

# Federal Health Program Reforms: Implications for Child Health Care

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ONE OF THE FIRST LEGISLATIVE INITIATIVES OF the Reagan administration was to propose several reforms of federal health care spending. Three major components included:

- A ceiling or “cap” on federal contributions to Medicaid, such that federal medical care expenditures would be allowed to increase only 5 percent in fiscal year 1982 and thereafter would be limited to increases indexed to the gross national product (GNP) deflator.
- “Block grants” to replace current formula grant and categorical health programs, the resulting federal grant moneys being combined into two broad blocks, one for preventive health activities and one for health services.
- A marked increase in state discretion in operating and determining eligibility for and coverage under Medicaid programs, and a parallel state role in determining the use of other federal health moneys newly combined under the two block grants.

In response, the Congress passed a somewhat modified program, but one that contained very significant changes in federal health care

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financing. The fixed ceiling on Medicaid was avoided in return for reduced federal payments to states and cost-saving provisions intended to keep annual Medicaid expenditures below targeted levels. Block grants were created, but exclude several key categorical programs and retain some significant federal restrictions on how states may use the funds. The net result represents substantially increased state discretion, but less than the administration had envisioned.

This paper analyzes the potential implications of these changes for child health services. The first section describes current spending and how the new legislation will modify existing federal programs that provide or purchase child health care. Since most federal health care dollars for children are specifically targeted to low-income populations and Medicaid is overwhelmingly the source of public spending for this group, the analysis that follows focuses on the economic characteristics and health care needs of Medicaid recipients and the likely effects of spending cuts and policy shifts. The final sections examine the recent block grant changes and discuss the implications of further developments that might be expected in the future.

## Existing Federal Programs and the New Amendments

### *Public Expenditures for Children's Health Care*

Expenditures for children comprise both a small proportion and a low absolute amount of federal expenditures for health care. In 1978, public expenditures for child health care were \$5.696 billion or 8.8 percent of the total public expenditures of \$65.042 billion (Fisher, 1980). Per capita public expenditures for children were \$81.99, compared with \$1,279.55 in public funds expended for those 65 and over, and \$218.13 for those aged 19 to 64.

Medicaid accounts for the largest proportion of public funds that are spent for children (Table 1). In 1978, Medicaid accounted for 55 percent of public funds spent for children's health, although that program accounted for only 28 percent of public expenditures for health care for all age groups and only 21 percent for those aged 65 and over. Although the aged have other sources of public spending,

TABLE 1  
 Estimated Personal Expenditures for Health Services and Supplies by Public  
 and Private Programs for Youth < 19 years, 1976-1978  
 (in \$ millions)

Type of Programs	1976	1977	1978
<i>All Public Programs</i>	\$4,801	\$5,206	\$5,696
Federal	3,194	3,413	3,757
State and local	1,607	1,793	1,939
<i>Major Program Areas</i>			
Medicare			
(Federal)	17	25	30
Medicaid	2,534	2,849	3,142
Federal	1,432	1,605	1,751
State and local	1,102	1,244	1,391
Other Medical Public			
Assistance State			
and local	83	93	100
Department of Defense			
(Federal)	811	788	823
<i>State and Local Hospitals</i>			
(Net)	83	88	85
<i>Other Public Expenditures for</i>			
<i>Personal Health Care</i>	1,273	1,363	1,515
Federal	935	995	1,151
State and local	338	368	364
<i>All Private Programs</i>	11,789	13,053	14,180
<b>Total</b>	<b>\$16,590</b>	<b>\$18,259</b>	<b>\$19,875</b>

Source: Fisher (1980), Tables A and C.

particularly Medicare, children receiving health care under public programs rely largely on Medicaid.

A variety of other health and health-related federal programs offer components of public support for maternal and child health care. The report of the Select Panel for the Promotion of Child Health (1981) identified 14 programs in addition to Medicaid that provide elements of direct financial support or health service, and numerous others that support health-related activities such as nutrition education, food supplementation, child development and daycare, special services for handicapped children, and social services. Among the relevant sources of direct federal funding, however, by far the most significant in

addition to Medicaid has been Title V of the Social Security Act. In 1981, Title V appropriations totaled \$407 million in grants to the states for maternal and child health care and crippled children's services.

The rate of increase in federal expenditures for child health care has not been high in recent years. Expenditures for children under all federal health care programs increased only 8.8 percent on average between 1976 and 1978, well below the rates for the other age groups (Fisher, 1980). For comparison, the medical care component of the consumer price index increased on average 9.4 percent annually over those two years, while the personal health expenditures index of the Health Care Financing Administration (HCFA) increased 4.3 percent annually (Gibson, 1980). Thus, there was either a small amount of real growth in federal expenditures for health care for children, as measured by the HCFA index, or a net loss in expenditures to inflation, as measured by the consumer price index. In either case, the rate of growth of federal spending for health care was much lower for children than for adults and the aged.

