Medicaid and Access To Care: Implications of DRA

Be Careful What You Wish For

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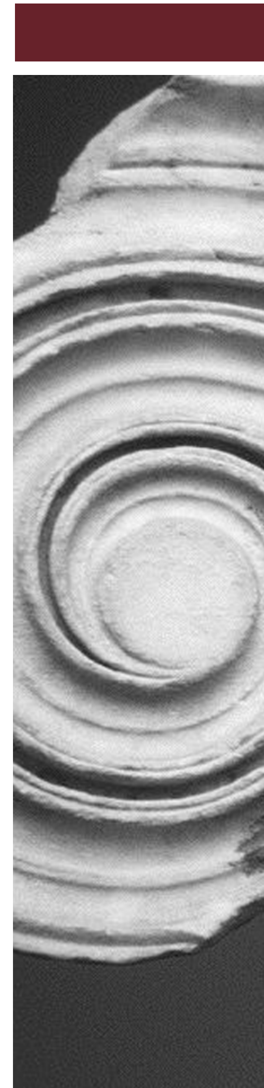

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"Medicaid is the federal-state program that provides federal funds to enable states to provide health coverage and long-term care assistance to over 39 million people in low-income families and 12 million elderly and disabled people, to fill in gaps in Medicare coverage for low income Medicare beneficiaries, and to support safety-net providers that serve low income, uninsured populations."

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“While I can explain the meaning of life, I don't dare try to explain how Medicaid works.”

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A History of Mixed Blessings For States

- PROS
  - Permits the State to provide health benefits to children and disabled people whose income – generally considerably below the federal poverty level -- is not adequate to pay for health care.
  - Permits the State to expand coverage to additional low-income populations
  - More than half of the cost is financed with federal dollars (approximately 55 to 80% federal dollars)
- CONS
  - There are strings attached to the Federal money
    - what health benefits must be paid for and conditions of availability (the "State plan")
    - rights of appeal when payment is denied
    - State must actually spend state money in order to get federal matching funds
  - The State is the program administrator, so when there is a program cut, the State takes the political heat.
  - Sometimes, there is litigation, injunction and courts retaining jurisdiction to monitor state compliance.

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Four Decades of State Pleas for Reform

- Get rid of the “State plan” -- make it a block grant (i.e., give us the money and get out of our hair).
- Give us a “demonstration waiver” of mandates regarding benefits and eligibility (i.e., get out of our hair and we’ll show you we can do it better).
- Give us more flexibility (i.e., get out of our hair and we will save you money and serve more people) –
  - to deal with beneficiaries, i.e., relief from “entitlement” and due process requirements
  - In deciding how to use federal funds, e.g., to pay providers vs. pay premiums vs. give “vouchers” to eligible individuals
  - I.e., to “modernize” Medicaid.
- Increase the federal match rate.

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Deficit Reduction Act of 2005 (DRA)

- Makes sweeping changes to Medicaid policy in 39 sections
  - Expected to generate $4.9 billion in net savings to the federal government over the next 5 years.
- Key process changes
  - Federal regulations generally are not required to implement these changes (changes to pharmacy payment is one of the four that does require a federal regulation)
  - States may use the state plan amendment (SPA) process to change their benefit packages
  - The Secretary of HHS has authority to do some new waivers that do not have to be budget neutral.

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Federal Rulemaking Is Complex

