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The Bush Administration's Medicaid and State Children's Health Insurance Program Proposal

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As part of his fiscal year 2004 budget, President Bush has proposed sweeping financing and programmatic changes for Medicaid and the State Children's Health Insurance Program. These changes would have huge implications for the 45 million people that receive their health coverage and long term care services through Medicaid, for states and communities, and for the broader health care system. In 2003, Medicaid is projected to be the largest single source of coverage in the country, both in terms of dollars spent and number of people covered.

Background

Over the past several months states have been struggling with staggering revenue shortfalls which, in turn, have focused much attention on Medicaid. Although the federal government pays the majority of Medicaid costs, state contributions are substantial, amounting, on average, to estimated 16 percent of state general fund expenditures in fiscal year 2002.¹ During this downturn, states have been looking to the federal government to temporarily assume a greater share of Medicaid costs. In the absence of federal fiscal relief, as of December 2002, an estimated one million people stood to lose their health care coverage as a result of proposed or implemented reductions in Medicaid and closely related state health coverage programs.² More recent reports show that state budget situations are becoming even more dire.³

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¹ National Association of State Budget Officers, "2001 State Expenditure Report", Summer 2002.

² L. Ku et al, "Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for One Million People." Center on Budget and Policy Priorities, January 6, 2003.

³ National Conference of State Legislatures, "State Budget Update: February 2003," February 4, 2003. State budget estimates are estimated in the range of \$70 - \$85 billion for state fiscal year 2003, or about 14.5 - 18 percent of all state expenditures; I.Lav and N. Johnson, "State Budget Deficits for Fiscal Year 2004 are Huge and Growing," Center on Budget and Policy Priorities, January 23, 2003; Plans for Medicaid spending reductions are surveyed in, V. Smith et al, Health Management Associates, and V. Wachino, "Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003," Kaiser Commission on Medicaid and the Uninsured, January 2003.

The White House has opposed giving states a temporary boost in federal Medicaid matching payments. Instead, the Bush Administration has announced a sweeping proposal that would undo key elements of the Medicaid and SCHIP programs.

Two Options

Under the proposal, states would have two options. They could continue to run Medicaid and the State Children's Health Insurance Program (SCHIP) under existing rules and receive the normal federal Medicaid and SCHIP federal matching payments. States that take this option get no fiscal relief.

Alternatively, states could opt to turn their Medicaid program into a block grant and merge their federal Medicaid and SCHIP funds. States would be granted broad new flexibility to change program rules but they would lose the financing flexibility that is a central element of Medicaid. Medicaid's system of financing coverage through shared state and federal contributions would be replaced by capped federal payments and a state "maintenance of effort" requirement. The capped federal payments would be frontloaded over the ten-year life of the block grant to provide states some additional funds in the first few years, but these funds would be repaid through reductions in federal payments to states in the later years. The proposal is described by Administration officials as being "budget neutral" to the federal government because the total amount of federal Medicaid payments provided to states over the next ten years would be capped at levels the Administration projects the federal government would otherwise spend on Medicaid during this period; there are no additional funds being provided to states for fiscal relief. Moreover, by eliminating the federal commitment to pay for actual costs, states will receive *less* federal funds under this structure than they would receive under current financing rules to the extent that actual costs over the next ten years exceed the capped federal payments.

Many of the critical elements of the proposal have not been developed and some elements of the plan are changing in the course of the briefings and discussions that are occurring following the release of the plan, but the basic outlines of the plan reveal the potential far-reaching impact of this proposal.

Financing

Under the block grant option, the system for providing federal financing for Medicaid and SCHIP would be changed along with state spending requirements under both programs.

- States would receive two annual allotments from the federal government—one for acute care (e.g., physician and hospital services) and one for long term care (e.g., nursing home and community-based services). They could move some portion of the funds between the two accounts (10 percent has been suggested in budget documents) and could use up to 15 percent of each of the allotments for program administration and direct payments to hospitals. Under current program operations, about five percent of Medicaid spending is used for program administration.

