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Report to the Chairman, Committee on the Budget, House of Representatives

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MEDICAID

Restructuring Approaches Leave Many Questions

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Health, Education, and
Human Services Division

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April 4, 1995

The Honorable John R. Kasich
Chairman, Committee on the Budget
House of Representatives

Dear Mr. Chairman:

Medicaid is a federal-state health entitlement program for the poor, disabled, and medically needy. The program accounts for a significant portion of the federal budget, and Medicaid expenditures continue to increase each year. The federal government spent about $75 billion for Medicaid in fiscal year 1993, and the Congressional Budget Office (CBO) estimates that this figure will climb to almost $150 billion by fiscal year 2000. In addition to rising costs, concerns have been raised about the many federal requirements, insufficient administrative control by the states, and variation in states' eligibility requirements and benefits for the poor.

Over the years, various remedies have been discussed and proposed to restructure the Medicaid program. One approach calls for providing federal funding through block grants to the states and giving them increased responsibility for administering the program. Another would turn Medicaid into a program that is entirely funded and administered by the federal government. Other proposals suggest splitting Medicaid into two programs, one encompassing acute and primary care and the other long-term care. These proposals vary in assigning responsibilities to the federal and state governments for funding and administering each of the two programs.

This report responds to your request that we provide information on previously discussed proposals for restructuring Medicaid. You asked us to compare the different restructuring approaches and discuss their implications for federal-state financing and administration of the program. You also asked us to provide information on the need to establish a federal "rainy day" fund if restrictions, such as block grants, were placed on federal revenues paid to states. Such a fund would mitigate the effects of potential reductions in state tax revenues and increased eligibility during recessionary periods. Finally, you requested that we provide the most recent data available on the amount of federal Medicaid funds provided to each state (see app. I).

Results in Brief

Different advantages and disadvantages for each of the three basic approaches to restructuring Medicaid have been cited by observers and proponents of the approaches.

- Using block grants to assist the states in funding their own programs would allow for greater control over federal expenditures, could increase states' administrative flexibility, and could result in greater operational efficiency and effectiveness. On the other hand, unless state contributions were required, some have predicted that substantial reductions in current state Medicaid spending would almost certainly occur. Also, since states would be responsible for 100 percent of additional costs, this approach would put them at greater risk for controlling program spending.
- Federalizing the Medicaid program (that is, 100 percent federal financing and administration, with no state involvement) would likely reduce inequities that result because of variation among the states in eligibility requirements and benefits. Such an approach, however, would greatly increase federal Medicaid costs in order to replace previous state contributions just to maintain the current level of benefits across the states. Also, designing and administering a national program that appropriately reflects the differences in local needs, preferences, medical prices, and health care delivery systems would be a very large and complex undertaking.
- The impact on the federal and state governments of splitting Medicaid into two programs would depend on how the split is designed and which responsibilities the governments assume. A split could combine elements of both the federalization and the block grant approaches.

We found that all the discussions we identified to restructure Medicaid have focused on the altered financing arrangements and lacked other information on how elements of program design (for example, eligibility criteria, services covered, and provider payments) would be structured. Further, little quantitative analysis has been done to determine any of the potential effects of restructuring.

Our statistical analysis demonstrates the important influence of the business cycle on Medicaid spending. A rainy day fund could be one way to assist states during economic downturns if strong limits are placed on federal contributions. We found that in at least 22 states, including 8 of the 10 largest states, Medicaid spending is sensitive to state economic conditions. On average, Medicaid spending rises by 6 percent for every 1 percentage point increase in the unemployment rate.

Background

Medicaid is a jointly funded federal-state entitlement program. It was established in 1965 to provide medical assistance to qualifying low-income people. Under broad federal guidelines, each state designs and administers its own Medicaid program that the Department of Health and Human Services' Health Care Financing Administration (HCFA) must approve for compliance with federal laws and regulations. The federal government matches state expenditures for services without a limit on federal outlays. The federal matching rate for each state is determined by the state's average per capita income and ranges from 50 to 83 percent. The federal government also oversees state administration of the program.

