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Thomas W. Grannemann
Centers for Medicare and Medicaid Services, Boston Regional Office

Mark V. Pauly
Department of Health Care Management
Wharton School, University of Pennsylvania
and
American Enterprise Institute

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Abstract

Medicaid program costs are shared by the federal and state governments according to a formula which sets the share of costs paid by the federal government: the federal medical assistance percentage (FMAP). The FMAP formula, which specifies these federal matching rates, has been largely unchanged for over the program's 43-year history (except temporary adjustments). The prospect of national health care reform, however, has caused policy makers to look again at how federal Medicaid payments are determined.

This paper suggests a method for computing Medicaid matching rates in a way that meets criteria for equity across states, for both the poor who benefit from the program and for the taxpayers who provide the funding. The results indicate that the current FMAP formula is poorly calibrated to support benefits in lower-income states. Equal-burden-for-equal-benefits matching rates, as defined here, could equalize the costs to taxpayers (as a percentage of state taxpayer income) of providing a standard level of benefits. The results have implications for Medicaid and national health care reform.

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I. Introduction

Medicaid matching rate reform has long been recognized as needed on equity grounds.[1] But there are considerable political barriers to changing the method states have come to depend on to allocate billions of dollars every year. This year, as Congress seriously considers major health care reform, the topic of changes in federal matching rates has emerged, almost of necessity, as Congress looks for ways to reconcile the objective of expanded health insurance coverage with the limited ability of the lower income states (where many of the uninsured reside) to pay more than they currently do for their Medicaid programs.

Federal Medicaid payments to the state have long been based on a formula that calculates a Federal Medical Assistance Percentage (FMAP) for each state based on its per capita income. The formula generally provides higher percentages for lower-income states, and lower percentage for high-income states subject to a lower limit of 50 percent which ensures the federal government pays at least half the cost of Medicaid in every state.

We suggest a new approach to setting federal Medicaid matching rates -- one that is relatively easy to understand and has some desirable properties of interstate equity. The objective is to determine what would it take to provide for equal benefits for the poor and equal tax burdens for state taxpayers? We simply ask what matching rates would be needed to provide each state with the ability to achieve the U.S. average level of benefits per poor person while spending a uniform average percentage of state taxpayer income on the state share of Medicaid.

II. What are EBEB Matching Rates?

Equal-Burden-for-Equal-Benefit (EBEB) matching rates are very simply the shares of Medicaid costs the federal government would need to pay to make both benefits for the poor and taxpayer burdens equal across all states. EBEB matching rates would enable each state to provide a specified level of benefits while spending no more than any other state as a percentage of taxpayer income on the state share of Medicaid. This would allow every state to provide a specified level of Medicaid benefits and raise the

[1] See Grannemann (1979), Grannemann and Pauly (1983), US GAO (1983), US GAO (1997), Miller and Schneider (2004).

revenue pay for the state share with a specified of state taxpayer income.[2] The calculation is relatively straightforward. The EBEB federal matching rate can be computed for a state as:

$$EBEBFMAP_i = 1 - (AggFiscal\ Cap_i * FixedPct) / (Npoor_i * StdBenPPP * MedPrice_i)$$

Where:

- **$EBEBFMAP_i$** is the equal-effort-for-equal-benefit matching rate
- **$AggFiscalCap_i$** is the measure of the state's aggregate fiscal capacity (such as adjusted gross income reported in individual tax returns)
- **FixedPct** is the fixed percentage of the fiscal capacity measure (e.g., state taxpayer income) to be devoted to state share to achieving the standard benefit level (in U.S. by our estimates 1.625 percent in 2006)
- **$Npoor_i$** is the number of persons below the federal poverty level in the state
- **StdBenPPP** is the dollar Medicaid benefit per poor person (U.S. average by our estimates $7,692 in 2006)
- **$MedPrice_i$** is a state medical care relative cost index based so the US level is 1.00 (our examples use the physician practice cost index)

It is then a simple matter to demonstrate the EBEB equity property:
The state percentage is 1.0 minus the federal share or:

$$StatePercentage = (AggFiscal\ Cap_i * FixedPct) / (Npoor_i * StdBenPPP * MedPrice_i)$$

The state payments are then:

$$State\ Payments = [StatePercentage] \times [MedicaidPayments_i]$$

If the state provided the standard benefit per poor person to very poor person in the state and pays providers based on its local medical prices, its cost would be:

$$State\ Payments_i = [(AggFiscal\ Cap_i * FixedPct) / (Npoor_i * StdBenPPP * MedPrice_i)] \times [(Npoor_i * StdBenPPP * MedPrice_i)]$$

$$= [AggFiscal\ Cap_i * FixedPct]$$

The state payments as a percentage of state taxpayer income (or other measure of fiscal capacity) is:

$$StatePayments_i / AggFiscal\ Cap_i = FixedPct$$

Which is the specified fixed percentage that would be the same for every state that provided the specified level of benefits (on average) to its poor population? In effect these rates are enabling in that they give each state the ability to achieve a specified real (cost-adjusted) benefit level at the same level of taxpayer effort or burden.

We provide an example of EBEB matching rates computed using data from 2006 and compared to matching under the current standard FMAP formula for 2009. Table 1 reports on four variations of EBEB

[2] This follows an approach originally suggested in Grannemann (1980) pp.118-120.

rates; basic EBEB, progressive EBEB, enhanced EBEB and progressive enhanced EBEB. All are computed with an adjustment for cost differences among states.[3] While we provide results of a simple computation here, if such rates are ever to be used in practice it will be important to consider carefully the measures of medical prices (perhaps a weighted average of regions within the states). Other measures of state fiscal capacity might be considered, but we see public choice advantages to using taxpayer income over some broader measures (such as the Treasury Department's Total Taxable Resources) simply because it is more meaningful as a concept for policy makers who need to understand the nature of the burden they are imposing on state taxpayers.

