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CENTERS FOR MEDICARE & MEDICAID SERVICES
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CMCS Informational Bulletin

DATE: August 8, 2019

FROM: Calder Lynch, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: **New State Flexibilities and Requirements regarding Alternative Benefit Plans (ABP) and Essential Health Benefits (EHB)**

Purpose

This Informational Bulletin provides updates to states about recent regulatory changes in Essential Health Benefit (EHB) standards affecting Medicaid Alternative Benefit Plans (ABPs). This Bulletin includes information about conforming changes related to updating the benchmark plan used to define EHBs. This Bulletin also addresses the state-required actions as a result of these changes, including state plan amendment (SPA) submissions and ABP public notice requirements.

Background

Under 42 CFR 440.347, ABPs authorized under section 1937 of the Social Security Act (the Act) are required to meet EHB standards. Currently, ABPs must include the EHB in one of the 10 base-benchmark plans provided at 45 CFR 156.100, subject to supplementation under 45 CFR 156.110(b) and substitution as permitted under 45 CFR 156.115(b). The base-benchmark plans provided at 45 CFR 156.100(a) are:

- The largest health plan by enrollment in any of the three largest small group insurance products by enrollment in the state's small group market,
- Any of the largest three employee health benefit plan options by enrollment offered and generally available to state employees in the state,
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible Federal employees, or
- The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the state.

The Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2019 Final Regulation (referred to in this Bulletin as the CMS 2019 Payment Notice)[1] published on April 17, 2018 finalized changes that will provide new flexibility to states regarding EHB that

[1] 83 FR 16930.

impact Medicaid ABPs.

New State Flexibilities and EHB Requirements

EHB-Benchmark Plan Flexibilities

The CMS 2019 Payment Notice created new choices with respect to states' selection of EHB-benchmark plans applicable to their individual and small group markets for plan years beginning on or after January 1, 2020. These options will also be available to states when choosing the benchmark plan used to define EHB in an ABP. Please note that a state may continue to use its current benchmark plan selection, including when it amends an existing ABP. However, if a state decides to change its benchmark plan used to define EHB in its ABP, or a state decides to implement a new ABP in which an initial benchmark plan selection must be made, and is not the same as the state's benchmark plan chosen for the commercial market, the state would be required to choose one of the following options to define EHB for its ABP:

1. **Option 1 - Select an EHB-benchmark plan from another state** – Under this option a state may select one of the EHB-benchmark plans used for the 2017 plan year by any other state.

2. **Option 2 - Replace category or categories with categories from another state's EHB-benchmark plan** – Under this option a state may replace any of the 10 required EHB categories of benefits in its EHB-benchmark plan with the same category or categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year.

3. **Option 3 – Propose a set of benefits** – Under this option a state may select a set of benefits consistent with the 10 EHB categories that would become its EHB-benchmark plan.

Under any of the above options, the EHB-benchmark plan is required to meet coverage and scope of benefits standards specified at 45 CFR 156.111(b), including that it is no more generous than the most generous among a set of comparison plans, including the EHB-benchmark plan used by the state in 2017 and any of the base-benchmark plan options for the 2017 plan year as described in 45 CFR 156.100(a)(1), supplemented as necessary. Lastly, the scope of benefits must be equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category, the scope of benefits provided under a typical employer plan as defined at 45 CFR 156.111(b)(2). For this purposes, a state may choose to compare its EHB-benchmark plan to one of the 10 base-benchmark plan options established at 45 CFR 156.100 that the state could have selected for the 2017 plan year, or compare to the largest health insurance plan by enrollment in one of the five largest large group health insurance products by enrollment in the state in accordance with 42 CFR 156.111(b)(2)(B).

When comparing benefits under the ABP for purposes of the maximum generosity and typical employer plan standards, the state need only compare the benefits used to define EHB. Services

provided under 1937 that are not considered part of the EHB-benchmark plan for the ABP should not be included in the comparisons.