- Allotments would be based on the amount of federal Medicaid funds, including Disproportionate Share Hospital (DSH) payments, a state received in fiscal year 2002. The new allotments would also include State Children's Health Insurance Program (SCHIP) funds. It appears that the proposal would eliminate separate funding for children's coverage through SCHIP.⁴
- Allotments would grow each year, with the rate of growth set for the next ten years based on a pre-determined formula, not on the number of people served or the actual cost of services. If program costs exceed the capped amount, a state opting for the block grant would not receive more federal funding. As explained below, states could attempt to keep their costs at or below the capped amounts in a number of ways that are not now permitted by federal standards.
- Details on how the growth rate for the federal payments would be calculated are not available. If one nationwide rate were used there would be different impacts for different states since the factors that influence state health care spending in any given year will vary from state to state. While a one-size fits all growth rate would not serve states well, state-specific growth rates are not likely. That would put states back into the kind of waiver negotiations that U.S. Department of Health and Human Services (HHS) Secretary Thompson has said would no longer be needed under this proposal.
- The fiscal relief carrot offered to states has been estimated as \$3.25 billion in 2004 and \$12.7 billion over seven years, to be shared among the states that choose the block grant option. (These amounts may be less if only a small number of states opt for capped payments.) The formula for distributing these dollars has not been spelled out, nor is it known whether states would have to sign up for the block grant by a certain date in order to receive any of the funds or, if not, how latecomers would benefit from these funds. Unlike other fiscal relief proposals that would provide states higher Medicaid matching payments for a temporary period of time, this proposal would require states to repay the funds. Repayment would be accomplished through a reduction in the capped allocations states would otherwise receive in years eight, nine and ten. (Budget documents show that by 2013, the last year of the block grant, federal Medicaid payments would be \$8.3 billion below the level that would be spent under current law.) In response to reporters' questions about how states would manage these repayments, the Secretary stated, "I'm not going to be here to solve that problem."⁵
- A significant, but often overlooked, aspect of the financing under the block grant option is that states would no longer have to put up state matching payments. Instead, states would be subject to a "maintenance of effort" (MOE) requirement that would be based on

⁴ SCHIP funding is authorized at the federal level only through 2007. Although the proposal (and the budget) assumes ongoing SCHIP funding, the continued authorization of SCHIP and the level of funding available through SCHIP is a matter for Congress to determine. The elimination of a separate stream of SCHIP funding for an identifiable group of children, as proposed in the President's plan, could jeopardize the reauthorization of SCHIP funds.

⁵ Transcript, "HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan", January 31, 2003, Washington DC, Kaiser Family Foundation, KaiserNetwork.org, page 20.

the amount of funds the state spent on Medicaid (and presumably SCHIP as well) in 2002. The MOE requirement would be adjusted annually over the ten-year period using the Medicaid Consumer Price Index (CPI), which has consistently grown at a considerably slower rate than Medicaid expenditures. For example, between 1995 and 2002, the MCPI grew by an average annual rate of four percent compared to Medicaid expenditures which grew by 7.5 percent.⁶ The slower growth rate could allow states to lower their contributions to the program over time.

- In addition, state spending could drop significantly relative to spending under current program rules because it would be difficult to design an MOE provision that would prevent states from substituting other state spending to meet the MOE requirement. If states are given broad new flexibility to determine how their federal funds will be spent (the flexibility provisions are discussed below), presumably that same flexibility would be granted with respect to allowable uses for the MOE funds. If that were the case, states could identify spending that is now outside of the Medicaid program (for example, state-funded mental health institutions, health care-related payments to schools) as meeting their MOE requirement. State spending, and therefore, total spending for the program, could decline significantly, particularly in light of state fiscal pressures.

The Elimination of the Federal Entitlement to Coverage and Federal Minimum Standards

In exchange for giving up open-ended federal financing, the block grant option would offer states, in the words of Secretary Thompson, “carte blanche” flexibility to change eligibility, benefits, cost sharing and other key features of the program for so-called “optional” groups.⁷ As explained below, it appears that all of the people now covered through Medicaid—mandatory as well as optional groups—could be affected by the elimination of federal standards and the block grant financing.

