



THE KAISER COMMISSION ON
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Issues Facing Medicaid and CHIP

Cindy Mann, J.D.
Senior Fellow

The Kaiser Commission on Medicaid and the Uninsured

For

“The Health Care Crisis of the Uninsured: What are the Solutions?”

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Thank you for the opportunity to offer testimony on how to sustain and expand health care coverage for low-income children and families, and disabled and elderly people in these challenging times. I am Cindy Mann, Senior Fellow with the Kaiser Commission on Medicaid and the Uninsured. The national bi-partisan Commission serves as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform.

My testimony this morning will highlight some of the progress that has been made in recent years extending coverage to many of the most vulnerable Americans and review the factors that threaten that progress. The downturn in the economy and rising health care costs are squeezing state budgets and prompting many states to propose reductions in coverage under Medicaid and, in some cases, in the State Children's Health Insurance Program. These include changes allowed under federal law, as well as changes that are not permitted under the law except through waivers. The broad and diverse group of people served by Medicaid and CHIP, including low-income children, parents working at low-paying jobs that do not offer health insurance, and elderly and disabled people with significant medical needs, could be affected.

Progress in recent years

Today, more than 38 million Americans are without health insurance. While little gain has been made in reducing the number of uninsured Americans, there has been notable progress in recent years for some groups of people, particularly children. Thanks largely to the impetus provided by the enactment of CHIP in 1997, the number of low-income children without health insurance (those with incomes below 200 percent of the poverty line, or about \$28,000 for a family of three in 2000) has been declining. In just the last year, the number of low-income uninsured children dropped by 2.5 percent, meaning that 1.8 million more low-income children had insurance coverage in 2000 as compared to the year before.

The driving force behind the improvement in coverage rates among low-income children was public program coverage. Employer-based coverage among low-income children rose modestly between 1999 and 2000, but coverage through Medicaid and CHIP grew by an even larger number. **(Figure 1)** States have used CHIP funds to expand eligibility for children in Medicaid and in separate child health program, allowing millions more children to qualify for coverage, and most states have simplified enrollment procedures and conducted new outreach efforts to boost participation among children eligible for Medicaid and CHIP. More than half (52%) of all poor children and nearly a third (30%) of near-poor children (those with incomes between 100% and 200% of the federal poverty line) were covered under Medicaid or CHIP in 2000. Currently, 40 states cover children with incomes at or above 200 percent of the poverty line. **(Figure 2)** As a result, most (84%) of the low-income children who are uninsured are eligible for coverage, either through Medicaid or through separate child health programs. The primary challenge now is to continue to make progress translating the promise of coverage into actual enrollment of children.

The focus on children in low-income working households inevitably turned attention to the parents in those same families. Medicaid eligibility levels for working parents have historically been very low; in half the states a parent with two children with an annual income of \$10,000 is "over income" for Medicaid. Since 1997, however, 12 states have moved forward to extend publicly funded coverage to parents of the children

eligible for Medicaid or CHIP. Eighteen states now cover parents with incomes at or above the poverty line.

People with serious illnesses or disabilities also have enjoyed greater access to coverage in some states in recent years. In 1997 and again in 1999, Congress adopted new Medicaid options allowing states to cover persons with disabilities who are working but unable to secure affordable private coverage. As of December 2001, 26 states had adopted either the new Medicaid buy-in or the so-called Ticket-to-Work option. Uninsured women diagnosed with breast or cervical cancer also have gained coverage under a federal Medicaid option created by Congress in 1999. In just two years time, 36 states have approved state plans extending coverage to women under the Medicaid Breast and Cervical Cancer Act.

Unfortunately, these steps may represent the "high water mark" in coverage expansions for some time to come. New circumstances are not only stalling the progress that has been made towards covering new groups of uninsured people, but are putting the coverage of some of the most vulnerable groups of people at risk.

