ABP3.1 - 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); 45 CFR 156.111

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 that will be used to establish the benefit package provided through the ABP with respect to the state's/territory's selection of EHB-benchmark plans on or after January 1, 2020.

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 want to completely align the benefit packages for the Adult group with the state's 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 will use this state plan PDF template for ABPs implemented January 1, 2020 or later. The state/territory will choose the benchmark plan used to define the EHBs in an ABP or choose which of the four statutorily designated plans will be used for the actuarial equivalent benefits provided in a benchmark-equivalent ABP benefit package.

The state/territory may continue to use its current benchmark plan selection, as defined in ABP3, including when it amends an existing ABP. However, if the state/territory decides to change its benchmark plan used to define EHB in its ABP, or a decides to implement a new ABP in which an initial benchmark plan selection must be made, and is not the same as the state's benchmark plan chosen for the commercial market, the state/territory would be required to choose one of the following options to define EHB

for its ABP using this state plan page template:

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

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

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

Under any of the above 3 options, the EHB-benchmark plan is required to meet coverage and scope of benefits standards specified at 45 CFR 156.111(b). The state/territory will choose from a set of comparison plans, including the EHB-benchmark plan used by the state in 2017 and any of the base-benchmark plan options for the 2017 plan year as described in 45 CFR 156.100(a)(1), supplemented as necessary. The state's/territory's selection must ensure that the benefits are not greater than the benefit offered by the most generous of comparison plans. Lastly, the scope of benefits must be equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category, the scope of benefits provided under a typical employer plan as defined at 45 CFR 156.111(b)(2). For this purposes, a state/territory may choose to compare its EHB-benchmark plan to one of the 10 base-benchmark plan options established at 45 CFR 156.100 that the state/territory could have selected for the 2017 plan year, or compare to the largest health insurance plan by enrollment in one of the five largest large group health insurance products by enrollment in the state/territory in accordance with 42 CFR 156.111(b)(2)(B).

When comparing benefits under the ABP for purposes of the maximum generosity and typical employer plan standards, the state/territory need only compare the benefits used to define the 10 EHB categories. Services provided under 1937 that are not considered part of the EHB-benchmark plan for the ABP should not be included in the comparisons.

Additionally, states/territories must document meeting these requirements through an actuarial certification and associated actuarial report from an actuary who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial

principles and methodologies. For additional information please see the New State Flexibilities and Requirements regarding Alternative Benefit Plans (ABP) and Essential Health Benefits (EHB) CMCS informational bulletin dated August 8, 2019.

An actuarial certification and associated report are not required if the state/territory implements an ABP that is the same as the state's benchmark plan chosen for the commercial market.

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 an 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 EHB-Benchmark Plan (formerly referred to as a Base Benchmark Plan) and the 1937 coverage option for the benefit package.

Selection of EHB-Benchmark Plan

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

First, provide the name of the EHB-benchmark plan in the text box provided.

Next select, ***Yes*** or ***No***, to indicate if the EHB-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 EHB-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 EHB-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.

Also, it is possible for the state/territory to designate as its 1937 coverage option ***State employee coverage that is offered and generally available to state employees*** that is not ***Any of the largest three state employee health benefit plans***

by enrollment. The state/territory must not select ***The EHB-Benchmark Plan is the same as the section 1937 coverage option or the plan that is the basis for the Benchmark-Equivalent package*** unless it is certain this is the case.

Review Criteria

The state/territory must indicate, Yes or No, if the EHB-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 EHB-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 EHB-benchmark plan option selected is different from the plan that is the basis for the section 1937 coverage option, the state/territory must select one of the four options for EHB-benchmark plans.

Review Criteria

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

If the first option, ***State/Territory is selecting the EHB-benchmark plan used by the state/territory for the 2017 plan year*** is selected, select one of the four options of EHB-benchmark plans that the state used for the 2017 plan year for the commercial market.

Review Criteria

If this option is selected the state must select one of the four sub-options. If no sub-option is selected the SPA cannot be approved.

If the second option, ***State/Territory is selecting one of the EHB-benchmark plans used for the 2017 plan year by another state/territory*** is selected;

- Select the state from the drop-down listing whose EHB-benchmark plan will be the basis for the ABP's EHB-benchmark plan.

Review Criteria

The state must select the state/territory whose 2017 plan year's EHB-benchmark plan will form the basis for the ABP's EHB-benchmark plan. If a state or territory is not selected the SPA cannot be approved.

- Select one of the four options to indicate the other state's EHB-benchmark plan that the other state used for the 2017 plan year for the commercial market that will be used as the ABP's EHB-benchmark plan.

Review Criteria

If this option is selected the state must select one of its four sub-options. If no sub-option is selected the SPA cannot be approved.

If the third option, ***State/ Territory selects the following EHB-benchmark plan used for the 2017 plan year but will replace coverage of one or more of the categories of EHB with coverage of the same category from the 2017 EHB-benchmark plan of one or more other states*** is selected;

- Select one of the four options of EHB-benchmark plans that the state/territory used for the 2017 plan year for the commercial market.

Review Criteria

If this option is selected the state/territory must select one of its four sub-options. If no sub-option is selected the SPA cannot be approved.

- Select one or more Essential Health Benefits (EHBs) that will be replaced with the EHB used by another state/territory.
- For each EHB selected, select the state/territory whose EHB is being used as a replacement from the drop-down listing.

Review Criteria

At least one EHB must be selected for replacement with that from another state/territory and the state must be identified from the drop-down listing. If this is not done the SPA cannot be approved.

If the fourth option, ***Select a set of benefits consistent with the 10 EHB categories to become the new EHB-benchmark plan. (Complete and submit the ABP5: Benefits***

Description form to describe the set of benefits.) is selected, the state/territory must provide a complete description of the benefits provided in the ABP5 form.

Assurances

The state/territory must select the first assurance that the scope of benefits does not exceed generosity or the most generous among a set of comparison plans, provides appropriate balance amongst the EHB categories, and the scope of benefits is equal to, or greater than that provided under a typical employer plan.

The state/territory provides this affirmative assurance by checking the box next to the assurance.

Review Criteria

The state/territory must acknowledge the assurance by checking the box next it. If the box is not checked the SPA cannot be approved.

Next, if the state/territory selected any EHB-benchmark plan option except the first option of its own EHB-benchmark plan used for the 2017 plan year, the state/territory must select the assurance concerning actuarial certification and an associated actuarial report from an actuary.

The state/territory provides this affirmative assurance by checking the box next to the assurance.

Review Criteria

The state/territory must acknowledge the assurance by checking the box next it. If the box is not checked the SPA cannot be approved.

Next, the state/territory must select the assurance that all services in the EHB-benchmark plan have been accounted for in the ABP5 form.

The state/territory provides this affirmative assurance by checking the box next to the assurance.

Review Criteria

The state/territory must acknowledge the assurance by checking the box next it. If the box is not checked the SPA cannot be approved.

Next, the state/territory must select the last assurance concerning the accuracy of all information in ABP5 depicting amount, duration and scope of parameters of services.

The state/territory provides this affirmative assurance by checking the box next to the assurance.

Review Criteria

The state/territory must acknowledge the assurance by checking the box next it. If the box is not checked the SPA cannot be approved.

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.

Other Information

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