CALIFORNIA BUDGET PROJECT

CENTER ON BUDGET AND POLICY PRIORITIES

Executive Summary

Revised July 21, 2004

GOVERNOR'S PROPOSAL TO RESTRUCTURE MEDI-CAL IS FINANCIALLY RISKY AND COULD INCREASE STATE COSTS

Governor Schwarzenegger has proposed a fundamental and risky restructuring of the state's Medi-Cal Program, which provides health coverage to certain families and individuals with low incomes and limited resources. Due to the broad scope of the options under consideration, the Administration must obtain a comprehensive "Section 1115" Medicaid waiver from the federal government. The Administration plans to submit a final restructuring proposal to the Legislature on August 2, 2004, and will apply for a federal waiver in September 2004.

KEY FINDINGS

This report finds that:

- **A Section 1115 waiver would cap federal funding for Medi-Cal.** Currently, the federal government pays half the costs of Medi-Cal expenditures, whether such costs are higher or lower than projected. A comprehensive Section 1115 waiver would fundamentally alter this financing structure. The federal government would require California to accept a cap on federal Medicaid funding as a condition of approving the proposed waiver. Rather than paying a fixed *percentage* of Medi-Cal costs, the federal government would provide no more than a fixed *amount* of funding, either on an aggregate basis or on a per-enrollee basis, regardless of California's actual Medi-Cal expenditures. In short, California would have to relinquish open-ended federal Medicaid funding in order to receive federal approval for a Section 1115 waiver.

- **The Bush Administration is likely to strictly enforce the federal funding cap.** All Section 1115 waivers include a federal funding cap. Historically, these caps have been generous and have not been strictly enforced. However, the federal context has changed in recent years. The Bush Administration has proposed to curtail federal Medicaid funding and to scrutinize state Medicaid programs more closely. It also negotiated a Medicaid waiver with South Carolina that imposed a rigid federal funding cap well below the state's historical Medicaid spending level. These developments, combined with the deteriorating federal fiscal outlook, suggest that the federal government is likely to strictly enforce a Section 1115 waiver with California in order to restrict federal funding for Medi-Cal.

- **A federal Medicaid funding cap would shift more of the financial risk for Medi-Cal from the federal government to California.** The inflexible nature of a federal funding cap would severely restrict California's ability to meet the needs of its residents in the event of an economic downturn

921 11th St., Ste. 502 ● Sacramento, CA 95814
(916) 444-0500 ● FAX (916) 444-0172

or an unexpected occurrence, such as an epidemic, a natural disaster, or the availability of a new health care drug or technology. California would have to pay 100 percent of any Medi-Cal costs above the federal cap or reduce costs by scaling back eligibility and benefits, increasing enrollees' out-of-pocket costs, and/or reducing reimbursement rates paid to Medi-Cal providers in order to stay below the cap.

- **The Governor's proposal to increase beneficiaries' out-of-pocket costs for health care services would likely reduce enrollment of eligible persons in Medi-Cal and discourage Medi-Cal enrollees, who have limited resources, from obtaining appropriate and timely care.** One option under consideration by the Schwarzenegger Administration would require certain enrollees, particularly low-income parents, the elderly, and people with disabilities, to pay significantly higher out-of-pocket costs to remain enrolled in Medi-Cal and access essential health care services. This could impair access to care and negatively affect the health outcomes of low-income persons. For example, Oregon made sweeping changes to its Medicaid program under a comprehensive Section 1115 waiver in 2003, including raising premiums and enforcing stricter premium payment policies. Enrollment fell from 96,000 to approximately 47,000, as beneficiaries were removed from the waiver program due to failure to pay premiums.

- **Increasing beneficiaries' out-of-pocket costs may produce short-term General Fund savings. However, savings would likely result from lower Medi-Cal enrollment and diminished use of health care services, rather than from increased revenues.** Oregon achieved state savings following the implementation of its Section 1115 waiver. Savings were attributable to the significant enrollment decline that occurred in its waiver program, rather than to higher premiums collected from Medicaid enrollees. In fact, total premiums collected in Oregon declined from about $900,000 per month prior to the implementation of waiver to about $500,000 per month afterward, as the state's Medicaid enrollment declined.

- **Increasing beneficiaries' out-of-pocket costs could increase the state's long-term Medi-Cal costs.** For example, some Medi-Cal enrollees with long-term care needs who live on their own with assistance or in community-based settings, such as board-and-care homes, would not be able to afford higher out-of-pocket costs for Medi-Cal services. However, Medi-Cal beneficiaries who receive long-term care services in nursing homes would be exempt from new Medi-Cal out-of-pocket costs, according to Administration officials. Thus, some beneficiaries living in their homes or in community-based settings would likely enter nursing homes in order to maintain Medi-Cal coverage. This would increase state General Fund costs for Medi-Cal enrollees with long-term care needs and substantially limit enrollees' independence.

- **Increasing beneficiaries' out-of-pocket costs could shift higher costs to other parts of the state's health care system.** Community clinics and public hospitals could incur higher costs as low-income individuals who leave Medi-Cal seek alternative sources of care. Uninsured individuals tend to lack a regular source of health care and often seek care in emergency rooms. A national survey found that uninsured persons relied on emergency rooms for 25.2 percent of their ambulatory care visits, as compared to 7.6 percent for persons with private insurance, in 2000-01.

- **California can improve the Medi-Cal Program without negatively affecting beneficiaries.** For example, drug manufacturers have been artificially inflating drug prices that are used to calculate Medicaid pharmacy reimbursement rates. California should aggressively enforce the law and obtain financial settlements from drug manufacturers that could be reinvested in the Medi-Cal Program. California could also simplify Medi-Cal eligibility rules to reduce the paperwork burden on both Medi-Cal enrollees and counties.

CALIFORNIA BUDGET PROJECT

CENTER ON BUDGET AND POLICY PRIORITIES

July 2004

GOVERNOR'S PROPOSAL TO RESTRUCTURE MEDI-CAL IS FINANCIALLY RISKY AND COULD INCREASE STATE COSTS

In January 2004, Governor Schwarzenegger announced plans to restructure the Medi-Cal Program, which provides health coverage to 6.7 million Californians who have low incomes and meet other eligibility criteria (see below). While the Administration has not released a final proposal, documents describing potential restructuring options were circulated by the Administration in early 2004, concurrent with a series of workshops convened to seek public comment on the Governor's proposal.[1]

The Administration's Timeline

The Administration has indicated that it plans to apply to the federal government for a comprehensive "Section 1115" waiver in September 2004, in order to implement the proposed Medi-Cal changes in 2005-06.[2] Prior to seeking federal approval, the Administration plans to submit the waiver proposal and proposed statutory changes to the Legislature on August 2, 2004.[3] If the Legislature does not enact changes to state law to accommodate the waiver before the Legislature recesses on August 31, the Administration intends to negotiate the waiver with the federal Health and Human Services Agency (HHS) during the fall of 2004 and "return to the Legislature in January 2005 for concurrence."[4]

What Is Medi-Cal?

Medi-Cal is California's version of Medicaid, a federal-state program that provides health coverage to certain individuals and families who have low incomes. Medi-Cal provides health care services to children, parents, elderly and blind persons, and persons with disabilities who receive public assistance or meet income and other eligibility criteria. Federal law requires states to provide coverage to certain groups, including children and pregnant women who meet income guidelines and Supplemental Security Income recipients. California's Medi-Cal Program additionally covers certain families and individuals with incomes that exceed minimum federal guidelines. State Medicaid programs must provide a core set of benefits, such as doctor visits, hospital care, nursing home care, and laboratory services. California additionally offers more than 30 federally optional benefits, including prescription drugs and adult dental services. Medi-Cal will enroll nearly one out of five Californians, an estimated 6.7 million individuals, in 2004-05. California will spend an estimated $11.9 billion (General Fund) on Medi-Cal in 2004-05. However, California's costs per beneficiary are the lowest in the nation. Medi-Cal spending, including state and federal funds, averaged $2,068 per enrollee in federal fiscal year 2000, compared to the national Medicaid average of $3,762. California ranked 51st out of 51 Medicaid programs in spending per enrollee.[5]

921 11th St., Ste. 502 ● Sacramento, CA 95814
(916) 444-0500 ● FAX (916) 444-0172

Key Restructuring Options Under Consideration

The Administration has circulated several options for restructuring the Medi-Cal Program that may be included in its Section 1115 Medicaid waiver proposal.[6] One option, which is analyzed below, would:

- Require certain Medi-Cal enrollees to pay new monthly premiums, new or increased copayments, and new co-insurance to receive certain Medi-Cal services;[7] and
- Allow Medi-Cal providers to deny some services to enrollees who do not pay required out-of-pocket costs.

