisions.

Adding Employment and Training

As a next step, also noted above, I would like to experiment with a system that adds Workforce Development Block Grant funds to this system. My instinct is that it would be too complex to integrate these funds into the formula-allocation system. Nevertheless, I believe "SuperBlock" should include this function as a third program component, because it would give much stronger power to the states to bring about social program integration in the new world of the "Devolution Revolution of 1995."

An Automatic Emergency Add-on

I believe another point needs to be added to this testimony that is drawn from an earlier Committee hearing when Charles Murray and I testified on H.R. 4, the House-passed welfare bill. I talked then about the desirability of an automatically-triggered emergency fund to deal with economic reversals as part of a welfare block grant. I quote from the earlier testimony.

> There need to be ways under a new approach to welfare reform to deal with emergency conditions, such as a recession, rapid inflation, or a disaster. The initial recourse should be automatic - and it should be grants, not loans.
>
> There have been previous laws and proposals in Congress to provide such counter-cyclical federal aid. Under President Ford in 1976, a version of this idea (called the Anti-Recession Fiscal Assistance Act) was enacted for $1.25 billion. A similar counter-cyclical revenue sharing bill was included in President Carter's 1977 Economic Stimulus Program for $1.34 billion, also with triggers based on the unemployment rate. Trigger mechanisms like this are used for unemployment insurance. There is a similar trigger mechanism for emergency loans in H.R. 4.
>
> It is essential to include such a feature in the family assistance block grant proposed here. It could, for example, automatically trigger emergency funds when there is a quarter-to-quarter decline in national GNP or the unemployment rate exceeds some level. There are ways to do this nationally, regionally, an on a state-by-state basis. Such a triggering device could be fully automatic or could be subject to Congressional disapproval within a certain time, with the stipulation that failure to disapprove constitutes favorable action.

This feature is needed to avoid hardship especially when a recession occurs. A political advantage to including it is that since CBO does not "score" a recession, such an emergency add-on would not affect the budget projections for "SuperBlock."

Other Questions

I have concentrated in this testimony on the second of the three questions asked by Senator Packwood in his letter inviting me to testify; "If the Medicaid formula is changed what factors should be taken into account in doing so?" Senator Packwood's letter also

asked about the "positive" and "negative" features of the current formula. As a technical expert for purposes of this testimony, I believe this question gets into areas involving heavy-duty national values. The big change being contemplated this year is closing the end on Medicaid. With a Medicaid growth cap, states are no longer guaranteed matching funds to cover a portion of their costs of serving all beneficiaries they determine to be eligible under their rules and within the framework of the federal law. There is no longer an entitlement to the states. Moreover, unless states chose to create one, there need not be an entitlement to individuals and families under the programs they operate with Medicaid funds once this program is transformed into a block-type program by closing the end on federal financing. To some this is a necessary action to achieve federal deficit reduction, hence a positive step. To others, it is a decidedly negative change.

As I mentioned earlier in my testimony, some people who oppose a state-by-state Medicaid growth cap want instead to institute a per capita cap. I have puzzled a lot about how that would work, especially at the outset when, like Senator Hutchinson's alternative distribution plan, my intuition is that it would probably produce very large changes in the shares of each state of Medicaid funds. Furthermore, I am unclear as to how (if deficit reduction is a priority objective) a per capita-cap could set a fixed annual limit on Medicaid spending. To do so, the per capita approach I presume would require recalibrating the cap annually in order to reduce it when state claims in the aggregate exceed the national cap. This could create situations in which large and unpredictable swings in federal funding could affect all states, even those in which the Medicaid benefit package did not change and its eligible population was stable.

The Chairman's third question asks about the availability and quality of data for factors discussed. I do not foresee large problems in this area. There are always limits to how good data can be for purposes such as this, but if we rely on U.S. Census Bureau statistics, our experience with revenue sharing, block grants, and categorical grants suggests that a new Medicaid formula-allocation system such as the one discussed in this testimony

would be workable. In an article on the 1980 Census, I discussed these issues. I ask consent to include this article in the record with my testimony.[1]

After I present my testimony, I will distribute a detailed state-by-state table on the illustrative alternative formula highlighted in this testimony. I was warned by the staff of the Committee that if I included the full table with the testimony, no one would hear a word of what I have to say.

* * * * *

Mr. Chairman. Thank you for this opportunity to testify. I have spent a whole career on "MEGO" issues for federal grants-in-aid. I don't know any part of this subject that is as dull and detailed as formula writing. I hope my presentation and discussion of this subject will not bog down. I apologize in advance if they do. Needless to say, however, the technical and seemingly-innocuous formula issues you are discussing today are crucial for the debate on the changes in direction in national domestic policy embodied in the 1996 federal budget resolution. As economist Joseph Schumpeter once said, and I am paraphrasing, it is in fiscal issues like this that you can hear the thundering hoofbeats of history.

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1. Richard P. Nathan, "The Politics of Printouts: The Use of Official Numbers to Allocate Federal Grants-in-Aid," *The Politics of Numbers*, William Alonso and Paul Starr, Editors (New York: Russell Sage Foundation, 1987) Chapter 10.

Paul E. Peterson

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MEDICAID: THE DISTRIBUTION FORMULA

Any change in the medicaid grant formula needs to achieve a balance among the following objectives:

* Encourage the introduction of cost-saving approaches by state governments.
* Assist the goal of deficit reduction.
* Discourage a race to the bottom.
* Provide greater assistance to states with lower tax capacity and lower per capita income.
* Respond to shifts in the need for medicaid services in particular states caused by demographic and economic change.

Current Matching Grant

The current medicaid formula matches state contributions with a federal grant that can vary between 50 and 83 percent of the state contribution, depending on a state's per capita income. Thirty-seven states receive a better than 50 percent match.

Advantages. The advantages of the current formula are several. Its design enables it to:

* Respond quickly to changes in a particular state's medicaid needs, which can shift quickly in response to economic and demographic fluctuations.
* Offset a tendency for states to "race to the bottom" by paying at least half the incremental costs.
* Encourage states to design programs so that needy people are entitled to medicaid benefits. For example, many state programs for disabled people have been redesigned so that they can be partially funded under medicaid, thereby shifting some of the costs to the federal government. Although some program-shifting may be inappropriate, it is generally quite appropriate for the federal and state governments to share both overall and incremental costs of social programs. Unless costs are shared, states will be forced into a "race to the bottom." See the appendix to this testimony.

* Be calculated expeditiously. Data needed to distribute funds are automatically collected as part of the administration of the program.

Disadvantages. The existing grant formula also has several disadvantages. Its does not:

* Obtain precise estimates of future costs of the program. Federal costs are determined by state decisions affecting eligibility, services covered, and payments to providers, all of which significantly affect program costs.

* Encourage cost-saving by states. Because a majority of the states pay for less than half their medicaid costs, they do not have maximum incentives to minimize costs. In fact they have incentives to increase costs that ease the overall state budget, such as provider state-tax payments and donations.

* Distribute more money to states with fewer economic resources, a goal of most federal grant programs. Grant monies go disproportionately to states with higher tax capacities and higher per capita income, because these states are more likely to have larger, higher-cost medicaid programs. The increase in the percentage match for states with lower per capita income is not steep enough to correct this bias in the grant.

Fixed Block Grant

The Congressional budget resolution proposes, as an alternative to the current matching formula, that each state receive a block grant equal to the amount the state received in 1994 (or some combination of prior years), with a percentage adjustment that averages about 1.9 percent.

Advantages. The block grant has certain advantages over the existing formula. Its design:

* Enables the federal government to predict future costs.

* Encourages states to introduce cost-saving techniques.

Disadvantages. But the proposed block grant has four major disadvantages. Its design:

* Locks in the funding pattern obtaining in 1994, a year when the distribution of funds is skewed by differential state access to "disproportionate share" funds and by other peculiarities, such as special arrangements particular states have reached with the Department of Health and Human Services through the waiver process.

* Is not responsive to changes in state economies and demographics. If one state grows faster than another, or if a region of the country suffers from a recession, creating an additional demand on the medicaid system, all the additional costs must be borne by the state.

* Is not responsive to state effort. A state could receive its entire block grant allocation, even if it totally eliminated its own state funding for medicaid. Instead of letting fifty flowers bloom, the block grant encourages fifty flowers to wilt.

* Perpetuates, even worsens, an inequitable pattern of funding. Monies go disproportionately to better-off states, whether or not they match federal funding.

* Requires states to pay for incremental medicaid costs. This is likely to set off a "race to the bottom." If a state suffers a downturn in its economy, it will have to bear the full impact of additional demands for medicaid services at a time when state revenues are falling. The state will be under pressure to cut eligibility standards and the range of services covered. To avoid becoming medicaid magnets, other states will be forced to follow suit. (See appendix for details).

Preferred Alternative: Per Recipient Matching

A more desirable alternative to a fixed block grant is a matching grant in which the federal contribution that is limited to a specific amount per recipient, provided the state matches this amount. The specific amount would need to be set separately for different kinds of medicaid recipients: the elderly, the disabled, adults, and children eligible by virtue of low income. The initial amount could be set for each state at the level existing in 1994, with an adjustment for changes in the overall CPI.

Advantages. A per recipient matching grant--also known as a "per capita cap"--has the following advantages:

* By placing a limit on the federal contribution, it would encourage states to introduce cost-saving policies.

* It would encourage cost-saving by introducing more cost-effective medical care delivery rather than by restricting eligibility standards to needy individuals. State programs would be more apt to bloom than wilt.

* It would respond to state demographic and economic change.

* It would check a race to the bottom by encouraging a maintenance of effort at the state level.

* Deficit reduction objectives could be realized by adjusting the per recipient limit.

* Feasibility. Data necessary for distributing the funds would be generated automatically as states determined the number of recipients in various categories.

Disadvantages. The per recipient matching grant has two disadvantages, both of which can be met by modifying its provisions.

* Future spending targets cannot be predicted precisely, because the number of recipients cannot be predicted. To address this problem, the formula for determining the per recipient matching grant could be adjusted nationally each year. It might be initially set to rise with the cost of living but then be adjusted downward, if further savings are needed.

* The per recipient matching grant continues to advantage states with greater tax capacity and higher per capita income. To ameliorate this problem, the matching grant formula could be modified so that states with higher per capita income might receive, say, a 40 percent instead of a 50 percent match. Alternatively, savings could be used for deficit reduction. More states below the national average could be given a better than 50 percent match. I am recommending here a general approach rather than any specific percentage or per capita income level, because it would be necessary to undertake a detailed computer analysis to ascertain a more equitable distribution formula that helped meet deficit-reduction objectives.

Block Grants based on Persons in Poverty

Some have proposed that medicaid block grants be distributed to the states according to the number of poor persons living in a state. These proposals have numerous deficiencies. Their design:

* Is insensitive to major inter-state differences in medical costs.

* Fails to take into account differences in state tax capacity and per capita income.

* Is based on census data that takes time to collect and report, reducing its responsiveness to rapid shifts in economic and demographic conditions.

* Dramatically reallocates monies among the states, creating short-term hardships.

* Forces cuts in eligibility standards and coverage, initiating a race to the bottom. Dramatic cuts in the grant to some states will very likely require cuts in eligibility standards and coverage.

