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October 14, 2005

## AN ANALYSIS OF THE NATIONAL GOVERNORS ASSOCIATION'S PROPOSALS FOR "SHORT-RUN MEDICAID REFORM"

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### Executive Summary

On August 29, the National Governors Association released "Medicaid Reform: A Preliminary Report," a set of recommendations for Congress as it develops budget legislation this fall to reduce projected federal Medicaid expenditures. These NGA proposals are intended to build on longer-term Medicaid recommendations the governors made in June.

Congress is likely to give these NGA proposals serious consideration. The Medicaid Commission that the Administration established this summer included several NGA proposals in recommendations it made to Congress on September 1 for achieving Medicaid reductions of \$10 billion over five years. In this paper, we analyze the major NGA proposals. We evaluate whether the proposals would reduce expenditures without harming the low-income children, families, senior citizens, and people with disabilities whom Medicaid serves.

The NGA proposals include constructive suggestions to reduce Medicaid expenditures for prescription drugs. Those proposals would produce significant savings, enabling Congress to achieve nearly all of its requirement to cut health-care entitlement expenditures by \$10 billion over the next five years, and would do so in ways that would not adversely affect low-income patients. Many NGA proposals in other areas, however, risk reducing access to needed health services for vulnerable low-income beneficiaries. Particularly problematic are NGA's proposals to allow substantial increases in the co-payments and premiums that Medicaid beneficiaries could be charged and to allow covered health care services to be scaled back significantly for many beneficiaries. Also troubling is an NGA proposal to count the value of an individual's home as an asset in determining eligibility for Medicaid coverage for long-term care.

- **NGA's proposals to reduce the amounts that Medicaid pays for prescription drugs hold promise.** Giving states new tools to reduce the amounts that their Medicaid programs pay for prescription drugs could save substantial sums without harming beneficiaries. There appears to be growing consensus on the need for reforms in Medicaid drug pricing procedures. Useful proposals in this area have been made by NGA, the Administration, its Medicaid Commission, health care providers, and advocates for beneficiaries.

NGA recommends a number of changes in this area. One such proposal calls for an *increase in the minimum rebate* that manufacturers of brand-name drugs pay to Medicaid. Such a reform is

overdue; the minimum rebate has not been raised since 1996, and there is evidence that the federal government could establish higher minimum rebates. This proposal would save \$3.2 billion over five years, according to the Congressional Budget Office. NGA also proposes specific *improvements in how the rebate is calculated* and how the rebate program is carried out, which would help respond to problems that have been identified by the Government Accountability Office (GAO) and the HHS Office of Inspector General.

In addition, NGA proposes to *extend the rebate to drugs that managed care plans purchase* for Medicaid patients. When the federal drug rebate law was designed, it was assumed that Medicaid managed care plans could negotiate discounted drug prices as favorable as those available under the rebate. In fact, managed care plans may be obtaining smaller discounts than those the rebate system provides. Extending the rebate to Medicaid managed care plans would ensure they obtain more favorable drug prices, saving about \$2 billion over five years, according to the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS).

NGA also proposes to *establish a limit on how much states may pay pharmacies* for prescription drugs dispensed to Medicaid beneficiaries. Most states base their payments to pharmacies on a drug's Average Wholesale Price (AWP), which is like a car's "sticker price" and substantially exceeds what pharmacists pay to acquire a drug from a manufacturer or wholesaler. The NGA proposal would establish a new federal requirement that these payments be based on the Average Manufacturer Price (AMP), the average actual price that manufacturers charge wholesalers. The Office of the Actuary estimates savings from this proposal of \$4.3 billion over the next five years. (The Administration proposed a similar provision that would require pharmacy payments to be based on the Average Sales Price.)

Finally, NGA proposes *changing the reimbursement rates paid to pharmacies for generic drugs*. The federal government sets limits (called "Federal Upper Limits" or FULs) on state Medicaid pharmacy reimbursement rates for generic drugs. The NGA proposes to use the AMP rather than the AWP as the basis for these rates. Because the AMP is based on the actual price at which manufacturers sell to wholesalers, using the AMP would be more accurate and cost-effective. This provision would produce savings of \$3 billion over five years according to the CMS Office of the Actuary.

- **NGA's cost-sharing proposals, by contrast, risk making coverage unaffordable for many low-income beneficiaries and would likely lead to reduced access to needed care.** NGA proposes to *scale back many of the federal standards that limit beneficiary cost sharing in Medicaid*. A longstanding body of research demonstrates that when cost sharing is increased significantly for low-income people, their use of essential health care services declines and their health status worsens. The NGA proposals allowing substantial increases in co-payments for many beneficiaries carry a high risk of inducing some beneficiaries to scale back markedly the use of needed health services. The proposals relating to premiums would likely cause some beneficiaries to lose coverage altogether and become uninsured.

Under the NGA proposals, there appear to be no limits on the co-payment and premium amounts that states could charge to most beneficiaries with incomes modestly above the poverty line, including children, except that total cost-sharing changes for a beneficiary could not exceed 5 percent of income for beneficiaries with incomes below 150 percent of the poverty line and 7.5 percent of income — nearly one month's income — for beneficiaries

above 150 percent of the poverty line. Beneficiaries with incomes *below* the poverty line, and children under six with incomes between 100 percent and 133 percent of the poverty line, would be shielded from the changes in cost sharing for health care services. Pregnant women also generally would continue to be exempt from such co-payments. These beneficiaries could, however, be required to pay substantially more for prescription drugs.

NGA proposes *authorizing states to increase co-payments significantly for prescription drugs* through tiered co-payment systems. Under a tiered co-payment system, the co-payments charged for drugs that a state does not designate as “preferred drugs” would be set higher than the co-payments charged for preferred drugs. In a sharp departure from current Medicaid law, under which co-payments charged to Medicaid beneficiaries for prescription drugs may not exceed \$3 per prescription, the NGA proposal would set few upper limits on the tiered co-payments that could be imposed for both non-preferred and referred drugs, with the exception of co-payment charges for preferred drugs prescribed for beneficiaries below the poverty line. This proposal could lead to a very substantial escalation in co-payment charges for prescription drugs for many beneficiaries. In some states, co-payments could be set at levels beyond what significant numbers of beneficiaries could afford, especially beneficiaries who need multiple prescriptions — as many elderly and disabled people do — and thus face multiple co-payments.

For beneficiaries with incomes below the poverty line, the co-payments charged for generic or preferred drugs would be nominal (e.g., \$3 or less). Even for these beneficiaries, however, there would apparently be *no* limits on the co-payment amounts that could be charged for non-preferred drugs. There also appear to be no limits on the amounts that could be charged for *either* preferred or non-preferred drugs for most beneficiaries above the poverty line.

Moreover, co-payments for medications could be charged to *all* beneficiaries — including those currently exempt from co-payments such as children, pregnant women, and people in nursing homes or other institutions. This represents a major change from current Medicaid requirements and could make it harder for these individuals to obtain medications they need.

