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THE ILLUSION OF CHOICE:
Vulnerable Medicaid Beneficiaries Being Placed in Scaled-Back "Benchmark" Benefit Packages

by Judith Solomon

The Deficit Reduction Act, signed into law in February 2006, permits states to vary the benefit packages they offer to some groups of Medicaid beneficiaries.[1] States can require most children and parents to enroll in new "benchmark" benefit packages that do not provide all the benefits covered by regular Medicaid. These benchmark benefit packages must receive federal approval.

The new law specifically exempts elderly persons, pregnant women, people with disabilities, and some other beneficiaries from these new rules, which means those individuals cannot be required to enroll in one of the benchmark plans. However, the Centers for Medicare and Medicaid Services (CMS) has given states greater flexibility than Congress intended, by allowing them to offer exempt beneficiaries the choice of enrolling in a benchmark package or remaining in regular Medicaid.

So far, CMS has approved benchmark benefit packages for three states (Kentucky, Idaho, and West Virginia), two of which (Kentucky and Idaho) have received approval to enroll exempt beneficiaries in benchmark packages. In implementing their plans, both Kentucky and Idaho have enrolled exempt beneficiaries in benchmark packages *without first offering them a choice* between the benchmark package and regular Medicaid and *without giving them a clear explanation of the differences* between the two kinds of plans. While it is not yet clear whether beneficiaries in Kentucky and Idaho will be harmed by being enrolled in the benchmark packages, allowing enrollment of exempt beneficiaries in benchmark plans has opened the door for other states to undercut the protection that Congress sought to provide for these groups of beneficiaries by exempting them from the benchmark benefit packages.

New Law Allows States to Provide Scaled-Back Benchmark Packages

Until enactment of the Deficit Reduction Act, states had to cover certain "mandatory" health care services for all adult Medicaid beneficiaries. States also had the choice of providing adults with certain "optional" services, such as dental care, prescription drugs, and speech and physical therapy.

[1] Section 6044 of the Deficit Reduction Act of 2005, Pub. L. 109-171, added a new section 1937 to the Social Security Act.

If a state provided any of these optional services, it had to provide them to all adult beneficiaries throughout the state.[2] In addition, states could not vary the availability of medically necessary benefits for different groups based on their age or health status.

The DRA altered these rules significantly. In designing benefit packages, states can now choose among several benchmark benefit packages modeled on (or equivalent to) benefit options offered to state and federal employees or the benefits provided by the state's largest HMO. States also have the option of offering "Secretary-approved coverage," which is defined as any coverage found "appropriate" by the U.S. Secretary of Health and Human Services. States can offer different benefit packages to beneficiaries in different parts of the state and can vary the benefit packages based on a beneficiary's assumed health care needs.[3]

DRA Exempts Many Beneficiaries from Benchmark Packages

In enacting the DRA, Congress recognized the importance of providing comprehensive health care benefits to the most vulnerable Medicaid beneficiaries. It therefore exempted 11 groups of beneficiaries from the benchmark coverage provision, including pregnant women, elderly beneficiaries, most people with disabilities, foster children, and women receiving treatment for breast and cervical cancer.

Congress created these exemptions because benefit packages modeled on commercial insurance generally are insufficient for these populations, which often have extensive health care needs. For example, current Medicaid rules require that each covered service be "sufficient in amount, duration, and scope to reasonably achieve its purpose."[4] A benchmark benefits package could restrict the number of visits for services such as mental health treatment even if that would limit the treatment's effectiveness for many individuals. In another example, Medicaid currently requires states to ensure that beneficiaries have transportation to and from health care providers, but benchmark benefits packages would not have to provide transportation.[5]

Under the DRA, states cannot require beneficiaries in the 11 exempt groups to enroll in the new benchmark packages. These beneficiaries must be permitted to continue receiving all mandatory Medicaid services and whatever optional services the state provides, without limits based on where they live, their health status, or other characteristics.

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[2] Children are entitled to receive all medically necessary mandatory and optional services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment program (EPSDT).

[3] A state that provides an alternative benefit package to children must provide additional "wraparound" coverage to ensure they continue to receive the full array of services provided through Medicaid's Early and Periodic, Screening, Diagnostic and Treatment or EPSDT program.

