Why State Medicaid Costs Vary: A First Look

by Jane Sneddon Little

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A First Look

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Medicaid is producing budgetary headaches all across the country. With education, it is one of the two largest individual programs in most state budgets, and it represents a growing share of total expenditures in every single state. While direct general expenditures of state and local governments grew over 200 percent between FY1975 and FY1989, Medicaid payments soared 350 percent. Accordingly, the share of state and local spending absorbed by Medicaid grew from 5 to 7 percent over this period.[1] As Map 1 shows, this budgetary burden is greatest in some of the Northeastern states, but, as Table A-1 indicates, Medicaid payments have grown fastest in several of the Southern and Western states. With over 30 states projecting FY1992 budget deficits late the previous fiscal year, the pressures to restrain Medicaid spending are intense. Richard G. Darman, U.S. Budget Director, has described the situation: "Medicaid is severely straining most state budgets as well as Federal resources....The system cannot tolerate budget shocks of the magnitude Medicaid has been providing." (Hilts 1991a)

*Economist, Federal Reserve Bank of Boston. Lawrence D. Herman provided valuable research assistance. This study is an expansion of a chapter in Federal Reserve Bank of Boston Research Report No. 72, Massachusetts in the 1990s: The Role of State Government.

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[1] Medicaid looms much larger in state than in state and local accounts. Indeed, in FY1989 Medicaid absorbed 18 percent of all state direct general expenditures. However, because states differ in the extent to which counties and cities bear responsibility for Medicaid, cross-state comparisons should be based on state and local spending.

Map 1

Medicaid Payments as a Share of State and Local Government Expenditures

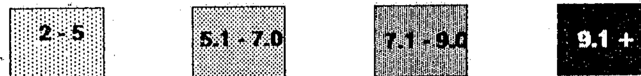
FY 1989, Percent

WASHINGTON 6.7
OREGON 4.6
IDAHO 5.6
MONTANA 6.6
NORTH DAKOTA 8.4
MINNESOTA 6.9
SOUTH DAKOTA 8.0
WISCONSIN 7.3
WYOMING 2.6
MICHIGAN 6.6
NEBRASKA 5.7
IOWA 6.3
NEVADA 3.1
UTAH 4.3
COLORADO 4.6
KANSAS 5.5
ILLINOIS 6.6
IN 8.2
OHIO 9.0
MISSOURI 6.6
KENTUCKY 8.9
WV 7.5
CALIFORNIA 5.6
ARIZONA
NEW MEXICO 5.1
OKLAHOMA 7.9
ARKANSAS 10.0
TENNESSEE 8.3
NO. CAROLINA 7.0
SO. CAROLINA 6.4
GEORGIA 6.8
ALABAMA 5.1
MS 7.5
LA 8.7
TEXAS 5.1
FL 5.3
ALASKA 2.4
HAWAII 4.3
MAINE 10.1
VT 7.3
NH 6.0
NEW YORK 12.3
MA 11.1
CT 8.3
RI 11.4
PENNSYLVANIA 7.5
NJ 6.9
DE 4.6
MD 6.3
DC
VIRGINIA 4.6

Note: Arizona does not participate in Medicaid, it has an alternative program.

Source: HCFA State Medicaid Data Disk for FY89, U.S. Bureau of the Census.

Medicaid Payments Share of State and Local Government Expenditure



Nevertheless, the state and local government share of total U.S. health care spending has actually declined since 1975. And Medicaid costs per recipient have not increased as fast as personal health care costs per capita over the last decade. Apparently, the states are being swept along on a swelling tide of national health care spending that has risen almost 40 percent faster than GNP over the last 25 years. Just 6 percent of total output in 1965, total health care expenditures now account for more than 12 percent of GNP, a considerably larger fraction than in any other industrialized country.

This study will begin by reviewing why governments have a role in providing health care for their citizens. The following sections will explain why the Medicaid program has become a substantial burden for many state governments and why that burden is likely to increase. The study will then examine why some states' Medicaid expenditures are well above average and will outline some choices that policymakers may be forced to consider in the immediate future.

Because state policymakers have considerable discretion in determining the scope of their state's Medicaid program, one frequently discussed option involves reducing existing benefits. For four representative states examined in this study, eliminating all benefits permitted but not required by the federal government would ostensibly reduce state government spending on Medicaid by at least 40 to 50 percent. The cost--financial, medical and emotional--of these public sector savings would fall primarily on elderly and disabled individuals whose assets had been depleted by uninsured medical and long-term care expenses. However, some of these public sector savings would undoubtedly resurface either within Medicaid itself or in other programs that

are fully state-funded. (The federal government reimburses the states for 50 to 80 percent of their Medicaid payments.) Some of these public sector savings would also resurface as additional uncompensated care that would, in turn, lead to increased charges to private patients and to higher insurance premiums. In other words, individuals will pay for health care delivered to the indigent either through higher tax bills or through higher medical and insurance bills. Shifting costs between and within sectors does not eliminate them.

If policymakers determine that a major restructuring of the Medicaid program is unwise, they still have some room to maneuver. A remaining -- and absolutely essential -- option involves promoting best-practice delivery and reimbursement systems to minimize unneeded care and increase efficiency. While the benefits of such administrative changes would take some time to accrue, efficient delivery appears to make considerable difference to the per recipient cost of the Medicaid program. However, because Medicaid operates as part of state and national health care systems, it cannot be reformed in isolation without creating serious access problems for the program's beneficiaries. Achieving ongoing savings within Medicaid requires controlling costs throughout the health care system.

I. Why Government Has a Role in Health Care Finance

Governments generally play an important role in the provision of health care. Indeed, in most developed countries the government's role is much larger than it is here in the United States. Among the major developed countries public financing accounted for 77 percent of all medical care

expenditures in 1987. In the United States the comparable figure was 41 percent (U.S. Congress 1990, p. 301).

Most basically, governments have an interest in the health of their citizens--just as they do in the education of their citizens--because a healthy population represents a more productive work force. Increased productivity and other benefits of good health spill over from one individual to other members of society without (full) compensation. Altruism, or avoiding the cost of altruism, offers another motive for government involvement with health care. Most high-income societies do not allow sick people to languish unattended; thus, governments either become the provider of last resort (or, over time, first resort) or they force/encourage people to save against the risk of ill health.

The sizable uncertainties surrounding an individual's need for health care have led industrialized societies to pool their risks by developing health insurance. Pooling risks allows a society to economize on the savings required by the risk of ill health, compared with the amounts that would be required if each individual were to self-insure. However, because individuals left to their own devices tend to underestimate how much medical care they will need or what it will cost at that time, they also tend to underinsure (Summers 1989). In addition, insurance providers know less than the insured about the likelihood of their needing health care. If adverse selection occurs, with only the riskiest individuals choosing to insure themselves, then these insurance policies become very expensive, and private markets may remain underdeveloped. For all of these reasons, government mandate or subsidization of private health insurance represents one model of government involvement with health care. The United States follows this tradition with much of its

social insurance provided through the workplace in the form of mandatory programs (Medicare, Part A) or subsidized fringe benefits (health insurance). Accordingly, obtaining medical insurance and medical care becomes a serious problem for the unemployed or self-employed.[2]

Because of the link between health insurance and the workplace found in this country, the government pays directly for medical care for poor people who cannot reasonably be expected to work. This group includes children and their caretakers, the elderly, and the disabled. Medicaid is the means-tested program providing this care.

When governments lift most of the cost of ill health from individuals--either through government payment or private insurance--much unneeded medical care may result. If patients bear no cost, they will demand (in an economic sense) any medical service that yields even a small benefit. If providers get paid in full for any and all services rendered, they are likely to recommend every procedure that might prove helpful in the smallest degree. Medical ethics, professional pride, and malpractice suits reinforce this outcome. Under these circumstances, then, the social costs of medical care are likely to outstrip individual benefits by substantial amounts--especially given the technological intensity of today's medicine.

Whether governments pay for medical care directly (as in the United Kingdom and Canada) or indirectly through subsidized health insurance (as in the United States, at least in part), they are currently under pressure to curb waste and rising health care costs. Government options include:

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[2]. Employees of small business also have difficulty obtaining health insurance and, thus, health care. Roughly 60 percent of the more than 35 million U.S. citizens without health insurance are either employed or are dependents of employed people.

1) asking consumers to share the costs through deductibles and co-payments;
2) forcing providers to share the risks, as in prepaid HMO programs;
3) rationing health care, as in the application of cost/benefit analysis.

Since cost/benefit spillovers and market failures appear to justify some role for government in providing health care, the question becomes, which level of government is most appropriate to the task? According to some observers, the scope of the spillovers, the generality of the market failures, and issues of equity suggest that the responsibility for setting health care policy belongs with the national government rather than at the state level. Although regional differences in the need for medical facilities or in the cost of health care services clearly exist, a national program should be able to account for such variations. A series of congressional mandates expanding Medicaid coverage for poor children and, to a lesser extent, the elderly suggest that national policymakers see a growing need for the federal government to define minimum public sector responsibilities for health care.

On the other hand, advantages to be gained by locating responsibility for health care (like education) at the state (or local) level include allowing for: 1) variations in the desired amount of public support; 2) differences in regional views concerning ethical issues (abortion, the right to die, and so forth); and 3) experiments in administering the health care system. With most societies groping to find some means of controlling spiraling medical costs, state initiatives in developing alternative delivery and reimbursement systems serve a useful purpose.

II. Medicaid: The Program

Medicaid is a jointly funded federal/state program that provides health care to specific categories of poor people. It became law in 1965 as part of the Social Security Act. The federal share varies inversely with state per capita income and in 1989 ranged from 50 to 80 percent. Within federal guidelines, each state administers its own program and has considerable discretion in determining eligibility criteria, the amount and scope of the services provided, and the rates and methods of reimbursement. Accordingly, Medicaid coverage of the indigent population and expenditures per recipient vary considerably from state to state.

Eligibility

The original federal guidelines required states to provide Medicaid coverage to poor children and their mothers (recipients of Aid to Families with Dependent Children, AFDC) and to poor aged, blind, and disabled individuals (now generally recipients of Supplemental Security Income, SSI). These groups are known as "categorically needy." Gradually, federal requirements have extended Medicaid coverage to related groups. Most recently, for example, the new federal budget package requires a gradual extension of Medicaid coverage to all children under 19 in families with incomes below the federal poverty level.[3] In addition, the states may choose to provide Medicaid coverage, with federal support, to others who are part of the same "categorically needy" groups but who have somewhat higher incomes.[4]

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[3] In FY1989, states were required to provide Medicaid services to poor children under six. The age limit will rise by one year annually for 13 years.

[4] One such group includes pregnant women and infants to age one whose family income falls below 185 percent of the federal poverty level.

The states also have the option of providing Medicaid coverage to "medically needy" people. Under this option, individuals may "spend down" to meet Medicaid eligibility criteria. They "spend down" by incurring medical or remedial care expenses that reduce their remaining income and liquid assets to a level below that allowed by their state's program.

As a result of these federal guidelines, childless adults (under age 65) who are not disabled are not eligible for Medicaid no matter how low their income or how high their medical expenses. In addition, because states can and do set their eligibility requirements below the federal poverty level (in 1989, $9,890 per year for a family of three in the 48 contiguous states), many poor families do not qualify for Medicaid. In 1989, Medicaid coverage of the categorically needy (generally AFDC and SSI recipients) amounted to just over one-half of the poverty-level population. Including people impoverished by medical expenses and covered by current medically needy programs (in the numerator but not in the denominator) brings the share to 65 percent.[5]

Because the states have a good deal of discretion in setting eligibility requirements, the share of the state's poverty population covered by its categorically needy program ranged from over 100 percent in Missouri to 27 percent in Idaho. (Table A-2 provides these ratios for all of the states.) In general, as Map 2 indicates, the highest ratios are clustered in the Northeast and upper Midwest; the lowest are found scattered through the Plains and Mountain states. These ratios reflect political decisions, and as Map 2 suggests, political choices concerning poverty programs have varied

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[5] These ratios overstate the share of the poor receiving Medicaid for yet another reason; that is, the poverty population refers to non-institutionalized people, while 7 percent of Medicaid recipients in FY1989 were (at least temporarily) institutionalized.

Map 2

Categorically Needy Medicaid Recipients as a Share of the Poverty Population

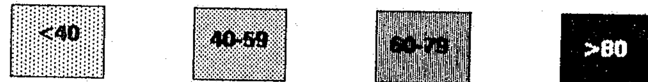
Percent, FY 1989

WASHINGTON 79.7
OREGON 44.7
IDAHO 27.0
MONTANA 40.3
NORTH DAKOTA 30.9
MINNESOTA 49.9
WISCONSIN 78.0
MICHIGAN 81.8
WYOMING 62.0
SOUTH DAKOTA 30.0
NEVADA 33.4
UTAH 40.7
COLORADO 52.8
NEBRASKA 45.1
IOWA 44.1
ILLINOIS 47.8
IN 44.5
OHIO 84.2
CALIFORNIA 66.9
ARIZONA
KANSAS 45.6
MISSOURI 108.4
NEW MEXICO 33.4
OKLAHOMA 46.0
ARKANSAS 36.9
TEXAS 37.5
LA 56.1
MS 60.5
ALABAMA 36.1
GEORGIA 55.1
FL 40.6
TENNESSEE 48.1
KENTUCKY 43.9
WV 50.8
DC
VIRGINIA 42.3
NO. CAROLINA 35.7
SO. CAROLINA 36.1
PENNSYLVANIA 71.6
NEW YORK 60.7
NJ 67.9
DE 52.1
MD 63.0
CT 73.1
RI 81.7
MA 81.4
VT 86.2
NH 47.5
MAINE 99.2
ALASKA 66.6
HAWAII 68.4

Note: Arizona does not participate in Medicaid, it has an alternative program.

