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Designing Medicaid Benchmark Benefits for New Adult Beneficiaries

BY DEBORAH BACHRACH AND EMILY LEE

On Dec. 16, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) within the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) released a bulletin providing guidance with respect to: (i) new state flexibility to design the ''essential health benefits'' (EHBs) that plans in the individual and small group markets sold inside and outside of Health Insurance Exchanges must cover; and, (ii) reference plans to which a state may link its EHBs.[1] Regardless of a state's choice of the EHB reference plan, the state's EHB package must include the 10 areas of care listed in the Patient Protection and Affordable Care Act (ACA) and may include state-mandated benefits at least in 2014 and 2015. HHS intends to revisit this approach in 2016. On Feb. 17, HHS issued a Frequently Asked Questions (FAQs) document providing additional guidance on its approach to defining EHBs.[2]

[1] CIIOO, Essential Health Benefits Bulletin (Dec. 16, 2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[2] Frequently Asked Questions on Essential Health Benefits Bulletin (Feb. 17, 2012), *available at* http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

Deborah Bachrach is a special counsel at Manatt, Phelps & Phillips LLP where she advises states, foundations, and private stakeholders on implementation of federal health reform. From 2007-2010, she was the Medicaid director of New York State. Emily Lee is an associate at Manatt, Phelps & Phillips.

The December guidance underscored an issue that is rapidly coming into focus as states grapple with their EHB choices in the individual and small group market (including Qualified Health Plans operating in state Exchanges); namely, states' EHB choices for design of ''benchmark benefits'' for individuals eligible for Medicaid under a new mandatory coverage group added under the ACA (the ''new adult group'').[3] In fact, three of the February FAQs specifically addressed the applicability of EHB to Medicaid. Pursuant to the ACA, the new adult group must be offered Medicaid benchmark benefits which must include all EHBs, although the EHB reference plan for Medicaid may differ from the one selected for the individual and small group market. Medicaid benchmark benefits for the new adult group also must conform to the Medicaid benchmark benefit rules in the Deficit Reduction Act of 2005 (DRA) as modified by both the ACA and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Fewer than a dozen states have used the DRA benchmark option[4] and thus states are going into uncharted waters in Medicaid benchmark development much as they are with respect to EHB design in their individual and small group markets.

This article reviews the statutory requirements and state options relevant to crafting the Medicaid benchmark benefit as well as the operational, financial and clinical implications of these options. We also note areas in which additional federal guidance is required before states can make final Medicaid benefit decisions.

Medicaid Benchmark Benefits Under the DRA

Beginning in 2006, the DRA offered states the opportunity to tailor and narrow Medicaid coverage for certain populations through benchmark benefit packages; it also permitted states to impose more than nominal cost-sharing for populations with incomes above 100 percent of the Federal Poverty Level (FPL).[5]

[3] ACA § 2001(a)(1)(C); codified at S.S.A. § 1902(a)(10)(A)(i)(VIII).

[4] In a 2010 regulation, CMS stated that it had approved 10 benchmark packages, and that eight of those packages fall into the category of Secretary-approved coverage. Final Rule, Medicaid Program: State Flexibility for Medicaid Benefit Packages, 75 Fed. Reg. 23068 (April 30, 2010).

[5] DRA, Pub. L. No. 109-171, § 6044 (2006); codified at S.S.A. § 1937; DRA, § 6041; codified at S.S.A. § 1916A.