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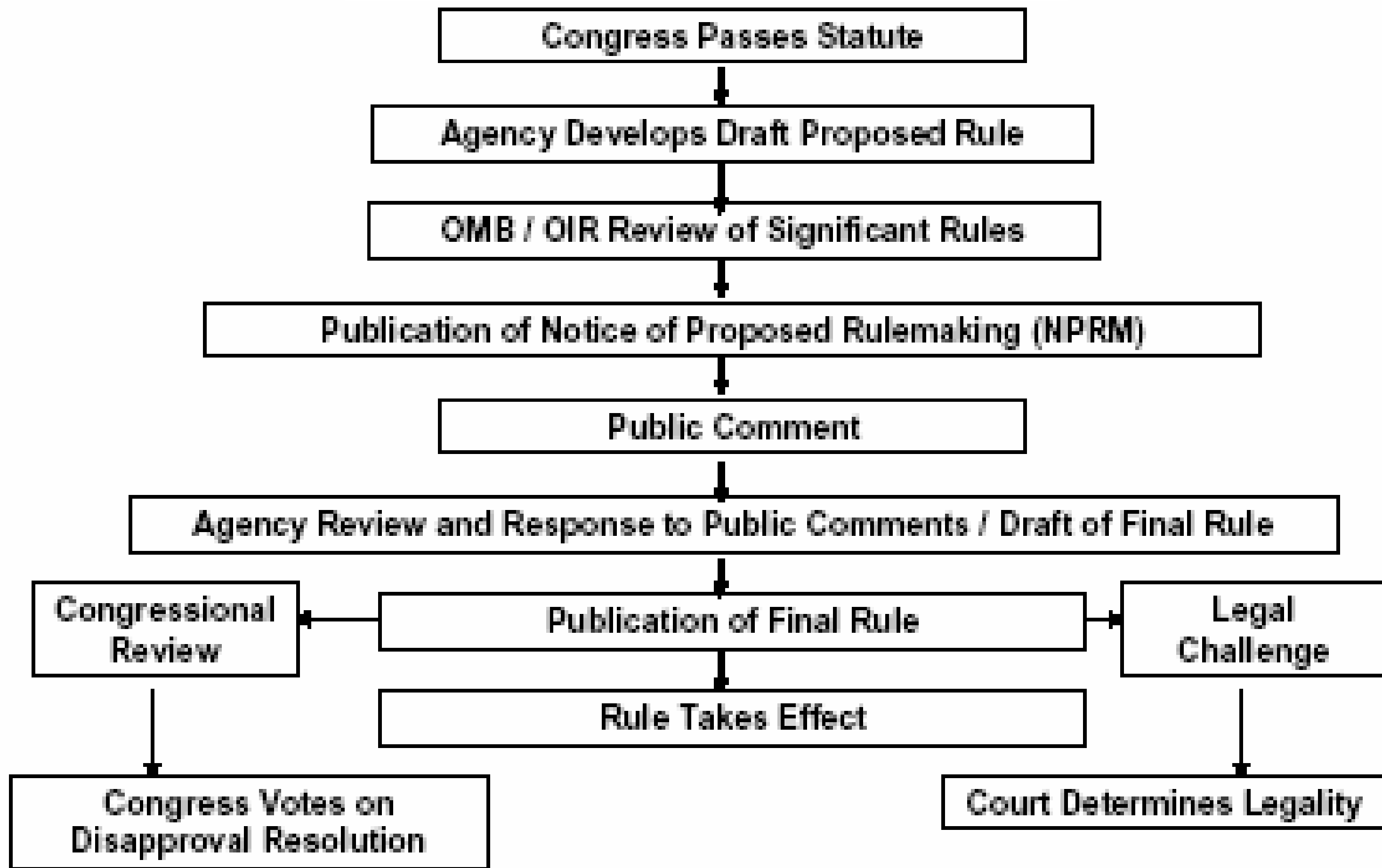

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Deliberate Speed On 39 DRA Changes

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- Of ten changes where rulemaking will be used, one (proof of citizenship) is already proposed.
- Two changes will be made by interim final regulation.
- CMS has also issued letters to State Medicaid Directors implementing each of the following:
  - Rebates on physician-administered drugs
  - asset transfer provisions (six changes)
  - long-term care partnership program
  - Recovery of pharmacy double payments due to restocking.
  - Premiums and cost-sharing
  - Alternative benefit packages
  - Non-emergency Medical Transportation;
  - Medicaid Transformation Grants, and
  - MCO rates for non-network emergency care providers
- CMS published a white paper on March 31 relating to the new “benchmark” benefits option.
- CMS released a comprehensive plan for the Medicaid Integrity Program
- CMS made a grant announcement for the “Money Follows the Person ‘Rebalancing’” Demonstration”

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DRA Access Provisions

- Permit a state to provide different benefit packages to different beneficiary groups in the state.
- Permit a state to charge premiums as a condition for an individual to be eligible for any Medicaid coverage.
- Permit a state to impose coinsurance and copayment amounts
- Permit copayments for “nonpreferred” drugs.
- Permit pharmacies and providers to refuse to provide non-emergency services unless the patient pays in advance.

KEY:

States had little flexibility to do any of this before the DRA but some could be implemented with federal approval and oversight under the waiver process.

