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Reviewing Your State's Essential Health Benefits (EHB) Benchmark Plan Selection

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On November 20th, the Department of Health and Human Services (HHS) released the *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* proposed rule ("Rule"), which outlines the policies and standards for coverage of EHBs in the individual and small group markets.[1] HHS defines EHB based on a state-specific "base-benchmark plan" selection process that must also include the Affordable Care Act's (ACA's) ten statutory benefit categories (See Figures 1 & 2). The Rule also lists the proposed EHB benchmark plans for the 50 states and the District of Columbia (DC).

States were encouraged to submit their EHB benchmark selection by October 1st to set the benchmark for 2014 and 2015.[2] Appendix A of the EHB Rule lists each state's benchmark plan selection or default (for states that did not select a plan). For each state, HHS has posted (1) a summary of "the specific benefits and limits, and prescription drug categories and classes" covered by the EHB benchmark plan, and (2) a list of state-required benefits.

HHS is requesting public comment on states' proposed EHB benchmark plans and the policies and standards in the EHB Rule.[3] The proposed rule has a short 30-day comment period with comments due on December 26th. If a state wishes to make an EHB benchmark selection or change its previous selection it must do so by the end of this comment period.[4] This EHB Step Guide is designed to help state advocates analyze the benchmark plan selected by their state, and includes some important considerations when reviewing benefits offered by EHB benchmark plans.

Figure 1: States can select their EHB base-benchmark from among ten options:

- the three (3) largest federal employee plans;
- three (3) largest state employee plans;
- three (3) largest small group plans in the state; or
- the largest commercial HMO operating in the state.

[1] EHB applicability to Medicaid will be defined in a separate regulation.
[2] 77 Fed. Reg. 70644 at 70649.
[3] See NHeLP's template comments on the policies and standards in the EHB Rule.
[4] 77 Fed. Reg. 70644 at 70649.

Figure 2: The plan selected as the EHB benchmark must include coverage of ten statutorily-designated categories of benefits:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services (including chronic disease management); and
- pediatric services, including oral and vision care.

Step 1: Identify and review your state's Proposed EHB Base-Benchmark Plan

- The plan selected by a state or through the default process is called the "base-benchmark plan". Once that plan has been appropriately supplemented and meets all the EHB requirements in the ACA, the plan is considered the "EHB-benchmark plan", which is the standardized set of EHBs that must be met by a Qualified Health Plan (QHP) or other issuer.

- The EHB Rule lists the Proposed EHB Benchmarks for each state and DC in Appendix A.[5]
  http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf

- A summary of the covered benefits and limits, and prescription drug categories and classes for each state's EHB benchmark plan is available at:
  http://cciio.cms.gov/resources/data/ehb.html

Resources to review your state's base-benchmark plan:

- A new Kaiser Family Foundation brief reviews states' EHB decisions and includes a table identifying the states for which the default benchmark applies.
  http://www.kff.org/healthreform/quicktake_essential_health_benefits.cfm

- The "State Refor(u)m" website has a chart which provides direct links to Evidence of Coverage (EOC) documents for some EHB base-benchmark plans.
  http://www.statereforum.org/analyses/state-progress-on-essential-health-benefits

- HHS' *Guide To Reviewing Proposed Benchmark Plans* includes additional statutory and proposed regulatory standards for EHB benchmark plans.
  http://cciio.cms.gov/resources/data/ehb.html#review benchmarks

[5] 77 Fed. Reg. 70644 at 70672-70676.

Step 2: Ensure the 10 EHB statutory benefit categories are covered

EHBs must be equal in scope to the benefits covered by a typical employer plan and cover at least the 10 statutorily designated benefit categories

- Review your state's EHB base-benchmark plan and make sure it includes items and services in the 10 EHB statutory benefit categories (See Figure 2).

- Take note of any EHB statutory categories that are not covered by the plan.

- HHS proposes supplementing base-benchmark plans only when no coverage is provided in the EHB statutory category. Therefore a plan with minimal coverage in one of these categories will not be supplemented. When reviewing your state's EHB base-benchmark plan, identify any areas where there is only minimal coverage in the EHB statutory category. Make sure to include these examples in your comments to HHS and recommend the Final Rule require supplementing and "filling the gaps" when there is insufficient coverage of an EHB statutory category.

  NOTE:

  - The EHB base-benchmark plans listed for each state may not offer the preventive services described in 45 C.F.R §147.130. However, the EHB Rule independently requires coverage of these services for all EHB benchmarks.