These changes would likely reduce enrollment of eligible persons and discourage Medi-Cal beneficiaries from obtaining necessary and appropriate care.[8] Other options proposed by the Administration would:

- Require a larger number of beneficiaries, including the elderly and persons with disabilities, to enroll in Medi-Cal managed care;
- Curtail the current requirement that Medi-Cal "correct or ameliorate" physical and/or mental health conditions that are discovered in children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program;[9]
- Restructure the Medi-Cal eligibility determination and enrollment process; and
- Restructure $2 billion in federal Medicaid supplemental payments to "safety net" hospitals.[10]

MEDI-CAL RESTRUCTURING PROPOSAL WOULD REQUIRE A FEDERAL WAIVER

The state must seek a comprehensive Section 1115 waiver of federal Medicaid rules because the changes proposed by the Governor are currently prohibited by federal Medicaid law and regulations (see below). Section 1115 of the Social Security Act allows the HHS Secretary to waive federal rules so that states may receive federal Medicaid funds for expenditures that are not otherwise permitted under federal law.[11] For example, under a Section 1115 waiver, states may cover populations or offer services that are not allowable under the Medicaid statute, such as expanding coverage to single adults without children.[12] While the HHS Secretary generally has broad authority in granting comprehensive waivers, certain federal requirements may not be waived.[13] Section 1115 waivers generally are in effect for five years and may be renewed.

A WAIVER WOULD EFFECTIVELY CAP FEDERAL FUNDING FOR THE MEDI-CAL PROGRAM AND SHIFT LONG-TERM FINANCIAL RISKS TO CALIFORNIA

Currently, the federal government guarantees that it will pay a percentage of a state's Medicaid costs, regardless of whether such costs are higher or lower than projected and regardless of enrollment. The Federal Medical Assistance Percentage (FMAP) for California's Medi-Cal Program is currently 50 percent, meaning the federal government pays half the cost of Medi-Cal expenditures.[14]

A comprehensive Section 1115 Medicaid waiver would fundamentally alter this financing structure. The federal government would require California to accept a cap on federal Medicaid funding as a condition of approving the proposed waiver. Rather than paying a fixed *percentage* of Medi-Cal costs, the federal government would provide no more than a fixed *amount* of funding, either on an aggregate basis or on a per-enrollee basis, regardless of California's actual expenditures.

Section 1115 Medicaid Waivers: A Four-Step Process

The Section 1115 federal Medicaid waiver process generally includes four steps:[15]

- A state submits a waiver concept paper to the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid, for informal feedback. During this period, the state is required to initiate a process that guarantees public input into the waiver design.[16] The Administration convened a series of public workshops in the spring of 2004 to review and gather feedback on its Medi-Cal restructuring proposal.[17] In addition, California has apparently initiated informal consultations with CMS and would likely submit to CMS the same concept paper it provides to the Legislature in August.
- The state submits a formal waiver application to CMS for review and approval. State and federal officials negotiate the terms and conditions of the waiver, including any modifications to the waiver application required by the federal government. Such negotiations include determining how the state will guarantee "budget neutrality" – that is, assuring that federal spending on the state's Medicaid program under a waiver will not exceed what it would otherwise have been in the absence of the waiver (this issue is discussed in more detail below). The CMS is not required to make a decision on the waiver within a particular period.
- Upon formal approval, the federal government works with the state to ensure the state's readiness to implement the waiver.
- The state implements the changes allowed by the waiver. Both the federal and state governments are required to evaluate and report on the impact of the waiver, as well as the public policy value of the waiver demonstration project. The waiver is generally in effect for five years.

The Federal "Budget Neutrality" Requirement

Budget Neutrality Requirement Would Limit Federal Medicaid Funding for California

The Office of Management and Budget (OMB) and the Centers for Medicare and Medicaid Services (CMS) require states seeking a comprehensive Section 1115 waiver to show that the proposed changes would be "budget neutral" for the federal government.[18] In other words, over the customary five-year waiver period, federal Medicaid expenditures may not exceed what the federal government would have spent on a state's Medicaid program in the absence of the waiver.[19] A state may meet the budget neutrality requirement by:

- Accepting an aggregate limit on all federal Medicaid spending subject to the waiver; or
- Accepting a capped allotment per Medicaid enrollee (a per capita limit).[20]

In either case, the state relinquishes its entitlement to open-ended federal financing. If California accepted an aggregate limit, for example, the federal government would be required to pay 50 percent of Medi-Cal costs only up to the amount permitted under the budget neutrality cap. At that point, California would not be eligible for additional federal funds, even though the state would have been entitled to such funds under the FMAP.[21]

The Federal Government Is Likely to Strictly Enforce a Budget Neutrality Agreement with California

In recent years, the budget neutrality requirement has often been interpreted flexibly to the benefit of states.[22] The federal government often negotiated generous caps and did not strictly enforce the budget neutrality requirement, in order to encourage states to expand Medicaid coverage. As a result, state Medicaid programs have not been adversely affected by the budget neutrality requirement.

However, the federal context has changed substantially. For example, the Bush Administration has:

- Sought to limit federal financial responsibility for Medicaid;[23]
- Proposed to scrutinize state Medicaid programs more closely;[24] and
- Negotiated a Medicaid waiver involving pharmacy benefits for the elderly in South Carolina that imposed a rigid budget neutrality limit well below the state's historical Medicaid spending level.[25]

These developments, combined with the deteriorating federal fiscal outlook, suggest that the federal government is likely to strictly enforce a Section 1115 waiver with California in order to restrict federal funding for Medi-Cal.[26]

Section 1115 Waivers Represent a Potential "Back Door" to a Medicaid Block Grant

In 2003, President Bush proposed to replace the current, open-ended system of federal Medicaid funding with a block grant.[27] States would receive an aggregate, capped allotment of federal Medicaid funding based on individual states' historical Medicaid spending, inflated by an annual trend rate, for most or all of a state's Medicaid program.[28] While Congress did not consider this proposal, there is evidence that the Bush Administration and certain states, such as Connecticut, Florida, and New Hampshire, are currently negotiating Section 1115 waivers.[29] This would allow the federal government to invoke the budget neutrality requirement and cap federal Medicaid funding state-by-state. In fact, the US Senate Finance Committee, which oversees Medicaid, recently expressed concern that "a new wave of waiver proposals are being developed that could dramatically reshape" federal Medicaid financing by capping federal payments.[30]

Section 1115 waivers thus represent a potential "back door" to the Bush Administration's goal of establishing a Medicaid block grant. Budget neutrality would effectively cap federal Medicaid funding, on either an aggregate or a per-enrollee basis, for most or all of a state's Medicaid program, as would occur under a block grant.

Budget Neutrality Cap Poses Financial Risks for California

A Cap Would Increase Funding Pressures on California if Medi-Cal Costs Are Higher Than Anticipated

The inflexible nature of a federal funding cap would severely restrict California's ability to meet the needs of its residents in the event of an economic downturn or an unexpected occurrence, such as an epidemic, a natural disaster, or the availability of a new health care drug or technology. If one or more of these events increased Medi-Cal costs to unanticipated levels, federal funds would not automatically increase due to the budget neutrality limit. California would have to pay 100 percent of any costs above the cap or reduce costs by scaling back eligibility and benefits, increasing enrollees' out-of-

pocket costs, and/or reducing reimbursement rates paid to Medi-Cal providers in order to stay below the cap. Alternatively, the state could spend federal matching funds in excess of the cap and fully repay the federal government after the waiver expires.[31]

Using a Per Capita Calculation to Meet the Budget Neutrality Requirement Does Not Eliminate Financial Risks to State

A per capita cap would automatically adjust for higher-than-expected increases in Medi-Cal enrollment, and therefore is preferable to an aggregate cap. For example, during an economic downturn, the number of people who lose their jobs and become eligible for Medi-Cal tends to rise. Under a per capita limit, the state would receive a fixed amount of federal funding for each new Medi-Cal enrollee, regardless of how high enrollment rises.[32] However, a per capita limit would increase the state's financial risk to the extent that Medi-Cal costs per beneficiary exceed the fixed amount provided by the federal government during the waiver period. For example, the development of expensive new drugs or other technological breakthroughs could drive up Medi-Cal costs to unanticipated levels.

