

Medicaid Expenditures and State Budgets: Past, Present, and Future

Abstract - Medicaid spending has become a major element in state budgets and support from federal Medicaid grants is now a main source of state government funding. We discuss recent, ongoing, and prospective reforms of intergovernmental finances and regulations, including the 1996 welfare reform, the introduction of Medicare Part D, Section 1115 waivers, SCHIP reauthorization, and a shift to block grant funding for Medicaid. Each would alter the current assignment of responsibilities between the state and federal governments, the viability of which is questionable due to current and future interstate demographic and policy variation, population aging, and federal fiscal imbalances.

INTRODUCTION

Medicaid is one of several major components of the Nation's health care system. It has grown dramatically over time and now provides health benefits for approximately 52 million people, about one-sixth of the national population. A program of this magnitude touches on all aspects of economic life, affecting beneficiaries, health-care providers, private insurers, taxpayers, and every level of government. In particular, Medicaid has become a major expenditure item for state governments, with Medicaid spending of more than \$315 billion in 2005, accounting for more than 21 percent of total state government spending in the nation as a whole. A large fraction of state Medicaid spending is financed by grants from the Federal government, and these grants are now major elements in the system of Federal transfers to the states.

The present discussion examines the Medicaid program from a fiscal perspective, especially with reference to the fiscal systems of state governments. The steady growth of Medicaid spending raises questions about fiscal sustainability. The states experienced a period of significant fiscal stress beginning in 2000, partly the consequence of weakened revenue flows and partly the result of earlier growth in expenditures. Revenue growth has since increased, but perhaps this offers only a temporary respite before the next economic downturn triggers another round of fiscal crises. Ominous demographic and other trends suggest that health care costs will continue to grow for decades to come. Will states be able to cope with the fiscal burden of Medicaid? Rising health care and other

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costs will subject the federal government to fiscal stress as well. Will the states find the federal government less willing in the future to share in the financial burden of Medicaid?

Lacking a crystal ball with which to provide definitive answers to these and other forward-looking policy questions, it is tempting to retreat to a cautious review of past trends and policy experience.¹ However, while it is not our purpose to engage in demographic, economic, fiscal, or political forecasting, it seems useful, nonetheless, to discuss, even if only in somewhat speculative terms, some of the policy options that the nation will face in the coming years.

We begin, in the second section, with an overview of Medicaid spending from the viewpoint of its impact on state budgets, describing its growth in aggregate terms and also the wide interstate variation in Medicaid spending. In the third section, we summarize some recent analytical efforts to explain observed Medicaid expenditures. Because the federal government plays such a large role in the Medicaid program, through its financing of state expenditures and through its regulation of the program, we focus particularly on the federal regulatory and fiscal determinants of Medicaid spending. We also present some preliminary results from ongoing research, highlighting possible interactions between the 1996 welfare reform and recent Medicaid spending growth.

The fourth section discusses the prospects for Medicaid in coming decades. Demographic change is likely to play a major role in the evolution of health care spending in the nation as a whole and may have very important effects on Medicaid

in particular. The future of Medicaid in state budgets will also depend crucially on federal government policies, such as the recently instituted prescription drug coverage provided by Medicare Part D. Recognizing that the federal government faces growing fiscal stress, it is natural to consider also the prospect of more fundamental alterations in the federal/state division of labor in providing and financing health care benefits for the poor, the elderly, and for other groups. We, therefore, discuss, in an admittedly somewhat speculative spirit, the implications of a policy reform for Medicaid similar to the welfare reform of a decade ago. The fifth section concludes with a brief summary.

MEDICAID GROWTH AND STATE GOVERNMENT FINANCES, 1990–2003

The rapid growth of Medicaid spending is well-known and widely documented. Here, we offer a concise review of this growth, mainly from the perspective of its implications for state government finances and intergovernmental fiscal relations.² We will frequently compare it to the major “cash welfare” programs—Aid to Families with Dependent Children (AFDC) prior to the 1996 welfare reform (the Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) and Temporary Assistance to Needy Families (TANF) subsequent to it. This comparison is of interest for at least two reasons. First, both Medicaid and cash welfare have been broadly targeted at low-income households and, indeed, they constitute two of the largest and most durable means-tested transfer programs in US history. Second, in both cases, a

¹ Some economists (see, e.g., Wildasin (1988)) expected that the elimination of state sales tax deductibility in the 1986 tax reform would lead to a reduction in the use of state sales taxes and an increase in the use of state income taxes or to the restoration of the sales tax deduction. These expectations seem (as yet) not to have been substantially confirmed.

² For a more detailed discussion of programmatic development in the Medicaid program, see Gruber (2003). McGuire and Merriman (2006) provide a thorough discussion of how state spending on social assistance programs varies over the business cycle.

large proportion of state government spending has been financed by transfers from the federal government. Prior to the 1996 welfare reform, the structure of intergovernmental transfers for both programs was substantially the same: the federal government provided each state with open-ended matching grants for both programs, with matching rates varying among the states inversely to state per-capita income, subject to a minimum federal share of 50 percent. The welfare reform replaced the matching grants for welfare by a system of lump-sum grants similar in amount to those previously awarded, while leaving matching grants for Medicaid unaffected. Comparison of these two programs provides a unique opportunity to study the response of state governments to changes in intergovernmental grants.

Table 1A summarizes some of the key trends in Medicaid spending since 1990. Medicaid spending now amounts to approximately 21 percent of aggregate state government spending, this share having nearly doubled in the past 15 years (column 3). The rate of growth varies somewhat over time and by state, but the overall trend is unmistakably and almost monotonically upward (see Figure 1). This may be compared with cash welfare spending, which was about 3.3 percent of state spending in 1990, but which fell to only 1.7 percent by 2005 (column 4). At its inception in 1967, Medicaid and welfare spending were approximately equal in amount, but Medicaid spending has grown substantially faster over time. By 1990, Medicaid spending was nearly four times as large as cash welfare spending, and by 2005, it was more than 12 times as large (column 5).

Medicaid spending varies substantially among the states, as illustrated in Table 1B.

In 2005, two states (Utah and Wyoming) had Medicaid expenditures that were less than 13 percent of total state spending. At the top end, Medicaid spending exceeded 30 percent of total state spending for three states (Tennessee, New York, and Maine) (column 3). Cash welfare spending also varies widely by state, with 14 states (Arizona being the lowest, at 0.49 percent) having TANF spending of less than one percent of total state spending in 2005, while two (California and New York) had TANF spending of more than 2.5 percent (column 4). Although New York stands out for high spending on both programs, California, which has the second-highest TANF expenditure share, is fifteenth from the bottom in Medicaid spending as a share of total state spending, and the simple correlation between expenditure shares on Medicaid and TANF spending, as shares of total state spending, is only 0.29. Thus, simple generalizations about state “generosity” toward welfare and Medicaid beneficiaries, based on this metric, are unlikely to withstand scrutiny.

As noted, intergovernmental transfers have played a critical role in the financing of Medicaid and cash welfare programs. In 2005, Medicaid matching rates³ were at the matching-rate floor of 50 percent in a dozen states, but exceeded 74 percent in West Virginia, New Mexico, Arkansas, and Mississippi (Table 1B, column 6). Prior to welfare reform, matching rates for AFDC exhibited similar variation among the states, but these matching rates all fell to zero after 1996. Given the large size and rapid growth of state Medicaid spending and given the high matching rates for this program, it is not surprising that federal transfers for Medicaid have become a major funding source for state governments. As a proportion of aggregate state government spending, Table 2A, column 2

³ We shall abuse terminology somewhat in speaking of “matching rates” when referring to the federal government share of state spending; thus, for instance, by “a matching rate of 75 percent (or 0.75),” we mean that the federal government pays 75 percent of each dollar of state expenditures—what in more “classical” usage might be called a “3 to 1 match.”