Not only do children account for a modest proportion of federal health dollars, but it is also clear that the public is financing only a small component of children's health care. In fact, most expenditures for child health care are private, not public. Over 71 percent of such expenditures (\$14.2 billion of \$19.9 billion) in 1978 were private, compared with 37 percent of expenditures for health care for the aged (65+) (Fisher, 1980). Direct (out-of-pocket) payment for personal health care is highest in the age group under 19, particularly for physician services. For that reason, changes in Medicaid are likely to have an effect on non-Medicaid patients as well. For example, if those physicians who do take Medicaid patients receive relatively lower payment, they will be likely to increase cross-subsidies from their non-Medicaid patients by raising charges. Since nearly 40 percent of physician payments for child medical care are out-of-pocket, this could have a direct effect on many working families as well as unemployed parents.

*Medicaid.* Title XIX of the Social Security Act established a joint federal-state program to provide medical benefits to low-income families. Federal payments are based on a matching formula that is designed to account for relative differences in per capita income among states. The matching formula rewards generous state programs because

total federal contributions increase as state Medicaid expenditures rise (Department of Health and Human Services, 1979a).

The benefits provided under Medicaid programs are a combination of services required by federal law and those that are permitted at a state's option. All states must provide inpatient and outpatient hospital care, other laboratory and X-ray services, physician services, and early and periodic screening, diagnosis, and treatment (EPSDT) services for children under 21. States are allowed to restrict the scope and duration of these basic services, and some do impose limits such as Alabama's ceiling of 20 hospital days annually. From the inception of Medicaid, mandatory benefits seldom have been changed, with the exception of EPSDT. States have increased the number of optional benefits to a small extent, but these changes have had minimal effect on costs (Congressional Budget Office, 1981).

Eligibility for Medicaid is defined by both the federal government and the states. The largest group of children receiving Medicaid benefits are those whose families are eligible for cash assistance (welfare) under the Aid to Families with Dependent Children (AFDC) program. The states determine the eligibility standards under which single-parent families qualify. Generally these standards are very low (Table 2). Children who are severely disabled and eligible for benefits under the Supplemental Security Income (SSI) program are frequently eligible for Medicaid. In one survey that included data on 32 states, approximately 85 percent of SSI children received Medicaid benefits (Rymer et al., 1979).

Children in families that meet AFDC or SSI categories but whose incomes are above the eligibility levels may also receive Medicaid if their state has elected to operate a "medically needy" program. In the 33 states with such a program, families who meet the categorical requirements may subtract their medical expenses from their total income. Once the medical expenses reach a certain level, the family then becomes eligible for Medicaid.

Another Medicaid option permits states to provide coverage to children in families that are financially eligible, whether or not they meet the categorical definitions. In that case, only the child and not the adults in the family may receive Medicaid. Twenty states have elected to provide Medicaid to children through this option. Overall, Medicaid excludes large numbers of children, and optional benefits and eligibility criteria vary sharply from state to state.

TABLE 2  
Annual Payment Standards for an AFDC Family of Four, 1979 Projected versus 1979 Actual

State	1970 Payment	1979 Projected* with Inflation	1979 Actual	Actual as a % of Projected
Alabama	2,760	5,172	1,776	34.3
Alaska	4,800	8,976	5,400	60.2
Arizona	—	—	—	—
Arkansas	2,112	3,960	2,256	57.0
California	5,184	9,696	5,844	60.3
Colorado	2,820	5,280	4,164	78.9
Connecticut	3,960	7,416	6,204	83.7
Delaware	2,832	5,304	3,444	65.0
District of Columbia	2,856	5,340	4,188	78.4
Florida	2,676	5,004	2,760	55.2
Georgia	1,776	3,324	2,040	61.4
Hawaii	3,156	5,904	6,552	111.0
Idaho	2,904	5,436	4,404	81.0
Illinois	3,384	6,336	3,996	63.1
Indiana	3,864	7,236	3,924	54.2
Iowa	2,916	5,460	5,028	92.1
Kansas	2,298	5,484	4,500	82.1
Kentucky	2,592	4,848	2,820	58.2
Louisiana	2,556	4,788	2,244	46.9
Maine	4,188	7,836	3,984	50.9
Maryland	2,352	4,404	3,528	80.1
Massachusetts	3,768	7,056	4,752	67.4
Michigan	3,156	5,904	5,640	95.5
Minnesota	3,588	6,720	5,448	81.1
Mississippi	2,784	5,208	3,024	58.1

Missouri	3,900	7,296	3,240	44.4
Montana	2,736	5,124	3,972	77.5
Nebraska	3,960	7,416	4,440	60.0
Nevada	3,804	7,116	3,564	50.1
New Hampshire	3,528	6,600	4,704	71.3
New Jersey	4,164	7,788	4,632	59.5
New Mexico	2,184	4,092	2,904	71.0
New York	4,032	7,584	5,712	75.7
North Carolina	1,896	3,552	2,520	71.0
North Dakota	3,132	5,856	4,668	79.7
Ohio	2,400	4,164	3,924	87.4
Oklahoma	2,220	4,152	4,188	100.9
Oregon	2,700	5,052	6,300	124.7
Pennsylvania	3,756	7,032	4,476	63.7
Rhode Island	3,156	5,904	6,216	105.3
South Carolina	1,236	2,316	2,748	118.7
South Dakota	3,600	6,732	4,332	64.4
Tennessee	2,604	4,872	1,776	36.5
Texas	2,148	4,020	1,680	41.8
Utah	2,544	4,764	4,668	98.0
Vermont	3,648	6,828	6,288	92.1
Virginia	3,132	5,856	4,020	68.7
Washington	3,636	6,804	5,786	85.2
West Virginia	1,656	3,096	2,988	96.5
Wisconsin	2,604	4,872	5,486	112.8
Wyoming	3,180	5,962	4,080	68.6

\* 1979 Expected if payment standard had increased at the same rate as did inflation.  
 Source: Rowland and Gaus (1981). Reprinted with permission of the authors.

