THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on

THE FUTURE OF MEDICAID

THE IMPACT OF THE "MEDIGRANT" PLAN ON FEDERAL PAYMENTS TO STATES

Prepared for:

The Kaiser Commission on the Future of Medicaid

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Conclusions and opinions expressed in this paper are solely those of the authors and do not necessarily reflect the views of the Urban Institute, The Kaiser Commission on the Future of Medicaid, or The Henry J. Kaiser Family Foundation.

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Summary of Findings

This report examines the conference agreement plan for the redistribution of federal funds under a Medicaid block grant. The plan begins with federal payments approximating current spending levels and allows the payments to states to increase by predetermined growth rates. Following similar legislation introduced in the House and Senate, the plan adjusts payments for the number of people in poverty, the mix of beneficiaries, and the cost of health services and attempts to move in the direction of correcting much of the unequal distribution that currently exists.

In this report, we show that the use of maximum growth rates for federal payments, i.e., ceilings, for high need / low-expenditure states and minimum growth rates for low need / high-expenditure states, i.e., floors, substantially reduces the amount of redistribution that would otherwise result from the formula. Thus, the approach finalized by the conference agreement, while innovative, does not achieve the objective of equity in federal payments it appears to seek. This is in part inevitable given the wide discrepancies in current spending from which the House and Senate were forced to begin their efforts.

The results also show that, not surprisingly, the reductions in federal spending are large. Reductions in federal payments, relative to the baseline, are over 17% between 1996 and 2002, and over 28% by the year 2002. Eighteen states would experience reductions in federal spending of over 30% by the year 2002. These states would need to make substantial adjustments to their programs unless they added new state revenue.

We examined the implications of the reductions in federal spending for beneficiary coverage. We find that if states were to add beneficiaries in line with our baseline projections they would have to limit spending per beneficiary growth to 1.3% or about 1.7% below the rate of general inflation. Since this is unlikely, states will probably reduce the growth in enrollment. States are more likely to be able to maintain current enrollment levels; however, to do so, states would have to control spending growth to 4.8%, about half the real rate of growth experienced historically.

This conclusion assumes that states would increase spending from their own revenues at the same rate as the growth in federal payments. The Medigrant plan, however, permits states to reduce their matching contributions. We find that if states reduced their matching contributions to the minimum levels required by the plan, combined federal and state Medicaid spending could fall by about one-quarter relative to the current baseline projections for 1996 to 2002 and by over one-third relative to projected 2002 levels.

We emphasize that our baseline expenditure projections at the national level are closely tied to Congressional Budget Office estimates. We believe that CBO estimates may overstate likely Medicaid expenditure growth. If this is true, then our baseline estimates would be too high and the federal spending reductions resulting from the Congressional plan would be lower than we project.

Introduction

The Congress has now passed a major plan which would significantly transform the Medicaid program. The bill has been sent to the president and is expected to be vetoed. The plan ends the open-ended federal matching for Medicaid (Title XIX) and replaces it with a block grant—Title XXI of the Social Security Act, The Medigrant Program for low-income individuals and families. In return for substantial flexibility in establishing policies regarding coverage, benefits, reimbursement of providers, and delivery system reforms, states would face explicit limits in federal payments.

The current Medicaid program is expected to grow by 111.0% between 1994 and 2002 (Table 1). On an annual basis, Medicaid spending would increase by 9.9% per year between 1994 and 2002, and by 10.0% between 1996 and 2002. These projections, known as the baseline, are dependent on a number of assumptions about increases in beneficiaries, inflation, and other factors. The estimates in Table 1 are based on Urban Institute assumptions and closely approximate the current (November) national estimates of the Congressional Budget Office (See Appendix Table A).

The Medigrant plan would result in a significant reduction in federal payments to states compared with the baseline. Under the Medigrant program, federal payments would be allowed to grow by 52.7% between 1994 and 2002. Federal spending would increase by 5.4% each year between 1994 and 2002 and by 4.8% between 1996 and 2002. We estimate that these growth rates would translate into a reduction in federal payments—relative to the baseline—of approximately 163 billion over 1996-2002.

Given reductions of this magnitude, the distribution of federal payments among states is a major issue. There currently exists extreme variation among federal spending per poor person among states, reflecting the wide variation in policies that states have adopted throughout the history of the Medicaid program. New York and Connecticut, for example, currently receive $3,200 and $4,300, respectively, per person in poverty. Low income states, in contrast, such as Florida, Mississippi and New Mexico receive less than $1,400 per poor person from the federal government. The result is that block grants tied to current levels of spending would retain the very different federal payments per low-income person among states. These differences are much more of a problem in a federal block grant program than under the current system where they are largely an outcome of state decisions.

A further issue is that many states (mostly in the south), with historically low levels of spending have been experiencing faster growth rates in recent years and are likely to continue to do so. The faster growth in these states reflect greater increases in population and expansions of coverage. In contrast, states in the northeast and midwest were growing more slowly because of slower population

Table 1
Total Federal Spending, 1994-2002
Urban Institute Baseline v. Conference Agreement Proposal

				1994-2002		1996-2002	
	1994	1996	2002	Total Growth	Average Annual	Total Growth	Average Annual
Total Federal Spending (billions)							
Baseline	$83.3	$100.2	$177.7	113.3%	9.9%	77.3%	10.0%
Conference Agreement[1]	$83.3	$96.2	$127.2	52.7%	5.4%	32.2%	4.8%

[1] *Does not include supplemental pool amounts.*
Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

growth in addition to a broad array of cost containment policies applied to higher levels of spending.

This paper begins by describing the distribution of funds under the Budget Resolution agreement of July 1995. We then discuss the proposed formula for the redistribution of federal funds under the Medigrant plan. We then present our estimates of the reduction in federal spending in the Medigrant plan as well as an analysis of the impact of the Medigrant allocation formula on federal payments per poor person. We then assess the implications of reduced federal payments for coverage of Medicaid beneficiaries. Finally, we estimate the possible impact of the proposal on total (federal and state) Medicaid expenditures.

Budget Resolution (July 1995)

The Budget Resolution agreement in July 1995 established targets for federal spending, but did not indicate how individual block grants to each state would be calculated. The most likely outcome was that equal percentage increases by year would be applied to states based on their current levels of spending. The result of uniform percentage growth rates would be that the policy would not have uniform effects across states.

For example, our analysis showed that many low-expenditure states such as Florida, Georgia, and Texas would have experienced reductions over the 1996 to 2002 period of over 25 percent. In contrast, states in the northeast and midwest, i.e., New York, Connecticut and New Jersey, would have received reductions relative to the baseline of about 15 percent. Finally, states with high levels of disproportionate share hospital (DSH) payments, i.e., New Hampshire and Missouri, would have experienced even smaller reductions in spending because their baseline expenditures were expected to grow at relatively slow rates because of the freeze on growth in DSH payments.

While most observers agree that building on the current spending base to distribute federal funds under a block grant would lock in historical spending differences, it is also widely recognized that equalizing federal payments – per low income person, for example – would result in a politically unacceptable amount of redistribution. Both the House and Senate in different ways attempted to address these problems by changing the distribution of funds. They modified the Budget Resolution agreement and under the Conference Agreement established a formula intended to move to a more equitable distribution over time. In this report, we illustrate the key features of this Conference Agreement and the potential fiscal impacts at the state level.

The Medicaid Transformation Act of 1995 – "Medigrant"

The Conference Agreement, following similar legislation from the House and Senate proposals, is designed with the purpose of converting Medicaid into a block grant program called "Medigrant." Federal payments to states are based on a pre-set level for 1996 (approximating current expenditures and other factors) and subsequently increased by a growth rate based on the 1996 base amount relative to estimated "need." Estimated need is based on a number of factors including the growth in the poverty population, casemix of the currently eligible population, and the costs of health services.

Under current law, states are reimbursed by the federal government for a fixed percentage (i.e., the federal medical assistance percentage or FMAP) of total program expenditures. With Medigrant, federal payments to states for eligible expenditures would also be based on total program spending, but the FMAP formula would be modified.[1] Total federal payments ("allotments") to states, however, would be limited by a state-

1 States would have the choice of three alternative FMAPs: (1) the formula as defined under current law; (2) the lesser of a new formula based on aggregate expenditure need (AEN, defined later in the text) and Total Taxable Resources or the current law formula plus 10% points; or (3) 60%.

specific cap determined by a complex allocation formula. These allotments are distributed and constructed in such a way that *total* federal payments across all states equal a fixed, predetermined amount.

The allotment for each state in 1996 is explicitly stated in the legislation. From 1997 onward, the state allotment is based on the previous years allotment and an estimate of state need called its "aggregate expenditure need." Aggregate expenditure need[2] (AEN) is a function of the number of people in poverty in the state in each year, 1994 national average Medicaid spending per poor, state health care costs, beneficiary casemix, and the legislated growth in total federal Medigrant spending (the national Medigrant expenditure growth percentage (NMGP)). The factors used in the calculations are shown in Table 2.

