

In Sickness and in Health: The Federal Budget Outlook

Judith Solomon
Center on Budget and Policy Priorities
March 15, 2005



Medicaid: Key Features

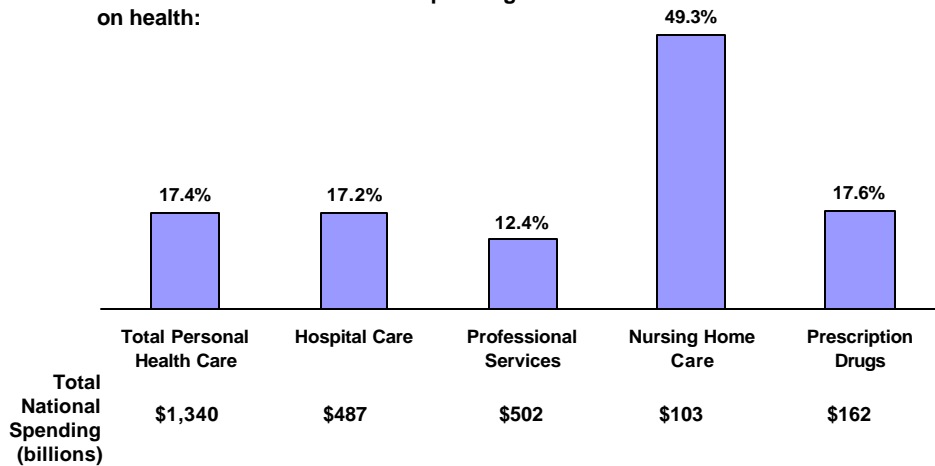
- Federal government and states share all costs
- Minimum eligibility levels
 - States can expand (or contract) above minimums
- Guarantee of coverage (“entitlement”)-no waiting lists
- Minimum benefits (including sufficient “amount, duration and scope”), EPSDT for children
- Affordable coverage (limited cost sharing)
- Coverage must be applied statewide
- States have broad flexibility to design service delivery system and set provider payment rates

Why is Medicaid at the Center of State and Federal Budget Debates?

- Rising health care costs, slow state revenue growth, and an aging population
- States' desire for more flexibility
- Federal deficits and an interest in reducing/capping federal spending

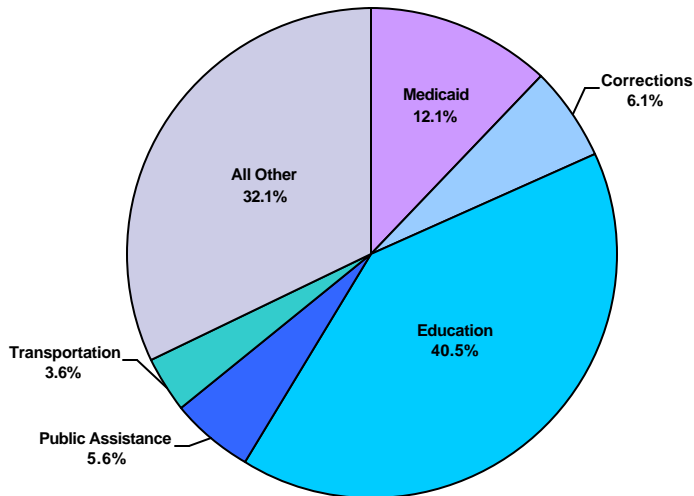
Medicaid's Role in the Health System, 2002

Medicaid as a share of national spending on health:



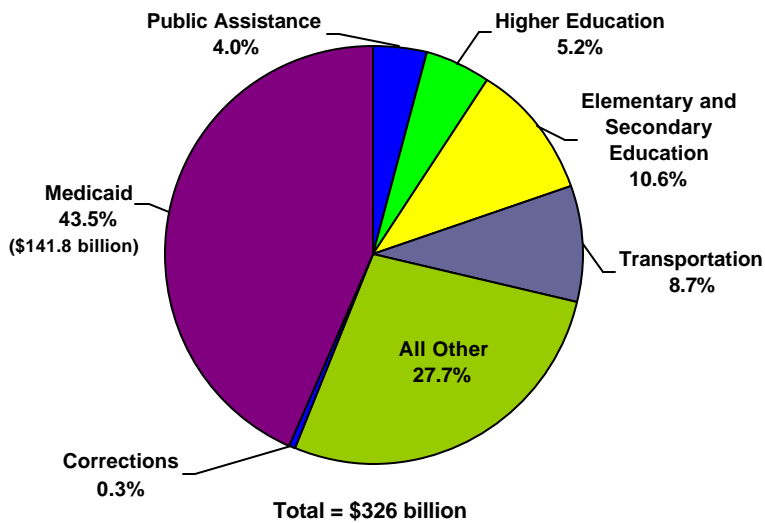
Source: Levit K, et. al. "Health Spending Rebound Continues in 2002." Health Affairs 23, no. 1 (January/February 2004): 147-159.

State Medicaid Spending as a Percent of Total California State Expenditures, 2002



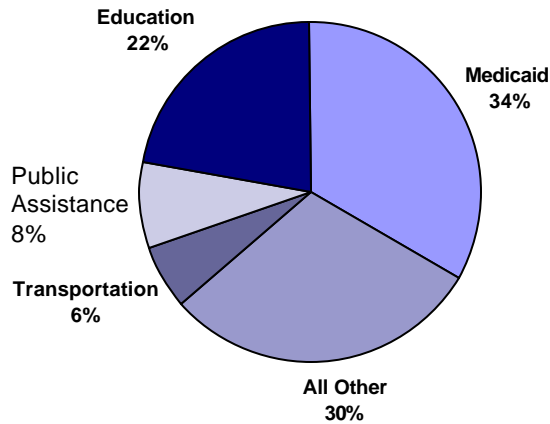
Note: Expenditures include State General Fund spending and Other State Fund spending. These calculations do not consider federal Medicaid payments. Source: National Association of State Budget Officers 2002 State Expenditure Report, Fall 2003.

Medicaid is the Largest Single Source of Federal Support to States, 2003



Source: Georgetown Health Policy Institute analysis based on National Association of State Budget Officers, 2003 State Expenditure Report, Fall 2004.

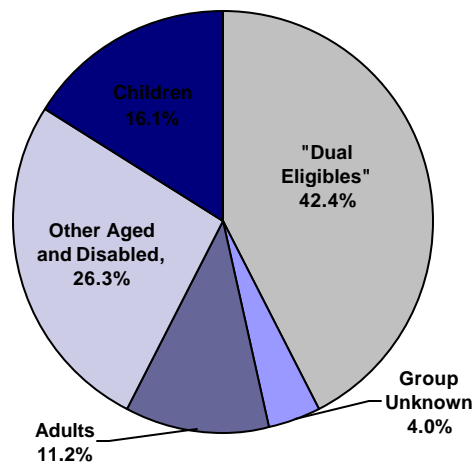
Federal Medicaid Payments as a Share of Total Federal Funds to California, 2002



Source: National Association of State Budget Officers 2002 State Expenditure Report Fall 2003

Medicaid Fills in for Medicare's Gaps

Over 42% of Medicaid Benefit Spending Nationwide -- \$91 billion -- is for Services for Medicare Beneficiaries (2002)



