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CRITICAL CHOICES: Will Congress Secure Health Care Savings by Targeting “Weak Claims” or “Weak Clients”?

By Sharon Parrott

Summary

The House Energy and Commerce Committee and the Senate Finance Committee are beginning to craft “reconciliation” legislation to reduce projected expenditures for programs under their jurisdiction. This year’s budget resolution requires \$10 billion in reductions in programs under these committees’ jurisdiction, and there now is pressure on Capitol Hill to cut more deeply than the budget resolution requires. This pressure stems from growing concerns about the costs associated with relief and rebuilding efforts related to Hurricane Katrina, although those costs do not materially affect the nation’s long-term deficit problems.¹

It has been widely assumed that these Committees will take all or most of these cuts out of Medicaid, the program that provides health care to low-income children, parents, seniors, and people with disabilities. These Committees do not have to achieve all of these savings through Medicaid, however, and some members of Congress (particularly in the Senate) are discussing securing cost savings in Medicare as well.

The cuts in Medicaid would be made as a part of this year’s budget “reconciliation” process, which provides fast-track legislative authority for two “reconciliation” bills — one that would cut entitlement programs (including Medicaid) by a total of \$35 billion over the next five years and a second bill that would cut taxes by \$70 billion over the same five-year period. Taken together, this year’s reconciliation process will *increase*, rather than decrease, the deficit, with the reductions in entitlement programs for low-income families such as Medicaid and food stamps being used to partially offset the cost of the tax cuts. Given the nation’s mid- and long-term deficit problems, moving forward with a process that would increase deficits (and cut programs for the poor at the same time) would be ill-advised.

¹ For a discussion about the impact of hurricane relief efforts on the long-term deficit and why focusing on the temporary increase in the short-term deficit rather than our longer run deficit problems is misplaced, see, Robert Greenstein, “Getting Serious about Deficits? Calls to Offset Hurricane Spending Miss the Point; Balanced Set of First Steps Toward Fiscal Discipline Needed,” www.cbpp.org/10-6-05bud2.htm

Policy changes that would erode health care access or coverage among the nation's low-income families would come at a particularly bad time. Recent Census data indicate that the ranks of the uninsured have risen significantly in recent years.

If, however, Congress proceeds with the reconciliation process (as seems likely) and crafts a bill to cut entitlement programs, *how* those cuts are made is of considerable importance. The Senate Finance Committee and the House Energy and Commerce Committee could achieve savings that are significantly larger than the Committee's targets by reducing payments to certain Medicare managed care companies. Congress' expert advisory body on Medicare payments has found these payments to be excessive and unwarranted. The Committees also could secure substantial savings by securing more favorable prices for the prescription drugs that Medicaid purchases. These policy changes could protect vulnerable, low-income Americans by allowing the Committees to meet their budgetary target by reducing the *cost* of the health care provided in these programs rather than by limiting low-income beneficiaries' access to care.

The *Medicare* cost-containment proposals discussed below all are recommendations issued in June by the congressionally chartered, non-partisan Medicare Payment Advisory Committee (MedPAC), which was formed to provide Congress with independent expert advice on Medicare payment issues. The *Medicaid* prescription drug pricing proposals discussed here were put forward by the National Governors Association (NGA), and in a number of cases, by the Administration's Medicaid Commission, and the Administration itself (in its 2006 Budget).

In contrast to these proposals, some proposals under consideration (some of which also have come from the NGA) would exact reductions in Medicaid in ways that almost certainly would reduce many low-income Americans' access to needed health care services and medications. Some of these proposals would lead to the elimination of coverage for necessary health services. Other proposals would shift more of the cost of health care and prescription drugs to low-income children, parents, seniors and people with disabilities. The likely result of these cost shifts — as evidenced by extensive research in the field — would be that substantial numbers of these people would go without health care coverage entirely or lose access to needed health care services or medications.

