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ECONOMIC COMMENTARY

Medicaid: Federalism and the Reagan Budget Proposals

by Paul Gary Wyckoff

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 questions 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.

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 authority is most evident. The regulations determining eligibility are quite complex, but in broad terms two groups of people are served by Medicaid.[1] First, the federal government requires Medicaid coverage for individuals receiving Aid to Families with Dependent Children (AFDC), which is a federal-state program to provide cash assistance to one-parent families, or Supplemental Security Income (SSI)—a primarily federal program that provides income support to poor people who are aged, blind, or disabled.

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 the recipients of these benefits can be covered under Medicaid if the states 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

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The views stated herein are those of the author and not necessarily those of the Federal Reserve Bank of Cleveland or of the Board of Governors of the Federal Reserve System.

1. The eligibility provisions of the Medicaid program are quite complex and the following is intended as only a summary. For details, see *The Medicare and Medicaid Data Book, 1983*, Baltimore, MD: U.S. Department of Health and Human Services, Health Care Financing Adminstration, December 1983.

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 or SSI—*except* for the income provisions. Specifically, a family is classified as medically needy if its income after medical expenses is no greater than 133 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 Medicaid. This dual-purpose result has occurred because of a gap in Medicare, the nation's program of medical insurance 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 illnesses require much longer nursing home stays, and because few private insurance policies cover nursing home care, the family of a long-term nursing home 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 are large relative to the family's income. Since nursing home care costs range from $20,000 to $50,000 per year, it is not hard to see how a large number of formerly middle-class patients end up on the Medicaid rolls. Medicaid now pays for over 40 percent of the nation's nursing home bills.[2]

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.[3] 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.[4] This second group is more likely to need long-term care and to be impoverished solely 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 SSI.[5]

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 commitment makes budgeting 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 satisfaction can be brought to these groups at the same level of cost by giving them unrestricted transfers of cash, to be used at their discretion. What justification, then, can be given for the present system?

Programs such as Medicaid, which give "in-kind" benefits, goods, or services 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, for example, the taxpayer may benefit from being exposed to fewer of these diseases. On the other hand, the taxpayer may benefit from simply knowing that medical care is available to all.

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 everyone, because citizens may derive direct satisfaction from knowing that society is (according to the taxpayer's criteria) compassionate or fair.[6] According to Thurow, equal access to medical care may be considered a societal "ground rule," entirely apart from the competitive struggle that dominates the distribution of other economic resources.

If in-kind transfers are to be provided to the poor, what level of government should provide them? The obvious answer is that the responsible government should include all individuals 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

2. See "Growing Demand for Long-Term Care . . . Drains Medicaid Coffers Nationwide," *C Q Weekly Report*, May 11, 1985, p. 892.

3. *Medicare and Medicaid Data Book, 1983*, pp. 85 and 115.

4. *Medicare and Medicaid Data Book, 1983.*

5. *Medicare and Medicaid Data Book, 1983*, p. 85.

6. See Lester C. Thurow, "Cash Versus In-Kind Transfers," *American Economic Review*, vol. 64, no. 2 (May 1974), pp. 190–95.

poor people in New York have adequate medical care, then the program should be financed by the federal government. Otherwise, under a state-run system, medical care is likely to be underprovided since the New York state legislature, for example, won't take account of the concerns of San Diego citizens in deciding on the amount of medical care for the poor.

On the other hand, if the benefits of in-kind transfers are purely *local* in nature, then a state or local government should foot the bill. Federal involvement in this case would thwart the ability of people in different states to decide on different levels of medical care for the poor. Instead of responding to the diversity of people's desire to provide medical care to the poor, a purely national system would force citizens of every state to pay for and "consume" the same amount of medical care for the poor.