Source: HCFA State Medicaid Data Disk for FY89,
U.S. Bureau of the Census.
University of Wisconsin-Madison, Institute for Research on Poverty,
Focus V11 No.3, Fall 1988.

Categorically Needy Medicaid Recipients as a Share of the Poverty Population



considerably across the nation. Ironically, perhaps, as a result of these differences, some high-income states with relatively broad Medicaid coverage receive more in federal matching funds for their state Medicaid program than their residents contribute, through federal tax payments, to federal support for Medicaid; in other words, the variation in state programs results in a transfer of funds from some comparatively poor to some wealthy states.

Dual Focus

By default, not by design, Medicaid has developed a split personality. It provides--as intended--acute/preventive care to specific categories of the vulnerable poor. It has also become the nation's primary long-term care program for people who fit the Medicaid categories, some of whom become impoverished by paying privately for long-term (generally nursing home) care. Although not its original focus, long-term care has grown as a share of Medicaid expenditures and in 1989 accounted for over 40 percent of Medicaid payments--made on behalf of less than 7 percent of the recipients.[6] While most long-term care recipients are elderly, the mentally retarded represent another important and very expensive group. In 1989 residents of institutions for the mentally retarded accounted for less than 1 percent of all Medicaid recipients but for 12 percent of Medicaid payments.

Medicaid became the nation's primary long-term care program because Medicare, the nationwide health insurance program for the aged and certain disabled, provides very limited coverage for long-term care. Legislators have

[6] In this paper, data on "long-term care" refer to services provided by skilled nursing facilities and intermediate care facilities (for the mentally retarded and other). A small share of these services actually represents convalescent rather than long-term care. However, a fraction of "home health" services, which are not included in the long-term care data, also constitute long-term care.

feared that including long-term care coverage within Medicare would overburden the already strained resources of the Medicare program. Accordingly, while Medicare paid 2 percent of nursing home care in 1988, Medicaid paid 44 percent.[7]

The complexions of the two programs differ significantly. Medicare is a social insurance program to which people contribute while they are working and from which they are entitled to draw earned benefits as the need arises. By contrast, Medicaid is stigmatized as a welfare program for the not-always-deserving poor. It can be painful, thus, for the middle-class elderly to be faced with huge nursing home costs, often exceeding $30,000 a year, and then be forced to turn to Medicaid, after exhausting the accumulated assets of a lifetime.

III. National Trends: Why Medicaid Is a Growing Problem for State Governments

According to a widely held view, Medicaid spending is largely driven by changing demographics and a growing need for long-term care for the aged. The elderly account for a growing share of the population, the argument goes. And the elderly are very expensive Medicaid recipients, in part because they are important consumers of long-term care. Because Medicaid is the provider of last resort for long-term care, a large share of this burden falls to the states.

Demographics

The pieces of this argument are all valid, but the conclusion is not. The elderly do indeed represent a growing share of the population. And the

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[7] Out-of-pocket private pay covered 48 percent and private insurance a mere 1 percent. The balance was covered by the Veterans Administration and state and local government public health expenditures.

share of the oldest old (individuals 85 and over, and the group most likely to need long-term care) is rising even faster. In the last 25 years, the U.S. population grew by about one-third, the elderly population nearly doubled and the oldest old tripled. These trends are projected to continue. The oldest old accounted for 1 percent of the population in 1980; they are expected to account for almost 2 percent in the year 2000 and for 5 percent by 2050. Recent research indicates that one out of four people who reach their eighties is likely to develop Alzheimer's disease or some other form of dementia. Victims of dementia often become unable to care for their physical needs and eventually need round-the-clock supervision.

As the popular view maintains, the elderly are also relatively expensive Medicaid beneficiaries. Medicaid payments per aged recipient equaled $5,900 in 1989 compared to $2,300 for the average recipient, in large part because of the elderly's need for nursing home care. Although much elder care is provided informally on an unpaid basis and although private individuals pay out-of-pocket for half of all nursing home care, Medicaid provides 90 percent of the long-term care financed by government. Accordingly, while state (and local) governments accounted for 10 percent of all personal health care expenditures, they paid for 20 percent of nursing home care in FY1988. In other words, the growing need for nursing home care places a disproportionate burden on the states.

Nevertheless, from 1975 to 1989 the rapid aging of the population was <u>not</u> the driving force behind Medicaid's expansion, and the growing need for long-term care contributed only modestly. As Table 1 shows, the aged actually declined as a share of all recipients between 1975 and 1989, and payments to the aged fell (although less than proportionately) as a share of total

Table 1
Share of Medicaid Recipients and Payments, by Category, FY1975 and FY1989
Percent

Category	United States				California			
	Recipients		Payments		Recipients		Payments	
	1975	1989	1975	1989	1975	1989	1975	1989
Aged:	16.4	13.3	35.6	34.1	19.1	12.6	26.6	22.8
Categorically needy	13.5	9.5	21.4	18.7	18.4	8.9	24.8	7.5
Medically needy	3.0	3.1	14.2	13.6	.6	3.7	1.8	15.3
Other[a]		.7		1.8		.0		.0
Disabled:	10.7	14.8	24.9	37.6	14.4	15.1	29.4	39.6
Categorically needy	9.3	13.1	19.6	29.1	14.1	13.7	28.0	30.0
Medically needy	1.4	1.5	5.4	7.6	.3	1.4	1.5	9.6
Other[a]		.3		.9		.0		.0
Blind:	.5	.4	.8	.8	.7	.7	1.2	1.3
Categorically needy	.4	.3	.6	.6	.7	.7	1.1	1.2
Medically needy	.1	.0	.2	.1	.0	.0	.0	.1
Other[a]		.1		.1		.0		.0
AFDC Child:	43.6	43.8	17.9	12.6	41.1	41.4	19.3	14.9
Categorically needy	39.8	38.1	15.6	10.3	37.6	31.5	17.3	9.3
Medically needy	3.8	4.4	2.2	1.7	3.5	9.9	2.0	5.6
Other[a]		1.3		.6		.0		.0
AFDC Adult:	20.6	24.3	16.8	12.7	20.8	27.2	20.6	19.2
Categorically needy	18.9	20.2	15.7	10.4	18.4	21.2	17.5	14.3
Medically needy	1.7	2.8	1.1	1.4	2.4	6.0	3.1	5.0
Other[a]		1.2		.8		.0		.0
Other[b]	8.2	3.4	4.0	2.3	3.9	2.9	3.0	2.2
Memo:								
All Nursing Facilities	6.3	6.8	38.4	40.7	4.3	3.7	23.2	27.1
ICF/Mentally Retarded[c]	.3	.6	3.1	12.2	.0	.3	.0	6.8
All Other	6.0	6.2	35.3	28.5	4.3	3.4	23.2	20.3

[a]Groups provided coverage by pre-1988 and 1988 legislation.
[b]Includes other Title XIX, basis of eligibility unknown and, in some cases, adjustments for double counting. [c]ICF = Intermediate Care Facilities.
Source: U.S. Health Care Financing Administration, State Medicaid Data Tables for FY1975 and FY1989, June 21, 1990. Based on data from HCFA form 2082.

payments over this period. While payments for nursing home care rose slightly in comparison to the total, the growth of payments to intermediate care facilities for the mentally retarded more than accounted for this change. California, the state with the largest number of Medicaid recipients and the second highest Medicaid expenditures, shows much the same picture: the elderly declined as a share of recipients and payments, while expenditures for nursing homes took a larger share of the total only because payments for facilities for the mentally retarded rose exceptionally fast. (Table A-3 provides comparable data for the five other states with the largest Medicaid expenditures in FY1989: New York, Ohio, Pennsylvania, Massachusetts, and Texas. Although their experiences were far from uniform, they generally corresponded with national trends.[8])

What explains this surprising outcome, given the demographic trends? Part of the explanation is that Social Security and private pensions have reduced poverty among the elderly.[9] In 1967 29.5 percent of the aged lived in poverty. In 1988 the comparable figure was 12.0 percent. Accordingly, a smaller proportion of the elderly now qualify for SSI and, thus, for Medicaid. Indeed, the absolute number of aged Medicaid recipients has actually declined since 1975. In addition, while the medically needy aged remained a constant share of total Medicaid recipients, many of the medically needy aged have

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[8] New York is a clear exception. There aged recipients and payments for the aged both grew as a share of their respective totals. Explanations for New York state trends may include its relatively generous eligibility criteria for the medically needy aged, its high nursing home reimbursement rates (the second highest in the nation after those in New Hampshire) and, possibly, its rapidly expanding program of home health care (Kolbert 1991).

[9] In addition, individuals who originally qualify for Medicaid as disabled retain that designation after they become aged. Accordingly, in 1990 18 percent of blind and disabled Medicaid recipients were also aged 65 and over.

Medicare coverage for a large share of their acute care needs and pay for part of their nursing home expenses out of current Social Security and private pension income. Support from these other sources helped to hold the growth of Medicaid payments per medically needy aged recipient to a below-average pace over this period. (By contrast, payments per categorically needy aged recipient grew at an above-average pace from 1975 to 1989.) In other words, while the aging of the U.S. population has undoubtedly contributed to raising U.S. health care costs, Social Security and Medicare have helped to shield Medicaid from the full impact of these trends.

In addition, the growth in payments for the elderly was heavily overshadowed by a huge increase in expenditures for the disabled. As Table 1 shows, the disabled greatly increased as a share of the recipient pool and, in particular, as a share of total Medicaid payments during the 1975-89 period. As the memo item in Table 1 indicates, much of the increase in the share of expenditures devoted to the disabled reflects the jump in payments to intermediate care facilities for the mentally retarded (ICF/MRs), already mentioned. This surge followed 1972 legislation extending Medicaid coverage to services provided by ICF/MRs that meet federal standards. Medicaid coverage for the mentally retarded is almost completely limited to these (usually large) special purpose residential institutions. Accordingly, state governments encouraged their ICF/MRs to upgrade to meet federal standards. As they did so, the number of residents who thereby qualified for Medicaid coverage more than doubled--despite a widespread exodus from these facilities over this period.

Because press and congressional inquiries uncovered abuse and neglect in some of the big state institutions in the early 1960s and because experience

increasingly showed that many mentally retarded people could lead semi-independent lives if they had support services in the community, a declining share of the mentally retarded population remained institutionalized. However, those that remained tended to be the most profoundly retarded, those with multiple disabilities, or those who were "medically fragile." In addition, rising expectations about what mentally retarded children could accomplish with special training and support spilled over into demands for better services within the ICF/MRs as well. Accordingly, the average Medicaid payment per ICF/MR resident rose almost 16 percent a year over this period to reach $45,000 in 1989. These big increases in payments for the institutionalized mentally retarded led to well-above-average increases in payments per disabled recipient.

More recent legislative and administrative changes have also expanded the disabled caseload. For example, in 1986 and 1987, the U.S. Congress provided Medicaid coverage for individuals with no permanent address and then required states to make an effort to ensure that homeless Medicaid beneficiaries received Medicaid identity cards. Partly as a result, the number of disabled Medicaid recipients rose 19 percent between 1985 and 1989. Most observers estimate that a majority of the homeless are mentally ill; yet, although one-quarter of the individuals receiving SSI disability are mentally ill, only 12 percent of the mentally ill who would be eligible for SSI, and thus Medicaid, actually receive benefits.[10] In other words, the scope for expanding coverage appears significant.

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[10] In general, these benefits would focus on acute care since Medicaid does not cover services in mental institutions for people ages 21 to 65.

Finally, the AIDS epidemic has contributed to the increased share of Medicaid expenditures absorbed by the disabled. Between 1981, when the first U.S. AIDS case was recorded, and 1989, payments for AIDS patients rose to an estimated 2 percent of the Medicaid total. Annual medical expenses for an AIDS patient typically range from $25,000 to $35,000; however, Medicaid frequently does not pay for the entire cost of the illness because many AIDS patients pay for part of their medical expenses privately--through insurance or out of pocket--until they meet medically needy eligibility standards.

Data for 1985 to 1989 undoubtedly provide better clues about future trends than do figures for the last 15 years. These more recent data suggest, first, that the effect of the 1972 legislation permitting Medicaid payments to residents of ICF/MRs has run its course. The number of recipients in ICF/MRs barely rose between 1985 and 1989, and payments per recipient climbed at a greatly reduced (but still above-average) pace.

In addition, the small absolute decline in the number of elderly Medicaid recipients that was evident between 1975 and 1985 has continued almost unabated. Seemingly, thus, the fall in poverty due to the Social Security program is still outweighing demographic trends. Whether the elderly will ever emerge as the driving force behind growing Medicaid expenditures remains to be seen. Washington may respond to growing demands for increased Medicaid coverage for community services for the mentally retarded and the mentally ill, for example, by mandating program expansions that will again swamp the impact of the aging population. In addition, one (probably overly) pessimistic scenario suggests that AIDS patients may account for 13 percent of Medicaid payments by the early 1990s (Congressional Research Service 1988, p. 489).