Rising costs, greater needs and declining state revenues

In recent years, at the same time states were expanding coverage through Medicaid and CHIP, the strong economy prompted employers to make health care benefits available to more people as a way of attracting and retaining workers in a competitive market. Employer-sponsored coverage and Medicaid and CHIP are sensitive to economic conditions, but privately funded and publicly funded coverage generally respond to those conditions in opposite ways. When the economy sours, employer-sponsored coverage declines. Medicaid and, to a lesser extent, CHIP are counter cyclical programs, meaning that when the economy contracts these programs will expand -unless action is taken to slow the normal enrollment growth that would occur as people lose income and their job-based health insurance or stay unemployed for longer periods of time. Using Congressional Budget Office estimates of Medicaid enrollment in 2002, simulations by the Urban Institute predict Medicaid enrollment for children and non-elderly adults would grow by over three million people if unemployment rises from 4.5% to 6.5%, assuming no change in current eligibility policies.

(Figure 3)

Enrollment under CHIP would also be expected to grow as unemployment rises and employer-based coverage declines. Although federal CHIP funding is capped, no state is now facing the pressure of the limit on federal CHIP funding. At least for the short term, CHIP, like Medicaid, will absorb newly eligible children unless states take action to reverse the natural tendency of the program to grow as more children need coverage.

Medicaid and CHIP's ability to do their job, however, is threatened by several, converging factors. The federal government and the states jointly finance both programs, and during economic downturns, states in particular find it difficult to fully finance their

share of program costs. (On average, states pay 43% of the cost of Medicaid and 30% of the cost of CHIP.) The recent fall off in state revenues has been deep and broad. As of January 2002, 40 states reported current year shortfalls of about \$40 billion. **(Figure 4)** Total tax revenues for states declined in each of the last two quarters of calendar year 2001 relative to the year before, something that has not happened for many years. **(Figure 5)** Although revenues are expected to rebound somewhat in fiscal year 2003, this rebound is off a low base. Projections are quite uncertain and depend on a number of factors, some beyond state control. The stimulus bill just signed into law, for example, includes tax changes that will have a negative ripple effect on state revenues. Because state tax policies are tied to federal rules in most states, states are expected to lose over \$14 billion between fiscal years 2002 and 2004 as a result of the changes in the federal depreciation tax rules.

Unlike the federal government, nearly all states operate under legal constraints that generally prevent them from deficit spending. When revenues fall, states can increase taxes or try to generate other new revenues, cut spending, or draw upon rainy day or stabilization funds, if available. While it is too early to know exactly what choices states will make over the coming months, it is clear at this point that regardless of what other steps states may take to address their budget problems, virtually every state will be considering spending cuts of one sort or another.

Medicaid is at the center of state efforts to reduce state spending. There are two basic reasons why Medicaid is so vulnerable at the state level. First, as states look at their spending, Medicaid stands out. On average, Medicaid accounts for 15 percent of state general expenditures, second only to education. (Medicaid also contributes considerable federal resources to states; it is the largest source of federal grants to states, accounting for 44% of all federal grants to states in 1999.) Medicaid's impact on state budgets reflects the fact that Medicaid is a significant player in the health care marketplace and that it provides health care coverage and long-term care services to a broad and diverse group of Americans. Nationwide, Medicaid accounts for 16.7 percent of all personal health care spending and 17 percent of all hospital and prescription drug spending. It pays for nearly half (48 percent) of all nursing home costs and covers over half of the people with AIDS while also covering one out of every five children and financing the delivery costs of more than one-third of all births. Children in foster care rely on Medicaid for their health insurance coverage as do nearly one out of six Medicare beneficiaries in the community who depend on Medicaid to fill the gap left by the Medicare benefit package and help pay Medicare premiums and cost sharing. Medicaid provides prescription drug coverage to 12 percent of all Medicare beneficiaries.

The second reason why attention has gravitated to Medicaid at the state level is that Medicaid costs are rising and consuming a larger share of shrinking state revenues. At the same time that state revenues are in a slump, Medicaid costs are growing by an average of 8 to 9 percent.

