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## MEDICAID PROVISIONS OF HOUSE RECONCILIATION BILL BOTH HARMFUL AND UNNECESSARY

### Senate Bill Achieves Larger Savings Without Reducing Access to Care

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#### Executive Summary

The House and the Senate are attempting to work out a conference agreement on a budget reconciliation bill that reduces funding for a range of programs, including Medicaid. The House and Senate bills differ dramatically in their approach to Medicaid.

The House bill would significantly increase the co-payments and premiums imposed on low-income Medicaid beneficiaries and restrict the availability of important health care services. The Congressional Budget Office (CBO) has found that if these provisions become law, many low-income people would forgo health care services, and others would lose health coverage altogether.

The Senate bill demonstrates that it is possible to achieve savings in health entitlement programs without compromising care for low-income people, by reducing the *cost* of health care rather than beneficiaries' *access* to it. The Senate bill achieves the bulk of its health care savings by reducing Medicaid payments for prescription drugs and curbing excessive Medicare payments to managed care plans (see box on page 3). The House bill, in contrast, largely shields drug companies and managed care plans and obtains the bulk of its savings by shifting costs to low-income beneficiaries.

The House bill contains other harmful elements as well. One such provision is aimed at preventing people who apply for Medicaid long-term care services from sheltering assets that could have been used to pay for long-term care. While the goal of this provision is reasonable, the House provision is poorly designed and would penalize many individuals who make small asset transfers,

#### KEY FINDINGS

- The House reconciliation bill would reduce low-income Americans' access to needed health care by permitting large increases in Medicaid co-payments and premiums and significant reductions in covered health care services.
- The Senate reconciliation bill achieves *larger* net savings in health care expenditures than the House bill does, but avoids policies that harm low-income beneficiaries.
- The House bill also contains other risky Medicaid provisions related to long-term care, documentation of citizenship, and individual health accounts.

such as birthday gifts or charitable donations, well before an unexpected decline occurs in their health that causes them to need long-term care. The asset-transfer provisions in the Senate bill are better targeted and would be more effective.

In addition, the House bill would impose a new requirement on states that U.S. citizens who apply for Medicaid must provide documentation of their citizenship status, generally by producing a birth certificate or passport. Government investigations have found no significant evidence that immigrants are obtaining Medicaid by falsely claiming citizenship, and the main effect of the House provision would be to make it harder for many eligible U. S. citizens to obtain Medicaid coverage because they do not have ready access to a passport or birth certificate.

The House bill also would establish a risky “Health Opportunity Accounts” demonstration project in up to ten states. Beneficiaries who opt for the accounts would be required to meet a substantial deductible before they could access their standard Medicaid benefits, and the accounts would not necessarily be large enough to cover the full deductible. As a result, some low-income beneficiaries could face a sizeable increase in their out-of-pocket health costs. The accounts also would *increase* federal Medicaid costs, since account-holders would be permitted to keep most of the unused funds in their account once they were no longer eligible for Medicaid. This provision, like the new documentation requirement, is not in the Senate bill.

Even as the Senate bill avoids imposing new risks and burdens on low-income people, it also reduces federal expenditures on health entitlement programs *more* than the House bill does. The net health entitlement savings over five years are \$9.3 billion for the Senate bill and \$8.6 billion for the House bill. Over ten years, the gap between the two bills is larger: the Senate bill reduces expenditures for health entitlement programs by \$53.3 billion over ten years, while the House bill reduces expenditures by \$42 billion.

For all of these reasons, any conference agreement should rely heavily on the savings proposals in the Senate bill, including those that reduce excessive payments to Medicare managed care plans and reduce what Medicaid pays for prescription drugs.

This paper outlines the provisions of the House bill that pose the greatest risks to low-income families and individuals.

## **House Bill Would Reduce Access to Health Care for Low-Income Beneficiaries**

The House bill would eliminate many federal standards that protect low-income Medicaid beneficiaries from excessive premiums and co-payments. The Senate bill, in comparison, maintains those cost-sharing protections.

An extensive body of research shows that even modest increases in co-payments can cause significant numbers of low-income beneficiaries to go without needed health care services and prescription medications. The research also demonstrates that when premium charges are imposed on low-income households, substantial numbers of these households do not enroll in health care coverage and end up uninsured. (The research findings are summarized in the box on page 8.)

## Senate Bill Reduces Medicaid Drug Costs and Medicare Managed Care Overpayments

In contrast to the House bill, the Senate reconciliation bill obtains savings in health entitlement programs primarily by reducing excessive payments to Medicare managed care plans and lowering the costs that Medicaid pays for prescription drugs.\* As a result, the Senate bill was able to protect vulnerable low-income Medicaid beneficiaries: the Senate package includes *no* increases in out-of-pocket costs for beneficiaries or cuts in health care services.

The Senate bill includes two provisions to reduce excessive payments to Medicare managed care plans in line with recommendations of the Medicare Payment Advisory Commission (MedPAC), the official, independent advisory body to Congress on Medicare payment policy. Together, these provisions would reduce Medicare spending by roughly \$12 billion over five years and \$36 billion over ten years. Along with a provision that rewards those Medicare providers that provide higher-quality care, these MedPAC-recommended Medicare provisions ensure that slightly more than half of the Senate bill's net savings in health care entitlements (54 percent of the savings over five years) come from Medicare.