California Would Be Penalized for Its Low Per Enrollee Spending on Medi-Cal

Budget neutrality caps are calculated based on a state's historical Medicaid spending. States that spend more per enrollee on their Medicaid programs would likely have a higher cap, on a per capita basis, than states that spend comparatively less. In 2000, Medicaid spending per enrollee in California was the lowest in the nation and the state has subsequently reduced Medi-Cal expenditures due to the current budget crisis.[33] The state's extremely low spending level would serve as the basis of a budget neutrality cap and would cause the cap to be set lower than if the state had spent more on Medi-Cal in recent years. It would be difficult for California to increase reimbursement rates for health care providers or make other improvements without breaching the budget neutrality cap.[34] Thus, a cap would penalize California for historically low Medi-Cal expenditures.

PROPOSAL TO INCREASE BENEFICIARIES' OUT-OF-POCKET COSTS WOULD LIMIT ACCESS TO HEALTH CARE AND COULD INCREASE LONG-TERM STATE AND LOCAL COSTS

One Medi-Cal restructuring option under consideration by the Schwarzenegger Administration would require certain enrollees to pay higher premiums and a larger share of costs to remain enrolled in Medi-Cal and obtain health care services. This includes the elderly and people with disabilities, who tend to have multiple and chronic conditions, use the most health services, frequently require long-term care, and are the most likely to avoid or delay needed health care due to cost considerations.[35] This option would also allow Medi-Cal providers to deny certain services to enrollees who do not pay required out-of-pocket costs. However, many families and individuals of limited means lack the discretionary income needed to pay for a larger share of their health care costs. Consequently, this proposal would likely reduce Medi-Cal enrollment and discourage beneficiaries from obtaining appropriate and timely care.

While the state may reap short-term General Fund savings due to lower Medi-Cal enrollment and lower utilization of services, increasing the out-of-pocket costs of Medi-Cal enrollees could increase General Fund expenditures in the longer term. For example, costs could increase if those who remain in Medi-Cal postpone preventive care due to higher cost sharing and later require more costly treatment. In addition, increasing out-of-pocket costs would likely cause some seniors and people with disabilities who need supervision and/or assistance with daily activities to enter nursing homes. Costs could also be shifted to other parts of California's health care system, including community clinics and

public hospitals, to the extent that low-income persons leave Medi-Cal and seek alternative sources of care, such as in emergency rooms.

Current Federal and State Premium and Cost-Sharing Requirements

Federal law currently allows states to require certain Medicaid enrollees to share the cost of their health care expenses through premiums and cost sharing (Table 1). While most Medicaid beneficiaries are exempt from premiums, states may require certain individuals, including working persons with disabilities, to pay premiums.[36] States may also impose cost sharing in the form of co-insurance, copayments, or deductibles on certain adults for some Medicaid services, although many Medicaid enrollees are exempt from cost sharing.[37] Currently, beneficiaries may not be denied services for failure to pay required cost-sharing amounts.[38]

Table 1: Common Types of Beneficiary Contribution Requirements to Receive Health Care Services

Type of Contribution	Definition	Current Federal Limits on Beneficiary Contributions in Medicaid
Co-insurance	A fixed percentage (20 percent, for example) of the cost of a service that beneficiaries must pay at the point of service.	No more than 5 percent of the cost of each service.
Copayment	A fixed dollar amount that must be paid at the time a service is provided or a prescription is filled.	No more than $3 per service, except for nonemergency services provided in an emergency room, for which states may charge up to twice the nominal amount.
Deductible	An amount that must be paid by the insured before the insurer will begin paying. For example, a covered individual with a $50 deductible would have to pay the first $50 of health care charges, after which the insurer would begin paying.	No more than $2 per family per month, except for nonemergency services provided in an emergency room, for which states may charge up to twice the nominal amount.
Premium	An amount paid at regular intervals, such as monthly, in order to maintain health care coverage.	Amounts vary according to the population group required to pay premiums, such as certain children and working persons with disabilities.

Source: General Accounting Office, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries* (March 2004) and Andy Schneider, *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured: July 2002).

California requires some adults, although not children, in Medi-Cal to pay premiums and/or copayments.[39] Premiums, however, are not prevalent in the Medi-Cal Program. The state assesses premiums on a small number of adults with disabilities, ranging from $20 to $250 per month for individuals to $30 to $375 per month for a couple.[40] California also requires certain adults, including most parents and some elderly persons who do not reside in nursing homes or other institutions, to make copayments for certain Medi-Cal services.[41] The state currently requires a copayment of $5 per visit for nonemergency services provided in an emergency room and $1 per visit for other services, including prescription drugs, outpatient hospital services, and physician services.[42]

Governor's Proposal: Increase Premiums and Cost Sharing and Allow Medi-Cal Providers to Deny Health Care Services

During the public workshops, the Administration presented an option to divide Medi-Cal enrollees into three "tiers." Enrollees in each tier would be subject to different premium and cost-sharing requirements:[43]

- Tier 1 would include children and youth up to age 21, pregnant women, and certain adults, including working parents with incomes at or below the federal poverty level (FPL, $15,670 for a family of three in 2004). Tier 1 would also include seniors and people with disabilities with incomes at or below the Supplemental Security Income/State Supplementary Payment (SSI/SSP) level ($9,480 per year for an individual). Tier 1 enrollees would be eligible for all Medi-Cal benefits, except that chiropractic and acupuncture services would be eliminated as benefits for all Medi-Cal beneficiaries.

  Tier 1 enrollees would be charged a $5 copayment for nonemergency services provided in an emergency room and $1 copayments for other benefits, including and prescription drugs and refills and outpatient and dental services. Tier 1 enrollees would not pay premiums or co-insurance, and children and youth up to age 21 would be exempt from copayments.[44] Medi-Cal providers would be responsible for collecting copayments, which would be deducted from their reimbursement rates. Providers would be allowed to deny non-emergency services to Medi-Cal enrollees who do not make copayments. The Department of Health Services (DHS) estimates that about 1.1 million elderly, blind, and disabled adults and about 700,000 other adults would be subject to these more stringent requirements.[45]

- Tier 2 would include parents with incomes above the FPL, as well as elderly and blind adults and adults with disabilities who have income above the SSI/SSP eligibility level. Children and all other Medi-Cal beneficiaries would be excluded from Tier 2. Tier 2 would include the same benefits as Tier 1; however, Tier 2 enrollees would have to pay a greater share of their health care costs through co-insurance, copayments, and premiums.[46] For example, the DHS estimates that more than 41,000 elderly, blind, and disabled adults and nearly 172,000 other adults would be subject to premiums.[47] Tier 2 beneficiaries who do not pay premiums could be dropped from Medi-Cal, while those who do not pay co-insurance or copayments could be denied non-emergency services.[48]

  - Premiums: Tier 2 enrollees with incomes at or above the FPL would pay a monthly premium to maintain Medi-Cal coverage. For example, enrollees with incomes up to 150 percent of the FPL ($23,505 for a family of three in 2004) would pay a premium of up to $10 per month.[49]

  - Co-insurance: Tier 2 enrollees who require health care services beyond a core set of Medi-Cal benefits would be charged 20 percent of the cost of the service.[50] This provision would severely affect low-income seniors, blind persons, and people with disabilities, who lack the discretionary income to pay a larger share of their health care or long-term care costs related to ongoing chronic conditions. Services that would be subject to co-insurance include:

    - Home health services,
    - Vision services,
    - Audiology and hearing aid services,
    - Over-the-counter drugs,

- Orthotic and prosthetic appliances,
- Hospice care, and
- Personal care services, including the Personal Care Services Program delivered through California's In-Home Supportive Services (IHSS) Program.[51]

- Copayments: A new $20 copayment per acute hospital admission would be created for Tier 2 enrollees. In addition, existing copayments would be increased for all services except prescription drugs.[52] For example, the copayment for receiving nonemergency services in the emergency room would double from $5 to $10, while the copayment for outpatient services would triple from $1 to $3. There would also be a $2 copayment for each dental service.

