State Health Watch

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While SCHIP enrollment declines in 11 states, it increases in 37 others

In This Issue

While the latest reports show enrollment of children in SCHIP declined during the second half of 2003 — the first enrollment decline since the program was enacted in 1997 — the need for it remains great, and the American Academy of Pediatrics (AAP) said more federal funding support for the program is needed.

Officials of the Kaiser Commission on Medicaid and the Uninsured, who released the enrollment statistics, said declines in 11 states and the District of Columbia more than offset moderate increases in 37 other states. The 50-state survey report was prepared by Health Management Associates for the commission and discussed at a July 23 news conference.

"The drop in SCHIP enrollment is a major setback when millions of uninsured children are eligible but not yet enrolled in public coverage programs," said Kaiser Commission executive director Diane Rowland at the briefing. "States have shown that bipartisan initiatives like SCHIP can work to reduce the number of uninsured children, but state budget

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Advocacy groups push for an extension of additional Medicaid federal match

As the June 30, 2004, date for the end to the emergency increase in the federal Medicaid match rate loomed, advocacy groups pushed Congress to extend the higher rate in recognition of the fact states still have significant financial problems and are dependent on the extra federal funds. But Congress' General Accounting Office (GAO) released a report urging caution lest states assume there will always be federal emergency help in tough times and not take steps to stabilize their own budgets.

Fiscal Fitness: How States Cope

The deadline passed without action being taken, although bills have been introduced for some level of extension. During Congress' midsummer recess, it was unclear whether action would be taken before a fall recess scheduled to occur earlier than usual because this is an election year.

An analysis released by the Children's Defense Fund (CDF) said 36 states would each lose at least $100 million in federal

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SCHIP enrollment

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constraints mean even this popular program has not escaped cutbacks."

Health Management Associates principal Vern Smith said a relatively modest SCHIP growth in 2003 (4.2%, compared with 9.7% in 2002) and the enrollment decline in the second half of the year can be attributed in part to state policy changes. In most states, he said, outreach funds were cut in 2002 and not restored in 2003.

Also, four states cut eligibility levels, one imposed an enrollment cap, several increased premiums, and nine states cut or restricted benefits.

Broad political support

On the positive side, reflecting, according to Mr. Smith, broad political support for SCHIP even in difficult fiscal times, one state eliminated an enrollment cap, six states expanded eligibility, and four states added or restored benefits.

As of December 2003, he said, SCHIP provided coverage nationally to 3.93 million children, a drop of roughly 37,000 from June 2003, when enrollment in the program reached 3.96 million.

Despite this nearly 1% decline in national enrollment, the majority of states continued to experience enrollment increases during the period. But the increases were offset by declines of nearly 145,000 spread across 11 states and the District of Columbia, with Texas accounting for 52% of the total decrease over the six-month period.

Ms. Rowland told the news conference that it has become clear over the years of SCHIP's existence "that this expanded coverage . . . has not only helped millions of children to obtain health care coverage, but it's also served a very important role in holding down our nation's growing uninsured population. . . . We see increases in the number of the uninsured largely now coming from the adult population where coverage through public programs is far less available. What we've seen with the advances in coverage of low-income children is that they have offset many of the increases in uninsurance among adults, and therefore, we've held down the number of uninsured through our progress on children."

Striking contrasts

Mr. Smith said the contrast between two groups of states — those that increased enrollment and those where declines took place — was striking.

"In some states, the rate of growth was very impressive," he said. "California continued to have a high rate of growth in this program, growing by around 85,000 over the course of the year. Florida had a large increase over the year. Georgia and Illinois had very significant increases. Double-digit growth occurred in 18 states, so even among the smaller states who don't make this list of states on the basis of the number of children, Hawaii had a 23% increase, Nebraska a 20% increase, North Carolina 17%, and Iowa 16%.

"On the other hand, there's a group of states where enrollment is not growing over this year. When you look at it, there were three states — Texas, Maryland, and New York — that accounted for almost all of the decline, 99.3% of the drop in enrollment among those states that had the drop in enrollment."

Mr. Smith explained that New York went through an eligibility review to make sure those who were enrolled in SCHIP were, in

fact, eligible for the program, and many of those dropped from SCHIP were transferred to Medicaid based on that review. "So there weren't so many children who actually lost coverage in New York," he said.

In discussing the situation in Texas, Anne Dunkelberg of the Center for Public Policy Priorities in Austin, said many of the changes there were in response to a dire budget situation as they entered the 2003 legislative session and cuts to Medicaid and SCHIP were intended to save $1.6 billion for 2004 and 2005.

Changes to SCHIP involved elimination of some benefits and reduction of others, she said. "We completely eliminated dental coverage, vision coverage (including both eyeglasses and exams), as well as hospice care, school nursing, tobacco cessation, and chiropractic," she added.

The state originally had proposed to virtually eliminate mental health care from the package as well, according to Ms. Dunkelberg, but through conversations with Medicaid and SCHIP authorities, came to realize the need to retain those benefits, although they were cut to roughly half of what was in the program in 2003.

Also enacted was a change in the coverage period from 12 months to six months, meaning beneficiaries have to renew twice a year rather than once. And premiums and copayments were increased across the board. Income deductions were eliminated, and an asset test was put in place.

"One of the most distressing things about what's happened with our program," Ms. Dunkelberg said, "is that virtually all of the decline in enrollment of SCHIP children in Texas has been among the lowest income families. Enrollment has always been concentrated in the lower income families, but we have seen an actual, possibly even a slight growth in the higher income folks between 150% and 200% of poverty, where virtually all the decline has been below poverty."

