MEMORANDUM

COUNCIL OF ECONOMIC ADVISERS

February 29, 1996

TO: CHRIS JENNINGS

FROM: LOUISE SHEINER /s

SUBJECT: FYI - Medicaid piece from Weekly Economic Briefing

Here is the Medicaid piece we discussed.

SPECIAL ANALYSIS

Medicaid: 51 Different Programs?

The National Governor's Association (NGA) recently released a proposal to reform the Medicaid program. The proposal would provide increased flexibility to states for determining Medicaid eligibility, and total flexibility to determine the amount, duration, and scope of services provided under the program. This article explores how the current Medicaid program varies across the states, in order to provide some background against which to assess the NGA proposal.

Federal requirements. In general, states are required to offer Medicaid to those receiving cash assistance (AFDC or SSI), as well as to poor children and poor pregnant women. Federal law determines the set of services (including hospital and physicians' services) that states must offer to this population. Federal law also places some requirements on the types of services states must include if they elect to offer coverage to other groups. States may place limits on coverage of these services, but their Medicaid programs must be adequate to provide reasonable health care.

Variation in state Medicaid programs. Medicaid programs vary along two key dimensions that determine differences in program spending across states.

Fraction of Poor Covered. The fraction of the poor eligible for Medicaid varies significantly across the states, largely reflecting differences in eligibility policies. For the non-elderly population, the ratio of people eligible for Medicaid to people with income at or below 150 percent of the poverty rate in recent years was 64 percent nationally—but varied from 41 percent to 88 percent across states. Lower-income states tend to cover a lower fraction of their poor, but because the poor comprise such a large share of their population, lower-income states generally provide Medicaid to a larger fraction of their total population than higher-income states.

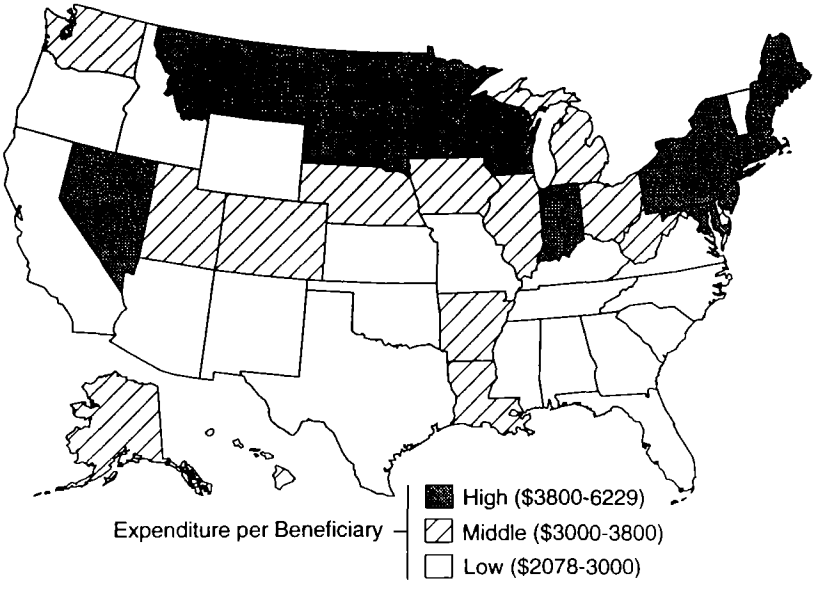
Expenditure per Beneficiary. Medicaid expenditures per beneficiary also vary substantially (see map on next page). In 1993, the mean expenditure per beneficiary (not including disproportionate share payments to hospitals) was about $3400. Expenditure varied from a low of $2078 in Mississippi to a high of $6229 in New York. Part of this variation in expenditure can be explained by the following factors:

- **Service limitations.** Many states have length-of-stay limits for hospitals, with these limits ranging from 12 to 45 days per year, while other states have no explicit limits on hospital stays. Similarly, a number of states limit physician visits. For example, Louisiana allows only 12 physician visits per year.

- **Payment rates.** Medicaid expenditures vary because average health care costs vary across states, and because Medicaid payments relative to average health care costs also vary across states. The ratio of maximum Medicaid physician fees to Medicare physician fees (which can be used as a gauge of average physician fees in the state) varies from 36 percent in New York to 164 percent in Alaska. The ratio of Medicaid to Medicare fees tends to be lower in higher income states, perhaps because Medicare fees reflect market prices more than Medicaid fees do.
- **Composition of Medicaid population.** Medicaid covers both acute care and long-term care. Because providing long-term care is more costly on average than providing acute care, the more the Medicaid population is comprised of those in need of long-term care, the higher the cost of the program. State policies can influence the composition of their Medicaid population. For example, state eligibility standards can affect how many institutionalized people qualify for Medicaid, and state nursing home reimbursement rates under Medicaid can affect the number of nursing home beds available.

Conclusion. Medicaid programs vary substantially across the states (though less than for AFDC, see box on next page). Part of this variation stems from differences in states' economies—like differences in average health care costs—and part stems from differences in Medicaid policies. Low-income states, despite having a higher Federal match rate on their Medicaid expenditures, tend to have relatively low Medicaid expenditures, and lower coverage of the poor.

Variation in Medicaid Expenditure



Note: Comparable data for Arizona are not available.

Variation in Medicaid Relative to AFDC

The variation across states in Medicaid expenditures is substantially lower than the variation in Aid to Families with Dependent Children (AFDC) expenditures. This finding might be explained by a number of factors, including greater similarity across the states in the level of health care than in the level of cash benefits that states want to provide for the poor. Another possible explanation is the fact that the Federal government regulates the Medicaid program more than it regulates the AFDC program. To the extent that this explanation is important, increasing the states' flexibility to determine benefits and eligibility would increase the variation in Medicaid benefits across the states.