Alternative Benefit Plans

Applicable Statutes, Regulations and Sub-Regulatory Policies

Statutory: Section 1937

Regulatory: 42 CFR Part 440, Subpart C (440.300 – 440.390)

Sub-Regulatory Policies:

State Medicaid Director Letter #06-008 – March 31, 2006

(Insert new SMD Letter here)

Introduction/Overview of Alternative Benefit Plans

Enacted as part of the Deficit Reduction Act of 2005, Section 1937 of the Social Security Act provides states with significant flexibility to design Medicaid benefits that are Medicaid coverable under the State plan. There are many options in selecting an Alternative Benefit Plan, and states may offer different Alternative Benefit Plans to targeted populations to appropriately meet their needs.

There are two basic types of Alternative Benefit Plans: "benchmark" or "benchmark-equivalent". Benchmark means that the benefits are at least equal to one of four statutorily specified benchmark plans. Benchmark-equivalent means that the benefits include certain specified services, and the overall benefits are at least actuarially equivalent to one of the four statutorily specified benchmark coverage packages. The four statutorily specified coverage benchmarks are:

> (1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program (hereafter referred to as "FEHBP")
> (2) State employee coverage that is offered and generally available to State employees (hereafter referred to as "State Employee Coverage")
> (3) A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the State (hereafter referred to as "Commercial HMO"), and
> (4) Secretary-approved coverage, which can include the full regular Medicaid state plan benefit package.

These benchmark options are minimum standards and states can augment coverage with additional benefits as described below. In addition, for children, states must assure EPSDT services are available either through the benefit package itself or through a combination of the benefit package and additional services. Finally, all Alternative Benefit Plans are required to comply with the Prescription Drug requirements of Section 1927 of the Act. This effectively means that states must provide their standard Medicaid State plan Prescribed Drug benefit as part of any such Plan.

Section 1937 specifies that certain populations are exempt from mandatory enrollment in an Alternate Benefit Plan. States are, however, permitted to offer voluntary enrollment in an Alternative Benefit Plan to those exempt groups. In addition, the Act excludes certain eligibility groups from participating in Alternative Benefits Plans. These excluded groups are identified in a chart in the Implementation Guide section pertaining Alternative Benefit Plan populations.

The Affordable Care Act made a number of changes relating to Section 1937. Specifically, under the Affordable Care Act:

- beginning on January 1, 2014, the new eligibility group for low-income adults (hereinafter referred to as the "adult group") became subject to section 1937;
- benefits offered through a benchmark-equivalent type of Alternative Benefit Plan must include coverage of prescription drugs and mental health services, family planning services and supplies must be included in any Alternative Benefit Plan;
- beginning January 1, 2014, any Alternative Benefit Plan must cover at least Essential Health Benefits as described in section 1302(b) of the Affordable Care Act and applicable regulations; and

- All Alternative Benefit Plans that deliver both medical and surgical benefits and mental health or substance use disorder benefits through non-managed care entities must ensure that any financial requirements and treatment limitations comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). In light of other statutory provisions that impose the same requirements for benefits delivered through managed care entities, this means that all Alternative Benefit Plans, regardless of delivery system, must comply with these parity requirements.

Application of Section 1937 to New Adult Group

As indicated above, the Affordable Care Act directs that benefits provided to the new adult group are limited to those Alternative Benefit Plans described in section 1937. This does not preclude a state from offering the new adult group the full Medicaid package. The Secretary-approved coverage can be used to offer the regular Medicaid state plan benefit to the new adult group, subject to Essential Health Benefits requirements discussed below.

Relationship of Alternate Benefit Plans to Essential Health Benefits

Under the framework set out in section 1302(b) of the Affordable Care Act, Essential Health Benefits include the following ten benefit categories, recognizing that some of the benefit categories include more than one type of benefit:

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,
10. pediatric services, including oral and vision care.

In addition, section 1302(b)(4) of the statute provides that benefit design cannot discriminate "on the basis of an individual's age, expected length of life, or of an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions; or on the basis of an individual's status as a member of a vulnerable population."

Regulations to be issued by CMS will outline how the precise parameters of Essential Health Benefits in each state will be established in the individual and small group markets. These provisions will generally apply to Medicaid too. However, because of the special nature of the Medicaid population, the role of the states in defining benefits, and existing title XIX statutory requirements, some modifications apply. These are discussed below.

States will be able to select a different section 1937 coverage option for Medicaid than they have chosen as the base benchmark plan for the individual and small group market: In the individual and small group market, states will select one plan as its **base benchmark plan**, operating both inside and outside of the Exchange. That base benchmark plan becomes the **EHB benchmark plan** after it is supplemented with any missing Essential Health Benefits, and adheres to principles of non-discrimination, etc.

For Medicaid, the first step a state will take is to select a **1937 coverage option** from among the choices identified in section 1937 (the FEHBP BC/BS standard option, a health benefits coverage plan offered to employees of the state in question, a health insurance coverage plan offered by the largest commercial HMO in the state in question, Secretary-approved coverage, or benchmark-equivalent coverage based on one of the previous four options).

