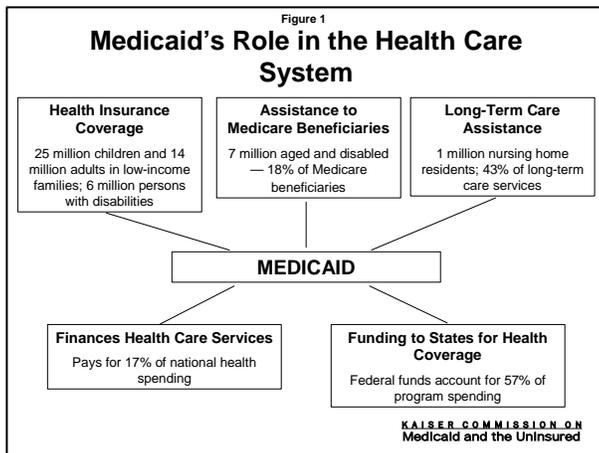


DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR MEDICAID

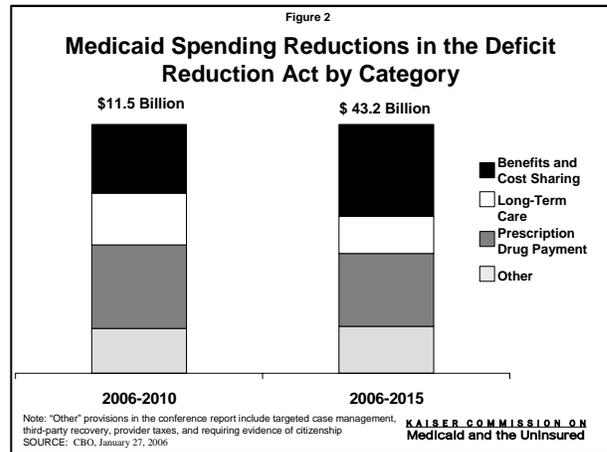
On February 8, 2006 the President signed the Deficit Reduction Act of 2005 (DRA). The Act is expected to generate \$39 billion in federal entitlement reductions over the 2006 to 2010 period and \$99 billion over the 2006 to 2015 period. The DRA includes net reductions of \$4.8 billion over the next five years and \$26.1 billion over the next ten years from 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) Many of the policy changes in the DRA would shift costs to beneficiaries and have the effect of limiting health care coverage and access to services for low-income beneficiaries.



The Congressional Budget Office (CBO) estimates that the DRA will reduce federal Medicaid spending by \$11.5 billion over the five year period and by \$43.2 billion over the next ten years. Provisions related to premiums and cost sharing, benefits, and asset transfers make up about half of the savings in the DRA and have the most significant implications for beneficiaries. Over the ten year period, the changes to benefits and cost sharing make up a larger share of the savings (27 percent over five years increasing to 37 percent of the savings over the ten year period). (Figure 2)

These reductions are offset by several provisions to increase spending, including health care relief related to Hurricane Katrina, for a net Medicaid reduction of \$4.8 billion over the next five years and \$26.1 billion over the

next ten years. Several provisions including the Family Opportunity Act and other long-term care changes are expected to have positive impact for beneficiaries.



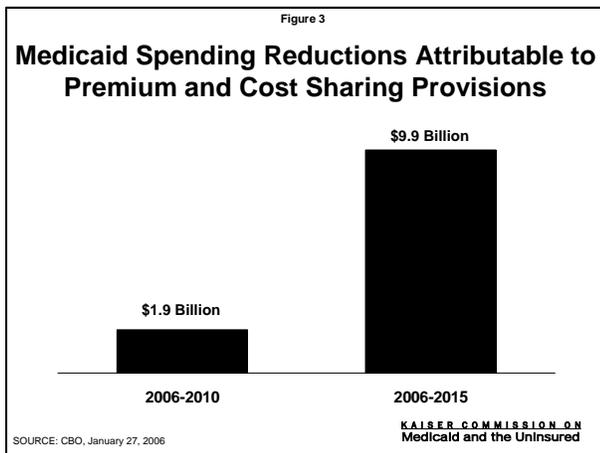
PREMIUMS AND COST SHARING CHANGES

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 co-payments, although beneficiaries remain liable for the amounts.