The Senate bill also would do much more than the House bill to moderate Medicaid prescription drug costs. To help ensure that Medicaid receives the best prices for the drugs it buys, the Senate bill includes a number of provisions that would significantly increase the rebates that drug manufacturers pay Medicaid. The House bill, on the other hand, includes only two minor rebate provisions (both of which also are in the Senate bill). Along with provisions that appropriately reduce reimbursements that pharmacies receive under the Medicaid program, the Senate bill would save *more than three times* as much as the House bill in the area of Medicaid drug pricing: \$8.2 billion over five years, compared to \$2.2 billion in savings under the House bill.

The Senate's provisions regarding Medicaid drug pricing and Medicare managed care payments account for roughly 74 percent of the bill's gross reductions in health care entitlement costs over five years. By contrast, the House's Medicaid drug pricing provisions account for just 17 percent of the bill's gross cuts in health care entitlements, and no savings would be secured by curbing excessive Medicare provider payments. Instead, half of the gross cuts in the House bill over five years would come from increasing cost-sharing requirements (i.e., co-payments and premiums) on low-income Medicaid beneficiaries and from reducing the health benefits they receive.

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\* Edwin Park, "Congressional Budget Office Estimates Reveal Severity of Medicaid Cuts in House-Passed Reconciliation Bill," Center on Budget and Policy Priorities, Revised November 22, 2005.

Some proponents of increasing co-payments and premiums argue they will make Medicaid beneficiaries more "responsible," implying that beneficiaries are over-using care because the amounts they are charged now are too low. This argument is not supported by the evidence. Recent research shows that adult Medicaid beneficiaries already pay a larger share of their limited incomes for out-of-pocket medical expenses — including expenses for health care services that Medicaid does not cover — than privately insured, middle-income people do. (Medicaid beneficiaries' medical expenses are lower in dollar terms, but higher as a percentage of income.) In addition, a recent Urban Institute study found that people on Medicaid use health care services at

about the same rate as people with private insurance and are somewhat more likely than privately insured people to have unmet needs for medication.<sup>1</sup>

## What the Bill Would Do<sup>2</sup>

### *Raise Premiums and Co-Payments Substantially for Many Beneficiaries*

The House bill would allow large increases in Medicaid co-payments. It also would permit states to impose substantial premiums on six million low-income children and many other beneficiaries for the first time. Those who would be most heavily affected by these changes include: children age six and over and working parents whose incomes are above the poverty line (\$16,090 for family of three); children under age six whose family incomes are above 133 percent of the poverty line; and people with serious disabilities and other adults whose incomes are above the poverty line and who are not also enrolled in Medicare.

Currently, low-income beneficiaries in these categories can be charged \$3 for each doctor or hospital visit (or other health service) and \$3 for each prescription, unless they are children or pregnant women.<sup>3</sup> Children and pregnant women are currently exempt from co-payments, in order to ensure that they receive preventive services like well-baby care and immunizations. In addition, Medicaid beneficiaries generally cannot be charged premiums under current law.

The House bill would radically weaken these protections for people with incomes above the poverty line:

- Premiums could be charged to beneficiaries, and there would be no dollar limit on how high the premiums could be set.
- Higher co-payments could be charged for each doctor visit, medication, or other health care service, and there would be no dollar limit on how high the co-payment could be set. A state could charge \$10, \$20, or more for each doctor visit.<sup>4</sup>

The sole limit on premium and co-payment charges under the House bill is that such charges as a whole could not exceed five percent of a family's annual income. Such a limit offers little protection to low-income families struggling to make ends meet, for two reasons.

- Co-payments and premiums set well below five percent of income have been shown to create large barriers to health care for many low-income individuals. For example, Urban Institute analyses, based on experiences in several states, indicate that if premiums reach five percent of a

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<sup>1</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>2</sup> This section does not provide an exhaustive list of the co-payment and premium charges in the House bill.

<sup>3</sup> Other groups exempt from co-payment charges under current law include pregnant women, people in long-term care institutions (who generally spend nearly their entire incomes on medical expenses), and terminally ill individuals receiving hospice services.

<sup>4</sup> The House bill would exempt preventive services for children, pregnancy-related services, emergency care, and family planning services from co-payments.

family's income, about three-quarters of those enrolled could lose coverage because of inability to afford the premiums.

- The five percent limit is an *annual* cap; a household's out-of-pocket costs could be much greater than five percent of its income during some months. For example, if a family making \$18,000 per year experienced a major health problem (say, the mother contracted a catastrophic illness or the family was injured in a car accident), the family might need to spend \$450 per month for two months — nearly a third of its income in each of those months — before reaching the five percent cap.

*Permit States to Increase Co-payments Faster than Growth in Poor Beneficiaries' Incomes*

For beneficiaries below the poverty line, the \$3 co-payment limit would be raised each year by the percentage increase in the medical care component of the Consumer Price Index (CPI). The medical CPI rises about twice as quickly as the overall CPI.<sup>5</sup> The incomes of people below the poverty line, by contrast, tend to rise more slowly than the CPI, on average. (Wages at the low end of the pay scale have stagnated, and the minimum wage has been frozen without any adjustment for inflation since 1997.)<sup>6</sup> As a result, many impoverished beneficiaries would face co-payments that consumed a larger share of their limited incomes with each passing year.

*Permit Providers to Deny Care for People Unable to Pay Co-Payments*

The House bill also would allow health care providers, for the first time, to deny health care services and prescription drugs to beneficiaries who are unable to pay the co-payments they are charged. Because more patients will have difficulty affording the new, higher co-payments, this change heightens the risk that patients will be unable to obtain medications or health care they need. The risk is greatest for people who are disabled or who have chronic health problems, since they require more care and thus face a larger volume of co-payments.

