



Implications for Children's Dental Medicaid Policy in the Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) made sweeping changes within the Medicaid program, many of which were previously only possible through a federally approved waiver. Many of the original tenets of the Medicaid program were discarded in DRA by providing the opportunity to eliminate such standards as “statewideness” and “comparability.” Building on previous DRA briefs issued by the Children's Dental Health Project this brief, excerpted from a technical analysis of the law, details the implications of these reforms for children's dental health policy.

Pre-DRA Medicaid Coverage Principles

Since 1967, EPSDT has been a required Medicaid benefit for persons from birth to age 21. The EPSDT benefit reflects Congress's intent to go beyond the already-significant coverage standards incorporated into law as part of Medicaid's 1965 enactment and grew out of great concerns over the health and development of low-income children and adolescents.ⁱ

Virtually since enactment, the EPSDT benefit has encompassed comprehensive health exams aimed at identifying physical and mental health conditions, complete vision, dental and hearing care, and provision of treatment needed to correct or ameliorate physical and mental health conditions. Furthermore, EPSDT provides for a unique, federally required medical necessity standard, that mandates coverage for any medical condition to *ameliorate or correct* the effects of the condition. In other words, coverage is required, even if the prognosis is to lessen or mitigate the effects of a condition, not correct it.

Among public and private health insurance, Medicaid historically has been unique in the populations it insures and the breadth of coverage it furnishes.ⁱⁱ Since its inception, federal Medicaid coverage policy has been predicated on several key concepts:

- *First*, coverage should be *statewide*. All Medicaid-eligible persons in a state should receive the same level of coverage in order to guard against discrimination against particular communities and sub-state populations.
- *Second*, coverage should be *comparable*. Coverage rules for various subclasses of beneficiaries should be the same in order to safeguard against discrimination among beneficiaries on the basis of their economic circumstances or their condition.
- *Third*, coverage should be *reasonable*. Ensuring the reasonableness of the *amount, duration, and scope* of covered benefits in light of their purpose and preventing arbitrary discrimination.
- *Fourth*, Medicaid cost sharing and premium requirements should be very modest given the poverty of program beneficiaries.

These coverage principles, when overlaid on Medicaid's broad coverage classes, created a program of unusual breadth and depth. Although provider payment standards historically have been very limited, the depth and scope of coverage has made Medicaid the nation's largest single source of health care financing for serious and chronic physical and mental health conditions.

Medicaid's Contrast with Commercial Insurance

Medicaid's unique coverage rules contrast significantly with those used in the commercial insurance industry, which are built on the fundamental goal that drives all such insurance products, namely, the avoidance of risk. Commercial insurance products, whether broad or for a special purpose, may carefully delineate coverage of certain benefits that act as exceptions to risk avoidance. At the same time, commercial insurance products are structured to help insurers avert financial risks and “medical losses” (i.e., payouts) that exceed those anticipated by an insurer.

Modern health insurance coverage encompasses several key features to give health benefit companies near-total discretion over both the broad outline of coverage and individual coverage decisions.ⁱⁱⁱ Those features include:

- Tightly drafted coverage definitions that exclude chronic and developmental conditions.
- Across-the-board exclusions of certain conditions, treatments, and settings.
- Embedding practice guidelines in the terms of coverage.
- A narrow definition of “medical necessity.”

Collectively these drafting techniques and legal rulings can be thought of as sticks aimed at controlling costs and utilization, with carrots being consumer incentives to use certain services (through variable cost sharing) and provider financial incentives (e.g., “pay for performance”) to reward certain treatment practices. What is lost, of course, is necessary clinical nuances in difficult cases that do not fit norms. This loss of flexibility in coverage poses particular challenges for children with complex conditions, as well as children whose health needs stem from conditions considered developmental rather than acute and restorable in nature.

DRA Options Jeopardizing Medicaid Principles

Following years of increasing pressure by states to relax Medicaid coverage standards in the face of escalating program costs, as well as a series of federal Medicaid demonstrations undertaken by the Bush Administration to allow greater alignment between Medicaid coverage and standard commercial practices,^{iv} Congress included a series of amendments in DRA that, taken together, allow states to fundamentally alter the rules of coverage for millions of children and adults. DRA made significant changes to Medicaid of importance to dental care for children. Those issues include, but are not limited to the following:

- *Alternative benefit* option, which eliminates comparability, statewideness, and other pre-DRA Medicaid coverage standards while also preserving but in certain respects modifying the EPSDT benefit;
- *Premium and cost-sharing* changes, including reforms permitting states to establish cost sharing “enforceability” by allowing health care providers to deny treatment at the point of service for failure to pay;
- *Health Opportunity Account (HOA)*, an addition to Medicaid allowing new federal/state authority to design and implement demonstrations that would introduce “high deductible health plans” coupled with savings accounts.