Rising Medicaid costs reflect the recent surge in health care costs. In 2000, national health expenditures for prescription drugs rose by more than 17 percent from the

previous year, and hospital and physician services increased 5 and 6 percent, respectively. As a result of rising costs, health insurance premiums for employers jumped by 11 percent between 2000 and 2001. **(Figure 6)**

The same forces that have pushed up the cost of employer-based coverage are affecting Medicaid costs. In order to keep providers in their Medicaid and CHIP coverage plans, states must respond to payment rate increases from health plans and providers, and they must pay for new technology and absorb the escalating cost of prescription drugs. In a survey of state Medicaid directors, 48 states identified prescription drugs as a main reason for the rising Medicaid costs in their states, and for good reason. Between 1997 and 2000, 16 percent of the increase in Medicaid expenditures was due to escalating drug costs. **(Figure 7)** During this time, Medicaid expenditures for prescribed drugs grew more than twice as fast as total Medicaid spending.

While the economic picture is brightening, state recovery often lags behind improvements in the economy. During the last recession, state budget problems continued for one to three years (depending on the state) after the worst of the economic downturn. Many states will continue to face difficult budget shortfalls even after the recession has ended because revenues will not have fully recovered from the downturn and limited funds that can forestall or limit the extent of cuts, like rainy day funds or tobacco settlement funds, already will have been tapped.

Moreover, the cost-related pressures that put the coverage provided approximately 46 million people under Medicaid and CHIP at risk are not likely to abate any time soon. The Congressional Budget Office projects that Medicaid costs will rise by between 8 and 9 percent over the next several years, outpacing projections of state revenue growth. The high cost of providing care to the elderly and disabled beneficiaries served by Medicaid accounts for a large share of the projected growth in Medicaid costs. An analysis of CBO's January 2002 Medicaid baseline shows that most (56%) of the growth in federal Medicaid expenditures between 2001 and 2002 is due to higher spending for elderly and disabled beneficiaries which, in turn, is driven largely (80%) by the increased cost of services.

State responses

As higher costs, declining revenues and a growing need for coverage converge, states have put a range of Medicaid and CHIP cost-savings measures on the table. In exchange for federal financial participation, federal Medicaid law requires states to cover certain groups of individuals and to provide certain services to the people they cover, but more than two-thirds of all spending under Medicaid is optional. **(Figure 8)** Under federal law, states can roll back in whole or in part optional eligibility expansions they have adopted or they can eliminate optional services they have chosen to cover. During previous downturns in the economy states have relied on these options to reduce provider payments rates (states set the rates they pay providers under Medicaid) and also by cutting back on coverage or benefits.

All of these measures will likely be in the mix of state actions taken over the next several months. Some states have implemented or will soon implement cost-saving measures that do not require legislative approval, but many of the changes that are under consideration must be approved by state legislatures. The process for sorting out the fiscal year 2003 budgets is still underway in most states, so it is too early to know which gubernatorial or legislative proposals ultimately will be enacted into law. Some of the most far-reaching measures that have been proposed may not be adopted, and some of the states that are hoping to hold the line and protect Medicaid and CHIP from major programmatic changes may not be successful in doing so. A broad range of proposals is on the table.

