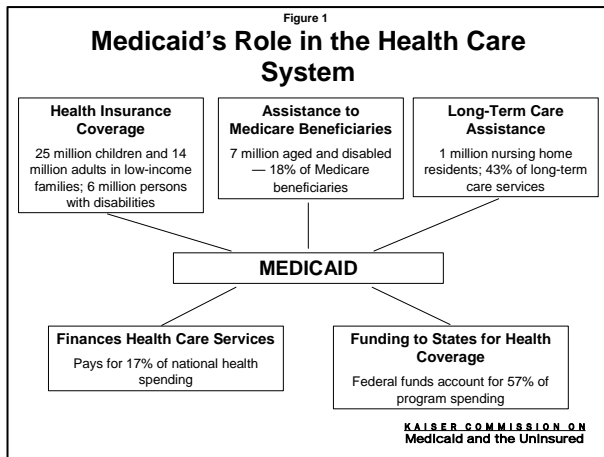


MEDICAID AND BUDGET RECONCILIATION: IMPLICATIONS OF THE HOUSE AND SENATE BILLS

In compliance with the budget resolution that passed in April 2005, the House and Senate both passed budget reconciliation bills that included spending reductions for Medicaid in November 2005. The House and Senate bills have very different implications for Medicaid, 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). Congress is in the process of working to reach an agreement on the two bills and is now scheduled to vote on a conference bill in mid-December. This issue brief provides an overview of the federal budget context and then highlights key proposals in the House and Senate bills and discusses the implications of the proposed changes.

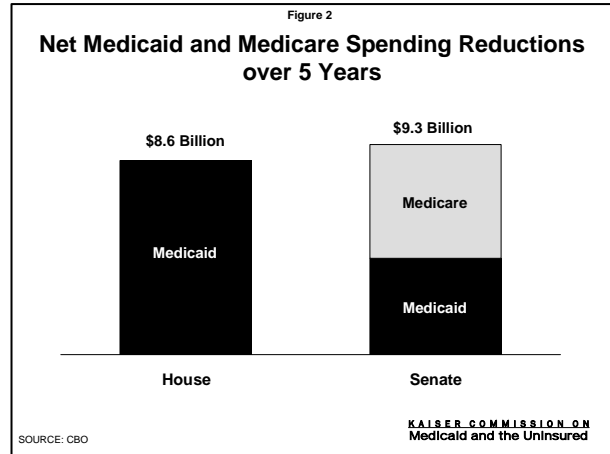


FEDERAL BUDGET CONTEXT

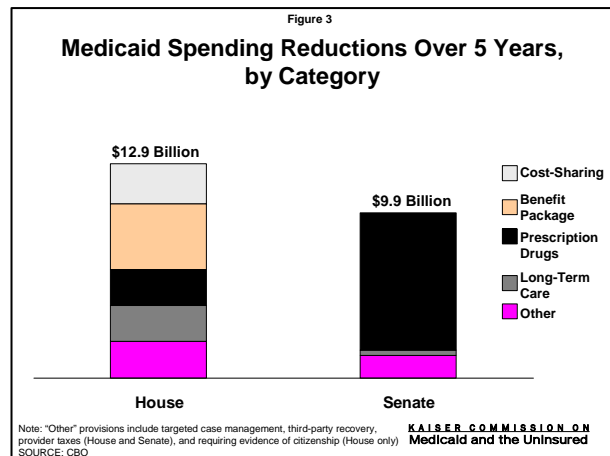
The current Medicaid debate is unfolding in the context of the federal budget process. In April, Congress passed a budget resolution that called for \$35 billion in entitlement cuts over the next five years, with a large share coming from the Medicaid program. The Senate reconciliation bill met the budget resolution target with \$35 billion in mandatory savings over the next five years, but the House package exceeded the target and generated five year savings of \$50 billion.

Of these totals, the Senate package included \$4.3 billion in net Medicaid savings (with an additional \$5.0 billion in net Medicare savings) and \$8.6 billion in net Medicaid savings in the House. These savings estimates represent less than

one percent of projected Medicaid spending over the next five years, but some proposals represent significant changes to Medicaid policy. The net savings figures reflect a series of savings proposals offset by spending proposals. (Figure 2)