Key Policy Considerations in States for DRA Provisions

Alternative benefits: The distinction between the EPSDT dental benefit and benchmark coverage is fundamental. EPSDT creates a legal entitlement to comprehensive dental care using the broadest possible definition of medical necessity. Benchmark coverage does not include *any* dental care as a minimum aspect of benchmark design. Some states may elect to include some level of dental coverage in benchmark-equivalent plans, but this is not necessary. It is safe to say that no other basic pediatric health benefit central to the health of all children is treated in a similar fashion under the alternative benefit provisions.

DRA does nominally preserve the EPSDT entitlement, but structuring the benefit to ensure that families continue to have access to the coverage let alone to services, will require skilled design, careful operationalization of the alternative coverage system, and broad educational efforts regarding the continued EPSDT benefit. The following are practical considerations when working with states as they shift toward an alternative benefit design.

- Retain the EPSDT entitlement through age 20.
- Include the entire EPSDT dental benefits as part of all alternative benefits, not as a second tier wraparound benefit.
- Consider incentivizing family use of dental services in order to foster dental access.
- Incentivize Medicaid pediatric dental plans to offer both appropriate benefit designs as well as to locate preventive and restorative services in a variety of settings including private offices, community health centers and schools.

Cost sharing: Experience with monthly enrollment fees suggests that even small fees have a distinct effect on care seeking by poor and near poor families.^v Similarly, extensive evidence suggests that even low co-payments can deter utilization of preventive services. The extensive literature on cost sharing and premiums suggest certain basic safeguards where use of cost sharing in a pediatric context is concerned:

- Avoiding the use of premiums and enrollment fees of more than nominal amount;
- Not imposing cost sharing on preventive and primary care services including all preventive dental care and basic restorative services;
- Not permitting “provider enforceability” in the case of children, regardless of whether the service is preventive, primary, secondary, or the result of a medical emergency.

Health opportunity accounts: It is, of course, too early to know whether HOAs will be actively pursued by states. Since *all* coverage safeguards are suspended under HOA demonstrations, this means the total loss of EPSDT benefits as well as cost sharing protections. If a state decides to proceed and to include children, then its HOA system should be limited to basic coverage only, with complete dental care as well as comprehensive supplemental coverage for physical and mental health conditions that could delay or impair pediatric growth and development. Whether CMS will permit such supplementation in an HOA demonstration is unknown. In the absence of supplementation, the loss of coverage would appear to have such potentially severe consequences for low-income children as to raise basic questions of safety.

Conclusion

The recent political environment has provided significant challenges to maintaining the stability of children’s dental coverage in Medicaid. Lessons from EPSDT’s 40 years should be used to advance, not undermine, the original comprehensive intent of children’s Medicaid coverage. Momentum created by policies such as DRA, have the potential to launch innovative strategies for providing essential dental care to families previously underserved. This is a critical time to identify and promote positive strategies to assure low-income children continued access to comprehensive dental care in this country.

For more information on Medicaid dental coverage or the Deficit Reduction Act go to www.cdhp.org.

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ⁱ Rosenbaum S, Mauery DR, Shin P, and Hidalgo J. (2005) *National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT* Washington, DC: The George Washington University School of Public Health and Health Services, Department of Health Policy, Washington D.C.

http://www.gwumc.edu/sphhs/healthpolicy/new_publications.html

ⁱⁱ S. Rosenbaum, *Defined Contribution Plans and Limited Benefit Arrangements: Implications for Medicaid Beneficiaries* (AHIP/GWU, September, 2006). <http://www.ahip.org/content/pressrelease.aspx?docid=17541>

ⁱⁱⁱ S. Rosenbaum, *Benefit Design and its Implication for Health Care Quality* (NICHQ, August, 2006)

^{iv} *Defined Contribution Plans*, op. cit.

^v A.R. Markus and S. Rosenbaum. *CHIP, Health Insurance Premiums, and Cost sharing: Lessons From the Literature* (HRSA Contract 98-OA 140506) (1998) http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/cost_sharing_litreview_overview.pdf