

# **Essential Health Benefits Reinsurance & Risk Adjustment**

Joint Select Committee, Health Reform  
Implementation  
October 17, 2012

Office of the Insurance Commissioner



- ▶ The Essential Health Benefits Package is a set of 10 service categories that must be covered by health plans beginning in 2014

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity & Newborn care
5. Mental health & substance use disorder services
6. Prescription drugs
7. Rehabilitative & habilitative services/devices
8. Laboratory services
9. Preventive & Wellness services; chronic disease management
10. Pediatric services, including oral & vision

## SERVICES and SUPPLIES

**Benchmark Plans** for the Individual and Small Group Markets:

Regence *Innova* small group plan

State CHIP dental benefits for the pediatric oral benefit category

- ▶ Essential health benefits are the basis for minimum individual and small group coverage, starting in 2014
- ▶ Plans sold both through the Exchange and outside the Exchange must cover the EHB package
- ▶ Medicaid has a separate benchmark EHB package – this process doesn't establish that benchmark

## Number of Washingtonians

### *Individual market:*

Today: 308,562

2014: approx. 466,000

### *Small group market:*

Today: 298,636

2014: approx 313,000

# Selecting the Benchmark Base Plan

---

- ▶ December 2011: HHS told states they had 10 benchmark options to choose from
- ▶ February 2012: HHS added explanation about supplementing the selected benchmark to make sure all 10 categories are covered
- ▶ March 2012: E2SHB 2319 becomes effective, requiring the Commissioner to designate the largest small group plan as the selected benchmark option
- ▶ April – May 2012: OIC collects enrollment data to determine the largest small group plan, and the second largest and third largest
- ▶ June 2012: HHS establishes templates and 9/30 deadline for submission of state EHB benchmark designations; ongoing verbal guidance to states during weekly calls (Aug-Sept)
- ▶ June 2012: OIC rule making for the EHB designation starts
- ▶ July – November: stakeholder work and public comment period related to supplementation of the benchmark, “meaningful benefits,” classification of services, and scope and limitation requirements
- ▶ October 2012: OIC submits designation to HHS on time

# Essential Health Benefits Development:

## Step 1: Designate the benchmark plan

---

- ▶ Instruction from the 2012 Legislature (E2SHB 2319 – section 13):

(1) Consistent with federal law, the commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state under P.L. 111-148 of 2010, as amended.

- ▶ Determine enrollment of small group plans in Washington state, including association health plans that sell to small groups only
- ▶ Identify the 3 plans with the largest enrollment: Regence Innova, Asuris and Kaiser HMO
- ▶ By expedited rule making, formally designate the benchmark base plan as the Regence Innova plan
  - ▶ Published June 2012
  - ▶ Adopted September 2012
  - ▶ Effective October 19, 2012

## Step 2: Determine what is covered in each category

- ▶ Instruction from the 2012 Legislature (E2SHB 2319 – section 13):

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148, as amended, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed to meet the minimum requirements of section 1302.

- ▶ Review plan documents on file for specifically identified covered services and supplies
- ▶ Review NAIC, other states and published lists of services classified to the 10 benefit categories
- ▶ Compile a service list based on specifically listed services in the plan, and services identified by these other sources
- ▶ Confirm the coverage information with Kaiser and Regence
- ▶ Initiate rulemaking in July related to supplementation of the benchmark plan – public comment period starts
- ▶ Start stakeholder discussions first week in August

# Step 3: Supplementation decisions

---

## HHS (12/16/11 Bulletin)

- ❖ Analyze need to supplement by category
- ❖ Benchmark choices to use for supplementation identified as 2<sup>nd</sup> & 3<sup>rd</sup> largest small group plans in the state
- ❖ Choices for pediatric oral limited to state CHIP or FEDVIP Metlife plan; for vision: FEDVIP BlueCross BlueShield vision.
- ❖ Habilitative services: define, and may require parity with rehabilitative services and may let carriers identify covered services based on the definition
- ❖ EHB package designated by state for 2014-2015; HHS will review again

# Step 4 (concurrent with step 3)

---

▶ Instruction from the 2012 Legislature (E2SHB 2319 – section 13):

(3) A health plan required to offer the essential health benefits...under PL 111-148 of 2010, as amended, may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner must:

(a) Ensure the plan covers the 10 EHB categories...and

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope & level of benefits in each of the 10 EHB categories...