- Budget documents and the Secretary’s statements stress that under the block grant option certain people would continue to benefit from federal minimum standards—so-called “mandatory” beneficiaries. “Mandatory” beneficiaries are those people who fall within the eligibility groups states are required to cover under Medicaid by federal law (if the state chooses to operate a Medicaid program and accept federal Medicaid funds). These groups are not defined strictly by their incomes levels; that is, not all poor people, or near-poor people are “mandatory” beneficiaries. For example, while all poor children are considered mandatory beneficiaries, many of their parents or grandparents (with the same family incomes) would not fall within a mandatory coverage group. (Figure 1)

⁶ Medicaid expenditure growth considers growth in costs *and* growth in enrollment while the MCPI is a measure of the change in the cost of a given set of goods and services.

⁷ Transcript, “HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan,” January 31, 2003, Washington DC, Kaiser Family Foundation, KaiserNetwork.org, page 25.

Figure
1
Medicaid Beneficiary Groups

“Mandatory” Groups

- Children under age 6 133% FPL
- Children age 6 and older 100% FPL
- Children in foster care
- Parents with incomes below state-established minimums (median = 59% FPL)
- Elderly and disabled SSI beneficiaries (incomes 74% FPL)
- Low-income Medicare beneficiaries

“Optional” Groups

- Children and parents above minimum requirements
- Pregnant women >133% FPL
- Disabled and elderly people > 74% FPL, including those in nursing homes
- Disabled and elderly people served under Home and Community Based waivers
- Women with breast and cervical cancer
- Certain disabled people who are employed and buy into coverage

- Under the proposal, it appears that mandatory groups would retain some, but perhaps not all, of the protections they receive under current law. States would have to provide a set of standard benefits (it is not clear whether these would be the same benefits that currently must be covered), but it appears that states would be able to change the rules relating to the optional benefits offered to these groups.⁸ (See Figure 2). It is unclear whether the cost sharing rules (e.g., copayment requirements) for mandatory groups could be changed, although it appears likely that states would be given broad flexibility charge mandatory beneficiaries fees for optional benefits, such as prescription drugs. It is also not known whether other federal standards regarding managed care, application processing or translation services would continue to apply to mandatory groups. In addition, the proposal originally called for the funding for the mandatory groups to come through the block grant, meaning that they too would lose the benefit of open-ended federal financing if a state chose the block grant option, but this feature of the proposal may no longer be in play.

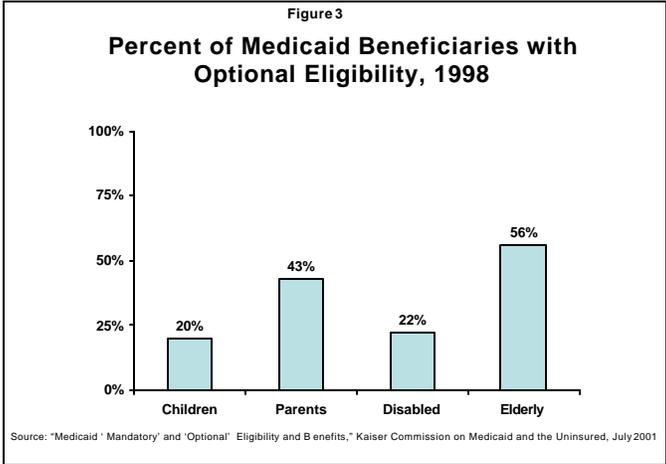
⁸ Although these benefits are “optional” under current law, once a state decides to use federal Medicaid funds to provide an optional benefit it must comply with certain federal minimum standards. For example, the benefit must be available to people throughout the state.

**Figure 2
Medicaid Services**

Mandatory Services	Optional Services
<i>Acute Care</i>	
<ul style="list-style-type: none"> • Physician, nurse practitioner and nurse midwife services • Laboratory and x-ray services • Inpatient and outpatient hospital services • Screening and treatment services for children (EPSDT) • Family planning services • Federally-qualified health center (FQHC) and rural health clinic (RHC) services 	<ul style="list-style-type: none"> • Prescribed drugs • Medical care or remedial care furnished by licensed practitioners under state law • Diagnostic, screening, preventive, and rehabilitative services • Clinic services • Dental services, dentures • Physical therapy and related services • Prosthetic devices • Eyeglasses • TB-related services • Primary care case management services • Other specified medical and remedial care
<i>Long-term Care</i>	
<ul style="list-style-type: none"> • Nursing facility services for adults • Home health care services (for people entitled to nursing facility care) 	<ul style="list-style-type: none"> • Intermediate care facility for people with mental retardation (ICF/MR) services • Inpatient and nursing facility services for people 65 or over in an institution for mental diseases (IMD) • Inpatient psychiatric hospital services for children • Home health care services • Case Management services • Respiratory care services for ventilator-dependent individuals • Personal care services • Private duty nursing services • Hospice care • Services furnished under a "PACE" program • Home and community-based (HCBS) services (under budget neutrality waiver)

