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Medicaid as a Health Insurer: Current Benefits and Flexibility

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The design of Medicaid's benefits package reflects the health and long-term care needs of the 50 million low-income individuals it covers. The populations served by Medicaid not only have a broad range of health care needs; they also have more significant health problems and face higher financial barriers to care than other Americans. Over a third of Medicaid beneficiaries (36%) report that their health status is fair or poor, compared to just 12% of people enrolled in private insurance plans, and over a quarter had a serious illness or health problem in the past year.[1] Low-income individuals typically subsist on tight family budgets, often just meeting their basic needs such as housing, food, and transportation.[2] Individuals with disabilities and the elderly often live with multiple chronic conditions that require ongoing access to a range of health services that are not widely available, such as costly prescription medications, special equipment, and supportive services.

Under current Medicaid law, states have broad discretion in designing their Medicaid programs to serve these populations:

- States have the discretion not to participate in the program at all. Federal Medicaid rules apply only to states that elect to receive guaranteed federal matching payments for the cost of health and long-term care services furnished to their low-income populations.
- States have the discretion to cover – or not to cover – "optional" population groups and "optional" services. If they choose to cover these groups and services, they receive federal matching funds for the resulting costs. Approximately 65 percent of all Medicaid spending is on such populations and benefits.[3]
- States have the discretion to limit the scope of the benefits that they do cover, whether those benefits are "mandatory," like inpatient hospital care, or "optional," like prescription drugs.
- States have the discretion to impose "nominal" cost-sharing requirements on some populations with respect to some benefits (e.g., low-income elderly beneficiaries for outpatient prescription drugs).
- States have the discretion to impose prior authorization and other utilization control requirements with respect to the services that they cover. With the exception of services to children, states have the discretion to adopt restrictive definitions of "medical necessity" for the purposes of determining that a payment will be made for a covered service.

- States have the discretion to purchase the benefits they cover from providers on a fee-for-service basis, from managed care plans on a capitation basis, or through a combination of payment structures. Nationally, the majority of Medicaid beneficiaries is enrolled in managed care.
- States have the discretion to set payment rates for almost all of the benefits they purchase on a fee-for-service basis at a level lower than the cost incurred by the provider in furnishing the service to a Medicaid patient.
- States have the discretion to request from the Secretary of Health and Human Services (HHS) waivers of most federal Medicaid rules for purposes of demonstrating innovations in benefits design. A number of states have received statewide demonstration waivers affecting benefits and cost-sharing, and the Administration has signaled its willingness to entertain requests from other states.

Faced with sharp declines in revenues, state policymakers are expressing a strong interest in even greater "flexibility," particularly with respect to benefits and cost-sharing.[4] This has triggered a debate over the extent to which the current minimum federal Medicaid requirements should be further relaxed and what the implications of such changes would be for the health status of the low-income populations that Medicaid serves. The fiscal context for minimum federal requirements is that, nationally, the federal government pays more than half of the costs of Medicaid services; in FY 2003, it will spend an estimated $84.5 billion on Medicaid acute care services alone.[5]

The purpose of this issue brief is to inform this debate by identifying those areas in which current federal Medicaid law does not extend unlimited discretion to states. Though the "flexibility" debate spans the breadth of the program, from eligibility to benefits and cost-sharing to administration,[6] this brief focuses on just one subset of "flexibility" issues: the current federal benefits and cost-sharing rules that apply with respect to acute care. Specifically, it discusses the minimum requirements that states must meet in order to receive federal Medicaid matching funds for the costs of the acute care benefits they purchase. (A companion issue brief examines state "flexibility" in the context of Medicaid's long-term care benefits).[7] This brief also examines two instances in which the minimum federal requirements have been waived for states to enable them to redesign their benefits packages for children and for adults. Although the brief describes the federal rules within which states establish their benefits packages, it does not provide a state-by-state listing of services covered or cost-sharing imposed.[8]

Minimum Federal Benefits Requirements

There are six basic rules in federal Medicaid law that govern the design of a state's Medicaid benefits package. These rules are intended to ensure that, in all states, low-income Americans eligible for Medicaid receive coverage for a

benefits package of a minimum scope, and that the scope of benefits offered by any particular state does not vary depending on an individual's medical condition or place of residence. These rules are aimed at making coverage affordable for the low-income population served, ensuring that services are adequate, and promoting fairness in the distribution of benefits financed with federal funds. The rules are also intended to ensure that most low-income children eligible for Medicaid receive services determined to be medically necessary even if the state Medicaid program does not offer the service to adult beneficiaries (so long as the federal government will match the cost of the service). These rules are supplemented by general prohibitions (not discussed in this issue brief) against discrimination on the basis of race or ethnicity, disability, or gender in programs of federal financial assistance.[9]

Mandatory Benefits. Medicaid is an individual entitlement program.[10] That is, low-income Americans who qualify are entitled to have payment made on their behalf, when medically necessary, for a defined set of benefits.[11] This defined set of benefits includes, at a minimum, so-called "mandatory" benefits that all states electing to participate in Medicaid must offer to most groups of beneficiaries. States may elect to expand this minimum benefits package with one or more "optional" benefits, and all states have chosen to do so. As a result, Medicaid benefits packages vary substantially from state to state. Figure 1 shows the statutory "mandatory" and "optional" benefits categories related to acute care services under current federal law.[12]

