

Financing State Coverage Expansions: Can New Medicaid Flexibility Help?

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As states like Massachusetts, Vermont, and Maine continue to implement their health reforms, other states are also considering ambitious coverage expansions. Financing is a key concern. In the past, states interested in drawing down federal Medicaid funds to expand coverage had two primary mechanisms available to them: filing a state plan amendment using available optional eligibility categories and income disregards, or applying for a Section 1115 waiver. Under the first approach, states are required to provide all the Medicaid mandatory benefits, and to cover all people who meet the eligibility standards, with full federal financial participation guaranteed. The waiver approach gives states flexibility in areas like benefit design and eligibility, but limits the amount of federal financial

participation because of budget neutrality requirements.

Under the Deficit Reduction Act of 2005 (DRA), a new approach is available that gives states some of the flexibility of the §1115 waiver, but without a cap on federal financial participation. Although at first glance the DRA did not appear to be a vehicle for expanding coverage, a closer read reveals that the DRA's language actually allows states to use their new flexibility with benefits design, coupled with income disregards in existing categories, to expand coverage.¹ This new flexibility, combined with long-standing Medicaid authority to expand eligibility by disregarding income, allows states to file state plan amendments in order to expand coverage to higher income populations in plans that look more like commercial insurance and charge limited premiums. Since the DRA became law, the Centers for Medicare and Medicaid Services (CMS) has urged states to make these types of changes through state plan amendments using new DRA authority rather than through §1115 waivers.

This *State Health Policy Briefing* provides a roadmap of options made possible with new authority in the DRA that may make it easier for states to finance coverage expansions with federal matching funds. It describes:

- the key language in the DRA,
- the long-standing authority to expand eligibility to certain Medicaid eligibility groups through income disregards,
- the new benefits and cost-sharing flexibility provided in the DRA, and
- how this authority might support state coverage expansions.

But first, a brief explanation of §1115 waivers and budget neutrality:

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TABLE 1. OPTIONS POSSIBLE UNDER DRA AUTHORITY

	Pre-DRA State Option	§1115 Waiver	Post-DRA State Option
Flexibility in Benefits Design	No	Yes	Yes
Flexibility in Cost Sharing	No	Yes	Yes
Continuous Federal Funding	Yes	No	Yes

Medicaid Section 1115 Waivers and Budget Neutrality

Medicaid is an entitlement program, which means that any individual who meets the eligibility requirements must be enrolled and that federal matching funding is available to help a state pay for the benefits and services provided. Under a state plan amendment, all eligible populations are entitled to Medicaid, and states are able to continue to draw-down federal funds to provide coverage. Under §1115 of the Social Security Act, the Secretary of Health and Human Services is authorized to waive many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to “promoting the objectives” of the federal Medicaid program while continuing to receive federal Medicaid matching funds. Under waiver authority, CMS has granted states permission to cover childless adults, who are otherwise ineligible for Medicaid under the federal statute.

However, with §1115 waivers, states must meet budget neutrality requirements, meaning that the waiver cannot result in a higher level of federal spending than would have been the case under the states’ Medicaid program. Budget neutrality requires states to compare, over a five-year proposed waiver period, the “with waiver” cost (what CMS would spend assuming approval of the waiver) against the “without waiver” costs (what CMS would spend assuming no waiver).² States must make a projection of expenditures with and without a waiver, and then defend the credibility of these assumptions, which are actively negotiated with CMS during the waiver negotiation process. Some states have met the budget neutrality requirements by using Medicaid Disproportionate Share funds to expand coverage. Other states have met this requirement by trimming benefits for existing beneficiaries to expand coverage to new populations.

Under some previous §1115 waivers, federal Medicaid funds have been capped.³ Some states, interested in covering as many eligible uninsured individuals as possible and continuing to draw down federal funds to support this goal, will prefer the entitlement structure. Other states may prefer more budget predictability and enrollment limits that a waiver offers.

What New Flexibility Is Available to States?

The DRA gives states new flexibility to enroll expansion populations in plans that are not traditional Medicaid, and to vary benefits packages and cost sharing for certain populations. A number of states have begun to use the benefits flexibility, in particular, to add benefits such as disease management and personal care services for certain groups.

STATES CAN ENROLL EXPANSION POPULATIONS IN PLANS THAT ARE NOT “TRADITIONAL MEDICAID”

Although at first the DRA’s statutory language seems to prevent states from using new benefits and cost-sharing flexibility to expand eligibility to higher income populations under long-standing Medicaid authority, a closer reading reveals that there is considerable room to do just this. The DRA specifies that a state can only provide alternative benefits plans via a state plan amendment for “an individual eligible under an eligibility category that had been established under the State plan on or before the date of enactment [February 8, 2006].”⁴ This statutory language actually leaves room for coverage expansions that would place new enrollees into alternative benefits plans, because many eligibility categories were established before February 8, 2006, and states can use long-standing income disregard authority to expand

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eligibility.

For example, assume that prior to February 8, 2006, a state had established the “eligibility category” of parents with income at or below earlier Aid to Families with Dependent Children (AFDC) income limits⁵ under the state plan. As part of a larger coverage expansion effort, the state could now decide it wants to expand coverage to parents up to 100 percent, but it wants to enroll these higher-income parents in an alternative benefits plan. The state could submit a state plan amendment that changed the methodology for counting income for parents by disregarding all income between 40 percent and 100 percent of the federal poverty level. This would effectively raise the income threshold for parents to the poverty line. The state could also specify in the state plan amendment that some or all of these parents would be enrolled in an alternative benefits plan.

