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STATE COVERAGE INITIATIVES

issue brief

Leveraging Local Funds to Expand Coverage in Lean Times

by Caton Fenz

"Lean times" is the phrase that defines most states' current budget environments. State revenue estimates for fiscal year 2002 continue to be revised downward, and the outlook for fiscal year 2003 is generally pessimistic.[1] In these tight budgetary times, many states have made, or are considering making, cuts in state health care spending.[2] One way to reduce spending and the number of uninsured is to leverage local dollars.

There are thousands of units of local government in the United States—such as counties, cities, hospital districts, and more[3]—that spend billions of dollars annually on health care services for the uninsured.[4] Almost all of this spending is unmatched by the federal government, even though most of it is devoted to low-income, uninsured individuals targeted by recent Bush administration efforts (e.g., the Health Insurance Flexibility and Accountability [HIFA] initiative) to broaden coverage.[5]

Some states have recognized this opportunity and are seeking approval from the federal government to leverage local dollars to pursue coverage expansions under Medicaid.

Local Governments and Medicaid

Since the inception of Medicaid in 1965, many states have required their local governments to participate in the administration and financing of the program. Currently, local governments help finance service costs in six states, help finance administrative costs and perform administrative functions in four states, and do both in 11 states (see Table 1).[6]

Federal law places few limitations on local government involvement in state Medicaid programs. The major statutory restrictions are: 1) a requirement that at least 40 percent of the non-federal share of Medicaid expenditures come from the state; 2) a prohibition against using federal dollars (e.g., federal grant dollars) to match local dollars; and 3) a limitation on the use of voluntary contributions and provider-specific taxes to finance the non-federal share.[7]

Since 1994, when the federal government issued policy guidance allowing states to demonstrate budget neutrality of Section 1115 Medicaid waivers over five-year periods, more than 25 states have submitted waiver proposals to expand coverage, some using a permutation of this model.[8] For example, in late 1995, Texas submitted a waiver proposal that included a coverage expansion to all children with family incomes up to 133 percent of the federal poverty level (FPL), and adults (with and without children) with incomes up to 45 percent FPL. The proposed financing method for the non-federal share of this new Medicaid coverage was voluntary intergovernmental transfers to the state from local governments. Budget neutrality would be achieved through reductions in Medicaid Disproportionate Share Hospital (DSH) funds and the savings that resulted from moving existing populations into capitated managed care.

After 12 months of negotiations between the state and the federal government, the waiver proposal was scaled back to include just the children's expansion. After another six months, the waiver was left pending. The primary reason was the prospect of passage of legislation in 1997 enacting the State Children's Health Insurance Program (SCHIP), which would

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cover all of the children the state proposed to cover with the original and revised waivers.

Another reason was the federal government's concern about limiting enrollment options for the expansion populations. Texas proposed to mandate the expansion populations into local government-sponsored health plans to ensure that the contributing entities retained control over the funds they raised through local taxation. The federal government at the time insisted that Texas offer the expansion populations a choice of at least two different plans. This issue was never formally resolved.

Federal Perspective

Recently announced federal policy initiatives provide new prospects for states that are interested in expanding coverage using local government dollars. The HIFA initiative, for example, with its emphasis on flexibility and maximizing existing resources, is an excellent opportunity for states to develop creative strategies to expand coverage, including leveraging local government funds.

Officials from the Centers for Medicare and Medicaid Services (CMS) confirmed that the federal government is willing to give states significant flexibility in program design and financing. This is primarily applicable to expansion populations that would be newly covered under the state's waiver proposal; the HIFA initiative has very specific protections built in for mandatory populations such as pregnant women and children.[9]

Past proposals that used local funds have generated federal concerns on two issues: limitation of enrollment options for expansion populations and potential variability in coverage levels around the state. CMS is willing to consider more flexibility on both issues.