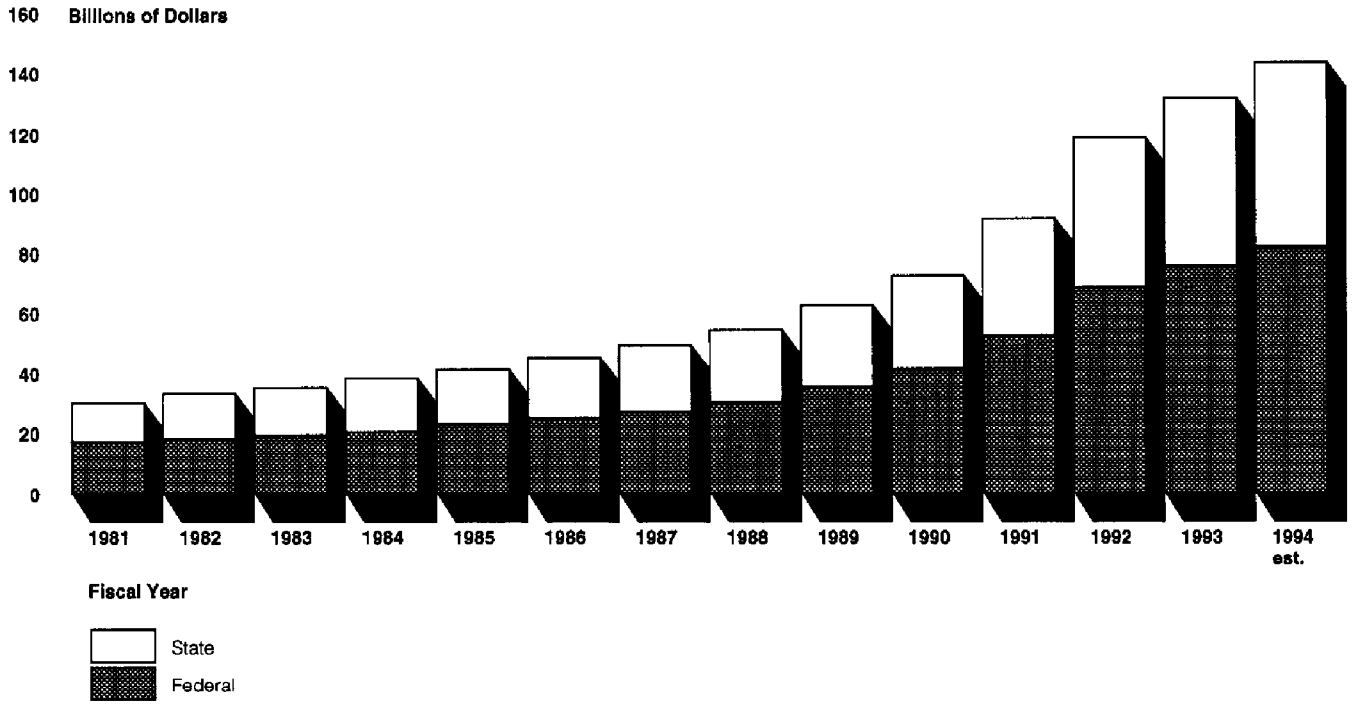
States are required to give Medicaid coverage to certain groups of people, including those eligible for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. However, they have considerable latitude in setting eligibility standards for the AFDC population and certain other groups. States can also choose to include optional groups, such as the medically needy and people requiring institutional care who do not meet the income requirement. States must also cover certain basic services, such as inpatient and outpatient hospital care, physician services, laboratory and X-ray services, and preventive health services for children. They can choose to include additional services, such as prescription drugs and dental, vision, and transportation services. Therefore, states vary considerably in the eligibility groups and services they cover, which results in significant spending variations among states, per beneficiary and overall.

The Congress has expanded the scope of the program over the years. While coverage of persons in the AFDC and SSI cash assistance programs still makes up the majority of the program, Medicaid now covers non-AFDC low-income children and pregnant women and low-income Medicare beneficiaries. These federally legislated program expansions, along with mandated increases in required services, have contributed to the escalation of Medicaid program costs in recent years.

After growing 10 percent or less per year through most of the 1980s, at the end of the decade and in the early 1990s Medicaid became one of the fastest growing items in the federal budget and in most state budgets. Federal spending for the Medicaid program in fiscal year 1994 was about $81 billion, and state spending was about $61 billion. During fiscal year 1993, approximately 18 percent of the total state spending was for Medicaid, with 11 percent from state-only sources. Figure 1 illustrates total federal and state Medicaid spending since 1981, and shows that it has

more than tripled since 1985. The growth in spending has moderated recently, although CBO still projects federal expenditures will be about $100 billion in fiscal year 1996 and climb to almost $150 billion in fiscal year 2000.

Figure 1: Medicaid Spending, 1981-94



To obtain information on Medicaid restructuring approaches and their implications for federal-state financing and administration, we contacted representatives of various organizations and conducted a computerized literature search. To assess the need for a rainy day fund, we performed a state-by-state statistical analysis of the relationship between unemployment and Medicaid spending. To provide information on federal Medicaid payments to the states, we collected the most recent data available from HCFA. Our scope and methodology are discussed in greater detail in appendix II.

Restructuring Medicaid

Since the early 1980s, several very different ideas and proposals have been discussed and set forth to fundamentally alter the financing and administrative structure of the Medicaid program. In 1981, the administration proposed a 5-percent cap on annual increases in federal Medicaid spending along with a significant reduction of federal Medicaid requirements. The administration later proposed that the federal government have sole responsibility for funding and administering Medicaid in exchange for the states completely taking over the AFDC and Food Stamp programs. In 1984, the National Study Group on State Medicaid Strategies proposed splitting Medicaid into two separate programs: acute and primary care, with the federal government responsible for funding and administration; and long-term care, with the states responsible for administration and with funding shared by the federal government and the states. A recent proposal has suggested essentially reversing the division of responsibility, with the federal government taking on long-term care and state governments taking on acute and primary care.

