CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Issue Brief:
Interaction between California State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits"

March 2012

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EXECUTIVE SUMMARY

In March 2010, the federal government passed the federal Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R.4872), enacting health care reform laws that dramatically affect the California health insurance market and its regulatory environment. These laws, referred to as the Affordable Care Act (ACA), include a number of provisions that would affect benefits covered by California health insurance products. The focus of this issue brief is on a specific benefit-related provision of the ACA that requires coverage of essential health benefits (EHBs) for most health insurance products sold in the individual and small group markets, including those that will be provided through state health benefit exchanges.

The California Health Benefits Review Program (CHBRP), a program established in 2002, responds to requests from the California State Legislature for independent evidence-based analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.[1] Since the federal EHB requirements would interact with California's existing laws and proposed mandate (or repeal) legislation, CHBRP has produced this issue brief to provide context for potential interaction effects between these federal requirements and the state bills CHBRP is charged with analyzing. Specifically, this issue brief aims to describe the complexities of state benefit mandates in California and how these state benefit mandates may potentially interact with the EHBs, as defined by the regulatory approach proposed in a Bulletin released by the federal Department of Health and Human Services (HHS) in December 2011.

California State Benefit Mandates

California has a bifurcated system of regulation for health insurance subject to state benefit mandates. State benefit mandates only apply to health insurance regulated at the state level by either the California Department of Managed Health Care (DMHC), which regulates health insurance *plans*, or the California Department of Insurance (CDI), which regulates health insurance *policies*. About 59% (21.9 million) of Californians currently have health insurance subject to state benefit mandates. Once California's State Health Benefits Exchange is operational, qualified health plans (QHPs) sold in the Exchange will be regulated by either DMHC or CDI and as such will be subject to state benefit mandates.

Although a majority of Californians have health insurance subject to one or more state benefit mandates, the number of enrollees affected varies by mandate, depending on the DMHC-regulated plans and CDI-regulated policies and the markets (individual, small group, and large group) included in the particular mandate law. In addition, benefit mandate laws are not uniform as to what condition(s) or disorder(s) they address or what kind(s) of requirements they impose.[2] There are 53 state benefit mandates in California known to CHBRP that each apply to a subset of DMHC-regulated plans and CDI-regulated policies and health insurance markets, and that require coverage for specific tests, treatments, and services for often overlapping conditions or diseases. Therefore, though state benefit mandates may be discussed in the aggregate, close analysis of each mandate is necessary in order to understand what impacts may result from it for some number of Californians.

[1] Additional information about the program is available on CHBRP's website at www.chbrp.org.
[2] Health insurance benefits generally involve screening, diagnosis, and/or treatment for a condition or disease.

The Affordable Care Act's Essential Health Benefits

The ACA requires coverage of EHBs for most plans and policies in California sold in the individual and small group markets, both inside and outside the state's Exchange. Broadly, inside the state's Exchange, DMHC- and CDI-regulated QHPs are required to provide coverage of the EHBs, and outside of the state's Exchange, nongrandfathered plans and policies[3] in the individual and small group markets will be required to cover EHBs.

Section 1302(b) of the ACA requires that at least some items and services within 10 specific categories of benefits must be included in the EHBs, but that the Secretary of HHS must define the EHBs through regulation. In December 2011, HHS released initial guidance on EHBs. HHS's proposed approach to defining the EHBs would allow states the flexibility to select a benchmark plan from four options that reflect the scope of services offered by a "typical employer plan." The benefits and services included in the benchmark plan option selected by the state would be the EHBs. State benefit mandates that fall *within* the benchmark plan a state selects would be included in the defined EHBs for 2014 and 2015, and a requirement in the ACA that states must defray the costs of state benefit mandates that fall outside the EHBs would be waived. However, for any mandates that fall *outside* the selected benchmark plan, the state would be required to cover the cost of those mandates. HHS has not yet offered guidance on how such cost calculations would be made.

Whether the coverage for an existing state benefit mandate will be included in the EHBs will depend on the benchmark plan the state selects. Each of the benchmark plan options will include a differing set of state benefit mandates. For example, one of the four benchmark plan options, the Federal Employee Health Benefits Plan, will not include any state benefit mandates as these plans are not subject to state benefit mandates. However, if the small group insurance product benchmark plan option were selected by the state, some subset of state benefit mandates would be included in the benchmark plan that would define the EHBs. Given the potential for additional marginal costs to the state of benefit mandates above the EHBs, there seems to be an incentive for states to select a benchmark plan inclusive of state benefit mandates.

Because of the complexity of identifying the differing benchmark plan options available for a state to choose from, and thus identifying the various possible EHBs for a state, it is challenging as of now to definitively say which state benefit mandates would be included and which not for each of the benchmark options. HHS has not released final guidance on defining the EHBs, nor has guidance been released on how states will defray the costs of state benefit mandates that fall outside the EHBs. Assuming HHS's proposed regulatory approach is followed for defining the EHBs, until California selects a benchmark plan, what state benefit mandates, if any, will be included in the EHBs for 2014 and 2015 in California is unknown, as is the potential cost to the state of benefit mandates outside the EHBs. As further guidance is released and decisions are made around EHBs on the federal and state level, CHBRP will continue to assess how state benefit mandates may interact with EHBs through an update to this issue brief or through other means.

[3] A grandfathered health plan is defined as "A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers" (http://www.healthcare.gov/glossary/g/grandfathered-health.html).

INTRODUCTION

In March 2010, the federal government passed the federal Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R.4872) enacting health care reform laws that dramatically affect the California health insurance market and its regulatory environment. These laws, referred to as the Affordable Care Act (ACA), include a number of provisions that would affect benefits covered by California health insurance products, as well as directly and indirectly prompt changes in health care delivery, finance, and coverage.

The California Health Benefits Review Program (CHBRP), a program established in 2002, responds to requests from the California State Legislature for independent evidence-based analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.[4] The focus of this issue brief is on a specific benefit-related provision of the ACA that requires coverage of "essential health benefits" (EHBs) for most health insurance products sold in the individual and small group markets, including those that will be provided through state health benefit exchanges. CHBRP focused on this specific ACA provision because of the Program's statutory charge to analyze proposed legislation that would newly mandate or repeal existing mandates of health insurance benefits. Since the federal EHB requirements would interact with California's existing laws and proposed mandate (or repeal) legislation, CHBRP has produced this issue brief to provide background on what is currently known about the federal EHB requirements, and thereby provide context for potential interaction effects between these federal requirements and the state bills CHBRP is charged with analyzing.

Specifically, this brief provides:

- A description of the health insurance subject to state benefit mandates in California, and how state mandates interact with each other and across health insurance products and markets.
- A discussion of which health insurance products to be sold in California's state-based health insurance exchange will be subject to state benefit mandates.
- A discussion of EHBs, the proposed federal regulatory approach to defining EHBs, and how state benefit mandates may interact with this proposed regulatory approach.

The description of state benefit mandates in California is intended to provide background on benefit mandates, and to introduce their complexities. Understanding the complexity of state benefit mandates will help in understanding the difficulty inherent in analyzing what will and will not be covered within a state under the proposed federal regulatory approach to defining EHBs.

To further assist the reader in understanding health insurance in California and California state benefit mandates, CHBRP maintains two documents that may be reviewed along with this issue brief. *Estimates of Sources of Health Insurance in California*[5] is updated each year, providing CHBRP's current estimates as to the number of enrollees in the varied segments of the health

[4] Additional information about the program is available on CHBRP's website at www.chbrp.org.
[5] Available at http://www.chbrp.org/publications.html.

insurance market. *Health Insurance Benefit Mandates in California State Law*[6] lists state benefit mandates currently known to CHBRP, as well as a number of federal benefit mandates.

It is important to note that some uncertainty exists with respect to the ACA on a national level. The ACA has been enacted into federal law, but a Supreme Court case to be heard in March 2012 challenging multiple aspects of the law could potentially impact the law. Based on public comments made by some congressional and presidential candidates, the outcomes of the November 2012 congressional and presidential elections may also impact the law (in addition to, or in contrast to, the ruling made by the Supreme Court). Despite some uncertainty, many states, including California, have moved forward with implementation of the law.

[6] Available at http://www.chbrp.org/publications.html.

STATE BENEFIT MANDATES

Health insurance benefits generally involve screening, diagnosis, and/or treatment for a condition or disease. State benefit mandates are common across all states, with a majority of states having more than 20, and a third having more than 40.[7] This section provides an in-depth look at California's state benefit mandates.