Policy changes that would erode health care access or coverage among the nation's low-income families would come at a particularly bad time. Recent Census data indicate that the ranks of the uninsured have risen significantly in recent years. Some of the policy changes now being considered — such as requiring some Medicaid beneficiaries to pay premiums that likely will prove unaffordable to many — would exacerbate this problem. In addition, many low-income families already are struggling to afford sharply higher gasoline and home heating costs and have had their household budgets squeezed by the failure of their wages to keep pace with inflation (due, in part, to the lack of any increase in the minimum wage for eight years). These families are likely to find sizeable increases in co-payments or premiums for health care services and prescription drugs particularly difficult to bear. The research strongly indicates that when copayments and premiums in Medicaid are increased, significant numbers of low-income individuals would forgo needed health care or medications.

Despite the adverse effects this latter group of proposals would have, the Committees may choose to meet their budgetary targets (or to secure even larger savings so they can exceed those targets) by adopting proposals of this nature, rather than by reducing excessive government payments to pharmaceutical companies and managed care plans to the degree that the evidence indicates is warranted. Pharmaceutical companies and the managed care industry constitute powerful special interests that contribute heavily to political campaigns, have extensive lobbying operations, and enjoy substantial clout on Capitol Hill.²

Indeed, the House Energy and Commerce Committee and the Senate Finance Committee face a classic case of a choice between “weak claims” and “weak clients.” In 1981, David Stockman, Director of the Office of Management and Budget under President Reagan, argued that when the federal government seeks to reduce the deficit, it should target areas where government resources are not warranted, instead of targeting politically weak constituents. “We are interested in curtailing weak claims rather than weak clients,” Stockman stated. “We have to show that we are willing to attack powerful clients with weak claims.”³

The coming weeks will show whether Congress and the Administration follow Mr. Stockman’s advice or whether they choose instead to protect excessive payments to drug companies and managed care companies — powerful clients with weak claims — over the health care needs of the most vulnerable Americans.

Cost Containment Measures that Can Reduce Government Costs without Reducing Needed Health Care Services for Vulnerable Families and Individuals

Congress can rely on proposals to reduce Medicare and Medicaid that have been developed by an independent Medicare advisory body, the National Governors’ Association, and the Bush Administration. MedPAC, a congressionally chartered independent commission of health care experts that serves as the official advisory body to Congress on Medicare payment policy, recently issued a set of recommendations to reduce excessive payments being made to Medicare managed care plans. These proposals alone would secure significantly more savings than these committees are required to achieve.⁴ In addition, the National Governors Association, the Bush Administration’s Medicaid Commission, and the Administration itself (in its fiscal year 2006 budget) all have issued cost-containment proposals that would reduce Medicaid prescription drug costs without reducing low-income Americans’ access to needed health care. The NGA drug-pricing proposals are the most comprehensive and well developed and would achieve the most savings.

Savings from
MedPAC
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overpayments to
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plans would
save
significantly
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\$10 billion the
Senate Finance
and House
Energy and
Commerce
committees are
required to
achieve.

² M. Asif Ismail, “Drug Lobby Second to None: How the Pharmaceutical Industry Gets Its Way in Washington,” Center for Public Integrity, July 7, 2005.

³ “The Education of David Stockman,” by William Greider, *The Atlantic Monthly*, December 1981.

⁴ This paper only summarizes these proposals. For a more in-depth discussion, see “Adopting MedPAC Recommendations to Reduce Excessive Medicare Managed Care Plan Payments Could Yield Large Budget Reconciliation Savings,” by Edwin Park, Center on Budget and Policy Priorities, October 2005.

Medicare Cost Containment Measures

In June 2005, the Medicare Payment Advisory Commission (MedPAC) issued a set of recommendations to reduce excessive payments being made by the Medicare program to managed care companies that serve Medicare beneficiaries. These recommendations flow from extensive analysis of the amounts that Medicare is paying these entities and how those payment levels compare to the amounts that Medicare pays to treat comparable beneficiaries under standard Medicare fee-for-service arrangements. Although both health maintenance organizations (HMOs) and regional preferred provider organizations (PPOs) were brought into the Medicare program in part to *reduce* costs and improve the quality of care, MedPAC found that Medicare is paying *more* to these entities, on average, than it would pay under traditional fee-for-service arrangements. MedPAC found that, on average, Medicare payments to private managed care plans exceed traditional Medicare costs for comparable beneficiaries by seven percent, a difference that adds up to billions of dollars of excess payments each year.