Deficit Reduction Act. CBO estimates that the provisions related to premiums and cost sharing in the DRA will reduce federal Medicaid spending by \$1.9 billion over the next five years and by \$9.9 billion over the next ten years, with about 70 percent coming from increased cost sharing and the remaining 30 percent from premiums. (Figure 3)

For beneficiaries (including children) with family incomes over 150 percent of the federal poverty level (FPL), or

\$24,900 for a family of 3 in 2006, 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 (including children) with incomes between 100 percent and 150 percent of the FPL. As 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.



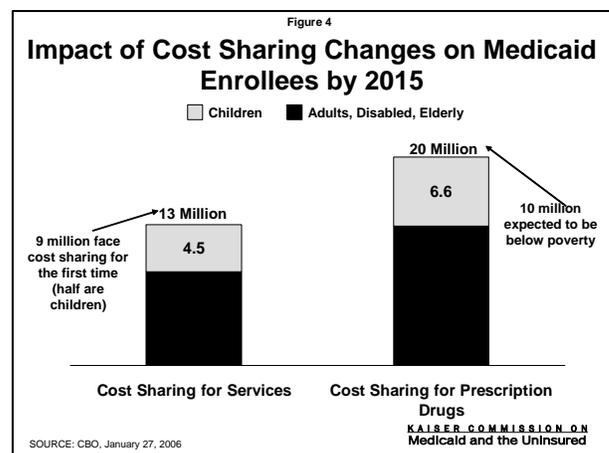
The DRA would allow higher co-payments for non-emergency services provided in an emergency room and increased cost sharing for non-preferred drugs. Unlike other services, no groups of beneficiaries are exempt from cost sharing for non-preferred prescription drugs. Families with incomes below 150 percent 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.

States would be able to vary the amount of premiums and cost sharing amounts imposed by area in the state, type of service as well as across and within eligibility categories. Total cost sharing and premium amounts cannot exceed five percent of a family's income over a one month or quarterly time period. The DRA would also allow states to 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. States could also make premiums enforceable and terminate coverage for failure to pay premiums for 60 days.

Impact. CBO estimates that 13 million, or 20 percent, of all Medicaid beneficiaries would be affected by the cost sharing provisions by 2015; 9 million (4.5 million children) would be faced with cost sharing for the first time and 3 million would face increased cost sharing amounts. About 13 million individuals would be affected by the provisions related to cost sharing for prescription drugs. About 80 percent of the savings would be attributable to decreased utilization of services or prescription drugs and the rest would reflect lower payments to providers.

By 2015, 1.3 million beneficiaries could face premiums ranging from 1 to 3 percent of family income. As a result of these premiums, CBO estimates that 65,000 beneficiaries, 60 percent of them children, would lose coverage by 2015. (Figure 4)



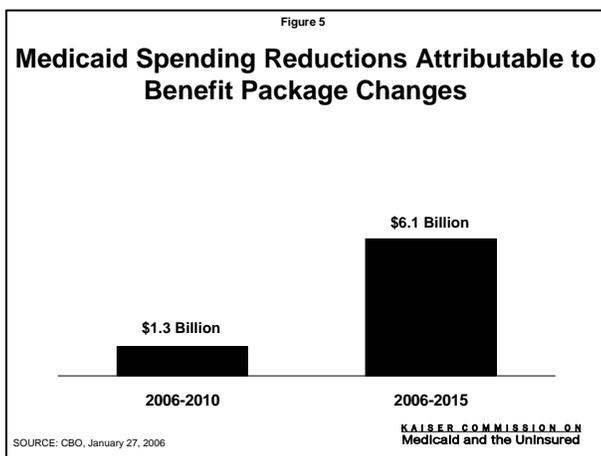
A large body of research, as well as recent experience with Medicaid 1115 waivers, has found that premiums and cost sharing can create barriers to obtaining or maintaining coverage, increase the number of uninsured, reduce use of essential services, and increase financial strains on families who already devote a significant share of their incomes to out-of-pocket medical expenses.¹ Studies also show that health insurance participation steadily declines when premiums are imposed, particularly at low levels of income. Providers often faced additional administrative burdens related to attempts to collect co-pays and a reduction in payment levels if they were unable to do so.

