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Realizing Health Reform's Potential

Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan

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Abstract: To improve the adequacy of private health insurance, the Affordable Care Act requires insurers to cover a minimum set of medical benefits, known as “essential health benefits.” In implementing this requirement, states were asked to select a “benchmark plan” to serve as a reference point. This issue brief examines state action to select an essential health benefits benchmark plan and finds that 24 states and the District of Columbia selected a plan. All but five states will have a small-group plan as their benchmark. Each state, whether or not it made a benchmark selection, will have a set of essential health benefits that reflects local, employer-based health insurance coverage currently sold in the state. States adopted a variety of approaches to selecting a benchmark, including intergovernmental collaboration, stakeholder engagement, and research on benchmark options.



OVERVIEW

With health care costs continuing to rise, even individuals who have health insurance coverage may be forced to pay costly medical bills or forgo needed care. Indeed, the number of “underinsured” individuals—those with health insurance, but high medical expenses relative to their income—has risen dramatically over the past decade. While many states address the adequacy of coverage by requiring health insurers to cover certain types of benefits and services, these coverage mandates often vary in scope, by market, and by state.

Recognizing the need to guarantee basic health protections for consumers, the Affordable Care Act requires insurers to cover 10 broad categories of medical benefits and restricts how much consumers must pay out-of-pocket. Effective January 1, 2014, insurers will be required to cover this “essential health benefits” package for individuals and small businesses.

In implementing this requirement, the federal government asked states to select a “benchmark plan” to serve as a reference point for coverage of essential health benefits. If a state does not select a plan, its benchmark will be the largest small-group plan in the state, based on enrollment. As a result, whether or not a state makes a selection, its benchmark plan will reflect local, employer-based health insurance coverage currently marketed and sold in the state. The United States Department of Health and Human Services (HHS) has indicated that the state benchmark approach is a transitional policy, which the agency will monitor and potentially revisit for 2016 and beyond.

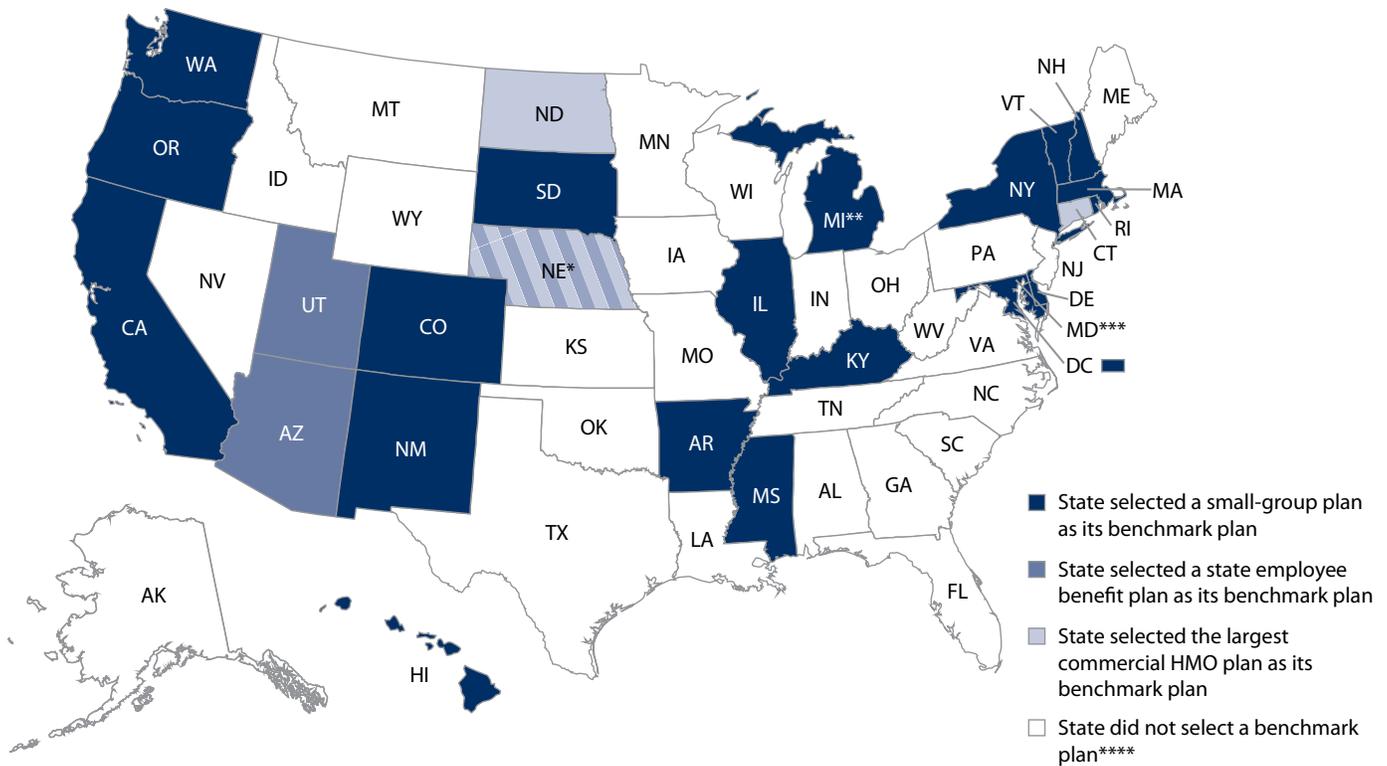
This issue brief examines actions taken by states between January 1, 2012, and October 15, 2012, to select an essential health benefits benchmark plan. The analysis shows that 24 states and the District of Columbia did so (Exhibit 1). Of these, most—19 states

and the District of Columbia—selected an existing small-group plan. Because the remaining 26 states will default to a small-group plan as their benchmark, all but five states are expected to have an existing small-group plan as their benchmark.

