

medicaid  
and the uninsured

May 2003

**BUSH ADMINISTRATION  
MEDICAID/SCHIP PROPOSAL**

With states facing their worst fiscal crisis since World War II, the Medicaid program now is in a period of significant stress. In light of severe budget problems and rising Medicaid costs, states have called on the federal government for more help in paying for Medicaid and more flexibility over Medicaid funds. In response, some in Congress have put forth proposals to temporarily increase the share of Medicaid that is paid for by the federal government, while others have encouraged a reexamination of Medicaid's role in paying for long-term care and prescription drugs for seniors enrolled in Medicare.

In January of 2003, the Administration put forth a proposal to restructure Medicaid and SCHIP in ways that could fundamentally alter the two programs. The proposal, which is the subject of this policy brief, is now being considered on Capitol Hill and by a Taskforce established by the nation's Governors to develop and evaluate Medicaid reform proposals. It gives states the choice of remaining in the current Medicaid/SCHIP program or opting into a new system that combines increased flexibility over benefits and coverage with capped federal financing. The proposal gives states immediate financial incentives to opt for the new system, but federal funding would be reduced in later years. In states that take the option, the new system would end Medicaid as an entitlement program for many beneficiaries and eliminate open-ended federal financing. Although, capped federal funding would increase over time by a specified trend factor, the combination of fewer rules over how the funds are used, repeal of matching requirements, and fixed federal allotments make the new structure essentially a block grant.

This policy brief begins with a brief overview of key challenges confronting the Medicaid program (Section I). It then provides a detailed explanation of what is known about the key elements of the Administration's proposal (Section II). The brief concludes with a discussion of the implications of the Administration's proposal (Section III).

## I. KEY CHALLENGES CONFRONTING MEDICAID

Medicaid is the nation's major public financing program for providing health and long-term care coverage to over 50 million low-income Americans (Figure 1). It plays a major role in the nation's health care system, paying for 17% of hospital care, 17% of prescription drug spending, and half of nursing home care. An entitlement to states and individuals, Medicaid provides open-ended federal matching funds to enable states to respond to unexpected changes in economic conditions, increases in poverty, rising health and long-term care costs, public health epidemics, and emergencies or disasters.

As a program financed jointly by the federal government and the states, Medicaid now is in a period of significant stress. States are facing their worst fiscal crisis since World War II due to dramatic declines in their revenues. Over the last two years state revenues have fallen faster and further than anyone predicted, creating state budget shortfalls of \$49 billion this year and close to \$70 billion for FY 2004 (Figures 2 and 3). The states' fiscal crisis is being driven by the economic downturn and outdated state tax structures, but also affects states' ability to finance their share of Medicaid costs, particularly given that Medicaid spending is growing relatively rapidly.

In fiscal year 2002, Medicaid spending grew 13 percent and this year it is expected to increase by 10 percent. The growth in the program is due in large part to the rapidly rising cost of providing prescription drugs and other health and long-term care services to elderly and disabled beneficiaries (Figure 4). Of particular note is the cost to Medicaid of covering "dual enrollees," low-income seniors and disabled individuals who are enrolled in both Medicare and Medicaid. Although dual enrollees receive their basic health care benefits through Medicare, they use Medicaid to help with the cost of prescription drugs, long-term care and other services not generally covered by Medicare, as well as with Medicare premium and cost-sharing obligations. Many dual enrollees have particularly extensive health care needs and, as a result, they consume a disproportionately high share of Medicaid spending -- a little under one-fifth of Medicaid enrollees also are enrolled in Medicare, but these dual enrollees consume more than a third of all Medicaid spending (Figure 5).

Turning first to rainy day and tobacco settlement funds, states have tried to preserve Medicaid and keep the federal dollars in the program and their state economies. But as these sources have become depleted, states have had to turn to cuts in Medicaid. A recent KCMU survey found that 49 states were planning or taking action to reduce the growth in Medicaid spending. Nearly half of the states were turning to reducing benefits or limiting eligibility (Figure 6).

In response to these fiscal pressures, states have called on the federal government for more help with the cost of operating Medicaid, particularly with the expense of providing prescription drugs and long-term care to Medicare beneficiaries also enrolled in Medicaid. They also have renewed long-standing calls for additional flexibility over

how they use their Medicaid funds. The Administration's proposal, outlined in detail below, also is being considered by members of Congress and Governors as a vehicle for addressing the concerns of states.

## II. THE ADMINISTRATION'S PROPOSAL

The Administration's proposal to restructure Medicaid and SCHIP was announced by Secretary Thompson at a press conference on January 31, 2003 and described briefly in the President's fiscal year 2004 budget materials. Although the written materials explaining the proposal are limited and many key details remain unspecified, it is possible to describe it in general terms. The proposal gives states a choice of remaining in the current Medicaid/SCHIP program or of opting into an alternative structure. The key elements of the alternative structure include:

- Broad state flexibility over use of funds
- Capped federal funding, which replaces the open-ended entitlement to Medicaid matching funds
- The possibility of some upfront fiscal relief for states (but their capped funding levels will be reduced in later years to ensure the proposal is budget neutral)
- A state "maintenance-of-effort requirement," which replaces the Medicaid matching rate system
- SCHIP funds folded into a state's capped funding levels

States can elect not to participate in the alternative system, but if they do not participate then they are ineligible for any upfront fiscal relief. In states that choose to pursue it, the block grant would end Medicaid as an entitlement program for many beneficiaries and eliminate open-ended federal financing. In exchange, states would receive far more flexibility over how they use federal funds.

The remainder of this section provides a detailed explanation of the proposal. For each key element, it reviews current law, describes the proposed change, and identifies some of the major issues raised by the proposal.

### A. BROAD STATE FLEXIBILITY OVER THE USE OF FEDERAL FUNDS.

#### Current Law

**Eligibility.** Under Medicaid, each state decides how to operate its program within federal guidelines. In exchange for receiving federal Medicaid matching payments, states must guarantee coverage to all individuals in certain "mandatory" groups, including pregnant women and children under age six with family income below 133 percent of poverty and older children with family income below 100 percent of poverty; most disabled and elderly people receiving SSI; and parents with income and resources below states' welfare eligibility levels in July of 1996. States also have broad flexibility to cover individuals in each of these categories at higher income levels ("optional groups"), but generally cannot extend coverage to childless adults under Medicaid without a waiver from HHS (Figure 7).