For 1997 and beyond, a state's allotment is calculated according to the following procedure:

- Total spending is multiplied by a modified FMAP formula to determine the amount eligible for federal reimbursement. Under current law, states are entitled to receive the entire amount of the reimbursement.
- States are then reimbursed for this amount *up to the total as specified in the allotment calculation.* Any expenditures beyond the allotment amount remain strictly the financial responsibility of the state. If a state does not spend up to its allotment amount, it may carry over the remainder for a future year.

AEN is defined in the legislation as follows:

$$AEN = n_{poor,s} * CaseMix * Cost_s * \frac{\$}{n_{poor,n}} * NMGP$$

$n_{poor,s}$= Number of people in poverty (3 year average) in state s, by year.

CaseMix = Index value (average =1.0) where a value greater than one implies that the state has relatively greater proportions of more expensive individuals (min=0.90, max=1.15).

$Cost_s$= Index value (average =1.0) that is based on the HCFA hospital wage index. A value greater than 1 would suggest that a state has higher than average health care costs.

$\$/n_{poor,n}$= National average spending per poor person in 1994.

NMGP = National Medigrant growth percentage. Simply, the percent increase in the total pool of federal funds available for the Medigrant program (7.1% in 1997, then approximately 4.2% per year thereafter).

Once need is defined, each state's allotment is determined by multiplying the AEN by the current law FMAP and a scalar. The scalar is simply a number multiplied across all states AEN so that the total allotment amount across all states equals the amount specified in the legislation. In concept, AEN is designed to direct relatively more funds (all else equal) to states with "greater need." In reality, however, the legislation specifies an array of floors and ceilings on the percentage increase for each state's allotment over the previous year – considerably reducing the effect that relative poverty would have on each state's allotment.

Table 3 summarizes the major details of the proposal. The total amount available to states for 1996 is 96.2 billion dollars, increased by 7.1% in 1997 and approximately 4.2% - 4.5% per year thereafter. The legislation also includes provisions for pre-enactment outlays (cost incurred before implementation, but not yet reimbursed) for 1996 and "supplemental" amounts for 1996 to 2000. Total federal dollars are not to exceed the sum of regular pool and supplemental pool amounts. Table 3 also

We do not investigate the effects of the new FMAPs in detail in this brief since we assume that states would spend to levels such that they would receive their maximum federal allotment, which is independent of the FMAP.

2 The easiest way to think of AEN is the total dollar amount (federal and state) that a state would need to spend on its poverty population if it spent the national average (adjusting for population casemix and cost of providing health care services) on each poor person in the state.

Table 2
State Factors Used in Estimation of Aggregate Expenditure Need and State Allotments

	1994 Medicaid Expenditures per Poor Person		Population Growth 1990-1993	Percent Poverty 1993	Input Cost Index	Case Mix
	(dollars)	rank (low to high)				
Total	3,182	—		17.7%	1.00	1.00
Alabama	1,916	5	1.2%	22.7%	0.83	1.15
Alaska	3,640	37	2.9%	16.0%	1.25	0.90
Arizona	2,867	23	2.4%	16.9%	0.98	0.90
Arkansas	2,112	9	1.0%	21.6%	0.80	1.15
California	2,713	21	1.6%	18.8%	1.21	0.95
Colorado	2,586	19	2.7%	13.2%	0.97	1.00
Connecticut	8,564	51	-0.1%	9.0%	1.18	0.96
Delaware	3,621	36	1.7%	11.4%	1.03	0.90
District of Columbia	5,616	46	-1.6%	27.0%	1.18	0.95
Florida	2,060	7	1.9%	19.4%	0.96	0.96
Georgia	2,376	12	2.2%	21.8%	0.92	1.02
Hawaii	2,789	22	1.9%	14.7%	1.11	0.98
Idaho	1,877	3	3.0%	16.5%	0.87	0.93
Illinois	2,541	17	0.8%	18.3%	0.98	0.96
Indiana	3,311	35	1.0%	15.5%	0.93	0.93
Iowa	3,039	28	0.4%	13.1%	0.86	1.04
Kansas	3,041	29	0.7%	13.1%	0.90	0.97
Kentucky	2,369	11	0.9%	22.1%	0.86	1.10
Louisiana	3,815	39	0.6%	26.4%	0.97	1.06
Maine	4,879	45	0.3%	15.6%	0.92	1.09
Maryland	3,255	33	1.3%	14.9%	1.00	1.01
Massachusetts	5,933	47	0.0%	13.8%	1.14	1.09
Michigan	2,969	26	0.7%	18.7%	1.04	0.93
Minnesota	4,180	43	1.1%	14.1%	1.00	0.97
Mississippi	1,758	1	0.9%	28.7%	0.75	1.13
Missouri	2,884	24	0.8%	17.5%	0.90	1.03
Montana	2,472	13	1.7%	17.6%	0.86	1.06
Nebraska	3,210	32	0.6%	12.2%	0.91	0.97
Nevada	2,092	8	5.0%	15.8%	1.09	0.97
New Hampshire	7,633	50	0.5%	11.0%	1.02	0.97
New Jersey	4,467	44	0.6%	13.8%	1.10	1.01
New Mexico	1,849	2	2.2%	23.9%	0.92	1.05
New York	6,372	49	0.4%	19.1%	1.20	1.03
North Carolina	2,662	20	1.6%	18.5%	0.90	1.00
North Dakota	3,060	30	-0.2%	15.3%	0.86	1.10
Ohio	3,306	34	0.8%	15.3%	0.95	0.97
Oklahoma	1,879	4	0.9%	18.7%	0.83	1.00
Oregon	2,903	25	2.6%	13.7%	1.04	0.91
Pennsylvania	3,853	40	0.5%	14.9%	1.01	1.07
Rhode Island	6,002	48	-0.1%	14.2%	1.08	1.15
South Carolina	2,506	16	1.5%	22.0%	0.88	1.13
South Dakota	2,503	15	0.9%	16.8%	0.81	1.07
Tennessee	2,570	18	1.5%	21.4%	0.88	1.10
Texas	2,262	10	2.0%	21.5%	0.92	0.91
Utah	2,482	14	2.6%	12.5%	0.96	0.90
Vermont	4,109	41	0.8%	12.5%	0.94	1.03
Virginia	2,007	6	1.6%	15.4%	0.91	1.06
Washington	4,160	42	2.6%	12.7%	1.04	0.91
West Virginia	3,084	31	0.5%	23.2%	0.86	1.00
Wisconsin	3,705	38	1.0%	12.6%	0.92	1.15
Wyoming	3,028	27	1.2%	11.7%	0.83	0.90

Medicaid expenditures are based on Urban Institute analysis of HCFA 2082 and 64 data. Population and poverty counts are from the 1991-1993 March Current Population Surveys.
Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

Table 3
Characteristics of the Conference Agreement
As of November 1995

Base Year	Federal payments to states (allotments) are explicitly specified in the legislation.
Pool Amounts	**(billions) %growth**
1996	96.2
1997	103.1 7.1%
1998	107.8 4.5%
1999	112.5 4.4%
2000	117.2 4.2%
2001	122.1 4.2%
2002	127.2 4.2%
Supplemental Pool Amounts	**(millions) %growth**
1996	627.3
1997	673.4 7.3%
1998	702.3 4.3%
1999	733.1 4.4%
2000	763.8 4.2%
	These funds are distributed to states (in addition to the amounts specified above) based on the number of undocumented aliens residing in each state
Growth Floors	
1997	3.5%
1998	3.0%-4.0%
1999	2.0%-4.0%
2000	2.0%-4.0%
2001	2.0%-4.0%
2002	2.0%-4.0%
	States with above average growth in allotments for 1996-1997 are subject to a floor of 4% until the year 2002. All other states are subject to the lower floor.
Growth Ceilings	
1997	9.0%
1998	5.3%-7.0%
1999	5.3%-7.0%
2000	5.3%-7.0%
2001	5.3%-7.0%
2002	5.3%-7.0%
	The 10 states with the lowest allotment per poor person by year would be subject to the higher growth ceiling. All other states growth would be capped at 5.33%.
Small State Adjustment	No state would receive less than .24% of the total allotment for the year, subject to the ceiling growth rates specified above.
Specific State Adjustments	Louisiana: $37 million in 1997 Nebraska: $106 million in 1997 Nevada: $90 million per year in 1996-1998
Specific State Allotments	LA: $2.622 billion per year for 1996-2000 NH: $360 million per year for 1996-2000

shows the ranges in allowed growth rates for each state's allotments by year. For 1996-1997 the rates range from a low of 3.5% to a high of 9.0%; in subsequent years, the range changes from 2% to 7%. States with growth rates above the average in 1996-1997 are subject to a floor growth rate of 4% instead of 2% for 1998 onward. The 10 lowest states in terms of federal allotment per poor person are allowed to grow at 7% instead of 5.3%.

