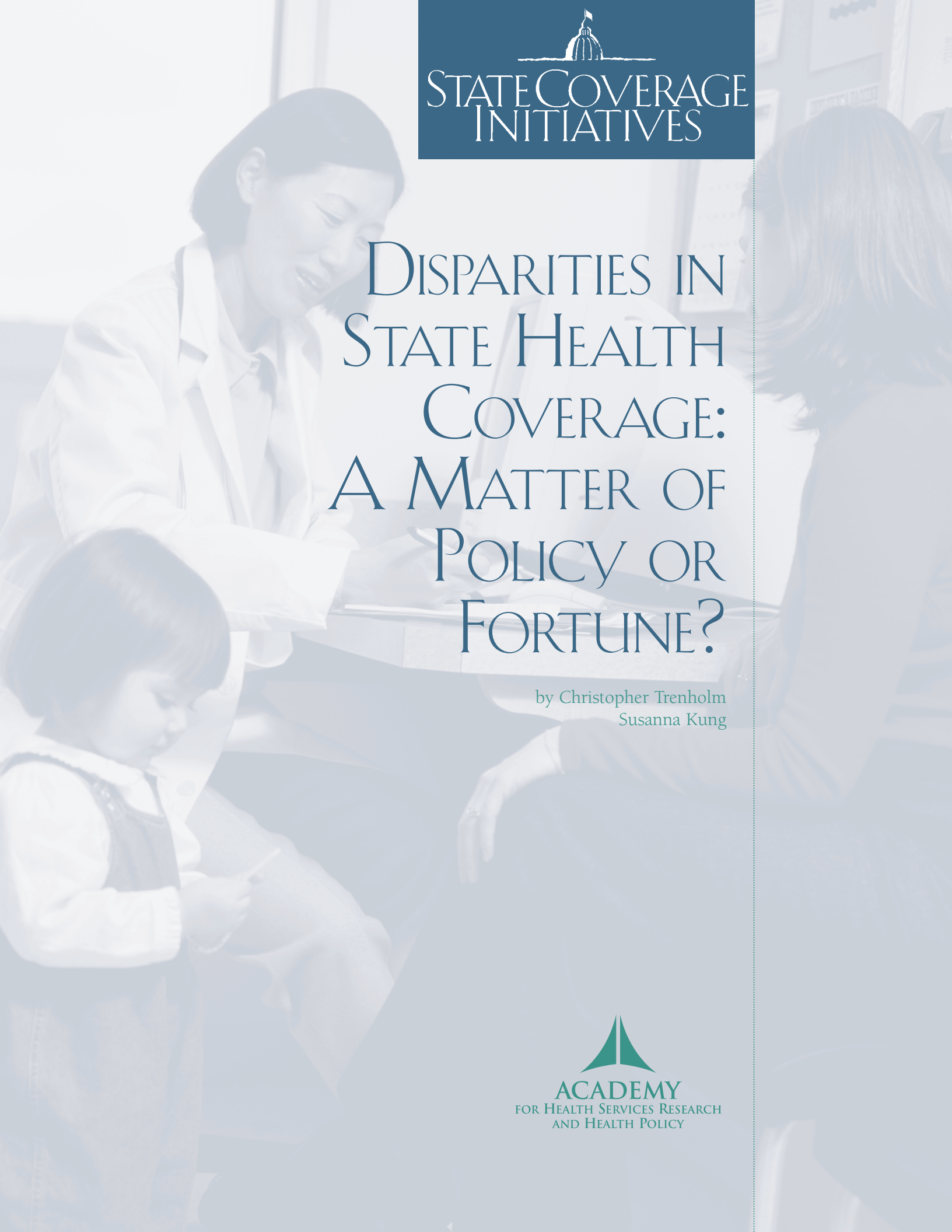

STATE COVERAGE INITIATIVES

Disparities in State Health Coverage: A Matter of Policy or Fortune?

by Christopher Trenholm
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ACADEMY
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AND HEALTH POLICY

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Executive Summary

More than 47 million low-income, non-elderly Americans are at risk of being uninsured because they lack access to both private and federal sources of health insurance. For this "at-risk" population, Medicaid is by far the largest health insurer in every state. The proportion of this population actually covered by Medicaid in each state, however, displays striking variability. During the period 1996-1998, Medicaid coverage of the at-risk population ranged by nearly threefold, from a low of 27 percent in Nevada to a high of nearly 75 percent in Vermont. In turn, these two states had the lowest and highest rates of overall coverage of the low-income population — 61.3 percent and 85.2 percent, respectively. Other states displayed a similar relationship, establishing a close link between Medicaid coverage of the at-risk population and reduced rates of uninsurance.

This paper explores the reasons why states differ in their Medicaid coverage of the at-risk population, focusing in particular on the large disparities in Medicaid spending associated with these differences. Two distinct sources for these disparities in spending are examined. First, they may be the result of two factors largely beyond state control: differences in state wealth (or "fiscal capacity"), and differences in the generosity of federal funding. Second, they may be the result of differences in state "fiscal effort," as measured by the ratio of state Medicaid spending to capacity.

Findings

Differences in Medicaid spending are clearly linked with differences in fiscal capacity. For example, of the 10 states that rank the highest in terms of spending, half rank among the top 10 in capacity (measured by per capita personal income), and only two rank lower than 17th. Likewise, of the 10 states that rank lowest in terms of spending, six rank among the bottom 10 in capacity.

Differences in Medicaid spending are also clearly linked with differences in fiscal effort. In fact, among states with the highest spending, strong fiscal effort is easily the most consistent correlate. Most of the states with notably strong fiscal effort depend less on high taxation than on an allocation of state revenues that favors Medicaid spending. Similarly, states with weak fiscal effort vary in their rates of taxation but typically allocate a relatively small share of revenue toward Medicaid spending.

Most states that display strong fiscal effort have above-average capacity, while most weak-effort states have below-average capacity. This pattern magnifies the differences in state Medicaid spending associated with fiscal capacity, which in turn contributes to the observed gaps in spending between rich and poor states. Interestingly, this pattern runs counter to the incentives of the federal matching formula, which gives poorer states a larger matching rate on each Medicaid dollar that they spend. One explanation for this pattern may be that due to a lack of discretionary funds, poor states simply have less opportunity to allocate large shares of their budget to Medicaid spending. It is interesting to note, however, that one of the poorest states, New Mexico, displays relatively strong fiscal effort (ranking sixth overall) despite having limited available revenue.

The federal matching formula is at best only marginally effective at reducing spending disparities between states. Under this formula, states with relatively high average personal income receive a low federal matching rate on their state Medicaid spending. In a wealthy state with a low rate of employer coverage (such as California), however, the need for federal support may be considerably greater than most states because the at-risk population is quite large. When taking into account cross-state differences in the size of the at-risk population, we find that the effective federal matching rate

received by a number of states is far higher or lower than justified by their level of need. This undermines the ability of the federal matching formula to reduce spending disparities between states — and in some cases, leads to perverse results. California is a notable example. It has large fiscal capacity and displays strong fiscal effort, suggesting that its overall Medicaid spending should be relatively high. However, because California receives a modest federal matching rate that it must spread thinly across a large at-risk population, the state actually ranks near the bottom (42nd) in overall spending.

Policy Implications

At the state level, the particularly close link between spending and fiscal effort suggests that the long-standing differences between states in spending and coverage are not a foregone conclusion. Indeed, a disparate group of low-capacity states — including Maine, New Mexico, Tennessee, Vermont, and West Virginia — have all substantially improved their relative spending levels through policies of strong fiscal effort. To the extent that other low-capacity states are willing and able to pursue similar policies, the spending gap between rich and poor states could be closed appreciably.

At the federal level, many alternatives to the current matching rate formula exist that might reduce spending disparities between states more accurately and appropriately. One approach would be to reconfigure the existing matching formula so that it accounts explicitly for the relative need for public coverage in each state. For example, the match might be adjusted according to each state's relative percent of population without private health insurance. This approach would eliminate the more extreme redistributional effects of current federal policy, though it might also invite greater crowd-out of private insurers. Another alternative is to provide federal subsidies to low-income families for the purchase of health insurance coverage. Any such plan would have to carefully consider a number of complex issues of efficiency and fairness. Nevertheless, the approach offers a clear opportunity to reduce the burden on states with limited capacity and/or large shares of the population at risk of uninsurance, a goal achieved with mixed success under existing federal policy.

I. Introduction

Access to employer-based and other private coverage is a far less critical determinant of uninsurance for the low-income population than for the general population.

While millions of low-income, non-elderly Americans are without health insurance, the rate of insurance coverage varies dramatically across individual states.[1] This variation in coverage has existed for years and has been relatively stable in its distribution. For example, of the 10 states with the lowest rates of health insurance coverage in 1998, eight of them fell into this category a decade earlier, and the other two states ranked 11th and 12th from the bottom (U.S. Census Bureau 2000).

Access to employer-based and other private coverage explains some of this cross-state variation, but it is a far less critical determinant of uninsurance for the low-income population than for the general population. In most states, less than half of the low-income population obtains coverage through private sources. Although some in this group may forgo offers of affordable employer-based coverage, the vast majority have, at best, only two options: obtain coverage through means-tested state health insurance programs, or go without health insurance entirely.