The Omnibus Budget Reconciliation Act of 1981 calls for the following changes in Medicaid (P.L. 97-35). A fixed level for federal spending was not enacted but payments to the states will be decreased by 3 percent in fiscal year 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984, compared with the amount of federal matching funds that would otherwise be required. The federal reduction can be modified according to state unemployment levels, fraud and abuse recoveries, and the presence of a hospital rate-setting program. Marking the first serious inroad into the "freedom of choice" guarantees of the Medicaid and Medicare laws are provisions that allow waivers so that states can require individuals to use particular providers under specified conditions. A previous penalty of a 1 percent reduction in federal matching payments under AFDC if states fail to meet EPSDT standards has been repealed. Medicaid coverage for individuals aged 19-20 is no longer required, and several requirements for services for the medically needy have also been repealed.

*Title V and Other Programs.* Enacted in 1935, Title V of the Social Security Act remains the only federal program exclusively aimed at improving the health of mothers and children. The program provides funds to the states to promote, improve, and deliver maternal and child health care and crippled children's services, usually via state departments of public health.

Title V has supported maternal and child health clinics, family planning, regionalized infant care, special primary care projects, and dental care. Funds are not targeted to the poor by legislation, but usually are used to offer services in low-income and rural areas. Crippled children's moneys often have been used via purchase of service arrangements to provide intensive and long-term hospital and clinic care for children with selected disabilities and chronic illnesses (Select Panel, 1981).

Title V appropriations have risen gradually over the past decade, from \$259 million in 1973, to \$351 million in 1977, to \$407 million in 1981. This trend has not proven enough to compensate for inflation in the cost of medical care, however, so that the program's real dollar resources in fact have diminished. Although Title V has been incorporated into the block grants described below, it is likely that the most significant change in the program to be expected in FY 1982 is the reduction in appropriation expected. At the time this paper is submitted, the FY 1982 authorization for the new Maternal and

Child Health Block (MCH) has been set at \$375 million, and actual appropriations are likely to be between the \$331 million recommended by the House of Representatives and \$340 million recommended by the Senate. After adjustment for inflation, this appropriation level will reflect a 25 percent cut in funds.

The reduction in money available is in fact somewhat greater than would appear, because the maternal and child health block grant includes five smaller categorical programs that previously had budgets of their own. This block consolidates the following programs: maternal and child health and crippled children's services (Title V), supplemental security income for disabled children, lead-based paint poisoning, genetic disease, sudden infant death syndrome, hemophilia treatment, and adolescent pregnancy. Remaining as categorical programs are those for childhood immunization, developmental disabilities, and family planning.

For the first time, no Title V moneys are earmarked for crippled children's services. Instead, the funds now can be distributed across all the programs in the block. One significant restriction on state discretion, however, is that no maternal and child health funds may be transferred to other blocks. The only reporting requirement for states is an annual report on how funds were expended, plus a report on compliance with assurances of "quality, fairness and appropriateness" of expenditures. Several areas were identified as funding priorities to maintain: reducing infant mortality, preventable diseases and handicapping conditions, and increasing maternity care, immunizations, and assessments of services to low-income children. For every four federal dollars, three state dollars must be matched in the MCH block grant.

## Assessing the Likely Effects

### *Medicaid*

To analyze the possible effects of reduced federal Medicaid expenditures, it is necessary to understand the current role of the program in providing medical services to poor children. Two characteristics of children receiving Medicaid are central—their relative poverty or wealth and their health status and needs for medical care.

Medicaid children are demonstrably poor and are unlikely to have other insurance or resources as compared with older groups (Kovar and Meny, 1981). In fact, Medicaid eligibles have become increasingly poor in recent years. Their poverty is more severe in two senses.

First, eligibility standards for the major welfare programs, particularly AFDC, have not kept pace with inflation (Rowland and Gaus, 1981). Comparing increases in welfare eligibility standards with the Consumer Price Index, we find that by 1979 only 11 states were within 90 percent or more of their comparable 1970 standard; 25 states were at 60–89 percent; and 13 states had eligibility standards set at only 30–59 percent of the 1970 level (Table 2). Thus, families have to be less well off now than previously in order to qualify for AFDC. Because individuals in families receiving AFDC comprise the majority of children receiving Medicaid benefits, erosion of the AFDC standard has caused a parallel restriction of Medicaid coverage to relatively poorer children.

Second, the poor who are eligible for AFDC receive actual payments that are often well below the eligibility standards. For example, in South Carolina, payment to a family of four with no income in 1978 was only \$117 per month. The highest payments were in New York, at \$476, and Hawaii, which paid \$533 for an eligible family (Social Security Administration, 1978).

