



HCBS And Insurance Coverage Purchased Through The Marketplace

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Vicki Gottlich and Daniel Davis
Administration for Community Living (ACL)



Marketplace Eligibility

- To be eligible to purchase a Qualified Health Plan (QHP) through the Marketplace, you:
 - Must live in the United States
 - Must be a U.S. citizen or national (or be lawfully present)
 - Not be incarcerated
 - Live in the area served by the Marketplace
 - Not have other Minimum Essential Coverage

Minimum Essential Coverage

- Minimum essential coverage includes:
 - Health insurance coverage provided by an employer
 - Medicare
 - Medicaid
 - TRICARE
 - VA

Qualified Health Plan

- Falls within a specified “metal level” that provides varying amounts of health insurance coverage
 - Bronze
 - Silver
 - Gold
 - Platinum
- Meets certain cost-sharing requirements
 - Ex: - No cost-sharing for preventive health benefits
- Provides coverage for 10 “essential health benefits”

Essential Health Benefits (EHB)

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

Will You Really Get All of the EHB Services You Need?

- The exact services provided in each category are based on services provided by the “EHB- benchmark plan” selected by each state. Options include:
 - Small group market health plan
 - State employee health benefit plan
 - FEHBP plan
 - HMO
- Largest plan by enrollment in small group market is the default option.
- If EHB-benchmark plan doesn't include all EHB, then benefits must be supplemented.

Will You Really Get All of the EHB Services You Need?

- QHPs set their own rules for services and cost sharing that are “substantially equal to the EHB-benchmark plan” including:
 - Covered benefits
 - Limitations on coverage including coverage of benefit amount, duration, and scope
 - Prescription drug benefits, but not all FDA-approved drugs must be included.
- QHPs can use standard utilization management techniques

Habilitation Services

- If the EHB- benchmark plan doesn't include habilitative services, QHP can
 - Cover habilitative services similarly to rehabilitative services OR
 - In a manner determined by the QHP and reported to HHS
- QHPs may substitute benefits (other than prescription drugs) if
 - The substituted benefit is actuarially equivalent to benefit being replaced
 - Is within the same EHB category

What's Missing from EHB?

- Per regulation, long-term/custodial nursing home care benefits cannot be included as EHB.
- Other services and supports that are missing include:
 - Custodial services at home
 - Companion services
 - Caregiver assistance
 - Transportation

Determining What's Covered

- Summary of benefits and coverage (SBC)
- Evidence of coverage
- State EHB benchmark

Medicaid Alternative Benefit Plans and Essential Health Benefits For the HCBS Conference

Nancy Kirchner, Deputy Director
Division of Benefits and Coverage
Disabled and Elderly Health Programs Group

Background

- Intended to be an alternative benefit plan to the Medicaid state plan
- Comparability and statewideness are waivable
- States define populations, benefit packages and identify delivery systems within SPA
- Cost sharing and payment methodology SPAs required if applicable
- May require changes to other authorities such as 1115s or 1915(b) waivers

Final Regulation Overview

- Section 1937 Medicaid Benchmark or Benchmark Equivalent Plans are now called Alternative Benefit Plans (ABPs)
- ABPs must cover the 10 Essential Health Benefits (EHB) as described in section 1302(b) of the Affordable Care Act, whether the state uses an ABP for Medicaid expansion or coverage of any other groups of individuals
- Individuals in the new adult eligibility group will receive benefits through an ABP

Ten Essential Health Benefits

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

Steps for Designing a Medicaid ABP

Step 1: States must select a coverage option from the choices found in section 1937 of the Act

Four benchmark options

- (1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program
- (2) State employee coverage that is offered and generally available to state employees
- (3) Commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state
- (4) Secretary-approved coverage, a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population

Steps for Designing a Medicaid ABP (continued)

Step 2: States must determine if that coverage option is also one of the base-benchmark plan options identified by the Secretary as an option for defining EHBs

- If so, the standards for the provision of coverage, including EHBs, would be met, as long as all EHB categories are covered
- If not, states must select one of the base-benchmark plan options identified as defining EHBs.

Steps for Designing a Medicaid ABP (continued)

- Step 3: Select a base benchmark plan to define the EHBs
 - Any of the three largest small group market health plans by enrollment
 - Any of the three largest state employee health benefit plans by enrollment
 - Any of the three largest federal employee health benefit plans by aggregate enrollment
 - The largest insured commercial non-Medicaid health maintenance organization operating in the state

Substitution Policy

- Aligns with the individual and small group market
- Allows flexibility for states to align benefit packages with their Medicaid state plan
- Requires actuarial equivalence and placement in the same essential health benefit category

Medicaid and Essential Health Benefits

- Primarily Medicaid will align with EHB provisions in the individual and small group market.
- States may use more than one EHB base benchmark to determine EHB coverage for Medicaid purposes
- There are a few exceptions to address the specific needs of the Medicaid population

Prescription Drugs

- The amount, duration, and scope of prescription drugs for an ABP is governed by the requirements of section 1937.
- EHB prescription coverage standard:
 - Provide at least the greater of:
 - 1 drug in every USP category and class; or,
 - Same # drugs in each category and class as EHB benchmark plan.
- States must include sufficient prescription drug coverage to reflect the EHB benchmark plan standards at 45 CFR 156.122, including procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the plan.
- To the extent that a prescription drug is within the scope of the ABP benefit as a covered outpatient drug, section 1927 and Federal rebates apply.

Habilitative Services and Devices

- Coverage based on the habilitative services and devices that are in the applicable base benchmark plan
- If habilitative services and devices are not in the applicable base benchmark plan, the state will define habilitative services and devices either in parity with rehabilitative services and devices or as determined by the state and reported to CMS in the ABP template

Preventive Services

- EHB requirements for coverage of preventive services, including the prohibition on cost sharing, will apply to section 1937 ABPs

Medical Frailty

- Definition of **“medically frail”** is modified and includes the addition of people with chronic substance use disorders
- Individuals in the new adult group, if determined to be medically frail, will receive the choice of ABP defined using **EHBs or ABP defined as state’s approved Medicaid state plan**

Additional Items

- States may include other benefits outside of 1905(a) described in sections 1915(i), 1915(j), 1915(k) and 1945 of the Social Security Act
- All children under 21 enrolled in an ABP must receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT), including pediatric oral and vision services
- ABPs must also comply with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA)
- ABPs must include family planning services and supplies, FQHC/RHC services, and an assurance of NEMT

Transition

- CMS has permitted transition time, if needed, as long as states are working toward, but have not completed a transition to the new ABPs on January 1, 2014 or a later effective date.