

*Defining Essential Health Benefits  
For Arkansas' Federally Facilitated  
Health Benefits Exchange*

*May 29, 2012*

# 1 Introduction

The purpose of this document is to provide the Arkansas Plan Management Advisory Committee and Health Benefit Exchange Steering Committee with information to assist in recommending a plan to serve as the benchmark for the essential health benefits package for the Federally Facilitated Partnership Exchange (FFE).

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 Exchange will be considered.

Several plan design components are out of scope in selecting essential health benefits, most notably member cost sharing provisions.. 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 Federally Facilitated Partnership 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, for any plan that would satisfy the individual mandate.

Further, the decision is a starting point in any effort that may eventually be made to align and integrate the Exchange and Medicaid. Many non-disabled low-income working families may transition 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 any plan offered inside and outside of the Exchange that is being purchased to satisfy the individual mandate 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 Attachment 2. Of all these mandates, the two that are likely to be considered by the federal government to be in excess of federal requirements are coverage of in-vitro fertilization and applied behavior analysis for autism spectrum disorder.

However, the Arkansas state mandate for autism treatment was enacted following passage of the Affordable Care Act, and it includes language to exempt the Exchange plans from the requirement if the requirement is not specified as an “essential health benefit.” The language reads thus:

i) On and after January 1, 2014:

(1) To the extent that this section requires benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered by a health care insurer in this state through the state medical exchange; and

(2) This section continues to apply to plans offered outside the state medical exchange.

The language in item (1) does not appear to have anticipated that the federal government would establish a process that allows each state to choose their own essential health benefits package from an existing state benchmark. In this way, if Arkansas chooses a benchmark that includes the autism mandate, that mandate will be considered an essential health benefit specified in section 1302(b) of PPACA. That appears to be the case unless the Arkansas state legislature moves to reverse the autism mandate.

Item (2) seems to contradict the federal emphasis on benefit parity among plans being offered inside and outside of the Exchange.

HMOs are exempt from the in-vitro fertilization mandate in Arkansas. If a plan that includes the IVF mandate is selected as the benchmark, then all plans sold in the small group and individual market that can be enrolled in to satisfy the individual mandate must include IVF, including the HMO plans.

However, if a plan that does not include IVF as a benchmark is selected, the cost of IVF coverage in those plans that still must include IVF must be paid by the state.

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 on to 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 1 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 that qualify to satisfy 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 and hearing aids (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.

The incremental cost of individual coverage mandates is typically far less than 1% of premium costs, but in vitro fertilization has proven to be a more expensive mandate according to Arkansas carriers. The mandate is estimated to add 1% to premium costs in part due to the multiple births that treatments may generate. Assuming the Arkansas Insurance Department's 2011 actuarial estimate of 113,000 Exchange participants in 2014 at a monthly premium rate of \$400, a 1% increment would come with an annual cost of \$5.4 million.

The mandate's \$15,000 coverage limit may counter cost control efforts in this area since lower cost treatments may result in higher risk of multiple births. Strategies to contain the cost of in-vitro fertilization in the context of an essential health benefits package may include removing the dollar limit and requiring treatments that involve single-embryo attempts.

The cost of the autism treatment mandate is estimated to be similar or more expensive than in-vitro fertilization according to Arkansas insurance carriers. Given the entry of more applied behavioral analysis providers into the market, the cost of care may result in a premium increment of up to 2%.

The state plan is self-insured and, therefore, exempt from state insurance mandates. Federal plans are also exempt from state insurance mandates.

It should also be noted that HMOs are exempt from the in-vitro fertilization mandate. Therefore, if an HMO small group plan is chosen as the benchmark, HMOs will continue to be exempt. However, if a PPO plan is chosen as the benchmark, both PPO and HMO plans will be subject to the IVF mandate.

## **2.8 Updating the Benchmark**

The federal Department of Health and Human Services has added that, while a state plan will likely remain a benchmark option through 2015; future updates to the benchmark may eliminate that possibility. 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.

## **2.9 Coordination of Exchange and Medicaid Benefits**

For low-income Arkansas families who are not qualifying for health care assistance on the basis of disability, Medicaid and Exchange tax credits will combine to create a single spectrum of coverage for those without employer-sponsored medical benefits and whose incomes are up to four times the federal poverty level (FPL)

Within this spectrum, Medicaid will cover parents with incomes up to 138% of FPL, inclusive of a 5% income disregard. Under new eligibility rules that take effect in 2014, income will be measured according to a tax-code methodology known as "modified adjusted gross income," or MAGI.

