Medicaid Alternative Benefit Plans: What States Should Consider When Designing Coverage for the Expansion Population and the Role for Advocates

Alternative Benefit Plans offer states a great deal of flexibility, as well as an opportunity to provide people in the expansion population with comprehensive coverage that meets their health care needs.

This brief looks at the issues that states should consider as they design a benefit plan for people who will be newly eligible for Medicaid. It also outlines opportunities where consumer advocates can engage in the process, both during the initial benefit design and when making improvements to the plan.

For a more detailed discussion of Alternative Benefit Plans, see Families USA’s *Medicaid Alternative Benefit Plans: What They Are, What They Cover, and State Choices*.

**In Brief: What are Alternative Benefit Plans?**

The Affordable Care Act requires that the expansion population be covered by an Alternative Benefit Plan. States that choose to expand Medicaid will need to establish these benefit packages for individuals who will be gaining Medicaid eligibility.

There are broad federal requirements that outline the benefits an Alternative Benefit Plan must include, but states have a great deal of flexibility in how they design the benefit package beyond those requirements.

Alternative Benefit Plans give states an opportunity to provide comprehensive health benefits to people who are gaining coverage through the Medicaid expansion. Advocates should get involved in the development and evaluation of these plans.
States must use one of four Medicaid coverage options as the foundation for designing an Alternative Benefit Plan.\(^1\)

1. The standard Blue Cross/Blue Shield preferred provider organization (PPO) option that is offered to federal employees through the Federal Employees Health Benefits (FEHB) Program

2. A plan that is offered and generally available to state employees

3. The commercial health maintenance organization (HMO) with the largest non-Medicaid enrollment in the state

4. Secretary-approved coverage: This is a benefit package developed by the state that the Secretary of Health and Human Services (HHS) approves as providing appropriate benefits for the population being covered. This option gives states substantial latitude in benefit design.\(^2\)

**Federal Requirements**

Alternative Benefit Plans must include a state’s essential health benefits (EHBs), as well as certain benefits that are designed to meet the specific health care needs of the Medicaid population. These minimum requirements apply regardless of the Medicaid coverage option a state selects.

States are also required to allow people who fall into one or more categories of high medical needs to have the option of enrolling in the state’s traditional Medicaid program.\(^3\) Because they do not have to enroll in an Alternative Benefit Plan, they are referred to as “exempt” individuals.

**State Flexibility**

Apart from the minimum federal requirements, states have a great deal of flexibility in Alternative Benefit Plan design. States can:

- **Add benefits** from any of the Medicaid coverage options, any of the EHB benchmark options,\(^4\) or the state’s traditional Medicaid plan. States can also add any Medicaid state plan benefits, whether or not they are part of the existing traditional Medicaid plan.\(^5\)

- **Substitute benefits** in their selected Medicaid coverage option with benefits from any of the choices outlined in the bullet above, as long as the benefit being added is of equal actuarial value to the one it replaces.\(^6\)

- **Design multiple Alternative Benefit Plans** to meet the needs of various groups of people (for example, people in different geographic areas, or people with specific medical needs).

- **Use their traditional Medicaid plan as the Alternative Benefit Plan** by choosing the “secretary-approved coverage” option.

For a more detailed description of the options states have when creating benefit packages, who is “exempt,” and how states can go about designing an Alternative Benefit Plan, see Families USA’s *Medicaid Alternative Benefit Plans: What They Are, What They Cover, and State Choices*, available online at [http://familiesusa2.org/assets/pdfs/medicaid/Alternative-Benefit-Plans.pdf](http://familiesusa2.org/assets/pdfs/medicaid/Alternative-Benefit-Plans.pdf).
The Nuts and Bolts

What States Should Consider: The Health Care Needs of the Medicaid Expansion Population

Creating one or more plans that are tailored to meet the health care needs of people gaining Medicaid coverage can mean better health for enrollees. That can translate into higher productivity for individuals who gain coverage and lower long-term health care costs, both of which are good for state economies.

