

State Fiscal Relief: Protecting Health Coverage in an Economic Downturn
Summary of Testimony of
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- This testimony focuses on the policy reasons why the proposed increase in the FMAP is a misguided approach for giving temporary aid to the states. It accepts as given that the Congress desires to help the states and has the additional funds to provide such help.
- The present FMAP formula creates two strong perverse incentives:
 - For states to expand Medicaid expenditures relative to unmatched state priorities when they have the state funds to do so;
 - For states to reduce state Medicaid expenditures relatively less than expenditures on unmatched parts of the state budget when economic conditions force states to reduce expenditures.
- The two ratchet effects are more prevalent in wealthier states than they are in poorer states. When federal Medicaid expenditures to the states are compared on a per capita basis (Federal Medicaid Expenditures per persons under 125 percent of poverty), the higher income states receive per capita payments more than three times as great as the poorest states.
- By boosting the FMAP, the proposal makes the perverse incentives worse and increases the dispersion in per capita payments. On average, the additional federal funding will help the states with the least number of people in poverty relative to the states with more poverty.
- The hold-harmless provision that prevents a state's FMAP from decreasing ends up protecting those states with the relatively higher increases in per capita personal income compared to those states whose economies are having the most trouble.
- I urge the Congress to consider putting an upper limit on the additional funding and finding a way to allocate the funding to the states that need it most.

TESTIMONY OF ROBERT B. HELMS

Thank you for the opportunity to testify before the Subcommittee on Health as you consider a proposal to temporarily increase the Federal Medical Assistance Percentage (FMAP) to provide additional federal assistance to the states to cover the costs of their Medicaid programs. For the purposes of this testimony I will take it as given that the Congress wishes to provide additional support to the states and those funds can be found to do so. I will concentrate on the policy implications of the proposed method of boosting the FMAP. My position is that this is not the best approach for aiding the states and that the proposed policy will make an already flawed policy even worse. This is not in the best interests of the millions of poor and disabled Americans that the Medicaid program is intended to help.

To understand my objection to this approach, it is first necessary to look at how the FMAP system works, the incentives it creates for the states, and how the formula has affected the flow of federal funds to the states.

The FMAP Formula

The FMAP formula was written into the original Medical legislation in 1965 and reflected both the politics and the availability of economic data at that time. Wilber Mills (AK), Harry Byrd (WV), and Russell Long (LA) were some of the powerful committee chairmen who adopted a formula that assured a higher federal matching rate for the poorest states like those that they represented. They based the formula on each states per capita income, a convenient statistic already provided by the government as part of the national accounts. By squaring the ratio of a state's per capita income relative to the national average, the formula worked to boost the federal matching rate of all the states

whose per capita income was below the national average.¹ To protect the highest income states, a provision was added that no state would receive less than a 50 percent match. In FY 2008, Mississippi has the highest matching rate (76.3 percent); 13 states have matching rates at 50 percent.²

Unlike Medicare that established federal funding for individuals who were aged or disabled, Medicaid was established as a joint federal-state program to be run and partially funded by the state. As intended, the states have had extensive latitude to expand both the medical benefits and the populations covered by their state plan. Since the federal matching system is open-ended, this created two strong incentives for each of the states:

- The incentive to increase state Medicaid spending when the state could afford to do so. Since each state received at least 50 percent reimbursement from the federal government, a state could expand its program without bearing the full burden of the additional expenditures. This has given states a reason to expand Medicaid relative to other state priorities.
- The incentive not to reduce Medicaid expenditures even when state finances create pressures to reduce state expenditures. A state with a 50 percent matching rate would have to reduce total Medicaid expenditures by \$2 million in order to reduce state spending by \$1 million. Mississippi would have to reduce total

¹ A scaling factor was also included in the formula to assure that the federal government provided 55 percent of the total funding for Medicaid. For an historical account of the passage of Medicaid in 1965 and its early years, see Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974). For a more complete description of the FMAP formula and procedures, see Vic Miller and Andy Schneider, *The Medicaid Matching Formula: Policy Considerations and Options for Modification* (research report 2004-09, Public Policy Institute, AARP, Washington, DC, September 2004), available at http://assets.aarp.org/rgcenter/health/2004_09_formula.pdf, accessed December 30, 2006.