Coverage in ARKids will continue to be available for children up to 200% of FPL. Federal maintenance of effort (MOE) provisions of the Affordable Care Act require continuation of ARKids eligibility using

federal Children’s Health Insurance Program (CHIP) funds (which are matched with Arkansas state funds) at this level.

One important health policy consideration in designing essential health benefits for the Arkansas Exchange will be continuity of care for families whose income fluctuates across the boundaries of Medicaid, ARKids and Exchange premium tax credit income guidelines. Nationally, this issue of “churning” is receiving considerable attention because millions of families will see their income fluctuate in ways that trigger these eligibility changes, and subsequently, trigger potential changes in medical benefits that may or may not coordinate.

The continuity of care issues facing Arkansas are unique because Medicaid and ARKids coverage is delivered through a fee-for-service model. While most states cover some portion of their Medicaid family enrollment through managed care plans, Arkansas is one of the only states that does not. Therefore, family income fluctuations in Arkansas may trigger changes that impact coverage of very specific medical benefit categories such as prescription drugs. Some Medicaid benefits are prescribed as mandatory under federal law, with states having the flexibility to add optional service categories. Mandatory Medicaid benefits are as follows:

### **Mandatory Medicaid Benefits**

#### **Clinics and Programs**

FQHC Core Services

Rural Health Clinics

Maternity Clinic

#### **Dental Services**

Oral Surgery Dentist (ADA Codes)

Oral Surgery Physicians

FQHC Dental

#### **EPSDT**

EPSDT Screening

EPSDT Immunizations

**Family Planning** (Not Prescription Drugs)

FP All Aid Cat, 90/10 Match

Family Planning Physician

Family Planning Clinics

FP Not Aid Cat 69 90/10 Match

Family Planning FQHC

Family Planning RHC

Family Planning Nurse Practitioner

Outpatient Hospital Family Planning

#### **Inpatient Hospital**

Inpatient Acute Care

Pediatric Inpatient

Inpatient AR Teaching

Critical Access Hospitals INP MED

Rural Inpatient

#### **Long Term Care** (See note below.)

ICF/INF/E.S.

Private SNF

Public ICF Mentally Retarded

Public SNF

#### **Other Care Services**

Home Health Services

#### **Other Practitioners**

Nurse Practitioner

Nurse Midwife

#### **Outpatient Hospital**

Outpatient Hospital

Pediatric Outpatient Hospital

Outpatient Teaching Hospital

Critical Access Hospitals OUT MED

#### **Physician Services**

Physician Services

Surgery

Maternity/Physician program cost

Ophthalmologist medical

Ophthalmologist

Prof Inpatient AR Teaching Hospital

#### **Prescription Drugs**

Family Planning Drugs

#### **Transportation**

Ambulance

NET Managed Care Waiver

**Lab and X-Ray**  
Radiologist  
Independent Lab  
Independent X-ray  
Pathologist

Non-Public Transportation  
Nonprofit Transportation  
FQHC Transportation

Below is a listing of optional Medicaid services by benefit category. Attached to this, Table 4 provides a comparative analysis of the major Medicaid benefit categories and how they compare to similar benefit categories offered in the small group plans that have the most membership in the Arkansas insurance market:

### **Optional Medicaid Benefits**

#### **Aging and Disability Services**

ElderChoices Waiver  
AAPD Attendant Care  
AAPD Environmental Adaptations  
AAPD Agency Attendant Care, Co Employer  
AAPD Counseling Case Management  
IndependentChoices  
DDS Alternative Com Service Waiver  
PACE

#### **Behavioral Health**

Mental Hospital Services - aged  
Community Mental Health (RSPMI)

#### **Case Management**

CSMT Age 60 and Older  
CSMT Age 21-59 with Developmental Disability

#### **Clinics and Programs**

Health Dept Communicable Disease  
ARKIDS - Immunology  
Ambulatory Surgical Centers

#### **Family Planning** (Not Prescription Drugs)

Family Planning Waiver  
FP Aid Cat 69, 75/25 Prof  
OP FP, All Aid Cat  
FP Aid Cat 69, 75/25 OP  
Family Planning Waiver RHC

#### **Long Term Care**

Assisted Living Agency  
Assisted Living Facility  
Assisted Living Pharmacy Consultant

