kaiser commission on medicaid and the uninsured

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Medicaid and Block Grant Financing Compared

State and federal budget pressures, rising health care costs, and new waiver initiatives have prompted debate over restructuring Medicaid at the state and federal levels. There are many aspects to this debate -- Medicaid provides coverage and long term care services to more than 50 million people; it affects virtually every aspect of the nation's health care system; and it is an economic engine in communities throughout the country. The consequences of a major overhaul of Medicaid are far-reaching and substantial.

While the restructuring discussion has many dimensions, questions about how the program should be financed are inevitably central to the debate. Medicaid is financed through a system that offers states federal "matching payments" for all Medicaid-qualified expenditures for eligible beneficiaries. In its Fiscal Year 2004 budget, the Administration proposed replacing that system with capped allotments under what is sometimes described as a "block grant." The proposal provoked a debate over the future of Medicaid and the differences between a block grant program in which federal funding is capped and an "entitlement" program in which federal funding is provided on an as-needed basis. Since labels can inform or obscure the discussion, it is important to be clear about the key aspects of and differences between an allotment or block grant system and the current Medicaid financing arrangement. This paper compares the current Medicaid financing system to a generic block grant financing system to illustrate the key differences in the structure and incentives of these alternative approaches.

Medicaid financing

The cost of Medicaid is split between the states and the federal government with the federal government paying anywhere from 50 to 83 percent of the costs (depending on a state's federal Medicaid matching rate). Although, on average, the federal government shoulders more than half of all costs, Medicaid accounts for a significant share of state spending (on average, about 16 percent of state general fund expenditures). At the same time, Medicaid is the largest source of federal funds coming in to states (43%).

Four key features define and distinguish the Medicaid financing system.

- **Federal payments are guaranteed to states on an "as-needed" basis**

  Under federal law and the federal budget process, the federal government is obligated to pay its share of each state's Medicaid costs, whatever those costs turn out to be, as long as the

expenditures meet the requirements of the program. There is no cap or ceiling on the amount of federal funding that is available for the health insurance coverage and long term care services provided through Medicaid, nationwide or for any particular state (although federal Medicaid payments to the territories are capped). If prescription drug or nursing home costs rise; if more people need coverage because of a slump in the economy; if a state raises its payment rates to keep managed care organizations or other providers in the program, federal payments automatically adjust to reflect the added costs and program improvements.

- **Uncapped federal financing allows the program to guarantee coverage to all eligible individuals**

Medicaid, like Medicare, guarantees that the people who are eligible for coverage can enroll and receive that coverage. Neither program can impose waiting lists or turn away eligible people. If people lose their jobs or their health insurance and they apply for Medicaid, they must be enrolled if they are eligible. The program is explicitly designed to respond to fluctuating need; eligibility criteria can be tightened (consistent with federal standards), but coverage cannot be rationed among eligible people on a first-come, first-serve basis . And, as is true in Medicare, under Medicaid eligible individuals can enforce their legal rights to coverage , services and patient protections.

The entitlement feature of the program is closely tied to the financing structure: the coverage guarantee is backed up by the guarantee that federal financing will be available on an "as-needed" basis. : States have considerable discretion to decide who will be eligible for Medicaid in their state, but once they decide on a set of rules, they must enroll all eligible people (or change their rules consistent with federal minimum standards). The federal government does not cap funding to states for Medicaid, and states cannot cap or stop enrollment of eligible people under Medicaid.

- **Federal Medicaid payments to states are based on actual state costs**

Federal funds are paid to states as reimbursement for the federal government's share of the actual cost of serving Medicaid beneficiaries in that state. States send the federal government an accounting of their expenditures, and this spending is the basis for determining the federal government's payments to states. In this way, the federal government has a mechanism for assuring accountability (federal dollars must be spent on qualifying services for eligible beneficiaries), and states are assured that their federal payments will be based on real, rather than projected or estimated costs or pre-set allocations.

