



Forum Session Meeting Announcement

Thursday, November 10, 2005
11:30am — Lunch
12:00–1:30pm — Discussion

The Changing Face of Medicaid: Contemplating New Approaches to Benefits and Cost Sharing

Featuring:

Genevieve M. Kenney, PhD
Principal Research Associate
The Urban Institute

Cindy Mann, JD
Executive Director
Center for Children and Families
Georgetown University Health Policy Institute

Matt Salo
Director
Health and Human Services Committee
National Governors Association

**With Commentary from State Medicaid Officials
and Senior Congressional Committee Staff**

Location

Washington Court Hotel
525 New Jersey Avenue, NW
Ballroom 2

Registration Required

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The Changing Face of Medicaid: Contemplating New Approaches to Benefits and Cost Sharing

OVERVIEW

This Forum session will provide an opportunity for thoughtful discussion of the proposed changes to Medicaid benefits and cost-sharing standards that are currently being debated in Congress. Speakers will present recent research examining the impact of cost sharing and benefits modifications on program enrollment and access to care. The Medicaid reform recommendations by the National Governors Association (NGA) will also be described, and individual state perspectives will be offered. The panel discussion will consider the how the cost sharing and benefits proposals will affect states, beneficiaries, and the federal government. Senior congressional committee staff will also offer insights into the outcome of the budget reconciliation process and its effect on the future of the Medicaid program.

For more information – Cindy Mann and Elizabeth Kenney, “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, Issue Brief, October 2005; available at www.cfgeorgetown.org/pdfs/differencesoct2005final.pdf. See also NGA, “Short-Run Medicaid Reform,” August 29, 2005; available at www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF. ■

SESSION

Most analysts have come to agreement that the rate of growth of Medicaid expenditures is no longer sustainable. Medicaid spending now constitutes nearly 20 percent of state budgets; it has increased from \$400 million in 1966 to more than \$220 billion in combined state and federal expenditures in 2004. Although Medicaid provides health coverage for more than 50 million low-income individuals, many believe that the program’s eligibility, benefits, and cost-sharing rules are overly complex and not best equipped to serve the vulnerable populations it was designed to protect.

Medicaid “reform” has been a highly charged topic for many years. There have been several attempts to change the program’s financing structure: President Reagan first proposed the “block grant” concept in 1981; in 1995, Congress enacted legislation, ultimately vetoed by President Clinton, that would have transformed Medicaid into a block grant program.¹ And the philosophical and budgetary debate continues. Most of the focus has been on changing the way Medicaid is financed, and along with it the nature

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of the state-federal relationship. Less often, debate has centered on the appropriateness of the program's benefit package—at times referred to as “Cadillac coverage”—and on statutory limitations requiring that cost-sharing amounts be “nominal.”

Although states have been granted exceptions to some of the cost-sharing and benefits rules through the section 1115 waiver authority, most of the fundamental aspects of the program, such as comparability of benefits,² have generally remained intact, until recently. In August 2001, the Bush administration announced a new approach that offered states additional flexibility through section 1115 waivers to contain Medicaid costs by limiting benefits and increasing cost sharing for certain populations. These new Health Insurance Flexibility and Accountability (HIFA) waivers have opened the door to restructuring the Medicaid program through administrative rather than statutory channels. The most recent example occurred on October 19, 2005, when the Department of Health and Human Services (DHHS) announced approval of Florida's Medicaid waiver proposal. Florida will be the first state to offer Medicaid benefits in the form of a “defined contribution” that will effectively limit the amount that can be spent on each Medicaid enrollee. According to the DHHS press release, “Under the Section 1115 demonstration...Florida will calculate an annual amount that it will provide for each enrollee which will be determined by reviewing the enrollee's ‘risk’ or health status and historic use of health care services.”³

In the past several years, these waiver approvals have raised red flags in Congress as well as the Government Accountability Office (GAO). There have been concerns that the waiver process lacks transparency and that some of the flexibilities permitted under HIFA conflict with the intent of the Medicaid statute. These factors, in addition to the increasing federal budget deficits, have prompted Congress to consider taking steps to restructure parts of the program.

