THE KAISER COMMISSION ON
Medicaid and the Uninsured

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MEDICAID AND BUDGET RECONCILIATION: OPTIONS AND IMPLICATIONS OF SAVINGS PROPOSALS

During the fall of 2005, Congress is planning to consider a variety of Medicaid savings proposals to meet the federal budget requirements to cut up to $10 billion from the program over the next five years. These plans were delayed as Congress turned their focus to legislation that would provide emergency relief and assistance to individuals and states affected by Hurricane Katrina.

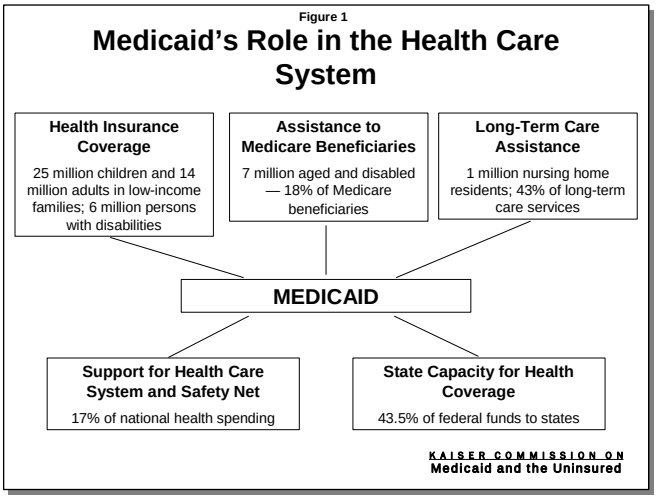
When Congress turns back to reconciliation, the options put forth by the Administration in the FY 2006 proposed budget, the National Governors Association (NGA), the Secretary's Medicaid Commission report released September 1, and the National Conference of State Legislatures (NCSL) are likely to be considered.

Specific legislative proposals are under development, but there are a few emerging themes for savings, including policy changes in the areas of Medicaid prescription drug payment, long-term care, cost sharing, benefits, and payment integrity. While there are also efforts at the state level to control Medicaid costs, this issue brief examines the context for federal Medicaid savings proposals, emerging themes for savings and the potential impact on Medicaid beneficiaries, states and providers.

These proposals all need to be reviewed in light of Medicaid's many roles in the health care system. The program 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)

Figure 1

Medicaid's Role in the Health Care System



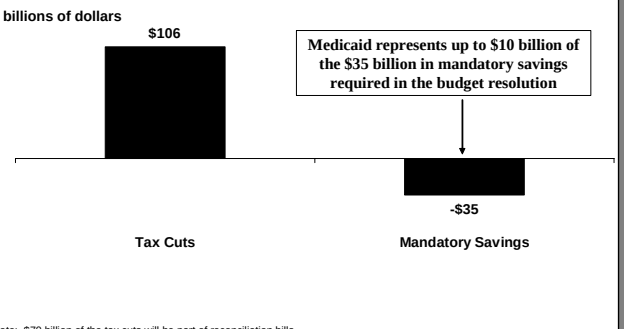
FEDERAL AND STATE BUDGET CONTEXT

The current Medicaid debate is unfolding in the context of the federal budget process. In April, Congress passed a budget resolution that called for up to $10 billion in cuts to federal Medicaid spending over the next five years. Congress is now scheduled to pass a reconciliation bill that contains legislative proposals that will meet the requirements in the budget resolution. The Senate Finance Committee and the House Energy and Commerce Committee have jurisdiction over Medicaid and will develop the legislative language for any Medicaid proposals.

Overall, the budget resolution increases deficit projections by $165 billion from 2006 to 2010 compared to the Congressional Budget Office (CBO) baseline estimates of current law. This increase in the projected deficit is primarily attributable to $106 billion in tax cuts that are partially offset by $35 billion in mandatory savings. Up to $10 billion of these mandatory savings targets could be drawn from Medicaid, but Committees could also get savings from other programs in their jurisdiction. (Figure 2) Aside from the delay in consideration, the budget resolution targets for spending and tax cuts were, to date, not changed by legislative activity around hurricane relief efforts.

