Congressional Research Service
Informing the legislative debate since 1914

Traditional Benefits and Alternative Benefit Plans Under Medicaid

(name redacted)
Specialist in Health Care Financing

May 6, 2014

Congressional Research Service
7-....
www.crs.gov
R43656

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The Medicaid program, which served an estimated 56.7 million people in FY2012, finances the delivery of a wide variety of preventive, primary, and acute care services as well as long-term services and supports for certain low-income populations. Benefits are available to beneficiaries through two avenues: traditional coverage and alternative benefit plans (ABPs, formerly known as benchmark plans, first established in P.L. 109-171, the Deficit Reduction Act of 2005).

The traditional Medicaid program covers a wide variety of mandatory services (e.g., inpatient hospital services, lab/x-ray services, physician care, nursing facility care for persons aged 21 and over), and other services at state option (e.g., prescribed drugs, physician-directed clinic services, physical therapy, prosthetic devices) to the majority of Medicaid beneficiaries across the United States. Within broad federal guidelines, states define the amount, duration, and scope of these benefits. Thus, even mandatory services are not identical from state to state.

With the enactment of the Patient Protection and Affordable Care Act in 2010 (ACA; P.L. 111-148, as amended), benefit requirements have expanded under ABPs. At a minimum, these plans must cover essential health benefits (i.e., ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services [including behavioral health treatment], prescribed drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care). In addition, at state option, a new group of citizens with income up to 133% of the federal poverty level is eligible for Medicaid as of January 1, 2014. These individuals are required to receive ABPs rather than traditional Medicaid benefits (with some exceptions for subgroups with special medical needs).

This report outlines the major rules that govern and define both traditional Medicaid and ABPs. It also compares the similarities and differences between these two benefit package designs.

Contents

Medicaid Eligibility and Benefit Coverage 1
Traditional Medicaid Benefits 4
Medicaid Alternative Benefit Plans (ABPs) 6
State Experience with ABPs 11
Mental Health Parity Requirements Under Both Traditional Medicaid and ABP Plans 19
Additional CRS Medicaid and CHIP Resources 19

Tables

Table 1. Examples of Medicaid Benefits, by Eligibility Classification 3
Table 2. Additional Information on Selected Mandatory Benefits for Most Medicaid Categorically Needy Beneficiaries 4
Table 3. Examples of Frequently Covered Optional Benefits Under Traditional Medicaid as of December 2010/January 2011 5
Table 4. Statutory and Regulatory Exceptions to Mandatory Enrollment in Medicaid ABPs 7
Table 5. Selected Characteristics of ABPs, by State, as of Mid-April 2014 12

Contacts

Author Contact Information 19

Medicaid was established in 1965 to provide basic medical services to certain low-income populations. It is a means-tested entitlement program that financed the delivery of primary and acute medical services, as well as long-term services and supports, to an estimated 56.7 million people in FY2012,[1] at a total cost of $431 billion with the federal government paying $249 billion (about 58%) of that total.[2]

Each state designs and administers its own version of Medicaid under broad federal rules. State variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are delivered and reimbursed. Benefit packages have always varied across states and across eligibility groups. Beginning in 2005, the Deficit Reduction Act (P.L. 109-171) added benchmark benefit packages (now called Alternative Benefit Plans or ABPs) as a state option. As of January 1, 2014, the Affordable Care Act (ACA; P.L. 111-148, as amended) required states to provide ABP coverage to the newly established optional eligibility group that includes all citizens with income at or below 133% of the federal poverty level (FPL).

Not everyone enrolled in Medicaid has access to the same set of services. Different eligibility classifications determine available benefits, as described below. This report begins with a summary of major Medicaid eligibility pathways. Then traditional Medicaid benefits and alternative benefit plans (previously called benchmark benefit plans) are described. The final section provides an analysis of state experiences with ABPs as of mid-April 2014. Additional CRS resources on Medicaid are provided at the end of this report.

Medicaid Eligibility and Benefit Coverage

Historically, eligibility for Medicaid was subject to "categorical restrictions" that generally limited coverage to the elderly, persons with disabilities, members of families with dependent children, certain other pregnant women and children, among others. As of January 1, 2014, federal law allows states to expand Medicaid eligibility for citizens with income up to 133% of the federal poverty level who do not fit into these traditional categories. The Congressional Budget Office (CBO) estimated that the coverage expansion provisions in the ACA would increase enrollment in both the Medicaid and the State Children's Health Insurance Programs by about 7 million in CY2014, rising to 13 million by CY2024.[3]

To qualify for Medicaid, applicants must have income (and sometimes assets) that meet financial requirements. These financial criteria are usually tied to specific percentages of the federal poverty level (FPL), and are sometimes based on certain cash assistance programs (e.g., Supplemental Security Income or SSI).[4]

[1] This enrollment figure is measured according to "person-year equivalents," which represents the average program enrollment over the course of a year, and differs from "ever enrolled" counts which measure the number of people covered by Medicaid for any period of time during the year. (Office of the Actuary [OACT], Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, National Health Expenditure Projects 2012-2022: Forecast Summary, 2013.)