- **States must spend their own funds in order to receive federal Medicaid payments**

Federal funds are provided to states in the form of "matching payments." This means that a state must spend its share of Medicaid costs as a condition of receiving federal payments. This aspect of the system serves a number of purposes. It generally functions as intended , although certain improvements could help avoid situations where some states have used financing loopholes to reduce their share of costs.

The matching system assures that there are significant state as well as federal investments in the program. In addition, since states must spend their own funds to receive federal matching funds, the matching component protects against runaway federal spending that might

otherwise occur in a totally federally-financed system. At the same time, since states lose at least one federal dollar for each state dollar they pull out of the program, the matching requirement serves as an incentive for states to maintain their investment in coverage and services that they are not required to offer under federal rules, even in tough budget times. However, when states do cut back on state spending, the resulting reductions in coverage or services are deeper as a consequence of the loss of the federal matching funds.

Block grant or capped financing

There are many definitions of a "block grant"[i] and variations of block grant or capped financing, but the element that is common to all federal block grants is that the federal funds are subject to a limit or ceiling.

- **The common element — capped federal funding**

Despite the different ways block grants have been designed, the common element is capped federal funding. The total amount of federal funding is limited to an amount that is pre-determined (typically by a dollar amount set in federal legislation), reflecting how much Congress has decided to spend on the program over a period of time. Block grant funding levels might rise or fall from year to year, but the level of the federal financing commitment is always constrained by a cap. Under a capped funding structure, a state (or local level of government) receives its allotment regardless of actual levels of need or cost. [ii]

- **Block grants do not provide a federal guarantee of coverage to intended program beneficiaries**

While it is theoretically possible to design a block grant that guarantees coverage to all eligible people, no federal block grant program has such a federal guarantee. The lack of a guarantee or individual entitlement is tied to the capped financing arrangement. Without assuring states that the federal government will fully share all program costs, it is not likely that Congress could or would require states to serve all eligible people. As a result, programs funded through capped federal grants typically limit the number of people served through priority lists, waiting periods, and by simply closing down enrollment. Individuals generally have no federal right to the services financed through the block grant .

- **Federal funding levels for capped programs can vary from year to year**

Block grants may or may not provide the same level of funding each year. Funding for some federal block grants is appropriated on an annual basis, while funding levels for other capped programs are set several years in advance. Those with multi-year funding may be level-funded (meaning the overall level of federal funding remains the same each year), or the funding might change (up or down) over the authorized period. In all cases, the key element common to all block grants still applies: the federal funds available are capped and do not automatically adjust based on actual costs or actual needs. Because block grants limit federal spending to a predictable level that can be controlled without regard to actual costs or spending at the state level, federal budgeters often turn to capped allotments as a tool for controlling and limiting federal spending.

- **Capped funds are typically allocated to states based on a formula**

Each block grant has its own method for distributing the capped federal funds to states (or local governments). Some divide the funds based on an estimate of each state's relative need, while others take into account the level of federal funding that each state received under the program or programs that were replaced by the block grant. Whatever system is adopted for allocating funds to states, each state's payments are subject to the ceiling that determines their individual allotment and the overall ceiling that caps the funding available nationwide.

Not surprisingly, the system for dividing and distributing capped federal funds can be quite contentious, as states press to have the factors that they believe best reflect their particular circumstances integrated into the distribution formula. It is virtually impossible to establish a formula or allotment that takes all states' different and evolving needs into account. As a result, formulas can lead to an inequitable and somewhat arbitrary distribution of federal funds across states. From the federal perspective, a capped program can lead to a significant mistargeting of federal spending, particularly over time.

- **Capped programs have different rules for whether states must spend their own funds as a condition of receiving federal block grant funds**

Another element of block grant financing that varies widely is the state spending requirement. Some capped federal programs do not require any state spending, while others require some level of state contribution, typically based on past levels of state spending in the program or programs replaced by the block grant (often referred to as a "maintenance of effort" or MOE requirement). The Medicaid proposal advanced by the Administration in 2003 would have replaced the current matching requirement with an MOE requirement. SCHIP is somewhat unique in that federal SCHIP payments are provided to states as matching payments.

