NATIONAL HEALTH LAW PROGRAM

An **Advocate's Guide** to Reproductive and Sexual Health in the Medicaid Program

Chapter V: Reproductive and Sexual Health Services for the Medicaid Expansion Population

The Deficit Reduction Act (DRA) of 2005 gave states flexibility to develop alternative Medicaid benefit packages for select groups of Medicaid enrollees that differ from the state's existing plan.[1] These Alternative Benefit Plans (ABPs), formerly known as Medicaid benchmarks, gained new significance under the ACA. Prior to the ACA, only a few states had selected the option to provide Medicaid benchmark benefits to enrollees in their state. With the enactment of the ACA, states that expand their Medicaid program must now offer ABPs to the newly eligible Medicaid population.[2] Thus, ABPs are important because they are the basis of benefits packages for some existing Medicaid populations at state option (as initially provided under the DRA of 2005) and the newly eligible Medicaid expansion population (as provided under the ACA).[3]

Most newly eligible Medicaid populations—those residing in states that have expanded their Medicaid program—are enrolled in Medicaid programs that have aligned their benefits.[4] "Aligned 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. Alignment of benefits can be advantageous for a number of reasons, including ensuring comprehensive services for enrollees, minimizing disruption for individuals moving among different eligibility categories, and reducing the state's administrative burden. However, "alignment" does not mean benefits are identical. It means the ABP includes all of the state plan services, but may include additional services as well.

States that offer "non-aligned" benefits, i.e., they do not model their ABP package after the state's existing Medicaid state plan benefits, must establish a process to identify exempt populations.[5] For example, pregnant women, individuals who are blind or have a disability, women in the breast or cervical cancer program, and medically needy or spend-down populations are considered "exempt" for ABP purposes.[6] States cannot require these and other groups of exempt individuals to enroll in the state's approved ABP package, but must create a process to identify and notify these individuals of their benefits options.

A. ABPs and Essential Health Benefits

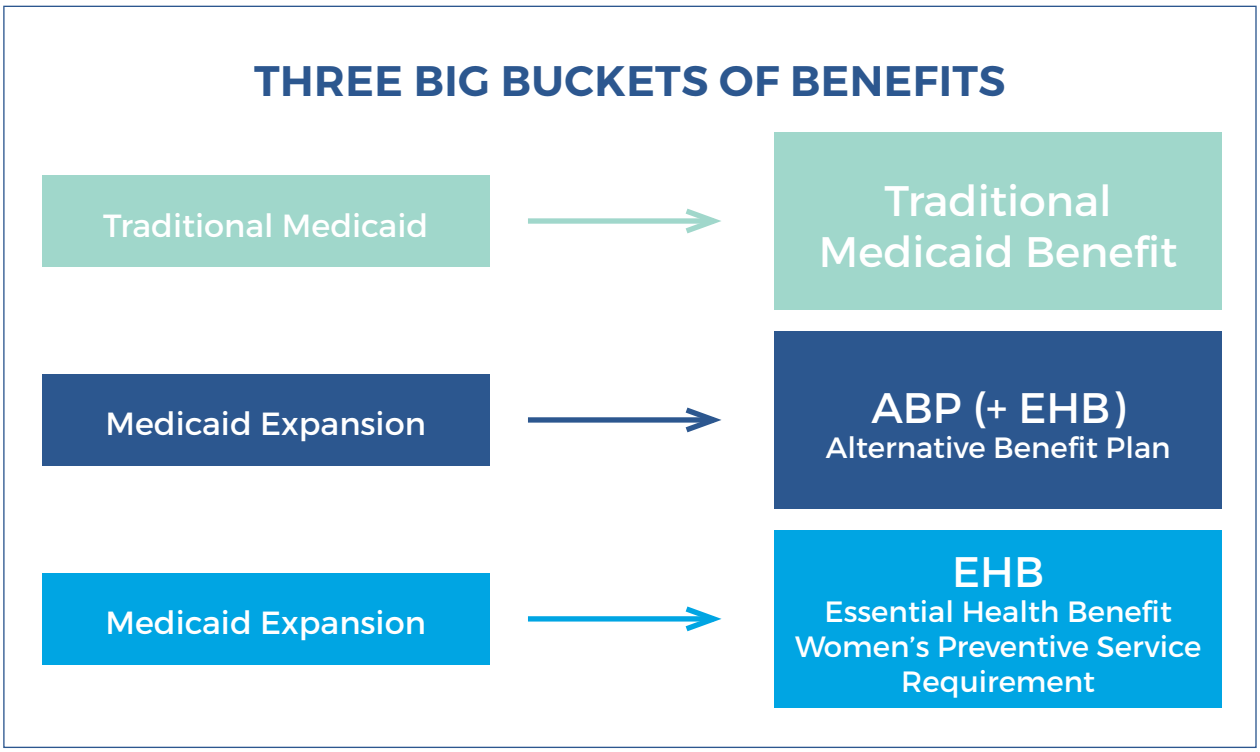
The ACA also included a requirement that ABPs provide, at a minimum, coverage for a core set of basic services known as Essential Health Benefits (EHBs). This requirement ensures that individuals enrolled through their state's Medicaid expansion program receive coverage for the following ten categories of service the ACA deemed as "essential":

EHB TEN STATUTORY CATEGORIES OF BENEFITS

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services (including chronic disease management); and
10. Pediatric services, including oral and vision care.

