



CDHP Issue Brief

Medicaid Flexibility in the Deficit Reduction Act of 2005: What Does It Mean for Children's Oral Health?

In February, President Bush signed into law the 2005 budget reconciliation billⁱ entitled the Deficit Reduction Act of 2005 (DRA). Budget bills rarely raise much interest or seem relevant to the dental care of children. However decisions impacting children's access to dental care are many times determined in the budget process rather than through more traditional legislative activities. As the title implies, DRA includes numerous mechanisms for reducing the federal deficit, including providing states with new budget cutting "flexibilities options" in Medicaid.

DRA Implications for Children's Dental Care

The federal budget is the avenue by which all federal spending and revenues are determined. Medicaid, the largest publicly funded health coverage program for the poor, provides health coverage—including dental coverage—to 27 million children. Medicaid is funded directly through the budget process. The annual budget process, starting with the release of the President's budget plan at the beginning of each year, provides insight into potential changes to federal programs. The budget reconciliation is frequently used to implement significant policy changes to a variety of programs including Medicaid.

Children's dental care in Medicaid has been addressed through past budget reconciliations including one that established EPSDT in 1967 and those that strengthened dental requirements in the late 1980s. Despite strong federal requirements on states, Medicaid reaches only about one-in-four children with comprehensive dental services. As a result, the majority of vulnerable children continue to have high levels of unmet dental needs. Changes proposed in DRA increase state options in an effort to reduce spending but also may hold promise for new and creative approaches to increasing children's use of dental services.

New State Options

After significant debate on DRA in Congress, Medicaid now includes state options to impose cost sharing, premiums and alternate benefit packages for children. According to cost estimates by the Congressional Budget Office (CBO), Medicaid changes are expected to cut \$7 billion in federal spending between 2006-2010. Because Medicaid is jointly funded by federal and state governments total spending cuts are anticipated to be considerably greater. How states will use their new authorities to reduce Medicaid spending and what effect these changes may have on children's use of dental services are yet unknown.

Because the final DRA language is not completely clear, there are currently disagreements over interpretations of the new Medicaid provisions. Chairmen of the key House of Representatives and Senate Committees have stated Congressional intent to retain all EPSDT benefits for all covered children. The DHHS Secretary has called upon states to "think creatively" and provide "basic care" to large numbers of people rather than "unlimited care" to the lowest income. Initial guidance from the federal Medicaid regulatory agency, Centers for Medicare and Medicaid Services (CMS) has not fully clarified requirements on states with regard to DRA Medicaid options.

So, what *do* we know about DRA with regard to Medicaid dental services for children?

1. Alternate benefits packages. Until DRA, State Medicaid programs were required to provide a comprehensive set of EPSDT benefits to all "mandatory"ⁱⁱ and "optional"ⁱⁱⁱ children. Under DRA, states have new authority to offer children^{iv} one of four "benchmark packages"^v as an alternative to EPSDT. None of the benchmark packages includes dental benefits. DRA further requires that children who receive the benchmark package also receive an EPSDT wrap around benefit. The "wrap" has not yet been defined in law or federal regulation. Nonetheless, CBO estimates that 1.6 million children will receive a reduced benefit package through the new option by 2015.

Mandatory Eligible Children

- Children under the age of 6 from families with incomes less than 133% FPL.
- Children age 6 to 19 with family income less than 100% Federal Poverty Level (FPL).
- Children in foster care.
- No cost sharing.
- No premiums.

Optional Eligible Children

- Children above minimum income requirements (*determined by the state*).
- State optional cost sharing up to 10-20% (based on family income) of the cost of non-preventive services.
- State optional premiums for families above 150% of FPL.

CDHP notes that CBO's estimate of 1.6 million children receiving reduced benefits is inconsistent with the Congressional intent that all children will retain their full EPSDT benefit. How will alternate benefit packages and wrap-around benefits be coordinated in ways that do not limit access to dental services? Will barriers to dental services arise that limit access? How will reduced spending be achieved? Will families be aware of dental coverage if not included in their children's basic coverage?

