CHCS Center for Health Care Strategies, Inc.

Policy Brief

Key State Considerations for Selecting an Essential Health Benefit Benchmark for Medicaid and the Exchange

By Veronica Guerra, MPA, Christian Heiss and Shannon M. McMahon, MPA, Center for Health Care Strategies

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As states move forward with the establishment of health insurance exchanges and optional Medicaid expansions under the Affordable Care Act (ACA), they are faced with the challenge of establishing and aligning the basic health benefits individuals will receive under the new law. Beginning in 2014, non-grandfathered health insurance plans in the individual and small group markets (both inside and outside of the insurance exchanges), Basic Health Programs, and Medicaid benchmark and benchmark-equivalent plans offered to the newly eligible, are required to provide a minimum package of services in 10 categories called "essential health benefits" (EHB). At minimum, EHB services will have to include services like chronic disease management, emergency services, hospitalization, maternity and newborn care, and mental health and substance use disorder services, among others.[1]

In establishing EHBs, states must consider many factors, including alignment of benefits across plans; fiscal and budgetary implications; and the health care needs of their populations. This brief, created by the Center for Health Care Strategies, highlights these key considerations for states as they move forward with ACA implementation.

IN BRIEF

Beginning in 2014, the ACA requires that newly-established health insurance plans in the individual and small group markets, the exchanges, and Medicaid provide a minimum package of services, known as "essential health benefits" (EHB). States must consider many factors in establishing EHBs, including: aligning their EHB packages between plans in order to ensure continuity of coverage; determining the fiscal and budgetary implications for EHB selection; and addressing the health care needs of their populations. This brief highlights these key considerations as states move forward with implementation of the ACA.

Benchmark Coverage

In December 2011, the Department of Health and Human Services' Center for Consumer Information and Insurance Oversight issued a bulletin to guide states through the early stages of implementing the EHB requirements.[2] The EHB bulletin proposes that states select an EHB benchmark plan for Medicaid as well as for the individual and small group markets, both inside and outside of the exchange. States participating in the Medicaid expansion are required to provide a benefit package consistent with section 1937 of the Social Security Act for individuals who become eligible for Medicaid on January 1, 2014. For Medicaid benchmark and benchmark equivalent plans, a state Medicaid agency may choose any of the options made available through the section 1937 benchmark requirements:

1) The standard Blue Cross/Blue Shield Federal Employee Health Benefit Plan (FEHBP);
2) The HMO plan with the largest commercial, non-Medicaid enrollment in the state;
3) Any generally available state employee plan; or
4) Any plan that the Secretary of HHS determines to be appropriate.

The EHB benchmark plan options proposed by HHS in the EHB Bulletin and available to Medicaid through section 1937 are both based on the approach established with the creation of the Children's Health Insurance Program (CHIP).[3,4] For the exchange EHB benchmark plan, states are able to choose any one of the three largest federal employee health plan options by enrollment; one of the three largest state employee health plans by enrollment; the largest HMO plan offered in the state's commercial market by enrollment; or one of the three largest small group plans in the state by enrollment. There is existing overlap between the available EHB benchmark options states can select for both Medicaid and the individual and small group markets.

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Benchmark Benefit Alignment as a Tool to Provide Continuity of Coverage

National studies, prior to the Supreme Court decision, estimated that after the 2014 expansion of Medicaid and the creation of the insurance exchanges, out of 56 million adults ages 18 to 64 below 200 percent FPL, 20 million would churn between Medicaid and the exchanges within 6 months and 28 million within 1 year.[5] Although the Congressional Budget Office has estimated that the Supreme Court decision will decrease the number of individuals who gain coverage through Medicaid,[6] states will continue to face the problem of churn and its effects on those gaining coverage through the insurance exchanges and Medicaid.

Those who cross the Medicaid-exchange divide face potential shifts in their plans and provider networks, and studies have shown that patients have increased difficulty gaining access to care as a result of changes in health plans even without gaps in coverage.[7] This group faces potential limitations in access due to coverage disruptions, and the states face an increased administrative burden due to above-average cycles of enrollment and disenrollment.

Because health insurance is largely regulated at the state level, coverage mandates vary from state to state. Therefore, some services are generally covered by almost all health plans in a given state, while others, such as hospice care for adults, substance abuse treatment, and home health are less widely covered. The EHB requirement will have a large impact on the individual and small group markets by creating standardized benefit categories that will provide a minimum scope of benefits to enrollees covered in a "typical employer plan."