*Permit Tiered Drug Co-Payments for Poor Children, Pregnant Women, and People in Nursing Homes*

In addition, the House bill would permit states to charge prescription drug co-payments even to populations who are exempt from the House bill's other cost-sharing changes — including children below the poverty line and pregnant women — if the state establishes a tiered prescription drug co-payment system. Under a tiered system, lower co-payments are charged for “preferred” drugs (such as generic drugs and specified brand-name drugs) than for “non-preferred” drugs. The House bill would allow states that establish a tiered system to charge children and pregnant women with

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<sup>5</sup> Shortly before the bill passed, the House modified this provision so that co-payment limits for beneficiaries below the poverty line would not rise to \$5 by 2008. But the House left in place the requirement that this co-payment limit be adjusted upward each year by the medical CPI. The modest change reduced CBO's estimate of the magnitude of the cost-sharing cuts by four percent, from \$12.1 billion over ten years to \$11.6 billion.

<sup>6</sup> Arloc Sherman and Isaac Shapiro, “Hardship Indicators Point to a Difficult Holiday Season,” Center on Budget and Policy Priorities, November 21, 2005.

incomes below the poverty line \$3 per prescription for non-preferred drugs; this co-payment limit would be raised each year with the medical CPI.<sup>7</sup>

Tiered co-payments are intended to encourage people to use drugs that are less costly and/or more effective than other drugs. States, however, already have significant tools to steer Medicaid beneficiaries towards more cost-effective medications. 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.<sup>8</sup> States can also require “step therapy,” under which more cost-effective drugs must be prescribed before more expensive drugs can be used, and can require that generic drugs (if available) be dispensed when a brand-name drug is prescribed. States can institute provider education programs to encourage use of low-cost and generic drugs.

Furthermore, states can already use tiered co-payments in their Medicaid programs — and many do — as long as the co-payments do not exceed federal co-payment limits. In addition, 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>9</sup> and can exclude coverage of certain classes of drugs entirely (such as fertility drugs, barbiturates, and over-the-counter drugs).

If designed and implemented appropriately, these existing policies can help states contain costs on prescription drugs *without* imposing co-payments on exempt populations like poor children and pregnant women, as the House bill would do. In fact, due to the use of existing policies, a majority

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<sup>7</sup> States could also choose to impose tiered drug co-payments on non-exempt groups. If they elected to do so, they would be required to adhere to certain limitations. They could charge beneficiaries with incomes below the poverty line up to \$3 per prescription for non-preferred drugs, with the \$3 “nominal” charge being raised each year by the percentage increase in the medical CPI. For individuals with incomes between 100 percent and 150 percent of the poverty line and for individuals with income above 150 percent of the poverty line, states could charge no more than two and three times the nominal co-payment, respectively, for non-preferred drugs. Co-payments for preferred drugs would be below these limits for most beneficiaries. However, states would not be permitted to charge preferred drugs copayments to exempt groups like mandatory children and pregnant women.

Since the House bill’s general cost-sharing provisions already would allow states to charge *unlimited* co-pays to individuals above the poverty line, subject only to the five-percent-of-annual-family-income limit, states are likely to use the bill’s specific provisions related to tiered co-payments for drugs only to charge drug co-payments to otherwise-exempt groups such as children and pregnant women. Under the House bill, states could use these provisions to charge nominal co-payments for non-preferred drugs for children and pregnant women, while imposing higher co-payments on other beneficiaries with incomes above the poverty line. (This is permitted because the House bill eliminates the comparability rule, under which states are required to charge the same cost sharing and provide the same benefits to all eligibility groups. As a result, states would be permitted to charge different levels of cost-sharing across groups of beneficiaries, including children.)

<sup>8</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.

<sup>9</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.

of the drugs prescribed in Medicaid already are generics, and Medicaid beneficiaries are about 28 percent more likely to use generic drugs than people with private insurance.<sup>10</sup>

### CBO Finds These Charges Would Reduce Access to Care

CBO estimates that the House bill's increases in co-payments and premiums would cause many Medicaid beneficiaries to forgo various health care services or not enroll in Medicaid at all. The House provisions would result in "reduced utilization of services due to higher cost-sharing requirements and decreased participation in Medicaid by individuals who would be required to pay premiums," CBO has written in its analysis of the House provisions.<sup>11</sup>

While states may wish to avoid making severe cost-sharing changes, they are likely to come under increasing pressure over time to institute such changes, as health care costs mount and more baby boomers enter their retirement years. Indeed, CBO anticipates that states will gradually increase levels of cost-sharing — and also make increasingly deep reductions in benefits, as discussed below — over the next ten years, so the effects of the House provisions grow more severe by the final years of the decade. CBO projects that the cost-sharing provisions would cause reductions in federal Medicaid expenditures of \$2.4 billion over five years and \$11.2 billion over ten years.

About 80 percent of the federal savings from the House bill's increases in co-payments would come from decreased use of services such as doctors' visits and prescribed medications, CBO projects. Ultimately, according to CBO, more than 100,000 people would lose coverage altogether because they would have trouble paying premiums.<sup>12</sup>

CBO also concluded that the reduced use of health care services would result in more emergency room visits and higher emergency care costs. Emergency care costs increase when people's health worsens because they have not received adequate preventive care or timely treatment.

### New Co-Payment and Premium Charges More Severe than Under Medicare or SCHIP

Finally, for beneficiaries below the poverty line, the new schedule of allowable charges for prescription drugs would be higher than those under the Medicare prescription drug law, while for Medicaid beneficiaries *above* the poverty line, the allowable charges would substantially exceed those permitted under the State Children's Health Insurance Program (SCHIP).

