Essential Health Benefits and State Mandates

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Milliman Healthcare Symposium
October 26, 2012

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HEALTH BENEFITS REVIEW PROGRAM

Outline

- How are states selecting their benchmark plans, thus defining their essential health benefits (EHBs) for 2014 and 2015?
- How are existing state mandates influencing states' decisions?
- What about post 2016?

Guidance on Benchmark Plans

- Department of Health and Human Services' (HHS) Center for Consumer Information and Insurance Oversight (CCIO) EHB bulletin, Dec. 2011
- Benchmark plans for:
  - Medicaid
  - Individual market, inside and outside exchange
  - Small group market, inside and outside exchange

Benchmark Plan Options: 10 possibilities

- Largest 3 small group products
- Largest 3 state employee health benefit plans
- Largest 3 national Federal Employee Health Benefit Plan options
- Largest insured commercial non-Medicaid HMO operating in the state

Essential Health Benefits

- Ten categories:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health
  - Prescription drugs
  - Laboratory services
  - Rehabilitiative and habilitative services and devices
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

Adjustment to Benchmark Plan

- Ten statutory EHB categories, which include some benefits that health plans might not yet be covering (e.g., pediatric dental and vision, habilitative care)
- State health insurance benefit mandates

Rationale for Benchmark Options

- Reduce impact of member churn between Medicaid and exchange
- Improve access
- Ease implementation of ACA and state health benefits exchanges

Cost of Excess Benefits

- Qualified health plans (QHPs) in the exchange may offer benefits in addition to the ten EHB categories
- Cost of additional benefits (i.e., state mandates) must be paid by the state
  - Cost waived in 2014 and 2015
- States very conscious of liability of future benefit mandates that exceed federal definitions.

Cost for Medicaid Expansion

- From 2014-2016, federal government will cover full cost of EHB benchmark plan benefits for Medicaid expansion population
- After 2016, federal match for this population decreases to 90 percent

State EHB Progress

- 31 states and District of Columbia (DC) have submitted EHB package notices to HHS
- 10 states taken steps toward recommending benchmark plans
- 9 states no formal steps toward recommending benchmark plans

What Have States Selected?

