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"Alternative Benefit Plans" Present Regulatory Hurdles for States Considering Medicaid Expansion

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The Affordable Care Act (ACA) expands Medicaid to cover a new group of low-income adults up to 138% of the federal poverty level (approximately $33,465 for a family of four). The ACA also requires states to provide enrollees in this new eligibility group with what the statute calls "benchmark" or "benchmark equivalent" coverage, which the Centers for Medicare & Medicaid Services (CMS) now calls an "Alternative Benefit Plan."

While the concept of benchmark coverage predates the ACA, new requirements added by the ACA have greatly complicated its scope, and the process put in place by CMS to establish that a benefit package qualifies as an Alternative Benefit Plan has added layers of complexity. Alternative Benefit Plan requirements have now become an ungainly hybrid between commercial market rules and traditional Medicaid regulations.

For some of the 30 states that have opted to expand Medicaid, the Alternative Benefit Plan rules have presented substantial obstacles that had to be overcome to secure federal approval. In those states in which expansion is still hotly contested, the strictures of the Alternative Benefit Plan requirements, unless modified or waived, could stand in the way of movement toward expanding Medicaid.

Background

Section 1937 Alternative Benefit Plans

The Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, added what is now Section 1937, State Flexibility in Benefits Packages, to the Social Security Act (SSA). Section 1937 was designed to give states the option to provide certain Medicaid enrollees benefits that looked more like commercial insurance than traditional Medicaid.[1] Congress called this new option "benchmark" or "benchmark-equivalent" coverage because the scope of benefits is based on one of four benchmark plans: (1) the Blue Cross/Blue Shield preferred provider organization (PPO) in the Federal Employee Health Benefits Plan (FEHBP); (2) the health benefit plan offered to state employees; (3) the largest insured non-Medicaid health maintenance organization (HMO) plan operating in the state; (4) or a "Secretary-approved" plan.[2] As long as the coverage met one of these benchmarks, states were permitted to mandatorily enroll certain Medicaid eligibility groups into this coverage "[n]otwithstanding . . . any other provision of [the Medicaid statute]."[3] However, because Section 1937 permitted states to provide more limited benefits than those offered through the Medicaid state plan, the "medically frail" and other special needs populations were exempted from mandatory enrollment.[4]

After the DRA was enacted, the Bush administration approved benchmark plans in several states and, in December 2008, published a final rule that would have permitted states to provide benchmark coverage that did not include some otherwise mandatory Medicaid benefits such as non-emergency transportation to medical providers, family planning services, and "early periodic screening diagnostic and treatment" or "EPSDT" services for children.[5] Implementation of that rule was delayed and reopened for comment by the incoming Obama administration in February 2009.[6] Later that month, Section 1937 was amended by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, Pub. L. No. 111-3.

The effect of CHIPRA's amendments was to undo some of the Bush administration's final rule and require states to include certain benefits in benchmark coverage, even if they were not included in the commercial plan being benchmarked. Specifically, CHIPRA required states to assure that children up to age 21 have access to full EPSDT services, even if enrolled in benchmark plans. CHIPRA also changed the "notwithstanding any other provision of this title" language in Section 1937 to "[n]otwithstanding . . . any other provision of this title *which would be directly contrary*" to the benchmark authority.[7] CMS interprets this to mean that states must continue to assure non-emergency transportation to medical appointments for individuals enrolled in benchmark or benchmark-equivalent plans.

When CMS re-issued its final rule on Section 1937 benchmark coverage in April 2010, it looked considerably different than the 2008 rule. The new rule required that benchmark coverage include: EPSDT benefits for individuals up to age 21, non-emergency transportation to medical appointments, and family planning services and supplies.[8]

While CHIPRA and the ensuing CMS regulation started to make Section 1937 coverage look more like traditional Medicaid, the ACA amendments quickly pulled back in the other direction. Specifically, the ACA amended Section 1937 to require that benchmark coverage include "essential health benefits" and comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).[9] Both the essential health benefits and the MHPAEA requirements apply to commercial plans in the individual and small group markets, including qualified health plans sold on the exchange, but neither applies to fee-for-service Medicaid generally.

ACA also specified that enrollees in the new low-income adult group must be enrolled in benchmark or benchmark-equivalent coverage, known as an "Alternative Benefit Plan."[10] The statute provides that no federal financial participation is available for benefits that are not Section 1937 benefits. While there is little legislative history explaining this provision, congressional drafters seem to have wanted to provide the new low-income adults with a benefit package similar to the qualified health plans sold through the exchanges.[11] However, when combined with the earlier CHIPRA amendments, and CMS' implementation of those amendments, Alternative Benefit Plan coverage ends up being a combination of features of both qualified health plans and traditional Medicaid coverage.

