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Understanding the Difference Between Medicaid and EHB Benchmarks: How These Systems Work and Interact

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Key Resources

In January and March 2012, NHeLP submitted comments on HHS' Essential Health Benefits Bulletin and Frequently Asked Questions, which can be found here and here respectively. NHeLP's earlier comments on this topic can be found here.

Also, see NHeLP's Overview to the Upcoming Supreme Court Decision on the ACA found here.

Upcoming comment deadlines:

- State Plan HCBS, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; due 7/2/12.
- Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of QHPs; due 7/5/12.
- Notice of Opportunity to Provide Comments - Reauthorization of Ryan White HIV/AIDS Program; due 7/31/12.

As health reform implementation moves forward, two health insurance "benchmark" systems are emerging as the critical determinants of the care and services that millions of individuals will receive beginning in 2014.[1] The first is the Medicaid benchmark, which already exists.[2] The second is the new Essential Health Benefits (EHB) benchmark, which sets the standard for benefits packages that individuals and employees of small businesses will receive through the Exchanges, Basic Health Plans, and other coverage options established by the Affordable Care Act (ACA).

This article provides an overview of the Medicaid and EHB benchmarks, and briefly describes some of the interactions between the two. NHeLP will release further analyses of these interactions in coming months.

WHO WILL GET THESE BENCHMARK BENEFITS?

Medicaid benchmark:

Medicaid benchmark plans have existed since the Deficit Reduction Act of 2005 allowed states the option of developing alternative Medicaid benefits packages for certain Medicaid-eligible individuals. Only a few states have selected this option, but the ACA brings new focus to Medicaid benchmarks because most of the newly eligible Medicaid expansion population will receive Medicaid benchmark coverage as of 2014.

The Medicaid Act exempts certain populations from benchmark coverage, so states cannot require beneficiaries within the following groups to enroll in Medicaid benchmarks:

- pregnant women;
- individuals who are blind or have a disability;
- individuals who are dually eligible for Medicaid and Medicare;
- terminally ill hospice patients;
- individuals who are eligible on the basis of hospitalization;
- individuals who are medically frail or have special medical needs;
- individuals qualifying for long term care services;
- children in foster care receiving child welfare services and children receiving foster care or adoption assistance;

[1] A benchmark is the standard by which benefits are measured or defined.

[2] This includes benchmark-equivalent plans, which are discussed later in this article.

- TANF and 1931 parents (i.e., individuals who would have been eligible for Aid to Families with Dependent Children before the program was abolished on July 16, 1996);
- women in the breast or cervical cancer program;
- limited services beneficiaries who qualify for Medicaid based on tuberculosis or who qualify for emergency services only; and
- medically needy or spend-down populations.

Although they cannot require exempt individuals to enroll in Medicaid benchmarks, states may offer these individuals the option to do so.

Essential Health Benefits benchmark:

In December 2011, the Department of Health and Human Services (HHS) released an Essential Health Benefits Bulletin defining the EHB standard as an EHB benchmark plan that includes the ACA's ten statutory categories of benefits (see Figure 2). Each state will select an EHB benchmark, which will serve as the basis of the benefits package offered to those in the Exchange, Basic Health Plans, and non-grandfathered plans sold in the small group and individual markets.[3] As a result, the EHB benchmark will set the scope of benefits that many individuals and employees of small businesses will receive in the private market.

WHAT ARE THE STATE'S OPTIONS FOR SELECTING A BENCHMARK PLAN?

Medicaid benchmark:

The Medicaid Act defines Medicaid benchmark plans as:

1. the standard Blue Cross/Blue Shield preferred provider option (PPO) under the Federal Employee Health Benefit Plan;
2. any generally-available state employee plan in the state;
3. the HMO plan with the largest commercial, non-Medicaid enrollment in the state; or
4. Secretary-approved coverage (which can include the state's existing Medicaid benefit package).

There is also a fifth option. States may design or select a benchmark-equivalent plan as long as it includes benefits within each of the following categories:

- inpatient and outpatient hospital services;
- physicians' surgical and medical services;
- laboratory and x-ray services;
- prescription drugs;
- mental health services;
- well-baby and well-child care (including immunizations); and
- "other appropriate preventive services" designated by the Secretary of HHS.[4]

Benchmark-equivalent coverage must have an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark plans listed above. To the extent the benchmark plan selected for comparison purposes includes vision and/or hearing services, the benchmark-equivalent package must also include these services at an actuarial value that is at least 75% of the actuarial value of the vision and/or hearing services in the benchmark plan.