Now, each of these significant changes can be implemented by a state under the SPA (State Plan amendment) process.

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CMS "must" approve an SPA if it complies with federal law

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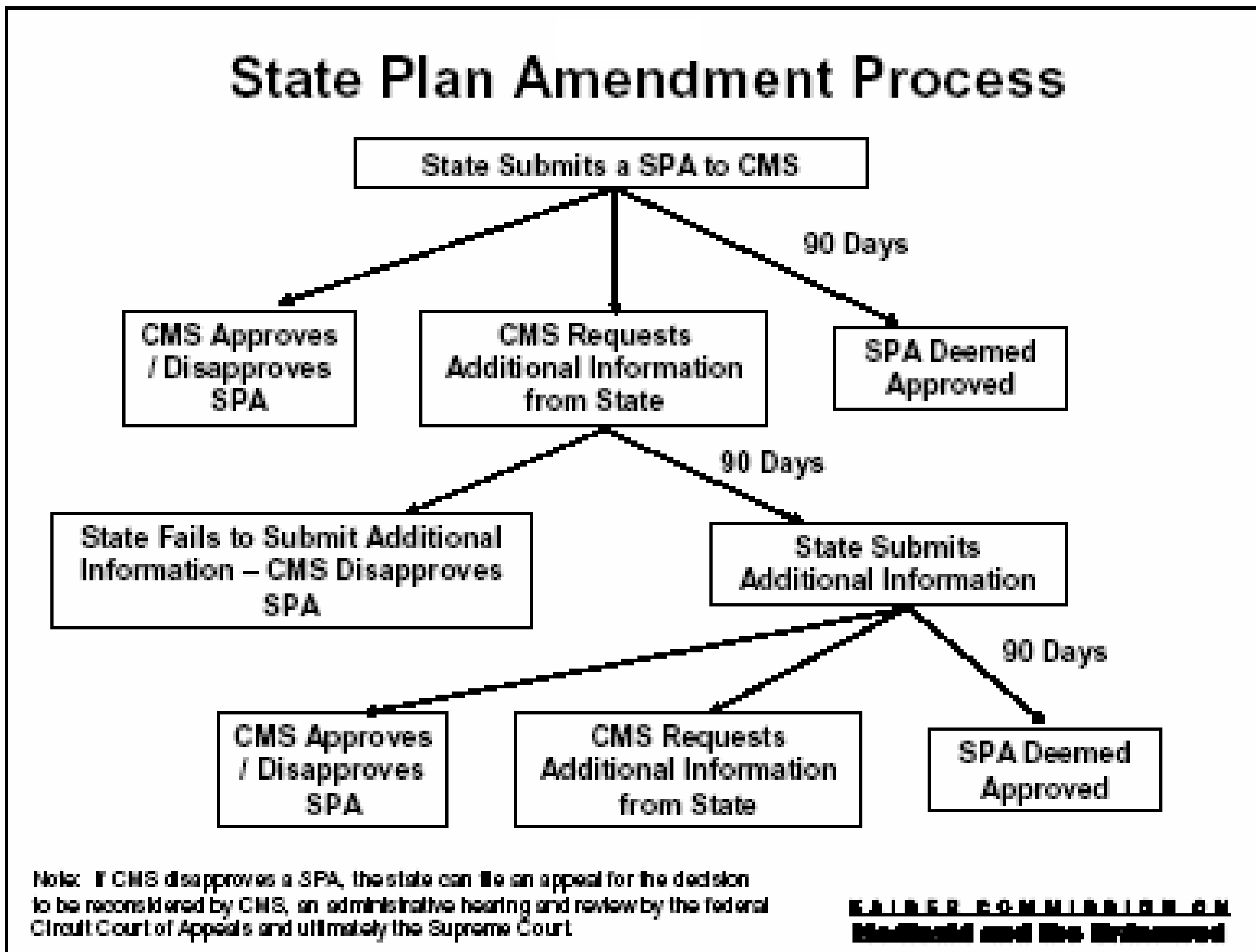

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Issue #1: Is this treatment covered?

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- State option through SPA process, to provide different "benchmark" benefits packages to individuals within one or more groups of individuals (primarily low-income children and parents).
  - Effective date March 31, 2006.
  - Same day, CMS sent SMD Letter interpreting the provision; issued a white paper describing the new DRA provision and how states could use it to modify their Medicaid programs.
  - As of August 1, 2006, six months after the law was signed, CMS had approved three "benchmark" benefits SPAs submitted by Idaho, Kentucky, and West Virginia.

