Calif. Takes Stab At Its Own Essential Health Benefits

Law360, New York (February 05, 2013, 12:11 PM ET) -- The long-awaited proposed rule to implement the "essential health benefits" provisions of the Affordable Care Act was published in late November 2012 with public comments due the day after Christmas.[1] Even before the U.S. Department of Health and Human Services released this proposal, some states proceeded with their own proposals for implementing the required essential health benefits package for their states' plans and exchanges.

These state-based efforts matter because the HHS' proposed rule gives the individual states leeway in defining the scope of essential health benefits. More specifically, the essential health benefits proposed rule confirms the general approach that the HHS forecasted in a December 2011 bulletin: Each state may choose a "benchmark" plan, which would serve as a baseline for all plans in the state that must provide essential health benefits. For states that decline to select a benchmark plan, the HHS proposes a "default" option.

California was one of the first states to announce its intended benchmark plan through SB 951.[2] This article takes a closer look at California's approach to defining essential health benefits and examines potential implications for health care stakeholders, particularly in light of the federal overlay provided in the recently issued proposed rule, which the HHS released after California announced its selection.

The Basic Federal Approach: Benchmark Plans

The ACA requires that by Jan. 1, 2014, state-based health benefits exchanges must be operating. All nongrandfathered health plans in the individual and small group markets — both within and outside of the exchanges — must provide essential health benefits as established under the ACA[3] and further defined by the HHS.

The statute identifies 10 categories of services that plans must cover and requires that the essential health benefits package reflect balance among these categories and be equal in scope to a typical employer health plan. The statute also instructs the HHS to take into account diverse populations and to ensure that the essential health benefits design does not discriminate or allow denials based on a person's age, disability or life expectancy.

Starting with that statutory skeleton, the HHS has proposed a framework that permits a state to select a "base-benchmark plan" from among four types of health care plans:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market

2. Any of the largest three state employee health benefit plans by enrollment

3. Any of the largest three national Federal Employee Health Benefits Program (FEHBP) plan options by enrollment

4. The largest commercial non-Medicaid health maintenance organization (HMO) operating in the state.[4]

For states that do not select their own base-benchmark plan, the HHS proposes to select, by default, the largest plan by enrollment in the largest product in the state's small group market.[5]

The proposed rule establishes benefit supplementation requirements in the event that a selected or default base-benchmark plan does not provide all of the required benefit categories.[6] It also states that essential health benefits requirements are not satisfied if a plan's benefit design or its implementation discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.[7]

A selected base-benchmark plan would become a state's essential health benefits benchmark plan only after satisfying all of the proposed rule's standards for coverage, supplementation, balance and nondiscrimination.[8]

California's Approach: SB 951

Sen. Ed Hernandez, D-Calif., introduced SB 951 in January 2012, shortly after the HHS issued its December 2011 bulletin regarding essential health benefits[9] but nearly a year before the HHS released its proposed rule in November 2012. SB 951 was approved by Gov. Edmund Brown and filed with the secretary of state on Sept. 30, 2012.

SB 951 designates the Kaiser Foundation Health Plan Small Group HMO 30 plan, as offered during the first quarter of 2012 , as California's benchmark plan for essential health benefits. Under this law, nongrandfathered individual or small-group plans issued, amended or renewed in California on or after Jan. 1, 2014, regardless of whether they are regulated by the California Department of Managed Health Care or the Department of Insurance and whether they are offered inside or outside the California Health Benefit Exchange, must provide a minimum level of benefits akin to coverage under the selected Kaiser plan.

SB 951 defines essential health benefits for California as including the ACA's 10 benefit categories, plus the health benefits covered by the selected Kaiser plan, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage and additional state-required benefits as discussed below.

SB 951 states that it intends to comply with federal law and to implement the essential health benefits requirements in a manner consistent with the ACA, including related federal regulations and guidance. It prohibits health insurers from indicating or implying that a plan covers essential health benefits, unless the plan meets all of SB 951's requirements.

ACA's 10 Essential Health Benefits Categories Under SB 951

SB 951 defines essential health benefits as including, but not limited to, items and services covered by the ACA's listed benefits categories, which are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.

To follow are some key considerations related to these benefit categories under SB 951.

Mental Health Parity

Consistent with the ACA's Section 1311(j), SB 951 requires that coverage of mental health and substance use disorder services comply with federal laws, regulations and guidance on mental health parity.