While there is diversity among the individuals in the Medicaid expansion population, many share certain characteristics.

Many Have Been Uninsured for a Long Time

Expanding Medicaid will provide health coverage to a population that has historically had difficulty getting health care. Many of these people may be enrolling in coverage for the first time, and they may have unmet health care needs.
Many Have Needs That Standard Commercial Health Coverage Does Not Meet

Commercial coverage is not designed to meet the needs of a low-income population that has been without insurance, and it does not typically offer the same services as Medicaid. For example, Medicaid covers community-based long-term care services that commercial plans typically do not.

Many Will Move between Different Types of Health Insurance (Referred to As “Churning”)

As people’s incomes and family situations change, their eligibility for coverage will change as well. For example, a parent with a dependent child might lose traditional Medicaid coverage and move into the expansion population when the child becomes independent. Similarly, an adult in the expansion population might start earning more money, such that he loses Medicaid eligibility and must buy health insurance through the marketplace. This movement between different types of coverage, referred to as “churning,” can disrupt care, leading to negative health consequences and increased costs.7

Keeping these characteristics in mind, states can use the flexibility they have in designing their Alternative Benefit Plans to create one or more options that will meet the needs of people who gain Medicaid coverage.

State Options for Alternative Benefit Plan Design

This section lists some approaches to benefit design for states to consider as they develop their Alternative Benefit Plans.

Use the State’s Current Medicaid Program as an Alternative Benefit Plan

States can use their existing Medicaid plan as the benefit plan for the expansion population.8 There are several reasons a state may want to take this approach.

The traditional Medicaid plan is particularly well-suited to meet the health care needs of low-income, vulnerable populations. The population gaining coverage through the Medicaid expansion is likely to include a large number of adults who have not had access to health care for many years. Traditional Medicaid benefits might best meet their health care needs.

Aligning the Alternative Benefit Plan with the traditional Medicaid plan would minimize disruptions in care if individuals move from the expansion population into traditional Medicaid. Consumers moving between different types of Medicaid coverage would still have access to the same services. Providing low-income people with a more consistent benefit package would reduce confusion and eliminate unnecessary barriers to health care.

States incur minimal added costs by selecting a more robust benefit package. A state’s Medicaid plan will generally offer more robust coverage.

Keeping these characteristics in mind, states can use the flexibility they have in designing their Alternative Benefit Plans to create one or more options that will meet the needs of people who gain Medicaid coverage.
than the other options states can use as the basis for their Alternative Benefit Plan. The federal government will cover the full cost of the Medicaid expansion until 2017. After that, the federal share gradually declines to 90 percent in 2020, where it stays. This formula applies regardless of the benefit plan a state selects. Therefore, states will face minimal added costs if they establish a more robust benefit package.

Selecting the Medicaid state plan as the benefit for the expansion population would mean that there would be only one benefit plan for adults in Medicaid. Having fewer benefit plans to manage could reduce state administrative costs.

Align Benefits with the Most Robust Plan Offered through the Marketplace

Despite the many advantages of choosing a state’s traditional Medicaid plan as the foundation for the Alternative Benefit Plan, this might not be a viable option in every state.

In states that don’t use their traditional Medicaid plan as an Alternative Benefit Plan, there are still many ways to create a good benefit package for the expansion population. States can use secretary-approved coverage to design an Alternative Benefit Plan that closely matches the most comprehensive plan offered in the state’s health insurance marketplace and includes benefits tailored to meet the health care needs of low-income consumers. States can do that by following these steps:

- Choose the most robust health plan offered in the state’s marketplace as a foundation for the Alternative Benefit Plan. States that select secretary-approved coverage as their Medicaid coverage option can use the benefit packages of plans on their state marketplace as the foundation for Alternative Benefit Plans. This approach will create consistency among marketplace plans and Medicaid. That can help reduce disruptions in care that occur when people move back and forth between the two types of coverage. It is estimated that, within six months, more than one-third of all adults with family incomes below 200 percent of the federal poverty level ($39,060 for a family of three) will experience a shift in eligibility from Medicaid to the marketplace.

