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RYAN WHITE CARE ACT OF 1990

Opportunities Are Available to Improve Funding Equity

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the distribution of funds to states and metropolitan areas under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. With over 400,000 people in the United States being reported as having the acquired immunodeficiency syndrome (AIDS) and over 240,000 people reported as having died of the disease, AIDS has become one of the most serious health threats to the American public. Currently, the CARE Act is the only federal program that makes funds available specifically for the provision of medical and support services to individuals with AIDS and the human immunodeficiency virus (HIV).

Title I of the CARE Act makes funds available to metropolitan areas disproportionately affected by HIV for the provision of medical and support services. During fiscal year 1994, $326 million in title I funds were appropriated and distributed to 34 eligible metropolitan areas (EMA)[1] in 17 states, the District of Columbia, and Puerto Rico. Title II of the act provides funds to states and territories for medical and support services, medication assistance, home health care, and insurance continuation. During fiscal year 1994, $184 million were appropriated under title II. Of the over $500 million in title I and II funds that were distributed to the states and EMAs in fiscal year 1994, over $300 million were distributed by formula. The remaining funds were distributed competitively through supplemental grants to EMAs and grants to programs determined to be Special Projects of National Significance.

Today, we are here to report on the results of a study we conducted at the request of the Chairman of the Senate Committee on Labor and Human Resources and Senator Brown. The study examined (1) how equitably the existing formulas are distributing title I and II funds, (2) which factors inhibit the formulas from achieving greater equity, and (3) what formula changes could improve equity. Our study focused on only those title I and II funds that are distributed by formula and did not consider funds that were awarded competitively.

We assessed the funding distribution resulting from the existing formulas using two widely recognized equity criteria.[2] The first criterion--beneficiary equity--considers the degree to which federal funds enable each EMA or state to purchase a comparable level of services for its HIV population. The second--taxpayer equity--considers the degree to which EMAs and states are able to

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[1]To be eligible for these funds, a metropolitan area must have reported a cumulative case count of more than 2,000 cases of AIDS or a cumulative case count of AIDS cases that exceeds one-quarter of 1 percent of its population.

[2]These criteria have been used to assess a variety of funding formulas. See bibliography.

supplement federal funds to finance a comparable level of services with comparable burdens on their taxpayers. To meet either the beneficiary or the taxpayer equity criterion, grant allocation formulas should reflect the following dimensions of state or local funding needs: (1) caseloads--that is, the number of people potentially needing services--and (2) the cost of providing those services. To satisfy the taxpayer equity criterion, formulas should also reflect the capacity of state and local taxpayers to fund services from state and local resources.

In brief, our study found that the CARE Act funding formulas result in per case funding disparities that are, to a large extent, unrelated to service costs or to the ability of states and EMAs to fund services from local sources. These funding disparities result from the fact that (1) EMA cases are inappropriately double counted in both the title I and II formulas, (2) there is no indicator that reflects differences in the cost of providing services in both states and EMAs, and (3) formula factors are present that inappropriately measure caseloads and funding capacity. We believe that greater funding equity could be achieved by changing the structure of the two titles to correct the bias introduced by double counting EMA AIDS cases and by using more appropriate measures of EMA and state funding needs.

BACKGROUND: THE CURRENT FORMULAS

The CARE Act was signed into law on August 18, 1990, "to improve the quality and availability of care for individuals and families with HIV disease." Title I of the act makes funds available to EMAs--localities disproportionately affected by HIV--for the purpose of providing medical and support services to individuals residing in their areas. Sixteen EMAs initially received title I funding in 1991, and the number has grown to 34 EMAs in fiscal year 1994 and to 42 in fiscal year 1995. Title II of the act makes funds available to states to provide medical assistance to people living outside EMAs and to provide other forms of assistance to all state residents.

Each title has a separate funding formula. The title I formula includes measures of EMAs' caseloads and funding capacities, but it does not include a measure of their service costs. Caseloads are measured by the cumulative number of AIDS cases reported since 1981, and funding capacity is measured by the EMAs' AIDS incidence rates (the number of cumulative AIDS cases per capita). In fiscal year 1994, the existing title I formula resulted in per case funding amounts that ranged from $805 in Riverside, California, to $2,556 in San Francisco--a difference of over 300 percent.

