January 24, 2012

DC Health Benefit Exchange Authority, Essential Health Benefits Working Group

Meeting Notes

Attendees: Bonnie Norton, Saul Levin, Kevin Dougherty, Steve Geishecker, Colleen Cohan, Sonia Nagda, Stuart Spielman, Catherine May, Stephanie Laguna, Lynne Pettey, Diana Palanker, Richard Levinson, Flora Terrell Hamillton, Susan Walker, Laura Myers, Brian Crissman, Jill Thorpe, Kishan Putta, Cora House, Louis Padilla, Gwen Melnick, Carol Desjeunes, Lida Etemad , Nicholas Rogers, Mila Koffman, John Fleig, Carmel Colica, Joseph Winn, Cindy Otley, Tonya Kinlow

Topic: DC HBE has selected CareFirst Blue Preferred Options 1 as the benchmark plan and identified four areas where additional decision-making needs to occur. The board is seeking a recommendation from this working group on the following items:

1. Mental Health & Substance Abuse Parity
2. Habilitative Coverage
3. Minimum Requirements for Prescription Drug Formularies
4. Substitution of Comparable Benefits

Mental Health & Substance Abuse Parity

The ACA requires all new small group and individual plans to cover mental health benefits at parity with medical and surgical benefits. Current CareFirst Benefit has visit or day limitations and different cost-sharing than medical benefits.

Options:

1) Bring mental health benefit up to parity
2) Substitute mental health benefit with another plan's benefit

Issues:

- Group expressed concern about coverage for substance abuse in particular and the need for this coverage to be equal with mental health coverage. Limitations on covered benefits often result in patients not seeking care. Methadone maintenance was specifically identified.
- In-patient mental health coverage should be in line with medical, including cost-sharing and any limitations.
- Request for unlimited coverage for co-occurring disorders.
- Request to balance concerns about cost of providing coverage with the costs of not providing coverage.
- Level of mental health coverage should not be diagnosis based.

Questions:

- What conditions are currently covered by the existing small group benefit? Any exclusions?

- Are there any means to cover care-coordination, whether in the EHB or otherwise?

Initial Recommendation: Benefit should be in complete equity with medical benefit.

Next Steps: Review existing benefit in small group and large group CareFirst plans. Craft final recommendation.

Habilitative Coverage

HHS has indicated in guidance that if habilitative services are not completely identified in the base benchmark, the state may determine the services included in the habilitative services category. If the state does not define, the plans must provide benefits that are in parity with rehabilitative services (including scope, amount, and duration) or allow the issuer to define the specific benefits included in the habilitative services category and report on that coverage to HHS. HHS will evaluate and further define these services in the future.

Options:

1) Define habilitative services benefit package
2) Define a habilitative services package in parity to that of the rehabilitative services packages
3) Allow issuers to define the benefits included in habilitative service in line with all federal or district rules

Issues:

- Habilitative coverage should include applied behavior analysis
- Significant racial and ethnic disparities exist in the recognition of autism spectrum disorders – how may the definition of habilitative services impact this.
- Potential issue that including “medically necessary” in a definition would not cover maintenance services.
- Would like to see services under habilitative defined like those services under rehabilitative.
- No age limits
- Concern of impact on cost if definition is too expansive

Questions/Requests:

- Compare D.C. and Medicaid definitions of habilitative coverage
- Review the definitions of habilitative coverage in other states
- Review approach to habilitative coverage in other states

Initial Recommendation: Seems group is leaning towards a defined benefit.

Next Steps: Review existing definitions and craft final; recommendation.

Minimum Requirements for Prescription Drug Formularies

Prescription drug must be covered at least the greater of

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

Drugs must be chemically distinct (e.g. two dosage forms in same strength and brand/generic equivalents would not be considered distinct).

Issues:

- Group had questions of how specific drugs were classified and/or covered under the benchmark plan
- Some members seemed to prefer a standardized formulary to be required across plans

Next Steps: Group needs to discuss where flexibility remains and frame initial recommendation.

Substitution of Comparable Benefits

EHB Working Group is charged with deciding whether to allow substitution of comparable benefits. Benefits substitutions

- Must be substantially similar (not clearly defined)
- Only allowed within categories, NOT across [Question – who is defining which services are bucketed into which categories]
- Doesn't apply to prescription drugs
- Must be actuarially equivalent with an actuarial certification
- States have the option to enforce a stricter standard on substitution or prohibit it completely

Issues:

- MD decided not to allow substitution of benefits
- Concern that standardization stifles innovation

Discussion was abbreviated due to time available.

Comments: UnitedHealth requested limited flexibility in substitution of benefits, specifically to allow for the same benefit in a different delivery format where there were amount or visit limitations.

Additional Questions

- Attendees requested clarity on additional questions submitted as comment on the benchmark plan.
    - Staff will work with CareFirst to answer/address.