These conclusions do not eliminate the need to develop a national consensus on how to pay for long-term care, however. State governments are already having a hard time financing their existing Medicaid obligations--even before the impact of ongoing demographic change kicks in. The success of Social Security and private pensions in maintaining the income of retired citizens may just have postponed the inevitable.

Finding an alternative solution to the long-term care problem would lift a big burden from the states. (See the box for a brief discussion of the social insurance approach to long-term care.) Depending on the groups and services covered, removing long-term care from Medicaid would transfer 30 to 45 percent of the states' Medicaid costs. A solution covering current services for the elderly (including currently very limited home health care) would remove one-third of the states' expenditures. A solution that included the mentally retarded would eliminate 45 percent of the states' outlays. Of course, shifting burdens does not eliminate costs. In the end, individuals will pay for long-term care--through higher taxes if the government pays directly, through lower wages and dividends and higher prices if the government subsidizes employment-related fringe benefits, or (very largely) in out-of-pocket expenditures and unpaid labor if the current arrangement goes unchanged. The costs are there. One way or another, society will pay.

Rising Health Care Costs Drive Medicaid Spending

Even if the long-term-care half of the Medicaid program could be spun off to a social insurance program or to private insurance markets--and neither development is likely over the near term--the states would still be left facing mini budget-busters whose costs are rising more than twice as fast as state revenues. In fact, a key point is that soaring medical costs have been

A Social Insurance Program for Long-Term Care

One frequently mentioned approach to paying for long-term care involves establishing a broad-based social insurance program (like Social Security and Medicare) to which most citizens contribute and from which they can draw, as a matter of right, in case of need. Many analysts have written on the need for such a social insurance program, and the reader is referred to a selection of their works listed in the bibliography. These writers have pointed out that the problem of providing long-term care is frequently a family problem spanning the generations, not an aged problem pitting young against old. They have emphasized how much of the current weight is carried by unpaid family members. This "solution" may be satisfactory from a state or federal budgetary perspective, but it exacts a price in terms of the health and productivity of current workers, particularly working women.

Solving the long-term care problem is beyond the scope of this study, especially since little consensus concerning the solution's basic outline has yet developed. Although recent Administrations have looked to private insurance markets to provide coverage for the risk of long-term care, many observers fear these markets may not prove adequate to the entire task. While a role for private insurance surely exists, the likelihood of underinsurance and risk aversion, discussed above, suggests that government intervention may be required. Because young workers underestimate their need for long-term care and because adverse selection among older workers becomes a problem, private policies are, and are likely to remain, limited and expensive.

One possible approach would extend Medicare to cover a basic package of long-term care with private Medigap policies covering deductibles, co-payments, and frills. Such a program could be funded by a payroll tax or from general revenues. The basic package could include elder day care, home care, and respite care--not with the expectation of saving money but to avoid a bias toward institutionalization. Indeed, the logistics of delivery and quality control appear to make home care programs more expensive than nursing home care for comparably incapacitated people. Moreover, since the demand for home care might soar if third-party payment were available, a long-term care program should probably require rigorous case management or significant co-payments for use of home care benefits (Ball and Bethel 1989).[11]

[11] Until recently, states had to apply for waivers to offer Medicaid coverage for home care. The October 1990 federal budget package gave states the option of providing Medicaid coverage of home care for frail or immobile elderly citizens. Federal contributions are capped at $580 million over a five-year period (Bacon 1990).

the major force driving Medicaid expenditures over the last 15 years. Total Medicaid payments more than quadrupled over this period. The total number of Medicaid recipients grew less than 7 percent. A shift in the composition of the recipient pool--from AFDC child to AFDC adult and from aged to disabled, for instance--contributed very little. Thus, more than 90 percent of the growth in Medicaid expenditures reflects the rising cost of U.S. medical care. Indeed, per capita personal health care expenditures actually rose faster than per recipient Medicaid costs over the last decade.[12]

Since 1975 U.S. personal health care expenditures have grown at a 12 percent annual average pace. According to a Health Care Financing Administration breakdown, this increase in personal health care expenditures has three components. Population growth accounted for roughly 10 percent, while the remaining 90 percent, the "costs," can be broken into two parts: price increases explain 60 percent and changes in "intensity" account for 30 percent of the growth in personal health care expenditures over this period. "Intensity" refers to the number or kind of services used; hospital costs provide an example of its impact. Hospital costs per inpatient day rose 13 percent a year between 1980 and 1986, in part because the number of diagnostic tests, like ultrasound and CAT scans, rose more than 75 percent on a per capita basis over this period. Moreover, although Social Security and Medicare have kept the aging of the population from driving total Medicaid expenditures, changing demographics have undoubtedly increased the intensity with which all U.S. medical care is used.

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[12] According to estimates made by Lewin/ICF (and published in Families USA Foundation 1990) per capita personal health care expenditures grew 139 percent between 1980 and 1990. During the same period (FY1980 to FY1989) per recipient Medicaid payments rose 115 percent.

Although state governments have been very inventive in trying to devise ways to curb rising medical costs, they have limited ability to stem this tide either together or, more particularly, on their own. State and local governments account for only 10 percent of personal health care expenditures (excluding insurance premiums and administrative expenses). Accordingly, individual state governments have limited market power. To make matters worse, if states try to set Medicaid reimbursement schedules below the going "market" rates, Medicaid recipients will have problems gaining access to care, as the whole history of the program demonstrates.

IV. State Medicaid Payments Per Capita

Although many national trends, such as soaring health care costs, changing federal mandates, and the aging of the population, affect Medicaid costs in all of the states, Medicaid payments per capita and per $1,000 of personal income vary considerably from one state to another. Table 2 displays these data for the 49 states with a Medicaid program in FY1989. As the table shows, Medicaid payments per capita ranged from highs of $568 in New York and $405 in Massachusetts to lows of $116 in Wyoming and $95 in Nevada. On the basis of Medicaid payments per $1,000 of personal income, New York and Rhode Island ranked highest with payments of $26.94 and $20.90 respectively, while Nevada and Virginia were at the bottom of the list at $4.91 and $7.12.

Recipients per Capita

Decomposing payments per capita into two parts, 1) recipients per capita and 2) payments per recipient, helps to explain the variation. To start with the first relationship, the share of Medicaid recipients in a state's population reflects variations in the incidence of poverty and in the share of

Table 2
Medicaid Payments per Capita and per $1,000 of Personal Income, FY1989
Dollars

Jurisdiction	Total Medicaid Payments (Millions)	Payments Per Capita	Payments per $1,000 of Personal Income
United States[a]	$54,110	$221.69	$12.59
Alabama	509	123.59	9.07
Alaska	124	235.68	10.89
Arkansas	491	204.16	15.83
California	5,498	189.18	9.49
Colorado	452	136.34	7.77
Connecticut	1,027	317.02	12.85
Delaware	110	163.84	8.87
Florida	1,912	150.89	8.55
Georgia	1,226	190.50	11.87
Hawaii	159	143.29	7.76
Idaho	134	132.53	9.67
Illinois	2,103	180.42	9.58
Indiana	1,157	206.79	13.11
Iowa	522	183.92	11.88
Kansas	380	151.23	9.17
Kentucky	810	217.28	15.81
Louisiana	1,036	236.38	18.30
Maine	371	303.98	18.70
Maryland	936	199.47	9.49
Massachusetts	2,393	404.71	18.25
Michigan	1,954	210.74	12.08
Minnesota	1,105	253.88	14.01
Mississippi	474	180.96	15.43
Missouri	781	151.42	9.29
Montana	155	192.05	13.65
Nebraska	256	159.02	10.29
Nevada	105	94.59	4.91
New Hampshire	183	165.35	8.16
New Jersey	1,920	248.21	10.44
New Mexico	235	153.55	11.68
New York	10,191	567.75	26.94
North Carolina	1,165	177.23	11.66
North Dakota	178	270.09	19.91
Ohio	2,666	244.42	14.93
Oklahoma	635	196.84	13.91
Oregon	409	144.95	9.11
Pennsylvania	2,458	204.16	11.82
Rhode Island	374	375.18	20.90
South Carolina	556	158.23	11.61
South Dakota	143	200.00	14.62
Tennessee	972	196.74	13.39
Texas	2,226	130.99	8.34
Utah	201	117.91	9.02
Vermont	133	234.50	14.32
Virginia	822	134.75	7.12
Washington	962	202.13	11.45
West Virginia	324	174.53	14.14
Wisconsin	1,119	229.99	13.98
Wyoming	55	115.91	8.00

[a]Excluding the District of Columbia, Puerto Rico and the Virgin Islands.

Note: Arizona does not participate in Medicaid; it has an alternative demonstration program.

Source: U.S. Health Care Financing Administration, State Medicaid Data Tables for FY 1989. U.S. Bureau of the Census, and U.S. Bureau of Economic Analysis. Population as of July 1, 1989; personal income for calendar year 1989.

Table 3
"Explaining" the Ratio of State to U.S. Recipients per Capita, FY1989

Jurisdiction	Ratio of State to U.S Medicaid Recipients per Capita					
		Hypothetical, if State = U.S. except for:				
	Actual (1)	Categorically Needy/Pov. Pop. (2)	Poverty Pop./ Total Pop. (3)	Medically Needy Aged/Aged Pop. (4)	Aged Pop./ Total Pop. (5)	Other Med. Needy/ Total Pop. (6)
U.S.	1.00	1.00	1.00	1.00	1.00	1.00
Alabama	.84	.67	1.47	.97	1.00	.91
Alaska	.74	1.12	.77	.97	.98	.91
Arkansas	1.08	.75	1.53	.97	1.01	.98
California	1.26	1.15	.96	1.02	1.00	1.13
Colorado	.62	.92	.80	.97	.99	.91
Connecticut	.75	1.22	.57	1.05	1.00	1.01
Delaware	.66	.94	.83	.97	1.00	.91
District of Columbia	1.70	1.26	1.33	1.03	1.00	1.00
Florida	.76	.88	.96	.97	1.01	.94
Georgia	.98	.98	1.10	.97	.99	.93
Hawaii	1.05	1.34	.74	1.04	.99	1.04
Idaho	.50	.55	1.15	.97	1.00	.91
Illinios	.96	.87	1.06	1.02	1.00	1.02
Indiana	.60	.81	.89	.97	1.00	.91
Iowa	.85	.79	1.16	.99	1.01	.95
Kansas	.76	.93	.82	1.01	1.00	.98
Kentucky	1.24	.85	1.28	1.02	1.00	1.14
Louisiana	1.28	.96	1.43	.97	1.00	.94
Maine	1.28	1.69	.82	.97	1.00	.94
Maryland	.74	1.12	.66	1.03	1.00	.99
Massachusetts	1.06	1.34	.67	1.06	1.00	1.10
Michigan	1.50	1.35	1.03	1.03	1.00	1.09
Minnesota	.80	.88	.84	1.05	1.00	1.01
Mississippi	1.66	1.03	1.73	.97	1.00	.91
Missouri	1.66	1.75	1.02	.97	1.00	.91
Montana	.81	.76	1.14	1.01	1.00	.94
Nebraska	.73	.80	1.04	.98	1.00	.92
Nevada	.44	.62	.90	.97	1.00	.91
New Hampshire	.36	.83	.47	1.00	1.00	.95
New Jersey	.74	1.20	.72	.97	1.00	.91
New Mexico	.80	.67	1.42	.97	.99	.91
New York	1.35	1.03	1.08	1.07	1.00	1.16
North Carolina	.80	.82	1.00	1.03	1.00	.96
North Dakota	.75	.59	1.06	1.06	1.00	1.06
Ohio	1.12	1.38	.90	.97	1.00	.91
Oklahoma	.83	.83	1.09	.97	1.00	.95
Oregon	.82	.97	.91	.97	1.00	.96
Pennsylvania	1.11	1.25	.90	.98	1.01	1.01
Rhode Island	1.12	1.35	.82	1.05	1.01	.95
South Carolina	.85	.80	1.23	.97	1.00	.91
South Dakota	.67	.70	1.14	.97	1.00	.91
Tennessee	1.19	.95	1.24	.98	1.00	1.04
Texas	.75	.75	1.14	.97	.99	.93
Utah	.60	.80	.87	.97	.99	.93
Vermont	1.03	1.42	.76	1.02	1.00	.94
Virginia	.61	.85	.79	1.01	1.00	.93
Washington	1.10	1.34	.86	.99	1.00	.98
West Virginia	1.37	.93	1.55	.97	1.00	.95
Wisconsin	1.03	1.29	.86	.98	1.00	.94
Wyoming	.82	1.05	.89	.97	.99	.91

Medicaid recipients per capita was calculated according to the following equation:

$$\frac{\text{Medicaid Recipients}}{\text{Total Population}} = \frac{\text{Cat. Needy}}{\text{Pov. Pop.}} \times \frac{\text{Pov. Pop.}}{\text{Tot. Pop.}} + \frac{\text{Med. Needy Aged}}{\text{Aged Pop.}} \times \frac{\text{Aged Pop.}}{\text{Tot. Pop.}} + \frac{\text{Other Med. Needy}}{\text{Total Pop.}} = RC$$

The actual ratio of state to U.S. Medicaid recipients per capita equals RC_{ST}/ RC_{US}. The hypothetical ratios were calculated RC_{US} / RC_{US} except that one variable at a time took on the state rather than the U.S. value.

