NHeLP Breaks Down Five Key Health Care Reform Standards That Will Impact Family Planning Benefits

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Understanding how access to family planning services will be impacted in Exchanges and Medicaid in the coming years requires understanding five key terms in the Affordable Care Act (ACA) which interact with each other in complex ways.

1. Qualified Health Plans (QHPs)

Qualified Health Plan is simply the name given to the health insurance plans that will be allowed to be sold on the health care Exchanges created in health care reform.[1] In order to qualify as a QHP, plans must cover at least all of the benefits included in the Essential Health Benefits package[2] (discussed below), and must agree to comply with all of the insurance reforms enacted in the ACA such as the prohibitions on discrimination[3] or on gender rating.[4]

One specific concern as CMS develops rules on QHPs is whether a plan that refuses to cover required reproductive health services based on a moral or religious objection can be certified as a QHP, and if so, what conditions will be imposed to ensure that enrollees get the covered services to which they are entitled in a timely and accessible manner. A "refusal clause" is a statute, regulation, or policy that allows providers or institutions (or in this case a coverage policy) to refuse to provide or cover necessary medical care, such as family planning services, that would usually be required, based on moral or personal objections. The ACA allows refusals for QHPs only with respect to abortion, in that it prohibits "discrimination" against any provider or facility because of its "unwillingness to provide, pay for, provide coverage of, or refer for abortions."[5] The ACA does not explicitly authorize refusals to provide coverage for other services such as family planning services, emergency services, prescriptions, services to individuals based on their sexuality, and other essential women's health services. Nonetheless, we expect religiously affiliated health plans to attempt to attain QHP status and retain their broad refusal policies.

2. Essential Health Benefits (EHB)

[1] ACA §1301(a); 42 U.S.C. 18021(a).
[2] *Id.* The EHB package is described at ACA §1302(b); 42. U.S.C. 18022(b).
[3] ACA §1557; 42. U.S.C. 18116.
[4] ACA §1201 (creating new §2701(a)(1) of the Public Health Service Act, codified as 42 U.S.C. §300gg(a)(1)). *See also* Public Health Service Act §2701(a)(5), codified as 42 U.S.C. §300gg(a)(5).
[5] ACA §1303(b)(4); 42 U.S.C. 18023(b)(4).

Essential Health Benefits (EHB) is a standard created in the ACA. EHBs are the minimum benefits package that Qualified Health Plans participating in an Exchange must cover.[6] It will also the minimum standard for Medicaid Benchmark Plans[7] (discussed below), and is also required in the group and individual markets through ACA reforms to the insurance market.[8]

The EHB package is only generally defined in the ACA,[9] and this general definition includes coverage of "maternity and newborn care" and "preventive and wellness services" but does not explicitly mention family planning services and supplies. HHS is charged with providing a more specific definition of the benefits package, based on the general categories set out in the ACA. The final HHS standard on EHB will have a tremendous impact on the access of millions of women to comprehensive women's health services.

In order to help develop the EHB standard, HHS contracted with the Institute of Medicine (IOM) to develop recommendations on criteria for developing the EHB benefits package.[10] NHeLP provided written recommendations, and was one of a small set of organizations invited to provide live testimony in the IOM process.[11]

Currently the IOM is preparing its final recommendations, which it is expected to provide to HHS by September 1, 2011. HHS will use the IOM recommendations to develop a final policy, which is expected to be released as a regulation[12] soon after it receives the IOM recommendations.

One related question is whether family planning services and supplies will be considered a "preventive service" (discussed below). There is a separate IOM process to make recommendations to HHS as to which women's health services should be required as "preventive health services."