* Uses an inappropriate indicator of need. Most medicaid costs cover the needs of a small number of elderly and disabled individuals. Changes in this number is not necessarily highly correlated with changes in a state's poverty rate.

APPENDIX:

BLOCK GRANTS MAY INTENSIFY THE RACE TO THE BOTTOM

Congress, in its budget resolutions, approved in the spring of 1995 plans to save over $100 billion in welfare and other poverty-related programs and another $182 billion in medicaid costs over the next seven years. Although the budget resolutions do not say exactly how these savings are to be achieved, separate legislation proposes to transform welfare and medicaid entitlement programs into block grants.

The House proposes to provide each state with a block grant equivalent to the size of the funds it received in 1994 under the Aid to Families with Dependent Children (AFDC) program. It contains no provisions for any inflation that might occur over the next seven years.

Growth in medicaid, according to the congressional budget resolution, is to be 7.2 percent in 1996, 6.8 percent in 1997, and 4 percent in the outyears. These rates fall far short of the 10 percent growth rate projected by the Congressional Budget Office, if current policies remain in place.

The Clinton Administration's deficit reduction proposals keep AFDC and medicaid entitlements intact. The Administration achieves $38 billion in poverty-related programs mainly by tightening eligibility standards. It proposes savings of $54 billion in the medicaid program by encouraging further movements toward managed care, tightening loopholes in the current funding formula, and placing a per recipient limit on the entitlement program.

The presidential and congressional proposals differ not just in proposed budgetary savings but, even more importantly, in their effect on federal-state relationships. While the Clinton Administration proposals continue to pay states in proportion to state programmatic costs, block grant proposals place a cap on federal funds, which makes state governments entirely responsible for all additional costs. These block grants will force states into an intensified race to cut welfare benefits and medicaid reimbursements. In the long run, they will shred the country's safety net.

Welfare Policy: The Current Race to the Bottom

The probable effects of the proposed block grants on state welfare and medicaid policies can be estimated by examining state

policies under the current AFDC program. The federal government sets minimum standards and pays at least half the cost of AFDC in all states. In the states with the lowest per capita income, the federal share can be higher than 80 percent. But even though costs are shared, states have extensive authority to set eligibility requirements and benefit levels.

Before 1970, shared federal and state funding of AFDC did not preclude a steady rise in welfare benefits. The mean benefit paid to a family in the average state climbed from $306 in 1940 to $605 in 1970 (benefits are calculated in 1993 dollars). This steady increase was made possible both by steady economic growth and by the fact that each state could set its policies without worrying too much about what its neighbors were doing.

State AFDC policies began to change around 1970. Instead of moving steadily forward, they began a retreat that has accelerated with time. Even by 1975 the mean cash benefit in the average state had slipped to $512; by 1985 it had fallen to $393; and by 1993 it reached its postwar nadir of $349. All in all, cuts between 1970 and 1993 amounted to no less than 42 percent.

These reductions in welfare benefits can hardly be attributed simply to newly conservative state political climates. For much of the period, Democrats controlled at least part of state government in most states, and in a substantial number they controlled both houses of the state legislature as well as the gubernatorial chair.

More important than politics was the ever increasing integration of the national economy. Capital, entrepreneurial activity, and labor have become ever more mobile, making states increasingly sensitive to the economic consequences of their policies. Today, 17 percent of the population changes residence each year, and 3 percent moves across state lines. Low income, welfare dependent families move at least as frequently as other demographic groups. States and localities can no longer make policy choices as if they are acting in isolation from other parts of the country.

The Welfare Magnet

States vary considerably in their willingness to provide welfare benefits to low-income families. In 1991 the maximum annual combined cash and food stamp benefits for a family of four varied between $5,952 in Mississippi and $11,898 in California. The amount of variation in cash benefits was even greater in 1990

than it had been in 1940. States whose welfare benefits are relatively high have become welfare magnets, places that attract poor people because they offer higher cash benefits than do many other states. The higher the benefit, the more magnetic the state--both by keeping poor people from moving elsewhere and by attracting additional poor people into the state. Professor Mark Rom and I estimate that after five years a high benefit state will have, ceteris paribus, a poverty rate approximately one percentage point higher than a low benefit state.[1]

Before 1970 differences in state welfare policies had little magnetic effect. Numerous state laws and administrative practices designed to make access to the welfare system difficult made it inadvisable to change residences merely to improve one's welfare opportunities. Many states denied welfare benefits to anyone who had not lived in the state for a year. Thus, before 1969, states could increase their welfare benefits without becoming a more attractive place of residence for poor people in other parts of the country.

In 1969 the Supreme Court, in Shapiro v. Thompson, ruled that denying welfare benefits to newcomers denied citizens equal protection before the law. This decision, together with the liberalization of numerous other state administrative practices, facilitated access to the welfare rolls, especially on the part of those moving from one state to another.

Once newcomers could obtain welfare benefits, state officials became increasingly concerned about becoming a welfare magnet. Rom and I estimate that after 1970 a states with high benefit levels cut (over a five year period) their annual benefits by over $1,200 more than states with low benefit levels. States with higher and more rapidly increasing poverty rates reduced annual welfare benefits by nearly $400 more than a state with lower poverty rates.

Intensifying the Race to the Bottom

These cuts in welfare benefits occurred despite the fact that the federal government paid at least half all incremental costs. If block grants are enacted, the cost of becoming a welfare magnet will double. The block grant is a fixed sum of money that does not change with the number of individuals in the state eligible for assistance. If poor people move to states with more generous benefits, then those states will experience an increase in their welfare burden without any commensurate increase in federal funding. To safeguard against rapidly rising state welfare costs, generous states will come under increasing fiscal and political

pressure to reduce their benefits. Eventually, all states will be engaged in the race for the bottom, each state trying to shift the cost of welfare to its neighbors.

The pressure on state budgets will be intensified by the fact that the block grant that each state receives is not scheduled to increase. Yet inflation has been climbing by an average of 3 percent a year, enough to reduce the real value of the block grant by approximately one-fourth over seven years. In addition, most states will experience overall population growth. Even if recipiency rates remain constant, the numbers of potential welfare recipients will increases. Some states will inevitably experience a recession, either as part of national economic slowdown or as a result of economic changes that have disproportionate regional economic impacts (such as the effects of the early 1980s collapse in energy prices on the Texas and Louisiana economies).

All of the additional costs generated by inflation, population growth and economic slowdowns will be borne entirely by state governments. To keep these costs from breaking their budget, some states will cut benefits dramatically. Poor people will have even stronger incentives to locate in higher benefit states. High benefit states will be under intensified pressure to match cuts made elsewhere. A race to the bottom is virtually assured.

Medicaid Magnets

Should medicaid be incorporated into a block grant program, the race to the bottom could become deadly. Instead of letting fifty flowers bloom, the block grant could very well encourage the fifty flowers to wilt.

Seventy percent of medicaid funds are spent in providing services to a disabled and elderly population whose medicare benefits have expired. The remaining 30 percent provide health-care benefits to low income families.

Both aspects of medicaid have reduced inequities in the utilization of health care. Because medicaid services are available, low birthweight and infant mortality rates have fallen, children from poor families are more likely to use hospital facilities, and differential access between children from poor and non-poor families has been noticeably reduced.

Like AFDC, medicaid is currently an entitlement program. A person or family is entitled to receive medicaid benefits if income and resource eligibility requirements are met. These eligibility

requirements are set by states, subject to certain federal guidelines. The federal government pays for at least one-half the cost of medicaid services in all states. In states with low per capita incomes, the federal government pays a higher share of program costs. Increases in the cost of a state's medicaid program are borne either equally by the states and by the federal government or disproportionately by the federal government.

The national framework for medicaid has helped provide better coverage to needy groups, especially low-income pregnant women and their children. In 1986 Congress expanded coverage to all pregnant women and infants living in families with incomes below the poverty line. In 1990 it was expanded to cover all children living in poverty up to the age of nineteen. The impact of these new federal standards on state policy was considerable. The uniform, minimum floor for coverage (for pregnant women and children) established in 1992 was two to three times higher than the coverage provided by the average state only four years earlier.

As a result of both policy and demographic change, the cost of medicaid has increased rapidly so that it is today by far the largest of all safety-net programs. It grew from $31 billion in 1975 to $73 billion in 1990 and, if no cuts are made, the Congressional Budget Office expects it to grow by another 10 percent per annum over the next seven years.

The proposed 4.9 percent average increase in the medicaid block grant is expected to be sufficient to cover anticipated demographic changes, such as overall population growth and increases in the size of the elderly and disabled populations (whose services account for approximately 71 percent of medicaid costs). But after the next two years, nothing is budgeted for inflation, despite the fact that in recent years overall inflation has averaged about 3 percent a year and health care costs have been rising at around 6 percent.

Although the budget resolutions do not make clear how the medicaid savings are to be obtained, members of Congress have said that such savings can be achieved by creating a block grant that gives states complete discretion over its medicaid program. After two years, any increase in the cost of the program beyond 4 percent would be borne entirely by the state government.

States will be under great fiscal pressure to race to the bottom. In research currently underway, Mark Rom and I have, in a preliminary analysis, ascertained that state medicaid expenditure reductions are influenced more by the medicaid policies of neighboring states than by any other single factor. If neighboring

state expenditures are lower, a state is more apt to cut the size of its program.

If states are asked to bear all additional costs beyond the federal 4 percent increment, the race to the bottom will be accelerated by the heavy burden states will be asked to bear. Even if health-care inflation can be kept to overall rates of inflation (a heroic assumption), inflation plus demographic changes will produce a natural increase in costs of 7 percent. Those states that experience a slowdown in economic growth will suffer even greater demands on their medicaid budget, as unemployed workers apply for medicaid coverage. Demands on the program can be expected to be further accentuated by the drop in employer-funded health care insurance.

Under extreme fiscal pressure, some states will be forced to change eligibility requirements, provider payments, and the range of covered services. Poor people in need of costly medical services will have especially large incentives to locate in places where medical benefits are more generous. As the more generous states experience a rise in their low-income, medically needy population, they will come under increasing pressure to match cuts that have occurred elsewhere. The race to the bottom could become quite deadly.

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REFERENCES

Blank, Rebecca M. 1985. "The Impact of State Economic Differentials on Household Welfare and Labor Force Behavior." Journal of Public Economics 18 (October): 25 -58.

Gramlich, Edward M. and Deborah S. Laren. 1984. "Migration and Income Redistribution Responsibilities." Journal of Human Resources. 19 (Fall): 489 - 511.

Peterson, Paul E. The Price of Federalism (Brookings, 1995).

Peterson, Paul E. and Mark Rom, Welfare Magnets: A New Case for a National Standard. Brookings, 1990.

Southwick, Lawrence, Jr. 1981. "Public Welfare Programs and Recipient Migration." Southern Economic Journal 40 (October): 22 - 32.

1. Peterson and Rom, 1990. This estimate is confirmed by an out-of-sample prediction for the 1986-1990 period reported in Peterson, 1995, Ch. 5. Similar effects of welfare benefits on the residential choices of the poor are reported in Blank, 1985; Gramlich and Laren, 1. 4, and Southwick, 1981.