- Many states, including Illinois, Florida, Iowa, Minnesota, and Montana are looking to or have already cut payments to nursing homes, hospitals and physicians caring for Medicaid beneficiaries. In light of the low provider rates that have historically been paid in Medicaid, these new rate reductions could raise serious questions about a state's capacity to provide access to medical assistance and long term care and the quality of the care it provides.
- Several states are proposing or have already imposed new cost sharing obligations for individuals and families enrolled in Medicaid and CHIP. Medicaid rules allow states to charge many of the individuals enrolled in Medicaid limited co-payments (children and pregnant women are exempted), and co-payments are permitted in separate CHIP programs subject to federal guidelines. This new round of cost sharing increases affects many of the lowest income people enrolled in Medicaid and CHIP. For example, Texas' CHIP program has changed its rules to require children with family incomes below poverty to pay \$3 for brand name drugs. The co-payment rises to \$20 for a family with income between 151% and 200% of poverty. Families also will be required to pay anywhere from \$25 (for a family with income just over the poverty line) to \$100 (for a family between 186% and 200% of the poverty line) for each hospital admission. Co-payments have been proposed for most adults in Medicaid in Illinois and Oregon.
- Several states are considering proposals to eliminate services covered under Medicaid and CHIP. Utah has dropped dental coverage for children eligible for CHIP, Massachusetts has eliminated dental coverage for adults enrolled in Medicaid, and Idaho and Indiana are considering limiting or eliminating dental coverage for adults in Medicaid. Missouri is considering the Governor's proposal to drop home health services for an estimated 9,700 disabled adults.
- A few states are also considering rolling back eligibility for coverage. In 1998, the last year for which national data are available, close to 12 million Medicaid beneficiaries were "optional" beneficiaries. **(Figure 9)** Idaho has just approved a new cap on the dollars it will spend to cover children in its

CHIP-funded Medicaid expansion, a limit that may require a roll back in the eligibility levels for children at some point during fiscal year 2003 (eligibility is now set at 150% of the federal poverty line, or about \$22,000 for children in a family of three). New Mexico is considering a particularly severe roll back in Medicaid and CHIP coverage for children; for children age six and older, eligibility under its Medicaid program would drop from 235 percent of poverty to 100 percent of poverty. Younger children would remain eligible at a higher, but also reduced, eligibility level. Minnesota is proposing to drop its plans to extend Medicaid coverage to uninsured women diagnosed with breast and cervical cancer, and, according to a report from the National Association of State Medicaid Directors, Georgia may not go forward to implement its buy-in plan for disabled people who need Medicaid coverage while they are working.

- Since CHIP does not create an entitlement or guarantee of coverage for eligible children, states can freeze enrollment in separate CHIP programs if they choose to do so as a result of budget pressures. Last year, North Carolina froze enrollment for close to eight months. Currently, at least two states - Montana and Utah - have stopped enrolling eligible children due to state funding pressures.
- So far, most states have continued to move ahead with actions to simplify the application or renewal process for Medicaid, but a few states have curtailed outreach or dropped measures that had been adopted to promote the enrollment and retention of eligible children. For example, Indiana dropped the Medicaid option to cover children for a 12-month continuous period, and Idaho stopped its outreach contracts with the Girl Scouts and other community-based organizations. If fiscal pressures continue to mount, barriers to enrollment and retention may reappear in many states.

One area of spending that has been subject to scrutiny in virtually every state concerns prescription drugs. Most states are proposing some measure to address pharmacy costs, including requiring generic drugs in most cases (Massachusetts), expanding drug utilization review procedures (Indiana), contracting with pharmacy benefit managers (Indiana), establishing a preferred drug list (Florida, Indiana, Michigan, Oregon), and reducing payments to pharmacies (Arkansas, Colorado, Florida, Maryland, Ohio, Oregon)

As these cost containment proposals unfold, it is important to take account of how federal matching payments affect the overall level of the reduction in coverage that results from an effort to reduce state Medicaid or CHIP spending. State spending cuts under Medicaid and CHIP result in much deeper overall cuts in coverage or services than the reductions in state spending would suggest because state Medicaid and CHIP spending is matched by federal spending. Consider, for illustrative purposes, a state that seeks to reduce state Medicaid spending by \$100 million (the actual amount of savings a state may target will, of course, depend on many factors including the overall size of its

Medicaid program). To achieve \$100 million in state savings, states like Massachusetts, Maryland, New York or New Hampshire with a 50 percent federal Medicaid matching rate would need to reduce services or coverage by \$200 million. States with matching rates hovering around 60 percent, such as Iowa, Kansas, North Carolina, and Wyoming, would need to make total reductions amounting to about \$250 million, while states like Arkansas and New Mexico with matching rates of 73 percent would need to cut services or coverage by a total of \$370 million. The loss of federal matching payments also takes its toll on a state's budget and the state and local economy.

