



# The Center for Children and Families

March 2006

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## **THE DEFICIT REDUCTION ACT: A Review of Key Medicaid Provisions Affecting Children and Families**

The Deficit Reduction Act (DRA), signed into law by President Bush on February 8, 2006, includes significant changes to Medicaid coverage rules affecting children and families. A number of these changes weaken the minimum federal standards for care that families receive through Medicaid. Since states can choose whether or not to rely on the weaker federal standards and face many choices if they do decide to make program changes, the ultimate effect of the DRA on children and families will depend largely on state response to the new program options.

## **KEY PROVISIONS**

This issue brief reviews the following Medicaid provisions in the DRA that affect children and families:

- **Changes in the Medicaid benefit standards.** Under a new option, states can provide a reduced package of benefits to some parents and most children in Medicaid. For children, states must supplement the reduced package of benefits to ensure they receive medically necessary care.
- **Changes to federal cost sharing and premium standards.** State will have new authority to impose charges on low-income children and parents for using care and enrolling in coverage.
- **New citizenship documentation requirement.** States face a new mandate to require current Medicaid beneficiaries and people newly seeking coverage to document their citizenship status.
- **“Health Opportunity Account” demonstrations.** Up to ten states will be allowed to experiment with high-deductible Medicaid coverage that is coupled with personal spending accounts.

While this analysis reviews these new rules separately, the interactive effect on children and families will need to be considered as states move forward. Together, these changes could shift more costs to low-income children and their families and make it more difficult for them to enroll in coverage and secure access to needed care.<sup>1</sup>

## CHANGES IN FEDERAL BENEFIT STANDARDS

The DRA makes major changes in the federal minimum standards that determine the benefits that states must provide to Medicaid beneficiaries. Depending on whether and how states implement these options, low-income parents could be left with substantially reduced benefit packages and children could face new barriers to securing medically necessary care.

### Pre-DRA Law

States must cover certain “mandatory” medical services for adults in Medicaid, such as hospital and physician care. Other services, such as prescription drugs and speech or physical therapy, are covered at state option. Within federal guidelines, states may impose limits on the scope of the services they will cover; for example, some states cap the number of inpatient hospital days or prescription drugs they will cover. Once a state decides which services it will cover, it must generally offer that coverage to all enrollees statewide.<sup>2</sup> Beneficiaries, however, are only covered for a particular service if they actually need the care, as determined by state and federal program standards.

The minimum standards that apply to children in Medicaid are stronger. These standards, known as the Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit, require states to:

- Cover age-appropriate checkups (including health, vision, and dental) and take steps to assure that children receive these check ups; and
- Cover any service that a child is found to need if it is care that could be covered under Medicaid. Under EPSDT, therefore, if a child is determined to need medical care, the service limits that a state might otherwise apply to adults cannot be applied to that child.

### The New DRA Option

The DRA creates a new benefits option for states. Under this option many of the benefit rules, including the rules regarding “mandatory” and “optional” services and statewide coverage, would no longer apply. Instead, states may enroll children and parents into “benchmark” or “benchmark-equivalent” plans that provide a limited package of benefits. Under the new option, however, children must still be provided EPSDT benefits either directly through the benchmark or benchmark equivalent plan or separately.

#### ■ New option applies to children and families.

The new option applies to most children enrolled in Medicaid and to some parents and pregnant women. Certain groups are exempt, including children in foster care, parents receiving TANF,<sup>3</sup> and children and adults who are eligible for Medicaid based on a disability (this does not exempt all those with disabilities — just people who are enrolled in Medicaid on the basis of their disability).<sup>4</sup>

■ **Broad flexibility to provide different benchmark benefit packages to different people.** States can decide which groups of families will be enrolled into these new plans; they can have multiple plans; and they can have different plans in different parts of the state. For example, a state could require families who work for certain employers to enroll in a benchmark plan that is available only through those employers, or it could limit enrollment into benchmark plans to families who live in rural areas of the state.<sup>5</sup>

■ **New option cannot be used for coverage expansions.** The benchmark benefits option can be applied only to eligibility groups established prior to the date of enactment (February 8, 2006). This limitation may discourage states from using the new benefit flexibility.

■ **Broad authority to design benchmark plans.** Any coverage plan that meets or is equivalent to one of four “benchmarks” is permitted. The “benchmarks” are essentially the same as those that apply to children under the State Children’s Health Insurance Program (SCHIP).<sup>6</sup> They are:

- The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP);
- Any state employee plan generally available in a state, without regard to whether most or any state employees sign up for that plan;
- The HMO plan that has the largest commercial, non-Medicaid enrollment in the state;
- Any plan determined to be appropriate by the Secretary of Health and Human Services (HHS).