▶ Guidance in the rule to carriers regarding the review standards for determining:

1. “substantial equality”
2. risk of health status bias
3. a meaningful benefit, both as to scope and level of benefits, in each of the ten categories

# Stakeholder input

---

## Formal Comment Periods as part of Rule making Process

- ▶ First formal comment period: June – September 18, 2012 on designation rule
- ▶ Second formal comment period: July – August 2012 on notice of intent to propose rules on supplementation, meaningful benefits and other standards related to the EHBs
- ▶ Third formal comment period: September – October 23, 2012 on proposed text of rules
- ▶ Public hearing #1 – October 24, 2012
- ▶ Fourth formal comment period: October 24 – November 27, 2012 on substitute proposed text of rules
- ▶ Public hearing #2 – November 28, 2012

# Informal stakeholder process

---

- ▶ Email reaching out to advocacy groups, lobbyists interested in healthcare issues, the OIC rulemaking list-serve, provider associations, carriers, tribes, state agencies with health care within their scope of authority, producers, small business, notifying of EHB development work, seeking input re what services should be included, and reserving dates for meetings (early August)
- ▶ Summary of written comments received, and classification of services list sent to stakeholders who responded (September)
- ▶ Meeting #1 with all stakeholders to discuss scope of the decisions, and possible principles to use for decision making on how to define a meaningful benefit for each category, for supplementation, and for scope and limitation requirements (September)
- ▶ Meeting summary sent to list; those seeking addition added; 1:1 meetings when requested; Materials posted on website; proposed text of rule published based on stakeholder input at meeting #1
- ▶ Meeting #2 with non-carriers (9/24) to discuss specific services; summary sent to all
- ▶ Meeting #3 with carriers (9/27) to discuss specific services; summary sent to all;
- ▶ Meeting #4 – small work group on pediatric oral benefits; summary to small group, and then to larger group
- ▶ Meeting #5 – small work group on habilitative services definition; draft suggested definition and send to work group with summary, then to larger group
- ▶ Meeting #6 – small work group pediatric oral benefits – final input
- ▶ Meeting #7 – small work group habilitative services – discussion re proposed definition and changes
- ▶ Draft proposed rule, version 2, sent to stakeholders for comment, with supplementation and definition of meaningful benefits, and scope & limitation requirements
- ▶ Meeting #8 – stakeholder discussion re proposed rule text (October 12, 2012)

# What it Means

---

- ▶ State mandates covered by the benchmark plan
- ▶ Commercial coverage is broader
  - ▶ Habilitative services
  - ▶ Pediatric oral and vision services
- ▶ Expanded coverage for the individual market in particular
  - ▶ Prescription drug coverage
  - ▶ Mental health services
- ▶ For small group coverage, deductibles and out of pocket maximums are capped
- ▶ Waiting periods for services can't be longer than 90 days
- ▶ Separate Rx deductible & OOP no longer permitted
- ▶ Doesn't apply to grandfathered plans or to self-funded or insured plans in the large group market

# Carrier Flexibility

---

- ▶ Benefits must be substantially equal to the benefits offered by the benchmark plan
- ▶ Actuarially equivalent substitution of services, quantitative limits or to adjust benefits within EHB categories or potentially across categories are permitted (HHS regulation on this not yet issued)
- ▶ Cost sharing choices by category will vary between carriers