² Kaiser Family Foundation, State Health Facts, <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4>

spending by approximately \$4.17 million in order to reduce state spending by \$1 million. This creates a strong incentive to cut non-matched programs relative to Medicaid when it becomes necessary to cut back.

The FMAP system of funding creates two kinds of ratchet effects. First, as economic activity expands and contracts, a state's revenue base also expands and contracts. When the state has funds to expand spending, the incentive is to expand Medicaid (and other matched programs) relative to unmatched programs. When economic conditions make it necessary for a state to reduce spending, there is an incentive to cut unmatched spending rather than matched Medicaid spending.

While this ratchet effect occurs in all states, it occurs in some states more than others. The states with the highest incomes have a larger tax base which they can use to support all state activities. While an original objective of the FMAP system was to help the poorer states relative to the wealthier states, the result has been just the opposite. The wealthier states have been able to expand their Medicaid programs to a greater extent than the poorer states. Even with higher federal matching rates, most of the poorer states have not been able to provide the level of coverage provided in the wealthier states.

The Effects of the FMAP

One common procedure for comparing state performance is to divide total Medicaid expenditures in each state by that state's Medicaid enrollment.³ This measure

³ Kaiser Family Foundation, State Health Facts, available at <http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4>

This comparison has been used by the Foundation for Health Coverage Education to identify the "ten best" and the "ten worst" states in terms of FY 2005 total Medicaid expenditures per enrollee. Disregarding the District of Columbia and Alaska who have special matching rates, they identify New York (\$7,733), Maine (\$7,961), and North Dakota (\$7,496) as spending the most per enrollee and California (\$2,701), Arizona (\$3,066), and Georgia (\$3,560) as spending the least. www.coverageforall.org

is useful as a crude indicator of the extent of coverage and benefits in a state and the relative efficiency of state programs. However, using Medicaid enrollment is not independent of a state's benefit and enrollment policies. This allows states that severely limit enrollment to appear to be relatively generous and states that expand enrollment to appear to be more efficient.⁴

To find a denominator that is independent of state Medicaid policies, and to focus on the efficiency of federal funding, I have divided FY 2006 (the latest CMS data available) federal Medicaid payments to each state by that state's population of people in poverty (less than or equal to 125 percent of the Federal Poverty Line, FPL). The number of people in poverty in each state is readily available from the Census Bureau, is independent of a state's Medicaid policies, and represents the population of people that the original Medicaid legislation singled out as the target population for assistance. This per capita calculation yields a national average of \$3,626 federal Medicaid expenditures per person in poverty, with a range from \$2,014 for Nevada on the low end to \$7,753 for Vermont on the high end. The District of Columbia (\$7,891) and Alaska (\$8,123) are higher, but they have congressionally mandated matching rates so are not subject to the FMAP per capita income formula. Figure 1 shows these state per capita amounts (on the vertical axis) in a scatter diagram where the states are arrayed from left to right by the percent of the state's population in poverty. As a central tendency, this chart illustrates that there is a negative relationship between the degree of poverty in a state and the amount of federal Medicaid money sent to the states. The poorer, mostly southern, states

⁴ Since the cost of treating the disabled exceeds the cost of treating children, the cost per enrollee in each state would be largely affected by the composition of the enrolled population.

receive relatively low federal payments per poor person while the wealthier, mostly northeastern, states receive payments more than three times as high as the lowest state.