To reduce these overpayments, MedPAC recommends:

- **Ensuring that regional preferred provider networks (PPOs) are not paid more than other Medicare managed care plans.** To accomplish this, MedPAC recommends two policy changes: (1) eliminating extra payments (so-called “stabilization fund” payments) for regional preferred provider networks (PPOs) that will be provided on top of the standard Medicare fees; and (2) standardizing how fees are set through the contracting process so that the base fees paid to regional PPO networks do not exceed the fees paid to managed care plans serving only a local geographic area (for an equivalent set of beneficiaries). The Congressional Budget Office estimates that those two reforms would save \$8 billion over five years.
- **Setting payment levels to Medicare managed care companies (including both regional PPOs and HMOs) at 100 percent of the costs of treating beneficiaries with comparable health conditions through traditional Medicaid fee-for-service arrangements.** Under current contracting practices, managed care reimbursement rates are set at levels that, on average, exceed the cost of providing Medicare benefits through traditional fee-for-service arrangements to comparable beneficiaries. CBO estimates that this reform would save \$12.6 billion over five years.
- **Setting payments to managed care plans to reflect the health status of their enrollees by phasing out the current “hold harmless” policy.** Managed care plans typically serve a healthier group of Medicare beneficiaries than are served in the traditional fee-for-service Medicare program. Medicare policy calls for managed care plans’ fees to be “risk adjusted” so the payments they receive are in line with the health status of the population they serve. Under current Medicare rules, however, managed care providers receive “hold harmless” payments that *re-inflate* their fees after the risk adjustment has appropriately reduced them. The Administration has said it will phase out these “hold harmless” payments administratively, but the Congressional Budget Office does not assume that the hold-harmless policy will, in fact, be ended. Writing the proposed phase-out into the statute would produce \$6.1 billion in savings, according to CBO.

- **Ending the practice under which the federal government essentially pays twice for some of the costs that teaching hospitals incur.** Teaching hospitals incur additional costs in treating Medicare beneficiaries because they are both caring for patients and training medical professionals. Medicare pays twice for some of the costs that teaching hospitals incur in treating Medicare beneficiaries enrolled in managed-care plans, because Medicare pays teaching hospitals directly for the teaching costs of these enrollees but also makes an upward adjustment to cover these costs in the payments that it makes to managed care plans. CBO estimates that eliminating these double payments would produce savings of \$2.6 billion over five years.

As the CBO estimates demonstrate, the reforms to Medicare managed care plans that MedPAC has called for would save more than \$20 billion over five years. MedPAC has additional recommendations; some of these — changes in Medicare physician reimbursements, rural hospital payments, and dialysis reimbursement rates — would increase costs over the next five years while others would achieve further savings. The combination of the managed care proposals discussed here and all of the MedPAC proposals that increase costs would still yield savings that are significantly higher than the \$10 billion these committees are required to cut from programs under their jurisdictions.

Medicaid Prescription Drug Cost-Containment Measures

NGA, the Administration's Medicaid Commission, and the Administration all agree that action should be taken to reduce the prices that states pay for prescription drugs in the Medicaid program. There is broad agreement that Medicaid *overpays* for prescription drugs in four ways.