She also pointed out the decline in SCHIP enrollment has not been matched by an increase in Medicaid enrollment, so it appears that at least some people are being completely lost to the system.

Maryland medical program finance director John Folkemer said the drop in Maryland SCHIP enrollment "is really more illusion than reality." He said when combined enrollment in SCHIP and Medicaid is considered, there has been growth each year, although that growth is now easing.

The Maryland legislature in 2003 imposed a $37 per month premium for families with incomes between 185% and 200% of the poverty level and also froze enrollment for those between 200% and 300% of poverty.

According to Mr. Folkemer, the impact of the new premium was immediate but also temporary. There was a drop over a two-month period, but since then, enrollment has been growing, he said, and they have seen 14% of those who dropped come back to the program.

When Maryland did a disenrollment survey, the state found many people who said the premium was not the main reason their child left SCHIP. Other reasons included availability of other insurance or other issues. Some 63% of survey respondents said they thought $37 per month per family was affordable, and more than half said they had obtained other health insurance for their children after dropping out of the program.

Maryland also looked at population characteristics and found that generally the children who seemed to be the healthiest were the ones who tended to drop coverage. The state also found that those who had fewer children were more likely to drop the coverage, not surprising since the premium remains the same no matter how many are covered.

Even with all the changes, the AAP said in a statement that "millions of working families depend on Medicaid and SCHIP for their health care. The government helped give birth to these programs, and its continued support is critical."

AAP officials said they are working at the federal and state level to protect Medicaid and SCHIP from funding cuts and harmful changes. Among its interests are:

1. passing the CHIP Act (S. 2759/H.R. 4936) to stop $1 billion in federal SCHIP funds from reverting to the federal government in September;
2. providing a federal financial incentive to states to enroll eligible children;
3. expanding coverage to include pregnant women and legal immigrant children;
4. simplifying the enrollment process;
5. increasing Medicaid physician payment because inadequate payment has an impact on access to care;

6. improving SCHIP to ensure states have adequate funds to be able to enroll and retain all eligible children.

"If these ideas are adopted, we can reduce the number of uninsured children in this country by 70%," said AAP president Carden Johnston.

"Children need the guaranteed coverage and benefits that Medicaid and SCHIP provide. An investment in the health of children is an investment in the future of our country," he explained.

AAP State Government Affairs Committee chairman Dave Clark, an Albany, NY, pediatrician, tells *State Health Watch* that the combination of state economic problems and an increase in the number of uninsured, especially children, has led to the problem, with many states choosing not to spend the money necessary to draw down federal funds that are available.

"But ultimately, they do pick up the bill because they are paying for kids coming to the emergency room for minor problems and other inappropriate care," Mr. Clark notes. "The academy would like each child to have a medical home so there is consistency and so care is given in the most appropriate setting."

He says it is difficult to tell what states will do because there are so many variables within each state. Some state health departments are finding innovative ways to fund prevention, Mr. Clark points out, and some smaller states are getting money from foundations for some preventive items such as bicycle helmets or improved prenatal care.

[The Kaiser report is available online at www.kff.org. Contact the American Academy of Pediatrics at (202) 347-8600 or go to www.aap.org.] ■

Fiscal Fitness

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Medicaid funding if the additional federal matches were allowed to expire, ranging from $10 million in Wyoming to more than $1 billion in California and New York. And Families USA released a report demonstrating the value Medicaid provides for state economies, using those data to encourage additional spending on Medicaid, not only for the health benefits such spending would provide, but also for the boost to local economies.

"Many states are still caught in a budget squeeze," CDF Health Division director Emil Parker explains. "Two-thirds of states are facing budget gaps for the next fiscal year that total $36 billion. While the increase in the federal match rate helped states avoid some Medicaid cuts, virtually all states still had to reduce Medicaid services last year. Many states are preparing to make even deeper cuts to Medicaid health services for poor and disabled Americans this year, in part because they expect that the federal match rate will drop on June 30, just as the new state fiscal year begins."

Mr. Parker tells *State Health Watch* the pressure on states to balance their budgets often forces them to slash vital public services in areas such as health care that disproportionately affect the lives of lower-income Americans. "Congress must act now to alleviate that pressure by continuing the enhanced federal match rate for another year," he adds. "The extension would protect vulnerable Medicaid beneficiaries — especially children, the elderly, and the disabled — from cuts in coverage and benefits."

CDF said that if the enhanced federal match were not extended, 29 states would each need to put up at least $100 million in additional non-federal funds to draw down the same amount of federal funding at the lower match rate. (**See chart, p. 5.**) As examples, Arizona would have to put up an additional $200 million in state match or lose $410 million in federal Medicaid funds; Georgia would have to put up an additional $270 million or forgo $410 million in federal funding; Iowa would need to find an additional $50 million; and Mississippi would need an extra $80 million in state funding, with $260 million in federal funds at stake in that state.

"Rather than removing this lifeline while states are still fighting to keep their heads above water," the CDF analysis said, "Congress should extend the enhanced match rate for one year, until June 30, 2005. An additional year of fiscal relief through the higher Medicaid match rate would allow the recovery to take hold in some of the states that continue to face budget pressures."

The enhanced match was part of $20 billion in relief Congress approved as part of the Jobs and Growth Tax Reconciliation Act of 2003. The enhanced match rate accounted for some $10 billion of the relief and was authorized from April 1, 2003, to June 30, 2004. Each state received an increase of at least 2.95 percentage points in its federal match rate. Only states that have not reduced Medicaid eligibility (relative to the level as of Sept. 2, 2003) qualified for the enhanced match rate.