For the millions who fall into the "at-risk" category — defined in this paper as low-income, non-private/federally insured — Medicaid is by far the largest health insurer in every state. The proportion of this group actually covered by Medicaid, however, displays striking variability across states and explains much of the variation in coverage of the low-income population. Based on the most recent data (1996-1998), Medicaid coverage of the at-risk population varied by nearly threefold, from a low of 27 percent in Nevada to a high of nearly 75 percent in Vermont (Kaiser Commission 2000). In turn, these two states also had the lowest and highest rates of overall coverage of the low-income population (61.3 percent and 85.2 percent, respectively).

Not surprisingly, variation in state coverage of the at-risk population can be closely linked to differences in public spending for health insurance. High-coverage states tend to have relatively liberal Medicaid eligibility guidelines, including high income thresholds for program eligibility, favorable spend-down limits, and no asset restrictions. In addition, many of these states have acted to simplify enrollment and improve outreach, typically with an expensive price tag. For example, in 1997 Vermont spent roughly $170 per capita to provide coverage to non-disabled adults and children; in contrast, Nevada spent about $88 the same year.

This paper explores the reasons states differ in their Medicaid coverage of the at-risk population, focusing in particular on the large disparities in Medicaid spending.[2,3] Two distinct sources for these disparities in spending are examined: first, they may be the result of factors largely beyond state control, including differences in state wealth or levels of federal funding; second, they may be the result of major differences in state policy, either in terms of efforts to raise revenue (that is, taxation) or the allocation of revenues to support coverage. Below, we describe these possibilities in greater detail.

A. Sources of State Variation

Of all the factors that affect state spending to cover the at-risk population, perhaps the most critical is the wide disparity in taxable resources (termed "state wealth" or "fiscal capacity") that exists across states. This disparity places poor, low-capacity states at a potential disadvantage in two respects. First, they are almost certain to face a greater need for Medicaid coverage than a

The design of the federal matching formula actually creates an incentive for poor/low-capacity states to pursue a "high-effort" policy.

typical state simply because they have a larger share of their population near or below the poverty level. Second, these states have a fundamentally lower capacity to support spending for Medicaid and other social safety-net activities. As a member of the oversight committee for Tennessee's Medicaid program, State Senator David Fowler recently remarked, "I'm not sure we can be No. 1 in providing health insurance and 49th in collecting taxes. We have other priorities and needs in state government."[4]

Federal matching rates for Medicaid play an important role in reducing the potential gap in spending between rich and poor states. As with most federal matching programs, the formula for matching state Medicaid spending is based on the ratio of each state's per capita income to the national average. The smaller this ratio for a given state, the larger its federal matching rate. This formula clearly benefits poorer states; however, the extent to which the formula actually raises these states' spending depends critically on the need for public coverage. Since most low-capacity states have more people at risk for being uninsured, the larger federal matching rate received by these states may not raise their level of spending *per capita at risk* any more than it does for wealthier states. In the case of a low-capacity state with a relatively modest need of public coverage, however, the federal matching rate may substantially increase its level of spending relative to that of other states.

Of course, the option always exists for a state to adopt a policy of high Medicaid spending per capacity, or high "fiscal effort." This effort may come about either through high taxation (measured by the ratio of state tax revenues to fiscal capacity) or through a larger allocation of these revenues to support Medicaid spending. The design of the federal matching formula actually creates an incentive for poor/low-capacity states to pursue a "high-effort" policy because it can bring these states more than $3 in federal funds (albeit earmarked for Medicaid) for every $1 in state Medicaid spending, compared to a dollar-for-dollar match in federal funds for the wealthiest states.

A final factor that may contribute to the variation in rates of spending across states is the cost per beneficiary. States with very high costs per beneficiary are at an obvious disadvantage in expanding coverage since their outlays rise more sharply with each new enrollee. The reasons for variation in costs per enrollee are complex and not a focus of this paper.[5] Nevertheless, it will be important to understand the extent to which they explain discrepancies between a particular state's rate of coverage and its level of spending.

B. Layout of the Paper

In Section II, we describe the variation in health insurance coverage across states, focusing on the low-income population. A key issue addressed in this section is the relative success of states in extending Medicaid to those without private coverage. In Section III, we look at the link between Medicaid coverage and Medicaid spending, briefly looking at how differences in costs per enrollee can obscure this link for certain states. In Sections IV through VI, we explore the respective roles that fiscal capacity, state fiscal effort, and federal policy play in determining the level of Medicaid spending and, ultimately, the extent of coverage. Finally, in Section VII, we summarize the individual factors that contribute to state spending differences and discuss their implications for state and federal policy.

II. Health Insurance Coverage Across States

Uninsurance is heavily concentrated among the low-income population, reflecting their lower access to private coverage.

The number of uninsured Americans has grown steadily over the past decade in spite of a strong U.S. economy. In total, the number of Americans without health insurance climbed by about 1 million per year between 1988 and 1998, leaving roughly 18 percent of non-elderly Americans without insurance (Kaiser Commission 2000). This rise in the number of uninsured was at first attributable to a decline in employer-sponsored health coverage. In the past few years, however, it has been associated largely with a sharp fall in Medicaid enrollment, particularly among low-income working families (Holahan and Kim 2000). Increasingly, research shows that the drop in Medicaid enrollment is in part attributable to welfare reform, which separated Medicaid and welfare eligibility and enrollment.

Not surprisingly, uninsurance is heavily concentrated among the low-income population, reflecting their lower access to private coverage. Between 1996 and 1998, only 38 percent of the non-elderly in households below 200 percent of the federal poverty level (FPL) actually had private coverage, compared to 87 percent of those in households above 200 percent FPL. More than 60 percent of the low-income population could be served by public insurance, were it made available to them.

A. General Distribution in Coverage

A majority of the non-elderly population in all states have private coverage, but the rates of coverage vary substantially from a low of 59 percent in New Mexico to a high of 81 percent in Wisconsin (Table 1, page 3). This variability is linked closely with the share of the population that is low-income, a result consistent with this group's more limited access to employer-based coverage and its weaker purchasing power.[6] In addition, access to employer-based coverage differs more generally between states, regardless of income level, leading to further variability in the rates of private coverage. Medicaid actually plays a relatively minor role in providing coverage to the overall non-elderly population, insuring fewer than 10 percent of this group in half the states and no more than 20 percent in any state. As with private coverage, the rate of uninsurance varies largely with a state's share of low-income households and individuals. Of the 11 states with rates of uninsurance above 20 percent, all have relatively large low-income populations.

Among the low-income population (Table 1, page 4), private health insurance coverage is far less prevalent than for the population as a whole. In fact, in 43 states, a majority of the low-income population is without private coverage. These rates show wide variability, which is again linked with differences in employment and access to (and possibly take-up of) employer-based coverage for those who work (Spillman 2000). This variability is of considerable policy importance, as it directly affects the size of the at-risk population in each state. For example, one state that is particularly disadvantaged in this respect is California, which combines a sizeable low-income population with the second lowest rate of private coverage of this group. At the other extreme, several Mountain and West North Central states — including Utah, Iowa, Colorado, Nevada, and Kansas — benefit from small low-income populations with relatively high rates of private coverage.

TABLE 1
DISTRIBUTION OF INSURANCE COVERAGE AMONG THE NON-ELDERLY POPULATION BY STATE, 1996-1998

	Full Population				Low-Income Population [a]		
States	**Private [b] (%)**	**Medicaid (%)**	**Uninsured (%)**	**% Low-Income**	**Private [b] (%)**	**Medicaid (%)**	**Uninsured (%)**
New England							
Connecticut	77.9	8.5	13.6	23.1	41.2	29.7	29.1
Maine	75.9	8.9	15.2	27.8	45.9	24.3	29.8
Massachusetts	74.0	12.7	13.4	25.5	37.3	39.0	23.7
New Hampshire	79.2	8.5	12.3	22.4	40.7	31.1	28.2
Rhode Island	77.9	10.2	12.0	24.9	42.1	35.0	22.9
Vermont	71.8	16.8	11.4	27.4	41.5	43.7	14.8
Middle Atlantic							
New Jersey	74.4	7.1	18.5	23.5	39.7	24.6	35.7
New York	64.6	15.8	19.6	34.3	29.3	39.5	31.2
Pennsylvania	77.2	11.1	11.6	27.6	44.4	33.2	22.4
South Atlantic							
Delaware	73.6	10.6	15.7	27.1	38.2	28.7	33.1
District of Columbia	61.9	20.0	18.1	38.7	29.7	44.8	25.5
Florida	67.5	9.9	22.6	35.3	40.3	23.3	36.4
Georgia	67.9	12.6	19.5	34.2	34.5	29.9	35.6
Maryland	78.1	6.3	15.6	22.4	40.0	22.5	37.5
North Carolina	72.9	9.5	17.7	31.7	41.9	25.1	33.0
South Carolina	72.7	9.0	18.3	32.5	40.5	22.5	37.0
Virginia	77.8	7.4	14.8	27.2	46.5	22.9	30.6
West Virginia	64.8	15.4	19.8	40.7	35.7	33.6	30.6
East South Central							
Alabama	72.0	10.6	17.5	34.6	43.4	25.6	31.0
Kentucky	70.6	12.5	16.9	32.6	36.6	32.3	31.1
Mississippi	65.3	12.7	22.1	45.0	40.1	25.1	34.8
Tennessee	63.4	20.9	15.6	38.1	33.3	41.7	25.0
West South Central							
Arkansas	63.0	12.0	25.0	45.3	39.8	22.9	37.4
Louisiana	65.5	12.2	22.3	40.4	38.8	26.7	34.5
Oklahoma	70.5	7.9	21.7	35.9	47.3	17.5	35.2
Texas	62.9	10.3	26.8	38.9	32.7	22.4	44.8
East North Central							
Illinois	75.8	9.9	14.4	27.2	40.2	31.2	28.7
Indiana	80.8	5.4	13.7	24.6	52.0	17.3	30.7
Michigan	74.5	12.8	12.8	27.0	36.3	38.4	25.3
Ohio	78.0	9.3	12.7	28.2	46.3	29.3	24.4
Wisconsin	81.4	8.0	10.6	23.6	47.9	29.8	22.3

