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In February 2006, the President signed into law budget reconciliation legislation—the so-called Deficit Reduction Act (DRA)—that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments. This series of issue briefs is designed to inform advocates about the specifics of these changes and to highlight key implementation issues and strategies to mitigate the harm these provisions could cause to people on Medicaid.

Medicaid Benefit Package Changes:
Coming to a State Near You?

Several of the provisions passed as part of the Deficit Reduction Act (DRA) could make it more difficult for people in Medicaid to obtain the services traditionally provided by the program. One potentially damaging provision establishes an option that allows states to change their benefit packages for certain groups of people in Medicaid. This issue brief explains the changes that states can choose to make in their Medicaid benefit packages, as well as the harm that might come from implementing such changes.

What Does the DRA Say about Medicaid Benefit Packages?

The DRA allows states to deviate from current federal Medicaid requirements and alter their existing package of services for some groups of people in Medicaid, replacing the current federal benefit requirements with new "benchmarks," or standards of coverage. These standards of coverage are the same as those in the State Children's Health Insurance Program (SCHIP). If a state chooses to implement this change, the new benefit packages must, at a minimum, be equivalent to one of the following:

- the Federal Employees Health Benefits Program (FEHBP),
- the state's own state employees health benefits plan,
- the HMO with the largest non-Medicaid enrollment in the state,
- the actuarial equivalent of any of these plans, or
- Secretary-approved coverage.

Although the DRA requires that the package of benefits and services be equivalent to one of the benchmarks listed above, it also states that *some services can be less than actuarially equivalent* to the benchmark plans. These services are mental health, hearing, and vision services, as well as prescription drugs. Furthermore, if the benchmark coverage package does not actually cover one of these four services, then the benchmark plan is not required to (though it may) include coverage for that service. So, a benchmark plan does not actually have to offer mental health, vision, hearing, or prescription drug services.

States also have the option of providing additional services not covered by the benchmark plan. States would be able to do this as a separate wrap-around.

These benchmarks give states great latitude to alter benefit packages. What's more, the "Secretary-approved coverage" option sets almost no standard at all—it allows a state to offer any package of benefits that would be "appropriate to the population" as a Medicaid benchmark plan, so long as it is approved by the Secretary of Health and Human Services (HHS). Reduced benefit packages will make it harder for beneficiaries to obtain necessary services in the states that choose to implement this option.

How Would This Differ from What Medicaid Beneficiaries Currently Receive?

Medicaid law *requires* states to provide certain services ("mandatory services") and *allows* states to cover other services ("optional services") and receive federal matching funds to provide them.[1] Prescription drugs are considered "optional," but many states choose to provide these benefits. And if a state chooses to provide a specific benefit or service, current law requires that that benefit or service be available to all Medicaid beneficiaries if it is medically necessary. Children have an added protection in "Early and Periodic Screening, Diagnosis and Treatment," or EPSDT, which allows them to have regular checkups and to receive virtually any service that is deemed "medically necessary."

Medicaid Mandatory vs. Optional Services

Mandatory Services

- Physician services
- Lab and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- EPSDT services for children under 21
- Family planning services
- Federally qualified health center services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Nursing facility services for those ages 21 and over
- Home health care services

Optional Services:

- Medical care/remedial care by licensed practitioners
- Prescription drugs
- Diagnostic, screening, preventive, and rehabilitative services
- Clinic services
- Primary care case management
- Dental services and dentures
- Physical therapy
- Prosthetic devices and eyeglasses
- Tuberculosis-related services
- Other specified medical and remedial care
- Intermediate care facility for the mentally retarded (ICF/MR) services
- Institute for mental diseases services for those ages 65 and over
- Inpatient psychiatric care for children under 21
- Home- and community-based care waiver services
- Other home health care services
- Targeted case management
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice care

Who Would Be Affected?