TABLE 1A
STATE GOVERNMENT TOTAL, MEDICAID, AND CASH WELFARE EXPENDITURES, 1990-2005, US AGGREGATE

(1) Year	(2) Total Expenditures millions of \$		(3) Medicaid Expenditures % of state total expenditures		(4) Cash Welfare Expenditures % of state total expenditures		(5) Medicaid Budget Share/ Cash Welfare Budget Share	
	millions of \$		millions of \$		millions of \$		millions of \$	
1990	572,318		72,187	12.61	18,906		3.30	3.82
1991	628,836		94,316	15.00	20,744		3.30	4.55
1992	701,601		120,157	17.13	21,915		3.12	5.48
1993	743,244		130,601	17.57	22,481		3.02	5.81
1994	779,459		143,807	18.45	22,582		2.90	6.37
1995	836,894		159,493	19.06	21,821		2.61	7.31
1996	859,599		159,655	18.57	20,208		2.35	7.90
1997	893,393		165,945	18.57	18,928		2.12	8.77
1998	930,037		177,281	19.06	21,881		2.35	8.10
1999	998,365		189,875	19.02	22,992		2.30	8.26
2000	1,084,097		206,083	19.01	24,624		2.27	8.37
2001	1,185,260		228,039	19.24	25,500		2.15	8.94
2002	1,282,852		258,216	20.13	25,205		1.96	10.24
2003	1,359,048		276,159	20.32	26,161		1.92	10.56
2004	1,406,175		296,281	21.07	25,653		1.82	11.55
2005	1,470,462		315,872	21.48	25,424		1.73	12.42

Data Sources: State total expenditures are from the U.S. Census Bureau State Government Finances Database, data on Medicaid expenditures are from the Centers for Medicaid and Medicare (CMS) Financial Management Reports (FMRs), and data on AFDC/TANF expenditures are from the U.S. Census Bureau Statistical Abstract of the United States and the U.S. Department of Health and Human Services Administration for Children & Families (ACF).

Figure 1. Annual Medicaid Expenditures as a Share of Annual State Total Expenditures

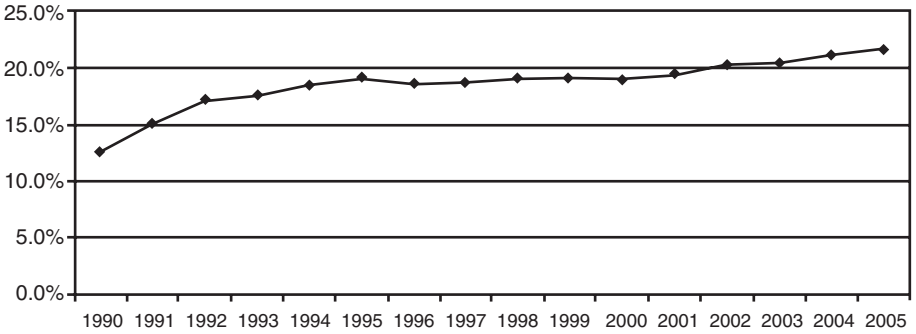


Figure 2. Annual Cash Welfare Expenditures as a Share of Annual State Total Expenditures

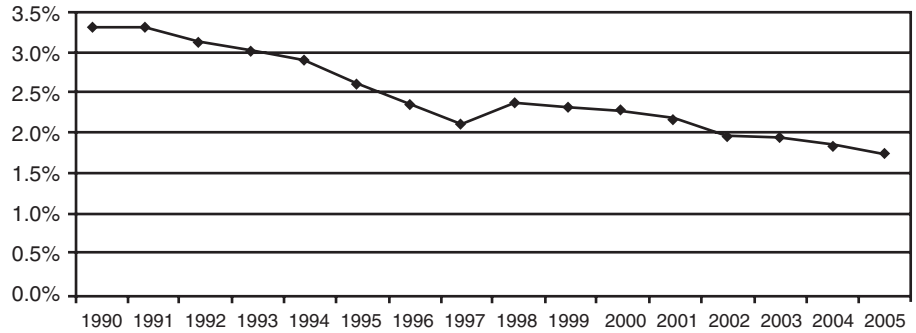


Figure 3. Ratio of the Annual State Medicaid Expenditure Share to the Annual State Cash Welfare Expenditure Share

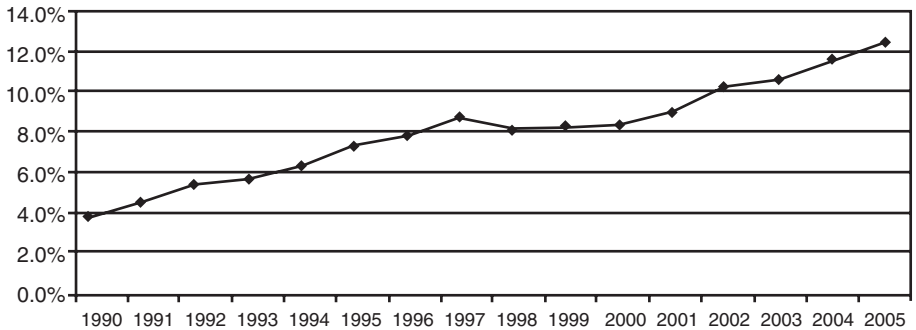


TABLE 1B
STATE GOVERNMENT TOTAL, MEDICAID, AND CASH WELFARE EXPENDITURES, 2005, BY STATE

(1) State	(2) Total Expenditures millions of \$	(3) Medicaid Expenditures		(4) Cash Welfare Expenditures		(5) Medicaid Budget Share/ Cash Welfare Budget Share	(6) Federal Medical Assistance Percentages (FMAP)
		millions of \$	% of state total expenditures	millions of \$	% of state total expenditures		
AL	21,047	3,925	18.65	123.38	0.59	31.81	70.83
AK	8,056	1,054	13.09	74.25	0.92	14.20	57.58
AZ	23,957	5,909	24.67	298.58	1.25	19.79	67.45
AR	13,634	2,920	21.42	66.63	0.49	43.83	74.75
CA	209,771	36,767	17.53	5,882.43	2.80	6.25	50.00
CO	18,770	2,917	15.54	213.74	1.14	13.65	50.00
CT	20,203	4,176	20.67	458.79	2.27	9.10	50.00
DE	5,904	923	15.64	61.31	1.04	15.06	50.38
FL	70,418	13,877	19.71	868.33	1.23	15.98	58.90
GA	33,807	7,741	22.90	520.07	1.54	14.88	60.44
HI	8,405	1,099	13.07	128.39	1.53	8.56	58.47
ID	6,137	1,072	17.46	39.78	0.65	26.94	70.62
IL	55,667	11,376	20.44	998.43	1.79	11.39	50.00
IN	26,452	5,480	20.72	306.73	1.16	17.87	62.78
IA	14,143	2,481	17.54	161.54	1.14	15.36	63.55
KS	11,765	2,091	17.77	154.30	1.31	13.55	61.01
KY	20,091	4,378	21.79	216.28	1.08	20.24	69.60
LA	21,402	5,475	25.58	186.38	0.87	29.38	71.04
ME	26,803	2,322	31.03	126.90	1.70	18.30	64.89
MD	38,025	7,485	20.27	348.94	1.30	15.57	50.00
MA	51,408	9,046	26.19	688.52	1.81	14.47	50.00
MI	30,169	5,847	19.38	1,175.29	2.29	7.70	56.71
MN	14,705	3,438	23.38	392.35	1.30	14.90	77.08
MS	23,147	6,828	29.50	78.87	0.54	43.59	61.15
MO	4,800	737	15.34	298.94	1.29	22.84	22.84
MT	7,273	1,471	20.22	43.92	0.91	16.77	71.90
NE	9,158	1,250	13.65	78.06	1.07	18.84	59.64
NV	5,784	1,302	22.51	69.95	0.76	17.87	55.90
NH	49,231	7,970	16.19	62.77	1.09	20.74	50.00
NJ	12,599	2,446	19.42	993.84	2.02	8.02	50.00
NM	136,786	44,052	32.20	127.40	1.01	19.20	74.30
NY	39,482	9,309	23.58	3,969.87	2.90	11.10	50.00
NC	3,491	530	15.18	447.86	1.13	20.79	63.63
ND	60,554	11,915	19.68	33.63	0.96	15.75	67.49
OH				990.07	1.64	12.03	59.68