Also recently, legislation has been proposed that would federalize Medicaid while giving the states complete responsibility for the AFDC, Food Stamp, and Job Opportunities Basic Skills training programs (JOBS); and the Special Supplemental Food Program for Women, Infants, and Children (WIC). In February 1995, the Cato Institute proposed that the federal government use block grants to provide Medicaid funds to the states.[1] A block grant approach, as experts have discussed, could require state contributions and could increase state responsibility and authority for administering the program.

These differing proposals make up three basic approaches to restructuring the Medicaid program: (1) changing it to a block grant program or otherwise capping federal expenditures, (2) federalizing the program, or (3) splitting Medicaid into two separate programs. These three approaches are discussed below. Appendix III summarizes the key elements of each approach.

Federal Block Grants and Caps on Federal Matching Contributions

To limit federal expenditures, proposals have been made to replace the existing open-end federal matching of state spending with either a block grant or a cap on federal spending. A block grant arrangement would involve lump-sum federal payments to pay for Medicaid services. A federal cap on expenditures would place a limit on the amount of state spending

[1] Cato Handbook for Congress (Washington, D.C.: Cato Institute, Feb. 1995).

the federal government would be willing to match. Under either approach, states would administer their own program with the federal money. With a block grant, or if their spending exceeded the cap, states would pay 100 percent for any additional spending. The presumed advantage to the states is increased flexibility on how to spend the federal funds.

An analysis of Medicaid financing options published in 1983 made several observations on the use of block grants.[2] First, it suggested that federal Medicaid block grants be made conditional on specified state contributions to the program. The analysis indicated that unless states are required to contribute to the Medicaid program, federal funding would have to be much greater to maintain average spending levels. This is because without federal matching of state spending, states would have a reduced incentive to contribute to the program and could be expected to reduce their spending substantially. The analysis further said that state Medicaid spending is responsive to the federal matching rate. Poorer states with high federal matching rates would face very high increases in the price of incremental services and thus would be the least likely to supplement a federal grant.

Second, the analysis suggested that need-based factors be considered in establishing the federal grant levels and the state contributions, such as the number of poor people, local medical care prices, and the cost of living, to ensure a uniform average benefit per person below a specified fraction of the poverty level. Also, the amount of any required or expected state contributions could be set to equalize the burden on taxpayers among states. Taking these considerations into account would mitigate inequities resulting from block grant formulas based on historical funding. Such an approach is used today for block grants that combine former categorical programs.[3]

It has been suggested recently that consideration should be given to applying a cap on a per capita basis rather than on an aggregate basis. These caps would constrain spending in different ways. A per capita cap would allow for increases in spending due to increased caseload, but would otherwise restrict spending. An aggregate cap would set an absolute limit on federal spending in each state.

[2]Thomas W. Grannemann and Mark V. Pauly, Controlling Medicaid Costs: Federalism, Competition, and Choice (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1983).

[3]Block Grants: Characteristics, Experience, and Lessons Learned (GAO/HEHS-95-74, Feb. 9, 1995).

Discussions of block grants or caps on federal spending seem to take for granted that states would receive the necessary flexibility to redesign their programs to meet spending targets. Our previous work on caps on federal expenditures indicates that while caps would achieve savings, they would have little effect on longer-term growth trends unless the Congress adjusted or gave states the flexibility to adjust eligibility and benefit formulas.[4] However, how much flexibility states would have under a Medicaid block grant or cap has not been addressed by the proposals. Prior discussions provide no details regarding what federal requirements would be maintained or rescinded.

Block grants created in the early 1980s gave states broad discretion in deciding what specific services and programs to provide, as long as they directly related to the goals of the program. However, over time the Congress placed additional constraints on states; for example, requiring that a minimum portion of funds be used for a specific purpose, which in effect recategorized them. Many of these restrictions were imposed because of congressional concerns that states' decisions were not consistent with national objectives.

Block grants and spending caps put states at full risk for the management of the program. Staying within specified funding levels would require states to accurately forecast spending due to program options. In our previous work, the majority of federal agency officials from mandatory programs reported that accurately projecting mandatory program spending was difficult.[5] While some see putting states at risk for the program spending increases as a problem, others see it as promoting efficiency.

Federalizing Medicaid

Another approach to restructuring Medicaid is to fully federalize the program. This approach calls for uniform national benefits and eligibility criteria in place of the wide variation that currently exists across the states. Under a federalized program, the federal government would have sole responsibility for the financing and administration of the Medicaid program.

In the early 1980s, the administration proposed to federalize the Medicaid program. This proposal, part of the New Federalism initiative, called for a major reshaping of the fiscal relationship between the federal and state

[4]Budget Policy: Issues in Capping Mandatory Spending (GAO/AIMD-94-155, July 18, 1994).