Source: Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book," July 2002

- So-called "optional" groups could lose all of their federal protections according to the information released to date. These groups comprise about one third of those served by Medicaid, including many people with incomes below or just above the poverty line. Parents working at low-wage jobs that do not offer health insurance, disabled people with incomes just above SSI levels, and most of the elderly people relying on Medicaid for nursing home care are in "optional" groups, along with one out of five children covered by Medicaid.



Changes to the State Children's Health Insurance Program (SCHIP)

Under the block grant option, SCHIP and Medicaid funds would be merged, raising a number of questions about the future of SCHIP.

- An HHS press release provides that states would receive SCHIP funds under the block grant based on their level of spending in SCHIP in fiscal year 2002.⁹ If this were the case it is not clear whether federal SCHIP funds that were not spent in 2002 would revert to the Treasury or would be redistributed to other states.¹⁰
- It is also unclear whether there would be any limits imposed on the use of SCHIP funds (for example, could SCHIP funds used for parents or childless adults as has been allowed through waivers?), or whether the flexibility accorded states with respect to the Medicaid funds would be extended to SCHIP. For example, would federal cost sharing protections and benefit standards still apply to SCHIP-eligible children? The Secretary cites SCHIP as a model for the new initiative, suggesting that SCHIP standards might remain in place. However, it would be odd for standards to be eliminated for optional Medicaid-eligible children (states would be provided "complete" flexibility for all optional groups according to the Secretary's statements) but maintained for SCHIP-eligible children who generally have somewhat higher incomes than Medicaid-eligible children.

Issues, Questions and Implications

Although many elements of the President's proposal have not been ironed out, it appears that the Medicaid and SCHIP programs would be fundamentally overhauled by this proposal. The ripple effect could be enormous: Medicaid accounts for close to 17 percent of all health care spending. It covers more than 45 million people, filling in for much of the gaps left by other insurers. By covering the sickest and most costly people among us, Medicaid covers people private insurance prices out of the market and helps keep private coverage afloat. Medicaid also fills in the gaps left by the Medicare program, providing prescription drug coverage, long term care, and help with cost sharing to six million of the lowest income Medicare beneficiaries. About 70 percent of all nursing home residents rely on Medicaid, and an estimated 35 percent of all state Medicaid costs are for so-called "dual" eligibles (people eligible for Medicaid and Medicare).

- The potential implications of the loss of federal minimum standards have to be considered in the context of the new financing arrangements. A block grant puts the program in a fiscal straightjacket. It eliminates the flexible, open-ended federal funding arrangement that is at the essence of the program. No longer would states be assured of additional federal Medicaid funds if a new treatment for AIDS or schizophrenia or cancer became available or if a plant closed down and hundreds more children in a community suddenly needed health insurance. Coverage and care would have to be managed within

⁹ HHS News, January 31, 2003.

