THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

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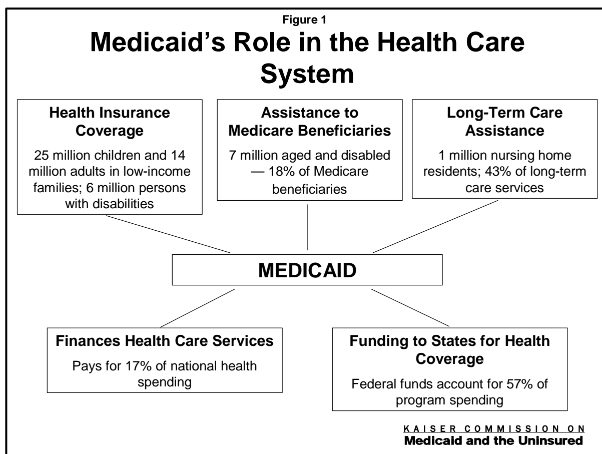
MEDICAID AND BUDGET RECONCILIATION: IMPLICATIONS OF THE CONFERENCE REPORT

In compliance with the budget resolution that passed in April 2005, the House and Senate both passed budget reconciliation bills making changes to Medicaid in November 2005. A compromise reconciliation bill, known as a conference report was voted on in late December; however technical modifications to the Senate bill will require the House to vote on the revised bill. The vote is scheduled for February 1, 2006.

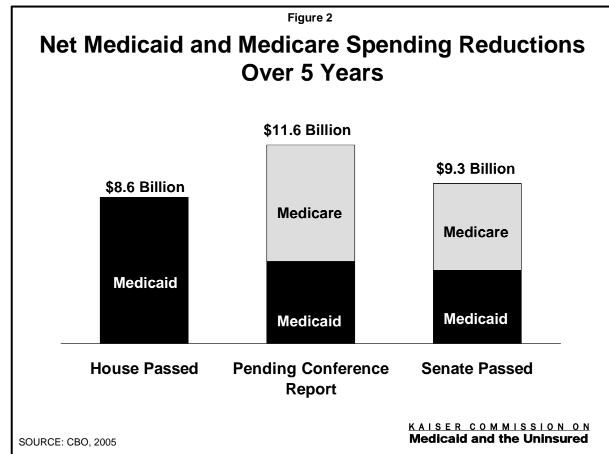
Medicaid is the program that partners with states to provide health coverage and long-term care assistance to over 39 million people in low-income families and 12 million elderly and disabled people, to fill in gaps in Medicare coverage, and to support safety-net providers (Figure 1). This issue brief provides an overview of the federal budget context and then highlights key proposals in the conference report and discusses the implications of the proposed changes.



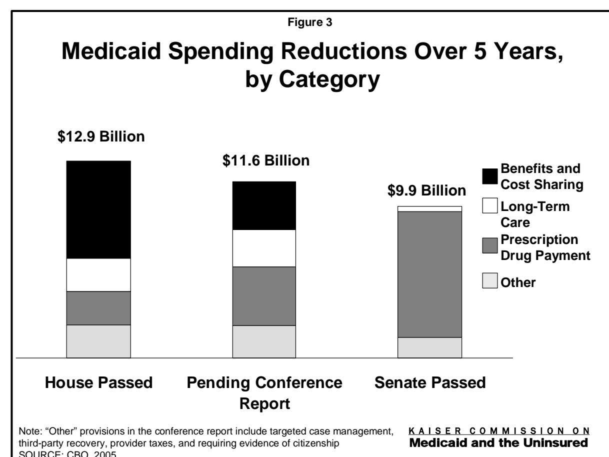
FEDERAL BUDGET CONTEXT

In April, Congress passed a budget resolution that called for $35 billion in federal entitlement cuts over the next five years, with a large share targeted to come from the Medicaid program. According to the Congressional Budget Office (CBO) the conference report would generate $40 billion in mandatory savings over the next five years (higher than the $35 billion included in the Senate bill but lower than the $50 billion included in the House bill).