Finally, in another striking departure from current law, *providers would be permitted to deny services and medications to people who are unable to meet the cost sharing charges*. This change would increase the likelihood that significant numbers of Medicaid beneficiaries would go without needed health care or medications because they could not afford the co-payments. Research suggests that the health of low-income beneficiaries could deteriorate as a result. The need for subsequent emergency room or hospital care also would be likely to increase.

- **Restrictions on benefits could diminish access to needed care.** NGA also proposes to *permit states to reduce the current Medicaid benefit package*, limiting it to a narrower set of benefits that is “actuarially equivalent” to the benefits provided under certain private or state employee insurance programs that operate in the state. Some categories of beneficiaries, such as pregnant women and children in “mandatory” Medicaid eligibility categories, as well as SSI recipients and individuals who are dually eligible for Medicare and Medicaid, would be exempt from this change. States would, however, be authorized to restrict benefits for other groups, such as children, pregnant women, and parents in the “optional” eligibility categories.

Allowing states to restrict benefit packages for substantial numbers of beneficiaries, as NGA proposes, would likely diminish access to care by making certain health care services unavailable

to broad groups of Medicaid beneficiaries. Moreover, this proposal appears to *eliminate* the requirement that all children in Medicaid receive all of the health care services they need for healthy development, as is currently provided through Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component. (EPSDT guarantees that children be covered for all health care services they are found to need.) The loss of the EPSDT guarantee for large numbers of children would be particularly risky for children with disabilities or other special health care needs. Under the NGA proposal, there also is a risk that long-term care services would no longer be available to some low-income beneficiaries.

- **NGA's long-term care proposal would treat a person's home as an asset in determining his or her eligibility for Medicaid, which would likely force some seniors to sell their homes to qualify for Medicaid coverage for long-term care.** Another far-reaching NGA proposal would *count home equity as an asset in determining seniors' eligibility for Medicaid long-term care services*, including home- and community-based services and nursing home care. In most states, seniors are eligible for Medicaid only if their countable assets — which do not include their homes — are below \$2,000 for an individual and \$3,000 for a couple. Counting home equity against these limits could present many seniors with the agonizing choice of selling their home or going without Medicaid coverage for long-term care.

To address this problem, NGA proposes that seniors obtain “reverse mortgages” and use the mortgages to pay for long-term care expenses. There is little research, however, which suggests that reverse mortgages would work adequately for low-income seniors. Some seniors might not be able to secure such mortgages. In addition, there are important unanswered questions about how the use of reverse mortgages would affect spouses and dependent disabled children who live in the home. Reverse mortgages must be repaid once the home is no longer the borrower's primary residence, raising questions about whether a spouse and dependent children would be forced out of the home if an individual had to enter a nursing home. Finally, research in the field raises questions about whether requiring reverse mortgages would be more effective in controlling costs than the current policy that requires states to recover costs from the estates of beneficiaries who received long-term care services.

- **Some of NGA's proposed changes in asset transfer policies could prove detrimental.** To prevent people from transferring assets that could be used to pay for long-term care by transferring those assets to family members or others, NGA proposes both to *extend the period of time that is examined to determine whether transfers of assets occurred* and to *change the way that penalties are set when a wrongful transfer is found*. These changes could have the unintended effect of penalizing people who make relatively small gifts or donations without any intention of doing so to qualify for Medicaid. The NGA proposal also lacks adequate protections to ensure that people are not inappropriately penalized. Congress could provide states with more targeted tools, some of which are described in the body of this analysis, to help curb the sheltering of assets by people of means.

To the degree Congress relies on the NGA reforms in putting together reconciliation legislation, it should look to those proposals that do not harm low-income beneficiaries. NGA's proposals to reduce prescription drug prices could achieve significant savings without adverse effects on low-income patients. Targeted tools to address some of the practices that individuals with significant resources may be using to qualify inappropriately for Medicaid coverage for long-term care also could achieve some savings. Many of the remaining NGA proposals, however, and in particular the

proposals made with respect to increased cost-sharing and reduced benefits, would make health coverage through Medicaid less affordable and accessible for low-income families and individuals.

## Drug Pricing Proposals Could Produce Most or All of the Savings Required in Reconciliation

The NGA recommendations include a number of promising proposals that would help reduce the amounts that Medicaid pays for prescription drugs. For many years, prescription drug costs have been the fastest-rising component of total Medicaid expenditures, increasing 17 percent to 21 percent per year from 1999 to 2003. States have been struggling to restrain prescription drug costs.

Adding to states' problems is the fact that they are about to lose a substantial amount of their negotiating leverage with drug manufacturers. On January 1, 2006, when the Medicare drug benefit takes effect, Medicare will take over drug coverage for people eligible for both Medicare and Medicaid (the so-called "dual eligibles"). Drug coverage for these individuals currently accounts for half of all Medicaid spending on prescription drugs.<sup>1</sup> As a result, states are likely to lose leverage in price negotiations with drug manufacturers and may become less able to rein in Medicaid prescription drug costs.<sup>2</sup> Although many states will achieve some savings when Medicare takes over drug coverage for the dual eligibles,<sup>3</sup> states' diminished leverage over drug pricing for beneficiaries whose drug coverage continues to be a Medicaid responsibility is a cause for significant concern.

Federal action to enable states to secure a better deal on prescription drug prices would help both the federal government and the states to save money without reducing beneficiaries' access to health care. A wide variety of stakeholders in the Medicaid debate — NGA, the Bush Administration, the Medicaid Commission, providers, and advocates for beneficiaries — all have proposed ways to restrain the prices Medicaid pays for prescription drugs.

The NGA proposals in this area would yield substantial savings. These proposals could produce most or all of the \$10 billion in savings that this year's congressional budget resolution calls for Congress to achieve in the health care entitlement area, according to cost estimates from CBO and CMS's Office of the Actuary.

The NGA proposals in the prescription drug pricing area include the following:

- **Increase the minimum drug rebate.** NGA proposes increasing the minimum rebate that manufacturers of brand-name drugs are required to pay to Medicaid. In recent years, some states with sufficient purchasing power have been able to go beyond the federal minimum rebate (which is set at 15.1 percent of the Average Manufacturer Price, or AMP) to negotiate supplemental rebates. This strongly indicates that the federal government could establish

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<sup>1</sup> Stephen Heffler, et al., "U.S. Health Spending Projections for 2004-2014," *Health Affairs*, February 23, 2005. See also John Holahan and Arunabh Ghosh, "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003," Kaiser Commission on Medicaid and the Uninsured, "July 2005 and "2003 State and National Medicaid Spending Data," Kaiser Commission on Medicaid and the Uninsured, January 2005.

<sup>2</sup> Vernon Smith, et al., "Implications of the Medicare Modernization Act for States: Observations from a Focus Group Discussion with Medicaid Directors," Kaiser Commission on Medicaid and the Uninsured, January 2005.