TABLE 1 (CON'T)
DISTRIBUTION OF INSURANCE COVERAGE AMONG THE NON-ELDERLY POPULATION BY STATE, 1996-1998

	Full Population				Low-Income Population [a]		
States	**Private [b] (%)**	**Medicaid (%)**	**Uninsured (%)**	**% Low-Income**	**Private [b] (%)**	**Medicaid (%)**	**Uninsured (%)**
West North Central							
Iowa	80.1	7.4	12.5	29.3	55.4	21.5	23.1
Kansas	79.1	7.8	13.1	29.7	52.8	22.8	24.4
Minnesota	77.8	11.5	10.7	23.9	34.7	41.0	24.4
Missouri	75.9	10.1	14.0	28.9	44.2	28.9	26.9
Nebraska	78.3	9.9	11.8	30.6	51.6	27.2	21.2
North Dakota	77.8	6.5	15.7	31.9	52.0	17.8	30.3
South Dakota	77.1	8.7	14.2	32.4	54.2	21.0	24.8
Mountain							
Arizona	61.6	10.6	27.8	42.7	32.8	21.8	45.3
Colorado	77.5	5.5	17.0	24.9	47.9	17.9	34.2
Idaho	71.0	9.6	19.5	36.1	45.6	18.4	35.0
Montana	67.3	11.9	20.8	40.5	41.3	25.3	33.3
Nevada	73.7	5.4	20.9	29.5	47.1	14.2	38.7
New Mexico	59.2	15.0	25.7	47.8	33.6	28.2	38.3
Utah	78.8	6.7	14.4	29.7	56.0	19.2	24.8
Wyoming	74.8	7.6	17.5	34.1	50.2	18.7	31.1
Pacific							
Alaska	72.6	8.6	18.8	24.7	38.1	26.1	35.9
California	62.8	13.7	23.5	37.5	30.2	31.6	38.3
Hawaii	77.3	12.5	10.2	33.5	50.2	32.6	17.2
Oregon	71.3	12.6	16.1	32.9	40.8	29.1	30.2
Washington	74.2	12.3	13.6	27.4	38.6	35.7	25.7

SOURCE: Kaiser Commission on Medicaid and the Uninsured (2000), based on Urban Institute estimates derived from the March 1997, 1998, and 1999 Current Population Survey (CPS).

[a] "Low-income" defined as below 200 percent of the federal poverty level (FPL).

[b] Includes a small percentage of the population in each state with federal coverage through Medicare or CHAMPUS.

While the challenge to extend Medicaid coverage is arguably greatest in states such as California, Medicaid is left to insure a sizeable share of the low-income population in every state.

While the challenge to extend Medicaid coverage is arguably greatest in states such as California, Medicaid is left to insure a sizeable share of the low-income population in every state. Across all states, the rate of Medicaid coverage averages 28 percent, ranging from a low of 14 percent (Nevada) to a high of 48 percent (District of Columbia). In eight states, Medicaid is a larger insurer of the low-income population than all private sources combined.

Variability in Medicaid coverage of the low-income population is closely linked with differences in uninsurance rates for this group. This is evidenced by a much higher statistical correlation between rates of uninsurance and Medicaid coverage than between rates of uninsurance and private coverage.[7] In addition, anecdotal evidence shows large differences in uninsurance rates among seemingly similar states that are entirely attributable to differences in Medicaid coverage. For example, there are numerous instances of neighboring states where one state has a smaller share of privately insured *and* a smaller share of uninsured individuals, due to far greater Medicaid coverage.[8]

B. Medicaid Coverage of the Population at Risk

As noted previously, there is striking variation across states in the rate of Medicaid coverage of the population at risk of being uninsured (Table 2).[9] States at the top of these rankings insure nearly 60 percent or more of those without private coverage, while states at the bottom insure fewer than 40 percent. States covering a large share of the at-risk population typically have far lower rates of uninsurance, both among low-income individuals and overall.[10] Some regional bias in these rankings is apparent; for example, five of the top 20 states are located in the Northeast. However, states from many regions are represented at both the top and the bottom of these rankings.

TABLE 2
RANKINGS OF STATES BY MEDICAID COVERAGE OF AT-RISK POPULATION
(LOW-INCOME, NON-PRIVATELY INSURED), 1996-1998

	Status of Population at Risk of Uninsurance (Low-Income, Non-Privately Insured) [a,b]		Overall Coverage of Low-Income Population [a]	
State	% Medicaid	% Uninsured	% Insured	Rank
1. Vermont	74.7	25.3	85.2	1
2. Hawaii	65.5	34.5	82.8	2
3. District of Columbia	63.7	36.3	74.5	16
4. Minnesota	62.7	37.3	75.6	9
5. Tennessee	62.5	37.5	75.0	14
6. Massachusetts	62.2	37.8	76.3	8
7. Rhode Island	60.4	39.6	77.1	6
8. Michigan	60.3	39.7	74.7	15
9. Pennsylvania	59.7	40.3	77.6	5
10. Washington	58.1	41.9	74.3	17
11. Wisconsin	57.2	42.8	77.7	4
12. Nebraska	56.2	43.8	78.8	3
13. New York	55.9	44.1	68.8	31
14. Ohio	54.6	45.4	75.6	9
15. New Hampshire	52.4	47.6	71.8	19
16. West Virginia	52.3	47.7	69.4	25
17. Illinois	52.1	47.9	71.3	20
18. Missouri	51.8	48.2	73.1	18

TABLE 2 (CON'T)
RANKINGS OF STATES BY MEDICAID COVERAGE OF AT-RISK POPULATION (LOW-INCOME, NON-PRIVATELY INSURED), 1996-1998

	Status of Population at Risk of Uninsurance (Low-Income, Non-Privately Insured) [a,b]		Overall Coverage of Low-Income Population [a]	
State	**% Medicaid**	**% Uninsured**	**% Insured**	**Rank**
19. Kentucky	50.9	49.1	68.9	29
20. Connecticut	50.5	49.5	70.9	21
21. Oregon	49.1	50.9	69.8	23
22. Kansas	48.3	51.7	75.6	9
23. Iowa	48.2	51.8	76.9	7
24. Delaware	46.4	53.6	66.9	33
25. South Dakota	45.9	54.1	75.2	12
26. Georgia	45.6	54.4	64.4	40
27. Alabama	45.2	54.8	69.0	28
California	45.2	54.8	61.7	47
29. Maine	44.9	55.1	70.2	22
30. Louisiana	43.6	56.4	65.5	36
Utah	43.6	56.4	75.2	12
32. Montana	43.2	56.8	66.7	34
North Carolina	43.2	56.8	67.0	32
34. Virginia	42.8	57.2	69.4	25
35. New Mexico	42.4	57.6	61.7	47
36. Alaska	42.1	57.9	64.1	42
37. Mississippi	41.9	58.1	65.2	37
38. New Jersey	40.8	59.2	64.3	41
39. Florida	39.0	61.0	63.6	43
40. Arkansas	38.0	62.0	62.6	45
41. South Carolina	37.8	62.2	63.0	44
42. Wyoming	37.6	62.4	68.9	29
43. Maryland	37.5	62.5	62.5	46
44. North Dakota	37.0	63.0	69.7	24
45. Indiana	36.0	64.0	69.3	27
46. Idaho	35.7	64.3	65.0	38
47. Colorado	34.4	65.6	65.8	35
48. Texas	33.3	66.7	55.2	50
49. Oklahoma	33.2	66.8	64.8	39
50. Arizona	32.5	67.5	54.7	51
51. Nevada	26.8	73.2	61.3	49

SOURCE: Calculated from tables reported by the Kaiser Commission on Medicaid and the Uninsured (2000), which are based on Urban Institute estimates derived from the March 1997, 1998, and 1999 Current Population Survey (CPS).

NOTE: Ranking are based on *estimates* of health insurance coverage in each state. As such, states ranking close to others may have estimated levels of coverage that are not statistically significant from one another. See Campbell (1999) for an indication of the statistical significance that underlies ranking of health insurance coverage for the full non-elderly population.

[a] "Low-income" defined as below 200 percent of the federal poverty level (FPL).