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<sup>10</sup> Congressional Budget Office, "Medicaid's Reimbursements to Pharmacies for Prescription Drugs," December 2004. G.E. Miller and J.F. Moeller, "Outpatient prescription drug prices and insurance coverage," in *Investing in Health: The Social and Economic Benefits of Health Care Innovation*, pp 23-57, 2001.

<sup>11</sup> Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Energy and Commerce," October 31, 2005.

<sup>12</sup> Congressional Budget Office, "Additional Information on CBO's Estimate for the Medicaid Provisions in H.R. 4221, the Deficit Reduction Act of 2005," November 9, 2005. The CBO estimate of the number of people who would lose coverage as a result of the imposition of premiums may be too low. The CBO assumption that 110,000 people ultimately would lose coverage (in 2015, after these changes had fully phased in) rests on an assumption that states would apply premiums only to two million beneficiaries. Under the House bill, states would be allowed to charge premiums to a much larger number of beneficiaries than that. If states did so, the number of eligible low-income people losing coverage would likely be higher. (In addition, CBO's estimate of the percentage of people who would lose coverage due to the premiums appears to be lower than the research literature would suggest.)

### 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 that higher premiums lead to fewer low-income people having health coverage. Key findings include:

- 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. Children had higher rates of anemia, for example, while adults had higher rates of high blood pressure and greater risk of death due to heart disease.
- University of Maryland researchers found that when states begin charging co-payments for drugs in their Medicaid programs, beneficiaries reduce their use of medications, and beneficiaries in poor health cut back on medications to a greater degree than people in good health do.
- After Oregon increased its Medicaid premiums and co-payments, 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. They also incurred larger medical debts and frequently were refused care because of those debts.
- An Urban Institute study estimated that charging low-income beneficiaries premiums of one percent of a family's income (\$15 per month for a family making \$18,000 per year) can reduce Medicaid enrollment by about 15 percent. Charging premiums of five percent of income can reduce enrollment by about 74 percent.
- A recent study conducted in a large public hospital in Minnesota found that after tiered co-payments for prescription drugs were imposed (\$1 for generic drugs and \$3 for brand name drugs), about half of Medicaid patients 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.

*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, et al., "The Impact of Increased Cost-sharing on Medicaid Enrollees," *Health Affairs*, 24(4):1107-15, July/August 2005. Leighton Ku and Teresa Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, 36:471-480 (Winter 1999-2000). Melody Mendiola, et al., "Consequences of Tiered Medicaid Prescription Drug Copayments Among Patients in Hennepin County, Minnesota," Hennepin County Medical Center, Minneapolis, MN.

- Under the Medicare drug law, Medicare drug co-payments for elderly and disabled people who also receive Medicaid and have incomes below the poverty line may not exceed \$1 for generic drugs and \$3 for brand-name drugs in 2006. These levels will be adjusted in future years by the overall Consumer Price Index. Under the House bill, as noted, Medicaid drug co-payments for poor beneficiaries would start at \$3 per prescription (for non-preferred drugs) and would be adjusted according to the medical CPI, which rises about twice as fast as the overall CPI.



- Similarly, for Medicaid patients modestly above the poverty line, the allowable cost sharing charges would be set much higher than the charges that can be imposed on people in the same income ranges under SCHIP. In SCHIP, children whose families have incomes between 100 percent and 150 percent of the poverty line can be charged no more than \$5 for each co-payment and no more than \$16 a month in premiums for a family of three. (These limits are in addition to an SCHIP rule that total co-payments and premiums may not exceed five percent of a family's income.) There would be no such dollar limits under the House bill.

## House Bill Would Eliminate Medicaid Benefit Standards for Millions of Beneficiaries

The House bill would do away with current federal standards governing the benefits that Medicaid provides to millions of children, parents, pregnant women, and adults with disabilities, and would establish little in the way of meaningful standards in their place.<sup>13</sup> For states facing budgetary pressures caused by factors such as rising health care costs, the aging of the population, and a future economic downturn, the elimination of these federal standards would permit them to reduce Medicaid expenditures by substantially weakening their Medicaid benefit packages.

Large number of beneficiaries could lose important health care services as a result. About six million children would lose the guarantee of comprehensive health benefits offered by Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Millions of adults and people with severe disabilities could also face significant reductions in health benefits. CBO estimates that the savings from this proposal would be significant: about \$4 billion over five years and more than \$18 billion over ten years. This makes the benefits provision the single largest source of Medicaid savings in the House bill.

### Who Would Be Affected?

Under the House bill, states could provide reduced benefit packages to the following groups of Medicaid beneficiaries:

- children age six to 17 with family income above the poverty line (\$16,090 per year for a family of three);
- children under age six with family income over 133 percent of the poverty line (\$21,400 per year for a family of three);
- *all* adults with disabilities who are not receiving Medicare, regardless of their income; and
- *all* parents, regardless of their income.<sup>14</sup>

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<sup>13</sup> Few seniors would be affected, because the bill exempts those eligible for both Medicaid and Medicare ("dual eligibles").

<sup>14</sup> Certain individuals in these groups would be exempt, including pregnant women, people in hospitals, nursing homes, hospices and other institutions, and individuals considered "medically frail" or having "special needs" as defined by the Secretary of Health and Human Services.