The current system is neither state nor federally financed, but is a hybrid of the two approaches. 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 cared for, but they derive even more satisfaction when the poor in their own city receive medical care. Under these circumstances, a federal matching grant causes states to reflect the wishes of out-of-state citizens in making decisions about Medicaid, while also allowing some geographic diversity in the levels of medical care provided. In such a system, the federal grant becomes a financial representation of the demands of out-of-staters for medical care for the poor within each state.

In developing federal aid formulas, therefore, the crucial question concerns the characteristics of out-of-staters' demand for in-state medical care. If it is anything like the demand for other, more normal kinds of goods, the out-of-state demand function can be represented by a smooth, downward-sloping curve. Under such an ordinary demand curve, the price a consumer is willing to pay for additional health care for the poor, declines steadily, not abruptly, as the amount of care increases. Such a curve demands an open-ended rather than closed-ended grant (see box), because the demands of out-of-staters do not suddenly drop to zero at a certain level of health care to poor people. Unless it is clear that, at some point, out-of-staters receive no satisfaction from additional health care for the poor, the ideal grant must be open-ended.

Three Types of Grants-in-Aid

Three types of aid have been discussed in connection with Medicaid. The present system of aid consists of an *open-ended matching grant*, which means that 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 that specifies 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 alternative now being discussed) are usually non-matching grants. Their amount is independent of the recipient's expenditures and they are restricted on a certain broad class of expenditures.

All of this reasoning helps rationalize the general form of the current Medicaid system, but not its particulars. A wide variety of matching rate structures are compatible with the arguments above, depending upon the exact nature of people's tastes for providing medical care to the poor. In choosing between these competing alternatives, the political process must strike a balance between 1) the fairness of a national 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.[7] Since it is the largest single program 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 rate of growth of this program has exceeded the rate of growth of the economy as a whole. Between 1973 and 1980, Medicaid payments grew at a compound annual rate of 15.3 percent, compared to a rate of 10.3 percent for the economy as a whole.[8] Small wonder, then, that the Reagan adminstration 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 Reponsibility Act of 1982 included savings valued at $1.14 billion over three years, and the administration's 1986 budget request included cuts of approximately $1 billion per year.

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

Given the program rationale outlined above, it is easy to see the fundamental concerns raised by such a restructuring of Medicaid. Federal funding of Medicaid presumes that the benefits of health care for the poor

7. See "Congress Shies Away from Any Cap on Medicaid Outlays," *C Q Weekly Report*, May 11, 1985, pp. 891 and 894.

8. *Medicare and Medicaid Data Book, 1983*, p. 23; and *Economic Report of the President*, February 1985, p. 239.

are not locally concentrated and forfeits any opportunity to tailor Medicaid programs to meet the preferences of local taxpayers. Furthermore, it might be difficult to justify the plan's realignment of responsibilties for long-term and other kinds of care. The proposal would function as if aid to 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 the same proportions as were used when 1984 funds were distributed. After 1986, the proposal would allow each state's payments to rise only as much as the rate of increase in the medical care component of the consumer price index. There would be no allowance in these increases for changes in the relative cost of providing health care or in the proportion of the population living in poverty.

This proposal stands in sharp contrast to the previous plan to federalize Medicaid. The implications about who is responsible for health care are markedly different. Under the swap proposal, the Reagan administration is implying that (for the portion of the program that doesn't cover long-term care) there is no *regional* interest in health care for the poor. Under the cap proposal, on the other hand, the administration is acting as if there is no *national* interest in additional expenditures on health care for the poor in each state. This is a radical departure from current policy, especially in the case of relatively poor states that have very limited Medicaid programs. Many reformers advocate improving these programs to make access to health care more equitable across states.

South Dakota, for example, covers just 23 percent of its poverty population under Medicaid, while California covers 97 percent. In 1980, Oregon spent $646 per recipient, while New York spent $1,985—more than three times as much. As if to underscore the importance of federal aid in addressing these imbalances, South Carolina has recently moved to expand its very limited program (third lowest Medicaid payments per recipient among states), but has legally conditioned these improvements on the availability of federal matching funds.

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 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. Additional 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.

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