# Criteria for Making Supplementation Decisions and Defining Meaningful benefits

---

## ACA/Institute of Medicine

- ▶ Be affordable for consumers, employers, and taxpayers.
- ▶ Maximize the number of people with insurance coverage.
- ▶ Protect the most vulnerable by addressing the particular needs of those patients and populations.
- ▶ Encourage better care practices by promoting the right care to the right patient in the right setting at the right time.
- ▶ Advance stewardship of resources by focusing on high-value services and reducing use of low-value services. Value is defined as outcomes relative to cost.
- ▶ Address the medical concerns of greatest importance to enrollees in Essential Health Benefits–related plans, as identified through a public deliberative process.
- ▶ Protect against the greatest financial risks due to catastrophic events or illnesses

## Washington Stakeholders

- ▶ 2014 – 2015 are transitional years
- ▶ The skinny coverage in the individual market means premium shock likely regardless of decision on EHB
- ▶ Protect against unexpected health problems – not just emphasize preventive care
- ▶ Visit limits can prevent those with certain diseases or conditions from receiving effective levels of care
- ▶ Medical necessity matters – enrollees need to understand what it is and how it is decided

# Regulatory Framework

---

## Plan Form Review

- ▶ Is the plan substantially equal to the benchmark plan as supplemented?
- ▶ Does the EHB package in the plan provide meaningful benefits?
- ▶ Does bias based on health status result from the overall plan design?
- ▶ Does the prescription drug benefit design create bias based on health status?

## Premium Rate Review

- ▶ Computation of actuarial value
- ▶ Metal tier designations
- ▶ Community rating
- ▶ Effect of reinsurance/risk adjustment
- ▶ Separate pricing for:
  - ▶ Pediatric oral benefits
  - ▶ Termination of pregnancy benefit

# Reinsurance and Risk Adjustment

Office of the Insurance Commissioner

# The RRR programs serve a critical purpose

**Risk Corridors:** Responds to the uncertainty of rating new QHPs in a new market. Lessens the risk of participating in the Exchange.

- ✓ Applies to individual & small group QHPs inside the exchange.
- ✓ Protects against inaccurate rate setting.
- ✓ Limits issuers losses & gains.
- ✓ Developed & administered by HHS.
- ✓ Temporary in nature: 2014-2016

# The RRR programs serve a critical purpose

**Reinsurance:** Offsets some of the expected costs of enrolling a large uninsured population with a pent up demand for care.

- ✓ Applies to the individual market, inside & outside the exchange.
- ✓ Can be operated by HHS or through a state non profit entity.
- ✓ Temporary in nature: 2014-2016
- ✓ Funded thru assessments on all fully insured & self insured plans.
- ✓ Payouts based on parameters: threshold, co-insurance, & cap.
- ✓ OIC has rule making authority.
- ✓ Consultation from Exchange Board.

# The RRR programs serve a critical purpose

**Risk Adjustment:** Protects against adverse selection in a market open to all consumers. Helps stabilize premiums. Encourages competition on price, quality and service.

- ✓ Applies to the individual and small group markets, inside & outside the exchange.
- ✓ Can be operated by HHS or through a state entity.
- ✓ Permanent risk management program.
- ✓ Transfers funds from plans with low risk populations to those plans with high risk populations.
- ✓ OIC has rule making authority.
- ✓ Consultation from Exchange Board.

# OIC RRR Workgroup

- ▶ Participants include:
- ▶ Commissioner Kreidler & staff
- ▶ Premera
- ▶ Regence
- ▶ Group Health
- ▶ UnitedHealthcare
- ▶ Molina
- ▶ Community Health Plan of WA
- ▶ Kaiser Permanente
- ▶ Washington Association of Health Plans
- ▶ Milliman, Inc.
- ▶ Exchange staff
- ▶ Governor's office

▶ **Reinsurance:**

- Maximum flexibility on parameters.
- Ability to keep reserves.
- Access to information for state reinsurance program.

▶ **Risk Adjustment:**

- Centralized data collection.
- Ability to use state weights.
- Consideration of reinsurance payouts.

