



## **The Deficit Reduction Act of 2005: Impact on Medicaid**

### **Introduction**

Signed into law on February 8, 2006, the Deficit Reduction Act of 2005 (DRA) contains 39 sections that impact the Medicaid program both at the federal and state level. Mandatory state compliance exists for 16 of these sections, while the remaining sections involve competitive demonstrations or optional changes that states can make to their Medicaid programs. The Medicaid policy changes included in the DRA are meant to reduce federal Medicaid spending by a net \$4.8 billion over the next five years and \$26.1 billion over the next ten years. Many of the DRA changes shift costs to beneficiaries and place limitations on health care coverage and access for low-income recipients.

### **Background on Medicaid Modifications**

The Medicaid program was enacted in 1965 through Title XIX of the federal Social Security Act, which contains the federal statutory and regulatory requirements of the program. For a state to participate in the Medicaid program and receive federal matching funds, they must have a state Medicaid plan that fits within the parameters of federal law. When Congress makes statutory changes to the Medicaid program, they amend portions of Title XIX. The Centers for Medicare & Medicaid Services (CMS) issues regulations and administrative guidance to states to explain changes in statutory requirements, which must then be reflected in each state’s Medicaid plan.

For a state to change to its Medicaid program it must either amend its state Medicaid plan or obtain a waiver of the Title XIX requirements at the federal level from the Secretary of the Department of Health and Human Services (DHHS). A state can amend its Medicaid plan through the submission of a State Plan Amendment (SPA) or may attain a waiver of federal statutory requirements by applying to CMS. Unlike the SPA process in which authorization is procedural, the Secretary has wide discretion in deciding whether to approve a state’s waiver application. Waivers must normally be “budget neutral” (i.e., the program cannot be more expensive under the Waiver), while SPAs are not restricted by this stipulation.

**Table 1. State Options for Implementing Medicaid Reform**

	<b>State Plan Amendments</b>	<b>Waivers</b>
<b>Purpose</b>	Permit states to implement program options that are allowable under federal Medicaid law	Permit states to waive sections of the Medicaid statute in order to implement reforms that are not possible under Medicaid law
<b>Approval Timeframe</b>	<b>Fast-</b> federal approval is procedural and must be completed within 90 days	<b>Varies-</b> often includes lengthy negotiation and question and answer process; no time limit, but typically takes 9 to 12 months
<b>Ability to Negotiate</b>	<b>Low-</b> states must adhere to federal limitations	<b>High-</b> Secretary can waive almost any provision of the statute, if supportive
<b>Transparency</b>	<b>Low-</b> no public process required for submission or approval	<b>High-</b> supposed to be a public process with opportunity to comment

Adapted from Avalere Health LLC, 2006

## **Implications of the DRA**

The February 2006 DRA contains significant changes to Medicaid policy, including provisions relating to benefits and cost-sharing that states may now implement through the SPA process instead of through the formal waiver process. This fact sheet discusses both mandatory and optional Medicaid changes found in the DRA, as well as how changes may shift costs to beneficiaries while limiting coverage and access to health care services for Medicaid beneficiaries.

### **Mandatory Medicaid Changes**

Several Medicaid policy changes in the DRA require mandatory compliance for all state Medicaid programs.

These include:

- A requirement that all U.S. citizens and nationals applying for or renewing their Medicaid coverage provide documentation of their citizenship status (exemption has been given through CMS guidance to Medicare beneficiaries and most individuals receiving Supplemental Security Income).
- Provisions to restrict provider taxes on managed care organizations.
- Specifications that tighten the definition of what meets the criteria for Medicaid targeted case management, including the enumeration of certain foster-care related activities that cannot qualify for reimbursement.
- Modifications to asset transfers related to eligibility for Medicaid long-term care services. These changes include:
  - increasing penalties for individuals who transfer assets for less than fair market value,
  - moving the start of the penalty period to the date of application for Medicaid,
  - increasing the look-back period for assessing asset transfers, and
  - counting as assets some previously exempt financial instruments (e.g. certain annuities, promissory notes, and mortgages).
- Changes in the way state Medicaid programs pay pharmacists to reduce federal and state payments for prescription drugs.

### **Optional Medicaid Changes**

The DRA provides states with the option to make certain changes to their Medicaid programs through the SPA process that previously would have required a waiver. These SPA options include:

#### **Increased Premiums and Cost-Sharing**

- For beneficiaries with incomes over 150 percent of the federal poverty level (FPL), states can use an SPA to charge unlimited premiums and co-payments up to 20 percent of the cost of medical services.
- Medicaid recipients with family incomes between 100 and 150 percent of FPL can not be charged premiums, but can be charged co-payments up to 10 percent of the cost of the service.
- Total cost-sharing and premium amounts can not exceed 5 percent of a family's income in a single month or quarter.
- Co-payments could be made "enforceable," meaning that providers or pharmacists could deny services if a recipient can not pay the cost-sharing amount at the time of service.
- States may also choose to make premiums enforceable by requiring applicants to prepay premiums prior to Medicaid enrollment or by terminating Medicaid coverage if a beneficiary fails to pay premiums for 60 days.