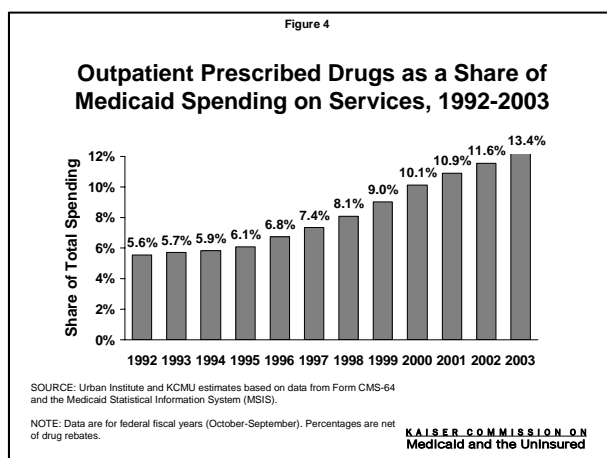
For Medicaid savings, the largest share of savings in the Senate package was generated by proposals related to prescription drugs. These provisions would reduce federal and state Medicaid expenditures and increase costs to pharmacists and drug manufacturers. Most of the savings in the House package were derived from proposals that would shift costs to Medicaid beneficiaries through reduced benefits packages and increased cost-sharing amounts. These provisions would shift additional costs to Medicaid beneficiaries. (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. 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 4) 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.



Proposed Changes. Overall, provisions to change prescription drug payment policies would generate \$8.2 billion under the Senate proposal (accounting for over 80 percent of the Medicaid savings in the Senate package) and \$2.2 billion under the House package. Both bills include provisions to change the way in which state Medicaid programs pay pharmacists for prescriptions from the AWP to a modified definition of the average manufacturers price (AMP) in the Senate and the retail average manufacturers (RAMP) price in the House. According to the Congressional Budget Office (CBO), these pricing changes would lower the reimbursement to pharmacies for Medicaid drugs and result in federal savings of about \$4.4 billion under the Senate proposal and \$1.9 billion under the House proposal.

The Senate proposal also includes provisions to increase the rebate levels paid by drug manufacturers from 15.1 percent to 18.1 percent on brand-name drugs and from 11 percent to 17 percent for generics. The bill would also extend rebates to Medicaid managed care enrollees

generating an additional \$3.9 billion over 5 years. Both bills also included small savings for provisions related to physician administered drugs authorized generic drugs.

Impact. Studies show that the AMP drug price is significantly lower than the AWP price.ⁱ Changes from AWP to AMP would decrease Medicaid revenues to pharmacists by reducing payments for drug ingredient costs (more so under the Senate bill). The Senate bill would decrease Medicaid revenues to drug manufacturers by increasing the rebates they owe. These proposals would reduce state costs for Medicaid prescription drugs and not shift costs to beneficiaries. The House bill would allow states to impose higher copayments for non-preferred drugs and allow pharmacists to deny access to drugs if beneficiaries cannot pay these copayments. These changes could change beneficiary access to Medicaid drugs.

PREMIUMS AND COST SHARING CHANGES

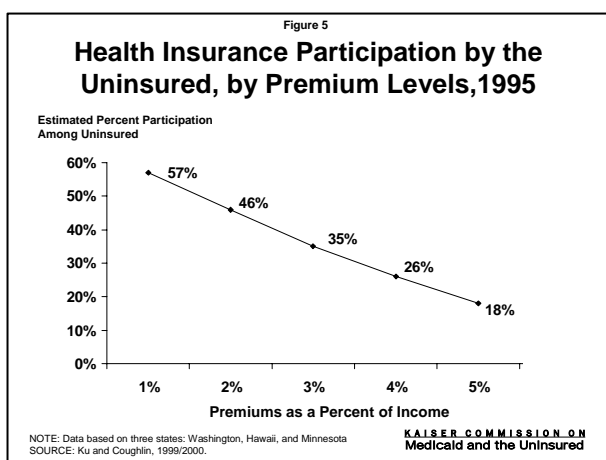
Current Law. Current law provides cost sharing protections that reflect the limited incomes and significant health care needs of Medicaid beneficiaries. States cannot charge most Medicaid beneficiaries premiums or enrollment fees. States can impose nominal cost sharing requirements (e.g. up to \$3) on certain populations for 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 copayments, although beneficiaries remain liable for the amounts.

Proposed Changes. The Senate package did not include any provisions to change current law for premiums and cost sharing. The House bill would allow states to charge higher copayments and premiums for some groups and/or to expand the number of groups that could be subject to premium and cost sharing requirements. In addition, the House included provisions to impose tiered co-payments for prescription drugs. The House also would make copayments “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. The cost sharing provisions in the House bill would generate \$2.4 billion over five years. CBO estimated that savings would be generated from decreased enrollment or service utilization.

Impact. By 2015, CBO estimates that 17 million Medicaid enrollees (27 percent) would be affected by the copayment provisions. This figure includes 11 million who would be newly affected by cost sharing (half of whom are expected to be children) and 6 million who would face higher cost sharing amounts. CBO assumed that by 2010 one million enrollees (2 million by 2015) would be charged premiums

resulting in a loss of coverage for 70,000 individuals (110,000 by 2015).

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.ⁱⁱ Studies have shown when premiums reach 5 percent of income, participation in insurance programs drops to 18 percent (Figure 5). 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 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.

