

Washington State Health Care Authority Comments:
Department of Health and Human Services Essential Health Benefit Bulletin

The Washington State Health Care Authority (HCA) is pleased to submit comments to the U.S. Department of Health and Human Services (HHS) on the guidance provided in the bulletin dated December 16, 2011 on the essential health benefits.

We are pleased that HHS will soon release rules about the essential health benefits. The HCA is currently responsible for developing the Washington State Health Benefit Exchange; additional guidance or direction must be quickly factored into our state's regulatory framework. The responsibility for the Exchange will be passed to the Washington State Exchange Board on March 15, 2012.

Questions

The HCA has four questions which are repeated in the body of this document:

- Question A: Can HHS prohibit the Washington State Legislature from delegating to an elected official such as an Insurance Commissioner the authority to modify the benchmark plan to ensure, for example, that the definition of essential health benefits covers all ten categories in Section 1302 of the Affordable Care Act?
- Question B: How would HHS like individual and small group health plans to define coverage for the habilitative benefit?
- Question C: How would HHS like individual and small group health plans to define coverage for the chronic care management benefit?
- Question D: Can HHS guidance direct that issuers must comply with the exact limits specified in a benchmark plan without making a coverage decision, and thus, conflicting with section 1302(b)(4)(B) of the Affordable Care Act?

The Essential Health Benefits

Beginning in 2014, individual and small group health insurance plans, inside and outside of the health benefits Exchange, will need to offer a set of essential health benefits that cover services within these ten categories:

- Ambulatory care
- Emergency care
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment

- Prescription drugs
- Rehabilitative and habilitative care
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision services

The scope of the essential health benefits will need to represent the coverage offered by a typical employer plan. The essential health benefits will reflect a balance among the ten categories. The definition of the essential health benefits cannot include cost-sharing provisions or make coverage decisions. In a report completed October 17, 2011, the Institute of Medicine recommended that the essential health benefits could balance cost and comprehensiveness by reflecting those plans offered in the small group market.

The essential health benefits cannot determine reimbursement rates, establish incentive programs, or discriminate against individuals because of their age, disability, or expected length of life. The essential health benefits must take into account the health care needs of a diverse population and cannot be denied based on issues such as an individual's age or quality of life. HHS will periodically review and update the essential health benefits.

The benefits for the Medicaid expansion population and the Federal Basic Health Option will be based upon the essential health benefits. The essential health benefits, however, do not apply to all health plans. Coverage provided by grandfathered plans, large group plans, and self-funded plans are not governed by the essential health benefits.

Qualified Health Plans must cover at least the essential health benefits. Not all state mandated benefits need be included in the essential health benefits. States, however, must assume the cost of subsidizing a state mandated benefit that is not defined as an essential benefit when that mandated benefit is offered through a QHP in an Exchange.

Analyzing the Essential Health Benefits Package

Our Legislature, now in session, will likely consider how to define our state's essential health benefits. As the recipient of the planning and establishment grants for Washington State's Health Benefit Exchange, the HCA is leading the analysis of HHS's initial guidance on the essential health benefit package. The HCA's comments reflect the assumptions specified, and the questions asked, as our state conducts an analysis of Washington State's ten benchmark options. The HCA requests that HHS contact us if any of our assumptions are not consistent with your current guidance or forthcoming rules.

Managing timeframes. The timeframes specified in your December 16, 2011 guidance led the HCA to specify our first assumption. Based on the guidance and the HHS conference call on January 26, 2012, health plans offered in the first quarter of 2012 are candidates for the ten benchmark options.

Assumption #1: By the end of the third quarter of 2012, Washington State will specify one of the ten benchmark plans identified in the first quarter of 2012 to become the benchmark plan for coverage in 2014.

Assumption #2: Any Washington State mandated benefit repealed, added, or modified in the current 2012 legislative session will not affect the benchmark benefit plan for 2014 coverage.