Revising the Medicaid Reimbursement Formula in an Era of Fiscal Austerity

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Testimony Prepared for a Public Hearing
on the Medicaid Distribution Formula

United State Senate
Committee on Finance
Room SD-215
Dirksen Senate Office Building
9:30 AM

July 27, 1995

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1 Introduction

Chairman Packwood, and Members of the Senate Finance Committee, I want to thank you for the opportunity to testify before you this morning on ways to think about revising the manner in which the federal government finances health care for the categorically needy (dependent children and their poor parent[s], the blind and disabled, and the elderly poor). My remarks round out earlier roles as a public servant at Treasury, and then the Joint Committee on Taxation, when I advised the Committee on ways to return federal taxes to state and local governments for general purposes in the 1970's, through the General Revenue Sharing program.

There is an important parallel between the Committee's deliberations today, and those of twenty odd years ago. In the 1970's, a small program of assistance to the states, what became Title XX, got out of hand with some help from California's welfare director. It grew from $281.6 million in fiscal year 1967 to $1,688.4 million in fiscal year 1972– that amounted to a 34% compound growth rate.

That program had a 70%, open-ended federal matching rate. HEW, through regulation, eliminated the categorical spending requirement for family planning, as I recall, and a number of states got very aggressive in seeking 70% matches. Indeed, one state proposed to finance its entire state budget through its Title XX application, and had gone into the private capital market for its match. This caused the Finance Committee great distress as you may recall. The Committee's reaction was to fix the Title XX appropriation at $2.5 billion, and distribute funds entirely on the basis of population. That had the effect of eliminating all matching, and defining quite clearly future federal financial exposure. The House went along with that approach, and it became a feature of Title XX for a considerable period of time.

Frankly, I am surprised that it has taken Congress so long to realize that the open-ended matching in Medicaid coupled with ingenious bookkeeping can lead to extraordinary federal financial exposure. There are, however, a number of aspects of the current situation which are different than the Title XX episode. These differences suggest to me that simply turning federal Medicaid into a very large general revenue sharing program might not be the wisest thing to do right now.

First, the Medicaid program is absolutely large and in terms of its share of federal budget, in terms of its impact on 33.4 million beneficiaries access to health services, and in terms of its impact on state and local budgets. Abrupt or unforeseen federal changes in financing policy could be very dislocating.

Second, if Medicaid were turned into a block grant for health services to the poor, it would be exceedingly difficult, due to the fungibility of money, to ensure that the monies continued to be used for the categorically needy. If it were determined that a state did not use, as required, federal block grant monies for health services for the poor, questions would then arise about what the consequences should be for such non-compliance, and whether any federal agency would be capable of actually enforcing it.

In the case of General Revenue Sharing, the fungibility of the federal grants was not viewed as a problem since the funds were for general purposes, and the Congress required that the federal funds be appropriated by recipient state and local governments under applicable state and local law. The fiction of "high priority" spending categories was part of the legislation, but was really just for Congressional political cover. It was particularly

important for Chairman Mills who was quite reluctant to embrace the notion of returning federal tax monies to state and local governments without any "strings."

The appropriations requirement resulted from some fairly healthy distrust between a certain US Senator and his Governor (both of the same party and neither now in office) and a pretty good staff suggestion. It still seems like a good idea for federal grant-in-aid legislation, but has not been in any others to my knowledge. It had the salutary effect of preventing fraud and misuse which had characterized some of the earlier, well-intentioned categorical aid programs of the 1960's.[1]

Third, while there continues to be widespread focus on Medicaid costs and its rate of growth, there seems to be a paucity of knowledge or facts about the beneficial impact of Medicaid on the health status of those historically covered as well as those most recently covered. If the explosive growth in spending has been accompanied by a parallel improvement in health status of the Medicaid recipients, then one may be more reluctant to slow-down or freeze federal support of the system. On the other hand, if the growth has simply resulted in pumping more money into the health care sector and/or state and local budgets without any improvement in the health status of the poor, then a question arises about whether these scarce resources are being most wisely used. Arguably, the rapid increases in Medicaid spending in the past few years have put continued upward pressure on various health care prices. However, in the absence of knowing what the preponderance of evidence is on actual health outcomes of the poor, I would urge caution before radically changing the nature of the program.

One of the most difficult aspects of analyzing health care for any group is the threshold question of how much health care is "enough". In a sense, one can never be "too" healthy. This is especially true given current and emerging medical technologies. Unfortunately, this point of view ignores the fundamental reality of economic scarcity, and the fact that resources withdrawn for use in health care could have been used for some other purpose.

Certainly federally financed health care to the poor must be financed through federal taxes on the non-poor who sacrifice some combination of private consumption and savings to that end. Once these realities are recognized, one can move to defining what we can afford at the federal level, given competing pressures for federal spending, and the need to reduce the federal operating deficit and reduce the share of federal debt to GDP.

A fundamental assumption of my testimony this morning is that the Congress is at the point of defining an aggregate dollar figure each year it is willing to spend on Medicaid for the next five to seven years.

The redesign of the Medicaid reimbursement formula can assume that all other aspects of the Medicaid program, or really all other aspects of the 56 Medicaid subprograms which serve these three demographic groups, can remain intact. I understand that is the major thrust of your inquiry this morning. However, there is also merit in exploring some broader issues and assumptions of federal purpose and responsibility, and varying theories of fiscal federalism in financing health services to these demographic groups. In my remarks below, I will not only address the technical issues you wish comments on, but also these broader issues. Changing some of these assumptions can lead to rather different formulas and factors, as well as qualitatively different federal-state relations.

My remarks are organized in three essential parts:

[1] I recall that one rather naively crafted criminal justice grant program to cities resulted in a federally funded Cadillac police car for a police chief.

- First, under the assumption that the Committee wishes to slow down the rate of change of federal Medicaid spending for budgetary purposes, I suggest a number of formula approaches that should prove workable in a bicameral legislative setting which faces severe fiscal austerity. These approaches have the character of achieving a stated fiscal goal, but are probably inelegant in addressing other aspects of health care issues;
- Second, I comment on the current Medicaid reimbursement formula, its advantages and disadvantages, and how the current formula might be changed; and,
- Third, I examine more broadly ways in which federal responsibility for providing health services for these three demographic groups might be expressed.

2 Aggregate Formula Approaches to Decelerating Medicaid Costs in the Short-Run

2.1 Can A Distribution Formula be Changed without Extra Hold-Harmless Monies?

My informed guess is that today's federal domestic fiscal environment is essentially cut-back in nature. This has direct implications for your ultimate ability to rationalize the current Medicaid reimbursement formula. There is no mystery about this conclusion. The history of federal and state grants-in-aid is not filled with many successful formula changes when the fiscal pot got smaller in real if not nominal terms. Without "hold-harmless" monies, it will be virtually impossible for both the Senate and House to separately pass formula changes which are, on a purely money basis, acceptable to both bodies in Conference, and gets signed into law by the President.

For example, when General Revenue Sharing was enacted in 1972, the Congress afforded each State the authority to modify the original within-state formula; however, no state was able to do so. I recall Governor Jimmy Carter of Georgia embarking on that journey, but rapidly abandoning it, once he realized that a bicameral legislature made it impossible to achieve his concept of distributive justice without devoting some of the state's own-source taxes. This was not something he was willing to do.

Similarly, when Congress renewed Revenue Sharing, it examined various changes in the inter-state and intra-state allocation formulae, but was unable to reach final agreement because the hold harmless amounts were simply larger than it wished to deal with.

If I am correct that getting agreement on a change in the Medicaid reimbursement formula in the short-run is politically unlikely, how might your budgetary objective of slowing the growth in federal Medicaid spending be achieved?

2.2 Partial Funding of *Predicted* Future Federal Medicaid Responsibilities

If the Congress is able to determine with some accuracy the annual amount of future federal Medicaid obligations over the next five to seven years, it is quite easy to simply

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fund only a percentage of each year's gross entitlement to the point which is budgetarily acceptable. Since federal reimbursement is after-the-fact, this sort of ratcheting down could be feasible. Doing so would also require not adding additional demographic groups to Medicaid enrollments eligible for federal reimbursement, and freezing the definition of health services covered by the federal share. In the current federal fiscal environment, achieving agreement on this would seem feasible.

The chief virtue of this approach is that it would freeze the *relative* position of each state's program, and, allow both the House and Senate to say that the "pain" of the deceleration was *proportionately* shared among the states. Of course, if there are unforeseen, dramatic shifts in per capita personal income among the states that cause federal reimbursement shares to change, and unforeseen, dramatic changes in case loads and health care prices, the "pain" will not in fact be proportionately distributed. On the other hand, there are many federal and state examples of this kind of reasoning being politically acceptable, and allowing one to reach a short-run accommodation.

A variant of this approach is to simply agree on acceptable growth rates which the federal government will fund, either in total, or state by state for a number of years, and tell the states that Medicaid expenditures beyond these growth targets are their fiscal responsibility.

2.3 Fixed Future Federal Medicaid Appropriations to Meet Budgetary Targets

If accurate forecasts of federal Medicaid responsibilities for the next five to seven years are not possible, Congress can simply agree on how much it will spend each year for the next five or seven years. If such funds are insufficient, one then calculates a percentage equal to the ratio of available funds by the result of summing the states' reimbursement claims. Application of that percentage to the reimbursement claims would reduce federal outlays to the desired target.[2]

It is easy to offer objections to these kinds of budgetary approaches to controlling the federal costs of Medicaid. For example, it rewards states which were not efficient or restrained historically in their programs. In effect, this ratification of current law may involve ratification of many objectionable features of the current program. Also, it offers no positive incentives for greater efficiency in the future other than simply enlarging the fiscal onus on the states (and local governments).

However, it is also quite likely that shifting more fiscal responsibility of Medicaid funding to the states will have some indirect, beneficial effects which may reduce the growth in state Medicaid spending. The availability of generous, open-ended federal matching *rates* has undoubtedly encouraged the states to expand their Medicaid programs beyond what they would have done out of their own-source revenues. Grannemann(1980) found that the states were very price sensitive to the Medicaid matching rate, and that they also demonstrated a fairly high income elasticity of demand for enrollment.

Table 1, from Phelps(1992), shows that the historical Medicaid matching rate had about the same relative price effect on the enrollment numbers of children and adults, as on the per beneficiary amount of Medicaid spending on these two demographic groups. (See Column [2]). The very high income elasticities for numbers of child and adult recipients in

[2]This can be viewed as a form of revenue driven budgeting. It has been used by Arkansas, for example, to ensure that the state balanced its budget.

Column [3] suggest that higher income states increased disproportionately their enrollment in terms of children and adults compared to lower income states; however, benefit levels to them were not nearly as responsive to higher income levels. This suggests that when Congress increased demographic coverage, higher income states increased enrollment far more dramatically than lower income states. It also suggests that participation rates or access rates are lower in lower income states than higher income states.

Table 1: Grannemann(1980) Income and Price Elasticities for States' Demand for Scope and Generosity of Medicaid Program

	Price Elasticity	Income Elasticity
Component	[2]	[3]
AFDC child recipients	-.30	2.17
AFDC adult recipients	-.25	2.32
AFDC child benefit level	-.26	0.26
AFDC adult benefit level	-.39	0.61
Total Medicaid Benefits	-.78	1.23

The overall price elasticity estimate of -.78, suggests that if the federal government were to only fund 90% of its obligation, a 10% reduction, the states would spend 7.8% less than they otherwise would have spent. Whether states are as price sensitive today as they were earlier is, of course, an open question. However, these considerations suggest that if the deceleration in federal participation is accompanied by effectively reducing the federal matching rate, the states will respond to this reduction in subsidy, and spend less than they otherwise would have.