California State Benefit Mandates

As defined by CHBRP's authorizing statute,[8] a health insurance benefit mandate law can require health insurance products to provide coverage or offer to cover[9] any of the following: (1) coverage for screening, diagnosis, or treatment of a specific disease or condition; (2) coverage for specific types of health care treatments or services; and/or (3) coverage for services by specific types of health care providers. A mandate can also specify that benefit coverage be provided with specified terms that may affect cost sharing, prior authorization requirements, or other aspects of benefit coverage. CHBRP is currently aware of 53 benefit mandate laws in California. The CHBRP document *Health Insurance Benefit Mandates in California State Law*[10] lists state benefit mandate laws currently known to CHBRP.[11] California state benefit mandates only apply to a subset of health insurance in California, regulated by two agencies, and can vary across the health insurance markets they address and the requirements they impose on health insurance products.

Health Insurance Subject to State Benefit Mandates in California

Uniquely, California has a bifurcated system of regulation for health insurance subject to state benefit mandates.[12] The California Department of Managed Health Care (DMHC)[13] regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers,[14] which offer benefit coverage to their enrollees through health insurance policies. State benefit mandates only apply to health insurance regulated at the state level by either DMHC or CDI. As CHBRP's

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[7] Blue Cross and Blue Shield Association. *State Legislative Healthcare and Insurance Issues: 2011 Survey of Plans.* Washington, D.C.: BCBS, 2011.

[8] Available at http://www.chbrp.org/documents/authorizing_statute.pdf.

[9] The majority of health insurance benefit mandates in California are "mandates to cover" particular service(s), treatment(s), health condition(s) or provider type(s) in all products, but there are also a number of "mandates to offer." CHBRP's list of California state benefit mandates includes information on which mandates are "mandates to cover" and which are "mandates to offer," available at http://www.chbrp.org/publications.html.

[10] Available at http://www.chbrp.org/publications.html.

[11] CHBRP's mandate is to review mandate laws. However, it is important to note that the state may place additional requirements on plans and policies in California outside of mandated benefit laws. For example, through a combination of law and regulation, plans regulated by the Department of Managed Health Care may be required to cover a set of "minimum benefits" or "basic health care services." This set of requirements is broad enough to interact with many benefit mandate laws and many Californians have health insurance subject to them.

[12] The history of this situation, the result of historical and political events and marketplace trends over a half century, is documented in reports published by the California HealthCare Foundation. The 2001 *Making Sense of Managed Care Regulation in California*, available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MakingSenseManagedCareRegulation.pdf, and the 2011 *Ready for Reform? Health Insurance Regulation in California Under the ACA*, available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20ReadyReformHealthInsRegulationACA.pdf.

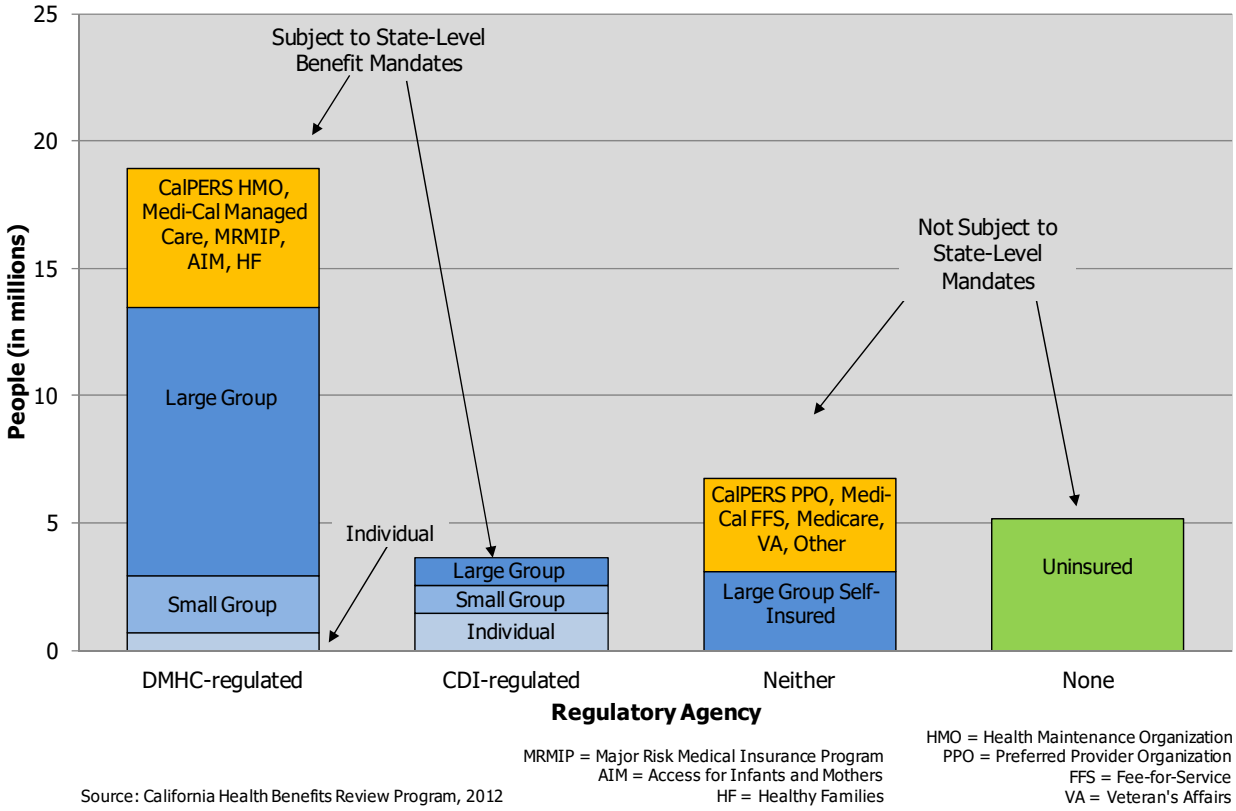
[13] DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

[14] CDI licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance but benefit mandates generally impact only health insurance policies, as defined in Insurance Code, Section 106(b) or subdivision (a) of Section 10198.6.

scope is limited to benefit mandate laws, this issue brief focuses on *DMHC-regulated plans* and *CDI-regulated policies*, only touching on health insurance not regulated by DMHC or CDI when it may interact with state benefit mandates.

Approximately 59% (21.9 million) of Californians currently have health insurance subject to state benefit mandates. Figure 1 provides an illustration of the number of people subject to state benefit mandates in DMHC-regulated plans and CDI-regulated policies, and those that are not. As the figure illustrates, two significant populations *do not* have health insurance subject to state benefit mandates: the uninsured (an estimated 14%, 5.1 million, in 2012); and enrollees with insurance not regulated at the state level (an estimated 18%, 6.8 million, in 2012), including self-insured large groups plans and a variety of publicly funded health insurance.

Figure 1. Estimated Sources of Health Insurance in California by Regulatory Authority, 2012[15]



Source: California Health Benefits Review Program, 2012

MRMIP = Major Risk Medical Insurance Program
AIM = Access for Infants and Mothers
HF = Healthy Families

HMO = Health Maintenance Organization
PPO = Preferred Provider Organization
FFS = Fee-for-Service
VA = Veteran's Affairs

Figure 1 categorizes health insurance regulated by DMHC or CDI as belonging to the large group market, small group market, or individual market. These categories describe the purchaser of health insurance, not the enrollee. An individual may purchase health insurance for himself or herself and his or her dependants through the individual market. Groups (most typically employers) purchase health insurance through the large group market or small group market, depending on the number of persons to be enrolled. California state law currently defines a large group as more than 50 enrollees.[16]

[15] Available at http://www.chbrp.org/publications.html.
[16] The ACA defines a large group as >100 employees, whereas state law currently defines it as >50. However, ACA Section 1304(b)(3) allows states to treat groups between 50 and 100 as large for plan years beginning before 2016.

Characteristics of DMHC-Regulated Health Insurance
As illustrated in Figure 1, about 51% (18.9 million) of Californians have health insurance regulated at the state level by DMHC and subject to state benefit mandates contained in the Health and Safety Code. DMHC-regulated health insurance includes privately purchased insurance in the large group, small group, and individual markets, as well as some publicly funded insurance—California Public Employees' Retirement System (CalPERS) Health Maintenance Organization (HMO), Medi-Cal Managed Care (MC), Healthy Families (HF), Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP). DMHC oversees the majority of state-regulated group health insurance; about 88% (12.8 million) of state-regulated, privately purchased group insurance in 2012.