[5]See GAO/AIMD-94-155, July 18, 1994.

and local governments. It called for a federal takeover of Medicaid in exchange for a state takeover of the full cost of the Food Stamp and AFDC programs.[6] This exchange was termed the "swap component" of the initiative. The administration believed that this exchange would make welfare less costly and more responsive to the needs of the poor because it would be designed and administered by those closer to the people that it served. To equalize the financial burden that the states would assume in administering these programs, the federal government would take over the Medicaid program.

One argument for federalizing Medicaid was that it would allow for better control of medical costs.[7] This could be achieved through the federal government's exercising its influence as the sole purchaser of medical services for both the Medicare and Medicaid programs to obtain lower prices for services.

Another argument for federalization is that it would address the lack of uniformity in benefits and eligibility requirements among recipients. Besides the obvious benefit of equity among beneficiaries, other benefits of federalization might include the reduction in the financial and administrative burden of Medicaid on the states and the elimination of persons migrating from states with low welfare benefits to those with higher benefits.[8]

There are many concerns, however, associated with the federalization of the Medicaid program. The federal government would face a serious challenge in defining uniform eligibility and service coverage for the country. If a federal program with generous services was adopted, it would substantially increase the cost of the Medicaid program. Federal Medicaid costs would greatly increase even if the current level of benefits was maintained across the states. A bare-bones approach that would limit federal spending could result in states that wished to maintain something close to the current levels of eligibility and service coverage having to finance and administer the additional services.[9]

[6]A similar proposal to federalize Medicaid, outlined in S.140, was recently introduced in the Senate. In exchange for the federal government assuming full cost of the Medicaid program, states would assume full cost of the WIC, Food Stamp, JOBS, and AFDC programs.

[7]See Controlling Medicaid Costs, 1983.

[8]See Controlling Medicaid Costs, 1983, and John Holahan and others, Balancing Access, Costs, and Politics (Washington, D.C.: Urban Institute Press, 1991).

[9]See Controlling Medicaid Costs, 1983 and John F. Holahan and Joel W. Cohen, Medicaid: The Trade-Off Between Cost Containment and Access to Care (Washington, D.C.: Urban Institute Press, 1986).

Experts have said that eligibility criteria and benefits might need to be adjusted to reflect variations in living costs among states and localities. The federal government may have a difficult time taking advantage of local circumstances to operate the program at maximum efficiency. For example, some areas may prefer to have more eligibles than extra, high-cost services. Also, the cost of certain services may be very high in some areas, and the use of alternative, lower cost services may be more efficient.[10]

Separating federal and state administration of Medicaid and other welfare programs will not eliminate what some believe is the more important problem—the need to restructure incentives for states, providers, and recipients to promote better use of Medicaid resources—and unnecessary reorganization of such enormous programs could be disruptive to program operations. Furthermore, some observers believe that deregulation of Medicaid at the federal level, modification of financial arrangements, and transfer of control to states are preferable to federalization.[11]

Splitting the Medicaid Program

Other alternatives to restructure Medicaid involve splitting it into two separate programs. One proposal would split it by type of service, with the federal government responsible for funding and administering acute and primary care and the states responsible for long-term care. Another would essentially reverse the roles for each level of government, with the federal government responsible for long-term care and the states responsible for acute and primary care.

A proposal to split Medicaid by type of service was put forth in 1984 by the National Study Group on State Medicaid Strategies.[12] The group was composed of nine state Medicaid, public health, and human service administrators. Under this plan, Medicaid would be split into (1) a federally financed and administered acute and primary care program with services provided by and payments made directly to prepaid capitated plans and (2) a federal- and state-funded but state-administered long-term care program. Federal financing for long-term care would be provided through per capita payments indexed for inflation and to reflect growth in the at-risk populations.

[10]See Controlling Medicaid Costs, 1983.

[11]See Controlling Medicaid Costs, 1983.

[12]Restructuring Medicaid: An Agenda for Change (Washington, D.C.: The Center for the Study of Social Policy, Jan. 1984).

The acute and primary care program would provide basic health care benefits (ambulatory and short-term institutional) for low-income individuals and families. Eligibility would be based on financial need and would not be tied to eligibility for cash assistance programs. A uniform, national eligibility level would be established at a set percentage (for example, 55 percent) of the national poverty level. Individuals with higher incomes would be entitled to coverage if their medical bills were so high that their incomes and assets fell below the established standard.

The long-term care program would provide a full range of institutional and community care services to low-income persons in two major service populations: the functionally impaired elderly and disabled, and the mentally retarded and developmentally disabled. States would provide services within broad federal criteria and guidelines.

The National Study Group argued that this split allowed the problems and needs of persons requiring these types of services to be addressed more thoroughly. By increasing states' flexibility over the long-term care component, states would have the freedom to find innovative ways to efficiently deliver long-term care services. The National Study Group believed that this approach might also clarify federal and state program responsibilities. Some have concluded that the advantages to this type of split would be that it would eliminate many of the current interstate inequities in the acute and primary care component of Medicaid by making uniform national eligibility and benefit levels. It would also eliminate inequities within the states by doing away with Medicaid program ties to cash assistance programs.[13]

A very recent proposal has suggested essentially reversing the responsibilities that the National Study Group's proposal assigns to the federal and state governments. It would require the federal government to create and operate a national long-term care program, a task that is likely more challenging than taking responsibility for the acute care component. Medicaid programs have been the predominant purchasers of long-term care, and program policies have shaped the long-term care market. The considerable variation in those policies has resulted in extensive variation in the volume and types of services across states.[14] As a result, the task of designing national benefit policies would be compounded by consideration of whether local service systems would have the capacity to

[13]See Trade-Off Between Cost Containment and Access, 1986.