- **Rebates from pharmaceutical companies are too low.** Under current law, companies that manufacture prescription drugs must provide a rebate to state Medicaid programs for drugs dispensed to Medicaid beneficiaries. The rebates are designed to ensure that Medicaid gets favorable prices for the drugs it covers. Some states, however, have been able to negotiate additional rebates; this indicates that higher minimum rebates could be established nationally. Indeed, there is bipartisan consensus that the current rebates are too low and should be increased. (Moreover, it is particularly important to improve the federal minimum rebate levels now, since states are likely to have an increasingly difficult time securing better rebates on their own once responsibility for drug coverage for elderly and disabled beneficiaries shifts from Medicaid to Medicare on January 1, 2006. When that occurs, the dollar value of the prescription drugs that state Medicaid programs purchase will be cut about in half. With substantially less drug purchasing power, state Medicaid programs will be in a weaker position to secure favorable drug prices from pharmaceutical companies.)
- **Drug companies do not pay rebates on drugs provided to Medicaid patients by managed care plans.** Drug manufacturers do not have to pay rebates when a managed care company provides prescription drugs to Medicaid patients. When this rule was instituted, it was assumed that the managed care companies would

The NGA proposals to reduce the cost of prescription drugs in the Medicaid program save in the range of \$10 billion.

themselves be able to negotiate prices for drugs as good as — or better than — the prices provided under the Medicaid rebate system for drugs prescribed for patients served in fee-for-service arrangements. It now appears, however, that Medicaid managed care plans are paying higher prices for drugs than the price states are paying under fee-for-service arrangements. Substantial savings could be achieved by requiring pharmaceutical companies to pay rebates on the drugs purchased for Medicaid beneficiaries by managed care plans.

- **Federal enforcement of the rebate could be improved.** Studies from the General Accountability Office and the HHS Office of Inspector General have identified problems with the administration and enforcement of the rebate program. Appropriate enforcement of the rebate would ensure that drug manufacturers are complying with the federal rebate and that Medicaid is getting a more favorable net price for prescription drugs.
- **Payments to pharmacies are too high.** The amount that state Medicaid programs pay to pharmacies to reimburse them for the cost of the medications they provide to Medicaid patients tends to be far above what pharmacies pay wholesalers for the drugs. Currently, the price that the Medicaid program pays for drugs is based on what is called the “average wholesale price” or AWP. While this term may make it sound as though this would be the appropriate basis for the price of drugs, this measure actually is akin to the “sticker price” on a car — effectively, it is the suggested price self-reported by manufacturers, *not* the price that pharmacies actually pay for drugs. As a result, studies by the HHS Office of Inspector General have determined that Medicaid payments to pharmacies tend to be set at excessive levels.

To address these concerns, the National Governors Association, the Administration, and/or the Administration’s Medicaid Commission have called for the following cost-containment measures:

1. Increase the minimum rebates that drug companies pay the Medicaid program. This recommendation has been made by the NGA.
2. Extend rebates to drugs purchased by managed care companies. Both the NGA and the Medicaid Commission have made this proposal.
3. Improve administration and enforcement of the rebate program. The NGA and the Medicaid Commission have both recommended this change, as well.
4. Base the price paid to pharmacies for prescriptions on actual drug prices, not on the flawed AWP or “sticker price.” The Administration, the NGA, and the Medicaid Commission all support using actual drug prices as the basis for pharmacy reimbursement rates (This could be done using either the Average Sales Price or the Average Manufacturer Price, both of which approximate — in somewhat different ways — the actual prices at which manufacturers sell drugs to wholesalers.)

These proposals are also consistent with the recommendations of the Government Accountability Office and the HHS Office of the Inspector General.⁵ Under these proposals, the

⁵ See, for example, General Accountability Office, “Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States,” GAO-05-102, February 4, 2005; Written Testimony of George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Services before the House Committee on Energy and Commerce: Subcommittee on Oversight and Investigation, December 7, 2004; HHS Office of the Inspector

federal and state governments both would realize savings, *without* restricting beneficiaries' access to medicines they need. Taken together, these proposals likely would save somewhere in the range of \$10 billion over five years, the level of savings that the House Energy and Commerce Committee and Senate Finance Committee are charged with achieving in the health care area.