CDF said 27 states used the enhanced Medicaid funding to avoid, postpone, or minimize potential Medicaid benefit cuts or freezes.

No state has directly reduced Medicaid eligibility since enactment of the federal fiscal relief, partly because such reductions would have

(Continued on page 6)

Estimated Loss of Federal Funding Due to Expiration of Enhanced FMAP

State	Proposed State Spending, SFY 2005[1,2]	FFY 2005 FMAP[3] (regular)	Federal Matching Funds	FFY 2005[4,5] Enhanced FMAP	Federal Matching Funds at Enhanced FMAP	*Reduction in Federal Matching Funds*	*Additional State Spending Needed at Regular FMAP*
Alabama	$1,142,029,484	70.8	$2,773,052,737	73.8	$3,213,536,817	**$440,000,000**	**$180,000,000**
Alaska	$179,036,400	57.6	$243,020,177	60.5	$274,564,816	**$30,000,000**	**$20,000,000**
Arizona	$1,353,708,200	67.5	$2,805,149,557	70.4	$3,219,630,314	**$410,000,000**	**$200,000,000**
Arkansas	$551,561,101	74.8	$1,632,839,299	77.7	$1,921,807,065	**$290,000,000**	**$100,000,000**
California[6]	$11,354,912,970	50.0	$11,354,912,970	53.0	$12,778,802,163	**$1,420,000,000**	**$1,420,000,000**
Colorado	$976,325,789	50.0	$976,325,789	53.0	$1,098,755,590	**$120,000,000**	**$120,000,000**
Connecticut	$1,377,400,000	50.0	$1,377,400,000	53.0	$1,550,123,911	**$170,000,000**	**$170,000,000**
Delaware	$352,581,700	50.4	$357,981,984	53.3	$402,896,552	**$40,000,000**	**$40,000,000**
D.C.	$420,260,300	70.0	$980,607,366	73.0	$1,133,382,213	**$150,000,000**	**$70,000,000**
Florida	$3,843,831,073	58.9	$5,508,555,966	61.9	$6,231,741,858	**$720,000,000**	**$500,000,000**
Georgia	$1,994,170,609	60.4	$3,046,705,551	63.4	$3,452,894,698	**$410,000,000**	**$270,000,000**
Hawaii	$146,465,528	58.5	$206,208,510	61.4	$233,175,550	**$30,000,000**	**$20,000,000**
Idaho	$295,778,500	70.6	$710,955,673	73.6	$823,322,900	**$110,000,000**	**$50,000,000**
Illinois	$3,660,000,000	50.0	$3,660,000,000	53.0	$4,118,958,555	**$460,000,000**	**$460,000,000**
Indiana	$1,209,600,000	62.8	$2,040,265,664	65.7	$2,320,017,741	**$280,000,000**	**$170,000,000**
Iowa	$390,829,404	63.6	$681,404,901	66.5	$775,825,533	**$90,000,000**	**$50,000,000**
Kansas	$1,161,900,000	61.0	$1,818,094,870	64.0	$2,062,017,869	**$240,000,000**	**$160,000,000**
Kentucky	$779,783,700	69.6	$1,785,294,261	72.6	$2,060,958,377	**$280,000,000**	**$120,000,000**
Louisiana	$1,067,076,365	71.0	$2,617,579,591	74.0	$3,035,485,592	**$420,000,000**	**$170,000,000**
Maine	$630,800,000	64.9	$1,165,839,134	67.8	$1,330,642,786	**$160,000,000**	**$90,000,000**
Maryland	$1,820,674,950	50.0	$1,820,674,950	53.0	$2,048,984,880	**$230,000,000**	**$230,000,000**
Massachusetts	$3,346,500,000	50.0	$3,346,500,000	53.0	$3,766,146,121	**$420,000,000**	**$420,000,000**
Michigan	$1,986,529,900	56.7	$2,602,358,758	59.7	$2,937,936,882	**$340,000,000**	**$260,000,000**
Minnesota	$1,858,558,000	50.0	$1,858,558,000	53.0	$2,091,618,408	**$230,000,000**	**$230,000,000**
Mississippi	$401,700,000	77.1	$1,350,917,801	80.0	$1,609,817,276	**$260,000,000**	**$80,000,000**
Missouri	$1,020,166,041	61.2	$1,605,743,974	64.1	$1,821,522,095	**$220,000,000**	**$140,000,000**
Montana	$67,991,234	71.9	$173,970,453	74.9	$202,351,645	**$30,000,000**	**$10,000,000**
Nebraska	$471,710,638	59.6	$697,047,137	62.6	$789,210,608	**$90,000,000**	**$60,000,000**
Nevada	$327,751,058	55.9	$415,448,620	58.9	$468,727,819	**$50,000,000**	**$40,000,000**
New Hampshire	$276,582,000	50.0	$276,582,000	53.0	$311,264,971	**$30,000,000**	**$30,000,000**
New Jersey	$2,150,000,000	50.0	$2,150,000,000	53.0	$2,419,606,801	**$270,000,000**	**$270,000,000**
New Mexico	$473,638,100	74.3	$1,369,311,705	77.3	$1,608,287,614	**$240,000,000**	**$80,000,000**
New York	$12,810,843,600	50.0	$12,810,843,600	53.0	$14,417,304,328	**$1,610,000,000**	**$1,610,000,000**
North Carolina	$2,975,639,361	63.6	$5,205,937,106	66.6	$5,928,128,924	**$720,000,000**	**$410,000,000**
North Dakota*	$145,912,249	67.5	$302,910,418	70.4	$347,701,584	**$40,000,000**	**$20,000,000**
Ohio	$3,842,466,000	59.7	$5,687,459,595	62.6	$6,439,755,033	**$750,000,000**	**$510,000,000**
Oklahoma	$142,249,000	70.2	$334,776,486	73.1	$387,148,097	**$50,000,000**	**$20,000,000**
Oregon*	$342,000,000	61.1	$537,629,630	64.1	$609,850,821	**$70,000,000**	**$50,000,000**
Pennsylvania	$4,000,751,000	53.8	$4,666,387,215	56.8	$5,258,103,432	**$590,000,000**	**$510,000,000**
Rhode Island	$520,172,254	55.4	$645,610,476	58.3	$728,141,291	**$80,000,000**	**$70,000,000**
South Carolina	$689,514,131	69.9	$1,600,469,698	72.8	$1,849,197,692	**$250,000,000**	**$110,000,000**
South Dakota	$101,884,715	66.0	$198,040,852	69.0	$226,563,754	**$30,000,000**	**$10,000,000**
Tennessee	$2,490,045,500	64.8	$4,585,957,626	67.8	$5,233,420,691	**$650,000,000**	**$350,000,000**
Texas	$3,049,342,640	60.9	$4,743,508,472	63.8	$5,378,912,307	**$640,000,000**	**$410,000,000**
Utah	$287,452,200	72.1	$744,321,669	75.1	$866,510,867	**$120,000,000**	**$50,000,000**
Vermont	$227,222,074	60.1	$342,399,571	63.1	$387,889,117	**$50,000,000**	**$30,000,000**
Virginia	$1,803,510,057	50.0	$1,803,510,057	53.0	$2,029,667,535	**$230,000,000**	**$230,000,000**
Washington	$1,670,051,000	50.0	$1,670,051,000	53.0	$1,879,472,911	**$210,000,000**	**$210,000,000**
West Virginia	$252,167,036	74.7	$742,574,723	77.6	$873,578,660	**$130,000,000**	**$40,000,000**
Wisconsin	$1,684,892,300	58.3	$2,357,555,637	61.3	$2,665,462,206	**$310,000,000**	**$220,000,000**
Wyoming*	$57,882,011	57.9	$79,604,951	60.9	$89,964,760	**$10,000,000**	**$10,000,000**

