HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

Financing

The issue

The system for financing public coverage for the low-income population has a great impact on the program's capacity to meet national goals related to health care coverage and fiscal sustainability – goals that generate some competing pressures.

Medicaid, our health insurance program for low-income people, faces multiple financial challenges. The cost associated with covering low-income Americans is growing due to rising health care costs, demographic pressures, shifts in the economy, and expensive gaps in Medicare for over 7 million low-income Medicare beneficiaries. Separate from these ongoing and mounting pressures on Medicaid costs, the recent economic downturn illustrated the countercyclical pressures on the program. In the weak economy, job loss, eroding private health insurance, and rising poverty led to increased enrollment in Medicaid and simultaneously, state revenues declined. That is, states' fiscal capacity to sustain Medicaid is most strained under the economic conditions in which Medicaid is most needed.

In considering financing issues, the experiences of Medicaid and SCHIP – two publicly sponsored coverage programs with distinctly different financing structures – are informative. State fiscal stresses generated by Medicaid have highlighted a number of limitations of the program's financing structure, and different responses with sharply different implications have been proposed. Some have pointed to the State Children's Health Insurance Program's (SCHIP) capped appropriations as a model for financing coverage for the low-income population, citing the controllability and predictability of spending under this approach. Others emphasize that financing determined by actual enrollment and utilization is a critical source of Medicaid's flexibility to respond to changing needs, but they propose a rebalancing of the state-federal financing partnership to more equitably reflect the much greater fiscal capacity of the federal government.

The evidence

While systemic pressures on the Medicaid program continue to push aggregate Medicaid spending upward, growth in per capita Medicaid spending has been modest compared with premium trends and increases in health spending in private insurance.

Medicaid's financing structure is responsive to changes in needs for coverage and care and it accommodates state policy choices, but a corollary result is that total Medicaid enrollment and spending fluctuate. Federal outlays for capped programs are more predictable, but the trade-off is that funding does not always relate to actual needs and becomes increasingly inadequate to meet growing needs over time. Under capped funding arrangements, important equity problems have also emerged, as can be seen in SCHIP. The allocation of federal SCHIP funds has not always aligned well with the actual distribution of low-income uninsured children and funds for the program have fallen short of need, leaving uninsured children who meet the income eligibility requirements without coverage.

Both Medicaid and SCHIP demonstrate that shared federal-state financing promotes shared accountability and interests. In both programs, the matching arrangement has also helped to promote national health objectives while maintaining flexibility for states. The enhanced federal matching rate in SCHIP (relative to Medicaid) contributed to the program's popularity and swift

implementation in the states, resulting in coverage for several million previously uninsured low-income children.

Shared financing has also created tensions between the states and the federal government, which state budget crises have heightened. These tensions are crystallized in many states' use of mechanisms to leverage federal Medicaid funding with limited or no state matching funds involved, changing the effective federal match rate.

The importance of the balance between federal and state financing is apparent in the impact of an 18-month increase in the federal Medicaid match rate, granted to give states temporary relief from the fiscal stress generated by effects of the economic downturn. The enhanced federal match proved an effective tool for improving the program's financial stability. The federal government was able to shoulder an increased share of Medicaid costs when state revenues ebbed and the demand for public coverage grew due to the economic downturn.

The Medicaid program, thought of mostly as a health insurance program for low-income families, finances other important needs as well. Forty percent of Medicaid spending is on behalf of 7.5 million "dual eligibles," low-income Medicare beneficiaries who also qualify for Medicaid. For these individuals, who are much poorer and in much worse health than other Medicare beneficiaries, state Medicaid programs pay Medicare's premiums and coinsurance and fill in major gaps in Medicare benefits, particularly for long-term care.