Medicaid law requires states to provide coverage on a statewide basis and, if a state decides to expand coverage beyond federal minimum levels, all individuals who meet the

expansion criteria are entitled to coverage. Although states can scale back or eliminate optional expansions to control costs and limit enrollment, they cannot establish waiting lists or impose enrollment caps.

**Benefits and cost-sharing.** States also must provide beneficiaries with coverage that includes specified benefits (“mandatory benefits”), such as physician visits and hospital care, but also can provide a broader array of benefits (“optional benefits”) than are required by federal law (Figure 8). The coverage must meet federal requirements that prevent states from imposing premium and cost-sharing obligations on children and pregnant women, and allow states to impose only “nominal” premiums and cost-sharing on most other groups. States also must provide comparable benefits across eligibility groups.

In some cases, states already have used Medicaid waivers to provide coverage that does not meet the standards outlined above, but states generally do not like to pursue waivers because they report that process of securing a waiver from HHS can be time consuming and cumbersome.

## **Proposal**

Under the proposal, states that take the block grant option would have to provide a specified set of services to mandatory populations. Otherwise, states would have what Secretary Thompson has described as “carte blanche” flexibility to decide how to use their funds. In response to queries, the Administration has clarified it would require states to use 85 percent of their funds for coverage. The remaining 15 percent could be used for administrative costs, direct payments to providers (such as those states currently make under the DSH program) or other community-based initiatives. Otherwise, there is little information available on the extent of any minimum federal standards for the use of block grant funds.

## **Key Questions**

### **1. What are the ways in which states might use the new flexibility to reduce coverage?**

In the current budget environment, nearly all states are seeking ways to reduce their Medicaid expenditures. The proposal would give states broad new flexibility to reduce coverage, particularly for optional Medicaid beneficiaries. It appears, for example, that states could do the following without securing a waiver:

- Impose enrollment caps;
- Increase cost-sharing above the nominal levels allowed under Medicaid and SCHIP;
- Limit health and long-term care services to people residing in selected regions within a state;

- Provide benefit packages that vary in scope from one beneficiary group to another (e.g., provide durable medical equipment to elderly people, but not the disabled).

The extent to which states use the new flexibility outlined above to reduce coverage will depend on both the political and fiscal environment in the states in the years ahead. Particularly given ongoing fiscal problems, states could face pressure to reduce their own spending on health and long-term care for low-income people (as allowed under the proposed maintenance-of-effort requirement, described below), as well as to secure fiscal relief by channeling some of their block grant funds to activities currently financed with state funds. Even if these pressures did not come into play, states would shoulder the full financial burden of covering these populations if their federal block grant funds turned out to be inadequate, potentially creating incentives to use the new flexibility to reduce coverage.

## **2. To what extent would the flexibility make it easier for states to expand coverage and improve long-term care services?**

When the economy improves, states may renew their efforts to expand and improve health and long-term care services for low-income people. Prior to the economic downturn, some states were looking for ways to extend coverage to childless adults, a group that cannot be made eligible for Medicaid under current rules without a waiver. Other states were looking for ways to promote home and community-based alternatives to institutional care for seniors and individuals with disabilities. Although states can use waivers in Medicaid to provide home and community-based care services to Medicaid-eligible seniors and disabled individuals who otherwise would require institutional care, federal rules limit the extent to which these beneficiaries can be granted control over how, when, and by whom such services are provided. Beneficiaries generally are not allowed to hire and fire their own personal attendant workers and Medicaid will not pay a beneficiary's family member for providing care.

The Administration's proposal would give states new flexibility to extend coverage to childless adults, as well as to disregard the current federal rules that limit the use of home and community-based services to those in need of institutional care and the extent to which beneficiaries can self-direct their care. The proposal, however, does not provide states with any new resources with which to finance such initiatives. The Administration has suggested that the flexibility provided by the block grant to cut benefits for current Medicaid and SCHIP beneficiaries could be used to "free up" resources to pay for new initiatives. In practice, however, this could prove unworkable. More than 80 percent of optional Medicaid spending is for elderly and disabled people, which means states would need to cut spending on their long-term care, prescription drugs, and other benefits to pay for coverage expansions for childless adults or improvements in home and community-based care services. Under the block grant structure, states also may be unlikely to undertake new initiatives given that they bear the sole risk of paying for any unexpected increases in their cost, as discussed in the financing section below.

### 3. Which Medicaid beneficiaries would be affected by the new flexibility over optional beneficiaries and benefits?

The new flexibility is likely to have the largest effect on optional beneficiaries and beneficiaries who rely heavily on Medicaid’s optional benefits. Some of the sickest and poorest Medicaid beneficiaries fall into the “optional” category and many of the most critical Medicaid benefits -- such as prescription drugs and many long-term care services -- are offered at state option. Overall, optional beneficiaries account for one-third of Medicaid enrollment, but spending on optional beneficiaries and benefits accounts for two-thirds of Medicaid spending (Figure 9). This is because the optional spending in Medicaid is primarily for elderly and disabled beneficiaries with extensive health and long-term care needs; indeed, 83 percent of optional spending in Medicaid is for elderly and disabled people (Figure 10).

#### **The Role of Optional Coverage and Benefits for Elderly and Disabled Medicaid Beneficiaries**

The Medicaid beneficiaries most likely to be affected by the flexibility aspects of the Administration’s proposal are those covered at state option or that rely heavily on optional benefits, primarily elderly and disabled people.

- **Elderly Beneficiaries.** More than half of elderly Medicaid beneficiaries are “optional.” For example, an elderly woman residing in a nursing home with annual income as low as \$7,200 – just above the SSI income limit -- is considered an “optional” Medicaid beneficiary. Many of the services used most heavily by the elderly are “optional,” including prescription drug coverage, some home health care services, personal care services, and hospice care. More than four out of five dollars (83 percent) spent on elderly Medicaid beneficiaries are for optional services and/or beneficiaries (Figure 11).
- **Disabled Beneficiaries.** Many disabled people enrolled in Medicaid are heavily dependent on the program’s “optional” services, including prescription drugs, prosthetic devices, home health care services, personal care services, and private duty nursing services. For example, the prescription drugs provided to a young woman with epilepsy or schizophrenia are considered “optional”, as is the personal care assistance that might enable someone with traumatic brain injury to reside in the community. Overall, two-thirds of Medicaid spending on the disabled is for “optional” services and/or beneficiaries (Figure 11).