The failure of eligibility standards and cash payments to keep up with inflation has had the following direct results:

1. Even though Medicaid programs have become somewhat more generous in optional benefits (Intergovernmental Health Policy Project, 1980) a lower proportion of poor children are now eligible for Medicaid than previously. All AFDC-eligible children are still covered by Medicaid programs, but AFDC criteria now include a diminishing proportion of families below the national poverty standard. In addition, many poor families with children do not qualify for AFDC because both parents are present in the household. Thus, Medicaid currently excludes large numbers of poor children—only 48 percent of children in families with incomes below the national poverty standard received Medicaid in 1980 (Kovar and Meny, 1981).

As welfare eligibility has lagged behind inflation, the number of Medicaid recipients has decreased and would continue to decline even

with present levels of eligibility. The number of dependent children less than 21 years of age decreased by 1.5 million between 1976 and 1978, a decline of 14.4 percent in just those two years (Department of Health and Human Services, 1980). During those same years, the total child population in the United States declined, but by only 2.5 percent (Budetti et al., 1981). Estimates of the decline in the total number of children receiving Medicaid benefits show similar declines from a peak of 11,654,000 in 1976 to 10,093,000 in 1978 (Department of Health and Human Services, 1979a).

2. The pool of indigents who are poor and uninsured has increased. Children in low-income families are unlikely to have insurance other than Medicaid, nor do they have the resources to pay for medical care.

Children under 19 represent 38.4 percent of the uninsured individuals in the United States, although they account for only 32.8 percent of the population (Congressional Budget Office, 1979). Over half (58 percent) of the uninsured children were in families with incomes less than \$10,000 in 1976, so that they were unable to self-insure in any meaningful way (Congressional Budget Office, 1979). In 1977–1978, there were 8 million uninsured children under the age of 18 (Department of Health and Human Services, 1979b).

Such declines in Medicaid eligibility and increases in the number of uninsured have serious implications for child health care. Without Medicaid, other insurance, or other financial resources, children are likely to decrease their health care utilization. This sensitivity of child health services to price is demonstrated by three types of evidence. First, utilization of health care services by poor children now approximates that of the nonpoor but did not begin to do so until after enactment of the Medicaid program. Aday et al. (1980) report that, overall, 87 percent of the children in the United States ages 1–5 saw a physician in 1976; the children ranged from 97 percent of those in families with high incomes to 78 percent of those in low-income families. They noted similar ratios for children ages 6–17 in households of different income status. In 1963, before the enactment of Medicaid, however, the differences in utilization were much greater: only 52 percent of the younger children and 41 percent of the older group in low-income families saw a physician in the previous year, compared with 87 and 70 percent, respectively, in the high-income

group. Other national studies have also confirmed the increased use of health services by poor children since enactment of Medicaid (Orr and Miller, 1981; Madans and Kleinman, 1980).

Similar findings have been reported recently from a microstudy of children in the Flint, Michigan, metropolitan area (Gortmaker, 1981). As a greater proportion of children in poverty and near-poverty households enrolled in Medicaid between 1973 and 1977, the previous gap in the utilization of health services by children in different income groups narrowed substantially. Using multivariate analytic techniques to control for variations in socioeconomic and health status confirmed the role of Medicaid in increasing two important areas of health care, total physician contacts and the use of preventive services.

Second, although children on Medicaid continue to demonstrate signs of difficulty in obtaining access to regular care by office-based physicians ("mainstream medicine"), they do identify some regular source of care about as frequently as privately insured children (Kovar and Meny, 1981). Children with no insurance, however, are almost twice as likely as children on Medicaid to have no regular source of care. The presence of a usual source of care is important, because children without a regular source of care are much less likely to get care when it is appropriate than children with such a source (Department of Health and Human Services, 1979b; Aday et al., 1980).

Third, there is direct evidence that the use of physician services is sensitive to increases in the out-of-pocket share of the cost of care (Scitovsky and McCall, 1977). Introduction of a 25 percent copayment requirement substantially reduced the use of health services by the population served by a large multispecialty group practice in California.

Taken together, these studies demonstrate the high likelihood that poor children removed from the Medicaid rolls would use far less medical care than they currently do. This result in itself is of concern for reasons of equity, but is even more serious in its implications for child health because of the types of services being provided by Medicaid and the relatively great health care needs of poor children.

As mentioned above, Medicaid has been shown to have increased the use of preventive services and physician contacts, and recent studies report that Medicaid children show no evidence of overuse of emergency facilities (Gortmaker, 1981; Weitzman et al., 1980). A particularly relevant finding by the University of Chicago's long-term

study (Aday et al., 1980:196) was that "whereas in 1963 [members of low-income families] saw a doctor for symptoms at considerably lower rates than the panel of physicians would have recommended, in 1976 their contact rates relative to what they 'should' be doing is much more like those of the other income groups."