Essential Health Benefits

The Alternative Benefit Plan construct was further complicated by CMS' approach to defining "essential health benefits." The ACA instructed the Secretary of the Department of Health and Human Services (HHS) to define the "essential health benefits"

that were required for commercial individual and small group plans and for Medicaid Section 1937 Alternative Benefit Plans. The ACA further instructed the Secretary that essential health benefits must include ten categories of services: (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 and chronic disease management; and (10) pediatric services, including oral and vision care. [12] In addition, the Secretary must "ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary."[13]

Instead of developing a package of essential health benefits within these parameters, the Secretary deferred to states to define the scope of the health benefits that would be deemed essential in each state. Similar to the Section 1937 process, CMS promulgated rules governing commercial plans allowing states to define essential health benefits by first choosing a "base-benchmark plan" from a handful of commercial options: any of the three largest FEHBP plans; any of the three largest state employee health plans; the largest non-Medicaid HMO plan in the state; or the largest plan in any of the three largest small group insurance products in the state's small group market. This list overlaps somewhat, but not completely, with the Section 1937 benchmarks. For states that did not select a benchmark, the default benchmark plan is the small group plan with the largest enrollment in that state. Once a base-benchmark has been chosen, states must convert it into an "EHB-benchmark plan" by supplementing it to cover any of the ten categories of essential health benefits that are missing from the base-benchmark plan, using another base-benchmark's category of services to fill the gap.[14]

CMS also decided that states should define the scope of essential health benefits for Medicaid Alternative Benefit Plans using the same process it created for the commercial market.[15] However, CMS allows states to develop different essential health benefits packages for Alternative Benefit Plans (e.g., by choosing a different base-benchmark than what is used in the state's commercial market).

Regulatory Burdens of Developing Alternative Benefit Plans

The various ACA and CHIPRA amendments to Section 1937, coupled with CMS' interpretation and implementation of Section 1937, have resulted in an onerous regulatory regime that requires states to comply with both commercial market rules and traditional Medicaid requirements.

Commercial Market Rules. States must cover a specific and extensive set of benefits based on commercial health plan(s), subject to commercial regulations. States must ensure that Medicaid Alternative Benefit Plans both cover the benefit package developed through the process for defining essential health benefits in the commercial market and cover all the benefits in one of the Section 1937 benchmark plans. To accomplish this goal, CMS requires states to develop Alternative Benefit Plans using a complex, multi-step process:

> Step 1: Start with the benefits in one of the four benchmarks identified in Section 1937: the Blue Cross/Blue Shield FEHBP PPO; the health plan generally available to state employees; the largest insured non-Medicaid HMO plan in the state; or a "Secretary-approved" plan
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> Step 2: Ensure coverage of essential health benefits: If the state's Section 1937 benchmark plan is the same as a base-benchmark plan option in the commercial essential health benefits rules, and the plan covers all ten essential health benefits categories, that plan is deemed to cover essential health benefits as is. If the Section 1937 benchmark is the same as a base-benchmark plan that does not cover all ten categories, the state must supplement the plan as specified in the commercial rules. If the Section 1937 benchmark and the base-benchmark plan are not the same, the state must combine the benefits in the two plans and supplement accordingly to cover all ten categories of essential health benefits.

In addition, Alternative Benefit Plans must comply with the commercial mental health parity requirements.[16]

The ability to "substitute" out benefits for other actuarially equivalent benefits gives states some flexibility to shape the scope of their Alternative Benefit Plans.[17] This mechanism has allowed many states to align their Alternative Benefits Plan with their state plan, with or without adding benefits to their Medicaid state plan. However, states can only substitute benefits within the same essential health benefits category; they cannot substitute out habilitative services entirely; and they cannot substitute at all within the prescription drug benefit.[18] Further, in calculating the actuarial value of the benefit being removed from the coverage, states may not account for the cost sharing that the commercial benchmark applied for that benefit, which makes it harder for a preexisting Medicaid benefit to be used as an actuarial equivalent substitute. Finally, the application of MHPAEA to Alternative Benefit Plans means that states must ensure that substitution does not result in a "treatment limitation" or "financial requirement" for mental health or substance use disorder benefits "that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees."[19]

Traditional Medicaid Rules. Once the state has established that the Alternative Benefit Plan satisfies the commercial requirements, it is reviewed for compliance with several Medicaid rules. The state must ensure that the Alternative Benefit Plan covers EPSDT for children under 21; family planning services and supplies; federally qualified health care and rural health care services; and non-emergency transportation.[20] If any of these services are missing, they must be added to the Alternative Benefit Plan.

In addition, CMS has taken the position that the Medicaid statute's exclusion for services delivered to individuals in an institution for mental diseases (IMD) prohibits Alternative Benefit Plans from covering benefits for enrollees who are in an IMD.[21] As a result, Alternative Benefit Plans cannot cover any services delivered to patients in a psychiatric hospital or other institution with more than 16 beds that is primarily engaged in treating mental health or substance abuse issues, even if those services are covered by the commercial benchmark.

Finally, CMS has taken the position that traditional Medicaid cost sharing rules apply to Alternative Benefit Plans. This means that Alternative Benefit Plans cannot charge the copayments and deductibles included in the commercial plans to which they are benchmarked, except to the extent that cost sharing is consistent with the very low level of cost sharing permitted under the Medicaid statute.

