Vol. IV, No. 4
April 2003

STATE COVERAGE INITIATIVES

issue brief

States' Experience with Benefit Design

by Isabel Friedenzohn

Health benefit design in public programs is one of the most complex public policy issues. It requires a multi-dimensional discussion and a willingness to ask questions that may not have rational answers.

As state officials determine what essential coverage is, and what cost-sharing requirements are appropriate for vulnerable populations, they must take into account fiscal implications and potential unintended consequences of benefit changes.

States have become increasingly interested in restructuring their public programs as Medicaid has taken up a greater share of their budgets, state revenues have declined, and health care expenditures have continued to grow. The states' interest in modifying benefits and cost-sharing arrangements, however, has a history that predates the current fiscal crisis and reflects the evolving role of the states as laboratories in health care reform.

In 2001 the National Governors Association presented a proposal clearly outlining states' interest in restructuring their Medicaid programs. The pervasive theme was a call for greater federal flexibility to tailor Medicaid to meet state-specific needs and keep the program sustainable. The administration responded to this proposal with the Health Insurance Flexibility and Accountability (HIFA) initiative. HIFA waivers offer states more options to restructure public programs and expand coverage to new populations, particularly the uninsured under 200 percent of the federal poverty level (FPL).

The process that officials must undertake to decide whether offering reduced coverage to more people is preferable to providing extensive coverage to a smaller group varies and is, understandably, imperfect. "Even in the best of circumstances, this discussion is a mix of evidence, opinion, politics, and emotion," says John Santa, M.D., former administrator of the Office for Oregon Health Plan Policy and Research.

This issue brief will highlight the experiences of Oregon, Utah, and Washington—each of which have embarked on the process of modifying the benefits packages of their Medicaid programs. Although they pursued different approaches, they had a similar motivation—to tailor their packages to the needs of specific populations and give more people health insurance coverage. The brief will also draw on other relevant examples of states that have developed new benefits strategies within the past two years.

Oregon

Many officials view Oregon as a benchmark state in the area of benefit design, because it was one of the first to experiment with restructuring Medicaid benefits in order to expand coverage. Ten years ago, the state implemented a prioritized list of conditions and treatments for Medicaid benefits under

AcademyHealth
Advancing Research, Policy and Practice

AcademyHealth is the national program office for SCI, an initiative of The Robert Wood Johnson Foundation.

the Oregon Health Plan (OHP) that ranks health services based on the "comparative benefit to the population to be served." The state felt the prioritized list would provide a way to ensure that the highest priority services were covered for the largest number of participants during harsh economic times.

John Santa is very familiar with the difficult trade-offs involved in making such coverage decisions. He helped develop Oregon's prioritized benefit list, and, more recently, worked with a team to implement a new plan to expand coverage to 60,000 Oregonians by restructuring the OHP. His team submitted both an 1115 and a HIFA waiver to the Centers for Medicare and Medicaid Services (CMS) in late May 2002 to implement major changes to Medicaid.

In 2001, the Oregon legislature passed House Bill (HB) 2519, a key piece of legislation outlining a process by which the state would restructure the OHP. The state's new demonstration is called the Oregon Health Plan 2 (OHP2). It will comprise three benefit packages.

- **OHP Plus** is equivalent to the existing OHP package. It will cover all mandatory populations and some optional populations, including pregnant women and children in families with incomes up to 185 percent of the federal poverty level (FPL).

- **OHP Standard**, a reduced benefit package, will be offered to optional and expansion populations that are not included in OHP Plus and that do not have employer-sponsored insurance. By creating OHP Standard, the state would use savings from this reduced package to expand coverage to those currently ineligible for the programs, including parents of children enrolled in Medicaid and SCHIP, and childless adults with incomes up to 185 percent FPL.

  This streamlined benefits package is budgeted at approximately 78 percent of the actuarial value of OHP Plus. State officials spent several months doing actuarial work in order to design a benefits package similar to a commercial plan that would save the state money and fit the needs of the OHP Standard population. HB 2519 required that this package be at least actuarially equivalent to the federally mandated Medicaid package (56 percent of OHP Plus).

