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NATIONAL HEALTH LAW PROGRAM

Memorandum

To: Interested Parties

From: National Health Law Program

Date: May 1, 2012

Re: CA EHB Legislation—Updated Analysis

The two Essential Health Benefits (EHB) bills in California, Senate Bill 951 (Hernandez) and Assembly Bill 1453 (Monning), were amended in March 2012, to include the state's selection of an EHB benchmark plan. The plan selected is the *second-largest small group plan*[1], a Kaiser HMO regulated by the Department of Managed Health Care (DMHC). This memo includes our updated analysis of the state's EHB benchmark selection process.

EHB Benchmark Selection process

States can select their EHB benchmark from among ten options: the three largest federal employee plans, three largest state employee plans, three largest small group plans, or the largest commercial HMO operating in the state. In California, the health benefit exchange board asked Milliman, an independent actuarial and consulting firm, to do an analysis of the ten potential EHB plans in CA. Milliman's analysis is posted on the health benefit exchange website.[2]

As we understand, the following criteria were considered when selecting an EHB benchmark plan for the state: the plan should include state benefit mandates and be a

[1] This ranking is based on Milliman's analysis, which used 2011 enrollment data. California Health Benefit Exchange, Milliman—Essential Health benefits—Plan Benefit Comparison, *available at* http://www.healthexchange.ca.gov/FederalGuidance/Pages/Default.aspx
[2] *See* http://www.healthexchange.ca.gov/FederalGuidance/Pages/Default.aspx

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DMHC regulated plan containing the Knox-Keene Act consumer protections (which require standards for particular benefits.)

State benefit mandates

The U.S. Department of Health and Human Services' (HHS) EHB Bulletin outlines the intended approach for handling state benefit mandates in 2014 and 2015.[3] For these two "transitional" years, if a state selects an EHB benchmark, which is subject to state benefit mandates, those mandates will be included in the state's EHB package and the state will not have to defray the cost of covering those benefits.[4]

Selecting an EHB benchmark plan in California that includes state mandates is important because the state has a total of 53 health insurance benefit mandates, which provide coverage for valuable services.[5] In California, only four of the ten possible EHB benchmark plans (the three small group plans and the largest commercial HMO) cover state benefit mandates. Therefore, the EHB benchmark selection process can be narrowed down to four plans.

Selecting a DMHC plan with Knox-Keene Act Protections

Out of the four plans that include state benefit mandates, three plans are DMHC regulated plans and one is a California Department of Insurance (CDI) regulated plan. The remaining plans (federal and state employee plans) are not regulated by either state agency. DMHC licenses approximately 125 health care service plans, 70 of which are full-service health plans and 55 specialized health plans, and covers approximately 21.6 million lives (significantly more than CDI.)[6]

DMHC regulated plans are also required to comply with the Knox-Keene Health Care Service Plan Act of 1975 and the accompanying laws that regulate managed care plans. The intent of the Knox-Keene Act is to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote

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[3] Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight, December 16, 2011, *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

[4] *Id.*

[5] California Health Benefits Review Program, *Health Insurance Benefit Mandates in California State Law*, April 13, 2012, *available at* http://chbrp.org/documents/ca_mandates.pdf

[6] California Healthcare Foundation, *Ready for Reform? Health Insurance Regulation in California under the ACA*, June 2011, *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20ReadyReformHealthInsRegulationACA.pdf

the interests of enrollees.[7] Therefore not only do Knox-Keene Act licensed plans have to provide valuable protections, they specifically must include particular services which are reflected in the plans' benefits package. By selecting a plan that is regulated by DMHC and includes Knox-Keene Act protections, the benchmark selection in the state is narrowed down to three plan options.

Evaluating the three DMHC benchmark plans

The following section offers a comparison of the Evidence of Coverage (EOC) for the three DMHC EHB benchmark plans: Small Group Anthem Blue Cross PPO30, Small Group Kaiser HMO, and Large Commercial Group Kaiser HMO.[8]

A. Small Group Anthem Blue Cross PPO30

The EOC for the Small Group Anthem Blue Cross plan had more limits on services than the other two plans, and the EOC was hard to follow, making it difficult to understand the specific coverage provided. Given the number of service limits, we did not consider this plan further. Therefore, the specific analysis of this plan is not included. The remaining two plans, the second-largest small group plan and the largest commercial HMO (both Kaiser plans) are compared below.

B. Comparing the Kaiser small group plan and Kaiser large group HMO

The benefit coverage under these two plans is comprehensive and both plans offer comparable benefits. However, there are a few areas where the plans do not adequately provide coverage: mental health services, rehabilitative & habilitative services, and pediatric vision services. Dental care is not covered by either plan and is supplemented by the Federal Employees Dental and Vision Insurance Program (FEDVIP), per the latest amendment to the EHB bills.[9]

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[7] California Health & Safety Code Section 1341(a).

[8] We used the EOCs used by Milliman and posted on the Exchange board website for this analysis. *See* California Health Benefit Exchange, Federal Exchange Guidance, Evidence of Coverage used by Milliman for Analysis, *available at* http://www.healthexchange.ca.gov/FederalGuidance/Pages/Default.aspx

[9] Amended SB 951 bill *available at* http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0951-1000/sb_951_bill_20120416_amended_sen_v97.pdf. AB 1453 was amended on April 17, 2012

These areas of concern apply to both plans:

- *Mental health services:* Both plans cover non-severe mental health care services for adults, but more limiting services for children. Specifically, the plans require a child to meet a strict "Severely Emotionally Disturbed" standard in order to access mental health services. We would recommend broader coverage for children.