There may be other ways a state can approach this. For example, a state could enroll all parents in the same “alternative benefits plan,” but provide those with lower incomes additional benefits. There are many other eligibility categories for which this might be an option, including young adults ages 19 and 20 in some states, non-mandatory pregnant women, and children (see more detailed analysis under “Expanding Coverage to Higher Income Populations” below).

STATES CAN VARY COVERAGE BY SUB-POPULATIONS

The DRA gives states the authority to provide benefit packages that are different for different groups of people in Medicaid.⁶ Before passage of the DRA, states needed to provide “comparability,” which meant that the benefits offered to one categorically eligible group must be comparable in amount, duration, and scope to those offered to another group. Additionally, states needed a waiver to vary benefits. Now, states can offer different benefit packages to parents than they do to young adults, or traditional Medicaid to lower income parents and an alternative benefits plan to higher income parents without a waiver. In this way, a state can choose to protect certain populations by preserving the full Medicaid benefits package for them.

This authority may give states freedom to tailor and target specific benefit packages for groups of people based on their different needs without meeting budget neutrality requirements. For example, a state could decide to expand coverage by keeping lower income Medicaid eligible parents in traditional Medicaid and higher income parents in an alternative benefits plan, and continue to draw down additional federal Medicaid dollars as it expands coverage.⁷

STATES HAVE FOUR ROUTES TO PROVIDING BENEFITS PACKAGES THAT ARE NOT “TRADITIONAL MEDICAID”

The DRA’s statutory language leaves room for coverage expansions that would place new enrollees into “alternative benefits plans” or plans with benefits packages that are different from traditional Medicaid. States can now enroll many populations into benchmark, benchmark-equivalent, secretary-approved coverage (similar to the State Children’s Health Insurance Program [SCHIP] that allows states to provide coverage that looks more like a commercial plan), and even employer-sponsored coverage by submitting a state plan amendment. So far, most states have gone the Secretary-approved route, likely because the benchmark and “alternative benchmark” options are more difficult standards to meet.⁸ States can use this benefits flexibility to finance coverage expansions that subsidize employer-sponsored coverage, “connector” arrangements, and other new types of state-organized coverage.

However, some Medicaid populations (See Table 2) may not be automatically enrolled in alternative benefits plans. If a state wants to enroll them in such a plan, they must instead inform each individual that enrollment in alternative benefits plans is voluntary and that an individual may opt out of the alternative benefits plan at any time and regain immediate eligibility for the regular Medicaid program under the state plan.

Route 1: Benchmark Coverage

The state can choose from three benchmark plans or the Secretary can use his/her discretion to allow other types of coverage.⁹ Similar to what is currently allowed in SCHIP, the three benchmark plans are:

- 1) the federal employee health benefit plan equivalent,
- 2) state employee coverage, and
- 3) the predominant HMO.

These three options are defined in a State Medicaid Director letter.¹⁰ The federal employee health benefit plan equivalent is defined as the standard Blue Cross/Blue Shield preferred provider option service benefit plan that is offered to federal employees. The state employee benefit plan is defined as a health benefits plan that is offered and generally available to state employees in the state considering an expansion. A predominant HMO is coverage offered by an HMO that has the largest insured commercial, non-Medicaid enrollment in the state.

Route 2: Benchmark-Equivalent Coverage

Benchmark-equivalent plans are supposed to be similar,

TABLE 2. POPULATIONS ENROLLED IN ALTERNATIVE BENEFITS PLANS

Can Be Automatically Enrolled in Alternative Benefits Plans	Cannot Be Automatically Enrolled in Alternative Benefits Plans
(" Non-Exempt Groups")	("Exempt Groups")
<ul style="list-style-type: none"> • Parents • Children (must receive EPSDT until they turn 19) • Young adults • Non-mandatory pregnant women 	<ul style="list-style-type: none"> • Blind or disabled • Dual eligibles • Terminally ill and receiving hospice care • Some people in institutions • People who are medically frail or have special medical needs • Beneficiaries applying for long-term care • Children in foster care or receiving foster care or adoption assistance • Women in breast or cervical cancer program • Medically needy or spend down populations • Mandatory pregnant women

but not identical to the benchmark plans listed above. The benchmark-equivalent plan does not have to include all the Medicaid mandatory services, but instead must include the following services:

- inpatient and outpatient hospital services,
- physicians’ surgical and medical services,
- laboratory and x-ray services,
- well-baby and child care, including appropriate immunizations, and
- other appropriate preventive services as designated by the Secretary (none have been designated at this time).

In order to meet the benchmark-equivalent standard, a state has to submit, with its state plan amendment, an actuarial report, that meets three conditions.¹¹ First, the benchmark-equivalent benefit package has to have an aggregate value that is at least equivalent to one of the benchmark packages. Second, if the benchmark used for comparison includes prescription drugs, mental health services, vision services, and hearing services, then the actuarial value of the coverage in the benchmark-equivalent coverage must be at least 75 percent of the actuarial value of the coverage for such categories of service in the benchmark plan used for comparison. Third, if the benchmark does not include prescription drugs, mental health, vision, or hearing services, then the benchmark-equivalent coverage is not required to include coverage for that type of service.

Route 3: Employer-Sponsored Health Insurance

States also have new flexibility to provide premium assis-

tance for employer-sponsored coverage. In a recent State Medicaid Director Letter, CMS writes “Use of a benchmark or benchmark-equivalent coverage is at the discretion of the State and may be used in conjunction with employer-sponsored health plans as a coverage option for individuals with access to private health insurance. For example, if an individual has access to employer-sponsored coverage and that coverage is determined by the State to be a benchmark-equivalent, a State may, at its options provide premium payments on behalf of the beneficiary to purchase employer coverage. The premium payments would be considered medical assistance and the state could require the beneficiary to enroll in the group plan.”¹²

This language suggests that if a state files a state plan amendment for a benchmark-equivalent plan, the state can make its own determination about whether employer-sponsored coverage is also a benchmark-equivalent plan (meeting the services and the actuarial standards outlined above). If the employer-sponsored health plan is determined to be a benchmark-equivalent plan, then Medicaid could subsidize the beneficiary’s premium.