Not necessarily all Medicaid populations will be affected by this option, even if a state chooses to exercise it. The DRA protects many groups from mandatory enrollment in the new benefit packages.

If the state exercises this option, the following groups *could be* subject to mandatory enrollment in a benchmark benefit package:	The following groups *are exempt* from mandatory enrollment in a benchmark benfit package but may enroll in one voluntarily:
• optional parents (with incomes over 1996 AFDC levels), and • children and seniors who are not members of the categories listed at right.	• pregnant women, • dual eligibles, • blind and disabled individuals,[2] • children in foster care, • TANF and Section 1931 (mandatory) parents,[3] • women in the breast or cervical cancer eligibility categories, • terminally ill hospice patients, • some institutionalized populations, • medically frail and special needs populations,[4] • beneficiaries who qualify for long-term care, and • Medically Needy individuals and those who spend-down to qualify for Medicaid.

However, although these groups cannot be forced into benchmark plans, they may voluntarily enroll in one as interpreted by new CMS guidance.[5] This appears to go against Congress' intent.[6] This new interpretation of the benchmark benefit package provision is a great cause for concern, since states may establish enrollment procedures that strongly encourage beneficiaries in these "protected" groups to enroll in a benchmark plan, or states may put barriers in place that would make it difficult for beneficiaries to choose "traditional" Medicaid over a benchmark plan. However, the CMS guidance states that the protected groups must be allowed to leave the benchmark plan at any time and go back into regular Medicaid.

Arguably, one of the most significant changes made by this provision is eliminating the requirement that benefit packages be "comparable" across groups of people in Medicaid. That is, for the first time, states will be able, without a waiver, to offer different benefit packages to parents than they do to people with disabilities or to children. Another significant change will allow states to have different benefit packages in different parts of the state. By far, the biggest group of people likely to be affected by the new standards is children, who make up approximately 50 percent of all people in Medicaid.

The DRA allows these benefit package changes only for groups that are currently covered under a state's Medicaid plan. Future Medicaid expansions cannot be covered by a benchmark benefit package.

How Would This Option Affect Children?

Children may be especially vulnerable in states that decide to adopt this option. As noted above, EPSDT is a vital protection that ensures that children in Medicaid receive all medically necessary services. Under this new option, states would be allowed to cut benefits for children. Although they would have to provide EPSDT as a "wrap-around" benefit for children under 19, this may not be adequate.

It is important to note that the legislative language regarding the EPSDT wrap-around is somewhat confusing and leaves many questions unanswered. In a written statement, CMS Administrator Mark McClellan tried to clarify that children would continue to receive the protections of EPSDT; however, children's coverage would be provided in two parts—benchmark coverage and EPSDT benefits that would wrap around the limited benefits package to provide what the benchmark does not cover. Such a system is disjointed and more complex than the current system, and this could lead to children slipping through the cracks and not obtaining certain services.

If a state chooses to implement benefit package changes for children, advocates will need to carefully monitor the situation to ensure that all children maintain the level of care they receive today.

What Are States Likely to Do with This New Option?

The new option that allows states to alter benefit packages is a sweeping provision that could have many different applications. During the fiscal crises that swept states in the early part of the decade, many states cut Medicaid benefits.[7] But some states and governors were frustrated because they were unable to cut benefits more selectively and maintain coverage for certain groups of people rather than having to eliminate services altogether.[8] This frustration has led to discussions about "tailoring" benefits packages for each discrete Medicaid population.

- **"Tailoring" Benefits**

  The National Governors Association (NGA), in its "Medicaid Reform" proposals released last summer, suggested using the federal SCHIP benchmark benefit packages as templates for tailoring benefit packages for healthy individuals in Medicaid.[9] In recent Section 1115 waiver proposals, some states have suggested the same.[10] States argue that they will save money by tailoring benefit packages so benefits are provided only to the populations that need them. For example, healthy adults do not need or use personal care services or durable medical equipment, so why provide access to such services?