Waivers

Even more fundamental changes in state Medicaid programs may come about through waivers. Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to "waive" most of the key provisions in the federal Medicaid and CHIP law thereby allowing a state to receive federal Medicaid or CHIP funds for coverage that either does not meet federal minimum standards or that goes beyond federally-established options. Waivers are not new to Medicaid; currently, about one-fifth of all Medicaid spending is under section 1115 waiver authority. However, the waivers under consideration at the state and federal level and those that are likely to be submitted in the coming months could move well beyond the expansions in coverage and revisions in benefits and service delivery that have been approved in the past and bring about fundamental changes for Medicaid beneficiaries and the Medicaid program.

This new phase of waiver activity could set precedents because the Department of HHS has signaled its willingness to use waiver authority to allow states to make major changes in their Medicaid programs that otherwise would not be permitted by law, and the downturn in the economy and rising health care costs are pushing some states to restrict coverage, limit benefits and increase cost sharing in order to lower state Medicaid costs. In some cases, states are making these changes to be able to extend coverage to more people without increasing either state or federal spending. At the heart of the current waiver debate is the tension between the federal guarantees to Medicaid beneficiaries in terms of coverage, benefits and affordability and states' interest in gaining broader flexibility to set program rules without compromising federal funding. Underlying this issues are fundamental questions about what constitutes adequate coverage for low-income individuals and families, the extent to which low-income people can contribute toward the cost of the medical services they need, whether it is reasonable to expect states to expand coverage without any new federal investment, and whether the waiver process is the appropriate venue for revisiting Medicaid's minimum standards and coverage options.

Key elements of the Medicaid program, including the entitlement to coverage, cost sharing rules, the benefits and the level and scope of federal financial participation are now being renegotiated through closed-door negotiations between federal and state agency staff.

- As of March 11, 2002, HHS has approved three state waivers under the new “Health Insurance Flexibility and Accountability” (HIFA) initiative. Utah's waiver was approved February 8, 2002, expanding coverage to adults, with income ranging from 0 to 150 percent of the poverty line (\$12,885 for a single individual). The expansion provides primary physician services and prescription drugs but leaves out hospital care, mental health services, substance abuse, and specialty care. After paying an enrollment fee of \$50 per year, newly covered adults must pay \$5 for each doctor visit or prescription. For some, the enrollment fee and copayments for two doctor visits and one prescription could consume more than 10 percent of their monthly income. It is unclear how many of the targeted group will be able to afford these costs. The waiver expansion is financed through reductions in benefits and new cost sharing requirements for parents already eligible for the program, including parents receiving TANF and those who have recently left TANF to work. These very low- income parents will need to pay \$3 for doctor visits, \$2 for prescriptions, and \$100 for inpatient hospital admissions.
- Washington is an example of a state with a pending waiver. It seeks authority to cap enrollment of children and adults now eligible for Medicaid under state options, and to reduce benefits or impose new cost sharing for a broad range of people, including children, parents, disabled people and the elderly. The waiver is unprecedented in that the specific changes the state would adopt are not identified. Within broad parameters, the state seeks the authority to make changes that are not otherwise permitted by federal law as it deems necessary over the course of the five-year waiver based on state fiscal constraints. To date, the Center for Medicare and Medicaid Services (CMS) has sought more specificity, but it is too early to know whether the Secretary will grant Washington the kind of authority over federal Medicaid funds it is seeking.

What could these changes mean?

The individuals and families served by the Medicaid program are among the most needy people in the nation. They include very poor children and their parents as well as families with children of more modest means. Medicaid covers disabled and elderly people so poor that they qualify for Supplemental Security Income (SSI) benefits as well as those with somewhat higher incomes but with very high medical expenses. The Medicaid benefit package and the Medicaid cost sharing rules were intended to ensure that those who cannot afford to purchase medical services or coverage would have access to the care they need. Few people whose incomes are low enough to qualify for Medicaid are able to afford dental services, vision care, or home health services if those services are not provided for through Medicaid. Disabled people and people with chronic illnesses are particularly vulnerable because their need for services is so great and the costs they must bear in the absence of adequate coverage are so high. Research has shown that even relatively modest costs imposed on poor people and people with

significant health care needs can create financial barriers to care and limit access to necessary services.