- Tier 3 would include individuals who are enrolled in an existing Medi-Cal waiver program or those who are institutionalized or at risk of institutionalization. Tier 3 enrollees would be subject to the premium and cost-sharing requirements of either Tier 1 or Tier 2, depending upon their income level.

Research Shows That Higher Out-of-Pocket Costs Impair Access to Health Care and Negatively Affect the Health Outcomes of Low-Income Individuals

A substantial body of research indicates that requiring low-income persons to pay higher out-of-pocket costs for health care coverage in public programs, such as Medicaid, results in lower enrollment of eligible persons, poor health outcomes, and lower use of needed care.[53] For example, studies have found that low-income individuals reduce use of effective services and medication when copayments are required.

While premiums and cost sharing are common among families with private health insurance, imposing higher out-of-pocket costs on low-income individuals can have serious consequences. People with low incomes already bear out-of-pocket medical costs that consume a significant portion of their incomes. Nationally, for example, low-income families spent 7 percent of their income on health care in 2000.[54] A recent survey of low-income families in three US cities found that many families, even those who are insured, "have large unpaid medical bills mostly from one-time and unexpected medical problems." Moreover, Medicaid beneficiaries tend to be in poorer health than are individuals with employer-sponsored health insurance. More than half of nonelderly adult Medicaid beneficiaries live with at least one chronic condition, as compared to less than one-third of persons with employer-sponsored coverage.[55]

Premium Increases Lead to Reduced Enrollment

Research on the impact of premiums finds that participation of low-income persons in health care programs "falls off sharply as the premium amount increases."[56] One study found that participation of eligible persons declined from 57 percent to 18 percent as premiums increased from 1 percent to 5 percent of family income. Similarly, studies of Florida's Healthy Kids program found that higher monthly premiums are associated with larger numbers of children exiting the program. When the Florida program lowered its premiums, fewer children left the program.[57]

A similar effect occurred in Oregon, which made sweeping changes to its Medicaid program under a comprehensive Section 1115 waiver in 2003. Oregon raised premiums to between $6 and $20 per month and enforced stricter premium payment policies.[58] These changes "appear to be largely responsible" for a dramatic decline in enrollment. The waiver program had an enrollment of about

96,000 when the waiver was implemented in February 2003. Subsequently, about 47,000 persons were removed from the waiver program for nonpayment of premiums between April and October 2003.[59]

Cost Sharing Can Lead to Poor Health Care Outcomes

Medicaid enrollees, particularly the elderly and people with disabilities, often have greater health care needs than do individuals with higher incomes.[60] Thus, their health is more likely to be affected by cost-sharing policies. A health insurance experiment conducted by RAND in the 1970s found better health outcomes for low-income individuals in plans without cost sharing as compared to low-income individuals in plans with cost sharing, including a 10 percent reduction in the risk of dying for those at high risk due to high blood pressure, high cholesterol, or smoking.[61]

Cost Sharing Reduces Use of Needed Health Care Services

A number of studies indicate that cost sharing reduces the use of needed health care services and/or prescription drugs among individuals with limited resources. For example, the RAND Health Insurance Experiment found that low-income adults and children reduced the use of effective medical care services by as much as 44 percent when they were required to make copayments, a much deeper reduction than occurred among those with higher incomes.[62] Other studies that examined implementation of Medi-Cal copayments in the 1970s found that "even small copayments resulted in fewer physician visits and less preventive care."[63]

Cost sharing also affects the use of prescription drugs. A recent study compared the use of prescription drugs among elderly and disabled Medicaid enrollees who live in states with copayments to those who live in states without copayments. While copayments had a minimal effect on patients who were in good health, persons who were in fair or poor health reduced medication use significantly in order to keep their costs down.[64] Moreover, a recent national survey found that more than 40 percent of Medicaid beneficiaries with two or more chronic conditions reported not obtaining prescription drugs due to cost barriers.[65]

Governor's Proposal Could Produce Short-Term General Fund Savings Due to Lower Medi-Cal Enrollment and Diminished Use of Health Care Services

The Administration has not estimated the number of low-income Californians who would leave Medi-Cal or how Medi-Cal usage would change if premiums and cost sharing are increased. Thus, it is not clear to what extent this proposal would reduce state General Fund spending on Medi-Cal as compared to current state policy. However, the Administration anticipates General Fund savings of $400 million in 2005-06 if the restructuring proposal is implemented.[66]

Increasing Medi-Cal beneficiaries' out-of-pocket costs may lead to short-term General Fund savings. However, savings would likely result from lower Medi-Cal enrollment and diminished use of health care services, rather than from increased revenues. Oregon achieved state savings following the implementation of its Section 1115 waiver. Savings were attributable to the significant enrollment decline that occurred in its waiver program, rather than to higher premiums collected from Medicaid beneficiaries.[67] In fact, total premiums collected in Oregon declined from about $900,000 per month prior to the implementation of the Section 1115 waiver to about $500,000 per month afterward, as the state's Medicaid enrollment declined.[68]

Governor's Proposal Could Increase Long-Term State and Local Costs to Provide Health Care Services

Even if the Governor's proposal results in short-term General Fund savings, raising Medi-Cal enrollees' out-of-pocket costs could increase long-term General Fund expenditures on Medi-Cal as well as shift health care costs to public hospitals and community clinics.

Medi-Cal Enrollees May Increase Use of Costly Emergency Room Services

State General Fund spending on Medi-Cal could increase relative to current policy if those who remain in Medi-Cal avoid preventive care due to higher copayments and co-insurance and later require more costly care in hospital emergency rooms. Studies conducted in the 1970s found that copayments were not effective in reducing overall Medicaid costs. After implementation of a $1 copayment for physicians' services, "use of ambulatory care services declined by 8 percent, but use of hospital inpatient services increased by 17 percent for the copay population, resulting in higher total Medicaid costs of 3 to 8 percent."[69]

Seniors and People with Disabilities in Medi-Cal Are Likely to Enter Costly Nursing Homes in Greater Numbers

In recent years, California has enabled individuals who require supervision and/or assistance with daily activities to remain in their own homes with assistance or in community-based, non-institutionalized settings, such as board-and-care homes that do not include on-site medical services.[70] Medi-Cal provides a range of services to achieve this goal, including home health care, physical therapy, medical supplies and equipment, personal care services, and non-emergency transportation. Home- and community-based care allows seniors and people with disabilities to maintain a degree of independence and can be less costly on a per-enrollee basis than care provided in nursing homes or other institutionalized settings.[71]

State Medi-Cal spending would increase to the extent that some of these seniors and people with disabilities enter nursing homes in greater numbers. Some Medi-Cal enrollees with long-term care needs who live on their own or in community-based settings would not be able to afford higher out-of-pocket costs for health care services. For example, individuals subject to Tier 2 cost sharing would have to pay 20 percent of the cost for many essential services, including personal care and medical equipment. However, individuals receiving long-term care in nursing homes would be exempt from new Medi-Cal out-of-pocket costs, according to Administration officials.[72] Thus, some of these Medi-Cal enrollees would likely enter nursing homes in order to maintain Medi-Cal coverage.[73] This would increase state General Fund costs for Medi-Cal enrollees with long-term care needs and substantially limit enrollees' independence.

Costs Could Be Shifted to Other Parts of the State's Health Care System

Even if higher premiums and cost sharing generate short-term General Fund savings in the Medi-Cal Program, other parts of California's health care system, including community clinics and public hospitals, could incur additional costs as low-income persons who drop off Medi-Cal seek alternative sources of care. Uninsured individuals tend to lack a regular source of health care and often seek care in hospital emergency rooms.[74] A national survey found that visits to physicians' offices by uninsured persons declined by about 37 percent between 1996-97 and 2000-01, while hospital emergency room visits by uninsured persons increased by about 10 percent during the same period. Further, in 2000-01,

uninsured persons relied on emergency rooms for 25.2 percent of their ambulatory care visits, as compared to 7.6 percent for individuals with private insurance. In Oregon, the number of emergency room visits by uninsured persons at a Portland hospital increased by 17 percent during the three months following the implementation of Oregon's Section 1115 waiver, as compared to the prior year.[75]

CALIFORNIA CAN IMPROVE MEDI-CAL WITHOUT NEGATIVELY AFFECTING BENEFICIARIES

During the public workshops, Administration officials argued that a waiver is necessary to improve Medi-Cal and shore up federal financing. However, neither higher cost sharing nor a Section 1115 waiver, which would subject the state to a cap on federal Medicaid funding, would improve Medi-Cal. On the contrary, these changes could limit Medi-Cal enrollment, discourage utilization of health care services, and threaten California's financial ability to provide Medi-Cal services. California could improve Medi-Cal by implementing cost-saving strategies, seeking additional federal Medicaid funding, and simplifying eligibility rules. These measures could be achieved by pursuing routine Medicaid state plan amendments, changing state law, seeking limited federal Medicaid waivers, and/or urging enactment of federal legislation.