OK	15,710	2,874	18.29	174.38	1.11	16.48	70.18
OR	19,217	3,063	15.94	268.82	1.40	11.39	61.12
PA	62,833	16,489	26.24	1,190.36	1.89	13.85	53.84
RI	6,754	1,754	25.97	168.05	2.49	10.44	55.38
SC	22,709	4,198	18.48	229.54	1.01	18.29	69.89
SD	3,262	633	19.40	30.40	0.93	20.82	66.03
TN	23,990	8,059	33.59	233.27	0.97	34.55	64.81
TX	81,369	17,927	22.03	850.59	1.05	21.08	60.87
UT	11,149	1,446	12.97	107.84	0.97	13.41	72.14
VT	4,436	918	20.70	67.50	1.52	13.60	60.11
VA	32,790	4,684	14.29	289.75	0.88	16.17	50.00
WA	33,059	6,206	18.77	524.96	1.59	11.82	50.00
WV	9,826	2,249	22.89	123.98	1.26	18.14	74.65
WI	28,828	4,956	17.19	445.94	1.55	11.11	58.32
WY	4,000	435	10.87	32.27	0.81	13.47	57.90

Data Sources: See Table 1A. State FMAPs are from the U.S. Department of Health and Human Services.

TABLE 2A
FEDERAL AND STATE GOVERNMENT MEDICAID AND CASH WELFARE EXPENDITURES, 1990-2005, US AGGREGATE

(1) Year	(2) Federal Spending on Medicaid		(3) Federal Spending on Cash Welfare		(4) State Spending on Medicaid		(5) State Spending on Cash Welfare	
	millions of \$	% of state total expenditures	millions of \$	% of state total expenditures	millions of \$	% of state total expenditures	millions of \$	% of state total expenditures
1990	40,913	7.15	10,330	1.80	31,274	5.46	8,576	1.50
1991	53,626	8.53	11,345	1.80	40,690	6.47	9,398	1.49
1992	68,960	9.83	12,074	1.72	51,197	7.30	9,842	1.40
1993	74,970	10.09	12,371	1.66	55,631	7.48	10,110	1.36
1994	82,257	10.55	12,376	1.59	61,550	7.90	10,206	1.31
1995	90,697	10.84	11,886	1.42	68,795	8.22	9,935	1.19
1996	90,719	10.55	10,939	1.27	68,936	8.02	9,270	1.08
1997	93,936	10.51	10,005	1.12	72,009	8.06	8,924	1.00
1998	100,119	10.77	11,273	1.21	77,162	8.30	10,608	1.14
1999	107,413	10.76	12,292	1.23	82,462	8.26	10,699	1.07
2000	116,894	10.78	13,302	1.23	89,189	8.23	11,321	1.04
2001	129,840	10.95	14,868	1.25	98,199	8.29	10,632	0.90
2002	146,643	11.43	14,456	1.13	111,573	8.70	10,750	0.84
2003	161,026	11.85	16,163	1.19	115,134	8.47	10,011	0.74
2004	174,988	12.44	14,301	1.02	121,293	8.63	11,352	0.81
2005	180,380	12.27	14,083	0.96	135,492	9.21	11,341	0.77

Data Sources: See Table 1A.

shows that Federal Medicaid grants have risen from about 7.15 percent in 1990 to over 12 percent in 2005. (By comparison, state individual income taxes and general sales each financed 15 percent of total state government expenditures in 2005.) Federal grants for cash welfare, on the other hand, have steadily declined in importance as state government funding sources. In 1990, AFDC grants were about 1.8 percent of total state spending, a figure that fell to only 0.96 percent by 2005 (column 3).

Table 2B, column 2 shows that Medicaid grants exceeded five percent of 2005 total expenditures in all states (Wyoming, at 6.38 percent, was the lowest), while these grants exceeded 20 percent of spending for two states, Maine (20.09 percent) and Tennessee (21.48 percent). TANF grants, by contrast, were comparatively insignificant, with amounts ranging from a minimum of 0.32 percent of total state expenditures in Arkansas to 1.44 percent in California and 1.47 percent in New York; aside from these last two, the corresponding figure was less than 1.4 percent in all other states (column 3).

Finally, it is interesting to note that intergovernmental transfers of all types increased from about 22 percent of state spending in 1990 to almost 28 percent in 2005; most of this increase occurred prior to 1993 and after 2003, with intergovernmental transfers remaining fairly steady as a share of state spending in the intermediate period, at about 25–26 percent (Table 3A, column 2). There is substantial interstate variation in this figure, however: in 2005, it ranged from a low of 19.57 percent (Vermont) to a high of 68.90 percent (Wyoming) (Table 3B, column 2). Table 3A, column 3 shows that Medicaid grants account for a rising proportion of fiscal transfers to the states, having increased from about 32 percent to over 44 percent of all intergovernmental grants between 1990 and 2005.

AFDC assistance accounted for about 8.18 percent of all Federal grants to the states in 1990, but this share has dwindled over time to less than 3.45 percent in 2005 (column 4). For Wyoming, Medicaid grants were only nine percent of all intergovernmental transfers in 2005, but more than 59 percent in Maine, Massachusetts, and Tennessee (Table 3B, column 3).

To summarize these observations, Medicaid spending has increased dramatically as a share of state government expenditures in the past two decades. It now constitutes a major expenditure item for all states, but there is, nonetheless, wide variation among the states. Medicaid grants from the federal government defray a large portion of Medicaid spending costs for every state, both on average and, because of matching provisions, at the margin: each dollar of Medicaid costs states at most \$0.50 and as little as \$0.24. These grants have become a mainstay of state government finances, though there is again wide interstate variation in this respect, and these grants now constitute one of the major elements in the system of federal fiscal support for the states. In all of these respects, cash welfare programs present a marked contrast. Federal support of state cash assistance to the poor long antedates state Medicaid programs (the Aid to Dependent Children program, a predecessor of AFDC and TANF, was first established during the Great Depression). For many years, AFDC spending by states was supported, as Medicaid has been since its inception, with open-ended matching grants, but these matching grants were replaced in 1996 with a system of block grants. Though spending on AFDC and Medicaid were approximately equal at Medicaid's inception, AFDC and now TANF expenditures have been declining as a share of state government spending and are now an order of magnitude smaller than Medicaid expenditures.

TABLE 2B
FEDERAL AND STATE GOVERNMENT MEDICAID AND CASH WELFARE EXPENDITURES, 2005, BY STATE

(1) State	(2) Federal Spending on Medicaid		(3) Federal Spending on Cash Welfare		(4) State Spending on Medicaid		(5) State Spending on Cash Welfare	
	millions of \$	% of state total expenditures	millions of \$	% of state total expenditures	millions of \$	% of state total expenditures	millions of \$	% of state total expenditures
AL	2,776	13.19	84	0.40	1,149	5.46	39	0.19
AK	679	8.43	33	0.42	375	4.66	41	0.51
AZ	4,057	16.94	200	0.84	1,852	7.73	98	0.41
AR	2,173	15.94	44	0.32	747	5.48	23	0.17
CA	18,677	8.90	3,015	1.44	18,090	8.62	2,868	1.37
CO	1,470	7.83	121	0.64	1,447	7.71	93	0.50
CT	2,099	10.39	240	1.19	2,077	10.28	219	1.08
DE	471	7.98	33	0.55	452	7.66	29	0.49
FL	8,153	11.58	500	0.71	5,724	8.13	369	0.52
GA	4,649	13.75	345	1.02	3,091	9.14	175	0.52
HI	644	7.66	56	0.67	455	5.41	72	0.86
ID	752	12.26	27	0.44	319	5.21	13	0.21
IL	5,725	10.28	568	1.02	5,650	10.15	430	0.77
IN	3,425	12.95	185	0.70	2,055	7.77	121	0.46
IA	1,581	11.18	100	0.70	900	6.36	62	0.44
KS	1,274	10.83	81	0.69	816	6.94	74	0.63
KY	3,039	15.13	144	0.72	1,340	6.67	72	0.36
LA	3,872	18.09	131	0.61	1,603	7.49	55	0.26
ME	1,504	20.09	89	1.19	819	10.94	38	0.50
MD	2,741	10.23	170	0.64	2,693	10.05	178	0.67
MA	5,011	13.18	330	0.87	4,949	13.02	359	0.94
MI	5,136	9.99	671	1.31	3,910	7.61	504	0.98
MIN	2,952	9.78	214	0.71	2,896	9.60	178	0.59
MS	2,633	17.91	57	0.39	805	5.48	22	0.15
MO	4,162	17.98	171	0.74	2,665	11.51	128	0.55
MT	533	11.09	28	0.59	204	4.25	16	0.33
NE	876	12.05	48	0.65	595	8.18	30	0.42
NV	707	7.72	43	0.47	543	5.93	27	0.30
NH	656	11.34	30	0.52	646	11.17	33	0.56
NJ	4,002	8.13	518	1.05	3,968	8.06	476	0.97
NM	1,820	14.45	92	0.73	626	4.97	35	0.28
NY	22,142	16.19	2,013	1.47	21,910	16.02	1,957	1.43
NC	5,913	14.98	251	0.64	3,396	8.60	196	0.50
ND	358	10.26	25	0.70	172	4.91	9	0.26