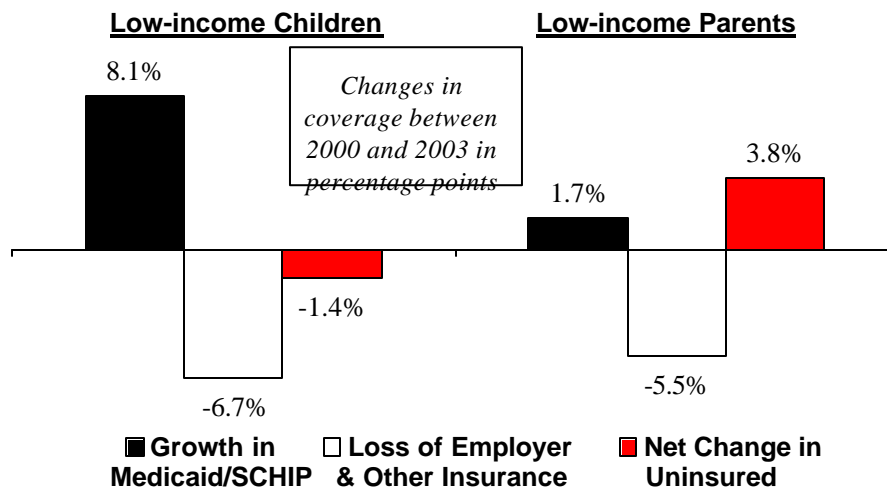
Total Expenditures = \$214.9 billion

Source: Bruen B, Holohan J. "Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government." Kaiser Commission on Medicaid and the Uninsured, November 2003.

Why Are Medicaid Costs Rising ?

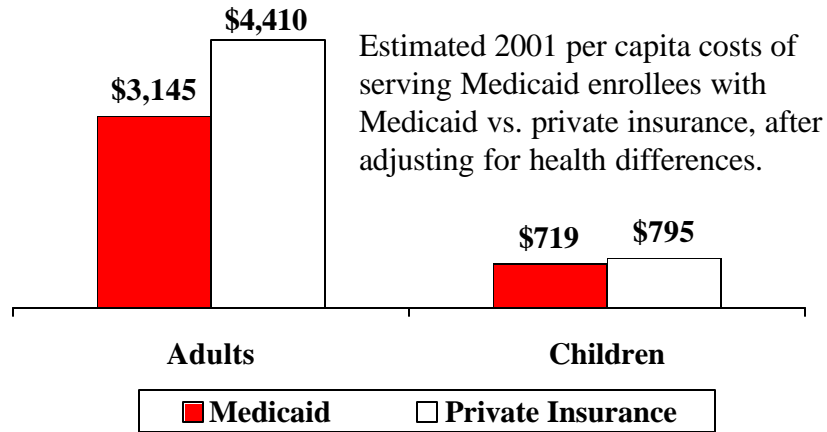
- Rising health care costs (public and private sector)
- Recent enrollment gains due to downturn in the economy
- Cost shift from federal government (Medicare) to states (Medicaid) – “dual eligibles”

Growth in Medicaid/SCHIP Enrollment Helped Offset Loss of Employer-Sponsored and Other Insurance Between 2000 and 2003



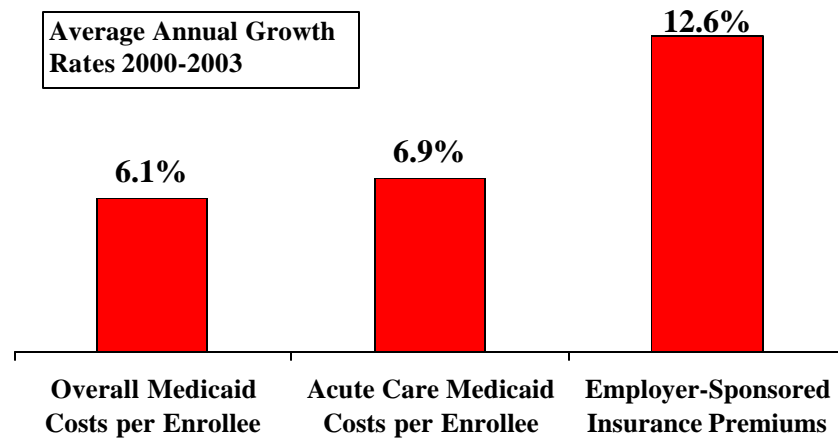
Source: CBPP analyses of the Current Population Survey.