The example calculations show how the current rate structure deviates from the rates needed to equalize benefits and burdens. In general the higher-income states would see reductions in federal matching and their lower-income states would see increases. But as the formula accounts for both number of poor and taxpayer income the greatest increases in federal matching are for states with many poor persons and lower-income taxpayers; the greatest decreases are in states with few poor persons and high income taxpayers. New York could receive an increase in federal matching for basic benefits while surrounding commuter states of Connecticut and New Jersey would see reduced federal assistance – in this case the formula would be doing a better job of spreading costs over the higher-income suburbs in the NY/NJ/CT tri-state area. Note, however, that while New York matching for basic benefits might be increased under the proportional version, this state could see lower rates at the margin under the progressive scenario due to its high-income taxpayers, and could see lower matching for much of its high-benefit program due to the step-down provision. California and Texas would tend to benefit under this system, in part due to large number of poor persons reflected in their higher-than-average poverty rates.

In a few states, with relatively small numbers of persons below the federal poverty level, the federal matching would be very low nearly as that state could achieve an average benefit for its poor without spending more than the specified average percentage of state taxpayer income on benefits -- even without any federal assistance. While it may not be politically feasible to reduce federal assistance for any state to zero, this analysis raises the question of what standard should be used for a matching formula. Clearly the present formula deviates greatly from a standard based on this criterion of "equal burden for

[3] We use the average physician practice cost index for all localities in the state as a deflator.

equal benefits." In fact the current formula would be much closer to this standard if Congress at the program's origins had not set (presumably for practical political purposes) a floor of 50 percent on the federal matching rates. So this question of a standard for matching goes back to the fundamental purpose of the program. Is it to equalize benefits and burdens of caring for the poor? Or is it to give some politically acceptable level of federal assistance to every state?

These example rates reflect current level of benefits and taxpayer burden. Over the longer term these parameters could be adjusted to reflect changes in cost, taxpayer income, the desire standard benefit level, and share of taxpayer income policy makers are willing to devote to the program. Thus the formula provides a framework for making long term adjustment to federal matching to reflect current policy while maintaining a structure that promotes some degree of equity among taxpayers and among the poor in different states. For example, suppose a goal was to make Massachusetts-level benefits affordable to all states willing to spend 10% more than the current the current US average state share of taxpayer income. Then computing rates with the formula with the Massachusetts value of benefits per poor person used for **StdBenPPP** and 1.1 times the current value of **FixedPct** would provide higher federal matching rates that would make such a benefit level attainable to all states willing to spend 10 percent more than the current average.[4] So rates can be computed with the above formula (using different parameters) that can reflect higher or lower average benefits and higher of lower state tax burdens. In effect, this matching rate *structure* provides a framework for setting matching rates in a more equitable way that can be adjusted for policy objectives and/or to meet budget requirements.

The aggregate income variable is essentially a measure of state fiscal capacity. Using aggregate adjusted gross income essentially employs taxpayer income as that measure of fiscal capacity. The rates that emerge will reflect a burden that is proportional to income rather than regressive or progressive. If, instead, we were to replace **AggFiscalCap** by federal income taxes paid in the state and **FixedPct** with the fraction of such an amount we think states should contribute toward Medicaid, then the resulting rates would reflect a progressive structure for the state share with higher-income states devoting a somewhat greater share of income to pay the state portion of Medicaid. Medicaid financing would then be made

[4] Our simulation of this suggests this would raise Connecticut's EBEB federal matching rate to 49 percent and most other states would have rates greater than 75 percent.

progressive to the same extent as the federal income tax structure. Thus this method provides a tool that can be adapted to achieve various policy objectives.

These rates can be adjusted for cost of living differences among the states by making the measure of the number of poor a count of the number of persons below some multiple of the Federal Poverty Level (FPL) adjusted for the cost of living. There is no suitable published federal measure of this concept, so we use the ACCRA index as a proxy for a state cost of living index and compute with interpolation an estimate based on Census figures for the number of persons below multiples of the FPL. We use these figures in our cost of living adjusted EBEB matching rates. We would suggest that the federal government establish a program to produce such an index on a regular basis as it would be needed not only for these matching rates but for any federal program requiring income adjusted eligibility criteria.; this is an adjustment that is needed to provide for greater equity in any such program.

A word of caution is in order here, however, as these rates would not guarantee equal benefits or burden among the states. States willing to spend more than the average share of taxpayer income could still choose to provide higher-than-average benefits; and states could choose to spend less than average and provide lower than average benefits.[5] But the step-down in rates for higher-spending states, and our observation that the share of income spent on Medicaid tends to vary less among states than benefits, suggests that both taxpayer burdens and benefits to the poor would be much more equal under this arrangement than we currently observe.

The politics of such a change could be interesting. We cannot realistically expect states that have received Medicaid matching at the 50 percent floor for more than forty years -- and built relatively generous Medicaid programs based on this federal financing floor – to willingly give up such advantages. However, this does suggest the direction in which future federal policy will need to go if we are to direct more federal Medicaid resources to states with greater numbers of poor and uninsured. The higher income states have no inherent right to continue receiving the windfall they have enjoyed from the current matching arrangement for many years.[6] We expect this is a situation that can only be changed in a

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[5] In previous work we explain why it is not possible with simple matching rates alone to achieve the goals of equal benefits, equal tax burdens, and satisfying voter demand for Medicaid (See Grannemann and Pauly, 1983, Appendix A).

[6] This also identifies a potentially important barrier to any national health care reform that provides benefits or subsidies to where the lower-income uninsured are located and finances it with taxes where the higher-

politically acceptable way if it is done gradually over a period of many years – perhaps a decade or more – with some form of hold-harmless provision in effect in the short run.

II.a. Enhanced Matching Rates

We illustrate the possibility of enhanced matching rates using this formula. Enhanced matching rates could be used to provide greater incentives for services or groups may be identified as important for meeting program goals – much as children are under the SCHIP program. As noted above, we question the value of enhanced rates set so high that a cap or allotment is needed to keep federal costs under control; but within the context of the enhanced rate formula suggested here, incentives could be provided for states to make greater efforts to provide benefits to children, to provide better access to primary care, or whatever goals Congress determines are particularly important. Determining these rates by augmenting the **StdBenPPP** parameter in the above formula ensures that the taxpayer and recipient equity characteristics of the original formula are maintained in setting the enhanced matching rates.

