Affordable Care Act: Adequacy of Medicaid Benefits

Improving access to essential health care for low-income and vulnerable populations

Medicaid is a safety-net health program administered by the states and jointly financed by the states and the federal government. States have used the broad flexibility historically allowed in Medicaid to create many eligibility, coverage, and financing policies that meet the diverse needs of their populations and satisfy state budgets. Thus, benefits have varied considerably by state.

The Affordable Care Act requires states to provide newly eligible adults, regardless of geographic location, with a minimum standard of benefits, also called a "benchmark" package. This package must include essential health benefits, as prescribed by the Secretary of Health and Human Services, that are equivalent to what will be available in the private health exchange.

Those who will be newly eligible for Medicaid under the Affordable Care Act include parents and childless adults who do not qualify for Medicare and have family incomes up to 133% of the federal poverty level (FPL).

Fast Facts:

- Forty-three state programs offer coverage for some form of tobacco-dependence treatment to Medicaid enrollees. Only New Mexico and New Jersey provide access to comprehensive tobacco-dependence treatments.
- Forty percent of Medicaid enrollees ages 50 to 64 received recommended colorectal cancer screening in the past 10 years. Eighty-three percent of Medicaid-enrolled women ages 18 to 64 received a Pap test in the past three years. Fifty-six percent of Medicaid-enrolled women ages 40 to 64 received a mammogram in the past two years.

Medicaid benefits currently vary greatly by state due to flexibility in the design of benefit packages.

Highlights of the Affordable Care Act

"Benchmark" Benefit Plans

- Newly eligible Medicaid enrollees, including many parents and childless adults up to 133% FPL who were not formerly eligible for the program, can enroll in new "benchmark" benefit plans.
- "Benchmark" and benchmark-equivalent health benefits coverage must include the essential benefits package: inpatient/outpatient hospital services; physicians' surgical and medical services; lab and x-ray services; and appropriate preventive services designated with an "A" or "B" rating by the U.S. Preventive Services Task Force (USPSTF) or recommended by the Secretary of HHS.
- Enrollees can be charged up to five percent of their family income and may be denied certain services if unable to pay.

Traditional Medicaid Plans

- Traditional Medicaid programs will still serve traditional categories including pregnant women, children, the disabled, some parents, and women with breast and cervical cancer.
- Traditional Medicaid health coverage includes: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), mental health services, transportation, durable medical equipment, case management, institutional care, and habilitation services.
- States could receive a one-percentage-point federal medical assistance percentage (FMAP) increase if states cover all USPSTF "A" or "B" recommended prevention services and eliminate cost sharing.
- Typical cost sharing is nominal. States may charge some groups higher co-pays and premiums. Groups exempt from cost sharing include children, pregnant women, individuals in hospice, and women with breast and cervical cancer. Services excluded from cost sharing include emergency, family planning and preventive services.

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Implications for the American Cancer Society and American Cancer Society Cancer Action Network (ACS CAN)

- ACS CAN will continue to monitor state efforts to design their own benchmark/benchmark-equivalent plans to ensure that plans adequately address cancer patients' needs.

- ACS CAN will strongly advocate for the inclusion of preventive and other services such as transportation in both traditional and "Benchmark" Medicaid plans, enabling states to provide more comprehensive, affordable and accessible care.