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# Medicaid Alternative Benefit Plan Coverage: Frequently Asked Questions

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# Medicaid Alternative Benefit Plan Coverage: Frequently Asked Questions

Medicaid is a federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. Medicaid is financed jointly by the federal government and the states. Federal Medicaid spending is an entitlement, with total expenditures dependent on state policy decisions and use of services by enrollees.

State participation in Medicaid is voluntary, although all states, the District of Columbia, and the territories choose to participate. States are responsible for administering their Medicaid programs. States must follow broad federal rules to receive federal matching funds, but they have flexibility to design their own versions of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs.

Most Medicaid beneficiaries receive services in the form of what is sometimes called *traditional Medicaid*. However, states also may furnish Medicaid in the form of *alternative benefit plans* (ABPs). ABPs were first introduced in the Deficit Reduction Act of 2005 (DRA 2005; P.L. 109-171 P.L. 109-171) and are referred to in the Social Security Act (SSA) as benchmark or benchmark-equivalent coverage.

In general, under traditional Medicaid benefit coverage, state Medicaid programs must cover specific required services listed in statute (e.g., inpatient and outpatient hospital services, physician's services, or laboratory and x-ray services) and may elect to cover certain optional services (e.g., prescription drugs, case management, or physical therapy services). Under ABPs, by contrast, states may furnish a benefit that is defined by reference to an overall coverage benchmark that is based on one of three commercial insurance products (e.g., the commercial health maintenance organization (HMO) with the largest insured commercial, non-Medicaid enrollment in the state) or a fourth, "Secretary-approved" coverage option rather than a list of discrete items and services. The 33 states and District of Columbia that have implemented the state option to expand Medicaid to low-income adults under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) are required to cover the ACA Medicaid expansion population using ABPs, and states also may elect to require other Medicaid populations to receive care through ABPs. States cannot require certain vulnerable populations to obtain benefits through ABPs.

ABPs must qualify as either *benchmark*, where the benefits are at least equal to one the statutorily specified benchmark plans, or *benchmark-equivalent* benefits, which means the benefits include certain specified services and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages. In addition, ABPs must include a variety of specific services, including services under Medicaid's early and periodic screening, diagnostic, and testing (EPSDT) benefit and family planning services and supplies. Unlike traditional Medicaid benefit coverage, coverage under an ABP must include at least the essential health benefits (EHB) that most plans in the private health insurance market are required to furnish. States choose whether to furnish ABPs through managed care or a fee-for-service delivery system. The Medicaid limitations on beneficiary premiums and cost sharing apply to services furnished through ABPs.

To date, states have chiefly used ABPs as the benefit package for the ACA Medicaid expansion population. However, several states have elected to use ABPs to serve other Medicaid populations (e.g., working individuals with disabilities or children and adults who do not have special health care needs). States can have more than one ABP coverage option to serve different target populations operating concurrently with traditional Medicaid benefit coverage. States have largely used the ABP design flexibility to align their benefit coverage with the traditional Medicaid benefit coverage.

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**M**edicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. Medicaid is financed jointly by the federal government and the states. Federal Medicaid spending is an entitlement, with total expenditures dependent on state policy decisions and use of services by enrollees.

State participation in Medicaid is voluntary, although all states, the District of Columbia, and the territories choose to participate. States are responsible for administering their Medicaid programs. States must follow broad federal rules to receive federal matching funds, but they have flexibility to design their own versions of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs.

Most Medicaid beneficiaries receive services in the form of what is sometimes called traditional Medicaid—an array of required or optional medical assistance items and services listed in statute. However, states also may furnish Medicaid in the form of alternative benefit plans (ABPs), referred to in the Social Security Act as benchmark or benchmark-equivalent coverage. Congress originally provided for ABPs in the Deficit Reduction Act of 2005 (DRA 2005; P.L. 109-171) to give states flexibility to provide a Medicaid benefit that more closely resembles commercial health insurance than traditional Medicaid does. Congress modified the ABP provisions in subsequent legislation, both by expanding the scope of states' service obligations in furnishing Medicaid through ABPs and by requiring that most Medicaid beneficiaries who first became eligible as a result of the Medicaid expansion in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) receive ABPs as their mandatory form of Medicaid coverage.<sup>1</sup>

This report answers frequently asked questions about Medicaid ABPs. The **Appendix** provides a glossary and abbreviations of selected terms.

## What Are the Differences Between Traditional Medicaid and ABPs?

In general, under Medicaid, states are required to provide a comprehensive set of services to all categorically needy individuals, with some exceptions.<sup>2</sup> The required Medicaid services are listed in the definition of medical assistance in the Social Security Act (SSA) and include a wide array of services and items, such as physician services; inpatient and outpatient hospital services; and services and items under the early and periodic screening, diagnostic, and treatment (EPSDT) benefit for individuals under the age of 21.<sup>3</sup> Medical assistance also includes certain optional services—that is, services that states can choose whether to provide under their state plans—

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<sup>1</sup> Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) §2001(a)(2)(A) (adding Social Security Act [SSA] §1902(k)); see also ACA §2001(a)(4)(E) (amending SSA §1937(a)(1)(B)).

<sup>2</sup> *Categorically needy* refers to certain groups of families and children, aged, blind, or disabled individuals, and pregnant women listed in SSA §1902(a)(10)(A), who comprise required and optional Medicaid eligibility groups. 42 C.F.R. §435.4. For more information about the Medicaid program in general, including a summary of Medicaid benefits, please see CRS Report R43357, *Medicaid: An Overview*.

