University of Maryland Francis Carey School of Law

Health Care Reform Roundtable: The State of the States

Essential Health Benefits Implementation
Implications for Medicaid Alternative Benefit Plans

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What “Benchmark” am I Talking About?

**Medicaid**
State-selected benefit package that must be provided to the new adult group and under the Section 1937 “Benchmark” option

**EHB**
State-selected benefit package defining “essential health benefits” (EHB)

- The “Medicaid Benchmark” is now called the...
- Alternative Benefit Plan (ABP)

- The “Benchmark” or “Reference Benchmark” is now called the...
- Base-Benchmark Plan
- Supplementation as necessary
- EHB-Benchmark Plan
ACA establishes new, mandatory Medicaid eligibility group of non-pregnant adults between 19-65 with incomes ≤138% FPL

- This “new adult eligibility group” generally consists of childless adults, and parents/caretakers above states’ current Medicaid levels to 138% FPL
- States must provide ABP coverage described under §1937 of the Social Security Act (DRA) of 2006, as modified by the ACA to adults in new adult eligibility group
- States will receive enhanced FMAP for “newly eligibles” within new adult eligibility group
ABPs must:

Include all 10 essential health benefits (EHBs):
- For new adult group (newly-eligible and currently-eligible)
- As defined by designated EHB base benchmark plan

Meet the Mental Health Parity and Addiction Equity Act (MHPAEA)

Provide early and periodic screening, diagnostic and treatment (EPSDT) services for individuals below age 21

Provide non-emergency transportation

Cover prescription drugs – must comply with Medicaid prescription drug requirements

10 EHBs:
- 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
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care
States must choose an EHB base benchmark plan for the ABP, and it may be different than the one selected for the individual and small group markets.
Selection Process for ABP

1. States must select from the four Section 1937 options in designing their ABPs
   - Standard BCBS PPO plan under FEHBP
   - Largest non-Medicaid commercial HMO in the State
   - Any generally available State employee plan
   - HHS-Secretary approved plan (e.g., standard Medicaid)

2. Is the ABP selection also one of the 10 EHB base benchmark options?
   - YES
   - NO

3. Does the base benchmark include all 10 EHB categories?
   - YES
   - NO: State must add missing EHB category to ABP

3a. State must select one of the EHB base benchmark options, determine whether the selected option includes all 10 EHB categories, and supplement any missing EHB categories.

3b. State must compare amount, duration and scope of benefits in the selected EHB base benchmark and selected 1937 option. State must expand ABP benefits if they are less generous in amount, duration and scope than those covered by the EHB base benchmark plan.

EHB Standard Met
Individuals Exempt from Mandatory ABP Enrollment

- Pregnant women
- Individuals who qualify for Medicaid based on being blind or disabled (regardless of SSI eligibility)
- Dual eligibles
- Terminally ill hospice patients
- Inpatients in hospitals, nursing home and ICF who must spend down
- TANF/Section 1931 parents and caretakers
- **Medically frail individuals**
  - Individuals who qualify for LTC services based on their medical condition
  - Individuals who only qualify for emergency care
  - Individuals who qualify based on spend down

- State receives enhanced FMAP for all newly eligible adults, including those that are exempt from mandatory ABP enrollment and select Medicaid Standard benefit package
- Individuals requiring LTC services may access them through Medicaid Standard
### Differences Between EHB in Exchange & Medicaid: Benefit Design

#### Pediatric Oral and Vision Services

- All medically necessary services, including pediatric oral and vision services, must be provided to eligible individuals under age 21 under Medicaid’s EPSDT benefit
  - **Any limitation to pediatric services in an EHB-benchmark plan does not apply to Medicaid**

#### Habilitative Services

- CMS proposes that states define the habilitative benefit in Medicaid, requests comments on the level of flexibility states should have in setting that definition:
  - Whether the state habilitative benefit definition for the Exchanges should apply to Medicaid or whether a separate habilitative benefit definition for Medicaid may be defined by states
  - Allowing states to fully define the benefit and approaches for defining the benefit
  - Whether the habilitative benefit should be offered in parity with the rehabilitative benefit

#### Prescription Drugs

- Current Medicaid rules (Social Security Act §1927) apply to prescription drugs covered in the ABP
  - States will be able to access Medicaid rebates for prescription drugs covered in the ABP
- Different rules apply to EHB requirements in the small group and individual markets
  - CCIIO requires the greater of: (1) one drug in every USP therapeutic category or class; or (2) the same number of drugs in each USP category and class as the state’s base benchmark plan
Thank You!

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