Implement Cost-Saving Strategies

California could pursue several strategies that would produce cost-savings or increase federal funding for Medi-Cal. For example, the state could:

- **More effectively enforce Medi-Cal drug rebate and fraud and abuse laws.** Drug manufacturers must pay rebates to states and the federal government for drugs provided to Medicaid beneficiaries.[76] California could do a better job of collecting these rebates. California has failed to collect at least $337 million and possibly as much as $1.34 billion in rebates owed to the state by drug manufacturers, according to the federal HHS Office of Inspector General.[77]

  In addition, there is increasing evidence that manufacturers are violating drug rebate rules. For example, drug manufacturers have not been accurately reporting the "best price" at which they sell their drugs. Manufacturers also have been artificially inflating drug prices that are used to calculate Medicaid pharmacy reimbursement rates.[78] California should aggressively enforce the law and obtain financial settlements from drug manufacturers that could be reinvested in the Medi-Cal Program.[79]

- **Continue to implement other pharmacy cost-containment measures.** Like other states, California has implemented significant Medi-Cal pharmacy reforms.[80] In addition, the Governor proposed to reduce pharmacy reimbursement rates in his May Revision.[81] Nonetheless, there is evidence that state Medicaid programs are overpaying pharmacies for prescription drugs dispensed to Medicaid beneficiaries.[82] States set their pharmacy reimbursement rates based on drug prices reported by manufacturers to commercial pricing services. However, such prices may be much higher than the prices pharmacies pay to wholesalers or manufacturers for drugs covered by Medicaid.[83]

  Some states require drug manufacturers to report accurate prices in order to rein in costs. In Texas, for example, drug manufacturers must submit accurate pricing information to the state's Medicaid program in order for their drugs to be covered by Medicaid.[84] California could use accurate pricing data to more effectively enforce drug rebate requirements and monitor fraud (discussed above), as well as to set a more cost-effective Medi-Cal pharmacy reimbursement rate.

Moreover, federal law allows states to set reimbursement limits for certain drugs that have at least two generic competitors. While California has adopted such limits for some drugs, it could expand that list to ensure that it does not overpay pharmacies for generic drugs dispensed to Medi-Cal beneficiaries.[85]

- **Make greater use of disease management programs.** Disease management provides coordinated specialty services to patients with chronic illnesses or conditions to ensure cost-effective, high-quality care. It is not yet clear whether disease management will produce substantial cost savings. However, both the private sector and public programs, such as Medicare and Medicaid, have begun experimenting with this approach.[86] States may claim federal Medicaid matching funds for health care and administrative services provided through disease management programs.[87] In 2003, California allocated funds to develop such programs.[88] The state could institute Medi-Cal disease management programs through a routine state Medicaid plan amendment.[89]

Maximize Federal Funding

California could also promote policy changes at the federal level to increase the amount of federal funding the state receives for Medi-Cal. The state could:

- **Urge the federal government to increase drug manufacturer rebates.** California could encourage Congress to increase the rebate amounts that manufacturers must pay to states.[90] Congress could also further expand the scope of the rebate. For example, manufacturers must pay additional rebates if prices for brand name drugs covered by Medicaid increase faster than the rate of inflation. The scope of the additional rebate could be extended to generic drugs.

- **Seek an extension of the temporary increase in the federal Medicaid matching rate.** In 2003, Congress temporarily increased the federal Medicaid matching rate to provide about $10 billion in fiscal relief to the states.[91] The increase expired on June 30, 2004. If Congress extended the increased match rate through federal fiscal year 2005, California would receive approximately $1.16 billion in additional federal funds.

- **Seek federal Medicaid funding for immigrants who have legally resided in the US for less than five years.** In 1996, Congress barred states from providing Medicaid coverage to immigrants who have legally resided in the country for less than five years. California uses state-only funds to cover this group through Medi-Cal. California could encourage the federal government to reverse its policy and allow federal Medicaid matching funds to be used for legal immigrants who meet all Medicaid eligibility requirements, but who have not resided in the US for at least five years.[92]

Simplify Eligibility Rules

California could reduce Medi-Cal spending by eliminating duplicative functions and reducing burdensome paperwork requirements. For example, the state could:

- **Simplify Medi-Cal income and assets rules.** States have broad flexibility to determine how to count income and assets in assessing Medicaid eligibility.[93] States may disregard various types of income as well as eliminate consideration of assets.[94] For example, California could eliminate the Medi-Cal assets test for parents, as it has done for children. California could also standardize income and assets rules across various means-tested programs, such as Medi-Cal and Food Stamps, in order to simplify program administration and eliminate duplicative functions. However, such

changes must be carefully designed to ensure that they do not exclude currently eligible individuals.

- **Allow beneficiaries to self-report their income and assets.** States also have broad flexibility regarding how they verify income and assets.[95] California could allow Medi-Cal applicants and enrollees to certify that their income and assets meet state and federal guidelines, thereby relieving counties of a significant administrative burden.[96] Alternatively, counties could use data from other programs, such as Food Stamps, to verify Medi-Cal eligibility without requiring applicants and enrollees to submit additional paperwork.

- **Eliminate burdensome reporting requirements and provide "continuous eligibility."** Federal regulations provide states with broad flexibility to adopt rules regarding when beneficiaries must report changes that may affect their eligibility.[97] For example, states may allow Medicaid beneficiaries to report income or asset changes only when such changes would make beneficiaries ineligible for Medi-Cal. However, California currently requires that parents in Medi-Cal report their income and assets twice per year, regardless of whether they have experienced a change in circumstances.[98] This creates a burden on beneficiaries, as well as on counties, which must process the paperwork. California could reduce unnecessary paperwork by allowing Medi-Cal enrollees to submit forms only when there is a change that affects their eligibility for Medi-Cal.

  Furthermore, California could implement "continuous eligibility" for additional Medi-Cal beneficiaries by disregarding changes in income and assets between annual eligibility reviews, which would effectively eliminate reporting until the next eligibility review.[99] California already provides 12 months of continuous eligibility for children and youth under age 21. In 2002, California received federal approval to effectively extend continuous eligibility to low-income parents enrolled in Medi-Cal, but the state has not implemented this provision.[100]

CONCLUSION

California's Medi-Cal Program provides essential health care services, in partnership with the federal government, to 6.7 million adults and children who have low incomes and limited resources. The Governor's proposal to fundamentally restructure Medi-Cal poses substantial risks not only for Medi-Cal beneficiaries, but also for California as a whole. Due to the broad scope of the proposal, the Administration must obtain a Section 1115 Medicaid waiver from the federal government. However, the federal government would require California to accept a cap on federal Medicaid funding as a condition of approving the waiver. A federal Medicaid funding cap would shift more of the financial risk for Medi-Cal from the federal government to California and would severely restrict the state's ability to meet the health care needs of its residents.

The options being considered by the Administration would likely have a profound and potentially negative impact on Medi-Cal beneficiaries, including the elderly and people with disabilities. For example, the Administration has proposed to increase out-of-pocket costs paid by certain Medi-Cal beneficiaries for health care services and to allow doctors to deny services to persons who do not meet cost-sharing requirements. These changes would likely reduce enrollment of eligible persons and discourage Medi-Cal beneficiaries, who have limited resources, from obtaining appropriate and timely care. While such changes may produce short-term General Fund savings, raising Medi-Cal enrollees' out-of-pocket costs could increase long-term General Fund expenditures on Medi-Cal, as well as shift health care costs to public hospitals and community clinics.