Many of the optional elderly and disabled people who rely on Medicaid are “dual enrollees,” low-income seniors and disabled people who are enrolled in both Medicaid and Medicare. Although they receive their basic health care benefits through Medicare, they rely on Medicaid to fill the gaps in their Medicare coverage. Medicaid provides them with prescription drugs and long-term care services, as well as with assistance in meeting Medicare premium and cost-sharing obligations.

#### **4. To what extent would the proposal affect mandatory beneficiaries?**

Although it is less widely recognized, the proposal could have significant implications for mandatory beneficiaries, including children in poor families, very low-income parents, and SSI recipients. Currently, it is unclear whether mandatory beneficiaries are included in the block grant. If so, states at risk of running out of block grant funds will face new fiscal incentives to reduce spending on mandatory beneficiaries. Even if the mandatory beneficiaries are excluded from the block grant structure, they could still be affected by the flexibility provisions of the proposal. The Administration has not indicated, for example, whether states could use their new flexibility to impose higher cost-sharing on mandatory populations.

### **B. BLOCK GRANTS REPLACE OPEN-ENDED ACCESS TO FEDERAL MEDICAID MATCHING FUNDS**

#### **Current Law**

Since its inception, Medicaid's financing structure has been one in which the federal government and states share responsibility for Medicaid expenditures through a matching rate system. The federal government matches state spending for services to eligible individuals on an open-ended or "entitlement" basis. The federal share of spending varies from 50 to 77 percent, depending upon the state's matching rate. As an entitlement program like Medicare and Social Security, Medicaid funding is not subject to the annual appropriations process in Congress. Instead, the federal government automatically provides states with the funds that they need each year to provide services to eligible individuals. In fiscal year 2003, total Medicaid spending is expected to reach \$286 billion, with the federal government paying \$163 billion and the states paying \$123 billion.

#### **Proposal**

If a state opted for the block grant, the matching rate structure used in Medicaid and SCHIP would no longer apply and federal funds would be capped. A state would receive two annual allotments—one for acute care and one for long-term care—from the federal government (Figure 12). States would be allowed to transfer up to 10 percent of the funds from one allotment to the other. Both the acute and long term care allotments would be based on a state's Medicaid and SCHIP spending in FY2002 trended forward at an unspecified rate plus the size of its unspent SCHIP allotments. States would be required to contribute maintenance of effort funds to secure their allotments (described in more detail below). The Administration has said the trend rate will be set higher in early years to generate fiscal relief, but then reduced in later years to ensure the proposal is budget neutral to the federal government over the next ten years. Otherwise, there is no information available on the trend rate that would be applied to allotments.



## Key Questions

### **1. How would capped federal funding affect states' ability to respond to unexpected increases in Medicaid costs and to implement new initiatives?**

Under the current system, states receive help from the federal government when their Medicaid expenditures rise unexpectedly, regardless of the reason and without the need for Congress to take action to appropriate additional funds. In recent years, states have experienced unexpected Medicaid spending increases due to the continued rise in the cost of prescription drugs and increases in enrollment driven by the economic downturn. The federal government currently also shares in the cost of new initiatives, such as recent state efforts to increase the use of home and community-based care among the disabled and elderly through waivers. Under capped federal funding, states are at risk for the full cost of any unexpected increases in the cost of providing health and long-term care services to a low-income population. They also may find that they do not have adequate funds in their federal allotments to implement new initiatives.

In practice, the risk that a state's block grant might prove inadequate would depend on the generosity of its allotments, as well as on its specific circumstances. Since the Administration has not specified the trend rate for allotments, it is impossible to evaluate their adequacy. Even if the trend rate were known, it is important to note that analysts at the state and federal level routinely fail to project Medicaid expenditures accurately. A state might estimate its federal allotments are more than adequate, but then find over time that the cost of providing health and long-term care to a low-income population have outstripped its expectations. It also is possible that the trend rate put forth by the Administration may not be the one that Congress elects to use if it takes action on the proposal or that it might lower the trend rate in future years to fill budget gaps or finance other spending priorities.

By replacing open-ended Medicaid funding with fixed allotments, the proposal also could increase the chance that Medicaid will lose its status as an entitlement program under congressional budget rules and become a discretionary program that is subject to the annual appropriations process. If Medicaid becomes a discretionary program, it will have to compete for funding each year with other popular discretionary programs, making it more vulnerable to cuts and subjecting states to uncertainty each year as to the amount of federal funding they ultimately will receive.

### **2. How would federal block grant funds be distributed among the states?**

By not providing information on the trend rate applied to allotments, the proposal leaves open the question of how federal funds would be distributed among the states. Would all states be subject to the same trend rate on their allotments, or would states with rapidly growing low-income and elderly populations be eligible for higher trend rates?

Initially, the Administration's proposal appeared to envision a uniform, national trend rate that did not take into account such state-specific variations. More recently, however, Administration officials have suggested that the proposal might include state-specific trend rates. In the absence of state-specific trend rates, the fiscal effect of opting into the alternative structure would vary significantly across states, with states that experience relatively rapid growth finding their allotments particularly inadequate. As suggested by the wide variation in states' historical Medicaid growth rates over the last decade (Figure 13), it seems clear that states can be expected to experience wide variation in the rate at which their need for federal funds grows over the next ten years.

## **C. UPFRONT FISCAL RELIEF**

### **Current Law**

The open-ended entitlement to Medicaid matching funds ensures that federal funding for Medicaid automatically rises in response to increased state spending during economic downturns, such as for higher caseloads. Otherwise, the federal government does not provide states with immediate fiscal relief during difficult economic times.

### **Proposal**

The Administration's proposal is designed to provide upfront fiscal relief to states by giving them allotments in the early years that exceed the amount they would have gotten under the current matching rate system. This will occur if the trend rate used to establish a state's allotments initially increases more rapidly than a state's actual spending on Medicaid and SCHIP. For example, consider a state that has seen its Medicaid spending grow 7 percent a year since fiscal year 2002 and that expects this trend to continue for the indefinite future. If it receives an allotment based on its fiscal year 2002 expenditures trended forward at a rate of 9 percent or 10 percent a year in the early years of the program, it will receive more money in the short-term under its allotments than under the current matching rate structure.