[2] Centers for Medicare and Medicaid Services, CMS-64 data. For more information about Medicaid, see CRS Report R43357, *Medicaid: An Overview*.

[3] See Table 2 in Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act—Congressional Budget Office, April 2014 at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

[4] For example, pregnant women and children under age 6 with family income below 133% of FPL are mandatory (continued...)

Below is a description of services available for Medicaid beneficiaries by eligibility classification. First, "categorical needy" individuals represent the vast majority of people enrolled in Medicaid, most of whom receive traditional Medicaid benefits (described in more detail in the "Traditional Medicaid Benefits" subsection). The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) required that a newly established categorically needy group consisting of poor nonelderly, non-pregnant adults with income below 133% FPL receive Medicaid benefits through Alternative Benefit Plans (ABPs). However, on June 28, 2012, the United States Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius* making this ACA Medicaid expansion optional.

For the medically needy subgroup, states may offer a more restrictive benefit package than is available to most categorically needy individuals. Such individuals include people who meet the main categorical restrictions described above but may have higher income. States electing the medically needy option must provide coverage to certain pregnant women (i.e., prenatal and delivery services) and children under age 18.[5]

Finally, states also use waiver authority to design benefit packages. Under Section 1115 waivers, states tailor benefits to state-specified subpopulations that can include both currently authorized groups and/or new groups not specified in federal statute. Each such waiver delineates the unique terms and conditions that are negotiated between a given state and the federal Centers for Medicare & Medicaid Services (CMS).[6,7]

Table 1 provides examples of Medicaid benefits available by selected eligibility classifications. Mandatory benefits are services that a state must cover in its state Medicaid plan. Likewise, there are also a number of optional benefits that states may choose to cover. As illustrated, different Medicaid subpopulations may have access to benefit packages that can be quite varied, and can be categorized into two broad groups: (1) traditional benefits, and (2) Alternative Benefit Plans (ABPs). Additional details are described further below.

(...continued)

eligibility groups under Medicaid. In 2014, the FPL for a family of four is $23,850—133% of FPL for such a family would equal $31,720.50. See http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf.

[5] If a state covers institutions for mental disease (IMDs), intermediate care facilities for the mentally retarded (ICF-MRs) or both, it must cover early and periodic screening, diagnostic, and treatment services (EPSDT) for all medically needy groups under age 18 or services listed in any 7 of paragraphs (1) through (24) of Section 1905(a) of the SSA, which also includes EPSDT at Section 1905(a)(5). Currently, ICF-MRs are referred to as ICF-IDDs (intermediate care facilities for individuals with intellectual and developmental disabilities).

[6] For additional information about Section 1115 waivers, see CRS Report R43357, *Medicaid: An Overview*.

[7] Also, under Section 1915(c) waivers, states may define benefits for individuals eligible for long-term services and supports under Medicaid. For more information about such waivers, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

Table 1. Examples of Medicaid Benefits, by Eligibility Classification

Type of Benefit and Benefit Package	Eligibility Classification: Categorically Needy (excluding ACA Medicaid Expansion Subgroup)	ACA Medicaid Expansion Subgroup	Medically Needy	Section 1115 Waivers
Mandatory	-Inpatient hospital -Nursing facility care (age 21+) -EPSDT (< age 21) -Physicians -Federally-qualified health centers -Family planning -Pregnancy-related services	-ABPs, which must cover 10 essential health benefits that include, for example, preventive care, mental health services, prescribed drugs, rehabilitative services, federally-qualified health center (FQHC) services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children up to age 21, family planning services and supplies, non-emergency medical transportation to and from Medicaid participating providers	-Prenatal and delivery services -Ambulatory services (< age 18; persons entitled to institutional care) -Home health for those entitled to nursing facility care	-Negotiated between the states and the Secretary of Health and Human Services (HHS)
Optional	-Clinic services -Prescribed drugs -Physical, occupational, and speech therapy -Other practitioners -Dental	-For special needs subgroups, option to have same benefits as categorically needy or enroll in an ABP plan	-Nursing facility care -Clinic services -Physical, occupational, and speech therapy -Other practitioners -Dental	-Negotiated between the states and Secretary of HHS
Benefit Package	Traditional Benefits with option of ABPs	ABPs with exceptions; see **Table 4** for details	Traditional Benefits	Not applicable (i.e., such waivers are state-specific)

Sources: Title XIX of the Social Security Act and related federal guidance.

Notes: EPSDT means "early and periodic screening, diagnostic and treatment." This benefit includes well-child visits, immunizations, and lab tests, as well as vision, dental and hearing screening services at regular intervals. With respect to medically needy groups, broader requirements apply if a state has chosen to provide coverage for medically needy individuals in intermediate care facilities for the mentally retarded or in institutions for mental diseases. In these cases, states are required to cover the same services as those which are mandatory for the categorically needy, or alternatively, the care and services described in 7 of the first 24 paragraphs in the federal Medicaid statute defining covered mandatory and optional services, which includes EPSDT.