[1] Estimates may include spending that is not eligible for the enhanced match rate, such as disproportionate share hospital payments, or spending that is ordinarily matched at a higher rate (e.g., family planning, services to Native Americans).

[2] Estimates may not include all state Medicaid funding that is eligible for the enhanced match rate.

[3] Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services; http://www.aspe.hhs.gov/health/fmap05.htm

[4] A state does not qualify for the enhanced match rate if it has cut Medicaid eligibility relative to the level as of September 2, 2003.

[5] We calculated the FFY 2005 enhanced FMAP using the FFY 2005 regular FMAP (from ASPE), rather than extending the FFY 2004 enhanced FMAP.

[6] Includes only state spending that, based on a December 29 estimate summary from the Fiscal Forecasting and Data Management Branch, would be matched at the regular FMAP (50 percent for California) under current law.
According to a California State Senate Budget Committee overview of the governor's proposed budget, "the loss of this enhanced federal financial participation results in an increased need of $655.4 million (General Fund)." This figure suggests that state (non-federal) spending would be lower at the enhanced FMAP and consequently CA would not draw down the full $1.4 billion in additional funds at the higher rate.

* Proposed state funding for SFY 2005 estimated by dividing the amount in the biennial budget evenly over the two years.

FMAP - Federal Medical Assistance Percentage, or federal Medicaid match rate
SFY 2005 - State fiscal year 2005 (generally July 1, 2004 through June 30, 2005)
FFY 2005 - Federal fiscal year 2005 (October 1, 2004 through September 30, 2005)

Source: Children's Defense Fund, Washington, DC.

cost them the higher match rate.

"Due to the expiration of fiscal relief and the growth in total Medicaid spending, states with high federal matching rates may see their state [nonfederal] spending on Medicaid increase by 20% or more from FY 2004 to FY 2005," CDF warned.

Helping local economies

The Families USA contribution to the debate looks at Medicaid as "good medicine for state economies." It said that while Medicaid's role in providing essential health services is clear, "what is less clear is the unique role that Medicaid plays in stimulating state business activity and state economies. Every dollar a state spends on Medicaid pulls new federal dollars into the state — dollars that would not otherwise flow into the state.

"These new dollars pass from one person to another in successive rounds of spending. . . . The magnitude of this multiplier effect varies from state to state, depending on how the dollars are spent initially and on the economic structure of, and conditions in, the state. Because of the multiplier effect, the aggregate impact of Medicaid spending on a state's economy is much greater than the value of services purchased directly by the Medicaid program," according to Families USA.

Congress' approval of the enhanced federal match followed a 2003 Families USA report that demonstrated that each dollar cut from state Medicaid spending would result in significant losses in business activity, jobs, and wages in the states.

For its updated report, intended to influence the debate over extending the enhanced match, Families USA came up with updated multipliers to predict the economic impact of potential state Medicaid spending increases or cuts in FY 2005, as well as the potential stimulus to state economies if Congress extended the fiscal relief formula past June 30, 2004.

Threefold benefit

In FY 2005, according to the analysis, the 50 states will spend an estimated combined total of more than $132 billion on Medicaid, which will generate an almost threefold return in state economic benefit — $367.5 billion in increased state-level output of goods and services from increased business activity. The rate of return per state dollar invested in Medicaid in FY 2005 will range from $6.22 in Mississippi to $1.92 in Delaware.

