are not locally concentrated and forfeits any opportunity to tailor Medicaid programs to meet the preferences of local taxpayers. Furthermore, it might be difficult to justify the plan’s realignment of responsibilities for long-term and other kinds of care. The proposal would function as if it were to those who need long-term care (primarily, the aged and disabled) would generate local benefits, but that help for those receiving other kinds of care would generate purely national benefits. A good case could be made, however, that it is the long-term beneficiaries who are a federal responsibility. As was noted above, members of this group often initially receive their medical care under Medicare, a national program, and they turn to Medicaid only after being placed in nursing homes. If there is a national interest in providing other kinds of medical care to this group, why not provide nursing home care also?

A second proposal was originally suggested in the 1982 budget and has resurfaced in President Reagan’s current budget. The 1986 version of the proposal would limit overall Medicaid payments to $22.2 billion and would distribute this total among states in the same proportions as were used when 1984 funds were distributed. After 1986, the proposal would allow each state’s payments to rise only as much as the rate of increase in the medical care component of the consumer price index. There would be no allowance in these increases for changes in the relative cost of providing health care or in the proportion of the population living in poverty.

This proposal stands in sharp contrast to the previous plan to federalize Medicaid. The implications about who is responsible for health care are markedly different. Under the swap proposal, the Reagan administration is implying that (for the portion of the program that doesn’t cover long-term care) there is no regional interest in health care for the poor. Under the cap proposal, on the other hand, the administration is acting as if there is no national interest in additional expenditures on health care for the poor in each state. This is a radical departure from current policy, especially in the case of relatively poor states that have very limited Medicaid programs. Many reformers advocate improving these programs to make access to health care more equitable across states.

South Dakota, for example, covers just 23 percent of its poverty population under Medicaid, while California covers 97 percent. In 1980, Oregon spent $646 per recipient, while New York spent $1,980—more than three times as much. As if to underscore the importance of federal aid in addressing these imbalances, South Carolina has recently moved to expand its very limited program (third lowest Medicaid payments per recipient among states), but has legally conditioned these improvements on the availability of federal matching funds.

Conclusion

There is always a tension between budget planners, who strive to bring spending in line with revenues, and program analysts, who want to expand or contract each program according to its own merits. With a limited amount of time and other resources, increasing the attention given to one of these aspects of public budgeting tends to diminish the attention given to the other.

The inconsistencies between the Reagan administration reform proposals, however, suggest that more attention should be paid to the goals of the Medicaid program itself. Excessive attention to dollar reductions risks thwarting the balance between national and regional concerns found in the existing program. Additional discussion about the purposes of Medicaid would seem to be warranted; only when this issue has been decided should reformers go on to the question of how best to save money while furthering program goals to the maximum extent possible.

As the nation’s program of medical assistance for the poor, Medicaid enters its 20th year, many fundamental policy questions about the program are still being worked out. Do steelworkers in Pittsburgh, for example, have an interest in the medical care given to the disabled in California? Are the health needs of the poor the responsibility of their county or state government, or of the nation as a whole? Is it more important to allow local control of the program, or to insure equal access to medical care across the country?

The need for answers to these questions has become more urgent because of the Reagan administration’s efforts to trim the federal budget. This Economic Commentary outlines the Medicaid program, examines the economic justifications for its existence, and analyzes the major Reagan administration proposals for altering funding for the program. The article strives to reveal the fundamental policy questions raised by reforms that have previously been discussed in purely budgetary terms. As will be shown below, an informed decision about dollars and cents cannot be made without thinking carefully about the ultimate goals of the program and the best means to implement those goals in a multi-government system.

The Medicaid Program

Medicaid, a program created in 1965 as Title XIX of the Social Security Act, is a joint responsibility of the federal government and the states. Although state governments administer the program, the legislation authorizing Medicaid calls for a high degree of interdependence and cooperation between the two levels of government. For example, funding for the program is roughly equally divided between federal and state governments; the federal government pays an average of 55 percent, and states pay an average of 45 percent. The federal government matches the expenditures of each state government at a rate that depends on the state’s per capita income (currently, the federal government’s share of expenditures in each state ranges from a low of 50 percent to a high of 77 percent).

It is in the area of eligibility, however, that the mixing of federal and state authority is most evident. The regulations determining eligibility are quite complex, but in broad terms two groups of people are served by Medicaid: First, the federal government requires Medicaid coverage for individuals receiving Aid to Families with Dependent Children (AFDC), which is a federal-state program to provide cash assistance to one-parent families, or of Supplemental Security Income (SSI) — a primarily federal program that provides income support to poor people who are aged, blind, or disabled. Even here, however, states have some influence because they determine need and payment levels under AFDC, and they control AFDC coverage for certain optional groups, such as families with two unemployed parents. State discretion also enters under the SSI program because of two options in the law. State governments may provide supplementary SSI benefits at their own expense, and any state may choose to provide benefits that are not covered under Medicaid if the states choose to do so. Also, states may choose to restrict Medicaid to those groups served by the state’s program of aid to the aged, blind, and disabled that was in place prior to the introduction of the SSI program in 1974, if that program was more restrictive in its eligibility than SSI.