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The DRA benchmark option, codified at Section 1937 of the Social Security Act (Act), is a departure from rules governing ''standard'' Medicaid programs. For standard Medicaid, federal law generally requires states to cover a list of mandatory services and provides the option of covering additional services as the chart below describes. [6]

Mandatory Services	Common Optional Services (number of states covering)
Inpatient and outpatient hospital care	Prescription drugs (50)
Physicians' services	Clinic services (50)
EPSDT for individuals covered in the State's Medicaid program under 21	Skilled nursing facility services for individuals under 21 (50)
Family planning services and supplies	Occupational therapy (50)
FQHC and RHC services	Targeted case management (50)
Home health services	Physical therapy (50)
Laboratory and X-ray	Hospice (48)
Nursing facility services	Inpatient psychiatric for individuals under 21 (48)
Nurse midwife and nurse practitioner services	Services for individuals with speech, hearing, and language disorders (45)
Tobacco cessation counseling and pharmacotherapy for pregnant women	Audiology services (43)
Non-emergency transportation	Personal care (35)
Freestanding birth center services	Rehabilitative services (33)

Under the DRA, Medicaid benchmark coverage is not based on the package of mandatory and optional services in standard Medicaid. Instead, Medicaid benchmark coverage may be based on any one of the following plans[7]:

- standard Blue Cross/Blue Shield (BCBS) PPO service plan under the Federal Employees Health Benefits Program (FEHBP);
- HMO plan with the largest commercial, non-Medicaid enrollment in the state;
- any generally available state employee plan; or
- any plan that the Secretary of HHS determines to be appropriate for the targeted population.

The DRA also gives states the option to offer benchmark-equivalent coverage with at least the same actuarial value as one of the benchmark plans described above, as long as it includes certain mandated services.[8] The DRA further requires all benchmark packages to include federally qualified health center (FQHC)/rural health clinic (RHC) services and, as a result of CHIPRA, early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21 and non-emergency transportation.[9]

While all Medicaid beneficiaries may be offered benchmark coverage, some groups retain the right to receive the standard Medicaid benefit package. In addition to certain very low-income parents and caretakers, the benchmark-exempt groups include the following:[10]

- the medically frail;
- children in foster care;
- hospice patients;
- individuals who qualify for Medicaid based on being blind or disabled; and
- individuals who qualify for long-term care services based on their medical condition.

Medicaid Benchmark Benefits for the New Adult Group Under the ACA

The ACA requires states to provide benchmark or benchmark-equivalent coverage described under Section 1937 of the Act to Medicaid beneficiaries in the new adult group. The new adult group includes nonpregnant individuals with incomes below 133 percent of the FPL, who are between the ages of 19 and 65, not entitled to or enrolled in Medicare Part A, not enrolled in Medicare Part B, and not eligible under any of the other mandatory eligibility categories.[11] For the most part, the new adult group definition encompasses childless adults, and parents who are above the state's 1996 welfare level.[12] Individuals who qualify for Medicaid under other eligibility categories, such as Supplemental Security Income-disabled or parents below a state's 1996 welfare level, will continue to be entitled to the standard benefit package. States will receive enhanced federal financial participation (FFP) for benchmark benefits provided to a subgroup of beneficiaries in the new adult group (newly eligibles), starting at 100 percent for 2014-2016 and phasing down to 90 percent in 2020 and thereafter.[13]

The ACA expands the definition of Medicaid benchmark benefits to include family planning services and

[6] *See* Medicaid and CHIP Payment and Access Commission Report to the Congress on Medicaid and CHIP, Chapter 2, Table 2-1 (March 2011), *available at* http://www.macpac.gov/reports.

[7] S.S.A. § 1937(b)(1); 42 C.F.R. § 440.325; 42 C.F.R. § 440.330.

[8] DRA § 6044; codified at S.S.A. § 1937(b)(2).

[9] 75 Fed. Reg. 23068 (April 30, 2010); 42 C.F.R. §§ 440.345 and 440.390.

[10] S.S.A. § 1937(a)(2)(B).

[11] ACA § 2001(a)(1)(C); S.S.A. § 1902(a)(10)(A)(i)(VIII).

[12] A state must cover parents at this minimum eligibility level, and can choose to cover parents at higher income levels. A Kaiser survey reports that as of January 2011, 33 states limited eligibility for parents to less than 100 percent of FPL, with 17 states limiting eligibility to less than 50 percent of FPL. ''Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults,'' *Kaiser Commission on Medicaid and the Uninsured* (February 2011), *available at* http://www.kff.org/medicaid/upload/7993-02.pdf.