In the House and Senate versions of the legislation, the 1996 base year allotment was a function of 1993, 1994 and 1995 Medicaid expenditures by state. In the Conference Agreement, however, the 1996 state allotments are specified explicitly in the legislation . Table 4 compares the 1996 allotment to actual 1994 federal expenditures. On average, federal payments are increased by 7.5% per year for 1994-1996.

While methodology for the calculation of the amounts is not stated in the legislation, it appears that many of the states with 1115 waivers—Tennessee and Oregon for example—have received relatively large 1996 allotment increases. New Hampshire and Louisiana receive considerable reductions in their 1996 bases as a result of a specific clause in the legislation restricting their allotment amounts until the year 2000 (because of their extremely high disproportionate share payments).

Since future allotments (from 1997 onwards) are based on the 1996 amounts, the 1996 allotments have a large impact on how each state fares under the proposal. These base amounts form the foundation of the redistribution of federal dollars among states; further redistribution is achieved through the calculation of how the allotments are allowed to grow by state and year.

A comparison of the 1996 allotment and the 1997 AEN and actual allotment is shown in Table 5. The AEN shows what a state would spend (federal dollars only) if it spent the same per poor person as the national average, after controlling for health care costs and the casemix of the Medicaid population. The re-

Table 4
1996 Allotments under Conference Agreement Proposal
Comparison with 1994 and 1996 Baseline Amounts
Urban Institute Baseline

	1994 Baseline (billions)	Conference Agreement[1] 1996 Allotment (billions)	Conference Agreement[1] Ave. Annual Increase in 1996 Allotment over 1994 Baseline
Total	83.31	96.25	7.5%
Alabama	1.30	1.52	8.0%
Alaska	0.16	0.20	13.6%
Arizona	1.18	1.37	7.8%
Arkansas	0.83	1.01	10.1%
California	8.12	8.95	5.0%
Colorado	0.64	0.76	8.9%
Connecticut	1.27	1.46	7.4%
Delaware	0.15	0.21	17.7%
District of Columbia	0.42	0.50	9.9%
Florida	3.05	3.72	10.3%
Georgia	2.14	2.43	6.5%
Hawaii	0.24	0.32	15.7%
Idaho	0.24	0.28	8.1%
Illinois	2.84	3.47	10.5%
Indiana	1.84	1.95	3.1%
Iowa	0.73	0.84	7.3%
Kansas	0.62	0.71	7.6%
Kentucky	1.37	1.58	7.2%
Louisiana	3.12	2.62	-8.4%
Maine	0.60	0.69	7.4%
Maryland	1.20	1.37	6.8%
Massachusetts	2.44	2.87	8.4%
Michigan	2.95	3.47	8.4%
Minnesota	1.44	1.79	11.5%
Mississippi	1.08	1.26	8.0%
Missouri	1.60	1.85	7.4%
Montana	0.26	0.31	9.9%
Nebraska	0.40	0.46	7.4%
Nevada	0.22	0.26	7.6%
New Hampshire	0.49	0.36	-14.0%
New Jersey	2.46	2.85	7.8%
New Mexico	0.52	0.63	10.6%
New York	11.10	12.90	7.8%
North Carolina	2.16	2.59	9.6%
North Dakota	0.21	0.24	7.6%
Ohio	3.45	4.03	8.1%
Oklahoma	0.79	0.91	7.4%
Oregon	0.76	1.09	20.0%
Pennsylvania	3.91	4.45	6.8%
Rhode Island	0.45	0.55	10.3%
South Carolina	1.41	1.62	7.2%
South Dakota	0.21	0.26	12.1%
Tennessee	1.87	2.52	16.2%
Texas	5.48	6.35	7.6%
Utah	0.41	0.48	8.5%
Vermont	0.18	0.25	16.0%
Virginia	1.00	1.14	7.2%
Washington	1.45	1.76	10.2%
West Virginia	1.01	1.16	6.8%
Wisconsin	1.43	1.71	9.3%
Wyoming	0.11	0.13	9.0%

[1] *Does not include supplemental pool amounts.*
Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

sults here are not surprising since these figures merely highlight the large differences between states in their spending on poverty populations. The potential redistribution of federal dollars that is found in the AEN is severely reduced when one places the legislation's floors and ceilings on growth. For example, Alabama, whose *unrestricted* AEN for 1997 would be 73.5% above their 1996 baseline allotment amount (Table 4, would only see a 9% increase in 1997 ($1,518 million to $1,654 million) as a result of the growth cap. Likewise, a state like Connecticut would see a 3.5% increase, even though their 1996 allotment is twice their 1997 needs amount.

Finally, the scalar has some complex influences on the allotment calculations. As shown in Table 5, the unrestricted AEN is $107.7 billion, but when the floors and ceilings are applied, this amount totals $102.3 billion (not shown). The legislation specifies a total allotment of $103.1 billion; to reach $103.1 billion, a scalar is applied until the legislated amount is achieved. The scalar, however, effects only a few states. Since most states' AEN amounts are either well above or below the capped growth amounts, the scalar would have no effect. Only those states with growth that is either near or between the floor and ceilings would be affected. A state that is near the floor could receive almost a 6 percentage point increase as a result of the scalar—while states below the floor would likely receive no adjustment.[3]

Results

The results presented here reflect a revision to the Urban Institute's Medicaid expenditure baseline. The revision (described later in the methods section) is based on more recent 1994 data, more conservative DSH estimates, and other changes. In most cases, the primary source of state-level differences between the

3 For example, Alabama, which is already receiving the maximum growth rate is unaffected by the scalar (assuming that it is greater than 1.0) since it would not be able to grow above this amount. Likewise, Connecticut, could only be affected if the scalar was sufficiently large (which is extremely unlikely) that its growth increased above 3.5%. As a result, the only states that are affected by the scalar are those whose unrestricted growth falls near or between the floors and ceilings. Wisconsin, for example, would have a 1996-1997 growth of 3.5% without the scalar; with the scalar applied, however, the effective growth rate cap quickly reaches 7.8%.

Table 5
Comparison of 1996 State Allotments with 1997 Needs Based Amount and Allotments
Conference Agreement

	1996 Allotment (millions)	1997 Aggregate Expenditure Need (federal share)[1] WITHOUT Floors, Ceilings or Scalars (millions)	1996-1997 % Change	ACTUAL 1997 Allotment (millions)	Allowed Growth Rate 1997	1998[2]
Total	96,246	107,715	11.9%	103,084		
Alabama	1,518	2,633	73.5%	1,654	9.0%	5.3%
Alaska	205	203	-1.0%	223	9.0% *	4.0%
Arizona	1,371	1,532	11.7%	1,494	9.0%	4.2% *
Arkansas	1,011	1,471	45.5%	1,102	9.0%	7.0%
California	8,947	14,033	56.9%	9,752	9.0%	5.3%
Colorado	757	1,005	32.7%	826	9.0%	5.3%
Connecticut	1,463	661	-54.8%	1,514	3.5%	3.0%
Delaware	212	159	-25.2%	220	3.5%	3.0%
District of Columbia	501	313	-37.5%	519	3.5%	3.0%
Florida	3,716	5,615	51.1%	4,050	9.0%	5.3%
Georgia	2,426	3,531	45.5%	2,645	9.0%	7.0%
Hawaii	323	385	19.2%	352	9.0%	7.0%
Idaho	278	440	58.2%	303	9.0%	5.3%
Illinois	3,467	4,198	21.1%	3,779	9.0%	5.3%
Indiana	1,952	1,940	-0.6%	2,128	9.0% *	4.0%
Iowa	835	852	2.0%	910	9.0% *	4.0%
Kansas	714	704	-1.4%	778	9.0% *	4.0%
Kentucky	1,578	2,232	41.5%	1,720	9.0%	7.0%
Louisiana	2,622	3,386	29.1%	2,622	9.0%	7.0%
Maine	694	496	-28.5%	719	3.5%	3.0%
Maryland	1,370	1,503	9.8%	1,493	9.0%	4.0% *
Massachusetts	2,870	2,005	-30.2%	2,971	3.5%	3.0%
Michigan	3,465	3,845	11.0%	3,777	9.0%	4.0% *
Minnesota	1,794	1,353	-24.6%	1,857	3.5%	3.0%
Mississippi	1,262	2,106	66.9%	1,375	9.0%	5.3%
Missouri	1,849	2,073	12.1%	2,016	9.0%	4.0% *
Montana	312	398	27.5%	340	9.0%	7.0%
Nebraska	464	442	-4.7%	496	6.9% *	3.0%
Nevada	258	497	92.8%	281	9.0%	5.3%
New Hampshire	360	250	-30.5%	360	3.5%	3.0%
New Jersey	2,855	2,448	-14.2%	2,955	3.5%	3.0%
New Mexico	635	1,134	78.7%	692	9.0%	5.3%
New York	12,902	8,577	-33.5%	13,353	3.5%	3.0%
North Carolina	2,588	3,003	16.0%	2,821	9.0%	7.0%
North Dakota	241	257	6.6%	263	9.0% *	4.0%
Ohio	4,034	3,885	-3.7%	4,356	8.0% *	4.0%
Oklahoma	911	1,431	57.0%	993	9.0%	5.3%
Oregon	1,089	1,042	-4.3%	1,169	7.4% *	4.0%
Pennsylvania	4,454	4,352	-2.3%	4,855	9.0% *	4.0%
Rhode Island	546	361	-33.9%	565	3.5%	3.0%
South Carolina	1,621	2,296	41.6%	1,767	9.0%	7.0%
South Dakota	263	296	12.5%	286	9.0%	4.0% *
Tennessee	2,520	2,891	14.7%	2,747	9.0%	6.2% *
Texas	6,352	8,488	33.6%	6,924	9.0%	7.0%
Utah	484	607	25.3%	528	9.0%	7.0%
Vermont	248	176	-29.2%	257	3.5%	3.0%
Virginia	1,145	1,942	69.6%	1,248	9.0%	5.3%
Washington	1,763	1,420	-19.5%	1,825	3.5%	3.0%
West Virginia	1,157	1,091	-5.7%	1,223	5.7% *	3.0%
Wisconsin	1,710	1,643	-3.9%	1,842	7.8% *	4.0%
Wyoming	133	112	-15.4%	138	3.5%	3.0%