Additionally, states must document meeting these requirements through an actuarial certification and associated actuarial report from an actuary who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. For additional guidance please see Attachment A (Questions and Answers) and Attachment B (Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)).

ABP Process Reminders

Amendments to ABPs

States choosing to update the benchmark plan selection used to define EHB using one of the new options under 45 CFR 156.111 will be required to submit a SPA. CMS reminds states that have chosen to align their ABPs with their Medicaid state plan that ABPs must be kept in alignment with or exceed the scope of the state's approved underlying state plan on an ongoing basis. In order to maintain alignment, states are required to submit an ABP SPA when they amend benefits in the state plan. For example, revisions that add, delete or change coverage based on limitations of amount, duration or scope or authorization requirements in the state's state plan will need to also be included in an amendment to the state's ABP(s). States are required to submit amendments to an ABP in the same quarter as corresponding changes in the state's traditional state plan in order to keep effective dates aligned between the state's state plan and the ABP. Please see the "Process for Amending Alternative Plans" CMCS Information Bulletin dated September 16, 2014 for more information.

Public Notice Requirements

CMS reminds states and stakeholders that prior to submitting a SPA to either establish an ABP or substantially modify an existing ABP, the state must have provided the public with advance notice of the amendment and reasonable opportunity to comment on such amendment, as specified at 42 CFR 440.386. Tribal consultation is also required, if applicable in the state. The notice published for public comment must include a description of the method for assuring compliance with 42 CFR 440.345 related to full access to Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). If a state is not certain whether a change to its ABP is substantially modifying the existing ABP, please consult with CMS well in advance of submitting the ABP SPA, to confirm whether the change requires public notice and, if required, to allow sufficient time for public notice, including a reasonable opportunity to comment.

For additional information about this Informational Bulletin, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at Kirsten.Jensen@cms.hhs.gov.

Attachment A
Questions and Answers

1) **Does a state with an existing Medicaid alternative benefit plan (ABP) have to change its base benchmark plan for purposes of defining EHB for the ABP when the new CCIIO flexibilities take effect?**
   No. There is no requirement for the state to make a change. Unless there are future regulatory changes, the state may continue to use its existing base benchmark plan.

2) **My state would like to offer a new Medicaid ABP. For the commercial market, the state uses a small group market plan for its Essential Health Benefits (EHB) benchmark plan. May we use the same EHB benchmark plan as the basis to define EHBs for our ABP?**
   Yes. The state would identify the benchmark plan in its SPA submission. An actuarial certification is not necessary in this circumstance.

3) **My state would like to offer an ABP. For the commercial market, our state uses a small group market plan for its EHB benchmark plan. However, for the ABP, we want to use the largest insured commercial non-Medicaid HMO another state used for the 2017 plan year. May we identify that plan as our benchmark plan used to define our ABP EHBs?**
   Yes. If the largest insured commercial non-Medicaid HMO was the other state's EHB benchmark plan for plan year 2017, then this decision would fall under Option 1 described in the Informational Bulletin. If it was not available, then this decision would fall under Option 3. Under either option, the state would identify the plan and the state the plan is from in its SPA submission.

4) **Our state would like to define EHB for our ABP using our state EHB benchmark plan, except for mental health services defined in the plan. We would like to use the mental health services defined in the EHB benchmark another state used in 2017. May we do that?**
   Yes. This decision would fall under Option 2 described in the Informational Bulletin. The state would identify the benchmark plan and the benchmark plan from which it selected the substituted category in its SPA submission.

