

National Conference of Insurance Legislators

July 16, 2015

Essential Health Benefits Discussion

Christopher S. Sears

(317) 236-5891

sears@icemiller.com

Overview

- ➔ Affordable Care Act requires, beginning in 2014, non-grandfathered plans in the individual and small group markets (both inside and outside the Exchanges) to cover “essential health benefits” (“EHBs”).
 - ➔ Does not apply to the large group market
 - ➔ Does not apply to employer self-funded plans subject to ERISA
- ➔ ACA requires:
 - ➔ Inclusion of benefits in 10 categories
 - ➔ Scope of EHBs must be equal to benefits provided under a “typical employer plan”

10 Categories of Services for EHBs

- ➔ Ambulatory patient services
- ➔ Emergency services
- ➔ Hospitalization
- ➔ Maternity and newborn care
- ➔ Mental health and substance use disorder services, including behavior health treatment
- ➔ Prescription drugs
- ➔ Rehabilitative and habilitative services and devices
- ➔ Laboratory services
- ➔ Preventive and wellness services and chronic disease management
- ➔ Pediatric services, including oral and vision care.

HHS Regulatory Approach

- Encompass the 10 categories of services identified in the statute;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Provide States a role in defining EHB; and
- Balance comprehensiveness and affordability for those purchasing coverage.

Choosing a Benchmark Plan

- ➔ To flesh out the required 10 broad categories of services, HHS rejected a national approach and provided states with flexibility define the services under the 10 categories.
- ➔ States chose a “benchmark” plan from a 2012 base plan.
- ➔ HHS provided four options from which a state could choose.
- ➔ All four options are popular products that provide coverage that reflects coverage under a “typical employer plan.”
- ➔ 2012 benchmark plan will continue to be benchmark through 2016.
- ➔ States will choose new benchmark plans for 2017 that will be based on 2014 plans (but states will still be required to pay for the cost of state-based mandates adopted after January 1, 2012 [see below] unless those benefits comply with federal mandates).

Benchmark Plan Options

- **Small group market health plan**
 - The largest health plan by enrollment in any of the three largest small group insurance products by enrollment in the State's small group market.
- **State employee health benefit plan**
 - Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.
- **FEHBP plan**
 - Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees.
- **HMO**
 - The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the state.
- **Default**
 - The largest health plan by enrollment in the largest small group insurance product by enrollment in the State's small group market (for territories it is largest FEHBP plan).

Benchmark Plan Choices

- ➔ About half of the states defaulted to the largest small-group product and about half affirmatively selected a plan
- ➔ 45 states and District of Columbia chose (affirmatively or by default) a product in the small group market
 - ➔ In 41 of those states, it is the largest product in the small group market
- ➔ Two states chose a state employee plan
- ➔ Three states chose the largest commercial HMO

Filling in Gaps

- ➔ If a Benchmark Plan does not cover all 10 categories, states have to supplement them through the addition of the entire category of such benefits offered under any other benchmark plan option
- ➔ Three specific categories often have to be supplemented
 - ➔ Pediatric oral services
 - ➔ Pediatric vision services
 - ➔ Habilitative services

Filling in Gaps – Pediatric Oral and Vision

- ➔ Pediatric oral and vision services must be supplemented by addition of the entire category of pediatric oral (or vision) benefits from one of the following:
 - ➔ The FEDVIP dental (or vision) plan with the largest national enrollment offered to federal employees; or
 - ➔ The benefits available under that state's separate CHIP plan, if one exists, to the eligibility group with the highest enrollment

Filling in Gaps – Habilitative Services

- Habilitative services are generally defined as services to attain a new function or skill, as opposed to rehabilitative services that focus on restoring functions or skills.
- HHS released a final rule in February 2015 that provided the following definition (states may provide benefits beyond this without them becoming “mandated benefits”):
 - Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities.
- If the benchmark plan does not include habilitative services, the state may determine which services are included in that category in a manner that meets one of the following:
 - Covers health services and devices that help a person keep, learn, or improve skills and functioning for daily living;
 - Does not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and
 - For plan years beginning on or after January 1, 2017, does not impose combined limits on habilitative and rehabilitative services and devices

Filling in Gaps – Everything Else

- ➔ For any other gaps, consult these plans in the following order:
 - ➔ The largest plan by enrollment in the second largest product by enrollment in the State's small group market;
 - ➔ The largest plan by enrollment in the third largest product by enrollment in the State's small group market; and
 - ➔ The largest national FEHBP plan by enrollment across States that is offered to federal employees.

