

TESTIMONY BEFORE THE SENATE COMMITTEE ON HEALTH

INFORMATIONAL HEARING OF THE SENATE HEALTH COMMITTEE AND HEARING ON SB X1 1 (HERNANDEZ AND STEINBERG)

IMPLEMENTING THE AFFORDABLE CARE ACT'S EXPANSION OF MEDICAID IN CALIFORNIA

FEBRUARY 27, 2013

BY THE

NATIONAL HEALTH LAW PROGRAM

The National Health Law Program (“NHeLP”) submits this testimony to the Senate Committee on Health. NHeLP protects and advances the health rights of low-income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels. NHeLP supports SB X1 1, which requires the newly eligible Medi-Cal Expansion population to receive the existing Medi-Cal (State Plan) benefits package supplemented by the Essential Health Benefits (EHBs). Last month, HHS released a proposed rule which addresses the interaction between the Medicaid Expansion benefits and the EHBs. NHeLP’s testimony will:

- 1) Provide an overview of HHS’ proposed rule on benefits for the Medicaid Expansion population,
- 2) Address the impact of HHS’ proposed rule on SB X1 1, and
- 3) Make a recommendation regarding the benefits package for the Medi-Cal Expansion population.

I. Overview of HHS’ proposed rule on benefits for the Medicaid Expansion population

A. Alternative Benefit Plans (formerly Medicaid Benchmarks)

Medicaid benchmark plans have existed since the Deficit Reduction Act of 2005 allowed states the option of developing alternative Medicaid benefits packages for certain Medicaid-eligible individuals. Only a few states have selected this option, but the Affordable Care Act (ACA) brings new focus to Medicaid benchmarks because the newly eligible Medicaid expansion population will receive Medicaid benchmark or benchmark-equivalent coverage. In recent guidance and in the proposed rule released last month (January 23, 2013), HHS renamed Medicaid Benchmarks, which are now called “Alternative Benefit Plans”.

The state must select an Alternative Benefit Plan (Medicaid benchmark) from the following options:

- Standard Blue Cross/Blue Shield PPO under the Federal Employee Health Benefit Plan;
- any generally-available state employee plan in the state;
- the HMO plan with the largest commercial, non-Medicaid enrollment in the state;
- Secretary-approved coverage; or
- “Benchmark equivalent” plan.

B. Interaction between Alternative Benefit Plans and EHBs

Beginning in 2014, pursuant to the ACA, Alternative Benefit Plans must provide at least the EHBs. HHS’ proposed rule outlines a two-step process for ensuring coverage of the EHBs.

If the state selects an Alternative Benefit Plan that is also an Exchange EHB base-benchmark option, then the Alternative Benefit Plan is deemed to have met the EHBs as long as all 10 of the EHB benefit categories are covered (see Figure 2 below).

If the state selects an Alternative Benefit Plan that is not also an Exchange EHB base-benchmark option, then the state must compare the Alternative Benefit Plan to an EHB base-benchmark. If the Alternative Benefit Plan is missing any of the 10 EHB statutory categories of benefits, then the state must supplement the Alternative Benefit Plan with the coverage of the EHB base-benchmark plan selected to ensure all ten EHB categories are covered.

Figure 1: Comparison of benchmark plan options for EHB and Medicaid (ABPs)

Type of Plan	EHB Base-Benchmark Plans*	Alternative Benefit Plans (formerly “Medicaid Benchmarks”)
Federal Employee Health Benefit Program (FEHBP)	1 of 3 largest	Standard BC/BS PPO
State Employee Coverage	1 of 3 largest	plan that is generally available to state employees
Small Group Plan	1 of 3 largest	n/a
Largest Commercial HMO in the State	✓	✓
Secretary-Approved Coverage	n/a	✓
Benchmark Equivalent Coverage	n/a	✓

*NOTE: The state can select its EHB base-benchmark from among ten options: the three (3) largest federal employee plans; three (3) largest state employee plans; three (3) largest small group plans in the state; or the largest commercial HMO operating in the state.

Figure 2: EHB ten statutory categories

- 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 (including chronic disease management); and
- pediatric services, including oral and vision care.

C. Other Benefits that States Must Provide under Alternative Benefit Plans

Under the ACA, states are also required to include the following benefits as part of their Alternative Benefit Plans:

- 1) Family planning services and supplies, and
- 2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21.

In addition, Alternative Benefit Plans must also comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.