5) **Prior to January 1, 2020, a state that wanted to create an ABP that aligned with the state's Medicaid state plan had to complete a two-step process to define the traditional services under EHB rules. Does the new flexibility require the same process?**
   Under the new flexibility, a state can use Option 1, 2 or 3 described in the Informational Bulletin. Using Option 1 and 2 would require the state to complete the same two-step process used prior to January 1, 2020. For example, under Option 3, a state may propose a set of benefits from its traditional Medicaid state plan to define EHB. However, the state must ensure that the set of benefits provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB

category, the scope of benefits provided under a typical employer plan, and are no more generous than the most generous of the comparison plans in the state. The state would do this by having an actuary perform this comparison and certify that the EHB services meet this criteria. The requirements for this certification are found at 45 CFR 156.111(e)(2). An example of an acceptable methodology for comparing benefits of a state's EHB-benchmark Plan Selection is found in Appendix B "Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)"[2].

[2] Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii), April 9, 2018. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf

Attachment B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: April 9, 2018

Title: Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)

Background

New flexibility will be available allowing Under 45 CFR 156.111 in the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) displayed on April 9, 2018,[1] we finalized that States may select a new essential health benefits (EHB) benchmark plan for plan years beginning on or after January 1, 2020. If a State opts to select a new EHB-benchmark plan utilizing any of the selection options at §156.111(a), the State is required under §156.111(e)(2)(i) and (ii) to submit an actuarial certification and associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies.

This actuarial certification and associated actuarial report must affirm that the State's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan ("Typical Employer Plan"), as defined at §156.111(b)(2)(i), and that it does not exceed the generosity of the most generous among the plans ("Comparison Plan") listed at §156.111(b)(2)(ii)(A) and (B). This set of comparison plans for purposes of the generosity standard includes the State's EHB-benchmark plan used for the 2017 plan year, and any of the State's base-benchmark plan options used for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110.[2]

This methodology below outlines an example of one approach for actuaries to follow when comparing benefits in order to complete the required actuarial certification and associated actuarial report under §156.111(e)(2)(i) for typicality. This approach could also be taken for comparing benefits for generosity in order to complete the required actuarial certification and associated actuarial report under §156.111(e)(2)(ii).

[1] A copy of the final rule is available on the Center for Consumer Information and Insurance Oversight website at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

[2] The States' EHB-benchmark plans used for the 2017 plan year are based on plans from the 2014 plan year, but we occasionally refer to them as 2017 plans because these plans are applicable as the States' EHB-benchmark plans for plan years beginning in 2017. The Essential Health Benefits: List of the Largest Three Small Group Products by State for 2017 is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf. States' EHB-benchmark plans used for the 2017 plan year are available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

Methodology for Comparing Benefits

The actuarial certification and associated actuarial report required by §156.111(e)(2) are required to comply with generally accepted actuarial principles and methodologies. This includes complying with all applicable Actuarial Standards of Practice (ASOPs). For example, ASOP 41 on Actuarial Communications[3] includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used for the actuarial certification and report. ASOP 8 on Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits[4] and ASOP 50 on Determining Minimum Value and Actuarial Value under the Affordable Care Act [5] also provides additional guidance. The actuarial certification for this requirement is in a template incorporated in the Paperwork Reduction Act (PRA) notice on the EHB-benchmark plans (OMB Control Number: 0938-1174).[6] This PRA notice includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary must be a Member of the American Academy of Actuaries.

One example of an acceptable methodology for comparing the benefits of a "Typical Employer Plan" or the "Comparison Plan" to the State's proposed EHB-benchmark plan is to compare expected values as follows. Note that there are other requirements that a State's EHB-benchmark plan must comply with at §156.111(b). If the actuary is using different plans as the "Typical Employer Plan" and "Comparison Plan," the actuary will need to repeat the below steps.

1. **Select a "Typical Employer Plan" Pursuant to §156.111(b)(2)(i) or a "Comparison Plan" Pursuant to §156.111(b)(2)(ii).** The 2019 Payment Notice defines a "Typical Employer Plan" as either:

    1. One of the selecting State's ten base-benchmark plan options established at §156.100 and available for the selecting State's selection for the 2017 plan year; or
    2. The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at §144.103, provided that:
        A. The product has at least ten percent of the total enrollment of the five largest large group health insurance products in the State;
        B. The plan provides minimum value, as defined under §156.145;
        C. The benefits are not excepted benefits, as established under §146.145(b), and §148.220; and
        D. The benefits in the plan are from a plan year beginning after December 31, 2013.