<sup>3</sup> States will have to make "clawback" payments to the federal government to reimburse it for most of the new costs it will assume as a result of Medicare's taking over prescription drug coverage for the dual eligibles.

higher minimum rebates. Increasing the minimum rebate to 20 percent of the AMP would save \$3.2 billion over the next five years, according to CBO.

- **Extend the rebate to managed care plans.** Drug manufacturers are not currently required to pay rebates on drugs dispensed to beneficiaries in Medicaid managed care plans. When the rebate law was designed, it was assumed that managed care plans could negotiate discounted drug prices that would be as favorable as the prices available under the rebate. (In addition, only a small percentage of beneficiaries were enrolled in managed care plans at that time. This is no longer true; in 2004, nearly 40 percent of Medicaid beneficiaries received coverage through managed care plans that are exempt from the drug rebate.)

Some analysts believe that managed care plans may be overpaying for prescription drugs. The NGA proposals would extend the rebate to drugs dispensed by managed care plans, thereby ensuring that these plans receive favorable prices and reducing state reimbursements to these plans. This could save \$2 billion over five years, according to the CMS Office of the Actuary.

- **Improve the rebate program.** NGA also proposes a number of needed improvements in how the rebate is calculated and how the rebate program operates. For example, NGA would ensure that rebate calculations take into account the price of a generic drug marketed by a manufacturer of a brand-name drug that is going off patent. NGA also proposes that states be given timely information on the drug prices reported by manufacturers, that such data be made easily auditable to ensure compliance with drug rebate requirements, and that stiffer penalties be imposed for manufacturer violations.<sup>4</sup> These changes would help respond to problems that the GAO and the HHS Office of Inspector General have identified with the rebate program<sup>5</sup> and should ensure that drug manufacturers comply with federal rebate rules.

Additional improvements to yield further savings could be made in the operation of the rebate program, beyond the improvements that NGA proposes. Additional measures could include ensuring that rebate calculations take into account the price discounts that pharmacy benefit managers obtain (which were rare when the rebate was originally designed) and increasing the minimum rebates for generic drugs.<sup>6</sup>

- **Establish federal limits on the amount Medicaid pays pharmacies for prescription drugs.** The NGA proposes to establish a federal upper limit on how much states may pay

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<sup>4</sup> NGA also proposes to require drug companies to give the same discounted prices that are available to Medicaid to other state health programs such as state pharmacy assistance programs, health insurance plans for state employees, prison health care systems, and other discount programs. An analogous provision exists in current law; manufacturers participating in the Medicaid drug rebate program must provide discounted prices through the Federal Supply Schedule to all federal agencies. The NGA proposal would reduce state health costs generally by allowing states to reduce their drug costs in state-funded programs but would not have any direct effect on Medicaid prescription drug costs. Reducing state costs in other state health programs, however, may help relieve budgetary pressures on state Medicaid programs.

<sup>5</sup> Government 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.

<sup>6</sup> Unlike brand-name drugs, the minimum generic drug rebate is set at 11 percent of AMP.

pharmacies for drugs that are dispensed to Medicaid beneficiaries. Rather than purchase drugs directly from manufacturers, Medicaid reimburses pharmacies for the drugs they dispense.

Under the NGA proposal, the pharmacy reimbursement limit would be based on the Average Manufacturer Price (AMP), the average price that manufacturers charge. Numerous reports by the HHS Inspector General have demonstrated that state Medicaid programs often pay pharmacies considerably more for prescription drugs than the pharmacies pay to acquire the drugs from wholesalers and manufacturers.<sup>7</sup> That is because most states pay pharmacies at the Average Wholesale Price (AWP), minus 10 or 15 percent. AWP is akin to a car's "sticker price" and substantially exceeds what the pharmacies actuarially pay to acquire a drug. Using a more appropriate measure for pharmacy reimbursement, such as the AMP, the actual acquisition cost, or the Average Sales Price (or ASP, which is the price that manufacturers charge wholesalers net of all discounts and rebates), would produce significant savings.<sup>8</sup> The NGA's AMP proposal would reduce Medicaid spending by \$4.3 billion over five years, according to the CMS Office of the Actuary. (The Administration has made a similar proposal, under which pharmacy payments would have to be based on the ASP).

Under the NGA proposals, states would continue to determine the amount they pay pharmacies to cover the cost of storing and dispensing drugs to Medicaid beneficiaries. A better way to ensure that these fees fairly compensate pharmacies for their costs would be to establish federal requirements for adequate dispensing fees. That could be done as part of the legislation making the other changes discussed.

- **Revise federal reimbursement rates to pharmacies for generic drugs.** The federal government sets limits (called "Federal Upper Limits" or FULs) on state Medicaid pharmacy reimbursement rates for generic drugs. These limits are set at 150 percent of the Average Wholesale Price of the least costly generic version of a drug. The NGA proposes to use the AMP rather than the AWP as the basis for these federal limits. This change would improve cost-effectiveness and accuracy and would save \$3 billion over the next five years, according to the CMS Office of the Actuary.

## Cost-Sharing Proposals Would Create Significant New Risks for Beneficiaries

Unlike NGA's proposals to reduce the price of prescription drugs, which would reduce state and federal Medicaid expenditures without adversely affecting beneficiaries, a number of the other NGA proposals — especially those relating to cost sharing — carry significant risks for beneficiaries.

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<sup>7</sup> HHS Office of the Inspector 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.

<sup>8</sup> The Administration proposed using the ASP as the basis of payments to pharmacies as part of its fiscal year 2006 budget. The Medicaid Commission endorsed NGA's proposal of using the AMP as the basis for pharmacy reimbursement rates.

## **Weakening of Cost-Sharing Protections Would Impose Burdens on Vulnerable Beneficiaries**

A longstanding body of research demonstrates that significant increases in cost sharing reduce the use of essential health care services by low-income people and thereby cause their health status to worsen. (See the box on page 9). Increased co-payments can cause substantial numbers of low-income people to have difficulty affording needed medical care or prescription drugs and to forgo health services or medications. Premiums can lead substantial numbers of low-income people not to enroll in public health coverage programs and to be uninsured as a result.

For these reasons, federal Medicaid law has strictly limited cost sharing. Children, pregnant women, and individuals in nursing homes are exempt from co-payments under Medicaid. The co-payments for other beneficiaries may not exceed “nominal” levels of \$3 per service or prescription. Premiums essentially are barred. Federal Medicaid law also states that health care providers cannot deny services to beneficiaries who are unable to afford the co-payments.

NGA proposes to scale back many of these federal standards that limit cost sharing in Medicaid and to authorize states to increase cost sharing substantially and impose premiums.