The formula for title II, like that for title I, includes measures of states' cases and fiscal capacities but not their service costs. Caseload is measured by the number of reported AIDS cases in each state for the 2 most recent fiscal years for which

data are available, and fiscal capacity is measured by states' per capita personal income. During fiscal year 1994, the existing title I and II formulas resulted in total per case funding amounts that ranged from $960 in Hawaii to $2,600 in New York--a difference of 270 percent.[3]

ASSESSING THE EQUITY OF THE FORMULAS

Title I Formula Meets Neither Equity Criterion

Our examination of the title I formula indicates that it currently meets neither the beneficiary nor the taxpayer equity criterion. The beneficiary equity criterion is not met because per case funding is not systematically related to the cost of treating people who have HIV. As mentioned before, per case funding in fiscal year 1994 varied by over 300 percent; but cost differences accounted for only 13 percent of this variation.[4] As an illustration, the Dallas and Oakland EMAs each received title I allocations of approximately $1,200 per person seeking services, but the costs of providing services in Oakland are about 37 percent higher than in Dallas.

Nor is the taxpayer equity criterion met. In addition to not being systematically related to cost differences, EMA grant amounts are not highly related to their funding capacity either. Our analysis of fiscal year 1994 funding for EMAs showed that over 40 percent of the variation in per case funding could not be accounted for by differences in cost and funding capacity. Using Dallas and Oakland as an example again, Oakland's funding capacity when measured in terms of its tax base, costs, and concentration of AIDS cases is 17 percent lower than that of Dallas. Under the taxpayer equity standard, Oakland should receive a larger grant to compensate for its higher costs and its lower funding capacity. Under the current title I formula, however, Dallas and Oakland receive the same per case funding amounts.

Combined Title I and II Funding Does Not Meet Equity Criteria

When we examined the distribution of CARE Act funding across states, we found that funds allocated under titles I and II did not

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[3]To obtain a more conservative estimate of this variation, we are not considering per case funding amounts for territories and states that received the minimum title II grant of $100,000.

[4]The two EMAs located in Puerto Rico--Ponce and San Juan--were excluded from this analysis. The inclusion of these EMAs would result in cost differences accounting for only 2 percent of the variation.

meet the beneficiary or the taxpayer equity criteria.[5] Total per case funding ranges from $960 to $2,600. For states like California and New York, per case funding is 20 percent and 30 percent above the national average, respectively, while states like Delaware, Hawaii, and Vermont have total per case funding levels about 50 percent below the national average. We found that cost and funding capacity could explain only 36 percent of these differences.[6] Approximately 64 percent of the variation in state funding per AIDS case appears to be unrelated to states' funding needs.

FUNDING INEQUITIES RESULT FROM THE STRUCTURE AND COMPONENTS OF THE TITLE I AND II FORMULAS

Multiple features of the title I and II formulas contribute to the funding inequities we have identified. Specifically, they occur because of the counting of EMA cases in both the title I and II formulas, the inclusion of an inappropriate caseload measure in the title I formula and inappropriate measures of EMAs' or states' funding capacities in both formulas, and the absence of any measure of EMAs' and states' service costs.

Double Counting EMA Cases

Our analysis of differences in states' per case funding amounts indicates that about half of this variation is due to the double counting of EMA cases in both the title I and II formulas rather than differences in funding needs (that is, cost or funding capacity differences). The inequities are larger in states where a majority of the cases live in EMAs, since a larger fraction of their caseload is double counted. For example, per case funding was about $1,000 in states without an EMA, $1,700 in states where less than half the state's caseload lived in an EMA, and $2,200 in states where more than half of the state's caseload lived in an EMA (see fig. 1). Thus, most of the variation in per case funding can be explained by the extent to which a state's caseload is double counted rather than by the state's funding needs.