II.b. Step-Down Rates

The EBEB rates have their desirable equity properties only for if states choose to set benefits at the benchmark benefit level. And we expect states will have incentives to move benefits tend to move toward the average. Nonetheless, some states may still choose to provide higher than average benefits. If the do so, they will receive additional federal assistance. We want the amount of federal subsidy for these benefits in excess of the benchmark to reflect what taxpayers in other states are willing to spend to support the higher benefits in that state. As noted, we think this declines as the benefit level rises; and so the matching rate for benefits in excess of the benchmark should decline the further above that benchmark the state goes. The match could continue for some higher than benchmark benefits but ought to decline to zero at some point (perhaps when the state benefits are twice the benchmark). Again this is a policy parameter; the match could decline slowly or quickly and the match could stop at 20% above or 50% above or 100% above the benchmark. (For purposes of our examples we will assume a match the declines in steps and stops at 75 percent above the benchmark which would allow some degree of federal matching for states that choose to provide benefits up to 175 percent of the benchmark)

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income taxpayers are located. The higher-income states may find it in their self interest to oppose national efforts for uniform benefits at lower levels and instead to pursue state efforts with enhanced federal subsidies in order to protect their favored status in obtaining federal financing

II.c. Phase-In Schedule.

What is suggested here is a fundamental restructuring of the financial foundations of the Medicaid program. This is not something that can easily be accomplished overnight. We would suggest phasing in the matching rates over a period of, perhaps five, years. In the first year matching rates would be a weighted average (80 percent old, 20 percent new) with the proportions shifting toward the new rates each year. This would give states time to find any additional state financing that may be needed, respond to the new incentives, and reshape their programs if desired. We would anticipate these adjustments would include expansions in eligibility and benefits is some lower-income, low-benefit states that would see increased federal matching, and finding additional state funds to support programs in some high-income, high-benefit states that would see lower federal matching. These state would also need time to take a hard look at their more expansive program elements (particularly in long-term care where their benefits are typically higher than other states) to see if these are all things they find important enough to support with a greater share of state funding. A phase-in period would also give Congress time to observe emerging state response and refine formula parameters if necessary. For example, if high benefit states begin to cut back substantially, that could provide room in the federal budget to increase the matching by using a somewhat higher standard benefit for all states.

III. Counter Cyclical Adjustments to EBEB Matching Rates

As we noted in our introduction to this work, one of the main reasons Medicaid is viewed as potentially unreliable is the tendency for states to expand eligibility and coverage in good times and the necessity to reduce eligibility and benefits when times are hard, just when the need is greatest. This creates problems for the poor who are uncertain benefits will be available when need, for providers who often face frozen or reduced payment rates, and for taxpayers who are threatened with the burden of additional costs just when many are experiencing difficulties themselves. Medicaid at present lacks an automatic adjustment mechanism to ensure states have timely access to the additional financial resources they need in economic downturns. This is one critical element needed to make Medicaid a program everyone can count on -- to do what it is supposed to do in both good times and bad.

This problem is not unique to Medicaid or even to the United States. In other countries with universal coverage, overall government budgetary problems often lead to fairly dramatic cuts in payment and benefit generosity levels for reasons unrelated to medical care benefits and costs. It will surely be difficult to find ways to advise the government to save itself from its own budgetary problems. But there are some things that could be done.

III.a. The Cyclical Problem

Let's consider, to start, the need to adjust medical assistance resources to cyclical economic activity – we set aside secular trends such as declining industries for now, although they are an issue as well and may not always be entirely distinguishable from the cycles. There are several factors to consider in designing a method for dealing with this situation. For one, states have less ability than the federal government to borrow or otherwise obtain funds to cover deficits in hard times. Also, it is important to understand that state needs in economic downturns are related to at least two distinct components that may differ among states, though they will be correlated with national economic conditions. These are first on the demand side downturn generate greater numbers of eligible Medicaid recipients; second on the supply side state fiscal capacity diminishes with reduced revenue, particularly from the traditional state funding sources of income taxes and sales taxes. These two factors are closely correlated but will play out differently in the individual states, in part due to differences in local economic conditions, in part due to differences in the poor populations, and in part due to differences in the states' tax structures.

On the demand (or need) side state economies differ in average severity of economic cycles. States with cyclic industries, such as the automotive industry, will be prone to larger swings in economic activity than others. It may also matter who is affected by the cycles. Changes in the financial services industry that affects relatively well paid workers may have proportionately less of an impact on Medicaid eligibility than on small manufacturing operations with lower skilled workers. Whatever the sources, any plan for cyclic corrections should be designed to deal fairly and effectively with these differences among states in the resulting need for medical assistance.

Next we consider the state revenue side. Virtually all tax sources are to some degree cyclical, but individual and corporate income taxes and general sales taxes are perhaps more so. The share of state taxes that comes from these three sources varies from more than 80 percent in ten states to less than 40 percent in

four other states.[7] Clearly states like Alaska and New Hampshire without income or general sales taxes will see less pronounced fluctuations in revenue than states such as Georgia, Massachusetts or California that heavily rely on such sources especially state individual income taxes.

Now consider secular trend such as industry decline and longer term displacement of workers. These may be relatively unrelated to the economic cycle though the associated problems may be aggravated by an economic downturn. Medicaid can play a useful role in ensuring access to medical coverage, particularly for children, while readjustment takes place, whether that comes from eventual relocation of the families or growth of replacement industries in the local area. From the recipients' side this situation may not be much different but in planning for any counter cyclical reform these one-time or irregular events may enter differently into the calculation of financial resources that need to be set aside to handle the associated changes in Medicaid eligibility.

III.b. Solution to the Cyclical Problem.

Our principles for reform of Medicaid with a counter cyclical provision includes methods to smooth financing that involve not only the federal government, but the states as well. The first part of the solution is to use the EBEB matching rates that we have proposed The EBEB matching rates are an improvement over current matching rates from the counter-cyclical standpoint. This is because they account not just for the one income measure in the current formula (state per capita income) but for both the number of poor, which rises in recession, and taxpayer income, which falls in such periods. It would thus be more responsive to economic conditions.

The difficulty is that matching rate changes are implemented with a lag so a counter cyclical program could impute more current figures into the matching formula in economic downturns. This will serve to entitle the states to a higher federal match on their benefits sooner. For this reason the second part of this solution is to provide for more timely updates to the matching formula. We would do this by basing interim matching rates and initial federal payment on prospective estimates of the formula parameters and then reconciling with states later when all the economic data are in. This would allow states to receive higher federal matching as an economic downturn is recognized and Medicaid enrollment rises; state that

[7] U.S. Bureau of Census, 2007 figures for state tax collection by source.

turn out to have a better economic experience than predicted by the formula would have an offsetting adjustment made to future federal matching payments.