- **FHIAP**, originally a state-only premium assistance program that has a commercial package, has been included in the 1115 waiver request, and consequently folded into the OHP2 structure. The program covers families and individuals with incomes up to 185 percent FPL by providing premium assistance on a sliding scale for employer-sponsored insurance.

Several key groups, including the Health Services Commission (HSC), the Insurance Pool Governing Board, the Health Insurance Reform Advisory Committee, and the Waiver Application Steering Committee, played integral roles in the benefits redesign process. The HSC, which is comprised of 11 volunteer members, was established in 1989 to develop the OHP's prioritized list. In December 2000, the HSC was asked to provide recommendations for developing the standard benefit package. Over the course of a year, the HSC evaluated various benefits packages and cost-sharing strategies and laid out recommendations in a formal report.

To accomplish its task, the HSC first prioritized the benefits in the existing OHP package, keeping in mind what is offered in the private insurance market and conducting rigorous public outreach. The pharmacy benefit was overwhelmingly considered to be the most important element and transportation the least important. Among many of the benefits the community was trying to balance, dental was more valued than the state had originally thought, tracking very similarly with mental health benefits.

As HSC approached its goal of reaching a 20 percent reduction in the actuarial value of the OHP package, it became clear that the state would need to impose cost-sharing requirements in order to keep some crucial benefits. "We learned that excluding the benefits low on the list (transportation, vision) would not save those in the middle (dental, mental health)," says Santa. "Indeed, we realized that only significant cost sharing across all benefits, including for hospital and prescription drugs, would allow us to retain important benefits." Actuaries were brought in to evaluate various iterations until a package was identified that reached the targeted reduction and satisfied stakeholders.

The final OHP Standard package includes 10 vital services. Ranked in order of their priority, they include: inpatient hospital, outpatient hospital, ER, physician services, lab and X-ray, ambulance services, prescription drugs, mental health and chemical dependency, durable medical equipment, and dental. The waiver stipulates that the legislature can further reduce the actuarial value of the package from 78 to 56 percent (the federally mandated level) if fiscally necessary. This would essentially remove the last four services from the package.

In November 2002, the Emergency Board of the Oregon Legislature removed coverage for each of these benefits except prescription drugs in order to balance its budget and avoid provider reimbursement decreases. Facing an estimated $2.5 billion budget deficit, the state eliminated prescription drug coverage on March 1, 2003. It was temporarily restored two weeks later. Oregon's legislature continues to struggle with both who and what will be covered as the state's budget situation worsens.

OHP Standard's premium structure requires all beneficiaries to pay a percentage of the premium share based on their income. Beneficiaries who fall within 0 to 10 percent FPL will be required to pay 2.4 percent of the premium ($6 per person), while those who fall at the top of the income eligibility range—170 to 185 percent FPL—must pay 50 percent, or $125 per person. OHP Plus beneficiaries will not have to pay premiums, but are required to make co-payments on prescription drugs and outpatient services.

Providers received the new cost-sharing requirements with skepticism. They did not believe that the program had enough credibility to ensure that the co-pays would be collected, particularly in light of a federal law requiring states to provide treatment regardless of beneficiaries' ability to pay. In response to pressure from providers, Oregon included an element in its waiver asking federal permission to allow providers to refuse treatment if patients do not pay. Oregon's waiver is the first to contain such a provision.

The state's decision to require co-pays for all beneficiaries enrolled in OHP Standard was made based on evidence from Washington's Basic Health plan (BH), a state-only plan that requires significant co-pays and premiums for low-income people, including some with no income. According to 2001 data, about 90 percent of beneficiaries paid their co-pays and pharmacy fees, and doctors successfully collected payments for approximately 85 percent of the remaining cases. "These data clearly indicate that the low-income populations appreciate health care coverage and are willing to make their co-payments the majority of the time," says Santa.