Under the proposal, states eventually would be required to "repay" the fiscal relief in later years. The "re-payment" would take the form of federal allotments that grow more slowly over time and that do not keep pace with the expected need for expenditures on the health and long-term care of low-income people. In public comments, Secretary Thompson has suggested, for example, that federal allotments might initially grow 10 percent a year, but in later years might increase by only 6 percent a year.

The Administration estimates its proposal will increase federal Medicaid/SCHIP spending above baseline levels by \$3.25 billion in fiscal year 2004 and by \$12.8 billion between 2004 and 2010, but then be offset by \$12.8 billion in reduced Medicaid expenditures in FY 2011 through 2013 (Figure 14). In fiscal year 2013, the Administration's expects the proposal to cause federal spending on Medicaid and SCHIP to fall \$8.3 billion below the level it is expected to reach if the proposal is not adopted.

## **Key Questions**

### **1. How much fiscal relief would the proposal offer?**

The Administration's proposal offers no federal fiscal relief to states in fiscal year 2003. Given that state budget shortfalls are expected to reach \$70 billion in 2004, the fiscal relief offered for 2004 is relatively modest -- \$3.25 billion. Many states may be reluctant to take advantage of the federal fiscal relief given that it requires them to accept capped federal funding and that their allotments will be adjusted in later years to offset the cost of the upfront fiscal relief.

### **2. How would the fiscal relief vary among the states?**

The proposal appears to offer the most fiscal relief to states with relatively low growth rates and little or no help – even in the short term – to states that are facing relatively rapid Medicaid spending growth. For example, consider a state that has seen its Medicaid spending grow 14 percent a year, and that expects this trend to continue through fiscal year 2004. Even in the short-term, such a state would actually lose federal Medicaid funds if it took the new option and ended up with a federal allotment that was based on its fiscal year 2002 spending trended forward at a rate of 9 percent or 10 percent a year.

## **D. MATCHING RATE SYSTEM REPLACED BY A STATE MAINTENANCE-OF-EFFORT REQUIREMENT.**

### **Current Law**

Under the current matching rate structure, the amount of federal Medicaid funding a state receives is a direct function of the amount it spends on its Medicaid program. The federal government reimburses each state for a set *share* of its Medicaid expenditures. This means that the federal government will match any increase in the cost of a state's Medicaid program, as well as that federal Medicaid spending declines if states reduce their Medicaid spending. Under the matching rate structure, a state that cuts its Medicaid spending by \$1 will lose an additional \$1 to \$3.35 in federal Medicaid funds, depending on the state's matching rate.

### **Proposal**

In states that take the block grant option, the Medicaid matching rate system would be eliminated. States, however, would need to spend a certain amount of their own money on Medicaid as a condition of securing their federal allotments. Under this maintenance-of-effort requirement, states must spend an amount each year that is equal to their FY2002 expenditures on Medicaid and SCHIP trended forward by the medical-CPI.

Under the current matching rate structure, states' own spending on Medicaid and SCHIP is expected to rise on average at a rate of 8 to 9 percent a year. Since the medical CPI usually increases at a rate of 4 to 5 percent a year, the proposal could reduce significantly the amount of their own funds states must spend as a condition of securing federal dollars in future years.

## **Key Questions**

### **1. How would the proposal affect states' incentives to invest in health and long-term care for their low-income populations?**

As Secretary Thompson increasingly is noting in his public comments, the Administration's proposal would allow states to reduce their own spending on health and long-term care for low-income people without it affecting the size of their federal allotments. Under the maintenance-of-effort requirement, states no longer would face the incentive to maintain their investment in Medicaid during difficult economic times created by the matching rate structure which ties the level of federal funding a state receives to its own spending. Similarly, they no longer would experience the same fiscal incentives inherent in the current matching rate structure to exercise options to expand coverage. Under the matching rate structure, states that invest funds in optional expansions of coverage receive a corresponding increase in federal Medicaid matching funds. In contrast, under the block grant, a state that increases its own spending to cover a new optional group receives no additional federal funds.

### **2. How might the maintenance-of-effort requirement affect the level of state investment in the health care system?**

The ability to pull state dollars out of the health care system for low-income people could help states address their budget shortfalls, but also could have a significant effect on beneficiaries. The amount of money that could be lost under the maintenance-of-effort requirement would depend on multiple factors, including what happened to the medical CPI and state behavior. As shown in Figure 15, the loss of dollars to the health care system for low-income people under the MOE requirement if all states were to opt into the new system could reach more than \$400 billion over ten years. Although it is unrealistic to assume all states would exercise the option, the figure gives a sense of the magnitude of funds at stake.

### **The State Maintenance-of-Effort Requirement**

Under the maintenance-of-effort requirement, states' spending requirements will be based on fiscal year 2002 spending trended forward by the medical CPI. The medical CPI is designed to capture changes in the price of health care services, rather than the full range of factors – such as enrollment increases and changes in utilization – that affect Medicaid spending. Historically, the medical CPI has grown at a significantly lower rate than Medicaid spending and it likely will continue to do so. For fiscal year 2003, the medical CPI is expected to increase 4.6 percent even as Medicaid spending rises 10 percent, and in fiscal year 2004 it is expected to increase 4.4 percent as Medicaid spending rises 8.9 percent.

In public comments, Secretary Thompson has said the medical CPI was selected precisely because it does not capture the full range of factors affecting Medicaid spending. By picking a trend rate that does not keep pace with cost of providing health and long-term care under Medicaid, the Administration intended to allow states to reduce their own spending on health and long-term care for low-income populations below the level that likely would have been seen under current Medicaid and SCHIP rules.

### **3. How might the loss of state funds affect beneficiaries?**

Unlike the fiscal relief that would be generated if the federal government increased its contribution to state Medicaid programs, the elimination of the matching rate system would help states with their budget problems primarily if they reduce coverage. In the short-term, some states might find they have “extra” federal funds available under their allotments with which to replace state spending on Medicaid, making it possible for them to reduce their own spending without reducing coverage. In the long run, however, the federal allotments are not designed to provide states with extra funds, suggesting states will need to reduce coverage if they reduce their own spending on health and long-term care for the low-income population. Since the vast majority of optional spending in Medicaid is for elderly and disabled individuals, they likely would be the most affected by any reductions in coverage that states adopt to reduce their own spending under the maintenance-of-effort requirement.