Traditional Medicaid Benefits

Under federal law, states must cover certain benefits, while other services may be offered at state option. Examples of benefits that are mandatory for most Medicaid groups (i.e., categorically needy populations excluding the ACA Medicaid expansion subgroup) include inpatient hospital services, physician services, laboratory and x-ray services, early and periodic screening, diagnostic and treatment services (EPSDT) for individuals under 21,[8] nursing facility services for individuals aged 21 and over, and home health care for those entitled to nursing facility care. Examples of optional benefits for such Medicaid groups include prescribed drugs, physician-directed clinic services, services of other licensed practitioners (e.g., chiropractors, podiatrists, psychologists), nursing facility services for individuals under age 21, physical therapy, and prosthetic devices.

Table 2 provides additional information on selected mandatory benefits for most categorically needy subpopulations under the traditional Medicaid program.

Table 2. Additional Information on Selected Mandatory Benefits for Most Medicaid Categorically Needy Beneficiaries

Benefit Category	Description
Certified pediatric nurse-practitioner and certified family nurse practitioner services	These services are covered regardless of whether the practitioner is under the supervision of, or associated with, a physician or other health care provider.
Emergency care for certain legalized aliens and undocumented aliens that meet all other Medicaid eligibility requirements	Treatment for life-threatening emergency medical conditions which are severe and acute. Such services exclude organ transplants. For undocumented aliens, emergency services include emergency labor and delivery. Services for pregnant women are available to certain legalized aliens (e.g., routine prenatal care, labor and delivery, and routine postpartum care).
Family planning services and supplies	This benefit includes services and supplies for women of child-bearing age, including minors who can be considered to be sexually active, and who desire such care. Each recipient must be free from coercion or mental pressure and free to choose a method of family planning. Neither abortions nor sterilization are covered under this benefit.
Laboratory and x-ray services	Includes professional and technical laboratory and radiologic services which are ordered and provided by or under the direction of a physician or other licensed practitioner operating within the applicable scope of practice state law, or ordered and billed by a physician but provided by an independent lab. Other caveats may also apply.
Nursing facility (NF) services for individuals ages 21 and over (excluding services in an institution for mental disease or IMD)	NFs provide a number of services to residents, including, for example, skilled nursing care and rehabilitation services. They must also meet requirements regarding residents' rights, and administration.

[8] With respect to EPSDT, states also must provide medical care that is necessary to address health problems identified through screenings, including optional services that states may not otherwise cover in their Medicaid programs.

Benefit Category	Description
Home health care for individuals entitled to NF care (i.e., individuals age 21 and above, plus Medicaid beneficiaries classified as medically needy)	Services are provided at a beneficiary's place of residence (excluding a hospital or NF). An individualized written plan of care is required and may include a number of services (e.g., home health aide, medical supplies and equipment, other therapy services).

Sources: Title XIX of the Social Security Act and related federal guidance.

Table 3 provides additional information for selected optional benefits covered by most states under the traditional Medicaid program near the end of 2010 and beginning of 2011.

Table 3. Examples of Frequently Covered Optional Benefits Under Traditional Medicaid as of December 2010/January 2011

Selected Optional Benefits	Number of States Offering Benefit	Description of Benefit
Examples of Preventive, Primary, and Acute Care Services		
Clinic Services	49	A wide range of health care services including services for prevention or treatment of health conditions or illnesses, surgery, and other care provided in a centralized facility
Hospice Services	48	Care for persons with illnesses that cannot be cured or fully treated. Hospice care involves a team of medical professionals who take care of the medical, physical, social, emotional, and spiritual needs of the patient, and also support the patient's family or caregiver
Occupational Therapy	50	Services to enhance an individual's participation in, or performance of, common activities such as eating, dressing, moving about, working, and going to school
Optometric Services	50	Services from an individual with training to diagnose and prescribe treatment for diseases of the eye and problems with vision, and may include eye glasses, lenses, exercises, or referrals for specialized treatment
Physical Therapy	50	Services to restore physical function to a person with a disability caused by illness, trauma, or birth defects (three states restrict such care to individuals under age 21)
Prescribed Drugs	50	Drugs that an individual can get only if a doctor (or another authorized health care provider) gives permission through a prescription
Speech and Language Therapy	49	Services to diagnose and treat speech and language problems (three states restrict such care to individuals under age 21)
Targeted Case Management	50	Services to help individuals be independent and learn to manage their health care, including linking such people with health care providers, social services, educational services, etc., based on that person's needs (one state restricts such care to individuals under age 21)
Examples of Long-Term Services and Supports		
Inpatient Psychiatric Services for Individuals < Age 21	48	Services that a person < age 21 might receive at a hospital or psychiatric residential treatment facility while staying overnight for treatment of mental illness, and may include services provided by a physician or nurse, lab work, surgery, and drugs
Intermediate Care Facilities for the Mentally	51	Services at a facility that provides 24-hour rehabilitative as well as health care and services for persons with

