

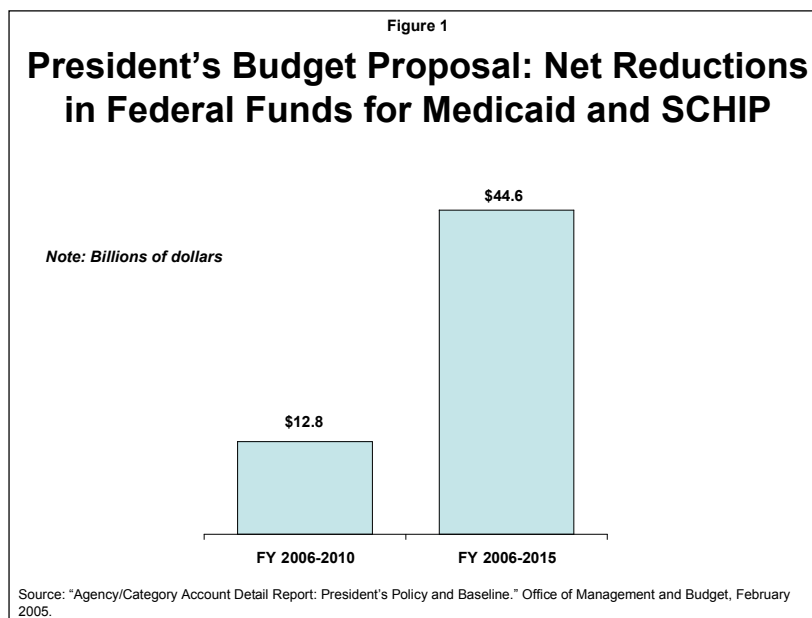


The President's Proposals for Medicaid and SCHIP: How Would They Affect Children's Health Care Coverage?

On February 7, 2005, President Bush released his budget proposal for fiscal year 2006. The proposal would reduce overall federal funding for Medicaid by at least \$45 billion over ten years, and it anticipates -- although does not spell out -- policy changes that could have a major impact on children's coverage. The deep cuts in spending proposed in the Budget combined with plans to make other, potentially far-reaching, programmatic changes in Medicaid and the State Children's Health Insurance Program (SCHIP) underscore the extent to which federal budget activities over the next few months could have significant consequences for children's access to coverage and care.

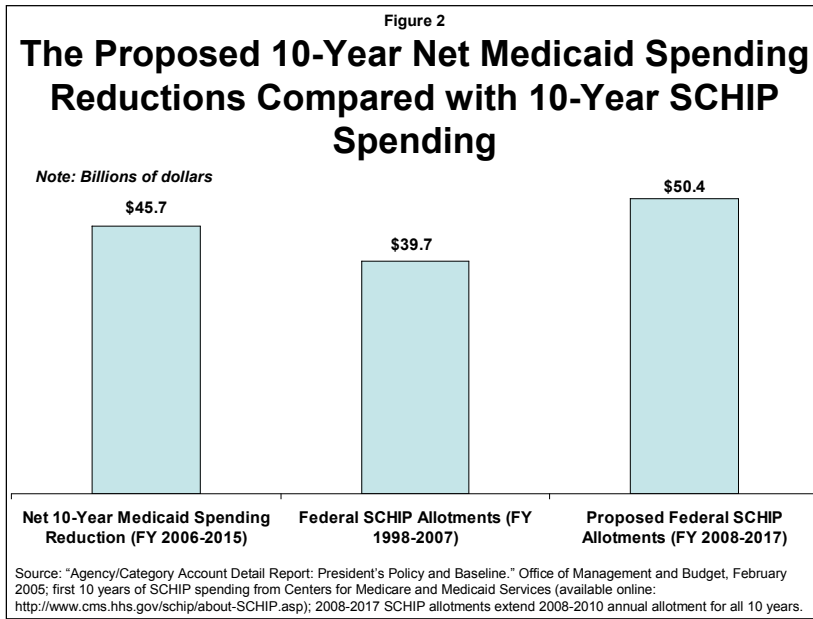
Federal Funding Reductions

Under the President's proposal, federal Medicaid funding would be reduced by at least \$45 billion over ten years (Figure 1). Some confusion about the Medicaid budget numbers has arisen, in part, because there are several moving parts, including "baseline" adjustments,¹ federal spending reductions, and new spending initiatives.