The Unattractive Alternative: Reducing Access to Needed Health Care for Vulnerable Americans

The aforementioned recommendations could achieve savings in Medicaid and Medicare without hindering access to health care for low-income children, parents, the elderly, and people with disabilities. However, proposals also are under consideration that would reduce vulnerable American's access to health care. These include proposals that would allow states to charge low-income Medicaid recipients significantly more for health care services or prescription drugs and to deny some beneficiaries coverage for certain health services entirely. Some members of Congress may seek to find savings in these areas, in part to avoid the politically more difficult step of reducing government payments to pharmaceutical manufacturers and managed care companies that enjoy substantial clout on Capitol Hill.

Increasing the Cost of Going to the Doctor and Securing Treatment

The NGA proposal would allow states to impose higher Medicaid copayments and premiums on certain Medicaid beneficiaries for health care services. (A related NGA proposal also would increase co-payments for prescription drugs; that proposal is discussed below.) This could mean that some Medicaid beneficiaries would have to pay premiums to qualify for any health services or would have to pay a significant amount each time they went to the doctor or hospital or needed lab work. The NGA has said its cost-sharing proposals for services other than prescription drugs would apply only to Medicaid beneficiaries with incomes above the poverty line or, in the case of children under six, below the federally mandated minimum eligibility limit (133 percent of the poverty line). Pregnant women with incomes above the poverty line would be exempt from cost-sharing for pregnancy-related services. Even with these restrictions, however, children, parents, and elderly and disabled people with incomes just above the poverty line — including individuals with serious medical conditions who qualify for Medicaid because of their high medical bills — could face substantial increases in cost-sharing requirements and be denied health care services if they could not make the co-payments.⁶

Significantly increasing the charges to these families could have serious consequences. These families have limited incomes. A family of three is considered above the poverty line when its income reaches \$1,341 per month (\$16,090 on an annualized basis). Although such a family is better

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General, "Medicaid Pharmacy: Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products," September 2002 and HHS Office of the Inspector General, "Medicaid Prescription Drug Comparison: Average Sales Price to Average Wholesale Price," June 2005.

⁶ The NGA proposal does exempt some services, like preventive care for children and emergency services, from co-payments.

Research has consistently shown that charging even modest premiums for health care coverage leads many low-income families to lose coverage, and that modest co-payments cause many low-income families to forgo needed health care services.

able to meet basic food and shelter needs than families well below the poverty line, people just above the poverty line often teeter on a financial edge and generally have little ability to pay significant amounts for health care. Adding to this problem, these families will incur additional costs in the months ahead due to increases in prices for gasoline and heating fuel. They will be even less able to handle increases in the costs of basic health care services.

These families' tenuous financial circumstances explain why research on cost sharing has consistently shown that charging even modest premiums for health care coverage leads many low-income families to lose coverage, and that modest co-payments cause many low-income families to forgo needed health care services. For example, the state of Missouri recently increased monthly premiums that families with incomes above 150 percent of the poverty line must pay for their children's health insurance; the premiums range from one to five percent of family incomes. The Missouri Medicaid agency has reported that about *half* of the children required to pay these premiums — more than 20,000 children — are slated to lose insurance coverage because they have not met the premium requirement.⁷ Other states that have instituted increases in premiums have witnessed a similar fall-off in coverage.⁸

Similarly, a substantial body of medical research, including the rigorous RAND Health Insurance Experiment, demonstrates that higher co-payments make it much more difficult for low-income people to obtain medical care — and result in significant numbers of adults and children becoming sicker because they forgo needed care. Among the effects that increases in cost-sharing have been found to have on low-income families and individuals are an increased risk of anemia among children and an elevated risk of death from heart disease among adults.⁹ These adverse health effects are the result of low-income individuals forgoing treatment or medication due to costs.

⁷ Virginia Young, "21,500 children are dropped from state health insurance," St. Louis Post-Dispatch, Oct. 4, 2005. This figure represents the number of children who have been notified that they will be terminated from the program for failure to pay the premiums unless they pay the past due premiums within the next month.