Both the amount and the nature of a state spending requirement (or the lack of a requirement) will affect the overall level of funding under a block grant and the incentives for states to invest or disinvest in the program services financed by the block grant. Without a matching requirement, states do not necessarily lose federal funding when they reduce their own state funding. As such, they are more likely to lower their state investment, particularly when state revenues collections are down.

- **Capped grants may provide for broad program flexibility although history has shown that Congress will often add strings over time**

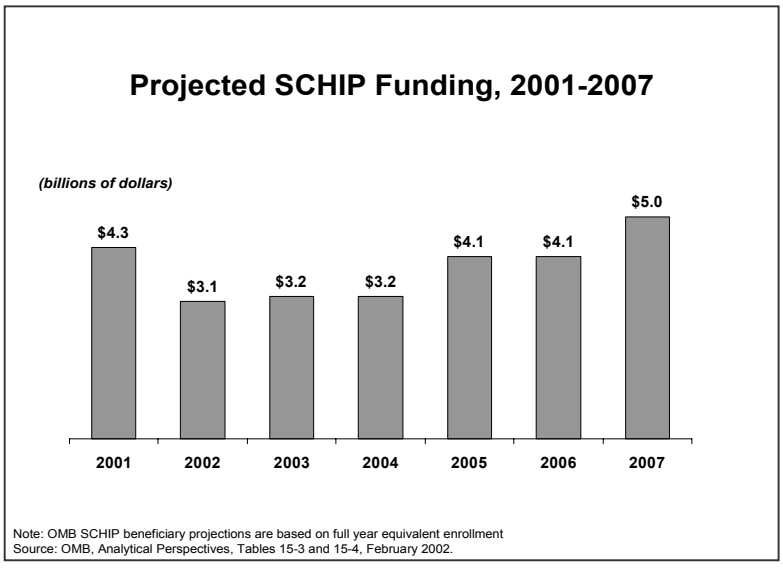
Block grants typically offer states broad discretion to decide how to spend federal dollars. The degree of flexibility accorded states, however, is not always a clear dividing line. Block grants can include federal standards and rules (for example, the SCHIP program has federal cost sharing and benefit standards), and federal programs that place a cap on federal funding can provide states a considerable degree of flexibility . [iii]

Although block grants are often established with a more limited set of federal rules and standards, this can change over the life of the block grant. (One of the more contentious issues in the reauthorization of the Temporary Assistance to Needy Families (TANF) block

grant has been whether to impose on states new federal work requirements.[iv]) In addition, the lack of federal standards and accountability has its trade offs from a financing perspective. When states are granted broad discretion over how federal funds may be used, Congress often has little information about how federal funds are being spent.[v] Limited accountability can lead to an erosion of support for a block grant among federal policymakers faced with competing demands for federal dollars.

The State's Children Health Insurance Program

The State Children's Health Insurance Program is an example of a federal block grant with multi-year funding that changes over time. (SCHIP covers many fewer people than Medicaid; in 2003, SCHIP covered about 4 million children while Medicaid covered about 21 million children and 34 million adults.) The level of funds dedicated to the program was set for ten years by the 1997 legislation that created SCHIP. $4.2 billion was available for each of the first four years of the program, but the overall level of federal funding dropped by nearly 26% in 2002. In 2005, funding begins to gradually rise back to pre-2002 levels. These rather erratic funding levels were set based on broader federal budget constraints, not on any projection of the year-by-year need for or cost of children's health insurance coverage. (SCHIP was originally enacted as part of the Balanced Budget Act of 1997, which was designed to eliminate the federal deficit by 2002.)[vi] The dip in SCHIP funds is projected to result in a significant drop in enrollment by 2005.