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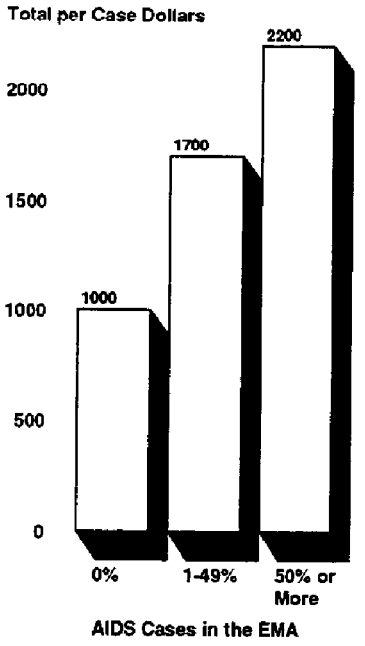
[5]For purposes of our comparisons, interstate funding equity was based on the total amount of title I and II funds allocated within the states. We did not perform a separate analysis of the title II formula.

[6]To develop a more valid estimate, we excluded from our analysis those states that received the minimum title II grant amount of $100,000.

Figure 1: State Funding by AIDS Cases Residing in an EMA

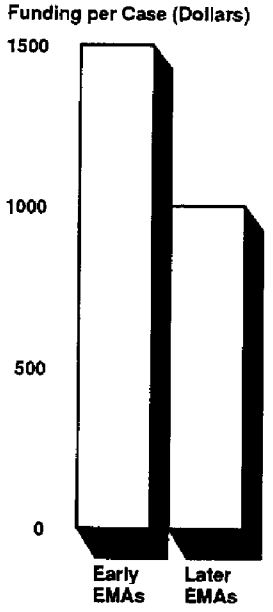


Inappropriate Title I Caseload Measure

The title I caseload measure is based on the cumulative number of people with AIDS that EMAs reported to the Centers for Disease Control and Prevention (CDC) since 1981, when reporting began. By the end of 1993, however, two-thirds of these people had been reported to have died and were, therefore, no longer using title I funded services.

Because the formula includes deceased persons, the EMAs that experienced more recent increases in AIDS cases receive substantially less per case funding than do the older EMAs. For example, the 18 EMAs that were first eligible to receive title I funds were funded in fiscal year 1994 at about $1,500 per case on average. In contrast, during this same fiscal year, the 16 EMAs that had become eligible later were funded at only $1,000 per case--one-third less than the older EMAs (see fig. 2).

Figure 2: Fiscal Year 1994 Funding per Case



Note: Early EMAs are the first 18 that entered the program, and later EMAs are the next 16 that became eligible under title I.

Absence of a Cost Measure

While the costs of providing AIDS and HIV services vary among EMAs and states, neither the title I nor title II formula includes a factor to measure those differences. Information on the actual costs of providing health and support services to people with AIDS and HIV within different geographic areas is not available. However, most of the delivery costs for these services appear to be associated with the personnel who provide the services. Titles I and II primarily fund outpatient health, support, and case management services, and these services are labor-intensive. A proxy measure for labor costs is available through the Medicare Hospital Wage Cost Index.[7]

Using this index for title I cities, we estimated that the cost of providing medical services was about 30 percent above the national average in the New York, Oakland, and San Francisco EMAs and about 10 percent below the national average in the Miami EMA--a difference of about 40 percent. This suggests that the New York, Oakland, and San Francisco EMAs must spend much more than the Miami EMA to provide a comparable level of services to their patients. Similarly, under title II, we estimated that the cost of providing

[7]The Medicare Hospital Wage Cost Index was derived from hospital salary surveys and was designed to be reflective of personnel costs in hospitals subject to the Medicare prospective payment system.

medical services was more than 15 percent above the national average in the states of Alaska, California, and New York and more than 10 percent below the national average in states like Alabama, Arkansas, and Mississippi.