- **Existing cost-sharing protections would remain for children whose coverage is “mandatory,” except with regard to prescription drugs.** Under the NGA proposal, young children (those under six) with incomes below *133 percent* of the poverty line would remain exempt from premiums and most cost sharing charges, as would children six and over whose incomes are below *100 percent* of the poverty line.<sup>9</sup> (Since the federal government requires states to cover these individuals, their coverage is referred to as “mandatory.”) However, these individuals would be subject for the first time to cost-sharing for prescription drugs. (This is described below.) For other beneficiaries with incomes below 100 percent of the poverty line, the current requirements that co-payment charges be “nominal” and premiums be prohibited would be maintained, except with respect to co-payments for prescription drugs.
- **Current cost sharing protections would be dramatically weakened for most other beneficiaries.** For beneficiaries with incomes above the poverty line (or above 133 percent of the poverty line for children under age six), states would be granted vast new discretion to increase cost sharing and impose premiums. There appear to be no limits on the dollar amounts of the co-payments and premiums that states could charge these groups, except that the total cost-sharing that a beneficiary would have to pay could not exceed 5 percent of the beneficiary’s income for beneficiaries with incomes below 150 percent of the poverty line, and 7.5 percent of income for beneficiaries above 150 percent of the poverty line.

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<sup>9</sup> NGA also would exempt terminally ill individuals receiving hospital care and institutionalized individuals from co-payments. In addition, co-payments would not be charged for preventive services for children (regardless of the children’s income category), emergency services, family planning services, and services related to pregnancy or a condition that could complicate a pregnancy.



## The Impact of Cost-Sharing: What Experience and Research Demonstrate

Numerous studies demonstrate that co-payments cause low-income beneficiaries to cut back on essential care and higher premiums lead to fewer low-income people being covered by health insurance. Some of the key evidence of the impact of increased cost-sharing has on low-income Medicaid beneficiaries is summarized here:

- The landmark RAND Health Insurance Experiment found that when co-payments were increased, low-income children and adults reduced use of essential health services and ended up in worse health. For example, children had higher rates of anemia, and adults had higher blood pressure and greater risk of death due to heart disease.
- Because those in poor health and with chronic health problems require more medical care, they are subject to more co-payments and experience greater problems obtaining care when co-payments are imposed or increased. Researchers at the University of Maryland found that in states that charge co-payments for drugs, beneficiaries in poor health forgo medications to a greater degree.
- Medicaid beneficiaries already bear substantial financial responsibility for their medical care. Analyses of federal survey data have found that the out-of-pocket medical cost burdens borne by poor Medicaid beneficiaries have risen twice as fast as their incomes in recent years, and have grown more rapidly than the out-of-pocket costs of middle-class privately-insured adults, when measured as a share of their incomes. Because Medicaid beneficiaries have such low incomes, even small costs can create serious barriers to health care.
- After the state of Oregon increased premiums and co-payments in its Medicaid program, problems ensued. About half of those enrolled, some 50,000 people, were unable to make premium payments and lost coverage; most became uninsured. Those who lost coverage were found to have much greater difficulty obtaining health care or paying for prescription drugs. They used less primary care and ended up needing more emergency room care. Those who lost coverage also incurred larger medical debts and frequently found they were refused care because of those debts.
- The state of Missouri recently imposed premiums ranging from one percent to five percent of income for children in families with incomes above 150 percent of the poverty line. Preliminary state data reveal that about half of the children in this income range -- over 20,000 children -- have been unable to pay and are slated to lose coverage.
- A recent study in Minnesota found that after tiered co-payments for prescription drugs (\$1 for generic drugs and \$3 for brand name drugs) were imposed, about half of the Medicaid patients at a large public hospital went without some medications due to cost problems. About one-third of those who went without medications experienced adverse effects, such as strokes, asthma and diabetes attacks, and needed emergency room care or hospitalization. This study is described in further detail on page \_\_\_\_\_. This is consistent with an earlier study in Quebec that found increased drug co-payments led to increased rates of emergency room use and other adverse effects among low-income adults and senior citizens.

Sources: Leighton Ku, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7 2005. Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, April 2003. Bill Wright, Matthew Carlson, Tina Edlund, Jennifer DeVoe, Charles Gallia and Jeanene Smith, "The Impact of Increased Cost-sharing on Medicaid Enrollees," *Health Affairs*, 24(4):1107-15, July/August 2005. Virginia Young, "21,500 children are dropped from state health insurance," *St. Louis Post-Dispatch*, Oct. 4, 2005.

This proposal would represent a major departure from current law and would leave most beneficiaries with incomes over the poverty line largely unprotected. The 5-percent-of-income and 7.5-percent-of-income limits would not provide meaningful protection from high out-of-pocket costs. A family of three with income just over the poverty line (which is now a little more than \$16,000 a year for a family of three) could be required to pay more than \$800 per year (or more than half a month's income) in out-of-pocket costs, while a family of three with income just over 150 percent of the poverty line could be required to pay more than \$1,800 a year in cost-sharing charges, or slightly less than a full month's income. Research demonstrates that serious problems occur for low-income households, including loss of insurance coverage and inability to pay for some needed health care services and medications, when cost sharing is set at levels well below these thresholds.<sup>10</sup>

Indeed, the NGA proposal offers *substantially fewer protections than the State Children's Health Insurance Program (SCHIP) provides its beneficiaries*. In SCHIP, for children with incomes below 150 percent of the poverty line, co-payments may not exceed \$5 per service or medication and premiums may not exceed \$19 a month. For children with incomes either below or above 150 percent of the poverty line, total cost-sharing also is limited to five percent of income. Under the NGA proposal, protections for children and other beneficiaries in these income ranges who are enrolled in Medicaid would be much weaker than the protections for comparable children in SCHIP.

The NGA proposal does not include the specific caps on co-payment charges for beneficiaries below 150 percent of the poverty line that SCHIP contains.<sup>11</sup> The NGA proposal would impose *no* limits on the co-payments that could be charged for health care services and medications for children and other beneficiaries with incomes over *100 percent* of the poverty line (or, in the case of children under six, for those over 133 percent of poverty), except for the 5-percent or 7.5-percent-of-income ceilings on total cost sharing<sup>12</sup> The NGA proposal also would place no dollar limit on the monthly premiums that could be charged. Finally, the NGA proposal would set the ceiling on overall cost-sharing charges at 7.5 percent of income for beneficiaries with incomes above 150 percent of the poverty line, rather than at 5 percent of income as under SCHIP.

- **Beneficiaries who could not afford the co-payments could be denied services.** In what would represent another major change in federal law, providers would be authorized to deny services to beneficiaries who could not make the required co-payments — including poor children and pregnant women who could not afford co-payments they were charged for medications — regardless of how sick or poor the beneficiaries are. This would significantly increase the likelihood that substantial numbers of beneficiaries would go without essential health care services or medications because they could not afford the co-payments. Research

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<sup>10</sup> For example, the premiums imposed by Missouri, noted in the box on page 9, are within the proposed NGA limits and are leading to major reductions in children's insurance coverage.

<sup>11</sup> Jocelyn Guyer and Cindy Mann, "Cost Sharing in Medicaid: Issues Raised by the National Governors Association Preliminary Recommendations," Center for Children and Families, Georgetown Univ. Health Policy Institute, July 2005.

