MEDICAIDAlert

In February 2006, the President signed into law budget reconciliation legislation—the so-called Deficit Reduction Act (DRA)—that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments. This series of issue briefs is designed to inform advocates about the specifics of these changes and to highlight key implementation issues and strategies to mitigate the harm these provisions could cause to people on Medicaid.

Overview:
Medicaid and the Deficit Reduction Act 101

This paper provides a brief description of the highlights of the new law. The Deficit Reduction Act (DRA) contains both mandatory and optional provisions. Mandatory provisions include a citizenship documentation requirement and stricter regulations for asset transfer laws that affect Medicaid long-term care eligibility. The optional provisions allow states to make changes through state plan amendments—changes that control things like cost-sharing increases, the implementation of premiums, changes to the Medicaid benefit package, and the introduction of health savings account demonstrations.

We have divided these provisions into two categories: 1) those that make it harder for applicants to get onto Medicaid and 2) those that make it harder for people in Medicaid to get services.

Changes That Make It Harder to Get onto Medicaid

- **Citizenship documentation requirement:** Mandatory provision, states must implement beginning July 1, 2006

  Before the DRA: People claiming to be U.S. citizens when applying for Medicaid could self-attest to their citizenship. No written proof was required in most states. Legal immigrants had to produce written proof of their immigration status.

  New DRA policy: New Medicaid applicants who claim to be U.S. citizens will have to provide documentation to prove their citizenship status. This documentation includes a passport, a driver's license (in states that require proof of citizenship to obtain one), or a birth certificate plus one other secondary piece of identification. People currently enrolled in Medicaid will have to provide proof of citizenship when they renew their coverage. People who do not produce the required documents will be denied enrollment into the program (new applicants) or will be cut off (current enrollees).

This policy affects all 51 million U.S. citizens currently enrolled in Medicaid, as well as anyone who applies for Medicaid after July 1, 2006. Because most people in Medicaid renew their coverage every six to 12 months, state human services agencies will have an enormous paperwork burden between July and December of 2006 and a slightly reduced but still intense workload between January and June 2007. This policy is likely to result in significant delays getting onto Medicaid for people who are otherwise eligible, and millions of eligible citizens could be cut off the program entirely.

- **Asset transfers:** Mandatory provision, affects any transfers made on or after February 8, 2006

  Before the DRA: When someone applied for Medicaid to help pay for nursing home care, the Medicaid agency "looked back" into the person's financial records to see if any transfers were made for less than fair market value in the previous three years. "Asset transfers" include such things as a grandparent giving her grandchild money for college, or a senior giving money to a church or other charitable group or organization.

  If a person had transferred any assets for less than fair market value (that is, less than the asset was worth) in the previous three years, the person was subject to a "penalty period" equal to the length of time that the money the person transferred would buy in nursing home care. The penalty period went into effect as soon as the money was transferred. For example, a woman gave her grandchild $12,000. A year later, she needed to go into a nursing home. Since nursing home care costs, on average, $4,000 in her state, her "penalty period" was three months ($12,000 transferred divided by $4,000). But because the penalty period began when the money was transferred, it had expired by the time she needed care a year after the transfer. So, she could still qualify for Medicaid.

  New DRA policy: The "look-back" period has been extended to five years for transfers made on or after February 8, 2006, and the start of the penalty period has been delayed until the time the person applies for Medicaid. So, the woman described above would not be able to get Medicaid for the first three months of her nursing home stay.

- **Premiums:** Optional provision (through a state plan amendment) beginning March 31, 2006

  Before the DRA: In general, states were prohibited from charging people on Medicaid a premium or other enrollment fees, with a few exceptions.[1]

  New DRA policy: States can now *choose* to require any person with family income over 150 percent of poverty to pay a premium.[2] This premium can be up to 5 percent of the person's monthly or quarterly income (combined with other out-of-pocket costs incurred through cost-sharing). States can choose to make

this an "enforceable" policy, meaning that if a person does not pay his or her premium within 60 days of the due date, the state Medicaid agency can terminate that person's enrollment.

