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The Honorable Nancy Kassebaum
Chairman, Committee on Labor
and Human Resources
United States Senate

The Honorable Hank Brown
United States Senate

The human immunodeficiency virus (HIV) epidemic has become one of the most serious health threats to the American public. The HIV infection rate is estimated to be as high as 1 in every 250 persons nationwide. Metropolitan areas are especially affected by HIV with rates as high as 1 in 25. By June 1994, over 400,000 people with HIV had been reported to have progressed to acquired immunodeficiency syndrome (AIDS), and more than 240,000 had been reported to have died of the disease.

Recognizing the need for additional resources for medical and support services for people with AIDS and HIV, the Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. In fiscal year 1994, a total of over $500 million in title I and title II funds were distributed to eligible metropolitan areas (EMAs) and states. Citing examples of disparities in per case funding, you expressed concerns that the existing funding formulas for titles I and II of the CARE Act may not result in the most equitable distribution of funds to states and EMAs.

At your request, we are finalizing our analysis of which factors, if any, inhibit the title I and II funding formulas from achieving greater equity. To accomplish this task, we relied upon equity criteria that we have developed over time and that have been recognized as reasonable standards of equity. These equity criteria reflect comparative needs among states and EMAs, as measured by the size of their caseloads, their per case cost of providing health care services, and their capacity to fund services from their own resources. We also identified formula changes that could improve equity.

This correspondence summarizes information we presented to your staff on our preliminary analyses of equity issues in the CARE formulas. A subsequent report will present more complete analyses of these issues.

We found that although the title I and II funding formulas currently include measures of some of the factors used in an equity-based formula, they resulted in per case funding disparities that may not conform with our equity criteria. We have identified the following issues that appear to inhibit title I and II formulas from achieving greater funding equity:

-- Both titles I and II include in their formulas individuals living in EMAs. Because not all states have an EMA, counting EMA cases for both titles can penalize states that do not have EMAs, and to a lesser extent, states whose EMAs contain a relatively small share of the state's total caseload.

-- The title I formula uses the cumulative number of AIDS cases reported since 1981 as a caseload measure. Since two-thirds of these cases are deceased, this factor may penalize states and EMAs that have recently experienced the most rapid growth in caseloads.

-- Neither the formula for title I nor II includes a factor to reflect differences in EMA and state costs of providing services to persons with AIDS. As a consequence, EMAs and states that must pay more for personnel and office space may not receive a level of funding to purchase services comparable to those that lower cost areas are able to purchase.

-- The title I formula uses AIDS incidence rates (cases per capita) to measure EMAs' funding capacity but does not consider their local tax bases. The AIDS incidence rate factor was adopted as a means of targeting more aid to EMAs whose funding capacity has been adversely affected by high concentrations of AIDS cases. However, not considering their tax bases can result in overstating the funding capability of such EMAs that have more limited tax bases.

-- Conversely, the title II formula uses per capita income to measure the states' funding capacity, but it does not measure the impact that a high concentration of AIDS cases has on the funding capability of a state. This can result in overstating the funding capability of states with high concentrations of AIDS cases.

TITLE I AND TITLE II OBJECTIVES

The CARE Act makes funds available to states, EMAs, and nonprofit entities for developing, organizing, coordinating, and operating more effective and cost-efficient service delivery systems.

In fiscal year 1994, approximately $326 million was appropriated for title I, which provides emergency assistance to EMAs--metropolitan areas disproportionately affected by the HIV epidemic. Fifty percent of the title I funds provided to EMAs are distributed by formula, and 50 percent are distributed competitively. To be eligible, a metropolitan area must have a cumulative count of more than 2,000 cases of AIDS since reporting began in 1981 or a cumulative count of AIDS cases that exceeds one-quarter of 1 percent of its population. In fiscal year 1994, there were a total of 34 EMAs in 17 states, the District of Columbia, and Puerto Rico.

Title II provides funds to states to improve the quality, availability, and organization of health care and support services for persons with HIV. Ninety percent of these funds are distributed by formula. In fiscal year 1994, $184 million was appropriated for title II.

USING BENEFICIARY AND TAXPAYER EQUITY CRITERIA TO ASSESS THE FORMULAS

To assess the title I and II formulas, we reviewed the enacting legislation and interviewed experts to examine the basic rationale for the factors used in the current CARE formulas. We also reviewed available literature and our previous reports on federal formula grant programs to identify two equity criteria--beneficiary and taxpayer--against which funding formulas could be compared. These criteria consider (1) size of caseloads, (2) per case cost of providing services, and/or (3) capacity to fund services from local resources.

The first criterion--beneficiary equity--considers the degree to which a formula allocates funds to ensure that each grantee is able to purchase a comparable level of services for its HIV population. Under this criterion, dollars would be distributed according to two indicators: (1) the potential number of persons with AIDS (caseload) and (2) the cost of providing services (cost). The second criterion--taxpayer equity--considers the degree to which EMAs and states are able to finance a comparable level of services with comparable burdens on their taxpayers. This second standard is broader than the first one. In addition to including the two indicators used in the first standard (caseload and cost), it uses a measure of each EMA's and state's capacity to fund AIDS and HIV services from its own resources (capacity).