Medicaid Costs Less Than Private Health Insurance: 30% Less for Adults and 10% Less for Children



Source: Hadley and Holahan, *Inquiry*, 2004

Medicaid Expenditures Per Person Have Grown More Slowly Than Private Insurance Costs



Source: Holahan and Ghosh 2005 and Kaiser-HRET Surveys 2004

Budget Debate Timeline

- President's Budget: Released Monday, Feb. 7th
- *Early March*: House and Senate will develop their own "budget blueprint" called a budget resolution
 - This will set targets for overall discretionary funding and cuts in entitlements
- *April*: Budget Resolution completed
- *May-July*: "Reconciliation bill" to achieve cuts required in budget resolution
- *Spring/Summer/Fall*: Appropriations process

President's Budget

- *Deep cuts* in domestic "discretionary" programs
 - Education, local law enforcement, community development, environmental programs, HIV/AIDS treatment funds, medical research (*Many of these programs are grants in aid to states.*)
- *Cuts in Medicaid and food stamps*
- Large cut in grants in aid to states
- Additional "mandatory" cuts and increases in user fees
- New Tax Cuts/Permanent Extensions of Already Enacted Tax Cuts
 - \$130 billion over 5 yrs /\$1.6 trillion over 10 yrs
- *Increases* in defense/homeland security
- NO DEFICIT REDUCTION

Budget Terms

- *Mandatory or Entitlement Programs*
 - Programs whose funding is *not* set each year through the appropriations process. Program costs typically rise and fall based on benefit costs and the number of eligible participants.
 - Examples: Medicare, Medicaid, EITC, farm programs, student loans, SSI, Food Stamps, Veteran's benefits, military/civil service retirement benefits, TANF
- *Discretionary Programs*
 - Programs whose funding is set through the annual appropriations process and includes much of what the government does outside of entitlements.
 - Examples: Education (including No Child Left Behind), FDA, NIH, Head Start, meat inspections

President's Budget *Medicaid*

- Reduces federal funds for Medicaid by a net of \$45 billion over 10 years
 - \$60 billion in cuts
 - \$15 billion in increased spending in Medicaid/SCHIP
- Cuts include:
 - Tightening how states finance the state share of Medicaid expenditures and a cap on administrative costs
 - Change in prescription drug pricing
 - Changes to policies on asset transfers for nursing home patients
- Budget also includes "modernization" proposal with few specifics
 - Strongly suggests that the Administration will support a cap on some Medicaid costs in exchange for state discretion on benefit package/eligibility criteria some beneficiaries, but makes no specific cap proposal.

President's Budget Proposal Reduces Federal Medicaid Costs But Increases State Costs

Proposal	Federal Impact FY 06-15	State Impact FY 06-15
Reduce Expenditures (e.g., lower pharmacy payments, transfers of assets)	-\$20 billion	-\$15 billion
Lower Federal, But Not State Spending (e.g., limit intergovernmental transfers, cap administrative expenses)	-\$ 41 billion	+\$ 41 billion
Extensions & New Initiatives (e.g., child outreach, extend TMA, New Freedom)	+\$15 billion	+\$9 billion
Total Impact	-\$ 45 billion	+\$ 34 billion

Source: Wachino, Schneider and Ku, "Medicaid Budget Proposals Would Shift Costs..." CBPP, Feb. 2005

What is the Difference Between the Current Medicaid Program and a Program with Capped Federal Funding?