Note: Medicaid recipients from Puerto Rico and the Virgin Islands have been removed from U.S. totals, and the population of Arizona has been removed from the U.S. total population. In addition recipients covered as a result of pre 1988 or 1988 legislation or whose status is "unknown" or "other" have been added to categorically needy in both state and national totals.

Source: U.S. Bureau of the Census, Statistical Abstract of the United States, 1990; U.S. Health Care Financing Administration, "A Statistical Report on Medicaid: State Medicaid Programs" (HCFA 2082), June 1990; University of Wisconsin - Madison, Institute for Research on Poverty, Focus, vol. 11 (Fall 1988).

elderly in the population as well as differences in the eligibility standards the state imposes.

Table 3 shows the results of an experiment in which each state was assumed to have national demographic characteristics and eligibility criteria. Using the equation shown at the bottom of the table, the experiment involved changing each variable, one at a time, from the national average to the state's own value and then comparing the resulting hypothetical number of state Medicaid recipients per capita to the U.S. average. If the variable in question makes little contribution to explaining why the state has more (or fewer) Medicaid recipients per capita than the nation, the ratio remains close to 1.0.

For example, the two states with the highest Medicaid payments per capita in FY1989 were New York and Massachusetts. In New York the share of Medicaid recipients in the population was well (35 percent) above average (as shown in column 1) because slightly generous eligibility criteria for the categorically needy (column 2) were reinforced by an above-average share of the population living in poverty (column 3) plus relatively inclusive eligibility criteria for the medically needy program (columns 4 and 6). By contrast, in Massachusetts the number of Medicaid recipients per capita was only 6 percent above the national average because relatively inclusive eligibility criteria for the categorically and medically needy programs (columns 2, 4, and 6) were partially offset by the relatively small share of the state's population living in poverty (column 3).

States with the highest ratios of Medicaid recipients per capita include Michigan, Missouri and Mississippi. In the first two states, generous categorically needy criteria are reinforced by slightly above-average levels

of poverty -- although Michigan has an inclusive medically needy program while Missouri does not. In Mississippi slightly broad coverage in the categorically needy program plus the highest incidence of poverty in the nation produce a well-above average Medicaid caseload -- despite the lack of a medically needy program.

Variations in the share of the population over age 65 make a noticeable difference in relatively few states. Rhode Island, Pennsylvania, Florida, Arkansas and Iowa experience higher Medicaid caseloads because they have above-average shares of elderly residents; several Southwestern, Western and Mountain states benefit from their relatively young populations.

Nevertheless, because the elderly are more costly than AFDC recipients and because the medically needy tend to be considerably more expensive than categorically needy beneficiaries, even a slightly above-average share of aged or medically needy recipients translates into substantially higher payments per capita. Accordingly, analysts in states facing budget crises often advocate tightening eligibility requirements either for the medically needy or across the board to bring them in line with the national average. One drawback to this approach, however, is that states often find that tightening eligibility requirements during a cyclical downturn is counterproductive because they lose the federal matching grant (recorded on the revenue side of the budget) but still wind up paying for much of the medical care for the excluded individuals through state-financed programs.

Payments per Recipient

Table 4 ranks the states according to the second crucial ratio--payments per Medicaid recipient, shown here in relation to the U.S. average. As column 1 indicates, Medicaid payments per recipient were roughly double the national

Table 4
Medicaid Payments per Recipient and Personal Health Care Expenditures per Capita in Relation to the U.S. Average, FY1989
(U.S. Average = 1.00)

Jurisdiction	Medicaid Payments per Recipient Actual	Medicaid Payments per Standardized Recipient[a] Categorically Needy	Medicaid Payments per Standardized Recipient[a] Categorically & Medically Needy[b]	Personal Health Care Expenditures per Capita
U.S. Average	1.00	1.00	1.00	1.00
New Hampshire	2.19	1.98	1.34	.82
New York	1.95	1.60	1.48	1.16
Connecticut	1.94	1.58	1.30	1.11
Massachusetts	1.77	1.19	1.19	1.25
North Dakota	1.65	1.60	1.45	1.10
Indiana	1.60	1.75		.91
Rhode Island	1.57	1.50	1.13	1.12
New Jersey	1.55	1.81	1.29	.92
Minnesota	1.48	1.92	1.59	1.02
Alaska	1.48	2.19		.94
South Dakota	1.39	.97		.96
Maine	1.31	1.36	.92	.90
Maryland	1.26	1.08	1.32	1.00
Delaware	1.24	1.38		.94
Idaho	1.24	1.33	.68	.71
Wisconsin	1.20	1.13	.78	1.01
Nevada	1.10	1.16		1.14
Montana	1.09	1.23	1.04	.85
Oklahoma	1.08	1.14	.85	.88
Vermont	1.07	1.08	.93	.81
North Carolina	1.03	1.11	1.26	.76
Virginia	1.03	.91	.98	.86
Colorado	1.02	1.11		1.00
Nebraska	1.02	1.22	.94	1.01
Ohio	1.01	1.40		1.03
Iowa	1.00	1.26	.92	.97
Washington	.97	1.21	.86	.95
Pennsylvania	.96	1.08	.92	1.05
Florida	.94	.78	.68	1.00
Kansas	.93	1.03	.98	1.05
Utah	.92	1.37	1.03	.74
Georgia	.91	.94		.85
New Mexico	.89	.80		.74
Arkansas	.88	.80	.70	.80
Illinois	.87	.89	.77	1.08
South Carolina	.87	.60		.70
Louisiana	.85	.97	.84	.90
Missouri	.83	.89		1.06
Oregon	.83	.75	.56	.95
Kentucky	.81	.67	.70	.77
Texas	.81	.93		.90
Tennessee	.77	.85	.72	.93
Wyoming	.77	.88		.72
Michigan	.75	.72	.66	1.06
Hawaii	.74	.54	.48	1.02
California	.71	.66	.68	1.19
Alabama	.68	.61		.94
West Virginia	.58	.68	.61	.86
Mississippi	.50	.56		.72

[a] Assuming each state had the same mix of Medicaid recipients as the nation but paid state costs.

[b] Only calculated for states with a medically needy program.

Source: HCFA State Medicaid Data Disk for FY1989; Families USA, Lewin/ICF estimates.

average in New Hampshire, New York, and Connecticut. Nevertheless, it is important to look at the composition of the recipient population because medical care for an AFDC child costs much less than medical care for an elderly or disabled nursing home resident.

As one might expect, payments per recipient rise by category from AFDC child to AFDC adult, to aged individual, to the blind and disabled, as Table 5 shows. In addition, payments to a medically needy recipient generally exceed those to a categorically needy person in each category. Accordingly, judging how out of line a state's payments per recipient really are requires calculating what the state's average payment would have been if the state had the same recipient mix as the nation but paid state costs.

The results of these "standardizing" calculations are shown in columns 2 and 3 of Table 4 -- again in relation to the U.S. average. Column 2 presents figures for a standard categorically needy recipient for all states. Column 3 shows standardized data for all recipients for those states with a medically needy program. Comparing the values in columns 1 and 3 indicates that 75 percent of the difference between Massachusetts and U.S. payments per recipient reflects composition,[13] while in New York recipient mix accounts for 50 percent of the difference.[14] In other words, these states have a very expensive mix of Medicaid beneficiaries, with above-average shares of the aged, the disabled, and the medically needy.

After standardizing the recipient pool, Minnesota and New York had the highest Medicaid payments per recipient among the states with a medically

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[13] [(77 - 19)/77] = .75

[14] [(95 - 48)/95] = .49

Table 5
U.S. Medicaid Payments per Recipient by Category, FY1989

Categorically Needy	
Aged	$4,613
Blind	3,859
Disabled	5,183
AFDC Child	641
AFDC Adult	1,211
Other	1,301
Medically Needy	
Aged	10,328
Blind	16,247
Disabled	12,002
AFDC Child	909
AFDC Adult	1,169
Other	714
Average	2,318

Source: U.S. Health Care Financing Administration, State Medicaid Data Tables for FY1989, June 21, 1990. Based on data from HCFA form 2082.

needy program. Minnesota payments per beneficiary were 59 percent above the national average in 1989, while New York's were 48 percent above average.

This remaining difference in costs per standardized recipient reflects both price and intensity of use. Differences in intensity include, for example, the fact that the Minnesota and New York Medicaid programs cover services that other states do not. For example, while they and 33 other states offered a medically needy program in 1989, nine states with a medically needy program provided no coverage of nursing home care for the elderly either because their medically needy program did not include the aged, or their medically needy program for the aged did not provide nursing home services.[15] In addition, states vary in the number of optional services they choose to provide and whether they will provide them for all recipients or just for the categorically needy. In 1987 Massachusetts[16] and Minnesota offered to all beneficiaries 31 and 30 out of 32 services permitted but not required by the federal government. By contrast, Wyoming offered eight optional services to the categorically needy only. Co-payments and limits on frequency of use also reduce intensity in some states. In other words, although this standardizing exercise avoids comparing apples with oranges, it still compares Granny Smiths with Macouns.

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[15] The distinction between states with and without medically needy programs for the aged is blurred, however. Federal law permits states to establish a special and fairly generous income level to be used only in determining Medicaid eligibility for individuals living in nursing homes. Although this federal provision makes no allowance for "spending down," all of the states that have no medically needy program use this special option to provide Medicaid coverage for nursing home residents, as will be discussed further in the text below. On the other hand, some states with a medically needy program limit the number of licensed nursing home beds as a device for controlling Medicaid payments.

[16] The press of its budget deficit has forced Massachusetts to eliminate or curtail several optional services in FY1990 and FY1991.

State variations in personal health care costs also affect this differential. For example, recently published data indicate that total health care spending per capita is currently 16 percent above the national average in New York--and the third highest in the nation (Lewin/ICF data published in Families U.S.A. 1990). New York's Medicaid payments per recipient will reflect the relatively high cost of personal health care in the state. Otherwise, New York Medicaid recipients will be denied access to care or will receive below-state-average quality of care. Of course, part of the cost differential may also represent relative inefficiencies in the state's program. By contrast with New York, Minnesota personal health care costs were very close to the national average; thus, that state's high Medicaid costs per recipient reflect a particularly high-quality Medicaid package (which, by reputation, it is) or below-average efficiency or some combination of the two.

V. Options for Controlling Medicaid Costs

Currently, in more than 30 states policymakers face serious fiscal problems and are under intense pressure to reduce the cost of their Medicaid programs. What are their options? They can shift costs from the public to the private sector, and they can make the existing program more efficient. From the perspective of society as a whole, shifting costs does not eliminate them; reducing unnecessary care or administrative inefficiency does. Unfortunately, the states' current fiscal problems may force policymakers to take a narrow view. Moreover, the suggested dichotomy is not complete, since shifting costs may eliminate some unneeded care, and the mechanism for reducing unneeded care may involve some cost shifts.

The following section will discuss the most frequently mentioned options for cutting state Medicaid spending according to this scheme. It will start with those choices that rely on shifting costs by: 1) eliminating optional programs and services; and 2) tightening eligibility requirements. The section will then explore approaches to increasing efficiency/reducing waste by: 1) asking the consumer to share the marginal cost; 2) reducing the return to the provider; and 3) increasing the use of managed care, a mild form of rationing.

Shifting Costs to the Private Sector

For states that have developed an unusually comprehensive Medicaid package, eliminating programs and services permitted but not required by the federal government represents one policy option. The states that offer an unusually broad Medicaid program are shown in Table 8 below. The following analysis will focus on four of them: New York and California, which have the largest payments; and Massachusetts and Minnesota, which offered the largest number of optional services in 1987.

Eliminating optional programs and services. HCFA data make it possible to estimate the budgetary impact of most (but not all) of the selected states' optional programs and services. Column 1 of Table 6 lists the maximum short-term spending cuts that these state governments could ostensibly achieve by eliminating each of these programs and services. Because the medically needy may use optional services, the savings listed under options I and II cannot be added together. Although eliminating both the medically needy program and the optional services would result in larger savings than either step taken alone, the savings would be less than the sum of options I and II.