OH	7,107	11.74	596	0.98	4,808	7.94	394	0.65
OK	2,016	12.83	113	0.72	858	5.46	61	0.39
OR	1,882	9.79	177	0.92	1,181	6.14	92	0.48
PA	8,921	14.20	783	1.25	7,568	12.05	407	0.65
RI	973	14.40	82	1.21	781	11.57	86	1.28
SC	2,928	12.89	165	0.73	1,270	5.59	65	0.28
SD	431	13.21	22	0.67	202	6.19	9	0.26
TN	5,154	21.48	95	0.40	2,905	12.11	138	0.58
TX	10,908	13.41	482	0.59	7,018	8.63	369	0.45
UT	1,028	9.22	83	0.74	418	3.75	25	0.22
VT	551	12.42	35	0.78	367	8.28	33	0.74
VA	2,357	7.19	147	0.45	2,327	7.10	143	0.43
WA	3,155	9.54	267	0.81	3,051	9.23	258	0.78
WV	1,663	16.92	90	0.91	586	5.97	34	0.35
WI	2,900	10.06	266	0.92	2,057	7.13	180	0.62
WY	255	6.38	23	0.56	179	4.49	10	0.24

Data Sources: See Table 1A.

TABLE 3A
 FEDERAL GOVERNMENT MEDICAID AND CASH WELFARE EXPENDITURES:
 TOTALS AND SHARES OF INTERGOVERNMENTAL TRANSFERS TO STATES, 1990–2005,
 US AGGREGATE

(1) Year	(2) Intergovernmental Transfers to States		(3) Federal Spending on Medicaid		(4) Federal Spending on Cash Welfare	
	millions of \$	% of state total expenditures	millions of \$	% of IG transfers	millions of \$	% of IG transfers
1990	126,329	22.07	40,913	32.39	10,330	8.18
1991	143,534	22.83	53,626	37.36	11,345	7.90
1992	169,928	24.22	68,960	40.58	12,074	7.11
1993	188,256	25.33	74,970	39.82	12,371	6.57
1994	204,518	26.24	82,257	40.22	12,376	6.05
1995	215,558	25.76	90,697	42.08	11,886	5.51
1996	221,369	25.75	90,719	40.98	10,939	4.94
1997	230,859	25.84	93,936	40.69	10,005	4.33
1998	240,789	25.89	100,119	41.58	11,273	4.68
1999	253,692	25.41	107,413	42.34	12,292	4.85
2000	274,382	25.31	116,894	42.60	13,302	4.85
2001	305,621	25.79	129,840	42.48	14,868	4.86
2002	335,434	26.15	146,643	43.72	14,456	4.31
2003	361,617	26.61	161,026	44.53	16,163	4.47
2004	394,613	28.06	174,988	44.34	14,301	3.62
2005	408,456	27.78	180,380	44.16	14,083	3.45

Data Sources: See Table 1A. Intergovernmental transfer figures are from the U.S. Census Bureau State Government Finances Database.

MEDICAID SPENDING AND FEDERAL/ STATE POLICY INTERACTIONS

What can account for the observed growth of Medicaid spending and its variation among states? This basic question is of crucial importance both from the viewpoint of budgetary planning and forecasting and from the viewpoint of policy analysis. Changes in medical technology, the prices of pharmaceutical drugs, and other “supply” factors clearly affect the cost of health care and, thus, must be important expenditure determinants. Other factors clearly influence the “demand” side of health spending generally and Medicaid spending in particular. Since much health care spending occurs late in life, for instance, the age structure of the population is certain to be an important spending determinant. Medicaid benefits are means tested: eligibility for Medicaid depends on a potential beneficiary’s income and asset holdings. Thus, income variations among states or over time are likely to influence Medicaid spending. A number of other demand and

supply factors may plausibly be conjectured to influence Medicaid spending.

From the perspective of public finance, it is important to recognize that Medicaid is only one category of state government spending and that it competes with other types of spending for scarce budgetary resources. The determination of the size and composition of sub-national government budgets has often been analyzed using some variant of the median voter model, as pioneered by such authors as Bergstrom and Goodman (1973). These models are helpful in highlighting the effects of the fundamental budget constraints facing a jurisdiction’s residents and policymakers. In particular, household and government constraints depend on the incomes of state residents, but may be significantly affected by federal grants, tax policies, and regulations. The effects of past or prospective policy reforms can be studied by analyzing how they alter the constraints, incentives, and, ultimately, expenditure and tax policies chosen by policymakers.

TABLE 3B
 FEDERAL GOVERNMENT MEDICAID AND CASH WELFARE EXPENDITURES: TOTALS AND SHARES
 OF INTERGOVERNMENTAL TRANSFERS TO STATES, 2005, BY STATE

(1) State	(2) Intergovernmental Transfers to States		(3) Federal Spending on Medicaid		(4) Federal Spending on Cash Welfare	
	millions of \$	% of state total expenditures	millions of \$	% of IG transfers	millions of \$	% of IG transfers
AL	7,461	35.45	2,776	37.21	84	1.13
AK	2,317	28.76	679	29.31	33	1.44
AZ	7,566	31.58	4,057	53.63	200	2.65
AR	4,113	30.17	2,173	52.82	44	1.07
CA	51,163	24.39	18,677	36.50	3,015	5.89
CO	4,536	24.17	1,470	32.41	121	2.66
CT	4,013	19.86	2,099	52.31	240	5.98
DE	1,157	19.60	471	40.71	33	2.82
FL	18,288	25.97	8,153	44.58	500	2.73
GA	9,861	29.17	4,649	47.15	345	3.50
HI	1,786	21.25	644	36.05	56	3.15
ID	1,750	28.51	752	43.00	27	1.53
IL	13,895	24.96	5,725	41.20	568	4.09
IN	6,949	26.27	3,425	49.29	185	2.67
IA	4,104	29.02	1,581	38.51	100	2.43
KS	3,220	27.37	1,274	39.57	81	2.51
KY	5,840	29.07	3,039	52.03	144	2.47
LA	7,088	33.12	3,872	54.63	131	1.85
ME	2,529	33.79	1,504	59.46	89	3.53
MD	6,705	25.02	2,741	40.88	170	2.54
MA	8,423	22.15	5,011	59.49	330	3.91
MI	12,993	25.27	5,136	39.53	671	5.17
MN	6,575	21.79	2,952	44.90	214	3.26
MS	5,769	39.23	2,633	45.64	57	0.99
MO	7,904	34.15	4,162	52.66	171	2.16
MT	1,814	37.79	533	29.36	28	1.56
NE	2,503	34.41	876	35.01	48	1.90
NV	1,901	20.75	707	37.22	43	2.25
NH	1,739	30.07	656	37.73	30	1.74
NJ	10,258	20.84	4,002	39.01	518	5.04
NM	3,978	31.57	1,820	45.76	92	2.32
NY	47,757	34.91	22,142	46.36	2,013	4.22
NC	12,842	32.53	5,913	46.05	251	1.96
ND	1,205	34.51	358	29.74	25	2.04
OH	15,746	26.00	7,107	45.13	596	3.78
OK	4,909	31.25	2,016	41.07	113	2.31
OR	4,474	23.28	1,882	42.06	177	3.96
PA	16,656	26.51	8,921	53.56	783	4.70
RI	2,079	30.78	973	46.79	82	3.94
SC	7,180	31.62	2,928	40.77	165	2.30
SD	1,236	37.89	431	34.85	22	1.77
TN	8,646	36.04	5,154	59.61	95	1.10
TX	26,701	32.82	10,908	40.85	482	1.80
UT	2,962	26.56	1,028	34.72	83	2.80
VT	1,260	28.42	551	43.71	35	2.74
VA	6,418	19.57	2,357	36.73	147	2.29
WA	7,398	22.38	3,155	42.65	267	3.61
WV	3,339	33.98	1,663	49.80	90	2.68
WI	6,694	23.22	2,900	43.32	266	3.97
WY	2,756	68.90	255	9.26	23	0.82

