McGraw Wentworth

REFORM Update

Issue Thirty-Seven January 2012

January 26, 2012

The Department of Health and Human Services (DHHS) recently issued a bulletin proposing the policy to establish essential health benefits. All insured plans in the individual and small group markets must cover essential health benefits whether or not they are in an Exchange.

One of the chief goals of health care reform is to ensure that Americans have access to quality, affordable health care coverage. To that end, the statute briefly defines a comprehensive plan as one that covers "essential health benefits." This coverage includes items or services in the following ten categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorders, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive/wellness services and chronic disease management
10. Pediatric services, including oral and vision care

The statute requires DHHS to study health plans to determine whether the above list adequately reflects current plan coverage. The challenge is to balance the requirement to cover essential benefits with the need to keep the plan affordable.

Summary of Input on Benefit Plans and State Mandates

DHHS sought input from a number of sources, including the Institute of Medicine (IOM), before developing its regulatory approach to essential benefits.

Department of Labor (DOL) survey data indicates all markets studied appear to cover the same general scope of services. The only significant variation occurs within the following benefits:

- Mental health and substance abuse disorder services
- Pediatric oral and vision care services
- Habilitative services

Small group markets limit mental health and substance abuse treatment coverage. Small group plans are not subject to mental health parity requirements. It is not clear as to the extent that plans cover

behavioral health treatment as a category of services, except for the treatment of autism. In general, plans cover autism treatment when a state requires it.

Plans offer a mix of different options for pediatric oral and vision care services. Some plans cover these services under the medical plan, while others cover them under the dental and vision plans.

There is no standard definition for habilitative services among plans; in fact, plans tend not to define these services as a distinct group. Some plans do not cover these services at all. Other plans allow coverage under rehabilitative services. Benefit limits almost always apply to these services.

DHHS also needed to consider state mandates requiring plans to cover certain benefits in specific ways. There are more than 1,600 state-mandated benefits or provider requirements across the 50 states and the District of Columbia. They vary widely in scope and topic. To gain perspective, DHHS compared all of these mandates to Federal Employee Health Plan benefits. The Federal Employee Health Plan covers about 95 percent of the 1,600 state-mandated benefits. The two primary benefits not covered are in-vitro fertilization and Applied Behavioral Analysis (ABA) therapy for autism. (Eight states require in-vitro fertilization coverage, and 29 states require coverage of ABA therapy for autism.)

The IOM submitted its recommendations in October 2011. Rather than providing details on specific services that should be covered, IOM recommended that the essential benefit plan be built to achieve a specific premium target. It recommended that the DHHS establish a process to update the essential benefits package to account for new evidence on treatment effectiveness and developments. IOM stressed flexibility in the approach to essential benefits. They emphasized that the package should strike a balance between anticipated cost and benefits provided.

DHHS also conducted a series of public meetings to discuss essential benefits with stakeholders. It then used all of this input to develop the proposed regulatory approach to essential benefits.

Intended Regulatory Approach to Essential Benefits

DHHS set a goal to develop an approach to essential benefits that:

- Encompasses the ten categories of service identified in the statute.
- Reflects the typical employer health benefits plan.
- Reflects balance among the ten categories.
- Accounts for the diverse health needs across populations.
- Ensures there are no incentives for coverage decisions, cost-sharing or reimbursements to impermissibly discriminate because of age, disability or life expectancy.
- Ensures compliance with the Mental Health Parity and Addiction Equity Act of 2008.
- Allows states to have a role in defining essential health benefits.
- Balances comprehensiveness of coverage with affordability.

To meet this goal, DHHS is allowing states to use a benchmark plan as their essential health benefit plan. The benchmark plan will serve as a reference, reflecting the scope of coverage and any limits a typical employer health plan offers. The reference plan will work in a way very similar to Medicare's standard Part D benefit plan. While standard benefits are set, carriers can vary coverage to achieve

an actuarial equivalent. DHHS will allow variation, subject to their parameters, in how different carriers in an Exchange cover certain services.

DHHS suggests that states look at four specific benchmark plans in 2014 and 2015 to determine which best reflects the standards for essential health benefits. The four possibilities are:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market.
2. Any of the largest three state employee health benefit plans by enrollment.
3. Any of the largest three Federal Employee Health Benefit plan options by enrollment.
4. The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

In 2016, DHHS will evaluate this benchmark process to determine whether it is working or if changes should be made. If the state fails to select a benchmark plan, DHHS proposed a default plan which would be the largest plan by enrollment in the largest product in the state's small group market.

The government will permit some flexibility for state-mandated benefits. States can choose one of the above benchmark plans that comply with current state mandates. This option allows mandates that are not part of the ten service categories to be part of the essential health benefits. To help plans defray some of the expense of complying with state mandates, the state could select a benchmark plan associated with the Federal Employee Health Plan, which would likely include some, but perhaps not all, state-mandated benefits. The ones not included would fall outside the essential health benefit package. This option is not particularly clear, because states require health plans to cover mandated benefits. The option may encourage states to streamline their coverage mandates.

Some state benchmark plan options may not cover all ten service categories. Health care reform requires that all ten categories be represented. If not all categories are included, the state will need to borrow from another benchmark option details on services covered. For example, suppose a state uses the largest plan by enrollment in the small group market as the benchmark plan but this plan does not cover prescription drugs, a required category. The state could supplement the benchmark plan with the prescription coverage found in one of the three largest state health benefit plan options.

In a few cases, none of the state's benchmark plans will cover a specific category. For example, there is concern about a lack of coverage for habilitative services, pediatric oral and vision services and mental health/substance abuse treatment in the small group market. DHHS provides the following options for states that may not have a benchmark.

Two options are available for habilitative services:

1. Plans could offer coverage parity with rehabilitative services.
2. Plans could decide which habilitative services to cover and report on that coverage to DHHS. DHHS will evaluate to define these services further.

Two pediatric oral services options are available:

1. The Federal Employee Dental and Vision Insurance Program's dental plan with the largest national enrollment.

2. The state's separate Children's Health Insurance Program (CHIP).

Only one option is available for pediatric vision services. The Federal Employee Dental and Vision Insurance Program's vision plan with the largest national enrollment can supplement these essential health benefits.

Only one option is available for mental health and substance abuse treatment. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) does not require employers to offer mental health coverage. However, because mental health/substance abuse services are part of the ten required coverage categories, they are essential health benefits. Essential health benefits will have to meet the requirements of the MHPAEA, regardless of employer size. It also means these plans must cover mental health/substance services.

What Does This Mean to Employers?

The development of an essential benefits plan is going to affect the small group and individual markets. Small group insured plans will need to cover essential benefits whether or not they are offered in an Exchange. Thus, the requirement to cover essential health benefits may change the types of services a small employer's plan covers.

The bulletin issued by DHHS does not have the same weight as actual regulations. DHHS will issue regulations in the future to formally define essential health benefits.

Essential health benefits must be covered, but they are only one part of plan development. DHHS will issue additional guidance on benefit limitations, medical management, and cost-sharing. This guidance will also explain how to determine a plan's actuarial value and how a plan qualifies as platinum, gold, silver and bronze.

It is not yet clear whether essential health benefits will be considered in determining qualifying coverage in 2014. In order to avoid penalties, employers will have to offer a benefit plan with a 60% coverage level at a cost that does not exceed 9.5% of an employee's household income for single coverage. Will the 60% coverage level be measured using essential health benefits? As yet, the answer is unclear.

This guidance helps states implement Health Exchanges. DHHS may expand the role of essential benefits in the future, but as of now, these benefits are only required for individual and small group plans in 2014.