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BULLETIN 13-02

Date: January 7, 2013

To: Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations ("Carriers")

Re: Essential Health Benefits Substitution Rules

The purpose of this Bulletin is to establish essential health benefits (EHB) substitution rules for non-grandfathered health benefit plans offered in the individual and small group markets for plan or policy years beginning on or after January 1, 2014. For the reasons described below, substitution of EHBs will not be permitted in the individual and small group markets for 2014. This approach will be reassessed for 2015.

Choice of EHB Benchmark Plan

In accordance with § 31-116 of the Insurance Article, on September 27, 2012, the Maryland Health Care Reform Coordinating Council (HCRCC) selected the CareFirst State of Maryland PPO State employee plan as its EHB benchmark plan, with liberal substitution for the *in vitro* fertilization (IVF) benefit included in that plan. In light of new guidance in a proposed rule on *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* ("proposed rule") released by the U.S. Department of Health and Human Services (HHS) in November 2012,[1] however, the HCRCC revisited that decision, and on December 17, 2012, selected the CareFirst BlueChoice HMO HSA Open Access plan from the largest small group product as Maryland's recommended base-benchmark plan. Additionally, as permitted by new federal guidance, the HCRCC recommended that all State-required benefits not covered by the base-benchmark plan be included in the EHB-benchmark plan for the markets in which they applied on December 31, 2011. Under this recommendation, two State-required benefits would continue to apply to plans in the individual market, but not in the small group market: (1) coverage of a hair prosthesis if hair is lost due to chemotherapy or radiation (Md. Code Ann. Ins. § 15-836; and (2) coverage of IVF services (Md. Code Ann. Ins. §15-810).[2]

[1] *See* 77 FR 70644 (Nov. 26, 2012) (to be codified at 45 C.F.R. pts. 147, 155, 156).
[2] More specific information about the benefits that will be required in the individual and small group markets for 2014 has been provided in Bulletin 13-1, issued on January 3, 2013.

Federal Requirements

According to the preamble to the proposed rule, the proposed EHB-benchmark plan approach, which would apply for at least the 2014 and 2015 benefit years, "would allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products." 77 FR 70648. The proposed rule prohibits discrimination in benefit design or in the implementation of benefit design based on "an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." 77 FR 70670 (proposed 45 C.F.R. § 156.125(a)). The proposed rule also specifies that to provide EHB benefits means that a health plan provides benefits that, among other things, are substantially equal to the EHB-benchmark plan, including covered benefits and limitations on coverage, including coverage of benefit amount, duration, and scope. 77 FR 70670 (proposed 45 C.F.R. § 156.115).

The proposed rule permits substitution of benefits relative to the benefits defined by the EHB-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.

77 FR 70670 (proposed 45 C.F.R. § 156.115 (b)(1)). The preamble to the proposed rule clarifies that a state has the option to enforce a stricter standard on benefit substitution or prohibit it completely. 77 FR 70651. HHS is seeking additional comment on "the tradeoff between comparability of benefits and opportunities for plan innovation and benefit choice" in response to its proposed approach to benefit substitution. *Id.*

Hearing Testimony

The Insurance Commissioner ("Commissioner") held a hearing on the subject of EHB benefit substitution on November 16, 2012. Comment was sought from carriers and other interested parties on the following four options:

1. Permitting substitution across the ten statutory EHB categories;[3]
2. Permitting substitution within EHB categories;
3. Permitting substitution among quantitative limits only; or
4. Permitting no substitution.

Comment also was requested on whether State mandates should be treated differently than other benefits when considering substitution, and the pros and cons of not permitting benefit substitutions for plan year 2014 subject to reassessment for purposes of plan year 2015.

