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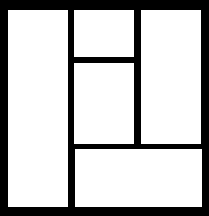

NEW FEDERALISM
HIGHLIGHTS FROM STATE REPORTS

A product of "Assessing the New Federalism," an Urban Institute Program to Assess Changing Social Policies

Health Policy for Low-Income People in Alabama

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Alabama is a politically conservative state in which traditional values play an important role in shaping public policy. Alabama citizens generally favor a small role for government, and the political culture, combined with a tight fiscal environment, leaves policymakers with little choice but to provide minimal levels of health and welfare benefits. Thus, social programs in the state are designed primarily to meet basic federal requirements and, in part, to maximize federal funds while minimizing state spending. Within this context, the state has introduced several innovative health programs for low-income residents, including a Medicaid maternity case management program. Alabama was also the first state to gain federal approval of its proposal to expand health insurance coverage under the newly created State Children's Health Insurance Program (S-CHIP). Finally, Alabama has supported a relatively strong safety net of health care providers through Medicaid federal matching funds and generous private third-party payments.

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State Characteristics

Alabama is a small, southern state with a large low-income population. In 1994–95 the population was 4.3 million, consisting of primarily non-Hispanic blacks and whites (table 1). Non-Hispanic black persons accounted for nearly 29 percent of the population, compared with about 13 percent for the country as a whole.

Historically, Alabama has been a very poor state, especially in rural areas, which contain more than one-third of the state's population. The percentage of the population with incomes below the federal poverty level (FPL) was 17.6 percent in Alabama in 1994, compared with the national average of 14.3 percent (table 1). Average per capita income was $19,181 in Alabama in 1995, 17.3 percent below the national average. However, the economy of Alabama has done well in recent years. Not only has per capita income grown faster than the national average, the unemployment rate is slightly below the national average. The state's economy, which relied in the past on agriculture and steel production (especially in Birmingham), has diversified into services, especially health care and high-technology services.

Alabama is below average among the states in health status of the population and has a higher proportion than average of uninsured people. In a ranking of the relative healthiness of the populations in all 50 states, Alabama was 41st in 1996.[1] Alabama has significantly higher rates of low birth weight, infant mortality, and premature death than the national average (table 1). The infant mortality rate, in particular, is quite high, but it has declined substantially in recent years.

Lack of health insurance in Alabama is a concern, with 16.9 percent of the nonelderly

Table 1
State Characteristics

Sociodemographic	Alabama	U. S.
Population (1994–95) (in thousands)	4,314	260,202
Percent under 18 (1994–95)	27.4%	26.8%
Percent 65+ (1994–95)	13.6%	12.1%
Percent Hispanic (1994–95)	0.8%	10.7%
Percent Non-Hispanic Black (1994–95)	28.9%	12.5%
Percent Non-Hispanic White (1994–95)	69.6%	72.6%
Percent Non-Hispanic Other (1994–95)	0.7%	4.2%
Percent Noncitizen Immigrant (1996)*	0.9%	6.4%
Percent Nonmetropolitan (1994–95)	36.8%	21.8%
Population Growth (1990–95)	5.3%	5.6%
Economic		
Per Capita Income (1995)	$19,181	$23,208
Percent Change in Per Capita Personal Income (1990–95)	26.0%	21.2%
Unemployment Rate (1996)	5.1%	5.4%
Percent below Poverty (1994)	17.6%	14.3%
Percent Children below Poverty (1994)	23.8%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	16.9%	15.5%
Percent Medicaid—Nonelderly (1994–95)	10.4%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	66.3%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	6.4%	6.2%
Smokers among Adult Population (1993)	18.5%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	9.0%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	10.2	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	67.1	54.4
Violent Crimes per 100,000 (1995)	632.4	684.6
AIDS Cases Reported per 100,000 (1995)	15.1	27.8

Source: Complete list of sources is available in *Health Policy for Low-Income People in Alabama* (The Urban Institute, 1997).
* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.

population uninsured in 1994–95.[2] However, somewhat surprisingly, given the state's restrictive Medicaid coverage, the state's uninsurance rate is less than two percentage points higher than the national average. A rate of employment-based health insurance that matches the national average contributes to keeping the uninsurance rate from being higher.