Proposed Changes. The Senate package does not include any provisions to alter the Medicaid benefits package, but the House package would allow states to apply SCHIP-like benefits to most of the Medicaid population. CBO estimated that this provision would generate \$3.9 billion in federal Medicaid savings over five years.

Impact. CBO estimates that by 2010 2.5 million (5 million by 2015) enrollees would have reduced benefits and about one-half of them would be children. Even using the more comprehensive SCHIP benefit benchmarks, there are several key Medicaid benefits that are not typically covered under stand-alone SCHIP plans, including Early and Periodic Screening Diagnosis and Treatment (EPSDT), long-term care, Federally Qualified Health Center (FQHC) and many rehabilitative services. Through the EPSDT benefit, Medicaid provides children access to a broad range of screening and treatment services, creating more uniform and comprehensive coverage for children across all states. (Figure 6) 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.

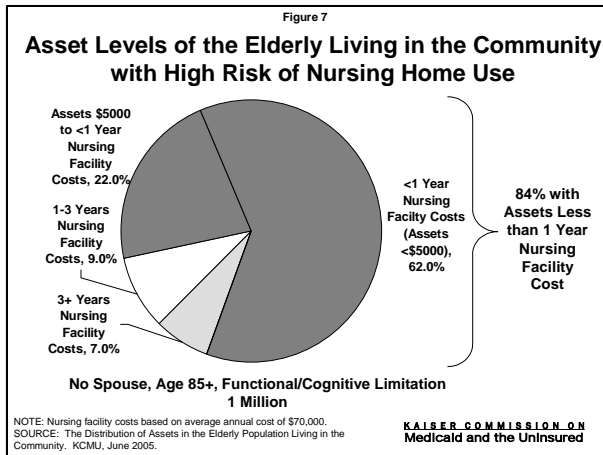


ASSET TRANSFER CHANGES

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. 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 7) 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.

Proposed Changes. The Senate package generates \$335 million in savings over five years by clarifying the calculation for the penalty period, counting some previously exempt assets (such as certain annuities, promissory notes and mortgages) and standardizing the waivers for undue hardship. The House package generates five year savings

of \$2.2 billion, largely attributable to increasing penalties on individuals who transfer assets for less than fair market value to qualify for nursing home care and by making individuals with more than \$750,000 in home equity ineligible for Medicaid nursing home benefits. The House proposal moves the start of the penalty period from the date of the asset transfer to the date of application for Medicaid and increases the look-back period for assessing transfers from three to five years.



Impact. The Senate proposal would generate a small amount of federal and state Medicaid savings, and would have relatively little impact on beneficiaries. Under the House package, CBO estimates that 120,000, or 15 percent of new Medicaid nursing home recipients, would face a delay in eligibility of about three months due to the penalty and look-back provisions. 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.

OTHER PROPOSED CHANGES TO REDUCE SPENDING

The Senate bill includes other savings proposals including provisions to reduce fraud, waste and abuse and managed care tax reform. The House bill would impose further restrictions on provider taxes and enhance third-party recovery. Both bills include provisions to clarify what qualifies as Medicaid targeted case management (TCM). This proposal specifies that foster-care related activities cannot qualify as TCM for Medicaid reimbursement.

MEDICAID SPENDING PROVISIONS

Katrina Relief. Both the Senate and House bills include 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. This relief expires on May 15, 2006. The House bill covers “home state” residents in addition to evacuees. The spending estimates for these provisions are \$1.8 billion for the Senate bill and \$2.5 billion for the House bill.

Family Opportunity Act. The Senate package includes legislation to allow states the option to permit parents with disabled children to “buy-in” to the Medicaid program if they have family income below 300 percent of the federal poverty level. CBO estimates that this provision would increase federal Medicaid spending by \$872 million over the next five years.

Health Opportunity Accounts. The House reconciliation package includes \$60 million in five year funding to establish “Health Opportunity Accounts” in ten states. These demonstrations are a significant policy issue, even though the funding 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.

Other Spending Increases. The Senate bill includes additional spending for “money follows the person” demonstration projects, relief from formula driven reductions to the federal matching percentage, continued reimbursement for certain adult day health services, changes to the Alaska FMAP and increased disproportionate share payments for the District of Columbia. The House bill includes additional funding for home and community based care and for the territories. Both bills include \$10 million to expand the long-term care partnership program to encourage the purchase of private long-term care insurance.

OUTLOOK

As the federal budget and Medicaid debates continue, it is important to understand the implications of some cost cutting measures on Medicaid beneficiaries. 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 beneficiaries and providers can result in barriers to health care access, unmet health care needs and poor health outcomes. Policies in the House bill related to benefits and cost sharing generate an even larger share of total savings after the five year budget window. While there are opportunities to make Medicaid more cost effective, these options 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 Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations. KCMU, March 2003