POLICY BRIEF

Defined-Contribution Plans and Limited-Benefit Arrangements: Implications for Medicaid Beneficiaries

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Introduction

This Policy Brief explores the implications of state Medicaid reforms -- whether implemented either as §1115 demonstrations or as part of state plan flexibility measures under the Deficit Reduction Act of 2005 (P.L. 109-171) -- that limit benefits, coverage, and payments for medically necessary health care. Following a background and overview, the Policy Brief identifies a series of considerations that come into play when states approach the issue of benefit re-design, particularly in the context of developing coverage innovations that utilize “consumer-driven” and “defined-contribution” arrangements.

As used in this Policy Brief, the term “defined-contribution” means the payment of a flat, per-capita amount toward the cost of health plan enrollment, regardless of benefit design or actual health care utilization and cost. The term “limited-benefit” plan means a health plan whose benefit and coverage design is narrower and more restricted than that utilized under “traditional” Medicaid benefit design. The use of more limited “alternative benefit” arrangements is now permitted for certain beneficiary groups under the DRA.1

Background and Overview

Medicaid’s Coverage Design Principles

Medicaid is the nation’s single largest source of health benefits, covering some 58 million children and adults.2 Its size means that Medicaid functions as one of the financial lynchpins of the nation’s health care system, as Figure 1 illustrates. Medicaid’s impact on the accessibility and quality of health care has been extensively documented.3

Medicaid has been specifically designed to serve the needs of low income beneficiaries, most of whom have no other source of health care coverage. Indeed, its eligibility, benefit, and coverage structure mean that Medicaid can take on unique and irreplaceable health care tasks, an often-overlooked fact when Medicaid reform is discussed.

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1 DRA, §6044.
Medicaid’s singular role is reflected in three basic elements of the program’s design:

- First, rather than being tied to pre-set enrollment periods, Medicaid is available to eligible low income and medically impoverished persons at the point of greatest health care need. Indeed, Medicaid eligibility can be retroactive, in order to ensure coverage of high health care costs incurred prior to the date of application.\(^4\)

- Second, Medicaid coverage is structured to cover and pay for comprehensive health services necessary for children and adults with serious and chronic physical and mental health conditions. In the case of children, Medicaid coverage requirements are especially notable; these requirements, which are part of the program’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (whose elements are shown in Figure 5) continue to apply under the DRA.

- Third, Medicaid limits permissible levels of patient cost-sharing, in recognition of beneficiaries’ virtual lack of discretionary income.

Over the past several years, and coinciding with Medicaid’s increasing emphasis on the purchase of private managed care products, the press for innovative coverage design in the privately sponsored market also has emerged as a key issue. Therefore, it should not be surprising that coverage innovation also would become a central theme in Medicaid reform.

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\(^4\) 42 U.S.C. §1396a(a)(34).
Several additional factors have intensified policymakers’ interest in restructuring Medicaid coverage:

- **First**, a steady increase in the number of enrolled working-age adults and children as a result of sustained poverty, the large number of persons working in low wage sectors, declining access to and -- worker uptake of -- employer-sponsored benefits in low wage industries, and Medicaid expansions, particularly for children. Indeed, Figure 2 shows that between 2000 and 2004 alone, the nation experienced a more-than 6 million person increase in the number of uninsured adults.\(^5\) Despite the fact that children and families comprise only about 30% of total program spending,\(^6\) outlays have grown in recent years as enrollment has grown, especially in the case of children.\(^7\) Despite the fact that spending increases are attributable to enrollment increases rather than changes in coverage or utilization, spending growth for these populations has attracted attention.

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\(^{7}\) Census data for 2005 show the first decline in children’s enrollment in a decade.
• Second, the rising cost of Medicaid in relation to overall state and federal budget expenditures. The rate of growth in Medicaid spending has slowed considerably and is anticipated to stay flat during 2006.\(^8\) But rapid spending is expected to resume as the result of demographic and health care-related factors linked to an aging society and the greater survival of children and both non-elderly and elderly adults with serious health conditions.

As states have sought to control the Medicaid growth rate, two important and related strategies have begun to emerge. The first is an effort to significantly limit benefits and coverage for certain populations. The second is to cap the total amount of per-enrollee expenditures.

• Many states have expressed a desire for flexibility to offer limited-benefit arrangements that would reduce the types, range, and depth of Medicaid benefit coverage. The Nation’s Governors made increased state benefit coverage flexibility a centerpiece of their 2005 Medicaid policy recommendations,\(^9\) and reduced benefit coverage has been a hallmark of federally sponsored state Medicaid demonstrations in recent years. Limited-benefit arrangements might be directly administered by state Medicaid agencies, or (more typically in today’s Medicaid programs) health plans that contract with states to provide coverage to Medicaid beneficiaries. Idaho, Kentucky, and West Virginia are the first states to use the benefit re-design flexibility permitted under the DRA to enroll low income children and their parents and caretakers in health plans that offer limited-benefit design in comparison to the more comprehensive coverage previously offered.