  - For 2014 and 2015, state benefit mandates enacted on or before December 31, 2011 (even if not effective until a later date) are not considered *additional* to the EHBs, so states will *not* have to defray the costs of covering these benefits. This is a change in HHS policy. Some states may have selected their base-benchmark plan based on the old policy requiring states to cover the costs of mandated services if a state selected an EHB base-benchmark plan not subject to state health insurance mandates (e.g. a Federal Employee Health Benefit Plan). Make sure your state's EHB base-benchmark plan selection was not negatively influenced by fear about mandate costs.

  - HHS has made available a list of state-required benefits for each state and DC at http://cciio.cms.gov/resources/data/ehb.html.

Step 3: If possible, compare the selected EHB base-benchmark plan to other EHB base-benchmark plan options and identify the best choice for your state

- Some states have made available to stakeholders the EOCs for all ten EHB base-benchmark plan options in the state. If that is the case in your state, review

the EOCs of these plans and ensure your state is using the best EHB base-benchmark.

- If your state selected an EHB base-benchmark plan, ask the state what criteria it used in selecting the plan. If you support the state's criteria, see if that narrows the ten EHB base-benchmark options, and only review the EOCs for the plans that meet the state's criteria.

Step 4: Ensure benefit categories are supplemented correctly

If your state's base-benchmark plan does not include coverage of an EHB statutory benefit category, make sure it is supplemented correctly and with the best EHB base-benchmark option to fill the gaps. Supplementing services does not guarantee adequate services. Therefore, make sure to provide HHS with examples of inadequate supplementation. Recommend that HHS change its policy and require substantial coverage in all ten EHB statutory benefit categories.

General supplementing methodology*:*

- If an EHB base-benchmark plan selected by a state does not include items or services in one or more of the 10 EHB statutory benefit categories, HHS proposes that the base-benchmark plan must be supplemented by adding that particular category *in its entirety* from any other EHB base-benchmark plan option.
    - Identify which base-benchmark option has the best coverage in areas where your state's base-benchmark plan is completely missing coverage of a statutory benefit, and recommend how each benefit category should be supplemented.

Special Supplementing Methodologies

There are certain EHB benefit categories with special supplementing methodologies:

Mental health and substance use disorder services (including behavioral health treatment services)

- Must comply with federal parity standards detailed in the Mental Health Parity and Addiction Equity Act of 2008.

- Some of the EHB benchmark plans listed for each state may not comply with this requirement yet, but will be required to do so.[6]

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[6] See http://cciio.cms.gov/resources/data/ehb.html#review benchmarks.

- Mental health, behavioral health, and substance abuse conditions ("MH/BH/SA") services have been historically excluded in private market health coverage, and parity is an important step. However, parity itself is not sufficient to ensure coverage, and has proven difficult to enforce. Recommend that in addition to parity requirements there should be comprehensive coverage of screening, assessment, and treatment of MH/BH/SA conditions to meet the ACA requirement for coverage.

Habilitative Services

- If an EHB base-benchmark plan does not include habilitative services, the state may determine which services are included in that category.

- If the state does not make the determination, then the plan must include habilitative services that meet one of the following: (1) parity with rehabilitative services, or (2) as determined by the issuer and reported to HHS.

    - The EHB Rule requirements for habilitative services may lead to inadequate coverage. Your state may set an inadequate definition, or if it sets no definition, insurers may set an inadequate definition using one of the options available to them. In your comment provide examples of how the Rule may lead to insufficient coverage in your state, and recommend that HHS require substantial coverage of habilitative services.

    - If your state is providing habilitative services at parity with rehabilitative services, make sure your state is not importing limits and exclusions that exist under the plan's rehabilitative services and applying them to habilitative services.

Pediatric Services, including oral and vision care[7]

- Most EHB base-benchmark plan options do not include oral or vision care coverage.[8]

- If a base-benchmark plan does not include one of these categories of benefits, HHS proposes supplementing the plan as follows:

    - Pediatric Oral Care

        a) Supplement with the Federal Employees Dental and Vision Program (FEDVIP) dental plan with the largest enrollment, which is MetLife

[7] In the proposed rule, HHS interprets "pediatric services" to mean services for individuals under the age of 19. *See* 77 Fed. Reg. 70644 at 70649.
[8] 77 Fed. Reg. 70644 at 70650.

Federal Dental Plan (See Appendix B of the Rule for a link to a Plan benefit brochure), or

b) Supplement with dental benefits available under the state's separate Children's Health Insurance Program (CHIP) plan.