Figure 1: Medicaid Acute Care Statutory Benefits Categories [13]

"Mandatory" Items and Services	"Optional" Items and Services
Physicians' services	Medical care or remedial care furnished by licensed practitioners under state law
Laboratory and x-ray services	Prescribed drugs
Inpatient hospital services	
Outpatient hospital services	
Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	Diagnostic, screening, preventive, and rehabilitative services
Family planning services and supplies	
Federally-qualified health center (FQHC) services	Clinic services
Rural health clinic (RHC) services	
Nurse midwife services	
Certified nurse practitioner services	
	Primary care case management services
	Dental services, Dentures
	Physical therapy and related services
	Prosthetic devices, Eyeglasses
	TB-related services
	Other specified medical and remedial care

Amount, Duration, and Scope. While all participating states must cover all mandatory benefits, a mandatory benefit in one state need not be identical to a mandatory benefit in another. For example, one state might cover an unlimited number of medically necessary inpatient days in a hospital, while another might impose a limit on the number of days, as in Florida and Oklahoma (45 and 15 days per year, respectively).[14] In all states, however, each "mandatory" benefit must be more than a benefit in name only. In technical terms, it must be "sufficient" in "amount, duration, and scope" to reasonably achieve its purpose.[15] This same requirement applies to any "optional" services, like prescription drugs, that a state chooses to cover. The Centers for Medicare & Medicaid Services (CMS) has never defined with precision what amount, duration and scope is minimally "sufficient" for each mandatory benefit. Instead, CMS has left this issue to state discretion, ultimately to be resolved by the federal courts.[16]

Comparability. Whatever amount, duration, and scope limits, if any, a state imposes on a particular mandatory or optional service, the service as so limited may not vary among individual beneficiaries, whether those beneficiaries are in mandatory or optional eligibility groups. Technically, this is referred to as the "comparability" requirement.[17] For example, a state may not limit eligible parents to 21 days of inpatient hospital services per year while offering unlimited inpatient hospital coverage to elderly or disabled individuals receiving Supplemental Security Income (SSI) benefits. Similarly, a state may not offer unlimited prescription drug coverage to elderly individuals receiving SSI while imposing a 5-prescription per month limit on disabled individuals receiving SSI.

Non-Discrimination. Federal Medicaid law also precludes states from limiting coverage for any particular mandatory service solely on the basis of diagnosis, type of illness, or condition.[18] Again, CMS has not defined this requirement with any specificity, but federal courts have on occasion ruled on the issue.[19] On its face, the rule precludes states from implementing benefits design policies that would, for example, specifically exclude eligible individuals with Alzheimer's from coverage for nursing facility services, exclude eligible women with breast cancer from coverage for non-experimental bone marrow transplants, or exclude eligible individuals with HIV/AIDS from coverage for inpatient hospital or physician services, while providing these same benefits to other groups.

Statewideness. State Medicaid programs may not vary the mandatory or optional benefits they offer by place of residence.[20] The purpose of this "statewideness" requirement is to ensure that benefits, whether mandatory or optional, do not vary from locality to locality, depending on, for example, the amount a locality is able or willing to contribute toward the state's share of program costs or on the partisan political orientation of the locality or its elected officials.[21] The "statewideness" requirement does not guarantee that an individual beneficiary will actually receive covered services in the community in which he or she resides; that is determined by the availability and accessibility of

providers. "Statewideness" does, however, mean that a state Medicaid program cannot offer unlimited coverage for hospital services in urban counties that contribute toward the costs of the program while limiting coverage to 21 days per year in rural counties that are unwilling or unable to make a contribution.

EPSDT Benefit for Children. As noted in Figure 1, states are required to furnish Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible children under age 21. While this benefit is subject to many of the same rules as other mandatory Medicaid benefits – e.g., no limitation based on diagnosis, type of illness, or condition; statewideness; comparability – it also has some unique features. As its name suggests, this mandatory service is a comprehensive benefit designed to address the wide range of medical, developmental, and behavioral problems affecting low-income children eligible for Medicaid.[22] The benefit includes:

(1) screening services at periodic intervals (including a comprehensive health and development history, physical exam, appropriate immunizations, laboratory tests including lead blood level assessments, and health education);
(2) vision services, including eyeglasses;
(3) dental services;
(4) hearing services, including hearing aids; and
(5) other diagnostic and treatment services necessary to address conditions discovered by the screening services.[23]

From the standpoint of flexibility, the most important feature of the EPSDT benefit is that the diagnostic and treatment services indicated as necessary for a child as the result of an EPSDT screen must be provided *whether or not the service is otherwise covered under the state's Medicaid program for any other group of beneficiaries* (so long as the service is among those for which federal matching payments are available). For example, if a child is determined to need speech therapy on a weekly basis but the state Medicaid program limits this service for adults to one session per month, the child is nonetheless entitled to have payment made for the weekly session.

