

Health Care Reform and Benchmark Plans: Considerations for Advocates

The Affordable Care Act (ACA) is intended to improve access to quality, affordable health care. One of the primary vehicles for reaching the goal of making health care accessible to all Americans is the expansion of Medicaid, the health insurance program for low-income people. The ACA requires that as of January 2014, states cover childless adults under age 65 with incomes up to 133% of the federal poverty level (FPL), those earning approximately \$14,400 dollars per year, through their Medicaid program.^{1,2} Until the changes made to Medicaid eligibility as part of the ACA, states have only been required to cover certain “categorically” eligible persons through the Medicaid program, such as children, pregnant women, women with children, and disabled persons.³ In most states, childless, adults under age 65, even those at or below poverty level, have been ineligible for Medicaid. Estimates published by the Kaiser Commission on Medicaid and the Uninsured, suggest that 16 to 22 million individuals are expected to enroll.⁴ Given recent findings that participation in Medicaid helps people increase use of preventive and primary care, decreases financial strain, and increases reported physical and emotional well-being, helping low-income people who are uninsured enroll in Medicaid can and should be a high priority for states and advocates for the uninsured.⁵

Once enrolled in Medicaid, the question becomes what benefits will people have access to? This paper provides a brief overview of benchmark plans and a summary of issues for advocates and others who are interested in benefit design and enrollment issues for the newly eligible Medicaid population.

BENCHMARK PLANS

While states can offer the newly eligible “expansion population” the state’s standard or traditional Medicaid benefit package; the ACA only requires states to offer benchmark or benchmark equivalent benefits. Benchmark coverage includes any one of the following as outlined in 42 CFR 440:

- Federal Employees Health Benefit Plan Equivalent Coverage (FEHBP – Equivalent Health Insurance Coverage)

¹ States can elect to begin enrolling eligible individuals prior to 2014, but cannot collect the higher federal matching rate until 2014.

² Under the ACA, income eligibility for Medicaid will use the modified adjusted gross income standard, which uses a 5% income disregard, effectively raising the income level to 138%.

³ For disabled persons, Medicaid eligibility in most states is tied to their eligibility for Supplemental Security Income (SSI). Persons with a sole diagnosis of a substance use disorder are not eligible for SSI under current Social Security rules.

⁴ Holahan, J., Headen, I. (2010, May). Medicaid coverage and spending in health reform: National and state by state results for adults at or below 133% FPL (Kaiser Commission on Medicaid and the Uninsured Report No. 8076). Washington, DC: Henry J. Kaiser Family Foundation.

⁵ Finkelstein, A., Taubman, S., Wright, B., Bernstein, M., Gruber, J., Newhouse, J.P., Allen, H., Baicker, K. (2011). The Oregon Health Experiment: Evidence From the First Year. (Working Paper No. 17190). Cambridge, MA: National Bureau of Economic Research.

- State employee coverage – health benefits plan that is offered and generally available to state employees
- A Health Maintenance Organization (HMO) plan that has the largest insured commercial, non-Medicaid enrollment in the State
- Other health benefits coverage that the Secretary of Health and Human Services (HHS) determines provides appropriate coverage for the proposed population

States can also elect to provide “benchmark equivalent” benefits to the expansion population. Benchmark equivalent benefits must have an actuarial value that is at least equivalent to coverage under one of the benchmark coverage outlined above.

ESSENTIAL BENEFITS

Prior to the passage of the ACA, benchmark plans did not have to cover prescription drugs or mental health (MH) and substance use disorder (SUD) services. The ACA states that benchmark and equivalent plans must include at least the following “essential health benefits”:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- **Mental health and substance use disorder services, including behavioral health treatment**
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The other notable improvement to benchmark and equivalent benefits made by the ACA is that these plans must comply with the Mental Health Parity and Addictions Equity Act (MHPAEA). This means that coverage limitations that apply to MH and SUD services cannot be any more restrictive than the predominant financial requirements or treatment limitations that apply to *substantially all medical/surgical benefits*.

It is important to keep in mind that while the broad categories of services are outlined in the ACA, the actual services that will be included as part of this “essential benefit package” have not yet been defined. States may also elect to include additional benefits and services to their benchmark plans.⁶

⁶ States must also assure that youth under 21 who are enrolled in benchmark plans are provided access to all medically necessary EPSDT services.

ENROLLMENT IN A BENCHMARK PLAN

While states can require that people who are newly eligible for Medicaid under the ACA enroll in a benchmark plan, certain categories of individuals cannot be required to enroll in a benchmark plan. People who are exempted from mandatory enrollment in a benchmark plan include:⁷

- Pregnant women
- Blind and disabled people regardless if the person is eligible for SSI
- People who are eligible for Medicare
- Terminally ill individuals
- People residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), or other medical institutions
- Medically frail or people with special needs which includes:
 - youth in foster care or receiving adoption assistance
 - dual eligibles
 - youth with serious emotional disturbance (SED)
 - people with disabling mental disorders
 - individuals with serious and complex medical conditions
 - individuals with physical and/or mental disabilities that significantly prevent them from performing one or more activities of daily living

States that elect to offer a benchmark benefit can choose to allow the exempt populations the option to enroll in a benchmark plan. If they offer them the option to enroll in the benchmark, states must provide information to enrollees which compare the benchmark to the standard benefit plan. States must also offer exempt populations the option to revert back to traditional Medicaid at any time.