- Pediatric Vision Services[9]

  a) Supplement with the FEDVIP vision plan with the largest national enrollment, which is FEP BlueVision (See Appendix B of the Rule for a link to a Plan benefit brochure), or
  b) Supplement with vision benefits available under the state's separate CHIP plan. (*This is a new option for supplementing vision services, which was not previously available in the EHB Bulletin.*)

<u>Default Benchmark Supplementing Methodology</u>

- For default base-benchmark plans missing coverage in any EHB statutory category, HHS will supplement the base-benchmark plan with the first of the following options that offers benefits in that particular EHB category:
  a) Largest plan by enrollment in the second largest product in the state's small group market,
  b) Largest plan by enrollment in the third largest product in the state's small group market,
  c) Largest national Federal Employees Health Benefits Program (FEHBP),
  d) FEDVIP dental plan with the largest national enrollment,
  e) FEDVIP vision plan with the largest national enrollment, and
  f) A habilitative benefit determined by the plan (by providing parity with rehabilitative services or as otherwise determined and reported to HHS) or as determined by the state.

  <u>NOTE:</u>

  - For both the state-selected and default processes, include in your comments any concerns regarding how a benefit is currently supplemented, and recommend an alternative plan. Also, remember to provide HHS with examples of inadequate supplementation and recommend that HHS change its policy and require substantial coverage in all ten EHB statutory benefit categories.

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[9] An HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) brief identified that eyeglasses for children are only covered by 8% of small group products. *See* ASPE Research Brief, "Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans." December 16, 2011, *available at* http://aspe.hhs.gov/health/reports/2011/Marketcomparison/rb.shtml.

Step 5: Review Prescription Drug Coverage

- HHS proposes that health plans offering EHB must cover at least the greater of: (1) One drug in every United States Pharmacopeia (USP) category of class; or (2) The same number of prescription drugs in each category and class as the EHB benchmark plan.

- See HHS' EHB Benchmark Drug List Count document which summarizes the process the Centers for Medicare and Medicaid Services (CMS) used to classify and analyze drug products in proposed state benchmark plan drug lists. http://cciio.cms.gov/resources/files/ehb-benchmark-drug-list-count.pdf

- Analyze the drug coverage in your state's base-benchmark plan and identify areas where the "one drug" coverage policy or the base-benchmark plan's coverage is inadequate.

  - Include in your comments the reasons why having one drug per class would lead to poor health outcomes for vulnerable individuals in your state. Recommend that HHS at least require two drugs per class, as is the norm in Medicare Part D.

  - Medicare Part D also requires coverage of *all* or *substantially all* drugs in six "protected classes" of drugs (immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics), which are critical to vulnerable populations. Recommend that HHS adopt Medicare's six "protected classes" for EHB.

Step 6: Ensure other ACA requirements are met

The ACA directs the Secretary of HHS to define EHB in a manner that (1) reflects a balance among the 10 categories of benefits; (2) ensures individuals are not discriminated against because of their age, gender, disability, or expected length of life, when coverage decisions and other related factors are determined; (3) includes the health needs of diverse populations; (4) ensures access to EHBs regardless of the individuals' age or anticipated life span, disability, quality of life or medical dependency.[10]

- HHS is soliciting comments on potential approaches to ensure the EHB-benchmark plans do not include discriminatory benefit designs and reflect an appropriate balance among EHB statutory benefit categories.

- HHS does not offer guidance on how it will apply these standards.

[10] ACA § 1302(b)(4)(A)-(D).

- HHS' proposed policies may lead to discrimination. The EHB Rule's supplementing methods do not guarantee service gaps will be filled and allows health issuers the flexibility to "substitute" benefits.

    - Coverage gaps can lead to discrimination against certain populations. If there are examples of this in your state's proposed EHB benchmark plan include them in your comments. Recommend that HHS prevent this discrimination by requiring substantial coverage of all ten EHB statutory benefit categories and through specific non-discrimination standards and monitoring and enforcement protocols.

The ACA directs the Secretary of HHS to periodically review EHBs and provide a publicly available report to Congress that includes an assessment: (1) whether enrollees are experiencing barriers to needed services, (2) whether services should be modified or updated to account for changes in medical evidence or scientific advancement, (3) addressing gaps in access, and (4) whether existing benefits need to be expanded or reduced and the impact on cost.[11]

- In the EHB Rule, HHS indicates the proposed EHB policies and standards will apply to the 2014 and 2015 benefit years, and it intends to revisit these policies for subsequent years. HHS invites comment on the process it should use to update EHBs over time. In your comments, recommend that HHS modify the EHB standards for 2016 and beyond to set a strong national EHB standard requiring substantial coverage in all ten EHB statutory benefit categories.

Conclusion

There are two broad objectives in commenting on the EHB Rule: (1) provide HHS with comments on your state's EHB benchmark selection, which includes the base-benchmark selected and the supplementing of that plan, and (2) provide comments on the EHB policies and standards in the Rule, and the critical issues it raises for vulnerable populations. Use this Step Guide to help you comment on your state's EHB benchmark selection and see NHeLP's template comments for help addressing the policies and standards in the proposed EHB Rule.

[11] ACA § 1302(b)(4)(G),(H).