- Improve coverage by supplementing the benefit package. States can improve upon the marketplace plan that is the basis of the Alternative Benefit Plan by adding Medicaid services. With this approach, the marketplace plan and the Alternative Benefit Plan would offer the same basic benefits, but the Alternative Benefit Plan would have some added services. States can add certain benefits that would be particularly helpful to people in Medicaid but that are not typically covered by commercial plans. A state can add Medicaid benefits to an Alternative Benefit Plan even if the state does not include those benefits in its traditional Medicaid plan. See “Adding Medicaid State Plan Benefits to Alternative Benefit Plans” on page 3 for more information.

- Tailor the plan to Medicaid enrollees by substituting benefits. States can also substitute benefits in the Medicaid coverage option they have selected. Benefit substitution must be within the same essential health benefits category, but the benefits do not have to be similar in nature. For example, ambulatory patient services can be substituted only with other ambulatory patient services, but the services themselves can be very different. A state could replace a benefit that it believes will be of marginal value to the expansion population with one that will have a more substantial health impact for this group.
In states that are basing their Alternative Benefit Plan on commercial health insurance plans, the option to add or substitute benefits allows states to tailor coverage to meet the specific health care needs of the expansion population.

**Develop Multiple Alternative Benefit Plans**

States can create more than one Alternative Benefit Plan to meet the health care needs of specific populations or to serve different geographic areas.

**Special Health Care Needs**

States have the flexibility to customize Alternative Benefit Plans for the specific health needs of different groups of people in their Medicaid program (e.g., a plan specifically designed for people with diabetes, with added benefits in nutritional counseling, podiatry, or enhanced case management services).

**Geographic Needs**

States might also consider separate Alternative Benefit Plans for different geographic regions, based on variations in the local health infrastructure. For example, states with large rural areas that have physician shortages might want to expand coverage of telemedicine in the plans for those regions.

**Process and Timeline for Plan Selection, Approval, and Modifications**

Before a state can move forward with its Alternative Benefit Plan, the plan needs to be approved by the Centers for Medicare and Medicaid Services (CMS). To get approval, states will need to submit an amendment to their Medicaid state plan outlining their choice of Alternative Benefit Plan(s).

If a state’s Alternative Benefit Plan includes cost-sharing or has a benefit package that is less comprehensive than the state’s existing Medicaid plan, the state must provide public notice and a comment period before submitting the plan to CMS for approval.12

CMS will approve Alternative Benefit Plans to run through December 31, 2015.13 States are not required to make any plan updates until then. Future guidance from the Department of Health and Human Services (HHS) will describe the frequency of required updates after 2015. Beyond any required updates, states can use the state plan amendment process to improve their Alternative Benefit Plans at any time.

Remember, there will be many opportunities to improve Alternative Benefit Plans in future years. If your state does not want to closely align its Alternative Benefit Plan with the traditional Medicaid plan now, consider whether it makes sense to start building momentum for moving toward using the state Medicaid plan in future years.
The Role for Advocates

Advocates can influence state decisions in benefit design and play a key role in making sure that Alternative Benefit Plans meet the health care needs of the expansion population.

Building the Case for a Strong Alternative Benefit Plan

In states that have not yet expanded Medicaid, designing benefits will be part of the expansion debate. Advocates should get engaged early and discuss the advantages of adopting a broad benefit package for those gaining Medicaid. In states that have already decided to expand, there may be ongoing debates about the benefit package. Advocates should participate in this process using the following strategies:

- Profile the health care needs of the state’s expansion population. Use data on the anticipated health care needs of the expansion population to support arguments for specific approaches to benefit design, such as adopting more comprehensive benefits or having multiple Alternative Benefit Plans. Explore the possibility of partnering with academics who have experience modeling the health care needs of specific populations to profile the expansion group.

