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Intergovernmental Trends and Options

Advisory Commission on Intergovernmental Relations
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EXECUTIVE SUMMARY

Medicaid was enacted as a joint federal-state program to give low-income people better access to mainstream medicine. Since its inception in 1965, Medicaid has grown into a major health care program, accounting for about 12 percent of total **U.S.** health care expenditures in 1990 and covering more than 10 percent of the population. Medicaid spending is expected to increase sharply in the near future because of rising health care costs, an aging population, and federally mandated changes in program conditions and requirements. The **U.S.** General Accounting Office found that new program requirements enacted since 1987 will be more costly for the states to implement than previous changes.

There are major problems with Medicaid. Some problems have resulted from legislation that changed the structure, size, and scope of the program; other problems stem from deficiencies in the overall health care system. A major restructuring of health care would be required to address all of Medicaid's problems adequately.

The Commission's recommendations for reforming Medicaid are intended to (1) restore balance in Medicaid decisionmaking between the federal government and the states; (2) increase program flexibility for the states; and (3) limit or reverse shifts in program funding within Medicaid and between Medicaid and other programs (see pages 3-5). The options are intended to slow the growth of Medicaid expenditures for the states, allow the states to serve the health care needs of their citizens better, and bring more accountability, balance, and certainty to Medicaid service delivery and financing.

Medicaid was established as a federal-state program. The federal government makes matching grants to the states to pay for the medical care of certain categories of individuals. The federal government and the states also share in policymaking for the program. Within federal guidelines, states determine eligibility criteria, services to be covered, provider reimbursement rates, and local roles in financing and administration. Although there is a great deal of diversity among the states with respect to these policies, each state's Medicaid program must be uniform statewide.

Medicaid was intended to be the major public health care program for disadvantaged persons, including low-income people, the elderly, and the disabled. Eligibility was tied to public assistance programs, particularly Aid to Families with Dependent Children. Numerous changes in requirements and options have affected the scope of Medicaid. For example, in 1982, states were given the option of extending coverage to certain groups of disabled children under age 18 living at home who would have been eligible for Supplemental Security Income **(SSI)** if they were institutionalized. Other changes, both required and optional, extended coverage to pregnant women with young children based on income in relation to the poverty level, regardless of AFDC eligibility. Services for the mentally retarded in intermediate care facilities and additional services for children broadened the scope of Medicaid.

In order to cope with the rising costs of expanded eligibility and services, states have been experimenting with nontraditional forms of health care. In areas where access to health care is difficult, states, operating under waivers from the Department of Health and Human Services' Health Care Financing Administration (HCFA), have enrolled Medicaid clients in managed-care programs or have required deductibles and copayments from certain recipients. Some states instituted controversial provider-assessment programs to help raise their share of Medicaid revenue. These programs were restricted by the Congress in 1991.

Expenditures

Total Medicaid expenditures grew from $1.3 billion in 1966 to $75.2 billion in 1990. The rate of growth in total Medicaid spending from 1966 to 1990 was slightly lower than the rate of growth of Medicare expenditures, but significantly higher than the rate of growth of other government-financed personal health care expenditures and total personal health care spending.

Medicaid spending outpaced enrollment growth and increases in general and medical price inflation. Between 1969 and 1990, Medicaid vendor payments (excluding administrative costs), per enrollee, grew by 10.7 percent per year—from $331 to $2,818 (3.1 percent per year, from $918 to $1,752, in constant 1982 dollars). In 1990, Medicaid was the fourth largest source of financing for medical services (12.2 percent), following private health insurance (31.8 percent), individuals' out-of-pocket payments (23.3 percent), and other federal, state, and local programs (14.1 percent). While, on average, Medicaid represented 12.2 percent of personal health care spending, it accounted for 11.1 percent of

hospital care, 9.0 percent of drugs and other medical nondurables, less than 4 percent of physician and dentist services, 31.9 percent of home health care, and 45.4 percent of nursing home care (the largest payer for such services).

Total Medicaid expenditures as a percentage of state general expenditures rose from less than 3 percent in 1966 to 14.8 percent in 1990, and is expected to reach 17 percent by 1995. However, national averages mask large variations in state budgets. For example, Medicaid spending as a proportion of total state expenditures in 1990 ranged from 4.2 percent in Alaska to 19.1 percent in Rhode Island. Similarly, increases in expenditures from 1989 to 1990 ranged from 0.6 percent in Montana to 75.7 percent in Michigan. In FY 1990, over half the states had to make supplemental Medicaid appropriations.

Federal Medicaid spending as a percentage of federal general expenditures increased steadily from less than 1 percent in 1966 to 4.0 percent in 1989, and are expected to reach 6.5 percent by 1996.

There are four major causes of rising Medicaid expenditures: (1) general price inflation, (2) medical care price inflation, (3) enrollment growth, and (4) residual factors.

General price inflation and medical care price inflation were the major sources of Medicaid expenditure growth—77.3 percent between 1979 and 1984, and approximately 60 percent between 1984 and 1989. Enrollment growth accounted for 0.7 percent of the growth for 1979-1984 and 16.8 percent for 1984-1989. The residual factors were responsible for 21.4 percent for 1979-1984 and 26.9 percent for 1984-1989.

Enrollment Growth

Although it is not possible to separate all of the residual factors into individual components, changes in the composition of the Medicaid clientele over the past 19 years have had a significant impact on Medicaid expenditures. The total number of Medicaid recipients from 1972 to 1990 grew by 3.6 percent per year on average. Disabled enrollees, including the mentally ill and mentally retarded, increased by 4.6 percent per year, and adults in AFDC families increased by 3.7 percent per year. The number of elderly, blind, and other Medicaid recipients decreased.

Despite the decline in the number of elderly Medicaid enrollees, their share of payments ranged between 34 and 38 percent during 1973-1990, with a slight decline since 1984. The disabled, who accounted for 15 percent of enrollees in 1990, received 37 percent of payments (9.2 percent and 21.5 percent in 1972). Adults and children in AFDC families made up 68.2 percent of recipients in 1990 but received only 37.2 percent of payments (62 percent and 43.4 percent in 1972).

The elderly and disabled are the most costly Medicaid groups, averaging nearly $6,717 per person in 1990, or Over 250 percent of the average for all recipients—$2,568. In contrast, the average payment for all other recipients ranged from less than $811 (32 percent of average) to just Over $1,429 (56 percent of average) in 1990. The most expensive service financed by Medicaid is for mentally retarded persons in intermediate care facilities, which cost slightly more than $50,000 per recipient in 1990.

PREFACE

Medicaid is a program that is rapidly increasing in cost and decreasing in effectiveness. Medicaid spending, exclusive of administrative costs, nearly tripled between 1980 and 1990, increasing from $24.8 billion to $71.3 billion. Enacted in 1965 to provide basic medical services for low-income persons, Medicaid has expended funds increasingly for long-term care, mainly for the elderly and disabled. As a result, while costs have escalated, many low-income families receive little or no regular benefits from Medicaid. In turn, as a joint federal-state program, Medicaid has placed increasing fiscal burdens on the states and many local governments, to the point where some states now spend more on Medicaid than they do on higher education for their children's future.

The program does little to encourage individual responsibility for health care and its costs; it encourages fraud on the part of citizens and health care providers; it discourages many physicians from accepting Medicaid patients; it often spends more on the last three months of a person's life than on the first three months of a child's life; and it frequently drives low-income people to seek expensive medical treatment in hospital emergency rooms.

Remedying the problems of Medicaid will not be easy, however, because it is only one component of the health care system and only one government health program. Nevertheless, the Commission felt it important to call attention to the problems of Medicaid, partly because of its dramatic impact on state budgets and partly because it is the single largest component of the grant-in-aid system today. Intergovernmental transfers for health increased from less than 5 percent of all federal intergovernmental revenues in 1961 to almost 35 percent in 1990. At the same time, the states' role in Medicaid diminished as the federal government sought to expand the scope of the program and to attach conditions to Medicaid funding.

In this brief report, the Commission has tried to identify the major trends in Medicaid in terms of the program's size, structure, clientele, and services, and its ability to respond to emerging needs. The Commission's recommendations, which are necessarily in the form of "band-aid" fixes for Medicaid's problems, can improve the responsiveness of the program by enhancing state and local roles in policymaking and by increasing state and local flexibility in administering and financing Medicaid services. These recommendations do not lessen the need for a comprehensive reform of the entire health care system; however, they will improve the efficiency with which the program can achieve its original goals.

Robert B. Hawkins, Jr.
Chairman

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Full responsibility for the content and accuracy of the report rests with the Commission and its staff.

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CONTENTS

Figures and Tables

FINDINGS

1. Without correcting the problems in the overall system of health care in the United States, little can be done through Medicaid to contain health care costs or to target benefits more effectively to low-income persons. Therefore, efforts to reform only Medicaid can produce only marginal results. However, cost pressures on the states could be reduced significantly by federal assumption of long-term health care financing and by changes in federal procedures in Medicaid rulemaking. Similarly, cost pressures on local governments in the **14** states that require local government financial participation in Medicaid could be reduced by state assumption of these costs.

Reform of Medicaid alone will not alleviate many of the problems in the nation's health care system because Medicaid accounts for only about 12 percent of all health care costs. A comprehensive reform of the overall health care system is required to correct the deficiencies of the Medicaid program.

Providing long-term care for Medicaid clients in nursing home facilities and in their homes accounted for 43 percent of all Medicaid payments in 1990. Federal assumption of these costs would reduce state fiscal pressures.

State and local government Medicaid costs are increased by unilateral federal changes in program requirements. These cost increases can be moderated by providing states and local governments a role in the rulemaking process. State program costs can also be moderated by granting states greater flexibility in designing programs to meet their specific needs, preferences, and capabilities.

States with local government administration and financing of Medicaid have higher total program costs than states without local participation. State assumption of local administrative and program costs would reduce the fiscal burden on local governments and reduce overall program costs.

Local governments would retain significant responsibilities for providing health care through their hospitals, clinics, public health programs, and school and community-based programs. These facilities and programs would be affected by changes in (1) Medicaid requirements for standards and procedures, (2) health care provider reimbursement policies, (3) eligibility criteria, and **(4)** required and optional services.

2. Medicaid policymaking has shifted disproportionately to the federal government, which has contributed to higher state expenditures.

Medicaid was designed originally as a partnership between the states and the federal government. However, in recent years, major unilateral changes in federal Medicaid requirements have become more frequent. Such changes often are costly for the states to implement. Sometimes, the states must start entirely new programs, and it may be necessary to make several changes to a program between the time a new requirement is enacted and final regulations are promulgated by the Health Care Financing Administration (HCFA). New federal requirements also may involve costly changes in computer programs, additional staff training, and other inputs.

The National Association of State Budget Officers (NASBO) estimates that the federal conditions and requirements enacted since 1988 will add approximately $17.4 billion to the states' share of Medicaid expenditures from 1990 through 1995. The U.S. General Accounting Office (GAO) predicts the new conditions and requirements will exacerbate the states' fiscal stress resulting from the current recession. In the near future, most states will find it extremely difficult to finance the new conditions and requirements without raising taxes, shifting Medicaid resources by eliminating optional services or closing public clinics, or reducing other state spending. Further, the new requirements limit state flexibility in providing for the health care needs of their citizens. GAO found that new program requirements enacted since 1987, extending Medicaid coverage to older children and expanded screening programs and follow-up care, will be more costly for the states to implement than previous changes.

3. States have unique needs and capabilities that may be better served through increased program flexibility.

Present Medicaid regulations require a waiver from the Health Care Financing Administration for any deviation from statewide norms regarding the amount, duration, and scope of services (AD&S) provided. State officials are hampered in responding to variations in their preferences and needs and the resources available to provide various services. Greater flexibility would improve the states' ability to experiment with case management or

home and community-based care, rather than institutional care. Furthermore, complying with federal regulations, procedures, and standards raises state Medicaid costs but does not always increase the quality of health care significantly.

4. Federal Medicaid funds can be targeted more effectively to states with greater need and lower fiscal capacity by changing the matching formula to replace per capita personal income with alternative measures of fiscal capacity such as ACIR's Representative Tax System (RTS) and Representative Expenditure System (RES).

The federal Medicaid matching ratio (FMAP) is based on the ratio of state per capita personal income to U.S. per capita personal income. Under current law, the FMAP can range from 50 percent in the highest income states to 83 percent in the lowest income states. (The highest matching ratio for FY 1992 is 79.99 percent in Mississippi.)

Per capita personal income is a poor measure of state fiscal capacity because, for many states, the ability to export taxes to nonresidents is high. In addition, aggregate measures of income are not accurate indicators of state revenue-raising capacity because two states with nearly identical average per capita income may have different proportions of poverty and affluence.

Population is a poor indicator of a state's "need" for public services and of the cost of providing state services. Other factors, such as the age and income distribution of the population, the prices of service inputs, and workloads (e.g., population in households with incomes below the poverty level), are much more accurate indicators of service needs and costs.

Changing the Medicaid allocation formula generally would mean a small difference in the amount of Medicaid funds a state would receive, but for some states the differences would be substantial.

5. The overall cost escalation in Medicaid stems, to a large extent, from general price inflation and medical care price inflation, both of which are beyond the control of state officials.

Medicaid expenditures, exclusive of administrative costs, nearly tripled between 1980 and 1990, increasing from $24.8 billion to $71.3 billion. Inflation in the price of medical care and in the general economy has been a major cause of these increases. For example, between 1979 and 1984, general and medical care price inflation accounted for 77.3 percent of Medicaid growth. Between 1984 and 1989, approximately 60 percent of the increased cost of Medicaid was due to inflation.

Enrollment growth accounted for 0.7 percent of Medicaid growth between 1979 and 1984 and 16.8 percent between 1984 and 1989. Other factors, such as changes in the composition of medical services used, increases in the frequency of use of medical services, increased use of expensive new technology, and additional miscellaneous factors have accounted for between 20 percent and 25 percent of the growth in Medicaid expenditures over the last decade.

For state governments, the increased cost of Medicaid is reflected in their budgets. Medicaid expenditures accounted for 14.8 percent of state general expenditures in 1990, the second largest category of spending. Medicaid expenditures now exceed state spending on higher education. Medicaid expenditures were 11.6 percent of state general expenditures in 1980 and 7.0 percent in 1970.

6. The costs of providing care through Medicaid for the long-term disabled and the elderly have grown faster than other Medicaid costs.

A major policy concern is the rising proportion of Medicaid spending devoted to long-term care for the elderly and the disabled (including mentally ill and mentally retarded individuals). For example, in 1990, the elderly and the disabled represented 27.4 percent of all Medicaid enrollees but received 70.0 percent of all Medicaid funds. In 1972, the elderly and the disabled made up 28.7 percent of all Medicaid enrollees and received 52.8 percent of all Medicaid funds. Long-term care expenditures (intermediate care facilities, skilled nursing facilities, and home health care) accounted for 43.4 percent of all Medicaid expenditures in 1990 and 34.2 percent in 1973.

If current demographic trends and policy provisions continue, Medicaid costs will increase dramatically in the future as the proportion of the population at age 85 and over increases from 1.2 percent in 1987 to 2.5 percent in 2030. This age group uses nursing home care to a much greater extent than those between the ages of 65 and 84. In addition, nursing home use will increase in the future as the "baby-boom" generation retires, beginning in about 2010, and becomes more susceptible to chronic disabilities and functional dependency.

RECOMMENDATIONS

SHORT-TERM RECOMMENDATIONS

Recommendation 1
Increase State and local Roles in Medicaid Policymaking

The Commission finds that in recent years, major changes in federal Medicaid conditions and requirements have become more frequent. State and local governments have found it difficult and costly to comply with these changes.

The Commission therefore recommends that (1) states should not be required to implement any changes to Medicaid until final regulations have been promulgated by HCFA and (2) the federal government will bear 100 percent of the cost of new Medicaid requirements for a period of two years. States will gradually assume some of the costs of the new requirements. After the fifth year, the state share of the cost of these conditions and requirements will be equal to the state matching rate determined by the Medicaid allocation formula.

The Commission further recommends that a permanent intergovernmental health commission be established to advise the Executive Branch, the Congress, and the states on (1) changes necessary to make Medicaid and other joint federal, state, and local health programs function more efficiently and effectively and (2) the fiscal impact on states and local governments of changes in the Medicaid program that are under consideration by the Congress or the Executive Branch, The commission will consist of members of the Executive Branch, appointed by the President; members of Congress, appointed by the leadership of the respective chambers; members of the state Executive Branch, appointed by the National Governors' Association (NGA); state legislative members appointed by the National Conference of State Legislatures (NCSL); county representatives appointed by the National Association of Counties (NACo); and municipal representatives appointed by the National League of Cities (NLC) and the U.S. Conference of Mayors (USCM).

The Commission further recommends that states make greater use of the **Negotiated Rulemaking Act** *(P.L. 101-468) to participate in Medicaid rulemaking, and the* **Administrative Dispute Resolution Act** *(P.L. 101-552) as an alternative to litigation.*

By requiring 100 percent financing of changes in federal requirements, the Congress and the Executive Branch will be more cognizant of the costs imposed on states and local governments by changes to Medicaid. Through the permanent health commission, states and local governments will gain a formal mechanism to initiate or evaluate Medicaid changes.

Recommendation 2
Increase State and Local Program Flexibility

The Commission finds that states need greater flexibility in designing their Medicaid programs to meet their needs and resources. A more flexible program would enable states and local governments to control Medicaid costs and target assistance to their neediest citizens more effectively. Successful state experiments with innovative methods of improving access to health care and cost control could be adopted by other states.

The Commission therefore recommends: (1) States, with the consent of the U.S. Secretary of Health and Human Services, should be allowed to experiment with case-management systems and with setting up their own clinics. These experiments may be statewide or limited to areas where access to health care through enrollee-chosen providers is not feasible. (2) Other states should be allowed to initiate their own programs without a waiver from the Health Care Financing Administration (HCFA), should these experiments prove successful, as determined by HCFA. (3) The federal government should waive the requirement that state-run clinics meet federal requirements as long as comparable state requirements are met, as determined by HCFA. (4) The federal govemment should not preempt comparable state laws regarding procedures and regulations for health care providers, as determined by HCFA. (5) Medicaid enrollees should be permitted to use these state-run clinics with Medicaid reimbursement even if the clinics do not meet federal requirements, so long as comparable state requirements are met, as determined by HCFA. (6) Health care providers should be eligible for Medicaid reimbursement if they conform to state standards, procedures, and regulations. Providers will not be reimbursed if federal standards, procedures, and regulations clearly offer better quality care, as determined by HCFA. (7) States should have the option to require copayments and deductibles from certain Medicaid clients, based on income and/or asset levels, in circumstances where these copayments and deductibles would

improve access to health care providers for a significant number of Medicaid enrollees.

For many Medicaid enrollees, especially those in sparsely settled rural areas and in inner cities, access to health care is often difficult. This results in their using hospital emergency rooms for primary care, which is costly and inefficient. Medicaid enrollees who do not have a primary medical care provider on a consistent basis are often sicker and require more services than other patients when they do seek medical care. To some extent, the difficulty faced by Medicaid enrollees in obtaining medical care is the result of low reimbursement rates for medical care providers.

Long-Term Recommendations

Recommendation 3
Adopt Interim Modifications to Medicaid and Implement Comprehensive Health Care Reform by 1994

The Commission finds that rising Medicaid costs are a factor in the deterioration of state fiscal conditions. To a large extent, the escalating cost of Medicaid stems from general price inflation and medical care price inflation, both of which are beyond the control of state officials. Increasing use of new medical technology, increasing use of medical services, and the aging of the population are also major factors contributing to the escalation of Medicaid costs. Without corrections of the deficiencies in the overall system of health care delivery, the benefits of these proposed recommendations to improve Medicaid will be limited.

The Commission therefore recommends that the interim modifications to Medicaid set forth here be adopted by Congress and a comprehensive reform of the US. health care system be implemented by ***1994.***

The current economic recession is causing fiscal stress in many states as revenue growth is slowed but expenditure needs, especially social service programs, increase. Medicaid expenditures account for slightly less than 15 percent of all state general expenditures. Steps taken now to reduce state Medicaid program costs would help reduce state fiscal stress.

Modifications to Medicaid will yield only marginal improvements in the health care system because Medicaid accounts for only 12 percent of all health care expenditures. Without effective methods of cost containment, any improvements in Medicaid's efficiency and effectiveness resulting from these improvements may be wiped out by rising costs.

Comprehensive health care reform would address all aspects of health care service delivery and financing, including **(1)** methods to control medical cost inflation; **(2)** methods to achieve universal access to health care; **(3)** the proper roles for the federal government, states, and local governments; and **(4)** the role of individuals in maintaining their health through lifestyle choices (e.g., proper diet and exercise, only moderate use of alcohol and tobacco, and reduced stress). Such reform is necessary to correct the problems with Medicaid and to correct problems in the overall health care system.

Recommendation 4
Transfer Local Medicaid Administrative and Program Costs to the States

The Commission finds that states with local government participation in Medicaid administration and financing have higher total program costs than states without local participation. State assumption of local administrative and program costs would reduce the fiscal burden on local governments and reduce overall program costs.

The Commission therefore recommends that states that require local government participation in administering or financing Medicaid assume all Medicaid administrative and program costs currently borne by their local governments.

The federal government does not specify the extent of any involvement by local governments in Medicaid; therefore, this reform must be an initiative of the states. Local government revenue bases are less elastic than state revenue bases. It is more difficult for local governments to finance increases in Medicaid expenditures resulting from program expansions or deteriorating economic conditions. Further, Medicaid regulations require statewide uniformity in services and application of eligibility criteria. Satisfying this regulation would be more efficient under state administration.

Recommendation 5
Transfer the Cost of Long-Term Care to the Federal Government under Medicare

The Commission finds that the cost of providing care through Medicaid for the long-term disabled and the elderly has grown faster than other Medicaid costs. The costs of providing such care will increase even more rapidly as the population ages and more people require nursing home services, and faster than state and local government ability to finance these services. New medical technology will continue to reduce mortality rates for all ages, raising the proportion of disabled persons in the population.

The Commission therefore recommends that the cost of providing care for the elderly and the disabled, including the mentally retarded, in skilled nursing facilities (SNF), intermediate care facilities ***(ICF),*** *intermediate care facilities for the mentally retarded (ICF/MR), and home health care programs be assumed by Medicare.*

The escalating cost of providing long-term care for the elderly and disabled currently enrolled in Medicaid will outstrip the ability of states, and in some cases local governments, to finance these services. For example, the annual cost of providing Medicaid services to an ICF/MR client was approximately $50,000 in 1990. The long-term costs for these groups should be assumed by Medicare because Medicare

has a more secure funding base than state governments and was established to provide for these groups.

