FIELD REPORT From Families USA
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The Good, the Bad, and the Ugly: Analysis of the National Governors Association's Medicaid Reform Proposal

On June 15, the National Governors Association (NGA) released "Medicaid Reform: A Preliminary Report," a proposal that describes the NGA's vision for the future of Medicaid, as well as some aspects of the broader health care system. The proposal is the culmination of several months of discussions among a small group of governors that includes both Democrats and Republicans. At NGA's July 15 meeting, governors voted to adopt this proposal as official NGA policy.

NGA's adoption of this proposal comes at an inauspicious time. This is because the congressional budget resolution requires that as much as $10 billion[1] be cut from the Medicaid program by mid-September as part of the so-called "budget reconciliation" legislation. In making these cuts, Congress has placed the cart before the horse, requiring that budget cuts be made *before* policy changes can be fully examined. The NGA proposal should not be adopted in the context of Congress's effort to obtain short-term budget savings. Instead, the changes proposed by NGA should be postponed until they can be carefully analyzed and until their impact on Medicaid beneficiaries are fully understood.

In this preliminary analysis, we highlight key concerns about the NGA proposal and describe some of the promising ideas as well. The analysis also assesses NGA's ideas for expanding federal assistance to the uninsured.

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Proposals That Hurt People Who Rely on Medicaid

Erecting Barriers to Health Care for the Poor

The NGA proposes giving states broad discretion to dramatically increase cost-sharing—the amount that people pay out of their own pockets in premiums, copayments, and deductibles to receive services through Medicaid. This proposal would remove the current reasonable limits on how much states can charge people who must rely on Medicaid—including low-income children, pregnant women, and people with disabilities, as well as seniors on low fixed incomes—before they can see a doctor, get a diagnostic test, pick up prescription drugs, or receive other timely treatment.

Current Medicaid program rules prohibit states from charging premiums (with some exceptions). While states may charge copayments, co-insurance, or deductibles for health care services, the amount they can charge is limited, and they may only charge one or the other of these per service. Children and pregnant women are specifically exempted from paying *any* out-of-pocket costs, which ensures that pregnant women can get prenatal care and children can obtain immunizations and other preventive and primary care services. The NGA proposal would remove these important limitations that ensure that low-income people can afford care.

Arguments for higher out-of-pocket costs suggest that the low-income people served by Medicaid (most live on budgets that are below the federal poverty level—some are well below that level) will thus be less likely to make unneeded visits to the doctor or to seek out unnecessary treatment. There is absolutely no evidence to support the assertion that low-income people are over-utilizing the health care system. However, there is ample evidence that increased cost-sharing discourages people from seeking necessary care: Increasing the copayments charged to the poor has been shown to reduce their access to critical needed services, leading them to seek more costly care later.[2] Further, a significant body of research has shown that charging premiums to low-income people deters them from enrolling in coverage and thereby increases the ranks of the uninsured.

NGA argues that its cost-sharing requirements are modeled on State Children's Health Insurance Program (SCHIP) policy, but, in reality, the NGA proposal allows for cost-sharing that is well beyond what is allowed in SCHIP. The SCHIP rules contain important protections that are absent in the NGA proposal: In SCHIP, for example, families with incomes below 150 percent of poverty may not be charged copayments that exceed $5 per service or premiums that exceed $19 per month.[3] Further, SCHIP rules are not appropriate for Medicaid, which serves a much poorer population (primarily people with incomes below the federal poverty level), while SCHIP serves children with family incomes up to 200 percent of the poverty level.

Picking and Choosing Who Gets What Health Care

The NGA proposes eliminating federal assurances that people who rely on Medicaid have access to critical health care services. In place of the current federal requirements that spell out the minimum set of benefits that must be provided to Medicaid enrollees, the NGA proposes that states be given very broad discretion to determine the services provided and to "tailor" services to meet the needs of broad categories of people. However, such a policy will lead to reductions in benefits, making essential health services out of reach for low-income children, seniors on low fixed incomes, people with disabilities, and other populations who must rely on Medicaid.

