Deficit Reduction Act Important Facts for State Policymakers

February 21, 2008

State Flexibility in Benefit Packages

The Deficit Reduction Act of 2005 allows States to vary the Medicaid benefit packages available to Medicaid beneficiaries.[1]

Background

Prior to passage of the Deficit Reduction Act (DRA) of 2005, Medicaid statute and regulations required States to cover specific services and allowed States the option to cover additional services for all of their Medicaid beneficiaries. DRA Section 6044 provides a unique opportunity for States to design a set of Medicaid services as an alternative benefit package to specified Medicaid–covered populations.

Benefit Packages under the Deficit Reduction Act

States now have the option to provide different "benefit packages" to certain populations. These benefit packages do not need to follow Medicaid's traditional rules requiring statewideness[2], freedom of choice, or comparability. The coverage can be modeled on "benchmark" or "benchmark equivalent" plans.

Benchmark Plans

The alternative benefit packages may be based on any of the following benchmark plans:

(1) the standard Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefit Plan
(2) the HMO plan with the largest commercial, non-Medicaid enrollment in the State
(3) any generally available State employee plan (regardless of whether any State employees select the plan)
(4) any plan that the Secretary of HHS determines to be appropriate

Benchmark Equivalent Plans

To be considered a benchmark-equivalent plan, the benefit package must include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, well baby and child care (including immunizations), and "other appropriate preventive services" designated by the Secretary of HHS.[3] Thus, it is possible for services such as prescription drugs, dental, mental health, vision and hearing services to be excluded.

A State may also choose to provide wrap-around benefits in addition to the benchmark or benchmark-equivalent plans.

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[1] Most eligible healthy children and parents may be enrolled into these benchmark benefit plans on a mandatory basis.
[2] Generally Medicaid beneficiaries throughout the State must receive the same scope of services.
[3] To date, the Secretary has not required that any additional services be made available.

Who May Be Covered?

- Full Benefit Eligibles in eligibility categories established under the State Plan on or before February 8, 2006
- Children under Age 19. These children must also have access to EPSDT benefits currently required under Title XIX[4]

States may allow, but *cannot* require individuals to obtain benefits through this option if they are:

- Mandatory pregnant women
- Blind or disabled individuals
- Dual eligibles
- Hospice patients
- Institutionalized individuals
- Medically frail and special needs individuals
- Children receiving Title IV-B social welfare services on the basis of being a child in foster care or Title IV-E foster care or adoption assistance
- Individuals in need of long-term care services
- Individuals eligible under the breast or cervical cancer group
- Individuals who qualify for Medicaid solely on the basis of qualifying for TANF
- Individuals not eligible for the full scope of Medicaid benefits

If your State is considering health reform, or other innovations in Medicaid, what should you think about?

Populations Covered

- Which populations will be offered the benchmark plan benefit package by the State?
- Can the State require mandatory enrollment for these populations, or must it be a voluntary opt-in due to their eligibility category?
- How will the State inform voluntary opt-in populations of their options, including a comparison to the benefits under the traditional State plan?

Benefits

- What benefits will the State offer under the new benefit packages?
- Which benchmark or benchmark equivalent plan will the State provide?
- Will the State provide wrap-around benefits in addition to the benchmark or benchmark equivalent plan?
- Will State legislative changes to the Medicaid program be necessary to implement the new benefit packages?

Delivery System

[4] If the benchmark or benchmark-equivalent benefit package does not offer EPSDT benefits, the State must provide wrap-around coverage to ensure that children have access to those services.

- What type of delivery system will be utilized for the new benefit packages? Possible delivery systems include managed care, fee-for-service, premium assistance, or a combination.
- Will the State leverage the private market by including employer sponsored health insurance in the benchmark?

Important Links

State Medicaid Directors Letter on DRA § 6044
http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp#TopOfPage

Alternative Benefits State Plan Amendment Preprint template
http://www.cms.hhs.gov/smdl/downloads/6044benchmarkpreprint.pdf

Approved State Plan Amendments for States with Alternative Benefit Packages
http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp#TopOfPage