Let me summarize the range of methods to decelerate Medicaid spending:

1. fund only a fixed percentage of predicted or actual Medicaid spending each year;
2. only allow federal Medicaid spending to grow at some fixed growth *rate*, or at the actual growth rate minus a fixed growth *rate*; this can be done overall, or per state;
3. fund only fixed dollar amounts of actual Medicaid spending, and reduce requested Medicaid reimbursements by the ratio of budgeted amounts by the sum of requested Medicaid reimbursements;

There are additional variants of the above schemes which one can imagine which will decelerate federal Medicaid spending. Only the last mechanism will ensure with certainty that federal budget targets are honored. Undoubtedly what those targets should be would be of intense interest to the states. The obvious advantage of this sort of approach is that it immediately addresses Congressional budgetary objectives and permits a more systematic evaluation of the substantive aspects of the Medicaid program, e.g. is it improving the health status of beneficiaries on a cost-effective basis?[3]

With these short-term approaches in mind, let me now turn to ways to revise the Medicaid reimbursement formula *per se*. Since substantive revision requires an understanding of the current formula, I begin with a brief review of its main features.

[3]I have not commented on whether these budgetary strategies run afoul of recently enacted prohibitions against further federal "mandates". Much depends on the specific statutory language which simply was not available to me as I developed these remarks. Given my initial supposition that demographic coverage, although not participation rates which might vary over the business cycle, and service coverage, should be

3 Approaches to Revising the Current Medicaid Reimbursement Formula

3.1 The Current Medicaid Reimbursement Formula

When Medicaid was enacted in 1967, the Congress determined its federal financial responsibility under the same financing formula used since the mid 1930's to determine federal financial responsibility for what became the AFDC program. The federal percentage share of actual AFDC and Medicaid costs is based on the ratio of squared per capita state personal income, as measured by the Bureau of Economic Analysis of the Department of Commerce, to the average US per capita personal income measured on the same basis. The federal share is 1 minus 45% of this ratio of squared per capita incomes. The calculated federal share is bounded by 80% for the lowest per capita income states, and 50% for the highest per capita income states.

Equation 1 displays the formula algebraically:

$$FederalShare = 1 - .45[\frac{StatePCY}{USAveragePCY}]^2 \tag{1}$$

If a state's personal per capita income is equal to that of the US, then the federal share reduces to 1-.45 * $\frac{1}{1}$ or .55. If a state's personal per capita income is, say, $15,000, while the US average is $20,000, or 75% of the US average, then the federal share becomes:

$$FederalShare = 1 - .45[\frac{\$15,000}{\$20,000}]^2 \tag{2}$$

or,

$$FederalShare = 1 - .45 * .75^2 = 1 - .253 = .747 = 74.7\% \tag{3}$$

Figure 3.1 shows how the federal cost share varies with the ratio of state per capita personal income to US per capita personal income and, in effect, the essential political agreement in our federal system that was reached in the 1930's.

The 80% ceiling means that any (poor) state with per capita personal income below 68% of the US average is "pegged" at the 80% ceiling. Similarly, any (rich) state with per capita personal income more than 5% above the US average is "pegged" at the 50% floor. The floor constraint thus insures that above-average per capita income states obtain 50% federal support for the costs of Medicaid and AFDC,[4] while the ceiling constraint insures that below-average per capita income states obtain no more than 80% federal support for the costs of Medicaid and AFDC.

Table 3.1 indicates that the federal share by state of Medicaid and AFDC costs has been fairly stable from the period 1984-1994, and that, while a significant number (14) of

Congressionally frozen as part of an immediate budget accord, it is not obvious to me that reimbursing at a somewhat lower rate constitutes an unfunded mandate. The Congress would not be asking the states to do something and not receive federal payment for it, rather they would receive fractionally less than in the past. Given how federal reimbursement rates vary with the relative economic position of each state, it seems that varying and/or reducing the rate of reimbursement would not constitute an unfunded mandate.

[4] See Table 3.3.1 below for a calculation per state of what Equation 1 provides without the 50% floor.

states are at the 50% floor, no state is now at the 80% ceiling.[5] It is also evident from Table 3.1 that the relative economic prosperity in the South and South East has resulted in their per capita personal incomes moving more quickly towards the national average[6], while a number of other industrial states have experienced a relative movement away from the national average and the federal share has been growing[7]

It should be noted that once a state's federal reimbursement rate rises above 50%, it has an incentive to give the appearance of spending for health care which it can then be reimbursed for. If the outlays are purely illusory, say based on a temporary loan or donation, then once the federal reimbursement is achieved, the loan can be repaid, and the match in excess of the 50% can be viewed as a fiscal windfall.

[5]It should be noted that the 1966 federal shares are the author's calculations based on one year of personal per capita income data, rather than a three year average. Also, the 1966 calculations for Texas and Arizona are hypothetical in that Arizona did not have a Medicaid program until the 1980's and the Texas program was not complete until the 1980's as well.

[6]The federal share has dropped systematically for Alabama, North Carolina, South Carolina, Tennessee, and Virginia.

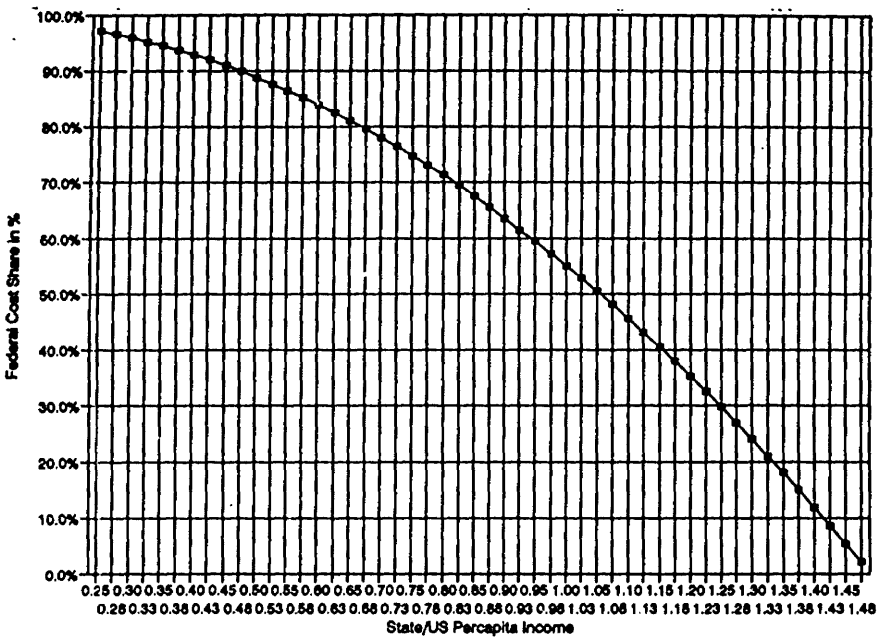
[7]This occurred for Indiana, Iowa, Michigan, Nebraska, Ohio, Oregon, Utah, Washington, and Wisconsin.

Table 2: Federal Share of AFDC and Medicaid Cost over Time: Highest to Lowest Federal Share in 1994

	1966	1984-5	1994
Mississippi	80.0%	77.6%	78.9%
West Virginia	78.7%	70.6%	78.7%
Arkansas	79.3%	73.7%	74.8%
Utah	68.3%	70.8%	74.4%
New Mexico	70.6%	69.4%	74.2%
Louisiana	73.4%	64.7%	73.5%
Alabama	78.1%	72.1%	71.2%
North Dakota	70.9%	61.3%	71.1%
South Carolina	78.4%	73.5%	71.1%
Montana	64.7%	64.4%	71.1%
Idaho	69.4%	67.3%	70.9%
Kentucky	74.1%	70.7%	70.9%
Oklahoma	68.9%	58.8%	70.4%
South Dakota	70.0%	68.3%	69.5%
Tennessee	74.6%	70.7%	67.2%
Arizona*	66.8%	61.2%	65.9%
Wyoming	61.5%	50.0%	65.8%
North Carolina	73.4%	69.5%	65.1%
Texas*	66.9%	54.4%	64.2%
Indiana	51.5%	59.9%	63.8%
Iowa	54.1%	55.2%	63.3%
Georgia	71.0%	67.4%	62.8%
Oregon	56.7%	57.1%	62.1%
Nebraska	56.7%	57.1%	62.0%
Maine	50.0%	70.6%	62.0%
Ohio	52.1%	55.4%	60.8%
Missouri	59.3%	61.4%	60.6%
Wi[illegible]sin	54.7%	56.9%	60.5%
Ve[illegible]ont	65.5%	69.4%	59.6%
Kansas	58.0%	50.7%	59.5%
Michigan	50.0%	50.7%	56.4%
Florida	65.0%	58.4%	54.8%
Minnesota	56.8%	52.7%	54.7%
Pennsylvania	54.8%	56.0%	54.6%
Colorado	56.4%	50.0%	54.3%
Washington	50.0%	50.0%	54.2%
Rhode Island	52.4%	58.2%	53.9%
Illinois	50.0%	50.0%	50.0%
Delaware	50.0%	50.0%	50.0%
Virginia	65.2%	56.5%	50.0%
Hawaii	50.0%	50.0%	50.0%
Alaska	50.0%	50.0%	50.0%
New Jersey	50.0%	50.0%	50.0%
California	50.0%	50.0%	50.0%
D.C.	50.0%	50.0%	50.0%
New Hampshire	59.6%	59.5%	50.0%
Nevada	50.0%	50.0%	50.0%
Massachusetts	50.0%	50.1%	50.0%
Connecticut	50.0%	50.0%	50.0%
New York	50.0%	50.0%	50.0%
Maryland	50.0%	50.0%	50.0%

3.2 Advantages and Disadvantages of the AFDC/Medicaid Reimbursement Formula

Figure 1: AFDC and Medicaid Reimbursement Formula: Federal Share vs. Ratio of State to US Per capita Personal Income



3.2.1 Advantages

The current reimbursement formula has a number of positive features.

1. The current reimbursement formula has, in one sense, stood the test of time. I think most would agree that if the federal government is to share with the states the financial burden of paying for health care for the categorically needy, then its participation should be greater in states which are less able to pay than in states which are more able to pay for the agreed-upon health services. This argument follows from justifying federal provision or support of health services on an income-redistribution basis;

2. Another advantage of the current Medicaid matching formula is that it has undoubtedly stimulated greater state spending on health services for the poor than they would have engaged in without federal matching;

3. Also, as noted in my brief sketch of the current formula, as regional economies have prospered and failed, the formula has reflected this and moved federal monies differentially. This adaptivity of the formula to changing economic prospects, plus the very size of Medicaid outlays now, may explain why the formula has remained intact.