As additional evidence that Medicaid services for children are not excessive or overly inclusive, some services that are widely accepted as necessary for basic maternal and child health are not even offered in many states. For example, in 1979, 19 states did not provide dental services; 17 did not provide eyeglasses; 8 did not provide emergency hospital services; and 20 did not provide inpatient psychiatric care for persons under 21 years of age. Similarly, prenatal care in the first pregnancy is still not provided by 19 states as of 1978 (Kovar and Meny, 1981). These findings strongly support the argument that program changes requiring persons now eligible for Medicaid to purchase their own care, out of pocket, will decrease the use of basic, not unnecessary, health care for children.

Such reductions in the utilization of basic services would be very significant because children receiving Medicaid are needy in a medical as well as an economic sense. Although Medicaid has substantially reduced the gap in the use of health care services between income groups, low-income children and expectant mothers still experience significant barriers to receiving medical care relative to those in higher income groups, as measured by the University of Chicago group's study of health care needs and services (Aday et al., 1980).

This gap between need and services persists because poor children have demonstrably greater health care needs than other children. Higher infant mortality rates among the poor are well known and have persisted even as overall improvement has occurred in all income groups (Dutton, 1981). Data from the National Health Interview Survey demonstrate lower health status for poor children as measured by parents' perception, restricted activity days, loss of time in school, days of hospitalization, and limitation of activity due to chronic conditions (Dutton, 1981; Kovar and Meny, 1981). Similarly, the Health and Nutrition Examination Survey conducted in 1971-1974 demonstrated a clear relation between low income and presence of decayed teeth or other conditions requiring dental care (Kovar and Meny, 1981).

The association between low income and poor health status in childhood is clear. Nevertheless, the causal relation has been challenged by Grossman et al. (1980), Edwards and Grossman (1979), and others at the National Bureau of Economic Research. In a preliminary report, they point out that the health status advantage enjoyed by higher-income children diminishes when other variables are held constant. In particular, for certain measures the level of education attained by the child's parents (usually mothers) accounts for approximately the same proportion of the health differential as does income.

These intriguing results by Grossman, Edwards, and colleagues are yet to be confirmed by other investigators. Moreover, their use of old (1963–1965) data and inclusion of some health status indicators of questionable significance (e.g., uncorrected vision, parental assessment of child's anxiety level) clearly call for more current and reformulated studies. Their tentative findings do, however, suggest an approach to teasing out the factors that produce the substantial gap in health status between children in different income groups. Until those other factors are both identified and ameliorated, programs such as Medicaid remain as a necessary means to meet the increased health care needs associated with poverty.

One major area of discretion with particular importance for children was requested by the National Governors' Association (1981a) and was met by the repeal of the penalty for failure to meet standards of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid. There have been serious concerns about the EPSDT program's effectiveness, but its emphasis on preventive care for children is not likely to be helped by this move if it appears to signal a lack of priority for the program. That is, with increasing stresses on Medicaid budgets, it should be recognized that giving states full discretion in spending EPSDT funds across age categories might well result in a marked reduction in total spending on behalf of children. Such an action might well mean a reduction in spending for preventive and diagnostic services.

Many states have expressed interest in having the right to be "prudent purchasers" of medical care with state funds. The principal effect of this reform thus far has been to reduce the freedom-of-choice requirements by the recently enacted liberal waiver provisions to

broaden the situations in which states may contract with a limited number of selected providers for indigent care.

One attractive feature of the "prudent purchaser" approach is that it would offer an opportunity for direct economic competition in the health care sector. States or other units of government would be able to conduct genuine negotiations and let bids for medical care services. Presumably, this could lead to increased efficiency in many areas. A major limiting factor, however, is the need to have enough money available to have at least some qualified providers willing to negotiate to provide the care. Thus, severe cutbacks in federal and state Medicaid funds would reduce the usefulness of "prudent purchaser" provisions.

Evidence is beginning to accumulate that legal recognition of limited providers would not necessarily encompass a significant departure from the ad hoc situation in many states. In California, for example, a limited number of hospitals provide the vast majority of all Medicaid care (Myers, 1979). Similarly, physician participation in the Medicaid program nationwide is not high and there has never been a requirement that all physicians participate and genuinely guarantee freedom of choice. In addition, because of restrictive provisions of the Social Security Act, the Health Maintenance Organization (HMO) Act, and regulations under both programs, participation by HMOs as providers of Medicaid services has been limited, a situation addressed in part by the 1981 amendments.

For children, the "prudent purchaser" approach to state discretion has a number of significant implications. For example, pediatricians provide about one-third of the care received by all persons under age 22. In a survey of 13 states that account for well over one-half of all Medicaid spending, Davidson (1981a, 1981b) and Davidson and Perloff (1980) found that pediatricians generally have very high rates of participation in the Medicaid program. That is, 85 percent of pediatricians in those states were participating to some degree in Medicaid and the vast majority of pediatricians who were accepting any new patients into their practice were, in fact, accepting all Medicaid patients who applied. Since many pediatricians are not members of organized practice settings that might compete effectively for Medicaid contracts, one result of a "prudent purchaser" approach might be a reduction in participation by private physicians. To avoid such a

trend, "prudent purchaser" activities by the states might well be separated into physician and hospital components in order to maximize the individual physician participation while minimizing the high-cost hospital role.