¹ Technically unrelated to the funding changes proposed in the President's Budget, the Office of Management and Budget (the White House's budget agency) reduced its Medicaid "baseline." It projects that federal Medicaid costs will be somewhat lower than earlier projections. OMB estimates a five-year growth rate (2006 – 2010) of 7.1 percent and a ten-year growth rate (2006 – 2010) of 7.6 percent (*not* considering any of the proposed policy changes).

The Budget proposes to *reduce* federal Medicaid payments by a total of \$60.1 billion over next ten years (between 2006 and 2015). It also proposes new initiatives that, according to OMB estimates, would *increase* federal Medicaid and SCHIP spending by \$16.5 billion over the same period. The media has sometimes reported \$60 billion in federal Medicaid cuts and at other times \$45 billion in Medicaid cuts. The *net* impact of the Administration’s budget proposal is at least \$45 billion in federal Medicaid spending cuts over the next ten years.



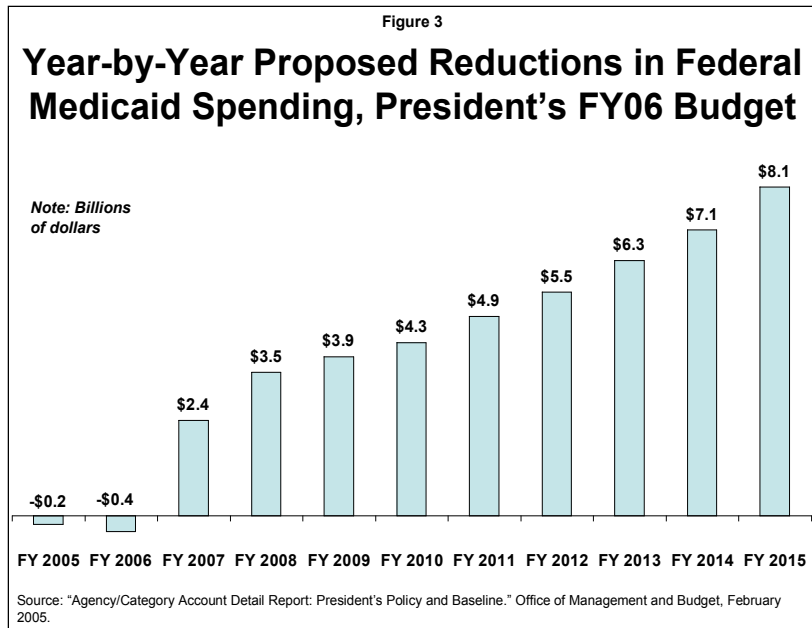
These net funding reductions, while representing only a small percentage of total federal funding for Medicaid and SCHIP, are quite large when considered in light of the fiscal stress already facing these coverage programs at the state level. To give some perspective to the numbers, the net reduction of \$45 billion is a bit more than the federal government’s

entire commitment to SCHIP for the first ten years of the program and a bit less than the entire federal SCHIP commitment proposed for the next ten years (Figure 2). It is a little more than the entire federal Medicaid contributions to four of the largest state Medicaid programs in the country in 2003 --Texas, Florida, Pennsylvania and Ohio-- and about the same as the total federal contributions to the Medicaid programs in ten mid-sized states in that year.² The funding reductions would grow over time, just as the baby boom generation begins to retire and long term care cost pressures in Medicaid deepen (Figure 3, next page).

² These states are Arizona, Connecticut, Indiana, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Washington, and Wisconsin, based on the Urban Institute’s analysis of state-reported Medicaid spending data (CMS 64).

Policy Proposals

The Administration's Budget includes a list of potential changes in the law to bring the federal savings to the net \$45 billion level. It also suggests that the Administration is considering other, as yet unspecified, changes that could more fundamentally restructure at least some aspects of Medicaid and SCHIP.



