ECONOMIC COMMENTARY

Medicaid: Federalism and the Reagan Budget Proposals
by Paul Gary Wyckoff

The Medicaid Program
Medicaid, a program created in 1965 as Title XIX of the Social Security Act, is a joint responsibility of the federal government and the states. Although state governments administer the program, the legislation authorizing Medicaid calls for a high degree of interdependence and cooperation between the two levels of government. For example, funding for the program is roughly equally divided between federal and state governments; the federal government pays an average of 55 percent, and states pay an average of 45 percent. The federal government matches the expenditures of each state government at a rate that depends on the state's per capita income (currently, the federal government's share of expenditures in each state ranges from a low of 50 percent to a high of 77 percent).

It is in the area of eligibility, however, that the mixing of federal and state authorities is most evident. The regulations determining eligibility are quite complex, but in broad terms two groups of people are served by Medicaid: those who are aged, blind, or disabled (SSI)—a primarily federal program that provides cash assistance to one-parent families, or Supplemental Security Income (SSI)—a primarily federal program that provides cash assistance to one-parent families, and they turn to Medicaid only after being placed in nursing homes. Furthermore, it might be difficult to justify the plan's realignment of responsibilities for long-term and other kinds of care. The proposal would function as if to aid those who need long-term care (primarily, the aged and disabled) would generate local benefits, but that help for those receiving other kinds of care would generate purely national benefits. A good case could be made, however, that it is the long-term beneficiaries who are a federal responsibility. As was noted above, members of this group often initially receive their medical care under Medicare, a national program, and they turn to Medicaid only after being placed in nursing homes. If there is a national interest in providing other kinds of medical care to this group, why not provide nursing home care also?

A second proposal was originally suggested in the 1982 budget and has resurfaced in President Reagan's current budget. The 1986 version of the proposal would limit overall Medicaid payments to $22.2 billion and would distribute this total among states in amounts that are proportional to the states' populations. Under the new proposal, states would be allowed to expand or contract each program according to its own needs. With a limited amount of time and other resources, increasing the attention given to one of these aspects of public budgeting tends to diminish the attention given to the other.

The inconsistencies between the Reagan administration reform proposals, however, suggest that more attention should be paid to the goals of the Medicaid program itself. Excessive attention to dollar reductions risks thwarting the balance between national and regional concerns found in the existing program. Additionally, discussion about the purposes of Medicaid would seem to be warranted: only when this issue has been decided should reformers go on to the question of how best to save money while furthering program goals to the maximum extent possible.

Conclusion
There is always a tension between budget planners, who strive to bring spending in line with revenues, and program analysts, who want to expand or contract each program according to its own merits. With a limited amount of time and other resources, increasing the attention given to one of these aspects of public budgeting tends to diminish the attention given to the other.

The need for answers to these questions has become more urgent because of the Reagan administration's efforts to trim the federal budget. This Economic Commentary outlines the Medicaid program, examines the economic justifications for its existence, and analyzes the major Reagan administration proposals for altering funding for the program. The article strives to reveal the fundamental policy question raised by reforms that have previously been discussed in purely budgetary terms. As will be shown below, an informed decision about dollars and cents cannot be made without thinking carefully about the ultimate goals of the program and the best means to implement those goals in a multi-government system.

As the nation's program of medical assistance for the poor, Medicaid enters its 20th year, many fundamental policy questions about the program are still being worked out. Do steelworkers in Pittsburgh, for example, have an interest in the medical care given to the disabled in California? Are the health needs of the poor the responsibility of their county or state government, or of the nation as a whole? Is it more important to allow local control of the program, or to insure equal access to medical care across the country?

The need for answers to these questions has become more urgent because of the Reagan administration's efforts to trim the federal budget. This Economic Commentary outlines the Medicaid program, examines the economic justifications for its existence, and analyzes the major Reagan administration proposals for altering funding for the program. The article strives to reveal the fundamental policy question raised by reforms that have previously been discussed in purely budgetary terms. As will be shown below, an informed decision about dollars and cents cannot be made without thinking carefully about the ultimate goals of the program and the best means to implement those goals in a multi-government system.

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This means that Medicaid recipients fall into two quite distinct groups. One group, the AFDC recipients, makes up two-thirds of all recipients; but because these individuals are relatively young (66 percent are under 21) the cost per person of serving this group is small, and they account for only 28 percent of program costs. A second group, the aged and disabled, constitutes only 28 percent of recipients but, because of their serious health problems, consumes 67 percent of program funds. This second group is more likely to need long-term care. It is therefore impoverished because of extraordinary medical bills. Of those Medicaid recipients age 65 and older, for example, 74.5 percent of payments are for individuals who are not receiving cash assistance like AFDC or SSD.