[13] ''Newly eligible'' is defined as individuals in the new adult group who are not under 19, not eligible under the state plan or under a waiver for full benefits or for benchmark coverage described in 1937, or were eligible under a waiver but not enrolled because of caps or limits on waiver enrollment. ACA § 2001(a)(3); S.S.A. § 1905(y)(2)(A). States that already cover childless adults and parents up to 100 percent of the FPL will receive the increase in federal funding for their previously covered childless adults at a lower rate initially, ramping up to the same level (90 percent) as other states by 2020.

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supplies.[14] While mental health parity previously applied only to Medicaid benefits (both standard and benchmark) offered through Medicaid managed plans, the ACA extends the federal mental health parity provisions with respect to financial requirements and treatment limitations to Medicaid benchmark benefits offered through fee-for-service plans.[15]

Effective Jan. 1, 2014, the ACA also requires Medicaid benchmark benefits to include the 10 categories of EHBs.[16] The categories of EHBs set forth in the ACA are: 1) ambulatory services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance abuse disorder services, including behavioral health treatment, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.[17] In addition, the ACA instructs the Secretary that the scope of EHBs shall equal the scope of benefits provided under a typical employer plan.[18]

The EHB Bulletin issued last December (the ''Bulletin'') advises that a state must define EHBs for its individual and small group markets by selecting an EHB reference plan from among four listed options.[19] Notably, per the February FAQs, a state may select a different EHB reference plan for its Medicaid benchmark benefit than it selects for the individual and small group market. Moreover, while the state may only have one reference plan for the individual and small group market, it may have more than one EHB reference plan for Medicaid, thereby allowing a state to design different benchmark benefit plans for different populations within the new mandatory eligibility group.[20]

For Medicaid benchmark, states may select an EHB reference plan from among three plans that are listed in the EHB Bulletin and described as benchmark plans under Section 1937 of the Act:

- the state's largest non-Medicaid HMO;
- the state's employee health plan; or
- the FEHBP BCBS plan.

A state would need to identify an EHB reference plan for Medicaid benchmark as part of its 2014-related Medicaid State Plan changes. If the reference plan selected for Medicaid benchmark purposes does not cover all 10 statutory benefit categories, then the state must supplement it. Where the benchmark plan selected for the individual and small group market is missing coverage of one or more of the 10 statutory categories, the FAQs provide that the state must supplement the benchmark by reference to another benchmark plan that covers the missing services. For the three categories of required services often missing from private health insurance plans—habilitative services, pediatric oral care and pediatric vision care—the FAQs suggest special rules.[21] The FAQs do not indicate whether Medicaid is to follow the same approach to supplementing benefits as must be followed with respect to development of a state's EHB for the individual and small group market.

Finally, the FAQs indicate that a state may choose to offer its standard (traditional) Medicaid benefit package as its benchmark reference plan under Section 1937's Secretary-approved option.[22] As with a commercial reference plan, the state would have to ensure that the 10 statutory categories of EHBs are covered. Notably, some of the services that are mandatory EHBs are not mandatory benefits under Medicaid. Examples include substance abuse disorder benefits, rehabilitative services, and habilitative services which are not currently covered by all state Medicaid programs. In this respect, a state's Medicaid benchmark benefit may be required to cover services that its standard benefit package does not.

Open Questions and Considerations in Designing Medicaid Benchmark Benefits

Application of EHBs to Institutions of Mental Disease. One of the 10 statutorily required services that must be included in EHBs and therefore by Medicaid's benchmark benefit is mental health and substance abuse disorder services. Currently, federal Medicaid does not cover services provided to patients between the ages of 21 and 65 who are patients of institutions of mental disease (IMDs), whether the service is provided to the IMD patient in or out of the facility.[23] IMDs are defined as facilities that primarily engage in providing diagnosis, treatment or care of individuals with mental diseases.[24] While Medicaid does not cover IMD services or IMD patients, it is highly unlikely that any of the EHB reference plans exclude IMD services or patients. This raises the question whether in extending EHBs, in particular mental health and substance abuse services, to Medicaid benchmark, the ACA effectively eliminates the restriction on Medicaid coverage for patients of IMDs who are otherwise eligible for benchmark coverage. And, would the answer to that question change if the services were provided in the IMD as opposed to services provided to an IMD patient outside the IMD?