# Next steps:

- ✓ Determine preferred direction
- ✓ RFQQ process underway
- ❑ Consult with Exchange Board
- ❑ October 2012: HHS publishes Notice of Benefit & Payment Parameters
- ❑ Oct-Nov 2012: Finalize WA's program design for R&R
- ❑ November 2012: File rule text – CR 102
  - ▶ OIC holds hearing on rule.
- ❑ December 2012: Finalize & adopt rules.
- ❑ March 2013: State publishes Notice of Benefit & Payment Parameters

# **Essential Health Benefits Addendum**

Office of the Insurance Commissioner  
Washington State

# Habilitative Services

---

- ▶ Not in the benchmark base plan
- ▶ Parity with rehabilitative benefits
- ▶ Definition based on small work group input:

Habilitative services: means the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping and learning age appropriate skills and functioning, within the individual's environment or to compensate for a person's progressive physical, cognitive and emotional illness and that:

- (i) Are provided in a manner consistent with RCW 48.43.045;
- (ii) Take into account the unique needs of the individual;
- (iii) Target measurable, specific treatment goals appropriate for the person's age, and physical and mental condition, and
- (iv) Are consistent with the carrier's utilization review guidelines and practice guidelines recognized by the medical community as efficacious, and not necessarily requiring a return to a prior level of function.

The habilitative services benefit definition includes health care devices that require FDA approval and a prescription to dispense the device.

# Details, details

---

## Classification of Services

- ▶ Classification of a service may affect the scope of the available benefit
- ▶ Proposed rule defines each category, and requires classification to conform to the definition
- ▶ Specific benchmark plan exclusions are not binding on carriers, but are permitted unless against federal or state law

## State & Federal Mandates

- ▶ Apply uniformly in both individual and small group markets
- ▶ No new state mandates created
- ▶ EHB not described in terms of providers but in terms of the service, sometimes the setting, and special populations (e.g. pregnant women, children)

# Chronic Disease Group Requests

---

## Cancer

- ▶ Access to oral/IV administered chemotherapy, stem cell transplant and radiation therapy
- ▶ Parity of coverage for IV and orally administered treatments
- ▶ Drug benefit coverage for 6 protected classes, with more than one drug per class
- ▶ Range of care from preventive to treatment options, including palliative care
- ▶ Cancer screenings for men & women

## Multiple Sclerosis

- ▶ Inpatient hospital services without caps
- ▶ Prohibit specialty medications being placed in a fourth or specialty tier with a different cost-sharing structure (discriminates against those with a chronic condition)
- ▶ No predetermined limit for Physical therapy

# Chronic Disease Requests (cont'd)

---

## Hemophilia and Blood Disorders

- ▶ Access to specialists at federally recognized hemophilia treatment centers (HTCs)
- ▶ Full range of FDA approved clotting factor products
- ▶ Range of specialty pharmacy providers
- ▶ “medical necessity” defined in concern with providers
- ▶ Coverage for screening of von Willebrand Disease for women with menorrhagia

## Cardiovascular Disease & Stroke/Disabilities community

- ▶ Assistive technology, home health & personal care services, and medical transport
- ▶ Rehabilitation and habilitation therapies not limited by visit number for post-myocardial or vascular incident treatment
- ▶ Nutritional counseling not limited where medically necessary

# Special Populations Requests

---

## Children

- ▶ Include eosiphilliac foods in medical food coverage
- ▶ Bright Futures guidelines reference included in the benefit package
- ▶ State CHIP dental benefits for pediatric oral benchmark
- ▶ Include maintenance therapy for rehab and habilitative services
- ▶ Classify autism services under mental health services, not rehabilitative services
- ▶ Cover eating disorder treatments under mental health services category
- ▶ Habilitative Services

## Women & Reproductive Health

- ▶ Cover dependent daughters for maternity care
- ▶ Newborn care should be equivalent regardless of mother's status as an enrollee-type