Characteristics of CDI-Regulated Health Insurance
About 8% (2.9 million) of Californians have health insurance regulated at the state-level by CDI and subject to state benefit mandates contained in the Insurance Code. All CDI-regulated policies are privately purchased through either the large group, small group, or individual markets. While DMHC regulates the majority of health insurance subject to state mandates by virtue of the small and large group markets' enrollment size, CDI regulates about 69% (1.4 million) of the total individual market.

The Complexities of California State Benefit Mandates

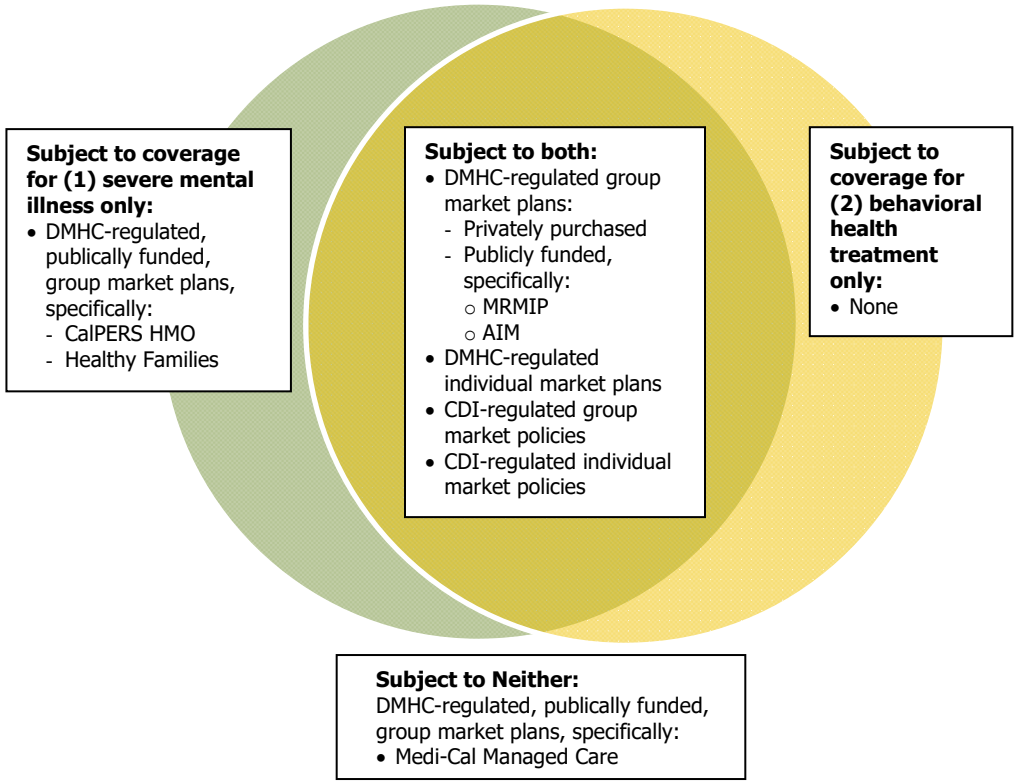
State benefit mandates are not uniform. While state benefit mandates can potentially apply to all DMHC-regulated plans and CDI-regulated policies in California, not all state benefit mandates address both, and, in fact, commonly they do not. Moreover, not all address both the group and individual markets, and some explicitly exempt health insurance when it is purchased by a specified entity. Further, while mandate laws address a wide range of conditions and diseases, they can sometimes address the same condition or disease but in different ways.

Variation and Overlap across Products and Markets
The exact number of Californians who have health insurance subject to a particular benefit mandate varies by mandate. Mandate laws are frequently written in such a way that the state benefit mandate only applies to a subset of health insurance that potentially could be subject to the mandate. For example, a mandate may be written only into the Health and Safety Code, which only applies to DMHC-regulated plans, or only into the Insurance Code, which only applies to CDI-regulated policies, making only those plans or only those policies subject to it. A mandate may be written such that it addresses only group market health insurance, which would mean that individual market health insurance would not be subject to it. Or, a mandate may exempt health insurance from compliance when it is purchased by a specific entity, usually a public agency purchasing health insurance on behalf of beneficiaries of a public program.

We provide a comparison of two state benefit mandates to see how they vary and overlap across the different products and markets to which they apply in California: (1) coverage for severe mental illness, and (2) coverage for behavioral health treatment for autism and related disorders. These two benefit mandates could *potentially* apply to all DMHC-regulated plans and CDI-regulated policies in the group and individual markets, and to all purchasers of health insurance subject to state benefit mandates. However, these two benefit mandates apply to a more limited set of plans and policies and markets than can be potentially subject. Figure 2

illustrates the overlap and variation in which plans and policies and markets are included and excluded in these two state benefit mandates.

Figure 2. Plans and Policies Subject to Two California State Benefit Mandates



Variation and Overlap across Conditions and Disease

As previously stated, benefit mandates generally involved screening, diagnosis, and/or treatment for a condition or disease. State benefit mandates address many conditions and diseases, but can overlap. When addressing a similar condition or disease, state benefit mandates can vary and overlap in the tests, treatments, and services for which they require coverage.

Taking the two California benefit mandates just discussed, coverage for severe mental illness and coverage for behavioral health treatment for autism and related disorders, both address coverage for mental health services and treatments. However, they differ in some regards in the:

- Coverage required for the condition or disorder (severe mental illness and behavioral health treatment for autism and related disorders);
- The tests, treatments, and services they require coverage for; and
- The specified terms of required coverage.

The table in Appendix A provides a comprehensive look at these two benefit mandates and how they vary and overlap in elements they require coverage for. Taking a small component of each of these mandates, we can begin to see the complexity of how state benefit mandates interact. The mandate for coverage of behavioral health treatment for autism and related disorders

explicitly requires coverage for applied behavioral analysis for pervasive developmental disorder or autism. However, the mandate for coverage for severe mental illness does not explicitly require coverage for applied behavioral analysis, but it may implicitly require this coverage as coverage for treatment for pervasive developmental disorder or autism is required.

Putting all the elements together of how a state benefit mandate may vary and overlap across products, markets, and conditions/disorders, the following appears to be true for the two mandates just discussed:

- DMHC-regulated plans enrolling Medi-Cal beneficiaries *are not* mandated to cover applied behavioral analysis for pervasive developmental disorder or autism;
- DMHC-regulated plans enrolling Healthy Families beneficiaries and CalPERS employees, retirees, and their dependants *may possibly be* mandated to cover applied behavioral analysis for pervasive developmental disorder or autism, depending on interpretation of the severe mental illness mandate; and
- All other DMHC-regulated plans and CDI-regulated policies *are* mandated to cover applied behavioral analysis for pervasive developmental disorder or autism.[17]

Summary: California State Benefit Mandates

Although a majority of Californians have health insurance subject to one or more state benefit mandates, the number of enrollees affected varies by mandate, depending on the DMHC-regulated plans and CDI-regulated policies and the markets included in the particular mandate law. In addition, benefit mandate laws are not uniform as to what condition(s) or disorder(s) they address or what kind(s) of requirements they impose. The above analysis only looked at a component of two California state benefit mandates. There are 53 state benefit mandates that all apply to a subset of DMHC-regulated plans and CDI-regulated policies and health insurance markets, and that require coverage for specific tests, treatments, and services for often overlapping conditions or diseases. Therefore, though state benefit mandates may be discussed in the aggregate, close analysis of each mandate is necessary in order to understand what impacts may result from it for some number of Californians.

California State Benefit Mandates and the Health Benefits Exchange

The ACA requires that states establish their own state health benefit exchanges, or, if a state does not, the federal government will establish one in a state.[18] State exchanges will offer health insurance in the small group and individual market[19] through qualified health plans (QHPs)—plans certified by and sold in a state's exchange. California state legislation enacted in 2010 (Assembly Bill (AB) 1602 and Senate Bill (SB) 900) established the California Health Benefits Exchange.[20] QHPs sold in California's Exchange will be regulated by DMHC or CDI and as such will be subject to California state benefit mandates. Table C looks at the market

[17] This analysis only addresses coverage *required* by California state benefit mandate. Coverage for applied behavioral analysis may be provided even when not required by a state benefit mandate.
[18] ACA Section 1311 and ACA Section 1321(c)
[19] Effective 2017, states may allow large group purchasing through the exchange, which would subject large group plans and policies to EHB requirements (ACA Section 1312(f)(2)(B)).
[20] The California Health Benefits Exchange Authorizing Statute is available here: http://www.healthexchange.ca.gov/Documents/California%20Codes%20Governing%20the%20Health%20Benefit%20Exchange.pdf

segments that can and cannot be subject to state benefit mandates both outside and inside the state's Exchange in 2014.