CHANGES TO MEDICAID BENEFITS

Current Law. Medicaid law requires states to provide certain mandatory services to mandatory populations. 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. States have the flexibility to determine what items and services are medically necessary

Deficit Reduction Act. CBO estimates that the DRA would generate \$1.3 billion in federal spending reductions over the next five years and \$6.1 billion over ten years. (Figure 5)

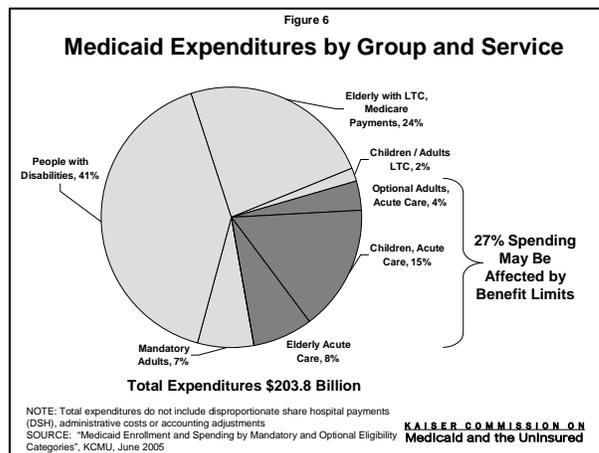


The DRA would allow states to replace the existing Medicaid benefits package for children and certain other groups with "benchmark" coverage. Like SCHIP, this "benchmark" coverage would include the standard Blue Cross Blue Shield Plan offered under the Federal Employee Health Benefits Plan, health coverage 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 DRA would require states to provide as "wrap around" benefits coverage for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under 19, and would require states to ensure that affected beneficiaries have access to rural health clinic and

federally-qualified health center (FQHC) services. Most 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.

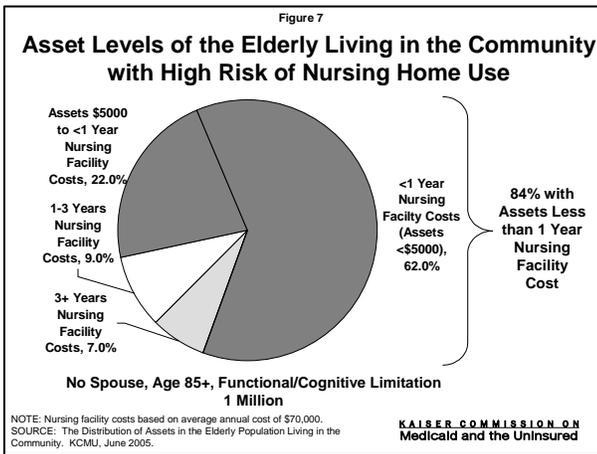
Impact. By 2015, CBO estimates that the benefit reductions would affect 1.6 million enrollees. Many eligibility groups are exempt, but acute care for the elderly, children and adults may be subject to the limited benefit package, however CBO expects that the limits would mainly be applied to adults. (Figure 6) Working adults as well as adults with incomes as low as 9 percent of the FPL (above mandatory coverage levels) could be subject to limited benefits. CBO estimates that spending for affected adults would be reduced by about one-third on average across states choosing the options.