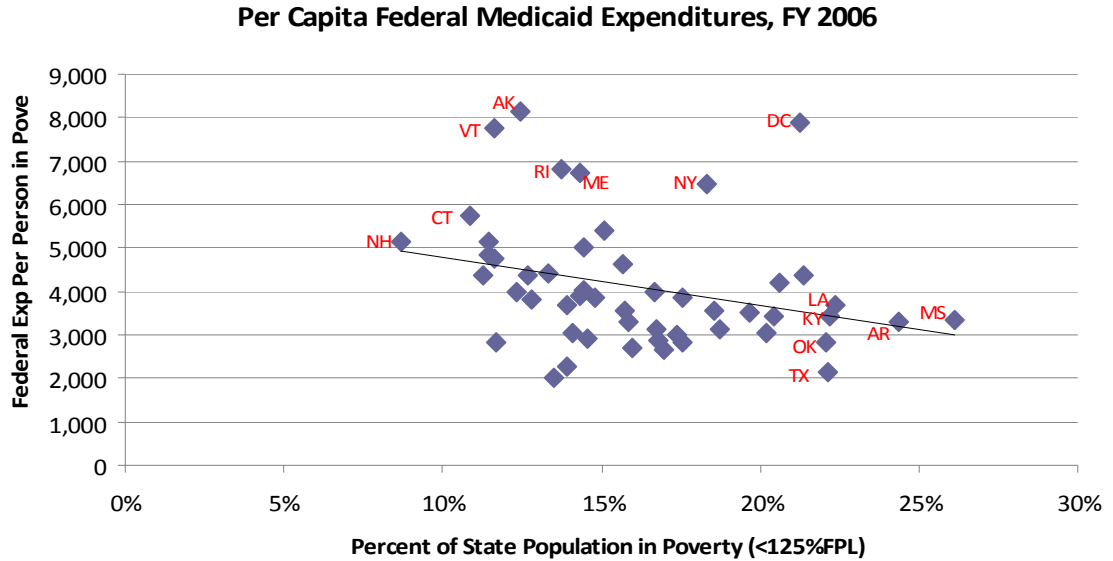


Figure 1: Federal Medicaid Expenditures from CMS, Form 64 data, FY 2006; Population figures from the Census Bureau. See Table 1 for the data and references.

What effect would the proposed addition to the FMAP have on this distribution?

Families USA has conveniently provided you with their estimates of the additional federal dollars that would flow to each of the states.⁵ Assuming that these estimates are approximately correct, we can use them to calculate the additional amount that each state would receive per person in poverty. This shows that on average the proposed addition to the FMAP will add \$160 per person in poverty through Medicaid expenditures and that this will range from a low of \$154 in Georgia to a high of \$564 in Vermont.⁶ The distribution of these estimated additional payments are illustrated in Figure 2 and show

⁵ Families USA July 2008 submission to the Subcommittee on Health, available at <http://energycommerce.house.gov/FMAP/EconImpact.HR5268.pdf>

⁶ No estimate was given for the District of Columbia. Alaska, not subject to the standard FMAP formula, would receive \$782 per person in poverty.

again that there will be a negative relationship between the additional per capita federal payments and the degree of poverty in the various states. The proposed addition to the FMAP will make the present disparity in state payments even larger. The largest share of the proposed new FMAP money would go to the states with the highest incomes and highest per-person Medicaid spending and the smallest share of the money would go to the poorer states.