<sup>12</sup> In the case of medications, limits on the amount of co-payments that could be charged for drugs would apply only to children with incomes below the poverty line. Children under six whose family incomes are between 100 percent and 133 percent of the poverty line would not be protected.

suggests that if this occurred, the health of these individuals could deteriorate and the need for emergency room or hospital care would increase.

- **Co-payments for prescription drugs could be raised significantly for all categories of beneficiaries.** The NGA proposal contains a series of rather sweeping recommendations with regard to tiered co-payments “for prescription drugs.” Under a tiered co-payment system, a state charges lower co-payments for “preferred” drugs, such as generic drugs and specified brand-name drugs, than for “non-preferred” drugs. States already can use tiered co-payments in their Medicaid programs (and many do) as long as the co-payments do not exceed federal limits. States generally must limit such co-payments to no more than \$3 per prescription, with some populations such as children and pregnant women being exempt from these charges. Tiered co-payments are intended to create incentives for Medicaid beneficiaries to use less costly and/or more effective drugs.

The NGA proposal would alter these procedures by allowing states that use tiered co-payments to charge *unlimited* amounts for drugs, as long as there is a differential between the charges for preferred drugs and non-preferred drugs. The NGA proposal also would eliminate the current exemptions from co-payments for medications; tiered co-payment charges could apply to *all* beneficiaries, including children and pregnant women. The only limit on the tiered co-payments would be that co-payments for *preferred* drugs would have to remain nominal (e.g., \$3 or less) for beneficiaries who had incomes below the poverty. Even these beneficiaries could face *unlimited* co-payment charges for non-preferred drugs.

Other Medicaid beneficiaries would face unlimited co-payment levels for *both* preferred *and* non-preferred drugs. In addition, unlike under current law, pharmacies would be permitted to *deny* medications to beneficiaries who could not pay these amounts.<sup>13</sup>

This proposal could lead to a substantial escalation in drug co-payment charges under Medicaid for both preferred and non-preferred medications, with charges being raised to levels that may not be affordable for significant numbers of low-income beneficiaries. Some states could, for example, decide to increase tiered drug co-payments to levels typically found in private insurance. The Kaiser Family Foundation’s annual survey of employer health benefits found that in private insurance plans that use tiered drug co-payments, the average co-payment for a preferred drug in 2005 was \$22, seven times the current Medicaid limit. The average co-payment charge for a non-preferred drug was \$35, or 11 times the current Medicaid limit.<sup>14</sup> For low-income beneficiaries who are sick and require multiple medications, the combined co-payment charges for the medications they need could reach levels well beyond their means to pay.

Serious questions also arise with regard to the impact of this policy on, for example, a poor beneficiary who needs a diabetes drug, HIV antiviral medication, or similar medication that has been placed on a state’s *non-preferred* drug list. If a state already requires prior approval before a

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<sup>13</sup> According to the CMS Office of the Actuary, the NGA tiered co-payment proposal would reduce federal Medicaid costs by \$2 billion over five years.

<sup>14</sup> Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2004 Annual Survey*, September 2005.

non-preferred drug is dispensed, as a majority of states do (and as all states can), the beneficiary (or her doctor) would have had to navigate the prior authorization system to obtain approval from the state Medicaid program for the non-preferred drug. The beneficiary or her doctor would have to show that the drug is medically necessary for the patient and that other alternative drugs are not appropriate. If the NGA proposal regarding tiered co-payments were instituted, an individual who had gone through this process and received approval for a non-preferred drug as being medically necessary could then face an unaffordable co-payment.

If such a beneficiary were unable to afford the co-payment, the beneficiary might have to go without the medication, since pharmacists would be authorized to refuse to dispense medications to patients who could not make the co-payments. Without the approved non-preferred drug, however, the patient might fail to receive necessary treatment. Or the patient might be forced to use a less-effective drug or a medication that *is* on the state's preferred drug list but has risky interactions with other drugs that the individual takes. Indeed, that could be the reason the patient received prior authorization for the non-preferred drug in the first place.

NGA's justification for its tiered co-payment proposal is that the proposal would "encourage cost-effective drug utilization for all beneficiaries, regardless of income." This justification is not persuasive. It overlooks the various measures that state Medicaid programs already can use to ensure drugs are used in a cost-effective manner.

- States already can institute a variety of procedures to increase reliance on lower-cost drugs. They can require step therapy, under which more cost-effective drugs must be prescribed before more expensive drugs can be used. States also can require that generic drugs be dispensed, if available, when a brand-name drug is prescribed. States can institute provider education programs to encourage use of low-cost and generic drugs. And under federal law, states are required to institute drug utilization reviews to ensure appropriate prescribing by providers and proper use by beneficiaries.
- State Medicaid programs also can set pharmacy reimbursement rates to favor use of certain preferred drugs over other drugs,<sup>15</sup> and they can exclude coverage of certain classes of drugs entirely (such as fertility drugs, barbiturates, and over-the-counter drugs).
- Most important, three-quarters of states have implemented or plan to develop formularies and/or preferred drug lists that require beneficiaries to seek prior authorization for a non-preferred drug before it can be dispensed.<sup>16</sup>

If designed and implemented appropriately, these existing policies can help ensure that states have more efficient spending on prescription drugs. Due to these policies, a majority of the

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<sup>15</sup> See, for example, Jeffrey Crowley, "Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey," Kaiser Commission on Medicaid and the Uninsured, December 2003 and the National Pharmaceutical Council, "Pharmaceutical Benefits under State Medicaid Programs, 2003," November 2004.

<sup>16</sup> National Conference of State Legislatures, "Medicaid Preferred Drug Lists," June 30, 2005, available at <http://www.ncsl.org/programs/health/medicaidrx.htm>. Federal law provides certain beneficiary protections. The preferred drug list must be developed by a Pharmacy and Therapeutics (P&T) committee consisting of physicians and pharmacists, prior authorization requests must be handled within 24 hours, and beneficiaries must be provided a 72-hour supply of the non-preferred drug in emergencies.

drugs prescribed in Medicaid already are generics. Beneficiaries on Medicaid are about 28 percent more likely to use generic drugs than people who have private insurance.<sup>17</sup>

In fact, some evidence suggests that the existing Medicaid policies may themselves be reducing some individuals' ability to obtain drugs they need. Recent research indicates that Medicaid beneficiaries can face difficulties in obtaining needed prescription drugs in states that have adopted certain prescription drug policies available under current law.<sup>18</sup> For example, one recent study in Minnesota found that even tiered co-payments of \$1 for generics and \$3 for brand-name drugs reduced some poor beneficiaries' access to drugs prescribed for them.<sup>19</sup> A new federal policy on tiered co-payments that eliminates federal limits on co-payment levels for prescription drugs for many beneficiaries and allows co-payment levels to be set well above current co-payment levels would be likely to exacerbate these problems substantially.