2. Cost sharing and Premiums

- Cost sharing: Prior to DRA, children were exempt from cost sharing for Medicaid services. The law defines cost sharing as, "any deduction, deductible, copayment, or similar charge." Under DRA, "mandatory" children remain exempt from cost sharing. However, states may impose cost sharing for children in the "optional" category for non-preventive services. The amount of cost sharing is based on family income. Cost sharing may be as high as 20 percent of the cost of non-preventive services. Under this complex provision, health care providers will need to collect the state-established Medicaid fee directly from the parent. CBO estimates that 3 million children will be subject to cost sharing by 2010 and nearly \$10 billion in Medicaid spending will be cut through this mechanism by 2015. CBO further estimates that 80 percent of this "savings" will result from reduced use of services and 20 percent from lower provider payments.
- Premiums: In addition to imposing new cost sharing, states may also elect to charge premiums for "optional" children from families with incomes above 150 percent federal poverty level—for example a family of four with an annual income of \$30,000.^{vi} CBO estimates that by 2010, 900,000 children and non-disabled adults will be charged premiums and 30,000 children are expected to lose Medicaid either from voluntarily dropping coverage or for premium non-payment.
- Authorization to terminate treatment for failure to pay: DRA provides states the option to terminate Medicaid coverage if premiums are not paid. Additionally, providers can be granted the right to deny care if Medicaid patients fail to pay copayments or other cost sharing. CBO estimates that 75 percent of states choosing to impose new cost sharing will allow providers to deny care. Denial of care is anticipated to create greater savings by decreasing utilization in those states.

CDHP believes that these cost sharing provisions will create additional barriers to care, will be burdensome on providers because of the need to collect copayments, will pose an ethical dilemma for dentists, and may further reduce dentists' participation in Medicaid. Families could end up with more severe oral health issues while providers may experience more uncollectible accounts.

- 3. End of "statewideness" requirement: Hallmarks of Medicaid prior to DRA were that access needed to be statewide, services provided had to be uniform across the state, and cost sharing provisions needed to be consistent across the state, thus assuring equal access to all Medicaid children through each state. These are no longer required under DRA.

CDHP is concerned that removing the requirement to provide equal access to Medicaid services statewide will create new disparities in access to dental care. Adequate distribution of Medicaid dental professionals has been a longstanding problem. This provision may result in more significant disparities in rural and low-income communities.

4. Health Savings Account Demonstrations in Medicaid: Starting January 1, 2007, DRA authorizes a 10-state pilot of high-deductible health plans coupled with personal “Health Opportunity Accounts” (modeled on health savings accounts) in lieu of traditional Medicaid. The 10-state demonstrations would deposit a specified amount of money in a health account for beneficiaries’ use to pay for health services at the Medicaid rate. If a beneficiary spends the entire health account allotment they could be required to pay a deductible to move back into traditional Medicaid coverage. The Secretary of Health and Human Services has the option in five years to expand the Health Opportunity Accounts to additional states and make the accounts permanent.

CDHP is concerned that moving children from traditional Medicaid into high-deductible health coverage will limit their access to comprehensive services, including dental care. Will low-income families have sufficient funds in their health accounts to pay for the full range of services? Will they be able to meet the required deductible to regain coverage if they exhaust their account? Will providers identify them properly as Medicaid recipients and bill them at Medicaid rather than commercial rates? Will other health needs crowd out spending for dental care?

Potential Impact

The ultimate impact of these DRA provisions depends first on federal clarity to states and then on whether and how states elect to implement new options. Collectively, these new options tend to shift authority, responsibilities, and costs to states or beneficiaries.

Engaging in state Medicaid discussions in the upcoming months and years will be key to maintaining effective dental benefits. Since each state has its own unique process for making policy changes in Medicaid, it is incumbent on child health advocates to learn their own state’s processes and educate policy makers about the need for maintaining dental coverage for low-income children.

For more information about DRA or assistance with educating policymakers in your state, please contact the Children’s Dental Health Project at (202) 833-8288 or through our website at www.cdhp.org.

ⁱ Budget reconciliation is legislation that bundles provisions with budget implications in order to *reconcile* existing law with provisions outlined in the budget resolution (an agreement between the House and Senate about how much Congress can spend and how much they expect to collect over the next five to ten years). Budget reconciliations has been used to make significant changes to programs – including Medicaid.

ⁱⁱ “Mandatory” Medicaid category of children include those under the age of 6 from families with incomes less than 133% FPL, children age 6 to 19 with family incomes less than 100% FPL, and children in foster care. (*DRA considers children 18-years old as adults for the purpose of cost sharing and premiums*)

ⁱⁱⁱ “Optional” Medicaid category of children include children above minimum income requirements and are determined by the state.

^{iv} Children in foster care and medically frail children are exempt from the alternative benefit packages.

^v The “benchmark” packages refer to the standard baseline for proposed alternative benefit packages. The benchmarks in SCHIP and in DRA legislation include: a) standard Blue Cross/Blue Shield preferred provider plan within the Federal Employee Health Benefits Plan, b) state employee coverage generally available in the state, c) an HMO with the largest commercial and non-Medicaid enrollment in the state, or d) a plan determined by the Secretary of Health and Human Services to be appropriate.

^{vi} In 2006, 100% of the Federal Poverty Level (FPL) for a family of four is \$20,000 and 150% FPL is \$30,000 within the 48 contiguous states and D.C.