MEMORANDUM

To: Connecticut Health Insurance Exchange Advisory Committees

From: Connecticut Health Insurance Exchange Staff

Re: Essential Health Benefits and Benchmark Plan Options

Date: June 4, 2012

In response to the Committees' request for additional information to aid in the development of a recommendation regarding the Essential Health Benefits (EHB) benchmark plan for the State of Connecticut, the Exchange staff has assembled the following information.

Attached is an exhibit (see **Exhibit 1**) summarizing the plan documents provided by the carriers for the plans identified as EHB benchmark plans. Please note that the health plans listed as the three largest small group plans for Connecticut have changed since the Committees' May meetings. This is due to changes made to the list of plans, as determined by the Center for Consumer Information and Insurance Oversight (CCIIO). While Connecticare HMO was initially listed as one of the three largest small group plans, CCIIO now reports that United Healthcare Oxford PPO is one of the three largest small group plans. However, Connecticare HMO remains an option for the state's EHB, due to the fact that it is the non-Medicaid HMO with the largest enrollment in Connecticut.

In Connecticut, the EHB benchmark plans are:

- The three largest small group insurance products by enrollment:
  - Oxford Health Insurance Preferred Provider Organization (PPO) Plan[1]
  - Anthem-Blue Cross Blue Shield (Anthem-BCBS) Blue Care Health Maintenance Organization (HMO) Plan[2]
  - Aetna Qualified Point of Service (POS) Plan[3]
- The largest three state employee health plans:[4]
  - Anthem State BlueCare POE
  - Anthem State BlueCare POS
  - Oxford HMO Select POE
- The three largest three national Federal Employees Health Benefits Program (FEHBP) plans:
  - Anthem-BCBS fee-for-service (FFS), Standard Option
  - Anthem-BCBS FFS, Basic Option

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[1] HIOS Number: 29462CT003

[2] HIOS Number: 8654CT101

[3] HIOS Number: 75017CT001

[4] There plans offered to Connecticut state employees differ only with respect to their network and cost sharing arrangements; they cover the same benefits and services and so for the purpose of the comparative analysis are synonymous with each other. The Exchange's analysis of the state employee plans is based on the plan documentation for the Anthem State Preferred BlueCare HMO (their POS Plan) and Unitedhealthcare Oxford HMO (their POE-G Plan), provided by the Healthcare Policy and Benefit Services Division within the state's Office of the Comptroller.

    - Government Employee Health Association (GEHA) Plan FFS, Standard Option
- The largest insured commercial non-Medicaid HMO:
    - ConnectiCare HMO[5]

Additional Background

Only qualified health plans (QHP) that include the EHB may be sold in the individual and small group markets, both inside and outside the Exchange, in 2014.

With limited guidance, the Affordable Care Act (ACA) delegates the responsibility for defining the specifics of the EHB package to the Secretary of HHS. 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 must cover all ten identified categories of services in a balanced manner and reflect a typical employer health benefit plan.

The Secretary published in December a Bulletin that proposes that the states have a much more significant role in defining the EHB package. Rather than specifying which health benefits will be included in the EHB package, the Secretary allows the states to select the EHB package within their state. In February 2012, the Center for Medicare and Medicaid released a FAQ with responses to comments related to the Bulletin.

While not a final rule, the Bulletin and FAQ suggest that HHS intends that each state will pick a plan from a list of ten potential benchmark plans from among four types of health insurance plans. Under the intended approach, Connecticut will need to select one of these benchmarks for 2014 and 2015. If Connecticut does not to select a benchmark health plan, CCIIO suggests that the default benchmark plan for each state will be the largest health plan by enrollment in the state's small group market. In Connecticut, the default plan is Aetna's Qualified POS Plan.

All benefits and services included in the benchmark health insurance plan selected by the state would be part of the EHB package. If a state selects a benchmark plan that does not cover all ten categories of services identified in the statute, then the state will need to supplement that benchmark plan.

The federal government is continuing to consider options for selecting the EHB package. However, the December Bulletin and February FAQ offer some additional guidance for categories of care that CCIIO has identified many typical employer plans lack sufficient coverage, specifically prescription drugs, habilitative services, pediatric oral care and pediatric vision care.