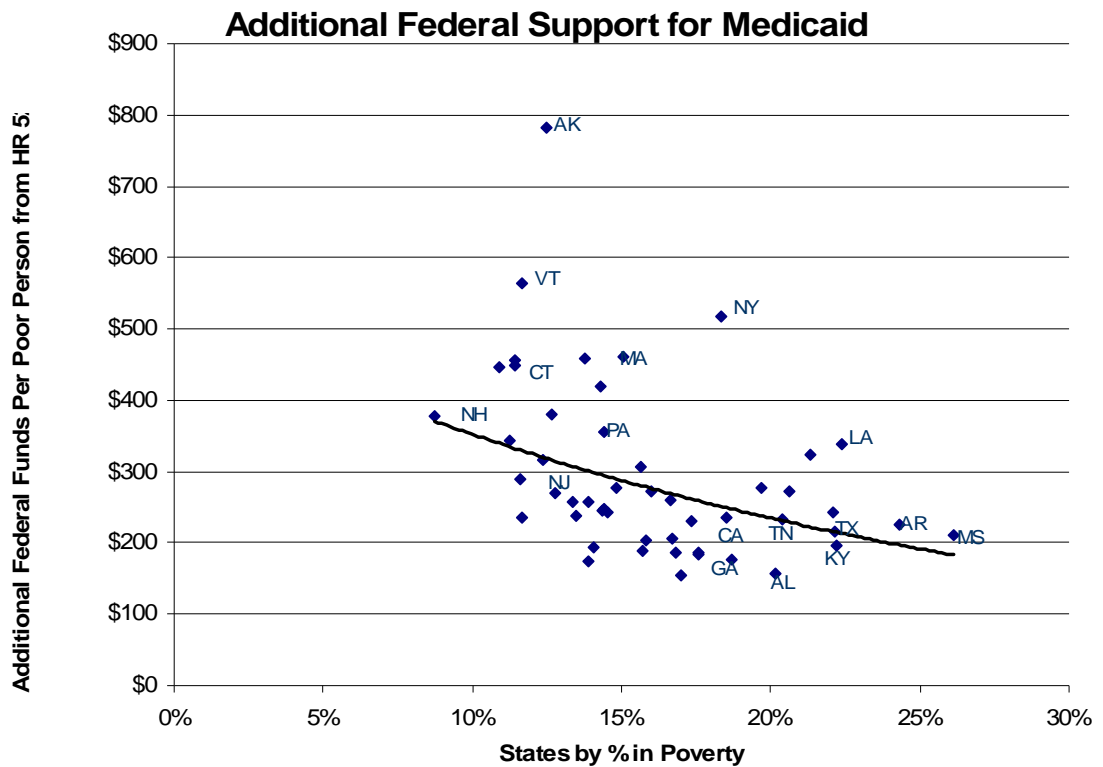


Figure 2: Additional Federal Support for Medicaid from Families USA; Population figures from the Census Bureau. See Table 2 for the data and references.

This result is not surprising given the provision in the bill that prevents a state’s matching rate from declining in the five quarters of Fiscal Years 2008 and 2009. The FMAP formula is based on a state’s per capita income *relative* to the national average. The main reason that a state’s matching rate would go down would be that it was a state

whose per capita income *increased* (or declined less) relative to the national average. As currently written, this hold-harmless provision of the proposal ends up giving additional help to all the states whose per capita income will increase and no help to all the states with declining per capita income.⁷ This provision could easily be corrected if the standard were the relative change in a state's per capita income rather than the FMAP matching rate.

Policy Objections to the Increase in the Medicaid Federal Matching Rate

There is now a large literature of academic⁸ and governmental studies critical of the FMAP formula and calling for its reform.⁹ This criticism has been truly bipartisan and coming from all ideological perspectives.¹⁰ My criticism, expressed in my dissent to the Medicaid Commission report,¹¹ is that the open-ended nature of the formula creates a set of perverse incentives that encourages states to engage in accounting and taxing schemes to increase federal funding rather than trying harder to improve the efficiency

⁷ It is possible for a state to receive a lower matching rate if its per capita income increases at a lower rate than the national average, but this is unlikely to be the case if national per capita income is actually declining.

⁸ See for example, Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs: Federalism, Competition, and Choice* (Washington, DC: AEI Press, 1983), 30–41; John Holahan and Alan Weil, “Toward Real Medicaid Reform,” *Health Affairs Web Exclusive*, February 23, 2007, pp. w254-w270.