[b] "At-risk population" defined as all non-elderly, low-income individuals who report no source of private or federal (Medicare/CHAMPUS) health insurance coverage during the year.

III. STATE COVERAGE DISPARITIES: LINKS TO SPENDING

States differ by as much as 300 percent in their Medicaid spending per person at risk.

States differ by as much as 300 percent in their Medicaid spending per person at risk (Table 3). Among the top 10 states alone, spending levels range from roughly $1,200 to $1,900 — a difference of more than 50 percent. These levels contrast sharply with states near the bottom of the rankings, which spend between $450 and $650. Regional variation is strongly evident in these rankings. Northeast and Mid-Atlantic states dominate the top of the rankings, while those in the Mountain and Southwestern regions comprise much of the bottom.

When these rankings of spending are compared to those of coverage (Table 2), a fairly strong link is evident between a state's coverage and the level of spending required to provide this coverage.[11] Among the states that rank in the top 10 in coverage, for example, five states also rank in the top 10 in spending, with only one state ranking below average (Minnesota: 29th). Similarly, among the states that rank among the bottom 10 in coverage, five states also rank in the top 10 in spending, and only one state ranks above average (Maryland: 5th).

The few instances where states differ substantially between rankings of coverage and spending can be directly linked to differences in costs per beneficiary (last two columns of Table 3).[12] Minnesota, for example, has one of the lowest costs per beneficiary (46th), which allows it to rank among the top 10 in coverage while spending at an average level. The exact opposite is true for a state such as Maryland, whose costs per beneficiary are among the highest of any state (3rd, behind only Hawaii and Alaska), raising its level of spending above that of most states, yet providing only a modest level of coverage.

TABLE 3
RANKINGS OF STATES BY MEDICAID SPENDING PER AT-RISK POPULATION, 1997

States	Total Medicaid Spending [a] ($M)	Total Population At Risk of Being Uninsured ('000)	Medicaid Spending Per Capita At Risk ($)	Costs Per Beneficiary ($)	Rank
1. Alaska	173	91.1	1,898	2,507	1
2. District of Columbia	213	122.2	1,744	2,068	2
3. Hawaii	277	166.3	1,665	1,629	12
4. Maine	241	160.1	1,505	1,883	8
5. Maryland	839	594.0	1,412	1,983	4
6. Rhode Island	158	114.3	1,382	1,580	14
7. Connecticut	488	388.1	1,257	1,683	10
8. Massachusetts	1,027	850.8	1,207	1,941	6
Vermont	101	83.7	1,207	1,074	49
10. New York	4,544	3,870.1	1,174	2,032	3
11. Washington	1,012	870.7	1,162	1,394	22
12. Utah	284	245.1	1,159	1,893	7
13. Delaware	124	109.5	1,132	1,531	17
14. New Hampshire	153	139.9	1,093	1,962	5
15. Tennessee	1,358	1,248.6	1,088	1,254	35
16. Oregon	611	567.7	1,076	1,323	27
17. Illinois	1,876	1,750.3	1,072	1,293	32
18. New Jersey	1,040	996.8	1,043	1,754	9
19. North Carolina	1,229	1,181.2	1,040	1,477	19

TABLE 3 (CON'T)
RANKINGS OF STATES BY MEDICAID SPENDING PER AT-RISK POPULATION, 1997

States	Total Medicaid Spending [a] ($M)	Total Population At Risk of Being Uninsured ('000)	Medicaid Spending Per Capita At Risk ($)	Costs Per Beneficiary ($)	Rank
20. Iowa	329	323.8	1,016	1,449	20
21. Pennsylvania	1,582	1,572.9	1,006	1,348	25
22. Kentucky	686	705.0	973	1,657	11
23. Indiana	574	601.4	954	1,305	31
24. West Virginia	357	377.5	946	1,308	30
25. Michigan	1,371	1,481.0	926	1,374	24
26. Nebraska	186	216.8	858	1,232	37
27. North Dakota	71	83.7	848	1,578	15
28. Colorado	387	460.7	840	1,560	16
29. Minnesota	559	671.0	833	1,242	36
Ohio	1,237	1,485.9	833	1,144	43
31. Missouri	611	741.6	824	1,076	48
32. Wisconsin	458	559.6	819	1,196	39
33. New Mexico	413	518.7	796	1,507	18
34. Georgia	1,206	1,520.6	793	1,312	28
35. Kansas	244	309.6	788	1,312	29
36. South Dakota	70	90.4	775	1,167	41
37. South Carolina	475	650.3	730	1,182	40
38. Wyoming	53	73.0	726	1,325	26
39. California	5,588	7,727.4	723	1,130	44
40. Louisiana	652	927.2	703	1,286	33
41. Florida	1,622	2,496.1	650	1,089	46
42. Oklahoma	347	540.2	642	1,088	47
Texas	2,984	4,648.2	642	1,381	23
44. Alabama	451	717.3	629	1,145	42
45. Virginia	521	842.6	618	1,048	50
46. Nevada	147	239.6	613	1,581	13
47. Arizona	697	1,199.1	581	1,258	34
48. Montana	97	190.5	509	1,406	21
49. Mississippi	321	659.5	487	950	51
50. Arkansas	286	609.4	469	1,212	38
51. Idaho	99	216.5	457	1,100	45

SOURCE: Medicaid spending data obtained from the Kaiser Commission and the Uninsured (1999), based on Urban Institute estimates derived from analysis of HCFA-2082 (Medicaid expenditure) reports. Population counts calculated from tables reported by the Kaiser Commission on Medicaid and the Uninsured (2000), which are based on Urban Institute estimates derived from the March 1997, 1998, and 1999 Current Population Survey (CPS).

NOTE: "At-risk population" defined as all non-elderly, low-income individuals who report no source of private or federal (Medicare/CHAMPUS) health insurance coverage during the year. "Low-income" defined as below 200 percent of the federal poverty level (FPL).

[a] Spending data are limited to the adult and child categories of Medicaid expenditures since these categories include the vast majority of individuals at risk of being uninsured.

IV. FISCAL CAPACITY: THE GREAT SPENDING DIVIDER

Most of the low-capacity states are located in the South and Mountain regions. The lowest-capacity state, Mississippi, has only about half the level of capacity of the top states, the District of Columbia and Connecticut.

Having summarized the disparities in state spending and links to coverage, we need to explore how the three key determinants of spending — state fiscal capacity, state fiscal effort, and federal matching — contribute to these disparities.[13]

As shown in Table 4, states differ markedly in their fundamental capacity to raise revenue.[14] States ranking among the top 10 in fiscal capacity are found predominantly in the Mid-Atlantic and Northeast regions. (Indeed, Illinois and Colorado are the only states representing other regions.) Each of those states has at least 30 percent greater taxable resources to draw on than the lowest-capacity states, giving them a substantial edge in terms of potential spending for Medicaid coverage. Most of the low-capacity states are located in the South and Mountain regions. The lowest-capacity state, Mississippi, has only about half the level of capacity of the top states, the District of Columbia and Connecticut.

Not surprisingly, these large differences in capacity are closely linked to differences in spending (Figure 1). For example, among the states that rank the highest in terms of spending, nearly all have large capacity, leading to the "clustering" of states in the top right corner of the figure. Similarly, most states ranking near the bottom in terms of spending also rank near the bottom in terms of their capacity, leading to a similar clustering in the bottom left corner.

A handful of states appear in the upper left quadrant of Figure 1, indicating that they rank considerably higher in terms of spending than capacity. The most extreme of these "above-capacity" states are: Maine, which ranks 37th in capacity but 4th in spending; Utah, which ranks 45th in capacity but 12th in spending; Vermont, which ranks 33rd in capacity but 8th in spending; and West Virginia, which ranks 50th in capacity but 24th in spending. In contrast, in the lower right quadrant of Figure 1, six states have spending levels that rank well below their level of capacity. The most extreme of these "below-capacity" states is Nevada, which ranks 11th in fiscal capacity but 46th in spending. Other states that are notably below capacity are Virginia (15th in capacity, 45th in spending) and California (13th in capacity, 39th in spending).

There are two possible explanations for these states that have spending well above or below capacity. First, their fiscal effort, as measured by their *state* Medicaid spending per capacity, is notably higher or lower than most states. Second, their federal matching rate is particularly high or low, given the comparative size of their at-risk population.

