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CCIIO Issues Bulletin on Plans to Define the Essential Health Benefits Package: Providing States with a Significant Role While Still Leaving Room for Public Input

RESOURCE LINKS

CCIIO Essential Health Benefits Bulletin:
http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

Comments Should Be Submitted Electronically to:
EssentialHealthBenefits@cms.hhs.gov

IMPORTANT DATES

Deadline to Submit Comments to CMS:
January 31, 2012

On December 16, 2011 the Center for Consumer Information and Insurance Oversight ("CCIIO") within the Centers for Medicare & Medicaid Services ("CMS") released a "bulletin" to "***provide information*** and ***solicit comments*** on the ***regulatory approach*** that the Department of Health and Human Services ("HHS") ***plans to propose*** to define essential health benefits ("EHB") under section 1302 of the Affordable Care Act."[1] **Public comments must be submitted to CMS by January 31, 2012.** Comments should be sent to EssentialHealthBenefits@cms.hhs.gov.

As we described in more detail in earlier publications (*see* the BNA *Health Insurance Report* article entitled "The Importance of Stakeholder Participation in the Process to Define the 'Essential Health Benefits Package'"; the Epstein Becker Green *Implementing Health and Insurance Reform* alert entitled "Meeting the Requirements for Defining the 'Essential Health Benefits Package': DOL Publishes Survey of Employer-Sponsored Coverage"; and the *Law360* article entitled "Defining the Essential Health Benefits Package"), the scope of the EHB package is defined in the Patient Protection and Affordable Care Act ("ACA") to include the following 10 categories of services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;

[1] Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin (Dec. 16, 2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (emphasis supplied) [hereinafter "CCIIO Bulletin"].

- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.[2]

Only "qualified health plans" that include the EHB package are eligible to be offered in the new state exchanges starting in 2014. Additionally, all products offered in the individual and small group markets, both inside and outside the state exchanges, must offer the EHB package.[3]

With limited additional guidance, ACA delegates the responsibility for defining the specifics of the EHB package to the Secretary of HHS (the "Secretary"). In defining the EHB package, the Secretary's approach must balance a number of competing considerations to ensure that, among other things, the benefit package covers all 10 categories of services identified in the statute in a balanced manner; "equals" a "typical" employer health benefit plan; and prevents incentives for coverage decisions, cost sharing, or reimbursement rates that discriminate against individuals because of their age, disability, or expected length of life.[4] The Secretary also must give states a role in this process, particularly as the saying "all health care is local" rings especially true when making coverage determinations (and deciding how to balance comprehensiveness with cost) related to the services included in the EHB package.

Accordingly, the Secretary, acting through CCIIO, published a "bulletin" as a way to provide information to stakeholders (*i.e.,* consumers, states, employers, and health insurance issuers) about what benefits are likely to be required to be offered through the state exchanges. In a somewhat unexpected departure from recommendations provided to the Secretary by the Institute of Medicine, CCIIO proposes to provide states with a much more significant role in defining the EHB package.[5] Rather than specifying which health benefits will be included in, and which will be excluded from, the EHB package, CCIIO proposes to allow the states to select the standard that will apply in their state to the health plans offered through the new state exchanges. States may choose from one of the following four benchmark plan types:

- The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- Any of the largest three state employee health benefit plans by enrollment;

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[2] *See* Section 1302(b)(1) of the Patient Protection and Affordable Care Act (Pub. L. 111-148) [hereinafter "ACA"].

[3] Even health plan products offered to large groups are impacted by which benefits are included in the EHB package through a prohibition on lifetime and annual benefit limits. See ACA § 1001, adding a new § 2711 to the Public Health Service Act.

[4] *See* CCIIO Bulletin at 8.