Two of these standards — the state employee plan (without regard to actual take-up by state employees) and Secretary-approved coverage — offer little in the way of objective benefit standards. In addition, the statutory language appears to provide states broad authority to determine many of the other rules governing “benchmark plans,” such as whether Medicaid managed care consumer protections or federal rules regarding whether the rates paid to these plans must be “actuarially sound” will apply.<sup>7</sup>

■ **Children must have coverage for the services required under EPSDT.** A state that enrolls families into a benchmark plan must provide children with an EPSDT “wrap-around benefit.”<sup>8</sup> While there has been considerable controversy about this provision and its exact meaning, Congressional leaders and CMS Administrators have stated that the DRA leaves EPSDT guarantees intact. States are not obligated to supplement the coverage provided to parents or pregnant women (unless they are under age 19).

■ **Effective dates.** The benefits option becomes effective January 1, 2007.

### Key Implications

The implications of the new benefit flexibility will depend on whether states decide to implement the new option and the kinds of plans they rely on if they do pick up the new option. In addition, the scope and impact of changes that result from the benefit flexibility will depend on how the new statutory language is interpreted by CMS and, ultimately, the courts.

The new plans could operate similar to the way many states with managed care currently design their Medicaid delivery systems. When a Medicaid managed care plan does not cover all of the services that Medicaid offers, states provide the additional services as a wrap-around to the managed care plan. A state with a benchmark plan could provide wrap-around EPSDT services to children in similar ways.

The practical consequences of the new provision, however, could be very different in states that allow different types of plans to operate. For example, it appears that a state could provide vouchers to families to enroll in any medical plan that is equivalent to a state benchmark. These might be employer-based plans, individual market plans, or new health plans that insurers market to Medicaid families. In these types of arrangements — where there are multiple plans with which the state might not have any direct or extensive contractual relationship — ensuring the wrap-around benefit and continuity of care might prove complex and difficult for the state as well as for families and providers.

In any of these types of arrangements, parents could be left with the more limited benefits covered under the benchmark.



## SECTION TWO

### CHANGES TO FEDERAL COST SHARING RULES

The DRA gives states significant new authority to impose charges on Medicaid beneficiaries, including children and parents living in poverty. The Congressional Budget Office has estimated that the new authority will cause millions of Medicaid beneficiaries to face new or higher cost sharing charges that reduce their use of care, as well as some 65,000 people to lose coverage altogether as a result of premiums.<sup>9</sup> If, however, states opt to not use the new flexibility or to do so only sparingly, the implications of the cost sharing changes could be made far more modest.

#### Pre-DRA Rules

Currently, federal rules prohibit states from requiring low-income children or their parents to pay a fee, such as a monthly premium, to enroll in Medicaid coverage. States also are barred from imposing co-payments on children in Medicaid. Parents and most other adults can be charged up to \$3 for using a Medicaid service or filling a prescription, but providers are not allowed to deny them care if they are unable to pay (although they remain liable for the charge).

#### DRA Provisions

The DRA makes significant changes to the federal rules governing the amount that children and their parents can be charged to use Medicaid services and, in some instances, to enroll in coverage.

- **New and higher charges allowed for children and parents.** For the first time, states will be allowed to impose cost sharing on children. For their parents, the DRA gives states authority to increase the charges that they face. The specific rules governing the amount that states can charge are complex and depend on a Medicaid beneficiary's age, income, and the service that they need (see tables on following page). The DRA also allows states to impose premiums on parents and children, but only if they have income above 150 percent of the Federal Poverty Level (FPL) (\$24,900 for a family of three, 2006).
- **New state option to deny care for non-payment.** The DRA allows states to permit providers to deny care to someone who does not meet a cost sharing obligation, even if they are unable to pay. On premiums, states will be allowed to require prepayment of premiums before individuals enroll and to terminate coverage if the individual (or, in the case of a child, his or her parent) does not pay within 60 days.
- **State flexibility to vary premium and cost sharing charges among Medicaid beneficiaries.** Under pre-DRA cost sharing rules, states generally must provide comparable treatment to all Medicaid beneficiaries on a statewide basis (e.g., a state that imposes a co-payment on prescription drugs cannot opt to do so for children with ADHD, but not for those with asthma). Under the DRA, states can vary the premiums and cost sharing that they charge by and within groups (as defined by a state), by geographic area, and by type of service. For example, a state that requires counties to contribute to the cost of Medicaid might allow the level of cost sharing (within federal guidelines) to vary by county.
- **Effective dates.** The new federal premium and cost sharing standards go into effect on March 31, 2006, except that new rules governing cost sharing for non-emergency use of an emergency room are effective January 1, 2007.