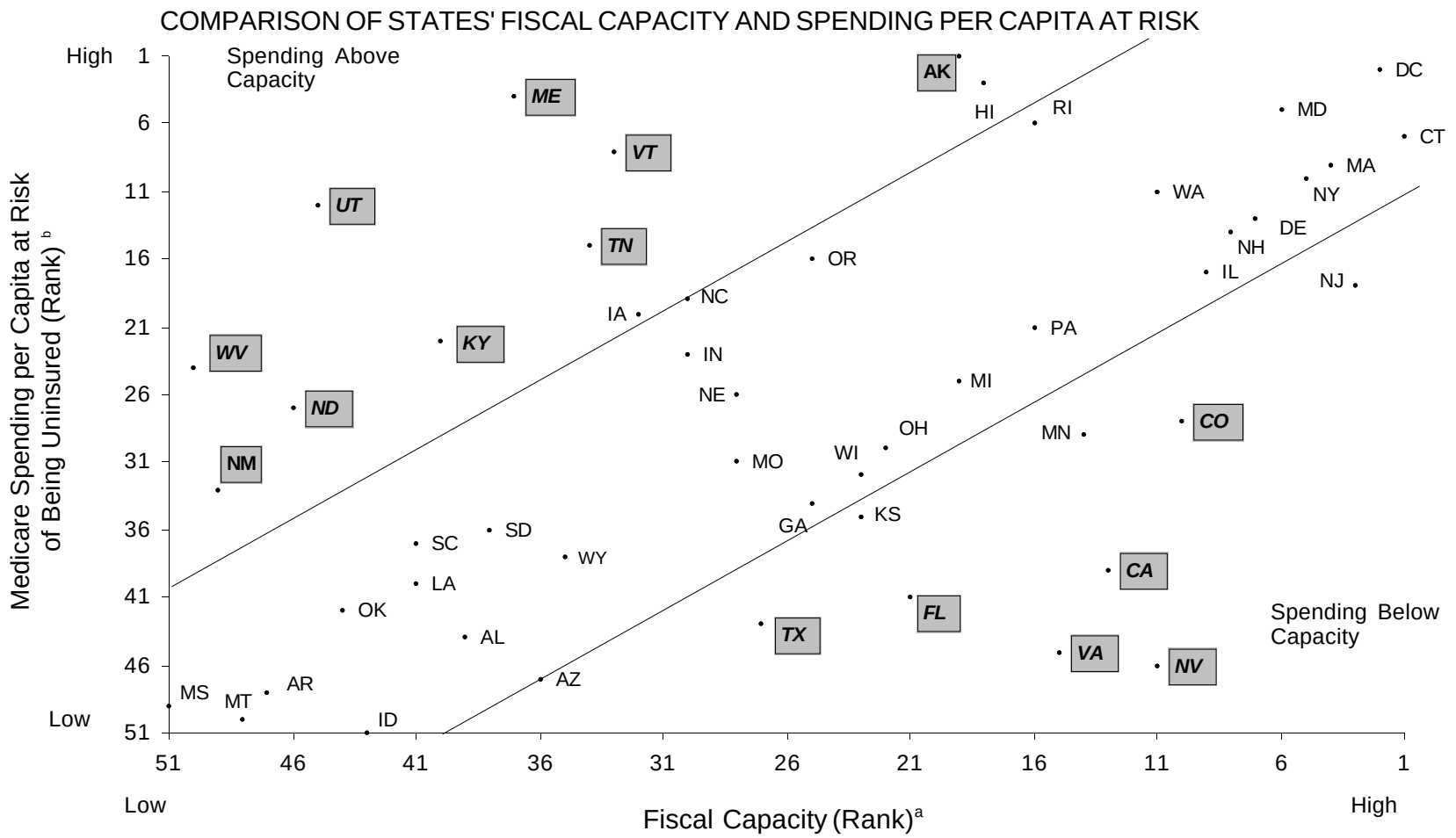
TABLE 4
RANKINGS OF STATES BY LEVEL OF FISCAL CAPACITY, 1997

States	Per Capita Personal Income[a] ($000)	States	Per Capita Personal Income[a] ($000)
1. Connecticut	35.9	27. Texas	23.7
2. District of Columbia	35.7	28. Missouri	23.6
3. New Jersey	32.4	Nebraska	23.6
4. Massachusetts	31.2	30. Indiana	23.2
5. New York	30.3	North Carolina	23.2
6. Maryland	28.7	32. Iowa	23.1
7. Delaware	28.5	33. Vermont	23.0
8. New Hampshire	27.8	34. Tennessee	22.7
9. Illinois	27.7	35. Wyoming	22.6
10. Colorado	27.0	36. Arizona	22.0
11. Nevada	26.5	37. Maine	21.9
Washington	26.5	38. South Dakota	21.1
13. California	26.3	39. Alabama	20.7
14. Minnesota	26.2	40. Kentucky	20.6
15. Virginia	26.1	41. Louisiana	20.5
16. Pennsylvania	25.7	South Carolina	20.5
Rhode Island	25.7	43. Idaho	20.4
18. Hawaii	25.6	44. Oklahoma	20.3
19. Alaska	25.0	45. Utah	20.2
Michigan	25.0	46. North Dakota	20.1
21. Florida	24.8	47. Montana	19.7
22. Ohio	24.2	48. Arkansas	19.6
23. Kansas	24.0	49. New Mexico	19.3
Wisconsin	24.0	50. West Virginia	18.7
25. Georgia	23.9	51. Mississippi	18.1
Oregon	23.9		

SOURCE: U.S. Department of Commerce (1999).

[a] Personal income is the most straightforward — and certainly the most commonly used — indicator of fiscal capacity. A number of alternative measures are available, most of which try to capture more comprehensively the resources potentially taxable by the state. The rankings shown above generally change very little under these alternative measures. However, some energy-producing states (most notably, Alaska and Wyoming) display much larger capacity under these alternative measures because they capture large income flows to non-resident shareholders of in-state energy producers.

FIGURE 1



SOURCE: Rankings of Medicaid spending based on data from the Kaiser Commission on Medicaid and the Uninsured (1999). Rankings of fiscal capacity based on data from the U.S. Department of Commerce (1999).

NOTE: "At-risk population" defined as all non-elderly, low-income individuals who report no source of private or federal (Medicare/CHAMPUS) health insurance coverage during the year. "Low-income" defined as below 200 percent of the federal poverty level (FPL).

[a] Based on each state's per capita personal income. See Table 4 for an ordered ranking and additional details.

[b] Based on the adult and child categories of Medicaid expenditures since these categories include the vast majority of individuals at risk of being uninsured. See Table 3 for an ordered ranking and additional details on the derivation of this measure.

V. FISCAL EFFORT: THE RICH SPEND RICHER

Substantial variation is evident in state fiscal effort, which is measured by the level of *state* Medicaid spending on adults and children per $1,000 in fiscal capacity (Table 5). The top 10 states spend between $3.11 and $5.69, which is at least twice the level of states ranking near the bottom. Overall, the variation in spending is distributed across regions in much the same way as fiscal capacity. States in the Pacific, Northeast, and Mid-Atlantic regions are typically those displaying the strongest fiscal effort. In contrast, states in the Mountain and Southern regions are most often those displaying a weak effort.

States in the Pacific, Northeast, and Mid-Atlantic regions are typically those displaying the strongest fiscal effort. In contrast, states in the Mountain and Southern regions are most often those displaying a weak effort.

Differences in allocation of revenues to support Medicaid spending is the primary reason for differences in fiscal effort. Nearly all the states that rank near the top of the rankings allocate a relatively large share of their revenues in support of Medicaid. However, a few high-effort states — including Alaska, Hawaii, and New Mexico — seem to depend more heavily on a high rate of taxation (that is, total revenues per capacity). Among states that rank in the bottom 10 in terms of effort, only one, South Dakota, ranks higher than 35th in its allocation to Medicaid spending.

Most states ranking near the top in terms of fiscal effort also have a relatively large fiscal capacity, suggesting that state fiscal effort actually *widens* disparities in coverage associated with state wealth. For example, of the 20 states ranking highest in terms of fiscal effort, six rank in the top 10 in fiscal capacity, but only two, West Virginia and New Mexico, rank among the bottom 10 (see Table 4). A similar pattern holds among states displaying weak fiscal effort. For example, of the 20 states ranking lowest in terms of fiscal effort, eight rank in the bottom 10 in fiscal capacity, but only one, Colorado, ranks in the top 10.

The fact that fiscal effort exacerbates capacity-based disparities in spending is contrary to the incentives of existing policy. Namely, as noted previously, the larger federal match received by low-capacity states should create a stronger incentive to pursue a high-effort policy. One factor that may act against this incentive is the more limited flexibility low-capacity states have to allocate their revenues in a discretionary manner. Indeed, this is consistent with the close association between low fiscal effort and low allocation seen in Table 5. Low-capacity states may also be more willing to substitute federal matching funds for state Medicaid spending (Adams and Wade 2000), which would again lead to a pattern of weak fiscal effort on their part. Despite these countervailing factors, it is interesting to note that two of the poorest states, New Mexico and West Virginia, actually rank near the top in terms of fiscal effort (6th and 13th, respectively).

Most states ranking near the top in terms of fiscal effort also have a relatively large fiscal capacity, suggesting that state fiscal effort actually widens disparities in coverage associated with state wealth.

