From Families USA
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The Bush Administration's Fiscal Year 2004 Budget: Analysis of Key Health Care Provisions

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President Bush released his budget proposal for fiscal year 2004 (FY 2004) on February 3, 2002. FY 2004 starts on October 1, 2003. This release is the first step in the congressional budget process. Each chamber of Congress must pass its own Budget Resolution and then the two chambers must reconcile any differences between their versions; if they fail to do so, legislation that requires funding will face more onerous procedural rules and, thus, be harder to enact. In particular, bills that would increase spending will require 60 votes in the Senate.

WHAT DID THE BUDGET SAY ABOUT MEDICAID AND SCHIP SPENDING?

Medicaid and SCHIP Restructuring/Fiscal Relief: The President's proposal, "the State Health Care Partnership Allocation," ties fiscal relief for the states to the restructuring of Medicaid and SCHIP: States that accept the fiscal relief ($12.7 billion over 7 years) will have to enter into an agreement with the federal government to block grant Medicaid and SCHIP. This block grant will combine all federal Medicaid and SCHIP funds (including Disproportionate Share Hospital, or DSH, funds) and give them to states in two funding streams: one for acute care and one for long-term care. The amount that a state receives will be based on its FY 2002 expenditures; it will increase annually based on a pre-defined rate. The President's proposal specifies a continued financial commitment on the part of states, often referred to as a "maintenance of effort" (MOE) requirement. Like the federal contribution, the state MOE would also be increased annually, but the rate is designed to grow more slowly than the federal contribution.

Under the new plan, states participating in the "State Health Care Partnership Allotment" program would not be subject to existing federal rules regarding the benefit package, cost-sharing, enrollment, and other features of the program. These federal rules provide essential protection to ensure that Medicaid beneficiaries get the care they need. Although there would be some protection for "mandatory" beneficiaries, states will be able to design individual programs for "optional" beneficiaries. Cost: This proposal is budget-neutral over 10 years.

Extending Expiring Programs:

Transitional Medical Assistance (TMA): President Bush proposes to extend the Transitional Medical Assistance (TMA) program for five years. TMA provides up to 12 months of Medicaid coverage to low-income families who enter the workforce and are no longer eligible for Medicaid. The Bush proposal would also simplify TMA by allowing states to provide 12 months of continuous coverage in TMA and eliminate paperwork requirements for beneficiaries. It would also allow states two ways to opt out of providing Medicaid coverage to TMA beneficiaries: 1) states that provide Medicaid to families with incomes up to 185 percent of poverty could opt out of TMA altogether, or 2) states could offer families vouchers to purchase private insurance instead of enrolling them in Medicaid. Cost: $20 million in FY 2004; $290 million over five years.

Qualified Individual-1Program: President Bush proposes to extend the Qualified Individual-1 (QI-1) program. Through the QI-1 program, Medicaid pays the Medicare Part B premium for Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty. Like the original legislation, QI-1 would continue as a block grant. Cost: $50 million in FY 2003, $115 in FY 2004, $645 million over five years

Extension of expiring SCHIP funds: At the end of FY 2002, approximately $1.2 billion in unspent SCHIP funds reverted to the U.S. Treasury and was lost to the SCHIP program. Bush proposes to extend some $830 million in SCHIP funds that are due to revert to the Treasury at the end of FY 2003. Under the Bush proposal, the funds will be available to the states until the end of FY 2004, but there are no details about how these funds will be distributed among states. What is more, there is nothing in the proposal about retrieving the $1.2 billion that expired in September 2002, extending any future expiring funds, or fixing the "SCHIP Dip." Cost: $35 million in FY 2004; $565 million over 10 years.

Prescription Drugs in Medicaid. The budget proposes "exploring" options to improve Medicaid's rebate-based drug pricing with the goal of generating savings. The only one of these options specifically mentioned is doing away with the "best price" requirement in Medicaid and moving to a system based on Average Manufacturer's Price (AMP), but the budget documents do not provide any details.

There is concern that the current rebate formula does not provide Medicaid with the lowest drug prices. There is also concern that Medicaid's "best price" provision limits other payers' ability to negotiate deep discounts. Changes to Medicaid's drug rebate program are needed and are positive-if the changes provide consistently lower drug prices for all states. While states should have the latitude to negotiate deeper discounts on their own, program changes should not shift the principal burden of price negotiations to the states. The federal government should continue to use its clout to obtain sizable discounts program-wide. Saving: $800 million in FY 2004; $13.2 billion over 10 years.

WHAT DID THE BUDGET SAY ABOUT MEDICARE SPENDING?