This new alternative benefits plan authority in the DRA may make it simpler for states to implement premium assistance in Medicaid.¹³ Before passage of the DRA, there were two ways that states could implement premium assistance programs: submitting a state plan using §1906 authority, or under a §1115 waiver.¹⁴ Under §1906, states had to prove “cost-effectiveness,” meaning that enrolling individuals into premium assistance programs could not be more expensive than enrolling eligible individuals into public programs, and ensuring that enrollees retained the same coverage they would under traditional

TABLE 3. MANDATORY VS. OPTIONAL MEDICAID SERVICES BEFORE DRA

Mandatory Services	Optional Services
<ul style="list-style-type: none"> • 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 age 21 and over • Home health care services 	<ul style="list-style-type: none"> • 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 (ICFMR) • Institute for mental disease services for those age 65 and over • Inpatient psychiatric care for children under 21 • Home and community-based waiver services • Other home health care services • Targeted case management • Respiratory care services for ventilator-dependent individuals • Personal care services • Hospice care

Medicaid, often by “wrapping around” employer-sponsored coverage with Medicaid benefits. Under a §1115 waiver, states need to prove budget neutrality. Under the DRA, for some populations, states will no longer have to demonstrate cost effectiveness, budget neutrality, or provide wrap-around services in order to use Medicaid funds to provide premium assistance to individuals with employer-sponsored coverage.

Route 4: Secretary-Approved Coverage

Under the DRA, the Secretary of HHS is given great discretion to allow states to offer other types of plans. The state can propose any other health benefits coverage that the Secretary of HHS approves and determines is appropriate coverage for the proposed population. Under CMS guidance,¹⁵ a state would need to submit a full description of the proposed coverage and include a benefit-by-benefit comparison of the proposed plan to one or more of the three benchmark plans mentioned above, as well as a full description of the population that would receive the coverage. However, a state would not need to provide actuarial information. The first three state plan amendments approved under this new authority were “Secretary-approved coverage.”

ALTERNATIVE BENEFITS PLANS CAN BE VERY DIFFERENT FROM “TRADITIONAL MEDICAID”

Before the DRA, Medicaid law required that states provide certain services and allowed states to cover additional services and receive federal matching funds. Some services like prescription drugs were considered optional but all states have chosen to provide them. In addition, before DRA, if a state chose to provide a specific benefit, it had to be available to all categorical Medicaid beneficiaries if it was medically necessary. Under the DRA, states can now vary the benefits provided to different groups by submitting a state plan amendment. Table 3 lists pre-DRA mandatory vs. optional covered services.

States Must Continue to Provide EPSDT for Children

Regardless of the decision to use an alternative benefits plan, a state must provide early periodic screening, diagnosis and treatment (EPSDT) for children from birth until they turn 19. A state can choose to wrap any benefit around the alternative benefits plan. CMS guidance states, “in the case of coverage described [benchmark benefits] a State, at its option, may provide such wrap-around or additional benefits as the State may specify.”¹⁶ Some states may even consider

TABLE 4. FEDERAL MEDICAID COST-SHARING RULES¹⁶

State plan	Non-exempt individuals below 100 percent of the FPL	Non-exempt individuals 100 to 150 percent of the FPL	Non-exempt individuals above 150 percent FPL
Premiums	Not Allowed		Allowed (see aggregate cap)
Cost sharing	Nominal	Maximum of 10% the cost of the service	Maximum of 20% percent of the cost of the service
Cost sharing for prescription drugs	Nominal		Maximum of 20% of the cost of the drug for non-preferred drugs
Non-emergency use of ER	Nominal	Two times nominal	No limit
Enforceability of co-payments	Not Allowed	Allowed	
Aggregate cap on premiums and cost sharing ¹⁸	5% of family income		

wrapping additional benefits around employer coverage. States have substantial experience – both under Medicaid managed care contracts and in cost-avoidance for third party liability – providing benefit packages under which private insurers deliver the majority of benefits and the state provides additional wrap-around benefits to those in need of services. However, educating beneficiaries and providers about the existence of wrap-around benefits and how to access them can be difficult.

COST-SHARING FLEXIBILITY

The DRA, CMS guidance, and technical amendments to the DRA that followed have created a complex array of cost-sharing rules (see Table 4 below). States that want to expand coverage by submitting a state plan amendment cannot charge premiums for individuals with incomes below 150 percent of the federal poverty level. However, for certain beneficiaries above 150 percent of the federal poverty level, the DRA allows states to charge premiums up to the aggregate cap of five percent of family income. The DRA also allows a range from nominal co-payments for the lowest income beneficiaries to 20 percent of the cost of the service for higher income beneficiaries.

These differences in cost-sharing rules make it easier for states to partially subsidize coverage expansions in alternative benefits plans – that more closely resemble commercial products – for people with incomes above 150 percent

of poverty. For some populations enrolled in plans with no other cost sharing, states would be allowed to charge premiums up to five percent of family income.¹⁷ Because Medicaid is a program known for its limited administrative costs – in part due to the simplicity in cost sharing and choice of plans – states may want to try to keep cost sharing and benefit choices limited to prevent additional administrative costs.