[1] *This is the amount that each state would receive if the allotments were based strictly on the poverty population, average spending per poor person, health care costs, casemix, and the current FMAP. The floor and ceiling growth rates, in addition to the scalar, are used to bring the total 1997 allotment down to the legislated level of $103.0 billion dollars.*

[2] *The floor growth for 1998 is 3.0%. This drops to 2.0% for 1999 and thereafter.*

**States that are affected by application of the scalar.*

Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

July and December baselines result from using 1994 as the base year instead of 1993. The more moderate assumptions for DSH growth had a small impact on most states since DSH was already frozen in states with large relative expenditures.

We note that our Urban Institute projections are close to those of the Congressional Budget Office at the national level (see appendix Table A). Our methodology uses a national projection linked to CBO's, but also incorporates each state's beneficiary composition and relative mix of acute and long term care services as well as its enrollment and expenditure growth in the recent past. We believe that the CBO national projections may overstate Medicaid growth, possibly by as much as one percent per year. Most of this is due to high CBO estimates of enrollment growth.[4]

Our baseline expenditure growth rates could also therefore be overstated, more in states with faster enrollment growth than in others. If CBO releases a new baseline projection, we would prepare new estimates that would be consistent with their revised national projections, but would retain our estimates of state variation.

The implication of a lower baseline is that the growth rates allowed by the Congress would not represent as much of a cut as in the results presented below. Another implication is that Medicaid spending is less a contributor to the deficit than has been assumed and that there is therefore less of a need for Medicaid savings for deficit reduction purposes.

Table 6 shows that the national average rate of growth under the Conference Agreement would be 5.4% between 1994 and 2002 and 4.8% between 1996 and 2002. For reasons described earlier, the allowed annual rates of growth are higher than the national average in some states and lower in others. For example, between 1996 and 2002, the average annual rate of growth is 7.3% in Arkansas, Georgia and Kentucky and South Carolina. On the other hand, the allowed rate of growth is 2.4% in Connecticut, Delaware, the District of Columbia, Maine, New Jersey, New York, Rhode Island, Vermont, Washington and Wyoming.

The table compares the allowed rates of growth under the Conference Agreement to actual experience between 1988 and 1994 and to the Urban Institute's estimates of growth between 1994 and 2002. As shown, the allowed rates of growth under the Conference Agreement are substantially below the actual rates of growth between 1988 and 1994. This is true even when we exclude DSH spending growth from the comparison.

The allowed rates of growth in the Conference Agreement are also well below Urban Institute projections for 1994-2002. Thus, states would have to do considerably better not only than past experience but also better than our projected expenditure growth to live within the Conference Agreement expenditure targets.

Table 7 shows the results of the Medigrant proposal as compared to baseline expenditures and the proposal which emerged from the Budget Resolution agreement last July.[5] We show the Budget Resolution results for comparison purposes to indicate the effect of increasing federal expenditures by a uniform growth rate for all states. Total expenditure reductions are less than the Budget Resolution since the yearly federal allotments are slightly higher.

Under the original Budget Resolution, high expenditure states such as New York (14.1%), Connecticut (14.4%) and New Jersey (14.1%) would have had below average reductions relative to the baseline. This reflects the fact

4 Recent data on 1994 Medicaid expenditures growth confirm our belief of a slowdown in Medicaid spending. See *Medicaid Update: Program Review, 1988-1994* from the Kaiser Commission on the Future of Medicaid.

5 The Budget Resolution results presented here reflect an update to the Urban Institute Medicaid expenditure baseline reported earlier in 1995. This baseline, as before, remains linked to CBO national projections. Individual state estimates, however, will differ somewhat from previously reported figures. See the methods section at the end of this document for important details.

Table 6
Average Annual Growth Rates 1988-1994, 1994-2002
Urban Institute Baseline and Conference Agreement

	Medicaid Expenditures			Federal Payments Under Conference Agreement[1]	
	1988-1994		1994-2002		
	Actual	Non-DSH	UI Baseline	1994-2002	1996-2002
Total	17.2%	14.8%	9.9%	5.4%	4.8%
Alabama	24.7%	19.2%	9.1%	6.5%	5.9%
Alaska	18.2%	17.0%	11.0%	7.3%	5.3%
Arizona	n/a	n/a	11.0%	6.1%	5.5%
Arkansas	16.3%	16.2%	10.1%	8.0%	7.3%
California	13.5%	10.7%	9.8%	5.7%	5.9%
Colorado	15.9%	14.0%	9.3%	6.7%	5.9%
Connecticut	19.3%	15.7%	9.0%	3.6%	2.4%
Delaware	18.3%	17.8%	10.9%	6.0%	2.4%
District of Columbia	12.6%	11.3%	11.3%	4.2%	2.4%
Florida	22.7%	22.1%	12.0%	7.0%	5.9%
Georgia	19.0%	16.7%	11.9%	7.1%	7.3%
Hawaii	19.0%	17.7%	11.2%	8.6%	6.3%
Idaho	17.3%	17.3%	9.7%	6.5%	5.9%
Illinois	18.3%	17.2%	11.2%	6.7%	5.5%
Indiana	17.8%	15.6%	9.6%	4.4%	4.8%
Iowa	14.4%	14.3%	9.8%	5.4%	4.8%
Kansas	19.4%	15.9%	9.8%	5.5%	4.8%
Kentucky	17.1%	16.4%	10.1%	7.3%	7.3%
Louisiana	27.6%	20.2%	9.1%	-0.5%	2.3%
Maine	18.9%	15.3%	10.1%	3.6%	2.4%
Maryland	16.1%	14.7%	9.8%	5.3%	4.9%
Massachusetts	15.5%	13.1%	8.7%	3.9%	2.4%
Michigan	15.9%	13.7%	10.1%	5.8%	4.9%
Minnesota	12.6%	12.3%	11.4%	4.6%	2.4%
Mississippi	20.0%	17.6%	10.8%	6.4%	5.9%
Missouri	23.0%	17.0%	7.5%	5.7%	5.1%
Montana	14.3%	14.3%	11.6%	7.2%	6.3%
Nebraska	16.6%	16.3%	10.6%	4.1%	3.0%
Nevada	27.4%	23.4%	9.0%	6.3%	5.9%
New Hampshire	-30.4%	17.7%	5.6%	-3.2%	0.7%
New Jersey	18.4%	13.9%	8.9%	3.7%	2.4%
New Mexico	19.2%	19.0%	11.5%	7.1%	5.9%
New York	14.1%	12.1%	8.9%	3.7%	2.4%
North Carolina	21.4%	18.9%	11.2%	6.8%	5.9%
North Dakota	7.2%	7.1%	8.9%	5.5%	4.8%
Ohio	14.7%	13.1%	9.1%	5.5%	4.7%
Oklahoma	9.4%	9.1%	8.4%	6.3%	5.9%
Oregon	19.6%	19.3%	12.2%	8.2%	4.6%
Pennsylvania	17.2%	14.7%	8.8%	5.3%	4.8%
Rhode Island	15.2%	12.8%	9.4%	4.3%	2.4%
South Carolina	25.8%	20.2%	9.4%	7.3%	7.3%
South Dakota	14.7%	14.7%	10.1%	6.9%	5.2%
Tennessee	17.3%	17.0%	9.5%	8.2%	5.7%
Texas	25.7%	21.5%	11.5%	7.1%	7.0%
Utah	16.9%	16.7%	10.1%	6.9%	6.3%
Vermont	17.4%	16.1%	10.1%	5.6%	2.4%
Virginia	15.5%	14.1%	10.4%	6.3%	5.9%
Washington	18.7%	16.4%	10.5%	4.3%	2.4%
West Virginia	25.9%	24.1%	11.7%	3.8%	2.8%
Wisconsin	11.6%	11.5%	9.1%	5.8%	4.6%
Wyoming	22.5%	22.5%	10.3%	4.0%	2.4%