Although some advocates in Oregon believe that increased cost-sharing will create access barriers, and there is a body of health services research supporting this view, Oregon officials contend that providing benefits with reasonable co-pays is preferable to not being able to provide any services. Other states may find Oregon's experience instructive as they develop new cost-sharing structures. It's worth noting that cost sharing for low-income populations was considered a top area for additional research by the 20 states awarded 2000 and 2001 State Planning Grants through the Health Resources and Services Administration (HRSA). These one-year grants are intended to help states collect coverage data on their uninsured and develop policy options to address this issue.

Oregon's waiver, approved in September 2002 and scheduled for inplementation in spring 2003, also broke new ground in the area of choice. The waiver includes a provision allowing low-income working adults eligible for OHP Plus to make an informed choice about which type of coverage they would like to receive. They can opt for employer-sponsored insurance with premium assistance through FHIAP or maintain OHP Plus benefits. The new provision does not oblige the state to provide additional wrap-around coverage for those selecting private coverage. However, CMS has required the state to inform beneficiaries that they are eligible for OHP Plus and that they or their children can choose to stop participating in private coverage and transfer to the Medicaid/SCHIP program at any time.

Table 1: Benefit Package Design in Oregon, Utah, and Washington

State	Programs	Eligibility	Benefits	Premiums & Cost-sharing
Oregon				
	Oregon Health Plan Plus (OHP Plus)	Mandatory and some optional populations, including pregnant women and children in families </=185%FPL	Existing OHP package	No premium, but co-pays for prescription drugs and outpatient services
	Oregon Health Plan Standard (OHP Standard)	Optional and expansion populations (those not included in OHP Plus, who do not have employer-sponsored insurance), including parents of children in Medicaid/SCHIP and childless adults </=185% FPL	Reduced OHP package (must be actuarially equivalent to the federally mandated Medicaid package) As of March 2003, the package includes: inpatient and outpatient hospital, ER, physician services, lab/x-ray, ambulance services, and prescription drugs.	Sliding scale premium
	Family Health Insurance Assistance Program (FHIAP)	Families and individuals </=185% FPL	Commercial package/employer package	Premium assistance on a sliding scale
Utah				
	Primary Care Network (PCN)	Adults (including childless), aged 19–64, who have not had health care coverage for >/=6 months, whose employer pays less than 50% of their health care benefit, and whose annual income is less than 150% FPL	Primary care focus (with access to donated hospital and specialty care): primary care visits, flu immunizations, urgent care, ER, lab/x-ray, ambulance, DME, basic dental, hearing tests, and vision screening	$50 annual enrollment fee $5 co-pay
Washington				
	Medicaid*	Optional populations with incomes above the poverty level	Comparable to commercial package	Premium: Based on income and family size; will not exceed 2.5% of family income $5 co-pay for brand-name drugs when generic available; $10 for non-emergent emergency room usage

*Waiver stipulating benefit changes has not been approved yet.

Although employer-sponsored plans typically require higher cost-sharing and less comprehensive coverage than traditional Medicaid, individuals may prefer private insurance because it carries fewer stigmas, offers broader provider networks, and may provide better access to care. Moreover, by opting for coverage through FHIAP, families can be insured through a single policy, even when parents and children are eligible for different programs. Oregon officials believe that informed choice is a less paternalistic approach than requiring all Medicaid-eligible individuals to enroll in that program.

Utah

Utah is also a pioneer in benefits design. In March 2002, the state received a first-of-its-kind Medicaid 1115 waiver to implement its Primary Care Network (PCN), which will provide primary care and preventive services to 25,000 low-income adults who would otherwise lack health insurance. To cover these additional beneficiaries, the state reduced benefits for some of its current mandatory and optional Medicaid populations. The state also folded its Utah Medical Assistance Program (UMAP), a state-only funded program, into Medicaid—a step that allowed $3.5 million in state funds to be redirected and converted into $20 million with additional federal resources.