• Florida has received permission to replace existing benefit design rules with a defined-contribution approach to coverage,\(^10\) and Oklahoma and South Carolina have made similar proposals. Under this alternative approach to benefit coverage, a state would make a premium payment to participating health benefit plans that, in turn, would be responsible for developing a benefit design that conforms to the state’s pre-set expenditure target.

Advocates for these new models argue that limited benefits, coupled with a defined-contribution strategy, would align Medicaid coverage principles with those that characterize the coverage received by non-Medicaid populations in the emerging commercial market. An important question therefore becomes what issues might arise were such a shift in Medicaid coverage principles to occur, given the unique characteristics of the Medicaid population and the role played by traditional Medicaid coverage principles.


\(^9\) The NGA’s policy position on Medicaid reform can be viewed at [http://www.nga.org/portal/site/nga/menuitem.8358ec82f5b198d18a278110501010a0/?vgnextoid=e5ff0640e8e34010VgnVCM1000001a01010aRCRD](http://www.nga.org/portal/site/nga/menuitem.8358ec82f5b198d18a278110501010a0/?vgnextoid=e5ff0640e8e34010VgnVCM1000001a01010aRCRD) (Accessed March 26, 2006)

The Important Safety Net Role Played by Medicaid

In many respects, Medicaid functions in a manner similar to health insurance, in that it covers eligible persons and pays participating health care providers for care and services that are furnished. But Medicaid’s similarities to insurance essentially stop there. Medicaid’s primary function is to provide a safety net for those who are most in need. The commercial insurance market, on the other hand, is designed principally to ensure that privately insured persons have peace of mind regarding significant health care costs. The fundamental differences between these two functions are reflected in three important ways:

• **Medicaid is designed to finance comprehensive health care coverage for a broad range of physical, mental, and developmental health conditions, particularly those that are serious and chronic.** Because of its role as a health care safety net, Medicaid reaches populations who experience poorer health and much higher rates of disability than persons with employer-sponsored health insurance. Consequently, Medicaid historically has guaranteed comprehensive coverage that is tailored to the unique needs of this population. Although certain coverage categories (e.g., parents with children) resemble those enrolled in private plans, closer examination of their characteristics reveals higher rates of illness and disability.

• **Medicaid employs extensive cost sharing restrictions.** Even post-DRA, Medicaid contains considerable cost sharing restrictions in the case of children, pregnant women, and certain populations who experience high health care needs.

• **Medicaid makes individuals eligible at the point of greatest health care need and eases their enrollment.** Privately insured individuals are generally drawn from the workforce, and eligible individuals typically are required to enroll during certain defined time periods (typically these time periods are known as “open enrollment” periods). These pre-set enrollment periods allow the insurance model to function properly, by encouraging beneficiaries to purchase coverage before they most need it.

In contrast and as previously noted, Medicaid allows -- and even encourages -- individuals to enroll at the time of need. Indeed, pregnancy, a child’s profound illness, a catastrophic injury experienced by a low income worker, serious physical or mental disability, or breast or cervical cancer, all offer explicit bases of eligibility. In fact, in the wake of federal welfare reform legislation enacted in 1996, which severed the link between cash assistance and Medicaid, the proportion of individuals enrolling in Medicaid as a result of health need rather than simply as an incident to the receipt of cash welfare (an analogue to employment in a health insurance context) has increased.\(^{11}\) Outstationed enrollment opportunities through health care safety net providers such as health centers and public and children’s hospitals -- a longstanding federal requirement\(^{12}\) -- further increases the likelihood of enrollment among persons with serious conditions at

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\(^{11}\) S. Rosenbaum, 2002. “Medicaid” *NEJM* 346:8 635-640 (Feb. 21)

\(^{12}\) Id. See also, A. Schneider et. al, 2003. *Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C.)
the point of illness and health care need. And because keeping Medicaid coverage is challenging (requiring proof of continuing health care need and low income), health improvements may lead to disenrollment, thereby reducing the chances of continuous coverage through periods of good health. Finally as noted, Medicaid even permits retroactive eligibility as a means of ensuring that enrollment only following a costly illness does not deprive a patient -- or the health care system -- of the financial support needed to address high health care bills incurred prior to enrollment.

In sum, Medicaid appears to function much like health insurance, but appearances can be deceiving.