Under current law, individuals in Medicaid *only* get the health care services that are medically necessary for them. Thus, it is unclear how much savings could be generated from "tailoring" the Medicaid benefit package for individuals or groups—unless the "tailoring" consists of eliminating coverage of health care services that are actually medically necessary for an individual or group in Medicaid.

As is true in the private insurance market, most of the costs in Medicaid arise from a relatively small number of high-cost cases, such as people in nursing homes and those needing inpatient hospital care. To contain costs, we should pursue the use of disease management, home- and community-based care, and other methods that promise to deliver quality health care services more efficiently, rather than arbitrarily strip away vital services from those who need them.

Out from Under: Eliminating Federal Oversight

The NGA proposes giving states broad new authority to waive various requirements in the Medicaid statute without federal oversight. The NGA argues that making changes to their Medicaid programs requires states to fill out too much paperwork. But more than half the funding for the Medicaid program comes from the federal government. It would be irresponsible for the federal government to give states such large amounts of money with little or no oversight. The federal government must preserve the ability to track and monitor how these federal dollars are being spent to efficiently advance the federal goals of the Medicaid program.

Moreover, considering the vulnerable low-income populations served by Medicaid and the very real impact that changes in that program will have on people's ability to get needed health care services, why should the federal government forgo its ability to review and negotiate these changes? And, finally, the waiver process should provide an opportunity for all stakeholders to learn about proposed changes and engage in a public debate about life-and-death Medicaid state policy decisions. Rather than eliminating the need for waivers, the federal government should require states to follow a public process that guarantees opportunities for low-income people, providers, and other stakeholder to provide input in decisions about major Medicaid changes.

- **Eliminating Judicial Oversight**

  The NGA proposes limiting the ability of people enrolled in Medicaid to enforce their legal rights. Although this proposal does not contain many details, it appears that the NGA would like to limit the use of judicial "consent" decrees in Medicaid cases in particular. This proposal coincides with legislation proposed by Senator Alexander (R-TN) that is currently pending in the Senate—legislation that would be extremely harmful for people who must rely on Medicaid. Consent decrees are an efficient means for willing parties to enter into a carefully negotiated agreement without litigation. What's more, the courts already apply a generous and flexible standard for allowing state and local governments to modify or terminate existing consent decrees.

- **Restricting Eligibility for Medicaid Long-Term Care Services**

  The NGA asserts that there is widespread abuse of current rules for qualifying for long-term care services through Medicaid. The President's budget proposal included language similar to the NGA's; both would make it more difficult for people to qualify for Medicaid by "transferring assets." The issue is also a key topic right now as Congress considers how to save federal Medicaid funds.

  Any proposal to modify the current rules on asset transfers must be carefully crafted to ensure that it does not create new rules that will impose an extreme hardship on low-income elderly people who need long-term care. Research shows that many elderly people at risk of needing long-term care have very limited assets and have too little wealth to warrant hiring an attorney to arrange an asset transfer.[4] Of the 1 million elderly at high risk for nursing home use, 84 percent have asset levels that would be exhausted within one year of nursing home care and, of these, three-quarters have assets of less than $5,000.[5]

  The changes proposed by NGA would, for example, allow states to look back at the sale of any property or other assets that occurred up to five years before a person enters a nursing home or enrolls in Medicaid. In order to receive Medicaid assistance, the person would have to demonstrate that he or she sold any property or other assets for "fair market value." A person who did not know the market, chose to trust a family member or acquaintance who did not pay fair market value, or did not have the ability to demand a certain price because financial needs were urgent, for example, would face an extremely harsh penalty. This person would have to leave the nursing home or go without health care—even though the money he or she received up to five years earlier had already been spent.

Medicaid Reform that Makes Sense

- **Prescription Drug Cost Savings**

  The NGA proposes reducing Medicaid costs by cutting spending on prescription drugs. Prescription drugs have consistently been among the fastest growing Medicaid costs in the past several years, and there is widespread agreement that Medicaid is paying too much

for drugs. This is one area where savings can be found without reducing services essential to those with Medicaid and where improvements are long overdue.