Medicaid Program

- ✓ Eligible people are guaranteed coverage
- ✓ Federal funding provided on an "as needed" basis
- ✓ Federal funds paid to states are based on actual costs
- ✓ State matching payments are required

Capped Federal Funding

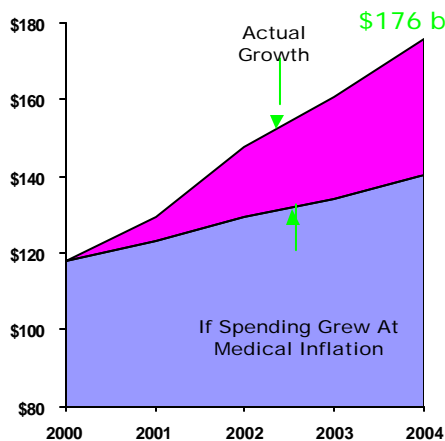
- ✓ No federal guarantee of coverage (for some or all people)
- ✓ Federal funding is capped
- ✓ Federal funds paid to states are based on a pre-set amount or formula
- ✓ State matching payments may or may not be required

CHANGE IN FUNDING LEVELS FOR VARIOUS BLOCK GRANTS SINCE THEIR CREATION

<i>Block Grant</i>	<i>Year Block Grant Started</i>	<i>Percentage Change in Funding, After Adjusting for Inflation</i>
TANF (Welfare reform block grant)	1998	-22% by 2009
SCHIP (State children's health insurance program)	1997	-20% by 2005
Social Services Block Grant	1973	-84%

Why Arbitrary Budget Caps Don't Work For Medicaid

Federal Medicaid Spending
(Billions, Fiscal Years)



➤ Flexible Federal spending and fiscal relief meant, from 2001-2004:

- **\$87 billion** more than if Federal Medicaid spending grew at the rate of medical inflation (\$36 billion in 2004)

Source: CBO Historical Medicaid spending; growth under "historical" is for '95-00; Council of Economic Advisors' Historical Medical Inflation; KFF, Financing the Medicaid Program: The Impact of Federal Fiscal Relief, April 2004.

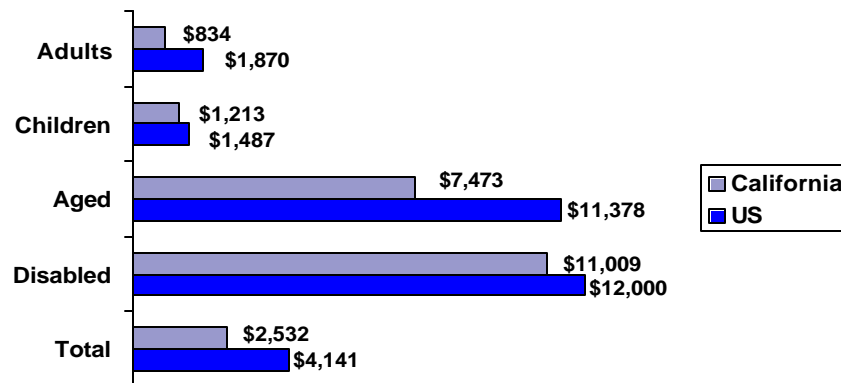
If federal funding is capped...

- How will states meet the growing cost of health care?
- How will states continue efforts to cover the uninsured?
- How will states maintain adequate benefits and ensure that coverage remains affordable to low-income people?
- How will states meet the challenge of an aging population?
- How will states respond to unanticipated public health emergencies?

Risks Capping Federal Funding for Medicaid Would Create

- Shifts risk of higher costs onto states and localities
 - Health care costs are notoriously hard to predict
- Inevitably results in relative “winners and losers” among states
 - No one formula can accommodate every state’s needs
- Impact of “flexibility” that comes with capped funding
- Likely bottom line: States will reduce coverage and benefits

California's Medicaid Expenditures Per Beneficiary, By Category, 2002



Source: CMS MMIS 2002 data for 50 states plus the District of Columbia

Notes: Does not include administrative costs, DSH payments, Medicare payments and certain payment adjustments

