



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

Douglas Holtz-Eakin, Director

November 9, 2005

Honorable Joe Barton
Chairman
Committee on Energy
and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has received several requests to provide additional information about our estimate of the budget impact of the Medicaid provisions in Title III of H.R. 4241, the Deficit Reduction Act of 2005, as reported by the House Committee on the Budget on November 7, 2005. Attached is a memorandum providing additional detail in response to those requests.

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

Sincerely,

Douglas Holtz-Eakin

Attachment

cc: Honorable John D. Dingell
Ranking Member

Honorable Jim Nussle
Chairman, Committee on the Budget

Honorable John M. Spratt Jr.
Ranking Member

Congressional Budget Office

Additional Information on CBO's Estimate for the Medicaid Provisions in [H.R. 4241](#), the Deficit Reduction Act of 2005

The Congressional Budget Office (CBO) estimates that the provisions of subtitle A of Title III of H.R. 4241 would reduce federal Medicaid spending by \$12 billion over the 2006-2010 period and \$48 billion over the 2006-2015 period (see CBO's cost estimate of the [reconciliation recommendations of the House Committee on Energy and Commerce](#), issued on October 31, 2005). 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, and permit states to restrict benefits for certain enrollees. 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 \$2.5 billion over the next five years and by \$6.8 billion over the next 10 years. Of those amounts, more than 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.
- Under current law, very few of the 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 bill, some of those individuals would simply not transfer assets and thus not incur a penalty, but instead accept a delay in Medicaid eligibility. The bill'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.
- CBO estimates that about 1 percent of the unmarried applicants for Medicaid nursing home benefits have homes valued at over \$500,000. (The policy would have a negligible effect on the treatment of the homes of married individuals.) That figure translates to about 5,000 affected individuals annually by 2010.

Cost Sharing

- CBO estimates that the provisions allowing states to impose higher cost-sharing requirements and premiums on certain recipients would reduce Medicaid spending by \$10 billion over the 2006-2015 period. Of that total, about two-thirds of the estimated savings are due to increased cost sharing and one-third 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 cost-sharing requirements primarily for services such as prescription drugs, physician services, and non-emergency visits to emergency rooms. 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 copay amounts and increase them over time, we expect that aggregate enrollee cost sharing would remain, on average, below limits established under H.R. 4241.
- Under the bill, CBO estimates that states with about one-half of all Medicaid enrollees would impose cost-sharing requirements (for at least one service) on enrollees who currently are not subject to cost sharing. We estimate that the number of affected enrollees would increase from 7 million in 2010 to 11 million by 2015, and that about 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 and thus increase copays for another 6 million enrollees by 2015. In sum, we expect that

about 17 million people—27 percent of Medicaid enrollees—would ultimately be affected by the cost-sharing provisions of the bill.

- We estimate that about 80 percent of the savings from higher cost sharing would be due to decreased use of services; 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 (such as prescription drugs or physician services) could be partly offset by higher spending in other areas (such as emergency room visits).

Premiums

- CBO estimates that about 75 percent of the savings from higher premiums under H.R. 4241 would be due to higher premium receipts and the remaining 25 percent would stem from individuals leaving the Medicaid program.
- States would charge premiums to about 1 million enrollees by fiscal year 2010 and to about 2 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 legislation. In response, some beneficiaries would leave Medicaid or would be disenrolled for nonpayment. CBO estimates that about 70,000 enrollees would lose coverage in fiscal year 2010 and that 110,000 would lose coverage in fiscal year 2015 because of the imposition of premiums.

Alternative Benefit Packages

- CBO's estimate assumes that states with about 20 percent of Medicaid enrollees would provide reduced benefit packages to at least some of their enrollees. Those benefit reductions would affect an estimated 2.5 million Medicaid enrollees in 2010 and about 5 million enrollees by 2015—about 8 percent of the Medicaid population—and that about one-half of those receiving alternate benefit packages would be children. 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 bill would prohibit states that provide limited benefit packages from expanding such coverage to groups not covered under the state plan when the bill is enacted.

- While many states trimming benefits likely would offer a benefit package for Medicaid children similar to that provided in the State Children's Health Insurance Program, we expect that others would look to their state employee programs or private-sector plans as models for benefits to offer parents, families, and some disabled adults. CBO anticipates that only a few states would offer benefit plans that offer leaner benefits than those types of plans, though the bill would permit them to do so.
- On average, CBO expects that alternative benefit packages provided by the states would reduce per capita spending by 15 percent to 35 percent for the affected populations, depending on the eligibility group targeted and 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 the amount, duration, and scope of coverage for other services.

Uncertainty of Estimates

CBO's estimates are particularly uncertain in two 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 react to this legislation 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 bill.