To better understand these decisions, we interviewed officials in 10 states. They reported a variety of approaches to benchmark plan selection, including intergovernmental decision-making, stakeholder engagement, and analysis of benchmark plan options. State officials also raised important questions about implementation of essential health benefits requirements, including how to implement in a short time frame, how to supplement benchmark plans, whether to allow benefit substitution, and how to handle ongoing monitoring and enforcement of the requirements.

Nearly all states will have an existing small-group plan as their benchmark. This allows them to

Exhibit 1. Essential Health Benefits Benchmark Plan Selection, as of October 15, 2012



* Nebraska selected a unique “Nebraska Option” as its benchmark plan. This plan was not among the 10 plan options outlined in federal guidance.
 ** Michigan selected a benchmark plan that is one of its largest small-group plans and also the state’s largest commercial HMO plan.
 *** Maryland originally selected a state employee benefit plan but later switched to a small-group plan during the HHS rulemaking process.
 **** States that did not select a benchmark plan will have the largest small-group plan in their state as their default essential health benefits plan.
 Source: Authors’ analysis.

minimize market disruption, particularly in the small-group market, by benchmarking to a plan that is commonly sold to small-business purchasers. Also, in many states, small-group market plans are required to cover states' benefit mandates. If a state mandates that insurers cover benefits in addition to what is included in the minimum essential health benefits package, the law requires the state to pay any additional premium costs associated with these benefits for individuals enrolled in plans sold through the marketplace, or exchange. Thus, selection of a small-group market plan means those mandates would be integrated into the benchmark package, saving the state from having to pay insurers or their enrollees to defray the cost of mandates that exceed the essential health benefits standard.

Our analysis suggests that these factors were considered in many states, regardless of whether the state ultimately selected a benchmark plan. These findings also suggest that states had significant flexibility in the process by which they selected their benchmark plan—as evidenced by the variety of approaches that states adopted. They also suggest that minimum federal standards for any future essential health benefits selection process could help ensure that it is an inclusive, public, and transparent process in all states. Greater stakeholder input and better disclosure of important plan documents can help ensure that consumers receive the type of benefits most consistent with the coverage promised under the Affordable Care Act. As states begin implementing the essential health benefits requirements, state and federal regulators are likely to grapple with important questions, such as whether to allow benefit substitution, and will need to be responsive to emerging issues as consumers and small-business owners shop for and access their new health benefits under the law.

BACKGROUND

As health care costs have increased, there have been growing concerns not only about the number of uninsured, but about the adequacy of coverage received by many of the insured. The number of “underinsured”—that is, those with health insurance, but high medical

expenses relative to their income—has risen dramatically in the past 10 years to an estimated 29 million adults in 2010.¹ To improve coverage for the uninsured and the underinsured, the Affordable Care Act set minimum standards that medical benefits insurers must cover. This “essential health benefits” package requirement, along with new limits on the amount consumers must pay out-of-pocket for health care, is designed to ensure that consumers have comprehensive coverage that meets their health needs and protects them from financial hardship. The essential health benefits are expected to be included in the coverage of up to 68 million Americans by 2016.²

Essential health benefits requirements will go into effect for new plans in the individual and small-group markets on January 1, 2014.³ The essential health benefits package includes—at a minimum—10 categories of defined essential health benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.⁴

Although many health insurance policies cover some of these benefits, coverage typically varies in scope, by market, and by state.⁵ To address this variation, the Affordable Care Act set out to establish the nation's first federal benefits standard while giving states the flexibility to require that coverage exceeds this minimum standard. However, if a state mandates that insurers cover benefits in addition to what is included in the minimum essential health benefits package, the law requires the state to pay any additional premium costs associated with these benefits for individuals enrolled in plans sold through the marketplaces.⁶

In December 2011, HHS released guidance indicating its intent to allow each state to select an existing health insurance plan as a coverage benchmark.⁷ Under this approach, states were offered the flexibility to select a “benchmark plan” that reflects the

benefits and limitations of a typical employer plan in that state. The benchmark plan must be chosen from among 10 existing plans in each state, as specified in federal guidance: the three largest small-group plans in the state, based on enrollment; the three largest state employee health plans, based on enrollment; the three largest federal employee health plans, based on enrollment; and the state's largest commercial HMO plan. If a state does not select a plan, the benchmark plan will be the largest small-group plan in the state, based on enrollment.