Identical EHB benchmark plan selection for both Medicaid, applicable to participating states, and the individual and small group market would assist in minimizing any potential gaps in coverage associated with churn. Potential alignment could occur by selecting similar benchmark plans which may include the Blue Cross/Blue Shield FEHBP, the largest commercial non-Medicaid HMO, one of the three largest state employee plans, or one of the three largest small group plans under the Secretary-approved option for Medicaid. Coverage changes resulting from churn could be further minimized if the same plans with the same provider networks participate in both the exchange and Medicaid markets. States could work with qualified health plans (QHPs) and Medicaid plans to ensure that products are certified to function in both markets and if possible share the same provider networks, patient protections, administrative systems, and quality and performance measures. To begin, states can include contract language for plans participating in the exchange and Medicaid that requires they coordinate care transitions for beneficiaries switching plans or products. Market and provider network alignment would promote continuity and quality of care for people moving across programs.

Additional Considerations in Selecting an EHB Benchmark Plan

State Fiscal Impact and Budgetary Implications

During the first three years after the Medicaid expansion, the federal government will cover the full cost of the EHB benchmark plan benefits selected for this population; however, participating states will need to cover an increasing portion of the costs as the federal match declines after 2016 to 90 percent. Therefore, a richer benefits package may not be sustainable for state budgets. As such, these states may want to consider the comprehensiveness of the chosen benchmark plan and the fiscal impact after 2016. Although the fiscal impact is important, states should also take utilization patterns and extent of limitations on

services into account when making benchmark determinations.

Furthermore, when determining and selecting an EHB benchmark plan participating states must consider whether the preferred plan requires any supplements to ensure the plan is inclusive of the 10 statutory EHB categories. Because health plans will still be required to offer any missing EHBs, the state will be required to adjust the benchmark plan to include those benefits which may also create administrative complexity. For example, many plans may not cover pediatric dental or pediatric vision services which will need to be supplemented by the state. Another category of concern is habilitative care, which remains largely undefined in many plans and may require further supplementation from the state to meet HHS standards. The EHB bulletin describes a transitional approach that allows habilitative services to be selected using the same services used for rehabilitative needs and offering them at parity or allowing plans to decide covered services with subsequent HHS approval.

The ACA allows states to require that QHPs within the exchange offer benefits in addition to the 10 EHB categories;[8] however, the cost of adding additional benefits (i.e., state mandates) must be paid by the state which might include paying the individual directly or paying the QHP. Within the exchange, HHS has provided flexibility to states by allowing them to select an EHB benchmark plan option for 2014 and 2015 that includes at least some of the state mandated benefits, waiving the requirement that the state defray the costs of covering state mandates. States would also want to assess the political implications and costs of selecting a benchmark plan that does not include state mandated benefits. A proper assessment of the potential for state costs would require further understanding and/or guidance on several aspects, including: number of QHP enrollees; baseline EHB benefits and what benefits are considered to be "in addition to" the EHBs; policies subject to EHBs and state mandated benefits; populations enrolled in plans; formula used to calculate a state's liability; and the definition of "costs" and "payments" for additional benefits.[9]

Health Care Needs of Population

To determine an appropriate EHB benchmark plan for both Medicaid and the commercial markets, a state should consider the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. Various studies have found that the populations to gain coverage will include many relatively healthy individuals, yet states should anticipate that enrollees will also include a significant number of individuals with multiple comorbidities and high levels of service utilization, especially in the first months after obtaining access to coverage. Disparities in rates of insurance coverage by race and ethnicity[10] are likely to exacerbate this effect, as populations with lower rates of insurance and greater pent-up demand seek care.

Closing Thoughts

States must determine their EHB benchmark plans by the third quarter of 2012 for use in the exchange; and participating expansion states must do so in time for submission of 2014-related changes to Medicaid state plans. This timeframe requires that states interested in selecting an EHB benchmark plan tailored to their state begin the process or they must adopt the HHS proposed default. It is recommended that the state engage the stakeholder community and potential beneficiaries of the EHB benchmark plan to ensure that the selected coverage meets the needs of the population. As outlined in this brief, states have various considerations in selecting their EHB benchmark plans for both Medicaid and the individual and small group markets and should take advantage of opportunities for alignment.

About the State Health Reform Assistance Network

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.rwjf.org/coverage.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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Endnotes

[1] The full list of categories is as follows: ambulatory and patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.
[2] Center for Consumer Information and Insurance Oversight. Essential Health Benefits Bulletin. December 16, 2011. http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, December 16, 2011.
[3] Ibid.
[4] Balanced Budget Act of 1997; Public Law 105-33
[5] B. D. Somers and S. Rosenbaum. "Issues In Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs*, February 2011, vol. 30 no. 2.
[6] Based on recent CBO estimates, in 2022 Medicaid and CHIP are expected to cover about 6 million fewer people than previously estimated, about 3 million more people will be enrolled in the exchanges, and about 3 million more people will be uninsured.
[7] Ibid.
[8] ACA 1311(d)(3)(B)
[9] California Health Benefits Review Program (CHBRP). "Issue Brief: Interaction between California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits." CHBRP, 2012.
[10] L. Clemens-Cope, et al. "The Affordable Care Act's Coverage Expansions will Reduce Difference in Uninsurance Rates by Race and Ethnicity." Health Affairs, May 2012, vol. 31 no. 5.