<sup>3</sup> See generally SSA §1905(a); 42 U.S.C. §1396d(a). Early and periodic screening, diagnostic, and treatment (EPSDT), the broad Medicaid pediatric benefit, encompasses periodic screenings (comprehensive child health assessments, including physical examinations, preventive dental services, vision and hearing testing, appropriate immunizations, and laboratory tests), certain interperiodic screenings, diagnosis, and treatment. For more information on EPSDT, see 42 C.F.R. Part 441, Subpart B; Centers for Medicare and Medicaid Services (CMS), *EPSDT: A Guide for States*, June 2014, at [https://www.medicaid.gov/medicaid/benefits/downloads/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf).

including routine dental services, prescription drug coverage, and care furnished by physical or speech therapists, among others. Among the broad federal requirements that apply to Medicaid benefit coverage, the federal law contains requirements relating to statewide and comparability, meaning that in general, the scope of Medicaid mandatory and optional benefits must be the same statewide and the services available to the various Medicaid eligibility groups (with limited exceptions) must be equal in amount, duration, and scope.<sup>4</sup>

ABPs, which are referred to in Section 1937 of the SSA as *benchmark* or *benchmark-equivalent* coverage, were introduced as a form of Medicaid coverage in DRA 2005.<sup>5</sup> One key difference between ABPs and traditional Medicaid benefits is that ABP coverage is defined by reference to an overall coverage benchmark that is based on one of three commercial insurance products or a fourth, “Secretary-approved” coverage option rather than as a list of discrete items and services. ABP coverage meets the requirements in DRA 2005 if (among other requirements) it either corresponds precisely to a benchmark plan selected by the state from options listed in the law or qualifies as benchmark-equivalent because the ABP has an aggregate actuarial value equivalent to the selected benchmark benefit package and meets various other requirements in the statute.<sup>6</sup>

A second major difference between ABPs and traditional Medicaid benefits is that states can choose to furnish ABP coverage to specific state-selected subgroups of Medicaid beneficiaries as their mandatory form of Medicaid coverage, notwithstanding the comparability and statewide requirements.<sup>7</sup> States can even design different ABPs for different beneficiary subgroups.<sup>8</sup> States are nonetheless prohibited from requiring various high-needs subcategories of Medicaid beneficiaries from receiving Medicaid through ABPs.<sup>9</sup>

The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009; P.L. 111-3) and the ACA with its implementing regulations made significant changes to the ABP requirements, relating both to the scope of benchmark and benchmark-equivalent coverage and to the populations that may be required to receive Medicaid through ABPs. Those changes are described below.<sup>10</sup>

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<sup>4</sup> SSA §§1902(a)(1), 1902(a)(10)(B); 42 C.F.R. §§431.50, 440.240.

<sup>5</sup> SSA §1937.

<sup>6</sup> Actuarial value is a measure of the percentage of the total average costs for covered benefits that a plan will cover (i.e., the portion of costs that enrollees are not expected to pay for themselves through some combination of deductibles, co-payments, and coinsurance). SSA §1937(a)(1). For a list of the types of health insurance coverage that constitute benchmark coverage for purposes of Medicaid alternative benefit plans (ABPs), see “What Are Medicaid ABP Benchmark and Benchmark-Equivalent Coverage?”

<sup>7</sup> SSA §1937(a)(1).

<sup>8</sup> State Medicaid Director Letter #12-003 (Nov. 20, 2012), p. 3, at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-003.pdf>.

<sup>9</sup> For rules regarding which populations must receive ABP coverage and which are permitted to receive ABP coverage at state option, see “May States Require Medicaid Beneficiaries to Receive Services via ABPs?” and “Do States Have the Option to Require Other Medicaid Beneficiaries to Receive Services via ABPs?”

<sup>10</sup> For more information, see “What Additional Coverage Requirements Apply to ABPs?,” “May States Require Medicaid Beneficiaries to Receive Services via ABPs?,” and “How Did the ACA Expand the Coverage Requirements for ABPs?”

## Where Does the Term *Alternative Benefit Plan* Come From?

SSA Section 1937 does not refer to alternative benefit plans; instead, it refers to benchmark or benchmark-equivalent coverage. The Centers for Medicare & Medicaid Services (CMS) introduced the term alternative benefit plan in lieu of those terms in the preamble to a July 2013 regulation.

CMS decided to refer to the Medicaid benchmark and benchmark-equivalent plans as ABPs in an effort to prevent confusion regarding the term benchmark, which is used in both the SSA's Medicaid regulations and private health insurance market regulations.<sup>11</sup> Although the term is used in both contexts, the benchmarks used for purposes of SSA Section 1937 ABPs and for purposes of the private health insurance market are different. In the private insurance market, CMS regulations implementing ACA requirements concerning the provision of essential health benefits (EHBs) in the individual and small-group markets use the term base-benchmark to refer to the specific health insurance plan selected by a state to determine the scope of its EHB package, in keeping with federal EHB benchmark plan guidelines.<sup>12</sup>

## What Are Medicaid ABP Benchmark and Benchmark-Equivalent Coverage?

The following types of health insurance coverage constitute benchmark coverage for purposes of Medicaid ABPs (ABP benchmark options):

- The standard Blue Cross / Blue Shield preferred provider option service plan offered through the Federal Employees Health Benefit Program (FEHBP)-equivalent health insurance coverage.
- The health benefits coverage plan offered to state employees.
- The commercial health maintenance organization (HMO) with the largest insured commercial, non-Medicaid enrollment in the state.
- “Secretary-approved coverage.”<sup>13</sup>

The fourth ABP benchmark option, *Secretary-approved coverage*, can be any health benefits coverage that the Secretary of Health and Human Services (HHS), upon application by a state, determines provides appropriate coverage for the proposed population.<sup>14</sup> Notably, Secretary-

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<sup>11</sup> Centers for Medicare and Medicaid Services (CMS), Final Rule, Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Final Rule, 78 *Federal Register* 42160, 42192 (July 15, 2013).

<sup>12</sup> The *essential health benefits* (EHBs) are benefits that most plans in the private health insurance market are required to furnish.

<sup>13</sup> SSA §1937(b)(1).

<sup>14</sup> Letter from Dennis G. Smith, director of the Centers for Medicaid and State Operations, to State Medicaid Director, SMDL #06-008, p. 4, March 31, 2006, at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD06008.pdf>.

approved coverage may correspond to the Medicaid state plan benefit package offered in the state.<sup>15</sup>

Alternatively, states may design and seek CMS approval for benchmark-equivalent coverage, which is coverage that a state seeks to offer as an ABP that does not correspond precisely to one of the four ABP benchmark options listed above. Benchmark-equivalent coverage must meet statutory requirements including the following:

- The coverage must include benefits within each of the following categories: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; prescription drugs; mental health services; well-baby and well-child care, including age-appropriate immunizations; and other appropriate preventive services.<sup>16</sup>
- The coverage must have an aggregate actuarial value equivalent to one of the ABP benchmark options.<sup>17</sup>
- If the benchmark-equivalent coverage includes vision or hearing services, the coverage for these services must have an actuarial value that is at least 75% of the actuarial value of the coverage in that category for the benchmark plan used to measure aggregate actuarial value.<sup>18</sup>

## What Additional Coverage Requirements Apply to ABPs?

The coverage included in a Medicaid ABP, in addition to qualifying as benchmark or benchmark-equivalent according to the standards described above, must meet other requirements. Some of these requirements were included with the original ABP provision in DRA 2005; others were added in CHIPRA 2009 or the ACA and its implementing regulations.