The provisions in the conference report are expected to reduce federal Medicaid spending by $4.3 billion and Medicare spending by $5 billion over the next five years. While these amounts are closer to those in the Senate package, many of the Medicaid proposals represent significant changes to Medicaid policy, similar to those included in the House bill. The net savings figures reflect a series of savings proposals offset by spending proposals. (Figure 2)



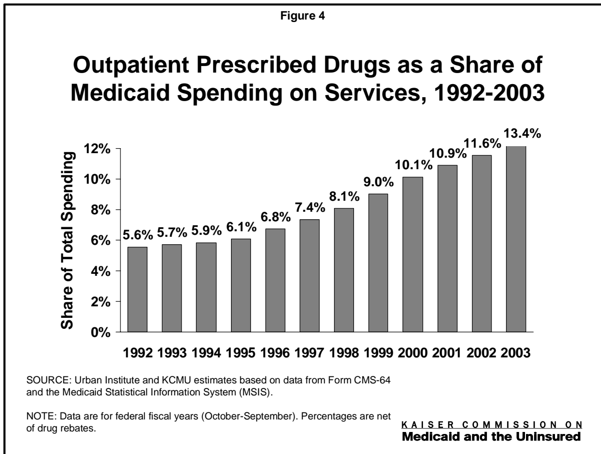
The Senate passed bill generated over 80 percent of the Medicaid savings from proposals related to prescription drug payment policies. Most of the Medicaid savings in the House package were derived from reduced benefits packages and increased cost-sharing amounts, areas where states have asked for additional flexibility. These provisions would shift additional costs to Medicaid beneficiaries. The conference report maintains 80 percent of the savings from the cost sharing provisions in the House passed bill and one-third of the savings from benefit reductions. (Figure 3)



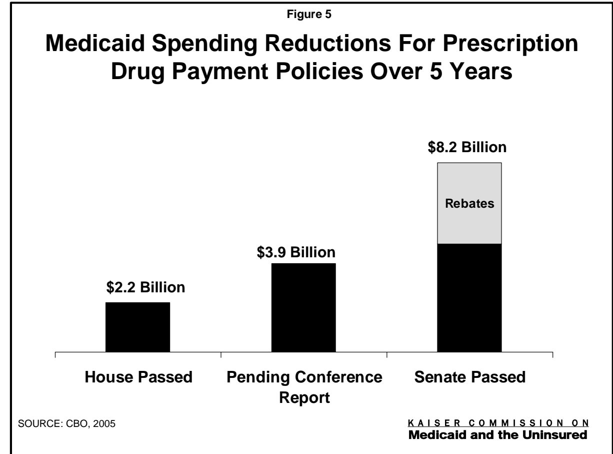
PRESCRIPTION DRUG PAYMENT CHANGES

Current Law. States typically reimburse pharmacies for Medicaid drugs at a discount off average wholesale price (AWP) plus a dispensing fee. Payments for most drugs are subject to federal upper limits (FULs) that are typically 150 percent of the lowest published price for equivalent drugs. In exchange for an open formulary (where Medicaid covers almost all prescription drugs), manufacturers must agree to pay the federal government a rebate on drug sales. The rebates are paid to the states and then shared between the federal and state governments. Some states require manufacturers to pay supplemental rebates.

Prescription drug spending has steadily increased as a share of overall Medicaid spending. (Figure 4) States have been actively trying to contain costs in this area using strategies such as prior authorization, utilization review, and generic substitution. On January 1, 2006, Medicaid drug coverage for individuals eligible for Medicare and Medicaid (duals) was shifted to Medicare as a result of the Medicare Modernization Act, although states are still required to provide payments to the federal government to help finance this coverage.