3.2.2 Disadvantages

On the other hand, the disadvantages with the reimbursement formula, in my view, are fairly numerous:

1. The per capita personal income concept used in the formula is conceptually flawed, because it includes various transfer payments, but ignores tax payments. If we want to examine by state the ability to pay of the average person (more below on whether the per capita amount is representative), then we should either examine income before transfers and before taxes (e.g. without the federal, state, and local government), or after transfers and after taxes;

2. It creates an open-ended obligation to the federal government to finance something which the states can inherently influence or control. The earlier noted experience with Title XX, and the more recent federal experience with the Disproportionate Share Hospital Program under Medicaid *per se* suggest that states will take advantage of fiscal opportunities whenever the federal government gets careless. [8];

3. The formula gives no recognition to differences in the general cost of living or differences in the costs of health care provision among the states; state per capita personal income must proxy for not only differential ability to pay but also differential costs;

4. The formula gives no recognition to differential case loads or health problem incidence rates among the three demographic recipient groups, but merely shares federal dollars on the basis of expenditures;

[8] See Urban Institute, *Medicaid Disproportionate Share and Other Special Financing Programs: A Fiscal Dilemma for States and the Federal Government*, (Washington, D.C.: Urban Institute, December, 1994).

5. The formula gives no recognition to differences among the states in the general practice of health care among the states. If one believes, as I do, that poverty and health status are inherently *relative* rather than absolute phenomena *by state*, then the current approach is inherently flawed. This is something I will return to in the third part of my remarks;

6. The formula neither rewards nor penalizes states which succeed or fail to achieve high rates of participation in health coverage for the poor. Since the states are providing health services on behalf of the federal government (the federal government pays at least half of all health care costs for the poor), this suggests either federal ambivalence in their being successful or mere disinterest. Given the staggering amounts of federal monies involved, this oversight of insisting on participation is somewhat troubling;

7. Some, such as the General Accounting Office, fault the formula because it does not measure the "fiscal capacity" of each state, or the "fiscal effort" each state expends in its own-source outlays for Medicaid. The metaphor in mind is that of a parent rewarding those children who try harder to spend monies on health care than other children who try less hard. This view of course ignores efficiency and efficacy questions, and may be tantamount to federal imposition of minimum state outlays for Medicaid out of state own-source monies. Another difficulty with state fiscal capacity as a factor to allocate federal funds is that it reflects not only tax base or fiscal supply considerations, but also the particular state tastes for particular public services which have been encouraged, in part, by differential federal matching rates;

8. The formula merely determines how much money the federal government contribute to state health programs for the categorically needy, without encouraging in the formula either efficiency or health outputs. In preparing this testimony I asked several legislative staff in state capitols if they knew or had reason to believe that Medicaid outlays had improved the health status of the three main demographic groups covered under Medicaid: dependent children and their poor parent[s], the blind and disabled, and the poor elderly. Perhaps not surprising, no-one had any sense of whether or not Medicaid "works", although each thought it was a reasonable question to pose.

Since my negative list is larger than my positive list, this suggests there is room for reform of current law. Let me turn to some incremental ways in which the Medicaid reimbursement formula might be amended.

3.3 Incremental Ways to Change the Reimbursement Formula

3.3.1 Changing the Measure of Ability to Pay

As noted, there are several reasons to take issue with BEA per capita personal income as the global measure of state ability to pay. If income is quite unevenly distributed, in particular if there are some very high income individuals, and if transfer payments are already significant, then this average can be quite misleading. Table 3.3.1 shows the effect on the *unconstrained* federal share were BEA per capita personal income replaced by Census

median household income.[9] Like the BEA concept, Census money income includes income transfers; however, by the point one reaches the 50'th percentile in any state's income distribution (half of all households had more and half had less income), such transfers are phased out. As a result, one has a more meaningful measure of the central tendency of each state's ability to pay.

Column [2] of Table 3.3.1 shows the 1992 BEA per capita personal income; note that the US overall average was $20,105. Column [2] shows 1992 Census median family income; note that median family income in 1992 was $30,786. Columns [3] and [4] compare each income concept to the respective US figure. Thus, Alabama's per capita personal income was .822 of the US or 82.2% of the US average, while its median household income was .841 or 84.1income.

For a number of states, there are very large differences in relative position as one moves from the per capita concept to the median concept. California's per capita personal income was 6.2% beyond the US average of per capita income, but its median household income was 14.2% beyond the median for the US. Similarly, Delaware's relative position changes. The District of Columbia, on the other hand, has a very high per capita personal income, probably due to the large income maintenance transfers and some very high income households, but a somewhat lower than average median household income viz. a viz. the US median. New York also moves from being considerably above average in per capita personal income, to being only marginally above the US figure for median household income.

Columns [6] and [7] of Table 3.3.1 show the effects on the federal reimbursement rate of moving from per capita personal income to median household income using the same reimbursement formula (e.g. Equation 1).

Note that I have not imposed the 80% maximum and 50% deminimus of current law in the various calculations in this table. A number of states are materially assisted by this current law minimum and the use of BEA per capita personal income. Were there no minimum, Connecticut would face a federal reimbursement rate of 17.9% rather than 50%.

Finally, I would be remiss if I did not point out to the Committee that under the median household income approach, Michigan's federal matching rate would fall from 57.3% to 50.3%.

[9]The data on median household income are from the Current Population Survey, Series P-60, "Money Income of Households, Families, and Persons in the U.S.", 1992.

Table 3: Effects of Using Median Household Income in Current AFDC/Medicaid Reimbursement Formula

	1992 BEA PCY	1992 Median Household Income	BEA: PCY STATE/US	Median INCOME STATE/US	Fed Share BEA PCY	Fed Share Median Y
US	$20,105	$30,786	1.000	1.000		
	[2]	[3]	[4]	[5]	[6]	[7]
Alabama	$16,522	$25,891	0.822	0.841	69.6%	66.2%
Alaska	$22,067	$41,989	1.098	1.363	45.8%	16.4%
Arizona	$17,401	$29,593	0.866	0.961	66.3%	58.4%
Arkansas	$15,635	$23,893	0.778	0.776	72.8%	72.9%
California	$21,348	$35,173	1.062	1.142	49.3%	41.3%
Colorado	$20,666	$32,716	1.028	1.063	52.5%	49.2%
Connecticut	$27,150	$41,059	1.350	1.334	17.9%	20.0%
Delaware	$20,724	$35,739	1.031	1.161	52.2%	39.4%
DC	$27,909	$30,357	1.388	0.986	13.3%	56.2%
Florida	$19,711	$27,456	0.980	0.892	56.7%	64.2%
Georgia	$18,549	$28,889	0.923	0.938	61.7%	60.4%
Hawaii	$22,200	$42,171	1.104	1.370	45.1%	15.6%
Idaho	$16,649	$27,784	0.828	0.902	69.1%	63.3%
Illinois	$21,774	$31,707	1.083	1.030	47.2%	52.3%
Indiana	$18,366	$28,663	0.914	0.931	62.4%	61.0%
Iowa	$18,275	$28,880	0.909	0.938	62.8%	60.4%
Kansas	$19,387	$30,447	0.964	0.989	58.2%	56.0%
Kentucky	$16,528	$23,567	0.822	0.766	69.6%	73.6%
Louisiana	$15,931	$25,479	0.792	0.828	71.7%	69.2%
Maine	$18,163	$29,705	0.903	0.965	63.3%	58.1%
Maryland	$23,268	$37,287	1.157	1.211	39.7%	34.0%
Massachusetts	$23,676	$36,568	1.178	1.188	37.6%	36.5%
Michigan	$19,586	$32,347	0.974	1.051	57.3%	50.3%
Minnesota	$20,503	$31,077	1.020	1.009	53.2%	54.1%
Mississippi	$14,082	$20,585	0.700	0.669	77.9%	79.9%
Missouri	$18,970	$27,490	0.944	0.893	59.9%	64.1%
Montana	$16,227	$26,602	0.807	0.864	70.7%	66.4%
Nebraska	$18,974	$30,177	0.944	0.980	59.9%	56.8%
Nevada	$21,648	$32,026	1.077	1.040	47.8%	51.3%
New Hampshire	$21,933	$39,644	1.091	1.288	46.4%	25.4%
New Jersey	$26,091	$39,227	1.298	1.274	24.2%	26.9%
New Mexico	$15,458	$26,158	0.769	0.850	73.4%	67.5%
New York	$24,095	$31,254	1.198	1.015	35.4%	53.6%
North Carolina	$17,863	$27,835	0.888	0.904	64.5%	63.2%
North Dakota	$17,048	$27,105	0.848	0.880	67.6%	65.1%
Ohio	$19,040	$31,479	0.947	1.023	59.6%	53.0%
Oklahoma	$16,420	$25,363	0.817	0.824	70.0%	69.5%
Oregon	$18,605	$32,114	0.925	1.043	61.5%	51.0%
Pennsylvania	$20,642	$29,965	1.027	0.973	52.6%	57.4%
Rhode Island	$20,276	$30,656	1.009	0.995	54.2%	55.4%
South Carolina	$16,212	$27,667	0.806	0.899	70.7%	63.7%
South Dakota	$17,198	$26,351	0.855	0.856	67.1%	67.0%
Tennessee	$17,674	$24,339	0.879	0.791	65.2%	71.9%
Texas	$18,437	$26,282	0.917	0.854	62.2%	67.2%
Utah	$15,573	$34,433	0.775	1.118	73.0%	43.7%
Vermont	$18,792	$32,829	0.935	1.066	60.7%	48.8%
Virginia	$20,883	$38,223	1.039	1.242	51.4%	30.6%
Washington	$21,289	$34,064	1.059	1.106	49.5%	44.9%
West Virginia	$15,598	$20,301	0.776	0.659	72.9%	80.4%
Wisconsin	$19,038	$33,415	0.947	1.085	59.6%	47.0%
Wyoming	$18,631	$30,379	0.927	0.987	61.4%	56.2%

3.3.2 Changing the Functional Form of the Federal Reimbursement Formula

There are a number of ways to alter the shape of the existing reimbursement function

that can reduce the federal reimbursement share. The use of squared state per capita personal income is essentially arbitrary, and leads to, as shown in Figure 3.1 above, a dispersed distribution of federal reimbursement rates. One can compress the distribution by keeping the same function, but not squaring the ratio of state to national per capita personal income. The reimbursement formula then becomes:

$$LinearizedFederalShare = 1 - .45[\frac{StatePCY}{USAveragePCY}] \quad (4)$$

Figure 2 displays the effects of this form of the reimbursement formula in comparison to current formula. Recall that for a poor state to reach the 80% ceiling under the current formula, its per capita personal income would have to be 68% of the US average or less. With this linearization of the reimbursement formula, the 80% ceiling would be reached by a state with only 44.4% of the US average. On the other hand, this would also pull up above average per capita income states. States with income 11% or greater than the US average would be at the 50% floor.

Table 3.3.2 displays the effects of using Equation 4 and both BEA per capita income and Census median household income to calculate the federal reimbursement rate. As in Table 3.3.1 above, I have listed the unconstrained reimbursement rates. Columns [2] and [4] correspond to using Equation 1, and Columns [3] and [5] correspond to using Equation 4. As expected, the linear versions of both the per capita personal income formula and median household income are generally more compact. Unfortunately, time limitations prevented calculations of their overall fiscal impact.

