DC Health Benefit Exchange Authority

February 4, 2013

# Recommendations of the Working Group on Essential Health Benefits (EHBs) to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Essential Health Benefits Working Group Chair (Dr. Saul Levin) and Vice Chair (Kevin Dougherty). The purpose of this report is to outline the recommendations of the Essential Health Benefits Working Group regarding Mental Health/Substance Abuse Parity (referred to in this report as Behavioral Health), habilitative services, prescription drug formulary requirements, and substitution of benefits.

## Background

Beginning in 2014, individual and small group health plans will be required under the Affordable Care Act to offer a standardized benefit package based upon a benchmark plan. A benchmark plan must include benefits in ten categories identified by the Department of Health and Human Services. These ten categories are:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment (to comply with federal mental health parity)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management and
10. Pediatric services, including oral and vision care

Each state must select a benchmark plan that reflects the scope of services offered by a typical employer plan. The benefits and services included in the benchmark plan will be the state's Essential Health Benefits. This benchmark plan will be used for two years. Health plans must provide benefits that, among other things, are substantially equal to the benchmark plan, including covered benefits and limitations on coverage (including amount, duration, and scope). States must "defray the cost" of any

state mandate that exceeds essential health benefit coverage when the coverage is purchased through the Exchange. This includes any mandates taking effect after January 1, 2012.

The District of Columbia selected the largest small group plan available in the District, BlueCross BlueShield CareFirst Blue Preferred PPO Option 1, as its benchmark plan. The pediatric dental and pediatric vision benefits have been supplemented by the FEDVIP BlueVision plan and FEDVIP MetLife plan.

The Exchange Board established a working group of stakeholders to review several outstanding policy issues related to the Essential Health Benefit benchmark selection and make recommendations to the Board. These outstanding issues include: questions of parity with the mental health and substance abuse benefit; the coverage of habilitative services; clarity on the drug formulary; and substitution of benefits.

**Behavioral Health Parity**

The Affordable Care Act requires that the Mental Health Parity and Addiction Equity Act apply to all qualified health plans and individual and group plans beginning in 2014. The Mental Health Parity and Addiction Equity Act requires that applicable insurers that cover mental health and substance use disorder services cover such services at parity with their medical and surgical services. The CareFirst benchmark plan currently does not cover behavioral health benefits at parity with medical coverage.

The working group is charged with ensuring that essential health benefit coverage of behavioral health services meets parity, particularly how to address existing day and visit limits on inpatient mental health and substance abuse services and detoxification services included in CareFirst benefit summary.

**Habilitative Services**

The Affordable Care Act requires that adult habilitative services are covered as an essential health benefit. The Department of Health and Human Services has indicated that a state may determine which services are included in the habilitative services category, if habilitative services are not covered in the benchmark plan. If the state does not define which services are included in the habilitative services category, plans must provide benefits that are in parity with rehabilitative services or defined by the issuer and reported to HHS.

CareFirst offers a habilitative benefit that aligns with the District's current statutory definition of habilitative care, which defines it only for children 21 and younger. The working group must assess how the guidance from Health and Human Services impacts the existing definition of habilitative services and how to expand applicability beyond children.

**Drug Formulary**

The benchmark submission includes the CareFirst Blue Preferred Option 1 drug formulary. The Department of Health and Human Services is currently considering a standard that applies the Medicare Part D model to the ACA. Under this approach, plans must cover the categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes. If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary. Plans must cover the greater of:

- One drug in every category and class; or
- The same number of drugs in each category as the EHB benchmark plan

The Department of Health and Human Services is considering using the most recent version of the United States Pharmacopeia's classification system. Using a standardized classification system would facilitate review, analysis, and comparison among the drug formularies of different plans.

The Working group will review the CareFirst formulary and the number of drugs offered in each category. The working group will assess the need to modify the benchmark drug formulary.

**Substitution of Benefits**

The proposed rule from the Department of Health and Human Services permits substitution of benefits relative to the benefits defined by the benchmark plan, provided that the substituted benefit is actuarially equivalent to the benefit that is being replaced, is made only within the same EHB category, and is not a prescription drug benefit. A state has the option to enforce a stricter standard on benefit substitution or prohibit it completely.

The charge of the working group is to assess the pros and cons of substitution and make a recommendation to the board.

## Working Group Participants

The Essential Health Benefit Working Group is comprised of representatives from health plans, small business, community advocates, providers, agents, exchange staff, and one member of the exchange board.

Four meetings were held on February 18, 24, 29, and 30th. Each lasted 2.5 hours, with in-person and telephone conference calling.