In November 2012, HHS codified its bulletin in a proposed rule, indicating that the benchmark plan would serve as a reference point in each state, providing a minimum baseline of covered items and services upon which new individual and small-group health plans must be built.⁸ HHS finalized these policies with few modifications in February 2013.⁹ HHS' rules allow insurers to substitute specific items and services within the specified benefit categories, if they are actuarially equivalent to the benefit being replaced.¹⁰ For example, if a state's benchmark plan covers blood screens for ovarian cancer, which would fall under the "laboratory services" category, an insurer would be allowed to not cover such screens, so long as it substituted that coverage with an actuarially equivalent service within the laboratory services category. In addition, HHS has determined that if a state benefit mandate was enacted before December 31, 2011, it will not be considered an addition to the essential health benefits package—meaning the state will not have to defray any costs associated with it.¹¹

Recognizing that some benchmark plans may not include coverage for all 10 categories of benefits, the rule requires that states' benchmark plans be supplemented using benefits from other specified plan options. For example, plans typically do not cover pediatric oral and vision care or provide clearly defined coverage of habilitative services (i.e., those that help people overcome long-term developmental problems, like speech, physical, or occupational therapy). As a result, HHS has provided additional guidance on how to supplement benchmark plans. States can supplement their

benchmark plan by adopting pediatric oral and vision services covered under the Federal Employees Dental and Vision Insurance Program or the state's Children's Health Insurance Program. Insurers can choose to offer habilitative services at parity with rehabilitative services or—at least on a temporary basis—decide which habilitative services to cover. States also have the option of defining habilitative services for purposes of the essential health benefits package.¹²

HHS asked states to select and report their benchmark plans to federal regulators by October 1, 2012.¹³ Although HHS has established a state-by-state approach to determining the essential health benefits package, it is unlikely that consumers will see dramatic differences in their coverage from state to state because of the minimum requirements in the law. All 10 benefit categories specified in the Affordable Care Act must be covered, and HHS's analysis of employer-based plans nationwide found minimal variation in the range of services covered.¹⁴ To the extent that there are significant differences, HHS found that they related to cost-sharing and not the scope of services covered.

ABOUT THIS STUDY

This analysis is based on a review of new action in the 50 states and the District of Columbia between January 1, 2012, and October 15, 2012, to select an essential health benefits benchmark plan. Our review of new action includes an analysis of state laws, regulations, subregulatory guidance, state websites, press releases, and other publicly available information related to benchmark plan selection. The resulting assessments of state action were confirmed by state regulators.

We also conducted in-depth interviews with state officials and analyzed nonlegal sources of information that include analyses, reports, and meeting minutes or transcripts in 10 states. These 10 states—Arkansas, Arizona, California, Connecticut, Mississippi, Montana, North Carolina, North Dakota, Utah, and Washington—were chosen because of their diverse approaches to selecting a benchmark plan. These approaches largely reflect the diversity

of approaches in all 50 states and the District of Columbia.

This analysis is limited to state processes and decisions that took place during the study period of January 1, 2012, to October 15, 2012. While we do not evaluate state decisions made after that time, if a state changed its benchmark selection during HHS’ rulemaking process, we have noted it. In addition, we do not evaluate the specific items and services covered in the selected plans or compare benefits among the benchmark options.

FINDINGS

Nearly half of the states—24 states and the District of Columbia—formally selected a benchmark plan. Of these, most—19 states and the District of Columbia—selected an existing small-group plan. Because the remaining 26 states will likely have a small-group plan as their benchmark, all but five states are expected to have an existing small-group plan as their benchmark. In addition, states adopted a variety of approaches to benchmark plan selection and raised critical questions about future implementation of essential health benefits requirements.

Nearly Half of States Formally Selected a Benchmark Plan

To date, 24 states and the District of Columbia selected a benchmark plan and submitted this selection to HHS (Exhibit 2). The other 26 states did not select

a benchmark plan and will default to the largest small-group plan, based on enrollment.

Twenty-Four States and District of Columbia Formally Selected a Benchmark Plans

To date, 24 states and the District of Columbia have selected a benchmark plan and submitted it to HHS (Exhibit 2). There was considerable uniformity: 19 states and the District of Columbia chose one of the three largest small-group plans as their benchmark prior to the October 1, 2012, deadline (Exhibit 3).¹⁵ Two states—Arizona and Utah—selected their state employee benefit plan. Two states—Connecticut and North Dakota—chose their largest commercial HMO plan. While Michigan chose its largest commercial HMO plan as the benchmark, the plan is also one of its three largest small-group plans. Nebraska submitted a unique “Nebraska Option” plan that was not among the 10 options listed in federal guidance. In its final rule, HHS has indicated that Nebraska’s benchmark will be the largest small-group plan in the state, by enrollment.¹⁶ No state selected a Federal Employees Health Benefits Plan (FEHBP) as a benchmark.

Although most of these states opted for a small-group plan, there was considerable variation in how states made decisions. Variations in the decision-making process included: which government entity made the selection, whether the state provided an opportunity for public comment during its selection process, and which factors were important to officials in selecting a benchmark. Very few states selecting a

Exhibit 2. States That Selected an Essential Health Benefits Benchmark Plan, as of October 15, 2012

Action to date	Number of states	State
State formally selected an essential health benefits benchmark plan	24 states and D.C.	Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Nebraska,* New Hampshire, New Mexico, New York, North Dakota, Oregon, Rhode Island, South Dakota, Utah, Vermont, Washington
State did not formally select an essential health benefits benchmark plan	26 states	Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Minnesota, Missouri, Montana, Nevada, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, West Virginia, Wisconsin, Wyoming

* Nebraska submitted the “Nebraska Essential Health Benefit Plan” as its benchmark option, but it was not one of the 10 benchmark options listed in HHS’ December 2011 bulletin.