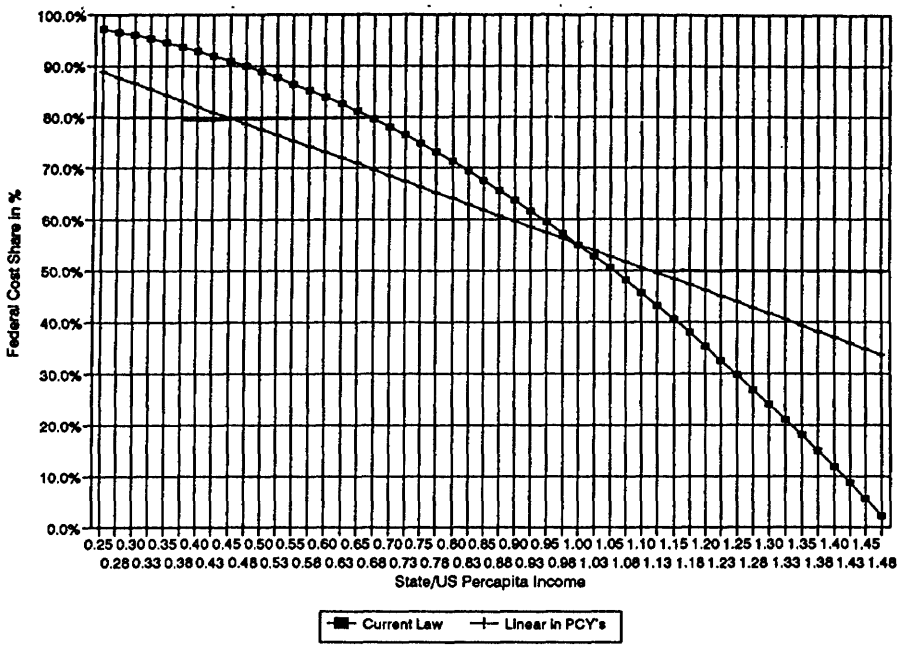
Table 4: Effects of Using Median Household Income in *Linearized* AFDC/Medicaid Reimbursement Formula

	Fed Share BEA PCY	Linear Fed Share BEA PCY	Fed Share Median Y	Linear Share Median Y
	[2]	[3]	[4]	[5]
Alabama	69.6%	63.0%	68.2%	62.2%
Alaska	45.8%	50.6%	16.4%	38.7%
Arizona	66.3%	61.1%	58.4%	56.7%
Arkansas	72.8%	65.0%	72.9%	65.1%
California	49.3%	52.2%	41.3%	48.6%
Colorado	52.5%	53.7%	49.2%	52.2%
Connecticut	17.9%	39.2%	20.0%	40.0%
Delaware	52.2%	53.6%	39.4%	47.8%
DC	13.3%	37.5%	56.2%	55.6%
Florida	56.7%	55.9%	64.2%	59.9%
Georgia	61.7%	58.5%	60.4%	57.8%
Hawaii	45.1%	50.3%	15.6%	38.4%
Idaho	69.1%	62.7%	63.3%	59.4%
Illinois	47.2%	51.3%	52.3%	53.7%
Indiana	62.4%	58.9%	61.0%	58.1%
Iowa	62.8%	59.1%	60.4%	57.8%
Kansas	58.2%	56.6%	56.0%	55.5%
Kentucky	69.6%	63.0%	73.6%	65.6%
Louisiana	71.7%	64.3%	69.2%	62.8%
Maine	63.3%	59.3%	58.1%	56.6%
Maryland	39.7%	47.9%	34.0%	45.5%
Massachusetts	37.6%	47.0%	36.5%	46.5%
Michigan	57.3%	56.2%	50.3%	52.7%
Minnesota	53.2%	54.1%	54.1%	54.6%
Mississippi	77.9%	68.5%	79.9%	69.9%
Missouri	59.9%	57.5%	64.1%	59.8%
Montana	70.7%	63.7%	66.4%	61.1%
Nebraska	59.9%	57.5%	56.8%	55.9%
Nevada	47.8%	51.5%	51.3%	53.2%
New Hampshire	46.4%	50.9%	25.4%	42.1%
New Jersey	24.2%	41.6%	26.9%	42.7%
New Mexico	73.4%	65.4%	67.5%	61.8%
New York	35.4%	46.1%	53.6%	54.3%
North Carolina	64.5%	60.0%	63.2%	59.3%
North Dakota	67.6%	61.8%	65.1%	60.4%
Ohio	59.6%	57.4%	53.0%	54.0%
Oklahoma	70.0%	63.2%	69.5%	62.9%
Oregon	61.5%	58.4%	51.0%	53.1%
Pennsylvania	52.6%	53.8%	57.4%	56.2%
Rhode Island	54.2%	54.6%	55.4%	55.2%
South Carolina	70.7%	63.7%	63.7%	59.6%
South Dakota	67.1%	61.5%	67.0%	61.5%
Tennessee	65.2%	60.4%	71.9%	64.4%
Texas	62.2%	58.7%	67.2%	61.6%
Utah	73.0%	65.1%	43.7%	49.7%
Vermont	60.7%	57.9%	48.8%	52.0%
Virginia	51.4%	53.3%	30.6%	44.1%
Washington	49.5%	52.3%	44.9%	50.2%
West Virginia	72.9%	65.1%	80.4%	70.3%
Wisconsin	59.6%	57.4%	47.0%	51.2%
Wyoming	61.4%	58.3%	56.2%	55.6%

3.3.3 Lowering the Basic Federal Matching Rate

Another way to systematically lower the federal matching rate in Equation 1 is to *increase* the .45 parameter which pre multiplies the ratio of the state to US ability to

Figure 2: Linear AFDC and Medicaid Reimbursement Formulae: Federal Shares vs. Ratio of State to US Per capita Personal Income



pay measure. Recall that when the state in question is at the national average of ability to pay, the current law formula provides a 55% reimbursement rate. Whether the federal government wishes to continue such a high reimbursement rate for this sort of state is clearly a value judgment that I have no particular scientific expertise in commenting on. However, if the Congress were to view partnership for the average state as a 50-50% relationship, rather than 55-45% relationship, then the mathematics would become:

$$FederalShare = 1 - .50[\frac{StatePCY}{USAveragePCY}]^2 \quad (5)$$

Geometrically, this has the effect of moving the curves shown in Figure 2 downward towards the origin. Presumably in redefining this fiscal partnership, one might revisit whether the 50% floor should be lowered as well.

3.3.4 Including Other Factors in the Federal Medicaid Reimbursement Formula

Several of my earlier criticisms of the current reimbursement formula centered around the fact that it does not directly contain any incentives for the states to improve their delivery and coverage of health care services to the categorically needy. One criticism involved the absence of any incentive for improved participation. The mathematics of introducing such an incentive are fairly straight-forward. Suppose that the nationally observed participation rate in Medicaid is 75%.[10] That is, suppose that 75% of all categorically eligible individuals currently participate in Medicaid. Further, suppose that the Congress wishes to reward states that have done better than the national average, and penalize states which are below the national average in terms of the federal share of Medicaid costs. In the context of the current Medicaid reimbursement formula, one would simply multiply the per capita income ratio by .75 divided by the state participation rate.

Again, an average state with an average participation rate would receive a federal matching rate of 55%. Now, however, better management would increase the federal share. Equation 6 shows how such an incentive would be incorporated into the current formula.

$$FederalShare = 1 - .45 * [StatePcy/UsPcy]^2[.75/StateParticipationRate] \quad (6)$$

If an average per capita income state were to have a participation rate of say 85%, it would receive a federal matching rate of $1-.45*1^2*(.75/.85 = 1-.45*.882 = 1-.397 = .603$ or 60.3%. It is my impression that participation rates are generally higher in higher income states, and lower in lower income states. This sort of modification of the formula might be considered in conjunction with lowering or eliminating the 50% floor.

[10] See Lopest and Gates(1993), Table D2, p. 95.

4 Federal vs. State Financial and Administrative Responsibilities and Another View of Benefit Determination

4.1 Sorting Out Federal-State Responsibilities: Financing vs. Administration

It is often suggested that the federal government should be responsible for income redistribution decisions so that we have one policy that is uniform through-out the nation. This is expressed both through our method of financing redistributive public services, the progressive individual federal income tax, and through federal expenditure policy. Poorer areas thus pay relatively less by virtue of the progressivity of the federal individual income tax into the redistributional pot, and receive relatively more from it if the incidence of poverty is greater. In this way we correct for what are viewed as the excesses or inadequacies of purely market driven forces. This is a fairly abstract description of what the tax committees of Congress do, but fundamentally that is one aspect of what transpires.[11]

In the course of making these decisions, the federal government must decide on whether such transfers are in cash, in kind, who the beneficiary unit is, and what sort of administrative and financial role[s] subfederal units of government should have in this redistributional enterprise. These are top-down institutional design questions; there are others which involve such matters as the design of the transfer institutions so that they can be evaluated, modified, and changed in an orderly, systematic way. "Management" of such redistributional activities of the federal government is far more than cost-containment, although it is typically costs (or lack of profits in the private sector) which gets an organization's elected or appointed leadership and stake holders (voters, shareholders) immediate attention.

A major peculiarity of the US system of income maintenance is the co-mingling of administrative and financial responsibilities of the state's (and localities in some instances). In a sense, we ask the states to be the fiduciaries of the federal government for certain classes of beneficiaries, or act on behalf of the federal government. However, I think it is easy to ask out loud whether we should expect a fiduciary to perform the intended job when their own, scarce tax dollars are at risk, especially if some do not accept the initial definition of the redistributional project. Progressivity on the financing side of the ledger means a poor state's residents will put in less per dollar received; inverse matching on the spending side means they have to spend less to get reimbursed. With such lower stakes, should we expect the same level of fiduciary application than in other areas facing different marginal incentives?

Sometimes it is argued that unless the states put up their own money in the income maintenance area, they will not pay attention to the program. I think this line of reasoning confuses several matters. First, federal taxes come from the citizens of each state, and such involuntary contributions surely curtail the ability of state government to impose their own state and local taxes for other purposes. Thus, even if an income maintenance program is entirely federally financed, e.g. SSI or Food stamps, it has distinct state by state fiscal/financial implications which we notice on April 15.

Second, if we merely presume that for a state to do a good job as a fiduciary, it must be paying a higher share of the income maintenance costs out of its own state levied tax dollars, we implicitly export responsibility for program management effectiveness from the federal government to each state capitol. The construct of state AFDC plans and

[11] Another, of course, is to see that sufficient funds are available to pay for federal public services.

their ambiguity might be viewed as yet another mechanism designed to insure blurred management if not administrative confusion. I think that co-mingling administrative and financing responsibility insures that there will be a muddle, and that redistributional goals will not be met.

"Federalization" of welfare or health-care sometimes is used to describe a circumstance in which the federal government takes over both financial and administrative control of a program. However, these two aspects of program design can be divided. If aid to the blind and disabled, and the poor elderly (e.g. long-term care) were completely federally financed, it remains entirely sensible for the federal government to contract with the states to do the job and have it done inexpensively and humanely.

Moreover, Federalization of the financing role of an income maintenance program does not mean the states are "off" the fiscal hook. Rather it means we agree to use the federal income tax system, imperfect that it may be, rather than the admixture of income, consumption, transaction, and property taxes which the states use when they finance their "share." If federal taxes were to go up to that end, I am hard pressed to believe that state residents would not insist that state and local taxes be correspondingly reduced. Many state-local restructuring bargains in fact require such tax roll-backs.[12]

The appropriate question to ask about federalization, in the financing sense, is which system of taxation makes more sense in financing these services, since the dollars will come forth under any model of financing, rather than whether it is a "federal" or "state" responsibility. Just as one can reach some fairly dour appraisals of our federal income tax system, one can wonder about the character of many of our state and local tax systems.