TABLE 5
RANKINGS OF STATES BY LEVEL OF FISCAL EFFORT, 1997

	Fiscal Effort		Taxation			Allocation	
	State Medicaid Spending per $1,000 in Fiscal Capacity [a,b]	=	State Tax Revenues per $1,000 in Fiscal Capacity [b,c]		x	State Medicaid Spending per $1,000 in State Tax Revenue [a,c]	
States	$		$	Rank		$	Rank
1. Alaska	5.69		106.52	1		53.42	4
2. District of Columbia	5.63		n/a	--		n/a	--
3. Hawaii	4.54		101.25	2		44.82	10
4. New York	4.14		63.52	33		65.17	3
5. Tennessee	3.95		54.28	46		72.72	2
6. New Mexico	3.39		93.16	3		36.41	18
7. Washington	3.37		75.44	14		44.70	11
8. California	3.28		72.82	19		45.10	9
9. Maine	3.21		74.25	16		43.30	14
10. Oregon	3.11		63.74	32		48.80	6
11. Delaware	2.97		83.41	7		35.57	20
12. Vermont	2.91		66.60	29		43.74	13
13. Rhode Island	2.88		64.98	31		44.28	12
West Virginia	2.88		85.47	5		33.65	25
15. Maryland	2.87		58.89	41		48.75	7
16. Illinois	2.83		55.86	43		50.58	5
17. Massachusetts	2.69		69.66	22		38.59	16
18. Georgia	2.59		60.91	39		42.58	15
19. North Carolina	2.58		73.36	17		35.13	22
20. Kentucky	2.55		84.81	6		30.08	32
21. Michigan	2.52		83.27	8		30.22	31
22. Texas	2.43		50.10	48		48.52	8
23. Pennsylvania	2.42		62.85	35		38.49	17
24. Arizona	2.40		68.20	25		35.17	21
25. New Hampshire	2.35		28.15	50		83.62	1
26. Minnesota	2.11		91.25	4		23.12	44
27. Louisiana	2.10		63.37	34		33.07	26
28. Connecticut	2.08		69.50	23		29.95	33
29. New Jersey	1.99		55.29	44		36.07	19
30. Florida	1.97		57.91	42		34.02	24
Wyoming	1.97		61.33	37		32.09	27
32. Nebraska	1.94		65.17	30		29.84	34
33. Missouri	1.91		61.16	38		31.24	29
Utah	1.91		73.08	18		26.07	37
35. Ohio	1.86		60.70	40		30.67	30
36. Iowa	1.85		71.01	21		26.02	38
37. South Carolina	1.81		69.26	24		26.09	36
38. North Dakota	1.78		82.48	9		21.55	45
39. Colorado	1.76		50.33	47		34.87	23

TABLE 5 (CON'T)
RANKINGS OF STATES BY LEVEL OF FISCAL EFFORT, 1997

	Fiscal Effort: State Medicaid Spending per $1,000 in Fiscal Capacity [a,b]	=	Taxation: State Tax Revenues per $1,000 in Fiscal Capacity [b,c]		x	Allocation: State Medicaid Spending per $1,000 in State Tax Revenue [a,c]	
States	**$**		**$**	**Rank**		**$**	**Rank**
40. Montana	1.74		72.79	20		23.88	42
41. Nevada	1.65		68.18	26		24.22	41
42. Indiana	1.62		66.87	28		24.24	40
43. Kansas	1.61		67.78	27		23.71	43
44. South Dakota	1.58		49.58	49		31.89	28
45. Arkansas	1.55		76.45	13		20.23	47
Oklahoma	1.55		75.08	15		20.58	46
47. Alabama	1.54		61.41	36		25.05	39
48. Wisconsin	1.50		81.43	10		18.43	48
49. Mississippi	1.48		81.31	11		18.22	49
50. Virginia	1.44		54.73	45		26.26	35
51. Idaho	1.28		79.37	12		16.18	50

SOURCE: Medicaid spending information obtained from the Kaiser Commission on Medicaid and the Uninsured (1999), based on Urban Institute estimates derived from analysis of HCFA-2082 (Medicaid expenditure) reports. Fiscal capacity estimates are based on 1997 personal income data obtained from the U.S. Department of Commerce (1999). State tax revenue estimates obtained from the U.S. Census Bureau (2000).

[a] State Medicaid spending includes only the adult and child categories of Medicaid expenditures since these categories include the vast majority of individuals at risk of being uninsured.

[b] Fiscal capacity based on total personal per capita income.

[c] State tax revenues include all taxes collected by the state. Major categories include individual income, sales, severance, and license taxes. See U.S. Census Bureau (2000) for more information.

VI. FEDERAL POLICY: LUCK OF THE DRAW

The extent to which the federal matching formula raises states' relative spending depends critically on the level of need in the state.

As one might expect, most states that rank much higher in spending than capacity display relatively strong fiscal effort, while most states that rank much lower in spending than capacity display relatively weak fiscal effort. At each extreme, however, we find notable exceptions. Utah and North Dakota, for example, both rank far higher in terms of spending than capacity, but their fiscal effort is actually lower than most states. Indeed, Utah ranks a stunning 33 spots higher in terms of spending than capacity (12th versus 45th, respectively), yet its level of fiscal effort ranks only 33rd. At the other extreme, Texas and Florida each rank more than 15 spots lower in terms of spending than capacity, yet their levels of effort rank about average (22nd and 30th, respectively). Even more striking, California ranks 26 spots lower in terms of spending than capacity (39th versus 13th, respectively) but ranks very near the top in terms of fiscal effort (8th).

How can a state such as Utah have spending far above capacity in spite of weak fiscal effort, or a state such as California have spending far below capacity despite a strong fiscal effort? The answer lies with the federal policy used to match state Medicaid spending. As described in the introduction, the extent to which the federal matching formula raises states' relative spending depends critically on the level of need in the state. Since most poor states have a proportionally large at-risk population, the "effective" federal matching rate received by these states — that is, their actual match rate scaled by the relative size of their at-risk population — might be no greater, and perhaps smaller, than it is for a wealthier state.[15] However, there are a handful of low-capacity states, Utah and North Dakota among them, that are fortunate enough to have a relatively small share of their population at risk of being uninsured. For these states, the effective match rate will be far larger than for a wealthier state. The opposite is true for a high-capacity state with a proportionately large at-risk population. Since these states receive a relatively small federal matching rate to begin with, the fact that they have a large at-risk population leads to an effective matching rate far smaller than that of a typical state. Take California, for example. As noted above, California has a large fiscal capacity and thus receives one of the lowest federal matching rates of any state. However, California also has a very large share of its population at risk for uninsurance, which, when taken into consideration, drives its effective matching rate even further below that of other states.

The resulting random fortunes of the federal matching formula are seen clearly in Table 6. States receiving the highest effective matching rate are those that combine low capacity with a high rate of private coverage. Utah and North Dakota actually rank first and second in their effective federal matching rates, which explains why these states achieve very high levels of Medicaid spending despite both limited capacity and weak fiscal effort. Meanwhile, high-capacity states with low rates of private coverage dominate the bottom of the rankings. California ranks next to last, just ahead of Washington, D.C. In fact, California is one of only three states — along with the District of Columbia and New York — that receive an effective federal matching rate that is below $1. Consequently, as seen above, California ranks far below average in terms of spending, despite both a strong fiscal capacity and a strong fiscal effort.

TABLE 6
RANKINGS OF STATES BY FEDERAL MATCHING RATE, ADJUSTED FOR THE SHARE OF POPULATION AT RISK OF BEING UNINSURED, 1997

State	Federal Matching Rate per $1 in State Spending	Share of Population at Risk of Being Uninsured (Relative to the Average State)	Effective Federal Matching Rate [a]
1. Utah	$2.61	71%	$3.70
2. North Dakota	$2.10	83%	$2.53
3. Indiana	$1.60	64%	$2.52
4. Iowa	$1.70	70%	$2.41
5. Mississippi	$3.39	145%	$2.33
6. South Dakota	$1.85	80%	$2.31
7. Oklahoma	$2.33	102%	$2.28
South Carolina	$2.39	104%	$2.28
9. Wisconsin	$1.44	66%	$2.17
10. Alabama	$2.28	106%	$2.16
Maine	$1.75	81%	$2.16
12. Kentucky	$2.34	112%	$2.10
13. Idaho	$2.13	106%	$2.00
14. Kansas	$1.43	76%	$1.89
15. West Virginia	$2.65	141%	$1.88
16. Louisiana	$2.50	133%	$1.87
17. Arkansas	$2.75	147%	$1.86
18. Nebraska	$1.44	80%	$1.81
Vermont	$1.57	87%	$1.81
20. Ohio	$1.46	82%	$1.78
North Carolina	$1.77	100%	$1.78
22. Montana	$2.23	128%	$1.74
23. Missouri	$1.50	87%	$1.72
24. Wyoming	$1.49	92%	$1.63
25. Colorado	$1.10	70%	$1.57
26. New Mexico	$2.66	172%	$1.55
27. Rhode Island	$1.17	78%	$1.50
28. Oregon	$1.53	105%	$1.45
29. New Hampshire	$1.00	72%	$1.40
30. Maryland	$1.00	72%	$1.38
31. Connecticut	$1.00	73%	$1.37
Minnesota	$1.16	84%	$1.37
33. Pennsylvania	$1.12	83%	$1.35
Virginia	$1.06	79%	$1.35
35. Michigan	$1.23	93%	$1.33
Tennessee	$1.82	137%	$1.33
37. Georgia	$1.60	121%	$1.32
38. New Jersey	$1.00	76%	$1.31
39. Arizona	$1.90	155%	$1.23
40. Alaska	$1.00	83%	$1.21

TABLE 6 (CON'T)
RANKINGS OF STATES BY FEDERAL MATCHING RATE,
ADJUSTED FOR THE SHARE OF POPULATION AT RISK OF BEING UNINSURED, 1997

State	Federal Matching Rate per $1 in State Spending	Share of Population at Risk of Being Uninsured (Relative to the Average State)	Effective Federal Matching Rate [a]
41. Nevada	$1.00	84%	$1.19
Texas	$1.67	141%	$1.19
43. Massachusetts	$1.00	86%	$1.16
44. Illinois	$1.00	88%	$1.14
45. Washington	$1.02	91%	$1.12
46. Delaware	$1.00	90%	$1.11
Florida	$1.26	114%	$1.11
Hawaii	$1.00	90%	$1.11
49. New York	$1.00	131%	$0.76
50. California	$1.01	142%	$0.71
51. District of Columbia	$1.00	147%	$0.68

SOURCE: Federal matching rates for 1997 are based on reporting from the Kaiser Commission on Medicaid and the Uninsured (1999). Estimates of relative populations at-risk calculated from tables reported by the Kaiser Commission on Medicaid and the Uninsured (2000), which are based on Urban Institute estimates derived from the March 1997, 1998, and 1999 Current Population Survey (CPS).