Verbal or written testimony, or both, was provided by or on behalf of 74 individuals or entities, including consumer advocacy organizations, individual and institutional health care providers, provider professional associations, health benefit plan carriers, a carrier association,

[3] The hearing was held prior to the publication of the proposed rule. Substitution across EHB categories in not permitted under the proposed rule. 77 FR 70670 (proposed 45 C.F.R. § 156.115).

two producer associations, a drug manufacturer, and a State legislator. The following is a summary of the comments received on substitution rules generally[4] for plan years 2014 and 2015.[5]

Consumer advocates testified in favor of prohibiting EHB substitutions in order to preserve a uniform and transparent set of benefits for consumers. Mental health advocates also expressed concern about the ability to ensure that substitutions would not lead to discriminatory benefit design and carrier "cherry picking" of more favorable risks. According to consumer advocates, carriers will have sufficient flexibility to accommodate plan management needs, consumer choice, and innovation through physician networks, quality initiatives, and the provision of additional, cost-saving benefits, for example, without the need for substitution of EHBs as defined in the HCRCC-selected benchmark plan. Additionally, in the view of consumer advocates, there would be significant challenges in (1) developing any substitution rules that would maintain appropriate coverage and balance; (2) appropriately identifying the most important elements of an acceptable substitution from a consumer or carrier perspective; and (3) complying with all applicable requirements under the Affordable Care Act (ACA).

Carriers were less unified in their positions. Two carriers ─ CareFirst BlueCross Blue Shield and Kaiser Foundation Health Plan of the Mid-Atlantic States ─ advocated for a no substitution policy. Reasons for this position included, among others, that: (1) permitting EHB substitutions could perpetuate competition on the basis of risk avoidance, rather than quality, service, and price; (2) permitting EHB substitutions would compromise consumers' ability to make apples-to-apples comparisons in the marketplace; (3) the benchmark plan has a comprehensive benefit design, making it difficult to identify benefits not already covered to substitute for EHB benefits; and (4) substitution provides no cost benefit, because any substituted benefits must be actuarially equivalent to the benefits they replace.

Three carriers ─ CIGNA, United HealthCare, and Coventry Health Care of Delaware, Inc. ─ advocated for flexibility in benefit design, but differed in their proposed approaches to achieve that end. Two carriers preferred that substitution be allowed within and across EHB categories,[6] although one of those carriers expressed concern about the ability to effectively substitute benefits for IVF if that benefit were in the maternity and newborn care EHB category. The third carrier supported limited substitution within EHB categories, but only where the substitution could be demonstrated to accomplish the same goal or purpose as the original benefit (an approach identified by another of the three pro-substitution carriers as ambiguous and potentially problematic). The League of Life and Health Insurers advocated for "some level of benefit design flexibility," but did not identify a preferred approach to achieving that goal. Similarly, the Maryland Association of Health Underwriters and the National Association of

[4] A number of witnesses testified specifically on the "liberal substitution of the IVF benefit" incorporated in the HCRCC's initial selection of the CareFirst State of Maryland PPO State employee plan as Maryland's EHB benchmark plan. That testimony is not summarized in this Bulletin because the HCRCC's initial selection has been superseded by its subsequent selection of the CareFirst BlueChoice HMO HSA Open Access plan, with an overlay of State-mandated benefits not covered in the benchmark plan, including coverage of IVF in the individual market.

[5] The Essential Health Benefits Advisory Committee convened on November 9, 2012 and December 12, 2012, to discuss the choice of the benchmark plan, as well as the options for substitution of benefits. The views of its members regarding substitution of benefits appeared largely to reflect those expressed by participants at the public hearing held by the Commissioner.

[6] Under the proposed rule, issued several days after the hearing, substitution across EHB categories is not permitted. 77 FR 70670 (proposed 45 C.F.R. § 156.115).

Insurance and Financial Advisors of Maryland testified in favor of flexibility as a general princip

A number of nutritionists and dieticians, as well as the Maryland Academy of Nutrition and Dietetics and the Director of the Johns Hopkins Diabetes Center, testified in favor of coverage for medical nutritional therapy (and, presumably, in favor of EHB substitution if necessary to provide such coverage). The Maryland Acupuncture Society, on the other hand, opposed permitting EHB substitution.