It is interesting to note that as World War II came to a close, there was active debate and a national commission formed to examine fiscal federalism issues that would confront the US once peace broke out. While we may be in the midst of a debate in Congress about how our federal system should evolve after the collapse of the Soviet empire, I worry that it has not been organized to take a sufficiently long view of the matter.[13] Rather, it is being driven by federal budgetary exigencies.

Indeed, the Advisory Commission on Intergovernmental Relations has been in very dire straits the past few years, rather than the focal point of a national discussion of where our federal system should go in light of the new realities of a more secure international environment, greater international economic interdependence, and rapid technological change. Bilateral negotiations with particular governors or groups of governors or state legislators are the daily part of any federal legislative process, but do not constitute a principled national debate or the formation of a national consensus of how our federal system should next evolve.

4.2 Is Poverty (and Health Status) Absolute or Relative?

A natural reaction to the above discussion of the muddle we have had for so long about income maintenance program design, administration, and financing responsibilities is that achieving national agreement on benefit levels has simply not been possible except in some

[12]Moreover, there are undoubtedly federal incentive schemes that could be constructed to make sure this would happen.

[13]See Strauss(1990) for some conjectures on how state tax policy might evolve as a result of world competitive pressures.

fairly limited areas (SSI, Food stamps, and the Earned Income Tax Credit). If one views poverty or health status as a relative, rather than absolute "problem" worthy of federal action, however, I think the problems of obtaining national agreement are reduced, and a more orderly division of financing and administrative responsibility between the federal government and states can be achieved.

Some years ago when working on Chairman Ullman's welfare reform bill, I took a macroscopic look at the sort of federalism bargain which was struck in the 1930's with AFDC, and came away fairly puzzled at the built-in contradictions that were enacted. They guaranteed non-stop conflict between the states and the federal government.

The guaranteed conflict arose from the initial design premise that each state through its state plan should be free to determine the basic level of need, and the federal government should decide on the benefit reduction rate, and the reimbursement rate to the states for state welfare spending. Moreover, while each state was to determine its definition of basic need, it was not required to fully fund it.[14]

At the outset, two cooks were put in charge of the menu, and it is not surprising that, ever since, they have argued over its contents and who should pay for the ingredients. The states through their program design (guarantee amounts, work expenses etc. were for many years simply parts of each state's plan) were always able to put the federal government at financial risk. Given the immutability of the reimbursement formula discussed above, this is even more evident today than some years ago.

What struck me as more peculiar was the fact that Congress was able to agree on a uniform financing and benefit package for the elderly in Social Security (and much later SSI and the Earned Income Tax Credit), but could not come to the same determination for poor widows with children and subsequently children of poor parent[s].

The explanation of this in part had to do with the difficulty Congress had at arriving at one guarantee or standard of need that would be acceptable in various parts of the country. High need standards, even if funded through the historical reimbursement formula discussed above, were not acceptable in poorer parts of the country. Various motives were ascribed to such resistance; however no-one disputed the fact that a high need standard in a poor part of the country would have a far more serious work-disincentive effect than in a high income part of the country. Implicit (and sometimes brutally explicit) in the debate over the years was the supposition that cash recipients should work once their children were of school age, and that federal transfers should not create work disincentives, especially differential ones among the states. Also, I think there was agreement that the elderly poor would not be expected to work, and thus a national minimum Social Security benefit, or later national SSI guarantee was acceptable.

This realization led to the staff development of a welfare reform proposal for Chairman Ullman in which the cash assistance guarantee by state was in the same *relative* position of the income distribution rather than being fixed at some arbitrary national dollar amount.[15] In particular, the guarantee in each state was 30% of the median family income for a family of four as reported by the Census Bureau. It is also worth noting that the cash benefit level did not vary with family size; this was something Chairman Ullman was very insistent on

[14]See, for example, Table 11 of the 1993 *Green Book* which displays by state the maximum AFDC grant in comparison to 100% of "need."

[15]See Strauss(1979) for a comparison of HR10711, Chairman Ullman's welfare reform bill, to President Carter's welfare reform bill, and a numerical analysis of the how each program reduced the variation in benefits available in *contiguous states*.

in 1977 and 1978, and a view I have come increasingly to respect.

Another feature of Chairman Ullman's welfare reform proposal was its systematic deceleration, over time, of state guarantees, for states who had generously provided cash assistance beyond 30% of the median family income, to the *relative* federal target guarantee. The attractiveness of this approach led to the defeat of the Carter welfare reform proposal before the Ad Hoc Welfare Reform Committee of the House. A little known fact is that the votes were also there for the Chairman's proposal, both in the Ad Hoc Committee as well as the full Ways and Means Committee. However, Chairman Ullman was reluctant to spend the extra $5 billion over current law at that time, and decided to simply derail welfare reform for the time being.

Having worked through this line of argument for defining cash benefit guarantees by state based on each state's definition of income some years ago, and noted the work expectations about the categorically needy, let me apply this logic to the a redesign of health services for the needy.

As before, I presume that, even though one can never be healthy enough, there are economic limits to what we can spend on medical assistance for the poor, blind, and disabled. Can we agree on a federal definition of health services (health status would be even more desirable) to be federally funded that is based on relative health standards per state? I think the answer is quite positively yes if we parse the problem as done above for cash transfers.

There are a number of ways this can be achieved. [16]

4.2.1 Medical Assistance Triggered by Relative Poverty Status

The simplest application of the above reasoning would simply be to tie current medical assistance to eligibility in the reformed welfare program.[17]

Were food stamps folded into cash assistance, and cash assistance based, by state, on a percentage of median family income, the only outstanding design issue would be choosing a benefit reduction rate.[18]

Under this definition of Medicaid reform, one would link access by children and poor parents to health care services based on the receipt of cash assistance.

It would not, however, deal with how to treat the blind and disabled, and the elderly poor who are in long-term care.

4.2.2 Defining Federally Reimbursable Health Services in terms of Relative Health Position

[16] Unfortunately the limitations of time precluded more than a sketch of how to do this. Also, it is likely that requisite data on health outcomes or expenditures by age, gender, income (and possibly marital status) and state are not readily available. It would strike me as a very worthwhile investment in federal statistical dollars to ascertain this.

[17] One would need to decide on work expenses, child care deductions, and a benefit reduction rate. An advantage of a guarantee based on a percentage of median family income is that one does not have to impose arbitrary caps, e.g. 185% of poverty, which have some fairly disastrous work incentive effects at the "cliff."

[18] By picking a guarantee which is a fraction of pre-tax, pre-transfer median family income, and picking a benefit reduction rate, one will always end assistance at the same relative point in the pre-tax, pre-transfer income distribution, state by state.

This approach is more ambitious, for it would restructure Medicaid itself on a state by state, relative basis, rather than simply taking as given the current constellation of mandatory and optional services which the federal government funds for the various demographic groups. Again, it does not rely on the notion of a state plan or list of necessary and optional services, but rather on some proportion of what the general health status or care is for representative individuals.

To devise a system of federally supported services based on *relative*, state by state health services, or health status of the population, we need a simple model or theory of health status or the demand for health care. I think it is fairly clear that three or four variables: age, gender and income (marital status is the possible fourth dimension) by state provide the essential dimensionality of differential health status[19] and certainly the essential dimensionality of differential health care expenditures.

The measurement problem then is to identify by age, gender, and income by state, what the preponderant or median health status or level of health services are available, and then to determine what the federal service level should be in each of these cells for the poor. The word "should" is used advisedly, because it presumes that the determination will be resource limited, and presumably informed by efficacy and long-term benefits in relation to costs. However, I think this line of reasoning rules out, at the outset, the sort of gold-plating of health care for the poor which is not available to much of the more general population in a state. For example, it is imaginable that orthodontal care is not pursued by families for children in median income families in our poorest states, but is pursued by families for children in median income families in our richest states.[20] The line of reasoning being proposed suggests that there would be some federal support of orthodontal care in a high income state, for the poor, but not in the poor state. Regional tastes for health care, affected no doubt by income, supply, prices, and insurance options, would thus be respected.[21]

Another variant of this relative approach would be to calculate what the cash value of what such services might be based on the three or four dimensions outlined above, and ascertain what kind of health insurance that might buy state by state in the market place.

5 Summary and Conclusions

While it is true that one can never be healthy enough, there is a limit as to what our society can or is willing to spend to provide health care to the poor, blind and disabled. Given the vast sums currently expended for Medicaid, it seems a first order of importance to identify the extent to which the health status of the poor has been enhanced by the program. I do not dispute that we are getting something for our federal tax dollars in this area; however, the rapid escalation in prices throughout the health care industry makes

[19]See Phelps(1992), Chapters 4 and 5, for example.

[20]The empirically found high income elasticity of demand for health care suggest this is quite likely.

[21]Thus, where many analysts express concern about the fact that poorer states have much lower Medicaid spending/recipient and wish to standardize such spending to some national figure, I see just another replay of the cash transfer debate discussed above. As living standards for the majority rise, and their preference for health care rises, so too, then would the definition of what services should be covered. Just as providing high cash benefits to the poor in a poor state is likely to generate community ill will by those working poor, so will providing very generous health care services in a poor state where the working poor have worse health care coverage.

me wonder if continued excess demand in the system, due to the lack of prices available to discipline individual users, has led to simply more money being spent rather than healthier individuals.

In my testimony I have outlined three different ways to think about the Medicaid reimbursement formula, and accordingly addressed different definitions of the problem at hand:

- different deceleration schemes were discussed that address short-term budgetary issues before the Congress; for the short run I see particular merit in simply fixing annual Medicaid appropriation figures, and adjust the reimbursement rates downward by the ratio of available funds divided by state requests for reimbursements. This will have the effect of allowing proportionate decelerations, and provide, I think, a basis for agreement between the Senate and House.

- For the medium term, there is merit in considering incremental modifications to the existing Medicaid reimbursement formula which respond to some fundamental design problems, and also reduce the states' incentive to increase Medicaid spending. I suggest that median household income per state is a more appropriate measure of the ability to pay in each state since it will not count transfers as does BEA per capita personal income.

  Also, I indicate how one might include participation rates in Medicaid into the existing formula, and how that might provide a rationale for eliminating the current 50% floor.

- Third, I sketch out a more ambitious agenda of Medicaid refomr that involves a reconceptualization of the federal responsibility in providing health services to the poor, blind and disabled. These considerations entail separating financing from administration questions, and moving towards federal health benefit definitions which are inherently *relative* rather than absolute. It disavows the notion of one poverty standard, and instead argues that poverty and health status are inherently *relative* in nature. In turn, this suggests that the federal redistributive role is to identify the appropriate proportion of what (roughly) median health consumers obtain in each state, after taking into account age, gender, and income rather than trying to move to a single definition of covered services or health status which each state would have to leap to. With such a federal definition of benefits and financing, the states can remain as the administrator of such programs of assistance.

Finally, I do not find attractive the idea of transforming Medicaid into a giant, formula block grant for health services to the poor. My experience with fungibility questions in General Revenue Sharing and the capacity of federal agencies to say "no" is that the monies would quickly get used for other purposes at the state and local level, and the Congress would get blamed for the leakage. There simply are too many people getting health services, and too much money at risk in the short run to make such a transformation.