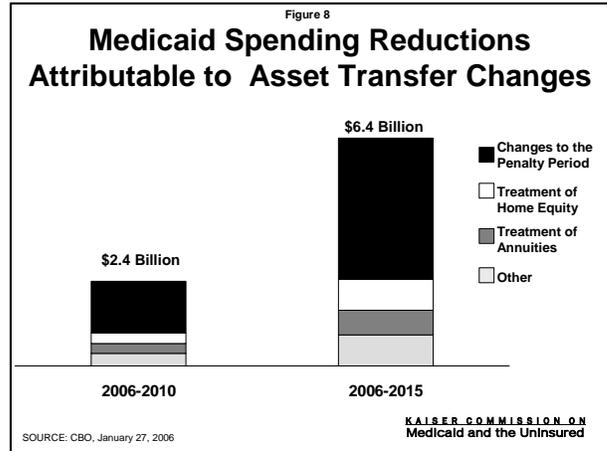
Even more comprehensive benchmark plans often do not cover key Medicaid services such as family planning and many rehabilitative services. EPSDT benefits under Medicaid have created more uniform and comprehensive coverage for children across all states under current law; it is unclear if the EPSDT wrap-around coverage will provide children the same access to a broad range of screening and treatment services. 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. 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 generally do not cover nursing home care, leaving many elderly to turn to Medicaid as the only alternative to help finance this care.



Deficit Reduction Act. The DRA would achieve \$2.4 billion in five year federal savings and \$6.4 billion over the 2006 to 2015 period. Over 60 percent of the savings is 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 DRA 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 DRA also counts as assets some previously exempt financial instruments (such as certain annuities, promissory notes and mortgages). (Figure 8)

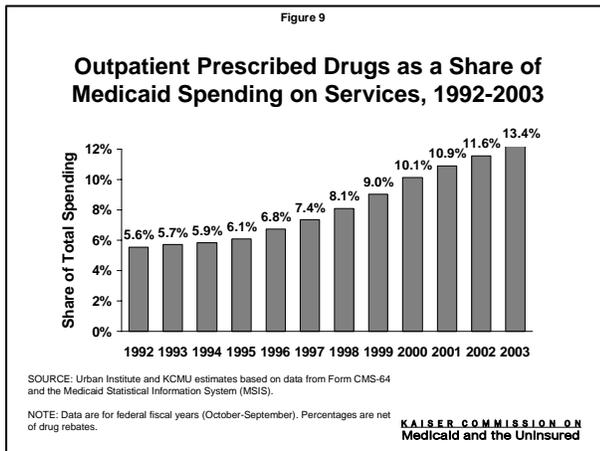


Impact. CBO estimates that moving the start of the penalty period from the date of the asset transfer to the date of application for Medicaid would result in an average delay of 3 months for Medicaid eligibility for 130,000 by 2015 (or 15 percent of new Medicaid nursing home beneficiaries annually). Changes in the treatment of home equity are expected to affect less than .5 percent of unmarried nursing home applicants (since home equity is not considered if a spouse is living in the home).

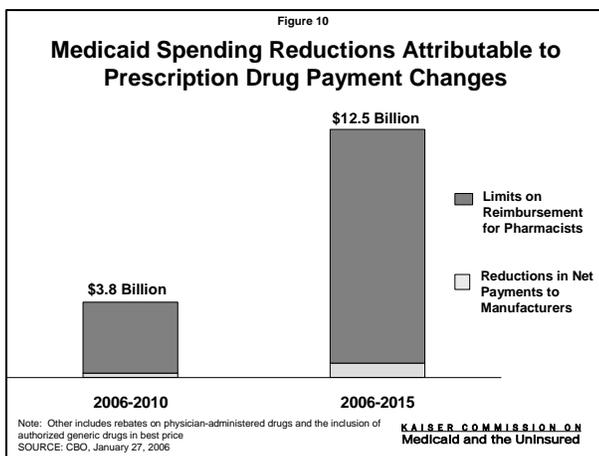
PRESCRIPTION DRUG PAYMENT CHANGES

Current Law. States typically reimburse pharmacies for Medicaid drugs at a discount off average wholesale price (AWP) plus a dispensing fee. Payments for most generic or multi-source drugs are subject to aggregate 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 9)

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.



