# SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: SM 2084

SPONSOR: Senator Pruitt

SUBJECT: Urging Congress to Change the Existing Formula for Distribution of Medicaid Funds

DATE: March 5, 2004 REVISED: _____ _____ _____ _____

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Parham | Wilson | HC | Favorable |
| 2. | | | RC | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## I. Summary:

This memorial urges the United States Congress to change the existing formula for distribution of Federal Medicaid program funding to the states from one that uses per capita income as a key indicator of the state's ability to fund medical services for the impoverished, to one based on total taxable resources and the poverty rate. The whereas clauses of the memorial express legislative findings. Copies of the memorial are to be dispatched to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida delegation to Congress.

## II. Present Situation:

**Medicaid**

Medicaid is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Medicaid is the largest program providing medical and health-related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some services, such as nursing home care and home health care, are mandatory services that must be covered in any state that participates in the Medicaid program. Other services, such as personal care, are optional. A state may choose to include optional services in its state Medicaid plan, but such services must be offered to all individuals statewide who meet Medicaid eligibility criteria. Individuals who are elderly or disabled, whose incomes are at or below 88 percent of FPL are an optional coverage group eligible for Medicaid under s. 409.904(1), F.S. Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S.

In 2002, Medicaid purchased medical and long-term care services for more than 50 million low-income children, their parents, people with disabilities, and seniors. It is the largest health care program in every state, averaging 16 percent of all state spending. Medicaid insures one-fifth of the nation's children, purchases about half the nation's nursing home care, and pays for more than half of all the costs of AIDS treatment.

Medicaid is estimated to serve 38 million children and parents in low-income families in 2004, according to the U.S. Congressional Budget Office. Additionally, Medicaid will provide care to 13 million seniors and individuals with disabilities, including 6 million Medicare beneficiaries dually eligible for Medicare and Medicaid. Nationally, Medicaid insured about 9 percent of all Americans in 2002.[1]

**Medicaid Financing**

Medicaid is an entitlement program, and is financed with both federal and state funds. In Florida, the counties contribute to the state's share of Medicaid costs. The federal government pays its share of the program through matching payments, which pay for more than half of all Medicaid spending.

The federal Medicaid matching rate is governed by a formula written in the Social Security Act, the federal law that governs the Medicaid program. The federal government matches each state's Medicaid spending at a set rate that varies by state. This rate is called the Federal Medical Assistance Percentage, or FMAP. Under this formula, a state's federal Medicaid matching rate is based on the ratio of its per capita income (PCI), squared, to the average PCI of all states, squared. States with PCIs above the national average receive a lower federal matching percentage; states with PCIs below the national average receive higher matching percentages. A state with an average PCI will have an FMAP of 55 percent. The effect of the square is to increase the range of the matching percentages. The function of the formula is restricted by two other statutory provisions: a minimum of 5 percent and a maximum of 83 percent. Congress temporarily increased these matching rates by nearly three percent in 2003 as part of a package providing fiscal relief to the states.

The FMAP produced by this formula applies to a state's spending for almost all Medicaid covered services and almost all Medicaid beneficiaries. However, Congress has established higher FMAPs for selected services and populations under the Medicaid program. For example,

[1] Kaiser Family Foundation. 2004. Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity.

for family planning services and supplies, each state's costs are matched at 90 percent, regardless of its normal FMAP. Similarly, to encourage states to take up the option of covering uninsured women who need treatment for breast or cervical cancer, the costs of treatment for these women are matched at the same enhanced FMAP that the state receives under the State Children's Health Insurance Program.

The Department of Health and Human Services (HHS) is responsible for calculating matching rates under the formula. HHS is required to calculate matching rates 1 year before the fiscal year in which they are effective, using a 3-year average of the most recently available PCI data reported by the Department of Commerce. Thus, fiscal year 2003 matching rates were calculated at the beginning of fiscal year 2002 using a 3-year average of PCI for 1998 through 2000. Publicizing matching rates a year in advance of their use allows states time to make program changes in response to changes in the rate at which the federal government will reimburse eligible program costs. However, the combination of a 1-year lag between the computation of state matching rates and their implementation, joined with the fact that a 3-year average of PCI is used, also means that the distribution of states' matching rates reflects economic conditions that existed several years earlier.

