Yet Another Blow to the Medicaid Expansion

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The Affordable Care Act extends and simplifies Medicaid eligibility beginning January 1, 2014, by replacing Medicaid’s previous multiple categorical groupings and limitations with one simplified overarching rule: all individuals aged <65 years with incomes less than 138% of the federal poverty level ($15,415 for an individual or $26,344 for a family of 3 in 2012) who meet citizenship/lawful US status and state residency requirements are entitled to Medicaid benefits. The expansion, however, has suffered several setbacks to date, including a Supreme Court ruling that states that do not wish to participate in the expansion will not be penalized for not participating. The latest—and less expected—setback was a decision by the Centers for Medicare & Medicaid Services (CMS) to only provide limited drug coverage for Medicaid beneficiaries in the Medicaid expansion population.

In the final rule on essential health benefits (EHBs), published July 5, 2013, CMS noted that requiring alternative benefit plans (ie, the plans that are offered to the Medicaid expansion population) to offer the same drug coverage as is offered under existing Medicaid would be “overinclusion,” because it would conflict with the states’ flexibility in defining the amount, duration, and scope of the benefit for covered outpatient drugs for the alternative benefit plans. Individuals who are enrolled in “traditional” Medicaid have access to all drugs that are manufactured by companies that participate in the Medicaid drug rebate program (meaning that Medicaid beneficiaries have access to most medications on the market).

The decision by CMS departs from the proposed rule, in which CMS proposed to require the same Medicaid coverage for alternative benefit plans as is required for the existing Medicaid program. Instead, individuals in the Medicaid expansion are entitled to a set of basic services (also known as EHBs), which include coverage of prescription drugs, along with inpatient and outpatient services, physicians’ services, laboratory services, mental health services, well-child care services, preventive services, and vision and hearing services.

The prescription drug coverage available to individuals in the expansion population will be the greater of one drug per class of drugs or the same number of drugs as contained in each class of drugs included in the state Medicaid benchmark plan that is selected by the state. In many cases, the prescription drug benefits that are available to individuals in the expansion population will be less robust than the coverage that is available to those in traditional Medicaid.

The overall effect on specific patient populations remains to be seen. The shift of discretion from federal standards to the states could result in a patchwork of coverage models for the Medicaid expansion population among the states (because each state’s benchmark coverage will be different). The originally proposed federal standards would have constituted minimum requirements for the states as a component of EHBs. Thus, the change in policy allows alternative benefit plans to reduce the coverage of prescription drugs for the Medicaid expansion population (alternative benefit plans are always free to cover additional drugs).

For providers, CMS’s final rule means that a patient with Medicaid is no longer just a patient with Medicaid. Rather, whether an individual is enrolled in traditional Medicaid or in an alternative benefit plan (as part of the expansion population) will determine the covered drugs that are available to them, and will therefore affect the physician’s prescribing behavior. The news is not all bad—most benchmark plans will offer robust prescription drug coverage and, in some cases, may prove less cumbersome than some of traditional Medicaid’s existing requirements, including fewer “fail-first” and “step-therapy” requirements.

References