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Issue #2: State Premium Option

- Allows states to condition Medicaid coverage on beneficiary payment of premiums. § 6041(a).
  - After 60 days of non-payment of premium, state may terminate eligibility of individual
- Premiums limited by federal law:
  - Between 100-150% (FPL), (and apparently all groups under 100% FPL) the state may impose no premiums)
  - Above 150% FPL, the state may charge premiums, and the total for a family of premiums plus cost-sharing for an individual item or service cannot exceed 5% of income.
  - Certain vulnerable groups are exempted from premiums and states may exempt additional groups. § 6041(a).

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OHP Standard Enrollment
January 2002-October 2003

100,952

95,701

← Premiums and Other OHP2 Changes Implemented

50,938

Jan-02, Feb-02, Mar-02, Apr-02, May-02, Jun-02, Jul-02, Aug-02, Sep-02, Oct-02, Nov-02, Dec-02, Jan-03, Feb-03, Mar-03, Apr-03, May-03, Jun-03, Jul-03, Aug-03, Sep-03, Oct-03

Source: McConnell, J. and N. Wallace, "Impact of Premium Changes in the Oregon Health Plan," Office for Oregon Health Policy and Research, February 2004.

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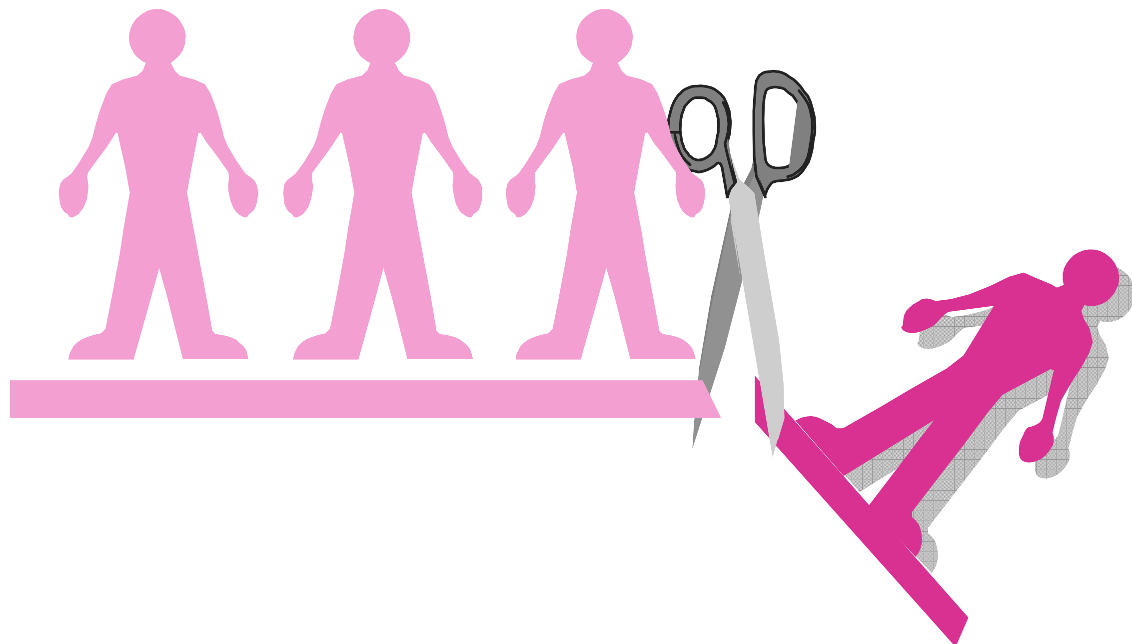
Implications: Some coverage will be lost



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Issue #3: Cost Sharing

- State option to impose mandatory cost-sharing through the SPA process.
  - Certain vulnerable groups are exempted from cost sharing (***except* cost-sharing for non-preferred drugs**), and states may exempt additional groups. § 6041(a).
  - Between 100-150% (FPL), cost-sharing may not exceed 10% of the cost of the item or service.
    - The total of cost-sharing plus premiums (including drug copays) for a family cannot exceed 5% of income.
  - Above 150% FPL, cost-sharing for an individual item or service cannot exceed 20% of the cost.
    - The total cost-sharing plus premiums (including drug coinsurance) imposed on a family cannot exceed 5% of income.
- Effective March 31, 2006.