In reality, Medicaid operates in accordance with unique rules that have been designed for a low income population in relatively poor health, who enroll in the program at the highest point of need, and whose enrollment is often tied to the receipt of specific medical and health treatments. Indeed, certain high-need populations such as disabled children and adults, women with breast cancer, or pregnant women, may lose their eligibility entirely once their illness or disability is addressed. In essence, Medicaid is built to serve people whose living and health conditions place them outside of population norms.

Medicaid’s unique characteristics do not mean that states cannot make active use of many care management practices employed in the commercial market. For example, many states contract with health plans to insure coverage and manage patient care, and these organizations have shown to be effective, particularly in experienced states that have a long history of managed care collaboration and that use actuarially sound rate structures. At the same time, however, beneficiary characteristics and their attendant health care needs compel careful scrutiny of proposed health reform efforts. To better understand these differences, it is helpful to review the evolution of Medicaid benefit coverage and the role of health plans in providing the benefits.

**Medicaid’s Evolution as a Purchaser of Health Benefit Plans**

For thirty years, as illustrated by Figure 3, federal Medicaid policy has explicitly permitted states to furnish medical assistance for most beneficiaries through the purchase of health benefit plans. Beginning with the HMO Amendments of 1976 and continuing with reforms enacted during the 1980s and 1990s, Congress has encouraged state Medicaid programs to move toward market-based coverage and care arrangements. This shift toward purchased coverage has been particularly evident in the case of families with children but also has gathered strength in recent years in the case of beneficiaries with disabilities. With few exceptions, these

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13 Due to the cumbersome process of reestablishing eligibility every 6 to 12 months, some Medicaid beneficiaries choose to wait until they or their children need medical care before reapplying.
14 Id. “Medicaid,” *NEJM* op. cit.
plans, either alone or in combination with other state plan services covered directly and outside of contractual arrangements (e.g., long term nursing home benefits) continued to cover all mandatory and optional services.

Interest in experimenting with changes in Medicaid’s broad-based benefit coverage took serious hold beginning in 1993, when the Clinton Administration, using its authority under §1115 of the Social Security Act, began to encourage states to expand eligibility among additional “demonstration” populations through enrollment in health plans offering more limited benefits than the coverage available to “traditional” populations.

The State Children’s Health Insurance Program (SCHIP), enacted in 1997, represented the next step in this evolution. SCHIP created new flexibility for states in the case of certain “targeted low income” children. At their option, states could expand Medicaid to reach additional children; alternatively however, SCHIP allowed states to cover these children through a non-entitlement program with benefit plans mirroring private sector coverage. By 2006 nearly all states had taken advantage of this coverage flexibility for at least some targeted low income children.

The Bush Administration continued this conversion to limited-benefit coverage by using §1115 demonstration authority to permit states to combine limited-benefit expansions for experimental populations with reduced benefits to traditional beneficiary groups. This special demonstration has been conducted as the Health Insurance Flexibility and Accountability (HIFA) initiative.

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19 http://www.cms.hhs.gov/HIFA/ (accessed March 12, 2006). For an excellent analysis of one early HIFA initiative that underscores how HIFA can create only limited access created for experimental populations while leading to new access barriers created for traditional populations, see S. Artiga et. al., (2006). Can States Stretch the Medicaid Dollar Without Passing the Buck?” Health Affairs 25:2 532-540 (Mar./Apr.)
Figure 3. Medicaid’s Legislative and Evolution as a Purchaser of Health Benefit Products: A Trend Towards Limiting Benefits

**HMO Act Amendments of 1976:** Established a legislative option to enroll Medicaid beneficiaries in federally qualified HMOs and other legislatively recognized health plans

**Omnibus Budget Reconciliation Act of 1981 (OBRA):** Added freedom of choice waivers that gave states the flexibility to condition coverage on enrollment in some form of managed care arrangement; added new forms of managed care arrangements, including primary care case management and partially and fully capitated prepaid plans.

**Clinton Administration’s Regulatory Changes:** Significantly increased the use of §1115 to establish a series of Medicaid reform demonstrations typically combining coverage expansions for previously uninsured populations with more limited coverage for experimental populations. Coverage achieved through broader use of general and special-purpose managed care systems, supplemented by direct coverage of state Medicaid plan services not furnished through purchased coverage arrangements.

**Balanced Budget Act of 1997:** Permitted states to mandate enrollment in managed care arrangements for certain populations as a state plan option and without federal freedom of choice waivers. Relaxed standards for managed care products while adding new contracting and performance measures.

**State Children’s Health Insurance Program (SCHIP) (1997):** Authorized federal funds to extend coverage to certain Medicaid-ineligible “targeted low income” children while allowing coverage arrangements through purchased “benchmark plans” or “benchmark equivalent” plans meeting minimum coverage standards more limited than federal Medicaid standards for children under EPSDT.