Limitation of Enrollment Options

Historically, CMS has expressed concern with state waiver proposals that limit the enrollment options of expansion populations. For example, CMS reacted coolly to a provision within Texas's 1995 proposal that would have mandated enrollment of an expansion population in a particular region into a single local government-sponsored health plan. Recently, however, CMS approved New Mexico's HIFA waiver, which permitted the state to make its premium-assistance model mandatory for its expansion population. This approval may signal a federal willingness to provide more flexibility with respect to enrollment options for expansion populations.

Table 1. Required Local Government Participation in State Medicaid Programs

Service Costs	Administrative Costs	Both	None
Arizona	California	Indiana	Alabama
Florida	Colorado	Minnesota	Alaska
Iowa	New Jersey	Nevada	Arkansas
Michigan	Ohio	New Hampshire	Georgia
Pennsylvania		New Mexico	Kansas
Wisconsin		New York	Kentucky
		North Carolina	Maryland
		North Dakota	Montana
		South Carolina	Tennessee
		Virginia	Texas
		Washington	Utah
		West Virginia	

Geographic Variations in Coverage

Another issue is potential variability in coverage levels from locality to locality. Michigan's recent HIFA request proposed to expand coverage to childless adults with family incomes between 36 and 100 percent FPL only in counties that choose to offer a county-sponsored health plan and finance the non-federal share of that coverage.

Because Michigan's HIFA proposal is currently classified as "inactive," CMS has not issued a formal ruling. It is worth noting, however, that no other approved HIFA demonstration allows for coverage levels and benefits to vary from county to county. If Michigan chooses to re-activate its proposal, the Bush administration will need to decide whether, and to what degree, to allow such local variation in coverage.[10] But the fact that CMS did not dismiss Michigan's proposal outright bodes well for states that want to try such an approach. Such states would have to present appropriate policy justification for the local variation and would likely have to build safety valves into their strategy (e.g., requiring a local maintenance of effort to prevent a "race to the bottom").

A corollary issue is whether CMS will approve waivers that propose to expand coverage only within one geographic area. While CMS has approved geographically limited waivers in the past, officials note that these have been in the context of long-term care demonstration projects (e.g., the Program of All-Inclusive Care for the Elderly) or restructuring demonstration projects (e.g., in Los Angeles), and not coverage demonstration projects. CMS encourages states that want to pursue this approach to submit their proposals with their policy justifications and initiate the decision-making process. As with other areas that are not addressed in the HIFA guidance, this issue would be decided on a case-by-case basis.[11]

State Efforts

Several states have taken advantage of HIFA to expand coverage to parents and other groups. Six have approved HIFA waivers and three others are awaiting approval; none of these attempt to leverage local financing. Two states, Michigan and Texas, have put forth proposals that would leverage local financing. Michigan is pursuing the HIFA route while Texas is using the regular 1115 process.

The Michigan HIFA proposal, which was submitted in 2002, would make various structural reforms to the state's Medicaid program in addition to expanding coverage. Under the proposal, coverage would be expanded to pregnant women

with family incomes from 186 to 200 percent FPL, disabled individuals up to 350 percent FPL, childless adults up to 36 percent FPL, and childless adults with incomes between 37 and 100 percent FPL in counties that choose to participate and offer a plan. Coverage for childless adults would be phased in over five years on a county-by-county basis as counties choose to develop locally administered health plans and contribute local resources. Budget neutrality would be achieved primarily through reconfiguring benefits for some existing and new enrollees and the state's unspent SCHIP allocation.

Michigan requested that CMS render its waiver application "inactive" because of the state's tight budget situation. Even though untapped local funds are available, officials are concerned that the required state funds may not be. Adding to the uncertainty is a recent change in the state's leadership; it is unclear what the new administration will do with the proposal.

Texas's recent waiver proposals originated in 2002 when three local governments offered to finance the non-federal share of a coverage expansion to parents of Medicaid-eligible children in their areas. The proposals seek to cover, at a minimum, populations that the state could cover under a Medicaid section 1931 expansion; require cost-sharing on a sliding scale; tailor the benefits to mirror services provided by local governments; and limit enrollment options for the expansion population to local government-sponsored health plans. These proposals do not fit the HIFA template, so Texas is pursuing them through the traditional 1115 waiver process.