Medicaid will continue to finance, for those elderly and disabled who are eligible, routine and preventive medical care as well as services that Medicare does not cover, such as eyeglasses, hearing aids, prosthetic devices, and dental examinations. The cost of these services and items may be quite burdensome for Iow-income elderly and disabled persons.

The amount of savings that would accrue to states by adopting this recommendation is difficult to determine. In 1990, Medicaid payments for SNF, ICF, and ICF/MR totaled $25.0 billion—38.6 percent of all Medicaid expenditures. However, a portion of this total was spent for routine medical care, for example, regular visits to physicians, prescription drugs, eyeglasses, and other sundries, some of which would still be covered by Medicaid under this recommendation.

If this recommendation were adopted, the federal government would assume all costs of providing medical care for the elderly, disabled, and mentally retarded. This action would reduce the fiscal burden on states; in 1990, these groups received 70.0 percent of all Medicaid vendor payments. To accomplish this task, all elderly persons (65 and over) would become eligible for Medicare regardless of previous employment. Currently, Medicaid enrollees over 65, if they were eligible, received Medicare benefits because states were required to "buy-in" to Medicare. Under this option, the custodial care costs of the elderly would be assumed by Medicare; similarly, the disabled, including the mentally retarded, would become eligible for Medicare immediately after they are certified as disabled.

Recommendation 6

Improve Targeting of Federal Medicaid Funds to States with Greatest Need and least Capacity to Meet Needs

The Commission finds that federal Medicaid funds could be allocated to states more effectively if state fiscal capacity were included directly in the matching formula. The major factor in allocating federal Medicaid funds to states is per capita personal income, which is not necessarily a good indicator of state revenue-raising ability or need.

The Commission therefore recommends that the state Medicaid matching formula be changed to the ratio of ACIR's measure of state revenue capacity to ACIR's estimate of cost-adjusted representative state expenditures as the measure of fiscal capacity, The Commission further recommends that states that would have their federal Medicaid finds reduced by adoption of the new formula should be "held harmless" for a period of two years to ease the transition.

Adoption of this Medicaid matching formula would target scarce federal funds to states with the lowest fiscal capacity more effectively than the current formula. However, studies indicate that for the large majority of states, the amount of federal Medicaid funds would be similar under both formulas. The political debate that would occur between the states that would stand to lose the most and those that would stand to gain the most from the proposed formula would be mitigated by the "hold-harmless" provision.

1. INTRODUCTION

This report presents ACIR's latest research findings and recommendations concerning Medicaid (Title XIX of the *Social Security Amendments of 1965*), the joint federal-state program to improve the access of low-income people to mainstream medicine.' Since its inception, Medicaid has grown into one of the major health care programs in the United States, accounting for about 12 percent of the nation's total health care expenditures and covering approximately 10 percent of the population in 1990.2 Medicaid spending is projected to rise sharply in the near future because of rising health care costs, an aging population, and federally mandated changes in program conditions and requirements. The additional Medicaid expenditures will put increased pressure on federal and state budgets, and may result in tax increases or reductions in the growth of other program expenditures.[3]

There are major problems with Medicaid, several of which have resulted from legislation that changed the structure, size, and scope of the program, and others that stem from problems in the overall health care system in the United States. A major restructuring of the health care system is required to address all of Medicaid's problems adequately.

The first two Commission recommendations can be implemented fairly quickly. The remaining four recommendations entail significant changes in Medicaid. These recommendations are intended to (1) restore balance in Medicaid policy decisionmaking between the federal government and the states and local governments, (2) increase program flexibility for state and local governments, and (3) limit or reverse shifts in funding within Medicaid and between Medicaid and other programs.

The recommendations are intended to control the growth of Medicaid expenditures for the states; to allow the states to provide for better health care; and to bring more accountability, balance, and certainty to Medicaid service delivery and financing.

In some cases, state costs for Medicaid may increase in the short run if these recommendations are adopted, or if the states change their provider reimbursement policies, or add other groups to the Medicaid clientele (e.g., persons now uninsured). In other cases, state costs may decline as the federal government assumes more of the burden of financing the health care needs of certain individuals.

The report reviews the original goals of Medicaid and discusses the changes in the structure of the program since its inception. The discussion focuses on expansions in the services provided and population groups served by Medicaid. It also describes the program options and requirements introduced by the federal government and, more generally, the recent shift in Medicaid policy decisionmaking to the federal government.

The report also examines trends in Medicaid spending (in current and constant dollars) in relation to (1) state expenditures, aggregate and state by state, (2) federal expenditures, and (3) other social welfare expenditures. Also examined are trends in enrollees by eligibility category, services provided, and Medicaid expenditures per enrollee by eligibility category and by type of service. In addition, the report presents data on the impacts on Medicaid spending growth of (1) general price inflation, (2) medical care price inflation, (3) enrollment growth, and (4) other factors (e.g., changing age-sex composition of the Medicaid clientele, increasing use of health care, and increasing use of new medical technology).

The report includes a chronological summary of major federal changes to Medicaid.

Notes

[1] The earlier report is U.S. Advisory Commission on Intergovernmental Relations, *Intergovernmental Problems in Medicaid* (Washington, DC, 1968).

[2] In 1990, Medicaid expenditures, including "buy-ins" to Medicare, were $76.3 billion; total health care expenditures were $666.2 billion. See Katherine R. Levitt, Helen C. Lazenby, Cathy A. Cowan, and Suzanne W. Letsch, "National Health Care Expenditures, 1990," *Health Care Financing Review* 13 (Fall 1991): 30, 41, 42, and 46.

[3] Harold A. Hovey, "Who Pays When State Health Care Costs Rise?" in *State Governments: The Effects of Health Care Program Expansion in a Period of Fiscal Stress* (Washington, DC: Advisory Council on Social Security, December 1991): 93.

2. STRUCTURE OF THE MEDICAID PROGRAM

The Medicaid program is financed jointly by the federal government and the states. It is a means-tested program through which the federal government makes matching grants to the states to pay for the medical care of certain categories of low-income individuals. The federal government and the states also share in Medicaid policymaking. Within federal guidelines, the states determine eligibility criteria, covered services, and provider reimbursement rates. The states administer Medicaid and, in some cases, require local governments to share in financing and/or administering the program.

This chapter describes the basic goals and elements of the Medicaid program: eligibility criteria, services, provider reimbursement, financing, and administration. It also discusses major changes in the program, including expansions of eligibility and services and the addition of federal options and requirements affecting the states. The implications of the structure of Medicaid and the program changes for such intergovernmental issues as uniformity or diversity of services and state discretion are emphasized throughout the chapter.

A BRIEF HISTORY OF MEDICAID

Medicaid (Title XIX of the *Social Security Amendments of 1965*) was enacted as a counterpart to Medicare, the national program to provide medical insurance for the elderly. By contrast, Medicaid was to be financed jointly with the states and to serve only certain groups enrolled in public assistance programs. Medicaid was intended to improve the access of these low-income people to mainstream medicine.[1]

Before Medicaid was enacted, the federal government helped finance medical assistance for the needy by sharing the cost of the cash assistance programs: Old Age Assistance (OAA), Aid to Families with Dependent Children (AFDC), Aid to the Blind (AB), and Aid to the Partially and Totally Disabled (APTD). The federal government also participated in the Kerr-Mills program of Medical Assistance for the Aged (MAA), which made medical care available to the needy aged and the medically needy, by reimbursing states for 50 to 80 percent of the cost of setting up their programs. The higher percentages of federal funds went to states with lower per capita income.

Title XIX extended Kerr-Mills principles by making medical vendor-payment benefits available to the recipients of all four federal-state cash assistance programs (OAA, AFDC, AB, and APTD), as well as to the category of the "medically needy." By substituting one program of medical assistance (at higher matching rates for most states) for the separate categorical plans, Medicaid provided uniformity within states in administration, eligibility standards, medical services, and federal-state cost sharing. However, individual states still had considerable discretion to set their own standards, within the federal guidelines, for eligibility, services, and other aspects of the program. Linking Medicare and Medicaid, Title XIX provided that states could "buy in" to Medicare's inpatient hospitalization costs (Part A) and physicians' care (Part B) for certain Medicaid eligibles by paying the appropriate premiums, coinsurance, and deductibles.[2]

DESCRIPTION OF MEDICAID

Since 1965, many significant changes have been made to the Medicaid legislation.[3] At the same time, many of the original principles still define the program—categorical eligibility, coverage of specified services, reimbursement of qualified providers, federal-state financing, and administration of approved state programs. Each of these elements is described briefly below.

Eligibility

Medicaid is a categorical, means-tested entitlement program. That is, specified groups of people whose income and resources are sufficiently low are automatically qualified for the program. Medicaid was not intended to provide universal coverage, not even for all of the poor. Medicaid provides (1) required coverage for the categorically needy and (2) optional coverage for the medically needy.

Categorically Needy

The categorically needy, who must be covered by state Medicaid programs, include, in general, those who receive or are eligible to receive cash assistance through Aid to Families with Dependent Children (AFDC) programs and pregnant women with incomes up to 133 percent of the poverty level.[4] However, eligibility standards for these programs, particularly for AFDC, vary from state to state. A third federal program used to define the categorically needy is the

federal Supplemental Security Income (SSI) program. As a federally administered program, eligibility for SSI does not vary by state. However, in 12 states (so-called 209(b) states), an SSI recipient may or may not be eligible for Medicaid.

For AFDC, each state establishes, by family size, a need standard and a payment standard, which may be equal to or lower than the need standard. Both standards are used in determining eligibility for AFDC: in most states, the payment standard is the maximum AFDC benefit. Actual benefits are determined by subtracting countable income from the payment standard? The limit for gross income is 185 percent of the need standard. Table 2-1 shows the 1990 need standard and maximum AFDC benefit in each state for a one-parent family of three in relation to the federal poverty level.

SSI has uniform eligibility requirements and payments. However, for Medicaid coverage, states may require SSI recipients to meet more restrictive eligibility standards that

Table 2-1
AFDC Need Standards and Maximum Benefit Levels for a Family of Three, by State, January 1990
(dollars per month)

State	Need Standard Amount	Need Standard Percent of Poverty Threshold*	Maximum Benefit Level Amount	Maximum Benefit Level Percent of Poverty Threshold*
New England				
Connecticut	$649	75%	$649	75%
Maine	652	75	453	52
Massachusetts	539	62	539	62
New Hampshire	506	58	506	58
Rhode Island	543	63	543	63
Vermont	973	112	662	76
Mideast				
Delaware	333	38	333	38
District of Columbia	712	82	409	47
Maryland	548	63	396	46
New Jersey	424	49	424	49
New York (Suffolk Co.)	703	81	703	81
New York (New York City)	577	66	577	66
Pennsylvania	614	71	421	48
Great Lakes				
Illinois	777	89	367	42
Indiana	320	37	288	33
Michigan (Washtenaw Co.)	611	70	546	63
Michigan (Wayne Co.)	575	66	516	59
Ohio	739	85	334	38
Wisconsin	647	75	517	60
Plains				
Iowa	497	57	410	47
Kansas	409	47	409	47
Minnesota	532	61	532	61
Missouri	312	36	289	33
Nebraska	364	42	364	42
North Dakota	386	44	386	44
South Dakota	377	43	377	43
Southeast				
Alabama	$578	67%	$118	14%
Arkansas	705	81	204	23
Florida	838	97	294	34
Georgia	414	48	273	31
Kentucky	526	61	228	26
Louisiana	658	76	190	22
Mississippi	368	42	120	14
North Carolina	544	63	272	31
South Carolina	419	48	206	24
Tennessee	387	45	184	21
Virginia	393	45	354	41
West Virginia	497	57	249	29
Southwest				
Arizona	621	72	293	34
New Mexico	264	30	264	30
Oklahoma	471	54	325	37
Texas	574	66	184	21
Rocky Mountain				
Colorado	421	48	356	41
Idaho	554	64	317	37
Montana	434	50	359	41
Utah	516	59	387	45
Wyoming	360	41	360	41
Far West				
California	694	80	694	80
Nevada	550	63	330	38
Oregon	432	50	432	50
Washington	907	104	501	58
Alaska	846	97	846	97
Hawaii	964	111	602	69

*Calculated based on poverty threshold of $10,419 annually for a three-person household.

Sources: Need standards and maximum benefit levels—U.S. House of Representatives, Committee on Ways and Means, *Background Material and Data on Programs within the Jurisdiction of the Committee,* Overview of Entitlement Programs (Washington, DC, 1990), Table 9, pp. 553-555.
1990 poverty threshold—U.S. Department of Commerce, Bureau of the Census, *Measuring the Effect of Benefits and Taxes on Income and Poverty: 1990* (Washington, DC, 1991), p. 132.

were in effect before the implementation of SSI (the 209(b) option) or they may extend Medicaid coverage to certain groups, such as those receiving certain state supplementary payments under SSI. Unlike AFDC benefits, SSI payments are increased automatically each year.

The Congress, particularly in recent years, has extended Medicaid eligibility to some categories of people who would not otherwise be covered, most notably pregnant women and children. States also may choose to extend Medicaid coverage to "optional categorically needy" groups, such as AFDC-related persons not actually receiving payments and low-income individuals who are institutionalized.

Medically Needy

State Medicaid coverage is optional for the other basic group of recipients, the medically needy. As of January 1991, 36 states and the District of Columbia included this group in their Medicaid programs. The medically needy are people whose income and/or resources are in excess of that entitling them to categorically needy coverage, but who meet the nonfinancial standards for categorical eligibility and whose income and resources, after deducting medical expenses, fall below specified standards.' Persons with income above the medically needy level may reduce income to the requisite level through spending on medical care, as many do on long-term nursing home care. In fact, a Congressional Research Service report states, "As a practical matter, the medically needy program is primarily a benefit for institutionalized elderly and disabled persons."[8]

From this brief description, it can be seen that states, as well as the federal government, have considerable control over Medicaid enrollment by setting eligibility policies. These policies include setting income levels for cash assistance programs, to which Medicaid eligibility is generally linked, deciding whether to extend eligibility to optional categorically needy and medically needy groups, and determining specific eligibility criteria within broader federal guidelines?

Medicaid Services

The Medicaid legislation sets out several requirements for state benefits, including mandatory and optional services for the categorically and medically needy, and general principles that must be satisfied in a state's plan. Within these guidelines, states have considerable discretion to define their benefit packages.

Mandatory services for the categorically needy are:

- Federally qualified health centers (FQHCs),
- Inpatient hospital services,
- Nurse practitioners,
- Outpatient hospital services,
- Physicians' assistants,
- Rural health clinic services,
- Other laboratory and X-ray services,
- Nursing facility services for those 21 or older,[10]
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children,
- Physician services,
- Home health services for any individual entitled to skilled nursing facility (SNF) care,
- Family planning services, and
- Nurse-midwife services.

There also are 32 categories of optional services for the categorically needy, including prescription drugs, eyeglasses, services in intermediate care facilities for the mentally retarded (ICFs/MR), clinic services, physical therapy, and dental services.

States with medically needy programs are required to provide the following services: (1) prenatal and delivery services for pregnant women; (2) ambulatory services for individuals under 18 and those entitled to institutional services; and (3) certain services provided to the categorically needy in institutions for mental diseases (IMDs) or intermediate care facilities for the mentally retarded (federal Medicaid funds may not be used for adults aged 21 to 65 who reside in IMDs).

States with medically needy programs also must make assistance available to individuals under age 18 and to pregnant women who would be eligible for categorical assistance except for income and resource levels. In 1993 and 1994, these states also will make assistance available for Medicare cost sharing for (1) qualified Medicare enrollees, (2) qualified disabled and working individuals, and (3) individuals who would be qualified for Medicaid except that their income exceeds the state eligibility level but is less than 110 percent of the official federal poverty line (120 percent in 1995 and thereafter).[11]

Table 2-2 shows the number of states providing 31 optional services in 1990, and whether they are provided only to the categorically needy or also to the medically needy.

In addition to the identification of covered services, each state's Medicaid plan must meet the following general requirements, unless granted a waiver:

- ***Amount, Duration, and Scope*** **(AD&S).** Each covered service must be sufficient in AD&S to reasonably achieve its purpose. Nevertheless, states may limit the coverage of services, such as the number of covered hospital days or physicians' visits.[12]
- ***Comparability.*** Services available to all categorically needy beneficiary/medically needy groups must be equal.
- ***Statewide Coverage.*** The AD&S of coverage must be the same throughout the state.
- ***Freedom-of-Choice.*** Beneficiaries may obtain services from any participating qualified provider.

Alternative Service Options

Several program options give states additional flexibility in designing their health care packages.[13] States may enter into risk contracts with health maintenance organizations (HMOs) and other similar organizations (often referred to as prepaid health plans or PHPs) or they may seek exemptions or waivers from the Secretary of the De-

Table 2-2
Number of States Offering Optional Medicaid Services, as of October 1, 1989[1]

Service	States Offering Service to: Categorically Needy	Categorically and Medically Needy	Categorically or Medically Needy
Podiatrists	12	33	45
Optometrists	14	36	50
Chiropractors	8	19	27
Other Practitioners	13	32	45
Private Duty Nursing	8	20	28
Clinics	15	40	55
Dentists	12	36	48
Physical Therapy	11	31	42
Occupational Therapy	8	26	34
Speech, Hearing, Language Disorders	11	29	40
Prescribed Drugs	16	38	54
Dentures	8	31	39
Prosthetic Devices	14	38	52
Eyeglasses	16	33	49
Diagnostic	5	21	26
Screening	4	19	23
Prevention	3	20	23
Rehabilitation	12	33	45
Services for Age 65 or Older in Mental Institutions:			
Inpatient Hospital	14	26	40
Nursing	11	22	33
Intermediate Care Facility for Mentally Retarded	21	28	49
Inpatient Psychiatric for under Age 21	10	29	39
Christian Science Nurses	1	2	3
Christian Science Sanitoria	4	11	15
Skilled Nursing Facility for under Age 21	20	30	50
Emergency Hospital	14	28	42
Personal Care	9	19	28
Transportation	14	37	51
Case Management	10	33	43
Hospice	9	24	33
Respiratory Care	3	11	14

[1] Includes American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

Source: Data from U.S. Department of Health and Human Services, Health Care Financing Adminstration, Medicaid Bureau, Intergovernmental Affairs Office, 1992.

partment of Health and Human Services for other federal Medicaid requirements.

Under a risk contract, the state pays an HMO or PHP for the enrollment of Medicaid participants. A fixed premium is paid, generally on a monthly basis, for each participant, and the plan agrees to provide all covered services. Use of risk contracts is entirely at the state's discretion.

Several types of waivers of federal Medicaid requirements are available. Section 2175 of *The Omnibus Reconciliation Act of 1981* (OBRA) authorizes the Secretary of Health and Human Services (HHS) to waive selected provisions of the Medicaid statute to allow states more flexibility in developing innovative health care delivery or reimbursement systems. Where Section 2175 waivers are used, the state must demonstrate that the program will be cost effective and will not impair the Medicaid enrollees' access to medically necessary services of adequate quality.

The most common use of the 2175 waiver is to establish primary-care case management. Sixteen states have some sort of managed-care system, and the Health Care Financing Administration (HCFA) estimates that they save $121 per year per enrollee.[14] Under a case-management system, either Medicaid enrollees choose a "gatekeeper" or primary physician (usually a general practitioner, internist, or pediatrician) or the state assigns the physician. This physician may be an independent practitioner or part of an HMO, and is responsible for assuring preventive care and for referrals to specialists. Usually, the state reimburses the gatekeeper a nominal fee per patient. The preliminary evidence available indicates that both physicians and patients are satisfied with the case-management system.[15]

The case-management system offers an alternative to using hospital emergency rooms for primary care, which is

costly and inefficient and often is the only care available for many Medicaid enrollees, especially in sparsely settled rural areas and inner cities. Medicaid enrollees who do not have a primary medical care provider on a consistent basis also are often sicker and require more services when they do seek medical care.[16] To some extent, the difficulty Medicaid enrollees face in obtaining medical care is the result of low reimbursement rates for providers."

Several waivers pertain to home and community-based services. Section 2176 waivers of comparability and statewide coverage requirements allow states to provide comprehensive home and community-based long-term care, often including non-medical social services, to individuals who would otherwise be at risk of institutionalization or require continuing care in hospitals or nursing homes.

Section 1915(d) waivers relax restrictions that limit the number of elderly participants in a Section 2176 waiver program to the number that would actually have occupied a Medicaid nursing home bed. Thus, this waiver expands the number of enrollees eligible for these home or community-based services.

The *Medicare Catastrophic Coverage Act* of *1988* establishes Section 1915(e), a new waiver for "boarder babies" born drug dependent or infected with the acquired immunodeficiency syndrome *(AIDS)*. Section 1915(e) waivers allow states to cover these and selected other children who would otherwise require care in a hospital or nursing facility.

Finally, several statutes, most importantly Section 1115(a) of the *Social Security Act,* give the Secretary of HHS general authority to grant waivers to the states for Medicaid demonstration projects. A state may be exempted from the requirements normally imposed for the Medicaid program or may receive matching federal funds for expenditures on medical services or other activities not ordinarily eligible. For example, Arizona's entire Medicaid program (Arizona Health Care Cost Containment System) operates under such general waiver authority.[18] Table 2-3 shows the number and type of approved waivers in each state in 1988.

As in setting eligibility policy, states have considerable discretion in developing their service packages. There is significant variation across states in the type and amount of care provided due to federal matching of optional services, limits states can place on the coverage of services, and available waiver programs.

Table 2-3
Approved Waiver Programs, by State, 1988[1]

State[2]	Section 2175 Waiver Programs	Section 2176 Waiver Programs		Section 1115 Demonstration Waivers
		Regular Programs	Model Waivers	
Alabama		2		
Arizona				1
California	4	6	1	2
Colorado	1		1	
Connecticut	1	2	1	
Delaware		2		
Florida		5		1
Georgia		1	2	
Hawaii		4		1
Idaho		1	1	
Illinois	1	3	1	
Indiana		1		
Iowa			1	
Kansas	1	1		
Kentucky	1	2	1	
Louisiana		1		
Maine		2		
Maryland		2	1	1
Massachusetts		2		1
Michigan	2	1	1	
Minnesota	1	3	1	2
Mississippi		1		
Missouri	1	2		
Montana		2		
Nebraska		1		
Nevada	1	2		
New Hampshire		2		
New Jersey		3	1	2
New Mexico		4		
New York	1	1	1	4
North Carolina		2	1	
North Dakota		2		
Ohio		2	3	
Oklahoma		1		
Oregon	2	2		
Pennsylvania	1	2		
Rhode Island			1	
South Carolina	1	1		
South Dakota		1		
Tennessee	1	3		
Texas			1	3
Utah	1	1		
Vermont		3		
Virginia		1		
Washington	1	2		
West Virginia		2		
Wisconsin	1	3		1
Number of States with Programs	18	42	17	11
Number of Programs	23	87	20	19

[1] February 1988 for the 2175 and 2176 waivers; August 1988 for the 1115 Projects.