NOTE: "At-risk population" defined as all non-elderly, low-income individuals who report no source of private or federal (Medicare/CHAMPUS) health insurance coverage during the year. "Low-income" defined as below 200 percent of the federal poverty level (FPL).

[a] Measured as the states' actual matching rate (shown in the second column) divided by its relative share of the population at risk of being uninsured (shown in the third column). This measure provides a more accurate indicator of the size of the federal subsidy to states because it accounts for the level of need for public coverage.

VII. SUMMARY AND CONCLUSIONS

When we combine all the determinants of spending (Table 7), a variety of explanations emerge for why individual states rank near the top or the bottom in terms of their spending. At the top of the rankings, for example, fiscal capacity seems to be the dominant factor explaining the spending levels of at least two states, Massachusetts and Connecticut. Meanwhile, states such as Maine and Vermont achieve high spending levels through a combination of strong fiscal effort and a favorable matching rate. Still other states, such as New Hampshire and North Carolina, seem to experience a slight benefit from all three factors.

State policy may be the most critical factor in determining which states will spend relatively more in covering families at risk of being uninsured.

A. Implications for State Policy

One pattern that does emerge at the top of the rankings is a consistent policy of strong fiscal effort. For example, among the states in the top 20 in spending, only four — Utah, Iowa, New Jersey, and Connecticut — rank below average in terms of fiscal effort, which is fewer than the number that rank below average in terms of fiscal capacity. This suggests that state policy may be the most critical factor in determining which states will spend relatively more in covering families at risk of being uninsured. Indeed, it is the only reason that a state such as Tennessee, which ranks 34th in its capacity and 35th in its effective federal matching rate, is able to raise its spending level above that of the vast majority of states.

States at the bottom of the rankings generally have low fiscal effort, which appears to lead to a number of missed opportunities. For example, two low-effort states — Nevada and Virginia — fail to exploit their notably strong capacity through even moderate fiscal effort, ranking 45th and 46th in their levels of spending. In addition, at least four states — Mississippi, Oklahoma, Alabama, and Idaho — seem to ignore the potential of a high effective matching rate and pursue a low-effort policy. This low-effort policy contrasts sharply with states such as West Virginia, Kentucky, and Maine, each of which clearly takes advantage of its high federal matching rate through a policy of strong fiscal effort and attains levels of spending equal to or greater than most states.

In sum, the particularly close link observed between spending and fiscal effort suggests that the long-standing differences between states in spending and coverage are not a foregone conclusion. Indeed, a disparate group of low-capacity states — including Maine, New Mexico, Tennessee, Vermont, and West Virginia — have all substantially improved their relative spending levels through policies of strong fiscal effort. To the extent that other low-capacity states are able and willing to pursue similar policies, the spending gap between rich and poor states could be reduced appreciably.

The particularly close link observed between spending and fiscal effort suggests that the long-standing differences between states and coverage are not a foregone conclusion.

B. Implications for Federal Policy

While the federal matching formula essentially serves as a form of indirect transfer from wealthy to poor states, its ultimate effect on both rich and poor states ranges from trivial to extreme. The clearest winners are states such as Utah, which receive a proportionately large federal matching rate that, in turn, can be distributed intensively over a small pool of at-risk

A completely separate alternative to the current formula approach is to provide federal subsidies to low-income families for the purchase of health insurance coverage.

individuals. At the other extreme are states such as California, which receive a relatively modest matching rate that must be spread thinly over a large, at-risk population. The states that fall in the middle are a heterogenous group, some of which have far greater need for this subsidy than others. Colorado and New Mexico, for example, receive an almost identical effective matching rate (about 60 percent); however, Colorado's level of per-capita income is more than 40 percent higher than New Mexico's.

Numerous alternatives exist to the current federal matching formula that might reduce spending disparities among states. One approach would be to reconfigure the existing matching formula so that it accounts for the relative need for public coverage in each state. For example, the matching rate might be adjusted for each state, depending on the state's relative percent of population without private health insurance. This approach would eliminate the more extreme redistributional effects of the current federal policy. A potential downside, however, is that it might also invite greater crowd-out of private insurers, since individual states would effectively realize reduced costs for enrollees who have access to private sources of coverage. Moreover, such a policy would require both current and accurate measures of private coverage in each state.

A completely separate alternative to the current formula approach is to provide federal subsidies to low-income families for the purchase of health insurance coverage. Many possible approaches to subsidization are available, and in practice, any proposed plan would need to balance the goal of increasing coverage with the complex and politically charged issues of efficiency and fairness (Blumberg 1999). Nevertheless, the approach offers a clear opportunity to reduce the fiscal burden on states with limited capacity and/or large shares of the population at risk of uninsurance, a goal achieved with mixed, largely random, success under existing federal policy.

TABLE 7
SUMMARY OF FACTORS LEADING TO STATE DISPARITIES IN MEDICAID SPENDING, 1997

State	Spending Per Capita at Risk [a]	Fiscal Capacity [b] (Rank)	State Fiscal Effort [c] (Rank)	Effective Federal Matching Rate [d] (Rank)
1. Alaska	$1,898	19	1	40
2. District of Columbia	$1,744	2	2	51
3. Hawaii	$1,665	18	3	46
4. Maine	$1,505	37	9	10
5. Maryland	$1,412	6	15	30
6. Rhode Island	$1,382	16	13	27
7. Connecticut	$1,257	1	28	32
8. Massachusetts	$1,207	4	17	43
Vermont	$1,207	33	12	18
10. New York	$1,174	5	4	49
11. Washington	$1,162	11	7	45
12. Utah	$1,159	45	34	1
13. Delaware	$1,132	7	11	48
14. New Hampshire	$1,093	8	25	29
15. Tennessee	$1,088	34	5	35
16. Oregon	$1,076	25	10	28
17. Illinois	$1,072	9	16	44
18. New Jersey	$1,043	3	29	38
19. North Carolina	$1,040	30	18	21
20. Iowa	$1,016	32	36	4
21. Pennsylvania	$1,006	16	23	33

TABLE 7
SUMMARY OF FACTORS LEADING TO STATE DISPARITIES IN MEDICAID SPENDING, 1997

State	Spending Per Capita at Risk [a]	Fiscal Capacity [b] (Rank)	State Fiscal Effort [c] (Rank)	Effective Federal Matching Rate [d] (Rank)
22. Kentucky	$973	40	20	12
23. Indiana	$954	30	42	3
24. West Virginia	$946	50	13	15
25. Michigan	$926	19	21	36
26. Nebraska	$858	28	32	19
27. North Dakota	$848	46	38	2
28. Colorado	$840	10	39	25
29. Minnesota	$833	14	26	31
Ohio	$833	22	35	20
31. Missouri	$824	28	33	23
32. Wisconsin	$819	23	48	9
33. New Mexico	$796	49	6	26
34. Georgia	$793	25	18	37
35. Kansas	$788	23	43	14
36. South Dakota	$775	38	44	6
37. South Carolina	$730	41	37	8
38. Wyoming	$726	35	31	24
39. California	$723	13	8	50
40. Louisiana	$703	41	27	16
41. Florida	$650	21	30	47
42. Oklahoma	$642	44	46	7
Texas	$642	27	22	41
44. Alabama	$629	39	47	11
45. Virginia	$618	15	50	34
46. Nevada	$613	11	41	42
47. Arizona	$581	36	24	39
48. Montana	$509	47	40	22
49. Mississippi	$487	51	49	5
50. Arkansas	$469	48	45	17
51. Idaho	$457	43	51	13

SOURCE: Rankings of Medicaid spending based on data from the Kaiser Commission on Medicaid and the Uninsured (1999). Rankings of the fiscal capacity based on data from the U.S. Department of Commerce (1999). Rankings of fiscal effort based on both these data sources. Rankings of effective federal matching rate based on data from the Kaiser Commission on Medicaid and the Uninsured (1999 and 2000).

NOTE: "At-risk population" defined as all non-elderly, low-income individuals who report no source of private or federal (Medicare/CHAMPUS) health insurance coverage during the year. "Low-income" defined as below 200 percent of the federal poverty level (FPL).

[a] Based on the adult and child categories of Medicaid expenditures since these categories include the vast majority of individuals at risk of being uninsured. See Table 3 for further details on the derivation of this measure.