**Bush Administration’s Regulatory Changes:** Further extended efforts to encourage purchased coverage arrangements, through the use of §1115 “HIFA” waivers that build on Clinton era demonstrations by permitting states to combine limited-coverage expansions for experimental populations with reduced coverage for traditional populations.

**Deficit Reduction Act of 2005:** Broadened state options to limit Medicaid coverage for low income children and adults to “benchmark” or “benchmark equivalent” levels similar to those used under SCHIP, with EPSDT wrap-around requirements in the case of children and optional wrap-around coverage in the case of adults.

The DRA and more recent §1115 demonstrations represent the latest chapters in this evolution toward limited-benefit plans and defined-contribution coverage approaches. The DRA opens a new era in Medicaid by permitting states to limit the coverage for poverty-level children and parents to “benchmark” or “benchmark-equivalent” products similar to those used in SCHIP.\(^\text{20}\) (The DRA actually prohibits states from using their benchmark flexibility for eligibility categories not included in state Medicaid plans as of the date of DRA enactment).\(^\text{21}\) States electing this “alternative benefit” option must continue to cover all EPSDT services for children under 19, and may also supplement adult coverage through optional “wraparound” services.\(^\text{22}\) Figure 4 summarizes the DRA’s alternative benefit coverage rules.\(^\text{23}\)

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\(^\text{20}\) §1937 of the Social Security Act, added by DRA §6044.

\(^\text{21}\) DRA, P.L. 109-362, §6044

\(^\text{22}\) Id.
A state must offer either a benchmark package or a benchmark equivalent package.

Benchmark packages are defined as (A) The standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to federal employees; (B) a health benefits coverage plan that is offered and generally available to State employees in the State involved; (C) the health insurance coverage plan offered by the state’s largest HMO commercial insurance plan; or (D) any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

Benchmark equivalent coverage is defined as coverage that (1) consists of, at a minimum, inpatient and outpatient hospital coverage, physician surgical and medical coverage, laboratory and x-ray services, and well-baby and well-child care including age appropriate immunizations and other preventive services identified by the Secretary; and (2) that has a value at least equal to a benchmark package.

Children under age 19 who are enrolled in benchmark or benchmark equivalent coverage also must have “wraparound” benefits consisting of all EPSDT services.

Continued coverage and payment rules for federally qualified health center (FQHC) and rural health clinic (RHC) services

In order to make these alternative benefit arrangements more attractive, the DRA also has been interpreted as setting aside previous legislative provisions24 -- known as statewideness and comparability of benefits25 -- that required states to offer the same coverage to all “categorically needy” recipients, and on a statewide basis. The elimination of these two provisions (which were subject to a number of exceptions even prior to the DRA)26 permits states to vary the level and range of coverage they furnish on the basis of recipient characteristics or geographic location. Thus, for example, a state could set more limited coverage standards for persons who at some point in time appear to be in relatively good health, while allowing more generous benefits for adults who already have been identified as having certain chronic physical or mental conditions and disabilities. Benefits in rural areas of a state could differ from those offered to residents of a metropolitan region.

The DRA also explicitly encourages states to experiment with “consumer driven” products through authorization of “Health Opportunity Account” demonstrations that will permit up to ten states to offer “high deductible” health plans linked to health savings accounts for selected groups of enrollees.27 These demonstrations are restricted to a defined number of states,

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24 Id.


26 Medicaid previously recognized numerous exceptions to comparability for distinct populations and services, such as pregnant women, persons with tuberculosis, children, persons receiving services under a home and community based care program, and other distinct classes.

27 DRA, §6082.
but the provision allows their continuation indefinitely unless the Secretary can demonstrate adverse outcomes in all demonstration sites. Finally, the DRA expands states’ premium and cost-sharing flexibility for families with children.

Early guidance published on March 31 by the Centers for Medicare and Medicaid Services (CMS) offers only a general assessment of the DRA alternative benefit provisions that offers no explanation of how the benchmark option interacts with the continued EPSDT coverage guarantee. Thus, it is difficult to know with precision which longstanding Medicaid coverage rules beyond such as statewideness and comparability will continue to apply in alternative benefit states, or how these states will be expected to carry out their continuing EPSDT obligations.

In certain respects, the notion of variable coverage is not new. Even though all categorically needy persons were eligible for all benefits, services could be furnished under prior law only if medically necessary. Furthermore, prior to the DRA and HIFA demonstrations, Medicaid managed care arrangements utilized contractual coverage for certain services covered under state plans, while retaining direct, state agency coverage, for certain classes of high cost care (what might be thought of as tiered coverage). This layering of coverage for both children and adults meant that services were configured to be available based on need. For example, a state might enroll low income children and their parents in managed care plans covering comprehensive primary, preventive, and acute benefits, but exclude from its contracts benefits and services used by children and adults with serious and chronic physical and mental health conditions. States also use multi-plan purchasing strategies, offering certain services through a basic plan, and certain advanced treatment systems through plans specializing in particular conditions (e.g., behavioral health plans for persons with severe mental illness).