Figure 2

Impact of the Budget Resolution on Taxes and Entitlement spending, 2006-2010



Note: $70 billion of the tax cuts will be part of reconciliation bills
Source: H.Con.Res.95 (FY 2006 Budget Resolution)

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Over the last four years, states have been working to reduce Medicaid spending in response to a dramatic decline in state revenues beginning in 2001 and high Medicaid cost growth. Despite the recent recovery in overall state revenues, revenue growth in some states remains slow. States are still under pressure to reduce Medicaid costs, but health care costs continue to climb, Medicaid enrollment continues to grow and 29 states are scheduled to receive reduction in the federal matching percentage (FMAP) as of October 1, 2005. Additionally, Hurricanes Katrina and Rita devastated some Gulf state economies and the national economic impact of the storms is not yet known.

The federal savings proposals are largely directed at reducing expenditures to the federal government. Some proposals will also help states cut Medicaid costs while others could shift costs to the states and/or to beneficiaries. The following discussion highlights several of the federal proposals under consideration.

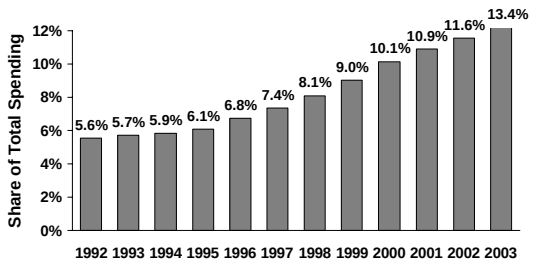
PRESCRIPTION DRUG PAYMENT CHANGES

Current Law. States typically reimburse pharmacies for Medicaid drugs at a discount off average wholesale price (AWP) plus a dispensing fee. 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 and states have been actively trying to contain costs in this area using strategies such as prior authorization, utilization review, and generic substitution. (Figure 3) Starting on January 1, 2006, Medicaid drug coverage for individuals eligible for Medicare and Medicaid (duals) will be shifted to Medicare as a result of the Medicare Modernization Act, although states will still be required to provide payments to the federal government to finance this coverage.

Figure 3

Outpatient Prescribed Drugs as a Share of Medicaid Spending on Services, 1992-2003



Source: Urban Institute and KCMU estimates based on data from Form CMS-64 and the Medicaid Statistical Information System (MSIS).

Note: Data are for federal fiscal years (October-September). Percentages are net of drug rebates.

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Savings Proposals. There are a number of options that would change the way in which state Medicaid programs pay pharmacists for prescriptions from the AWP to the average manufacturers price (AMP) or the average sales price (ASP). AWP is essentially a "sticker price" but AMP and ASP are figures reported directly to the Center for Medicare and Medicaid Services (CMS) based on drug acquisition costs for pharmacists. There are additional proposals that would increase rebate levels, allow states to establish closed formularies, and develop purchasing pools. Other cost saving proposals that would allow states to implement or expand the use of tiered co-pays for prescription drug are discussed in the premiums and cost sharing section.

Impact. Studies show that the ASP or AMP drug price is significantly lower than the AWP price.[i] Changes from AWP to ASP or AMP would decrease Medicaid reimbursement levels to pharmacies and changes to Medicaid rebate levels would impact drug manufacturers. These proposals would reduce state costs for Medicaid prescription drugs and not shift costs to beneficiaries.

ASSET TRANSFER AND OTHER LONG-TERM CARE 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.