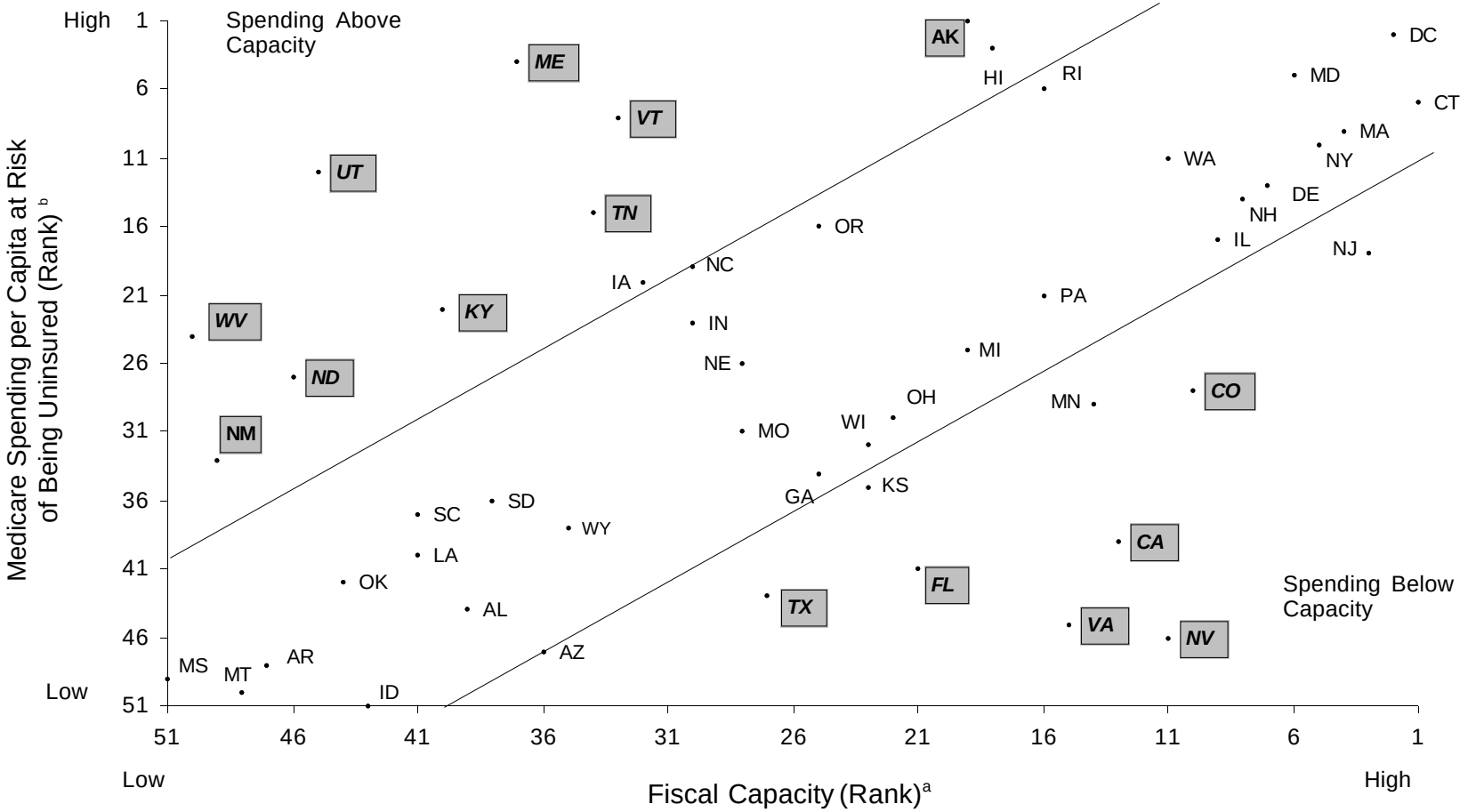
[b] Based on each state's per capita personal income. See Table 4 for an ordered ranking and additional details.

[c] Based on the ratio of state Medicaid spending and fiscal capacity. See Table 5 for an ordered ranking and additional details.

[d] Based on the actual matching rate in each state, scaled by the relative share of the population at risk of being uninsured. See Table 6 for an ordered ranking and additional details.

FIGURE 1

COMPARISON OF STATES' FISCAL CAPACITY AND SPENDING PER CAPITA AT RISK



SOURCE: Rankings of Medicaid spending based on data from the Kaiser Commission on Medicaid and the Uninsured (1999). Rankings of fiscal capacity based on data from the U.S. Department of Commerce (1999).

NOTE: "At-risk population" defined as all non-elderly, low-income individuals who report no source of private or federal (Medicare/CHAMPUS) health insurance coverage during the year. "Low-income" defined as below 200 percent of the federal poverty level (FPL).

[a] Based on each state's per capita personal income. See Table 4 for an ordered ranking and additional details.

[b] Based on the adult and child categories of Medicaid expenditures since these categories include the vast majority of individuals at risk of being uninsured. See Table 3 for an ordered ranking and additional details on the derivation of this measure.

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Endnotes

[1] For purposes of this paper, the "low-income" population includes all non-elderly individuals in households below 200 percent of the federal poverty level (FPL). This is the common reference point used in the literature examining the low-income uninsured.

[2] Estimates of Medicaid coverage are based on the latest Current Population Survey (CPS) estimates for the period 1996-1998, as reported by the Kaiser Commission (2000). Estimates of spending are based on a recent analysis of HCFA-2082 Medicaid expenditure data for 1997, as reported by the Kaiser Commission (1999). The spending estimates include expenditures only by recipients in the non-disabled adult and child enrollment categories, as they comprise the vast majority of the at-risk population insured through Medicaid.

[3] Data on low-income enrollment and spending in other state health insurance programs (SCHIP and various state-only programs) are either unavailable or are poorly verified for a number of states. Available evidence suggests, however, that these numbers are small relative to Medicaid enrollment and spending and would not significantly alter the rankings in state coverage and spending presented in this paper.

[4] Source: The Times and Free Press News, May 25, 2000.

[5] Among the factors that dictate costs per beneficiary are the costs of private-market medical services, the level of state Medicaid payments relative to these costs, the extent of managed care, the characteristics of enrollees, and the availability and quality of services.

[6] The correlation coefficient between the rate of private insurance and the percent low-income is -0.74, confirming their close association.

[7] For the low-income population, the correlation coefficient between the rates of uninsurance and Medicaid coverage is -0.52, compared to a correlation of -0.38 between rates of uninsurance and private coverage. Note that for the full population, private coverage is far more closely correlated with uninsurance (-0.83, compared to 0.15 for Medicaid).

[8] Examples include: Arkansas and Louisiana; New Mexico and Nevada; New York and New Jersey; Florida and Georgia; Tennessee and Kentucky; Vermont and Maine; and Oregon and Washington.

[9] Note that the rankings in Table 2 are based on estimates of health insurance coverage in each state. As such, states that rank near each other may or may not differ significantly in their estimated rates of coverage. Nevertheless, the general stability in these rankings over the past decade suggests that they provide a good indication of the relative levels of coverage in individual states.

[10] For the low-income population, the correlation between Medicaid coverage of the at-risk population and uninsurance is -0.83. For the overall population, this correlation remains quite high, at -0.65.

[11] Overall, 19 states have spending and coverage rankings that differ by five spots or less, and half the states have rankings that differ by fewer than 10 spots. The overall correlation between these two sets of rankings is 0.56; this correlation rises to 0.77 when one removes the six most significant outlier cases (where the two rankings are furthest apart).

[12] Well-known limitations with the CPS data used to develop estimates of Medicaid coverage may also contribute to some of these differences (see Czjaka and Lewis 1999). In addition, the Medicaid spending data includes some beneficiaries who are not counted among the at-risk population, either because they had annual income above 200 percent of the FPL or because they had private insurance for at least part of the year. Although the number of these beneficiaries is small, this group may contribute modestly to any differences between states' rankings of coverage and spending.

[13] Algebraically, these determinants of spending may be expressed as follows: Total Medicaid spending = (state fiscal capacity*state fiscal effort)*(1 + the federal matching rate). State fiscal effort may then be further dichotomized as: state fiscal effort = (state Medicaid spending per capacity) = (tax revenues per capacity)*(share of taxes allocated to Medicaid).

[14] The rankings in Table 4 are based on the level of per-capita personal income in each state. This measure is the most straightforward and certainly the most commonly used indicator of fiscal capacity. A number of alternative measures are available, most of which try to capture more comprehensively those resources potentially taxable by the state. The rankings shown in Table 4 generally change very little under these alternative measures. However, some energy-producing states (most notably, Alaska and Wyoming) display much larger fiscal capacity under these alternative measures because they capture large income flows to non-resident shareholders of in-state energy producers.

[15] For example, based on Table 1, only about 13.1 percent of Utah's population qualifies as at risk because it is low-income and lacks private insurance. Dividing this by the average across all states (18.5 percent) leads to a scaling factor of 0.71. In 1997, the federal matching rate for Utah was $2.61 for every $1 in state Medicaid spending. Dividing this amount by the scaling factors leads to an effective matching rate for Utah of $3.70.

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