Congress of the United States
House of Representatives
Washington, DC 20515

January 31, 2006

Medicaid Cuts Hurt Beneficiaries

Dear Democratic Colleague:

We commend to your attention a new report released by the Congressional Budget Office (CBO) last week that confirms how damaging the Medicaid cuts in the reconciliation conference report, the Deficit Reduction Act, will be for children and working families. This analysis clearly shows that the reconciliation bill imposes new barriers to health care for children, seniors, working families, and people with disabilities, causing delays in access to care, as well as an increase in the number of uninsured Americans. Following are some key points from the report to consider:

- Of the $28 billion in cuts to Medicaid over 10 years, about 75 percent — nearly $22 billion — is due to provisions that will increase the number of uninsured and under-insured by raising co-payments and premiums, cutting benefits, and tightening access to long-term care. When adding in other provisions, the total amount of the cuts that will fall upon seniors, working families, their children, and people with disabilities exceeds $25 billion over 10 years.

- By 2015, 4.5 million children will be affected by higher cost-sharing charges for services such as physician visits. Thirteen million people in total would face higher charges to access their healthcare services.

- In addition, by 2015, *twenty million people* would face higher charges *to access medically necessary prescription drugs*. One-third of those individuals affected by the drug cost-sharing (6.6 million) would be children and half (10 million) would have incomes below the poverty level (incomes less than $1,380 a month for a family of three).

- The vast majority — 80 percent or $5.5 billion over 10 years — of the savings from cost-sharing increases are because Medicaid enrollees will cut back on their use of healthcare services. The remaining savings are from $1.4 billion in reduced payments to providers over 10 years.

- The reconciliation bill also increases the number of uninsured. Twenty percent of the savings from new premium charges under this bill would come from *families no longer being able to maintain their Medicaid coverage* due to the new charges. Not only would those who today have health insurance coverage under Medicaid lose it, but additional beneficiaries who are eligible for coverage would simply not be able to afford it and therefore not enroll due to the new premiums. In total, 65,000 fewer people would be

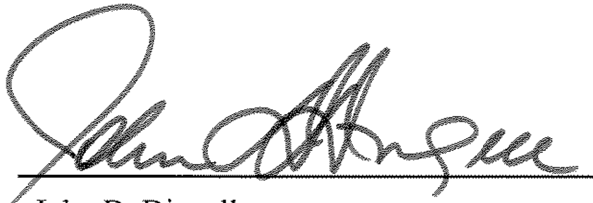
enrolled in Medicaid due to new and much higher premiums for low-income populations in 2015 alone. *Sixty percent of those losing coverage due to new premium charges would be children.*

- Benefit reductions would on average cut the value of health coverage by one-third of what people have today. Most of the reductions in benefits would be for services like mental health, dental care, vision, and certain therapies particularly important to people living with disabilities. In 2015, 1.6 million individuals would see their benefits reduced. These numbers could be even higher because the CBO estimates do not take into account potential reductions in benefits for low-income children who are insured by Medicaid and whose benefits could dramatically change from what they are guaranteed today.

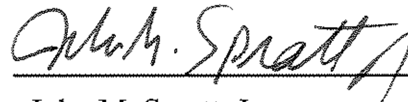
- By 2015, 130,000 individuals will be denied Medicaid coverage for long-term care at a point when they have no money to pay for that care.

This reconciliation bill has clear and negative effects for the estimated 58 million children, seniors, disabled and parents who rely upon Medicaid coverage for their health care. We urge you to vote "No."

Sincerely,



John D. Dingell
Ranking Member
Committee on Energy and Commerce



John M. Spratt, Jr.
Ranking Member
Committee on the Budget

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

January 27, 2006

Honorable John M. Spratt Jr.
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

On November 9, 2005, the Congressional Budget Office produced a memorandum providing additional information about our estimate of the budget impact of the Medicaid provisions of H.R. 4241, the Deficit Reduction Act of 2005, as reported by the House Committee on the Budget. At the request of your staff, we have updated that memorandum to reflect changes in the Medicaid provisions made in the conference agreement for S. 1932. That memorandum is attached.