⁸ Artiga, S. and O'Malley, M., Increasing Premiums in Medicaid and SCHIP: Recent State Experiences, Kaiser Commission on Medicaid and the Uninsured, May 2005.

⁹ Leighton Ku and Victoria Wachino, "The Effect Of Increased Cost-Sharing In Medicaid: A Summary Of Research Findings," Center on Budget and Policy Priorities, Revised July 7, 2005.

Rising Energy Costs and Stagnating Wages Would Make Absorbing Higher Health Care Costs Even Harder for Low-Income Families

If legislation is enacted in coming weeks that requires the nation's poor to pay significantly more out of pocket for needed health care and medications — causing some to forgo needed health care services and medications and possibly to become uninsured — this will come at a particularly unfortunate time. Recent Census data show that the number of Americans lacking health insurance grew to 46 million in 2004, or more than one in every seven Americans. As the number of working families able to obtain or afford employment-based health insurance has declined, Medicaid has helped to fill some of the gap by covering more people who would otherwise become uninsured. Without recent increases in the number of people receiving Medicaid, the increase in the ranks of the uninsured would have been substantially larger.

Moreover, low-income Americans will be hard-pressed to afford increased health care costs as they struggle to keep up with high gasoline and home heating prices. Recent increases in fuel prices will be difficult for many low-income families to absorb. Department of Energy data show that gasoline prices rose by 93 percent between October 2003 and October 2005, and the cost of home heating fuel is projected to be 47.5 percent higher this winter than last winter. Unfortunately, low-wage workers' wages are not rising with gasoline prices or the cost of heating their homes. The minimum wage has not been raised in eight years; its value, in inflation-adjusted terms, has fallen by 17 percent over that period. In addition, recent government statistics indicate that real wages (i.e., wages adjusted for inflation) for the bottom half of workers have *fallen* in 2005.

Research consistently shows that low-income people have difficulty meeting increased health care costs and often go without health care when premiums and co-payments for health care services and prescription drugs are increased. Given these realities, it is hard to justify requiring low-income families with stagnant incomes and rising energy costs to absorb increased medical costs when there are sound alternatives for achieving the required levels of savings in government health care programs.

Increasing "Tiered" Copayments for Prescription Drugs

The NGA and the Administration's Medicaid Commission have proposed allowing states to increase co-payments for prescription drugs well above existing federal limits. In fact, both entities have proposed allowing states to require even the poorest Medicaid beneficiaries to make copayments of *unlimited size* for certain drugs that are not included on a state's "preferred" drug list, even when a particular medication may be medically necessary for an individual patient.

Under current law, states are permitted to create a list of "preferred" drugs, comprised of generic drugs and certain specified brand-name drugs, and to attach different co-payment requirements to "preferred" drugs than to drugs not on the preferred list. This practice is referred to as "tiered" co-payments for prescription drugs.

Federal law places limitations on the *level* of the co-payments that may be charged to Medicaid beneficiaries for both preferred and non-preferred drugs and prohibits co-payments on medications for children and pregnant women enrolled in Medicaid. Under the NGA and Medicaid commission proposals, most of these protections, which are designed to ensure that Medicaid beneficiaries have access to needed medications, would be eliminated.

If the NGA proposals on prescription drug copayments are adopted, patients with very low incomes could face a choice between paying substantial amounts for needed medications – in some cases leaving too little for food or heat – or going without effective treatment.

Under these proposals:

- States could charge *all Medicaid beneficiaries co-payments of unlimited size for non-preferred drugs*, even if a drug is the most appropriate medication for a particular patient. A non-preferred drug may be essential for a person who has an uncommon medical condition or must take that particular drug because the “preferred” drug for that condition could interact in a dangerous way with other drugs the person has been prescribed. Under these proposals, states could charge high copayments for non-preferred drugs to *any Medicaid beneficiary*, including pregnant women and children with incomes far below the poverty line.
- States could charge *Medicaid beneficiaries with incomes just above the poverty copayments of unlimited size even for preferred drugs*. This would particularly affect children and pregnant women, since they make up the bulk of beneficiaries with incomes above the poverty line.
- States could charge *nominal copayments for preferred drugs to children and pregnant women with incomes below the poverty line*. These beneficiaries currently are exempt from co-payments in light of their low incomes and the critical importance of good health for children’s development.
- Finally, providers could *deny needed medications to Medicaid beneficiaries who are unable to pay co-payment charges*, regardless of the health consequences. This represents another significant departure from current law.

