CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Memorandum:
Regarding Essential Health Benefits Bulletin

Below are a set of questions regarding the December 16, 2011, Essential Health Benefits Bulletin[1] from the Center for Consumer Information and Insurance Oversight (CCIIO). The California Health Benefits Review Program (CHBRP), a program established in 2002, responds to requests from the California State Legislature for independent evidence-based analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. Additional information about CHBRP's scope and analytic methods is available via the web.[2]

CHBRP is preparing to meet its legislative charge for analysis during the next few legislative cycles. To do so, faculty and staff have reviewed the bulletin closely, hoping to be able to inform the California Legislature about potential interaction between state bills' proposed mandates (or repeals) and the federal Affordable Care Act.[3] Because CHBRP's role requires neutrality, below is a set of clarifying questions, rather than comments. CHBRP's purpose is to be able to correctly interpret the bulletin and forthcoming guidance in support of our analysis, not to guide any decisions. We hope that future guidance and regulations will answer the following questions we have posed.

The questions are divided into three sections, each dealing with an action (or set of actions) that will be influenced by the final guidance on essential health benefits (EHBs):

- establishing a benchmark plan
- creating qualified health plans
- defraying the cost of state requirements that exceed EHBs

ESTABLISHING A BENCHMARK PLAN

The bulletin (p.9) suggests that states may select a single benchmark plan to serve as the EHB standard. The bulletin notes (p.10) that modifications may need to be made if the selected benchmark plan does not cover all 10 EHB categories and suggests that the supplemental benefits that address any omitted EHB category be drawn from other benchmark plan options.

1. Which state-level entity (or entities) will initially select the benchmark plan, determine whether it needs to be supplemented, and select the supplemental benefits to address any omitted EHB category? Would state legislatures vote or would executive agencies decide? Will a federal entity need to review and concur? If so, will timelines be established for federal review?
2. Will other benchmark plan options be the only source of supplemental benefit definitions? Must a state identify the benchmark options, then construct the final benchmark only from the benefits described by one or more of those benchmark option plans?
3. Is there any limit as to how often the state may change or update its benchmark plan?

[1] Available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
[2] Available at www.chbrp.org
[3] The 2010 Patient Protection and Affordable Care Act (P.L.111-148) and the 2010 Health Care and Education Reconciliation Act (H.R.4872) are referred to here as the Affordable Care Act (ACA).

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The bulletin (p.9) describes four types of benchmark plan options and gives the HealthCare.gov definition of products and plans, noting that multiple "plans" with different cost-sharing structures and rider options may derive from a single "product."

4. To aid in the identification of benchmark plan options, please provide further definition or hierarchy clarification for "products," "plans," "cost-sharing options," and "riders."
    a. If products are sets of covered services, how can plans be cost-sharing subsets of products with varying rider options? If an issuer offers a health plan contract with durable medical equipment (DME) coverage as an optional rider, the set of services would differ, depending on whether or not the rider was purchased. In this example, would there be two products or two plans?
    b. In terms of the cost-sharing variations that would differentiate the "plans" that are "benchmark plan" options, might additional guidance be offered? HealthCare.gov defines cost-sharing as "The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums." This definition does not capture all possible forms of cost-sharing.
        i. In defining "plans" that may be benchmark options, would variation in additional benefit coverage terms that *explicitly* reference enrollee costs (annual dollar limits) create different plans? If so, would enrollment counts need to be subdivided among these plans in order to establish which is the largest, and therefore the potential benchmark plan? For example, would enrollee counts need to be divided between a plan with an annual dollar limit and a plan *without such a limit* in order to establish a benchmark plan option?
        ii. Similarly, would variation in any additional benefit coverage terms that *only implicitly* reference enrollee costs (such as visit number or frequency limits or age limits, which imply 100% cost-sharing in specified circumstances) create different plans and so potentially impact enrollment counts? For example, would enrollee counts need to be divided between a plan that specifies visit or frequency limits and a plan *without such limits* in order to establish a benchmark plan option?

The first type of benchmark plan option suggested by the bulletin is "the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market."

5. If an issuer has one of the state's largest small group products (by enrollment) but has derived many plans from that product – assuming that for the enrollment count enrollees must share *identical* service packages and *identical* cost-sharing terms – might the largest plan in the largest product contain relatively few enrollees?

The second type of benchmark plan option is "any of the largest three state employee health benefit plans by enrollment."

6. State employee health benefit plans may enroll a variety of persons, including active state employees and their dependents, other public (county, city) employees and their dependents, quasi-public (university) employees – as well as retired employees from any or all of these categories. For enrollment counts that define a benchmark plan option, are only active state employees and their dependants to be counted?

7. Could a self-insured state employee health benefit plan (which would not be subject to any state-level benefit mandates) be selected as the benchmark plan (if it meets the enrollment criteria)?

The third type of benchmark plan option is "any of the largest three national FEHBP plan options by enrollment."

8. For enrollment, are only active federal employees and their dependants to be counted? Would federal retirees utilizing the FEHBP plan as primary health insurance be counted?
9. Does the adjective "national" mean that only FEHBP plan options that are available in all states are possible benchmark plan options?
10. Is the enrollment count for FEHBP plan options to be limited to enrollees residing in the state? Or is it to be a national count, including all eligible federal enrollees?