Inappropriate Fiscal Capacity Measures

State and EMA funding capacities depend on the size of their tax bases and the service demands placed on those tax bases. The current title I formula measures the demand for services through the use of an AIDS incidence rate factor, but the strength of each EMA's tax base is not included. As a result, the title I formula does not adequately adjust EMAs' allocations to target those with smaller tax bases and fewer resources to draw upon for financing the needs of the cases they must serve.

The title II formula does measure the strength of each state's tax base through the use of per capita personal income. However, it does not consider the demand for services that is placed on state tax bases. As a result, the title II formula does not adequately adjust state allocations to target states with tax bases that are burdened by a heavy demand for services.

GREATER FUNDING EQUITY CAN BE ACHIEVED

A formula for allocating funds may meet either the beneficiary equity criterion or the taxpayer equity criterion, but no formula is likely to completely satisfy both criteria simultaneously. As a result, the choice of developing a formula that meets one or a combination of the two equity criteria depends on judgments about whether beneficiary or taxpayer equity should be emphasized. Regardless of which criterion is emphasized, however, the following changes could make the title I and II formulas more reflective of these equity criteria.

First, the current title I and II structure could be revised to avoid inequities created by counting EMA cases in both formulas. Presently, funding for titles I and II might not reflect the division of service responsibilities between EMAs and state governments. Through title I, EMAs provide medical services to people in their areas of coverage. Through title II, states provide medical services to people in non-EMA areas and administer services such as medication assistance and insurance continuation statewide for all cases.[8] Nonetheless, while EMAs provide the bulk of medical services to people living within the EMA, title II provides funding as if the state were providing both medical and statewide services to the EMA cases. This results in a higher level of per case funding to cases living in the states with EMAs.

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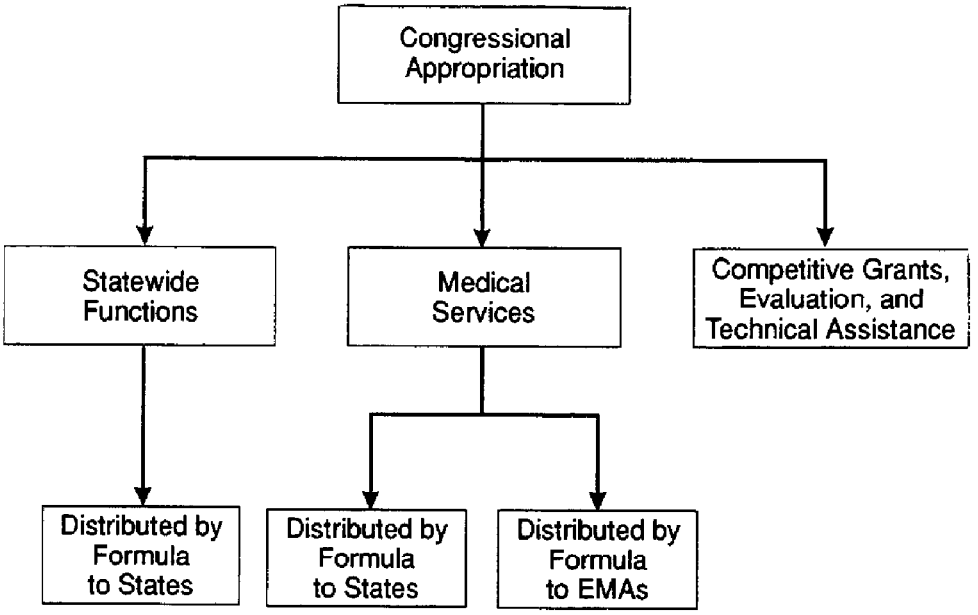
[8]At their discretion, states may provide medical services to people who live in EMAs.

In our opinion, a more equitable structure would, in effect, double count all cases. Cases would be counted once for the statewide services such as medication assistance and insurance continuation, and once for medical services whose provision may be divided between the states and EMAs.