The Health Care Financing Administration, which makes Medicaid grants to the states, uses the term "categorically needy" to describe those who are eligible for Medicaid because they have certain health impairments or medical costs. The most important option available to states under Medicaid is to allow a second group of people — the "medically needy" — to be covered...
under the program. These are individuals whose long-term care needs are large in relation to their income and who meet all the eligibility standards for AFDC or SSI—except for the income component. Specifically, a family is classified as medically needy if its income after medical expenses is no greater than 135 percent of the state’s maximum AFDC payment for the same size family. Currently, 31 states cover the medically needy.

The fact that some states cover the medically needy is of more than administrativerelevance. The medically needy option has fundamentally affected the operation of the Medicaid program, setting up, in effect, two very different programs within Medicaid. This dual-purpose result has occurred because of a gap in Medicare, the nation’s program of medical insurance for the elderly and disabled.

After an elderly or disabled individual has a serious illness, Medicare pays for hospital bills and 100 days of care in a skilled nursing facility. (This benefit is intended to provide rehabilitation after an acute illness and not for long-term care.) Since many individuals require more care than Medicare nursing home stays, and because few private insurance policies cover nursing home care, the family of a long-term nursing home patient is frequently forced to pay for this care out of their own pocket. Once the family uses up all of its assets (savings, securities, etc.), however, the patient can qualify as medically needy if these nursing home bills are large relative to the family’s income. Since nursing home care costs range from $20,000 to $50,000 per year, it is not hard to see how a large number of formerly middle-class patients end up on the family’s income. Since nursing home care costs range from $20,000 to $50,000 per year, it is not hard to see how a large number of medically needy individuals are classified as medically needy if their income after medical expenses is no greater than 135 percent of the state’s maximum AFDC payment for the same size family. Currently, 31 states cover the medically needy.

The Economic Rationale for Federal Grants

The current financial structure of Medicaid has its drawbacks. Since it is an open-ended grant, the unrestricted nature of the federal government’s spending is subject to rapidly increasing meeting and expenditure control difficulties. From the state’s perspective, restrictions about which services are to be covered and what groups are to be served limit the state’s effectiveness in targeting resources. And from the viewpoint of the recipients of the program, the constraint that program funds be used only for medical care may not make sense if the purpose is simply to alleviate the miseries of poverty. If recipients are capable of deciding how best to spend the resources at their command, greater satisfaction can be achieved by providing cash to individuals at the same level of cost by giving them unrestricted transfers of cash, to be spent at their discretion. What justification, then, can be given for the present system?

Programs such as Medicaid, which give in-kind benefits, goods, or services rather than cash, are irrational unless taxpayers receive some sort of satisfaction from knowing that the poor are receiving a particular service. That is, it must be the recipient’s consumption of the program’s services, and not his general level of well-being, that is of concern to the taxpayer. In the case of medical care, this concern might spring from both selfish and unselfish motives. If the program leads to a reduction in the incidence of communicable diseases, the taxpayer may benefit from being exposed to fewer of these diseases. On the other hand, the taxpayer may benefit from simply knowing that medical care is available to all.

Economist Lester Thurow has pointed out that it is not necessarily contradictory to have a competitive market economy and yet decide that certain “merit goods” ought to be provided on an equal basis to everyone, because citizens may derive direct satisfaction from knowing that society is (according to the taxpayer’s criteria) compassionate or fair. Accord- ing to Thurow, equal access to medical care may be considered a societal “ground rule,” entirely apart from the competitive struggle that dominates the distribution of other economic resources.

If in-kind transfers are to be provided to the poor, what level of government should provide them? The obvious answer is that the responsible government should include all individuals who receive satisfaction from the transfers, and no one else. If these benefits are national in scope, so that citizens of San Diego care whether

The Reagan Proposals

In 1984, Medicare served 22 million people, costing the states $17 billion and the federal government $21 billion. The Reagan administration proposed a program of grants-in-aid to state and local governments, Medicare is a temtting budget target for an administration committed to cutting back federal domestic spending.

Furthermore, like health expenditures generally, the growth rate of this program has exceeded the rate of growth of the economy as a whole. Between 1973 and 1980, Medicare pay- s out grew at a rate of 15.3 percent, compared to a rate of 10.3 percent for the economy as a whole.2 Small wonder, then, that the Reagan administration has made vigorous efforts to reduce the rate of growth of this program. The Omnibus Budget Reconciliation Act of 1981 specified cuts of $1 billion per year, the Tax Equity and Fiscal Responsibil- ity Act of 1982 included savings valued at $1.14 billion over three years, and the administration’s 1986 budget re- quest included cuts of approximately $1 billion.

The Reagan administration has made two major proposals to reform the financing of Medicaid. In 1982, as part of its “deficit reduction proposal,” the administra- tion offered to allow states to assume full financial responsibility for the program under their state plan for full state assumption of AFDC. Later, this proposal was revised to omit the long-term care portion of Medicaid from this swap, so that long-term med- ical care would continue to be run by the states under a block grant from the federal government.

The Reagan administration outlined above, it is easy to see the fun- damental concerns raised by such a proposal. Federal Medicaid funding of Medicare presumes that the benefits of health care for the poor