Defining Essential Health Benefits For the Arkansas Exchange

April 27, 2012

1 Introduction

The purpose of this document is to provide the Arkansas Plan Management Advisory Committee with the necessary information to recommend a plan to serve as the benchmark for the essential health benefits package for the Arkansas Exchange.

Specifically, this report summarizes: 1) the essential health benefits (EHB) requirements set forth in federal law; 2) recommendations from the U.S. Department of Labor (DOL) and the Institute of Medicine (IOM) on an approach for defining the EHB package, and 3) guidance from the U.S. Department of Health and Human Services (HHS) to states on developing an EHB package.

This report also describes the ten categories of services that the Affordable Care Act requires to be included in the EHB package and the sixteen benefits that are mandated to be covered by Arkansas State law. Finally, this report provides a benefit inventory of the potential benchmark plans currently offered within the State of Arkansas to determine if they meet federal and state requirements. This inventory also provides an opportunity to identify differences among the seven plans. Near the end of the paper, the policy and cost implications of choosing any one of these seven eligible benchmarks to serve as the essential benefits package of the Arkansas Exchange will be considered.

Several plan design components are out of scope in selecting essential health benefits, most notably member cost sharing provisions and benefit utilization frequency limits. Those components of plan design may be proposed by issuers as they respond to the actuarial requirements of Exchange plan tiers (the "metal" levels that differentiate bronze, silver, gold and platinum offerings inside the Exchange). Still, the essential benefits package shapes those tiers by establishing the "standard plan" against which plan tiers are measured.

Even so, issuers will have flexibility in proposing various benefit mixes that are "substantially equivalent" to the selected benchmark plan by maintaining a comparable actuarial value to the standard plan.

Choosing a state benchmark to serve as the essential benefits package of the Arkansas Exchange is an important first step in establishing the certification criteria for participating plans. The decision also poses larger policy implications since federal law requires the essential health benefits package to be the "floor" for coverage in the individual and small group market both inside and outside the Exchange.

Further, the decision has important implications for the alignment and integration of the Arkansas Exchange and Medicaid. Many non-disabled low-income working families may transition with some frequency between Exchange and Medicaid coverage. Benefit alignment may be significant to facilitating continuity of care and assuring that health care benefits do not decrease when household income rises above poverty levels.

2 Guidance on Essential Health Benefits

2.1 ACA Requirements

Section 1302(b)(2) of the Affordable Care Act (ACA) requires that any health insurance plan that is offered to an individual or small business must cover the ten broad categories of services that are listed below. This list applies to plans offered inside and outside of the Exchange and represents the **minimum services that must be covered**. Plans may cover additional services at their own discretion.

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

The ACA required HHS to provide more details on the ten service categories in order to create a comprehensive EHB package. According to the ACA, the EHB package is intended to represent "the scope of benefits provided under a typical employer plan."

Section 1311(d)(3)(B) of the ACA indicates that states may be required to defray the cost of state mandated benefits in excess of the ten benefit categories. Because HHS has not yet issued guidance to specify procedure-level requirements that must be included for a state benchmark to qualify as meeting each broad EHB category, determining if state mandates exceed federal EHB requirements remains open to interpretation.

The State of Arkansas' sixteen mandated benefits are identified in Section 3.1 herein. Of all these mandates, the two that are most likely to be considered in excess of federal requirements are coverage of in-vitro fertilization and applied behavior analysis for autism spectrum disorder.

After receiving input from DOL, IOM, and other stakeholders, HHS released a "benchmark" approach for defining the EHB package. Below is a summary of the input that informed HHS's approach and the key takeaways from this process.

2.2 DOL Recommendations to HHS

The ACA directed DOL to "conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers" and report their results to HHS. In April 2011, DOL submitted to HHS a summary of Bureau of Labor Statistics National Compensation Survey results from 2008 and 2009. This summary included information on coverage and cost sharing by service category across employer plans.