Selected Optional Benefits	Number of States Offering Benefit	Description of Benefit
Retarded		developmental disabilities (one state restricts such care to individuals under age 21)
Nursing Facility Services for Individuals < Age 21	50	Skilled nursing, rehabilitation, and other services provided in a facility to assist individuals with illness, injuries, or other disabilities to recover or improve, and to provide long-term care to those who need support with daily activities such as bathing, dressing, and eating
Personal Care Services	35	Services that help individuals with chronic or temporary conditions to remain in their homes by helping them with activities of daily living (e.g., bathing, dressing, grocery shopping); such services can be delivered by agencies or individual providers or can be directed by patients or their families
Targeted Case Management for Mental Health	51	Services to help individuals with mental health needs learn how to manage their health care

Source: Centers for Medicare & Medicaid Services, derived from http://www.healthcare.gov and individual state Medicaid websites as of December 2010 and January 2011, personal communication, winter of 2011.

Note: The definition of state includes the District of Columbia and excludes the five territories.

The breadth of coverage for a given benefit can and does vary from state to state, even for mandatory benefits. For example, states may place different limits on the amount of inpatient hospital services a beneficiary can receive in a year (e.g., up to 15 days of inpatient days per year in one state versus unlimited inpatient days in another state). In general, in defining a covered benefit, federal guidelines require that (1) services be sufficient in amount, duration, and scope to reasonably achieve their purpose; (2) the amount, duration, and scope of services must be the same statewide; (3) within a state, services available to various categorically needy groups must be equal in amount, duration, and scope; and (4) with some exceptions, beneficiaries must have freedom of choice of providers among health care practitioners or managed care entities participating in Medicaid. States can modify these rules via existing waiver authority provided in Section 1115 of the Social Security Act.

Medicaid Alternative Benefit Plans (ABPs)

As an alternative to providing all the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to enroll state-specified groups in what were referred to as benchmark or benchmark-equivalent coverage, but are currently called ABPs.[9] The ACA made significant changes to both ABP design and requirements.[10] Examples of those changes are provided below.

Individuals eligible for Medicaid through the ACA Medicaid expansion are required to have ABP coverage. States can also require "full benefit eligibles" (or specific subgroups of these

[9] These ABPs were later modified by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) and the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Prior to the ACA, ABPs were called benchmark and benchmark-equivalent plans.

[10] Existing benchmark and benchmark-equivalent plans prior to the ACA will also have to conform to ACA requirements.

individuals) to enroll in Medicaid ABPs. A full benefit eligible is someone who is eligible for all the mandatory and optional services that a state covers under its traditional Medicaid program. States have the option to provide ABP coverage to other sub-populations, and these plans can also exist in sub-state areas.

Medically needy and certain spend-down populations (e.g., individuals whose Medicaid eligibility is based on a reduction of countable income for costs incurred for medical or remedial care) are excluded from the definition of a full benefit eligible. Medically needy populations can continue to receive coverage through the medically needy program, or if they are eligible for the ACA Medicaid expansion subgroup, they can receive services through an ABP. Such individuals can choose which coverage option they believe would be most beneficial to them.

Additional sub-groups are also exempt from mandatory enrollment in ABPs (e.g., those with special health care needs such as disabling mental disorders or serious and complex medical conditions). **Table 4** provides a description of each of these other exempted populations.

Table 4. Statutory and Regulatory Exceptions to Mandatory Enrollment in Medicaid ABPs

(i) mandatory eligibility for pregnant women with income below 133% of the federal poverty level (FPL)
(ii) blind or disabled individuals without regard to whether the individual is eligible for Supplemental Security Income (SSI) benefits and certain children under age 19 who meet the SSI disability definition, require an institutional level of care and the expected cost of care outside an appropriate institution is less than the expected cost that would be incurred within an appropriate institution; this latter group is sometimes referred to as the Katie Beckett group
(iii) Medicaid beneficiaries entitled to benefits under Medicare
(iv) terminally ill individuals receiving Medicaid hospice benefits
(v) inpatients in an institution who are required to pay for the costs of such care, excluding a minimal amount required for personal needs (e.g., hair care, clothing, telephone services)
(vi) certain persons who are medically frail (e.g., individuals with disabling mental disorders and individuals with chronic substance use disorders) or have special needs such as children under age 19 eligible for SSI, or foster care or other out-of-home placement, or those receiving foster care or adoption assistance, or receiving community-based services through certain Title V Maternal and Child Health grants, individuals with serious and complex medical conditions, people with physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or individuals with a disability determination based on Social Security criteria, or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.
(vii) beneficiaries qualifying for long-term care services (e.g., nursing facility services or similar level of care in any similar institution, certain home and community-based waiver services under Section 1915(c) and (d), and other optional state plan long-term care services); excludes several specific services (e.g., home health care, and personal care services for certain non-institutionalized individuals)
(viii) certain children in foster care receiving child welfare services (under Title IV-B) or certain children for whom adoption or foster care assistance is made available (under Title IV-E), without regard to age, and young adults up to age 26 if they were in foster care at age 18.
(ix) Temporary Assistance for Needy Families (TANF) and certain low-income parents as per Section 1931