[2] There are no waiver programs in Alaska, Hawaii, and Wyoming.

Source: U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis,* Committee Print 100-AA, November 1988.

Table 2-4
Basic Reimbursement Methods for Medicaid Providers, by State

State	Hospital Inpatient (1989)	Nursing Homes: Skilled Nursing or Intermediate Care Facility (1987)	Nursing Homes: Intermediate Care Facility for the Mentally Retarded (1987)	Physicians (1989)	Hospital Outpatient (1987)
New England					
Connecticut	Prospective	Prospective	Prospective	Fee Schedule	Prospective
Maine	Prospective	Cost[2]	Prospective	Fee Schedule	Reasonable Cost
Massachusetts	Prospective	Prospective	Prospective	Fee Schedule	Prospective
New Hampshire	Prospective	Cost[2]	Prospective	Reasonable Cost	Reasonable Cost
Rhode Island	Prospective	Prospective	Prospective	Fee Schedule	Prospective
Vermont	Prospective	Prospective	Prospective	Fee Schedule	Reasonable Cost
Mideast					
Delaware	Cost	Prospective[3]	Prospective[3]	Fee Schedule	Reasonable Cost
District of Columbia	Prospective	Prospective	Prospective	Fee Schedule	Prospective
Maryland	Prospective	Prospective	Prospective	Fee Schedule	Prospective
New Jersey	Prospective	Prospective	Cost	Fee Schedule	Cost/Charge Ratio
New York	Prospective	Prospective	Prospective	Fee Schedule	Fee Schedule
Pennsylvania	Prospective	Cost	Cost	Fee Schedule	Fee Schedule
Great Lakes					
Illinois	Prospective	Prospective	Prospective	Fee Schedule	Fee Schedule
Indiana	Prospective/Cost[1]	Prospective	Prospective	Reasonable Cost	Reasonable Cost
Michigan	Prospective/Cost[1]	Prospective	Cost	Fee Schedule	Prevailing Cost
Ohio	Prospective	Cost	cost	Fee Schedule	Reasonable Cost
Wisconsin	Prospective	Prospective	Prospective	Fee Schedule	Prospective
Plains					
Iowa	Prospective	Prospective	Prospective	Fee Schedule	Reasonable Cost
Kansas	Prospective	Prospective	Prospective	Fee Schedule	Fee Schedule
Minnesota	Prospective	Prospective	Prospective	Fee Schedule	Prevailing Charges
Missouri	Prospective	Prospective	Prospective	Fee Schedule	Percentage of Cost/Charges
North Dakota	Prospective	Prospective	Prospective	Fee Schedule	Reasonable Cost
South Dakota	Prospective	Prospective	Prospective	Fee Schedule	Reasonable Cost
Southeast					
Alabama	Prospective	Prospective	Prospective	Fee Schedule	Fee Schedule
Arkansas	Prospective	Prospective	Cost	Fee Schedule	Fee Schedule
Florida	Prospective/Cost[1]	Prospective	cost	Fee Schedule	Prospective
Georgia	Prospective	Prospective	Prospective	Fee Schedule	Cost/Charge Ratio
Kentucky	Prospective/Cost[1]	Prospective	Prospective	Reasonable Cost	Percentage of Charges
Louisiana	Prospective/Cost[1]	Prospective	Prospective	Fee Schedule	Reasonable Cost
Mississippi	Prospective/Cost[1]	Prospective	Prospective	Fee Schedule	Reasonable Cost

Reimbursement of Providers

States use different payment approaches and standards to reimburse providers for services covered by Medicaid. Federal legislation establishes specific payment rules for only a few types of services, although federal regulations establish payment ceilings or other tests of reasonableness of state reimbursement methods for other services. Providers who participate must accept Medicaid reimbursement as payment in full, except for any beneficiary cost sharing provided for in state plans.

Before 1980, states were required to use the same reasonable cost system for Medicaid that Medicare used to pay for inpatient hospital and nursing home services—providers were reimbursed on the basis of actual costs incurred. (These services accounted for 68 percent of all Medicaid payments in 1989.) The *Omnibus Reconciliation Acts of 1980 and 1981* removed this requirement for nursing homes and hospitals, permitting states to pay amounts needed to finance economical and efficient institutions and to maintain beneficiaries' access to care. However, the aggregate annual amount spent by a state for inpatient hospital services may not exceed what would have been spent if the state used the current Medicare payment system.

Most states have moved to prospective payment systems for reimbursing hospitals and nursing homes. The payment for a unit of service (e.g., a day of care or a type of treatment) is established in advance, or payments are based on a percentage of actual costs or charges. States are re-

Table 2-4 (cont.)
Basic Reimbursement Methods for Medicaid Providers, by State

State	Hospital Inpatient (1989)	Nursing Homes: Skilled Nursing or Intermediate Care Facility (1987)	Nursing Homes: Intermediate Care Facility for the Mentally Retarded (1987)	Physicians (1989)	Hospital Outpatient (1987)
Southeast *(cont.)*					
North Carolina	Prospective	Prospective	Prospective	Fee Schedule	Percentage of Cost
South Carolina	Prospective	Prospective	Prospective	Fee Schedule	Percentage of Allowable Cost
Tennessee	Prospective	Cost	Cost	Prevailing Charges	Reasonable Cost
Virginia	Prospective/Cost[1]	Prospective	Cost	Fee Schedule	Reasonable Cost
West Virginia	cost	Prospective	Prospective	Fee Schedule	Fee Schedule
Southwest					
Arizona	not applicable				
New Mexico	Prospective/Cost[1]	Prospective	Prospective	Fee Schedule	Reasonable Cost
Oklahoma	Prospective	Prospective	Prospective	Fee Schedule	Percentage of Inpatient Per Diem Rate
Texas	Prospective	Prospective	Prospective	Reasonable Cost	Reasonable Cost
Rocky Mountain					
Colorado	Prospective	Prospective	Prospective	Fee Schedule	Percentage of Cost/Charges
Idaho	Prospective/Cost[1]	Cost	Cost	Fee Schedule	Reasonable Cost
Montana	Prospective	Prospective	Cost	Fee Schedule	Reasonable Cost
Utah	Prospective	Prospective	Cost	Fee Schedule	Percentage of Charges
Wyoming	Cost	Prospective	Prospective	Reasonable Cost	Reasonable Cost
Far West					
California	Prospective/Cost[1]	Prospective	Prospective	Fee Schedule	Negotiable/Fee Schedule
Nevada	Prospective	Prospective	Cost	Fee Schedule	Physician Fee Schedule
Oregon	Prospective	cost	Cost	Fee Schedule	Percentage of Allowable Cost
Washington	Prospective	Prospective	Prospective	Fee Schedule	Prospective/Fee Schedule
Alaska	Prospective	Prospective	Prospective	Reasonable Cost	Prospective
Hawaii	Prospective	Prospective	Prospective	Reasonable Cost	Negotiated

'Payment equals lesser of the two amounts.

[2] Prospective payment method was used for intermediate care facilities.

[3] Public nursing facilities are reimbursed using a cost method.

Sources: Hospital Inpatient Reimbursement—National Governors' Association, *Rural Hospitals* in *Evolution: State Policy Issues and Initiatives, 1989* (Washington, DC, 1990), Table 1.
Other Providers—U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis,* Committee Print 100-AA, November 1988.

quired to make additional payments to "disproportionate share" hospitals that serve higher than average numbers of Medicaid and low-income patients.

States can develop their own payment systems for physicians and other individual practitioners (8 percent of payments in 1989), but they generally base reimbursements either on prevailing or reasonable charges or on a maximum amount. Prevailing charges are generally determined by the method used for Medicare reimbursement, which reflects some percentile (usually the 75th) of the customary charges of all providers in an area for comparable services. States that set maximum amounts for reimbursement use either (1) fee schedules that specify a flat maximum payment for each type of service or (2) relative value scales that assign each service a specific weight, which is then multiplied by a fixed dollar amount.

States use reasonable cost, fee schedule, prospective payment, and other methods to reimburse hospital outpatient services (5 percent of total vendor payments in 1989). Reimbursements may not exceed the amount that would have been paid by Medicare, which uses a reasonable cost basis for these services.[19] However, in *The Omnibus Budget Reconciliation* Act of 1990, the Congress also added teeth to the so-called Boren Amendment, which requires that federally qualified health centers (FQHC), nursing homes, and community health centers be reimbursed for all reasonable costs of services required to attain or maintain the well-being of each Medicaid-eligible resident.[20] This will most likely increase the upward pressure on Medicaid expenditures. Table 2-4 summarizes, by state, the basic reimbursement methods for the four types of providers discussed above.

Medicaid regulations establish aggregate limits on payments for prescription drugs (7 percent of total 1989 payments), with separate limits for multiple-source drugs (those for which therapeutic equivalents are available from at least three manufacturers) and all others. A state's total spending on multiple-source drugs during a given period may not exceed the price limits, set by HCFA at 150 percent of the estimated wholesale cost of the least expensive therapeutic equivalent plus a reasonable dispensing fee. For all other drugs, aggregate statewide payments may not exceed the lesser of the state-estimated acquisition cost of ingredients plus a reasonable dispensing fee or the pharmacies' usual and customary charge. In addition, OBRA 1990 requires that drug manufacturers enter into rebate agreements with HHS for prescription drugs reimbursed under Medicaid and denies matching funds to states that cover products not governed by such an agreement.

Federal Medicaid law specifies payment rules for only a few other services, including rural health clinics, laboratories, and hospice care. Payment for these services must generally follow Medicare rules.

Reimbursement is one tool available to states to control Medicaid costs. Hospitals and other providers in many states, however, have complained that Medicaid reimbursements do not cover their costs, and the U.S. General Accounting Office (GAO) recently found that "the methods used by most states indicated an attempt to pay providers less than going market rates."[21] In addition, low fees have been responsible in part for low physician participation in the Medicaid program.[22] In June 1990, the U.S. Supreme Court ruled in Wilder v. *Virginia Hospital* Association that hospitals, nursing homes, and other providers have the right to sue directly in federal court for higher payments. (Hospitals and nursing facilities sued and won in state and federal courts prior to *Wilder*.) Such suits could result in states being required to raise their reimbursement levels for certain types of providers. For example, in July 1991, a federal judge ruled that the Medicaid program in Washington State did not meet the "reasonable and adequate" standard and ordered increased payments for participating hospitals.

Medicaid Financing

Medicaid is financed jointly by the federal government and the states through federal matching grants for covered state expenditures. The grants are based on a variable matching formula, which provides a higher rate to states with lower per capita incomes.[23] *Also,* the grants are open-ended, that is, there is no limit on the amount of allowable state costs that can be matched. By law, the state matching rates can range from 50 to 83 percent. The highest rate at present is 79.99 percent; this will decrease to 79.01 percent in FY 1993 (see Table 2-5).[24] Administrative costs are matched at 50 percent for all states. Selected administrative costs are matched at higher rates, including, for example, 75 percent for the compensation and training of professional medical personnel and support staff to administer the program, 90 percent for developing and 75 percent for operating automated claims processing systems, and 100 percent for implementing and operating an immigrant status verification system."

Medicaid is funded almost entirely out of federal and state general funds, unlike Medicare, which receives insurance premiums and earmarked taxes. States may require local governments to share in up to 60 percent of the nonfederal costs of the program, and as of 1986, 15 did so.[26] The local funding formulas, as of 1986, are shown in Table 2-6.[27]

The original Medicaid legislation prohibited cost sharing (i.e., deductibles, coinsurance, enrollment fees, copayments, and premiums) for inpatient hospital services for all persons eligible for Medicaid. The law permitted cost sharing for other services based on the recipient's income and resources, thus effectively exempting the categorically needy. The 1972 *Social Security Amendments* and TEFRA 1982 changed the options, and the states may require small amounts of *cost* sharing for nearly all services, mandated or optional, provided to the categorically and medically needy. As of January 1, 1991, 26 states and the District of Columbia had copayment programs.

Provider Assessments

In 1985, the states were given greater flexibility in raising their share of Medicaid funds. The states believe they should be allowed maximum flexibility in determining how the state share will be raised. Several states use provider assessments, which may be specific taxes on providers of medical services or donations or voluntary contributions by these providers. The states view provider assessments as a legitimate financing technique. The Office of Management and Budget and the Department of Health and Human Services consider provider assessments to be a scheme to increase the federal share of the overall costs of the Medicaid program while limiting further financial commitment on the part of a state.[28] As a result, HCFA has tried repeatedly to limit the states' use of this financing technique. In each instance, the Congress intervened on behalf of the states and issued a moratorium precluding HCFA's action. In 1991, however, the Congress passed legislation that will ban voluntary contributions and severely restrict provider taxes and intergovernmental transfers.

The new legislation prohibits states from obtaining federal Medicaid matching funds for money donated by hospitals or other health care providers. States will be allowed to levy and obtain matching payments for taxes on health care providers, but the taxes in most cases may not account for more than 25 percent of Medicaid expenditures. The 25 percent cap will expire after three years. The legislation also imposes a cap of 12 percent of expenditures on the amount states may pay to hospitals that serve a "disproportionate share" of Medicaid and other low-income patients.[29]

Who Pays. Provider assessments apply to or for hospitals; nursing homes; community health clinics; home health care operations; doctors, dentists, and pharmacists; and prescription drugs. Programs vary significantly from state to state and, in some instances, may pertain to all health care providers. In fiscal year 1991, 23 states had provider tax pro-

Table 2-5

Federal Medicaid Assistance Matching Ratios, Selected Fiscal Years, 1966-1993

State	1966	1971	1976	1981	1986	1991	1992	1993e
New England								
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Maine	69.57	68.33	70.60	69.53	68.86	63.49	62.40	61.81
Massachusetts	50.00	50.00	50.00	51.75	50.00	50.00	50.00	50.00
New Hampshire	61.31	59.18	60.28	61.11	54.42	50.00	50.00	50.00
Rhode Island	56.13	51.70	56.55	57.81	56.33	53.74	53.29	53.64
Vermont	68.44	64.96	69.82	68.40	67.06	61.97	61.37	59.88
Mideast								
Delaware	50.00	50.00	50.00	50.00	50.00	50.00	50.12	50.00
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New York	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Pennsylvania	54.38	54.60	55.39	55.14	56.72	56.64	56.84	55.48
Great Lakes								
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	55.77	5285	57.47	57.28	6282	63.24	63.85	63.21
Michigan	50.31	50.00	50.00	50.00	56.79	54.17	55.41	55.84
Ohio	52.33	52.42	53.39	55.10	58.30	59.93	60.63	60.25
Wisconsin	57.60	55.21	59.91	57.95	57.54	59.62	60.38	60.42
Plains								
Iowa	60.39	55.27	57.13	56.57	58.90	63.41	65.04	62.74
Kansas	61.45	57.78	54.02	53.52	50.00	57.35	59.23	58.18
Minnesota	60.46	56.95	56.84	55.64	53.41	53.43	54.43	54.93
Missouri	53.90	59.29	58.98	60.36	60.62	59.82	60.84	60.26
Nebraska	60.39	57.25	55.59	57.62	57.11	62.71	64.50	61.32
North Dakota	66.67	70.48	57.59	61.44	55.12	70.00	72.75	72.21
South Dakota	71.05	69.91	67.23	68.78	67.82	71.69	72.59	70.27
Southeast								
Alabama	79.85	78.54	73.79	71.32	72.30	72.73	72.93	71.45
Arkansas	81.67	79.76	74.60	72.87	73.83	75.12	75.66	74.41
Florida	65.21	64.10	57.34	58.94	56.16	54.46	54.69	55.03
Georgia	74.91	71.48	66.10	66.76	66.05	61.34	61.78	62.08
Kentucky	76.70	74.30	71.37	68.07	70.23	72.96	72.82	71.69
Louisiana	76.41	73.57	72.41	68.82	63.81	74.48	75.44	73.71
Mississippi	83.00	83.00	78.28	77.55	78.42	79.93	79.99	79.01
North Carolina	75.58	73.96	68.03	67.64	69.18	66.60	66.52	65.92
South Carolina	81.30	78.68	73.58	70.97	72.70	72.58	72.66	71.28
Tennessee	76.86	74.62	70.43	69.43	70.20	68.57	68.41	67.57
Virginia	66.96	65.04	58.34	56.54	53.14	50.00	50.00	50.00
West Virginia	74.27	75.73	71.90	67.35	71.53	77.00	77.68	76.29
Southwest								
Arizona	63.94	66.42	60.48	61.47	62.28	61.72	62.61	65.89
New Mexico	70.73	71.48	73.29	69.03	68.94	73.38	74.33	73.85
Oklahoma	70.32	68.84	67.42	63.64	57.60	69.65	70.74	69.67
Texas	67.27	65.66	63.59	58.35	53.56	63.53	64.18	64.44
Rocky Mountain								
Colorado	53.08	56.24	54.69	53.16	50.00	53.59	54.79	54.42
Idaho	70.73	68.91	68.18	65.70	69.36	73.65	73.24	71.20
Montana	62.86	64.72	63.21	64.28	66.38	71.73	71.70	70.92
Utah	66.30	68.23	70.04	68.07	7262	74.89	75.11	75.29
Wyoming	55.47	60.38	60.94	50.00	50.00	68.14	69.10	67.11
Far West								
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Nevada	50.00	50.00	50.00	50.00	50.00	50.00	50.00	52.28
Oregon	54.12	56.35	59.04	55.66	61.54	63.50	63.55	62.39
Washington	50.81	50.00	53.72	50.00	50.06	54.21	54.98	55.02
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Hawaii	52.97	50.75	50.00	50.00	51.00	54.14	52.57	50.00

e—estimate

Note: The federal Medicaid matching ratio (FMAP), vanes from a minimum of 50 percent to a maximum of 83 percent. FMAP = 100 percent - state share. State share = [(state per capita personal income)^2/(U.S. per capita personal income)]^2 X 45 percent.

Source: U.S. Department of Health and Human Services, Health Care Financing Adminstration, *Medicaid Data* Book, *1988,* Table 4.19; *Medicare and Medicaid Data Book, 1990,* Table 4.9; and *Federal Funds Information for States,* Issue Brief, September 12, 1991, p. 7.

Table 2-6
Local Funding Formulas for Medicaid Vendor Payments
(March 31, 1986)

Arizona	Counties pay 22.5 percent of the cost of Arizona Health Care Cost Containment System. This statewide Medicaid demonstration project exempts the state from federal restrictions on local matching.
Colorado	The 20 largest counties pay 2 percent of the state's share for all new ICF nursing home admissions.
Florida	Counties pay 35 percent of cost or $55 per month, whichever is less, for each nursing home resident; 35 percent of cost for inpatient hospital days over 12 and less than 46.
Iowa	Counties match federal funds for ICF/MRs.
Minnesota	Counties pay 10 percent of the state's share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 4.67 percent of total expenditures.
New Hampshire	Local contribution of approximately 25 percent of nursing home costs, excluding residents in state institutions.
New York	Counties pay 50 percent of the nonfederal share, except for long-term care for which they pay 28 percent of nonfederal share, 20 percent in 1986.
North Carolina	Counties pay 15 percent of the nonfederal share for all services.
North Dakota	Counties pay 15 percent of the state share except for ICF/MRs, clinic services, and waivered community and home-based services for MR and A/D- related recipients.
Pennsylvania	Counties pay 10 percent of the state's share for county nursing homes plus $3 per invoice administration fee.
South Dakota	$60 per month for each ICF/MR resident and local school district for crippled childrens' hospital.
Utah	Local contribution of less than 1 percent for specific services (e.g., mental health).
Wisconsin	Local contribution of 10-20 percent for mental health services.

Sources: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Program Statistics: Analysis of State Medicaid Program Characteristics, 1986* (Washington, DC, August 1987); and Bruce Spitz, "The Medicaid Local Match: A Guide to Diffusing a Fiscal Time Bomb," *County Health* Report *(NACo) 2* (February 4, 1991).

Table 2-7
Provider Assessments, 1991
(in millions)

Provider Tax	Amount	Donation	Amount
Alabama	$174	California	$65
Arkansas	20	Florida	85
Florida	174	Georgia	88
Illinois	275	Maryland	1
Indiana	88	Michigan	452
Kentucky	181	Missouri	160
Massachusetts	490	Mississippi	39
Maryland	142	North Carolina	67
Maine	85	Pennsylvania	565
Minnesota	52	South Carolina	84
Mississippi	20	Utah	5
Montana	2		
New Hampshire	35		
New Jersey	51		
Nevada	60		
New York	341		
Ohio	400		
South Carolina	40		
Tennessee	344		
Vermont	7		
Washington	35		
Wisconsin	16		

Source: American Public Welfare Association, Voluntary Contributions and Provider-Specific Taxes Survey Results, 1991.

grams, yielding an estimated $2.9 billion in state funds with a federal match of $4.4 billion. Eleven states had voluntary contribution programs, producing an estimated $1.7 billion in state funds with a federal match of $2.3 billion[30] (see Table 2-7).

How the Programs Operate. Although programs vary, the general pattern is for a state to impose a specific tax on a Medicaid provider or accept a voluntary donation from a hospital, nursing home, doctor, or other medical service provider participating in the program. The revenue from the tax or the donation is used to pay the state share of Medicaid, triggering a federal matching amount. (The state share is between 21 percent and 50 percent of total costs, depending on the federal matching.) Thus, both the state outlay and the federal match are returned to Medicaid providers as program expenditures, with the federal outlay representing net additional spending. How much of a "return on investment" is generated by the health care provider may depend on whether the tax revenues or donations "contribute to a fund that is used directly to obtain the federal match with contributions proportional to Medicaid business . . ." or go to the state's general fund, in which case the allocation of total funds (state and matching federal) to a particular provider may be less certain.[31]

There are some interesting variations among existing or proposed state programs. In Florida, for example, to compensate for the fact that a small number of hospitals handles most Medicaid patients, the state imposes a tax on all net hospital revenues to reimburse Medicaid providers. Maryland raised the allowable Medicaid fees for health

care providers and then imposed a tax to recapture the fee increase. Pennsylvania is considering a plan to permit provider donations to be borrowed on behalf of its counties rather than requiring that they be made in cash. Massachusetts recouped nearly $500 million for expenditures through its uncompensated care fund for Medicaid eligibles, some of which were made almost three years ago. In the District of Columbia, most of the revenue from a proposed provider tax would be used to leverage a federal Medicaid match, but part of the yield would be devoted to other health purposes.[32]

Impact on Federal Medicaid Costs

As noted earlier, provider assessments produced approximately $6.7 billion in additional federal Medicaid outlays in 1991. A recent OMB-HHS report projects that total Medicaid spending will increase from approximately $72 billion to over $200 billion by 1996. OMB and HHS estimate that the federal share could equal $120 billion, or approximately 60 percent.[33]

The state revenues raised by provider assessments are particularly needed in light of Medicaid expansions recently mandated by the federal government and the continuing health care cost inflation that characterizes the program. Some of the specific intergovernmental issues raised by provider assessments will be considered in a later section.