Excluded Services

- ➔ The following services are not EHBs – even if they are included in a benchmark plan
 - ➔ Routine non-pediatric dental services
 - ➔ Routine non-pediatric eye exam services
 - ➔ Long-term/custodial nursing home care benefits
 - ➔ Non-medically necessary orthodontia
 - ➔ Abortion services

Other EHB Requirements

- Benefits provided under a plan must be “substantially equal” to the benchmark plan including:
 - Covered benefits;
 - Limitations on coverage (e.g., visit limits, duration of services, and other limitations); and
 - Prescription drug benefits that meet regulatory requirements.
- Plan must also:
 - Not exclude an enrollee from coverage in any EHB category except pediatric services;
 - Comply with the Mental Health Parity and Addiction Equity Act;
 - Include preventive ACA health services described;
 - For plan years beginning on or after January 1, 2016, provide coverage for pediatric services to enrollees until at least the end of the month in which the enrollee turns 19; and
 - Meet cost-sharing limitations (in 2016, \$6,850 for self-only coverage and \$13,700 for family coverage)

State-Based Mandated Benefits

- ➔ States have traditionally required nongroup, small group, and/or large group plans to cover certain benefits or reimburse certain providers
- ➔ Common specific services such as emergency services, prescription drugs, diabetic supplies, and treatment of mental health and substance abuse disorders
- ➔ Specialized services such as autism benefits and infertility
- ➔ Minimum levels of benefits (e.g., inpatient mental health care of at least 20 days)
- ➔ Requirements to reimburse non-physician providers (such as dentists, social workers, and podiatrists) for services

ESB and State Mandated Benefits

- ➔ States may continue to enact benefit mandates that go beyond the required EHBs.
- ➔ However, in order to preserve the balance between comprehensive coverage and affordability, states must pay for the increased cost associated with individuals who purchase a qualified health plan.
- ➔ States must now more carefully weight the cost of mandated benefits and the additional value that they may (or may not) provide to policy holders.
- ➔ **Note that increased costs related to new mandates can also increase the likelihood of an employer being responsible for the Excise Tax on High Cost Plans (the so-called “Cadillac Tax”).**

ESB and State Mandated Benefits

- ➔ The Exchange is responsible for identifying which state-required benefits are in excess of EHB.
- ➔ The QHP issuer in the state is responsible for quantifying the cost attributable to each additional required benefit. State will have to make payments:
 - ➔ To an individual enrolled in a qualified health plan offered in the state; or
 - ➔ On behalf of such an individual directly to the qualified health plan in which he or she is enrolled.
- ➔ The amount of the required payment is equivalent to the cost of the additional benefits, which may be based on either (i) the statewide average cost of additional state-required benefits outside the scope of EHB, or (ii) each QHP issuer's actual cost

ESB and State Mandated Benefits – Example

- ➔ State select largest small group market plan as benchmark.
- ➔ In Spring of 2013, legislature enacts new mandate for acupuncture – which was not originally covered in the chosen benchmark plan.
- ➔ State must now assume the actuarial cost of providing that benefit to individuals enrolled in qualified health plans.
- ➔ Exchange would identify acupuncture as an additional state mandate.
- ➔ Plans would quantify the actuarial cost of the benefit.
- ➔ State would pay the additional incremental cost to individuals or directly to the plan.

ESB and State Mandated Benefits

- ➔ The following are not considered to be state-based mandated benefits for purposes of reimbursement:
 - ➔ Requirements for a health plan to reimburse specific health care professionals who render a covered service within their scope of practice.
 - ➔ Dependent mandates which might require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children).
 - ➔ State anti-discrimination requirements relating to service delivery method (e.g., telemedicine).

ESB and State Mandated Benefits

- ➔ HHS says that typical FEHBP plans include 95% of state benefit mandate categories (e.g., emergency services, inpatient and outpatient services for mental health and substance abuse, prescription drugs, etc.).
- ➔ Most state-based benchmark plans cover most typical mandated benefits.
- ➔ Typical variations exist in these categories:
 - ➔ In vitro fertilization
 - ➔ Applied behavioral analysis therapy for autism
 - ➔ Dental care
 - ➔ Acupuncture
 - ➔ Bariatric surgery
 - ➔ Hearing aids

ESB and State Mandated Benefits

- ➔ Most states dealt with this issue by choosing a state-based small group plan as the benchmark plan.
 - ➔ Such plans would, by definition, already cover state mandates, so those state mandates became part of the base benchmark plan.
- ➔ In some states, there is a disconnect between small group and nongroup markets
 - ➔ A benchmark small group plan might not mandate some benefits that are mandated in the nongroup market. Those nongroup mandates would go beyond the benchmark and could give rise to state liability.
 - ➔ An early study that estimated that one state could incur between \$10 and \$80 million in mandate liability depending on the benchmark plan it chose because of differences in small group and nongroup mandates involving fertilization, morbid obesity, and smoking cessation treatments.

ESB and State Mandated Benefits

- ➔ EHB requirements only apply in the nongroup and small group markets.
- ➔ EHB requirements do not apply in the large group market.
- ➔ Therefore, states may continue to mandate benefits in large group market plans without incurring liability to pay for those mandated benefits.



Ice on Fire

Design: Creative Commons Attribution 4.0 International License

THANK YOU