Medicare Restructuring and Prescription Drugs: The President's budget includes $400 billion for Medicare "modernization," including some prescription drug coverage. As earlier media accounts have indicated, the President's plan does not propose to make prescription drugs part of the Medicare benefit package; rather, the drug coverage would only be available through HMOs and other private plans. There are no specifics as to what the coverage would look like, if it would be the same in each plan, or if it would require drug coverage in all plans. While the President's budget mentions "modernizing fee-for-service," there is no mention of adding drug coverage to the traditional or fee-for-service component of Medicare. Instead, the budget document makes reference to "a rationalized" cost-sharing system and protection for beneficiaries against catastrophic costs. Further, the President's budget clearly states a desire to restructure Medicare to increase competition within the Medicare+Choice plans in an effort to make Medicare coverage look like private insurance.

Because the Administration has combined Medicare restructuring with efforts to add a drug benefit, it is impossible to separate the money for prescription drug coverage from the money for restructuring. However, even if the entire $400 billion were allocated to prescription drug coverage, this amount is insufficient to meet the growing drug needs of the 41 million Medicare beneficiaries. The Congressional Budget Office's most recent estimate suggests spending for prescription drugs by and on behalf of Medicare beneficiaries would total $1.84 trillion over the same 10-year period. Even in the best of circumstances, the President's budget would cover, at most, 20 percent of the prescription drug cost for all beneficiaries. Costs $400 billion over 10 years.

Medicare's Financial Health: While the Administration acknowledges that the Medicare Part A Health Insurance Trust Fund is financially solvent until at least 2030, the Administration continues to raise questions about the long-term financial health of the Medicare program. Although no specific proposal is presented, the Administration continues to push for a combined measure of financial solvency of the Part A Health Insurance and Part B Supplemental Medical Insurance Trust Funds. Previous versions of the Breaux-Frist Medicare reform bills have included attempts to combine Part A and Part B. Such proposals raise concerns about the Administration's interest in reducing the existing general revenue commitment to Medicare, as defined in law. Cost: None provided.

Other Prescription Drug-Related Proposals: The budget proposes increasing Food and Drug Administration (FDA) funding by $13 million for FY 2004 to speed generic drug reviews. Faster reviews mean greater consumer access to generics. Efforts to speed generic approval are positive; delayed access to generics is costing consumers and other health care payers billions of dollars.

Unfortunately this increase is still not enough; users fees continue to fund a significant portion of the FDA's budget. In FY 2004, the FDA budget includes $250 million in user fees paid under the Prescription Drug User Fee Act. These are largely payments that a company makes to the FDA when applying for new drug approval. In 2004, user fees would account for 18 percent of FDA's total program level budget. Concerns about conflicts of interest arise whenever a regulated industry heavily contributes to the ongoing operations of the regulating agency. Cost: $13 million only for FY 2004.

WHAT DID THE BUDGET SAY ABOUT EXPANDING HEALTH CARE TO THE UNINSURED?

Tax Credits

The budget proposes $89 billion over 10 years in new health tax credits. Individuals with incomes under $15,000 annually could receive a maximum $1,000 tax credit. Families with incomes under $25,000 could receive a maximum $3,000 tax credit (a maximum credit of $1,000 per adult and $500 per child up to a total of $3,000). The tax credit would phase out for individuals with incomes of $30,000 and for families with incomes of $60,000. For people who do not owe taxes, the tax credit would be refundable. The individual tax credits proposed by the Bush Administration are far too small to make health coverage affordable for low-income workers and offer no relief for many recently unemployed workers. They are part of the Administration's desire to gradually replace employer-provided health coverage with individual-based coverage-a system that could jeopardize sick and disabled seniors' ability to secure health coverage. Cost: $89 billion over 10 years.

Families USA is the national organization for health care consumers. It is nonprofit and nonpartisan and advocates for high-quality, affordable health care for all Americans.

1-Under current law, manufacturers must pay a rebate, which is shared between state and federal governments, on the drugs sold to Medicaid beneficiaries. The rebate for brand drugs is the greater of 15.1 percent of the Average Manufacturer's Price (AMP) or the manufacturer's best price for that drug (many sales, such as to the VA and state pharmacy assistance programs, are excluded from the best price calculation). For generics, the rebate is 11 percent. 2-Herman, Donald W., "Medicaid Drug Rebate Program: Perspectives from Medicaid Directors and Consumer Advocates," presented to National Governors Association, Washington, D.C., May 15, 2000.
3-These are the savings estimates that appear in HHS's 2004 budget. The Office of Management and Budget (OMB) estimates that savings from Medicaid rebate reform will be less; the White House's 2004 Budget, using OMB's estimates, shows savings of $384 million in FY04; $6.4 Billion over 10 years.
4-Total user fees are budgeted at $307 million.