Medicaid Administration

States are responsible for developing and administering their Medicaid programs within federal guidelines. To receive matching funds, states must have a federally approved plan for basic eligibility, coverage, and reimbursement. The plan must also detail administrative procedures, such as processing claims (many states contract with private "fiscal agents" to perform this function), detecting errors and fraud and abuse, reviewing service utilization, and maintaining a system to collect program information and complete reports required by the federal government. Most states were required to have such a Medicaid Management Information System (MMIS) by 1985.

As of 1986, six states delegated some program administration to local agencies, but the state maintains responsibility for overall policy determination. According to the National Association of Counties, all such local agencies are county agencies. Local administration might include eligibility determination, claims processing, and contracting with providers.

Federal law sets standards and certification procedures for institutional providers, such as hospitals and nursing facilities. For example, OBRA 1987 contained a major revision of Medicaid policy on nursing home standards, survey review and certification procedures, and sanctions. States administer their own licensing and monitoring programs for other kinds of providers.

Changes in Medicaid

Since its enactment, Medicaid has undergone frequent and significant changes. The major federal changes are summarized in the Appendix. There also have been numerous state changes.[34] This section will focus on some of the issues raised by these changes for the intergovernmental structure of Medicaid.

Federal Program Expansions

Enacted as a program to give recipients of cash assistance access to mainstream medicine, Medicaid has expanded to serve additional population groups and to cover a broader range of services.

Population Groups

AFDC and SSI recipients are still the primary groups served by Medicaid. However, the proportion of categorically needy Medicaid clients actually receiving cash assistance payments declined, from 75 percent in 1979 to less than 70 percent in 1989.

Over time, federal provisions have expanded Medicaid eligibility. For example:

- A 1982 provision allowing states to extend Medicaid to certain disabled children under 18 living at home who would be eligible for SSI if they were institutionalized;
- The 1984 requirement that states provide Medicaid coverage to first-time pregnant women, pregnant women in two-parent unemployed families, and children in two-parent families meeting the income and resource criteria for AFDC, even if they would not otherwise be covered under a state's AFDC program;
- The 1985 requirement that states extend Medicaid coverage to all pregnant women in families meeting AFDC income and resource standards, including those in two-parent families where the principal earner is not unemployed; and
- The 1986 requirement that states continue Medicaid coverage for certain disabled SSI recipients who lose their eligibility due to earnings from work.

An even further departure from the original principle of linking Medicaid eligibility to the categorical cash assistance programs occurred when The Omnibus Budget and Reconciliation Act of 1986 allowed states to extend eligibility to all pregnant women, infants, and children up to age 5 in families with incomes up to 100 percent of poverty, without regard to their eligibility for cash assistance. The legislation also made elderly and disabled individuals with incomes up to 100 percent of poverty eligible for Medicaid, as long as they met the SSI asset test.

Other recent expansions in eligibility require states to cover pregnant women, infants, and children up to age 6 in families with incomes up to 133 percent of poverty, and children born after September 30, 1983, up to age 18 in families with incomes up to 100 percent of poverty. States have the option of covering pregnant women and infants up to 185 percent of poverty. Elderly and disabled individuals with incomes below 100 percent of poverty, who are qualified for Medicare, are now also covered by Medicaid

because the states are required to buy them into Medicare and to pay any applicable cost-sharing amounts. The incremental expansion of Medicaid eligibility to a broader range of groups has been described by some observers as steps in an implicit policy of using the Medicaid program to achieve universal health insurance for the low-income population. The eligibility expansions have created numerous categories of Medicaid recipients, contributing to complex application procedures and program administration.

Services

Just as the Medicaid target populations expanded, so, to some extent, did services. For example, nurse-midwife services were required to be covered in 1980. Since the program began, ICF/MR, hospice, and case management have been added to the list of optional services available for federal reimbursement. The program also has expanded required services for certain groups. For example, in 1989, federal legislation required that all medically necessary services identified through **EPSDT** screens be provided to those children, whether or not the state covers such services under its Medicaid program.

More significantly from a cost standpoint, Medicaid has come to be a major provider of certain services in the overall health care system. For example, Medicaid is the largest third-party payer, public or private, for nursing home services (including ICF/MR) and, along with Medicare, one of the two largest payers for home health care. Some of the services for which Medicaid is a major payer are also the ones with the most rapidly rising costs (see Chapter 3).

These examples point up the changing emphasis of Medicaid from financing traditional medical services to financing the fast-growing, less traditional areas of health care. Illustrative of the shift to these types of services are the authorization of 2176 waivers for home and community-based long-term care in 1981 and a program for home and community-based care for the frail and immobile elderly and developmentally disabled in 1990. Medicaid is also a significant provider of *specialized* services to the mentally retarded, mentally ill, and developmentally disabled. For example, eligible individuals in ICF/MRs are entitled to all Medicaid services, mandatory and optional, within the state.

Federal Options and Requirements

As Medicaid has evolved, numerous federal legislative and regulatory options and requirements have been added. Optional expansions allow targeted coverage to high priority groups and for the most needed services.

Options

Options allow the states to receive matching funds for certain aspects of their programs, such as an optional service or extending eligibility to an optional population, if they conform to federal specifications. For states that provided an option before it became part of the Medicaid program, such a change allowed them to be reimbursed for a portion of their costs. The changes also made it possible for other states to provide the option at less cost than without federal matching funds.

Some Medicaid provisions that began as options became requirements. For example, coverage of pregnant women and infants up to 100 percent of poverty became an option in 1986 and a requirement in 1988. Likewise, a Medicare "buy-in" for elderly and disabled individuals below 100 percent of poverty became optional in 1986 and required in 1988. This phenomenon of Medicaid options becoming requirements has been dubbed the "option-mandate two-step."

Mandates

Because the federal government matches state Medicaid costs, most new requirements take the form of conditions a state program must meet to continue to receive federal funds." New requirements have affected all areas of the program, including eligibility and service coverage, provider certification and reimbursement, and administrative requirements.

These new requirements have implications for state costs, policy flexibility, and administration. The requirements often cause states to incur new costs to meet revised program conditions. This can be a significant burden, particularly in periods of fiscal stringency. For example, the National Association of State Budget Officers (NASBO) estimates that Medicaid expansions enacted since 1988 will cost the states an additional $2 billion in fiscal 1991 and $17.4 billion through 1995.[36] Costly mandates also reduce budgetary flexibility because state revenues must be dedicated first to meeting the federal Medicaid requirements. Thus, in 1989, 48 governors signed a resolution calling for a two-year moratorium on further Medicaid mandates, based on their "increasing concern with the impact of the last three years of Medicaid mandates on our budgets, and, consequently, on our ability to properly fund education and other important services."[37] When additional requirements were enacted in 1989 and 1990, the National Governors' Association (NGA), in a resolution passed at its Winter 1991 meeting, called for the Congress to "delay the mandated implementation of the 1990 mandates for two years."[38]

Closely related to the issue of mandate costs is the argument that expanding Medicaid requirements reduces state discretion in service provision within and outside the Medicaid program. Resources, budgetary and otherwise, must be directed first to satisfying the federal requirements. An example of federal requirements reordering state priorities occurred in California, which, rather than enact the nursing home reforms in OBRA 87, passed a bill that "was believed to offer a superior option compared to further program expansion under OBRA 87."[39] HCFA rejected California's Medicaid plan due to its alleged failure to implement the OBRA 87 nursing home reforms. California amended its plan to include the OBRA provisions. In another example, GAO found that federal requirements to expand Medicaid eligibility and services to pregnant women and children had improved the access of these groups to the program but had also eroded Medicaid

benefits in some of the more generous states, thus leading to more program uniformity across the states.[40]

Frequent changes to federal Medicaid requirements also present administrative difficulties for states. Recent legislation has required implementation regardless of promulgation of regulations. For example, the nursing home reforms of OBRA 87 were to become effective October 1, 1990, but by that date, HCFA had not published all of its final regulations. States, therefore, are implementing federal statutes without guidance from HCFA at the risk of losing federal funds or having to redesign programs when regulations are published months or years later.

State programs and systems have to be revised continually and workers have to be retrained and computer systems redesigned. In addition, future changes may supersede past legislation. For example, the 1988 *Medicare Catastrophic Coverage Act* required states to extend Medicaid eligibility to pregnant women and infants up to 75 percent of poverty by July 1, 1989, and up to 100 percent of poverty by July 1, 1990, but OBRA 89 required states to raise the eligibility levels for these groups to 133 percent of poverty by April 1990.

The costs associated with these changes are often substantial. Thus, NGA expressed in its 1991 resolution on short-term medicaid policy that "states must not be expected to implement any Medicaid program changes until the Health Care Financing Administration (HCFA) has published final regulations to guide program administration."[41]

State Program Changes

States establish their Medicaid programs within federal guidelines. Thus, the states have a significant degree of control over eligibility criteria, service options, provider standards and reimbursement methods, and local participation. Consequently, there is considerable diversity among state Medicaid programs and costs.

Many states (and local governments) have used Medicaid as a vehicle to expand medical services to needy populations. For example, in the 1980s, many states supported federal options to raise eligibility levels for pregnant women and children and waivers to expand home and community-based care, and they added those elements to their programs.

States also are concerned about controlling Medicaid costs. Because Medicaid is an entitlement program, costs cannot be controlled directly. Rather, within the constraints set by the federal government, states must use the elements of the program (e.g., eligibility, services, payment methods) as policy levers to expand or contract the overall costs of the program. For example, according to NGA, during the 1981-82 recession, states took actions to reduce program costs by using a "continuum of cuts," which ranged in seriousness from administrative changes through cuts in optional services, instituting copayments, and reforming payment systems to cuts in eligibility.[42] Currently, many states are finding it necessary to cut services. For example, Arkansas cut back on a number of options, including its adult medically needy program, which was a major service. Missouri made cuts in podiatry and dental services. Michigan made across-the-board reductions in the program and is considering deleting certain optional services entirely.[43]

SUMMARY

- Medicaid was enacted to serve certain groups of people enrolled in cash assistance programs. Medicaid coverage has been expanded to include groups whose eligibility is based on a percentage of income below or above the poverty level. Medicaid has never provided universal coverage for the low-income population.
- The intent of the Medicaid program was to improve access to mainstream medical care for those eligible. Medicaid has become a major vehicle for providing some of the fast-growing, less traditional types of health care, such as nursing home services and home health care.
- Medicaid policymaking, financing, and administration are shared between the federal and state governments (and local governments in 14 states). Within federal guidelines, there is considerable diversity across states in eligibility criteria, covered services, reimbursement methods, and local financing and administration. States use these elements of the program as levers to accomplish policy and cost objectives. Waivers provide some opportunities for state innovation.
- The Medicaid program has undergone frequent change, including the addition of federal options and requirements affecting states. Such options and requirements have had significant cost, flexibility, and administrative implications for the states.

Notes

[1] See, for example, Frank A. Sloan, "State Discretion in Federal Categorical Assistance Programs: The Case of Medicaid," *Public Finance Quarterly* 12 (July 1984): 321-346; Charles J. Barrilleaux and Mark E. Miller, "The Political Economy of State Medicaid Policy," *American Political Science Review* 82 (December 1988): 1089-1107; and U.S. General Accounting Office, *Medicaid: Interstate Variations in Benefits and Expenditures* (Washington, DC, 1987), p. 7.

[2] U.S. Advisory Commission on Intergovernmental Relations, *Intergovernmental Problems in Medicaid* (Washington, DC, 1968), ch. 11.

[3] This section relies on U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis*, Committee Print 100-AA (Congressional Research Service), November 1988.

[4] The Supplemental Security Income (SSI) program, enacted in 1974, replaced the programs of Old Age Assistance, Aid to the Blind, and Aid to the Partially and Totally Disabled.

'Countable income is defined as family income from all sources less child care allowances (up to $175 per month per child over age 2 and up to $200 per month per child under age 2), work related expenses ($90 per month), and the first $30 per month of earnings and one-third of the remainder. *Social Security Bulle-*

tin: Annual Statistical Supplement, 1991 54 (December 1991): 85-87.

[6] As of October 1, 1991, 12 states exercised the 209(b) option; 31 states and the District of Columbia provided automatic Medicaid coverage to SSI recipients who received state supplementary payments only.

'The 1967 amendments to the Social Security Act established a maximum income level for federal financial participation in the cost of medical assistance to the medically needy of 133-1/3 percent of the maximum cash assistance level, after deducting medical expenses.

[8] *Medicaid Source Book,* p. 70.

[9] For example, Jerry Cromwell, Sylvia Hurdle, and Gerard Wedig also cite rigorousness of eligibility certification as a tool for controlling enrollment in "Impacts of Economic and Programmatic Changes on Medicaid Enrollments," *The Review of Economics and Statistics 68* (1986): 232-240.

[10] Includes Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF). The *Omnibus Reconciliation Act of 1987* eliminated the programmatic distinction and payment differentials between SNFs and ICFs, as of October 1, 1990. Prior to this law, SNF services were mandatory but ICF services were optional.

"See *United States Code,* Sections 1396-1396u, Subchapter XIX, Chapter 7, Title 42, 1902(a)(10) pp. 1043-1044.

[12] As of December 1986, 22 states had restrictions on inpatient hospital length of stay; 29 limited the number of physicians' visits.

[13] This section relies on *Medicaid Source Book,* Chapter V.

[14] *Medicine and Health Perspectives,* October 7, 1991.

[15] Ibid.

[16] Emily Friedman, "Medicaid Overload Sparks a Crisis," *Hospitals* 52 (January 10, 1987): 51.

"States have considerable leeway in determining eligibility criteria for Medicaid and in setting reimbursement schedules for medical care providers. In some cases, states will set rigid eligibility criteria but offer a high number of optional services and set reimbursement rates at a reasonable level so that medical care providers will take Medicaid patients. Other states will have generous eligibility criteria so that large numbers are eligible for Medicaid, but they either offer a limited number of optional services or set reimbursement rates so low that many medical care providers will not participate. See Friedman, pp. 51-52; and Robert Pear, "Low Medicaid Fees Seen as Depriving the Poor of Care," *New York Times,* April 2, 1991.

[18] The authority of the Secretary of Health and Human Services to grant such waivers comes from section 1115(a) of the *Social Security Act.* The approval of such waivers is at the discretion of the Secretary.

[19] The Medicare reasonable charge for a specific service to a specific patient is the lowest of (a) the provider's actual charge for that service; (b) the provider's customary charge for comparable services; or (c) the prevailing charge in the area for comparable services.

[20] OBRA 90 required states to take into account the costs of maintaining practicable client functioning in a nursing facility. For FQHC, OBRA 90 required 100 percent reasonable cost reimbursement when the FQHC subcontracts with an HMO.

[21] U.S. General Accounting Office, *Medicaid: Interstate Variations in Benefits and Expenditures,* p. 3.

[22] Numerous factors, in addition to reimbursement levels, affect physician participation in Medicaid. These include physician characteristics, the number and type of physicians in an area, population characteristics, and various other aspects—including administrative hassle—of each state's Medicaid program. See Physician Payment Review Commission, *Annual Report to Congress: 1990* (Washington, DC, March 1990), ch. 16.

[23] The formula for determining a state's matching rate, or Federal Medical Assistance Percentage (FMAP) is:

$$\text{FMAP} = 100 \text{ percent} - \text{state share}$$

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times 45 \text{ percent}$$

[24] The FMAPs are recalculated annually based on the average per capita income for the three most recent years of data. For example, the FMAPs in effect for FY 1992 are based on 1987, 1988, and 1989 data.

[25] See *Medicaid Source* Book, p. 199.

[26] Only New York and Arizona approach the 60 percent maximum, according to Bruce Spitz, "The Medicaid Local Match: A Guide to Diffusing a Fiscal Time Bomb," *County Health Report* (NACo) 2 (February 4, 1991).

[27] Little information is available on local government participation in Medicaid. Both the National Association of Counties and the National Association of County Health Officials are undertaking surveys to gather data on the administrative and financial role of counties in the program.

[28] See Ellen Perlman, "Feds Call States' Medicaid Donations 'Scam,'" *City and State,* June 17, 1991.

[29] *Congressional Quarterly Weekly Report,* November 30, 1991, p. 3531.

[30] American Public Welfare Association, Voluntary Contributions and Provider Specific Taxes Survey Results, 1991.

[31] *State Policy Reports* 9 (June 1991, Pt. 1): 18.

[32] See Lawrence J. Haas, "Creative Financing," *National Journal* 23 (July 20, 1991): 1806-1807, Perlman, p. 31, and *State Policy Reports* 9 (July 1991): 14.

[33] S. Rich, "Task Force Says Medicaid Costs May Reach $200 Billion in 1996," *Washington Post,* July 11, 1991.

[34] Two good sources of information on state Medicaid program changes are National Governors' Association, State Medicaid Program Information Center, *A Catalogue of State Medicaid Program Changes* (updated periodically); and Intergovernmental Health Policy Project, *Major Changes in State Medicaid and Indigent Care Programs* (annual) and *State Health Notes* (monthly)

[35] Others impose requirements on providers, such as the 1990 legislation requiring that drug manufacturers enter into rebate agreements with HHS, or participants.

[36] Statement of Raymond C. Scheppach, Executive Director, National Governors' Association, before the House Budget Committee regarding State Fiscal Conditions, June 13, 1991.

[37] NGA letter to Members of Congress, August 1, 1989.

[38] National Governors' Association, Resolution on Short-Term Medicaid Policy, Sect. 27.1, passed February 5, 1991.

[39] NGA, *Governors' Budget Summary, 1991-92,* p. 75.

[40] GAO briefing to ACIR representatives, December 17, 1990.

[41] NGA, Resolution on Short-Term Medicaid Policy.

[42] Meeting with John Luehrs, NGA, January 15, 1991.

[43] NGA Task Force on Health Care, Governors' Roundtable Discussion on Restructuring Medicaid, February 3, 1991. (The Arkansas service reductions were reversed when additional revenues were collected through a new provider tax program.)

3. TRENDS IN THE MEDICAID PROGRAM

This chapter addresses the growth of the Medicaid program by looking at trends in Medicaid expenditures and recipients, including payments by type of recipient and by type of service. Several factors have affected the growth of the program—including inflation, changes in service population, and changes in the utilization of medical services by Medicaid recipients. Each of these factors will be considered.

MEDICAID IN RELATION TO THE OVERALL HEALTH CARE SYSTEM

Since its inception, Medicaid has grown into one of the major health care programs in the United States, accounting for more than **10** percent of all health care spending since **1975** and serving about 10 percent of the population. Total Medicaid expenditures grew from **$1.3** billion in **1966** to **$75.2** billion in **1990.** Table **3-1** shows the growth of Medicaid expenditures in relation to total health care expenditures.[1]

Table **3-2** shows the growth of total Medicaid vendor payments in current and constant dollars, relative to all personal health care expenditures. Over the life of the program, Medicaid vendor payments have grown by **1,681** percent, or **14.7** percent per year on average. Much of that growth is attributable to general inflation and inflation in medical care prices, which has generally been higher. In constant dollars, Medicaid has grown by **311** percent (7.0 percent per year on average), while total personal health care expenditures have grown by **134** percent **(4.1** percent per year annual average **growth).**[2] This near-constant growth in deflated dollars illustrates that increases in total Medicaid expenditures have generally outpaced even medical care inflation; from **1969-1990,** the only annual decline in constant dollar expenditures occurred between **1981** and **1982.** However, Figure **3-1** shows that the rate of growth in total Medicaid expenditures was slightly lower than that for Medicare expenditures but significantly greater than growth in other government-financed personal health care expenditures and total personal health care expenditures from **1966** to **1990.**

In 1990, Medicaid was the fourth largest source of funds for medical services. Private health insurance financed **31.8** percent of all personal health care, individuals financed **23.3** percent through out-of-pocket payments,

Table 3-1
Medicaid Expenditures Relative to Total Health Care Expenditures, 1966-1990[1]

	Total Medicaid Expenditures (millions)	Total Health Care Expenditures (millions)	Medicaid as Percent of Total Health Care
1966	$1,323	$45,860	29%
1967	3,193	51,655	6.2
1968	3,613	58,478	6.2
1969	4,267	65,739	6.5
1970	5,415	74,377	7.3
1971	6,845	82,331	8.3
1972	8,472	92,307	9.2
1973	9,599	102,467	9.4
1974	11,280	116,070	9.7
1975	13,696	132,944	10.3
1976	15,476	152,168	10.2
1977	17,756	172,037	10.3
1978	19,782	193,382	10.2
1979	22,668	216,604	10.5
1980	26,411	249,054	10.6
1981	30,679	288,554	10.6
1982	32,467	323,792	10.0
1983	35,671	356,114	10.0
1984	38,411	386,995	9.9
1985	42,204	420,058	10.0
1986	45,676	452,294	10.1
1987	51,335	492,498	10.4
1988	55,602	543,994	10.2
1989	63,464	604,134	10.5
1990	75,200	666,200	11.3

[1]Total health care expenditures include amounts spent for research, construction, public health activities, and program administration, as well as direct payments for medical services.

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of National Cost Estimates.