Medicaid and SCHIP "Modernization"

The Budget calls for "modernizing Medicaid and SCHIP coverage" by "providing states with additional flexibility in Medicaid to further increase coverage among low income individuals and families without creating additional costs for the Federal government."³ According to the Budget narrative, the Administration's plans for restructuring Medicaid would build upon SCHIP and the kinds of changes states have adopted through section 1115 Medicaid waivers.⁴

Remarks made by the newly confirmed HHS Secretary, Mike Leavitt, a few days before the release of the budget shed further light on the Administration's intentions with respect to "Medicaid and SCHIP modernization." In his February 1st speech, Secretary Leavitt also drew on the experience of SCHIP and waivers. He proposed extending broad new flexibility to states with respect to "optional" Medicaid populations, posing the question, "Wouldn't it be better to provide health insurance to more people, rather than comprehensive care to a smaller group? Wouldn't it be better to give Chevies to everyone rather than Cadillacs to a few?"⁵

A few years back, in Secretary Leavitt's home state of Utah, then Governor Leavitt ushered in a new Medicaid waiver initiative that offered some uninsured people (and

³ President's Budget for Fiscal Year 2006, page 137.

⁴ The Budget specifically references the Health Insurance Flexibility and Accountability initiative (HIFA), a waiver initiative first announced by the Bush Administration in 2001 to promote coverage of the uninsured through Medicaid and SCHIP without adding any new federal costs. See <http://www.cms.hhs.gov/hifa/default.asp>; *The New Medicaid and SCHIP Waiver Initiatives*, Kaiser Commission on Medicaid and the Uninsured, February, 2002; and *Medicaid Section 1115 Waivers: Current Issues*, Kaiser Commission on Medicaid and the Uninsured, January 2005.

⁵ Address of Mike Leavitt Secretary of Health and Human Services to the World Health Care Congress Tuesday, February 1, 2005.

some people previously covered through a state-funded program) coverage limited to primary care. The plan does not cover hospital services, mental health services, or other specialty care. Since waivers require “federal budget neutrality” and do not make any new federal funds available to states to pay for coverage expansions, Utah financed its new “primary care network” (PCN) plan with savings realized by reducing existing coverage – mostly by charging parents with very low incomes copayments.⁶ The waiver also eliminated the Medicaid guarantee of coverage for those that qualify for the new PCN benefits. With no new federal dollars, state budget constraints, and a waiver that did not include any individual guarantee of coverage, enrollment in the PCN program has been closed for more than a year.⁷

According to the most recent data available, one of every five children served by the Medicaid program (and more than 40 percent of the parents and pregnant women covered in Medicaid) is enrolled under a so-called “optional” eligibility category.⁸ These are generally children with family incomes between the poverty level and twice the poverty level (\$304 to \$608 in gross weekly earnings for a family of three).⁹ Currently, these low-income children are assured a comprehensive Medicaid package, including preventive care and other medically necessary treatment. Research shows that children enrolled in Medicaid are likely to have greater health care needs than the general population and that when they are enrolled in coverage through Medicaid they are generally able to access the care they need.¹⁰ Children with chronic health conditions, like asthma and diabetes, and other special health care needs would be particularly at risk if the federal Medicaid benefit and cost sharing standards that apply to so-called “optional” children were eliminated.

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Changes in Medicaid’s Financing Structure

The Budget documents do not explain the kinds of financing changes the Administration may be seeking as part of the modernization effort, but they do state that Medicaid “modernization” would be accomplished “without creating additional costs for the Federal Government.”¹¹ This suggests that some kind of federal spending cap would

⁶ *Overview of the Utah Waiver*, Kaiser Commission on Medicaid and the Uninsured, July 2004, <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14329>

⁷ The state opens enrollment for limited periods of time when attrition reduces the number of enrollees below the cap. State enrollment information is posted at <http://health.utah.gov/pcn/>.

⁸ Urban Institute estimates based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports.

⁹ These are 2005 poverty levels, *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

¹⁰ E. Howell, *Access to Children’s Mental Health Services Under Medicaid and SCHIP*, Urban Institute, August, 2004; G. Kenney, J. Haley, A. Tebay, *Children’s Insurance Coverage and Services Use Improve*, Urban Institute, July 31, 2003; *Health Coverage for Children*, Kaiser Commission on Medicaid and the Uninsured, June 2004.