Exempt Beneficiaries

Some beneficiaries are exempt from premiums and cost sharing altogether:

- Children that states must cover (children under age six in families with income below 133 percent of the federal poverty level, children age 6 to 18 in families with income below 100 percent of the federal poverty level). Note: in some states, infants must be covered up to 185 percent of the federal poverty level.
- Children in state foster care and adoption assistance programs, regardless of age.
- Children with disabilities who are eligible for Medicaid under the Family Opportunity Act.
- People in a hospital, nursing home, or other institution that requires them to contribute all but a nominal amount of their income, and terminally ill individuals receiving hospice care.
- Women receiving Medicaid under the Breast and

Cervical Cancer Screening and Treatment program.

- Pregnant women (effectively, see discussion in Expanding Coverage to Higher Income Populations).

Exempt Services

There are special cost-sharing limitations for some services:

- States cannot impose cost sharing on pregnant women for services relating to their pregnancy or any other medical condition which may complicate their pregnancy.
- States cannot impose cost sharing on emergency services or family planning services and supplies.
- States can impose nominal co-payments for non-preferred drugs and the use of emergency room for non-emergency services for populations that are otherwise exempt from cost sharing.²¹

Expanding Coverage to Higher Income Populations

The DRA's new alternative benefits and cost-sharing authority, combined with long-standing Medicaid authority, allows states to expand coverage to parents, higher income pregnant women, and children – and in some states to young adults as well – by enrolling them in plans that look more like private coverage.

Although other Medicaid populations (See Table 2) may not be automatically enrolled in alternative benefits plans, these new plans are an option for them as well. A state must inform each individual that enrollment in alternative benefits plans is voluntary and that the individual may opt out of the alternative benefits plan at any time and regain immediate eligibility for the regular Medicaid program under the state plan.

LONG-STANDING AUTHORITY TO EXPAND MEDICAID ELIGIBILITY BY DISREGARDING INCOME

Under long-standing Medicaid authority, states have the ability to expand Medicaid eligibility by changing the methodology for calculating the family income of certain categories of enrollees and wide latitude to disregard income from that calculation. Because of federal rules and individual state policies, no state determines family income by looking solely at the family's take-home pay. All states disregard certain types of income and most deduct certain expenses when determining eligibility. The specific amounts and types of disregards and deductions vary among states and between programs.

States may go beyond federal minimum eligibility requirements for certain groups by using a more liberal method to calculate family income. They can both increase the number and amount of disregards. For example, a state can waive all family income between 133 and 200 percent of the federal poverty level for children ages 1 to 6. In 2000, more than half of states used a more liberal method for calculating income than required under federal law.²²

STATES CAN USE THIS NEW DRA OPTION TO EXPAND ELIGIBILITY TO PARENTS, YOUNG ADULTS, PREGNANT WOMEN AND CHILDREN

Parents

States can now cover higher income parents by enrolling them in alternative benefits plans, and can charge modest premiums for higher income parents. Before passage of the DRA, states would have needed a waiver to enroll parents in coverage that was not traditional Medicaid or to vary types of coverage to parents by income level.

All states are required to cover parents with incomes below 1996 AFDC income thresholds in Medicaid, regardless of whether they receive cash assistance.²³ However (as explained earlier) states have great flexibility to serve additional low-income parents via income disregards, asset disregards, and increasing income and asset limits.²⁴ Many states have already taken advantage of this flexibility and expanded eligibility to parents.²⁵ As of 2006, 15 states covered parents with incomes at or above 100 percent of the federal poverty level and 9 states covered parents with incomes at or above 150 percent of the federal poverty level.²⁶

Under CMS's new interpretation of DRA authority, states can automatically enroll parents into alternative benefit plans.²⁷ Under the DRA, states are also allowed some flexibility in cost sharing for parents, unless they fall into otherwise exempt groups (such as if they are under 18 and below 100 percent of the federal poverty level). However, states can only charge premiums for parents above 150 percent of the federal poverty level.

Young Adults Ages 19 and 20

Fifteen states can choose to expand coverage to young adults by enrolling them in alternative benefits plans and can charge modest premiums through a state plan amendment. The advantage to a state plan amendment is that if a state is trying to finance a major coverage expansion, and wants to cover young adults in coverage that does not look quite like traditional Medicaid as part of the expansion, the state can continue to draw down federal Medicaid matching

TABLE 5. MAXIMUM MONTHLY PREMIUMS ALLOWABLE UNDER DRA

Percent FPL	Maximum monthly premiums allowable (5% income) by family size in 2007			
	1	2	3	4
150% FPL	\$63.81	\$85.08	\$107.31	\$129.06
200% FPL	\$85.56	\$114.08	\$143.08	\$172.08
250% FPL	\$106.35	\$142.90	\$178.85	\$215.10
300% FPL	\$127.62	\$170.16	\$214.62	\$258.12

(Note: This table assumes *no additional cost sharing* in terms of co-payments or deductibles because there is an aggregate cap on premiums and cost sharing at 5 percent of family income).

funds without meeting the budget neutrality requirements of a §1115 waiver.

Fifteen states – Alaska, California, Connecticut, Iowa, Maine, Maryland, Minnesota, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Tennessee, and Vermont – already provide Medicaid coverage for young adults age 19 and 20 in a Ribicoff youth program.²⁸ Under the DRA, if one of these states was interested in providing an alternative benefits plan to this group, it would have to determine that this eligibility category had been established in the state plan by February 8, 2006. These states could cover additional young adults ages 19 and 20 by using long-standing authority to disregard income and asset limits above the original AFDC levels.²⁹ As of 2006, 12 of these 15 states covered 19 and 20 year olds at or above 50 percent of the federal poverty level and 3 of these states covered these young adults at or above 100 percent of the federal poverty level.³⁰ If any of these fifteen states wanted to continue to expand coverage to young adults by using income disregards and enroll them into an alternative benefits plan, it would be possible. Note: States that did not cover 19 and 20 year olds pre-DRA (other than those who happened to fall into another eligibility group, e.g., for SSI recipients or pregnant women) can still opt to cover this age group but cannot automatically enroll them in alternative benefits plans.

