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THE BUSH ADMINISTRATION'S FY 2004 BUDGET: Implications and Opportunities for Nevada

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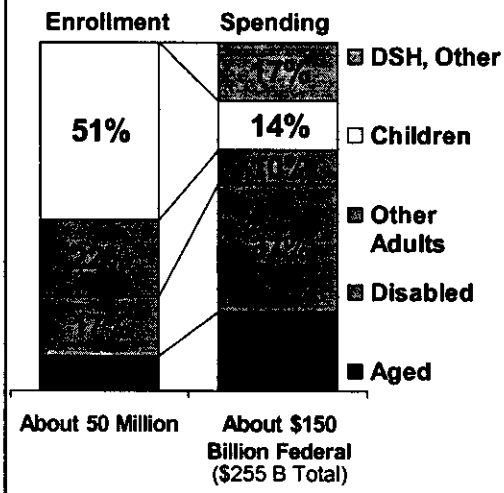
March 10, 2003

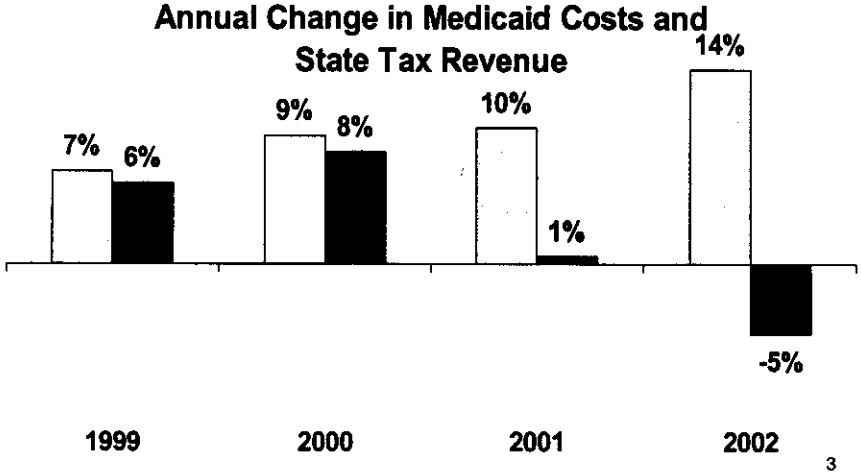
MEDICAID/SCHIP: BACKGROUND



- **Source of Coverage For:**
  - 11% of all Americans
  - 20% of all children
  - About one-third of all births
- **Major Payer Of:**
  - Long-term care accounts for 35% of Medicaid benefit spending -- 48% of nursing home spending nationwide
  - Medicaid pays for 20% of prescription drug costs nationwide

Sources: CBO, March 2002; CPS; CMS, National Health Accounts

Growing Gap Between Medicaid Costs & State Revenue Growth



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•Sources: OMB Historical Budget Tables; Rockefeller Institute (quarterly tax revenue changes averaged for this analysis)

Nevada's Revenue Shortfalls Surpass Growth In Medicaid Costs

- Nevada's budget mirrors national trends
- Nevada faces an estimated $359 million budget deficit for FY 04
  - Represents 19 percent of the state budget
- Medicaid expenditures represent 15.4 percent of the state budgets

Source: Iris Lav and Nicholas Johnson, State Budget Deficits for Fiscal Year 2004 are Huge and Growing. January 23, 2003.