(x) optional breast and cervical cancer women (under age 65, who are identified through the Centers for Disease Control screening program who need treatment for either of these cancers and are not eligible for other creditable coverage)

(xi) limited services beneficiaries, including optional tuberculosis-infected individuals with income up to the level applicable to mandatory SSI populations, or individuals who are not a qualified alien (e.g., certain aliens lawfully admitted for permanent residence in the United States) and for whom only treatment of emergency medical conditions is covered (as per Section 1903(v))

Source: Section 1937(a)(2)(B) of the Social Security Act and 42 CFR 440.315.

These exempted groups may get traditional Medicaid benefits or may be offered voluntary enrollment in ABPs. In such cases, states must describe the differences between traditional Medicaid and ABPs to these beneficiaries in order to facilitate an informed choice.

In general, ABPs may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of EPSDT and transportation to and from medical providers (as per a 2010 regulation),[11] that might make them more generous than private health care insurance. Starting in 2014, both ABP and ABP-equivalent packages[12] must cover at least the 10 essential health benefits that also apply to plans in the private individual and small group health insurance markets. These essential health benefits (EHBs) are (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) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) lab services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.[13] For calendar years 2014 and 2015, HHS requires states to define details for each EHB; however, this process may change in the future. Certain services are not considered to be EHBs, including (1) routine non-pediatric dental services, (2) routine non-pediatric eye exams, (3) long-term/custodial nursing home care, or (4) non-medically necessary orthodontia.[14] All ABP plans must also cover family planning services and supplies. Such plans must also comply with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) mental health services.[15] In addition, for children under age 21, ABP and ABP-equivalent coverage must include EPSDT. Also, Medicaid beneficiaries enrolled in such coverage must have access to services provided by rural health clinics and federally qualified health centers.

In designing a Medicaid ABP, several steps are required. First, states select a coverage option among the following choices: (1) the Blue Cross/Blue Shield standard provider plan under the Federal Employees Health Benefits Program (FEHBP), (2) a plan offered to and generally available to state employees, (3) the largest commercial health maintenance organization (HMO) in the state, and (4) Secretary-approved coverage appropriate to meet the needs of the targeted population. ABP-equivalent coverage[16] must have the same actuarial value as one of the four

[11] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Program: States Flexibility for Medicaid Benefit Packages, Final Rule, 75 *Federal Register*, 23068 (April 30, 2010).

[12] ABP-equivalent plans must have the same actuarial value as one of the standard ABPs.

[13] For additional information on essential health benefits in the Medicaid program, see the State Medicaid Directors Letter (SMDL # 12-003 dated November 20, 2012).

[14] See 42 CFR 156.115(d).

[15] Centers for Medicare and Medicaid Services, Letter to State Health Officials, RE: *Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans*, SHO # 13-00, ACA #24, January 16, 2013, and 42 CFR 440.345.

[16] In addition, ABP-equivalent coverage must include (1) inpatient and outpatient hospital services, (2) physician (continued...)

ABPs. Second, states then determine if the selected option is also one of the health insurance exchange base-benchmark plan options that the Secretary of HHS has indicated can be used to define all 10 essential health benefits (listed above). The EHB base benchmark choices include (1) any of the three largest small group market health plans by enrollment, (2) any of the three largest state employee health benefit plans by enrollment, (3) any of the three largest federal employee health benefit plans by aggregate enrollment, and (4) the largest, insured commercial non-Medicaid health maintenance organization (HMO) operating in the state. As long as all of the EHB categories are covered, the requirements for the provision of coverage would be met. If not, states must select one of the EHB base-benchmark plan options and supplement it with any missing EHB benefits from other EHB base-benchmark plans, or the Medicaid state plan as necessary.[17]

Benefit *substitution* rules also apply to EHBs in ABPs and ABP-equivalent plans.[18] States may substitute benefits when (1) a service is actuarially equivalent to the benefit being replaced, (2) the replacement benefit is selected only within the same EHB category, and (3) the service is not a prescription drug benefit. In addition, benefit substitutions can be made when a state submits evidence of actuarial-equivalence that (1) has been certified by a member of the American Academy of Actuaries, (2) is based on an analysis performed in accordance with generally accepted actuarial principals and methodologies, (3) is based on a standardized plan population, and (4) is determined regardless of beneficiary cost-sharing.