As a third part to this solution we suggest the establishment of Medicaid cyclical trust funds both the states and federal governments that might help fund such cyclical swings in payments. To support this system the federal government may need to establish a "Medicaid Counter Cyclical Trust Fund" to stabilize budgets as Medicaid spending fluctuates with the economy. The fund would retain some of the federal budget allocated for matching funds in good economic years when federal matching rates are relatively low and disburse additional funds to the states in poor economic years when federal matching rates are higher.

Similarly states could be required to contribute in good times a corresponding amount based on their state's FMAP share. The state portion of the trust could be maintained at the federal or state level. As this contribution would increase in good economic times it would provide a counterweight to the state tendency to over expand eligibility and benefits when state budgets are flush and cut them in more difficult times.

This trust fund would allow both federal and state Medicaid budgets to be more stable and predictable over time. The fund would have a related but distinct purpose from the Medicare trust fund. The Medicare trust fund is intended to assure funds will be available with long term changes in population demographics. This fund for Medicaid would assure funds are available through cyclic changes in state fiscal capacity and to meet the needs of the greater number of otherwise uninsured poor that appear in economic hard times. Research would be needed to determine the appropriate parameters for such a counter-cyclical adjustment and for the criteria for accumulating and releasing funds from a counter-cyclical trust.

Finally, it may be that an increase in the state share for higher-income states that have most extended coverage in good times will itself furnish a kind of cushion as program expansions are chosen by states with a closer eye to the benefits relative to the spending. We cannot guarantee that this intuition is true; short term fluctuations in tax collections may destabilize well chosen and high value programs as much as those more at the margin. But some automatic improvement does seem possible, and we can at least be sure that states will take the possibility of the need to protect against bad times more seriously when they are putting up more of their own money.

III. c. Expected Effects and Advantages

The proposed matching rate structure would represent an improvement over the current FMAP system in supporting more equal treatment for both recipients and taxpayers across states. Additional work remains to specify the parameters of a new matching formula, simulate expected impacts, and adjust the parameters to reflect level of commitment in the current political environment. In any case, we believe the approach outlined here provides a framework for a serious discussion about how Medicaid with some key changes could better meet the need of the poor, provide for a more equitable distribution of its costs, and play a significant role in helping states address the problems of the uninsured -- all this within a context that better represents taxpayer/voter preferences for public resources that should be allocated to medical care for disadvantaged groups.

IV. Illustrative Examples of EBEB Possibilities

We indicate the structure such a revised matching rate system might have and illustrate with some computed examples of the equal burden for equal benefit matching approach. Table 2 shows, for every state, the key elements that will be determining variables in the matching formula. It shows the wide interstate differences in poverty measures and in taxpayer income as well as the current Medicaid benefits per poor person, which ranged from $4,559 in Nevada to more than three times that in New York.

IV.a. Case One Proportional EBEB

Rates Designed to move all states toward a national average benefit level. EBEB matching rates would be computed in accordance with the formula above using the US averages for the taxpayer burden and standard benefit parameters. Matching rates that illustrate this are shown in Table 3. This table shows a basic rate and enhanced rate computed with this formula. The basic rate uses the U.S. average benefit per poor person as a standard. The enhanced rate uses a rate 30 percent higher (roughly equivalent to rates the current benefit level in Pennsylvania, Delaware, or New Hampshire). This shows how the formula could be used to compute matching rates that would support a higher benefit levels at the same level of state taxpayer contribution.

IV.b. Case Two Progressive EBEB

Table 3 also shows progressive rates computed for the same two benefit levels. These progressive rates would allow states to achieve the standard benefit by contributing as the state share an amount

proportional to its taxpayers' obligations under federal personal income taxes. Relative to the proportional rates, this produces lower rates in states with high income taxpayers such as New York and higher rates in several of the Southern and western states without a thick upper tail of very high income taxpayers on their income distribution. This is also show with basic and enhanced rates.

IV.c. Case Three Proportional EBEB with Cost-of-Living Adjustment and Step-Down

Case three adds two key elements to the matching: a cost-of-living adjustment and step-down rates to apply to spending above the national average. In order to reduce the incentive for a few states to provide benefits much in excess of the standard amount the tiered rate structure shown Table 4. A state's Medicaid spending per poor person would determine the applicable tier for each portion of state spending. In this example state would get the full EBEB matching for benefits up to 100 percent of the standard benefit times the number of poor in the state; 75 percent of EBEB matching for spending between 100 and 125 percent of the standard; 50 percent of EBEB matching for spending between 125 and 150 percent; and 25 percent of EBEB matching for spending between 150 and 175 percent of the standard. States would not receive federal assistance for payments in excess of 175 percent of the standard times the number of poor persons in the state. This step-down example provides that federal taxpayers will not be expected to support Medicaid benefits in a state that approach twice the national average. . It is worth noting that even with the cost of living adjustment we see several high income states with revised FMAPs below 50 percent. The formula does tend to provide higher rates for some states with many low income persons such as California.

IV.d.Case Four Progressive EBEB with Cost-of-Living Adjustment and Step-Down

Our fourth example, with results shown in Table 5, incorporates the element of Case 3 but with a progressive structure to the state contribution. It includes all of our key elements to promote greater equity in matching rates EBEB rates to provide a base, a progressive structure for state contributions related to taxpayer income, and step down to limit the extent to which low-benefit states might subsidize high-benefit states. The progressive structure tends to trim the federal matching in the highest states, particularly with income distributions skewed to the right, that is, with some very high income industries or wealthy individuals such as Connecticut and New York

IV.e. Case Five Progressive EBEB with Cost-of-Living Adjustment, Step Down and 50 Percent Minimum on Base Matching

The final case shown in Table 6 is the same as Case 4 but scales the entire matching schedule upward by raising the standard benefit in the calculation and keeping state contribution the same to allow for a minimum of 50 percent matching on the base spending with other states higher to ensure all states have at least that amount of federal support on state benefits up to 125 percent of the higher standard amount. In order to maintain the equity properties of the EBEB with even high income states receiving 50 matching the standard benefit had to be increased substantially to $9,351 per person below 125 percent of the FPL. Bringing New Hampshire and Connecticut to 50 percent would lead to a matching rate of 90 percent in Mississippi and over 80 percent in twelve other states.