Beyond the specific reductions in services and coverage that could result from budget cuts and waivers is the potential for the waiver process to accomplish a major restructuring of the program without Congressional input. Over the years, most recently in 1995- 1996, virtually all of the issues that are now being raised through the waiver process were debated in Congress. The question now is whether the beneficiary protections and federal standards that were maintained in federal law will disappear, state by state.

Actions that could help sustain and strengthen coverage

The enactment of CHIP in 1997, new Medicaid options also adopted in 1997 to help states improve participation in Medicaid among children and disabled individuals, and subsequent legislation offering states new Medicaid options, including Ticket to Work and the Breast and Cervical Cancer Act, are evidence of strong bipartisan support for the goal of insuring more low-income children and adults and an appreciation of the role that publicly-funded programs play in accomplishing that important goal. In these challenging times, when revenues are down and costs are up, it is particularly important for the federal government and states to take whatever action they can to strengthen public programs' ability to function effectively.

We have seen, through CHIP and other options that offer enhanced matching funds to states to improve coverage, that the level of federal financing available to states makes a difference. In the unemployment insurance system, when the economy sours and more workers turn to UI for help, the federal government pitches in with more federal financing for extended benefits. A similar approach in the Medicaid program would help states and beneficiaries weather the storm and assure that the program responds appropriately when the need for coverage rises. Other measures might also alleviate some of the fiscal strain that states are experiencing. Since prescription drug spending has been a major driver of health care costs generally and Medicaid costs in particular, measures that would lower drug costs through higher manufacturer rebates and that would relieve states from having to shoulder the considerable cost of providing drug benefits to the poorest Medicare beneficiaries would be particularly important.

In addition, the restrictions on Medicaid funding for immigrants that were adopted in 1996 have caused states and safety net health care providers to pick up much of the cost of covering the care provided to newcomers. Relief in this area would improve state finances and promote coverage of children and adults in the immigrant community.

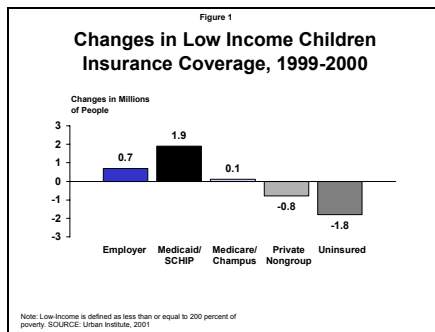
CHIP funding also requires some re-examination. In fiscal year 2002 and 2003, some \$3.2 billion in federal CHIP funds will revert to the Treasury unless the Congress changes the CHIP funding formula. CHIP's success in enrolling children could be affected adversely in the absence of some change in federal financing; the OMB projects that CHIP enrollment of children will drop by 900,000 children between 2003 and 2006

because of the reduction in federal CHIP funds that was built in to the original CHIP funding formula adopted in the Balance Budget Act of 1997. **(Figure 10)**

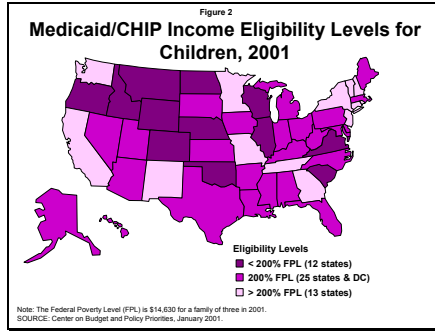
In addition to these fiscal measures, attention will need to be paid to the waiver process. To the extent that states rely on CHIP funds to finance coverage expansions under waivers, CHIP funds that may be needed to cover children could be diverted to other populations. To the extent that waivers rely on savings from reducing coverage for currently enrolled beneficiaries to expand coverage for other groups or seek authority to limit coverage primarily to reduce state spending, waivers could make coverage unaffordable to the most vulnerable people covered under Medicaid and result in truncated benefit packages. Waivers raise difficult and complex questions that will need to be considered carefully, mindful of the particular circumstances of Medicaid beneficiaries.