2.3 IOM Recommendations to HHS

In September 2011, IOM submitted their recommendations to HHS on how the process of defining the EHB package should be conducted. Key aspects of their recommendations included the following:

- Start with a typical plan that is offered to *small* employers today.
- Modify it to include the ten EHB categories.
- Refine the package so that the cost meets an affordable "target premium."
- Create a process for updating EHB requirements based on evidence-based practices.
- Allow states the flexibility to create their own EHB packages, as long as they meet the same standards as the federal package.

IOM cautioned that HHS and other federal and state agencies must continue to develop strategies to reduce the growth of health care spending across all sectors to ensure that individual and small group plans will be able to meet affordability standards in future years.

2.4 Additional Input

HHS hosted a number of listening sessions to gain feedback from individuals, providers, state officials, and other parties regarding the content of the EHB package. Additionally, a number of states and organizations submitted letters to HHS advocating for the inclusion of specific benefits as EHB.

2.5 The "Benchmark" Approach

Rather than defining one EHB package that would apply to all states, HHS has published guidance indicating that **each state may choose its own benchmark plan** to act as the EHB for that state. In a December 2011 bulletin, HHS provided four benchmark options from which a state can choose:

- One of the three largest small group plans in the State by enrollment;
- One of the three largest State employee health plans by enrollment;

- One of the three largest federal employee health plan options by enrollment; and
- The largest HMO plan offered in the State's commercial market by enrollment.

For the purpose of choosing its benchmark plan, the Arkansas Plan Management Advisory Committee will need to select from one of the seven insurance plans set out in Section 4 herein.

The CCIIO guidance issued on December 16 made many important points in addition to specifying guidance on how states must choose the essential health benefits of their Exchange.

First, CCIIO noted that the DOL surveys and other information sources revealed little variation among federal, state and small group plans with regard to major categories of benefit coverage such as primary care physician, specialty physician, surgeries and procedures, inpatient and outpatient hospital, routine diagnostic examinations and prescription drug coverage.

CCIIO noted that the major source of variability among American health insurance plans tends to be cost sharing, not the definition of covered benefits. But as state exchanges choose their essential benefits package, cost sharing is out of scope.

The December 16 CCIIO guidance also sought to shed light on the narrow benefit differences that typically exist between federal, state and small group plans in each state. A key reason for this difference is that federal employee plans and self-insured plans are exempt from state mandates. State employee plans are typically self-insured, as is the case in Arkansas.

Using the DOL survey and corroborating sources such as the Kaiser Family Foundation, CCIIO found that many states have passed mandates requiring coverage of applied behavior therapy for autism treatment as well as in-vitro fertilization for infertile couples. This is the case in Arkansas. Federal plans do not provide this coverage. The state employee plan in Arkansas provides coverage for autism treatment but excludes coverage of in-vitro fertilization. The CCIIO guidance went onto say that their market research concluded that coverage of in-vitro fertilization typically raises premiums by about 1% and coverage of applied behavior analysis for autism treatment typically increases premiums by 0.3%.

CCIIO also identified benefits that are included in the national Blue Cross/Blue Shield federal employee health plan that are not included in many state small group plans. These include preventative and basic dental care, acupuncture, bariatric surgery, hearing aids and smoking cessation programs and medications. Table ___ compares the benefit categories CCIIO has identified as being the most likely source of differences among the plans eligible to serve as state benchmarks for essential health benefits.

2.6 Effect on Current Health Plans

Once a state has chosen a benchmark plan, all other plans in the individual and small group markets will be required to offer benefits that are "substantially equal" to the benchmark plan. Plans will have the flexibility to adjust the specific services that are included as part of the benefit, as well as any quantitative limits on certain services, as long as the coverage has the same *value* as the benchmark plan. This is noteworthy because if Arkansas selected the Blue Cross federal employee plan to serve as the Exchange

benchmark, then preventative and basic dental care, acupuncture, bariatric surgery, hearing aids and smoking cessation (or equivalent benefits that have the same value) become mandated benefits for individual and small group plans sold both inside and outside of the Exchange in Arkansas.