Prescription Drugs

The December 2011 bulletin suggested that plans may be able to satisfy the essential health benefits prescription drug coverage requirements by covering one drug per therapeutic class. The proposed rule provides, instead, that plans must cover the greater of: one drug in every category and class or the same number of drugs in each category and class as the benchmark plan.[10]

It also requires plans to implement procedures to ensure enrollees' access to clinically appropriate drugs that a provider prescribes but are not included on the plan's formulary.[11] Several patient advocacy groups have expressed concern that the proposed rule's approach, while an improvement over the bulletin, provides insufficient access protections for individuals with serious and chronic conditions, which could lead to poor clinical outcomes and increased spending on other medical services, such as hospitalizations.

For California, this proposal means that state-regulated plans required to offer essential health benefits must provide the same number of drugs, per therapeutic class, as the selected Kaiser plan (as offered during first quarter of 2012). If the Kaiser plan covers zero drugs in any category, plans must cover at least one drug in each such category.

Plan documents indicate that although the selected Kaiser plan's formulary covers multiple drugs in several classes, options may be limited for a number of health conditions. This approach to prescription drug coverage contrasts with other possible approaches, such as an "open formulary" as certain FEHBP plans use.

Habilitative Services and Devices

SB 951 defines "habilitative services" and requires plans to cover such services under the same terms and conditions as rehabilitative services.

Pediatric Services

SB 951 requires the same health benefits for pediatric vision services as provided under the largest Federal Employees Dental and Vision Insurance Program vision plan as of first quarter of 2012.

For pediatric oral care, SB 951 requires plans to cover the same benefits as required under the pediatric dental plan available to Healthy Families Program subscribers in 2011 to 2012, including medically necessary orthodontia provided under the federal Children's Health Insurance Program Reauthorization Act of 2009.

Plans must provide these pediatric benefits in addition to any such services covered under the selected Kaiser benchmark plan.

Additional State-Required Benefits Under SB 951

The ACA permits states to include additional state-required benefits in their definitions of essential health benefits if the state defrays such benefits' cost. Importantly, for states (like California) with state-mandated benefits provisions that predate — and exceed — the federal essential health benefits requirements, the HHS proposes that states would not be required to defray the costs of additional state-mandated benefits that were in place before Dec. 31, 2011.

Under the proposed rule, then, California would not have to defray the costs of state-mandated benefits included in SB 951's definition of essential health benefits, which include the following, among others, as offered under the selected Kaiser plan during first quarter of 2012, pursuant to statutes enacted before Dec. 31, 2011:

- Medically necessary basic health care services, as defined under California law, including physician services, hospital inpatient and ambulatory care services, diagnostic laboratory and diagnostic and therapeutic radiologic services, home health services, preventive health services and emergency health care services
- HIV testing and AIDS vaccine
- Certain medically necessary equipment and supplies for managing and treating diabetes, even if available without a prescription
- Breast cancer screening, mammography and mastectomies
- Screenings for prostate, cervical and other cancers
- Cancer clinical trials

SB 951 states that its coverage requirements apply only to the extent that federal law does not require the state to defray the costs.

Key Considerations for Stakeholders Moving Forward

Given the significant state-by-state variation permitted under the proposed federal rule's approach to defining essential health benefits, stakeholders would be wise to focus on states' individual efforts to implement these requirements, in addition to following the emerging federal overlay.

These developments are proceeding under aggressive timelines — and carry weighty implications for patient access to coverage both within and outside of the exchanges. While California's approach in SB 951 provides just one example of how the essential health benefits requirements are taking shape in each state, this large state's early efforts may be particularly informative to stakeholders following these fast-paced developments.

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[1] the HHS, Proposed Rule, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70643 (Nov. 26, 2012).

[2] SB 951, as approved by the Governor and filed with the Secretary of State on Sept. 30, 2012.

[3] Specifically, Section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

[4] Proposed 45 C.F.R. § 156.100(a), 77 Fed. Reg. at 70669.

[5] Proposed 45 C.F.R. § 156.100(c), 77 Fed. Reg. at 70669.

[6] Proposed 45 C.F.R. § 156.110(a)–(c), 77 Fed. Reg. at 70669–70670.

[7] Proposed 45 C.F.R. § 156.125, 77 Fed. Reg. at 70670.

[8] Proposed 45 C.F.R. §§ 156.100(b) & 156.110, 77 Fed. Reg. at 70669–70670.

[9] the HHS Center for Consumer Information and Insurance Oversight, Essential Health

Benefits Bulletin (Dec. 16, 2011).

[10] Proposed 45 C.F.R. § 156.120(a), 77 Fed. Reg. at 70670.

[11] 77 Fed. Reg. at 70652 ; see also proposed 45 C.F.R. § 156.120(c), 77 Fed. Reg. at 70670.