Medicare financed **18.6** percent, and Medicaid financed **12.2** percent. The remainder, **14.1** percent, was financed through other federal, state, and local programs. While Medicaid represented **12.2** percent of personal health care spending on average, it accounted for **11.1** percent percent of hospital care, **9.0** percent of drugs and other

Table 3–2

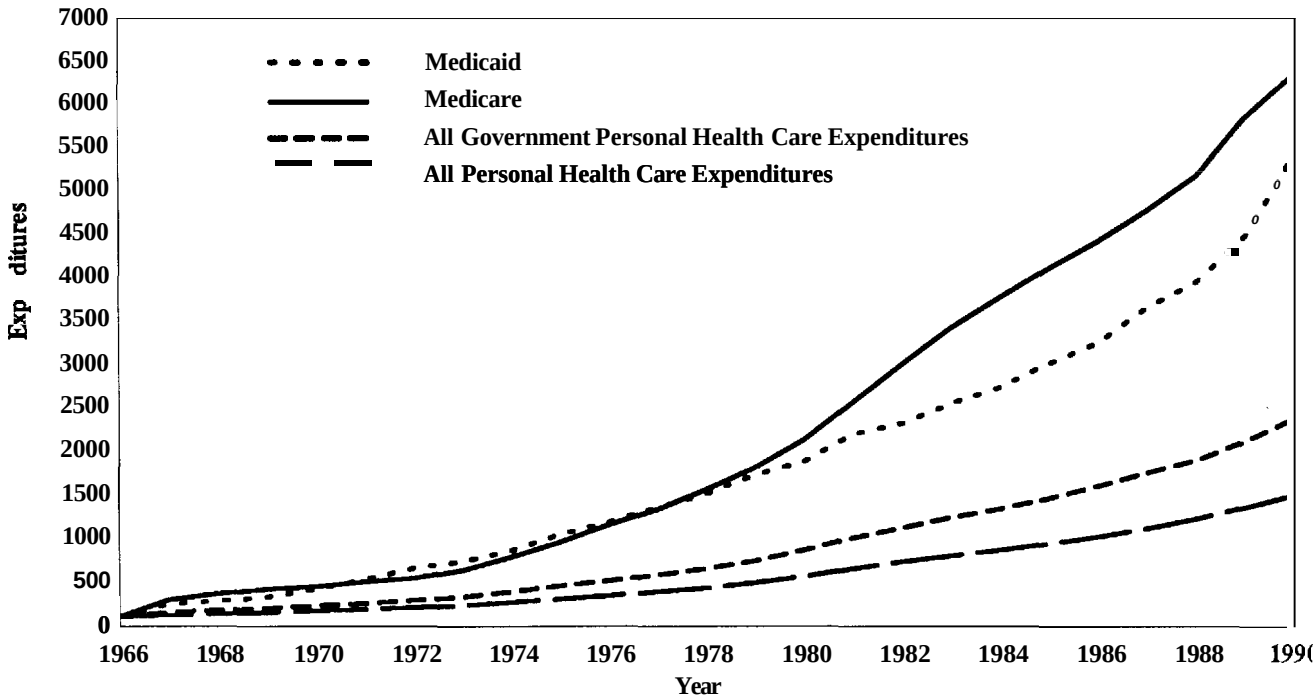
Medicaid Vendor Payments and Total Personal Health Care Expenditures, Current and Constant (1982) Dollars, 1969-1990

Calendar Year	Medicaid Expenditures (billions)		Personal Health Care Vendor Payments (billions)		Medicaid Vendor Payments (dollars per recipient)		Personal Health Care Expenditures (dollars per recipient)		Medicaid Payments as a Percentage of Personal Health Care Expenditures[1]			
									Total Expenditures		Expenditures Per Recipient	
	Current Dollars	Constant Dollars	Current Dollars	Constant Dollars	Current Dollars	Constant Dollars	Current Dollars	Constant Dollars	Current Dollars	Constant Dollars	Current Dollars	Constant Dollars
1969	$4.0	$11.1	$57.1	$155.7	$331	$918	$268	$732	7.0%	7.1%	123.4%	125.4%
1970	5.1	13.2	64.9	166.9	349	911	302	777	7.8	7.9	115.6	117.2
1971	6.4	15.8	71.3	173.1	358	880	328	797	9.0	9.1	109.1	110.4
1972	8.0	18.8	79.4	184.9	455	1,068	362	844	10.1	10.2	125.7	126.5
1973	9.1	20.2	88.6	197.6	461	1,028	401	894	10.2	10.2	115.0	115.0
1974	10.6	21.6	101.6	208.3	495	1,008	456	935	10.5	10.4	108.6	107.9
1975	12.9	23.8	116.6	216.6	586	1,081	519	964	11.1	11.0	112.8	112.1
1976	14.5	24.7	1328	227.0	635	1,082	586	1,002	10.9	10.9	108.4	108.0
1977	16.6	26.2	149.2	235.9	726	1,146	653	1,032	11.1	11.1	111.2	111.0
1978	18.5	26.9	167.2	245.2	841	1,227	725	1.083	11.0	11.0	116.0	113.3
1979	21.2	28.4	188.6	254.4	985	1,320	810	1,092	11.2	11.2	121.6	120.9
1980	24.8	30.0	219.4	266.3	1,149	1,389	928	1,126	11.4	11.3	123.8	123.3
1981	28.9	31.5	253.2	276.9	1,314	1,433	1,066	1,165	11.4	11.4	123.2	123.0
1982	30.6	30.6	286.4	286.4	1,415	1,415	1,184	1,184	10.8	10.8	119.5	119.5
1983	33.6	31.5	312.4	292.1	1,558	1,462	1,289	1,205	10.7	10.8	120.9	121.3
1984	36.0	32.0	338.6	298.2	1,667	1,480	1,384	1,219	10.6	10.7	120.4	121.4
1985	39.7	33.6	367.2	306.8	1,818	1,540	1,486	1,242	10.8	10.9	122.4	124.0
1986	42.9	34.8	397.7	316.7	1,905	1,547	1,594	1,270	10.8	11.0	119.5	121.8
1987	48.2	37.4	434.7	327.5	2,089	1,618	1,726	1,300	11.1	11.4	121.0	124.4
1988	52.3	38.1	478.3	337.8	2,284	1,662	1,881	1,329	10.9	11.3	121.4	125.1
1989	59.3	39.6	530.7	345.0	2,523	1,686	2,068	1,345	11.2	11.5	122.0	125.3
1990[2]	71.3	45.7	585.3	364.1	2,818	1,752	2,255	1,402	12.2	12.6	125.0	125.0
					Overall Increase							
1969–90	1681.1%	311.4%	925.0%	133.8%	751.8%	90.8%	741.4%	91.5%				
					Average Annual Increase							
1969–90	14.7%	7.0%	11.7%	4.1%	10.7%	3.1%	10.7%	3.1%				

[1] Percentages differ for current and constant dollars because of slight differences in price deflators for Medicaid expenditures and all personal health care expenditures.

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of National Cost Estimates, unpublished data; and ACIR staff estimates of constant dollar figures.

Figure 3-1
Index **of** Expenditures **for** Medicaid, Medicare, Government-Financed Personal Health Care Expenditures, and All Personal Health Care Expenditures, 1966-1990
(1966 = 100)



Source: U.S. Department of Health and Human Services, Health Care Financing Administration.

medical nondurables, and less than 4 percent of physicians' and dentists' services, but 31.9 percent of home health care and 45.4 percent of nursing home care, making it the largest payer for such services.[3]

The relationship between Medicaid and Medicare is of particular interest. Both programs were enacted by the ***Social Security Amendments*** of ***1965*** and both finance health care for certain groups—Medicare for the elderly (aged 65 and over) and certain disabled individuals, and Medicaid for the needy, including the aged. Between 1972 and 1984, Medicare grew significantly faster than Medicaid (total Medicaid expenditures fell from 92.3 percent of Medicare expenditures to 58.6 percent). Since 1984, Medicaid expenditures have risen somewhat faster than Medicare (in 1990, Medicaid expenditures were 65.5 percent of Medicare expenditures).

Medicare expenditures grew faster between 1972 and 1984 because (1) the number of Medicare beneficiaries increased faster than did Medicaid beneficiaries and (2) Medicare expenditures are weighted more heavily toward hospital care and physicians' services than are Medicaid expenditures, and the costs of these services grew faster than other medical costs during this period." Conversely, between 1984 and 1990, Medicaid expenditures grew faster than Medicare. The number of Medicaid beneficiaries rose 17.1 percent, from 21.6 million to 25.3 million, while the number of Medicare enrollees rose by 12.1 percent, from 30.5 million to 34.2 million.[5] However, Medicare's annual medical price inflation rate in the 1984-1988 period was 5.5 percent per year versus 5.0 percent per year for Medicaid.[6]

TRENDS IN MEDICAID EXPENDITURES

Growth in Expenditures

The growth of Medicaid expenditures has nearly consistently outpaced that of general government expenditures. Table 3-3 and Figure 3-2 show that between 1966 and 1972, as states joined the program, total annual Medicaid expenditure increases averaged 36.3 percent, well ahead of federal and state-local general expenditure growth. Between 1973 and 1981, annual Medicaid increases moderated somewhat (15.6 percent), following more closely but still higher than federal and state-local general expenditures (11 to 12 percent average). After 1982, the average growth of Medicaid and general government expenditures slowed again, but became more erratic. Until 1987, Medicaid's average annual increases of 11 percent outpaced general expenditure growth by 2.7 to 2.9 percentage points. Medicaid growth rates of 12.4 percent in 1987, 14.1 percent in 1989, and 18.5 percent in 1990 exceeded this spread considerably.

Medicaid has entered a new phase of very high growth. Total 1990 costs of $75.2 billion represent an 18.5 percent increase over 1989. Current expenditure increases (not taking into account any future changes in the program) are projected to be 24.5 percent in FY 1991, dropping to 15.6 percent in FY 1992 and floating down to 12.5 percent by FY 1996.[7]

Table 3-3
Growth of Medicaid Expenditures Relative to Growth of Government Budgets, 1966-1990

Year	Total Medicaid Expenditures: Amount (millions)	Total Medicaid Expenditures: Annual Percentage Increase	Total Federal General Expenditures: Amount (millions)	Total Federal General Expenditures: Annual Percentage Increase	Total State-Local General Expenditures: Amount (millions)	Total State-Local General Expenditures: Annual Percentage Increase	Total State General Expenditures: Amount (millions)	Total State General Expenditures: Annual Percentage Increase
1966	$1,323		$119,679		$82,843		$46,090	
1967	3,193	141.3%	138,565	15.8%	93,350	12.7%	53,305	15.7%
1968	3,613	13.2	151,990	9.7	102,411	9.7	60,395	13.3
1969	4,267	18.1	158,618	4.4	116,728	14.0	68,023	12.6
1970	5,415	26.9	166,942	5.2	131,332	12.5	77,642	14.1
1971	6,845	26.4	177,922	6.6	150,674	14.7	89,118	14.8
1972	8,472	23.8	188,100	5.7	168,549	11.9	98,810	10.9
1973	9,599	13.3	208,457	10.8	181,357	7.6	108,086	9.4
1974	11,280	17.5	221,413	6.2	198,959	9.7	119,891	10.9
1975	13,696	21.4	253,492	14.5	230,721	16.0	138,303	15.4
1976	15,476	13.0	289,652	14.3	256,731	11.3	153,690	11.1
1977	17,756	14.7	315,404	8.9	274,215	6.8	164,351	6.9
1978	19,782	11.4	348,000	10.3	296,983	8.3	179,802	9.4
1979	22,668	14.6	389,986	121	327,517	10.3	200,518	11.5
1980	26,411	16.5	446,590	14.5	369,086	12.7	228,223	13.8
1981	30,679	16.2	516,910	15.7	407,449	10.4	253,654	11.1
1982	32,467	5.8	568,373	10.0	436,896	7.2	269,490	6.2
1983	35,671	9.9	624,170	9.8	466,764	6.8	285,042	5.8
1984	38,411	7.7	664,046	6.4	505,008	8.2	309,684	8.6
1985	42,204	9.9	747,498	12.6	553,899	9.7	345,133	11.4
1986	45,676	8.2	796,209	6.5	605,623	9.3	376,519	9.1
1987	51,335	12.4	832,200	4.5	657,134	8.5	403,939	7.3
1988	55,602	8.3	878,523	5.6	704,921	7.3	432,178	7.0
1989	63,464	14.1	910,438	3.6	762,311	8.1	462,269	7.0
1990	75,200	18.5	NA	NA	833,003	9.3	507,875	9.9
				Average Annual Percentage Increase				
1966-72		36.3%		7.8%		12.6%		13.6%
1973-81		15.6		12.0		10.6		11.3
1982-90		11.1		7.0		8.4		8.2

NA—not available

Sources: Medicaid Expenditures—Health Care Financing Administration, Office of National Cost Estimates
General Expenditures—U.S. Department of Commerce, Bureau of the Census, ***Historical Statistics on Governmental Finances and Employment,*** Census of Governments, various years, and ***Government Finances in (year).***

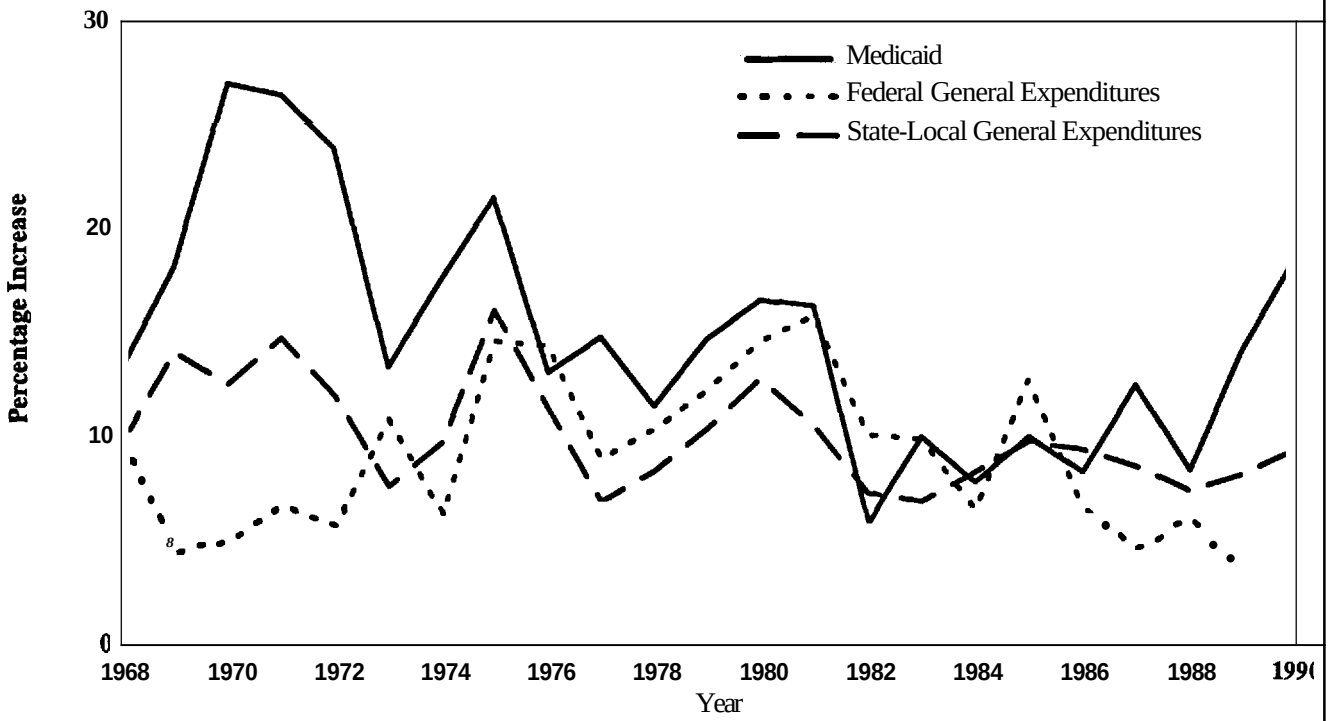
Medicaid as a Percentage of Federal and State Budgets

Medicaid's higher than average rates of expenditure growth imply that the program has increased as a share of government budgets. To examine this, Table 3-4 shows Medicaid expenditures relative to general government expenditures.

Direct Medicaid expenditures are paid initially out of state budgets (and in 14 states local government budgets). Total Medicaid expenditures as a percentage of state general expenditures have shown near-constant growth, from less than 3 percent in 1966 to 14.8 percent in 1990, with a slight slowdown between 1984 and 1987 (see Table 3-4). (Medicaid spending rose from 1.6 percent to 9.0 percent as a percentage of state and local general government expenditures over the same period.) The percentage of each state's FY 1991 budget represented by state-only Medicaid expenditures is shown in Table 3-5.

The National Association of State Budget Officers (NASBO) projects that state Medicaid spending will reach an average of 17 percent of state budgets by 1995.[8] The U.S. General Accounting Office (GAO) predicts that new conditions and requirements will exacerbate the states' fiscal stress resulting from the recession? GAO found that program requirements enacted since 1987 extending Medicaid coverage to older children and expanding screening programs and follow-up care will be more costly for the states to implement than previous changes.'' In the near future, most states will find it difficult to finance the new conditions and requirements without raising taxes, shifting Medicaid resources by eliminating optional services or closing public clinics, or reducing other state spending.

Figure 3-2
Increases in Medicaid and General Expenditures,
1968-1990



Source: ACIR from data **supplied by U.S.** Department **of** Health **and** Human Services, Health **Care** Financing Administration.

Further, the new requirements limit state flexibility in providing health care for their citizens.

When the portion of Medicaid expenditures financed by state and local governments is compared to total state expenditures, the pattern of increase is generally the same, but the magnitude is much less. **As** a percentage of state general expenditures, state and locally financed Medicaid expenditures grew from 1.5 percent in 1966 to **6.4** percent in 1990.[11] **(If** Medicaid spending is compared to state and local government general expenditures, the proportions fall to 0.8 percent and 3.9 percent, respectively.)

Since Medicaid began, over half of the total program spending (55.5 percent on average) has been financed by the federal government. Federal Medicaid expenditures as a percentage of federal general expenditures increased nearly steadily from less than 1 percent in 1966 to 3.4 percent in 1981, leveled off for several years at 3.1 percent, and began to rise again in 1986, reaching 4.0 percent in 1989 (see Table 3-4). Federal Medicaid expenditures are projected to reach 6.5 percent of the federal budget **by** 1996.[12]

State Variations

National averages mask large variations in state budgets, both across states and within states between years. Table 3-5 shows Medicaid expenditures as a percentage **of** each state's budget in fiscal years 1987 to 1991, as well as the expenditure increases in those years. Medicaid spending ranged from 2.3 percent in Alaska in 1987 to 20.2 percent in Rhode Island in 1991. Expenditures decreased 19.5 percent in New Hampshire in FY 1988 and increased 75.7 percent in Michigan in FY 1990. These generally **high,** but uneven, rates of growth make budgeting for Medicaid difficult. For example, in FY 1990, over half the states had to make supplemental Medicaid appropriations.[13]

Numerous studies have indicated that the major factors affecting the size of a state's Medicaid program are both economic and political. Economic factors include conditions that affect the number of people eligible (unemployment, for example), the cost of medical care, state income or wealth, and taxpayer burdens. Political factors include the degree of state liberalism, interest group (including physician) density, size of the Medicaid bureaucracy, and the use of local governments to administer Medicaid.[14]

Income and taxpayer burdens are of particular interest because of their importance in determining state Medicaid spending. States with higher personal incomes and lower taxpayer burdens are strongly associated with higher Medicaid spending. The Medicaid financing system attempts to change taxpayer burdens by varying state matching rates, using a formula that incorporates state personal income." Under current law, the federal Medicaid matching ratio (FMAP) *can* range from 50 percent in the highest income states to 83 percent in the lowest income states. (The highest ratio for FY 1992 is 79.99 percent in Mississippi.)

Personal income does not accurately measure a state's capacity to raise revenues because, for many states, the ability to export taxes to nonresidents is **high.**[16] In addition, aggregate measures of income are not accurate indicators of state revenue-raising capacity because, for example,

Table 3 4
Medicaid Expenditures as a Percentage of Governmental Budgets, 1966-1990

Year	Total Medicaid Expenditures	Medicaid Expenditures Financed by: Federal Government: Millions of Dollars	Federal Government as a Percent of Federal General Expenditures	State & Local Governments: Millions of Dollars	State & Local Governments as a Percent of State Own-Source General Revenues'	Total Medicaid Expenditures as a Percentage of State General Expenditures'	*Exhibit:* Percentage of Medicaid Expenditures Financed by: Federal Government	State-Local Governments
1966	$1,323	$642	0.5%	$680	2.0%	2.9%	48.5%	51.4%
1967	3,193	1,554	1.1	1,638	4.3	6.0	48.7	51.3
1968	3,613	1,877	1.2	1,736	4.0	6.0	52.0	48.0
1969	4,267	2,354	1.5	1,915	3.9	6.3	55.2	44.9
1970	5,415	2,916	1.7	2,498	4.3	7.0	53.9	46.1
1971	6,845	3,899	2.2	2,946	4.8	7.7	57.0	43.0
1972	8,472	4,642	2.5	3,831	5.4	8.6	54.8	45.2
1973	9,599	5,036	2.4	4,562	5.7	8.9	52.5	47.5
1974	11,280	6,400	2.9	4,880	5.5	9.4	56.7	43.3
1975	13,696	7,556	3.0	6,139	6.3	9.9	55.2	44.8
1976	15,476	9,295	3.2	6,181	5.8	10.1	60.1	39.9
1977	17,756	10,110	3.2	7,647	6.3	10.8	56.9	43.1
1978	19,782	11,085	3.2	8,697	6.4	11.0	56.0	44.0
1979	22,668	12,910	3.3	9,759	6.5	11.3	57.0	43.1
1980	26,411	14,660	3.3	11,751	6.9	11.6	55.5	44.5
1981	30,679	17,392	3.4	13,287	7.1	12.1	56.7	43.3
1982	32,467	17,669	3.1	14,797	7.2	12.0	54.4	45.6
1983	35,671	19,425	3.1	16,246	7.5	12.5	54.5	45.5
1984	38,411	20,667	3.1	17,744	7.1	12.4	53.8	46.2
1985	42,204	23,401	3.1	18,803	6.8	12.2	55.4	44.6
1986	45,676	25,631	3.2	20,044	6.8	12.1	56.1	43.9
1987	51,335	28,230	3.4	23,150	7.3	12.7	55.0	45.1
1988	55,602	31,405	3.6	24,197	7.2	12.9	56.5	43.5
1989	63,464	36,139	4.0	27,325	7.5	13.5	56.9	43.1
1990	75,200	42,900	NA	32,300	8.3	14.8	57.0	43.0

NA—not available

[1] **Local governments contribute to Medicaid financing in Colorado, Florida,** Iowa, **Minnesota, Montana, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Pennsylvania, South Dakota, Utah, and Wisconsin.**

Sources: See Tables 3-1 and 3-2

two states with nearly identical average per capita income may have different proportions of poverty and affluence.