2.7 Effect on State Mandates

The ACA requires states to pay for the portion of Exchange premiums that are attributable to state insurance mandates not included in the EHB package. This provision was intended to ensure that federal dollars would not be used to subsidize coverage of state mandates in the Exchange.

However, any small group plan that is currently offered within the state includes all current state insurance mandates. The state plan is self-insured and, therefore, exempt from state insurance mandates. Federal plans are also exempt from state insurance mandates.

By choosing one of the three eligible small group plans to serve as the benchmark for essential health benefits, the Arkansas Exchange will guarantee that no state insurance mandates fall outside of the EHB package. An alternative solution to assuring that the Exchange is not liable for the cost of benefits in excess of federal EHB requirements is to enact legislation eliminating those state mandates. If Arkansas chooses a federal plan that does not include applied behavior analysis for autism or in-vitro fertilization, the Exchange will be liable for about 1.3% of premium costs for its plans.

HHS added that, while a state plan will likely remain a benchmark option through 2015; future updates to the benchmark may eliminate that possibility. Thus, states are encouraged to continually monitor the necessity and effectiveness of their current state mandates.

2.8 Updating the Benchmark

HHS expects to formally propose that EHB benchmark options be updated in the future to ensure that benefits reflect the most current and appropriate medical practices and insurance market practices. The schedule and scope of those updates has yet to be released, but will require carefully balancing the desire for innovation with the need for stability and reliability.

3 Mandated Benefits

3.1 Essential Health Benefits Mandated by the ACA

Section 1302(b)(1) of the Affordable Care Act (ACA) provides that EHB packages include items and services within the following ten benefit categories:

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity and Newborn Care
5. Mental Health and Substance Use Disorder Services (including Behavioral Health Treatment)
6. Prescription Drugs
7. Rehabilitative and Habilitative Services and Devices
8. Laboratory Services
9. Preventive and Wellness Services and Chronic Disease Management
10. Pediatric Services (including Oral and Vision Care)

The ACA and federal guidance issued to date do not define the parameters of the ten categories beyond the categorical framework provided above.

3.2 Health Insurance Benefits Mandated by Arkansas State Law

Arkansas law mandates service coverage for 16 types of treatment that are defined in each of the applicable State statutory provisions. Arkansas' statutory provisions do not reference EHB categories (most State mandates preceded the ACA). The State statutory provisions often reference diagnostic categories or conditions and related treatment that might occur as part of several EHB categories, such as emergency services, hospitalization, ambulatory services, and rehabilitative services. Arkansas' mandates pertain to:

- Autism spectrum disorders;
- Breast reconstruction/mastectomy;
- Children's preventative healthcare;
- Colorectal cancer screening;

- Dental general anesthesia for individuals with a physical or mental condition that prevents the effective use of local anesthesia;
- Diabetic supplies/education;
- Inclusion of contraceptives if an outpatient prescription drug benefit is offered;
- Medically necessary foods, formula for PKU and low-protein modified food products;
- Gastric pacemakers;
- In-vitro fertilization;
- Treatment of loss or impairment of speech or hearing;
- A minimum stay in hospital in connection with childbirth;
- Coverage of mental health treatment in parity with physical health treatment;
- Coverage of prescription drugs to treat cancer that have not been FDA approved for treatment of that specific cancer type.
- Coverage of orthotic or prosthetic devices or services;

Of the 16 treatments mandated by Arkansas state law, two others besides in-vitro fertilization and autism spectrum may be interpreted by the Arkansas Division of Insurance and CMS to require a degree of coverage that is not required under the ACA. They are 1) coverage of gastric pacemakers, 2) coverage of general anesthesia for dental procedures in cases where a physical or mental health condition precludes use of local anesthesia. However, a final interpretation on this is unclear. If these benefits are interpreted to exceed federal requirements, the State may also be required to pay for the portion of health insurance exchange premiums that are attributable to State insurance mandates that exceed the minimum requirements under the ACA.