Source: Authors’ review of state websites and interviews with state officials.

Exhibit 3. State Essential Health Benefits Benchmark Plan Selections, as of October 15, 2012

State	Benchmark plan	Type of plan
Arizona	United Healthcare EPO	State employee benefit plan
Arkansas	Arkansas Blue Cross Blue Shield Health Advantage POS	Small-group plan
California	Kaiser Permanente Small Group HMO	Small-group plan
Colorado	Kaiser Ded/CO HMO 1200D	Small-group plan
Connecticut	ConnectiCare HMO	HMO plan
Delaware	Blue Cross Blue Shield EPO	Small-group plan
District of Columbia	Blue Cross Blue Shield CareFirst BluePreferred Option 1	Small-group plan
Hawaii	HMSA Preferred Provider Plan 2010 PPO	Small-group plan
Illinois	BCBS of Illinois BlueAdvantage Entrepreneur PPO	Small-group plan
Kentucky	Anthem Preferred Provider Organization PPO	Small-group plan
Maryland	Blue Choice 20*	Small-group plan
Massachusetts	BCBS of Massachusetts HMO Blue	Small-group plan
Michigan	Priority Health HMO	Small-group plan/HMO plan**
Mississippi	BCBS of Mississippi Network Blue	Small-group plan
Nebraska	Nebraska Essential Health Benefit Plan	N/A***
New Hampshire	Matthew Thornton Blue	Small-group plan
New Mexico	Lovelace Classic PPO	Small-group plan
New York	Oxford Health EPO	Small-group plan
North Dakota	Sanford Health Plan	HMO plan
Oregon	PacificSource Preferred CoDeduct Value	Small-group plan
Rhode Island	Blue Cross Blue Shield Rhode Island Vantage Blue	Small-group plan
South Dakota	Wellmark Blue Cross Blue Shield Blue Select	Small-group plan
Utah	PEHP Utah Basic Plus	State employee benefit plan
Vermont	Blue Cross Blue Shield Vermont Health Plan HMO	Small-group plan
Washington	Regence Blue Cross Blue Shield Innova	Small-group plan

* Maryland initially selected CareFirst State of Maryland PPO, a state employee benefit plan, as its benchmark. During HHS' rulemaking process the state changed its selection to a small-group plan.

** Michigan's benchmark selection was both one of the state's three largest small-group plans and the state's largest commercial HMO.

*** Nebraska's selection is a high-deductible option that has benefits similar to the largest small-group plan in the state. It is not currently being marketed or sold by any insurer in the state. Because it was not one of the 10 plan options identified in HHS's December 16, 2011, bulletin, HHS has proposed that Nebraska's benchmark be the largest small-group plan by enrollment, Blue Cross Blue Shield of Nebraska's BluePride PPO.

Source: Authors' analysis of state websites and interviews with state officials.

benchmark have publicly posted plan documents (i.e., a policy contract), significantly limiting the ability of consumers, providers, and others to understand what is covered—and not covered—under the selected plan.¹⁷

Twenty-Six States Have Not Formally Selected a Benchmark Plan

Twenty-six states did not submit a benchmark plan selection to HHS (Exhibit 2). In some cases, state officials publicly stated they will not select a benchmark plan. For example, at least a dozen state officials submitted a letter to HHS, asserting that officials could not select a benchmark plan because of a lack of formal

rulemaking from federal regulators.¹⁸ Officials in some states also indicated they could not select a benchmark plan primarily because legislative action would be required and their 2012 legislative sessions had already closed.

States Adopted a Variety of Approaches in Selecting a Benchmark Plan

Among our 10 study states, benchmark plans were selected by the department of insurance (DOI), the governor, or the legislature (Exhibit 4). Three states—California, Utah, and Washington—selected their benchmark plan (or established a process by which

Exhibit 4. State Process to Select Essential Health Benefits Benchmark Plan, as of October 15, 2012

State	State entity that selected the benchmark plan?	State made plan analysis available to the public?	State provided opportunity for public comment on benchmark plan selection?
Arizona	Governor	Yes	Yes
Arkansas	DOI	Yes	Yes
California	Legislature	Yes	Yes
Connecticut	Governor	Yes	Yes
Mississippi	DOI	No	No*
Montana	n/a	No	No
North Carolina	n/a	Yes	No
North Dakota	DOI	Yes	No
Utah	Legislature**	Yes	Yes
Washington	Legislature	Yes	Yes

* While Mississippi's Insurance Department did not hold a formal public comment period, it did use the Health Exchange Advisory Board and Advisory Subcommittees, composed of a wide range of health care stakeholders, to receive input on the state's benchmark options.

** Utah's Health System Reform Task Force selected the state's benchmark's plan. The selection was subsequently adopted through a Department of Insurance regulation.

Source: Authors' analysis of state laws, regulations and subregulatory guidance, and interviews with state officials.

regulators would do so) by passing new legislation. In Arizona and Connecticut, the governor selected the benchmark plan, while insurance regulators made the final benchmark plan selection in Arkansas, Mississippi, and North Dakota. The remaining two states—Montana and North Carolina—did not select a benchmark plan.

