Transforming Medicaid

The nation's Medicaid program, which covers about 50 million people, faces a significant overhaul under the Affordable Care Act. The $400-billion-a-year, joint state-federal program will be expanded in 2014 to cover all Americans under age 65 with family incomes at or below 133 percent of federal poverty guidelines—$14,856 for an individual and $30,657 for a family of four in 2012.

Currently, the program covers low-income children, pregnant women, the elderly, people with disabilities, and adults with dependent children, but largely excludes childless adults. They will make up a large percentage of the newly eligible population—estimated to total about 16 million—in 2014. Additionally, a change in how eligibility will be calculated, called "modified adjusted gross income," will effectively raise the eligibility level to 138 percent of the poverty level for most applicants. Another provision, the maintenance-of-effort requirement, forces each state to maintain the same Medicaid eligibility level that was in place on March 23, 2010.

These changes, however, will add strain to Medicaid budgets that, for the last several years, have been feeling the compound effect of decreases in state revenues and increases in enrollments—13.6 percent hike in entrollment between 2007 and 2009, and 7.2 percent between 2009 and 2010. These increased enrollments, coupled with the ACA-required expansions in 2014, will swell the cost of Medicaid, making it more important than ever for states to improve the program's effectiveness and efficiency.

In 2011, 47 states implemented at least one new policy to control Medicaid costs—such as reducing benefits and provider reimbursement rates— and 50 states plan to do so this year, according to the Kaiser Family Foundation. States are also experimenting with more long-term reforms, such as attaching provider payments to patients' health results, creating medical homes or streamlining services for those eligible for both Medicaid and Medicare.

Some policymakers see the Medicaid changes in federal health reform as an opportunity for states to improve the health care system and expand coverage to more people. New Jersey Assemblyman Herb Conaway (D) thinks the law will help states stabilize the financial health of hospitals and safety-net providers, which are currently required to provide some services without compensation. He acknowledges the fiscal challenges the expansion poses for states, but says, "As a physician, I think we need to ensure access to health insurance to hard-working people and their families."

Many lawmakers want flexibility from the federal government to make changes in the rules for Medicaid, including those for eligibility.

"State legislatures allocate massive amounts of state funds to Medicaid," says Alabama Representative Greg Wren (R). "We must be included in forming benefit, reimbursement, eligibility and enrollment policy. We can no longer be sent the invoice while being excluded from the discussion." *—Melissa Hansen*

States Decide Essential Benefits

States have long required insurance companies to offer certain benefits. More than 1,500 state laws mandate coverage, although they apply to different types of insurance. Idaho, for example, has only seven mandated services, Iowa has 20, while Florida has 40 and Maryland 55. By 2014, policies sold through exchanges, and most new plans sold to individuals and small employers, will have to cover the minimum or "essential" benefits approved by the federal government.

The federal law calls for states to pay consumers' costs for any state-mandated benefits not deemed essential by the new law and under rules to be issued by the U.S. Department of Health and Human Services (HHS).

Most observers expected a national, one-size-fits-all definition of essential benefits.

But last December, the HHS proposed giving states unexpected flexibility in deciding which of several existing insurance plans—small group plans, state and federal employee health plans, HMOs—to use as a benchmark for required coverage in their own states.

Under the proposed new rules, state officials will be able to choose among several plans that already cover their state-mandated benefits and have one such plan designated the HHS-approved standard. Essential benefits will then vary among states but states won't have to pay extra for consumers to purchase services required under state mandated benefits. The standards will apply to policies bought through exchanges as well as those sold outside of exchanges. The proposed rules may help states avoid incurring some new costs.

Although the increased flexibility is widely popular among many legislators, contentious issues remain. Lawmakers may be asked to reconcile differences among comprehensive coverage packages, or select a benefit package with fewer services at reduced premiums. Discussions of what is fair, what is affordable and what is medically necessary will likely keep this issue high on state legislative agendas. *—Richard Cauchi*

What Insurers Must Cover

- Ambulance services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance abuse services.
- Prescription drugs.
- Rehabilitative and self-help services and devices.
- Laboratory tests.
- Preventive wellness services and chronic disease management.
- Pediatric services, including dental and vision care.
- Other services determined by state mandates in state-selected benchmark plans.

Note: Federal rules require coverage for a range of women's preventive health services in new policies as of Aug. 1, 2012.