Essential Health Benefits and State Mandates

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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
- Rehabilitative 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, habitative 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

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
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