California could implement a number of options that would improve Medi-Cal without increasing the state's financial risks or negatively affecting Medi-Cal beneficiaries. These options include implementing cost-saving strategies, seeking additional federal Medicaid funding, and simplifying Medi-Cal eligibility rules. These measures could be achieved by pursuing routine Medicaid state plan amendments, changing state law, seeking limited federal Medicaid waivers, and/or urging enactment of federal legislation.

Scott Graves of the California Budget Project (CBP) and Edwin Park of the Center on Budget and Policy Priorities (CBPP) prepared this report. Support for this report was provided by grants from the California Endowment and The California Wellness Foundation. The CBP was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. Support for the CBP comes from foundation grants, publications, and individual contributions. The CBPP is a non-partisan, non-profit policy institute that conducts research and analysis at both the federal and state level on fiscal policy and on programs and policies affecting low- and moderate-income families.

ENDNOTES

[1] Public workshops were held in March and April 2004 and covered Med-Cal issues ranging from benefits and cost sharing to finance and cost savings. Bobbie Wunsch, *Medi-Cal Redesign Stakeholder Report* (Pacific Health Consulting Group: May 7, 2004).
[2] Section 1115 of the Social Security Act allows the Secretary of the Health and Human Services Agency to waive federal rules so that states may receive federal Medicaid funds for expenditures that are not otherwise permitted under federal law. For example, under a Section 1115 waiver, states may cover populations or offer services that are not allowable under the Medicaid statute, such as expanding coverage to single adults without children. The Section 1115 waiver process is discussed in detail below.
[3] The Legislature would likely need to make statutory changes in order for the Administration to implement the federal waiver.
[4] California Health and Human Services Agency, *Medi-Cal Redesign Update* (May 13, 2004), downloaded from http://www.chhs.ca.gov/docs/Medi-Cal%20Redesign%20Update%20May%2013%202004.pdf on June 3, 2004.
[5] California Health and Human Services Agency, *Medi-Cal Redesign Update* (May 13, 2004), downloaded from http://www.chhs.ca.gov/docs/Medi-Cal%20Redesign%20Update%20May%2013%202004.pdf on June 3, 2004.
[6] Since a final proposal is not available, this *Budget Brief* analyzes public documents describing concepts and options that the Administration circulated in the spring of 2004.
[7] Co-insurance is an amount that beneficiaries must pay at the point of service that is based on a fixed percentage (20 percent, for example) of the cost of the service. A copayment, in contrast, is a fixed amount ($5, for example) that beneficiaries must pay when they receive a service, regardless of the cost of the service. Co-insurance can impose a significant cost burden on beneficiaries since the amount owed is based on the cost of the service provided. Andy Schneider, *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured: July 2002), p. 63.
[8] This report analyzes the option to increase Medi-Cal enrollees' out-of-pocket costs and allow providers to deny services because these changes would affect more than 2 million adult Medi-Cal beneficiaries.
[9] The federal EPSDT Program provides a comprehensive package of benefits to children and youth under age 21 who are enrolled in a state Medicaid program. Jane Perkins, *Fact Sheet: Early and Periodic Screening, Diagnosis, and Treatment* (National Health Law Program: March 1999).
[10] California provides supplemental Medicaid payments to "safety net" public and private hospitals through its Selective Provider Contracting Program waiver, which is scheduled to expire on December 31, 2004, and the Disproportionate Share Hospital program.
[11] States may seek comprehensive waivers that encompass most or all of a state Medicaid program or relatively limited waivers that affect certain beneficiaries and/or apply to a limited set of services. States may, for example, seek less expansive waivers to provide home- and community-based care services to beneficiaries with long-term care needs, provide family planning services, require mandatory managed care, or limit the provider network serving Medicaid beneficiaries.
[12] California currently has 20 federal Medicaid waivers, most of which are for specified groups and services. For example, the Multipurpose Senior Services Program provides home- and community-based services to Medi-Cal recipients who are at least 65 years old and are medically needy. This waiver enables these individuals to live in their own home rather than a nursing care facility. Senate Budget and Fiscal Review Subcommittee #3 on Health, Human Services, Labor and Veterans Affairs, *Analysis of Health, Human Services, Labor, and Veterans Affairs Issues as Proposed in the Governor's 2004-05 Budget Bill* (February 5, 2004), pp. 3-16 to 3-17.
[13] For example, federal courts have ruled that the HHS Secretary may not waive certain federal requirements related to the Medicaid drug rebate program or to beneficiary cost-sharing limits.
[14] The temporary fiscal relief enacted by Congress in 2003 provided California with an enhanced FMAP of 52.95 percent during the first three quarters of federal fiscal year 2004. The current FMAP of 50 percent took effect on July 1, 2004. The FMAP is a state-specific percentage that is adjusted annually by the federal government based on a state's per capita income relative to the national average. For the current FMAP percentages, see 67 Federal Register 69223 (November 15, 2002), available at www.aspe.dhhs.gov/health/fmap04.htm.
[15] Centers for Medicare and Medicaid Services, *Steps in the 1115 Demonstration Proposal Process* (November 1, 2002), available at www.cms.hhs.gov/medicaid/1115/gensteps.asp.
[16] Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors #02-007 (May 3, 2002), citing 59 Federal Register 49249 (September 27, 1994).
[17] Bobbie Wunsch, *Medi-Cal Redesign Stakeholder Report* (Pacific Health Consulting Group: May 7, 2004).
[18] Cindy Mann, *The New Medicaid and CHIP Waiver Initiatives* (Kaiser Commission on Medicaid and the Uninsured: February 2002). For a discussion of the federal budget neutrality requirement and the fiscal risks it would pose for California, see Edwin Park and Kristen Golden Testa, *State of California Would Be Accepting Risky Budget Neutrality Cap If the State Proceeds with Medi-Cal Restructuring Through a Comprehensive Section 1115 Waiver* (April 27, 2004), available at http://www.100percentcampaign.org/resources/publications/fs-040427.htm.
[19] Budget neutrality is not required by federal statute or regulation, but rather is a long-standing OMB policy.