Application of the Benchmark Exemptions to the New Adult Group. As noted above, Section 1937 provides that

[14] ACA § 2303(c); S.S.A. § 1937(b)(7). The ACA further adds mental health services and prescription drug coverage to the list of required services that must be included in benchmark-equivalent plans. ACA § 2001(c)(2)(B); S.S.A. § 1937(b)(2)(A).

[15] The ACA provides that with respect to Medicaid benchmark, ''the financial requirements and treatment limitations applicable to . . . mental health or substance use disorder benefits [must] comply with the [federal mental health parity] requirements . . . in the same manner as such requirements apply to a group health plan.'' ACA § 2001(c)(3); S.S.A. § 1937(b)(6)(A). In addition, pursuant to Section 1937(b)(6)(B), benchmark packages are deemed to satisfy federal parity requirements if they provide EPSDT benefits to individuals under age 21 (which they are required to cover). *See also* Congressional Research Service Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010* (Dec. 28, 2011).

[16] ACA § 2001(c)(3); S.S.A. § 1937(b)(5).

[17] ACA § 1302(b)(1).

[18] ACA § 1302(b)(2).

[19] The listed options are: (1) one of the three largest plans in the state's small group market; (2) any of the three largest state employee plans; (3) one of the three largest national FEHBP plan options; or (4) the largest insured commercial non-Medicaid HMO. CCIIO, Essential Health Benefits Bulletin (Dec. 16, 2011).

[20] FAQs, Q&A No. 21.

[21] FAQs, Q&A No. 5.

[22] FAQs, Q&A No. 22.

[23] S.S.A. § 1905(a); 42 C.F.R. § 435.1008; 42 C.F.R. § 441.13.

[24] 42 C.F.R. § 435.1010.

certain populations, such as the medically frail and children in foster care, may not be required to enroll in benchmark benefits. A question has been raised as to whether the Section 1937 benchmark exemptions apply to individuals in the new adult group who would otherwise be limited to benchmark benefits. While a full discussion of the issue is beyond the scope of this paper, we believe the better reading of the statute is that the exemptions apply. Section 1902(k)(1) of the Act states that ''[t]he medical assistance provided to an individual described in [the provision defining the new adult group] shall consist of benchmark coverage . . . or benchmark equivalent coverage . . . Such medical assistance shall be provided subject to the requirements of section 1937 . . . unless an individual described in [the provision defining the new adult group] is also an individual for whom, under [Section 1937(a)(2)(B], the State may not require enrollment in benchmark coverage . . . or benchmark equivalent coverage . . .''[25]

Use of Secretary-approved option. The reference in the FAQs to the Secretary-approved option under Section 1937 raises the question of how far a state could go under this option. Could a state design a unique set of EHBs (i.e., a benefit package not tethered to a listed reference plan) on which to base its Medicaid benchmark benefit for the new adult group? Notably, the FAQs specifically preclude such an approach with respect to development of EHBs for the individual and small group markets.[26]

The FAQs state that ''. . . the medical assistance provided to the expansion population of adults who become eligible for Medicaid as of January 1, 2014, will be a benefit package consistent with *section 1937* benchmark authority.''[27] And, as noted above, the FAQs specifically reference using the Secretary-approved option under Section 1937 to allow a state to select its standard Medicaid benefit package as the EHB reference plan in designing the Medicaid benchmark for the new adult group. Thus, it would appear that by using the Section 1937 Secretary-approved option, a state could design a unique set of EHBs so long as they otherwise meet the requirements of Section 1937 and the ACA, including coverage of the 10 statutory categories of benefits. Finally, regulations promulgated under Section 1937 require that where a state seeks to use the Secretary-approved option, the Secretary must determine that the proposed benefit package ''provides appropriate coverage to meet the needs of the population provided that coverage.''[28]