Although many urban areas, such as Birmingham, have a wealth of health care providers, the state as a whole has a lower concentration of physicians—but a greater density of hospital beds—than the country overall. In 1995, there were 179 physicians per 100,000 population in Alabama, whereas there were 228 physicians per 100,000 in the nation. In contrast, the state had 526 hospital beds per 100,000 population, while the country as a whole had 411 hospital beds per 100,000 population.

Political and Fiscal Landscape

Conservatism mixed with populism characterizes Alabama politics among Democrats and Republicans alike. According to some observers the state's conservatism is rooted in maintenance of the status quo, rather than in a philosophical commitment to the superiority of competitive markets. Fundamentalist Christian values also play an important political and cultural role in the state. As in most of the South, Republicans have made very dramatic gains (especially for higher office) in a state that was previously solidly Democratic. Governor Forrest "Fob" James is a Republican, but the legislature remains heavily Democratic.

Structurally, Alabama state government is characterized by a strong governor and a weak legislature and minimal delegation to counties of control over public programs. Part-time legislators meet for only 30 working days within a 105-calendar-day session each year and have very small staffs. Legislators have a strong local focus, reflecting an unusual aspect of Alabama's constitution that greatly restricts the power of county government. As a result, matters of local interest are often taken up by the state legislature. The short length of the legislative session, the lack of legislative staff, and the emphasis on matters of local interest often mean that little time is available to address issues of statewide importance other than the budget.

Alabama—along with Mississippi—is inextricably associated with the civil rights revolution of the 1950s and 1960s. Overt racism by public officials has disappeared, but many observers, especially black persons, believe that race is still an extremely important determinant of state and local policy.

The budgetary environment of the state is determined by two related factors. First, there is very strong anti-tax sentiment in Alabama. Although there is a modest state income tax and a relatively high sales tax, property taxes are among the lowest in the country. Overall, state and local taxes per capita are very low. Second, the vast majority of Alabama taxes are earmarked for one of two funds—the general fund and the Alabama Special Educational Trust Fund. Sales and income taxes, which account for the bulk of revenues, are earmarked for education purposes, while a wide variety of miscellaneous revenue sources fund the rest of state government, including Medicaid, public health, welfare, and public safety. The net

effect of these two related factors, in conjunction with the relatively low average income of the population, is that financial resources for health and welfare are unusually constrained. Programs often rely extensively on federal funds, and the state operates few, if any, programs of fiscal significance that do not qualify for federal support. It should be noted that political and, thus, budgetary support for Medicaid is higher than for cash welfare assistance, in part because well-financed provider groups that are financially dependent on Medicaid, particularly the for-profit nursing home industry, lobby to protect the program.

Medicaid Budget Issues

Alabama's Medicaid program is limited in its eligibility and benefits, mostly following minimum federal standards. Because state matching funds are usually not available, Alabama has not attempted to maximize the amount of federal dollars flowing into the state by increasing its own spending and capitalizing on its high federal matching rate (nearly 70 percent). Instead, federal funds have been used to stabilize state spending for Medicaid and other social programs by financing the expenditure growth.

As a result of these constraints, the state is always close to budgetary crisis and is particularly vulnerable to changes in federal rules that require additional spending. During 1996, the state faced major problems in meeting federal requirements for its Medicaid disproportionate share hospital (DSH) payment program; failure to do so could have meant the loss of very large amounts of federal dollars. Alabama has been extremely aggressive in its use of the DSH program in conjunction with intergovernmental transfers and provider taxes to maximize federal revenues. Alabama's use of intergovernmental transfers and provider taxes goes far beyond providing state matching funds to finance DSH payments and accounts for the vast majority of the state's match for Medicaid. In fact, state general fund expenditures constitute only about a quarter of the state's Medicaid matching funds. Whereas Medicaid in Alabama accounted for 17.5 percent of total state expenditures from all sources (including federal) in 1995, the program consumed only 5.0 percent of state general fund expenditures. State general fund expenditures on Medicaid have been relatively stable for the past several years.

Alabama's use of intergovernmental transfers and provider taxes goes far beyond providing state matching funds to finance DSH payments and accounts for the vast majority of the state's match for Medicaid.