Deficit Reduction Act. CBO estimates that the DRA 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 DRA would change the way in which state Medicaid programs pay pharmacists for prescriptions from AWP to average manufacturer price (AMP). The DRA would then set the FULs at 250 percent of AMP for multiple source drugs. The DRA did 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. The DRA included small savings for provisions related to rebates for physician administered drugs and for the inclusion of authorized generic drugs in the calculation of “best price” for drugs. (Figure 10)



Impact. Studies show that AMP is significantly lower than AWP.ⁱⁱ 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 DRA. 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 DRA that allow states to impose higher co-payments for non-preferred drugs and allow pharmacists to deny access to drugs if beneficiaries cannot pay these co-payments could change beneficiary access to Medicaid drugs.

OTHER PROPOSED CHANGES TO REDUCE SPENDING

Documentation Requirements. Beginning July 1, 2006, the DRA would require most new applicants, as well as most current beneficiaries at re-determinations, to document their citizenship (only aliens who are Medicare enrollees and SSI beneficiaries would be exempt). Documentation includes a U.S. passport, birth certificate or driver’s license from a state that verifies social security numbers. CBO estimates that this provision would result in a loss of coverage for 35,000 Medicaid enrollees. 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.ⁱⁱⁱ

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

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

MEDICAID SPENDING PROVISIONS

Katrina Relief. The DRA 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 DRA 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 and \$64 billion over ten years. CBO estimates that an additional 115,000 children would receive Medicaid as a result of this provision.

Health Opportunity Accounts (HOA). The DRA directs the Secretary to establish a demonstration program for HOAs in which up to 10 states may participate during the first five years. These Medicaid demonstrations are a fundamental policy change, where 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. The Medicaid benefits could be limited from current law or face additional cost sharing as permitted by other sections of DRA. 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 DRA 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. CBO estimates that the provision would extend additional services to about 120,000 enrollees.

Other Spending Increases. CBO estimates that states would use funding from the “money-follows-the-person” demonstrations to move 100,000 individuals from nursing homes to community settings and 60,000 enrollees would participate in cash and counseling programs where they would purchase long-term care services in the community using a predetermined budget. Other provisions that would increase Medicaid spending include changes to the Alaska FMAP, increase disproportionate share payments for the District of Columbia, increase funding for the territories and provide 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.

OUTLOOK

The DRA both reduces federal and state Medicaid spending and also changes health care access and coverage for low-income beneficiaries. For the first time children could be subject to cost sharing under Medicaid, many adults could face a more limited set of Medicaid benefits than under current law, and the elderly could face delays in Medicaid coverage for nursing home services. Most of the benefits and cost sharing changes would take effect on March 31, 2006 and the asset transfer changes are effective upon enactment of the bill.

According to CBO estimates, the DRA could have significant implications for a substantial share of Medicaid enrollees; however, these are estimates based on assumptions and it is possible that some provisions, especially those related to cost sharing, premiums, and increased documentation requirements could affect more beneficiaries than expected. Many states supported provisions that were included in the DRA. The actual impact for beneficiaries depends on whether states adopt new options available to them; if more states than CBO assumed opt to impose cost sharing requirements, the impact would be greater.

The President signed the DRA two days after the release of the Administration’s budget for FY 2007 that includes an additional \$65 billion in proposed entitlement reductions over the next five years, including proposals to reduce Medicaid spending by \$14.1 billion over five years through both regulatory and legislative changes. Many of the Medicaid proposals in the President’s FY 2007 budget submission would shift costs to states. If these proposed changes were to become law, states might face added financial pressure to use options such as increased cost sharing or benefit limits that were included in DRA.

While there remain opportunities to make Medicaid more cost effective, new proposals to reduce federal Medicaid spending should be assessed in conjunction with the effects of the changes enacted as part of the DRA. Additionally, careful monitoring tools should be established to evaluate how these recent changes affect Medicaid spending and the adequacy of health coverage for low income beneficiaries.

ⁱ Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations. KCMU, March 2003

ⁱⁱ Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price. Office of Inspector General, DHHS. June 2005.

ⁱⁱⁱ In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families. KCMU, October 2005

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