The EPSDT benefit covers a very broad array of services for over 25 million low-income children, ranging from those in excellent health to those with special health care needs. EPSDT has a number of distinctive features designed to ensure that eligible children actually receive the services they need. It includes a requirement that states notify eligible children and their parents of the availability of screening services and appropriate immunizations and that they make arrangements for productive treatment when needed.[24] Similarly, the EPSDT benefit has its own definition of "medically necessary" services that is far less limiting than that which commonly applies to other Medicaid services (or in the commercial marketplace).[25] In contrast to most other Medicaid benefits categories, EPSDT is one area in which CMS has issued administrative guidance

to states (e.g., establishing a protocol for blood lead level assessments).[26] Finally, Congress has required the Secretary of HHS to establish annual goals for states with respect to participation by eligible children in EPSDT and has required states to report annually on their progress in attaining these goals.[27] Perhaps not surprisingly, EPSDT is perhaps the most frequently litigated Medicaid benefit.[28]

Minimum Federal Cost-Sharing Requirements

Cost-sharing refers to out-of-pocket payments that individuals enrolled in Medicaid are required to make in connection with the furnishing of a covered service. Cost-sharing may include deductibles, copayments, or coinsurance requirements. (Cost-sharing does not include premiums, the payment of which enables an individual to qualify for coverage; cost-sharing applies only when an individual has already established eligibility for coverage). The purpose of cost-sharing requirements is to deter unnecessary utilization of covered services, thereby reducing the costs of coverage for the Medicaid program. The imposition of cost-sharing on low-income populations, however, can deter both the use of needed as well as unnecessary services.[29] In addition, non-elderly, non-disabled adult Medicaid beneficiaries with incomes below the poverty line spend on average more than 4 times the share of income on out-of-pocket medical expenses as middle-income adults.[30]

Federal law limits state flexibility to impose cost-sharing on low-income Medicaid beneficiaries in four ways. Certain categories of beneficiaries are exempt from any cost-sharing whatsoever, as are certain types of services. In addition, the cost-sharing that states may impose must be "nominal," and participating providers may not withhold services from beneficiaries who cannot afford the deductible, copayment, or coinsurance requirement.

Federal Medicaid law exempts several categories of beneficiaries from cost-sharing entirely, two of which are pertinent here.[31] The largest category is children under 18 with respect to all services, including EPSDT. The second category is pregnant women. In this case, the exemption applies to any services relating to pregnancy or any other medical condition that may complicate the pregnancy. The purpose of these two exemptions is to ensure, as a matter of public health policy, that low-income children and pregnant women are not deterred from using needed services.[32]

Federal Medicaid law also exempts two types of services from the imposition of cost-sharing requirements: emergency services and family planning services and supplies. Emergency services are defined by CMS as "services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in – (i)

placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part."[33] Family planning services and supplies have not been defined by CMS. The exemption for emergency services reflects a policy judgment that necessary use of emergency services, whether in a hospital ER or elsewhere, should not be discouraged. The exemption for family planning services reflects a concern that cost-sharing may discourage the use of the service by low-income women, thereby resulting in avoidable unwanted pregnancies.[34]

With respect to all non-exempt groups of beneficiaries and types of services, states have the discretion to impose "nominal" cost-sharing.[35] Under CMS regulations, which have not been revised since 1983:

- a "nominal" deductible is $2 per month per family,
- a "nominal" copayment may range from 50 cents to $3.00, depending on the amount of the state's payment for the item or service, and
- a "nominal" co-insurance requirement is five percent of the state's payment rate for the item or service.[36]

The regulations also contain an exception to deter misuse of hospital emergency rooms. In the case of non-emergency outpatient services furnished in a hospital ER, a state may impose a deductible or copayment up to twice the "nominal" amount if the state shows that beneficiaries "have actually available and accessible to them alternative sources of non-emergency, outpatient services."[37]

Cost-sharing, whether in the form of deductibles, copayments, or coinsurance, is commonly collected by providers at the point of service. Providers are not required to participate in Medicaid, but if they do so they must accept the amounts that Medicaid pays for a service as payment in full. Medicaid programs will generally deduct from their payment rates the amount of any cost-sharing imposed on the service, assuming that the provider will collect the amount directly from the beneficiary. Since Medicaid beneficiaries are by definition poor or near-poor, many may be unable to pay some or all of the required amount. Under federal Medicaid law, participating providers may not withhold covered items or services from beneficiaries who are unable to pay.[38] As a legal matter the beneficiaries remain liable to the provider for the allowed cost-sharing amount, but as a practical matter these sums are often uncollectible. In these circumstances, cost-sharing requirements operate as reductions in provider reimbursement rates and have the effect of discouraging providers from participating in the program.