BENEFITS FOR VULNERABLE POPULATIONS

Among advocates for vulnerable populations such as people who are homeless or people with mental health or substance use disorders, there has been legitimate concern that a state's benchmark benefit plan may not offer the types of services and supports that these groups may need. There is also worry that the enhanced federal match states will receive for people who enroll under the new "financial only" eligibility category, will provide a major incentive for states to enroll as many people as possible in this new eligibility category regardless of their health or disability status.⁸ Advocates and others worry that because of this incentive states will not be as judicious as they should be in ensuring that people with disabilities who would otherwise qualify under an existing eligibility category (and therefore are not

⁷ A complete listing of populations who are exempt from inclusion in a benchmark plan can be found at 42 CFR Part 440.

⁸ In order to assist states with paying for the expansion of their Medicaid program, the federal government will pay 100% of the medical costs associated with the expansion for the first three years, with the percentage gradually decreasing through 2020 to 90%. This enhanced federal match however only applies to those people who enroll under the expansion, not to people who enroll under one of the existing Medicaid categories.

eligible for the enhanced federal match or mandatory enrollment in a benchmark plan) are informed of the enrollment pathway that will allow them access to the benefit package that will best meet their needs.

For new enrollees with mental or substance use disorders, the primary question will be what will offer the most “robust” benefit to meet their needs, the benchmark plan or a state’s standard Medicaid plan? The answer is still unclear and ultimately will depend on how a state’s standard Medicaid plan compares with that of the benchmark plan. In states with many services for people with mental health needs under the Medicaid Rehabilitation Option, Targeted Case Management, or 1915(i) state plan options, pursuing enrollment through the state’s enrollment process for people with disabilities is likely to be the route to the “best benefit.”⁹ However in states with a limited standard benefit that includes few services for people with mental health or substance use needs and provides services through a “fee-for-service” mechanism, enrollment in a benchmark plan might offer more comprehensive coverage. This is in part because the MHPAEA (e.g. the parity law) does not apply to fee-for-service Medicaid but **does** apply to services offered as part of a benchmark plan and to Medicaid managed care plans. It is also possible that as a way to incentivize people to participate in the benchmark plan, states will elect to include additional benefits that are not available as part of its standard Medicaid plan.

CONSIDERATIONS FOR ADVOCATES

Until the essential services are defined and states determine what if any additional benefits or services they will add to their benchmark plan, it will be difficult to determine if a state’s benchmark plan or their standard benefit plan is going to offer the most comprehensive benefit for people in need of mental health and substance use treatment. A state-specific analysis and comparison of the benchmark plan with the standard plan will be required in order to make the most informed decision. However that does not mean that advocates need to take a “wait and see” approach to the issues of benefit design and enrollment as part of health care reform activities in your state. States are developing their enrollment processes, outreach activities, and planning for benefit design now; participating in your state’s stakeholder process will be the best way to ensure that the needs of vulnerable groups are considered in the planning and implementation process. The following are some key areas to watch and influence as state’s move forward with implementing key ACA provisions:

- **What are your state’s plans for outreach and enrollment of vulnerable populations?** Section 2201 of the ACA requires states to establish procedures for reaching out to and enrolling vulnerable and underserved populations including youth, unaccompanied homeless youth, racial and ethnic minorities, and individuals with mental health or substance-related disorders. Many of these vulnerable populations will be exempt from enrollment in a benchmark plan and are likely to qualify for Medicaid under one of the existing eligibility groups. **How will the state**

⁹ In thirty-four states, people who qualify for SSI are automatically enrolled in Medicaid without having to complete a separate application. In the remaining 18 states, people must apply separately for Medicaid. People with a sole substance use disorder are not considered disabled according to current Social Security Administration rules.

ensure that vulnerable populations who are exempt from enrollment in a benchmark plan are made aware of the enrollment pathway (e.g. SSI) that will allow them to access the benefit that will best meet their needs?

- **What benefit package will the state offer the newly eligible expansion population?** Will they offer a benchmark plan or the standard benefit package? What, if any additional services does that state plan to offer as part of the benchmark package? Given that low-income childless adults under 65 with a sole substance use disorder are not eligible for SSI and are not included in one of the groups who are “excluded” from enrollment in a benchmark, inclusion of a range of substance abuse treatment services under a state’s benchmark plan will be particularly important. While the requirement for mental health and substance use parity in benchmark plans is positive and will ensure access to substance use treatment services, it does not necessarily mean that a full range of substance use treatment services will be available.
- Individuals with physical and/or mental disabilities that significantly prevent them from performing one or more activities of daily living are exempted from enrollment in a benchmark plan. **How will the state make this determination? If the state elects to offer exempt populations the option to enrollment in a benchmark plan, how will the state ensure that this population is offered “informed choice” between the benchmark and the standard benefit?** States are required to inform people in exempt categories that they are indeed “exempt”, that their enrollment in a benchmark plan is voluntary, and they must provide a comparison of how the benchmark compares to standard Medicaid. The design and development of materials that are easily understandable will help people make an informed decision about the benefits and limitations of enrollment in a benchmark versus the standard Medicaid plan.