Certain people are exempt from premiums, including the following:

- "mandatory" children (children ages 0-5 with family incomes at or below 133 percent of poverty and children ages 6-18 with family incomes below poverty);
- foster children;
- pregnant women;
- hospice patients;
- people living in institutions; and
- women in either the breast or cervical cancer eligibility category.

Changes That Make It Harder for People on Medicaid to Get Services

- **Cost-sharing:** Optional provision beginning March 31, 2006

  Before the DRA: Limited cost-sharing was allowed at so-called "nominal" amounts of between $0.50 and $3.00 per service (depending on the cost of the service). Some states also had Section 1115 waivers that allowed them to charge higher cost-sharing rates. States were allowed to charge non-pregnant adults on Medicaid co-insurance (a percentage of the cost of the service—as opposed to a flat dollar amount) of up to 5 percent of the cost of the service for certain services, but this option was seldom used.[3] Providers were prohibited from turning someone away if the patient could not afford the cost-sharing amount.

  New DRA policy: The "nominal" copayment amount will rise annually at the same rate as the medical consumer price index increases ("medical inflation"). States are allowed to charge co-insurance of up to 10 percent of the cost of the service for people with family incomes between 100 and 150 percent of poverty, and they can charge up to 20 percent of the cost of the service for people with family incomes above 150 percent of poverty.[4]

  States can choose to make cost-sharing enforceable, which means providers can turn people away if they are unable to pay their cost-sharing at the time of service.

  The following groups are exempt from cost-sharing:

  - mandatory children;
  - foster children;
  - hospice patients;
  - people living in institutions; and
  - women in either the breast or cervical cancer eligibility category.

The following services are also exempt from cost-sharing:

- preventive services to *any* children;
- pregnancy-related services;
- emergency services; and
- family planning services.

The DRA also allows states to begin charging new co-insurance for "non-preferred" prescription drugs. States taking this option will decide which drugs are considered "non-preferred." People otherwise exempt from cost-sharing and people with family incomes at or below 150 percent of poverty can be charged up to the nominal copayment amount for each non-preferred drug. People with incomes above 150 percent of poverty can be charged up to 20 percent of the cost of each non-preferred drug.

Finally, beginning January 1, 2007, the DRA allows states to begin charging cost-sharing for the use of hospital emergency rooms for non-emergency care. The ER physician determines if the patient's condition is an emergency. People exempt from other cost-sharing can be charged up to the nominal copayment amount. People with family incomes at or below 100 percent of poverty can be charged up to twice the nominal copayment amount. There is no limit to the amount that people with incomes above poverty can be charged.

Total out-of-pocket spending for all cost-sharing and premiums combined cannot be more than five percent of a family's monthly or quarterly income (states choose either monthly or quarterly). States can decide whether and how to track out of pocket expenses, and they may choose to require families to track their own out-of-pocket costs.

- **Changes to benefits packages:** Optional provision beginning March 31, 2006

  Before the DRA: The federal government established a limited set of "mandatory" services that states had to provide to people in Medicaid, as well as a list of services that states were permitted to provide. If a state offered an "optional" benefit, it generally had to offer it to all people in Medicaid. States determined the amount, duration, and scope of the services they covered. Children in Medicaid were guaranteed "EPSDT" (Early and Periodic Screening, Diagnosis, and Treatment)—which ensured that children got the health care they needed even if the service would not otherwise have been covered.

  New DRA policy: States now have the option to change their Medicaid benefits packages to mirror one of the following:

  - the Federal Employees Health Benefits Program package (FEHBP) or equivalent;
  - the State Employees Health Benefits Package or equivalent;
  - the benefits package of the HMO in the state with the largest non-Medicaid enrollment;

- the actuarial equivalent of any of the three previous plans; or
- "Secretary-approved" coverage.