Population is a poor indicator of a state's "need" for public services and of the cost of providing services. Other factors, such as the age and income distribution of the population, the prices of service inputs, and workloads (e.g., population in households with incomes below the poverty line), are more accurate indicators of service needs and costs.[17]

Research has shown that, while state Medicaid spending is responsive to the federal matching rates, the reimbursement rates in low-income states have not completely offset the lesser ability of these states to pay for Medicaid services.[18] As a result, the U.S. General Accounting Office (GAO) proposed in 1983, and again in recent congressional testimony, that the Medicaid formula be revised by incorporating a better measure of tax capacity than personal income and adding the poverty population as a measure of need, as well as by reducing the minimum federal matching rate to 40 percent. ACIR's representative tax system was identified in the 1983 report as providing such an improved measure of tax capacity.[19]

Changing the Medicaid allocation formula would generally mean a small difference in the amount of Medicaid funds a state would receive, but for some states the differences would be substantial.[20] GAO's simulation under a federal budget-neutral constraint, using a formula incorporating tax capacity and adding poverty population as a measure of need, shows changes in federal Medicaid grants ranging from a decline of more than 20 percent in Wyoming and more than 15 percent in Wisconsin and Indiana to an increase of almost 19 percent in Florida.[21] A second simulation under federal budget-neutral conditions, with a 40 percent minimum federal share rather than

Table 3-5

State Medicaid Expenditures, Total, as Percentage of State General Expenditures, and Percentage Change, Fiscal Years 1987-1991

State	Amount (millions)					as Percentage of State General Expenditures					Percentage Change			
	1987	1988	1989	1990	1991[a]	1987	1988	1989	1990	1991[a]	1987-88	1988-89	1989-90	1990-91
New England														
Connecticut	$600	$694	$816	$964	$1,170	8.6%	8.6%	9.3%	10.2%	12.1%	15.7%	17.6%	18.1%	21.4%
Maine	283	314	392	3%	445	14.6	15.0	15.7	14.9	15.3	11.0	24.8	1.0	12.4
Massachusetts	1,423	1,593	1,766	2,612	2,581	9.7	10.5	10.6	15.2	15.0	11.9	10.9	47.9	-1.2
New Hampshire	144	183	140	215	258	12.7	13.1	13.1	11.9	17.7	27.1	-23.5	53.6	20.0
Rhode Island	293	313	348	428	463	17.9	16.3	16.6	19.1	20.2	6.8	11.2	23.0	8.2
Vermont	98	110	113	146	192	10.4	10.5	9.8	11.9	14.9	12.2	2.7	29.2	31.5
Mideast														
Delaware	90	96	114	131	156	5.4	5.2	5.6	6.0	6.8	6.7	18.8	14.9	19.1
District of Columbia	298	362	354	NA	NA	9.3	8.6	8.1	NA	NA	21.5	-2.2	NA	NA
Maryland	804	906	996	1,152	1,216	9.2	9.7	9.8	10.2	10.4	12.7	9.9	15.7	5.6
New Jersey	1,551	1,741	1,913	2,256	2,646	11.7	12.0	12.0	13.8	14.6	12.3	9.9	17.9	17.3
New York	6,330	6,960	7,698	8,362	9,639	17.6	17.4	17.7	18.0	19.6	10.0	10.6	8.6	15.3
Pennsylvania	2,125	2,252	2,511	2,670	3,910	11.7	11.6	122	12.2	15.9	6.0	11.5	6.3	46.4
Great Lakes														
Illinois	1,784	1,850	2,151	2,250	2,540	10.6	10.7	11.9	11.9	123	3.7	16.3	4.6	12.9
Indiana	933	1,017	1,136	1,446	1,766	126	13.2	13.8	16.0	17.8	9.0	11.7	27.3	22.1
Michigan	1,576	1,677	1,593	2,799	2,553	10.7	10.8	10.0	16.0	13.9	6.4	-5.0	75.7	-8.8
Ohio	2,037	2,250	2,269	2,800	3,376	11.5	11.7	11.6	13.3	14.6	10.5	0.8	23.4	20.6
Wisconsin	1,114	1,155	1,251	1,423	1,537	10.2	11.7	12.2	12.9	13.0	3.7	8.3	13.7	8.0
Plains														
Iowa	428	478	533	624	740	6.4	7.8	8.0	8.9	10.0	11.7	11.5	17.1	18.6
Kansas	249	281	325	409	513	6.9	7.3	7.6	8.6	9.9	12.9	15.7	25.8	25.4
Minnesota	1,109	1,194	1,277	1,421	1,606	11.1	13.8	14.0	14.2	14.5	7.7	7.0	11.3	13.0
Missouri	566	621	722	832	1,281	8.8	8.9	9.9	10.4	15.0	9.7	16.3	15.2	54.0
Nebraska	195	231	260	311	320	9.6	10.6	10.8	11.3	9.5	18.5	12.6	19.6	2.9
North Dakota	166	156	170	174	186	13.6	11.1	11.1	11.5	12.4	-6.0	9.0	2.4	6.9
South Dakota	114	123	144	160	180	10.8	10.7	13.4	13.8	13.8	7.9	17.1	11.1	12.5
Southeast														
Alabama	421	463	538	834	1,118	7.8	7.2	7.7	11.3	13.9	10.0	16.2	55.0	34.1
Arkansas	358	436	507	600	637	10.3	11.3	12.3	13.2	13.3	21.8	16.3	18.3	6.2
Florida	1,394	1,576	2,001	2,407	3,281	8.3	8.5	9.4	10.6	121	13.1	27.0	20.3	36.3
Georgia	911	1,087	1,240	1,497	2,001	11.5	12.5	12.4	127	15.9	19.3	14.1	20.7	33.7
Kentucky	629	708	815	946	1,198	9.6	9.7	11.3	12.2	12.2	12.6	15.1	16.1	26.6

Table 3-5 *(cont.)*

State Medicaid Expenditures, Total, as Percentage of State General Expenditures, and Percentage Change, Fiscal Years 1987-1991

State	Amount (millions)					as Percentage of State General Expenditures					Percentage Change			
	1987	1988	1989	1990	1991[e]	1987	1988	1989	1990	1991[e]	1987-88	1988-89	1989-90	1990-91
Southeast (cont.)														
Louisiana	882	903	1,147	1,319	1,691	12.0	12.3	15.5	15.6	17.8	2 4	27.0	15.0	28.2
Mississippi	384	401	464	608	707	10.5	10.3	11.3	14.9	15.0	4.4	15.7	31.0	16.3
North Carolina	823	931	1,119	1,358	1,565	9.3	9.6	10.5	11.5	12.4	13.1	20.2	21.4	15.2
South Carolina	421	455	612	752	1,003	7.8	7.7	8.8	9.8	11.9	8.1	34.5	22.9	33.4
Tennessee	820	995	1,038	1,370	1,633	13.4	16.5	15.3	18.2	20.0	21.3	4.3	320	19.2
Virginia	702	734	901	1,004	1,301	7.5	7.1	7.9	8.2	9.9	4.6	22.8	11.4	29.6
West Virginia	255	252	333	451	482	7.6	7.6	10.0	12.3	11.9	-1.2	321	35.4	6.9
Southwest														
Arizona	NA	311	442	643	909	NA	6.4	8.4	10.7	12.7	NA	42.1	45.5	41.4
New Mexico	192	216	255	279	341	7.1	7.1	8.4	7.3	8.9	12.5	18.1	9.4	22.2
Oklahoma	525	577	636	706	817	10.4	11.2	11.3	11.9	12.2	9.9	10.2	11.0	15.7
Texas	824	2,153	2,408	3,069	4,308	4.6	11.4	13.0	13.0	16.4	161.3	11.8	27.5	40.4
Rocky Mountain														
Colorado	399	440	476	584	701	8.9	9.5	9.3	11.0	12.9	10.3	8.2	227	20.0
Idaho	84	100	112	149	200	6.3	6.9	7.2	8.2	9.8	19.0	120	33.0	34.2
Montana	144	157	171	172	201	9.3	9.7	9.5	9.8	10.0	9.0	8.9	0.6	16.9
Utah	208	197	207	270	327	7.8	6.9	7.3	8.4	9.4	-5.3	5.1	30.4	21.1
Wyoming	41	43	55	62	65	2.4	2.6	4.6	4.5	4.6	4.9	27.9	127	4.8
Far West														
California	5,329	5,659	6,209	7,170	8,670	10.1	9.9	10.1	10.7	11.4	6.2	9.7	15.5	20.9
Nevada	121	103'	114'	NA	NA	8.9	7.3''	7.3[e]	NA	NA	-14.9	10.7	NA	NA
Oregon	286	304	330	524	700	4.8	4.9	5.0	7.5	9.3	6.3	8.6	58.8	33.6
Washington	795	920	995	1,209	1,431	8.9	9.8	9.8	10.7	10.7	15.7	8.2	21.5	18.4
Alaska	75	100	113	156	200	2.3	3.1	3.5	4.2	5.3	33.3	13.0	38.1	28.2
Hawaii	176	190	210	239	254	5.8	5.8	5.8	5.5	4.9	8.0	10.5	13.8	6.3

NA—not available

[e]—estimate

Source: National Association of State Budget Officers, *State Expenditures Reports* for 1988, 1989, 1990, and 1991.

the current 50 percent, yielded the largest decreases in federal Medicaid funds of 36 percent to Wyoming and 21 percent to Connecticut and New Jersey, and the largest increases of 21 percent to Florida and 10 percent to Texas.[22]

Local government contributions to state Medicaid programs are less than 10 percent of total state costs. Outside New York State, most local contributions are services rather than direct payments. States with local Medicaid administration spend significantly more on the program than the other states. Researchers have posited three reasons for this effect. First, adding local administration increases the complexity of the process and hence program costs. Second, costs may increase because of duplication, confusion, and disagreement. Third, because local officials do not bear the full financial burden of their decisions, they have incentives to administer the program liberally, thus increasing program spending?' In addition, local revenue bases are considered to be less elastic than state revenue bases, making it more difficult for local governments to finance increases in Medicaid expenditures resulting from program expansions or deteriorating economic conditions.[24] The implication of these findings is that, to better achieve the objective of cost control and to reduce local fiscal stress, Medicaid should be administered entirely by the state government.

Alternatively, locally administered Medicaid programs may result in higher overall program spending simply because needs are more apparent and better addressed under these decentralized systems. More research and analysis are needed on this issue.

MEDICAID IN RELATION TO OTHER SOCIAL WELFARE EXPENDITURES

Medicaid has grown in relation to other types of social welfare expenditures, as shown in Table 3-6. For all governments combined, Medicaid has roughly doubled its importance relative to all other types of social services and income maintenance programs, rising from 12.8 percent of such expenditures in 1969 to over 25 percent in 1989. In 1969, cash assistance outlays exceeded Medicaid. In 1979,

Table 3-6
Medicaid in Relation to Other Social Welfare Expenditures, 1969, 1979, and 1989

	1969	1979	1989
All Governments			
Total Social Services and Income Maintenance (millions)'	$33,278	$111,995	$237,390
Medicaid	12.8%	20.2%	26.7%
Cash Assistance	18.8	17.0	15.3
Health and Hospitals	35.8	33.2	35.8
All Other	32.5	29.6	22.1
Federal Government			
Total Social Services and Income Maintenance (millions)'	19,610	69,504	136,818
Medicaid	12.0%	18.6%	26.4%
Other Public Welfare[2]	33.8	42.2	37.6
Health and Hospitals	20.7	17.1	17.1
All Other	33.5	22.2	18.9
Exhibit:			
Total Federal Grants (millions)	20,164	82,858	121,976
Medicaid	11.3%	15.0%	28.4%
Other Payments to Individuals	24.6	18.3	26.8
All Other Grants	64.1	66.7	44.8
State and Local Governments			
Total Social Services and Income Maintenance (millions)'	21,297	71,922	168,729
Medicaid	9.0%	13.6%	16.2%
Cash Assistance	28.8	16.6	12.3
Health and Hospitals	40.0	39.2	40.1
All Other	22.2	30.6	31.4

[1] Includes cash assistance programs, medical and other vendor payments, welfare institutions, program administration, health and hospitals, social insurance administration, and veterans' benefits.

[2] Includes intergovernmental transfers to state and local governments for cash assistance programs, Supplemental Security Income (formerly Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled), welfare institutions, and program administration.

Sources: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of National Cost Estimates, unpublished data; U.S. Department of Commerce, Bureau of the Census, *Government Finances in (Year)*; and Office of Management and Budget, Budget of the United States Government, Fiscal Year 1992.

Medicaid expenditures exceeded cash assistance—$22.6 billion vs. $19.0 billion. In 1989, Medicaid accounted for 26.7 percent of total spending for social services and income maintenance, cash assistance for 15.3 percent.

These figures suggest that the growing Medicaid program has substituted for other social service and income maintenance programs. This inverse relationship is particularly evident in the figures for cash assistance provided by state and local governments. One researcher found strong empirical support for the hypothesis that between 1960 and 1984 total welfare benefits grew in line with income, but states substituted Medicaid, as well as Food Stamp values, for AFDC benefits.[25]

Medicaid appears to have substituted for health and hospitals and all other social service and income maintenance programs to a greater extent in the federal budget than in state and local budgets.[26] Table 3-6 also shows that Medicaid reached 26.4 percent of all federal intergovernmental expenditures in 1989, and fueled the increase in payments to individuals as a percentage of total federal grants from about one-third of all grants in 1968 to well over half in 1989. The importance of all other grants in the federal budget has declined as a result.

Trends in Medicaid Recipients

Total Recipients

Table 3-7 shows the total number of Medicaid recipients over time in relation to the total population and the population living in poverty. While the number of Medicaid recipients more than doubled between 1968 (11.5 million) and 1990 (25.3 million), as a percentage of the total

Table 3-7
Number of Medicaid Recipients Relative to Resident and Poverty Populations, 1968-1990
(millions)

Year	Medicaid Recipients	Resident Population	Poverty Population	Number of Recipients as Percentage of Population: Resident	in Poverty[1]
1968	11.5	199.4	25.4	5.8%	45.3%
1969	12.1	201.4	24.1	6.0	50.0
1970	14.5	204.0	25.4	7.1	57.1
1971	18.0	206.8	25.6	8.7	70.2
1972	17.7	209.3	24.5	8.5	72.4
1973	18.5	211.4	23.0	8.7	80.3
1974	21.1	213.3	23.4	9.9	90.2
1975	22.0	215.5	25.9	10.2	85.0
1976	22.8	217.6	25.0	10.5	91.3
1977	22.8	219.8	24.7	10.4	92.4
1978	22.0	222.1	24.5	9.9	89.7
1979	21.5	224.6	26.1	9.6	85.1
1980	21.6	227.2	29.3	9.5	82.8
1981	22.0	229.4	31.8	9.6	75.0
1982	21.6	231.6	34.4	9.3	67.9
1983	21.6	233.8	35.3	9.2	62.7
1984	21.6	235.8	33.7	9.2	64.1
1985	21.8	237.9	33.1	9.2	65.9
1986	22.5	240.1	32.4	9.4	69.5
1987	23.1	242.3	32.2	9.5	71.8
1988	22.9	244.5	31.7	9.4	71.8
1989	23.5	248.8	31.5	9.4	74.6
1990	25.3	249.5	33.6	10.1	75.3
		Percentage Change: 1968-1990			
Total	120.0%	25.1%	32.3%		
Annual average	3.6%	1.0%	1.3%		

[1] This comparison is to show relative scale only. It is not meant to indicate the portion of individuals in poverty that receive Medicaid services or the portion of Medicaid services that go to individuals in poverty.

Sources: Medicaid Recipients—HCFA Forms 2082.
U.S. Population—U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States, 1991,* Table 2.
Number in Poverty—U.S. Department of Commerce, Bureau of the Census, *Measuring the Effect of Benefits and Taxes on Income and Poverty: 1990* (Washington, DC, 1991), p. 12; *Statistical Abstract of the United States,* 1991 and 1975.

Table 3-8
Unduplicated Number of Recipients, by Type of Eligibility, Fiscal Years 1972-1990
(thousands)

Fiscal Year	Total	Aged 65 or Older	Blind	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other[2]
1972[1]	17,606	3,318	108	1,625	7,841	3,137	1,576
1973	19,622	3,496	101	1,804	8,659	4,066	1,495
1974	21,462	3,732	135	2,222	9,478	4,392	1,502
1975	22,007	3,615	109	2,355	9,598	4,529	1,800
1976	22,815	3,612	97	2,572	9,924	4,774	1,836
1977	22,832	3,636	92	2,710	9,651	4,785	1,959
1978	21,965	3,376	82	2,636	9,376	4,643	1,852
1979	21,520	3,364	79	2,674	9,106	4,570	1,727
1980	21,605	3,440	92	2,819	9,333	4,877	1,499
1981	21,980	3,367	86	2,993	9,581	5,187	1,364
1982	21,603	3,240	84	2,806	9,563	5,356	1,434
1983	21,554	3,371	77	2,844	9,535	5,592	1,129
1984	21,607	3,238	79	2,834	9,684	5,600	1,187
1985	21,814	3,061	80	2,937	9,757	5,518	1,214
1986	22,515	3,140	82	3,100	10,029	5,647	1,362
1987	23,109	3,224	85	3,296	10,168	5,599	1,418
1988	22,907	3,159	86	3,401	10,037	5,503	1,343
1989	23,511	3,132	95	3,496	10,318	5,717	1,175
1990	25,255	3,202	83	3,635	11,220	6,010	990
Average Annual Change	2.0%	-0.2%	-1.5%	4.6%	2.0%	3.7%	2.5%

[1] 1972 is the earliest year for which these data are available.

[2] Primarily children who do not meet the statutory definition of dependent child.

Sources: Social Security Administration and HCFA 2082 forms.

population they declined from a peak of 10.5 percent in 1976 to 10.1 percent in 1990. For the years before 1976, the average annual Medicaid population growth rate of 3.6 percent compares to the 1.0 percent average annual growth of the overall population. Since 1976, the number of Medicaid recipients has grown at an average annual rate of 0.7 percent, while overall population growth continued at about 1 percent per year.

Although Medicaid is a means-tested entitlement program, it has never provided coverage for all of the poor. The Census Bureau reports that 45.2 percent of the poverty population was covered by Medicaid in 1990.[27] Moreover, many Medicaid recipients are not poor. The comparison between the number of Medicaid enrollees and the poverty population is to show relative scale only. Some Medicaid enrollees have incomes above the poverty level, especially as a result of the medically needy option and recent expansions of Medicaid to pregnant women and children up to 133 percent of poverty and higher. Therefore, correlations between Medicaid recipients and the proportion of the population in poverty should be interpreted with caution and used to show relative sizes only.

Type of Eligibility

The Medicaid population can be classified into seven major categories:

- The elderly (age 65 and over);
- The blind;
- The disabled, defined as permanently and totally disabled, including the mentally retarded, mentally ill, and developmentally disabled;
- Dependent children under age 21, primarily those in families receiving AFDC, SSI, or defined as medically needy;
- Adults in families with dependent children;
- Pregnant women and children under age 6 in families with incomes less than 133 percent of the poverty level; and
- Other Title XIX beneficiaries, mainly children who meet income and asset requirements for cash assistance programs but do not meet the definition of dependent child (e.g., children under 21 in two-parent families).

Table 3-8 shows that the largest category of recipients is dependent children under 21, numbering over 11.2 million in 1990 and making up 44.3 percent of the total. Adults in families with dependent children numbered 6.0 million (23.8 percent); the elderly, 3.2 million (12.6 percent); the disabled, 3.7 million (14.7 percent); and the blind and other categories, 1.1 million (4.4 percent).

Table 3-9

Medicaid Recipients, by Type of Service, Fiscal Years 1972-1990

(thousands)

Fiscal Year	Inpatient Hospital	Skilled Nursing and Intermediate Care Facilities	Intermediate Care Facility for the Mentally Retarded	Physicians Dentists, and Other Practicioners[2]	Prescription Drugs	Outpatient Hospital	Home Health Care	All Other[2]
1972[1]	2,872	552	–	15,889	11,139	5,215	105	5,393
1973	3,333	1,111	29	17,743	12,116	7,437	110	9,816
1974	3,363	1,249	39	20,452	14,240	8,482	144	6,170
1975	3,499	1,312	69	21,264	14,155	7,437	343	4,026
1976	3,634	1,361	89	22,327	14,883	8,482	319	5,555
1977	3,852	1,395	107	23,080	15,370	8,619	371	9,726
1978	3,858	1,379	104	22,433	15,188	8,628	376	8,387
1979	3,681	1,376	114	21,818	14,283	7,710	359	7,534
1980	3,747	1,396	121	20,543	13,707	9,705	392	7,569
1981	3,793	1,385	151	21,801	14,256	10,018	402	8,810
1982	3,602	1,324	149	20,777	13,547	9,853	377	8,470
1983	3,776	1,367	151	20,516	13,732	10,069	422	9,241
1984	3,503	1,355	141	20,970	13,935	10,035	438	9,122
1985	3,494	1,375	147	20,921	13,921	10,072	535	10,799
1986	3,597	1,399	145	21,802	14,704	10,702	593	11,148
1987	3,824	1,421	149	22,146	15,083	10,979	609	11,473
1988	3,892	1,445	145	22,074	15,323	10,533	569	11,934
1989	4,260	1,452	148	21,577	15,916	11,344	609	12,962
1990	4,685	1,461	147	23,491	17,294	12,370	719	14,443
Average Annual Change	2.8%	5.6%	10.0%	2.2%	2.5%	4.9%	11.3%	5.6%

Note: "All Other" includes clinic services, laboratories and X-rays, family planning, and health clinics.

[1] 1972 is the earliest year for which these data are available.

[2] Estimated by ACIR.

Sources: Social Security Administration and HCFA 2082 forms.

As noted above, the growth in the number of Medicaid recipients (3.6 percent per year on average) was faster than the rate of growth of the general population until recently. Among Medicaid recipients, the number of disabled has grown almost three times as fast as the total, and adults in families with dependent children about twice as fast. Between 1972 and 1990, however, the number of elderly, blind, and other categories of Medicaid recipients decreased.

The decline in the number of elderly receiving Medicaid is particularly striking, since the proportion of the aged in the population has been growing. Two reasons have been given for the decline. First, fewer elderly are receiving SSI benefits now than in 1974 due to the growth of Social Security benefits and the income from private pensions and other assets.[28] Second, the low level of countable assets ($1,900 for a single person and $2,850 for a married couple in 1988) disqualifies many aged for SSI.[29] To some extent, the reduction in the number of elderly receiving Medicaid as a result of SSI eligibility has been offset by the increase in the number who are classified as medically needy.[30]

Type of Service

The number of Medicaid recipients receiving each type of service is shown in Table 3-9. Beneficiaries may receive more than one type of service in any year. In fact, between 1972 and 1990, the number of services utilized per recipient increased on average for all services.

