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Federal Essential Health Benefits under the Affordable Care Act: Technical Assistance Guide to California Implementation

FOR DISCUSSION PURPOSES

BACKGROUND AND CONTEXT

This is a discussion guide to inform California's implementation of the requirement in the federal Patient Protection and Affordable Care Act (PPACA) that health coverage sold to individuals and small groups offer minimum coverage, defined as essential health benefits. The goal of this discussion guide is to highlight approaches in state law that could contribute to uniformity and consistency for California consumers in the minimum essential health benefits, regardless of whether they purchase coverage overseen by the state Department of Managed Health Care or the California Department of Insurance.

A consistent set of minimum benefits across all products, as contemplated in the ACA, would allow consumers to evaluate their coverage options by focusing on other elements of the coverage plans available, such as levels of cost sharing, network of providers, quality and performance metrics and additional benefits above the minimum which they may choose to purchase.

Pursuant to federal guidance,[1] hereafter referred to as *the Bulletin*, states can choose from among ten benchmark plan options to define essential health benefits. For illustration purposes only, this discussion guide was developed using one of the ten benchmark options for California, a Kaiser HMO plan sold to small groups, (and the Evidence of Coverage (EOC) for that plan), which is currently proposed as the California benchmark in pending state legislation.

Depending on the benchmark option the state selects, the mix of appropriate provisions could be different. The starting point benchmark plan will in many ways be the underpinning for how state implementation would need to proceed. If policymakers consider designating another of the ten coverage options as the benchmark plan, we can provide similar technical assistance on what provisions would contribute to the goal of uniformity and consistency of essential health benefits across the individual and small group markets.

[1] *Essential Health Benefits Bulletin*, Center for Consumer Information and Insurance Oversight, December 16, 2011.

POTENTIAL PROVISIONS APPLICABLE TO HEALTH CARE SERVICE PLANS UNDER THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF OF 1975, CALIFORNIA HEALTH AND SAFETY CODE SECTION 1341 ET SEQ

a) To the extent required in federal law, commencing January 1, 2014, health care service plan contracts marketed, offered or sold to individuals, or to small groups as defined in Section 1357, other than a grandfathered plan contract, shall include coverage for, at a minimum, essential health benefits pursuant to PPACA and as outlined in this section. Essential health benefits pursuant to PPACA includes the following general categories:

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; and
10) Pediatric services, including oral and vision care.

For purposes of this section, ***"PPACA"*** means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(b) For purposes of this section, the "***benchmark plan"*** for essential health benefits shall be the Kaiser Small Group HMO Plan contract (product number 40513CA035), a health care service plan contract licensed pursuant to this Act, and shall include the services and items covered by that plan as it was offered and in effect December 31, 2011. All references to specific sections of existing law or requirements applicable to the benchmark plan shall be references to those sections or requirements as applicable as of December 31, 2012, unless otherwise specified.

(c) For purposes of this section, ***"essential health benefits***" shall include:

1) Medically necessary basic health care services as defined in Section 1345 (b), 28 CCR 1300.67 and covered by the benchmark plan:

A) Physician services, including consultation and referral;
B) Hospital inpatient services and ambulatory care services;
C) Diagnostic laboratory and diagnostic and therapeutic radiologic services;
D) Home health services, up to 100 visits per calendar year ***[Benchmark limitation]***;
E) Preventive health services;
F) Emergency health care services, to include ambulance and ambulance transport services, including transport services provided through the "911" emergency response system; and
G) Hospice care.

[Note: The health plan offering the benchmark plan may have some statutorily authorized differences from Health and Safety Code Section 1371.4 (and by reference HSC 1317.1), relating to coverage for emergency services, than would otherwise apply to Knox-Keene plans]

2) Services that are not basic health care services in state law but are required essential health benefits in federal law and subdivision (a), including but not limited to:

   A) Prescription drugs ***[The benchmark plan applies a formulary to this benefit]***;

   B) Pediatric vision and oral care; and

   [not defined in the ACA or the federal Bulletin -- the Bulletin outlines two options for dental coverage for children: states may select from (1) the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan, or (2) the State's separate Children's Health Insurance Program. The Bulletin states that non-medical orthodontic benefits would be excluded. For vision, states must use the FEDVIP with the largest enrollment]

   C) Habilitative services.

   [not defined in the ACA or the federal Bulletin -- the Bulletin outlines two options being considered: (1) Habilitative services would be provided at parity with rehabilitative services or (2) Plans could decide what to cover and report to DHHS].