### *Block Grants*

In addition to changes in Medicaid, the move to block grant funding—and in particular the creation of the Title V Maternal and Child Health block grant—has a variety of potentially serious consequences for the extent and quality of child health care. The new federal approach has two aspects that deserve separate consideration. First, it will involve a substantial reduction in the total amount appropriated for maternal and child health and crippled children's services, as much as 25 percent in FY 1982. This reduction comes at a time when, as mentioned earlier, the Title V program already has begun to fall behind in real dollar appropriations and when those states who have overmatched the federal contribution are going to find it hard to continue to do so.

Title V funding reductions must be considered jointly with cutbacks in Medicaid. Most states serve many of the same children in both programs, or rely on the joint implementation of the two programs to provide essential services in areas with sizable low-income populations. It is clear that the multiplier effects of simultaneous reductions in Medicaid and Title V are the most significant problem the states must face. Implications for the adequacy of care are likely to be very serious, regardless of how ingenious state authorities are in administering reduced funds. These cutbacks are likely to translate into various eligibility and benefit restrictions under state maternal and child health and crippled children's programs, and thinner staffing, both medical and administrative, at all levels.

The second aspect of block grant funding is increased state discretion in allocation, administration, and monitoring of Title V. In particular, money will now be fungible across the maternal and child health (MCH) and crippled children's (CC) components, as well as the previously categorical programs now included in the block. The lessened, but still substantial, constraints on state behavior suggest the following results are likely:

1. State governments will worry a great deal at first about how to administer the new grants, and what they imply for organizational charts within umbrella human services agencies. In most states, however, Title V programs will continue to enjoy a relatively low status, and Title V program managers and clients will not compete well with other factions for marginal resources beyond the program funds themselves. In competing for limited Title V funds, crippled children's constituencies who focus on one or more specific diseases may be in a somewhat better position than the diffuse constituency of low-income mothers and children who use MCH programs. But these effects are apt to be small in comparison with the net effect on staffing and scope of services resulting from across-the-board reductions in program funding.

2. Reporting requirements to federal authorities are not likely to be much more or less burdensome, or informative, than in the recent past. State expenditures of Title V moneys have never been especially well documented, largely because from its inception the program has been seen as a mechanism for discretionary formula grant support to the states. The new block grant legislation requires a biennial audit to ensure that funds are not misused, but this function is entirely under state control. Otherwise, the new law calls only for minimal planning and reporting procedures, which are likely to be taken seriously by only a few states.

3. Increased discretionary authority may well accentuate the already considerable differences of quality and commitment among state Title V programs. Those states with relatively strong Title V efforts also tend to be those that are more affluent in general, have stronger and more capable human services staff, tend to document the use of funds more fully, and are more attuned to the joint implementation of various related programs and policies. Conversely, those states whose current efforts are most limited tend to be the same ones with limited state and local revenue bases, low commitment to public support of health services, limited staff capability in human services agencies and state legislatures, and poorest track records in data collection, analysis, and program evaluation. More state discretion may allow further improvement by those agencies that are already administering effective and efficient programs, but may lead to new problems in agencies whose current policies have occasioned concern.

### *Implications of Other Proposed Reforms in Federal Spending for Children's Health Care*

There is a good reason to believe that the proposals to cap or otherwise fix a limit on the federal contribution to Medicaid, and to increase state discretion in the management of programs even further, will be pursued in future years by the administration. President Reagan has "vowed to go 'back and back and back' to Congress to untie some of the block grant strings attached by the Democrats and to block some of the programs that were left categorical." The president has characterized the changes to date as but a step "leading to the day when [the States] will have not only the responsibility . . . but . . . the tax sources now usurped by Washington returned . . . , ending that round trip of the people's money to Washington and back, minus a carrying charge" (National Health Council, 1981:9).

Pressures for further modification of federal health efforts will come principally from the values underlying the administration's proposals to date, but will also flow from concerns over the inadequacies of existing programs. As documented in the previous sections, although many inequities have been greatly relieved, there are still a large number of poor who are not covered and for whom a wide range of necessary services are not provided. The costs of meeting those needs are so great and fiscal constraints have been so tight at every layer of government that the 96th Congress under President Carter was not willing to extend Medicaid coverage beyond the present levels. Similarly, although clearly responsible for major advances in maternal and child health services, Title V programs have suffered from a variety of structural administrative and fiscal limitations (Select Panel, 1981). Proponents of changes designed to meet additional health care needs will continue to point out that extensive funding cutbacks without corresponding changes in the delivery system and reimbursement methods would further reduce the availability and use of needed medical care services by poor children and would therefore be worse than the status quo.

The major components of the remaining proposals—a Medicaid cap, block grants without strings, and increased state discretion—are not necessarily linked in design. Nevertheless, each proposal would clearly interact with the others if passed—e.g., unfettered block grants would have more significance for states under a Medicaid cap than under

a continuing federal matching formula. In the coming years, the Congress may well choose to enact some variations, or only additional aspects of those proposals, or to make no further changes at all.