If the State wants to avoid any liability for health insurance exchange premiums, the Arkansas Division of Insurance (as the authority having jurisdiction over the interpretation and enforcement of the State mandates) could stipulate that it does not intend to interpret any of the State mandates as requiring coverage that would not be required as part of an EHB under the ACA. This interpretation could be subject to legal challenge.

Alternatively, Arkansas State law could be amended to include such an across-the-board stipulation. Finally, the Arkansas Legislature could choose to delete State mandates that exceed the minimum requirements under the ACA.

4 Analysis of Health Benefit Plans

This section summarizes the benefit descriptions submitted to the Arkansas Division of Insurance with respect to a total of seven plans. The benefit descriptions submitted by the plans to the Arkansas Division of Insurance are attached hereto as Appendices A through G. The extent to which each plan covers EHB items or services mandated by the ACA is listed herein in Section 4.

4.1 Small Group Plans

The three largest small group insurance products in Arkansas are as follows:

1. Qual Choice Point of Service (POS);
2. Health Advantage Open Access Point of Service (POS); and
3. Blue Cross/Blue Shield Comprehensive Major Medical PPO.

4.2 State Employee Plans

The state employee health benefit plans in Arkansas is as follows:

1. AR Benefits for State and Public School Employee Plan

4.3 Federal Employee Plans

Listed are the three largest federal employee health benefit plans in Arkansas:

1. Blue Cross/Blue Shield FEHP Standard Option
2. Blue Cross/Blue Shield FEHP Basic Option
3. Qual Choice POS

4.4 HMO Plan

According to the Arkansas Insurance Department, Arkansas is an "any willing provider" state that has no health maintenance organizations that restrict networks and provide no out of network care. Health Advantage provides HMO coverage under the state and public school employee plan, which is the same benefit package already identified under "state employee plan." Therefore, the fourth category of options available to states in selecting their essential health benefits provides no additional option for Arkansas.

The table prepared and included on the pages that follow this narrative assess the benefits covered under the seven plans eligible to serve as EHB benchmarks to determine 1) their compliance with the ten federally required EHB categories, and 2) compliance with state benchmarks. A separate table is provided

that compares the narrow set of benefits most likely to vary among the seven plans, according to CCIIO analysis.

5 Arkansas EHB Benchmark Options and Key Considerations

Option 1: Blue Cross/Blue Shield Comprehensive Major Medical PPO (Small Group)

- The pediatric dental and vision benefits under this plan may not be robust enough to meet federal minimum requirements. Therefore, this plan may require an adjustment to add pediatric dental and vision benefits if it is selected.
- This plan does not cover smoking cessation services, which may be required under the federal category of "prevention and wellness services," though these remains open to interpretation.
- This plan does not cover, adult dental, chiropractic care, weight loss programs, hearing aids and acupuncture for use as anesthesia.
- This plan covers all state mandates.

Option 2: Health Advantage Open Access POS (Small Group)

- The pediatric dental and vision benefits under this plan may not be robust enough to meet federal minimum requirements. Therefore, this plan may require an adjustment to add pediatric dental and vision benefits if it is selected.
- This plan does not cover smoking cessation services, which may be required under the federal category of "prevention and wellness services," though these remains open to interpretation.
- This plan does not cover adult dental, weight loss programs, hearing aids, bariatric surgery and acupuncture for use as anesthesia.
- This plan covers all state mandates.

Option 3: Qual Choice POS (Small Group)

- The pediatric dental and vision benefits under this plan will likely not be robust enough to meet federal minimum requirements. Therefore, this plan will likely require an adjustment to add pediatric dental and vision benefits if it is selected.
- This plan does not cover smoking cessation services, which may be required under the federal category of "prevention and wellness services," though these remains open to interpretation.
- This plan does not cover adult dental, weight loss, bariatric surgery, and acupuncture as anesthesia.
- This plan covers all state mandates.