## Key Implications

The implications of the changes to federal cost sharing and premium standards will depend on states' response to the new flexibility. If states aggressively use the new flexibility as a means for reducing Medicaid spending growth, low-income children and families can be expected to miss out on needed care or drop out of coverage altogether. A comprehensive body of literature confirms that even relatively

modest-sounding cost sharing charges and premiums can deter low-income families from using necessary services and enrolling in care.<sup>10</sup> Unintended consequences, including higher rates of hospitalization or more use of emergency room care, could result. If, however, states opt not to use the new options or they use them sparingly and in targeted ways, the implications of these changes for low-income children and families will be far more modest.

### FEDERAL COST SHARING STANDARDS FOR CHILDREN IN THE DRA

	<b>“Mandatory” Children*</b>	<b>Other Children with Family Income up to 150% FPL</b>	<b>Other Children with Family Income Above 150% FPL</b>
<b>Most services</b>	No charges allowed	Up to 10% of the cost of the service	Up to 20% of the cost of the service
<b>Prescription drugs***</b>	Up to \$3 for non-preferred/ \$0 for preferred	Up to \$3 for a non-preferred/ may charge less for preferred	Up to 20% of cost for non-preferred/may charge less for preferred
<b>Non-emergency use of an ER</b>	Up to \$6	Up to \$6	Any amount
<b>Preventive services</b>	No charges allowed	No charges allowed	No charges allowed
<b>Aggregate cap on charges</b>	No aggregate cap	5% of monthly or quarterly income	5% of monthly or quarterly income
<b>Premiums</b>	Not allowed	Not allowed	Allowed (no upper limit except 5% aggregate cap)

### FEDERAL COST SHARING STANDARDS FOR PARENTS IN THE DRA

	<b>Parents with Family Income below 100% FPL</b>	<b>Parents with Family Income between 100% and 150% FPL</b>	<b>Parents with Family Income Above 150% FPL</b>
<b>Most services</b>	DRA is unclear**	Up to 10% of the cost of the service	Up to 20% of the cost of the service
<b>Prescription drugs***</b>	Up to \$3 for non-preferred/ states may charge less for preferred	Up to \$3 for non-preferred/ states may charge less for preferred	Up to 20% of cost for non-preferred/may charge less for preferred
<b>Non-emergency use of an ER</b>	Up to \$6	Up to \$6	No upper limit
<b>Preventive services</b>	Up to \$3 (No special limits)	Up to 10% of the cost of the service	Up to 20% of the cost of the service
<b>Aggregate cap on charges</b>	No cap	5% of monthly or quarterly income	5% of monthly or quarterly income
<b>Premiums</b>	Not allowed	Not allowed	Allowed

\* “Mandatory children” include children under age six with family income below 133 percent of the federal poverty level and children ages six to 17 with family income below 100 percent of the federal poverty level. (For purposes of the cost sharing and premium provisions of the DRA, 18-year olds are treated as adults.) The rules that apply to mandatory children also apply to children (without regard to age) for whom Title IV foster care or adoption assistance is being provided.

\*\* Due to an apparent drafting error, the DRA does not explicitly establish any new federal standards governing cost sharing for parents below 100% of the poverty line. The drafters of the bill, however, have stated that their intent was to limit cost sharing to nominal levels (indexed by medical inflation beginning in 2006) and Administration officials have suggested that this may be how they interpret the law.

\*\*\*States have the authority to decide which medications are preferred versus non-preferred. If a physician determines that a non-preferred medication is not as effective or would have adverse effects (or both), it must be made available to a beneficiary at the same charge as the preferred medication.

Beginning in 2006, all maximum allowable charges are indexed by medical inflation.



## SECTION THREE

### NEW REQUIREMENT TO DOCUMENT CITIZENSHIP STATUS

Under the DRA, states must begin requiring citizens applying for or renewing Medicaid coverage to document their citizenship status, adding to the paperwork burden faced by children and parents in need of Medicaid. Unlike many of the other Medicaid changes in the DRA, the new documentation requirement is not optional for states, although they may be able to work with community groups and others to ease its negative impact.