The second step is for a state to determine the benefit package that will define the provision of Essential Health Benefits. Options for this benefit package will be described at 45 CFR 156.100(a) as the list of **base benchmark plans**. The benefit package selected to define the provision of Essential Health Benefits in the individual and small group market need not be the same as the one selected to define Essential Health Benefits for Medicaid. States are allowed to select more than one benefit package to define Essential Health Benefits for Medicaid, in keeping with states' ability to implement more than one **1937 coverage option** for targeted populations. It should be noted that this second step is only necessary when the 1937 coverage option selected by the State is not

on the list of base benchmark plans. A 1937 coverage option that also appears on the list of base benchmark plans may be used to define Essential Health Benefits.

If one of the required Essential Health Benefits categories is missing from the benefit package selected by the state to define Essential Health Benefits, the state would look to another benefit package on the list of **base benchmark plans** so that all Essential Health Benefits are defined and provided. If none of these benefit packages includes the absent category, the regulations on Essential Health Benefits will describe the process that will be used in the individual and small group market.

For Medicaid, once the state has ensured the provision of all Essential Health Benefits in the selected **1937 coverage option**, the state must additionally ensure the provision of all services required to be furnished by section 1937 (this includes requirements to adhere to EPSDT, the provision of Non-Emergency Medical Transportation, family planning services, etc.). These requirements are not new with the inclusion of Essential Health Benefits, but are historic provisions of section 1937.

The resulting service package in Medicaid is called the **Alternative Benefit Plan**

EHB provision for Medicaid is different than for the individual and small group markets in certain circumstances.

- Habilitation: At a minimum, habilitative services for acquiring skills and function will be provided in parity with rehabilitative services for restoring skills and function. States (rather than issuers) will have the ability to add additional habilitative services to the Medicaid Essential Health Benefit benchmark plan to meet this requirement.

- Pediatrics: The state has options to supplement its Essential Health Benefit Benchmark plan in the individual and small group market if it is lacking with respect to pediatric services. For Medicaid, all medically necessary pediatric services in general, including pediatric oral and vision services, are covered under the Medicaid Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit, which applies to every Section 1937 Alternate Benefit Plan. Therefore, since all Alternative Benefit Plans must meet the EPSDT assurance (whether through the plan itself or through a combination of the Alternate Benefit Plan plus additional services) such plans will be deemed to meet the Essential Health Benefits requirements in this category of services.

- Prescription Drugs: Prescribed drugs are “optional” 1905(a) Medicaid services under the State plan. However, every state provides coverage of drugs and, in accordance with section 1902(a)(54), is subject to the requirements in section 1927 of the SSA. Section 1927 sets forth requirements for covered outpatient

drugs, which require drug manufacturers to pay statutorily-defined rebates to the states through the Medicaid drug rebate (MDR) program. The requirements for covered outpatient drugs will apply to Alternative Benefit Plans, including the provisions of section 1927 and applicable Federal regulations. This means that the State must offer its standard State plan Prescribed Drug benefits to participants in Alternative Benefit Plans. States can adopt prior authorization and other utilization control measures as well as policies that promote use of generic drugs.

Relationship of other provisions of Title XIX to section 1937

When implementing an Alternative Benefit Plan based on one of the commercial benchmarks identified in section 1937, the state will necessarily adopt the key elements of benefit design of that selected benchmark benefit package. This includes service definitions; amount, duration and scope of services; and provider qualifications. In addition, as provided in section 1937, states do not have to comply with title XIX provisions relating to statewideness and comparability when they implement an Alternative Benefit Plan. They can target Alternative Benefit Plans to different populations and have different Alternative Benefit Plans in effect in different areas of the state.

Consistent with Section 1937(a)(1)(A), all other requirements under Title XIX of the Social Security Act apply, unless the state can demonstrate that implementing such other requirements would be directly contrary to their ability to implement Alternative Benefit Plans under section 1937. In general, a state wishing to not apply any other requirements under Title XIX must be able to demonstrate as part of the State Plan Amendment process that complying with the Title XIX provision would significantly interfere with implementing an Alternative Benefit Plan under section 1937.

Examples of title XIX provisions that will continue to apply:

- The exclusion of federal financial participation (FFP) for services furnished to inmates of a public institution (except as a patient in a medical institution) or furnished to individuals residing in an Institution for Mental Disease (IMD). This exclusion extends to all "medical assistance" including medical assistance furnished through Alternative Benefit Plans.

- Cost-sharing applied to Alternative Benefit Plans is governed by section 1916 or 1916A of the Act, not by the cost sharing associated with the benchmark benefit package selected by the state.