One can envision several ways a state might take advantage of the Section 1937 Secretary-approved option in designing its Medicaid benchmark beyond simply relying on its standard benefit package plus the missing EHBs. A state might start with the state's largest non-Medicaid HMO and eliminate state-mandated benefits such as infertility diagnosis and treatment, autism spectrum disorder therapies, and chiropractic services—thus avoiding additional costs to the state Medicaid program.[29] Alternatively, a state might start with its standard benefit package and eliminate Medicaid optional benefits such as home health services while adding in any missing EHBs. In sum, it appears that a state should be able to offer any package under the Secretary-approved option so long as the 10 EHB categories of services are included and other Section 1937 rules (such as mental health parity) are met.

Aligning Medicaid Benefits. Starting in 2014, non-disabled Medicaid beneficiaries between the ages of 19 and 65 will be eligible for different benefit packages, depending on their eligibility pathway. Beneficiaries in the new adult group (childless adults and parents above the state's 1996 welfare eligibility level) will be eligible for benchmark benefits, while beneficiaries in other Medicaid categories (such as parents below the state's 1996 welfare eligibility level) will generally be eligible for standard benefits.

In obligating a state to use the same reference plan for both the individual and small group market, the FAQs find that ''selecting one benchmark for these markets in a State would result in a more consistent and consumer-oriented set of options that would also serve to minimize administrative complexity.''[30] In considering the benefit options available to Medicaid beneficiaries, states will likewise want to consider how best to achieve a ''consistent and consumer-oriented set of options'' that ''minimize administrative complexity'' and appropriately accommodate state budget constraints.

At the outset, states must consider how to ensure that beneficiaries in different eligibility groups have access to benchmark or standard benefits as required by the ACA and the DRA. Consider a state that today does not cover non-disabled childless adults under Medicaid and only covers parents up to 50 percent of the FPL. The 1996 welfare level in this state (i.e., mandatory coverage level for parents) was 30 percent of the FPL. In that state, all childless adults and all parents with incomes between 30 percent and 133 percent of the FPL will be considered beneficiaries in the new adult group entitled to benchmark benefits. Parents with incomes below 30 percent of the FPL will be considered eligible under an existing, mandatory eligibility category and entitled to a standard benefit package. Thus, in addition to determining that a parent's income is below 133 percent of the FPL and eligible for Medicaid, a state will have to go further and determine whether that parent's income is below 30 percent of the FPL in order to determine whether they are eligible for benchmark or standard benefits.[31]

One way states might reduce the complexity associated with different benefit packages for different adults is to offer benchmark benefits to all non-disabled adults under age 65 while simultaneously providing notice that certain populations may be eligible for standard Medicaid benefits. Notably, with respect to some ser-

[25] S.S.A. § 1902(k)(1).

[26] FAQs, Q&A No. 14.

[27] FAQs, Q&A No. 20 (emphasis in original).

[28] 42 C.F.R. § 440.330(d).

[29] The additional costs of state mandates may be more theoretical than actual for 2014 -2016 since the federal government pays 100 percent of the cost of services for all newly eligibles until 2017 and HHS has indicated that it will revisit its approach to EHB and state mandated benefits in 2016.

[30] FAQs, Q&A No. 1.

[31] While distinctions between new and old eligibles are relevant to the level of federal matching funds, with states receiving enhanced federal dollars for services to newly eligibles, CMS has made clear that they will authorize states to use proxies and other alternative methodologies so as not to unduly burden the income eligibility process 76 Fed. Reg. 51148, 51173-78 (Aug. 17, 2011).