Table 6
Estimated Impact of Eliminating Optional Medicaid Programs and Services in Selected States, FY1989

State	Benefits Eliminated	Medicaid Payments Eliminated ($ millions) (1)	Gross Savings/ Total Medicaid Payments (Percent) (2)	Savings/Net Federal Matching Funds Lost ($ millions) (3)	Net Savings/ Total Spending of State Resources (Percent) (4)
New York	I. Medically Needy Program Only				
	Total	5,394.1	52.9	2,697.1	11.0
	Aged	3,145.1	30.9	1,572.6	6.4
	Disabled and Blind	1,737.0	17.0	868.5	3.5
	AFDC - Total[a]	443.2	4.3	221.6	.9
	Other	68.8	.7	34.4	.1
	II. Optional Services Only				
	Total	2,865.0	28.1	1,432.5	5.8
	ICF/MRs	1,309.3	12.8	654.6	2.7
	ICF/Other	389.7	3.8	194.9	.8
	Dental Services	84.0	.8	42.0	.2
	Other Practitioners	59.2	.6	29.6	.1
	Clinic Services	309.3	3.0	154.6	.6
	Prescribed Drugs	402.0	3.9	201.0	.8
	Other	311.5	3.1	155.8	.6
California	I. Medically Needy Program Only				
	Total	1,984.2	36.1	992.1	4.0
	Aged	842.4	15.3	421.2	1.7
	Disabled and Blind	536.1	9.8	268.0	1.1
	AFDC - Total[a]	581.0	10.6	290.5	1.2
	Other	24.7	.4	12.4	.1
	II. Optional Services Only				
	Total	1,361.3	24.8	680.6	2.7
	ICF/MRs	374.6	6.8	187.3	.8
	ICF/Other	27.6	.5	13.8	.1
	DentalServices	.9	0	.4	0
	Other Practitioners	63.4	1.2	31.7	.1
	Clinic Services	171.7	3.1	85.8	.3
	Prescribed Drugs	457.6	8.3	228.8	.9
	Other	265.5	4.8	132.8	.5
Massachusetts	I. Medically Needy Program Only				
	Total	1,286.0	53.7	643.0	6.6
	Aged	841.8	35.2	420.9	4.3
	Disabled and Blind	314.9	13.1	157.4	1.6
	AFDC - Total[a]	55.3	2.3	27.6	.3
	Other	74.0	3.1	37.0	.4
	II. Optional Services Only				
	Total	1,040.7	43.5	520.4	5.4
	ICF/MRs	295.9	12.4	148.0	1.5
	ICF/Other	427.2	17.9	213.6	2.2
	Dental Services[b]	24.4	1.0	12.2	.1
	Other Practitioners[b]	20.3	.8	10.2	.1
	Clinic Services	79.4	3.3	39.7	.4
	Prescribed Drugs[b]	115.7	4.8	57.8	.6
	Other	77.8	3.2	38.9	.4
Minnesota	I. Medically Needy Program Only				
	Total	429.1	38.8	201.4	4.5
	Aged	273.9	24.8	128.5	2.9
	Disabled and Blind	112.0	10.1	52.6	1.2
	AFDC - Total[a]	10.4	.9	4.9	.1
	Other	32.8	3.0	15.4	.3
	II. Optional Services Only				
	Total	466.5	42.2	218.9	4.9
	ICF/MRs	214.4	19.4	100.6	2.3
	ICF/Other	120.4	10.9	56.5	1.3
	Dental Services	12.1	1.1	5.7	.1
	Other Practitioners	11.1	1.0	5.2	.1
	Clinic Services	15.8	1.4	7.4	.2
	Prescribed Drugs	53.0	4.8	24.9	.6
	Other	39.7	3.6	18.6	.4

[a]If a state chooses to have a medically needy program, federal law requires that the program cover pregnant women and children.
[b]Recent state legislation has placed some limits on Medicaid coverage of these services.
Source: Author's estimates based on data from HCFA form 2082, and U.S. Bureau of the Census.

As column 2 shows, a decision to terminate these optional benefits would reduce these states' Medicaid expenditures by a dramatic one-fourth to one-half--on a gross basis. Column 3 records these savings net the resulting loss of federal matching funds (with the federal share assumed to be 50 percent across the board). Column 4 shows these net public sector savings as a share of total state spending of state resources (total direct spending less revenue from the federal government).

As Table 6 indicates, the bulk of these public sector savings would derive from eliminating the medically needy program or services provided by intermediate care facilities. Accordingly, the cost of these public sector savings would fall largely on the mentally retarded and on elderly individuals impoverished by uninsured medical and long-term care expenses. These people (and their families) would face all the costs shown in column 1--whether in the form of out-of-pocket expenses or medical care forgone--while the state would save the amount shown in column 3.

But what would be the impact of this cutback on other income support and health care programs funded by these states? While some institutionalized individuals could undoubtedly live with their families, what would be the cost in terms of family members' time, health, income, and thus, tax revenue? The average resident of a long-term care facility is a woman in her eighties with three or four chronic illnesses. One-third are non-ambulatory. Nationally, roughly one-half of all elderly long-term care residents have Alzheimer's disease or a related disorder (U.S. Congress, Senate, 1990, p. 84). And many of these institutionalized individuals have no immediate family. If a needy individual is eliminated from Medicaid eligibility, where does the cost of his care resurface?

A significant portion would undoubtedly reappear within the Medicaid program itself, since it seems unlikely that these states would choose to be the only ones in the nation (among those without a medically needy program) not using the "300-percent rule." Federal law permits states to establish a special income level to be used only in determining Medicaid eligibility for individuals living in nursing homes or in need of (currently very limited) home and community-based services. This special income level is capped at 300 percent of the basic SSI payment level for an individual (3 X $386 or $1,158 per month in 1990); thus it is known as the "300-percent rule." All of the states that have no medically needy program use this special option to provide Medicaid coverage for nursing home residents. Over half of this group of states use the maximum income level permitted. This income level is sufficiently high to cover almost half of elderly men and perhaps 80 percent of elderly women (Neuschler 1988).

Table 7 presents data for the states without a medically needy program covering nursing home care for the elderly. As a group, these states do not succeed in eliminating the costs of caring for the elderly from their Medicaid program. As the table shows, in these states without a medically needy program for the aged, elderly Medicaid beneficiaries and beneficiaries receiving nursing home services (other than in institutions for the mentally retarded) represented a slightly above-average share of total recipients. Payments for nursing homes were also above average as a share of total payments, although total payments for the aged were somewhat below the national average. These data suggest that not offering a medically needy program for the aged would generally not eliminate the cost of providing long-term care for the indigent aged from the state's Medicaid program. By

Table 7
States with No Medically Needy Program for the Aged, FY1989:
Aged and Nursing Facility Recipients and Payments as a Share of Total Recipients and Payments
Percent

Jurisdiction	Aged as a Share of Total		ICF + SNF[a] as a Share of Total	
	Recipients	Payments	Recipients	Payments
Alabama	20.86	35.47	6.57	29.91
Alaska	7.87	22.16	3.09	25.19
Colorado	18.79	33.41	11.00	31.53
Delaware	12.69	39.19	5.99	33.92
Georgia	16.69	29.11	6.82	24.57
Idaho	13.89	31.70	10.19	29.96
Indiana	14.05	31.92	14.33	36.24
Mississippi	14.17	31.38	4.19	26.09
Missouri	15.48	37.20	8.21	33.70
Nevada	16.37	28.84	6.61	27.02
New Mexico	11.42	25.61	5.24	25.51
Ohio	9.08	30.17	7.71	32.19
South Carolina	16.45	27.52	4.60	21.32
South Dakota	18.60	38.16	13.04	33.35
Texas	18.29	36.06	7.06	24.89
Wyoming	15.81	42.11	9.00	40.91
16 State Average	15.03	32.50	7.73	29.77
U.S. Average	13.32	34.05	6.17	28.50

[a]Intermediate care facilities (other than those for the mentally retarded) and skilled nursing facilities.

Source: HCFA State Medicaid Data Disk for FY 1989.

contrast, such a step might succeed in shifting a part of the cost of acute/preventive care for these individuals out of Medicaid. However, the Medicaid provisions of the Medicare Catastrophic Coverage Act of 1988 (provisions that were not later repealed) will soon limit the acute care savings to be obtained by ending medically needy programs for the aged (or disabled). These provisions require state Medicaid programs to pay Medicare premiums, deductibles and co-insurance for aged and disabled individuals whose income is below the federal poverty level in January 1992.[17] In other words, these provisions extend Medicaid acute-care coverage to aged and disabled individuals whose income falls between the SSI standard and the poverty line.

Where the cost of any acute/preventive care eliminated from Medicaid coverage would reemerge is less obvious. It does seem clear, however, that much of any increase in uncompensated care delivered would be covered by higher charges to private patients and, eventually, by higher insurance premiums. Some costs would also spill over into parts of the budget not directly related to health care. For example, the state of Massachusetts is currently considering eliminating prenatal care during the first two trimesters of pregnancy from Medicaid coverage. However, a U.S. Office of Technology Assessment study has found that the medical costs of caring for the additional low birthweight children likely to be born under this policy would more than offset the savings to the Medicaid program. In addition, because low birthweight children are much more likely than normal birthweight children to require special education, the costs of eliminating coverage of early

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[17] And whose nonexempt resources are at or below twice the resource standard used in the SSI program.

prenatal care will also impinge on the state's education budget (Chaikind and Corman 1990).

Another method of shifting the costs of specific benefits away from the Medicaid program involves setting limits on the use of covered services (for example, on the number of doctor's visits permitted per year). The problem with limits set by administrative fiat is that they are not very flexible. Accordingly, they may not be cost effective. For example, in the early 1980s New Hampshire had set a limit on Medicaid-covered prescriptions at three per month. As a result, according to a recent study, admissions to New Hampshire nursing homes doubled; hospitalization rates also rose, but to a lesser extent. Doctors admitted patients to these institutions as a way to obtain required drugs, and because some individuals' health actually deteriorated (Winslow 1990). By contrast, the Massachusetts legislature's 1990 decision to eliminate several optional services from program coverage incorporates some flexibility; by exception, a doctor may certify that the services are medically necessary, as might be the case, for instance, with podiatric services for diabetics.

Oregon's widely discussed effort to develop a hierarchy of Medicaid-covered services based on cost/benefit criteria represents still another experiment in setting administrative limits. The state's first attempt at ranking services resulted in such a bizarre list that it was sent back to the drawing board. (For example, since duration of benefit was given a 50 percent weight, orthodontics preceded treatment for meningitis.) The major problem with setting limits by fiat will remain, however, regardless of how "reasonable" the final list may be. Although the classifications of service or diagnosis may be very detailed, medical cost/benefit will always depend on

individual patient circumstances and require individual judgment. Accordingly, Oregon's efforts to reduce waste, should they be implemented, are likely to result in a good deal of cost shifting. (Incidentally, Medicaid services for the elderly were originally expected to be exempt from this cost/benefit analysis in Oregon's plan. However, press discussion indicates that they may be included in 1992.)

Tightening eligibility criteria. Tightening eligibility criteria to bring them close to national standards represents an alternative way of shifting public sector costs to the private sector. (Again, the estimated savings from tightening eligibility criteria and the estimated savings from eliminating optional services are not additive; the policy choices overlap to an unknown extent.) For example, New York and Massachusetts are two states where medically needy Medicaid recipients represent an unusually large share of the state's elderly population. At current cost and benefit levels, tightening eligibility requirements for the medically needy aged would cut New York and Massachusetts' Medicaid spending by 20 to 25 percent (gross); net the loss of federal matching funds, such changes would save between 3 and 6 percent of these states' own resources.

A less fiscally promising route to cutting state Medicaid expenditures would involve reducing the share of the state's impoverished population covered by the categorically needy program to the national average level. Moreover, such a step would require tightening eligibility for AFDC and SSI as well, and in most states the AFDC standard of need ranges from just at to well below the federal poverty level. In addition, new federal requirements phasing in Medicaid payments for pregnant women, children, the elderly and the disabled with incomes below the federal poverty level will soon limit the

Table 8
Medicaid Payments per Actual and per Standardized Recipient and Personal Health Care Expenditures per Capita in Relation to the U.S. Average, States with Relatively Comprehensive Programs,[a] FY 1989

	Jurisdiction	Medicaid Payments per Actual Recipient Relative to US Avg.	Medicaid Payments per Standardized Recipient Relative to US Avg.	Personal Health Care Expenditures Per Capita Relative to US Avg.	PCHRG[b] Rank	No. of Services, 1987
	United States	1.00	1.00	1.00		
I.	Connecticut	1.94	1.30	1.11	5	24
	Maine	1.31	0.92	0.90	12/13	27
	Massachusetts	1.77	1.19	1.25	4	31
	Minnesota	1.48	1.60	1.02	1	30
	Montana	1.09	1.05	0.85	23	27
	New Hampshire	2.19	1.34	0.82	37/38	28
	New Jersey	1.55	1.29	0.92	7	28[c]
	New York	1.95	1.48	1.16	3	25
	North Dakota	1.65	1.45	1.10	31	25
II.	California	0.71	0.68	1.19	6	26
	Illinois	0.87	0.77	1.08	18	26
	Michigan	0.75	0.66	1.06	10	28
	Oregon	0.83	0.56	0.95	9	26[c]
	Washington	0.97	0.84	0.95	8	26[c]
	Wisconsin	1.20	0.77	1.01	2	27[c]

Note: Group I includes states where relative Medicaid payments per standardized recipient are higher than relative personal health care expenditures per capita. Group II includes states where relative Medicaid payments per recipient are lower than relative personal health care expenditures per capita.

[a] States offering at least 25 services and a medically needy program or offering a program ranked in the top 10 by the Public Citizen Health Research Group in 1987; and Families USA, Lewin/ICF estimates.
[b] Public Citizen Health Research Group.
[c] Some services offered to categorically needy group only.

Source: Health Care Financing Administration, State Medicaid Data Disk FY 89; Congressional Research Service, Medicaid Source Book, November 1988, pp. 98-99; Erdman and Wolfe, Poor Health Care for Poor Americans: A Ranking of State Medicaid Programs, Public Citizen Health Research Group, 1987; and Families U.S.A., Lewin/ICF estimates.

states' ability to shift costs by tinkering with categorically needy eligibility requirements.