Specifically, the NGA has identified the following positive reforms that will save significant federal and state Medicaid dollars:

- increase the minimum rebates that states collect on brand-name and generic drugs;
- require that authorized generics be included in “best price” calculations for purposes of determining rebates;
- force discounts on the front end of drug purchasing;
- enact sanctions for companies and individuals that fail to accurately report the average sales price;
- allow states to join purchasing pools; and
- allow managed care organizations to obtain rebates directly for the Medicaid populations they serve.

In addition to these proposals, policy changes that encourage states to restructure pharmacists’ reimbursements could also result in very significant savings. In particular, moving away from payments based on Average Wholesale Price (AWP) to another pricing calculation, such as one based on average sales price (ASP—the weighted average of all non-federal sales prices to all purchasers, excluding sales exempt from the best price calculations,[6] net of rebates, discounts, and other price concessions), would save money for both states and the federal government without hurting the people who must rely on Medicaid. With this change, pharmacy dispensing fees should be set at a flat rate that adequately covers reasonable costs and that does not create incentives for pharmacists to dispense higher-priced drugs. The administration of the current drug rebate program also needs to be strengthened.[7]

■ Reforming State Contributions to the Medicare Drug Benefit

The NGA proposes that the so-called “clawback” be eliminated. The clawback is a provision of the Medicare drug law that establishes a complex formula to determine how much states must pay to the federal government for drug coverage for dual eligibles. The money that states would have saved by not paying for drug coverage for dual eligibles must instead be paid back to the federal government to cover Medicare program costs—hence the term “clawback.” In many states, the clawback will actually cause states to spend more in Medicaid than they would have in the absence of the Medicare drug law.[8]

The perverse incentives created by the Medicare drug bill’s clawback provision must be remedied. Because the only way states can lower their clawback payments is by cutting dual eligibles, this provision creates an incentive for some states to cut dual eligibles from their Medicaid programs. Dual eligibles are some of the lowest-income and most vulnerable Medicaid enrollees.

The Medicare drug law must be fixed. It is unreasonable to make states pay for a federal Medicare drug benefit, particularly when their Medicaid budgets are already stretched. Short of eliminating the clawback payment, states that cover dual eligibles beyond the federal minimum could be relieved of a portion of their clawback payments.

- **Improving Access to Home- and Community-Based Care**

  The NGA proposes giving states more ways to encourage seniors and people with disabilities (and their caregivers) to opt for home- and community-based care instead of care in nursing homes. Medicaid long-term care benefits should be designed to provide access to a full array of health and support services in different settings. Medicaid is the primary source of federal funding for long-term care services and support. The level and range of services can vary widely among people in long-term care settings.

  Home- and community-based services are often more cost-effective than expensive institutional care. Such services can help states prevent unnecessary spending on expensive institutional care by allowing people to receive care in the most appropriate setting. However, it is vitally important that adequate funding be provided for all necessary services for people in non-institutional settings and that states not set arbitrary spending caps on such services.

Expanding Federal Help to the Uninsured

The main purpose of this set of NGA proposals is to shift costs from states to the federal government—hence the use of *federal* tax credits in place of Medicaid (a state-federal partnership). These proposals *spend more* federal money—they do not save it. Therefore, they do not make sense when federal legislators are also seeking Medicaid savings.

- **Individual Health Care Tax Credit**

  A workable individual tax credit must be large enough that low-income individuals and families can afford to use it, and it must also provide a fair, accessible place to purchase health coverage in the individual market. The NGA's proposed refundable tax credit of a maximum of $3,000 per family is not large enough to help: Employer-sponsored coverage now costs $9,950 per year for a family.[9] Also, it is unclear where individuals and families would purchase coverage unless legislation is enacted that requires insurers to sell to any potential buyer, and at an affordable rate. Finally, it has been shown that individual tax credits cause many workers to lose job-based coverage and become uninsured.[10]

- **Employer Health Care Tax Credit**

  Targeting a health care tax credit at small employers is a good idea. If limited funds are available to invest in employer tax credits, then the tax credit could be targeted to employers who currently do *not* offer coverage or to workers who cannot afford to take up health coverage offered by their employers. Such an approach could yield the best reduction in the uninsured rate for the money spent. Also, because employer-sponsored

coverage for a family costs $9,950 per year, the NGA's proposed $200 per year is too small to influence employers' ability to provide coverage.

