ABP3 - Selection of Benchmark or Benchmark-Equivalent Benefit Package

Statute: Section 1937(b) of the Social Security Act
Section 1302(b) of the Affordable Care Act

Regulation: 42 CFR 440.325; 42 CFR 440.330; 42 CFR 440.335; 42 CFR 440.347
45 CFR 156.100(a)

INTRODUCTION

This fillable PDF (state plan page) is designed for the state/territory to select its Alternative Benefit Plan's (ABP) section 1937 coverage option and its EHB-benchmark plan (formerly base benchmark plan) that will be used to establish the benefit package provided through the ABP for plan years **prior to 1/1/2020**. It will also be used if the state/territory is only changing the section 1937 coverage option for an ABP with an EHB-benchmark plan that was established for a plan year **prior to 1/1/2020**. This fillable PDF should not be used to select EHB-benchmark plans for plan years beginning 1/1/2020 or later. If the state/territory is selecting its EHB-benchmark plan for 1/1/2020 or later, please use the ABP3.1 fillable PDF instead.

BACKGROUND

Under section 1937 of the Social Security Act the state/territory has the option of selecting its 1937 coverage option from two basic types of ABP benefit packages: "Benchmark" or "Benchmark-Equivalent". Benchmark benefit packages are those in which the benefits are at least equal to one of the three statutorily specified commercially based benchmark plans. Secretary-approved coverage is also available as a benchmark option and coverage must be sufficient to meet the needs of the population. For states/territories that choose to completely align the benefit packages for the Adult group with its approved Medicaid state plan, the "equal to" standard also applies.

Benchmark-equivalent means that the benefits include certain specified services, and the overall benefits are at least actuarially equivalent to one of the four statutorily specified benchmark benefit packages.

The state/territory indicates on this state plan fillable PDF page which benchmark plan it will use to establish the benefit package for the ABP or which of the four statutorily designated plans will be used for the actuarial equivalent benefits provided in a benchmark-equivalent ABP benefit package.

The second step is for a state/territory to determine the benefit package that will define the provision of Essential Health Benefits (EHB) required by section 1302(b) of the Affordable Care Act. Options for this benefit package are described in regulations at 42 CFR 440.347 and 45 CFR 156.100(a) as the list of base benchmark plans. The benefit package selected to define the provision of the state/territory's EHB in the individual and small group market does not need to be the same as the one selected to define EHB for Medicaid.

This second step is only necessary when the section 1937 coverage option selected by the state/territory is not on the list of base benchmark plans. A section 1937 coverage option that also appears on the list of base benchmark plans may be designated as the state/territory's base benchmark plan for the ABP and used to define EHB.

Note: 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) published on April 17, 2018 replaces the phrase 'base benchmark' with 'EHB-benchmark' when describing benefit packages used to define the ABP.

TECHNICAL GUIDANCE

The state/territory first selects one of two options presented to indicate the type of ABP Benefit Package submission:

- ***The state/territory is amending one existing benefit package for the population defined in ABP1***
- ***The state/territory is creating a single new benefit package for the population defined in ABP1***

Review Criteria

The state/territory must select from the two options presented. If a selection is not made, the SPA cannot be approved.

Note: If the state/territory needs to define more than one benefit package for the ABP, it must complete this state plan page and the others related to the creation of the benefit package (ABP4 - Cost-Sharing, ABP5 - Benefit Description, and ABP8 – Service Delivery Systems for Benchmark benefit packages, or ABP4 – Cost-Sharing, ABP6 - Benchmark-Equivalent Plans, and ABP8 – Service Delivery Systems for

benchmark-equivalent benefit packages), as appropriate, for each benefit package it is creating.

Next, the state/territory names the benefit package, depending on the selection made, in the text box provided. If amending an existing benefit package, be sure that the name matches the name of the benefit package that is being amended in the approved ABP. It is suggested that the name be different than the name currently used to refer to the state/territory's current approved Medicaid state plan.

For each named benefit package, the state/territory must complete the following series of options to designate the 1937 coverage option and base benchmark plan for the benefit package.

Selection of Section 1937 Coverage Option

Next, the state/territory must select its section 1937 coverage option by indicating whether it is providing its Alternative Benefit Plan's benefit package as a

- ***Benchmark Benefit Package***, or a
- ***Benchmark-Equivalent Benefit Package***.

The state/territory may only select one of these options for each benefit package.