V. Implications for Reform

Perhaps what is most striking about EBEB matching rates is the extent to which these rates based on equity principles differ from the current Medicaid FMAP formula. The current formula, it would seem, is quite skewed in favor of higher-income states in that it does not adequately compensate for the dual fact that low-income state have both greater need for assistance and lower fiscal capacity than higher-income states. In fact the poor calibration of the current matching formula may well have contributed significantly to the lower Medicaid eligibility and benefits we observe in the lower income states primarily in the south and the west – and to the higher rates of uninsurance we see in those states.

The implication for national health care reform, whether it applies only to Medicaid or more broadly, is that any reforms directed toward reducing the number of uninsured may need to redress the inequities of the current Medicaid funding before the lower-income states can justifiably be asked to contribute more in state taxpayer dollars (as might occur with eligibility and benefit mandates). This implies that the bulk of any new funding will need to go to lower-income states and that any program expansion may equitably entail higher state contributions (to new or existing programs) from some of the highest income states, particularly those with comparatively few poor residents.

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Appendix Table 1:Equal Burden for Equal Benefit Matching Illustrative Parameter Alternatives

	Current Matching		**EBEB US Benchmark level** (current US average burden and benefit)		**EBEB Enhanced Level** (130% of current US average burden PA benefit level)	
	FMAP	Enhanced FMAP	EBEB	Progressive EBEB	EBEB	Progressive EBEB
Aggregate State Fiscal Capacity	N/A	N/A	Adjusted Gross Income	Federal Personal Income tax	Adjusted Gross Income	Federal Personal Income tax
Fiscal burden multiplier	N/A	N/A	U.S average % of state income devoted to state Medicaid	U.S average % of federal tax devoted to state Medicaid	U.S average % of state income devoted to state Medicaid	U.S average % of federal tax devoted to state Medicaid
Benefit level benchmark	U.S. average	U.S. average	U.S. average	U.S. average	130% of U.S. average (Pennsylvania)	130% of U.S. average (Pennsylvania)
Top matching rate	76%	83%	80%	85%	84%	88%
Minimum Matching Rate Standard Benefits	50%	65%	3%	26%	0%	6%
Minimum Matching Rate for high benefits (with step down)	50%	65%	zero	zero	zero	zero
Overall generosity of benefits	Same as US present	Same as US present	Same as US present	Same as US present	Same as Pennsylvania	Same as Pennsylvania
Progressivity of financing, state share	Regressive	Regressive	Neutral as % of taxpayer income	Progressive equivalent to US income taxes	Neutral as % of taxpayer income	Progressive equivalent to US income taxes

Appendix Table 2

	Poverty			Cost	Taxpayer Income		Benefit level
State	**Number below FPL**	**Percent poor**	**Percent of US poor**	**Physician practice cost index average**	**Adjusted gross income (000)**	**PI Tax amount (000)**	**Medicaid Payments per poor person 2006**
United States	38,757,253	13.3	100.0%	1.000	$7,945,456,251	$1,023,644,566	$7,692
Alabama	743,556	16.6	1.9%	0.909	$96,623,613	$10,979,024	$5,191
Alaska	71,120	10.9	0.2%	1.037	$17,947,050	$2,262,567	$13,289
Arizona	860,355	14.2	2.2%	0.970	$147,978,344	$17,982,915	$7,194
Arkansas	471,161	17.3	1.2%	0.893	$50,651,815	$5,432,649	$6,058
California	4,686,706	13.1	12.1%	1.083	$1,035,151,862	$137,232,470	$7,220
Colorado	539,332	11.6	1.4%	0.978	$138,876,098	$18,062,971	$5,285
Connecticut	281,079	8.3	0.7%	1.103	$141,719,454	$23,161,751	$14,474
Delaware	88,749	10.7	0.2%	1.016	$24,150,367	$3,008,775	$10,660
District of Columbia	99,671	18.1	0.3%	1.124	$21,406,242	$3,305,255	$12,891
Florida	2,232,534	12.6	5.8%	1.052	$510,336,621	$71,125,036	$5,653
Georgia	1,340,255	14.8	3.5%	0.971	$216,331,873	$25,885,124	$4,835
Hawaii	117,811	9.4	0.3%	1.059	$33,030,898	$3,769,398	$9,263
Idaho	182,933	12.8	0.5%	0.917	$31,708,725	$3,488,498	$5,613
Illinois	1,536,133	12.3	4.0%	0.989	$362,235,603	$48,970,055	$6,488
Indiana	768,642	12.5	2.0%	0.944	$142,501,220	$15,908,786	$7,333
Iowa	315,973	11.0	0.8%	0.906	$66,192,610	$7,105,899	$8,035
Kansas	327,103	12.2	0.8%	0.918	$66,432,725	$7,871,434	$6,290
Kentucky	694,866	17.0	1.8%	0.912	$82,558,702	$8,772,812	$6,230
Louisiana	808,319	19.4	2.1%	0.971	$91,887,850	$11,428,639	$5,800
Maine	163,293	12.7	0.4%	0.950	$29,466,685	$3,090,195	$11,614
Maryland	436,978	8.0	1.1%	1.012	$181,096,029	$23,280,923	$11,249
Massachusetts	623,775	10.0	1.6%	1.091	$222,928,374	$31,883,724	$15,328
Michigan	1,328,888	13.5	3.4%	1.022	$233,372,609	$26,793,190	$6,198
Minnesota	487,044	9.7	1.3%	0.962	$145,576,400	$17,874,175	$11,020
Mississippi	588,288	20.9	1.5%	0.910	$49,860,479	$5,083,420	$5,507
Missouri	783,101	13.8	2.0%	0.949	$131,089,335	$15,084,043	$8,150
Montana	132,537	14.4	0.3%	0.897	$20,404,746	$2,162,864	$5,430
Nebraska	194,595	11.3	0.5%	0.904	$41,039,481	$4,654,025	$7,704
Nevada	257,828	10.5	0.7%	1.018	$77,211,961	$10,427,538	$4,559
New Hampshire	101,872	8.0	0.3%	1.006	$40,176,027	$5,176,919	$10,663
New Jersey	740,721	8.7	1.9%	1.111	$302,073,205	$43,577,647	$12,297
New Mexico	350,120	18.3	0.9%	0.943	$39,282,794	$4,434,035	$6,982
New York	2,670,773	14.2	6.9%	1.078	$604,209,378	$89,771,971	$16,307
North Carolina	1,256,624	14.6	3.2%	0.941	$203,102,967	$22,977,310	$6,940
North Dakota	71,059	11.7	0.2%	0.883	$14,228,763	$1,575,940	$7,018
Ohio	1,475,788	13.2	3.8%	0.975	$266,209,812	$30,242,439	$7,974
Oklahoma	576,689	16.7	1.5%	0.903	$74,932,461	$9,029,858	$4,979