Section 1115 Demonstration Waivers of Minimum Federal Requirements

Although states have considerable discretion in Medicaid benefits design, some states have sought additional flexibility to depart from the minimum requirements described above. Under section 1115 of the Social Security Act,

the Secretary of HHS has the authority to waive many of these requirements for the purposes of testing "experimental, pilot, or demonstration project(s) which, in the judgment of the Secretary, (are) likely to assist in promoting the objectives of… (the Medicaid statute)" while allowing a state to continue receiving federal Medicaid matching funds.[39] The Secretary's ability to waive federal cost-sharing requirements is more constrained than his ability to waive federal benefits requirements.[40] As of May 2003, 24 states were operating section 1115 demonstration waivers.[41]

Most of these demonstration waivers exempt states from federal rules regarding eligibility or delivery systems. An increasing number, however, affect benefits and cost-sharing or use private models of coverage for Medicaid beneficiaries;[42] since August 2001, the Secretary of HHS has granted waivers to New Jersey, New Mexico, Oregon, Tennessee, and Utah reducing benefits or increasing cost-sharing for some groups of Medicaid beneficiaries.[43] These waivers offer concrete examples of the types of changes states would make in their Medicaid benefits packages if the current law minimum requirements were relaxed. The following discussion focuses on the waivers being implemented in Oregon and Utah, which illustrate changes in benefits design for both children and adults.[44]

Coverage for Children in Oregon: EPSDT versus the Prioritized List

Oregon has been operating its 1115 demonstration waiver, which affects both low-income adults and children, for nearly a decade.[45] Under the waiver, called the Oregon Health Plan (OHP), the state provides Medicaid benefits based on a list of "condition/treatment" pairs, ranked by priority of acuity and effectiveness of treatment. For example, contact dermatitis/medical therapy is condition/treatment pair number 552 on the April 29, 2003 "Prioritized List of Health Services."[46] The state legislature sets a threshold for which condition/treatment pairs on the list OHP will cover based on the state budget, subject to approval by the Centers for Medicare & Medicaid Services; OHP covers services only if they are for condition/treatment pairs that are ranked above the funding threshold. As of January 1, 2003, OHP covered the first 558 on its Prioritized List of 743 condition/treatment pairs.[47] Both the listing of pairs and the threshold may change over time.

This approach to benefits design differs fundamentally from the Medicaid EPSDT benefit. As discussed above, the EPSDT benefit entitles eligible low-income children under 21 to coverage for preventive services as well as diagnostic and treatment services necessary to address conditions discovered by an EPSDT screen. OHP's coverage of preventive services appears to be similar to that of EPSDT, although OHP places higher priority on preventive services to children 10 and under.[48] OHP also covers all diagnostic services for eligible children, whether or not the condition diagnosed is above or below the funding line. However, if a child is screened and diagnosed with a condition below the

funding line, OHP will not pay for the treatment for that condition, including any "ancillary services" like prescription drugs.[49] For example, under the April 29, 2003 Prioritized List, if the funding line remains at condition/treatment pair 558, OHP would not cover the treatment of children diagnosed with chronic bronchitis (577) or chronic conjunctivitis (682).

Coverage for Adults in Oregon and Utah: Limited or "Basic" Health Services

Medicaid beneficiaries age 21 or older are not entitled to EPSDT benefits. Instead, they are entitled to the other "mandatory" Medicaid services listed in Figure 1, plus any "optional" items or services, such as prescription drugs, that a state chooses to offer. Similarly, as discussed above, adult Medicaid beneficiaries are, at state option, subject to "nominal" cost-sharing on most services; eligible children are not. Thus, the "flexibility" issues in benefits (and cost-sharing) design for adults differ somewhat from those for children. This section discusses the limitations imposed on benefits for adults under the Oregon and Utah demonstration waivers.

In 2002, Oregon received permission from the Secretary to make significant changes to the benefits package offered under its 1115 waiver. Effective March 1, 2003, OHP offers two benefits packages: OHP Plus and OHP Standard.[50] Both are based on the state's Prioritized List of condition/treatment pairs; as discussed above, treatment for a particular condition is covered only if that condition is above the funding line set by the legislature based on the state budget. The OHP Standard package is offered to uninsured adults who are not receiving cash assistance (whether through SSI, TANF, or the state General Assistance program) and also meet the state's income and resource requirements. These individuals receive fewer benefits and pay higher cost-sharing than Medicaid beneficiaries eligible for OHP Plus.[51] For example, while people in OHP Plus receive coverage of mental health, durable medical equipment, dental, vision, and hearing services, those in OHP Standard do not. Figure 2 compares the OHP Standard package to the benefits available to adults under the regular Medicaid program and to the benefits available under the private plan used by the majority of federal employees. Figure 3 compares the cost-sharing requirements for common services under the OHP Standard package with those allowed under regular Medicaid rules and those in place under the private plan. As is evident from these figures, individuals enrolled in OHP Standard receive more limited benefits than those in traditional Medicaid and, like individuals enrolled in private plans, pay significantly higher cost-sharing.

