CATALYST CENTER
IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

Your Questions on the Essential Health Benefits Bulletin Answered

In every issue of *Catalyst Center Quarterly*, we tackle a current topic related to the Affordable Care Act (ACA) and children and youth with special health care needs (CYSHCN). Below is a compilation of several questions that we've been asked by stakeholders regarding the *Essential Health Benefits Bulletin* issued by the U.S. Department of Health and Human Services (HHS) on December 16, 2011, and its possible impact on CYSHCN.

Q: I've been hearing a lot about the proposal to allow states to define the Essential Health Benefits (EHB) in the Exchange plans using a benchmark approach. Can you tell me what I need to know about this proposal and its possible impact on coverage for CYSHCN?

A: The proposal you're referring to came out in a bulletin from the HHS in mid-December, 2011.[i] To better understand the proposal, let's first take a look back at the relevant ACA provisions to give it some context.

As called for under Sections 1302 and 1311 of the ACA, each state will ensure access to an "Affordable Insurance Exchange," ready to open by 2014. The goal of the Exchanges is to provide a centralized marketplace where individuals and small businesses can easily compare and apply for affordable health coverage – similar to the way in which online websites help travelers choose the least expensive and most convenient plane tickets to buy from among many airlines.
The EHB provision is a key component of the Exchanges. This provision is intended to ensure that the plans offered through the Exchanges, as well as by all individual and small group health insurers, not only provide affordable coverage but also include a comprehensive set of benefits. You may recall the Catalyst Center identifies three "essential components" of health care coverage

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[i]Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), *Essential Health Benefits Bulletin*, Baltimore, MD (December 16, 2011).

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for CYSHCN: CYSHCN require coverage that is 1) universal and continuous, 2) adequate, and 3) affordable.[ii] The goals of the EHB are right in line with these essential elements for the CYSHCN who will get their health care coverage through the individual and small group markets and the Exchange plans after 2014.

Q: I know the EHB will be part of the Exchange plans, but why did you refer to the individual and small group markets? Do all health plans have to provide EHB?
A: The EHB will apply to 1) all new plans offered through each state's Exchange; 2) other new plans in the individual and small group markets and; 3) Medicaid benchmark coverage, starting in 2014.[iii] Health plans that do not participate in the state's exchange, or in the individual and small group markets, do not have to provide EHB.

Q: What are the ten benefit categories of EHB under the ACA?
A: The ten broad categories include:[iv]

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Q: The benefits in the EHB appear to be fairly comprehensive with the potential to really address underinsurance among CYSHCN. But the law did not provide details about the scope, duration, or definition of these benefits. How were these details supposed to be decided?
A: Under the ACA, HHS was charged with determining the details of what would be included in the EHB.[v] States and other stakeholders were eager for clarification under each of the categories so they could plan their Exchanges prior to implementation in 2014.
After considering expert recommendations and reviewing research from a variety of

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[ii]The Catalyst Center: Improving Financing of Care for Children and Youth with Special Health Care Needs. *The Essential Components of Health Care Reform for Children with Special Health Care Needs*, (September, 2009). Available at http://hdwg.org/catalyst/essentialcomponents
[iii]Section 1302 (b) of the Affordable Care Act
[iv]Section 1302 (b)(1) of the Affordable Care Act
[v]Section 1302 (b) of the Affordable Care Act

sources, on December 16, 2011, HHS proposed using a benchmark approach similar to the one used when the state Children's Health Insurance Program (CHIP) began. Under this plan, states will be able to choose one of four kinds of plans to use as a benchmark or model. According to HHS, one of the primary reasons for this decision was to allow for state flexibility and consumer choice.[vi] Using the precedent set by CHIP implementation,[vii] this approach acknowledges that what may work well in one state may not in another, and allows a state to choose the health services that it believes best meet the unique needs of its residents.

Q: What are the four categories of plans states can choose from as their benchmark?
A: They include:

- One of the three largest small-group plans in the state by enrollment, or
- One of the three largest state-employee health plans by enrollment, or
- One of the three largest federal-employee health plan options by enrollment, or
- The largest HMO plan offered in the state's commercial market by enrollment.

Q: What if states don't make a choice or the Exchange in a particular state is being federally run?
A: The default choice will be the largest small-group plan in the state.

Q: Have any of the ten benefit categories under the ACA changed?
A: No, they remain the same, but you may remember the requirement under ACA that the EHB be balanced across all ten categories and look like the "typical employer-sponsored benefit package."[viii] This requirement continues under the Bulletin, and it remains a bit of a conundrum, since the majority of "typical" plans don't include every category of service required under the EHB. Many stakeholders had hoped that a robust national standard determined by HHS would help alleviate some of the existing gaps in services for people with chronic illnesses and disabilities, including CYSHCN. Research by HHS confirmed that coverage in a few of the benefit categories is often limited in the benchmark plans, including habilitative, behavioral health, pediatric vision, and pediatric oral health services.[ix] The latest data from the 2009

[vi]Press Release, U.S. Department of Health and Human Services, *HHS to give states more flexibility to implement health reform* (December 16, 2011). Available at http://www.hhs.gov/news/press/2011pres/12/20111216b.html
[vii]Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), Essential Health Benefits Bulletin, Baltimore, MD (December 16, 2011).
[viii]Section 1302 (b)(2) of the Affordable Care Act

National Survey of Children with Special Health Care Needs backs up this finding for CYSHCN in particular. It found that 7.9% of insured CYSHCN had two or more unmet needs for 14 specific health services.[1] Thirty-four percent, or an estimated 3.6 million, currently insured CYSHCN have parents who report their child's coverage is inadequate in meeting their health care needs.[x]

The Bulletin proposes a solution to filling in existing gaps in the benchmark plans. If a service category is missing from the benchmark plan chosen by an individual state, it must be added using what is offered through one of the other benchmark plans. The exact definition, duration, and scope of services under these categories will vary from state to state.