What is important to stress is that, although this layered approach to coverage can raise certain types of access and coordination challenges, it nonetheless ensures that beneficiaries continued to qualify for all Medicaid services if the medical need arises.

The DRA, as well as the HIFA demonstrations, alter this picture for certain groups of children and adults. Adults can completely lose coverage for many classes of benefits that may be vital in the case of serious illness and disability. Children remain covered for all EPSDT benefits (shown in Figure 5) but only on an undefined “wraparound” basis. CMS guidance does not address the relationship between EPSDT and the new coverage benchmark for children (e.g., “well child” exams); as a result, it is unclear which EPSDT benefits belong in supplemental coverage arrangements and which should be available as part of a basic alternative plan. For example, all children are entitled to developmental assessments as part of a periodic EPSDT exam. Whether an element so intrinsic to routine care for children at risk can be recast simply as part of a “supplemental” level of coverage is a very serious question.

28 “Roadmap to Medicaid Reform” issued by HHS on March 31, 2006. State Medicaid Director Letter 06-608 (March 31, 2006)
29 Negotiating the New Health System, op. cit.
30 In a letter sent to Secretary Leavitt on March 31, the Senate and House leadership on Medicaid reform reiterated their expectation that EPSDT would be preserved as the law was understood at the time of DRA enactment.
The DRA permits states to approach alternative benefit purchasing on the basis of either a limited-benefit contract (with an EPSDT supplement), or alternatively, a defined-contribution that reflects an actuarial value for the enumerated classes of services, with plans responsible for ensuring that coverage meets benchmark standards regardless of actual experience with payment levels. Under this approach, a state might offer plans per capita payment levels that appear to be actuarially equivalent to a benchmark, but that are not necessarily sound in relation to the actual needs of patients. It then would be up to participating plans to design -- and redesign -- their benefit and coverage rules in order to stay within the payment levels offered, regardless of how limited the per capita payments might turn out to be in relation to the promised benefit. In essence, payments would be more akin to a block grant than the type of actuarially sound enrollment fee that is analogous to insurance premiums.

Medicaid & Defined Contribution Plans
GWU/SPHHS (September, 2006)

Defined- Contribution and Limited-Benefit Coverage:
Assessing the Population and System Implications for Medicaid

In this developing Medicaid coverage environment, states electing to pursue DRA, HIFA, or other §1115 demonstration flexibility face many important questions related to benefit and coverage design:

• which classes and categories of benefits to cover;
• whether to permit certain types of coverage limitations and exclusions that are a feature of health insurance products for non-Medicaid populations (such as limits on coverage for certain conditions, exclusion of coverage considered “educational” or “social,” and fixed limits on certain benefits); and
• how to define medical necessity, particularly in the context of children and adults with serious and chronic physical, mental, and developmental conditions.32

In this respect, deciding whether to restrict Medicaid coverage either through defined-contribution or limited-benefit strategies raises a number of important issues. 33 Both approaches can result in serious consequences for beneficiaries and the health care system on which they rely.

1. The economic and health status of Medicaid beneficiaries

As noted, the Medicaid populations most affected by this evolving approach to coverage (whether carried out through the DRA or §1115 demonstrations including HIFA) are families with children. Demographically, children and parents enrolled in Medicaid may resemble the employed population. But in many cases, their overall health and economic status sets them apart. Figure 6 shows that in general, Medicaid beneficiaries are sicker than the general population of privately insured persons.

32 Negotiating the New Health System op. cit.
33 Since 1995 the Department of Health Policy has maintained a broad range of projects aimed at assisting states engaged in managed care purchasing. The Department’s analyses and purchasing tools can be viewed at http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/ (sample purchasing specifications) and http://www.gwumc.edu/sphhs/healthpolicy/nnhs4/ (multi-state analyses of purchased products).
These differences in health status persist, even when the Medicaid beneficiary population is further stratified by eligibility pathway; that is, when one considers only beneficiaries who gain their Medicaid coverage through eligibility pathways other than disability status.