The Texas proposals would achieve budget neutrality by expanding coverage only to a population that the state could cover at its option—in this case, parents of Medicaid-eligible children via section 1931. The state is not attempting to expand coverage to any other group, such as childless adults. This is an important distinction because the federal government gives states credit on the "without-waiver" portion of the budget neutrality calculation for populations that states could cover at state option. Because of this credit, the "with-waiver" calculation of federal expenditures for any project that proposes to cover those same populations would automatically be equal to or less than the without-waiver calculation, assuming the state can keep expenditures within a growth rate that is agreed upon at the outset. The key question is whether the state can keep expenditures within CMS's proposed growth rate, which at this point in the discussion is the Medicaid growth rate assumed in the Bush budget. Texas officials are carefully evaluating the feasibility of this task because the growth rate is locked in at the beginning of the waiver, and the state is fully at risk if expenditures grow beyond the agreed-upon rate.[12]

Intergovernmental Transfers

One unique way in which states use local government funds in their Medicaid programs is through intergovernmental transfers (IGTs). Several states (e.g., Iowa, Pennsylvania) use IGTs to maximize federal funding through their Medicaid Disproportionate Share Hospital (DSH) programs or Upper Payment Limit (UPL) arrangements.

In general, IGT arrangements work as follows: first, local governments transfer a sum of money to the state via an IGT. Next, the state returns those funds, usually less some portion retained by the state, to the local government in the form of a Medicaid payment. Finally, the state claims federal matching funds for the expenditure at the state's standard federal matching assistance percentage, which ranges from 50 to 83 percent.

According to the U.S. General Accounting Office, in federal fiscal year 2000, states used IGTs to increase federal Medicaid reimbursement without additional state expenditures to the tune of $5.8 billion.[13] The use of IGTs, especially for UPL arrangements, has come under intense scrutiny in the last two years, resulting in new regulations that further restrict the use of IGTs by states.[14] Therefore, any state that proposes to use IGTs as part of a coverage expansion initiative must proceed cautiously and provide ample justification.

The Texas proposals, which may be consolidated into a statewide initiative at some point, are in the conceptual phase, meaning that broad outlines of the three proposals have been submitted to CMS for their preliminary review.[15] CMS suggested that additional research and discussion are necessary, primarily in the area of limitation of enrollment options.[16]

Pros and Cons

For states, the benefits of leveraging local spending are increasing the number of people with health insurance; raising federal revenues flowing into the health care economy (resulting in increased economic activity and tax revenue); reducing health care spending through improved medical management; and encouraging a more efficient health care system—all with a negligible impact on the state's bottom line.[17,18] A drawback is that expanding Medicaid coverage can create an expectation that the state will continue to provide coverage if the local government withdraws from the arrangement.

For local governments, the benefits are similar except that they can also stretch local dollars farther by leveraging federal funds. This may relieve upward pressure on local taxes. A drawback is that, once local governments opt to participate in financing an expansion, they may find it politically difficult to withdraw from it if necessary. Local officials who participate in financing their state Medicaid programs express frustration because the inflationary pressure of Medicaid comes from a program over which they have little administrative control.[19]

Next Steps

State and local officials interested in leveraging local funds to expand coverage can:[20,21]

- Quantify the amount spent on health care for the uninsured by local governments. State policymakers can engage state-level associations that represent local governments in this task. This spending data must be detailed enough to distinguish categories of spending (e.g., parents with family incomes below 200 percent FPL). Then state and local decision-makers can tentatively select target populations for the expansion based on where unmatched local government dollars are being spent.

- Develop a conceptual model of the expansion, including the target population, benefits package, cost sharing, delivery system, and method of achieving budget neutrality. Present the model to key state and local and external interest groups. Use their comments to refine the conceptual model. Submit the concept paper to CMS for preliminary review and comment.