  The problem with this argument, however, is that it assumes that people in Medicaid are receiving care and services that they do not need. In Medicaid, an individual

can only receive a service that a physician deems "medically necessary." If a state is running its Medicaid program efficiently, beneficiaries only receive care that is medically necessary. Therefore, "tailoring" benefit packages does not cut down on unnecessary care; rather, it will achieve cost savings only by cutting services that beneficiaries actually need.[11]

There is another problem with tailoring benefit packages. Under the DRA, these tailored packages could be applied in different parts of a state and/or for different subgroups within Medicaid. For example, a state could create a different package of benefits for an urban area of a state than it has in a rural area. This is an idea first espoused by the Bush Administration in 2003 when it released its first proposal to turn the Medicaid program into a block grant.[12] Another way that these packages could be divided is to segment the Medicaid population into groups based on their health status at the time they applied for Medicaid. Packages could be designed based on certain health care conditions or on the average health care needs of people who are a certain age. For example, states could eliminate long-term care services and personal care services for parents in Medicaid. While most parents will not need these services, those who develop a new medical condition or who suddenly need such services because of an accident will be out of luck.

The tailored benefits model set forth by the NGA and adopted by Congress in the DRA fails to address an important implementation issue: What happens when a relatively healthy Medicaid enrollee becomes gravely ill or disabled, effectively becoming a member of one of the protected groups that continues to receive regular Medicaid benefits? Or, what happens if an individual qualifies for Medicaid because he or she is a low-income parent, but that person has a chronic health condition that requires more medications or other services than the limit in the states' new benchmark package? If the new model is designed to save money, these individuals, who have relied on Medicaid for access to vital health care services in the past, will no longer have access to necessary health care services.

- **Increasing the Role of Private Insurance**

  In addition to allowing states to provide more limited Medicaid benefit packages, this new provision will make it easier for states to subsidize the purchase of private health insurance for people who qualify for Medicaid. A key goal of the Administration is to increase the role of private health insurance for people who qualify for Medicaid. Several of the Administration's initiatives have been aimed at encouraging people in Medicaid to enroll in employer-sponsored health insurance (if they have an offer) and at helping people purchase individual, private health insurance rather than enrolling in Medicaid.

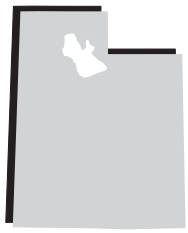
The problem is that private insurance plans tend to have more limited health coverage than Medicaid, as well as significantly higher cost-sharing, and they lack important consumer protections that Medicaid has. Until now, to cope with these problems, federal Medicaid law required states to provide "wrap-around" coverage through Medicaid, enabling those few individuals with an offer of employer health coverage to enroll in that coverage but still have affordable, comprehensive coverage. This requirement has made it administratively cumbersome for states to move people into private coverage without first getting a Section 1115 waiver.

Allowing states to offer multiple benefit packages and to reduce the coverage that Medicaid offers will make it easier to move more people from Medicaid into private health insurance plans that don't have the protections offered by Medicaid. This is especially true for children who qualify for Medicaid with slightly higher family incomes and who therefore are somewhat more likely to have access to private health insurance options.

How Would This Change Affect State Governments and Enrollees?

States will have the option to change their Medicaid benefit packages for non-exempt populations by providing a different standard of coverage. But adopting benefit packages based on "benchmark" packages may have severe consequences for Medicaid beneficiaries because this could limit access to critical health care services. Extensive research and recent experience have shown that Medicaid benefit cuts result in significant delays and loss of access to necessary health care. The recent experiences of two states illustrate this point.

- **Utah**: When Utah expanded Medicaid coverage for uninsured adults with incomes below 150 percent of the federal poverty level (in 2006, about $14,700 per year for an individual) through a Section 1115 waiver demonstration, it opted to provide only primary and preventive care for this new coverage category. This demonstration program, known as the Primary Care Network (PCN), lacks many vital services, including hospital care, specialist care, mental health coverage, and substance abuse care.