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[3] A non-grandfathered plan is a plan that must implement the changes required by health care reform because it came into existence after the law passed (March 23, 2010) or was in existence before the law but made significant changes causing it to lose its grandfathered status.
[4] There is some overlap between these benchmark-equivalent categories of benefits and the ten statutory categories of benefits for EHB (see Figure 2 for a list of the EHB categories).

Of the few states currently offering Medicaid benchmark coverage, most have selected option #4, Secretary-approved coverage (i.e., any other health benefits coverage that the Secretary determines, upon application by a state, provides appropriate coverage for the population that will receive those benefits). The Secretary-approved coverage is limited to benefits available under benchmark coverage or the standard full Medicaid coverage package.

Essential Health Benefits benchmark:

States can select their EHB benchmark from among ten options:

- the three (3) largest federal employee plans;
- three (3) largest state employee plans;
- three (3) largest small group plans in the state; or
- the largest commercial HMO operating in the state.

Once the state selects a plan, it must supplement it as needed to include all ten EHB statutory categories of benefits (see Figure 2).

Figure 1: Comparison of benchmark plans for EHB and Medicaid

Type of Plan	Essential Health Benefits (EHB) Benchmark Plans[5]	Medicaid Benchmark Plans
Federal Employee Health Benefit Program (FEHBP)	1 of 3 largest	Standard BC/BS PPO
State Employee Coverage	1 of 3 largest	plan that is generally available to state employees
Small Group Plan	1 of 3 largest	n/a
Largest Commercial HMO in the State	✓	✓
Secretary-Approved Coverage	n/a	✓
Benchmark Equivalent Coverage	n/a	✓

ARE THERE SPECIFIC SERVICES THAT MUST BE INCLUDED?

Medicaid benchmark:

All Medicaid benchmarks must include: 1) family planning services and supplies; and 2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21.

Beginning in 2014, pursuant to the ACA, Medicaid benchmark coverage also must provide at least the EHBs (see Figure 2).

Figure 2: The plan selected as the EHB benchmark must include coverage of ten statutorily-designated 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.

[5] Based on enrollment data from the first quarter of 2012.

Essential Health Benefits benchmark:

If a state chooses an EHB benchmark plan that is missing any of these categories, the state must supplement the benchmark to include that category of benefits. If a state chooses an EHB benchmark plan that is subject to state health insurance mandates (e.g., a small group market plan), those mandates become part of the EHB benchmark at no additional cost to the state until 2016.[6] If a state does not choose an EHB benchmark plan that is subject to mandates (e.g., a Federal Employee Health Benefit Plan), the state must pay the additional costs associated with mandated services. In 2016, HHS will revisit coverage of state mandates in the EHB benchmark.

INTERACTION BETWEEN MEDICAID AND EHB BENCHMARKS

Further guidance on how states should proceed is needed to assess how these two benchmarks will interact. In the meantime, it is important for advocates to understand how these benchmark systems work, identify the options available in their states, and closely monitor state implementation to identify opportunities for advocacy and education.

CONCLUSION

NHeLP will continue to monitor the interactions and challenges described above, and advocates should closely monitor the implementation of these benchmark standards in their states. This monitoring should include:

- Making sure states understand that the EHB requirement enhances, but does not replace, existing Medicaid benchmark requirements.
- Analyzing the importance of aligning benefit coverage offered to different populations (e.g., the Medicaid expansion population and current Medicaid-covered populations).
- Requesting future guidance on how states will know if their Medicaid benchmark appropriately covers the EHBs and, if necessary, how to supplement.
- Ensuring that important state mandates are included as part of the EHB at no additional cost to the state beyond 2016.

NHeLP has already prepared several comments on the underlying principles of the EHB, available on our website. We will continue to post information and analyses, so please visit our website regularly for more information.

[6] Mandated benefits are benefits that health insurance companies or health plans are required to provide. Since private insurance regulation has historically been the responsibility of the states, most mandated benefits are established by state legislatures, and are therefore state mandates. Some common mandated benefits are substance abuse treatment, maternity minimum stay, and mammography screening.

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.

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