Also, there are no special prohibitions on enrolling this population in benchmark benefits or special exceptions to cost-sharing requirements, unless these young adults are in foster care, receive state foster care or adoption assistance, or fall under another exempt group. However, states can only charge premiums to youth above 150 percent of the federal poverty level.

Pregnant Women

States can now expand coverage to higher income pregnant

women by enrolling them in alternative benefits plans that have modest premiums. However, states must carefully design benefits to guard against plans that impose cost sharing for services relating to pregnancy or other conditions that may complicate their pregnancy.

All states currently must cover pregnant women up to 133 percent of the federal poverty level and higher if the state had a higher income level in effect on December 19, 1989. States can use income disregards under §1902(r)(2) of the Social Security Act to expand coverage to additional pregnant women. Currently, 43 states cover women at income above 133 percent of the federal poverty level and 17 states cover pregnant women at 200 percent of the federal poverty level or higher.³¹ Under the DRA, states can require women above 133 percent of the federal poverty level to participate in a alternative benefits plan.³² States can charge limited premiums for pregnant women above 150 percent of the federal poverty level. However, states cannot charge premiums for pregnant women, and even under an alternative benefits plan, states cannot impose cost sharing on pregnant women for services relating to their pregnancy or any other medical condition which may complicate their pregnancy. And, because coverage for pregnant women qualifying through the mandatory or optional pathway for low-income pregnant women is limited to services related to the pregnancy or complications of the pregnancy, the result is that pregnant women are effectively exempt from cost sharing.

Children Under Age 19

States can also continue to expand coverage to higher income children and enroll them (possibly, along with their parents) in alternative benefits plans. However, the state must ensure that children under age 19 continue to receive EPSDT services.

Many states cover children above federal minimum

requirements. States have great flexibility to use income disregards to expand coverage to children under §1902(r) (2) of the Social Security Act.³³ As of 2006, 36 states cover at least some categories of children at or above 150 percent of the federal poverty level; 24 states cover at least some categories of children at or above 150 percent of the federal poverty level.

Children can be required to be enrolled in benchmark coverage, but additional wrap-around benefits must be sufficient so that, in combination with benchmark or benchmark-equivalent benefits package, they receive full EPSDT services. States submitting an SPA must describe how the wrap-around benefits or additional services will be provided to ensure that these beneficiaries receive full EPSDT.³⁴ States cannot charge premiums or co-pays to children in “mandatory” groups (children under age six in families with income below 133 percent of the federal poverty level, children age 6 to 18 in families with income below 100 percent of the federal poverty level). However, states can charge limited premiums to children in families with income above 150 percent of the federal poverty level.

Using DRA Authority As Part of Broader State Health Reform Initiatives

Many states are in the process of developing ambitious universal coverage plans. As part of a broader health reform effort, a state can identify those people who might become Medicaid eligible and those plans that might be considered alternative benefits plans. The state could then file a state plan amendment and have federal Medicaid funds available to help finance its coverage expansion and make coverage dramatically more affordable for the state and for individuals.

THE “CONNECTOR” OR OTHER “STATE ORGANIZED COVERAGE” MODEL

A handful of states are considering creating a type of “Connector” or central locus for accessing private health insurance as a way to provide affordable health insurance options for their residents. The only “Connector” to date is an independent public authority in Massachusetts which administers two programs: Commonwealth Care³⁵ and Commonwealth Choice. Commonwealth Choice offers three general categories of coverage: bronze, silver, and gold. They all include the same benefits packages but have differing actuarial values because of differing co-pays and deductibles.³⁶

Massachusetts does not subsidize coverage offered through Commonwealth Choice, because it is intended for people with incomes above 300 percent FPL.³⁷ However, other states are also interested in setting up programs similar to Commonwealth Choice that subsidize the cost for lower income individuals and families. For example, California’s legislature has compromised on a plan to create a purchasing pool similar to Commonwealth Choice, with premiums not to exceed 5 percent of family income.³⁸ And, Washington State recently passed legislation that would create a pilot program to modify the current small business insurance pool and rename it the “Health Insurance Partnership,” and which is modeled on the Connector in Massachusetts.³⁹

A state may instead want to contract with one or more insurers to provide coverage with a certain set of benefits. One example of state-organized private insurance coverage is Catamount Health in Vermont, which will contract with private insurers to offer low-cost, reasonably comprehensive policies to the uninsured.⁴⁰ Individuals with income up to 300 percent of the federal poverty level will receive a subsidy that will help them purchase private insurance. Another example of state-organized private coverage is Dirigo Choice in Maine. The state contracts with Anthem BC/BS to provide benefits in the Dirigo Choice program, and some Medicaid beneficiaries who work for small employers and meet the income requirements are enrolled in this coverage.⁴¹

WOULD A CONNECTOR OR STATE-ORGANIZED PRIVATE COVERAGE MEET THE ALTERNATIVE BENEFITS PLAN REQUIREMENTS AND COST-SHARING LIMITS?

Under new DRA authority, a Connector-like program could be designed with a variety of plans meeting the benchmark plan package standards or the alternative benchmark actuarial values. However, some states may find these benefit package standards too robust for certain populations at certain income levels or too limiting when wanting to devise different benefits choices and could seek approval from the Secretary of HHS to approve additional benefits packages. Also, in order to draw down federal Medicaid funds under a state plan amendment, cost sharing in the plans provided through the Connector would need to be kept to a minimum to meet the DRA cost-sharing rules, and premiums could not be more than five percent of family income. An additional challenge for states will be covering childless adults, whose coverage Medicaid cannot finance without a waiver.