As part of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Congress created a Medicaid Commission whose first task was to recommend \$10 billion in “scorable Medicaid savings” by September 1, 2005. By December 31, 2006, the Commission must make longer-term recommendations on the future of Medicaid that ensure the long-term sustainability of the program.⁴ These recommendations will presumably include options for modifying the Medicaid benefit standard and loosening the limitations on cost sharing.

THE NGA PROPOSAL

As part of its mission to represent the interests of the states, the NGA has engaged in the Medicaid debate. It offered a series of recommendations for improving the program through state flexibility, while reducing the burden on state budgets. Among other things, the NGA proposes that Congress formalize the flexibility around benefits and cost sharing

that has been granted states through the section 1115 waiver process. The NGA first released a set of recommendations in June 2005 and published a revised version in August.

- **Benefits.** The NGA recommends that states be permitted to tailor Medicaid benefit packages to meet the different health care needs of the diverse Medicaid population. They also encourage increased utilization of managed care for the medically frail. The NGA recommends that states be permitted to choose from one of four “benchmark” benefit package options in addition to the standard Medicaid package, similar to those available under the State Children’s Health Insurance Program (SCHIP).⁵ The August 2005 proposal included several exceptions for which the benefits flexibility would not apply, including mandatory eligibility groups of pregnant women and children, supplemental security income (SSI) recipients, persons dually eligible for Medicare and Medicaid, terminally ill individuals receiving hospice care, and medically frail and special needs populations.
- **Cost Sharing.** The NGA’s proposed cost-sharing modifications are more specific. Citing the desire to increase Medicaid beneficiaries’ accountability for the cost and utilization of health care, the proposal recommends permitting states to impose cost sharing beyond nominal levels for beneficiaries with incomes above the federal poverty level and to make cost-sharing requirements “enforceable.”⁶ Using SCHIP as a model, the NGA proposal suggests a 5 percent cap on the total amount of cost sharing that can be charged to families with incomes below the federal poverty level (FPL), and increasing the amount to 7.5 percent for families with incomes above 150 percent of the FPL. The proposal also suggests that states be given flexibility to experiment with premiums and to create tiered co-payment structures for prescription drugs that could exceed nominal levels and would be enforceable.⁷ As with the benefits proposal, the NGA added several exceptions to the cost-sharing recommendations, noting that cost sharing should not be imposed for any services provided to mandatory eligibility groups of infants and children, preventive services for all children, pregnancy-related services, any service provided to individuals receiving hospice care, inpatients in hospitals and institutionalized individuals, emergency services, and family planning services and supplies.

The NGA has been working closely with Congress to craft language that would implement these proposals through the impending budget reconciliation process. The House and Senate are both expected to include provisions in their respective budget reconciliation packages that would reduce federal Medicaid expenditures. The Senate Committee on Finance’s budget reconciliation package does not appear to include any changes that would affect Medicaid’s benefits and cost-sharing rules, but Joe Barton (R-TX), the chairman of the House Committee on Energy and Commerce, has modeled his committee’s proposed package after the NGA’s recommendations. Debate in both chambers is under way.

WHAT IF MEDICAID LOOKED LIKE SCHIP?

The creation of SCHIP in 1997 was, in some ways, a response to ongoing dissatisfaction with some aspects of the Medicaid program. In order to achieve passage, the legislation included new flexibility for states to provide alternate benefit packages and to impose additional cost sharing. These variations from the Medicaid standards acknowledged, in part, the higher incomes of the families that would be the target of the new program (those with incomes up to 200 percent of the FPL). However, the changes were also an attempt to make the new program appear more like a commercial insurance product and less like a “welfare” program, an association that continues to be a challenge for Medicaid.