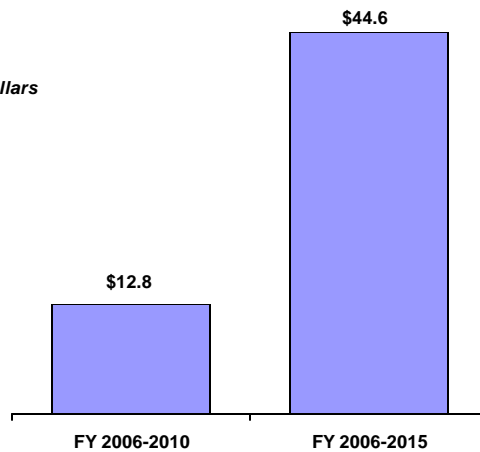
California's expenditures for adults are unusually low because a large number of enrollees only receive family planning services

President's Budget *Medicaid*

- Some proposals may be worth additional consideration, especially prescription drug pricing
- But, savings should be devoted to *helping states* meet Medicaid costs. Any proposal that reduces federal funding must:
 - Maintain coverage, benefits, and access for beneficiaries
 - Generate savings for states as well
 - Reinvest federal savings in the program to help states maintain Medicaid coverage

President's Budget Proposal: Net Reductions in Federal Funds for Medicaid and SCHIP

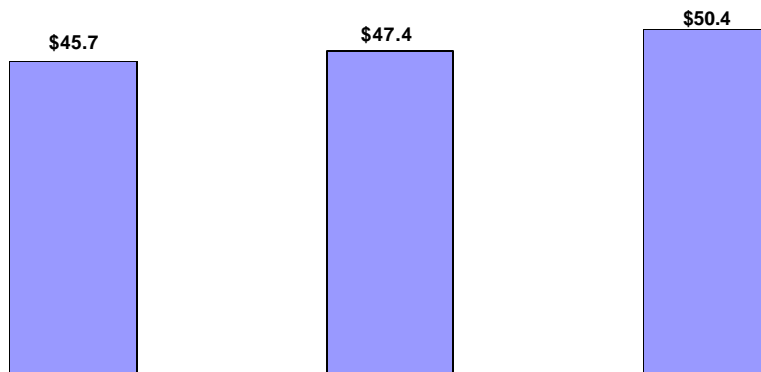
Note: Billions of dollars



Source: "Agency/Category Account Detail Report: President's Policy and Baseline." Office of Management and Budget, February 2005.

The Proposed Net Medicaid Spending Reductions Compared with Total SCHIP Spending

Note: Billions of dollars

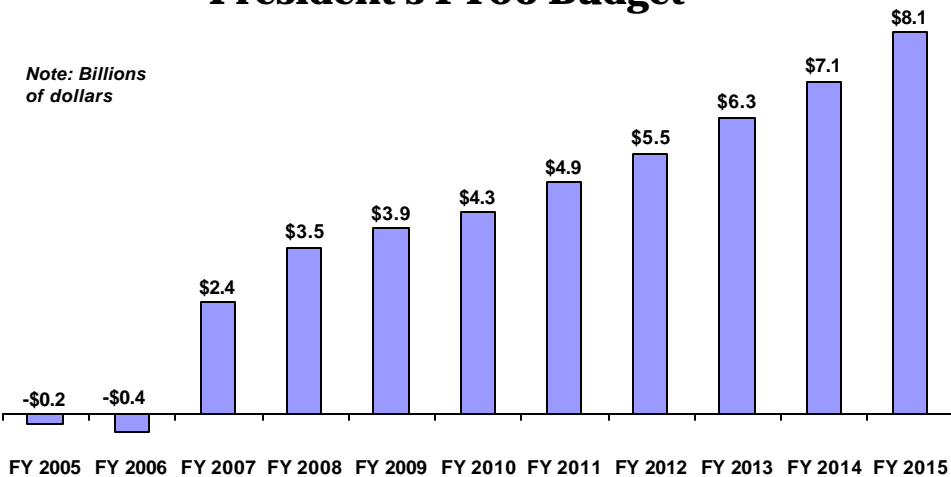


Net 10-Year Medicaid Spending Reduction (FY 2006-2015)	Federal SCHIP Allotments (FY 1998-2007) adjusted for inflation	Proposed Federal SCHIP Allotments (FY 2008-2017)
---	---	---