Moreover, given the realities of the federal budget, you simply do not have the budgetary leeway to find "hold-harmless" funds as you move from reimbursable expenses to monies paid based on a formula. Given the fiscal realities of the federal budget, and the necessities of bi-cameral agreement, I doubt it would be possible in a month or two to agree on such a massive revenue sharing scheme.

The issues surrounding Medicaid are simply one of many domestic policy issues that confront the Nation. It is my hope that as the fiscal exigencies of the moment are addressed, it will then be possible to have a systematic debate about where our federal system should go in terms of federal and state service, financial and administrative responsiblities, given the new realities of greater international security, international economic competition, and technological change.

6 References

Committee on Ways and Means, U.S. House of Representatives, 103d Congress, 1st Session, (1993). Overview of Entitlement Programs. **1993 Green Book.**(USGPO, July 7, 1993, (WMCP 103-18).

General Accounting Office (1993). *Medicaid: Improving Funds Distribution.* GAO/HRD-93-112FS).

General Accounting Office (1995). *Medicaid: Restructuring Approaches Leave Many Questions.* (GAO/HEHS-95-103).

General Accounting Office (1995). *Medicaid: Experience with State Waivers to Promote Cost Control and Access to Care.* (GAO/HEHS-95-115).

General Accounting Office (1995), *Medicaid: Spending Pressures Drive States toward Program Reinvention.* (GAO/HEHS=95-122).

Grannemann, T. W. (1980), "Reforming National Health Insurance for the Poor," in M.V. Pauly (editor), *National Health Insurance: What Now, What Later, What Never?.* (Washington, D.C.: AEI).

Loprest, Pamela and Michael Gates (1993). *State-Level Data Book on Health Care Access and Financing.* (The Urban Institute Press).

Phelps, Charles E. (1992), *Health Economics* (New York: Harper Collins).

Strauss, Robert P.,(1979) "Incremental Versus Comprehensive Welfare Reform," in Haskins and Gallagher (editors), *Models for Analysis of Social Policy: An Introduction.* (Norwood, New Jersey: ABLEX Publishing Corporation, 174-201).

Strauss, Robert P. (1990)"Fiscal Federalism and the Changing Global Economy", *National Tax Journal*, 43, 3 September, 1990, 315-320.

Urban Institute, *Medicaid Disproportionate Share and Other Special Financing Programs: A Fiscal Dilemma for States and the Federal Government*, (Wasnington, D.C.: Urban Institute, December, 1994).

COMMUNICATIONS

NACDS

National Association of Chain Drug Stores

Mr. Chairman and members of the Senate Finance Committee. The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit a statement regarding its views on Medicaid reform. This Committee will soon consider major changes in the Medicaid program, which serves over 36 million low-income senior citizens, children, and people with disabilities. We appreciate the Committee's consideration of the issues outlined below.

Prescription Drug Coverage Under Medicaid

Although an optional benefit, all state Medicaid programs cover outpatient prescription drugs. Medicaid spent $8 billion on prescription drugs in 1993, about 8 percent of total Medicaid spending. The program paid for approximately 350 million outpatient prescriptions for 24 million Medicaid recipients in the United States that year.

Medicaid prescription drug spending has been one of the fastest growing components of the Medicaid program, increasing from $1.8 billion in 1983 to $8 billion in 1993, a 344 percent increase. This sharp increase was not due to significant increases in prescription drug utilization per Medicaid beneficiary. According to a study completed by the PRIME Institute at the University of Minnesota in December 1994, the primary factors driving increases in Medicaid prescription drug program spending between 1983 and 1993 were an 88 percent increase in drug manufacturers' prices for prescription drugs, and a 74 percent increase in the number of Medicaid beneficiaries receiving prescription drugs (see attached chart).

The PRIME Institute study concludes that pharmacy reimbursement was not a major factor in escalating Medicaid drug program expenditures. Medicaid reimbursement to pharmacists decreased in constant dollars by 6.1 percent during this period.

NACDS Support Retention of the OBRA 90 Drug Manufacturer Rebate Program

> ***NACDS supports retention of the OBRA 90 drug manufacturer rebate program under a block grant to give states another option to manage their prescription drug expenditures.***

Before 1990, Medicaid paid the highest prices in the market for prescription drugs. To help state better manage prescription drug program expenditures, Congress enacted a drug manufacturer rebate program as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. The program requires drug manufacturers to provide rebates to state Medicaid programs as a condition for coverage of their products under Medicaid. The purpose of the program is to assure that Medicaid - the largest single payer for prescription drugs in the United States -- pays prices similar to other large purchasers of prescription drugs.

Over the past three years, the drug rebate program has proven effective in states' efforts to manage overall Medicaid drug expenditures. States have grown to rely on the rebate program to help balance their growing Medicaid budgets. Since 1991, the rebate program has generated $4.2 billion for the states and the Federal government. Medicaid costs have increased for most services, but average annual per capita drug expenditures decreased $59 or 18 percent in 1993, from $333.50, to $274.37 after drug manufacture rebates were subtracted (see attached chart).

The CBO estimates that the rebate program will generate at least $1.8 billion annually over the next several years. Facing reductions in their Medicaid budgets, states will be looking for effective ways to simultaneously deliver quality care and reduce costs. The drug rebate program provides the states with such a tool. If Congress enacts a Medicaid block grant program, it is possible that most of the current Medicaid statutes will be repealed. However, we believe that Congress should retain the rebate program in Federal law because it will:

- give states flexibility to "carve out" their pharmacy benefit from managed care programs, if they choose to do so; and,

- help states manage pharmaceutical expenditures for Medicaid recipients outside of managed care, such as recipients in nursing homes and rural areas.

NACDS Supports a "Carve Out" of the Medicaid Prescription Drug Program

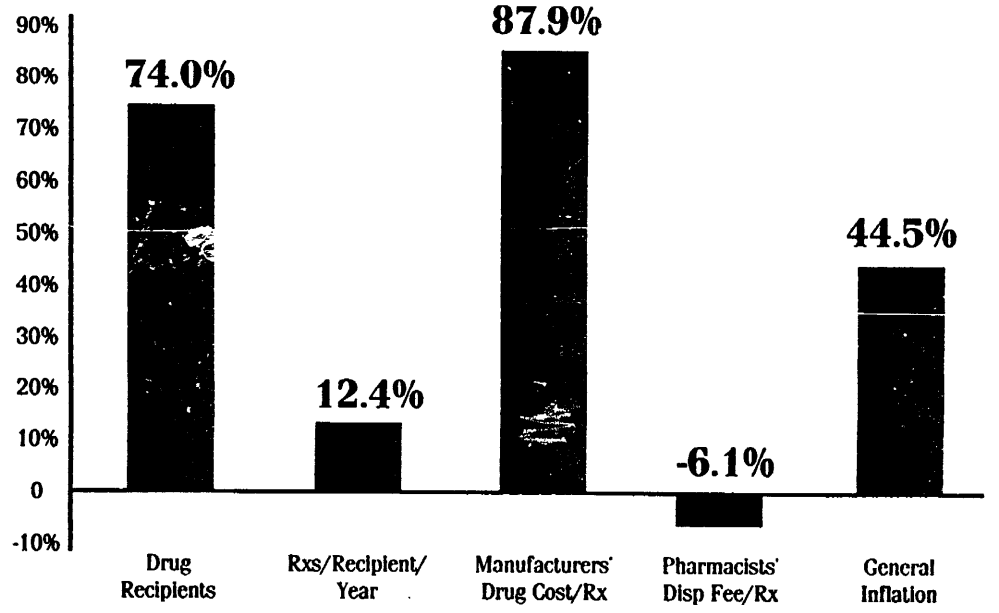
NACDS supports a "carve out" of prescription drug benefits from Medicaid managed care plans to maximize rebate savings to the state, enhance overall Medicaid recipient access to prescription drugs and pharmacy services, increase quality of care, and help support the community pharmacy infrastructure in the United States.

NACDS believes that the best approach to delivering prescription drugs and pharmacy services to Medicaid recipients is by carving out pharmacy from Medicaid managed care plans, and retaining the current fee for service program. This "carve out" allows a state to continue to collect millions of dollars each year in drug manufacturer rebates required under OBRA 90, maximizes access to pharmacy services for Medicaid recipients, and helps to maintain the vital community pharmacy infrastructure for all citizens. Several states have already made the decision to "carve out" pharmacy from Medicaid managed care programs, including Texas, Nebraska, Delaware, and Maine. Other states, such as New York and West Virginia, are considering such a pharmacy carve out.

Managed care organizations often form restrictive pharmacy networks, limiting Medicaid recipients' access to pharmacy providers. Medicaid recipients, particularly the elderly and people with disabilities, do not have the means to travel long distances to fill their prescriptions, and therefore may not have them filled as quickly as possible, or at all. When Medicaid recipients delay taking prescriptions, additional Medicaid expenditures can ensue as their medical condition worsens.

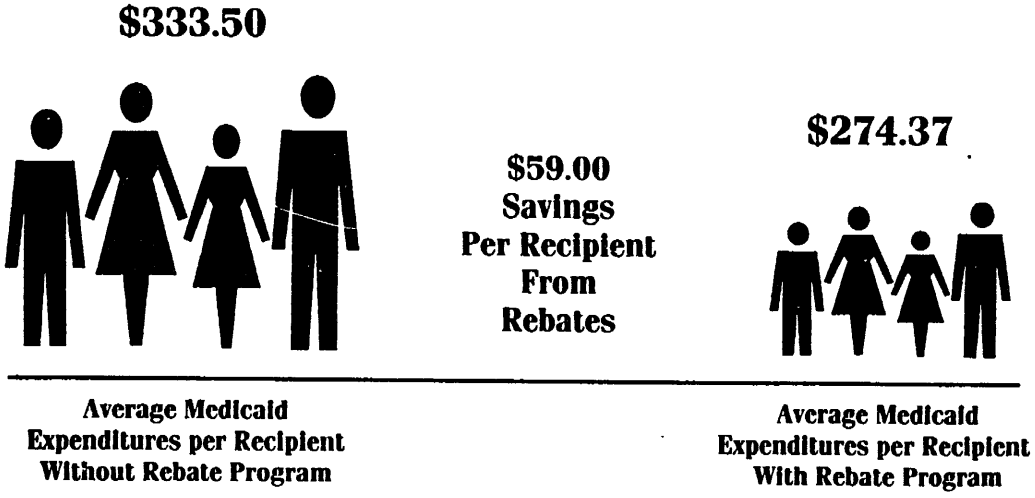
In addition, many pharmacies cannot afford to lose their Medicaid prescription business -- about 12 percent of total annual sales -- which often results from being locked out of participating in restrictive pharmacy networks. Community retail pharmacies operate on small margins and many could go out of business if they lose Medicaid prescription revenue. Loss of community pharmacies will create access problems for both Medicaid and non-Medicaid recipients.

Medicaid Drug Expenditure Components: Percent Change from 1983 to 1993 in Inflation-Adjusted Dollars



Source: PRIME Institute, Univ. of Minnesota, December 1994.

With Drug Manufacturer Rebate Program, Average 1993 Medicaid Expenditures per Recipient Were $59 Less or 18% Lower



Source: Institute for Health Services Research, University of Minnesota, Report to HCF[illegible] April 1995