List of Participants:

| Participant Name | Organization |
|---|---|
| Dr. Saul Levin (Chair) | District of Columbia Department of Health |
| Kevin Dougherty (Vice Chair) | National Multiple Sclerosis Society |
| Steve Geishecker | Whitman Walker Health |
| Erin Loubier | Whitman Walker Health |
| Stuart Spielman | Autism Speaks |
| Dr. Catherine May | Psychiatrist, and, Board Chair of the MSDC |
| Stephanie Laguna | Kaiser Permanente |
| Richard McCarthy | Kaiser Permanente |
| Dania Palanker | National Women's Law Center |
| Laura Meyers | Planned Parenthood of Metropolitan Washington DC |
| Lynne Pettey | Keller Benefit Services |
| Hannah Turner | Keller Benefit Services |
| Aarti Subramanian | The Psychiatric Institute Of Washington |
| Carol Desjeunes | The Psychiatric Institute Of Washington |
| Howard Hoffman | The Psychiatric Institute Of Washington |
| Brian Crissman | The Foundation for Contemporary Mental Health |
| Doreen Hodges | Family Voices of the District of Columbia |
| Jill Thorpe | AFrame Digital |
| Luis Padilla | Unity Health Care |
| Susan Walker | DC Coalition on Long Term Care |
| Lida Etemad | United Healthcare |
| Nicholas Rogers | United Healthcare |
| Colleen Cohan | United Healthcare |
| John Flieg | United Healthcare |
| Carmel Colica | United Healthcare |
| Troy Pelfrey | United Healthcare |
| Joseph Winn | Aetna |
| Cindy Otley | CareFirst |
| Tonya Kinlow | CareFirst |
| Kishan Putta | Advisory Neighborhood Commission |
| Flora Hamilton | Family and Medical Counseling Service |
| Peter Rosenstein | The American Academy of Orthotists and Prosthetists |
| Lindsey Steinberg | DC Behavioral Health Association |
| Gwen Melnick | GWCSW |

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| Jeremy Furniss | DC Occupational Therapy Association |
| Dr. Barry Lewis | HBE Advisory Board/MSDC |
| Sarah Hunt | Stateside Associates |
| Ron Swanda | Citizen/Advocate |
| Sonia Nagda | Office of the Deputy Mayor for Health and Human Services |
| Dr. Richard Levinson | District of Columbia Department of Health |
| Brendan Rose | Dept. of Insurance, Securities and Banking |
| Bonnie Norton | DC Health Benefit Exchange |

## Recommendations

1. **Behavioral Health (mental health and substance abuse):**
    a. **Charge:** To bring behavioral health benefits in the District's definition of essential health benefits into parity with coverage of other services under the benchmark plan's (CareFirst's BluePreferred PPO) benefits

    b. **Recommendation:** Behavioral health inpatient and outpatient services be covered without day or visit limitations to the benefit.

**Commentary:** There was no opposition voiced to the recommendation that the limitation in the benchmark plan on the number of covered inpatient days for behavioral health (60 days) be removed. On outpatient visits for behavioral health, the benchmark plan differentiates cost-sharing for the first 40 visits from remaining visits, and from office visits for other medical care.

Since essential health benefits do not encompass specific cost-sharing guidelines, the working group makes no recommendation on cost-sharing per se.

Nevertheless, there was considerable discussion of whether patient cost-sharing should be at parity with primary care or specialty care, where there is a distinction in cost-sharing between the two.

There was a sentiment expressed by many in the working group that cost-sharing for behavioral health be at parity with primary care (when copayments are lower for primary than specialty care). Conversely, some members of the working group voiced concerns about the impact on premiums and the elimination of the choice of different plan designs.

2. **Habilitative Services**
    a. **Charge:** To recommend a definition of habilitative services for essential health benefits which, by contrast with the District's existing definition of habilitative services for children only, meets the Affordable Care Act's prohibition on age discrimination**.**

    b. **Recommendations:**
        i. That there be no age restriction on eligibility for habilitative services.

        ii. That the National Association of Insurance Commissioner's (NAIC) definition of habilitative services be adopted, "Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."

        iii. That coverage of applied behavior analysis (ABA) be included as part of habilitative services.

**Commentary:** There was no opposition voiced to the recommendation to eliminate the age "discrimination" inherent in the District of Columbia's current mandate for pediatric habilitative services.

Further, because the District's existing definition of habilitative services does not cover adults, a majority of the working group wished to consider adopting an entirely new definition – rather than just remove the age limitation in the District's existing definition, and asked staff to research whether doing so might be considered a new mandate for which the District would have to pay. Staff reported back that a new definition would not result in a new mandate for the District.

A majority of the working group recommends a new definition of habilitative services (the NAIC definition quoted above) be adopted, with the intent being to build upon the District's current definition of habilitative services as a floor. The federal government has indicated that per their written guidance, the District would not have to pay for habilitative benefits under this new definition as an additional mandate.

Also, one member of the working group feels that the word "maintain" should be added to the habilitative definition, in keeping with the Consortium for Citizens with Disabilities (CCD) definition of habilitation (See Appendix I for all three definitions).

Citing concerns about affordability, some members of the working group were uncomfortable with recommending the NAIC definition over the District's existing definition with the age

limitation removed. Additional concerns were noted about singling out ABA: for example, what other therapies might be raised for specific inclusion? CareFirst opposed adding coverage of ABA to the definition of habilitative citing a need for more scientific research and the unknown cost impact (See communication from CareFirst in Appendix II).