Oregon	487,358	13.4	1.3%	0.962	$88,482,771	$9,928,326	$5,950
Pennsylvania	1,442,858	12.0	3.7%	1.003	$320,781,502	$39,844,090	$10,674
Rhode Island	117,585	11.5	0.3%	1.048	$28,128,464	$3,466,035	$14,235
South Carolina	657,405	15.7	1.7%	0.927	$91,820,608	$9,923,162	$5,985
South Dakota	102,589	13.6	0.3%	0.890	$17,667,783	$2,140,096	$5,868
Tennessee	947,105	16.1	2.4%	0.927	$134,041,381	$16,328,905	$6,350
Texas	3,862,741	16.9	10.0%	0.983	$562,874,768	$76,430,684	$4,578
Utah	269,611	10.7	0.7%	0.950	$57,463,484	$6,254,166	$5,377
Vermont	61,694	10.2	0.2%	0.959	$15,779,630	$1,761,930	$15,349
Virginia	713,181	9.6	1.8%	1.012	$230,254,681	$29,554,772	$6,461
Washington	736,907	11.8	1.9%	1.004	$186,216,128	$24,113,543	$7,496
West Virginia	310,842	17.6	0.8%	0.926	$31,973,340	$3,251,470	$6,680
Wisconsin	589,377	10.9	1.5%	0.959	$141,048,306	$16,407,580	$7,776
Wyoming	51,728	10.3	0.1%	0.906	$17,059,474	$2,536,350	$8,071

Sources: U.S. Census, U.S. IRS, Kaiser Family Foundation www.kff.org

Appendix Table 3

	Current		Proportional		Progressive	
Fixed pct:	**n/a**	**n/a**	**1.6252%**	**1.6252%**	**12.62%**	**12.6157%**
Standard Benefit:	**n/a**	**n/a**	**$7,692**	**$10,000**	**$7,692**	**$10,000**

State	**Current FMAP 2009**	**Current Enhanced FMAP 2009**	**EBEB Matching US Std**	**Enhanced EBEB Matching**	**EBEB Matching US Std**	**Enhanced EBEB Matching**
51 Jurisdictions (mean)	59.98%	71.99%	53.22%	64.02%	55.01%	65.06%
51 Jurisdictions (median)	60.27%	72.19%	55.66%	65.89%	58.81%	68.31%
Alabama	67.98%	77.59%	69.80%	76.77%	73.36%	79.51%
Alaska	50.53%	65.37%	48.58%	60.45%	49.68%	61.30%
Arizona	65.77%	76.04%	62.54%	71.18%	64.66%	72.81%
Arkansas	72.81%	80.97%	74.56%	80.43%	78.82%	83.71%
California	50.00%	65.00%	56.91%	66.85%	55.66%	65.89%
Colorado	50.00%	65.00%	44.37%	57.21%	43.83%	56.80%
Connecticut	50.00%	65.00%	3.42%	25.71%	0.00%	5.75%
Delaware	50.00%	65.00%	43.41%	56.47%	45.27%	57.90%
District of Columbia	70.00%	79.00%	59.63%	68.95%	51.61%	62.78%
Florida	55.40%	68.78%	54.09%	64.68%	50.33%	61.79%
Georgia	64.49%	75.14%	64.88%	72.98%	67.38%	74.91%
Hawaii	55.11%	68.58%	44.06%	56.97%	50.45%	61.88%
Idaho	69.77%	78.84%	60.06%	69.28%	65.89%	73.76%
Illinois	50.32%	65.22%	49.62%	61.25%	47.13%	59.33%
Indiana	64.26%	74.98%	58.51%	68.08%	64.04%	72.34%
Iowa	62.62%	73.83%	51.15%	62.42%	59.29%	68.68%
Kansas	60.08%	72.06%	53.26%	64.04%	57.01%	66.93%
Kentucky	70.13%	79.09%	72.47%	78.83%	77.30%	82.53%
Louisiana	71.31%	79.92%	75.26%	80.97%	76.12%	81.63%
Maine	64.41%	75.09%	59.87%	69.13%	67.33%	74.87%
Maryland	50.00%	65.00%	13.48%	33.44%	13.66%	33.58%
Massachusetts	50.00%	65.00%	30.79%	46.76%	23.16%	40.89%
Michigan	60.27%	72.19%	63.69%	72.07%	67.64%	75.11%
Minnesota	50.00%	65.00%	34.35%	49.50%	37.43%	51.87%
Mississippi	75.84%	83.09%	80.32%	84.86%	84.43%	88.02%
Missouri	63.19%	74.23%	62.73%	71.33%	66.71%	74.39%
Montana	68.04%	77.63%	63.74%	72.11%	70.16%	77.05%
Nebraska	59.54%	71.68%	50.71%	62.08%	56.61%	66.62%
Nevada	50.00%	65.00%	37.85%	52.19%	34.84%	49.88%
New Hampshire	50.00%	65.00%	17.17%	36.29%	17.15%	36.27%
New Jersey	50.00%	65.00%	22.44%	40.34%	13.15%	33.19%
New Mexico	70.88%	79.62%	74.86%	80.66%	77.97%	83.06%
New York	50.00%	65.00%	55.66%	65.89%	48.86%	60.66%
North Carolina	64.60%	75.22%	63.71%	72.08%	68.13%	75.48%
North Dakota	63.15%	74.21%	52.09%	63.14%	58.81%	68.31%
Ohio	62.14%	73.50%	60.91%	69.93%	65.53%	73.48%
Oklahoma	65.90%	76.13%	69.60%	76.61%	71.56%	78.12%