Data Sources: See Table 3A.

We have already discussed the role of matching grants in Medicaid financing. However, Medicaid grants are subject to significant regulatory controls that affect the types of households and medical expenditures that are eligible for financial support. In order to limit Medicaid benefits to “poor” households, the federal government has generally required states to impose means tests based on income and assets (with some state discretion in the size of the asset limits). In addition, regulations have restricted eligibility based on age (for instance, some beneficiaries qualify by virtue of their participation in the federal Supplemental Security Income (SSI) program, which provides cash benefits to the elderly poor), participation in AFDC/ TANF, health status (e.g., disability) or other individual or household attributes. The regulatory structure of Medicaid has varied over time; as Gruber (2003) characterizes the evolution of Medicaid during the period 1987–2000, “[t]he pattern of legislative action ... was one of initial federal permission for states to expand their programs, followed within a period of several years by federal mandates to cover [various beneficiary] groups.”

Many of the determinants of Medicaid spending, such as the age structure of the population, the level and distribution of income, or the rate of technological progress in the health care sector, are only indirectly influenced by state or federal policies. From the viewpoint of potential policy reforms, the impact of Federal financing and regulatory policies on Medicaid spending are of particular interest because they may provide a much more direct mechanism through which to influence state government spending.

Several studies have shed considerable light on this issue.

As is reported in Chernick (2000), both Granneman and Pauly (1983) and Chernick (1999) attempt to estimate a matching rate (or own price) elasticity of demand for state Medicaid expenditures. Granneman and Pauly (1983) use data from 1977 to 1980 and find a matching rate elasticity of 0.78. Using a longer time series of data between 1983 and 1995, Chernick (1999) finds a matching rate elasticity of 0.65.⁴ In addition, Chernick (1999) reports a strong positive cross-price elasticity between cash benefits and Medicaid spending on AFDC recipients (who are categorically eligible for Medicaid). This cross-price effect is somewhat at odds with the finding presented in Kousser (2002) that states exercise more discretion over expenditures on optional Medicaid enrollees. Finally, Baicker (2001) analyzes the impact of mandated Medicaid expansions during the late 1980s and finds that states responded to these mandates by increasing Medicaid expenditures, while at the same time reducing other welfare expenditures by almost exactly the same amount.

In a recent theoretical analysis (Marton and Wildasin, 2007a), we build a stylized model to study how federal grant policies may affect state government spending on cash and health programs that benefit low-income households. In that model, state expenditures are financed either by state taxes on high-income residents or by grants from a higher-level government. High-income households are postulated to benefit from cash and in-kind transfers to poor residents because they value both the well-being (utility) of the poor and their health. In their preference structures, which are respected by poli-

⁴ Interestingly, Chernick (2000) surveys several studies that have attempted to estimate the matching rate (or own price) elasticity of demand for AFDC/TANF and concludes that “... the fiscal impact of matching grants for cash assistance is negligible, suggesting that even very deep price subsidies are incapable of eliciting an expansion in cash transfers to low income families.”

cymakers, state expenditures on cash and health benefits are partial but not perfect substitutes. Intergovernmental transfers for each program may take the form of matching or lump-sum grants. In contrast to lump-sum grants, matching grants lower the price of program expenditures to taxpayers.

This model can be used to examine the impact on state government expenditures of changes in matching grant rates, such as those brought about by the 1996 welfare reform. The analysis shows that a reduction in matching grant support for one program results in an "own price effect" that leads a state to reduce spending on that program, a standard result in the literature. It also shows, however, that a reduction in matching grant support for one program gives rise to a "cross price effect" that can influence spending on the other program as well. The magnitude of these cross-price effects depends on the degree of substitutability, in the preference structure of high-income households, between the health of the poor and their general welfare, as well as upon the substitutability, in the preference structure of low-income households, between health and other consumption. For instance, suppose that matching grant support for state cash welfare expenditures is cut. Intuitively, if both high- and low-income households view cash and health benefits as nearly perfect substitutes, a reduction in the matching rate for cash welfare will result in a large reduction in cash benefits, which are now relatively more costly, and a large increase in health benefits, which are now relatively cheaper and are "just as good" from the viewpoint of taxpayers and beneficiaries. By contrast, low substitutability in taxpayer and beneficiary preferences would reduce the magnitude of such "cross-program substitution."

This analysis shows how the effects of a change in matching grant support for state cash welfare programs need

not be confined to expenditures on those programs alone, but may "spill over" to programs that are "close substitutes" to cash welfare. By eliminating matching grants in support of state AFDC/TANF expenditures, the 1996 welfare reform increased the price to the states of providing cash welfare benefits to the poor, and by a large amount. In all states, the marginal cost of financing an additional dollar of cash welfare benefits rose by at least a factor of two and, for those states that previously had faced the most generous matching grant support, by a factor of four. Since Medicaid matching grant rates were unaffected by the welfare reform, the relative price of providing cash and health benefits also changed in the same proportion. For a state facing a matching grant rate of 0.75, for instance, the relative price of expenditures for cash welfare and health benefits, prior to welfare reform, was $0.25/0.25 = 1$, whereas after the welfare reform, this price changed to $1/0.025 = 4$. The substitution effect resulting from this change in relative price is equivalent to that which would be produced by a 75 percent reduction in the cost of all health care services, a very large relative price change over a short period of time. Relative price changes of this magnitude could be expected not only to reduce state government expenditures on cash welfare, but to increase expenditures on Medicaid, possibly substantially, if these programs are substitutable.

We have begun to examine this hypothesis in some ongoing empirical research (Marton and Wildasin, 2007b). As yet, we are only able to report some preliminary but suggestive findings. Our analysis begins by determining the prices that states face for their expenditures on cash welfare (AFDC/TANF) and Medicaid, as determined by the matching grant rates for each state, year, and program. We estimate the effects of these prices on the composition of state expenditures and, in particular,

on the share of each state's expenditures devoted to Medicaid and AFDC/TANF expenditures.⁵ The estimated own-price elasticities for these programs are generally negative and—of particular interest—the cross-price elasticities are generally positive, although the precise magnitudes of these estimates depend on the detailed specification of the model. By way of illustration, in one simple specification, we estimate that a one percentage point increase in the “price” of Medicaid spending results in a decrease of -0.16 percentage points in the share of state expenditures devoted to Medicaid, that is, a negative own-price elasticity, while a one percentage point increase in the “price” of cash welfare results in an increase of 0.06 percentage points in the share of the state expenditures devoted to Medicaid spending, that is, a positive cross-price elasticity.

To interpret the meaning of these estimates, note that the 1996 welfare reform raised the price of cash welfare expenditures by at least 50 percentage points for each state, and by as much as 75 percentage points for some, with a simple mean increase of about 60 percentage points. Given an estimated cross-price coefficient of 0.06 , this would lead to an estimated increase in the Medicaid share of state expenditures of about $0.06 \times 60 = 3.6$ percentage points. This estimate may be compared with the observed 1996–2005 increase in the Medicaid share of state expenditures from 18.6 percent to 19.5 percent, as reported in Table 1. We reiterate that our estimates are provisional.