### Proposal Could Eliminate EPSDT and Other Benefits

NGA proposes to permit states to scale back the current Medicaid benefit package and to substitute a lesser set of benefits that is "actuarially equivalent" to the benefit packages available under certain other private or government employee insurance plans in a state.<sup>20</sup> NGA argues that states need the ability to "target" benefits more narrowly for various categories of beneficiaries. NGA cites SCHIP as a model for these more limited benefits packages.

Under the NGA proposal, states would be able to restrict benefits for children, pregnant women, and parents in the "optional" eligibility categories (i.e., children age six or over with incomes above

#### Closed Prescription Drug Formulary Would Impede Beneficiary Access to Needed Prescription Drugs

Under the Medicaid drug rebate law, states generally must cover all drugs marketed by manufacturers who agree to pay drug rebates. The NGA plan would apparently permit states, at their option, to impose a new policy that would provide coverage *only* for drugs listed in a state's Medicaid "formulary." (States that elected this option would no longer be able to participate in the federal drug rebate program.) In general, under a "closed formulary" of the nature proposed by NGA, few or no exceptions would be allowed for beneficiaries to obtain drugs that are *not* included in the formulary.

A closed formulary of the type envisioned by NGA is not consistent with the private health insurance marketplace. Only two percent of private plans currently use a closed formulary.<sup>1</sup>

Furthermore, the two federal programs that NGA cites as a precedent for closed formularies — drug coverage for veterans through the Veterans Administration and the new Medicare Part D drug benefit — do not use true closed formularies; they provide certain beneficiary access protections. For example, each VA facility is required to have a timely process for allowing coverage of *non*-formulary drugs.<sup>1</sup> In addition, federal regulations require that Medicare Part D plans include adequate coverage of the types of drugs most commonly needed by Part D enrollees and offer complete treatment options for a number of medical conditions, including asthma, diabetes, depression, lipid disorders, hypertension, and HIV. Medicare Part D plans also must establish formularies that do not have the effect of discriminating against certain beneficiaries, such as those with particular medical conditions. Finally, Part D plans must have an appeals process for exceptions to their formulary rules.<sup>a</sup> The NGA proposal does not describe what beneficiary access protections would be provided, if any, under its closed formulary option.

<sup>a</sup> Hoadley, *op cit.*

100 percent of the poverty line, pregnant women and children under six with incomes above 133 percent of the poverty line, and parents with incomes over income thresholds that are set well below the poverty line), as well as for elderly and disabled people who are not on SSI, among others. States would not be allowed to restrict Medicaid benefits for pregnant women, children, or parents in the “mandatory” eligibility categories, SSI recipients, “dual eligibles” (people enrolled in both Medicaid and Medicare), and “medically fragile or special needs populations” (a term that is left undefined).

This proposal raises a number of serious concerns.

- **It apparently ends the guarantee of EPSDT coverage for children in the optional eligibility categories.** For children, Medicaid guarantees access to comprehensive preventive and follow-up care through its EPSDT (Early and Periodic Screening, Diagnosis and Treatment) benefit. Under EPSDT, children are eligible for health care screening and are covered for all health care treatments they are found to need.

The NGA proposal would allow states to restrict health care coverage to a considerably narrower set of benefits for children above the poverty line (or above 133 percent of the poverty line for children under age six), such as the benefits offered under some private insurance plans or state employee plans. Those plans may not cover certain preventive services or treatments that are needed to address health problems detected during health-care screenings.

For example, some private plans do not cover vision, hearing, or dental exams or the eyeglasses, hearing aids, or dental care needed to remedy problems that can impede a child’s ability to learn. Private plans also may not cover some of the special therapies (such as physical therapy or speech therapy) that children who are developmentally delayed or have serious illnesses may require.

- **The proposal could end long-term care for some senior citizens and people with disabilities.** Private insurance usually does not cover long-term care services such as nursing home or home and community-based care, except for short-term aid needed to recuperate after an illness or surgery. Under the NGA proposal, some seniors and people with disabilities who are not dual eligibles or SSI recipients — including elderly and disabled people who have incomes slightly above the SSI income limits (which are set well below the poverty line) and elderly or disabled people in home- and community-based care — could lose Medicaid coverage for long-term care services. The NGA proposal says that “medically frail or special needs populations” would be exempted, but it provides no definition of these terms, and it is unclear which beneficiaries they would protect.

More broadly, the lack of specifics about the criteria to be used to determine the “benchmark” private insurance plans — i.e., the plans whose benefit packages could essentially be substituted for Medicaid’s — as well as the technical uncertainties associated with determining “actuarial equivalence” mean that the NGA proposal provides only a vague standard for the health care coverage that would have to be provided. It is not clear what standards, if any, would guide decisions on which health care services would need to be covered or the levels at which deductibles and co-payments could be set. If a state offers its state employees an insurance option with a \$1,500 deductible, does this mean the state could reduce the value of its Medicaid benefits for some groups by an actuarially equivalent amount?

NGA argues that this policy would help states tailor benefits to the needs of different populations. But the approach NGA suggests carries considerable risks. For example, states apparently would be able to “target” benefits by providing a more limited benefit package to children in optional eligibility categories who are not classified as disabled. Some of these children may have significant illnesses or chronic conditions without meeting Medicaid’s strict definition of disability. They may need some of the same services that a child who is disabled would need.

Similarly, a state could decide it was unnecessary to offer coverage for certain types of heart surgery to children or non-elderly adults because they do not usually require this surgery. Such a decision would not affect many children. But it could create life-threatening problems for a small number of children or non-elderly adults who *do* need such care. The types of limitations on benefit coverage that the NGA proposal apparently would allow could be highly problematic for people who have serious conditions that are unusual for their eligibility category or are unusual generally.

It also is unclear whether, or how, individuals would be able to switch to different coverages if their health status changed. An individual may seem healthy and in need of more limited care until a health condition is diagnosed. If a state uses the authority it would receive under the NGA proposal to place such an individual into more limited coverage based on an assumption of health, that coverage might not cover treatment for a condition the individual is subsequently found to have. What would happen in such a case? Developing systems to address such problems on an immediate basis, as would be necessary in some cases, could be difficult and complicated.<sup>21</sup>

Without greater clarity from NGA, it is difficult to determine the nature and scope of the health care services that states might cease to provide for various categories of beneficiaries under this proposal. If, as some have suggested in seeking to defend this proposal, the changes would be very small in nature, then the savings also would be extremely modest and would not be worth the risks of making such a radical change in basic Medicaid coverage rules. If the changes (and the reductions) in coverage would be broader, the savings could be larger but the loss of health care services for low-income beneficiaries would be greater as well.

Adding to the reasons for doubts about this proposal is the fact that states already have tools they can employ to ensure appropriate use of services. States have broad discretion over which benefits to offer, and they generally can determine the amount, duration, and scope of these services. Medicaid also has protections, such as prior authorization and drug utilization review, to ensure that beneficiaries use only medically necessary services.<sup>22</sup> Mechanisms are available to states to help ensure that Medicaid beneficiaries are not receiving unnecessary care.