¹¹ President’s Budget for Fiscal Year 2006, page 137.

accompany the new flexibility proposals. In the absence of basic coverage standards, a cap would likely be needed to limit the extent that states could use federal dollars to refinance existing health services and thereby increase federal costs. The Administration's models for modernization -- the SCHIP program and section 1115 waivers -- both operate within federal financing caps. The Budget's only direct mention of a financing cap, however, is with respect to the Administration's proposal to cap federal payments to states for Medicaid administrative expenditures. (This proposal is discussed below.)

SCHIP Reauthorization

Authorization for SCHIP expires at the end of 2007, but the Budget proposes to consider program reauthorization a year early, in this budget cycle. It also proposes to level fund SCHIP throughout the next ten years. No new federal funds would be added to the SCHIP program to account for federal SCHIP funding shortfalls projected in 19 states¹², rising health care costs, or the importance of continuing to make progress covering more uninsured children. Two SCHIP policy changes are mentioned in the Budget: a new two-year grant initiative to promote children's outreach in Medicaid and SCHIP (discussed below) and a change in the law to "better target SCHIP funds" to states (no new formula is specified in the Budget). Targeting has been a problem in the SCHIP program, but now that state programs have ramped up, there are many fewer "unspent" dollars in SCHIP to retarget.¹³ The challenge going forward will be to assure that there is an adequate federal funding commitment to the program.

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Specific Policies Proposed to Achieve Spending Targets

A list of proposals for policy changes are included in the Administration's budget, laying out ways the net federal spending reductions proposed could be achieved. Most of the changes would reduce federal Medicaid spending while some would offset federal savings through new investments. Most of the proposals are not new—they have been advanced before, often without any specific legislative proposal materializing to flesh out the proposal. Many are likely to be met with considerable resistance in Congress. This suggests that the particular policies listed in the budget may not be the policies taken up as the process unfolds. The budget reduction target (i.e., the dollar amount of the

¹² Projections by the Center on Budget and Policy Priorities of federal SCHIP funding shortfalls have been developed by the Center on Budget and Policy Priorities based on state-reported projections of SCHIP spending. (For earlier projections and descriptions of the model, see, E Park and M. Broaddhus, *Congress Can Preserve \$1.1 Billion In Expiring Children's Health Insurance Funds And Help Avert SCHIP Cutbacks*, Center on Budget and Policy Priorities, September 28, 2004.)

¹³ Challenges presented by SCHIP's capped financing system are considered in C.Mann and R Rudowitz, *Financing Health Care Coverage: The State Children's Health Insurance Program Experience*, Kaiser Commission on Medicaid and the Uninsured, February 2005.

proposed reduction in federal Medicaid spending), however, will need to be met one way or another if it is included in a reconciliation bill.

A little more than two-thirds of the \$60 billion in gross spending reductions is linked to policy proposals that would change the way the federal government reimburses states for Medicaid expenditures. If adopted, many would further deepen states' difficulties paying for health care. One proposal, for example, would place a cap on the funds the federal government provides to states to administer their programs. Medicaid administrative costs are generally lower than the private sector; a pre-set cap on federal funding for administrative costs could inhibit technology advances, eligibility systems improvements, program integrity activities, and children's outreach initiatives.

The remaining \$20 billion in savings would come from drug pricing proposals and a proposal to tighten up the Medicaid long term care asset transfers rules. Some aspects of these proposals -- part of the drug pricing proposal, for example -- have merit and could help states as well as the federal government constrain Medicaid spending, but resistance to these proposals may be strong.¹⁴

The Administration's Medicaid and SCHIP spending initiatives are also not new. They include \$1 billion in grants for children's outreach (distributed over two years); \$3 billion for the President's "New Freedom" long term care initiatives; \$1.4 billion to expand the vaccine for children program; and the rest (less than \$1 billion) to pay for one-year extensions of provisions in the Medicaid program that would otherwise expire. (These are all ten-year numbers.)

