Qualified Health Plan Certification Advocacy: Essential Health Benefits Checklist

The Affordable Care Act (ACA) requires that certain health plans, including Qualified Health Plans (QHPs) offered on the marketplace, contain a core set of health care services known as the 10 Essential Health Benefits (EHB).[1] Before each plan year, the Centers for Medicare & Medicaid Services (CMS) and state insurance regulators review QHP applications for details on benefit design and provider networks, as well as other requirements. This QHP certification period (April 11 – Sept. 8, 2016 for 2017 plans) offers advocates an opportunity to weigh in with their state regulators on how QHPs can offer benefits that better follow the rules and intent of the ACA – protecting enrollees from high out-of-pocket costs for needed care while maintaining affordable premiums.

The following advocacy guide provides a background on EHB and a checklist of common problem areas that advocates can raise with their state regulators as they review plans for certification as well as for general monitoring purposes throughout the year. We understand that it is not feasible to address every issue and encourage advocates to focus on one or two that are most salient based on what consumer stories and complaints reveal.

Essential Health Benefits Background

Rather than establishing a national standard for how EHB should be designed, the ACA gave states the flexibility to choose a benchmark plan that serves as a model for all the state's QHP benefit packages. States that do not actively select a benchmark plan during the selection period default to the largest small-group plan in the state, based on enrollment. States that had an active selection process are able to modify and improve the benchmark plan to ensure a balanced scope of benefits, as well as compliance with federal rules.[2]

To date, CMS has asked states to select benchmark plans two times. States' first EHB benchmarks (applied to plan years 2014-2016) revealed deficiencies in some EHB categories and even instances of non-compliance with federal law. In the fall of 2015, CMS gave states the opportunity to select a new EHB benchmark that could better meet consumer needs for 2017 and beyond. Some states offered an active and transparent review process during which advocates could identify how the benchmark could work better for consumers. However, many states did not conduct an open review process, nor did they offer opportunities for stakeholders to weigh

[1] HealthCare.gov. Essential Health Benefits. Retrieved from https://www.healthcare.gov/glossary/essential-health-benefits/

[2] Rules include the Mental Health Parity Act of 2008; Section 1557 Non-Discrimination Regulations; Notice of Benefit and Payment Parameters and Letter to Issuers.

in, which may lead to 2017 benchmarks that perpetuate the previous year's problems. Although QHPs must adhere to all applicable EHB regulations and guidance – and should not carry over the problems in the benchmark – many plan benefit packages can still have deficiencies.

Apart from benchmark setting, consumer groups can work with state regulators during the annual QHP certification period to ensure that gaps in coverage and areas of noncompliance do not persist into the following plan year. This next section provides an advocacy checklist to help in that effort.

QHP Certification EHB Checklist

Leading up to the QHP certification period, advocates can identify benefit design problem areas by collecting consumer stories and encouraging consumers to submit complaints to state regulators and insurers. Whereas story collection illustrates the shortcomings of QHP benefit design, consumer complaints generate data for regulators and policymakers for monitoring and to use as evidence to take action. In addition, various consumer health or health advocacy organizations may have a sense of common issues, especially those related to specific populations (children's health, substance use disorders, mental health, people with disabilities, LGBT and women's health, just to name a few). State Departments of Insurance (DOIs) who are tasked with collecting consumer complaints and analyzing the QHP benefits template may also have information on common problems.

State DOIs enforce both state and federal laws regarding QHPs. Engaging with them to discuss common issues with QHPs is an important way to ensure that marketplace coverage is not falling short of federal and state laws, nor causing issues for consumers. Many state DOIs create checklists for internal use during the QHP certification process. In some states, like New York and Ohio, the DOI makes these checklists available online to help the public compare with the QHP benefits package and identify areas that may be problematic. Ask DOI staff if they are comfortable sharing their checklist publicly to improve transparency in the certification process. See this guide for more tips on working with your DOI.

The following sections can help build an advocacy checklist to use in discussions with your state regulator in charge of QHP certification.[3] This is a non-comprehensive list that is meant to be modified according to what is most significant for consumers in your state. Additionally, we know it is not possible to work on the entirety of all of these issues and encourage you to focus on those that are most viable in your state.

Non-discrimination

The ACA requires that benefits are provided without discrimination based on health condition, race, color, national origin, age, disability, sex, sexual orientation or gender identity.[4] State regulators could consider greater oversight on plan techniques, such as utilization management

[3] As necessary, CMS will enforce market-wide provisions in direct enforcement states (Alabama, Missouri, Oklahoma, Texas, and Wyoming).