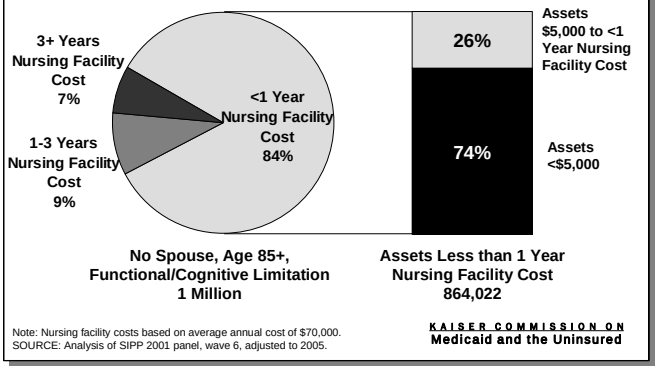
Savings Proposals. There are a number of proposals to tighten existing rules regarding transfers of assets by changing the start of the penalty period from the date of the asset transfer to the date of application for Medicaid and by increasing the look-back period for assessing transfers beyond three years. There are also a number of proposals designed to increase community based care, but these proposals are less specific and may not generate savings. Some have also proposed capping long-term care financing to achieve savings.

Impact. Changes to asset transfer rules would increase the administrative burden for beneficiaries, providers and states related to nursing home eligibility determinations. Savings would likely be generated from relatively few individuals. 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.[ii] (Figure 4) Private insurance and Medicare do not cover nursing home care, leaving many elderly to turn to Medicaid as the only alternative to help finance this care.

More far reaching proposals that would cap long-term care financing would fundamentally change the nature of Medicaid as a federal matching program and would shift an even greater share of long-term care financing to the states as the population ages and long-term care needs increase.

Figure 4

Distribution of Elderly Living In the Community at High Risk for Nursing Home Use by Asset Level, 2005



Note: Nursing facility costs based on average annual cost of $70,000.
SOURCE: Analysis of SIPP 2001 panel, wave 6, adjusted to 2005.

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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 services, including prescription drugs. Groups such as 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 copays, although beneficiaries remain liable for the amounts.

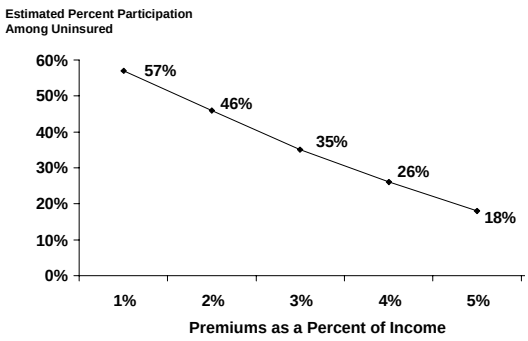
Savings Proposals. Options to allow states to charge higher copays and premiums for some groups and/or to expand the number of groups that could be subject to premium and cost sharing requirements are under discussion. Some proposals suggest using SCHIP as a model for premium and cost sharing requirements. Congress may also consider options to enable states to implement or expand the use of tiered co-pays for prescription drugs. This would allow higher cost sharing for non-preferred drugs or for beneficiaries with higher incomes. Many of these proposals would make copays "enforceable" meaning that providers or pharmacists could deny services or access to drugs if a beneficiary cannot pay the cost-sharing amount.

Impact. Under SCHIP and some state Medicaid expansions to higher income groups, premiums and cost sharing were utilized to better align public coverage with private coverage and to encourage more personal responsibility over health care choices. However, for low-income populations, 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] (Figure 5) Most Medicaid spending is for the elderly and disabled who already bear a larger responsibility for higher cost sharing for many long-term care services. Additional cost sharing for drugs could be particularly problematic for beneficiaries with chronic conditions who must take multiple drugs to manage their health conditions.

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. Research also suggests that states are not likely to generate substantial revenue from imposing premiums and cost-sharing; however, they will achieve savings from decreased enrollment or service utilization.[iv]

Figure 5

Health Insurance Participation by the Uninsured, by Premium Levels,1995



NOTE: Data based on three states: Washington, Hawaii, and Minnesota
SOURCE: Ku and Coughlin, 1999/2000.