The five states with the highest rate of return for every state dollar spent on Medicaid in FY 2005 will be:

- Mississippi ($6.22);
- New Mexico ($5.57);
- Arkansas ($5.48);
- Utah ($5.45);
- West Virginia ($4.95).

Of the remaining 45 states, 22 will see a return of at least $3 in increased state business activity for every dollar the state invests in Medicaid.

According to Families USA, estimated FY 2005 spending will generate more than 3.3 billion jobs with wages in excess of $133 billion in the 50 states. These jobs will include Medicaid personnel, other employment in the health care sector, and jobs generated as the Medicaid dollars circulate through different sectors of the economy.

On average, investing $1 million of state funds in Medicaid will generate nearly $1.23 million in new wages. The five states with the largest increase in wages per $1 million on state funds invested in Medicaid will be:

- Mississippi ($2.31 million);
- New Mexico ($2.1 million);
- Arkansas ($2.03 million);
- Utah ($2.02 million);
- Oklahoma ($1.81 million).

If Congress were to extend the higher match for one year, Families USA said, the 50 states taken together would realize an additional $48.4 billion in new business activity, a 13.2% increase. An additional 447,553 jobs would be created and additional wages of $17.5 billion would be generated.

Direct and indirect boosts

Medicaid spending adds to state economies in both direct and indirect ways. Medicaid payments to hospitals, nursing homes, and other health-related businesses have a direct impact, paying for goods and services and supporting jobs in the states.

Those dollars trigger successive rounds of earnings and purchases as they continue to circulate through the economy. They create income and jobs for individuals not directly, or even indirectly, associated with health care.

Thus, for example, health care employees spend part of their salaries on new cars, which adds to the income of auto dealership employees, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. This ripple effect of spending is called the economic multiplier effect.

But Medicaid spending also provides a positive, countercyclical stimulus to a state's economy during a recession or downturn. State Medicaid spending has a greater economic impact than other state spending.

Increases in state government spending on most programs do not have the same multiplier effect as Medicaid spending increases because most state government expenditures simply reallocate spending from one sector of the economy to another. When a state increases its Medicaid spending, however, new federal matching dollars are brought into the state's economy.

Families USA said the magnitude of Medicaid's unique positive impact varies from state to state, based on both the size of the state's federal matching rate and the state's economic conditions.

The organization's analysis developed estimates of the positive impact of Medicaid spending for each state, showing the significant return — in increased business activity, new jobs, and additional wages — states will gain from their investment of dollars in the Medicaid program. State policymakers can use the analyses to estimate the economic impact of both Medicaid increases and cuts, Families USA said.

The report said Medicaid is the only source of financial help for millions of families struggling to pay for nursing home or other long-term care services for a parent or family member.

"Every Medicaid spending decision made by state policy-makers affects people in very real, and often irrevocable, ways," it said. "At the same time, the economic downturn and state budget pressures have forced state policy-makers to confront hard choices about state spending priorities. As state budget options are weighed and balanced, the equation should include recognition of the economic benefit of using state spending on Medicaid to pull in new federal dollars. These new dollars are a powerful stimulus to state economies. The federal dollars that flow into a state to match state Medicaid spending generate new business activity, increase output of goods and services, create new jobs, and increase aggregate state income. In turn, these positive effects increase state revenues, which can then support further state spending," the report said.

Extension would help states

"These positive effects are even greater when the federal government provides additional federal funds for each dollar spent by the states. If Congress extends the temporary federal fiscal relief past the June 30, 2004, expiration, the additional federal funds provided will help states struggling to cope with increasing health care costs as they emerge from the economic crisis that has gripped them for the past three years. Thus, Medicaid spending is good medicine — both for the health of state residents and for ailing state economies," the report pointed out.

The report from the GAO looked at distribution of the $10 billion in unrestricted non-Medicaid temporary fiscal relief payments to states under the Jobs and Growth Tax Relief Reconciliation Act of 2003. Funds were distributed on a per capita basis, with smaller states guaranteed a minimum payment, rather than based on where the greatest need was. But the auditors maintained that because recessions affect states unevenly, targeting unrestricted funds to states most affected and with less available resources could yield better results.

The report said that from an economic perspective, allocation of relief payments among the states was less than optimal. The first payments were distributed to states when the overall economy was beginning to expand as measured by gross domestic product growth. "Consequently," the auditors said, "it is doubtful that these payments were ideally timed to achieve their greatest possible economic stimulus."

But the auditors also noted employment growth lagged behind the economic recovery measured by gross domestic product and state income and sales tax receipts are closely linked to employment levels. From the start of the recovery to receipt of the first fiscal relief payment overall, nonfarm employment continued to decline, and therefore, the fiscal relief payment likely helped resolve ongoing budgetary problems, the report said.

The magnitude and timing of cyclical economic downturns affects states unevenly. Also, due to variations in their underlying fiscal capacities, states differ in their ability to weather economic downturns. "Ideally," the GAO said, "countercyclical fiscal assistance should take into account when and how severely states are affected by a recession and their fiscal capacities. Failure to take these differences into account reduces the effectiveness of such assistance in terms of facilitating economic recovery or in moderating fiscal distress at the state level."

States dependent on feds?

GAO cautioned that even if countercyclical assistance were well timed and targeted, its provision could have adverse consequences for how states manage their finances. Before the recent recession, the auditors noted, many states put away reserves that they were able to draw upon to help meet revenue shortfalls. However, several states put away little or no reserves. "If states now believe that in response to any future recession the federal government will again provide unrestricted fiscal assistance, they could be less apt to fund budgetary reserves," the report declared.