### **E. SCHIP FUNDS FOLDED INTO ALLOTMENTS.**

#### **Current Law**

The SCHIP program currently provides states with an enhanced federal matching rate for the cost of expanding coverage to uninsured, low-income children. The enhanced matching rate reduces the cost of expanding coverage for children by 30 percent relative

to the cost under Medicaid. States can use their SCHIP funds to expand coverage for children through Medicaid or through a separate child health program. If they opt for a separate child health program, states have flexibility to provide a more limited benefit package and charge higher cost-sharing than under Medicaid, but they still must meet some federal standards in these areas.

## **Proposal**

In states that take the block grant option, SCHIP funding would be folded into the states' allotments, eliminating the dedicated funding stream and enhanced matching rate for children's coverage. States could use the SCHIP funds that have been folded into their allotments for SCHIP-like coverage of low-income children, but would not be required to do so. As a result of states opting into the block grant, the Administration expects spending on the SCHIP program as a distinct program to fall sharply (Figure 16).

## **Key Questions**

### **1. How would children's coverage be affected by folding SCHIP funds into the block grants?**

Since the inception of the program in 1997, state officials and others have suggested that states universally took up the SCHIP option to expand coverage for children in part because the program provided them with an enhanced matching rate for doing so. If SCHIP funds are folded into larger block grants where the enhanced matching rate no longer applies, it is possible states would be less likely to maintain their children's health coverage programs. Under fixed allotments, children could end up competing with the other groups for limited federal funds. As discussed above, states also may face new fiscal incentives to reduce their own spending on coverage under the proposal, including children's coverage.

### **III. IMPLICATIONS OF THE ADMINISTRATION'S PROPOSAL**

If adopted, the effect of the Administration's proposal will depend heavily on how the details of the proposal are filled in, as well as on the decisions made by states that take the block grant option. In states that adopt the new approach, the Administration's proposal could have significant implications for Medicaid beneficiaries, as well as for the financial relationship between the states and the federal government.

#### **Implications for beneficiaries**

In the current fiscal environment, states already face substantial pressure to reduce Medicaid and SCHIP spending to address budget shortfalls. The financing provisions of the Administration's proposal would add to this existing pressure by creating new fiscal incentives for states to impose cuts. If the matching rate system were eliminated, states could cut back on spending without foregoing federal Medicaid matching funds, eliminating an important disincentive to cut Medicaid and SCHIP. Moreover, states at risk of running out of federal funds under their capped allotments would face particularly strong pressure to impose cuts to avoid having to pay for an "excess" spending entirely with state funds.

The Administration's proposal also gives states more flexibility to cut back on coverage in ways not allowed under current law. States no longer will be required to provide beneficiaries with coverage that meets federal guidelines, including guidelines designed to keep cost-sharing at nominal levels, ensure a comprehensive benefit package, prohibit waiting lists, and promote the comparable treatment of beneficiaries within a state and across eligibility groups. To the extent the proposal encourages further cutbacks, elderly and disabled beneficiaries may be most at risk since they account for more than 80 percent of "optional" spending on Medicaid.

For beneficiaries, some of the most important potential benefits of the Administration's proposal arise from the flexibility it provides states to extend coverage to childless adults and to promote home and community-based alternatives to institutional care for seniors and individuals with disabilities. However, it is likely to prove difficult for states to pursue such initiatives under the Administration's proposal. The proposal does not provide states with any new resources with which to take advantage of the new flexibility to adopt expansions or improve coverage. To the contrary, states will face capped federal funding which may make it difficult for them in the long-term simply to maintain their current programs and services.

The proposal also contains some risks to recent initiatives aimed at helping particular groups of beneficiaries, such as SCHIP and new Medicaid options to provide coverage to the working disabled, women with breast and cervical cancer, and other groups. In states that adopt the new approach, SCHIP funds disappear into states' allotments where they can be used for whatever a state likes. Similarly, coverage of the

working disabled and women with cancer would be totally at state discretion and would have to compete with other groups for the limited funds available under the allotments.

### **Implications for the fiscal relationship between states and the federal government.**

The implications of the proposal for the fiscal relationship between states and the federal government are equally significant. Some states may find that they receive more federal funds in the short-term under the block grant option than under the current system. But, these states can receive upfront fiscal help only if they are willing to accept the risk of capped federal funding and allotments in later years that are slated to grow more slowly than the cost of providing health and long-term care to a low-income population. Under the block grant structure, states must bear the full cost of any unexpected increases in the cost of providing health and long-term care services to a low-income population, including increases in need for coverage driven by economic downturns, public health epidemics, and higher than expected health care inflation.

By replacing open-ended Medicaid funding with fixed allotments, the proposal also could increase the chance that Medicaid will lose its status as an entitlement program under congressional budget rules and become a discretionary program that is subject to the annual appropriations process. If Medicaid becomes a discretionary program, it will have to compete for funding each year with other popular discretionary programs, making it more vulnerable to cuts and subjecting states to uncertainty each year as to the amount of federal funding they ultimately will receive.

Under the proposal, states would have significant new flexibility to reduce their own spending on Medicaid and SCHIP without a corresponding loss of federal dollars. States, however, will be able to take advantage of this source of “fiscal relief” only if they cut health and long-term care services for low-income populations.

Even in the short-term, states facing the most rapid increase in their Medicaid spending apparently would receive little or no fiscal relief from the proposal – they would receive less federal money under their allotments than under the current Medicaid system and would be particularly hard-pressed to use the opening created by the maintenance-of-effort requirement to reduce state spending. These states -- as well as others that are unwilling to take the block grant option because they consider the risk of capped federal funding to be too great -- will receive no help under the Administration’s proposal.

As noted in the beginning of this brief, the major challenges confronting Medicaid include the fiscal crisis among the states generated by dramatic revenue declines and the rising cost of providing health and long-term care services to a low-income population. Although it would fundamentally alter the health care safety net in this country, the Administration’s proposal does not appear to provide states with the tools they will need to address these underlying challenges. In the absence of substantial help with their fiscal problems or with the pressures placed on Medicaid by the gaps in Medicare coverage,



states will continue to struggle with the challenges presented by Medicaid and beneficiaries will be at risk for further erosion in their coverage.

This Policy Brief was prepared by Jocelyn Guyer of the Kaiser Commission on Medicaid and the Uninsured. She would like to thank her colleagues at the Kaiser Family Foundation for their comments and assistance.