[4] 42 CFR §440.230.

[5] 42 CFR §431.53.

CMS Guidance Allows States to Enroll Exempt Groups in Benchmark Plans on Voluntary Basis

CMS provided guidance to the states on how to implement the DRA's benchmark coverage provision on March 31.[6] The guidance lists the groups that are exempt under the DRA but then says that states can enroll these exempt beneficiaries in benchmark packages on a voluntary basis.

According to the guidance, when a state decides to offer exempt beneficiaries the choice of enrolling in a benchmark package, it must let them know how the benchmark package differs from the coverage they would receive under standard Medicaid. The state also must "inform the individual that such enrollment is voluntary and that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan."

Kentucky and Idaho have received CMS approval of their plans to establish benchmark packages and to allow exempt beneficiaries to enroll in them. Yet even though CMS's March 31 guidance states that any enrollment of exempt beneficiaries in benchmark packages must be voluntary, both Kentucky and Idaho have enrolled exempt beneficiaries in benchmark packages without offering them a true choice, as explained below.

Kentucky Enrolls Exempt Beneficiaries in Benchmark Plans and Discourages "Opting Out"

On May 3, Kentucky received federal approval for its plan to offer benchmark benefits. The state has established three new benefit packages (called Family Choices, Optimum Choices, and Comprehensive Choices) alongside its current Medicaid benefit package (now called Global Choices).[7]

Family Choices is designed for children. Optimum Choices and Comprehensive Choices are designed for elderly persons and people with disabilities who need long-term services. Thus, the Optimum Choices and the Comprehensive Choices benefit packages are focused entirely on elderly people and people with disabilities who are exempt from mandatory enrollment in benchmark benefits.

Currently, the list of acute care benefits for Optimum Choices and Comprehensive Choices is largely the same as the list for Global Choices. The major difference appears to be how long-term care services will be provided. Under the benchmark packages, beneficiaries will get long-term care services based on an assessment of their needs. The only service guaranteed is care management.

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[6] The guidance was in the form of a letter to State Medicaid Directors, SMDL #06-008, http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf.

[7] At the same time that it established new benchmark benefit packages, Kentucky made some changes in its regular Medicaid coverage, including new limits on the number of visits allowed for some health care services (such as occupational, physical, and speech therapy) and new cost-sharing charges. The state also will offer disease management programs to beneficiaries with chronic health conditions in some parts of the state. These beneficiaries will be eligible for additional services such as smoking cessation treatment after one year if they comply with their disease management programs. CMS Fact Sheet on Kentucky Medicaid Reform at http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp. See also Kaiser Commission on Medicaid and the Uninsured, "KYHealth Choices Medicaid Reform: Key Program Changes and Questions," July 2006.

Under regular Medicaid, these beneficiaries also would be guaranteed home health care or care in a nursing home if they need it. On the other hand, under the new plans, these beneficiaries may get home and community-based services that will not be available under regular Medicaid.[8] Whether an individual beneficiary is helped or harmed by being enrolled in benchmark plans in Kentucky will not be clear until the state provides more detail on exactly what services the beneficiary will be eligible to receive.

On May 15, Kentucky sent letters to Medicaid beneficiaries informing them of the changes to its program. Some elderly beneficiaries and people with disabilities received letters assigning them to Comprehensive Choices or Optimum Choices. The letters told these beneficiaries that "you may opt-out and you will be placed into the Global Choices plan, but you will be required to pay higher co-payments."[9] Beneficiaries were not offered a choice before they were enrolled in one of the benchmark packages, and the letter does not explain that the long-term care services they will receive will depend on their individual care plan. In addition, as noted above, beneficiaries who opted out of the benchmark plan were warned they would face higher co-payments, thereby discouraging them from exercising their right to opt out.

Idaho Enrolls Exempt Beneficiaries in Benchmark Plans and Offers No Chance to "Opt Out"

Idaho received federal approval for its plan to provide benchmark benefits on May 19. The state is offering three benchmark benefit packages: a basic package for children and "working-age adults," an enhanced package for individuals with disabilities and elderly people, and a coordinated package for elderly and disabled beneficiaries eligible for both Medicare and Medicaid (the "dual eligibles"). All three benchmark plans include new benefits such as health screenings and nutritional services. Idaho began implementing the basic and enhanced packages on July 1; the coordinated package is scheduled for implementation on October 1.