In addition, Medicaid spending is affected by many other pressures that are outside states' control. Rising health care costs, aging and disability trends, economic downturns, and erosion in the private health insurance market all drive Medicaid costs upward. In this environment, the federal government and states are not equal fiscal partners. The federal government's larger revenue base and broader authorities give it a much greater fiscal capacity. Since the 1950s, the federal government has typically collected almost twice as much revenue as all state and local governments combined. The federal government also possesses broad borrowing authority that the states do not. And while the states are required to balance their budgets, the federal government can deficit spend.

Because of the constrained and highly variable fiscal capacity of states, and given states' different policy preferences, approaches that rely heavily on state funding to cover the uninsured tend to produce wide variation in coverage. In light of the federal government's dominant role in government finance and the growing pressures on more fragile state finances, federal stabilizing mechanisms could strengthen the financing system for publicly sponsored coverage for low-income Americans.

Financing that is determined by enrollment and utilization directs public dollars most efficiently to meet health coverage and care needs. Evidence from public programs whose financing is capped and allocated by formula shows that accurately matching funds to needs is difficult and that funding levels tend to deteriorate over time.

Federal matching of state spending permits the costs of coverage to be shared and can promote national priorities while preserving state policy discretion. A federal-state financing partnership that takes into account the national trends causing health care costs to rise, countercyclical pressures at the state level, and the federal government's greater fiscal capacity could provide a strong and sustainable source of support for a program of health coverage for low-income Americans.

Key Evidence

Financing that is based on actual enrollment and use of services has enabled Medicaid to respond to changing needs for coverage and care.

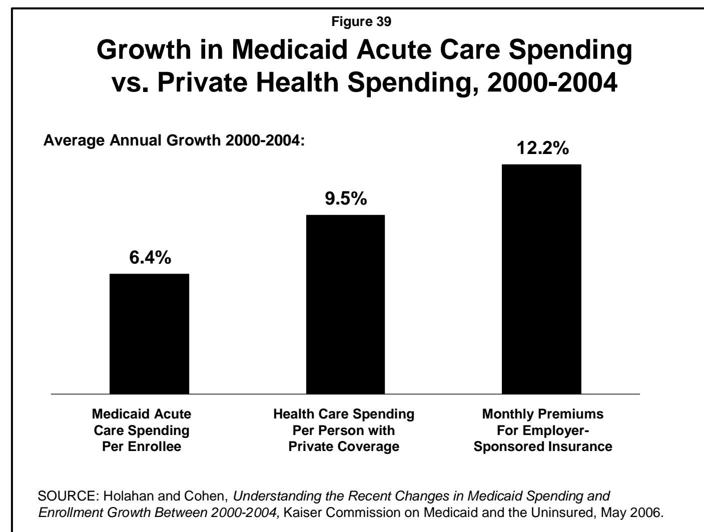
- In the recent economic downturn, Medicaid enrollment expanded to cover millions of low-income Americans who would otherwise have become uninsured.[1]

- As-needed financing has allowed Medicaid to respond promptly in a rapidly evolving public health and clinical care environment. For example, the guarantee of federal matching funds has helped states to cover thousands of low-income Americans affected by the HIV/AIDS pandemic and to ensure them access to new life-saving drugs and therapies as they emerge.[2]

- Between 2000 and 2004, Medicaid and the State Children's Health Insurance Program (SCHIP) extended coverage to millions of people affected by increasing unemployment and poverty rates and the erosion of employer-based coverage. Medicaid more than offset the losses of job-based coverage among children in this period, and without Medicaid, the increase of some 6 million uninsured adults would have been even larger.[3]

- The availability of federal matching funds as needed has enabled state Medicaid programs to respond to unanticipated emergencies, such as the terrorist attacks of September 11, 2001, by covering many thousands affected by the disaster.[4]

- While per capita health spending has been increasing across the board, Medicaid per capita spending has been rising more slowly than per capita spending among those with private insurance (Fig. 39).[5]