Utah's section 1115 demonstration waiver allows the state to make significant changes in its Medicaid program. By reducing benefits and increasing cost-sharing for previously eligible parents, the state expects to generate a small amount of savings that it will use to finance an expansion of a narrow benefits package (with relatively high cost-sharing) to certain low-income adults who were

not previously eligible for Medicaid coverage. The Utah waiver is unique in that it allows a Medicaid program to provide beneficiaries coverage for benefits limited to primary care. For the newly-eligible adults receiving the "Primary Care Network" (PCN) benefits package, there is no coverage for services such as hospital care, specialty care, and mental health services.[52] Secretary Thompson has cited Utah's approach to benefits design as an example of the type of changes states could make to their programs if granted flexibility.[53]

Figure 2 compares Utah's PCN benefits with those available to adults under the regular Medicaid program, those available under the OHP Standard plan, and those available under the Blue Cross/Blue Shield Standard Option PPO Benefit offered to federal employees. As is evident, the Utah PCN benefits are significantly more limited in scope than any of the other packages. Figure 3 compares the cost-sharing requirements of Utah's PCN package with those of the regular Medicaid program, OHP Standard, and Blue Cross/Blue Shield Standard Option, with respect to four common services – inpatient hospital, outpatient hospital, physician, and prescription drug. Individuals covered under Utah's PCN benefits package are also expected to pay cost-sharing above traditional Medicaid levels. Further, because Utah's PCN benefits package does not cover hospital or specialty care services, the cost-sharing requirements for such services will by definition be 100 percent.

Figure 2:
Acute Care Services Available to Adults Under
Regular Medicaid, Private Coverage, and Oregon and Utah Waiver Programs, 2003

	Medicaid*	BC/BS*	OHP Standard*	Utah PCN*
Mandatory Medicaid services				
Inpatient hospital services	✓	✓	✓	Not covered
Outpatient hospital services	✓	✓	✓	Not covered
Physicians' services	✓	✓	✓	Primary care only
Laboratory and x-ray services	✓	✓	✓	Primary care only
Family planning services and supplies	✓	✓	✓	Limited coverage[1]
FQHC/RHC services	✓	Not specified	✓	✓
Nurse midwife & nurse practitioner services	✓	✓	Not specified[2]	✓
Transportation services	✓	[3]	[3]	[3]
Optional Medicaid services**				
Prescription drugs (inpatient and outpatient)	✓	✓	[4]	Limited coverage[5]
Care furnished by chiropractors, psychologists, and podiatrists	✓	✓[6]	Not specified[2]	Not covered
Diagnostic, screening, and preventive services	✓	✓	✓	✓
Clinic services	✓	✓	Not specified	✓
Dental services and dentures	✓	✓[7]	Not covered	[8]
Physical therapy and related services	✓	✓[9]	✓	Not covered
Prosthetic devices, including eyeglasses	✓	✓[10]	Not covered	[11]
Primary care case management	✓	✓	✓	Not covered

* "Medicaid" based on mandatory acute care benefits and optional acute care benefits offered in the majority of states; states may apply limits to these benefits per the rules described above. "BC/BS" based on PPO benefits available under Blue Cross/Blue Shield Standard Option offered under the Federal Employees Health Benefit Program (FEHBP) for 2003. "OHP Standard" based on benefits available to non-categorically eligible individuals under Oregon's section 1115 demonstration waiver. Services are covered only if they are for conditions/treatments that are ranked above the funding line in Oregon's Prioritized List of health services. "Utah PCN" based on Utah's "Primary Care Network" coverage available to non-categorically eligible adults enrolled under Utah's section 1115 demonstration waiver.

** Includes optional Medicaid services offered by most states.

[1] Coverage limited to scope of coverage for physician and pharmacy; some services are excluded.

[2] Coverage may vary according to enrollee's managed care plan; mental health services provided by psychologists are not covered.

[3] Emergency and transport ambulance services only.

[4] Prescription drug coverage ended on March 1, 2003 but was temporarily extended until June 30, 2003.

[5] Coverage limited to 4 drugs per month, with no exceptions.

[6] Excludes chiropractor and routine foot care.

[7] Excludes dentures, orthodontia, or services for TMJ or periodontal disease.

[8] Coverage limited to relief of pain and infection.

[9] Physical, occupational, and speech therapy limited.

[10] Coverage limited to equipment for recovery; no coverage for eyeglasses.

[11] Excludes routine eyeglasses and hearing aids.

Figure 3:
Adults' Cost-Sharing Requirements for Selected Services Under Regular Medicaid, Private Coverage, and Oregon and Utah Waiver Programs, 2003

	Medicaid	BC/BS*	OHP Standard*	Utah PCN*
Deductible				
	At state option, up to $2 per month	$250/year for an individual, $500/year for a family[1]	None	None
Coinsurance & Copayments				
Inpatient hospital services	At state option, up to 50% of the state's payment for first day of care per admission	$100 per admission	$250 per admission	Full cost
Outpatient hospital services	At state option, copayments of $0.50 to $3 per visit[2]	10% of allowable charges coinsurance	$20 copayment for surgery $5 copayment for other services	Full cost
Physician services	At state option, copayments of $0.50 to $3 per visit[2]	$15 per physician office visit 10% of allowable charges coinsurance for all other physician charges[3]	$5 copayment for office visits $3-$10 copayment for procedures	No cost for preventive care $5 copayment for other primary care Full cost of specialty care
Prescription drugs	At state option, copayments of $0.50 to $3 per visit[2]	25% coinsurance for drugs obtained from a retail pharmacy[4]	Up to 100% FPL: $2 generic; $15 brand[5] 100-185% FPL: $5 generic; $25 brand[5]	$5 copayment for generic Full cost of name brand if generic equivalent 25% coinsurance for name brand if no generic equivalent