Moreover, a recent study by the Urban Institute finds there is little evidence of overutilization of health care services in Medicaid. After controlling for differences in age, income, race and ethnicity, health status, and other factors, the researchers found that adults on Medicaid and adults with

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<sup>21</sup> *Op cit*, p. 2.

<sup>22</sup> Centers for Medicare and Medicaid Services, “Medicaid Services,” see [www.cms.hhs.gov/medicaid/mSERVICE.asp](http://www.cms.hhs.gov/medicaid/mSERVICE.asp)

private insurance had comparable rates of use of many key services, such as physician services, breast exams, and Pap smears.<sup>23</sup>

## Long-Term Care Proposals Have Troubling and Far-Reaching Implications

Another NGA proposal would affect the ability of seniors who own their homes to obtain Medicaid coverage for long-term care services. This proposal, which was not included in the recommendations that NGA issued in June, would, for the first time, count home equity as an asset in determining Medicaid eligibility for seniors. It would likely force many people to sell or mortgage their homes when they needed Medicaid coverage for long-term care services.

Several other NGA proposals are intended to stop or limit practices that some people who are applying for Medicaid long-term care services may employ to shelter assets.<sup>24</sup> Some of these proposals have merit and could help ensure that Medicaid does not provide coverage for individuals who have sufficient resources to pay for care. Other of these proposals are less carefully designed and could harm vulnerable people.

### Counting Home Equity as an Asset

Under longstanding Medicaid rules, home equity has not been considered an asset in eligibility determinations. Under the NGA proposal, however, home equity *would* be considered a countable asset for seniors applying for coverage for long-term care services, including home- and community-based services and nursing home care. The new policy would apply to existing beneficiaries as well as new applicants.

In most states, seniors are eligible for Medicaid only if their countable assets are below \$2,000 for an individual and \$3,000 for a couple. Counting home equity consequently would present most seniors who have even a modest amount of equity in their homes with the choice of selling (or mortgaging) their homes or going without Medicaid coverage for long-term care.

The NGA proposal suggests that people 62 or older could obtain “reverse mortgages” to “convert home equity to cash.” Reverse mortgages are loans in which a lender provides money to an individual age 62 or older in exchange for a future claim on the individual’s home. The NGA proposal assumes that seniors could use the funds generated through reverse mortgages to pay for health and long-term care expenses.<sup>25</sup>

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<sup>23</sup> 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.

<sup>24</sup> The NGA also proposes to allow all states to adopt the Long-Term Care Partnership program, which currently exists in four states. The Partnership program encourages the purchase of long-term care insurance by allowing purchasers to shelter some assets from consideration in the determination of Medicaid eligibility and estate recovery.

<sup>25</sup> The NGA would allow an individual who obtains a reverse mortgage to “shelter” 10 percent of the market value of the home, or \$50,000, whichever is lower. The proposal does not offer details as to exactly how this exemption would work.



For many seniors, however, reverse mortgages would not be a viable option. Some seniors would not qualify for reverse mortgages because they already have mortgage debt or own their homes jointly with someone who is under the age of 62.<sup>26</sup> Reverse mortgages also are not an option for some people who need care in a nursing home or other setting outside the home, because a reverse mortgage loan must be repaid once the home is no longer the primary residence of the borrower. Under the NGA proposal, those who were not able to obtain a reverse mortgage could be left with no choice but to sell their homes when they needed help with long-term care expenses.

Moreover, if a senior could get a reverse mortgage, other family members who live in the home but are not co-owners could be forced to leave the home when the homeowner died or entered a long-term care institution, since the loan would have to be paid at that time. In addition, the costs of obtaining a reverse mortgage can be high; as much as one-third of the home value can go to pay interest and closing costs and thus would not be available for home care and other living expenses.<sup>27</sup>

NGA argues that this proposal would help states by saving them the trouble of recovering Medicaid costs after beneficiaries have died. NGA also says the proposal would make “individuals be responsible upfront for their health care costs.” Yet there has been little experience with using reverse mortgages to pay for long-term care. What research is available suggests this would be a limited and relatively ineffective alternative to current estate recovery policies, under which states may recover the costs of providing long-term care from an individual’s estate. As indicated above, there also are important unanswered questions about how this would affect the ability of an individual’s spouse and dependent disabled children to remain in the community when the individual needs to enter a nursing home.

### **NGA Asset-Transfer Policy Could Have Unintended Consequences**

NGA also proposes changes in policies regarding the treatment of asset transfers by people who apply for long-term care services under Medicaid. While there are anecdotal reports of state Medicaid programs providing long-term care to people who could have used their own resources to obtain such care, little actual data are available on the extent of such practices. A recent GAO study found that none of the nine states it studied had tracked or analyzed data on asset transfers.<sup>28</sup>

Some of the NGA proposals could deter abusive practices. Other NGA proposals could have unintended consequences, such as penalizing people who make small transfers such as birthday gifts or charitable donations *before* an unexpected decline occurs in their health that causes them to need long-term care.<sup>29</sup> The NGA proposals in this area include the following.

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<sup>26</sup> Alexis Ahlstrom, Anne Tumlinson, Jeanne Lambrew, “Linking Reverse Mortgages and Long-Term Care Insurance,” (Washington, DC: The Brookings Institution and George Washington University, 2004).

<sup>27</sup> Mark Merlis, “Home Equity Conversion Mortgages and Long-Term Care,” (Washington, DC: Georgetown University Long-Term Care Financing Project, 2005).

<sup>28</sup> United States Government Accountability Office, “Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage,” (September 2005).

<sup>29</sup> A recent review of the literature found that there is little evidence that nursing home residents transfer assets to gain nursing home eligibility. Ellen O’Brien, “Medicaid’s Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety net,” (Washington, DC: Georgetown University Long-Term Care Financing Project, 2005).

*Changing the “look-back” period and the date that the penalty period starts:* Under current law, if an applicant for Medicaid coverage of long-term care services has made a charitable donation or a gift to relatives within the previous three years, a “penalty period” can be imposed during which the individual is ineligible for Medicaid long-term care. The penalty period begins at or near the time of the transfer; its length is computed by dividing the amount of the gift or donation by the average cost of nursing home care in the state. For small gifts or donations, the penalty period usually is over by the time long-term care is needed.

Under the NGA proposal, which the Administration’s Medicaid Commission also picked up, the “look-back” period (the period examined to determine whether wrongful transfers have occurred) would be lengthened from three to five years. In addition, the penalty period would begin *not* at the time of the transfer, but on the date of application for Medicaid long-term care services — in other words, precisely when the senior needs long-term care — even if the transfer was made years before at a time when the individual was healthy and had no way of knowing he or she later would need long-term care.<sup>30</sup>

The NGA proposal thus would make it more likely that low-income individuals who made small transfers without contemplating that they would later need coverage for long-term care services would face penalty periods. These individuals would have few, if any, resources with which to pay for the long-term care services they needed during the penalty period. If this NGA proposal is adopted, protections for such individuals will need to be strengthened.