The formula for allocating capped SCHIP funds among states has also created problems for the program. Payments to states were originally based on each state's relative share of uninsured low-income children. That formula led to some anomalous results, largely due to shortcomings in state-level uninsured data and the fact that the uninsured levels did not account for the numbers of uninsured children who were eligible for Medicaid prior to the SCHIP-funded expansions. The distribution of funds among states has been adjusted by Congress almost every year since the law was passed. The law has been amended to allow states more time to spend their annual allocations, to permit some redistribution of unspent funds to higher-spending states, to restore funds that had been unspent and that had reverted to the federal treasury, and to allow some states to use their SCHIP funds to cover children who were eligible for Medicaid prior to SCHIP. The frequent need to revisit the formula reveals some of the difficulties coming up with a responsive and equitable system for sharing capped funds among states whose needs inevitably shift in unanticipated ways over time. The changes generally have been welcomed by most states, but they have come at the expense of predictability. With so many changes, states cannot reasonably anticipate the amount of federal funds they will have in any given year to cover SCHIP children.

Table 1: Key Features of Financing Systems and Their Implications

Key Features	Medicaid	Capped Grants
Federal Funding	**Provided on an "As Needed" Basis** Federal funding "follows the people" in that it is guaranteed for all qualifying services provided to eligible beneficiaries. States and federal government share the risk of growing enrollment or escalating health care costs. Helps states take advantage of program options by making additional federal funds available for program improvements. Federal spending obligations are not certain since they are based on actual costs in each state.	**Funding is Capped** Federal funding is pre-set by amount or by formula, not based on actual or current costs or need. States bear the risk of rising enrollment and unpredicted hikes in health care costs. No additional federal funding for program expansions or improvements; heightens competition for funds for different services or groups of people. Overall level of federal expenditures is predictable and easier to control from a federal budget perspective.
Entitlement/ Guarantee of Coverage or Services	**Eligible People Guaranteed Coverage** The guarantee that the federal government will fully share in all costs allows the program to guarantee coverage for all eligible people; waiting lists and enrollment caps not allowed. Individuals eligible for coverage can appeal denials of coverage and benefits, and enforce patient protection rules. If enrollment costs exceed projections, states may continue coverage with additional federal funding, or reduce spending by rolling back optional eligibility (eliminating coverage for somewhat higher income groups), or reducing benefits or provider payments.	**No Federal Guarantee of Coverage** Since states are not guaranteed full federal participation in costs, block grants do not guarantee coverage for eligible people; waiting lists and enrollment freezes permitted. Typically, eligible individuals have no federal right to ensure coverage , benefits levels or patient protections. If enrollment costs exceed federal payments, states may pick up those costs with state funds, stop enrollment, or reduce eligibility, benefits, or provider payments States would likely have broader flexibility to narrow or eliminate eligibility or benefits than under current program rules.

Table 1: Key Features of Financing Systems and Their Implications (Continued)

Key Features	Medicaid	Capped Grants
Federal Funds Paid to States	**Based on Actual Costs** Federal funds are provided to each state based on that state's Medicaid program costs; no competition among states for federal funding. Amount received by a state varies (up and down) based on actual costs. Federal government shares the risk of unpredicted changes in Medicaid spending. System in which payments are based on actual cost of services provided to eligible people create a mechanism for promoting accountability regarding use of federal funds.	**Based on a Pre-Set Amount or Formula** Explicit or implicit competition among states for limited federal funds; any formula that benefits some states will disadvantage others, given overall cap on funding. Allocations do not automatically adjust based on changing need. States bear the risk of shortfalls in federal funding. Depending on the formula or factors for distributing funds (and the quality and timeliness of the data used under the formula), distribution can be (or can become overtime) somewhat arbitrary. . Depending on the formula (and how often it is revisited by federal policymakers), states may not have much certainty about the level of federal payments they will receive; federal spending could be subject to annual review through the appropriations process. Typically, there is less accountability and information available at the federal level with respect to how funds are spent, which can erode support for funding over time.
State Matching Payments	**Required** Together, state spending and federal matching payments enhance overall level of funding available for coverage. State matching requirement serves as a "brake" on federal spending since states must spend their own funds to draw down federal dollars Creates an incentive for states to keep their funding in the system because they lose federal funds whenever they reduce state funding. However, if state does reduce state spending, overall level of reduction in coverage in services is greater because of the loss of federal matching funds.	**May or May Not Be Required** If no state spending or less state spending is required, overall level of funding for coverage could be reduced. A state spending requirement, however, may deter a state from drawing down its full federal allotment. Without a matching requirement in which states lose federal funds whenever they withdraw state funds, states have less fiscal incentive to maintain or enhance their state spending. However, when state withdraws state funds, overall level of reduction in coverage or services could be less because federal funding may not be affected.