### The Economic Rationale for Federal Grants

The current financial structure of Medicaid has its drawbacks. Since it is an open-ended grant, the unrestricted nature of the federal government’s spending authority may lead to state and local governments’ demand for medical care to the poor. The current system is neither state nor federally financed, but is a hybrid. This makes economic sense only if the benefits of ensuring that the poor receive adequate health care accrue to the whole nation, but are concentrated more heavily in the local geographic area. For example, citizens of San Diego derive pleasure from knowing the poor in New York are receiving adequate medical care. Under these circumstances, a federal matching grant which states can increase the amount of federal aid without limits simply by spending more on the program. By contrast, a closed-ended matching grant is one which states have a maximum limit on aid. President Reagan’s proposal to “cap” Medicaid grants would convert the present system into a closed-ended grant. Block grants (an alternate matching discussion for non-matching grants) Their amount is independent of the recipient’s expenditures but they are restricted to a certain broad class of expenditures.

All of this reasoning helps rationalize the general form of the current Medicaid system, but not its particular structures which are compatible with the arguments above, depending upon the exact nature of people’s tastes for medical care for the poor. In choosing between these competing alternatives, the political process must strike a balance between 1) the fairness of a class system of medical care, which provides the same level of care to everyone regardless of where they live, and 2) the efficiency of a state system, which allows local differences in tastes to be expressed in different levels of medical care.

### The Reagan Proposals

In 1984, Medicaid served 22 million people, costing the states $17 billion and the federal government $21 billion. Medicaid is the largest type of grants-in-aid to state and local governments, Medicaid is a tempting budget target for an administration committed to cutting back federal domestic spending.

Furthermore, like health expenditures generally, the growth rate of this program has exceeded the rate of growth of the economy as a whole. Between 1973 and 1980, Medicaid pay- ments rose at an annual rate of 13.5 percent, compared to a rate of 10.3 percent for the economy as a whole. Small wonder, then, that the Reagan administration has made vigorous efforts to reduce the rate of growth of this program. The Omnibus Budget Reconciliation Act of 1981 specified cuts of $1 billion per year, the Tax Equity and Fiscal Responsibil- ity Act of 1982 included savings valued at $1.4 billion over three years, and the administration’s 1986 budget re- quest included cuts of approximately $2 billion.

The Reagan administration has made two major proposals to reform the financing of Medicaid. In 1982, as part of the Reagan budget proposal, the administration offered to assume full financial responsibility for the Medicaid program for full state assumption of AFDC. Later, this proposal was revised to omit the long-term care portion of Med- icaid from this swatch, long-term med- ical care would continue to be run by the states under a block grant from the federal government. Given the Omnibus Budget Reconciliation outlined above, it is easy to see the fund-amental concern raised by such a proposal. Medicaid. Federal funding of Medicaid presumes that the benefits of health care for the poor

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under the program. These are individuals whose medical expenses are large in relation to their income and who meet all the eligibility standards for AFDC orSSI—except for the income-related provisions. Specifically, a family is classified as medically needy if its income after medical expenses is no greater than 135 percent of the state’s maximum AFDC payment for the same size family. Currently, 31 states cover the medically needy.

The fact that some states cover the medically needy is of more than administrative interest. The medically needy option has fundamentally affected the operation of the Medicaid program, setting up, in effect, two very different programs within Medi- care. This dual-purpose result has occurred because of a gap in Medicare, the nation’s program of medical insur- ance for the elderly and disabled.

After an elderly or disabled individual has a serious illness, Medicare pays for hospital bills and 100 days of care in a skilled nursing facility. (This benefit is intended to provide rehabilitation after an acute illness and not for long-term care.) Since many ill elderly or disabled people are not in hospitals, however, and because private insurance policies cover nursing home care, the family of a long-term care patient is frequently forced to pay for this care out of its own pocket. Once the family uses up almost all of its assets (savings, securities, etc.), however, the patient can qualify as medically needy if these nursing home bills exceed 12 percent of his family’s income. Since nursing home care itself can exceed $20,000 to $50,000 per year, it is not hard to see how a large number of formerly middle-class families might be brought onto the Medicaid rolls. Medicaid now pays for over 40 percent of the nation’s nursing home bills!