Our preliminary results, if taken at face value, suggest that the 1996 welfare reform may have contributed to recent increases in Medicaid spending. However, they do not imply, and we do not suggest,

that the welfare reform is solely responsible for the changes in Medicaid spending in recent years. On the contrary, as our earlier discussion emphasizes, Medicaid spending depends on many factors, all of which should be presumed to play a role in the growth of expenditures over time. The potential spillover effects between cash welfare and Medicaid spending that we have identified are only one part of the extremely complex regulatory and fiscal interactions between the state and federal governments. Additionally, a host of other demographic, technological, political, and economic factors have played a large role in the evolution of Medicaid spending. This is a topic that warrants and will no doubt receive considerable attention in future research.

POLICY OPTIONS AND PROSPECTS

States continuously re-examine budgetary priorities in the face of changing circumstances. Medicaid is now such a large element in state budgets that large fiscal consequences will flow from continued growth or possible retrenchment. Furthermore, federal Medicaid assistance to the states has become a mainstay of state government finances. Significant changes in the level or type of assistance to the states offered through Medicaid would have potentially quite large impacts on the intergovernmental fiscal system. In this section, we discuss what Medicaid-related changes may be in store for state finances and intergovernmental transfers in the future.

Of course, predicting “turning points” in fiscal policy—moments when spending program or tax policies break with past practice and start on what appears in

⁵ In this preliminary analysis, we define expenditure shares using data on state total expenditures from the U.S. Census Bureau State Government Finances Database, data on Medicaid expenditures from the Centers for Medicaid and Medicare (CMS) Medicaid Statistical Information System (MSIS), and data on AFDC/TANF expenditures from the U.S. Census Bureau Statistical Abstract of the United States and the U.S. Department of Health and Human Services Administration for Children & Families (ACF).

retrospect to be significant new paths—is as difficult as predicting macroeconomic turning points, to which, incidentally, they may or may not be related. As McGuire and Merriman (2006) observe, cyclical shocks sometimes do, and sometimes do not, appear to affect different components of state fiscal policies. In fact, their analysis suggests that social welfare expenditures are, if anything, somewhat immune to cyclical shocks. To paraphrase Herbert Stein, however, unsustainable trends will not be sustained. Medicaid spending growth is bound to stop short of the point where it consumes 100 percent of state budgets. This simple observation is worth bearing in mind as we discuss some of the demographic trends that are relevant for Medicaid. Growing incentives for fiscal adjustment are likely to bring about one or more of several possible significant changes in Medicaid policy and, thus, in state finances, the intergovernmental fiscal system, and the nation's health care system.

Demographics

The elderly account for a very large share of all medical expenditures and a very large share of current Medicaid spending in particular. As noted in the Economic Report of the President (White House, 2007, p. 95), “the elderly and disabled covered by Medicare account for about one-quarter of Medicaid enrollees, but they account for about two-thirds of Medicaid spending,” an observation that also highlights the fact that a large portion of health care spending for the elderly is presently allocated through the Medicaid program rather than through Medicare. In 2003, Medicaid payments for aged beneficiaries were approximately \$13,677, compared to an average of \$4,487 for all beneficiaries, and only \$1,606 for children (CMS, 2006). The national old-age dependency ratio (the number of working-age

persons (age 15–64 years) per older person (65 years or older)) is expected to rise from its current value of 0.20 to 0.31 by 2025, 0.38 by 2050, and 0.41 by 2075 (Board of Trustees of the Federal OASDI Trust Funds, 2006, p. 78). A 50 percent increase in the relative size of the aged population by 2025 and a doubling by 2075 portend rapid and large increases in the demand for health care and corresponding upward pressure on Medicaid spending, at least in the absence of significant reforms.

As important as the total size of the elderly population is its distribution among the states. As of 2005, the old-age dependency ratio varied from a low in Alaska of 0.10 to a high of 0.28 in Florida. According to Census estimates, this ratio is expected to range from 0.22 (Utah) to 0.44 (Florida) in 2025, having increased in all states (U.S. Census Bureau, 2007). At that time, the dependency ratio is expected to be lower than Florida's 2005 value of 0.28 in ten states (Alaska among them), but to exceed 0.40 in seven states. The projected rate of increase varies from less than 50 percent in six states to more than 90 percent in five states (and more than 100 percent in three). State Medicaid budgets are, thus, likely to be affected quite unevenly by population aging.

Immigration, an important determinant of population size and composition, can have significant impacts on state (and federal) expenditures and revenues. The rate of immigration is expected to be almost as large as the rate of natural increase of the population in coming decades (see, e.g., OASDI Trustees (2006, p. 76)), and the foreign-born population will rise well beyond the current 12.4 percent share of the US population. Immigration impacts differ dramatically by state: the population share of the foreign born ranges from less than five percent in 20 states to a high of 27.2 percent in California (U.S. Census

Bureau, 2005a).⁶ On average, recent immigrants are relatively young and have high fertility rates, dampening the shift toward an older age structure in the national population. On the other hand, many immigrants are poorly educated and have low earnings; these immigrants are disproportionately low contributors to state and federal fiscal systems and impose significant fiscal burdens, illustrated by the fact that about 18 percent of participants in the Food Stamp, AFDC/TANF, and Medicaid programs are non-natives.⁷ The Deficit Reduction Act of 2005 attempts to address this issue by holding states responsible, for the first time, for Medicaid expenditures for individuals who claim to be US citizens but are unable to provide documentation supporting their citizenship and identity.

International migration in the US is dwarfed in magnitude by internal migration. Between 1995 and 2000, about 20 percent of the US population—both elderly and young—moved from one state to another. High lifetime mobility explains the fact that only 60 percent of the US population resided in their state of birth in 2000—a figure that was under 40 percent for five states (Nevada was lowest, at 21.3 percent, followed by Florida, at 32.7 percent) but that exceeded 75 percent in three states (Louisiana was the highest, at 79.4 percent) (U.S. Census Bureau, 2005b). Since many of those who still reside in their states of birth are young, the probability that an individual will remain in his/her state of birth over the entire life cycle must be well below 0.5.

Internal migration is a major factor behind the present uneven interstate distribution of the population by age,

and state fiscal treatment of the old can potentially alter the evolution of this distribution over time. Whether or not some states emerge as “Medicaid magnets,” the provision of health benefits for the elderly may well have significant impacts on the locational choices of those at or near retirement (Conway and Houtenville, 2001), impacts that state policymakers have incentives to take into account.

In summary, the states do now and are expected in the future to vary widely along demographic dimensions that are important for health care and, more particularly, for state government Medicaid spending. In the absence of policy reforms, immigration and the aging of the population are likely to impose rapidly increasing health care costs on state governments, but the distribution of these among the states will be far from uniform. In the third subsection of this section, we return to some of the potential fiscal implications of interstate migration.

Intergovernmental Coordination of Health Policy for the Old and the Young: Medicare Part D and SCHIP

The provision of Medicaid assistance to the states is only one aspect of the Federal government’s involvement in the nation’s health care system, and is by no means the largest in budgetary terms. The federal government spent \$330 billion in 2006 to provide benefits for more than 42 million Medicare beneficiaries, accounting for about 12 percent of the federal budget, as compared to federal Medicaid spending of \$191 billion (White House, 2007, p. 86). For many elderly and disabled beneficiaries, health care costs are divided

⁶ Borjas (2004) analyzes changes in the distribution patterns of immigrants across states and finds that in the 1990s there was a shift in the distribution of immigrants away from traditional immigrant-receiving states (mainly California) and toward other parts of the county, mainly the South.

⁷ We are grateful to C. Bollinger (private communication) for providing these figures. See Wildasin (2006a, 2006b) for further discussion of the fiscal impacts of migration and immigration. This is an issue of global importance, as all developed nations grapple simultaneously with aging populations and rising immigration, especially from less-developed countries.

between these two programs, and changes in Medicare policy inevitably interact with the Medicaid system.