  Research on the effect of the PCN program has shown that, while those enrolled have received primary and preventive care they might not otherwise have gotten, they are unable to get needed care that is not covered. In response, Utah's Department of Health created a "charity care" outreach initiative to connect people with providers willing to provide the non-covered services at little-to-no cost. However, the numbers indicate that charity care is not an effective alternative to comprehensive coverage.[13] Additional research indicates that 76 percent of surveyed PCN enrollees used or needed services beyond the scope of their coverage.[14] So, for PCN enrollees, a lack of coverage for certain

services translates into delaying care for some illnesses and conditions. When prolonging care is no longer an option, those individuals wind up in the emergency room, and state and local governments are left to foot the (often higher) bill.

- **Oregon:** In 2003, Oregon sought and received federal approval of a Section 1115 Medicaid waiver. Although the waiver sought a series of coverage expansions, benefit reductions, and cost-sharing increases, the state's budget problems prevented it from implementing the coverage expansions. The benefit reductions affected parents and other adults with incomes above 100 percent of the federal poverty level (in 2006, about $9,800 per year for an individual). The benefit cuts included mental health services, durable medical equipment, dental and vision services, and prescription drugs.[15] Evidence from a focus group study indicates that the reduction in services created barriers to obtaining care, particularly for those needing mental health services. Participants noted that their "health and quality of life were deteriorating" due to these losses in coverage. And beneficiaries were choosing to forgo care rather than pay for these services out-of-pocket.[16]

When and How Could Changes Occur?

The DRA provisions take effect on March 31, 2006, meaning that states can implement the benefit package changes on or after that date. In order for a state to implement the flexible benefits package option, it must first amend its Medicaid state plan. The state Medicaid agency must write the amendment, and then the state submits the change for approval to the Centers for Medicaid and Medicare Services (CMS), the federal agency that oversees Medicaid. In many states, this change requires state legislative approval before it can go to CMS. However, there may be some states where legislative approval is not necessary and the state may make this change through administrative rule-making. It is therefore vitally important that advocates know the laws governing the amendment of Medicaid state plans in their state and keep an eye out for rule-making notices or legislative bills.

The Bottom Line

The DRA gives states new options to offer Medicaid benefits more selectively than they have under previous federal law. This new option allows states to cut benefits for some people in Medicaid while maintaining the full Medicaid benefit package for others. States will be able to offer different benefit packages to people in different parts of the state or to different groups in Medicaid. The bottom line: This new option challenges the goal of the Medicaid program to "furnish medical assistance on behalf of [those] whose income and resources are insufficient to meet the costs of necessary medical services."[17] Depending on the choices states make if they decide to implement this provision, individuals who rely on Medicaid for vital health care services may end up competing for scarce Medicaid resources. And somebody will lose.

Endnotes

[1] This part of the Medicaid law will remain in effect for states that do not choose to implement the option of new benchmark benefit packages. And even if a state implements changes to its benefit package, this part of the Medicaid law still pertains to groups that are exempted by the DRA provision (see list of groups on page 3).

[2] Individuals who are enrolled in Medicaid on the basis of their disability or blindness.

[3] There are different interpretations of the exemption for parents. The DRA itself is ambiguous. The heading of the exemption says "TANF and Section 1931 parents," while the description reads in part "the individual qualifies for medical assistance on the basis of eligibility to receive assistance" under TANF. The conference report seems to also indicate that only those receiving TANF cash assistance are exempt. However CMS' "Dear State Medicaid Director" letter on the benchmark benefits provision confusingly states that this exemption relates to "individuals who qualify for Medicaid solely on the basis of qualification under the State's TANF rules." Since Medicaid and TANF eligibility were never linked, this exemption is meaningless, and under CMS' interpretation, no parents are exempt from the benchmark benefits provision.