[14]Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

fulfill them. Further, federalization might weaken a key element of long-term care cost containment efforts. States have historically been aggressive about trying to limit the number of nursing home beds out of concern about their share of Medicaid spending—a concern that would not exist under a federalized program.

Proposals to exchange responsibilities are not necessarily budget-neutral for either the federal government or individual state governments. Depending on the programs exchanged, a proposal could be budget-neutral or not. Among programs, Medicaid is several times larger than others mentioned. Within Medicaid, acute and primary care services expenditures are far greater than the amount spent on long-term care.

The Business Cycle and a Rainy Day Fund

Our analysis of Medicaid spending for federal fiscal years 1980 though 1993 clearly demonstrates the important influence of the business cycle. A rainy day fund or similar mechanism would be one way to assist states during recessionary periods if strong limits are placed on federal contributions. Independent of other factors, Medicaid expenditures tend to increase during recessions—as more individuals qualify for benefits—and decrease during economic expansions—as individuals leave the rolls. In general, an increase in the unemployment rate of 1 percentage point is associated with about a 6-percent increase in Medicaid expenditures. A fall in the unemployment rate causes a commensurate decrease in Medicaid expenditures. A rainy day fund might prevent states from having to reduce benefits, limit enrollment, or increase taxes during economic downturns.[15]

After controlling for long-term trends, we found a statistically significant relationship between Medicaid expenditures and the unemployment rate in 22 states, including 8 of the 10 largest states in terms of total expenditures: California, Florida, Massachusetts, Michigan, New Jersey, New York, Ohio, and Pennsylvania.[16,17] Spending in these 22 states accounted for over 63 percent of total Medicaid spending, or approximately $79.1 billion in fiscal year 1993.

[15]State tax revenues are also cyclically sensitive. They generally decline during recessions, while Medicaid eligibility and expenditures increase. For this report, we did not conduct any quantitative analyses of such effects on state tax revenues.

[16]This fundamental relationship may not be obvious from a casual inspection of the data because other factors, such as medical inflation, changes in utilization, and enrollment increases caused by normal population growth, also affect Medicaid spending.

[17]The remaining 14 states are Connecticut, Delaware, Hawaii, Indiana, Maine, Maryland, Minnesota, Missouri, New Hampshire, North Dakota, Rhode Island, Utah, Vermont, and Virginia.

Lack of statistical significance does not necessarily mean the relationship does not exist in the remaining states. Other factors (such as spending on disproportionate share hospitals) may have confounded the data and made it impossible to isolate the specific influence of economic activity in some states.[18] Alternatively, some state programs may be much less sensitive to changes in economic activity.

Figures 2 and 3 illustrate the effect of the business cycle on Medicaid spending in New York and California. Between 1980 and 1993, annual spending increases averaged 11.5 percent in New York and 10.5 percent in California; these overall trends in expenditures are shown with the dashed lines in the figures. The solid lines show how the business cycle—measured by the unemployment rate—affects spending relative to the trend. In the early 1980s, the recession caused high unemployment (8.6 percent in New York, 9.8 percent in California) and increased Medicaid spending above the long-term trend. The economic recovery that began in the mid-1980s reduced unemployment (to 4.4 percent in New York and 5.2 percent in California) and lowered Medicaid spending relative to the long-term trend.

[18]Because available HCFA data do not separately identify disproportionate share hospital payments before 1993, these payments could not be excluded from the analysis.