The requirements are the following:

- Beneficiaries under the age of 21 enrolled in ABPs are entitled to the EPSDT benefit, just the same as if they were receiving traditional Medicaid benefits. EPSDT may be furnished through ABP coverage or through traditional Medicaid, as a wraparound benefit, whereby supplemental services are offered to meet the EPSDT level of coverage.<sup>19</sup>

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<sup>15</sup> Letter from Cindy Mann, director of the Centers for Medicaid and State Operations, to State Medicaid Director, SMDL #12-003, ACA #21, November 20, 2012, pp. 1-2, at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-003.pdf>.

<sup>16</sup> SSA §1937(b)(2). The requirement that benchmark-equivalent coverage include mental health services and prescription drug coverage was added by the ACA. (See ACA §2001(c)(2)(A), amending SSA §1937(b)(2).)

<sup>17</sup> SSA §1937(b)(3) sets forth requirements concerning determination of actuarial value under alternative benefit plans (ABPs).

<sup>18</sup> SSA §1937(b)(2)(C).

<sup>19</sup> State must ensure that all medically necessary services are covered for Medicaid enrolled individuals under the age of 21. When necessary, states may offer supplemental services often referred to as *wraparound* services to create a comprehensive pediatric benefit. SSA §1937(a)(1)(A)(ii); State Medicaid Director Letter #12-003 (Nov. 20, 2012), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-003.pdf>, pp. 1-2.

- Coverage under an ABP must include federally qualified health center services and rural health clinic and associated ambulatory services.<sup>20</sup>
- Coverage under an ABP must include at least the EHBs, which non-grandfathered individual and small-group plans in the private health insurance market are required to furnish.<sup>21,22</sup>
- If coverage under an ABP includes both medical and surgical benefits and mental health or substance use disorder (SUD) benefits, then the financial requirements and treatment limitations that apply to the mental health and SUD benefits must comply with the mental health parity requirements described in the Public Health Service Act.<sup>23</sup>
- Coverage under an ABP must include family planning services and supplies for individuals of childbearing age to the same extent that such services would be covered under traditional Medicaid.<sup>24</sup>
- Under Medicaid regulations, if a benchmark or benchmark-equivalent plan does not include medically necessary ambulance and nonemergency medical transportation services, the state must nevertheless ensure that these services are available to beneficiaries enrolled in an ABP as a wraparound benefit.<sup>25</sup>

In general, states are allowed to provide additional benefits, beyond those required by the law, under an ABP.<sup>26</sup>

## How Do States Establish ABP Coverage?

The Medicaid state plan is a document comprehensively describing a state's Medicaid program. States must administer their Medicaid programs in keeping with the state plan for the state to receive federal financial participation in Medicaid expenditures. States establish ABP coverage by amending their Medicaid state plans.<sup>27</sup> CMS provides a state plan amendment "preprint," on which states provide detailed information, including the populations to be covered via ABPs, which benchmark benefit package the state selected and whether it is offering benchmark or benchmark-equivalent coverage, which base benchmark the state selected as the basis for providing the EHBs, and the scope of coverage of each of the 10 categories of EHBs. For each EHB category, the state must indicate in the state plan amendment any benefits the state has

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<sup>20</sup> SSA §1937(b)(4); 42 C.F.R. §440.365.

<sup>21</sup> SSA §1937(b)(5); 42 C.F.R. §440.347.

<sup>22</sup> For a description of the EHB requirements, see "What Are the EHBs, and What Is the Process for States to Meet EHB Requirements in Their ABPs?"

<sup>23</sup> SSA §1937(b)(6); 42 C.F.R. §§440.345(c), 440.395.

<sup>24</sup> SSA §1937(b)(7); 42 C.F.R. §440.345(b).

<sup>25</sup> 42 C.F.R. §440.390.

<sup>26</sup> SSA §1937(b)(7). Technically, states are not allowed to use federal Medicaid funds to provide such additional benefits to individuals who receive ABP benefits as members of the ACA Medicaid expansion group. See SSA §1903(i)(26); 42 C.F.R. §440.360. In fact, however, states may include additional benefits in their ABP for this group if they elect the "Secretary-approved" option, "due to the flexibility inherent in the definition of that type of section 1937 coverage option." See Health and Human Services (HHS), CMS, *Alternative Benefit Plan Implementation Guides, ABP5 – Benefits Description*, p. 2, at <https://wms-mmdl.cms.gov/MMDLDOC/abpIG.html>.

<sup>27</sup> SSA §1937(a)(1).

elected to substitute in lieu of those provided for in the base benchmark plan, as well as any additional benefits the state has elected to provide.<sup>28</sup>

A state must file a Medicaid state plan amendment not only when initially establishing an ABP but also each time it seeks to modify substantially an existing ABP, such as by adding or removing a beneficiary group receiving Medicaid through ABPs or altering the scope of ABP coverage.

## **Is the ACA Medicaid Expansion Population Required to Receive Services via ABPs?**

States *must* require individuals who are eligible for Medicaid as a result of the ACA Medicaid expansion (the *ACA Medicaid expansion population*) to receive Medicaid through ABPs.<sup>29</sup> Attaching consequences to this requirement, the ACA limited federal financial participation in Medicaid expenditures for the ACA expansion population to expenditures for coverage under ABPs.<sup>30</sup>

## **Do States Have the Option to Require Other Medicaid Eligibility Groups to Receive Services via ABPs?**

With respect to other non-ACA Medicaid expansion population eligibility groups, states have the option to require enrollment in ABP coverage, with the exception of some eligibility groups, as explained below.

States *may* impose on individual beneficiaries the requirement to enroll in ABPs only on a group-by-group basis, based on the categorically needy eligibility groups.<sup>31</sup> In SSA Section 1937, Congress waived the application of the statutory comparability requirement (SSA §1902(a)(10)(B)) to ABPs. This means that states may require one or more Medicaid eligibility

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<sup>28</sup> See State Medicaid Director Letter #12-003, November 20, 2012, p. 4, at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-003.pdf>; see also HHS, CMS, *Alternative Benefit Plan Implementation Guides, ABP5 – Benefits Description*, p. 2, at <https://wms-mmld.cms.gov/MMDLDOC/abpIG.html>.