Figures 7A and 7B underscore the reduced health status of even those Medicaid beneficiaries who bear a demographic resemblance to the population with employer-based health insurance. Figure 7A shows that only half of all adults with a disabling condition enter Medicaid through the Supplemental Security Income (SSI) program, underscoring the extent to which even “able-bodied” Medicaid adults experience significant health problems. The situation is even more pronounced in the case of children: only 15 percent of children with functional health limitations enter Medicaid as SSI recipients. The vast majority of children with significant physical, mental, or developmental conditions in fact are enrolled in Medicaid through categories associated with healthy children.
In sum, these data suggest that even when a purchasing initiative attempts to exempt persons who are known to have a serious health condition linked to disability status, it is likely that the compulsory enrollment group will include many -- and in the case of children, the overwhelming majority of -- beneficiaries with functional limitations. For low income people
with disabilities, defined benefits are of critical importance as a quality and safety measure, because their health care needs, utilization patterns, and available resources may bear little to no resemblance to actuarial norms for working age families with children. Indeed, at least one study has estimated that families linked to welfare have per capita costs under Medicaid nearly 25% greater than their privately insured counterparts.\(^{34}\)

Given their higher health risks, Medicaid beneficiaries can be expected to have significantly elevated health care needs, and limited-benefit and defined-contribution strategies can leave health plans without the resources to properly manage their care. In other words, for the Medicaid population, which is characterized by poverty and reduced health status, a restrictive approach to coverage design can create significant quality and safety concerns.

2. The potential for benefit gaps and the loss of coverage for critical health care needs

Limited-benefit and defined-contribution strategies elevate the risk of significant coverage gaps. The benchmark equivalency standard under the DRA offers only narrow coverage, omitting among other benefits and services, prescription drugs, rehabilitation services, diagnostic services, and durable medical equipment. Considering the health status of adults enrolled in Medicaid and their higher health costs, use of a benchmark equivalency standard could result in coverage in name but not in impact. A recent study of the impact of limited coverage under a HIFA waiver found that persons eligible for the coverage continued to experience serious gaps in health care and serious health care shortages; indeed, more than three quarters reported health care needs that went well beyond their coverage.\(^{35}\)

The problem of limited benefits for Medicaid populations can go well beyond the impact on children and adults with known and serious conditions. Patients, health professionals, and health plans can find that coverage is seriously inadequate as a result of unanticipated health emergencies (such as a pandemic influenza outbreak or other severe population-wide health threat) or membership in plans holding more members with poor health than originally projected by a state agency, and thus higher levels of health expenditures for care. In other words, a defined-contribution model significantly heightens the financial risks facing Medicaid-participating health plans.

Where children are concerned, benchmark coverage might be supplemented with EPSDT wraparound benefits. But if the benchmark is set too low -- or is steadily revised downward as the result of a defined-contribution approach that effectively pressures health benefit plans to continuously reduce coverage in relation to an artificially fixed premium -- then children’s health care costs simply are shifted to the EPSDT wraparound. Furthermore, the pressure to squeeze coverage in relation to actual need will be most acutely experienced by children with functional health limitations and elevated health care needs. Figure 7B suggests that simply exempting children who have been formally determined to be disabled from benchmark arrangements may

\(^{34}\) W.P. Welch and M. Wade, 1995. “The Relative Cost of Medicaid Enrollees and the Commercially Insured in HMOs,” \textit{Health Affairs} 14:2 212-23 (Summer)

\(^{35}\) “Can States Stretch the Medicaid Dollar?” op. cit.
have limited impact, since these children represent only a minority of all children with functional limitations.

Furthermore, were a state to opt for a limited-benefit or defined-contribution strategy, supplemented by EPSDT wraparound benefits, many pediatric health services important for children with growth and developmental delays effectively could be moved out of basic coverage and into “wraparound” status. Because these services and benefits would be *extracontractual* (i.e., outside of the scope of the limited-benefit arrangement) both health plans and families could find that they are far harder to secure. *Appendix A* underscores the considerable differences between EPSDT and a commercial benchmark plan. Even when care is secured, it may be disjointed as a result of different provider networks, standards of care, and payment disputes between the two coverage arrangements regarding which payer bears primary responsibility for children with high health needs, especially if the two systems use different criteria to determine when health care is medically necessary. Indeed, in calculating the savings resulting from the use of benchmark plans, the Congressional Budget Office concluded that EPSDT services, while still covered, would be more limited in an access context because of the difficulties associated with navigating multiple sources of coverage that use different networks, different coverage standards, and different means of arranging for care.

3. The importance of attracting and maintaining a strong and competitive health plan market for Medicaid beneficiaries

In establishing purchased health benefit systems, states have consistently expressed interest in attracting companies with a strong records of performance, experience in selling health benefit services to a wide range of purchasers in many markets, and the ability to develop and manage high quality networks. Who stays and who leaves the Medicaid market among health plans is affected by many factors, one of which is the design of contractual coverage and another of which is the use of actuarially sound principles to guide coverage and payment decisions made by purchasers. The degree to which a contract permits companies to evaluate the potential for high quality performance in a market by comparing purchaser expectations and payments is an important consideration in market entry and exits.