Moreover, as suggested previously, some poor people denied eligibility to Medicaid are likely to turn to other state programs. Although many other variables are involved, in states like Massachusetts and New York, where Medicaid pays a well-above-average share of all personal health care costs, "other (non-Medicare) public" funds pay a below-average share; in states like Nevada, New Mexico, Idaho, Texas and North Carolina, by contrast, Medicaid pays a below-average and "other public" funds pay an above-average fraction of all health care spending (Lewin/ICF estimates in Families U.S.A. Foundation 1990).

Improving Program Efficiency

Whether or not state policymakers decide to eliminate or reduce optional benefits, they will undoubtedly want to pursue efforts to improve the efficiency of the Medicaid program. Without such efforts, even a pared-down program will most likely continue to grow considerably faster than state revenue. Unfortunately, the savings that could result from promoting best-practice delivery and reimbursement systems may seem comparatively modest, but they will cumulate. By contrast, when benefits are cut, the savings are immediately apparent. It is the costs that emerge over the long term.

Even so, the short- and medium-term savings to be obtained from best practice procedures are not inconsequential. Table 8 shows the states offering the most comprehensive Medicaid programs in terms of number of optional services provided. As the table indicates, states that offer most optional services and programs do not necessarily bear above-average costs per standardized recipient. Indeed, Table 8's Group II includes states with among

the lowest per recipient expenditures in the country. While a full explanation of the remarkable differences in per recipient costs among states with relatively comprehensive Medicaid programs is beyond the scope of this paper, the following sections may provide some clues. At the very least, Table 8 clearly suggests that administrative decisions taken by these states may matter a great deal.[18]

The issue of improving efficiency introduces a whole set of administrative decisions and procedures. These issues include the need for co-payments, the value of alternative delivery mechanisms (like health maintenance organizations) and managed care, alternative reimbursement methods, volume purchasing, and estate recovery programs.

As mentioned earlier, options for improving efficiency, given current technology and health needs, fall into three categories: 1) increasing the marginal cost to recipients; 2) putting the provider at risk of paying the marginal cost of care; and 3) rationing through increased use of managed care. All across the country state officials grappling with an ever-expanding Medicaid program are combining these methods in a great variety of ways. Dozens of experiments are underway in the 50 state laboratories. A good many large corporations, stung by rising health insurance costs, are also becoming

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[18] This paper will only discuss some of the administrative choices available within the confines of the Medicaid program -- although the scope for reducing administrative costs throughout the entire U.S. health care system appears substantial. For instance, a paper recently published in The New England Journal of Medicine reports that in 1987 administration absorbed almost one-quarter of U.S. health care spending compared with 11 percent in Canada. The authors conclude that the fragmented and complex structure of the U.S. medical payments system is inherently less efficient than the Canadian single-payor system (Woolhandler and Himmelstein 1991). Nevertheless, the ability of individual states to remedy this situation appears limited.

involved.[19] They are experimenting with increased co-payments and deductibles, for example, encouraging the use of preferred provider organizations (PPOs), even setting up their own health care delivery systems. All segments of society are groping toward ways to control medical costs.

So far, very little consensus exists concerning what works and what does not, especially since many current efforts merely shift costs from one group to another. Today's promising answer often turns out to be tomorrow's disappointment.[20] For example, not too long ago health maintenance organizations (HMOs) were being hailed as a preferred delivery mechanism. Later it became apparent that their relatively low costs partially reflected favorable selection; younger, healthier people were choosing HMOs while older, riskier individuals were sticking with traditional indemnity insurance. Yet subsequent demonstration programs, wherein individuals were assigned at random to an HMO or a traditional health insurance program, suggested that HMOs can deliver some significant short-term savings in an experimental setting. Whether HMOs reduce the cost of providing health care to Medicaid recipients over the long term has yet to be demonstrated. Moreover, while HMOs appear to reduce unneeded care and improve efficiency, they cannot slow the underlying pace of medical care inflation based on technical change or demographics.

Despite this rampant agnosticism, a few observations emerge from all the conflicting evidence and advice. In the following discussion, the various administrative procedures that states can use to affect costs will be

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[19] A survey by A. Foster Higgins, a benefits consulting firm, found that corporate medical costs rose 21.6 percent in 1990 and absorbed an amount equal to more than one-quarter of net income (Fettig 1991).

[20] Indeed, according to the same survey cited in the preceding note, half of the corporate respondents believe that their efforts to cut health care costs are not effective.

categorized according to whether they involve raising the marginal cost to the consumer, raising the marginal cost to the provider, or rationing through managed care.

Asking the Consumer to Share the Marginal Cost

As already observed, Medicaid officials face an inherent conflict between providing access to medical care to those who cannot afford it and controlling costs. This conflict is highlighted by the use of co-payments to limit Medicaid recipients' use of Medicaid services. While increased use of co-payments to discourage waste by health care consumers generally makes very good sense, requiring co-payments of welfare recipients might deter some necessary acute/preventive care and not prove cost-effective in the long run. The budgetary impact of the "nominal" co-payments permitted by federal law is also likely to be limited. For instance, if one-fifth of all purchases of prescription drugs were deterred by such co-payments, the average state's Medicaid expenditures would fall by less than 1.5 percent--in the immediate term. If essential medications were forgone, however, co-payments could raise total Medicaid costs over the longer term. A more promising alternative to co-payments might be increased use of managed care, as will be discussed below.

Exceptions to this criticism of co-payments for Medicaid recipients might include their imposition in cases of inappropriate use of emergency wards, and for elective surgery and home/community care--although case management might again be preferable. One problem with imposing co-payments for "inappropriate" use of hospital emergency wards is that in many poor communities alternative facilities simply do not exist.

Asset recovery. Another potential source of "co-payments" derives from state efforts to recover assets from institutionalized beneficiaries or from the estates of elderly deceased Medicaid recipients. The asset of interest is usually the recipient's house. Federal law requires states to exclude a Medicaid applicant's primary residence from her assets as she spends down to medically needy levels. However, if a state determines that a beneficiary is permanently institutionalized, it may deem the house a countable asset and force its sale, as long as the recipient's spouse, dependent child (or, in limited cases, a sibling) does not live in that home. Moreover, under the same circumstances, federal law permits (but does not require) states to place liens on a permanently institutionalized Medicaid recipient's home. (Although medically needy nursing home residents may not transfer an asset for less than market value, federal law does not prevent the spouse remaining in the community from making such a transfer. In addition, Medicaid applicants may not have made such a transfer within the past 30 months. For some chronic conditions that develop slowly, like Alzheimer's, this look-back period may be too short to prevent asset shifts. These loopholes permit some families to shift sizable assets to the next generation while obtaining Medicaid coverage of current nursing home costs. These loopholes need to be closed at the federal level.)

Three states (Kentucky, Michigan, and Missouri) place no restriction on an institutionalized Medicaid recipient's ownership of a home. Another 27 states (including California, Florida and Texas) place no time restrictions on an institutionalized recipient's home ownership as long as the beneficiary has expressed an intent, usually in writing, to return to that home. However, six states (including New York and Massachusetts) require a doctor to determine

whether the recipient is likely to return home, and 13 states end the protection of a home after six to 12 months of institutionalization (Gordon and Daniel 1990).

Roughly half the states make provision for recovering funds from elderly recipients' estates, but only a few, like Oregon and California, currently have vigorous estate recovery programs. In 1985, for example, Oregon ranked first out of 21 states in recoveries as a share of nursing facility payments. In that year it recovered $4.0 million at a cost of $306,000. That effort, which Oregon officials claim was well understood and accepted, yielded over 5 percent of state Medicaid payments to nursing homes and almost 2 percent of total state Medicaid payments. Following the principle that the elderly have a responsibility to provide for their own long-term care needs before passing significant assets on to their heirs, this program might bear further investigation and reinvigoration in most states.

The U.S. General Accounting Office (1989) has estimated that in the eight states examined in 1985, an average of 14 percent of the nursing home residents receiving Medicaid owned a home when they applied for assistance. (The figures ranged from 9 to 21 percent.) Moreover, over 80 percent of the homes owned by the elderly are free of mortgages. Accordingly, at the median sales price of existing homes in Rochester, New York, nursing home beneficiaries in New York State may hold roughly $1 billion in housing assets that could eventually be used to repay the state Medicaid program. That amount represents approximately 40 percent of the Medicaid payments made to nursing homes in New York in 1989. In other words, placing liens on institutionalized Medicaid recipients' homes and exercising them as a matter of course when permitted seems to be a relatively equitable way to alleviate

the states' Medicaid burden--without reducing needed medical care. With over half of the states facing fiscal problems, such an effort seems preferable to cutting Medicaid services and programs.

Reducing the Return to the Provider

Any prepaid delivery mechanism or prospective reimbursement system requires the provider to risk paying the marginal cost of care. (In this context "provider" refers to contracting organizations such as HMOs in addition to the institutions and physicians giving direct care.) An important advantage to HMOs and similar prepaid provider mechanisms is that they present strong incentives to minimize unnecessary care. They also foster efficient delivery. On the other hand, they may encourage the provider to stint on quality of care.[21] For this reason it may be useful to let recipients vote with their feet instead of forcing them to go to a specific prepaid provider. While it is important in assessing an HMO's cost effectiveness to make sure that it is serving a broad cross-section of patients, allowing Medicaid recipients to go to one of several HMOs/PPOs rather than requiring a specific organization might facilitate quality control.

Table 9 provides data on the share of total Medicaid recipients enrolled in prepaid "capitated" plans. The great majority of these prepaid plans cover acute care and often are designed for AFDC recipients only. Only four states, California, Massachusetts, Minnesota, and New York, have prepaid plans

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[21] However, in areas with relatively few medical facilities where Medicaid recipients may be forced to turn to hospital emergency rooms for treatment, HMOs may increase the quality of care, because they would permit ongoing patient-physician relationships. By the same token, channeling Medicaid recipients to HMOs may not permit the same cost savings as might be expected from the experience of the general population. In comparison with the average U.S. health care consumer, Medicaid recipients are likely to have more severe health problems and to be receiving less opulent health care currently.

Table 9
Medicaid Recipients Enrolled in Capitated Plans[a] as a Share of Total Recipients, June 1990
Percent

State	Percent	State	Percent
Texas[b]	98.7	Massachusetts	6.5
Indiana[b]	87.2	Missouri	5.9
Wisconsin	28.0	Colorado	4.5
Oregon	24.8	Washington	4.3
Utah	14.1	Tennessee	2.9
Maryland	13.5	Hawaii	2.8
Pennsylvania	12.4	New York	2.4
Michigan	11.5	New Hampshire	2.1
Illinois	11.4	Iowa	1.6
California	10.7	Alabama	.8
Ohio	10.4	New Jersey	.8
Minnesota	7.5	Rhode Island	.4
Florida	6.7	North Carolina	.1

[a]These capitated plans include health maintenance organizations (HMOs) providing a comprehensive range of services; prepaid health plans (PHPs) which provide a less comprehensive range of services or services on a non-risk basis; and health insuring organizations (HIOs).

[b]In Texas and Indiana the state pays a health insuring organization (HIO) to act as its risk-bearing fiscal agent statewide. These HIOs do not arrange for provider services. The plans cover most services provided by the states' Medicaid programs.

Source: HCFA, Medicaid Bureau, Medicaid Managed Care Office, "Report on Medicaid Enrollment in Capitated Plans as of June 30, 1990"; and HCFA 2082 data disk for FY1989.

covering long-term care, and with the exception of California, enrollment in these long-term care programs is very small. As Table 9 indicates, five of the six states with comprehensive Medicaid programs and low per recipient costs -- California, Illinois, Michigan, Oregon, and Wisconsin -- have a significant share of recipients enrolled in these capitated programs. Their experiences suggest that these prepaid plans may indeed help to keep per recipient Medicaid costs relatively low.

Prospective payments systems for hospitals and nursing homes (wherein reimbursement rates are set in advance) also place the provider at risk of paying a share of marginal costs. Accordingly, they may provide incentives to avoid expensive patients. For this reason, best-practice reimbursement systems should probably incorporate a set of payment categories instead of using one flat rate. Examples of payment classes include the diagnosis-related groupings (DRGs) used by Medicare for hospitals, the 16 resource utilization groups (RUGs) used by the state of New York for nursing homes, and the relative value scales (RVSs) used by a few states for physicians' services.

Another crucial issue is the level at which Medicaid reimbursement rates are set. For instance, New Hampshire and New York (Group I states in Table 8) have the highest nursing home reimbursement rates in the nation (Kolbert 1991). By contrast, in California (a Group II state) nursing home reimbursement rates are approximately one-half those in New York -- despite the fact that per capita personal health care expenditures are actually higher in California.

Unfortunately, if Medicaid rates are set well below those for other area patients, Medicaid recipients will have trouble getting care. Maintaining

access has been an ongoing problem for the Medicaid program in many parts of the country. For example, Michigan nursing home operators acknowledged in federal court that they respond to inadequate Medicaid rates by reducing the quality of care or curbing access for Medicaid beneficiaries (Pear 1990). In addition, according to a Michigan administrator, with an April 1, 1991 cut in reimbursement rates for physicians, Michigan has "one hell of an access problem" with regards to physicians as well. Not surprisingly, California is another state that has recently received much adverse press coverage because of problems with access and quality in its Medicaid program. (See, for example, Pear 1991a.) And, although New York sets its nursing home reimbursement rates relatively high, its physician reimbursement rates are among the lowest in nation. As a result, only one-fourth of New York State doctors treat Medicaid patients on a regular basis (Kolbert 1991). Indeed, with their Medicaid rates set between 30 and 94 percent of their Medicare reimbursement rates, 44 states have trouble getting doctors to participate in Medicaid, according to the Physician Payment Review Commission (Pear 1991b).