Oregon	62.45%	73.72%	60.12%	69.33%	65.27%	73.28%
Pennsylvania	54.52%	68.16%	53.17%	63.97%	54.84%	65.26%
Rhode Island	52.59%	66.81%	51.77%	62.90%	53.87%	64.51%
South Carolina	70.07%	79.05%	68.17%	75.51%	73.29%	79.46%
South Dakota	62.55%	73.79%	59.12%	68.55%	61.56%	70.43%
Tennessee	64.28%	75.00%	67.74%	75.19%	69.50%	76.54%
Texas	59.44%	71.61%	68.68%	75.91%	66.99%	74.60%
Utah	70.71%	79.50%	52.60%	63.54%	59.95%	69.19%
Vermont	59.45%	71.62%	43.65%	56.65%	51.16%	62.43%
Virginia	50.00%	65.00%	32.59%	48.15%	32.84%	48.34%
Washington	50.94%	65.66%	46.82%	59.09%	46.55%	58.88%
West Virginia	73.73%	81.61%	76.53%	81.95%	81.47%	85.75%
Wisconsin	59.38%	71.57%	47.27%	59.44%	52.39%	63.38%
Wyoming	50.00%	65.00%	23.09%	40.84%	11.24%	31.72%

Appendix Table 4:Proportional EBEB COL-Adjusted Matching with Step-Down Tiers

Cost-of-Living Adjusted EBEB

	Proportional EBEB Matching US Std			
Fixed pct:	**1.6252%**	**of taxpayer income**		
Standard Benefit:	**$5,877**	**per person < 125% FPL**		
State	**Tier 1 up to standard benefit per poor person**	**Tier 2 up to 125% of standard benefit per poor person**	**Tier 3 up to 150% of standard benefit per poor person**	**Tier 4 up to 175% of standard benefit per poor person**
Alabama	61.71%	46.28%	30.85%	15.43%
Alaska	55.63%	41.72%	27.81%	13.91%
Arizona	67.41%	50.56%	33.70%	16.85%
Arkansas	65.73%	49.30%	32.87%	16.43%
California	73.38%	55.04%	36.69%	18.35%
Colorado	41.25%	30.93%	20.62%	10.31%
Connecticut	37.41%	28.06%	18.70%	9.35%
Delaware	46.25%	34.69%	23.13%	11.56%
District of Columbia	68.80%	51.60%	34.40%	17.20%
Florida	58.18%	43.64%	29.09%	14.55%
Georgia	60.24%	45.18%	30.12%	15.06%
Hawaii	67.20%	50.40%	33.60%	16.80%
Idaho	50.59%	37.94%	25.30%	12.65%
Illinois	40.05%	30.04%	20.03%	10.01%
Indiana	53.12%	39.84%	26.56%	13.28%
Iowa	36.79%	27.59%	18.39%	9.20%
Kansas	49.53%	37.15%	24.77%	12.38%
Kentucky	69.11%	51.83%	34.55%	17.28%
Louisiana	68.05%	51.04%	34.03%	17.01%
Maine	63.70%	47.78%	31.85%	15.93%
Maryland	41.74%	31.30%	20.87%	10.43%
Massachusetts	49.59%	37.19%	24.80%	12.40%
Michigan	55.11%	41.33%	27.55%	13.78%
Minnesota	36.82%	27.61%	18.41%	9.20%
Mississippi	79.99%	59.99%	40.00%	20.00%
Missouri	56.00%	42.00%	28.00%	14.00%
Montana	63.82%	47.87%	31.91%	15.96%
Nebraska	40.98%	30.74%	20.49%	10.25%
Nevada	46.44%	34.83%	23.22%	11.61%
New Hampshire	20.46%	15.35%	10.23%	5.12%
New Jersey	49.48%	37.11%	24.74%	12.37%
New Mexico	70.57%	52.92%	35.28%	17.64%
New York	67.97%	50.98%	33.98%	16.99%
North Carolina	67.53%	50.64%	33.76%	16.88%
North Dakota	42.42%	31.81%	21.21%	10.60%
Ohio	56.34%	42.26%	28.17%	14.09%

Oklahoma	59.87%	44.90%	29.93%	14.97%
Oregon	66.36%	49.77%	33.18%	16.59%
Pennsylvania	50.93%	38.20%	25.47%	12.73%
Rhode Island	57.64%	43.23%	28.82%	14.41%
South Carolina	66.41%	49.81%	33.20%	16.60%
South Dakota	43.46%	32.60%	21.73%	10.87%
Tennessee	61.81%	46.36%	30.91%	15.45%
Texas	65.31%	48.98%	32.65%	16.33%
Utah	52.34%	39.26%	26.17%	13.09%
Vermont	60.03%	45.03%	30.02%	15.01%
Virginia	35.17%	26.38%	17.58%	8.79%
Washington	44.58%	33.44%	22.29%	11.15%
West Virginia	69.37%	52.03%	34.68%	17.34%
Wisconsin	46.91%	35.18%	23.46%	11.73%
Wyoming	32.38%	24.28%	16.19%	8.09%