It may be easier for states to meet the new DRA alternative benefits plan requirements in state-organized coverage with one or more private insurers offering plans with the same benefits. If the state contract required plans to meet

TABLE 6. MOCK STATE EXPANSION

Group	Current Medicaid Eligibility by FPL	Expansion with Traditional Medicaid Benefits by FPL	Expansion with NewCare Alternative Benefits by FPL
Parents	Working 36% FPL Non-working 29% FPL	29/36%-150%	150-300% modest premium and cost sharing*
Pregnant women	150% FPL	0-150%	150-300% no premiums or cost sharing
Young adults 19-20	50% FPL	0-150%	150-300% modest premium and cost sharing*
Children 0-1	150% FPL (Up to 200% FPL with SCHIP)	150/133/100-150%	150-300% modest premium and cost sharing with EPSDT wrap ⁴²
Children 1-5	133% FPL (Up to 200% FPL with SCHIP)		
Children 6-19	100% FPL (Up to 200% FPL with SCHIP)		
Resulting income-based eligibility for parents, pregnant women, young adults and children		0-150%	150-300% modest premium and cost sharing (EPSDT wrap for children under 19)*
*NewCare would have no cost sharing for pregnancy-related services, emergency services, or family planning services and supplies, to meet the DRA requirements.			

the benchmark or alternative benchmark authority, then the state could file a state plan amendment and draw down federal Medicaid funds to subsidize the cost of premiums for enrollees. Or the state could receive approval from the Secretary of HHS for each plan offered. As with Connectors, states would have to make sure that plans met the cost-sharing limits in the DRA.

CAN THE NEW FLEXIBILITY BE USED IN A WAY THAT SIMPLIFIES STATE MEDICAID RULES?

States may be concerned that the flexibility under the Deficit Reduction Act may make the Medicaid program more complicated and as a result increase administrative costs. However, there may be ways to simplify eligibility categories and the type of coverage in which people enroll while expanding coverage.

For example, imagine that a state wanted to expand coverage to all residents – regardless of eligibility category – up to 300 percent of poverty and wanted to draw down federal Medicaid funds to help subsidize a new program, “NewCare,” that would cover additional populations. The

state could use the new DRA alternative benefits and cost-sharing authority, in combination with long-standing income disregard rules, to help finance the expansion for parents, pregnant women, and children.

The state would have many options in terms of the “NewCare” Benefit Package under DRA Authority. A state might choose to contract with a health plan or a few plans like some states – like Vermont’s Catamount Care⁴² – and use Medicaid to help subsidize coverage up to 300 percent of the federal poverty level and open that same type of coverage up to higher income individuals, families, and even employers at full cost. Or, a state might choose to create a “Connector” type-authority as in Massachusetts, and draw down federal Medicaid matching funds to help subsidize the coverage to people with income up to 300 percent of the federal poverty level and who purchase coverage, and then allow higher income individuals to buy coverage on their own.

The state could also require individuals with income above 150 percent FPL – except pregnant women – to pay a modest premium (up to 5 percent of income if there were no

other cost sharing) for the coverage. However, in order to use a Medicaid state plan amendment to finance the expansion, a state cannot impose cost sharing for services relating to pregnancy or other conditions that may complicate a woman's pregnancy; and for children, EPSDT must wrap around any alternative benefits package. However, the state would not be able to draw down Medicaid funds to help finance a coverage expansion for childless adults without a waiver. In addition, certain Medicaid populations would have to remain in the traditional Medicaid program along with the lower-income populations shown in Table 6.

ADDITIONAL DESIGN QUESTIONS

Retroactivity

Federal Medicaid law provides that Medicaid coverage is retroactive to any or all of the three months prior to application, if the individual would have been eligible during the retroactive period. However, private health insurance plans do not generally provide retroactive coverage. Under a state plan amendment, this requirement would continue to apply and Medicaid expansion populations enrolled in alternative benefits plans would be eligible for retroactive Medicaid coverage. Under a §1115 waiver, CMS may give a state permission not to provide retroactive coverage. Some states may prefer to receive a waiver rather than find a way to continue to provide retroactive coverage. States required to provide retroactive coverage under a state plan amendment could pay for it outside of the capitated rate, like they often do in Medicaid managed care.

Enrollee Rights

Under federal law, Medicaid beneficiaries have specific rights and protections, including the right to apply for Medicaid, the right to request a fair hearing if the state's Medicaid agency makes an adverse determination (denies a request for assistance terminates, suspends or reduces a beneficiary's Medicaid services), and notice of adverse action. Under some proposed §1115 waivers, notice and grievance and appeal rights would have been curtailed.⁴⁴

Conclusion

Although at first the Deficit Reduction Act of 2005 may not appear to be a likely vehicle for expanding coverage, it actually provides a new approach for financing coverage expansions that offers states both flexibility in benefits design and access to full federal participation. Medicaid §1115 waivers

continue to provide an avenue for using federal funds to cover childless adults, but they limit the amount of federal funds ultimately available for coverage expansions. In addition, the Centers for Medicare and Medicaid Services (CMS) is urging states to make changes to the Medicaid program through state plan amendments using new DRA authority rather than through §1115 waivers. This new authority under the DRA – coupled with traditional Medicaid law – is an important new tool for states to use as they move to expand coverage and implement broad health care reforms.