Note further, the EHB standard also forms the minimum coverage standard for the Basic Health Plan option[13] and a Multi-State Qualified Health Plan.[14]

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[6] ACA §1301(a)(1)(B); 42 U.S.C. 18021(a)(1)(B).
[7] ACA §2001(c); 42 U.S.C. 1396u–7(b)(5).
[8] ACA §1201 (creating new §2707 of the Public Health Service Act, codified as 42 U.S.C. 300gg–6).
[9] ACA §1302; 42 U.S.C. 18022.
[10] Information about the IOM process is available at: http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx. HHS may also consider the results of a DOL survey on employer coverage; see http://www.hhs.gov/news/press/2011pres/04/20110415b.html.
[11] Comments available at: http://healthlaw.org/images/stories/Comments_to_IOM_Essential_Health_Benefits.pdf.
[12] The ACA requires the opportunity for public notice and comment on the essential health benefits package as initially designed by the Secretary, and as amended in future years. *See* ACA §1302(b)(3); 42 U.S.C. 18022(b)(3).
[13] The Basic Health Plan is an optional program the ACA authorizes states to implement, with Federal funding support, and as an alternative to the Exchange, to cover individuals who are between 133% and 200% of the Federal Poverty Level (and not eligible for Medicaid). The ACA requires these Basic Health Plans to meet the EHB standard at a minimum. ACA §1331(a)(1); 42 U.S.C. 18051(a)(1).
[14] Health care reform establishes 'Multi-State Plans', which are Qualified Health Plans authorized to operate in multiple states, subject to requirements in the ACA, including that they cover at least the EHB package. ACA §1334(c)(1)(A); 42 U.S.C. 18055(c)(1)(A).

3. Benchmark Plans

Benchmark benefits were created in Medicaid through the 2005 Deficit Reduction Act (DRA) as an optional alternative to the standard state Medicaid benefits package.[15] Instead of being based on the traditional Medicaid covered services in the state, they can be based on any one of several 'benchmark' standards established by the DRA. For example, one Benchmark option is the typical plan available to state employees in the state.[16] Through 2010, few states (about 8) have used this Benchmark authority to create Benchmark benefits packages.[17]

Health care reform vastly expands the role of Benchmarks by making Benchmark benefits the default benefits package for the Medicaid Expansion population (newly eligible individuals with incomes of up to 133% FPL).[18] There are specific exceptions in the Medicaid statute for populations that are not allowed to be put in Benchmark packages (such as mandatorily covered pregnant women and women in breast and cervical cancer category programs).[19]

As mentioned, Benchmark benefits packages can generally be pegged to any one of the several 'benchmark' standards listed in the Medicaid Act.[20] However, the ACA requires that all Benchmark packages must at least cover the EHB standard (discussed above).[21] Thus, the EHB standard forms the minimum for individuals in Qualified Health Plans in the Exchange *and* the many Medicaid Expansion enrollees who will get a Benchmark benefit.

Significantly, the ACA[22] expands the Medicaid coverage requirements of the Benchmark benefit to include family planning services and supplies.[23] Therefore, regardless of whether the EHB standard includes it, family planning *must* be included in any Benchmark plan. Further guidance on the Benchmark benefit appears in a July 2, 2010, Dear State Medicaid Director letter discussing Family Planning Services and Benchmarks.[24]

4. Preventive Care

"Preventive care" is a term of art in the ACA, and is significant for at least two key reasons. First, as discussed above, preventive care is a required category of benefits in the essential health benefits package.[25] Second, preventive care services which have an "A" or "B" rating from the U.S. Preventive Service Task Force (USPSTF) must be provided without cost-sharing (such as

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[15] *See* Social Security Act §1937; 42 U.S.C. 1396u-7.
[16] Social Security Act §1937(b)(1)(B); 42 U.S.C. 1396u-7(b)(1)(B).
[17] *See* "The Crunch Continues" from the Kaiser Family Foundation at page 43, identifying the states as: West Virginia, Idaho, Kentucky, Virginia, Washington, Kansas, South Carolina and Wisconsin. Report available at: http://www.healthmanagement.com/files/The%20Crunch%20Continues-%20Medicaid%20Spending,%20Coverage%20and%20Policy%20in%20the%20Midst%20of%20a%20Recession.pdf
[18] ACA §2001(a)(2)(A); 42 U.S.C. 1396a(k)(1).
[19] Social Security Act §1937(a)(2)(B); 42 U.S.C. 1396u-7(a)(2)(B).
[20] Social Security Act §1937(b); 42 U.S.C. 1396u-7(b).
[21] ACA §2001(c); 42 U.S.C. 1396u–7(b)(5).
[22] ACA §2303(c).
[23] Social Security Act §1937(b)(7); 42 U.S.C. 1396u-7(b)(7)).
[24] *Available at*: http://www.cms.gov/smdl/downloads/SMD10013.pdf.
[25] ACA §1302(b)(1)(I); 42 U.S.C. 18022(b)(1)(I).