Table C. Market Segments Subject and Not Subject to California Benefit Mandates Inside and Outside the Exchange in 2014[21,22]

Market Segment	Subject to State Benefit Mandates	Not Subject to State Benefit Mandates
Large Group Market	**Outside the Exchange:** • DMHC-regulated plans: - Privately purchased insurance - Publicly funded health care service plans, including: o CalPERS HMO plans o Medi-Cal Managed Care o MRMIP o AIM o HF • CDI-regulated policies	**Outside the Exchange:** • Medi-Cal Managed Care—County Organized Health Systems (COHS) (a)
Small Group Market	**Outside the Exchange:** • DMHC-regulated plans and CDI-regulated policies **Inside the Exchange:** • DMHC- and CDI-regulated QHPs and CO-OP plans (b)	**Inside the Exchange:** • Multi-State Plans offered by the federal Office of Personnel Management (OPM) (c)
Individual Market	**Outside the Exchange:** • DMHC-regulated plans and CDI-regulated policies **Inside the Exchange:** • DMHC- and CDI-regulated QHPs, including: - CO-OP plans (b) - Catastrophic plans (d) - Interstate health care choice compacts (e)	**Inside the Exchange:** • Multi-State Plans offered by the federal Office of Personnel Management (OPM) (c)

Notes: (a) A COHS is a non-profit, independent public agency that contracts with the state to administer Medi-Cal benefits through local care providers and/or Health Maintenance Organizations. With the exception of one COHS in California which appears to be subject to state benefit mandates under DMHC-regulation, it appears that in general COHS are not subject to state benefit mandates.
(b) ACA Section 1322 defines and appropriates funding for the establishment of "CO-OP" plans—nonprofit, member-run health insurance issuers offering qualified health plans in the individual and small group markets. It is presumed here that these plans would likely be regulated in California by either DMHC or CDI.
(c) ACA Section 1334 directs OPM to offer at least two multi-state qualified health plans in each state exchange.
(d) ACA Section 1302(e) defines catastrophic plans.
(e) For the individual market, states have the option of entering into an interstate health care choice compact, which must cover EHBs and are subject to the laws and regulations in the state in which the plan or policy was written (ACA Section 1333).

Table C shows the overlap and variation in the market segments for DMHC-regulated plans and CDI-regulated policies subject to state benefit mandates inside and outside the Exchange. As previously discussed, within the plans and policies potentially subject to state benefit mandates, there is variation in which benefit mandates are required to be covered.

[21] The table address whether a market segment *can be* subject to California state benefit mandates, not whether a particular mandate applies to one or all of these markets. Whether a market segment is subject to a mandate varies mandate by mandate.
[22] There are other sources of health insurance, including self-insured plans, Medi-Cal fee-for-service, the VA, and Medicare, that are not addressed in this table. These sources of health insurance are not subject to California state benefit mandates.

Federal Benefit Mandates

Federal benefit mandates, like state benefit mandates, generally apply to both the individual and group market, unless a market is specifically excluded from the federal benefit mandate coverage requirement. However, federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans.[23] There were federal benefit mandates in place prior to the passage of the ACA, and the ACA added federal benefit mandates that apply to many, but not all, DMHC-regulated plans and CDI-regulated policies in the individual and group markets in California.

Appendix B, as well as CHBRP's document *Health Insurance Benefit Mandates in California State Law*[24] outline federal benefit mandates. It is important to remember that while much of the focus on benefit coverage in the ACA is on EHBs, discussed in the next section, there are federal benefit mandates that will also interact with state benefit mandates and the EHBs coverage requirement. Understanding the complexities of how state benefit mandates interact with each other and with federal benefit mandates may be useful as states begin to plan for and implement other coverage requirement aspects of the ACA.

[23] As previously stated, this issue brief focuses on DMHC-regulated plans and CDI-regulated policies, only touching on health insurance not regulated by DMHC or CDI when it may interact with state benefit mandates.
[24] Available at http://www.chbrp.org/publications.html.

ESSENTIAL HEALTH BENEFITS

Starting in 2014, health insurance products within a state's exchange and many outside a state's exchange are required by the ACA to cover EHBs. Provisions in the ACA specify parameters for the EHBs and require the Secretary of Health and Human Services (HHS) to further define EHBs. This section will discuss the parameters in the ACA for the EHBs, the steps taken thus far by the Secretary of HHS to define the EHBs, and how California state benefit mandates may interact with HHS' proposed regulatory approach to defining EHBs.

The Ten Categories of Essential Health Benefits in the Affordable Care Act

Section 1302(b) of the ACA requires the Secretary of HHS to define the EHBs through regulation, but requires that at least some items and services within specific categories of benefits must be included. The 10 ACA EHB categories are:

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

When defining the EHBs within these categories, the Secretary of HHS has to ensure that the EHB floor "is equal to the scope of benefits provided under a typical employer plan."[25] The Secretary of HHS is required to take into account: the need for balance between the 10 ACA specified EHB categories; the needs of diverse segments of the population; and the need to not discriminate against individuals because of age, disability, or expected length of life.

Appendix B provides an analysis of how state benefit mandates may potentially interact with the 10 ACA EHB categories.

Plans and Policies Subject to the Essential Health Benefits Coverage Requirement in California

The ACA requires coverage of EHBs for most plans and policies in California sold in the individual and small group markets, both inside and outside the state's Exchange.[26] Inside the state's Exchange, DMHC- and CDI-regulated QHPs are required to provide coverage of the EHBs.[27] Outside of the state's Exchange, nongrandfathered plans and policies[28] in the individual

[25] ACA 1301 (b)(2)(A)
[26] ACA Section 1302 and ACA Section 1201, modifying Section 2707 of the PHSA
[27] ACA Section 1301
[28] A grandfathered health plan is defined as: "A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers" (http://www.healthcare.gov/glossary/g/grandfathered-health.html).

and small group market will be required to cover EHBs.[29] While grandfathered plans and policies in the small group and individual market are exempt from the EHB requirements, the federal government estimates that by 2013, nationally 49% to 80% of plans in the small group market and 40% to 67% of policies in the individual market will have relinquished their grandfathered status.[30] The large group market, which only exists outside the Exchange, is not subject to EHB coverage requirements.[31]

In addition, in California insurers *not* participating in the Exchange will be required to provide at least one plan or policy that parallels products offered in the Exchange's four "precious metal" coverage levels.[32,33] (The four "precious metal" levels—bronze, silver, gold, or platinum—correspond to an actuarial value for the plan or policy based on the cost-sharing features, not the benefits covered.) Conversely, plans or policies operating in the Exchange must offer the same plan or policy outside of the Exchange.[34] These plans and policies will cover the EHBs.

Table D below illustrates what market segments, both inside and outside the Exchange, are required to cover EHBs in 2014.

[29] ACA Section 1201 modifying Section 2707 of the PHSA
[30] Department of the Treasury, Department of Labor, and Department of Health and Human Services. *Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule*, Federal Register: 75: 116: pages 34538-34570, June 17, 2010. Available at http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf. Accessed February 8, 2012.
[31] In 2017, states may allow large group purchasing through the Exchange, which would subject large group plans and policies to EHB requirements (ACA Section 1312(f)(2)(B)).
[32] Neuschler E, Curtis R. *Health Benefit Exchange: California vs. Federal Provisions*. Oakland, CA: California HealthCare Foundation; 2011. Available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthBenefitExchangeCAvsFederal.pdf. Accessed February 15, 2012.
[33] ACA Section 1302(d)
[34] For more information, please see the California Health Benefits Exchange website: http://www.healthexchange.ca.gov/Pages/Default.aspx.