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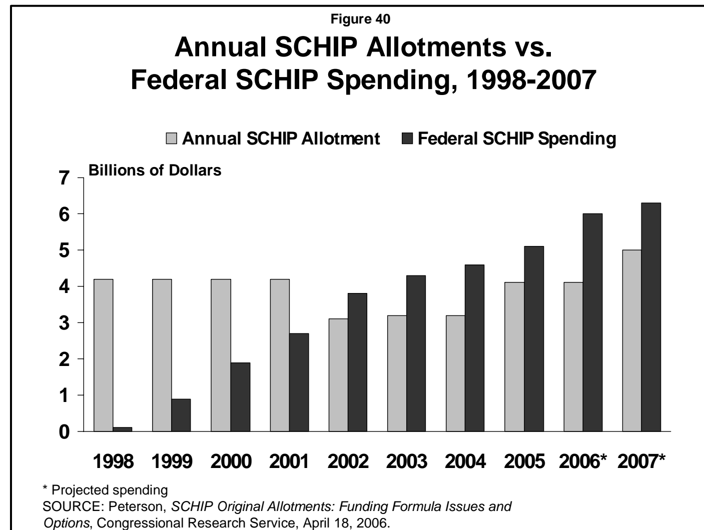
SCHIP's capped funding has allowed the federal government to limit its outlays and given states leverage to control their program spending, but inadequate and mistargeted funds have limited the program's impact.

- The legislation establishing SCHIP in 1997 fixed year-by-year federal funding levels for a ten-year period. The law also specified the formula for allocating federal funds to the states. Over time, actual federal SCHIP spending has not tracked well with annual SCHIP allotments (Fig. 40). For SCHIP's first four years, the total amount provided to states in original allotments exceeded federal SCHIP spending for the year. Beginning in FY 2003, however, states' total annual federal SCHIP spending exceeded the total amounts originally allotted, resulting in greater reliance by many states on unspent funds redistributed from other states.[6 7 8]

Figure 40



* Projected spending
SOURCE: Peterson, *SCHIP Original Allotments: Funding Formula Issues and Options*, Congressional Research Service, April 18, 2006.

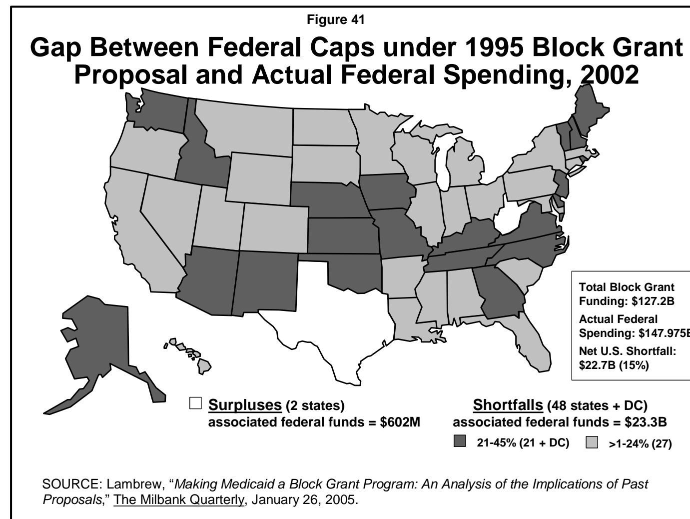
- The cap on federal matching funds for SCHIP has permitted states to cap enrollment in SCHIP programs, thereby limiting state outlays.[9]

- Federal actuaries project that if annual federal SCHIP allotments are frozen at $5 billion as the President's budget for FY 2007 proposes, SCHIP enrollment will decline after 2006 and the number of uninsured children will rise, unless states finance coverage for these children with state-only dollars.[10]

- The Congressional Research Service projects that 18 states may likely face shortfalls of federal SCHIP funds in FY 2007 under current law. If, when SCHIP is reauthorized, appropriations are frozen at the FY 2007 level, CRS projects that the number of states with shortfalls will likely rise annually for several years.[11]

Program experience shows the tendency of capped financing to become insufficient to meet actual program needs.