Total Medicaid expenditures in Alabama grew from $829.5 million in 1990 to nearly $2 billion in 1995, at an annual rate of growth of 19.2 percent, which was faster than the national average (table 2). As with the rest of the country, expenditure growth rates were much higher between 1990 and 1992 than between 1992 and 1995. While growth in DSH expenditures in the early 1990s explains a significant

Table 2
Medicaid Expenditures by Eligibility Group and Type of Service, Alabama and United States
(Expenditures in Millions)

	Alabama			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Total	**$1,993.8**	**36.2%**	**9.0%**	**$157,872.5**	**27.1%**	**9.9%**
Benefits						
Benefits by Service	$1,536.7	29.4%	12.4%	$133,434.6	18.8%	11.0%
Acute Care	930.3	30.2%	14.6%	79,438.5	22.1%	13.0%
Long-Term Care	606.4	28.3%	9.3%	53,996.1	14.8%	8.3%
Benefits by Group	$1,536.7	29.4%	12.4%	$133,434.6	18.8%	11.0%
Elderly	$497.9	28.1%	8.9%	$40,087.4	16.7%	8.1%
Acute Care	126.4	16.1%	7.1%	9,673.7	18.5%	11.9%
Long-Term Care	371.5	33.5%	9.6%	30,413.7	16.2%	7.0%
Blind and Disabled	$630.3	25.0%	15.9%	$51,379.4	17.7%	12.9%
Acute Care	400.2	29.6%	20.6%	29,760.7	22.8%	15.2%
Long-Term Care	230.1	19.8%	9.3%	21,618.7	12.3%	10.1%
Adults	$185.2	29.7%	9.9%	$16,556.9	20.4%	9.2%
Children	$223.2	47.4%	13.2%	$25,410.9	24.3%	13.3%
Disproportionate Share Hospital	**$417.5**	**63.2%**	**0.0%**	**$18,988.4**	**261.5%**	**2.7%**
Administration	**$39.6**	**20.2%**	**2.0%**	**$5,449.4**	**9.8%**	**12.8%**

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Table 3
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	Alabama			United States		
		Average Annual Growth			Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Elderly						
Total expenditures on benefits (millions)	$497.9	28.1%	8.9%	$40,087.4	16.7%	8.1%
Enrollment (thousands)	79.3	1.2%	0.6%	4,116.6	5.1%	3.0%
Expenditures per enrollee	$6,279	26.7%	8.3%	$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	$630.3	25.0%	15.9%	$51,379.4	17.7%	12.9%
Enrollment (thousands)	145.7	9.3%	8.0%	6,405.2	9.8%	9.5%
Expenditures per enrollee	$4,325	14.4%	7.3%	$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	185.2	29.7%	9.9%	$16,556.9	20.4%	9.2%
Enrollment (thousands)	96.6	11.6%	–1.5%	9,584.2	11.5%	4.6%
Expenditures per enrollee	$1,918	16.2%	11.6%	$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	223.2	47.4%	13.2%	$25,410.9	24.3%	13.3%
Enrollment (thousands)	300.0	19.1%	6.1%	21,566.0	13.1%	4.8%
Expenditures per enrollee	$744	23.8%	6.7%	$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

share of the rapid rate of growth, benefit payments for all service categories and eligibility groups increased rapidly as well. In particular, large increases occurred among the blind and disabled and among children, fueled in equal parts by growth in enrollment and expenditures per enrollee (table 3). Since 1992, growth in both expenditures per enrollee and enrollment have slowed for all four beneficiary groups. In particular, enrollment growth has tapered off, and enrollment levels are projected to stay fairly constant over the next several years.

The Alabama Medicaid program covers relatively few services and places limits on many of them (e.g., the program covers only 16 hospital days per year). In addition, Alabama has very strict financial eligibility criteria for its Medicaid program. In 1995, approximately 10.6 percent of the state's population was enrolled in Medicaid. This represents 46.7 percent of the population with incomes below 150 percent of the federal poverty level (FPL), well below the 63.6 percent for the country as a whole.

Other Insurance Initiatives

Because of its large number of uninsured children, Alabama is eligible for $86 million in federal funds in fiscal year 1998 ($397 million for 1998–2002) for the S-CHIP established by the federal Balanced Budget Act of 1997. On January 30, 1998, Alabama became the first state to gain approval of its S-CHIP program from the federal government. Using S-CHIP funds, Alabama will extend Medicaid eligibility to youth ages 14 through 18 with family incomes up to 100 percent of the FPL, which is a small expansion relative to that of many other states. The state does not have any other state-funded insurance programs for persons ineligible for Medicaid. Moreover, private health insurance reform appears to be a low priority, with the state seeking only to comply with the minimum requirements of the Health Insurance Portability and Accountability Act of 1996.