The basic package (for children and working-age adults) does not cover extended mental health benefits, organ transplants, or long-term services such as nursing homes stays. Those services are covered in the enhanced package, and individuals enrolled in the basic package can transfer to the enhanced package if the excluded services are deemed to be medically necessary for them. The coordinated package is limited to counties covered by Medicare Advantage plans (health plans that provide all *Medicare*-covered services through a network of providers, including HMOs, preferred provider organizations, and special needs plans). Beneficiaries must enroll in a Medicare Advantage plan to receive the coordinated package.

According to a fact sheet that CMS issued on the Idaho plan, the three new benefit packages are "voluntary alternatives to traditional Medicaid," and enrollment will "occur only after beneficiaries are advised of the differences in coverage and informed that they may opt out and return to traditional Medicaid at any time."[10] However, neither the state's information release to health care

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[8] See *KyHealth Choices:* Kentucky's Medicaid Transformation Initiative, May 2, 2006 at http://chfs.ky.gov/dms/kyhealthchoices.htm.

[9] The letters sent to beneficiaries are at http://chfs.ky.gov/dms/kyhealthchoices.htm.

[10] CMS Fact Sheet on Idaho Value-Based Medicaid Reform at http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp.

providers on the new packages nor the "Frequently Asked Questions for Participants" section of the state's website explain that enrollment in the basic and enhanced packages is voluntary and that beneficiaries have a choice of remaining in the regular Medicaid program.

Moreover, the information release for providers states that participants who are found eligible for Medicaid will be enrolled in either the basic or enhanced benefit package and does not suggest the option of the regular Medicaid program. Similarly, the FAQ section of the website tells Medicaid applicants that they will be placed in either the basic or enhanced package, depending on their health needs. Current beneficiaries are told they will be enrolled in either the basic or enhanced benefit package at their renewal date and that they "don't have to do anything."

The coordinated benefit package has not yet been implemented. It is not yet clear whether Idaho will automatically enroll in the package all dual eligibles who participate in Medicare Advantage plans. A state fact sheet on the coordinated benefit package says that beneficiaries enrolled in both Medicare and Medicaid "will receive benefits from the Coordinated Plans." This suggests that dual eligibles will have to enroll in Medicare Advantage plans — which have restricted networks of providers — and will not be given a choice of staying in the regular Medicare program. If that in fact is the case, then some beneficiaries may end up in Medicare Advantage plans that do not include their current health care providers and those beneficiaries may be compelled to leave their current providers for new ones.

Enrolling Exempt Beneficiaries in Benchmark Packages Undermines Medicaid Standards and Protections Putting Beneficiaries at Risk

Over the coming months, additional states will likely consider taking up the DRA option to offer benchmark benefit packages. CMS, by allowing states to enroll exempt beneficiaries in benchmark benefit packages, has weakened the protection that Congress intended for the exempt groups. While each state's plan to establish benchmark benefits packages requires prior CMS approval, the state plans approved so far do not explain *how* the state will implement the new benchmark packages, and the DRA does not specifically require states to report to CMS on that matter. Nor are states being required to evaluate the impact on beneficiaries of the changes they make in the benefits that they offer or in the way that they provide benefits.

CMS has specified that exempt beneficiaries must be given a choice of whether or not to enroll in benchmark benefit packages. Most beneficiaries would not knowingly choose a scaled-back benefit package over regular Medicaid coverage. Yet CMS appears not to be enforcing its own requirement here. The examples of Kentucky and Idaho suggest there is a significant risk that beneficiaries will not be given the information they need to make an informed choice.

Even though elderly and disabled Medicaid beneficiaries in Kentucky and Idaho may not be harmed by being enrolled in benchmark benefit packages (this isn't clear yet), CMS has now made it possible for states to disregard the protections that Congress intended to provide in exempting various groups of beneficiaries from the benchmark plans. There is considerable risk that beneficiaries in other states whom Congress intended to exempt will be "opted-in" to scaled-back benefit packages that do not meet their needs, and that Congress's clear intent to provide these vulnerable beneficiaries with full Medicaid coverage and protections may be negated.