- Current regulations allow states to supplement benchmark benefit packages with any service available under section 1905(a) of the Act. In a forthcoming regulation, CMS intends to propose that states be allowed to expand the range of

coverable services as Secretary-approved or as additional services to include State Plan services authorized under section 1915(i), 1915(j), 1915(k) and 1945 of the Social Security Act (or under any other Medicaid State authority that may be enacted under title XIX of the SSA). One of the major reasons for proposing to expand the scope of benefits in this way is to allow states to cover a broader range of long-term services and supports in Alternative Benefit Plans than they can under current regulations. Section 1905(a) offers only limited coverage of these services.

Alternative Benefit Plans – Statute and Regulations

Statute

Alternative Benefit Plans is codified in title XIX of the Social Security Act (the Act) in Section 1937 entitled State Flexibility in Benefit Packages.

As indicated above, other than statewideness and comparability, all other requirements under Title XIX of the Social Security Act apply, unless the state can demonstrate that implementing such other requirements would be directly contrary to their ability to implement Alternative Benefit Plans under section 1937.

Regulations

Regulations pertaining to Alternative Benefit Plans are in the Code of Federal Regulations at 42 CFR Part 440, Subpart C.

Implementation Guide – Organization and Structure

The Alternative Benefit Plans part of the Implementation Guide is organized along the following lines:

- An Introductory section where the State selects which sections of an existing Alternative Benefit Plans it is amending. This is the first section completed when amending an Alternative Benefit Plan.
- A Population Definition section where the state names and defines the Alternative Benefit Plan Population and associates it with one or more Alternative Benefit Plans. This is the first section completed when submitting a new Alternative Benefit Plan.
- Assurances pertaining to Voluntary and Mandatory participants in Alternative Benefit Plans, including state processes for identifying and notifying exempt participants and documenting participation status in the case record
- Selection of the 1937 Coverage Option and Base Benchmark Plan
- A Cost-Sharing section where the state indicates how cost-sharing applies to the Alternative Benefit Plan

- Section 1937 Coverage Option Benefit Packages (listed below) where benefits may be specified from a combination of an administrative template containing the benefits in the selected 1937 coverage option and the base benchmark plan, or Medicaid State Plan benefits (in the case of Secretary Approved Coverage), supplemental essential health benefits added on the administrative template, and additional benefits that may be added within the Benchmark Benefit Package template.
    - Federal Employees Health Benefit Plan
    - State or Territory Employee Coverage
    - Commercial HMO
    - Secretary Approved Coverage
    - Benchmark-Equivalent Benefits
- Benefit-related Assurances
- Benchmark-Equivalent Benefit Package Assurances if the state is providing coverage through a Benchmark-Equivalent benefit package
- Service Delivery Systems used to deliver Alternative Benefit Plan benefits and services
- Employer Sponsored Insurance premium payments for participants in an Alternative Benefit Plan
- General Assurances pertaining to all Alternative Benefit Plans
- Alternative Benefit Plan Termination and Phase-Out Plan
- Alternative Benefit Plan Benefits Payment Methodologies
- Alternative Benefit Plan Components to associate a defined benefit package and service delivery system with an Alternative Benefit Plan population
- Administrative Templates
    - FEHBP Coverage
    - State/Territory Employee Coverage
    - Commercial HMO Coverage
    - Base Benchmark Plan Coverage
    - State Plan Benefits Table

Only certain templates will need to be completed, depending on the options selected by the State. In addition, there are other MACPro screens that deal with the submission of Alternative Benefit Plans in the Initial Application section of the system, including sections on Public Comment and Tribal Consultation.

The Implementation Guide is keyed to the Alternative Benefit Plans templates themselves. In other words, there is a separate guide section for each Alternative Benefit Plan section. The individual guide sections are identified by the name of the tab in the Benchmark Data Template to which the guide section belongs. For example, the tab for template for Section of 1937 Coverage Option Benefit Package is B4. The guide section pertaining to that template is therefore identified as “Template B4”. This allows for easy reference and cross-reference to the various templates and their corresponding guide sections. The guide content for the B4a FEHBP Coverage, B4b State Employee Coverage and B4c Commercial HMO Coverage have been combined into one section as these templates are constructed in an identical manner.

The guide sections for the Alternative Benefit Plan templates follow a common format. Each guide section consists of:

• An Introduction, which explains the general purpose of the template for which the guide section is written.

• A Background section, which provides general information about the content of the template.

• A Technical Guidance section. This section explains in detail how to complete the template for which the particular guide section was written.

There are some things to keep in mind when working with the templates themselves and the guide sections written for them.

• The system is designed so that certain templates must be completed before other templates can be completed and saved. This is because the system is designed to use the information a State provides in certain templates to either display or not display later templates, based on whether a particular template is applicable to that State.
For example, States are required to complete Template B4 to select its Section 1937 Coverage Option and Base Benchmark Plan before completing the administrative templates related to these selections. Therefore, the system will not allow other Benchmark Benefit Package templates to be displayed until the State has completed Template B4. There are other templates to which this applies. The guide sections identify those templates and explain what must be done in order for a State to move through other templates. The guide sections identify and explain when this situation applies.