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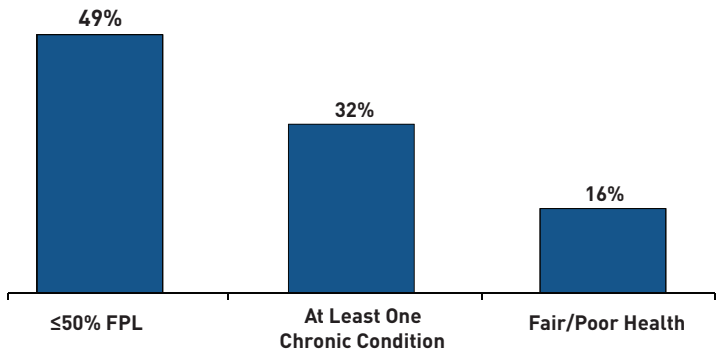
EXPLAINING HEALTH REFORM: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries

Under the Patient Protection and Affordable Care Act (PPACA; Public Law 111-148), signed into law on March 23, 2010, Medicaid plays a major role in covering more uninsured people. On January 1, 2014, the program will be expanded to provide eligibility to nearly all people under age 65 with income below 133 percent of the federal poverty level (FPL).[1] As a result, millions of low-income adults without children who currently cannot qualify for coverage (except in a handful of states with waivers), as well as many low-income parents and, in some instances, children now covered through the Children's Health Insurance Program (CHIP), will become eligible for Medicaid. In addition, the health reform law is expected to result in more people who already are eligible for Medicaid under current rules learning about and signing up for coverage. In total, Medicaid, along with its smaller companion program, CHIP, is expected to cover an additional 16 million people by 2019.[2]

Many of the people who will be enrolled in Medicaid are very low-income and a substantial number face significant health problems (Figure 1). Half of all uninsured adults below 133 percent FPL have income below 50 percent FPL. When it comes to their health status, about one-third have a diagnosed chronic condition, such as hypertension or depression, and about 1 in 6 are in fair or poor health. The majority of uninsured adults below 133 percent FPL – 69 percent – are adults without dependent children, and 31 percent are parents. In light of the characteristics of these newly-eligible adults, a key question is what kind of coverage they will have. This brief provides the details of the benefit and cost-sharing rules that will govern the coverage available to newly-eligible adult Medicaid beneficiaries. The rules for children in Medicaid are distinctly different; federal law requires states to cover all medically necessary services for children and provides stronger cost-sharing protection to them (Appendix).

Figure 1

Uninsured Adults ≤133% FPL, by Income and Health Characteristics



Note: 100% of the HHS federal poverty level (FPL) was $10,400 for an individual in 2008.
SOURCE: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS (income data). KFF analysis of 2007 Medical Expenditure Panel Survey (health data).

Background

As of January 1, 2014, states are required to provide Medicaid to nearly all people under age 65 with income below 133 percent FPL (about $14,400 for an individual in 2010). From 2014 through 2016, the federal government will finance 100 percent of the cost of those who become eligible for Medicaid due to the expansion. In subsequent years, the federal matching rate will decline somewhat, but it will eventually settle at 90 percent, well above the regular Medicaid matching rates for states. States are required to provide most people who become newly eligible for coverage under the Medicaid expansion with "benchmark" benefits. As discussed below, states also have authority to provide benchmark benefits to certain other groups of Medicaid beneficiaries who qualify under existing rules (i.e., "already-eligible" Medicaid beneficiaries).

Set forth in the Deficit Reduction Act of 2005 (DRA), the concept of benchmark benefits is relatively new to Medicaid. Prior to the DRA, states were required to cover a federally-specified set of services for adult Medicaid enrollees and they had the option to cover additional services. For example, under the traditional rules, adult beneficiaries must be provided with hospital care, physician services, lab and x-ray services, nursing home

care, and family planning services. But states also can cover prescription drugs (which all of them do) and other additional services, such as dental care and vision care, and personal care and other community-based services for people with disabilities.