"We moved forward during a time when there wasn't any other chance to make progress," says Rod Betit, executive director of the Utah Department of Public Health. Although Utah's plan shares HIFA's philosophical emphasis on flexibility, it was approved as a traditional 1115 waiver. One important way in which Utah's waiver differs from HIFA is that it allows the state to streamline benefits for some mandatory Medicaid beneficiaries rather than only optional and expansion groups.

The most significant changes for the mandatory population include the elimination of non-emergency transportation and a reduction in mental health services. Individuals will have mental health coverage for 30 days of inpatient care and 30 outpatient visits, with the ability to substitute an inpatient day for an outpatient visit and vice versa. The optional population will experience reductions in coverage for speech, vision, and dental services, as well as a cap for physical therapy, chiropractic, and psychiatric visits. The state has instituted a $50 annual enrollment fee for newly enrolled eligibles and for the optional Medicaid population.

The PCN benefits package has a preventive care focus, covering primary care office visits, flu immunizations, urgent care visits, emergency room visits, lab, x-ray, ambulance transport, medical equipment, medical supplies, oxygen, basic dental care, hearing tests, and vision screening. Eyeglasses and prescription drugs are not covered. Although the expansion population's benefits package does not cover inpatient hospitalization, the program incorporates features outside the waiver that may help address this limitation.

During the development of the waiver, Betit negotiated a voluntary arrangement with Utah's hospital systems to provide up to $10 million in donated hospital care annually to eligible PCN enrollees. Beneficiaries can take advantage of several resources donated from the community, including hospital and specialty care, and pharmacy assistance programs. The intent of the PCN was to establish an organized framework for providing preventive care to people previously dependent on the safety net system while attempting to address gaps in access to specialty care.

After receiving support from Health and Human Services Secretary Thompson during initial deliberations, Utah moved quickly to complete the waiver. The state folded the development of PCN program into the state's HRSA State Planning Grant—which gave stakeholders the chance to comment and refine the proposal.

Insurance representatives and low-income advocates both expressed concern over Utah's plan. Insurers complained that the state was offering a product with which they could not compete, because insurers were legally required to offer more comprehensive services. This concern was eliminated when the state passed HB 122, a bill allowing private carriers to offer a similar product.

Low-income advocates felt that the pared-down benefits called for under the waiver represented an erosion in coverage for vulnerable individuals, especially mandatory Medicaid populations. Utah officials were sensitive to this concern, but they felt it necessary to determine appropriate benefits packages for various populations. "We absolutely agree that you need a comprehensive package for categorical groups," says Betit. "However, beyond those, we must address benefits in a manner that fits the populations we are trying to cover." As public programs continue to move up the income scale, Betit says, states must move toward benefits packages that are more comparable to those offered in the private market. "We don't want to leave people so dependent on public coverage that they can't eventually replace it with coverage in the marketplace."

Throughout the planning process for the HRSA grant, Utah officials engaged in discussions with low-income advocates about the trade-offs that were associated with the state's plan. State representatives pointed out, for example, that the state would only have been able to cover 5,000 uninsured people had it used a traditional 1931 waiver for its expansion, whereas the PCN proposal allowed it to extend coverage to 25,000 people.

Utah wanted to establish a cost-sharing structure akin to commercial benefit packages, including a premium. State officials characterize the $5 co-pays required for the PCN as "reasonable" rather than "nominal," the word they used to describe the $2 co-pays imposed under existing Medicaid. "People need to understand that services cost money," says Betit. So far, beneficiaries seem to recognize that, he continues. "We have not received complaints about cost sharing."

As of March 2003, PCN enrolled more than 13,000 beneficiaries. The growth in enrollment equates to a lower cost per member per month (pmpm). At the inception of the program in July 2002, the average pmpm was more than $100. By December 2002, it had gone down to $66.03, reaching initial program expectations. Almost 70 percent of expenditures are spent on pharmacy and outpatient hospital services.