A formula for allocating funds could meet either the beneficiary equity criterion or the taxpayer equity criterion. No formula, however, is likely to completely satisfy both criteria simultaneously.

Our preliminary examination of the title I formula indicates that it may not currently meet either the beneficiary or the taxpayer equity criterion. The beneficiary equity criterion may not be met because per case funding is not systematically related to the cost of treating persons with HIV. Specifically, our analysis of fiscal year 1994 funding for EMAs showed that per case funding ranged from $805 to $2,556--a difference of over 300 percent; however, only 13 percent of this variation was related to cost differences.[1] As an illustration, the Dallas and Oakland EMAs each received title I allocations of approximately $1,200 per person seeking services in their EMAs, but the costs of providing services in Oakland are about 37 percent higher than in Dallas.

The taxpayer equity criterion may also not be met by the title I formula because, in addition to not being systematically related to cost differences, EMA grant amounts are not highly related to their funding capacity. Our analysis of fiscal year 1994 funding for all EMAs showed that about half the variation in EMAs' per case funding was related to differences in cost and funding

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[1]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.

capacity. For example, the Dallas and Oakland EMAs received about the same per case funding, but 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.

In addition, the distribution of combined title I and title II funding across states does not appear to meet either the beneficiary or the taxpayer equity criterion.[2] Total per case funding for states like California and New York 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. These funding differences do not seem to be explained by differences in states' costs and fiscal capacity to provide services. Specifically, differences in service costs and funding capacity account for 36 percent of these differences.[3] Approximately 64 percent of the variation in state funding per AIDS case appears to be unrelated to states' funding needs as measured by differences in the costs of providing services or a state's funding capacity.

OTHER FACTORS MAY INCREASE FORMULA EQUITY

The choice of developing a formula that meets one or a combination of the two criteria depends on judgments about whether beneficiary equity or taxpayer equity should be emphasized. Regardless of the equity criteria applied, certain measures may need to be considered in the allocation of title I and II funds.

DOUBLE COUNTING OF EMA CASES

Our preliminary analysis of states' per case funding differences 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). On

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

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

average, per case funding was $1,000 in states without an EMA, $1,700 in states where less than half the state caseload lived in an EMA, and $2,200 in states where more than half of the state's caseload lived in an EMA.

Funding for title I and title II separately does not always reflect the division of service responsibilities between EMAs and state governments. Presently, EMAs are responsible for providing medical and support services to the individuals who reside in their areas of coverage. States are responsible for administering medical and support services to individuals living outside EMAs. At their discretion, states may provide additional funding for such services to individuals in EMAs. Moreover, states are also responsible for administering certain services throughout the entire state, specifically, home health care, assistance with purchasing medications, and insurance continuation.

The definition of a caseload measure for state governments under title II is complicated by the fact that state governments are responsible for multiple types of services with potentially differing scopes of coverage. This complicates decisions regarding the appropriate caseload count for allocating federal aid to state governments under title II. Some of the services state governments provide encompass the caseload of the entire state, which would imply using the state's total caseload in the allocation formula. On the other hand, EMAs provide the bulk of medical services for people living within an EMA, and states are primarily responsible for those cases living outside an EMA. This suggests that the appropriate caseload measure for these services should be based primarily on state cases living outside an EMA.

A means of overcoming this complication would be to make separate appropriations, one for services that state governments provide statewide (for example, home health, medications, and insurance continuation) and one for medical services whose provision is shared by the state governments and EMAs.[4] 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

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[4]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.

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. Such a funding arrangement would eliminate the double counting of caseloads that occurs under the current system.

TITLE I FORMULA CASELOAD MEASURES

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

When 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, EMAs that were first eligible to receive title I funds were funded at about $1,500 per case, on average, in fiscal year 1994. In contrast, during this same time, EMAs that recently became eligible to receive these funds were funded at only $1,000 per case--one-third less than the older EMAs.

COST MEASURES IN TITLE I AND TITLE II FORMULAS

While the cost of providing AIDS and HIV services varies among EMAs and states, neither the title I nor title II formulas include a factor to measure those differences. Information on the actual costs of providing health and support services to persons 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. Based on our discussions with various experts, we used the Medicare Hospital Wage Cost Index as a proxy measure for labor costs.

This index indicates that wage rates for hospital workers were 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, wage rates for hospital workers

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

TITLES I AND II 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 size 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 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. In addition, using total taxable resources (TTR)[5] in the title II formula instead of personal income could result in a more comprehensive measure of state tax bases.

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We hope this information proves useful to you. Please contact me on (202) 512-4561 or Jerry Fastrup, Assistant Director, at (202) 512-7211 if you or your staff have any questions.

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[5]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.

Sincerely yours,

William J. Scanlon

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