[20] Andy Schneider, *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured: July 2002), citing Centers for Medicare and Medicaid Services, *Budget Neutrality of Comprehensive Section 1115 Waiver Demonstrations* (December 1996).
[21] The budget neutrality limit is set at a level negotiated by a state and the federal government. In general, the limit is based on a state's historical Medicaid spending for the parts of the Medicaid program to which the waiver applies. This baseline spending level is then inflated annually by a negotiated trend rate. The federal government sets year-by-year federal spending targets and periodically reviews state compliance to determine if the state is meeting the budget neutrality requirement.
[22] Cindy Mann, *The New Medicaid and CHIP Waiver Initiatives* (Kaiser Commission on Medicaid and the Uninsured: February 2002).
[23] In addition to the 2003 Medicaid block grant proposal (discussed below), the Bush Administration recently proposed to reduce federal Medicaid spending by $24 billion over 10 years through a crackdown on state Medicaid financing mechanisms. See Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2005* (February 2004).
[24] In an unprecedented and potentially unlawful move, the Bush Administration has proposed to prospectively withhold federal Medicaid funds from states unless the federal government has approved a state's Medicaid budget six months in advance. The Administration is also planning to place up to 100 federal auditors in state budget offices to ensure that states are using federal Medicaid funds appropriately. Centers for Medicare and Medicaid Services, Draft Letter to State Medicaid Directors (October 16, 2003). See also 69 Federal Register 922 (January 7, 2004).
[25] Jocelyn Guyer, *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Caps* (Kaiser Commission on Medicaid and the Uninsured: May 2003).
[26] Comprehensive Section 1115 waivers accounted for nearly one-fifth of total Medicaid spending nationwide in FFY 2001. Andy Schneider, *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured: July 2002).
[27] For analyses of the Bush Administration's 2003 Medicaid block grant proposal, see Cindy Mann, Melanie Nathanson, and Edwin Park, *Administration's Medicaid Proposal Would Shift Fiscal Risks to States* (Center on Budget and Policy Priorities and Georgetown Health Policy Institute: Revised April 22, 2003); Jocelyn Guyer, *Bush Administration Medicaid/SCHIP Proposal* (Kaiser Commission on Medicaid and the Uninsured: May 2003); and John Holahan and Alan Weil, *Block Grants Are the Wrong Prescription for Medicaid* (Urban Institute: May 27, 2003).
[28] The block grant proposal would also provide states with significant flexibility in determining Medicaid eligibility, benefits, and cost sharing under the block grant proposal, similar to the flexibility sought by the Schwarzenegger Administration through a Section 1115 Medicaid waiver.
[29] See Daniel Barrick, "Health Chief Weighs Cap on Medicaid: Possible Limit on Federal Money Worries Health Care Community," *Concord Monitor* (April 16, 2004); Marc Caputo, "Medicaid Proposals Criticized: Governor Jeb Bush Wants to Revamp Medicaid, Leading Democrats to Charge He's Setting the Stage to Slash Healthcare Costs and Privatize More of the Program," *Miami Herald* (April 25, 2004); and Hilary Waldman, "State May Try Medicaid Cost-Cutting Plan," *Hartford Courant* (May 1, 2004).
[30] Letter from Senator Charles Grassley and Senator Max Baucus to Mark McClellan, Administrator, Centers for Medicare and Medicaid Services (June 16, 2004).
[31] No state has ever elected this repayment option. A forthcoming analysis will examine how California might fare financially under a budget neutrality cap. Cindy Mann and Joan Alker, *Federal Medicaid Waiver Financing Policies Can Create Significant Financial Risks for California* (Kaiser Commission on Medicaid and the Uninsured: July 2004, forthcoming).
[32] A per-capita cap on federal Medicaid funding, however, could discourage California from covering certain populations, such as the elderly or people with disabilities, who have high health care costs and may need the most assistance.
[33] Total Medicaid spending, including both federal and state funds, in California was $2,068 per enrollee in federal fiscal year 2000, as compared to a national average of $3,762 per enrollee. Kaiser Commission on Medicaid and the Uninsured, *2000 State and National Enrollment and Spending Data (MSIS)* (March 2004).
[34] Low provider reimbursement rates have limited physicians' participation in Medi-Cal, which has, in turn, restricted Medi-Cal beneficiaries' access to physician care. California Health Care Foundation, *Public Programs: Access to Physicians in California's Public Insurance Programs* (May 2004).
[35] Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Center on Budget and Policy Priorities: May 7, 2003), p. 4.
[36] US General Accounting Office, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), pp. 6-7. States generally may not require premiums "from certain low-income individuals within certain groups, including children, pregnant women, individuals in families with dependent children, individuals with disabilities, and elderly persons, but exceptions exist."
[37] US General Accounting Office, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), p. 9. States may not impose cost sharing on certain children less than 18 years of age or on pregnant women for services related to the pregnancy. In addition, states may not impose cost sharing on most Medicaid enrollees for emergency services; family planning services; hospice care; or services furnished to persons residing in a nursing home or other institution, who were required to spend most of their income for medical care. However, states may require nominal copayments, co-insurance, or deductibles "within federal limits from other Medicaid beneficiaries or for other services."

[38] According to the General Accounting Office, "Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts." US General Accounting Office, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), p. 9.
[39] California currently does not require Medi-Cal enrollees to pay co-insurance or deductibles. However, "medically needy" individuals, who are required to spend a certain amount of their income on health care each month before Medi-Cal services will be provided, are effectively charged a monthly deductible.
[40] US General Accounting Office, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), pp. 45-47. According to the General Accounting Office, "States may require premiums from certain working adults with disabilities who received Medicaid coverage under the Balanced Budget Act of 1997 or the Ticket to Work and Incentives Improvement Act of 1999." The category of adults with disabilities includes working adults.
[41] US General Accounting Office, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), p. 49. The state also requires some adults with disabilities and some adults classified as medically needy to make copayments.
[42] US General Accounting Office, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), p. 51.
[43] The description of tiers and premium and cost-sharing requirements is taken from Department of Health Services, *Medi-Cal Redesign: A Conceptual Framework for a Tiered Approach to Benefits and Cost Sharing* (April 2004). Individuals who are required to spend a certain amount of their income on health care expenses each month before Medi-Cal services are provided (the "medically needy") would be exempt from additional cost-sharing requirements, such as premiums and copayments.
[44] In addition, copayments would not be charged to certain other Tier 1 beneficiaries, including pregnant women and persons living in institutions, or for certain services, including emergency services and family planning, according to the Administration.
[45] Department of Health Services, "Table 1 – Medi-Cal Redesign: Summary," downloaded from http://www.medi-calredesign.org/pdf/04122004_MC_Redesign_FFS_Fiscal_Summary.pdf on July 9, 2004.
[46] According to the DHS, copayments would not be charged to certain Tier 2 beneficiaries, including pregnant women and persons living in institutions such as nursing homes, or for certain services, such as emergency services. Moreover, while DHS documents indicate that Tier 2 enrollees who reside in nursing homes would be charged premiums and co-insurance, Administration officials stated during the public workshops that nursing home residents receiving long-term care services would in fact be exempt from additional cost sharing.
[47] Department of Health Services, "Table 5: Medi-Cal Redesign: Premiums (Average $15)," downloaded from http://www.medi-calredesign.org/pdf/04122004_MC_Redesign_Premium_Summary.pdf on July 9, 2004. These figures include adult enrollees in both fee-for-service and managed care Medi-Cal.
[48] Department of Health Services, *Medi-Cal Redesign: A Conceptual Framework for a Tiered Approach to Benefits and Cost Sharing* (March 2004), p. 3.
[49] Enrollees with incomes greater than 150 percent of the FPL ($23,505 for a family of three in 2004), but less than or equal to 200 percent of the FPL ($31,340 for a family of three in 2004) would pay a premium of up to $20 per month to maintain Medi-Cal coverage.
[50] Core benefits would include inpatient and outpatient hospital services, emergency room services, and prescription drugs.
[51] Medicaid personal care services include a range of services provided to "persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability." Services include assistance with eating, bathing, dressing, and personal hygiene. Centers for Medicare and Medicaid Services, *Personal Care Services*, downloaded from http://www.cms.hhs.gov/medicaid/ services/pcserv.asp.
[52] The copayment for prescription drugs would remain at $1 per prescription and refill.
[53] For comprehensive reviews of the relevant literature, see Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003) and Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Center on Budget and Policy Priorities: May 7, 2003).
[54] The data are from the 2000 Bureau of Labor Statistics' Consumer Expenditure Survey. "Low-income" is defined as families who earned less than 200 percent of the FPL, or $27,476 for a family of three in 2000. Claudia Williams et al., *Challenges and Tradeoffs in Low-Income Family Budgets: Implications for Health Coverage* (Kaiser Commission on Medicaid and the Uninsured: April 2004), pp. 1-2. This report is based on in-depth interviews with a dozen families in three US cities.
[55] Peter J. Cunningham, *Prescription Drug Access: Not Just a Medicare Problem* (Center for Studying Health System Change, Issue Brief Number 51: April 2002), p. 2. Chronic conditions include diabetes, heart disease, and depression.
[56] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003), p. 5.
[57] Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Center on Budget and Policy Priorities: May 7, 2003), p. 11.