I hope this information is helpful to you. The staff contacts for further information are Jeanne De Sa, Eric Rollins, and Tim Gronniger.

Sincerely,

Donald B. Marron
Acting Director

Attachment

cc: Honorable Jim Nussle
Chairman

Honorable Judd Gregg
Chairman
Senate Committee on the Budget

Honorable Kent Conrad
Ranking Member

Identical letter sent to the Honorable John D. Dingell

January 27, 2006

Additional Information on CBO's Estimate for the Medicaid Provisions in the Conference Agreement for S. 1932, the Deficit Reduction Act of 2005

The Congressional Budget Office (CBO) estimates that the provisions of subtitle A of title VI of S. 1932 would reduce federal Medicaid spending by $7 billion over the 2006-2010 period and $28 billion over the 2006-2015 period (see CBO's cost estimate of the conference agreement for S. 1932, the Deficit Reduction Act of 2005, issued on January 27, 2006). About 75 percent of those savings are due to provisions that would increase penalties on individuals who transfer assets for less than fair market value in order to qualify for nursing home care, restrict eligibility for people with substantial home equity, allow states to impose higher cost-sharing requirements and/or premiums on certain enrollees, permit states to restrict benefits for certain enrollees, and require recipients to document their U.S. citizenship. This memorandum provides additional information about the estimates and the number and types of Medicaid enrollees who would be affected by those provisions.

Asset Transfers and Home Equity

- CBO estimates that the provisions changing the treatment of asset transfers and home equity would reduce net Medicaid outlays by $2.4 billion over the next five years and by $6.4 billion over the next 10 years. Of those amounts, about three-quarters is due to the proposed change to the start date of the penalty for prohibited transfers and the prohibition of nursing home benefits for individuals with home equity exceeding $500,000 (states would be able to increase that limit up to $750,000).

- Under current law, very few applicants for Medicaid incur penalties for prohibited asset transfers. CBO estimates that changing the start date of the penalty would result in a delay of Medicaid eligibility for approximately 120,000 people in 2010, growing to approximately 130,000 in 2015. Such delays would occur because individuals would either incur a penalty for prohibited transfers or refrain from making such transfers and instead pay for some nursing home care themselves. Those figures represent about 15 percent of the new recipients of Medicaid nursing home benefits each year.

- The majority of penalties or delays would apply to individuals who otherwise would have employed a strategy to preserve half of their assets—the so-called "half-a-loaf" strategy. Under the act, some of those individuals would simply not transfer assets and thus not incur a penalty, but instead accept a delay in Medicaid eligibility. The act's provisions that allow greater exemptions for hardship situations reduce the number of affected individuals, while the changes to the look-back window increase that number.

- The period of delayed eligibility for affected recipients would range from one day to more than one year, averaging about three months in 2006 and decreasing to an average of about two months in 2015. The length of the delay would decrease because payment rates for nursing home services are expected to grow faster than assets.

- We expect that most states would adopt the $750,000 cap on home equity allowed by the act. We estimate that fewer than one-half of one percent of the unmarried applicants for Medicaid nursing home benefits have home equity greater than that amount. (The policy would have a negligible effect on the treatment of the homes of married individuals.) That figure translates to about 2,000 affected individuals annually by 2010.

Cost Sharing

- CBO estimates that the act's provisions allowing states to impose higher cost-sharing requirements and premiums on certain individuals would reduce Medicaid spending by $9.9 billion over the 2006-2015 period. Of that total, about 70 percent of the estimated savings are due to increased cost sharing and 30 percent to higher premiums. We anticipate that states would phase in changes in cost sharing and that those changes would not be fully effective until 2012.