Notes

- 1 However, it is important to note that the DRA still did not provide states with the ability to cover childless adults who are not elderly or disabled without a waiver. In fact, the DRA makes it clear that states can no longer cover childless adults with SCHIP funds.
- 2 See Charles Milligan, *Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage*. (Washington, DC: State Coverage Initiatives, May 2001). Retrieved August 27, 2007. <http://www.statecoverage.net/pdf/issuebriefs01.pdf>.
- 3 For example, see Vermont's Global Commitment Waiver. Jocelyn Guyer, *Vermont's Global Commitment Waiver: Implications for the Medicaid Program*. (Menlo Park, CA: Kaiser Family Foundation, April 2006). Retrieved August 27, 2007. <http://www.kff.org/medicaid/7493.cfm>.
- 4 The Deficit Reduction Act, P.L. 109-171, §6044(a)(1)(B). The CMS guidance on benchmark plans echoes the statutory language, "A state may only require that individuals obtain benefits by enrolling such coverage if they are a "full benefit eligible" in an eligibility category established under the State plan on or before February 8, 2006, and are not within exempted categories under the statute. Full benefit eligible individuals are individuals who would otherwise be eligible to receive the standard full Medicaid benefit package under the approved Medicaid State plan, but do not include individuals determined eligible by the State for medical assistance under section 1902(a)(10)(C) of the Act, or by reason of section 1902(f), or otherwise eligible based on a reduction of income based on costs incurred for medical care or other remedial care (medically needy and spend-down populations). Generally, these individuals are healthy adults and healthy children in Medicaid." SMDL #06-008. March 31, 2006. See also, President signs §1932, Deficit Reduction Act of 2005, (Washington, DC: The White House, February 8, 2006). Retrieved August 27, 2007. <http://www.whitehouse.gov/news/releases/2006/02/20060208-8.html>.
- 5 AFDC income limits ranged from 22 to 142 percent of federal poverty level (FPL) in 1997. National Academy for State Health Policy calculations based on HHS, *Aid to Families with Dependent Children: The Baseline*, Table 5.1, June 1998 and HHS 2007 Federal Poverty Guidelines.
- 6 The DRA says "A state at its option as a State Plan Amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through enrollment in [benchmark coverage]."
- 7 Some states may choose not to tailor the benefits package. Medicaid only pays for medically necessary services, so even if a given service is covered, it does not mean that a beneficiary is automatically entitled to have Medicaid pay for it. States can also use utilization review and prior authorizations in order to manage the services received.
- 8 The Deficit Reduction Act, P.L. 109-171, §6044. See also, SMDL #06-008, March 31, 2006.
- 9 SMDL#06-008, March 31, 2006.
- 10 SMDL #06-008, March 31, 2006.
- 11 See SMDL #06-008, March 31, 2006, page 5 for more details.
- 12 SMDL #06-008, March 31, 2006.
- 13 While states have had a similar option in SCHIP, it has been particularly difficult for states to meet the cost-effectiveness test in SCHIP, because a state often must show that it is cost-effective to cover both an eligible child and a non-eligible parent or other family member in employer sponsored coverage. See Cynthia Shirk, et al., *Premium Assistance in Medicaid and SCHIP, Ace in the Hole or House of Cards?* (Washington, DC: National Health Policy Forum, July 17, 2006) page 8. Retrieved August 27, 2007. http://www.nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf.
- 14 Currently, 21 states have premium assistance programs, including eight operating programs under an §1115 waiver and eight operating under §1906 authority. Five states operate their programs under both §1115 and §1906 authority.
- 15 SMDL #06-008, March 31, 2006. This is not expressly mentioned in the statute.
- 16 SMDL #06-008, March 31, 2006.
- 17 A recent literature review suggests that a sliding scale of affordability works better and that no premiums should be charged below 300% FPL, and that for people between 300% FPL and 600% FPL a progressive sliding scale from 4% to 8.5% of income makes sense. Christine Barber and Michael Miller, *Affordable Health Care for All: What Does Affordable Really Mean?* (Boston, MA: Community Catalyst, April 2007). Retrieved August 27, 2007. http://www.communitycatalyst.org/doc_store/publications/affordable_health_care_for_all_apr07.pdf.
- 18 Cost-sharing information comes from SMDL #006-015 (June 16, 2006) and the Tax Relief Health Care Act of 2006, which became law after the SMDL was issued. For a synthesis of the cost-sharing rules, see Judith Solomon, *Cost-Sharing and Premiums in Medicaid, What Rules Apply?* (Washington, DC: Center on Budget and Policy Priorities, February 28, 2007). Retrieved August 27, 2007. <http://www.cbpp.org/2-28-07health.htm>.
- 19 The Secretary of Health and Human Services has discretion to define nominal co-payments. Current regulations define a range of nominal co-payments from \$.50 to \$3 depending on the Medicaid payment for the service.
- 20 This can be applied on a monthly or quarterly basis, as determined by the state.
- 21 Children can only be charged a co-pay for non-emergency services in an emergency room if the child has access to an alternative provider such as a doctor's office or community health center. The hospital must provide the beneficiary with the name of the alternative provider along with a referral to coordinate scheduling an appointment. And, this new rule does not modify a hospital's obligation to provide services under the Emergency Medical Treatment and Labor Act (EMTALA).
- 22 See, Neva Kaye and Lynda Flowers, *How States Have Expanded Medicaid and SCHIP Eligibility*, (Portland, ME: National Academy for State Health Policy, January 2002). See also, Leighton Ku, et al., *What Counts? Determining Medicaid and CHIP eligibility for Children*. (Washington, DC: Urban Institute, 1999). Retrieved August 27, 2007. <http://www.urban.org/publications/409076.html>.
- 23 §1931.
- 24 §1931(b)(2)(c) provides authority for income disregards. For more information about income and asset disregards, see Neva Kaye and Lynda Flowers, *How States Have Expanded Medicaid and SCHIP Eligibility*, (Portland, ME: National Academy for State Health Policy, January 2002), Jocelyn Guyer and Cindy Mann. *Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid*. (Washington, DC: Center on Budget and Policy Priorities, Revised August 19, 1998). Retrieved August 27, 2007. <http://www.cbpp.org/702mcaid.htm>. See also, Matthew Broaddus, Shannon Blaney, Annie Dude, et al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families*. (Washington, DC: Center on Budget and Policy Priorities, Revised February 13, 2002). Retrieved August 27, 2007. <http://www.cbpp.org/1-2-02health.htm>.
- 25 Note, some of these states have expanded eligibility to parents through §1115 waivers in addition to or instead of through state plan amendments.