3) Services which may not be basic health care services, or essential health benefits in federal law as outlined in subdivision (a), but which are covered in the benchmark plan, including the following:

   A) Acupuncture services, typically for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain;
   B) Durable medical equipment (DME) for home use ***[Benchmark plan applies a formulary for these benefits stating that most DME is not covered]***;
   C) Health education counseling;
   D) Routine hearing screenings and hearing exams to determine the need for hearing correction;
   E) Routine vision screenings that are preventive care services;
   F) Skilled nursing facility care, up to 100 days per benefit period. For purposes of this benefit, consistent with benchmark plan, the benefit period begins on the date a covered person is admitted to a hospital or skilled nursing facility and ends on the date they have not been an inpatient in a hospital or skilled nursing facility for 60 consecutive days ;
   G) Routine vision services that are preventive and eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses; and
   H) Prosthetic and orthotic devices subject to specified limits and conditions in the benchmark plan ***[Benchmark plan EOC states that most prosthetic and orthotic devices are not covered]***.

4) Mandated benefits pursuant to state and federal law enacted prior to December 31, 2012.

d) Scope and duration limits imposed on essential health benefits as defined in this section shall be no greater than the scope and duration limits imposed on those items and services under the benchmark plan. However, no scope and duration limits may be imposed on essential health benefits that are otherwise inconsistent with the requirements of this section.

e) This section shall not be construed to prohibit a health plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code, however, such benefits shall not be deemed to be essential health benefits for the purposes of this section.

f) This section shall apply regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

h) No health care service plan, or its agent, solicitor or representative, shall offer, market, represent or sell any product, contract or discount arrangement as minimum coverage, or as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

i) For health plan contracts sold to individuals and small groups, all references to basic health care services in this chapter shall be deemed to be a reference to essential health benefits. Coverage for essential health benefits shall be subject to the requirements of this Act and its implementing regulations applicable to basic health care services, including, but not limited to the enrollee's right to independent medical review pursuant to section 1374.30 et seq. In addition, health plan contracts subject to this section shall comply with the following:

   1) All medically necessary care and services shall be covered for severe mental illnesses pursuant to section 1374.2, notwithstanding any contract provisions limiting or excluding such care, and shall comply with the federal Mental Health Parity and Addiction Equity Act of 2008; and
   2) All medically necessary prescription drugs must be provided pursuant to Section 28 CCR 1300.67.24; and
   3) Coverage for prescription drugs shall be subject to the same coverage standards applicable to prescription drugs in the benchmark plan as determined by the Director, including at a minimum, drug formulary disclosure as in Section 1363.01, 1367.20 and Section 1367.24, and continuity of drug coverage pursuant to Section 1367.22.

j) Nothing in this section shall impose on health care service plan contracts the cost sharing or network limitations of the benchmark plan except to the extent otherwise required to comply with provisions of this chapter applicable to all health care service plan contracts offered to individuals and small groups.

k) No later than February 1, 2013, the Director shall, in consultation with the Commissioner of Insurance, develop and publish one final list of essential health benefits for all individual and small

group coverage, consistent with federal law and this section, to ensure consistency and uniformity of minimum benefits in health care service plan contracts subject to this section and health insurance policies subject to _____. In developing the benefit list, the Director and Commissioner shall take into account federal rules and guidance applicable to essential health benefits as of that date and shall consult with the federal Department of Health and Human Services.

POTENTIAL PROVISIONS APPLICABLE TO HEALTH INSURERS UNDER THE CALIFORNIA INSURANCE CODE:

a) To the extent required in federal law, commencing January 1, 2014, policies of health insurance marketed, offered or sold to individuals, or to small groups as defined in Section 10700, other than a grandfathered policy and policies described in subdivision (i), shall include coverage for, at a minimum, essential health benefits pursuant to PPACA and as outlined in this section. Essential health benefits required pursuant to PPACA includes the following general categories:

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; and
10) Pediatric services, including oral and vision care.

For purposes of this section, ***"PPACA***" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(b) For purposes of this section, the "***benchmark plan"*** for essential health benefits shall be the Kaiser Small Group HMO Plan contract (product number 40513CA035), a health care service plan contract licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code Section 1341 et seq, and shall include the services and items covered by the contract as it was offered and in effect December 31, 2012. All references to specific sections of existing law or requirements applicable to the benchmark plan shall be references to those sections or requirements as applicable as of December 31, 2012, unless otherwise specified.

(c) For purposes of this section, ***"essential health benefits***" shall include:

1) Medically necessary basic health care services covered in the benchmark plan, as follows:

A) Physician services, including consultation and referral;
B) Hospital inpatient services and ambulatory care services;
C) Diagnostic laboratory and diagnostic and therapeutic radiologic services;
D) Home health services, up to 100 visits per calendar year ***[Benchmark limitation]***;
E) Preventive health services;

F) Emergency health care services, to include ambulance and ambulance transport services, including transport services provided through the "911" emergency response system; and
G) Hospice care.

2) Medically necessary services that are not basic health care services in state law but are required essential health benefits in federal law and subdivision (a), including but not limited to:

A) Prescription drugs ***[Benchmark plan applies a formulary to this benefit];***

B) Pediatric vision and oral care ; and

[not defined in the ACA or the federal Bulletin -- the Bulletin outlines two options for dental coverage for children: states may select from (1) the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan, or (2) the State's separate Children's Health Insurance Program. The Bulletin states that non-medical orthodontic benefits would be excluded. For vision, states must use the FEDVIP with the largest enrollment]

C) Habilitative services.