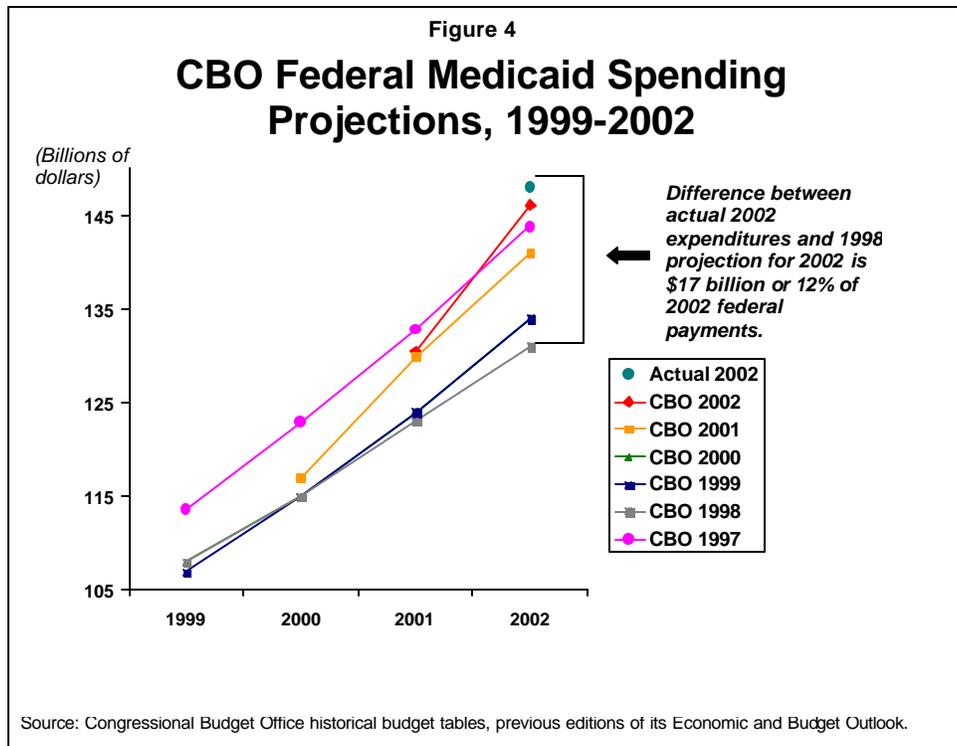
¹⁰ Under current law, states have up to three years to spend their SCHIP allotments. After the three-year period, states that have fully expended their allotments receive funds from other states that have unspent federal SCHIP funds. Any unspent reallocated funds revert to the U.S. Treasury after one year.

the confines of fixed federal payments, just at a time when health care costs are rising and the population is aging.

- The 2002 base year for state allotments would affect states in different ways. Some states that had not expanded coverage to many optional groups or that had adopted significant retrenchments in their program by 2002 would have relatively smaller base allotments compared to other states that had expanded coverage or that did not cut back on spending until later in the economic downturn. Other factors could also lead to variations across states. For example, states that benefited from Medicaid “Upper Payment Limit” financing arrangements that were subsequently outlawed might have those UPL payments folded into their base allotments even though under current law these payments would gradually phase down.
- The formula for setting the growth rate for the allotments has not been determined, but no pre-set formula could accurately account for and predict the influence of all of the factors that affect health coverage spending in different states, particularly over such a long period of time. For example, the Congressional Budget Office’s 1998 projection for federal Medicaid spending for 2002 turned out to be 12 percent below the actual level of 2002 spending.¹¹ (Figure 4) Ten year projections are even more likely to be off the mark. States have had similar difficulty projecting costs due to the unpredictability of the economy, the cost of prescription drugs, the introduction of new health care treatments and other factors that underlie Medicaid costs.¹² This is why the principle that funding follow the people actually covered is central to Medicaid’s ability to offer relatively stable coverage.

¹¹ Some of the variation between the 1998 estimate and the actual spending for 2002 was due to states’ use of Medicaid upper payment limit rules (governing payments to hospitals and nursing homes) which led to a growth in federal Medicaid spending, but much was due to changes in participation rates (down and then up) following the implementation of the federal welfare law and SCHIP, more reliance on managed care, an upsurge in costs, particularly in prescription drug expenditures, and other factors that may not be the same factors that would influence spending over the next ten years but that are the kind of unpredictable changes that inevitably arise.

¹² Some of these problems are reviewed in V. Smith, et al, Health Management Associates, and V. Wachino, “Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003,” Kaiser Commission on Medicaid and the Uninsured, January 2003; and V. Smith, et al, Health Management Associates, and V. Wachino, “Medicaid Spending Growth: Results from a 2002 Survey,” Kaiser Commission on Medicaid and the Uninsured, September 2002.