- An analysis of the Medicaid block grant proposed in 1995 shows that federal spending under the block grant would have exceeded the level of actual federal Medicaid spending from 1996 to 1999. On the other hand, in 2002 alone, federal payments under the block grant would have fallen $23 billion (or 16%) short of the amount of actual federal Medicaid spending that year (Fig. 41). Over the 7-year budget period used by the Congressional Budget Office, federal Medicaid payments under the block grant would have been between $4 billion and $18.5 billion (1% to 2%) beneath the amount of actual federal spending during that time.[12]



SOURCE: Lambrew, "*Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*," The Milbank Quarterly, January 26, 2005.

- Federal funds earmarked for the AIDS Drug Assistance Program (ADAP) are capped and allocated to the states according to a formula. (ADAP is a source of prescription drugs for low-income people with HIV/AIDS who have no or limited drug coverage.) In March 2005, due to ADAP budget shortfalls, 11 state ADAPs had waiting lists representing 627 people in need of services. In additional actions, 12 ADAPs had capped enrollment, reduced the number of drugs offered, tightened eligibility, or taken other cost-containment measures that adversely affected access.[13]

- The federal government appropriates funds to the Indian Health Service (IHS) to provide health care to American Indians and Alaska Natives (AIAN). A government study shows that because IHS appropriations have not kept pace with growth in the AIAN population and health care costs, current appropriations provide only 59% of needed federal funding for the system. According to the study, it would take an additional $1.8 billion to provide IHS users with services at the same level as provided in a mainstream health plan, such as that offered to federal employees.[14 15]

- The history of other block grants, such as the Social Services Block Grant, is that the real value of the block grant declines significantly over time.[16 17]

Distributing federal funds based on a pre-set formula leads to inequities and targeting problems.

- The impact of the block grant proposed for Medicaid in 1995 would have varied considerably across states, ranging in 2002 from a shortfall of at least 20% in 25 states to caps that exceeded actual federal spending in Texas and West Virginia.[18]

The formula used to allocate federal funds under the Ryan White CARE Act is based on AIDS case burden rather than HIV infection. As a result, allocations may not reflect recent trends in the epidemic or the full burden of affected individuals in all jurisdictions.[19]

Federal matching of state spending produces shared financial responsibility and is a means of promoting national priorities while maintaining state flexibility.

- Shared financing has mitigated the full cost impact of Medicaid on both states and the federal government. States' access to federal matching payments has led to greater expansion of coverage than the states would have been able to achieve with state revenues alone.[21]

- Federal matching enables states to obtain substantial federal support while retaining broad discretion to shape and administer their programs. This arrangement accommodates the wide variation in state policy priorities and choices, and it permits states to change course without placing their ability to receive federal matching funds at risk or requiring restructuring of the financing system.[22, 23]

- The state dollars at stake in Medicaid give states a strong interest in managing the program, controlling costs, and obtaining better value for the dollars the program spends. In 2006, all states implemented at least one new Medicaid cost containment strategy (e.g., provider payment freezes or cuts, eligibility restrictions) and 49 states planned at least one for 2007. At the same time, all but one state implemented more expansive policies in FY 2006 and 49 states have adopted policies in FY 2007 to enhance provider rates or to expand or restore benefits or eligibility. As their revenue situations improve, states are also investing in disease management and other quality improvement initiatives.[24]

- Federal matching rates have been used as a lever to influence state policy. The enhanced federal match rate for SCHIP was one factor that spurred states' swift implementation of the program. Higher federal match rates have also been provided for selected Medicaid services and activities (e.g., improved Medicaid management information systems, availability of family planning services) to promote federal goals.[25, 26]

Shared financing has also created tensions between the states and the federal government, and raised concerns about accountability, fiscal management, and equity.