[5] The Institute of Medicine, in a report requested by the Secretary and published on Oct. 7, 2011, provided guidance on criteria and methods that the Secretary should use in determining and periodically updating the EHB package. Recommendations in this report include, but are not limited to, the following: a "typical" employer plan should be based on what is offered in the small group market; the scope of what is "typical" should be tied to the premium rather than to a specific benefit definition and the Secretary should establish a national average premium target; the Secretary should offer as much specificity as possible in order to "ensure a more consistent national benefit package"; the Secretary should develop a "preliminary service list" with inclusions and exclusions across the 10 categories of services; and coverage limits should be "evidence based" and covered if medically necessary. *See* Institute of Medicine, "Essential Health Benefits: Balancing Coverage and Costs" (Oct. 7, 2011), *available at* http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

- Any of the largest three national Federal Employees Health Benefits Program ("FEHBP") plan options by enrollment; or
- The largest insured commercial non-Medicaid health maintenance organization ("HMO") operating in the state.[6]

Under this approach, states will select one of these benchmarks for 2014 and 2015.[7] The benefits and services included in the benchmark health insurance plan selected by the state would be the EHB package, thereby effectively deeming all of the benefits and services covered by the benchmark plan "essential" and potentially allowing states to avoid having to assume costs for additional state-mandated benefits.[8] Health plans have the ability to modify coverage within a benefit category so long as the overall value of the coverage is not reduced. If a state selects a benchmark plan that does not cover all 10 categories of services identified in the statute (*e.g.,* mental health and substance use disorder services, habilitative services, pediatric oral services, and pediatric vision services), then the state will need to supplement that benchmark plan.[9] If a state chooses not to select a benchmark health plan, CCIIO suggests that the default benchmark plan for that state would be the largest health plan by enrollment in the largest product in the state's small group market.

The "bulletin" does not address whether a federal benchmark will be developed for multistate plans established through the Office of Personnel Management ("OPM").[10] These particular health plans are required to cover the EHB package and meet all the requirements of a qualified health plan included in a state exchange, but additional guidance will have to be provided by CCIIO for these plans to understand what benchmark should be applied to them.

Additionally, the "bulletin" does not address how to calculate the actuarial value of a plan,[11] and how to determine the provision of minimum value by employer-sponsored coverage.[12] CCIIO intends to release additional guidance on cost-sharing rules (*i.e.,* deductibles, copayments, and coinsurance)

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[6] *See* CCIIO Bulletin at 9.

[7] CCIIO intends to "assess the benchmark process for 2016 and beyond ***based on evaluation and feedback***." CCIIO Bulletin at 9 (emphasis supplied).

[8] ACA § 1311(d)(3)(B) allows states to require plans offered through the state exchange to offer benefits in addition to the EHB package, but must assume the cost to the individual for those additional benefits.

[9] CCIIO states that it is considering various policy options for how a state supplements a benchmark plan if certain benefit categories are not covered. Suggested policy options include using benefits from any other benchmark option, using the largest plan in a benchmark type (*e.g.,* small group plans, state employee plans, or FEHBP plans) by enrollment offering the benefit, or using the FEHBP plan with the largest enrollment. Additional policy options specifically for supplementing habilitative, pediatric oral and pediatric vision services also are discussed in the "bulletin." *See* CCIIO Bulletin at 10-11.

[10] ACA § 1334 requires OPM to contract with health insurers to offer at least two multistate health plans (at least one of which is a nonprofit plan) through the exchanges in each state. OPM is authorized to prohibit multistate plans that do not meet standards for medical loss ratios, profit margins, and premiums.

[11] ACA § 1302(d)(1) describes four levels of coverage that must be included in the EHB package. The level of coverage determines the actuarial value of the benefits provided under a qualified health plan: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.