# What is covered ?

EHB Category	Services
Ambulatory patient services	<ul style="list-style-type: none"><li>•Primary and specialist provider visits and treatments</li><li>•Home health care</li><li>•Hospice services, including respite care</li><li>•Outpatient surgery, including supplies and facility fees</li><li>•Urgent care center services</li><li>•Spinal manipulation (10 per year)</li><li>•Acupuncture (12 per year)</li><li>•Dialysis in home or in an outpatient setting</li><li>•Annual vision exam and a pair of glasses or contacts</li></ul>

EHB Category	Services
Emergency services	<ul style="list-style-type: none"> <li>•Ambulance transport and services related to transport to an emergency room</li> <li>•Emergency care and services</li> </ul>
Hospitalization	<ul style="list-style-type: none"> <li>•Hospital Inpatient care and services in a hospital, including in-patient pharmacy and surgery (except for bariatric surgery, reversal of sterilization or sex re-assignment surgery)</li> <li>•Transplant services for donors, and recipients</li> <li>•Dialysis</li> <li>•Skilled nursing facility non-custodial care</li> <li>•Anesthesia for dental procedures if medically needed to be done in a hospital</li> </ul>
Maternity & newborn care	<p>Pre-natal and post-natal care</p> <p>Genetic testing</p> <p>In utero treatment</p> <p>Termination of pregnancy</p> <p>Newborn care (professional and nursery services)</p>

# What is covered? (cont'd)

EHB Category	Services
Mental health including behavioral health treatment	<ul style="list-style-type: none"><li>• Inpatient, outpatient and residential treatment for substance use disorders</li><li>• Inpatient, outpatient and residential treatment for DSM-IV or V diagnoses</li><li>• 4 employee assistance program counseling sessions</li><li>• Detoxification services</li></ul>
Prescription drug	<ul style="list-style-type: none"><li>• Generic and Brand-name drugs, medication and drug therapies placed on the benchmark plan's formulary</li><li>• Medical foods to treat inborn errors of metabolism</li><li>• Diabetes supplies</li></ul>
Rehabilitative and Habilitative Services	<ul style="list-style-type: none"><li>• Therapies</li><li>• Durable medical equipment</li><li>• Diabetes supplies/equipment</li></ul>
Laboratory Services	<ul style="list-style-type: none"><li>• Diagnostic tests</li><li>• Blood and blood services</li><li>• Imaging and scans (X-ray, CAT, MRI, PET, ultrasound)</li></ul>

EHB Category	Services
Preventive and wellness services, including chronic disease management	<ul style="list-style-type: none"> <li>•Immunizations</li> <li>•Well child and adult visits</li> <li>•USPTSF A&amp;B guideline services (preventive and chronic care)</li> <li>•Bright Futures pediatric guideline services</li> <li>•Includes tobacco cessation services, colorectal and prostate cancer screens</li> <li>•Women’s preventive and wellness services (HRSA guidelines)</li> </ul>
Pediatric services	<ul style="list-style-type: none"> <li>•All the services above</li> <li>•Low vision optical devices and low vision services</li> <li>•Diagnostic, preventive and restorative dental care</li> <li>•Endodontic and periodontal dental care</li> <li>•Crowns, fixed bridges and removable prosthetics related to oral care</li> </ul>

# Scope and Limitation requirements

---

## Adjusted

- ▶ Nutritional counseling
- ▶ Waiting period for transplant services
- ▶ Exclusion of maternity coverage for dependent daughters
- ▶ Different newborn coverage duration based on dependent status of mother
- ▶ 30 day limitation on chemical dependency inpatient rehabilitation
- ▶ Eating disorder treatment exclusion

## Retained

- ▶ 10 spinal manipulations per year
- ▶ 12 acupuncture per year
- ▶ 25 outpatient rehab visits per year
- ▶ Neurodevelopmental therapy through age 6
- ▶ DSM-IV or V diagnoses treatment under mental health category