Table D. Market Segments Subject and Not Subject to the Essential Health Benefit Requirements Inside and Outside the Exchange in 2014[35]

Market Segment	Subject to EHB Requirement	Not Subject to EHB Requirement
Large Group Market (a)		**Outside the Exchange:** • DMHC-regulated plans and CDI-regulated policies
Small Group Market	**Outside the Exchange:** • DMHC-regulated plans and CDI-regulated policies **Inside the Exchange:** • DMHC- and CDI-regulated QHPs and CO-OP plans (b) • Multi-State Plans offered by the federal Office of Personnel Management (OPM) (c)	**Outside the Exchange:** • Grandfathered DMHC-regulated plans and grandfathered CDI-regulated policies
Individual Market	**Outside the Exchange:** • DMHC-regulated plans and CDI-regulated policies **Inside the Exchange:** • DMHC- and CDI-regulated QHPs, including: - Catastrophic plans (d) - CO-OP plans (b) - Interstate health care choice compacts (e) • Multi-State Plans, offered by the federal Office of Personnel Management (OPM) (c)	**Outside the Exchange:** • Grandfathered DMHC-regulated plans and grandfathered CDI-regulated policies

Notes: (a) Effective 2017, states may allow large group purchasing through the exchange, which would subject large group plans and policies to EHB requirements (ACA Section 1312(f)(2)(B)).
(b) ACA Section 1322 defines and appropriates funding for the establishment of "CO-OP" plans—nonprofit, member-run health insurance issuers offering qualified health plans in the individual and small group markets. It is presumed here that these plans would like be regulated in California by either DMHC or CDI.
(c) ACA Section 1334 directs OPM to offer at least two multi-state qualified health plans in each state exchange.
(d) ACA Section 1302(e) defines catastrophic plans.
(e) For the individual market, states have the option of entering into an interstate health care choice compact, which must cover EHBs and are subject to the laws and regulations in the state in which the plan or policy was written (ACA Section 1333).

The Essential Health Benefits Bulletin

The Secretary of HHS has taken steps over the past year toward defining the EHBs through regulation, as required. The ACA required the Secretary of Labor to conduct a survey of employer-sponsored coverage and provide a report to the Secretary of HHS, which was completed in April 2011. The Secretary of HHS requested the Institute of Medicine (IOM) to conduct a study that would ultimately make recommendations on the criteria for determining the EHBs to further inform the regulatory direction. Additionally, HHS engaged in its own research and "listening sessions" across the country. The reports, research, and community engagement culminated in the release of a Bulletin from HHS in December 2011 describing the regulatory approach that HHS proposes for defining the EHBs.[36] This section will discuss the

[35] There are other sources of health insurance, including self-insured plans, the VA, and Medicare, that are not addressed in this table. These sources of health insurance are not subject to the EHB coverage requirements.
[36] CCIIO, *Essential Health Benefits Bulletin*. Available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. Accessed December 16, 2011.

Secretary of Labor and IOM reports, the regulatory approach for defining the EHBs proposed in HHS' Bulletin, and how this regulatory approach may interact with state benefit mandates.

The Secretary of Labor and Institute of Medicine Reports

The Secretary of Labor submitted the report required by the ACA on employer-sponsored coverage to the Secretary of HHS on April 15, 2011.[37] The report summarized information from the Bureau of Labor Statistics National Compensation Survey on what employees receive through the surveyed employers, specifically: (1) the types of plans and overall plan limits; and (2) the covered services and cost-sharing requirements made on enrollees of employer-sponsored plans. The report provided additional information on specific benefits of interest to HHS, where the data was available to provide this information.

The IOM-appointed committee and resulting study aimed "to propose a set of criteria and methods that should be used in deciding what benefits are most important for coverage" as well as recommend a process for updating the benefits to account for "advances in science, gaps in access, and the impact of any benefit changes on cost."[38] The IOM released the study in October 2011, of which the title, *Essential Health Benefits: Balancing Coverage and Cost*, captured a key theme for the committee—the need to try and achieve two competing goals: providing health insurance for a wide range of health needs and making it affordable.

The IOM committee came to the conclusion that the initial EHBs should be a modification of what small employers are currently offering, deciding that the solution should be to "build on what currently exists, learn over time, and make it better."[39] The recommended modifications to a small employer benefits package included taking into account the 10 general EHB categories of the ACA and developing an initial package within a premium target. This latter modification was the committee's way of addressing the affordability issue. The committee further recommended that only medically necessary services should be covered; a certain amount of flexibility in defining the contents of the EHBs should be allowed to encourage innovation at the state level; the EHBs should be updated every year; and the public should be involved in both defining and updating the EHBs.

The Essential Health Benefits Bulletin: Benchmark Plan Approach

Taking from the information provided by the Department of Labor report, the IOM report, and the HHS research and HHS listening sessions held across the country, in December 2011 the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services (CMS), which sits within HHS, released its first initial guidance on EHBs. This guidance came in the form of a Bulletin that provides information on the regulatory approach HHS proposes to define the EHBs.[40] The Bulletin specifically did not touch

[37] Department of Labor, *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services*. Available at www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. Accessed January 4, 2012.
[38] IOM, *Essential Health Benefits: Balancing Coverage and Cost (Report Brief)*. Available at http://www.iom.edu/~/media/Files/Report%20Files/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost/essentialhealthbenefitsreportbrief4.pdf. Accessed January 4, 2012.
[39] IOM, *Essential Health Benefits: Balancing Coverage and Cost (SUMMARY)*. Available at http://books.nap.edu/openbook.php?record_id=13234. Accessed January 4, 2012.
[40] CCIIO, *Essential Health Benefits Bulletin*. Available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. Accessed December 16, 2011.

on aspects of plan cost sharing or the calculation of actuarial value,[41] only addressing covered services.

HHS' proposed approach to defining the EHBs would allow states the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." States could choose one of the following benchmark plan types as their EHBs:

- 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;
- Any of the largest three national Federal Employee Health Benefits Plan (FEHBP) options by enrollment[42]; or
- The largest insured commercial non-Medicaid HMO operating in the state.

The benefits and services included in the benchmark plan option selected by the state would be the EHBs. If one of the 10 EHB categories is missing from the selected benchmark plan, it still must be covered by the health plans required to offer the EHBs, and, in this case, a state would need to supplement the benchmark plan to cover each of the 10 categories. A health plan would be required to offer benefits that are "substantially equal" to the benefits of the selected benchmark plan; plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. HHS is considering allowing substitutions across benefit categories.

The ACA allows a state to "require that a qualified health plan offered in [the Exchange] offer benefits in addition to the essential health benefits."[43] If the state does so, the state must make payments to defray the cost of those additionally mandated benefits, either by paying the individual directly, or by paying the qualified health plan. HHS' proposed approach in the Bulletin to defining EHBs would provide states a transition period in which they could coordinate their benefit mandates while minimizing the likelihood a state would be required to defray the costs of mandates in excess of the defined EHBs. State benefit mandates that fall *within* the benchmark plan a state selects would be included in the defined EHBs for 2014 and 2015 and the requirement that the state defray the costs of these mandated benefits would be waived. However, for any mandates that fall *outside* the selected benchmark plan, the state would be required to cover the cost of those mandates. HHS has not yet offered guidance on how such cost calculations would be made.

To define the "plans and products" within each benchmark plan option, a state is to use "enrollment data from the first quarter two years prior to the coverage year," which will then be used to "select a benchmark in the third quarter two years prior to the coverage year." Thus, for 2014 a state would use enrollment data from the first quarter of 2012 to determine the plans and policies that meet the size qualifications and would select a benchmark plan in the

[41] HHS released a Bulletin on Friday, February 24, 2012 that addressed cost sharing and actuarial value, available at http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.
[42] The Bulletin did not specify for the two benchmark options, the state employee health benefits plan and the FEHBP, whether these plans can be insured versus self-insured. For example, in California the largest state employee health plan by enrollment may be a self-insured California Public Employees' Retirement System plan, which would, in such case, be exempt from existing state health insurance benefit mandates.
[43] ACA 1311(d)(3)(B)

third quarter of 2012.[44] If a state does not choose a benchmark plan, HHS proposes that the default benchmark plan will be the small group plan with the largest enrollment in the state. HHS proposes this approach for 2014 and 2015, intending to assess the process for 2016.[45]

Benchmark Plan Approach to Defining Essential Health Benefits: Potential Interaction with State Benefit Mandates

If the regulatory approach proposed in the Bulletin is followed, states will need to identify the benchmark plan options in their state, which can be a complex task.[46,47] As these benchmark plan options relate to existing state benefit mandates, whether the coverage for an existing mandate will be included in the EHBs will depend on the benchmark plan the state selects. Each of the benchmark plan options will include or not include a differing set of state benefit mandates.

Given the complexity of establishing the differing benchmark plan options available for a state to choose from, and thus identifying the various possible EHBs for a state, it is challenging as of now to definitively say which state benefit mandates would be included and which not for each of the benchmark options. However, we can use the following framework to begin to understand how state benefit mandates may possibly interact with the different benchmark plan options. A state benefit mandate will:

- Probably fall *within* the selected benchmark plan option;
- Probably fall *outside* the selected benchmark plan option;
- Be *unclear* as to how it will relate to the selected benchmark plan option; or
- Probably *not interact* with the selected benchmark plan option.

