

FROM THE FIELD

State Variation In Medicaid Spending: Hard To Justify

Although some cross-state spending variation is to be expected, low-income Americans fare differently depending on where they live—a situation that calls for a nationwide solution.

by John Holahan

ABSTRACT: There is great variation among states in Medicaid spending per low-income person. This variation has many determinants, including state discretion and differences in prices and amounts of services used. Incentives in Medicaid to have low-income states spend more have generally not worked. The decentralized approach to Medicaid and the variations in spending created thereby have consequences in access and health outcomes that seem to belie a presumed national interest in equity. The current trend toward state-based solutions to health care coverage would likely exacerbate existing variations. A federal solution, though not likely, would be necessary to eliminate state variations. [*Health Affairs* 26, no. 6 (2007): w667–w669 (published online 18 September 2007; 10.1377/hlthaff.26.6.w667)]

THE PAPER BY Anne Martin and colleagues provides a rich amount of data on overall personal health care spending as well as per capita spending for people in Medicare and Medicaid.¹ This Perspective focuses on Medicaid spending, which shows greater variation among states than Medicare or overall spending does. For example, the data show that Medicaid spending per enrollee for 2004 varied from \$10,199 in New Jersey and \$10,173 in New York to \$4,089 in Alabama and \$3,664 in California—close to a threefold variation in per enrollee spending. Medicaid spending per low-income person is even greater, as discussed below.

Spending per enrollee can vary for many reasons. One is the extent of the benefits that states choose to cover; the most important of these is the extent to which states cover and

fund long-term care benefits. Spending also varies depending on so-called Medicaid maximization strategies; spending will be higher to the extent that states have brought previously state-funded programs into Medicaid or taken advantage of upper payment limit (UPL) or disproportionate-share hospital (DSH) programs.

But spending per enrollee also varies because of differences in the price and quantity of services. The price of services is affected by the cost of inputs in the state—that is, the cost of delivering hospital and physician services. It also depends on state policy—what share of costs is met by the state when it pays various providers—and on the mix of services provided. States that cover sicker populations are purchasing more-expensive services. The quantity of services depends also on case-mix;

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sicker people use more services. But it also depends on measures taken by states to control the use of services. For example, states with costly managed care plans can affect the quantity of services that are used.

Martin and colleagues' paper does not address another major source of variation in Medicaid spending: that states cover very different shares of their low-income populations. Moreover, people with low incomes are a higher share of the population in some states than others. States face very different problems in covering their low-income populations because of the variation in employer-sponsored insurance. This insurance varies among states because of industry and firm size, composition, education, income, and a number of other factors.² As a result, states are left with very different shares of the population without employer-sponsored insurance. States then vary greatly in the extent to which public programs cover those who remain without coverage. As a result, uninsurance rates differ greatly among states.³ This is in part because states have very different problems to address.

In the end, state spending is determined by federal matching rates that vary inversely with state per capita income and with states' willingness to spend from their own resources. The latter depends a lot on per capita income—that is, states' ability to pay—but it also depends on the general philosophy toward income transfers to lower-income populations. The evidence shows that although federal matching rates are inversely related to income with the intent of encouraging states to spend more—that is, the marginal cost of additional spending is lower for lower-income states—the fact is that most states don't take advantage of the federal offer of higher matching funds.⁴ That is, higher-income states tend to spend far more per capita from their own resources, such that even with the lower federal matching contributions, the federal and state spending on Medicaid services is much higher

in high-income states than in low-income states. The incentives in Medicaid to have low-income states spend more by having federal payments offset lower state per capita incomes have simply not been successful.

Between the variation in spending per enrollee and the share of low-income populations that are covered, the variations in Medicaid spending are quite extensive. Some variation is inevitable and exists in Medicare and private coverage as well. But whether the variation that we observe in Medicaid is acceptable is another matter. We have shown elsewhere that states with lower levels of spending have lower levels of access and worse health outcomes.⁵ Thus, the spending variations have consequences that are felt at the national level.

Although the nation has chosen to have a decentralized system to provide coverage to low-income Americans, a great deal of federal money supports these programs. For example, more than half of the cost of Medicaid and the State Children's Health Insurance Program (SCHIP) is borne by the federal government. Medicaid programs spent \$314.5 billion for health services in 2006.⁶ Of this, \$179.0 billion was spent by the federal government and \$135.5 billion by states. States must provide a minimum amount of coverage and benefits, but they have considerable flexibility in extending coverage and structuring benefit packages, including the degree in which they cover long-term care services.

But it can be argued that there is a national interest in how these programs work. If there is a strong national interest, then wide state variations are problematic. The large federal contribution to Medicaid and SCHIP and the fact that state matching rates vary inversely with state per capita income seems to recognize a national interest in extending coverage to low-income groups, regardless of where they live. Moreover, the recent interest in extending subsidies to low-income people through federal tax credits suggests that even

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those who oppose expanding government insurance programs in general accept the need to extend health insurance coverage to low-income Americans, regardless of where they live. There would actually be more national uniformity in the Bush administration tax proposals than exists in the current Medicaid and SCHIP structure.

Ironically, the recent interest in state health reform is likely to make current inequities worse. Massachusetts has enacted a plan to achieve (close to) universal coverage. Other relatively progressive states including New York, Connecticut, Vermont, Pennsylvania, and Illinois have enacted or are seriously considering major proposals to extend coverage to all. In American politics today, it is likely that only these more progressive states can achieve the political consensus necessary to substantially extend coverage. Other states will be left with the current mix of programs. Coverage of individuals and spending on health services will be subject to state officials' willingness to pay, regardless of the generosity of federal matching payments available to them.

A national solution will be needed to eliminate the extensive variations that the current system has brought. But such a solution would have huge costs to the federal government. Moreover, political agreement on an approach to extending coverage to all will be difficult to achieve. The result of a stalemate will be that low-income people will continue to be treated very differently depending on where they live. This not only will have consequences for the states in which they reside, but because poor access to health care will affect health outcomes, it will have implications for the nation as well.

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The views expressed are those of the author and should not be attributed to the Urban Institute, its directors, officers, or staff.

NOTES

1. A.B. Martin et al., "Health Spending by State of Residence, 1991–2004," *Health Affairs* 26, no. 6 (2007): w651–w663 (published online 18 September 2007; 10.1377/hlthaff.26.6.w651).
2. Y. Shen and S. Zuckerman, "Why Is There State Variation in Employer-Sponsored Insurance?" *Health Affairs* 22, no. 1 (2003): 241–251.
3. J. Holahan, "Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?" in *Federal and Health Policy*, ed. J. Holahan, A. Weil, and J. Weiner (Washington: Urban Institute Press, 2003).
4. Ibid.
5. Ibid.
6. Centers for Medicare and Medicaid Services Form CMS-64 data, 2006.