Conference Report. CBO estimates that the Conference Report would generate $3.9 billion in savings attributable to changes in prescription drug payment policies, accounting for one-third of the Medicaid savings in the bill. The bill would change the way in which state Medicaid programs pay pharmacists for prescriptions from AWP to average manufacturer price (AMP). The bill would then set the FULs at 250 percent of AMP for multiple source drugs. The conference bill does not include provisions like those included in the Senate bill to increase the rebate levels paid by drug manufacturers or to extend rebates to Medicaid managed care plans. Like the House and Senate bills, the conference bill included small savings for provisions related to physician administered drugs authorized generic drugs. (Figure 5)

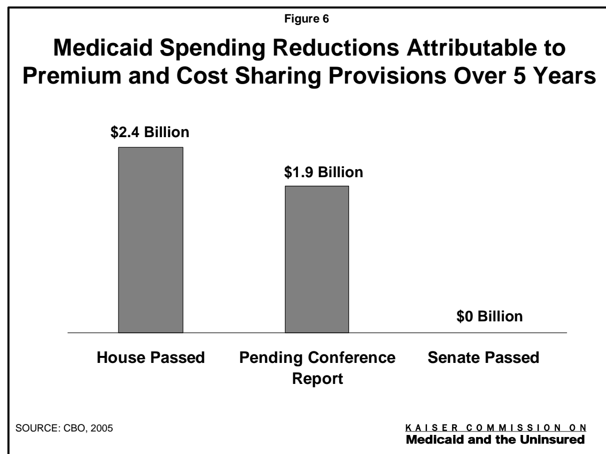


Impact. Studies show that AMP is significantly lower than AWP.[i] Changes from AWP to AMP would decrease Medicaid revenues to pharmacists by reducing payments for drug ingredient costs. The rebate provisions that were in the Senate bill were not included in the conference report. The exclusion of the rebate provisions diminished the impact on drug manufacturers. Drug pricing changes reduce federal and state costs for Medicaid prescription drugs without shifting costs to beneficiaries; however, other provisions in the conference bill to allow states to impose higher copayments for non-preferred drugs and allow pharmacists to deny access to drugs if beneficiaries cannot pay these copayments could change beneficiary access to Medicaid drugs.

PREMIUMS AND COST SHARING CHANGES

Current Law. Current law provides cost sharing protections that reflect the limited incomes and significant health care needs of Medicaid beneficiaries. States cannot charge most Medicaid beneficiaries premiums or enrollment fees. States can impose nominal cost sharing requirements (e.g. up to $3) on certain populations for most services, including prescription drugs. This nominal amount was last amended in the early 1980s. Some groups including children and pregnant women cannot be charged cost sharing. Cost sharing is prohibited for certain services such as emergency room visits, family planning services, and hospice care. Providers generally cannot deny services or drugs to beneficiaries based on unpaid copayments, although beneficiaries remain liable for the amounts.

Conference Report. CBO estimates that the provisions related to premiums and cost sharing in the conference report will reduce federal Medicaid spending by $1.9 billion over the next five years. No such provisions were included in the Senate bill, but the conference report makes slight modifications to the provisions in the House bill. (Figure 6)