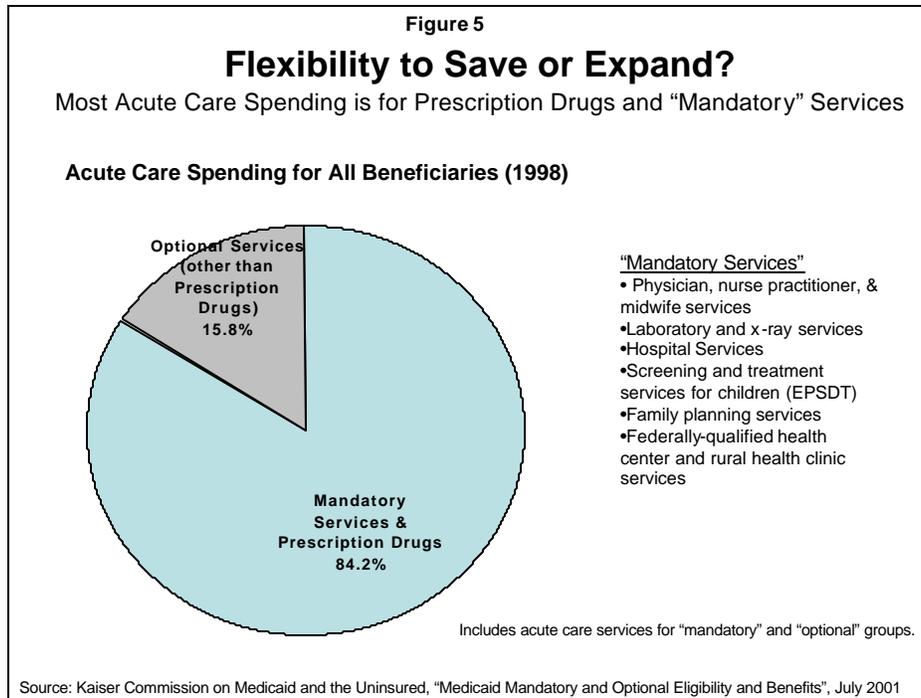


- Perhaps most notable given states' interest in having the federal government assume a greater share of the cost of long term care services is that this proposal moves the policy in exactly the opposite direction. Federal spending for long term care (nursing home care and home and community-based services) would be capped. States are already under considerable pressure to expand home and community-based long term care services, but cost has been a major barrier to reform. That problem would only worsen if federal payments for long term care were constrained by a cap particularly in light of the growth in the portion of Americans who will need long term care services over the next few decades.¹³
- Fiscal constraints flowing from this proposal would push states to rely on the “carte blanche” flexibility in order to reduce their costs. Federal standards relating to matters as diverse as nursing home quality, cost sharing, the scope of benefits provided, timely processing of applications, and patient protections under managed care would apparently no longer apply to at least a third of all beneficiaries, at state option. States might also be given the flexibility to change the basic way in which the program operates. Vouchers for a defined amount of health services and subsidies for hospitals, state-run health facilities and private care managers could replace Medicaid's insurance approach. To the extent that the MOE requirement allowed the states to effectively pull out some of their own state funding for the program (which accounts for 43 percent of Medicaid spending), the scope of the programmatic changes would be that much more extreme.

¹³ According to U.S. Census Bureau projections, the portion of the population that will be 65 years of age or older will increase from 12.7% in 1999 to 16.5% in 2020 and to 20.3% in 2040. “Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin”, Population Division, U.S. Census Bureau, January 13, 2000.

- Those living in rural parts of a state (and the providers that serve them) could be particularly hard hit. In his press comments, Secretary Thompson noted how difficult it was for his home state of Wisconsin to pay for services in a remote area of the state as he promoted that aspect of Administration’s proposal that would end the requirement that services be available on a statewide basis.¹⁴
- The proposal also appears to have broad implications for SCHIP. By eliminating SCHIP as a separate funding source, the targeted focus on covering uninsured children could be lost. In addition, depending on how the financing would work, states that would need to rely on reallocated SCHIP funds to cover children could face funding shortfalls. Currently, states that spend all of their SCHIP funds on children receive reallocated funds from other states that have not fully expended their funds. If, under the block grant, states would have full access to all of their SCHIP allotment regardless of whether they needed those funds to cover children eligible for SCHIP, there would be no funds to reallocate to other states that have made aggressive use of their SCHIP funds to cover children. On the other hand, if states are limited to the amount of SCHIP funds they used in 2002, some states would receive more SCHIP funds than they would receive under current law while others would be locked in to a lower amount of SCHIP funds than they might have received. Either way, the block grant proposal would freeze SCHIP allotments to states for the ten-year period, eliminating the limited but important flexibility built into current law to reallocate funds from state to state depending on state SCHIP enrollment and costs.
- A potential benefit of the proposal would be to allow states to cover adults who they cannot now cover under Medicaid except with a waiver (i.e., adults who are not living with children and who are not pregnant, disabled or elderly). The flexibility to cover this group of people, however, is likely to be illusory. Because federal payments would be capped, states would not receive any new federal funds to help them cover new groups of uninsured people. New coverage would have to be financed through reductions in spending for those who are currently covered by Medicaid or SCHIP (or with state-only dollars). States might achieve some savings through management efficiencies and some cost containment initiatives, but, in general, they can take these steps under current law and already have a strong fiscal incentive to do so because of the state matching requirement. States would have new opportunities to achieve savings by reducing coverage or benefits (or raising fees) from currently covered groups, but what services would be taken away? There is not much “fat” in Medicaid. In 1998, more than 84 percent of acute care spending (for all beneficiaries—mandatory and optional) was for prescription drugs and for services that are required under federal law – services that most would consider basic to insurance coverage, such as hospital care and physician care. All other optional acute care services (such as rehabilitative care, durable medical equipment, eyeglasses, and dental care) accounted for only 16 percent of total acute care spending. Figure 5

