Issue Brief: Mandatory Offerings and Qualified Health Plans (QHPs)

Background

Arkansas has eight *mandatory benefit offerings* that must be offered by most health plans in the state. These benefits do not have to be *included* in the health plan but must be *offered* to individuals to purchase as an additional benefit. Of the eight mandatory benefit offerings, six of them are now included in the state Essential Health Benefits package, meaning that they are required benefits for non-grandfathered individual and small group plans. (Benefits that are included in the health plan meet the mandatory offering provision). The remaining two benefits (TMJ and Hearing Aids) do not have to be included in a health plan benefits package, but must be *offered* to consumers at time of application.

The table below lists the coverage status of mandatory offerings in Arkansas.

Mandated Offerings	QHP Coverage
Alcohol and Drug Dependency	Included in EHB Benchmark
Hospice	Included in EHB Benchmark
Mental Disorders	Included in EHB Benchmark
Mammogram	Included in EHB Benchmark
Out-Patient Service	Included in EHB Benchmark
Psychological Examiners	Included in EHB Benchmark
TMJ (Musculoskeletal Disorders of Face, Neck or Head)[1]	Typically offered through riders
Hearing Aids[2]	Typically offered through riders

Issue

Benefits for hearing aids and TMJ are not included in the state benchmark plan and are currently offered separately through riders. CCIIO has indicated to AID that benefits offered in coordination with QHPs must be regulated by CCIIO as part of the FFM QHP certification process. Benefits offered as riders do not affect the rates of QHPs, but they do change the amount that consumers pay for their total benefits package if they purchase riders. Additionally, the law for TMJ indicates that the benefits must be offered at time of application.[3]

CCIIO has indicated that in order to review benefits, they must be included in the plan templates. Templates do not allow for variable benefits; benefits and cost-sharing that is part of the plan must be included in the template. Due to technical limitations in the FFM, these plans can't be differentiated as supplemental or plan variations, but will appear on the FFM as additional plan options for consumers.

Considerations and Options

There are several possible avenues for incorporating riders into QHPs, as outlined in the table below. The options are differentiated primarily by tradeoffs in consumer choice and additional administrative burdens for issuers and AID. Another consideration is the potential confusion for consumers if many plans are offered that vary only by mandatory offerings (some of the options suggested below would need to be approved by CCIIO

[1] §23-79-150 (See appendix A)
[2] §23-79-1401 (See Appendix B)
[3] See Appendix A

in order to circumvent the "meaningful difference" standard for plans that are nearly identical). It should also be noted that this issue is a partial result of technical limitations in the FFM that could be mitigated in the future with a state-based marketplace.

Options for Mandatory Offerings in Qualified Health Plans

Options		Pros	Cons
Option 1	Require each QHP to also offer three shadow plan supplements: • One plan with TMJ included; • One plan with Hearing Aids included; • One with *both* TMJ and Hearing Aids included	• Consumer options do not change; one, both, or all can be purchased for all plans	• Number of plans submitted and reviewed would multiply. For example, current market could have up to 272 plans (instead of 68) • This number of plans would likely be confusing for consumers
Option 2	Require each QHP to also offer one shadow plan with *both* TMJ and Hearing Aids included	• Fewer plans would be required (i.e. up to 136)	• Consumers wishing to purchase just one option would be required to purchase both inside Marketplace
Option 3	Require *all* QHPs to offer TMJ and Hearing Aids (essentially making the benefits mandatory for QHPs only)	• No additional plans would be required • The cost for hearing aids and TMJ may be reduced for consumers using those services	• The overall premium may increase for all consumers enrolled in QHPs
Option 4	Incorporate TMJ and Hearing Aids into state-mandated benefits for individual and small group markets	• Consistent pricing inside and outside Marketplace • Lower costs for consumers that use TMJ / Hearing Aids	• This option would require changes to AR insurance laws • Overall premiums may increase for all consumers

Appendix A –Coverage for Musculoskeletal Disorders

§23-79-150. Health care plan — Health carrier.

(a)(1)(A) "Health care plan" means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a carrier in this state, including indemnity and managed care plans.

(B) "Health care plan" does not mean a plan that provides coverage only for:

(i) A specified accident or accident-only coverage or long-term care insurance as defined in the Long-Term Care Insurance Act, § 23-97-201 et seq.

(ii) A Medicare supplement policy of insurance, as defined by the Insurance Commissioner by regulation;

(iii) Coverage under a plan through Medicare, Medicaid, or the Federal Employees Health Benefit Program;

(iv) Any coverage issued under Chapter 55 of Title 10 of the United States Code, existing on January 1, 2001, and any coverage issued as supplemental to that coverage; and

(v) Any coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; and

(2) "Health carrier" means any accident and health insurance company, referred to in law as disability insurance company, hospital or medical services corporation, or health maintenance organization, including a so-called dental maintenance organization, issuing or delivering health care plans in this state.

(b)(1) Every health carrier shall offer optional coverage in its health care plans for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures.

(2) This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

(3) This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.

(c)(1) The policyholder shall accept or reject the optional coverage in writing on the application.

(2) The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

(d) Nothing in this section shall prevent an insurer from including such coverage for any or all musculoskeletal disorders affecting any bone or joint in the face, neck, or head as part of a policy's basic coverage, in lieu of offering optional coverage.

(e) This section shall apply to those health care plans issued, delivered, renewed, extended, amended, or modified on or after August 13, 2001.

Appendix B – Coverage for Hearing Aids

23-79-1401. Definitions.

As used in this subchapter:

(1)(A) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer in this state.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) Governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2009.

(C) "Health benefit plan" does not include:

(i) Accidental injury insurance plans;
(ii) Dental insurance plans;
(iii) Vision insurance plans;
(iv) Specified disease insurance plans;
(v) Disability income plans;
(vi) Credit insurance plans;
(vii) Insurance coverage issued as a supplement to liability insurance;
(viii) Medical payments under automobile or homeowners' insurance plans;
(ix) Health benefit plans provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;
(x) Insurance under which benefits are payable with or without regard to fault and the benefits that are statutorily required to be contained in any liability policy or equivalent self-insurance; and
(xi) Plans that provide only indemnity for hospital confinement; and

(2) "Hearing aid" means an instrument or device, including repair and replacement parts, that:
(A) Is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;
(B) Is worn in or on the body; and
(C) Is generally not useful to a person in the absence of a hearing impairment.

23-79-1402. Coverage for hearing aids required.

(a) A health benefit plan that is offered, issued, or renewed in this state shall offer coverage for a hearing aid or hearing instrument sold on or after January 1, 2010, by a professional licensed by the state to dispense a hearing aid or hearing instrument.
(b) The coverage offered for hearing aids under this section:
(1) Shall not be for less than one thousand four hundred dollars ($1,400) per ear for each three-year period;
(2) Shall provide coverage of not less than one thousand four hundred dollars ($1,400) per ear beginning on the first day of coverage; and
(3) Is not subject to policy deductibles or copayment requirements.

23-79-1403. Rules.

The State Insurance Department shall develop and promulgate rules for the implementation and administration of this subchapter.