

HB 1566: A Brief Analysis

What would the legislation do?

This legislation would make Medicaid spending on a variety of Medicaid services and eligibility groups contingent on the annual appropriations process. The bill provides a vehicle for making cuts in the Missouri Medicaid program each year without passing substantive statutory amendments to Missouri statutes, §§ 208.151 and 208.152. These two statutes mandate that the Missouri Medicaid program cover specific populations and services.

Current Missouri law identifies certain groups and types of services that Missouri Medicaid will cover. HB 1566 would make all “optional” Medicaid coverage and services *subject to the annual appropriations process*. “Optional” services are those services that a state may choose to cover but which the state is not required to cover under federal Medicaid law. Similarly, there are certain “optional” groups of people that states may cover under Medicaid but are not required to cover under federal law. Like all other states, Missouri covers a wide variety of so-called “optional” groups and services.¹

The term “optional” is somewhat misleading because it is unrelated to the *importance* of specific health care services. For example, prescription drugs are hardly “optional” for the elderly and disabled Missourians who rely on Medicaid coverage for their medications. These services are only optional in a *legal* sense, that is, they were not a part of what was required of states when the *federal* Medicaid law was enacted in the mid-1960s. (Of course, under current *Missouri* law, many of these services are not even “optional” in a legal sense – the State must provide them to beneficiaries because the legislature has required that they be part of health care coverage under the Medicaid program.)

The bill would make Medicaid coverage of all “optional” eligibility groups listed in § 208.151 and all optional services listed in § 208.152 “subject to appropriations.” The bill also would *specifically* make the Medical Assistance for Workers with Disabilities (MAWD) and the SCHIP program subject to appropriations, thus revising §§ 208.146 and 208.631 of Missouri law.²

What does it mean to change state requirements regarding optional services and eligibility groups?

Once states choose to cover an “optional” Medicaid group or service, the state receives federal matching funds for all of those groups and services. For most Medicaid recipients, the federal government pays over 61% of the costs of health care services that it provides. For SCHIP participants (sometimes referred to as “MC+ for Kids” in Missouri), the federal government pays for over 72% of the cost. These federal dollars trigger economic activity and jobs that would not otherwise occur in the state – without the infusion of these additional federal dollars. Thus, the economic impact of Medicaid

spending on optional services is no different from the impact of spending on so-called “mandatory” services.

Spending on optional groups and optional services constitutes a major portion of Medicaid spending nationwide and in Missouri. The House Interim Committee on Medicaid Costs and Containment noted that optional services cost Missouri \$1,584,413,849 each year (based on FY 2002 data).³ However, *because over 60% of this \$1.5 billion figure is federal matching funds, these optional services actually cost the state about \$634 million per year.*⁴

The majority of such “optional” Medicaid spending is for prescription drugs and long-term care for elderly and disabled beneficiaries. The Interim Committee noted that pharmacy cost more than \$930,000,000 in FY 2003.⁵ In fact, 83% of optional Medicaid spending nationwide is for elderly and disabled beneficiaries and over two-thirds of optional spending is for prescription drugs and long-term care.⁶ HB 1566 would change current law by making these services dependent on the annual appropriations process.

The bill could have the additional impact of making such services subject to “line-item veto” authority of the executive branch when the legislature does appropriate funds for certain services or eligibility groups. If a Governor were to veto the appropriations for specific services or eligibility groups, an appropriation would not be available and the “subject to appropriations” provisions would seem to apply. The bill could also create confusion about which “optional” groups and services are authorized since departmental appropriations do not always indicate with precision how appropriations are to be allocated among Medicaid eligibility and services categories.

Which eligibility groups could lose health coverage under HB 1566?

Medicaid beneficiaries who would be at risk of losing eligibility every year include:

- Pregnant Women between 133% and 185% of the federal poverty level
- Children under age one between 133% and 185% of the federal poverty level.
- All children in Missouri’s SCHIP program (there is a specific provision in the bill that would make these children’s eligibility subject to appropriations although there already are some provisions in current law to this effect).
- Disabled and elderly Missourians with incomes above the SSI income limit but under the federal poverty level
- Women with breast and cervical cancer
- People with disabilities who are working but covered under the Medical Assistance for Workers with Disabilities (MAWD) Program
- Presumptively Eligible Pregnant Women
- Recipients of Blind Pension Benefits
- Families with incomes above the 1996 AFDC income limits (\$292 per month for a family of three).⁷

What Health care services could be eliminated under HB 1566?