Source: "Agency/Category Account Detail Report: President's Policy and Baseline." Office of Management and Budget, February 2005; first 10 years of SCHIP spending from Centers for Medicare and Medicaid Services (available online: <http://www.cms.hhs.gov/schip/about-SCHIP.asp>); 2008-2017 SCHIP allotments extend 2008-2010 annual allotment for all 10 years.

Year-by-Year Proposed Reductions in Federal Medicaid Spending, President's FY06 Budget

Note: Billions
of dollars



Source: "Agency/Category Account Detail Report: President's Policy and Baseline." Office of Management and Budget, February 2005.

The Congressional Budget Debate

Congress will start with the President's budget, but *will* make many changes.

Congress may:

- Seek *more deficit reduction*
- Seek *more cuts* in entitlement programs like Medicaid, Food Stamps, EITC, SSI, etc.
- Not accept certain cuts/fees Administration has proposed, such as:
 - Cuts in farm subsidies, prescription drug prices in Medicaid, changes in Medicaid asset transfer rules, cuts in certain discretionary programs such as AMTRAK and veterans' health care
- Consider caps on entitlement programs and discretionary programs that lead to large cuts in the future

Budget Approach Likely to be Unbalanced

- Raising revenues: off the table
- More tax cuts likely to be considered
- 100% of deficit reduction efforts will focus on domestic programs
 - Cuts in entitlements
 - Cuts in domestic discretionary programs
 - Efforts to impose “caps” on entitlement and discretionary programs

The Congressional Budget Debate *Entitlement Cuts Through Reconciliation*

- “Reconciliation” is a process Congress can use to force cuts in entitlement programs
- Step 1: Congress sets multi-year deficit targets in the budget resolution and tells *each congressional committee* with jurisdiction over entitlement programs how much it must cut from its programs
- Step 2: Each congressional committee crafts a bill to make benefit, eligibility and other changes to entitlement programs under its jurisdiction to secure required cuts.
- Step 3: The bills making cuts in entitlement programs are folded into one “reconciliation bill.” The bill is considered under special fast-track procedures. (No filibuster is allowed in the Senate.)

The Congressional Budget Debate ***Entitlement Cap Proposals***

- Entitlement cap proposals generally impose an annual cap on the total cost of most entitlement programs other than Social Security (and perhaps Medicare). Caps would become permanent (or virtually permanent) budget feature.
- The annual caps are set below the projected cost of entitlement programs. Under most proposals, the cap is adjusted each year for inflation and changes in the number eligible for various programs.
 - Largest entitlement programs are health programs, whose costs are growing – in tandem with increases in health care costs across the economy – faster than the general inflation rate.
- Enforcement Mechanisms: Can include automatic cuts
- Defeated by House last year, but expected to re-emerge and to attract increased support in 2005.

The Congressional Budget Debate ***Medicaid Cap Proposals***

- If Congress is trying to make large cuts in Medicaid, lawmakers may find a block grant or cap more attractive than:
 - Specifying which groups should lose Medicaid coverage
 - Specifying cuts to health care providers or drug companies
 - Specifying which health services should be cut
- If Medicaid is weakened, states are likely to cut back on coverage and benefits, and the number of uninsured and under-insured Americans will rise significantly



Key Legislative “Targets” for Medicaid

Assume for the moment that the budget resolution and reconciliation bills will pass...

1. Size of the reconciliation instruction
(Is Medicare going to “contribute” to the reconciliation “deficit reduction” target?)
Essential to minimize Finance Committee’s “reconciliation directive”
2. Any global or entitlement spending cap
Budget resolution and/or separate bill
(Can’t do entitlement cap in reconciliation)