Washington

More than a year ago, Washington submitted an 1115 waiver to CMS in an effort to curb costs. The waiver requested significant flexibility on benefit design and the ability to impose an enrollment cap. However, CMS officials stated that the waiver did not include sufficient detail for them to approve it. In August 2002, Washington submitted an amended waiver that incorporated information requested from key stakeholders and legislators. Through its waiver, the state

seeks to cover 20,000 parents, single adults, and couples with title XXI funds through the Basic Health plan, a state-only plan that does not require significant co-pays and premiums for low-income people and those with no income. Washington also requested permission to streamline benefits packages and adjust cost-sharing provisions for its Medicaid program. The package will include premiums for the highest-income Medicaid clients and co-pays for all clients to discourage inappropriate use of emergency rooms and brand-name prescription drugs.

State administrators felt they had no choice but to evaluate a variety of interventions to stem the rapid growth of medical expenditures. In concert with the legislature, they implemented a series of cost-containment measures that failed to produce the level of savings that the state's budget situation demanded. "It was obvious that we needed to look at further options, including reducing benefits," says Roger Gantz, Washington's Medicaid director.

Washington officials were committed to giving state policymakers as much flexibility as they could to run the Medicaid program. They looked to the Basic Health plan as a template to provide the parameters for services to adults in the optional population. The state felt comfortable establishing the Basic Health plan as a floor because its benefits are comparable to those offered in the commercial market. Officials also compared utilization rates in the Medicaid versus Basic Health populations to identify which services to maintain. "We didn't go through the exercise that Oregon did to guide our benefit reduction," says Gantz.

The state will use co-pays to create incentives for beneficiaries to use the appropriate services. Under the waiver, clients will be required to pay approximately $5 for brand-name drugs when a generic is available, and $10 for the non-emergent use of the hospital emergency room (an increase from the $3 co-pay currently charged in Medicaid). From the state's perspective, these fees seemed reasonable and in line with what other states have done. In the end, "the numbers reflect more of an institutional history than an analytical analysis of demand elasticity," says Gantz.

Washington performed modeling exercises to assess the impact of various premium levels on families' incomes. Unfortunately, officials did not find a great deal of research to guide them in determining an appropriate premium structure that would not create a barrier to accessing services. In the Basic Health plan, administrators only witnessed a 3 percent drop in enrollment, of which only 1 percent was associated with non-payment of premiums. The final waiver submitted to CMS proposed that optional beneficiaries with incomes above the poverty level (about 20 percent of the Medicaid population) pay a small premium for Medicaid coverage that will not exceed 2.5 percent of a family's income. The premiums were calculated based on income and family size. For example, a family of four with two children at 190 percent FPL (annual income of $34,390) would pay $20 per month.

Learning from New Strategies

The changes that these states are implementing argue for broader evaluation of new benefit approaches. Utah included a research design phase in the development of its PCN that will address two fundamental questions:

1) Does the availability of primary and preventive care improve the uninsured's health status and promote employment? and

2) Does the availability of primary and preventive care reduce the amount of uncompensated care in the Utah health care system?

It will take a few years to assess the impact of the program, but Betit hopes that Utah will be able to demonstrate the validity of the PCN program and carve a path for other states.

Washington is also intent on evaluating the impact of premiums on various populations. The state will be a good laboratory for studying this as several populations are paying premiums in the Basic Health plan, the state's SCHIP program, and the Medicaid program. "There is a need to do more evidence-based designing, but we aren't confident that we know how to do that yet," says Gantz.

Other States of Interest

Tennessee

Tennessee has used benefits redesign as a major strategy in its rethinking of TennCare—the state's 1115 expansion program. On May 30, 2002, CMS approved an 1115 waiver that included a plan to restructure TennCare. Like Oregon's OHP2, the new TennCare will offer three products.

- **TennCare Medicaid** will be available to the mandatory Medicaid population. Barring some modest changes to the benefits package, these beneficiaries will continue to receive the same comprehensive package that was available under the previous demonstration.