Small transfers that occurred during the look-back period should be exempt from the transfer-of-asset rules. In addition, the current policy under which individuals are exempt from these rules in cases where the application of the rules would cause undue hardship should be strengthened by incorporating a definition of “undue hardship” into the Medicaid statute. While CMS guidelines for state Medicaid programs currently define undue hardship, the addition of a definition to the statute would ensure uniform application of the undue hardship exception and make it less likely that low-income and vulnerable individuals would be deprived of necessary long-term care services.<sup>31</sup>

*Changing the treatment of annuities, trusts, and promissory notes.* A much more targeted way to prevent individuals from inappropriately qualifying for Medicaid long-term care coverage would be to curb the use of annuities, trusts, and promissory notes to shelter assets. Such an approach, which NGA briefly refers to in its proposal but on which it offers few specifics, has strong merit. Unlike the NGA proposal to expand the look-back period and revise the penalty period, restricting sheltering mechanisms like annuities would not harm innocent individuals who have made small transfers for purposes unrelated to qualifying for Medicaid long-term care coverage.

In some instances, individuals who apply for Medicaid long-term care coverage currently are able to use the purchase of an annuity to shelter assets and income that otherwise would be available to pay for health care services. Trusts also can be used to shelter property from consideration in

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<sup>30</sup> The penalty period would start in the month following the transfer for people already receiving Medicaid long-term care services.

<sup>31</sup> The CMS guidelines state that undue hardship “exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered,” and when “application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life.” Centers for Medicare and Medicaid Services State Medicaid Manual, §3258.10.

determining Medicaid eligibility, even when the applicant may still have access to the property or the income that it produces. Similarly, promissory notes are sometimes used to shelter property through loans between family members with no real expectations of repayment.

Reforms in this area could limit abusive practices. For example, states should be required to treat “balloon annuities” and other annuities purchased within the look-back period as countable assets in determining eligibility for Medicaid long-term care services. Balloon annuities — which pay out minimal monthly payments, followed by a large “balloon” payment at the end of the annuity term — are particularly abusive. Because the monthly payments are minimal, the amount of income considered in the determination of Medicaid eligibility can be tiny. Meanwhile, the funds used to purchase the annuity are sheltered in the annuity itself, which is not considered an available resource.<sup>32</sup>

Another useful reform would be to treat promissory notes entered into without an expectation of repayment, including those that are automatically cancelled at the death of the individual who made the loan, as improper transfers.<sup>33</sup>

### **Health Insurance Tax Credit Proposal Would Weaken Employer Health Coverage and Could Increase Medicaid Enrollment**

NGA proposes to reinvest some of the savings that its recommendations would produce in federal tax credits for individuals to purchase health insurance and for small employers to offer health insurance. NGA has described this proposal as being intended to prevent further erosion of employer-based coverage and consequently to reduce pressure on Medicaid enrollment. However, while tax credits targeted on small employers, particularly those with large numbers of low-wage workers, are likely to encourage some firms to offer health insurance, health tax credits for individuals could have the opposite effect. They risk weakening the employer-based health insurance system.

The availability of an individual health tax credit would lead some employers to cease providing coverage to their workers or, in the case of new employers, not to offer coverage in the first place. Firms with low-wage labor forces would know that their workers could now get a tax credit to help purchase coverage in the individual market.

Yet older and sicker workers often would not be able to obtain health insurance in the individual market, however, because the individual market generally varies premiums based on age and health status and can exclude sicker people entirely. If employers drop coverage, some older and sicker workers are likely to wind up uninsured. Two leading researchers who analyzed the Bush Administration’s tax credit proposal estimated that under the proposal, 3.4 million people would

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<sup>32</sup> This recommendation is consistent with a report from the National Association of Medicaid Directors (NASMD). National Association of State Medicaid Directors, “The Role of Annuities in Medicaid Financial Planning: A Survey of State Medicaid Agencies,” October 2003. (available at <http://www.nasmd.org/pubs/pubs.htm>)

<sup>33</sup> See Statement of Vincent J. Russo, National Academy of Elder Law Attorneys, Special Committee on Aging, United States Senate, July 20, 2005.

lose employer-based coverage, and 1.3 million of them would become uninsured.<sup>34</sup> Moreover, some workers who lost employer-based coverage but would be able to find coverage in the individual market likely would be able to secure only bare-bones coverage with fewer benefits than the comprehensive coverage commonly available through the employer-based system.

An individual tax credit also could trigger an “adverse selection” cycle.<sup>35</sup> Young and healthy workers could abandon employer-based coverage, because they could use the tax credit to purchase coverage in the individual market at a lower cost than they would face under their employer’s plan. Older and sicker workers, by contrast, would generally want to remain in employer-based coverage. The departure of a first wave of younger, healthier employees would cause premiums for employer-based coverage to rise, because the workers left in such coverage would be older and sicker, on average. Over time, this could lead to a vicious cycle under which growing numbers of healthier workers abandoned employer-based coverage as premium charges climbed and those who remained in such coverage became an increasingly less healthy group. Such developments would place further upward pressure on premiums. The premium increases ultimately could lead more employers to drop coverage or to raise premium charges for employees to levels that many workers could find difficult to afford.

The individual tax credit consequently could destabilize the employer-based system and result in more workers who are sicker and older becoming uninsured. That, in turn, could increase the number of individuals in need of costly care who seek public program coverage through Medicaid or SCHIP. Instead of relieving demand for Medicaid coverage, as the NGA intends, the individual tax credit might exacerbate budget pressures on state Medicaid programs.

As a potential reinvestment of federal funds, the tax-credit proposal thus leaves much to be desired. For the cost of the Administration’s tax credit proposal — \$64 billion over ten years — Congress could instead provide significant direct support for state Medicaid programs. Such reinvestments could include a countercyclical federal matching rate increase during economic downturns and a reduction in the clawback payments that states must make to the federal government under the new Medicare prescription drug legislation.

## Conclusion

Congress is likely to give serious consideration to the NGA proposals. NGA proposals to reduce what Medicaid pays for prescription drugs would produce significant savings, enabling Congress to achieve nearly all of its requirement to reduce projected health-care entitlement expenditures by \$10 billion over the next five years and to do so without harming low-income beneficiaries. A number of NGA proposals in other areas, however, especially those that would substantially increase cost-sharing and limit access to covered benefits, risk reducing access to needed health services for vulnerable low-income beneficiaries.

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<sup>34</sup> See Leonard E. Burman and Jonathan Gruber, “Tax Credits for Health Insurance,” Urban/Brookings Tax Policy Center, June 2005.

<sup>35</sup> See Kaiser Family Foundation, “Coverage and Cost Impacts of the President’s Health Insurance Tax Credit and Tax Deduction Proposals” March 2004; Edwin Park, “Administration’s Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Coverage,” Center on Budget and Policy Priorities, April 6, 2004.