[not defined in the ACA or the federal Bulletin -- the Bulletin outlines two options being considered: (1) Habilitative services would be provided at parity with rehabilitative services or (2) Plans could decide what to cover and report to DHHS].

3) Medically necessary services which may not be basic health care services in state law, or essential health benefits in federal law as outlined in subdivision (a), but which are covered in the benchmark plan, including the following:

A) Acupuncture services, typically for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain;
B) Durable medical equipment (DME) for home use ***[Benchmark plan applies a formulary for these benefits stating that most DME is <u>not</u> covered]***;
C) Health education counseling;
D) Routine hearing screenings and hearing exams to determine the need for hearing correction;
E) Routine vision screenings that are preventive care services;
F) Skilled nursing facility care, up to 100 days per benefit period. For purposes of this benefit, consistent with benchmark plan, the benefit period begins on the date a covered person is admitted to a hospital or skilled nursing facility and ends on the date they have not been an inpatient in a hospital or skilled nursing facility for 60 consecutive days ;
G) Routine vision services that are preventive and eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses; and
H) Prosthetic and orthotic devices subject to specified limits and conditions in the benchmark plan ***[Benchmark plan EOC states that most prosthetic and orthotic devices are <u>not</u> covered]***.

4) Mandated benefits pursuant to state and federal law enacted prior to December 31, 2011.

d) Scope and duration limits imposed on essential health benefits as defined in this section shall be no greater than the scope and duration limits imposed on those items and services under the benchmark plan. However, no scope and duration limits may be imposed on essential health benefits that are otherwise inconsistent with the requirements of this section.

e) This section shall not be construed to prohibit a health insurance policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code, however, such benefits shall not be deemed to be essential health benefits for the purposes of this section.

f) This section shall apply regardless of whether the health insurance policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

h) No health insurer, or its agent, solicitor or representative, shall offer, market, represent or sell any product, policy or discount arrangement as minimum coverage, or as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

i) This section shall not apply to a policy that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec 300gg-21) ***[Note: These types of benefits and products cannot be licensed at all under the Knox-Keene Act so this reference is not needed in the Health and Safety Code.]***

j) Coverage for essential health benefits shall be subject to the requirements of this Code and its implementing regulations, including, but not limited to the insured's right to independent medical review pursuant to section 10169 et seq. In addition, health insurance policies subject to this section shall comply with the following:

   3) All medically necessary care and services shall be covered for severe mental illnesses pursuant to section 1374.2, notwithstanding any contract provisions limiting or excluding such care, and shall comply with the federal Mental Health Parity and Addiction Equity Act of 2008; and
   4) All medically necessary prescription drugs must be provided pursuant to Section 28 CCR 1300.67.24; and
   5) Coverage for prescription drugs shall be subject to the same coverage standards applicable to prescription drugs in the benchmark plan as determined by the Commissioner in consultation with the Director of Managed Health Care, including at a minimum, drug formulary disclosure as in Section 1363.01, 1367.20 and Section 1367.24, and continuity of drug coverage pursuant to Section 1367.22.

k) Nothing in this section shall impose on health insurance policies the cost sharing or network limitations of the benchmark plan except to the extent otherwise required to comply with provisions of this Code, including this section, and as otherwise applicable to all health insurance policies

offered to individuals and small groups.

l) No later than February 1, 2013, the Commissioner shall, in consultation with the Director of the Department of Managed Health Care, develop and publish one final list of essential health benefits for all individual and small group coverage, consistent with federal law and this section, to ensure consistency and uniformity of minimum benefits in health care service plan contracts subject to this section and health insurance policies subject to _____. In developing the benefit list, the Commissioner and Director shall take into account federal rules and guidance applicable to essential health benefits as of that date and shall consult with the federal Department of Health and Human Services.

KELCH POLICY GROUP

Supported by a grant from the California HealthCare Foundation to the Kelch Policy Group, the ***Health Insurance Alignment Project*** provides policy research, analysis and strategic assistance to advance the goals of reducing duplication, improving transparency and maximizing consumer protections in health insurance oversight in California.

The objectives of the Project are to: (1) Advance federal Affordable Care Act health insurance market reforms by providing California-specific analysis and offering technical assistance and process facilitation to key decision makers and staff; (2) Improve coordination and accountability of health insurance oversight through analysis and commentary, highlighting state challenges and opportunities related to health insurance oversight; and (3) Engage in a process and develop a framework for assessing long-term progress toward implementation of ACA reforms and effective health insurance oversight in California.

Kelch Policy Group is an independent health policy research and consulting firm based in Sacramento, California. The firm founder, Deborah Reidy Kelch, MPPA has more than 30 years of experience in California health policy, including 15 years as policy and fiscal staff to the California State Legislature.