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Cost-sharing for non-preferred drugs

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The Federal Medicaid Statute says:

"In order to encourage beneficiaries to use drugs (in this subsection referred to as 'preferred drugs') identified by the State as the least (or less) costly effective prescription drugs within a class of drugs (as defined by the State), … the State may—

''(A) provide cost sharing (instead of the level of cost sharing otherwise permitted …), and

''(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not otherwise be imposed."

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What?

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Non-Preferred Cost Sharing Limits

- For "mandatory eligible" children, preventive services for children, pregnancy related services for pregnant women, people with a terminal illness, cost-sharing for non-preferred drugs must be "nominal in amount"
  - So, no cost-sharing for preferred drugs/"nominal" cost sharing for non-preferred drugs.
- For an individual whose family income does not exceed 150 percent of the federal poverty level, cost-sharing for non-preferred drugs must be "nominal in amount."
- For an individual whose family income exceeds 150 percent of the federal poverty level, cost-sharing for non-preferred drugs must be not exceed 20 percent of the cost of the drug.

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A hidden access challenge …

- “Nominal” cost sharing has been defined in federal regulation for decades (DRA now requires annual updating by the medical CPI).
  - Under current regulations a nominal copayment may range from $0.50 to $3.00, depending on state’s payment amount for the item or service.
  - A nominal coinsurance requirement is 5% of the state’s payment for the item or service.
- Pre-DRA, those state plans that imposed cost-sharing on drugs have acted under the “copayment” provisions of the federal regulation, not the “coinsurance” provisions.
- The access problem is that the DRA uses the term “cost-sharing” when talking about non-preferred drugs.
- CMS’s first approval of an SPA with non-preferred drug cost-sharing in KY imposed 5% coinsurance – which is “nominal” under the federal regulations.

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Unintended Consequences?

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Excerpts from CBO Analysis (1/27/2006)

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- "We expect that about 13 million people—20 percent of Medicaid enrollees—would ultimately be affected by cost-sharing provisions. CBO anticipates that by 2010 about 13 million individuals, including those already subject to cost sharing for prescription drugs under current law, would face higher cost sharing for prescription drugs that are not preferred drugs."
- "About one-third of those affected would be children and almost half would be individuals with income below the poverty level."
- "We estimate that about 80 percent of the savings from higher cost sharing would be due to decreased use of services (or, in the case of prescription drugs, to the use of lower-cost drugs); the remaining 20 percent would reflect lower payments to providers."
- "CBO anticipates that about three-quarters of states imposing cost sharing would allow providers to deny services for lack of payment and that there would be greater decreases in utilization in those states."
- "The estimate accounts for the fact that savings from the reduced use of certain services could be partly offset by higher spending in other areas (such as emergency room visits)."

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Implications?

- Congress knew that the savings achieved through mandatory cost-sharing for drugs would be achieved by beneficiaries being denied access to care.
- Congress knew that in the Congressional Budget Office estimate, those denials of care would result in increased use of more invasive medical procedures, such as visits to the emergency room.
  - It is up to the states to deal with the fact that Congress has given states the authority to achieve savings for the federal and state governments through allowing beneficiaries to go without care.
  - It is up to the states to deal with the fact that the flexibility they have under the DRA permits them to make their drug benefit offer less to low income beneficiaries than is available under Medicare Part D.

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Medicare Part D better than Medicaid?

	Medicare Part D with Low-Income Subsidy	DRA Medicaid Nominal Cost-sharing
Institutionalized dual eligibles	No copayments	Up to 5% of each non-preferred prescription?
Dual-eligibles under 100% FPL	Up to $1 generic/$3 brand	Up to 5% of each non-preferred prescription?
Income 100% FPL to 135% FPL	Up to $2 generic/$5 brand	Up to 5% of each non-preferred prescription?
Income 135% FPL to 150%	Up to15%	Up to 5% of each non-preferred prescription?
Over 150%	Up to 100%	Up to 20% of the cost of the drug

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Intervention To Protect Access

- Whether or not Medicaid is transformed into a program that is less protective of low-income persons' access to prescriptions in your State will depend on the political process that affects your State's choices in deciding how to use the new flexibility given by Congress in the DRA.

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