[58] These changes applied to certain adults whose incomes did not exceed the FPL and who were not receiving Temporary Assistance for Needy Families (TANF) cash assistance or General Assistance.
[59] Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program* (Kaiser Commission on Medicaid and the Uninsured: June 2004), p. 10.
[60] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003), p. 3. The authors note that 18 percent of low-income individuals report poor or fair health, compared to 8 percent of individuals with higher incomes.
[61] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003), p. 9. The study also found improved diastolic blood pressure for those with hypertension and improved vision among low-income persons in plans without cost sharing as compared to those in plans with cost sharing. The RAND experiment defined "low income" as the bottom 20 percent of the income distribution. The RAND Health Insurance Experiment "was a randomized, controlled experiment supported by the federal government, and remains the most comprehensive and rigorous study of the relationship between cost-sharing, health utilization, and outcomes that exists, although it is now over 20 years old." Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003), p. 6.
[62] Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Center on Budget and Policy Priorities: May 7, 2003), p. 1.
[63] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003), p. 7.
[64] Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Center on Budget and Policy Priorities: May 7, 2003), pp. 9-10.
[65] Peter J. Cunningham, *Prescription Drug Access: Not Just a Medicare Problem* (Center for Studying Health System Change, Issue Brief Number 51: April 2002), p. 2. The survey also found that beneficiary access to prescription drugs is affected to a much greater extent in states that have implemented several prescription drug cost controls, such as copayments and setting dispensing limits that restrict the number of prescriptions. These findings are based on the 2000-01 Community Tracking Study Household Survey. The survey contains observations on about 60,000 persons.
[66] *Governor's Budget Summary 2004-05* (January 2004), p. 100.
[67] Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program* (Kaiser Commission on Medicaid and the Uninsured: June 2004), p. 3.
[68] Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program* (Kaiser Commission on Medicaid and the Uninsured: June 2004), p. 16.
[69] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003), p. 10.
[70] The aggregate costs of these services provided in a non-institutional setting may not exceed the cost of institutional care, such as that provided in a nursing home.
[71] See, for example, Joshua M. Wiener, David G. Stevenson, and Jessica Kasten, *State Cost Containment Initiatives for Long-Term Care Services for Older People* (Congressional Research Service: May 8, 2000).
[72] While DHS documents indicate that Tier 2 enrollees who reside in nursing homes would be charged premiums and co-insurance, but not copayments, Administration officials stated during the public workshops that nursing home residents receiving Medi-Cal long-term care services would be exempt from additional cost sharing.
[73] Persons receiving Medi-Cal long-term care services in nursing homes and other medical facilities are currently required to pay a share of cost. The share of cost is based on a person's countable income above the $35 per month that individuals are allowed to keep for personal expenses. Income may be disregarded in determining the share of cost if it is used to support a non-institutionalized spouse, to provide for the upkeep of a home, or for other reasons.
[74] Peter Cunningham and Jessica May, *Insured Americans Drive Surge in Emergency Department Visits* (Center for Studying Health System Change, Issue Brief Number 70: October 2003).
[75] Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program* (Kaiser Commission on Medicaid and the Uninsured: June 2004), p. 3. The study did not control for other factors that may have influenced emergency room use.
[76] Social Security Act, Section 1927.
[77] Office of Inspector General, *Audit of the Medicaid Drug Rebate Program in California* (US Department of Health and Human Services: December 23, 2003).
[78] Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers* (Taxpayers Against Fraud Educational Fund: November 2003).

[79] The federal Medicaid rebate law, federal Medicare and Medicaid fraud and abuse laws, the federal False Claims Act, and the California False Claims Act provide California with adequate legal authority to pursue litigation against drug manufacturers. Social Security Act, Section 1927(b)(3)(C); Social Security Act, Section 1128A; 31 United States Code, Sections 3729-3733; and California Government Code, Sections 12650-12655. See also Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers* (Taxpayers Against Fraud Educational Fund: November 2003).

[80] For example, in the 2003-2004 Budget, the state established education programs to encourage physicians to prescribe more cost-effective drugs and implemented "step-therapy" requirements so that beneficiaries use less costly drugs before proceeding to more expensive drugs. Senate Committee on Budget and Fiscal Review, *Final Action Report: A Summary of the 2003 Budget Act* (September 25, 2003).

[81] The Governor's May Revision proposed to reduce California's pharmacy reimbursement rate from AWP minus 10 percent to AWP minus 20 percent. It also proposed to offset part of this reduction by increasing the dispensing fee that pharmacists charge from $3.59 to $8.30. California Department of Finance, *Governor's Budget: May Revision 2004-05* (May 13, 2004). However, this across-the-board rate reduction does not reflect differences in price between classes of drugs (pharmacies can obtain generic drugs at much lower prices than brand-name drugs) or among drugs within the same class (some new brand-name drugs cost substantially more than older brand-name drugs).

[82] Office of Inspector General, *Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products* (US Department of Health and Human Services: September 16, 2002).

[83] Many states, including California, reimburse pharmacies at the average wholesale price (AWP) minus 10 percent. However, the Office of Inspector General found that pharmacies paid on average AWP minus 17.2 percent for single source drugs and AWP minus 72.1 percent for generic drugs with at least three competing manufacturers. Office of Inspector General, *Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products* (US Department of Health and Human Services: September 16, 2002).

[84] See Texas Health and Human Services Commission, *Request for Information for New Drug Product or for Additional Information of Products Currently Included in Texas Medicaid* (Revised May 1, 2002).

[85] Federal law requires "federal upper limits" (FULs) on drugs costs for generic drugs with at least two generic competitors. Federal law permits states to set their own payment limits, known as Maximum Allowable Cost (MAC) limits. California applies such limits to 37 drugs under its Maximum Allowable Ingredient Cost (MAIC) program. Andy Schneider, *Medicaid: Purchasing Prescription Drugs* (Kaiser Commission on Medicaid and the Uninsured: January 2002); National Pharmaceutical Council, *Pharmaceutical Benefits under State Medicaid Programs: 2002* (2003); Senate Rules Committee, Office of Senate Floor Analyses, *Analysis of SB 1170* (April 22, 2004).

[86] Ashley Short, Glen Mays, and Jessica Mittler, *Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care* (Center for Studying Health System Change: October 2003).

[87] Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors (February 28, 2004).

[88] Senate Committee on Budget and Fiscal Review, *Final Action Report: A Summary of the 2003 Budget Act* (September 25, 2003).

[89] The Centers for Medicare and Medicaid Services cites existing state flexibility under Social Security Act, Sections 1905(a)(6), 1905(a)(13), and 1932(a). Social Security Act Section 1905(a)(19) would also likely provide authority for disease management programs under the existing case management benefit.

[90] Manufacturers must pay a rebate equal to the higher of (1) 15.1 percent of the average manufacturer price (AMP) or (2) the "best price" at which manufacturers sell to wholesalers and other purchasers for subsequent retail sales. The minimum rebate percentage has remained at 15.1 percent since January 1, 1996.

[91] Public Law 108-27, Section 401. States received a 2.95 percentage point increase in their FMAP for the last two quarters of federal fiscal year 2003 and the first three quarters of federal fiscal year 2004.

[92] The proposed Immigrant Children's Health Improvement Act (ICHIA) would allow states like California that provide state-funded coverage to legal immigrants to receive federal Medicaid matching funds for pregnant women and children who have legally resided in the country for less than five years. ICHIA was included in S. 845, the Senate-passed version of the Medicare drug legislation, but was dropped from the final Medicare drug bill passed by Congress in 2003.

[93] Social Security Act, Section 1902(r)(2). However, states may not adopt criteria that are more restrictive than the criteria under an applicable cash assistance program. For example, states may not adopt Medicaid eligibility criteria for the elderly and people with disabilities that are more restrictive than the criteria for the Supplemental Security Income program. Section 1931(b)(2)(C) of the Social Security Act gives states similarly broad flexibility in setting Medicaid eligibility criteria for families with children that include parents. In this case, eligibility criteria may not be more restrictive than the criteria in place under the Aid to Families with Dependent Children (AFDC) program prior to enactment of federal welfare reform in 1996.

[94] Eligibility criteria for Medicaid may include a family's financial assets. The vast majority of states, including California, have eliminated the assets test for children under both Medicaid and the State Children's Health Insurance Program (SCHIP) in order to reduce administrative complexity and streamline the enrollment process, as many low-income families have few or no resources. However, only 21 states have eliminated the assets test for parents under Medicaid.

[95] The sole federal requirement is that states must verify the immigration status of applicants. Social Security Act, Section 1137(d).

[96] In California, counties administer the Medi-Cal Program, along with most other health and human services programs.

[97] Under federal Medicaid regulations, states must have procedures in place to ensure that beneficiaries make timely and accurate reports about changes in circumstances and that states act promptly to reassess eligibility based on that information. 42 Code of Federal Regulations, Section 435.916(b).
[98] The 2000-01 Budget eliminated the requirement for adults to submit quarterly forms to retain Medi-Cal coverage and allowed beneficiaries to self-report changes in income or other circumstances within 10 days. However, the state increased the reporting requirement by adopting "semi-annual" reporting in 2003. Children are exempt from Medi-Cal reporting requirements.
[99] States can modify income and resource counting rules to effectively provide 12 months of continuous eligibility for parents under federal law. Social Security Act, Section 1931(b)(2)(C).
[100] Medicaid State Plan Amendment Transmittal Number #01-019, downloaded from http://www.cms.hhs.gov/medicaid/stateplans/state_data/CA/spa/CA01_019.