Assumption #3: Any Washington State mandated benefit effective in 2013 can become a benefit in the benchmark plan for 2015, but only if the mandate applies to the benchmark plan selected by Washington State.

For example, if Washington State selects one of the federal employee plans as a benchmark plan for 2014, then a new state mandated benefit effective in 2013 would not likely apply if our state were to maintain a federal employee plan as our benchmark plan for 2015.

Assumption #4: States may select a different (than the benchmark plan selected for 2014) benchmark plan for 2015, and can select that benchmark plan from the ten benchmark plan options available in the first quarter of 2013.

Assumption #5: New guidance from HHS may or may not modify Washington State's definition of essential health benefits for 2016.

Interpreting flexibility: The segment of the HHS guidance under *Benefit Design Flexibility*, and the HHS conference call on January 26, 2012, specify flexibility for issuers and clarify that HHS has not extended the same flexibility to states to modify the benchmark plan it selects. Issuers have the flexibility to offer substantially equal benefits (to the state's benchmark plan) that modify covered services and quantitative limits; coverage in all ten essential health benefit categories must continue in the modified plan. HHS will also issue further rules or guidance that specify how issuers can substitute services – while continuing to offer substantially equal benefits – within and across the ten essential health benefit categories.

Private sector plans in Washington State, to date, have not typically defined a specific coverage for habilitative services. Also, the private-sector health plans do not typically offer coverage in the essential health benefit category of pediatric oral or vision services.

Assumption #6: States, under HHS rules and guidance, will direct how to:

- Modify the benchmark benefits.
- Substitute benefits within a specific benefits plan.
- Maintain a substantially equal benefits plan.
- Offer habilitative services.

- Offer standalone pediatric oral or vision plans in section 1302(b)(4)(F).

Question A: Can HHS prohibit the Washington State Legislature from delegating to an elected official such as an Insurance Commissioner the authority to modify the benchmark plan to ensure, for example, that the definition of essential health benefits covers all ten categories in Section 1302 of the Affordable Care Act? HHS guidance provides issuers with the flexibility to modify the benchmark plan under specific circumstances. HHS should not attempt to limit the flexibility of state elected officials to modify the benchmark plan to ensure that a state's definition of essential health benefits meets federal goals.

Question B: How would HHS like individual and small group health plans to define coverage for the habilitative benefit?

Question C: How would HHS like individual and small group health plans to define coverage for the chronic care management benefit?

Governing benefits: The HHS guidance also specifies that the benchmark plan will serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by section 1302(b)(2)(A) of the Affordable Care Act. Section 1302(b)(4)(B) of the Affordable Care Act specifies that the Secretary in defining the essential health benefits shall not make coverage decisions. That leads to a question about the guidance:

Question D: Can HHS guidance direct that issuers must comply with the exact limits specified in a benchmark plan without making a coverage decision, and thus, conflicting with section 1302(b)(4)(B) of the Affordable Care Act?

Assumption #7: Without an answer to Question D, the HCA's analytic framework will continue to assume that the state can specify whether quantitative limits, and the precise limitations and exclusions specified in a plan's summary of benefits, apply to each individual and small group plan in 2014.

For example, the services covered under a benefit in the benchmark plan would reference the benefits to be covered in an individual and small group plan in 2014. The state, however, would determine if a benchmark plan's quantitative limits, and limitations and exclusions, should apply to each individual and small group plan in 2014.

Covering optional benefits: In the HHS conference call on January 26, 2012, HHS officials began to suggest that optional benefits offered as "riders" that fell within the ten essential health benefit categories could be considered an essential benefit of the benchmark plan. HHS, however, concluded the discussion of riders by stating that further written clarification on the topic would be issued.

Assumption #8: As we await clarification, the HCA's analytic framework will need to assume that a rider associated with any of the ten essential health benefit categories is a benchmark benefit that must be covered by an individual or small group plan in 2014.

The Health Care Authority would like to express our thanks to the many staff at the Department of Health and Human Services who played a role in delivering guidance to Washington State.

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