Many concerns have been raised with regard to the adequacy of the FMAP formula. The formula has been criticized because it does not take sufficient account of the proportion of states' populations that live in poverty or of the variation in taxable resources from state to state. Some have expressed concerns that the matching formula essentially redistributes wealth from wealthier states to poorer ones; others think it should be more redistributive, not less distributive. The formula has also been criticized because it does not provide additional incentives to states that provide more coverage.

**US General Accounting Office (GAO) Report**

The GAO report[2] on the FMAP found that the Medicaid formula narrows the average difference in states' funding ability by 20 percent but often widens the gap between individual states and the national FMAP average. Although the receipt of federal matching funds shifts 30 states closer to the national average, making the average difference in funding provided smaller, it also shifts 21 states farther away from the average, widening the average difference in funding. These 21 states include 3 that are among the states with the largest populations in poverty—California, Florida, and New York. After federal matching aid is added, states' funding ability ranges from 26 percent below the national average to 179 percent above the average.

Because of the formula's current structure, in many instances, two states allocating similar proportions of their own funding resources to Medicaid can spend very different amounts per person in poverty. For example, in fiscal year 2000, Wisconsin and California allocated the same proportion of their states' own resources to fund their Medicaid programs (about $8 per $1,000 of total taxable resources). Yet, after receiving federal matching funds, Wisconsin's funding ability was almost 50 percent above the national average and California's was 26 percent below the national average. Because the current Medicaid matching formula does not reflect the fact

[2] U.S. General Accounting Office. 2003. *Differences in Funding Ability among States Often are Widened*.

that Wisconsin has fewer people in poverty and has lower costs to provide health care services to its population in poverty than California, Wisconsin's federal matching rate enables it to spend more than twice what California could spend per person in poverty—$7,532 compared with $3,731.

## III. Effect of Proposed Changes:

The memorial expresses legislative findings that:

- Florida is the fourth most populous state, with 16.4 million residents; more than 2 million Floridians live in poverty and approximately 2.8 million Floridians have no health insurance;
- It is a moral incumbency that every Floridian have access to quality, affordable health care;
- Impoverished Floridians have more difficulty securing quality, affordable health care, especially if they are uninsured;
- Florida participates in the Federal Government's Medicaid program to support those impoverished citizens and ensure their access to health care;
- When Medicaid was created in 1965, one of its purposes was to reduce the differences among the states regarding their respective abilities to fund medical services for the impoverished;
- Federal funds for Medicaid are distributed to the states based on a funding formula that uses PCI as a key indicator of a state's ability to support its impoverished population, and numerous reports from GAO dating back to the early 1980s demonstrate that PCI is a poor indicator of a state's funding ability;
- The use of PCI assumes that states with lower PCIs have higher rates of poverty, which is a false assumption based on data from the US 2000 Census;
- The funding formula does not account for states' respective populations in poverty, the wealth distribution of larger states, or the costs to serve Medicaid populations in respective states, and the use of PCI in the funding formula fails to accurately reflect the needs of the more populous states;
- The use of a state's total taxable resources in the formula, as recommended by GAO, would result in Florida receiving hundreds of millions of dollars more in federal funds, which amounts to its fair share;
- According to the 2002 financial data of the Agency for Health Care Administration, uncompensated care in Florida's hospitals is growing at the rate of 12 to 13 percent per year; Medicaid caseloads grew almost 7 percent in the last fiscal year, and the costs of the Medicaid program continue to grow at an alarming rate; and
- Because of the poor reimbursement rates offered to Florida's physicians due to the disparity created by the funding formula, many doctors have limited their provision of services for Medicaid patients and some have stopped treating Medicaid patients altogether, and this decline in the number of physicians who will treat Medicaid patients threatens the quality and availability of health care to impoverished Floridians.

This memorial urges the United States Congress to change the existing formula for distribution of Federal Medicaid program funding to the states from one that uses per capita income as a key

indicator of the state's ability to fund medical services for the impoverished, to one based on total taxable resources and the poverty rate.

The Legislature of the State of Florida resolves that a copy of this memorial be delivered to the President of the United States, the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the Congress of the United States.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings under the requirements of Article I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, s. 19(f) of the Florida Constitution.

## V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Amendments:

None.