Health Advocate

E-Newsletter of the National Health Law Program

Volume 28 August 2014

Alternative Benefit Plans

Prepared by: Michelle Lilienfeld

Key Resources

Alternative Benefit Plans for the Medicaid Expansion Population: Trends in Approved Benefit Plans and Tools for Advocates, available here.

Medicaid: Essential Health Benefits in Alternative Benefit Plans Final Rule (July 15, 2013), available here.

CMS' Alternative Benefit Plans Implementation Guides, available here.

Coming in September's Health Advocate:

Managed Care

Alternative Benefit Plans (ABPs), formerly known as Medicaid benchmarks, have existed since the Deficit Reduction Act of 2005 gave states the authority to develop alternative Medicaid benefit packages for select groups of Medicaid beneficiaries. Prior to the Affordable Care Act (ACA) only a few states had selected this option. But the ACA brought new significance to ABPs by making them the benefit packages offered to the newly eligible Medicaid expansion population. This issue of the Health Advocate provides an overview of ABPs and what states have selected as their ABP for the Medicaid expansion population.

How do states decide what benefits to include in the ABP?

States must 1) select an ABP coverage option that serves as the basis for the ABP, 2) ensure the ABP includes the Essential Health Benefits, and 3) ensure other ABP service requirements are met.

<u>Step 1: States select an ABP coverage option</u>

States select one of five coverage options (referred to as "benchmark" plans) to define the ABP package. When selecting a benchmark plan, the state is not selecting the actual plan, but rather the list of benefits the plan offers.

The options are:

- Standard Blue Cross/Blue Shield PPO under the Federal Employees Health Benefits Program;
- Any generally-available state employee plan in the state;
- The HMO plan with the largest commercial, non-Medicaid enrollment in the state;
- Secretary-approved coverage (states can use this option to align the ABP with the state's approved Medicaid state plan benefits); or
- "Benchmark equivalent" plan (the overall benefits package is at least actuarially equivalent, i.e., comparable in terms of coverage, to one of the four options above.)

Step 2: States ensure the ABP includes the Essential Health Benefits

Next, states must ensure the ABP includes the Essential Health Benefits (EHBs.) Introduced by the ACA, EHBs are a set of ten health care service categories that plans must provide to ensure certain items and services are included in the plan. (*See Figure 1 for a list of the ten EHB categories.*) Health plans offered in the individual and small group markets (both inside and outside the Marketplace) must include the EHBs. As of January 1, 2014, ABPs must also include the EHBs so that individuals receiving coverage through an ABP also have access to the types of services available to those purchasing coverage in the individual and small group market.

Figure 1: EHB ten statutory categories of benefits

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services (including chronic disease management); and
- pediatric services, including oral and vision care.

States ensure the ABP includes the Essential Health Benefits by selecting an EHB base-benchmark plan from among ten options:

- the three largest Federal Employees Health Benefits Program plans;
- the three largest state employee plans;
- the three largest small group plans in the state; or
- the HMO plan with the largest commercial, non-Medicaid enrollment in the state.

If in Step 1 the state selected an ABP coverage option that is also an EHB base-benchmark option, then the ABP is deemed to have met the Essential Health Benefits requirement as long as all ten categories of benefits are covered. (*See Figure 2 for a comparison chart of ABP and EHB plans.*)

If in Step 1 the state selected an ABP coverage option that is **not** an EHB base-benchmark option, then the state must compare the Essential Health Benefits in the ABP and the EHB base-benchmark plan. If the ABP is missing any of the ten categories of benefits, the state must supplement the ABP with the benefits in the EHB base-benchmark plan.

- NOTE: *Substitution of benefits*. The state can also substitute one or more benefits within each EHB category as long as the services are "actuarially equivalent" (i.e., comparable in terms of coverage.)