[4] 45 CFR 155.120(c); 42 CFR 600.165; and http://www.hhs.gov/civil-rights/for-individuals/section-1557/section-1557-proposed-rule-faqs/index.html

policies, cost-sharing and substitution that may lead to discriminatory benefit design. Common discriminatory practice elements include:

- **Age limits.** CMS has cautioned that both issuers and states should look out for age limits on EHB that may be discriminatory when applied to services that have been found clinically effective at all ages. For instance, one state's benchmark plan provides eye exams only for children age 5 and older, while another state benchmark covers autism assessments only for children up to age 5 with autism.[5]
- **Waiting periods.** Issuers are not allowed to impose benefit-specific waiting periods for EHB which discriminate against individuals with significant health needs or present/predicted disability.
- **Women's access.** An analysis of QHPs showed that a vast majority of issuers have offered coverage that violates specific requirements of federal law across a range of women's health concerns. Please visit this resource and companion document by National Women's Law Center for more analyses on women's EHB coverage.
  - **Maternity coverage violations** include arbitrary limits on maternity benefits; excluding maternity coverage of dependents; missing services such as pre-/inter-conception, prenatal, delivery and postpartum care; and stricter coverage limits of emergency services outside of the plan's service area.
  - **Preventive services coverage violations** such as cost-sharing or arbitrary limits on women's preventive services[6]; coverage restrictions on breastfeeding support and supplies; and failing to cover all methods of birth control.
- **Transgender coverage and sex discrimination violations.** A majority of issuers do not cover services for the treatment of gender dysphoria.[7] In anticipation of section 1557 regulations addressing transgender care coverage, plans should not be permitted to have blanket exclusions for transgender medical services or deny coverage for primary/preventive/acute care services on the basis of the enrollee's gender marker registered with the plan. The same rules around other EHB should also apply to transgender medical services, where insurers should be required to have a qualified in-network provider available for gender transition-related services.

Pediatric Dental

The ACA requires that the pediatric dental EHB be either embedded in the QHP or offered as a stand-alone dental plan in the marketplace. While the pediatric dental benefit has to be offered, it does not have to be purchased if in a stand-alone plan. Thus, many families buying QHPs may be disincentivized to purchase a separate dental plan and then bypass the entire pediatric dental EHB. This approach differs from how medical benefits are offered, posing a number of challenges to children enrolled in QHPs:

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[5] Touschner, J. (December 2014). HHS Proposes EHB Rule Changes. *Georgetown University Health Policy Institute Center for Children and Families.* Retrieved from http://ccf.georgetown.edu/all/hhs-proposes-ehb-rule-changes/

[6] HealthCare.gov. Preventive care benefits for women. Retrieved from https://www.healthcare.gov/preventive-care-women/

[7] Keith, K. (March 2016). 15 States and DC Now Prohibit Transgender Insurance Exclusions. *Georgetown Center on Health Insurance Reforms. (March 2016). 15 States and DC Now Prohibit Transgender Insurance Exclusions*. Retrieved from http://chirblog.org/15-states-and-dc-now-prohibit-transgender-insurance-exclusions/

- **Affordability of stand-alone dental plans**. A stand-alone plan requires a family to pay a separate premium in which the family's premium tax credits do not apply unless there are tax credits in excess of the medical plan.[8] Although stand-alone dental plans tend to have first-dollar preventive coverage (the plan must pay these services before the enrollee has met the deductible) and a low separate deductible, their benefits may be limited in scope (such as for orthodontics or restorative services).[9]
- **Affordability with embedded dental plans**. Embedded dental plans protect families from two premiums but expose them to a single deductible (averaging $2,800) that may lead to higher out-of-pocket expenses for families with only dental needs. [10]Advocates can highlight the importance of embedded plans that have a much lower or entirely exempt dental deductible.
- **Consumer protections.** Stand-alone dental plans are exempt from a number of important consumer protections in the ACA including no-cost preventive services, cost-sharing reductions for families up to 250 percent of the federal poverty level, prohibition against denial of coverage for pre-existing conditions and right to an external appeals process. In order to receive a full range of consumer protections for pediatric dental benefits, the QHP would need to embed such benefits.[11]

Pediatric Vision

The biggest challenge with the pediatric vision benefit is the lack of comprehensive and consistent coverage across states.

- **Lack of comprehensive and consistent coverage**. Plans' annual limits and comprehensiveness vary dramatically state to state. In these cases, it is important to monitor complaints and collect consumer stories about restricted access to these services. The vision community and parent advocates can be important partners in identifying gaps in benefits for children.

Mental Health and Substance Use Disorders (SUD)

The Federal Mental Health Parity and Addiction Equity Act ("federal parity law") prohibits QHPs from discriminating in the coverage of mental health and SUD benefits. Despite these federal rules, some EHB benchmark plans contain parity violations that disadvantage consumers with behavioral health needs. Advocates could evaluate health plans for the following:

- **Annual dollar and/or aggregate lifetime limits.** Plans cannot impose annual or lifetime dollar limits on mental health and/or SUD benefits that are considered EHB. Such limits can be converted to actuarially equivalent treatment or service limits. However, the plan may not impose such limits only on mental health and substance use disorders treatment and services.
- **Quantitative treatment limitations.** Under the federal parity law, quantitative treatment limitations for covered behavioral health services cannot be more restrictive than for other medical or surgical services.