- *Habilitative services*: per the current requirements in the EHB legislation, these services must be covered the same way the EHB benchmark plan covers *rehabilitative services*, but the EOCs for both the small group and large group Kaiser plans do not include much information about how rehabilitative services are covered. In addition, although the EHB legislation currently expands the definition of "habilitative services", it is not clear how specific services are included. Therefore we recommend the following amendments to the EHB legislation:

    (1) Change the current definition of "habilitative services" in the EHB bills, to the Medicaid definition as follows: "habilitation services" means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, including prevocational, educational, and supported employment services.
    (2) Remove the language that requires habilitative services to be covered the same way the plan covers rehabilitative services (due to the limitations in the plan coverage.)

- *Pediatric vision care*: Both plans do not cover eyeglass lenses and frames, contact lenses including fitting and dispensing, eye exams for purpose of obtaining or maintaining contact lenses, and low-vision devices. The recent amendments to the EHB legislation, added language to supplement the EHB benchmark with the vision services of the FEDVIP.[10] We support this amendment.

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to match the language of the EHB Senate bill, *see* http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1451-1500/ab_1453_bill_20120417_amended_asm_v97.pdf.

[10] *Id.*

Key differences between the plans

There are three specific areas where the large group Kaiser plan appears to cover more services than the small group plan: 1) coverage of some infertility services[11], 2) prosthetic and orthotic devices, in particular coverage of footwear when custom made for foot disfigurement due to disease, injury or developmental disability,[12] and 3) substance abuse care in a residential rehabilitation program, when approved in writing by the Medical group.

Even though the small group plan EOC says infertility service coverage is excluded, these services are mandated in CA.[13] Therefore some infertility service coverage may be available in the small group plan, although this is unclear given the EOC explicitly says the services are excluded.

Another difference in the plans' EOCs is that the small group plan EOC includes the word "treatment" when referring to primary, specialty care and urgent care, while the large plan only mentions consultations and exams, but not specifically treatment. While the word "treatment" is omitted from this section of the large plan's EOC, it is possible that it is simply because "treatment" is covered under other sections of the EOC, and there is no substantive difference between the plans. However, the EOC as written is unclear and that should be clarified.

While overall, the benefit coverage between these two plans is comparable, there are a few areas where the large group plan covers more benefits than the small group plan, as described above. There are also significant cost-sharing differences between these plans, although those are not considered in this analysis because cost-sharing will be based on actuarial value.[14] Another difference between the plans that was not

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[11] The coverage is limited to services for diagnosis and treatment of involuntary infertility and artificial insemination. All other services related to conception by artificial means (e.g. in vitro fertilization) are not covered.

[12] The large group plan covers prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity, rigid and semi-rigid orthotic devices required to support or correct a defective body part, and covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability.

[13] California Health and Safety Code Section 1374.55.

[14] In February 2012, HHS released its Actuarial Value (AV) and Cost-Sharing Reductions Bulletin, which addresses how AV will be calculated. HHS proposes to use a central "calculator" based on a "standard population" of claims data for creating the estimates. *Available at* http://www.cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

considered is grandfathered status. Although the large group plan is a grandfathered plan, while the small group plan is not, this does not appear to be an issue for EHB benchmark selection purposes, and therefore is not part of this analysis.[15]

Correlation with Medicaid Benchmark selection process

Medicaid benchmarks must include the EHBs.[16] Therefore the benefits provided by the EHB benchmark plan and any additional coverage mandated by the 10 statutory categories of the ACA must be included in Medicaid Benchmark plan. Selecting the largest commercial HMO as the EHB benchmark and as the Medicaid benchmark would provide uniformity between the Exchange population and the Expansion population.[17] But uniformity between the traditional Medicaid population and the Medicaid Expansion population is necessary because of the likelihood of churning between Medicaid populations. Therefore, including the traditional Medicaid state plan services in the Medicaid benchmark is also critical. We are working on a separate analysis of the Medicaid benchmark selection process and plan to have a call with state advocates to discuss this in the next few weeks.

Conclusion—Further Amendments Necessary

The National Health Law Program (NHeLP) supports the state's current criteria in selecting an EHB benchmark plan (i.e., includes state benefit mandates, regulated by DMHC and contains Knox-Keene Act consumer protections). This narrows the EHB benchmark plan selection from ten to three. Out of the three plans, the Kaiser small group plan and large group plan offer comparable coverage. Overall these two plans offer comprehensive coverage, with a few exceptions, including mental health services for children, rehabilitative & habilitative services, and vision services. We support recent amendments to the legislation supplementing vision services with FEDVIP, but *further amendments are needed regarding mental health services and habilitative services.*

[15] Question #12 of HHS' EHB FAQ says the "preventive services described in section 2713 of the PHS Act, as added by section 1001 of the ACA, will be part of the EHB" which means these preventive services will be included in the EHB regardless of whether the plan selected is grandfathered or not. *See* http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.
[16] Social Security Act § 1937(b)(5), added by §2001(c)(3) of the ACA.
[17] Small group plans are not an option for Medicaid benchmarks. 42 U.S.C. Section 1396u-7(b)(1).

In addition, *the EHB bills should be amended to include explicit language about "benefit substitution".* While there may already be some protections in the Knox-Keene Act, the EHB legislation should explicitly prohibit substitution of covered services even if actuarially equivalent. We are concerned about allowing insurer-driven benefit substitutions as they would make it more difficult to compare plans and could segment risk in the market. We believe the state has the authority to prohibit benefit substitution because HHS has only released guidance on this subject and it has not yet released a regulation saying this must be allowed.

In conclusion, selecting either the small group plan or large group plan as CA's EHB benchmark offers a strong benefits package. Yet the large group plan is also an option in the Medicaid benchmark, therefore selecting it leaves the door open for more uniformity between the Exchange and Medicaid expansion populations. We also believe uniformity between the traditional Medicaid population and Expansion population is critical but that may have to be addressed in separate legislation.