A large pharmaceutical company was supportive of permitting EHB substitution, subject to certain rules to ensure that plans do not adjust services in a manner that discriminates against vulnerable consumers, including: (1) requiring carriers to identify each substitution and to submit an actuarial opinion certifying actuarial equivalence within the affected EHB category and of the plan overall in reference to the benchmark plan; (2) prohibiting substitution where the Commissioner finds that the resultant benefit design would discriminate against certain individuals; and (3) allowing a member to utilize the appeals and grievance process under Title 15, Subtitle 10A of the Insurance Article to obtain access to a medically necessary health care service that is covered by the EHB-benchmark plan, even if the particular benefit has been removed due to the substitution process.

Decision Regarding Substitution of Benefits

Having carefully considered all of the testimony in this matter, as well as the provisions of HHS's proposed rule, the Commissioner concludes as follows:

1. The option of substitution across EHB categories is prohibited by the proposed rule. 77 FR 70670 (proposed 45 C.F.R. § 156.115).

2. With regard to substitution within EHB categories, those carriers in favor of permitting such substitution offered no specific examples of actuarially equivalent within-category substitutions they may wish to make. The chosen benchmark plan has a comprehensive benefit design. If substitution within categories were permitted, in order to make such a substitution a carrier would be required to determine the EHB category to which the benefit belongs and then identify another benefit (i) in the same EHB category; (ii) that is not included in the benchmark plan; and (3) that is actuarially equivalent to the benefit being replaced. It is not clear that this would be practicable, or even possible, with respect to at least some categories. For example, as at least one carrier noted, it may not be possible to effectively substitute benefits for IVF if that benefit were determined to belong to the maternity and newborn care EHB category.

3. With regard to substitutions among quantitative limits only, there are very few benefits within the chosen benchmark plan that have limitations on the amount or duration of benefits.[7] The ability to increase a quantitative limit on one benefit as a substitution for

[7] The benchmark plan contains quantitative limits for the following benefits only: (1) outpatient rehabilitation visits; (2) outpatient cardiac rehabilitation visits; (3) chiropractic care; (4) skilled nursing care facility; (5) nutritional services; (6) hearing aids for children; (7) home visits following mastectomy; and (8) IVF benefits (IVF benefits would be applicable only to the individual market).

reducing a quantitative limit on a different benefit could result in effectively eliminating a benefit included in the EHB-benchmark plan. For example, if the chiropractic visit limit were substantially reduced in order to substantially increase the outpatient physical therapy visit limit, a person seeking chiropractic care may find the reduced visit limit for chiropractic benefits to result in a benefit that is not meaningful in relation to that person's needs. Such substitutions also may complicate consumers' ability to compare benefits across health plans.

4. The concerns suggested by nutritionists and dieticians that nutritional therapy would not be covered unless substitution were allowed appear to be moot, because nutritional services are covered under the selected base-benchmark plan.

5. The pharmaceutical company's recommendation that EHB substitution be permitted, but that any medically necessary benefit in the EHB-benchmark plan be covered, even if the benefit had been removed through the substitution process, appears contrary to the concepts of carrier flexibility and benefit choice underlying the idea of EHB substitution in the first instance.

6. The arguments in favor of prohibiting EHB substitution appear to outweigh those in favor of permitting it, at least for 2014. Further guidance is expected from the Secretary of HHS in a final rule governing the 2014-2015 transition period, and subsequently for plan years in 2016 and beyond. In the near term, standardization of EHBs will facilitate consumers' ability to compare plans and will enhance transparency. It also will reduce the risk of plan designs intended to "cherry pick" more favorable risks. Carriers will have opportunities for innovation and plan differentiation through features such as enhanced physician networks, quality initiatives, cost-sharing requirements, levels of care management, and additional, cost-saving benefits. For 2014, a no-substitutions approach will allow Maryland to build on coverage that already is widely available in the individual and small group markets, minimize market disruption, and provide consumers with familiar products.

For the reasons set forth above, substitution of essential health benefits in the individual and small group markets will not be permitted for 2014. The Commissioner will reassess this approach for 2015.

Questions about this Bulletin may be directed to the Life/Health Section of the Maryland Insurance Administration at 410-468-2170.

Signature on original
Therese M. Goldsmith
Commissioner