In the DRA, Congress gave states the option to provide certain groups of Medicaid enrollees with an alternative benefit package (i.e., "benchmark" or "benchmark-equivalent" coverage) based on one of three commercial insurance products or determined to be appropriate by the Secretary of Health and Human Services ("Secretary-approved coverage"). With respect to groups receiving benchmark or benchmark-equivalent coverage, the DRA gave states flexibility to disregard Medicaid's longstanding requirements for "comparability" (i.e., the same coverage must be provided to all categorically eligible Medicaid beneficiaries and cannot vary based on a person's diagnosis, age, or other factors) and "statewideness" (i.e., the state must provide the same scope of services to Medicaid beneficiaries throughout the state, regardless of where they live). States can also disregard other Medicaid requirements, but only if they are "directly contrary" to the flexibility they need to provide benchmark benefits.[3]

To date, states have used the benchmark benefits option sparingly. Since the option's creation in 2005, just ten states have used benchmark benefits for some of their beneficiaries.[4] In most cases, the option was adopted as a means to provide additional services to certain groups of adults with special conditions, for example, to provide disease management services and enhanced access to nurse help lines to people with selected chronic conditions, such as heart disease and diabetes.

In the health reform law, Congress made some changes to the standards for benchmark benefits. Most notably, it added a requirement that benchmark packages provide all "essential health benefits," which are the benefits that must be provided to people signing up for Exchange plans or coverage in the individual or small group insurance market, beginning in 2014. The HHS Secretary is charged with defining "essential health benefits," and, as a result, it may be some time before it is clear how significant a change in benchmark benefit rules the inclusion of essential health benefits will represent. In addition, the health reform law added new requirements that benchmark benefits include family planning services and, in instances where a state relies on "benchmark-equivalent coverage," mental health services and coverage of prescription drugs.

Federal Standards for Benchmark and Benchmark-Equivalent Benefits

As noted above, the health reform law requires states to provide most newly-eligible adult Medicaid beneficiaries with benchmark or benchmark-equivalent coverage. The major federal rules governing benchmark coverage include:

- **Coverage of essential health benefits.** Benchmark and benchmark-equivalent coverage must include "essential health benefits." These essential health benefits, which will be outlined in more detail by the Secretary of Health and Human Services in the years ahead, also form the basis for the coverage that will be provided to people enrolled in Exchange plans and the individual and small group insurance markets. The specific categories of service that the essential health benefits must include are:
    - Ambulatory patient services;
    - Emergency services;
    - Hospitalization;
    - Maternity and newborn care;
    - Mental health and substance use disorder services, including behavioral health treatment;
    - Prescription drugs;
    - Rehabilitative and habilitative services and devices;
    - Laboratory services;
    - Preventive and wellness services and chronic disease management; and
    - Pediatric services, including oral and vision care.

In providing more detail on these services, the HHS Secretary must ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan. It is not yet clear to what extent the federal rules will address the amount, duration and scope of benefits that must be provided.

- **Coverage must consist of "benchmark" or "benchmark-equivalent" benefits.** In addition to providing essential health benefits, the coverage must be equal to the coverage provided in one of three benchmarks, equivalent in actuarial value to one of the three benchmarks, or a package approved by the Secretary:[5]
    - **Blue Cross/Blue Shield plan.** The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP);
    - **State employee plan.** Any state employee plan generally available in a state;
    - **Commercial HMO product.** The HMO plan in a state that has the largest commercial, non-Medicaid enrollment in the state; or
    - **Secretary-approved coverage.** Any plan that the HHS Secretary determines is appropriate for the people who will be covered by it. HHS recently has indicated that it will consider the full Medicaid benefit package to be an appropriate plan under the Secretary-approved coverage option.[6]

States also can provide additional benefits on top of what is included in a benchmark-equivalent plan as long as the services are included in the benchmark plan or could be covered under "regular" Medicaid.[7] For example, a state could decide to provide additional disease management services, care coordination, or therapies.