The most frequently used services are physicians, dentists, and other practitioners (used by 23.5 million in 1990); prescription drugs (17.3 million); outpatient hospital services (12.4 million); and all other services, including clinics, laboratory and x-rays, family planning, EPSDT, and rural health clinics (14.4 million). Inpatient hospital services were used by 4.7 million Medicaid clients, and 1.6 million received nursing home services. Only 719,000 individuals used home health care, and 147,000 received ICF/MR care, but use of these two services has grown more than six times as fast as the overall Medicaid population.[31] The largest beneficiary populations and the most frequently used services do not necessarily represent the most costly parts of the Medicaid program.

Distribution of Medicaid Payments by Type of Recipient and Service

By Type of Recipient

Table 3-10 shows the distribution of total Medicaid vendor payments by type of recipient. Although dependent

Table 3-10

Medicaid Vendor Payments, by Type of Recipient Eligibility Category, Fiscal Years 1972-1990

(percentage of total)

Fiscal Year	Total	Aged 65 or Older	Blind	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other[2]
1972[1]	100.0%	30.6%	0.7%	21.5%	18.1%	15.3%	13.9%
1973	100.0	37.4	0.8	23.3	16.5	16.7	5.2
1974	100.0	37.0	0.8	23.9	17.0	17.1	4.3
1975	100.0	35.6	0.8	24.9	17.9	16.8	4.0
1976	100.0	34.8	0.7	27.1	17.3	16.2	3.8
1977	100.0	33.9	0.7	29.4	16.1	16.0	3.9
1978	100.0	35.1	0.6	30.6	15.3	14.9	3.6
1979	100.0	34.4	0.5	33.1	14.1	14.8	3.1
1980	100.0	37.5	0.5	32.2	13.4	13.9	2.6
1981	100.0	36.5	0.6	34.2	12.9	13.8	2.0
1982	100.0	36.5	0.6	34.8	11.8	13.9	2.3
1983	100.0	36.9	0.6	34.5	11.8	13.9	2.3
1984	100.0	37.8	0.6	34.7	11.7	13.0	2.1
1985	100.0	37.6	0.7	35.2	11.8	12.7	2.1
1986	100.0	36.8	0.7	35.7	12.5	11.9	2.4
1987	100.0	35.6	0.7	36.6	12.2	12.4	2.4
1988	100.0	35.2	0.7	37.5	12.0	12.1	2.5
1989	100.0	34.1	0.8	37.6	12.6	12.7	2.1
1990	100.0	32.3	0.7	37.0	14.0	13.2	1.6
Average Annual Change	13.8%	14.3%	13.4%	17.3%	12.2%	12.9%	1.0%

[1] 1972 is the earliest year for which these data are available.

[2] Primarily children who do not meet the statutory definition of dependent child.

Sources: Social Security Administration and HCFA 2082 forms.

dent children and adults in dependent families made up 68 percent of total Medicaid recipients in 1990, they accounted counted for only 27 percent of total Medicaid payments. Furthermore, the categories of dependent children under 21, adults in families with dependent children, and other recipients have decreased their share of total payments (but they show slight upturns in their shares since 1986, presumably as a result of the expansions of eligibility for AFDC families, pregnant women, and children.) The elderly, who accounted for only 13 percent of Medicaid recipients in 1990, maintained one of the largest payment shares of any group, ranging between 34 and 38 percent over the 1973-1990 period, with a slight decline since 1984. The fastest growing share of payments has gone to the disabled. Accounting for 15 percent of the Medicaid population in 1990, the disabled received the largest share (37 percent) of total Medicaid payments, up 15.5 percent since 1972. The percentage of payments going to the blind has remained at less than 1 percent since the program began. Figure 3-3 shows the relationship between the number of recipients and the share of payments for each eligibility group in 1990.

By Type of Service

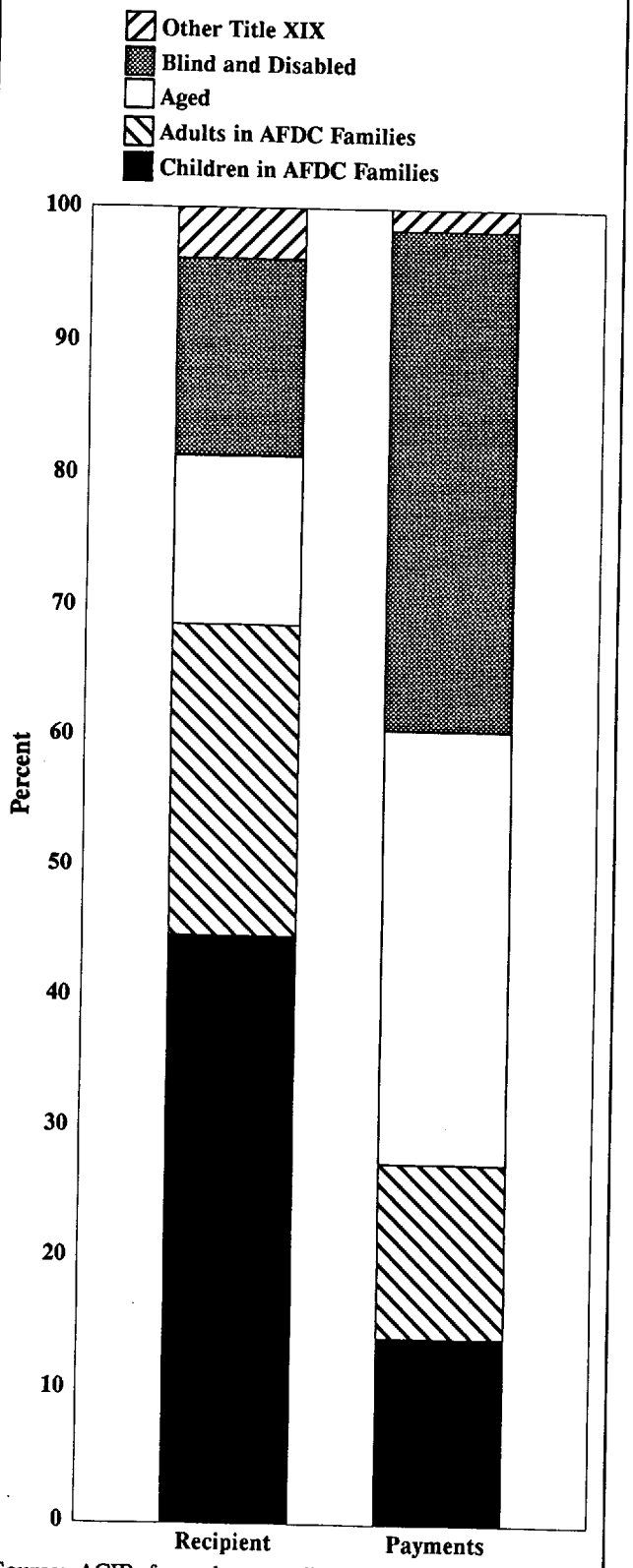
Table 3-11 (page 37) shows the percentage of total Medicaid payments for each major category of service for 1972 through 1990. The two largest categories of spending are inpatient hospital services and nursing home care, which together were 55.7 percent in 1990. The percentage has decreased, however, from nearly two-thirds of all Medicaid spending in 1972. In particular, inpatient hospital spending and payments to physicians, dentists, and other practitioners (which decreased from 16.2 percent in 1972 to 7.7 percent in 1990) have shown the slowest annual average growth in total Medicaid payments.

Payments for nursing home services grew only slightly faster than total Medicaid vendor payments from 1972 to 1990 and, despite the growth of the elderly population (the primary users of these services), have decreased as a share of total Medicaid payments since 1979. While the number of nursing home beneficiaries rose by 20.4 percent per year between 1972 and 1979, between 1977 and 1990 the annual increase averaged only 0.3 percent.

The two services with the greatest annual average increases in payments and recipients are ICF/MR and home health care. Both categories may include services that are not strictly medical, such as custodial care for the mentally retarded or assistance with activities of daily living (ADLs) in the case of home health care. The ICF/MR share of total Medicaid payments was 11.3 percent in 1990, a slight decrease from the peak of 12.6 percent in 1983-1985.

Figure 3-3

Percentage Distribution of Medicaid Receipients and Payments, by Type of Eligibility, FY 1990



Source: ACIR from data supplied by U.S. Department of Health and Human Services, Health Care Financing Administration.

The 5.2 percent share for home health care in 1990 reflects continuing rapid growth. The 1990 payment shares for prescription drugs (6.8 percent) and outpatient hospital services (5.1 percent) decreased slightly since 1972, while the 8.2 percent share for all other services has grown.

Average Medicaid Payments by Type of Recipient and Service

By Type of Recipient

Table 3-12 (page 38) shows the annual average medical vendor payment for each recipient category between 1972 and 1990. The average benefit for all recipients grew from $358 to $2,568, at an average rate of 11.6 percent per year ($1,068 to $1,752, at 3.1 percent per year, in constant 1982 dollars). The elderly and disabled (and to a slightly lesser extent, the blind) are the most expensive groups to cover under Medicaid, averaging nearly $6,717 per recipient in 1990 (approximately $5,212 for the blind), or over 250 percent of the average for all recipients. Average annual payments for these groups also have grown fastest, exceeding the average for all recipients by 1 to 3 percentage points. In contrast, the average payment for dependent children, adults in dependent families, and all other recipients ranged from less than $811 (32 percent of average) to just over $1,429 (56 percent of average) in 1990, with growth rates 2 to 8 percentage points below the average for all groups.

The large differences in average payments among recipient groups arise because the elderly use more costly services, such as nursing homes, to a much greater extent than do other groups. In fiscal year 1986, for example, 81 percent of all Medicaid payments for SNF and ICF services were for the elderly, compared to 19 percent for the nonelderly.[32] The disabled are disproportionate users of ICF/MR services, which are the most costly services provided by Medicaid.

By Type of Service

Table 3-13 (page 39) shows the annual average payments per recipient by type of service from 1972 to 1990. This table differs from the previous one because it shows the annual average payment for those who actually received the service rather than for all recipients in an eligibility category. By far the most expensive service financed by Medicaid is ICF/MR care, which cost slightly more than $50,000 per recipient per year in 1990. The next most costly service is nursing home care, which averaged about $12,110 per person in 1990. Home health care was next, at $4,733, and inpatient hospital costs followed closely, at $3,925. ICF/MR and home health care growth rates, in this case in cost per recipient, have grown the most rapidly. Average costs for all other Medicaid services, including individual practitioners, outpatient hospital services, and prescription drugs, averaged only $200 to $366 per recipient in 1990, and generally grew more slowly than the average for all services.

Source of Growth in Medicaid Expenditures

Using a methodology and data provided by HCFA, the growth in Medicaid expenditures can be divided into four factors: general price inflation, medical care price inflation,

Table 3-11

Medicaid Vendor Payments, by Type of Service, Fiscal Years 1972-1990

(percentage of total)

Fiscal Year	Inpatient Hospital	Skilled Nursing and Intermediate Care Facilities	Intermediate Care Facility for the Mentally Retarded	Physicians Dentists, and Other Practicioners[2]	Prescription Drugs	Outpatient Hospital	Home Health Care	All Other[2]
1972[1]	42.4%	23.3%	–	16.2%	8.1%	5.8%	0.4%	3.7%
1973	34.8	33.0	1.9	14.0	7.0	3.1	0.3	5.7
1974	33.0	33.9	2.0	14.5	7.1	3.2	0.3	5.9
1975	30.9	35.3	3.1	13.8	6.7	3.0	0.6	6.7
1976	31.5	33.2	4.5	13.4	6.7	3.9	1.0	5.8
1977	31.7	32.8	5.6	12.9	6.3	5.4	1.1	4.2
1978	31.4	34.6	6.6	11.6	6.0	4.6	1.2	3.9
1979	31.4	34.9	7.3	10.9	5.8	4.1	1.3	4.2
1980	30.8	33.8	8.5	10.9	5.7	4.7	1.4	4.1
1981	29.7	31.4	11.0	10.6	5.6	5.2	1.6	5.0
1982	29.4	32.0	11.8	9.5	5.4	4.9	1.7	5.3
1983	30.1	30.9	12.6	8.9	5.5	4.9	1.8	5.4
1984	29.2	31.4	12.6	8.6	5.8	4.9	2.3	5.3
1985	28.4	30.9	12.6	8.1	6.2	4.8	3.0	6.0
1986	28.0	30.3	12.4	8.1	6.6	4.8	3.3	6.5
1987	28.2	29.4	12.4	7.9	6.6	4.9	3.8	6.7
1988	27.6	29.3	12.4	7.8	6.8	5.0	4.1	7.0
1989	27.2	28.5	12.2	7.7	6.8	5.2	4.7	7.6
1990	28.4	27.3	11.3	7.7	6.8	5.1	5.2	8.2
Average Annual Change	11.3%	14.8%	25.0%	9.2%	12.7%	13.1%	31.7%	18.9%

Note: "All Other" includes clinic services, laboratories and X-rays, family planning, and health clinics.

[1] 1972 is the earliest year for which these data are available.

[2] Estimated by ACIR.

Sources: Social Security Administration and HCFA 2082 forms.

growth in the number of Medicaid recipients, and a residual that measures all other effects. The residual can be thought of as all factors affecting the intensity of medical care utilization in the program, including the age-sex composition of the Medicaid population, changes in the availability and use of medical technology, and changes in service utilization.[33] This methodology has been questioned by some analysts because it does not adequately account for changes in quality in determining the medical price inflation component.

Figure 3-4 (page 40) provides data on the relative contribution of each of these factors to the growth of Medicaid expenditures for each five-year interval between 1969 and 1989.[34] Examined on an annual basis, the four factors contributing to Medicaid expenditure growth exhibit erratic patterns. For example, the growth in the number of recipients accounted for more than 90 percent of Medicaid expenditure growth in 1971 but -33.4 percent in 1978 because the number of Medicaid recipients decreased in that year, as well as in 1979, 1982, and 1988 (thus making negative contributions). Averaging the data over five-year intervals smooths out such annual fluctuations.

One of the most striking features of Figure 3-4 is the extent to which increases in Medicaid expenditures have been determined by price inflation. Except in the 1969-1974 period, the combination of general price inflation (measured by the GNP fixed-weight price deflator) and medical price inflation (measured by the HCFA price deflator) accounted for well over half of all Medicaid expenditure growth.[35] In the 1979-84 period, the inflation factor was close to 80 percent. Furthermore, the contribution of medical care inflation has increased in each five-year interval, from 7.7 percent in 1969-1974 to 24.5 percent in 1984-89.[36]

In the absence of restructuring the entire U.S. health care system, both general and medical price inflation are relatively uncontrollable factors from the point of view of policymakers trying to hold down Medicaid costs, given that Medicaid represents only approximately 12 percent of all medical care spending and a far smaller share of the overall economy.[37] For example, the rate of medical care inflation is influenced by several factors, including provider responses to private insurance payment systems, physician malpractice insurance premiums, and the development and use of expensive new medical technologies and drugs.

Table 3-12

Average Annual Payment, by Eligibility Category, Fiscal Years 1972-1990

Fiscal Year	Total	Aged 65 or Older	Blind	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other[2]
1972[1]	$358	$580	$417	$833	$145	$307	$555
1973	440	925	644	1,117	165	356	302
1974	465	989	593	1,075	179	388	283
1975	556	1,206	850	1,296	228	455	273
1976	618	1,359	990	1,487	245	479	295
1977	711	1,512	1,258	1,759	270	545	327
1978	819	1,868	1,412	2,088	293	576	347
1979	951	2,095	1,369	2,534	317	661	369
1980	1,079	2,540	1,358	2,659	335	662	398
1981	1,238	2,948	1,784	3,108	366	725	405
1982	1,361	3,315	2,047	3,646	363	764	480
1983	1,503	3,545	2,379	3,932	402	802	662
1984	1,569	3,957	2,766	4,149	411	789	590
1985	1,719	4,605	3,104	4,496	452	860	657
1986	1,821	4,808	3,401	4,721	512	864	720
1987	1,949	4,975	3,644	5,008	542	999	760
1988	2,126	5,425	4,005	5,366	583	1,069	892
1989	2,318	5,926	4,317	5,858	668	1,206	968
1990	2,568	6,717	5,212	6,595	811	1,429	1,062
Average Annual Change	11.6%	14.6%	15.1%	12.2%	10.0%	8.9%	3.7%

[1] 1972 is the earliest year for which these data are available.

[2] Primarily children who do not meet the statutory definition of dependent child.

Sources: Social Security Administration and HCFA 2082 forms.

Changes in the number of Medicaid recipients contributed significantly to Medicaid expenditure growth only in the initial period, 1969-1974, and in the latest, 1984-1989. In the first five years, the change in the number of recipients (averaging 12 percent annually) accounted for 60 percent of the 21.6 percent annual growth in Medicaid expenditures. In 1984-1989, the growing number of recipients (1.7 percent annually) contributed 17 percent to the 10.5 percent annual growth of Medicaid expenditures. The growth of recipients in the latter period was accounted for primarily by the blind, the disabled, and dependent children. Between 1974 and 1984, changes in the number of recipients contributed less than 1 percent of the overall growth of Medicaid expenditures.

The "residual" or "intensity" factor has shown a good deal of variation over the life of the program, representing from less than 10 percent of growth in 1969-1974 to about 40 percent in 1974-1979.[38] In the latest ten-year interval of 1979 to 1989, it accounted for between 20 and 25 percent of Medicaid expenditure growth. The "intensity" factor and the number of recipients are the primary variables available to policymakers to control Medicaid growth.

The Outlook for Medicaid

Numerous economic, medical, and demographic factors can be expected to affect future Medicaid costs. Assuming no change in the structure of the overall health care system, economic factors like medical inflation will likely continue to drive up medical costs generally. Medical factors, such as the appearance of new diseases and the cure of known ones, or technological advances in treatment, also will affect all health care program costs.

General economic conditions will continue to influence demand for Medicaid (the number of eligible recipients) as well as the ability of states and the federal government to finance the program. The supply and distribution of medical providers also will have an impact on program costs. Factors such as these will affect individual states in different ways.

Demographic factors will also play a major role in determining Medicaid costs. Because of their higher costs, the major groups of concern for the Medicaid program are the elderly and the disabled. As a whole, the elderly (those age 65 or over) are projected to grow from 3.9 percent of the population in 1987 to 6.0 percent in 2030. However,

Table 3-13

Average Payments per Recipient, by Type of Service, Fiscal Years 1972-1990

Fiscal Year	Inpatient Hospital	Skilled Nursing and Intermediate Care Facilities	Intermediate Care Facility for the Mentally Retarded	Physicians Dentists, and Other Practicioners[2]	Prescription Drugs	Outpatient Hospital	Home Health Care	All Other[2]
1972[1]	$930	$2,665	-	$64	$46	$70	$229	$43
1973	903	2,569	5,690	68	50	51	227	51
1974	979	2,709	5,205	71	50	57	215	95
1975	1,080	3,292	5,538	80	58	50	204	202
1976	1,220	3,442	7,135	85	63	65	420	148
1977	1,336	3,819	8,570	91	66	102	485	70
1978	1,466	4,517	11,486	93	71	97	559	83
1979	1,748	5,198	13,022	102	84	110	733	115
1980	1,918	5,650	16,439	123	96	113	847	127
1981	2,128	6,168	19,812	132	108	141	1,065	153
1982	2,400	7,104	23,312	135	118	146	1,316	183
1983	2,581	7,317	27,006	140	129	156	1,415	190
1984	2,823	7,847	30,170	139	141	164	1,767	198
1985	3,047	8,427	32,238	146	166	178	2,093	210
1986	3,191	8,887	35,089	153	183	185	2,280	239
1987	3,324	9,322	37,490	162	198	203	2,775	263
1988	3,456	9,880	41,413	173	215	229	3,541	287
1989	3,485	10,696	44,999	196	232	250	4,223	320
1990	3,925	12,110	50,048	212	256	269	4,733	366
Average Annual Change	8.3%	8.8%	13.6%	6.9%	10.0%	7.8%	18.3%	12.6%

Note: "All Other" includes clinic services, laboratories and X-rays, family planning, and health clinics.

[1] 1972 is the earliest year for which these data are available.

[2] Estimated by ACIR.

Sources: Social Security Administration and HCFA 2082 forms.

the number of those age 85 or over (the very old) are projected to grow even faster, doubling their share of the population from 1.2 percent to 2.5 percent. The higher numbers of the very old are important because, on average, Medicaid spends more per capita as the age of the recipient increases. In 1987, Medicaid spent three times as much on recipients age 75-79 as on those age 65-69, and seven times as much for recipients age 85 or over.[39]

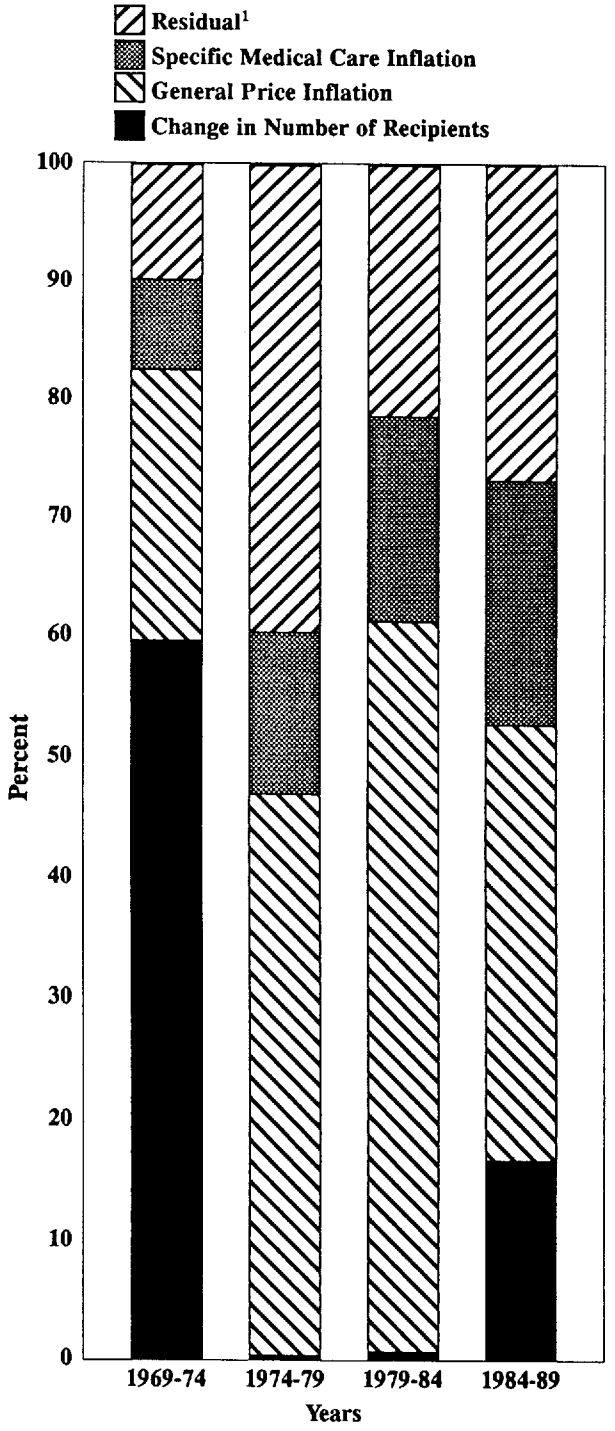
According to HCFA, this variance is attributable to the heavy concentration of Medicaid spending on nursing homes, which the very old use much more than others do. Estimates of the number of elderly needing nursing home care or home care services in the future vary, but all show increased use of these services into the next century, particularly as a result of the aging of the baby boom generation.[40]

The aging of the population also has implications for the number of disabled. As mortality rates have declined, the population appears to have become more disabled. The very old, especially, are at significantly higher risk of disability, as well as functional dependency, chronic illness, and institutionalization. In addition, research suggests that the number of disabled who are nonelderly (estimated at 47 percent in 1979-1980) may also be increasing.[41] Given the growth in the need for services projected for the elderly and disabled populations, as well as the immediate needs of such groups as AIDS patients and babies born with drug dependencies, Medicaid can be expected to continue to grow rapidly not only in the near future but in the longer term as well.