#### **Other Care Services**

Durable Medical Equipment/Oxygen  
Eyeglasses  
Hemodialysis  
Hyperalimentation  
Ventilator  
Tuberculosis  
Vaccine administered in pharmacy  
Personal Care Services  
Nursing Home Hospice  
Hospice  
Private Duty Nursing Services

#### **Other Practitioners**

Optometrist/Ocularist  
CRNA  
Chiropractor

#### **Outpatient Hospital**

Outpatient Rehab  
Outpatient Transplant

#### **Physician Services**

Physician Transplant Services  
Managed Care Fees

#### **Prescription Drugs**

Prescription Services

Family Planning Waiver Other Facilities  
**Inpatient Hospital**  
Inpatient Transplant  
Inpatient Rehab

Separately, Medicaid includes coverage requirements for children through a federal program called Early Periodic Screening, Diagnostic and Treatment Services. These services are built into ARKids coverage in Arkansas, thereby giving those children enrolled in ARKids broad access to preventative coverage for developmental screening services. The Affordable Care Act also strengthened preventative coverage effective September 23, 2010:

**Additional Benefits Age < 21**

**Aging and Disability Services**

RSPD Residential Rehab Center  
RSPD Extended Rehab Services  
Developmental Rehab Services

**Behavioral Health**

Inpatient Psychiatric for Under Age 21  
School-Based Mental Health Services  
DYS Rehab Services  
Sexual Offender Program

**Case Management**

Case Management CMS  
TCM/DYS  
Targeted Case Management

Case Management DCFS

**Clinics and Programs**

Therapy Individual/Regular Group  
Therapy School District/Esc Group  
Developmental Day Treatment Clinic

**Dental Services**

Dental Services  
Dental Services EPSDT

**EPSDT**

EPSDT Prosthetic Device  
EPSDT Orthotic Appliances  
EPSDT DMS Expansion  
EPSDT Podiatry  
EPSDT Psychology Services

**Other Care Services**

Hearing Aid  
Private Duty Nursing EPSDT

**Other Practitioners**

Audiologist  
Licensed Mental Health Provider

### **3 Benefit Coordination and Essential Health Benefits**

Arkansas Medicaid benefits vary by eligibility category. Higher benefit levels are provided to children living in families with incomes below 133% of poverty (ARKids A) as well as for the elderly and disabled. Benefits are more restrictive for higher income children (ARKids B). Benefits are particularly restricted for parents who qualify on the basis of eligibility for Temporary Assistance to Needy Families (TANF) and transitional Medicaid. In general, the most comprehensive Medicaid benefit plans, especially those for children enrolled in ARKids A, is richer than the small group benchmark plans eligible to be used to establish essential health benefits for Arkansas' federal partnership Exchange. This is not the case, however, for the most restrictive Medicaid benefit plans.

When Medicaid eligibility expands in Arkansas in 2014 due to the requirements of the Affordable Care Act, states will be required to provide the "newly eligible" Medicaid enrollees with access to the same broad categories of "essential health benefits" that are outlined in federal law as being required to be included in Exchange qualified health plans. However, this does not mean that Medicaid must adopt the same essential health benefits benchmark that will be used to certify health plans in the Exchange. If Medicaid wishes to adopt a more restrictive benefit schedule for "newly eligibles" than benefits currently provided to children or the elderly and disabled, Medicaid could do so under benchmark plan authority that was first enacted in the Deficit Reduction Act of 2005.

Further, the current decision on alignment of Arkansas essential health benefits to a state benchmark only commences the process of issuers developing plan products that will be distinguished according to the "metal levels" and will include a variety of schedules and cost sharing that will coordinate with Medicaid to more or less degrees.

While Medicaid and Exchange coordination is an important continuity of care issue for those individuals who will be moving back and forth across the boundary of these programs in 2014 and beyond, establishing policies to effectuate this coordination are more relevant to the next phase of qualified health plan certification criteria development, which considers quality and other health policy requirements the Exchange could impose on issuers as a condition of participating in the Exchange. These may include the design of "Medicaid bridge" plans which are created with the specific intent of appealing to consumers who self-assess a high risk of frequent transition between the Exchange and Medicaid and are seeking a plan that best anticipates the continuity of care issues that would entail.

Arkansas Medicaid may also choose to establish coverage models and standards that better align with the Exchange, such as establishing new or different roles for plans or primary case management. Coordination with Medicaid will continue to be explored in future plan management issue briefs.