These interactions are illustrated by the recent expansion of federal government responsibility for the costs of prescription drugs through Medicare Part D. This reform has potentially far-reaching implications for Medicaid, which has experienced rapid growth in prescription drug expenditures in recent years. For the aged, Medicaid drug costs per beneficiary doubled in real terms between 1996 and 2003, from \$1,256 (\$2003 dollars) in 1996 to \$2,514 in 2003, accounting for 12.0 percent of Medicaid spending per aged beneficiary in 1996, but rising to 18.4 percent by 2003 (CMS, 2006). The new Medicare benefit may relieve the states of some of this burden, as elderly beneficiaries obtain coverage from Medicare Part D instead of Medicaid.⁸ The states are still in the initial stages of adapting to this new Medicare program, but the potential expenditure impact on the states is substantial, particularly over a horizon of one or two decades, as compared with the trajectory that might otherwise occur given the rapid aging of the population. It should be noted, however, that the states are not relieved of the entire burden of pharmaceutical costs for their “dually eligible” aged Medicaid populations, as a substantial portion of their potential cost savings reverts to the federal government through so-called “clawback” provisions (see Schneider (2004), Kaiser Commission on Medicaid and the Uninsured (2005, 2006)). The size of the clawback is scheduled to decline over time, but states will still bear sig-

nificant portions of the pharmaceutical costs for their “dually eligible” elderly Medicaid populations, reducing the size of the net fiscal transfer from the federal government to the states resulting from the introduction of Medicare Part D.

The prescription drug benefit is only one of many ways in which federal health care policy interacts with the Medicaid system. More generally, by assuming major responsibility for the costs of health care for the elderly through Medicare, the federal government protects state governments from the fiscal disparities that would otherwise arise from the uneven interstate distribution of the elderly described in the first subsection of this section. Medicaid expenditures by the states nevertheless continue to cover much of the cost of financing health care for the aged, particularly the costs associated with nursing and other long-term care. The introduction of Medicare Part D represents a partial shift of some age-related health costs from the states to the federal government. Whether future reforms will continue or reverse this trend remains to be seen.

The evolution of and the current reauthorization debate surrounding the State Children’s Health Insurance Program (SCHIP) also illustrates the importance of federal-state health care policy interactions. SCHIP was created by the Balanced Budget Act of 1997 under Title XXI of the Social Security Act. The purpose of the program is to expand health coverage for low-income, uninsured children who are not income eligible for Medicaid.

⁸ In the Centers for Medicare and Medicaid Services publication *Medicare & You 2007*, Medicare recipients are informed that if they receive full drug coverage from their state Medicaid program and are eligible for Medicare, then Medicare will automatically enroll them in Medicare prescription drug coverage if they have not already chosen to do so (p. 49). Therefore, Medicare, not Medicaid, will provide their drug coverage. Placing the primary financial burden of dually eligible recipients on the Medicare program is not unusual. States often pay the Medicare Part B premium on behalf of their dually eligible citizens so that Medicare, rather than the state Medicaid program, becomes the primary insurer of physician services. According to Phelps (1997, p. 453), states covered the part B premium for 75 percent of their dually eligible elderly citizens and 20 percent of their dually eligible permanently disabled citizens.

The structure and the financing of the SCHIP program were no doubt influenced by the political climate during which it was created. Like TANF, SCHIP provides states a great deal of flexibility in terms of the generosity and structure of their programs. States were able to choose whether or not to create a new program to cover children, expand their existing Medicaid program, or some combination of the two.⁹ In order to give states a financial incentive to take advantage of this new program, the federal government offered states matching rates on SCHIP expenditures that are more generous than the standard Medicaid matching rates. Unlike the Medicaid program, federal funds allocated to each state for their SCHIP program are capped annually, though states can roll over any unused balances into the future.¹⁰

As SCHIP moves toward its 10-year anniversary, it is coming up for reauthorization. Many states have balanced their SCHIP budget in recent years by using unspent funding from previous years, but are now exhausting these funds and face the full cost of additional expenditures. Some states are adjusting by freezing SCHIP enrollments or are considering the scaling back of income eligibility thresholds. States are lobbying for increased support from the federal government under the reauthorization in the form of more generous annual allotments. In an effort to control costs, the Bush administration has proposed holding the allotments at their current levels and restricting some of the program's flexibility by limiting coverage to children in families with income up to 200 percent of the Federal Poverty Level

(FPL).¹¹ The resolution of this debate may provide insight into the sorts of issues that could arise should Medicaid financing be reformed in a similar way.¹²

Medicaid Reform and the "Assignment Problem"

In this subsection, we consider the potential for Medicaid reform from a federalism perspective, recognizing that both the federal and state governments face pressures for reform that will surely increase over time. Any major reform of Medicaid is likely to redraw the boundaries of federal and state responsibilities for health care. In the literature of federalism, the division of responsibilities among different levels of government is known as the "assignment problem" (see, e.g., Oates (1972)). A persistent theme in this literature suggests that responsibility for redistributive policy belongs at the national level. On the other hand, sub-national governments should play a prominent role in the provision of public goods for which the benefits and costs vary in accordance with local conditions about which these governments are better informed. Intergovernmental transfers from higher- to lower-level governments are often seen either as a form of generalized fiscal assistance or as a means by which the higher-level government can influence the allocative decisions of recipient governments, especially to take spillover effects into account. The evolution of policy responsibilities in a federation can be viewed as a reflection of a shifting balance among these sometimes conflicting considerations.

⁹ Some policymakers were initially concerned that such state flexibility may give rise to "substandard" care. Today others are concerned that states have pushed this flexibility "too far" by increasing the income eligibility ceiling too high in their state or enrolling parents as a means to attract more children to their program.

¹⁰ A state's annual allocation is a function of the number of children in families with incomes below 200 percent of the Federal Poverty Level and the number of uninsured children in families with income below 200 percent of the Federal Poverty Level.

¹¹ Some states have used the flexibility afforded to them under SCHIP to enroll parents as well as children and/or extend the income eligibility ceiling above 200 percent FPL.

¹² For more on SCHIP reauthorization, see Kenney and Yee (2007).

In the US, the federal government does assume a leading role in financing cash and in-kind redistributive transfers. For the elderly, the Social Security system and Medicare, both entirely federal programs, are the two major sources of cash and health care benefits. Other federal-only policies provide cash or near-cash benefits targeted at the poor, including the Supplemental Security Income (SSI) and Food Stamp programs and the Earned Income Tax Credit (EITC).¹³ The budgetary costs of these programs fall on the federal government, either through increased outlays or through foregone tax revenues (tax expenditures). However, as exemplified by Medicaid, AFDC/TANF, and the State Children's Health Insurance Program (SCHIP), redistributive policy in the US federation has long involved the state governments as well, although in ever-changing proportions.¹⁴ The recent introduction of prescription drug benefits in Medicare Part D is one more step in this evolution, a partial "upward reassignment" that consolidates more of the responsibility for health care for the elderly in the hands of the federal government.

The timing and nature of future major reforms of Medicaid, of related health programs such as Medicare, or of related cash or in-kind programs of assistance to the poor such as TANF, SSI, Food Stamps, or the EITC, cannot be known. However, the federal government is entering a multi-decade period of fiscal stress, driven largely by the demographic trends discussed earlier.¹⁵ There will be strong incentives to limit expenditure growth

under these conditions, and the amount and form of federal Medicaid assistance to the states is certain to face close scrutiny. Because federal grant support for AFDC and Medicaid were so similar in structure prior to the 1996 welfare reform, and because this reform was followed by significant reductions in welfare expenditures, a similar reform of federal Medicaid assistance to the states is one policy option that will surely attract attention. Indeed, as discussed by Lambrew (2005), Medicaid reforms of this type have previously been proposed, by President Reagan in 1981, Speaker of the House Newt Gingrich in 1995, and President Bush in 2003.