Looking again at a treatment component of one of the state benefit mandates discussed previously—applied behavioral analysis coverage for autism[48]—we can assess how this component of one of California's state benefit mandates may potentially interact with the differing benchmark plan options (see Table E below).

[44] HHS released a document, *Frequently Asked Questions on Essential Health Benefits Bulletin,* in February 2012 available at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf, which clarified that the benchmark plan selected in 2012 for 2014 and the resulting EHBs would also be the benchmark plan and EHBs in a state in 2015. Thus, there would be a consistent set of benefits across these two years.

[45] The Bulletin was open for public comment through January 31, 2012. Given CHBRP's neutral role, CHBRP submitted questions about the Bulletin, rather than comments on the overall approach laid out in the Bulletin. The questions submitted to HHS on the Bulletin are available on CHBRP's website here: http://www.chbrp.org/documents/cciio_bulletin.pdf.

[46] For example, in California, CalPERS—the state employee health benefits plan—covers local governmental entities, California State University employees, and state employees. An analysis of state employee enrollment may require a deeper dive to determine which of the three CalPERS HMO and three CalPERS PPO plans are the appropriate benchmark to consider.

[47] CCIIO released a document, *Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State*, that provided information on the products with the three largest enrollments in the small group market in each state using data from HealthCare.gov, available at http://cciio.cms.gov/resources/files/Files2/01272012/top_three_plans_by_enrollment_508_20120125.pdf.

[48] Applied behavioral analysis coverage for autism is a component of a California benefit mandate that requires DMHC-regulated plans and CDI-regulated policies (with the exception of health insurance provided to Medi-Cal beneficiaries through contracts with DHCS) to provide coverage for behavioral intervention therapy, including applied behavioral analysis, for pervasive developmental disorders or autism, at parity with other benefits.

Table E. The Potential Interaction of Essential Health Benefits with a California Benefit Mandated Treatment—Applied Behavioral Analysis for Autism

Essential Health Benefits	Potential Interaction of Essential Health Benefits with Mandated Treatment: Applied Behavioral Analysis for Autism
10 ACA EHB categories	Unclear
HHS' proposed regulatory approach for 2014-2015	
Benchmark plan option 1: Small group insurance product	Within
Benchmark plan option 2: State employee health benefits plan—CalPERS HMO	Unclear
Benchmark plan option 2: State employee health benefits plan—CalPERS self-insured PPO	Outside
Benchmark plan option 3: FEHBP	Outside
Benchmark plan option 4: Largest commercial HMO	Within

Benchmark plan option 1: small group insurance product
If one of the three largest small group insurance products is chosen as the benchmark plan, it is likely that the mandate requiring coverage for applied behavioral analysis for autism would be included in the EHBs. The small group market in California, both the portion regulated by DMHC and the portion regulated by CDI, are subject to state-level benefit mandates, unless explicitly exempted from the mandate. DMHC-regulated plans and CDI-regulated policies in the small group market are required to provide coverage for this benefit mandate, thus this mandate would likely fall *within* the EHBs if this were the benchmark plan option chosen in the state.

Benchmark plan option 2: state employee health benefits plan
In California, CalPERS—the state employee health benefits plan—includes both HMO plans as well as self-insured PPO plans. Assuming the benchmark plan is solely based on enrollment, and not whether a plan is insured or self-insured, the benchmark plan could be either of these options. In our analysis here, we look at CalPERS HMO and CalPERS PPO plans separately, as state benefit mandates inclusion in the EHBs may differ depending on whether it was an HMO or a PPO plan selected within this benchmark plan option.

- CalPERS HMO: CalPERS HMO plans fall under DMHC regulation and are subject to state benefit mandates, but the mandate requiring coverage for applied behavioral analysis for autism exempted CalPERS HMO plans. However, an older mental health mandate requiring coverage for severe mental illness (previously discussed) mentions behavioral health and does not exempt CalPERS HMOs. This older mandate leaves coverage for applied behavioral analysis for autism *unclear* if this were the selected benchmark.

- CalPERS self-insured PPO: Self-insured plans are not subject to state-level mandates, and thus a CalPERS self-insured PPO is not required by California mandate law to provide coverage for applied behavioral analysis for autism so this benefit mandate would probably fall *outside* the EHBs. In general, as self-insured plans are not subject to state benefit mandates, if this benchmark plan option were selected no state benefit mandates would be included in the EHBs.[49]

[49] While state benefit mandates would not be included in the EHBs as defined by a self-insured plan, this does not mean that some services or treatments required by state benefit mandates would not be in the EHBs. Self-insured plans independently will cover some of the services and treatments required by state benefit mandates and will not cover others. Whether a particular service or

Benchmark plan option 3: FEHBP
Like a CalPERS self-insured PPO, FEHBP plans are not subject to state-level benefit mandates, and thus coverage for applied behavioral analysis for autism would most likely fall *outside* EHBs defined by this benchmark option. And, like a CalPERS self-insured PPO, if this benchmark plan option were selected, no state benefit mandates would be included in the EHBs.

Benchmark plan option 4: largest commercial HMO
In California, it is likely that the largest insured commercial non-Medicaid HMO in the state will be in the large group market. Like the small group market, the large group market is subject to state-level benefit mandates, unless explicitly exempted from the mandate. DMHC-regulated plans and CDI-regulated policies in the large group market are required to provide coverage for applied behavioral analysis for autism, thus this mandate would likely fall *within* the EHBs if this were the benchmark plan option chosen in the state.

Benchmark Plan Approach to Defining Essential Health Benefits: Additional Complexities

Without final guidance from HHS on defining the EHBs and without knowing the benchmark plan option the state would select, it is challenging to identify which state benefit mandates, if any, would be included in the EHBs. Moreover, there are further complexities that make assessing the potential interaction of state benefit mandates with EHBs even more challenging, such as the potential fiscal costs for states, when EHBs are set, and the permitted level of flexibility in benefit design.[50]

Fiscal costs for state benefit mandates
Adding to the complexity of how existing state benefit mandates will interact with the EHBs is the provision of the ACA related to fiscal costs for these mandates. Beginning in 2014, enrollees in the individual or small group markets who purchase health insurance through the exchange will qualify for federal tax subsidies. The ACA requires that states bear the additional cost for any state benefit requirements that go beyond the defined EHBs.[51] Assessing the potential for state costs will require additional understanding and/or guidance on:

- The number of enrollees in QHPs;
- The benefits covered within the selected state benchmark plan;
- Which benefits will be considered part of the EHBs and which benefits are considered as being "in addition to" the EHBs;
- What populations will be enrolled in plans and policies subject to EHBs and state mandated benefits;
- The specific formula that will be used to calculate a state's liability; and
- How "costs" and "payments" for additional benefits are defined.

As previously discussed, the flexibility HHS intended to provide with the benchmark plan approach provides states the option of choosing a benchmark plan for 2014 and 2015 that includes at least some state benefit mandates, waiving the requirement that a state defray the

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treatment will be included in the EHBs defined by a self-insured plan will depend on what benefits are and are not covered by the selected plan. As of last year, applied behavioral analysis for autism was not covered within a CalPERS self-insured PPO plan; see CHBRP's report, *Analysis of Senate Bill TBD 1: Autism*, available at http://www.chbrp.org/docs/index.php?action=view.
[50] Listed in this issue brief are only a few of the complexities in the Bulletin. CHBRP's questions submitted to HHS on the Bulletin contain a more complete list of questions, available on CHBRP's website here: http://www.chbrp.org/documents/cciio_bulletin.pdf.
[51] ACA Section 1311(d)(3)(B)

cost for those mandates. While no information is currently known on defraying the costs of state benefit mandates outside the EHBs, it is likely that, similar to the estimates CHBRP makes when assessing the costs of potential new state benefit mandates,[52] the costs of state benefit mandates outside the EHBs would probably be of marginal impact. However, given the potential for additional costs to the state of benefit mandates outside the EHBs, states have some incentive to select a benchmark plan inclusive of state benefit mandates.

Additionally, the Bulletin states that a state will need to select a "benchmark in the third quarter two years prior to the coverage year." Thus, for coverage year 2014 the baseline would be the third quarter of 2012. Given that the Bulletin does not address how state fiscal responsibility will be determined, it may pose a further challenge for states if they have to select a benchmark plan before having an understanding of how they will need to defray the costs for those mandates that fall outside the EHBs.