Placing a ceiling on the federal contribution of Medicaid would eliminate the current incentive for states to increase spending in order to maximize federal matching dollars. Simultaneously, it would increase the states' existing incentive to use Medicare resources whenever possible. Using a federal Medicaid cap to reduce the annual real-dollar federal share of state programs would cause states to further emphasize the cost-cutting responses now available to them: to place limits on mandatory benefits, eliminate optional benefits, decrease dollar thresholds or otherwise restrict eligibility, decrease payment or reimbursement rates, and attempt to increase the efficiency of the programs (Montgomery Securities, 1981; National Governors' Association, 1981a; Holahan et al., 1977; Intergovernmental Health Policy Project, 1981).

Creating unfettered block grants, to replace the recently enacted ones and to incorporate the remaining categorical health programs, might mean the elimination of many child health programs. Under that approach the funds would be generally available to states to spend for a wide range of health services and preventive health activities for all age groups, resulting in less targeting to specific maternal and child health objectives.

Finally, further increasing state discretion and control over federal health dollars could have several different results. On the one hand, states could develop innovative programs for delivery of services to the indigent and might correct many current inequities. On the other hand, the simultaneous reduction of federal direction and funding could worsen existing inequities among states and undercut much of the progress of recent years.

One clear direction for future proposals will be to provide increases in state discretion over health program expenditures. The areas of state flexibility to be stressed by the administration generally reflect the approach favored by the National Governors' Association (NGA) (1981a), the National Association of Counties (NACo), and the National Conference of State Legislatures (NCSL). These groups have long advocated a marked increase in state discretion to manage and spend Medicaid moneys. They do not, however, favor a complete ceiling on federal participation, although they have suggested capping

the long-term care component alone. These groups also tend to favor broader state discretion to spend formula grant moneys and greater state access to categorical program funds, but they are becoming increasingly aware of the problems of visible accountability for program cutbacks.

Legislative developments in the past year have prompted reconsideration by many states of their original enthusiasm for block grants. This was brought about by the combination of less discretionary authority over funds than had been expected, very substantial funding cuts, and the realization that the new block grant mode renders federal health moneys more vulnerable politically to further cuts than when allocated categorically. In a recent meeting, the National Governors' Association (1981b) adopted a resolution refusing to endorse any further cuts in the block grants; the text acknowledges the new vulnerability and reflects second thoughts at a time when the Reagan administration is about to look again to domestic programs for a second round of budget reductions.

Another major area of Medicaid discretion sought by the states is to have the prerogative of requiring copayment by categorical eligibles for mandatory services as well as for optional services. One serious issue regarding copayment concerns keeping "minimal" copayments minimal in fact. Given the very limited resources of the population group now receiving Medicaid services, even a seemingly modest copayment requirement could be significant enough to severely reduce utilization of needed services. Unlike the situation with adults over age 65, children receiving Medicaid are unlikely to have other insurance and are unlikely to have the resources to purchase private insurance for first-dollar medi-gap coverage. Thus, the role of copayments in Medicaid needs to be differentiated from that of copayments in Medicare.

Institution of copayments has been clearly linked to decreased utilization rates, which, as noted above, may mean reduced use of preventive and primary care. If so, the result might well be a need for more intensive and expensive care at a later stage of illness or a higher level of disability in the population. Children would also be affected disproportionately in simple dollar terms by a fixed copayment rate (compared with a percentage-based copayment) because child health care charges are generally lower than those for similar services for adults (Kasper et al., 1980).

Physician fees under Medicaid are generally well below market rates defined by Medicare rates or charges. This is the single most important determinant of physician participation in Medicaid, although other factors such as coverage of the medically needy and the scope of benefits provided are also highly significant (Davidson, 1981a). Thus, allowing states freedom to manipulate physician rates when they are convinced that maximizing primary-care physician participation in Medicaid would reduce expenditures could increase office-based physician participation.

The implications of expanding purchase of service agreements and rate-setting under Medicaid are also significant for hospital care, in particular the care provided in the nation's children's hospitals. Children's hospitals typically have a higher proportion of Medicaid reimbursement than other hospitals, meaning that they are more vulnerable to changes in eligibility, scope of benefits, and rates under the program (A.D. Little, 1978). These hospitals often provide a very significant percentage of tertiary care for children with selected conditions in an entire region, and some offer a full range of services, including primary care, to low-income children in their immediate communities.

If services are to be maintained, Medicaid cutbacks will force increasing cross-subsidies of low-income patients from private sources. Alternatively, children's hospitals will increasingly have to turn Medicaid business away, being able to generate sufficient revenues only by limiting access to a more affluent clientele. Purchase of service arrangements offers no solution to this problem if negotiated reimbursement levels for hospital care are so low that children's hospitals cannot participate. Moreover, to the extent that indigency rates increase and cause a greater burden of bad hospital debt, privately incorporated children's hospitals will continue to have less recourse than public hospitals to direct local or state subsidies as compensation. Thus an unexpected consequence of federal cutbacks may be to reduce the private sector's role in providing child health care and increase the burden on county hospitals and publicly operated teaching facilities.