- **Additional Medicaid requirements.** Benchmark and benchmark-equivalent coverage must meet other Medicaid requirements, including requirements to cover transportation services, family planning services, and care provided by rural health clinics and federally qualified health centers. Also, such coverage, if it is provided through managed care entities, must comply with Medicaid managed care requirements. In addition, states must secure public input prior to filing a proposal with HHS to use benchmark or benchmark-equivalent coverage.[8]

Groups Exempt from Benchmark Coverage

The DRA identified a number of groups of people who cannot be required to enroll in benchmark benefits. In the health reform law, Congress explicitly carried these "exemptions" over, applying them also to those newly eligible for Medicaid due to the expansion to 133 percent FPL. The following groups of beneficiaries – including those eligible under traditional Medicaid rules and those eligible under the new expansion to 133 percent FPL – are exempt from mandatory enrollment in benchmark coverage and, instead, must be offered the traditional, full Medicaid benefit package:[9]

- **People with disabilities.** People who qualify for Medicaid because they are blind or disabled, as well as people who are receiving certain long-term care services.
- **Dual eligibles.** People who are enrolled in both Medicaid and Medicare.
- **Medically frail.** People who are medically frail or who otherwise have special medical needs. HHS' final rule on benchmark benefits clarified that a state's definition of who is medically frail must, at a minimum, include people with "serious and complex medical conditions" and people with "physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living." A state, however, also could define medically frail more broadly.[10]
- **Certain low-income parents.** Parents or caretaker relatives whom a state is required to cover under federal minimum Medicaid standards (i.e., "Section 1931 parents"). The federal minimum standard for parent coverage varies across states from a low of 17 percent FPL to a high of more than 133 percent FPL; the median is 64 percent FPL for a working parent.[11]
- **Other special groups.** Others whom states cannot require to enroll in benchmark coverage include pregnant women, women who qualify for Medicaid because of breast or cervical cancer, children in foster care or receiving adoption assistance, the medically needy, and individuals receiving only emergency services.

Given that significant health care conditions are relatively prevalent among the low-income adults who will become eligible for Medicaid under the expansion to 133 percent FPL, a considerable share of this population can be expected to be exempt from mandatory enrollment in benchmark coverage.

Premiums, Deductibles, and Cost-Sharing for Adults

The rules governing how much states can charge newly-eligible adult Medicaid beneficiaries for coverage and services are complex and they vary depending on a beneficiary's income and the service that is being used. In general, though, states are strictly limited in the premiums, deductibles, and cost-sharing amounts that they can charge adult Medicaid beneficiaries, with particularly strong rules for those below 100 percent FPL.[12] For adults in this lowest income range, states cannot charge more than a nominal amount for most services, nor can they impose premiums or any charge for emergency services or family planning services. At state option, adults with more income can face somewhat higher cost-sharing charges – for most services, up to 10 percent of the cost of the service for those with income between 100 percent and 150 percent FPL, and up to 20 percent for those with income above 150 percent FPL. Adults cannot be charged premiums until their income reaches 150 percent FPL. In addition, states must ensure that the total cost of Medicaid premiums, deductibles, and cost-sharing charges for a family in a year does not exceed 5 percent of the family's income.

MEDICAID PREMIUM AND COST-SHARING STANDARDS FOR ADULTS

	≤100% FPL	101%–150% FPL	>150% FPL
Premiums	*Not allowed*	*Not allowed*	*Allowed*
Cost-Sharing (may include deductibles, copayments, or coinsurance) "Nominal" is defined as up to $2.30[1] deductible per month per family, up to $3.40[1] copayment, or up to 5% coinsurance.			
Most services[2]	*Nominal*	*Up to 10% of the cost of the service or a nominal charge*	*Up to 20% of the cost of the service or a nominal charge*
Prescription drugs			
• **Preferred**	*Nominal*	*Nominal*	*Nominal*
• **Non-preferred**	*Nominal*	*Nominal*	*Up to 20% of the cost of the drug*
Non-emergency use of emergency department	*Nominal*	*Up to twice the nominal amount*	*No limit, but 5% family cap applies*
Preventive services	*Nominal*	*Up to 10% of the cost of the service or a nominal charge*	*Up to 20% of the cost of the service or a nominal charge*
Cap on total premiums, deductibles, and cost-sharing charges for all family members	*5% of family income*		
Service may be denied for non-payment of cost-sharing	*No*	*Yes*	*Yes*

NOTE: Some groups of adults are exempt from premiums, deductibles, and most cost-sharing charges described in this table. They include pregnant women (except that those above 150 percent FPL can be charged very modest premiums), terminally ill individuals receiving hospice care, institutionalized spend-down individuals, breast and cervical cancer patients, and Indians who receive services from Indian health care providers. These groups can be charged cost-sharing for non-emergency use of an emergency department and for use of a non-preferred prescription drug.