Given Medicaid's role as our health and long-term care safety net, and CHIP's new role covering children with incomes above traditional Medicaid eligibility levels, it is essential that reasonable attempts to constrain costs not set back the important progress that has been made and compromise the care available to the poorest and sickest people in our nation.

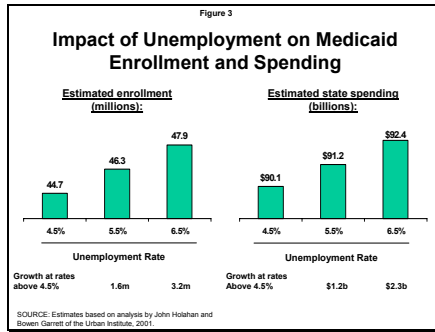
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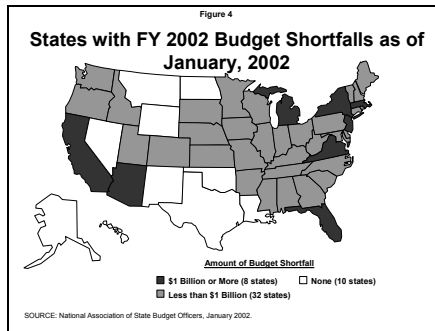
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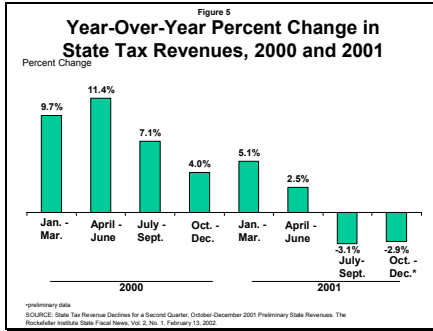
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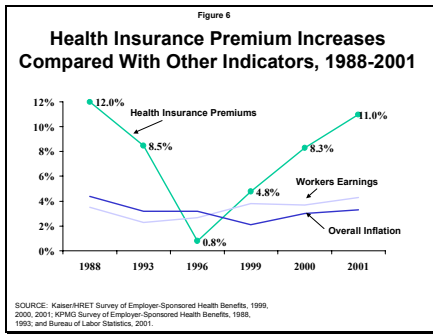
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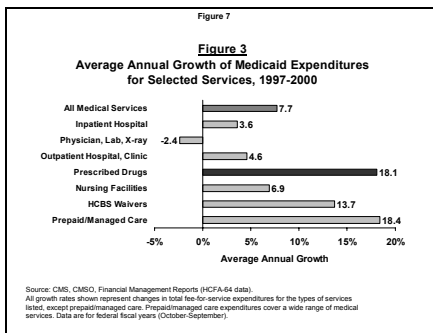
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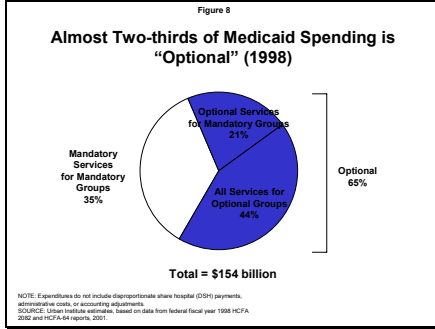
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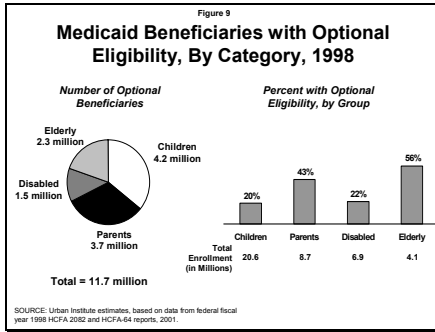
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