- Engage in a formal deliberative process to solicit public input. This could take the form of a special legislative committee, an agency advisory committee, or a public-private task force. Assimilate input and finalize the model.

- Seek formal approval from the federal government, negotiate terms of approval, and begin implementation.

Conclusion

Lean times necessitate creative approaches to financing and delivering health care. Leveraging existing local government spending on health care is a ripe opportunity for state and local officials to work together to stretch tax dollars as far as possible, manage health care spending, and expand coverage.

About the Author

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Endnotes

1 States faced a collective $27 billion shortfall in their Fiscal Year (FY) 2002 budgets compared to original budgets. See "State Fiscal Update for FY 2002–April 2002," Fiscal Affairs Program, National Conference of State Legislatures, April 2002. Available at www.ncsl.org/legis/fiscal/sfo2002.pdf. See also "The Fiscal Survey of States," National Governors Association and National Association of State Budget Officers, November 2002. Available at www.nga.org/cda/files/nov2002fiscalsurvey.pdf.

2 Carey, K., "States Cut Spending in FY 2002 and FY 2003: Additional Cuts Likely Unless New Revenues Are Raised," Center on Budget and Policy Priorities, October 22, 2002. For an overview of the potential effects of cuts on states, see Fenz, Caton, "State Health Care Spending: A Systems Perspective," State Coverage Initiatives Program, AcademyHealth, May 2002.

3 "Units of local government" include counties, cities, and special taxing districts whose primary responsibility is health care (e.g., hospital districts, emergency services districts), and combinations of the three (e.g., consolidated city-county health services departments). In some cases, it could include school districts.

4 Staff of the National Association of Counties report that no national-level data exist on the amount spent by local government on health care for the uninsured. Some state data are available. See Fenz, "Providing Health Care to the Uninsured in Texas: A Guide for County Officials," The Access Project, September 2000. Available at www.statecoverage.net/statereports/tx1.pdf.

5 Engquist, G. and P. Burns, "Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States," State Coverage Initiatives Program, AcademyHealth, August 2002. See also www.cms.hhs.gov/hifa.

6 Data compiled from the National Association of Counties Health and Human Services Survey, available at www.naco.org/health/hhssurvey.htm and Scanlon, W. J., "Medicaid: Local Contributions," U.S. General Accounting Office, Publication #GAO/HEHS-95-215R, July 28, 1995. Data were only available for 33 of 51 states plus the District of Columbia. The table does not count states that have voluntary DSH, UPL, or other arrangements with their units of local government, as states that require local government to participate in the administration and financing of their basic Medicaid programs (see sidebar).

7 42 U.S.C. Sec. 1396a(a)(2); 42 U.S.C. Sec. 1396b(w).

8 59 Federal Register 49249, September 27, 1994.

9 Interview with Theresa Sachs, Centers for Medicare and Medicaid Services, November 2002.

10 Ibid.

11 Ibid.

12 Interview with Debbie Blount, Texas Health and Human Services Commission, November 2002. See Milligan, Charles, "Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage," State Coverage Initiatives Program, AcademyHealth, May 2001.

13 "Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes," U.S. General Accounting Office, Publication #GAO-02-147, October 30, 2001.

14 42 C.F.R. Part 447.

15 See www.cms.hhs.gov/medicaid/1115/gensteps.asp.

16 Interview with Debbie Blount, Texas Health and Human Services Commission, November 2002.

17 See "Coverage Matters: Insurance and Health Care," Committee on the Consequences of Uninsurance, Board of Health Care Services, Institute of Medicine, 2001.

18 The effect on the bottom line will be negligible rather than zero because the state may incur some administrative costs. As with service costs, these administrative costs could be shared with or devolved entirely to the participating units of local government.

19 Interview with Frank Kolb, National Association of Counties, October 2002.

20 Note that local and state officials must work together on any proposal; units of local government have no mechanism to apply for waivers directly.

21 External resources are available to assist states in developing coverage expansion models. The State Coverage Initiatives Program of AcademyHealth, for example, awards small and large policy planning grants for this purpose. See www.statecoverage.net.

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