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vices such as substance abuse treatment or services considered rehabilitative or habilitative, the benchmark benefit package may be broader than the standard benefit package. Under Section 1937, a state may offer a benchmark-exempt beneficiary enrollment in a benchmark plan so long as the state informs the individual that enrollment in benchmark is voluntary and that they may opt out of benchmark and receive standard benefits at any time. In addition, the state must inform the individual of the differences in benefits between the benchmark plan and standard Medicaid.[32]

Under this approach, states would offer all nondisabled Medicaid beneficiaries between the ages of 19 and 65 benchmark benefits and would inform them of their right to receive the standard benefit package. A beneficiary who does not require long-term care services (which are likely to be offered only in standard Medicaid) may well find the benchmark benefit acceptable as long as the cost-sharing obligations in benchmark and standard are consistent.

A second group of beneficiaries that states may want, or may be required, to offer the opportunity to enroll in standard benefits are benchmark-exempt populations. If, as discussed above, the benchmark exemptions in Section 1937 apply to the new adult group, then these subgroups would be entitled to standard benefits and the state would be required to offer them the opportunity to enroll in standard Medicaid. Notably, if the benchmark exemptions apply, the state should be eligible for enhanced federal matching dollars for the provision of standard benefits to newly eligibles within the new adult group.

If the benchmark exemptions do not apply, a state may nonetheless want to offer some or all of these otherwise benchmark-exempt individuals the full benefits available under the state's standard Medicaid benefit package. Two of the FAQs suggest such an approach would be possible. First, a state may have two benchmark benefit plans. Second, a state, under Section 1937's Secretary-approved option, could use its standard (traditional) benefit package as a benchmark plan. A state may want to facilitate access to long-term care services or certain other benefits offered only in the standard Medicaid benefit package so that a beneficiary in the new adult group who requires such services can access them without going through a disability determination.[33] Significantly, an SSI-disabled individual is not considered a newly eligible for which the state may receive enhanced federal matching dollars and thus a state may consider it financially advantageous to offer long-term care services in its benchmark plan.

Another and potentially more streamlined approach a state could take to address the issues that arise with different benefit packages for beneficiaries in the new adult group and beneficiaries in traditional eligibility categories would be to provide the state's standard benefits plus the missing EHBs to both. In other words, the state could seek Secretary approval to use the standard benefit package (including any missing EHBs) to define benchmark benefits for all beneficiaries in the new adult group. Individuals who are eligible for standard would thus have access to the full range of EHBs and individuals who are eligible for benchmark would have access to the full range of benefits in the state's standard benefit. In short, the two groups would have access to the same benefits. Again, as noted above, while the benchmark eligible group would thus be eligible for long-term care services, few will require such services and when they do, it appears that they will be subject to Medicaid's existing post-eligibility criteria (both financial and functional) for long-term care services. If the long-term care post-eligibility requirements apply, then states will have a level of assurance that those in the new adult group accessing long-term care services meet Medicaid's existing more stringent eligibility rules.

Conclusion

As evident from the discussion above, the construction of benchmark benefits for the new adult Medicaid population will be challenging for states and will have implications for all stakeholders. From a legal standpoint, states must start with the basic Medicaid benchmark rules established by the DRA and then overlay the ACA requirements which, among other things, link Medicaid benchmark benefits to essential health benefits. Within these legal constraints, states will have to balance several considerations, including the complexity of multiple benefit packages for consumers, plans, and the state; the clinical needs of the new adult group; and, the ability to maximize federal financial support. Further guidance from CMS will draw these issues into sharper focus, but in the end each state will have to determine the Medicaid benchmark strategy that works best for it and for the consumers, plans, and providers in its state.

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[32] 42 C.F.R. § 440.320; CMS, State Medicaid Director Letter, SMDL # 06-008 (March 31, 2006).

[33] An open question is whether a state could require an asset test for individuals in the new adult group who seek long-term care services, given that the ACA requires states to assess financial eligibility for most Medicaid populations (including the new adult group) based on the modified adjusted gross income methodology which prohibits the use of asset tests. ACA § 2002(a); S.S.A. § 1902(e)(14).