The fourth type of benchmark plan option is "the largest insured commercial non-Medicaid Health Maintenance Organizations (HMO) operating in the state."

11. Is the HMO a product or a plan?
12. Whether the HMO is a product or a plan, if many issuers have derived many products from HMOs and/or many plans from HMO products – assuming that for the enrollment count enrollees must share *identical* service packages and *identical* cost-sharing terms – might the largest HMO product/plan contain relatively few enrollees? If many derivations are present in the large group market but few in the small group market, might the largest HMO product/plan (by enrollment) be a small group market product/plan?

The bulletin notes (p.9) that enrollment counts to identify benchmark plan options will be based on the first quarter of the year, two years prior to the coverage year. Therefore counts from the first quarter of 2012 would determine which could be the 2014 benchmark plan options.

13. Would the benchmark plan options' benefit coverage and cost-sharing provisions be "set" as of the first quarter 2012? Would changes to plans' benefit coverage or cost-sharing after the end of the first quarter be disregarded in terms of defining the benchmark plan?
14. If a state has an enacted mandate that is scheduled to be in effect for the benchmark plan after the first quarter of 2012, would the mandate be considered "grandfathered"? Or, will there be a review process to consider such situations?

CREATING QUALIFIED HEALTH PLANS

The bulletin mentions (p.8) that the benchmark plan would be the reference for both "scope of services" and "any limits." The bulletin also mentions (p.9) that "issuers could adopt the scope of services and limits of the state benchmark or vary it."

15. What are the definitions of "scope" and "limits?" Does either definition interact with cost-sharing?
16. If decisions around scope and services fall initially to issuers, what entities will need to review and concur? If initial review is at the state level, will HHS or some other federal entity also need to review and concur? If so, will timelines be established for review?

The bulletin notes (p.11) that as a transitional approach to covering habilitative services "plans might decide as to which habilitative services to cover and report to HHS."

17. Please confirm: as used in this instance "plans" are issuers.
18. In such an approach, what would be the roles of state-level entities (such as regulators, exchanges, legislatures)? Prior to a decision being made at the federal level, would plans be expected to comply with state-level requirements or would state-level requirements be inoperative until federal guidance is issued?

The bulletin (p.7) notes that Mercer found "widespread coverage of prescription drugs," probably meaning that most enrollees have an outpatient pharmacy benefit (OPB). Prescription drugs may be covered under what is referred to as a "medical benefit" when bundled into hospital or provider office visits. Alternatively, prescription drugs delivered through a pharmacy on an outpatient basis are frequently covered under what is referred to as an OPB. All health insurance provides coverage for prescription drugs consumed during a hospital stay but some health insurance has no OPB. The lack of an OPB restricts an enrollee's prescription drug coverage – but does not eliminate it, since drugs bundled into a hospital stay or provider office visit are still covered.

19. Please confirm: prescription drug coverage as an EHB category should be understood as inclusive of an OPB.

DEFRAYING COSTS OF STATE REQUIREMENTS IN EXCESS OF ESSENTIAL HEALTH BENEFITS

The bulletin discusses (p.9) states being required to defray the cost of benefits required of plans and policies sold via an exchange that are in excess of EHBs.

20. Will states be required to defray the cost of benefit excesses required by regulation as well as by law? Although health insurance benefit mandates are usually discussed in terms of statutes, regulation may also place benefit-related requirements on some or all plans or policies in some or all markets (large group, small group, individual).
21. By what criteria will a state-level benefit requirement be determined to be equivalent to or in excess of EHBs?
22. Which entity will initially determine whether a state-level benefit requirement is in excess of EHBs? If initial determination is at the state level, will HHS or some other federal entity need to review and concur? If so, will timelines be established for review?
23. How will a state's fiscal responsibility for a requirement in excess of EHBs be calculated? Which entity will initially calculate fiscal responsibility? If initial calculation is to be at the state level, will HHS or some other federal entity need to review and concur? If so, will timelines be established for review?
24. When will guidance in regards to determining excess and calculating fiscal responsibility be available? Are states expected to establish a benchmark plan in advance of receiving guidance in regards to determining excess and calculating fiscal responsibility? Because regulations and statutes are frequently applicable only to particular markets (large group, small group, individual) or exempt particular purchasers (states purchasing for employees, etc.), the designation of a benchmark plan is likely to "grandfather in" some but not all benefit-relevant regulations and statutes. Might states be in the position of choosing a benchmark plan that "grandfathers in" one mandate but not another without knowing the state's potential fiscal responsibility?

The bulletin mentions (p.10) a 2016 evaluation that may lead to exclusion of some state-level mandates from the EHB package.

25. Might the evaluation lead to a more standardized definition of EHBs that would eliminate the grandfathered inclusion of some state-level mandates?
26. Alternatively, might the evaluation lead to explicit exclusion of some benefit mandates (or types of mandates), regardless of prior inclusion due to state-designated benchmark plans?