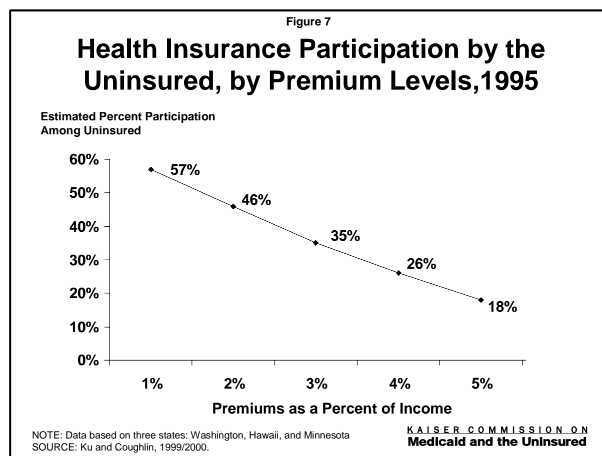
For beneficiaries with family incomes over 150 percent of the federal poverty level (FPL), or $24,135 for a family of 3 in 2005, states may charge unlimited premiums and may charge co-payments up to 20 percent of the cost of medical services. Co-payment limits are set at 10 percent of the cost of the service for beneficiaries with incomes between 100 percent and 150 percent of the FPL. As currently drafted, beneficiaries below poverty have no protections from premiums or cost sharing amounts for services; however, given the protections for beneficiaries at higher incomes, this policy appears to be inconsistent. States are prohibited from imposing premiums and cost sharing for services and preferred drugs on certain groups (including mandatory children and pregnant women). Certain services (including preventive services for children, pregnancy related services and emergency services) are also exempt from cost sharing.

The bill would allow higher co-payments for non-emergency services provided in an emergency room and increased cost sharing for non-preferred drugs. [ii] Unlike other services, no groups of beneficiaries are exempt from cost sharing for non-preferred prescription drugs. Families with incomes below 150 percent of the FPL could be subject to nominal cost sharing for non-preferred drugs and families with incomes over 150 percent of the FPL could face copayments up to 20 percent of the cost of non-preferred drugs. Nominal cost sharing amounts are currently $3 and states could increase that amount by the medical component of the consumer price index.

Total cost sharing and premium amounts cannot exceed five percent of a family's income over a three month period. The bill would also make copayments and premiums "enforceable" meaning that providers or pharmacists could deny services or access to drugs if a beneficiary cannot pay the cost-sharing amount at the point of service or terminate coverage for failure to pay premiums for 60 days.

Impact. CBO estimates that reduced spending would result from decreased enrollment or service utilization subsequent to beneficiary cost sharing increases. Consistent with the CBO estimates, a large body of research, as well as recent experience with Medicaid 1115 waivers, has found that premiums and cost sharing can create barriers to obtaining or maintaining coverage, increase the number of uninsured, reduce use of essential services, and increase financial strains on families who already devote a significant share of their incomes to out-of-pocket medical expenses.[iii]

Studies have shown health insurance participation steadily declines when premiums are imposed, even at low levels of income. When premiums reach 5 percent of income, participation in insurance programs drops to 18 percent. (Figure 7) Those with the lowest incomes are the most likely to disenroll and become uninsured. Providers may face additional administrative burden related to attempts to collect co-pays and a reduction in payment levels if they are unable to do so.

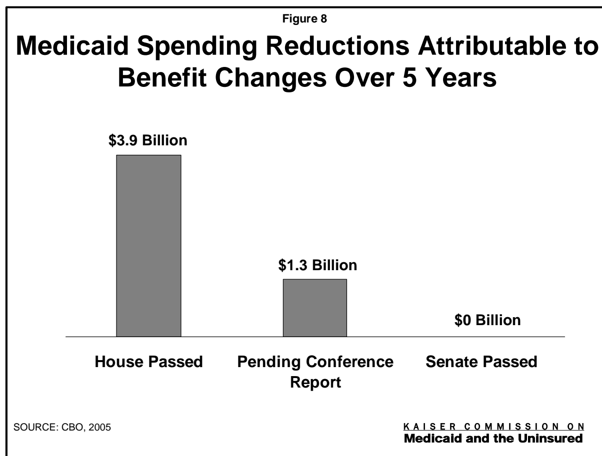


CHANGES TO MEDICAID BENEFITS

Current Law. Medicaid law requires states to provide certain mandatory services. In addition, states may receive federal matching funds for the costs of covering people and services not mandated by federal statute. Some critical services, including prescription drugs, are categorized as