SCHIP offered states enhanced federal matching funds for expanding coverage for children either through Medicaid or by creating a “separate SCHIP program.” Under the separate program option, states can offer different and less comprehensive benefit packages than Medicaid requires, and premiums and cost sharing are permitted for children in families with higher incomes as long as the total amount does not exceed 5 percent of family income. Today, 39 states have created separate SCHIP programs; 4 million children received health coverage through all SCHIP programs in 2004.⁸

The program has generally been considered a success, prompting suggestions that Medicaid should be restructured to look more like SCHIP. The SCHIP benefit package and cost-sharing requirements are at least comparable to the private sector, and millions of children who would not have otherwise had health coverage now have a consistent source of care. However, the health needs of the Medicaid population do not mirror those of the commercial population. For example, the low-income families that are served by Medicaid have higher rates of asthma, allergies, and other chronic illnesses, and the children are at higher risk of developmental disabilities and delays.⁹

Many are concerned that such an across-the-board change to the Medicaid program could be extremely detrimental to some of the nation’s most vulnerable individuals. The Medicaid program finances care for those who are the poorest and have the most complex health conditions. Medicaid pays for 50 percent of all care provided in nursing facilities,¹⁰ is the primary source of health coverage for the disabled, and covers the costs of care for approximately 30 percent of all children with special health care needs.¹¹ In addition, the program ensures that poor families and children have access to both preventive and acute care in times of need.

Although the specifics of the potential changes to benefits are yet to be defined, applying the flexibility of the SCHIP benefit structure to Medicaid would have broad implications. One of the key differences between SCHIP and Medicaid is the absence of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children enrolled in SCHIP. EPSDT was designed by Congress to ensure the availability of medical services needed to “correct or ameliorate defects and physical and mental health

conditions.”¹² It guarantees low-income children access to health services that prevent the long-term (and costly) effects of chronic illness and disability.

The benefits flexibility recommended by the NGA would allow states to exclude specific services such as dental, vision, mental health, and physical and speech therapy for low-income families who qualify under the optional eligibility categories. States could also discontinue long-term care services for the elderly and disabled who are currently eligible through optional coverage groups. Finally, the exception for “medically frail and special needs populations” may or may not protect those who spend their assets in order to become eligible for Medicaid as “medically needy.” Many such individuals reside in nursing facilities.

The flexibility to increase cost-sharing requirements could also have a significant impact on access to care for Medicaid beneficiaries. For example, an Urban Institute analysis of state Medicaid waivers that include increased cost sharing found that only 18 percent of individuals enroll in health coverage when premiums reach 5 percent of income.¹³

Over the next several weeks, the debate will undoubtedly flesh out many of these implications and may lead to modified or completely new approaches to stemming the cost growth of Medicaid.

KEY QUESTIONS

This Forum session is intended to offer a venue for discussion of the proposed changes to Medicaid benefits and cost-sharing requirements. The session will provide insights into the potential implications of these changes for beneficiaries, states, and the federal government in hopes of informing the debate that is under way in the Congress and within the Medicaid Commission. Key questions for consideration include:

- What circumstances are best suited for benefits and cost-sharing flexibility? Are there circumstances where such flexibility is not appropriate?
- What have been the states’ experiences in utilizing cost sharing in SCHIP (and Medicaid) programs to date? Are there fiscal benefits to the state?
- Does the presence of cost-sharing requirements affect program retention and cycling on and off of Medicaid?
- How have states used benefits flexibility to improve care management and/or to achieve program savings?
- Is it possible to find a balance between state autonomy and federal uniformity?
- How might these proposed legislative changes affect the future of section 1115 demonstrations? Will the need for waivers be eliminated?