Mr. Parker tells *State Health Watch* the legislation that was introduced would only fund a portion of the enhanced match rate into the future, but still would be a help.

A bill introduced by Sens. Jay Rockefeller (D-WV) and Gordon Smith (R-OR) would provide a 1.26% increase, less than half of the enhanced match percentage increase. Under the bill, $4.8 billion in additional Medicaid match funds would be spent over 15 months. States would be eligible for this increase only if they maintain their Medicaid eligibility levels at least at the level in effect on Sept. 2, 2003. The bill also would reimburse states for the expected $1.2 billion they will have to spend to implement the new Medicare drug bill.

In the House, Mr. Parker says, Reps. Pete King (R-NY) and Sherrod Brown (D-OH) introduced the Medicaid Relief Act of 2004 with a 1.6% match increase worth $6 billion. That bill does not specifically allocate funds for implementation of the Medicare drug bill.

Mr. Parker says there is a "pretty broad coalition" backing extension of an enhanced Medicaid match, but the effort could be hurt by the small number of legislative days remaining in this session of Congress between end of the summer recess and adjournment in time to campaign, especially given that most appropriations bills still needed to be dealt with. "It's not clear if anything is going to happen this year," he continues, "but we want to build momentum for next year."

[Contact the Children's Defense Fund's Emil Parker at (202) 662-3565 and Families USA at (202) 628-3030; or go on-line to www.childrensdefense.org and www.familiesusa.org. Download the GAO report from www.gao.gov.] ■

Public programs crowd out private insurance

Expansions in public health insurance programs are designed to offer a safety net to vulnerable Americans unable to obtain basic health insurance and regular access to medical care.

In recent years, expansions of state Medicaid programs under SCHIP have reduced the number of uninsured children in this country.

But such efforts come with a price. For every expansion that covers those previously uninsured, some people may drop coverage, or not seek coverage they are eligible for to participate in the public program. This phenomenon is known as "crowd-out" — the public assistance program crowding private insurance out of the market.

Policy-makers are concerned about crowd-out because it limits the impact of public coverage expansions. When crowd-out occurs, some of the scarce resources are used to cover people who would have purchased private insurance anyway.

The Robert Wood Johnson Foundation (RWJF) recently asked researchers from the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota in Minneapolis to study the incidence of crowd-out.

The problem, says Gestur Davidson, PhD, senior research associate at SHADAC and the lead author of the RWJF's Synthesis Report on crowd-out, is that no one really knows the best way to measure public program crowd-out, and many efforts at doing so have used different definitions and methods, thus making comparisons difficult. "Quite a few conceptualizations of crowd-out are used in the literature, and then, within individual ways of defining the concept, there can be some differences in the way it gets measured," he notes.

There are three ways that crowd-out can occur:

- **People drop private coverage for public.** A person or family drops private insurance, either employment-based or individually purchased, to enroll.
- **A public program enrollee refuses an offer of private coverage.** Someone with public coverage refuses an employer's offer of insurance, which that person would have accepted in the absence of the public program. This phenomenon is known as "within enrollment" crowd-out.
- **An employer changes coverage offerings in response to the existence of a public program.** An employer changes elements of its insurance offerings, for instance, dropping dependent coverage or increasing employee premiums, resulting in an employee losing or deciding to drop private coverage and enroll in a public health insurance program.

Researchers measure crowd-out by examining changes in public and private coverage after creation or expansion of public programs. It is difficult, however, to determine whether changes in private coverage are directly related to public-program expansions (i.e., wouldn't have occurred if public program expansion did not exist). Estimates are imprecise and vary greatly depending on type of coverage expansion and assumptions, methods, and data used, as well as time period covered by the study.

Researchers often measure crowd-out by observing total change in health insurance coverage occurring over a period of time due to all possible causes including those independent of the expansion of a public program and those related to it. Then, using sophisticated statistical

models, they construct likely scenarios to estimate how much private and public insurance coverage would have changed in the absence of the expansion. Their estimate of crowd-out, presented as a range rather than a single number, is the difference between these model-based estimates of the changes that would have occurred without the program and those that did occur when the program was introduced.

Confusing differences

However, researchers often use different definitions of crowd-out, which contributes to confusion when differing estimates of crowd-out are compared. The most common definition compares the reduction in the share of the population with private coverage to the increase in the share of the population with public coverage due to the expansion. A less restrictive definition focuses on the amount of crowd-out that occurs throughout the public program following an expansion — not just among the newly eligible population. This definition usually produces lower estimates of crowd-out than the previous one. Still other studies compare the decline in private coverage associated with program expansions to the overall decline in private coverage during the period, rather than to the increase in public coverage. This approach tends to also produce lower estimates of crowd-out.

Some estimates focus on the extent to which program expansions reduce the number of uninsured, but this broad definition can, and often does, produce a larger crowd-out estimate than the narrow definition, which focuses on how much private coverage fell as a result of the expansions. Although the variety of definitions and methodologies can be confusing, it's important to understand that different definitions are used to answer different questions, Mr. Davidson says. "The different definitions/conceptualizations, in fact, serve different purposes. And one could say they yield different perspectives on how important crowd-out might actually be."

For example, using one definition, a researcher might determine that a certain number of people enrolled in a newly expanded public assistance program would have access to private insurance. However, that number might include both people enrolling in the new program with less strict requirements and people dropping coverage who are only eligible for the older portion of the plan with stricter enrollment requirements.