¹⁴ Transcript, “HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan”, January 31, 2003, Washington DC, Kaiser Family Foundation, KaiserNetwork.org, page 15.



- “Mandatory Services”**
- Physician, nurse practitioner, & midwife services
 - Laboratory and x-ray services
 - Hospital Services
 - Screening and treatment services for children (EPSDT)
 - Family planning services
 - Federally-qualified health center and rural health clinic services

- Aside from not being able to find the savings to cover new groups, under a capped federal payment structure states lose much of the fiscal incentive they have under current law to cover new groups of people or to offer optional benefits. The federal match, combined with the system of providing states options to provide more comprehensive benefits and expanded coverage, offers states the opportunity and the incentive to serve more people and offer an array of benefits. Under a capped financing system, states would receive no additional federal dollars (assuming they are spending up to the cap) if they expanded enrollment, and, indeed, they would have fiscal incentives to keep eligibility and participation rates down.

Would States Take The Block Grant Option?

Although there are clear long term disadvantages to states under the block grant structure, the proposal seeks to entice states to take up the option by front loading the allocations and granting such broad flexibility that states could potentially use Medicaid funds (and the lack of a state match requirement) to work through much of their current budget problems.

On the other hand, states would face daunting challenges under the block grant, particularly in the later years as funds declined. Capped funding creates a “zero sum” game; states would be required to juggle a myriad of needs and demands with a fixed pot of funds. Much of the reason why states have grown their Medicaid programs over the years is because they recognized the value of taking advantage of the open-ended federal funding to help finance the demand for coverage and long term care services. The block grant ends this partnership. The federal government’s commitment and risk is capped leaving states even more vulnerable to the demands of growing health care costs and the needs of an aging population. The question is

whether the immediate budget pressures, the opportunity to operate outside the confines of current federal standards, and, in some cases, ideological and political allegiances will prompt state policymakers to support the proposal.

Conclusion

While many details of the Administration's plan are not known, it appears that the proposal would shift health care costs to states and communities and put providers of care and the people served by Medicaid and SCHIP at risk. In addition, carte blanche flexibility not only removes critical federal standards and consumer protections for people who depend on Medicaid for their health care coverage, it also calls into question whether there would be any real accountability for the federal funds that would be provided to states.

Solutions are needed to address rising prescription drug and other health care costs, the lack of a drug benefit for Medicare beneficiaries (the cost of which is picked up by state Medicaid programs for the lowest income Medicare beneficiaries), and the growing number of people who lack coverage and need long term care services. States' legitimate need for fiscal relief ought to be met by measures that can help them contain costs in effective and responsible ways while assuring that adequate resources are available to help them maintain health care coverage. If Medicaid is to remain a viable and stable source of insurance for those the private market largely will not cover the federal government will need to remain a full funding partner and continue to insist on a certain degree of accountability and value for the substantial federal funds it provides to states for coverage and long term care. With 41 million uninsured people in this country and rapidly rising health care costs in both the private and public sectors, approaches are needed that move us forward, not backward, toward the goal of assuring that all people have access to health care.