[1] *Does not include supplemental pool amounts.*

Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

Table 7
Projected Changes in Federal Medicaid Expenditures, 1996-2002
Conference Agreement Proposal

	Baseline[1] (billions)		1996-2002 Uniform Growth Cap[2]		1996-2002 Actual		2002 Actual	
	1996-2002	2002	(billions)	Percent	(billions)[3]	Percent	(billions)[3]	Percent
Total	953.0	177.7	(180.7)	-19.0%	(166.5)	-17.5%	(50.4)	-28.4%
Alabama	14.2	2.6	(2.2)	-15.3%	(1.4)	-9.5%	(0.5)	-17.7%
Alaska	1.9	0.4	(0.5)	-24.3%	(0.2)	-11.4%	(0.1)	-23.7%
Arizona	14.4	2.7	(3.4)	-23.8%	(2.8)	-19.5%	(0.8)	-30.3%
Arkansas	9.7	1.8	(1.9)	-20.1%	(0.8)	-8.0%	(0.3)	-14.3%
California	91.9	17.2	(16.6)	-18.1%	(16.0)	-17.4%	(4.5)	-26.4%
Colorado	7.1	1.3	(1.2)	-16.8%	(0.7)	-9.8%	(0.2)	-17.6%
Connecticut	13.7	2.5	(2.0)	-14.4%	(2.6)	-19.2%	(0.8)	-33.1%
Delaware	1.9	0.4	(0.4)	-23.6%	(0.2)	-13.4%	(0.1)	-30.1%
District of Columbia	5.1	1.0	(1.3)	-25.2%	(1.3)	-26.1%	(0.4)	-40.7%
Florida	39.4	7.6	(11.1)	-28.1%	(7.9)	-20.0%	(2.3)	-30.7%
Georgia	27.5	5.3	(7.6)	-27.8%	(6.1)	-22.2%	(1.5)	-29.4%
Hawaii	3.0	0.6	(0.7)	-24.9%	(0.2)	-6.0%	(0.1)	-17.5%
Idaho	2.7	0.5	(0.5)	-18.4%	(0.3)	-12.8%	(0.1)	-21.3%
Illinois	35.0	6.6	(8.7)	-25.0%	(5.8)	-16.7%	(1.9)	-28.1%
Indiana	20.8	3.8	(3.8)	-18.1%	(4.7)	-22.8%	(1.3)	-32.6%
Iowa	8.3	1.5	(1.5)	-18.4%	(1.4)	-16.7%	(0.4)	-27.7%
Kansas	7.0	1.3	(1.3)	-18.3%	(1.1)	-16.0%	(0.4)	-27.5%
Kentucky	15.9	3.0	(3.2)	-19.9%	(2.0)	-12.7%	(0.6)	-19.0%
Louisiana	33.8	6.3	(4.8)	-14.2%	(14.8)	-43.8%	(3.3)	-52.2%
Maine	6.9	1.3	(1.3)	-19.2%	(1.6)	-23.8%	(0.5)	-38.3%
Maryland	13.7	2.5	(2.6)	-18.7%	(2.4)	-17.6%	(0.7)	-28.4%
Massachusetts	26.2	4.8	(3.5)	-13.4%	(4.4)	-16.8%	(1.5)	-30.6%
Michigan	34.1	6.4	(6.8)	-19.9%	(5.5)	-16.2%	(1.8)	-27.6%
Minnesota	17.9	3.4	(4.6)	-25.4%	(4.3)	-24.1%	(1.3)	-39.5%
Mississippi	13.0	2.5	(2.9)	-22.7%	(2.3)	-17.6%	(0.7)	-27.5%
Missouri	15.8	2.9	(1.0)	-6.1%	(0.5)	-3.0%	(0.4)	-12.6%
Montana	3.3	0.6	(0.9)	-26.6%	(0.6)	-17.1%	(0.2)	-27.5%
Nebraska	4.8	0.9	(1.1)	-22.3%	(1.1)	-22.4%	(0.3)	-38.7%
Nevada	2.4	0.4	(0.3)	-14.4%	0.0	1.7%	(0.1)	-18.1%
New Hampshire	4.3	0.8	0.2	4.1%	(1.8)	-41.4%	(0.4)	-50.2%
New Jersey	26.5	4.9	(3.7)	-14.1%	(4.9)	-18.3%	(1.6)	-32.1%
New Mexico	6.5	1.2	(1.7)	-26.2%	(1.1)	-17.4%	(0.3)	-27.9%
New York	119.9	21.9	(16.9)	-14.1%	(22.0)	-18.4%	(7.0)	-32.0%
North Carolina	26.6	5.0	(6.6)	-24.9%	(4.4)	-16.7%	(1.4)	-27.7%
North Dakota	2.3	0.4	(0.3)	-14.3%	(0.3)	-12.0%	(0.1)	-22.2%
Ohio	38.0	6.9	(6.0)	-15.7%	(5.0)	-13.3%	(1.6)	-23.7%
Oklahoma	8.3	1.5	(1.0)	-11.9%	(0.6)	-7.2%	(0.2)	-14.6%
Oregon	9.9	1.9	(2.9)	-29.1%	(1.0)	-10.5%	(0.5)	-25.2%
Pennsylvania	41.8	7.6	(5.6)	-13.4%	(5.2)	-12.3%	(1.7)	-22.8%
Rhode Island	5.0	0.9	(0.8)	-16.5%	(0.8)	-16.8%	(0.3)	-31.4%
South Carolina	15.7	2.9	(2.6)	-16.8%	(1.4)	-9.2%	(0.4)	-14.5%
South Dakota	2.4	0.5	(0.5)	-19.9%	(0.2)	-9.5%	(0.1)	-21.1%
Tennessee	20.9	3.8	(3.7)	-17.5%	0.5	2.3%	(0.3)	-8.8%
Texas	68.0	13.1	(17.1)	-25.2%	(12.4)	-18.2%	(3.5)	-27.1%
Utah	4.8	0.9	(0.9)	-19.9%	(0.6)	-11.8%	(0.2)	-21.2%
Vermont	2.1	0.4	(0.4)	-20.0%	(0.3)	-12.0%	(0.1)	-28.0%
Virginia	11.8	2.2	(2.5)	-21.5%	(2.1)	-17.5%	(0.6)	-26.4%
Washington	17.2	3.2	(3.7)	-21.7%	(3.8)	-22.1%	(1.2)	-36.9%
West Virginia	12.9	2.5	(3.5)	-27.0%	(3.9)	-30.5%	(1.1)	-44.5%
Wisconsin	15.6	2.9	(2.4)	-15.2%	(1.7)	-11.0%	(0.6)	-22.1%
Wyoming	1.3	0.2	(0.3)	-21.1%	(0.3)	-23.3%	(0.1)	-37.4%

[1] *These estimates are based on our revised (December) baseline reflecting new Medicaid expenditure data. The baseline estimates will differ somewhat from that in earlier reports.*

[2] *These figures are based on the Budget Resolution formula, July 1995*

[3] *These figures do not include the supplemental pool amounts.*

Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

that these states' expenditures would grow more slowly than the national average largely because of lower population growth. In contrast, low expenditure states such as Florida (28.1%), Georgia (27.8%), and Texas (25.2%) would have had higher percent reductions. The latter states are projected to grow more rapidly because of population growth and expansion of coverage in response to both mandates and increases in their poverty populations.

States with high levels of disproportionate share payments such as Alabama (15.3%), Louisiana (14.2%), and Missouri (6.1%) would have had relatively small reductions because their DSH payments are frozen under current law, thus their baseline growth is lower than most other states and the effect of a uniform growth cap would be somewhat less. New Hampshire actually gained under the Budget Resolution because the state has a very low growth in its baseline primarily because of the very high level of DSH payments. Applying the uniform growth rates to New Hampshire's baseline results in a small increase in federal payments.