Other rules apply to Medicaid ABP coverage for prescription drugs, rehabilitative services and devices and habilitative services and devices, and preventive care. A health plan will not be considered to provide EHBs unless it covers at least the greater of (a) one drug in every U.S. Pharmacopeia (USP) category or class, or (b) the same number of prescription drugs in each category and class as the EHB base benchmark plan. A health plan must also submit its drug list to the health insurance exchange, the state, or the Office of Personnel Management (OPM), as applicable. And a health plan providing EHBs must have procedures in place that allow an enrollee to have access to clinically appropriate drugs not covered by the health plan.[19]

As noted above, rehabilitative and habilitative services and devices are among the 10 EHB categories, and thus are mandatory benefits under ABPs. There is not a standard definition for these services in federal statute. The July 15, 2013, final rule indicates that the Centers for Medicare and Medicaid Services (CMS) is not prescribing a specific definition for these services, and states may choose to adopt service definitions that are similar to those provided by the National Association of Insurance Commissioners (NAIC). Rehabilitative services and devices include long-term services and supports designed to assist a person to *prevent* deterioration and *regain or maintain* a skill or function acquired and then lost or impaired due to illness, injury, or disabling condition. In addition, NAIC notes that habilitative services and devices are designed to *attain or maintain* a skill or function *never* learned or acquired due to a disabling condition. CMS

(...continued)

services, (3) lab and x-ray services, (4) emergency care, (5) well-child care, including immunizations, (6) prescribed drugs, (7) mental health services, and (8) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the applicable ABP for vision care and hearing services (if any).

[17] See 42 CFR 156.110(b)(1) through (b)(3).

[18] See 42 CFR 156.115(b).

[19] See 45 CFR 156.122 for additional details.

has also indicated that it will consider the need for further guidance, based on experience in implementing these services and devices.[20]

Under traditional Medicaid state plan coverage, states *may* cover preventive services, such as vaccinations or regular physical examinations, diagnostic services, rehabilitative services, and the services of other practitioners recognized by the state, although they may be included with *mandatory* services such as early and periodic screening, diagnosis and treatment (EPSDT) or home health care. Medicaid ABPs *must* cover preventive care at least at the minimum level required for EHBs.[21] This means that they must cover preventive services that are rated A or B by the U.S. Preventive Services Task Force, adult immunizations recommended by the Advisory Committee on Immunization Practices, and women's services recommended by the Health Resources and Services Administration. Cost-sharing for these preventive services is prohibited under Medicaid ABPs.[22]

The ACA also created health insurance exchanges in which individuals ineligible for Medicaid due to income can purchase coverage that meets their needs. Some benefit requirements overlap between Medicaid ABPs and health insurance exchange plans.[23] Thus, when individuals' income changes (increases or decreases over time), they can move back and forth between ABPs and health insurance exchange coverage as needed. In addition, common requirements between health insurance exchange coverage and ABPs (e.g., essential health benefits, supplementation and substitution of benefits) can also be used by states to align traditional Medicaid benefits with ABP coverage.

As noted above, states have had the authority to implement benchmark benefit packages in their Medicaid programs since the Deficit Reduction Act of 2005. The requirements applicable to the current ABPs are different from the requirements that applied to former benchmark plans. These latter plans must adhere to the new ABP requirements if states wish to continue using them.

It is unclear how state experiences with Medicaid benchmark plans to date will influence the design of such benefit packages in 2014. States with no such experience may look to those states that have implemented benchmark packages for lessons learned in order to make choices tailored to their given circumstances and resources. Also, states that implement the ACA Medicaid eligibility expansion could decide to provide ABP coverage to other eligibility groups. And states that do not take up this eligibility expansion might decide to utilize ABP coverage for other subpopulations.

---

[20] For additional information, see the description of rehabilitative and habilitative services and devices on page 42214 in the Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, Final Rule," Vol. 78, No. 135, July 15, 2013. Also see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by (name redacted).

[21] 78 *Federal Register*, July 15, 2013, Preamble to the final regulation, page 42224.

[22] Ibid.

[23] For additional details about coverage through health insurance exchanges, see CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted); also for more information about the interaction between Medicaid and health insurance exchange coverage, see CRS Report R42978, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*, by (name redac ted) and (name redacted).

State Experience with ABPs

Table 5 provides information about selected characteristics of ABPs for 15 states. This table is not exhaustive nor is it comprehensive for each state listed, but rather is intended to illustrate cross-state similarities and variation in covered ABP benefits. All of the plans shown are being implemented statewide. For a few states, covered ABP benefits are the same as those offered under traditional Medicaid. Dental care for adults (or selected subgroups of adults) is covered in six states (Kentucky #2, Minnesota, Nevada, Ohio, Oregon, and Vermont). Non-emergency medical transportation is offered in four states (Arizona, Maryland, Nevada, and Oregon). And four states (Maryland, Minnesota, Nevada, and Ohio) include coverage of nursing facility care in their ABPs.