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FLEXIBILITY AROUND BENEFITS

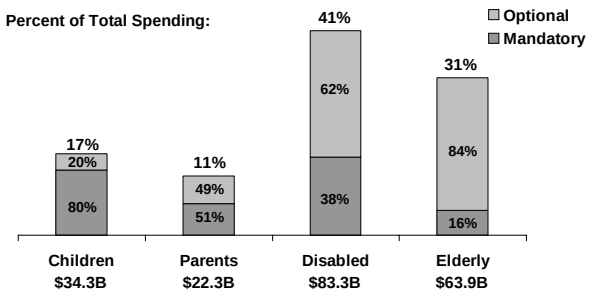
Current Law. States may receive federal matching funds for the costs of covering people and services not mandated by federal statute. These are known as "optional" eligibility groups and "optional" services. Many individuals who qualify under optional categories are very poor elderly and disabled with extensive health and long-term care needs. 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 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.

Savings Proposals. Some proposals under consideration would allow states to vary benefit packages for optional populations. This could mean allowing states to eliminate mandatory benefits (such as nursing home services or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children) or to provide a more limited benefits package, closer to the SCHIP benefit package to some optional populations. Some proposals would eliminate the rules for comparability, state-wideness and non-discrimination, giving states the ability to provide different benefits to different eligibility groups and/or to vary benefits across geographic regions and by illness or diagnosis.

Impact. Providing more limited benefits could make it more difficult for beneficiaries to access care as they are likely to have difficulty paying for uncovered services. Limiting benefits could also result in unmet health care needs and negative health consequences as shown by some recent experiences with Medicaid 1115 Waivers. To generate significant savings from benefit reductions, states would either need to impose deep benefit cuts for children and parents who are relatively inexpensive populations or restrict benefits for the elderly and disabled who are more expensive because they utilize a wide range of services. (Figure 6) Options currently used to control drug costs such as utilization review could be a better option to control unnecessary care use without eliminating access to medically necessary benefits.

Figure 6

Medicaid Expenditures by Eligibility Category and Type of Service



NOTE: Optional services for mandatory groups are counted as "optional" spending.
SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

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Providers may be faced with increased costs for providing uncovered services or problems ensuring continuity of care for patients. Providing differential benefit packages across populations and/or geographic areas would create further inequities across beneficiary groups and areas within a state as well as additional administrative complexity.

OTHER PAYMENT CHANGES

Current Law. Under current law, states may use intergovernmental transfers (IGTs) to help fund their Medicaid programs. The most common example of an IGT is a financial matching requirement for counties to help fund part of the state's share of Medicaid costs. While GTs are a legal financing source for states, they may become problematic when they are used to raise the federal share of Medicaid funding above a state's statuatory federal matching rate. Under current law, Medicaid administrative costs are matched at 50 percent and costs associated with prosecuting fraud and abuse are matched at 75 percent.

Savings Proposals. Proposals related to payment integrity such as restricting the use of certain IGTs and limiting payments to state and local hospitals and nursing homes to the cost of services provided to Medicaid patients are under consideration. Other proposals would cap administrative expenditures.

Impact. Some restrictions to IGTs may help support program integrity but would have different implications across states and may close what many states have viewed as a "safety-valve" in financing their programs. Proposals to cap Medicaid administrative costs could limit states capacity to oversee program operations and create disincentives to carry-out important functions such as nursing home survey and certification or fraud and abuse prevention and detection activities.

OUTLOOK

As the Medicaid debate continues, it is critical to understand and evaluate the implications of cost cutting measures on various stakeholders. While there are opportunities to make Medicaid more cost effective, some policy changes could have negative implications for beneficiaries, states and providers. For example, changes to prescription drug payment policies could yield program savings for the federal government and the states without negatively impacting beneficiaries. Policies that reduce federal Medicaid spending by shifting costs to states, such as some payment reforms, can limit state capacity to fund health care coverage. Finally, policies that restrict benefits or shift costs to beneficiaries and providers can result in barriers to health care access and poor health outcomes.

Efforts to focus on the elderly and disabled populations by coordinating and managing care could help to deliver better care and potentially reduce costs. However, without comprehensive health reform that would address the growing uninsured problem and long-term care costs, Medicaid as a safety net needs to be maintained.

[i] Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price. Office of Inspector General, DHHS. June 2005.
[ii] The Distribution of Assets in the Elderly Population Living in the Community. KCMU, June 2005.
[iii] Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations. KCMU, March 2003
[iv] Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences. KCMU, May 2005

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