One means for achieving this would be to make separate appropriations for the major activities funded by the CARE Act rather than for the levels of government that are responsible for administering the funds as does current practice.[9] One appropriation would be made for services that state governments provide statewide (that is, home health, medications, and insurance continuation), and a second appropriation would be made for medical services whose provision is shared by the state governments and EMAs (see fig. 3).[10] An equity-based formula could then be developed to allocate funding for statewide services based on the total caseload of each state. Similarly, funds appropriated for medical services could be divided into allocations to state governments, based on the non-EMA portion of state caseloads, and another allocation for EMAs based on AIDS cases living in their service delivery area.

Figure 3: Proposed Structure



[9]Currently, title I makes an appropriation for EMA functions, and title II makes a separate appropriation for state functions, some of which overlap the EMA functions.

[10]A third appropriation could be made for discretionary purposes (that is, competitive grants, evaluations, and technical assistance).

A second change that would improve equity would be to include a caseload measure that estimates the number of people living with AIDS and excludes deceased persons. We have developed such an estimate from existing CDC data.

Third, the formulas could include a cost measure, such as the Medicare Hospital Wage Cost Index. Use of such a measure would better compensate the EMAs and states that must pay more to provide services to their clients because of their higher private sector health care costs.

Finally, to increase resources in states and EMAs with poorer funding capacity, the current fiscal capacity factors could be revised to better measure the EMAs' and states' AIDS incidence rates and tax bases. Currently, the title I fiscal capacity factor lacks a measure of EMAs' tax bases, and the title II factor lacks a measure of states' incidence rates. By having more complete measures of EMA and state fiscal capacities, the formulas could adjust grants based on both the demand for services and the strength of tax bases. In addition, using total taxable resources (TTR)[11] in the state formula instead of personal income could result in a more comprehensive measure of state tax bases.

CONCLUSIONS

Our analysis of the existing formulas suggests that federal funding under titles I and II of the CARE Act can be made more equitable. An important purpose of the legislation was to target emergency funding to areas of greatest need. When the legislation was enacted, high incidences of HIV were found in fewer areas of the country, service delivery networks were just beginning to form, and these service delivery systems had to rely primarily on private and volunteer resources.

However, HIV has become much more a nationwide rather than a localized epidemic in the past 5 years. A key question now is: Does the distribution of CARE Act funds fairly reflect the relative funding needs of states and EMAs charged with caring for this vulnerable population?

Our study indicates that greater equity can be achieved in the distribution of funds. This can be done by changing the current structure of the two titles to count both EMA and non-EMA cases in

[11]TTR measures a state's fiscal capacity by measuring all income potentially subject to a state's taxing authority. TTR is an average of personal income and per capita Gross State Product (GSP). Personal income is compiled by the Department of Commerce and used to measure the income received by state residents. GSP measures all income produced within a state, whether received by residents, nonresidents, or retained by business corporations.

the distribution of both medical services and statewide services funding, changing the title I caseload measure to better reflect the service population, changing both formulas' fiscal capacity measures to better reflect EMA and state resources, and including cost measures in each of the formulas to adjust grants based on the costs that EMAs and states incur to provide services.

Modifying the formulas to achieve a more equitable distribution of funds will involve significant changes in grants to some EMAs and states. To avoid undue disruption of service delivery, any change could include a phasing-in of formula modifications. Measures such as these should minimize, if not avoid, disruption of the service delivery networks the CARE Act has made possible over the last 5 years.

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Mr. Chairman, this concludes my prepared remarks. We would be pleased to respond to any questions at this time.

For more information on this testimony, please call Jerry Fastrup, Assistant Director, at (202)512-7211. Other major contributors included Greg Dybalski, Senior Economist, and Mark Vinkenes, Senior Social Science Analyst.

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FORMULA FACTORS

	Title I	**Title II**
Current factors		
Caseload	Cumulative AIDS cases	AIDS cases for the 2 most recent fiscal years
Cost	Not measured	Not measured
Fiscal capacity	Per capita AIDS incidence	Cubed root of per capita personal income
Proposed factors		
Caseload	Weighted estimates of persons living with AIDS	
Cost	Medicare Hospital Wage Cost Index	
Fiscal capacity	Tax base adjusted by AIDS incidence rates	

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