In the three states that passed new legislation, state officials reported various reasons for doing so. California, for example, has a bifurcated regulatory structure in which the DOI regulates commercial health insurance and the department of managed health care regulates HMOs. Because the essential health benefits requirements extend to all individual and small-group insurers, which includes both commercial insurers and HMOs, legislators felt they were best positioned to set policy across the two markets. In addition, they viewed the selection of a benchmark plan as a public policy decision that fell squarely within the purview of the legislature.¹⁹ Utah's legislative leaders had a similar view.²⁰

The legislation in these three states had similarities and differences. In both California and Washington, legislators specifically identified the state's benchmark plan as one of the largest small-group plans.²¹ In contrast, legislators in Utah did not identify

a specific benchmark plan but instead established a process by which state officials would select a benchmark.²² The legislation directed the Health System Reform Task Force to recommend a benchmark plan to the insurance commissioner, who was then required to issue a regulation specifying the benchmark plan selection.

This decision-making and collaboration among state officials and government agencies was more common in states that did not pass new legislation. State officials reported the selection process required collaboration among entities as diverse as the legislature, legislative task forces, the governor's office, the state's health insurance marketplace, and the DOI. For example, insurance regulators in North Dakota requested an extension of the October 1, 2012, deadline so the state's legislature, which is only in session once every two years, could select the benchmark plan during its 2013 legislative session.²³ After federal regulators rejected this request, the DOI submitted an analysis of benchmark options to the state's interim Legislative Health Care Reform Review Committee, which reviewed the options. It then held a straw vote on two plans, with a majority supporting the HMO plan.²⁴ Other states, however, reported a lack of clarity regarding which entity should select the benchmark

plan. In Montana, state officials suggested that choosing an essential health benefits package would more properly be the purview of the legislature, but there was no public decision regarding who or what would be the appropriate person or entity to make the selection.²⁵ The Montana legislature did not meet in 2012 (as in North Dakota, it has biennial sessions) and did not take up the issue. Regulators in North Carolina similarly considered benchmark plan selection to be a legislative or executive decision, with the DOI serving primarily as a “technical resource” for legislators.²⁶ Because neither legislature selected a benchmark, both states will have the default plan as their benchmark.²⁷

Study States Engaged the Public in Selecting a Benchmark Plan

State officials played a significant role in engaging the public and analyzing benchmark plan options in the 10 study states. Most states conducted targeted outreach to stakeholder groups through requests for input, held meetings with the public and interested advocacy groups, and convened stakeholder committees or task forces (Exhibit 4). All but two states held public meetings, with six states also soliciting public comment and five states publicly releasing detailed plan documents. The two states that had no public process—Montana and North Carolina—failed to select a benchmark plan.

According to officials, this public engagement informed states’ final benchmark plan selection, which reflected input from advisory groups, steering committees, and task forces. For example, in Connecticut, the governor approved the marketplace board’s recommendation to select the state’s largest commercial HMO plan.²⁸ State officials indicated that the governor’s approval was largely pro forma because stakeholders supported the board’s selection process, which included plan analysis as well as public engagement.²⁹

State officials also reported that stakeholders—including consumer and patient groups, insurers, and specialty providers—in all 10 study states were highly engaged in the benchmark plan selection process. Arizona officials, for example, reported that specialty providers gave considerable feedback regarding the particular diseases they treat.³⁰ While some state officials

expressed concern about low levels of engagement by small businesses, others reported active engagement. In Connecticut, small businesses were reportedly “very vocal” about the need to balance comprehensiveness and affordability.³¹

Study States Analyzed Benefit Coverage and Cost in Selecting a Benchmark Plan

State officials also collected and analyzed data on plan enrollment and covered services in the benchmark options. Of the 10 study states, all but Montana conducted or commissioned a comparative analysis of some or all benchmark options. Three states—Arkansas, California, and North Carolina—also commissioned actuarial analysis of the costs associated with these options. With the exception of Mississippi, state officials made these analyses publicly available by publishing them online (Exhibit 4).

Analysis of the 10 study states found that virtually all plan options would need to be supplemented, particularly for pediatric oral and vision services and habilitative services. The analyses also found that covered items and services were fairly consistent, with only a few exceptions such as the coverage of long-term acute care, bariatric surgery, residential treatment services, and orthopedic care, among others.

State officials reported that these analyses helped them narrow their options, identify which plans covered state benefit mandates, assess plan variation, and identify areas where supplementation would be needed. For example, analysis commissioned by California’s marketplace was described as key to helping the legislature hone in on its options and ultimately select a Kaiser Permanente small-group HMO plan that fell between the state’s “most generous” and “leanest” options.³² North Carolina regulators concluded that the federal default option would be acceptable after finding little variation among benchmark options—even after an extensive analysis of the financial, social, and medical implications of not covering outlier benefits.³³

Based on these analyses and public comment, officials in all 10 study states identified the preservation of state mandates as a primary factor in their selection.

This desire was universal, regardless of whether the state was “mandate-rich,” such as Connecticut or “mandate-light,” such as Utah.³⁴ In Arizona and North Dakota, analyses helped states exclude FEHBP coverage early in the decision-making process because these plans do not cover state-mandated benefits.³⁵ State mandates, however, were not without controversy. In Arkansas, for example, one of the most controversial issues involved the state’s mandate that PPOs—but not HMOs—cover in-vitro fertilization (IVF).³⁶ Because the three largest small-group plans in Arkansas included two HMO plans and one PPO plan, the state’s benchmark plan selection had significant consequences for future coverage of this benefit.³⁷ Although the Exchange Plan Management Committee recommended the PPO option, the DOI ultimately selected an HMO plan.³⁸ It remains unclear how and whether Arkansas will make changes to this mandate, which remains applicable to PPO products.