CBO estimates that for people affected by the benefit reductions, health care expenditures made on their behalf would drop by an average of 15 percent to 35 percent. This would mean that by 2015,

- Medicaid expenditures for children's health care would be reduced by \$542 to \$1,264 per affected child;
- Medicaid expenditures for adults' health care would be reduced by \$651 to \$1,518 per affected adult; and
- Medicaid expenditures for health care for people with disabilities would be reduced by \$4,194 to \$9,786 per affected individual.<sup>15</sup>

These figures reflect health care services that beneficiaries would have received under current Medicaid rules but would not receive under the benefit reductions the House bill would permit.

### The Choices Facing States

The House bill would permit a state to change its Medicaid benefit package for affected groups of beneficiaries to match any of the following: the benefit package offered by the standard health plan offered to federal employees, any health plan offered and generally available to state employees, or the plan offered by the health maintenance organization (HMO) with the largest enrollment in the state.

Alternatively, a state could change its Medicaid benefit package to one that is "actuarially equivalent" to the coverage offered by one of the above plans.<sup>16</sup>

The benefits offered could be very limited. Under the House bill, for example, South Carolina could offer Medicaid beneficiaries a health plan with an actuarial value equivalent to the state's "Savings Plan," which it began offering state employees in 2005. That plan includes deductibles of \$3,000 for a single individual and \$6,000 for a family.

A state could even develop a new state employee health plan option with bare-bones coverage in order to use the plan as the benchmark for its Medicaid coverage. As long as the plan was "offered" to state employees, such a practice would be permitted under the House bill, even if no state employees signed up for the plan. (The state could offer several options to its employees, one of which was the bare-bones plan. That would be sufficient to allow the state to use this plan as the benchmark for Medicaid coverage and strip back its Medicaid benefit package sharply for various categories of beneficiaries.)<sup>17</sup>

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<sup>15</sup> Jeanne Lambrew and Karen Davenport, "Medicaid: House Budget Proposal Harms Millions," Center for American Progress, November 2005. These figures are in 2015 dollars.

<sup>16</sup> This "benchmark-equivalent coverage" would be required to cover certain services, such as inpatient and outpatient hospital care, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care, and other preventive services designated by the Secretary of Health and Human Services.

<sup>17</sup> Cindy Mann and Jocelyn Guyer, "House Budget Bill Would Eliminate All Current Federal Medicaid Benefit Standards for Six Million Children and Other Vulnerable People," Georgetown University Health Policy Institute Center for Children and Families, November 2005.

CBO estimates that over the next decade, states containing about 20 percent of all Medicaid enrollees would institute the benefit reductions permitted by the House bill. Overall, CBO estimates that 5 million Medicaid beneficiaries would be affected by 2015, half of them children. The number who *could* be affected is considerably larger. Health care experts Jeanne Lambrew and Karen Davenport estimate that if all states take advantage of this new option, as many as 26 million people could have their benefits reduced.<sup>18</sup>

### Children Would Lose Guarantee of Comprehensive Care

The House bill would eliminate the guarantee of EPSDT benefits for about six million children enrolled in state Medicaid programs. Congress added EPSDT to Medicaid in 1967 and strengthened it in subsequent years in recognition of the critical role that Medicaid plays in promoting the health and development of low-income children.<sup>19</sup> Under EPSDT, states must ensure that all children enrolled in Medicaid receive regular check-ups, including vision, dental, and hearing exams, as well as all necessary immunizations and laboratory tests. Children also must receive all necessary follow-up diagnostic and treatment services, even if a state Medicaid program has chosen not to cover some of those services for adults.

Under the House bill, states would no longer have to provide ESPDT benefits to children above the poverty line. In the case of children under age six, states would no longer have to provide ESPDT benefits to children above 133 percent of the poverty line.

Coverage for children under commercial insurance plans, on which states would be permitted to model their scaled-back Medicaid benefit packages, often differs significantly from what children receive under EPSDT. Commercial insurers often limit coverage and treatment and use restrictive definitions of medical necessity. While states would be required to continue to cover immunizations, well-child care, and a limited number of other services, they could, under the House bill, decide what other services to provide.<sup>20</sup> For example, they could limit the type and amount of mental health services they provide, a step that a number of states have taken in their State Children's Health Insurance Programs.<sup>21</sup>

In contrast to the guidelines used by commercial insurers, the EPSDT component of Medicaid provides an additional protection for children enrolled in Medicaid by requiring states to provide them with all health care services necessary "to correct or ameliorate defects and physical and mental health conditions."<sup>22</sup> Under EPSDT, states cannot limit services like speech or physical therapy that a child needs to maintain health. Commercial insurance plans often cut off such services when an

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<sup>18</sup> Lambrew and Davenport, op.cit.

<sup>19</sup> Sara Rosenbaum, D. Richard Mauery, Peter Shin, and Julia Hidalgo, "National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT," George Washington University School of Public Health and Health Services, April 2005.

<sup>20</sup> Cindy Mann and Elizabeth Kenny, "Differences that Make a Difference: Comparing Medicaid and the State Children's Health Insurance Program Federal Benefit Standards," Center for Children and Families, Georgetown Health Policy Institute, October 2005.

<sup>21</sup> Sara Rosenbaum, Anne Markus, Colleen Sonosky, "Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP," *Journal of Health and Biomedical Law*, 1 (2004).

<sup>22</sup> Section 1905(r) of the Social Security Act.

### Scaling Back Medicaid Benefits Could Eliminate Important Services for Children

In 2003, the Connecticut General Assembly authorized a state waiver that would have reduced Medicaid benefits for children to match those provided under the health plan made available to state employees. Even though Connecticut's state employee plan is relatively generous, a comparison of the two benefit packages shows that adopting the plan for children on Medicaid would have cost those children important benefits. (The General Assembly repealed authorization for the waiver in 2004, before it was submitted to the federal government.)