Comprehensive service and benefit expectations, along with the sound payment principles to back them up, are important to the relationship between states and health plans. Health plans seek to offer comprehensive products with the ability to improve health care and health outcomes. Restrictive benefits, as well as approaches to coverage that use fixed contributions that may not be sufficient to maintain promised benefit levels, create an environment in which plans have inadequate resources in relationship to member need and ultimately make the inevitable decision to exit the market. The result is a less, rather than more, competitive environment for publicly supported health benefit purchasing.

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4. The importance of comprehensive benefits in attracting and maintaining a strong provider network

By integrating coverage and care, today’s health benefit plans represent a potentially important advance for Medicaid beneficiaries who historically have experienced serious health care access barriers, particularly with respect to specialty care. Central to sound plan operations is a high quality and adequate network of primary and specialty care providers, health care service providers, and health care institutions. Health plans must be able to promise comprehensive coverage and adequate payment levels in order to be able to create such a network. To that end, reasonable payment levels – indeed, any payment -- for health care furnished to plan members is dependent on comprehensive coverage design.

Both limited-benefit and defined-contribution strategies to Medicaid coverage create the risk that health plans will be unable to attract and sustain strong and capable provider networks. In a limited coverage environment, even were a plan to offer relatively high payment levels and financial incentives, limited coverage rules would leave providers without an assured means of financing necessary care, especially in the case of children and adults whose health conditions are more serious and chronic and who therefore need care of greater intensity and duration.

5. The importance of purchasing arrangements that advance cross-plan accountability for efficiency and patient safety and quality

Uniform, strong, and statewide coverage arrangements built on a comprehensive benefit design and actuarially sound payment rules are essential to market-oriented, consumer-driven, performance based purchasing reforms. Without sustainable financing, good coverage, and comparability across regions, it is very difficult for states to build a market or pursue comparative effectiveness measurement of plan performance, particularly in the case of initiatives that target sparsely populated areas or populations with higher health needs. Furthermore, it is not possible to hold health plans to high quality care standards if the underlying coverage scheme does not support adequate levels of health care regardless of geographic location or other factors unrelated to the need for care. For example, it would not be possible to hold plans accountable for the effective management of depression where the coverage scheme excludes treatment for mental illness and substance abuse, a common co-occurring condition.

In a health system characterized by concepts of efficiency and high performance, the goal is to measure the costs and performance of competing health systems that have been given sufficient resources with which to work. A limited-benefit strategy that permits reduced coverage in certain geographic regions leaves policy makers with no realistic way to compare the quality and efficiency of plan performance. Plans serving under-insured populations in low-coverage regions are left without needed resources to create high quality health systems.

Furthermore, rather than stimulating markets, strategies that turn on significantly limited coverage -- or on payments that have been locally de-linked from coverage rules altogether -- can hinder efforts to measure performance and improve outcomes. Quality purchasing has become a hallmark of Medicaid program managed care initiatives. But plans cannot be held to comprehensive performance expectations of the type found in quality benchmarking systems as HEDIS® and other measurement tools if benefit coverage is so variable and limited.

**Conclusion**

As Medicaid’s evolution into a purchaser of coverage products proceeds, it is important that the purchasing strategies that emerge combine innovations with accountability, patient safety, and the ability to measure efficiency, costs, and quality within markets. Furthermore, given the health status of Medicaid beneficiaries, purchasing strategies need to be formulated with a full appreciation of beneficiary health risks and needs, as well as the value of empowering health plans to attract and keep high quality health care providers. The use of purchased coverage arrangements under Medicaid continues to evolve. Whether this evolution produces strengthened and competitive health systems that are capable of furnishing comprehensive care to the population will ultimately depend in great part on the benefit design approach chosen by states. Limited-benefit and defined-contribution strategies that appear to offer an attractive approach to trimming Medicaid costs ultimately may lead to serious gaps in coverage and care, the loss of participating plans and providers, and undermine rather than advance population health status.

The challenge facing Medicaid purchasers is to maintain a comprehensive approach to coverage design, while incentivizing participating plans and providers to seek efficiencies in the provision of appropriate health care. This type of approach is built on sound financing tied to a thoughtful approach to coverage design structure, a careful approach in combining basic coverage with supplemental benefits for certain high need populations, and the integration of quality purchasing strategies to promote high performance. This approach takes time but holds promise in yielding improved quality, healthier outcomes in a more cost-effective manner.
## Appendix A. Comparing EPSDT and Benchmark Equivalent Coverage