<sup>29</sup> SSA §1903(i)(26); 42 C.F.R. §440.305(b). The ACA established a new mandatory Medicaid eligibility group comprised of non-elderly adults with household income at or below 133% of the federal poverty level (FPL) who were not eligible for Medicaid under any existing Medicaid eligibility category (the *ACA Medicaid expansion population*). On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, holding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution. The holding effectively rendered the ACA Medicaid expansion optional to states. For a list of states with CMS approval to expand coverage to the ACA Medicaid expansion population, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*. See also ACA §2001(a)(2)(A) (adding SSA §1902(k)); see also *ibid.* §2001(a)(4)(E) (amending SSA §1937(a)(1)(B)).

<sup>30</sup> ACA §2001(a)(2)(B) (adding SSA §1903(i)(26)).

<sup>31</sup> SSA §1937(a)(1)(B); State Medicaid Director Letter #06-008, March 31, 2006, p. 1, at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD06008.pdf>. States may require ABP coverage for eligibility groups other than the ACA expansion population only if the eligibility group existed in the state as of the date of enactment of Deficit Reduction Act of 2005 (DRA 2005; P.L. 109-171), February 8, 2006.

groups to receive Medicaid in the form of ABPs. A state also may design different ABPs tailored to different eligibility groups.

Only full benefit eligibles (FBEs) may be required to receive Medicaid through ABPs.<sup>32</sup> Medicaid beneficiaries are FBEs if they have been determined eligible to receive the standard full Medicaid benefit package under the state plan, if not for the application of the ABP option.<sup>33</sup> The term *FBE* excludes partial-benefit Medicaid beneficiaries, such as those who receive Medicaid only in the form of Medicare cost sharing and/or premiums. The term also excludes medically needy individuals and other spenddown populations—Medicaid beneficiaries who have income that exceeds applicable income limits and qualify for a limited package of Medicaid benefits by using medical expenses to spend down excess income.<sup>34</sup>

## Which Medicaid Beneficiaries Are Exempt from Mandatory Enrollment in ABPs?

States are prohibited from requiring some categories of Medicaid beneficiaries to receive Medicaid via ABPs even if they otherwise qualify as FBEs. The categories of ABP-exempt beneficiaries include the following:

- pregnant women who qualify for Medicaid as a result of having household income below 133% of the federal poverty level (FPL);
- individuals who qualify for Medicaid on the basis of being blind or disabled, including members of the “Katie Beckett” eligibility group (certain children under the age of 19 who require an institutional level of care and receive home- and community-based services);
- individuals entitled to Medicare benefits;
- terminally ill individuals receiving hospice benefits under Medicaid;
- individuals who qualify for Medicaid institutional care on a spenddown basis;
- individuals who qualify as medically frail;
- individuals who qualify for long-term care services (including nursing facility services and home- and community-based services);
- individuals who qualify for Medicaid because they are children in foster care or are former foster care children under the age of 26;
- parents and caretaker relatives whom the state is required to cover under Section 1931 of the SSA;
- women who qualify for Medicaid based on breast or cervical cancer;
- those who qualify for Medicaid on the basis of tuberculosis infection; and
- noncitizens who receive Medicaid only in the form of a limited emergency medical assistance benefit.<sup>35</sup>

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<sup>32</sup> SSA §1937(a)(2)(A).

<sup>33</sup> 42 C.F.R. §440.310(b).

<sup>34</sup> SSA §1937(a)(2)(C)(ii). For more information on partial-benefit Medicaid beneficiaries, please see CRS Report R43357, *Medicaid: An Overview*.

<sup>35</sup> SSA §1937(a)(2)(B); 42 C.F.R. §440.315.

For purposes of the *medically frail* category above, states have some discretion in defining the term. According to the implementing regulations, the definition must include at least (1) certain special-needs children; (2) individuals with disabling mental disorders, chronic substance use disorders, or complex medical conditions; (3) individuals with physical, intellectual, or developmental disabilities that significantly impair their ability to perform one or more activities of daily living; and (4) individuals with a disability determination based on the Supplemental Security Income program or Medicaid state plan criteria.<sup>36</sup>

States may offer ABP-exempt beneficiaries the option of enrolling in an ABP. If a state chooses this option, it must inform the exempt individual of the benefits available under the ABP and the costs under the ABP and provide a comparison of how they differ from the costs and benefits under traditional Medicaid.<sup>37</sup>

## **What Happens When the ACA Medicaid Expansion Population Includes an ABP-Exempt Individual?**

The law contains a tension concerning the ACA Medicaid expansion population insofar as it intersects with ABP-exempt beneficiary groups. States are prohibited from using federal funding to provide Medicaid to the expansion population other than through ABPs; at the same time, the ACA Medicaid expansion population may include ABP-exempt individuals, who by law cannot be required to enroll in an ABP. CMS addressed this issue in the implementing regulations by defining the term *ABP-exempt beneficiaries* to exclude members of the ACA Medicaid expansion population. The regulations also required states to give any member of the ACA Medicaid expansion population who otherwise would qualify as ABP-exempt the option to enroll in an ABP “that includes all benefits available under the approved state plan.”<sup>38</sup>

## **How Did the ACA Expand the Coverage Requirements for ABPs?**

The most significant way the ACA expanded the existing ABP requirements was by requiring that ABP coverage include at least the EHBs, as defined in Section 1302(b) of the ACA.<sup>39</sup> The content of the EHBs and the process for states to meet EHB requirements through their ABP state plan amendments are described below.<sup>40</sup>

The ACA also added a requirement that, to the extent that coverage under an ABP includes both medical and surgical benefits and mental health and substance use disorder benefits, the entity offering the ABP must ensure that the financial requirements and treatment limitations applicable to these benefits comply with the mental health parity requirements added to the Public Health Service Act (PHSA) by the Mental Health Parity and Addiction Equity Act of 2008.<sup>41</sup>

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<sup>36</sup> 42 C.F.R. §440.315(f).

<sup>37</sup> 42 C.F.R. §440.320(a).

<sup>38</sup> 42 C.F.R. §440.315.

<sup>39</sup> SSA §1937(b)(5).

<sup>40</sup> See “What Are the EHBs, and What Is the Process for States to Meet EHB Requirements in Their ABPs?”