#### Pre-DRA Provisions

States have the option of allowing citizens who are applying for Medicaid to “self declare” in writing, under penalty of perjury, that they are citizens. Applicants who are immigrants must provide proof of their legal immigration status. In the past, CMS has actively encouraged states to use the self-declaration option for citizens and to then verify the accuracy of the declarations by checking their vital statistics databases or through other kinds of post-eligibility reviews. Nearly all states (47) now take advantage of the self-declaration option for citizens.<sup>11</sup>

#### DRA Provisions

The DRA mandates that states require all citizens applying for Medicaid on or after July 1, 2006, to provide documentation of their citizenship status. People who are already enrolled must provide such documentation when their coverage comes up for renewal. For children, the provision is generally expected to mean that their families, at a minimum, will be required to provide a copy of their birth certificate to the Medicaid agency. Most parents seeking coverage for themselves will need to produce both their driver’s license and birth certificate.<sup>12</sup>

#### Key Implications

The new documentation requirement will make applying for and renewing Medicaid more complicated for citizen children and their families, increase the cost and burden to states of evaluating Medicaid eligibility, and adversely affect health care providers whose patients face delays in securing coverage or miss out on it altogether. The magnitude of the negative effect will depend, in part, on the way that the new requirement is implemented. For example, the Secretary of HHS has some discretion to broaden the list of documents that can be used to prove citizenship status. State and local officials, as well as community groups, may also be able to ease implementation of the new documentation requirement by educating people about it and helping them to gather the necessary paperwork before they apply for Medicaid or seek renewal of their coverage.

## HEALTH OPPORTUNITY ACCOUNT DEMONSTRATIONS

Up to ten states will be permitted to experiment by allowing Medicaid beneficiaries to enroll in high deductible Medicaid coverage coupled with a personal spending account, known as a “Health Opportunity Account.” These type of high deductible plans and personal accounts are relatively new to the private market and largely untested, particularly among low-income people who are disproportionately in poor health.

### Pre-DRA Provisions

Medicaid rules prevent states from imposing high deductibles on Medicaid beneficiaries. There are no provisions allowing states to create personal accounts with Medicaid funds that can be used for health care services.

### DRA Provisions

The DRA authorizes a new demonstration program for ten states to establish “Health Opportunity Accounts” (HOAs) for a five-year period beginning January 1, 2007.<sup>13</sup> The intent of the demonstration is to “create patient awareness” of the high cost of medical care, “reduce inappropriate use of health care services,” and “enable patients to take responsibility for health outcomes.” Children and some parents are the primary group of Medicaid enrollees that could participate — persons over 65, people eligible for Medicaid based on a disability, pregnant women, parents on TANF, and new enrollees are exempt for the first five years. The act gives the Secretary of HHS the authority to implement these new accounts nationwide after five years.

Under such a demonstration, states (using federal and state Medicaid dollars) would make a contribution to a Health Opportunity Account for families to use for health care expenses. In exchange, the state’s Medicaid coverage for these families would be subject to a substantial deductible before Medicaid coverage became available. The size of the deductible could vary by family income level, but could not exceed \$1,000 per child or \$2,500 per adult. The amount of the state’s contribution to the HOA could be equal to 90-100 percent of the deductible amount. In other words, a state could choose to establish a deductible of \$1,000 per child but place only \$900 in the account. Families would use these accounts to cover medical expenses but would face a potential liability of \$100 per

child (\$250 for adults) if expenses exceeded the amount in their account. Participation in the demonstration would be voluntary for families.

Families could use the funds in their accounts for health care services, including services not covered by Medicaid. After they become ineligible for Medicaid, beneficiaries could keep 75 percent of their remaining funds for a period of up to three years. They could use these “leftover” funds for health care expenses or, at state option, other expenses, such as education and job training.

### Key Implications

The implications of the HOA demonstration program will depend on the number of states that elect the option, as well as the response of families in those states. For families who voluntarily enroll, the implications will largely depend on their health care needs.