The differences among the benchmark options generated discussion over the appropriate balance between comprehensive coverage and cost, and policymakers in our 10 study states adopted different approaches to address this balance. In California, officials selected a plan “by process of elimination” based on a desire to cover certain benefits such as reproductive services and autism treatment.³⁹ However, to balance affordability, legislators resisted lobbying efforts to increase the generosity of coverage beyond the benchmark plan.⁴⁰ Officials in some states opted for more basic options in an effort to maintain affordability. For example, the majority of members on North Dakota’s interim Legislative Health Care Reform Review Committee signaled support for a basic plan,⁴¹ while Mississippi officials supported the “leanest” option because “plans can always build on a leaner baseline.”⁴²

States Raise Questions Regarding Implementation of Essential Health Benefits Requirements

Following the selection of a benchmark plan or the decision to default, state officials are now turning to implementation of the essential health benefits

requirements. In this section, we discuss critical questions—related to enforcement, timing, supplementation, and substitution—raised by state officials in the 10 study states.

Oversight and Compliance. Officials expressed uncertainty about their DOI’s authority and capacity to enforce essential health benefits requirements. While insurers must follow federal law, DOIs may not have explicit authority to enforce federal standards. Because of this limitation, several officials noted that they would likely need to enact state legislation to ensure the DOI’s ability to reject noncompliant policies and conduct ongoing oversight. In Arizona, for example, officials recognized that the DOI would not have the authority to enforce the essential health benefits requirements since regulators do not have the authority to enforce federal law.⁴³ Montana’s DOI does not have statutory authority to enforce federal law, but officials stated they are likely to review plans for voluntary compliance with the minimum requirements of the Affordable Care Act.⁴⁴ At the same time, some states—such as Connecticut, California, and Washington—have already enacted legislation conferring regulators with the requisite authority.

Further, officials in all 10 study states expressed concern about their DOI’s capacity to conduct a meaningful review of policy forms. Arizona officials raised this concern in the context of a reduced staff and noted: “It’s not just about adding more bodies, but about finding the bodies with the right skill set.”⁴⁵ Other states noted that essential health benefits requirements are novel to state regulators. Washington State officials noted, “This is really different from anything we’ve ever done.”⁴⁶ Other officials cautioned against relying too heavily on software to review forms and emphasized the need to read all policy form language to truly understand what a plan covers. As one put it, “A policy might say it covers prescription drugs, but in the fine print there could be an exclusion saying they’ll never pay for drugs in a certain category.”⁴⁷

Timing. During the study period of January 1 to October 15, 2012, state officials raised concerns about the lack of published federal regulations and guidance

on critical issues such as whether insurers will be allowed to substitute benefits within or across categories, how to demonstrate actuarial equivalence, and how states will defray costs associated with mandates not included in the benchmark plan. In Arizona, for example, state officials raised concerns that federal rulemaking on essential health benefits could “drag on into the spring,” which could limit insurers’ ability to finalize products for sale. One official said, “Insurers can’t price a product if they don’t know what they’re covering.”⁴⁸ Many of these questions were addressed in HHS regulations, published in final form in February 2013.

Most state officials in the 10 study states expressed concern about the short time frame between benchmark plan selection, the state’s form review process, and open enrollment for marketplaces, beginning October 1, 2013. In many states, the DOI’s review of insurers’ policy forms to ensure they satisfy state requirements can take 90 days or more. In Arkansas, state officials are increasingly concerned about the ever-shortening timeline to review and approve new policies for 2014. According to one official, “We talk about the compressed time frame every week.”⁴⁹ Other states, such as Connecticut, asked insurers to file policy forms for review by November 1, 2012, to give regulators six months to review new policies, but officials acknowledged the expectation to be “increasingly unrealistic.”⁵⁰ In contrast, other states do not anticipate needing a long lead time to conduct reviews. Mississippi officials expect they will ask insurers to submit their policy forms by September 2013 because regulators can review and approve products “pretty quickly.”⁵¹ Other states, such as Utah, have a “file and use” regulatory system with no need for DOI approval of forms and thus are less concerned about when new products can be finalized for sale.⁵²

Supplementing and Substituting Benefits. While most states felt that HHS’ proposed options for supplementing pediatric oral and vision care were adequate to meet consumers’ needs, they were less sanguine about the proposed approach for supplementing habilitative care. In early guidance, HHS had indicated that insurers would be allowed to define the scope of covered

habilitative services under their policies.⁵³ States took varying approaches to this issue. In California, for example, legislators chose to define habilitative services rather than leave it up to insurers to define.⁵⁴ Other state officials indicated they would closely monitor insurers’ coverage of habilitative services. Arkansas, for example, issued a directive on the essential health benefits package, noting that the DOI has “the power to reject the...filing if habilitative services are not covered in a way that follows the spirit of the federal law.”⁵⁵ Still other states, such as Connecticut, indicated that they will allow insurers to define habilitative services consistent with federal guidance.⁵⁶ States’ approaches to benefit substitution were similarly diverse. In California and Washington, officials expressed concerns that this flexibility could affect consumers’ ability to make apples-to-apples comparisons among plans and allow plans to use benefit design to cherry-pick healthier enrollees.⁵⁷ Cherry-picking through benefit design can occur, for example, when an insurer replaces coverage of items and services needed by people with chronic conditions with those that might appeal to young, healthy individuals. State officials reported that California banned benefit substitution because the state did not want benefit substitution “from both a regulator perspective and from a policy perspective” and because allowing substitution is “against the spirit of the law.”⁵⁸ Conversely, Arizona and Utah officials favored the flexibility that substitution provides, with Utah officials noting that insurers should be able to “differentiate themselves” in this way to provide consumers with choice.⁵⁹