Conclusion

The feature common to all block grants – and the feature that most distinguishes block grant financing from Medicaid financing – is that under a block grant, the overall level of federal funding and each state's share of that funding is subject to a ceiling. Under federal block grants, states (or local governments) receive set amount of funds regardless of actual costs or needs. Federal block grant payments to states might vary from year to year, but whether or not the funds are capped at a consistent level or are capped at different levels over time, a finite amount of federal funds are available to states collectively and individually to carry out the purposes of the program. This key difference between block grants and the Medicaid financing system has important implications for states and communities, as well as for the low-income people that rely on Medicaid and their health care providers.

This paper was prepared for the Kaiser Commission on Medicaid and the Unsinsured by Cindy Mann, J.D., Research Professor, Georgetown University Health Policy Institute. For additional information, please contact the Kaiser Commission on Medicaid and the Uninsured at (202) 347-5270.

[i] The definition often cited was developed by the now defunct Advisory Commission on Intergovernmental Relations (ACIR) which identified five traits of a block grant: (1) federal aid is authorized for a wide range of activities; (2) recipients have substantial discretion under the program; (3) federally imposed requirements and oversight are generally limited; (4) federal funding is distributed on the basis of a statutory formula; and (5) the recipients are typically state or local governments. Advisory Commission on Intergovernmental Relations, "Block Grants: A Comparative Analysis" (1977) cited in J.Mashaw, D. Calsyn, "Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain", 14 Yale Law and Policy Review297 (1996). Commenters have noted that many block grants do not satisfy all of these components.

[ii] A block grant might provide for supplemental allocations for states that meet certain conditions (the TANF block grant, for example, has supplemental grants), but these supplemental payments are themselves capped and distributed based on a pre-set formula. Such mechanisms allow for another layer for allocating funds among states; they do not alter the basic element of block grant financing.

[iii] For a discussion of the scope of state flexibility in Medicaid, see, Andy Schneider et al, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured July 2002; Cindy Mann, *The Flexibility Factor: Finding the Right Balance,* Health Affairs, Vol. 22, No.1, January 2002; Policy Brief, *Medicaid "Mandatory" and "Optional" Eligibility and Benefits,* Kaiser Commission on Medicaid and the Uninsured, July 2001.

[iv] See, for example, Statement of the Honorable Raymond Meier, New York State Senate on behalf of the National Conference of State Legislatures Regarding Welfare Reform Before the Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, April 11, 2002, www.ncsl.org/programs/press/2002/Meiretestimony.html; Statement by Robert Greenstein, Executive Director, Center on Budget and Policy Priorities, on President Bush's Announcement Regarding TANF Reauthorization, January 16, 2003, www.cbpp.org/1-14-03tanf..html.

[v] General Accounting Office, *Welfare Reform: Information on TANF Balances,* GAO-03-1094, September 2003; Mark Greenberg et al, *How States Used TANF and MOE Funds in FY2002: The Picture from Federal Reporting*, Center for Law and Social Policy, July 2003, http://www.clasp.org/DMS/Documents/1057932457.18/02_TANF_spending.pdf.

[vi] For more background on SCHIP financing rules, see, Policy Brief, Issues Relating to Unspent S-CHIP Money, Kaiser Commission on Medicaid and the Uninsured, October 2001.

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