[1] $2.30 and $3.40 are the "nominal" amounts for federal fiscal year 2009 – the latest available from HHS. They will be adjusted over time to reflect inflation in medical care costs.

[2] Cost-sharing of any kind is prohibited for some services, including emergency services and family planning services.

Policy Implications

Under the health reform law, states will have considerable flexibility within federal guidelines to design Medicaid benefit packages and cost-sharing rules that are appropriate for newly-eligible adult beneficiaries. The often-extensive health care needs and very low income of the newly-eligible adults are important considerations for states to take into account in making their design choices. The available federal financing is another important factor for states to weigh. The federal government will finance the full cost of care for newly-eligible Medicaid adults for the first three years of reform, and at least 90 percent of the cost thereafter. The matching rate is lower for other, already-eligible populations, but the federal government will still pick up at least 50 percent – and in most cases, more – of the cost of providing them with benefits.[13]

Beyond the question of benefits for the newly-eligible population in particular, the broader issue for states is how to create a coherent Medicaid program that provides the full range of groups served by the program with the benefits that they need when they need them. Many people are likely to experiences changes in their circumstances that move them in and out of "exempt" status. For example, individuals who are mandatorily enrolled in benchmark or benchmark-equivalent coverage could become exempt if they become pregnant, develop a medical condition that causes them to be classified as "medically frail," qualify for Medicare, or experience a drop in income that puts them below pre-reform federal minimum eligibility standards. Given that such changes in income, health status, and other factors are common, coordination and consistency of coverage between groups and over time are key aims. Because individuals may also shift between eligibility for Medicaid and Exchange coverage, identifying ways in which states can promote continuity of care between the two systems is a priority.

As state policymakers decide their direction regarding benefits for newly-eligible Medicaid adults, two major options available to them are:

- **Provide the traditional, full Medicaid package.** While HHS has yet to issue guidance on Medicaid benefits in the context of the health reform law, its recent final rule on benchmark coverage suggests that states will be able to provide newly-eligible adults with the traditional, full Medicaid benefit package.[14] Given the newly-eligible population's low income and health profile, states that have established a Medicaid package for already-eligible adults that is well-designed to meet their needs may decide that they should use the same package for newly-eligible adults. Also, because states must continue to provide full Medicaid benefits to many adults (both already-eligible and newly-eligible) who belong to the groups exempt from mandatory benchmark coverage, this option may be attractive to states seeking to run a streamlined and simplified Medicaid program that does not require them to track beneficiaries in order to capture changes in exempt status.
- **Provide a benchmark benefit package with essential health benefits.** States can elect to use a benchmark benefit package (or benchmark-equivalent package) based on one of three commercial products or an appropriate package under the Secretary-approved coverage option, as long as it covers essential health benefits and complies with other Medicaid requirements. States that rely on a benchmark benefit package (or benchmark-equivalent package) may consider adding services that are tailored to the specific health care needs of low-income adult Medicaid beneficiaries, such as additional mental health services, support for managing chronic conditions, or assistance in care coordination.

Along with making decisions about the benefit package for newly-eligible adults in Medicaid, states will need to explore using delivery systems that are coordinated or even overlapping with those used in Exchange plans while ensuring, at the same time, that beneficiaries retain access to vital, Medicaid-specific services, such as transportation and, in some cases, more extensive help with chronic conditions, serious health issues, and care coordination.

Conclusion

The content of the coverage provided to the millions of low-income adults slated to secure Medicaid coverage under the health reform law will depend, in part, on how the federal government addresses key issues, such as the definition of "essential health benefits." Most importantly, it will depend on the decisions of state policymakers in the months and years ahead. In light of the limited income and often extensive health care needs of newly-eligible adult Medicaid beneficiaries, it will be critical that they be provided with benefits designed to reflect their unique needs if health reform is to work as intended.