[12] For purposes of determining eligibility for premium tax credits available to assist low-income individuals and families who cannot obtain affordable health insurance through their employers to purchase coverage through the state exchanges, the affordability and minimum value of an employer-sponsored plan must be determined. An employer-sponsored plan provides "minimum value" only if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent. *See* ACA § 1401, adding a new § 36B to subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits).

that will impact the determination of a plan's actuarial value, as well as guidance on how the EHB package will be implemented in the Medicaid program.[13]

As we have stated previously, it is imperative that the procedural process for defining the EHB package be inclusive, transparent, and efficient.[14] By releasing a "bulletin" before a formal notice of proposed rulemaking, in addition to seeking input from the Institute of Medicine, the Department of Labor, and the public through public listening sessions, CCIIO is attempting to be as inclusive as possible. However, those affected by these positions need to make their issues known in order to continue to shape the outcome in a way that makes sense to achieve a positive outcome.

Indeed, the process of releasing a "bulletin" in advance of a proposed rule or an interim final rule with comment period, in order to give the public an idea of the agency's thinking on a policy, itself, is unusual. While other government agencies release bulletins or notices for public comment,[15] CMS does not generally provide an opportunity for public comment on its guidance documents outside of the formal rulemaking process or through published requests for information.

By stating that the "bulletin" describes what CCIIO "plans to propose" or "intend[s] to propose," this suggests that a notice of proposed rulemaking will be published in the future. However, it is not clear whether a future rulemaking will take the form of a proposed rule or an interim final rule with a comment period. Also, because comments on the "bulletin" are submitted to an email address rather than through the public Regulations.gov website, and, therefore, may not be made available to the public, it is not clear the extent to which CCIIO will specifically respond to any of the comments received in any such future rulemaking. Regardless, the more feedback HHS receives on this important provision, the greater the likelihood that the Secretary will be able to reach an appropriate balance that addresses the manifold interests at stake including, but not limited to, the breadth of services covered, the affordability of the EHB benefit package, the desire to establish baseline guidance to create some uniformity across states, and the need to give states the flexibility to determine what benchmark is the most appropriate for the needs of the individual state. Stakeholders

[13] Benefits for newly eligible Medicaid recipients are limited to the benchmark and benchmark-equivalent packages established under the Deficit Reduction Act of 2005 (Pub. L. No. 109-171), regardless of whether the state has opted to provide benchmark coverage as provided under the DRA. No federal matching is available for benefits beyond the benchmark or benchmark-equivalent definition. Effective January 1, 2014, Medicaid benchmark benefit packages and benchmark-equivalent coverage must use the EHB package offered through the state exchanges as the benchmark.

[14] *See* BNA's *Health Insurance Report*, "The Importance of Stakeholder Participation in the Process to Define the 'Essential Health Benefits Package'" (Jan. 5, 2011), *available at* http://www.ebglaw.com/showarticle.aspx?Show=13830.

[15] For example, the Office of Management and Budget published a draft bulletin for public comment entitled "Agency Good Guidance Practices" to establish policies and procedures for the development, issuance, and use of significant guidance documents by Executive Branch departments and agencies. *See* 70 Fed. Reg. 71,866 (Nov. 30, 2005). In another more recent example, a number of agencies participated in a coordinated effort to issue draft notices soliciting public comments on various policy issues related to the development of accountable care organizations under the Medicare Shared Savings Program. The Internal Revenue Service published a draft notice soliciting comments on the application of tax-exempt organization requirements to hospitals or other health care organizations participating in the Medicare Shared Savings Program. *See* IRS Notice 2011-20 (Mar. 31, 2011), *available at* www.irs.gov/pub/irs-drop/n-11-20.pdf. The Office of the Inspector General published a notice with CMS soliciting public input on possible waivers to the application of the Physician Self-Referral Law, the federal anti-kickback statute, and certain civil monetary penalties law provisions to specified financial arrangements involving accountable care organizations under the Medicare Shared Savings Program. *See* 76 Fed. Reg. 19,655 (Apr. 7, 2011). The Federal Trade Commission and the Department of Justice also issued a joint notice seeking public comments on a "Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program." *See* 76 Fed. Reg. 21,894 (Apr. 19, 2011).

interested in the EHB package definition process should consider submitting comments and actively engaging in public dialogue with HHS on the process now.

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For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, please contact one of the authors below or the member of the firm who normally handles your legal matters.

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