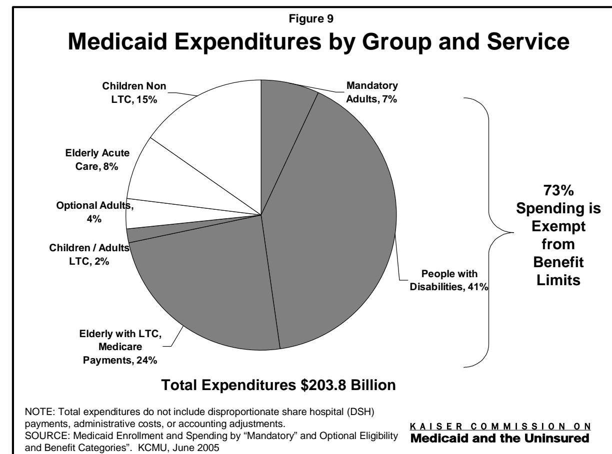
"optional". About 60 percent of all Medicaid expenditures are for optional services. States also have flexibility to determine the amount, duration and scope of the services they provide under the program. For example, states must cover hospital and physician services, but they can set hospital length of stay or annual visit limits. Once a state decides to cover a service, it generally must offer the service to all Medicaid beneficiaries, regardless of eligibility group, in every region of the state. While all groups within a state are generally covered for the same set of benefits, individuals are only covered for medically necessary care.

Conference Report. CBO estimates that the conference report would generate $1.3 billion in federal spending reductions over the next five years (one-third the amount included in the House bill). (Figure 8) The Senate package did not include any provisions to alter the Medicaid benefits package.



The conference report would allow states to replace the existing Medicaid benefits package for children and certain other groups with "benchmark" coverage. Like SCHIP, this "benchmark" coverage would include the standard Blue Cross Blue Shield Plan offered under the Federal Employee Health Benefits Plan, health coverage for state employees, or the health coverage offered by the largest commercial HMO in the state. "Benchmark" coverage would also include any coverage proposed by the state that CMS determines provides "appropriate" coverage for the populations affected. The conference report would require states to provide as "wrap around" benefits coverage for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and would require states to ensure that affected beneficiaries have access to rural health clinic and federally-qualified health center (FQHC) services. Certain groups would be exempt from this "benchmark" coverage, including mandatory pregnant women, mandatory parents, individuals with disabilities or special medical needs, dual eligibles and people with long-term care needs. The limited benefit options are only applicable to non-exempt eligibility groups covered under a state Medicaid plan prior to enactment of this option and are not applicable to new eligibility groups.

Impact. Even more comprehensive benchmark plans often do not cover key Medicaid services such as family planning and many rehabilitative services. EPSDT benefits under Medicaid have created more uniform and comprehensive coverage for children across all states under current law; it is unclear if the EPSDT wrap-around coverage will provide children the same access to a broad range of screening and treatment services. Because so many groups are exempt from the benefit reductions, the savings may assume relatively large spending reductions for non-exempt groups. (Figure 9) Providing more limited benefits could result in unmet health care needs and make it more difficult for beneficiaries to access care as they are likely to have difficulty paying for uncovered services. States cannot use the limited benefits as an option to expand coverage to new groups since the provision is only applicable to groups already covered by the state plan.

