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**Center for Medicaid and CHIP Services**

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# Medicaid/CHIP Affordable Care Act Implementation

*Answers to Frequently Asked Questions*

## Benefits and Delivery Systems

### Q1: How will Essential Health Benefits (EHB) be defined for Medicaid benchmark or benchmark-equivalent plans?

A: Since 2006, State Medicaid programs have had the option to provide certain groups of Medicaid enrollees with an alternative benefit package known as "benchmark" or "benchmark-equivalent" coverage, based on one of three commercial insurance products or a fourth, "Secretary-approved" coverage option. Beginning on January 1, 2014, all Medicaid benchmark and benchmark-equivalent plans must include at least the ten statutory categories of Essential Health Benefits. Under the Affordable Care Act, the medical assistance provided to the expansion population of adults who become newly eligible for Medicaid as of January 1, 2014, must be provided consistent with section 1937 benchmark authority.

For Medicaid alternative benefit plans, three of the benchmark plans described in section 1937 (the State's largest non-Medicaid HMO, the State's employee health plan, and the FEHBP BCBS plan) may be designated by the Secretary as EHB benchmark reference plans, as described in the EHB Bulletin (link below). A State Medicaid Agency could select any of these section 1937 benchmark plans as its EHB benchmark reference plan for Medicaid. There would be no default EHB benchmark reference plan for purposes of Medicaid; each State Medicaid Agency would be required to identify an EHB benchmark reference plan for purposes of Medicaid as part of its 2014-related Medicaid State Plan changes.

If the EHB benchmark reference plan selected for Medicaid were to lack coverage within one or more of the ten statutorily-required categories of benefits, the section 1937 alternative benefit plan would need to be supplemented to ensure that it provides coverage in each of the ten statutory benefit categories. This would be in addition to any other requirements for Section 1937 plan, including Mental Health Parity and Addition Equity Act compliance.

For more information about the Essential Health Benefits, please see CCIIO's bulletin from December 2011 (available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) and

the CMCS informational bulletin from February 2012 (available at **http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-02-17-12.pdf**).

**Q2. Could a State select a different Essential Health Benefits (EHB) benchmark reference plan for its Medicaid section 1937 alternative benefit plans than the EHB reference plan it selects for the individual and small group market?**

A: Yes. A State is not required to select the same EHB benchmark reference plan for Medicaid section 1937 plans that it selects for the individual and small group market, and it could have more than one EHB benchmark reference plan for Medicaid (for example, if the State were to develop more than one benefit plan under section 1937).

**Q3. Could a State select its regular Medicaid benefit plan as its section 1937 alternate benefit plan for the new adult eligibility group?**

A: Yes. A State could propose its traditional Medicaid benefit package as a section 1937 alternate benefit plan under the Secretary-approved option available under section 1937 of the Social Security Act. The State would have to ensure that the ten statutory categories of EHB are covered, either through that benefit plan or as a supplement to that plan. (See Question 1 for more information)

**Q4. How do the managed care rules at 42 CFR 438 apply to benchmark benefit plans?**

A: The managed care regulations apply to all benefits delivered through a managed care delivery system, regardless of the authority under which the benefits are provided or enrollment is required. Thus, any State which uses a managed care organization to deliver benefits under the authority of section 1937 of the Act must comply with the managed care regulations at 42 CFR 438.

**Q5. Will 1915(c) waivers continue in the future?**

A: Yes. 1915 (c) waivers are optional programs that most States currently operate and can continue to operate. States interested in making changes to their 1915(c) waivers should contact their CMS Regional Office with specific questions.