- Carefully review the state’s cost estimates. Make sure that any cost estimates the state develops are based on realistic assessments of enrollment and service use.

- Build a case for aligning Alternative Benefit Plans with the traditional Medicaid plan. Using the existing Medicaid program as the Alternative Benefit Plan would ensure that the expansion population receives comprehensive benefits that are tailored to meet the needs of low-income people. The added costs to the state for adopting a more comprehensive benefit package will be minimal because the federal government is covering virtually all of the costs of the Medicaid expansion. In addition, because the state will have only one benefit package to administer, administrative costs might be lower than with other approaches.14

- Make the case for adding or substituting benefits. If the state is not using its existing Medicaid plan as its Alternative Benefit Plan, evaluate the package the state is considering and see which areas need added benefits. Then, make a case for adding or substituting benefits. States will likely be most open to benefits that could reduce state costs for long-term care or that might have a broad public health benefit. Public health or professional associations can be good sources for data to build both a medical and financial case for adding certain benefits.

- Consider whether multiple benefit plans are needed. Depending on the benefit plan being considered, advocates may want to urge the state to consider establishing plans that target certain groups based on medical needs or region. The most persuasive arguments include data showing that overall costs can go down if the plan provides certain benefits. For example, advocates could present data showing that enhanced medication management and nutritional counseling reduce overall health care costs for people with diabetes.

- Take advantage of the opportunity for public comment. If an Alternative Benefit plan does not include all the benefits in the existing Medicaid plan, states must provide a reasonable opportunity for public comment. This public comment period gives advocates and the public an opportunity to voice concerns. It is helpful for groups that share common concerns to repeat them in multiple comment letters.
Encouraging States to Monitor and Evaluate Alternative Benefit Plans

Advocates should work to ensure that the state has a good process for monitoring and evaluating whether its Medicaid program is meeting the needs of the expansion population.

Identifying “Exempt” Individuals

People who fall into one of several groups with high medical needs must have the option of enrolling in traditional Medicaid. This is an important consumer safeguard that is particularly critical in states where the Alternative Benefit Plan is different from traditional Medicaid. Advocates should make sure that their state has effective processes for identifying “exempt” individuals both at the time of enrollment and in the event that their status changes. States also need to give these consumers complete and easy-to-understand information about their options for enrolling in traditional Medicaid.

Evaluating the Benefit Package

Advocates should encourage states to collect data on how well the Alternative Benefit Plan works. In addition, states should be required to issue a public report summarizing that data. The report could include data on rates of hospitalization and other use of health services, as well as an analysis comparing actual service use against expected use. The report could also compare service use among the expansion population, traditional Medicaid, and the state’s marketplace plans.

Consumer and provider surveys should also be part of data collection. Surveys should gather information on how satisfied enrollees are, how well they understand program benefits and options, whether they get the care they need, and whether the state has properly identified exempt individuals in a timely fashion. Surveys should include questions to help determine whether exempt individuals understand their plan choices and are given adequate information to fully evaluate their options.

THE ADVOCATE’S CHECKLIST

What advocates can do to help their state establish the best Alternative Benefit Plan for the expansion population:

- Encourage the state to establish an Alternative Benefit Plan that is as close as possible to the state’s current Medicaid program.
- Build the case for adding benefits if the state is not using the Medicaid plan at its Alternative Benefit Plan.
- Consider whether the state should develop multiple Alternative Benefit Plans.
- Make sure the state is collecting data that will help it measure how well the Alternative Benefit Plan is meeting enrollees’ needs.
- Ensure that the state is identifying and educating exempt individuals about their option to enroll in traditional Medicaid.
- Stay involved, and prepare for opportunities to improve the benefit package in future years.
Advocating for Improvements

There will be opportunities to improve the Alternative Benefit Plans that states establish. Advocates should monitor how well the benefit package works for enrollees and use that information to work with the state to improve the benefit package.