Figure 2: New York Medicaid Spending

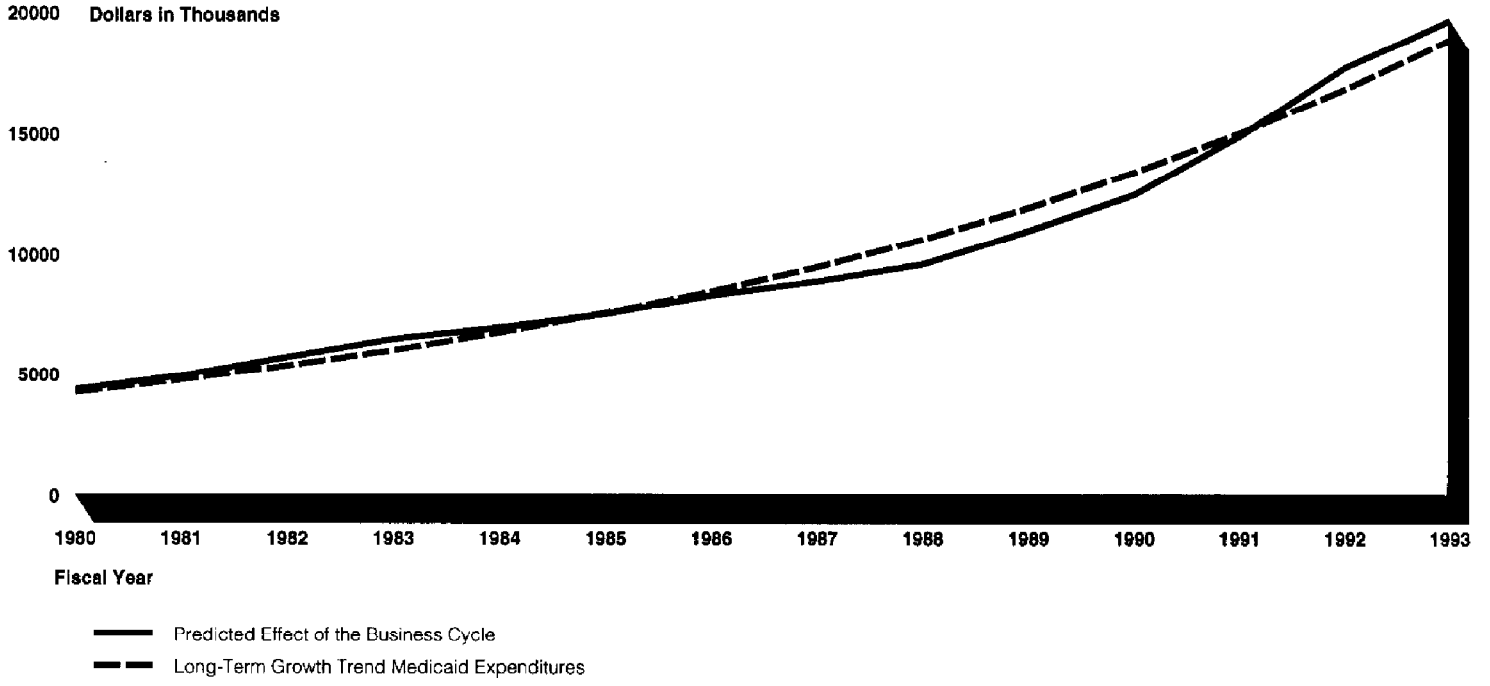
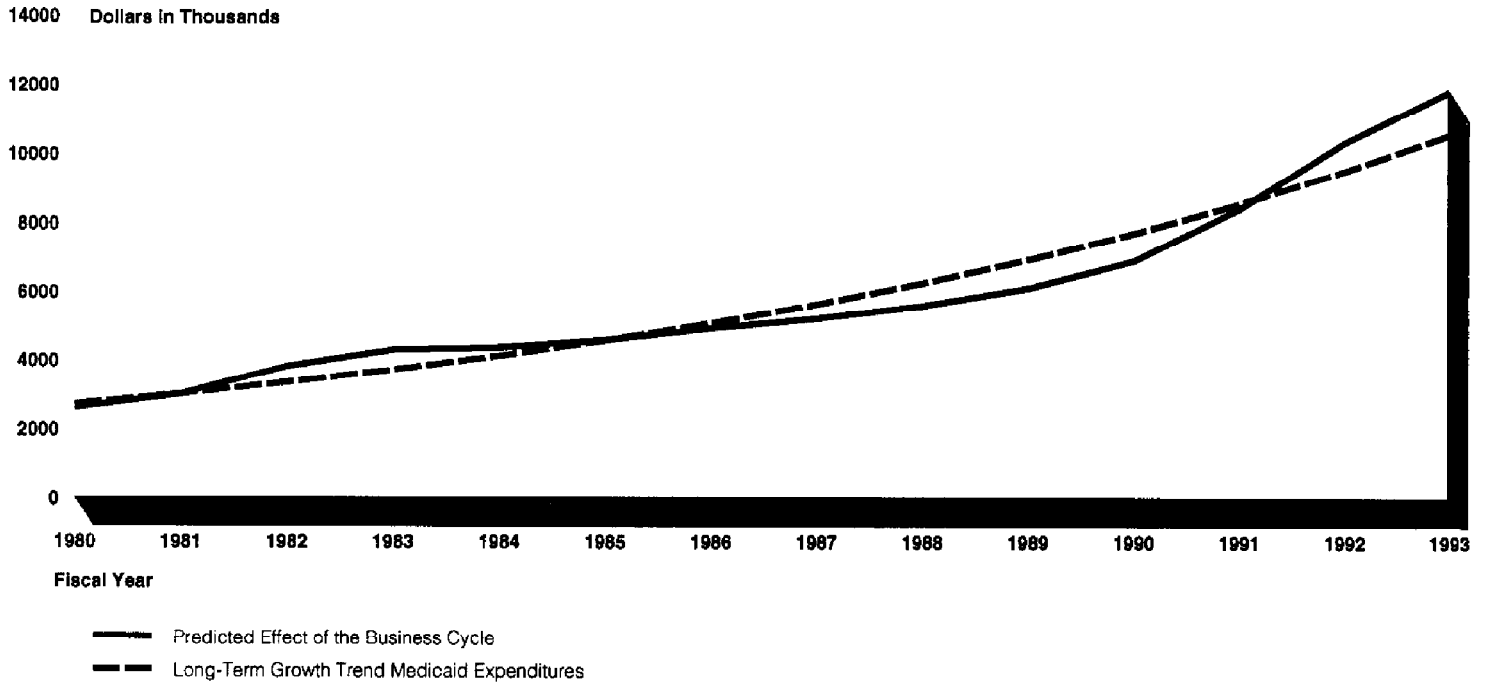