A question of legal interpretation was also raised about the potential impact of expanding coverage requirements under essential health benefits on requirements for large group coverage in D.C. [The argument is that the ACA requires that a large employer who covers an essential health benefit has to cover services meeting the definition of that essential health benefits that apply to small groups. This was unknown to staff and several members of the working group. This issue is being researched in time for the Board meeting on February 7th].

3. **Prescription Drug Formulary:**
    a. **Charge:** To recommend how many prescription drugs should be required in each of the drug categories published by the Center for Consumer Information & Insurance Oversight (CCIIO) as part of the District's definition of essential health benefits.

    b. **Recommendation:** The drug formulary of every issuer of qualified health plans include at least the number of drugs listed in each category of the attached draft analysis of the benchmark plan's formulary (See Appendix III for the draft list of minimum number of drugs per CCIIO's categorization). CareFirst is currently finalizing the categorization of the formulary and a final copy will be distributed upon completion.

**Commentary:** The working group engaged in a lengthy discussion of coverage for long term interventions in behavioral health, such as Suboxone, and for injectables generally. Out of this discussion arose a number of concerns that the working group would like to share with the Board:

- As apparently is the case with CareFirst's formulary, long term medication-assisted treatment for opioid dependency should be a covered service.
- Clarity should be provided to providers and consumers of the coverage for injectables – specifically, whether they are covered in the prescription drug formulary or under medical services.
- Formularies for qualified health plans should be developed with input from practicing clinicians.
- The prior authorization process needs to be timely, so as to not discourage appropriate patient treatment and adherence to drug regimens.
- The working group is looking to CCIIO for guidance on the treatment of prescription drugs that do not fit into one of the USP drug categories.

Also, concern was raised about discrimination against transgender patients in accessing prescription drugs. CareFirst's formulary was compared to the AIDS Drug Assistance Program (ADAP) formulary, and all HIV/AIDS Drugs/Anti-Retrovirals are included.

Questions were raised by one member of the working group about other drugs that could not be found on the formulary (See Appendix IV). The working group did not go further to investigate these or other questions about the inclusion of specific drugs on the benchmark plan's formulary because this was not considered part of its charge; rather, doing so might well require considerable time and professional resources well beyond the composition of the working group.

4. **Substitution of Comparable Benefits:**
    a. **Charge:** To recommend whether or not the Board should allow issuers to do the following and, if so, under what conditions--substitute coverage of one service for another within a category of essential health benefits and without changing the actuarial value of coverage by virtue of the substitution.

    b. **Recommendation:** Issuers not be allowed to substitute coverage of one service or for another, at least for 2014.

**Commentary:** The ACA gives the exchange the authority to allow qualified health plans to cover some services instead of others in a benefits package. Substitution is only allowed within each of the ten categories of essential health benefits and not between categories, and substitution must not result in a diminution of the actuarial value of services covered. The example frequently cited is that, if the benchmark plan covers up to 20 visits each for physical therapy, speech therapy, and occupational therapy, another qualified health plan might cover up to 50 visits for all three categories combined. This substitution might better serve beneficiaries and/or accommodate differences in claims paying and reporting systems from issuer to issuer. Three options were laid before the group;

i. Allow qualified health plans to substitute one benefit for another within an essential health benefit category, subject to maintenance of actuarial value and approval of the exchange;

ii. Allow such substitution only under conditions and standards prescribed by the exchange; or,

iii. Prohibit benefits substitution completely for year 1.

Discussion:

(i). The arguments for the first position are that substitution might improve the efficiency or effectiveness of benefits, and/or that some individuals might simply prefer one set of interventions over another e.g., acupuncture or chiropractic over physical therapy, and so allowing for actuarially-neutral substitution increases choice without increasing costs.

(ii). The arguments for the second position are similar, with the added protection of limiting the circumstances in such substitutions. The arguments against the first position are that substitutions could be used to attract better health risks (or discourage sicker enrollees), and the arguments against the first two positions are that the exchange lacks the resources and time to review all such proposed changes and "sign-off" on their validity.

(iii). The arguments for the third position were largely predicated on the absence of a strong, credible case made for such flexibility. When asked for examples of reasonable substitutions, none were cited: the "usual case" is the one cited above about PT/ST/OT coverage, but since those are covered in the benchmark plans without limitations on the number of visits, this example was deemed irrelevant to the District's benchmark plan, and no other examples were cited.

Also, worries about risk selection among carriers and the exchange's workload in year-1 were cited as supporting standardization, at least in the exchange's first year. Finally, it was noted that Maryland had decided against allowing substitution at least for one year and, given the overlap of markets and health plans in the two jurisdictions, this was an additional reasons not to allow substitution. No one objected to the recommendation as phrased above.

**5. Ongoing review of the components of essential health benefits**

Finally, as a general observation the working group suggests that the Board consider establishing a process for ongoing review of the components of essential health benefits, as guidance from CCIIO and community standards of medical practice evolve.