[8] Children's Dental Health Project. (February 2015). Buying Children's Dental Coverage Through the Marketplaces. Retrieved from https://s3.amazonaws.com/cdhp/Buying+Children%27s+Dental+Coverage+Through+the+Marketplace+(2015)
[9] Ibid
[10] Ibid
[11] Ibid

- **Authorization**. Plans often apply some authorization standards for all kinds of services. But if they require providers to obtain authorization for mental health and/or SUD services at earlier stages of treatment or with greater frequency (for example, every five outpatient visits), or they apply their authorization standards more restrictively to such services, then they are likely in violation of parity.
- **Court-ordered treatment.** Some plans exclude coverage for court-ordered treatment, treatment related to illegal activity or legal charges, or addiction services that are not "voluntary." Because the kinds of treatment affected are almost exclusively mental health and/or SUD services, plans applying these exclusions are very likely in violation of the federal parity law.

Habilitative Services and Devices

Before the ACA, habilitative services were excluded from private plans, which contribute to current benchmarks that may have limited to no coverage of this benefit. In addition to requiring its inclusion in EHB, CMS has responded to advocacy by creating a federal minimum definition for the habilitative services and devices benefit. For more information about how habilitative services can fall short for consumers, visit this American Occupational Therapists Association EHB report.

- **Compliance with federal minimum.** Beginning in 2016, plans must conform to a federal minimum definition for habilitative services or apply a state definition approved by CMS.[12] Advocates should ensure adherence to the federal definition and even push for a stronger state definition if there is traction. Because CMS has recognized that the habilitative services and devices EHB could keep changing with the advent of new medical technologies, there is flexibility for states to strengthen this definition without incurring additional costs.
- **Separate limits between habilitative and rehabilitative services and devices**.[13] Benefit packages must include separate limits on habilitative and rehabilitative services and devices. If limits for habilitative services and rehabilitative services are combined, advocates should push for that number to be applied to each, rather than splitting the number. Further, QHPs cannot impose limits on the coverage of habilitative services and devices that are less favorable than those imposed on rehabilitative services and devices. This will be particularly important for adults and children in need of these services to support their growth and development.
- **Age limits.** Attention should be given to inadequate coverage for services and devices such as wheelchairs and hearing aids as well as coverage only for specific conditions or the imposition of arbitrary age limits for services. These can elevate to an anti-

[12] Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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. Finalized by 2016 NBPP: https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf and found in CMS Glossary of Health Coverage and Medical Terms: https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf

[13] For more of the differences and examples between habilitative and rehabilitative services visit: National Disability Navigator Resource Collaborative. Fact Sheet #4: Rehabilitation and Habilitation Services and Devices. Retrieved from http://www.nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-4/

discrimination issue. Advocacy can be effective in eliminating arbitrary age limits commonly applied to the habilitative services benefit.

Prescription Drugs

Plans cannot discriminate against individuals through shifting drugs onto the highest cost-sharing tiers. Starting in 2016, plans must follow new prescription drug benefit requirements to guarantee appropriate coverage.[14]

- **Cost-sharing.** Plans cannot assign most or all drugs to the highest cost-sharing tiers. This practice, known as "adverse tiering," has been deemed a form of discrimination by CMS, which creates barriers to access for consumers with specific conditions.[15] Adverse drug tiering has been proven common for health conditions like HIV, cancer, schizophrenia, bipolar disorder, depression, rheumatoid arthritis, multiple sclerosis, Hepatitis C, diabetes and asthma.[16,17,18]
- **Availability**. Plans must include one drug in every United States Pharmacopeia (USP) category or class or the same number of prescription drugs in each category and class as the EHB benchmark plan.[19] Advocates and state regulators should monitor how existing EHB prescription drug requirements may be insufficient for consumers, especially with constantly evolving prescription drug technology. For example, gaps can occur when a QHP does not cover a single-tablet regimen or extended-release product for HIV patients and is just as effective as a multi-tablet regimen.[20]

Conclusion

As more people gain marketplace coverage, it is important that plans provide a scope of benefits that are meaningful and non-discriminatory to consumers. Advocates can use the QHP certification period to raise common issues with QHP benefit design to state regulators as part of a larger monitoring strategy to ensure that all consumers have a positive experience in choosing and using their health care.

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[14] NHeLP. (May 2015). Essential Health Benefits Prescription Drug Standard Issues #1-5. Retrieved from http://www.healthlaw.org/publications/browse-all-publications/EHB-Prescription-Drug-Standard-Formulary-Transparenc#.VxZTOvkrK70
[15] 45 CFR Parts 144, 147, 153. Available from: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.
[16] Avalere Health. (June 2014). An Analysis of Exchange Plan Benefits for Certain Medicines. Retrieved from http://www.phrma.org/sites/default/files/20140521_FINAL%20PhRMA_High%20Coinsurance%20and%20Tier%20Placement_Avalere%5B7a%5D_0.pdf
[17] Avalere Health. Exchange Benefit Designs Increasingly Place All Medications for Some Conditions on Specialty Tier. Retrieved from: http://avalere.com/expertise/life-sciences/insights/avalere-analysis-exchange-benefit-designs-increasingly-place-all-medication.
[18] Jacobs, D., Sommers, B. (January 2015). Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace, *New England Journal of Medicine, 372(5),* 399-402. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMp1411376
[19] 45 CFR 156.122
[20] 45 CFR 156.125