Review Criteria

The state/territory must select from the two options presented. If a selection is not made, the SPA cannot be approved.

Selection of Benchmark Benefit Package

If the benchmark benefit package option is selected, the state/territory is presented with the four section 1937 statutorily-defined benchmark plan options to define which of these will be the basis for the ABP benefit package. The state/territory must choose one of these options:

- ***The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit program (FEHBP)***
- ***State employee coverage that is offered and generally available to state employees (State Employee Coverage)***

- If selected, the state/territory must record the name of the benefit plan in the text box provided

- ***A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state (Commercial HMO)***
  - If selected, the state/territory must record the name of the benefit plan in the text box provided
- ***Secretary-Approved Coverage***

Review Criteria

The state/territory must select from the four options presented. If State Employee Coverage or Commercial HMO is selected, the name of the plan must be provided. If a selection is not made or if the name of the plan is not provided (for State Employee Coverage and Commercial HMO), the SPA cannot be approved.

Selection of Benchmark-Equivalent Option
If the benchmark-equivalent benefit package is chosen, the state/territory must identify the benchmark plan that will be used to establish actuarial equivalency by choosing one of the options.

- The first three options are the same as the benchmark plan benefit package options.
  - If State Employee Coverage or Commercial HMO is selected, the state/territory must provide the name of the plan in the text box provided.
- The fourth option, Secretary-Approved Coverage, defaults in this case to the Medicaid state plan coverage provided to the Categorically Needy (Mandatory and Options for Coverage). The approved Medicaid state plan usually (but not always) forms the basis for any Secretary-Approved coverage.

Review Criteria

The state/territory must select from the four options presented. If State Employee Coverage or Commercial HMO is selected, the name of the plan must be provided. If a selection is not made or if the name of the plan is not provided (for State Employee Coverage and Commercial HMO), the SPA cannot be approved.

Selection of Base Benchmark Plan

Next, the state/territory selects the base benchmark plan that will be the basis for establishing the Essential Health Benefits in the ABP.

The state/territory first indicates, ***Yes*** or ***No***, if the base benchmark plan is the same as the section 1937 benefit package coverage option for the benchmark benefit package or the option that forms the basis for the benchmark-equivalent benefit package. This is only possible for the first three options listed in section 1937(b)(1). **The state/territory must not indicate it is the same if it has selected Secretary-Approved Coverage as a benchmark benefit package or Medicaid State Plan as the basis for a benchmark-equivalent benefit package.** If the state/territory indicates that it is the same as the section 1937 coverage option, no further selections are required.

Note: ***The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state*** is the only choice that is always the same for both the benchmark benefit package and the base benchmark plan option. The section 1937 coverage options for the Federal Employees Health Benefits Plan (FEHBP) and the State Employees Coverage may or may not be the same as the base benchmark plan options that are similar.

Although, initially the base benchmark plan FEHBP option of ***any of the largest three national FEHBP plan options open to federal employees in all geographies by enrollment*** includes the 1937 coverage option, ***the Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP)***, over time this may not always be the case.

Another option for the states/territories is to designate the ***State/Territory employee coverage that is offered and generally available to state/territory employees*** as its 1937 coverage option. However, it cannot be ***any of the largest three state employee health benefit plans by enrollment***. The state/territory must not select ***the Base Benchmark Plan is the same as the section 1937 coverage option or the plan that is the basis for the Benchmark-Equivalent package*** on the template unless it is certain this is the case.

Review Criteria

The state/territory must indicate, Yes or No, if the base benchmark plan is the same as the section 1937 coverage option. If the state/territory does not provide a response, the

SPA cannot be approved. The state/territory also must not indicate that the base benchmark plan is the same as the section 1937 coverage option if the 1937 coverage option is Secretary-approved coverage (for benchmark benefit packages) or Medicaid state plan (for benchmark equivalent benefit packages). If the state/territory does not follow this direction, the SPA cannot be approved.

If the base benchmark plan option selected is different from the plan that is the basis for the section 1937 coverage option, the state/territory must

- Select a base benchmark plan, and
- Provide the name of the plan in the text box provided.

Review Criteria

If the base benchmark plan is different from the section 1937 coverage option, the state/territory must select a base benchmark plan and provide the name of the plan in the text box provided. If this is not done, the SPA cannot be approved.

Other Information

At its option, the state/territory may provide additional information concerning its selection of plan options.