Appendix Table 5:Progressive EBEB COL-Adjusted Matching with Step-Down Tiers

Cost-of-Living-Adjusted EBEB

Progressive EBEB Matching US Std

Fixed pct: 12.62%of federal taxes

Standard Benefit: $9,351per person < 125% FPL

State	Tier 1 up to standard benefit per poor person	Tier 2 up to 125% of standard benefit per poor person	Tier 3 up to 150% of standard benefit per poor person	Tier 4 up to 175% of standard benefit per poor person
Alabama	66.22%	49.67%	33.11%	16.56%
Alaska	56.57%	42.43%	28.29%	14.14%
Arizona	69.26%	51.94%	34.63%	17.31%
Arkansas	71.47%	53.60%	35.73%	17.87%
California	72.61%	54.46%	36.30%	18.15%
Colorado	40.68%	30.51%	20.34%	10.17%
Connecticut	20.59%	15.45%	10.30%	5.15%
Delaware	48.02%	36.02%	24.01%	12.01%
District of Columbia	62.60%	46.95%	31.30%	15.65%
Florida	54.76%	41.07%	27.38%	13.69%
Georgia	63.07%	47.30%	31.53%	15.77%
Hawaii	70.95%	53.21%	35.47%	17.74%
Idaho	57.81%	43.35%	28.90%	14.45%
Illinois	37.09%	27.82%	18.54%	9.27%
Indiana	59.37%	44.53%	29.69%	14.84%
Iowa	47.32%	35.49%	23.66%	11.83%
Kansas	53.58%	40.19%	26.79%	13.40%
Kentucky	74.52%	55.89%	37.26%	18.63%
Louisiana	69.16%	51.87%	34.58%	17.29%
Maine	70.45%	52.84%	35.23%	17.61%
Maryland	41.86%	31.39%	20.93%	10.46%
Massachusetts	44.03%	33.03%	22.02%	11.01%
Michigan	59.99%	44.99%	30.00%	15.00%
Minnesota	39.78%	29.83%	19.89%	9.94%
Mississippi	84.17%	63.12%	42.08%	21.04%
Missouri	60.70%	45.52%	30.35%	15.17%
Montana	70.23%	52.67%	35.12%	17.56%
Nebraska	48.04%	36.03%	24.02%	12.01%
Nevada	43.85%	32.89%	21.93%	10.96%
New Hampshire	20.44%	15.33%	10.22%	5.11%
New Jersey	43.43%	32.57%	21.71%	10.86%
New Mexico	74.21%	55.66%	37.11%	18.55%
New York	63.06%	47.29%	31.53%	15.76%
North Carolina	71.48%	53.61%	35.74%	17.87%
North Dakota	50.49%	37.87%	25.25%	12.62%

Ohio	61.50%	46.12%	30.75%	15.37%
Oklahoma	62.46%	46.84%	31.23%	15.61%
Oregon	70.70%	53.02%	35.35%	17.67%
Pennsylvania	52.69%	39.52%	26.35%	13.17%
Rhode Island	59.48%	44.61%	29.74%	14.87%
South Carolina	71.82%	53.86%	35.91%	17.95%
South Dakota	46.84%	35.13%	23.42%	11.71%
Tennessee	63.89%	47.92%	31.94%	15.97%
Texas	63.43%	47.58%	31.72%	15.86%
Utah	59.74%	44.80%	29.87%	14.93%
Vermont	65.36%	49.02%	32.68%	16.34%
Virginia	35.40%	26.55%	17.70%	8.85%
Washington	44.29%	33.22%	22.15%	11.07%
West Virginia	75.82%	56.86%	37.91%	18.95%
Wisconsin	52.06%	39.05%	26.03%	13.02%
Wyoming	21.95%	16.47%	10.98%	5.49%

Appendix Table 6:Progressive EBEB COL-Adjusted 50% Minimum Basic Matching with Step-Down Tiers

Cost-of-living-adjusted EBEB

	Progressive EBEB Matching US Std			
Fixed pct:	**12.62%**	**of federal taxes**		
Standard Benefit:	**$5,877**	**per person < 125% FPL**		

State	**Tier 1 up to standard benefit per poor person**	**Tier 2 up to 125% of standard benefit per poor person**	**Tier 3 up to 150% of standard benefit per poor person**	**Tier 4 up to 175% of standard benefit per poor person**
Alabama	78.77%	59.08%	39.39%	19.69%
Alaska	72.71%	54.53%	36.35%	18.18%
Arizona	80.68%	60.51%	40.34%	20.17%
Arkansas	82.07%	61.55%	41.03%	20.52%
California	82.78%	62.09%	41.39%	20.70%
Colorado	62.72%	47.04%	31.36%	15.68%
Connecticut	50.09%	37.57%	25.05%	12.52%
Delaware	67.33%	50.50%	33.67%	16.83%
District of Columbia	76.49%	57.37%	38.25%	19.12%
Florida	71.57%	53.68%	35.78%	17.89%
Georgia	76.79%	57.59%	38.39%	19.20%
Hawaii	81.74%	61.31%	40.87%	20.44%
Idaho	73.48%	55.11%	36.74%	18.37%
Illinois	60.46%	45.35%	30.23%	15.12%
Indiana	74.47%	55.85%	37.23%	18.62%
Iowa	66.89%	50.17%	33.45%	16.72%
Kansas	70.83%	53.12%	35.41%	17.71%
Kentucky	83.99%	62.99%	41.99%	21.00%
Louisiana	80.62%	60.46%	40.31%	20.15%
Maine	81.43%	61.07%	40.71%	20.36%
Maryland	63.46%	47.59%	31.73%	15.86%
Massachusetts	64.83%	48.62%	32.41%	16.21%
Michigan	74.86%	56.14%	37.43%	18.71%
Minnesota	62.15%	46.61%	31.08%	15.54%
Mississippi	90.05%	67.54%	45.02%	22.51%
Missouri	75.30%	56.47%	37.65%	18.82%
Montana	81.29%	60.97%	40.65%	20.32%
Nebraska	67.35%	50.51%	33.67%	16.84%
Nevada	64.71%	48.53%	32.36%	16.18%
New Hampshire	50.00%	37.50%	25.00%	12.50%
New Jersey	64.44%	48.33%	32.22%	16.11%
New Mexico	83.79%	62.84%	41.90%	20.95%
New York	76.78%	57.59%	38.39%	19.20%
North Carolina	82.08%	61.56%	41.04%	20.52%
North Dakota	68.88%	51.66%	34.44%	17.22%
Ohio	75.80%	56.85%	37.90%	18.95%

Oklahoma	76.40%	57.30%	38.20%	19.10%
Oregon	81.58%	61.19%	40.79%	20.40%
Pennsylvania	70.27%	52.70%	35.13%	17.57%
Rhode Island	74.53%	55.90%	37.27%	18.63%
South Carolina	82.29%	61.72%	41.14%	20.57%
South Dakota	66.59%	49.94%	33.29%	16.65%
Tennessee	77.30%	57.98%	38.65%	19.33%
Texas	77.02%	57.76%	38.51%	19.25%
Utah	74.70%	56.02%	37.35%	18.67%
Vermont	78.23%	58.67%	39.11%	19.56%
Virginia	59.40%	44.55%	29.70%	14.85%
Washington	64.99%	48.74%	32.49%	16.25%
West Virginia	84.80%	63.60%	42.40%	21.20%
Wisconsin	69.87%	52.40%	34.94%	17.47%
Wyoming	50.95%	38.21%	25.47%	12.74%