To maintain access for Medicaid beneficiaries (and avoid wasteful cost-shifting exercises), thus, a best-practice reimbursement system should probably incorporate an all-payor rate-setting methodology. In an all-payor system, all third-party payors--Medicaid, Medicare, and private insurance companies--base their payments on the same rates or rate-setting methodology.

Table 10 presents information on reimbursement systems used by the states with relatively comprehensive programs (the two groups of states shown in Table 8). As Table 10 indicates, all-payor systems tend to be found in states with above-average Medicaid payments per recipient. In addition, the

Table 10
Reimbursement Systems Used in States with Relatively Comprehensive Medicaid Programs[a]

	State	FY1989 Medicaid Payments per Standard Recip.[b] Relative to US Avg.	1990 Personal Health Care Expenditures Per Capita Relative to US Avg.	Change in Medicaid Payments per Standard Recipients FY1980-89 (percent)	Change in Personal Health Care Expenditures Per Capita 1980-1990 (percent)	1987 Reimbursement Method: Hospital In-Patient	1987 Reimbursement Method: Nursing Facilities
	United States	1.00	1.00	114.3	138.7		
I.	Connecticut	1.30	1.11	197.8	135.2	Prospective, All-Pay exc. Mcare	Prospective; case mix; ceilings
	Maine	.92	.90	210.1	150.0	Prospective, All-Pay exc. Mcare	SNF, prospective; ICFs, cost
	Massachusetts	1.19	1.25	147.6	136.0	Prospective, budgeted All-Pay exc. Mcare	Prospective budgeted
	Minnesota	1.60	1.02	121.0	123.4	Prospective, DRG	Prospective, case mix, ceilings
	Montana	1.05	.85	154.7	139.7	Prospective, DRG	SNF-ICFs, prospective; ICF-MR, cost ceiling
	New Hampshire	1.34	.82	292.3	143.6	Cost	SNFs, cost; ICFs, prospective
	New Jersey	1.29	.92	172.8	139.2	Prospective, DRG, All-Pay incl. Mcare	SNFs-ICFs, prospective; ICF-MR, cost
	New York	1.48	1.16	107.2	124.2	Prospective, w. ceils; All-Pay exc. Mcare	Prospective, case mix; ceilings
	North Dakota	1.45	1.10	107.8	149.7	Cost	Prospective
II.	California	.68	1.19	130.4	143.9	Prospective, selective contracting	Prospective, ceilings
	Illinois	.77	1.08	76.1	139.6	Prospective, selective contracting	Prospective, case mix
	Michigan	.66	1.06	37.9	134.3	Prospective, DRG	SNF-ICFs, prospective; ICF-MR, cost
	Oregon	.56	.95	69.3	146.0	Prospective, DRG	Cost ceilings
	Washington	.84	.95	130.5	148.7	Prospective, DRG	Prospective, ceilings
	Wisconsin	.77	1.01	26.4	123.2	Prospective,	Prospective, ceilings

Key: All-Pay exc. Mcare: all-payor except Medicare.
DRG: diagnosis-related groupings
ICF;ICF-MR: intermediate care facility; ICF for the mentally retarded.
SNF: Skilled nursing facility.

Note: Group I includes states where relative Medicaid payments per recipient are higher than relative personal health care expenditures per capita. Group II includes states where relative Medicaid payments per recipient are lower than relative personal health care expenditures per capita.

[a] See Table 8 for selection criteria.

[b] State Medicaid payment per recipient, assuming national average recipient mix, relative to U.S. payment per recipient.

Source: HCFA 2082 data disk for FY1989; Congressional Research Service, Medicaid Source Book, Tables IV-1 and IV-2; and Families USA Foundation 1990.

all-payor states have generally had above-average increases in Medicaid payments per (actual or standardized) recipient both from 1980 to 1989 and more recently from 1985 to 1989. However, this relatively rapid rise in Medicaid payments per recipient contrasts with a below-average increase in total health care spending per person in most of these same all-payor states. Perhaps all-payor systems reduce the players' ability to shift costs, strengthen the overall bargaining position/determination of the third-party payors and, thus, help to restrain total health care costs. In addition, the experiences of New Hampshire and North Dakota strongly suggest that prospective systems are better than cost-based methods for slowing the growth in Medicaid (and total health care) payments.

Managed Care

Managed care represents a flexible form of rationing that stands a chance of reducing waste more and transferring costs less than does rationing by administrative list or limit. Managed care systems could include screening, second opinions, and peer reviews, in addition to contracts with managed care providers such as HMOs or individual physicians who oversee patient care on a fee-for-service basis. On the other hand, although a currently popular concept, managed care is not a panacea. It may reduce waste, but it will not slow technological or demographic change. And, a point often overlooked, its administration requires resources.[22]

Nevertheless, the scope for reducing waste by such methods appears substantial. For example, the World Health Organization has pointed out that

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[22] In addition, because Medicaid recipients already have below-average access to medical care and, being poor, aged or disabled, tend to have above-average medical problems, enrolling Medicaid beneficiaries in managed care systems may not yield the same savings observed from the population at large.

"there is no justification for any region to have a rate (of Caesarean sections) higher than 10 to 15 percent." (Terris 1990) Yet in the United States the rate is over 25 percent. Other surgical procedures that appear to be greatly over-used in this country include tonsillectomies, hysterectomies, and, arguably, bypass surgery. Utilization of these procedures varies greatly across the states and even from one side of town to another.

One advantage to managed care is that some consumers might welcome it. Given the pain and inconvenience involved, no one wants to face unnecessary procedures even at little or no financial cost. Accordingly, consumers might embrace case management or second opinions as ways of obtaining objective advice on the most effective course of action. In other words, managed care could help reduce an important source of market failure that discourages efficient medical care--the dearth of well-informed and rational consumers. While doctors may resent case-by-case "peer" reviews, especially by non-physicians, perhaps they would not object to a periodic report on the rate at which they perform certain procedures compared to the regional, national, and "best practice" standards.

On a small scale, the Massachusetts appropriations act of FY1991 contains an example of a peer review program that emphasizes education as well as immediate cost control and should benefit the Medicaid recipient as well as the Massachusetts taxpayer. The legislation establishes a drug utilization review to identify and remedy: underutilization as well as overutilization of prescription drugs; prescribing and dispensing patterns inconsistent with norms, acceptable medical practice or program regulation; and risks of patient harm from drug therapy failure, adverse reactions, or contraindicated drug use. The program is also required to identify trends in drug utilization in

institutional care settings (are certain nursing homes oversedating their residents?) and to assess the effects of new drugs on therapeutic efficacy as well as program costs.

Similarly, HMOs like Massachusetts' Harvard Community Health Plan seek to control costs through an inhouse committee of physicians that develops guidelines concerning best-practice responses to specific symptoms as well as best-practice procedures for confirmed diagnoses (Sass 1991). From time to time individual doctors receive reports on how their own practice differs on average from recommended practice. Eventually they may be required to justify such deviations.

Perhaps the states or even the federal government could use such an approach to slow the rise in national health care costs. Perhaps we could establish state commissions or even a Federal Health Board, dominated by providers but including all major third-party payors and some consumer groups, to develop best-practice strategies and procedures. Then, pooling data from all major third-party payors, physicians could receive periodic reports on how their own habits differ on average from the guidelines. Should major deviations persist, the third-party payors could ask the provider to justify his decisions. This approach would permit physicians to retain considerable flexibility in dealing with individual cases; yet it would tackle ineffective care throughout the state or, preferably, the nation. A comprehensive approach is important since it is difficult to slow Medicaid cost increases in isolation. (See Ellwood 1991, for a similar suggestion.)

Governments at all levels, here and abroad, are grappling with the problem of controlling health care costs. Agreement about what methods work best is limited but growing. Under these circumstances, state policymakers

may want to proceed, but proceed cautiously, with their own carefully evaluated experiments--with the beneficiaries assigned at random to the experimental program or to a control group. Other states' experiences also warrant serious review. Changes made in haste just for the sake of "doing something about Medicaid" are unlikely to prove very effective.

VI. Conclusions

As this study has pointed out, financing Medicaid has become a serious problem for all state governments. Medicaid is one of the largest and fastest-growing programs in most state budgets, and soaring national health care costs account for most of the program's explosive growth. By contrast, and contrary to widespread opinion, the aging of the country's population and the growing need for expensive long-term care have not been the primary forces driving Medicaid spending over the last 15 years. The success of Social Security and private pensions in reducing poverty among the elderly has offset and postponed the likely impact of changing demographics on the Medicaid program. With the states facing sizable difficulties in funding Medicaid even now, this finding merely underscores the nation's need to address the issue of paying for long-term care.

The per capita burden of Medicaid expenditures varies considerably across the states. One part of this ratio, the number of Medicaid recipients per capita, reflects each state's political choices concerning eligibility criteria, as well as differences in the incidence of poverty and the age structure of the population. In some states a strong economy and low unemployment rates have until recently offset relatively generous eligibility criteria, thereby keeping the ratio of their Medicaid recipients to their

total population close to the national average. Should the downturn continue, however, the balance may tip, with adverse consequences for these states' budgets.

Payments per recipient also vary a great deal, even when these expenditures are adjusted to account for state differences in recipient mix. Payments per standardized recipient again reflect a range of political choices concerning the comprehensiveness of the program, as well as differences in state personal health care costs and the tightness with which these programs are administered.

Regardless of the big differences in per capita and per recipient Medicaid costs, the program is absorbing a growing share of state and local expenditures in every single state. With more than half the states facing budget deficits, policymakers everywhere are under great pressure to cut Medicaid. How can they control their state's Medicaid spending? Policymakers face two choices. They can shift costs to the private sector by reducing benefits permitted but not required by the federal government, and they can make the existing programs more efficient.

Paring the programs back to mandatory levels represents the most Draconian policy choice. In the four states examined, eliminating all optional benefits could cut state Medicaid spending by 40 to 50 percent in the immediate term. The great bulk of these public sector savings would stem from terminating the medically needy program or coverage of long-term care provided by the ICFs. Such an action would concentrate large financial, medical, and emotional costs on elderly and mentally retarded individuals (and their families if they exist). The state governments' savings would be far smaller on a net than on a gross basis because of the loss of federal reimbursements.

Moreover, in time, some fraction of these "savings" would undoubtedly resurface within Medicaid or in other income support and health care programs fully funded by the state. At the very least, the 300-percent rule would ensure that most long-term care recipients returned to the Medicaid umbrella almost immediately. The share of the public sector "savings" that resulted in extra uncompensated care would largely be paid by the private sector through higher medical and health insurance bills.

Tightening eligibility requirements could also produce large short-term savings on a gross basis, smaller savings net the loss of federal reimbursements, and similar feedbacks into state-supported programs. Setting limits by law or regulation, on the number of prescriptions permitted, say, or curbing prenatal care to the last trimester of pregnancy, are also unlikely to be cost-effective.

If state policymakers determine that a drastic restructuring of their Medicaid program is likely to be unproductive and unwise, they must turn their attention to the less dramatic but crucially important issue of reducing inefficiencies in the health care system. Indeed, they must turn their attention to this problem in any event lest the mandatory portion of the Medicaid program continue to mushroom at budget-buster rates. Moreover, examining the states with reasonably comprehensive programs indicates that administrative issues can make a considerable difference in per recipient costs.

Nevertheless, states with well-above-average personal health care costs cannot keep their Medicaid payments per recipient far below average without developing a serious problem with quality and access. Because Medicaid operates as part of each state's health care system, it cannot be reformed in

isolation. Achieving ongoing savings within Medicaid requires curbing cost increases throughout the entire health care system.

All sectors of society are groping for ways to limit rising health care costs, and little consensus concerning the best approach exists. Nevertheless, a few tentative conclusions seem possible. For example, co-payments generally seem out of place in a program designed to deliver health care to the poor. They are likely to deter needed preventive care and early intervention.

On the other hand, one form of "co-payment" seems appealing for reasons of equity as well as for its potential significance to the states. Reinvigorating state efforts to tap the seemingly significant housing assets of permanently institutionalized or deceased Medicaid beneficiaries (with appropriate protection for a spouse or dependent child) could well prove very productive. In other words, placing liens on institutionalized Medicaid recipients' homes and exercising them as a matter of course when permitted seems to be a relatively equitable and effective way of alleviating the states' long-term care burden without reducing needed care. With most states facing fiscal pressures, such a step seems preferable to cutting Medicaid programs and services.

In addition, prospective reimbursement systems or prepaid health plans show some promise of slowing the rise in health care costs. While all-payor and case-mix systems may help to ensure that Medicaid recipients receive close to state average medical care, they appear less effective than selective contracting and flat rate systems in curbing cost increases. Nevertheless, the experiences of many states indicate that it is not possible to hold

Medicaid costs per recipient significantly below state per capita personal health care costs without creating severe problems with access or quality.