- **State Purchasing Pools**

  While NGA's proposal to set up purchasing pools at the state level is generally a good idea, more details need to be provided. First, the federal government must set standards to protect consumers from unfair premiums in order to get the benefits of being a group plan in a state purchasing pool. Also, risk pools cannot provide a substitute for Medicaid coverage. The Medicaid population is low-income and unique and needs special protections in terms of cost-sharing, benefits design, and appeal rights; these protections are not available in purchasing pools. This group is different from people in the commercial population who would benefit from this type of pool and should not be included.

- **Catastrophic Care/Reinsurance Model**

  NGA's proposal to promote reinsurance may be a useful strategy in trying to create a more stable and predictable private insurance market. Reinsurance is a way that government or other funds can subsidize the cost of health coverage by sharing the risk covered by insurance companies. However, it is a blunt instrument to use when trying to cover the uninsured. Reinsurance can make health insurance more affordable for employers, but unless employers are provided with a very large subsidy, this strategy is unlikely to allow employers to purchase coverage if they do not do so already. Also, a good reinsurance system should provide incentives (such as disease management or providing other preventive care services) for employers or the health system to contain costs, not just reimburse employers for high cost cases.

Conclusion

Again, now is *not* the time to enact structural changes to the Medicaid program. The NGA proposals should be reviewed in the course of a careful examination of the Medicaid program and should not be adopted in the context of achieving short-term budgetary savings. Giving states broad discretion to make health coverage unaffordable, to choose who gets what health care, and to eliminate federal oversight are all bad ideas, particularly during the current budget-driven process, and will hurt vulnerable people who must rely on Medicaid. However, in the area of prescription drug savings and state contribution to the Medicare drug benefit, there is significant room for positive reform that saves money and does not harm the people who rely on Medicaid for health care.

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[1] The congressional budget resolution requires that $10 billion be cut *from programs under the jurisdiction of the Senate Finance Committee.* Similarly, it requires $14.7 billion in cuts *from programs under the jurisdiction of the House Energy and Commerce Committee.* Medicaid is under the jurisdiction of both committees, but this does not mean that the cuts must come exclusively from Medicaid.

[2] Leighton Ku, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (Washington: Center on Budget and Policy Priorities, May 2005).

[3] 42 CFR § 467.540.

[4] Ellen O'Brien, *Medicaid's coverage of nursing home costs: Asset shelter for the wealthy or essential safety net?* (Washington: Georgetown University, Long-Term Care Financing Project, May 2005).

[5] *The Distribution of Assets in the Elderly Population Living in the Community* (Washington: Kaiser Family Foundation, June 2005).

[6] Sales excluded from Medicaid's best price calculation include sales to federal purchasers (VA, Department of Defense, Indian Health Service, etc.), state pharmacy assistance programs, the federal supply schedule prices, and sales that are at a nominal price.

[7] See *Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States* (Washington: Government Accountability Office, February 2005) (GAO-05-102), which reviewed CMS's Medicaid rebate program administration. This report found inconsistent guidance, poor reporting on price concessions, and erratic audits.

[8] See Marc Steinberg, *Trouble Brewing? New Medicare Drug Law Puts Low-Income People at Risk* (Washington: Families USA, July 2005).

[9] *Employer Health Benefits 2004 Annual Survey* (Washington: Kaiser Family Foundation and Health Research and Educational Trust, 2004).

[10] See Leonard E. Burman and Jonathan Gruber, *Tax Credits for Health Insurance* (Washington: Tax Policy Center, June 23, 2005).

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