Benefit	HUSKY A (Medicaid)	State Employee Plan
Durable medical equipment such as wheelchairs, walkers, and nebulizers	covered	not covered
Special shoes and braces	covered	not covered
Medically necessary over-the-counter drugs	covered	not covered
Eyeglasses	covered	not covered
Hearing aids	covered	not covered
Medical and surgical supplies (including mattress and pillow covers and vacuum filters for children with asthma)	covered	not covered
Physical, occupational, and speech therapy	covered to attain or maintain optimal level of health	covered if therapy is expected to result in reasonable improvement
Non-emergency medical transportation	covered	not covered

Source: Judith Solomon, Mary Alice Lee and Joan Alker, "The Impact of Co-payments and Reduced Benefits on Children Enrolled in HUSKY A," (Farmington, CT: Connecticut Health Foundation, January 2004).

individual's condition is no longer improving, even when the services are essential just to maintain the progress that has been made.<sup>23</sup>

The comprehensive coverage provided through EPSDT is especially important for children with special health care needs, including physical, emotional, behavioral, developmental, or other ongoing health conditions. According to one study, almost 40 percent of children with special health care needs rely on Medicaid for health coverage.<sup>24</sup> EPSDT provides them with special equipment such as wheelchairs, medical supplies to treat asthma and diabetes, and ongoing services such as physical therapy, speech therapy, and mental health treatment. Under the House bill, many children with special health care needs who have incomes just above the poverty line could lose these and other critical services.

<sup>23</sup> Sara Rosenbaum, Anne Markus, Colleen Sonosky, and Lee Repasch, "State Benefit Design Choices under SCHIP – Implications for Pediatric Health Care," Center for Health Services Research and Policy, George Washington University, May 2001.

<sup>24</sup> Ha T. Tu and Peter J. Cunningham, "Public Coverage Provides Vital Safety Net for Children with Special Health Care Needs," Center for Studying Health System Change, September 2005.

### Providing Health Coverage Aid to Katrina Survivors

The House bill also includes a modest provision making additional Medicaid funding available to states that are providing Medicaid coverage to Katrina survivors who have been evacuated from Louisiana, Mississippi, and Alabama. The bill would temporarily increase the federal Medicaid matching rate to 100 percent for all Medicaid costs incurred by a state on behalf of a Katrina survivor.

The bill would also temporarily increase the federal Medicaid matching rate to 100 percent for all Medicaid costs in Louisiana and Mississippi, the states most directly affected by Katrina. The bill would increase the federal Medicaid matching rate to 100 percent for Alabama, but only for those counties that have been declared disaster areas.

These provisions would be effective for the period between August 28, 2005 and May 15, 2006. Altogether, CBO estimates they would increase federal Medicaid costs by \$2.5 billion over five years.

The House bill's Katrina-related Medicaid provisions are preferable to the Katrina-related Medicaid provisions in the Senate bill, which would provide much less relief to Louisiana and Mississippi than the House bill would. Such relief is essential. Louisiana, in particular, has sustained a heavy blow to its revenue base as a result of Hurricanes Katrina and Rita. In a recent special legislative session, Louisiana already began scaling back its Medicaid program significantly, even though many Louisiana residents have no income or assets since the hurricane and thus are eligible for Medicaid.

It is important to note, however, that neither the House nor the Senate bill adequately addresses the health care needs of low-income Katrina victims. For example, neither bill permits states to temporarily cover impoverished Katrina survivors who do not fit into one of Medicaid's traditional eligibility categories. This means that many Katrina survivors — especially adults under 65 who do not have dependent children and are not “sufficiently” disabled — are likely to go without health coverage even if they have serious medical conditions.\*

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\*See for example, Donna Cohen Ross, “Many Katrina Survivors Seeking Medicaid in Louisiana Shelters Remain Without Coverage: Medicaid Eligibility Rules Continue to Be the Major Barrier,” Center on Budget and Policy Priorities, October 12, 2005.

### Adults, Including Many with Disabilities, Would Face Loss of Needed Services

While children would be the biggest losers from the benefit cuts authorized by the House bill, millions of adults could lose important benefits as well. The impact would be greatest on adults with disabilities.

Under the House bill, a number of services that Medicaid now provides would no longer be guaranteed, including family planning services and home health care services for people who would otherwise need to be placed in a nursing home.

Even more harmful is the House bill's elimination of protections regarding how health care services must be provided. Current Medicaid rules require that each covered service be “sufficient in amount, duration, and scope to reasonably achieve its purpose.” States cannot discriminate among individuals based on their diagnosis, type of illness, or condition, and generally cannot

provide different benefits to different individuals based on their age or health status. Moreover, states must ensure that Medicaid beneficiaries have transportation to and from providers.<sup>25</sup> Under the House bill, all of these protections would be lost for millions of beneficiaries, including almost all parents and many adults with disabilities, even those with incomes below the poverty line.

Without these protections, states could treat different groups of beneficiaries very differently. The risk of harm would be greatest for persons with certain chronic conditions and disabilities who rely on the comprehensive coverage and ongoing treatment that Medicaid now provides. Thus, a state could provide personal care services to adults with cerebral palsy, but not to adults with other conditions that also require personal care assistance. A state could provide different benefit packages to beneficiaries living in rural areas and urban areas, and it could restrict the number of visits allowed for mental health treatment even if that would limit the effectiveness of most individuals' treatment. In addition, low-income beneficiaries would no longer be guaranteed transportation to doctor visits. In short, the harm caused by the House bill would go beyond the loss of specific benefits.