APPENDIX: Federal Rules Regarding Benefits for Children in Medicaid

The health reform law is expected to make some children newly-eligible for Medicaid. In particular, children ages 6 to 19 in separate CHIP programs with income between 100 percent and 133 percent FPL will move into Medicaid when the major Medicaid expansion takes place on January 1, 2014.

Like other children in Medicaid, those who become newly eligible for Medicaid must be provided with the "EPSDT" benefit, which federal Medicaid rules have long required for children. EPSDT – Early and Periodic Screening, Diagnosis, and Treatment – is designed to cover all medically necessary care for children, in recognition of their unique developmental needs. Under EPSDT, states must fully cover preventive and primary care, including dental, hearing, and vision care, as well as all acute care needs. Further, the EPSDT benefit extends beyond acute care to address long-term care needs, including therapies, medical equipment and other support services that are particularly important for children with special health care needs.

States can provide children in Medicaid with benchmark benefits, but, if they do so, they must supplement the coverage as needed to ensure the child receives the full EPSDT benefit. Technically, states are required to provide benchmark coverage to children who move from separate CHIP plans into Medicaid following the expansion of Medicaid eligibility to 133 percent FPL. However, as a practical matter, the law appears to give states broad flexibility to decide the best way to ensure that Medicaid children receive the EPSDT benefit. Thus, states can opt to use a benchmark issuer (e.g., a state employee plan) to provide coverage and then supplement it as needed. Alternatively, it appears that states can rely on the same delivery system they use for other children to provide benchmark benefits and any supplemental services needed to reach an EPSDT level of coverage.

MEDICAID PREMIUM AND COST-SHARING STANDARDS FOR CHILDREN

	"Mandatory Children"[1]	Other children ≤150% FPL	Children >150% FPL
Premiums	*Not allowed*	*Not allowed*	*Allowed; may vary by group*
Cost-Sharing (may include deductibles, copayments, or coinsurance) "Nominal" is defined as up to $2.30[2] deductible per month per family, up to $3.40[2] copayment, or up to 5% coinsurance.			
Most services[3]	*Not allowed*	*Up to 10% of the cost of the service*	*Up to 20% the cost of the service*
Prescription drugs			
• **Preferred**	*Not allowed*	*Not allowed*	*Nominal*
• **Non-preferred**	*Nominal*	*Nominal*	*Up to 20% of the cost of the drug*
Non-emergency use of emergency department	*Nominal*	*Up to twice the nominal amount*	*No limit*
Preventive services	*Not allowed*		
Cap on total premium and cost-sharing charges for all family members	*5% of family income*		
Service may be denied for non-payment of cost-sharing	*No*	*Yes*	*Yes*

Note: Indian children who receive services from Indian health care providers, as well as children in foster care or adoption assistance programs, are exempt from all premiums and cost-sharing charges except those for non-preferred prescription drugs and non-emergency use of the emergency department. Disabled children who qualify for coverage under the Family Opportunity Act option are exempt from cost-sharing charges, but can be charged certain premiums.

[1] "Mandatory children" are those whom the federal government requires states to cover in Medicaid, including children ages 0-5 with family income below 133 percent of FPL and ages 6-18 with family income below 100 percent of FPL. Starting in 2014, under the Affordable Care Act, children of all ages with family income up to 133 percent of FPL will be "mandatory children."

[2] $2.30 and $3.40 are the "nominal" amounts for federal fiscal year 2009 – the latest available from HHS. They will be adjusted over time to reflect inflation in medical care costs.

[3] Cost-sharing of any kind is prohibited for some services, including emergency services and family planning services.

[1] As under prior law, undocumented immigrants will remain ineligible for Medicaid and CHIP, and only certain legal immigrants can secure coverage.

[2] Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," March 20, 2010.