Many of our 10 study states indicated they would allow insurers to substitute benefits at least initially and likely faced limitations in the ability to restrict substitutions without explicit statutory authority. State insurance regulators indicated they would monitor benefit substitution during the form review process, and officials in some states—such as North Carolina and Connecticut—suggested that insurers may, at least initially, refrain from many substitutions because those who do not substitute may “get a faster review” at the DOI.⁶⁰

POLICY IMPLICATIONS

Our findings reveal that nearly half the states—24 states and the District of Columbia—have formally selected an essential health benefits benchmark plan. Of these, most—19 states and the District of Columbia—chose a small-group plan. Only a handful of states selected a state employee benefit plan or the largest commercial HMO plan. No state selected an FEHBP plan as its benchmark. The 26 states that did not formally select a benchmark plan will default to the largest product in the small-group market. Thus, all but five states are likely to have an existing small-group plan as the state's benchmark.

The decision by 19 states and the District of Columbia to select an existing small-group plan suggests that state policymakers preferred a plan that was already widely marketed and sold to small-business employers, minimizing any dramatic changes in the scope and cost of coverage. In addition, selecting an existing small-group plan allowed states to avoid having to defray the cost of mandates that exceed the state's essential health benefits standard. State officials universally reported that these factors—in addition to the need to balance comprehensiveness with affordability—were primary considerations in most states, regardless of whether the state formally selected a benchmark plan. And, by selecting an existing small-group plan as the default benchmark plan, federal regulators appeared to recognize that this option represents an optimal balancing of these factors for many states.

Our findings also suggest that states had significant flexibility in their decision-making process, as evidenced by the variety of approaches states adopted. Among the 10 study states, benchmark plans were selected by the legislature, the governor, and the insurance department. Many states adopted novel inter-governmental decision-making processes that were informed by advisory groups, steering committees, task forces, and the public.

Most of the study states adopted benchmark selection processes that included comprehensive analysis of plan options, the release of plan summaries for review by interested parties, and an opportunity for

public comment. This was true even though it was not required by federal regulators. But, because federal regulators provided little guidance on how a state must select its benchmark plan, not all states adopted transparent and inclusive processes. This resulted in significant variation, with officials in some states establishing clear and public selection processes and prioritizing the need for stakeholder engagement, while officials in other states conducted their own, internal analyses and made decisions without stakeholder input.

With all but five states expected to have an existing small-group plan as the benchmark, it is difficult to conclude whether one approach resulted in a better outcome than another. However, HHS has provided that the state benchmark approach will be a transitional, two-year policy, giving federal and state officials an opportunity to monitor its effectiveness and impact on consumers and small-business purchasers. While HHS has indicated it may revisit its approach, if it determines that state-based benchmarks are appropriate beyond the two-year transition period, federal regulators should consider establishing minimum standards that states must follow when selecting or updating their benchmark plans. Federal regulators could, for example, require states to make all plans publicly available and ensure that decisions are made through a public, transparent process that includes stakeholder engagement. Minimum federal standards for the benchmark selection process could help ensure that consumers receive the type of benefits most consistent with the coverage promised under the Affordable Care Act.

We also found that state officials face many unanswered questions as they turn from the task of selecting a benchmark plan to implementing essential health benefits requirements. While many of these questions and concerns were addressed in federal guidance, there remain a number of outstanding questions relating to the cost and adequacy of the essential health benefits package. State and federal regulators should anticipate the need to be flexible and responsive to new issues as these new plans are reviewed by regulators and marketed to and used by consumers.