A low-income mother with two children who signs her family up for an HOA could face up to \$450 in out-of-pocket costs (\$250 for herself and \$100 for each child) if her account is depleted. For many low-income families on Medicaid, such costs would deter them from securing needed care. If, however, the family has minor health care expenses, the account could provide some additional help with costs after leaving the program or allow them to purchase services not covered by Medicaid. For states, HOA demonstration waivers could prove costly because HOAs are likely to attract people with modest health care costs who could be cheaper to serve through the traditional Medicaid program. Also, “leftover” funds can be used by people even after they no longer qualify for Medicaid, which effectively means states can end up paying for health care for people who are ineligible for Medicaid.<sup>14</sup>



## CONCLUSION

The changes to the Medicaid program for children and families included in the DRA were aimed at producing federal budget savings and promoting state flexibility, not at strengthening and improving coverage for children and families. As such, they represent a potential setback in coverage for low-income children and their parents, particularly in states that make extensive use of the new options or combine benefit cuts with increases in cost sharing. However, with the notable exception of the new citizenship documentation requirement, the DRA does not mandate changes that adversely affect low-income children and their families. As a result, the ultimate effect on low-income children and families of the Medicaid provisions of the law will depend heavily on the choices made by state policymakers.

## ENDNOTES

- 1 The DRA includes additional provisions affecting children and families that are not reviewed here. These include a new state option to extend Medicaid to disabled children in middle-class families, a limited redistribution of State Children's Health Insurance Program (SCHIP) funds, some restrictions on SCHIP waiver authority, and an extension of transitional Medicaid for families. For a comprehensive review of all changes see the Congressional Research Service Report for Congress, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, January 30, 2006 available at [http://openncrs.cdt.org/rpts/RL33251\\_20060130.pdf](http://openncrs.cdt.org/rpts/RL33251_20060130.pdf).
- 2 States may offer a narrower set of benefits to people enrolled through "Medically Needy" categories; these are people who are covered at state option and who have particularly high medical expenses relative to their incomes.
- 3 The statutory language governing which parents are subject to the new benefit flexibility is flawed, but, according to the conference report prepared on the DRA, the intent of the language is to exempt parents receiving TANF assistance.
- 4 The exempt groups are listed at Sec. 1937(a)(2)(B).
- 5 Individuals cannot be required to enroll in benchmark plans unless they have access to services provided through federally qualified health centers or rural health centers.
- 6 For a description of how the federal SCHIP benefit standards differ from the Medicaid standards pre-DRA, see C. Mann and E. Kenney, *Differences That Make A Difference*, Center for Children and Families, October 2005. <http://ccf.georgetown.edu/pdfs/differencesoct2005final.pdf>.
- 7 The section that grants states new flexibility over the benefit standards begins by stating that this new flexibility applies "notwithstanding" other provisions in the federal Medicaid law. Sec 1937(a)(1)(A). Further clarification may define the scope of this provision.
- 8 The EPSDT wrap-around requirement is at Sec. 1937(a)(1)(A)(ii). Under the new benefits option, EPSDT is required for children under age 19; otherwise, EPSDT coverage must be available to children under age 21.
- 9 Specifically, CBO estimated that by 2015, 9 million people (4.5 million children) would face charges for the first time for services; 13 million would face higher charges for services; and 13 million people would face new or increased cost sharing for prescription drugs. It also estimated that some 65,000 people (60 percent of them children) would lose coverage altogether. The net effect of these changes would be to reduce Medicaid spending by \$9.9 billion between fiscal year 2006 and fiscal year 2015. Of the savings attributable to new or higher cost sharing charges, CBO estimated that 80 percent would be due to decreased utilization of care and 20 percent to reductions in provider payments.
- 10 S. Artiga & M. O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP; Recent State Experiences*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2005.
- 11 HHS Office of the Inspector General, *Self-Declaration of U.S. Citizenship for Medicaid*, July 2005.
- 12 Some additional forms of documentation are acceptable, including naturalization papers and passports (although most American adults do not own a passport). For a more detailed discussion, see Ku and Broaddus, *New Requirement for Birth Certificates or Passports Could Threaten Medicaid Coverage for Vulnerable Beneficiaries: A State-by-State Analysis*, Center on Budget and Policy Priorities, February 17, 2006. Congress appears to have intended to exempt people who are enrolled in SSI or Medicare from the Medicaid documentation requirement, but, due to a drafting error, the requirement also applies to them.
- 13 See Section 6082 of the Deficit Reduction Act. The act specifies that a state could establish HOAs in counties or other sub-state regions and not statewide. Waivers will not be required; states may seek to participate in the demonstration by submitting a state plan amendment.
- 14 The Congressional Budget Office estimated the HOA demonstration program would cost the federal government more than \$260 million over ten years. If the estimate is correct, the states that undertake the demonstration program presumably would experience corresponding increases in their state Medicaid spending.