[4] The DRA leaves it to the discretion of the Secretary of Health and Human Services to define "medically frail" and "special needs." In CMS guidance, individuals with "special medical needs" are defined as: dual eligibles and certain children under 19 who are eligible for SSI; TEFRA children, children in foster care or other out-of-home placement; children receiving foster care or adoption assistance; or children receiving service through a family-centered, community-based, coordinated care system that received grant funds under Title V and are defined by the state in terms of program participation or special health care needs.

[5] Centers for Medicaid and Medicare Services, Dear State Medicaid Director Letter #06-008, March 31, 2006.

[6] H. R. Conf. Rep. 109-362, at H12724 (2005).

[7] *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2004).

[8] For a discussion of Washington's rationale for seeking a waiver with flexibility to reduce benefits rather than taking the more drastic measure of cutting beneficiaries, see *Washington State Medicaid and SCHIP Reform Waiver*, Draft, September 24, 2001, available online at http://fortress.wa.gov/dshs/maa/medwaiver/MSRWD7.pdf. Although they later cut almost 200,000 people from the TennCare program, Tennessee's Governor Bredesen initially believed that by cutting benefits, he could save the program. See Skip Cauthorn, "Bredesen delivers cure for TennCare," *The City Paper* (Nashville: The City Paper LLC, February 18, 2004).

[9] National Governors Association, *Short-Run Medicaid Reform* (Washington: National Governors Association, August 2005), available online at http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF. Tailored benefit packages may also be called "targeted benefit packages."

[10] Kentucky was the first state to attempt to restructure its Medicaid program using tailored benefit packages based on the different needs of beneficiary groups. The federal government indicated it was likely to approve its waiver in January 2006. Idaho and West Virginia have developed waiver concept papers with ideas similar to Kentucky's, although neither state has yet submitted a formal waiver application or received federal approval.

[11] Cindy Mann and Elizabeth Kenney, *Differences that Make a Difference: Comparing Medicaid and the State Children's Health Insurance Program Federal Benefit Standards* (Washington: Georgetown University Health Policy Institute Center for Children and Families, October 2005).

[12] Transcript of press conference, "HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan," January 31, 2003, Washington, D.C., available online at http://www.kaisernetwork.org/health_cast/uploaded_files/kff013103_hhs_medicaid.pdf, p. 15.

[13] In 2002-03 (the most recent year for which data are publicly available), 221 of more than 16,000 people enrolled in PCN contacted the state to inquire about charity care, and only half of those received such care. Utah Department of Health, *Utah Primary Care Network Annual Report: July 2002-June 2003*, available online at http://health.utah.gov/pcn/FY03AnnualReport.pdf, as cited in Families USA, *Utah's Primary Care Network Medicaid Program* (Washington: Families USA, April 2005). New research indicates that PCN enrollees are generally able to obtain hospital care, but specialty care under the charity care program—especially outside of the Salt Lake City area—is much more difficult to obtain. Caitlin Oppenheimer, Angela Jaszczak, Sidra Goldman, Daniel S. Gaylin, Samantha Artiga, and David Rousseau, *A Case Study of the Utah Primary Care Network Waiver: Insights Into Its Development, Design, and Implementation* (Washington: Kaiser Commission on Medicaid and the Uninsured, March 2006).

[14] Samantha Artiga, David Rousseau, Barbara Lyons, Stephen Smith, and Daniel S. Gaylin, "Can States Stretch the Medicaid Dollar Without Passing the Buck? Lessons From Utah," *Health Affairs* 25, no. 2 (March/April 2006), pp. 532-540.

[15] The prescription drug benefit was later restored in 2004.

[16] Gene LaCouteur, Michael Perry, Samantha Artiga, and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights* (Washington: Kaiser Commission on Medicaid and the Uninsured, December 2004).

[17] 42 U.S.C. 1396.