This process should include reviewing any usage and quality data from the state, other states, or CMS. Advocates should also gather information and personal stories from providers, patient groups, and consumers. These sources can help advocates determine whether consumers in the expansion population are getting the care they need and whether states are identifying exempt individuals and educating them about their option to enroll in traditional Medicaid.

If Alternative Benefit Plans fall short, advocates have a critical role to play in building the case to change plan benefits.

Conclusion

States that expand Medicaid have considerable flexibility in designing their Alternative Benefit Plans, which provides an opportunity for states to meet the health care needs of their expansion populations. Consumer advocates will have an important role in plan selection, program implementation, and ongoing monitoring and evaluation to make sure that people in the Medicaid expansion population are getting coverage that meets their health care needs.

Advocates should take advantage of the many opportunities to get involved in the development and evaluation of Alternative Benefit Plans.

Endnotes

1 Social Security Act, State Flexibility in Benefit Packages, Section 1937 [42 U.S.C. 1396u-7].
3 For a list of exempt individuals, see Social Security Act, “State Flexibility in Benefit Packages,” Section 1937(a)(2)(B)(i-xi).
4 This refers to a state’s “EHB benchmark options,” which are 10 commercial plans that the state could use to develop its essential health benefits (EHB) package. For a more detailed discussion of state options in designing Alternative Benefit Plans, see Families USA’s Medicaid Alternative Benefit Plans: What They Are, What They Cover, and State Choices, available online at http://familiesusa2.org/assets/pdfs/medicaid/Alternative-Benefit-Plans.pdf.
5 Medicaid.gov lists mandatory and optional benefits that can be part of a state’s Medicaid plan at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html. While all states cover the mandatory benefits, coverage of the optional benefits varies a great deal from state to state. States can add any Medicaid state plan benefit to an Alternative Benefit Plan, whether or not that benefit is currently covered by the state’s traditional Medicaid plan. Doing so will not change the state’s existing Medicaid plan. For a more in-depth discussion of this process, see Families USA’s Medicaid Alternative Benefit Plans: What They Are, What They Cover, and State Choices, available online at http://familiesusa2.org/assets/pdfs/medicaid/Alternative-Benefit-Plans.pdf.
6 The process for supplementing benefits in Alternative Benefit Plans follows the same process that is used for supplementing benefits in exchange plans. This process is outlined at 45 CFR 156.115(b).
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10 States can select secretary-approved coverage as their Medicaid coverage option and designate one of the marketplace plans as the foundation for the Alternative Benefit Plan. For more details about the process for designing Alternative Benefit Plans and the options available to states, see Families USA’s Medicaid Alternative Benefit Plans: What They Are, What They Cover, and State Choices, available online at http://familiesusa2.org/assets/pdfs/medicaid/Alternative-Benefit-Plans.pdf.

11 Benjamin D. Sommers and Sara Rosenbaum, op. cit. The estimates in this article are based on the assumption that all states expand Medicaid, and this rate does not include churning caused by changes in job-based coverage.

12 Specifically, states must give public notice at least two weeks before submission of any Medicaid state plan amendment that aims to 1) establish an Alternative Benefit Plan that is less than the coverage provided by the current state plan or that includes cost-sharing of any kind, or 2) amend an already approved Alternative Benefit Plan by adding or increasing cost-sharing or by reducing benefits. See Code of Federal Regulations, Part 440, “Services: General Provisions,” Section 440.386, and Families USA’s State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs, available online at http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf.

13 The Department of Health and Human Services (HHS) will be reviewing the benefits that are included in essential health benefit plans between 2014 and the end of 2015. At that time, HHS may make changes to the essential health benefits. Since Alternative Benefit Plans must include the essential health benefits, any changes will require states to change their Alternative Benefit Plans.