# Health Insurance Exchanges, Part II: Essential Health Benefits

**November 8, 2011**
1:00-2:30 pm Eastern

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00-1:05</td>
<td>Anne Hance</td>
<td>Introduction</td>
</tr>
<tr>
<td>1:05-1:20</td>
<td>Joel Ario</td>
<td>Status of Development and Implementation of Health Insurance Exchanges and Essential Health Benefits</td>
</tr>
<tr>
<td>1:20-1:40</td>
<td>Julie Barnes</td>
<td>An In-Depth Look at Essential Health Benefits</td>
</tr>
<tr>
<td>1:40-2:00</td>
<td>Mary Beth Senkewicz</td>
<td>The States’ Perspective on Essential Health Benefits</td>
</tr>
<tr>
<td>2:00-2:30</td>
<td>All</td>
<td>Panel Discussion and Q&amp;A Session</td>
</tr>
</tbody>
</table>
Health Insurance Exchanges, Part II: Essential Health Benefits

Sponsored by the Healthcare Reform Educational Task Force; and the Health Information and Technology; and Payors, Plans, and Managed Care Practice Groups.

Tuesday, November 8, 2011 · 1:00-2:30 pm Eastern

Presenters:

Joel Ario, Esquire, Former Director, Office of Health Insurance Exchanges, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Washington, DC, joelario.pa@gmail.com

Julie Barnes, Director of Health Policy, Bipartisan Policy Center, Washington, DC, jbarnes@bipartisanpolicy.org

Mary Elizabeth Senkewicz, Deputy Commissioner, Life & Health, Florida Office of Insurance Regulation, Tallahassee, FL, marybeth.senkewicz@floir.com

Moderator:

Anne W. Hance, Esquire, Partner, McDermott Will & Emery, Washington, DC, ahance@mwe.com
Joel Ario, Esquire, Former Director, Office of Health Insurance Exchanges, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Washington, DC, joelario.pa@gmail.com
American Health Benefit Exchanges

Two Visions of Exchanges

- New way to purchase insurance product via web
  - Insurance info is transparent, accessible

- New way to ensure continuous coverage
  - Creates options for low-income childless adults, individuals with pre-existing conditions
  - Stabilize coverage between Medicaid and Exchange
Current Progress

Where we are now

- 5 proposed rules released July and August
- July NPRMs focus on state flexibility
  - Exchange Establishment
  - Reinsurance, Risk Adjustment and Risk Corridors
- August NPRMs focus on uniformity, standard consumer experience
  - Exchange Eligibility Determination
  - Medicaid and Eligibility
  - Premium Tax Credits
- Comment deadline extended (Oct. 31); final rules in spring
State Action

- Grants
  - $1M planning grants to 49 states
  - Approximately $400M distributed by HHS
  - Upcoming establishment grants
- Many states moving from planning to establishment
  - Exchange progress dependent on state politics
- Focus on regulation in 2012
  - States want more details from HHS
  - Essential Health Benefits are key concern
Timeline for EHBs

- States concerned about EHB impact on budget
- Stakeholders – need rules finalized by June 2012
  - Federal govt. unlikely to commit to release deadline
- Much work remains to be done
  - Need deliberative process
  - Department of Labor and Institute of Medicine contributed to studies to inform HHS work on EHBs
  - Shared learning opportunities
EHB Strategies

Two main theories on EHB package:

1. Be specific
   - HHS should create very exact list of minimum benefits

2. Emphasize flexibility
   - HHS should allow state discretion in determining benefits
Julie Barnes, Director of Health Policy, Bipartisan Policy Center, Washington, DC, jbarnes@bipartisanpolicy.org
Overview

- Exchanges and PPACA
- Qualified Health Plans
- Actuarial Values
- IOM Report and Recommendations
- Stakeholder Concerns
Exchange Update

- Federal-State Hybrid for Exchanges
- Five core functions:
  - Consumer Assistance
  - Plan Management
  - Eligibility
  - Enrollment
  - Financial Management
- Leverage current state capabilities, federal assistance where necessary
Essential Health Benefits: Overview

Four Key Terms:

- Qualified Health Plans
- Essential Health Benefits
- Actuarial Value
- Cost-Sharing
Qualified Health Plans

- Section 1301 of PPACA
- All plans in exchange must be certified as QHPs
- “Qualified” plans must:
  - Be certified by HHS Secretary *(meet marketing requirements, ensure choice of providers, etc.)*
  - Provide Essential Health Benefits
  - Be offered by insurer in good standing
Essential Health Benefits: Overview

- Section 1302 of PPACA
- EHB is the list of services that must be included in the health insurance product sold in the exchanges
- Goal: standardized, comprehensive benefit package
- EHBs must be part of the following plans:
  - Sold through insurance exchange
  - Offered to newly eligible adult Medicaid beneficiaries (133% FPL)
  - Basic health plans
- HHS Secretary determines EHB standards with advice from DOL, IOM
10 Essential Categories

Definition of EHBs must include at least:

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
<table>
<thead>
<tr>
<th>For Plan Years Beginning January 1, 2014 or Later</th>
<th>Must Provide Essential Health Benefits</th>
<th>Must Limit Cost Sharing and Deductibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchange Plans</td>
<td>Small Group</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Group</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Exchange Plans</td>
<td>New Plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-insured</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Large Group</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Small Group</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Group</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Basic Health</td>
<td>Yes</td>
</tr>
<tr>
<td>Grandfathered Plans</td>
<td>Self-insured</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Large Group</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Small Group</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Non-Group</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: American Cancer Society Cancer Action Network Briefing on Essential Health Benefits.  
Actuarial Value

- Actuarial value is the average of what insurance pays for a standard population of enrollees
- In PPACA, it refers to the percentage of total average costs for covered benefits that a health insurance plan will pay
- Example: a plan with an actuarial value of 70%, the plans will, on average, pay 70% of costs of all covered benefits for a typical population
Actuarial values do not:

- Predict out-of-pocket costs
- Provide a precise measure of the extent of coverage under a health plan
- Incorporate information about provider networks and quality
Actuarial Value

• Actuarial value will be used to categorize plans in exchanges by benefit tiers
  – Platinum = 90% actuarial value
  – Gold = 80% actuarial value
  – Silver = 70% actuarial value
  – Bronze = 60% actuarial value

• There is no uniform method of determining an actuarial value

• http://www.kff.org/healthreform/upload/8177.pdf
Cost-Sharing

- Cost to **individual** for item/service depends on actuarial value of plan
  - 60% (Bronze), 70% (Silver), 80% (Gold), or 90% (Platinum)

- Cost-sharing structure will vary from plan to plan
  - Example: higher deductible but lower coinsurance percentage
  - Example: cover X physician visits before deductible is met, but plan has a higher deductible or coinsurance percentage
Cost-Sharing

- ACA requires plans to cap maximum out-of-pocket costs
- OOP limits are based on high-deductible plans paired with a Health Savings Account
- Current limits are $5,950 (individual) and $11,900 (family)
Rulemaking Process for EHBs

- Dept. of Labor survey of large employer plans (*April 2011*)
- IOM Committee makes recommendations to HHS Secretary (*Fall 2011*)
- Secretary uses IOM framework to determine Essential Health Benefits (*Spring/Summer 2012*)
Institute of Medicine (IOM) Report

- Released October 7, 2011
- Focus on criteria and policy foundations for EHB determination
- Key questions: (1) how to determine EHBs and (2) how to update
IOM Report Findings

- EHB package must balance comprehensiveness of coverage and affordability
- Recommend reflecting scope and design of small employer plans, modified with 10 categories
- Updates and determination must consider costs
  - Affordability is key to intent of PPACA: access
- Ongoing data gathering/review will ensure EHB package is fully evidence-based, specific, and value-based over time
Stakeholder Concerns

Medical Industry
- If EHB package declines to cover certain drug or device, the economic viability of company producing it will be seriously jeopardized

Small and mid-sized employers
- Concerned generous mandated benefits will increase costs without changing underlying cost drivers
Mary Elizabeth Senkewicz, Deputy Commissioner, Life & Health, Florida Office of Insurance Regulation, Tallahassee, FL, marybeth.senkewicz@floir.com
State Perspective

- States may include benefits beyond EHB minimum (Section 1311(d)(3)(B))
  - Benefit standards vary from state to state
  - 2,156 coverage mandates across the states in 2010
  - Range from mammography screening (50 states) to varicose vein removal (1 state)
State Perspective

- **However**, States must pay for any mandated benefits beyond EHB requirements (sec. 1311(d)(3)(B)(ii))
  - PPACA requires states to reimburse exchange qualified health plans or individuals who purchase the plan for any associated cost
  - What is the cost, exactly? No definitive study known.
- Strain on state budgets (but hard to project)
- Enforcement?
- Unaffordable package for small businesses could lead to increase in Medicaid population
Florida Landscape

- Almost 900,000 covered lives in the small group market in 2010
- Exchange work – nothing underway with respect to ACA (FL is the lead state in the 26-state suit challenging constitutionality of the law)
- FL has an exchange-type work underway (the Marketplace) pursuant to a 2008 law, but it will not qualify to be a federally-approved exchange as constructed
Typical Small Business Package

- Pretty comprehensive in range of covered services
- As usual, the devil is in the details – in the limitations, conditions and exclusions
- Deductibles, copays and coinsurance can very greatly. In the new order, this will be part of the precious metals calculations
Future of the Market

- Beginning in 2014, there will be two markets – inside the exchange and outside the exchange
- Critically important that both markets operate under the same set of rules
- Of course, the elephant in the room is the cost of health care
- Important that essential benefits package be flexible and affordable
Q&A
Health Insurance Exchanges, Part II: Essential Health Benefits© 2011 is published by the American Health Lawyers Association. All rights reserved. No part of this publication may be reproduced in any form except by prior written permission from the publisher. Printed in the United States of America.

Any views or advice offered in this publication are those of its authors and should not be construed as the position of the American Health Lawyers Association.

“This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought”—from a declaration of the American Bar Association