Essential health benefits defined in time: first quarter two years prior to the coverage year
According to the Bulletin, a state will use enrollment data from the first quarter two years prior to the coverage year to define the "plans and products" within each benchmark plan option and will chose their benchmark plan option in the third quarter of that year. From the Bulletin, and in additional guidance released by CMS, *Frequently Asked Questions on Essential Health Benefits Bulletin*,[53] it appears that the benefits covered as of the first quarter two years prior to the coverage year will be the benefits covered in the coverage year, and thus the EHBs. Therefore, a state would select a benchmark to define the EHBs in their state for 2014 based on the benefits covered in the first quarter of 2012, and these benefits would be the EHBs. The *Frequently Asked Questions on Essential Health Benefits Bulletin* clarified that any state benefit mandates enacted after December 31, 2011, would not be part of the EHBs for 2014 or 2015. These state benefit mandates would fall outside the EHBs and would appear to be subject to the requirement that states defray the cost of benefit mandates outside the EHBs.[54]

Benefit design flexibility
As laid out in the Bulletin, HHS intends to provide additional flexibility in how a health plan meets the EHB coverage standard. A health plan will be required to offer benefits that are "substantially equal" to the benefits of the benchmark plan selected by a state. HHS proposes that a health insurance issuer "have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories."[55] This flexibility, HHS notes, will provide greater plan choice to consumers and promote innovation, while ensuring a certain level of benefits are covered. However, this approach may also allow for greater variation in covered benefits between plans and policies required to cover EHBs.

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[52] Further information on CHBRP's methods for assessing the cost impacts of proposed benefit mandate or repeal bills is available on CHBRP's website here: http://www.chbrp.org/costimpact.html.
[53] CMS, *Frequently Asked Questions on Essential Health Benefits Bulletin*. Available at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. Accessed February 17, 2011
[54] This appears to be true, unless a state selected a benchmark option where the benefits were already covered, in which case the mandate may not exceed EHBs, and depending on the overlap with the new mandate, may not be subject to the requirement that states defray the cost of benefits outside the EHBs.
[55] CCIIO, *Essential Health Benefits Bulletin*. Available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. Accessed December 16, 2011.

Recent California benefit mandate language

In 2011, legislators in California began to add language to some benefit mandate bills that addresses how the mandate would interact with the EHBs come 2014. Some bill language would eliminate the mandate if it fell outside the EHB definition and other bill language would eliminate the mandate if the state were to incur fiscal costs for the mandate. For example, in the case of the new benefit mandate for coverage for behavioral intervention therapy, including applied behavioral analysis, for pervasive developmental disorders or autism, the law states that no benefits are to be provided that fall above the definition of the EHBs. If the chosen benchmark does not include coverage for this therapy, coverage requirements could be eliminated in California, subject to regulatory interpretation.

CONCLUSION

This issue brief aimed to outline the complexities of state benefit mandates, and to demonstrate how state benefit mandates may interact with essential health benefits as defined in HHS' Essential Health Benefits Bulletin. The regulatory approach to defining EHBs proposed in the Bulletin leads to a number of different potential EHBs. While each of the benchmark plan options is based on a "typical employer plan," and may be similar, how they interact with state benefit mandates is different. Some benchmark plan options may include a number of state benefit mandates, whereas others will have none. On a broad level, the benchmark options may provide some level of coverage for the same or a similar set of conditions or diseases, but the tests, treatments, and services within each benchmark plan may be different, depending on the state benefit mandates included or not included in the selected benchmark plan.

This issue brief looked at a single component of a multifaceted California state benefit mandate in assessing how state benefit mandates may potentially interact with a given benchmark plan option. California has 53 state benefit mandates that CHBPR is aware of. Each of these benefit mandates applies to a varying *and* overlapping set of products and markets in the state, and requires coverage for a specific set of tests, treatments, and services for a given condition or disease. To understand how state benefit mandates will interact with each benchmark plan would require an in-depth analysis of all 53 state benefit mandates, looking at the products and markets to which they apply, the conditions and diseases they address, and the tests, treatments, and services for which they require coverage. This in-depth understanding of how state benefit mandates would interact with the benchmark plan options in California is not currently known.

HHS has not released final guidance on defining the EHBs, nor has guidance been released on how states will defray the costs of state benefit mandates that fall outside the EHBs. Assuming HHS' proposed regulatory approach is followed for defining the EHBs, until California selects a benchmark plan, what state benefit mandates, if any, will be included in the EHBs for 2014 and 2015 in California is unknown, as is the potential cost to the state of benefit mandates outside the EHBs. As further guidance is released and decisions are made around EHBs on the federal and state level, CHBRP will continue to assess how state benefit mandates may interact with EHBs through an update to this issue brief or through other means.

APPENDIX A. COMPARISON: BENEFIT MANDATE ELEMENTS OF TWO STATE-LEVEL MANDATES

Mandate	Coverage for severe mental illness[56]	Coverage for behavioral health treatment for autism[57]
Coverage required for conditions or disorders	Severe mental illness (SMI), defined as including: • Schizophrenia • Schizoaffective disorder • Bipolar disorder (manic-depressive illness) • Major depressive disorders • Panic disorder • Obsessive-compulsive disorder • Pervasive developmental disorder or autism (PDD/A) • Anorexia nervosa • Bulimia nervosa For children, serious emotional disturbances (SED), defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code	Pervasive developmental disorder or autism (PDD/A), explicitly defined by reference to SMI mandate
Coverage required for tests, treatments, and services	Coverage for diagnosis and treatment of SMI and (in children) SED, defined as including: • Outpatient services • Inpatient hospital services • Partial hospital services • Prescription drugs (if the plan/policy includes coverage for prescription drugs)	Behavioral health treatment for PDD/A, defined as including: • Applied behavioral analysis • Evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet a specified criteria
Specified terms for required coverage	Required benefit coverage must be in parity with other benefit coverage	Requires—implicitly, through reference to SMI mandate—benefit coverage to be in parity with other benefit coverage
Other	Exempts health insurance: • Purchased by the state for Medi-Cal beneficiaries	Exempts health insurance: • Purchased by the state for Medi-Cal and Healthy Families beneficiaries • Purchased by CalPERS Specifies that benefits that exceed essential health benefits as defined by the Affordable Care Act are not required

[56] California Health and Safety Code 1374.72 and California Insurance Code 10123.15 and 10144.5
[57] California Health and Safety Code 1374.73 and California Insurance Code 10144.51 and 10144.52

APPENDIX B. FEDERAL BENEFIT MANDATES

Federal benefit mandates, like state benefit mandates, generally apply to both the individual and group markets, unless a market is specifically excluded from the federal benefit mandate coverage requirement. However, federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans. There were federal benefit mandates in place prior to the passage of the ACA, and the ACA added federal benefit mandates that apply to many, but not all, DMHC-regulated plans and CDI-regulated policies in the individual and group markets in California. CHBRP's document *Health Insurance Benefit Mandates in California State Law*[58] lists the federal benefit mandates currently known to CHBRP.

Federal Benefit Mandates Prior to the Affordable Care Act

CHBRP is aware of four federal benefit mandates that were in effect prior to the ACA:[59]

- The Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act (Pregnancy Discrimination Act);
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act);
- The Women's Health and Cancer Rights Act (WHCRA); and
- The Mental Health Parity and Addiction Equity Act (MHPAEA).

For these federal benefit mandates, the mandate applies to the group market,[60] and only applies *if* coverage for the service or treatment is part of the health plan or policy. For example, the Newborns' Act does not require that a group plan or policy cover maternity, but, if maternity coverage is provided, a minimum length of stay in a hospital following childbirth is required.

Federal Benefit Mandates in the Affordable Care Act

The passage of the ACA added additional federal benefit mandates to products in the individual and group market, with the exception in some cases of grandfathered health plans.[61] These new federal benefit mandates include:

- Prohibitions on lifetime and annual limits on the dollar value of benefits for any individual.[62]
- Where emergency services are provided, requirements that the services are provided: regardless of whether the provider is in or out of network; with the same cost-sharing levels in network as out of network; and without prior authorization.[63]
- Prohibition on requiring prior authorization or referral before covering services from a health care professional who specializes in obstetrics or gynecology.[64]
- Prohibition on denying coverage for children with preexisting conditions.