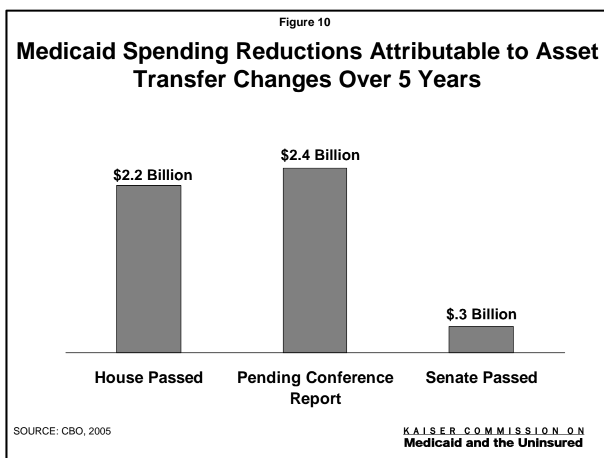


ASSET TRANSFER CHANGES

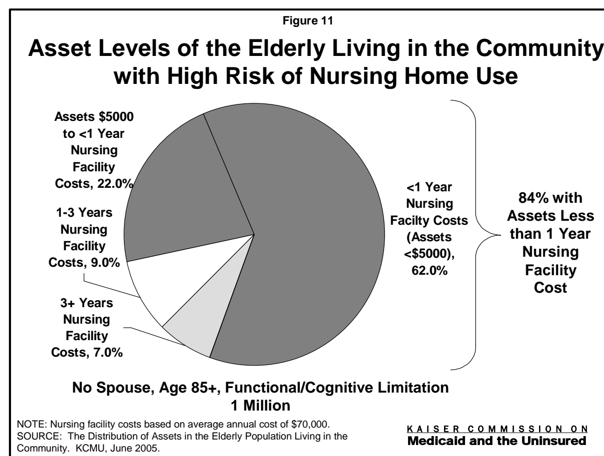
Current Law. Current law requires individuals applying for Medicaid long-term care services to divest all but a minimum level of assets ($2,000) before becoming eligible. Countable assets include savings accounts and investments but exclude the home, one car, life insurance with a face value of less than $1,500, and certain other items. Special rules allow a community spouse of a nursing home resident to keep a portion of the couple's

income and assets to prevent impoverishment. If applicants transfer assets for amounts below fair market value within three years of applying for Medicaid nursing home care, they are subject to a delay in eligibility.

Conference Report. The conference report would achieve $2.4 billion in five year federal savings, slightly higher than the savings in the House bill and seven times larger than savings in the Senate bill. (Figure 10) Spending reductions are largely attributable to increasing penalties on individuals who transfer assets for less than fair market value to qualify for nursing home care, by moving the start of the penalty period from the date of the asset transfer to the date of application for Medicaid and by increasing the look-back period for assessing transfers from three to five years. The bill makes individuals with more than $500,000 in home equity ineligible for Medicaid nursing home benefits, but gives states the option to raise this threshold to $750,000. The bill also counts as assets some previously exempt financial instruments (such as certain annuities, promissory notes and mortgages) a provision included in the Senate bill.



Impact. CBO analysis of the House bill (which is very similar to the conference bill) estimated that 120,000, or 15 percent of new Medicaid nursing home residents, would face a delay in eligibility of about three months due to the penalty and look-back provisions. Small transfers not related to determining eligibility for nursing home care will now be considered in the application process. CBO also estimated that less than one percent of applicants (mostly unmarried) for Medicaid nursing home benefits would be affected by the inclusion of home equity in the eligibility determinations. Most elderly living in the community who are at high risk for nursing home use do not have sufficient assets, excluding home equity, to finance a nursing home stay of one year or more. (Figure 11) Private insurance and Medicare generally do not cover nursing home care, leaving many elderly to turn to Medicaid as the only alternative to help finance this care.



OTHER PROPOSED CHANGES TO REDUCE SPENDING

Documentation Requirements. The conference report includes a provision that would require most new applicants, as well as most current beneficiaries, to document their citizenship (Medicare enrollees and SSI beneficiaries would be exempt). Documentation includes a U.S. Passport or a birth certificate and certain other documents. Many low-income Americans do not have such documentation in their possession and may find their Medicaid coverage delayed or denied altogether while they attempt to obtain it from the state agency that maintains vital records. Research consistently shows that increased documentation requirements are a barrier to Medicaid enrollment.[iv]

Targeted Case Management. The conference report includes a provision to tighten the definition of what qualifies as Medicaid targeted case management (TCM). This proposal specifies that foster-care related activities cannot qualify as TCM for Medicaid reimbursement.