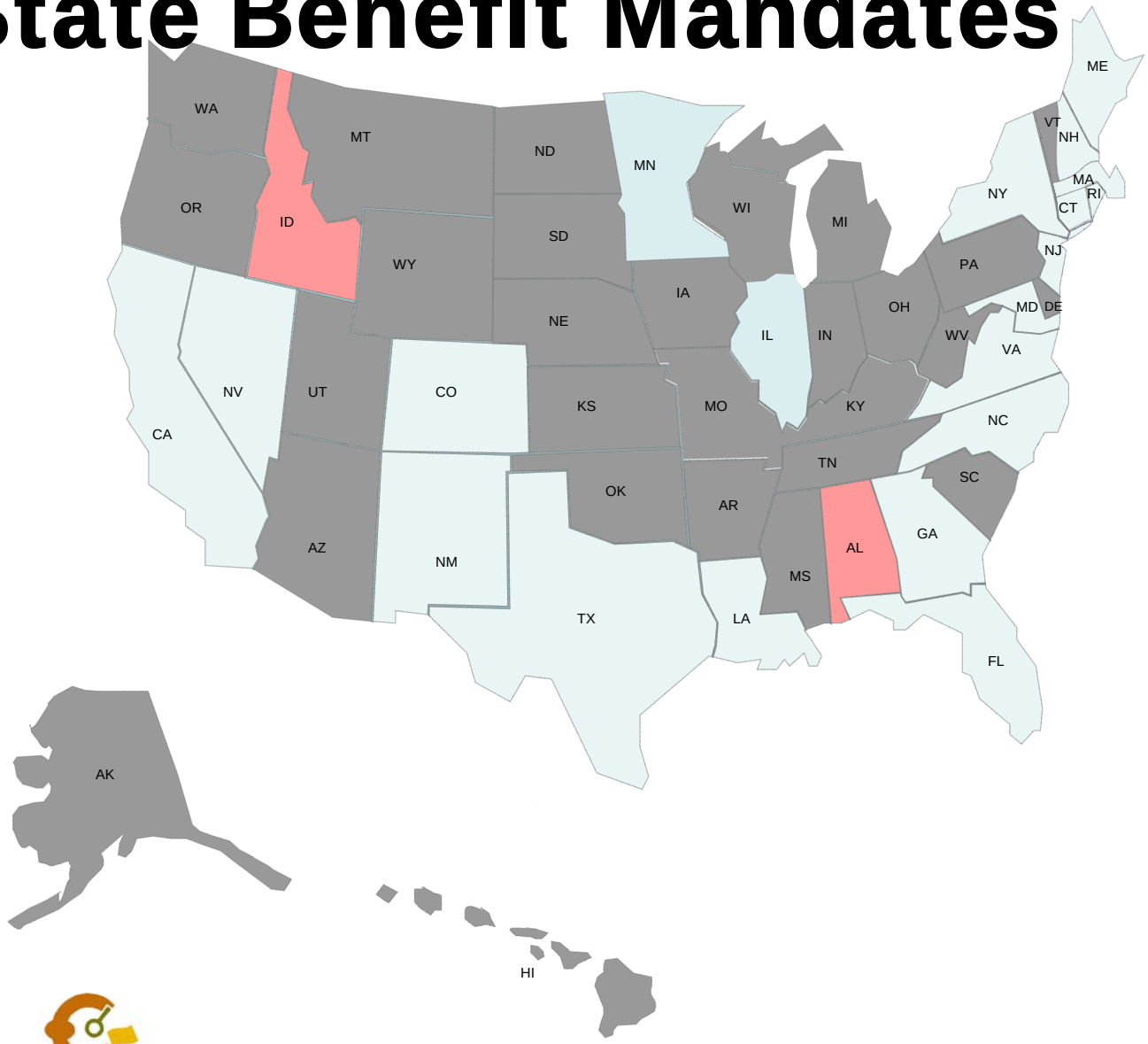
- 15 states, small employer plan
- 10 states and DC, largest small group plan
- 3 states, HMO plan
- 2 states, state employee plan

- A tracking poll can be accessed at: http://www.statereforum.org/analyses/state-progress-on-essential-health-benefits
- "Soft deadline of 9/30/2012.

Coverage Variation in Benchmark Plans

- California, Washington, and Maryland include acupuncture services
- Oregon rejected bariatric surgery, but endorsed cochlear implants for hearing-loss patients
- Virginia and Michigan favor plans with chiropractic services, while Oregon does not
- Mental health offerings vary widely
- Overall, wariness about adding benefits that could later not receive federal subsidies

State Benefit Mandates



Less than 20

20 to 40

More than 40

Source: Blue Cross and Blue Shield Association. *State Legislative Healthcare and Insurance Issues: 2010 Survey of Plans.*

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California Health Benefits Review Program (CHBRP)

- A program administered by the University of California, but institutionally independent
- Created by law to provide timely, independent, evidence-based information to the Legislature to assist in decision-making
- Charged to analyze medical effectiveness, cost, and public health impacts of health insurance benefit mandates or repeals
- Requested to complete each analysis within 60 days without bias or policy recommendations

Who are we?

- Task Force of faculty and researchers
- Actuarial firm: Milliman, Inc
- Librarians
- Content Experts
- National Advisory Council
- CHBRP Staff

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Encourage Value-Based Benefit Design

- Guidance includes number of visits, but not terms and conditions of coverage
- States can encourage plans to innovate with:
  - The terms and conditions of coverage (e.g., cost-sharing structure, network limitations)
  - Administration of terms and conditions of coverage (e.g., whether or not a service is medically necessary)

EHBs Beyond 2016

- Recommendations from the Institute of Medicine (IOM) in 2011:
  - Balance between access and affordability
  - EHBs updated annually
  - Establish a National Benefits Advisory Council to advise HHS on updates