In the EHB final rule of 2013, HHS tied the EHB's preventive service requirement to the ACA's preventive services requirement in §2713 of the Public Health Service Act (PHSA).[7] To comply with §2713 of the PHSA, plans that are subject to the requirement, including ABPs, must cover:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA.



B. ABPs and Preventive Services for Women

Section 2713 requires ABPs to cover a range of preventive services for adults and children.[8] ABPs may not impose cost sharing on Medicaid enrollees who seek such services. As described, the EHBs also incorporate through regulation the additional ACA requirement that cover women's preventive services.[9] This requirement ensures a specific set of preventive services for women are also covered without cost-sharing.[10] The required services are based on a set of recommendations from the Health Resources and Services Administration (HRSA).[11] These services are listed below:[12]

PREVENTIVE SERVICE	DESCRIPTION
Breast Cancer Screening for Average-Risk Women	Annual or biennial mammography screening for average-risk women ages 40-74 in consultation with health care provider.
Breastfeeding Services and Supplies	Comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period).
Screening for Cervical Cancer	Cervical cancer screening for average-risk women ages 21-65 years.

PREVENTIVE SERVICE	DESCRIPTION
Contraception	Full range of female-controlled FDA-approved contraceptive methods (18 prescribed methods), sterilization procedures, and effective family planning practices for adolescent and adult women. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., management, and evaluation as well as changes to and removal or discontinuation of the contraceptive method).
Screening for Gestational Diabetes Mellitus	Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation. Women with risk factors for gestational diabetes should be screened at the first prenatal visit.
Screening for Human Immunodeficiency Virus	Annual counseling and testing for HIV for all sexually active adolescents and women throughout the lifespan.
Screening for Interpersonal and Domestic Violence	Annual screening and counseling for interpersonal and domestic violence for adolescents and women.[13] When needed, provide or make referrals for initial intervention services.
Counseling for Sexually Transmitted Infections (STIs)	Directed behavioral counseling for all sexually active adolescents and adult women at an increased risk for STIs based on sexual history and risk factors.
Well-Woman Preventive Visits	Annual preventive care visit beginning in adolescence and continuing across the lifespan to obtain recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.

Preventive services are an important benefit for all cisgender and transgender women, and women of color in particular. Women of color are more likely to suffer from preventable health conditions and to delay/forgo care due to the cost of care. The median time of survival for black women who are diagnosed with breast cancer is nearly three years shorter than that of white women. Researchers in the Journal of the American Medical Association attributed this disparity, in part, to more advanced disease at the time of diagnosis.[14] The ACA's requirements to cover a range of women's preventive services—including mammograms, cancer screenings, and well-woman visits—with no out-of-pocket costs will help more women of color receive an earlier diagnosis and treatment. Further, the overlapping requirement for Medicaid ABPs to comply with both the preventive services requirement and Medicaid's requirement to cover family planning services and supplies helps to ensure that women enrolled in ABPs are guaranteed coverage for a range of preventive services that most commercial insurance plans must also cover under the ACA.[15]

Importantly, the women's preventive services requirement to provide contraception with no cost sharing covers the full range of 18 FDA-approved contraceptive methods used by women, including female sterilization and contraceptives that are generally available over-the-counter and prescribed to women.[16] Additionally, HHS has clarified that the ACA contraceptive coverage requirement includes related follow-up and side effect management, and device removal.[17]

Yet, the federal requirement also lacks some important coverage groups and services. For example, while the women's preventive service requirement cannot be limited to an individual's sex assigned at birth, gender identity, or recorded gender when medically appropriate, it does not extend to men or include male methods of contraception.[18] Medicaid managed care plans are also permitted to use "reasonable medical management techniques" as a way to limit enrollee's usage of preventive services and control costs.[19] As a result, plans may limit no-cost coverage to only one form of contraception in each of the FDA-approved contraceptive method categories, as long as doing so would be medically appropriate.[20] A more detailed review of utilization controls in family planning is provided in Chapter IV, Section B5.

Endnotes

1 42 U.S.C. § 1396u-7 (added by Deficit Reduction Act § 6044 and amended by CHIPRA § 611 and ACA §§ 2001, 2303); 42 C.F.R. §§ 440.300-440.390 (eff. July 1, 2010) (added by Benchmark Benefit and Benchmark-Equivalent Coverage, 73 Fed. Reg. 73724 (Dec. 3, 2008), as amended by 74 Fed. Reg. 5809 (Feb. 2, 2009); 74 Fed. Reg. 15221 (Apr. 3, 2009), 74 Fed. Reg. 62501 (Nov. 30, 2009), and 75 Fed. Reg. 23101 (Apr. 30, 2010)).