Figure 3: California Medicaid Spending



The impact of economic recessions on Medicaid spending is proportionately greater in some states than for the country as a whole. This is true for two reasons. First, some Medicaid programs are much more sensitive than others to statewide economic conditions. Second, individual state unemployment rates are subject to much greater changes than are national unemployment rates. For example, between 1980 and 1993, the largest 1-year increase in the national unemployment rate was 1.7 percentage points. At the state level, the largest annual increase occurred in West Virginia, where the unemployment rate jumped 3.9 percentage points in 1983. Massachusetts, one of the 10 states with the largest Medicaid expenditures, experienced a 1-year unemployment rate increase of 2.8 percentage points in 1991. Our analysis suggests that this increased unemployment added 17.6 percent, or $590 million, to Massachusetts' Medicaid spending that year.

How large a Medicaid rainy day fund is needed cannot be determined without specifying how it would be used, structured, and financed. Its size

would depend, in part, on the expected depth and breadth of the recessions the rainy day fund was meant to bridge. The conditions that would trigger the use of the fund also matter; a fund designed only to meet increased expenses directly resulting from an economic recession—and not unexpected spending increases incurred for other reasons—could be smaller than a fund with broader objectives. The size would also depend upon whether a single national rainy day fund was created or each state maintained its own fund. Because economic recessions hit some geographical areas harder or at different times, a single national fund—by diversifying the risk—could be smaller than the aggregate of 50 separate state funds.

A rainy day fund could be established as a revolving loan fund, financed initially by an appropriation and subsequently by loan repayments and possibly interest payments. This structure is similar to the Unemployment Insurance program, which permits states to borrow from the federal unemployment trust fund when their balances are insufficient to pay benefits. States are required to pay interest on loans, however, which has tempered the demand for loans. Alternatively, a Medicaid rainy day fund could be financed by an appropriation and serve as an additional specified amount of funds available for payments to states under certain conditions.

Agency Comments

Program officials from HCFA and the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation commented on a draft of this report. We have incorporated their comments where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, and the Assistant Secretary for Planning and Evaluation. We will also make copies available to others on request.

If you or your staff have any questions about this report, please call me on (202) 512-4561 or Richard Jensen on (202) 512-7146. Ron Viereck, Aleta Hancock, Carla Brown, and James Cosgrove also contributed to this report.

Sincerely yours,

William J. Scanlon
Associate Director
Health Financing and Policy Issues

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Abbreviations

AFDC	Aid to Families with Dependent Children
CBO	Congressional Budget Office
HCFA	Health Care Financing Administration
JOBS	Job Opportunities and Basic Skills
SSI	Supplemental Security Income
WIC	Special Supplemental Food Program for Women, Infants, and Children

Medicaid Expenditures, Fiscal Year 1993

Dollars in thousands

State	Federal	State	Total
New York	$10,263,276	$10,152,189	$20,415,465
California	7,122,922	7,026,776	14,149,698
Texas	4,761,080	2,644,917	7,405,997
Pennsylvania	3,222,982	2,573,717	5,796,699
Ohio	3,192,868	2,106,343	5,299,211
Illinois	2,628,783	2,597,134	5,225,917
Florida	2,810,093	2,286,183	5,096,276
New Jersey	2,390,784	2,367,690	4,758,474
Michigan	2,539,435	1,999,501	4,538,936
Massachusetts	2,127,897	2,112,367	4,240,264
Louisiana	2,611,684	944,893	3,556,577
North Carolina	1,966,127	1,028,773	2,994,900
Georgia	1,807,117	1,102,486	2,909,603
Indiana	1,804,877	1,053,825	2,858,702
Tennessee	1,831,339	883,598	2,714,937
Washington	1,347,782	1,095,609	2,443,390
Connecticut	1,172,956	1,159,943	2,332,899
Missouri	1,393,812	919,310	2,313,122
Minnesota	1,257,490	1,029,617	2,287,107
Wisconsin	1,313,952	860,174	2,174,127
Maryland	1,037,895	1,018,729	2,056,624
Kentucky	1,369,587	546,108	1,915,695
Virginia	942,274	924,408	1,866,682
South Carolina	1,241,829	512,212	1,754,041
Alabama	1,193,754	480,503	1,674,257
Arizona	962,580	497,149	1,459,730
West Virginia	934,215	297,488	1,231,703
Mississippi	962,308	263,928	1,226,236
Oklahoma	810,051	364,067	1,174,118
Colorado	619,003	508,829	1,127,832
Arkansas	789,432	279,208	1,068,640
Oregon	643,506	393,845	1,037,351
Iowa	643,593	384,022	1,027,615
Kansas	537,857	383,138	920,996
Maine	546,291	338,230	884,521
Rhode Island	455,158	392,449	847,606
District of Columbia	356,699	352,787	709,486