Provider Taxes. The conference report includes other provisions to restrict provider taxes on managed care organizations.

MEDICAID SPENDING PROVISIONS

Katrina Relief. The conference bill appropriates $2 billion for the Secretary of HHS to pay states that have provided care to affected individuals or evacuees under a Section

1115 waiver to pay for the non-federal share for medical care for Medicaid and SCHIP through June 30, 2006. Through January 31, 2006 the funds also cover other health care services approved under 1115 waivers (uncompensated care pools), reasonable administrative costs and other purposes approved by the Secretary. In contrast, the Senate and House bills included temporary funding to provide full federal financing (100 percent FMAP) for Medicaid and SCHIP costs for individuals who were living in designated parts of Louisiana, Mississippi and Alabama in the week prior to Hurricane Katrina without limits and without ties to the 1115 waiver states.

Family Opportunity Act. The conference report includes legislation to allow states the option to permit parents with disabled children to "buy-in" to the Medicaid program for their children if they have family income below 300 percent of the federal poverty level. CBO estimates that this provision would increase federal Medicaid spending by $1.4 billion over the next five years. This provision was in the Senate bill but not included in the House bill.

Health Opportunity Accounts. The conference report includes $64 million in five year funding to establish "Health Opportunity Accounts" (HOAs) in ten states. These Medicaid demonstrations are a fundamental policy change, even though the funding for the demonstrations is not substantial. States would set up accounts for individuals to pay for medical services. However, after the money in the account is exhausted, beneficiaries could face additional cost sharing requirements to meet a deductible before they had access to full Medicaid benefits. These accounts are similar to Health Savings Accounts (HSAs) and proposals that several states have included in their 1115 Waiver plans. These waivers and the HOA demonstrations move away from a defined Medicaid benefit to a defined contribution model.

Home and Community Based Services. The conference report includes additional spending for home and community based services for the elderly and disabled by allowing states to offer these services as an optional benefit instead of requiring a waiver; however, unlike other optional services (such as rehabilitation or personal care), states would be allowed to cap the number of people eligible for the services.

Other Spending Increases. The conference report includes additional spending for "money follows the person" demonstration projects, changes to the Alaska FMAP, increased disproportionate share payments for the District of Columbia, increased funding for the territories and funding to expand the long-term care partnership program to encourage the purchase of private long-term care insurance. The report includes provisions to extend transition Medical Assistance (TMA) through December 31, 2006 and also extends and increases the annual appropriation for the abstinence education block grant program. Provisions to provide relief from formula driven reductions to the federal matching percentage that were included in the Senate bill were not included in the conference report.

OUTLOOK

If signed into law, the reconciliation bill would both reduce federal and state Medicaid spending and also change health care access and coverage for low-income beneficiaries. The level of savings and beneficiary impact largely depends on the number and extent to which states adopt new options included in the bill. While states opposed proposals that would shift costs from the federal government, they supported many of the provisions in the bill including those that would help reduce Medicaid spending for prescription drugs, change asset transfer rules and those that would increase flexibility around benefits and cost sharing.

Changes to prescription drug payment policies would yield program savings for the federal government and the states without negatively impacting beneficiaries. However, if states opt to reduce Medicaid spending by increasing cost-sharing or limiting benefits, more costs would shift to beneficiaries impacting their ability to meet health needs. While there are opportunities to make Medicaid more cost effective, provisions in the conference report should be assessed not just in terms of the federal budget savings they produce but also in terms of their impact on low income beneficiaries and the adequacy of health coverage.

[i] Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price. Office of Inspector General, DHHS. June 2005.
[ii] A provision that limited physician and hospital liability for imposing cost sharing in the emergency room for non-emergency services absent a finding of gross negligence was struck from the Senate bill because it was determined to be not germane to the bill. This change (in addition to other minor changes) will require the House the vote on the bill again.
[iii] Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations. KCMU, March 2003.
[iv] In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families. KCMU, October 2005.

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