## **4 Mandated Benefits**

### **4.1 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.

### **4.2 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), except for the autism mandate. 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;

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.

The following pages begin to describe specific details about coverage in each of the seven plans eligible to serve as the Arkansas benchmark.

## **5 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.

### **5.1 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.

### **5.2 State Employee Plans**

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

1. AR Benefits for State and Public School Employee Plan

### **5.3 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

### **5.4 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)**

- This plan provides a \$15,000 lifetime maximum benefit for in-vitro fertilization in compliance with the state mandate.
- This plan provides applied behavioral analysis (ABA) for treatment of autism up to a maximum of \$50,000 per year.
- 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, 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)**

- This plan is exempt from the in vitro fertilization state mandate and does not cover that service.
- 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 adult dental, weight loss programs, hearing aids, bariatric surgery and acupuncture for use as anesthesia.

### **Option 3: Qual Choice POS (Small Group)**

- This plan is exempt from the in vitro fertilization state mandate and does not cover that service.
- 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 adult dental, weight loss, bariatric surgery, and acupuncture as anesthesia.

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

- A comprehensive adult and pediatric dental benefit is included with this plan.
- 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, bariatric surgery, hearing aids and acupuncture as anesthesia.
- Coverage of therapies is broader than the small group plans.

#### **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 chiropractic, bariatric surgery, hearing aids and acupuncture as anesthesia.
- Comprehensive adult and pediatric dental is offered.

#### **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, bariatric surgery, hearing aids and acupuncture as anesthesia.
- The scope of therapies coverage is broader than the small group plans.

#### **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.

- Autism services are covered.
- 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. Bariatric surgery is only available through a pilot program.
- Coverage of therapies is broader in scope than the small group plans.

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

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

- a) Select Small Group Plan – 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 bariatric surgery, hearing aids, chiropractic and acupuncture as anesthesia. These added benefits would 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. The scope of benefits covered under the federal plan are higher than the small group plans, such that “substantially equivalent” benefits would be richer (and more expensive) than a small group benchmark.

**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 limited to a few key categories. The BCBS PPO plan is not exempt from any of the state mandates and, therefore, provides coverage for in-vitro fertilization where the POS plans only provide infertility diagnostic coverage. The Health Advantage and Qual Choice plans do not. 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. The BCBS PPO plan is the small group plan with the highest enrollment in the state. An argument for selecting the POS plan is to not extend the IVF mandate to HMO plans in the small and individual group markets.

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

Neither the state or federal plans cover in-vitro fertilization, but the federal plans also do not cover autism spectrum disorder treatment. In general, the federal plan has more optional benefits than the state employee plan, such as coverage for adult dental and bariatric surgery.

### **Supplementing the Selected Benchmark**

At its recent “gate review” staff of the Arkansas Federally Facilitated Health Benefits Exchange asked staff of CCIIO to clarify the process for benefits supplementation once the selected benchmark is selected. CCIIO has requested that Arkansas identify its preferred process, though informal federal guidance has suggested that Arkansas would need to look to benefits included in other eligible benchmarks and could not supplement above the federal minimum standards without accepting state liability for the cost of benefits in excess of the federal minimum.

CCIIO indicated that the dental or vision benefit schedule included in stand-alone plans were not eligible to serve as a supplemental benchmark, though stand-alone plans must be allowed to be offered in the Exchange.

CCIIO also generally expressed doubt that Arkansas could get too granular in its supplementation process, indicating that “essential health benefits” define broad categories of coverage that allow plans to innovate with “substantially equivalent” approaches.

On May 11, the Arkansas Plan Management Advisory Committee met. A motion was made at the meeting to adopt the Blue Cross Blue Shield PPO small group plan as the state’s essential health benefits benchmark. On an initial voice vote, the motion was supported by 15 attending advisory committee members and opposed by 2 attending committee members. In a dissenting opinion, those opposing indicated that the Advisory Committee should not enact a benefit standard that contradicts legislative action. Specifically, the opponents do not believe the committee should require HMO plans to cover in-vitro fertilization when the Legislature specifically exempted HMOs from this requirement.

The following week, the motion carried on an electronic vote of 16 in favor and 11 opposed.

On May 25, Arkansas’ Federally Facilitated Partnership Exchange Steering Committee moved to recommend to the Insurance Commissioner that he adopt any one of the three small group plans as the essential health benefits benchmark. This motion passed with one opposing vote.

As of May 29, the issue now goes before the Arkansas Insurance Commissioner for final consideration.