2 *See* ACA § 2001(a)(2) (adding 42 U.S.C. § 1396a(k)(1)). Individuals who fall within one of the 42 U.S.C. § 1396u-7 excluded groups cannot be required to enroll into benchmark coverage. See 42 U.S.C. § 1396a(k)(1); CMS, Dear State Medicaid Director at 3 (SMDL # 10-005) (Apr. 9, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd10005.pdf.

3 *See* Michelle Lilienfeld, Nat'l Health Law Prog., *Alternative Benefit Plans for the Medicaid Expansion Population* (2014), https://healthlaw.org/resource/alternative-benefit-plans-for-the-medicaid-expansion-population/ [hereinafter Lilienfeld, Alternative Benefit Plans].

4 Lilienfeld, *Alternative Benefit Plans, supra* note 3.

5 For a list of ABP coverage options for states that opt not to align, see Michelle Lilienfeld, Nat'l Health Law Prog., *Health Advocate: Alternative Benefit Plans,* https://healthlaw.org/resource/health-advocate-alternative-benefit-plans/.

6 42 U.S.C. § 1396a(k)(1). Enrollees in the new adult expansion group who meet an ABP exemption "must be given the option of an Alternative Benefit Plan that includes all benefits available under the approved State plan" instead of being required to receive the ABP that the state has selected for the expansion group. See 42 C.F.R. § 440.315; *see generally Lilienfeld, Alternative Benefit Plans, supra* note 3.

7 45 C.F.R. § 156.115(a)(4). Plans required to cover the ten EHB categories must also provide benefits that "include preventive services described in [45 C.F.R. § 147.130]." 45 C.F.R. § 147.130 lists what the services plans need to cover in order to comply with § 2713 of the PHSA.

8 ACA § 1001 (adding § 2713 of the Public Health Services Act) (codified at 42 U.S.C. § 300gg-13(a)).

9 45 C.F.R. § 156.115(a)(4). For a fuller explanation of this coverage requirement see Nat'l Health Law Prog, *Q and A: Preventive Services for Women Coverage Requirements (Updated)* (July 2013), https://healthlaw.org/resource/q-a-preventive-services-for-women-coverage-requirements-updated/. The ACA' coverage for preventive services applies to "women," however joint federal guidance clarified that sex-specific recommended preventive care cannot be based on an individual's assigned at birth sex, gender identity, or government-recorded gender. *See* U.S. Dep't of Labor, HHS, and Treasury, FAQs About Affordable Care Act Implementation (Part XXVI) at 6, (May 11, 2015) [hereinafter Joint FAQs Part XXVI], https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf.

10 U.S. Dep't of Labor, HHS, and Treasury, Frequently Asked Questions about Affordable Care Act Implementation (Part XII) (Feb. 20, 2013) [hereinafter Joint FAQs Part XII], https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf.

11 HRSA's initial recommendations were adopted in 2011 from an expert committee convened by the Institutes of Medicine (IOM). *See* IOM, *Clinical Preventive Services for Women: Closing the Gaps* (July 19, 2011), http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. HRSA subsequently updated the guidelines in 2016 based on recommendations from the Women's Preventive Services Initiative, a committee convened by the American College of Obstetricians and Gynecologists. *See* Women's Preventive Services Initiative, *Recommendations for Preventive Services for Women* (2017), https://www.womenspreventivehealth.org/final-report/.

12 HRSA, Women's Preventive Services Guidelines webpage, https://www.hrsa.gov/womens-guidelines/index.html (last visited Jun. 24, 2019).

13 Interpersonal violence screenings involve the patient answering a series of questions, either self-administered or in response to provider prompts, to discern signs of abuse. For many women, interpersonal violence and HIV are often a cyclical intersection. Women in violent relationships are four times more likely than women in non-violent relationships to contract STIs, including HIV. Interpersonal violence among women with HIV is more than double the national rate. Thus, the ACA preventive service requirement to cover interpersonal violence screenings can help address the risk for HIV infection. *See* Lindsey Dawson & Jennifer Kates, Kaiser Family Found., *HIV, Intimate Partner Violence, and Women: New Opportunities under the Affordable Care Act* (Oct. 21, 2014), http://kff.org/hivaids/issue-brief/hiv-intimate-partner-violence-and-women-new-opportunities-under-the-affordable-care-act/).

14 Jeffrey Silber, et al., *Characteristics Associated with Differences in Survival Among Black and White Women with Breast Cancer*, JAMA 310(4), 389-397 (2013); Erin Armstrong, Network for Public Health, *How Affordable Care Act Requirements May Help Address Health Disparities* (Aug. 27, 2013), https://www.networkforphl.org/the_network_blog/2013/08/27/231/how_affordable_care_act_requirements_may_help_address_health_disparities.

15 42 C.F.R. § 440.345(b) (requiring that Alternative Benefit Plans cover family planning services and supplies).

16 Joint FAQs (XII), *supra* note 10 at 7.

17 *Id.* at 8.

18 Joint FAQs (Part XXVI), *supra* note 9.

19 The extent of permissible medical management techniques is not defined, however federal regulations and guidelines permit plans and issuers to determine the "frequency, method, treatment, or setting" in which the service is delivered. 45 C.F.R. § 147.130(a)(4).

20 Joint FAQs (XII), *supra* note 10, at 7.