[3] Prior to technical corrections included in the Children's Health Insurance Program Reauthorization Act (P.L. 111-3), the DRA could have been read as giving states broader flexibility to disregard even those Medicaid requirements not directly in contravention of benchmark benefits. As a result of the technical corrections, CMS stated in its final rule on benchmark benefits, issued on April 30, 2010 (Federal Register, Vol. 75, No. 83), that states still must comply with any Medicaid requirement not directly contrary to benchmark benefit flexibilities, including Medicaid managed care regulations and the requirement to provide transportation services.

[4] See page 23076, Federal Register, Vol. 75, No. 83, April 30, 2010.

[5] If a state uses a benchmark-equivalent package, it must submit an actuarial report that attests that the coverage has an aggregate actuarial value equivalent to the benchmark. In making such an assessment, the actuary may take into account the state's ability to reduce benefits to reflect the increase in actuarial value created by using Medicaid cost-sharing rules rather than the benchmark's rules. In addition, the benchmark-equivalent package must include coverage for inpatient and outpatient hospital services, physician services, laboratory and x-ray services, well-baby and well-child care (including immunizations), emergency services, other appropriate preventive services, and, as a result of changes included in the health reform law, family planning services, prescription drugs and mental health services. To the extent the benchmark includes vision and hearing services, the equivalent package also must provide these services and ensure they have an actuarial value equal to at least 75 percent of vision and hearing services in the benchmark.

[6] 42 CFR 440.330(d).

[7] Specifically, states can provide additional services if they use the option to provide benchmark-equivalent coverage, as long as the services could be covered under regular Medicaid rules or are included in the benchmark package. See page 23086, Federal Register, Volume 75, Number 83, April 30, 2010 for a discussion of this issue and 42 CFR 440.335 for the regulatory language.

[8] The basis for the application of these additional requirements varies. For example, the DRA requires that beneficiaries continue to have access to federally-qualified health centers and rural health centers (as has long been required under Medicaid law). In light of technical corrections included in Section 611 of CHIPRA (Public Law 111-3), CMS more recently clarified in its final rule on benchmark benefits, published April 30, 2010, that states are required to provide transportation services and to comply with Medicaid managed care regulations. Finally, the requirements to provide family planning services and comply with mental health parity requirements were included in Sections 2001 and Section 2302, respectively, of the Affordable Care Act (Public Law 111-148), although CMS notes that the family planning services would have been required in benchmark-equivalent plans even without the statutory change because of the existing requirement to provide "appropriate preventive services."

[9] At their option, exempt individuals can choose to sign up for benchmark benefits. They must be informed of any differences between the benefits or cost of coverage under the benchmark benefit package (or equivalent) and a state's standard full Medicaid benefit, be given ample time to arrive at an informed choice, and voluntarily and affirmatively choose to enroll in the benchmark package. Once enrolled, an exempt individual can disenroll from benchmark coverage at any time and must be "promptly" moved into the standard full Medicaid benefit. While the disenrollment request is being processed, exempt individuals must be able to secure all standard Medicaid services.

[10] 42 CFR 440.315(f).

[11] Ross et al. *A Foundation for Health Reform: Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009*, Kaiser Commission on Medicaid and the Uninsured, December 2009.

[12] A large body of research indicates that Medicaid beneficiaries otherwise are at high risk of going without needed care. See, for example, Hudman and 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.

[13] Heberlein et al, *Financing New Medicaid Coverage under Health Reform: The Role of the Federal Government and States*, Kaiser Commission on Medicaid and the Uninsured, June 2010.

[14] See 42 CFR Part 440.330(d), which states that "the scope of a Secretary-approved health benefits package will be limited to benefits within the scope of the categories available under a benchmark coverage package or *the standard full Medicaid coverage package under section 1905(a) of the Act"* (emphasis added). In addition 42 CFR Part 440.360 clarifies that states can cover additional services for people enrolled in benchmark or benchmark equivalent plans if the services are within the scope of what is normally allowed under Medicaid. This option also appears to give states the choice to provide a traditional, full Medicaid benefit package.

This brief was prepared by Jocelyn Guyer of Georgetown University's Center for Children and Families and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The authors wish to thank Judith Solomon of the Center on Budget and Policy Priorities for her review.

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