Figure 1

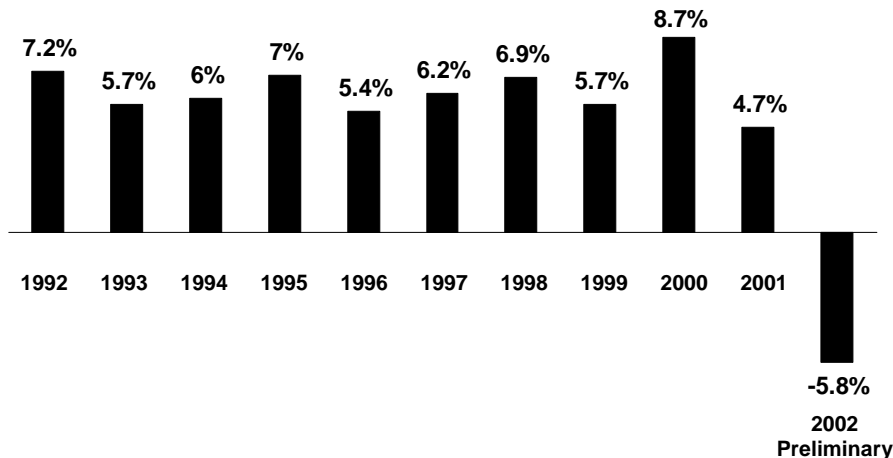
## Medicaid's Role

- **Provides long-term care and health care coverage for over 50 million people**
  - Provides comprehensive, low-cost health insurance for 38 million people in low-income families; covers one in four American children
  - Covers over 12 million seniors and people with disabilities, including over 6 million Medicare beneficiaries (“dual enrollees”) who rely on Medicaid for long-term care, prescription drugs, and help with Medicare cost-sharing
- **Guarantees entitlement to states and individuals; open ended financing**
- **Provides 43% of federal funds to states through federal matching payments**
- **Pays for nearly 1 in 5 health care dollars in the U.S, including 17% of hospital care, 17% of prescription drug spending, and 48% of nursing home care**

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Figure 2

## Change in State Tax Revenue Collections, 1992-2002



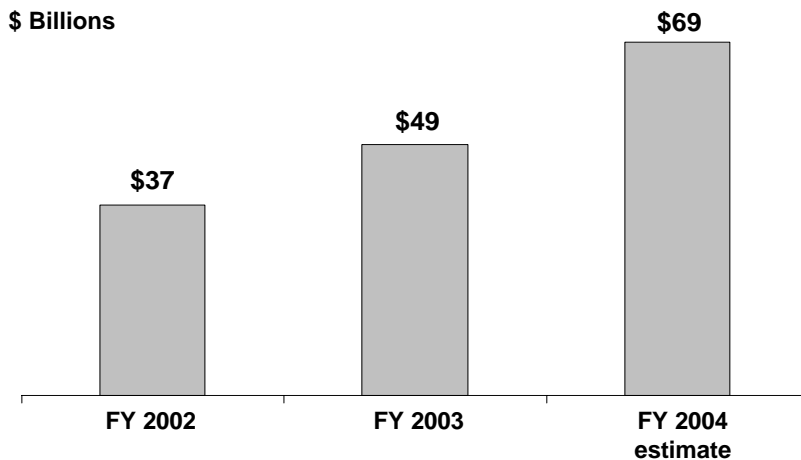
SOURCE: Rockefeller Institute of Government, State Revenue Report, December 2002.

Changes are shown in nominal terms and are not adjusted for tax-related legislative changes

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Figure 3

## Total State Budget Shortfalls FY 2002 – FY 2004

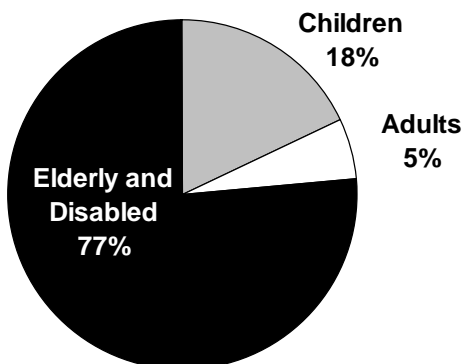


SOURCE: NCSL, State Budget & Tax Actions Preliminary Report, 2002; Center on Budget and Policy Priorities

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Figure 4

## Sources of Growth in Federal Medicaid Expenditures on Benefits, 2002-2003



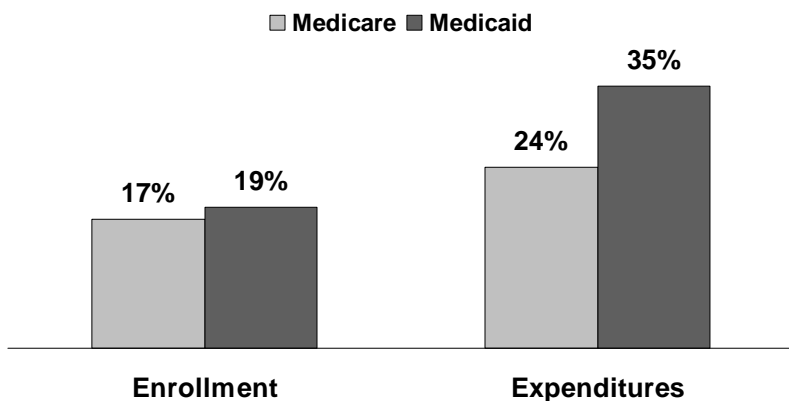
**\$11 Billion Increase  
in Federal Expenditures on Benefits**

SOURCE: KCMU analysis of CBO Medicaid baseline, March 2003.

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Figure 5

## Dual Enrollees: Enrollment and Expenditures, 1999

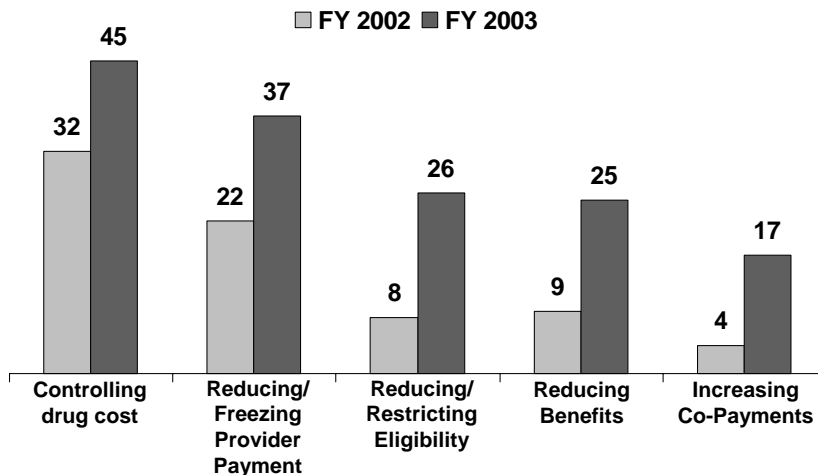


SOURCE: ORDI Medicare Current Beneficiary Survey;  
Medicaid Office of the Actuary

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Figure 6

## States Undertaking Medicaid Cost Containment Strategies, FY2002 vs. FY2003



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by  
Health Management Associates, June and December 2002.