- The DRA does permit increased co-payments for non-emergency services provided in an emergency room and higher cost-sharing for non-preferred drugs. Unlike other services (see below), no groups of beneficiaries are exempt from cost-sharing for non-preferred prescriptions.
- *Exemptions:* States are prohibited from imposing premiums and cost-sharing for services and preferred drugs for certain groups, including pregnant women and mandatory children. Additionally, the DRA does single out certain services which are exempt from cost-sharing (e.g., preventive services for children, pregnancy related services, and emergency services).

### **Benchmark Benefits**

- The DRA permits states to replace the existing Medicaid benefits package for children and certain other groups with “benchmark” coverage (i.e., limited benefit coverage compared to existing Medicaid benefits).
- Benchmark plans include the standard Blue Cross Blue Shield Plan offered under Federal Employees Health Benefits Program, a state’s employee coverage plan, the health maintenance organization (HMO) with the largest number of non-Medicaid enrollees in a state, or any other plan approved by the Secretary of DHHS.
- States would be required to provide wrap-around or comprehensive benefits for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children. Furthermore, states have to ensure that affected recipients have access to rural health clinic and federally-qualified health center (FQHC) services.
- Many Medicaid eligibility groups are exempted from benchmark coverage, including:
  - mandatory pregnant women and parents,
  - individuals with disabilities or special medical needs,
  - dual eligibles, and
  - people with long-term care needs.
- However, the DRA allows states to automatically enroll all beneficiaries in benchmark coverage provided that recipients are notified of their right to opt out of benchmark plans into traditional Medicaid coverage. This automatic enrollment can take place even for Medicaid recipients who were originally exempt (see previous bullet) under the DRA statute.
- Benchmark benefits are only applicable to groups covered under a state Medicaid plan prior to enactment of the DRA.
- States can have multiple health plans and these plans can vary by region.

### **Home and Community Based Services**

- The DRA allows states seeking federal Medicaid matching funds for home and community-based services for individuals with disabilities or the frail elderly to use the SPA pathway instead of a waiver.
- Unlike other optional benefits in the Medicaid program (e.g., rehabilitation or personal care) states could cap the number of people eligible for the services.
- This new SPA option does not replace the section 1915(c) waiver authority for home and community-based services that has existed since 1981. In fact, the SPA option differs from the waiver authority in several ways, most notably in that budget neutrality is not required under the SPA pathway.

## **Competitive Waiver Demonstrations**

The DRA created three new waiver authorities for which states can apply. They include:

- A “Health Opportunity Accounts” waiver that offers alternative benefit packages that have high deductibles combined with a Health Opportunity Account. This waiver deliberately overrides the statewide and comparability requirements found in Medicaid statute. The demonstration is targeted at low-income children and parents in up to 10 states. Additionally, budget neutrality is not required and enrollment by the target population must be voluntary. The state would contribute funds to a recipient’s Health Opportunity Account and the recipient then uses these funds to pay for the high deductible and other health care costs.
- The “Money Follows the Person” (MFP) rebalancing waiver gives states enhanced federal matching funds to transition elderly or disabled individuals out of hospitals, nursing homes, or other institutions and back into the community. As in the Health Opportunity Accounts waiver, several Medicaid statuses are waived and budget neutrality is not required under MFP. States would receive an enhanced federal match ranging from 75 to 90 percent of the costs of community-based, long-term care services for the first 12 months after an individual leaves an institutional setting. Total federal spending for all states selected for the MFP competitive waiver is capped at \$1.75 billion over a five year period.
- A “Home and Community-Based Services” waiver that offers alternatives to psychiatric residential treatment services. Total federal spending is capped at \$218 million over a five year period.

## **Potential Effect on Medicaid Beneficiaries**

Some Medicaid-related sections of the DRA will have positive effects on beneficiaries of the program. However, the DRA was ultimately meant to reduce federal and state Medicaid spending. Many of these cost-saving features change health care access and coverage for low-income beneficiaries. Research shows that premiums and cost-sharing requirements create barriers to obtaining and maintaining health insurance coverage; reduce the utilization of essential medical services; increase financial strains on families; and increase the number of uninsured. Additionally, limiting the benefit package for Medicaid beneficiaries may result in unmet health care needs and may make it more difficult for recipients to access needed care.

The mandatory changes of the DRA will have a significant impact on Medicaid enrollees. Additionally, even more beneficiaries will be impacted by optional DRA changes that states may choose to implement in their Medicaid plans. Both states and the federal government should carefully monitor the effect of the DRA as it is implemented at the state level. Unmet health care needs or an increase in the number of uninsured would ultimately increase the cost of health care and counter the original cost-saving intention of the DRA.

## **References and Further Information on the DRA**

Robin Rudowitz and Andy Schneider, “The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act,” Kaiser Commission on Medicaid and the Uninsured, 2006, available at [www.kff.org/kcmu](http://www.kff.org/kcmu).

Sara Rosenbaum and Anne Markus, “The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services,” The Commonwealth Fund, 2006, available at [www.cmf.org](http://www.cmf.org).

The Kaiser Commission on Medicaid and the Uninsured, “Deficit Reduction Act of 2005: Implications for Medicaid,” Kaiser Family Foundation, 2006, available at [www.kff.org/kcmu](http://www.kff.org/kcmu).

The Kaiser Commission on Medicaid and the Uninsured, “New Requirements for Citizenship Documentation in Medicaid,” Kaiser Family Foundation, 2006, available at [www.kff.org/kcmu](http://www.kff.org/kcmu).