Option 4: Federal Employee Blue Cross/Blue Shield Standard Option

- This plan does not cover two state mandated benefits – in vitro fertilization and applied behavior analysis for autism spectrum disorder.
- This plan covers benefits that are not covered by some or all of the state small group plans, including adult dental, chiropractic, smoking cessation, bariatric surgery, hearing aids and acupuncture as anesthesia.

Option 5: Federal Employee Blue Cross/Blue Shield Basic Option

- In general, the Basic option is distinguished from the Standard option by benefit limitations, not categorical inclusion or exclusion of benefits.
- Skilled nursing facility coverage is not covered under this plan. The federal standard option covers skilled nursing for those enrolled in Medicare Part A.
- This plan does not cover two state mandated benefits – in vitro fertilization and applied behavior analysis for autism spectrum disorder.
- This plan covers benefits that are not covered by some or all of the state small group plans, including adult dental, chiropractic, smoking cessation, bariatric surgery, hearing aids and acupuncture as anesthesia.

Option 6: QualChoice Federal Plan

- Dental coverage under this plan is significantly more limited to the two other federal plans and would likely need to be supplemented to meet federal ACA requirements.
- This plan does not cover two state mandated benefits – in vitro fertilization and applied behavior analysis for autism spectrum disorder.
- This plan covers benefits that are not covered by some or all of the state small group plans, including chiropractic, smoking cessation, bariatric surgery, hearing aids and acupuncture as anesthesia.

Option 7: ARBenefits State and Public School Employee Plan

- Dental benefits under this plan are significantly limited. If this plan is chosen as the state benchmark, supplemental dental benefits would need to be added to the schedule of benefits.
- This plan does not cover one state benefit – in vitro fertilization.
- Among variable benefit categories, the state employee plan generally covers more than the small group plans but less than the federal plans. Acupuncture as anesthesia is not covered. Only

smoking cessation medications are covered. Bariatric surgery is only available through a pilot program.

The Plan Management Advisory Committee may wish to consider action on essential health benefits as two decision points.

1) ***Should the Arkansas Exchange select a small group plan or a federal/state group plan as its benchmark?***

   a) Select Small Group Plan – This choice assures that the Exchange will not bear the cost of state benefit mandates in excess of federal requirements. Because the small group plans have slightly fewer optional benefits than the federal or state plans, lower premium costs are likely to result, though given the modest nature of the benefit differences, these premium differences may only be in the range of 1% to 3%, based on information from CCIIO and the Department of Labor.

   b) Select Federal Employee or State Employee Group Plan – In general, a reason for selecting one of the non-small group plans as the state benchmark would be to enhance the benefit package offered inside the Exchange for select benefits such as smoking cessation, bariatric surgery, hearing aids, chiropractic and acupuncture as anesthesia. These added benefits would slightly increase premium costs. The federal plans also do not cover in-vitro fertilization. Because this is a state mandate, this benefit would either need to be added to the EHB or the state mandate would have to be ended.

2) ***If a small group plan is chosen, which one should it be?***

   Once dental benefits are adjusted to comply with federal requirements, benefit differences among these three plans will be minimal. BCBS PPO does not cover chiropractic care while the other two plans do, but BCBS PPO covers bariatric surgery, while the other two plans do not. Health Advantage Open Access PPO does not cover midwife services for maternity care, while the other two plans do. Given these small differences, Arkansas could choose to pick the small group plan with the highest enrollment in the state to align care with what most residents currently have.

3) ***If a Federal/State Employee Group Plan is Chosen, which one should it be?***

   Choosing the state employee plan would minimize the Exchange's potential cost exposure for autism spectrum services, since they would be part of the essential benefits package. Neither the state or federal plans cover in-vitro fertilization, but the federal plans also do not cost autism spectrum disorder treatment. In general, the federal plan has a few more optional benefits than the state employee plan, such as broader coverage for smoking cessation and bariatric surgery.

The Advisory Committee will review these decision points at its meeting next Friday, May 4