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Figure 7

## Medicaid Beneficiary Groups

### Mandatory Populations

- Children age 6 and older below 100% FPL (\$15,260 a year for a family of 3)
- Children under age 6 below 133% FPL
- Parents below AFDC cutoffs from July 1996 (median = 42% FPL)
- Pregnant women  $\leq$ 133% FPL
- Elderly and disabled SSI beneficiaries (income  $\leq$  74% FPL)
- Certain working disabled
- Medicare Buy-In groups (QMB, SLMB)

### Optional Populations

- Children above federal minimum income levels
- Parents above federal minimum income levels
- Pregnant women  $>$ 133% FPL
- Disabled and elderly between SSI (74% FPL) and 100% FPL
- Nursing homes residents up to 300% SSI
- Disabled (under HCBS waiver)
- Certain working disabled ( $>$ SSI levels)
- Medically needy

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Figure 8

## Medicaid Benefits

### “Mandatory” Items and Services

- Physicians services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Nursing facility (NF) services for individuals 21 or over

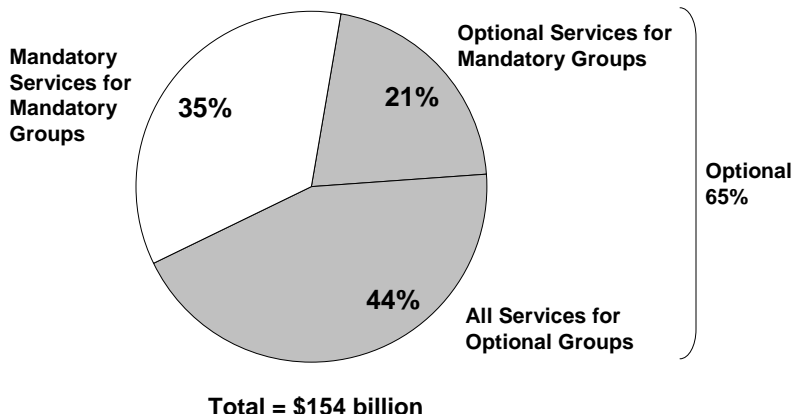
### “Optional” Items and Services

- Prescription drugs
- Medical care or remedial care furnished by licensed practitioners
- Diagnostic, screening, preventive, and rehab services
- Clinic services
- Dental services, dentures
- Physical therapy
- Prosthetic devices, eyeglasses
- TB-related services
- Primary care case management
- ICF/MR services
- Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
- Inpatient psychiatric hospital services for individuals under age 21
- Home health care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Private duty nursing services
- Hospice services

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Figure 9

## Medicaid Expenditures by Eligibility Group and Type of Service, 1998



Total = \$154 billion

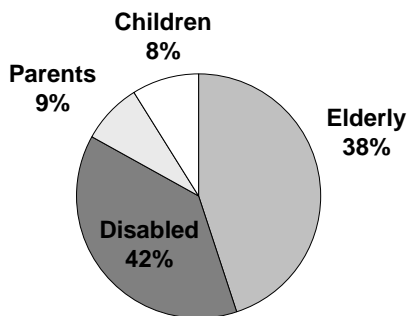
Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.  
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

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Figure 10

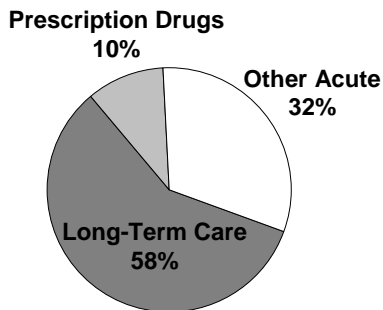
## Medicaid Optional Spending by Eligibility Group and Service, 1998

### ELIGIBILITY GROUP



Total = \$100 billion

### SERVICE



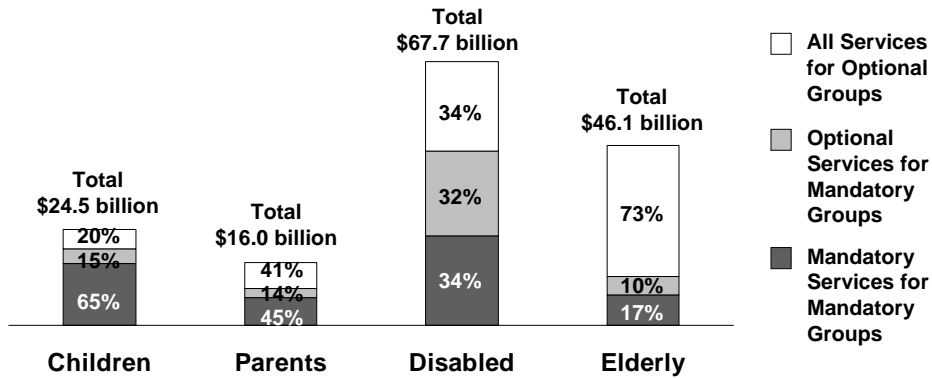
Total = \$100 billion

Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.  
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

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Figure 11

## Distribution of Medicaid Spending by Eligibility Group and Type of Service, 1998



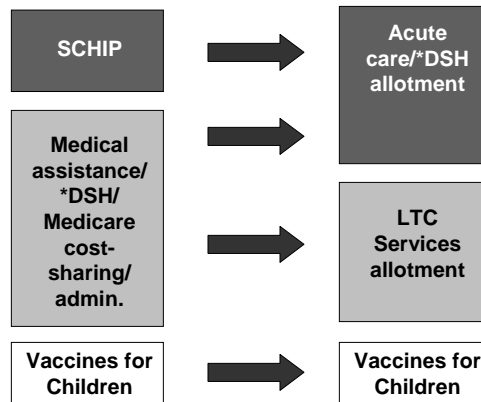
Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