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[3] http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop041_120.pdf.
[4] http://www.actuarialstandardsboard.org/wp-content/uploads/2014/08/asop008_176.pdf.
[5] http://www.actuarialstandardsboard.org/wp-content/uploads/2015/10/asop050_182.pdf.
[6] The PRA documents include the required template for this actuarial certification. Documents associated with the PRA are posted on the Centers for Medicare & Medicaid Services' PRA website at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html. Comments on these documents should be submitted to www.regulations.gov.

To select a "Typical Employer Plan," the State may need to determine which of the plans in the State meet the above definition and depending on the selection under this definition, the actuary may need to affirm that the plan provides minimum value in accordance with §156.145.

A "Comparison Plan" is defined as the State's EHB-benchmark plan used for the 2017 plan year, or any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110. Specifically, if a State selects as a "Comparison Plan" under the above definition a base-benchmark plan that does not provide any coverage in one or more of the categories of EHB, as defined at §156.110(a),[7] the actuary would need to supplement the selected plan with the category or categories of such benefits from another plan that meets the definition of "Comparison Plan," using the supplementation process described at §156.110(b).

To reduce burden, the actuary may want to consider using the same plan, for both the typicality and the generosity tests, provided that the plan meets the standards at both §156.111(b)(2)(i) and (ii). For example, the actuary may only need to do one plan comparison for the purposes of both of these certification requirements. Specifically, the actuary could use the same plan, such as the State's EHB-benchmark plan used for the 2017 plan year. That plan would, by definition, be a "Comparison Plan." Because the State's EHB-benchmark plan used for the 2017 plan year would simply be one of the State's base-benchmark plans, supplemented as necessary under §156.110, that plan also could be used for purposes of determining typicality, as a proposed State EHB-benchmark plan that was equal in scope of benefits to the State's EHB-benchmark plan used for the 2017 plan year within each EHB category at §156.110(a) would be equal to or greater in scope of benefits within each EHB category at §156.110(a) than the base-benchmark plan underlying the EHB-benchmark plan used for the 2017 plan year, to the extent of the required supplementation.

2. **Calculate the expected value of covering all of the benefits at 100 percent actuarial value in each EHB category in the proposed EHB-benchmark plan and in the "Typical Employer Plan" or "Comparison Plan," including any necessary supplementation.** The State must use reasonable actuarial assumptions and methods in accordance with generally accepted actuarial principles and methodologies. For example, the actuary may use data acquired from issuers in the State for a recent plan year, and weight the services and benefits provided in each EHB category. Other potential data sources include any all-payer claims databases maintained by the State or other databases that reflect the State's population.

[7] The EHB categories at §156.110(a) are: 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; and pediatric services, including oral and vision care.

3. **Compare the expected value of covering all of the benefits (at 100 percent actuarial value) in each EHB category of the "Typical Employer Plan" or the "Comparison Plan" to that of the corresponding EHB category of the proposed State's EHB-benchmark plan.** Under this example methodology, we would consider the State's proposed EHB-benchmark to satisfy the "Typical Employer Plan" requirement, if the State's actuary certifies that the expected value of each applicable EHB category of benefits in the State's proposed EHB-benchmark plan has an expected value equal to, or greater than, 100 percent of the expected value for those same categories of benefits of the "Typical Employer Plan." In the case of the generosity standard, we would not consider the State's proposed EHB-benchmark to satisfy the requirement if the expected value for each applicable EHB category of benefits in the proposed State's EHB-benchmark plan exceeds 100 percent of expected value for those same EHB categories of benefits in the most generous "Comparison Plan."