The Medigrant plan attempts to move in the direction of a more equal distribution of federal payments by allowing for different allotment growth rates for different states. It would reduce federal payments to currently low need / high-expenditure states (including most high DSH states) and increase payments to high need / low expenditure states. States with lower 1996 expenditures relative to their 1997 AEN would have higher growth rates under the Medigrant plan than under the Budget Resolution. As a result, their percentage reductions are lower as seen in Alabama, Florida, Georgia, North Carolina, and Texas. However, because of the ceilings, the changes relative to the Budget Resolution are not great.

On the other hand, low-income states whose 1996 expenditures are high relative to their AEN, such as West Virginia and Maine, would receive the floor growth rate of 2 percent after 1999. Unlike most other low income states, their spending is sufficiently high that they received the minimum growth rate. As a result, the reductions in spending are greater for West Virginia and Maine under the Medigrant plan than under the Budget Resolution.

High expenditure states such as Connecticut, Massachusetts, New Jersey, and New York all receive the minimum growth rate and have greater reductions under the Medigrant plan than under the Budget Resolution. Again, because of the floors, the differences are not great.

Finally, states such as Alabama and Missouri that have high DSH payments and thus have small reductions under the Budget Resolution have even smaller losses under the Medigrant plan because, despite their DSH spending, their overall 1996 expenditures are below their 1997 AEN. On the other hand, New Hampshire and Louisiana which have the highest level of DSH payments in the U.S. (as a percent of the Medicaid expenditures) are much worse off because the Medigrant proposal reduces their 1996 allotments below 1994 expenditures and freezes federal payments from 1996 to 2000.

The last two columns of Table 7 show that federal payments would be $50.4 billion or 28.4% below the 2002 baseline. Eighteen states would have a reduction in federal payments of at least 30%.

We then examined the impact of the Medigrant plan on federal expenditures per poor person in each state. Table 8 shows that the Medigrant plan does move towards a more equal distribution of federal expenditures, but that the distribution still remains highly unequal even in the year 2002. The first two columns show expenditures per poor person in the year 2002 under the Budget Resolution. Under the Budget Resolution, the same growth rates were applied to each states' 1994 spending: thus the 1994 distribution of spending per poor person was preserved.

With Medigrants, growth in federal payments varies inversely with the level of spending relative to estimated need, with floors and ceilings limiting the amount of redistribution

Table 8
Federal Expenditures per Poor Person, 2002
Uniform Growth Cap v. Conference Agreement Proposal

	Uniform Growth Cap[1]		Conference Agreement	
	(dollars)	Index	(dollars)	Index
Total	2,507	1.00	2,570	1.00
Alabama	1,886	0.75	2,088	0.81
Alaska	2,315	0.92	2,737	1.07
Arizona	2,411	0.96	2,600	1.01
Arkansas	2,183	0.87	2,717	1.06
California	1,848	0.74	1,931	0.75
Colorado	1,789	0.71	2,011	0.78
Connecticut	6,426	2.56	5,745	2.24
Delaware	2,471	0.99	2,652	1.03
District of Columbia	4,621	1.84	4,321	1.68
Florida	1,503	0.60	1,736	0.68
Georgia	1,927	0.77	2,243	0.87
Hawaii	1,865	0.74	2,418	0.94
Idaho	1,641	0.65	1,818	0.71
Illinois	1,814	0.72	2,049	0.80
Indiana	2,937	1.17	2,776	1.08
Iowa	2,776	1.11	2,842	1.11
Kansas	2,584	1.03	2,664	1.04
Kentucky	2,352	0.94	2,767	1.08
Louisiana	4,007	1.60	2,585	1.01
Maine	4,401	1.76	3,931	1.53
Maryland	2,260	0.90	2,299	0.89
Massachusetts	4,437	1.77	4,036	1.57
Michigan	2,390	0.95	2,511	0.98
Minnesota	3,186	1.27	3,069	1.19
Mississippi	1,942	0.77	2,148	0.84
Missouri	2,479	0.99	2,585	1.01
Montana	2,342	0.93	2,741	1.07
Nebraska	2,847	1.14	2,627	1.02
Nevada	1,174	0.47	1,288	0.50
New Hampshire	5,542	2.21	2,861	1.11
New Jersey	3,207	1.28	2,886	1.12
New Mexico	1,777	0.71	2,063	0.80
New York	4,652	1.86	4,186	1.63
North Carolina	2,333	0.93	2,649	1.03
North Dakota	3,241	1.29	3,336	1.30
Ohio	2,849	1.14	2,937	1.14
Oklahoma	1,835	0.73	2,006	0.78
Oregon	2,281	0.91	2,881	1.12
Pennsylvania	3,045	1.21	3,090	1.20
Rhode Island	4,885	1.95	4,606	1.79
South Carolina	2,409	0.96	2,843	1.11
South Dakota	2,436	0.97	2,783	1.08
Tennessee	2,340	0.93	2,957	1.15
Texas	1,904	0.76	2,219	0.86
Utah	2,321	0.93	2,647	1.03
Vermont	3,471	1.38	3,614	1.41
Virginia	1,364	0.54	1,487	0.58
Washington	2,811	1.12	2,645	1.03
West Virginia	3,465	1.38	3,129	1.22
Wisconsin	3,135	1.25	3,297	1.28
Wyoming	2,738	1.09	2,519	0.98

[1] *These figures are based on the Budget Resolution formula, July 1995. Since uniform growth rates were applied to base year spending, these ratios are the same as those under current law in 1994.*

Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

that can take place. A comparison of Columns 2 and 4 shows that the Medigrant plan moves in the direction of a more even distribution of federal dollars. A low expenditure state, such as Florida would receive $1,736 federal dollars per poor person under the Medigrant plan versus $1,503 under the Budget Resolution. Florida increases from 60% of the national average to 68% under the Medigrant plan. In contrast, Connecticut's payments fall from $6,426 to $5,745, or from 2.56 to 2.24 times the national average.

Impact on Coverage

In this section we examine the likely impact on coverage of Medicaid beneficiaries. We do not make estimates of changes in coverage, rather we examine the control on growth in spending per beneficiary that would be required to achieve certain enrollment levels. We assume that states would increase their own expenditures by the allowed growth rates in the Conference Agreement. We make three alternative assumptions regarding enrollment:

- States add all the beneficiaries that are projected to be enrolled by 2002.
- States increase beneficiaries at the same rate as the increase in poverty.
- State freeze enrollment growth at 1995 levels.

Under the first assumption, states would add all the beneficiaries that are projected to be added to Medicaid rolls by the year 2002. Medicaid enrollment is projected to grow from 35.4 million enrollees in 1995 to 45.3 million enrollees in 2002. This projection is below the CBO projection of 46.9 million in 2002. If states were to add all the beneficiaries in the baseline projections, they would have to limit the growth in spending per beneficiary to 1.3% per year between 1996 and 2002. This is 1.7% below the rate of general inflation. This would be difficult and suggests that states are not likely to cover all projected beneficiaries.

Under the second assumption, states would increase beneficiaries at the same rate

as increases in poverty. Under this assumption, states would add 2.5 million individuals to the Medicaid rolls, or 7.4 million less than under the baseline projections. In order to cover these enrollees, states would have to limit expenditure growth to 3.8%. This is slightly less than one percent above the rate of general inflation. This is feasible, but substantially below past experience.

Finally, we assume that states would freeze enrollment growth at 1995 levels. Under this assumption, expenditures per beneficiary could grow at 4.8%. This is about 1.8% above the rate of growth in general inflation, and about the half the real rate of non-DSH spending growth over the 1988 to 1994 period. This is feasible, but again difficult.

Impact of New Matching Requirements on Federal and State Expenditures

In the previous section, we assumed that states would increase their own spending at the same rate as federal payments. However, under the Medigrant proposal matching requirements on the part of many states are reduced. States are allowed to choose between their current matching rate, the minimum of a new federal matching assistance formula or the current rate plus 10%, or 60%. The new matching assistance formula is based on a comparison of total taxable resources to the states aggregate expenditure need.

Table 10 shows the new state matching requirements – each states contribution for each dollar of Medicaid spending. For more than half the states the federal matching assistance formula is changed permitting states to reduce their contribution to the program. Most states that are currently at a 50% matching rate would be able to reduce their states share to 40% – effectively a 20% reduction in required state spending. A number of other states including Florida, Louisiana, Mississippi, South Carolina and Tennessee would also see their matching requirements fall.