- Some states have used a variety of mechanisms, combining legal intergovernmental transfers (IGT) and the disproportionate share hospital (DSH) and upper payment limit (UPL) programs, to leverage federal Medicaid matching funds with limited or no state funds involved. These "creative financing" strategies have increased the effective federal share of Medicaid in the states that have employed them, distorting the federal-state financing partnership defined by the statutory Medicaid matching formula and obscuring Medicaid spending patterns.[27, 28, 29, 30, 31]

- Some states have used federal funds generated through creative financing arrangements to strengthen Medicaid coverage or to provide additional resources to safety-net providers serving the Medicaid and low-income uninsured populations. However, other states have diverted these federal funds to a range of other purposes, including non-health-related purposes. States' use of these "federal maximization" mechanisms has raised legitimate questions about the program's financial integrity and accountability for the use of public funds.[32, 33, 34, 35]

- Historically, the level of federal investment in financial management of Medicaid has been low and it has declined even as Medicaid spending has increased. Until recently, the federal agency with responsibility for Medicaid has lacked a dedicated source of funds for financial management and program integrity activities, and though it represents a quarter of a trillion dollars in federal and state expenditures, Medicaid has had no published, comprehensive financial management plan similar to Medicare's. The Deficit Reduction Act of 2005 created and provided funding for a new Medicaid Integrity Program, which includes a requirement that CMS develop a comprehensive Medicaid program integrity plan. A range of measures used in the private sector and in Medicare and other government programs could be adopted to significantly improve Medicaid's financial and program management without altering the program's basic financing structure.[36 37]

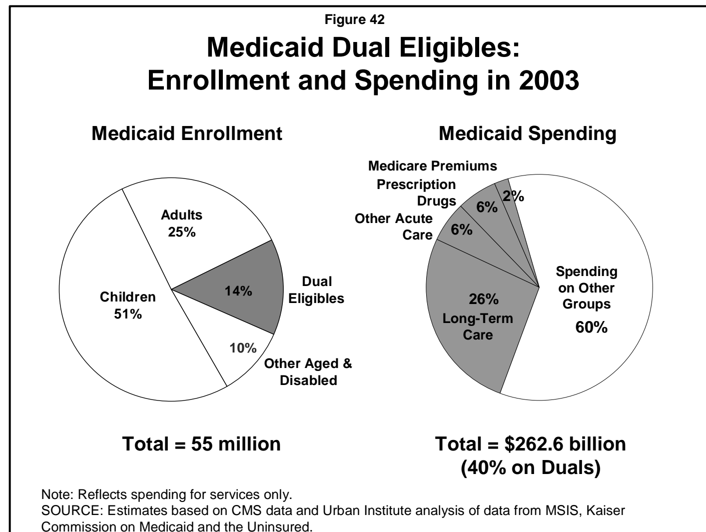
The federal matching formula has been criticized for several shortcomings. A recent temporary enhancement of the federal share to provide fiscal relief to states demonstrated the important role of the federal-state financing balance in ensuring Medicaid's sustainability.

- Because of lags in the data used to compute the federal Medicaid assistance percentage (FMAP) and the absence of a countercyclical adjustment to provide fiscal relief to states in recessionary periods, match rates may not be aligned well with states' economic circumstances. In addition, analysts widely agree that the formula used to determine the FMAP does not adequately reflect the different fiscal capacities of the states or take into account the circumstances of states with high concentrations of poor citizens.[38]

- A survey of the 50 states indicates that the temporary increase in the federal share of Medicaid costs, a form of federal fiscal relief during the economic downturn, helped states to preserve Medicaid coverage. Forty-two states reported that the federal fiscal relief helped them to meet increased Medicaid costs by resolving budget shortfalls. Over half the states reported that they used the fiscal relief to avoid, minimize, or postpone Medicaid cuts or freezes. The survey also found concern among states that, when the fiscal relief expired in June 2004, they would lack the fiscal resources necessary to fill the gaps left.[39]

A large share of Medicaid spending is determined by the cost of low-income Medicare beneficiaries.