If Congress adopted these proposals and states implemented these new approaches, many Medicaid beneficiaries would likely be unable to afford some prescription drugs that are most appropriate for their medical conditions. States would impose the highest copayment levels on drugs not on their preferred drug lists. However, “preferred drugs” are not better, safer or more effective than “non-preferred” drugs in every case, given the diversity of patient needs and medical conditions. Although less expensive brand-name and generic drugs are available to treat many conditions, individual patients often need newer, more expensive drugs due to their particular circumstances. Such drugs are much less likely to be on a state’s preferred drug list.

For example, a commonly used generic anti-convulsant drug for patients with epilepsy is not effective for all patients, and a newer, more expensive brand-name drug is effective for some of those who cannot take the generic drug. If a state places the commonly used generic on its preferred drug list but not the newer, more expensive drug, some individuals who suffer from epilepsy could face much higher co-payments to take the drug that works best in their case. This is not an isolated example — there are multiple drugs to treat high blood pressure, high cholesterol and other conditions. In many cases, cheaper generic drugs are safe and effective, but in other cases, more expensive brand-name drugs are the most appropriate for particular patients. If the NGA proposal is adopted, patients with very low incomes could face a choice between paying substantial co-payments for medically necessary medications (and running the risk of having insufficient resources left to heat their homes or buy adequate food) and going without effective medical treatment.

Minnesota's Experience with Tiered Copayments Should Serve as a Warning

In 2003, Minnesota implemented a tiered copayment structure for prescription drugs in its Medicaid program. Under the Minnesota policy, generic drugs cost Medicaid beneficiaries \$1, while brand name drugs cost \$3.

After this policy was implemented, about half of the Medicaid patients being seen at a public hospital were found to have forgone some medications because of the new copayment requirement. Many experienced a deterioration in their health status and required emergency room care or hospitalization after losing access to their medications. For example, some of those who could not afford their blood pressure medications experienced strokes, dizziness and other problems and ultimately required more expensive forms of treatment.^a

The NGA proposal would allow states to go far beyond the copayment levels imposed in Minnesota. Under this proposal, there would be *no limit* on the size of the copayments that could be imposed.

^a Melody Mediola, et. al, "Medicaid Patients Perceive Copays As A Barrier To Medication Compliance," Hennepin County Medical Center, Minneapolis, MN, presented at the Society of General Internal Medicine national conference, May 2005 and American College of Physicians Minnesota chapter conference, Nov. 2004

In addition, some Medicaid beneficiaries may be unable to afford even "preferred" drugs under the NGA proposal. Medicaid beneficiaries with incomes just above the poverty line — most of whom are children and pregnant women — could be charged unlimited copayments for preferred drugs. Furthermore, children and pregnant women with incomes *below* the poverty line would — for the first time — face "nominal" co-payments for preferred drugs (i.e., payments of up to \$3 per medication). The research indicates this would likely induce some very poor children and pregnant women to forgo medications.

Proponents of these policy changes argue that they are needed to steer Medicaid beneficiaries to less expensive drugs. Yet current law already gives states a number of mechanisms to steer patients to preferred drugs. Most states already have preferred drug lists; in these states, a patient's physician must attain authorization for a "non-preferred" drug before prescribing it to a Medicaid beneficiary. In addition, states can (and do) charge beneficiaries higher co-payments for non-preferred drugs, but the co-payment levels are limited to ensure that beneficiaries can afford the needed medications.