<sup>41</sup> ACA §2001(c)(3), adding SSA §1937(b)(6)). SSA §1937(b)(6) refers to the parity requirements located at Public Health Service Act (PHSA) §2705(a). ACA §1001(1) redesignated PHSA §2705 as PHSA §2726. PHSA §2726(a)

Additionally, the ACA added a requirement that where a state elects to provide benchmark-equivalent coverage rather than benchmark coverage, the benchmark-equivalent coverage must include coverage of prescription drugs and mental health services.<sup>42</sup>

Finally, the ACA added a requirement that any coverage provided through ABPs (i.e., either benchmark or benchmark-equivalent coverage) must include coverage of family planning services and supplies for individuals of childbearing age.<sup>43</sup>

## **What Are the EHBs, and What Is the Process for States to Meet EHB Requirements in Their ABPs?**

The ACA required all non-grandfathered health plans in the individual and small-group private health insurance markets to offer a core package of health care services, known as the essential health benefits (EHBs).<sup>44</sup> The ACA required the HHS Secretary to define the EHBs, with the following limitations.

First, the EHBs are required to include the following general categories of items and services:

- 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.<sup>45</sup>

In addition, by statute, the EHBs are required to be equal in scope to the benefits provided under a typical employer plan, as determined by the HHS Secretary.<sup>46</sup>

The HHS Secretary implemented the EHB requirements for the individual and small-group private health insurance markets not by establishing the EHBs at the federal level but by requiring each state to select a coverage benchmark based on existing employer-sponsored or commercial

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contains the parity requirements that apply to ABPs. See also 42 C.F.R. 440.395.

<sup>42</sup> ACA §2001(c)(2), amending SSA §1937(b)(2)(A).

<sup>43</sup> ACA §2303(c), adding SSA §1937(b)(7).

<sup>44</sup> ACA §1301(a)(1)(B). This includes plans in and out of the individual and small-group health insurance exchanges. It does not include self-insured small-group plans. For more information about the essential health benefits, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*. For more information about private health insurance markets and types of plans, and applicability of federal requirements to them, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

<sup>45</sup> ACA §1302(b)(1).

<sup>46</sup> ACA §1302(b)(2)(A).

insurance—an approach very similar to the one set forth in SSA Section 1937 for ABPs.<sup>47</sup> Each state must begin from a *base-benchmark* option to establish its EHBs for the individual and small-group health insurance markets. Through plan year 2019, the base-benchmark options are similar, but not identical, to the benchmark options for Medicaid ABPs under SSA Section 1937. The EHB base-benchmark options are (1) the largest health plan by enrollment of any of the three largest small-group insurance products in the state; (2) any of the largest three employee health plan options offered to state employees in the state; (3) any of the largest three national FEHB program plan options offered to all health-benefits-eligible federal employees; or (4) the plan with the largest insured commercial non-Medicaid enrollment offered by an HMO operating in the state.<sup>48</sup>

The state must supplement the base-benchmark, if needed, to ensure the EHB package includes benefits in each of the 10 categories listed above.<sup>49</sup> The resulting standardized set of health benefits that must be met by each plan is referred to as the *EHB-benchmark plan*.<sup>50</sup>

Starting in plan year 2020, states may choose to change their EHB-benchmark plans by doing any one of the following: (1) using the entire EHB-benchmark plan that another state used for plan year 2017;<sup>51</sup> (2) using another state's 2017 EHB-benchmark plan to replace one or more EHB categories in its 2017 EHB-benchmark plan; or (3) "otherwise selecting a set of benefits that would become the State's EHB-benchmark plan."<sup>52</sup>

Per regulations finalized in April 2018, as of plan year 2020, a state's selected EHB benchmark plan still must be at least equal in scope to a typical employer plan but also "[must] not exceed the generosity of the most generous among a set of comparison plans," as listed.<sup>53</sup>

In their Medicaid state plan amendments establishing or amending an ABP benefit, states must identify both the ABP benchmark benefit package selected (for purposes of determining whether the coverage qualifies as benchmark or benchmark-equivalent) and the EHB base-benchmark package selected.<sup>54</sup> If the ABP benchmark selected is the same as the EHB base-benchmark and includes services from all 10 EHB benefit categories, then the plan is deemed to cover the EHBs.<sup>55</sup> Where the EHB base-benchmark differs from the ABP benchmark, and the base-benchmark lacks an EHB category, the state must supplement the ABP to include the missing category.

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<sup>47</sup> 45 C.F.R. §156.100; HHS, "Final Rule, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," 78 *Federal Register* 12834, 12840-12842 and 12866, February 25, 2013; HHS, "Final Rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016," 80 *Federal Register* 10750, 10811-10813, 10871, February 27, 2015.

<sup>48</sup> 45 C.F.R. §156.100(a). Notably, a state may choose a different essential health benefit (EHB) base-benchmark for purposes of its Medicaid ABP package than it selected for purposes of the individual and small-group private health insurance markets.

<sup>49</sup> 45 C.F.R. §156.100(b).

<sup>50</sup> 45 C.F.R. §156.20.

<sup>51</sup> States selected base-benchmark plans in 2017. These selections are applicable through plan year 2019.

<sup>52</sup> 45 C.F.R. §156.111(a).

<sup>53</sup> 45 C.F.R. §156.111; see HHS, "Final Rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019," 83 *Federal Register* 16930, 17068-17069 (April 17, 2018).

<sup>54</sup> See "What Are Medicaid ABP Benchmark and Benchmark-Equivalent Coverage?" above.

<sup>55</sup> HHS, CMS, *Designing an Alternative Benefit Plan*, at <https://www.medicaid.gov/medicaid/benefits/abp/designing-abp/index.html>.

The state is allowed to substitute benefits that are included in the ABP benchmark or benchmark-equivalent package for actuarially equivalent benefits of the same benefit type in the same category of EHB.<sup>56</sup> For example, within the “rehabilitative and habilitative services and devices” category, if a state’s ABP benchmark package includes speech therapy but not occupational therapy, whereas its EHB base-benchmark package includes the latter but not the former, the state may elect to furnish speech therapy instead of occupational therapy, so long as the benefits are actuarially equivalent.

## **Are ABPs Required to Be Furnished Using Managed Care?**

ABP coverage is *not* required to be provided using Medicaid managed care.<sup>57</sup> Even though the various benchmark options on which the coverage is built (with the exception of “Secretary-approved coverage”) are commercial or employer-sponsored insurance plans, states may choose to provide ABP coverage on a fee-for-service basis.