## Conclusion

As the Reagan administration and the 97th Congress move to reduce federal spending across a wide range of social services and programs,

one might question the reasons for particular concern over child health care. To many, particularly with first-hand experience in the delivery of child health services, the reasons are self-evident, i.e., to ensure that our ability to relieve pain and suffering, avoid unnecessary deaths, and help children achieve their maximum potential does not decline. Beyond the individual level the arguments fall into three broad categories: child health as a social investment, the political vulnerability of children, and the need for specific health services.

There is a clear societal value in healthy children. Health is of importance in determining school performance and behavior, and may seriously affect future employment. Thus, efforts that improve the health of children are, in a very real sense, a long-term national investment that will pay important social dividends.

The importance of this social investment will increase as demographic trends change the age distribution of the American population so that there will be fewer children relative to other age groups (the elderly in particular). That means we will need more productivity per child, or at least fewer children who are nonproductive.

Because health care and good health status are necessary preconditions for many realms of achievement, health should have a high priority among the realms of policy toward young children. To the degree that early investment is preemptive of later problems, it not only increases productivity but also saves the society money. Present evidence allows this point to be applied conclusively to only a limited range of health conditions and treatments, such as vaccination against poliomyelitis. Nevertheless, there are many who believe this argument is also true of a number of health interventions, even if their exact contribution is difficult to document. In particular, there is impressive evidence that maternal and child health care; policies in family planning, prenatal care, delivery and postnatal care; and early health interventions for special needs all make a difference for child health (Select Panel, 1981). The relative value of such an investment with proven return is great, among the choices open to society, and thus warrants special attention.

Common to each of the underlying reasons for promoting child health is a recognition that children will always be a constituency in need of proxy representation. Children's issues will always be debated and decided—or even neglected and made worse—by adults. This

political vulnerability of child issues has several important ramifications.

Unlike most other industrialized countries, the United States has had no consistent, long-term national child health policy, and no major administrative structure in the federal government to implement such a policy. In particular, the financing of health care services predominantly through employment-related insurance and Medicare for the aging has evolved a system that pays little deliberate attention to the needs of children. As a result it should not be surprising that our system creates more incentives for high-technology, specialized acute care of the elderly than for preventive or primary care services for children. Attempts to assist children are fragmented, sporadic, and take place in the absence of an overall context or well-established sense of priorities, and may suffer disproportionately in times of fiscal cutbacks and program consolidation.

Children must rely on others as advocates of their needs. Their best interests are represented by parents and public officials in some cases, but the interests of other groups often tend to come first. The needs of children—because they seem less urgent, have a higher ratio of preventive to acute care, are less appropriately concentrated in the hospital and tertiary care sectors, and are represented by diffuse rather than concentrated interest groups—may be put at the end of the queue for public resources when cutbacks and consolidations take place.

Even some of the most rudimentary and uncomplicated health needs for mothers and children are not being met by the present service system. Major progress has been made in recent years, but the health care needs of many adolescent, black, poor, inner-city and rural, chronically ill, and other children, as well as the health care needs of pregnant women, are not adequately served (Budetti et al., 1981). This situation is particularly perplexing for at least two reasons. First, a great deal is known about what those health care needs are and what long-term benefits result from providing specific preventive, diagnostic, and therapeutic medical and support services. In addition, the persistence of a large body of unmet needs is in marked contrast to the continually expanding supply of pediatricians and the continuing increases in expenditures for medical care services. The basic issue that emerges is the importance of looking carefully as our present health care system is modified, so that the financial programs and

incentives and the mix of practitioners that result will provide at least the minimum necessary for all children, and not create additional areas of unmet needs.

The recent developments discussed in this paper have refocused the long-standing concern for child health. These shifts in the locus of governance and funding cutbacks have serious ramifications for child health programs and policies that have been evolving over the past 15 to 45 years. For example, the extensive work of the Select Panel for the Promotion of Child Health was carried on under a mandate from the 95th Congress to develop a comprehensive national plan for achieving specific goals with respect to the promotion of health status of children and expectant mothers. Now, those who created this mandate and to whom the panel was to report are largely out of power. The result is a need to develop new mechanisms to maintain and expand on the child health gains made in the last decade in a new decade of reduced spending and federal direction.

The change in political atmosphere has created a fear that new policies might erode the progress of the past rather than correct the deficiencies of generally highly successful programs. Some fears are reasonably well grounded. There is evidence, for example, suggesting that block grants will increase administrative control of state health agencies over local public health departments (DeFries et al., 1981). This has led one former state health director to decry the current shifts of power as "dangerous" and to assert that local governments reflect "a broad spectrum of unreadiness—even inability—to undertake the sort of rigorous administration of public health services needed to make the 'model' work" (Tilson, 1981:1103).

To some degree, however, current fears are as much a manifestation of differences of political philosophy as of relevant empirical evidence. Certainly at least some of the advocates of the new approach genuinely believe that child health interests will be served better through state and local than through federal control, and blame the shortcomings of existing programs on the inefficiency of large central governments. What seems most likely, however, is that the new order will prove far less important than the magnitude of federal fiscal reductions. Increased state discretion in operating Medicaid and maternal and child health programs can hardly be expected to compensate for very great federal funding cutbacks, and resolution of the underlying philosophical debate will be a trivial concern in comparison with the

practical realities caused by far less federal spending for health programs.

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