<table>
<thead>
<tr>
<th>EPSDT</th>
<th>Benchmark Equivalent Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Periodic and “as needed” screening services that include:</strong></td>
<td>Well-baby and well-child care, including age-appropriate</td>
</tr>
<tr>
<td>• Unclothed physical examination</td>
<td>immunizations</td>
</tr>
<tr>
<td>• Comprehensive health and developmental history (including assessment of both physical and mental health development)</td>
<td>• Required at full actuarial equivalence</td>
</tr>
<tr>
<td>• Immunizations recommended by the CDC advisory committee on immunization practices (ACIP)</td>
<td>• Undefined in content</td>
</tr>
<tr>
<td>• Laboratory tests including assessment of blood lead levels</td>
<td>• Undefined in frequency</td>
</tr>
<tr>
<td>• Health education and anticipatory guidance</td>
<td></td>
</tr>
<tr>
<td><strong>Vision services (periodic and as needed)</strong></td>
<td>Vision services</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Not required</td>
</tr>
<tr>
<td>• Diagnosis</td>
<td>• Undefined in content</td>
</tr>
<tr>
<td>• Treatment, including eyeglasses</td>
<td>• If furnished, 75% of actuarial value</td>
</tr>
<tr>
<td><strong>Hearing services (periodic and as needed)</strong></td>
<td>Hearing Services</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Not required</td>
</tr>
<tr>
<td>• Diagnosis</td>
<td>• Undefined in content</td>
</tr>
<tr>
<td>• Treatment, including hearing aids and speech therapy</td>
<td>• If furnished, 75% of actuarial value</td>
</tr>
<tr>
<td><strong>Dental services (periodic and as needed)</strong></td>
<td>Other appropriate preventive services as designated by HHS</td>
</tr>
<tr>
<td>• Preventative beginning not later than age 3 or earlier if medically indicated</td>
<td>• Required but only at Secretarial discretion</td>
</tr>
<tr>
<td>• Restorative beginning not later than age 3 or earlier if medically indicated</td>
<td>• Undefined in frequency or content</td>
</tr>
<tr>
<td>• Emergency care beginning not later than age 3 or earlier if medically indicated</td>
<td>• If required by secretary, full actuarial value</td>
</tr>
<tr>
<td><strong>Diagnostic and treatment services that are medically necessary and the need for which is disclosed by a periodic or interperiodic screen</strong></td>
<td>Hospital, physician, and laboratory services</td>
</tr>
<tr>
<td>• Standard of coverage: early, to correct or ameliorate defects and physical and mental health conditions discovered by screening services, whether or not such services are covered under the state medical assistance plan. These services include:</td>
<td>• Required</td>
</tr>
<tr>
<td>• Physician services</td>
<td>• Undefined in frequency and standard of coverage</td>
</tr>
<tr>
<td>• Hospital Services (outpatient and inpatient)</td>
<td>• Full actuarial value</td>
</tr>
<tr>
<td>• Federal qualified health center services</td>
<td></td>
</tr>
<tr>
<td>• Rural health clinic services</td>
<td>Prescription drugs</td>
</tr>
<tr>
<td>• Family planning services and supplies</td>
<td>• Optional</td>
</tr>
<tr>
<td>• Medical care or any other type of remedial care recognized under state law or furnished by</td>
<td>• Undefined</td>
</tr>
<tr>
<td>• Laboratory and x-ray services</td>
<td>• 75% actuarial value</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Benchmark Equivalent Coverage</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>licensed practitioners within the scope of their practice; as defined by state law</td>
<td>• Required</td>
</tr>
<tr>
<td>• Home based care</td>
<td>• Undefined</td>
</tr>
<tr>
<td>• Private duty nursing services</td>
<td>• Full actuarial value</td>
</tr>
<tr>
<td>• Dental services</td>
<td></td>
</tr>
<tr>
<td>• Clinic services</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy and related services</td>
<td></td>
</tr>
<tr>
<td>• Prescribed drugs</td>
<td></td>
</tr>
<tr>
<td>• Dentures</td>
<td></td>
</tr>
<tr>
<td>• Prosthetic devices</td>
<td></td>
</tr>
<tr>
<td>• Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial service (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Services in an intermediate care facility for the mentally retarded and inpatient psychiatric services for individuals under age 21</td>
<td>• Optional</td>
</tr>
<tr>
<td>• Nurse midwife and certified pediatric nurse practitioner services to the extent that such services are authorized under state law</td>
<td>• Undefined</td>
</tr>
<tr>
<td>• Case management</td>
<td>• 75% actuarial value</td>
</tr>
<tr>
<td>• Respiratory care</td>
<td></td>
</tr>
<tr>
<td>• Personal care services</td>
<td></td>
</tr>
<tr>
<td>• Any other medical or remedial care recognized by the Secretary of Health and Human Services</td>
<td></td>
</tr>
</tbody>
</table>