These Alternative Benefit Plan requirements stand in contrast to the flexibility states have traditionally had with respect to Medicaid benefits. For state plan coverage, federal law makes several types of services mandatory (e.g., inpatient and outpatient hospital, physician's services), but states otherwise have broad discretion to choose which benefits to make available to adults

and to put reasonable utilization limits on the benefits covered.[22] In contrast, Alternative Benefit Plans must cover or substitute for a specific and extensive set benefits, i.e., all the benefits in a commercial benchmark plan(s), in addition to complying with several traditional Medicaid requirements. This process could have been avoided if CMS were to accept a state's approved Medicaid state plan as a benchmark for determining essential health benefits coverage.

Alternative Benefit Plans May Discourage Medicaid Expansion

The strictures of the Alternative Benefit Plan requirements, unless modified or waived, could stand in the way of additional states expanding Medicaid.

States trying to extend their existing Medicaid benefits to the new low-income adult group have had to painstakingly compare their preexisting state plan benefits to the commercial benchmark plan to demonstrate compliance with the Alternative Benefit Plan requirements. If the state plan does not cover every essential health benefit in the commercial benchmark, the state must add benefits to the state plan. For example, if habilitative services covered by the commercial benchmark are not covered for adults through the state plan, a state seeking to align must add the commercial benchmark's habilitative benefit to its state plan. Similarly, because an Alternative Benefit Plan cannot include benefit limits stricter than those in the commercial benchmark (unless it substitutes), benefit limits in the state plan that are stricter than those in the commercial benchmark must be removed or substituted out.

In addition, states that have sought to cover the new low-income adult group with commercial-like coverage substantially different than their traditional Medicaid benefits must also supplement coverage. For example, New Hampshire will provide the expansion population with premium assistance to purchase qualified health plans that comply with the ACA's insurance market reforms, including the essential health benefits requirements. Yet New Hampshire must still wrap-around certain Medicaid benefits (e.g., non-emergency transportation, some EPSDT services) not covered by the commercial plans. In addition, New Hampshire must pay the expansion population's copayments and deductibles to the extent necessary to ensure that enrollees are not subject to cost sharing amounts in excess of the very low levels authorized under the Medicaid rules.

In states where the ACA remains politically polarizing, the fact that state flexibility is sharply limited by these Alternative Benefit Plan requirements is another significant obstacle to expanding Medicaid.

With less than 18 months of the Medicaid expansion behind us, the implications of these new Alternative Benefit Plan requirements are still not entirely clear. For example, we do not know how challenging it will be for states to keep the state plan and the Alternative Benefit Plan aligned every time the state plan is amended.[23] In addition, it is uncertain whether states can maintain alignment during difficult economic times, when the optional state plan benefits that facilitate alignment may become the target of budget cuts. It is entirely possible that a state might end up needing to provide a richer package of benefits to the new low-income adult population than it does to the needy families, individuals with disabilities, and impoverished seniors that Medicaid has traditionally served.

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[1] *See, e.g.,* H.R. Rep. No. 109-276, at 389-90 (Nov. 7, 2005).
[2] 42 U.S.C. 1396u-7 (Section 1937)(b)(1).
[3] *Id.* at Section 1937(a)(1)(A).
[4] *Id.* at Section 1937(a)(2)(B).
[5] 73 Fed. Reg. 73694 (Dec. 3, 2008).
[6] 74 Fed. Reg. 5808 (Feb. 2, 2009).
[7] Pub. L. No. 111-3, § 611(a)(1)(A), (a)(1)(C) (emphasis added).
[8] 75 Fed. Reg. 23068, 23077, 23085 (April 30, 2010); *see also* 42 C.F.R. §§ 440.345, 440.365, 440.390.
[9] ACA § 2001(c); § 1937(b)(5)-(6).
[10] *See* ACA § 2001(a)(2); SSA § 1902(k)(1).
[11] *See* H.R. Rep. No. 111-299, 610-11 (2009); Chairman Max Baucus (D-MT), Senate Finance Committee, *Framework for Comprehensive Health Reform* (2009).
[12] ACA § 1302(b).
[13] *Id.*
[14] *See* 45 C.F.R. Part 156, Subpart B.
[15] 42 C.F.R. § 440.347(a).
[16] *Id.* at § 440.345(c).
[17] *See* § 440.347(b).
[18] *See* 78 Fed. Reg. 42160, 42205 (July 15, 2013); 45 C.F.R. § 156.115(b).
[19] 80 Fed. Reg. 19418, 19433-52 (April 10, 2015).
[20] §§ 440.345, 440.365, 440.390.
[21] 78 Fed. Reg. at 42197.
[22] SSA §§ 1902(a)(10)(A), 1905(a).
[23] *See* CMS, Center for Medicaid and CHIP Services, Informational Bulletin, *Process for Amending Alternative Benefit Plans* (Sept. 16, 2014) ("ABPs must be kept in full or partial alignment with the state's approved underlying state plan on an ongoing basis, not just at the point of initial approval for those states that have chosen to align with their Medicaid state plan. . . . For example, state plan amendments that add, delete or change coverage based on limitations of amount, duration or scope or authorization requirements will need to be included in the new ABP submission.").