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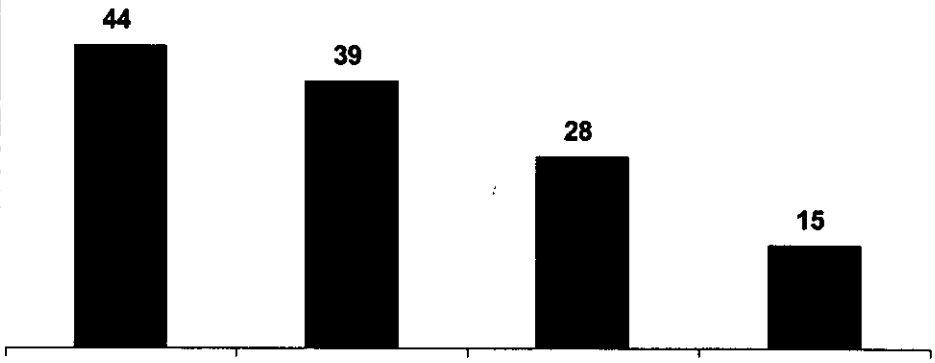
What's Driving Medicaid Costs

State-Reported Top Factors in Medicaid Cost Increases



* Due to economic downturn, carryover from expansions of the late 1990s

Source: KFF, September 2002

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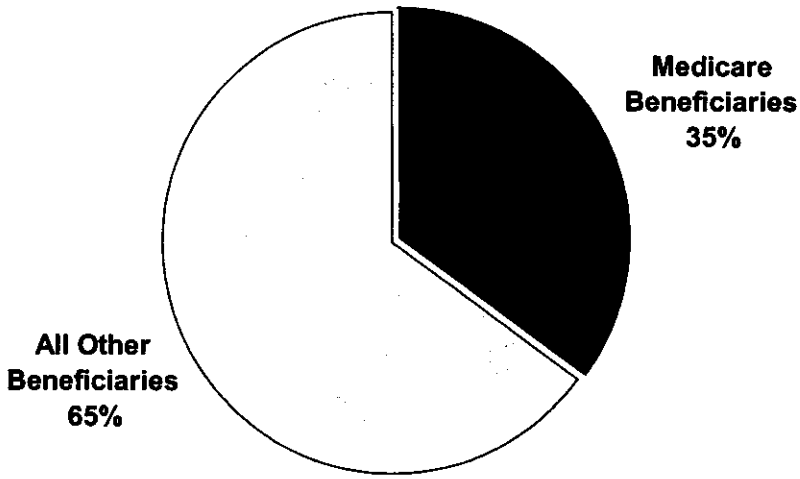
Medicaid Fills Medicare's Gaps

Over One-Third of Medicaid Benefit Costs -- $68 Billion – Covers Services for Medicare Beneficiaries

This Grows Over Time With The Baby Boomers' Retirement



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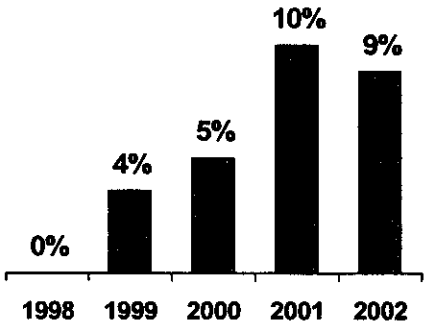
Source: Secretary's Advisory Committee on Regulatory Reform, June 2002. Data for 1999.

State Medicaid Programs Have Lessened Recession Impact

Medicaid Enrollment Growth



- **Medicaid / SCHIP Prevented an Even Greater Increase in the Uninsured**
  - 1.4 million increase in uninsured in 2001 could have been twice as high without Medicaid's enrollment increase
- **Health Care Jobs in States Prevented Worse Unemployment**
  - About 570,000 new health care jobs were created in the last 2 years
  - Without these new health care jobs, the reduction in U.S. employment would have been twice as high
  - "Multiplier" effect: Loss of $1 in Medicaid spending generates additional loss of $1.37 from local economies

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Source: KFF 9/02, 1/02; BLS Jan '01-03; Families USA

Coverage Trends in Nevada: *The Good News*

- 165,000 low-income Nevadans (children, families, seniors, and people with disabilities) are insured through Medicaid
- Significant gains in enrollment of families, children and pregnant women in Nevada's Medicaid program (26% increase from Dec. 00 to Dec 01)
- 25,500 children in Check Up
- 7500 seniors in Nevada's state-only Rx program
- 23, 064 Nevadans receiving mental health services