Q: If states will be choosing from plans that are already in operation, what about state mandated benefits? How will they be impacted?
A: Under the ACA, each state is responsible for the cost of any mandated benefits they may require that go *beyond* the EHB.[xi] There was some concern that this part of the ACA could put existing mandated benefit laws at risk of revocation. The Bulletin allows states the option of choosing a benchmark plan that includes their mandated benefits – they would not have had this same opportunity if there was a national standard. The general consensus is the small group plans (because they're regulated by the individual states) will include the applicable mandated benefits,[xii] so states (especially those with a comprehensive array of mandated benefits) will probably be leaning in the direction of choosing this category of plan. Under the parameters laid

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[1]The specific services include routine preventive care, specialist care, preventive dental care, other dental care, prescription medicines, habilitative therapies, mental health care or counseling, substance abuse treatment or counseling, home health care, vision care or eyeglasses, hearing aids or hearing care, mobility aids or devices, communication aids or devices, disposable medical supplies, and durable medical equipment.

[ix]Skopec, L., Henderson, A., Todd, S., Yong, P. (2011). Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans. Retrieved 3/22/2012 from http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.pdf
[x]National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 3/22/2012 from http://www.childhealthdata.org
[xi]Section 1311(d)(3) of the Affordable Care Act
[xii]Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), *Frequently Asked Questions on Essential Health Benefits Bulletin*, Baltimore, MD (February 17, 2012).

out by the Bulletin, states that are concerned about the cost impact of their mandated benefits will now have an option other than revoking existing law(s). It's important to note that only mandated benefit laws passed prior to December 31, 2011 that go beyond the scope of the EHB can be included without states having to pay any additional cost.

Mandated benefits may still be at risk, though, because the option for relief that we've just described will only be offered for the first two years after the Exchanges open in 2014. The Bulletin says this issue will be revisited in 2016.

Q: How will medical necessity be determined?
A: One issue that the Bulletin did not address is the definition of medical necessity. Pending further guidance from HHS, it seems reasonable to assume that the medical necessity determination process currently used by each benchmark plan will probably roll over into the Exchange plans.

Q: A term I've heard with regard to the benchmark approach that I'm not familiar with is actuarial equivalency. What do I need to know about it?
A: While plans must cover services in each of the ten benefit categories, they have some flexibility in making adjustments to exactly what is covered under each, as long as the benefits are "actuarially equivalent." This means plans can replace some benefits with others that have the same "value." A recent HHS guidance publication gave one hypothetical example: a plan that allows 20 covered physical therapy (PT) visits and 10 occupational therapy (OT) visits would instead be able to allow 10 covered PT visits and 20 OT visits.[xiii] What does this mean for CYSHCN? Operationalizing actuarial equivalence may redirect some benefits important to children to other benefit categories.

Q: Can you summarize what all of this could mean to CYSHCN?
A: The February 17, 2012, "Frequently Asked Questions on Essential Health Benefits Bulletin" guidance offers some clarification with regard to benefit, scope and duration limits, and the coverage of preventative services that appear to have positive implications for CYSHCN. The new plans must be substantially equal to the original benchmark plan, both in terms of the scope of benefits and any limits within them. Moreover, the anti-discrimination provisions in the ACA apply to these new plans and HHS says it will be carefully monitoring them for compliance: plans cannot refuse to cover anyone with pre-existing conditions; are prohibited from coverage rescission; must guarantee issue and renewal regardless of health status, gender, or age; and must

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[xiii]Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), Frequently Asked Questions on Essential Health Benefits Bulletin, Baltimore, MD (February 17, 2012).

not have annual and lifetime benefit caps within them. In addition, the preventive services described under Section 1001 of the ACA are to be part of the EHB, including many that are specific to children.

With no national standardization in the scope, duration, and definition of benefits, variability among states will continue. Children and youth with special health care needs in one state whose coverage comes through the individual or small group market or the Exchange plans might be offered coverage for a different array of services than children with similar coverage and health care needs in neighboring states.

Stakeholder input will be vital in helping decision makers choose a benchmark plan that is comprehensive enough to meet the needs of CYSHCN. Stakeholders should stay informed and get involved with their state's Exchange development.[2] As HHS releases further guidance on the EHB and states make their choices, the Catalyst Center will be providing additional news and analysis to help in this effort.

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[2]An excellent resource for finding out where your state is at in developing its Exchange is the Kaiser Family Foundation's Health Reform Source website (http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17).

About the Catalyst Center

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