SPEAKERS

Genevieve M. Kenney, PhD, will report new research findings that examine the effects of public premiums on program enrollment and overall insurance coverage rates. Dr. Kenney is a principal research associate and health economist at The Urban Institute, with over 20 years of experience conducting health policy research. She is one of the nation's leading experts on the State Children's Health Insurance Program (SCHIP). She has examined a range of issues related to SCHIP, including family coverage policies and the structure of SCHIP financing, participation and barriers to enrollment, access and use differentials among low-income children, the effects of premium increases on enrollment, and the impacts of SCHIP on insurance coverage, crowd-out, and access to care. She also has conducted research on a number of Medicaid and Medicare topics.

Cindy Mann, JD, will discuss the differences between the Medicaid and SCHIP benefits standards and the implications of the proposed changes for medically vulnerable populations. Ms. Mann is the executive director of the Center for Children and Families (CCF) and has extensive experience in the design, implementation, and analysis of federal and state policies affecting children and families. Her specific areas of focus at CCF include Medicaid and SCHIP financing, federal developments affecting health care coverage, and state waiver policy. Previously, Ms. Mann served as the director of the Family and Children's Health Programs Group at the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services). In addition to her work with CCF, she is currently a research professor at the Georgetown University Health Policy Institute and an associate commissioner with the Kaiser Commission on Medicaid and the Uninsured.

Matt Salo is the director of the Health and Human Services Committee at the National Governors Association (NGA). Mr. Salo will present the NGA's recommendations for restructuring the benefits and cost-sharing standards and offer insights into the state perspective on Medicaid. Prior to joining NGA as their chief health lobbyist in 1999, Mr. Salo spent five years working for the National Association of State Medicaid Directors. His responsibilities at the NGA include analysis of issues including Medicaid, Medicare, public health, long-term care, prescription drugs, and managed care, and securing the state tobacco settlement.

Tricia Leddy, administrator of the Center for Child and Family Health at the Rhode Island Department of Human Services, will join in the discussion to offer her reactions to the research presented and share her experiences with cost sharing in RIte Care, Rhode Island's Medicaid managed care program. In addition, **senior congressional Committee staff** will share insights into the current status of the debate and consider the prospects for enactment of the proposed legislative changes.

ENDNOTES

1. For more information see Jeanne M. Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals," *Milbank Quarterly*, January 29, 2005, 5–7; available at www.milbank.org/quarterly/8301lambrew.pdf.
2. The Medicaid statute requires states to offer services in the same amount, duration, and scope to one mandatory eligibility group as it offers to another group of mandatory individuals. This concept is known as comparability.
3. Department of Health and Human Services, "HHS Approves Innovative Medicaid Reform Demonstration in Florida," press release, October 19, 2005; available at www.hhs.gov/news/press/2005pres/20051019.html.
4. For more information on the Medicaid Commission, see www.cms.hhs.gov/faca/mc/default.asp.
5. National Governors Association (NGA), "Short-Run Medicaid Reform," August 29, 2005, 6–7; available at www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF.
6. Current Medicaid rules prohibit providers from denying care, even in cases where an individual is unable to pay a cost-sharing charge at the point of service. Although providers can and do bill individuals for this care, beneficiaries cannot be disenrolled from Medicaid for nonpayment.
7. NGA, "Short-Run Medicaid Reform," 5–6.
8. Vernon Smith and David Rousseau, "SCHIP Enrollment in 50 States: December 2004 Data Update," Kaiser Family Foundation, September 2005, available at www.kff.org/medicaid/upload/7348.pdf.
9. Cindy Mann and Elizabeth Kenney, "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, Issue Brief, October 2005, 7; available at www.ccfgeorgetown.org/pdfs/differencesoct2005final.pdf.
10. John Holohan, Alan Weil, and Joshua M. Wiener, "Federalism and Health Policy: An Overview," in *Federalism and Health Policy* (Washington, D.C.: Urban Institute Press, 2003), 4.
11. Mann and Kenney, "Differences that Make a Difference," 9.
12. Social Security Act, section 1905(r)(5); available at www.ssa.gov/OP_Home/ssact/title19/1905.htm.
13. Mann and Kenney, "Differences that Make a Difference," 2.



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