In Table 11 we estimate the potential impact of the reduced state matching requirements on reductions in total (federal and state) Medicaid spending. We assume that states would reduce their spending to the minimum contribution and then calculate the reduction in federal and state spending relative to the baseline. We estimate that federal and state spending would fall by 25.4% relative to the baseline and by 35.3% in 2002. That is, because of the combination of the reduction in federal Medigrant payments and the reduction in re-

Table 9
Total Federal Spending per Beneficiary, 1994-2002
Urban Institute Baseline v. Conference Agreement Proposal

				1994-2002		1996-2002	
	1994	1996	2002	Total Growth	Average Annual	Total Growth	Average Annual
Federal Spending per Beneficiary							
Assumption: States add all beneficiaries in baseline projections							
Baseline	$2,453	$2,707	$3,926	60.0%	6.1%	45.1%	6.4%
Conference Agreement[1]	$2,453	$2,599	$2,811	14.6%	1.7%	8.2%	1.3%
Assumption: States increase beneficiaries at the same rate as the increase in poverty							
Conference Agreement[1]	$2,453	$2,689	$3,361	37.0%	4.0%	25.0%	3.8%
Assumption: States freeze enrollment growth at 1995 levels							
Conference Agreement[1]	$2,453	$2,716	$3,590	46.3%	4.9%	32.2%	4.8%

[1] *Does not include supplemental pool amounts.*
Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

Table 10
State Share of Total Medicaid Spending
Current FMAP v. Medigrant Minimum Required Contribution

	1994 Current	Medigrant[1]
Alabama	28.8%	25.5%
Alaska	50.0%	40.0%
Arizona	34.1%	34.1%
Arkansas	25.5%	25.5%
California	50.0%	40.0%
Colorado	45.7%	40.0%
Connecticut	50.0%	40.0%
Delaware	50.0%	40.0%
District of Columbia	50.0%	40.0%
Florida	45.2%	35.2%
Georgia	37.5%	32.1%
Hawaii	50.0%	40.0%
Idaho	29.1%	29.1%
Illinois	50.0%	40.0%
Indiana	36.5%	36.5%
Iowa	36.7%	36.7%
Kansas	40.5%	40.0%
Kentucky	29.1%	27.9%
Louisiana	26.5%	23.1%
Maine	38.0%	38.0%
Maryland	50.0%	40.0%
Massachusetts	50.0%	40.0%
Michigan	43.6%	37.1%
Minnesota	45.4%	40.0%
Mississippi	21.2%	19.3%
Missouri	39.4%	39.4%
Montana	29.0%	29.0%
Nebraska	38.0%	38.0%
Nevada	49.7%	40.0%
New Hampshire	50.0%	40.0%
New Jersey	50.0%	40.0%
New Mexico	25.8%	23.3%
New York	50.0%	40.0%
North Carolina	34.9%	34.9%
North Dakota	28.9%	28.9%
Ohio	39.2%	39.2%
Oklahoma	29.6%	29.6%
Oregon	37.9%	37.9%
Pennsylvania	45.4%	40.0%
Rhode Island	46.1%	40.0%
South Carolina	28.9%	26.0%
South Dakota	30.5%	30.5%
Tennessee	32.9%	29.0%
Texas	35.8%	35.8%
Utah	25.7%	25.7%
Vermont	40.5%	40.0%
Virginia	50.0%	40.0%
Washington	45.8%	40.0%
West Virginia	24.3%	24.3%
Wisconsin	39.5%	39.5%
Wyoming	34.4%	34.4%

[1] States would have the choice of three alternative FMAPs: (1) the formula as defined under current law; (2) the lesser of a new formula based on AEN and Total Taxable Resources or the current law formula plus 10% points; or (3) 60%. The Medigrant column assumes that states choose the maximum of the three options.

quired state contributions, Medicaid spending could fall by about one-quarter relative to the current baseline, and by over one-third relative to projected 2002 levels. Stated differently, while federal spending could fall by about $163 billion, federal and state expenditures could potentially decline by over $400 billion between 1996 and 2002, if states reduce their outlays to the minimum required contributions.

Conclusions

In this paper, we have examined the approach adopted by the Congress for addressing the uneven distribution of federal Medicaid payments. The plan accounts for differences in the number of people in poverty, growth in poverty, costs of health services and case-mix. However, differences in Medicaid spending among states are large and the Congress chose to limit the impact of the AEN by imposing ceilings and floors on annual rates of growth. The result is that the actual amount of "leveling" or redistribution that takes place is quite limited. States which faced large reductions under the original Budget Resolution relative to their baseline continue to do so.

Perhaps more important than the distributional effects, however, are the size of the reductions in federal spending. Reductions in federal payments relative to the baseline are over 17% between 1996 and 2002; and about 28.4% by the year 2002. Eighteen states would experience reductions in federal spending of over 30% by the year 2002.

We have also analyzed the implications of the Medigrant proposal for future enrollment growth. We conclude that it would be difficult for states to cover the same number of individuals as under the enrollment assumptions in the baseline projections. It would be more feasible for states to maintain current enrollment levels. To maintain current enrollment levels states would have to reduce the real rate of

Table 11
Total Federal and State Expenditures, 1996-2002
Urban Institute Baseline v. Conference Agreement Proposal

	Baseline Projections (billions)		Assuming States Drop to Minimum Contribution 1996-2002		2002	
	1996-2002	2002	(billions)	change from baseline	(billions)	change from baseline
Total	1,665.0	310.1	1,241.8	-25.4%	200.7	-35.3%
Alabama	20.0	3.7	17.3	-13.8%	2.9	-21.6%
Alaska	3.8	0.7	2.9	-25.1%	0.5	-35.5%
Arizona	22.0	4.2	17.5	-20.2%	2.9	-30.9%
Arkansas	13.1	2.4	11.9	-8.7%	2.1	-14.9%
California	182.2	34.1	126.4	-30.6%	21.1	-38.2%
Colorado	13.1	2.4	10.7	-18.1%	1.8	-25.2%
Connecticut	27.4	5.0	18.5	-32.4%	2.8	-44.1%
Delaware	3.7	0.7	2.7	-26.8%	0.4	-41.0%
District of Columbia	10.2	1.9	6.3	-38.1%	1.0	-50.3%
Florida	71.8	13.8	48.6	-32.3%	8.1	-41.3%
Georgia	44.1	8.4	31.4	-28.7%	5.5	-35.2%
Hawaii	5.9	1.1	4.7	-21.4%	0.8	-31.0%
Idaho	3.9	0.7	3.3	-13.8%	0.6	-22.1%
Illinois	69.8	13.2	48.7	-30.3%	8.0	-39.9%
Indiana	32.9	6.1	25.3	-23.0%	4.1	-32.8%
Iowa	13.1	2.4	10.9	-17.0%	1.7	-28.0%
Kansas	11.7	2.2	9.8	-16.5%	1.6	-28.0%
Kentucky	22.5	4.2	19.2	-14.4%	3.3	-20.6%
Louisiana	46.1	8.6	24.6	-46.7%	3.9	-54.6%
Maine	11.2	2.1	8.5	-24.0%	1.3	-38.5%
Maryland	27.2	5.1	18.8	-30.9%	3.0	-40.0%
Massachusetts	52.1	9.5	36.3	-30.4%	5.5	-42.0%
Michigan	60.6	11.3	45.4	-25.0%	7.3	-35.2%
Minnesota	32.8	6.3	22.7	-30.9%	3.4	-44.8%
Mississippi	16.5	3.1	13.3	-19.8%	2.2	-29.5%
Missouri	26.2	4.7	25.3	-3.2%	4.1	-12.9%
Montana	4.6	0.9	3.8	-17.8%	0.6	-28.1%
Nebraska	7.8	1.5	5.8	-24.8%	0.9	-38.9%
Nevada	4.8	0.9	3.6	-23.9%	0.6	-31.1%
New Hampshire	8.6	1.5	4.2	-50.9%	0.6	-58.3%
New Jersey	52.9	9.7	36.1	-31.8%	5.5	-43.3%
New Mexico	8.8	1.7	7.0	-20.7%	1.2	-30.7%
New York	239.0	43.7	163.1	-31.8%	24.8	-43.2%
North Carolina	41.1	7.8	34.1	-17.2%	5.6	-28.1%
North Dakota	3.2	0.6	2.8	-12.9%	0.4	-23.0%
Ohio	62.6	11.5	54.1	-13.5%	8.7	-23.9%
Oklahoma	12.0	2.2	11.0	-8.6%	1.8	-15.9%
Oregon	16.0	3.1	14.2	-11.1%	2.3	-25.7%
Pennsylvania	76.5	14.0	61.1	-20.2%	9.8	-29.6%
Rhode Island	9.1	1.7	6.9	-24.6%	1.0	-37.8%
South Carolina	22.2	4.1	19.3	-13.4%	3.3	-18.5%
South Dakota	3.5	0.7	3.2	-9.9%	0.5	-21.4%
Tennessee	31.3	5.8	30.2	-3.5%	4.9	-14.0%
Texas	106.5	20.5	86.7	-18.6%	14.8	-27.5%
Utah	6.5	1.2	5.6	-13.0%	0.9	-22.3%
Vermont	3.6	0.7	3.1	-12.8%	0.5	-28.6%
Virginia	23.4	4.4	16.2	-30.8%	2.7	-38.3%
Washington	32.4	6.1	22.3	-31.3%	3.4	-44.3%
West Virginia	16.5	3.2	11.8	-28.5%	1.8	-42.8%
Wisconsin	25.9	4.8	23.0	-11.1%	3.7	-22.2%
Wyoming	2.0	0.4	1.5	-23.6%	0.2	-37.6%

Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

growth in Medicaid spending to half of its historical rate.