Table 5. Selected Characteristics of ABPs, by State, as of Mid-April 2014

State and Eligibility Groups	Type of ABP and Proposed Effective Date	Base Benchmark Plan for Providing Essential Health Benefits	Examples of Covered Benefits	Geographic Area	Delivery Systems	Other Information
Arizona, expansion adult group	Secretary approved, January 1, 2014	Any of the largest three state employee health benefit plans by enrollment	Same as services offered under approved state plan (e.g., non-emergency medical transportation for outpatient care only; custodial nursing facility (NF) care when hospitalization is necessary if NF services were not provided; certified pediatric or family nurse practitioner)	Statewide	Managed care and fee-for-service	Arizona's Medicaid program operates under a Section 1115 waiver
Colorado, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Same services offered under traditional Medicaid plus additional preventive services not currently offered in the state plan, and habilitative services	Statewide	Behavioral health services (mental health and substance use disorders) administered by behavioral health managed care organizations (BHOs)	Populations exempt from mandatory enrollment in ABPs such as the medically frail will be offered the choice of the state's approved Medicaid state plan package

State and Eligibility Groups	Type of ABP and Proposed Effective Date	Base Benchmark Plan for Providing Essential Health Benefits	Examples of Covered Benefits	Geographic Area	Delivery Systems	Other Information
Connecticut, expansion adult group	Secretary approved; January 1, 2014	Any of the largest three national FEHBP plan options open to federal employees in all geographies by enrollment (Blue Cross and Blue Shield Service Benefit Plan – Basic Option)	Same services offered under traditional Medicaid (including same limitations)	Statewide	Under the fee-for-service delivery system, services are managed under an administrative services organization (ASO) arrangement	State proposes to fully align its ABP with its existing, approved state plan services (including the same limitations applicable to the state plan services)
District of Columbia, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Same as the services offered under the approved state plan (e.g., nursing facility services, routine eye exam for adults, outpatient nurse practitioner services)	Statewide	Managed Care Organizations and Fee-For-Service	All benefits and associated limits will apply
Iowa, expansion adult group who are medically frail	Secretary approved; January 1, 2014	Any of the largest three state employee health benefit plans by enrollment	Covered benefits under the state employee coverage based on the approved state plan (e.g., prescription drugs, urgent dental care to treat infections, acute pain or trauma)	Statewide	Managed care organizations (MCOs), Primary Care Case Management, and Fee-for-Service	The state will identify individuals exempt from mandatory enrollment in an ABP; such individuals will be given a choice between ABP services or Medicaid state plan benefits

State and Eligibility Groups	Type of ABP and Proposed Effective Date	Base Benchmark Plan for Providing Essential Health Benefits	Examples of Covered Benefits	Geographic Area	Delivery Systems	Other Information
Kentucky #1, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Covered benefits are based on the approved state plan	Statewide	Managed care organizations (MCOs) and Prepaid Ambulatory Health Plans (PAHPs)	Anthem preferred provider organization (PPO) will serve as the base benchmark plan
Kentucky #2, current Medicaid eligibles who meet ICF-IDD (intellectual and developmental disabilities) patient status criteria	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Dental services (i.e., one cleaning and one x-ray per year) for those over age 20; case management services for specific subgroups (e.g., children under state supervision; pregnant women < age 20; individuals with moderate or severe substance use disorder diagnosis)	Statewide	Managed care organizations (MCOs) and Prepaid ambulatory health plans (PAHPs)	The ABP is fully aligned with Kentucky's state plan benefit package; should misalignment occur in the future, exempt individuals will have the option to select the state plan benefits
Maryland, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment among the three largest small group insurance products in the state's small group market	Podiatrist services; non-emergency transportation to/from Medicaid providers subject to prior authorization; outpatient mental health clinic services (not in an institution for mental disease); nursing home custodial care including hospice services	Statewide	Managed care organizations (MCOs) and fee-for-service	Prior authorization is required for some services that are not EHBs (e.g., non-emergency medical transportation and outpatient mental health clinic services)

State and Eligibility Groups	Type of ABP and Proposed Effective Date	Base Benchmark Plan for Providing Essential Health Benefits	Examples of Covered Benefits	Geographic Area	Delivery Systems	Other Information
Minnesota, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Certain adult dental services, podiatrist services, freestanding birth centers, private duty nursing, nursing facility services for long-term stays	Statewide	Managed care organizations (MCOs) and fee-for-service	Individuals exempt from mandatory participation in ABPs may choose the benefit package they wish to receive
Nevada, expansion adult group	Secretary approved; January 1, 2014	Any of the largest three national FEHBP plan options open to federal employees in all geographies by enrollment	Non-emergency transportation, certain dental services for individuals > age 21, nursing facility care (based on level of care screens), peer supported rehab services to restore recipient to highest level of functioning	Statewide	Managed care organizations (MCOs) and fee-for-service	All ABP benefits are based on the approved Medicaid state plan
New Jersey, expansion adult group	Secretary approved; January 1, 2014	Largest insured commercial non-Medicaid HMO	Medicaid state plan benefits including substance abuse services, psychiatric emergency rehabilitation services, and tobacco cessation services	Statewide	Managed care organizations (MCOs) and fee-for-service	The state's ABP prescription drug benefit is the same as under the approved Medicaid state plan for prescribed drugs