- **TennCare Standard** will cover medically eligible and uninsured individuals under 200 percent FPL and non-Medicaid dual eligibles. The standard package will be comparable to the state employees' HMO package, except for mental health benefits, which will be maintained from the previous demonstration.

  Enrollees with incomes above 100 percent FPL will pay premiums and co-pays similar to those imposed previously. Tennessee will institute a three-tiered pharmacy co-pay for enrollees in the TennCare Standard program. Beneficiaries under 100 percent FPL will pay $1, $3, or $5, depending on the drug. Those above 100 percent FPL will pay higher co-pays ($5, $10, $15).

- **TennCare Assist** would provide subsidies to families at or below 200 percent FPL that have access to private insurance.

Michigan

Michigan had been in negotiations with CMS for an aggressive HIFA waiver that would expand coverage to approximately 200,000 uninsured. In September 2002, Governor Engler requested that work on the waiver be delayed in light of budget constraints in the state. Since then, there has been a change in the gubernatorial administration and the state has incurred a revenue shortfall of close to $2 billion. There is no indication that the plan will be reinstated.

Michigan administrators intended on providing a limited benefit product for adults with incomes between 36 and 100 percent FPL—

a population that has been dependent on the safety net for years—by creating partnerships with county governments. The team in Michigan also wanted to create a benefit package focused on preventive services and primary care for adults with incomes up to 36 percent FPL.

"We wanted to test our capacity for creating differing benefit packages that are reflective of the needs and socioeconomic characteristics of certain populations in our state," said Carol Isaacs, former administrator in the Michigan Department of Community Health.

Michigan's plan, called the MIFamily proposal, incorporated two new plans to cover optional parent populations. Parents below 50 percent FPL would have coverage similar to a commercially available plan, with $5 co-pays for office visits and $25 for non-emergency use of the emergency room. Michigan established co-pays in relation to economic levels of the beneficiaries. Parents between 51 and 100 percent FPL would have higher co-pays.

Mississippi

Mississippi has been struggling to maintain its Medicaid program in light of budgetary problems. Officials are beginning to examine how benefits can be tailored even within the mandatory population. The state has embarked on a 12- to 18-month project to evaluate the existing Medicaid program and determine appropriate modifications.

Rica Lewis-Payton, executive director of the Mississippi Division of Medicaid, is interested in targeting specific benefits to categories of eligibles, as opposed to having all benefits available to all beneficiaries. "We have a benefits structure that gives everything to everybody with no correlation between necessary services and beneficiaries' health," says Lewis-Payton. Mississippi will also evaluate cost-sharing practices. In 2002, the state passed legislation mandating that the Medicaid program maximize the amount of co-pays to the extent allowed by federal law. Lewis-Payton plans on following in Oregon's footsteps, particularly with regard to working with stakeholders.

Conclusion

To some extent, states' efforts to redesign their benefits packages have yielded as many questions as answers. The current budgetary environment has prompted the states to adopt creative and resourceful approaches to expanding coverage. Nonetheless, as states continue to restructure their programs in the years to come, their experiences will broaden, and they will continually learn from one another's successes and failures. Meanwhile, policymakers can look to the lessons gleaned from the states outlined in this brief for guidance as they evaluate the merits of new coverage policies.

About the Author

Isabel Friedenzohn is an associate on the State Coverage Initiatives (SCI) program, which helps states improve the availability and affordability of health insurance coverage through providing grants, technical assistance, workshops, and information on best practices. She can be reached at 202.292.6700 or isabel.friedenzohn@academyhealth.org.

AcademyHealth
Advancing Research, Policy and Practice

1801 K Street, NW, Suite 701-L
Washington, DC 20006
tel: 202.292.6700
fax: 202.292.6800
e-mail: SCI@academyhealth.org
web: www.statecoverage.net

Nonprofit
Organization
U.S. Postage
PAID
Permit No. 3999
Washington, DC