***** "BC/BS" based on PPO benefits available under Blue Cross/Blue Shield Standard Option offered under the Federal Employees Health Benefit Program (FEHBP) for 2003. Cost-sharing assumes use of PPO Providers; higher deductibles, coinsurance, and out-of-pocket maximums are in place for non-PPO Provider utilization. Employees' share of premiums for standard coverage is $99 per month for individual coverage and $228 per month for family coverage. Private coverage also has a $4,000 per year out-of-pocket maximum for deductibles, coinsurance and copayments (some exceptions apply).

* "OHP Standard" based on benefits available to non-categorically eligible individuals under Oregon's section 1115 waiver. Services are covered only if they are for conditions/treatments that are ranked above the funding line in Oregon's Prioritized List of health services. Enrollees' premiums for coverage are based on income and vary from $6 per month for those with incomes up to 50% FPL to $20 per month for those with incomes from 86-100% FPL and $125 per month for those with incomes from 171-185% FPL. Premiums are doubled for couples. Some preventive services are exempt from cost sharing.

* "Utah PCN" based on Utah's "Primary Care Network" coverage available to non-disabled parents and other adults under section 1115 waiver. Most enrollees also required to pay an enrollment fee of $50. Total out-of-pocket costs for cost-sharing for covered services are capped at $1,000 per enrollee per year.

[1] Deductible does not apply to some services, such as inpatient hospital care, charge for office visit, preventive services, and diagnostic cancer tests.

[2] States may alternatively opt to impose coinsurance up to 5% of its payment rate for the item service.

[3] No coinsurance for preventive services and diagnostic cancer tests.

[4] $10/$35 copayment for generic/brand name drugs obtained through prescription drug mail-in service.

[5] As of March 1, 2003, prescription drug coverage ended and enrollees pay 100% of the cost of prescription drugs; coverage was temporarily extended until June 30, 2003. Lower copayments apply for brand-name drugs for cancer or HIV.

Conclusion

States enjoy considerable discretion under current law to administer their Medicaid programs. State policymakers are requesting additional "flexibility," particularly with respect to benefits and cost-sharing design. These requests have triggered a debate over how the Medicaid program can most effectively improve the health status of the low-income population it serves. Several demonstration projects, including one in Oregon and another in Utah, are already underway to test the impact of benefits packages that are less comprehensive and impose higher cost-sharing requirements than the current federal minimum standards allow. Based on Oregon's experience to date, however, it is uncertain whether additional flexibility in benefit design can help states address their budget problems.[54] Policymakers at both the federal and state level may wish to consider the results of these demonstrations when determining what alternative benefits and cost-sharing designs are appropriate to the low-income children, families, individuals with disabilities, and the elderly.

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[1] Unpublished data from Kaiser/Commonwealth 1997 Survey of Health Insurance.
[2] Hudman, J. and M. O'Malley. *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations.* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): March 2003.
[3] Holahan and Bruen, *Medicaid "Mandatory" and "Optional" Eligibility and Benefits* (July 2001), Figure 11, www.kff.org/content/2001/2256/2256.pdf.
[4] In testimony to the Congress in March of 2003, Governor Jeb Bush of Florida urged that states (among other things) be allowed to (1) provide "different coverage for different populations to meet different needs…[that] might include a core package of benefits, a long-term care package, and a supplemental package for lower income individuals with specific chronic health conditions;" (2) "design benefit packages that look more like commercial models;" (3) "…encourage Medicaid beneficiaries to be active participants in the program by … sharing in the cost of their care and helping to control program costs;" and (4) "…encourage choice through private health insurance, supplementing costs when necessary." *Testimony of Governor Jeb Bush on Medicaid Reform*, before the Subcommittee on Health of the House Committee on Energy and Commerce (March 12, 2003) pp. 10-11, http://energycommerce.house.gov/108/Hearings/03122003hearing815/hearing.htm.
[5] Congressional Budget Office, *Fact Sheet for CBO's March 2003 Baseline Medicaid and the State Children's Health Insurance Program* (March 2003).
[6] Mann, C., "The Flexibility Factor: Finding the Right Balance," *Health Affairs* (January/February 2003), pp. 62 - 76.
[7] Schneider, A. and R. Elias, *Medicaid and Long-term Care Assistance: Current Benefits and Flexibility*, (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): September 2003.
[8] For a state-by-state listing of categories of services covered as of November 2002, see Centers for Medicare & Medicaid Services, *Medicaid At-a-Glance 2002: A Medicaid Information Source*, pp. 7-11, http://cms.hhs.gov/states/maag2002.pdf. For a more recent state-by-state listing of categories of services covered, see Health Management Associates, *Medicaid Benefits: Services Covered, Limits, Copayments, and Reimbursement Methodologies for 50 States, District of Columbia and the Territories*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured and the National Conference of State Legislatures), forthcoming August 2003.
[9] 42 CFR 430.2.