This final category can be anything that the Secretary of the Department of Health and Human Services (HHS) approves. States can also define new groups of people who will get the new benefit package. There is no requirement that the state offer the same benefits statewide, meaning that it could offer a more comprehensive package in one area of a state and a limited package in another area.

Certain people cannot be required to enroll in a benchmark plan:[4]

- pregnant women;
- dual eligibles (people eligible for both Medicaid and Medicare);
- hospice patients;
- people living in institutions;
- medically frail and special needs populations;
- people eligible for long-term care;
- the blind;
- people with disabilities;
- foster children;
- parents who receive cash assistance in TANF; and
- women in either the breast or cervical cancer eligibility category.

Children enrolled in a "benchmark" benefit package are still entitled to EPSDT. However, the state can provide it separately from the other health care benefits as a "wrap-around" benefit. This will complicate their coverage and could make it less likely that they will actually get the care they need.

- **Health Opportunity Accounts:** Optional provision beginning January 1, 2007

  Before the DRA: This is a new concept for Medicaid, although a few states have recently begun to consider ways to adapt Health Savings Accounts to Medicaid through Section 1115 waivers.

  New DRA policy: The DRA creates a new opportunity for up to 10 states to develop demonstration projects that create "Health Opportunity Accounts" (HOAs). HOAs function as a type of health savings account and work jointly with a new deductible for health care in Medicaid. The state will deposit up to $2,500 per adult and $1,000 per child per year into an HOA, which people then use to pay for any health services they receive. Their deductible (which is set by the state) can be up to 10 percent more than the amount the state puts into their account. People with an HOA can use Medicaid providers and will pay them Medicaid rates for all services. If the money in their HOA runs out in less than a

year (before the state deposits more money into the account), the person will have to pay for any health services they need out of their own pocket until they have met the deductible. After that amount is paid, the person gets coverage under the state's standard Medicaid package.

For example, let's take a mother of two who has $4,500 deposited in her family's HOA. If she spent through that, she would have to pay all health care costs for herself or her two children out of her own pocket up to $450 before she would have access to the standard Medicaid benefits in her state.

If a person loses Medicaid eligibility during the year and has money left in his or her HOA, the person can use the money to help pay for private insurance or other uses the state approves (such as tuition, employment training, etc.).

Certain groups are not permitted to enroll in HOAs:

- people over age 65;
- people disabilities;
- people eligible for medical assistance because of pregnancy;
- people eligible for medical assistance for three months or less; and
- people exempt from mandatory enrollment in a benchmark benefit package (listed in the "Changes to benefit packages" section).

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[1] States were permitted to charge premiums to a few people who qualified for Medicaid through the "Ticket-to-Work" program, which allows people with disabilities who have jobs to "buy in" to Medicaid if they do not have employer-sponsored health insurance coverage. Some states have also experimented with imposing premiums through Section 1115 waivers.

[2] What is likely a drafting error in the bill appears to permit states to charge premiums and cost-sharing to people with incomes below the federal poverty level without any limits. We believe this is not the intent of Congress and that it will be changed via guidance or legislation. We expect this clarification to say that people with incomes below poverty will not be subject to premiums but can be charged "nominal" cost-sharing unless they are otherwise exempt.

[3] The DRA does not specify any cost-sharing limits for people with family incomes below the federal poverty level. Senator Grassley (R-IA) and Representative Barton (R-TX) sent a letter to Secretary Leavitt noting that the absence of any reference to people with incomes below poverty should be read as making no change to current federal law regarding premiums and cost-sharing for that group of people. Congressional intent was to exempt people with incomes below 150 percent of poverty from premiums and to limit cost-sharing for people with incomes below poverty to the nominal amount. CMS has not yet released guidance on this provision.

[4] Although individuals listed here cannot be required to participate in benchmark benefit plans, they can "voluntarily" enroll in a benchmark plan.

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