- Almost 7.5 million Medicaid enrollees are low-income Medicare beneficiaries. These individuals, known as "dual eligibles," make up 14% of Medicaid enrollees and 18% of Medicare beneficiaries. They account for 40% of Medicaid spending (Fig. 42). Dual eligibles are both poorer and in worse health than other Medicare beneficiaries. Nearly three-quarters have annual income below $10,000, compared with 12% of all other Medicare



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beneficiaries. Nearly one-quarter of dual eligibles are in nursing homes, as contrasted to 2% of other Medicare beneficiaries; over half are in fair or poor health, twice the rate for others in Medicare. On average, total health care costs for dual eligibles are double those of other Medicare beneficiaries. Medicaid covers 38% of their total costs.[40]

- In 2003, two-thirds of Medicaid spending on behalf of dual eligibles was for long-term care services, 14% was attributable to prescription drugs, 15% went for other acute health care services, and payment of Medicare premiums made up the remaining 5%. While Medicare now covers prescription drugs, states remain obligated to finance a portion of this coverage through a payment to the federal government and Medicaid continues to fill in the other gaps in Medicare for dual eligibles.[41 42]

Many of the pressures driving the cost of public coverage are outside states' control.

- Major factors driving the cost of covering low-income Americans include rising health care costs, growth in enrollment of disabled individuals and low-income Medicare beneficiaries with high health needs, and increasingly, the aging of the population. These trends and dynamics are largely or entirely beyond states' control. Some regions and states will feel the cost pressures associated with an aging population sooner and more strongly than others.[43]

- Countercyclical effects play a role in squeezing states' budgets. Economic downturns tend to increase demands for public assistance and spending at the same time that state revenues decline (Fig. 43). Medicaid researchers have estimated that a one percentage point increase in the national unemployment rate from 4.5% to 5.5% could increase Medicaid enrollment 3.6%, adding over 1.5 million beneficiaries if states maintained their current eligibility standards. If the unemployment rate rose to 5.5%, enrollment could grow by 7.2%, or 3.3 million beneficiaries. In a weakened economy, states are likely to lack the means to pay for the costs of these new enrollees.[44 45 46 47]

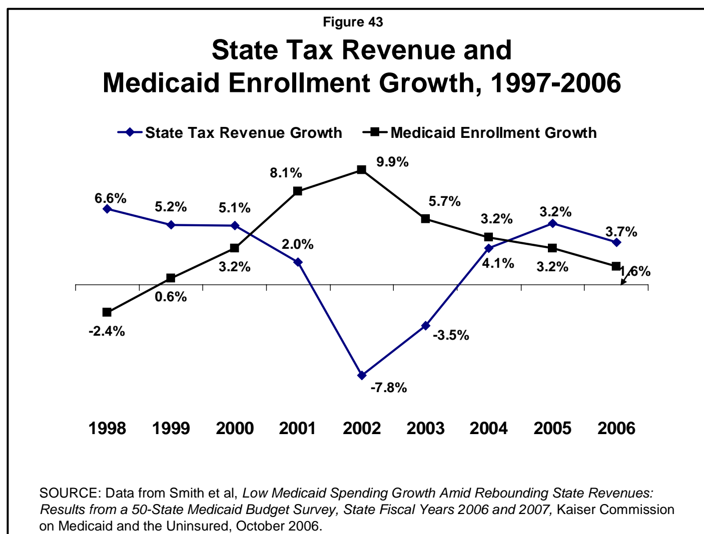


Figure 43
State Tax Revenue and Medicaid Enrollment Growth, 1997-2006

SOURCE: Data from Smith et al, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, October 2006.

- More people became eligible for Medicaid during the economic downturn due to rising unemployment, increased poverty, and declining employer-based coverage rates. Medicaid and SCHIP coverage among children increased by 5.2 percentage points, or 4.3 million children, over the period 2000-2004. Medicaid coverage of adults, for whom eligibility is much more limited, increased by 1.2 percentage points, or 2.6 million.[48]

- From 2001 through 2004, states experienced severe fiscal stress. Over that period, cumulative state budget shortfalls exceeded $250 billion. Revenue growth began to rebound in FY 2005; for the first time since 1998, state revenue growth exceeded Medicaid cost growth in FY 2006.[49]

- The economic recovery has been uneven across the country. Nationwide, state revenue growth from 2005 to 2006 averaged 3.7% after accounting for inflation and legislative, but growth was slowest in the Great Lakes region (-0.3%) and fastest in the Rocky Mountain region (7.2%).[50]

Health care provided to those who lack health insurance imposes substantial costs on the nation that are financed primarily by taxpayers.