NOTES

- 1 C. Schoen, M. M. Doty, R. H. Robertson and S. R. Collins, “Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent,” *Health Affairs*, Sept. 2011 30(9): 1762–71.
- 2 Institute of Medicine, Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans, *Essential Health Benefits: Balancing Coverage and Cost* (Washington, D.C.: National Academies Press, 2011).
- 3 Affordable Care Act § 1302(b). The Affordable Care Act also prohibits insurers from imposing lifetime and annual limits on the dollar value of essential health benefits and limits premium tax credits and cost-sharing subsidies to essential health benefits.
- 4 *Ibid.* § 1302(b) (codified at 42 U.S.C. § 18022(b) (2006)).
- 5 *Supra* n. 2.
- 6 Affordable Care Act § 1311(d)(3)(B) (codified at 42 U.S.C. § 18031(d)(3)(B) (2006)).
- 7 U.S. Department of Health and Human Services, *Essential Health Benefits Bulletin* (Washington, D.C.: Center for Consumer Information and Insurance Oversight, Dec. 16, 2011).
- 8 *Federal Register* 77(227):70644, 70670.
- 9 *Federal Register* 78(37):12834.
- 10 *Ibid.* at 12867.
- 11 *Ibid.* at 12865.
- 12 *Ibid.* at 12866, 12867.
- 13 In its proposed rule on essential health benefits subsequent to the deadline, HHS identified each state’s essential health benefits benchmark plan. States that had not yet done so were allowed to select a benchmark plan, and states were also able to change or modify their selection, up to December 26, 2012. The final list of state benchmark plans for 2014–2015 is provided in the appendix to HHS’ final essential health benefits rule. Only one state—Maryland—changed its benchmark selection, although several changed the plans from which pediatric oral and vision benefits would be supplemented. HHS has indicated that the benchmark approach will be evaluated and possibly revisited in 2016.
- 14 *Supra* n. 7.
- 15 One state—Maryland—initially submitted its state employee benefits plan as its benchmark but switched its selection to one of its small-group plans during HHS’ rulemaking process, bringing the total to 19 states.
- 16 *Federal Register* at 12871.
- 17 Of the states selecting a benchmark plan during the study period, only eight posted detailed plan documents.
- 18 StateReform, *State Progress on Essential Health Benefits*.
- 19 Personal correspondence with California state officials (Sept. 11, 2012) (on file with authors).
- 20 Personal correspondence with Utah state official (Sept. 5, 2012) (on file with authors).
- 21 2012 WA H.B. 2319.
- 22 2012 UT H.B. 144.
- 23 Commissioner Adam Hamm letter to Secretary Kathleen Sebelius, Mar. 1, 2012, <http://www.nd.gov/ndins/uploads/resources/712/ehb-request.pdf>.
- 24 Personal correspondence with North Dakota state official, North Dakota Insurance Department (Sept. 14, 2012) (on file with authors).
- 25 Personal correspondence with Montana state official, Office of Commissioner of Securities and Insurance (Sept. 14, 2012) (on file with authors).
- 26 Personal correspondence with North Carolina state official, North Carolina Department of Insurance (Sept. 14, 2012) (on file with authors).
- 27 *Supra* n. 25; *supra* n. 26.
- 28 Personal correspondence with Connecticut state official, Connecticut Insurance Department (Oct. 5, 2012) (on file with authors).
- 29 Personal correspondence with Connecticut state official, Connecticut Insurance Department (Sept. 25, 2012) (on file with authors).
- 30 Personal correspondence with Arizona state officials (Sept. 21, 2012) (on file with authors).
- 31 *Supra* n. 29.

- ³² *Supra* n. 19; Milliman, Report to David Panush, Director, Government Relations, California Health Benefit Exchange, Re: Summary of cost variations for specific services between the California Essential Health Benefits (EHB) benchmark plans (Feb. 21, 2012), http://www.healthexchange.ca.gov/FederalGuidance/Documents/Milliman-Essential_Health_Benefits_Comparison-Cost_of_Services2-21-2012.pdf.
- ³³ *Supra* n. 29.
- ³⁴ *Supra* n. 20; *supra* n. 29.
- ³⁵ See, e.g., Mercer, Essential Health Benefits: Arizona Department of Insurance (June 1, 2012), <http://www.azgovernor.gov/hix/documents/Grants/EHBReport.pdf><http://www.azgovernor.gov/hix/documents/Grants/EHBReport.pdf>; analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act prepared for the North Dakota Insurance Department (Aug. 2012), <http://www.nd.gov/ndins/uploads/resources/734/ins-ehb-report.pdf>.
- ³⁶ Personal correspondence with Arkansas state official, Arkansas Insurance Department (Sept. 11, 2012) (on file with authors).
- ³⁷ *Ibid.*
- ³⁸ Arkansas Insurance Department, Directive 2-2012 (Sept. 21, 2012), <http://www.insurance.arkansas.gov/Legal%20Dataseservices/Directives/2-2012.pdf>.
- ³⁹ *Supra* n. 19.
- ⁴⁰ *Supra* n. 19.
- ⁴¹ *Supra* n. 24.
- ⁴² Personal correspondence with Mississippi state official, Mississippi Insurance Department (Sept. 7, 2012) (on file with authors).
- ⁴³ *Supra* n. 30.
- ⁴⁴ *Supra* n. 25.
- ⁴⁵ *Supra* n. 30.
- ⁴⁶ Personal correspondence with Washington state official, Washington State Office of the Insurance Commissioner (Sept. 5, 2012) (on file with authors).
- ⁴⁷ *Supra* n. 25.
- ⁴⁸ *Supra* n. 30.
- ⁴⁹ *Supra* n. 36.
- ⁵⁰ *Supra* n. 28.
- ⁵¹ *Supra* n. 42.
- ⁵² *Supra* n. 20.
- ⁵³ In its final rule, HHS allows states to define the scope of habilitative services for purposes of the essential health benefits package. If the state does not define it, insurers may either cover habilitative services at parity with rehabilitative services coverage, or they may define the scope of habilitative services coverage and report to HHS. 45 C.F.R. §156.115.
- ⁵⁴ *Supra* n. 19.
- ⁵⁵ *Supra* n. 38.
- ⁵⁶ *Supra* n. 28.
- ⁵⁷ *Supra* n. 46.
- ⁵⁸ *Supra* n. 19.
- ⁵⁹ *Supra* n. 20.
- ⁶⁰ *Supra* n. 26; *supra* n. 28.

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