Summary

- Medicaid is the fourth largest source of health care spending in the United States, accounting for over 10 percent of total health care expenditures.
- Medicaid serves more than 1 in 10 Americans. The number of program recipients is about 75 percent of the number of individuals in poverty. In 1990, 40 percent of citizens below the poverty level were served by Medicaid.

Figure 3-4
Sources of Increases in Medicaid Expenditures, 1969-1989



[1] Includes changes in technology, real per capita personal income, age-sex composition of the recipient population, other factors which lead to increases in use and intensity of medical care, and measurement error.

Source: ACIR from data supplied by U.S. Department of Health and Human Services, Health Care Financing Administration.

- Inflation (general and medical care) has accounted for over half of Medicaid expenditure growth since 1975. Growth in the Medicaid population accounted for 17 percent of expenditure growth between 1984 and 1989. Changes in the intensity of utilization of Medicaid services accounted for 20 to 25 percent of the program's growth between 1979 and 1989.
- The rate of growth for Medicaid spending has exceeded inflation and has been more rapid than the rate for other forms of health care spending, including Medicare and total health care spending.
- Medicaid expenditure growth has exceeded the rate of growth of federal and state-local general government expenditures. Medicaid is projected to grow between 12.5 and 25 percent per year between 1990 and 1995. Factors affecting long-term costs also point to continuing Medicaid growth.
- Total Medicaid expenditures represented 14.8 percent of state budgets in 1990, and state costs are projected to rise to 17 percent of state budgets by 1995. The federal government finances over half of these expenditures. Federal Medicaid expenditures constituted 3.6 percent of the federal budget in 1989 and are projected to reach 6.5 percent by 1996.
- State Medicaid spending is influenced by state income and taxpayer burdens, even after accounting for the equalizing effects of the federal matching formula. States with local Medicaid administration spend more on their Medicaid programs. Medicaid's growth apparently occurred at the expense of other social welfare expenditures, particularly cash assistance provided by state and local governments, and other federal intergovernmental expenditures.
- Adults and children in dependent families represent over two-thirds of the Medicaid population but account for only about one-quarter of total Medicaid payments. Furthermore, the share of payments going to these groups has decreased over time. The annual average payments for these groups of recipients are only 30 to 50 percent of the average for all recipients and are growing more slowly than the average for all recipients.
- The elderly, whose annual average payments have grown faster than the average for all Medicaid recipients, account for a disproportionate share of Medicaid payments. Nevertheless, the number of elderly recipients has been declining as a share of the total Medicaid population. The elderly are disproportionate users of nursing home services, which cost more than $12,000 per recipient in 1990.
- The disabled, who constituted 14 percent of total Medicaid recipients in 1990, represent the fastest growing group of recipients and the largest (37 percent) and fastest growing share of Medicaid payments. As a group, the disabled are nearly as

expensive to cover under Medicaid as the elderly, with average annual payments growing faster than the average for all recipients. The disabled are disproportionate users of ICF/MR services.

- ICF/MR services and home health care are two of the least frequently used Medicaid services, but they have had the greatest annual growth in number of users, share of payments, and average cost per recipient. ICF/MR is the most expensive type of service covered by Medicaid, costing nearly $50,000 per recipient in 1990.
- The most frequently used Medicaid services are those provided by physicians, dentists, and other practitioners. The largest shares of Medicaid spending are for inpatient hospital services, skilled nursing home care, and intermediate care facilities. However, the percentage of Medicaid funds going to these three services has decreased over time.

Notes

[1] The Medicaid figures include administrative costs and amounts spent to "buy-in" eligible Medicaid recipients to the Medicare program. Amounts spent on these "dual eligibles" are classified as Medicare payments in the National Health Accounts. Total health care expenditures include amounts spent for research, construction, public health activities, and program administration, as well as direct payments for medical services.

[2] Medicaid vendor payments and total personal health care expenditures are deflated by separate fixed-weight price deflators for medical care developed by HCFA.

[3] Out-of-pocket payments were the second largest source of funds for nursing home care, representing 45.0 percent of all spending. Medicare, which pays for only limited stays in nursing facilities, financed only 4.7 percent of all expenditures for such services, and private insurance paid even less, 1.1 percent of all payments. *Health Care Financing Review* 13 (Fall 1991): 52.

[4] Between 1972 and 1984, Medicare coverage grew by 43 percent—from 21.3 million enrollees to 30.5 million enrollees. In contrast, the number of Medicaid recipients grew by only 22 percent during this period, from 17.7 million to 21.6 million. (The peak years for Medicaid coverage during the 1972-1984 period were 1976 and 1977, when 22.8 million persons received Medicaid benefits). See Health Insurance Association of America, *Source Book of Health Insurance Data, 1990* (Washington, DC, 1991), p. 40; and *Social Security Bulletin, 1989 Annual Supplement* 52 (December 1989): 302.

Medical care prices for Medicare rose faster than for Medicaid between 1972 and 1984. In this period, the overall rate of medical care price inflation was 8.5 percent per year. For Medicare and Medicaid, the annual rates of price increase were 8.8 percent and 8.4 percent, respectively. Ross H. Arnett et al., "National Health Care Expenditures in 1988," *Health Care Financing Review* 11 (Summer 1990): 36; "Revisions to the National Health Accounts and Methodology," *Health Care Financing Review* 11 (Summer 1990): 52; and unpublished data from HCFA.

The difference in the rate of growth of medical care price inflation for Medicare and Medicaid is due to the heavier hospital care and physicians' services in Medicare spending. The annual rate of price increases for hospital care and physicians' services between 1972 and 1984 were 8.8 percent and 9.0 percent, respectively, compared to the overall medical care price inflation of 8.5 percent per year. Expenditures for hospital care and physicians' services accounted for 72.5 percent and 21.7 percent of all Medicare expenditures in 1980. For Medicaid, the corresponding weights were 39.1 percent and 8.5 percent, respectively.

[5] For Medicaid recipients, see HCFA 2082 forms. For Medicaid enrollment, see Health Care Financing Administration, *1990 HCFA Statistics* (Washington, DC, 1991), p. 6.

[6] Arnett, pp. 36, 52.

[7] Administration (OMB and HCFA) budget estimates.

[8] National Association of State Budget Officers, unpublished estimates based on Congressional Budget Office baseline.

[9] *The Omnibus Budget Reconciliation Act of 1989* (OBRA) requires provision of all Medicaid-allowed treatment to correct problems identified during Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), even if the treatment is not otherwise covered under the state Medicaid plan. The act requires additional screenings under EPSDT if medical problems are suspected. OBRA 1990 requires Medicaid coverage of children under age 18 if the family income is below 100 percent of the federal poverty line. U.S. General Accounting Office, *Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress* (Washington, DC, June 1991), p. 42.

[10] Ibid., pp. 4-5.

[11] Generally, Medicaid is funded from the state general fund, an amount that is smaller than state general expenditures. For example, in fiscal year 1988, state general expenditures totaled $432 billion, while state general funds totaled only $233 billion. Because state general funds are not earmarked, Medicaid must compete with other programs for funding. As Medicaid costs rise, less money is left in the general fund for other purposes.

[12] Congressional Budget Office, *The Economic and Budget Outlook: An Update* (Washington, DC, August 1991), pp. 52, 54.

[13] *State Budget and Tax News* 9 (June 20, 1990): 4.

[14] See, for example, Charles J. Barrilleaux and Mark E. Miller, "The Political Economy of State Medicaid Policy," *American Political Science Review* 82 (December 1988): 1089-1107; Robert J. Buchanan, Joseph C. Cappelleri, and Robert L. Oshfeldt, "The Social Environment and Medicaid Expenditures: Factors Influencing the Level of State Medicaid Spending," *Public Administration Review* 51 (January/February 1991): 67-73; John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-Off between Cost Containment and Access to Care* (Washington, DC: The Urban Institute, 1986); Saundra K. Schneider, "Intergovernmental Influences on Medicaid Program Expenditures," *Public Administration Review* 48 (July/August 1988): 756-763; Frank A. Sloan, "State Discretion in Federal Categorical Assistance Programs: The Case of Medicaid," *Public Finance Quarterly* 12 (July 1984): 321-346; and U.S. General Accounting Office, *Medicaid: Interstate Variations in Benefits and Expenditures* (Washington, DC, May 1987), pp. 38-41.

[15] Under current law, federal Medicaid funds are used to reimburse states according to the ratio of state per capita personal income to U.S. per capita personal income.

The federal matching rate
(FMAP) = 1.00 - .45 percent [state PCI/USPCI]^2

PCI is based on a three-year average. The minimum matching rate is 50 percent and the maximum is 83 percent. With some minor exceptions, the matching rate for administrative costs is 50 percent.

[16] This is especially true in states with large mineral deposits or timber resources. States can raise significant amounts of revenue from severance, property, and other taxes levied on these sources. Similarly, states with large tourist industries can raise significant revenues from taxes on restaurant meals, amusements, and temporary lodgings.

[17] See ACIR, *1988 State Fiscal Capacity and Effort*, and *Representative Expenditures: Addressing the Neglected Dimension of State*

Fiscal Capacity, by Robert W. Rafuse, Jr. (Washington, DC, 1990).

[18] See Barrilleaux and Miller, p. 1101; Sloan, p. 342, and General Accounting Office, *Medicaid: Interstate Variations in Benefits and Expenditures*, p. 41.

[19] U.S. General Accounting Office, *Changing Medicaid Formula Can Improve Distribution of Funds to States* (Washington, DC, March 1983), and *Medicaid Formula: Fairness Could Be Improved*, statement of Janet L. Shikles before the House of Representatives, Committee on Government Operations, Subcommittee on Human Resources and Intergovernmental Relations, December 7, 1990.

[20] U.S. General Accounting Office, *Medicaid: Alternatives for Improving the Distribution of Funds* (Washington, DC: May 1991), pp. 18-19.

[21] Ibid.

[22] Ibid., pp. 12-13.

[23] Schneider, p. 758; and Buchanan et. al., p. 69.

[24] Elasticity is defined as the ratio of change in tax yield to change in economic base, usually personal income. Local government revenue systems are not elastic because of their heavy reliance on property taxes. J. Richard Aronson and John L. Hilley, *Financing State and Local Governments*, Fourth Edition (Washington, DC: The Brookings Institution, 1986), p. 52.

[25] Robert Moffitt, "Has State Redistribution Policy Grown More Conservative?" *National Tax Journal* XLIII (June 1990): 123-142.

[26] Federal health spending includes spending through the Departments of Veterans Affairs and Defense, as well as public health activities, research, and construction.

[27] U.S. Department of Commerce, Bureau of the Census, *Poverty in the United States 1990* (Washington, DC, 1991), p.168.

[28] SSI benefits were received by 1.89 million recipients aged 65 and over in January 1974 and by 1.44 million in March 1990. *Social Security Bulletin, Annual Statistical Supplement, 1989* 52 (December 1989): 318; and *Social Security Bulletin* 53 (September 1990): 75.

[29] U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book*, Committee Print 100-AA (Congressional Research Service, November 1988), p. 42.

[30] Ibid., p. 43.

[31] The growth of the Medicaid ICF/MR population from only 29,000 in 1973 to current levels can be attributed partly to facilities being brought into compliance with Medicaid standards, as opposed to an intrinsic increase in the portion of the Medicaid population needing such services or the expansion of the program to groups benefiting disproportionately from this service.

[32] *Medicaid Source Book*, p. 348.

[33] The estimates of the relative contribution of each factor were derived by dividing total Medicaid expenditures into the following constituent parts:

$$E = (M/G) * (G) * (P) * (E/M*P)$$

where:

E = total Medicaid expenditure in any year.

M = the fixed weight medical care price index developed by HCFA.

G = the fixed weight price deflator for gross national product.

P = the number of Medicaid recipients.

The term (M/G) is the index for specific medical care price inflation, and the last term (E/MP) is the residual. The relative contribution of each factor to Medicaid growth is obtained by summing the percentage change for each factor and then dividing the percentage change for each factor by that sum. See *Health Care Financing Review* 10 (Summer 1989): 4-5, and unpublished data from HCFA.

[34] HCFA provided the data for 1969 through 1988. ACIR estimated the data for 1989 from medical care price indexes in the *Social Security Bulletin* 53 (September 1990): 56-59, GNP price deflators in the *Survey of Current Business* 70 (July 1990): 90, and a Department of Health and Human Services *News Release*, December 20, 1991.

[35] The relatively small contribution of medical care price inflation in the 1969-1974 period is partly the result of price controls put on medical care between 1972 and 1974. HCFA, "National Health Care Expenditures in 1988," p. 4.

[36] The contribution of medical care inflation to Medicaid expenditure growth has been positive every year since 1969, with the exception of 1972, because medical prices have tended to rise faster than the general price level. Medical care prices increased 35 percent faster than the level of general prices over the entire period studied, and 61 percent faster in the last five-year interval.

[37] Creating a single-payer universal health system or instituting comprehensive national medical expenditure limits may be effective in restraining medical price inflation. Such procedures would, however, have to include all public and private health programs, not just Medicaid.

[38] The large residual in the 1974-1989 period can be explained partly by the extremely high utilization of hospital services in 1982 relative to 1971. HCFA, "National Health Expenditures in 1988," p. 4.

[39] Daniel R. Waldo, Sally T. Sonnefeld, David R. McKusick, and Ross H. Arnett, III, "Health Expenditures by Age Group, 1977 and 1987," *Health Care Financing Review* 10 (Summer 1989): 111-120.

[40] See, for example, Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly* (Washington, DC: The Brookings Institution, 1988), p. 10; and U.S. Department of the Treasury, *Financing Health and Long-Term Care* (Washington, DC, March 1990), Table 2.1.

[41] Sean Sullivan and Marion Ein Lewin, eds., *The Economics and Ethics of Long-Term Care and Disability* (Washington, DC: American Enterprise Institute, 1988), ch. 2.

Appendix. MAJOR FEDERAL CHANGES IN MEDICAID

1965 Medicaid (Title XIX of *Social Security Amendments of 1965*) enacted.

1966 Medicaid program began January 1.

1967 *1967 Social Security Amendments* enacted.

- Established maximum income level of 133-1/3 percent of actual payment level under AFDC for medically needy.
- Provided that federal matching would not be available for services that could have been covered by buying-in to Medicare but were not.
- Established "freedom of choice" requirement.

1970 Statutory deadline in original legislation for states to come into the program.

1972 *1972 Social Security Amendments* enacted.

- Allowed states to impose nominal copayments for optional services on categorically needy.
- Provided that states could receive 90 percent matching rate for developing a Medicaid Management Information System (MMIS) or comparable system, and 75 percent funding for ongoing operation of the system.
- Authorized federal Medicaid funding for ICF/MR care, provided institutions meet federal standards.

1974 Original ICF/MR standards published by the Secretary of Health and Human Services.

1976 *Health Maintenance Organization Amendments of 1976* enacted.

- Included the first specific federal requirements for Medicaid contracts with HMOs or comparable organizations.

1977 *Medicare/Medicaid Anti-Fraud and Abuse Amendments* enacted.

- Provided 90 percent federal matching for first three years of operation of a State Medicaid Fraud Control Unit (SMFCU) and 75 percent thereafter, with funding limit.

1980 *Omnibus Reconciliation Act of 1980* enacted.

- Repealed requirement that states follow Medicare "reasonable cost" reimbursement principles for nursing home services.
- Required states to cover nurse-midwife services.

Mental Health Systems Act of 1980 enacted.

- Required all states to have an MMIS meeting federal standards by September 30, 1982 (later changed to 1985) or face reductions in federal financial participation in administrative costs.

1981 *Omnibus Budget Reconciliation Act of 1981* enacted.

- Reduced federal Medicaid contributions to each state by 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984. States could offset these reductions by certain circumstances or actions.
- Changed treatment of earned income of AFDC recipients, which reduced their eligibility for both AFDC and Medicaid.
- Repealed requirement that states follow Medicare "reasonable cost" reimbursement principles for hospital inpatient services, but required that states take into account the situation of hospitals with "disproportionate shares" of low-income patients with special needs.
- Removed requirement that payment for physicians' and certain other services not exceed reasonable charge levels as defined under Medicare.
- Established "2175" freedom of choice waivers.
- Established "2176" waivers for home and community-based long-term care services.

1982 *Tax Equity and Fiscal Responsibility Act of 1982* enacted.

- Allowed states to extend Medicaid eligibility to certain disabled children under 18 living at home who would be eligible for SSI if they were institutionalized ("Katie Beckett" provision)
- Permitted states to require cost sharing (copayments, coinsurance, and deductibles) for nearly all mandated or optional services provided to both the categorically and medically needy.
- Established a 3 percent target error rate for eligibility determinations and penalties for failure to fall below these levels.

1984 *Deficit Reduction Act of 1984* enacted.

- Required states to provide Medicaid coverage to first-time pregnant women, pregnant women

in two-parent unemployed families, and children up to age 5 in two-parent families meeting the income and resource criteria for AFDC.

- Contained AFDC program changes intended to restore or continue Medicaid coverage to working poor families.
- Granted automatic eligibility for 1 year to babies born to women already receiving Medicaid.

Social Security Disability Benefits Reform Act of 1984 enacted.

- Extended through 1987 a provision allowing a disabled person receiving SSI to continue to receive Medicaid benefits after returning to work.

1985 *Consolidated Omnibus Budget Reconciliation Act of 1985* enacted.

- Required states to extend Medicaid coverage to all pregnant women in families meeting AFDC income and resource standards, including those in two-parent families where the principal earner is not unemployed.
- Required states to provide post-partum coverage to eligible pregnant women for 60 days after pregnancy ended.
- Established optional hospice and case-management benefits.
- Required annual rather than biennial calculation of the FMAP beginning with FY87.

1986 *Omnibus Budget Reconciliation Act of 1986* enacted.

- Established option for states to extend Medicaid coverage to all pregnant women, infants up to age 1, and children up to age 5 (phased in) with family incomes up to 100 percent of the poverty level.
- Established option for state to extend Medicaid coverage to all elderly and disabled individuals with incomes up to 100 percent of the poverty level and meeting SSI asset test, or to buy them into Medicare.
- Gave the states an option to establish a period of up to 45 days of "presumptive eligibility" for pregnant women to receive ambulatory prenatal care.
- Required states to continue Medicaid coverage for disabled individuals with severe impairments who lose their eligibility for SSI as a result of earnings from work.
- Specified that federal matching funds were not available for Medicaid services to aliens not lawfully admitted for permanent residence, except in the case of emergency medical conditions.

1987 *Medicare and Medicaid Patient and Program Protection Act of 1987* enacted.

- Contained major expansion of the antifraud and abuse authorities applicable to both Medicare and Medicaid, including broadening the grounds for exclusions from the programs and clarification of civil money penalties.

Omnibus Budget Reconciliation Act of 1987 enacted.

- Contained major revisions of Medicaid policy toward nursing homes, including making nursing services mandatory and specifying standards for scope of services to be provided, levels and qualifications of staff, assessment of each resident's functional capacity, survey and certification procedures, and sanctions.
- Gave states the option to extend Medicaid coverage to pregnant women and infants up to age 1 with incomes up to 185 percent of the federal poverty level.
- Gave states option to accelerate coverage to children below poverty up to age 5 and to expand coverage to those under age 8.
- Established a new home and community-based services waiver authority for persons over 65.

1988 *Medicare Catastrophic Coverage Act of 1988* enacted.

- Required states to extend Medicaid eligibility to pregnant women and infants under age 1 with income up to 75 percent of poverty by July 1, 1989, and up to 100 percent of poverty by July 1, 1990.
- Required Medicaid to pay Medicare cost-sharing for elderly and disabled recipients below 100 percent of poverty (to be phased in by 1992).
- Increased the amount of income and assets a non-institutionalized spouse of a Medicaid recipient receiving nursing home services may retain.
- Imposed new national "transfer of assets" policy for institutionalized Medicaid recipients.

Family Support Act of 1988 enacted.

- Requires states to continue Medicaid coverage for 12 months to working poor families who leave cash assistance due to earnings.
- Requires states to provide full Medicaid coverage to all members of two-parent families on AFDC where the principal earner is unemployed (AFDC-UP), even in months when cash assistance benefits are not paid.

1989 *Omnibus Reconciliation Act of 1989* enacted.

- Required states to raise Medicaid eligibility for pregnant women and infants to 133 percent of poverty.
- Required states to cover children through age 6 up to 100 percent of poverty, and to pay for all "medically necessary" services for problems identified during regular Medicaid-covered checkups.
- Made coverage optional for children though age 6 up to 133 percent of poverty.

1990 *Omnibus Reconciliation Act of 1990* enacted.

- Required states to phase in coverage of children through age 18 in families at or below 100 percent of poverty.

- Requires continuous coverage of 60 days post-partum for pregnant women and 1 year for infants, extends presumptive eligibility for pregnant women, and requires states to conduct outreach.
- Authorizes programs within Medicaid for home and community-based care for frail or immobile elderly and developmentally disabled.
- Requires drug manufacturers to enter into rebate agreements with the Secretary of HHS for prescription drugs reimbursed under Medicaid; denies matching funds to states whose programs cover products not governed by such an agreement.
- Requires states to establish drug review programs.

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