## **May States Use a Premium Assistance Model to Furnish ABP Coverage?**

The law authorizes states to pay for the costs of insurance premiums for Medicaid beneficiaries for a health plan offered in the individual insurance market.<sup>58</sup> SSA Section 1937 specifically provides that states may furnish ABP coverage using this private insurance mechanism.<sup>59</sup> Where states use a premium assistance approach, a private insurer serves as payer. The state Medicaid agency pays Medicaid beneficiaries’ premiums to enable them to enroll with the private insurer.<sup>60</sup> The state is required to furnish any additional benefits otherwise required under the ABP and not provided by the insurer, and the state must give enrollees information on how to access these additional benefits.<sup>61</sup>

## **Are There Limitations on Medicaid Beneficiaries’ Cost-Sharing Responsibilities Under an ABP?**

CMS has taken the position that the limitations on premiums and cost sharing that apply under traditional Medicaid also apply under ABPs.<sup>62</sup> Therefore, where a benefit package that a state has

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<sup>56</sup> HHS, CMS, *Designing an Alternative Benefit Plan*, at <https://www.medicaid.gov/medicaid/benefits/abp/designing-abp/index.html>.

<sup>57</sup> SSA §1937(a)(1)(E)(i).

<sup>58</sup> SSA §1905; 42 C.F.R. §435.1015.

<sup>59</sup> SSA §1937(a)(1)(D); see also 42 C.F.R. §440.355.

<sup>60</sup> 42 C.F.R. §435.1015(a).

<sup>61</sup> 42 C.F.R. §435.1015(b).

<sup>62</sup> In the Medicaid regulations, *cost sharing* is defined as “any copayment, coinsurance, deductible, or other similar charge.” 42 C.F.R. §440.50. Cost sharing typically is incurred at the point of service. *Premium* means “any enrollment fee, premium, or other similar charge” and is typically a monthly fee paid to enroll in or remain enrolled in coverage. CMS, “Final Rule, Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges:

selected as its ABP benchmark includes premiums and cost sharing that exceed the Medicaid limits, the state must nonetheless adhere to the Medicaid limits in furnishing Medicaid through ABPs. Where a state uses a premium assistance model to provide a Medicaid ABP, the state must ensure that the beneficiary does not incur cost-sharing liability in excess of the Medicaid limits, even if other enrollees in the same commercial health insurance product incur higher cost sharing.<sup>63</sup>

Notably, states are barred from applying cost sharing to certain preventive services furnished under ABPs, because cost sharing may not be applied to certain preventive services described under Section 2713 of the Public Health Service Act (42 U.S.C. §300gg-13) and its implementing regulations furnished through private health insurance plans.<sup>64</sup>

## How Many States Have Implemented ABPs?

CMS does not publish a complete list of the states that have implemented ABPs. Congressional Research Service (CRS) analysis of Medicaid state plan information available on the CMS website indicates that 35 states (including the District of Columbia) and three territories had CMS-approved ABP state plan amendments as of August 6, 2018.<sup>65</sup> Although states have most commonly used ABPs to furnish Medicaid to ACA Medicaid expansion enrollees (as required by law),<sup>66</sup> some states have extended ABP coverage to other populations, as well.

For example, ACA Medicaid expansion states (e.g., Indiana, Kentucky, Pennsylvania, Virginia, and West Virginia) had chosen to use ABPs for populations other than the ACA Medicaid expansion population.

Further, three non-ACA Medicaid expansion states (Idaho, Kansas, and Wisconsin) had chosen to implement ABPs for various non-expansion Medicaid FBE populations.

Finally, three territories—Puerto Rico, the Virgin Islands, and Guam—had implemented the ACA Medicaid expansion and had implemented an ABP state plan amendment.

## How Have States Designed ABPs for the ACA Medicaid Expansion Population?

States have most commonly used ABPs to furnish Medicaid to ACA Medicaid expansion enrollees. Selection of the ABP benchmark is a key decision for states implementing the expansion.

Overwhelmingly, ACA Medicaid expansion states have implemented an ABP composed of “Secretary-approved coverage” based on the traditional state plan benefit as described below. Based on CRS analysis of Medicaid state plan information available on the CMS website as of

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Eligibility and Enrollment; Final Rule,” 78 *Federal Register* 42224, 42226, July 15, 2013.

<sup>63</sup> 42 C.F.R. §435.1015(a)(3).

<sup>64</sup> Vicki Wachino, Director, Center for Medicaid and CHIP Services, *CMCS Informational Bulletin: Alternative Benefit Plan Conforming Changes*, HHS, CMS, January 28, 2016, p. 4, at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf>.

<sup>65</sup> Medicaid ABP State Plan Amendments are available at <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html>.

<sup>66</sup> For more information, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

August 6, 2018, of the 32 expansion states (including the District of Columbia) that had in effect a state plan amendment escribing the ABP benefit furnished to their expansion population, all had elected benchmark rather than benchmark-equivalent coverage, and 31 (all except North Dakota) elected to use Secretary-approved coverage as the ABP benchmark.<sup>67</sup>

Of the 31 expansion states that had elected Secretary-approved coverage, 25 had chosen to align the ABP benefits with traditional Medicaid benefits under the state plan as of August 6, 2018. This policy decision has the potential to minimize the disruptive effect of so-called churn between the ACA Medicaid expansion enrollee eligibility category and other Medicaid eligibility categories.<sup>68</sup>

Some of the states that aligned the ABP benefit with traditional state plan benefits did add or remove some benefits for purposes of the ABP. As two examples, Colorado included in its ABP benefit preventive and habilitative services not covered under traditional Medicaid.<sup>69</sup> West Virginia included physical and occupational therapy and home health services under its ABP that were not covered under traditional Medicaid.<sup>70</sup>

By contrast, as of August 6, 2018, the remaining six expansion states (Arkansas, Indiana, Iowa, New Hampshire, New Mexico, and Pennsylvania) had selected a private health benefits package or some combination of benefits available under the state plan and within a private health benefits package as their selected form of Secretary-approved coverage. This choice has the potential to minimize disruption when individuals churn between the ACA Medicaid expansion enrollee category and coverage in the individual and small-group market.<sup>71</sup> Notably, three of those six states—Arkansas, Iowa, and New Hampshire—at least initially had chosen to implement their Medicaid expansions through a premium-assistance model.<sup>72</sup>

## How Have States Designed ABPs for Other Populations?

The uptake of the ABP option to furnish services to populations other than ACA Medicaid expansion enrollees has been limited. As of August 6, 2018, per CRS analysis, three states that had not elected to implement the ACA Medicaid expansion (Idaho, Kansas, and Wisconsin) had

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<sup>67</sup> Medicaid ABP State Plan Amendments are available at <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html>. North Dakota was the only state that did not choose Secretary-approved coverage. It chose a commercial health maintenance organization as its benchmark.