### **Asset Transfer Rules Would Penalize Some Seniors Who Need Long-Term Care Coverage**

Both the House and Senate reconciliation bills would change the rules regarding the treatment of asset transfers made by people who apply for long-term care services under Medicaid, but the two bills would change those rules in sharply different ways. The Senate bill would target abusive practices that can be used to shelter assets that otherwise could have been used to help pay for long-term care services. In contrast, the House bill would likely harm low-income seniors who make small transfers such as birthday gifts or donations without contemplating that they would later need coverage for long-term care services.

The Senate bill would stop individuals from sheltering assets that could pay for long-term care by purchasing annuities or making loans without expectation of repayment. For example, it would stop the use of "balloon annuities," which pay out minimal monthly payments followed by a large "balloon" payment at the end of the annuity term. Even when an annuity is found to be legitimate, the Senate bill would require that the state be named as a beneficiary so it could receive repayment after a person's death for Medicaid funds spent on the person's long-term care services.<sup>26</sup>

In contrast to the Senate's more targeted provisions, the House bill would penalize people who made small transfers *before* an unexpected decline occurred in their health that caused them to need long-term care.

Under current law, if an applicant for Medicaid 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

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<sup>25</sup> See generally Andy Schneider, "The Medicaid Resource Book," Kaiser Commission on Medicaid and the Uninsured, July 2002, Chapter 2.

<sup>26</sup> The House bill includes a far more limited provision that would limit the use of only some annuities used to shelter assets. The House would also make the state the beneficiary of annuities that are deemed legitimate.

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 actually is needed.

Under the House proposal, the “look-back” period (the period examined to determine whether wrongful transfers have occurred) would be lengthened from three to five years. In addition — and of greatest concern — the penalty period that is imposed when a transfer is discovered would begin *not* at the time of the transfer but at the time that the individual needs Medicaid coverage for long-term care services, even if the transfer was made years before.

Because of this latter change, the House bill would penalize healthy seniors when they make charitable donations or small gifts to relatives several years before needing long-term care. For example, a healthy woman who gave her grandchild \$2,000 a year for college tuition for four years could be left without any resources to pay for long-term care several years later when she unexpectedly became very ill. Under the House bill, individuals like her would be left unable to pay for necessary long-term care services because the penalty would begin precisely at the time they need Medicaid coverage for long-term care services.

### **Documentation Requirement Would Create New Barrier to Coverage**

The House bill would impose a new requirement on states that U.S. citizens who apply for Medicaid must provide documentation of their citizenship status, generally by producing a birth certificate or passport.<sup>27</sup>

Sponsors of this provision may think this new procedure would prevent ineligible immigrants from falsely obtaining Medicaid coverage. Yet HHS’ Office of Inspector General (OIG), which recently investigated this issue, found no substantial evidence that immigrants obtain Medicaid by falsely claiming citizenship, and OIG did not recommend a documentation requirement such as the House bill would impose.<sup>28</sup>

Federal law already requires immigrants who apply for Medicaid to provide proof of their legal immigration status.<sup>29</sup> States demand such documents on their Medicaid applications, and they take other steps to verify immigrants’ legal status as well. When people apply as *citizens*, they normally attest under penalty of perjury that they are citizens, and states do not require documentation of citizenship on a routine basis. However, if there is any question about an applicant’s citizenship, almost all states require documentation of citizenship. The OIG findings confirm this.

The Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services, which oversees Medicaid, concurs with OIG. CMS has reported that it has no evidence there is a problem in this area. Similarly, state Medicaid administrators have reported, based on the

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<sup>27</sup> Some other documents, such as citizenship naturalization papers, are allowed, but birth certificates and passports are the main documents that would be used by native-born citizens. HHS may specify other permissible documents.

<sup>28</sup> HHS Office of the Inspector General, “Self-Declaration of U.S. Citizenship Requirements for Medicaid,” July 2005.

<sup>29</sup> Undocumented immigrants are eligible only for emergency medical care, not full Medicaid coverage.

results of their quality control review systems, that “they have not seen a problem with self-declaration of citizenship.”<sup>30</sup>

This suggests the House provision would generate little or no savings from rooting out ineligible immigrants who have applied for Medicaid and falsely claimed to be citizens. The bulk of the savings from this provision, which CBO estimates to be \$735 million over ten years, would come instead from reducing or delaying enrollment among *U.S. citizens*.

Many citizens, particularly low-income citizens, do not have birth certificates in their possession and do not have passports. This could be a particular problem for people who are in need of immediate medical care, including people who are elderly or have physical or mental disabilities.

Under the House provision, a mother whose child is injured may not be able to obtain timely medical care because she does not have a valid copy of a birth certificate readily available. Citizens who are homeless or who have experienced a disaster such as Hurricane Katrina or a fire may be unable to enroll in Medicaid because they do not have the required documents in their possession. Obtaining a duplicate birth certificate or passport can take weeks and require costly fees. It can cost \$5 to \$23 to get a birth certificate. A passport costs \$87 to \$97.