(continued)

Dollars in thousands

State	Federal	State	Total
New Mexico	437,194	154,356	591,550
Nebraska	361,037	227,335	588,372
Utah	377,418	130,448	507,866
Nevada	230,528	207,681	438,208
New Hampshire	218,889	213,880	432,770
Hawaii	200,595	197,524	398,119
Montana	238,598	97,637	336,235
Idaho	222,450	93,428	315,878
Alaska	169,943	145,216	315,159
North Dakota	202,103	79,495	281,598
South Dakota	193,796	79,971	273,767
Vermont	164,466	108,814	273,280
Delaware	135,923	131,149	267,071
Wyoming	96,401	46,675	143,076
Total	**$74,862,631**	**$55,795,752**	**$130,658,383**

Scope and Methodology

To obtain information on Medicaid restructuring approaches and their implications for federal-state financing and administration, we contacted representatives of the organizations listed below and requested any pertinent reports or other documents. We also conducted a literature search using computerized databases to obtain various other related publications such as reports, journal articles, books, studies, and proposed congressional bills.

Organizations GAO Contacted

Alpha Center for Health Planning
American Enterprise Institute
American Medical Association
Association for Health Care Policy Research
Cato Institute
Center for Strategic and International Studies
Center for the Study of Social Policy
Heritage Foundation
Intergovernmental Health Policy Project
Kaiser Commission on the Future of Medicaid
National Center for Policy Analysis
National Governors' Association
Progressive Policy Institute
Urban Institute

To provide information on the need to establish a rainy day fund if restrictions were placed on federal Medicaid payments to the states, we analyzed the sensitivity of Medicaid spending to the business cycle. We collected annual state unemployment information from the Bureau of Labor Statistics and combined federal-state Medicaid spending data for each of the states and the District of Columbia from HCFA for federal fiscal years 1980 through 1993. We used standard multivariate statistical techniques to estimate the separate influence of unemployment on Medicaid expenditures for each state, after controlling for long-term spending growth.

To provide information on actual federal Medicaid payments to the states, we collected the most recent data available from HCFA. We did our work in accordance with generally accepted government auditing standards.

Approaches to Restructuring Medicaid

	Block grants/cap on spending[a]	Federalization[b]	Federal/state split[c]
Goal			
	Control federal costs Increase state flexibility	Eliminate states' variation in eligibility and services Redefine federal-state relationship	Better serve needs of distinct populations Clarify federal and state responsibilities Control costs
Federal role			
	Block grants: Provide grants Possibly establish minimum program requirements **Cap**: Match state funds to cap limit Establish minimum program requirements	Fully fund program Administer program Establish policy and requirements	Assume responsibility for acute and primary care program Share in funding (block grants) and establish minimum requirements for state long-term care programs
State role			
	Block grants: Administer program Establish policy and requirements Possibly contribute funds **Cap**: Contribute funds Administer program Take on greater policy and requirements setting responsibility	None	Assume responsibility for long-term care program with federal government sharing funding

(continued)

	Block grants/cap on spending[a]	Federalization[b]	Federal/state split[c]
Benefits			
	Not addressed	National benefit package	Basic acute and primary care benefits; full range of health and social long-term care services
Eligibility			
	Not addressed	National standards	All persons with incomes less than a federally designated percentage of the poverty level for acute and primary care; functionally impaired dependent persons within the federal guidelines for long-term care eligibility
Administration			
	States responsible	Federal government responsible	Federal government responsible for acute and primary care; states responsible for long-term care
Financing			
	Block grants: Federal grants No mandatory state contribution, or some state contribution supplementing the federal contribution **Cap**: Federal matching of state funds	Federal government fully funds program	Federal government fully funds acute and primary care; federal government and states share funding of long-term care

(Table notes on next page)

[a]Block grants are discussed in Controlling Medicaid Costs, 1983, and proposed in Cato Handbook for Congress, 1995. In 1981, the administration proposed a 5-percent cap on annual increases to federal Medicaid spending along with reduced federal requirements.

[b]The administration proposed to federalize the Medicaid program in the 1983 budget. As part of the proposal, the states would have assumed complete responsibility for the AFDC and Food Stamp programs. S.140 would federalize Medicaid and give the states complete responsibility for the AFDC, Food Stamp, JOBS, and WIC programs. Federalization was also discussed in Controlling Medicaid Costs, 1983.

[c]A proposal to split Medicaid into two programs is contained in Restructuring Medicaid: An Agenda for Change, 1984.

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