Services that Missouri Medicaid is required to cover pursuant to Section 208.152 that would be at risk include:

- Prescription drugs
- Dental services
- Dentures and prosthetic devices
- Vision services
- Personal Care Services
- Rehabilitation services
- Mental health services provided by community mental health clinics⁸
- Hospice care
- Alcohol and drug treatment services
- Services in an ICF-MR for individuals over 21 years of age
- Audiology services
- Podiatry

By far, the most costly optional service is pharmacy. Under HB 1566, the state could decide each year whether or not it will cover prescription drugs for Missourians, as opposed to current law which requires the Division of Medical Services to provide this service. This legislation would remove Missouri's low-income seniors' and disabled residents' statutory right to obtain prescription drugs under the Medicaid program. **The bill would eliminate the certainty that seniors now have that they can receive prescription drugs under Medicaid** and make the provision of prescription drugs dependent on the outcome of the budget process each year. Under current Missouri law, the general assembly would have to pass a law that specifically eliminates coverage of prescription drugs for the Department to discontinue coverage of this service --- a far more difficult undertaking than allowing coverage to be terminated whenever appropriations are insufficient. Moreover, the degree of public scrutiny and legislative involvement in a decision to cut services based on appropriations would not be as great as it would if a substantive statutory amendment were required to eliminate a particular service.

Two other optional services that would likely be eliminated under the proposed legislation (in that this year's budget legislation proposes to eliminate funding for these services) are dental and optical services. While eliminating these two services would save the state about \$7 million in general revenue, it would also deprive the state of about \$11 million in federal matching funds. At the same time, these optional services have a positive health impact on the people who receive them. It is widely acknowledged, for example, that preventative dental care can forestall greater health problems and more costly medical expenses which can mean higher costs in other parts of the Medicaid budget later on.⁹ Similarly, vision services help facilitate employment opportunities for low-income adults who need to see in order to perform such job functions as reading, driving, using a computer or a cash register, avert work-related injuries, and prevent permanent disabilities and blindness (which can occur if conditions like glaucoma go unidentified or untreated).¹⁰ Whereas these services are protected from cuts by current

Missouri law, HB 1566 could make it easier for the State to eliminate these services, as proposed in this year's House Budget legislation.

Conclusion

Under HB 1566, the legislature and the Governor would decide each year – through the budget process -- who would receive health care coverage and who would not, what type of health care they would receive and what they would not. This approach would replace current legal requirements governing who is covered by Medicaid and the scope of health coverage under the program. This change would make it easier for the legislature or the Governor to cut the Medicaid program each year.

-- Joel Ferber --
-- March 11, 2004 --

¹ Not every Medicaid eligibility group or service is set out in state statute. However, when a specific eligibility group or service is identified in Missouri law, they generally are covered without regard to the annual appropriations process.

² Missouri's SCHIP provisions already include language subjecting the program to appropriation but HB 1566 clarifies that if funds are not provided on an annual basis, **individuals otherwise eligible for SCHIP coverage "shall no longer be eligible."**

³ Report of the House Interim Committee on Medicaid Costs and Containment at 11, 49.

⁴ Report at 11.

⁵ Report at 3, 86

⁶ Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*, January 2004.

⁷ The bill does not address this population directly but also does not exclude these families from the new "subject to appropriations" language. Similarly, families eligible for an extra year of transitional Medicaid under Missouri's extended TMA program are not specifically mentioned in Missouri law.

⁸ Clinic services provided by FQHC and RHCs are mandatory. Other clinic services furnished by or under the direction of a physician are optional.

⁹ See, e.g., U.S. Dept. of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, 2000.

¹⁰ See Leighton Ku, *The Significance of Vision Benefits in Medicaid*, Center on Budget and Policy Priorities, December 2002.