Some native-born citizens would encounter particular problems because they were born at home rather than a hospital and may never have had a birth certificate. This is especially a problem for some elderly African Americans, who were born in an era when African Americans (especially in the South) had less access to hospitals due to racial discrimination. One study estimated that as many as one-fifth of African-Americans born around 1940 lack a birth certificate.<sup>31</sup>

Requiring greater documentation would also make it more difficult to administer Medicaid. Program administrators have reported that the requirement would increase administrative costs and could reduce enrollment significantly because of the additional administrative barriers it would create. Connecticut’s Medicaid director, for example, has observed that requiring documentation “would be an enormous administrative burden,” while Wisconsin’s Medicaid director has stated that the proposal “would have a material and significant effect on enrollment.”<sup>32</sup>

### **Health Opportunity Accounts Increase Federal Costs, as Well as Risks to Beneficiaries**

The House bill also includes a risky provision to establish “Health Opportunity Accounts” for Medicaid beneficiaries in up to ten states.<sup>33</sup> Beneficiaries who opt for the accounts would be

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<sup>30</sup> HHS Office of the Inspector General, *op cit*.

<sup>31</sup> S. Shapiro, “Development of Birth Registration and Birth Certificates in the United States,” *Population Studies*, 4:86-111, 1950. Cited by I. Rosenwaike and M. Hill, “The Accuracy of Age Reporting Among Elderly African-Americans: Evidence of a Birth Registration Effect,” Population Aging Research Center, Univ. of Pennsylvania, Working Paper, July 1995.

<sup>32</sup> John Reichard, “Critics Say New Documentation Rules for Medicaid Would Reduce Enrollment,” *CQ HealthBeat*, Nov. 8, 2005.

<sup>33</sup> For a more detailed analysis of Health Opportunity Accounts, see Edwin Park and Judith Solomon, “Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach,” Center on Budget and Policy Priorities, Revised November 1, 2005.



## Senate Bill Includes Provisions to Change Redistribution of Unspent SCHIP Funds

In fiscal year 2006, 16 states are expected to have insufficient federal funding under the State Children's Health Insurance Program (SCHIP) to sustain their existing SCHIP programs.\* As a result, these states will likely have little choice but to scale back health coverage for low-income children.

While the House reconciliation bill includes no provisions to remedy this problem, the Senate reconciliation bill includes several SCHIP provisions that are intended, in part, to ensure that states have sufficient SCHIP funding in the short term.\*\* CBO estimates that these provisions would cost \$140 million over five years.

The principal Senate SCHIP provision would modify federal rules related to the availability and redistribution of federal SCHIP funds. Under current law, states have three years to spend their annual allotment of federal SCHIP funding. The Senate bill would reduce this period of availability to two years for fiscal year 2004 funds and fiscal year 2005 funds. Any unspent funds remaining after two years would then be redistributed to other states that face federal funding shortfalls. This would result in no state having insufficient federal funding in 2006. It would, however, still leave 22 states with inadequate SCHIP funds in 2007.

The Senate bill is clearly preferable to the House bill in the area of SCHIP financing. An additional desirable step, besides the provisions in the Senate bill, would be to restore \$1.1 billion in unspent SCHIP funds that expired and reverted to the Treasury in 2004 and use those funds to help eliminate states' SCHIP shortfalls in both 2006 *and* 2007.

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\*CBPP SCHIP spending model updated to reflect states' fiscal year 2005 SCHIP expenditures reported as of August 2005.

\*\* Another provision would prohibit the Secretary from granting any new section 11115 waivers that use SCHIP funds to cover childless adults.

required to meet a substantial deductible before they could access their standard Medicaid benefits. In return, the state would establish Health Opportunity Accounts in their name and contribute funds to the accounts, which beneficiaries would use to pay for costs they incurred before Medicaid coverage kicked in. Once beneficiaries reached the deductible, they would be required to pay Medicaid's standard co-payments and other cost-sharing charges.

Under the proposal, states would not be required to fully offset the costs that beneficiaries would incur before reaching the deductible. As a result, some beneficiaries — particularly those in poorer health who exhaust the funds in their accounts but still have not met the deductible — could face a substantial increase in out-of-pocket costs. That, in turn, could discourage them from using medically necessary services.

In addition, Health Opportunity Accounts would *increase* federal and state Medicaid costs. CBO estimates the accounts would increase federal Medicaid spending by \$60 million over the next five years. This would happen for several reasons:

- Participating beneficiaries would be permitted to keep 75 percent of any funds remaining in their accounts if they became ineligible for Medicaid. This means the federal government

would essentially continue to pay for individuals who no longer qualified for Medicaid.

- Beneficiaries would be permitted to reimburse certain health care providers (using the funds in their accounts) that charge higher rates than the state's Medicaid program pays.
- States could allow beneficiaries to use their accounts to pay for medical services not otherwise covered under Medicaid, and even to pay for *non*-medical services after they have left the Medicaid program, such as job training and tuition.

The scope of the Health Opportunity Accounts demonstration project would be limited for the first five years. A maximum of ten states would be permitted to participate in the project, and enrollment would be voluntary on the part of beneficiaries. Seniors, people with disabilities, pregnant women, and beneficiaries who had been on Medicaid for less than three months would not be permitted to participate.

However, the House bill would permit the Secretary of Health and Human Services to extend the demonstration project nationwide after the initial five-year period; Congress would have no role in this decision. Unless the Secretary determined that every one of the individual state demonstrations was "unsuccessful," the provision could become permanent on a national basis. At that point, *all* states could establish Health Opportunity Accounts, and *all* beneficiaries, including the exempt populations, could participate. The result could be a more substantial increase in costs.

Indeed, CBO expects the use of Health Opportunity Accounts to become more widespread after the first five years. CBO estimates the provision would cost \$205 million in the second five years (2011-2015), more than triple its cost over the first five years. Thus, the Health Opportunity Accounts provision would increase Medicaid spending by a total of \$265 million over the ten-year period.