Another strategy, he adds, is to express how much of the total public program enrollment growth over the period might have been the result of people who otherwise would have had some private insurance. This method is likely to show less crowd-out than the previous one, but researchers may have specific reasons for using this method. "Policy-makers examining different studies need to be aware of the different ways that crowd is measured and defined so that they don't make inadequate comparisons," Mr. Davidson says.

According to the report, the potential for crowd-out is greater among families with income above the federal poverty level that are more likely than poor families to have private insurance coverage. Crowd-out rates also may be higher if whole families can enroll together in public coverage.

Crowd-out rates likely will change over time, influenced by the economy, labor market conditions, characteristics of private coverage, and attitudes toward public coverage. Examining the raw data also does not tell the entire story behind public program crowd-out, Mr. Davidson adds. "In some cases, people who drop their private insurance to enroll in the public program can substantially lower out-of-pocket costs since their premium contributions — if they are participating in an employer-sponsored program or, if they are directly purchasing private, nongroup insurance coverage — can actually be quite high, relative to their available income. Moreover, many who drop private insurance might gain in the services and benefits covered as well as access to care that they now have with the public program."

This is an important point for policy-makers worried about crowd-out to consider, he notes. Crowd-out can mean important benefits to some with very low incomes. "I'm sure policy-makers do not like to think that those who could afford private insurance are taking some of the available public monies. But it is not clear how much of the crowd-out that public programs are experiencing comes from those who could easily afford good private coverage and don't buy it, but enroll in the public program instead."

Unfortunately, there's no good way to measure the last phenomenon. "Even if we had a single definition of crowd-out and method for measuring, it is technically so very difficult to estimate the amount of crowd-out that might be present," he says. "You cannot look at an individual case that enrolls — knowing what insurance they had just before enrolling — and confidently predict that they would have had private insurance for all or even good parts of their enrollment in the public program if the public program had not existed. People drop private insurance coverage all the time, for all kinds of reasons; enrolling in a less expensive public program is just one of them."

Just because someone drops

private insurance and later enrolls in a public program does not mean the program was the motivating factor. "There is a similar problem with identifying cases of no crowd-out from those who are uninsured and then enroll in the public program," he says. "Some of them might have enrolled in private insurance without the public program's availability. In other words, knowing where someone came from, doesn't tell you where they would have been."

States most commonly have used waiting periods and, more recently, cost-sharing as tools to limit crowd-out in SCHIP, the authors stated. While, no real evidence exists on the effectiveness of waiting periods, logically they are likely to reduce some forms of crowd-out.

To ease problems for families facing serious hardships, some states exempt families from waiting periods if they have high medical expenses, experience involuntary loss of coverage, or purchase coverage in the individual market. Cost sharing also may limit crowd-out by reducing the difference in out-of-pocket costs between public and private coverage, but may discourage the uninsured from enrolling in or using health benefits offered by public programs. Measures to control crowd-out, though hard to evaluate, likely will result in some reductions but may discourage the uninsured, those the program expansions are designed to help, from participating.

"There is an inherent trade-off between targeting efficiency [keeping crowd-out at low levels] and making significant inroads in reducing the number of uninsured," Mr. Davidson says. "You could define a program that could probably achieve very low levels of crowd-out — say, restricting it to only those who are currently unemployed or who have very low cash reserves and no possibility of using a COBRA program. That would yield a very low crowd-out, but also have very low numbers enrolling compared to the total number of uninsured."

Policy-makers should consider the trade-offs between limiting crowd-out and covering the uninsured. Crowd-out limits the impact of public coverage efforts, but lower-income families enrolling in public programs may gain a more stable source of insurance. While anti-crowd-out measures will probably reduce the substitution of public for private coverage, they also may lower participation in public programs and raise equity concerns. They also can be costly and require substantial effort to implement. To achieve meaningful reductions in the number of uninsured, some amount of crowd-out seems inevitable.

"This trade-off will exist, to some extent, no matter what the specific policy approach is to reducing the number of uninsured. It is not restricted to the direct expansions of public programs," Mr. Davidson says. "Programs that would provide refundable tax credits to individuals to purchase private, nongroup coverage would also entail public dollars [in the form of taxes not collected], [thus] displacing private dollars, which is the essence of crowd-out. There is no getting around it," he notes.

(To see the RWJF report, go to www.policysynthesis.org.) ■

This issue of *State Health Watch* brings you news from these states:

Safety net services are replacing private insurance

One unintended consequence of the nation's health care safety net — which includes public hospitals, community health centers, local clinics, and some primary care physicians — is that it is crowding out, or replacing, other insurance options for unmarried childless adults, according to new research by Anthony Lo Sasso, research associate professor at the Institute for Policy Research at Northwestern University.

According to an issue brief published by Academy Health, national program office for the Robert Wood Johnson Foundation Changes in Health Care Financing and Organization initiative, Mr. Lo Sasso and colleagues examined the effect of uncompensated care provided by clinics and hospitals on insurance coverage for two groups — children younger than 14 and unmarried childless adults between 18 and 64. They found that adults with good access to safety net services were less likely to have health insurance.

"Our analysis provides a unified framework bringing together privately offered insurance characteristics, Medicaid eligibility, and characteristics of the local safety net to better explain and understand the health insurance decisions of firms and individuals," Mr. Lo Sasso says. "We hope policy-makers will use the information to craft policies and provide incentives to providers to minimize distortions in the private market, while still providing care to those truly in need." Sometimes, he tells *State Health Watch*, policy-makers are not aware of the unintended consequences on the private sector of decisions made on public programs, and his research is intended to highlight those consequences and urge that they be considered.