These existing policies have been quite effective at increasing the use of generic drugs in the Medicaid program. The majority of drugs used by Medicaid beneficiaries are generic drugs. In fact, Medicaid beneficiaries are 28 percent more likely than patients with private insurance to be prescribed generic drugs.

It also should be noted that even under current law, there are troubling cases in which these procedures have resulted in beneficiaries not obtaining a non-preferred drug when they need it.¹⁰ Providing states with a much blunter policy tool under which many drugs could be priced out of reach for low-income patients would likely lead to more cases in which low-income Americans go without appropriate medication.

¹⁰ See, for example, Jane Tilly and Linda Elam, "Prior Authorization for Medicaid Prescription Drugs in Five States: Lessons for Policymakers," Kaiser Commission on Medicaid and the Uninsured, April 2003.

Terminating Coverage for Certain Health Services

NGA also has proposed allowing states to scale back benefits for some Medicaid beneficiaries, including children and pregnant women with incomes only modestly above the poverty line.

NGA also has proposed allowing states to scale back on the health care services that Medicaid covers for various groups of beneficiaries. Under the NGA proposal, states could restrict benefits for: non-disabled parents at all income levels; children under six and pregnant women who have incomes above 133 percent of the poverty line; children six and older with incomes over 100 percent of the poverty line; and people with disabilities who are not on SSI, are not receiving Medicare, and are not institutionalized, among others. States could scale back benefits, including services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements that currently apply to children. Under the EPSDT provisions, children must receive periodic health examinations and treatment for all medical conditions that are diagnosed in those screenings. The EPSDT provisions ensure, for example, that children who are diagnosed with hearing loss or vision problems are provided with the hearing aids and glasses they need to have a chance to succeed in school.

The NGA's proposal in this area is vague, but it suggests that the benefits that Medicaid covers could be scaled back for these groups of beneficiaries and made comparable to the benefits provided under certain private insurance plans, the state's SCHIP program, or a state employees' health insurance plan. This proposal fails to recognize several fundamental differences between Medicaid beneficiaries and people with other forms of coverage. Medicaid beneficiaries tend to be in poorer health and are more likely to have chronic medical conditions. Medicaid beneficiaries also have little in the way of income or assets and, in particular, little discretionary income that can be devoted to health care services without infringing on their ability to pay rent and utilities and keep food on the table. While some health plans may not cover some of the services that Medicaid covers, most privately insured individuals, who tend to be healthier and have higher incomes, generally do not need coverage for such services and often have the disposable income to pay for such services directly if they should subsequently turn out to require them.

Finally, despite claims that such policy changes are needed to curtail unnecessary health care utilization, recent research indicates that, after accounting for the fact that people on Medicaid tend to be in poorer health than people who are privately insured, Medicaid beneficiaries use about the same level of medical services as those with private health insurance. That is, those on Medicaid do not overuse health services.¹¹

¹¹ Teresa Coughlin, Sharon Long and Yu-Chu Shen, "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs*, 24(4):1073-1083, July/August 2005.

Conclusion

Congress has an important choice as it seeks to secure savings from federal health care programs. It can enact policy changes that reduce the *cost* of health care by reigning in the price that Medicaid pays for prescription drugs and by reducing overpayments to Medicare managed care providers. Policies proposed by the nonpartisan Medicare Payment Advisory Committee, the NGA, the Administration's Medicaid Commission, and the Administration itself in these areas could secure savings substantially in excess of the \$10 billion over five years that the budget resolution envisions.

But Congress also can chart a different course. It can enact changes that reduce low-income Americans' *access* to needed health care by increasing the costs that Medicaid beneficiaries must pay to enroll in the program, receive health care services, and purchase prescription drugs.

One path — reducing the price of health care — requires Congress to take on powerful interests such as health care providers and the pharmaceutical industry. The other path allows Congress to leave these powerful interests untouched and instead asks the poorest Americans to bear a substantial share of the load and to face policy changes that risk compromising their health. Policymakers will choose in the weeks ahead.