



Department of Consumer and Business Services

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Essential Health Benefits

Testimony of

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For the record my name is Anthony Behrens. I am a Senior Policy Analyst for the Insurance Division of the Department of Consumer and Business Services (DCBS). I am here today to talk about essential health benefits under the Patient Protection and Affordable Care Act (ACA). Determining the essential health benefits for health plans in Oregon is an important element in moving forward with health care reform. The state's essential health benefit package will impact multiple markets both inside and outside of the Exchange.

Background

As the Committee is aware, the Affordable Care Act, the federal health care reform law signed by the President on March 23, 2010, requires non-grandfathered health benefit plans in the individual and small group markets, both inside and outside of the Exchange, and Medicaid plans to cover essential health benefits beginning in 2014. The ACA defines the ten categories of essential health benefits as (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. The ACA further requires the Secretary of the United States Department of Health and Human Services (HHS) to define the services that must be provided within these benefit categories. These services will serve as the minimum coverage required. Although an employer could choose to purchase additional coverage, subsidized coverage through the Exchange would only apply to the essential health benefit package. States must defray the costs of any state-mandated coverage that exceeds essential health benefit minimum required coverage if that coverage is purchased through the Exchange.

Guidance from the Federal Government

On December 16, 2011, the federal government, through the Center for Consumer Information and Insurance Oversight (CCIIO) issued a bulletin to provide information about the planned regulatory approach HHS proposes to use to define essential health benefits. I need to note that this information is preliminary. While it provides information about the direction CCIIO is headed, there are still a number of questions that need to be answered, and until federal regulations are final, CCIIO could still change course. In summary the bulletin and subsequent verbal guidance from CCIIO indicates the following:

- States will have the option to determine essential health benefits by selecting one of the following ten benchmark plans, which will serve as the state's essential health benefit package:
 - The largest plan (cost sharing) in each of the three largest products (benefit offering) in the small group market;
 - Size is based on enrollment.
 - The three largest state employee benefit plans by enrollment;
 - The three largest federal employee health benefit plans;

- The largest commercial, non-Medicaid Health Maintenance Organization (HMO).
- HHS will collect product and plan enrollment data for the largest plans in each of the three largest products in every state's small group market. Based on verbal guidance from CCIIO, it appears they may identify each state's largest commercial, non-Medicaid HMO as well.
 - HHS will identify these benchmarks for states using first quarter 2012 enrollment data. It is unknown when HHS will communicate the benchmark plans to the states.
- By September 30, 2012, each state must choose its benchmark. Failure to choose a benchmark by that date will result in a default to the state's largest plan in the largest product in the small group market.
- Other than to identify the three small group benchmarks, it appears that a plan's existing cost-sharing, such as deductibles, copayments, and co-insurance is not relevant.
 - It is unknown when cost-sharing and actuarial-value guidance will be provided to the states.
- This guidance is subject to change and does not address how essential health benefits will apply to Medicaid plans. It's possible that the selection of an essential health benefit benchmark plan will impact the Medicaid expansion in 2014.
 - It is unknown when HHS will provide guidance regarding essential health benefits and Medicaid plans.

DCBS and Partners

The department is in the process of analyzing the guidance that has been provided and, along with other several other states, has submitted a number of

questions to HHS for clarification. We are developing a data call for issuers of benchmark plans and are working closely with the Exchange Corporation as well as the Oregon Health Authority, including the Medicaid program, to develop a work plan for benchmark identification and comparison and to determine the best way to proceed with this analysis.

Because the decision around the state's essential health benefit package impacts multiple markets both inside and outside of the Exchange, the department and the other entities involved believe that the selection process, whatever that ends up looking like, should include a public discussion and be transparent.

The guidance provides some further clarity on the essential health benefit but there are still many questions that need to be answered. As the department obtains these answers and develops a work plan with our partners, we will continue to provide information to the Committee as desired.

I appreciate the opportunity to speak with you and am happy to answer any questions you might have.