[10] Medicaid is also an entitlement to states. See Schneider, A., D. Rousseau, and V. Wachino, *Medicaid Financing* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): (forthcoming)
[11] States can provide a more limited benefits package to individuals qualifying as "medically needy" than they provide to other Medicaid beneficiaries. For more information, see: Crowley, J. *Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage.* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): January 2003.
[12] For a more extensive discussion, see Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (July 2002), Chapter II: Medicaid Benefits, p. 49 – 80, www.kff.org.
[13] Transportation services are not a statutory benefits category. However, states are required to ensure necessary transportation for beneficiaries to and from providers, 42 C.F.R. 431.53, and federal Medicaid matching funds are available for transportation expenses, 42 C.F.R. 440.170(a).
[14] Health Management Associates for the National Conference of State Legislatures, unpublished survey results (March 2003).
[15] 42 CFR 440.230(b). This "sufficiency" requirement applies to "optional" as well as "mandatory" services
[16] See cases cited in Perkins, J. and S. Somers, *An Advocate's Guide to the Medicaid Program* (June 2001), Section 4.6, note 76, www.healthlaw.org.
[17] Section 1902(a)(10)(A)(B) of the Social Security Act, 42 USC 1396a(a)(A)(10)(B), 42 CFR 440.240(b)(1) requires that state Medicaid plans provide that the services available to any individual in a categorically needy eligibility group be "equal in amount, duration, and scope for all recipients within the group." This "comparability" requirement also applies to individuals covered as medically needy; however, the amount, duration, and scope of the services available to the medically needy may be smaller than that of the services available to the categorically needy. 42 CFR 440.240(b)(2).
[18] 42 CFR 440.230(c).
[19] See cases cited in Perkins, J. and S. Somers, *An Advocate's Guide to the Medicaid Program* (June 2001), Section 4.6, note 77, www.healthlaw.org.
[20] Section 1902(a)(1) of the Social Security Act, 42 USC 1936a(a)(1), 42 CFR 431.50.
[21] Since its enactment in 1965, the Medicaid program has given states the discretion to delegate eligibility determinations and other administrative functions to counties and localities, as well as to require localities to contribute a portion of the state share of spending. Some states, including California and New York, have take up one or both of these options.
[22] For a detailed discussion of the EPSDT benefit, see Perkins, J. and S. Somers, National Health Law Program, *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic, and Treatment Services for Poor Children and Youth* (April 2003), 97 pp., www.healthlaw.org.
[23] Section 1905(r) of the Social Security Act, 42 USC 1396d(r).
[24] Section 1902(a)(43) of the Social Security Act, 42 USC 1396a(a)(43).
[25] Section 1905(r)(5) of the Social Security Act, 42 USC 1396d(r)(5) requires state Medicaid programs to pay for health care, diagnostic services, treatment, and other measures for which federal matching funds are available "necessary … to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."
[26] CMS, *State Medicaid Manual*, HCFA Pub. 45-5, sections 5010 – 5350, www.cms.gov/states/.
[27] Section 1902(a)(43)(D) of the Social Security Act, 42 USC 1396a(a)(43)(D).
[28] Perkins, J., National Health Law Program, *EPSDT Case Docket*, http://www.healthlaw.org/pubs/EPSDTdocket.html; *EPSDT Mental and Behavioral Health Case Docket*, http://www.healthlaw.org/pubs/EPSDTdocket.mh.html.
[29] Hudman, J. and M. O'Malley. *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations.* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): March 2003.
[30] Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (May 7, 2003), p. 3, www.cbpp.org.
[31] The other two categories exempt from any cost-sharing are (1) inpatients in hospitals, nursing facilities, or intermediate care facilities for the mentally retarded (ICFs/MR) who, as a condition of eligibility, are required to apply most of their income to the cost of care; and (2) terminally ill

individuals receiving hospice care. In the former case, the beneficiary is already sharing substantially in the cost of care, and imposition of additional cost-sharing requirements would serve no useful purpose. In the latter case, the purpose of the exemption is to avoid deterring terminally ill individuals from using hospice benefits.

[32] Office of Technology Assessment, U.S. Congress. *Benefit Design in Health Care Reform: Background Paper—Patient Cost-sharing*, OTA-BP-H-112 (Washington, DC: U.S. Government Printing Office): September 1993; Roemer, M. et al. "Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish." *Medical Care,* 13(6): 457-66; Helms, J., J. Newhouse, and C. Phelps. "Co-payments and Demand for Medical Care: The California Medicaid Experience." *Bell Journal of Economics.* 9:192-208.

[33] 42 CFR 447.53(b)(4).

[34] Aved, B. and V. Harp. "Assessing the Impact of Co-Payment on Family Planning Services: A Preliminary Analysis in California." *American Journal of Public Health.* 73(7): 763-5.

[35] Note that in order to qualify for Medicaid through the "medically needy" pathway, individuals must "spend down" by paying a portion of their income toward the cost of care. For more information, see: Crowley, J. *Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage.* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): January 2003. States may also impose cost-sharing requirements on these individuals for non-exempt services, but these charges must be "nominal."