<sup>68</sup> CMS, “Final Rule, Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule,” 78 *Federal Register* 42202, July 15, 2013.

<sup>69</sup> Colorado State Plan Amendment CO-14-0010 (effective April 1, 2014), at <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html>.

<sup>70</sup> West Virginia State Plan Amendment WV-15-0004 (effective July 1, 2015), at <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html>.

<sup>71</sup> CMS, “Final Rule, Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule,” 78 *Federal Register* 42216, July 15, 2013.

<sup>72</sup> See Arkansas State Plan Amendment AR-13-30 (effective January 1, 2014); Iowa State Plan Amendments IA-14-006 and IA-14-0024 (effective January 1, 2014); New Hampshire State Plan Amendment 14-0005 (effective August 15, 2014). Effective January 1, 2016, Iowa suspended the use of premium assistance for its expansion population; see Iowa State Plan Amendment IA-16-0026 (effective January 1, 2016).

in effect ABP state plan amendments. Examples of ABPs in two non-expansion states, Kansas and Idaho, are provided below.

Kansas has used ABPs to help working individuals with disabilities. Under Kansas's Working Healthy program, non-elderly adults who meet the Social Security definition of disability and are earning income are eligible to receive a full package of Medicaid benefits and are allowed to pay a small monthly premium in lieu of the spenddown obligation that they otherwise would have to meet to be covered as medically needy individuals.<sup>73</sup> Kansas selected an ABP benchmark based on state plan benefits, as well as additional services, including personal assistance services, assistive technology, and independent living counseling, intended to enable the individuals to attain independence.<sup>74</sup>

Idaho offers three different ABPs.<sup>75</sup> For each, Idaho elected the Secretary-approved option and modeled the coverage on its EHB base-benchmark plan (a small-group plan), adding certain other benefits. The Basic ABP is available to children and adults who do not have special health needs. The benefit package includes the benefits under the base-benchmark plan, as well as additional prevention and wellness and SUD benefits. The Enhanced ABP is designed for individuals with disabilities and includes, in addition to the benefits included in the base-benchmark plan, additional services such as SUD services, private duty nursing, hospice, and home- and community-based waiver services. Finally, the Medicare/Medicaid Coordinated Alternative Benefit Plan is designed for dual-eligible beneficiaries (who are eligible for both Medicare and Medicaid) and includes, in addition to the benefits under the base-benchmark plan, additional SUD, community-based rehabilitation, and home health services, among others.

## **What Types of Benefits Are Commonly Included in ABPs That May Not Be Included in Traditional Medicaid, and Vice Versa?**

It is difficult to draw generalizations about the ways in which ABP benefits differ from traditional Medicaid, because the scope of each type of benefit package differs from state to state. Under traditional Medicaid, states may choose which optional benefits to cover, in addition to the mandatory Medicaid state plan services. Under ABPs, states choose the ABP benchmark on which to base the benefit package. States also choose the base-benchmark for the EHBs that must be contained within the ABP.

However, differences in the federal law between the scope of required services under traditional benefits and required benefits under ABPs highlight common differences between the two types of benefits. For example, care in a nursing facility for individuals over the age of 21 is a required service under traditional Medicaid, whereas nursing home care is not a required benefit under ABPs. Conversely, rehabilitative and habilitative services and devices, preventive and wellness services, and mental health and substance use disorder services are all required under ABPs. By contrast, under traditional Medicaid, the categories of medical assistance do not correspond precisely to these service categories. Items and services in these categories could fall within different categories of medical assistance, including some required and some optional, and

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<sup>73</sup> Kansas Department of Health and Environment, *WORK Program Policy Manual*, revised January 29, 2018, pp. 7-9.

<sup>74</sup> Kansas State Plan Amendment KS-14-0016 (effective January 1, 2014).

<sup>75</sup> Idaho State Plan Amendments ID-17-0009; ID-17-0008; ID-17-0006; ID-17-0005; ID-17-0001; ID-16-0010; ID-16-0004; ID-15-0010; ID-14-0009; ID-14-0005; ID-14-0003.

therefore coverage of these categories under traditional Medicaid varies widely from state to state.

## How Do Behavioral Health Benefits Delivered via ABPs Differ from Behavioral Health Benefits Delivered Under Traditional Medicaid?

Behavioral health benefits are mandatory under ABPs, and most types of behavioral health benefits are optional under traditional Medicaid. Each ABP benefit package must include at least the EHBs.<sup>76</sup> The EHBs include “mental health and substance use disorder services, including behavioral health treatment.”<sup>77</sup> The required categories of medical assistance under Section 1905 of the SSA, by contrast, do not explicitly include *behavioral health* or any similar term. Many of the most prevalent types of behavioral health services and items, such as the services of clinical psychologists and licensed clinical social workers and prescription drugs, are optional to states under traditional Medicaid; therefore, coverage of these categories under traditional Medicaid varies widely from state to state.

In addition, in furnishing any ABP coverage, whether through managed care or on a fee-for-service basis, states must ensure that any financial requirements and treatment limitations that apply to the benefit package comply with parity requirements in Section 2726 of the Public Health Service Act.<sup>78</sup> This means, for example, that financial requirements (such as cost sharing) or treatment limitations (such as limits on the number of allowed visits) placed on Medicaid ABP behavioral health benefits may not be any more restrictive than for medical and surgical benefits for a given classification of services. By contrast, for traditional Medicaid benefits, the parity requirements affect only services delivered through managed care, not for services delivered in the fee-for-service setting.

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<sup>76</sup> ACA §2001(c)(3), adding SSA §1937(b)(6)). SSA §1937(b)(6) refers to the parity requirements located at PHSA §2705(a). ACA §1001(1) redesignated PHSA §2705 as PHSA §2726. PHSA §2726(a) contains the parity requirements that apply to ABPs. See also 42 C.F.R. §440.395.

<sup>77</sup> 45 C.F.R. §156.110(a)(5).

<sup>78</sup> See SSA §1937(b)(6).