In contrast to the situation with adults, the researchers found only weak evidence that children are being crowded out of private or public insurance. Children in need of health care services typically have more insurance options than do adults, according to the researchers, particularly public insurance coverage. And because so many low-income children are eligible for either Medicaid or SCHIP, any safety net providers they see usually are able to get them enrolled in the appropriate program.

Mr. Lo Sasso says the safety net is a patchwork of providers that is supported by a diverse and haphazard array of funding mechanisms. Although their funding may be uncertain from year to year, or political administration to administration, safety net providers generally offer a combination of comprehensive medical care and enabling services such as language translation and transportation targeting the needs of those likely to require safety net care. "The safety net clearly has a purpose and a place in the American health care system," Mr. Lo Sasso explains. "But it's not without risks." He sees it as an informal, uncoordinated system of care whose continued existence is not guaranteed.

Many would argue that it already is stretched thin, he adds. Witness the fact, for instance, that between 1990 and 1998, federally qualified health centers experienced a 60% increase in the number of uninsured patients.

Then, in the 1990s, expansions in Medicaid and creation of SCHIP allowed many individuals who were covered under private insurance to be eligible for public programs. Premiums for public coverage were more affordable than for private insurance and, in some cases, the health care delivered may have been better, leading many to speculate that public coverage was crowding out private. Mr. Lo Sasso notes that because so many low-income people continue to be uninsured despite the expansions in program eligibility, the researchers wanted to identify alternative reasons for why take-up of private insurance is low for these groups.

Federally qualified health centers provide a substantial amount of uncompensated care. Overall uncompensated care they provided increased from some $450 million in 1990 to nearly $700 million in 2000. Hospitals also provide a large amount of uncompensated care annually; hospital uncompensated care increased from just under $19 billion in 1990 to nearly $21 billion in 2000.

Results of their study provided the researchers mixed evidence on the extent of crowd-out. Thus, hospital uncompensated care does not appear to crowd out coverage for children or adults, while health center uncompensated care appears to crowd out private coverage for childless adults.

"Less crowd-out for hospital uncompensated care may be plausible," according to Mr. Lo Sasso, "given that hospital uncompensated care pays for big-ticket items rather than more routine care that individuals may think of when making coverage decisions."

According to the study, low-income people frequently believe they can avoid the need for health insurance by using free clinics or public hospitals. Employer-provided health insurance likely is to have greater costs than Medicaid or safety

net care, both in terms of premiums and out-of-pocket costs such as deductibles or copayments. Therefore, a dependable safety net may result in workers accepting employment without health insurance or declining coverage offered by their employers because of the cost.

Also, for many workers in low-wage jobs, employers don't offer private insurance; and when it is offered, premiums and deductibles often make it cost-prohibitive. Buying coverage in the individual insurance market is similarly expensive.

From employers' perspective, the availability of a safety net may affect their decision to offer — or not offer — coverage. They may come to rely on the safety net as a substitute to provide care for their low-income workers, which saves them money.

Small employers in a particular area may choose not to offer health insurance to workers because of the availability of safety net health care services.

Academy Health said that for many policy-makers, one of the most challenging aspects of safety net care is striking the right balance between promoting appropriate take-up of safety net services and preventing crowd-out of other coverage options.

On one hand, the goal and role of safety net institutions is provide health care access to low-income Americans who cannot afford coverage through other vehicles, the report said.

On the other hand, a rich safety net may induce people with access to other types of insurance to forgo it for a seemingly free program.

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Clip files / Local news from the states

This column features selected short items about state health care policy.

West Virginia could set precedent with drug price controls

WASHINGTON, DC—Struggling with skyrocketing drug costs, West Virginia lawmakers are poised to go head to head with the powerful pharmaceutical industry, potentially becoming the first state to impose price controls on prescription drugs. The move by West Virginia, where residents take five more prescription medications daily than the national average, could set a precedent for other states. Early this year, lawmakers approved legislation creating a council, made up of health officials, pharmacists, drug company officials, and professors, to come up with recommendations for reducing drug prices. The recommendations were due Sept. 15, and lawmakers were expected to go into special session in October to vote on the measures, which could include price controls. The council is looking at a range of options including consolidating the buying power of the state's agencies to buy drugs cheaper in bulk and allowing the state to team with other states to buy drugs. A more aggressive approach would allow the state to negotiate prices on behalf of all residents — similar to what the Department of Veterans Affairs does for veterans. The council also is considering requiring drug companies to disclose the money spent on marketing drugs.

—*Newsday,* Aug. 16, 2004

Governor increases aid payments to Virginia obstetricians

RICHMOND, VA—Virginia Gov. Mark R. Warner has issued an emergency regulation boosting state reimbursements to doctors who provide obstetrical care to indigent women. The governor described the unprecedented action as a first step toward addressing concerns by obstetricians who say they cannot afford to continue delivering babies. According to the Virginia Department of Medical Assistance Services, 775 obstetricians in Virginia offer care to Medicaid patients. The governor, a Democrat, said higher state payments for obstetrical services would begin Sept. 1. Reimbursements for nonsurgical deliveries will rise 34%, from $1,121 to $1,502. Payments for caesareans will increase from $1,270 to $1,702. The new rates represent approximately 80% of the amount private insurance companies pay for their customers in Virginia. The new reimbursement rates have an estimated price tag of $14.4 million annually. The state will pay half, with the federal government picking up the rest of the tab.

—*The Virginian-Pilot,* Aug. 13, 2004