⁹ Miller and Schneider, *The Medicaid Matching Formula*. Miller and Schneider list the following Government Accounting Office (GAO) studies: GAO, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27, March 9, 1983; GAO, *Medicaid Matching Formula's Performance and Potential Modifications*, GAO/T-HEHS-95-226, July 27, 1995; GAO, “Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending,” memo to Senator Daniel Patrick Moynihan (D-N.Y.), GAO-HEHS-99-29R, February 19, 1999; and GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620, July 2003.

¹⁰ see: John R. Graham, “Taming the Medicaid Monster,” *Health Policy Prescriptions* 4, no. 8 (August 2006); Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform*, (Washington, DC: Medicaid Makeover, 2006), available at <http://www.medicaidmakeover.org/MedicaidMakeoverPlan.pdf> (accessed December 29, 2006); Pamela Villarreal, “Federal Medicaid Funding Reform” (brief analysis 566, National Center for Policy Analysis, Dallas, TX, July 31, 2006, available at www.ncpa.org/pub/ba/ba566/ (accessed December 29, 2006); Holahan and Weil, “Toward Real Medicaid Reform.”

¹¹ U.S. Department of Health and Human Services, Medicaid Commission, *Final Report and Recommendations: Medicaid Commission*, December 29, 2006, available at <http://aspe.hhs.gov/medicaid/122906rpt.pdf> (accessed on July 19, 2008). A longer version of my dissent explaining the methodology behind these charts is at <http://www.aei.org/publication25434>.

and medical effectiveness of their programs. The result is the uncontrollable growth of federal outlays and the continuing diversion of federal funds away from the areas of the country with the highest rates of the uninsured. In addition, this set of incentives creates constant conflict between congressional and administrative budget officials and state officials, what Alan Weil and his colleagues at the National Academy for State Health Policy refer to as, “The Tug of War.”¹² The proposed temporary increase in the FMAP does nothing to reform these perverse incentives and, in fact, makes them worse by rewarding this kind of behavior with an even higher matching rate. The proposal does nothing to target the additional federal funds toward the states with the worst economic problems or states with the most uninsured, disabled, and poor people.

Some states may put the additional funds to good use, but there is no guarantee they will use this money in their Medicaid program. Medicaid federal matching funds are made on a retrospective basis to reimburse states for past expenditures. Anticipating the higher match allows the state government to use the additional funds anywhere in the state budget that it desires. If this proposal is implemented, it will be the second time this decade that such a “temporary” approach has been used. This sends a strong message to the states that they do not have to plan ahead for a rainy day. The result is to exacerbate the ratchet effect from the FMAP formula and make eventual reform even more difficult.

Conclusion

If the Congress decides that it wants to provide additional assistance to the states, I urge you to rewrite the proposal so that you provide the available funds in the form of a fixed grant to the states. This approach would provide temporary financial assistance to

¹² Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, *Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, 2006), available at www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf (accessed December 29, 2006).

the states without making the present incentives worse. If the funds could be allocated to the states on the basis of their economic performance and their populations of the poor and the disabled, the chances of improving the health and well-being of our most vulnerable populations would be greatly improved. This exercise could also provide a useful experiment to inform us how to reform the entire FMAP system, a task that almost every thoughtful person knows must eventually be done.