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Coverage Trends in Nevada: *The Not So Good News*

- On average, one out of six Americans is uninsured (16.5%)
- In Nevada, 18.4% of the non-elderly population is currently uninsured
- 15.8% of Nevada's children lack insurance
- 19.6% of Adults in the state are without coverage

Source: KCMU, Health Insurance Coverage in America: 2001 Data Update. January, 2003

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States are facing significant challenges

- Worst state fiscal crunch since 1930s, according to National Governors Assn.
- Crisis = danger and opportunity:
  - Present levels of public services not sustainable under current revenue structures
  - Either revenue systems must be reformed or services will decline
  - Need for rethinking of fiscal federalism – states cannot be a catch-all for federal funding inequities.

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Things you will hear about Medicaid that should make you skeptical

- No changes are necessary
- Medicaid is broken
- Medicaid is a Cadillac
- Medicaid crowds out other state spending
- Flexibility will save money

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Percent Real Per Capita Growth in State Government Spending, 1990 to 1999

	1990-95	1995-99
Total General Spending	20.5	6.4
Medical Vendor Payments	77.6	0.7
K-12 Education	13.2	15.4
Higher Education	11.0	6.3
All Other	14.0	4.7

Source: Rockefeller Institute analysis of Census and BEA data, in Spectrum, Spring 2002

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Federal Activity

- Legislation to provide state fiscal relief
- Congressional budget resolutions
- Administration's budget proposal
  - SCHIP policy
  - Medicaid drug rebates
  - Transitional Medicaid
  - QI-1s
  - HCBW demonstration

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ADMINISTRATION'S MEDICAID PROPOSAL
Overview

- **Creates State Option to Accept Irrevocable Cap on Federal Medicaid/SCHIP Spending (Block Grant)**
- **States Accepting Federal Funding Cap Get:**
  - **Additional flexibility (undefined, but likely focusing on "optional" categories)**
  - **Temporary fiscal assistance structured as a "loan":**
    + $3.25 billion in FY 2004
    + $12.8 billion from FY 2004-10
    - $12.8 billion federal reduction from FY 2011-13
  - **Federal payment reduction after seven years to offset early-year funding increases**

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Structure of Federal Funding Cap

CURRENT FUNDING:
Feds and State Split Costs
Based on Formula (FMAP)

PROPOSED FUNDING:
Fed. Funding is Pre-Set, Capped
States Pay 'Maintenance of Effort'

- **States' Maintenance of Effort (Required Contribution) Set By:**
  - **Base:** FY 2002 State Medicaid/SCHIP Spending
  - **Growth:** Unnamed factor that includes medical inflation
- **Federal Funding Caps Imposed on 'Optional' Costs Set By:**
  - **Base:** FY 2002 Federal Medicaid/SCHIP Spending
  - **Growth:** Unknown; probably single national factor that projects medical inflation, utilization, enrollment growth
  - **Early-year add on for fiscal relief, out-year cut to recoup fiscal relief**
- **Federal Funding Caps Divided into Acute Care, Long-Term Care**
  - States could transfer up to 10% from one account to the other
  - States could use up to 15% for administration, special hospital payments

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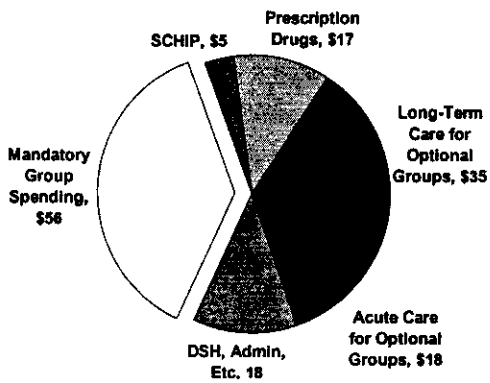
"Optional" Spending Subject to Federal Funding Caps

Federal Medicaid/SCHIP Spending, FY 2004



* Note: Budget documents suggest that all spending would be included in the caps; this chart assumes that only spending for optional enrollees is included. "Core" indicates cost of mandatory enrollees' mandatory services. Based on FY 2004 spending (PB) and splits from KFF 7/01.