An additional \$10 billion is added to the cost of these initiatives, based on the Administration's projections that the children's outreach grants will result in added enrollment, primarily in Medicaid. The level of new enrollment that would actually be realized from these outreach grants would depend on many factors, including whether states decide to take advantage of the grants and how they may be put to use. Any new enrollment associated with the grants would result in new state costs since states pay, on average, 43 percent of Medicaid costs. Given state fiscal pressures, the prospect of new state costs could discourage states from using these outreach grants; many states have stopped their outreach efforts because of the cost implications associated with new enrollment. (It is not clear whether states would apply for these grants or whether the grants would be offered to non-state entities.) This aspect of the new Medicaid investments, therefore, is somewhat speculative.

Follow the Money

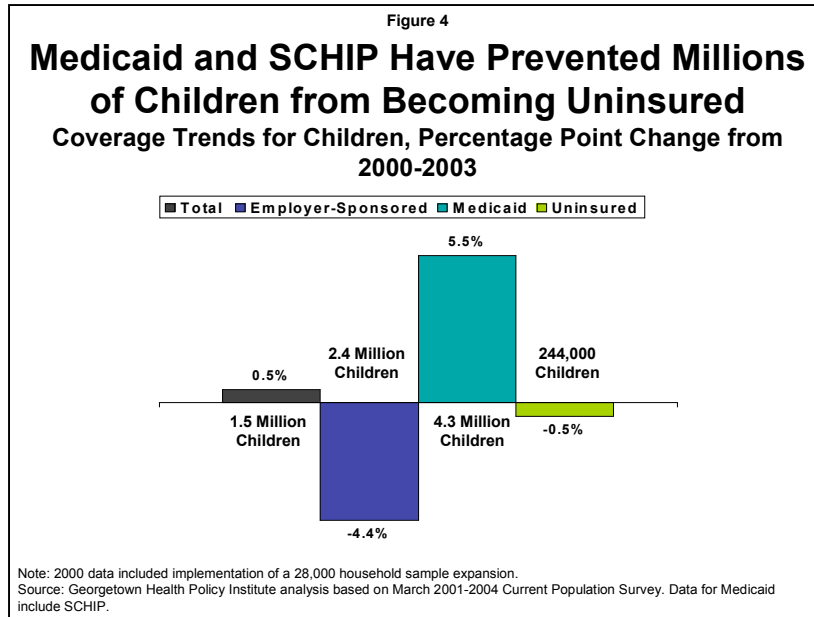
The next step in the budget process is for the House and the Senate to develop their own proposals. This is expected to occur in early March. In the meantime, Secretary Leavitt will testify before various congressional committees, and he may, through those

¹⁴ Recent hearings on Medicaid drug pricing were held by the House Energy and Commerce Committee, Subcommittee on Oversight and Investigation, December 7, 2004; <http://energycommerce.house.gov/108/Hearings/12072004hearing1411/hearing.htm>.

appearances or through other actions, offer more detailed proposals for Medicaid and SCHIP restructuring.

The new Medicaid proposals have been advanced as part of the response to the growing federal deficit, not by a concern over how best, and most efficiently, to maintain and expand coverage for children or other groups of people served by the Medicaid program.

Medicaid is already under considerable fiscal stress, growing more slowly on a per person basis than private health insurance but more quickly than many states can sustain over the longer term. This is particularly true in light of the growing costs associated with serving the elderly. (Medicaid is the single largest source of funding for nursing home care.)



Medicaid and SCHIP have made enormous contributions lowering the number of uninsured children, even during the recent economic downturn (Figure 4). Efforts to reduce federal support for Medicaid and SCHIP will almost certainly reverse this progress. If it is possible to make changes that could achieve savings and improve program operations without damaging coverage or shifting more costs to states, a key question facing policymakers is whether such savings should be reinvested to assure that Medicaid and SCHIP can do their jobs more effectively. Without an ongoing, strong federal financial commitment to these coverage programs, fiscally-strapped states will not be able to maintain the coverage that now exists, never mind continue to make progress in covering more of the almost nine million uninsured children.