Finally, increased use of managed care, although not a panacea, may yield results as well. Certainly, the scope for reducing waste by channeling recipients to managed care providers appears substantial. Moreover, the HMOs' internal efforts at cost control may suggest a model that could be applied at the state or national level. In particular, a state or national board, dominated by physicians but representing consumers and third-party payors as well, could develop guidelines on cost-effective responses to specific symptoms and diagnoses. Eventually, physicians whose own practice deviated substantially from best practice over a significant period of time could be asked to justify their actions. Such an approach would permit physicians to retain considerable flexibility in dealing with individual cases but would increase cost-effectiveness throughout the health care system. And a comprehensive approach is essential since it is extremely difficult to slow Medicaid cost increases in isolation.

All in all, many state experiments seem to be steps in the right direction. In particular, the increased emphasis on managed care, peer reviews, negotiated prices, and prospective reimbursement systems appears appropriate. Given the lack of consensus concerning the most effective approaches, however, any efforts to experiment with "best-practice" reimbursement and delivery systems need to be designed (and preferably financed) to permit careful evaluation.

Unfortunately, in the current press of fiscal distress, some state policymakers may feel driven to make drastic cuts in their states' Medicaid programs. But, measures taken in haste without careful evaluation could prove medically disastrous for some U.S. citizens and fiscally unproductive for the states.

Table A-1
Medicaid Payments as a Share of State and Local Direct General Expenditures, FY 1975 and FY 1989
Percent

Jurisdiction	Medicaid Payments/ Direct General Expenditures FY 1975	FY 1989	Annual Percent Change in: Medicaid Payments	Direct General Expenditures
All[a]	5.3	7.2	9.4	6.3
New York	10.1	12.3	6.6	4.4
Rhode Island[b]	7.4	11.4	10.8	6.5
Massachusetts	7.2	11.1	10.1	5.5
Maine	6.1	10.1	12.4	7.3
Arkansas	6.0	10.0	10.9	5.8
Ohio	3.6	9.0	14.4	5.4
Kentucky	3.5	8.9	15.0	5.8
Louisiana	4.0	8.7	14.0	6.1
North Dakota	3.5	8.4	14.4	5.8
Connecticut	4.9	8.3	12.8	7.6
Tennessee	3.4	8.3	14.8	6.0
Indiana	3.9	8.2	13.2	5.8
South Dakota	3.2	8.0	13.1	3.5
Oklahoma	5.9	7.9	9.4	6.4
Mississippi	4.8	7.5	10.4	5.9
West Virginia	1.8	7.5	18.0	3.8
Pennsylvania	5.9	7.5	6.7	4.1
Wisconsin	7.2	7.3	5.4	5.2
Vermont	5.8	7.3	8.8	6.3
North Carolina	3.6	7.0	13.8	7.3
Minnesota	5.3	6.9	9.1	6.4
New Jersey	4.5	6.9	10.9	6.6
Georgia	5.6	6.8	10.0	8.0
Washington	4.2	6.7	11.3	6.7
Illinois	5.7	6.6	5.4	3.7
Missouri	2.5	6.6	14.8	5.1
Montana	3.6	6.6	11.0	4.7
Michigan	5.7	6.6	5.6	4.0
South Carolina	3.1	6.4	14.1	6.8
Maryland	3.1	6.3	12.0	4.7
Iowa	2.9	6.3	12.8	4.7
New Hampshire	3.7	6.0	12.9	8.2
Nebraska	3.4	5.7	9.8	4.4
California	5.6	5.6	7.3	7.2
Idaho	3.0	5.6	11.3	5.1
Kansas	4.7	5.5	7.4	5.8
Florida	2.2	5.3	17.9	9.4
Alabama	4.4	5.1	7.8	6.2
Texas	4.5	5.1	10.1	8.8
New Mexico	2.5	5.1	15.0	8.3
Virginia	3.3	4.6	10.7	7.3
Delaware	2.1	4.6	14.4	6.7
Oregon	2.7	4.6	11.4	5.8
Colorado	3.5	4.6	9.6	6.7
Utah	2.6	4.3	13.1	8.1
Hawaii	2.7	4.3	8.9	4.1
Nevada	2.1	3.1	13.0	9.3
Wyoming[b]	1.0	2.6	18.1	8.3
Alaska	.9	2.4	20.5	11.0

[a]Excluding Arizona (which has an alternative program to Medicaid), and Puerto Rico, the Virgin Islands and the District of Columbia.

[b]Medicaid data are estimated.

Source: HCFA State Medicaid Data Disk for FY 89 and State Data Tables for FY75; and U.S. Bureau of the Census.

Table A-2
Medicaid Recipients as a Share of the Total Population and as a Share of the Poverty Population, FY89
Percent

Jurisdiction	All Medicaid Recipients as a share of Total Population	Share of Population Living in Poverty[a]	Categorically Needy Medicaid Recipients as a Share of the Poverty Population[b]	All Medicaid Recipients as a Share of the Poverty Population[b]
All[c]	9.2	14.0	55.6	65.4
Alabama	7.8	21.5	36.1	36.4
Alaska	6.9	10.4	66.6	66.6
Arkansas	10.1	22.4	36.9	45.0
California	11.7	13.4	66.9	87.7
Colorado	5.8	10.8	52.8	53.5
Connecticut	7.1	7.2	73.1	98.0
Delaware[d]	5.8	11.3	52.1	51.4
District of Columbia	5.9	19.2	72.8	83.0
Florida	7.1	13.3	40.6	53.4
Georgia	9.2	15.6	55.1	58.8
Hawaii	8.5	9.9	68.4	85.8
Idaho	4.7	16.4	27.0	28.5
Illinois	9.0	15.0	47.8	59.9
Indiana	5.6	12.2	44.5	46.1
Iowa	7.9	16.5	44.1	48.1
Kansas	7.1	11.2	45.6	63.3
Kentucky	11.6	18.5	43.9	62.4
Louisiana	11.9	20.8	56.1	57.4
Maine	12.0	11.1	99.2	107.9
Maryland	6.9	8.5	63.0	81.8
Massachusetts	9.9	8.8	81.4	112.4
Michigan	12.1	14.4	81.8	84.0
Minnesota	7.5	11.5	49.9	65.1
Mississippi	15.5	25.6	60.5	60.5
Missouri	15.5	14.3	108.4	108.4
Montana	7.6	16.3	40.3	46.5
Nebraska	6.8	14.6	45.1	46.5
Nevada	3.9	12.4	33.4	31.6
New Hampshire	3.3	5.6	47.5	59.3
New Jersey	6.9	9.5	67.9	72.7
New Mexico	7.5	20.7	33.4	36.3
New York	12.6	15.2	60.7	82.8
North Carolina	7.5	14.0	35.7	53.6
North Dakota	7.0	14.9	30.9	46.8
Ohio	10.4	12.4	84.2	84.2
Oklahoma	7.8	15.5	46.0	50.4
Oregon	7.7	12.6	44.7	61.2
Pennsylvania	9.2	12.4	71.6	74.0
Rhode Island	10.4	11.2	81.7	92.6
South Carolina	8.0	17.6	36.1	45.4
South Dakota	6.2	16.2	30.0	38.5
Tennessee	11.1	17.8	48.1	62.3
Texas	7.0	16.2	37.5	43.4
Utah	5.6	11.9	40.7	46.9
Vermont	9.6	10.2	86.2	94.0
Virginia	5.7	10.6	42.3	54.2
Washington[d]	9.2	11.7	79.7	78.6
West Virginia	12.8	22.8	50.8	56.1
Wisconsin[d]	8.3	11.8	78.0	70.2
Wyoming[d]	6.5	12.3	62.0	52.7

[a]Estimated for 1985-87 by the Institute for Research on Poverty, University of Wisconsin - Madison.
[b]Assuming the poor account for the same share of the total population in 1989 as in 1985-87.
[c]Excluding Arizona, which has an alternative program to Medicaid, Puerto Rico, and the Virgin Islands.
[d]Reported Medicaid data are not consistent.
Source: Health Care Financing Administration, HCFA State Medicaid Data Disk FY89. U.S. Bureau of the Census, Statistical Abstract of the United States 1990. University of Wisconsin-Madison, Institute for Research on Poverty, Focus Vol.11, No.3, Fall 1988.

Table A-3
Share of Medicaid Recipients and Payments, by Category, FY1975 and FY1989
Percent

Category	New York				Ohio				Pennsylvania				Massachusetts				Texas			
	Recipients		Payments		Recipients		Payments		Recipients		Payments		Recipients		Payments		Recipients		Payments	
	1975	1989	1975	1989	1975	1989	1975	1989	1975	1989	1975	1989	1975	1989	1975	1989	1975	1989	1975	1989
Aged:	13.7	15.0	31.6	43.4	14.8	9.1	33.6	30.2	7.7	12.3	41.2	37.1	22.3	18.0	42.5	42.8	34.0	18.3	57.8	36.1
Categorically needy	7.5	7.0	5.6	12.5	14.8	9.1	33.6	30.2	4.7	9.8	18.2	31.2	10.9	8.3	8.8	7.6	34.0	17.9	57.8	35.9
Medically needy	6.2	8.0	26.0	30.9	.0	.0	.0	.0	3.0	1.3	23.0	5.3	11.5	9.6	33.8	35.2	.0	.0	.0	.0
Other[a]		.0		.0		.0		.0		1.2		.6		.0		.0		.4		.2
Disabled:	10.5	15.2	24.9	36.2	13.4	12.1	32.4	35.9	7.3	16.0	19.0	33.6	10.7	16.2	21.4	36.1	10.6	11.6	19.2	33.0
Categorically needy	7.8	11.1	15.9	19.6	13.4	12.1	32.4	35.9	6.2	14.5	10.7	30.2	8.2	13.5	15.1	22.9	10.6	11.5	19.2	32.9
Medically needy	2.7	4.1	9.0	16.6	.0	.0	.0	.0	1.1	.5	8.2	2.9	2.5	2.7	6.3	13.1	.0	.0	.0	.0
Other[a]		.0		.0		.0		.0		1.0		.5		.0		.0		.1		.0
Blind:	.2	.2	.6	.8	.3	.1	.5	.3	1.1	.1	1.0	.1	1.3	1.4	1.3	2.4	.5	.4	.6	.6
Categorically needy	.1	.1	.3	.4	.4	.1	.5	.3	.9	.1	.8	.1	.4	1.4	.4	2.4	.5	.4	.6	.6
Medically needy	.1	.0	.3	.4	.0	.0	.0	.0	.2	.0	.2	.0	.9	.0	.8	.0	.0	.0	.0	.0
Other[a]		.0		.0		.0		.0		.0		.0		.0		.0		.0		.0
AFDC Child:	44.6	43.6	22.1	10.0	45.7	49.9	14.6	18.5	37.3	55.4	9.5	17.2	39.4	36.0	19.2	7.1	39.2	46.5	10.3	13.6
Categorically needy	37.0	36.0	18.4	7.4	45.7	49.9	14.6	18.5	33.0	46.5	7.3	13.7	37.2	31.6	18.0	6.3	39.2	39.5	10.3	10.9
Medically needy	7.6	7.6	3.7	2.6	.0	.0	.0	.0	4.3	6.6	2.2	2.6	2.2	4.4	1.2	.8	.0	2.2	.0	.8
Other[a]		.0		.0		.0		.0		2.3		.8		.0		.0		4.8		1.9
AFDC Adult:	21.0	20.3	16.9	8.2	25.8	24.5	19.0	13.4	27.4	23.4	13.4	10.0	18.4	21.5	9.0	8.6	15.7	23.0	12.1	16.6
Categorically needy	19.1	16.0	16.1	6.4	25.8	24.5	19.0	13.4	24.3	20.3	11.2	8.8	17.4	17.6	8.4	7.0	15.7	16.8	12.1	10.7
Medically needy	1.8	4.3	.8	1.7	.0	.0	.0	.0	3.1	2.2	2.1	.8	1.0	3.9	.5	1.5	.0	1.0	.0	.9
Other		.0		.0		.0		.0		.9		.4		.0		.0		5.2		5.0
Other[b]	10.1	5.8	4.0	1.5	.0	4.2	.0	1.7	19.8	-7.2[c]	16.0	2.0	7.8	7.0	6.7	3.1	.0	.2	.0	.1
Memo:																				
All Nursing Facilities	7.5	5.7	36.4	39.7	11.9	8.5	43.5	44.3	5.3	6.9	54.5	50.5	9.7	8.8	46.5	46.8	12.1	8.1	55.9	43.1
ICF/Mentally Retarded	0.7	0.7	2.9	12.9	.6	.7	8.6	12.1	.0	.7	.0	16.2	0.4	0.7	8.1	12.4	1.0	1.0	6.3	18.2
All Other	6.8	5.0	33.4	26.8	11.3	7.7	34.9	32.2	5.3	6.2	54.5	34.3	9.2	8.1	38.4	34.5	11.1	7.1	49.6	24.9

[a]Groups provided coverage by pre-1988 and 1988 legislation.

[b]Including other Title XIX, basis of eligibility unknown and in some cases, adjustments for double counting.

[c]Published data are inconsistent.

Note: ICF = Intermediate Care Facilities.

Source: U.S. Health Care Financing Administration, State Medicaid Data Tables for FY1975 and FY1989, June 21, 1990. Based on data from HCFA form 2082.

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