Table 1: Per Capita Federal Medicaid Expenditures, FY 2006

$y = -11064x + 5898.3$

$R^2 = 0.0898$

State	Federal Expenditures	Number of People in Poverty (<125% FPL)	Poverty Per Capita Federal Expenditure	Total State Population	Percentage of State Population in Poverty
Alabama	2,763,644,184	914,000	3,024	4,532,000	20.17
Alaska	666,095,954	82,000	8,123	658,000	12.46
Arizona	4,316,318,646	1,231,000	3,506	6,256,000	19.68
Arkansas	2,196,087,457	669,000	3,283	2,748,000	24.34
California	18,950,167,716	6,279,000	3,018	36,160,000	17.36
Colorado	1,503,346,575	667,000	2,254	4,797,000	13.90
Connecticut	2,151,327,920	376,000	5,722	3,457,000	10.88
Delaware	505,886,341	98,000	5,162	858,000	11.42
Dist. Of Col.	954,848,676	121,000	7,891	569,000	21.27
Florida	7,775,987,128	2,883,000	2,697	18,029,000	15.99
Georgia	4,188,297,564	1,585,000	2,642	9,334,000	16.98
Hawaii	693,176,003	159,000	4,360	1,254,000	12.68
Idaho	772,915,789	233,000	3,317	1,472,000	15.83
Illinois	5,328,020,948	1,838,000	2,899	12,633,000	14.55
Indiana	3,728,449,318	845,000	4,412	6,334,000	13.34
Iowa	1,700,298,729	420,000	4,048	2,913,000	14.42
Kansas	1,318,271,766	457,000	2,885	2,719,000	16.81
Kentucky	3,142,388,682	911,000	3,449	4,106,000	22.19
Louisiana	3,489,842,065	942,000	3,705	4,206,000	22.40
Maine	1,261,905,508	188,000	6,712	1,313,000	14.32
Maryland	2,748,101,632	631,000	4,355	5,607,000	11.25
Massachusetts	5,126,632,733	953,000	5,379	6,324,000	15.07
Michigan	4,946,397,396	1,749,000	2,828	9,953,000	17.57
Minnesota	2,852,412,871	588,000	4,851	5,145,000	11.43
Mississippi	2,532,351,566	755,000	3,354	2,887,000	26.15
Missouri	4,196,091,430	907,000	4,626	5,797,000	15.65
Montana	541,920,803	174,000	3,114	930,000	18.71
Nebraska	981,791,028	253,000	3,881	1,765,000	14.33
Nevada	686,841,223	341,000	2,014	2,530,000	13.48
New Hampshire	586,087,496	114,000	5,141	1,308,000	8.72
New Jersey	4,771,894,780	1,006,000	4,743	8,650,000	11.63
New Mexico	1,803,626,068	414,000	4,357	1,939,000	21.35
New York	22,532,588,396	3,487,000	6,462	19,021,000	18.33
North Carolina	5,837,793,891	1,639,000	3,562	8,847,000	18.53
North Dakota	350,610,079	91,000	3,853	615,000	14.80
Ohio	7,459,345,850	1,881,000	3,966	11,297,000	16.65
Oklahoma	2,164,884,030	770,000	2,812	3,489,000	22.07
Oregon	1,933,924,642	619,000	3,124	3,705,000	16.71
Pennsylvania	8,917,780,430	1,777,000	5,018	12,326,000	14.42

Rhode Island	988,517,303	145,000	6,817	1,054,000	13.76
South Carolina	2,855,371,559	742,000	3,848	4,224,000	17.57
South Dakota	428,535,863	121,000	3,542	770,000	15.71
Tennessee	4,130,336,062	1,207,000	3,422	5,916,000	20.40
Texas	11,050,086,685	5,140,000	2,150	23,208,000	22.15
Utah	1,080,200,957	357,000	3,026	2,536,000	14.08
Vermont	558,206,347	72,000	7,753	618,000	11.65
Virginia	2,477,692,764	878,000	2,822	7,532,000	11.66
Washington	3,089,672,098	779,000	3,966	6,310,000	12.35
West Virginia	1,567,801,215	373,000	4,203	1,810,000	20.61
Wisconsin	2,791,369,827	760,000	3,673	5,471,000	13.89
Wyoming	252,546,230	66,000	3,826	516,000	12.79
National Totals	180,177,264,894	49,688,000	3,626	296,450,000	16.76

Source: Centers for Medicare and Medicaid Services, Form 64, FY 2006
U.S. Census Bureau