"Optional" Populations and Benefits:

- 12-15 Million Beneficiaries
  - Children comprise the largest group of 'optional' enrollees
- 65% of All Spending
- 100% of Prescription Drugs
- 85% of Nursing Home Residents

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PROS

- **Permits More Flexibility in Eligibility & Benefit Design**
  - Allows states to more easily increase cost-sharing, alter benefit packages, and cap enrollment, thus enabling states to reduce costs without dropping coverage altogether
- **Allows States to Expand Without Waivers**
  - Removes barriers to accessing federal funds for certain groups, services
- **Represents a Medicaid Package that Bush Administration Will Definitely Support**

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CONS
Inadequate Federal Fiscal Assistance

- **No Funding for FY 2003**
- **Overall Budget Reduces Federal Funding to States, Even Counting Medicaid / SCHIP State Assistance**
- **Bipartisan Congressional Bills Would Provide All States With More Assistance**
- **No Federal Contribution for Future Expansions**

Source: President's Budget Analytic Perspectives, p. 255; CB PP, CBO

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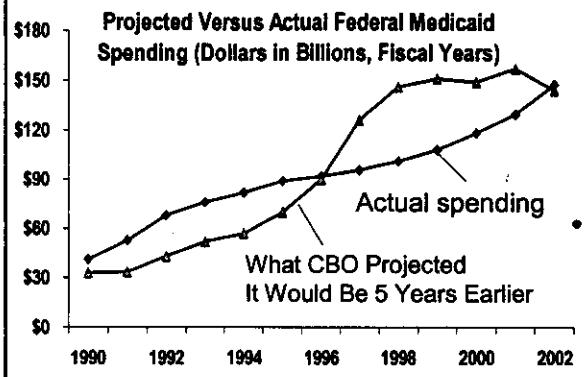
Capping Federal Funding Puts States At Considerable Risk



SOURCE: Congressional Budget Office historical budget tables, previous editions of its Economic and Budget Outlook.

- **Health Spending Is Hard To Predict:**
  - New medical advances
  - Epidemics and increases in chronic disease
  - Changes in practice patterns
- **Medicaid / CHIP Are Even More Challenging**
  - Enrollment affected by economic slowdowns
  - Costs affected by Medicare
  - Pays for care for the oldest, sickest

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2002 State Actions And Base Spending Locked In Forever

- **States Penalized for Efficiency, Cuts in 2002 (Base Year)**
- **States' Federal Caps Grow by the Same Rate – Regardless of State-Specific Factors**
- **Provides No Protection Against Future Unfunded Mandates**
- **States with High Growth in Elderly Populations at Particular Risk**
- **Federal Funding Will Always be at Risk**

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Federal Government Shifts Risk and Burden to States

- **Inadequate, Capped Funding Will Ensure Federal Savings But Force States to Wield Politically-Painful Scalpel to Keep in Budget**
- **Shifts Burden to States Before Any Action Is Taken on Medicare Drug Coverage and Long-Term Care**
- **States May Have to Raise Taxes to Sustain Coverage**
- **Program Cuts and Tax Increases Will Hurt State Economies**

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Key points to consider

- **State fiscal assistance is needed to grow the economy and avert program cuts, tax increases, and job loss**
- **Medicare should assume the costs of health care of its beneficiaries currently shifted to states**
- **Flexibility to manage the program should be provided – independent of financing changes**
- **Capping Federal payments risks:**
  - Hurting long-term economic growth
  - Limiting rather than increasing federal responsibility for Medicare's benefit gaps
  - Ending the shared federal-state risk for cost savings and cost growth in Medicaid

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