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[58] Available at http://www.chbrp.org/publications.html.
[59] There may be other federal benefit mandates that are not included in this list. The federal health insurance benefit mandates discussed in this issue brief most closely align with the definition of benefit mandates in CHBRP's authorizing statute.
[60] How the group market is defined for federal benefit mandates does not always align with how the group market is defined for state benefit mandates. For example, the Newborns' Act applies to group plans with 15 or more people.
[61] Some of the new federal benefit mandates in the ACA do not apply to grandfathered health plans (ACA Section 1251).
[62] ACA Section 1001 modifying Section 2711 of the Public Health Services Act (PHSA)
[63] ACA Section 1001 modifying Section 2719A of the PHSA
[64] ACA Section 1001 modifying Section 2719A of the PHSA

- Prohibition on denying coverage to anyone with a preexisting condition in 2014.[65]
- Requirements for coverage of specified preventive health services without cost sharing,[66] including:

    - Evidence-based items or services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF)[67];
    - Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)[68];
    - Infants, children, and adolescents of evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)[69]; and
    - Preventive care and screenings for women provided for in comprehensive guidelines supported by HRSA.[70]

In addition to these new federal benefit mandates in the ACA, the ACA also expands the Mental Health Parity and Addiction Equity Act by applying it to qualified health plans offered in a state's exchange "in the same manner and to the same extent as such section applies to health insurance issuers and group health plans."[71] The ACA further expands MHPAEA to include the individual market and the small group market, which were previously excluded from this parity requirement.[72]

The Interaction of Federal and State Benefit Mandates

Just as state benefit mandates vary and overlap with each other, federal benefit mandates and state benefit mandates also vary and overlap across products and markets, as well as conditions and disorders addressed by the benefit mandate. For example, the federal Newborns' Act requiring a minimum length of stay in a hospital following childbirth, if maternity services are covered, is very similar to a California state benefit mandate. However, the DMHC-regulated plans and CDI-regulated policies subject to these mandates vary and overlap, as Figure 3 demonstrates. It is important to note that plans and policies subject to both state and federal benefit mandates must meet or exceed the more demanding benefit mandate, whether that is the state benefit mandate or the federal benefit mandate.

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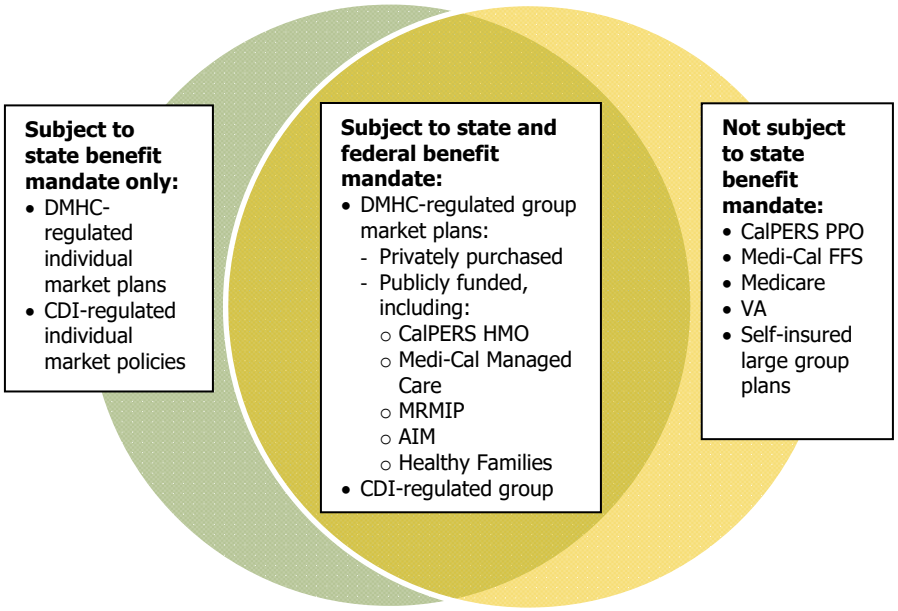
[65] ACA Section 1201 modifying Section 2704 of the PHSA
[66] ACA Section 1001 modifying Section 2713 of the PHSA
[67] A list of the USPSTF A and B recommendations is available here: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
[68] A list of the immunizations recommended by the ACIP is available here: http://www.cdc.gov/vaccines/pubs/ACIP-list.htm.
[69] Comprehensive guidelines for infants, children, and adolescents supported by HRSA appear in two charts: the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available here http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf; and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available here http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf.
[70] A list of the guidelines supported by HRSA for women's preventive care and screening is available here: http://www.hrsa.gov/womensguidelines/.
[71] ACA Section 1311(j)
[72] ACA Section 1563(c)(4) modifying Section 2726 of the PHSA

Figure 3. Minimum Length of Stay Following Childbirth Benefit Coverage Requirements in California



APPENDIX C. THE TEN ESSENTIAL HEALTH BENEFIT CATEGORIES: POTENTIAL INTERACTION WITH STATE BENEFIT MANDATES

The breadth of the 10 EHB categories has challenged states in their attempt to understand how their state benefit mandates will interact with the ACA-defined EHB categories. However, one mechanism for beginning to tease apart this complex issue is to do preliminarily analysis to assess whether a state benefit mandate may:

- Probably fall *within* the 10 ACA EHBs categories;
- Probably fall *outside* the 10 ACA EHBs categories;
- Be *unclear* as to how it will relate to the 10 ACA EHBs categories; or
- Probably *not interact* with the 10 ACA EHBs categories.

Using the above framework, we can assess how existing California mandates would probably interact with the 10 ACA defined EHB categories. Below are examples of several existing California mandates.

Maternity services: Probably within the EHBs
California has a few benefit mandates around maternity services that apply to portions of the regulated insurance markets not subject to the federal Pregnancy Discrimination Act (see Appendix B. One of the EHBs categories is maternity and newborn care. In this case, given the clear alignment of the EHB category with the state benefit mandates for maternity care, it is likely that these California mandates would fall *within* the EHBs.

Mammography: Probably outside the EHBs
Mammography screening would most likely fall within the EHB category of preventive and wellness services and chronic disease management, and so would likely be covered by EHBs to some extent. The ACA requires for breast cancer screening, mammography, and prevention that the USPSTF requirements prior to November 2009 be followed, which mandate screening for women 40 years or older.[73] A California state benefit mandate for CDI-regulated policies provides for a baseline mammogram for women aged 35 to 39, regardless of risk factors. While mammography will most likely be covered within the EHBs (or within the preventive services requirements to cover specific USPSTF recommendations—see Appendix B), the mandate for mammography for CDI-regulated policies would most likely fall *outside* the EHBs because of the age at which baseline screening is mandated to start.

Behavioral health treatment for autism and related disorders—coverage for applied behavioral analysis: Unclear
As previously discussed, DMHC-regulated plans and CDI-regulated policies, with the exception of health insurance provided to Medi-Cal beneficiaries through contracts with the Department of Health Care Services, will be required to provide coverage for behavioral intervention therapy, including applied behavioral analysis, for pervasive developmental disorders or autism, at parity with other benefits. One of the EHB categories is mental health and substance use disorder services, including behavioral health treatment. Looking again specifically at a treatment component of this overall mandate, coverage for applied behavioral analysis, applied behavioral analysis is a common behavioral health treatment for autism, but it is an expensive treatment. Whether it would be included in EHBs based on a "typical employer plan" is *unclear*. It is

[73] ACA Section 1001 modifying Section 2713 of the PHSA

possible that the definition of the EHBs may not be specific enough to establish whether coverage for applied behavioral analysis would be included or not included within this EHB category. Additionally, coverage for applied behavioral analysis has been contentious, and it is possible that the decision of whether applied behavioral analysis as a treatment for autism is included within the EHBs may be a decisions made by regulators or the courts, only then establishing a clear understanding of whether applied behavioral analysis is to be covered.[74]

Dementing illness exclusion prohibition: Probably not interact with the EHBs

A California mandate within both DMHC-regulated plans and CDI-regulated policies requires that, if a plan or policy covers long-term care facility services or home-based care, it cannot exclude individuals diagnosed as having dementing illness. The mandate does not require coverage for long-term care facility services or home-based care; it just mandates that a specific group of individuals cannot be excluded from these services if they are offered by a plan or policy. Because there is not a requirement for coverage within this mandate, it would most likely not interact with the EHBs, and would float to the side of the EHB definition, neither within nor outside, just *not interactive*. Additionally, it is likely that, as with applied behavioral analysis above, the definition of EHBs would not reach the level of specificity reached in this, and other, state benefit mandates, leaving a lack of clarity around how some state benefit mandates would interact with the 10 ACA EHB categories.

[74] It appears that DMHC and CDI have largely determined that applied behavioral analysis is a covered treatment for pervasive development disorder or autism. However, at the time CHBRP released the report, *Analysis of Senate Bill TBD 1: Autism* in 2011 available here http://www.chbrp.org/docs/index.php?action=view, it was not clear whether applied behavioral analysis was a covered treatment.

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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