- According to the Institute of Medicine, the nation spends roughly $35 billion annually – 2.8% of total national spending for personal health care services – on the uncompensated health care that is provided to those who are uninsured for all or part of a year. The IOM estimates that 75% to 85% of these costs are covered by taxpayers, primarily through government subsidies to hospitals and clinics.[51]

Underlying constraints in state fiscal capacity limit states' ability to absorb the increasing costs of covering low-income Americans. Fiscal capacity is much greater at the federal level.

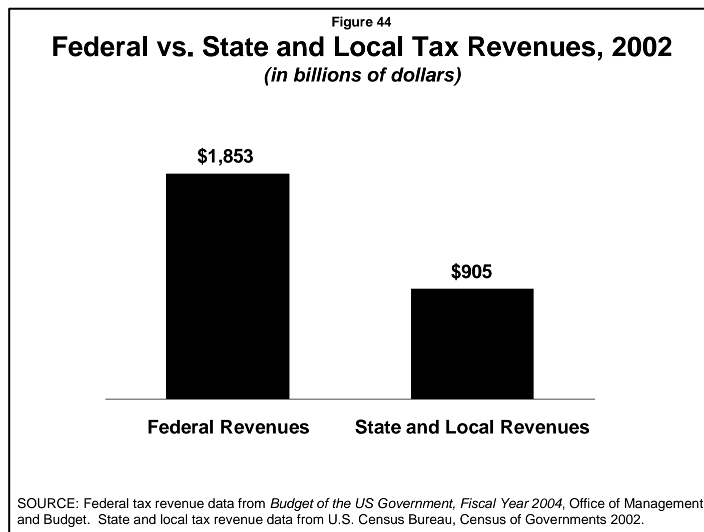
- The federal government and state and local governments are not equal fiscal partners. Since the 1950s, the federal government has typically collected almost twice as much revenue as all state and local governments combined (Fig. 44).[52 53]

- Many states expect longer-term spending to outpace revenue, resulting in structural deficits. Research shows that key factors underlying state structural deficits include state tax policy that has not adapted to the economy's shift from goods to services, the erosion of state corporate and income taxes, the growth of internet and online commerce, excessive reliance on slower-growing tax sources such as sales and excise taxes, and federal policies that impede states ability to tax certain activities.[54 55]

Figure 44

Federal vs. State and Local Tax Revenues, 2002

(in billions of dollars)



SOURCE: Federal tax revenue data from *Budget of the US Government, Fiscal Year 2004*, Office of Management and Budget. State and local tax revenue data from U.S. Census Bureau, Census of Governments 2002.

- In a March 2006 survey of state legislative fiscal offices, almost half the states estimated that available revenues would fall short of projected expenditures in one or more of FY 2007, FY 2008, and FY 2009.[56]

- State constitutions require states to balance their budgets, meaning that state revenues need to be in balance with spending. By contrast, the federal government can deficit spend. Additionally, a number of states have constitutional or other requirements that make it difficult for policymakers to modernize tax codes and adjust to budgetary needs, and there is little political will to raise taxes and fees among elected officials and the public in most states.[57 58]

- Due to state budget and fiscal constraints, even more constrained and variable resources at the local level, and different state and local tax policy preferences, approaches that rely heavily on state and local funding to cover the uninsured tend to produce wide variation in coverage. Citing the federal government's dominant role in government finance, and the growing demands that covering the low-income population places on more fragile state finances, some fiscal policy analysis concludes that federal financing mechanisms are needed to stabilize support for publicly sponsored health insurance for low-income Americans.[59] [60]

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