Managed Care

Compared to those in some other states, the health care market in Alabama has yet to experience the expansion of managed care on a broad scale. About 11 percent of the state's privately insured population is enrolled in an HMO, which is about half the national rate. The dominance of Blue Cross/Blue Shield, which insures or is the third-party administrator for approximately 70 percent of the insured population in the state, has impeded development and growth of HMOs. The lack of strong HMOs, as well as the medical establishment's antagonism toward managed care, has led the Medicaid program to rely on less comprehensive approaches to managed care, such as primary care case management. Many credit a decade-old freedom of choice Medicaid waiver mandating case management for pregnant women (along with

federally imposed Medicaid eligibility expansions) with substantially reducing infant mortality. In addition, Alabama has rolled out a primary care case management program for the general Medicaid population, and it is currently operating in more than 20 counties. The state also has a Medicaid research and demonstration waiver under way in Mobile County, in which Medicaid recipients enroll in a single HMO.

Faced with potential reductions in federal DSH payments as a result of the rules imposed by the Omnibus Budget Reconciliation Act of 1993, the state worked with hospitals to create eight prepaid health plans (PHPs) to receive capitated payments for hospital care. DSH payments are folded into the capitation rate, and the PHPs are able to distribute DSH payments however they choose without regard to federal rules. While many observers believe that these PHPs are transparent efforts to evade federal rules, the Medicaid agency resolutely maintains that these organizations provide managed care. The Balanced Budget Act of 1997 grandfathered the Alabama PHP structure for the short term; however, the law raises questions about the ability of the state to continue to use these entities to distribute DSH funds in the future, and it also reduces the state's federal DSH allotment over time.

Safety Net Providers

Alabama's safety net, which provides health care to the uninsured and Medicaid populations, is reasonably solid, partly compensating for the limits of Medicaid and other insurance coverage. The lack of aggressive price competition in the health care market gives providers the ability to cross-subsidize care for the uninsured. The DSH program is also critical to funding uncompensated care delivered by hospitals in the state, many of which are county facilities that receive limited local tax support.

The state health department, operating out of county health departments, plays an important role in providing services, especially maternal and child health and home health care. In recent years, Medicaid beneficiaries' use of health department services has declined as managed care has linked patients to private physicians.

Alabama's public local and state university hospitals and community health centers provide a substantial amount of health care to the uninsured. Birmingham, with its large number of health care providers, is a city where the uninsured may obtain care for acute episodes or emergencies, but where ongoing management of health problems can be problematic. Access to health care in rural areas can be particularly difficult because of transportation problems and the lack of providers. With the expected expansion of managed care in the employer-sponsored and Medicaid markets and the development of a more competitive market, the question for the future is whether the existing facilities will continue to provide substantial levels of uncompensated care.

Long-Term Care

Long-term care for the elderly and younger people with disabilities is a critical component of the state's involvement in health care and a significant part of the Medicaid program. The long-term care delivery system has a strong institutional bias, although substantial strides have been made in shifting toward home and community-based services for the mentally ill and people with mental retardation/developmental disabilities. In 1997, Medicaid reimbursement for nursing homes was a bitter issue between Governor James and the nursing home industry, with the governor proposing 20 to 30 percent reductions in nursing home rates to solve a significant Medicaid budget overrun. This proposal was rejected by the legislature, which chose instead to establish a commission to make recommendations on nursing home reimbursement, increase the nursing home provider tax, and make modest reimbursement rate changes. Reliance on the provider tax means that the federal government will finance most of the budget shortfall through its Medicaid match.

Challenges for the Future

Alabama faces several challenges for the future. First, how will the state adjust to changes in the federal rules on DSH payments? Second, will Alabama be able to expand managed care—in both the private and public sectors—in a way that does not undermine the safety net? And, finally, with the repeal of federal rules on nursing home reimbursement, will the state reduce reimbursement rates, and what will be the consequences of doing so?

Notes

1. ReliaStar Financial Corporation, *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States,* 1996 edition,

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