Table 2: Additional Federal Support for Medicaid

October 2008 - December 2009

$$y = -1312.9x +$$

$$505.68$$

$$R^2 = 0.1775$$

State	Additional Federal Funds from HR 5268	State Population	Population <125% FPL	Additional Federal Funds per #<125%FPL	% Under 125% FPL
Alabama	144,099,000	4,532,000	914,000	\$158	20.167696
Alaska	64,106,000	658,000	82,000	\$782	12.462006
Arizona	340,875,000	6,256,000	1,231,000	\$277	19.67711
Arkansas	150,142,000	2,748,000	669,000	\$224	24.344978
California	1,442,915,000	36,160,000	6,279,000	\$230	17.364491
Colorado	116,806,000	4,797,000	667,000	\$175	13.904524
Connecticut	167,572,000	3,457,000	376,000	\$446	10.876482
Delaware	44,085,000	858,000	98,000	\$450	11.421911
Florida	783,103,000	18,029,000	2,883,000	\$272	15.990904
Georgia	243,976,000	9,334,000	1,585,000	\$154	16.98093
Hawaii	60,444,000	1,254,000	159,000	\$380	12.679426
Idaho	47,432,000	1,472,000	233,000	\$204	15.828804
Illinois	448,135,000	12,633,000	1,838,000	\$244	14.549197
Indiana	216,699,000	6,334,000	845,000	\$256	13.340701
Iowa	104,131,000	2,913,000	420,000	\$248	14.418126
Kansas	85,721,000	2,719,000	457,000	\$188	16.80765
Kentucky	179,076,000	4,106,000	911,000	\$197	22.187043
Louisiana	317,679,000	4,206,000	942,000	\$337	22.396576
Maine	78,784,000	1,313,000	188,000	\$419	14.318355
Maryland	217,318,000	5,607,000	631,000	\$344	11.25379
Massachusetts	438,530,000	6,324,000	953,000	\$460	15.069576
Michigan	321,901,000	9,953,000	1,749,000	\$184	17.572591
Minnesota	268,308,000	5,145,000	588,000	\$456	11.428571
Mississippi	158,686,000	2,887,000	755,000	\$210	26.151715
Missouri	278,013,000	5,797,000	907,000	\$307	15.646024
Montana	30,886,000	930,000	174,000	\$178	18.709677
Nebraska	62,072,000	1,765,000	253,000	\$245	14.334278
Nevada	81,530,000	2,530,000	341,000	\$239	13.478261
New Hampshire	42,978,000	1,308,000	114,000	\$377	8.7155963
New Jersey	290,807,000	8,650,000	1,006,000	\$289	11.630058
New Mexico	134,429,000	1,939,000	414,000	\$325	21.351212
New York	1,805,626,000	19,021,000	3,487,000	\$518	18.332369
North Carolina	386,858,000	8,847,000	1,639,000	\$236	18.526054
North Dakota	25,240,000	615,000	91,000	\$277	14.796748
Ohio	487,671,000	11,297,000	1,881,000	\$259	16.650438
Oklahoma	187,613,000	3,489,000	770,000	\$244	22.069361
Oregon	128,247,000	3,705,000	619,000	\$207	16.707152
Pennsylvania	629,954,000	12,326,000	1,777,000	\$355	14.41668
Rhode Island	66,546,000	1,054,000	145,000	\$459	13.757116
South Carolina	139,070,000	4,224,000	742,000	\$187	17.566288

South Dakota	22,866,000	770,000	121,000	\$189	15.714286
Tennessee	280,620,000	5,916,000	1,207,000	\$232	20.402299
Texas	1,110,201,000	23,208,000	5,140,000	\$216	22.147535
Utah	68,853,000	2,536,000	357,000	\$193	14.077287
Vermont	40,580,000	618,000	72,000	\$564	11.650485
Virginia	206,307,000	7,532,000	878,000	\$235	11.65693
Washington	247,214,000	6,310,000	779,000	\$317	12.345483
West Virginia	101,173,000	1,810,000	373,000	\$271	20.607735
Wisconsin	195,631,000	5,471,000	760,000	\$257	13.891428
Wyoming	17,738,000	516,000	66,000	\$269	12.790698

Source: Families USA, Census Bureau