# Appendix. Glossary and Abbreviations of Selected Terms

## Glossary

<b>ABP-exempt beneficiaries</b>	Categories of Medicaid beneficiaries whom states are prohibited from requiring to receive Medicaid via ABPs, even if they otherwise qualify as full benefit eligibles.
<b>ACA Medicaid expansion population</b>	The ACA Medicaid expansion population includes non-elderly adults with incomes up to 133% of the federal poverty level in states that have adopted this state plan option.
<b>Actuarial value</b>	A measure of the percentage of the total average costs for covered benefits that a plan will cover (i.e., the portion of costs that enrollees are not expected to pay for themselves through some combination of deductibles, co-payments, and coinsurance).
<b>Alternative Benefit Plan (ABP)</b>	Medicaid state plan option to provide certain groups of Medicaid enrollees with benchmark or benchmark-equivalent coverage that is based on one of three commercial insurance products, or a fourth, Secretary-approved coverage option.
<b>Ambulatory services</b>	Outpatient care that beneficiaries receive without being admitted to a hospital.
<b>Base-benchmark plan</b>	The specific health insurance plan selected by a state to determine the scope of its essential health benefit package when determining the provision of essential health benefits in the individual and small-group markets.
<b>Benchmark coverage</b>	Benchmark means that the benefits are at least equal to one the statutorily specified Medicaid benchmark plans.
<b>Benchmark-equivalent coverage</b>	Benchmark-equivalent means that the benefits include certain specified services, and the overall benefits are at least actuarially equivalent to one of the statutorily specified Medicaid benchmark coverage packages.
<b>Categorically needy</b>	Categories of individuals listed in Medicaid statute who are served by the Medicaid program.
<b>Centers for Medicare and Medicaid Services (CMS)</b>	The federal agency that is responsible for administering the Medicaid program in partnership with the states.
<b>Comparability</b>	Federal Medicaid benefit requirement that services available to the various Medicaid eligibility groups (with limited exceptions) must be equal in amount, duration, and scope.
<b>Department of Health &amp; Human Services (DHHS)</b>	The DHHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
<b>Early and periodic screening, diagnostic, and testing (EPSDT)</b>	EPSDT is a broad Medicaid pediatric benefit that encompasses periodic screenings (comprehensive child health assessments, including physical examinations, preventive dental services, vision and hearing testing, appropriate immunizations, and laboratory tests), certain interperiodic screenings, diagnosis, and treatment.
<b>Essential health benefits (EHBs)</b>	Core package of health care services that most plans in the private health insurance market are required to furnish.
<b>EHB base-benchmark plan</b>	The specific health insurance plan selected by a state to determine the scope of its essential health benefits (EHB) package when determining the provision of essential health benefits in the individual and small-group markets.

<b>Federal Employees Health Benefits Program (FEHBP)</b>	A system for providing employee health benefits to civilian government employees and annuitants of the United States government.
<b>Federal poverty level (FPL)</b>	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine your eligibility for certain programs and benefits, including Medicaid coverage.
<b>Federally qualified health center (FQHC)</b>	A community-based health care provider that meets certain specified requirements and receives funds from the Health Resources & Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas.
<b>Full benefit eligibles (FBEs)</b>	Medicaid beneficiaries are FBEs if they have been determined eligible to receive the standard full Medicaid benefit package under the state plan, if not for the application of the ABP option.
<b>Health maintenance organization (HMO)</b>	In general, Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. An HMO is a type of managed care plan under which a primary care physician serves as a “gatekeeper” to provide referrals before a beneficiary may see a specialist.
<b>Katie Beckett eligibility pathway</b>	Medicaid eligibility pathway that includes certain children under age 19 who require an institutional level of care and who receive home- and community-based services.
<b>Medicaid fee-for-service (FFS) delivery system</b>	Under the FFS delivery system, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee.
<b>Mandatory benefits</b>	Medicaid services that states must provide under the state plan.
<b>Medicaid eligibility pathway</b>	The specific federal statutory reference that extends Medicaid coverage to certain groups of individuals.
<b>Medicaid managed care delivery system</b>	Under the managed care delivery system, Medicaid enrollees get most or all of their services paid through an organization under contract with the state.
<b>Medicaid medical assistance</b>	The Medicaid services that are listed in the definition of medical assistance in the Social Security Act.
<b>Medically frail</b>	States have some discretion in defining the term, but according to the implementing regulations, the definition must include at least (1) certain special-needs children; (2) individuals with disabling mental disorders, chronic substance use disorders, or complex medical conditions; (3) individuals with physical, intellectual, or developmental disabilities that significantly impair their ability to perform one or more activities of daily living; and (4) individuals with a disability determination based on the Supplemental Security Income program or Medicaid state plan criteria.
<b>Medically needy individuals</b>	Medicaid beneficiaries who have income that exceeds applicable income limits and qualify for a limited package of Medicaid benefits by using medical expenses to spend down excess income.
<b>Optional benefits</b>	Medicaid services that states can choose to provide under the state plan.
<b>Premium assistance</b>	State option to permit states to pay for the costs of insurance premiums for Medicaid beneficiaries for a health plan offered through an employer or in the individual insurance market that meets certain specified requirements.
<b>Public Health Service Act (PHSA)</b>	The Public Health Service Act of 1944 consolidated and revised almost all legislations relating to public health services. The act outlines a policy framework for federal state cooperation in public health.
<b>Rural Health Clinic (RHC)</b>	A type of clinic that provides physicians health care services to Medicare beneficiaries and Medicaid beneficiaries in rural or medically under-served areas.

<b>Secretary-approved coverage</b>	Any health benefits coverage that the Secretary of Health and Human Services, upon application by a state, determines provides appropriate coverage for the proposed population.
<b>Spend down</b>	A process by which a person whose income is too high to qualify for Medicaid might still be able to get Medicaid if their uncovered medical costs or cost sharing (such as premiums and deductibles) exceed their available income. In this situation, states may permit a person to “reduce” their countable income by subtracting the medical expenses and cost-sharing from their income. This process is called the “spend down.”
<b>Statewideness</b>	Federal Medicaid benefit requirement that the scope of Medicaid mandatory and optional benefits must be the same statewide.
<b>Traditional Medicaid Coverage</b>	Under “traditional” Medicaid benefit coverage, state Medicaid programs must cover specific required services listed in statute (e.g., inpatient and outpatient hospital services, physician’s services, or laboratory and x-ray services) and may elect to cover certain optional services (e.g., prescription drugs, case management, or physical therapy services).

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