- We assume that states would impose higher cost-sharing requirements primarily for services such physician services, non-emergency visits to emergency rooms, and prescription drugs. We also anticipate that states would require greater cost-sharing payments by individuals and families with higher income than by those with income just above the poverty level. Although states would be likely to raise nominal copayment amounts and increase them over time, we expect that aggregate enrollee cost sharing would remain, on average, below limits established under S. 1932.

- Under the act, CBO estimates that states with about one-half of all Medicaid enrollees would impose cost-sharing requirements for at least one service (not including prescription drugs, which are discussed below) on certain enrollees who currently are not subject to cost sharing. We estimate that the number of affected enrollees would increase from 6 million in 2010 to 9 million by 2015, and that half of those enrollees would be children. States also would increase cost-sharing requirements for many of those who are subject to cost sharing under current law; we expect such increases to affect copays for another 3 million enrollees by 2015. In sum, 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. That figure would rise to about 20 million by 2015. 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).

Premiums

- CBO estimates that about 80 percent of the savings from higher premiums under S. 1932 would be due to higher premium receipts and the remaining 20 percrent would stem from individuals leaving the Medicaid program.

- States would charge premiums to about 900,000 enrollees by fiscal year 2010 and to about 1.3 million enrollees by fiscal year 2015. CBO expects that most of those enrollees would be nondisabled adults and children and that, on

average, premiums would range from 1 percent to 3 percent of family income. Those amounts would be less than the maximum allowed by the act.

- In response to the new premiums, some beneficiaries would not apply for Medicaid, would leave the program, or would become ineligible due to nonpayment. CBO estimates that about 45,000 enrollees would lose coverage in fiscal year 2010 and that 65,000 would lose coverage in fiscal year 2015 because of the imposition of premiums. About 60 percent of those losing coverage would be children.

Alternative Benefit Packages

- CBO's estimate assumes that states with about 20 percent of Medicaid enrollees would provide reduced benefit packages. (Under the act, states would be able to provide reduced benefit packages mainly to certain adults who are not disabled.) Those benefit reductions would affect an estimated 900,000 enrollees in 2010 and about 1.6 million enrollees by 2015—about 3 percent of the Medicaid population.

- We anticipate that states would phase in benefit reductions and that those changes would not be fully effective until 2015. CBO expects that only a limited number of states would exercise that option because the act would prohibit states that provide limited benefit packages from expanding such coverage to groups not covered under the state plan when S. 1932 is enacted.

- We expect that many states trimming benefits would look to their state employee programs or large commercial health plans as models for alternative benefits. CBO anticipates that only a few states would offer benefit plans that offer leaner benefits than those types of plans, though the act would permit them to do so.

- On average, CBO expects that alternative benefit packages provided by the states would reduce per capita spending by about one-third for the affected population, but that reduction could vary depending on the generosity of the state's program under current law. Most of the reductions would be for services such as dental, vision, mental health, and certain therapies, but also could include restrictions on coverage for other services.

Documentation of Citizenship

- CBO estimates that requiring enrollees to document their U.S. citizenship would reduce Medicaid spending by $220 million over five years and by $735 million over ten years. We expect that provision would result in an estimated 35,000 Medicaid enrollees losing coverage by 2015.

- CBO expects that most of those losing coverage would be illegal immigrants; the remainder would be citizens who were unable to produce documentary evidence of their citizenship.

Uncertainty of Estimates

CBO's estimates are particularly uncertain in three areas. We have limited information about people's asset holdings prior to their admission to nursing homes and about the number of people engaging in asset transfers that would be prohibited by the bill. How states would view the new options to impose cost sharing and premiums and reduce benefits is also very uncertain. We anticipate wide variation in the extent to which different states would reshape their Medicaid programs by increasing cost sharing or premiums or by restricting benefits. Some states might make limited changes, such as increasing cost sharing for a few specific services or certain enrollees, while others would make more far-reaching changes. Our estimates, therefore, account for a range of possible responses by states to the act. Finally, it is unclear how stringently the requirement for enrollees to document their U.S. citizenship would be enforced.