co-pays or deductibles) for individuals in Exchanges,[26] the group and individual markets,[27] employment insurances,[28] and Medicare.[29] The ACA also requires Medicaid to cover all of the "A" or "B" USPSTF designated preventive services starting 2013.[30] Note that Medicaid already prohibits cost-sharing for family planning services and supplies, with very limited exceptions.[31] In summary, if family planning services are identified as a "preventive" service as per above, then they must be covered without any cost-sharing by all Exchange and Medicaid Expansion plans.

Unfortunately, the USPSTF list does not currently include family planning on the "A" or "B" preventive services lists.[32] For this reason, HHS regulations on preventive services issued on July 14, 2010, did not include family planning services among the list of preventive care services, and instead indicated that HHS has requested recommendation from the IOM on preventive women's health services.[33] NHeLP provided comments and testimony for the IOM on this standard.[34]

The IOM is expected to provide final recommendations to HHS in the summer of 2011, and then HHS is expected to issue its policy around September 2011.

5. Essential Community Providers (ECPs)

Health care reform requires the Secretary to issue regulations which establish criteria to certify Qualified Health Plans (discussed above). These criteria must include a requirement for QHPs to include "essential community providers."[35] Some examples of ECPs are provided in the ACA statute, including numerous provider types which provide women's health services (such as Title X clinics), and the term could be interpreted to include many types of women's health providers. Therefore, all plans sold in Exchanges should be expected to contract with a range of safety net and other providers that provide women's health services, but advocacy may influence just how expansively that range is defined.

HHS may issue a detailed policy on the ECPs in a broad regulation addressing the Exchanges which is expected to be released by summer 2011.

Conclusion

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[26] ACA §1001 (creating new §2713 of the Public Health Service Act, codified as 42 U.S.C. 300gg–13).
[27] *Id*.
[28] *Id*. *See also* ACA §1302(c)(2)(D); 42 U.S.C. 18022(c)(2)(D).
[29] ACA §4104(b); 42 U.S.C. 1395l(a)(1).
[30] ACA §4106(a); 42 U.S.C. 1396d(a)(13).
[31] Medicaid programs may not charge cost-sharing for family planning services. They may only charge nominal cost-sharing for family planning drugs or supplies which are not on the state's preferred drug listing. *See* Social Security Act §1916(a)(2)(D), 42 U.S.C. 1396o(a)(2)(D); §1916(b)(2)(D), 42 U.S.C. 1396o(b)(2)(D); §1916A(c), 42 U.S.C. 1396o(b)(2)(D); and CMS, *Dear State Medicaid Director* (June 16, 2006), *available at*: http://www.cms.gov/smdl/downloads/SMD061606.pdf.
[32] *Available at*: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
[33] *See* Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726 (July 19, 2010).
[34] Comments available at: http://healthlaw.org/images/stories/NHeLP_Comments_to_HHS_Sept17.pdf.
[35] ACA §1311(c)(1)(C); 42 U.S.C. 18031(c)(1)(C).

Advocates should consider providing comments on the policy guidance and regulations released by CMS in the coming months to begin defining the critical health reform standards discussed above. CMS is expected to provide guidance or regulations on the Essential Health Benefits package and the definition of Preventive Services, as well as a major regulation implementing health care Exchanges which will include many more important standards. NHeLP will be preparing and circulating comments on these policies and encourages advocates to weigh in on these critical standards to help ensure access to family planning services and supplies in Medicaid and the Exchanges.