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Figure 12

## How Allotments Would Change Current Medicaid/SCHIP Funding

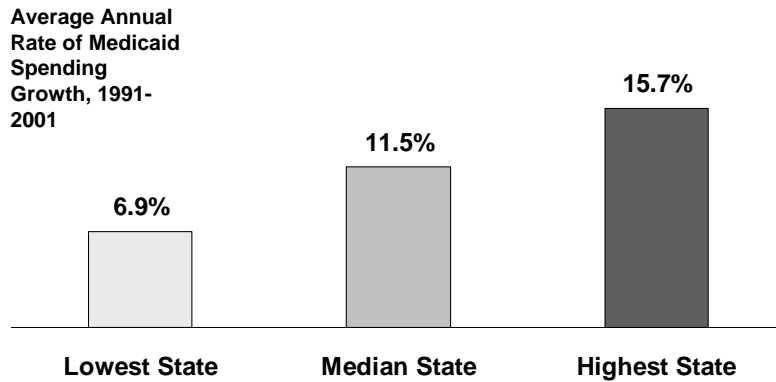


\* Disproportionate Share Hospital (DSH)  
SOURCE: FY2004 Budget

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Figure 13

### State Variation in Medicaid Spending Growth Rates, 1991 - 2001

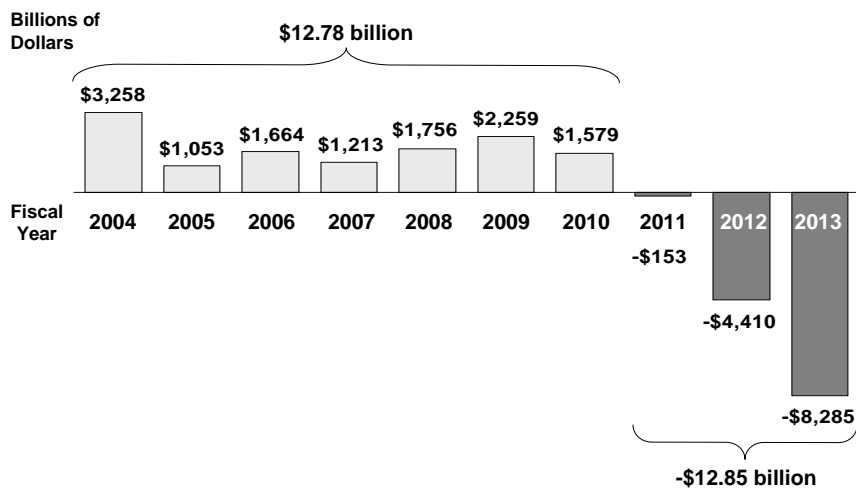


SOURCE: Data provided by the Urban Institute based on Form 64. Data include expenditures on DSH, but excluded administrative costs and accounting adjustments.

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Figure 14

### Administration Estimate of Effect of its Proposal on Federal Medicaid/SCHIP Spending Relative to Current Law



SOURCE: FY2004 Budget

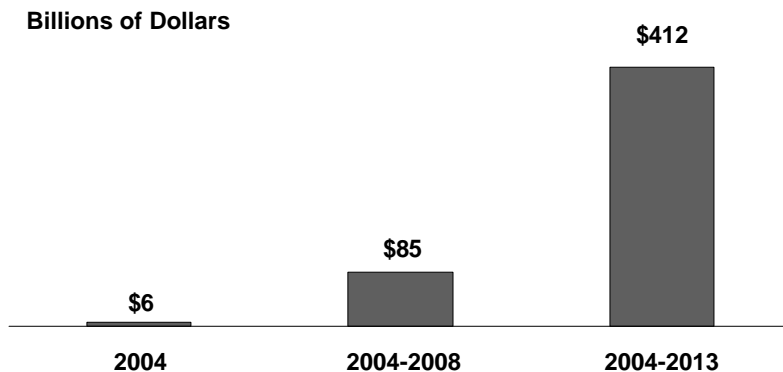
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M e d i c a i d a n d t h e U n i n s u r e d



Figure 15

## Potential Loss of State Funds If a Maintenance of Effort Requirement Replaces the Matching Rate System

Assumes (1) all states opt into the block grant and reduce state spending to the maximum extent allowable under the MOE requirement; and (2) mandatory populations are under the block grant.



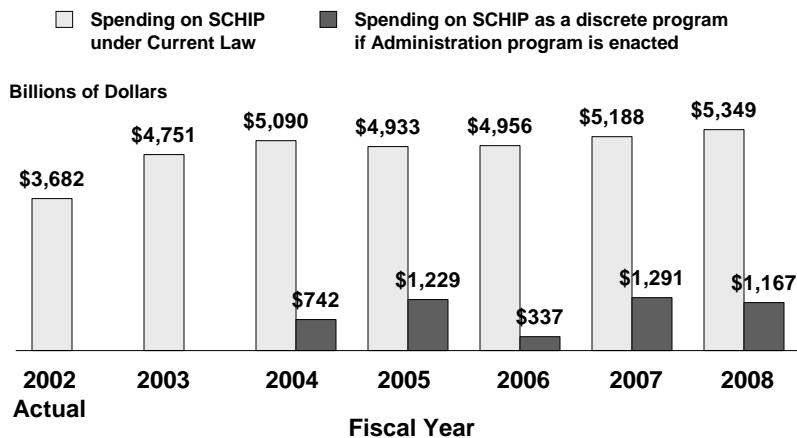
Notes: KCMU analysis based on March 2003 CBO estimates of Medicaid and SCHIP spending and medical CPI. Estimates show the difference between state spending expected under current Medicaid and SCHIP rules versus the minimum state spending level estimated to be required under the MOE requirement.

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Figure 16

## Effect of the Proposal on Spending on SCHIP as a Discrete Program

Administration estimates show spending on SCHIP as a discrete program declining under the proposal because SCHIP funds would be folded into the allotments of states opting into the block grant.



SOURCE: FY2004 Budget. The estimate also includes the positive effect on SCHIP expenditures of a smaller, separate proposal that would extend the period of time for which states can use fiscal year 2000 SCHIP funds.

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1330 G STREET NW, WASHINGTON, DC 20005  
PHONE: 202-347-5270, FAX: 202-347-5274,  
WEBSITE: WWW.KFF.ORG

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