We then examined the implications for Medicaid spending of new matching requirements. Under the Medigrant program states are permitted to reduce the contributions they make to the program to obtain federal Medigrant payments. Our results shows that if all states were to reduce payments to the minimum required, state contributions Medicaid spending would fall about one-quarter relative to the current baseline over the 1996-2002 period, and by over one-third relative to projected 2002 levels.

We emphasize that our baseline estimates are based on a projection that is linked to CBO national projections. We believe that the CBO national projections likely overstate Medicaid enrollment and expenditure growth. As a result, the baseline projections that we have made for the nation and for each state may well in fact overstate the true baseline. The implication of this is that the spending reductions estimated in this paper would actually be lower. A new lower baseline would also suggest that Medicaid is less of a contributor to future deficits than has generally been assumed.

Appendix

Methods

Projecting Medicaid spending growth is a complicated task, simply because the program itself is so complex. Medicaid serves many different types of beneficiaries and covers both acute and long-term care services. In the past, different beneficiary groups have experienced different rates of growth. In general, enrollment of the disabled has grown more rapidly than enrollment of the aged; among adults and children, the number of cash assistance beneficiaries has grown faster than non-cash beneficiaries. In addition, there has been explosive growth among poverty-related pregnant women and children—although this growth has been slowing in recent years. Total expenditures for acute and long-term care services have also grown at distinctly different rates. More important, there have also been substantial differences in growth rates among states.

Any approach to forecasting Medicaid expenditure growth must take these various factors into account. In our approach, we make separate forecasts for beneficiary growth among different enrollment groups in addition to separate estimates of growth in spending per beneficiary for acute and long-term care. We also developed a procedure to take into consideration differential growth experiences found locally in each state in addition to regional variations in the different census regions. States have had, and are expected to retain, different growth rates in both beneficiaries and expenditures per beneficiary because of differences in program policies; growth rates among states also vary because different enrollment groups and services (i.e., acute vs. long-term care) vary in importance among states.

There are five broad reasons for Medicaid spending growth. These include growth in:

- beneficiaries
- price inflation
- utilization and reimbursement above inflation (real growth in spending per beneficiary)
- DSH payments
- administrative costs

We make separate projections for each. Details of methodology used to combine these factors may be found in earlier reports.[6]

Revised Urban Institute Medicaid State-Level Baseline

The expenditure and beneficiary baselines have been updated to reflect the addition of more recent 1994 Medicaid data. Furthermore, the methods for calculating DSH, administrative costs, and adjustments and collections have been modified. In short, the changes may be summarized as follows:

- Addition of 1994 data. The Medicaid expenditure data on which projections are based has been updated from 1993 to 1994. Our 1994 estimates based on 1993 data differed nationally by approximately 2%. Most states actually grew faster, not slower, than we had originally projected.
- State-level adjusters. The weight given to each state's historical growth experience for the projection of future expenditures and beneficiaries was increased.
- Changes in the calculation of disproportionate share payments (DSH). In our previous baseline expenditure projections, DSH was calculated under the assumption that states would continue to maximize their DSH payments as allowed under current law. More recent figures for DSH growth by states show a drop in growth for most states. As such, we have reduced our future projections for the use of DSH by states.
- Administrative costs. The calculation of administrative costs has changed in two ways. First, the previous projections assumed that the federal share of administrative costs was equal to the federal share of

6 Holahan J, Liska D: *The Impact of the House and Senate Budget Committees' Proposals on Medicaid Expenditures*, Kaiser Commission on the Future of Medicaid Policy Brief, May 1995. Holahan J, Liska D: *The Impact of a Five Percent Medicaid Expenditure Growth Cap: A State Level Analysis*, Kaiser Commission on the Future of Medicaid Policy Brief, March 1995.

benefits (i.e., the FMAP). In reality, the federal share of administrative payments is uniform across states and usually higher than the FMAP used for benefits. Second, actual 1994 data for federal administrative costs were used instead of the previous estimates.

- Adjustments and Collections. States sometimes report sizable expenditures under an adjustment section on the HCFA 64. Historically, these "accounting adjustments" are not usually figured into total spending calculations since they frequently include spending by states from prior years. It appears, however, that legislative intent will be to include these adjustments in some form. As such, we have included the adjustments amounts for 1994 into the total spending for each state. Because of the potential for fluctuations in these amounts, we did not grow them over time and kept them constant for the entire 1996-2002 period.
- Fiscal Year Expenditures now reflect fiscal instead of calendar years.

Table A shows the revised federal expenditure and beneficiary estimates at the national level, with a comparison to estimates produced by the Congressional Budget Office.

Comparison with Estimates from GAO

The General Accounting Office (GAO) has released estimates of the allotments by state that will differ from the ones presented here. The differences can primarily be attributed to the following:

- 1994 baseline expenditures. The GAO originally used preliminary numbers from HCFA to determine the 1994 expenditure levels. This report uses data that is current as of September 1995.
- Poverty calculations and growth assumptions. The estimates here are based on the Urban Institute's TRIM2 adjustments to the 1991-1993 March Current Population Surveys. Furthermore, the GAO did not allow poverty counts to change by state over time, effectively ignoring any changes that would accrue to a state with a growing poverty population. In the Urban Institute model, state growth in poverty populations were based on historical patterns and indexed to CBO assumptions.
- Use of HCFA 37 data. The GAO used state estimates of spending for 1995 as specified on the HCFA 37 form. The Urban Institute did not use these data since prior analyses have shown these figures to be unreliable.
- Since the allotment calculations are essentially a zero sum game, any data issues that affect one state will have varying effects on the remainder; what one state gains another must lose in order to keep the total federal allotments to the predetermined levels. Therefore small changes in the data used can have implications that are difficult to predict.

Table A
Federal Medicaid Expenditure and Beneficiary Projections, 1996-2002

Urban Institute, October 1995

Expenditures (billions)	1996	1997	1998	1999	2000	2001	2002	1996-2002 Total
Total	100.2	110.4	121.7	134.1	147.2	161.7	177.7	953.0
Growth		10.1%	10.2%	10.2%	9.8%	9.8%	9.9%	10.0%
Benefits	85.5	94.9	105.5	116.9	129.1	142.5	157.3	831.6
Growth		11.1%	11.1%	10.9%	10.4%	10.4%	10.4%	10.7%
DSH	9.2	9.5	9.8	10.3	10.8	11.3	11.9	72.7
Growth		3.7%	3.8%	4.6%	4.7%	4.8%	5.1%	4.4%
Administration	4.1	4.5	4.9	5.3	5.9	6.4	7.0	38.1
Growth		9.3%	9.2%	9.3%	9.5%	9.5%	9.7%	9.4%
Adjustments & Collections	1.5	1.5	1.5	1.5	1.5	1.5	1.5	10.6
		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Beneficiaries (millions)								
Total	37.2	38.6	40.1	41.5	42.7	44.0	45.3	
Growth		3.9%	3.9%	3.4%	3.1%	3.0%	3.0%	3.4%

Source: Urban Institute Medicaid Expenditure Growth Model, December 1995.

CBO

Expenditures (billions)	1996	1997	1998	1999	2000	2001	2002	1996-2002 Total
Total	99.3	110.0	122.0	134.8	148.1	162.7	177.8	954.7
Growth		10.8%	10.9%	10.5%	9.9%	9.9%	9.3%	10.2%
Benefits	86.6	96.4	107.5	119.3	131.9	145.6	160.0	847.3
Growth		11.3%	11.5%	11.0%	10.6%	10.4%	9.9%	10.8%
DSH	8.9	9.4	9.8	10.3	10.5	10.8	11.0	70.7
Growth		5.6%	4.3%	5.1%	1.9%	2.9%	1.9%	3.6%
Administration	3.8	4.2	4.7	5.2	5.7	6.3	6.8	36.7
Growth		10.5%	11.9%	10.6%	9.6%	10.5%	7.9%	10.2%
Beneficiaries (thousands)								
Total	37.6	39.0	40.5	42.0	43.6	45.2	46.9	
Growth		3.7%	3.8%	3.7%	3.8%	3.7%	3.8%	3.8%