In hindsight, the fact that a number of states had applied for and received AFDC administrative waivers prior to 1996, enabling them to experiment with significant welfare reforms, was an early indicator of major changes to come. Indeed, some of those experiments served as models for the 1996 reform. Grogger and Karoly (2005) provide a detailed discussion of these waivers and point out that at the time of the 1996 reform, waivers had been approved for more than 40 states. The 1996 welfare reform codified this trend toward increased policy autonomy for all states, contributing to significant changes in welfare administration in many states that continues today. Coupled with a shift toward lump-sum grants, the 1996 reform effectively resulted in a significant "downward reassignment" of regulatory and "financial responsibility at the margin" for cash welfare benefits for the poor. This reassignment allows the

¹³ Some states choose to supplement the Federal SSI and EITC programs with programs of their own.

¹⁴ Prior to the Great Depression, cash assistance to the poor was mainly a state and local function. Indeed, the tradition of local involvement in assistance to the poor goes back much further, as described, for instance, in Brown and Oates (1987). Wallis (1984) discusses the beginnings of federal government participation in poverty relief during the Depression. Aid to Dependent Children, the forerunner of AFDC and finally TANF, began at this time.

¹⁵ Unfunded liabilities for Social Security and Medicare over a 75-year horizon are estimated to be more than \$15 trillion of current GDP, larger than the current federal debt of \$8.8 trillion. See Board of Trustees of the federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2006, p. 61) and Board of Trustees of the Federal OASDI Trust Funds (2006, p. 56).

states to adapt policy to local conditions, even as it shifts an important element of redistributive policy away from the national government.¹⁶

Whether an early indicator of major Medicaid reform or not, a number of states have recently been granted waivers enabling them to alter their Medicaid systems, showing that policy experimentation continues in the “laboratory of the states.” The National Conference of State Legislatures (2007) provides information on recently approved “1115” Medicaid waivers in 11 states, as well as proposals being circulated in ten other states. In Kentucky, for example, CMS recently approved the “KYHealth Choices” waiver, which restructures the standard Medicaid benefit package into four distinct plans tailored towards different types of enrollees (the general population, children, elderly, and beneficiaries with disabilities or mental retardation) and increases cost sharing for enrollees on an income-based sliding fee scale.¹⁷

Reforms being implemented or considered in other states include making risk-adjusted premiums available to enrollees to purchase private insurance plans (Florida and South Carolina) and the provision of personal health savings accounts (multiple states) to purchase health-related products and services. Some states (Vermont and Georgia) have even proposed conversion of their federal matching grant to a block grant (thus providing more cost certainty to the federal government) in return for greater state control of the administration and

structure of their programs.¹⁸ The fact that state Medicaid waiver proposals differ widely may be an indication that local benefit and cost conditions do vary from one state to another and that there may be efficiency gains from decentralization of Medicaid policy.

A reform of Medicaid financing that (like the 1996 welfare reform) replaces the current system of open-ended matching grants with lump-sum grants similar to those introduced under TANF, coupled with further regulatory liberalization, would result in a substantial “downward reassignment” of responsibility for the provision of health care for the poor. By raising the cost of Medicaid spending by at least a factor of two for all states, and much more than this for some, such a reform would create powerful new incentives for states to limit Medicaid expenditures on the poor.

To conclude, we note that there remain two potential sources of significant fiscal externalities associated with state government spending on health care for the non-elderly poor. Both are related to the fact that health care costs are concentrated near the end of life and to the high lifetime mobility of the US population. Some health care expenditures for the young, including children, produce benefits throughout life. The high mobility of the US population implies that a substantial share of the later-in-life benefits of health care costs incurred on behalf of a state’s younger residents will accrue to future residents of other states, that is, a large portion of the long-term benefits of health care spending spill across state boundaries. This

¹⁶ Some states have used the flexibility afforded by TANF to decentralize important aspects of welfare policy to local governments, a “second generation devolution” of the welfare system. See Fording (forthcoming) for discussion of Florida’s post-TANF decentralization of many aspects of TANF implementation to county-level bodies. Florida now contracts out significant welfare-administration tasks to private-sector firms. Interstate variation in TANF policy presumably reflects local benefit and cost variations.

¹⁷ Kenney, Allison, Costich, Marton, and McFeeters (2007) and Marton (2007) examine the impact of increased cost sharing in public insurance programs.

¹⁸ Vermont received federal approval for its proposal and was scheduled to begin a five-year demonstration of this new financing arrangement in 2006.

is a “horizontal” fiscal externality.¹⁹ In a federal system in which the federal government bears a large share of the cost of health for the elderly, there are also “vertical” fiscal externalities associated with state-level medical interventions for the young. Such interventions—programs for children or younger adults that preserve cardiovascular fitness, for instance—can reduce federal government health care costs in later years.²⁰

To our knowledge, these horizontal and fiscal externalities have not previously been studied, but they appear to warrant further investigation. If they give rise to significant horizontal or vertical spillovers, complete decentralization of the responsibility for the health care costs of the non-elderly poor may result in inefficiently low state government health-related spending (including expenditures for non-medical preventive programs). Matching grants might be used to “internalize” these externalities, the magnitudes of which would depend upon the effect of early-in-life state government health interventions on subsequent health care costs covered by the federal and other state governments. More precisely, the external benefit from a particular health intervention could be estimated by calculating the present value of future health care cost savings at the federal level and for other state governments. The latter amount would depend on the estimated probability of interstate migration which, as noted above, certainly exceeds 0.5 over the life cycle. Creating fiscal incentives for state governments to take these spillover effects into account could encourage them to direct their health-related spending in ways that benefit the broader society. There is little reason to presume that the current system of match-

ing grants, with matching rates inversely dependent on per-capita income, internalize these spillovers effectively. Furthermore, spillover effects are greatest for early-in-life interventions that produce later-in-life health benefits, a fact that should be reflected in a well-designed system of fiscal incentives to internalize these external effects.

CONCLUSION

Due to its rapid growth in recent years, Medicaid has become one of the major components of state government budgets. Perhaps ominously, there is little prospect that spending pressures will diminish in the foreseeable future. On the contrary, powerful demographic forces are likely to stimulate demand for still higher Medicaid expenditures. Continued growth in a program that already accounts for a large share of state government spending may impose significant stress on state fiscal systems. It is true that the current system of matching grants relieves states from much of the financial burden that Medicaid spending would otherwise impose; these costs are instead absorbed by the federal government. But this cost shifting may stimulate federal interest in policy reforms that limit future expenditure growth.

Major Medicaid reforms are likely to involve some change in the intergovernmental fiscal and regulatory relations that now underpin the program. Already, many states are seeking waivers that allow them to experiment with programmatic modifications. Similar developments preceded the welfare reform of 1996, which, as we have emphasized, led to a fundamental restructuring of federal government financial support

¹⁹ A parallel may exist in the state funding of higher education for the young. See Bound, Groen, Kezdi, and Turner (2004) for further discussion.

²⁰ Obesity, substance abuse, and other behavior-dependent disease risk factors are attracting new attention to “TLC” (therapeutic lifestyle change) interventions. Ideally, many of these interventions would begin early in life.

for, and oversight of, the system of cash welfare benefits provided to the poor. Parallel reforms for Medicaid have been proposed. Such reforms have potentially far-reaching effects on sub-national governments. Our earlier theoretical analysis highlights the possibility that the welfare reform may have encouraged states to shift their redistributive transfers to the poor toward health care benefits and away from cash welfare, and our preliminary empirical research finds some tentative support for this hypothesis. A major reform of Medicaid—which, by now, is of far greater budgetary importance to the states than AFDC/TANF spending ever was—would affect all aspects of state government finances. Prospective policy reforms could profit from additional analytical effort devoted to understanding what some of these effects might be.

Determining the appropriate roles of the state and federal governments in health care policy is a difficult and complex task. We have identified some but certainly not all of the issues that need to be taken into account in determining what each level of government is best able to do and how their policies should be mutually adapted. Students of fiscal federalism and of health policy alike can and should contribute much to ongoing and future policy debates regarding Medicaid and the broader health care policy issues facing the nation.

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