Prescription Drugs

Most health plans sold in Connecticut include coverage of prescription drugs but provide coverage through a rider that is sold separately and added to the medical benefits. For the purposes of identifying the benchmark plan, CCIIO's current position does not allow the state to include the drug rider as part of the state's selected EHB benchmark plan. Instead, if benefits in a statutory category are offered only through the purchase of a rider, the state would need to supplement the benchmark plan through the use of another benchmark plan's benefits.

Among Connecticut's small group benchmark plans, all the plans include their prescription drug coverage through a rider. As do all the state employees' health plans. However, all three of the federal plans cover prescription drugs as part of the base plan.

[5] HIOS Number: 75091CT108

Unless CCIIO alters its current position with regard to the treatment of riders, the state will need to select the Oxford PPO or one of the federal plans as its EHB benchmark plan, or supplement the benchmark plan chosen with the prescription drug benefit included in the federal plans or the Oxford PPO plan.

Specialty Drugs

In response to the committees request for information on specialty drugs, the federal health plans cover specialty drugs. The FEHBP plan defines these drugs as typically high in cost and having one or more of the following characteristics:

- Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology
- Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects
- Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage

Rehabilitative/Habilitative Care

The Bulletin acknowledges that there is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. Suggested definitions of habilitative services include: defining it as habilitation as focusing on learning new skills/functions[6]—as distinguished from rehabilitation which focuses on relearning existing skills/functions; or, defining "habilitative services" as it is used in the Medicaid program to include the concept of "keeping" or "maintaining" functions "for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."

As a transitional approach for habilitative services, the Bulletin discusses two alternative options:

1) Habilitative services would be offered at parity with rehabilitative services—a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or
2) As a transitional approach, plans would decide which habilitative services to cover, and would report that coverage to HHS.

Connecticut's mandated coverage for treatment of autism spectrum disorders, included in every small group and state employee plan, would likely fall under habilitative treatment. Also, all of the benchmark plans cover physical therapy, occupational therapy and speech therapy with various limits (and exclusions) that may also be applied to habilitative services.

Pediatric Dental and Vision

Pediatric Dental Care

[6] An example of such a habilitative service is speech therapy for a child who is not talking at the expected age.

Coverage of dental and vision care services are typically provided through a mix of comprehensive health coverage plans and stand-alone coverage separate from the major medical coverage.

Routine dental coverage is typically provided only through a separate rider. However, in Connecticut, the state mandates that all individual and small group plans include coverage for general anesthesia, nursing and related hospital services provided in conjunction with in-patient, outpatient or one-day dental services that are deemed medically necessary.

For pediatric oral care, HHS is considering proposing that the state would supplement the benchmark plan with benefits from either:

1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
2) The state's Children's Health Insurance Program (CHIP) dental benefit.

The FEDVIP dental plans covers basic and preventive dental services such as cleanings and fillings, as well as advanced dental services such as root canals, crowns and medically necessary orthodontia. According to CCIIO, HHS intends to propose the EHB would not need to include non-medically necessary orthodontic benefits. Further clarification from CCIIO has been requested with regard to pediatric dental benefits that must be included in the state's EHB.

Exhibit 2 compares Connecticut's current Husky B dental benefits and the FEDVIP dental plan offered by Aetna.

Pediatric Vision

For pediatric vision care, HHS is considering proposing that the state would need to supplement the EHB benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment. This plan covers routine eye examinations with refraction, corrective lenses and contact lenses. In some of the benchmarks, vision services, including pediatric vision, is covered by a medical plan.

Preventive and Wellness Care

All of the benchmark plans include preventive healthcare coverage that meets or exceeds the stipulations listed in Section 2713 of the Public Health Service Act,[7] as added by section 1001 of the Affordable Care Act.

[7]from Public Health Services Act: Section 2713. Coverage of Preventive Health Services.
(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening,

The plans wellness features are not typically included in their certificate of coverage. Most plans, however, include supplementary benefits intended to help their members improve their health. Such assistance could include care management programs for enrollees with chronic conditions, nutritional hotline and wellness program discounts. While typically described in each plan's brochures and promotional material, these types of programs are not generally included as part of the Certificate of Coverage filed with the Connecticut Insurance Department.

Exhibits

1 – Comparative Analysis of EHB Benchmark Plans

2 – Potential Supplementary Coverage for Pediatric Dental Coverage

3 – Summary of Comparative Analysis of EHB Benchmark Plans

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mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.