[36] 42 CFR 447.50 – 447.59.

[37] 42 CFR 431.57.

[38] Section 1916(e) of the Social Security Act, 42 USC 1396o(e), 42 CFR 447.15.

[39] Section 1115(a) of the Social Security Act, 42 USC 1315(a). For background on section 1115 waivers and Medicaid, see Mann, C., *The New Medicaid and CHIP Waiver Initiatives* (February 2002), www.kff.org/content/2002/4028/4028.pdf; Lambrew, J., *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program* (July 2001), www.kff.org/content/2001/4001/4001.pdf; Gill, S., J. Guyer, and C. Mann. *Section 1115 Medicaid and SCHIP Waivers: Policy Implications of Recent Activity.* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): June 2003.

[40] Section 1916(f) of the Social Security Act, 42 U.S.C. 1396o(f), prohibits waiver of the cost-sharing requirements unless the waver is for a demonstration project that is limited to a period of 2 years, will provide benefits to Medicaid enrollees that are reasonably equivalent to the risks, involves a methodologically sound test of a reasonable hypothesis, and assumes liability for preventable damage to beneficiaries.

[41] Kaiser Commission on Medicaid and the Uninsured, unpublished analysis of section 1115 waivers based on information from the Centers for Medicare & Medicaid Services, May 2003.

[42] Some states are using "premium assistance programs" to subsidize private insurance coverage for Medicaid beneficiaries. For more information, see: Alker, J. *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity.* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): June 2003.

[43] Gill, S., Guyer, J., and Mann, C., *Section 1115 Medicaid and SCHIP Waivers: Policy Implications of Recent Activity*, Table 1 (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured): June 2003.

[44] For more information on these and other waivers experimenting with benefits design, see: Friedenzohn, I. *States' Experience with Benefit Design.* State Coverage Initiatives Issue Brief, Vol. IV, No. 4, April 2003, http://www.statecoverage.net/pdf/issuebrief403benefits.pdf.

[45] *Oregon Section 1115 Waiver Fact Sheet* (February 2003), www.kff.org/content/2003/waivers.

[46] Oregon Health Services Commission, *Prioritization of Health Services: A Report to the Governor and the 72nd Oregon Assembly,* Appendix F, Prioritized List of Health Services (April 29, 2003), www.ohppr.state.or.us/hsc/bireport_hsc.htm.

[47] The April 29, 2003 revised list proposes to re-arrange condition/treatment pairs into a list of 730 items and fund the first 549 on the list. Oregon Health Services Commission, *Prioritization of Health Services: A Report to the Governor and the 72nd Oregon Assembly,* http://www.ohppr.state.or.us/hsc/2003-2005FinalReport/HealthServices-2003-BiennialReport-COMPLETE.pdf.

[48] On the April 29, 2003 Prioritized List, "Preventive Services (Birth to 10 Years of Age)/Medical Therapy" is ranked 144 out of 730 condition/treatment pairs; "Preventive Services with Proven Effectiveness, Over Age 10/Medical Therapy" is ranked 184; and "Preventive Dental Services/Cleaning and Flouride" is ranked 301. *Ibid*.

[49] Under the Oregon Health Plan, "ancillary services" are goods, services, and therapies, including prescription drugs, that are considered to be integral to the successful treatment of a condition. They are covered only when used in conjunction with a condition ranked above the funding line. *Ibid*.

[50] Oregon's section 1115 waiver also allows the state to refinance and expand the state's premium assistance program, the Family Health Insurance Assistance Program (FHIAP). FHIAP does not provide enrollees a specific set of benefits, but rather subsidizes the purchase of private insurance that meets certain standards. For more information on FHIAP, see: Kaiser Commission on Medicaid and the Uninsured, *Fact Sheet: Oregon Section 1115 Waiver*, February 2003, available at www.kff.org.

[51] "The new OHP Standard benefit package looks like commercial health insurance. Clients who get that benefit package are better prepared for coverage found in the private sector. Most people with private coverage pay premiums and make copayments." Oregon Department of Health Services, *FAQ: Changes to the Oregon Health Plan Medicaid Program*, http://www.dhs.state.or.us/healthplan/data_pubs/ohp2faqgp.html#4.

[52] See *Utah Section 1115 Waiver Fact Sheet* (February 2003), www.kff.org/content/2003/waivers; and Betit, R. L. *Utah's Primary Care Network: The Link to Inpatient Hospital Care.* State Coverage Initiatives State Reports, February 2003, http://www.statecoverage.net/statereports/ut10.pdf.

[53] Transcript from "HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan." (Washington, DC: kaisernetwork.org): January 31, 2003.

[54] In June 2003, Oregon sent a letter to the Secretary of HHS stating that the 2002 changes to the Oregon Health Plan had not stabilized the fiscal situation in the state and that further cuts and changes to the prioritized list would be needed in the coming year. Kulongoski, T.R., Courtney, P., and Minnis, K. Letter to Secretary Thompson, June 6, 2003.

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