D. Individuals that cannot be required to enroll in Alternative Benefit Plans

Prior to the enactment of the ACA, under the federal Medicaid Act, certain groups of individuals could not be required to enroll in Alternative Benefit Plans, although states could offer these individuals the option to do so. The ACA does not change this policy. These groups are:

- Pregnant women;
- Individuals who are blind or have a disability;
- Individuals who are dually eligible for Medicaid and Medicare;
- Terminally ill hospice patients;
- Individuals who are eligible on the basis of hospitalization;
- Individuals who are medically frail or have special medical needs;
- Individuals qualifying for long term care services;
- Children in foster care receiving child welfare services and children receiving foster care or adoption assistance;

- TANF and 1931 parents (i.e., individuals who would have been eligible for Aid to Families with Dependent Children);
- Women in the breast or cervical cancer program;
- Limited services beneficiaries who qualify for Medicaid based on tuberculosis or who qualify for emergency services only; and
- Medically needy or spend-down populations.

II. Impact of HHS' proposed rule on SB X1 1

SB X1 1 requires the Medi-Cal Expansion population to receive the existing Medi-Cal State Plan benefits package supplemented by the EHBs. This constitutes the state's Alternative Benefit Plan under the Secretary-Approved coverage option described above. In HHS' proposed rule released last month, HHS broadened the benefits that can be provided under the Secretary-approved coverage option, and clarified that the benefits added under this option are eligible for the enhanced (100%) federal match.

Specifically, the proposed rule states that Secretary-approved coverage may include:

- benefits of the type available under one or more of the standard Alternative Benefit Plan coverage packages (e.g., Standard Blue Cross/Blue Shield PPO under the Federal Employee Health Benefit Plan),
- state plan benefits described in section 1905(a),
- any other Medicaid State plan benefits enacted under title XIX,
- home and community based services,
- self-directed personal assistant services,
- community first choice,
- coordinated care through a health home for individuals with chronic conditions, and
- benefits available under one of the EHB base-benchmark plans.

This means that under the Secretary-Approved coverage option, the state can provide the Expansion population with the Medi-Cal state plan benefits and additional services (as described above) and get an enhanced federal match for doing so (at a 100% match for the first 3 years.)

III. NHeLP's Recommendation

As required by SB X1 1, the state should provide a comprehensive benefits package to the Medi-Cal Expansion population. Since HHS has clarified that under the Secretary-approved coverage option the state can provide the Expansion population with additional benefits, and receive the enhanced federal match (100%) for the first three years and almost full federal funding for years thereafter, this benefits the state and Medi-Cal beneficiaries alike.

In fact, given the 100% federal reimbursement available for benefits offered through the Alternative Benefit Plans this is an opportunity for the state to go even further by providing this

group some of the optional benefits eliminated in 2009, including adult dental services. The state should also provide these services to the traditional Medi-Cal population in order create alignment of benefits. In addition, services (such as audiology services) which are part of the Essential Health Benefits as defined in state law based on the Kaiser Small Group Plan selected as the EHB base-benchmark plan for the Exchange will be fully funded by the federal government as part of the Alternative Benefit Plan.

Aligning the benefits provided to the Expansion population with those benefits provided to the traditional Medi-Cal population is advantageous for a number of reasons, including:

- **Uniformity of benefits for Medi-Cal groups:** Households where children are eligible for traditional Medi-Cal and parents are eligible through the Expansion will receive the same benefits. Also, since churning between the traditional and Expansion populations is likely to occur, having the same benefits package for both groups means the state, providers and beneficiaries do not have to keep track of the different benefits packages available and the benefits an individual is receiving at any given time.
- **Minimize Churning:** The potential for churning between the traditional and Expansion populations is minimized because individuals will not move from one group to the other due to differences in benefits.
- **Administrative simplicity:** The state will not have to monitor individuals that cannot be mandatorily enrolled in Alternative Benefit Plans based on income, pregnancy and/or health status, and will not have to notify applicants and beneficiaries of the differences in benefit packages.
- **Cost-savings:** A simpler eligibility and enrollment process can lead to cost-savings for the state. There is no need for an additional level of eligibility determinations if the benefits are the same (e.g. disability determination).

Conclusion

SB X1 1 requires that the Medi-Cal Expansion population receive the existing Medi-Cal benefits package supplemented by the EHBs and that the traditional population receive the additional EHB benefits as well. This allows for alignment between Medi-Cal populations that will be beneficial to the state, providers and Medi-Cal beneficiaries.

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