Figure 2: Comparison of benchmark plan options for ABPs and EHBs

Type of Plan	Alternative Benefit Plans	EHB Base-Benchmark Plans
Federal Employees Health Benefits Program (FEHBP)	Standard BC/BS PPO	1 of 3 largest federal employee health plans
State Employee Coverage	Plan that is generally available to state employees	1 of 3 largest state employee health plans
Small Group Plan	n/a	1 of 3 largest small group plans in the state
Largest Commercial HMO in the State	✓	✓
Secretary-Approved Coverage	✓	n/a
Benchmark Equivalent Coverage	✓	n/a

Step 3: States must meet other ABP service requirements

Finally, the state ensures the inclusion of other required services. The ABP package must include:

- Family planning services and supplies, and
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21.

In addition, ABPs must comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008, and individuals enrolled in ABP coverage must have access to rural health clinics and federally-qualified health centers.

What have states selected as their ABP for the Medicaid expansion population?

States implementing the Medicaid expansion must obtain approval from the Centers for Medicare and Medicaid Services (CMS) of a State Plan Amendment (SPA) establishing an ABP for the adult expansion group. The first ABP SPA approvals for the Medicaid expansion population were issued in December 2013 and others have followed.

So far, of the 27 states (including D.C.) implementing the Medicaid expansion, nineteen states have aligned their ABPs with their Medicaid state plan benefits.[1] Aligning benefits means the state modeled its ABP package after the state's existing Medicaid state plan benefits rather than after a public employee or commercial market plan option. Alignment of benefits also means all Medicaid populations have access to the same services, which can be advantageous for a number of reasons, including ensuring comprehensive services for beneficiaries, minimizing disruption for individuals moving among different eligibility categories, and reducing the state's administrative burden.

[1] To date, nineteen states have aligned their ABPs with their Medicaid state plan benefits, five states have not aligned benefits, and three states are still pending ABP SPA approval.

Certain vulnerable populations cannot be required to enroll in an ABP

There are certain groups of individuals who cannot be required to enroll in the state's approved ABP package. These individuals must have the option to receive a benefits package that equals the state plan benefits. Therefore, states that have not aligned their ABP with their Medicaid state plan benefits must create a process to identify and notify ABP "exempt" individuals of their benefit options. Aligned states do not have to establish such a process, so this administrative simplicity is one of the reasons most states have decided to align benefits.

For the expansion population, most "exempt" individuals will be "individuals who are medically frail or have special medical needs."[2] States must set up a process to allow beneficiaries to seek an ABP exemption, and if a state denies the exemption it must provide the determination in writing and include an explanation of the appeals process, including the right to a hearing.

Conclusion

The ACA brought new significance to ABPs by making them the benefit packages offered to the newly eligible Medicaid expansion population. To date, most states participating in the Medicaid expansion have aligned their ABP for the expansion population with their traditional Medicaid state plan benefits. There are many advantages to aligning benefits for all Medicaid populations. For more details on aligned and non-aligned benefits, trends in approved ABP SPAs for the expansion population, and other important considerations, please refer to NHeLP's materials on ABPs and tools for advocates on our website.

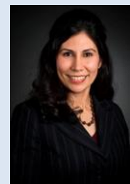
About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Authors

The following NHeLP attorney contributed to this month's *Health Advocate*:

Michelle Lilienfeld
Senior Attorney
LA Office



Offices

Washington, DC
1444 I Street NW, Suite 1105
Washington, DC 20005
(202) 289-7661
nhelpdc@healthlaw.org

Los Angeles
3701 Wilshire Blvd, Suite 750
Los Angeles, CA 90010
(310) 204-6010
nhelp@healthlaw.org

North Carolina
101 East Weaver Street, Suite G-7
Carrboro, NC 27510
(919) 968-6308
nhelpnc@healthlaw.org

Support

NHeLP's work is supported by individual donations, which are tax deductible. To learn more, please visit www.healthlaw.org

[2] *See* 42 C.F.R. § 440.315(f) (2014), for the full list of ABP "exempt" individuals.