- 26 Data in Table 3 are based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2007. Donna Cohen Ross and Laura Cox. *Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*. (Washington, DC: Center on Budget and Policy Priorities, January 2007). Retrieved August 27, 2007. <http://www.kff.org/medicaid/upload/7608.pdf>.
- 27 The statute itself is unclear. The DRA heading reads “TANF and Section 1931 parents,” but 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 indicate that only those who qualify for Medicaid on the basis of receiving cash assistance are exempt. CMS guidance states that parents who qualify for Medicaid solely on the basis of qualification under the states’ TANF rules cannot be enrolled in alternative benefit plans. However, because states’ TANF and Medicaid eligibility were never linked, this exception is effectively meaningless. In other words, CMS’s interpretation of the statute does not prevent states from enrolling parents at any income level (both above and below the former AFDC-income eligibility level) into an alternative benefit plan. See SMDL #06-008, March 31, 2006; Letter to Medicaid and TANF Directors from HHS, June 5, 1998. Retrieved August 27, 2007. <http://www.acf.hhs.gov/programs/ofa/medicaid.htm>. *Medicaid Benefit Package Changes: Coming to a State Near You?* (Washington, DC: Families USA, March 2006). Retrieved August 27, 2007. <http://www.familiesusa.org/assets/pdfs/DRA-Benefit-Package.pdf>.
- 28 Social Security Act §1902(a)(10)(A)(ii)(I). Table 1 in Harriette B. Fox et al., *The Public Health Insurance Cliff for Older Adolescents*, (Washington, DC: Incenter Strategies, April 2007). Retrieved August 27, 2007. <http://www.incenterstrategies.org/jano7/factsheet4.pdf>. States have had the option to cover Ribicoff Children through age 18, 19, or 20 for more than two decades. Note: Although states can also expand coverage to young adults through medically needy programs, medically needy eligibles are not allowed to be automatically enrolled in benchmark plans.
- 29 1902(r)(2).
- 30 See Fox op cit.
- 31 Kaiser State Health Facts, *Income Eligibility Levels for Pregnant Women Applying for Medicaid by Annual Income and as a Percent of Federal Poverty Level (FPL)*, 2006. Washington, DC: Kaiser State Health Facts.org. Retrieved August 27, 2007. <http://www.statehealthfacts.org/comparatable.jsp?cat=4&ind=206>.
- 32 Mandatory pregnant women (income at or below 133% FPL) cannot be required to enroll in benchmark, but can be enrolled and given opt out. See The Deficit Reduction Act, P.L.109-171, §6044(a)(2)(B)(i).
- 33 See, Neva Kaye and Lynda Flowers, *How States Have Expanded Medicaid and SCHIP Eligibility*, (Portland, ME: National Academy for State Health Policy, January 2002).
- 34 SMDL #06-008, March 31, 2006. Some states have already done this for years in their HMO programs.
- 35 Commonwealth Care provides subsidized insurance to people whose annual income is up to 300 percent of the Federal Poverty Level. Commonwealth Care is essentially the model discussed below (a state contract with multiple vendors). In Commonwealth Care, every health plan has the same medical services, but each one has different extra services, such as programs for weight loss or diabetes management. Some offer telephone help lines or discounts at fitness centers. Massachusetts helped finance its coverage expansion through a §1115 waiver. It is simply used as an example here).
- 36 Commonwealth Connector website. (Boston MA: Commonwealth of Massachusetts 2007) Retrieved August 27, 2007. <http://www.mahealthconnector.org/portal/site/connector/>.
- 37 Also, in some cases, employers are paying for a portion of the cost along with the individual.
- 38 See *Perata and NuNez Merge Health Care Reform Bills* (Sacramento, CA: Website of Senator Don Perata, June 21, 2007). Retrieved August 27, 2007. http://disto9.casen.govoffice.com/index.asp?Type=B_PR&SEC={D27AA7A3-C83D-49B9-969F-81F2B831EE24}&DE={A7207C30-B7D3-4C5D-A3AC-84904E7C77AD}.
- 39 For more information, see Washington House Bill 1569.
- 40 Vermont’s reforms were also financed in part by a §1115 waiver.
- 41 Note, Maine developed Dirigo Choice before passage of the DRA, so this was not an option at the time.
- 42 For more information see Neva Kaye, *Health Reform in Maine, Massachusetts, and Vermont: An Examination of State Strategies to Improve Access to Affordable, Quality Care* (Portland, ME: National Academy for State Health Policy, 2007).
- 43 Note, SCHIP could also provide enhanced federal funding for children in the alternative benefits plan if the benefit package was also allowable under SCHIP rules and the state uses income disregards. Under current SCHIP rules, states have flexibility to cover children with SCHIP funding more than 50 percentage points above Medicaid levels. See, Cindy Mann and Michael Odeh, *SCHIP Reauthorization: Can the Nation Move Forward without Going Backward?* (Washington, DC: Center for Children and Families, June 2007). Retrieved August 27, 2007. <http://ccf.georgetown.edu/pdfs/ccfForwardWObkward.pdf>.
- 44 Samantha Artiga and Cindy Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2005). Retrieved August 27, 2007. <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=52128>.

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