State and Eligibility Groups	Type of ABP and Proposed Effective Date	Base Benchmark Plan for Providing Essential Health Benefits	Examples of Covered Benefits	Geographic Area	Delivery Systems	Other Information
Ohio, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Certain dental services for individuals age 21+ years, long term custodial care in a nursing facility for qualified individuals, one pair of adult eyeglasses every 24 months, freestanding birthing center services	Statewide	Managed care organizations (MCOs) and fee-for-service (the fee-for-service delivery system is used for the new ACA adult group until these individuals are enrolled in a MCO)	Benefits are the same as in the approved state plan but in a different amount, duration and/or scope
Oregon, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Certain dental services for non-pregnant adults age 21+ years, non-emergency medical transportation provided through a brokerage system authorized under an 1115 waiver, personal care services authorized through a treatment/service plan including assistance with activities of daily living	Statewide	Managed care organizations (MCOs), Prepaid Ambulatory Health Plans (PAHPs), and fee-for-service	Benefits are the same as in the approved state plan and are aligned with the current secretary approved benefit package via a Section 1115 demonstration waiver
Rhode Island #1, expansion adult group	Secretary Approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	Medicaid state plan benefits (list not available in source documentation)	Statewide	Not clear from source documentation	Benefits correspond to the state's existing "Rhody Health Partners" package of Medicaid state plan benefits

State and Eligibility Groups	Type of ABP and Proposed Effective Date	Base Benchmark Plan for Providing Essential Health Benefits	Examples of Covered Benefits	Geographic Area	Delivery Systems	Other Information
Rhode Island #2, expansion adult group	Secretary Approved; January 1, 2014	Wrap-around payments and services tied to the plan described above for Rhode Island #1	Premium assistance program used when cost effective. Medicaid pays (1) the employee portion of the employer sponsored insurance (ESI) premiums, and (2) wraparound payments and services (e.g., for dental care, and other copayments); applies to a small number of individuals in this state	Statewide	Depends on delivery system used by employers	Established under a Section 1115 waiver; This RIte Share premium assistance component enrolls individuals who are eligible for Medicaid, and who are employees (or dependents of an employee) of an employer that offers a "qualified" plan under the employer sponsored insurance (ESI) coverage.
Vermont, expansion adult group	Secretary approved; January 1, 2014	Medicaid state plan benefits	Dental (prophylaxis), home visits for pregnant women, therapeutic substance abuse services, community mental health services	Statewide	Traditional state-managed fee-for-service; managed care model for long-term care (includes all state plan and any approved demonstration services under the state's long term care waiver called "Choices for Care")	Based on existing approved state plan for the new adult group (but the state will not have newly eligible groups under the ACA)

State and Eligibility Groups	Type of ABP and Proposed Effective Date	Base Benchmark Plan for Providing Essential Health Benefits	Examples of Covered Benefits	Geographic Area	Delivery Systems	Other Information
West Virginia, expansion adult group	Secretary approved; January 1, 2014	Largest plan by enrollment of the three largest small group insurance products in the state's small group market	ABP closely mirrors Medicaid state plan coverage; up to 30 visits/year for physical therapy and occupational therapy; up to 60 visits/year for home health services with additional prior approval for up to 100 visits/year	Statewide	New adult group receives ABP benefits through a fee-for-service delivery system. Also, when applicable, beneficiaries will receive a benefit package that includes a wrap of benefits around ESI that equals the benefit package to which the individual is entitled. Any related premiums and cost-sharing will not exceed applicable nominal amounts in federal regulations.	People who self-identify as medically frail at the time of application will notify the state that they would like to be dis-enrolled from the applicable ABP.

Source: State plan amendment documents at http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html, last accessed on April 17, 2014.

Notes: Kentucky has a third SPA stating that its purpose is to take down the current ABP that is to be replaced by the other two SPAs described in this table.

Mental Health Parity Requirements Under Both Traditional Medicaid and ABP Plans

The federal mental health parity requirements, as established in the Public Health Service Act (Section 2726), generally mandate that, under a given insurance plan, coverage of mental health and addiction services (if offered) should be on par with coverage of medical and surgical services in terms of the treatment limitations (e.g., amount, duration, and scope of benefits), financial requirements (e.g., beneficiary co-payments), in- and out-of-network covered benefits, and annual and lifetime dollar limits. Managed care plans under both traditional Medicaid and ABPs must comply with all federal mental health parity requirements. ABPs that are not managed care plans are only required to comply with federal requirements for parity in treatment limitations and financial requirements. These plans are deemed to comply with federal mental health parity requirements if they offer EPSDT to individuals under age 21, for which they are statutorily required to cover.[24]

Additional CRS Medicaid and CHIP Resources

CRS Report R43357, *Medicaid: An Overview*

CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*

CRS Report R42978, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*

CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*

Author Contact Information

(name redacted)
Specialist in Health Care Financing
[redacted]@crs.loc.gov, 7-....

[24] For more detailed information on mental health parity under Medicaid including substance use disorder services, see CRS Report R41768, *Mental Health Parity and Mandated Coverage of Mental Health and Substance Use Disorder Services After the ACA*, by (name redacted).