The Economic Rationale
for Federal Grants

The current financial structure of Medicaid has its drawbacks. Since it is an open-ended grant, the unrestricted nature of the federal government’s spending desires makes meeting and expenditure control difficult. From the state’s perspective, restrictions about which services are to be covered and what groups are to be served limit the state’s effectiveness in targeting resources. And from the viewpoint of the recipients of the program, the constraint that program funds be used only for medical care may not make sense if the purpose is simply to alleviate the miseries of poverty. If recipients are capable of deciding how best to spend the resources at their command, greater satisfac- tion can be achieved under the same level of cost by giving them unrestricted transfers of cash, to be spent at their discretion. What justi- fication, then, can be given for the present system?

Programs such as Medicaid, which give "in-kind" benefits, goods, or ser- vices rather than cash, are irrational unless taxpayers receive some sort of satisfaction from knowing that the poor are receiving a particular service. That is, it must be the recipient’s consumption of the program’s services, and not his general level of well-being, that is of concern to the taxpayer. In the case of medical care, this concern might spring from both selfish and unselfish motives. If the program leads to a reduction in the incidence of communicable disease, this result may benefit the taxpayer because of extraordinary medical bills. Of those Medicaid recipients age 65 and older, for example, 74.5 percent of payments are for individuals who are not receiving cash assistance like AFDC orSSI.

Contrary to the inherent assumption that the poor are not capable of deciding how best to spend the resources at their command, greater satisfaction can be achieved under the same level of cost by giving them unrestricted transfers of cash, to be spent at their discretion. What justifi- cation, then, can be given for the present system?

Economist Lester Thurow has pointed out that it is not necessarily contradictory to have a competitive market economy and yet decide that certain "merit goods" ought to be provided on an equal basis to every- one, because citizens may derive direct satisfaction from knowing that society is (according to the taxpayer’s cri- teria) compassionate or fair. Accord- ing to Thurow, equal access to medi- cal care may be considered a societal "ground rule," entirely apart from the competitive struggle that domi- nates the distribution of other eco- nomic resources.

In-kind transfers are to be pro- vided to the poor, what level of gov- ernment should provide them? The obvious answer is that the responsible government should include all indi- viduals who receive satisfaction from the transfers, and no one else. If these benefits are national in scope, so that citizens of San Diego care whether poor people in New York have adequate medical care, then decisions about who should be financed by the federal government. Otherwise, under a state-run system, medical care is likely to be unaffordable, because the New York state legislature, for example, won’t take account of the concerns of San Diegans. Since we have pointed out that it is not necessarily contradictory to have a competitive market economy and yet decide that certain "merit goods" ought to be provided on an equal basis to everyone, because citizens may derive direct satisfaction from knowing that society is (according to the taxpayer’s criteria) compassionate or fair, the question then arises of whether we should give equal access to medical care.

The current system is not the only nor necessarily the best way to provide medical care to the poor. That is, it must be the recipients of medical care who are citizens of San Diego who derive satisfaction from knowing that Medicaid is a purely national system that would force the poor to receive adequate health care to the poor. Instead of respond- ing to the diversity of people’s demand for medical care to the poor, a purely national system would force citizens of every state to pay for and "consume" the same amount of medi- cal care for the poor.

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The Reagan administration has made two major proposals to reform the financing of Medicaid. In 1982, as part of its "New Federalism" proposi- tal, the administration offered to assume full financial responsibility for all state programs for full state assumption of AFDC. Later, this proposal was revised to omit the long-term care portion of Med- icaid from this swap, long-term med- ical care would continue to be run by the states under a block grant from the federal government.

Given the national scene outlined above, it is easy to see the fun- damental concerns raised by such a proposal. Medicaid. Federal funding of Medicaid presumes that the benefits of health care for the poor
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Even here, however, states have some influence because they determine need and payment levels under AFDC, and they control AFDC coverage for certain optional groups, such as families with two unemployed parents. State discretion also enters under the SSI program because of two options in the law. State governments may provide supplementary SSI benefits at their own expense, and states may choose to do so. Also, states may choose to restrict Medicaid to those groups served by the state's program of aid to the aged, blind, and disabled that was in place prior to the introduction of the SSI program in 1974, if that program was more restrictive in its eligibility than SSI.

The Health Care Financing Administration, which makes Medicaid grants to the states, uses the term "categorically needy" to describe those who are eligible for Medicaid because they receive AFDC or SSI payments. The most important option available to states under Medicaid is to allow a second group of people—the "medically needy"—to be covered.